The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Public Trust Board of Directors' Meeting

Friday 23 May 2025, 10.15 – 12.15

Venue: Culture Centre Boardroom, Royal Victoria Infirmary

Agenda

Item		Lead	Paper	Timing
1.	Apologies for absence and declarations of interest	Paul Ennals	Verbal	10:15 – 10:16
2.	Minutes of the Meeting held on 28 March 2025 and Matters Arising	Paul Ennals	Attached	10:16 – 10:17
3.	Chair's Report	Paul Ennals	Attached	10:17 – 10:25
4.	Acting Chief Executive's Report	Rob Harrison	Presentation	10:25 – 10:35
Strategic items:				
5.	Patient and Staff Stories	Lee-Ann Naidoo	Attached	10:35 – 10:40
6.	Board Visibility Programme	Rachel Carter	Attached & Board Reading Room	10:40 – 10:50
7.	CQC update	Ian Joy	Attached	10:50 – 11:00
8.	Winter Plan Review	Sue Hillyard and Nichola Kenny	Attached	11:00 – 11:10
9.	Integrated Board Report	Patrick Garner	Attached	11:10– 11:25
	Refreshment break			***11:25 – 11:30***
Items to receive *[NB for information – matters to be raised by exception only]*:				11:30 – 11:50
10.	Director reports:			
	a. Joint Medical Directors Report including:	Michael Wright & Lucia Pareja-Cebrian	Attached	
	i) Guardian of Safe Working Report		Attached	
	b. Executive Director of Nursing update:	Ian Joy		
	i) Nurse Staffing Deep Dive		Attached & Reading Room	
	ii) Allied Healthcare Professions (AHP) staffing		Attached	
	c. Maternity:	Ian Joy & Jenna Wall		
	i) Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress report		Attached & Reading Room	

	ii) Maternity Safety Champion Report	Liz Bromley	Attached	
	d. Quality Account update	Rachel Carter	Attached	
11.	Committee Chair Meeting Logs	Committee Chairs	Attached	

Items to approve:

12.	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report	Vicky McFarlane-Reid	Attached	11:50 – 12:00
13.	Governance documents:			12:00 – 12:07
	i) Board Committee Annual Reports	Kelly Jupp	Attached	
	ii) Charity Committee Annual Report including Terms of Reference and Schedule of Business	Kelly Jupp	To follow	

Any other business:

14.	Meeting Action Log	Paul Ennals	Attached	12:07 – 12:10
15.	Any other business	All	Verbal	12:10 – 12:15

Date of next meeting:
Public Board of Directors – Friday 25 July 2025

Sir Paul Ennals, Interim Shared Chair

Mrs Liz Bromley, Non-Executive Director

Mr Rob Harrison, Acting Chief Executive

Mr Ian Joy, Executive Director of Nursing

Dr Michael Wright, Joint Medical Director

Mrs Lucia Pareja-Cebrian, Joint Medical Director

Dr Vicky McFarlane-Reid, Director for Commercial Development & Innovation

Mrs Rachel Carter, Director of Quality & Safety

Mr Patrick Garner, Director of Performance and Governance

Mrs S Hillyard, Interim Director of Operations

Mrs Nichola Kenny, Director of Improvement and Delivery

Mrs Jenna Wall, Director of Midwifery

Mrs Kelly Jupp, Trust Secretary

Ms L Naidoo, Improvement Programme Manager

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PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 28 MARCH 2025

Present:	Sir Paul Ennals *[Chair]*	Interim Shared Chair
	Mr R Harrison	Acting Chief Executive Officer [ACEO]
	Mr J Bilcliff	Chief Finance Officer [CFO]
	Dr M Wright	Joint Medical Director [JMD-W]
	Mrs L Pareja-Cebrian	Joint Medical Director [JMD-PC]
	Mr Ian Joy	Executive Director of Nursing [EDN]
	Dr V McFarlane Reid	Director for Commercial Development & Innovation [DCDI]
	Mr B MacLeod	Non-Executive Director (NED)
	Mrs L Bromley	NED
	Mr D Weatherburn	NED
	Mrs A Stabler	NED
	Mr B McCardle	NED
	Mr P Kane	NED
	Ms W Balmain	NED

In attendance:
Dr N Adetuberu, Associate NED
Mr M Wilson, Director - Great North Healthcare Alliance (GNHA) & Strategy [DG&S]
Mrs C Docking, Director of Communications and Corporate Affairs [DCCA]
Mrs R Carter, Director of Quality and Safety [DQS]
Mrs K Jupp, Trust Secretary [TS]
Mrs S McMahon, Chief Information Officer [CIO]
Mrs A Laverty, Chief Experience Officer [CXO]
Mr P Garner, Director of Performance and Governance [DPG]
Mrs D Watson, Acting Associate Director of People and Organisation Development [ADP]
Mrs J Wall, Director of Midwifery [DoM] *(for item 25/08 c. i))*
Ms J Taylor, Freedom to Speak Up Guardian [FTSUG] *(for item 25/07 iv))*
Mr J Dixon, Associate Director – Environmental Sustainability [ADES] *(for item 25/07 viii))*

Observers:
Mr M Bridge, GP and North Tyneside GP Fellowship Clinical Lead
Ms T Armstrong, Appointed Charity Governor
Mr G Davies, Co-founder, Director of Sales & Business Development – The Bravest Path
Professor P Home, Public Governor
Mr S Volpe, Health Reporter at the Chronicle
Mr R Purewal, Senior Healthcare Director c2-ai
Mr S Bailey, Healthcare Solutions Lead - NTT DATA UK & Ireland
Mr M Mathers, Correspondent - Health Service Journal

Secretary: Mrs L Thompson Corporate Governance Manager / Deputy Trust Secretary

Note: The minutes of the meeting were written as per the order in which items were discussed.

25/06 STANDING ITEMS:

The Chair welcomed all to the meeting and declared that the meeting will be recorded.

i) Apologies for Absence and Declarations of Interest

Apologies were received from Sir Jim Mackey, Chief Executive Officer, Mr H Kajee, NED and Mr P Hanson, Director of Estates, Facilities and Strategic Partnerships.

Mr MacLeod declared an interest that he is an appointed member of the Council, Newcastle University.

It was resolved: to (i) **note** the apologies for absence and that there were no new declarations of interest.

ii) Minutes of the previous meeting held on 31 January 2025 and matters arising

The minutes of the meeting held on 31 January 2025 were accepted as a true record of the business transacted.

It was resolved: to **agree** the minutes as an accurate record and to **note** there were no matters arising.

iii) Chair's Report

The Chair's Report was received for information.

The Chair highlighted the wide range of activity taking place between partners and the GNHA was gathering momentum which was encouraging for the NHS.

It was **resolved:** to **receive** the report.

iv) Acting Chief Executive's Report

The ACEO highlighted the following points:

- There had been changes within the Executive Team following the secondment of the CEO. He gave thanks to the Executive Team members for taking on additional roles in the interim.
- Mrs S McMahon, who leaves the Trust at the end of April, was thanked for all her contributions and work as CIO.

- Mr D Elliott, Chief Digital Officer and Mrs S Hillyard, Interim Director of Operations were welcomed to the team.
- With regards to Martha's Rule, this had now gone live across all adult services and was a positive step for people to raise any concerns.

  Mrs Stabler advised that the Quality Committee receives regular updates which will feed into Trust Board.
- In relation to improved operational performance, thanks were given to all staff involved in emergency pathways.
- There was a clear focus on reducing the cancer backlogs and improving diagnostic performance.
- Three more wards had now been accredited under the Accrediting Clinical Excellence programme. The EDN added that there were now 11 wards in total that had been accredited. Improvement plans were in place for those wards which did not achieve accreditation.
- The NHS England (NHSE) transition was noted.
- There was continued focus on quality improvement and the importance of the organisations approach within the resources available.

  The Chair expressed his gratitude to the ACEO and Executive Team members, who had all stepped up to take on additional roles following the secondment of the CEO. Systems had continued to operate as normal whilst Sir Jim moved to his interim role.

  Mr Kane sought clarification with regards to how the wards are monitored post accreditation to which the EDN advised that the Trust continued to monitor compliance and metrics which are reported to the Quality Committee. Inspection takes place within one year and the team were currently looking at incorporating research questions into the accreditation process.

  Mr Kane noted that the accreditation programme had been funded by Newcastle Hospitals Charity for two years.

  Mrs Bromley questioned if there were any concerns that the ACEO had and if the Board of Directors were fully sighted on these. The ACEO advised that the Board of Directors were fully sighted on significant issues for example the improvements to the governance structure, with the importance of transparency highlighted.

It was **resolved:** to **receive** the report.

25/07 **STRATEGIC ITEMS:**

i) **Patient and Staff Stories**

The CXO highlighted the following points:

- During March there had been a strengthened focus on Equality, Diversity and Inclusion (EDI).

- The first story was in relation to a patient living with Crohn's Disease and having had 90% of their bowel removed. It reflected the emotional impact and vulnerability, along with the importance of family and psychological support.

  The ACEO emphasised the importance of ensuring communications and support was clear, and available. The CXO agreed however highlighted that the patient had an overwhelming feeling of gratitude for their life being saved therefore it was more difficult to obtain learnings/identify areas for improvement.

  The ADP highlighted that she had personal family experience of an ileostomy procedure, being a unique procedure, and recommended reviewing whether pastoral support was available from external interest groups for these patients. The JMD-W explained that there was support available from third sector organisations.

  The Chair queried if support available from patient groups had reduced during the COVID pandemic to which the JMD-W advised that it had and would take time to recover.

  Mr McCardle noted the important role that friends, family and visitors play. The EDN highlighted the need to empower local leaders to make decisions on allowing visiting outside of standard visiting hours on an exceptional basis as appropriate.

  The Chair expressed his gratitude to the patient for sharing their story and noted the need to maximise the benefits of support.

- The second story was in relation to a staff member who took on the role of Chair of the Race Equality Network (REN). Board members had participated in a recent session with REN members on race.

  The story shared a reflection on hope and investment in leadership.

  The Chair highlighted the positive Board session that took place earlier in the week exploring our personal approaches to race and discrimination, which recognised the possibilities for hope and change.

  Mr McCardle thanked the staff member for sharing their story and noted the importance of working with all the staff networks who provide a rich source of insight.

  The DCDI referred to the significant effort from the staff network Chairs in driving positive change.

  Dr Adetuberu emphasised the importance of staff being accountable for their behaviours. She noted that behaviours must in line with the culture and values of the organisation, with a priority being for the Trust to be inclusive.

  Mr Kane queried if patients and staff could be invited to the Public Trust Board to talk about their experience in person or via Teams. The CXO noted that recordings had

been used previously but sometimes the timings were difficult to coordinate. Whilst noting that many patients would not feel comfortable in sharing their experiences in a public setting, it was agreed that the Executive Team would discuss whether patients/staff members should attend and present their own story or whether to revert back to using video recordings **[ACTION01]**.

The Chair commended the staff networks for their continuous hard work and highlighted that the Board of Directors need to own and be accountable for EDI.

It was **resolved:** to **receive** the Patient and Staff Story.

ii) Patient and Staff Experience including:

a. Patient Experience Right Time Results

The ACEO highlighted the importance of considering the impact that certain situations have on patients and staff, and the approach to improving quality. The patient experience programme was expanding, and responding to the staff survey feedback was noted to be very important.

The CXO highlighted the following points:

- The link between the Patient Experience Programme and the Accrediting Clinical Excellence (ACE) Programme.
- Feedback had been received from 40 wards within the organisation to date, with staff moral and wellbeing being key areas of feedback.
- Circa 70,000 people had been willing to provide feedback with regards to the quality of care across the organisation.
- There was an opportunity to map feedback and ensure this was included in the engagement.
- The feedback was encouraging in terms of culture for the organisation.
- The priorities for the next 12 months were included within the report.

Mrs Stabler noted her support for the programme and referred to the NED informal visits, explaining that the feedback she had received from wards on the patient experience programme was extremely positive and allowed improvements to be made to patient care more quickly. She highlighted the importance of triangulating with the staff survey results.

The EDN advised that further work was needed to look at the distribution of wards that had requested to be part of the second phase of the real time programme to ensure it was representative. It was agreed that the CXO and EDN would review the distribution of wards in phase two of the programme and consider any wards not yet asking to be included **[ACTION02].**

The CXO advised that learning can take place from Clinical Boards who use the intelligence to make a difference for example Surgical and Associated Services.

The JMD-W referred to the good quality patient feedback, and that work was taking place to link this with the medical and dental staff appraisal structure.

It was resolved: to **receive** the update.

b. Staff Survey 2024

The CXO highlighted the following points:

- The positive increase in response rate to 60%.
- The importance of capturing the learning.
- The statistical gains present in all domains which was encouraging.
- Further improvement was needed to strengthen the Trust's performance both regionally and nationally.
- The previous year on year decline in response rate had halted with an improved score in 83% of questions.
- There would be focussed attention on culture and EDI.
- There had been an increase in the levels of violence and aggression experienced by staff as referenced in the survey results.
- The feedback received has directly informed the year 2 people plan actions and data would be mapped as part of the plan.

The ADP explained that the data correlated with feedback from Corporate Services, Clinical Boards and staff networks.

Mr McCardle commended the excellent work that had taken place and noted that staff engagement was a key priority.

Mrs Bromley referred to the positive 60% improvement and asked if there were any key lessons learned to which the CXO advised that communicating stories as to why contributing to the staff survey mattered was important. I-Pads had been used on the wards to help staff who did not have access to technology, learning had been identified to highlight that this needed to be done earlier in the process. Circa 10,000 free text comments had been submitted which would be reviewed in detail.

The Chair advised that the increased staff engagement was positive however there was further improvement to be made. The People Committee were actively receiving updates in relation to the staff survey and EDI work.

It was resolved: to **receive** the update.

iii) Board Visibility Programme

The DQS explained that there was a robust process in place for ward/department visits which ran alongside the NED informal visits. The visits provided an opportunity for staff and patients to raise any concerns.

The report summarised the themes from the 12 visits held, with a more detailed report within the Trust Board Reading Room on AdminControl. Any urgent issues arising during the visits were escalated at the earliest opportunity, with staff appreciating the responsiveness.

Mrs Stabler advised she was assured that swift action was taken when necessary. For example, she attended an evening walkabout with Mr MacLeod and there were concerns with regards to discriminatory behaviour which she discussed with the EDN who acted straight away to look into the concerns. Feedback had been shared with the staff member who raised the concern and they had advised that the position had now improved.

Mr MacLeod advised that the programme had improved over the last 12 months and there was need to visit corporate services such as catering and domestics. Mr McArdle explained that he has visited some corporate teams but that further needed to take place.

It was agreed that the DQS would revisit the walkabout arrangements and provide an update at the next Public Trust Board meeting **[ACTION03].**

The Chair noted the benefit for staff with regards to the NEDs carrying out night visits in particular and the importance of triangulating all of the data received.

It was **resolved:** to **receive** the report.

iv) <u>Freedom to Speak Up Guardian (FTSUG) Report</u>

The Chair highlighted that this would be Ms J Taylor's last report to the Trust Board. He thanked the FTSUG for her work and wished her well in her new role.

The FTSUG highlighted the following points:

- The service had developed significantly and there had been an increase in activity over the last 12 months.
- A secure database was created in August 2024 to log concerns raised. In addition a confidential Power Business Intelligence (Power BI) dashboard had been created which was nearly ready to go live. Feedback would be provided to the Clinical Boards which would help them with targeted interventions.
- There had been a significant improvement in the reputation of the service which had led to several actions and feedback. CQC feedback had indicated the need to ensure the feedback loop was effective.
- The national Freedom To Speak Up (FTSU) policy had been adopted which was more user friendly.
- 11 FTSU Champions had been trained and there would be further development of this network to increase visibility. The aim of the role was to signpost to relevant processes as appropriate.
- There had been an increase in activity by 67% from quarter one to quarter three. This would increase further in quarter four.
- The role of the FTSUG has changed significantly since 2015. The introduction of the role was centred around patient safety concerns; however on the majority of occasions the concerns were behavioural/people related.

- The biggest challenges were in relation to capacity, time management and closing the feedback loop.

The DCDI thanked the FTSUG for her work and noted that further work needed to take place to review resources.

Mr McCardle explained that as the NED lead for FTSU he regularly met with the FTSUG. He highlighted the importance of the dashboard, and that Clinical Board ownership would make a significant difference. The FTSUG was one element of speaking up processes and there was a need for better triangulation.

Mr McCardle queried whether staff accessing the FTSUG for behavioural issues meant that accessing the FTSUG for potential patient safety concerns was restricted. The ACEO advised that the FTSUG was providing advice on how to reframe the role, and acknowledged the skills needed in the new postholder to hold management to account in a meaningful way.

Mrs Stabler explained that behaviour and culture can impact negatively on staff and patients, and potentially in relation to safety.

The EDN noted the importance of staff having confidence that managers were taking local action however queried if managers were sufficiently trained to do so. The FTSUG advised that there was a gap in knowledge, particularly on having difficult conversations, and that there needed to be a compassionate leadership approach.

Mr MacLeod explained that the role was a benefit to the organisation however there was a need to communicate this to staff. The FTSUG highlighted that the dashboard and learning from the experience team would support this.

The ADP noted the importance of line management capability to support with issues that arise.

The Chair thanked the FTSUG for the update and noted the need to look forward to ensure greater trust and development. Processes were underway regarding increasing autonomy and delegating responsibilities to Clinical Board leaders. The interaction between safety and culture issues was acknowledged, with regular reports presented through the People Committee and in the future would be shared at Public Trust Board meetings.

It was **resolved:** to **receive** the report.

[The FTSUG left the meeting at 11.15am]

v) <u>Alliance progress update</u>

The DG&S highlighted the following points:

- The Private Trust Board meetings received updates monthly however the report had been shared in public to highlight the benefits.

- Positive assurance had been received from the Integrated Care Board (ICB) on the Alliance plans and progress made.
- The process to recruit a Shared Chair across three pf the Alliance Trusts had commenced.
- There were opportunities with regards to the NHSE and ICB transition.
- Examples were included within the report in relation to patient benefits which included the new Clinical Diagnostic Centre (CDC), and improvements in waiting times in cardiology and audiology.
- There was energy and excitement from teams working together and learning from one another.
- Project progress was included within the AdminControl Reading Room for Board members. Further work was ongoing to measure and celebrate successes, and work was taking place to identify four/five areas to make the biggest difference.

It was agreed that the next Alliance update would include an update on the outcomes from the Alliance Committee on the areas of biggest progress **[ACTION04].**

Mrs Stabler advised that she was a member of the Alliance Committee and noted that the patient focus was very positive, which needed to be maintained.

It was **resolved:** to **receive** the report.

vi) Care Quality Commission (CQC) update

The EDN advised that he was now Executive Lead for the CQC work, and that progress had been made in relation to the improvement plan which was included in the AdminControl Reading Room for Board members. Three actions were behind plan with one now having been resolved. Representatives from the CQC, NHSE and the ICB attended the Integrated Quality Improvement Group (IQIG) meeting in February and there had been a request for a further meeting to carry out a deep dive into service specific action plans. The next IQIG meeting would take place at the end of April 2025.

The EDN explained that there were no matters for escalation and the de-escalation criteria was an action for the CQC. Work was ongoing at the CQC Delivery Group and the Quality Committee received regular updates with regards to safety and high quality care.

The Chair asked if there was an inclination as to when the CQC will return to reinspect the Trust to which the EDN advised that it was still uncertain.

It was **resolved:** to **receive** the report.

vii) Integrated Board Report (IBR)

The DPG highlighted the following points:

- January 2025 saw a significant reduction in Clostridioides difficile infections compared to the previous month returning to no special cause concerning variation.

- There was a slight increase in adult falls in January 2025 with 10 falls being categorised as moderate or greater harm. Patient Safety Incident Response Framework (PSIRF) reviews were taking place where necessary.
- In relation to cancer performance, the Trust achieved the Faster Diagnosis Standard (FDS) in February 2025 and the position was looking positive for March 2025.
- 62-day compliance for December 2024 was 64.0%, reflecting improving special cause variation despite an overall consistent failure to hit the target.
- The Council of Governors were updated earlier in the week with regards to analysis of pathway delays for cancer tumour groups.
- The long waits backlog of patients was usually circa 200 however this week it was down to 104 patients with the Trust being on track to be below 100 by the end of March 2025.
- In relation to diagnostics, performance had improved for five successive months with 17.9% of patients waiting over six weeks at the end of January 2025 and the position had improved in February 2025.
- A Health Inequalities update would be included in the next report.
- With regards to sickness absence, the total remained at 5.47% which was above the target. Work was underway to agree the priorities for staff psychological support and wellbeing.
- Appraisal compliance reduced in January 2025 however there was a new process being launched in April 2025 which was actively discussed at the People Committee.

The CFO advised that the Trust was forecasting to hit the financial targets for the year end however there was a considerable amount of work to do in 2025/26 to deliver the required Cost Improvement Programme. The Chair noted that it was an ambitious target for the next financial year.

Mr Weatherburn noted that reducing sickness absence should be an action in the year 2 people plan.

Mr MacLeod explained that there had been an improvement with regards to performance and that Clinical Boards presented at the Finance and Performance Committee meetings. He explained that the Council of Governors had queried diagnostic performance and noted that the Finance and Performance Committee received regular deep dives into this area. In relation to finance, 2025/26 would be a challenging year for the organisation.

Mr Kane queried bank and agency utilisation within the Medicine and Emergency Care Clinical Board to which the Chair advised that the Trust had a low figure compared to other Trusts. The EDN explained that the highest was in relation to enhanced care observation requirements and safety for one-to-one care which was currently under review. The CFO added that some related to specific medical posts which were difficult to fill however work was taking place in specific specialties to improve the position.

The Chair highlighted that all sections within the report had been explored in the relevant Committee meetings.

It was **resolved:** to **receive** the report.

viii) Sustainable Healthcare in Newcastle

The ADES highlighted the following points:

- A suggestion to include sustainability reporting within the IBR.
- A sustainability dashboard had been developed.
- In relation to care emissions, anaesthetic gas emissions continued to track below the carbon reduction target. There had been a 61% reduction in emissions since the baseline year of 2019/20 which had been led by clinical staff.
- Transitioning from fossil-fuel derived heat and power for the Trust's building energy remained the biggest challenge. The first successful grant to the National Energy Efficiency Fund (NEEF) was announced in January.
- There was a new Estates Net Zero Team in place.
- A national requirement was in place to refresh the Green plan. The strategy and action plan would be complete by the end of March 2026.
- The proposal was to continue with the current Climate Emergency Strategy 2020-25 into the final year of its action plan meanwhile developing a new strategy for 2025-30 to be published next year. Leadership input would be sought, and work would take place with the Clinical Boards.
- Energy costs were still increasing however some savings had been made.

The Chair agreed that it would be useful to include a measure on sustainability performance in the IBR.

The DCCA advised that the Charity Committee had been pleased to support the projects as they had made a difference to patients however highlighted that it would be useful to move to a more sustainable approach rather than considering grants on an ad hoc basis. The ADES noted that the aim was to triangulate patient benefits with charitable aims and to assess projects according to their impact.

Mr MacLeod sought clarification with regards to Alliance opportunities in relation to sustainability and emissions. The ADES advised that the Alliance Sustainability leads meet regularly to discuss prospects which were linked into the Estates programmes.

The JMD-W explained that engagement work had taken place with the ICB as an Alliance and net zero was a key area of feedback.

The ACEO advised that there were opportunities in relation to innovation for example taxis and couriers. The use of drones for deliveries was an area currently being explored. The ADES noted that he was liaising with the Innovation Team with regards to the drones however there were financial constraints.

The ADES explained that opportunities were present and that national guidance was available. The CFO said that work was taking place to look at partnerships and finance across the Alliance and that there were well developed sustainability policies.

It was agreed that the ADES and DPG would discuss opportunities in relation to Taxis and courier opportunities **[ACTION05]**.

Mrs Stabler noted that following staff feedback, it had been raised that there was a lack of electronic vehicle charging points for staff and queried if the number could be increased. The ADES advised that there was a commitment to decarbonise hospitals sites however this could be raised outside of the meeting. The CFO agreed to discuss the lack of electronic vehicle charging points and raising awareness of the location of the existing charging points **[ACTION06]**.

[JW joined the meeting at 11:48]

The Chair highlighted that the positive discussion affirmed the Trust's commitment to sustainability and that the Board of Directors encouraged progress, noting that funding was a key barrier.

It was **resolved**: to receive the report.

ix) <u>Equality, Diversity and Inclusion (EDI) update</u>

The DCCA highlighted the following points:

- The DCCA and CXO were now the Executive Leads for EDI.
- The intention was to make demonstrable improvements for staff.
- Work would take place to link the staff survey, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) results.
- There was a need for meaningful engagement with regards to what would make a difference.
- Health Inequalities would be a key focus.
- The EDI Steering Group had been reviewed.
- The Chief Executive Officer, Chair and Board Members must have objectives relating to EDI, with collective EDI leadership. It was noted that the NEDs and Chair do have such objectives currently.
- In relation to the six high impact actions, the EDI steering group would review and a clear action plan would be set, ensuring engagement with the operational teams.
- There was an away day planned in early April with some Executive members and staff networks to discuss next steps regarding EDI and development of an EDI strategy.
- The following recent activities had taken place:
    - Celebration of International Women's Day which included powerful emotional and inspiring stories.
    - An Iftar gathering at the Freeman Hospital. 50 people attended and it was an emotional event with positive learning opportunities.

  The Trust would like to support more of these events.

As referenced earlier, the CXO noted the Board Development Session which took place earlier in the week with the staff network on 'Let's Talk About Race' which enforced the commitment of Board of Directors.

Dr Adetuberu sought clarification with regards to where the EDI Steering Group reported into, to which the DCCA advised that it would report into the People Programme Board which reported into the People Committee. EDI would be a clear objective within the year 2 people plan and discussions ould take place in relation to objectives at the away day,.

It was **resolved:** to **receive** the report.

x) Update on a Public Health / Health Inequalities Strategy

The JMD-PC advised that the report included an update on the Trust's efforts to address Health Inequalities. A plan and strategy were in development with the six pillars outlined within the report. Work was ongoing to strengthen governance arrangements for reporting and completion of a self-assessment tool.

The Chair noted that the strategy was discussed at the Quality Committee in April. Ms Balmain added that good discussions had taken place at the Quality Committee with further points raised for consideration. It was important to recognise the large number of staff members and the diverse community in which the Trust operated. She noted that it would take time to get the strategy right and that considerations might need to take place as to the options for an Alliance-wide approach.

It was **resolved:** to **receive** the report.

25/08 ITEMS TO RECEIVE

i) Director reports:

a. Joint Medical Directors (JMD) Report

The JMD-W highlighted the following points:

- In relation to urgent and emergency care, there had been an improvement with regards to the 4-hour standard and type one attendance.
- With regards to cancer performance, there had been small improvements in relation to the 104 day pathways however performance was still less than desired.
- A deep dive had taken place into harm reviews for patients waiting over 104 days.
- The job description for the Cancer Lead roles had now been agreed and significant work had been conducted to improve cancer pathways.
- Call for Concern (Martha's Rule) had been rolled out across the organisation.
- Quality and Safety focussed Quality and Performance Reviews (QPRs)had taken place which had highlighted some of the positive work undertaken.
- A more detailed report would be presented at the Quality Committee with regards to PSIRF priorities, which included referrals and management of abnormal results.
- The move to remote hosting had been postponed from February 2025 however it was noted that the upgrade would have a positive impact on the Electronic Patient Records (EPR) in the future.

Mrs Stabler explained that there was a robust process in place for harm reviews and that regular reports were received through the Quality Committee in relation to this and Duty of Candour (DoC).

It was **resolved**: to **receive** the report.

b. Executive Director of Nursing Report

The EDN highlighted the following points:

- There was a clear focus on enhanced care observations.
- Challenges were present within the Learning Disability and Safeguarding teams with regards to increased activity. The risk framework had been escalated through to the Quality Committee.
- Further information was available in the Trust Board Reading Room on Admin Control.

It was **resolved**: to **receive** the report.

c. Maternity

i) Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress report

The DoM highlighted the following points:

- There had been a positive impact seen with regards to phase one of the midwifery staffing review with no red flags in December 2024 and one in January 2025.
- In relation to staff absence, there were currently 17 staff on maternity leave.
- 150 babies had been safely delivered.
- The service had maintained its Operational Pressures Escalation Levels (OPEL) status.
- There were no further infections within the neonate's intensive care unit in February and March 2025.
- There was an outbreak of carbapenemase-producing enterobacterales (CPE) declared in February 2025. Comprehensive work took place with the Infection Prevention Control (IPC) team with Estates team support, with planned estates work expedited. There had been some closures of cots due to isolation which was being discussed with specialised commissioners.

The DPG noted that he had carried out a leadership walkabout last week in maternity and the staff were positive in relation to staffing levels.

It was **resolved**: to **receive** the report.

ii) Maternity Safety Champion Report

Mrs Bromley explained that she visited when the CPE outbreak was declared and noted that whilst it was hard to manage there was a positive willingness and attitude from staff to manage the situation well.

The Chair queried the existing accommodation to which the ACEO advised that work was underway with the Estates team. The decant of the neonatal unit was included in the capital plan for 2025/26.

The Chair asked if staff felt the Trust was responding to challenges in the best possible way to which the DoM advised that they did, and that the staff felt supported by the Estates team.

iii) Mortality/Learning from Deaths

The DQS advised that the report had been discussed in detail at the most recent Quality Committee meeting.

It was **resolved**: to **receive** the report.

ii) Committee Chair Meeting Logs

The Trust Board received the Committee Chair Meeting Logs for information.

Mr Weatherburn noted his confidence that the correct information was being discussed at the relevant Committee meetings which has resulted in the Audit, Risk and Assurance Committee documentation being lighter than normal at the previous meeting.

It was **resolved**: to **receive** the report.

25/09 ITEMS TO APPROVE:

i) Board Assurance Framework (BAF) 2024/25

The Chair highlighted that a Board Development Session took place earlier in the week with regards to the development of the 2025/26 BAF.

The DPG advised that risk scores remained unchanged and that three threat assurance levels had changed since the last meeting. The BAF was discussed in detail at the last Audit, Risk and Assurance Committee meeting.

The DPG explained that internal audit had carried out an audit on the BAF and a good level of assurance was received which was an improvement from the previous year.

It was **resolved**: to **receive** the report and **approve** the Board Assurance Framework.

ii) Gender Pay Gap report

The DCDI advised that the report was a statutory report to be published on the Trust's website. The recommendation was to approve the content in relation to the data. The DCDI highlighted that the report was not an equal pay report.

The DCDI highlighted that 78% of the workforce was female and the gap was 21% in pay which was a minor improvement from the previous year.

It was noted that further work needed to take place to improve the position.

Mr MacLeod queried the 12% pay gap between medical and dental trainees. The DCDI agreed that she would confirm the reason for the 12% pay gap on medical and dental trainees **[ACTION07]**.

Mr McCardle advised that this had been discussed at the People Committee however there was a need for more targeted action.

The JMD-PC explained that the 12% gap query could be due to part time workers and Mrs Stabler added that it could also include staff on maternity leave.

It was **resolved**: to **receive** the report and **approve** the Gender Pay Gap report for publication.

iii) <u>Governance documents:</u>

a. Board Committee Terms of Reference and Schedules of Business

The TS advised that all Board Committee Terms of Reference and Schedules of Business had been approved through the relevant Committee meetings.

It was **resolved**: to **receive** the report and **approve** the Board Committee Terms of Reference and Schedules of Business.

b. Public, Private and Charity Board of Directors Schedules of Business

The Chair asked for the Winter Plan scheduling to be updated on the Schedule of Business **[ACTION08]**.

It was **resolved**: to **receive** the report and **approve** the Public, Private and Charity Board of Directors Schedules of Business following the above amendment.

c. Accountability Framework

It was agreed that this item would be discussed at the Private Board of Directors meeting which followed this meeting.

It was **resolved**: to **receive** the report at the Private Board of Directors.

25/10 <u>ANY OTHER BUSINESS:</u>

i) Meeting Action Log

The action log was received and the content noted. The completed actions were agreed.

It was agreed to close action 130 and for the CXO to pick up outside of the meeting.

ii) Any other business

There was no any other business discussed.

The meeting closed at 12.20pm.

Date of next meeting:
Public Board of Directors – Friday 23 May 2025

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Agenda Item A3

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025					
Title	Chair's Report					
Report of	Sir Paul Ennals, Interim Shared Chair					
Prepared by	Sir Paul Ennals, Interim Shared Chair Victoria Champion, Corporate Governance Officer and PA to Chair and Trust Secretary Kelly Jupp, Trust Secretary					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	This report outlines a summary of the Chair's activity and key areas of recent focus since the previous Public Trust Board meeting in March 2025, including: • Informal Visits • Research • Conferences and Events • Activity with Governors • The Great North Healthcare Alliance ('the Alliance') • Engagement with Regional Partners					
Recommendation	The Trust Board is asked to note the contents of the report.					
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. Pioneers – Ensuring that we are at the forefront of health innovation and research.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☐	☐	☐
Link to the Board Assurance Framework [BAF]	No direct link however provides an update on key matters.					
Reports previously considered by	Previous reports presented at each meeting.					

CHAIRS REPORT

As we are nearing the end of May, I have continued my focus on increasing engagement and transparency across the organisation and more widely.

I am keen to raise awareness of positive improvements; and to be more open about the problems and issues we face through increasing the amount of information that we share and discuss in our Public Board meetings.

I have had the privilege of speaking at several events to celebrate individual and charity successes within the Trust. I also had the honour of speaking at a memorial tree planting event at the Freeman Hospital, to remember our colleagues who have sadly taken the difficult decision to end their own lives prematurely. Our Executive Team have initiated a piece of work to:

- Support teams more broadly in relation to Health and Wellbeing;
- Identify a more strategic approach to learning and communications, access to support and suicide prevention; and
- Clarify the initial Trust response when notified of the death of a member of staff.

We recently celebrated 40 years since the first heart transplant was performed at the Freeman Hospital, an extraordinary milestone and a very moving event.

I have continued with my informal visits across all parts of the organisation to meet with staff. Of late I also met with Professor John Isaacs, Associate Medical Director, to talk about our research activity. John will be providing an update at our Council of Governors meeting on 21 May 2025. I also recently met Professor Andy Long, Vice Chancellor of Northumbria University, and we discussed the current positive collaborations between the Trust and the University, and the considerable potential for strengthening University links more widely across the city.

This report also summarises the different engagement activities undertaken, including Alliance meetings and engagements with the Council of Governors and Members.

INFORMAL VISITS

I had a very informative visit to the North East Children's Transport and Retrieval (NECTAR) service and was provided with updates on recent improvements and future plans.

I had the honour to be the keynote speaker at the National Clinical Audit and Quality Improvement Awards on 24 March 2025. These awards celebrate quality improvement and clinical effectiveness. Well done to all of the award winners.

I was very pleased in April to be the main speaker at a Next Generation GP North East event. This programme is a fully funded leadership programme, dedicated to equipping trainees and GPs with essential skills and unleashing their potential for impactful changes.

On the 8 April 2025, I had the pleasure of introducing the event, Celebrating Your Support, A Thank you to Our Charity Partners. This was dedicated to honouring the charitable organisations that support Newcastle Hospitals and recognising their contributions. A very big thank you to all our charity partners, who provide so much important input to the work of the Trust.

Early in May 2025, I was very privileged to attend and speak on behalf of the Board at a Memorial Tree Planting at the Freeman Hospital. This is a National Memorial Tree Campaign led by the medical Mental Health charity Doctors in Distress. The tree was planted on a small patch of grass at the front of the Freeman Hospital with a plaque in memory of all colleagues who have taken their own lives.

I also had lots of other informal meetings with staff from across the Trust, and visits to different services – too many to mention here.

CONFERENCES AND EVENTS

On the 14 May 2025, I was honoured to speak to over 400 of our staff at the Nursing, Midwifery and Allied Health Professional (AHP) Conference; 'Empowering Every Voice'. Congratulations to all those who won awards at this conference.

On the same day, I gave a speech at the North East Public Sector, Sustainable Supplier event. Our Trust has been pioneering the work in seeking to ensure that organisations that supply goods and services to us develop strategies for reaching net zero emissions; the conference was organised jointly by us and Newcastle City Council as we lead the process of engaging all the public sector in our region in combatting climate change. Over 200 attendees were at the City Hall.

ACTIVITY WITH GOVERNORS

I continue to work collectively with our Council of Governors both formally and informally and during this period we held a Governor Workshop in March and a formal Council of Governors meeting in April. I also continued to have informal drop-in sessions which are very informative and it is great to engage with our Governors.

At the drop in session which took place in March we talked substantially about the national and regional changes to the NHS and their impact on the Trust, communications around the new Call for Concern system; a discussion with regards to the staff survey and consideration as to how staff can contribute to increasing our productivity. In April we discussed the findings from the staff survey; how the Accessible Information Standard could be progressed, the processes for making outpatient appointments in some clinics, and follow-up letters sent to patients.

At the formal Council of Governor meeting in April, updates were provided on the Alliance, our Estates strategy, commercial strategy developments and the Transplantation Committee.

In early April, I opened our Members Event – From hospital to home: innovative solutions to looking after our health. The event brought together Trust Members and Governors with representatives from the National Institute for Health and Care Research (NIHR), Newcastle University and clinicians from Newcastle Hospitals. Members were given the opportunity to discuss their opinions and to provide feedback on the topics discussed. This event was very well received, and a lot of positive feedback was given. One area for improvement was identified regarding 'sound quality' in the room, which is something that has proven challenging for us to resolve historically due to technological constraints but we will continue to explore potential solutions.

ALLIANCE

I attended the Alliance Joint Committee meetings in April and May 2025, and the Alliance Steering Group in May 2025. At the Alliance Joint Committee meetings we received updates on progress with the three workstreams - Finance, Research, Innovation and Digital. These discussions are reported separately to Public Board.

In early April 2025, an event took place for Governors across the Alliance. This provided both an opportunity for Governors to learn more about each of the organisations within the Alliance and allowed our Governors to build networks with fellow Governors across the Alliance.

RECOMMENDATION

The Trust Board is asked to note the contents of the report.

Report of Sir Paul Ennals
Interim Shared Chair
15 May 2025

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Agenda item A5

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025		
Title	Patient and Staff Stories		
Report of	Annie Laverty – Chief Experience Officer		
Prepared by	Marilyn Hodges – Associate Director Service Improvement – Patient and Staff Experience Lee-Ann Naidoo – Improvement Programme Manager – Patient and Staff Experience		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☐	☒
Summary	**Patient experience story:** A former Royal Navy Lieutenant Commander shared his personal journey following an unexpected and life-altering diagnosis of kidney failure in 2010. After experiencing sudden and severe symptoms during his advanced warfare training, he was admitted urgently to hospital, where blood tests confirmed renal failure. Despite no prior health warnings, his condition led to medical discharge from the Navy in 2011. The experience marked a profound shift in his identity, lifestyle, and mental health, taking nearly two years to adjust. His story underscores the importance of early detection, awareness of non-visible illnesses, and compassionate care during sudden health transitions. This vital work has been undertaken by the National Renal Complement Therapeutics Centre (NRCTC) at Newcastle Hospitals. He also refers to his local hospital in this story, highlighting the important interplay of local and national services for patients with complex conditions. **Staff experience story:** Our staff story is about a housekeeper, Alison, who received praise for her interaction and communication with patients on ward 34 at the Freeman Hospital. In this brief story, a Patient Experience Feedback facilitator shares her observation of Alison on the ward and the impact of her interaction on patients. It serves as a reminder of the meaningful contributions that the wider team have on the experience of care, and that small acts of compassion and kindness are often what matters most. Offering comfort, encouragement and human connection, stood out powerfully.		
Recommendation	The Board are asked to receive both stories for information and to note our commitment to learning from all experiences of care and to recognize the contribution of all staff.		
Links to Strategic Objectives	Putting patients at the heart of everything we do and providing care of the highest standard focusing on safety and quality.		

Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☒	☐

Link to Board Assurance Framework [BAF]	Linked to key areas in the BAF relating to Effective Patient Safety and Workforce, these stories are associated with strategic aims of putting patients at the heart of everything we do and providing care of the highest standard focusing on safety and quality.
Reports previously considered by	Patient and People stories are a recurrent feature of all Public Board meetings.

PATIENT STORY:

"Man up, ...it's a cold or something!" one of my colleagues shouted. It was 29 March 2010, roughly 6 weeks into my advanced warfare course in Portsmouth as a young Lieutenant Commander in the Royal Navy. The beautiful thing about being in the military is that adventure, camaraderie and banter come as standard. The mindset across all the British Armed Forces is one of a 'can-do' attitude. Suffice to say, that includes continuing to work even if you feel under the weather.

Socialising the previous evening in the Officer's mess I had consumed a couple of pints of Guinness. When I awoke the following morning, I felt disproportionately poorly. My ankles were incredibly itchy and swollen (to the point of distraction), I felt sick. I had a pounding headache and my vision was blurry. Having forced down the obligatory eggs on toast and some orange juice, I headed for work. Whilst walking there I felt progressively worse. Breathless, my heart trying to climb out of my chest, my eyes feeling as though they were in a vice. Feeling nauseous and unwell, unlike anything I had ever experienced, I decided to go to the base medical centre, where I started to bang on the doors. I was let in ahead of their opening because one of the nurses could see that I was suffering. Going there probably saved my life. On the same day, my life changed forever.

The blood pressure machine attached to my arm inflated the cuff. As it deflated, the nurse said that the machine was probably broken and not reading correctly. She attached a manual cuff and put the stethoscope against my forearm. "I'm just going to do one more reading" she said. She looked at me in slight shock, maybe dismay. When I asked what the reading was, she returned "242 over 160". After a quick phone call, she said that an ambulance would take me to hospital. I was triaged on arrival and went straight to have some bloods taken. Over the next four or five hours I waited for an update from the blood test. The doctor eventually approached me and said that I was to be admitted to one of the wards. When I asked what ward, the reply came back "Renal." I had kidney failure!

Even I knew that kidney failure was not a case of taking two ibuprofen and resting. Three weeks on the ward taking medication helped. The kidneys regulate blood pressure. For an unknown time, I had been in a vicious cycle of increasing blood pressure, deteriorating kidneys, increase in blood pressure and so on. My major concern was why? The complex diagnoses meant nothing. The important part is that my kidneys were not functioning well.

In 2011, I was medically discharged from the navy. The career that I worked so hard for was over. My sense of identity and the adventure gone. In all honesty, it probably took me two years to accept that my life had changed, and I was ill. In 2014, I started a new job. And we had our first child.

Later, came an intense episode of illness, high blood pressure and absolute lethargy. In June of 2016, I was feeling so unwell that en-route to work, I would drift into almost narcoleptic spells that meant I was unsafe behind the wheel of the car. Unable to commute, I stopped work to become a stay-at-home Dad.

Between 2010 and 2022, I also had to endure debilitating bouts of gout. Pain levels were horrendous. And I was gradually losing kidney function.

During 2019, my initial diagnosis was re-examined and revised as featuring aHUS. Learning that aHUS is a genetic coding error in my DNA sequence, an immediate concern was whether my son had inherited my condition. I am delighted to say that after having his DNA tested clear.

Through my consultant at Dorchester and following the revised diagnosis, I was introduced to Dr Edwin Wong and the wonderful team at the National Renal Complement Therapeutics Centre (NRCTC) in Newcastle. Through regular telephone appointments they educated on what my prognosis looked like going forward, with my possible saviour in the form of Eculizumab.

In January of 2022, my kidney function tumbled. My body didn't look like I remember it in the mirror. I have severe lower-leg oedema that spread up as far as my groin. I was breathless, struggled to walk, struggled to sleep. My kidneys were now in the latter stages of their usefulness. Water retention added some 20kg /4 stones to my body weight!

My consultants at Dorchester called me in to organise surgery ahead of dialysis. I based my choice of dialysis treatment on a few things, from risk level to whether I could swim regularly, play sports with my son and walk the dog.

It was important to me that my son didn't see me in treatment. I wanted my dialysis very separate from our home lives. I also didn't want to be in the house any more than I had to be. Being a stay-at-home dad and ill was a lonely existence.

Dialysis became the next stage of my life. After a few months, I slowly regained confidence and felt better than I had in years. I dialyze every other weekday. Including travel time, I'm out of the house 6 hours a day.

Fortunately, my diagnosis of aHUS allows possible transplantation. I have been on the transplant list for a deceased donor organ for 18 months. Prior to transplant, I will receive an infusion of Eculizumab. Assuming transplant goes well, I'll then receive Eculizumab every two weeks. The drug should prevent aHUS from damaging the new donor kidney.

There is no doubt that the last few years have been tough. I still have several hurdles ahead of me. The reality for me is that it isn't always easy, it isn't always pleasant and there are certain things that I cannot do anymore. I have relied upon services and support networks to cover my shortfall as a now-single dad. There is no shame in being ill. Allow yourself to be ill. For me, I choose that I will not be beaten by my illness.

There is still stuff I can do and responsibilities I must honour as best I can. Hopefully, in years to come, this chapter in my life will just be an interesting story.

STAFF STORY:

I visited Ward 34 as part of my role as a Patient experience feedback facilitator. I was struck by the light-hearted atmosphere coming from both patients and staff. The first patient I interviewed had nothing but lovely comments for the ward, especially the staff! One staff member, Alison, had come onto the bay and started chatting with patients. It was clear to me how deeply she cared about the patients, treating them like family!

One of the patients I was interviewing had lovely things to say about her, explaining that Alison takes incredible care of them, ensuring that they eat or at the very least encouraging them to try! She had a little joke with the first patient and then went on to joke and hug another patient. It was clear how fond the patients were of her, and it was incredibly heartwarming to see how much she cared for them! This small interaction really reminded me of why every single role is important in delivering excellent care.

I informed the senior sister that she had gotten this wonderful comment, responding that Alison is a real asset to the team. I think that this is an important story to tell as sometimes the biggest impact we have on patients is the smallest gestures.

This is what the patient said about Alison: “The domestic staff on the ward are all just so lovely. If you are not eating much because of the chemo they encourage us to eat. Alison is just fantastic – she looks after me and makes sure I can eat.”

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Agenda item A6

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025		
Title	Board Visibility Programme		
Report of	Rachel Carter, Director of Quality & Safety		
Prepared by	Fiona Gladstone, Clinical Effectiveness Advisor & Gavin Snelson, Interim Head of Quality and Effectiveness		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	The objective of the Board Visibility programme is to provide a structure that enables identification of areas where care delivery may require improvement, support and expertise to address these more difficult issues that may be impacting on quality and safety of patients and staff. The walkabouts raise awareness of front-line issues and support the visibility and accessibility of senior leaders within the organisation. This report provides an overview of the findings from the seven walkabouts and visits undertaken during March and April 2025. During this time one scheduled Leadership Walkabout was cancelled due to an unexpected change in availability at short notice. Key themes identified include: • Overall, there was a positive culture and staff feel supported. • Staff are comfortable raising concerns, however in some areas are not always confident that they will be dealt with effectively. • Staff are enthusiastic about the Accrediting Excellence (ACE) accreditation process. • Nursing nightshift staffing resource was raised as a concern. Some nightshift staff feel undervalued leading to a sense of high stress levels and low morale. • Lack of awareness of InPhase and Patient Safety Incident Response Framework (PSIRF) was reported in several areas. • Outstanding estates work is a cause of frustration in several areas. Issues for escalation include: • Information Technology (IT) solutions for poor Wi-Fi and improvement of visibility of bed availability. • Non-compliant staffing guidelines in Speech Therapy. • Closure of Eden Court and the Winter Ward leading to a loss of up to 47 beds. • Refurbishment of Ward 5 at the Freeman Hospital. New process for recording of Leadership Walkabouts:		

	A new process for the recording of leadership walkabouts is currently being piloted within Surgery & Specialist Services Clinical Board during May 2025. If successful, the new process will be rolled out to all Clinical Boards and Non-Executive Directors (NEDs) in June 2025.					
Recommendation	The Trust Board is asked to note the contents of this report in relation to both positive feedback from Trust staff, and concerns/suggestions raised for improvements.					
Links to Strategic Objectives	Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.					
Reports previously considered by	The previous Leadership Walkabouts and NED Informal Visits Report was presented to the Trust Board in March 2025.					

BOARD VISIBILITY PROGRAMME

1. INTRODUCTION

The objective of the Board Visibility programme is to provide a structure that enables Trust leaders to focus on staff colleagues well-being, safety and opportunities for improvement. The programme will also identify areas where care delivery may require improvement, support and expertise to address these more difficult issues that may be impacting on quality and safety of patients. The programme raises awareness of front-line issues and supports the visibility and accessibility of senior leaders within the organisation.

Since 2023, Non-Executive Directors (NEDs) have commenced an informal visits programme to supplement the pre-existing Leadership Walkabout programme. The informal visits are unaccompanied visits to areas/services across the Trust, with the areas selected generally identified by the individual NED. In addition, Executive Team members also undertake informal visits.

This report provides an overview of the findings from the seven walkabouts and visits undertaken during March and April 2025. During this time one scheduled Leadership Walkabouts was cancelled due to an unexpected change in availability at short notice.

2. PROCESS

The leadership walkabout programme involves two ‘streams’ which run in parallel each month:

Stream 1 [Leadership Walkabouts]: Two senior leaders (Executive Team, Directors of Operations, Board Chairs, Associate Directors of Nursing, Heads of Nursing other senior managers within the Trust (Agenda for Change band 8C and above) and senior managers from the Clinical Governance and Risk Department (CGARD)) participate in a one-hour joint visit to a pre-defined clinical or corporate area. Within this the Director of Operations and Clinical Board Chair are allocated a visit within their own Clinical Board with the aim of increasing visibility of the Board Leadership Team to staff working in that area.

Stream 2 [NED informal visits]: NEDs undertake informal visits to a specific area within a Clinical Board that they are aligned to, or to an area that they are interested in visiting. In addition, the Chair undertakes regular informal visits to various areas/services across the organisation and the feedback from those visits is included within this report.

Management of the Leadership Walkabout schedule is co-ordinated by the Quality and Effectiveness team in CGARD (stream one) and the Corporate Governance Team (stream two).

The leadership walkabouts are announced, with the ward or area being notified of the walkabout, the team visiting and the time of their visit. The aim is to provide this information approximately one week prior to the visit.

A short guide is provided to the walkabout team/NED visits which offers a summary of the purpose of the visit and includes prompts to facilitate informal productive conversations.

For example:

- What does a great day here look like?
- What stops you having great days?
- What could be done to make things even better?

Following the visit, the walkabout team are asked to provide a free-text summary report which highlights what they felt were the most important themes from the staff they spoke to. The template allows the inclusion of brief details of any issues addressed during visits and if any further action is required. The data is then collated by the Quality & Effectiveness team (combined with the NED visits information) and presented in this report.

3. SUMMARY OF FINDINGS

The table below summarises the seven walkabouts undertaken at the Royal Victoria Infirmary (RVI) and Freeman Hospital (FH), three within stream one and four by the NEDs as part of stream two. Further detail is provided in the Summary of Findings Report in the Board of Directors Reading Room.

Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
Stream One	Wards 5, 6, 7 and 8	FH	Clinical Board Chair, Associate Director of Operations, Head of Nursing, Patient Safety Manager	Nurse in Charge, Staff Nurse, Healthcare Assistant, Ward Clerk, Housekeeper
	Maternity	RVI	Director of Midwifery, Director of Performance and Governance	Not specified
	Wards 18 and 38	RVI	Medical Director and Clinical Board Director of Operations	Consultant, Charge Nurse, Nursing Staff, Junior Doctors
Stream Two	Night visit to Ward 1a, Ward 1b, Emergency Department, Wards 6, 9, 10, 3, 4, 5, 20, 22 and 23	RVI	3 x Non-Executive Directors	Nursing staff, Junior Doctor
	Patient Flow	RVI	Non -Executive Director	Associate Director of Operations and colleague
	Cardio Ward 50, 50a and Day Unit	FH	Non-Executive Director	Clinical Director, Matron, Band 7 Sisters, Band 6
	Speech Therapy	RVI	Non-Executive Director	Lead Speech and Language Therapist

Key themes identified include:

- Overall, there was a positive culture and staff feel supported.
- Staff are comfortable raising concerns, however in some areas are not always confident that they will be dealt with effectively.
- Staff are enthusiastic about the ACE Accreditation process.
- Nursing nightshift staffing resource was raised as a concern. Some nightshift staff feel undervalued leading to a sense of high stress levels and low morale.
- Lack of awareness of InPhase and PSIRF reported in several areas.
- Outstanding estates work was a cause of frustration in several areas.

Issues for escalation include:

- IT solutions for poor Wi-Fi and improvement of visibility of bed availability.
- Non-compliant staffing levels related to National Institute for Health and Care Excellence (NICE) guideline recommendations for Adult Speech Therapy. This is being reviewed through the relevant escalation and governance processes within the Clinical Board to ensure the risk of this is being accurately assessed and mitigations in place.
- Closure of Eden Court in addition to the winter ward closure will lead to the loss of up to 47 beds which may affect patient flow.
- Refurbishment of Freeman Hospital Ward 5.

4. FUTURE PROCESS

Feedback was received from ward colleagues receiving a leadership walkabout regarding the timescale between visits. The feedback identified concerns that some wards/areas were receiving a visit regularly whilst other areas were not receiving a visit at all. The conclusion was due to two separate walkabout streams (Trust Executives/Clinical Board Leaders and also NEDs) there was no centralised diary system for all Trust colleagues undertaking a walkabout, to easily view and establish which ward/area would benefit from a visit. Therefore, it was recommended that a new process to capture this information be developed.

A new database has been built using an excel spreadsheet within SharePoint. SharePoint allows colleagues (who have been provided access), to very quickly and easily view all wards and areas throughout the Trust. These areas highlight when a visit has been undertaken and by whom. SharePoint also allows colleagues to update the database at the same time without any disruption to each other.

Once a visit has been undertaken it is straightforward to record the outcome within the spreadsheet which will include a thematic review and escalation process.

As leadership walkabout colleagues are asked to complete the database themselves around their own availability, this alleviates the pressure on Quality & Effectiveness team coordinating diary invites with the aim of reducing frequent short notice cancellations.

The new database is being piloted with Surgery & Specialist Services during May 2025. If positive feedback is received, this new process could be rolled out Trust wide from June 2025.

The Quality & Effectiveness team will manage the database and collection of the walkabout outcomes so there will be no change to the current reporting structure.

5. RECOMMENDATION

The Trust Board is asked to note the contents of this report in relation to both positive feedback from Trust staff, and concerns/suggestions raised for improvements.

Report of Rachel Carter, Director of Quality & Safety

Prepared by Fiona Gladstone, Clinical Effectiveness Advisor and Gavin Snelson, Interim Head of Quality and Effectiveness

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Agenda item A7

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025					
Title	Care Quality Commission (CQC) Update					
Report of	Ian Joy, Executive Director of Nursing					
Prepared by	Ian Joy, Executive Director of Nursing Elle Marshall, Business Manager					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☒			
Summary	This report to the Trust Board provides an overview on progress with CQC action plans and the current process of enhanced scrutiny and oversight which remains in place with external partners. The following key points are noted for the Trust Boards attention: • Progress against the Phase 2 Improvement Plan can be found in the report. There are 49 actions excluding Section B (Service Improvement Plans) of which 29 are completed and 5 are behind plan. • The Trust requested Internal Audit to review of a sample of Clinical Board CQC Action plans. The report is pending finalisation and updates will be provided once complete. • The Trust commissioned The Value Circle to undertake an independent review of progress with embedding improvement actions in the Cardiothoracic Clinical Board. The report has recently been received, and an updated improvement plan is in the process of being developed. This will be overseen by the Cardiac Oversight Group and the Quality Committee. • NHS England (NHSE) and the Integrated Care Board (ICB) are working collaboratively to review the de-escalation criteria relating to additional oversight. At the latest meeting held on 25 April 2025, maternity and medicines management were de-escalated from the agenda. • Work continues around the well-led domain across the Trust and an external well-led review will be commissioned in due course. The Phase 2 Improvement Plan will be available in the 'Reading Room'.					
Recommendation	The Trust Board is asked: To note: • Progress against the Phase 2 Improvement Plan. • The current position regarding additional oversight from external partners. • The current position relating to understanding potential de-escalation criteria.					
Links to Strategic Objectives	Performance – Being outstanding now and in the future.					
Impact	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability

(please mark as appropriate)	☒	☒	☐	☐	☐	☐
Link to Board Assurance Framework [BAF]	1.2 - Failure to implement effective governance systems and processes across the Trust to assess, monitor and drive improvements in quality and safety.					
Reports previously considered by	Regular report.					

Agenda item A7

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Care Quality Commission (CQC) Update

23 May 2025

Healthcare at its best
with people at our heart

Overview of progress with action plans

- A Phase two action plan which relates to Effective Governance and Well Led is in place and focuses on testing embeddedness of systems and process in practice now that the transactional elements of the action plan are complete.

- There are 49 actions in total of which 29 are complete. Of those which remain open, 5 are behind plan and are planned to be resolved by June. These are:
  - EGWL 2 – Strengthening governance mechanism for reporting performance at a formal Tier 2 committee.
  - EQWL10 – Following the stocktake review by The Value Circle (TVC) evaluate and implement recommendations, reporting into CQC delivery group for accountability.
  - D11 – Embed the refreshed Matrons Governance Report and complete post-implementation evaluation.
  - D14 – Develop a trustwide Patient Reported Outcome Measures (PROMS) implementation plan.
  - F3 – Implement new policy for anti-racism.

- Section B service specific action plans have either been reviewed and refreshed, or are in the process of being reviewed, to ensure they have clear actions to test embeddedness in practice as part of phase two.

Cardiothoracic Review

The Newcastle upon Tyne Hospitals NHS Foundation Trust

- Review took place 25th - 28th March.
- Final report received 2nd May.
- Clinical Board currently working through recommendations for improvement and consolidating into revised improvement plan which will be overseen by the Cardiac Oversight Group and the Quality Committee.
- Highlights from the report have demonstrated areas of notable improvement but with areas that require continued support and oversight.
- Further update will be provided once the improvement plan is finalised.

Integrated Quality Improvement Group (IQIG)

- IQIG met on 25 April 2025 whereby the Trust provided updates on:
  - The Cardio TVC process.
  - The re-vascularisation Multi-disciplinary Team (MDT) audit.
  - The Emergency Department (ED) improvement Group.

  And requested de-escalation of Maternity and Medicines Management from IQIG.

- IQIG agreed de-escalation of the requested services.

- NHS England (NHSE)/Integrated Care Board (ICB) provided feedback from the assurance meeting to the Executive Director of Nursing on 20 March 2025. No concerns were raised, and all parties found the meetings useful to demonstrate areas of assurance and areas requiring further work.

- Work is in progress to review and agree de-escalation criteria with NHSE and ICB colleagues.

Well-led

- Well-led sessions undertaken by Ellen Armistead continue for Clinical Board Triumvirates.
- Well-led documentation / supporting information packs have been prepared for the Trust Board.
- Agreement to commission an external well-led review – process has commenced.
- The Board Development Programme, supported by TVC, will be tailored to align to the well-led framework and preparing for a future CQC inspection.

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Agenda item A8

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025		
Title	Winter Plan Evaluation		
Report of	Sue Hillyard, Interim Executive Director of Operations		
Prepared by	Nichola Kenny, Director of Improvement and Delivery		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	The main purpose of the winter plan was to ensure optimal quality and safe care provision at a time when services are put under pressure. The Trust's winter plan for 2024/25 followed a similar approach to the previous winter, with the core elements of the plan being additional beds on the Winter Ward 12 at the Freeman Hospital and the bolstering of the workforce front of house and back of house to manage outlying patients. During winter additional transport was sourced to support with discharging and transfers between the two acute sites, and the frailty service was established at the front door using funding from the Better Care Fund (BCF) slippage. In the main, the key performance measures demonstrated overall a better winter than the previous. The most adverse metrics were ambulance delays over 60 minutes and the volume of diverts into the Trust. The Trust did support the wider system to help minimise ambulance delays and this led to the early occupancy of the additional bed capacity that was created. Planning for this winter has already commenced with a view to have a finalised plan in June, building in learning taken from the most recent winter.		
Recommendation	Members of the Trust Board are recommended: • To review the report for information and take assurance that the plan had a positive impact in being able to maintain safe services. • Note the current work to finalise the Winter Plan for 2025/26.		
Links to Strategic Objectives	Patients and performance		

Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☐	☐	☐

Link to Board Assurance Framework [BAF]	• Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.

	• Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care.
Reports previously considered by	The Winter Plan was shared with the Trust Board in November 2024.

Agenda item A8

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

2024/25 Winter Plan Evaluation

Trust Board
23 May 2025

Nichola Kenny, Director of Improvement and Delivery
Melanie Cunningham, Associate Director Patient Access and Organisational Resilience
Rob Cranston, Emergency Care Facilitator

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What went well?

- **Trust-wide focus on occupancy reduction -** *achieving occupancy of 72% by 24 December 2024. There is a continued drive to improve accurate recording of Expected Discharge Date (EDD).*
- **Additional bed capacity. Opening of Winter Ward 12 (Freeman Hospital) 27 beds**
- **Excellent oversight of Infection Prevention Control (IPC) and minimal loss of beds due to infection**
- **Ability to support the wider system, although this led to increased diverts and repatriations**
- **Establishment of Frailty at the front door.** *Continues to evaluate well on admission avoidance*
- **The Integrated Discharge Team, ahead of winter, changed their model which led to reductions in length of stay by reducing time to assessment (seen in reduced vol. of patients >21 days)**
- **Timely discharging supported by additional transport dedicated to Newcastle Hospitals**
- **Establishment of second discharge lounge at the Freeman Hospital to support both elective and non-elective flow.** *At times capacity was protected for non-elective flow.*

What did not go so well?

- **Later opening of Winter Ward (end December) led to early cancellation of the elective programme in November.** *Cancellations post opening were specific to Neuro and Critical Care capacity and Paediatric Intensive Care Unit (PICU) capacity*
- **Both Intensive Treatment Unit (ITU) and PICU were challenged in maintaining admitting capacity due to staff sickness**
- **Multiple transport options led to some double bookings**
- **Elective planning in Paediatrics requiring PICU at times of significant pressure led to cancellations**
- **Periodic pressures arising from delays in domestic services**

How did we perform?

The Newcastle upon Tyne Hospitals NHS Foundation Trust

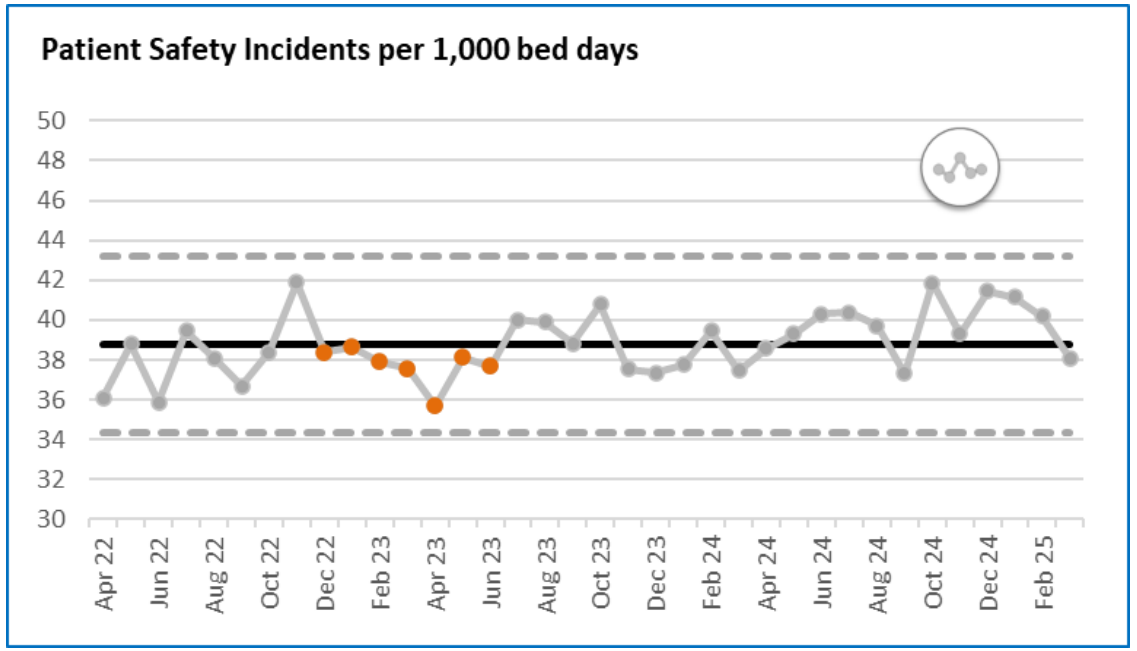
- ***Emergency Department (ED) 4 hour standard improved on last year***
- ***Overall demand was down, but emergency admissions increased***
- ***Long waits in ED and long waits for beds both reduced, however ambulance delays over 60 minutes increased***

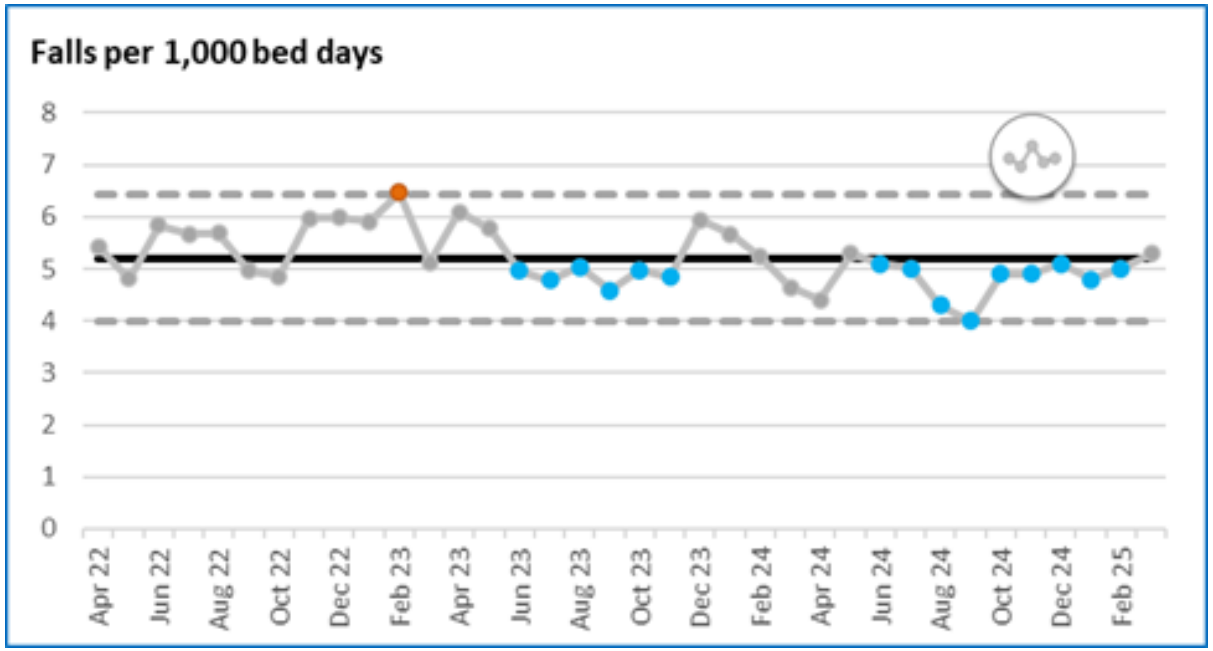
Activity	1 Dec 2023 – 31 Mar 2024	1 Dec 2024 – 31 Mar 2025	Difference
ED 4-hour Performance (All Types)	73.64%	76.17%	+2.53%
Type 1 Attendances Total	49,482	48,011	-1,471
- ED arrivals by ambulance	12,266	12,818	+552
- Walk ins	37,216	35,193	-2,023
Emergency Admissions (Accident & Emergency)	14,167	14,368	+471
Ambulance handovers <30 minutes	7,523	8,330	+807
Ambulance handovers >60 minutes	202	366	+104
North East Ambulance Service 45 minutes release activated	N/A	0	
Patients in ED > 12 hours	2,040	1,471	-569
Patients waiting >12 hours for a bed	209	166	-43
Bed Occupancy	89.50%	90.78%	1.28%
Medical Patients Boarded – Max over period	134	120	-14

How did we perform? – through a quality and safety lens

The Newcastle upon Tyne Hospitals NHS Foundation Trust

- ***Whilst Falls per 1,000 bed days remained low through the winter period, compared to last year, overall patient safety incidents were increased***





Development of 2025/26 Winter Plan

- **Currently planning for:**
  - Bed capacity options– i.e. Winter Ward 12 (Clarity on approach across North providers to be confirmed), surge options, reduced elective programme
  - Urgent Treatment Centre (UTC) Go Live December 2025
  - Bolstering of workforce in relevant areas – both front and back of house
  - Evolution of Frailty Model
  - Refreshed Operational Pressures Escalation Levels (OPEL) action cards to be in place to support surges in activity
  - Accommodating essential estate works (throughout the year)

- **Actions being followed up as a result of learning**
  - Improved use of EDD recording and reporting and use of Ready for Discharge field (ward) and Ready to Proceed field (ED)
  - Improved booking of Patient Transport Service (PTS) transport with aim to negate need for additional transport
  - Need to protect PICU capacity and improve elective care planning over the period
  - Establish an approach to levelling ambulance arrivals between Newcastle Hospitals and Northumbria Specialist Emergency Care (NSEC)
  - Achieve established use of continuous flow model which was agreed but rarely implemented

Current key risks

- **There is a significant schedule of planned bed closures to support estate works, including fire remediation works throughout the year.**
- **Role of the System Co-ordination Centre (SCC) in light of Integrated Care Board (ICB) changes and how active / responsive it may be this winter**
- **Ability of neighbouring trusts to manage own demand / provide bed additionality**
- **Plan affordability**
- **Loss of Intermediate Care Capacity**

Next steps

- **Regional winter debrief – 9th May 2025**
- **Internal winter planning has commenced, working to have final costed plan mid-June**
- **Ongoing engagement with partners, specific to:**
  - Neighbourhood communities (any opportunities this year)
  - Refreshed approach to volunteering, and growth in volunteers (exploring new roles)
  - Acute Respiratory Infection (ARI) hub model
  - Psychiatric liaison/ crises
  - Intermediate Care plans (noting ongoing risk)
  - Social care
  - Transport

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2024/25 Winter Plan Data Pack

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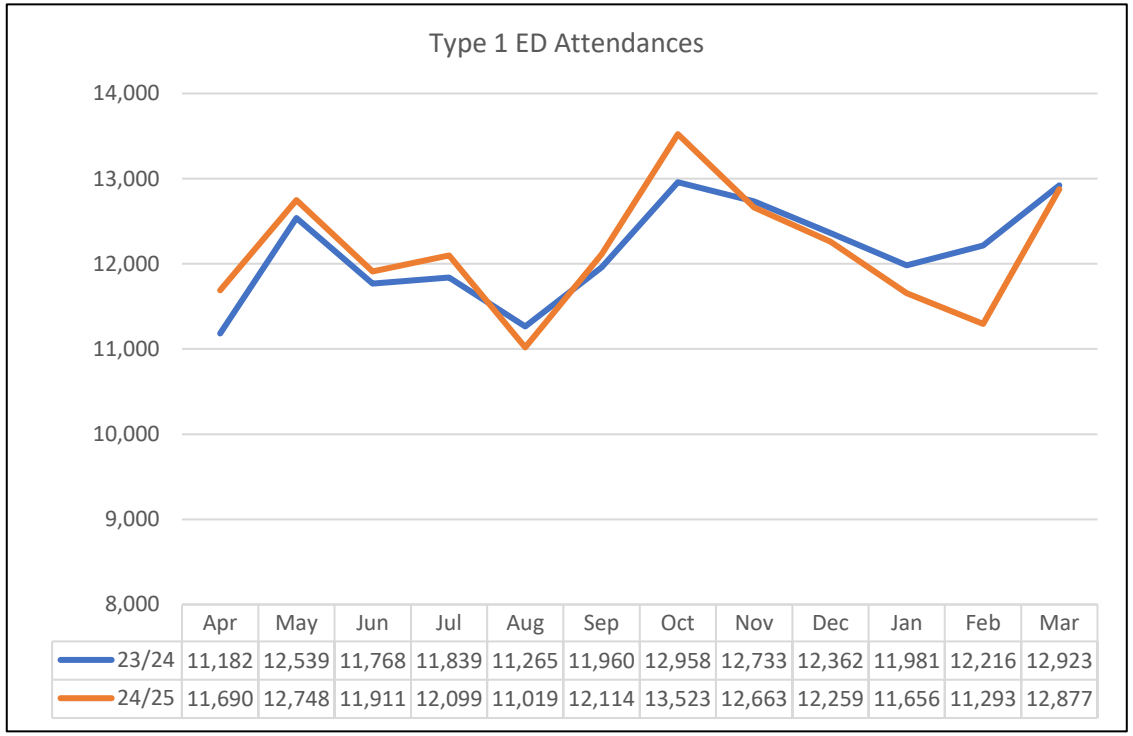
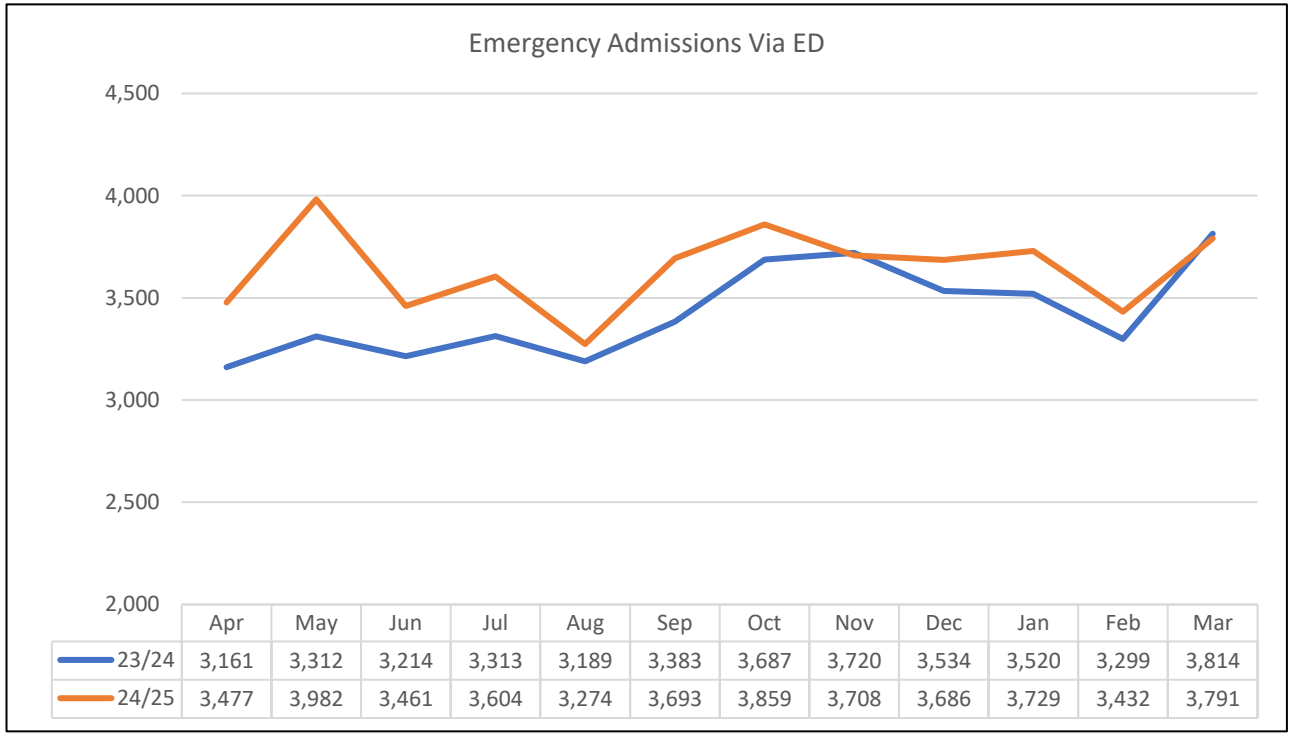
ED Activity – Attendances & Admissions

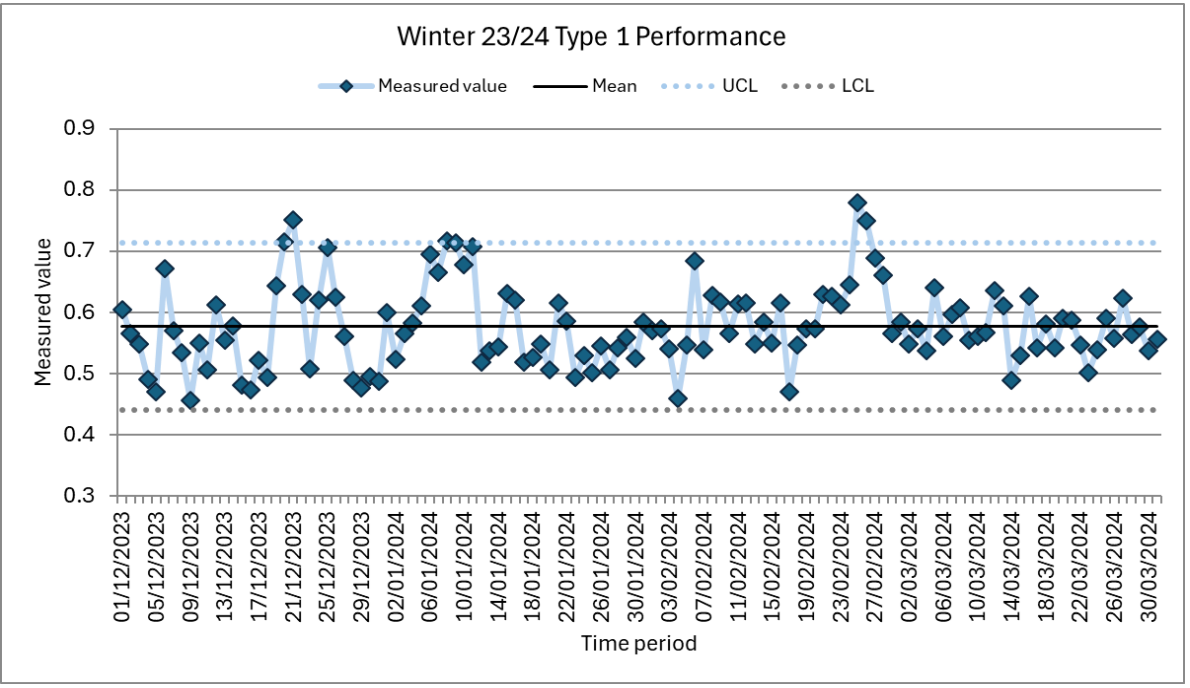


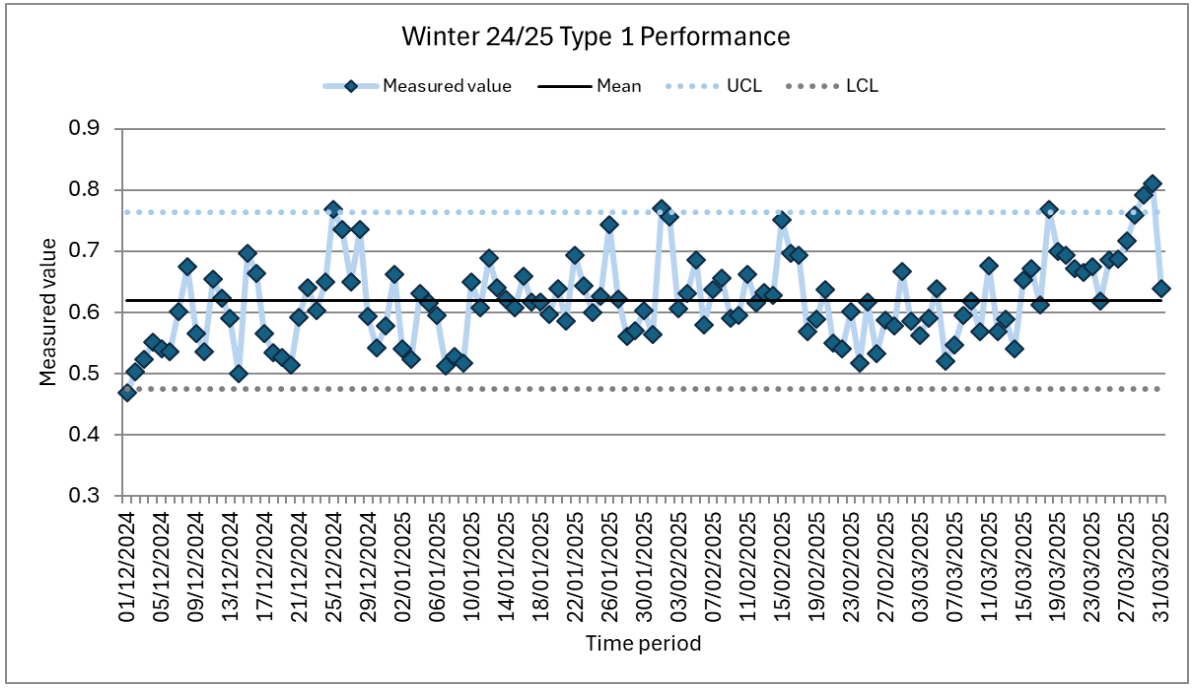
	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
23/24	11,182	12,539	11,768	11,839	11,265	11,960	12,958	12,733	12,362	11,981	12,216	12,923
24/25	11,690	12,748	11,911	12,099	11,019	12,114	13,523	12,663	12,259	11,656	11,293	12,877

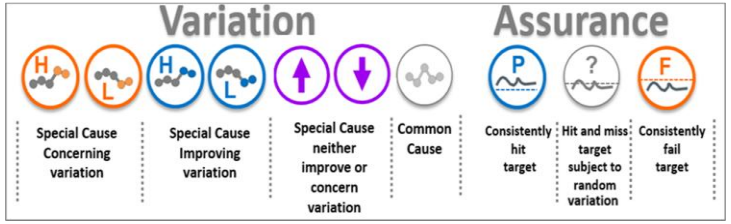


	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
23/24	3,161	3,312	3,214	3,313	3,189	3,383	3,687	3,720	3,534	3,520	3,299	3,814
24/25	3,477	3,982	3,461	3,604	3,274	3,693	3,859	3,708	3,686	3,729	3,432	3,791

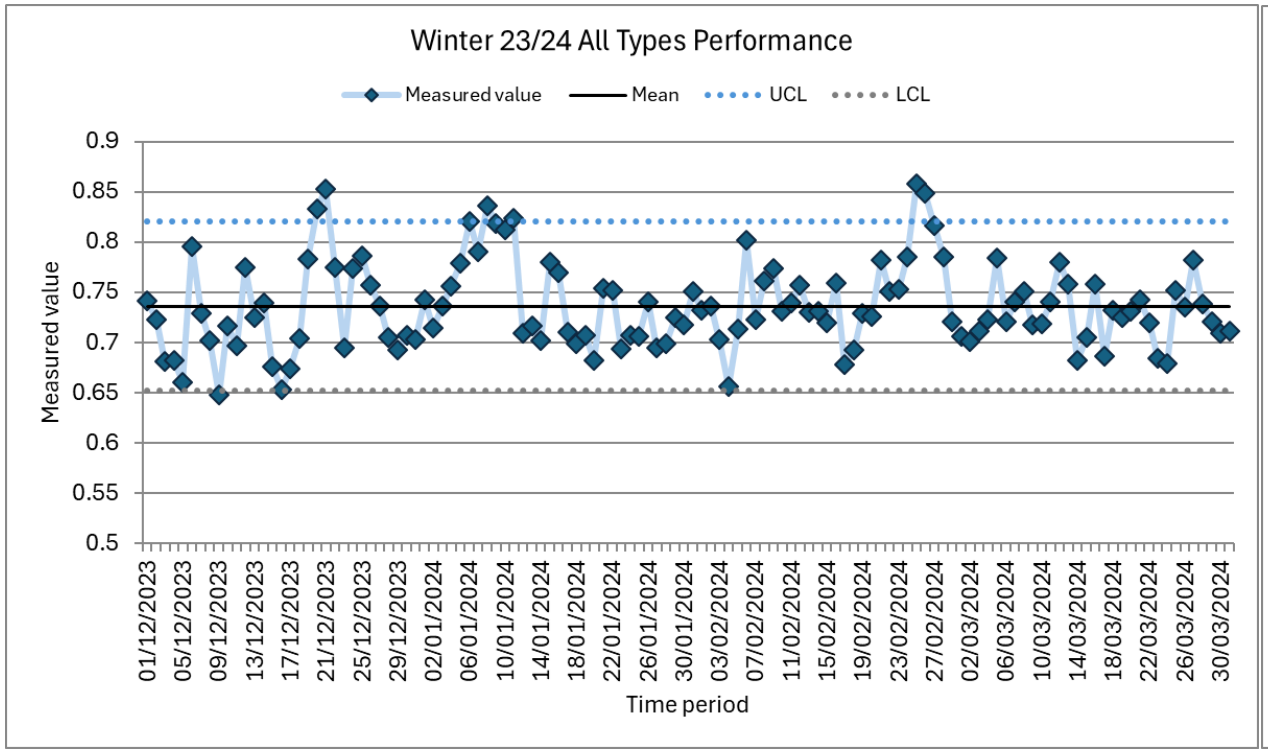
ED Performance Type 1

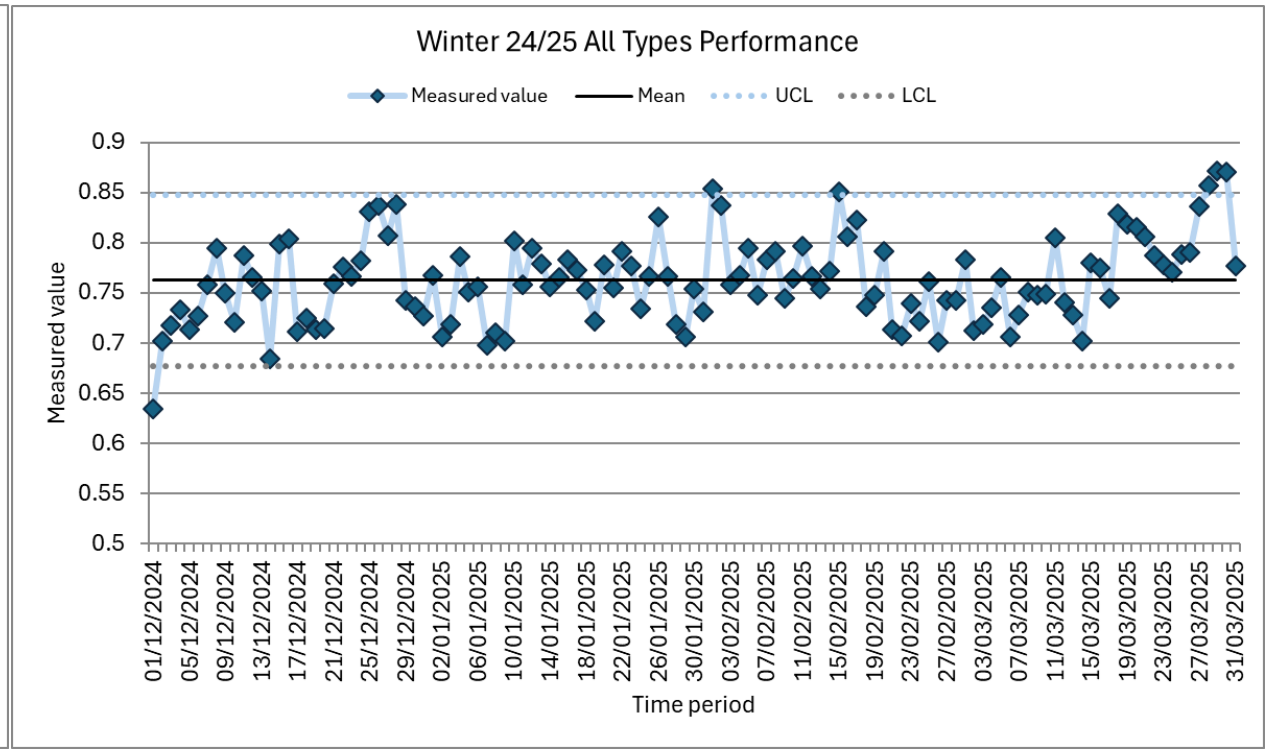


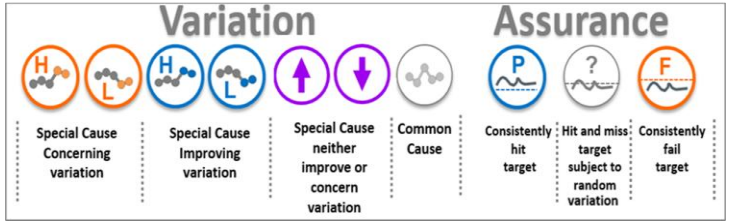




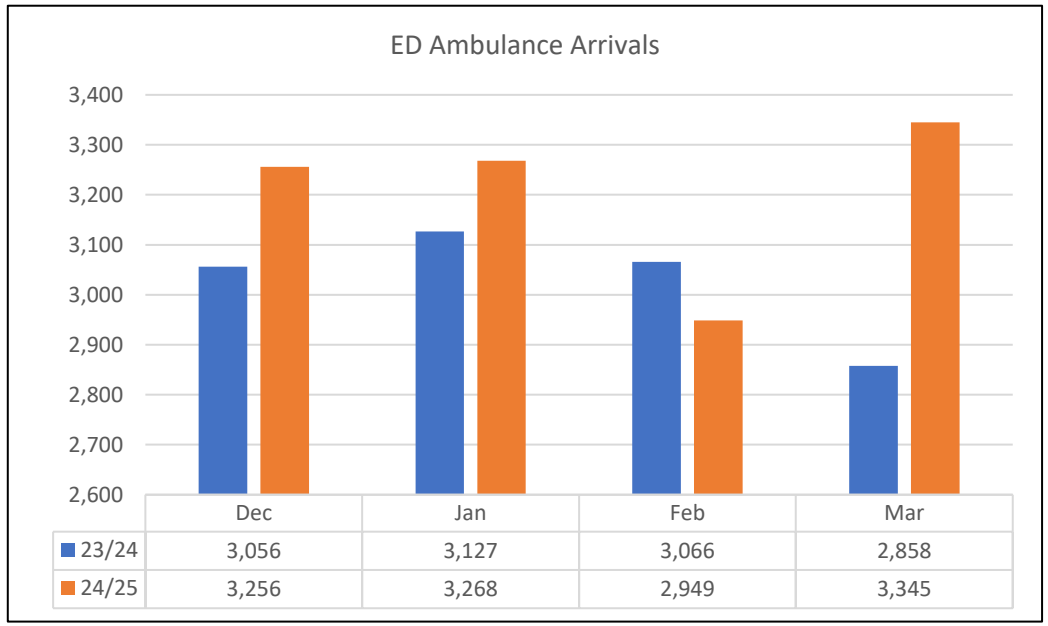
ED Performance All Types



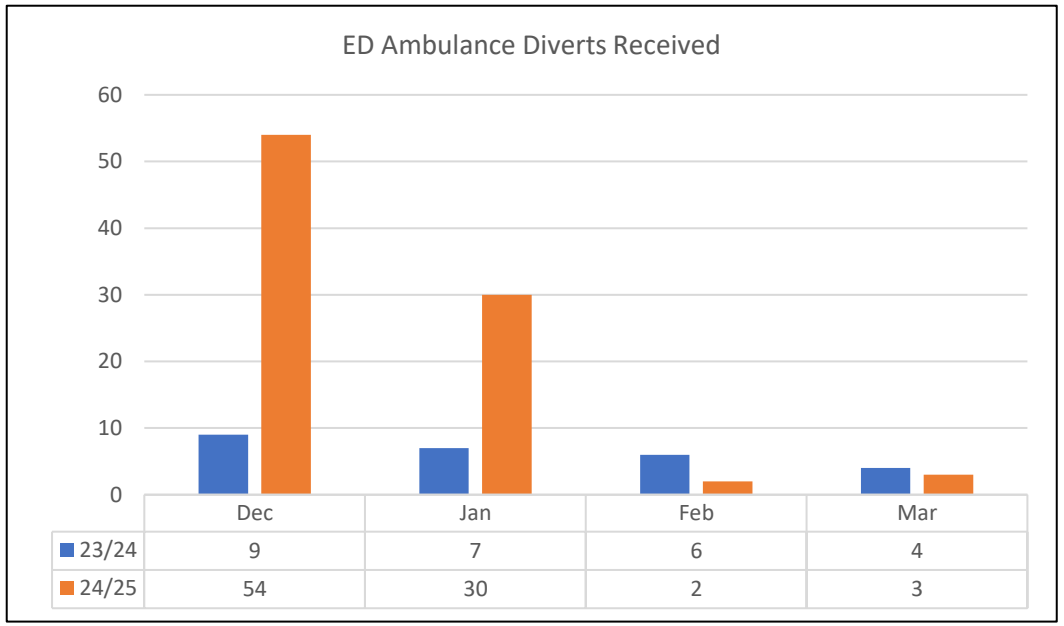




Ambulance arrivals and diverts in and out



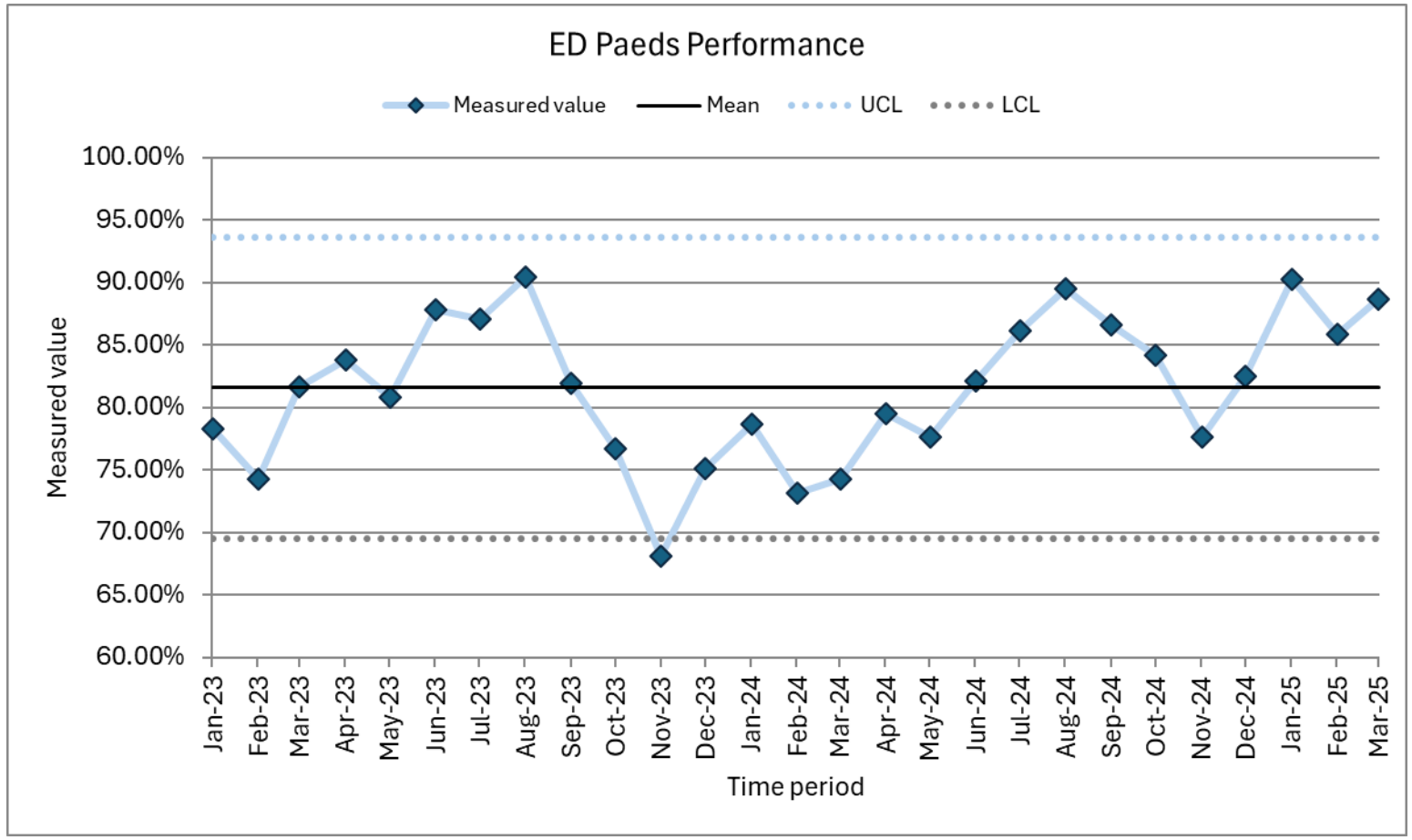
	Dec	Jan	Feb	Mar
23/24	3,056	3,127	3,066	2,858
24/25	3,256	3,268	2,949	3,345



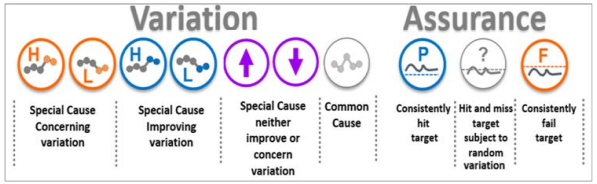
	Dec	Jan	Feb	Mar
23/24	9	7	6	4
24/25	54	30	2	3

No ED Ambulances Diverted from Royal Victoria Infirmary (RVI) in 2023/24. Compared to 6 in 2024/25.

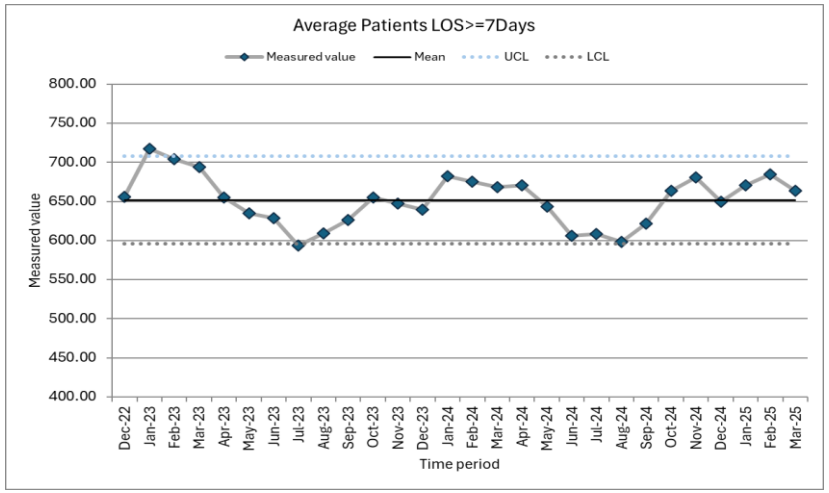
Type 1 Paeds ED Performance

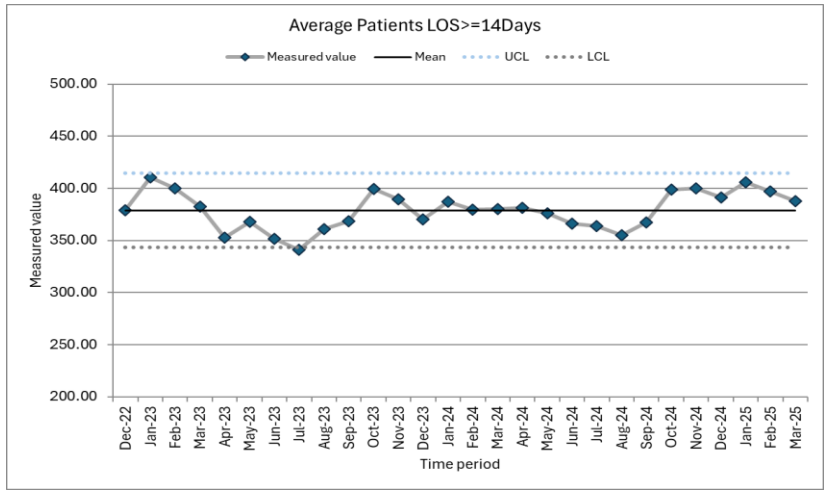


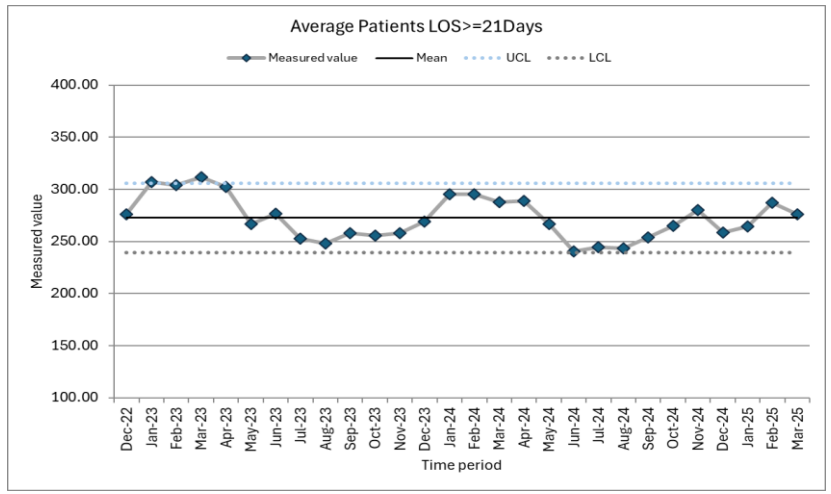
There is ongoing work to improve performance in Paediatric ED



Length of stay







Expected Date of Discharge (EDD) recording

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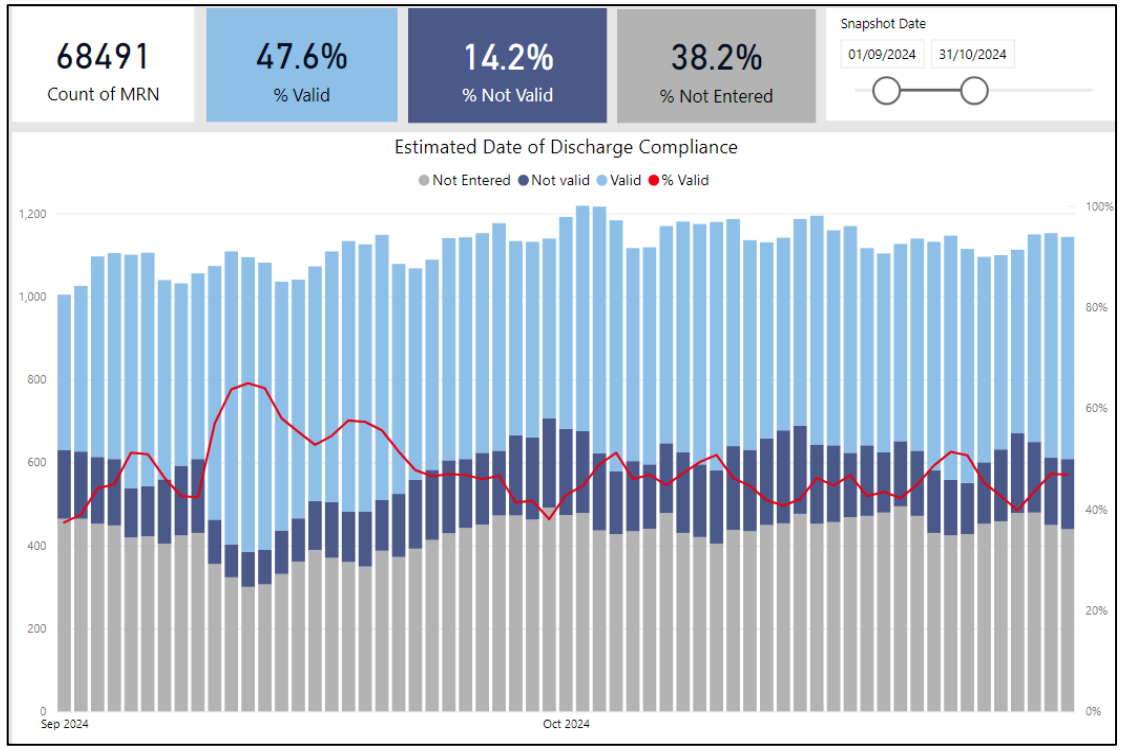
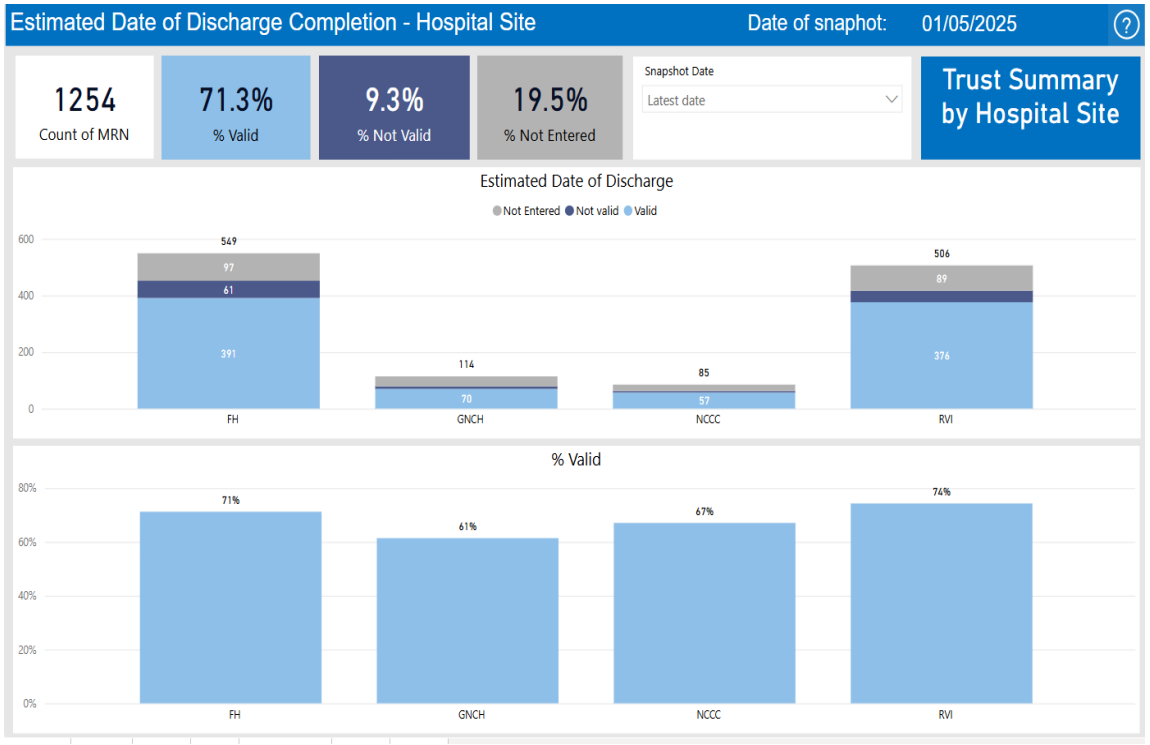
Pre-November

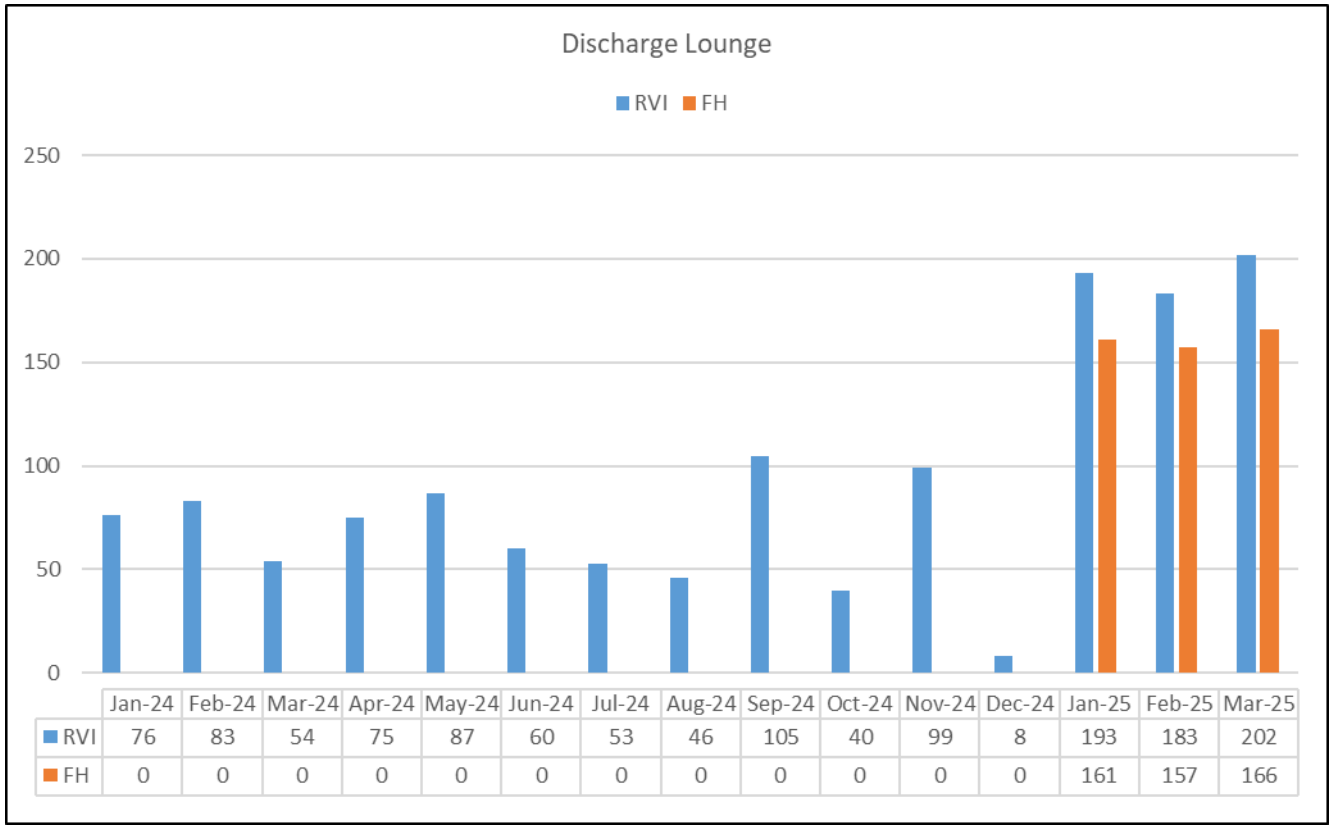


1st May 2025



- Circa 17-18% improvement in capture and recording of EDDs. Continues to be work in progress to improve accuracy.

Discharge Lounge Activity

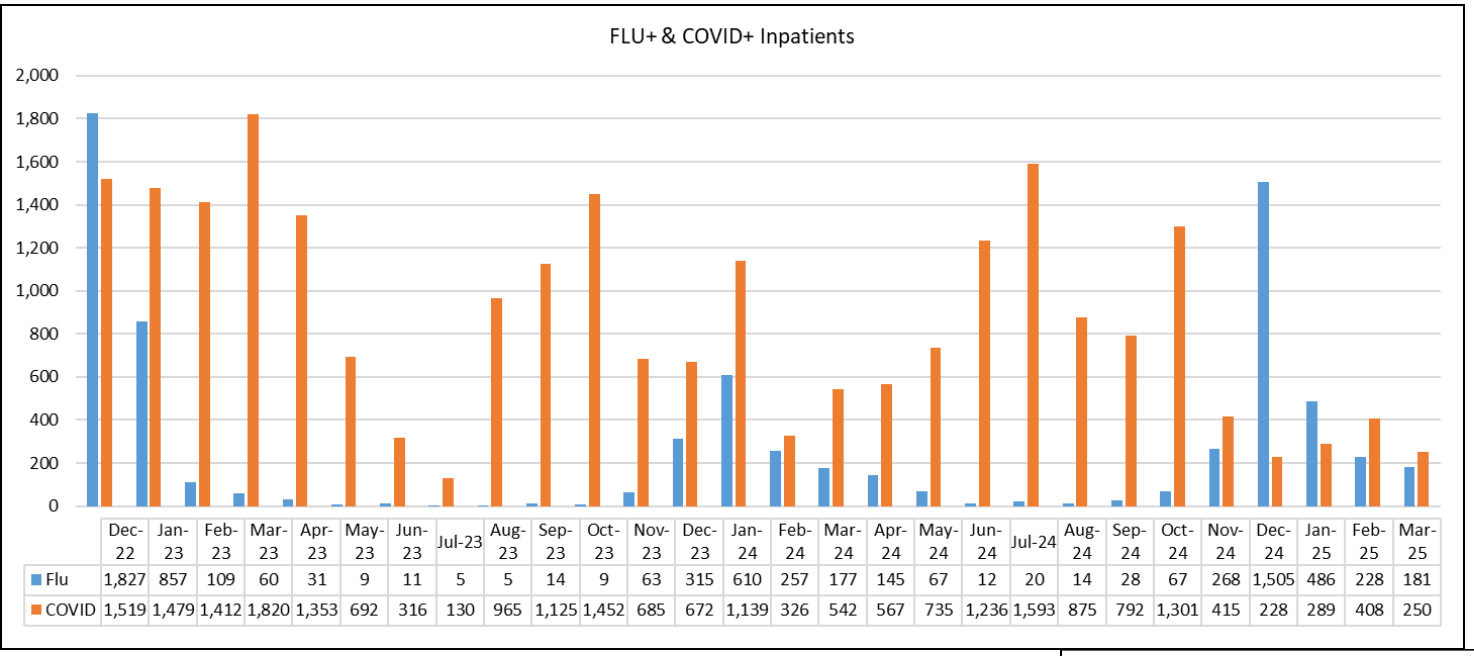


	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
RVI	76	83	54	75	87	60	53	46	105	40	99	8	193	183	202
FH	0	0	0	0	0	0	0	0	0	0	0	0	161	157	166

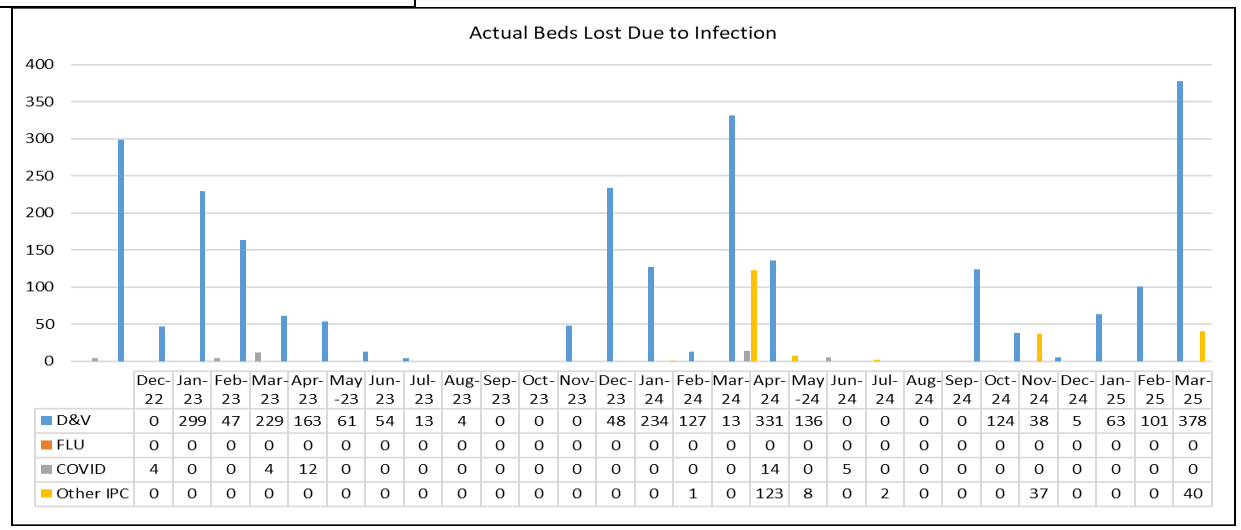
Prior to winter the discharge lounge at the RVI operated on bank staff. A business case was agreed to provide a discharge lounge on both sites from 1st April 2025. The winter funding enabled substantive recruitment from January 2025 hence the increase in use.

Flu & COVID Impact

The Newcastle upon Tyne Hospitals NHS Foundation Trust



	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Flu	1,827	857	109	60	31	9	11	5	5	14	9	63	315	610	257	177	145	67	12	20	14	28	67	268	1,505	486	228	181
COVID	1,519	1,479	1,412	1,820	1,353	692	316	130	965	1,125	1,452	685	672	1,139	326	542	567	735	1,236	1,593	875	792	1,301	415	228	289	408	250



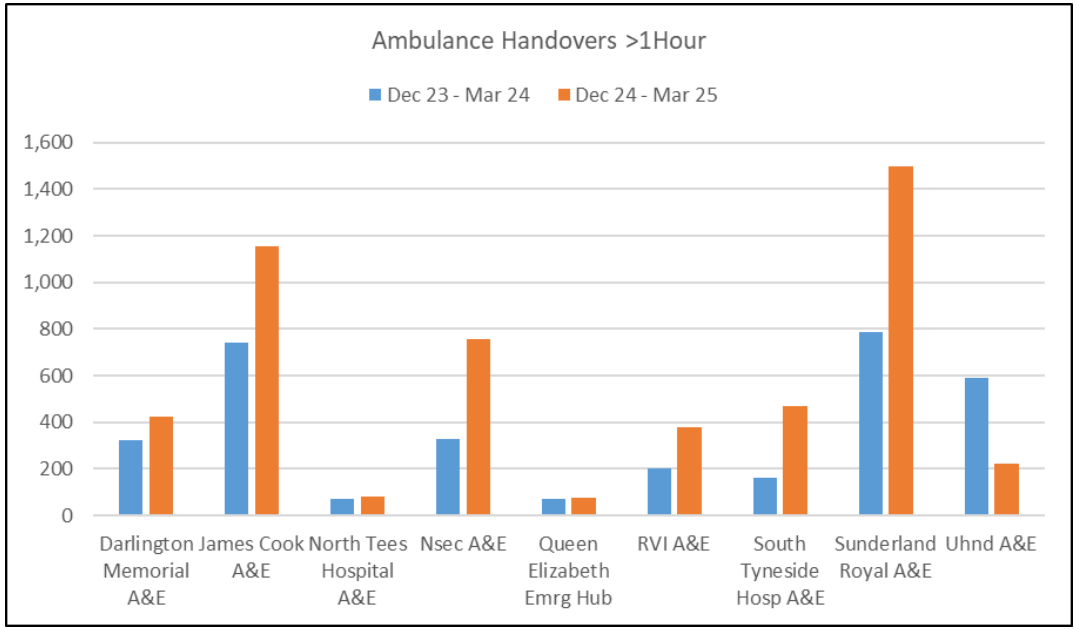
	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
D&V	0	299	47	229	163	61	54	13	4	0	0	0	48	234	127	13	331	136	0	0	0	0	124	38	5	63	101	378
FLU	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
COVID	4	0	0	4	12	0	0	0	0	0	0	0	0	0	0	0	14	0	5	0	0	0	0	0	0	0	0	0
Other IPC	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	123	8	0	2	0	0	0	37	0	0	0	40

System context – ambulance handovers >1 hour and average arrive to clear

The Newcastle upon Tyne Hospitals NHS Foundation Trust

All Trusts under pressure. Regular surge calls in place to mitigate acute pressure, mainly to minimise ambulance queuing and handover delays

	Dec 23 - Mar 24	Dec 24 - Mar 25	Diff
North East Region	**3,276**	**5,049**	**1773**
Darlington Memorial A&E	322	422	100
James Cook A&E	742	1,154	412
North Tees Hospital A&E	69	80	11
Nsec A&E	329	755	426
Queen Elizabeth Emrg Hub	71	76	5
RVI A&E	202	378	176
South Tyneside Hosp A&E	162	467	305
Sunderland Royal A&E	787	1,497	710
Uhnd A&E	592	220	-372



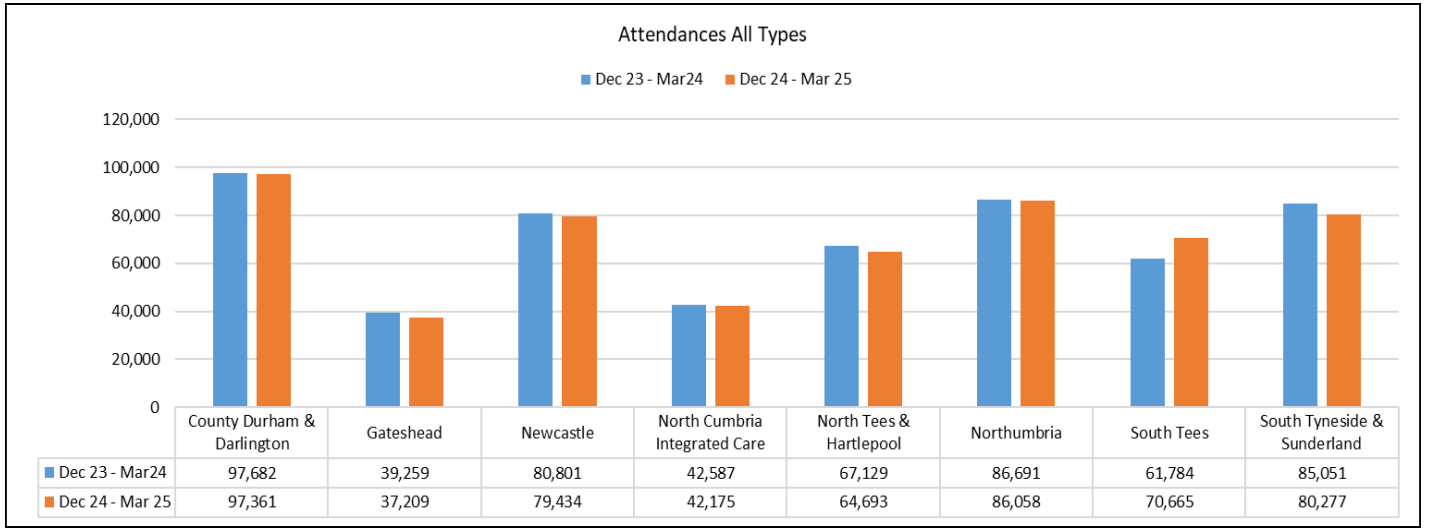
Average (Mean) Arrive to Clear (HH:MM)

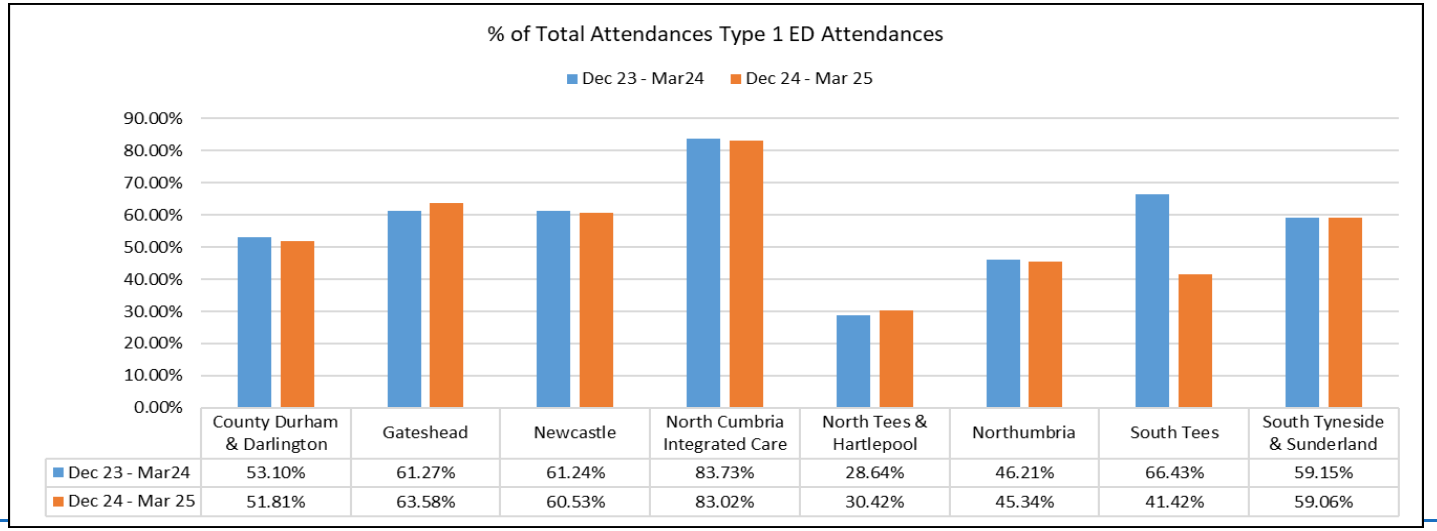
Month	RVI	NSECH	QE	Sunderland	S Tyneside	UHND	Darlington	N Tees	James Cook
Dec-24	0:41:00	0:47:00	0:37:00	1:09:00	0:57:00	0:39:00	0:47:00	0:37:00	1:03:00
Jan-25	0:40:00	0:44:00	0:35:00	0:59:00	0:51:00	0:35:00	0:47:00	0:35:00	0:54:00
Feb-25	0:40:00	0:41:00	0:33:00	0:44:00	0:45:00	0:35:00	0:36:00	0:34:00	0:43:00
Mar-25	0:40:00	0:39:00	0:35:00	0:39:00	0:37:00	0:33:00	0:34:00	0:33:00	0:40:00
Apr-25	0:42:00	0:39:00	0:33:00	0:43:00	0:42:00	0:34:00	0:36:00	0:34:00	0:40:00

System Context – ED activity

The Newcastle upon Tyne Hospitals NHS Foundation Trust

	Total Attendances - All Types	
	Dec 23 - Mar 24	Dec 24 - Mar 25
Region	**560,984**	**557,872**
County Durham & Darlington	97,682	97,361
Gateshead	39,259	37,209
Newcastle	80,801	79,434
North Cumbria Integrated Care	42,587	42,175
North Tees & Hartlepool	67,129	64,693
Northumbria	86,691	86,058
South Tees	61,784	70,665
South Tyneside & Sunderland	85,051	80,277

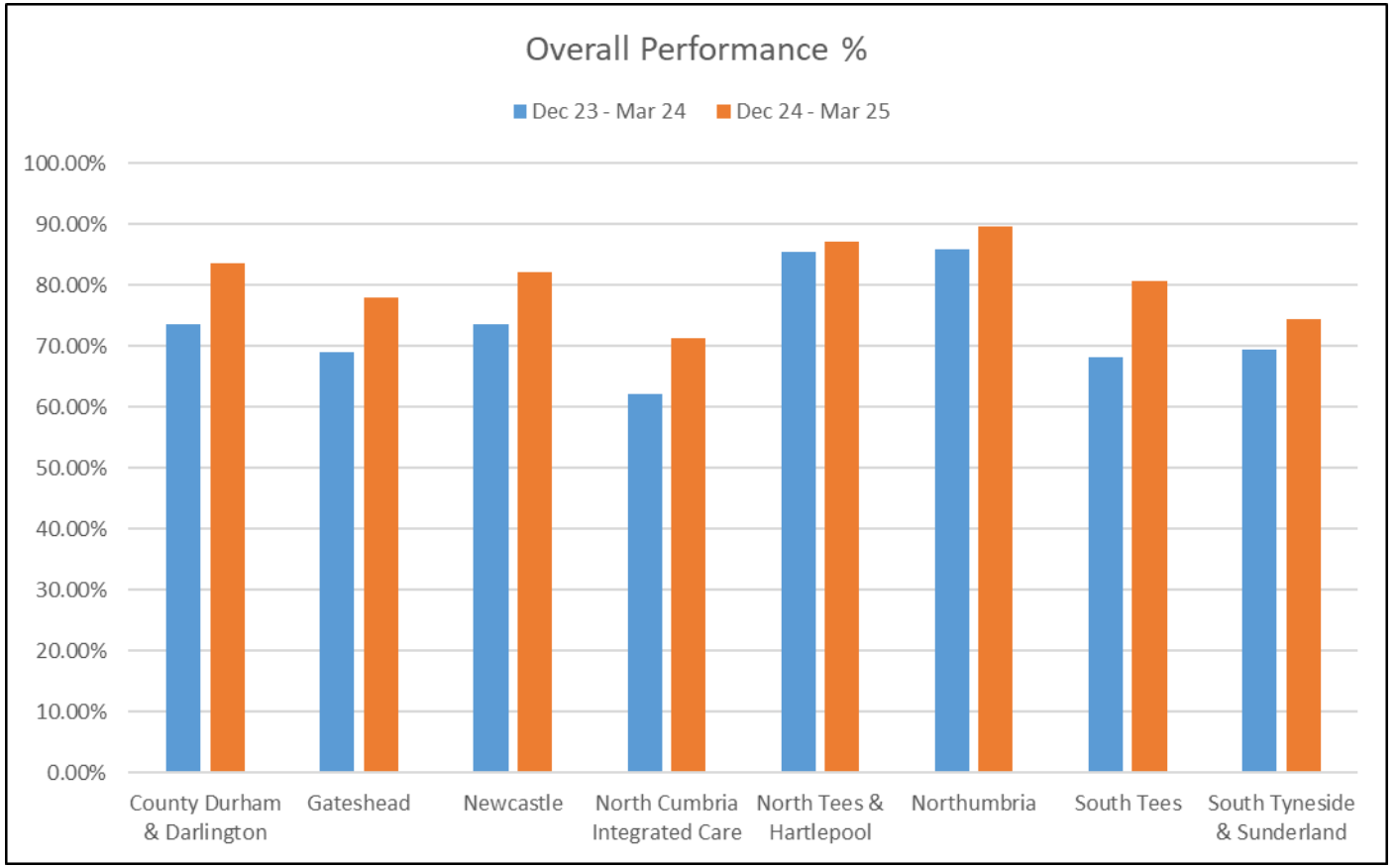




System context – ED performance

The Newcastle upon Tyne Hospitals NHS Foundation Trust

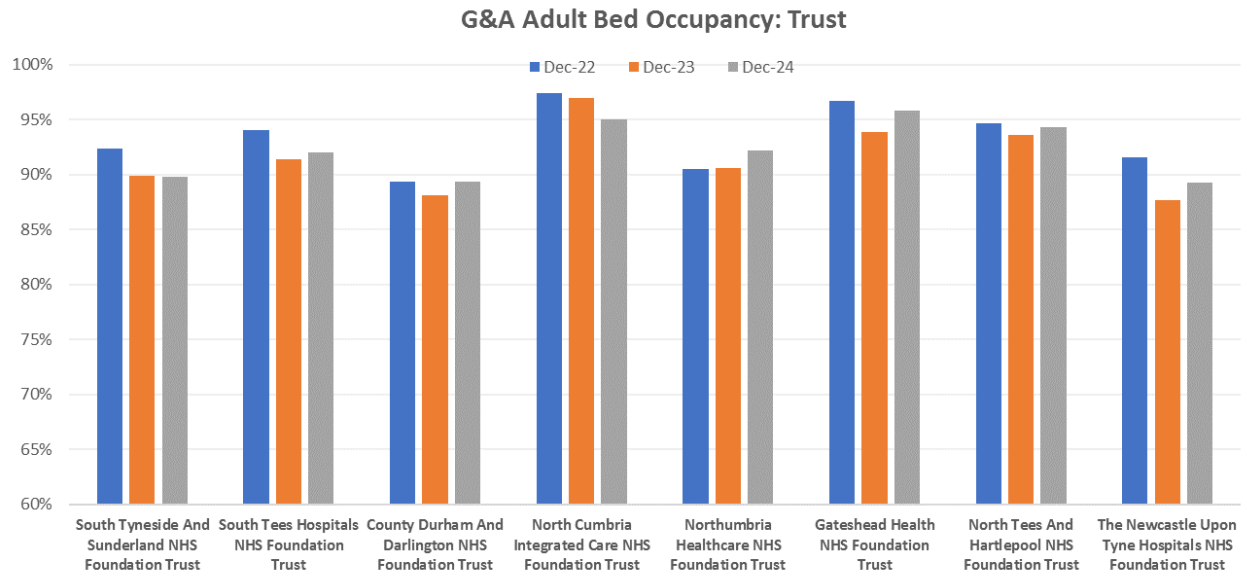
	Overall Performance All Types %	
	Dec 23 - Mar 24	Dec 24 - Mar 25
Region	**74.47%**	**81.73%**
County Durham & Darlington	73.54%	83.53%
Gateshead	68.97%	77.91%
Newcastle	73.63%	82.18%
North Cumbria Integrated Care	62.20%	71.38%
North Tees & Hartlepool	85.43%	87.07%
Northumbria	85.89%	89.66%
South Tees	68.12%	80.72%
South Tyneside & Sunderland	69.36%	74.41%



System context – Bed Occupancy (December Comparison)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

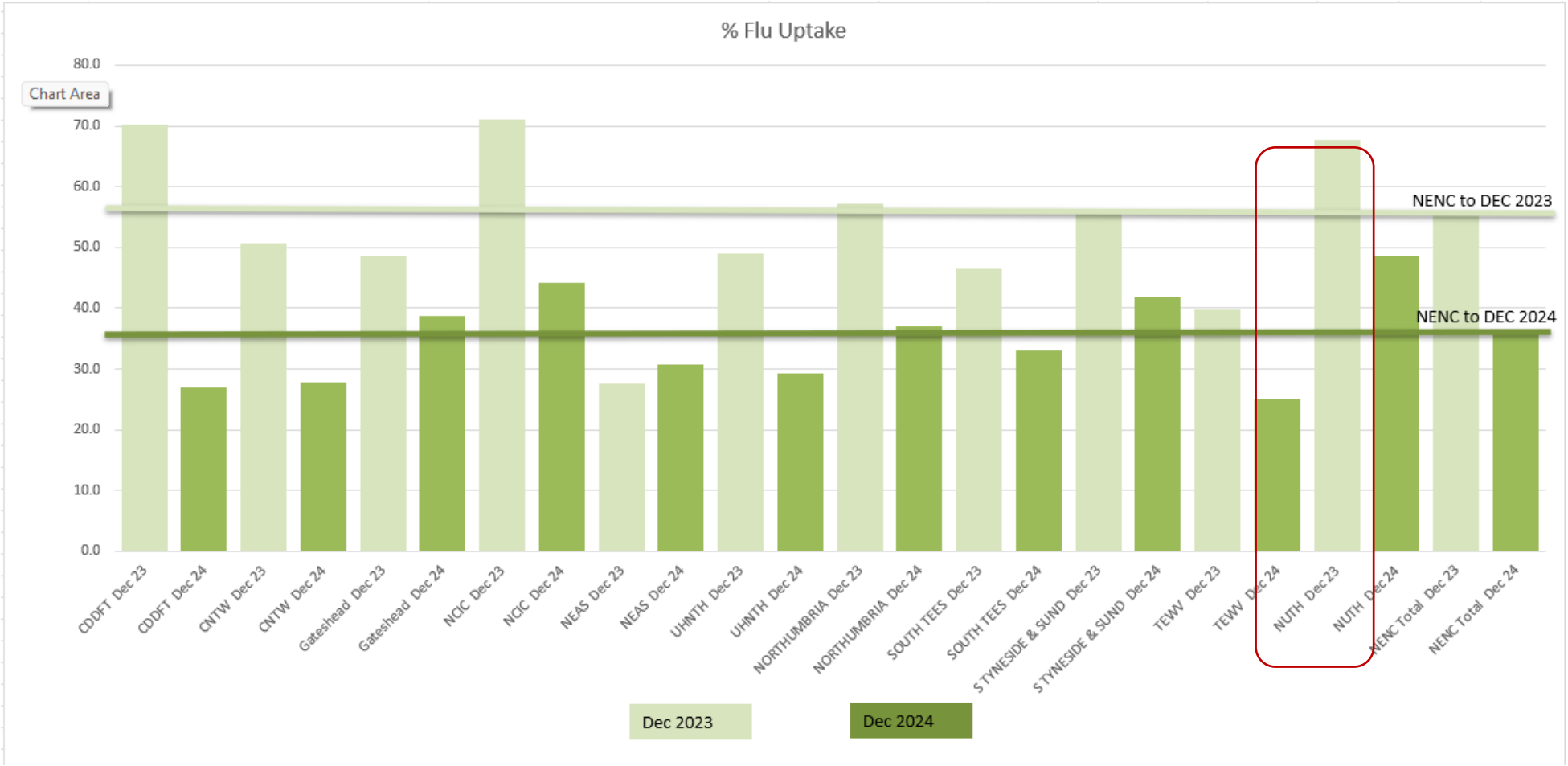
Level	Dec-22	Dec-23	Dec-24
National	95.4%	94.3%	94.4%
North East and North Cumbria	92.8%	90.8%	91.5%
South Tyneside And Sunderland NHS Foundation Trust	92.4%	89.9%	89.8%
South Tees Hospitals NHS Foundation Trust	94.1%	91.4%	92.0%
County Durham And Darlington NHS Foundation Trust	89.4%	88.1%	89.4%
North Cumbria Integrated Care NHS Foundation Trust	97.4%	97.0%	95.0%
Northumbria Healthcare NHS Foundation Trust	90.5%	90.6%	92.2%
Gateshead Health NHS Foundation Trust	96.7%	93.9%	95.8%
North Tees And Hartlepool NHS Foundation Trust	94.7%	93.6%	94.3%
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	91.6%	87.7%	89.3%



Workforce Vaccination uptake

The Newcastle upon Tyne Hospitals NHS Foundation Trust

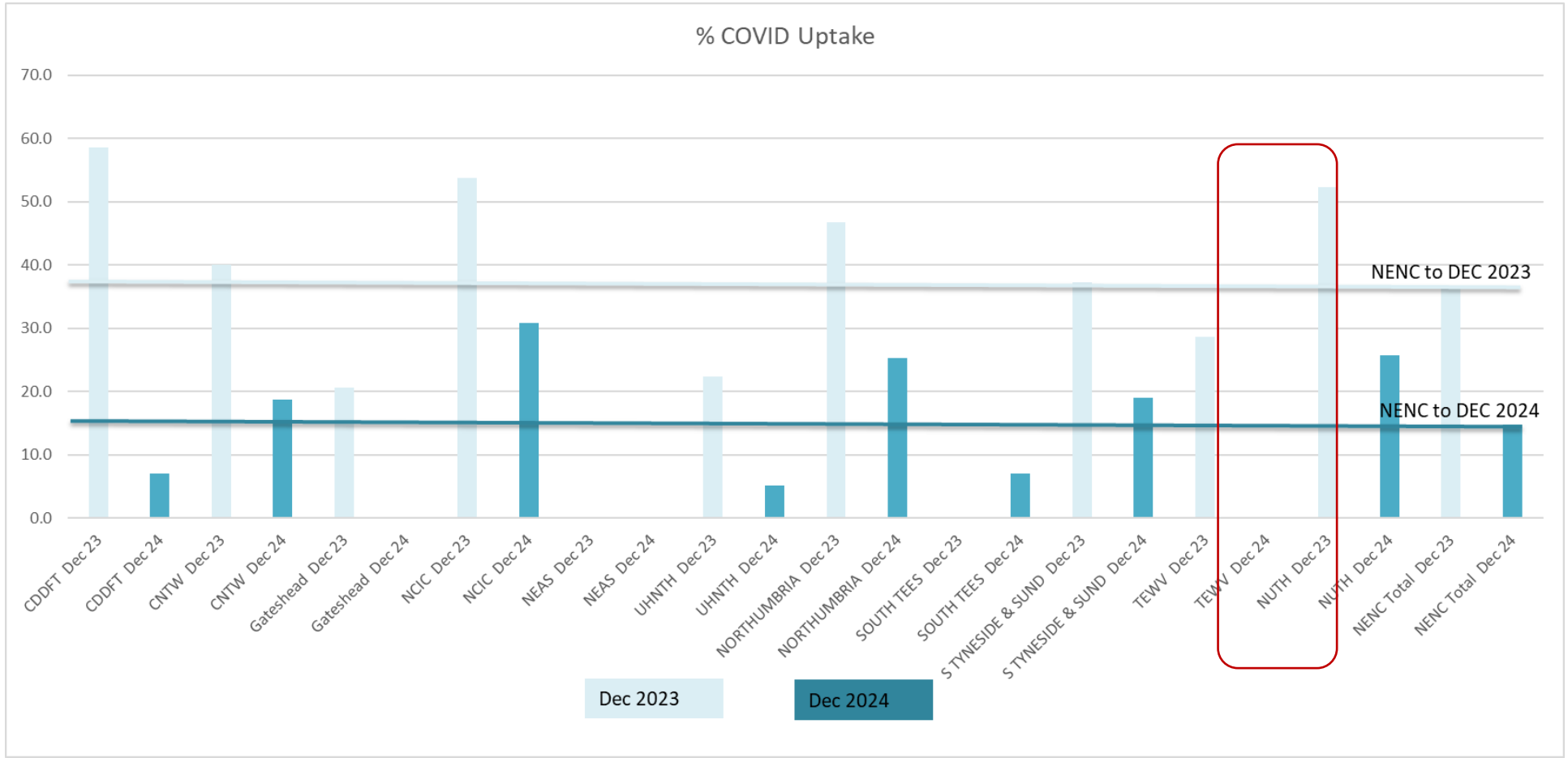
- Overall uptake for Flu, all staff currently at 51.33%. Most recent ICB comparison below:



Workforce Vaccination uptake

The Newcastle upon Tyne Hospitals NHS Foundation Trust

- Overall uptake for COVID, all staff currently at 26.96%, most recent ICB comparison below.



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Agenda item A9

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025		
Title	Integrated Board Report		
Report of	Patrick Garner, Director of Performance & Governance Rachel Carter, Director of Quality & Safety		
Prepared by	Elliot Tame, Head of Performance		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	This paper is to provide assurance to the Board of Directors on the Trust's performance against key indicators relating to Quality & Safety, Access, People, Finance and Health Inequalities. **Quality** • The Clostridioides difficile cases for March saw a slight decrease this month (18 v 19) compared to the previous month and continues to remain within the parameters of common cause variation. • The average Postpartum haemorrhage (PPH) rate for England is 33 per 1,000 and the North East North Cumbria (NENC) average is 32 per 1,000. The PPH rate for Newcastle Hospitals in March is 36 per 1,000 deliveries (down from 50 per 1,000 in January), this is indicative of the complexities of the high-risk patient group and provision of the Placenta Accreta Spectrum service as confirmed by the previous review. Each case has been reviewed and any learning enacted. **Performance** • In February, the 77% 28 Day Faster Diagnosis Standard (FDS) was achieved for the first time in eight months (83.4%). This follows the deployment of additional resource into pathway tracking within Skin. • The total waiting list (WL) size decreased further in March and continued to demonstrate improving variation. Referral to Treatment (RTT) 18-week performance was recorded at an improving 72.4%. • Overall emergency care 4-hour performance improved for the fourth successive month increasing to 77.48% (+0.73%), just fractionally short of target. Performance remains in line with common cause variation. **People** • 12 month rolling total sickness absence increase to 5.53% in March against a target of 4.50%. Whilst common cause variation is identified within the data the Trust continues to consistently fail to meet target. Funding from Charities has been agreed to pilot a staff psychology service for two years and reintroduce Mental Health First Aiders.		

<table>
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- Appraisal compliance improved to 85.8% but rates are consistently failing the target. A new appraisal process for all staff (excluding Medical & Dental) went live in April with ongoing communications and engagement events (c.1,000 attendees in first 4 weeks of engagement).

Finance

- As at Month 12 the Trust is reporting a break even against the planned break-even (after Control Total). The financial information includes the costs of the Consultant Pay Reform agreement for 2023/24 paid in May, with a pressure on drugs, partly off-set with income. The delivery of the plan has a significant Cost Improvement Plan (CIP) and includes a number of non-recurrent factors.

Health Inequalities

- The Health Inequalities reporting programme for 2025/26 will commence in Summer 2025.

</td></tr>
<tr><td>Recommendation</td><td colspan="6">For assurance.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality.

Performance – Being outstanding now and in the future.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☒</td><td>☐</td><td>☐</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">Linked to all.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">This is a regular paper provided to Trust Board.</td></tr>
</table>

Agenda item A9

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

Quality, Performance, People, Finance, Health Inequalities

May 2025

Healthcare at its best
with people at our heart

Contents

SPC Assurance Matrix

VARIATION	P	?	F	No Target	↑
H / L	• Trust BSOTS Midwifery Care Yellow - within 1 hour • Mandatory Training	• Adult Patient Falls • Trust BSOTS Midwifery Care Orange - within 15 minutes • Trust BSOTS Medical review Green - within 2 hours • Trust BSOTS Medical review Yellow - within 2 hours • Trust BSOTS Midwifery Care Green - within 4 hours • Trust Turnover	• RTT 18 Weeks Performance (%) • RTT >65 Week Waits • Cancer 62 Day Referral to Treatment Standard • Diagnostic 6 Week Performance	• Urinary Catheters (Community) % >28 Days • Falls per 1,000 bed days • Severe/Fatal Patient Safety Incidents per 1,000 bed days • Maternal deaths • Serious incidents • BSOTS Initial Triage within 15 minutes • RTT Waiting List Size • Diagnostic Waiting List Size • EDI - Disability • EDI - Ethnicity	
	• Infectious Diseases • FA2 20 week Anomaly scan • ST2 Timeliness of Antenatal Screening	• Number of C. diff Cases • Number of MSSA Cases • Number of E. coli Cases • Number of Klebsiella Cases • Number of Pseudomonas aeruginosa Cases • Inpatient Acquired Pressure Ulcers • Never Events • Trust BSOTS Medical review Red - Seen Immediately • ST3 Completion of FOQ • S01 - % screen compliant <72hrs of age • S03 - % hip USS attended between 4-6 weeks • S05 - % suspected bi-lateral undescended testes seen <24 hrs • ED Performance - All Types (%) • ED Arrival to Admission / Discharge >12 hours • ED Trolly Waits >12 hours • Cancer 28 Day Faster Diagnosis Standard	• Trust & LMNS BSOTS Medical review Orange - within 15 minutes •NB2 Avoidable NBBS repeats • Appraisal Compliance	• Urinary Catheters (Hospital) % >28 Days • Pressure ulcers per 1,000 bed days • Patient Safety Incidents per 1,000 bed days • Number of Verbal Duty of Candour Not Complete within 10 Days • Total number of inpatient deaths • Proportion of inpatient admissions where death occurred • Registerable Births • Stillbirths • Early neonatal deaths (0-7 days) • Perinatal Mortality cases • Caesarean section Deliveries (Total) • Elective Caesarean Deliveries • Emergency Caesarean Deliveries • Overall "Induction Of Labour" • Blood Loss >1500ml (per 1,000 deliveries)	• Maternal Re-admissions (Total) • Neonatal Re-admissions (Total) • Pregnancy Bookings • Moderate incidents • CQC/MSNI/CQC concern or request for action • Regulation 28 made directly to the Trust • ST4a • ST4b • S04 - % of hip referral outcome decision made (<6wks corrected age) • Short-term Sickness Absence
H / L		• Number of MRSA Cases • Percentage of Verbal Duty of Candour Completed • ATAIN	• Cancer 31 day Combined Decision to Treat to Treatment Standard • Trust Sickness Absence	• Percentage of Written Duty of Candour Completed • Number of level 2 mortality reviews undertaken • FA3 T21, T18, T13 Screening • Long-term Sickness Absence	• Registerable (Maternal) Deliveries • S02 - % eye abnormality suspected/seen <14 days of examination
					↓

ASSURANCE

Quality

Quality Overview

Metric	Period	Actual	Target	Variation	Assurance
HCAI - MSSA	Mar-25	15	9		
HCAI – C. Diff	Mar-25	18	12		
Harm Free Care – IP Acquired Pressure Ulcers	Mar-25	54	69		
Harm Free Care – Adult Patient Falls	Mar-25	251	203		
Stillbirths	Mar -25	1			
Blood Loss >1500ml (per 1,000)	Mar -25	36 per 1000			
ATAIN	Feb - 25	6%	5%		

Health Care Acquired Infections (HCAI)

- The *Clostridioides* difficile cases for March saw a slight decrease this month (18 v 19) compared to the previous month and continues to remain within the parameters of common cause variation.
- The number of Methicillin-susceptible Staphylococcus aureus (MSSA) continued to increase to 15 in March (15v 12) - this remains above the monthly target (10% reduction on previous year) and now exceeds the year-to-date overall target ≤98.

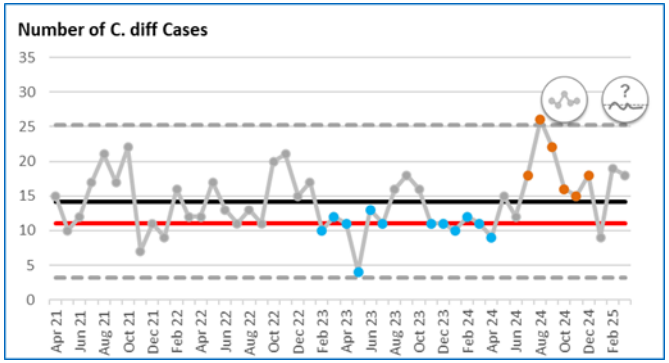
Harm Free Care

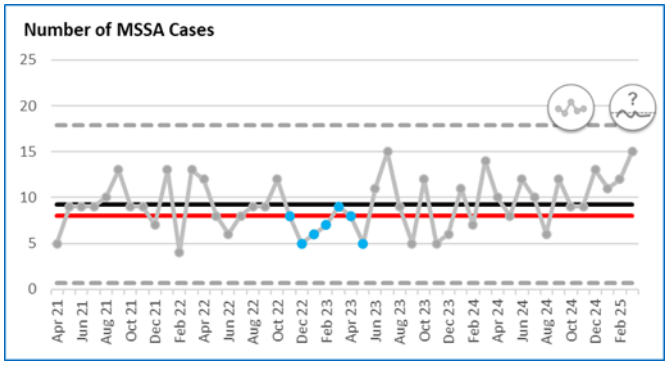
- The number of acute pressure ulcers (PU) reported in March increased slightly (54 v 51), no special cause variation has been highlighted.
- In March there was an increase in falls (251 v 220), this was the highest number of falls in a month in the financial year.

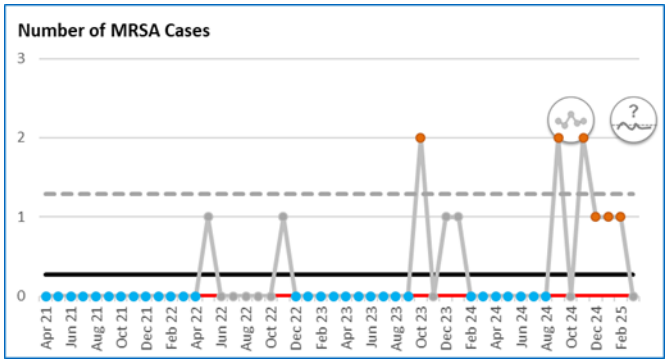
Perinatal Quality Surveillance

- The rate of admission peaked in February at 13% and has subsequently reduced to 6% in March. The Trust is benchmarking against other Tertiary services, but a deep dive has commenced as hypothermia is the second most common reason for admission, with a task and finish group established. Further work is needed to reduce the rate.
- The average The Post-partum haemorrhage (PPH) rate for England is 33 per 1,000 and the North East North Cumbria (NENC) average is 32 per 1,000. The PPH rate in March is 36 per 1,000 deliveries (down from 50 per 1,000 in January), this is indicative of the complexities of the high-risk patient group and provision of the Placenta Accreta Spectrum service as confirmed by the previous review. Each case has been reviewed and any learning enacted. This will be closely monitored, and a high-level review of February and March cases has been undertaken to identify any new or emergent themes.

Healthcare Associated Infections (HCAI) (1/2)







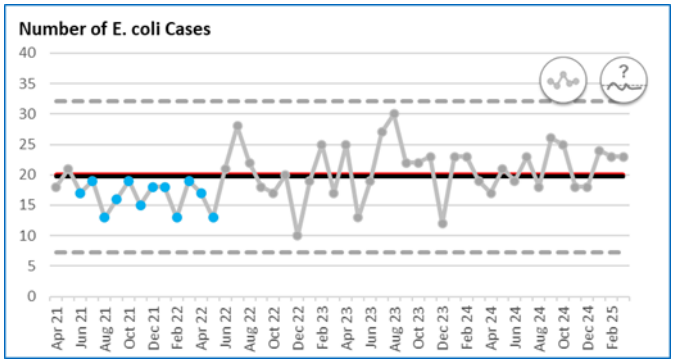
Standards

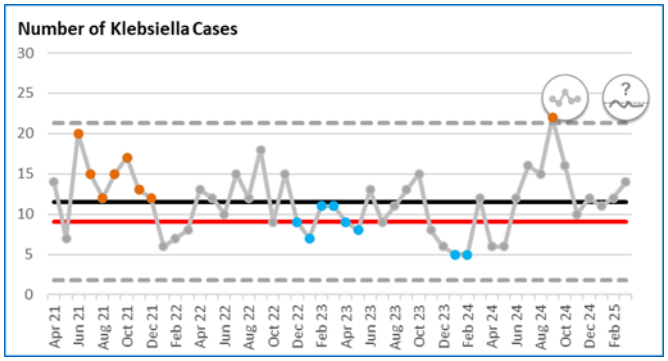
- **Zero methicillin-resistant Staphylococcus aureus (MRSA)** cases.
- **No more than 98 MSSA** cases across the financial year (local target - 10% reduction from 2023/24).
- **No more than 136 Clostridioides Difficile Infection (CDIs), 247 *E. coli*** cases, **108 Klebsiella** cases or **39 Pseudomonas aeruginosa** cases across the financial year.

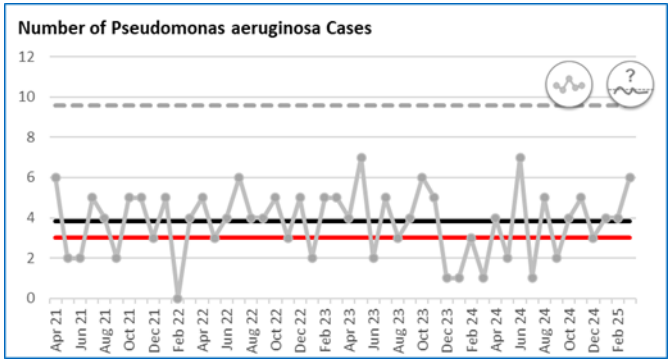
Current Position

- March saw a slight decrease in CDI cases compared to the previous month (18 v 19) and continues to be within the parameters of common cause variation. The cumulative total is 197 this is over the National Threshold by 31% and mirrors the North-East and North Cumbria HCAI percentage. It is an increase of 27% when compared to 2023/24 cases. There were 4 Community Onset Healthcare Associated (COHA) cases and 14 Hospital Onset Healthcare Associated (HOHA) cases, of which 4 were unavoidable, and 10 are pending review.
- The number of MSSA cases have slightly increased compared to the previous month (15 v 12). Of these there were 14 HOHAs and 1 COHA. Of the HOHA cases 4 were deemed unavoidable, 1 avoidable and 9 are pending review. Themes identified were issues with wound and cannula care documentation.
- There were no Methicillin-Resistant Staphylococcus aureus (MRSA) cases in March and is now within the parameters of common cause variation, rather than the special cause concerning variation seen in previous months.
- There was no change seen in the number of *Escherichia coli* (*E. coli*) bacteraemia cases compared to the previous month (23 v 23). The overall rate of *E.coli* cases was 3% above the National Threshold for 24/25 (255 v 247) however in comparison to the previous year 23/24 this is a 1% reduction. There were 7 COHA cases and 16 HOHA, of which 5 HOHA were deemed unavoidable, and the remaining 11 are pending review.
- The was a slight increase in Klebsiella bacteraemia cases this month compared to the previous month (14 v 12). Cumulative total is 152, which is over the National threshold of 41%. All cases (14) were HOHAs. Of these 7 were deemed unavoidable, and 7 are pending review.
- There was a slight increase in Pseudomonas Aeruginosa cases compared to previous months (6 v 4) and remains in line with common cause variation. Cumulative total is 47, exceeding the National threshold by 21%. There were 1 COHA and 5 HOHA, of which 2 HOHA were deemed unavoidable, and the remaining 3 are pending review.

Healthcare Associated Infections (2/2)



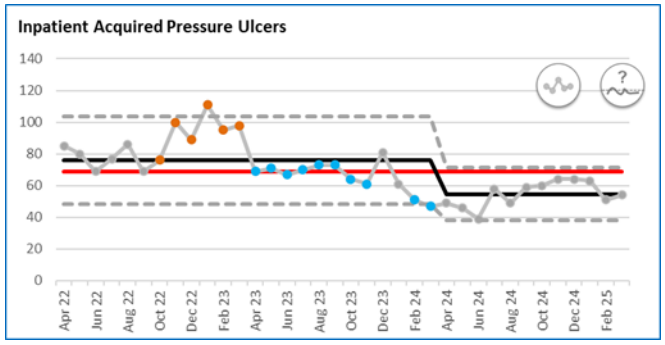


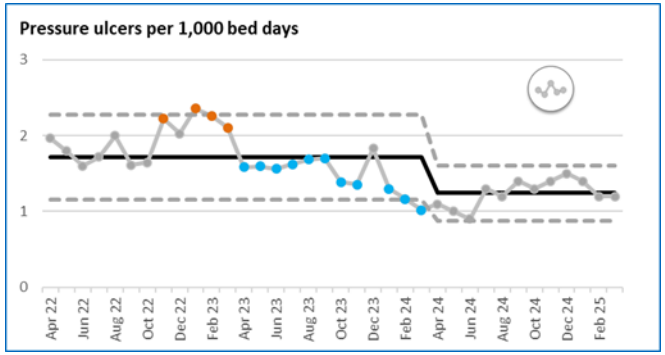


Action taken

- To improve cannula invasive device management B Braun are supporting a Trust wide audit. When results are known this information will be disseminated at various forums with improvement actions to be reported and monitored in Clinical Board Governance meetings.
- Clinical Boards continue to receive patient level data on MRSA screening compliance, and inappropriate antibiotic prescriptions for MRSA from the Clinical Informatics Microbiology Lead.
- MRSA Quality Improvement pilot continues within Surgical and Associated Services (SAS) Clinical Board due to high incidence; to improve MRSA screening compliance and management.
- The Antimicrobial Stewardship (AMS) Team are working with digital health to initiate a flag to alert clinicians that patients have a history of MRSA.
- Collaboration continues between Infection Prevention and Control (IPC), Facilities Teams, Patient Services Coordinator (PSC) Teams and clinical leaders to facilitate safe and timely patient placement and prompt specialised cleaning when required.
- IPC are working collaboratively with the Accrediting Excellence (ACE) programme by providing an IPC coach to those areas who are preparing for accreditation.
- Clinical Boards have reviewed the AMS risk within their departments and added to their individual risk registers for action, where appropriate**.** The corporate AMS risk has been transferred from Patient Services to Pharmacy to ensure monitoring through Medicines Management Oversight Group. These risks are monitored at IPC Committee.

Harm Free Care: Pressure Damage





Standard

- A reduction target has been set at **20% year on year for pressure ulcers** at Category II and above.

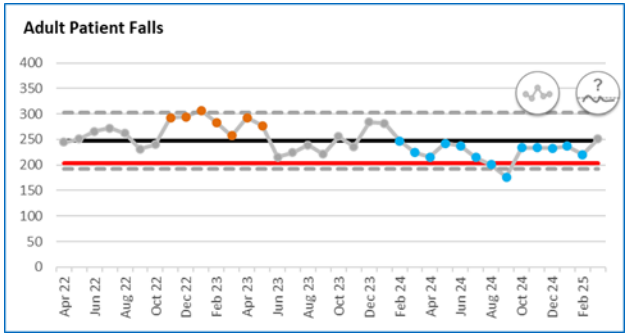
Current position

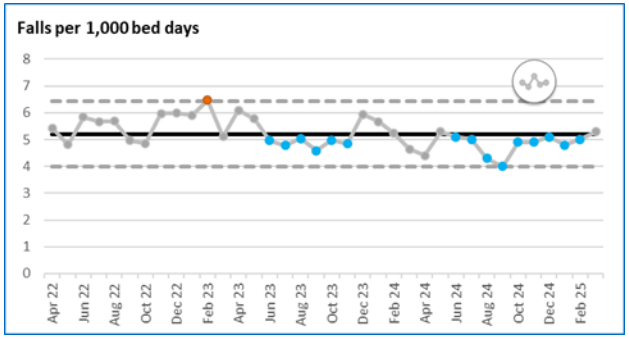
- The number of acute pressure ulcers (PU) reported in March increased from 51 to 54. The chart has been adapted to reflect a sustained reduction, therefore highlighting no special cause variation.
- The number of Category (Cat) III pressure ulcers in March also increased from 1 to 4 . Investigations into all of these are underway.

Action taken

- The themes and trends from pressure ulcer investigations in February show shortfalls in documentation and images had not been taken in a timely manner. Skin and pressure ulcer risk assessments required completion. Staff will undertake pressure ulcer prevention and categorisation training.
- Freeman mattress audit took place 18th-20th March. From 868 mattresses 570 were checked (66%), 225 were condemned (39%), 104 repairs took place (18%) and 241 passed (42%). The reasons behind missed checks were: patients not being able to get out of bed, infection control concerns, specialist mattresses in place or the bed was not in bed space at the time of the audit. All condemned mattresses were replaced with new Static Air HZ at the time, all repairs were completed at the time of the audit.
- Two wards were not audited at that time as they were closed due to infection control outbreaks. These two wards were audited later, and an additional 17 mattresses were replaced.
- Royal Victoria Infirmary (RVI) mattress audit will be undertaken in September 2025.

Harm Free Care: Falls





Standard

- A reduction target has been set at **20% year on year for adult patient falls**.

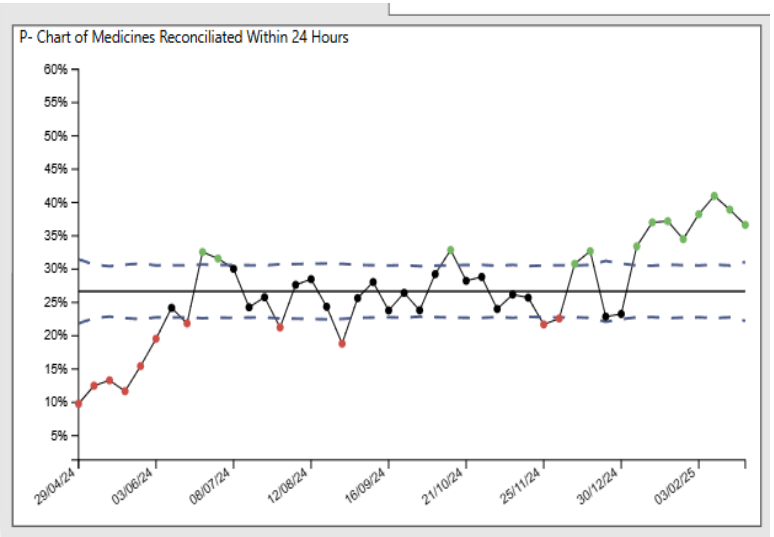
Current position

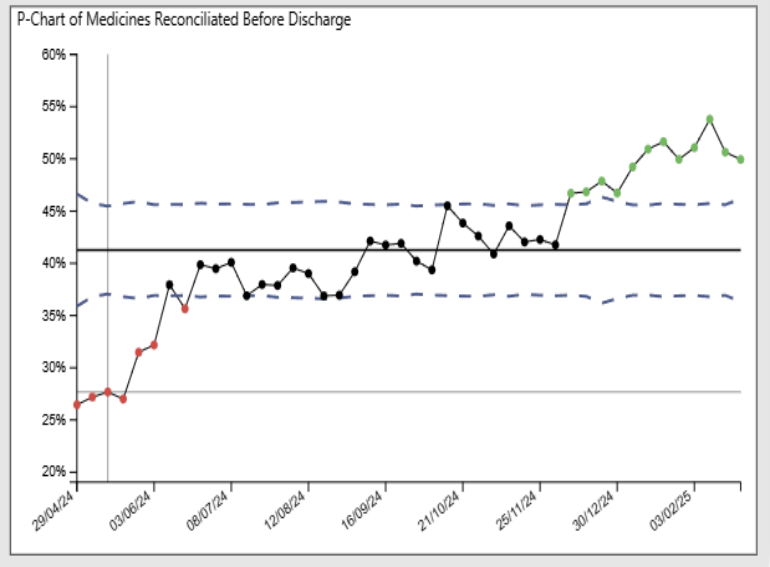
- In March, there was an increase in falls compared to the previous month (251 vs 220).
- Falls with moderate or above harm were recorded as 3.6% of falls (9).
- There were 2 major harm incidents resulting in 1 fractured neck of femur and 1 head injury. There were 7 moderate harms.

Action taken

- Following investigations into 2 previous moderate and above falls in February, the wards identified actions to help prevent future falls: to improve Enhanced Care Observation (ECO) assessment, improve staff knowledge on vision assessments, completion of lying and standing blood pressure, ensure completion of Rapid Clinical Test for Delirium (4AT), ensure Falls Risk Assessment and Falls Care Bundle are completed on admission, transfer and conditional change and to work with the Dementia team to support the use of the Abbey Pain Scale, a tool which is used to assess individuals who have difficulties communicating their pain.
- Compliance with mandatory Falls Prevention training remains high at 97.9%.
- The Falls Prevention Coordinator (FPC) is now the Co-chair of the North-East Falls group, establishing relationships with other falls leads and sharing best practice across the region.
- Best practice in falls prevention has been selected as a presentation at the Trust Nursing, Midwifery and Allied Health Professionals (NMAHP) conference next month
- ECO training continues to be rolled out across the Trust, updates on training numbers are sent to the Heads of Nursing bimonthly.
- A Trust wide ECO audit was undertaken in April 2025, the results of which are being collated and will be shared.

Medicines Reconciliation (Med Rec)





Standards

- Target 40% (with existing staffing); 60% after approval of phase 1 of staffing business case; 80% after approval of phase 3 of the staffing business case.

Action taken

- Quality Improvement (QI) project being undertaken to test different ways of working that aim to improve medicines reconciliation rates without adversely impacting core services (e.g. patient flow, medicine supply, operational duties).
- Phase 1 of the staffing business case to be submitted February 2025.

Current Position

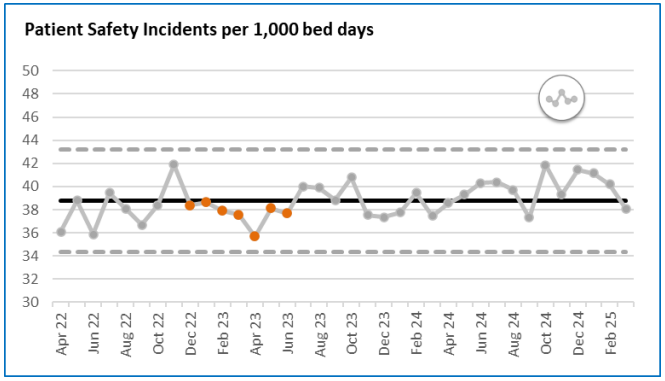
- Improvements visible, nearing towards 40% target within 24 hours.
- Continuing increase in med rec before discharge.

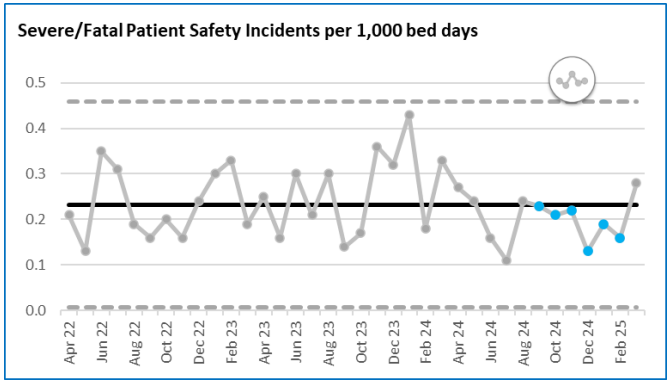
	Med rec within 24 hours	Total Med Rec before discharge
May 2024	**13%**	28%
June 2024	**24%**	36%
July 2024	**27%**	38%
Aug. 2024	**25%**	38%
Sept. 2024	**26%**	41%
Oct. 2024	**29%**	43%
Nov 2024	**24%**	42%
Dec 2024	**27%**	46%
Jan 2025	**34%**	51%
Feb 2025	**39%**	52%

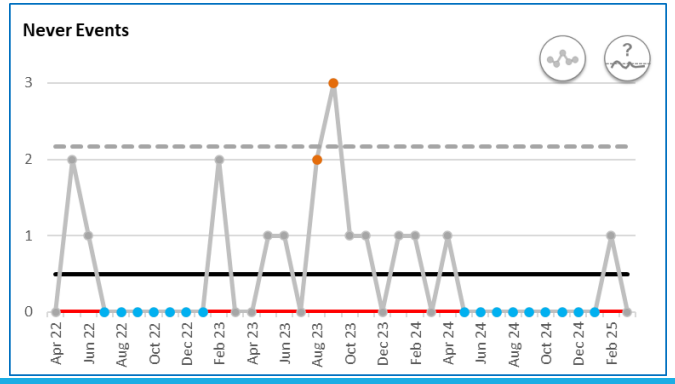
Narrative February

- Continued rise in figures due to continued targeting of surgical patients pre-admission before elective surgery at Freeman Hospital (FRH).
- Have also rolled out to target elective cardiothoracic patients pre-admission at Freeman Hospital.

Incident Reporting







Standards

- Continued trend of **increased incident reporting** across the Trust.
- Aim to achieve a target of **zero Never Events**.

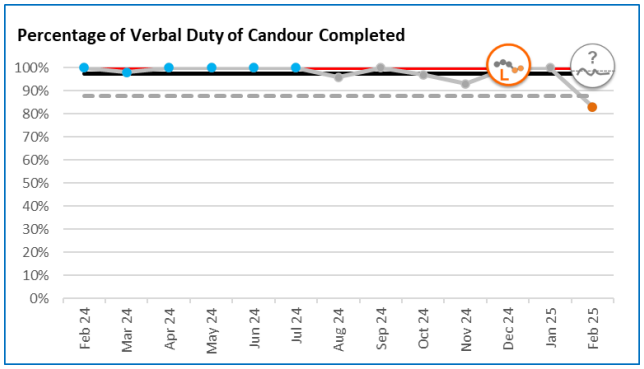
Current Position

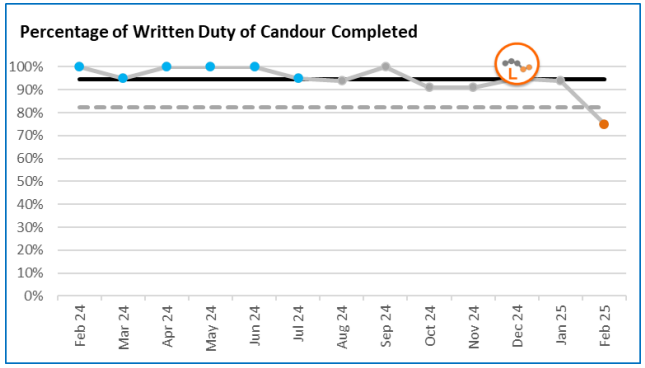
- The total number of patient safety incidents per 1,000 bed days reported in March 2025 has decreased compared to February.
- The number of severe/fatal safety incidents per 1,000 bed days has increased in March 2025, compared with February.
- Four Patient Safety Incident Investigation was declared in March 2025.
- Four After Action Reviews were declared in March 2025.
- Two Thematic Reviews were declared in March 2025.

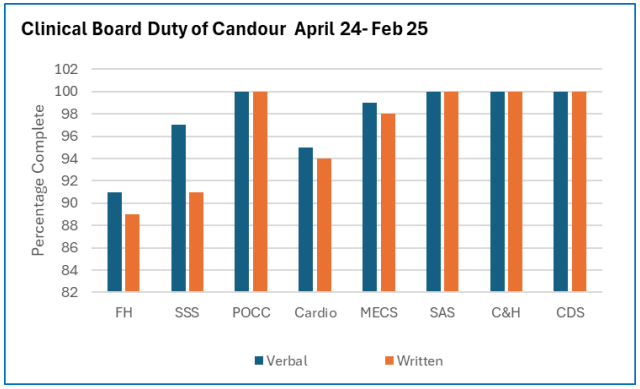
Action taken

- Clinical Boards have access to incident reporting rates and have identified areas of low reporting, implementing targeted plans to address this.
- Clinical Boards have employed a Patient Safety and Clinical Governance Lead. The patient safety team are providing education around incident management for the new group.
- Patient Safety Training has been delivered to the new Patient Safety and Clinical Governance Leads.
- Raising awareness of incidents and dissemination the learning continues to take place through the Patient Safety Bulletin, Patient Safety Briefings and Clinical Risk Group.
- Questions relating to patient safety are included in the Trustwide peer reviews and the Accrediting Excellence Programme.
- The position on Never Events continues to be monitored Trustwide.

Duty Of Candour







Standards

- Statutory Duty of Candour (DoC) - notification of the relevant person of suspected or actual notifiable safety incidents) to be undertaken for all notifiable safety incidents.
- To encourage openness and a timely apology, the trust's policy outlines verbal and written duty of candour should be completed as soon as reasonably practicable.

Current Position

- Overall trust compliance for verbal duty of candour had increased to 98% for the reporting period compared with 97% for the previous month.
- Overall trust compliance for written duty of candour had increased to 95% for the reporting period compared with 94% the previous month.
- Compliance will continue to improve as incidents are reviewed, and apologies provided to patients and their families.
- Clinical Board oversight is monitored through Patient Safety Group, Quality and Performance reviews and Quality Oversight Groups.

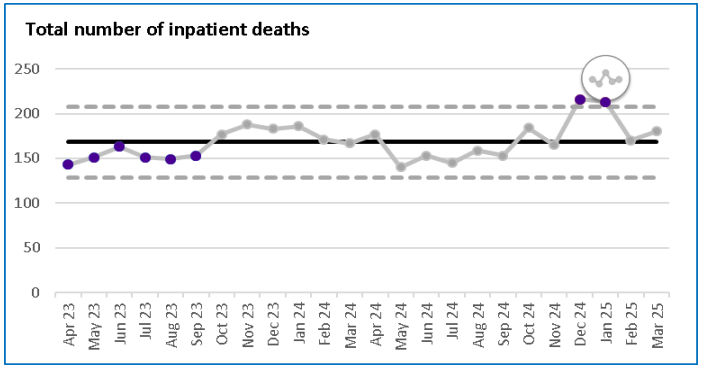
Action taken

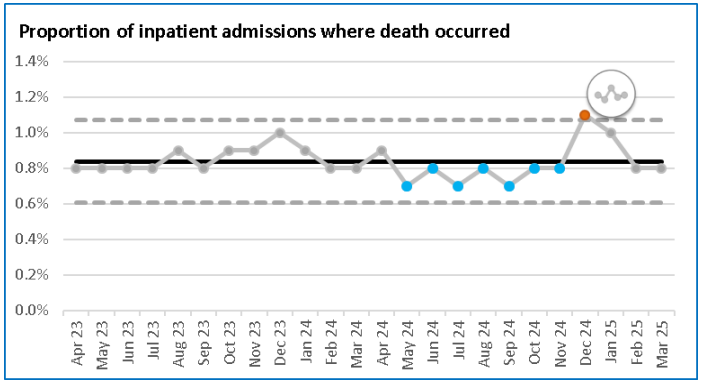
- Learning Lab module on duty of candour developed in conjunction with the training, education and learning (TEL) team. Review and finalisation in progress.
- A focus is being made on the quality of duty of candour responses with a quality audit to include patients being developed.
- Review and update of the duty of candour policy to provide more succinct and relevant guidance. Introduction of 'policy on a page'.
- Ongoing work to introduce Family Liaison roles within the trust to support engagement in safety events and DoC requirements.

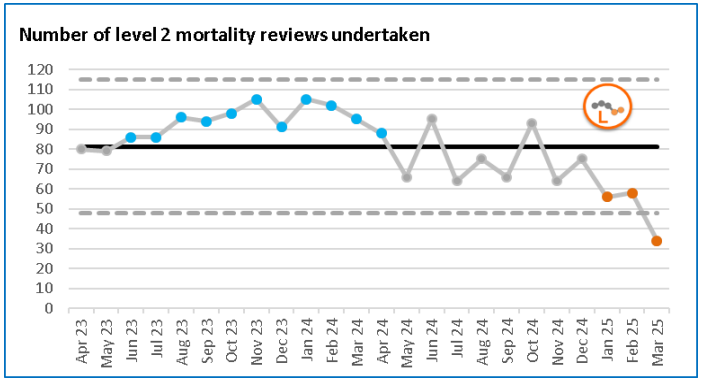
Measures of Success

- All patients involved in a notifiable patient safety incident resulting in moderate or above harm to receive timely verbal and written apology.
- High quality, patient focused verbal and written communication with patients throughout the incident investigation.

Mortality Indicators (1/2)







Standards

- Due to the recent changes nationally to the Medical Examiner (ME) process, from September 2024 it is now a statutory requirement **all deaths are reviewed** by either the Coroner or ME (level 1 mortality review criteria).

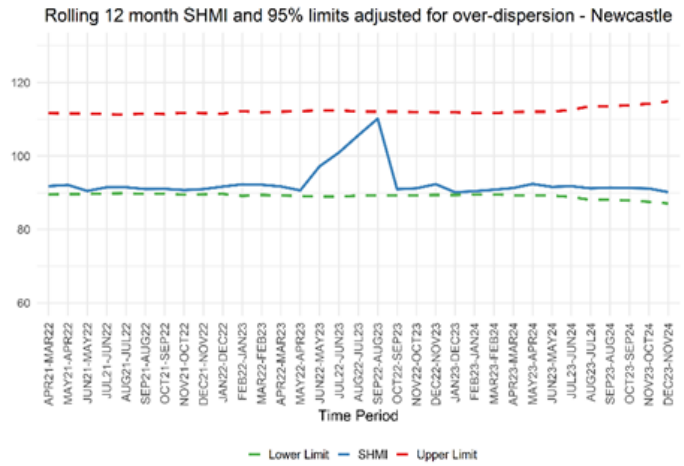
Current Position

- There were 180 inpatient deaths in total reported in March 2025. This is an increase of 10 on the previous month.
- The crude mortality rate in March 2025 is 0.8%. This is unchanged from the previous month.
- Out of the 180 inpatient deaths reported, there are 34 completed level 2 mortality reviews entered into the Trust mortality review database to date.
- None of the level 2 reviews completed in March 2025 to date have been scored with a high HOGAN or National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading.
- Seven patients with a confirmed learning disability died in March 2025.

Action taken

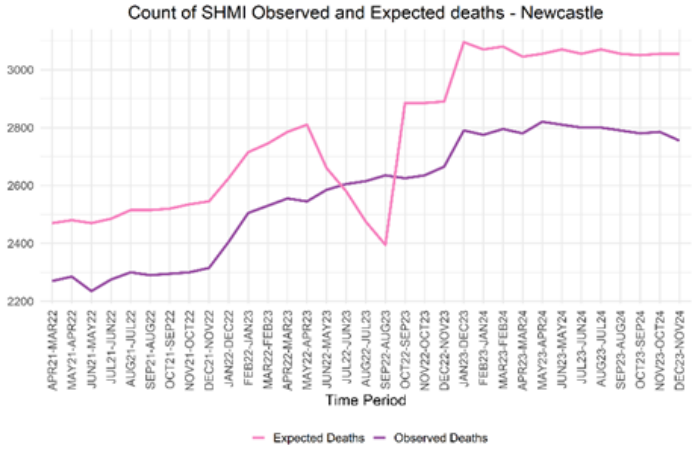
- All inpatient deaths are continually monitored.
- The number of level 2 mortality reviews will rise significantly over the coming months as Morbidity and Mortality (M&M) meetings continue to take place.
- Review of mortality database identified 77 reviews from deaths in 2024 still in draft – followed up with respective M&M leads for urgent finalisation.
- In April 2025, in response to information from the UK Health Security Agency (UKHSA) regarding expected rises in admissions due to respiratory conditions comparable to the 2022/2023 winter season, an audit was undertaken of all inpatient deaths in December 2024 and January 2025 for patients under the care of Medicine and Emergency Care.
- The purpose of the audit was to review causes of death to ascertain whether there was any impact on deaths in the same period.
- 40.7% of all patients who died under the care of specialties within the Medicine and Emergency Care board (excluding ED) in this period (*n = 248*) had a respiratory cause documented as the primary cause of death.
- Audit results presented to Mortality Surveillance Group 30 April 2025.

Mortality Indicators (2/2)



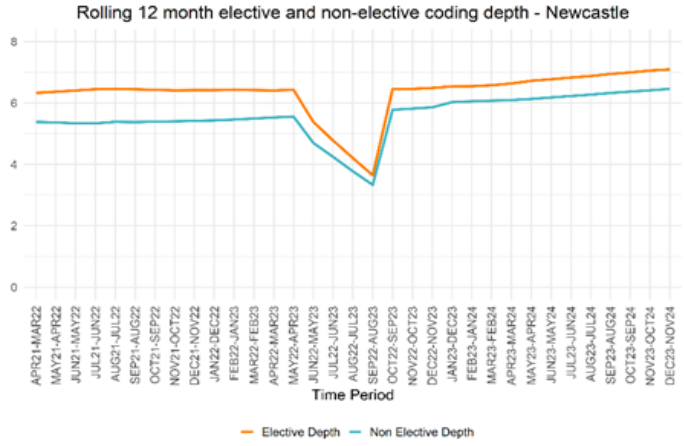
SHMI (Summary Hospital-level Mortality Indicator)
Within the latest published SHMI data (December 2023 – November 2024) the Trust SHMI is at 0.90. This is within the "as expected" category.

Observed & Expected deaths
Between December 2023 – November 2024, the Trust has 2,755 observed deaths and 3,055 expected deaths.



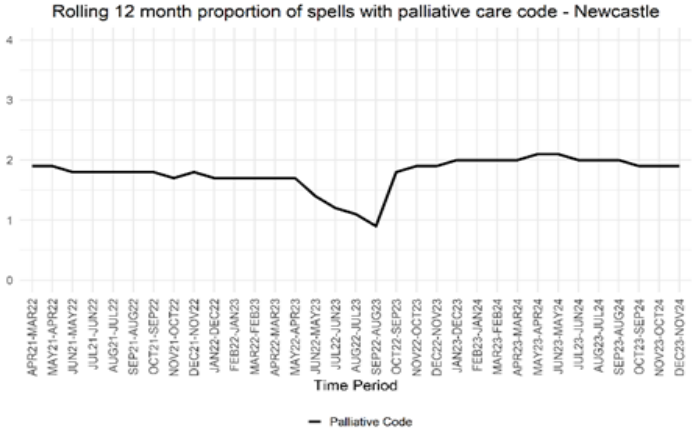
All data rolling 12 month periods. Data as reported by NHS England.

* An issue with the Trust's SUS data flow affected clinical coding completeness (now resolved).

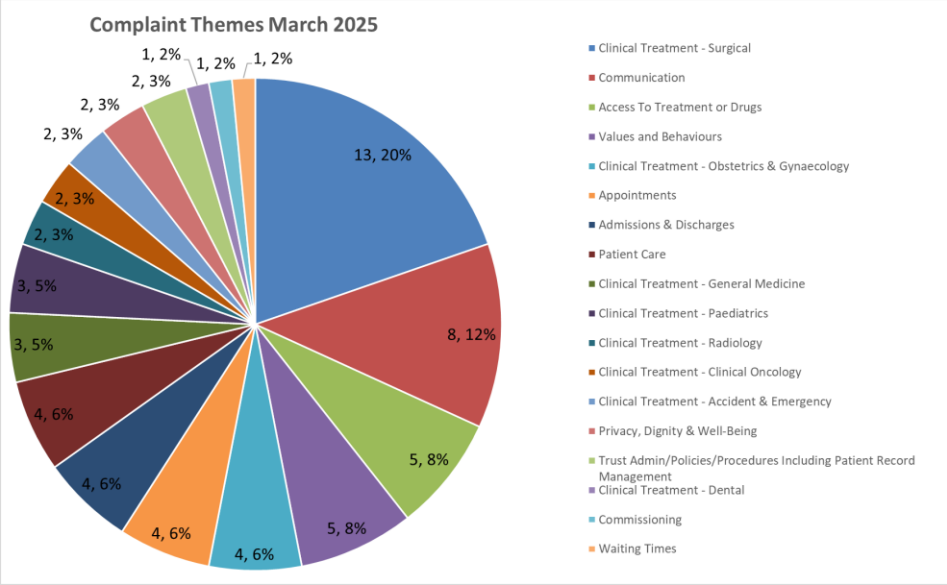


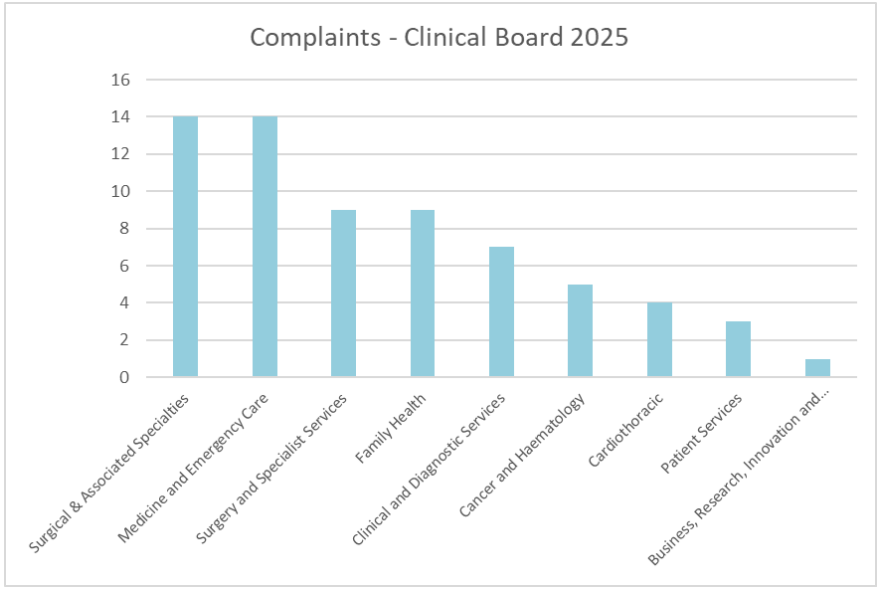
Coding Depth
Coding depth has a substantial impact on mortality indicators. Within the latest published SHMI data the Trust has an elective coding depth of 7.1 and a non-elective coding depth of 6.5*.

Spells with palliative code
Between December 2023 – November 2024, the Trust has a 1.9% palliative care coding rate.



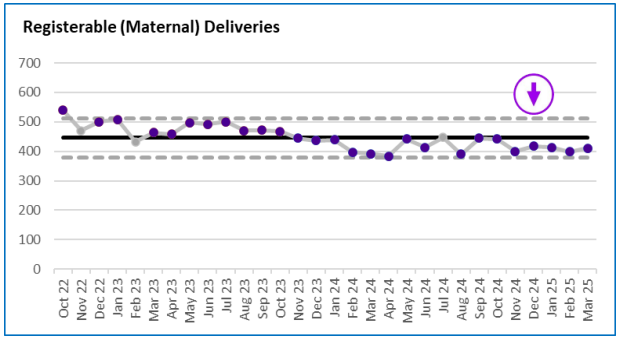
Formal Complaints

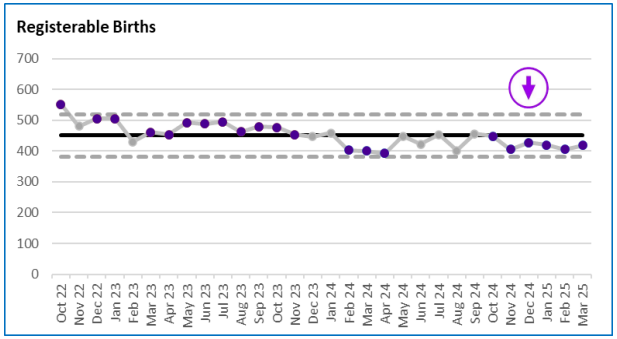


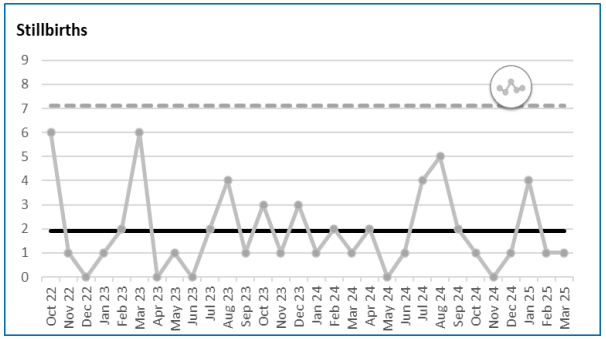


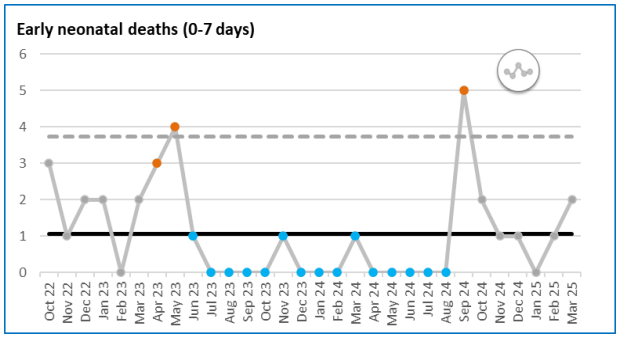
- The Trust has had 66 formal complaints In March 2025. The average number of complaints opened this financial year is 54, which is six complaints higher than the Trust average for the previous financial year.
- The main theme for complaints continues to be Clinical Treatment – Surgical, accounting for 20% of the complaints (13).
- Clinical treatment accounts for the most complaints collectively with 45% of complaints opened this month (30).
- The most complaints were opened for the following Clinical Boards:
  - Medicine 14 (21%)
  - Surgical & Associated Specialties 14 (21%)
  - Family Health 9 (14%)
  - Surgery and Specialist Services 9 (14%)

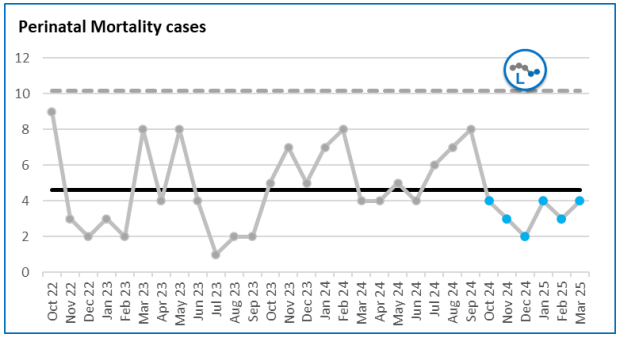
Perinatal Quality Surveillance: Births











Deliveries/Births

- There were 605,479 live births in England and Wales in 2022, a 3.1% decrease from 624,828 in 2021 and the lowest number since 2002. The impact of the reduced birth rate has been augmented by a reduction in market following the suspension of the Newcastle Birth Centre (NBC) services. This has had a significant impact on activity in other units and on patient safety. Mutual aid has been provided by Newcastle to neighbouring Trusts on a weekly basis. The NBC was re-opened on the 2 December 2024. Activity will continue to be closely monitored.

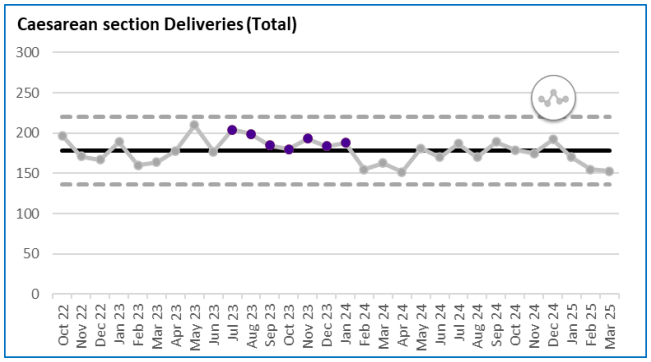
Stillbirths

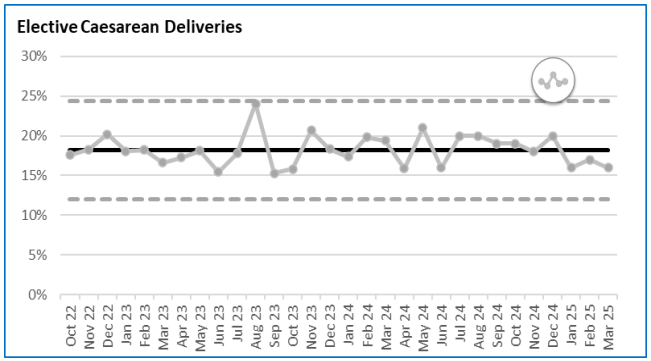
- Newcastle is a tertiary referral Fetal Medicine Unit, providing care to the most complex cases from across NENC. This data includes termination for fetal anomalies >24 weeks gestation. There was 1 stillbirth in March 2025. This will be reviewed via the Perinatal Mortality Review process. (Average per 1000 births: England 3.2, NENC 3.6).

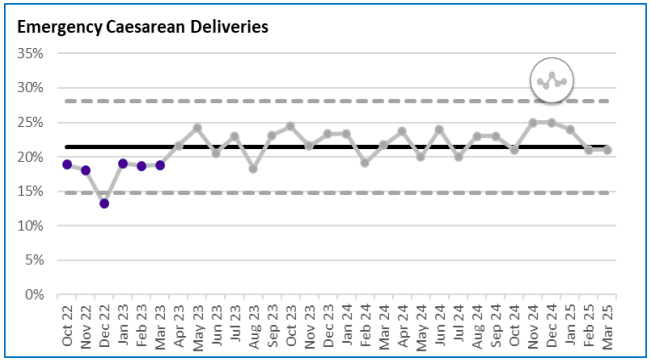
Early Neonatal Deaths

- The Trust has the highest level of neonatal intensive care provision supporting extremely premature babies. These deaths are reported to the Child Death Review panel who will have oversight of the investigation and review process. There were 2 early neonatal deaths in March 2025.

Perinatal Quality Surveillance: Deliveries







Caesarean section deliveries

- There is no defined national metric for caesarean section rates.
- National reports, including Ockenden and Reading the Signals (East Kent) have highlighted lower caesarean section rates do not reflect patient safety or the importance of offering individualised and personalised care where women's voices are heard.
- In England 42.9% of births are caesarean section, in the NENC this is 39.2%. The Trust is comparable with a caesarean section rate of 37% in March, 38% in February and 41% in January 2025.

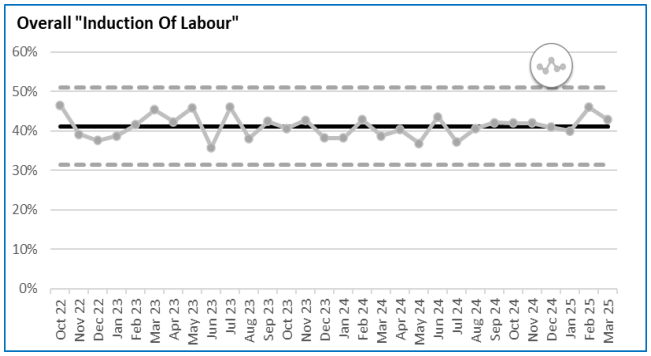
Elective Caesarean section

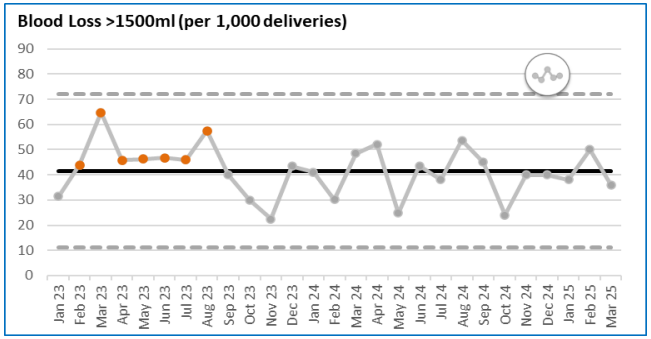
- The average England elective caesarean rate is 18.2%.
- The Trust elective caesarean rate reduced to 16% in March from 17% in February and 20% in December.
- The national rise in elective caesarean rates is partially due to an increasing proportion being undertaken due to maternal request in accordance with the National Institute for Health and Care Excellence (NICE) guidance.
- The Trust has a shared decision-making philosophy and offers informed, non-directive counselling for women over mode of delivery. There is an obstetrician/midwifery specialised clinic to facilitate this counselling and patient choice.

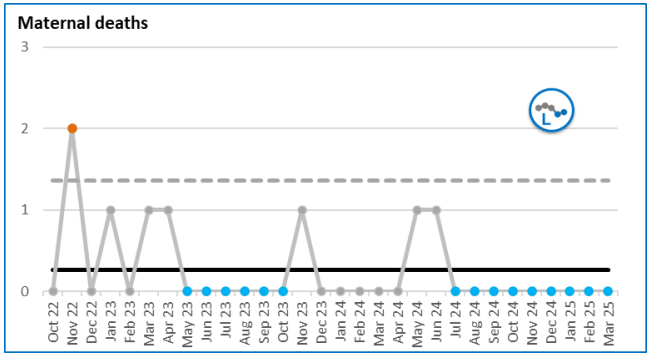
Emergency Caesarean section

- NHS Digital data for January 2024 47% of deliveries were spontaneous vaginal births, 10% had instrumental assistance, 19% were elective caesarean sections and 24% were emergency caesarean sections, the Trust is comparable with this national data.
- The Trust emergency caesarean rate remained 21% in March and was the same in February, these are the lowest rates for 8 months.
- Maternity is a consultant led service with dedicated consultant presence on Labour Ward 8am-10pm daily, consultant led multi-disciplinary ward rounds occur twice daily. The majority of obstetric consultants remain onsite overnight, from 10pm-8am and are involved with all decisions for emergency caesarean section.

Perinatal Quality Surveillance: Labour







Induction of Labour

- The number of women being induced during pregnancy has increased due to changes in national guidelines. Evidence suggests that inducing women in additional risk groups would improve outcomes and has driven a further increase in the induction rate, for example women with hypertension, diabetes in pregnancy and advanced maternal age. England average for induction of labour Q2 2024-25 29.3% and NENC 33.2%. The Trust induction of labour rate has been between 40 and 42% for the previous 6 months. In March the induction rate was 43% following a peak in February to 46%. There is currently an Induction of Labour Quality Improvement Plan (QIP) reviewing pathways and patient experience.

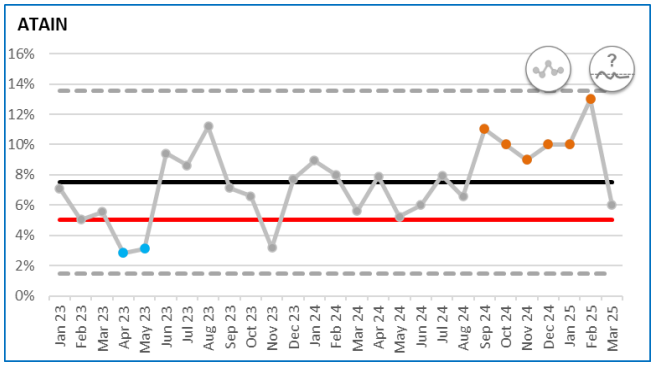
Blood Loss >1500ml

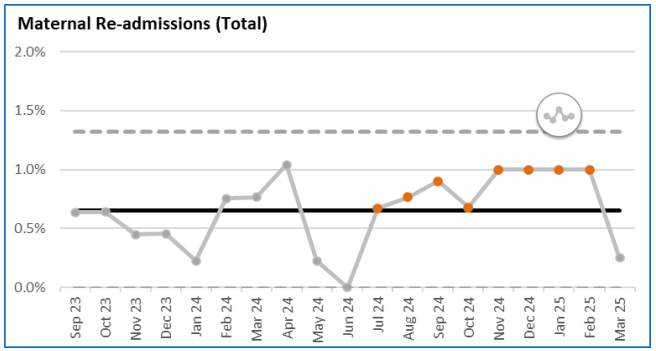
- In 2023 the Trust triggered a safety signal for postpartum haemorrhage >1,500ml per 1,000 births on the NENC clinical dashboard, which instigated a deep dive and audit. The recommendations of the review were enacted and resulted in a reduction in the PPH rate. The average PPH rate for England is 33 per 1,000 and NENC average is 32 per 1,000. PPH rate in January was 38 per 1,000, in February it rose to 50 per 1000, in March there has been a reduction to 36 per 1,000. Higher rates are indicative of the complexities of the high-risk patient group and provision of the Placenta Accreta Spectrum service as confirmed by the previous review. A high-level review of February and March cases has been undertaken to identify any new or emergent themes.

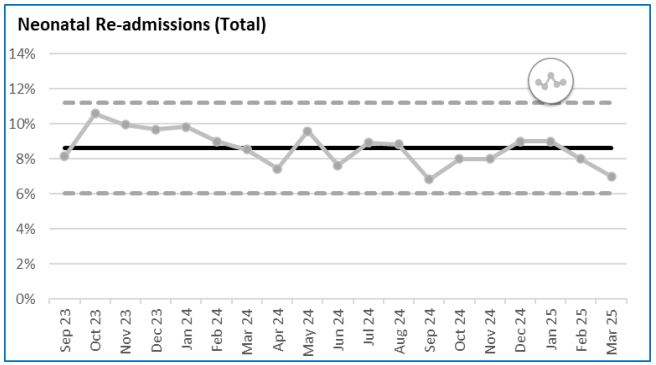
Maternal Deaths

- Maternal deaths are reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) and an annual national report is provided. Early maternal deaths are the death of a woman while pregnant or within 42 days of pregnancy (including termination of pregnancy). Late maternal deaths are reported from 42 days to 365 days of pregnancy. Direct deaths result from obstetric complications of the pregnant state. Indirect deaths are those from pre-existing disease or disease that developed but has no direct link to obstetric cause and was aggravated by pregnancy. Early maternal deaths are also reported to Maternity & Newborn Safety Investigations (MNSI), investigation is dependent on certain criteria. There have been no maternal deaths reported between July 2024 and March 2025.

Perinatal Quality Surveillance: Admissions







Avoiding Term Admission into Neonatal Units (ATAIN)

- All unplanned admissions of term babies (37 – 41 weeks) into the neonatal unit are reviewed at a regular multi-disciplinary meeting and quality improvement themes identified. The Trust previously reviewed cases where admission time on Neonatal Intensive Care Unit (NICU) was >4hours. The Trust is now reviewing all admissions including those babies who experience a short period of separation from their mother. The National benchmark for term admissions is 5%. The Trust are currently benchmarking term admission rates with other Tertiary units to understand our performance against similar units for this metric and has commenced a deep dive to review the admission of infants of diabetic mothers. The Local Maternity and Neonatal System (LMNS) have been asked to agree a NENC definition of unplanned admission. The rate of admission peaked in February at 13% and has subsequently reduced to 6% in March.

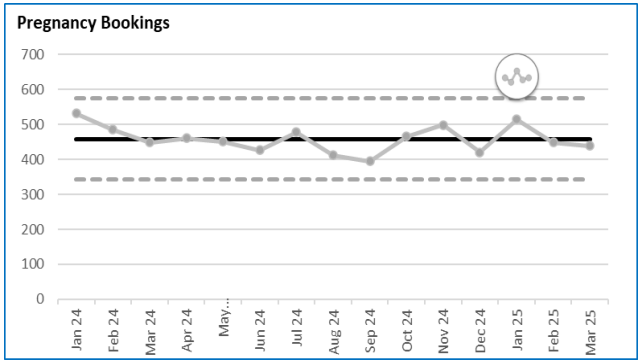
Maternal Readmissions

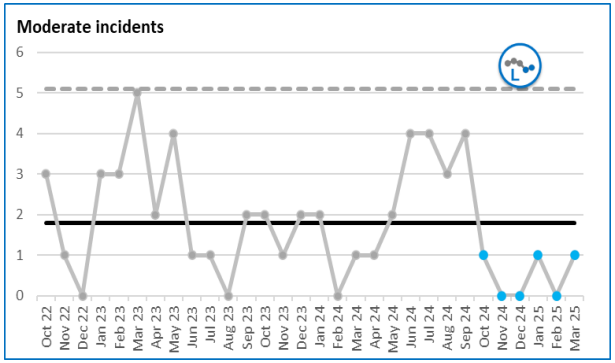
- National Maternity & Perinatal Audit (NMPA) Report (2022) the maternal postnatal readmission rate for England was 3.3%, with rates being higher following caesarean section compared with vaginal birth (4.3% vs 2.9%). The LMNS are working to agree a NENC KPI for this metric. Maternal readmission rate for March remained less than 1%, significantly less than the England average.

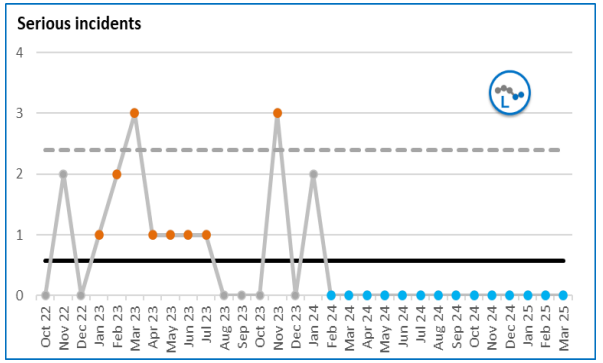
Neonatal Readmissions

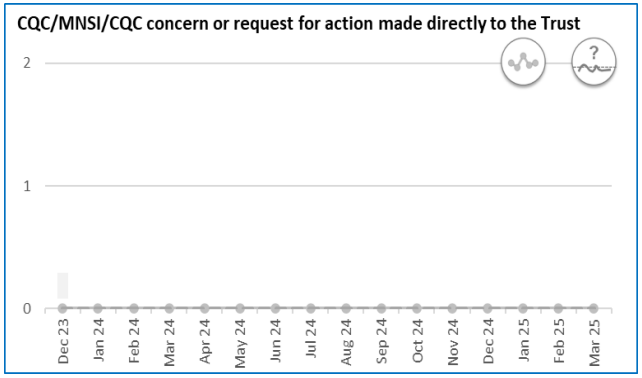
- This is a new metric; work is ongoing to benchmark performance with national parameters. Clinical Quality Improvement Metrics (CQIM) for 'Babies readmitted to hospital who were under 30 days old' data is available for this indicator from March 2024- June 2024. The national rate for this period ranges from 5.3- 5.5%. The Neonatal readmission rate for January was 9%, February was 8% and March 7%. This will be explored further once the LMNS agree the NENC KPI for this metric.

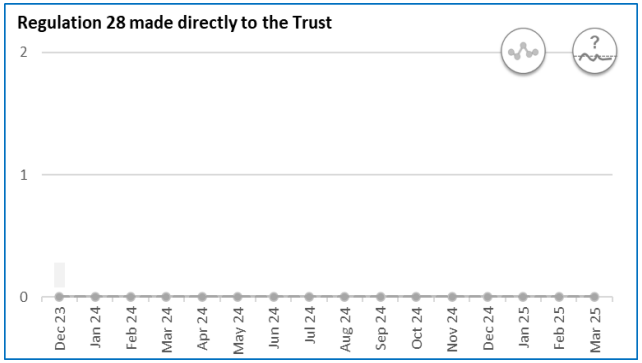
Perinatal Quality Surveillance: Incidents & Bookings











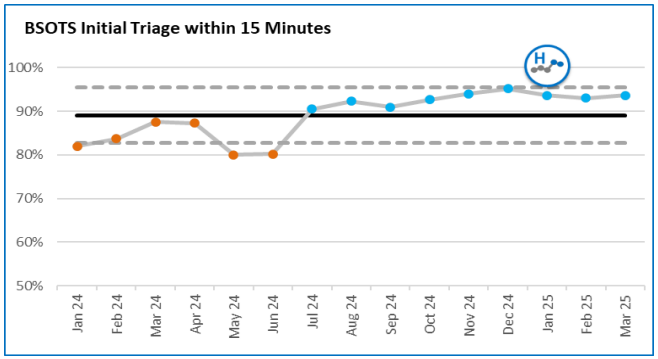
Incidents

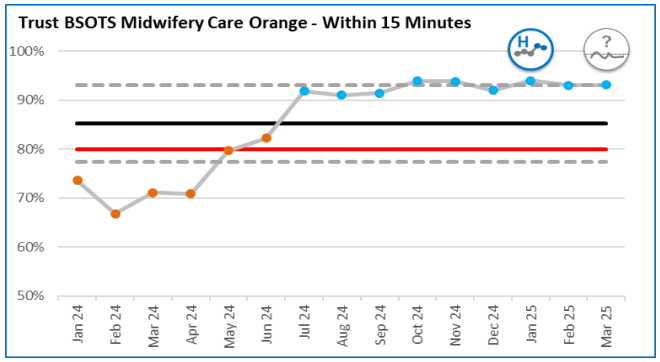
- There has been one moderate (and above) incident reported in perinatal services in March 2025, this will be reviewed through a Patient Safety Incident Investigation (PSII) and does not meet MNSI referral criteria.
- Most moderate incidents fit the criteria for referral to MNSI for external review. These include cases involving neonatal brain injury - Hypoxic Ischaemic Encephalopathy (HIE), Term Intrapartum Stillbirths, Early Neonatal deaths and Maternal deaths.
- There have been no CQC/MNSI concerns or requests for action in last 12 months.
- There have been no regulation 28 notices in the last 12 months.

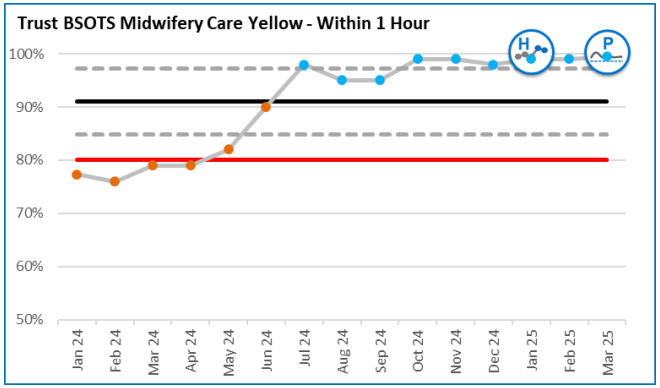
Pregnancy Bookings

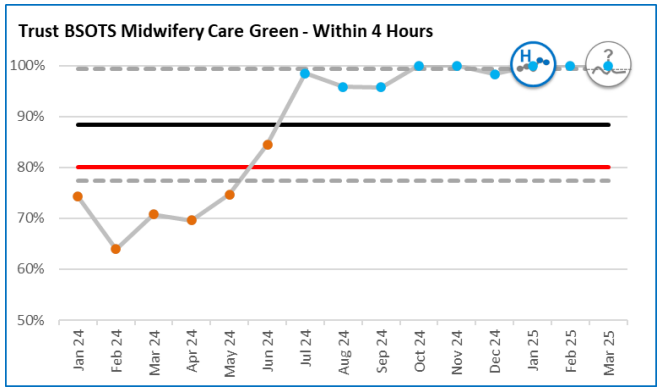
- The number of women choosing to book for care and delivery at the Trust had fallen steadily since January 2024. The Trust is aware that this decision was influenced by the closure of the Newcastle Birthing Centre. The number of bookings in January rose to 514, which dropped in February to 448 and to 439 in March. This metric will continue to be monitored closely but the service are optimistic this is in response to the opening of the birthing centre.

Perinatal Quality Surveillance: Triage - Midwifery Care Timings





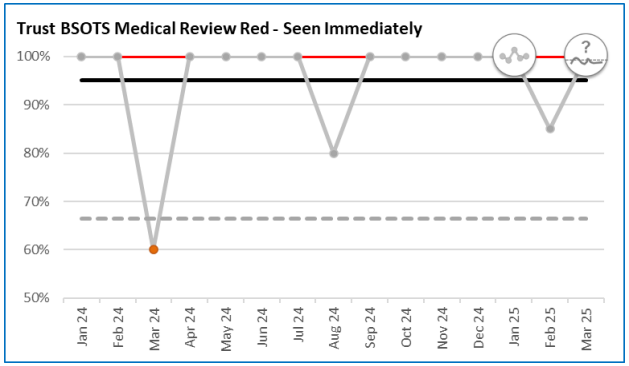


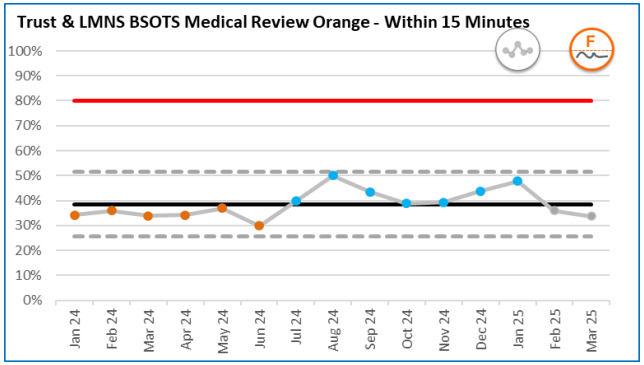


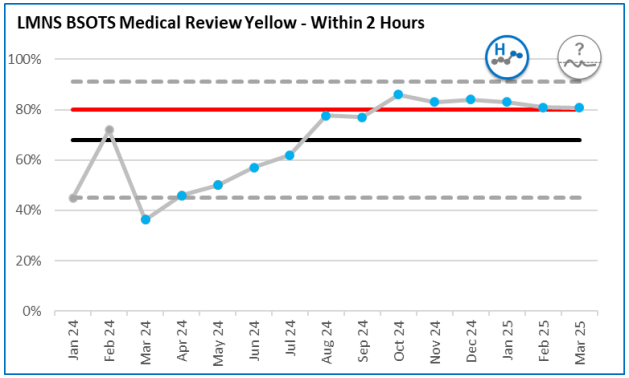
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

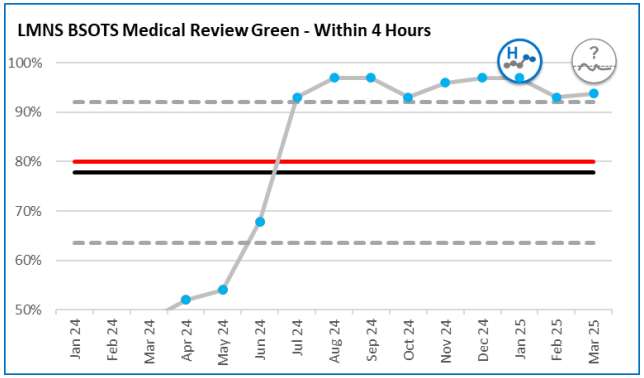
- The Trust implemented the BSOTS triage system in January 2024. Midwifery triage and subsequent review has improved considerably and has exceeded the Trust and LMNS target.
- Good performance across every category for midwifery review.

Perinatal Quality Surveillance: Triage - Medical Review Timings





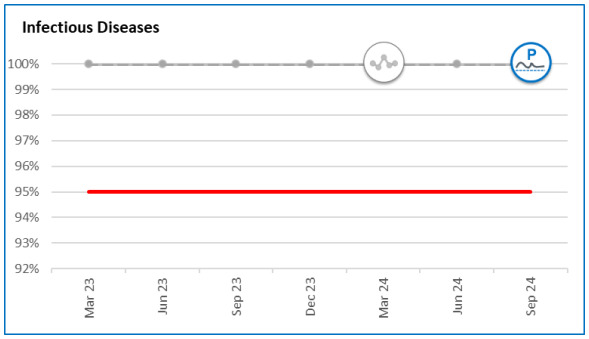


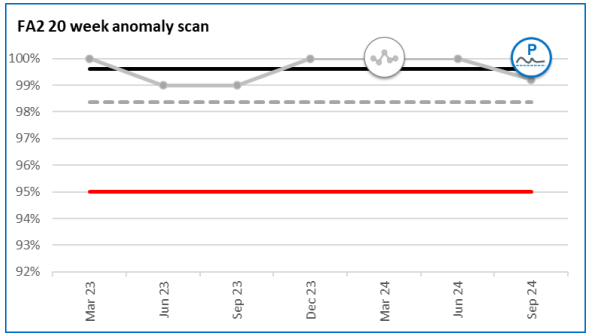


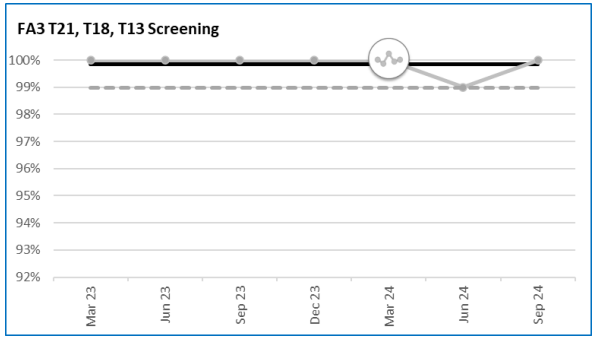
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

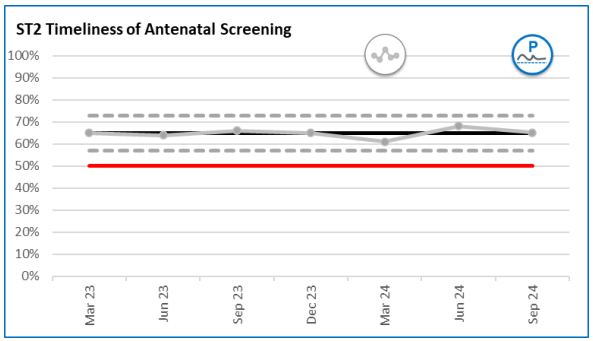
- The Trust has now bench marked performance against the NENC LMNS target for each of the categories. It is worth noting that the timescales for review are longer for women in the yellow category (2 rather than 1 hour) and the targets for compliance lower than those previously set internally.
- The service will continue to aspire to reach the Trust performance target but will be benchmarked against the LMNS target on the NENC Triage Dashboard.
- There is still work to do to improve performance for reviews within 15 minutes however there has been significant improvements in performance in the last 12 months.

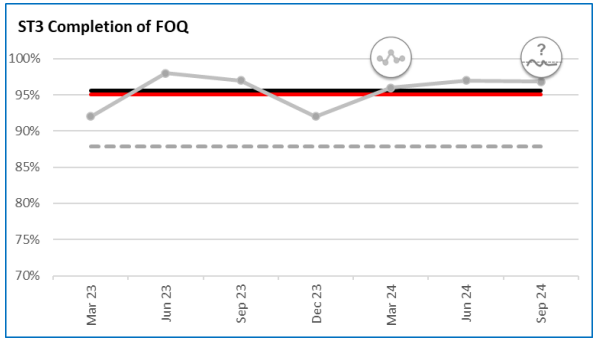
Perinatal Quality Surveillance: Antenatal Screening

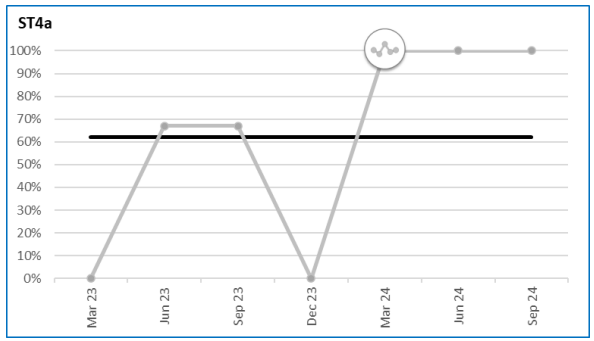


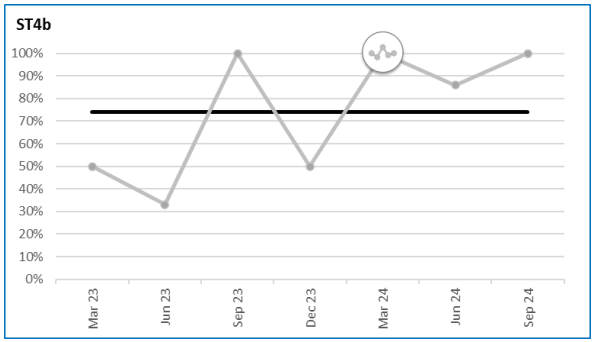


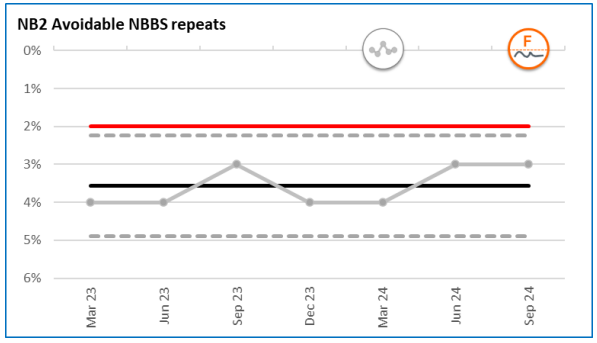








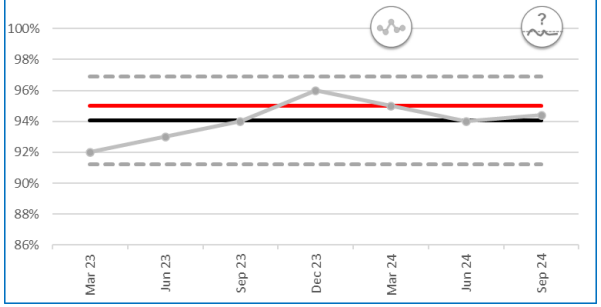




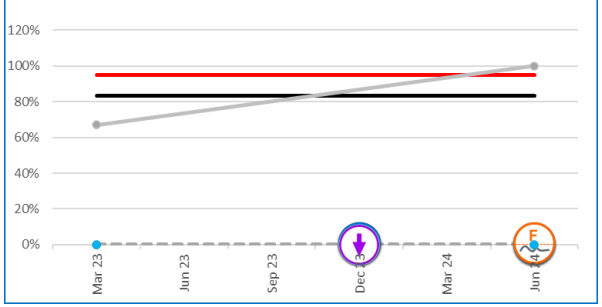
- 3 Patient Safety Incident Investigations (PSII) completed.
- Comprehensive action plan in place. Incident oversight group with NHSE & ICB colleagues meeting has been stood down.
- QIP to review antenatal clinic patient flow, failsafe and administration processes underway and making good progress.

Perinatal Quality Surveillance: NIPE Screening

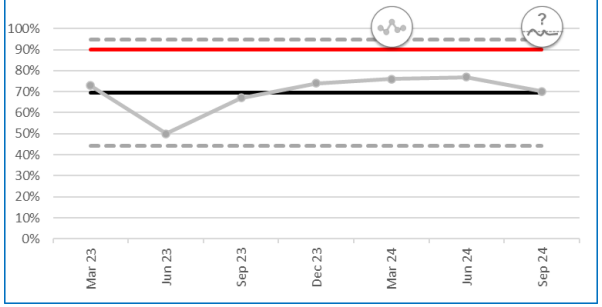
S01 - % screen compliant <72 hrs of age



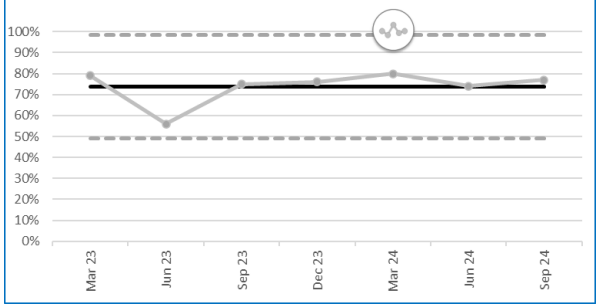
S02 - % eye abnormality suspected/seen <14 days of examination



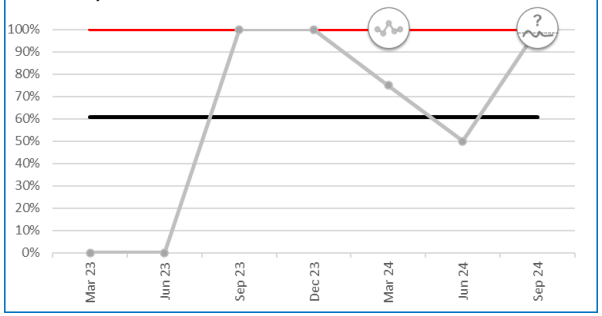
S03 - % hip USS attended between 4-6 weeks



S04 - % of hip referral outcome decision made (<6 weeks corrected age)



S05 - % suspected bi-lateral undescended testes seen <24 hrs



Perinatal Quality Surveillance: Patient Experience

Care after birth						
Question	Question Text	2025 01	2025 02	2025 03	Change	
F1	Thinking about your postnatal care, were you involved in decisions about your care?	86%	85%	94%	8%	Top 20%
F2	If you contacted a midwifery or health visiting team, were you given the help you needed?	92%	88%	96%	8%	Top 20%
F4	Would you have liked to have seen or spoken to a midwife...	79%	73%	80%	7%	Top 20%
F5	Did the midwife or midwives that you saw appear to be aware of the medical history of you and your baby?	80%	87%	86%	-1%	Top 20%
F6	Did you feel that the midwife or midwifery team that you saw or spoke to always listened to you?	88%	89%	89%	0%	Middle 60%
F7	Did the midwife or midwifery team that you saw or spoke to take your personal circumstances into account when giving you advice?	87%	88%	92%	3%	Top 20%
F8	Did you have confidence and trust in the midwife or midwifery team you saw or spoke to after going home?	89%	88%	89%	1%	Top 20%
F10	Did a midwife or health visitor ask you about your mental health?	92%	95%	87%	-8%	Bottom 20%
F11	Were you given information about any changes you might experience to your mental health after having your baby?	69%	72%	73%	0%	Middle 60%
F12	Were you told who you could contact if you needed advice about any changes you might experience to your mental health after the birth?	72%	80%	80%	0%	Middle 60%
F13	Were you given enough information about your own physical recovery after the birth?	69%	76%	85%	9%	Top 20%
F14	In the four weeks after the birth of your baby did you receive help and advice from a midwife about feeding your baby?	80%	76%	87%	10%	Top 20%
F15	If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?	82%	71%	66%	-5%	Middle 60%
F16	In the four weeks after the birth of your baby did you receive help and advice from midwives about your baby's health and progress?	86%	72%	80%	8%	Middle 60%
F19	At any point during your maternity care journey, did you consider making a complaint about the care you received?	73%	73%	78%	5%	Top 20%
	Average	82%	81%	84%	3%	

Patient perspective

- This report includes all responses from women during March 2025, 396 surveys were delivered, with 55 responding (14%).
- The Trust is in the top 20% of Trusts overall. It is in the top 20% on 47 questions (up 9 from February 2025), middle 60% on 9 questions and bottom 20% on 1 questions (down 1 from February 2025).
- Overall, results are good in these areas, communication with staff at all stages of pregnancy, cleanliness, help with feeding, not leaving alone at a worrying time. Results could be improved in, asking women about their mental health, elements of postnatal care in the hospital, and postnatal follow up. These themes are echoed in patient complaints and are being addressed by the postnatal quality improvement action plan, which is making good progress.

Performance

Performance Overview

Metric	Period	Actual	Target	Variation	Assurance
A&E Arrival to Admission / Discharge	Mar-25	77.5%	78%		
RTT 18 Weeks	Mar-25	72.4%	92%		
>65 Week Waiters	Mar-25	88	0		
Cancer 28 Day FDS	Feb-25	83.4%	77%		
Cancer 31 Day	Feb-25	74.8%	96%		
Cancer 62 Day	Feb-25	61.0%	70%		
Diagnostic 6 Weeks	Mar-25	16.3%	5%		

Emergency Care

- Overall performance improved for the fourth successive month increasing to 77.48% (+0.73%), just fractionally short of target. Performance remains in line with common cause variation.
- The standard for 12 hours from Accident & Emergency (A&E) arrival to admission/discharge was achieved for the second successive month.

Elective Waits

- March saw an 11% decrease in the number of >52 week waits at Newcastle Hospitals, reducing to 1,505 - a 50% reduction from March 2024 levels.
- >65 week waits decreased from February to 88 (-69) as the Trust made further progress with its ambitions to eradicate waits of this length.
- The total waiting list (WL) size decreased further in March and continued to demonstrate improving variation. RTT 18-week performance was recorded at an improving 72.4%.

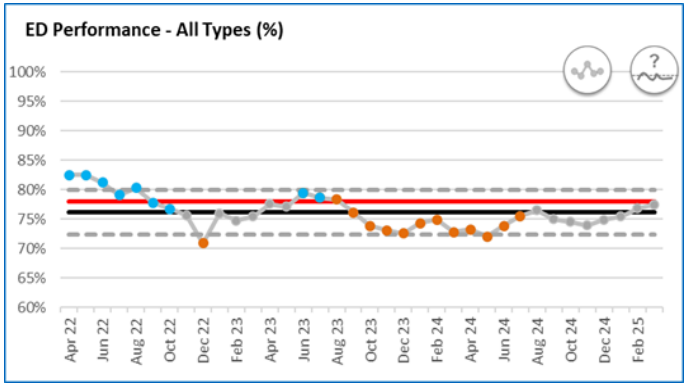
Cancer Care

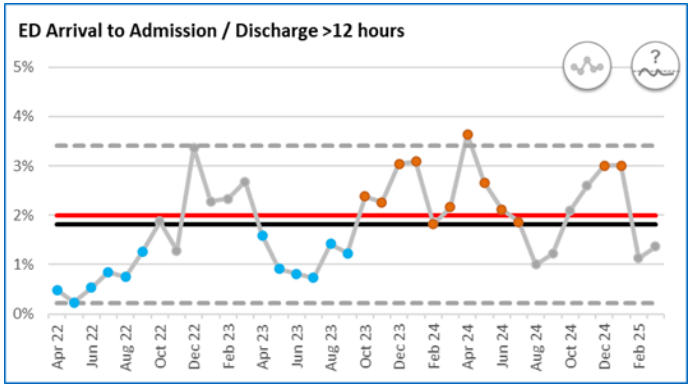
- In February, the 77% 28 Day Faster Diagnosis Standard (FDS) was achieved for the first time in eight months (83.4%). This follows the deployment of additional resource into pathway tracking within Skin.
- 31 Day performance (74.8%) showed a marked improvement for the first time since August 2024, but nonetheless remains outside the control limits and significantly below standard.
- 62 Day compliance for February was 61.0%, consistent with a continuation of improving special cause variation.

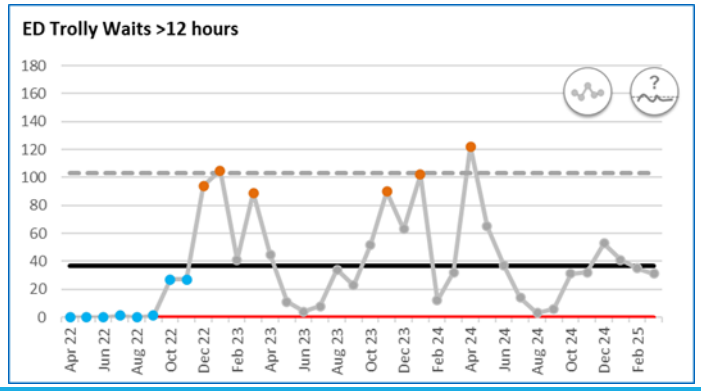
Diagnostics

- Performance against the 5% standard worsened in March for the first time in 7 months. 16.3% of patients were waiting over six weeks at the end of March compared to 13.0% in February.

Emergency Care







Standards

- 78% of patients to be admitted/transferred/discharged from A&E in <4 hours (by Mar-25).
- No ambulance handovers to Accident & Emergency (A&E) exceeding 60 minutes.
- Less than 2% of patients to wait over 12 hours from A&E arrival to admission/discharge.

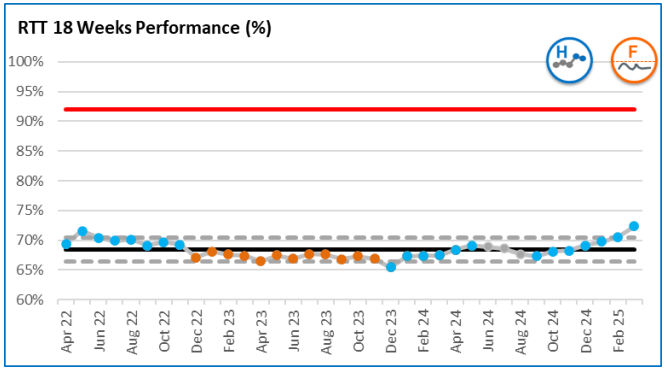
Current position

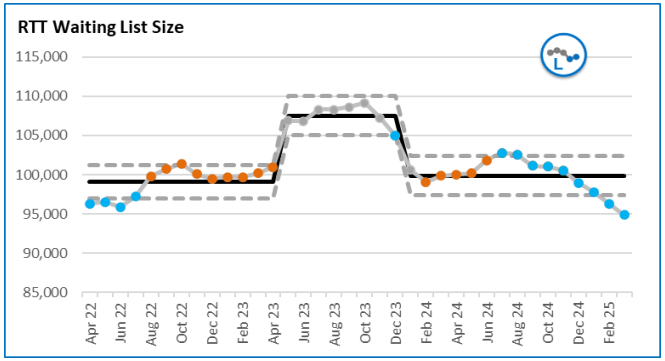
- Overall and type 1 performance improved for the fourth successive month increasing to 77.48% (+0.73%) and 64.59% (+2.22%), remaining in line with common cause variation.
- Whilst March Emergency Department (ED) attendances (all types) was the highest since October 2024 at 12877, the overall performance saw a 2.9% increase compared to October.
- Ambulance handovers >60 mins in March were 97, this is a 52% increase compared to February 2025, but a 29% decrease compared to March 2024.
- ED Arrival to Discharge >12 hours achieved the target for the second consecutive month at 1.36%. This compares to 2.16% in March 2024.
- ED trolley waits > 12 hours have continued to decline since October 2024. There were 31 in March, a 13% decrease compared to February 2025.
- March saw a total of 6652 Emergency Admissions, the highest number since October 2024.

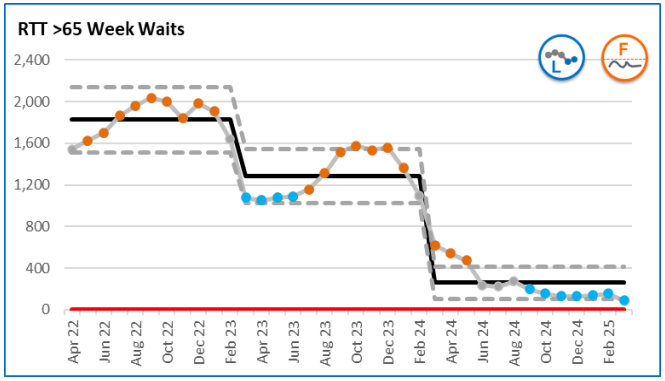
Action taken

- The Clinical Board continue to develop plans for the Urgent Treatment Centre and Same Day Emergency Care expansion, to decrease volume of attendances through the majors pathway. A perfect week for expansion of Same Day Emergency Care (SDEC) is planned for June.
- Continued work takes place through the ED quality improvement group to improve quality with main workstreams including decreasing corridor care, improving safety of the waiting room and floor management across front of house services.
- Improvement work continues around reducing ambulance handover times, extra nursing shifts are being trialled and change in layout of current queuing system to both improve privacy and dignity, and flow of ambulance arrivals.
- The ED team are working with Cumbria, Northumberland, Tyne and Wear (CNTW) to encourage use of Newcastle Safe Haven for patients experiencing mental health crisis.

Elective Waits







Standards

- 92% of patients on incomplete RTT pathways to be waiting less than 18 weeks.
- Zero tolerance on incomplete RTT waits over 65 weeks (by Sep-24).

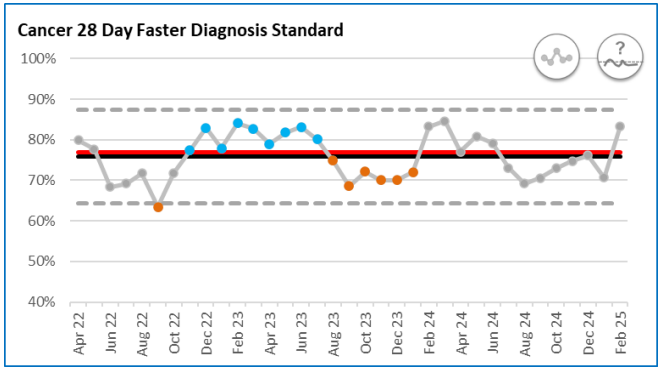
Current position:

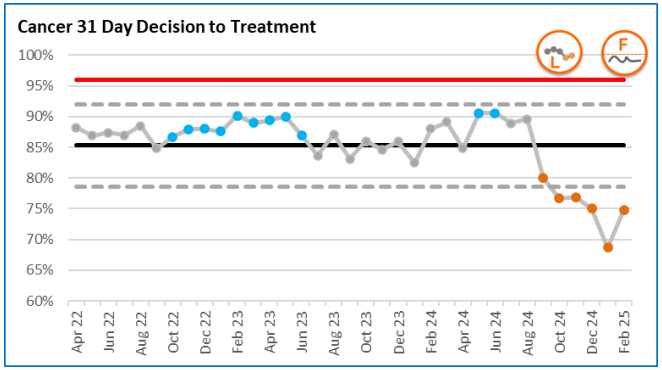
- March saw an 11% decrease in the number of >52 week waits at Newcastle Hospitals, reducing to 1,505, whilst showing a 50% reduction from March 2024 levels. The number of >65 week waits decreased from February to 88 (-69) as the Trust made further progress with its ambitions to eradicate this cohort of patients.
- The total number of patients waiting >78 weeks dropped to 13 (-3) with breaches centred in Spinal Surgery, Trauma & Orthopaedics (T&O) and Ophthalmology (corneal grafts).
- Whilst strong progress has been made in reducing long waiters throughout 2024/25, challenges remain at both specialty and sub-specialty level that mean the Trust has been unable to completely eradicate its 78 & 65-week waiters, including:
    - Demand outstripping capacity within the Foot and Ankle service in T&O, further impacted by consultant sickness.
    - Capacity issues in the North East Adult Deformity Service (NEADS) in Spinal Surgery exacerbated by a pause in the service.
- The total waiting list (WL) size decreased further in March and continued to demonstrate an improving variation. The total number of patients waiting >18 weeks dropped to 26,210, with RTT 18-week performance recorded at an improving 72.4%.

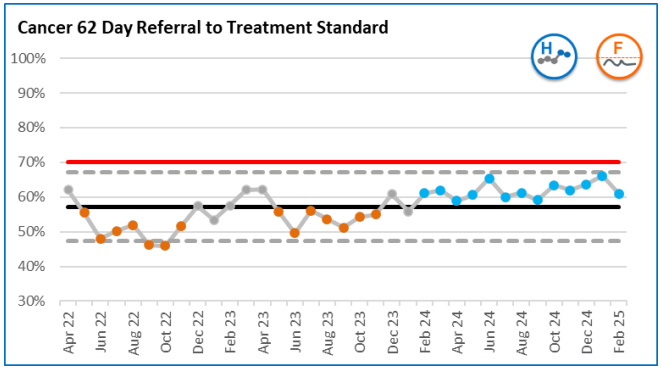
Action taken

- Mutual aid is in place with both Gateshead and Northumbria for Foot and Ankle surgery with 10 patients per month being sent to each Trust. Work is being carried out at the front-end of the pathway to re-refer patients back to other providers where appropriate.
- A new clinical lead is in place for the Orthopaedic Spinal Service, with weekly Multi-Disciplinary Team (MDT) meetings implemented to progress treatment for patients, in addition to participation in the regional NEADS MDT. Fortnightly meetings continue to take place with the Nuffield to discuss patients who are appropriate to transfer for treatment.
- The Trust has committed to another validation sprint between April-June 2025. The last sprint saw over 6,000 patients removed from the RTT waiting list.

Cancer Care







Standards

- Faster Diagnosis Standard (FDS) - 77% of patients on a suspected cancer or breast symptomatic pathway to receive results/diagnosis within 28 days of referral (by Mar-25).
- 96% to wait no more than 31 days from diagnosis to first cancer treatment.
- 70% of patients to wait no more than 62 days from urgent/screening referral to first cancer treatment (by Mar-25).

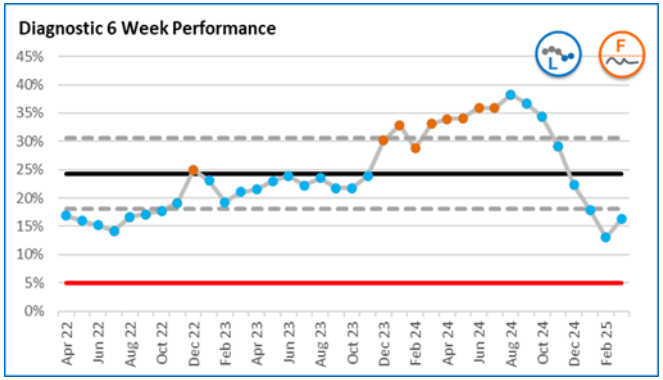
Current position:

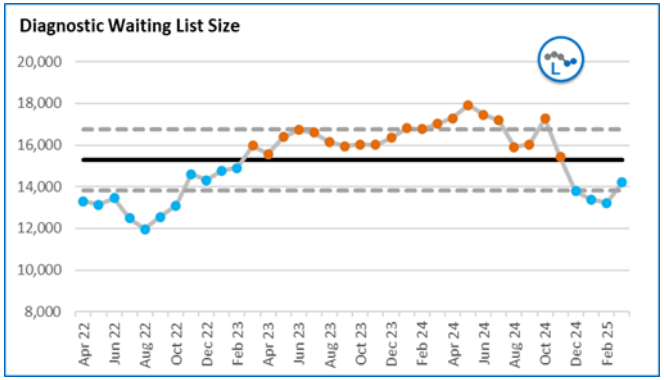
- In February, the 77% 28 FDS was achieved for the first time in eight months (83.4%). This follows the deployment of additional resource into pathway tracking within the Skin service.
- 31 Day performance (74.8%) showed a marked improvement for the first time since August 2024 - when the radiotherapy service began to experience both an increase in referrals and a reduction in capacity, owing to retirements and turnover across various sections of the radiotherapy pathway - specifically scheduling, dosimetry and treatment radiographers.
- 62 Day compliance for February was 61.0%, consistent with a continuation of improving special cause variation despite an overall consistent failure to hit the target. A reduction in performance was anticipated with particular focus placed on reducing the volume of patients waiting over 62 days for treatment – at the end of February this stood at 149, a 31% reduction compared to December 2024. This has reduced further to less than 100 at the beginning of April 2025.

Action taken

- Skin continue to scope options to resolve issues with teledermatology take up, including paying primary care for good quality photos or hosting a photography hub in primary care.
- Issues identified through the Perfect Cancer Pathway work within Radiotherapy include a backlog in scheduling, incorrect recording of Earliest Clinically Appropriate Date (ECAD) treatment dates and a lack of treatment capacity. An over-recruitment of schedulers has commenced, with training provided to staff on correct ECAD implementation, as well as a senior review of all breaches being implemented to ensure accuracy.
- Pathway analysis has now been undertaken across most tumour groups, with areas identified where the largest gains can be achieved. Focus groups with key stakeholders are now taking place to explore pathway blockages, concerns and potential improvement ideas.
- Indicative performance for March suggests an improving position against the 62 day standard.

Diagnostics





6 Week Diagnostic Performance by Modality – February 2025			
MRI	18.9%	CT	8.5%
Non-obs US	6.6%	DEXA	5.5%
Audiology	2.2%	ECHO	45.4%
Electrophysiology	0.0%	Neurophysiology	2.3%
Sleep Studies	81.3%	Urodynamics	7.3%
Colonoscopy	14.4%	Flexi-Sig	19.1%
Cystoscopy	6.8%	Gastroscopy	13.3%
Newcastle Hospitals Total			**13.0%**

Standards

- <=5% of patients on incomplete diagnostic pathways waiting six weeks or longer.

Current position:

- Performance against the 5% standard worsened in March for the first time in 7 months. 16.3% of patients were waiting over six weeks at the end of March compared to 13.0% in February. However, this is still a considerable improvement from 38.3% as recently as August 2024. The target continues to be consistently failed but there is special cause variation of an improving nature. Echo compliance worsened most considerably in March to 65.0% waiting over 6 weeks.
- The waiting list grew by 986 patients in March, with Echo, Audiology and Non-obs Ultrasound the biggest contributors to the growth. However, special cause variation of an improving nature remains as October 2024-February 2025 saw the waiting list size fall by over 4,000 patients - the biggest drop in a four-month period for many years.
- Having fallen in recent months, March saw the volume of patients waiting >13 weeks rise by 11.6% to 644. Echo (242) and Magnetic Resonance Imaging (MRI) (231) have the most >13 week waiters. Echo have had IT issues which have prevented the service's Metrocentre Community Diagnostic Centre (CDC) capacity from being utilised. Additionally, multiple MRI scanners have experienced downtime recently as they required upgrades.

Action taken

- Audiology have submitted bids regionally to secure new and replacement equipment to ensure the service is sustainable and reduce capacity lost due to equipment downtime.
- As well as improving DM01 compliance, Audiology are focusing on the next phases of their recovery plan including reducing the waiting lists for hearing aid fittings and reassessments.
- Deepresolve Acceleration software has been installed on Neuroradiology scanners to reduce scanning times. The software is also being installed in the main Radiology department.
- IT issues with new Sleep Studies equipment have been resolved and the equipment has been installed. The new kit will be used 7 days per week once staff training is complete.
- A working group has been established to deal with the issue of particularly long waits for certain complex MRI scans, in order to reduce over 13 week waiters.
- New dashboards have been created and analysis undertaken to improve the reporting and understanding of the diagnostic waiting times and turnaround times for patients on cancer pathways. This should help identify potential bottlenecks in pathways.
- The Trust's 2025/26 Planning submission to NHS England included plans to meet the DM01 5% standard both at Trust level and within individual modalities by March 2026.

Contractual & Planning Standards (1/2)

Theme	Standard	Dec-24	Jan-25	Feb-25	Mar-25	Num.	Den.	24/25 YTD
Activity & Elective Care								
Day Case	**100%** of 24/25 Plan (equivalent to 107% of 19/20 value-weighted activity)	100.5%	102.8%	100.6%	**98.3%**	10,918	11,102	**99.5%**
Elective Overnight		105.0%	91.6%	95.5%	**97.6%**	1,786	1,829	**98.5%**
Outpatient New		99.7%	101.5%	97.6%	**92.8%**	24,654	26,561	**97.2%**
Outpatient Procedures		106.4%	103.7%	107.7%	**105.5%**	21,096	19,992	**106.3%**
Outpatient Review	**N/A**	123.7%	123.3%	118.3%	**115.0%**	66,440	57,786	**116.1%**
Non-Elective		95.1%	94.1%	91.4%	**91.1%**	989	1,086	**90.1%**
Emergency		106.4%	106.9%	108.8%	**108.3%**	6,497	6,001	**105.9%**
RTT 18 Week Wait	**92%**	69.1%	69.8%	70.6%	**72.4%**	68,683	94,893	**69.0%**
>78 Week Waiters	**Zero**	22	22	16	**13**	13		
>65 Week Waiters	**Zero** (by Sep-24)	130	138	157	**88**	88		
>52 Week Waiters	As per submitted trajectory	1,683	1,780	1,707	**1,505**	1,505		
RTT Waiting List Size	As per submitted trajectory	98,980	97,798	96,323	**94,893**	94,893		
Diagnostic Activity	**120%** of 19/20 activity	126.8%	126.9%	120.2%	**124.2%**	22,398	14,836	**118.7%**
Diagnostic 6 week wait	<=**5%** (local target of <=15%)	22.3%	17.1%	13.0%	**16.3%**	2,313	14,201	**29.7%**
Day case rates (BADS procedures)	**85%**	86.8%	**87.6%**	TBC	TBC			
Capped Theatre Utilisation	**85%**	74.1%	79.1%	81.3%	**79.7%**			
Urgent Ops. Cancelled Twice	**Zero**	0	0	0	**0**	0		**0**
Cancelled Ops. Rescheduled >28 Days	**Zero**	15	13	11	**16**	16		**146**
OP Activity Ratio: New/Procedure	**46%**	41.5%	**40.9%**	TBC	TBC	46,130	112,789	**41.6%**
>12 Week Waiters Validated	**90%**	74.4%	77.4%	82.2%	**88.6%**	22,781	25,725	**72.6%**
Outpatient Review Reduction	**25%** reduction vs 19/20 baseline	114.0%	111.1%	114.6%	**135.6%**	89,380	69,059	**110.8%**
PIFU Take-up (%)	>=**5%** of all OP atts. (by Mar-25)	2.2%	2.4%	2.4%	**2.5%**	2,936	119,328	**2.2%**

Contractual & Planning Standards (2/2)

Theme	Standard	Dec-24	Jan-25	Feb-25	Mar-25	Num.	Den.	24/25 YTD
Cancer Care								
28 Day Faster Diagnosis	**77%** (by Mar-25)	**76.1%**	**70.7%**	**83.4%**	TBC	1,932	2,317	**75.1%**
31 Days (DTT to Treatment)	**96%**	**75.0%**	**68.7%**	**74.8%**	TBC	1,010	1,350	**81.4%**
62 Days (Referral to Treatment)	**70%** (by Mar-25)	**63.7%**	**66.1%**	**61.0%**	TBC	248	406	**62.0%**
>62 Day Cancer Waiters		**217**	**197**	**165**	**112**	112		
Urgent & Emergency Care								
A&E Arrival to Admission/Discharge	**>=78%** under 4 hours (by Mar-25)	74.9%	75.4%	76.7%	**77.5%**	16,487	21,262	**74.9%**
	<=2% over 12 hours	2.7%	2.1%	1.1%	**1.4%**	300	21,262	**2.1%**
A&E Decision to Admit to Admission	**Zero** over 12 hours	53	41	35	**37**	37		**476**
Adult General & Acute Bed Occupancy	**<=92%**	88.0%	90.4%	91.4%	**90.3%**	1,297	1,436	**89.5%**
Ambulance Handovers <15 mins	**65%**	45.8%	47.6%	45.8%	**46.5%**	1,555	3,345	**51.8%**
Ambulance Handovers <30 mins	**95%**	80.1%	82.7%	82.8%	**82.1%**	2,747	3,345	**84.0%**
Ambulance Handovers >60 mins	**Zero**	114	91	64	**97**	97		**918**
Urgent Community Response Standard	**>=70%** under 2 hours	89.5%	75.1%	74.7%	**74.2%**	328	442	**80.8%**
Safe, High Quality Care								
Mixed Sex Acommodation Breach	**Zero**	72	76	**60**	TBC	60		**909**
VTE Risk Assessment	**95%**	**92.2%**	TBC	TBC	TBC			
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour	**55.0%**	TBC	TBC	TBC			
Sepsis Screening Treat. (All)		**89.0%**	TBC	TBC	TBC			

People

People Overview

Metric	12-Month Rolling	Actual	Target	Variation	Assurance
Sickness	Mar-25	5.53%	4.5%		F
Short-term	Mar-25	1.92%			
Long term	Mar-25	3.84%			
Turnover	Mar-25	8.98%	10%	L	?
Mandatory training	Mar-25	92.67%	90%	H	P
Appraisal	Mar-25	85.83%	90%		F
Disabled staff	Mar-25	5.66%		H	
Ethnicity (BAME staff)	Mar-25	18.66%		H	

Staff in post (whole-time equivalent (WTE))

- March is 15,338 wte, 1,909 wte (14.2%) above pre-Covid and 737 wte (5.05%) above plan (14,601 wte).
- Clinical staff (excluding Medical & Dental) highest increase +1,249 wte (14%).

Sickness

- 12-month rolling average increased +0.03% to 5.53%.
- Top reasons for sickness: anxiety/stress/depression 31%; other musculoskeletal problems 11%; gastrointestinal problems 10%,
- Short-term sickness reduced in March -0.25% to 1.92%.
- Long term sickness reduced in March -0.16% to 3.84%.

Retention & Turnover

- 12-month rolling average increased +0.11% to 8.98%.
- Top reason for leaving: work-life balance 14.94%.
- Top destinations: no employment 39.10%; other NHS organisation 32.59% (includes retire-return).

Mandatory training

- Performance improved +0.13% to 92.67%.
- Lowest is Medical and Dental - dropped -0.36% to 79.89%.
- Two courses are below 80%: Paediatric and adult basic life support.

Appraisal

- Performance improved +1.1% to 85.83%.

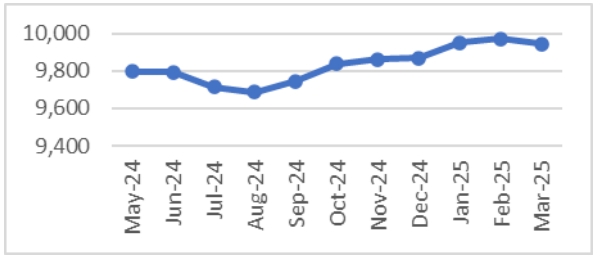
Equality & Diversity

- Disabled staff reduced -0.06% to 5.66%.
- BAME staff increased +1.19% to 18.66%.

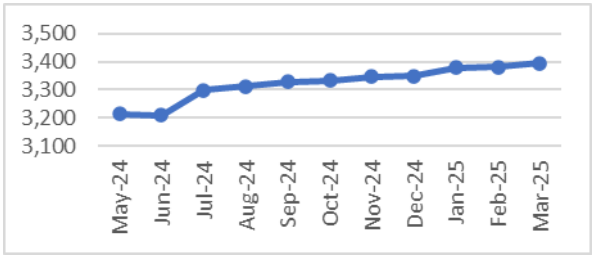
Provider Workforce Return (PWR)

Metric	Benchmark January 2020	Plan (WTE) March 2025	Actual (WTE) March 2025	Difference Jan 20 Actual v Mar 25 Actual	Difference Jan 20 Plan v Mar 25 Actual
Total non-medical - clinical substantive staff	8,696	9,681	9,945	+ 1,249	+264
Total non-medical - non-clinical substantive staff	2,875	2,925	3,394	+ 519	+469
Total Medical and Dental substantive staff	1,722	1,909	1,953	+ 231	+44
Any other staff (substantive total)	135	39	46	- 89	+7
Total WTE Substantive Staff	**13,429**	**14,601**	**15,338**	**+ 1,909 (14.22%)**	**+737 (5.05%)**

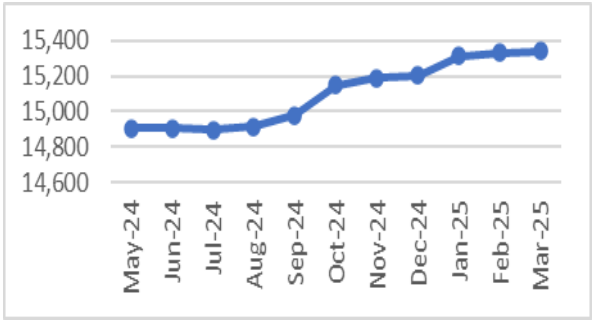
Total non-medical – clinical substantive staff



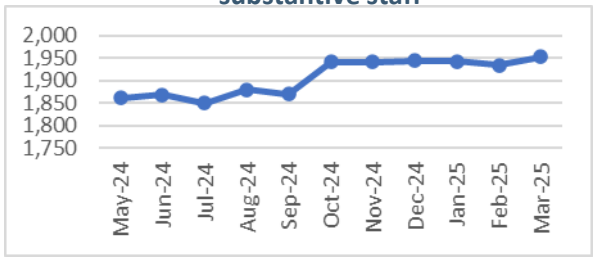
Total non-medical – non-clinical substantive staff



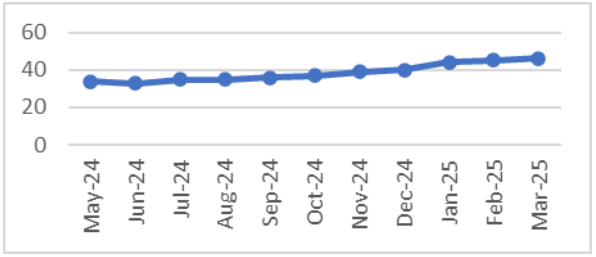
Total WTE substantive staff



Total Medical and Dental substantive staff



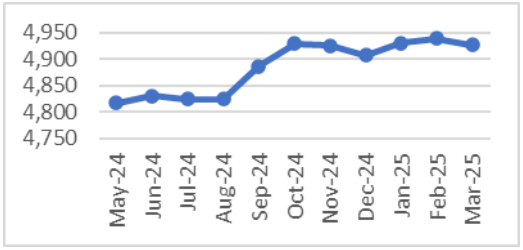
Any other substantive staff



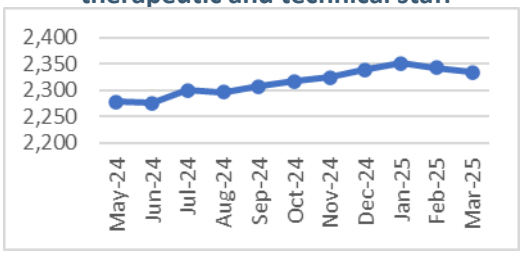
Provider Workforce Return (PWR) Staff Groups

Metric	Benchmark January 2020	Plan (WTE) March 2025	Actual (WTE) March 2025	Difference Jan 20 v Mar 25
Registered nursing, midwifery and health visiting staff (substantive total)	4,214	4,768	4,926	+ 712
Registered/qualified scientific, therapeutic and technical staff (substantive total)	1,993	2,279	2,333	+ 340
Support to clinical staff (substantive total)	2,489	2,634	2,685	+ 196
Total NHS infrastructure support (includes Admin & Clerical, estates, managers) (substantive total)	2,875	2,925	3,394	+ 519
Medical and Dental (substantive total)	1,722	1,909	1,953	+ 231
Any other staff (substantive total)	135	39	46	- 89
Total WTE Substantive Staff	**13,429**	**14,601**	**15,338**	**+ 1,909 (14.22%)**

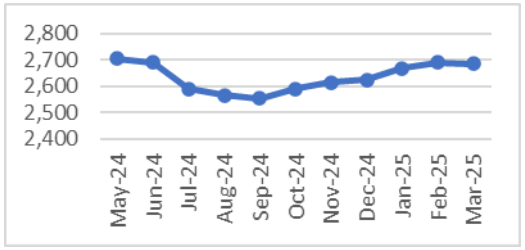
Registered nursing, midwifery and health visiting staff



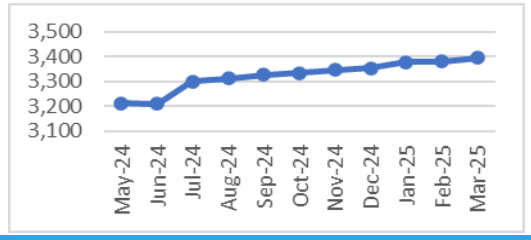
Registered/qualified scientific, therapeutic and technical staff



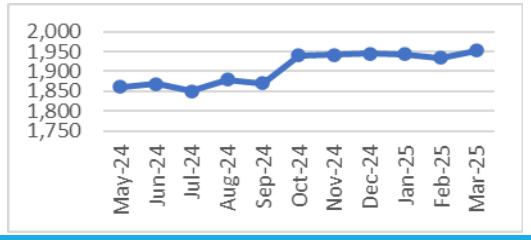
Support to clinical staff



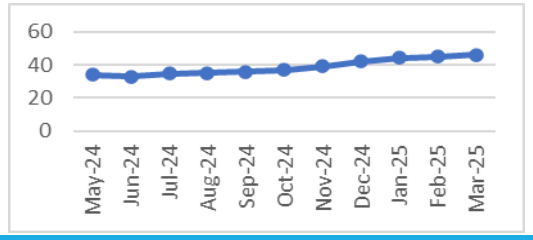
Total NHS infrastructure support



Medical and Dental



Any other staff

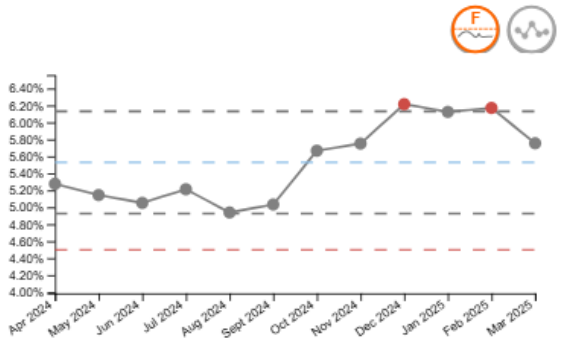


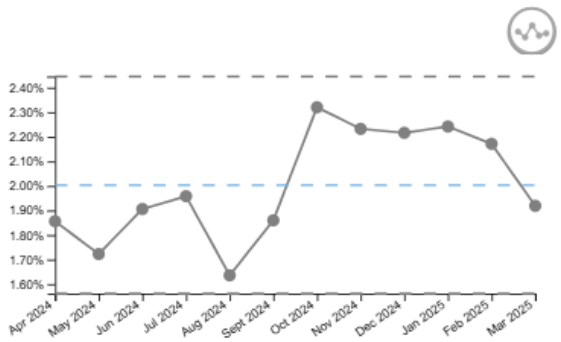
Sickness Absence

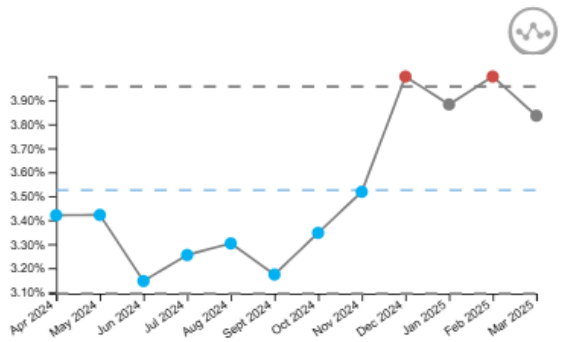
Trust Sickness %	12-Month Rolling	Value	Target
	Mar 25	5.53%	4.50%

Metric	Value
Short Term Sickness %	1.92%

Metric	Value
Long Term Sickness %	3.84%







Current Position:

- 12-month average to March 5.53%.
- March total sickness 5.75%:
  - short-term 1.92%
  - long-term 3.84%
- Top reasons for sickness:
  - Anxiety/stress/depression (S10) 31%
  - Other musculoskeletal problems 11%
  - Gastrointestinal problems 10%

Underlying Issues

- Anxiety/stress/depression (S10) is main reason for sickness absence and has had an underlying upward trend since May 2023.
- Total days lost: 290,637 full-time equivalents (FTEs).
- Average time lost per person: 19 days.
- Total cost of sick pay: £32m.
- Variation in sickness rates across Clinical Boards. March position:
  - lowest – Clinical and Diagnostic Services at 4.34% (short-term 1.79%, long term 3.81%)
  - highest – Family Health at 6.41% (short-term 2.41%, long term 4.35%)

Actions Undertaken:

- Health and Wellbeing (HAWB) offer – funding from Charities has been agreed to pilot a staff psychology service for two years and reintroduce Mental Health First Aiders
- New HAWB policy – being finalised in conjunction with Staff Side.
- Sickness absence – a target reduction in sickness absence of 0.5% and a cost reduction in sick pay of £5m have been set for 2025/26.
- Accountability – monthly performance reviews held with Clinical Boards; monthly meetings held between HR and Clinical Boards/Corporate Services. All areas to be asked to renew focus and double-down on non-compliance.

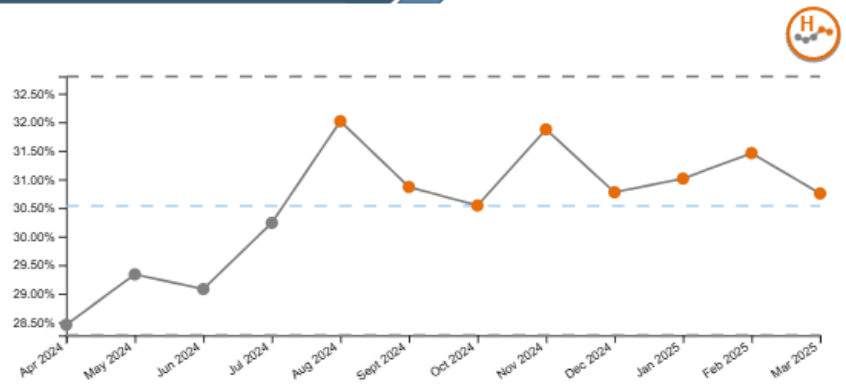
Sickness Absence – Absence reasons

Trust Sickness %	12-Month Rolling	Value	Target
	Mar 25	5.53%	4.50%

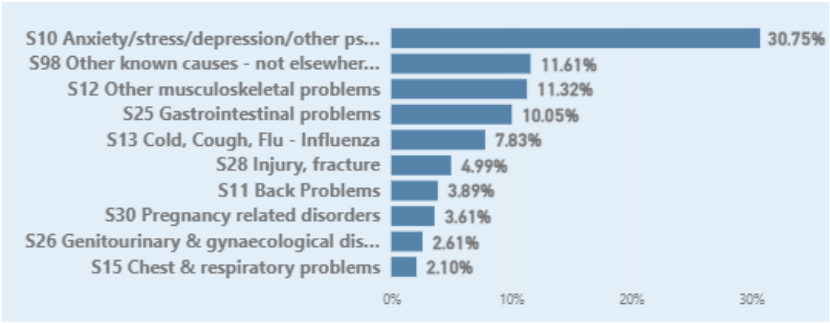
Sickness Reasons - SPC

S10 - Anxiety/stress/depression/ other psychiatric illness

30.75%

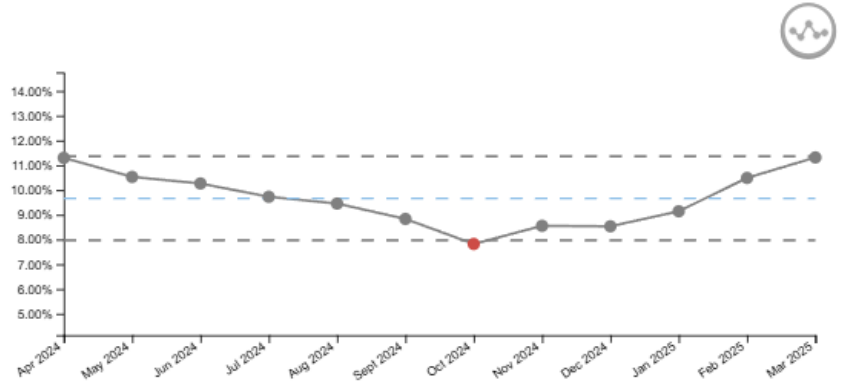


Top 10 Sickness Abscences



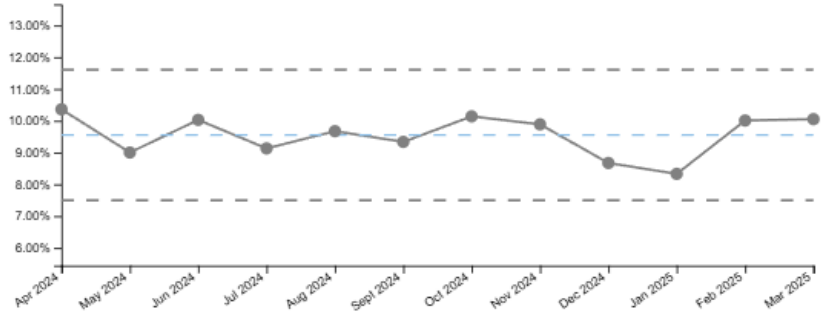
S12 - Other musculoskeletal problems

11.32%

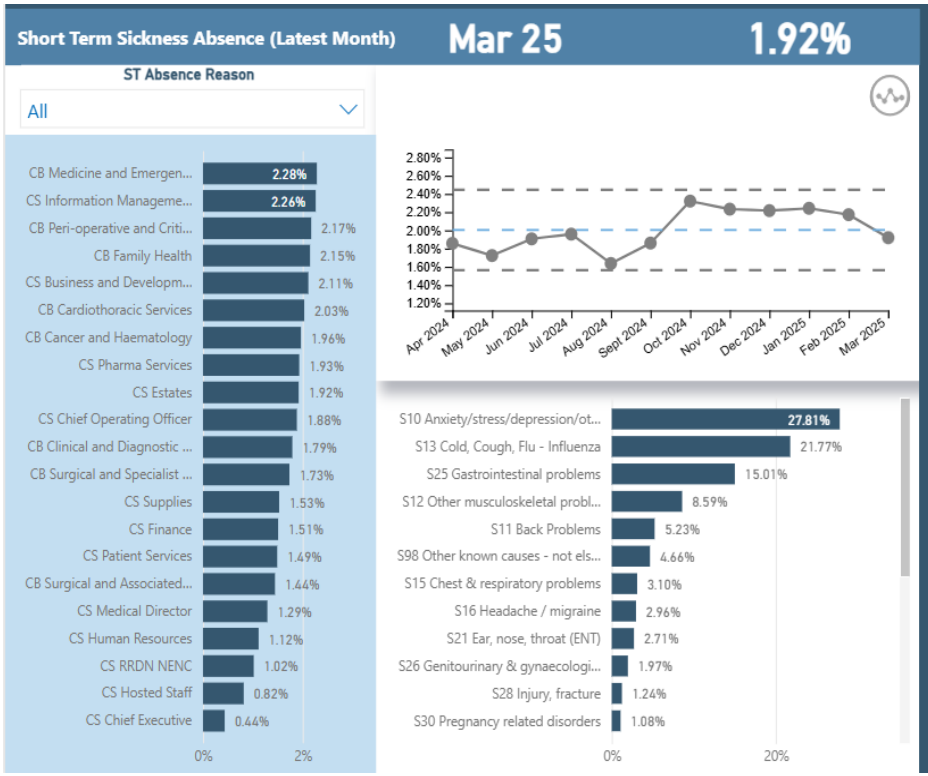


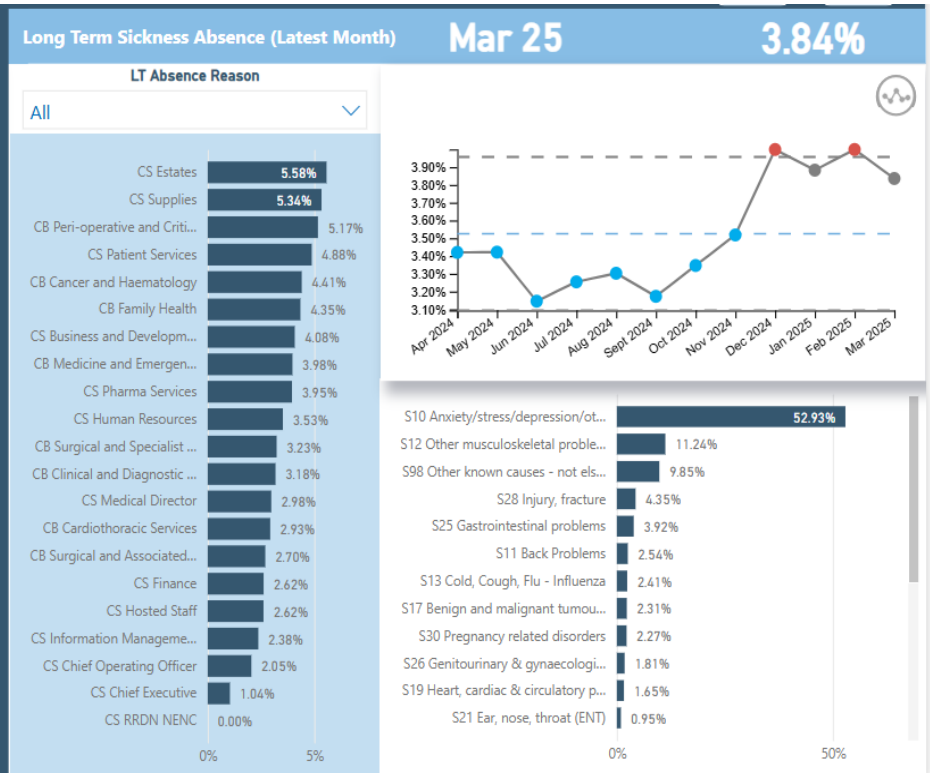
S25 - Gastrointestinal problems

10.05%



Sickness Absence





Sickness – FTE working days lost & Formal Action

Sickness - FTE working days lost

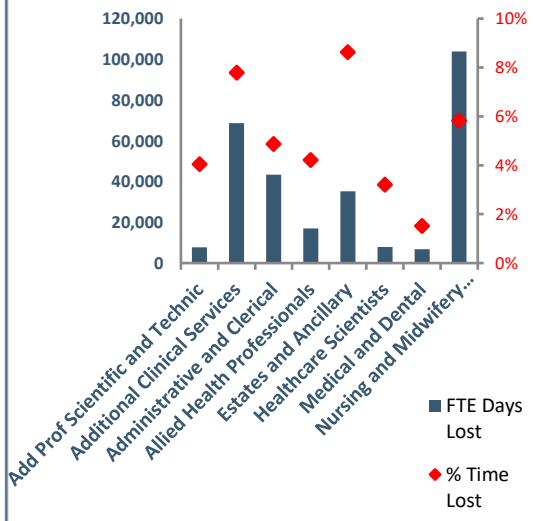
FTE Working Days Lost due to sickness

290,637

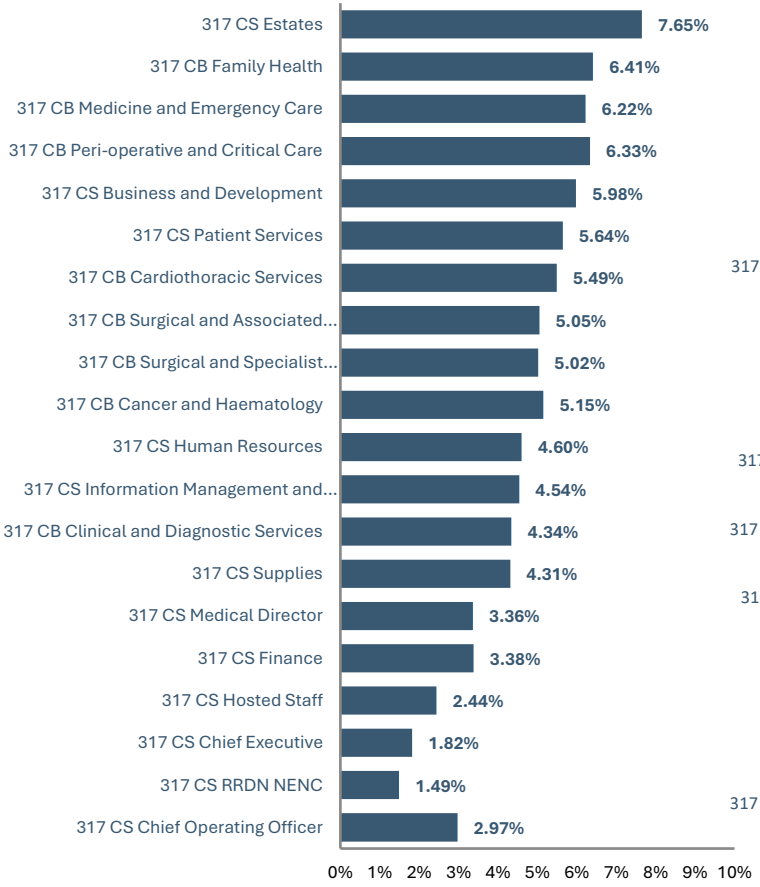
267,690

Compared to the previous year.

Sickness Absence by Staff Group

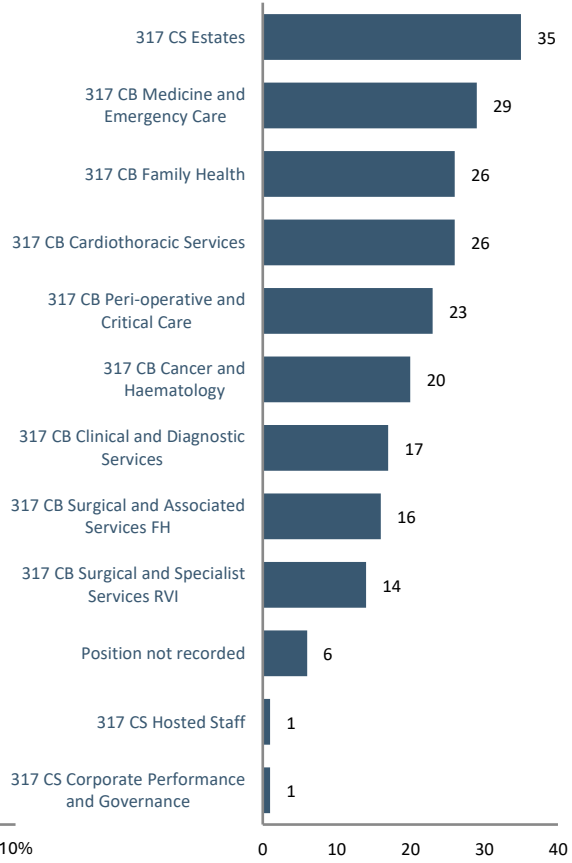


Sickness Absence (% Time Lost) by Clinical Board



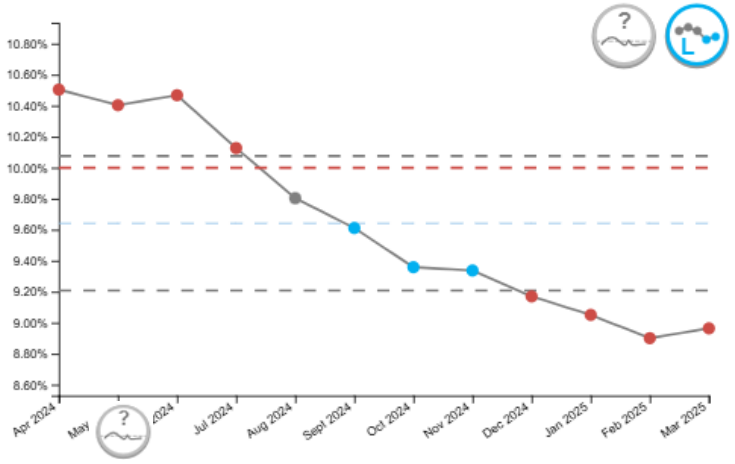
Sickness - Formal Action

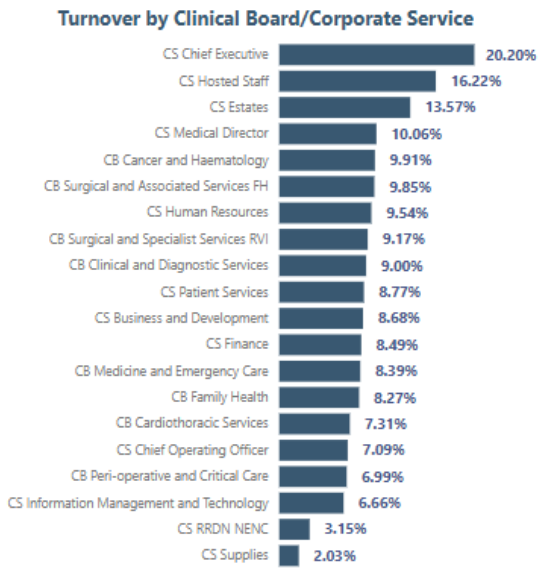
Attendance Management – Formal Action by Clinical Board/ Corporate Service

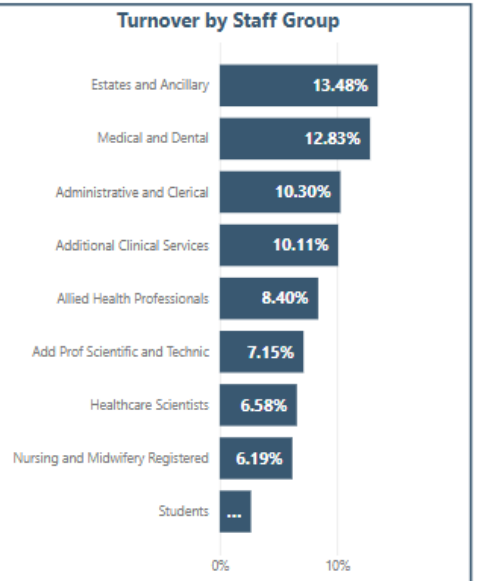


Turnover

Trust Turnover %	12-Month Rolling	Value	Target
	Mar 25	8.94%	10.00%







Current Position:	Underlying Issues	Actions Undertaken:
• Chart shows underlying downward trend in turnover since June 2024. • Overall target met since August 2024. • All Clinical Boards are better than target.	• 1,480 leavers in 12-months to March 2025: 22% were Nursing & Midwifery (339) and 19% were Additional Clinical Services (288). • Top destinations – No Employment (578, 39%); Other NHS organisation (482, 33%). • Top reasons – Work life Balance (220, 16%); Relocation (210, 14%) Retirement Age (202, 14%).	• Flexible working – supported and encouraged across the Trust. • Exit process – work on-going to act on reasons and trends why staff leave. • 'Stay conversations' – being explored. • Monitoring – daily information available to managers via People Dashboard; monthly performance reviews held with Clinical Boards; monthly meetings held between HR and Clinical Boards/Corporate Services.

Turnover

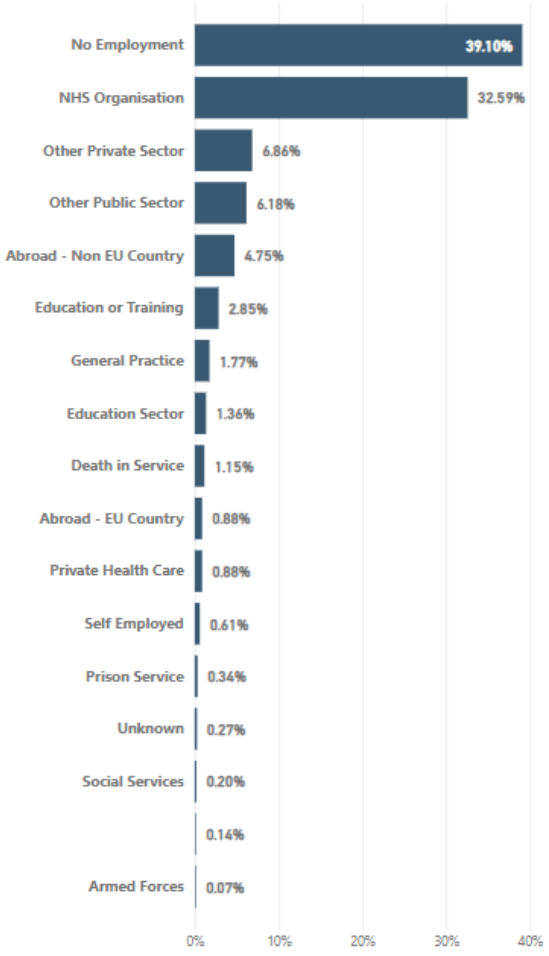
Trust Turnover %	12-Month Rolling	Value	Target
	Mar 25	8.98%	10.00%

Leaving Reasons

Leaving Reasons

Leaving Reason	Leaving Reason %
Voluntary Resignation - Work Life Balance	14.94%
Voluntary Resignation - Relocation	14.26%
Retirement Age	13.65%
Voluntary Resignation - Promotion	9.16%
Flexi Retirement	8.96%
End of Fixed Term Contract	6.52%
Voluntary Resignation - Health	6.25%
Voluntary Resignation - To undertake further education or training	4.28%
Voluntary Resignation - Incompatible Working Relationships	3.60%
Voluntary resignation - Pay and Reward Related	2.85%
Voluntary Resignation - Lack of Opportunities	2.24%
End of Fixed Term Contract - Other	1.97%
Voluntary Resignation - Child Dependants	1.97%
Dismissal - Capability	1.63%
Death in Service	1.22%
End of Fixed Term Contract - Completion of Training Scheme	1.15%
Voluntary Resignation - Other/Not Known	0.88%
Retirement - Ill Health	0.81%
Dismissal - Conduct	0.61%
Voluntary Early Retirement - with Actuarial Reduction	0.54%
Voluntary Resignation - Adult Dependants	0.54%
Redundancy - Compulsory	0.48%
Voluntary Early Retirement - no Actuarial Reduction	0.48%
Dismissal - Statutory Reason	0.27%
End of Fixed Term Contract - End of Work Requirement	0.27%
End of Fixed Term Contract - External Rotation	0.20%
Redundancy - Voluntary	0.20%
Bank Staff not fulfilled minimum work requirement	0.07%

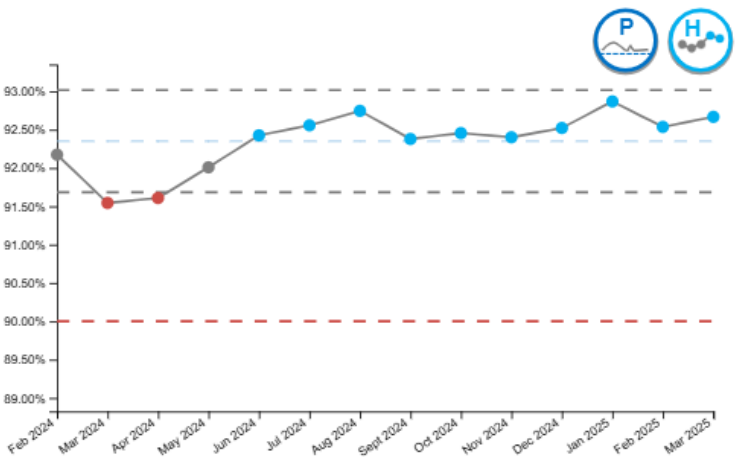
Destination on Leaving

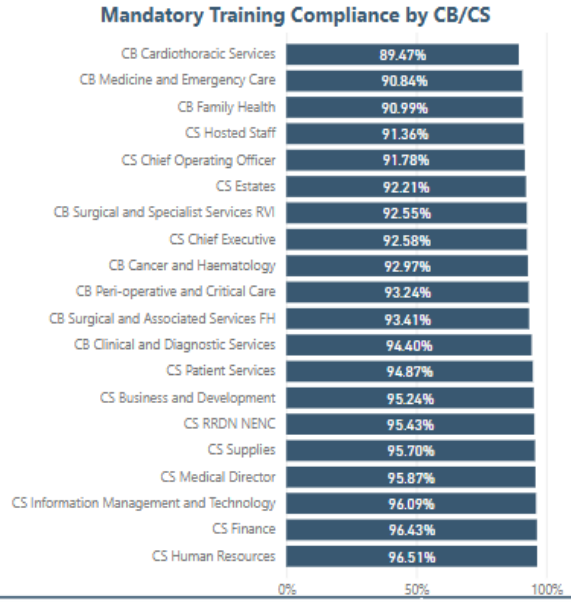


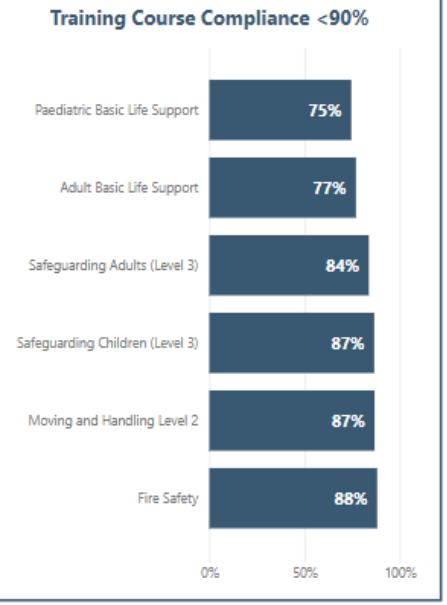
Destination On Leaving	Destination On Leaving %
No Employment	39.10%
NHS Organisation	32.59%
Other Private Sector	6.86%
Other Public Sector	6.18%
Abroad - Non EU Country	4.75%
Education or Training	2.85%
General Practice	1.77%
Education Sector	1.36%
Death in Service	1.15%
Abroad - EU Country	0.88%
Private Health Care	0.88%
Self Employed	0.61%
Prison Service	0.34%
Unknown	0.27%
Social Services	0.20%
	0.14%
Armed Forces	0.07%

Mandatory Training

Mandatory Training Compliance	Month	Value	Target
	Mar 25	92.67%	90.00%







Current Position:

- Chart shows improvement with overall target consistently met.

Underlying Issues

- Medical and Dental – have lowest overall compliance (79.89%) with low compliance in Adult Basic Life Support (51.04%), Paediatric Basic Life support (45.28%); Safeguarding Children (Level 3) (68.97%).
- Paediatric Life Support – overall compliance low at 75% for March 2025.

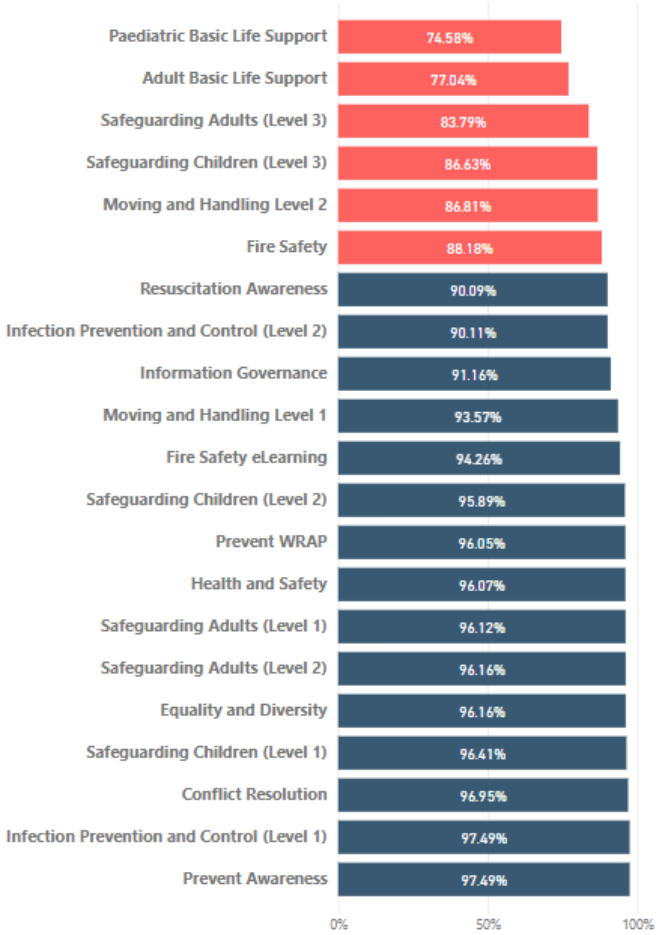
Actions Undertaken:

- Resus –delivery model continues to evolve, exploration of an Alliance model currently being scoped
- Stat & man national review –national policy now published, work ongoing to adopt within the trust. Development of a digital passport has been deprioritised and development paused.
- Mental Capacity Act Level 2 has now been implemented
- Safeguarding Level 3 & 4 – learning resources identified, redesign of e-learning packages now underway, L4 prospectus now designed
- Oliver McGowan –work with Alliance partners and key stakeholders continues to develop an Alliance-wide alternative training programme.

Mandatory Training

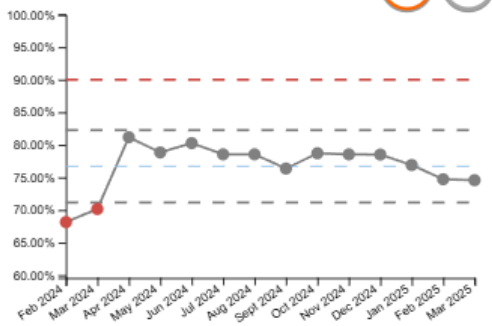
Mandatory Training Compliance	Month	Value	Target
	Mar 25	92.67%	90.00%

Training Course Compliance %

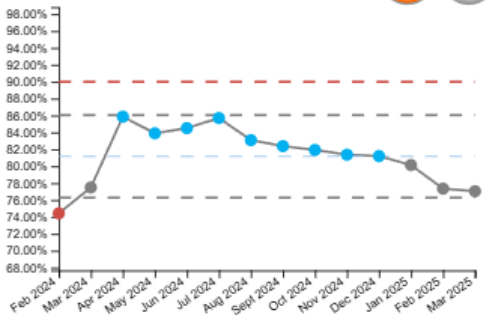


Lowest 4 Mandatory Training Compliance %

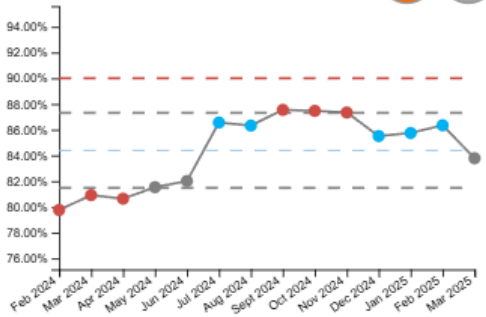
Paediatric Life Support 75%



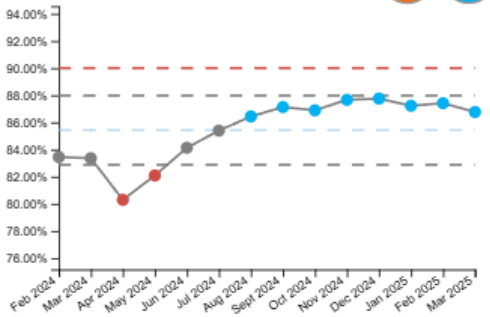
Adult Life Support 77%



Safeguarding Adults Level 3 84%

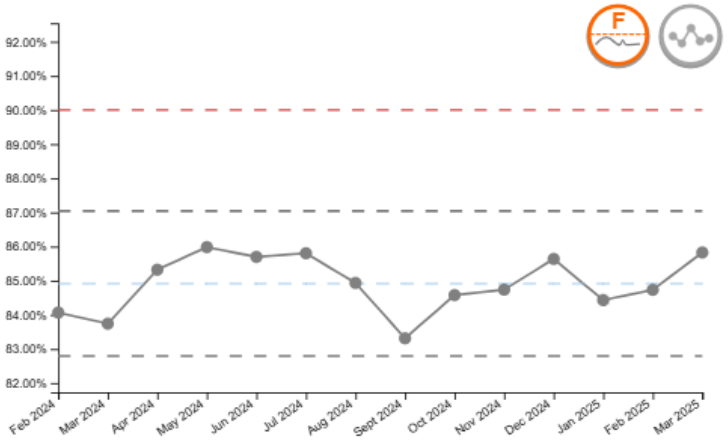


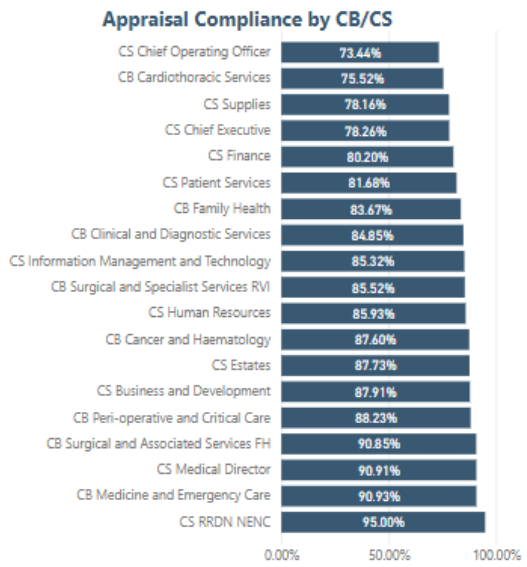
Safeguarding Children Level 3 87%

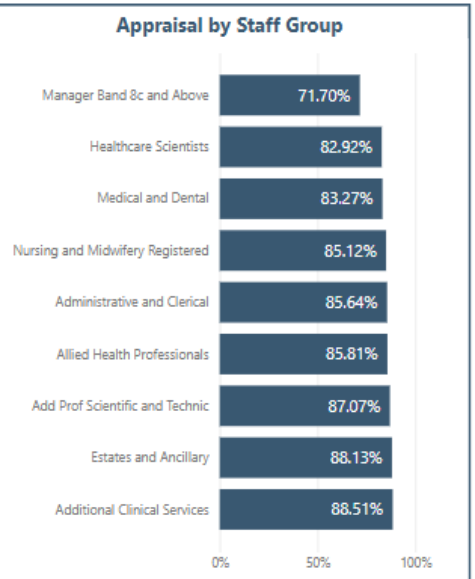


Appraisal Compliance

Appraisal Compliance	Month	Value	Target
	Mar 25	85.83%	90.00%







Current Position:

- Chart shows overall performance is consistently below target.
- Only 4 (21%) of the 19 areas reported have met the target.

Underlying Issues

- 1,964 appraisals are overdue with highest numbers in Nursing and Midwifery (686) and Additional Clinical Services (333).
- Clinical Board performance varies between 75.52% (Cardio) to 90.93% (Medicine & ED).
- Corporate Service performance varies between 73.44% (COO) to 95% (RRDN NENC).

Actions Undertaken:

- New appraisal process for all staff (excluding M&D) went live in April with ongoing communications and engagement events (c.1,000 attendees in first 4 weeks of engagement)
- Plan for some ongoing feedback work for additional assurance and link to pilot national ‘scope for growth’ framework.
- Accountability – monthly performance reviews held with Clinical Boards; monthly meetings held between HR and Clinical Boards/Corporate Services. All areas to be asked to renew focus and double-down on non-compliance.

Bank use – (£)

Bank Utilisation (£)	12-Month period ending	Total Bank Expenditure (£)	Total Bank Difference (£)
	Mar 25	£17,028,903	-£426,738

Bank Utilisation (£)

Staff Group	Apr 23 - Mar 24	Apr 24 - Mar 25	Difference
Admin & Clerical	£1,149,655	£290,705	-£858,950
Ancillary	£348,714	£1,098,506	£749,793
Estates			
Nursing & Midwifery (Registered)	£5,900,011	£5,635,246	-£264,765
Nursing & Midwifery (Unregistered)	£9,073,675	£9,233,950	£160,276
Professional & Technical	£983,587	£770,495	-£213,092
Total	£17,455,642	£17,028,903	-£426,738

Current Position:

- Cost of Bank for year to March 2025 increased +£29,596 compared to February.
- Annual cost to March 2025 is 2.44% lower than the previous year.

Underlying Issues

- Notable reductions in Nursing & Midwifery (registered), Admin & Clerical and Professional & Technical.
- Notable increases in Ancillary due to recruitment, retention and sickness absence.

Actions Undertaken:

- Work continues to reduce bank usage with effective rostering and direction.
- Aiming to reduce agency use for HCAs to zero in coming months by increasing bank, establishing a core team of HCAs on the bank to support deployment to areas requiring enhanced care, review and validation of enhanced care requirements through audit/training/ observation.

Agency use – (£)

Agency Utilisation (£)	12-Month period ending	Total Agency Expenditure (£)	Total Agency Difference (£)
	Mar 25	£3,428,544	-£1,267,389

Agency Utilisation (£)

Staff Group	Apr 23 - Mar 24	Apr 24 - Mar 25	Difference
Admin & Clerical	£746,294	£100,927	-£645,368
Ancillary	£13,464	£16,333	£2,870
Estates	£61,078	£26,346	-£34,732
Nursing & Midwifery (Registered)	£275,064	£488,411	£213,348
Nursing & Midwifery (Unregistered)	£2,684,321	£1,503,378	-£1,180,943
Professional & Technical	£915,712	£1,293,148	£377,436
Total	£4,695,933	£3,428,544	-£1,267,389

Current Position:

- Cost of agency for year to March 2025 increased +£12,596 compared to February.
- Annual cost to March 2025 is 27% lower than the previous year.

Underlying Issues

- Notable reductions in Nursing & Midwifery (unregistered) and Admin & Clerical.
- Significant increase in Professional & Technical due to recruitment in radiology and pathology.
- Registered nurse agency use – hotspots in Theatres and Cardiothoracic Services for scrub and anaesthetic nurses. Pressures also continue for Nurse Practitioners.

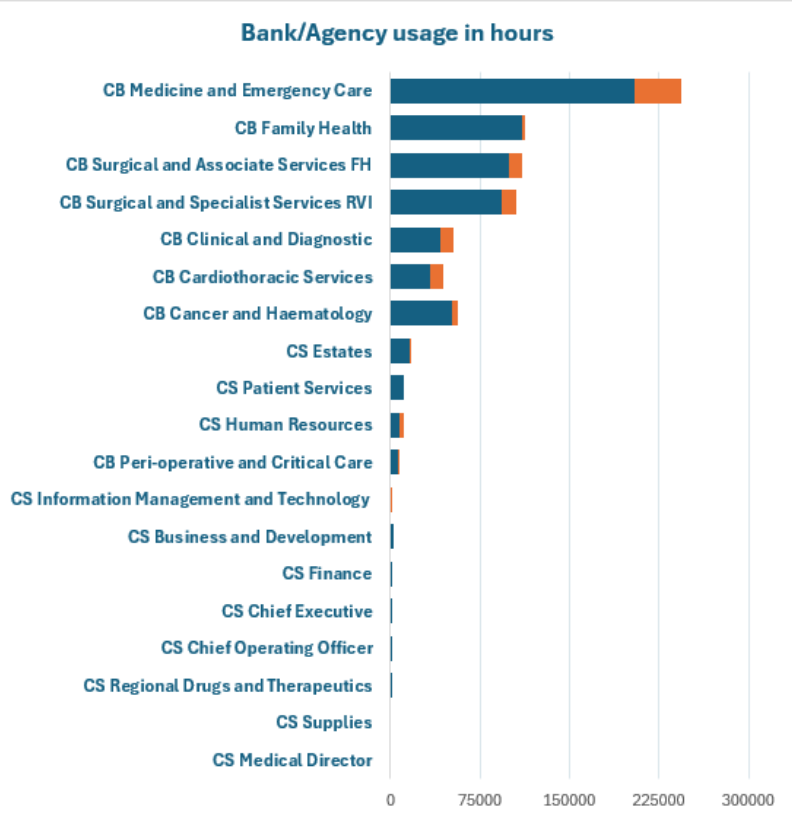
Actions Undertaken:

- Agency cost – a target reduction of £2m has been set for 2025/26.
- Increasing bank availability to reduce agency use.
- Agency usage reviewed and challenged monthly.

Bank & Agency Utilisation - Hours

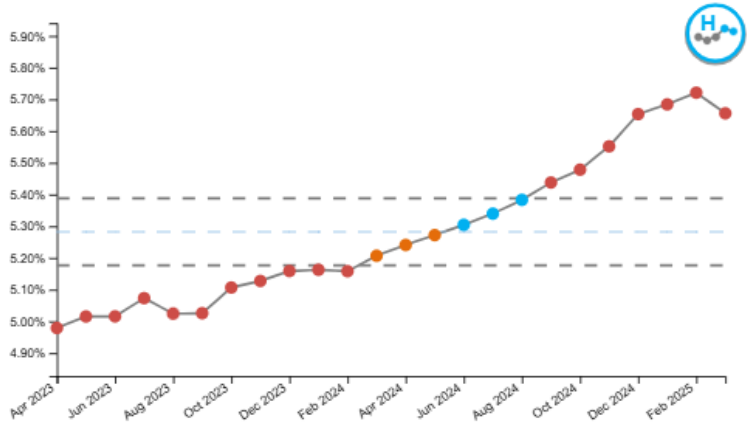
Bank & Agency	12-Month period ending	Total Bank and Agency Hours
	Mar 25	776,908

Clinical Board	Bank Hours	Agency Hours	Total Hours
CB Medicine and Emergency Care	204,179	39,372	243,551
CB Family Health	109,618	2,687	112,305
CB Surgical and Associate Services FH	99,484	10,631	110,115
CB Surgical and Specialist Services RVI	93,335	12,516	105,851
CB Clinical and Diagnostic	42,235	10,685	52,920
CB Cancer and Haematology	51,776	4,913	56,689
CB Cardiothoracic Services	32,738	11,845	44,583
CS Estates	15,993	923	16,916
CS Patient Services	10,951	0	10,951
CS Human Resources	7,907	3,558	11,465
CB Peri-operative and Critical Care	5,675	1,691	7,366
CS Business and Development	2,595	0	2,595
CS Information Management and Technology	105	362	467
CS Chief Executive	840	0	840
CS Finance	184	0	184
CS Chief Operating Officer	99	0	99
CS Regional Drugs and Therapeutics	13	0	13
CS Medical Director	0	0	0
CS Supplies	0	0	0

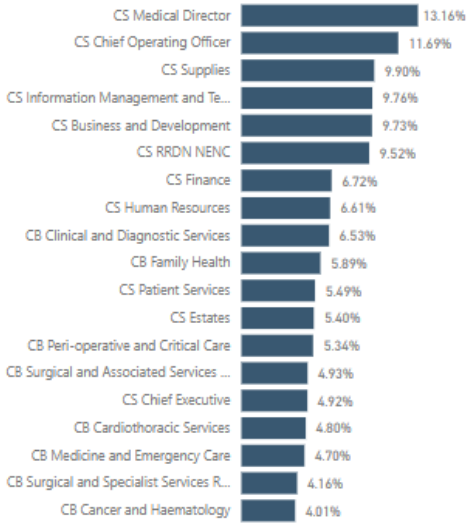


Equality, diversity and Inclusion (EDI) - Disability

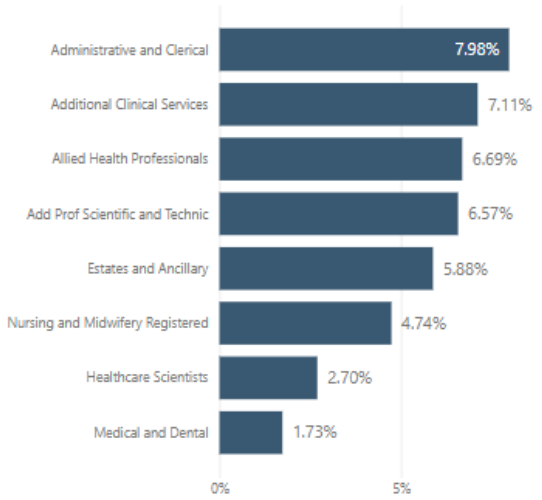
EDI - Disability	Month	Value	Trust Headcount
	Mar 25	5.66%	16,531



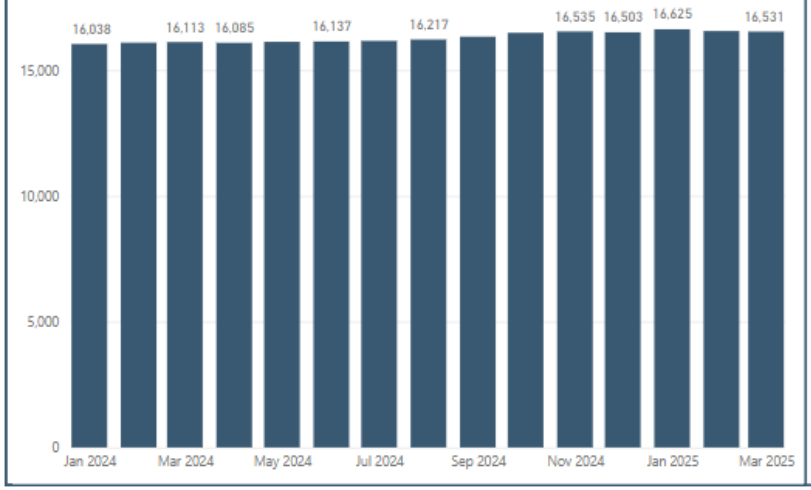
Disability by CB/CS



Disability by Staff Group



Trust Headcount Trend



Age Band

	Age Band	Disability %
1	<=20 Years	8.00%
2	21-25	10.75%
3	26-30	6.86%
4	31-35	5.65%
5	36-40	4.68%
6	41-45	4.77%
7	46-50	4.12%
8	51-55	4.82%
9	56-60	5.65%
10	61-65	5.43%
11	66-70	3.23%
12	>=71 Years	4.92%

Current Position:

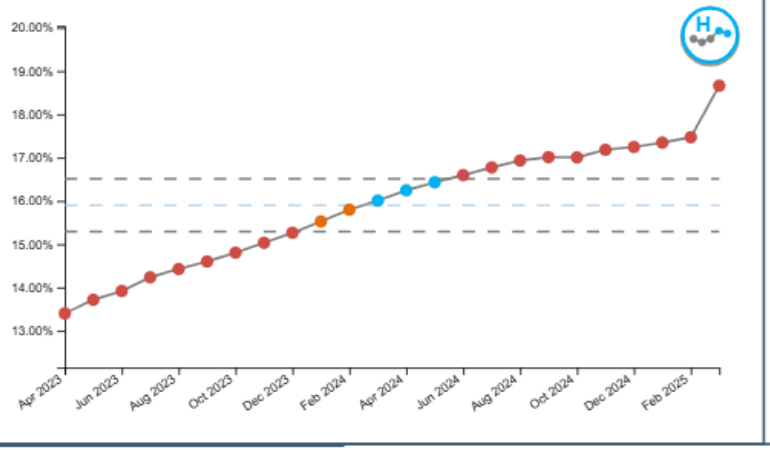
Charts show percentage of staff in post each month by those disclosing a disability.

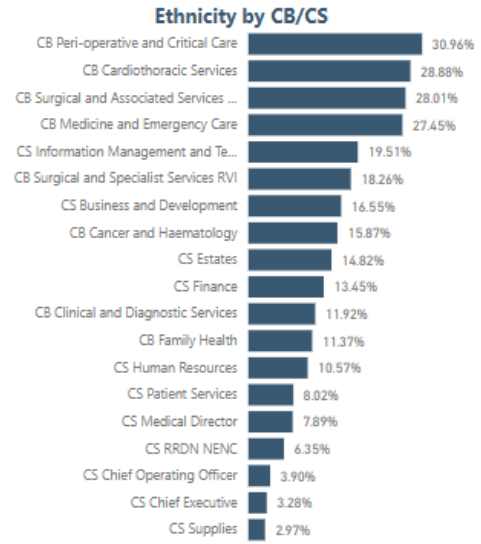
Percentage of staff employed disclosing a disability reduced in March 2025 to 5.66%

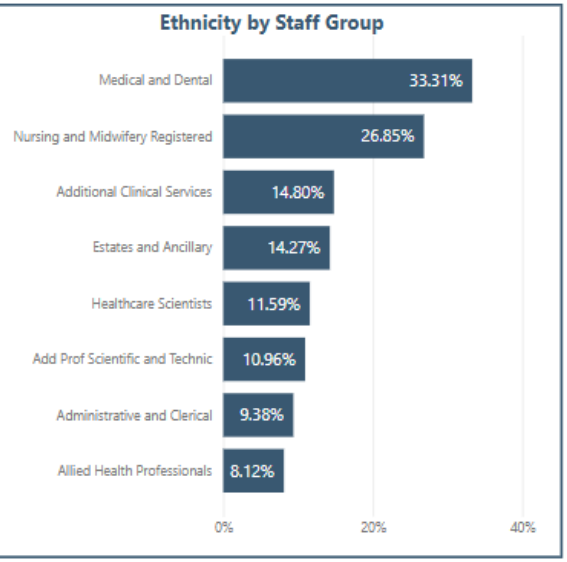
Percentage of staff who have not disclosed their status is 10%. An EDI campaign is in place from October to encourage staff to update their EDI record in ESR.

Equality, diversity and Inclusion (EDI) - Ethnicity

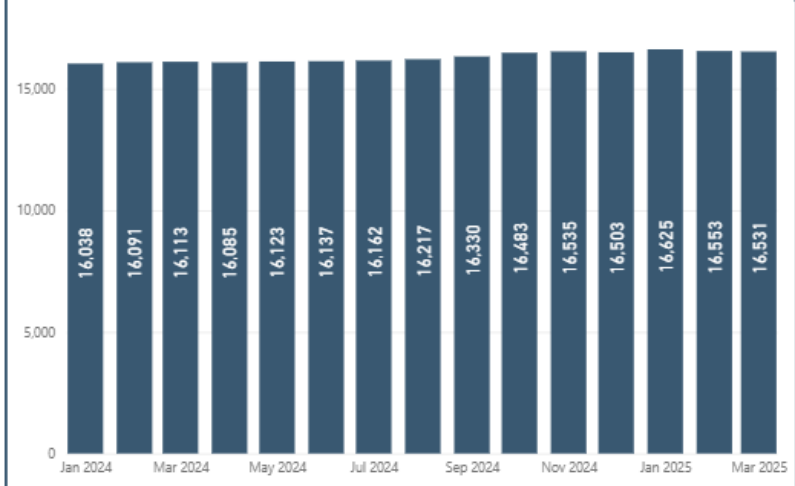
EDI - Ethnicity	Month	Value	Trust Headcount
	Mar 25	18.66%	16,531







Trust Headcount Trend



Age Band

	Age Band	BME %
1	<=20 Years	15.33%
2	21-25	19.14%
3	26-30	26.24%
4	31-35	25.03%
5	36-40	23.26%
6	41-45	14.90%
7	46-50	20.87%
8	51-55	16.66%
9	56-60	9.65%
10	61-65	6.18%
11	66-70	6.45%
12	>=71 Years	6.56%

Current Position:

Charts show percentage of staff in post each month by ethnicity (BAME).

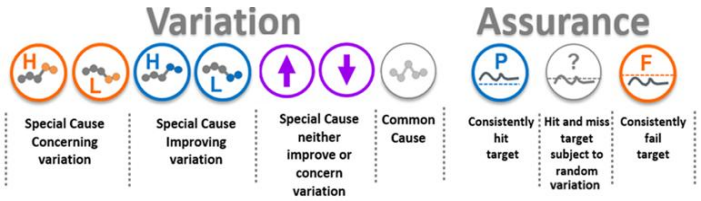
Percentage of BAME staff continues to demonstrate a month-on-month increase with the latest position reflecting BAME staff at 18.66% of the workforce.

Percentage of staff who have not disclosed their status is very low at 1%. An EDI campaign is in place from October to encourage staff to update their EDI record in ESR.

Finance

Finance Overview

Metric	Period	Actual	Plan
Income	Mar-25	£1, 771.9m	£1,646.0m
Expenditure	Mar-25	£1,771.9m	£1,646.0m
Surplus /(Deficit)	Mar-25	(£0m)	(£0m)
I&E Margin	Mar-25	(0.0%)	(0.0%)
Cost Improvement – Recurrent	Mar-25	£38.5m	£69.3m
Cost Improvement – Non-Recurrent	Mar-25	£68.6m	£38.7m
Elective Income	Mar-25	£323.9m	£320.8m
Capital (CDEL)	Mar-25	£44.8m	£32.8m



Income & Expenditure

- Total income is £125.9 million ahead of plan, with pass through drugs, devices and deferred income at £28.7 million ahead of plan and employer's pension contribution of £54.9 million.
- Total expenditure is £125.9 million ahead of plan, off-set by income above and pressure of Industrial Action, drugs growth and Cost Improvement Programme (CIP), including employer's pension contribution of £54.9 million.

Cost Improvement

- There is reliance on non-recurrent measures to bridge the recurrent CIP gap of £30.8 million.

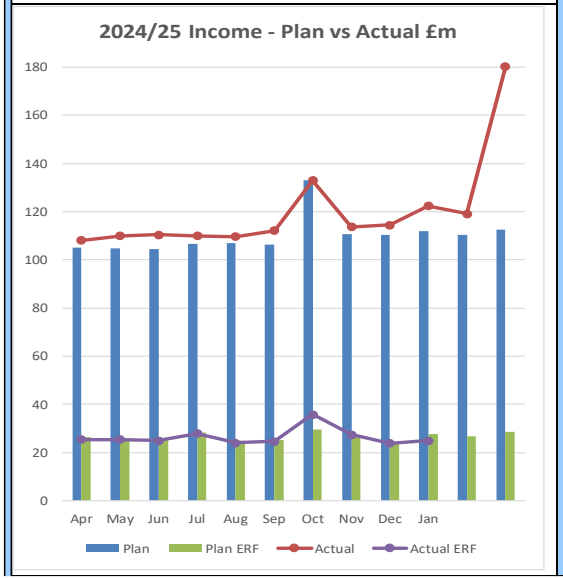
Elective Income

- The trust is ahead on the Elective Recovery Fund (ERF) income by around £3.1 million.

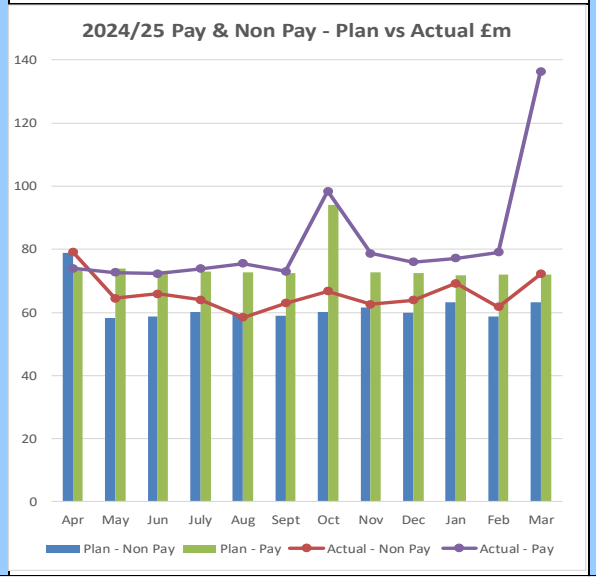
Overall Finance Position (1/4)

Financial Overview as at 31st March 2025

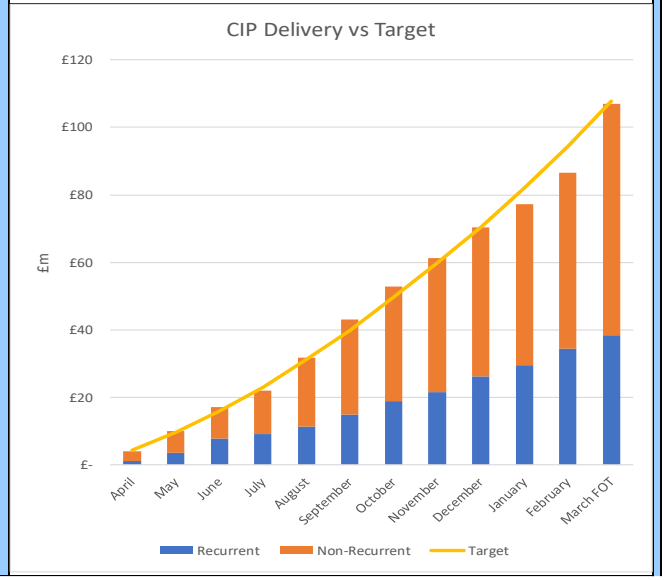
Income



Expenditure



Cost Improvement Analysis



This page summarises the financial position of the Trust for the period ending 31st March 2025. The Trust has agreed a Financial Plan for 2024/25 with a break-even position. As at Month 12 the Trust is reporting a break even against the planned break-even (after Control Total). The financial information includes the costs of the Consultant Pay Reform agreement for 2023/24 paid in May, with a pressure on drugs, partly off-set with income. The delivery of the plan has a significant Cost Improvement Plan (CIP) and includes a number of non-recurrent factors. The graphs reflect the income and expenditure associated with the backdated Pay Award paid in October. It should be noted there is matched income and expenditure for the employer's pension contribution paid in March via the NHS Pensions Agency that is shown in the income and expenditure graphs above.

Capital Expenditure - The Plan for March is £32.8 million and the year end expenditure is £44.8 million creating a variance of £12 million.

Risks -

- Delivery of the required levels of activity compared with 2019/20 activity levels - Green
- Reliance on non-recurrent income and expenditure benefits - Green
- Achievement of CIP targets - Green
- Assumptions relating to inflation, subject to change and unfunded - Green

Overall Finance Position (2/4)

Income & Expenditure Statement	In Month (March 2025)			Year To Date (March)		
	Plan	Actual	Variance	Plan	Actual	Variance
	£000's	£000's	£000's	£000's	£000's	£000's
Operating income from patient services	122,041	184,405	62,364	1,425,117	1,523,487	98,369
Other Patient Care - & Non NHS	2,315	4,554	2,238	27,786	34,052	6,266
Non Patient Care - Other Income	16,741	22,106	5,365	190,131	205,006	14,875
TOTAL OPERATING INCOME (WITHIN EBITDA)	**141,097**	**211,065**	**69,968**	**1,643,034**	**1,762,545**	**119,511**
Employee expenses	74,213	136,314	62,101	905,722	986,719	80,997
Drugs	25,456	26,623	1,167	284,424	289,331	4,907
Supplies & Services Clinical	13,642	17,525	3,883	160,773	183,217	22,445
Operating expenses excl. employee expenses	18,975	20,328	1,353	213,902	233,423	19,520
TOTAL OPERATING EXPENSES (WITHIN EBITDA	**132,287**	**200,790**	**68,504**	**1,564,821**	**1,692,690**	**127,869**
NET FINANCE COSTS	**5,462**	**5,939**	**477**	**84,773**	**71,674**	**(13,099)**
OPERATING SURPLUS/(DEFICIT)	**3,349**	**4,335**	**987**	**(6,560)**	**(1,819)**	**4,741**
Control Total & IFRS16 PFI Adjustments	1,140	135	(1,005)	(6,560)	(1,924)	4,741
SURPLUS/(DEFICIT) FOR THE PERIOD/YEAR - CONTROL TOTAL	**2,208**	**4,200**	**1,992**	**0**	**(0)**	**(0)**

The reported performance for March 2025 is as follows:-

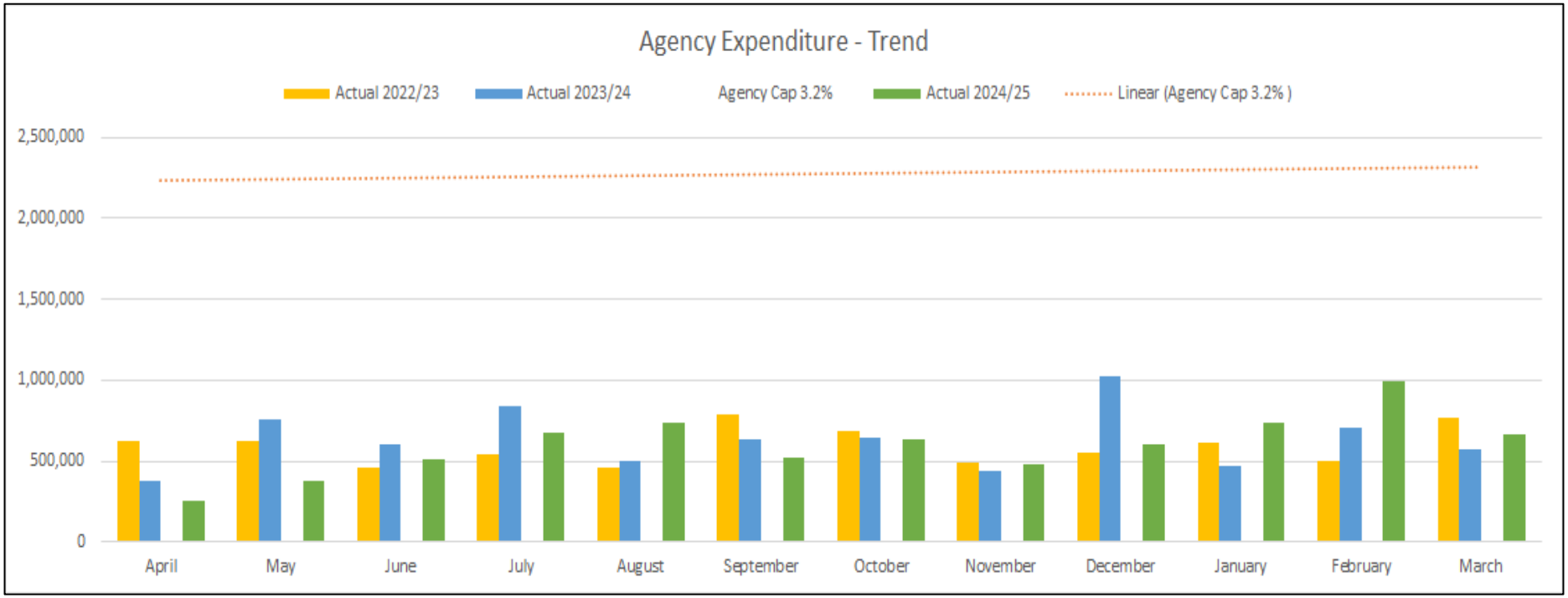
Income

- The in-month position is an overall favourable variance of £62.1 million partly due to over-performance on matched drugs and devices and an over achievement on Non-recurrent income CIP. ERF income is on plan despite the impact of industrial action, with employer's pension contribution matched by expenditure of £54.9 million.

Expenditure

- Pay costs are £81 million over plan at month 12, including the pension contribution income (noted above) and include the costs associated with industrial action. Total operating expenditure is £47m above plan due to increased costs relating to drugs and clinical supplies (including circa £12m that is matched with income) and unachieved CIP (£31m behind on expenditure).

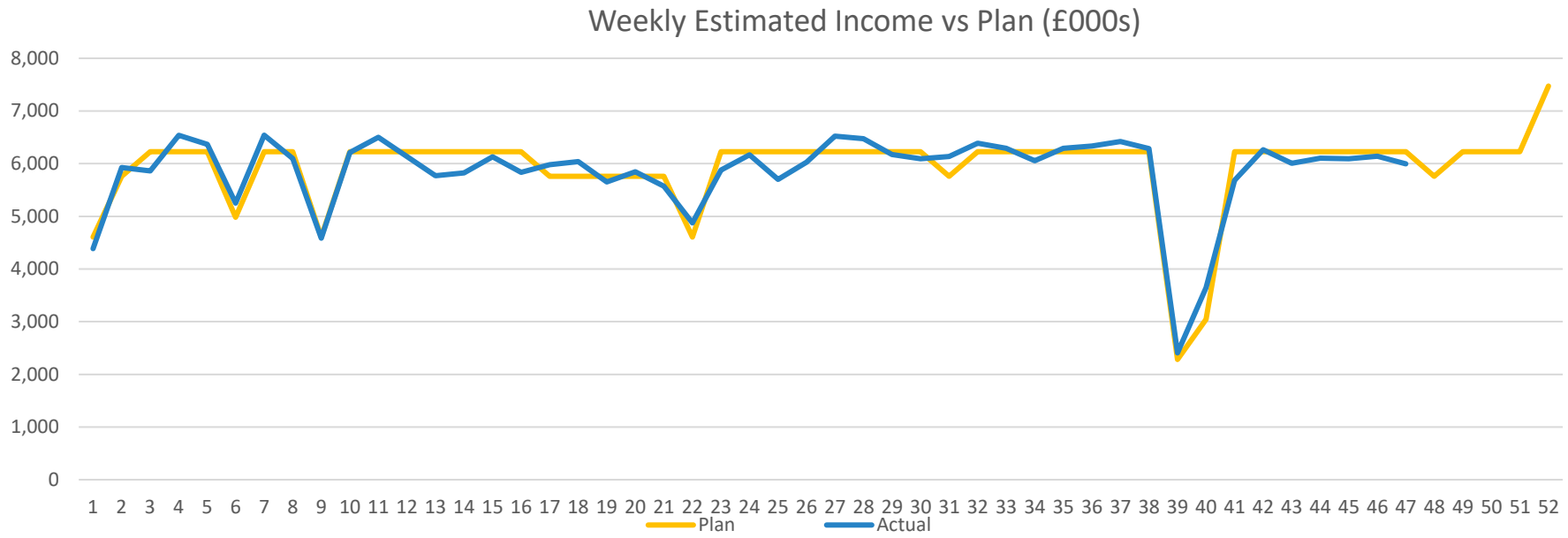
Overall Finance Position (3/4)



Agency

- This shows the overall trend in agency usage over the last two years. This is running at around 0.7% of the gross staff costs. This is below the national target set at 3.2%. Although this is positive compared with the national target, there continues to be medical agency usage across a number of specialties where it is proven difficult to recruit on a permanent/substantive basis. This will continue to be managed and monitored on an ongoing basis to reduce the reliance on agency, with an reduction in March (Month 12) compared to the previous month.

Overall Finance Position (4/4)



Elective Recovery Performance

Background

- Elective income (Ordinary Elective, Day Case, Outpatient New and Outpatient Procedure Income) is paid on a tariff basis
- The Clinical Boards have committed to deliver a plan of £318m which is £4m higher than the nationally set target for elective activity. The graph above shows estimated performance against this plan.
- There is a time lag in recognising income relating to outpatient procedures - outpatient procedures attendances in review appointments default to outpatient reviews (which are outside of the ERF tariff payment) until they coded.

Current Position

- To week 47, total delivery is £668k away from the agreed plan (on the basis of the weekly model), however this is expected to improve back to target as outpatient procedures are coded.

Health Inequalities

The Health Inequalities reporting program for 2025/26 will commence in Summer 2025.

A Guide to SPC

SPC Icons & How to Interpret (1/4)

	Variation/Performance Icons		
Icon	**Technical Description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	**Something's going on!** Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	**Something good is happening!** Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	**Something good is happening!** Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	**Something's going on!** This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

SPC Icons & How to Interpret (2/4)

	Assurance Icons		
Icon	**Technical Description**	**What does this mean?**	**What should we do?**
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

SPC Icons & How to Interpret (3/4)

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: (blank)
H	**Excellent** **Celebrate and Learn** • This metric is improving. • Your aim is high numbers and you have some. • You are consistently achieving the target because the current range of performance is above the target.	**Good** **Celebrate and Understand** • This metric is improving. • Your aim is high numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** **Celebrate but Take Action** • This metric is improving. • Your aim is high numbers and you have some. • HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	**Excellent** **Celebrate** • This metric is improving. • Your aim is high numbers and you have some. • There is currently no target set for this metric.
L	**Excellent** **Celebrate and Learn** • This metric is improving. • Your aim is low numbers and you have some. • You are consistently achieving the target because the current range of performance is below the target.	**Good** **Celebrate and Understand** • This metric is improving. • Your aim is low numbers and you have some. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** **Celebrate but Take Action** • This metric is improving. • Your aim is low numbers and you have some. • HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	**Excellent** **Celebrate** • This metric is improving. • Your aim is low numbers and you have some. • There is currently no target set for this metric.
(blank)	**Good** **Celebrate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	**Average** **Investigate and Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • Your target lies within the process limits so we know that the target may or may not be achieved.	**Concerning** **Investigate and Take Action** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	**Average** **Understand** • This metric is currently not changing significantly. • It shows the level of natural variation you can expect to see. • There is currently no target set for this metric.
H	**Concerning** **Investigate and Understand** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • HOWEVER you are consistently achieving the target because the current range of performance is below the target.	**Concerning** **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** **Investigate and Take Action** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • Your target lies below the current process limits so we know that the target will not be achieved without change	**Concerning** **Investigate** • This metric is deteriorating. • Your aim is low numbers and you have some high numbers. • There is currently no target set for this metric.

SPC Icons & How to Interpret (4/4)

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: (blank)
Low	**Concerning** **Investigate and Understand** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • HOWEVER you are consistently achieving the target because the current range of performance is above the target.	**Concerning** **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies within the process limits so we know that the target may or may not be missed.	**Very Concerning** **Investigate and Take Action** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • Your target lies above the current process limits so we know that the target will not be achieved without change	**Concerning** **Investigate** • This metric is deteriorating. • Your aim is high numbers and you have some low numbers. • There is currently no target set for this metric.
Improving				**Unsure** **Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event above the upper process limits; a continued upward trend or shift above the mean. • There is no target set for this metric.
Deteriorating				**Unsure** **Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event below the lower process limits; a continued downward trend or shift below the mean. • There is no target set for this metric.
(blank)				**Unknown** **Watch and Learn** • There is insufficient data to create a SPC chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

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Agenda item A10

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025					
Title	Joint Medical Directors Trust Board Report					
Report of	Lucia Pareja-Cebrian / Michael Wright, Joint Medical Directors					
Prepared by	Associate Medical Directors					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☒			
Summary	This report highlights issues the Joint Medical Directors wish the Board to be made aware of. The following items are described in more detail within this report: • Urgent and Emergency Care Update • Cancer Update • Quality & Safety • Medicines Management • Job Planning Update • Remote Hosting Organisation (RHO) Update The report of the Guardian of Safe Working is attached for information.					
Recommendation	The Board are asked to note the contents of this report and: • Note the actions being taken related to front door frailty to improve urgent and emergency care performance. • Note ongoing concerns about performance against cancer targets and the actions being taken to improve this.					
Links to Strategic Objectives	All.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link.					
Reports previously considered by	This is a regular report to Board. Previous similar reports have been submitted.					

JOINT MEDICAL DIRECTORS TRUST BOARD REPORT

1) URGENT & EMERGENCY CARE

April performance for urgent and emergency care dropped to Type 1 60.16%, likely influenced by the closure of the winter ward at the Freeman Hospital. Performance in May has subsequently improved, with Type 1 currently at 73.04% and overall Trust performance at 80.89%. Type 2 performance (Eye casualty) has deteriorated slightly, and it was 88% in April, although remains above the national target.

Working groups have been established to assess and improve Paediatric flow, Eye casualty, general discharge processes and main Emergency Department (ED) performance and quality of care. Learning from Winter 2024/25 has been evaluated, with proposals for winter plans for 2025/26 being drafted (refer to agenda item A8 for further information). Immediate challenges include closure of community beds and Connie Lewcock and loss of inpatient beds at the Freeman Hospital due to the need to refurbish ward 16. Rolling repairs of bays on Royal Victoria Infirmary (RVI) Assessment Suite will also start in June 2025 lasting 6-9 weeks, which will also likely have an impact on patient flow.

2) CANCER UPDATE

i) Performance

28 Day Faster Diagnosis Standard (FDS) Target

2024/25 FDS 77% (78% internal stretch target)
2025/26 FDS 80% (85% internal stretch target)

		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust Total	Actual	77.0%	80.8%	79.2%	73.0%	69.2%	70.6%	73.1%	74.7%	76.1%	70.7%	83.4%	

		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Brain/CNS	Actual			50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	
Breast	Actual	95.5%	96.4%	95.8%	94.7%	93.9%	96.3%	96.8%	97.8%	96.0%	94.4%	97.0%	
Breast Symptomatic	Actual	65.3%	55.8%	60.9%	60.4%	54.7%	80.2%	85.4%	82.7%	61.9%	63.6%	70.9%	
Childrens	Actual	100.0%	100.0%	60.0%	66.7%	60.0%	100.0%	100.0%	60.0%	0.0%	66.7%	100.0%	
Colorectal	Actual	60.6%	70.0%	65.9%	61.7%	63.5%	59.2%	65.8%	69.5%	71.1%	64.0%	80.2%	
Gynae	Actual	59.7%	72.4%	69.4%	70.5%	50.0%	59.3%	60.5%	73.1%	71.6%	80.4%	82.0%	
Haematology	Actual	72.7%	93.8%	75.0%	81.8%	73.3%	72.7%	100.0%	91.7%	89.5%	100.0%	94.4%	
Head & Neck	Actual	87.2%	91.5%	92.1%	91.4%	91.2%	89.9%	89.7%	87.1%	91.8%	90.9%	93.3%	
Lung	Actual	85.7%	81.6%	71.0%	60.8%	82.5%	63.0%	78.6%	75.5%	76.3%	86.0%	82.5%	
NSS	Actual	80.0%	100.0%	92.3%	92.9%	87.5%	87.5%	86.7%	90.9%	85.7%	63.6%		
Other	Actual	100.0%		100.0%		0.0%		100.0%	50.0%	0.0%		100.0%	
Sarcoma	Actual	42.9%	66.7%	66.7%	88.9%	80.0%	87.5%	88.9%	85.7%	92.9%	100.0%	72.7%	
Skin	Actual	75.7%	78.8%	78.2%	66.4%	62.6%	58.6%	63.0%	65.2%	68.9%	60.9%	81.5%	
Testicular	Actual	100.0%	100.0%	91.7%	100.0%	100.0%	90.0%	92.3%	87.5%	93.8%	90.9%	90.0%	
Upper GI	Actual	73.2%	76.0%	62.6%	65.9%	59.3%	60.8%	74.3%	76.7%	85.9%	86.5%	88.2%	
Urology	Actual	69.9%	75.7%	77.7%	82.4%	80.9%	80.6%	64.5%	60.2%	50.9%	31.7%	56.3%	
HPB	Actual	12.5%	66.7%	0.0%	33.3%	0.0%	20.0%	33.3%	16.7%	66.7%	0.0%		
OGD	Actual	79.2%	74.1%	61.9%	65.5%	60.3%	59.7%	75.9%	82.8%	92.4%	88.5%		

62 Day Time to Treatment Target

2024/25 62-day 70%
2025/26 62-day 75% (85% internal stretch target)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Trust Total	Actual	59.0%	60.2%	65.2%	59.9%	60.8%	59.4%	63.4%	62.0%	63.7%	66.1%	61.0%	

		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25
Brain/CNS	Actual	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	92.6%	100.0%	100.0%	90.0%	
Breast	Actual	89.9%	93.8%	97.8%	89.7%	89.9%	91.8%	87.5%	90.5%	90.8%	87.7%	88.1%	
Childrens	Actual			100.0%			100.0%		100.0%	100.0%	100.0%		
Colorectal	Actual	25.3%	46.4%	28.8%	49.3%	47.5%	48.1%	34.8%	44.1%	31.3%	50.6%	34.5%	
Gynae	Actual	45.0%	63.2%	73.7%	60.0%	56.3%	77.8%	76.9%	57.7%	35.5%	64.0%	48.0%	
Haematology	Actual	82.1%	66.7%	93.2%	90.0%	90.0%	81.8%	83.0%	92.1%	83.3%	100.0%	85.3%	
Head & Neck	Actual	80.0%	66.7%	79.4%	80.0%	77.2%	66.7%	72.9%	75.0%	59.0%	85.4%	80.7%	
Lung	Actual	29.3%	46.0%	48.3%	34.8%	29.3%	33.5%	39.2%	43.1%	55.1%	45.1%	36.3%	
Other	Actual	77.8%	78.0%	33.3%	28.6%	83.3%	33.3%	62.5%	63.6%	100.0%	50.0%	41.7%	
Sarcoma	Actual	71.4%	77.8%	85.7%	53.8%	64.7%	76.9%	81.3%	58.3%	57.1%	68.2%	94.7%	
Skin	Actual	80.5%	87.9%	87.9%	83.5%	92.6%	87.0%	89.2%	75.4%	77.9%	82.3%	79.2%	
Upper GI	Actual	45.3%	41.4%	40.4%	36.7%	51.1%	39.8%	46.5%	39.2%	37.6%	40.4%	53.2%	
Urology	Actual	47.0%	38.4%	52.4%	46.9%	37.8%	44.6%	50.4%	50.0%	58.4%	66.7%	40.5%	
HPB	Actual	44.2%	23.1%	41.7%	58.1%	44.7%	52.4%	37.9%	41.4%	46.2%	41.0%		
OGD	Actual	47.6%	56.3%	54.5%	38.2%	44.4%	48.4%	59.1%	55.9%	54.2%	61.3%		

Cancer performance is below the standard required and that we would want to see although there has been a progressive improvement in performance against the 28-day time to diagnosis standard. This needs to be built upon with further improvement and specific focus on addressing time to tell a patient that they have cancer as this time interval tends to be significantly longer than the time needed to tell a patient that they do not have cancer.

The 31-day target data (not shown above) continues to be adversely affected by radiotherapy performance. This is being reviewed both internally and at tiering meetings, and has a specific workstream. Performance is improving and average time to treatment is falling but it will take several months to achieve the 'binary' target of treatment within 31 days.

Significant improvement has been seen in several patients on the urgent suspected cancer pathway and currently beyond day 62. The level is currently 96, down from 149 in February and just over 300 at its peak. This move towards more working in real time will facilitate improvements in average time to treatment and in turn improvement in the specific cancer target performance metrics.

The most consistently challenged tumour groups in terms of 62-day performance remain, lower GI, upper GI, lung and urology.

All tumour groups have updated their action plans over the last 2 months to detail how this performance can be improved; improvement team members are embedded in this work. Tiering meetings with NHS England (NHSE) are focussing on action plans by tumour group and the considerable efforts being put in by teams to both streamline service delivery and improve data recording has been noted and commended.

Pathway Changes

There have been several changes in the breast pathway at County Durham and Darlington NHS Foundation Trust (CDDFT) over the last 3 months. Currently a colleague from Newcastle Hospitals is providing support to the team in CDDFT and there have been several new breast surgical appointments there. Work from CDDFT is not seen to be impacting capacity at Newcastle Hospitals currently.

Lung surgery work from Durham, currently done at Newcastle Hospitals, will move under the auspices of the thoracic surgical team at South Tees Hospitals NHS Foundation Trust from August 2025. Whilst this will reduce the demand for surgical slots at Newcastle Hospitals this reduction will, in fact, be offset by the expansion of targeted lung health checks so the change in pathway will facilitate accommodating more patients picked up at screening but will not result in reduced demand. There is ongoing discussion about the best site to deliver non-surgical oncology services to the Durham population.

Visibility of Cancer Pathways

It is still not possible for clinicians to quickly establish whether a patient is on a cancer pathway as this data is not stored in an easily accessed place in eRecord. We will focus on looking at options to improve this visibility now that the remote hosting work has been completed.

ii) Cancer Governance

Harm Reviews

The process of reviewing the case of each patient who is not treated for cancer within 104 days of referral continues. We are making progress in dealing with the backlog of reviews and would plan to present a further update in approximately 4 months or by exception if the data is changing. Data was last submitted to the Trust Board in March 2025. A finalised policy covering harm review completion should be submitted to the next Clinical Policy Group (CPG) meeting.

Internal Peer Review

All tumour group teams are currently revising and developing Multidisciplinary Team (MDT) operational policies, annual reports and work plans for 2025/26. These are due for submission by the end of June and internal peer review visits to each team will continue. To date visits have been completed with skin, breast and head and neck teams. A common theme to emerge is formalisation and clarity of governance across organisations, where MDTs straddle multiple Trusts; this will be a focused piece of work with each MDT as part of their operational policy development.

National Cancer Experience Survey 2023 (published 2024)

This data has been shared with all teams and action plans requested as part of the annual tumour-specific MDT action plan. Newcastle Hospitals scored well sitting at 21/133 centres. Areas with lower scores which will be a focus for our teams were: patients being told they had cancer in a way that they could understand, provision of additional help at home and

access to information about clinical trials. The adoption of the data capture workstream with Flatiron will allow up to 100% of the patients, who have a wholly Newcastle Hospitals-delivered cancer pathway, to contribute to research and all patients will be given information about this work so this may improve patient's experience of involvement in research.

iii) Summary

Whilst progress on performance feels slow, there is ongoing improvement. The reduction in 62-days backlog to 96 will facilitate real time working and improvement in 62-day performance but the average time to treatment still needs to be reduced to allow that target to be met reliably.

3) QUALITY AND SAFETY

The InPhase launch for incident reporting has gone smoothly to this point with no drop off in incident reporting numbers to date.

Martha's Rule/ Call for Concern is becoming established in adult wards and maturing. It links in with the 'Right Time' patient experience project which will provide further opportunities when the pilot is evaluated. The release of national toolkit and branding was later than anticipated and there is now current work to incorporate into Newcastle Hospitals material and expand the communication offer to the top 5 languages.

The pilot will be launched at the Great North Children's Hospital (GNCH) and Freeman Hospital (FRH) Children's sites on 1 July 2025. GNCH phone holder remains a challenge in paediatrics and will be part of the evaluation of the pilot.

Patient Safety Incident Response Framework (PSIRF) priority projects are in the final phases prior to new ones being identified. Two current projects (failure to respond to abnormal results and failure of internal referrals) will continue as major digital projects and indeed it is clear that patient safety in our digital and administrative processes is where much of our focus will continue to be.

There will be increased focus on clinical effectiveness for the rest of the year with challenge to the Quality Oversight Groups (QOGs) through the Quality and Performance Reviews (QPRs) process and elsewhere regarding how clinical departments actively measure and respond to outcomes.

In response to internal monitoring and external scrutiny we are undertaking safety analysis and work regarding major complications associated with vascular access (principally femoral artery) for procedures within interventional radiology, neuroradiology and cardiology. This will sit within the PSIRF Oversight Group as an action in relation to specific cases and be reported via the Quality Committee.

Robotics: the business case for the second Da Vinci device at the RVI remains challenging considering our Cost Improvement Programme (CIP) demand and financial position. Work

continues on a solution to achieve this in a financially sustainable way but is considered a key element in immediate and longer-term delivery of best quality of care in certain surgical specialties.

Meanwhile, Newcastle Hospitals has been hosting the Shelford Group in a series of sessions to support other trusts to develop a robotics training programme across the country.

A new meeting structure to integrate Board Quality and Safety Leads (medical and non-medical) with the senior Clinical Governance and Risk Department (CGARD) team is proposed and will be initiated over summer.

4) MANAGING MEDICINES UPDATE

The reporting and governance structure for medicines management has been reviewed and updated to enable better oversight and assurance. In parallel, and at an operational level, work is ongoing work to ensure that patients receive the most cost-effective treatments available by making best use of biosimilar agents, when available. We continue to work with the Integrated Care Board (ICB) to overcome the challenges that come following the approval of new drugs by National Institute for Health and Care Excellence (NICE) to enable their introduction to the Newcastle Hospitals formulary.

5) JOB PLANNING UPDATE

The implementation of the new senior medical and dental staff job planning policy began in April 2025. The first tranche of proposed job plans under the new policy led to concerns about potential financial pressure because of increased overall job plan programmed activity (PA) allocation and possible reduction in time available for direct clinical care (DCC), as a result of increase in supporting professional activity (SPA) as a proportion of total job plan PAs.

It was agreed with Trust Board that a detailed review of all job plans should be undertaken when submitted by staff, before approval of any job plan changes and associated salary alterations. The initial discussion of job plans is undertaken by Clinical Directors and Directors of Operations. The further review of job plans has been carried out by the Associate Medical Director who is leading on job plan implementation and one of the Medical Directors.

There are currently 1,203 Consultant and Specialty and Associate Specialist (SAS) staff working for Newcastle Hospitals. Review of 540 job plans submitted so far has been undertaken. This review showed that there was sufficient information to confirm compliance with the new job planning policy in approximately 60% of job plans. The remaining 40% of job plans require further information or discussion and these have been returned for further discussion at Clinical Board level.

The review has identified some areas of excellent practice in job planning with implementation of all the elements of the new policy. Further work is required in other

areas to ensure that there is clear definition of proposed activity and personal objectives and consistency of funded roles across Clinical Boards.

The likely financial implications and effect on clinical capacity are significantly less than appeared to be the case from the initial assessment of the first tranche of job plans submitted, based on the larger review. Further analysis of this is underway.

Initial progress has been made to fully implement the changes in job plans approved following review with confirmation of appropriate salary changes. It is hoped that the job planning process for the current financial year will be completed by the end of June.

Further national job planning guidance is awaited and will be considered when available.

6) REMOTE HOST ORGANISATION (RHO) UPDATE

On 2 May 2025, the Trust, led by the Digital team, was able to successfully complete the transfer of the Electronic Patient Record (EPR) system to a remote hosted organisation. This process was a necessary first step to enable the upgrade of the EPR and allow the necessary changes required to optimise the system in line with the requirements of the clinical teams. The next stages of this work will be overseen by the Care Optimisation Group.

Report of
Dr Lucia Pareja-Cebrian / Dr Michael Wright
Joint Medical Directors

16 May 2025

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Agenda item A10(a)(i)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025					
Title	Guardian of Safe Working Quarterly Report (Q4 2024-25)					
Report of	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Prepared by	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	The terms and conditions of service of the new junior doctor contract (2016) require the Guardian of Safe Working Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant. The content of this report outlines the number and main causes of exception reports for the period 27 December 2024 to 26 March 2025 for consideration by the Trust t Board.					
Recommendation	The Trust Board is asked to note the contents of this report.					
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link to the BAF. In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training.					
Reports previously considered by	Quarterly report of the Guardian of Safe Working Hours.					

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

This quarterly report covers the period 27 December 2024 to 26 March 2025.

There are now 1,118 resident doctors on the TCS of the 2016 contract, and a total of 1,149 resident doctors in the Trust.

There were 130 exception reports in this period. This compares to 134 exception reports in the previous quarter.

The main area of exception reports is general medicine.

The main cause of exception reports is when the staffing levels available are insufficient for the workload.

2. INTRODUCTION / BACKGROUND

The Resident Doctor Contract came into effect on 3 August 2016 and was reviewed in August 2019. From August 2023 Locally Employed Doctors at Newcastle Hospitals are also employed on a contract which mirrors the 2016 contract.

The TCS of the 2016 contract allows for exception reporting to raise reports on breaches of working hours and educational opportunities. The Guardian of Safe Working Hours must provide a quarterly report to the Trust Board to give assurance to the Board that the doctors' hours are safe and compliant. There are currently negotiations between NHS Employers and the British Medical Association (BMA) to reform the contract, particularly exception reporting. Changes are expected to be implemented by September 2025. We are awaiting the revised TCS.

3. HIGH LEVEL DATA

		(Previous quarter data for comparison)
Number of Resident Doctors on New Contract	1,118	(1,102)
Total Number of Resident Doctors	1,149	(1,140)
Number of Exception reports	130	(134)
Number of Exception reports for Hours Breaches	127	(133)
Number of Exception reports for Educational Breaches	14	(3)
Fines	8	(8)
Admin Support for Role	Good	
Job Planned time for supervisors	Variable	

4. EXCEPTION REPORTS

4.1 Exception Report by Speciality (Top 4)

		(Previous quarter for comparison)
General Medicine	97	(80)
General Surgery	12	(25)
Ophthalmology	7	(9)
Haematology/Oncology	7	(3)

4.2 Exception Report by Rota/Grade

General medicine

Royal Victoria Infirmary (RVI) (F1)	27
Freeman Hospital (FH) (F1)	45
FH (Core Trainee (CT)/Internal Medicine Trainee (IMT)/ Locally Employed Doctor (LED))	25

General Surgery

FH (F1) including Hepato-Pancreato-Biliary (HPB), colorectal, vascular	12

Ophthalmology

Specialty Training Registrar (StR)	7

Haematology/Oncology

Senior House Officer (SHO)	7

4.3 Example Themes from Exception Reports

General Medicine RVI/FH

“Working on minimum staffing level. High workload resulting in late finish and inability to attend departmental teaching.”

Exception reports submitted when there was excessive workload for the workforce available – either due to clinical complexity of patients or reduced staffing levels. Teaching also missed when clinical pressures prevent doctors from leaving the ward.

General Surgery FH

"I had to stay behind 45 minutes to complete my day jobs. There were various tasks that I had to do that could not be handed over; namely documentation and updating the handover list. I was not able to have a lunch break today due to work pressures."

There has been a significant drop in numbers of exception reports. Most exception reports are for when doctors are staying <1 hour past their scheduled finish time.

Ophthalmology

The majority of exceptions related to non-resident on call hours worked.

Haematology/Oncology

"Multiple admissions during the on call shift; needed to stay late to finish documenting clerking."

5. EXCEPTION REPORT OUTCOMES

5.1 Work Schedule Reviews

1 work schedule review was completed on the back of exception reports, reviewing General Surgery handover times.

5.2 Fines

8 fines have been issued:

- General Medicine (1 fine): Rule breached "Late finish; Exceeded the maximum 13-hour shift length". Total fine money £43.54.
- General Surgery (1 fine): Rule breached "Late finish; Unable to achieve breaks; Exceeded the maximum 13-hour shift length". Total fine money £190.05.
- Orthopaedic Surgery (1 fine): Rule breached "Late finish; Exceeded the maximum 13-hour shift length". Total fine money £43.54.
- Ophthalmology (2 fines): Rule breached "Unable to achieve breaks; Unable to achieve minimum overnight continuous rest of five hours between 22:00 and 07:00 during a non-resident on-call (NROC); Unable to achieve the minimum 8 hours total rest per 24-hour NROC shift". Total fine money £302.28.
- Haematology/Oncology (2 fines): Rule breached "Late finish; Exceeded the maximum 13-hour shift length". Total fine money £298.13.
- Otolaryngology (1 fine): Rule breached "Late finish; Exceeded the maximum 13-hour shift length". Total fine money £80.11.

6. ISSUES ARISING

6.1 Workforce and workload

The recurring theme as to when exception reports are raised is when there is a reduction of doctor numbers on the ward or high workloads.

6.2 Supervisor Engagement

Supervisor engagement is generally good.

6.3 Administrative Support

Administrative support is currently good.

7. LOCUM SPEND

The purpose of reporting locum spend is as a source of information indicating where there is a workload/workforce imbalance.

Lead Employer Trust (LET) Locum Spend

January to March (Q4 2024-2025)	£687,977
October to December (Q3 2024-25)	£585,008

Comment from finance team:

"In terms of expenditure, we rely on the invoices from the LET and so there are differences between the actual incidence of spend and the Trust being invoiced for it. There was an increase of £103k between Q3 24/25 & Q4 24/25. Of this increase, £206k was Medicine & Emergency Care, offset by -£57k in Perioperative and Critical Care & -£26k in Cardiothoracic."

Trust Locum Spend

January to March (Q4 2024-25)	£774,552
October to December (Q3 2024-25)	£600,046

Comment from finance team:

"With regards to Clinical Boards the increase in spend can be seen particularly in Medicine & Emergency Care (£140k) & Cardiothoracic (£43k)."

8. RISKS AND MITIGATION

The main risk remains medical workforce coverage across a number of rotas. This is exacerbated by changes in working patterns and training requirements. The predicted changes to the contract are likely to greatly increase exception reporting numbers, although we are awaiting the final details of these changes.

9. RECOMMENDATIONS

I recommend that we continue to review the workforce workload balance to ensure safe and sustainable staffing.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours
15 May 2025

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Agenda item A10(b)(i)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025		
Title	Nurse Staffing Review Paper – Deep Dive		
Report of	Ian Joy, Executive Director of Nursing		
Prepared by	Lisa Guthrie, Deputy Director of Nursing Peter Towns, Associate Director of Nursing Lindsey Cooper, Senior Nurse: Nurse & Midwifery Staffing		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	This report, which was presented to the Quality Committee on 13 May 2025 comprises both the Nurse Staffing six-month review (2024/25 Quarters 3 and 4) and the quarterly safe staffing assurance report. The report fulfils the recommendations of the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) and adheres to the recommendations set out by the National Quality Board (NQB 2016): How to ensure the right people, with the right skills, are in the right place at the right time. It updates the Board of Directors in relation to the following: **Key points/risks to bring to the Board's attention.** • Robust staffing oversight remains in place through the Nurse Staffing and Clinical Outcomes Group. One ward (Great North Children's Hospital (GNCH) 3) has required high-level support due to staffing concerns. This is being mitigated by closed beds and a supportive action plan is overseen by the Head of Nursing. Recruitment has been successful, and it is anticipated that the beds will open in mid-June. The action plan is reviewed monthly, and a review will be undertaken in May. • Level two staffing escalation will remain in place until the de-escalation criteria has been met. All relevant mitigations and actions are in place and included in the report. • There has been a reduction in red flag incidents reported since March 2024. This is expected based on improved fill rates and a reduced vacancy and turnover position. • The vacancy and turnover rates have improved for registered nurses and healthcare support worker staff. This is evidenced through fill rates, reduction in red flags and Care Hours Per Patient Day (CHPPD) metrics. • Temporary staffing is closely monitored and there has been a reduction in agency spend. • In line with national guidance, the Nurse Staffing Review Process has been completed, and the details are contained within the report. Where potential recurrent funded staffing shortfalls exist, mitigating actions are in place. • Where areas may require additional resources as outlined in this report, options are being explored from existing establishments based on acuity and dependance data and professional judgment. Any areas where this cannot be achieved will be escalated to the Executive Director of Nursing.		

<table>
<tr><td></td><td colspan="6">

- Based on the information contained within this report, acknowledging the mitigating actions and the continued work required, the staffing establishments are broadly fit for purpose.
- A nursing safe staffing guidance document is provided along with the Safe Staffing Dashboard in the Trust Board Reading Room to complement the details contained within this report.

</td></tr>
<tr><td>Recommendation</td><td colspan="6">Trust Board is asked to:
i) Receive and review the quarterly staffing and outcomes review.
ii) Receive and review the deep dive staffing review report.
iii) Comment on the content of this approach, which has been prepared in line with national guidance.
iv) Acknowledge and comment on actions outlined within the document.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Putting patients at the heart of everything we do. Providing care of the highest standards focusing on safety and quality.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
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<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">BAF risk ID 1.1 - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">The Quality Committee and Board have previously received the annual nurse staffing review report, the six-month review report and quarterly safer staffing assurance reports.</td></tr>
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NURSE STAFFING REVIEW PAPER

1. INTRODUCTION/BACKGROUND

This report combines the nurse staffing six-month review report along with the quarterly safe staffing assurance report. The purpose of the report is to provide assurance that the Trust remains compliant with national guidance in relation to safer staffing. The Developing Workforce Safeguards (2018) guidance makes clear the requirement to undertake an in-depth nurse staffing review every six months and update be provided to the Trust Board on actions and progress.

2. NURSE STAFFING UPDATE

A guidance document providing an overview of nursing safe staffing metrics and the Ward and Department Monthly Safe Staffing Dashboard can both be found in the Board Reading Room to complement the details contained within this report.

2.1 Nurse Staffing Escalation

The Trust Nursing Safe Staffing Guidelines provide a robust framework to ensure safe nurse staffing governance and identifies a clear process for safe staffing escalation. The Trust staffing escalation is currently operating at level two due to the following thresholds being met:

- Sustained sickness absence greater than 6% for the registered nursing and midwifery workforce.
- Intermittent surge beds remain utilised, which creates intermittent increased staffing requirements.

The following actions remain in place and are overseen by the Executive Director of Nursing:

- Senior nursing team provide a twice daily staffing review which is reported into the Trust operational and tactical control teams.
- SafeCare (daily deployment tool) is utilised to deploy staff within and across Clinical Boards.
- Daily review of staffing red flags and incident (Datix) reports.
- Staff bank Healthcare Assistant (HCA) pool is reviewed daily, using Safecare to identify areas of shortfall and reduce agency requirement.

Weekend Matron cover continues, which enhances staffing and professional oversight out of hours. Level two escalation will remain in place until the de-escalation criteria has been met.

2.2 Nurse Staffing and Clinical Outcomes

The monitoring of safer staffing metrics against clinical outcomes/nurse sensitive indicators as mandated in national guidance continues via the Nurse Staffing and Clinical Outcomes Operational (NSCO) Group. Below is an overview for the last quarter:

Month	Total wards reviewed	Clinical Board	High level support	Medium level support	Low level support
Jan-25		Family Health Services	GNCH 3	GNCH 2a	GNCH 4, 9, 12. RV40
		Surgical and Specialist Services RVI			FH19, RV16, 20
		Perioperative Services			
		Cardiothoracic Services		FHPICU	FH23, 24
		Medicine and Emergency Care Services		RVAS, 30	FH13, 16, 18 RV42
		Surgical and Associated Services FH			FH8, RV44
		Cancer and Clinical Haematology Services		NCCC34	NCCC33
Total	**22**		**1**	**5**	**16**
Feb-25		Family Health Services	GNCH 3	GNCH 2a	GNCH 4, 9, 12. RV40
		Surgical and Specialist Services RVI			FH 19, RV16, 20, 22
		Perioperative Services			
		Cardiothoracic Services		FH PICU	FH23, 24
		Medicine and Emergency Care Services		RV30, RVAS	FH13, 16, 18. RV42
		Surgical and Associated Services FH			FH8, RV44
		Cancer and Clinical Haematology Services		NCCC 34	NCCC 35
Total	**23**		**1**	**5**	**17**
Mar-25		Family Health Services	GNCH 3	GNCH 2a	GNCH 4, 9, 12. RV40
		Surgical and Specialist Services RVI		RV22	FH 19, RV16, 20
		Perioperative Services			
		Cardiothoracic Services		FH PICU	FH23, 24
		Medicine and Emergency Care Services		RVAS	FH13
		Surgical and Associated Services FH			FH8, RV44
		Cancer and Clinical Haematology Services		NCCC 34	NCCC 35
Total	**19**		**1**	**5**	**13**

Key:
GNCH – Great North Childrens Hospital
NCCC – Northern Centre for Cancer Care
FH – Freeman Hospital
RV – Royal Vicotira Infirmary
AS – Assessment Suite
PICU – Paediatric Intensive Care Unit

The key points to note:

- One ward (GNCH 3) has required high-level support due to staffing concerns. This is being mitigated by closed beds and a supportive action plan overseen by the Head of Nursing is in place. Recruitment of five Registered Nurses (RNs) has been successful, and no vacancy remains. Three RNs commence in May and will have completed their supernumerary period by mid-June. This will allow the beds to be opened. The action plan is reviewed monthly, and a review will be undertaken in May.
- A review of the NSCO process is being undertaken, to triangulate with the ward accreditation and peer review processes.

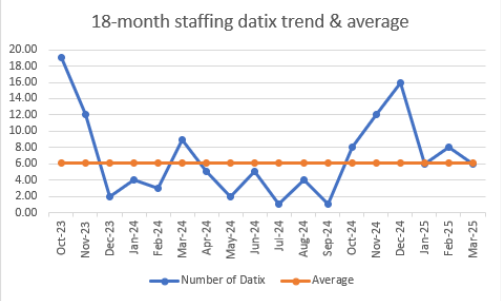
2.3 Datix and Red Flag data

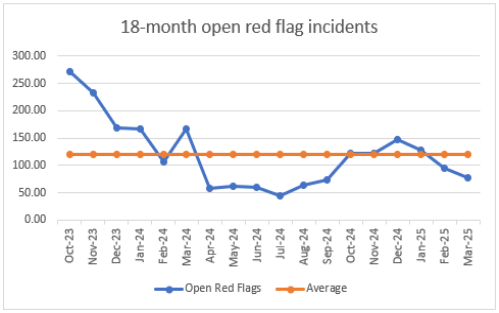
Red flag and incident data is reviewed daily (Monday-Friday) by the senior nursing team and included in the daily staffing briefing and presented to the NSCO Group monthly.

The key points to note:

- There is no statistically significant variation in incidents reporting this quarter.
- Staffing incidents are reported most frequently in Medicine and Emergency Care, who have the highest requirement for enhanced care observation and includes front of house services. Local oversight of safe staffing remains in place. No new trends for escalation have been noted.

- There has been a reduction in red flag incidents reported over the last year, with the number of reports remaining below the 18-month average. This is expected based on improved fill rates and a reduced vacancy and turnover position.
- The two most reported reg flag types are “shortfall in RN time” and “missed intentional rounding”. This continues to be closely monitored, with data and themes reported to the Professional Practice Assurance Group (PPAG) each month.





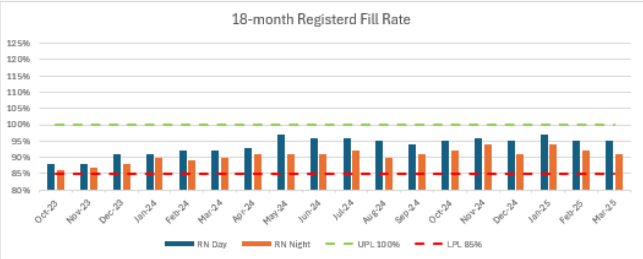
2.4 Care Hours Per Patient Day (CHPPD) data

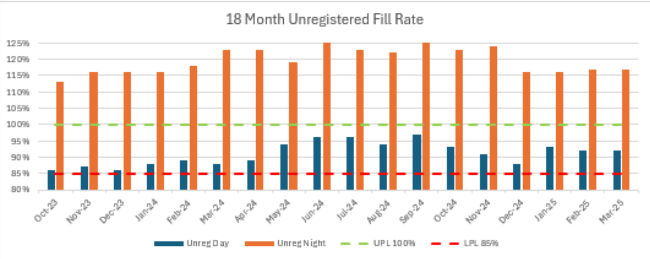
The staffing team monitor Ward-specific CHPPD on the Safer Staffing Dashboard and is reviewed at the NSCO Group every month. The Trust CHPPD remains above Trust 18-month average despite surge bed capacity and high sickness rates. This may be related to reduction in vacancy rates and initiating full electronic reporting. CHPPD for the last quarter has been maintained between 8.8-9.0, compared with the peer median CHPPD of 7.8 (Model Health). It should be noted that the number of critical care/highly specialised areas in the Trust impacts the overall position and inflates the Trust level figure. It is important therefore to look at local ward benchmarking and for non-specialist in-patient wards, they benchmark lower than the Model Hospitals Dashboard comparator in most services recognising direct comparative benchmarking is difficult. There are no new areas for escalation.

2.5 Planned versus actual hours (fill rates)

The planned and actual staffing hours are converted into percentage “fill rates” which are entered onto the safer staffing dashboard, rag rated and reviewed monthly by the NSCO group. RN fill rates <85% are reported to the Executive Director of Nursing every month. Key points to note:

- In the last quarter an average of four wards reported <85% RN fill rate for days and 12 on nights based on planned versus actual data. Rostering practice is being reviewed in relevant areas.
- Four critical care areas reported <85% RN fill rate. This is based on 100% occupancy and is therefore staffed to meet service need and mitigate risk. In the other areas, local staffing mitigations remained in place.
- In the last quarter, there was a reduction in the overfill of HCA nightshift, and an increase in the HCA dayshift fill rates, which may be associated with improved rostering practices.





2.6 Temporary Staffing

Newcastle Hospitals Staff Bank supply temporary staffing to wards and departments to fill short-term vacancies or absence. Additional oversight is provided by temporary staffing reports and agency usage reports which are distributed to the senior corporate nursing team and heads of nursing every week.

Key points to note:

- Temporary staffing spend has fluctuated month-to-month with a gradual increasing trend. Bank spend has an upward trend, influenced by pay increases and back-dated pay awards.
- Unregistered agency spend continues a downward trajectory. The significant spend increase in month 12 is related to adjustments to figures from previous months but recorded in month 12.
- The number of requested temporary staffing shifts for both registered and unregistered staff has continued to reduce on a downward trend over the past 18 months. The fill rates for both have remained stable. This is expected based on improvement in vacancy rates but is reassuring to note.

2.7 2024/2025 Nurse Staffing Review (NSR) Update

2.7.1 Progress of review

A comprehensive nurse staffing review of all in-patient areas took place throughout October and November 2024. The actions from these reviews are being finalised and collated for high-level discussion in Clinical Boards from April to July 2025. It was noted in the November 2024 Trust Board report that the variations in acuity and dependency, combined with service changes has resulted in a comprehensive undertaking in some areas which will be ongoing throughout this financial year.

An in-depth nurse staffing review of non-bed holding wards and departments will take place from April to September 2025, prioritising departments which are undergoing transformational change.

The corporate nursing team co-ordinate the NSRs to explore the results of the evidence-based staffing tools (Safer Nursing Care Tool – SNCT, Community Nursing Safer Staffing Tool – CNSST) with nurse-sensitive indicators and professional judgement to inform recommendations for staffing establishments, in line with national guidance. SNCT data is collected 6-monthly for most in-patient wards, except for critical care areas and wards

under 12 beds, where the tool is not recommended for use. An Emergency Department (ED) SNCT tool is used for Paediatric and Adult Majors ED. There are no evidence-based nurse establishment setting tools recommended for out-patients, day units and small wards, therefore a professional judgement framework alongside national guidance is utilised.

When calculating in-patient nursing establishments, a budgeted allowance is included to cover annual leave, sickness and parental leave. The adult in-patient and CYP SNCT assume 22% within their calculations. The Trust funds a 20% uplift (14% annual leave, 3% sickness and 3% study leave). The 20% uplift is applied using a margin calculation (whole-time equivalent (WTE) 1.0 x 1.2), rather than a markup calculation (WTE 1.0/0.8). This gives a headroom calculation on the total budgeted establishment of closer to 17%. This method of calculation is reflected in national staffing guidance. The allocation of maternity leave is not included in the Trust uplift calculation. To mitigate this risk, maternity leave posts offered substantively for Band 3 Healthcare Support Workers (HCSW) and Band 5 RN posts, to maximise the available workforce. This means that the SNCT calculation will always include a 2% differential. It should be noted that the 3% sickness absence allowance is consistently exceeded, and additional types of “other leave” such as bereavement leave is not accounted for within the uplift. The margin calculation, increased sickness absence and other leave, can create a gap between planned and actual staffing levels which may result in the use of temporary staffing, overtime or reduced staffing levels. This is recognised and the risk mitigated where possible.

2.7.2 Adult In-Patient Wards and Assessment Suite

In accordance with national guidance, a SNCT data capture was undertaken across eligible Adult and Assessment Suite in-patient areas in February 2025. Light-touch reviews are being held with ward leaders and Matrons to gain their professional judgement to inform the in-depth nurse staffing reviews taking place following the August data capture with Heads of Nursing, Director of Operations and Finance Managers (or their delegates) in September and October 2025.

A summary of findings to date is listed below:

• **Family Health Services:** the NSR process has demonstrated an inconsistency in the staffing and delivery of in-patient, day unit and emergency gynaecology services. Work is ongoing to review demand for all these services, alongside a review of processes and activity. The service is reliant on temporary staff to mitigate risks at current levels and further work is being undertaken on patient pathways to determine the future staffing model.

• **Surgical and Specialist Services:** NSR combined with information from the NSOG has indicated a staffing shortfall in trauma and orthopaedic wards at the RVI due to acuity and dependency profiles. A potential staffing model has been developed and costed, but it has been identified that further training and validation is required. Temporary staffing is being deployed to mitigate any current risk. Other sub-speciality establishments are broadly fit for purpose pending some further review in specific areas.

• **Perioperative and Critical Care Services:** NSR process recommends that establishment can meet basic requirements for bedside nursing with some skill mix adjustments and movement of resource across departments to ensure consistency and equity of staffing

levels between the critical care units. These are being costed and will be reviewed by the Executive Director of Nursing for approval. It is expected that this will be completed within the next quarter.

It has been acknowledged that there are some elements of the Guidelines for the Provision of Intensive Care Services (GPICS) standards which the units are not compliant with, such as clinical educator: nurse ratio. This will be evaluated in future nurse staffing reviews, alongside their GPICS peer review reports, when these become available.

• **Cardiothoracic Services:** Efficiencies have been identified predominantly within Cardiology which can support the staffing shortfalls in the respiratory ward and surgical wards who are currently using bank and agency to mitigate. The major transformational change enacted to improve quality, safety and patient flow in Wards 27 and 25 will fund each other but will require close monitoring over the next 12 months to ensure that the new establishments are fit for purpose. These establishment changes are expected to be enacted within the next quarter. Adult Cardiothoracic Critical Care establishment is compliant with GPICS standards; however, the bed capacity can be limited by providing Extra Corporeal Membrane Oxygenation (ECMO) treatment to patients which is under review.

• **Medicine and Emergency Care Services:** There have been some efficiencies identified in respiratory medicine. This will enable funding of HCA provision for Wards 19 and 48 who are currently reliant on temporary staffing for their core service which outstrips their establishment due to the acuity and dependency profile and high number of cubicles. It has identified that the medical wards are not established for their Enhanced Care Observation (ECO) requirement. Risk is currently mitigated through use of bank and agency HCA. An option of an ECO team is currently being explored, to enhance quality and safety and reduce temporary staffing and the Trust is part of cohort 2 for the national enhanced care improvement work. The review of Assessment Suite has demonstrated an establishment gap, and a 3-stage demand template has been costed, which was developed collaboratively with the ward leaders and Matron team. Temporary mitigations remain in place.

• **Surgical and Associated Services Freeman:** Professional judgement and benchmarking data recommends an additional night shift registered nurse in two areas. The cost can be partially mitigated by a reduction in unregistered staffing and is in the process of being reviewed. The surgical wards at the Freeman Hospital demonstrate a shortfall in staffing compared with SNCT outcomes. Options to resolve this are being explored. Ward 44 RVI has changed its nursing establishment to reflect a change in function to a medical ward. Further data capture is required to ensure that the establishment is fit for purpose. The remaining wards nursing establishments are broadly fit for purpose.

• **Cancer and Clinical Haematology Services:** NSR has demonstrated that nursing establishment is broadly fit for purpose. However, two wards have substantial temporary staffing costs, believed to be due to ECO. Work is being undertaken to review demand templates for efficiency and to understand the temporary staffing requirement.

2.7.3 Children and Young People (CYP) In-Patient Wards

The Trust uses SNCT (CYP) as the evidence-based establishment-staffing tool for CYP in-patient nursing establishments. SNCT data capture was undertaken across eligible CYP in-

patient areas in February 2025. Light-touch reviews are being held with ward leaders and Matrons to gain their professional judgement to take forward for the in-depth nurse staffing reviews, after the August data capture with Heads of Nursing, Director of Operations and Finance Managers (or their delegates) in September and October 2025.

Family Health Services:
• The children's haematopoietic stem cell transplant unit's establishment appears to be fit for purpose. The ward has had staffing shortages caused by vacancy which required oversight by the NSOG.
• It was recognised at the 2023/24 NSR that the trauma and orthopaedic ward establishment provided less leadership allocation than other wards. This has been costed and a skill mix change actioned following sign off from the Executive Director of Nursing.
• It was recognised that there is a shortfall in administrative time for the burns lead nurse in the Burns and Plastics ward, this is being reviewed.
• The Paediatric Intensive Care Unit (PICU) currently falls short of national standards in terms of uplift (which is partially mitigated by over-recruitment into maternity leave), play staff, critical care outreach services, and clinical educator posts. A staged approach to compliance is being worked through.
• The children's medicine and surgical wards demonstrate a shortfall for their full bed capacity compared with SNCT outcomes. This is due to their acuity profile and high level of neonatal patients. This is currently being mitigated by responsive bed management based on acuity and is under review.

Cardiothoracic Services:
• The PICU and Ward 23 require further benchmarking and discussion due to their highly specialised services. PICU has experienced high vacancy rates for several years, and their establishment is complicated by the provision of ECMO treatment to patients which is under review.

2.7.4 Adult and Paediatric Emergency Departments

The Trust uses SNCT (ED) as the evidence-based establishment-staffing tool for the ED nursing establishments. The recommended NSR for Adult ED separation of adult major and minor injuries department budgets and demand templates to better understand staffing requirements and improve oversight has been completed. An updated training package was delivered to adult and paediatric ED leaders in February and March 2025.

The adult ED SNCT suggests that their establishment is fit for purpose, but the department is reliant on high levels of temporary staffing due to ECO requirements and long-stay (>12 hour) patients. Further work is required to understand this additional staffing requirement. It was also acknowledged that the impact of the planned co-located urgent treatment centre is unknown but may reduce demand.

A staged demand template has been developed for the paediatric ED and assessment unit to improve staffing to respond to department attendance, which will align to national guidance. Both templates have been costed and will be reviewed by the Clinical Board.

2.7.5 Community (CNSST)

Version 2 of the CNSST was launched in January 2025. A 14-day data capture took place in March 2025, following a process of training and validation. The data is undergoing analysis, and a further data capture, planned for September 2025, will need to be undertaken and analysed before any recommendations can be made.

2.7.6 Non-bed holding areas

In-depth NSRs will take place from April – August 2025 for all outpatient, community, day unit and theatre areas to review nursing establishment using a professional judgement framework.

In the 2024/25 NSR of non-bed holding areas several areas with a funding deficit were identified. In Family Health Services demand templates and patient pathways are being reviewed, in the emergency gynaecology service and the children's haemodialysis unit. In Surgical and Specialist Services, there are overruns in emergency eye casualty department and in Clinical and Research Services it is noted that interventional radiology (IR) procedures are increasing nationally, in both areas an extended working day is recommended to meet service need, which will also positively impact patient experience.

Cardiothoracic Services have seen an increase in transcatheter aortic valve implantation (TAVI) work, which can be funded through nurse staffing efficiencies in other areas of Cardiothoracic Services. Medicine and Emergency Care Services has been impacted by increased activity the dialysis unit and a business case has secured additional investment.

Due to the number of theatres and complexity of some of the services offered, the creation of appropriate staffing models is likely to be a lengthy process in Perioperative and Critical Care Services. In Cancer and Haematological Services at Freeman and in Cumbria benchmarking is being undertaken to review the skill mix and leadership capacity.

Work has been undertaken with the corporate nurse staffing team and the respective Clinical Boards.

2.8 Nursing Skill Mix

Skill mix reviews form part of the triangulation of data as recommended by the Developing Workforce Safeguards (2018) guidance. Skill mix reviews are conducted annually or if a ward has altered their primary function.

Key points to note:

- All skill mix changes to demand templates are subject to a quality impact assessment and are costed. The updated demand template and costings are shared with the Head of Nursing, Matron and Senior Sister/Charge Nurse/Operating department practitioners (ODP) ahead of changes to the demand template or business case submissions.
- During the current nurse review process, skill mix changes have been explored in many areas to embed the nursing associate role where this is clinically appropriate.

2.9 Conclusions and Actions from the Nurse Staffing Review

From this deep dive staffing review, the following conclusions have been drawn:

- In line with national guidance, the SNCT data capture has been completed and the results triangulated with professional judgment. The staffing establishments in the majority of clinical areas remain broadly fit for purpose.
- There are a number of areas highlighted in this report which may necessitate additional resource. Temporary mitigations are in place whilst options are explored to identify funding from within Clinical Boards and if this cannot be achieved, an investment strategy will be sought. Based on risk, areas will be prioritised as required.
- Robust staffing oversight remains in place through the NSOG. One ward has required high level support and have been discussed in the Quality Committee.
- The vacancy and turnover rates have improved for registered nurses and healthcare support worker staff. This is evidenced through fill rates, reduction in red flags and CHPPD metrics. Whilst this is positive, the skill and experience of the workforce remains a concern and close monitoring is in place.
- There are opportunities to optimise roster management to maintain fair and transparent rotas. To support this check, challenge and coach meetings are in place.

The following actions are proposed:

- Finalise revised demand templates and costings for all areas requiring potential additional resource. Efficiencies within Clinical Boards will be progressed in the first instance and any gaps escalated. All changes will be reviewed and signed off by the Executive Director of Nursing.
- Conclude the staffing review in non-bed holding areas.
- Continue to provide scrutiny and oversight regarding the re-deployment of staff to respond to continued service pressures based on the level of staffing escalation.

5. RECRUITMENT AND RETENTION

Key points to note:

- The current RN turnover is 6.23%. This demonstrates a reduction from the previously reported 8.43% in the same period last year.
- The current RN vacancy rate is 1.86%. This remains stable, although is slightly above the figure of 0.58% reported in the same period last year. This relates to current substantive staff in post and does not include those staff currently in the recruitment process.
- As the vacancy rate is low, the Trust will provide the same supportive measures in the recruitment of the September registrants, which was positively evaluated last year. Should there be no vacancy in the students preferred place of work, those who are successful at interview are placed on a reserve list. The student then receives weekly contact from either a Matron or Practice Educator until they are matched to the next available vacancy based on interview score and preference.
- The current HCSW turnover rate currently 7.71% and demonstrates a reduction from 10% in the same period last year.
- The HCSW vacancy rate is currently 7.9%. This remains stable, although is above the figure of 6.5% reported in the same period last year.

6. RECOMMENDATIONS

The Trust Board is asked to:

i) Receive and review the quarterly staffing and outcomes review.
ii) Receive and review the deep dive staffing review report.
iii) Review and note the progress with the actions from the previous review.
iv) Comment on the content of this approach which has been prepared in line with national guidance.
v) Acknowledge and comment on actions outlined within the document.

Report of Ian Joy
Executive Director of Nursing
16 May 2025

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Agenda item A10(b)(ii)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025					
Title	Allied Health Professions (AHP) Workforce Report					
Report of	Ian Joy, Executive Director of Nursing					
Prepared by	Ewan Dick, Associate Director of AHP's & Therapy Services Gemma James, AHP Practice Education and Workforce Lead					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☒	☒			
Summary	A comprehensive Allied Health Professional (AHP) workforce report was presented and discussed at the Quality Committee on 15 April 2025. This is a highlight report providing an overview of key risks, developments and achievements. The following key points are noted for the Board's attention: • Work is underway to develop an AHP safe staffing framework in lieu of any nationally agreed or endorsed structure. An initial project plan has been developed, and this work will require organisational endorsement and support which will be overseen by the Executive Director of Nursing. • The report contains an overview of workforce metrics and data analysis. There are several risks and challenges presented within the report, but specific attention is paid to the impact of lack of establishment uplift on service provision due to the historic nature of how some of the establishments set. • Turnover rates are improving and below national average but remain high in occupational therapy, therapeutic radiography and orthoptics, which are indicative of regional and national challenges. The rates are also high in those within the first two years of employment due to a high number of fixed term contracts. Work is underway to explore ways to address this. • The substantive appointment of the AHP Workforce, Education and Practice Development posts is positive progress. This has enabled the continuation of work related to the developing AHP Workforce Strategy, whilst providing future sustainability. Several achievements are contained within the report.					
Recommendation	The Trust Board is asked to: i) Note the contents of the report and the risks and challenges outlined within it. ii) Endorse and support in the development of the AHP Safe Staffing Framework and its practical application to the workforce. iii) Comment on the structure and detail of the presentation of this report and the required content of future reports.					
Links to Strategic Objectives	Putting patients at the heart of everything we do. Providing care of the highest standards focussing on safety and quality.					
Impact	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability

(please mark as appropriate)	☒	☐	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	BAF risk ID 1.1 - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.					
Reports previously considered by	Bi-annual reports presented to Quality Committee for information and assurance purposes.					

ALLIED HEALTH PROFESSIONALS (AHP) WORKFORCE REPORT

1. INTRODUCTION

Across Newcastle Hospitals, we have 1,250 AHPs and 250 AHP Support Workers, across nine professions - *Dietetics, Diagnostic Radiography, Occupational Therapy, Operating Department Practitioners, Orthoptics, Physiotherapy, Podiatry, Speech and Language Therapy, and Therapeutic Radiography.*

2. BACKGROUND

AHPs do not have mandated or nationally reported safe staffing tools, and whilst there is both local and national work ongoing to develop agreed metrics, each profession will have unique staffing, clinical & professional standards and outcomes that form the basis of their staffing framework.

There is no uplift in the staffing establishment of AHPs. Most services are funded on a 43 week basis, with no holiday, sickness, awayness and study cover. This adds significant fragility (especially in smaller teams) and is reflected in staff survey feedback.

NHS England (NHSE) expects that AHP's have job plans (in an electronic and therefore reportable format) - which should include appropriate direct clinical care (DCC) / supporting professional activity (SPA) allocation. The majority of AHP professions have introduced paper job plans but some are challenging to achieve due to appropriate balance in practice, with clinical pressures taking priority over Continuing Professional Development (CPD), professional, clinical and service development time. There is not currently a system for e-job planning (e.g. through Allocate e-job planning module, or other systems) and as a Trust we are unable to routinely report on job planned capacity, and in relation to demand. Work is underway supported by HR colleagues to review and progress with exploring an electronic solution.

Throughout the workforce report there is reference to the Registered AHP workforce (RAHP) and the AHP Support Workforce (SW).

3. SAFE STAFFING FRAMEWORK

The development of an AHP Safe Staffing Framework will focus around 4 key areas:

- **Job planning** – development and implementation of an AHP Job Planning Framework to ensure consistency in approach, to include a core template / agreed definitions / standard SPA & DCC allocation percentages.
- **E-job planning** – Explore the potential for e-job planning using allocate software, and complete a cost vs benefit analysis. Scoping of the functionalities of e-job planning software, and the requirements of the Newcastle Hospitals AHP workforce.

- **Annual Staffing Review** – to develop processes for services to map job planned capacity and demand in relation to an AHP Annual Staffing Review Template. This will enable gap analysis and identification of risk.
- **Operational Guidance** - Develop and agree operational guidance on baseline staffing rostering, deployment and reporting to support the consistent use of the safe staffing framework.

4. RISKS AND CHALLENGES

- Across Newcastle Hospitals, the majority of AHP staffing establishment is historic, rather than based on an agreed baseline of demand, capacity and skill-mixed teams.
- There has been a collective RAHP whole-time equivalent (WTE) staffing growth of 1.3% (15.2wte) since February 2024. This is lower comparatively to the regional and national average of 3%
- Collective RAHP turnover rate (staff leaving the Trust) has remained static since February 2024, with an average of 8.5%. Total turnover rate for RAHP (inclusive of internal movement of staff) is currently 11.6%, which is the equivalent to 130wte.
- 40.8% of all RAHP leavers between February 2024 and February 2025, left within their first 2 years of employment, attributed to a high number of fixed-term contracts and low early-career retention, contributing to instability across the workforce.
- Turnover rates are above the Trust target of 10% in: Occupational Therapy (12%), Therapeutic Radiography (15.6%) and Orthoptics (19.35%), indicative of regional and national challenges. Sickness absence rates are high for both Occupational Therapy (8.08%), and Operating Department Practitioners (9.35%), with high levels of long-term sickness impacting on service delivery.
- Apprenticeship numbers remain proportionately low in comparison to individual workforce sizes, and considerably lower than the requirement of the regional training expansion plan.

5. KEY ACHIEVEMENTS

AHP Workforce, Education and Practice Development posts (2.0wte) were made substantive in December 2024 and enabled sustainable development of AHP Workforce Strategy.

Achievements include:

- Development of a strategic AHP workforce planning template and structure to look at workforce supply and demand over the next 5 years.
- Implementation of a Training Needs Framework - identifying training gaps and need, and to contribute to the wider organisational training plan.
- AHP Forum to connect AHPs across the organisation, including a programme of webinars related to workforce priorities, retention, practice development, career pathways, and preceptorship.
- Pre-preceptorship training for 3rd year AHP students – Newcastle Hospitals being the first Trust across the North East and North Cumbria (NENC) to implement this training.

  - Development of a Practice Development Plan and toolkit, supporting a culture of learning across the AHP workforce.
- 5 AHPs completed a Clinical Fellowship within the NENC Integrated Care Board (ICB), focusing on several system-wide workforce priorities.
- International Recruitment within Therapeutic Radiography in direct response to national workforce shortages, and cancer waiting times. Newcastle Hospitals were the only Trust across the UK to be successful in applying for funding with five international recruits to arrive in Newcastle at the beginning of April 2025.
- NENC ICB funding to support four AHP degree apprentices across Operating Department Practitioners (ODPs) and Podiatry.

6. RECOMMENDATIONS

The Trust Board are asked to:

- Consider the detail of this report in relation to the risks and challenges outlined above.
- Provide endorsement and support in the development of the AHP Safe Staffing Framework and its practical application to the workforce.
- Provide comment on structure and required content for future reporting.

Report of Ewan Dick
Associate Director of AHP's & Therapy Services
16 May 2025

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025		
Title	Perinatal Quality Surveillance Report, including Maternity Incentive Scheme update		
Report of	Ian Joy, Executive Director of Nursing		
Prepared by	Jenna Wall, Director of Midwifery		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. Key points/risks to note: • The Trust have triggered the second quarterly safety alert for the number of stillbirths on the North East North Cumbria Clinical Indicators Dashboard. In accordance with the Local Maternity and Neonatal System (LMNS) safety signal process this is now considered to be a safety alarm and instigates further review. The Trust has completed a local review of the number and type of cases and has no immediate concerns as several of the cases are associated with congenital abnormalities or the patients have received care in a neighbouring trust but opted to deliver their baby in Newcastle Hospitals. • The maternity service maintained Operational Pressures Escalation Level (OPEL) 1 for the whole of March 2025. There were no staffing Datix and no community escalations to support the acute service. Further work is ongoing to assess the staffing requirements for the intrapartum services as to whether additional midwifery staffing is required as the current midwifery establishment does not meet the acuity for >90% on Delivery Suite, there is some concern that the current Peri-Operatives model is impacting on the midwifery staffing meeting acuity. • The North East and North Cumbria (NENC) Integrated Care Board (ICB)/LMNS has not commissioned the Maternity and Neonatal Voices Partnership (MNVP) in accordance with the national guidance and is therefore not compliant with the requirements of Safety Action 7. • The 10 actions from the Care Quality Commission (CQC) specific core action plan have been completed and evidenced. The 10 actions from the CQC maternity report have been progressed and transitioned to business as usual processes. The Trust has made good progress with the Oversight Framework enhanced surveillance exit criteria and is meeting with the ICB/LMNS regarding exit and return to routine perinatal quality surveillance monitoring via the LMNS. • The Carbapenemase Producing Enterobacteriaceae (CPE) outbreak on the Neonatal Intensive Care Unit is being investigated as a patient safety incident investigation with the engagement of ICB and NHS England (NHSE) colleagues. There have been no further colonisations.		

<table>
<tr><td></td><td colspan="6"></td></tr>
<tr><td>Recommendation</td><td colspan="6">The Trust Board is asked to:

i. Receive and discuss the report.
ii. Note compliance with the Perinatal Quality Surveillance Model (PQSM) and the receipt of the minimum data measures.
iii. Note the escalation to the ICB/LMNS of non-compliance with Safety Action 7.
iv. Note the current risk and mitigations in place.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Putting patients at the heart of everything we do. Providing care of the highest standards focussing on safety and quality.</td></tr>
<tr><td rowspan="2">Impact

(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☒</td><td>☐</td><td>☐</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">Principal Risk - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.
Threat - Failure to improve the safety and quality of patient and staff experience in Maternity Services.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Previous reports have been presented to the Trust Board, Maternity Update, Midwifery staffing paper, Maternity Incentive Scheme (Clinical Negligence Scheme for Trusts (CNST)).</td></tr>
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PERINATAL QUALITY SURVEILLANCE REPORT

1. INTRODUCTION

This report provides the Trust Board with an overview of the Maternity Service compliance with the PQSM, based on the locally and nationally agreed measures to monitor maternity and neonatal safety. The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. The report outlines the Trusts current self-assessed position against the Year 7 Maternity Incentive Scheme 10 Safety Actions and any escalations.

2. MINIMUM DATA MEASURES

The development of the perinatal quality surveillance metrics reported in the Integrated Board Report has been completed and therefore the number of data measures incorporated in this report have been reduced.

2.1 Clinical Indicator Dashboard

The Trust have triggered the second quarterly safety alert for the number of stillbirths on the North East North Cumbria Clinical Indicators Dashboard. In accordance with the LMNS safety signal process this is now considered to be a safety alarm and instigates further review. The Trust has completed a local review of the number and type of cases and has no immediate concerns as several of the cases are associated with congenital abnormalities or the patients have received care in a neighbouring trust but opted to deliver their baby in Newcastle Hospitals. The Trust has agreed with the LMNS to conduct further analysis and review of the data, this is currently being undertaken by the North East Yorkshire NHSE analytics team. The data review will consider the booking trust (currently reported as delivery trust) and gestation at delivery. Congenital abnormalities will be excluded. Following the data review, a meeting will be held to agree whether Newcastle Hospitals has triggered a genuine safety alarm and the next steps required.

2.2 Midwifery staffing

Organisational requirements for safe midwifery staffing for maternity settings (National Institute for Health and Care Excellence (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. Midwifery staffing is reported separately to the Quality Committee and Trust Board biannually to meet the requirements for the maternity incentive scheme.

Maternity Assessment Unit

Midwifery initial triage within 15 minutes is 94% and Birmingham Symptom Specific Obstetric Triage System (BSOTS) ongoing midwifery care across all categories is above LMNS

targets. Turnover is 6.3% across the antenatal team, long term sickness 5.09% and short-term sickness 2.36%. Overall, the midwifery staffing establishment is adequate to maintain safe midwifery triage times.

Antenatal inpatient ward and Day Care Unit

The daily BirthRate Plus acuity tool assessment demonstrated that phase 1 midwifery staffing met acuity 92% in February 2025, with an improvement in the confidence factor in completion to 78%. There will be a focus on improving the BirthRate Plus daily acuity tool scoring compliance to increase the confidence factor further.

Fill Rate Midwife Day Shift	Fill Rate Midwife Night Shift	Fill Rate Support Staff Day
110%	110%	79%

There were no red flags recorded in March 2025, down from 3 in February 2025, relating to delayed or cancelled time critical activity and delay in pain relief.

Intrapartum care (Delivery Suite and Newcastle Birthing Centre)

The daily BirthRate Plus acuity tool assessment demonstrated that the phase 1 staffing met acuity 77% for Delivery Suite in March 2025 (up from 64% in February 2025) and 99% for Newcastle Birthing Centre (NBC) in March 2025. The confidence factor in completion is good. The turnover rate is 3.18%, long term sickness 2.19% and short-term sickness 1.87%.

Fill Rate Midwife Day Shift	Fill Rate Midwife Night Shift	Fill Rate Support Staff Day	Fill Rate Support Staff Night
87%	88%	82%	75%

There was one red flag in March 2025 for intrapartum care recorded, relating to delayed or cancelled time critical activity. There were no red flags for delays in induction of labour.

There were with no occasions when one to one care could not be provided, and no occasions during the shift when the coordinator was not supernumerary.

Further work is ongoing to assess the staffing requirements for the intrapartum services as to whether additional midwifery staffing is required as the current midwifery establishment does not meet the acuity for >90% on Delivery Suite, there is some concern that the current Peri-Operatives model is impacting on the midwifery staffing meeting acuity.

In January 2025 there were eighty-four occasions when a midwife was required to scrub for a theatre case, therefore the midwifery staffing available to provide intrapartum care was depleted. The current obstetric theatre staffing model provides a theatre team of two staff, one registered and one non-registered. A midwife attending the theatre is assigned to the baby and is considered the third person but does not hold theatre competencies. The out-of-hour anaesthetic and recovery staffing is one registered staff member lone working. If a theatre case presents whilst they are still recovering the previous patient, they must hand over the recovery to a midwife, prior to the usual recovery discharge criteria being met. A

full Equality Impact Assessment (EQIA) is being completed, and work is ongoing with the Peri-Operative leadership team regarding the future staffing model.

Postnatal and transitional care wards

The daily BirthRate Plus acuity tool assessment demonstrated that the phase 1 midwifery staffing met acuity 99% in March 2025. The turnover rate is 3.1%%, long term sickness 3.04% and short term sickness 2.46%.

Fill Rate Midwife Day Shift	Fill Rate Midwife Night Shift	Fill Rate Support Staff Day	Fill Rate Support Staff Night
104%	99%	98%	148%

There were no red flags on the postnatal ward.

Community midwifery teams

The homebirth service remains fully operational with 97% of on calls covered. The turnover rate is 6.9%, long term sickness 3.37% and short-term sickness 2.14%. Phase 1 midwifery staffing is adequate to maintain safe caseloads across the 4 community teams, although caseloads are currently allocated to two bank members of staff. Work is ongoing to realign caseloads and case mix at an individual midwife level to support equity of caseload, with a focus on safeguarding complexity.

The maternity service maintained OPEL 1 for the whole of March 2025. There were no staffing Datix and no community escalations to support the acute service.

2.3 Staff experience

The Culture and Staff Wellbeing action plan will be re-visited following the publication of the Staff Survey results, in addition the service will be piloting the Right Time staff experience programme from April 2025 to further inform the actions required to support staff experience and retention. There were no staffing Datix in March 2025.

3. MATERNITY INCENTIVE SCHEME

The Maternity Incentive Scheme (MIS) Year 7 was launched by NHS Resolution on 2 April 2025. The MIS year runs to the 30 November 2025. Ten safety actions are covered by the scheme and require provider trusts to provide evidence of compliance with each safety action. The final submission date to NHS Resolution is 3 March 2026.

The LMNS and Northern Neonatal Network on behalf of the NENC ICB are required to verify evidence for safety actions 3,4,5, 6, 7 and 9. The Perinatal Quality Surveillance Oversight Model quarterly meetings are utilised to share key safety and quality information and compliance with all the safety actions are monitored via this meeting. Papers to update the LMNS Board and the ICB Chief Nurse will be provided to summarise the positions and progress of Trusts following Perinatal Quality Surveillance Oversight Meetings (PQSOM).

Safety Action	Trust self-assessed position
Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?	On track
Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	On track
Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?	On track
Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?	On track
Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	On track
Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives (SBL) Care Bundle Version 3.2?	On track
Safety action 7: Listen to women, parents & families using maternity and neonatal services & co-produce services with users.	At risk
Safety action 8: Can you evidence the following three elements of local training plans and 'in-house', one day multi professional training?	On track
Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	On track
Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025	On track

The required standard for Safety Action 7 is that Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including the supporting infrastructure. The evidence required to demonstrate compliance with this standard being in place includes the following.

- Job descriptions for MNVP team
- Contracts for service or grant agreements
- Budget with allocated funds for Information Technology (IT), communications, engagement, training and administrative support
- Local service user volunteer expenses policy including out of pocket expenses and childcare costs

The NENC ICB/LMNS has not commissioned the MNVP in accordance with the national guidance and is therefore not compliant with the requirements of Safety Action7.

If the above evidence of an MNVP, commissioned and functioning as per national guidance, is unobtainable, there should be evidence that this has been escalated via the PQSM at Trust, ICB and regional level to ensure the Trust is compliant with the requirements of Safety Action 7. The Trust has escalated its concern to the LMNS and this will be discussed in the PQSOM in May 2025.

4. CQC ACTION PLAN

The 10 actions from the CQC specific core action plan have been completed and evidenced. The 10 actions from the CQC maternity report have been progressed and transitioned to business-as-usual processes. The Trust has made good progress with the Oversight Framework enhanced surveillance exit criteria and is meeting with the ICB/LMNS regarding exit and return to routine perinatal quality surveillance monitoring via the LMNS on 9 May 2025.

5. ESCALATION

Neonatal Intensive Care Unit Infection Outbreaks

An outbreak of CPE was identified in late February 2025 and in response all infants on the Neonatal Intensive Care Unit (NICU) were screened. A total of four infants were identified as being colonised, two of the colonised babies were very vulnerable and subsequently developed bacteraemia. The Patient Safety Incident Investigation (PSII) with ICB and NHSE involvement has commenced.

Extensive infection prevention and control (IPC) measures were put in place and there has been no further colonisations since the first week of March 2025. The IPC team are providing guidance regarding the cessation of some of the measures which were initially introduced. Mothers have been able to resume skin to skin contact and the communal areas have re-opened. Access to Crawford House has been reinstated following the introduction of a screening tool prior to admission.

The Estates team have completed remedial work in all bays. The Director of Infection Prevention and Control (DIPC) has recommended that a cot remains closed in each Intensive Treatment Unit (ITU) bay due to the proximity to the sink in the bay, this would result in 3 medium term cot closures until the planned estates work and decant occurs. The next meeting to consider the decant is in early May 2025.

6. CONCLUSION

The Trust Board members are provided with an update on the Maternity Service compliance with the Perinatal Quality Surveillance Model and the main quality and safety considerations of the perinatal service.

The Trust has embedded the six requirements to strengthen and optimise Trust Board oversight of perinatal safety, this has been supported by the further development of the Integrated Board Report metrics and the visibility of the performance metrics, as included in this report, and the risk associated with the infection outbreaks on NICU.

There are robust improvement plans for the areas of risk for the service, performance is being tracked and progress monitored to ensure the mitigations in place are supporting patient safety.

7. RECOMMENDATIONS

The Trust Board is asked to:

i. Receive and discuss the report.
ii. Note compliance with the PQSM and the receipt of the minimum data measures.
iii. Note the escalation to the ICB/LMNS of non-compliance with Safety Action 7.
iv. Note the current risk and mitigations in place.

Report of Ian Joy
Executive Director of Nursing
7 May 2025

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Agenda Item A10(c)(ii)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025					
Title	Maternity Safety Champion Report					
Report of	Liz Bromley, Non-Executive Director (NED) and Trust Maternity Safety Champion					
Prepared by	Liz Bromley, NED and Trust Maternity Safety Champion					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☒			
Summary	This report summarises feedback from the Maternity Safety Champion since the last report shared at the March 2025 Trust Board meeting.					
Recommendation	The Trust Board is asked to receive the report and consider/discuss the content.					
Links to Strategic Objectives	Performance: Being outstanding now and in the future.					
Impact (Please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐
Link to Board Assurance Framework (BAF)	No direct link. Risks are detailed within the main body of the report.					
Reports previously considered by	Last report presented at the Public Board meeting on 28 March 2025.					

MATERNITY SAFETY CHAMPION REPORT FOR MAY 2025

I'm delighted to report that all the matrons are now back in the maternity department and working to full strength, meaning that the senior management team is now able to work to their strategic roles rather than having to manage the day-to-day operations of the department.

The atmosphere in the maternity department is busy, lively and positive. People are in a very different space to where they were culturally and 'professionally emotionally' a year ago. Despite the ongoing challenges of the estate and the reputational issues around the UK's maternity services, the Newcastle Hospitals team is robust and self-aware.

There are now 28 midwives who are expecting babies of their own (the equivalent of 20.1 Full Time Equivalent (FTE)). The department is planning to maintain 'Phase One' staffing levels throughout the period likely to be disrupted by maternity leave. The Maternity Unit therefore will be slow to get to staffing levels 2 and 3 but it is right that leaders are building their plans around what is actually happening with the staff in the department.

The Maternity Operations Oversight Group is working well, and confident that the service is meeting demand. The Birthing Centre is now open and fully operational, having seen 172 successful deliveries and a very high level of patient satisfaction.

Managers are confident that the Care Quality Commission (CQC) maternity survey action plan is being delivered. Full tracking of patient experience and progress against the action plan suggests that the department is doing the right thing right now, which is reassuring. The staff survey is being trialled with a start date of the 9 May 2025. There is an upward trajectory in terms of uptake. Transitional Ward 34 is now one year old (where has that time gone?). The ward has matured and settled and colleagues from postnatal are now much more relaxed about the new ways of working, with teams seeming happy to work together. A 'neonatal civility exercise' is under way across the department, also contributing to cultural expectations and this will be used as a platform from which to launch of the Royal College of Obstetrics and Gynaecology's new Toolkit.

I am delighted to report that there have been walk rounds with members of the estates team and plans to start urgent building work in the department soon. This feels good as there is now a timeline for work to start in September 2025 with the first phase being the decant of neonates to postnatal. This will strengthen the team working mentioned above.

In further good news on the 26 April 2025 there was a maternity Open Day which was well attended and generated lots of interest. The team is confident that they will be able to recruit more staff as a result of this Open Day and that new recruits will be joining a happy team which is moving in the right direction to deliver not just a happy service but a service that is of a high-quality standard premised on excellent patient care.

Report of
Liz Bromley, Non-Executive Director
15 May 2025

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Agenda item A10(d)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025					
Title	Quality Account 2024/2025					
Report of	Mrs Rachel Carter, Director of Quality & Safety					
Prepared by	Anne Marie Troy-Smith, Quality Development Manager					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☒		☒		☒	
Summary	Each year the Trust is required to produce and publish a Quality Account. Contained within this is a review of the previous 12-month performance against the agreed Quality Priorities, as well as a narrative detailing the identified priorities for the coming year. The Trust Board is asked to review and approve the Quality Account for publication. Continuing the revised arrangements put in place three years ago, NHS foundation trusts are no longer required to include a quality report in their annual report.					
Recommendation	The Trust Board is asked to: • Review and approve the Quality Account for publication, noting priority detail to date with a change in focus for 2025/2026. • Note a decrease in compliance with some Key National Priorities with plans for improvement identified.					
Links to Strategic Objectives	All.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☐	☒	☒	☐
Link to Board Assurance Framework [BAF]	Not applicable.					
Reports previously considered by	Annual report to the Trust Board. Progress reported throughout the year at Quality Committee.					

QUALITY ACCOUNT 2024/2025

Review of Quality Performance 2024/2025

Patient Safety:

Priority 1 – **To improve patient safety by ensuring staff feel free to report safety concerns; incidents and near-misses, resulting in an overall increase in incident reporting rates**.

We have seen a 4.8% increase reported Patient Safety Incidents and a 7.8% increase of all Trust incidents reported. There has been an improving position in the NHS Staff Survey (2024) (published March 2025) with significantly higher scores in all People Promise elements, compared to 2023, with more staff able to raise concerns about unsafe practice (70%) and more staff confident that their concerns would be addressed (55.8%), compared to 2023. An uptake of patient safety syllabus training has steadily increased, with compliance 88% for level 1, 77% for level 2, and 82 Lead Investigators trained for level 3. Attendance at Patient Safety Briefings remains challenging. Improvement work will continue as a priority into 2025/2026, with greater focus on a variety of modes for sharing learning.

Priority 2 – **Achieve a reduction in the incidence of surgical 'never events' with a specific focus on Ophthalmology, sharing the learning to inform and improve practice across other surgical specialities.**

Regular audits were undertaken throughout the Department. Surgical Safety Checklists received 100% compliance at the Cataract Centre. Datix and governance systems have been used to monitor the occurrence of events. There has been one never event reported within the Quality Account reporting period (April 2024 – March 2025). This was reported in April 2024 regarding a patient who received an intraocular lens implant into the incorrect eye which occurred at the end of 2023. A bimonthly audit of compliance by the peri-operative directorate is ongoing showing compliance with the cataract pathway checklists.

Clinical Effectiveness:

Priority 3 – **To ensure reasonable adjustments are made for patients with suspected or known Learning Disability &/or Autism. Appropriate and consistent use of Mental Capacity Assessment & Deprivation of Liberty Safeguards for patients with vulnerabilities.**

Training compliance in line with the Trust standard (Diamond Standard Mandatory Training) is at 95% and this includes the Maternity Diamond Standard training. Safeguarding Adults training compliance is closely monitored at the Safeguarding Committee. Currently Level 1 training demonstrates good compliance with 96% and Level 2 96%. Safeguarding Adult Level 3 compliance is 85% and below the Trust 90% standard. Safeguarding Children Level 1 compliance rates are 96% and Level 2 95%. Level 3 Children's safeguarding sits at 86% which is below the required target. The Safeguarding Adults/Children Training Development Manager is progressing work to improve statutory mandatory compliance rates across the Trust. Level 1 Mental Capacity Act mandatory training for all clinical and patient facing staff is in place. Compliance currently sits at 96%. The Level 2 Mental Capacity Act and Deprivation of Liberty e-learning package has now been created and was launched on 9

December 2024. The aim is to achieve 90% compliance by the end of June 2025. Current compliance rate sits at 48% which is on target based on planned percentage uptake per month.

Quarterly audit of the patient record in regard to the quality of Deprivation of Liberty Safeguards referrals was undertaken. Patient feedback was sought via focus groups led by Skills for People. Production of the complaints easy read leaflet, continue to progress work with development of further easy read documents.

Patient Experience:

Priority 4 - To ensure the Trust has a systematic way of improving from patient and staff feedback in all its forms.

Success was evidenced by excellent engagement with patients, families, and communities – we now have the largest patient experience programme in the NHS. We reached an average of:

- 1,000 responses from inpatient services a month
- 1,000 responses a month from patients using the Emergency Department.
- 6,400 responses a month from outpatients
- 1,600 responses a month from day case services
- 100 responses a month across antenatal, labour/birthing and postnatal services

Quarterly staff surveys and evidenced based improvement programme.

Priority 4a - With new midwifery leadership, agree a staffing model for the birthing unit and associated staff development plan, to honour our commitment to consistent opening of the birthing centre.

Services remain open twenty four hours a day, seven days a week, with all women having choice in the place of their birth. There is continuous monthly review of the safe staffing dashboard alongside patient experience, clinical outcomes and staff experience. We have seen a reduction in midwifery vacancy rate to less than 10 whole time equivalents and a reduction in midwifery turnover rate to 6.4% on the Delivery Suite and 4.3% on the postnatal ward. 100% one to one labour in labour for all women achieved. Improvement in patient experience feedback from 'right time' surveys.

Quality Priorities for Improvement 2025/2026:

Patient Safety:

Priority 1 – Supporting staff to report incidents and with an enhanced focus on shared learning and systems-based improvements.

Building on last year's improvements we are focusing on improving our incident reporting management system, developing a shared learning toolkit and implementing an updated approach to Patient Safety Briefings to include community based learning. This will be supported by education and training packages that will encourage reporting, effective investigation and psychological safety.

Priority 2 – Safer and more effective medicines use.

We are concentrating on ensuring patient's medication lists are updated and accurate when they come into hospital, that medicines are stored safely, reducing waste from medicines returned to Pharmacy and we will increase the number of staff who have medicines management training in line with national standards.

Clinical Effectiveness:

Priority 3 – **Ensuring mental capacity, best interests decision making and deprivation of liberty safeguards are considered appropriately for patients with a Learning Disability.**

We will ensure the completion of quarterly audits of mental capacity assessments, best interest decisions and application of deprivation of liberty safeguards for patients with a learning disability. We will aim to increase the number of staff who have had training in the Mental Capacity Act.

Priority 4 – Expanding the Accrediting Excellence programme for wards and departments.

We are focusing on supporting staff by recognising the outstanding care that they deliver every day though a local accreditation process which focusses on assessing core standards of care and is designed to celebrate excellence. Thirty wards and departments will start the accreditation process over the next 12 months.

Patient Experience:

Priority 5 - **Waiting safely- Improving safety for patients who are waiting for treatment.**

We will focus on patients who are waiting for a Total Knee Replacement operation, with the aim of optimising health pre, peri, and post-procedure.

Priority 6- **Roll out of the Patient Experience real time surveys.**

Following a successful pilot on 14 wards, we want to expand our current programme and capture patient experience feedback from patients whilst they are still with us in hospital. This will be rolled out to 40 wards over the next 12 months.

Mrs Rachel Carter, Director of Quality & Safety
Anne Marie Troy-Smith, Quality Development Manager
16 May 2025

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

QUALITY ACCOUNT 2024/2025

The Newcastle upon Tyne Hospitals NHS Foundation Trust

CONTENTS

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

PART 1

The Newcastle upon Tyne Hospitals NHS Foundation Trust

CHIEF EXECUTIVE'S STATEMENT

Thank you for taking the time to read our Quality Account which gives us an opportunity to reflect on the last year and to openly share our performance and outcomes with you.

It's a pleasure to present this report in my role as acting Chief Executive, having taken over from Sir Jim Mackey as he moved to be the transition Chief Executive at NHS England. My focus in this role is on continuity, ensuring that we make progress with the clear plans and the improvements that Jim led during his time as Chief Executive Officer.

Our commitment to providing high-quality care remains the central focus, and over this year, we have worked hard to continue with our improvement journey, in particular strengthening our clinical and quality governance approach which enables us to implement learning so that we can improve care for patients; and developing our People Plan to support our staff.

Due to the efforts of all our colleagues, we are able to report significant progress in key areas of service delivery, patient safety, performance and overall patient experience which are set out in this account. This progress was recognised by the Care Quality Commission and this enabled the conditions on our licence, which had been imposed in December 2023, to be lifted in August 2024.

We have worked hard to become more transparent and open in our decision making so that we are able to be held accountable for our actions and the choices we make.

In this account, we highlight our achievements, challenges, and the patient safety priorities that will shape our plans moving forward. We are focused on embedding quality improvements across all services and engaging with our staff, patients, and stakeholders to better understand their needs and aspirations.

I would like to thank all our staff and volunteers for their incredibly hard work, dedication and compassionate care throughout the year.

Rob Harrison
Acting Chief Executive
April 2025

The Newcastle upon Tyne Hospitals NHS Foundation Trust

WHAT IS A QUALITY ACCOUNT?

Quality accounts are annual reports to the public from providers of NHS healthcare that detail information about the quality of services they deliver.

They are designed to assure patients, service users, carers, the public and commissioners (purchasers of healthcare), that healthcare providers are regularly scrutinising each one of the services they provide to local communities and are concentrating on those areas that require the most improvement or attention.

Quality accounts are both retrospective and forward-looking. They look back on the previous year's information regarding quality of service, explaining where an organisation is doing well and where improvement is needed. They also look forward, explaining the areas that have been identified as priorities for improvement over the coming financial year.

The account includes additional information required by NHS England for quality reports, due to Newcastle Hospitals being a Foundation Trust.

PART 2

Our Quality Priorities for Improvement 2025/2026

Following discussion with the Board of Directors, the Council of Governors, patient representatives, staff and public, the following priorities for 2025/2026 have been agreed. A public consultation event was held in January 2025.

This section of the Quality Account is forward looking and sets out the improvement priorities identified by the Trust for 2025/2026. The rationale for these priorities is based on a range of factors including actual data from the previous year, feedback from stakeholders or as identified through discussion with clinical teams and governors.

Our priorities were also informed by the intelligence and data the Trust has from its safety and quality outcomes (including learning from patient safety events, reviews, reviewing mortality and harm, complaints, clinical audit, outcomes from quality panel reviews, patient and staff experience surveys, and best practice guidance such as from National Institute for Health and Care Excellence and national audit).

In developing our programme for 2025/2026 we have been mindful of a golden thread through all of our proposed initiatives that focus on delivery of the highest levels of patient experience and clinical outcomes. Criteria for the selection of objectives included:

- Priority identified as important relative to other possible areas for improvement
- Achievable yet stretching targets within the timeframes envisaged
- Measurable, with sufficiently sensitive metrics to be able to track changes across the course of the year
- Largely within the control of the Trust to influence.

The quality priorities we have agreed are:

Priority 1 – Supporting staff to report incidents with an enhanced focus on shared learning and a systems-based approach to improvement. (A systems-based approach focuses on the analysis of the collective effects of a wide range of factors such as environment, tasks, tools and technology and interactions between people to help develop stronger improvement ideas and a culture of continuous learning).

Priority 2 – Safer and more effective medicines use.

Priority 3 – Ensuring mental capacity, best interests decision making and deprivation of liberty safeguards are considered appropriately for inpatients with a learning disability.

Priority 4 – Expanding the Accrediting Excellence programme for wards and departments.

Priority 5 – Waiting safely - Improving safety for patients who are waiting for treatment. (We will focus on patients who are waiting for a total knee replacement operation, with the aim of optimising health before and after the procedure).

Priority 6 – Roll out of our patient experience real time surveys.

PATIENT SAFETY

Priority 1 – Supporting staff to report incidents with an enhanced focus on shared learning and a systems-based approach to improvement. (A systems-based approach focuses on the analysis of the collective effects of a wide range of factors such as environment, tasks, tools and technology and interactions between people to help develop stronger improvement ideas and a culture of continuous learning).

Why have we chosen this?

Staff need to have confidence in our incident reporting and learning mechanisms so that they know how to report events, and how these events will be escalated and acted on. We want to develop a 'Just Culture' where incidents are investigated effectively and supported by compassionate leadership which is underpinned by fairness, openness and learning, whilst encouraging staff to speak up without fear of blame.

This priority aligns to the NHS National Patient Safety Strategy and our implementation of the Patient Safety Incident Response Framework. Using intelligence gathered from staff and external reports, we have worked throughout 2024/2025 to simplify the incident reporting system and make it easier for staff to report when things go wrong and to identify any potential for learning.

This also builds on last year's priority to improve patient safety by ensuring staff feel safe to report events, incidents and near misses which has resulted in an overall increase in incident reporting and a greater focus on learning and improvements.

By ensuring that learning and feedback is captured and disseminated, we will strengthen the reporting culture across the organisation and improve safety overall.

What we aim to achieve?

- More safety incidents will be reported
- Learning from safety events and incidents will be widely shared and understood across the organisation and actions will be put in place which deliver safety improvements. This will lead to a reduction in harm caused to patients.
- Staff will report feeling able and psychologically safe to report and escalate concerns in a timely way.

How will we achieve this?

- We will make reporting an incident as easy as possible through a new IT system.
- We will strengthen the 'Patient Safety Walkabout' programme to further engage with front line staff, to encourage and support openness with staff when speaking about their concerns.
- We will use real time information on incidents to support Clinical Boards to monitor and action improvements made as a result of learning.
- We will agree a new communications approach which will include standard ways to share information with staff in partnership with clinical board quality oversight leaders.

- We will review and refresh investigator training to ensure relevant staff are trained in systems-based investigations and improvement.

How will we measure success?

- We will see an increase in incident reporting rates by at least 3% overall.
- A continued improvement will be seen in relevant questions from 2025 NHS Staff Survey compared to 2024.
- Improved outcomes from General Medical Council trainee survey report.
- 90% of relevant clinical staff will have been trained in patient safety.
- Trust investigator training will be completed for relevant staff and evaluated.
- We will develop and implement our communications plan.
- In the longer term, we will evaluate the patterns of harm to patients to assess the effectiveness of the improvements we make.

Priority 2 – Safer and more effective medicines use.

Why have we chosen this?

Medicines are the most widely used intervention in healthcare and unfortunately medication errors and adverse drug reactions are common. This leads to poor patient outcomes, and significant consequences for patients, staff and organisations.

In 2024 there were 2,364 medication incidents across Newcastle Hospitals, the fourth most common incident reported. Medication safety is therefore a key priority. We want to focus on making sure that we make improvements when patients are admitted to hospital, the safe storage of medication in clinical areas, and also the quality of information about discharge medicines sent to General Practitioners.

What we aim to achieve?

We aim to improve medicines reconciliation rates (formal checks by the pharmacy team to make sure we have the correct records about a patients medicines when they are admitted to hospital), reduce omitted (missed) doses of medicines for patients in hospital, reduce medicine related waste, improve the safe and secure handling and storage of medicines and improve the accuracy of information to GP's on discharge.

How will we achieve this?

- We will develop and implement a pharmacy workforce plan to ensure we have the right staff in place.
- Undertake consistent medicines reconciliation processes which are audited.
- Introduce audits on the omitted doses of all medicines.
- Improve the information available to clinicians about medication issues, including the outcome of clinical audits.

- Develop a long term plan for electronic drug storage with biometric access so drugs and stored safe and secure (Omnicell) and automated temperature monitoring.
- Refresh and improve training for clinical staff.
- Review and improve discharge processes to improve the quality of discharge medicines information sent to General Practitioners.
- Implement a robust medicines assurance framework around the safety and security of medicines which is part of regular multi-disciplinary review with a clear escalation pathway for areas of non-compliance.

How will we measure success?

- We will see increased rates of medicines reconciliation within 24 hours of admission to hospital.
- Over 90% compliance per ward/clinical area on the medicines assurance framework.
- Our clinical audit plan and subsequent action plans will be in place.
- We will measure, set targets and reduce omitted doses of medicines.
- We will see increased reporting of medication incidents by March 2026.
- 80% of nursing staff will have received medicines management training by March 2026.
- Information being sent to GP's on discharge from hospital will be accurate and audited.
- A medicines safety dashboard will be available and will highlight performance and any areas of concern.

CLINICAL EFFECTIVENESS

Priority 3 – Ensuring mental capacity, best interests decision making and deprivation of liberty safeguards are considered appropriately for inpatients with a learning disability.

Why have we chosen this?

This priority builds on our previous work which aimed to increase compliance with the requirements for mental capacity assessments, best interests' decisions and Deprivation of Liberty Safeguards applications for this patient group.

This priority has a specific focus on patients with a learning disability because we want to continue to improve the standards of care we provide, by ensuring there is appropriate application of the Mental Capacity Act and Deprivation of Liberty Safeguards for inpatients with a known learning disability.

The Mental Capacity Act 2005 provides a statutory framework to empower and protect any person over the age of 16 in England and Wales who may not be able to make their own decisions. It sets out roles and responsibilities of staff and family (and other) carers.

The Deprivation of Liberty Safeguards legislation was introduced in 2009, as an addendum to the Mental Capacity Act, 2005, providing a legal framework and legal protection for those aged 18 and older, who are, or may become, deprived of their liberty.

What we aim to achieve?

We will continue to monitor, and aim to improve compliance with, the Mental Capacity Act 2005 and the Equality Act 2010 for all inpatients with a known Learning Disability. We will also increase clinical staff understanding of when and how to complete mental capacity assessments and applications for a Deprivation of Liberty Safeguards authorisation.

We want to improve the way we work with and listen to families and carers because they are often the people who know our patients best. For those patients who lack capacity to consent for the purposes of care and treatment we will improve documented evidence of best interest decision making and how families have been involved.

How will we achieve this?

- We will ensure staff have the appropriate training.
- We will increase our audits of medical records of inpatients with learning disabilities to ensure improvements. This audit will include:
  - Quality of Mental Capacity Assessment,
  - Quality of Deprivation of Liberty Safeguards applications actioned
  - A review of standards in relation to best interests' decisions.
- Each clinical board will develop a local quality and safety priority to focus service specific improvements.
- Information and learning opportunities will be shared widely to raise awareness.

How will we measure success?

- Training compliance will be in line with Trust standard of 90% there will also be a clear delivery plan for implementing mandated training for learning disabilities and autism following the national consultation.
- We will agree a clinical audit programme to ensure actions are demonstrating improvements with clear improvement trajectories.

Priority 4 – Expanding the Accrediting Excellence programme for wards and departments.

Why have we chosen this?

High quality clinical and professional standards are fundamental to the delivery of safe and effective care. Local accreditation programmes have been widely implemented across NHS organisations and they play a vital role in driving continuous improvement, and enhancing patient and staff experience. Accreditation also offers an opportunity to recognise and celebrate excellence.

Feedback from staff highlighted that they would value a clear framework of standards, to provide a structured approach to maintaining and improving clinical and professional standards. The Accrediting Excellence Programme is designed to support staff to take pride in their work and to recognise and celebrate the care delivered in Newcastle Hospitals every day.

What we aim to achieve?

Using our agreed framework we will support 30 wards and departments across 2025/2026 to undertake assessment. This will be across the following areas:

- Inpatient Wards – Adult and Babies, Children, and Young People
- Critical Care – Adult and Babies, Children, and Young People
- Community
- Day Units – Adult and Babies, Children, and Young People.

How will we achieve this?

- We will introduce 30 wards to the accreditation programme through a structured and supportive approach, these will be representative of several Clinical Boards, some self-selected and others identified through existing governance structures. This will involve initial engagement, a baseline support offer, recognition and celebration and sharing of excellence.
- We will monitor cross organisational harm free care metrics to understand the impact of the accreditation process in reducing avoidable harm and improving the patient and staff experience. This will include an audit of sustained achievement post accreditation.

How will we measure success?

We will measure our success through the following key measures:

- Baseline support: Record the total number of baseline and repeat baseline support offers undertaken.
- Accreditation outcomes: Track all accreditation results and celebrations.
- Introduce 30 wards and departments to the accreditation programme.
- Evaluation of the Accrediting Excellence Programme.
- Monitor harm free care metrics and patient/staff experience metrics in accredited and non-accredited areas to understand impact and identify areas for learning and improvement.

PATIENT EXPERIENCE

Priority 5 – Waiting safely- Improving safety for patients who are waiting for treatment. We will focus on patients who are waiting for a total knee replacement operation, with the aim of optimising health before and after the procedure.

Why have we chosen this?

Waiting safely is an initiative that will be used within orthopaedics to support patients waiting for planned surgery. Some patients are waiting for planned orthopaedic

procedures including knee replacement surgery for longer than we would want, and this can lead to deconditioning, dissatisfaction, and prolonged recovery following surgery.

Getting it Right First Time (2023) tell us that patients undergoing a total knee replacement can benefit from interventions before surgery to maximise their health and improve preparedness for surgery, and this can improve post-operative outcomes (length of stay and patient satisfaction).

Based on this we are developing a multi-targeted approach to support our patients awaiting total knee replacement. This will involve prehabilitation interventions to an appropriate group of patients and 'enhanced recovery after surgery' principles to all patients. Whilst on the waiting list for surgery, patients will have access to educational resources in various formats including digital resources, group-based pre-operative education and 1-1 assessments and treatment sessions.

What we aim to achieve?

- Patients with complex needs will be flagged for additional therapy input when identified for surgery, offered an assessment of functional capability pre-operatively to influence post-op outcomes and have on-going pre-operative therapy whilst they are waiting for surgery.
- We will develop pre-operative education for patients to access whilst waiting for surgery which supports them to be in best health for their operation based on 'Getting it Right First Time' recommendations.
- More patients with low complexity to be discharged by day one when they have their total knee replacement, and we will also reduce length of stay for patients identified with complex needs.

How will we achieve this?

- We will make sure that we have clear processes to identify patients' needs and good communication with patients to explain what will happen.
- We will provide new interventions to those patients identified with complex additional needs that supports and monitors wellbeing throughout their wait for surgery.

How will we measure success?

- We will develop patient information resources.
- 100% patients awaiting total knee replacement will be offered pre-operative education.
- The patients identified as having complex needs will be offered the multi-disciplinary team prehab-based intervention. We will measure and act on information about average length of stay.

Priority 6 – Roll out of patient experience real time surveys

Why have we chosen this?

Our 'real time' surveys programme engages with patients and their families on the wards to provide timely data so that we can better understand patients experience and drive service improvements.

Each month, we will carry out hundreds of face-to-face interviews and questionnaires. The results will be shared with ward staff within 24 hours of speaking to patients enabling a prompt response to any concerns.

Between July and December 2024, we piloted the program on 14 wards across the Freeman Hospital and Royal Victoria Infirmary. During the pilot we received feedback from 1,025 patients, who gave an average score of 9.18 out of 10 for care quality.

This is a valuable tool for driving change and wards are keen to take part.

As a result of the pilot 'real time' feedback, service improvements included:

- Visiting times were adjusted on a day unit in line with patient and family feedback
- A better range of snacks were provided
- Soft-close bins and latches on doors were introduced
- Teams have tested new ways of enhancing information provided to families.

We also want to learn about the experience of patients in the Emergency Department, which will involve telephoning patients who have attended emergency care within 24 hours to capture their experience.

What we aim to achieve?

We will roll out this approach to 40 wards in 2025.

We will work with our colleagues across the Great North Healthcare Alliance to introduce patient experience measurement in our emergency departments.

How will we achieve this?

We are very grateful for the support of the Newcastle Hospitals Charity – their investment has enabled us to recruit a Patient and Staff Experience team funded for 21 months to undertake this work.

How will we measure success?

Success will be measured through the successful implementation and delivery of the 'real time' programme to 40 wards across the organisation. We would aim to see a statistical improvement in patient's overall rating of the quality of care within twelve months. This links to our ambition to achieve top decile performance in national survey programme within three years.

The quality of emergency care is captured for us by an independent Care Quality Commission approved contractor every month – our aim is to see our results in the top 20% of NHS provider organisations within 12 months.

COMMISSIONING FOR QUALITY AND INNOVATION INDICATORS

The Commissioning for Quality and Innovation payment framework is designed to support the cultural shift to put quality at the heart of the NHS. Local Commissioning for Quality and Innovation schemes contain goals for quality and innovation that have been agreed between the Trust and various Commissioning groups.

NHS England paused the nationally mandated Commissioning for Quality and Innovation scheme in 2024/2025 and this pause will continue in 2025/2026.

STATEMENT OF ASSURANCE FROM THE BOARD

The Quality Account is an annual account that providers of NHS services must publish to inform the public of the quality of the services they provide, in addition to sharing useful information for current and future patients.

It also supports us to focus on and to be open about service quality. The following section provides an explanation of our quality governance arrangements which provide assurance to the Board.

Following inspection by the Care Quality Commission in 2023 the Trust and Group received a Notice of Decision placing restrictions on the Trust Provider Licence requiring the Trust and Group to make improvements in relation to our governance systems.

The Trust partnered with The Value Circle to review and support the development of new effective systems for quality governance, in addition an Interim Quality Support Director was appointed to support the delivery of improvement plans resulting from the Care Quality Commission inspection and the improvements required to achieve NHS Provider Licence conditions. These conditions were lifted in August 2024.

Our revised governance arrangements have been in place since March 2024, and continue to embed and evolve. This included the establishment of a quality and safety governance framework, quarterly performance reviews focusing on quality and safety, quality and safety peer reviews and a revised Quality Committee reporting and escalation structure to ensure effective quality governance reporting and escalation mechanisms from ward to board.

Services are provided through our eight Clinical Boards – groups of services each led by a Clinical Board Chair (a medical leader), Director of Operations and a Head of Nursing.

Each Clinical Board has a monthly Quality Oversight Group, led by a Quality and Safety Lead, who is a senior medical leader. The Quality Oversight Group is attended by key

staff within the Clinical Board and supporting corporate services. The meetings have a standard agenda which ensures a review of each element of quality, including highlighting any risks for escalation. This structure is being replicated into the individual directorates and specialties. These arrangements have been further strengthened by the appointment of non-medical Quality and Safety Leads to drive improvements across all services.

The Board of Directors also continues to receive a regular Integrated Board Report that includes an overview of the Trust's position across the domains of quality, people, and finance.

The Quality Committee

The Quality Committee is a non-statutory Committee established by the Board of Directors to monitor, review and provide assurance on the quality of care, specifically in relation to patient safety, clinical effectiveness and patient experience. The committee is chaired by a Non-Executive Director and has met twelve times this year, members include both non-executive and executive directors, as well as representatives from the operational teams and clinical experts.

The Quality Committee is responsible for providing assurance to the Board of Directors for the following;

Some examples of how the Quality Committee undertakes its role include;

- Following the introduction of the new Patient Safety Incident Response Framework in January 2024 the Committee has continued to monitor and receive assurance updates for each of the three identified Trust priorities.
- The Committee has undertaken several 'deep dives' during the year to provide enhanced assurance for keys areas of consideration. In July, this focussed on Duty of Candour looking at factors affecting recording of completion of this process. In October, they focused on the allied health professional workforce and therapy services clinical directorate risks.
- Quality Committee implemented a review of the structure of its committees and feeder groups. This improved structure was proposed and agreed in January 2025.

- To provide assurance for the governance of Clinical Boards a stocktake for governance was completed in October 2024.
- To support the Clinical Boards, they were each invited to present their top three quality and safety priorities to Quality Committee in December 2024.
- The Committee receives regular assurance updates as part of the oversight of the rapid quality and safety review programme. This update provides enhanced assurance in addition to the usual baseline audits and compliance checks.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

PART 3

REVIEW OF QUALITY PERFORMANCE 2024/2025

This section of the Quality Account describes the progress made against priority areas for improvement in the quality of health services identified last year.

It includes why they were chosen, what we hoped to achieve, and what we actually achieved in each priority

The information presented in this Quality Account has been monitored over the last 12 months by the Trust Board, Council of Governors, Quality Committee, and the North East and North Cumbria Integrated Care Board.

Our priorities were:

Priority 1 – To improve patient safety by ensuring staff feel free to report safety concerns, incidents and near-misses, resulting in an overall increase in incident reporting rates.

Priority 2 – Achieve a reduction in the incidence of surgical ‘never events’ with a specific focus on Ophthalmology, sharing the learning to inform and improve practice across other surgical specialities.

Priority 3 – To ensure reasonable adjustments are made for patients with suspected or known Learning Disability &/or Autism. Appropriate and consistent use of Mental Capacity Assessment & Deprivation of Liberty Safeguards for patients with vulnerabilities.

Priority 4 - To ensure the Trust has a systematic way of improving from patient and staff feedback in all its forms.

Priority 4a - With new midwifery leadership, agree a staffing model for the birthing unit and associated staff development plan, to honour our commitment to consistent opening of the birthing centre 2024/2025.

Most of the account represents information from all eight Clinical Boards presented as total figures for the Trust. The indicators to be presented and monitored were selected following discussions with the Trust Board and Executive Team having been developed with guidance from senior clinical staff.

PATIENT SAFETY

Priority 1 – To improve patient safety by ensuring staff feel free to report safety concerns, incidents and near-misses, resulting in an overall increase in incident reporting rates.

Why we chose this?

Staff need to have clarity and confidence in our incident reporting and learning mechanisms, knowing reported events will be escalated and acted on in an effective manner and supported by compassionate leadership as part of a 'Just Culture' that supports fairness, openness and learning, whilst encouraging staff to speak up without fear of blame.

This priority aligns to the NHS National Patient Safety Strategy and enhanced the early implementation work of the Patient Safety Incident Response Framework.

Using intelligence gathered from staff and our Care Quality Commission report (2023), there was an acknowledgement that we needed to simplify the incident reporting system, to make it easier for staff to report when things go wrong and to increase incident reporting rates. In addition, by ensuring that learning and feedback was captured and disseminated, we would strengthen the reporting culture across the organisation and improve safety performance.

What we aimed to achieve?

We aimed to improve staff understanding and confidence in incident reporting mechanisms, improving the incident reporting rates and flow of learning throughout the organisation, supporting the reduction of harm. We wanted staff to feel empowered and psychologically safe to report and escalate concerns in a timely way, demonstrating a positive and supportive culture of learning.

What we achieved?

1. **We reviewed and simplified the Datix system**
   Significant work has been undertaken to review, simplify and improve the Datix system. The Trust's is now implementing a replacement system, InPhase, and this programme has incorporated learning gained from our experience with Datix.

2. **Development of incident metrics have been made available on dashboards.**
   We can now demonstrate reduced numbers of overdue incidents. (368 overdue as of 21st March 2025, compared to 1,039 in November 2023).

3. **We provided support to the Quality Oversight Groups to develop sharing of important information.**
   Two stocktakes of the sharing learning mechanisms within clinical boards have been undertaken, with boards continuing to improve how they learn and share findings from incidents.

4. **Provided staff education and training packages to encourage reporting, effective investigation and psychological safety.**
   The Trust has implemented the NHS England Patient Safety Syllabus and training uptake continues to increase, as follows:
   - level 1 - essentials for patient safety – 89%
   - level 2 - access to practice - 78%
   - level 3 PSIRF investigator training - 82 investigator leads
   - level 4 & 5 – patient safety specialists – 5 patient safety specialists.

   Trust Induction and local investigator training has been refreshed, with information strengthened including incident reporting and psychological safety themes.

5. **Regular staff communications take place, including Patient Safety Bulletins and monthly Patient Safety Briefings.**
   Monthly patient safety briefings have taken place. The briefings are now recorded and shared via the Teams for staff to easily access. There are also plans to extend to community services.

6. **Established twice yearly Patient Safety Incident Response Framework thematic reviews for Clinical Boards.**
   All the Clinical Boards have presented an overview of the no harm, low harm and local investigations undertaken since the start of the Patient Safety Incident Response Framework. They can visually review no harm and low harm incidents more easily and can analyse any trends within their data and whether this has led to any quality improvement projects.

   For local investigations, the Clinical Boards analyse the themes, trends and where the learning has been shared. The learning from After Action Reviews and Patient Safety Incident Investigations has been presented at the Patient Safety Incident Forum from May 2024 onwards and are shared with local teams.

7. **Engagement with staff**
An overarching communications and engagement plan was put in place for incident reporting and learning. A Patient Safety Walkabout weekly programme continues into 2025, engaging with front line staff across both main in-patient sites and community sites.

8. **Evidence of Increased reporting rates**
From 1st February 2023 to 31st January 2024, **25,534** incidents for all Trust services were reported on the Datix system. For the period 1st February 2024 to 31st January 2025, **27,530** incidents were reported. This represents an overall 7.8% increase in reporting for the organisation for all types of incidents. (Figure 1).

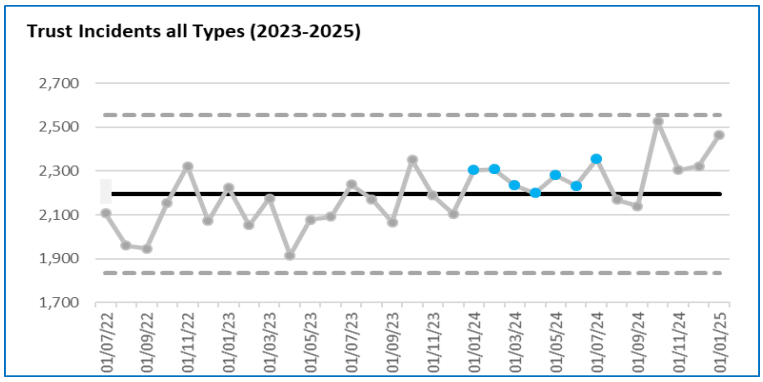


Figure 1

From 1st February 2023 to 31st January 2024, **20696** Patient Safety Incidents (PSI) were reported on the Datix system. For the period 1st February 2024 to 31st January 2025, **21,746** incidents were reported, an increase of **4.8%**. (Figure 2).

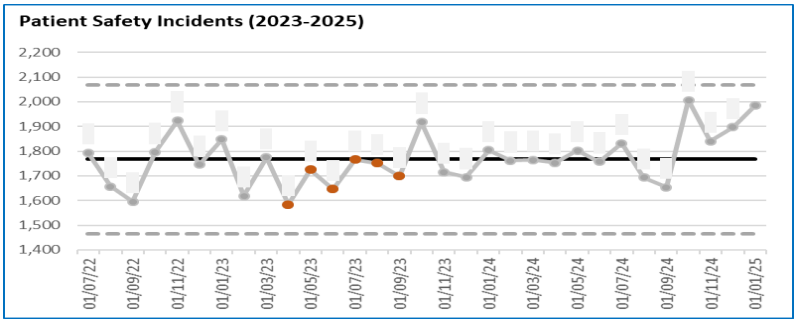


Figure 2

How we measured success
Over the year we have seen:

- An increase in incident reporting rates.
- Improving position in NHS Staff Survey 2024 (published March 2025), with significantly higher scores compared to 2023 in relevant areas including more staff able to raise concerns about unsafe practice (70%) and more staff confident that their concerns would be addressed (55.8%).
- Uptake of patient safety syllabus training has increased.

- Attendance at Patient Safety Briefings remains challenging. This will be reviewed as we develop priorities for 2025/2026.
- We have developed ways of sharing learning form incidents within clinical services.

Priority 2 – Achieve a reduction in the incidence of surgical 'never events' with a specific focus on Ophthalmology, sharing the learning to inform and improve practice across other surgical specialities.

Why we chose this?

A Never Event is "*A serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by healthcare providers*."

Within ophthalmology there had been three Never Events in 2023/2024 (1 x wrong site surgery x 2 wrong lens implant)

What we aimed to achieve?

We aimed for a reduction of Never Events in ophthalmology to zero within 2024/2025.

What we achieved?

All new staff now undertake a training package on the use of 'local safety standards for invasive procedures' in the department. All staff completed this training by March 2025.

A quarterly audit undertaken around the compliance of Local Safety Standards Invasive Procedure is in place, with the results showing 87% compliance. As part of the recommendations from this audit, there is now a review of second checker availability by the ward sister and an escalation process if a second checker is unavailable. There is also an annual peer review around local safety standards invasive procedure.

For cataract surgery we have reviewed and updated the local policy relating to the cataract surgery lens check procedure and specialty specific World Health Organisation surgical checklist. This has included a review of the 'site marking' procedure to ensure site marking was always visible during the 'draping' procedure.

How we measured success

One never event was reported within the reporting period (in April 2024). This was regarding a patient who received an intraocular lens implant into the incorrect eye, the surgery was carried out at the end of 2023.

Over the year new processes and training have been introduced to support staff compliance and regular audits have been undertaken throughout the department.

Datix and governance systems have been used to monitor incidents. Audits of compliance are ongoing.

CLINICAL EFFECTIVENESS

Priority 3 – To ensure reasonable adjustments are made for patients with suspected or known Learning Disability &/or Autism. Appropriate and consistent use of Mental Capacity Assessment & Deprivation of Liberty Safeguards for patients with vulnerabilities.

Why we chose this?

We must ensure we are compliant with the Mental Capacity Act 2005 which provides a statutory framework to empower and protect any person over the age of 16 in England and Wales who may not be able to make their own decisions. The Mental Capacity Act and safeguarding legislation have a significant overlap in order to ensure that people's rights are protected, and they are kept safe.

The Deprivation of Liberty Safeguards legislation was introduced in 2009, as an addendum to the Mental Capacity Act 2005, providing a legal framework around depriving people of their liberty.

What we aimed to achieve?

We aimed to increased compliance with Mental Capacity Act, Best Interest Decision making, Deprivation of Liberty Safeguards and the Equality Act 2010 so that patients were appropriately supported and protected whilst in our care

Clinical Staff must understand relevant processes and documentation, what this means for the patient and where to store and retrieve the appropriate information.

The collaborative work aims to reduce health inequalities for patients with a learning disability by working in partnership with people with lived experience and their families.

What we achieved?

Reasonable Adjustments

- Training sessions relating to autism awareness have been provided to attendees of all disciplines. Further training will be provided in response to requests, and a maternity e-learning training package was implemented in November 2024.
- Project work with local advocacy organisations Skills for People has commenced in both adults and children's emergency departments, this has led to easy read documentation about raising a complaint, implementation of reasonable adjustments and a pilot of Quality Checkers (experts by experience reviewing services). Skills for People have also developed a

training video about the use of the reasonable adjustments form, and they are helping us with the development of our Learning Disability and Autism Strategy.

Mental Capacity Act

- We've seen an increase in the number of Mental Capacity Act and Deprivation of Liberty related enquiries which demonstrates increase in staff knowledge. Staff continue to complete assessments of capacity for patients who are deprived of their liberty. Ongoing audits show the quality of best interest assessments has improved.

How we measured success

We can report that

- Training compliance is in line with trust standard:
  - Diamond Standard Mandatory Training is at 95% (this includes the Maternity Diamond Standard training)
  - Safeguarding Adults training demonstrates good compliance with level 1 at 96% and level 2 at 96%. Safeguarding Adult Level 3 compliance is 85% (below trust standard)
  - Safeguarding Children level 1 compliance rates are 96% and Level 2 95%. Level 3 Children's safeguarding sits at 86% which is below the required target.
  - Level 1 Mental Capacity Act mandatory training for all clinical and patient facing staff is in place. Compliance currently sits at 96%. The Level 2 Mental Capacity Act and Deprivation of Liberty e-learning package has now been created and was launched in December 2024. The aim is to achieve 90% compliance by the end of June 2025. Current compliance rate sits at 48% which is on target based on planned percentage uptake per month.
- There is a quarterly audit of the patient record regarding the quality of Deprivation of Liberty Safeguards referrals.

We would like to acknowledge and thank Skills for People for their support with this work.

PATIENT EXPERIENCE

Priority 4 - To ensure the Trust has a systematic way of improving, following patient and staff feedback in all its forms

Why we chose this?

Our people are central to improving the quality and delivery of safe and compassionate care. How they experience the culture of the organisation and how they feel about their workplace directly impacts on their ability to care for patients, their team, themselves, and their families.

In most NHS organisations, patient experience remains the weakest of the three elements of quality. It does not get the same attention as safety and clinical effectiveness and this needs to change.

Although patient experience was captured through the Friends and Family test and national surveys, there has been remarkably little improvement in NHS patient experience data since surveys were introduced in 2002 – we were not always measuring the right things, feedback is not representative or timely enough, and we didn't get information to staff in ways that motivate them to act on results.

We have employed an approach to understanding and improving patient and staff experience across multiple hospital sites, which has been used successfully in other trusts. We set out to really understand quality in real time and with enough granularity to inform improvement.

What we aimed to achieve?

Our ambition was to develop a patient and staff experience programme at Newcastle Hospitals that is the most comprehensive in the NHS. We planned to capture performance at a site, clinical board, speciality, and ward level.

This work also built on the previous funding provided by the charity to develop the patient experience of care. Patients told us they wanted to be asked about their experience, they wanted their feedback to visible and they wanted to know how their feedback made a difference. This programme therefore let us deliver the aims set out in the experience of care strategy.

What we achieved?

- A pilot of real time patient experience measurement ran from June 2024 to December 2024 on 14 wards at Freeman Hospital and Royal Victoria Infirmary. Across the pilot 1,025 patients provided us with feedback while they were still cared for on our wards. Real time ward reports were published and accessible to patients' families and public.
- Right time patient feedback is a partnership with Patient Perspective, a Care Quality Commission approved contractor to follow up patients after care. The programme commenced in September 2024. 68,438 responses have been received so far with feedback on inpatient, outpatient, emergency care and maternity services. Hospital site and specialty data is now routinely shared across the organisation.
- During the Trust's 'Perfect Week' initiative in September 2024, all patients receiving care during the week were asked to complete a survey in relation to their experience of care in either inpatient/outpatient services or the emergency department. We received feedback from 2,903 individuals.
- Patient and staff stories feature at all public Board meetings. Patient and staff experience results are reported to our Council of Governors, Chief Executive staff roadshows, Management Groups, Quality Committee and Board.

- Our new approach allows for much greater feedback for the Friends and Family test question, experiencing a 519% increase in responses since right time measurement was introduced.
- Staff experience feedback: ‘First 100 days (since appointment of new Chief Executive) survey conducted in April 24, hearing from 4,577 colleagues. All free texts comments formally analysed and priorities for improvement shared with staff and leaders.
- As we have developed our People Plan, we have agreed a programme to measure staff experience.
- Health inequalities: A report based on the views of 45,000 patients reviewed the quality of care from the perspective of groups represented by protected characteristics. Results were shared with Quality Committee and Board as of February 2025, and this will be incorporated into future work.

How we measured success

Success was evidenced by excellent engagement with patients, families, and communities – we now have the largest patient experience programme in the NHS.

We reached an average of:

- 1,000 responses from inpatient services a month
- 1,000 responses a month from patients using the Emergency Department.
- 6,400 responses a month from outpatients
- 1,600 responses a month from day case services
- 100 responses a month across antenatal, labour/birthing and postnatal services.

As well as improvements in national patient and staff experience survey results.

Priority 4a - With new midwifery leadership, agree a staffing model for the birthing unit and associated staff development plan, to honour our commitment to consistent opening of the birthing centre 2024/2025

Why we chose this?

Planning where to have your baby is an important decision. Women should be able to make decisions about the support they need during birth and where they would prefer to give birth, whether this is at home, in a midwifery unit or in an obstetric unit, after full discussion of the benefits and risks associated with each option. The NHS wants everyone using maternity services to receive safe, personalised care. This means that care is centred around the unique needs and circumstances of each individual using maternity services and their baby. It also means that they have had genuine choice about the care they receive, informed by impartial information.

Care that is personalised, which includes choice of place of birth, is a core theme in the three year plan for Maternity and Neonatal Care. We have heard from women via the Maternity and Neonatal Voice Partnership, that place of birth is an important choice and that access to midwifery led birth services, as well as homebirth and obstetric led care is essential to them.

What we aimed to achieve?

To provide a safe and sustainable midwifery staffing model to support choice in place of birth either at home, in the co-located midwifery led unit (Newcastle Birthing Centre) and on the Delivery Suite for all women who choose to have their babies in Newcastle.

To make the maternity services an attractive place to work, with a comprehensive recruitment and retention plan, with accessible career development pathways.

To ensure the midwifery staffing model fulfils the requirements of Birth Rate+ methodology and the effectiveness of the staffing model is evaluated, considering women's experience of care, clinical outcomes and staff experience.

What we achieved?

We opened the Newcastle Birthing Centre on 2nd December 2024, welcoming 35 babies into the world in the Birthing Centre in December, and 38 in January 2025.

We have also developed a staffing model that ensures we can responsively staff each intrapartum area to ensure every woman received one to one care in labour in the birth location of her choice.

To achieve this, we also;

- Commissioned a Birth Rate+ staffing review providing a detailed understanding of the staffing requirements across all maternity services and a recruitment and retention self-assessment and action plan
- Successfully recruited early career and internationally educated midwives and reviewed the preceptorship package to support early career midwives.
- Introduced staffing escalation guidance for each clinical area to always ensure safe staffing and developed a staffing dashboard to review staffing monthly, alongside experience and clinical outcomes. This information is then used to continually plan safe staffing for the services and inform the staffing plan.
- Worked with the Maternity Neonatal Voice Partnership to engage service users and inform the induction of labour working group and the communication strategy. We have established a perinatal engagement and inclusion group to review service user feedback and plan improvements.
- Piloted the 'real time' and 'right time' patient experience programme in maternity services which has informed the development of a postnatal care improvement action plan and an induction of labour working group.
- Launched our new social media platforms to improve communication with our service users.

How we measured success

Our services remain open twenty four hours a day, seven days a week, with all women having choice in the place of their birth.

We continuously review our safe staffing dashboard alongside patient experience, clinical outcomes and staff experience and have seen a reduction in the midwifery

vacancy rate to less than 10 whole time equivalents, and a reduction in midwifery turnover rate to 6.4% on the Delivery Suite and 4.3% on the postnatal ward.

Most importantly, 100% of women were able to have one to one support in labour, leading to an improvement in patient experience feedback from ‘right time’ surveys.

National guidance requires Trusts to include the following updates in the annual Quality Account:

Update on the statutory duty of candour

Being open and transparent is an essential aspect of patient safety. Promoting a restorative, just and learning culture helps us to ensure we communicate in an open and timely way when things go wrong.

An open and fair culture encourages staff to report incidents, to facilitate learning and continuous improvement to help prevent future incidents, improving the safety and quality of the care the Trust provides.

If a patient in our care experiences harm or is involved in an incident because of their healthcare treatment, we explain what happened and apologise to patients and/or their family as soon as possible after the event.

There is a statutory requirement to implement Regulation 20 of the Health and Social Act 2008: Duty of Candour. Within the organisation we have a multifaceted approach to providing assurance and monitoring of our adherence to the regulation for patients who have experienced significant harm.

The Trust's duty of candour policy provides structure and guidance to our staff on the standard expected within the organisation. Our compliance is assessed by the Care Quality Commission and we also monitor our own performance on an ongoing basis. This ensures verbal and written apologies have been provided to patients and their families and assures that those affected are provided with an open and honest account of events and fully understand what has happened.

Compliance with recording of duty of candour is improving. In 2024/2025 further work has been carried out to improve the way compliance data is captured. A dashboard has also been launched to allow Clinical Boards to maintain oversight of their own compliance, and this is closely monitored across the organisation. It is a standing agenda item at Patient Safety Group, Quality and Performance Reviews and Quality Committee.

A key element of the Patient Safety Incident Response Framework is patient and family engagement in the investigation process, work is ongoing to have the patient / families involved and at the centre of our learning responses.

Regular training on duty of candour is provided.

Statement on progress in implementing the priority clinical standards for seven-day hospital services

The Board Assurance framework for seven-day hospital services was updated in 2022 to reduce internal data collection for Trust Boards, moving from data that was required to be uploaded twice yearly to a national portal, to Trust's producing a report signed off by the Executive Medical Director, at least once a year.

The Trust has undertaken an audit in 2024/2025 to assess performance as required by this guidance. The review has included all four of the core standards.

- Emergency admissions should be seen as soon as possible by a consultant and within 14 hours of admission.
- Emergency and urgent access to appropriate consultant-led diagnostic tests (and reported results) should be available every day.
- Emergency and urgent access to appropriate consultant-led interventions should be available every day.
- Patients admitted in an emergency should be reviewed by a consultant once daily (twice daily in high-dependency and critical care).

This report will be presented to the Trusts Audit, Risk and Assurance Committee and the Quality Committee in May 2025.

Gosport Independent Panel Report and ways in which staff can speak up

"In its response to the Gosport Independent Panel Report, the Government committed to legislation requiring all NHS trusts and NHS Foundation Trusts in England to report annually on staff who speak up (including whistleblowers). Ahead of such legislation, NHS trusts and NHS Foundation Trusts are asked to provide details of ways in which staff can speak up (including how feedback is given to those who speak up), and how they ensure staff who do speak up do not suffer detriment. This disclosure should explain the different ways in which staff can speak up if they have concerns over quality of care, patient safety or bullying and harassment within the Trust".

All staff permanent, temporary and bank workers are informed as part of their induction process about the ways that can report concerns about issues in the workplace. This information is also clearly set out on the intranet.

We want staff who work for Newcastle Hospitals to be confident they have a voice and that they can raise concerns safely. This includes the ability to provide information anonymously through our Work in Confidence system.

Any of the reporting methods set out below can be used to log an issue, query, or question; this may relate to patient safety or quality, staff safety including concerns about inappropriate behaviour, leadership, governance matters or ideas for best practice and improvements.

Work in confidence – the anonymous dialogue system

All staff are able to use the anonymous dialogue system 'Work in Confidence', a platform which enables people to raise ideas or concerns directly with senior leaders, including members of the Executive Team and the Freedom to Speak Up Guardian. The conversations are categorised into subject areas, including staff safety.

This secure web-based system is run by a third-party supplier. It enables staff to engage in a dialogue with senior leaders in the Trust, safe in the knowledge that they

cannot be identified. Reports on themes raised are reported to the People Committee.

Freedom to Speak up Guardian

The Trust Freedom to Speak up Guardian acts as an independent, impartial point of contact to support, signpost and advise staff who may wish to raise serious issues or concerns. This person can be contacted, in confidence, by telephone, email or in person.

To support this work, a network of Freedom to Speak up Champions, spread across the organisation and sites, has been developed.

Staff engagement to raise awareness about the roles and how to make contact have been undertaken using a range of communications platforms.

In addition, the Freedom to Speak up Guardian reports bi-annually to the People Committee, and Board, to provide assurance and ensure learning.

We have created a reporting database and dashboard which is about to go live to allow accurate and targeted reporting but maintaining confidentiality for staff reporting issues.

Freedom to Speak Up policy

This policy provides assurance to employees who raise concerns, that they will be supported and will not face any detriment because of raising their concerns.

The Trust is working hard to improve our culture of safety and learning to protect patients and staff. We recognise that the ability to engage in this process and feel safe and confident to raise concerns, is key to rectifying or resolving issues and underpins a shared commitment to continuous improvement.

Union and Staff Representatives

The Trust recognises 14 trade unions and works collaboratively in partnership with their representatives to improve the working environment for all. Staff are able to engage with these representatives to obtain advice and support if they wish to raise a concern.

Staff Networks

We have four staff networks which have been established for several years. These are the Womens Network, Pride Network, Race Equality networks and the Enabled Network.

Each network has a Chair and Vice Chair and has its own independent email account and staff can make contact this way, and/or attend a staff network meeting. The Staff Networks can either signpost staff to the best route for raising concerns, can raise a general concern on behalf of its members or can offer peer support to members.

Cultural Ambassadors

Cultural Ambassadors, trained to identify and challenge cultural bias, were introduced during 2020. These colleagues are an additional resource to support Black and Minority Ethnic colleagues who may be subject to formal employment relations proceedings.

A summary of the Guardian of Safe Working Hours Annual Report

The responsibility of the Guardian of Safe Working Hours is to make sure that issues of compliance with trainee doctors safe working hours are addressed by the doctor and department as appropriate, and that all trainee doctors are safely rostered, so they work hours that are safe in compliance with the resident doctor (previously known as junior doctor) contract.

This consolidated annual report covers the period April 2024 – March 2025. The aim of the report is to highlight the vacancies in junior doctor rotas and steps taken to resolve these.

Gaps are present on several different rotas; these are due to gaps in regional training rotations, lack of recruitment of suitable locally employed doctors, and delays of locally employed doctors coming into post following appointment. Gaps are also seen when doctors working less than full time are in full time posts. There are currently no areas of recurrent or residual concern.

The Trust minimises the impact of gaps by active recruitment; utilisation of locums; and by rewriting work schedules to ensure that key areas are covered.

In addition to the specific actions above, the Trust takes a proactive role in management of gaps through the work of the Junior Doctor Recruitment and Education Group. Members of this group include the Director of Medical Education, Finance Team representative and Medical Staffing personnel. In addition to recruitment into locally employed doctor posts, the Trust runs several successful trust-based training fellowships, including a newly created Newcastle medical rotation and a teaching fellow programme. It has supported temporary and permanent expansion of the Foundation Training Programme, recruitment into less than full time gaps and additional newly approved posts in Accident and Emergency.

Learning from deaths

The Department of Health and Social Care published the NHS (Quality Accounts) Amendment Regulations 2017 in July 2017. These added new mandatory disclosure requirements relating to ‘Learning from Deaths’ to Quality Accounts from 2017/2018 onwards. These new regulations are detailed below:

1. During 2024/2025, 2055 of the Newcastle upon Tyne Hospitals NHS Foundation Trust’s patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period: 470 in the first quarter; 457 in the second quarter; 565 in the third quarter; 563 in the fourth quarter.

2. During 2024/2025, 796 case record reviews and five investigations have been carried out in relation to 2055 of the deaths included in point 1 above. In three cases, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was: 247 in the first quarter; 206 in the second quarter; 229 in the third quarter; 119 in the fourth quarter.

3. Five, representing 0.24% of the patient deaths during the reporting period were judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of four, representing 0.85% deaths for the first quarter, one, representing 0.22% for the second quarter, none, representing 0.00% for the third quarter, and none, representing 0.00% for the fourth quarter. (To date, not all incidents have been fully investigated). Once all investigations have been completed, any death found to have been due to problems in care will be summarised in 2026/2027 Quality Account. All deaths will continue to be reported via the Integrated Board Report). These numbers have been estimated using the HOGAN evaluation score as well as patient safety investigation and infection prevention control investigation toolkits.

Summaries from five completed cases judged to be more likely than not to have had problems in care which have contributed to patient death:

Summary	Lessons learned from review	Action	Impact/Outcome
A patient who underwent orthopaedic surgery had three doses of anticoagulation medication omitted following surgery. They developed a fatal pulmonary embolus 12 days later.	Recognition that improvement in the prevention of hospital acquired venous thromboembolism is required.	Orthopaedic venous thromboembolism guideline to be reviewed. Prevention of hospital acquired venous thromboembolism is one of the Trust's Patient Safety Incident Response Framework priorities*.	A Trustwide quality improvement plan has been established for hospital acquired venous thromboembolism prevention including: A new venous thromboembolism risk assessment form which is regularly audited and has a compliance rate of 98%. A venous thromboembolism dashboard to support oversight and monitoring. Use of Artificial Intelligence technology to support identification of inpatient venous

Summary	Lessons learned from review	Action	Impact/Outcome
			thromboembolisms for review by Specialist Nurses. Mandatory venous thromboembolism prevention training introduced for all staff in a clinical role. This has contributed to a 28% reduction of preventable hospital acquired venous thromboembolisms.
A blood test result indicative of a new diagnosis of type II diabetes was not acted upon and the patient later sadly died due to diabetic ketoacidosis.	Development of a standardised approach, with an agreed framework, to be used by staff to support them in providing seamless admission and discharge of patients with complex care needs. Strengthened digital processes to support staff to interpret and manage patient results this is one of the Trust's Patient Safety Incident Response Framework priorities*.	The Trust is developing a Safety Improvement Plan to support the development of a standardised organisational approach for patients with complex care needs. We are exploring with the Great North Care Record whether abnormal results can be shown in red when outside of diagnostic thresholds.	HbA1c results over the expected diagnostic range are now shown in red text within the Patient Administration System to highlight these to clinical staff for action. Learning from this incident has been shared widely in the trust and other organisations.
Missed opportunities for intervention and escalation were identified in the care of a patient who deteriorated post-operatively and suffered cardiac arrest from which they could not be resuscitated.	Timely recognition and escalation of abnormal patient observations is essential to identifying a potential deterioration. Handover between teams should include all relevant information and ensure there is clear guidance and advice available for medical teams managing post-surgical patients across the organisation.	Handover mechanisms and guidelines reviewed. Education for nursing staff on fluid balance recording and escalation of urine outputs, Post-operative fluid balance and acute kidney injury management incorporated into resident doctor teaching. Production of clear	Standard Operating Procedure for medical advice escalation pathways agreed and shared. Ongoing education programme delivered to staff by the deteriorating patient team. Roll out across the Trust of Call for Concern (Martha's Rule) from February 2025.

Summary	Lessons learned from review	Action	Impact/Outcome
		escalation pathway for clinicians managing post-surgical patients requiring general medical advice. Review of Out of Hours registrar level medical cover.	
A patient waited 30 months for urgent surgical intervention following referral during which time their clinical condition deteriorated and they became too unwell to undergo treatment and sadly passed away.	Importance of ensuring outcomes from MDT meetings are tracked and actioned, and that any identified delays are escalated promptly.	The Trust has implemented regular scheduled surgical lists for the procedure in question. Oversight of the waiting list is facilitated by the nurse co-ordinator who has an established escalation process for any patient waiting longer than 16 weeks.	A second nurse Co-ordinator has since been appointed in February 2025. Multi-disciplinary team documentation and administration is now more robust, and outcomes are tracked to ensure they are actioned.
A patient sustained an inadvertent major vascular injury during surgery, causing significant haemorrhage which contributed to their death.	Major vascular injury is a well-recognised complication of spinal surgery. There are national and local standards for the presence of a vascular surgeon during anterior lumbar spinal surgery. The investigation recommended that a vascular surgeon be present for cases involving an oblique approach.	Review the arrangements for the presence of a vascular surgeon during anterior and oblique lumbar interbody fusion procedures. Review the location and number of emergency vascular trays in theatre suites. Undertake a surgical outcomes review.	Get it Right First Time have been approached to consider supporting a super-regional Multi-disciplinary team.

* The national Patient Safety Incident Response Framework replaced the previous Serious Incident Framework from January 2024 at Newcastle Hospitals.

4. 163 case record reviews and 6 investigations were completed after April 2024 which related to deaths which took place before the start of the reporting period.

5. 5, representing 3% of the patient deaths before the reporting period are judged to be more likely than not to have been due to problems in the care provided to the patient.

6. 33, representing 1.72% of the patient deaths during 2023/2024 are judged to be more likely than not to have been due to problems in the care provided to the patient.

The Trust will monitor and discuss mortality findings at the quarterly Mortality Surveillance Group and Patient Safety Incident Forum (formerly Serious Incident Panel) which will be monitored and reported to the Trust Board and Quality Committee.

INFORMATION ON PARTICIPATION IN NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

During 2024/2025, 81 national clinical audits and six national confidential enquiry reports / review outcome programmes covered NHS services that the Newcastle upon Tyne NHS Foundation Trust provides.

During that period, we took part in in 75 (93%) of the national clinical audits and six (100%) of the national confidential enquiries / review outcome programmes which we were eligible to participate in. These are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2024/2025	Percentage Data completion	Outcome if participated / If did not participate why?
Environmental Lessons Learned and Applied to the Bladder Cancer Audit	British Association of Urological Surgeons	Related to the Getting It Right First-Time decarbonisation recommendations for bladder cancer care pathway.	Yes	Bespoke data submission by the healthcare provider	Published report expected June 2025
Impact of Diagnostic Ureteroscopy on Radical Nephroureterectomy Audit	British Association of Urological Surgeons	Assesses practices for the diagnostic evaluation of patients and evaluates compliance with standard-of-care practices.	Yes	Bespoke data submission by the healthcare provider	No publication date yet identified
Penile Fracture Audit	British Association of Urological Surgeons	Assess the outcomes of patients undergoing penile repair and assess variations in clinical pathways.	Yes	Bespoke data submission by the healthcare provider.	Published report expected June 2025
Breast and Cosmetic Implant Registry	NHS England	Captures the details of all breast implant procedures completed by the NHS and private providers.	Yes	Continuous data submission	No publication date yet identified
British Hernia Society Registry	British Hernia Society	Permits large-scale, cost-effective embedded research, guide product development, track outcomes and	Yes	Data collection 1st June 2024 – 31st March 2025	Published report expected June 2025

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2024/2025	Percentage Data completion	Outcome if participated / If did not participate why?
		improve patient safety.			
Case Mix Programme	Intensive Care National Audit and Research Centre	Looks at patient outcomes from adult, general critical care units in England, Wales and Northern Ireland.	Yes	Continuous data collection	Published report expected March 2026
Clinical Health Clinical Outcome Review Programme: Emergency Surgery in Children and Young People	National Confidential Enquiry into Patient Outcome and Death	Aims to assess the quality of healthcare and stimulate improvement in safety and effectiveness.	Yes	Data collection 17th June 2024 – 31st March 2025	Published report expected late 2025
Child Health Clinical Outcome Review Programme: Juvenile Idiopathic Arthritis	National Confidential Enquiry into Patient Outcome and Death	This study will review the quality of care in children and young adults with Juvenile Idiopathic Arthritis	Yes	Data Collection 1st April 2024 – 1st July 2024	Published report expected February 2025
Cleft Registry and Audit Network Database	Royal College of Surgeons of England	The Cleft Registry Database collects information about all children born with cleft lip and/or cleft palate in England, Wales and Northern Ireland.	Yes	Continuous data collection	Published report expected December 2025
Emergency Medicine Quality Improvement Programme: Care of Older People	Royal College of Emergency Medicine	This audit assesses care of older people in the emergency department against clinical standards and aims to improve patient quality of care.	Yes	Data collection 1st January 2025 – 31st December 2025	Published report expected Spring 2025
Emergency Medicine Quality Improvement Programme :Time Critical Medications	Royal College of Emergency Medicine	This audit looks at the prescription of time critical medicines for patients in the Emergency Dept..	Yes	Data collection 1st January 2025 – 31st De 2025	Published report expected Spring 2026
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Royal College of Paediatrics and Child Health	The clinical audit aims to improve the quality of care for children and young people with seizures and epilepsies	Yes	Bespoke data submission by the healthcare provider	No publication date yet identified
Learning for Lives	NHS England	This audit aims to	Yes	Continuous	No publication

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2024/2025	Percentage Data completion	Outcome if participated / If did not participate why?
and Deaths – People with a learning disability and autistic people		improve the health of people with a learning disability and reduce health inequalities.		data collection	date yet identified
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal Morbidity Confidential Enquiry	Mothers & Babies Reducing Risk through Audits and Confidential Enquiries (MBRACE) National Perinatal Epidemiology Unit, University of Oxford	This enquiry reviews the care received following all deaths of women who die during pregnancy or up to a year after the end of pregnancy.	Yes	Data collection 1st January 2024 – 31st December 2024	Published report expected October 2025
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal Mortality Confidential Enquiry	MBRACE National Perinatal Epidemiology Unit, University of Oxford	Reviews the care received following all deaths of women who die during pregnancy or up to a year after the end of pregnancy.	Yes	Data collection 1st January 2024 – 31st December 2024	Published report expected October 2025
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal Mortality Surveillance	MBRACE National Perinatal Epidemiology Unit, University of Oxford	Reviews the care received following all deaths of women who die during pregnancy or up to a year after the end of pregnancy.	Yes	Data collection 1st January 2024 – 31st December 2024	Published report expected October 2025
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality and Serious Morbidity	MBRACE National Perinatal Epidemiology Unit, University of Oxford	Reviews the care received following all deaths of women who die during pregnancy or up to a year after the end of pregnancy.	Yes	Data collection 1st January 2024 – 31st December 2024	Published report expected December 2025
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality Surveillance	MBRACE National Perinatal Epidemiology Unit, University of Oxford	Reviews the care received following all deaths of women who die during pregnancy or up to a year after the end of pregnancy.	Yes	Data collection 1st January 2024 – 31st December 2024	Published report expected December 2025
Medical and Surgical Clinical Outcome	National Confidential	Aims to assess the quality of healthcare	Yes	Data collection	Published report

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2024/2025	Percentage Data completion	Outcome if participated / If did not participate why?
Review Programme: Acute Limb Ischaemia	Enquiry into Patient Outcome and Death	and stimulate improvement in safety and effectiveness.		1st August 2024 – 31st March 2025	expected November 2025
Medical and Surgical Clinical Outcome Review Programme: Blood Sodium Study	National Confidential Enquiry into Patient Outcome and Death	This audit aims to assess the quality of healthcare and stimulate improvement in safety and effectiveness.	Yes	Data collection 15th April – 31st March 2025	Published report expected November 2025
Medical and Surgical Clinical Outcome Review Programme: End of Life Care	National Confidential Enquiry into Patient Outcome and Death	This audit aims to assess the quality of healthcare and stimulate improvement in safety and effectiveness.	Yes	Data collection 1st April – 30th April 2024	Report published December 2024. Action plan is being developed
Medical and Surgical Clinical Outcome Review Programme: Managing Acute Illness in People with Learning Disabilities	National Confidential Enquiry into Patient Outcome and Death	This audit aims to assess the quality of healthcare and stimulate improvement in safety and effectiveness.	Yes	Data collection 1st March 2025 – 31st March 2025	No publication date yet identified
Medical and Surgical Clinical Outcome Review Programme: Rehabilitation following Critical Illness	National Confidential Enquiry into Patient Outcome and Death	This audit aims to assess the quality of healthcare and stimulate improvement in safety and effectiveness.	Yes	Data collection 1st April 2024 – 31st October 2024	Published report expected Spring 2025
Mental Health Clinical Outcome Review Programme: Real-time Data Collection of Probable Suicide Deaths by Mental Health Inpatients who died within 14 days of discharge	National Confidential Inquiry into Suicide and Safety in Mental Health, University of Manchester	This audit aims to decrease suicide rates, particularly in people under mental health care and in patient subgroups.	The Trust is not eligible to participate in this audit as it does not provide this service.		
Mental Health Clinical Outcome Review Programme: Suicide and Homicide by People under Mental Health Care	National Confidential Inquiry into Suicide and Safety in Mental Health, University of	This audit aims to decrease suicide rates, particularly in people under mental health care and in patient subgroups.	The Trust is not eligible to participate in this audit as it does not provide this service.		

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2024/2025	Percentage Data completion	Outcome if participated / If did not participate why?
	Manchester				
Mental Health Clinical Outcome Review Programme: Suicide by People in Contact with Drug and Alcohol Services	National Confidential Inquiry into Suicide and Safety in Mental Health, University of Manchester	This audit aims to decrease suicide rates, particularly in people under mental health care and in patient subgroups.	The Trust is not eligible to participate in this audit as it does not provide this service.		
National Audit of Cardiac Rehabilitation	University of York	Aims to support cardiovascular prevention and rehab services to achieve the best outcomes for patients with cardiovascular disease,	Yes	Continuous data collection	Published reports expected April, July, September and December 2025
National Audit of Cardiovascular Disease Prevention in Primary Care	NHS Benchmarking Network	Analysis and reporting is designed to support systematic quality improvement using the findings from annual audit reports and the associated Data & Improvement Tool, to reduce health inequalities and improve outcomes.	This Trust is not eligible to participate in this audit as this service is provided by Primary Care.		
National Audit of Care at the End of Life	NHS Benchmarking Network	A national comparative audit of the quality and outcomes of care experienced by the dying person and those important to them during the last admission leading to death.	Yes	Continuous data collection	Published report expected August 2025
National Audit of Dementia	Royal College of Psychiatrists	Measures the performance of general hospitals in England and Wales against standards which are known to impact people with dementia while in	The provider has confirmed that this audit will not go ahead in 2024/2025		

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2024/2025	Percentage Data completion	Outcome if participated / If did not participate why?
		hospital.			
National Audit of Pulmonary Hypertension	NHS England	The quality of care provided to people referred to pulmonary hypertension services.	Yes	Continuous data collection	No publication date yet identified
National Bariatric Surgery Registry	British Obesity and Metabolic Surgery Society	This registry aims to report on outcomes following bariatric surgery.	The Trust is not eligible to participate in this audit as it does not provide this service.		
National Cancer Audit Collaborating Centre: Breast Cancer, Metastatic	Royal College of Surgeons of England	Aims to report on all patients diagnosed with metastatic breast cancer in NHS hospitals in England and Wales.	Yes	Continuous Data Collection	Published report expected September 2025
National Cancer Audit Collaborating Centre: Breast Cancer, Primary	Royal College of Surgeons of England	Report on all patients newly diagnosed with primary breast cancer (stages 0 to 3) in NHS hospitals in England and Wales.	Yes	Continuous data collection	Published report expected March 2025
National Cancer Audit Collaborating Centre: Kidney Cancer	Royal College of Surgeons of England	Looks at the diagnosis, treatment and management of patients diagnosed with kidney cancer.	Yes	Data collection 1st October 2022 – 30th June 2024	Published report expected September 2025
National Cancer Audit Collaborating Centre: National Bowel Cancer Audit	Royal College of Surgeons of England	Supports hospitals to improve the quality of care received by patients diagnosed for the first time with bowel cancer.	Yes	Data collection 1st April 2022 – 31st March 2023	Report awaiting baseline assessment
National Cancer Audit Collaborating Centre: National Lung Cancer Audit	Royal College of Surgeons of England	Supports lung cancer services in England and Wales to improve the quality of care for people diagnosed with lung cancer	Yes	Continuous data collection	Published report expected April 2025
National Cancer Audit Collaborating Centre: National Esophagogastric Cancer Audit	Royal College of Surgeons of England	This audit evaluates patient care received from diagnosis to completion of primary treatment	Yes	Data collection 1st April 2022 – 31st March 2023	The Trust is compliant with the recommendations of the

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2024/2025	Percentage Data completion	Outcome if participated / If did not participate why?
		delivered in hospital environments.			report.
National Cancer Audit Collaborating Centre: National Prostate Cancer Audit	Royal College of Surgeons of England	The first national clinical audit of the care that men receive following a diagnosis of prostate cancer.	Yes	Data collection 1st October 2022 – 24th June 2024	Published report expected September 2025
National Cancer Audit Collaborating Centre: Ovarian Cancer	Royal College of Surgeons of England	Produces information on diagnosis, treatment and surgery to assess improvements in care.	Yes	Continuous data collection	Published report expected September 2025
National Cancer Audit Collaborating Centre: Pancreatic Cancer	Royal College of Surgeons of England	Aims to accelerate national efforts to improve the care and treatment of patients diagnosed with pancreatic cancer.	Yes	Data collection 1st October 2022 – 30th June 2024	Published report expected September 2025
National Cardiac Arrest Audit	Intensive Care National Audit & Research Centre and the Resuscitation Council UK	Looks at all in-hospital cardiac arrests in the UK and Ireland.	Yes	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme: Left Atrial Appendage Occlusion	National Institute for Cardiovascular Outcomes Research	The aim of this audit is to collect clinical and outcome data on structural heart intervention services carried out in the UK.	Yes	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme: Myocardial Ischaemia National Audit Programme	National Institute for Cardiovascular Outcomes Research	This audit looks at the patient journey from call to emergency services through diagnosis, treatment and discharge.	Yes	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme: National Adult Cardiac Surgery Audit	National Institute for Cardiovascular Outcomes Research	This audit reports on quality measures of all types of cardiac procedures undertaken.	Yes	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme:	National Institute for	This audit collects information about all	Yes	Continuous data	No publication date yet

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2024/2025	Percentage Data completion	Outcome if participated / If did not participate why?
National Audit of Cardiac Rhythm Management	Cardiovascular Outcomes Research	implanted cardiac devices and all patients receiving interventional procedures for the management of cardiac rhythm disorders in the UK.		collection	identified
National Cardiac Audit Programme: National Audit of Percutaneous Coronary Interventions	National Institute for Cardiovascular Outcomes Research	This audit provides an overview of the delivery of PCI services in the UK, as well as reporting on several specific quality improvement metrics	Yes	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme: National Audit of Congenital Heart Disease Audit	National Institute for Cardiovascular Outcomes Research	This audit collects data to assess patient outcomes after therapeutic paediatric and congenital cardiovascular procedures (surgery, transcatheter and electrophysiological interventions) at all NHS hospitals.	Yes	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme: National Heart Failure Audit	National Institute for Cardiovascular Outcomes Research	This audit collects data on patients with an unscheduled admission to hospital in England and Wales who are discharged with a primary diagnosis of heart failure.	Yes	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme: Percutaneous Foramen Ovale Closure	National Institute for Cardiovascular Outcomes Research	The aim of this audit is to collect clinical and outcome data on structural heart intervention services carried out in the UK.	Yes	Continuous data collection	No publication date yet identified
National Cardiac Audit Programme: Transcatheter Aortic Valve Implantation	National Institute for Cardiovascular Outcomes Research	Aims to capture detailed information on how it is used to treat patients with severe aortic	Yes	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2024/2025	Percentage Data completion	Outcome if participated / If did not participate why?
		stenosis and significant comorbidities.			
National Cardiac Audit Programme: Transcatheter Mitral and Tricuspid Valve Procedure	National Institute for Cardiovascular Outcomes Research	The aim of the audit is to collect clinical and outcome data on structural heart intervention services carried out in the UK.	Yes	Continuous data collection	No publication date yet identified
National Child Mortality Database Programme	University of Bristol	Collates information nationally to ensure that deaths are learned from, that learning is widely shared and that actions are taken, locally and nationally, to reduce the number of children who die.	Yes	Continuous data collection	Published report expected July 2025 and December 2025 respectively
National Clinical Audit of Psychosis	Royal College of Psychiatrists	Aims to improve the quality of care that NHS Mental Health Trusts provide to people with psychosis.	The Trust is not eligible to participate in this audit as it does not provide this service.		
National Comparative Audit of Blood Transfusion: Audit of National Institute for Health and Care Excellence Quality Standard 138	NHS Blood and Transplant	A programme which looks at the use and administration of blood and blood components in NHS and independent hospitals in England.	Yes	Data collection 1st October 2024 – 1st November 2024	Published report expected February 2025
National Comparative Audit of Blood Transfusion: Bedside Transfusion Audit	NHS Blood and Transplant	Looks at the use and administration of blood and blood components in NHS & independent hospitals in England.	Yes	Data collection 1st April 2024 – 3rd May 2024	No publication date yet identified
National Diabetes Audit: Diabetes Prevention Programme Audit	NHS Digital	looks at how information on non diabetic hyperglycaemia is recorded in GP practices.	The Trust is not eligible to participate in this audit as this service is provided by Primary Care.		
National Diabetes Audit: National Core	NHS Digital	Collects information on people with	Yes	Continuous data	No publication date yet

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2024/2025	Percentage Data completion	Outcome if participated / If did not participate why?
Diabetes Audit		diabetes and whether they have received their annual care checks and achieved their treatment targets as set out by NICE guidelines.		collection	identified
National Diabetes Audit: National Diabetes Foot Care Audit	NHS Digital	Patients referred to specialist diabetes foot care services for an expert assessment on a new diabetic foot ulcer.	Yes	Continuous data collection	No publication date yet identified
National Diabetes Audit: National Diabetes Inpatient Safety Audit	NHS Digital	This audit is an annual snapshot audit of diabetes inpatient care in England and Wales	The Trust did not participate in this audit due to difficulties in data submission. A plan has been put in place to ensure this does not reoccur in the future, including Caldicott registration.		
National Diabetes Audit: National Pregnancy in Diabetes Audit	NHS Digital	This audit aims to support clinical teams to deliver better care and outcomes for women with diabetes who become pregnant.	Yes	Continuous data collection	No publication date yet identified
National Diabetes Audit: Transition (Adolescents and Young Adults) and Young Type 2 Audit	NHS Digital	The Young People with Type 2 Diabetes report aims to document the number of people with type 2 diabetes up to the age of 40 years, their characteristics and the diabetes care they receive.	Yes	Continuous data collection	No publication date yet identified
National Early Inflammatory Arthritis Audit	British Society of Rheumatologists	This audit aims to improve the quality of care for people living with inflammatory arthritis.	Yes	Continuous data collection	Published report expected October 2025
National Emergency Laparotomy Audit: Laparotomy	Royal College of Anaesthetists	National Emergency Laparotomy Audit aims to look at structure, process, and outcome	Yes	3rd April 2024 – 2nd April 2025	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2024/2025	Percentage Data completion	Outcome if participated / If did not participate why?
		measures for the quality of care received by patients undergoing emergency laparotomy.			
National Emergency Laparotomy Audit: No Laparotomy	Royal College of Anaesthetists	National Emergency Laparotomy Audit aims to look at structure, process, and outcome measures for the quality of care received by patients undergoing emergency laparotomy.	Yes	23rd April 2024 – 22nd April 2025	No publication date yet identified
National Falls and Fragility Fracture Audit Programme: Fracture Liaison Service Database	Royal College of Physicians of London	This audit has developed the Fracture Liaison Service Database to benchmark services and drive quality improvement.	The Trust did not participate in this audit due to clinical and service pressures. Following the appointment of a new Consultant in summer 2025, it is envisaged that this will resume in the next reporting cycle.		
National Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls	Royal College of Physicians of London	This audit provides the first comprehensive data sets on the quality of falls prevention practice in acute hospitals.	Yes	Data collection 1st January 2024 – 31st December 2024	Published report expected November 2025
National Falls and Fragility Fracture Audit Programme: National Hip Fracture Database	Royal College of Physicians of London	This audit measures quality of care for hip fracture patients and has developed into a clinical governance and quality improvement platform.	Yes	Data collection 1st January 2024 – 31st December 2024	Published report expected September 2025
National Joint Registry	Healthcare Quality Improvement Partnership	The registry records and monitors outcomes in a continuous drive to improve service quality.	Yes	Data collection 1st January 2024 – 31st December 2024	Published report expected September 2025
National Major Trauma Registry Network	Outcomes and Registries Programme, NHS England	This audit aims to highlight areas where improvements could be made in	Yes	Continuous data collection	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2024/2025	Percentage Data completion	Outcome if participated / If did not participate why?
		either the prevention of injury or the process of care for injured patients.			
National Maternity and Perinatal Audit	Royal College of Obstetrics and Gynaecology	A large-scale audit of NHS maternity services across England, Scotland and Wales, collecting data on all registrable births delivered under NHS care.	Yes	Continuous data collection	No publication date yet identified
National Neonatal Audit Programme	Royal College of Paediatrics and Child Health	Assesses whether babies requiring specialist neonatal care receive consistent high-quality care and identify areas for improvement in relation to service delivery and the outcomes of care.	Yes	Continuous data collection	No publication date yet identified
National Obesity Audit	NHS Digital	Brings together comparable data from different types of adult and children's weight management services across England to drive improvement for the benefit of those living with overweight and obesity.	Yes	Continuous data collection	No publication date yet identified
National Ophthalmology Database Audit: Age-related Macular Degeneration Audit	Royal College of Ophthalmologists	Aims to provide real-world benchmarks that can enable patients, providers, and commissioners to compare clinical outcomes and key process at different sites to improve the quality of care.	Yes	Continuous data collection	No publication date yet identified
National Ophthalmology	Royal College of Ophthalmologist	This audit measures the outcomes of	Yes	Continuous data	No publication date yet

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2024/2025	Percentage Data completion	Outcome if participated / If did not participate why?
Database Audit: Cataract Audit	s	Cataract surgery.		collection	identified
National Paediatric Diabetes Audit	Royal College of Paediatrics and Child Health	This audit covers registrations, complications, care process and treatment targets.	Yes	Continuous data collection	No publication date yet identified
National Respiratory Audit Programme: Asthma Secondary Care	Royal College of Physicians of London	This audit looks at the care of people admitted to hospital adult services with asthma attacks.	Yes	Continuous data collection	Published report expected June 2025
National Respiratory Audit Programme: Children and Young People Asthma	Royal College of Physicians of London	This audit looks at the care children and young people with asthma receive when they are admitted to hospital because of an asthma attack.	Yes	Continuous data collection	Published report expected June 2025
National Respiratory Audit Programme: Chronic Obstructive Pulmonary Disease Secondary Care	Royal College of Physicians of London	The aim of this audit is to drive improvements in the quality of care and services provided for Chronic Obstructive Pulmonary Disease patients.	Yes	Continuous data collection	Published report expected June 2025
National Respiratory Audit Programme: Pulmonary Rehabilitation	Royal College of Physicians of London	This audit looks at the care people with Chronic Obstructive Pulmonary Disease get in pulmonary rehabilitation services.	Yes	Continuous data collection	Published report expected June 2025
National Vascular Registry	Royal College of Surgeons of England	The National Vascular Registry collects data on all patients undergoing major vascular surgery in NHS hospitals in the UK.	Yes	Continuous data collection	Published report expected November 2025
Out of Hospital Cardiac Arrest Outcomes	University of Warwick	Working with UK Ambulance Services to try and find out the reasons behind differences in survival following out of hospital cardiac	This Trust is not eligible to participate in this audit as this service is provided by Ambulance Services.		

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2024/2025	Percentage Data completion	Outcome if participated / If did not participate why?
		arrest.			
Paediatric Intensive Care Audit Network	University of Leeds	Aims to support the improvement of paediatric intensive care provision throughout the UK by providing detailed information on activity and outcomes.	Yes	Continuous data collection	Published report expected November 2025
Perinatal Mortality Review Tool	Royal College of Emergency Medicine	Aims to introduce the Perinatal Mortality Review Tool to support standardised perinatal mortality reviews across NHS maternity and neonatal units	Yes	Continuous data collection	Published report expected Autumn 2026
Perioperative Quality Improvement Programme	National Perinatal Epidemiology Unit, University of Oxford	Measures complications, mortality and patient reported outcomes from major non-cardiac surgery.	Yes	Continuous data collection	Published report expected July 2025
Prescribing Observatory for Mental Health: Opioid Medications in Inpatient Mental Health Services	Royal College of Psychiatrists	Aims to help clinical services maintain and improve the quality of their prescribing practice and reduce risks	The Trust is not eligible to participate in this audit as it does not provide this service.		
Prescribing Observatory for Mental Health: Rapid Tranquillisation	Royal College of Psychiatrists	Aims to help clinical services maintain and improve the quality of their prescribing practice and reduce risks	The Trust is not eligible to participate in this audit as it does not provide this service.		
Prescribing Observatory for Mental Health: Use of Melatonin	Royal College of Psychiatrists	Aims to help clinical services maintain and improve the quality of their prescribing practice and reduce risks	The Trust is not eligible to participate in this audit as it does not provide this service.		
Quality and Outcomes in Oral and Maxillofacial Surgery: Non-Melanoma Skin Cancers	British Association of Oral and Maxillofacial Surgeons	This audit looks at the rate of diagnostic biopsies and the need for re-operation.	The Trust did not participate in this audit due to clinical and service pressures. Non-participation was discussed and agreed at Clinical Outcomes and Effectiveness Group.		

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2024/2025	Percentage Data completion	Outcome if participated / If did not participate why?
Quality and Outcomes in Oral and Maxillofacial Surgery: Oncology and Reconstruction	British Association of Oral and Maxillofacial Surgeons	This audit looks at complications, postoperative stays and commencement of radiotherapy.	The Trust did not participate in this audit due to clinical and service pressures. Non- participation was discussed and agreed at Clinical Outcomes and Effectiveness Group.		
Quality and Outcomes in Oral and Maxillofacial Surgery: Oral and Dentoalveolar Surgery	British Association of Oral and Maxillofacial Surgeons	This audit looks at treatment pathway timings, management, length of stay and procedure outcomes.	The Trust did not participate in this audit due to clinical and service pressures. Non- participation was discussed and agreed at Clinical Outcomes and Effectiveness Group.		
Quality and Outcomes in Oral and Maxillofacial Surgery: Orthognathic Surgery	British Association of Oral and Maxillofacial Surgeons	The Orthognathic registry assess quality of care across all orthognathic surgery activity but mainly focuses on LeFort I and mandibular ramus osteotomies.	The Trust did not participate in this audit due to clinical and service pressures. Nonparticipation was discussed and agreed at Clinical Outcomes and Effectiveness Group.		
Quality and Outcomes in Oral and Maxillofacial Surgery: Trauma	British Association of Oral and Maxillofacial Surgeons	This audit looks at unexpected returns to theatre, readmissions after discharge and complications.	The Trust did not participate in this audit due to clinical and service pressures. Nonparticipation was discussed and agreed at Clinical Outcomes and Effectiveness Group.		
Sentinel Stroke National Audit Programme	Kings College London	This audit collects data on all patients with a primary diagnosis of stroke, including any patients not on a stroke ward.	Yes	Continuous data collection	Published report expected November 2025
Serious Hazards of Transfusion UK National Hemovigilance Scheme	Serious Hazards of Transfusion	Collects and analyses anonymised information on adverse events and reactions in blood transfusion from all healthcare organisations that are involved in the transfusion of blood and blood components	Yes	Continuous data collection	Published report expected July 2026
Society for Acute Medicine Benchmarking Audit	Society for Acute Medicine	The aim is to describe the severity of illness of acute medical patients presenting to acute medicine, the speed of their assessment, their	Yes	Data collection 20th June 2024	No publication date yet identified

National Audit issue	Sponsor / Audit	What is the Audit about?	Trust participation in 2024/2025	Percentage Data completion	Outcome if participated / If did not participate why?
		pathway and progress at seven days after admission and to provide a comparison for each participating unit with the national average.			
UK Cystic Fibrosis Registry	Cystic Fibrosis Trust	This audit looks at the care of people with a diagnosis of cystic fibrosis under the care of the NHS.	Yes	Continuous data collection	Published report expected August 2026
UK Renal Registry: Chronic Kidney Disease Audit	UK Kidney Association	The care provided to patients with chronic kidney disease (including pre-Kidney Replacement Therapy) at each of the UK's adult and paediatric kidney centres against the UK Kidney Association's guidelines	Yes	1st January 2023 – 31st December 2023	Published report expected June 2025
UK Renal Registry: National Acute Kidney Injury Unit	UK Kidney Association	the care provided to patients with chronic kidney disease (including pre-Kidney Replacement Therapy) at each of the UK's adult and paediatric kidney centres against the UK Kidney Association's guidelines	Yes	1st April 2024 – 31st March 2025	Published report expected June 2025

An additional 14 audits have been added to the list for inclusion in 2025/2026 Quality Account. The audits include:

- British Spine Registry
- Emergency Medicine Quality Improvement Programme: Mental Health Self Harm
- National Audit of Eating Disorders
- National Cancer Audit Collaborating Centre: National Non-Hodgkin Lymphoma Audit

- National Comparative Audit of Blood Transfusion: 2025 Major Haemorrhage Audit
- Prescribing Observatory for Mental Health: Improving the quality of valproate prescribing in adult mental health services, Use of clozapine and, Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services.
- UK Cystic Fibrosis Registry: Cystic Fibrosis Adults and Cystic Fibrosis Children.

The reports of national clinical audits were reviewed in 2024/2025 and the Trust intends to take the following actions to improve the quality of healthcare provided:

- The Trust has firmly embedded monitoring arrangements for national clinical audits with the identified lead clinician asked to complete an action plan and present this to the Clinical Audit and Guidelines Group.
- On an annual basis the group receives a report on the projects in which the Trust participates and requires the lead clinician of each audit programme to identify any potential risk, where there are concerns action plans will be monitored on a regular basis.
- In addition, each Clinical Board is required to present an annual clinical audit report to the clinical audit and guidelines group detailing all audit activity undertaken both national and local. Clinicians are required to report all audit activity using the Trust's clinical effectiveness register.
- Clinical Boards are asked to include national clinical audit as a substantive agenda item at their Quality Oversight Group meetings, to review any areas required for improvement.
- Compliance with national confidential enquiries is reported to the Clinical Outcomes and Effectiveness Group and exceptions subject to detailed scrutiny and monitored accordingly.
- Non-compliance with recommendations from national clinical audit and national confidential enquiries are considered in the annual business planning process.

The reports of 502 local audits were reviewed in 2024/2025 and the Trust intends to take the following action to improve the quality of health care provided:

- Each Clinical Board is required to present an Annual Clinical Audit Report to the Clinical Audit and Guidelines Group detailing all audit activity undertaken both national and local.
- Any areas of non-compliance with standards are risk assessed and escalated as appropriate to the Clinical Outcomes and Effectiveness Group.

INFORMATION ON PARTICIPATION IN CLINICAL RESEARCH

In the last year over 11,304 participants were recruited to clinical trials provided or hosted by Newcastle Hospitals, of which 10,216 enrolled onto the National Institute for Health and Care Research Clinical Research Network portfolio studies.

A wide range of clinical trials take place, ranging from complex and rare disease to common conditions that affect many of our patients.

One such trial AuToDeCRA2 shows a promising potential treatment for rheumatoid arthritis called tolerogenic dendritic cell therapy. This treatment could provide significant benefits to people living with rheumatoid arthritis by ‘switching off’ the disease and avoiding the need for life-long treatments, with their associated side effects.

The Trust continues to be one of the top research trusts in the country for the number of individuals participating in research and for the number of studies open.

INFORMATION ON THE USE OF THE COMMISSIONING FOR QUALITY AND INNOVATION INDICATORS FRAMEWORK

NHS England did not operate the nationally mandated Commissioning for Quality and Innovation scheme in 2024/2025, however they did continue to publish Commissioning for Quality and Innovation indicators as a non-mandatory list. These optional indicators were generated on the basis that they form part of wider national delivery goal and had broad stakeholder and clinical support. Trust participation in these Commissioning for Quality and Innovation schemes was reviewed and a number were continued in 2024/2025.

These Commissioning for Quality and Innovation schemes included:

- Staff flu vaccinations
- Recording of and appropriate response to National Early Warning Score 2 (NEWS2) for unplanned critical care admissions
- Identification and response to frailty in emergency departments
- Prompt switching of intravenous antimicrobial treatment to the oral route of administration as soon as patients meet switch criteria
- Timely communication of changes to medicines to community pharmacists via the Discharge Medicines Service
- Achieving progress towards Hepatitis C elimination within lead Hepatitis C centres
- Achievement of revascularisation standards for lower limb ischaemia.

INFORMATION RELATING TO REGISTRATION WITH THE CARE QUALITY COMMISSION

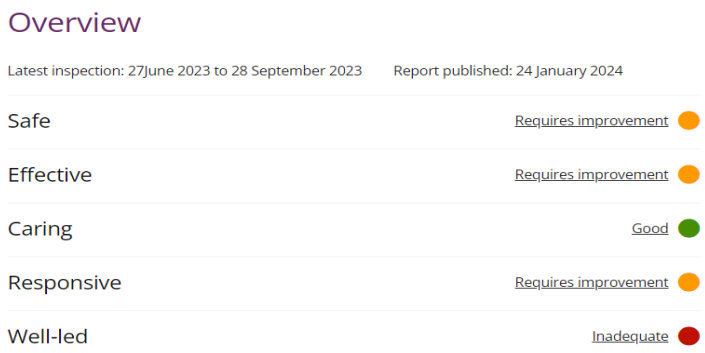
Newcastle Hospitals is required to register with the Care Quality Commission and its current registration status is fully registered. Newcastle Hospitals currently has no conditions imposed on its registration.

We are registered with the Care Quality Commission to deliver care from seven separate locations and 21 community locations for ten regulated activities.

In 2023, the Care Quality Commission visited the Trust. They looked at how the organisation was led and assessed some services at the Royal Victoria Infirmary and Freeman Hospital, which included urgent and emergency care, medicine, surgery, maternity, children and young people, as well as NECTAR the regional patient transport service. They also spent some time in the cardiothoracic surgery department.

The inspectors found that overall Newcastle Hospitals' 'requires improvement'. They also highlighted areas for improvement with the way some services are run and that changes were required to ensure that learning always takes place when things don't go as planned.

Following the inspection by the Care Quality Commission in 2023, a Notice of Decision to impose conditions on the Trust license was issued on 18th December 2023. This notice outlined the need to implement an effective governance system. In response to the inspection findings, we acted quickly to implement a rapid and focused programme of improvement which was reported monthly to the Care Quality Commission. Following significant progress, the license conditions were removed on 3rd September 2024.



INFORMATION ON THE QUALITY OF DATA

The Newcastle upon Tyne Hospitals NHS Foundation Trust submitted records during 2024/2025 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Which included the patient's valid NHS number was:

- 99.6% for admitted patient care.
- 99.8% for outpatient care.
- 99.0% for accident and emergency care.

Which included the patients valid General Medical Practice Code was:

- 99.9% for admitted patient care.
- 100.0% for outpatient care.
- 100.0% for accident and emergency care.

Clinical Coding Information

Score for 2024/2025 for Information Quality and Records Management, assessed using the Data Security and Protection Toolkit.

Our annual Data Security and Protection Clinical Coding audit for diagnosis and treatment coding of inpatient activity demonstrated an excellent level of attainment and satisfies the requirements of the Data Security and Protection Toolkit Assessment.

200 episodes of care were audited, covering the following three specialties:

- Neurosurgery
- Cardiothoracic Surgery
- Gynaecology.

The level attained for Data Security Standard 1 Data Quality – Standards Exceeded.
The level attained for Data Security Standard 3 Training – Standard Exceeded.

Table shows the levels of attainment of coding of inpatient activity:

	Levels of Attainment		
	Standards Met	Standards Exceeded	Trust Level
Primary diagnosis	>=90%	>=95%	99.5%
Secondary diagnosis	>=80%	>=90%	98.2%
Primary procedure	>=90%	>=95%	97.0%
Secondary procedure	>=80%	>=90%	96.5%

KEY NATIONAL PRIORITIES 2024/2025

The key national priorities are performance targets for the NHS, which are determined by the Department of Health and Social Care and form part of the Care Quality Commission Intelligent Monitoring Report. A wide range of measures are included and the Trust's performance against the key national priorities for 2024/2025 are detailed in the table below.

Operating and Compliance Framework Target	Target	Annual Performance 2023/2024	Annual Performance 2024/2025
Incidence of *Clostridioides difficile* infections (*C .difficile:* variance from plan)	National Threshold ≤136	144 cases	197 cases
Incidence of Methicillin-resistant *Staphylococcus aureus* bacteraemia	Zero tolerance	4 cases	7 cases
28 day faster diagnosis standard - wait from urgent referral to patient told they have cancer (or cancer is definitively excluded)	77%	76.5%	74.4% (Provisional Apr-Mar)
31 day (decision to treat to treatment) - wait from a decision to treat/earliest clinically appropriate date to first or subsequent treatment of cancer	96%	86.3%	81.3% (Provisional Apr-Mar)
62 day (referral to treatment) - wait from an urgent suspected cancer or breast symptomatic referral, or urgent screening referral, or consultant upgrade to a first definitive treatment for cancer	70%	56.7%	62.0% (Provisional Apr-Mar)
referral to treatment - admitted compliance	90%	65.6%	67.8%
referral to treatment - non-admitted compliance	95%	76.7%	75.5%
referral to treatment - incomplete compliance	92%	67.1%	68.7%
maximum 6-week wait for diagnostic procedures	95%	66.9%	84.2%
Emergency Depatment: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	76%	75.65%	74.9%
cancelled operations – those not admitted within 28 days	Not defined	79.39%	78.49%
*maternity bookings within 9 weeks 6 days	Not Defined	65.83%	69.25%

Details on Hospital-level Mortality Indicator please refer to page 60.

We have detailed below some of the reasons for not meeting the required standards.

1. **Infection Prevention and Control:** Increase in the number of Methicillin-resistant *Staphylococcus aureus* bacteraemia cases.

Regional Methicillin-resistant *Staphylococcus aureus* bacteraemia bloodstream infections have increased in comparison to national figures. Investigations have identified poor compliance with Methicillin-resistant *Staphylococcus aureus* bacteraemia screening and decolonisation, issues with line documentation and wound management and poor antimicrobial stewardship, and an action plan is in place.

To address this we are:

- Looking at patient level data on inappropriate antibiotic prescriptions for Methicillin-resistant *Staphylococcus aureus* bacteraemia.
- Working to initiate a 'flag' to alert clinicians that patients have a relevant history of antimicrobial issues.
- Undertaking audits for Methicillin-resistant *Staphylococcus aureus* bacteraemia screening compliance and themes disseminated.
- Increased the visibility if the infection control team to support the clinical areas.

2. Increase in the number of *Clostridioides difficile* Infections cases.

Clostridioides difficile infection rates in England have risen by 50%, North East and North Cumbria have reported a rise of 30%, which is mirrored in the Trust figures. Themes identified are delays in sampling, delay in isolation, delay in obtaining treatment and poor antimicrobial stewardship and proton pump inhibitors management.

To address this we are:

- Introducing an end of shift nursing digital assessment document
- Raising awareness of isolation and encouraging clinical teams to report when isolation cannot be achieved. These incidents continue to be reviewed, with escalation when required.
- A robust process for antimicrobial review in *Clostridioides difficile* infection cases with the antimicrobial pharmacist continues to support real time feedback to clinical teams and rapid improvement actions.
- Weekly infection prevention and control multi-disciplinary team bloodstream infection and *clostridioides difficile* infection review process, to identify emerging themes and classifications of healthcare associated infections.

Cancer Wait times

A number of issues have contributed to this position including increased demand across all services and capacity across all pathways. Pressures in primary care have had an impact in relation to dermatology.

Our focus on reducing the over 62 day backlog has impacted on our overall 62 day performance, and some capacity and scheduling issues in radiotherapy have had an impact on 31 day compliance.

To address this we have:

- Undertaken analysis for all major pathways, identifying areas which will deliver greatest improvement and impact on performance, and implemented actions.

- Implementation of the best practice, timed pathways across the region.
- Increasing capacity in key areas:
    - Looking to increase endobronchial ultrasound capacity, navigational bronchoscopy and ablation
    - Initiatives to reduce demand on cancer pathways e.g. development of a nodule clinic in lung and rollout of a breast pain and bleeding on HRT pathway
    - Development of pre-assessment clinic slots in pressured tumour areas
    - Increased capacity for cancer patients in outpatients, pre-assessment clinic and endoscopy
    - Improved our ability to discuss patient treatments options by increasing access to multidisciplinary team discussions
    - Plans underway to start a community photography hub to allow high quality images to be taken prior to referral, which will result in less patients requiring a face to face appointment before a decision is made on treatment options.
- Implemented a combined gastrointestinal pathway which has seen 28 day performance in both Upper and Lower gastrointestinal rise to over 80%.
- Improved pathology and radiology cancer turnaround times
- Developed straight to test pathways e.g. lung, prostate, gynaecology.

It should be noted that harm reviews are completed on all patients who have waited over 104 days.

Referral to Treatment Targets:

Over the last year, the overall referral to treatment incomplete performance has remained at around 68% although most recently achieving 70%. The national planning guidance aims for 74% by April 2026 moving to achieve 92% over the next 5 years.

There has been an unrelenting focus on treating the longest waiters and a significant achievement has been to maintain zero patients waiting over 104 weeks for treatment. There has also been a significant reduction in 78 and 65 week waiting. Patients on the waiting list continue to be prioritised by clinical need and longest waits.

Maximum 6-week wait for diagnostic procedures

There has been a notable improvement in this key national priority from 66.9% to 84.2%. This has in the main, been due to audiology undertaking a targeted piece of work to reduce the waiting list.

Emergency Department: maximum waiting time of 4 hours from arrival to admission/transfer/discharge:

Over the first half of the year there were significant gaps in the Emergency Department medicine rota which has now been resolved through investment and recruitment. In the second part of the year high occupancy levels and infection outbreaks affected flow.

CORE SET OF QUALITY INDICATORS

Data is compared nationally when available from the NHS Digital Indicator portal. Where national data is not available the Trust has reviewed our own internal data.

Measure	Data Source	Target	Value	2024/25		2023/2024				2022/2023			
1. The value and banding of the summary hospital-level mortality indicator for the Trust	NHS Digital Indicator Portal https://digital.nhs.uk/data-and-information/publications/statistical/shmi	Band 2 as expected		Oct23 - Sept 24 **NUTH Value:** 0.9128 **NUTH Band 2**	Jul23 - Jun 24 **NUTH Value:** 0.9177 **NUTH Band 2**	Apr23 - Mar 24 **NUTH Value:** 0.9128 **NUTH Band 2**	Jan23 - Dec 23 **NUTH Value:** 0.9011 **NUTH Band 2**	Oct22 – Sept 23 **NUTH Value:** 0.9095 **NUTH Band 2**	Jul22 - Jun 23 **NUTH Value:** 1.0095 **NUTH Band 2**	Apr22 - Mar 23 **NUTH Value:** 0.9170 **NUTH Band 2**	Jan22 - Dec 22 **NUTH Value:** 0.9167 **NUTH Band 2**	Oct21 – Sept 22 **NUTH Value:** 0.9105 **NUTH Band 2**	Jul21 - Jun 22 **NUTH Value:** 0.9148 **NUTH Band 2**
			National Average	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
			Highest National	1.3094	1.3121	1.3193	1.2548	1.2293	1.2129	1.2074	1.2186	1.2340	1.2112
			Lowest National	0.6968	0.6946	0.7142	0.7202	0.6770	0.7097	0.7191	0.7117	0.6454	0.7047
2. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust	NHS Digital Indicator Portal https://digital.nhs.uk/data-and-information/publications/statistical/shmi	N/A	Trust	47%	48%	47%	44%	41%	29%	39%	40%	41%	41%
			National Average	44%	44%	43%	42%	42%	41%	40%	40%	40%	40%
			Highest National	67%	69%	67%	67%	66%	66%	66%	65%	65%	65%
			Lowest National	17%	18%	11%	16%	15%	14%	14%	12%	12%	12%

Measure 1. The value and banding of the summary hospital-level mortality indicator for the Trust.

Newcastle Hospitals considers that this data is as described for the following reasons:

The trust continues to perform well on mortality indicators. Mortality reports are regularly presented to the Trust Board. The Newcastle Hospitals has taken the following actions to improve this indicator, and so the quality of its services by closely monitoring mortality rates and conducting detailed investigations when rates increase. We continue to monitor and discuss mortality findings at the Quarterly Mortality Surveillance Group; representatives attend this group from multiple specialities and scrutinise Trust mortality data to ensure local learning and quality improvement. This group complements the departmental mortality and morbidity meetings within each speciality of all clinical boards.

Measure 2. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust.

Newcastle Hospitals considers that this data is as described for the following reasons:

The use of palliative care codes in the trust has remained static and aligned to the national average percentage over recent years. The Newcastle Hospitals continues

to monitor the quality of its services, by involving the Coding team and End of Life team in routine mortality reviews to ensure accuracy and consistency of palliative care coding. We continue to monitor and discuss patients with a palliative care coding at the quarterly Mortality Surveillance Group.

Measure 3. The Patient Reported Outcome Measures scores for groin hernia surgery.

Collection of groin procedure scores ceased on 1 October 2017.

Measure 4. The Patient Reported Outcome Measures scores for varicose vein surgery.

Collection of varicose vein procedure scores ceased on 1 October 2017.

Measure 5. The Patient Reported Outcome Measures scores for hip replacement surgery.

Measure	Value	2023/24	2022/23	2021/22	2020/21	2019/20	2018/19
5. The patient reported outcome measures scores (PROMS) for primary hip replacement surgery (adjusted average health gain – EQ5D)	Trust Score	*	**0.52**	**0.47**	**0.52**	**0.46**	**0.50**
	National average:	0.46	0.46	0.46	0.47	0.46	0.47
	Highest national:	0.58	0.55	0.53	0.57	0.54	0.56
	Lowest national:	0.35	0.36	0.37	0.39	0.35	0.35
6. The patient reported outcome measures scores (PROMS) for primary knee replacement surgery (adjusted average health gain – EQ5D)	Trust Score	*	**0.38**	*	**0.35**	**0.36**	**0.31**
	National average:	0.32	0.33	0.32	0.32	0.34	0.34
	Highest national:	0.41	0.41	0.42	0.40	0.42	0.41
	Lowest national:	0.23	0.24	0.25	0.18	0.22	0.27

Newcastle Hospitals considers that this data is as described for the following reasons:

Patient Reported Outcome Measures scores are good, and we are committed to increasing our participation rates going forward. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty multidisciplinary team.
Finalised Patient Reported Outcome Measures scores data have now been published for 2022/2023 and 2023/2024; in 2023/2024 the number of modelled records for both primary hip are less than 30 for NUTH so the health gain figures are not shown for the Trust.

Measure 6. The Patient Reported Outcome Measures scores for knee replacement surgery.

Newcastle Hospitals considers that this data is as described for the following reasons:
Patient Reported Outcome Measures scores are good, and we are committed to increasing our participation rates going forward. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty multidisciplinary team.

Finalised Patient Reported Outcome Measures scores data have now been published for 2022/2023 and 2023/2024; in 2023/2024 the number of modelled records for primary knee are less than 30 for NUTH so the health gain figures are not shown for the Trust.

Measure 7. The percentage of patients aged— (i) 0 to 15; and (ii) 16 or over readmitted within 28 days of being discharged from hospital.
7a. Emergency readmissions to hospital within 28 days of discharge from hospital: Children of ages 0-15.

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
2012/2013	31,841	2,454	7.7
2013/2014	32,242	2,648	8.2
2014/2015	34,561	3,570	10.3
2015/2016	38,769	2,875	7.4
2016/2017	35,259	1,983	5.6
2017/2018	35,009	2,077	5.9
2018/2019	36,387	2,003	5.5
2019/2020	42,238	4,609	10.9
2020/2021	29,319	2,643	9.0
2021/2022	34,112	3,080	9.0
2022/2023	33,945	2,859	8.4
2023/2024	33,865	2,637	7.8
2024/2025	34,573	2,914	8.4

7b. Emergency readmissions to hospital within 28 days of being discharged aged 16+.

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
2012/2013	173,270	8,788	5.1
2013/2014	177,867	9,052	5.1
2014/2015	180,380	9,446	5.2
2015/2016	182,668	10,076	5.5
2016/2017	186,999	10,219	5.5
2017/2018	182,535	10,157	5.6
2018/2019	185,967	10,461	5.6
2019/2020	192,365	12,648	6.6
2020/2021	142,629	10,730	7.5
2021/2022	185,434	12,104	6.5
2022/2023	193,003	13,575	7.0
2023/2024	203,143	15,065	7.4
2024/2025	212,005	15,907	7.5

This indicator was last updated in December 2013 and future releases have been suspended pending a methodology review. Therefore, the trust has reviewed its own

internal data and used its own methodology of reporting readmissions within 28 days (without Payment by Results exclusions). The Newcastle Hospitals considers that this data is as described for the following reasons: The trust has a robust reporting system in place and adopts a systematic approach to data quality improvement.

Newcastle Hospitals intends to take the following actions to improve this indicator, and so the quality of its services, by continuing with the use of an electronic system.

Measure 8. The Trust's responsiveness to the personal needs of its patients.

Measure	Data Source	Value	2022/23	2021/22	2020/21	2019/20	2018/19	2017/18
8. The Trust's responsiveness to the personal needs of its patients	NHS Information Centre Portal https://indicators.ic.nhs.uk/	Trust percentage	Ceased Publication August 2020	Ceased Publication August 2020	77.7%	72.6%	73.1%	74.9%
		National Average:			74.5%	67.1%	67.2%	68.6%
		Highest National:			85.4%	84.2%	85.0%	85.0%
		Lowest National:			67.3%	59.5%	58.9%	60.5%

This data used in the table above ceased to be published in August 2020.To assign a score to indicate the patient experience, the table below uses the Care Quality Commission benchmark data from the National Adult Inpatient Survey. The data shows that the Trust scores above the national average in this indicator. The results of the Inpatient 2023 survey were published in August 2024. The 2024 survey results are due to be published in August 2025.

Measure	Data Source	Value (out of 10)	2023 (Published August 2024)	2022 (Published Sept 2023)	2021 (Published August 2022)
8. Overall rating of experience	CQC Benchmark results for National Adult Inpatient Survey Adult inpatient survey 2022 - Care Quality Commission (cqc.org.uk)	Trust score	8.3	8.4	8.6
		National Average score:	8.1	8.1	8.1
		Highest National:	9.3	9.3	9.4
		Lowest National:	7.5	7.4	7.4

Measure 9. The percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends changed to "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation" in 2021/2022 survey and has continued to be the same for the 2023/2024 survey. It has also changed from question ID 23d to 25d.

Measure	Data Source	Value	2024/25	2023/24	2022/23	2021/22	2020/21	2019/20
9. The percentage of staff employed by, or under contract to, the trust who would recommend the trust as a provider of care to their family or friends	http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/Results/	Trust percentage	76.6%	77.4%	82.6%	85.4%	91.3%	90%
		National Average	61.5%	63.3%	61.9%	66.9%	74.3%	71%
		Highest National	89.6%	88.9%	86.4%	89.5%	91.7%	95%
		Lowest National	39.7%	44.3%	39.2%	43.6%	49.7%	36%

Newcastle Hospitals considers that this data is as described for the following reasons:
The Trust continues to score well above the National average in relation to staff survey Q25d. By ensuring all colleagues have a voice and continuing to listen and act on all sources of staff feedback, The Newcastle Hospitals is committed to maintaining the highest quality of services for both patients/service users and its staff.

Measure 10. The percentage of patients that were admitted to hospital who were risk assessed for Venous thromboembolism

Measure	Data Source	Target	2024/25				2023/24			
10. The percentage of patients that were admitted to hospital who were risk assessed for Venous thromboembolism	https://www.england.nhs.uk/statistics/statistical-work-areas/vte/	Trust %	Q4	Q3 92%	Q2 89%	Q1 88%	Q4	Q3	Q2	Q1
		National Average:	Not available	90%	89%	89%	Not available	Not available	Not available	Not available
		Highest National:	Not available	**100%**	**100%**	**100%**	Not available	Not available	Not available	Not available
		Lowest National:	Not available	**14%**	**14%**	**15%**	Not available	Not available	Not available	Not available

National data collection has now resumed post COVID-19.

Measure 11. The number of cases of *Clostridioides difficile* infection reported within the Trust amongst patients aged 2 or over

Measure	Data Source	Target	2024/2025	2023/2024	2022/2023	2021/2022	2020/2021
11. The number of cases of *Clostridioides difficile* infections reported within the Trust amongst patients aged two or over	UKHSA Data Capture System	Trust number of cases	197 HOHA* = 157 COHA* = 40	144 HOHA* = 114 COHA* = 30	172 HOHA* = 138 COHA* = 34	169 HOHA* = 135 COHA* = 34	111 HOHA* = 85 COHA* = 26
		National Average number of cases	HOHA* = 62 COHA* = 24	HOHA* = 56 COHA* = 21	HOHA* = 53 COHA* = 19	HOHA* = 44 COHA* = 18	HOHA* = 36 COHA* = 16
		Highest National number of cases	HOHA* = 315 COHA* = 79	HOHA* = 275 COHA* = 82	HOHA* = 212 COHA* = 76	HOHA* = 189 COHA* = 76	HOHA* = 151 COHA* = 60
		Lowest National number of cases	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0

*HOHA = Hospital Onset – Healthcare Associated
*COHA = Community Onset – Healthcare Associated

Newcastle Hospitals considers that this data is as described for the following reasons: The Trust has robust mechanisms for Healthcare Associate Infections reporting and investigation with mitigations in place to provide assurance of patient safety. The Newcastle Hospitals have taken the following remedial actions:

- Formulation of clinical board specific action plans, addressing themes from their of *Clostridioides difficile* infection cases. These action plans will be monitored within clinical boards with oversight from the Infection Prevention and Control Committee.
- Introduction of the end of shift nursing digital assessment document to assist in the improvement of stool documentation.
- The Infection Prevention and Control team are raising awareness regarding isolation, and encouraging clinical teams to report incidents whereby isolation cannot be achieved due to a lack of isolation facilities due to high occupancy levels. These incidents continue to be reviewed in the Infection Prevention and Control Operational Group, with escalation to Board when required.
- A structured robust process for antimicrobial review in *Clostridioides difficile* infection cases with Antimicrobial Pharmacist continues. The in-depth review supports real time feedback to clinical teams and implementation of rapid improvement actions to facilitate safe and high standards of care.
- This is supported by the weekly Infection Prevention and Control multi-disciplinary team Bloodstream Infection and *Clostridioides difficile* infection review process which has been pivotal in helping us identify emerging themes and classifications of Healthcare Associate Infections.

Measure 12. The number and rate of patient safety incidents reported

Measure	Data Source	Target	2024/2025	2023/2024	2022/2023	2021/2022
12. The number and rate per 100 admissions of patient safety incidents reported *NB: Changed to rate per 1000 bed days April 2014*	NHS Information Centre Portal https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/	Trust no.	April 2024 – March 2025 21,768	April 2023 – March 2024 20,909	April 2022 – March 2023 20,464	April 2021 – March 2022 18,440
		Trust %	40.56	39.3	38.7	37.5
		National Average	Not available	Not available	Not available	Not available
		Highest National	Not available	Not available	Not available	Not available
		Lowest National	Not available	Not available	Not available	Not available

The Newcastle Hospitals considers that this data is as described for the following reasons:
In January 2024 the Trust introduced the Patient Safety Incident Response Framework which resulted in new processes for review and escalation of incidents.
Incident data, themes and organisational learning is reported annually through the Trusts governance structures to Quality Committee and Trust Board.
Trust patient safety priorities have been agreed, and quality improvement projects are in progress. Details can be found in the Trust Patient Safety Incident Reporting Plan.
Incident reporting and learning is discussed at monthly Clinical Board Quality Oversight Groups.
Work has been undertaken to identify low incident reporting areas, understand the reasons for this and provide support to improve incident reporting rates.
Formal and ad-hoc training and education has been provided to support staff to understand the importance of incident reporting and how to report incidents
Patient safety communication, for example the Patient Safety Bulletin and Patient Safety Briefing, has been shared Trust wide. Information provided includes learning from good practice as well as patient safety incidents and is directly related to the clinical environment.

Measure 13. The number and percentage of patient safety incidents that resulted in severe harm or death

Measure	Data Source	Target	2024/20245		2023/2024		2022/2023	
13. The number and percentage of patient safety incidents that resulted in severe harm or death	NHS Information Centre Portal https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/	Trust no.	April 2024 – March 2025 **Death** 28	April 2024 – March 2025 **Severe Harm** 84	April 2023 – March 2024 **Severe Harm** 115	April-2023 March 2024 **Death** 50	April 2022 – March 2023 **Severe Harm** 88	April 2022 – March 2023 **Death** 53
		Trust %	0.4%	0.1%	0.6%	0.2%	0.4%	0.2%
		National Average	Not available	Not available	Not available	Not available	Not available	Not available
		Highest National	Not available	Not available	Not available	Not available	Not available	Not available
		Lowest National	Not available	Not available	Not available	Not available	Not available	Not available

The Newcastle Hospitals considers that this data is as described for the following reasons:
The introduction of the Patient Safety Incident Response Framework has introduced new ways in which the Trust investigates and learns from incidents with significant harm.
Patient Safety Leads in each Clinical Board review all moderate and above harm incident reports and undertake a rapid review where appropriate, as defined by internal processes.
Trust oversight of moderate and above harm incidents is through a weekly Response Action Review Meeting, which includes membership from the Integrated Care Board and NHS England as well as Trust Executive Directors.
The learning response outcomes allocated at the Response Action Review Meeting are closely monitored through the Patient Safety Group, and investigation findings are shared at the monthly Patient Safety Incident Forum.
Where appropriate, incident investigations undertaken in collaboration with neighbouring Trusts and findings and recommendations are shared across the Integrated Care Board.
Learning from incidents is shared across the Trust through a number of forums.

WORKFORCE FACTORS

The tables below provide data on the loss of workdays. The table directly below reports on the Trust and regional position rate (data taken from the NHS Information Centre) and the next table provides an update on the Trust number of staff sick days lost to industrial injury or illness caused by work.

This table shows the loss of workdays (rate).

	Dec 2023	Jan 2024	Feb 2024	Mar 2024	Apr 2024	May 2024	Jun 2024	Jul 2024	Aug 2024	Sept 2024	Oct 2024	Nov 2024
The Newcastle Upon Tyne Hospitals	5.69	6	5.71	5.37	5.23	5.1	5.07	5.23	4.94	5.02	5.67	5.73
South Tyneside and Sunderland	6.11	6.48	5.98	5.47	5.57	5.58	5.43	6.19	5.95	5.94	6.54	6.87
County Durham and Darlington	6.07	6.25	5.88	5.45	5.7	5.5	5.39	5.83	5.42	5.26	5.73	6.13
Gateshead Health	6.03	6.29	5.59	5.2	5.52	5.64	5.5	5.33	4.75	5.33	6.3	6.18
North Tees and Hartlepool	5.96	5.9	5.61	5.73	5.79	5.74	5.66	5.99	5.72	5.73	6.13	6.19
Northumbria Healthcare	6.03	6.05	5.48	5.2	5.29	5.05	5.02	5.16	4.81	5.07	5.79	5.98
South Tees Hospitals	6.34	6.58	5.75	5.34	5.28	5.25	5.3	5.7	5.36	5.32	5.98	5.99
England	5.51	5.48	5.1	4.74	4.76	4.71	4.87	5.2	4.79	4.96	5.41	5.43

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year Total
2014/15 no. of days	333	284	178	206	1001
2015/16 no. of days	360	194	365	219	1138
2016/17 no. of days	230	387	136	84	837
2017/18 no. of days	137	90	51	122	400
2018/19 no. of days	214	131	188	326	859
2019/20 no. of days	249	172	67	123	611
2020/21 no. of days	65	61	335	212	673
2021/22 no. of days	318	475	618	409	1820
2022/23 no. of days	319	119	139	321	898
2023/24 no.of days	525	381	445	457	1808
2024/25 no.of days	251	306	557	526	1640

2024 NHS STAFF SURVEY RESULTS SUMMARY

The last few years have been exceptionally difficult for everyone working in the NHS, and it is important to hear what colleagues think about working in our Trust – to help improve working lives.

A full census survey was sent via email to all eligible employees of the Trust (via external post for those on maternity leave), giving all 16,353 members of our staff a voice. 10,371 staff participated in the survey, equalling a response rate of 64%, which is a 60% improvement on the 2023 response returns of 6,457.

The NHS Staff Survey is aligned to the NHS People Promise. This sets out the things that would most improve their working experience, and is made up of seven elements:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team.

Alongside the NHS People Promise are two main themes:

- Staff Engagement
- Morale.

Newcastle Hospitals People Promise Benchmarked Results:

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.17	5.70	6.59	6.08	5.50	5.93	6.48	6.83	5.93
Best result	7.69	6.30	7.14	6.53	6.09	6.86	7.12	7.39	6.38
Average result	7.21	5.92	6.67	6.09	5.64	6.24	6.74	6.84	5.93
Worst result	6.61	5.24	5.95	5.54	4.76	5.60	6.26	5.98	5.13
Responses	10334	10337	10236	10266	9919	10252	10305	10350	10348

All seven People Promise elements are recording higher scores in 2024 compared to 2023, with **all** People Promise sections showing statistically significant improvement, these are:

People Promise elements	2023 score	2023 respondents	2024 score	2024 respondents	Statistically significant change?
We are compassionate and inclusive	7.09	6444	7.17	10334	Significantly higher
We are recognised and rewarded	5.59	6451	5.70	10337	Significantly higher
We each have a voice that counts	6.49	6375	6.59	10236	Significantly higher
We are safe and healthy	5.95	6398	6.08	10266	Significantly higher
We are always learning	5.32	6258	5.50	9919	Significantly higher
We work flexibly	5.72	6414	5.93	10252	Significantly higher
We are a team	6.34	6420	6.48	10305	Significantly higher
Themes					
Staff Engagement	6.76	6446	6.83	10350	Significantly higher
Morale	5.76	6452	5.93	10348	Significantly higher

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

Although we have seen a statistical improvement over time across all our People Promise domains, we still fall below the national average when compared to other NHS Trusts:

2024 scores vs NHS average and NHS best	CDDFT	STSFT	North Tees	South Tees	Gateshead	Newcastle	Northumbria	NHS Average	NHS best
We are compassionate and inclusive	7.18	7.33	7.36	7.16	7.36	7.17	7.61	**7.21**	7.69
We are recognised and rewarded	5.82	6.00	5.99	5.80	5.92	5.70	6.24	**5.92**	6.3
We each have a voice that counts	6.63	6.83	6.75	6.59	6.74	6.59	7.03	**6.67**	7.14
We are safe and healthy	6.04	6.30	6.24	5.94	6.10	6.08	6.53	**6.09**	6.53
We are always learning	5.68	5.85	5.47	5.39	5.79	5.50	5.89	**5.64**	6.09
We work flexibly	6.24	6.49	6.32	5.83	6.35	5.93	6.15	**6.24**	6.86
We are a team	6.68	6.80	6.76	6.54	6.76	6.48	6.91	**6.74**	7.12
Staff engagement	6.70	6.92	6.86	6.78	6.84	6.83	7.13	**6.84**	7.39
Staff morale	5.86	6.20	6.02	5.84	5.93	5.93	6.38	**5.93**	6.38

below national average
above national average
same as national average
same as NHS best

Improvements in staff experience and engagement must be targeted at relationships within and across teams – the association with patient safety, patient experience and performance is clear. With the Trust remaining committed to doing more to protect colleagues from increasing levels of violence, aggression and discrimination from patients and the public.

Finally, these 2024 NHS Staff Survey results will directly inform the Year 2 objectives in the People Plan and be shared widely across Clinical Boards and Corporate services.

INVOLVEMENT AND ENGAGEMENT 2024/2025

The Trust is committed to listening to local communities and to work with community-based organisations.

One of the ways we do this is through close working partnership with Healthwatch who play an important role in representing the views of patients across the region. This year Healthwatch saw a higher than usual number of concerns with regards to the provision of our audiology services and are supporting the Trust to share timely updates and information with local communities.

Healthwatch Newcastle have also facilitated a discharge from hospital survey, and we will work with them to analyse the results to help improve the experience for patients.

We have also continued to work with a wide range of other local voluntary community organisations across the region. This helps us to reach and involve our wide and diverse populations in shaping health services. An example of this is the progress we have made on the Deaf Link Navigator Project, which has also been adopted this year by Northumbria Healthcare Foundation Trust and Cumbria, Northumberland, Tyne and Wear Foundation Trust. This collaborative approach has shown tangible improvements for people who are D/deaf and need to access a diverse range of services across the region.

Another example is our collaborative work with Newcastle Carers, who have helped the Trust to identify and improve the care and support we provide to carers and people who are cared for when coming into hospital. This year the focus has been on staff carers and how we support our staff in their caring roles and to help them to remain in work.

This year we will launch our Partnership and Involvement Panel, recruiting people with lived experiences across the region to apply for the voluntary roles of Involvement Partners. This is an exciting step, and we look forward to welcoming and working with our Involvement Partners from May 2025.

In 2025/2026 the focus will be:

- Launch of the Partnership & Involvement Panel
- Embedding of the Involvement Partner voluntary roles
- Continue to work in partnership with local communities on projects and concerns which matter to them
- Build our collaborative working across the Alliance.

ANNEX 1:

STATEMENT ON BEHALF OF THE NEWCASTLE HEALTH SCRUTINY COMMITTEE

STATEMENT ON BEHALF OF NORTHUMBERLAND COUNTY COUNCIL

STATEMENT ON BEHALF OF THE NEWCASTLE & GATESHEAD INTEGRATED CARE BOARD

STATEMENT ON BEHALF OF HEALTHWATCH GATESHEAD,HEALTHWATCH NEWCASTLE HEALTHWATCH NORTH TYNESIDE AND HEALTHWATCH NORTHUMBERLAND.

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Agenda item A11

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025		
Title	Committee Chair Meeting Logs		
Report of	Bill MacLeod, Chair of the Finance and Performance Committee Anna Stabler, Chair of the Quality Committee Liz Bromley, Chair of the Digital and Data Committee Bernie McCardle, Chair of the People Committee Phil Kane, Chair of the Charity Committee David Weatherburn, Chair of the Audit, Risk and Assurance Committee		
Prepared by	Lauren Thompson, Corporate Governance Manager / Deputy Trust Secretary		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	The following Committee Chairs Logs are included since the last Public Trust Board meeting in March 2025: • Finance and Performance Committee – 24 March 2025 and 22 April 2025 • Quality Committee – 10 March 2025 and 15 April 2025 • People Committee – 18 March 2025 • Charity Committee – 17 April 2025 • Audit, Risk and Assurance Committee – 25 March 2025 and 22 April 2025 • Digital and Data Committee – 20 March 2025 ***[To follow]***		
Recommendation	The Trust Board is asked to note the contents of the Committee Chair Logs.		
Links to Strategic Objectives	Links to all strategic objectives.		

Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☒	☐	☐

Link to Board Assurance Framework [BAF]	Detailed in the individual Committee Chairs Logs.
Reports previously considered by	Public Board meeting – March 2025.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Finance and Performance (F&P) Committee - Chair's Log

Meeting: Finance and Performance Committee	**Date of Meeting**: 24 March 2025
Connecting to: Audit, Risk and Assurance Committee Trust Board	**Date of Meeting**: 22 April 2025 23 May 2025

Key topics discussed in the meeting

- In relation to the month 11 finance report, there is a reported variance against plan of £2m which relates to unfunded industrial action costs and more significantly the in year pay award. Further work is being undertaken in partnership with the Integrated Care Board (ICB).
- At month 11, the total capital expenditure to date was £30.3m against a plan of £34.4m. This included donated assets of £3m therefore the Trust is currently £7.1m behind plan from a Capital Departmental Expenditure Limit (CDEL) perspective.
- Committee members approved the 2025/26 Financial Plan for national submission on 27 March 2025 and for the Trust Board to endorse on 28 March. A final planning submission was made on the 21 March 2025 to the ICB which showed an improvement of £44m to achieve a breakeven plan. The Committee noted the significant risk identified to deliver the proposed plan of breakeven.
- Committee members approved the 2025/26 Planning Guidance and Final Plan for national submission on 27 March 2025 and for the Trust Board to endorse on 28 March 2025. It was noted that the plans meet or exceed all national targets set out in the 2025/26 planning guidance and the plans triangle with finance and workforce plans. The plans are dependent on income over and above the current Elective Recovery Fund (ERF) cap.
- The Surgical and Specialist Services Clinical Board provided an update in relation to their financial position, Cost Improvement Programme (CIP) performance, elective recovery performance and CIP plans for 2025/26. The Clinical Board at month 10 reported a £2.5m overspend and the CIP target of 1.5% has been achieved with £1.4m recurrently.
- The Integrated Board Report (IBR) was presented. The 31-day performance has continued to deteriorate, and the 62-day compliance was 64%, which reflects improved special cause variation despite an overall consistent failure to hit the target. Diagnostic performance has improved for five successive months with 17.9% of patients waiting over six weeks at the end of January 2025. In relation to cancer care, skin has continued to improve which is a high volume pathway.
- The Committee received a comprehensive update with regards to the Emergency Department (ED) which included an update on the Trusts current performance against key emergency care standards, potential obstacles to achieving the standards and actions that are being taken. The Trust has not achieved the 4-hour national standard of 78% since August 2023. In February 2025, there was an 15% reduction in breaches compared to February 2024.

- Committee members considered the assurance levels and updates aligned to the three risks on the Finance and Performance Committee Board Assurance Framework. 12 action timescales have been adjusted which mainly relate to risk 5.1, failure to maintain the standards of the Trust Estate, Environment, and infrastructure. The Committee were assured that risk actions are progressing and approved the BAF for consideration at the March Audit, Risk and Assurance Committee and Trust Board meetings.
- The Committee received an update with regards to overseas visitors and patient eligibility for treatment and it was noted that there is a robust process in place in line with the Trusts statutory obligations.
- The Newcastle Hospitals Pharma Services Ltd Operational Plan was approved. A Business Plan will be worked up and will include financial information.
- The Committee received the following documents:
  - Minutes of the Capital Management Group in February, Supplies and Service Procurement Group in February and Financial Recovery Steering Group in January.
  - The month 11 Financial Recovery Report.

Actions agreed in the meeting	Responsibility / timescale
1. It was agreed that the Director of Performance and Governance (DPG) would bring back further detail in relation to cancer diagnostic performance and scans to a future Committee meeting.	1. DPG / May 2025
2. Updates to be received in relation to the progress against the 2025/26 Financial and Planning Guidance and Final Plan.	2. CFO/DPG
3. The Newcastle Hospitals Pharma Services Ltd Business Plan to be worked up and approved at a future Committee meeting.	3. DPG / May 2025
4. The Chief Finance Officer (CFO) to review the monthly financial recovery report which is received for information to see if the detail can be included elsewhere.	4. CFO / April 2025

Escalation of issues for action by connecting group	Responsibility / timescale
The Committee agreed to escalate the 2025/26 Financial Plan and the Planning Guidance and Final Plan to Trust Board in March. It was noted that these items are included on the Private Trust Board agenda.	The Committee Chair / March 2025

Risks (Include ID if currently on risk register)	Responsibility / timescale
• Risk ID 6.1 - Failure to manage our finances effectively to improve our underlying deficit and deliver long term financial sustainability. • Risk ID 6.2 - Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care. • Risk ID 5.1 - Failure to maintain the standard of the Trust Estate, Environment, and Infrastructure could result in a disruption to clinical activities and impact on the quality of care delivered.	Not applicable.

• Risk ID 4392 – IT – financial risk arising from a 5-year contract ending. • Risk ID 4505 – Business and Development – Finance/Value for Money (VfM) caused by a lack of Trust operational readiness to deliver the commercial income targets set as part of the 2024-2027 financial recovery plan.	

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Finance and Performance (F&P) Committee - Chair's Log

Meeting: Finance and Performance Committee	**Date of Meeting**: 22 April 2025
Connecting to: Audit, Risk and Assurance Committee Trust Board	**Date of Meeting**: 20 May 2025 23 May 2025
Key topics discussed in the meeting	

- In relation to the month 12 finance report, the Trust has reported a breakeven position which is in line with the 2024/25 financial plan. There have been in year pressures and significant under performance against the recurrent Cost Improvement Programme (CIP) plans that have been mitigated with a variety of non-recurrent measures enabling achievement of the planned breakeven position.
- At month 12, the total capital expenditure to date was £60.5m against a plan of £35.1m. This included donated assets of £4.1m and Public Dividend Capital (PDC) funded assets of £8.9m therefore the Trust is currently £8.1m ahead from a Capital Departmental Expenditure Limit (CDEL) perspective.
- The 2025/26 Capital Programme was discussed in detail, and it was noted that the programme is oversubscribed however there are mitigations in place including potential VAT savings as well as likely slippage. The Committee approved the 2025/26 Capital Programme.
- The month 12 Integrated Board Report was presented. It was highlighted that overall and type one emergency care performance has improved for the third successive month and the total waiting list size decreased further in February 2025. 31-day performance has continued to deteriorate with performance outside the control limits for four successive months.
- A comprehensive presentation took place in relation to Elective Waits, Children & Young People Key Performance Indicators (KPIs) and reporting turnaround times for cancer pathways. In relation to Referral to Treatment (RTT), non-admitted compliance was 74.9% in February 2025, while admitted compliance was 52.1% - overall compliance stood at 70.6%. The Trust has submitted a trajectory in the final planning submission where compliance reaches 74% by March 2026.
- The Committee received and noted the Board Assurance Framework (BAF) recommendations approved by the Audit, Risk and Assurance Committee and Trust Board in March 2025 relating to the Committees area of focus.
- A summary of Internal Audit reports relating to the Committee was received with 12 internal audits within the Trusts 2024/25 Internal Audit plan relating to this Committee.
- The Committee received an update on the Newcastle Hospitals Pharmaservices Limited (NHPL) which included progress made to date and future actions.
- A reviewed version of the Intellectual Property (IP), Revenue Sharing & Equity Policy was discussed and approved at the Committee meeting. It was noted that there will be a Frequently Asked Questions (FAQ) page on the staff internal intranet and awareness sessions will take place.
- The Committee received the following documents:

○ Minutes and Chairs Logs of the Capital Management Group in March, Supplies and Service Procurement Group in March, Estates Strategy and Capital Investment Group in January and Financial Recovery Steering Group in February. ○ The month 12 Financial Recovery Report.	
Actions agreed in the meeting	**Responsibility / timescale**
1. In relation to the Integrated Board Report (IBR) Mr MacLeod, Committee Chair, requested further detail in relation to some outlying performance results. 2. The Committee agreed that a further Intellectual Property (IP), Revenue Sharing & Equity Policy update will be received in six months' time.	1. Head of Performance (HoP) / May 2025 2. The Director of Commercial Development and Innovation (DCDI) / October 2025
Escalation of issues for action by connecting group	**Responsibility / timescale**
No issues to escalate.	Not applicable.
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Risk ID 6.1 - Failure to manage our finances effectively to improve our underlying deficit and deliver long term financial sustainability. • Risk ID 6.2 - Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care. • Risk ID 5.1 - Failure to maintain the standard of the Trust Estate, Environment, and Infrastructure could result in a disruption to clinical activities and impact on the quality of care delivered. • Risk ID 4392 – IT – financial risk arising from a 5-year contract ending. • Risk ID 4505 – Business and Development – Finance/Value for Money (VfM) caused by a lack of Trust operational readiness to deliver the commercial income targets set as part of the 2024-2027 financial recovery plan.	Not applicable.

Agenda item A11

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Quality Committee Chair's Log

Meeting: Quality Committee	**Date of Meeting**: 18 March 2025
Connecting to: Audit Risk & Assurance Committee Trust Board	**Date of Meeting**: 20 May 2025 23 May 2025
Key topics discussed in the meeting	

- During the Executive update the Director of Nursing escalated issues regarding a CPE outbreak on the Neonatal Intensive Care Unit (ICU). An overview of actions, mitigations and progress was provided and key external stakeholders (NHS England (NHSE)/Specialised Commissioning/Integrated Care Board (ICB)) have been updated.
- Care Quality Commission (CQC) – A general update on progress within the following areas were received:
    - Medicines Oversight Group
    - Emergency Department
    - Duty of Candour
    - Update from CQC Delivery Group and phase 2 action plan and NHS Quality Improvement Group
- Cancer Patient Outcomes / Harm
  An update was provided on work surrounding the review of potential harm for any patient who has breached 104 days on a cancer pathway. It was noted that there have been improvements in compliance with completion of 104-day harm reviews for cancer patients since April 2024 with 100% compliance from those undertaken between April and October 2024. If harm is identified, processes are in place to facilitate relevant case discussion at rapid review meetings and Quality Oversight Group. It was noted that harm had occurred in a number of patients on the lung cancer pathway which was discussed in detail, including oversight of actions and duty of candour where applicable. A number of patients who experienced harm were referred late from external Trust and wider learning is being shared.
- Management Groups Chairs Logs
    - Patient Safety Group (PSG). Key topics for discussion included Harm Free Care Group Annual Report including targeted fall prevention work and achievement of 20% reduction in pressure ulcers. Central Alert System Report for July to December 2024 demonstrating compliance with management and dissemination of safety alerts. Trust Wide no harm/low harms showed an increase in reporting. Legacy Serous Incident Action Plan has been completed with all actions closed appropriately.

- Clinical Outcomes & Effectiveness Group (COEG). Key topics for discussion included National Confidential Enquiry into Patient Outcome and Death (NCEPOD) reports for Community Acquired Pneumonia: Consolidation required and End of Life. New governance structure and membership of COEG, Terms of Reference COEG, New Interventional Procedures – new procedure request, Non-compliant National Institute for Health and Care Excellence (NICE) guidelines rated >15 and COEG Group Risk Report – risks rated >15.
- Transplantation Committee. Key topics for discussion included Implementation Steering Group for Organ Utilisation (ISOU) recommendations to develop a strategy and produce an annual report, Assessment and Repair Centre (ARC) Development plan, Beechwood house and its need for refurbishment.

- Learning From Deaths (Mortality Review) Quarter 3
  The report aimed provide assurance that processes for Learning from Deaths across the organisation are in line with best practice as defined in the National Quality Boards (NQB) National Guidance on Learning from Deaths (LFD) March 2017. It also summarised the processes in place to provide assurance to the Committee that all deaths are reviewed including those with potentially modifiable factors.
- Rapid Quality and Safety Peer Reviews.
  The Quality and Safety Peer Review process has been developed to provide Trust-wide oversight on the level of compliance to quality and safety standards. It highlights areas for improvement as well as those areas achieving high quality standards.
  The report highlighted themes identified across the organisation around compliance with core standards since the previous report and detailed the proposal for 2025/2026 quarter 1 and 2 reviews, which were endorsed. It was agreed to continue to provide this report on a quarterly basis.
- Perinatal Quality Surveillance Report including Maternity Incentive Scheme Update.
  The report informed the Quality Committee of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. The maternity service maintained Operational Pressures Escalation Level (OPEL) 1 and 2 in December 2024 and January 2025. The Trust has volunteered to be a pilot site for the testing and validation processes for the Maternity Outcome Signal System. An update in relation to Post Partum Haemorrhage was included as requested as an action from the previous meeting. This matter was resolved with no concerns to note.
- Wards of Concern & Accrediting Excellence
  The report highlighted wards of concern raised via the professional Nurse Staffing and Clinical Outcomes group (NS&O) along with an update on the Accrediting Excellence Programme (ACE). This revised report was endorsed and will continue bi-monthly.
- Equality & Quality Impact Assessment (EQIA) for Cost Improvement Schemes
  The Trust has a process to ensure cost improvement schemes have appropriate governance, with auditable documentation which complies with quality and safety priorities. The process requires completion of an EQIA form for cost improvement schemes which may impact the delivery of a service. The report provided an overview of which schemes meet the criteria and progress against oversight of this process in year. The revised approach to reporting in 2025/26 was endorsed which includes increased rigor around the EQIA process as the screening and delivery stages.
- Health Inequalities update
  The report provided an update of progress on a Public Health/Health Inequality Strategy and governance for the Trust as well as to seek assurance regarding progress relevant to various public health work streams. It highlighted key challenges, potential risks and gaps but also opportunities around delivery of the public health and health

inequality programmes of work. It was noted that significant work is still required in this area of work and that the draft strategy, which was due to be delivered in April, would be delayed until further work could be undertaken.

- Audiology Update
  A first review of all historic auditory brainstem response (ABR) patients identified by the ICB peer review has been completed by an ICB subject matter expert. An update on progress on any patients recalled was provided.
- The Integrated Quality & Performance Report was presented which provided assurance to the committee on the Trust's performance against key Indicators relating to Quality & Safety, Access, People, Finance and Health Inequalities.
- Board Assurance Framework (BAF). The report aimed to support the Quality Committee to gain assurance that strategic risks aligned to the committee were being managed effectively; that risks have an appropriate action plan in place to mitigate them; and that risk scores are realistic and achievable. The BAF had recently been reviewed and critiqued where more assurance was needed. It was agreed that the ratings were appropriate with no areas for escalation or recommended to change.
- Quality focussed Quality Performance Reviews (QPR)
  In February 2025, the first round of Quality & Safety Quality & Performance Review (QPR) meetings took place. The report provided an overview of these meetings, detailing any areas of risk and matters for escalation to Quality Committee. Areas of good/excellent practice are also detailed for information and sharing. One escalation was noted relating to Governance process in the Great North Children's Hospital (GNCH) which the Executive Team are addressing.
- Quality Committee Terms of Reference and Schedule of Business 2025/26
  The Terms of Reference and Schedule of Business 2025/26 was reviewed, considered and approved.
- The Terms of Reference for the following Groups which feed in to Quality Committee were approved
  - Patient Safety Group (PSG)
  - Clinical Outcomes and Effectiveness Group (COEG)
  - Care For All Group
  - Medicines Management Oversight Group
  - Experience of Care Group

Actions agreed in the meeting	Responsibility / timescale
1. IPC assurance paper in line with Trust policy to be produced for the Committee	• Director of Infection Prevention Control and Executive Director of Nursing – July 2025
2. Position update to be provided following the withdrawal of contract with Eden Court and the subsequent impact on discharges	• Director of Operations for Medicine & Emergency Care – April 2025
3. Cancer Patient Outcomes / harm - Lack of timely download may lead to patients being missed: the manual nature of the process means that if a patient breached 104 days but is treated prior to the weekly download then they will not be picked	• Joint Medial Director / Dr Gail Jones - Consultant Haematologist – April 2025

up as requiring a harm review. To check that this is recorded on the risk register.	
4. Cancer Patient Outcomes / harm – next update to be received by the Committee in 6 months' time and include and update on Duty of Candour compliance	• Joint Medial Director / Dr Gail Jones - Consultant Haematologist – September 2025
5. Audiology Update to be provided to the Committee	• Director of Operations - Surgical and Associated Specialties - July 2025
6. Health Inequalities - a draft strategy would be presented in May followed by a quarterly update. There would also be a report via a Chairs log from the Health Inequalities Committee on a monthly basis	• Joint Medial Director / Consultant in Public Health – May for Strategy then update in June, September, December and March
7. Anna Stabler, Phil Kane, Wendy Balmain and Nini Adetuberu to be included in all of the Tier 2 Committee meeting dates (plus Health Inequalities for Wendy) and to receive papers for the meetings.	• Committee Chair's secretariat
Escalation of issues for action by connecting group/Trust Board	**Responsibility / timescale**
• There were no issues for escalation to ARAC or Trust Board.	• Not applicable.
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Detailed within the BAF	• Not applicable.

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Quality Committee
Chair's Log

Meeting: Quality Committee	**Date of Meeting**: 15 April 2025
Connecting to: Audit Risk & Assurance Committee Trust Board	**Date of Meeting**: 20 May 2025 23 May 2025
Key topics discussed in the meeting	

- CQC – A general update on progress within the following areas was received:
  - Cardiac Oversight Group
  - Medicines Oversight Group including Medicines Management Action Plan
  - North East Children's Transport and Retrieval (NECTAR)
  - Emergency Department
  - Update from NHS England (NHSE)/Integrated Care Board (ICB) Quality Assurance Deep Dive
- Duty of Candour Deep Dive (DoC) - Recorded compliance with the statutory DoC had significantly improved since the previous report. Several notable actions have been undertaken to improve compliance. A DoC dashboard was launched in June 2024 to support local and Clinical Board level monitoring. There has been improved oversight of Trust data with inclusion of DoC in the Integrated Board Report and monthly Quality Committee updates. As overall compliance improves, there is a focus on improving the quality of our DoC responses, ensuring they are increasingly patient focused and with high quality information made available.
- Management Groups Chairs Logs
  - **Patient Safety Group (PSG).** Key topics for discussion included:
    - Majority of actions in the action log were complete and marked as closed.
    - Updates were received on the Patient Safety Incident Response Framework (PSIRF) priorities (Venous Thromboembolism (VTE) / Lost to Follow Up / Action on Abnormal Results from Radiology).
    - PSIRF Annual Report 2024/2025 was discussed. Overall, successful first year with increase in reporting, investigation and appropriately learning responses applied. Concerns of overall communications for any patient safety messages which will be targeted by a Task and Finish Group.
    - Current data for Rapid Reviews, Local Investigations, After Action Review (AAR) and Patient Safety Incident Investigation (PSII) was shared. Overall, an improving picture.
  - **Experience of Care Group** Key topics for discussion included:

        - The Working for Carers project is a partnership of Newcastle Carers, North Tyneside Carers Centre and Carers Northumberland, funded by the UK Government Shared Prosperity Fund, with the North-East Combined Authority as the lead authority. The group acknowledged the success and positive outcomes of the projects and noted the key challenges in continuing this work without access to funding or resourcing.
        - The Experience of Care Group replaces the Patient Engagement and Experience Group in line with previous agreement at the Quality Committee.
        - An overview of the Complaints Improvement Plan was discussed with progress reports provided in future reports.
        - An overview of the development of a Partnership and Improvement Panel was discussed.
        - The Quarter 3 (Q3) Learning Disability report was received by the group.
    - **Transplantation Committee**. Key topics for discussion included:
        - Beechwood house was discussed, plans to put a formal agreement in place was explored.
        - An update on the business case for the Assessment and Repair Centre (ARC) was provided.
        - An update on the performance pack was provided. It was noted that the performance information is developing.
        - The new risks emerging with regards to infection prevention control and decanting the theatres were discussed in detail.
- Patient Identity Check Audit - A Trust wide inpatient audit of compliance against the Trust Patient Identification Policy was undertaken in December 2024. This demonstrated concerns with in a number of areas with not all patients being managed in accordance with the policy. The audit demonstrated that there was poor adherence to the Trust's Patient Identification Policy requirements, particularly in relation to paediatric patients who are cared for out with the critical care environment. Urgent actions were undertaken as outlined in the report and an action plan has been established to improve compliance. Another audit will be undertaken in September 2025 but in the interim, rapid quality and safety peer reviews are monitoring compliance with the most recent reviews demonstrating improved compliance.
- Perinatal Quality Surveillance Report including Maternity Incentive Scheme Update. The report provided the Quality Committee of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. A number of items were brought the committees attention as outlined in the report summary section.
- Patient & Staff Experience update including interim strategy 12-month work plan. The presentation provided an update on patient and staff experience results for January and February 2025.
    - **Patient Experience.** Since introducing the right time programme in September 2024, we have received feedback from close to 70,000 patients. Results are consistently good, with inpatients, outpatients and maternity care all performing in the top 20% when compared to national NHS data.

  - **Staff Experience** In January 2025, there was a commitment to share our 12-month work plan linked to the Experience of Care strategy, the interim Trust strategy and the new Quality strategy that is currently under development nationally.
- 'Call for Concern' (Martha's Rule) update - Call for Concern – Martha's Rule is a Patient Led Escalation system that will be mandated by NHSE. Newcastle Hospitals has been a pilot trust from May 2024 and has developed local systems which launched in adult wards on 17 February 2025. Initial data confirms a low volume service, with most calls not representing genuine deterioration in a patient's condition. A small number of calls however have in fact given rise to important interventions including admission to critical care. Concerns were noted regarding lack of progress in the Great North Children's Hospital (GNCH) which was debated by the group. The Executive Director of Nursing was tasked with leading further discussions.
- Care planning and Care Optimisation. The report provided the Quality Committee with an overview of the work which has been undertaken to optimise care planning to ensure the delivery of personalised and compassionate healthcare. This report had been previously discussed at the Digital and Data Committee.
- Legal update & Learning from Claims. The report outlined the number of claims and Inquests the Trust received in Q1-4 of 24/25 broken down by speciality and claim type and highlights learning from litigation and Inquests. It also highlights any legal matters arising in the reporting period which the Quality Committee should be aware of.
- Allied Health Professionals (AHP) Workforce update. The report provided the Quality Committee with an update on the AHP workforce.
  - Work is underway to develop an AHP safe staffing framework in lieu of any nationally agreed or endorsed structure.
  - The report contained and overview of workforce metrics and data analysis.
  - Turnover rates were improving and below national average but remain high in occupational therapy, therapeutic radiography and orthoptics which are indicative of regional and national challenges.
  - The substantive appointment of the AHP Workforce, Education and Practice Development posts is positive progress. This has enabled the continuation of work related to the developing AHP Workforce Strategy, whilst providing future sustainability.
- The Integrated Quality & Performance Report was presented which provided assurance to the committee on the Trust's performance against key Indicators relating to Quality & Safety, Access, People, Finance and Health Inequalities.
- Board Assurance Framework (BAF). The report provided the Quality Committee with the Trust Board approved BAF risks relating to the Quality Committee's area of focus. All committee recommendations proposed to the Audit, Risk and Assurance Committee and Trust Board were agreed in full and the Board Assurance Framework was approved at Trust Board on 28th March 2025.
- Summary of Internal Audit Reports relating to the Quality Committee. The report aimed to support the Quality Committee to monitor and seek assurance relating to internal audit plan and associated recommendations aligned to the Quality Committee area of focus.
  - There are eleven internal audits within the Trust's 2024/2025 Internal Audit Plan relating to the Quality Committees area of focus. Four of the internal audits are yet to be completed, assurance levels will be updated as and when the final reports are produced.

- There are currently seven open recommendations aligned to the Quality Committee area of focus, these relate to Safe Staffing and World Health Organisation Surgical Checklist.

- PSIRF Annual Report:
  - The PSIRF Annual Report demonstrated an increase in incident reporting since implementation.
  - Review and reporting rates are regularly monitored.
  - There have been 28 PSIIs declared.
  - 80 senior staff have been trained in-house to Healthcare Safety Investigation Branch (HSIB) Level 2 equivalent in Incident Investigation.
  - Each Clinical Board has recruited at least one governance lead at Band 7 or above.
  - A branded toolkit and a Safety Spotlight have been developed for sharing learning.
  - Trust PSIRF priorities will be reported separately by their steering groups.

Actions agreed in the meeting	Responsibility / timescale
1. Medicines Management Action plan – Ambient temperature monitoring and automated processes. Timescale for launch.	• Executive Director of Nursing and Director of Pharmacy – May 2025
2. NECTAR update – to include compliance rates from bespoke Clinical Assurance Toolkit (CAT) in the next report.	• Associate Director of Operations – Family Health Clinical Board – June 2025
3. To determine how many Emergency Department Guidelines and Standard Operating Procedures (SOPs) are left to complete and when they will all be completed.	• Head of Nursing - Medicine and Emergency Care – May 2025
4. Duty of Candour update	• Director of Quality & Safety – September 2025
5. Patient Safety Group – update paper on previous PSIRF priorities	• Clinical Director for Quality & Safety/Chair of Patient Safety Group – September 2025
6. Revised process for complaints handling and compliance Deep Dive report to be included in subsequent Experience of Care update.	• Executive Director of Nursing – July 2025
7. Patient Identity Check Audit to be added to the AuditOne internal audit plan for Q4 2025/26 or into 2026/27 audit plan.	• Acting Deputy CEO

8. Update Paper on Eden Court to be added to agenda	• Director of Operations Medicine and Emergency Care - May 2025
9. 'Call for Concern' (Martha's Rule) - The Executive Director of Nursing was tasked with leading further discussions.	• Executive Director of Nursing – verbal update to be provided at May meeting.
10. 'Call for Concern' (Martha's Rule) update paper	• Associate Medical Director for Quality & Safety - July 2025
11. 'Call for Concern' (Martha's Rule) – what has been learned from health inclusion and health inequalities perspective	• Associate Medical Director for Quality & Safety - March 2026
12. Allied Healthcare Professionals Workforce Update to be added to schedule of business on a 6 monthly basis	• Associate Director of Allied Health Professionals & Therapy Services – September 2025
13. Care Optimisation update to be added to future Quality Committee agenda	• Executive Director of Nursing to discuss with Director of Improvement & Development – Date to be determined
14. To provide information as to how many staff had undertaken an actual investigation from the 80 senior staff who had been trained in-house to HSIB Level 2 equivalent in Incident Investigation	• Director of Quality & Safety - May Committee
Escalation of issues for action by connecting group/Trust Board	**Responsibility / timescale**
• Concerns in relation to the number of extensions to recommendations in audit reports. • Longer term strategy in relation to intermediate care beds following the loss of Eden Court would be to be escalated to Board	• Anna Stabler – April Committee • Anna Stabler – April Board
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Detailed within the BAF	• Not applicable.

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

People Committee - Chair's Log

Meeting: People	**Date of Meeting**: 18 March 2025
Connecting to: Audit, Risk and Assurance Committee (ARAC) Trust Board	**Date of Meeting**: 20 May 2025 23 May 2025
Key topics discussed in the meeting	

- A review of the People Plan year 1 actions was discussed with 25 actions being fully delivered, one action was incomplete however is on track for completion and two actions remain under review to enable Alliance discussions.
- A draft of the People Plan year 2 actions was presented which will be reviewed with the Staff Networks and the new People Programme Board. An engagement plan will be developed.
- An update was provided in relation to setting up the new People Programme Board which will commence in April 2025. The People Programme Board will seek assurance of the operational delivery of the steering groups and the progress for the People Plan year 2 actions.
- The Committee received a presentation on the Staff Survey results for 2024 with 10,371 responses received. It was noted that all seven People Promise elements are recording higher scores in 2024 compared to 2023, with all People Promise sections showing statistically significant improvement. The 2024 results will directly inform the year 2 objectives within the People Plan and will be widely shared across the Clinical Boards and Corporate Services.
- An update was provided with regards to Health and Wellbeing which included action that has been taken and the current position in relation to the proposed Charity bid which will help progress the substantive Health and Wellbeing offer.
- The People Committee Board Assurance Framework was ratified for Trust Board approval. It was noted that action timescales have been adjusted for six actions.
- The Joint Medical Director provided an update in relation to the new job planning guidance implementation and the workplan that has been developed to support monitoring the implementation programme. There will be monthly reporting of the 2025/26 job plans as part of the workforce return. The Committee approved the Job Planning Oversight Group Terms of Reference.
- A Communications update was provided which included an update on current activity and the stories that have been in the news recently.
- The Committee received an update on the Equality, Diversity and Inclusion (EDI) improvement plan and initial actions. The update included that the Chief Executive, Chair and Board members must have specific and measurable EDI objectives however it was noted that the Chair and Non-Executive Directors already have a specific EDI objective. Plans will be developed to eliminate pay gaps and address health inequalities within the workforce.

- The Committee received the People Integrated Board Report which included an update on sickness absence rates, appraisal rates and mandatory training.
- A deep dive into Statutory and Mandatory training took place. The areas of low compliance were discussed, an update on the actions being taken to address the areas of concern and an update on the national review of Statutory and Mandatory Training. The national policy is due to be published in spring and work continues with regards to digital passports for staff members moving between organisations.
- The minutes from the February Sustainable Healthcare Committee and a table of sub-group meetings which took place in 2024 were received.
- The People Committee Terms of Reference and Schedule of Business for 2025/26 were ratified for Trust Board approval.

Actions agreed in the meeting	Responsibility / timescale
1. A governance document for People will be presented to the relevant groups including the People Committee and Trust Board.	1. The Acting Associate Director of People and Organisational Development (AADPOD) – May 2025
2. The Executive Director of Nursing (EDN) said that it would be useful to have a visual of the governance structure and reporting for the People Programme Board.	2. AADPOD / May 2025
3. Mr McCardle (Chair) highlighted the importance of men's mental health which should be a key part of the Health and Wellbeing offer.	3. AADPOD / May 2025
4. The Committee agreed that financial elements/considerations of the new job planning process would be discussed at the Finance and Performance Committee.	4. The Joint Medical Director / when appropriate
5. Mr McCardle (Chair) asked for further detail to be included in a future performance update with regards to understanding the reasons for sickness absence.	5. AADPOD / April 2025
6. The Acting Chief Executive Officer (ACEO) asked for further work to be carried out internally to understand the approach, methods and the most efficient way for staff to carry out Statutory and Mandatory Training.	6. The Deputy Head of Workforce / April 2025
Escalation of issues for action by connecting group	**Responsibility / timescale**

There were no issues for escalation.	Not applicable.
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
Risk ID 2.1 - Failure to have sufficient capacity and capability in our workforce to deliver safe and effective care. Risk ID 2.2 - Failure to develop, embed and maintain an organisational culture in line with our Trust values and the NHS people promise. Risk ID 2.3 - Failure to effectively develop and implement a new approach to leadership and organisational development to ensure that everyone feels supported appropriately by the organisation.	Not applicable.

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Charity Committee - Chair's Log

Meeting: Charity Committee – Funding only	**Date of Meeting**: 17 April 2025
Connecting to: Audit, Risk and Assurance Committee Trust Board	**Date of Meeting**: 20 May 2025 23 May 2025
Key topics discussed in the meeting	
• Funding proposals were discussed in relation to: ○ Corporate/Non-Clinical - £70,156 – A Helping Hand Social Welfare Advice for Trust Staff – Supported. ○ Corporate/Non-Clinical - £20,000 – Staff Network Funding – Supported. ○ Corporate/Non-Clinical - £30,000 – Celebrating Excellence Awards – Supported. ○ Cardiothoracic Services - £31,080 – Non-Invasive Ventilators for Cardiothoracic Intensive Treatment Unit (ITU) – Supported subject to Capital Management Group (CMG) Approval. ○ Cancer and Haematology - £22,832 – Ward 34 and Ward 35 TV Application 2025 – Supported. • The summary of funding agreed since the last meeting was received (bids up to £20k).	
Actions agreed in the meeting	Responsibility / timescale
No actions from these applications.	Not applicable.
Escalation of issues for action by connecting group	Responsibility / timescale
Not applicable.	Not applicable.
Risks (Include ID if currently on risk register)	Responsibility / timescale
Not applicable.	Not applicable.

The Newcastle upon Tyne Hospitals
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Audit, Risk and Assurance Committee (ARAC) - Chair's Log

Meeting: ARAC	**Date of Meeting**: 25 March 2025
Connecting to: Trust Board	**Date of Meeting**: 23 May 2025
Key topics discussed in the meeting	

- The meeting action log was received and no matters were identified for escalation from other Board Committees to ARAC. The People Committee Chair noted two areas which the Committee planned to focus on at future meetings, being absence management and staff appraisal compliance. The Finance and Performance Committee Chair highlighted the challenges associated with the Financial Plan for 2025/26.

  The ARAC Chair referred to a recent Non-Executive Director (NED) informal visit and Committee members discussed staff awareness and implementation of the new risk management system (InPhase).

- Clinical Board Risk Deep Dive – Surgical and Specialist Services – The Clinical Board Quality and Safety Lead and the Director of Operations provided an overview of their risk profile and mitigating actions for the highest scoring risks. The following points were noted:
  - 37 risks are included on the risk register, of which 7 are categorised as tolerated. Of the total 37 risks, 8 are scored 15+.
  - Several of the risks relate to Ophthalmology and therefore the Clinical Board has undertaken a number of improvement actions covering the following areas:
    - Lost to follow-up.
    - Waiting list records and times.
    - Capacity within the Glaucoma service.
    - Software.
  - The Risk Evaluation Tool was shared at the Quality Oversight Group meeting.
  - An overview of the risk reporting and management structure was shared.
  - 12 of the 37 risks are over two years old.
  - The top 3 risks were discussed, all of which related to ophthalmology and relate to demand, workforce capacity and record keeping.

- Board Assurance Framework (BAF) Report – The BAF was presented for information. Committee members discussed risk ID 1.2 (risk aligned to ARAC), and agreed the risk rating recommendations. The Director of Performance and Governance (DPG) highlighted that the focus for the coming months would be in ensuring that actions recorded in the BAF have a direct impact on mitigating the threats identified.

- The mortuary update from the Designated Individual (DI) was discussed. The Head of Corporate Risk and Assurance (HCRA) provided an update on the recent Fuller Enquiry Team visit and on the Human Tissue Authority (HTA) inspection. A Task and Finish Group had been

established to further strengthen the governance arrangements in place within the Newcastle Surgical Training Centre.

Committee members were briefed on the mutual aid being provided for Darlington Post Mortems and on the charges relating to the Coroner's Autopsy Service.

- Two Internal Audit reports were received, with the following assurance levels:
  - Risk Management - A good assurance rating was awarded.
  - Board Assurance Framework (BAF) - A good assurance rating was awarded.

Committee members noted the positive progress made during the year 2024/25.

A session was scheduled with Board members later in the week to discuss the risks for the new 2025/26 BAF, along with the Trust Risk Appetite Statement.

- The updated Accountability Framework was presented for approval. The main changes being in relation to the agreed shift to a more devolved accountability model. Committee members approved the Framework subject to further discussion at the Trust Board meeting scheduled later in the week.

- The Committees Chairs Logs were received for the following Committee meetings:
  - Finance and Performance Committee –25 February 2025
  - People Committee – 11 February 2025
  - Quality Committee – 11 February 2025
  - Charity Committee – 10 February 2025
  - Compliance and Assurance Group – 7 March 2025

Actions agreed in the meeting	Responsibility / timescale
1. The Trust Secretary (TS) agreed to share the details of the InPhase launch with Trust NEDs and Trust Governors.	1. TS / 28 March 2025
2. The Head of Corporate Risk and Assurance (HCRA) agreed to feedback to the DI queries raised in relation to: a. The cost differential/uplifts for the additional work being undertaken for the Corner's Service. b. Long-term plans for the extra autopsy work being conducted for Darlington and County Durham.	2. HCRA / 22 April 2025
Escalation of issues for action by connecting group	**Responsibility / timescale**
No escalations were identified however it was noted that the Accountability Framework would be discussed further at the Board meeting on 28 March 2025.	Not applicable.
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
All BAF risks were detailed in the BAF report.	Not applicable.

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The Surgical and Specialist Clinical Board risks were discussed – IDs: 4290, 4292, 3871, 2298, 3947, 4093, 4216, 4219, 4221, 4222, 4223, 4224, 4615 and 4617.	

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The Newcastle upon Tyne Hospitals
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Audit, Risk and Assurance Committee (ARAC) - Chair's Log

Meeting: ARAC	**Date of Meeting**: 22 April 2025
Connecting to: Trust Board	**Date of Meeting**: 23 May 2025
Key topics discussed in the meeting	

- The meeting action log was received and there were no matters requiring attention. AS noted, that following the receipt of the Legal & Claims update the Quality Committee had requested that any learning from claims would be integrated in to future papers. It also requested that a process be established for the sign off any extensions to recommendations within internal audits, and should be approved with Executive Director oversight.
- Board Assurance Framework (BAF) Report – The report provided an end of year position in relation the 2024/25 Board Assurance Framework and an update on the progress made towards reviewing and resetting the Board Assurance Framework ready for 2025/26.
- The Operational Internal Audit Plan (2025/26) was presented which outlined the proposed coverage of 569 internal days, which was equal to those provided in 2024/25. This was approved by the Committee subject to any minor amendments in year.
- The draft Head of Internal Audit Opinion 2025/26 was provided by the Associate Director of Internal Audit. The year end position was noted as reasonable at this point but there were some positives in terms of the BAF and Risk Management.
- Internal audit plan progress was noted. Eight final reports have been issued since the last Audit, Risk and Assurance Committee (Audit Focus) meeting in January 2025 and 14 reports are currently at draft / review stage. There have been no final reports issued with limited assurance since the last Audit, Risk and Assurance Committee meeting.
- External Audit Annual plan and 3-year strategic plan. The report summarised the audit approach, including the significant audit risks and areas of key judgement that had been identified.
- Counter Fraud Report - The report provided an update on the counter fraud work that has been undertaken during the quarter, with specific reference towards the compliance with the Government Functional Standards 013: Counter Fraud (GovS 013).
- The draft annual accounts for 2024/25 headline summary were received. The report detailed the changes in the annual report and accounts timetable, including any sub-sequent changes as a result. The report also provided an update on progress to date and plans currently in place to achieve these reporting deadlines.

- The Going Concern Statement 2024/25 was received.
- A Workforce 'Special' Payments Report was received.
- The draft Annual Governance Statement was discussed in detail noting that further information was needed to provide a balanced conclusion.
- The following reports were received for information and the contents noted:
    - Schedule of approval of single tender action and breaches and waivers exception report
    - Debtors and creditors balances
    - Schedule of losses and Compensation
- The Committees Chairs Logs were received for the following Committee meetings:
    - Finance and Performance Committee – 24 March 2025
    - People Committee – 18 March 2025
    - Quality Committee – 18 March 2025
    - Charity Committee – 19 March 2025
    - Digital & Data Committee – 20 March 2025

Actions agreed in the meeting	Responsibility / timescale
1. The Executive Director of Nursing agreed to raise the request of a process being established to include Executive Director sign off for any extensions to recommendations in internal audit reports.	• Executive Director of Nursing – 20 May 2025
2. Further information to be added to the Draft Annual Governance Statement.	• Head of Risk & Assurance / Acting CEO – 20 May 2025.
Escalation of issues for action by connecting group	**Responsibility / timescale**
None	N/a
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
All BAF risks were detailed in the BAF report.	N/a

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025		
Title	Workforce Disability Equality (WDES) Report		
Report of	Vicky McFarlane-Reid, Director for Commercial Development and Innovation Interim Executive Lead for the People Directorate		
Prepared by	Karen Pearce, Head of Equality, Diversity and Inclusion (People)		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☐
Summary	The purpose of this report is to provide the Trust's position in relation to Workforce Disability Equality Standards (WDES) metrics for 2024/25 which requires publication by 31 May 2025 on the Data Collection Framework website and the Trust's website. Both WRES and WDES results have improved but remain a long way from where we need them to be and must be a focus going forward. Analysis indicates that we have not observed significant shifts in outcomes since the introduction of WDES, fluctuations, both positive and negative, with no clearly defined trend in most metrics. The exception to this relates to the following indicators and signals a positive trend but on the most part these indicators still require ongoing improvement. – The likelihood of entering the formal capability process on the grounds of performance, as measured by entry into the formal capability procedure. – Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts where the last 4 years have seen year on year improvements. – Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from patients, service users or the public which has seen improvements over the last three years. – Percentage of staff who reported harassment, bullying or abuse the latest time it happened has seen improvement over the last three years. To achieve genuine and measurable organisational impact, responsibility for change must be embedded and owned within Clinical Boards and operational leadership structures. Sustained progress will require local accountability, local engagement and visible leadership at every level. A Board Development Session took place recently which included an item on Equality Diversity and Inclusion (EDI) and a workshop with key stakeholder to identify priorities going forward, this work will continue to identify required outcomes with the development of an associated action plan.		
Recommendation	Trust Board is asked to: • Note the contents of this report.		

	• Agree the requirement to publish data by 31 May 2025 on the Data Collection Framework website and the Trust's website.					
Links to Strategic Objectives	People – Supported by our People Plan, we will ensure that each member of staff is able to liberate their potential.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☒	☒
Link to Board Assurance Framework [BAF]	Not applicable.					
Reports previously considered by	Trust Board - 30 May 2024					

WORKFORCE DISABILITY EQUALITY UPDATE

EXECUTIVE SUMMARY

This report provides the Trust's position in relation to the WDES report for 2024/25 which requires publication by 31 May 2025. Whilst there have been improvements across, the Trust still has some significant challenges.

Analysis indicates that we have not observed significant shifts in outcomes since the introduction of WDES, only fluctuations, both positive and negative, with no clearly defined trend. The exception to this relates to the following indicators and signals a positive trend but on the most part still requires on going improvement;

- the likelihood of entering the formal capability process on the grounds of performance, as measured by entry into the formal capability procedure.
- relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts where the last 4 years have seen year on year improvements.
- percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from patients, service users or the public which has seen improvements over the last three years
- percentage of staff who reported harassment, bullying or abuse the latest time it happened has seen improvement over the last three years

This year's WDES results are generally more positive with all but one 'Indicator' showing some improvement.

To achieve genuine and measurable organisational impact, responsibility for change must be embedded and owned within Clinical Boards and operational leadership structures. Sustained progress will require local accountability, local engagement and visible leadership at every level.

WDES Indicator	Headline Data	Improved
Indicator 1 Percentage of Disabled staff in each of the Agenda for Change (AfC) bands 1-9, VSM (including executive board members), medical/dental and other staff, compared with the percentage of non-disabled staff in these categories.	– 4.23% of staff have declared a disability – 89.72% of staff have self–reported their disability status – 10.28% of staff have not declared their disability status – Non-clinical staff -the percentage of – disabled staff in the non-clinical workfor dropped by 1.14% – Clinical staff the percentage of disabled staff in the clinical workforce has dropped by 0.88% – The percentage of null records has decreased	No

WDES Indicator	Headline Data	Improved
Indicator 2: Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.	– Non-Disabled staff are staff are 1.04 times more likely to be appointed	Yes
Indicator 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance, as measured by entry into the formal capability procedure.	– This indicator continues to improve and has show the biggest improvement since WDES was introduced.	Yes
Indicators 4a - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from patients, service users or the public	– The percentage of Disabled staff experiencing bullying, harassment and abuse (BH&A) from patients, relatives or the public is 28.03% which is 7.64% higher than non-disabled staff and 1.34 % lower than the benchmark data.	Yes
Indicators 4a - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from managers	– The percentage of Disabled staff experiencing BH&A from a line manager is 13.81% which is 5.66% higher than non-disabled staff and 1.22% lower than the benchmark data.	Yes
Indicators 4a - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from other colleagues	– The percentage of Disabled staff experiencing BH&A from other colleagues is 25.18% which is 9.44% higher than non-disabled staff and 0.06% lower than the benchmark data.	Yes
Indicator 4b: Percentage of staff who reported harassment, bullying or abuse the latest time it happened.	– The percentage of Disabled staff experiencing BH&A and reporting it is 50.64% which is 3.1% higher than non-disabled staff and 1.18% lower than the benchmark data.	Yes
Indicator 5: Percentage of Disabled staff compared to non-disabled staff. believing that the Trust provides equal opportunities for career progression or promotion.	– The percentage of Disabled staff who believe the trust provides equal opportunities for career progression or promotion is 51.15% which is 6.57% lower than non-disabled staff and 0.15% lower than the benchmark data.	Yes

WDES Indicator	Headline Data	Improved
Indicator 6: The percentage of Disabled staff who indicated they have felt pressure from their manager to come to work despite not feeling well enough to perform	– The percentage of Disabled staff who indicated they have felt pressure from their manager to come to work despite not feeling well enough to perform duties is 26.24% which is 6.96% higher than non-disabled staff and 0.61% lower than the benchmark data.	Yes
Indicator 7: Percentage of Disabled staff compared to non-disabled staff. saying that they are satisfied with the extent to which their organisation values their work.	– The percentage of Disabled staff who indicated they are satisfied with the with the extent to which their organisation values their work is 30.36% which is 11.49% lower than non-disabled staff and 4.37% lower than the benchmark data.	Yes
Indicator 8: Percentage of Disabled staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work.	– The percentage of Disabled staff who feel the Trust has made adequate adjustments to enable them to carry out their work is 75.66% which 1.68% higher than the benchmark data	Yes
Indicator 9a: The staff engagement score for Disabled staff, compared to non-disabled staff.	– Disabled staff report higher levels of engagement 6.81 than non-disabled staff 6.43. Engagement score for disabled staff is 0.14 less than the national benchmark.	Yes
Indicator 10: Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: – By voting and non-voting membership of the Board. – By Executive and non-exec membership of the Board	– As at March 2025 the difference between Disabled representation on the Board and in the overall workforce was 1 (-1%). This is an improved position form last year. – Voting and Executive membership: the difference between Disabled representation on the board and in the workforce was -10 for both.	Yes *For disabled representation on the Board*

WORKFORCE DISABILITY EQUALITY STANDARD

1. INTRODUCTION

The report focuses on the experiences of disabled staff at work, who bring valuable knowledge and expertise into the delivery of healthcare and other work of the Trust. By using the WDES as a catalyst for change, the gaps in equity are highlighted enabling inequity to be identified with the aim of supporting positive working and career experiences of all staff, benefitting not only staff but services users and patients as well. Our overall ambition is to increase the representation of Disabled people in the workforce and see the disparities between Disabled and non-disabled staff reduce, supported by an inclusive culture. In summary;

- 4.23% of our workforce have recorded themselves as having a disability.
- 89.72% of our workforce have recorded themselves as not having a disability.
- 6.05% of staff remain undeclared.

Our data shows improvements in all indicators except for Indicator 1, where we have seen an overall reduction in the percentage of disabled people employed by the Trust. To achieve the results, we are aiming for local accountability must be introduced, to achieve genuine and measurable organisational impact, responsibility for change must be embedded and owned within Clinical Boards and operational leadership structures. Sustained progress will require local engagement and strong visible leadership at every level.

2. STAFF SURVEY – PEOPLE PROMISE

The response rate for the 2024 staff survey 2024 increased to 64% with the best NHS Trust reporting a response rate of 70.92%. The Trust received 10,371 responses, up from 6,457 in 2023 - a 60.62% improvement.

A summary of the People Promise Scores are outlined below comparing results for staff who have a long-term health condition (LTC) and those who don't (no LTC).

	LTC		No-LTC	
PP Themes	2023	2024	2023	2024
We are a team	5.93	6.12	6.49	6.57
We are always learning	4.82	4.99	5.48	5.64
We are compassionate and inclusive	6.71	6.86	7.23	7.26
We are recognised and rewarded	5.12	5.27	5.78	5.83
We are safe and healthy	5.42	5.56	6.18	6.26
We each have a voice that counts	6.10	6.21	6.63	6.71
We work flexibly	5.28	5.47	5.88	6.05

For staff with or without a long-term condition 'every' people promise theme has improved.

	LTC		No-LTC	
PP Sub Themes	2023	2024	2023	2024
Advocacy	6.66	6.74	7.11	7.16
Appraisals	3.78	4.02	4.57	4.83
Autonomy and control	6.35	6.43	6.89	6.93
Burnout	4.25	4.36	5.11	5.17
Compassionate culture	6.92	6.99	7.28	7.34
Compassionate leadership	6.03	6.37	6.61	6.73
Development	5.85	5.94	6.37	6.44
Diversity and equality	7.74	7.87	8.26	8.27
Flexible working	5.22	5.35	5.82	5.97
Health and safety climate	4.90	5.12	5.30	5.50
Inclusion	6.15	6.24	6.75	6.72
Involvement	6.07	6.18	6.69	6.76
Line management	5.87	6.14	6.44	6.53
Morale	5.36	5.51	5.93	6.07
Motivation	6.32	6.37	6.91	6.94
Negative experiences	7.11	7.22	8.13	8.12
Raising concerns	5.84	5.98	6.37	6.50
Staff engagement	6.35	6.43	6.90	6.95
Stressors	5.80	5.91	6.32	6.37
Support for work-life balance	5.28	5.59	5.93	6.14
Team working	6.98	6.10	6.49	6.57
Thinking about leaving	5.57	5.68	6.27	6.44
Work pressure	4.72	4.93	5.19	5.42

5 of the People promise sub themes have worsened in the last 12 months for all staff, team working is the only one where staff with a no long-term health condition have seen an improvement and those with a long-term health condition have not.

3. WDES DATA

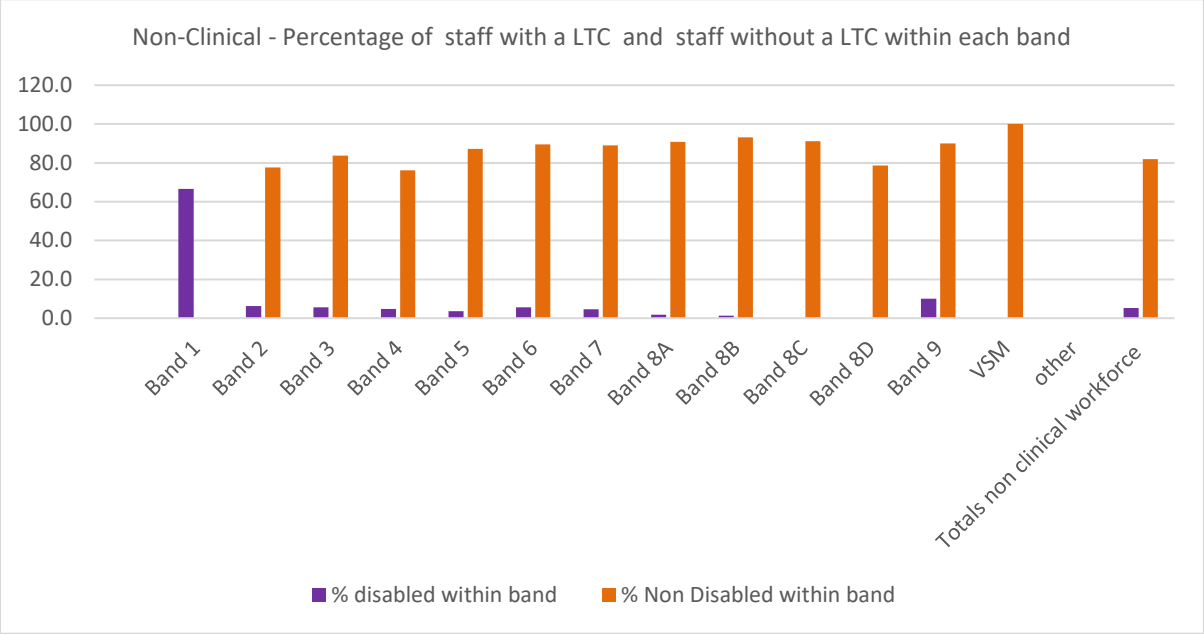
The WDES is a set of ten specific measures which enables the Trust to compare the workplace and career experiences of disabled and non-disabled staff. The Trust will use the data to develop and publish an improvement plan. Three metrics are taken from the Electronic Staff Record (ESR), and the remainder are taken from the staff survey. All percentages relate to those who completed the staff survey.

Data Collection Timetable	Date
WDES	1st May to 31st May 2025

Indicator 1: Percentage of Disabled staff in each of the Agenda for Change (AfC) bands 1-9, VSM (including executive board members), medical/dental and other staff compared with the percentage of staff in the overall non-clinical workforce.

Non-Clinical Workforce

	% Disability 2024			% Disability 2025		
Band	% Disabled staff of whole Non-Clinical Workforce	% Non-Disabled staff of whole Non-Clinical Workforce	% Not Recorded staff of whole Non-Clinical Workforce	% Disabled staff of whole Non-Clinical Workforce	% Non-Disabled staff of whole Non-Clinical Workforce	% Not Recorded staff of whole Non-Clinical Workforce
Band 1	0.05	0.00	0.03	0.05	0.00	0.02
Band 2	2.07	22.76	6.49	1.95	24.50	5.09
Band 3	1.67	18.05	3.32	1.28	19.36	2.49
Band 4	0.94	12.27	4.05	0.82	12.79	3.19
Band 5	0.68	8.87	1.18	0.40	9.43	0.99
Band 6	0.47	5.00	0.39	0.32	5.06	0.27
Band 7	0.26	4.73	0.42	0.27	5.16	0.37
Band 8A	0.10	2.30	0.18	0.05	2.47	0.20
Band 8B	0.05	1.57	0.08	0.02	1.68	0.10
Band 8C	0.00	0.94	0.10	0.00	0.77	0.07
Band 8D	0.00	0.24	0.08	0.00	0.27	0.07
Band 9	0.03	0.21	0.00	0.02	0.22	0.00
VSM	0.00	0.42	0.00	0.00	0.22	0.00
Other	0.00	0.00	0.00	0.00	0.00	0.00
Total	**6.33%**	**77.35%**	**16.32%**	**5.19%**	**81.95%**	**12.87%**

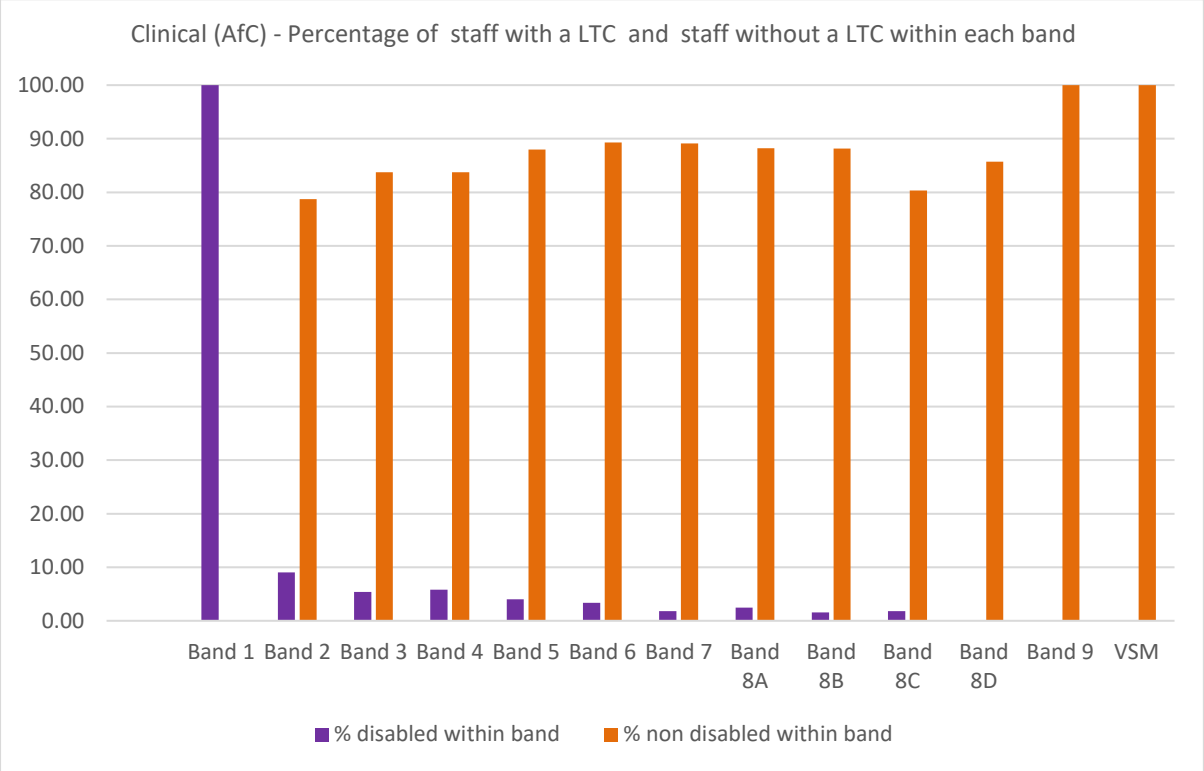


- The percentage of disabled staff in the non-clinical workforce has dropped by 1.14%
- The percentage of 'Null' records non-clinical staff has reduced by 3.45%
- Disabled staff make up 5.2% of the non-clinical workforce
- Percentage of AfC clinical staff with a declared disability by Cluster
  - Cluster 1 (bands 1-4) 5.7%
  - Cluster 2 (5-7) 4.4%
  - Cluster 3 (bands 8a – 8b) 1.6%
  - Cluster 4 (bands 8c to VSM) 1.5%

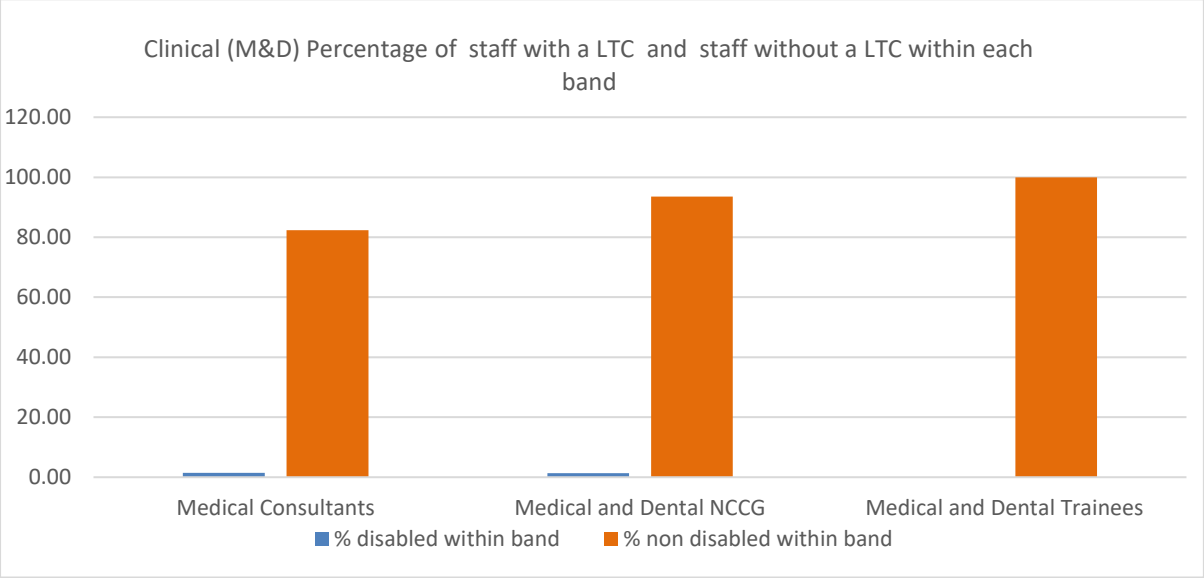
Clinical Workforce

	% Disability 2024			% Disability 2025		
Band	% Disabled staff of whole Clinical Workforce	% Non-Disabled staff of whole Clinical Workforce	% Not Recorded staff of whole Clinical Workforce	% Disabled staff of whole Clinical Workforce	% Non-Disabled staff of whole Clinical Workforce	% Not Recorded staff of whole Clinical Workforce
Band 1	0.02	0.00	0.00	0.02	0.00	0.00
Band 2	0.77	6.78	1.29	0.71	6.21	0.97
Band 3	0.70	9.63	1.64	0.66	10.21	1.32
Band 4	0.23	3.57	0.56	0.26	3.72	0.46
Band 5	1.43	25.34	2.75	1.17	25.49	2.31
Band 6	0.94	15.63	1.60	0.62	16.37	1.34
Band 7	0.42	10.11	1.47	0.23	11.09	1.12
Band 8A	0.13	2.54	0.33	0.08	2.83	0.30
Band 8B	0.02	0.88	0.16	0.02	0.88	0.10
Band 8C	0.02	0.31	0.09	0.01	0.35	0.08
Band 8D	0.00	0.05	0.01	0.00	0.05	0.01
Band 9	0.00	0.01	0.01	0.00	0.03	0.00
VSM	0.00	0.02	0.02	0.00	0.03	0.00

Medical and Dental Consultants	0.00	0.00	0.00	0.12	6.58	1.30
Non Consultant Career Grades	0.09	6.17	1.54	0.04	2.75	0.15
Trainee Grades	0.04	2.51	0.18	0.00	0.01	0.00
Totals	**4.81%**	**85.55%**	**11.65%**	**3.93%**	**86.61%**	**9.46%**



- The percentage of disabled staff in the clinical workforce has dropped by 0.88%
- The percentage of 'Null' records clinical staff has reduced by 2.19%
- Disabled staff make up 3.93% of the clinical workforce previously 4.81% a drop of 0.88%
- Percentage of AfC clinical staff with a declared disability by Cluster
    - Cluster 1 (bands 1-4) 6.7%
    - Cluster 2 (5-7) 3.4%
    - Cluster 3 (bands 8a – 8b) 2.2%
    - Cluster 4 (bands 8c to VSM) 1.4%

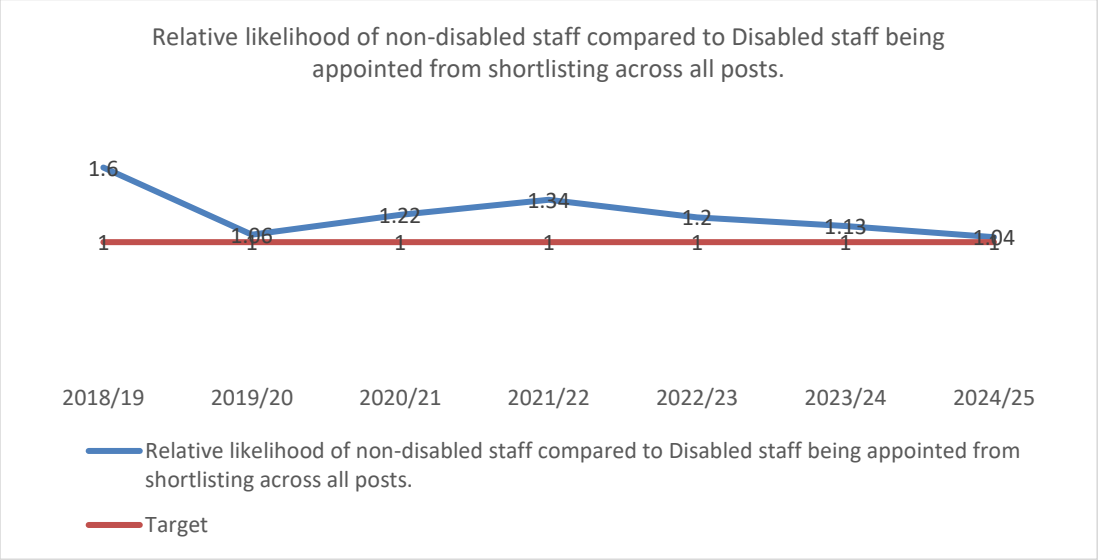


A Model Employer Disability: A Model Employer sets a stretching aspiration for all NHS organisations to reach equality in BME representation across their workforce pipeline by 2028. The table below has been calculated in the same way for disabled staff and shows the number of disabled staff in post at each band as of 31 March 2025. The table identifies the number of additional Disabled staff required for each of the pay bands to be representative. The recalculation takes account of the Trust having a disabled workforce at 4.2%

	2025 - Number of Disabled staff per band	**2025 - Additional staff required to achieve equity**
Band 8a	12	79
Band 8b	3	32
Band 8c	1	15
Band 8d	0	4
Band 9	1	1
VSM	1	4

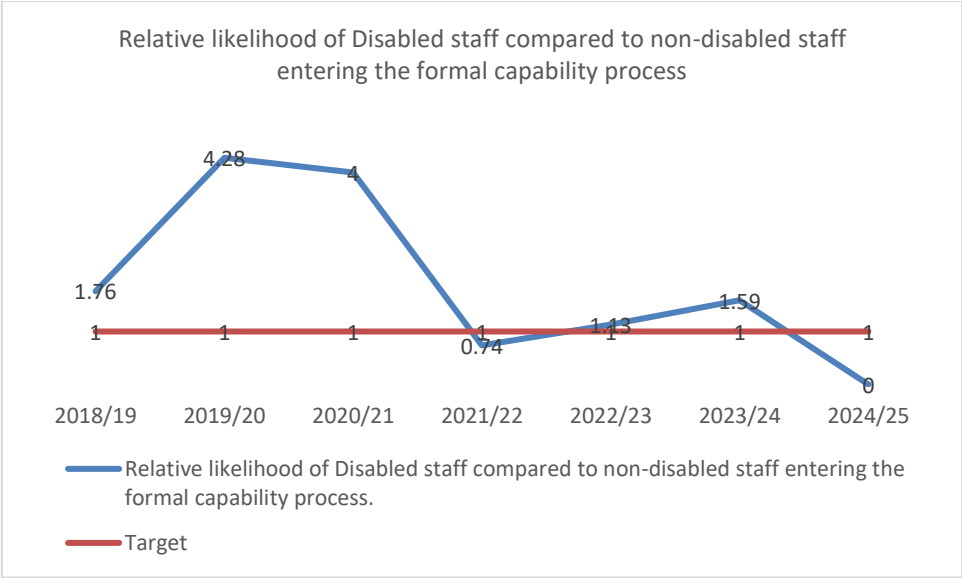
Indicator 2: Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts.

A figure below 1 indicates that Disabled staff are more likely than non-disabled staff to be appointed from shortlisting.



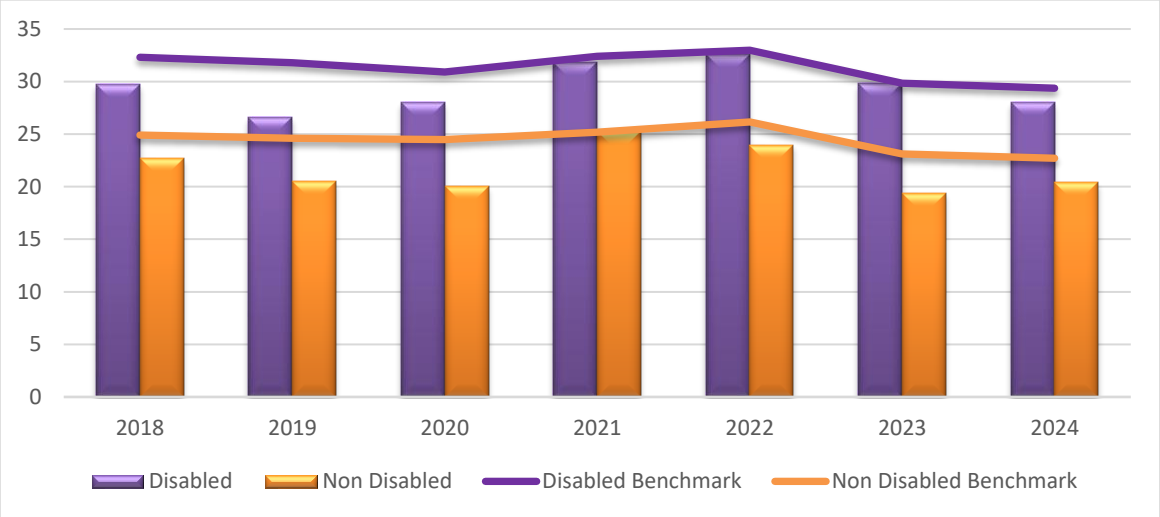
- Non-disabled staff are 1.04 times more likely to be appointed from shortlisting across all posts.
- This shows a year-on-year improvement over the last 4 years.
- Specifically, 324 out of 1127 disabled candidates were appointed from shortlisting (28.74%) compared to 3398 out of 11287 non-disabled candidates (30.10%).
- This indicator has slightly improved from last years (0.09).

Indicator 3: Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process.



- No Disabled staff entered formal capability process.
- Disabled staff are less likely to enter the formal capability process.
- Specifically, 48.5 Disabled staff entered the formal capability process over the last 2 years, all were on the grounds of ill health (0.5 occurs as the data is averaged over a 2-year period) and 491 non-disabled staff entered the formal capability process over the last 2 years, 486.5 were on the grounds of ill health.
- This indicator has improved from last year.

Indicator 4a - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from patients, service users or the public.



	Disabled	Non-Disabled	Disabled Benchmark	Non-Disabled Benchmark
2021	31.8	25.3	32.4	25.2
2022	32.57	23.98	32.98	26.16
2023	29.82	19.41	32.35	23.76
2024	28.03	20.39	29.37	22.71

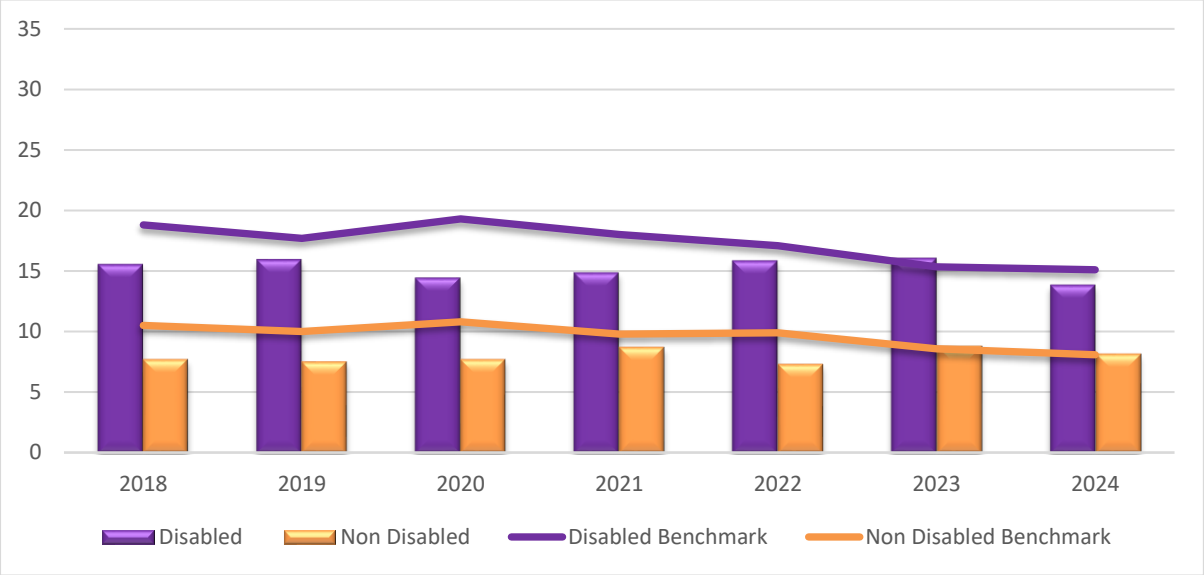
- The percentage of Disabled staff experiencing BH&A from patients, relatives or the public is 28.03% which is 7.64% higher than non-disabled staff and 1.34 % lower than the benchmark data.
- This indicator has seen improvements over the last three years.
- The gaps between disabled and non-disabled staff have reduced.
- Trust data remains below national benchmark data which is also showing a reduced experience.

Clinical Boards

Clinical Boards reporting a higher percentage than the Trust overall are identified below.

Disabled staff experiencing B&H from patients Trust wide	28.00%
Cardiothoracic Services	30.00%
Family Health	38.50%
Medicine and Emergency Care	56.20%
Surgical and Associated Services FH	36.90%
Surgical and Specialist Services RVI	36.80%

Indicator 4a - Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from a line manager.



	Disabled	Non- Disabled	Disabled Benchmark	Non-Disabled Benchmark
2021	14.8	8.7	18	9.8
2022	15.79	7.31	17.09	9.88
2023	16	8.79	15.33	8.56
2024	13.81	8.15	15.1	8.08

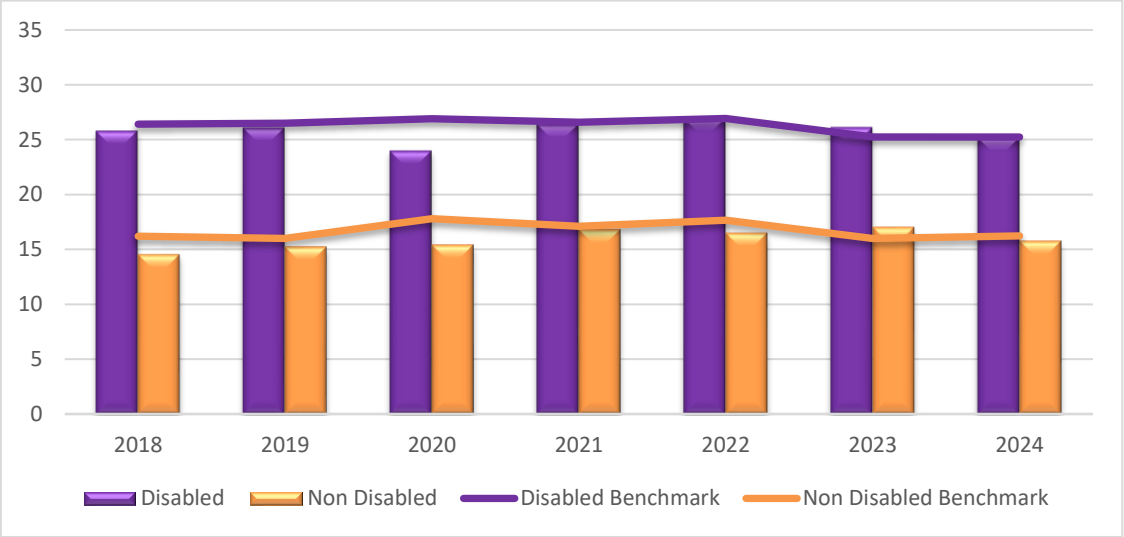
- The percentage of Disabled staff experiencing BH&A from a line manager is 13.81% (which is 5.66% higher than non-disabled staff and 1.22% lower than the benchmark data.
- Experience of disabled staff has improved and the gap between disabled and non-disabled staff has reduced 1.55% points.
- Disabled staff experience is slightly better than the benchmark data.

Clinical Boards

Clinical Boards reporting a higher percentage than the Trust overall are identified below.

Disabled staff experiencing B&H from Managers Trust wide	13.80%
Cancer and Haematology	16.00%
Chief Executive Office	30.80%
Clinical and Diagnostic Services	13.90%
Human Resources	19.60%
Medical Director	16.70%
Medicine and Emergency Care	15.50%
Patient Services	16.70%
Peri-operative and Critical Care	17.70%
Surgical and Specialist Services RVI	13.90%

Indicator 4a – Percentage of Disabled staff compared to non-disabled staff experiencing harassment, bullying or abuse in the last 12 months from other colleagues.



	Disabled	Non-Disabled	Disabled Benchmark	Non-Disabled Benchmark
2021	26.4	16.8	26.6	17.1
2022	26.98	16.46	26.93	17.67
2023	26.12	16.98	25.26	16.01
2024	25.18	15.74	25.24	16.22

- The percentage of Disabled staff experiencing BH&A from other colleagues is 25.18% which is 9.44% higher than non-disabled staff and 0.06% lower than the benchmark data.
- This indicator has seen minor improvements in the last three years.
- Disabled staff experience has improved slightly, although the gap between disabled staff experience and non-disabled staff experience of BH&A from colleagues has grown by 0.3.
- Data for disabled staff has improved slightly against the national benchmark data.

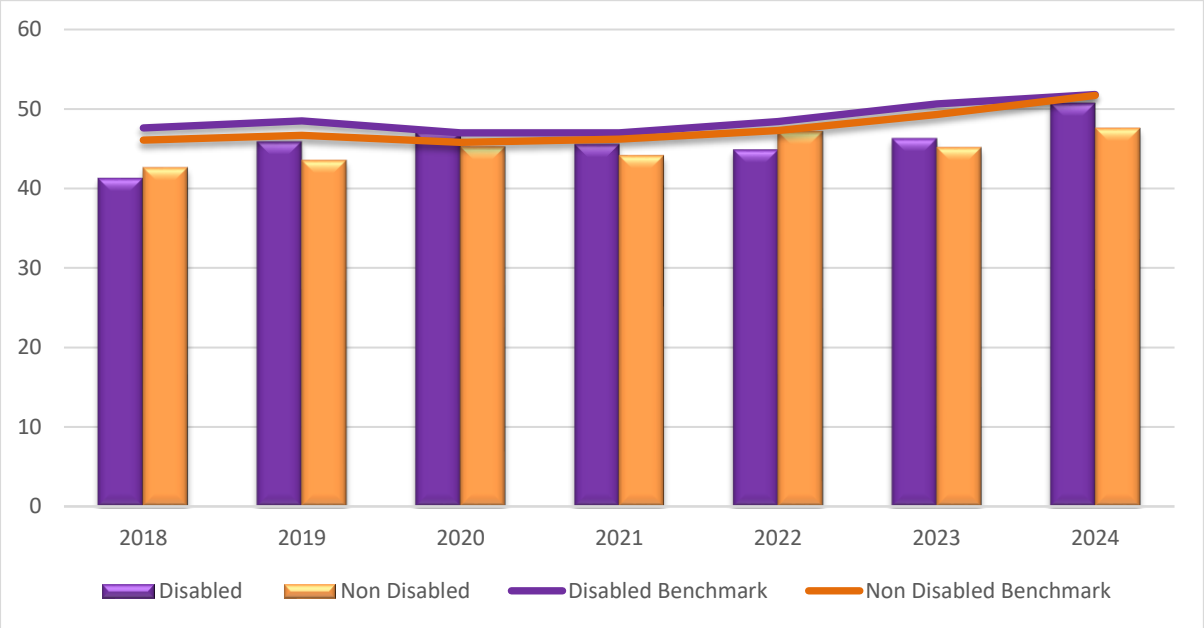
Clinical Boards

Clinical Boards reporting a higher percentage than the Trust overall are identified below.

Disabled staff experiencing B&H from colleagues Trust wide	25.20%
Cancer and Haematology	28.60%
Cardiothoracic Services	34.30%
Chief Executive Office	38.50%
Estates	24.10%
Family Health	26.80%
Human Resources	30.40%
Medicine and Emergency Care	23.90%

Patient Services	35.40%
Peri-operative and Critical Care	30.80%
Surgical and Specialist Services RVI	29.80%

Indicator 4b: Percentage of staff who reported harassment, bullying or abuse the latest time it happened.



	Disabled	Non-Disabled	Disabled Benchmark	Non-Disabled Benchmark
2021	45.5	44.1	47	46.2
2022	44.78	47.14	48.43	47.3
2023	46.21	45.11	50.64	49.31
2024	50.64	47.54	51.82	51.71

- The percentage of Disabled staff experiencing BH&A and reporting it is 50.64% (which is 3.1% higher than non-disabled staff and 1.18% lower than the benchmark data.
- There has been a 4.43 increase in the percentage of disabled people reporting BH&A but it remains 0.06 points lower than the national benchmark data.

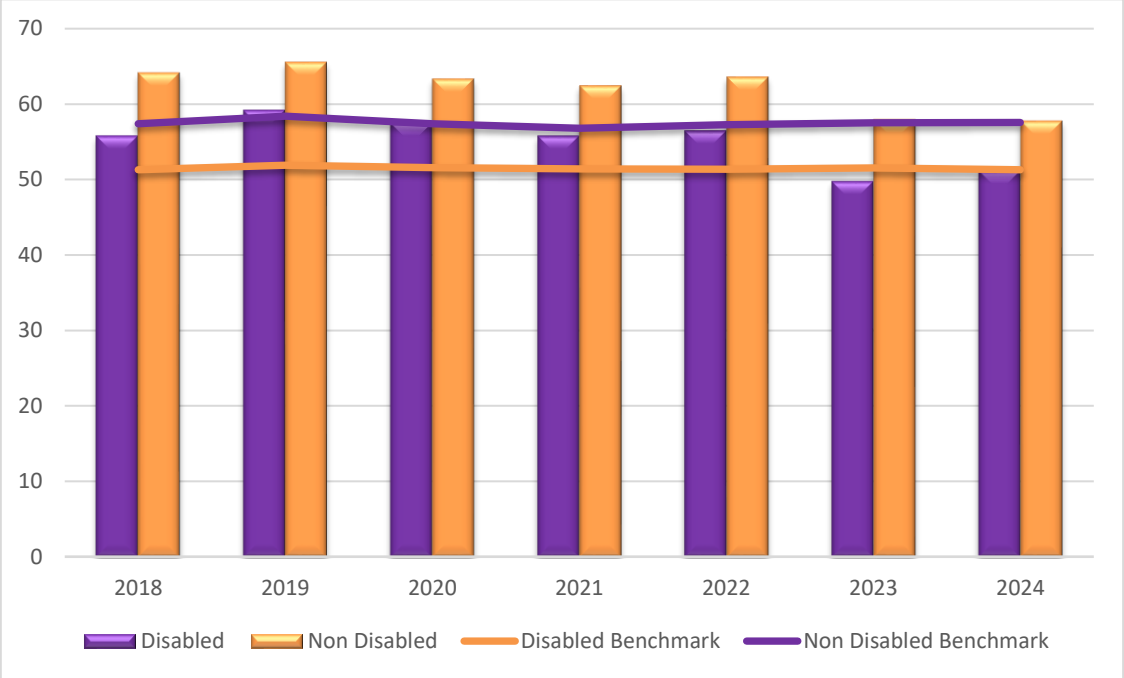
Clinical Boards

Clinical Boards reporting a higher percentage than the Trust overall are identified below.

Percentage of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it.	50.70%
Cancer and Haematology	40.00%
Cardiothoracic Services	44.30%
Estates	48.50%
Information Management and	50.00%

Peri-operative and Critical Care	46.30%

Indicator 5: Percentage of Disabled staff compared to non-disabled staff believing that the trust provides equal opportunities for career progression or promotion.



	Disabled	Non-Disabled	Disabled Benchmark	Non-Disabled Benchmark
2021	55.8	62.4	51.4	56.8
2022	56.48	63.53	51.39	57.25
2023	49.77	57.92	51.54	57.52
2024	51.15	57.72	51.3	57.57

- The percentage of Disabled staff who believe the trust provides equal opportunities for career progression or promotion is 51.15% this is an increase of 1.38
- This is 6.57% lower than non-disabled staff although the gaps has lessened and
- Remains and 0.15% lower than the benchmark data, although again this has improved but not significantly

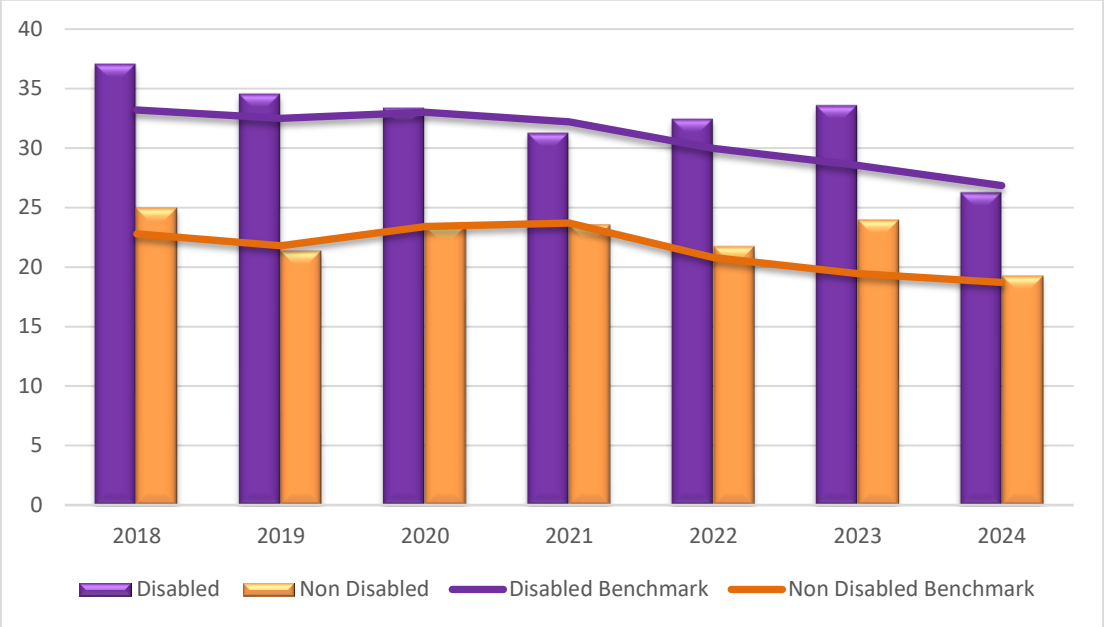
Clinical Boards

Clinical Boards reporting a higher percentage than the Trust overall are identified below.

Percentage of staff believing that the Trust provides equal opportunities for career progression or promotion	50.10%
Cardiothoracic Services	46.00%
Chief Executive Office	38.50%
Estates	42.60%
Human Resources	35.70%
Patient Services	48.90%

Peri-operative and Critical Care	46.90%
Surgical and Specialist Services	48.80%

Indicator 6: % of staff who have felt pressure from their manager to come to work despite not feeling well enough to perform duties.



	Disabled	Non-Disabled	Disabled Benchmark	Non-Disabled Benchmark
2021	31.2	23.6	32.2	23.7
2022	32.4	21.78	29.97	20.8
2023	33.52	24	28.55	19.46
2024	26.24	19.28	26.85	18.71

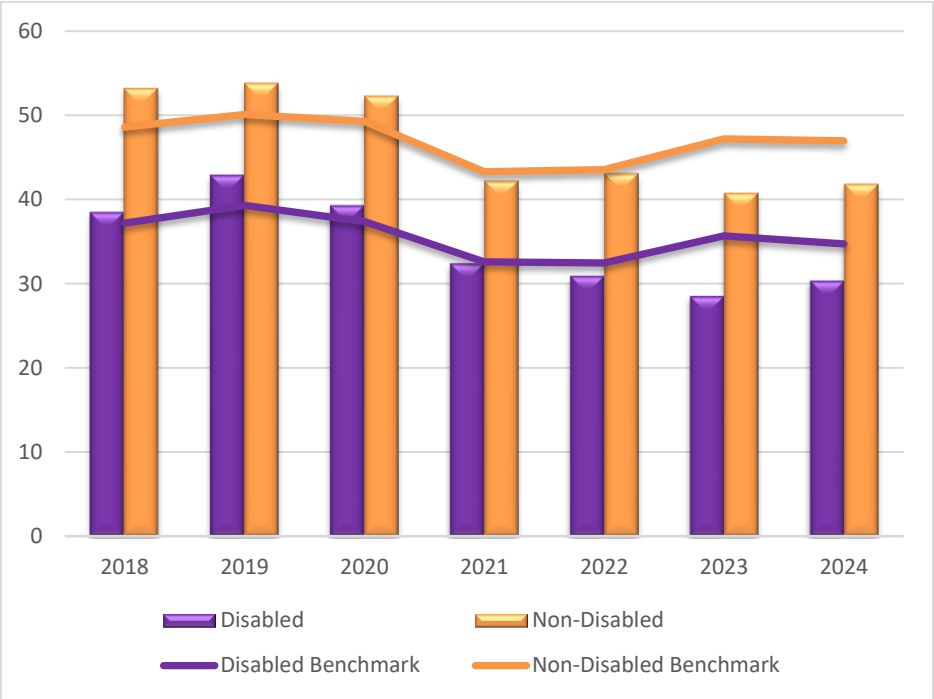
- The percentage of Disabled staff who indicated they have felt pressure from their manager to come to work despite not feeling well enough to perform duties has reduced by 7.28 to 26.24%
- The gap between disabled and non-disabled staff has decreased to 6.96% but remains higher than non-disabled staff
- There has been a positive shift when reviewed against national benchmark data

Clinical Boards

Clinical Boards reporting a higher percentage than the Trust overall are identified below.

% of staff who have felt pressure from their manager to come to work despite not feeling well enough to perform duties.	26.20%
Cardiothoracic Services	30.40%
Estates	33.10%
Family Health	27.60%
Peri-operative and Critical Care	41.50%

Indicator 7: % of staff satisfied with the extent to which their organisation values their work.



	Disabled	Non-Disabled	Disabled Benchmark	Non -Disabled Benchmark
2021	32.4	42.2	32.6	43.3
2022	30.92	43.1	32.46	43.56
2023	28.51	40.78	35.66	47.19
2024	30.36	41.85	34.73	46.98

- The percentage of Disabled staff who indicated they are satisfied with the with the extent to which their organisation values their work is 30.36%, an improvement in the last 12 months
- The gap between Disabled and Non-Disabled staff has improved by 0.78
- Trust date remains below national benchmark data however the gap has reduced
- Until the most recent result this indicator had seen a worsening position reported each year from 2019

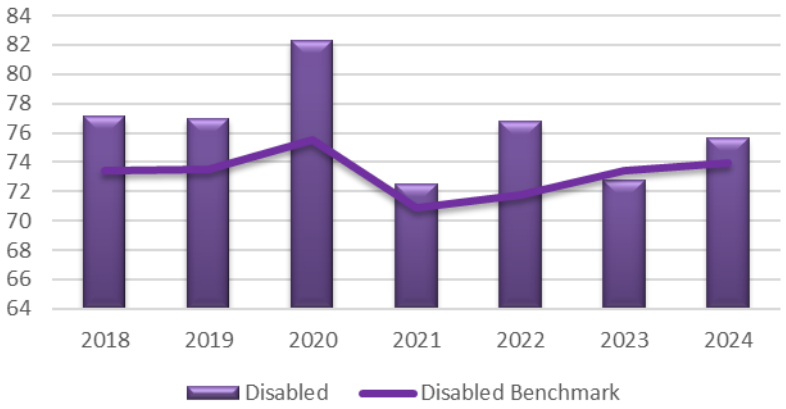
Clinical Boards

Clinical Boards reporting a higher percentage than the Trust overall are identified below.

% of staff satisfied with the extent to which their organisation values their work.	30.40%
Cancer and Haematology	26.70%
Cardiothoracic Services	26.80%
Estates	26.90%

Medicine and Emergency Care	26.40%
Peri-operative and Critical Care	17.80%
Surgical and Specialist Services RVI	28.20%

Indicator 8: % of disabled staff who said their employer has made adequate adjustments to enable them to carry out their work.



	Disabled	Disabled Benchmark
2021	72.5	70.9
2022	76.76	71.76
2023	72.79	73.38
2024	75.66	73.98

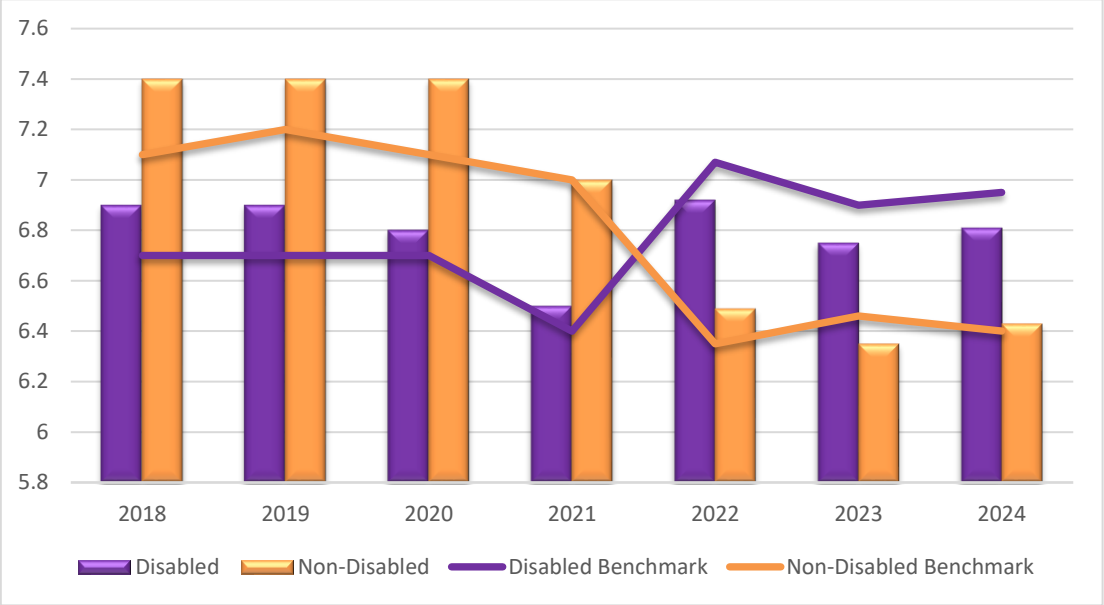
- The percentage of Disabled staff who feel the Trust has made adequate adjustments to enable them to carry out their work has increased to 75.66%
- This is 1.68% higher (0.59% lower) than the national benchmark data

Clinical Boards

Clinical Boards reporting a higher percentage than the Trust overall are identified below.

% of disabled staff who said their employer has made adequate adjustments to enable them to carry out their work.	75.70%
Cardiothoracic Services	74.70%
Estates	66.20%
Medicine and Emergency Care	73.10%
Peri-operative and Critical Care	65.90%
Surgical and Specialist Services RVI	72.20%

Indicator 9a: Staff Engagement

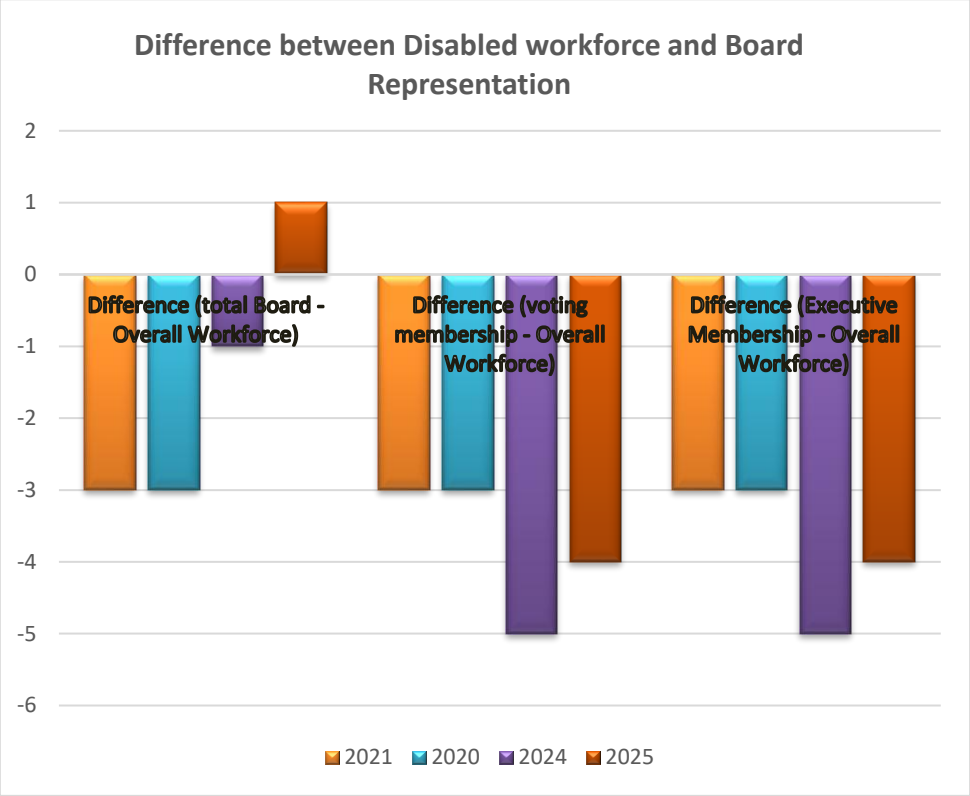


	Disabled	Non-Disabled	Disabled Benchmark	Non-Disabled Benchmark
2021	6.5	7	6.4	7
2022	6.92	6.49	7.07	6.35
2023	6.75	6.35	6.9	6.46
2024	6.81	6.43	6.95	6.4

- Across the Trust our staff engagement score is 6.81.
- Disabled staff continue to report higher levels of engagement than non-disabled staff.
- Staff engagement scores for Disabled staff are below national benchmark data.

Indicator 10: Percentage difference between the organisation's board voting membership and its organisation's overall workforce.

The Board representation indicator is calculated by deducting the percentage of Disabled staff in the workforce from the percentage of Disabled members on the Board of Directors. A value of "0.0" means that the percentage of Disabled members on the Board of Directors is exactly the same as the percentage of Disabled staff in the workforce. A positive value means that the percentage of Disabled members on the Board of Directors is higher than in the workforce, and a negative value means that the percentage of Disabled members on the board of directors is lower than in the workforce.



- As at March 2025 the difference between Disabled representation on the Board and in the overall workforce was 1. This is an improved position from last year.
- A positive value means that the percentage of Disabled members on the Board of Directors is higher than in the workforce.
- Voting and Executive membership: the difference between Disabled representation on the Board and in the workforce was -4 for both.

4. ACTIONS TAKEN IN THE LAST 12 MONTHS

People Program Board - Our People Programme Board was formed to guide and ensure the success of the NHS People Plan and our people priorities, emphasising a cultural focus. It drives delivery, identifying priorities and planning transformative initiatives in line with the Trust's people agenda.

EDI Steering Group - EDI Steering Group provides a platform to engage staff to achieve a more inclusive culture. Its main purpose is to drive forward the development and Trust-wide delivery of the Trust's Equality, Diversity and Inclusion agenda. The Steering Group will support the strategic direction for equality and diversity in line with the Trust's Programme Board, people strategy, vision and core values and drive the identification, development and delivery of key priorities that will serve as a catalyst for change by promoting equity and cohesion whilst tackling inappropriate behaviours and discrimination.

Lived Experience – An important part of change is changing attitudes and increasing understanding around impact but it's also about improving the 'experiences' of minority groups within the Trust and the most effective way is to enable staff to influence the design and delivery of our People Priorities, providing an authentic voice and unique insights that

challenge assumptions and motivate us to do things differently. Staff network representatives have a seat on the EDI Steering group but there is also a standing agenda item where the network can highlight staff voice through lived experience.

Choices College: Through our supported internship programme for young adults with learning difficulties, disabilities or autism we continue to provide meaningful opportunities for participants to develop employability skills and transition into the workplace. Since its launch 130 young people have completed the programme with a 74% internship to employment transition rate making it one of the most successful programmes in the NHS. Our program consistently outperforms national outcomes. As changes continue to emerge across the NHS it is important that we take steps to future proof the scheme, ensuing its long-term viability ensuring continued success in supporting inclusive employment pathways. Through Choices College we work hard to challenge and change cultures, demonstrating how young people with a learning disability can enrich our workforce, bring incredible skills and talent, encourage greater diversity and meet a real business need. The project takes a person-centred approach to learning and development. We know there is a lack of awareness about learning disability, and this often includes limited understanding about what people with a learning disability can do. Choices College has such a positive impact within teams but also has a transformational impact on the young people in terms of feeling valued for their contribution and achieving additional independence.

Reasonable Adjustment and Neurodiversity Managers Guides: The introduction of both guides aimed to strengthen our commitment to creating an inclusive and supportive workplace. These resources were co-produced to equip managers with the knowledge and build confidence to make timely appropriate person-centred adjustments and better understand the diverse cognitive needs of their teams. By fostering greater awareness and reducing barriers to support, these guides not only promote equity and wellbeing but also help unlock the full potential of all colleagues, enhancing engagement, retention and overall team performance.

5. ORGANISATIONAL PRIORITIES GOING FORWARD

Embed the Civility Charter - continue to embed and reinforce positive messaging across the Trust.

Targeted Improvement Approach: A more focused approach across specific and identified Clinical Boards will help shift the dial by focusing efforts where they are most needed and can have the greatest impact and build inclusive cultures at a local level. This approach enables deeper engagement and faster progress.

Equality Impact Assessments: Place equity and fairness at the heart of decision making by systematically assessing the potential impacts of policies, practices, staff and service changes on those with protected characteristics. Our Equality Impact Assessment policy and guidance has been updated to improve our decision making and help ensure that no group is unfairly disadvantaged, intentionally or unintentionally. However, in the coming year we need to work to embed the process and raise understanding of the benefits across Trust. By ding this we will aim to ensure we;

- Promote fair and inclusive decision making by highlighting risks of discrimination or inequity early.
- Strengthen our compliance with the Public Sector Equality Duty.
- Encourage transparency, accountability.
- Improve service design and delivery by centring the needs and experiences of diverse groups.
- Minimise risks through positive identification and mitigation of discriminatory impacts.
- Build trust with staff and communities by demonstrating a genuine commitment to equity and inclusion.

Reasonable Adjustments: A key action in last year's WDES action plan was to explore the development of a centralised reasonable budget model to improve consistency and staff experience. This approach would remove financial barriers at a local level, promote uniform decision making and would enable tracking and forecasting of adjustment costs, supporting better financial planning. By aligning this approach with the Access to Work Scheme we could ensure timely support for staff while also ensuring the Trust reclaims eligible costs making the process both inclusive and financially sustainable. It would also allow the tracking and redistribution of equipment when staff leave the organisation, initial scoping has taken place, and this will be taken back to the EDI Steering Group.

Equality Dashboard: Implementation of the people equality dashboard into the performance management framework was launched several years ago with the aim of ensuring local accurate and meaningful data to help monitor progress and inform decisions about EDI priorities at a Directorate level. The Dashboard needs to be redeveloped and realigned to our Clinical Board Structure.

6. ACTIONS

Trust Board is asked to:

- Note the contents of this report.
- Agree the requirement to publish data by 31 May 2025 on the Data Collection Framework website and the Trust's website.

Report of Karen Pearce
Head of Equality, Diversity and Inclusion (People)
16 May 2025

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Agenda item A12

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025		
Title	Workforce Race Equality (WRES) Report		
Report of	Vicky McFarlane-Reid, Director for Commercial Development and Innovation Interim Executive Lead for the People Directorate		
Prepared by	Karen Pearce, Head of Equality, Diversity and Inclusion (People)		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☐
Summary	The purpose of this report is to provide the Trust's position in relation to Workforce Race Equality Standards (WRES) metrics for 2024/25 which requires publication by 31 May 2025 on the Data Collection Framework website and the Trust's website. Both WRES and WDES results have improved but remain a long way from where we need them to be and must be a focus going forward. The response rate for the 2024 staff survey increased to 64% with the best NHS Trust reporting a response rate of 70.92%. The Trust received 10,371 responses, up from 6,457 in 2023 - a 60.62% improvement and Responses from Black and Minority Ethnic (BME) staff to the WRES questions ranged from 1,544 to 1,565 staff a significant improvement on the previous year. Analysis shows that we have not seen significant shifts in outcomes, particularly in relation to the Staff survey data linked to behaviours which have been consistently a concern from 2014. Changes have been both marginal and inconsistent, both positive and negative with no sustained positive trend. Elements that have seen a decline this year; – BME staff are 1.81 times less likely to be appointed – a negative downward trend over the last two years. – BME staff are 1.50 times more likely to enter formal disciplinary processes, this is unusual for the Trust. 2012/22 is the only other year BME staff been recorded as more likely to enter formal disciplinary processes within the Trust. This is the worst position the Trust has report since WRES was introduced. – A higher percentage of BME staff report experiencing harassment, bullying or abuse from patients, relatives or the public. To achieve genuine and measurable organisational impact, responsibility for change must be embedded and owned within clinical boards and operational leadership structures. Sustained progress will require local accountability, local engagement and visible leadership at every level. A Board Development Session took place recently which included an item on Equality Diversity and Inclusion (EDI) and a workshop with key stakeholder to identify priorities going forward, this		

<table>
<tr><td></td><td colspan="6">work will continue to identify required outcomes with the development of an associated action plan.</td></tr>
<tr><td>Recommendation</td><td colspan="6">Trust Board is asked to:

• Note the contents of this report.
• Agree the requirement to publish data by 31 May 2025 on the Data Collection Framework website and the Trust's website.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">People – Supported by our People Plan, we will ensure that each member of staff is able to liberate their potential.</td></tr>
<tr><td rowspan="2">Impact

(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td><td>☒</td><td>☒</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">Not applicable.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Trust Board - 30 May 2024</td></tr>
</table>

WORKFORCE RACE EQUALITY UPDATE

EXECUTIVE SUMMARY

This report provides the Trust's position in relation to the WRES report for 2024/25 which requires publication by 31 May 2025. WRES covers 9 metrics with the aim of supporting the system to understand both the nature and the challenge of race equity with the aim of improvement.

The response rate for the 2024 staff survey increased to 64% with the best NHS Trust reporting a response rate of 70.92%. The Trust received 10,371 responses, up from 6,457 in 2023 - a 60.62% improvement and Responses from BME staff to the WRES questions ranged from 1,544 to 1,565 staff a significant improvement on the previous year

Analysis shows that we have not seen significant shifts in outcomes, particularly in relation to the Staff survey data linked to behaviours which have been consistently a concern from 2014. Changes have been both marginal and inconsistent, both positive and negative with no sustained positive trend. To create meaningful and lasting change we must move beyond isolated effort and the responsibility for tackling both individual and systemic racism must be embedded within Clinical Boards and operational leadership. Change must be driven through collective ownership, with clear accountability, visible leadership and active engagement across all parts of the Trust.

The key challenges for the Trust remain behaviours, discrimination and representative leadership:

WRES Indicator	Headline Data	Improved from 2023/24 Yes/No/ No change
Indicator 1: Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.	– The percentage of BME staff in post has increased by 1.32% in non-clinical roles and 1.36% in clinical roles. – Growth has taken place predominantly at bands 3-6 with smaller changes in higher bandings. – Representation becomes a problem at bands 6 & 7. – Medical staff are under-represented at consultant level and within Medical Management.	Yes

WRES Indicator	Headline Data	Improved from 2023/24 Yes/No/ No change
Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts	– White staff are 1.81 times more likely to be appointed. – This is the worst result the Trust has had for this metric. – Metric worsened due to a lower percentage of BME candidates having been appointed from a larger number of BME applicants being shortlisted.	No
Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.	– BME staff are 1.50 times more likely to likely to enter formal disciplinary processes. – Atypical result for the Trust for this metric. – 0.40% of the white workforce entered formal process compared to 0.61% of the BME workforce. – There were 2 disciplinary cases where ethnicity was unknown. – Currently, outside the non-adverse range of 0.8 – 1.25.	No
Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD	– White staff are 0.86 times less likely to access non-mandatory training and Continuing Professional Development (CPD). – 35.45% of the white workforce compared to 41.33% of the BME workforce. – 18% of staff did not identify an ethnicity.	Yes
Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public.	– The percentage of BME staff experiencing Bullying & Harassment (B&H) from patients is 24.66% which is 2.63% higher than white staff and 3.61% lower than the BME benchmark.	No
Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months	– The percentage of BME staff experiencing B&H from staff is 26.98% which is 6.03% above that of white staff and 2.2% higher than the BME benchmark.	Yes

WRES Indicator	Headline Data	Improved from 2023/24 Yes/No/ No change
	– There has been a 5.64% percentage points decrease in BME staff experiencing harassment, bullying or abuse from staff.	
Indicator 7: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion	– The percentage of BME staff believing the Trust provides equal opportunities for career progression is 47.24% which is 10.6% lower than that of white staff and 2.46% lower than the BME benchmark.	Yes
Indicator 8: Percentage of staff experiencing discrimination at work from a manager / team leader or other colleagues	– The percentage of BME staff who experience discrimination at work from a manager/team leader or other colleagues in the last 12 months is 19.11% which is 12.8% higher than white staff and 3.39% higher than the BME benchmark.	Yes
Indicator 9: Percentage difference between the organisations' Board membership and its overall workforce	– As at March 2025 the difference between BME representation on the Board and in the workforce was -8.7%.	Yes

WORKFORCE RACE EQUALITY STANDARD

1. INTRODUCTION

Implementing the Workforce Race Equality Standard (WRES) is a requirement for NHS commissioners and NHS healthcare providers including independent organisations through the NHS standard contract. NHS providers are expected to show progress against a number of indicators of workforce equality.

The national NHS People Plan identifies 'Looking after Our People' as a key theme. Through the ambitions of the People Plan and the People Promise, the NHS declared a commitment to creating and maintaining a compassionate and inclusive culture where diversity is valued and celebrated as a critical component, and not just a desirable one.

Newcastle Hospitals strives for equality of opportunities and equity of outcomes for both our staff and our patients. While progress has been made, there is still much more to be done to create a truly inclusive environment. We recognise that like many NHS Trusts we face challenges in achieving representative leadership, tackling unacceptable behaviours and incivility and addressing barriers that many colleagues experience in progressing their careers. These are not isolated issues, they reflect wider systematic patterns across the NHS. We are committed to taking meaningful, sustained action to make changes. Our challenge is to shift the mind-set at all levels and to radically alter leadership expectations, plans, ideas and behaviours towards inclusion.

Creating a compassionate and inclusive culture is the responsibility of us all, particularly our leaders, and requires a concerted action to change. We have a number of challenges ahead to improve staff experience.

1.1 The People Promise themes & Sub-themes.

We are compassionate and inclusive is the best scoring for white and BME staff

	BME		White	
PP Themes	2023	2024	2023	2024
We are a team	6.53	6.68	6.32	6.42
We are always learning	5.69	6.17	5.26	5.35
We are compassionate and inclusive	6.99	7.09	7.10	7.18
We are recognised and rewarded	5.69	5.90	5.59	5.66
We are safe and healthy	6.06	6.21	5.96	6.06
We each have a voice that counts	6.56	6.72	6.49	6.56
We work flexibly	5.95	6.17	5.68	5.85

The sub themes show improvements in all areas for white staff and improvements in most areas for BME staff, with motivation, stressors seeing a less positive position.

BME	White

PP Sub Themes	2023	2024	2023	2024
Advocacy	7.44	7.57	6.94	6.96
Appraisals	5.12	5.87	4.27	4.40
Autonomy and control	6.85	6.91	6.73	6.78
Burnout	4.99	5.10	4.86	4.93
Compassionate culture	7.62	7.71	7.13	7.17
Compassionate leadership	6.65	6.80	6.44	6.61
Development	6.24	6.46	6.23	6.29
Diversity and equality	7.20	7.34	8.23	8.32
Flexible working	5.79	5.97	5.65	5.78
Health and safety climate	5.67	5.91	5.14	5.32
Inclusion	6.49	6.49	6.60	6.63
Involvement	6.61	6.77	6.52	6.59
Line management	6.54	6.70	6.27	6.39
Morale	5.95	6.21	5.76	5.88
Motivation	7.24	7.16	6.69	6.72
Negative experiences	7.55	7.64	7.89	7.93
Raising concerns	6.28	6.54	6.24	6.34
Staff engagement	7.10	7.16	6.72	6.76
Stressors	6.26	6.29	6.17	6.25
Support for work-life balance	6.11	6.37	5.72	5.93
Team working	6.54	6.67	6.38	6.46
Thinking about leaving	5.86	6.37	6.11	6.21
Work pressure	5.75	5.97	4.99	5.18

2. WRES DATA

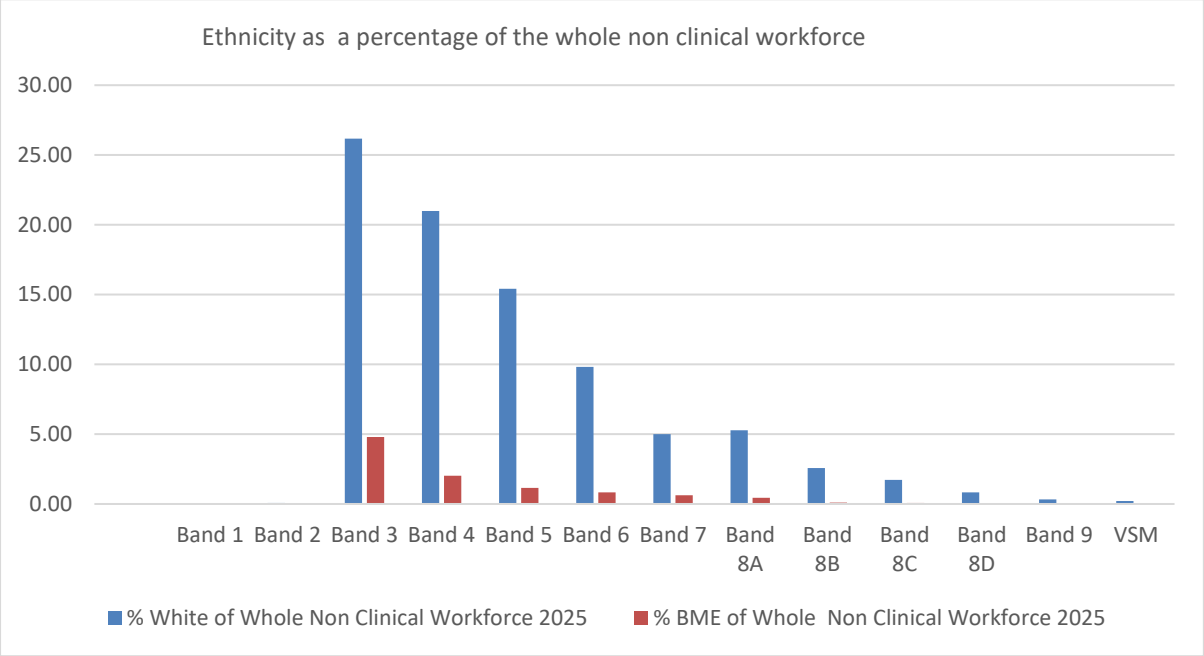
Indicator 1: Percentage of staff in each of the AfC Bands 1-9 and VSM (including executive Board members) compared with the percentage of staff in the overall workforce.

The percentage of BME staff in both Non-Clinical and Clinical roles has increased (increased Clinical 1.36% and Non-Clinical by 1.32%) This discounts data where ethnicity is unknown.

Non-Clinical Workforce

	Ethnicity 2024			Ethnicity 2025		
Band	% White of whole Non-Clinical Workforce	% BME of whole Non-Clinical Workforce	% Not Recorded of whole Non-	% White of whole Non-Clinical Workforce	% BME of whole Non-Clinical Workforce	% Not Recorded of whole Non-

			Clinical Workforce			Clinical Workforce
Band 1	0.08	0.00	0.00	0.00	0.00	0.00
Band 2	26.80	3.97	0.52	0.07	0.00	0.57
Band 3	20.97	1.75	0.34	26.18	4.79	0.12
Band 4	15.87	1.12	0.26	20.99	2.03	0.22
Band 5	9.86	0.76	0.13	15.41	1.16	0.15
Band 6	5.20	0.60	0.05	9.83	0.84	0.02
Band 7	4.97	0.39	0.05	5.01	0.62	0.07
Band 8A	2.48	0.08	0.03	5.29	0.44	0.05
Band 8B	1.65	0.05	0.00	2.57	0.10	0.00
Band 8C	1.05	0.00	0.00	1.73	0.07	0.00
Band 8D	0.29	0.03	0.00	0.84	0.00	0.00
Band 9	0.21	0.03	0.00	0.32	0.02	0.00
VSM	0.42	0.00	0.00	0.22	0.02	0.00
Totals	**89.83%**	**8.78%**	1.39%	**88.47%**	**10.10%**	**1.21%**

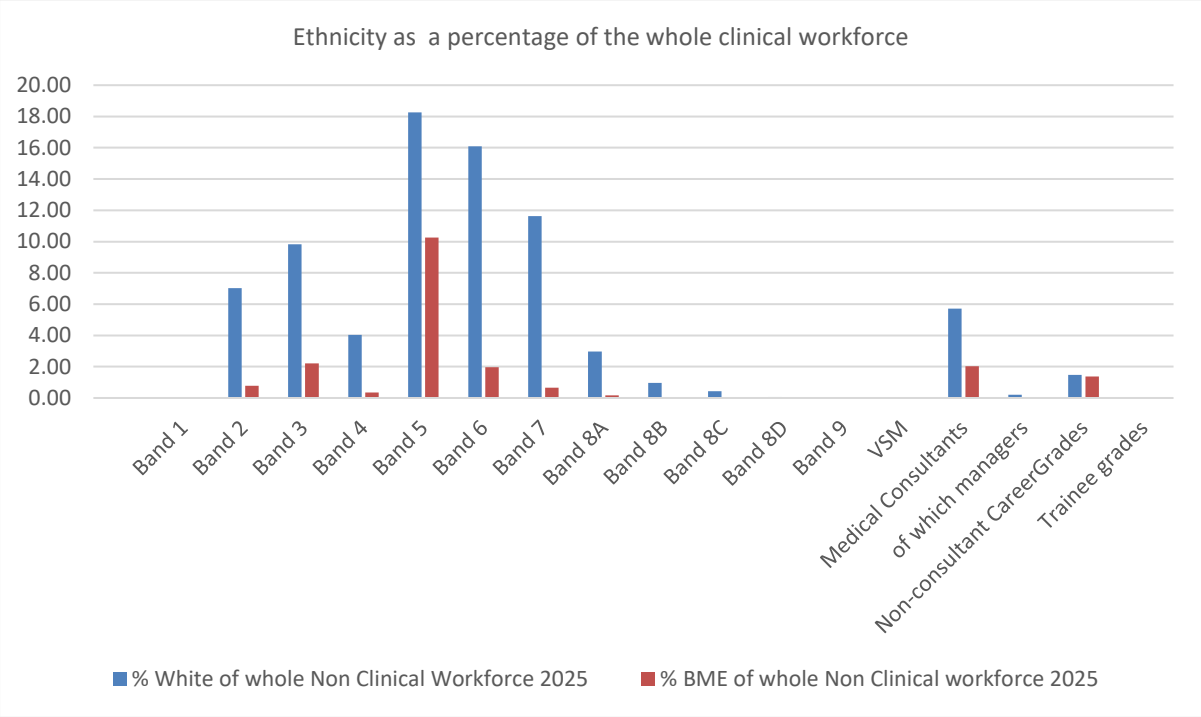


- Ethnic non-clinical workforce has grown by 1.32% in the last 12 months
- Growth has taken place at bands 3-6 with smaller changes in higher bandings
- In 2024 there were 7 members of non-clinical staff at band 8A and above, in 2025 this has increased to 9
- Ethnicity is under- represented following band 7

Clinical Workforce

	Ethnicity 2024			Ethnicity 2025		
Band	**% White of whole Clinical Workforce**	**% BME of whole Clinical Workforce**	**% Not Recorded of whole Clinical Workforce**	**% White of whole Clinical Workforce**	**% BME of whole Clinical Workforce**	**% Not Recorded of whole Clinical Workforce**
Band 1	0.02	0.00	0.00	0.02	0.00	0.00
Band 2	8.10	0.65	0.07	7.02	0.78	0.08
Band 3	10.28	1.54	0.12	9.83	2.21	0.12
Band 4	3.98	0.31	0.06	4.04	0.36	0.04
Band 5	18.72	10.29	0.44	18.27	10.27	0.36
Band 6	16.23	1.71	0.17	16.10	1.97	0.23

Band 7	11.30	0.52	0.15	11.62	0.67	0.12
Band 8A	2.79	0.13	0.06	2.98	0.16	0.05
Band 8B	1.02	0.02	0.02	0.97	0.02	0.01
Band 8C	0.42	0.00	0.00	0.43	0.00	0.01
Band 8D	0.06	0.00	0.00	0.05	0.00	0.00
Band 9	0.02	0.00	0.00	0.03	0.00	0.00
VSM	0.05	0.00	0.00	0.03	0.00	0.00
Consultants	5.64	1.91	0.22	5.70	2.04	0.24
Senior Medical Manager	0.21	0.05	0.00	0.21	0.05	0.00
Non-Consultant Career Grade	1.29	1.39	0.03	1.48	1.37	0.08
Trainee Grades	0.02	0.00	0.00	0.01	0.00	0.00
Other	0.00	0.00	0.00	0.00	0.00	0.00
Totals	80.14%	18.52%	1.34%	**78.79%**	**19.88%**	**1.32%**



Clinical Workforce

- Ethnic workforce has grown by 1.36%
- As at March 2024 there were 19 clinical BME members of staff at band 8A and above, in 2025 this has increased to 23
- Clinical staff are underrepresented above band 6
- Ethnicity - consultants increased by 19, no changes to medical management numbers nor non-consultant careers grades
- Medical and Dental under-represented in Consultant and Medical Management

All Staff Disparity Ratio

The race disparity ratio compares the progression of white staff through the organisation with the progression of BME staff through the organisation. If the race disparity ratio is greater than "1.0" this means that progression favours white staff, whilst if the race disparity ratio is below "1.0", this means that progression favours BME staff.

Disparity Ratio	All staff Ratio 2023 – target 1.5	All staff Ratio 2024 – target 1.5	All staff Ratio 2025 – target 1.5
Lower to Middle	2.54	2.89	2.75
Middle to Upper	1.85	2.47	2.44
Lower to Upper	4.69	7.15	6.71

From the table above BME staff are:

- 2.75 times less likely to progress from bands 1-5 to bands 6-7 (lower to middle)
- 2.44 times less likely to progress from band 6-7 to band 8a+ (middle to upper)
- 6.71 times less likely to progress from bands 1-5 to band 8a+ (lower to upper)

Although there has been a very slight improvement it's not a significant shift.

Nursing Disparity Ratio's

Disparity Ratio	Nursing Ratio at March 2024 – target 1.5	Nursing Ratio at March 2025 – target 1.5
Lower to Middle	7.75	6.88
Middle to Upper	11.06	14.10
Lower to Upper	85.71	96.98

From the table above BME nursing staff are:

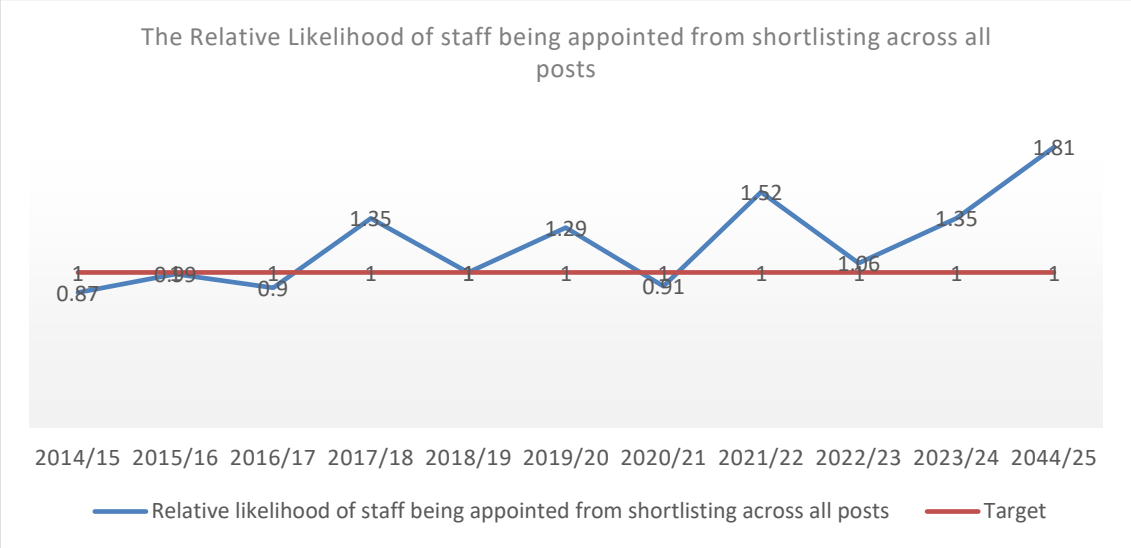
- 6.88 times less likely to progress from bands 1-5 to bands 6-7 (lower to middle)
- 14.10 times less likely to progress from band 6-7 to band 8a+ (middle to upper)
- 96.98 times less likely to progress from bands 1-5 to band 8a+ (lower to upper)

A Model Employer: A Model Employer sets a stretching aspiration for all NHS organisations to reach equality in BME representation across their workforce pipeline by 2028. The table below shows the number of BME staff in post at each band in 2018, 2023 and 2024. The table identifies the number of additional BME staff required for each of the pay bands to be representative. The recalculation takes account of the Trust having increased the percentage of BME staff in post in the preceding years and highlights those increases are predominately from the lower bands. Overall BME staff in post data has increased. Increases are in the lower bands which are not positively impacting on our representation at higher levels nor the disparity ratio's.

A Model Employer Data as at March 2025

	2023 - Number of BME staff per band	2023 - Additional staff required to achieve equity	2024 - Number of BME staff per band	2024 - Additional staff required to achieve equity	2025 - Number of BME staff per band	2025 - Additional staff required to achieve equity
8a	22	39	20	57	25	66
8b	3	20	4	28	5	30
8c	0	11	0	15	0	16
8d	1	3	1	2	1	3
9	0	0	1	1	1	1
VSM	0	3	0	4	0	5

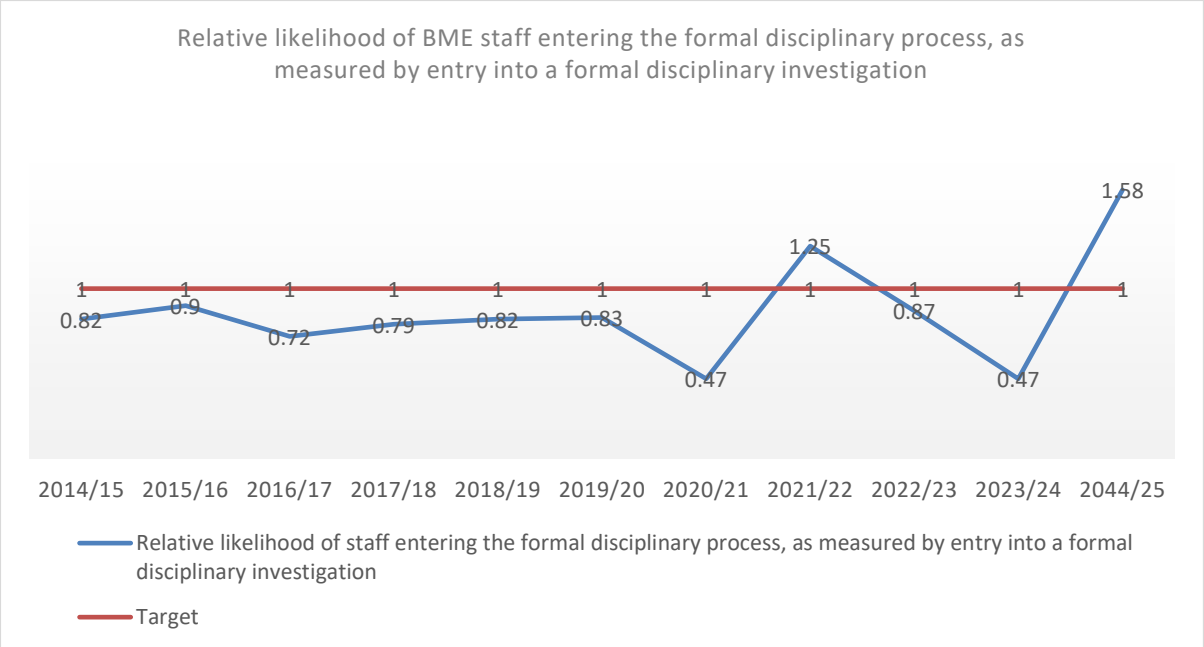
Indicator 2: Relative likelihood of staff being appointed from shortlisting across all posts. 1.0 is the target. An outcome greater than 1.0 means the indicator is more favourable to white 1 staff, whilst if the outcome is below 1.0 the indicator is more favourable to BME staff.



- The data shows that white staff are 1.81 times more likely to be appointed from shortlisting. Specifically, 2758 out of 7489 white candidates were appointed from shortlisting (36.83% of white candidates) compared to 1,024 out of 5,038 BME candidates (20.33% of BME candidates) by comparison last year 27.42% of BME colleagues were appointed from shortlisting.
- *Last years data: The North-East and Yorkshire WRES report 2024 showed that for this indicator our data (2024) scored at 27% (0% best in country 100% worst in country)*

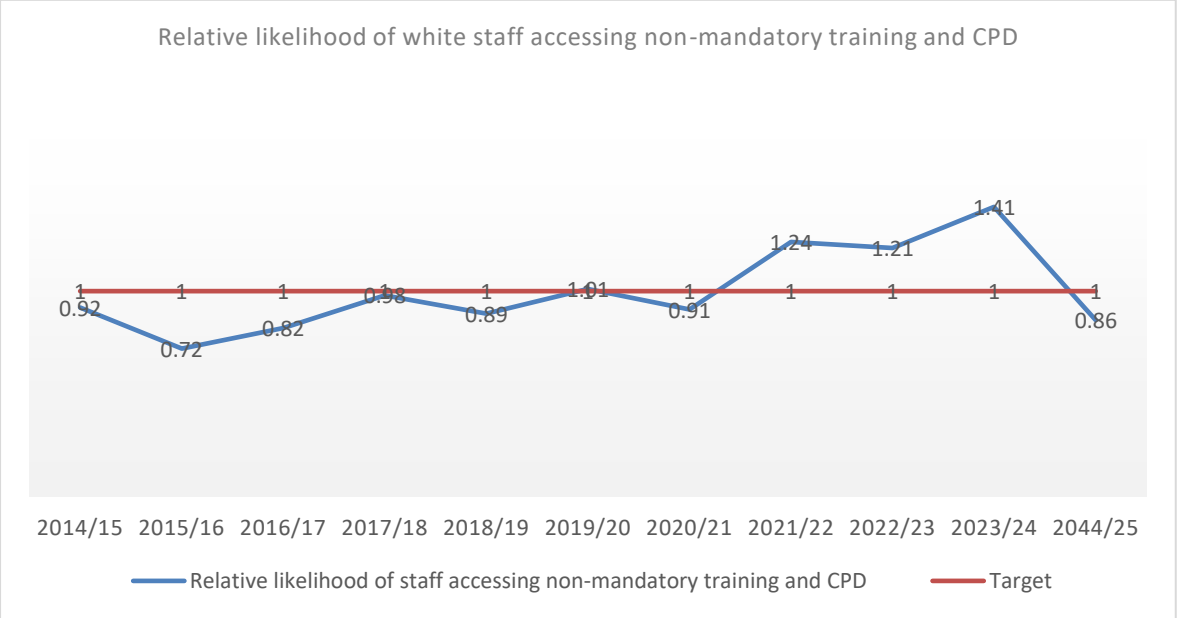
Indicator 3: Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation.

1.0 is the target. An outcome greater than 1.0 means the indicator is more favourable to white staff, whilst if the outcome is below 1.0 the indicator is more favourable to BME staff.



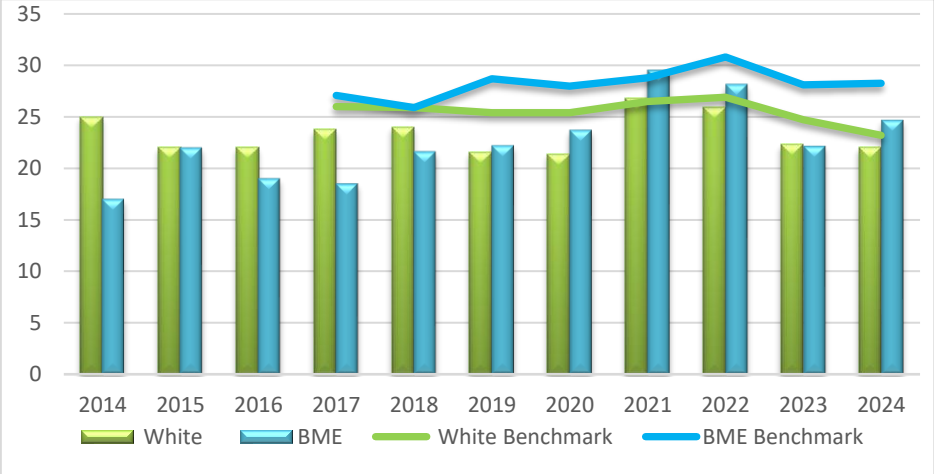
- The data shows that BME staff are 1.58 times more likely to enter formal disciplinary processes (0.54% of the white workforce and 0.86% of the BME workforce),
- 2012/22 is the only other year BME staff been recorded as more likely to enter formal disciplinary processes within the Trust.
- The Trust is outside the non-adverse range of 0.8 – 1.25 for this indicator.
- *Last year's data: The North-East and Yorkshire WRES report showed for this indicator our data scored at 74% (0% best in country 100% worst in country)*

Indicator 4: Relative likelihood of staff accessing non-mandatory training and CPD.
1.0 is the target. An outcome greater than 1.0 means the indicator is more favourable to white staff, whilst if the outcome is below 1.0 the indicator is more favourable to BME staff.



- White staff are 0.86 times less likely to access non-mandatory training and Continuing Professional Development (CPD) compared to BME staff.
- Specifically, 4828 out of 13619 white staff undertook non-mandatory training (35.45% of the white workforce) compared to 1296 out of 3136 BME staff (41.33% of the BME workforce).
- The percentage of staff accessing non-mandatory training and CPD has grown in the last 12 months.
- *Last year's data: The North-East and Yorkshire WRES report 2024 showed for this indicator our 2024 data scored at 55% (0% best in country 100% worst in country)*

Indicator 5: Percentage of staff experiencing harassment, bullying or abuse from patients, relatives, or the public.



	White	BME	White Benchmark	BME Benchmark
2021	26.8	29.5	26.5	28.8
2022	25.89	28.13	26.91	30.82
2023	22.34	22.15	24.72	28.11
2024	22.03	24.66	23.21	28.27

- The percentage of BME staff experiencing B&H from patients is 24.66% which is 2.63% below that of white staff and 3.61% lower than the BME benchmark,
- Percentage of BME staff experiencing has gone up but the gap in experience between white and BME staff has also grown.
- Trust remains below the National benchmark,
- *Last years data: The North East and Yorkshire WRES report 2024 shows that for this indicator our 2024 data scored at 16% (0% best in country 100% worst in country)*

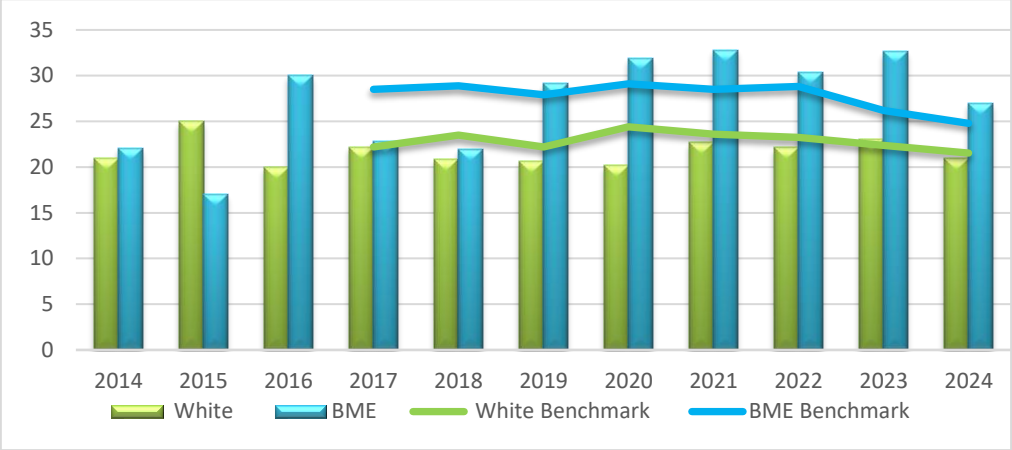
Clinical Boards

Clinical Boards reporting a higher percentage than the Trust overall are identified below.

BME staff experiencing B&H from patients Trust wide	24.66%
Family Health	27.88%
Medicine and Emergency Care	46.51%
Patient Services	35.71%
Surgical and Associated Services FH	32.02%
Surgical and Specialist Services RVI	31.08%

The largest increases from last year are Patient Services, Clinical and Diagnostic Services and Estates

Indicator 6: Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months.



	White	BME	White Benchmark	BME Benchmark
2021	22.7	32.8	23.6	28.5
2022	22.15	30.33	23.25	28.81
2023	23.01	32.62	22.37	26.2
2024	20.95	26.98	21.53	24.78

- The percentage of BME staff experiencing B&H from staff is 26.98% which is 6.03% above that of white staff and 2.2% higher than the BME benchmark,
- 5.64% percentage points decrease in BME staff experiencing harassment, bullying or abuse from staff and the gap between staff experience has reduced by 4.22.
- *Last year's data: The North-East and Yorkshire WRES report 2024 showed for this indicator our data scored at 99% (0% best in country 100% worst in country)*

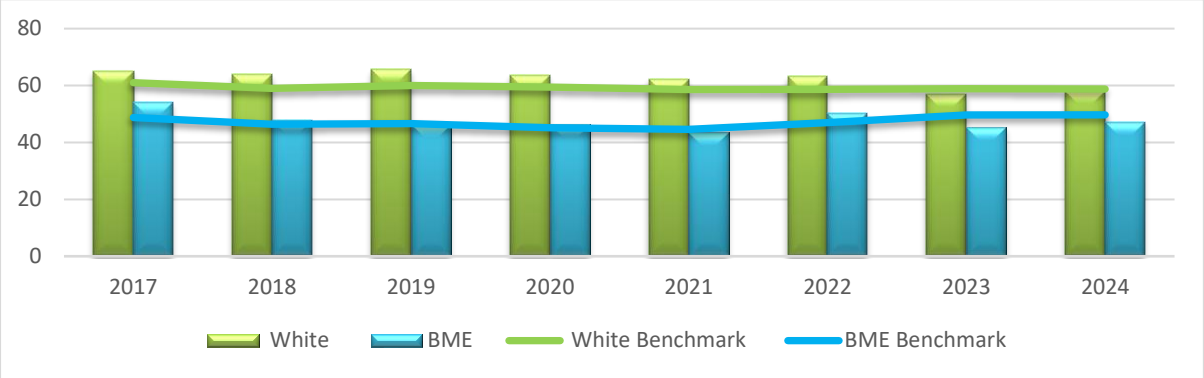
Clinical Boards

Clinical Boards reporting a higher percentage than the Trust overall are identified below.

BME staff experiencing harassment, bullying or abuse from staff	26.98%
Cardiothoracic Services	30.00%
Estates	29.35%
Family Health	27.70%
Medicine and Emergency Care	29.55%
Patient Services	35.71%
Peri-operative and Critical Care	28.02%
Surgical and Associated Services FH	27.78%
Surgical and Specialist Services RVI	29.70%

The largest increases from last year are Patient Services, Information Management and Technology and Finance

Indicator 7: Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion.



	White	BME	White Benchmark	BME Benchmark
2021	62.3	43.5	58.6	44.6
2022	63.12	50.25	58.65	47
2023	57.04	45.45	58.84	49.64
2024	57.84	47.24	58.82	49.7

- The percentage of BME staff believing the Trust provides equal opportunities for career progressions is 47.24% which is 10.6% lower than that of white staff but 2.46% lower than the BME benchmark. The gaps in experience of white and BME staff has decreased as has the gap between the Trust BME figures and the BME benchmark data.
- *Last year's data: The North-East and Yorkshire WRES report 2024 showed for this indicator our data scored at 79% (0% best in country 100% worst in country)*

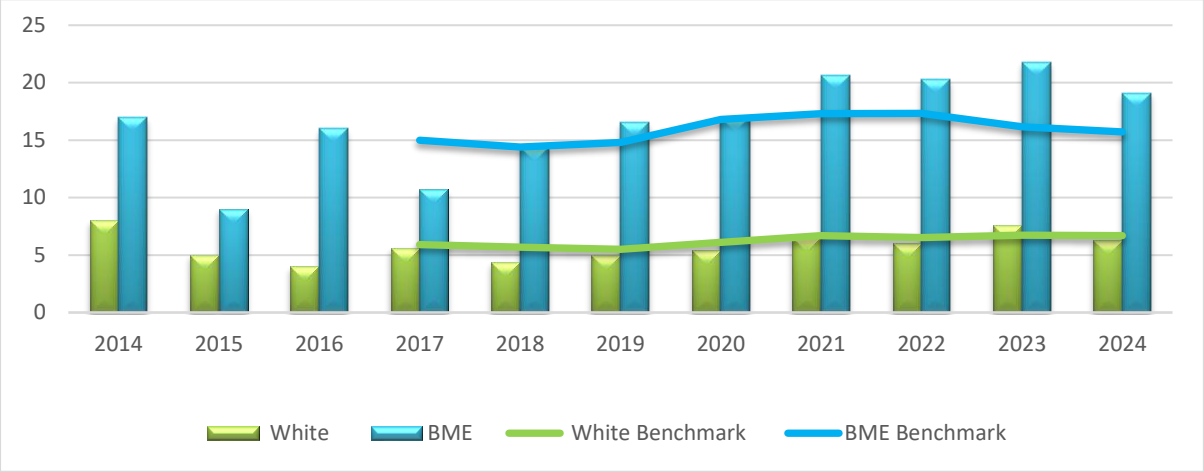
Clinical Boards

Clinical Boards reporting a higher percentage than the Trust overall are identified below.

Percentage of BME staff believing the Trust provides equal opportunities for career progressions	47.24%
Cancer and Haematology	52.50%
Estates	51.11%
Finance	83.33%
Information Management and Technology	47.50%
Medicine and Emergency Care	51.61%
Surgical and Associated Services FH	49.07%
Surgical and Specialist Services RVI	49.07%

The largest increases from last year are Clinical and Research Services, Clinical and Diagnostic Services and Finance

Indicator 8: Experience discrimination at work from a manager / team leader or other colleagues in the last 12 months



	White	BME	White Benchmark	BME Benchmark
2021	6.5	20.6	6.7	17.3
2022	6.03	20.3	6.52	17.33
2023	7.58	21.81	6.73	16.17
2024	6.31	19.11	6.69	15.72

- This indicator remains the most challenging for the Trust. Ethnicity minority staff continue to report in significantly higher percentages than white staff in relation to experience of discrimination at work from a manager/team leader or other colleagues.
- The percentage of BME staff who experience discrimination at work from a manager/team leader or other colleagues in the last 12 months has reduced to 19.11% which is 12.8% higher than white staff and 3.39% higher than the BME benchmark.
- The gap in staff experience has decreased and although still below the national benchmark for BME staff the gap has also decreased.
- *Last year's data: The North-East and Yorkshire WRES report 2024 showed for this indicator our 2024 data scored at 96% (0% best in country 100% worst in country)*

Clinical Boards

Clinical Boards reporting a higher percentage than the Trust overall are identified below.

Percentage of BMR staff experiencing discrimination at work from a manager / team leader	19.11%
Cardiothoracic Services	25.58%
Family Health	20.27%
Human Resources	33.33%
Medicine and emergency Care	21.81%
Patient Services	35.71%
Peri-operative and Critical Care	20.23%
Surgical and Associated Services FH	20.63%

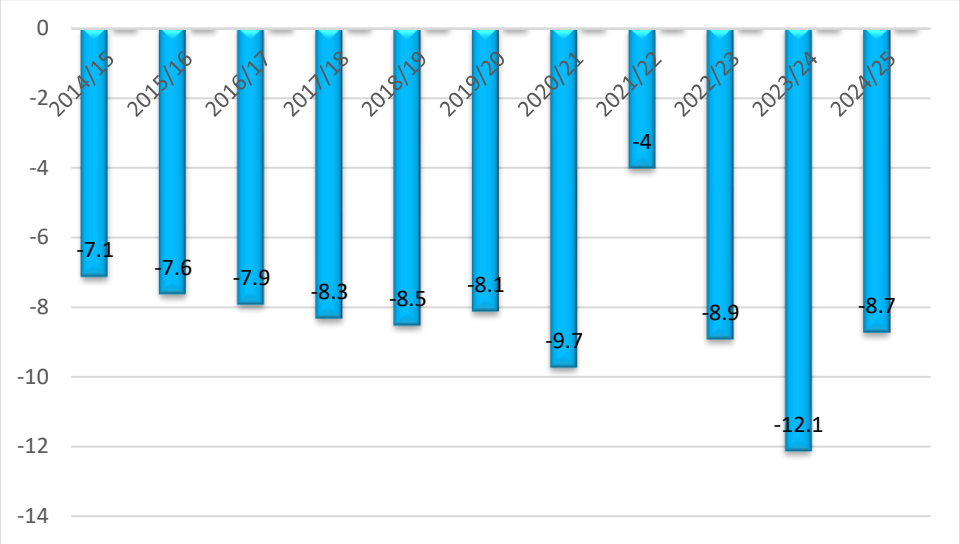
The data below is taken form the **National 2024 WRES report**. The areas shown in red identify the degree of 'poor outcome', relative to the benchmark is very high. Orange depicts the degree of poor outcome, relative to the benchmark is high.

Occupation	Ethnicity	Survey year				
		2019	2020	2021	2022	2023
Allied health prof.	White	5%	6%	7%	7%	8%
	BME	13%	11%	16%	16%	16%
Medical and dental	White	5%	5%	7%	7%	8%
	BME	11%	10%	16%	19%	26%
Ambulance (operational)	White	SUPP	SUPP	SUPP	SUPP	SUPP
	BME	SUPP	SUPP	SUPP	SUPP	SUPP
Nurses and midwives	White	5%	5%	7%	5%	8%
	BME	23%	25%	25%	22%	24%
Healthcare assistants	White	8%	5%	5%	6%	8%
	BME	15%	22%	38%	32%	30%
Wider care team	White	4%	6%	6%	5%	6%
	BME	16%	10%	13%	15%	10%
General management	White	3%	3%	3%	5%	4%
	BME	SUPP	SUPP	SUPP	SUPP	SUPP
Other	White	5%	5%	5%	7%	8%
	BME	11%	15%	22%	26%	27%

Ethnicity		Survey year				
		2019	2020	2021	2022	2023
This organisation	White	5%	5%	6%	6%	8%
	BME	16%	17%	21%	20%	22%
North East and Yorkshire	White	5%	5%	6%	6%	6%
	BME	14%	16%	17%	17%	16%
National	White	6%	6%	7%	7%	7%
	BME	15%	17%	17%	17%	15%
This organisation, detailed breakdown	White British	5%	5%	6%	6%	7%
	White "other"	11%	10%	14%	9%	14%
	Asian	18%	18%	23%	21%	20%
	Black	28%	27%	24%	25%	30%
	Mixed/other	7%	10%	11%	17%	23%

Indicator 9: Percentage difference between the organisations' Board membership and its overall workforce disaggregated:

The Board representation indicator is calculated by deducting the percentage of BME staff in the workforce from the percentage of BME members on the Board of Directors. A value of "0.0" means that the percentage of BME members on the Board of Directors is exactly the same as the percentage of BME staff in the workforce. A positive value means that the percentage of BME members on the Board of Directors is higher than in the workforce, and a negative value means that the percentage of BME members on the Board of Directors is lower than in the workforce.



As at March 2024 the difference between BME representation on the Board and in the workforce was -8.7%. BME members on the board are underrepresented in terms of Headcount.

Last year when comparing Nationally the Trust performed better than 57% of Trusts.

3.0 ACTIONS TAKEN IN THE LAST 12 MONTHS

Over the last year we have listened to feedback and understand that experiences of inclusion and equity vary across the Trust. This is something that we are determined to change. Improving peoples experience is not just the right thing to do, it's essential to our culture, our performance and to maintain the trust our staff and patients place in us. We have and will continue to take a reflective and transparent look at our data, culture and systems to better understand the barriers that exist and how we can improve. **In the past 12 months we have:**

- Developed and piloted our Compassionate Leadership Programme, designed to embed values-led leadership across all levels of the organisation. The programme focuses on self-awareness, listening, inclusion, and psychologically safe team cultures. Feedback from the pilot has shaped our plans for full rollout and wider adoption.
- Updated our appraisal process to centre on values, behaviours and meaningful conversations about personal and professional development. We've shifted away from purely transactional performance reviews, towards a culture of regular feedback and recognition—supporting both wellbeing and accountability.
- Developed and launched a Behaviour and Civility Charter co-designed with staff from across the Trust. This sets clear expectations for how we treat one another with the aim of promoting a culture where respect and kindness are non-negotiable. The Charter is being embedded through training, team discussions and visible leadership support. Linked to this we continue to deliver our Incivilities/Micro-aggressions training; for staff on civilities/micro-aggressions, supporting the roll out of our People Programme and raising awareness of poor behaviour.

- Reviewed and refreshed key policies and procedures to ensure they actively promote inclusion and equity.
- Strengthened our approach to Equality Impact Assessments (EIAs) to ensure that all service changes, policy updates and major decisions are assessed through an inclusion lens. We've delivered targeted training to leaders and to improve both the quality and consistency of EIAs across the organisation.
- Introduced a new Sexual Violence Policy in response to NHS-wide data insights locally and nationally. This policy strengthens our support for staff who experience sexual harassment or violence and reinforces our zero-tolerance approach.
- Commenced our Anti-Racism Programme, informed by staff feedback, workforce data and best practice. This work is focused on becoming an actively anti-racist organisation, which includes leadership accountability, safe spaces for staff, and a structured programme of listening, learning and action. Additionally, we have held a 'Let's Talk Race' Board Development session organised by our REN Staff Network and facilitated by the EDI Team.
- Held and EDI action planning workshop.

4.0 ORGANISATIONAL PRIORITIES GOING FORWARD

While progress has been made, there is still much more to be done to create a truly inclusive environment. We acknowledge that our approach to equality, diversity and inclusion hasn't always been effective enough to meet the needs of our people and patients. We are committed to being honest about where we are, and intentional about where we want to go in making improvements.

We have seen some early signs of improvement following our staff survey results. A 60% improvement in staff survey responses is to be celebrated and our results overall are in line with the NHS average when benchmarked against other acute and acute & community Trusts with statistically significant gains in compassionate leadership, health and safety climate, support for work-life balance, flexible working and relationships with line managers are encouraging. However, going forward we need a concerted focus on culture and EDI – both WRES and WDES results have improved but remain a long way from where we need them to be. Improvements in staff experience and engagement must be targeted at relationships within and across teams – the association with patient safety, patient experience and performance is clear. Staff Survey results from will directly inform the Year 2 objectives in the People Plan and be shared widely across Clinical Boards and Corporate services.

Key priority areas as identified from the WRES data.

Indicator 1:	Career progression in clinical roles lower to middle levels and lower to upper levels
	Representative leadership
Indicator 2:	Improvement in the likelihood of BME staff being appointed

Indicator 3:	Improvement in the likelihood of BME staff being subject to formal disciplinary action
Indicator 8	Reduction in discrimination from a managers/team leaders or other colleagues
Prioritise Clinical Boards	Take a more focused business partner approach within clinical boards

The Trust had recently held a Board Development Session which included an item on EDI and a workshop to identify organisational priorities against EDI. This will be co-produced and presented back when finalised.

Trust Board is asked to:

- Note the contents of this report.
- Agree the requirement to publish data by 31 May 2025 on the Data Collection Framework website and the Trust's website.

Report of Karen Pearce
Head of Equality, Diversity, and Inclusion (People)
16 May 2025

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Agenda item A13(i)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	23 May 2025					
Title	Committee Annual Reports 2024/25					
Report of	Kelly Jupp, Trust Secretary					
Prepared by	Lauren Thompson, Corporate Governance Manager/ Deputy Trust Secretary					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☒	☐			
Summary	The purpose of this report is to provide assurance to the Trust Board that the Audit, Risk and Assurance, Finance and Performance, People, Quality & Digital and Data Committees have met their key responsibilities for 2024/25, in line with their Terms of Reference. The Committee Annual Reports outline overall achievements throughout the year and action points for continuing development during the coming year. The Annual Reports have been considered at the relevant Committee meetings. The Finance and Performance Committee and Audit, Risk and Assurance Committee Annual Reports are in draft and will be discussed at the relevant Committee prior to the Trust Board meeting. The Committee Terms of Reference (ToR) and Schedules of Business (SoB) have been discussed at each respective Committee meeting and approved at the March 2025 Trust Board meeting.					
Recommendation	The Trust Board is asked to approve the Committee Annual Reports, outlining 2024/25 work undertaken and note the key areas to revisit during 2025/26.					
Links to Strategic Objectives	Performance – Being outstanding, now and in the future.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link.					
Reports previously considered by	Annual Review. Submission to the relevant Committee meetings has taken place in advance of the 23 May 2025 Board meeting.					

AUDIT, RISK AND ASSURANCE COMMITTEE ANNUAL REPORT 2024-2025

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Audit, Risk and Assurance Committee has met its key responsibilities for 2024-25, in line with its terms of reference and the requirements of the updated Audit Committee Handbook republished in December 2024.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. AUDIT COMMITTEE RESPONSIBILITIES

The key purpose of the Audit, Risk and Assurance Committee is to provide the Board with:

- an independent and objective review of financial and organisational controls, the system of integrated governance and risk management systems and practice across the whole of the organisation's activities (both clinical and non-clinical);
- assurance of value for money;
- compliance with relevant and applicable law;
- compliance with all applicable guidance, regulation, codes of conduct and good practice; and
- advice as to the position of the Trust as a "going concern."

It does this through receipt of assurances from auditors, management and other sources.

3. AUDIT, RISK AND ASSURANCE COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board from the Non-Executive Directors of the Trust and consists of at least four members with a quorum being two members. During 2024/25 there were several changes in NEDs which meant that the minimum number of four Committee members was not always achieved however the meetings were quorate on every occasion.

Ten ordinary meetings were held between 1 April 2024 and 31 March 2025. The meeting scheduled in August 2025 was a 'check in' Committee meeting and therefore attendance is not included in the table below:

	Attendance at ordinary meetings
Mr B MacLeod, Non-Executive Director *Committee Chair until 31 August 2024*	10 of 10
Mr D Weatherburn, Non-Executive Director *Committee Chair from 1 September 2024*	6 of 6

	Attendance at ordinary meetings
Mr J Jowett, Non-Executive Director *Committee member until 31 August 2024*	4 of 4
Ms J Baker, Non-Executive Director *Committee member until 31 May 2024*	1 of 2
Mr B McCardle, Non-Executive Director *Committee member from 22 August 2024*	4 of 6
Mrs A Stabler, Non-Executive Director *Committee member from 21 May 2024*	7 of 9

The Committee met the minimum number of five meetings per year and other attendees at the meetings have included:

- External and Internal Audit, as well as the Trust's Fraud Specialist Manager.
- Management, which included the Chief Executive Officer, the Chief Finance Officer, the Director of Communications and Corporate Affairs, the Chief Information Officer, the Executive Director for Commercial, Development and Innovation, the Managing Director/Deputy Chief Executive Officer, the Director of Performance and Governance and other Executive Team members.
- The Trust Secretary and team members who Secretariat Support to the Committee.
- The Head of Corporate Risk & Assurance.
- Clinical Board/Corporate Services representation.
- The Designated Individual for Autopsy Services.
- The Chair and other NEDs.
- The auditor of the Trust Charity.
- Senior finance team and IT team members.

In addition, Governors Philip Home and Chris Record observed six Committee meetings in total.

During 2024/25, the following training/briefing sessions were provided to Committee members (and offered to all Board members)

- Board Assurance Framework and Risk Appetite – 26 March 2025. The purpose of the session was to discuss the Boards Risk Appetite in order to develop a new Risk Appetite Statement.

4. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee is required to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities that supports the achievement of the Trust's objectives, internal control and risk management.

The Audit, Risk and Assurance Committee had a Schedule of Business for the year and uses a rolling programme and action log to track committee actions.

The Committee has reviewed:

- Its Terms of Reference and Schedule of Business.
- The Head of Internal Audit opinion (June 2024).
- The Board Assurance Framework (BAF); being the underlying assurance processes that indicate the achievement of corporate objectives and the effectiveness of management of principal risks.
- Risk management arrangements, the revised Risk Management Policy and the annual BAF Risk Management Annual Report.
- Amendments required to the Scheme of Delegation, Standings Orders and Standing Financial Instructions.
- The response to the External Auditors on:
    - ISA+240: Audit Committee responsibilities for preventing fraud in the Annual Accounts.
    - ISA+250: Audit Committee responsibilities for being satisfied that the Annual Accounts comply with laws and regulations.
    - ISA+501: Specific consideration of the potential for, and actual, litigation and claims affecting the financial statements.
    - ISA+570: Consideration for the Going Concern Assumption in an audit of financial statements.

  Committee members endorsed the response for submission to the External Auditors for the year.

The BAF focuses on the key risks against achievement of the strategic objectives. The BAF is a 'live' document which is continuously reviewed and updated by the Corporate Risk & Assurance Department with regular updates to the Committee.

Each Committee of the Board has a responsibility to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the BAF specific to the Committee purpose and function. Bi-monthly each Committee of the Board receives a report detailing the:

- Executive Lead review undertaken during the previous month and any recommendations for risks held on the Board Assurance Framework aligned to that Committee;
- Assurances received and any areas requiring Committee consideration;
- Risks held on the BAF and movements in the risks, along with risk mitigations, threats, assurances and any gaps in assurance.

During 2024/25 the Trust continued to work with The Value Circle who provided advice and support in ensuring an effective governance system was in place from Ward to Board.

Escalations from other Committees appears as a standing agenda item on the ARAC meeting agendas, with any matters raised for the Committee members' attention by exception.

The 2024/25 Risk Management and BAF audit reports received good assurance ratings from AuditOne, with no high-risk recommendations, reported to the March 2025 Committee meeting.

Bi-monthly deep-dives were conducted into Clinical Board risks, conducted on rotation across the Clinical Boards.

The Committee is satisfied that the system of risk management in the organisation is adequate in identifying risks and allows the Board of Directors to understand the appropriate management of those risks. The Committee believes there are no areas of significant duplication or omission in the systems of governance (that have come to the Committee's attention) that have not been adequately resolved.

5. INTERNAL AUDIT

The Committee has ensured that there is an effective internal audit function established by management that meets mandatory Internal Audit Standards and provides appropriate independent assurance. The Trust receives its internal audit service from AuditOne.

This was achieved by:

- Reviewing and approving the Internal Audit Plan 2024/2025, including regular updates of performance against the Plan.
- Consideration of the major findings arising from internal audit work and management's responses.
- Receipt of the Internal Audit Annual Report, Head of Internal Audit Opinion and Internal Audit Charter/Protocol.
- Monitoring progress with implementation of agreed audit recommendations.
- Integrated Care Board (ICB) external review of Financial and Workforce controls report.

The Committee received a report from the internal auditor at each of its Committee meetings which summarised the audit reports issued since the previous meeting.

The internal audit plan for 2024/25 was based on a risk assessment approach centred on discussions with senior staff and Directors and was linked to the organisation's assurance framework. Assurances from Internal Audit reports are, where possible, mapped to the BAF clearly in the BAF document itself.

Good progress continued to be made during the year in relation to the completion of historic internal audit recommendations.

A number of high priority recommendations were identified by Internal Audit and reported during 2024/25, these covered the following internal audits:

- Security over sensitive area - Reasonable Assurance (reported April 2024).
- Enhanced Care Observation (ECO) Policy - recommendations related to record keeping, monitoring arrangements for coverage of ECO in local induction, the local induction checklist being out of date and excluding ECO arrangements for appropriate staff, the ECO Policy not define which staff are "appropriate" in relation to ECO

training and non-compliance with section 10 of the ECO policy - Limited Assurance (reported April 2024).

- Starters and Leavers Processes – recommendations related to investigating the inactive accounts and where necessary disabling such accounts, and establishing a regular review process to monitor the activity and usage of accounts within the Active Directory (including periodic audits) - Limited Assurance (reported April 2024).
- Emergency Department Mental Capacity and Mental Health Screening - Unrated advisory report (reported April 2024).
- Inpatient Capacity and Mental Health Screening - Unrated advisory report (reported April 2024).
- Consultant Job Planning - Unrated advisory report (reported April 2024).
- Safeguarding – recommendations related to establishing a schedule of planned safeguarding related audits and associated progress monitored, reporting of issues and actions arising from the NSAB meetings and Trust representation at such meetings, use of standing agenda items for the Safeguarding Committee/Group meetings and terms of reference updates to include reporting lines - Limited Assurance (reported July 2024).
- Risk Management - a recommendation was reiterated regarding Datix functionality and improvements required - Reasonable Assurance (reported July 2024).
- Policy management and maintenance - a recommendation was highlighted in relation to prioritising out of date policies according to their risk profile - Reasonable Assurance (reported July 2024).
- Catering Stores - a recommendation was raised regarding the completion of hygiene inspection reports - Reasonable Assurance (reported July 2024).
- Appraisals - the recommendation related to taking further actions to improve appraisal compliance rates - Reasonable Assurance (reported October 2024).
- Management of Slips, Trips and Falls - a recommendation was raised regarding completion of adult inpatient falls assessments and associated assurances - Reasonable Assurance (reported October 2024).
- WHO Surgical Checklist - the recommendations related to record keeping and completion of surgical checklist - Reasonable Assurance (reported October 2024).
- Fundamentals of Care - Unrated advisory report (reported October 2024).
- NHS England / ICB Financial Controls Review - Unrated advisory report (reported January 2025).
- Enhanced Care Observation Policy (Follow Up) - recommendation reiterated from the previous report (see earlier point) - Reasonable Assurance (reported January 2025).
- Dermatology (Waiting List Management) - the recommendation related to arrangements for monitoring the waiting list - Reasonable Assurance (reported January 2025).

Regular updates on the progress in relation to high priority recommendations were received by Committee members during the year from management and internal audit.

Internal Audit performance against Plan was discussed regularly during the year.

Benchmarking reports were provided by AuditOne on:

- Outstanding recommendations

- Head of Internal Audit Opinions

6. EXTERNAL AUDIT

The Committee has reviewed the work and findings of external audit and considered the implications and management responses to their work.

This was achieved by:

- Discussing and agreeing with the external auditor the nature and scope of the audit as set out in the External Audit Annual Plan.
- Reviewing external audit reports, together with the appropriateness of management responses.
- Reviewing the Audit Strategy Memorandum for 2023/24.
- Receiving the year-end Audit Completion Report (which included the Annual Audit Opinion) and the Annual Audit Report (which referenced the Value for Money audit work).

The Council of Governors has the statutory responsibility for the appointment of the external auditors, and this process is led by a sub-group of public Governors supported by Trust officers and the Chair of the Audit Committee. During 2023/24, a robust procurement and evaluation process was undertaken regarding the external audit contract with Mazars LLP reappointed as the Trust's external auditors for an initial three year term commencing in the 2024/25 financial year – approval from the Trust's Council of Governors was granted in February 2024. This followed a satisfactory review of external audit performance undertaken.

The Mazars LLP external audit fees for 2024/2025:

- Statutory Accounts £145,000 (excluding VAT) which is higher than the statutory fee invoiced for 2023/24 (£90,000 excluding VAT). The fee increase arose during the tender exercise whereby it was evident that existing Trust external audit fees were low when benchmarked against other Trusts. In addition several external audit providers were withdrawing from the NHS audit market and therefore the fee increase was as expected. Contact with e.g. other Trusts within the Great North Healthcare Alliance has identified that the 2024/25 audit fees remain both relatively and factually lower than others.

The audit of the Charity Accounts is undertaken separately by Robson Laidler, with a 3-year contract in place.

For 2024/25, there was no mandated requirement to undertake external audit procedures on the Quality Report and therefore no fee was charged in relation to this.

To ensure that the independence of the external auditors is not compromised where work outside the scope of the Audit Code has been procured from the external auditors, the Trust has a policy which requires that no member of the team conducting the external audit may

be a member of the team carrying out any additional work and their lines of accountability must be separate.

During 2024/25, the Trust's policy on Non-Audit Work was reviewed and updated. It was considered at the July 2024 Committee meeting and subsequently reviewed/approved by the Council of Governors. The policy requires review every three years.

No additional services/non-audit work was carried out by Mazars LLP during 2024/25.

7. MANAGEMENT

The Committee has challenged the assurance process when appropriate and has requested and received assurance reports/verbal updates from Trust management throughout the year. Examples of areas of challenge have included:

- Production of the Risk Appetite Statement.
- Identifying a process to cross reference content from the required disclosures in the Annual Reporting Manual with those in the Group/Trust Annual Report.
- Referrals back to the Quality Committee to seek an update/assurances on processes regarding:
    - The implementation plan/rollout of the new InPhase incident/risk system.
    - Reporting of claims and incidents.

8. FINANCIAL AREAS OF REVIEW

The Committee has ensured that the systems for financial reporting to the Board are subject to review.

The Committee has achieved this primarily through review and approval of the Annual Accounts, including those of the Newcastle upon Tyne Hospitals NHS Charity. The Committee also reviewed the External Audit Opinion and fed back relevant comments for consideration by the external auditors.

In the course of 2024/25, there were no significant issues that the Committee had to consider in relation to the financial statements. During the year, the Committee reviewed the following key areas of management judgement and significant risks:

- PFI/IFRS 16 transition (Trust);
- Management over-ride of controls (Group and Trust);
- Valuation of property, plant and equipment (Group and Trust); and
- Risk of fraud in revenue recognition (Group and Trust).

Other areas discussed between External Audit and Management during the year, and reported to the Committee (as appropriate), related to the value for money work and subsidiary developments.

These have been considered through the presentation of the external audit plan, associated progress updates and discussions during Committee meetings.

The Committee Chair attends the Trust PFI Steering Group meetings, alongside the CFO and Director of Estates, Facilities and Strategic Partnerships.

9. OTHER AREAS OF ACTION AND REVIEW

The Committee has:

- Reviewed details of all Losses and Compensation Payments.
- Received reports on approved single tender actions and breaches and waivers where applicable.
- Reviewed regular debtors and creditors reports.
- Received and approved the Counter Fraud annual plan and self review tool, as well as regular updates in the form of the Fraud response log, associated progress reports, and the Annual Report on Counter Fraud.
- Reviewed the content of the statutory Annual Report (including the Annual Governance Statement).
- Received an update from the Designated Individual for the Trust Mortuaries and a subsequent report on regulatory compliance and improvement plans.
- Reviewed and approved changes to the Trust Scheme of Delegation, Standing Financial Instructions and Standing Orders.
- Approved changes to the Accountability Framework.
- Received the Annual Accounts preparation timetable and subsequently the Annual Accounts and Going Concern Review.
- Considered the findings of an external review undertaken by The Value Circle and the associated action plan.
- Received updates on
    - Changes to the Compliance and Assurance Group;
    - An assessment of overdue internal audit recommendations;
    - Standards of Business Conduct, including declarations of interest and the annual review of the register of gifts and hospitality;
    - The Clinical Audit Process and National Clinical audits;
    - External Visits compliance;
    - Fit and proper persons; and
    - The national payroll exercise.
- The Annual Report of the Committee / self-effectiveness review.
- Received an annual report on special severance payments/settlement agreements.
- Approved the Trust's Annual Modern Slavery Act Statement.
- Received the Health and Safety Annual Report.
- Received an action log to follow up previous Committee meeting actions.
- Discussed assurance from the People Committee as to whether arrangements by which staff may raise concerns are operating effectively.
- Approved the Internal Audit Charter and Protocol (July 2024).
- Reviewed the performance of Internal Audit, External Audit and Counter Fraud.

- Received the minutes / chairs logs from associated Committees/Groups – Finance; People; Quality; Charity; Digital and Data; and Compliance and Assurance.

10. PROGRESS FOR 2024-2025, REVIEW OF EFFECTIVENESS & AREAS OF FOCUS FOR 2025-26

The self-assessment checklist from the HFMA Audit Committee Handbook (the December 2024 version being the latest version) has been completed and is due to be discussed at the May 2025 Committee meeting.

An annual effectiveness survey was circulated to Committee members – the format of this was agreed with the Interim Shared Chair and used for all Committees. Feedback was received from 4 ARAC Committee members, which highlighted the following:

- Responses were generally positive. Most respondents agreed (as a minimum 3 from 4) that:
    - The Committee has a clearly defined role, purpose and objectives (as set out in its Terms of Reference).
    - The meeting is well managed in terms of scheduling, agenda setting and time management.
    - The skill mix and number of the Committee's membership is appropriate.
    - The number of people who attend is appropriate.
    - The purpose of papers being presented is made clear by the author, with actions, issues and assurances clearly defined.
    - Committee members actively participate and make relevant contributions to discussions.
    - The cross-representation of members at Committee meetings enhances the quality and reliability of decisions.
    - There is no duplication between Committees.
    - The frequency of the meetings enables business to be conducted effectively.
    - The Chair clearly captures decisions and actions arising throughout the committee meetings.
    - The Chair clearly captures the decision-making process and ensures it is understood by Committee members.
    - It is clear when the Committee needs to escalate matters for the attention of the Board or to another Committee.
    - The Committee Chair effectively addresses conflicts, concerns or issues that arise within the Committee.
    - The Committee Chair effectively manages time allocated to allow discussion on key items.
    - The Committee Chair encourages participation from newer / less experienced members.
    - The Committee effectively considers and weighs the potential risks and benefits associated with the decisions made.
    - The Committee members are given the opportunity to provide input and contribute to the decision making process.
    - The style and quality of meeting papers is appropriate for the meeting.

  - The Committee values and considers diverse perspectives and opinions when making decisions.
  - The Committee's decision making process is clear, transparent and inclusive.
  - The Committee ensures that processes are in place to create robust action plans with clear ownership, timeframes, and dependencies all of which are monitored and followed up at subsequent meetings.
  - The Committee receives assurance that identified actions are completed in line with agreed timescales.
  - The Committee's goals, objectives and activities are clearly aligned with the Trust's vision and strategy.
  - The Committee's meetings and agendas are focussed on addressing priorities aligned with the Trust's vision and strategy.
  - The Committee's decision-making process reflects the Trust's vision and strategy.
  - The Committee effectively fosters a culture and environment that supports the pursuit of the Committee's vision and strategy.
  - The Committee is actively engaged in discussions and decision-making processes that contribute to the realisation of the Trust's vision and strategy.
  - The Committee is effective in communicating and reporting on risks, issues and performance, and escalating these where necessary.
  - The Chair provides adequate support and guidance in managing risks, issues and performance.
- There were three statements where one respondent included 'disagree' being:
  - The number of people who attend is appropriate.
  - The purpose of papers being presented is made clear by the author, with actions, issues and assurances clearly defined.
  - Meeting papers are succinct and set out the key issues, assurances and any gaps in assurances.
- Additional feedback comments were included which covered:
  - Inclusive chairing enhances the meeting and the pre-meet is extremely helpful.
  - ARAC has undergone significant change, although streamlined more might be done to reduce the numbers in regular attendance.
  - Length of reports needs to be reduced significantly, executive summaries improved and recommendations more specific.
  - A consideration as to whether the Committee could meet bi-monthly as the agenda can be light sometimes.

Based on the feedback above the following three areas of focus have been identified for Committee members to consider in 2025/26:

- Reviewing the quality of reports in terms of succinctness and clarity.
- Reviewing the attendees at Committee meetings to consider whether future attendance should continue.
- Revisiting the Schedule of Business to ascertain whether the meeting frequency should be reduced.

In the 2023/24 annual report of the Committee, the key area of focus for 2024/25 was to fully embed the role of the new ARAC and ensure appropriate reporting and flow of risks

and assurances into the Committee meeting. Significant work was undertaken during 2024/25 to strengthen risk management arrangements from Ward to Board, this included ensuring regular attendance from Clinical Boards at Committee meetings to discuss their high rated and longstanding risks.

Report of Kelly Jupp
Trust Secretary
9 May 2025

FINANCE AND PERFORMANCE COMMITTEE ANNUAL REPORT 2024-2025

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Finance and Performance Committee has met its key responsibilities for 2024/25, in line with its Terms of Reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. COMMITTEE RESPONSIBILITIES

The Finance and Performance Committee is a non-statutory Committee established by the Trust Board of Directors to provide assurance to the Board on the delivery of the financial aspects of the Trust's annual Operational Plan, including financial strategy and planning, transformation and sustainability, the financial performance of the Trust, and on commercial and procurement activity including strategic investments.

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors, that:

- the strategic financial principles, priorities, risk and performance parameters are aligned and support the Trust's strategic objectives and its long-term sustainability;
- the Trust's degree of exposure to financial risk, and any potential to compromise the achievement of the strategic objectives is being effectively managed;
- reporting on the financial performance of the Trust is being triangulated against agreed plans, progress and performance measures, reporting on progress to the Trust Board;
- the Trust's resources and assets are being used and maintained effectively and efficiently;
- financial management and planning information is robust, credible and high quality, and that such information is reviewed and triangulated by the Committee;
- the Trust complies with current statutory and external reporting standards and requirements, including NHS and Treasury policies and procedures;
- the Trust's capital investment programme is fully developed, effectively managed and delivered, and that it is fit for purpose;
- mitigations and action plans as set out in the Board Assurance Framework specific to the Committee purpose and function are effective;
- procurement decision-making and documentation is robust; and
- Committee associated strategies are developed and delivered.

It does this through the receipt of assurances from management groups in the form of updates from Executive Team members and receipt of minutes from management groups such as the Capital Management Group, the Supplies and Services Procurement Group and the Strategy, Planning and Capital Investment Group. In addition, the Committee receives

regular reports relating to areas which impact the financial position of the Trust and considers reports on the management of risks relating to the Committee's area of focus.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of a minimum of six members, drawn from the Non-Executive Directors and members of the Executive Team.

The Committee's quorum is four members and include the Chair or Vice-Chair and at least one other Non-Executive Director.

Eleven meetings were held between 1 April 2024 and 31 March 2025. The August meeting was arranged as a 'check in' meeting with a more informal agenda to discuss the month 4 finance report, medium term plan, Integrated Quality Performance Report, the BAF and some procurement reports. Attendance at the 'check in' Committee meeting is not included in the table below.

The attendance during the year was as follows:

	Attendance at ordinary meetings
Ms C Smith, Non-Executive Director – Committee Chair until 22 April 2024.	0 of 1
Mr G Chapman, Non-Executive Director – Committee member until 22 April 2024 [Chaired the April 2024 meeting].	1 of 1
Mr B MacLeod, Non-Executive Director – Chair of the Committee from August 2024.	7 of 7
Mrs L Bromley, Non-Executive Director [Chaired the May 2024 Committee meeting]	5 of 11
Mr P Kane, Non-Executive Director, Interim Committee member	6 of 6
Mr B McCardle, Non-Executive Director Interim Committee member, joined the Committee permanently from March 2025	3 of 3
Mrs A Stabler, Non-Executive Director [Interim Committee Chair for the June and July Committee meetings]	2 of 2
Mr H Kajee, Non-Executive Director – member of the Committee from February 2025	1 of 2
Mrs J Bilcliff, Chief Finance Officer	11 of 11
Mr R Harrison, Managing Director/ Deputy Chief Executive [NB Acting Chief Executive from 1 March 2025]. Member of the Committee from 23 May 2024.	11 of 11
Mr M Wilson, Chief Operating Officer / Director – GNHA & Strategy – Committee member until 22 May 2024	1 of 2
Mr R Smith, Estates Director – Committee member until January	6 of 9

2025	
Mr P Hanson, Director of Estates, Facilities and Strategic Partnerships – Committee member from February 2025	1 of 2
Dr V McFarlane-Reid, Director for Commercial Development and Innovation	11 of 11
Mrs S McMahon, Chief Information Officer	8 of 11

The Committee met for the minimum number of ten meetings per year and other attendees at the meetings have included:

- The Chief Executive Officer and other Executive Team members;
- The Interim Shared Chair and the Associate Non-Executive Director;
- A Non-Executive Director from Northumbria Healthcare Foundation Trust;
- Directors, including the Procurement and Supply Chain Director;
- Deputy Directors, Associate Directors, Assistant Directors and Heads of Services;
- Senior Performance Managers;
- Clinical Board Chairs, Directors of Operations and Finance Managers; and
- The Trust Secretary and the Deputy Trust Secretary.

During 2024/25, a process was put in place to allow one Governor to observe Committee meetings on a three-monthly rotational basis by expression of interest. Throughout the year, Public Governors Eric Valentine, Philip Home, Alexandros Dearges-Chantler and Peter Bower observed meetings of the Finance and Performance Committee.

4. REPORTING & AREAS OF REVIEW

During the year, the Committee:

- Received, and constructively challenged the content of the regular reports on the Trust financial position, including the closing position for the year and an update on the Annual Accounts for 2023/24.
- Discussed:
    - The 2024/25 Finance and Activity Planning submission.
    - ERF Performance for 2023/24.
    - Escalation measures.
    - Subsidiary Company options.
    - CIP schemes – equality and quality impact assessments.
    - Data Partnerships.
    - Planning guidance for 2025/26 and the financial and activity plans which were approved.
    - The Financial Plan and Budgets for 2025/26 which were approved.
- Received regular finance and performance reports, and the Annual Report of the Committee.
- Sought assurance over the financial and performance management arrangements regarding:
    - The Financial Recovery Plan/Cost Improvement Programme;
    - The Medium Term Plan;
    - The Capital Plan;
    - The Winter Plan;

  - The ICB external review of Financial and Workforce controls;
  - Development of the Financial and Activity Plans for 2025/26; and
  - The Commercial Strategy.
- Requested 'deep dives' into a number of areas and risks e.g. Cancer and Diagnostics, Emergency Care, Medicine, Cardiothoracic, Family Health, Capital Plan, Cancer and Haematology, Peri-Ops and Critical Care, International Patients, Clinical and Research Services and Surgical and Specialist Services, and overseas patients income recovery.
- Considered the Newcastle Hospitals Pharma Services Ltd Business Plan.
- Sought and received regular updates from the Procurement and Supply Chain Director regarding the Procurement Plan, the Provider Selection Regime and the new Procurement Act.
- Reviewed Commercial Schemes.
- Received updates from the Quality Performance Reviews and Clinical Boards/Corporate Services. This included a discussion on Accountability and Autonomy.
- Approved tenders, investments and business cases (BC) in accordance with the delegated authority of the Committee e.g. the Medicines Manufacturing Business Case.
- Approved the Terms of Reference for the Capital Management Group.
- Endorsed the Annual National Cost Collection Exercise.
- Received an update on the utilisation of the Day Treatment Centre (DTC), on business cases not approved and utilisation of the Community Diagnostic Centre (CDC).
- Received a report on Internal Audits relating to the Committee.

5. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2024/25 and utilised a rolling programme and action log to track committee actions.

The Committee received regular updates on risks recorded on the Board Assurance Framework which relate to the Committee's area of focus. There were three risks recorded on the BAF during 2024/25 relating to the Committee being:

- Failure to manage our finances effectively to improve our underlying deficit and deliver long term financial sustainability.
- Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care.
- Failure to maintain the standard of the Trust Estate, Environment, and Infrastructure could result in a disruption to clinical activities and impact on the quality of care delivered.

During the year, the Committee has reviewed its Terms of Reference (ToR) and Schedule of Business (SoB) and the bi-monthly BAF Assurance Reports.

The updated ToR and SoB were agreed at the February 2025 Committee meeting. In summary the changes were additions/amendments relating to:

- Subsidiary company reporting.
- Financial Recovery Steering Group reporting.

- Updates to role titles and report names.

In addition a summary of internal audit reports relating to this Committee was developed and reported to the Committee.

Significant work was conducted with the Executive Lead and new Committee Chair during the year to realign Committee meeting agendas around the strategic risk areas.

An annual effectiveness survey was circulated to Committee members – the format of this was agreed with the Interim Shared Chair and used for all Committees. Feedback was received from 3 Finance and Performance Committee members, which highlighted the following:

- Responses were generally positive. Most respondents agreed (as a minimum 2 from 3) that:
  - The Committee has a clearly defined role, purpose and objectives (as set out in its Terms of Reference).
  - The meeting is well managed in terms of scheduling, agenda setting and time management.
  - The skill mix of the Committee's membership is appropriate.
  - The number of people who attend is appropriate.
  - The purpose of papers being presented is made clear by the author, with actions, issues and assurances clearly defined.
  - Committee members actively participate and make relevant contributions to discussions.
  - The cross-representation of members at Committee meetings enhances the quality and reliability of decisions.
  - The frequency of the meetings enables business to be conducted effectively.
  - The Chair clearly captures decisions and actions arising throughout the committee meetings.
  - The Chair clearly captures the decision-making process and ensures it is understood by Committee members.
  - It is clear when the Committee needs to escalate matters for the attention of the Board or to another Committee.
  - The Committee Chair effectively addresses conflicts, concerns or issues that arise within the Committee.
  - The Committee Chair effectively manages time allocated to allow discussion on key items.
  - The Committee Chair encourages participation from newer / less experienced members.
  - The Committee effectively considers and weighs the potential risks and benefits associated with the decisions made.
  - The Committee members are given the opportunity to provide input and contribute to the decision making process.
  - The style and quality of meeting papers is appropriate for the meeting.
  - Meeting papers are succinct and set out the key issues, assurances and any gaps in assurances.
  - The Committee values and considers diverse perspectives and opinions when making decisions.

- The Committee's decision making process is clear, transparent and inclusive.
- The Committee ensures that processes are in place to create robust action plans with clear ownership, timeframes, and dependencies all of which are monitored and followed up.
- The Committee receives assurance that identified actions are completed in line with agreed timescales.
- The Committee's goals, objectives and activities are clearly aligned with the Trust's vision and strategy.
- The Committee's meetings and agendas are focussed on addressing priorities aligned with the Trust's vision and strategy.
- The Committee's decision-making process reflects the Trust's vision and strategy.
- The Committee effectively fosters a culture and environment that supports the pursuit of the Committee's vision and strategy.
- The Committee is actively engaged in discussions and decision-making processes that contribute to the realisation of the Trust's vision and strategy.
- The Committee is effective in communicating and reporting on risks, issues and performance, and escalating these where necessary.
- The Chair provides adequate support and guidance in managing risks, issues and performance.

- There was one statement where one respondent included 'disagree' being:
  - There is no duplication between Committees.
- Additional feedback comments were included which covered:
  - Skill mix, strong on finance but less so on performance.
  - Attendance at the committee and best use of people's time.
  - Papers are more succinct but need to continue to focus on this.

6. MANAGEMENT

The Committee has challenged the assurance process when appropriate and has requested and received assurance reports/verbal updates from Trust management throughout the year.

7. PROGRESS FOR 2024/25 & REVIEW OF EFFECTIVENESS

In the prior year Committee Annual Report, the following areas were identified to progress in 2024/25 – updates are shown in italic text below:

- Given the significant financial challenges anticipated in 2024/25, it is recommended that the Committee ensures sufficient time is allocated on each meeting agenda to reviewing delivery regarding the Finance and Activity Plans. To continue to have deep dives into performance areas as outlined within the report.

Good progress has been made in embedding deep dives into each Committee meeting agenda. Comprehensive updates have been received throughout the year in relation to the

Finance and Activity Plans and the meeting agendas were re-shaped to ensure greater coverage/time was included to discuss Performance items.

The Committee has oversight of all key performance indicators outlined in the Trust Integrated Board Report. This includes with regular reporting on the latest performance against the national performance standards and actions taken to for any improvements required.

8. NEXT STEPS AND ACTIONS FOR 2025/26

The survey results have identified the following areas of focus for 2025/26:

1. Corporate Governance Team to review Committee meeting agendas collectively to ensure duplication is limited/eradicated.
2. Committee membership to be reviewed to ensure skill mix is sufficient for the purpose of the Committee.
3. Attendees to be revisited to ensure best use of people's time.
4. Continued development of Committee meeting papers in terms of succinctness and clarity.

Report of Kelly Jupp
Trust Secretary
10 May 2025

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PEOPLE COMMITTEE ANNUAL REPORT 2024/25

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the People Committee has met its key responsibilities for 2024/25, in line with its Terms of Reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

The Terms of Reference and Schedule of Business for the Committee have been reviewed and changes recommended for agreement at the Committee and Board meetings in March 2025.

2. COMMITTEE RESPONSIBILITIES

The People Committee is a non-statutory Committee established by the Board of Directors to monitor, review and report to the Board on the cultural and organisational development of the Trust, the strategic performance of people and workforce priorities, and the impact of the Trust as a significant employer, educator and partner in health, care and research.

During 2024/25 the purpose and function of the Committee was to gain assurance, on behalf of the Board of Directors, that:

- The strategic people and workforce priorities for the Trust as a significant employer and as a partner in training, education, and development of health and care capacity in the region and nationally are identified;
- The organisation has a clear understanding of strategic workforce needs (including well-being, recruitment, retention, development of people, and organisational capacity) and the quality and effectiveness of plans to deliver them;
- The commitments of the NHS Constitution, the NHS People Promise, and the stated values of the Trust and standards of behaviour, are being practiced throughout the organisation, based on evidence;
- The approach to all aspects of employment and culture in the Trust are informed by relevant and up-to-date research on innovation and practice;
- The effectiveness of mitigations and action plans as set out in the Board Assurance Framework are reviewed, assessed and assurances obtained specific to the committee purpose and function;
- Legislative and regulatory compliance is achieved as an employer, including anticipation of, and planning for, future requirements;
- Staff governance in the organisation is fully developed, including staff engagement processes;
- Strategic communications and engagement are developed, and reputation management is robust with internal and external stakeholders, local communities and partners;

- The impact on workforce of changing professional and organisational practices is considered, including those involved in increased system-based and partnership working (in collaboration with the other Committees of the Board as appropriate); and
- The Trust fulfils its leadership and influencing role on service quality standards and practice, as an organisation of national importance, as a significant service provider in the North East, and as a partner in training, education and development of health and care capacity in the region (in collaboration with the Quality Committee).

It does this through the receipt of assurances from management, the receipt of regular reports relating to areas which impact Trust staff, as detailed in section 4 below, and discussions and reports on the management of risks relating to the Committee's area of focus.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of at least six members (as specified in the Terms of Reference), drawn from the Non-Executive Directors and members of the Executive Team.

The Committee's quorum is four members, with at least two Non-Executive Directors present.

During 2024/25 meetings were held monthly. 11 ordinary meetings were held between 1 April 2024 and 31 March 2025. The meeting scheduled on 19 August 2025 was a 'check in' Committee meeting and therefore attendance is not included in the table below.

Attendance at the meetings was as follows:

	Attendance at ordinary meetings
Steph Edusei, Non-Executive Director (NED) (Committee Chair until 31 May 2024)	2 of 2
Bernie McCardle, NED (Committee Chair from 1 June 2024)	10 of 10
Jonathan Jowett, NED member until 31 August 2024	3 of 4
Bill MacLeod, NED, Interim Committee member	2 of 2
Liz Bromley, NED	8 of 11
Wendy Balmain, NED and Committee member from 18 March 2025	1 of 1
Christine Brereton, Chief People Officer (Executive Lead for the Committee from January 2023 to 28 February 2025)	8 of 10
Vicky McFarlane-Reid, Executive Lead for the Committee from 1 March 2025 ^Vicky became a Committee member as Executive Lead for People and OD in March 2025, she also attended 2 Committees during the year in an attendee capacity	1 of 1^
Caroline Docking, Director of Communications and Corporate Affairs	9 of 11
Rob Harrison, Managing Director/Deputy Chief Executive Officer	11 of 11*

*became Acting CEO in March 2025 and therefore attended the 20 March 2025 meeting as an attendee rather than a Committee member	

Other attendees at meetings have included Executive Team members, Associate/Assistant Directors, Heads of Service/Departments, Deputy Heads of Service, Team Leaders, Directors of Operations, Health, Safety and Risk Lead, Heads of Nursing, the Guardian of Safe Working, the CEO, the Chair, the Associate NED, the Director and Deputy Director of Medical Education, a Clinical Board Chair, the People Systems and Data Manager and Secretariat Support.

The following Governors observed some Committee meetings during the year:

- Mrs Judy Carrick, Public Governor
- Dr Chris Record, Public Governor

4. REPORTING

i) Regular Reports

Over the course of the year, Committee members received regular reports/updates on:

- The Trust People Strategy/Plan/Priorities:
    - Health and Wellbeing;
    - Leadership and Management;
    - Valued and Heard;
- The Behaviours and Civility Charter;
- An Equality, Diversity and Inclusion (EDI) update;
- The People Committee Board Assurance Framework Report;
- The Guardian of Safe Working Hours Quarterly Reports and Annual Report (prior to receipt at the Board of Directors);
- The NHS Staff Survey results and staff engagement;
- Education, Training and Workforce Development Reports, covering e.g. Statutory and Mandatory Training, Appraisal Compliance, and Education and Training Update;
- The People and Culture Dashboard;
- Communications;
- Legal Cases/Employee Relations; and
- Freedom to speak up Guardian (FTSUG) reports (bi-annual);

ii) Annual Reports

The following Annual Reports were received by the Committee:

- Workplace Race Equality Standard (WRES) and Workplace Disability Equality Standard (WDES) Data and Action Plan (prior to approval at Trust Board);
- Gender Pay Report;
- Communication strategy;
- Apprenticeships Update;
- Sustainability Report;
- Equality and Diversity Update / EDS - including action plan;
- Trade Union Faculty Time Report; and

- Annual Report of the Committee, Committee Terms of Reference and Schedule of Business.

iii) Ad-Hoc Reports

In addition to those reports listed above, a number of reports were received by the Committee. These included:

- Emerging People risks;
- Medical and Dental Staff - People Update;
- Health and wellbeing update;
- Leadership Development, Talent and Succession planning;
- Deep dive into Violence and Aggression;
- NHS EDI Improvement Plan;
- National Workforce Plan;
- Clinical Board updates;
- Workforce Age Profile and Demographics update;
- Nursing, Midwifery and AHP update;
- Maternity Safety Champion observations – People update; and
- Care Quality Commission (CQC) – People updates.

The Committee also received the minutes of both the Learning and Education Group, Health and Wellbeing Steering Group, EDI Steering Group and the Sustainable Healthcare Committee as a standing item.

5. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2024/25 and utilised a rolling programme and action log to track committee actions.

As highlighted in Section 4(i), the Committee receives regular updates on risks recorded on the BAF which related to the Committee's area of focus. During 2024/25, the three risks included in the BAF and regularly discussed at the Committee were:

- Risk ID 2.1 - Failure to have sufficient capacity and capability in our workforce to deliver safe and effective care.
- Risk ID 2.2 - Failure to develop, embed and maintain an organisational culture in line with our Trust values and the NHS people promise.
- Risk ID 2.3 - Failure to effectively develop and implement a new approach to leadership and organisational development to ensure that everyone feels supported appropriately by the organisation.

The Committee received regular updates on mitigations in place and discussed the threats identified which might cause the principal risks to materialise if not mitigated against.

In addition at the end of every meeting debriefs are held and matters for escalation to the Trust Board agreed (and captured within the meeting minutes).

6. PROGRESS FOR 2024/25 & REVIEW OF EFFECTIVENESS

In the Annual Report of the Committee for 2024/25, two areas were identified as for action during 2025/26, with progress updates highlighted in italic font:

1. The Trust Secretary to work with the Chief People Officer to develop a more detailed review of Committee effectiveness to incorporate assurances gained.

An annual effectiveness survey was circulated to Committee members – the format of this was agreed with the Interim Shared Chair and used for all Committees. Feedback was received from 5 People Committee members, which highlighted the following:

- *Responses were generally positive. Most respondents agreed (as a minimum 3 from 5) that:*
    - *The Committee has a clearly defined role, purpose and objectives (as set out in its Terms of Reference).*
    - *The meeting is well managed in terms of scheduling, agenda setting and time management.*
    - *The skill mix and number of the Committee's membership is appropriate.*
    - *The purpose of papers being presented is made clear by the author, with actions, issues and assurances clearly defined.*
    - *Committee members actively participate and make relevant contributions to discussions.*
    - *The cross-representation of members at Committee meetings enhances the quality and reliability of decisions.*
    - *There is no duplication between Committees.*
    - *The frequency of the meetings enables business to be conducted effectively.*
    - *The Chair clearly captures decisions and actions arising throughout the committee meetings.*
    - *The Chair clearly captures the decision-making process and ensures it is understood by Committee members.*
    - *It is clear when the Committee needs to escalate matters for the attention of the Board or to another Committee.*
    - *The Committee Chair effectively addresses conflicts, concerns or issues that arise within the Committee.*
    - *The Committee Chair effectively manages time allocated to allow discussion on key items.*
    - *The Committee Chair encourages participation from newer / less experienced members.*
    - *The Committee effectively considers and weighs the potential risks and benefits associated with the decisions made.*
    - *The Committee members are given the opportunity to provide input and contribute to the decision making process.*
    - *The style and quality of meeting papers is appropriate for the meeting.*
    - *Meeting papers are succinct and set out the key issues, assurances and any gaps in assurances.*
    - *The Committee values and considers diverse perspectives and opinions when making decisions.*
    - *The Committee's decision making process is clear, transparent and inclusive.*

  - *The Committee ensures that processes are in place to create robust action plans with clear ownership, timeframes, and dependencies all of which are monitored and followed up at subsequent meetings.*
  - *The Committee receives assurance that identified actions are completed in line with agreed timescales.*
  - *The Committee's goals, objectives and activities are clearly aligned with the Trust's vision and strategy.*
  - *The Committee's meetings and agendas are focussed on addressing priorities aligned with the Trust's vision and strategy.*
  - *The Committee's decision-making process reflects the Trust's vision and strategy.*
  - *The Committee effectively fosters a culture and environment that supports the pursuit of the Committee's vision and strategy.*
  - *The Committee is actively engaged in discussions and decision-making processes that contribute to the realisation of the Trust's vision and strategy.*
  - *The Committee is effective in communicating and reporting on risks, issues and performance, and escalating these where necessary.*
  - *The Chair provides adequate support and guidance in managing risks, issues and performance.*
- *There were three statements where one respondent included 'disagree' being:*
  - *There is no duplication between Committees.*
  - *The frequency of the meetings enables business to be conducted effectively.*
  - *Meeting papers are succinct and set out the key issues, assurances and any gaps in assurances.*
- *Additional feedback comments were included which covered:*
  - *Supporting Committee meetings moving to bi-monthly (agreed for 2025/26).*
  - *Reviewing membership/attendees and level of contributions, with the Chair encouraging other members/attendees to contribute more during meetings.*
  - *Good progress made on improving reports into the Committee but further work needed on:*
    - *i. The People dashboard;*
    - *ii. Ensuring more succinct Executive summaries;*
    - *iii. Improving clarity of recommendations;*
    - *iv. Reducing duplication e.g. vacancies had been discussed at Quality, People and Finance Committee meetings;*
    - *v. To triangulate information with the Finance and Performance Committee (where relevant); and*
    - *vi. Reporting on workforce planning, FTSU, EDI, Leadership and OD (to support cultural improvement).*

2. To further develop the Schedule of Business and shape Committee meeting agendas around the strategic risks aligned to the Committee.

Significant work was conducted with the Executive Lead and new Committee Chair during the year to realign Committee meeting agendas around the strategic risk areas.

7. NEXT STEPS AND ACTIONS FOR 2025/26

The Committee has worked effectively during the year, and the survey findings have identified the following key focus areas for 2025/26 to further strengthen the Committee:

- Membership, attendance and encouraging contributions from those present.
- Continuing to ensure all meeting papers have succinct Executive summaries, clear recommendations, issues and decisions.
- Refinement of the People dashboard.
- Reducing duplication across/improving triangulating with Committees as appropriate.
- Enhancing reporting on priority areas: workforce planning, FTSU, EDI, Leadership and OD.

Meetings have now been moved to bi-monthly for 2025/26.

Report of Kelly Jupp
Trust Secretary

Lauren Thompson
Corporate Governance Manager / Deputy Trust Secretary
4 May 2025

QUALITY COMMITTEE ANNUAL REPORT 2024/25

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Quality Committee has met its key responsibilities for 2024/25, in line with its Terms of Reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during 2024/25.

2. COMMITTEE RESPONSIBILITIES

The Quality Committee is a non-statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the quality of care to the Trust's patients, specifically in relation to patient safety, clinical effectiveness and patient experience.

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors, that:

- The Trust has appropriate quality governance structures, systems, processes and controls in place and to meet Trust legal and regulatory requirements;
- Any shortcomings in the quality and safety of care are identified and addressed;
- The Trust's approach to, and delivery of, continuous quality improvement processes for all Trust services is effective;
- The Trust's research and development activities and its clinical practice are based on a robust mechanism of research governance which is subject to regular scrutiny and monitoring;
- The quality impact of changing professional and organisational practices is considered;
- The Trust fulfils its leadership and influencing role on service quality standards and practice; and
- Effective mechanisms are in place for the involvement of patients and the public, staff, partners and other stakeholders in improving quality assurance and patient safety.

It does this through the receipt of assurances from the management groups, the receipt of regular reports relating to areas which impact the quality of care provided to patients and discussions and reports on the management of risks relating to the committee's area of focus.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of at least 7 members is required as per the Terms of Reference, drawn from the Non-Executive Directors, members of the Executive Team and other senior staff members.

The Committee's quorum is four members and includes the Chair or Vice-Chair, and at least one other Non-Executive Director.

During 2024/25, the Committee met monthly in recognition of the improvements needed/assurances required as part of the CQC inspection findings. Eleven ordinary meetings were held between 1 April 2024 and 31 March 2025 and one 'check in' meeting in August 2024. Attendance at the ordinary meetings was as follows:

	Attendance at ordinary meetings
Steph Edusei, Non-Executive Director (Committee Chair April 2024 and Committee member May 2024)	1 of 2
Liz Bromley, Non-Executive Director *	1 of 1
Martin Wilson, Chief Operating Officer/Director – GNHA & Strategy (until 22 May 2024)	0 of 2
Anna Stabler, Non-Executive Director (Chair from May 2024)	10 of 10
Bill MacLeod, Non-Executive Director	10 of 11
Phil Kane, Non-Executive Director (from July 2024)	6 of 8
Bernie McCardle, Non-Executive Director *	2 of 2
Michael Wright, Joint Medical Director	5 of 11
Lucia Pareja-Cebrian Joint Medical Director	9 of 11
Ian Joy, Executive Director of Nursing	11 of 11
Rob Harrison, Managing Director (member from 23 May 2024)	9 of 9
Angela O'Brien, Director of Quality and Effectiveness (until end September 2024)	4 of 5
Louise Hall, Interim Director of Quality and Effectiveness (member for the October and November meetings)	2 of 2
Rachel Carter, Director of Quality & Safety (from December 2024)	4 of 4
Gus Vincent, Associate Medical Director, Patient Safety & Quality	1 of 11
Annie Laverty, Chief Experience Officer (member from 23 May 2024)	8 of 9
Lisa Guthrie, Deputy Chief Nurse	8 of 11

* Denotes Interim Committee member

The terms of reference for the Committee from 23 May 2024 to 28 March 2025 included the following Committee members:

1. Clinical Board Representatives for Quality and Safety; and
2. Corporate Nursing, Medical and AHP leaders responsible for Quality and Safety.

Due to the volume of individuals falling within the two categories above, and the alternating of attendance of individuals across Clinical Boards/Corporate leaders, they have not been included in the table above however representation of both 1 and 2 was present at every Committee meeting from May 2024 to March 2025.

Other attendees at the meetings have included:

- The Interim Chair, other Non-Executive and Associate Non-Executive Directors;

- Other Executive Team members, Directors and Deputy Directors;
- Associate Medical Directors;
- The Director of Infection Prevention and Control;
- Clinical Directors;
- Heads of Services;
- Heads of Nursing, Clinical Board Chairs and Directors of Operations;
- Associate Directors of Nursing;
- Quality & Safety Leads;
- The Director of Midwifery;
- Associate Directors of Operations;
- Consultants – Neonatal, Paediatrics, Obstetrician, Palliative Medicine, Ophthalmologist, Paediatric Cardiologist, Public Health;
- The Director and Assistant Director of Pharmacy;
- The Quality Improvement Programme Manager /Patient Safety & Quality Lead;
- Patient Safety & Quality Leads;
- A Radiologist/ Director of Breast Screening and the Breast Screening Programme Manager;
- The Director of Nursing (North) and the Deputy Director of Nursing (Quality), North East and North Cumbria Integrated Care Board;
- Associate Medical Directors;
- The Senior Project Manager – Transformation;
- The Corporate Governance Manager / Deputy Trust Secretary and PA to Chairman and Trust Secretary / Corporate Governance Administrator who provided Secretariat Support to the Committee.

During 2024/25, a process was put in place to allow one Governor to observe Committee meetings on a three-monthly rotational basis by expression of interest. Throughout the year, Public Governors Eric Valentine, Pam Yanez, Chris Record and Claire Watson observed Quality Committee meetings.

4. MANAGEMENT GROUPS

To ensure that the Committee maintained adequate oversight of the management of quality related matters across the Trust, a series of Management and Oversight Groups continued to report into the Committee, with terms of references updated/approved by the Committee during the year as appropriate:

- Patient Safety;
- Patient Experience and Engagement;
- Clinical Outcomes and Effectiveness including updates from the Clinical Ethics Advisory Group;
- Compliance and Assurance [during the year this Group moved to reporting into the Audit, Risk and Assurance Committee];
- Transplantation Committee; and
- Cardiac Oversight Group.

The Committee receive a report from a minimum of one group at each meeting, rotating across the course of the year. The reports detail the activities of the Management Groups

and any risks/matters requiring escalation to the Committee. Additionally, the minutes or Chairs Logs from the Management Groups are received by the Committee at each meeting.

The Terms of Reference for each of the Management Groups, which clearly define the remit of each of the groups, were approved by the Committee on establishment, with any changes captured in the minutes of the groups shared with the Committee routinely.

In addition, a bi-annual Research and Development report is received by the Committee however during 2024/25 it was agreed that Research and Development will report into a new Research Board Committee once established in 2025/26.

5. REPORTING

i. Regular Reports

During the year, the following regular reports/agenda items were discussed by the Committee:

- The Integrated Board Report;
- Regulatory Updates e.g. Care Quality Commission Update Reports;
- Cardiac Oversight Group (including the Terms of Reference which were approved);
- Feedback from NED informal visits and leadership walkabouts until it was agreed for this report to feed directly in to Trust Board;
- New and emerging risks;
- Patient and Staff Experience update;
- Updates from the Executive Director of Nursing, Joint Medical Directors, Managing Director/Deputy CEO, ICB and Committee Chair;
- Maternity Updates / CNST / Perinatal Quality Surveillance Report, including Maternity;
- Wards of concern;
- Incentive Scheme Update and Midwifery staffing; and
- Board Assurance Framework review.

ii. Quarterly, Biannual and Annual Reports

The following Quarterly and Annual reports were received by the Committee during 2024/25:

- Safeguarding and Mental Capacity Act;
- Learning Disability;
- Legal Cases Update;
- Quality Committee Risk Report relating to the Committee's area of focus;
- Mortality and Learning from Deaths;
- Research Update Bi-Annual Report;
- End of Life and Palliative Care Bi-Annual Report;
- Clinical Audits;
- Alliance update;
- Quality Committee Internal Audit Report;
- Serious Incident Close Out Assurance Report;

- Patient Safety Incident Response Framework (PSIRF) Priorities e.g. internal referrals and Updates;
- Quality Oversight Group Terms of Reference (which were approved);
- Audiology updates;
- Duty of Candour, including a deep dive;
- National Patient Safety Strategy & Patient Safety Incident Response Framework Update;
- Marthas Rule;
- Health Inequalities;
- Annual Report of the Quality Committee;
- Nurse Staffing Deep Dive/Six monthly reports;
- Quality Account Bi-Annual Report / Quality Priorities updates;
- Infection Prevention and Control Bi-Annual update;
- Allied Health Professionals Staffing Report; and
- Maternity Staffing Report.

iii. Ad-Hoc Reports

In addition to those reports listed above, a number of ad-hoc reports have been received by the Committee. These included:

- Revised Quality Committee Governance Structure for Review (which was approved);
- Cancer and Non-cancer Patient Harm Reviews;
- Outpatient Transformation Programme;
- Performance;
- CQC updates/themes/areas requiring improvement:
    - Medicines Management, including a deep dive on medicines reconciliation and Medicines Oversight Group updates;
    - NECTAR;
    - Digital;
    - Duty of candour:
    - Rapid Quality & Safety reviews;
    - Update from CQC Engagement and NHS Quality Improvement Group;
    - Areas for scalation; and
    - Emergency Department.
- Update from CQC Delivery Group and phase 2 action plan;
- Feedback from thevaluecircle Improvement Review;
- Quality Oversight Group (QOG) stocktake;
- Non-RTT long waits;
- Transplantation Committee Terms of Reference (which were approved);
- Clinical Board Top 3 Quality and Safety issues to raise to Quality Committee;
- Mental Health Committee Update;
- Anti-microbial Stewardship (AMS);
- Clinical Board Quality and Safety Priorities;
- HTA/Mortuary services report;
- Internal Audit Reports on – Enhanced Care Observation (and follow up), and Safe Staffing;
- VTE update;

- AHP Update;
- Privacy and Dignity Update;
- Breast Screening Quality Assurance Action Plan Update;
- Screening quality assurance visit report for North Cumbria Breast Screening Service;
- Delays in physiotherapy following amputation;
- Feedback from the Pancreatic Cancer GIRFT review;
- Waiting List Management;
- Accrediting Excellence Programme;
- Update on unverified letters and compliance with discharge summaries;
- IPC BAF Report;
- Clinical Board Quality & Safety Escalation Report; and
- Quality Oversight Group monitoring and evaluation report.

6. GOVERNANCE, INTERNAL CONTROL AND RISK MANAGEMENT

The Committee developed a revised Schedule of Business during 2024/25 and utilised a rolling programme and action log to track committee actions.

As highlighted in Section 5(ii), the Committee received regular updates on risks recorded on the Board Assurance Framework (BAF) which related to the Committee's area of focus. One risk was recorded on the BAF during 2024/25 relating to the Committee in relation to the inability to maintain and improve patient safety and quality of care that delivers. There were 11 threats identified in relation to the risk and the Committee received a detailed report regarding the risk and threats.

The Committee received regular updates on the mitigating actions in relation to the risk above and sought assurance that the risk was being managed effectively.

7. PROGRESS FOR 2024/25 & REVIEW OF EFFECTIVENESS

In the prior year Committee Annual Report, the following area was identified to progress in 2024/25 – updates are shown in italic text below:

- Development of the Trust Quality Strategy and Quality Priorities.

Committee members regularly received updates on the Quality Priorities. The development of the Trust Quality Strategy was paused whilst work continued on the development of the overarching Trust Strategy and also the Clinical Strategy.

An annual effectiveness survey was circulated to Committee members – the format of this was agreed with the Interim Shared Chair and used for all Committees. Feedback was received from 5 Quality Committee members, which highlighted the following:

- Responses were generally positive. Most respondents agreed (as a minimum 3 from 5) that:
    - The Committee has a clearly defined role, purpose and objectives (as set out in its Terms of Reference).

- The meeting is well managed in terms of scheduling, agenda setting and time management.
- The skill mix of the Committee's membership is appropriate.
- The purpose of papers being presented is made clear by the author, with actions, issues and assurances clearly.
- Committee members actively participate and make relevant contributions to discussions.
- The cross-representation of members at Committee meetings enhances the quality and reliability of decisions.
- There is no duplication between Committees.
- The frequency of the meetings enables business to be conducted effectively.
- The Chair clearly captures decisions and actions arising throughout the committee meetings.
- The Chair clearly captures the decision-making process and ensures it is understood by Committee members.
- It is clear when the Committee needs to escalate matters for the attention of the Board or to another Committee.
- The Committee Chair effectively addresses conflicts, concerns or issues that arise within the Committee.
- The Committee Chair effectively manages time allocated to allow discussion on key items.
- The Committee Chair encourages participation from newer / less experienced members
- The Committee effectively considers and weighs the potential risks and benefits associated with the decisions made.
- The Committee members are given the opportunity to provide input and contribute to the decision making process.
- Decision-making: The style and quality of meeting papers is appropriate for the meeting.
- The Committee values and considers diverse perspectives and opinions when making decisions.
- The Committee's decision making process is clear, transparent and inclusive.
- The Committee ensures that processes are in place to create robust action plans with clear ownership, timeframes, and dependencies all of which are monitored and followed up.
- The Committee receives assurance that identified actions are completed in line with agreed timescales.
- Alignment to vision and strategy: The Committee's goals, objectives and activities are clearly aligned with the Trust's vision and strategy.
- Alignment to vision and strategy: The Committee's meetings and agendas are focussed on addressing priorities aligned with the Trust's vision and strategy.
- Alignment to vision and strategy: The Committee's decision-making process reflects the Trust's vision and strategy.
- Alignment to vision and strategy: The Committee effectively fosters a culture and environment that supports the pursuit of the Committee's vision and strategy.
- Alignment to vision and strategy: The Committee is actively engaged in discussions and decision-making processes that contribute to the realisation of the Trust's vision and strategy.

  - Alignment to vision and strategy: The Committee is effective in communicating and reporting on risks, issues and performance, and escalating these where necessary.
  - Alignment to vision and strategy: The Chair provides adequate support and guidance in managing risks, issues and performance.
- Additional feedback comments were included which covered:
  - There have been noticeable improvements in the last year with greater involvement.
  - Given the size and complexity of the agenda time keeping can be challenging, the chair does give presenters the option to leave once they have presented their item if not a core member of the committee / The Chair does a good job of keeping to time with the agenda / A huge number of people attend this meeting - it has improved but we need to be mindful of balance between efficiency and involving staff.
  - Papers are improving however they need to be more explicit regarding risk mitigations / the quality of papers is variable but improving / Similarly on papers, they have improved but some can still be very long and wordy.

Significant work was conducted with the Executive Lead and new Committee Chair during the year to realign Committee meeting agendas around the strategic risk areas.

8. NEXT STEPS AND ACTIONS FOR 2025/26

As identified in the survey, the key areas of focus for 2025/26 are:

- Meeting attendees – review of meeting attendance to ensure best use of time. This was completed prior to April 2025.
- Meeting papers – continued work to ensure meeting papers are succinct and clear.
- Meeting agendas/time management – continuing focus on ensuring meeting agendas are aligned to risks and do not become overburdened.

The Terms of Reference and Schedule of Business for the Committee have been reviewed and minor changes agreed at the Committee and the Trust Board in March 2025. In summary the changes were:

- Amendments to membership and membership role titles.
- Chairs Logs from the Medicines Management Group, Care for all Group and the Transplantation Committee will be received.
- A quarterly summary of internal audit reports relating to the Quality Committee will be reported.
- Updates on the Accrediting Excellence (ACE) progress will be provided regularly.
- Agreement that a new Board Committee be established for Research.

Report of Kelly Jupp
Trust Secretary
10 May 2025

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DIGITAL AND DATA COMMITTEE ANNUAL REPORT 2024/25

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Digital and Data Committee has met its key responsibilities for 2024/25. It also outlines overall achievements throughout the year and action points for continuing development during the coming year.

The Terms of Reference and Schedule of Business for the Committee have been reviewed and minor changes recommended for agreement at the Committee meeting in March 2025.

2. COMMITTEE RESPONSIBILITIES

The Digital and Data Committee is a non-statutory Committee established by the Board of Directors to:

- Provide assurance to the Board on the development and implementation of the Digital Strategy, including the delivery of associated roadmaps;
- Oversee the delivery of significant digital transformation projects, procurement of major or critical digital systems or equipment and the development of the Trust's digital infrastructure; and
- Assure the Trust Board on compliance with legislation/relevant regulations for information governance, cyber security and information security, as well as on the governance of the Trust's data quality.

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Director:

- That the Digital Strategy enables improvements in the efficiency and safety of patient and staff experience, as well as in corporate processes;
- That the strategic digital principles, priorities, risk and performance parameters are aligned and support the Trust's strategic objectives and its long-term sustainability;
- That the Trust's degree of exposure to digital and cyber risk, and any potential to compromise the achievement of the strategic objectives is being effectively managed;
- That reporting on the digital performance of the Trust is being triangulated against agreed plans, progress and performance measures, reporting on progress to the Trust Board;
- That Trust's digital resources and assets are being used and maintained effectively and efficiently to ensure value for money;
- On the Trust's compliance with current digital statutory and external reporting standards and requirements;
- On the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the committee purpose and function;
- On the robustness of systems and processes for prioritisation of investments related to the Digital Strategy, including digital infrastructure;

- On compliance with legislation/relevant regulations for information governance and information security, as well as on the governance of the Trust's data quality; and
- On the robustness of processes for review of any Digital and/or Data incidents.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of 19 members (as specified in the Terms of Reference), drawn from the Non-Executive Directors and members of the Executive Team and Management Team.

The Committee's quorum is four members, including the Chair or Vice Chair.

Meetings are held bi-monthly. Six ordinary meetings were held between 1 April 2024 and 31 March 2025.

Attendance at the meetings was as follows:

	Attendance at ordinary meetings
Graeme Chapman, Non-Executive Director (NED) Committee Chair until 22 April 2024	1 of 1
Liz Bromley, NED Committee member until 22 April then became Interim Committee Chair from 23 April 2024	5 of 6
Kath McCourt, NED Interim Committee member – Chaired the August meeting in the absence of the Chair	1 of 1
Bernie McCardle, NED Interim Committee member for the 4 June 2024 Committee meeting	1 of 1
Phil Kane, NED Committee member from 24 June 2024	4 of 4
Shauna McMahon, Chief Digital Information Officer and Senior Information Risk Owner	6 of 6
Rob Harrison, Deputy Chief Executive Officer *became Acting CEO in March 2025 and therefore attended the 20 March 2025 meeting as an attendee rather than a Committee member	5 of 6*
Michael Wright or Lucia Pareja-Cebrian, Joint Medical Director	5 of 6
John Crossman, Associate Medical Director – Digital	1 of 6
Vicky McFarlane-Reid, Director for Commercial Development and Innovation	5 of 6
Jackie Bilcliff, Chief Finance Officer	4 of 6
Annie Laverty, Chief Experience Officer	0 of 6
Lisa Guthrie, Deputy Director of Nursing	2 of 6
Chris Plummer, Chief Clinical Information Officer	5 of 6
Gordon Elder, Chief Nursing Information Officer / Chris Bill, Chief Nursing Information Officer	6 of 6
Wasique Chaudry, Director of Operations – Clinical & Research Services Clinical Board;	0 of 6
Lisa Sewell, Head of Digital Innovation & Delivery	5 of 5
Natalie Yeowart, Head of Corporate Risk & Assurance	5 of 6

Tim White, Head of Risk, Compliance and Assurance	1 of 6
Gary Towns, Head of IT Service Management	4 of 6

Other attendees at meetings have included Heads of Service, Executive Team members, the Chair, a Finance Manager, the Associate Director for Commercial Enterprise, representatives from Northumbria Healthcare, a Clinical Director, the Director of Performance and Governance (who became a Committee member from 28 March 2025) and Secretariat support.

Governor observers throughout the year included Sandra Mawdesley who attended meetings on 12 December 2024 and 20 March 2025.

4. REPORTING

i) Regular Reports

Over the course of the year, Committee members received regular reports/updates on:

- CIO report;
- Cyber Security;
- BAF/risk report & emerging risks;
- Digital financial plan/position/investments;
- Digital change projects e.g. Laboratory Information Management System,
- SIRO report;
- Digital/Data incident review, including considering external incidents such as Crowdstrike and the Guys and St Thomas' cyber attack;
- Digital & Data Priorities/Updates; and
- External/Internal audit/review reports related to Digital & Data.

ii) Annual Reports

The following Annual Reports were received by the Committee:

- Digital and Data Committee Terms of Reference and Schedule of Business 2025/26; and
- Annual Digital Workplan/Annual Digital Strategy.

iii) Ad-Hoc Reports

In addition to those reports listed above, several reports were received by the Committee. These included:

- Digital Maturity Assessment;
- Information Governance and SARS update;
- Digital Roadmap and EPR optimisation plan;
- Data Security & Protection (DSPT) – optional audit requirements;
- Cart Refresh;
- Update on Electronic Patient Record - Adoption Coaches;
- Accessible Information Standard (Improving Patient Experience);
- Improving patient safety schemes e.g. Medisight;

- Partnerships e.g. Cloud Solutions, Newcastle Alliance Collaboration;
- Care Quality Commission (CQC) updates;
- End User Experience & EPR Optimization (SystemOne/Cerner Oracle/Badgernet/ICE) – Useability survey;
- Digital Achievements/Benefits and Challenges;
- Oracle Cerner Remote Hosting and EPR Upgrade
- Digital Programme Project Delivery Update;
- Data Quality;
- Funding bids; and
- Commercial opportunities – Digital and Cloud solutions, Digital Partnerships Committee.

5. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2024/25 and utilised a rolling programme and action log to track committee actions.

As highlighted in Section 4(i), the Committee receives regular updates on risks recorded on the BAF which related to the Committee's area of focus. During 2024/25, the one risk included in the BAF and regularly discussed at the Committee was:

- *Failure to deliver digital systems, processes, and infrastructure to support the provision of safe effective patient care and our digital aspirations for the future.*

Three threats were identified that might cause the principal risk to materialise if not mitigated, being:

- Lack of standardisation in clinical pathways, lack of capacity and capability resulting in failure in maximise our investment in E-record and digital systems.
- Failure to protect and prevent against cyber-attack.
- Lack of agreed digital strategy and aligned financial plan for digital investment.

The Committee received regular updates on mitigations in place. In addition, at the end of every meeting debriefs are held and matters for escalation to the Trust Board agreed (and captured within the meeting minutes).

6. PROGRESS FOR 2024/25 & REVIEW OF EFFECTIVENESS

An annual effectiveness survey was circulated to Committee members. Feedback was received from 7 members, which highlighted the following:

- Most respondents agreed (as a minimum 5 from 7) that:
    - The meeting was well managed in terms of scheduling, agenda setting and time management.
    - The skill mix and number of the Committee's membership was appropriate.
    - The purpose of papers being presented was made clear, with actions, issues and assurances clearly defined.
    - Committee members actively participate and make relevant contributions.
    - There was no duplication between committees.

  - The frequency of meetings enabled business to be conducted effectively.
  - The Chair clearly captured decisions and actions arising throughout meetings, as well as the decision-making process and ensured it was understood by Committee members.
  - It was clear when the Committee needed to escalate matters for the attention of the Board/another Committee.
  - The Committee Chair effectively addressed any conflicts/concerns/issues that arose and managed the meeting time.
  - The Committee effectively considered and weighed the potential risks and benefits associated with decisions made.
  - Committee members were given the opportunity to provide input and contribute to the decision making process.
  - The Committee valued and considered diverse perspectives and opinions when making decisions.
  - The Committee's decision making process was clear, transparent and inclusive.
  - The Committee's goals, objectives and activities were clearly aligned with the Trust's vision and strategy.
- For the following statements, less than 5 respondents either agreed or strongly agreed that:
  - The cross-representation of members at Committee meetings enhanced the quality and reliability of decisions (overall 4 agreed and 3 selected 'neither agree or disagree').
  - The Committee role, purpose and objectives were clearly defined (overall 4 agreed, 2 selected 'neither agree or disagree' and 1 disagreed).
  - The Committee Chair encouraged participation from newer/less experienced team members, (overall 4 agreed and 3 selected 'neither agree or disagree').
  - The style of meeting papers was appropriate (overall 3 agreed, 3 selected 'neither agree or disagree' and 1 selected 'disagree').
  - Meeting papers were succinct and set out the key issues/assurances/gaps in assurance (overall 2 agreed, 4 selected 'neither agree or disagree' and 1 disagreed).
  - The Committee ensured that processes were in place to create robust action plans which were monitored and followed up subsequently (overall 3 agreed, 3 selected 'neither agree or disagree' and 1 disagreed).
  - The Committee received assurances that identified actions were completed in the agreed timescales (overall 4 agreed and 3 selected 'neither agree or disagree').
  - The Committee's meetings and agendas were focussed on addressing priorities aligned to the trust's vision and strategy (overall 4 agreed, 2 selected 'neither agree or disagree' and 1 disagreed).
  - The Committee's decision making process reflected the Trusts vision and strategy, (overall 3 agreed, 1 selected 'neither agree or disagree', 1 disagreed and 1 selecting 'cannot say').
  - The Committee effectively fostered a culture and environment that supports the pursuit of the Committee's vision and strategy (overall 4 agreed, 1 selected 'neither agree or disagree', 1 disagreed and 1 selecting 'cannot say').
  - The Committee was actively engaged in discussions and decision and decision making processes that contributed to the realisation of the Trusts vision and

strategy (overall 4 agreed, 1 selected 'neither agree or disagree', 1 disagreed and 1 selecting 'cannot say').
    - The Committee was effective in communicating and reporting on risks, issues and performance and escalating these where necessary (overall 4 agreed, two selected 'neither agree or disagree' and 1 disagreed).
    - The Chair provided adequate support and guidance in managing risks, issues and performance (overall 4 agreed, and 3 selected 'neither agree or disagree').
- As the Committee had only been in operation for circa 12 months at the time of the survey one respondent referenced this and therefore was still 'forming' (being embedded within the governance structure).
- One respondent highlighted that it was not always evident that agenda items linked back to the Terms of Reference. A further respondent noted that the Committee may perhaps be too focussed on operational management issues and needed to take a more strategic approach in seeking assurance.
- The quality of the meeting papers varied as per one respondent.
- One respondent noted that 'quite a few' members/attendees didn't contribute during the meetings and noted that a NED with specific digital expertise may be beneficial as a Committee member.

7. NEXT STEPS AND ACTIONS FOR 2025/26

2024/25 was the first full year of the Committee being in operation. In addition during the year there was a change in the Committee Chair (on an Interim basis) and NED membership, as well as changes in Executive Team member roles. Despite this the Committee has progressed well and the survey findings have identified key focus areas for 2025/26 to further embed and strengthen the Committee, being:

- The quality of meeting papers, in particular focussing on succinctness, style and clarity of issues/decisions.
- Revisiting Committee membership and attendance.
- Action plan development and monitoring.
- Clarity of priorities, risks, and alignment of these to strategy/strategies and the Committees purpose.

The above will be discussed with the new Chief Digital Information Officer and the permanent Committee Chair with further work to be actioned in year.

Report of Kelly Jupp
Trust Secretary

Lauren Thompson
Corporate Governance Manager / Deputy Trust Secretary
4 May 2025

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PUBLIC BOARD MEETINGS - ACTIONS

Agenda item A14

Log No.	BOARD DATE	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
130	29 November 2024	Staff Story	AL to check with the Staff member who shared their story as to whether they had revisited the ED to see how improvements are working in practice [ACTION02].	AL	ON HOLD		06.12.24 - AL confirmed that an offer has been made to the staff member however they are currently on leave. An update to be provided when the staff member returns and if the offer is accepted. 20.03.25 - Update requested from AL. 28.03.25 - The Board agreed for AL to pick this action up outside of the meeting. Propose to close action.
132	29 November 2024	Maternity Incentive Scheme progress report	To include financial figures and benchmarking against other organisations in future reports [ACTION04].	JW			05.12.24 - JW confirmed that this information will be included in future reports once all returns have been received. 31.01.25 - JW advised that she would continue to try and obtain the required information from finance colleagues. 21.03.25 - JW has been unable to get the data via the Head of Midwifery network however IJ will discuss with the regional Directors of Nursing during our April forum. 14.05.25 - Action not yet complete.
136	28 March 2025	i) Patient and Staff Stories	It was agreed that the Executive Team would discuss whether patients/staff members should attend and present their own story or whether to revert back to using video recordings [ACTION01].	All			04.04.25 - Sent email to IJ & AL requesting update 14.05.25 - This was explored at the Executive Team meeting and it was agreed to try a mixed method approach using film where possible / as appropriate but recognising the limitations. Propose to close action.
137	28 March 2025	ii) Patient and Staff Experience including: a. Patient Experience Right Time Results	It was agreed that the CXO and EDN would review the distribution of wards in phase two of the programme and consider any wards not yet asking to be included [ACTION02].	AL & IJ			04.04.25 - Sent email to IJ & AL requesting update 14.05.25 - IJ/AL have discussed and are happy with the current allocation and agreed to monitor in regular 1:1s and respond to service needs as required. Propose to close action.
138	28 March 2025	iii) Board Visibility Programme	It was agreed that the DQS would revisit the walkabout arrangements and provide an update at the next Public Trust Board meeting [ACTION03].	RC			04.04.25 - RC advised it is in hand. 14.05.25 - The detail is included in the May Board Visibility Programme Paper. Propose to close action.
139	28 March 2025	v) Alliance progress update	It was agreed that the next Alliance update would include an update on the outcomes from the Alliance Committee on the areas of biggest progress [ACTION04].	MWi			04.04.25 - MWi advised that the Alliance update wont be presented to Trust Board until September 2025. The template has been amended to include this information going forward. Propose to close action.
140	28 March 2025	viii) Sustainable Healthcare in Newcastle	It was agreed that the ADES and DPG would discuss opportunities in relation to Taxis and courier opportunities [ACTION05].	PG/JD			04.04.25 - PG has a meeting in the diary to discuss with JD on 15 April 2025. 14.05.25 - PG advised that after meeting JD it has been agreed that some additional wording will be included in the interim strategy on sustainability. JD is also going to attend the Travel & Transport Working Group moving forward. Propose to close action.
141	28 March 2025	viii) Sustainable Healthcare in Newcastle	The CFO agreed to discuss the lack of electronic vehicle charging points and raising awareness of the location of the existing charging points [ACTION06].	JB			16.04.25 - The provision of EV charging points has been raised with the Director of Estates, given the cost and complexity of this, increasing staff awareness will be considered. Propose to close action.
142	28 March 2025	ii) Gender Pay Gap report	Mr MacLeod queried the 12% pay gap between medical and dental trainees. The DCDI agreed that she would confirm the reason for the 12% pay gap on medical and dental trainees [ACTION07].	VMR			04.04.25 - LPC advised that the gender gap in this group is likely to be due to maternity leave and LTFT trainees who are most commonly women with carers responsibilities. Propose to close action.

Log No.	BOARD DATE	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
143	28 March 2025	iii) Governance documents: b. Public, Private and Charity Board of Directors Schedules of Business	The Chair asked for the Winter Plan scheduling to be updated on the Schedule of Business [ACTION08].	KJ			09.04.25 - SoB updated with the months that the winter plan will be presented at. Propose to close action.

KEY

NEW ACTION	To be included to indicate when an action has been added to the log.
ON HOLD	Action on hold.
OVERDUE	When an action has reached or exceeded its agreed completion date. Owners will be asked to address the action at the next meeting.
IN PROGRESS	Action is progressing inline with its anticipated completion date. Information included to track progress.
COMPLETE	Action has been completed to the satisfaction of the Committee and will be kept on the 'in progress' log until the next meeting to demonstrate completion before being moved to the 'complete' log.