The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Public Trust Board of Directors' Meeting

Friday 25 July 2025, 10.15 – 11.45

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 May 2025 and Matters Arising	Paul Ennals	Attached	10:16 – 10:17
3.	Chair's Report	Paul Ennals	Attached	10:17 – 10:22
4.	Acting Chief Executive's Report, including: - 10 year Health Plan for England	Rob Harrison	Presentation	10:22 – 10:35
Strategic items:				
5.	Patient and Staff Stories	Annie Laverty	Attached	10:35 – 10:40
6.	Board Visibility Programme	Rachel Carter	Attached & Reading Room	10:40 – 10:45
7.	CQC update	Ian Joy	Attached	10:45 – 10:55
8.	Winter Plan [FOR APPROVAL]	Sue Hillyard & Nichola Kenny	Attached	10:55 – 11:05
9.	Integrated Board Report	Patrick Garner	Attached	11:05– 11:15
Items to receive *[NB for information – matters to be raised by exception only]*:				
10.	Director reports: a. Joint Medical Directors Report including: i) Guardian of Safe Working Annual Report 2024/25 and Quarter 1 2025/26 Report	Michael Wright & Lucia Pareja-Cebrian	Attached Attached & Reading Room	11:15 – 11:35
	b. Executive Director of Nursing Report including	Ian Joy	Attached & Reading Room	
	c. Maternity: i) Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress report	Ian Joy & Jenna Wall	Attached	
	ii) Maternity Safety Champion Report	Liz Bromley	Attached	
11.	Committee Chair Meeting Logs	Committee Chairs	Attached	

Items to approve:				11:35 – 11:43
12.	Interim Strategy	Patrick Garner	Attached	
13.	Trade Union Report	Vicky McFarlane-Reid	Attached	
14.	Modern Slavery Declaration	Kelly Jupp	Attached	
15.	Board Assurance Framework (BAF)	Patrick Garner	Attached	
16.	Risk Appetite Statement	Patrick Garner	Attached	
Any other business:				
17.	Meeting Action Log	Paul Ennals	Attached	11:43 – 11:44
18.	Any other business	All	Verbal	11:44 – 11:45

Date of next meeting:
Public Board of Directors – Friday 26 September 2025

Sir Paul Ennals, Chair

Mrs Liz Bromley, Non-Executive Director and Maternity Safety Champion

Mr Rob Harrison, Acting Chief Executive Officer

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

Mr Patrick Garner, Director of Performance and Governance

Mrs Sue Hillyard, Interim Director of Operations

Mrs Annie Laverty, Chief Experience Officer

Mrs Rachel Carter, Director of Quality and Safety

Mrs Nichola Kenny, Director of Improvement and Delivery

Mrs Jenna Wall, Director of Midwifery

Mrs Kelly Jupp, Trust Secretary

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PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 23 MAY 2025

Present:	Sir Paul Ennals *[Chair]*	Chair
	Mr R Harrison	Acting Chief Executive Officer [ACEO]
	Dr M Wright	Joint Medical Director [JMD-W]
	Mrs L Pareja-Cebrian	Joint Medical Director [JMD-PC]
	Mr I Joy	Executive Director of Nursing [EDN]
	Dr V McFarlane Reid	Director for Commercial Development & Innovation [DCDI]
	Mr P Hanson	Director of Estates, facilities and Strategic Partnerships [DEFSP]
	Ms S Hillyard	Interim Director of Operations [IDO]
	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
	Mr H Kajee	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]
Mr P Garner, Director of Performance and Governance [DPG]
Mrs J Mason, Deputy Chief Finance Officer [DCFO]
Mrs K Jupp, Trust Secretary [TS]
Mrs J Wall, Director of Midwifery [DoM] *(for item 25/13 c.)*
Mrs N Kenny, Director of Improvement and Delivery [DID] *(for item 25/12 iv))*
Ms LA Naidoo, Improvement Programme Manager [IPM] *(for item 25/12 i))*
Ms J Samuel, Director of Infection, Prevention and Control [DIPC]

Observers:
Ms W Saviour, Deputy Chief Executive at thevaluecircle
Ms K Sheard - Deputy Director of Nursing and AHPs, South Tyneside and Sunderland NHS Foundation Trust
Mr D Gleghorn - Field Access Manager, UCB, North East & Scotland
Ms L R Oliver - Pre Sales Manager, Liaison Group
Mr A Bailey - Market Access Manager, Uniphar Commercial
Ms C Heslop – Public Governor

Mr P Bower – Public Governor

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.

25/11 STANDING ITEMS:

The Chair welcomed all to the meeting and declared that the meeting would be recorded, with the recording to be made available online. He highlighted how more business was now being discussed at the Public Board of Directors' meetings and therefore the agendas for the Private Board of Directors meetings had reduced.

i) Apologies for Absence and Declarations of Interest

Apologies were received from Mrs J Bilcliff, Chief Finance Officer [CFO], Lucia Pareja-Cebrian, Joint Medical Director [JMD-PC] and Mrs Annie Laverty, Chief Experience Officer [CXO].

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 28 March 2025 and matters arising

The minutes of the meeting held on 28 March 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 advised that he had been appointed as the Shared Chair across Newcastle Hospitals, Northumbria Healthcare and Gateshead Health NHS Foundation Trusts. He highlighted his pride in initially becoming the Interim Shared Chair and noted how much prouder he felt to be appointed as the substantive Shared Chair. The Chair expressed his gratitude to all who had supported him and shared messages of thanks.

The ACEO congratulated the Chair on behalf of the Board of Directors.

The Chair advised that he would share his vision for the Alliance at a future Board meeting or development session **[ACTION01]**.

The next stage would be to appoint a permanent Vice Chair during the Summer, with the process to be led by the Council of Governors. Mrs Bromley was noted to be the current Interim Vice Chair.

The Newcastle Hospitals Charity had recently worked with Eddie Howe and the Newcastle United Football team, with brilliant support received for the international day of the Midwives.

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

iv) Acting Chief Executive's Report

The ACEO highlighted the following points:

- The regular dashboard included further financial context. A great deal of work had taken place to achieve a breakeven position for the financial year 2024/25.
- For 2025/26, the Trust had a significant Cost Improvement Programme (CIP) to deliver. At month 1 there was a renewed focus on reducing waste and inefficiencies, and improving productivity.
- A corporate vacancy freeze had been enacted to aid delivery of the financial plan. Impact assessments were being conducted regarding vacancy freezes to ensure there was no impact on quality.

  The DPG explained that a series of service reviews had been expedited to protect vulnerable services. This was important where there was a funding mismatch or productivity challenges. The results would be reviewed in the next three months due to the significant financial challenges.
- The importance of the Big Signals, which included enhancing technology to support staff and patients. In May the digital team, operational teams and clinical teams had worked together successfully to transfer the Electronic Patient Record (EPR) to a remote hosted environment. A period of system downtime was enacted, with the process overseen by the JMD-PC. The process ran smoothly, with safety prioritised. The transfer would now enable necessary system upgrades to be made, with system speed and functionality improved.
- The Trust was continuously improving reporting and safety systems, with the recent implementation of InPhase for the reporting of incidents and other functionality. Staff had not reported any significant issues or unrest during the changeover which demonstrated the success of the implementation. There would be further benefits seen from the different system modules available.
- In relation to the Trust's approach to reshaped governance, preparations were taking place for an external well led review, commissioned by the Trust. It was anticipated that the review would take place over the next eight weeks to provide additional assurance to regulators.
- With regards to patient experience, more data and themes were now available through the real time programme, with the information fed back to service areas to support them with their improvement plans.
- The Capital Programme was discussed and approved at the most recent Finance and Performance Committee (F&PC) and Private Board of Directors meetings. The Capital

Programme was oversubscribed; however the DEFSP was working with the clinical leadership team to align the clinical priority requirements and ensure critical areas were covered.

- In relation to the development of Integrated Neighbourhood Health Teams, delivery work and future engagement would be taking place from June 2025 to be part of an integrated model.

  The Chair highlighted that this had been a popular area of discussion and once the finances were stabilised, this would be a main area of focus.

Mrs Stabler referred to the impact of the static elective funding and queried the impact on waiting lists. In relation to Estates, she recommended it would be useful to understand if some projects staff were expecting to be delivered (for example the Northern Centre for Cancer Care (NCCC) ambulatory care unit) had been deferred, and if staff had been made aware. The ACEO explained that there was a targeted approach to balance what was required from a performance standard perspective and that the activity plan was required to be agreed with commissioners. Focus had been placed on maximising opportunities in the activity plan, with some risks taken, and aim to reduce long waiting times.

Activity, and the associated income, would be monitored closely throughout the year. If needed further discussions would be held with commissioners regarding any significant variances emerging.

The importance of messaging and communications regarding the CIP and cost recovery was noted. The month 1 finance report included additional narrative on associated risks and the forecasted position.

The IEDO advised that the Trust was focussed on achieving the ambitious targets in the activity plan and reducing long waiters by end of this year. Whilst contracting discussions were part of the planning process, all teams were aware of the need to deliver the plan.

In response to the query from Mrs Stabler on estates, the DEFSP advised that all agreed projects were proceeding as planned. The Capital Programme was discussed at the Trust Management Group (TMG) with regards to priorities and the programme had been shared within the organisation.

Mr MacLeod referred to the national pay increases and risks of industrial action. He queried what local engagement was taking place with different staff groups. The ACEO explained that now that the information was available, the business continuity plans used successfully in the past for industrial action would be updated and engagement would continue locally to maintain positive local relationships. The JMD-W noted that plans would be enacted to manage the position if required, with a continued priority to maintain safety during any periods of industrial action. The Local Negotiating Committee (LNC) continued to engage and conversations were actively taking place.

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

25/12 STRATEGIC ITEMS:

i) Patient and Staff Stories

The IPM highlighted the following points:

- A story was shared regarding a patient who was diagnosed with renal failure following no prior symptoms. The patient was now included in the transplant list for a new kidney when available.
- Positive work had taken place between Newcastle Hospitals staff and some pharmaceutical companies on drug provision to ensure that the required drug would be available immediately when the transplant took place. This provided reassurance to the patient.

  The Chair noted the excellent example of teamwork that had taken place wider than the Trust.

  The EDN highlighted the importance of the impact that Trust teams could have nationally and the high-quality care provided across the United Kingdon (UK). The story demonstrated the impact, captured the individual patient experience and the learning as an organisation.
- In relation to the staff experience story, it demonstrated the positive feedback received with regards to one staff member and how they uplifted their patients to make them feel happier. The housekeeper's interaction with patients was powerful, with genuine compassion and kindness.

  The Chair reminded Board members as to the importance of visibility and talking to staff members during their visits. He recommended that further consideration be given to the sharing of both positive and less positive stories with the Trust Board.

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

ii) Board Visibility Programme

The DQS highlighted the following points:

- The report detailed the two different streams of visits carried out to wards and departments. It was noted that many other visits took place in the background as part of daily operations.
- Both areas that were doing well and areas of concern were included within the report.
- The Corporate Governance Team and Quality and Safety team worked together to coordinate the leadership walkabout programme (Executive Team members and Senior Staff members) and Non-Executive Directors (NED) visits.
- The TS and Mr Gavin Snelson, Interim Head of Quality Assurance and Clinical Effectiveness had worked together to improve the process to act on feedback as certain wards and departments felt they were not receiving a visit or were visited more than once in a short period of time.
- A SharePoint document had been created to record visit information and outcomes.

- The detailed feedback was included in the AdminControl Board of Directors Reading Room.
- Feedback identified that staff felt comfortable to raise concerns but further improvement was needed to communicate where concerns had been listened to and progressed.
- Significant positive feedback had been received on the Accrediting Excellence (ACE) programme.
- Concerns were raised in relation to nurse staffing resource on nights. Feedback was shared with the relevant staff members and any actions progressed.
- Positive feedback has been received on the recent visits with regards to the InPhase system. This had changed significantly from March/April whereby there was a lack of awareness of the InPhase system during visits at that time.

Mr Weatherburn highlighted that the NED walkabouts were informative and that the Executive Team members responded timely. It was positive that staff felt comfortable talking to Board members and seeing a response to actions raised. All agreed that rapid live feedback was important.

Mr McCardle highlighted the importance of the NEDs seeking assurance that issues raised were acted upon and in ensuring that all areas were covered in the programme, with actions followed up consistently.

The ED noted that it was helpful to see the feedback themes and noted the value of the NED walkabouts. He had tested an action from a visit which wasn't as embedded as expected and therefore was following up accordingly.

The ACEO explained that there was a need for the Executive Team members to consider how to work with local line managers to resolve issues timelier, to communicate the actions taken and keep staff engaged.

Dr Adetuberu advised that she had witnessed a difference between day and night visits, that some staff in wards were more open to talk than others and some wards were visited more frequently than others. She highlighted the positive progress in moving to using SharePoint. Dr Adetuberu queried if the non-clinical areas were receiving visits/walkabouts. The DQS advised that the refreshed process/use of SharePoint for coordinating the visits would highlight any gaps and further work could be undertaken to ensure each area had been visited. The DQS agreed to include non-clinical environments/areas in the walkabouts programme and an update to be provided in the next report **[ACTION02]**.

The Chair advised that if he heard of an issue, he often then visited the area where the issue was referenced.

Mr Weatherburn advised that staff were understanding of the current estate challenges and were comfortable with the speed of response to actions raised from visits.

The Chair thanked all involved with the visibility programme and noted the good quality of the visit reports. On balance responsiveness was good however further work was needed to

ensure actions were followed up and fully embedded. He noted the importance of keeping a record of the communication and adopting the 'you said we did' approach, which was a crucial part of the overall quality assurance process.

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

iii) Care Quality Commission (CQC) update

The EDN highlighted the following points:

- In relation to the phase two action plan, the transactional elements of the action plan were complete, with further work needed to embed systems and processes.
- Of the 49 actions, 29 actions were now complete; however 5 were behind plan which were planned to be resolved by June 2025. Three of the 5 actions were complete but had not been through the governance process in terms of check and challenge to ensure completion.
- Service improvement plans had been refreshed, with testing of embeddedness underway.
- The Quality Committee received an update on the action plans monthly at each meeting.
- The Trust was working with The Value Circle (TVC) who were undertaking an independent review of progress with embedding improvement actions in the Cardiothoracic Clinical Board. The review took place in March 2025 and the final report was received on 2 May 2025. The report highlighted some areas to improve and that the Clinical Board required continued support and oversight, however there was also signs of positive progress/improvement referenced in the report. An action plan would be developed.

  The Cardiac Oversight Group discuss progress against the action plans and the improvement plan, with updates provided to the Quality Committee.
- Oversight remained in place with NHS England (NHSE), the Care Quality Commission (CQC) and the Integrated Care Board (ICB) through the Integrated Quality Improvement Group (IQIG) meetings.
- De-escalation of some services from oversight had taken place (medicines management and maternity) through the IQIG; however it was noted that there was still oversight of some remaining services. Work was taking place with colleagues to review the de-escalation criteria and this would be discussed at the June IQIG meeting.
- Work continued on the well led domain and to support Clinical Board leaders, with an external Well Led review planned to identify any areas for development and improvement.

The Chair highlighted the evidence of positive improvement and that as the Trust was now considered lower risk the CQC were prioritising other organisations for re-inspection before Newcastle Hospitals. Whilst there was an expectation that the Trust would receive an inspection visit within the next 12 months, in the interim, an external Well Led review would take place. The ACEO noted that being lower risk was a positive step. He advised that the

ICB and NHSE had agreed to use the external well led review as a proxy for consideration of de-escalation from IQIG. A robust CQC action plan remained in place.

Mrs Stabler advised that the Quality Committee had agreed to de-escalate some of the services from their direct review as tier 2 groups were now meeting and reporting into Quality Committee, with feedback through the management reports.

Mr McCardle acknowledged the positive process and noted that to fully embed some actions would take longer than others such as the shift in culture would be a long-term change. The EDN agreed and advised that the CQC action plan would transition into a longer term improvement plan.

The Chair highlighted the importance of moving to business as usual and to focus on seeking assurance that changes were having a long-term impact. The Board of Directors noted the positive direction of travel.

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

iv) Winter Plan Review

The IDO advised that the Trust were currently in the Winter planning phase and several areas that worked well last Winter had now been embedded as business as usual. Work was taking place with system partners to ensure actions were not progressed elsewhere that would have a negative impact on the Trust.

The DID highlighted the following points:

- The report detailed additional capacity needed to address the winter pressures and holiday period.
- Work had been taking place throughout the year on frailty with regards to the impact of the Same Day Emergency Care (SDEC) unit.
- Utilisation of the discharge lounges at the Royal Victoria Infirmary (RVI) and Freeman Hospital (FH) to free beds earlier where safe and appropriate to do so.
- Additional transport was sourced to support with discharge and transfers including during the night.
- Key performance indicators such as accident and emergency (A&E) and ambulance handovers demonstrated overall a better winter performance than the previous winter. Taking diverts from other organisations was noted to be an area of pressure for teams.
- The Elective programme was maintained however there were challenges in the Intensive Treatment Unit (ITU).
- A lesson learned was to better plan elective activity between adults and children.
- The draft winter plan would be discussed at the Private Board of Directors in June 2025.

Mrs Bromley queried if there was an impact on planning and capacity if staff were not available due to sickness or planned absences for example in the Paediatric Intensive Care Unit (PICU), a high number of midwives were expecting babies of their own. The DID noted

that work took place to understand how many staff members needed to be released and highlighted the importance of absence planning with the teams at an early stage. Absence planning was part of the overall planning approach which also included productivity considerations and ensuring programmes were delivering as expected.

Mr Kajee queried the governance of the plan and in testing its robustness. The DID explained that the planning team included representatives from various departments and Clinical Boards. The Urgent and Emergency Care Group was an established improvement group and actions cards were up to date, with the plan to be signed off through the F&PC and Trust Board.

Mr MacLeod sought clarification with regards to the recent decrease in staff vaccinations and if this was considered as part of the planning work. The EDN advised that the Vaccination Steering Group had already started to meet and that there were some key learning points from previous years which would be shared in due course.

Ms Balmain noted the positive steps in relation to frailty and the discharge lounges which would help to discharge more people directly from the wards. The DID agreed that it was a positive step however there were a variety of reasons for delayed discharges including data availability, patients/carers not being ready, medicines management and patients waiting for medicine.

Mrs Stabler sought clarification with regards to how the plan and learning from previous years was being cascaded across the organisation. The DID explained that opportunities that have previously worked well were being used such as having Clinical Board representation at the meetings, this allows them to cascade the information to all staff in their Clinical Boards.

The plan was noted to be in the early stages of development, with communications a critical part. A workstream on communications had been established.

Mr Kane queried if any concerns had been raised by relatives that patients had been discharged early and whether readmission rates had increased. He referred to staff shortages and queried if staff were offered Respiratory Syncytial Virus (RSV) vaccinations to which the EDN advised that he would follow this up at the Vaccination Steering Group **[ACTION03]**. The DIPC noted that the RSV vaccination criteria was very strict however it was being rolled out within maternity services. The DID advised that main area of feedback from relatives/patients tended to be regarding social care delays.

Dr Adetuberu queried the evaluation of the winter plan and the link to the patient experience programme. The DID explained that the real time patient experience process information had been obtained and would be built into the Winter Plan.

The ACEO explained that further development was needed to improve on specific areas e.g. ambulance handovers and patients waiting over 12 hours. Engagement with staff was a key part of the plan, particularly in understanding roles and for staff to take leadership in their own areas. There were also opportunities for innovation.

The Chair highlighted that the Trust performed well last winter however corridor care needed to reduce. Further discussion would take place on the Plan in June 2025 which would include the points raised during this meeting, such as vaccinations and patient flow.

The Chair highlighted the importance of staff communications and innovation. Data received on the Australian flu season would be useful to gauge the pressure points.

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

v) Integrated Board Report (IBR)

The DPG highlighted the following points:

- In relation to infection, prevention and control metrics, improvement was noted to be required. This was being closely monitored through the Quality Committee with a deep dive taking place at the July Committee meeting.
- Four out of seven of the quality metrics were improving and the March 2025 data continued to improve.
- The Trust had achieved the cancer 28-day faster diagnosis standard (FDS).
- 62 Day compliance for February was 61.0%, consistent with a continuation of improving special cause variation. The number of patients waiting over 62 days was circa 100 which was an improved position from previous years.
- With regards to people, mandatory training continued to slightly improve however there was further work to be conducted in relation to appraisals. A new appraisal process had been implemented with new documentation which started in April 2025 which was more user friendly.

The DCFO highlighted the following points:

- There was a reliance on non-recurrent measures to bridge the recurrent CIP gap of £30.8 million in the Plan.
- The Trust did not achieve the CIP recurrently for 2024/25 and this would affect the financial position this year.
- The Trust submitted a breakeven plan which included a £106m CIP to the ICB.
- At month 1 the Trust was currently on plan as a result of bringing forward some non-recurrent measures.

The ACEO highlighted the importance of staff in all areas within the Trust identifying opportunities and supporting colleagues with CIP delivery. There was a need to identify recurrent CIP and to target any specific areas of concern and risk regarding non-delivery. The ACEO explained that in relation to the new Performance Assessment Framework and the capital plan, organisations who were in the highest performance segments would have greater capital flexibilities and access to capital. He noted that the plan delivery must be balanced with performance and quality considerations, to support care delivery.

The EDN explained that the Board of Directors had been briefed previously on a Carbapenemase-producing Enterobacterales (CPE) outbreak which remained an area of concern and investigations were ongoing to manage the outbreak and provide learning.

Estates colleagues were involved regarding screening, and the Quality Committee would receive an update once available.

The DIPC advised that work was taking place with regards to identifying infection risks regarding the estate and infrastructure, which would be detailed in future reports.

Mrs Stabler highlighted the continued non-achievement of the internal appraisal target to which the DCDI advised that this was actively discussed at the People Committee in relation to the different ways of carrying out appraisals and that the new documentation to help reduce the burden. The aim was to demonstrate to staff the value in having appraisal conversations.

Mr Weatherburn referred to examples from the private sector regarding the use of Apps and software to support appraisal compliance.

Mr Kane said that it would be useful to review the relevance of content included in the Trust statutory and mandatory training programme for staff. The DCDI explained that this was currently taking place and updates would be provided once available.

Dr Adetuberu highlighted the sickness rates for nursing staff and queried the role of the Clinical Boards and the HR department in reducing rates. She emphasised the importance of having clear roles and responsibilities. Mr McCardle explained that was a challenge regularly discussed at the People Committee which received regular deep dives into specific areas.

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

25/13 ITEMS TO RECEIVE

i) Director reports:

a. Joint Medical Directors (JMD) Report

The JMD-W highlighted the following points:

- With regards to Emergency Department performance, the Trust was not in the desired position however performance was improving.
- Cancer performance remained a key focus and improvements were being seen in most of the targets including the 28 Day Faster Diagnosis Standard (FDS) and 62 day time to treatment target. Significant improvement had been seen in the waiting list for the urgent suspected cancer pathway and currently beyond day 62.
- There had been several changes in the breast pathway at County Durham and Darlington NHS Foundation Trust (CDDFT) over the last 3 months due to service provision difficulties with Newcastle Hospitals having provided support.
- Lung cancer service provision was being reshaped with additional capacity through the lung health check programme.
- A great deal of work had taken place by Dr Gail Jones, Associate Medical Director, with regards to conducting harm reviews, particularly for patients who had waited over 104

days for cancer treatment. The CQC had highlighted this work as an area of good practice to another organisation.

- Martha's Rule/Call for Concern was becoming established on adult wards and was due to be piloted on children's wards from 1 July 2025.
- The launch of InPhase, to replace the Datix system, ran smoothly and would provide a number of benefits.
- The Trust was part way through the new job planning process for Medical and Dental staff. A review of the submitted 540 job plans had been undertaken out of circa 1,200 job plans. The information allowed the team to better understand the costs and benefits of the implementation of the new Job Planning Policy. Recent discussions had taken place with the ACEO, JMD-PC and the LNC. The full position would be known by the end of June 2025.
- The Trust, led by the Digital team, was able to successfully complete the transfer of the EPR system to a remote hosted organisation. Thanks was given to all staff members involved.

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

i). <u>Guardian of Safe Working (GoSW) Report</u>

The JMD-W advised that regulations with regards to exception reporting were changing in the autumn which would make a significant difference to the number of exception reports. The shift in exception reporting would be seen over quarter 3 and further discussions would take place as this developed.

Mr Kajee sought clarification with regards to the recommendation in the report on continuing to review the workforce and queried whether the Trust was considered to be safe in terms of working hours. The JMD-W explained the role of the Guardian in ensuring that working conditions were safe and to highlight exception reporting. The JMD-W agreed to ask the GOSW to highlight further information in terms of assurance as to safety in future reports **[ACTION04]**.

The ACEO referred to the increases in resident doctor posts and that it would be useful to include content with regards to the changes that had been made, how this aligned to outcomes within the report and to whether this had a positive or negative impact in those areas from an exception reporting perspective. The JMD-W agreed to follow up **[ACTION05]**. The GOSW reports were noted to be presented to the Quality Committee regularly.

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

b. <u>Executive Director of Nursing update:</u>

i) <u>Nurse Staffing Deep Dive</u>

The EDN highlighted the following points:

- The Nurse Staffing Deep Dive report was presented at the most recent Quality Committee meeting and provided assurance in line with national guidance.

- The areas that were not aligned to best practice were well known and actions were in place. Additional resource requirements remained under review and staff were moved between departments as appropriate to maintain safety.

The Chair queried if there had been a reduction in agency/locum staff costs to which the EDN advised that there had been however acknowledged that additional work was still required. Establishments were broadly fit for purpose and Mrs Stabler highlighted that budgets allocated for staffing appeared appropriate.

Mrs Bromley sought clarification with regards to temporary staff, which were noted to be staff bank. Mrs Bromley queried if a reduction had been seen in relation to agency spend. The EDN explained that there had been a reduction in Health Care Assistant spend and that the information was included within the IBR. There had been a positive change with regards to grip and control and the movement of staff between departments.

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

ii) Allied Healthcare Professionals (AHP) staffing

The EDN highlighted the following points:

- A more detailed report was discussed at the most recent Quality Committee meeting.
- The aspiration was to have equal focus and attention for AHP staffing as to nurse staffing.
- There was a recognition that the AHP governance and reporting structure had not been as robust.
- The AHP safe staffing framework would focus on four key areas:
  - Job planning;
  - E-job planning;
  - Annual staffing review; and
  - Operational guidance.

Mrs Stabler highlighted that this was an area of best practice as other organisations were yet to conduct this work.

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:

- The Trust had 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 was now considered to be a safety alarm and instigated further review. This had impacted on other organisations rates.

- The North East and North Cumbria (NENC) ICB/LMNS had not commissioned the Maternity and Neonatal Voices Partnership (MNVP) in accordance with the national guidance and the Trust was therefore not compliant with the requirements of Safety Action 7.
- The perinatal quality metrics would be reported in the IBR.
- A plan was needed with regards to Maternal Mental Health services and the ICB were yet to commission these services for Newcastle and Gateshead.

Mrs Stabler advised that there would be a financial implication of not achieving safety action 7 if it had not been escalated to the Board of Directors. In relation to commissioning for Maternal Mental Health provision, this was a disadvantage for women and the Quality Committee raised this with the ICB representative at the last meeting. An update would be provided at the next Quality Committee meeting.

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

ii) <u>Maternity Safety Champion Report</u>

Mrs Bromley highlighted the following points:

- She had gained a good understanding of the leadership arrangements and the data within Maternity Services.
- The positive culture shift and engagement of the management and leadership teams.
- A presentation was provided at the Council of Governors on 21 May 2025 which included patient experience, outcomes and work within the department.
- The ward 34 staff story discussed previously was an amazing example of staff comforting new mothers and families.
- The ongoing Estate challenges however the Estates department visibility had been valuable and there was now a timeline in place.
- The Infection Prevention Control (IPC) concerns were alleviating.

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

d. <u>Quality Account update</u>

The Chair acknowledged the work undertaken in producing the Quality Account and noted that there had been significant consultation.

The DQS advised that the final Quality Account would be approved at the Quality Committee as the Trust was still in the 30-day consultation period until next week. Feedback had been sought from stakeholders, the Overview and Scrutiny Committee and the ICB. The DQS acknowledged the honest culture and the improvements that had been seen.

Mrs Stabler asked for the Board of Directors to delegate the final sign off to the Quality Committee to which the Board of Directors agreed.

It was **resolved**: to **receive** the report and **approve** the delegation of final sign off of the Quality Account to the Quality Committee.

ii) Committee Chair Meeting Logs

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

Mrs Stabler explained that a discussion took place at the most recent Quality Committee with regards to the provision of integrated care beds due to a loss of 45 beds. She noted that the ACEO would be discussing through the Newcastle Place meetings as there were concerns for next winter. The ACEO referred to the building work to commence next week, he noted the commitment to develop an integrated care strategy and the internal mitigations in place with additional beds opened at the Freeman Hospital. He highlighted the importance of the out of hospital strategy.

Mr Weatherburn explained that the Audit, Risk and Assurance Committee was moving to bi-monthly meetings which would release time back to the Clinical Boards and Executive Team colleagues to focus on other aspects of work.

Mrs Bromley advised that Mr Kajee has commenced as the Digital and Data Committee Chair and that a handover meeting had taken place, attended by the Chief Digital Officer (CDO).

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

25/14 ITEMS TO APPROVE:

i) Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report

VMR highlighted the following points:

- The reports were not action plans as such and therefore further work was underway to develop such plans.
- With regards to WDES, nine out of 10 indicators had improved however the improvements were not significant when compared year on year.
- In relation to WRES, six out of nine indictors had improved however indicators two and three were of concern. The Board of Directors were sighted on this.

Mr McCardle advised that a detailed discussion took place at the most recent People Committee and that there would be targeted actions with clear expectations.

The Chair highlighted that a great deal of work was taking place to develop the EDI strategy and the DCCA added that conversations were taking place with key stakeholders and a further Board Development session update was scheduled. An antiracism policy was under development and there was a need for a real step change in addressing the challenges.

Dr Adetuberu advised that the indicator performance had not changed much over the years for Newcastle Hospitals. She commended the EDI workshop and Board Development session

held previously which provided opportunities to explore key principles, priorities and action plans however queried timescales. The DCCA explained that timescales were being worked through and that the EDI Steering Group was taking place next week to discuss finalising the action plan which would be aligned to the People Plan Year 2 objectives.

Mr Kajee noted that the figures were alarming and hurtful as a member of the Board of Directors. He highlighted the importance of continuing to work on EDI as a priority, which would in turn have a positive impact on patient outcomes. The Chair agreed and noted the importance of a reformed action plan.

It was **resolved**: to **receive** the report and **approve** the WRES report and WDES report for publication.

ii) Governance documents:

a. Board Committee Annual Reports

The TS advised that all Board Committee Annual Reports had been reviewed approved through the relevant Committee meetings.

It was **resolved**: to **receive** the report and **approve** the Board Committee Annual Reports.

b. Charity Committee Annual Report including Schedule of Business

Mr Kane advised that the Charity Committee Terms of Reference were not enclosed due to ongoing discussions and would be ratified at the next Trust Board meeting.

The Chair noted that all Committees were running effectively and thanked the Corporate Governance Team.

It was **resolved**: to **receive** the report and **approve** the Charity Committee Annual Report and Schedule of Business.

25/15 ANY OTHER BUSINESS:

i) Meeting Action Log

The action log was received and the content noted. The completed actions were agreed and Board members agreed action 132 could be closed.

ii) Any other business

There was no any other business discussed and the meeting closed at 12.20pm.

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

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Agenda Item A3

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 2025					
Title	Chair's Report					
Report of	Sir Paul Ennals, Chair					
Prepared by	Sir Paul Ennals, Chair Gillian Elsender PA and Corporate Governance Officer 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 Trust Board meeting held in Public in May 2025: • Board Activity • Governor Activity • Informal Visits • Alliance • External Meetings					
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

In May the recruitment process concluded for a shared Chair for Newcastle Hospitals, Gateshead Health NHS Foundation Trust ('Gateshead Health') and Northumbria Healthcare NHS Foundation Trust. I was delighted to be appointed into the role and would like to thank everyone who was involved in the recruitment exercise and who supported me during the process.

Within Newcastle Hospitals we have recently begun a Governor-led process to appoint a permanent Vice Chair with interviews scheduled in early August 2025.

Over the last few weeks, I have commenced a period of induction at Gateshead Health meeting with Executive and Non-Executive colleagues and the Lead and Deputy Lead Governors, as well as observing some Committee meetings ahead of commencing substantively in the role in October 2025.

BOARD ACTIVITY

Our Board Development session in June focussed on our Equality, Diversity and Inclusion (EDI) plan and strategy which is aligned to Year 2 of our People Plan and will focus on challenging and addressing inappropriate behaviours, improving how valued and heard staff feel as well as improving how we lead and manage.

We looked at our strategies and discussed how different strategies fit together and how we support this through our approach to quality improvement, focussing on 3 priorities as we address our Big Signals. This will be done by:

- Focussing on the fundamentals of delivering high quality, safe and compassionate patient care, improving performance and managing our money.
- Making it better for colleagues by improving IT kit, digital systems and correspondence with patients, supporting colleagues through our People Plan with better psychology support and greater equality, diversity and inclusion, and improving the estate for colleagues and patients.
- Looking to the future by working with partners to create Neighbourhood teams, focussing on the Great North Children's Hospital as the regional specialist centre providing world class paediatric care, and developing our Clinical and Trust strategy, as a member of Great North Healthcare Alliance.

The remainder of the session focussed on our work with the Board's Care Quality Commission (CQC) preparedness, discussing any remaining gaps and/or areas of weakness and what immediate actions should be taken as a unitary Board.

The annual round of appraisals of Non-Executive Directors (NEDs) has now been completed for 2024/2025. Meetings were arranged on a one-to-one basis for an in-depth exchange of information and views on progress made during another challenging year. In all cases performance against the corporate and personal objectives for each NED were discussed. In addition, NEDs were asked to self-assess themselves using the self-assessment form within

the new NHS Leadership Competency Framework, and 360-degree feedback was obtained for each NED.

I am delighted to advise that all NEDs have met, or exceeded, their objectives.

In June I completed the Annual Fit and Proper Persons return and this was submitted to the NHS England Regional Director ahead of the 30 June 2025 deadline. Testing was conducted in accordance with the NHS England Fit and Proper Person Framework and the outcomes of the testing enabled me to submit a return which provided full assurance that all Board members were 'fit and proper'. Board member references were completed for all leavers as appropriate and a detailed report has been produced for consideration at the Audit, Risk and Assurance Committee meeting on 22 July 2025.

ACTIVITY WITH GOVERNORS

Our Governor elections also took place in May and sadly we said goodbye to some of our long-standing Governors who were unsuccessful in being re-elected. We are very grateful for their valuable contributions and dedication to the Trust. I would also like to congratulate those Governors who were successfully re-elected and to welcome all of our new governors who I had the opportunity of meeting at our Governor Induction in June.

At our Council of Governors meeting in June, in addition to our standard reports we welcomed Dr Kate Reilly, Clinical Psychologist, and Sally Mundill, Assistant Psychologist, who delivered a short presentation on the HIV Confident 2024 Staff Survey Results. I am delighted to advise that Newcastle Hospitals has pioneered HIV Confident work by being the first pilot site to take part in this scheme outside London which aims to reduce HIV stigma through increasing staff knowledge about HIV, improving employee attitudes towards people living with HIV and providing people living with HIV a way to report any stigma or discrimination they experience.

We also heard from Teri Baylis, Charity Director, who provided a very informative presentation on the Newcastle Hospitals Charity detailing their duties and strategy milestones. The Charity's current and future priorities were outlined, being an enabler to improving the health and wellbeing of the patients, people and wider communities of Newcastle Hospitals, providing support for compassionate and innovative healthcare, education and research, locally and nationally.

In addition to our formal Council of Governors meeting, I also met informally with some of our Governors at our regular drop-in session, which provides an opportunity for them to seek updates on any specific areas of interest or queries. The topics we discussed included utilisation of our Day Treatment Centre and the impact of the Community Diagnostic Centre.

INFORMAL VISITS

I have continued with my informal visits across all parts of the organisation to meet with staff. Of late I visited the Emergency Department at the Royal Victoria Infirmary, where I met with Marcus Weatherly, our new Director of Operations and members of his team who have

been instrumental in the significant improvements within the department to help enrich patient experience. It was encouraging to see the progress in building the new Urgent Treatment Centre on the site – which provides us with the opportunity to review the way in which we manage the flow of patients in and out of the Emergency Department.

ALLIANCE

The momentum for joint working continues at pace, and each month we can see more evidence of positive outcomes from the collaborative work that we have initiated. Our most recent meeting earlier in July focussed on the medium-term financial plan and updates on workforce, primary care and place-based working.

I also spoke at an Alliance Market Event on 11 July which focused on estates and facilities work and, specifically, developing a coordinated approach to construction. Paul Hanson, Director of Estates, Facilities and Strategic Partnerships had organised a highly successful event on behalf of the Alliance, where we set out our plans for what we are currently calling the "Strategic Build" programme, to redevelop our estate over the next fifteen years. Working together we can develop a truly ambitious plan – currently costed at a cool £3 billion - and we had 150 representatives from the building trade and from partners in local government to share thoughts on how we might work together.

OTHER MEETINGS

Monthly I meet with the Chair, CEO and senior officers of the Integrated Care Board (ICB), along with other Foundation Trust Chairs, to discuss issues of common interest. Latterly, focus was on the impact of the recently published 10-year health plan for England, aiming to fundamentally transform the NHS. The plan focuses on three key shifts: moving care from hospitals to communities, embracing digital technology, and prioritising prevention over treatment. This ambitious plan seeks to address challenges such as an aging population, evolving healthcare needs, and rising costs. We are in the process of reviewing the content of the plan as part of our work in developing a longer term strategy for the Trust.

RECOMMENDATION

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

Report of Sir Paul Ennals
Shared Chair
15 July 2025

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Agenda item A5

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 2025					
Title	Patient and Staff Stories					
Report of	Annie Laverty – Chief Experience Officer					
Prepared by	Marilyn Hodges – Associate Director Service Improvement and Alice Millican – Senior Communication Officer					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	**Patient experience story:** Our patient story is from Lexi, a 14-year-old girl being cared for on ward 3 at the Great North Children's Hospital (GNCH). Ward 3 provides highly specialist care and treatment for babies, children, and young people who require Haemopoietic stem cell transplants (bone marrow transplants). Lexi has significant expertise to share relating to her experience of care at the GNCH as she has had extensive stays and treatment on several wards. Lexi received her initial transplant in May 2024. Unusually, she required an additional top-up in 2025. During her first transplant, she wrote "Lexi's letter," a powerful plea to Health care professionals on how to provide compassionate, person-centered care. We are currently working with Lexi and her family to explore how we might creatively share this advice with colleagues across the Trust and NHS. **Staff experience story:** Our staff story provides insights into Ward 8 at the Freeman Hospital, a ward specialising in vascular surgery. Most admissions are emergency ones, with the majority being diabetes related. Since COVID, Ward 8 has increased staffing to account for the increased prevalence of patients requiring care with a 50% uplift in consultants specialising in vascular conditions. Angela Adams, Senior Sister, detailed the increased patient acuity since COVID, and observed that she's now seeing the highest level of amputations in her 21 years of working in Newcastle Hospitals. Emma Wenn, Matron shares her views on the benefit of the real time patient experience programme for patients and colleagues, and why she's excited to see it rolled out onto all wards in the Surgical and Associated Services Clinical Board.					
Recommendation	The Board is asked to receive both stories and accompanying letter, for information, and to note our commitment to learning from all experiences of receiving and providing care.					
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.					
	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐

Agenda item A5

Link to Board Assurance Framework [BAF]	Linked to key areas in the BAF relating to the quality and safety of care and workforce.
Reports previously considered by	Patient and People stories are a recurrent feature of all Public Board meetings.

PATIENT STORY:

Picture 1: Lexi in June 2023, after chemo and transplant.

Context: Lexi is a 14-year girl being cared for on ward 3 at the Great North Children's Hospital (GNCH). Ward 3 provides highly specialist care and treatment for children who require Haemopoietic stem cell transplants (bone marrow transplants) – one of only two units in the country.

Babies, children, and young people on the ward need to be in maximum (red) isolation when they receive conditioning treatment (chemotherapy and monoclonal therapy) before donor stem cells can be infused. During this time, they are exceptionally vulnerable to infection and can become extremely unwell. Once the new donor cells start to work sufficiently, the level of isolation reduces to medium (purple).

Generally, patients are in red isolation for at least 3 weeks (up to 5 weeks) and then purple isolation for another 3- 12 weeks. In total, children can be on ward 3 for anything from 6 weeks up to 4 months.

Lexi received her initial transplant in May 2024. Unusually, she required an additional top-up in 2025.

Lexi has significant expertise to share relating to her experience of the GNCH. She has had 13 nasogastric tubes passed (they come out when she was sick after chemo). She has been down to theatre for a procedure under general anaesthetic six times. Lexi has had three long stays in Ward 3 and one short stay. She has used five of the ten rooms in Ward 3. She has also been in Ward 1a and Ward 10 for overnight stays, and in Ward 4 and 8 for day admissions.

Lexi's story: My 13th birthday was the day after my central line was inserted and one of my ovaries removed. My 14th birthday around the time of the top-up of donated stem cells earlier this year. I had day release – we went to Durham to family for a barbecue. I had the special edition of the Colin the caterpillar cake – the Highland cow one. It took my mind off it all for a bit.

We celebrate my transplant birthday too – there is a banner on my hospital wall: "Happy 1st transplant birthday!". For that one, I got a necklace with my transplant birthday birthstone – and a double helix, to symbolize DNA. My dad says it will cost them a fortune if we celebrate all of them with gifts! Many of my birthdays have been spent in a hospital setting.

In room 4 – just across from here - that is where I was before I had my first stem cell transplant in May 2024. I was in red isolation, a time I had to be extremely careful about infection. I had chemotherapy to prepare my body for the transplant. One day, a doctor told me I had to leave my room for a scan. My mom was out of the room at that moment. I knew I could not, I told him – it is not safe! He ignored me. I burst out in tears. More things like that happen – not being listened to, not being included… that's why I wrote the letter. I will tell you more about that later.

I have different wall sections in the hospital room I am in now. I have my movie wall – I am really into Stranger Things! And I love animals, hence that wall covered with animal cards. I am getting cards from all over the world – my parents asked for people to choose and send animal cards. On the side, that is my Art wall – I made the big letters spelling L.E.X.I. Today's school lesson is Art. When I am well, I have an hours' school from the hospital school team. They are great and it means I don't get left behind. I am getting down to business now – in Science I am doing GCSE work and will start the rest in September. An hour of brain work means my brain is not thinking about all the other stuff – the hard stuff.

There are so many amazing people. The play specialists every day, the school team and my youth worker, Hannah Potter. Yesterday, Hannah and I baked triple choc chip cookies. We used the hospital school classroom. I can now start to go out of this room for a little bit. I like cooking - more savoury stuff. We brought the cookies for the staff. They loved it. I don't think they left any for Zoe! [Zoe is Ward 3's ward manager].

There is a lot of hard stuff. Sometimes I just shut down… when there is a lot of new information and they expect you to know something that you don't. They don't always understand why I am not okay with it. That is when I need my parents to step in. One of them is always here – one during the week, one on the weekend. One with me, and one with my sister back home. I really want to go home – it is hard being here again...

I want healthcare professionals to talk directly to me, to see me… I might not know all the big medical words, but I know me. There are things that make a difference. Being friendly, using words I can understand and being gentle – especially about the tough news. There has been a lot of tough news… We now have worked out a better process. They talk to my parents first in a quiet room. They then work with the team to find the best way to talk to me about it. It depends on what it is.

That is why I wanted to write the letter – in my words. To tell people what help, what makes a difference… and what makes it even harder. My mom helped me to write it down. Hospitals are loud and scary. You get to go home and have a break from it. I am surrounded by it all the time, through every day and every night shift. I have had many experiences in hospital over many years, some of them positive, some scary, some painful.

All these experiences stay with me… they are all me.

Picture 2: Lexi holding a bag of additional stem cells.

Dear Healthcare Professional

When you come and spend time with me in my hospital room, please remember that

- This might be the only time I will have this conversation on this topic, please be aware of that even if it is something you talk about all the time
- You should introduce yourself, even if you have a badge or you have been in before. I see a lot of healthcare professionals and (especially if you are wearing a mask) it can be hard to remember everyone. Tell me what job you do and why you are in my room
- I am in the room, don't talk about me to others in the room without including me
- I can only have one conversation at once, especially if it is complex information or instructions you are trying to tell me
- Things which are normal for you might be strange or scary for me, I might never have heard of them before or have only have half-knowledge about things you are talking to me about
- I might need time to digest information and come back to you with questions before making a decision
- You can ask me to explain back to you what I think is happening to me or is about to happen. Then you will know if I understand
- You know more about the medical side of things than I do, but I am the expert on me and my story
- For me, my time in hospital is a single experience which affects all of me - medically, socially and psychologically- please try to consider all three of these aspects not just one at a time
- I might seem ok, even be laughing and smiling, but I might not be ok
- I am a person with interests, passions, likes and dislikes, just as you are. You can ask me about them. You can also look at what is around me or what I am wearing for clues and ask me about what you see. It might help me if you share something about yourself.
- I have had many experiences in hospital over many years, some of them positive, some scary, some painful. All these experiences are with me as we are talking now
- You can ask me how I like to communicate, how I like to be told information, what I like to be called and how I want to be told difficult news if there is any
- I might feel self-conscious about my body, especially if it has changed through treatment or I need personal care from you. I might feel embarrassed over not being able to look after myself, or about loss of personal dignity
- Hospitals are loud, scary, bright, stuffy, clinical and strange places. You get to go home and have a break from it. I'm surrounded by it all the time, through every day and night shift.
- It's ok to have a laugh and a joke, try to take your cue from me whether it's time for fun or time to be serious
- When you leave the room, please tell me what you are going to do, and what I should expect to happen next, and when. I must stay, I don't know what's happening outside my room/ bed space. Whilst you are busy, I am often waiting for information or for the next stage in my treatment.
- I can feel stuck in a system I don't understand as well as you do. Please keep me informed even if nothing specific is happening yet, and explain to me the steps along the way

Thank you for all your expertise, your care and your commitment to the wellbeing of your patients, even when I'm grumpy.

Lexi

Dear Healthcare Professional

Thank you for all your care and expertise, I am so grateful for all that you are doing to help my child. Here's what it is like for me to be the parent living with a child in hospital:

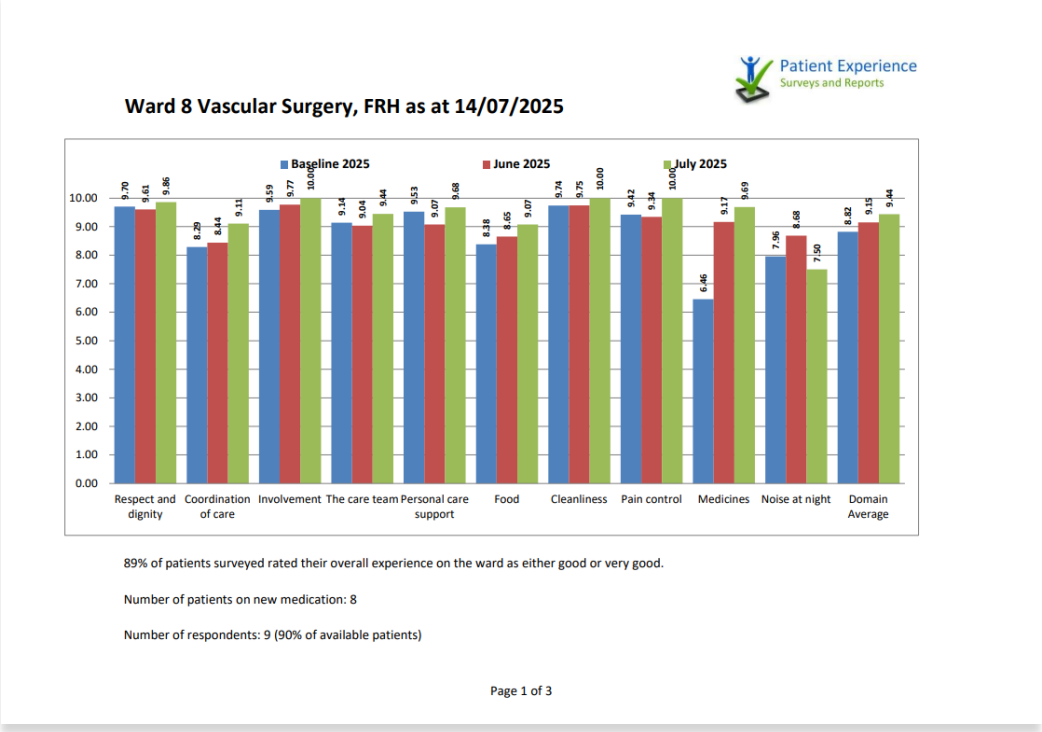
When no one else is in the room I might need to be my child's carer, teacher, play specialist, nurse, healthcare assistant, clown, counsellor or punchbag.

- I often have to get my child to do something they don't want to do
- I'm my child's personal assistant and their chronicler. I am trying to be their place of safety, their champion and their voice when they need it.
- I want my child to be well, to be able to live their life to the fullest. The idea of anything bad happening to them is awful for me.
- I hold my child's health history in my head
- I have responsibility for making choices for my child. I must live with the impact of those choices.
- I might be scared and upset but I don't want to show it in front of my child.
- I am here because my child is unwell. I have been dealing with their health since they were born.
- I've been in many medical spaces with my child, I've had many conversations with many healthcare professionals, and I've been there for countless medical procedures.
- If my child is in pain or worried, then I will be feeling worried.
- If my child needs a general anaesthetic, I will be strong until they are in theatre and then I will feel emotional until they have recovered.
- I don't understand everything you say, but it's sometimes my job to explain it or reinforce it with my child.
- I have other caring responsibilities beyond this room. I have another child, I have a husband, I have a house, a cat, family, friends and a job. I have houseplants.
- I find it difficult to look after myself properly when I am in hospital with my child.
- This is my child's room. I sleep on a camp bed which gets put away every day. I have no space, no privacy and no time to myself. Everything in this room revolves round my child.
- I might not be getting much sleep. If my child is on a monitor or a machine, then I am sensitive to its every beep.
- I am the point of contact for everyone else who cares about my child, most of whom are concerned and worried.
- If I am outside of this room and away from my child, I feel like I am in the wrong place.
- Whilst you are here doing your day job, I am in the middle of a crisis.
- I have no control over what is happening, and very little agency.

Thank you for all that you do

Liz

STAFF STORY:



Picture 3: Ward 8 Real Time feedback report

Context: Ward 8 at the Freeman Hospital specialises in vascular surgery. Most admissions are emergency ones, with the majority being diabetes related. Since COVID, Ward 8 has increased staffing to account for the increased prevalence of patients requiring care with a 50% uplift in consultants specialising in vascular conditions.

Angela Adams, Senior Sister, detailed the increased patient acuity over the last few years, and observed that she's now seeing the highest level of amputations in her 21 years of working in Newcastle Hospitals.

Emma Wenn, Matron shares her views on the benefit of the real time programme for patients and colleagues, and why she's excited to see it rolled out onto all wards in the Surgical and Associated Services Clinical Board.

Emma and Angela's Story: In the 21 years that I've worked at Newcastle, I have never known us to do the number of amputations that we are doing now. Since COVID, patients are coming in sicker.

We're the only vascular ward in Newcastle Hospitals and we pride ourselves on being a regional unit. Many of our patients have recurring admissions and stay in our care for a long time.

Vascular care is busy and complex; it's a hard place to work. Our patients have complex needs, and many come from some of the most deprived areas of Newcastle. Peoples' home circumstances are a lot more varied than they used to be.

Some struggle with alcohol or drug addictions, and making lifestyle changes vase dib the advice given in hospital is not always taken on board. It's disheartening when people are readmitted requiring leg amputation, which possibly could have been prevented.

We don't ever just get a vascular patient – we know about their relationships, their family, their histories. Some behaviours can be very challenging to manage in the ward environment which impacts on our staff.

We had some results from the National Staff Survey that were whilst expected, not as good as we would like them to be, but I believe a lot of this is due to the complexity of needs on Ward 8.

If Vascular isn't your thing, then it's difficult. We get a lot of bank staff and newly qualified staff who come here and think "Woah, this is a lot." But we've recently implemented additional support to nurture staff coming through, and if we did the Staff Survey again, I feel it would be different.

That is why we were so keen to be part of the Real Time programme - our patients are the people that matter, and staff on Ward 8 are the people that would need that patient feedback more.

At first, I was a bit worried when the Real Time survey started, nervous about what the feedback might be. A lot of things that patients say, would junior staff get offended? Vascular patients sometimes have a particular sense of humour, and you only understand that through experience.

Finding reassurance in the reports that "we are doing a good job" or hearing things directly from patients like "the staff never stop" - that makes it concrete for us, and it shows that we're really trying our hardest.

One of the things that came out of the Real Time report was our medication waiting time. This is something we suspected was an issue because we've got quite a big junior workforce, but having the real time survey gave us tangible feedback. We've made changes and are starting to see scores increase and positive feedback about medication waiting times because we can measure the improvement.

It's important to be open about the results with patients and relatives, even the not-so-great stuff. We want everyone to be aware of issues so that we can act on it. It will be helpful when we also get to see the results of the other wards across the Trust.

Enthusiasm about work is definitely better since bringing in Real Time. I know colleagues will want to see if their name has been mentioned by patients because it would mean that you'd done something good and that gives you a reason to feel so proud.

You can see we're displaying our results; it proves that we're proud of our care.
I know all the challenges that Ward 8 has but seeing that 100% of our patients rated our care as Good or Very Good that was huge for us. The icing on the cake for

our staff.

Having the display visible for all gives patients and families reassurance about their care and, importantly, what we're doing to improve it. If I was walking in as a patient and saw that 100% of people rated the ward as Good or Very Good, I wouldn't be as worried. I'd love to display our feedback at the front of our ward.

A higher percentage of Ward 8 staff probably go home thinking they maybe haven't done all that they should, but because of patients' comments, they can see that they are doing a great job.

Newcastle Hospitals needs this work - it lifts staff morale.

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Agenda item A6

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 2025		
Title	Board Visibility Programme		
Report of	Rachel Carter, Director of Quality & Safety		
Prepared by	Fiona Gladstone, Clinical Effectiveness Advisor		
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. Key themes identified include: • Overall, there was a positive culture and staff feel supported and are comfortable raising concerns. • Staff are enthusiastic about the Accrediting Excellence (ACE) Accreditation process, and it has had a positive impact on morale. • Dealing with difficult patients and reports of incivility between staff were identified. • Lack of awareness of InPhase was reported in several areas. • Outstanding estates work was a cause of frustration in several areas. Issues for escalation include: • Various Estates issues reported, including electrical sockets fault, new environment for Echo Physiology, high temperatures in wards, fire alarm reset and soft door closures. • IT solutions for emergency case list. • Aging equipment in Nectar. • Cases of aggression towards staff, and reports of incivility between staff. A new process for the recording of leadership walkabouts has been piloted within the Surgical & Specialist Services Clinical Board during May and June 2025. It is now being rolled out to the remaining Clinical Boards throughout July, followed by Executive and Non-Executive Directors (NEDs). In response to Trust Board feedback on the last paper, a table of visits over the last 12 months has also been included in the Summary of Findings Report in the Board of Directors Reading Room.		
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 May 2025.					

BOARD VISIBILITY PROGRAMME

1. INTRODUCTION

This report provides an overview of the findings from the 15 walkabouts and visits undertaken during May and June 2025. During this time one scheduled Leadership Walkabouts was cancelled due to an unexpected change in availability at short notice.

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.

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, Clinical 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. Visits are also being coordinated to corporate services areas and 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 15 walkabouts undertaken at the Royal Victoria Infirmary (RVI) and Freeman Hospital (FH), six within stream one and nine 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. A table of visits for the last 12 months is also included in Appendix 1.

Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
Stream One	Ward 15	RVI	Director of Operations, Matron	Not specified
	Burns and Plastics Outpatients	RVI	Associate Director of Operations, Matron	Not specified
	Ward 47	RVI	Associate Director of Operations, Matron	Not specified
	Ward 37	RVI	Associate Director of Operations, Matron	Not specified
	Ward 39	RVI	Associate Director of Operations, Matron	Not specified
	Ophthalmology Outpatients, Eye Emergency Department	RVI	Director of Operations, Matron	Not specified
Stream Two	Cardio Theatres	FH	Non-Executive Director	Operational Service Manager, Consultant, Matron, Sister, Recovery Nurses, Operating Department Practitioner, Nurse Educator
	Ward 21 & 21a, Echo Physiology	FH	Non-Executive Director	Director of Operations, Sister, Physiologists
	Ward 31, 32, 35, 34, 33, 37 & Critical Care Unit (CCU), 23, 24 & 24a, Paediatric Intensive Care Unit	FH	2 x Non-Executive Director	Consultant, Staff Nurses, Nurse Practitioner, Healthcare Assistant, Medical Trainee,

Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
	(PICU), 25, 27,29. Assessment suite.			
	Rheumatology	FH	Non-Executive Director	Operational Service Manager, Sister
	Night Visit to Medical Assessment Suite, Accident & Emergency (A&E), Birth Centre, Maternity Assessment Suite, Delivery, Postnatal, Transitional Care, Neonatal Intensive Care Unit (NICU), 36, 37, 38, 49, 50A, 50, 48, 52, 44, 47, 46, 40, 43, 41, 42. Security Team in A&E.	RVI	Non-Executive Director x 3, Trust Secretary	Nursing Staff, Healthcare Assistants, Midwifery Assistant, Consultant, Security
	Night Visit to Assessment unit, wards 2, 3, 6, 7, 8, 9, 10, 13, 14, 15, 17, 18, 19 and 20, Security, Night Reception	FH	Non-Executive Director x 2	Nursing Assistant, Healthcare Assistant
	Palliative Care	FH	Non-Executive Director	Clinical Director, Nurse Specialist
	Nectar		Non-Executive Director	Matron, Sisters, Medical Staff, Housekeeping, Ambulance Driver
	Theatres and Critical Care	RVI	Non-Executive Director	Head of Nursing, Matron, Clinical Director, Consultant, Sister

Key themes identified include:

- Overall, there was a positive culture and staff feel supported and are comfortable raising concerns
- Staff are enthusiastic about the ACE Accreditation process, and it has had a positive impact on morale.
- Dealing with difficult patients and reports of incivility between staff were identified.
- Lack of awareness of InPhase was reported in several areas.
- Outstanding estates work was a cause of frustration in several areas.

Issues for escalation include:

- Various Estates issues reported, including electrical sockets fault, new environment for Echo Physiology, high temperatures in wards, fire alarm reset, soft door closures.
- IT solutions for emergency case list.
- Aging equipment in Nectar.
- Cases of aggression towards staff, and reports of incivility between staff.

4. SUMMARY OF BOARD VISIBILITY VISITS

During the period of June 2024 to May 2025, a total of 262 leadership visits took place throughout the Trust. A full summary of these can be found in table 1 in the Reading Room summary of findings document.

203 visits were carried out by NEDs, these included visits which took place during evening and night shift hours.

59 visits were made by a Senior Team including Executive Directors, Clinical Board Chairs, Director and Associate Directors of Operations, Senior Nurses and Senior members of the Clinical Governance and Risk Department.

There were seven occasions where an area received two visits within the same month, these are highlighted in the table, along with areas who had not yet received a visit.

5. 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) and that 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 has been piloted within the Surgical & Specialist Services Clinical Board during May and June 2025. Work is now underway to roll this out to all the remaining Clinical Boards throughout July, followed by Executive and Non-Executive Directors.

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.

6. 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

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Agenda item A7

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 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 Care Quality Commission (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 50 actions excluding Section B (Service Improvement Plans) of which 37 are completed and 5 behind plan. • At the most recent Integrated Quality Improvement Group (IQIG) meeting, the de-escalation criteria was revised and it was agreed to reduce the frequency of the meetings to bi-monthly. • The most recent CQC engagement meeting, held on 13 June 2025, provided an update on progress and included a service visit to the Emergency Department (ED) and Royal Victoria Infirmary Cardiology. • An independent well-led review has been commissioned with Grant Thornton and commences throughout July/August with a report expected by the end of September. • A planned CQC inspection was carried out in the Sexual Assault Referral Centre (SARC) on 2 July 2025. The final report is awaited. The Phase 2 Improvement Plan is available in the Board of Directors 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.					
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]	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.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

CQC Update

25 July 2025

Healthcare at its best
with people at our heart

Phase 2 Action Plan - summary

Phase 2 Action Plan Progress	Status				
Theme	Complete	1	2	3	Grand Total
Effective Governance and Well Led	11	1			12
A. Risk Management	3			3	6
C. Incident Reporting and Learning	5	1	1		7
D. Ward to Board	9	1	1	2	14
E. Staff Engagement	3				3
F. Speaking up Safely	3	1			4
G. Learning from External Reviews	2	1	1		4
Grand Total	**37**	**5**	**3**	**5**	**50**
	74%	**10%**	**6%**	**10%**	

- 5 actions currently behind plan of which 2 are overdue for completion
- 9 actions completed since last update to IQIG

Status Level – Progress
1) Fully on plan across all actions
2) Actions defined - most progressing, where delays are occurring interventions are being taken
3) Actions defined - work started but behind plan
4) Actions defined - but largely behind plan
5) Actions not yet fully defined

Integrated Quality Improvement Group

- IQIG met on 2 July 2025 whereby the Trust provided update on:
  - Cardiothoracic Services
  - Freedom To Speak Up (FTSU) benchmarking
  - Clinical documentation and audit one report
  - Learning disability and autism
  - Emergency Department

- IQIG revised de-escalation criteria were discussed and agreed. Three criteria remain in place and will be the focus of future meetings.

- It was agreed to reduce the frequency of meetings to bi-monthly.

CQC Engagement meeting

- CQC engagement meeting undertaken on 13 June 2025. The Trust provided an update on:
  - Phase 2 Action Plan
  - Overview of progress and areas for escalation across the 5 core CQC domains
  - Overview of open CQC/Trust cases
  - Overview of recent external peer reviews

- We welcomed 2 new staff members from the CQC to the meeting and undertook service visits to ED and RVI Cardiology as part of the engagement meeting. Future engagement meetings will include service visits where possible.

- No new areas of escalation from the meeting to bring the Trust Board's attention

Improvement programme

Well-led Review

We have commissioned Grant Thornton (GT) to undertake an independent external well-led review.

This is because:

- We have moved down the CQC risk profile so would not expect a CQC inspection imminently.
- We want to test how far we have come since our CQC report in January 2024 and following the removal of our licence conditions in September 2024.
- We are still under enhanced oversight with NHS England and the Integrated Care Board and one of the exit criteria relates to the outcome of an independent well led review.
- Review to take place throughout July/August, with a report expected by end of September.
- The GT team will have the independence to choose which areas they include in the review.

CQC planned inspection - Sexual Assault Referral Centre (SARC)

- On the 18 June 2025, the CQC contacted the Trust to inform us of a planned inspection of our SARC service on the 2 July 2025.
- Data was requested from the CQC in advance, and this was supplied as requested on the 26 June 2025.
- A pre-inspection discussion was undertaken by the CQC with service leaders and the visit went ahead as planned.
- Currently awaiting the final report. Preliminary feedback stated that there were no regulatory concerns with areas of good practice noted across all the inspection domains.
- 7 areas for improvement/consideration were provided during the high-level feedback. Actions are underway to address these.

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Agenda item A8

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 2025		
Title	Winter Plan 2025/26		
Report of	Sue, Hillyard, Interim Executive Director of Operations		
Prepared by	Nichola Kenny, Director of Improvement and Delivery (Operations)		
Status of Report	Public	Private	Internal
	☒	☒	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☐
Summary	The main purpose of the Trust's winter plan 2025/26 is to ensure optimal quality and safe care provision at a time when services are put under pressure. The Trust's winter plan for 2025/26 mirrors the previous year's winter plan - an additional 27 bed capacity 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. Throughout the year other improvement and service development activity across the Trust will also contribute to achieving a safe winter. These include: • Development of the Frailty Same Day Emergency Care (SDEC) Model • Expansion of the Frailty Virtual Ward • Development of an Ambulance Care Unit in the Northern Centre for Cancer Care (NCCC) • Establishment of the new co-located Urgent Treatment Centre (UTC) at the Royal Victoria Infirmary (RVI) Other improvement work is ongoing that will also contribute to a safe winter and this will continue throughout the remainder of the year. There will be continuous focus on the usual Emergency Department (ED) Key Performance Indicator (KPI) bundle and this will be extended to report on the use of corridor spaces and ambulance delays >45 minutes. The key risks to winter for the Trust arise from the unknown impact of partner plans at this stage in planning for winter. The cost of the winter plan is in line with the allocated budget, however work is underway to review transport requirements. An Equality Impact Assessment has been conducted in accordance with the Trust process.		
Recommendation	Members of the Trust Board are recommended to:		

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- Approve the core plan that is being proposed to mitigate this year's winter pressures and sustain safe services, with a level of ED performance >80% in line with submitted planning trajectories.
- Acknowledge the improvement work that will continue over the course of the next few months and contribute to being 'ready for winter'.
- Note the key risks of the plan and the need for system partners and those in the wider ICB still to come together to ensure there is a robust regional plan in place to mitigate winter that has been tested.

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<tr><td>Links to Strategic Objectives</td><td colspan="6"></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">

- 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.

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<tr><td>Reports previously considered by</td><td colspan="6">The Winter Plan 2024/25 evaluation was shared with the Trust Board in May 2025. The draft Winter Plan for 2025/26 was shared with the Finance and Performance Committee in June 2025.</td></tr>
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WINTER PLAN 2025/26

1. INTRODUCTION

This paper sets out the core elements of this year's Winter Plan.

The main objective of the plan is to ensure service provision is as optimised as it can be to protect standards of patient care and safety, when services become under acute and sustained pressure. The plan also aims to:

- Support the workforce through leadership, engagement and effective health and wellbeing initiatives, including increased uptake of vaccinations
- Achieve the bundle of ED performance metrics; 4 hours above 80%, and effective flow that minimises the risk of overcrowding in ED and minimise periods of excessive corridor care, and no ambulance handovers taking over 45 minutes.
- Deliver a sustained elective programme throughout the period.

There was the expectation that the winter plan was prepared much earlier this year and the winter planning group was established in May in order to compile the plan. The group will commence with plan mobilisation from August.

2 PLAN ASSUMPTIONS

The key assumptions made in planning for this winter include:

- In line with previous winters the activity forecast does not include any significant growth in attendances or admissions, however average length of stay does increase, compounded by infections, leading to higher occupancy levels.
- Intermediate care provision is a valued step down resource to ensure a safe interim transfer of care following a patient's period of acute care, and it is assumed that:
  - All estate works are completed at Connie Lewcock Centre and all 21 beds are in use from the end October 2025.
  - There is a reprovision of the 16-20 bed loss from Eden Court Care Home into an alternative community setting, enabling the closure of the temporary 11 beds open on Ward 20.
- There is an expectation that a proportion of RVI ED activity will be managed differently through the new co-located UTC, from Quarter 4 onwards. The new UTC creates additional capacity and new opportunities to enhance streaming.
- There is no additional funding over and above the allocated winter budget. The budget is in line with last year set at £2.1m.
- It is assumed in line with previous years that the impact of Respiratory Syncytial Virus (RSV) in children will commence from October. It is expected that the impact will be less due to an improving uptake in the vaccination in pregnant women (up at 60% last year), however preparations are being made to improve the advance planning of elective lists during a three-week peak period that minimises the demand required of the Paediatric Intensive Care Unit (PICU).
- There is no planned scaling back of the adult elective programme. Work has been ongoing in the first part of this year to create headroom, should any activity be lost during the winter period.

At the time of writing the plan, the Australian respiratory surveillance report is showing a similar trend to last year, but it is too early to understand the scale of the peak. Based on the last few weeks in May, early indications are that the rates are lower than in 2022, 2024 and the five-year average. At this stage of planning, it is assumed that flu trends will be similar to last year.

3 CORE WINTER PLAN

The key components of the winter plan are:

- Additional 27 bed capacity provided on Winter Ward 12 at the Freeman Hospital, operational from 29 December 2025 until 26 April 2026. The workforce plan mirrors the success of last year with a number of substantive appointments made and the team recruited to in advance of the ward opening. This will not adversely affect headcount statistics with sufficient turnover in both qualified (6.2%) and unqualified (7.7%) nursing roles to be able to redeploy.
- Additional medial workforce to support front of house and back of house teams.
- Additional transport.*
- Lab consumables to support increased Point of care testing (Adult and Paediatrics).
- Vaccination programme – working to deliver a minimum 5% improvement in uptake on last year (55.2%). The programme has already commenced. GNCH staff will be a priority group.
- Enhanced hotel services.

*A transport review is underway which may negate or lessen the requirement for additional transport.

The plan is designed to deal with moderate surge as experienced in previous years. Extreme escalations will be further mitigated through:

- Additional temporary opening of surge beds, as per the Trust's bed escalation plan.
- Cancellation of elective surgery to create non-elective capacity.
- Operational Pressure Escalation Levels (OPEL) 4 actions which includes releasing staff from SPA time, cancelling meetings and training to support the most pressured areas.

4 OTHER SERVICE DEVELOPMENTS IN CLINICAL BOARDS

A number of service developments and improvements taking place in Clinical Boards will help ease winter pressures, including:

Medicine, Emergency Care	Community
• Development of an UTC – Go live early to mid-January 2026. Plans are being developed to trial the new pathways ahead of opening. • Reset in SDEC – revisiting ED metrics/ triggers, to be reviewed by medical colleagues, formalise as policy/ guidance. • Embedding of ED Flow Co-Ordinator roles. • Improved use of Estimate Date of Discharge (EDD) recording and reporting and use of Ready for Discharge field (ward) and Ready to Proceed field (ED).	• Supporting vaccination of workforce across community sites. • Doubling of Frailty virtual ward capacity with redeployment of staff from Eden Court. • Increasing Urgent Community Response (UCR) capacity x10 per day. • Working with care homes on health plans to help avoid admission.

• Triaging to Pharmacy First pathways.	
Clinical and Diagnostic Services	**Family Health**
• Sustaining of Hot Lab capacity - constant recruitment to keep pace with turnover. • Therapy recruitment. Permanent support into Ward 20, still not recruited an Occupational Therapist (OT). • More work to do on Carbapanemase-producing Enterobacterals (CPE) screening to seek clarity on process and avoid duplication of effort by trusts.	• Regional focus on RSV vaccination for pregnant women. • Elective programme planning - advanced plan to enact over 3 week period to minimise impact on PICU. • Paediatrics surge escalation plan.
Cancer & Haematology	**Peri-ops and critical Care**
• Acute oncology service on-line early July, expanded to run 8am-8pm, 7 days – hosted on Ward 36, with Band 6 & 7 nurses to improve decision making. Helps minimise any patients routed through ED and releases x 4 inpatient beds.	• Planning of critical care refurbishment decant and theatre fire remediation and ventilation works to minimise disruption – x15 theatres. • Updating OPEL. • Visibility of live Intensive Treatment Unit (ITU) status (and PICU, Neonatal Intensive Care Unit (ICU)).
Surgery and Specialist Services	**Surgery and Associated Specialties**
• Working on early discharge initiatives. Already achieved reduction in arthroscopy procedures from 5 to 2.5 days and doing more daycase. • Early scoping an Enhanced Recovery After Surgery (ERAS) model to support earlier discharge – subject to investment. • Recruitment into Eye Casualty – will improve timeliness of access to urgent care. • Ward clerk project to improve discharge practice.	• Plan to increase emergency theatre capacity at the Freeman Hospital, increasing over-flow lists – to reduce volume of patients waiting in beds for surgery. • Timely repatriation of vascular patients. • Specialty nurse support and input at front door. • Developing plans for lower limb ischaemic services – aiming to prevent some admissions.
Cardiothoracics	
• Embedding of configuration changes ahead of winter.	

There are a number of additional schemes that could add further benefit should any additional funding become available:

- Increased lab capacity for CPE screening.
- Further enhance frailty SDEC with additional locum/Senior House Officer (SHO) to develop a direct assessment pathway.
- Second discharge vehicle (subject to transport review).

5 WINTER PREPARATIONS AND EXTERNAL ASSURANCES

There was a requirement to start winter planning much earlier this year. There has been a series of national preparedness questionnaires issued, and the recent Urgent and Emergency Care (UEC) Plan set out specific requirement:

Requirements	**Newcastle Hospitals Response**
Review of systems and processes for preventing and managing infection and outbreaks. (Survey submitted by 4th July).	The Trust meets all best practice with the exception of the desired bed spaces. This is mitigated through use of cubicles and effective and responsive patient cohorting. A review of Personal Protective Equipment (PPE) and Respiratory Protective Equipment (RPE) is underway with no initial concerns regarding availability.
Improve vaccination rates, and accessible vaccination offer.	In place and includes 5% improvement target.
Improve ambulance handovers.	Task and Finish Group in place working to deliver improvement.
More children to be seen within 4 hours.	Focussed piece of work is ongoing.
Setting of stretch targets for daily pathway 0 discharged and profile them through the week. Setting of local performance targets for pathways 1, 2 and 3.	Discharge improvement programme underway. Supported by a series of Improvement weeks covering – continuous flow, use of the discharge lounges, use of Patient Transport Service (PTS), Expected Date of Discharge capture and use of Capman (pilot wards). Occupancy reduction target of circa 70% by 24 December 2025.
Demonstrate effective use of capacity across the full system by reviewing bed usage, returning people to home-based care where possible, and providing surge capacity alongside Infection Prevention and Control (IPC) cohorting where it is effective and appropriate to do so.	The Trust's OPEL actions cards are being expanded to other departments and being updated to ensure surge capacity is optimised. It is being branded and made more visible to the organisation. Work with system partners is ongoing to support a response to the Trust's OPEL status. Key rotas are being bolstered to maximise capacity and other team rotas will be dynamically assessed, as they are now, to maximise capacity and safe staffing.

The Trust has contributed to the compilation of a Local A&E Delivery Board (LAEDB) winter readiness checklist. This will be used to inform a discussion at the UEC Network on 17 July to enable the Integrated Care Board (ICB) to have an agreed winter plan by the 29 July. It is expected there will be NHS England (NHSE) feedback to follow on the robustness of the ICB plan, and plans will be tested

and refined during August and September. There is a national expectation plans support winter, surge and extremis.

LAEDB meetings have only recently been re-established by the ICB. Winter will be the focus of the July meeting for system partners. Work with partners has not stopped in the absence of meetings and includes:

- Work is underway with primary care to confirm arrangements/model for the Acute Respiratory Infection (ARI) hubs and ability to triage to them. A service specifications has been drafted by the ICB.
- Community Pharmacy is already linked in with acute colleagues to optimise use of Pharmacy First.
- Review of ability to level ambulance arrivals dynamically working with Northumbria Specialist Emergency Care Hospital (NSECH) and the North East Ambulance Service NHS Foundation Trust (NEAS).
- Working with NEAS to improve utilisation of PTS.

During July and August there is a series of winter planning webinars that members of the winter planning group will attend and bring back any learning.

Internally, there is the opportunity for the workforce to get involved in further shaping the winter plan and the support offered to staff during the winter period. This will be through a series of engagements using various operational fora and the Clinical Board Town Halls.

A Board Assurance Checklist and Assurance Statement has recently been received. This is included as Appendix 1. It is partially completed and it will be finalised for Board review in September. Boards are expected to submit the Assurance Statement to the UEC team by 30 September. This is to allow a period of testing of plans.

6 WINTER PERFORMANCE AND MONITORING

It is expected that ED performance will be improved on last year in line with the Trust' plan submission and the ambition to achieve >80%.

In addition to the usual ED bundle there will be increased scrutiny on corridor care and ambulance handovers taking more than 45 minutes.

Locally, the Trust will continue to improve the visibility and reporting of use of corridor spaces and incorporate patient and staff real time experience measures over the winter period.

It is expected that the System Co-ordination Centre (SCC) will continue to provide support and oversight to the region.

7 PLAN RISKS AND MITIGATION

The key risks to the plan are set out overleaf, alongside some mitigation options:

Key risks	Mitigations/Actions
Early onset of winter pressures pre-opening of additional bed capacity (as per last year).	Pop up beds on inpatient ward, ideally Ward 20 - subject to Intermediate care bed provision.
Local Authority (LA) / ICB unable to re-provide loss of Eden Court beds	Retain temporary beds on Ward 20 (subject to funding).
Private Finance Initiative (PFI) Fire remediation works unable to be completed outside of winter period	The majority of works for retained estates will be completed by end of Summer. A schedule of works is still to be received for the PFI estate and agreed. Agreement will be sought to avoid any significant bed losses over the winter peak period.
Additional capacity is eroded to support with wider system pressures.	There will be ongoing dynamic risk assessment to support the safe management and flow of patients in ED and Assessment Suite (AS), working in the system with SCC support to repatriate patients, not overwhelm any one individual trust whilst protecting specialist bed capacity.

8 SUMMARY

The core winter plan delivers additionality in terms of bed capacity and workforce as in previous years. However, the overall success of the plan is both a combination of the core plan, plus in-year service developments that deliver additional capacity and/or process improvements.

The Trust has effective IPC controls in place and a strong vaccination offer and has a range of improvement activity underway.

The loss of intermediate bed capacity is a new risk this year and is yet to be fully mitigated at this stage of planning.

Whilst the earlier planning has enabled the Trust to compile its' plan and mobilise sooner, there is more work to do to understand the impact of others' plans and finalise the Newcastle system overall plan and to test it.

9 RECOMMENDATIONS

Members of the Trust Board are recommended to:

- Approve the core plan that is being proposed to mitigate this year's winter pressures and sustain safe services, with a level of ED performance >80%.

- Acknowledge the improvement and engagement activity that will continue over the course of the next few months and contribute to being 'ready for winter'.
- Note the key risks of the plan and the need for system partners and those in the wider ICB to still come together to ensure there is a robust and tested regional plan in place to mitigate winter.

Nichola Kenny
Director of Improvement and Delivery (Operations)
4 July 2025

Agenda item A8

Winter Planning 25/26

Board Assurance Statement (BAS)

NHS Trust

Introduction

1. Purpose

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

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

Section A: Board Assurance Statement

Please double-click on the template header and add the Trust's name.

This section gives Trusts the opportunity to describe the approach to creating the winter plan, and demonstrate how links with other aspects of planning have been considered.

Section B: 25/26 Winter Plan checklist

This section provides a checklist on what Boards should assure themselves is covered by 25/26 Winter Plans.

3. Submission process and contacts

Completed Board Assurance Statements should be submitted to the national UEC team via england.eecpmo@nhs.net by **30 September 2025.**

DRAFT

Provider:	The Newcastle upon Tyne Hospitals NHS Foundation Trust

Section A: Board Assurance Statement

Assurance statement	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Governance		
The Board has assured the Trust Winter Plan for 2025/26.	Yes – at this point in time	Any changes will be made to the plan to reflect learning and feedback following the various system tests and check points.
A robust quality and equality impact assessment (QEIA) informed development of the Trust's plan and has been reviewed by the Board.	Yes	
The Trust's plan was developed with appropriate input from and engagement with all system partners.	Yes	Work continues with place partners and the wider system
The Board has tested the plan during a regionally-led winter exercise, reviewed the outcome, and incorporated lessons learned.	Not at this stage	This work is planned in from July through to September
The Board has identified an Executive accountable for the winter period, and ensured mechanisms are in place to keep the Board informed on the response to pressures.	Yes	Interim Executive Director of Operations
Plan content and delivery		
The Board is assured that the Trust's plan addresses the key actions outlined in Section B.	Yes	
The Board has considered key risks to quality and is assured that appropriate mitigations are in place for base, moderate, and extreme escalations of winter pressures.	Yes	
The Board has reviewed its 4 and 12 hour, and RTT, trajectories, and is assured the Winter Plan will mitigate any risks to ensure delivery against the trajectories already signed off and returned to NHS England in April 2025.	Yes	

Provider CEO name	Date	Provider Chair name	Date

Provider:	The Newcastle upon Tyne Hospitals NHS Foundation Trust

Section B: 25/26 Winter Plan checklist

Checklist	Confirmed (Yes / No)	Additional comments or qualifications (optional)
Prevention		
1. There is a plan in place to achieve at least a 5 percentage point improvement on last year's flu vaccination rate for frontline staff by the start of flu season.	Yes	
Capacity		
2. The profile of likely winter-related patient demand is modelled and understood, and plans are in place to respond to base, moderate, and extreme surges in demand.	Yes	
3. Rotas have been reviewed to ensure there is maximum decision-making capacity at times of peak pressure, including weekends.	Yes	Rotas front and back of house include additional staffing over winter. Other rotas will be dynamically assessed as they are now. On-call rotas in place and well-established
4. Seven-day discharge profiles have been reviewed, and, where relevant, standards set and agreed with local authorities for the number of P0, P1, P2 and P3 discharges.	Yes	Discharge metrics and targets have been set and are the focus of improvement activity
5. Elective and cancer delivery plans create sufficient headroom in Quarters 2 and 3 to mitigate the impacts of likely winter demand – including on diagnostic services.	Partial	This work in ongoing to create headroom
Infection Prevention and Control (IPC)		
6. IPC colleagues have been engaged in the development of the plan and are confident in the planned actions.	Yes	
7. Fit testing has taken place for all relevant staff groups with the outcome recorded on	Yes	Further checks underway regarding PPE

	ESR, and all relevant PPE stock and flow is in place for periods of high demand.		supply but no concerns being raised.
8.	A patient cohorting plan including risk-based escalation is in place and understood by site management teams, ready to be activated as needed.	Yes	
Leadership			
9.	On-call arrangements are in place, including medical and nurse leaders, and have been tested.	Yes	
10.	Plans are in place to monitor and report real-time pressures utilising the OPEL framework.	Yes	This framework is being refreshed.
Specific actions for Mental Health Trusts			
11.	A plan is in place to ensure operational resilience of all-age urgent mental health helplines accessible via 111, local crisis alternatives, crisis and home treatment teams, and liaison psychiatry services, including senior decision-makers.	-	
12.	Any patients who frequently access urgent care services and all high-risk patients have a tailored crisis and relapse plan in place ahead of winter.	-	

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 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 number of Methicillin-susceptible staphylococcus aureus (MSSA) increased in May (16 v 12) and are now within the parameters of special cause concerning variation. • The number of acute pressure ulcers (PU) reported in May increased 59 v 51, but no special cause variation has been highlighted. There was a notable increase in falls (251 v 222). • In 2023 the Trust triggered a safety signal for postpartum haemorrhage (PPH) >1,500ml per 1,000 births on the North East and North Cumbria (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 Quarter 4 (Q4) 2024/25 in England is 33 per 1,000 and NENC average is 29 per 1,000. The Trust PPH rate for May 2025 is 33%, with a mean average of 41%. 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. **Performance** • Overall 4-hour performance improved in May to 79.1%, the first time the standard has been met since August 2023. ED Arrival to Discharge >12 hours (Type 1) for May was 1.7%, a significant reduction from the 3.9% recorded in April. • May 2025 witnessed a decrease in >52-week waiters at Newcastle Hospitals, falling to 1,455 (-66). The number of >65 week waits also decreased to 108 (-8). The total waiting list (WL) size decreased sharply to 89,451, due to participation in an NHS England coordinated validation sprint. The Trust's performance has been one of the strongest nationally. Referral to Treatment (RTT) 18-week performance sat at 73.1%. • The 28 Faster Diagnosis Standard (FDS) for cancer was achieved for the fourth successive month (80.8%). 31 Day performance (76.9%) sustained the marked improvement displayed throughout early 2025 but nonetheless remains outside the control limits and significantly below standard. 62 Day compliance for May was 69.5%, consistent with a		

<table>
<tr><td></td><td>continuation of improving special cause variation despite an overall consistent failure to hit the target.

People
• 12 month rolling total sickness absence remained at 5.55% in May against a target of 4.50%. Whilst common cause variation is identified within the data the Trust continues to consistently fail to meet target.
• Appraisal compliance improved to 86.0% 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
• The trust has a plan to break even for the 2025/26 financial plan. To do this, it needs to deliver £106m of savings, manage expenditure within budgets and to deliver Elective Recovery Fund Income of £335m. At month 2 the Trust is reporting an £8.1m deficit which is in line with the plan, however in delivering this position, the trust has had to bring forward technical savings to offset new pressures and under delivery of the Cost Improvement Programme (CIP).

The new NHS Oversight Framework for 2025/26 has been finalised, attempting to implement a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

The Trust will be assessed against a combination of 21 different metrics - cutting across the themes of access, patient experience and safety, workforce, finance and productivity - and benchmarked against comparable Trusts, with scores issued based on our ranking against other providers. The consolidated ranking issued will determine the segment of assurance the Trust is placed in, ranging from 1 (high performing) to 4 (significantly off-track in a range of domains).

The detail behind the framework is complex, but initial assessment has placed the Trust in segment 3 (off-track in a range of domains). Further explanation of the framework, analysis of Trust performance and delivery against the metrics and subsequent segmentation will be detailed in future reports.</td></tr>
<tr><td>Recommendation</td><td>For assurance.</td></tr>
<tr><td>Links to Strategic Objectives</td><td>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>Impact
(please mark as appropriate)</td><td>
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<tr><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></td></tr>
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Reports previously considered by	This is a regular paper provided to Trust Board.

Agenda item A9

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

Quality, Performance, People, Finance, Health Inequalities

July 2025

Healthcare at its best
with people at our heart

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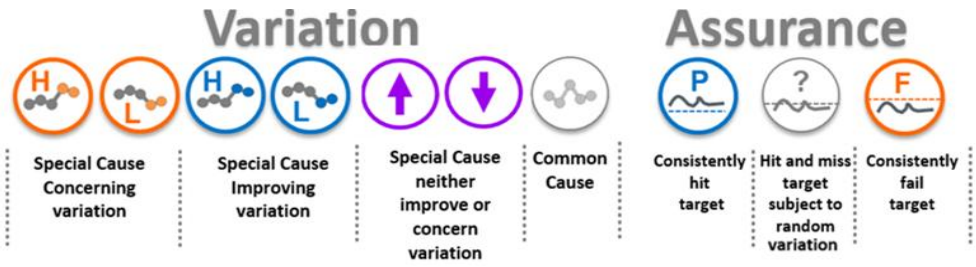
SPC Assurance – Changes from previous report

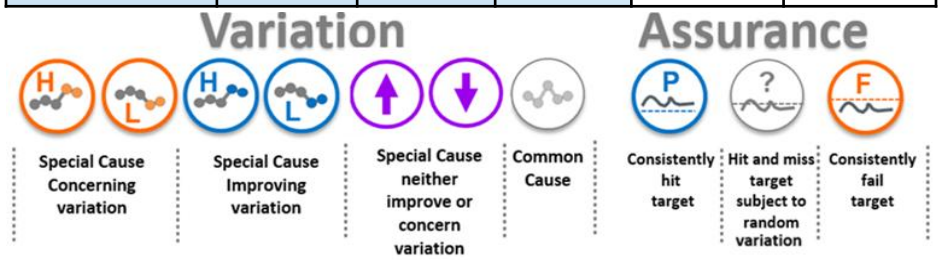
	Apr-25	May-25
HCAI - MSSA		H
Patient safety incidents per 1,000 bed days		H
Maternal readmissions	H	
Trust & LMNS BSOTS Medical review Orange - within 15 minutes		H
A&E Arrival to Admission/Discharge		H
Mandatory Training	H	L



Quality

Quality Overview

Metric	Period	Actual	Target	Variation	Assurance
HCAI - MSSA	May-25	16	9		
HCAI – C. Diff	May-25	11	11		
Harm Free Care – Inpatient Acquired Pressure Ulcers	May-25	59	Sustained reduction		
Harm Free Care – Adult Patient Falls	May-25	251			
Stillbirths	May-25	1			
Blood Loss >1500ml (per 1,000)	May-25	33 per 1000			
ATAIN	May-25	9%	5%		



Health Care Acquired Infections

- The *Clostridioides* difficile Infection (CDI or C.Diff) cases for May reduced (11 v 18) compared to the previous month and are within the parameters of common cause variation.
- The number of Methicillin-susceptible staphylococcus aureus (MSSA) increased in May (16 v 12) and are now within the parameters of special cause concerning variation.

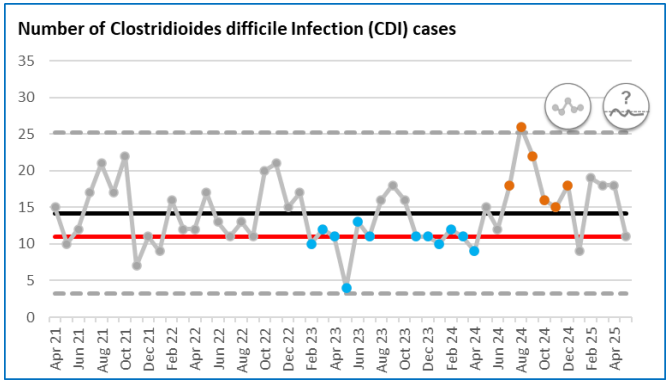
Harm Free Care

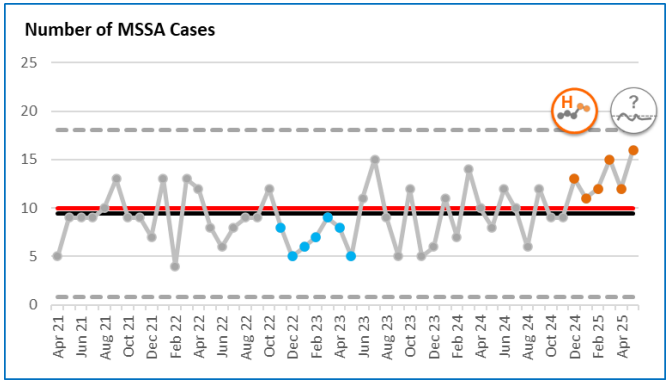
- With the sustained reduction in falls and pressure ulcers over the last two years, targeted reductions have not been set. Instead, a sustained reduction demonstrated through statistical process control is sought.
- The number of acute pressure ulcers (PU) reported in May increased 59 v 51, but no special cause variation has been highlighted.
- In May there was a notable increase in falls (251 v 222).

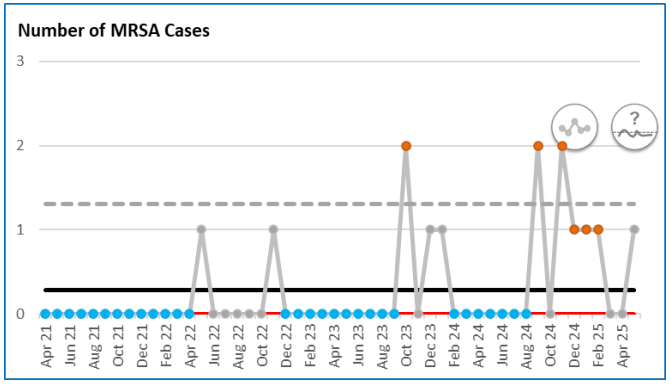
Perinatal Quality Surveillance

- The National benchmark for term admissions is 5%. The Trust rate remains consistently above the national 5% target. The Trust Quarter 3 (Q3) ATAIN rate was 7.45% and the Q4 rate was 6.3% on the North East North Cumbria (NENC) Clinical Indicators Dashboard and whilst this does not constitute a safety signal it has instigated internal quality improvement activity.
- In 2023 the Trust triggered a safety signal for postpartum haemorrhage (PPH) >1500ml 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 Q4 2024/25 in England is 33 per 1,000 and NENC average is 29 per 1,000. The Trust PPH rate for May 2025 is 33%, with a mean average of 41%. 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.

Healthcare Associated Infections (1/2)







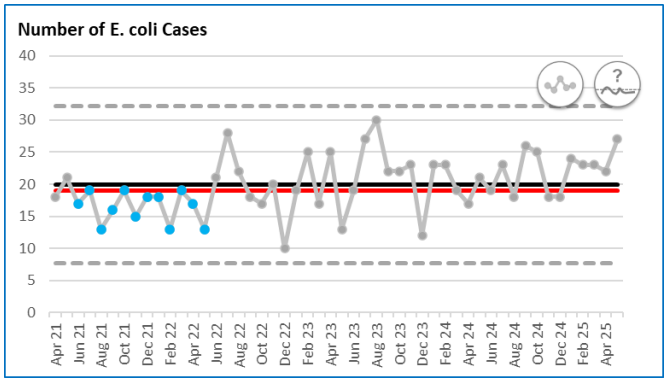
Standards

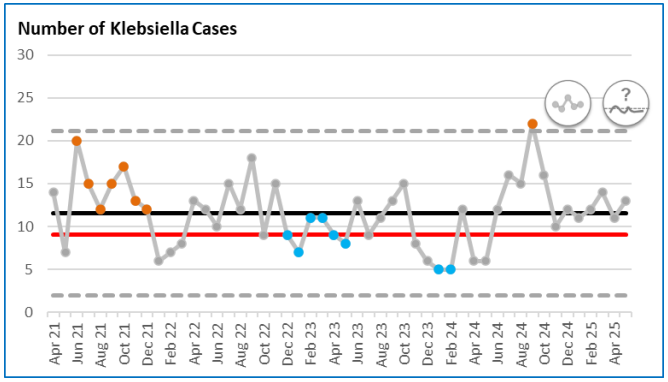
- **Zero Methicillin-Resistant Staphylococcus aureus (MRSA)** cases.
- **No more than 115 MSSA** cases across the financial year (local target - 10% reduction from 2024/25).
- **No more than 136 CDIs, 225 Escherichia coli (E. coli)** cases, **108 Klebsiella** cases or **34 Pseudomonas aeruginosa** cases across the financial year.

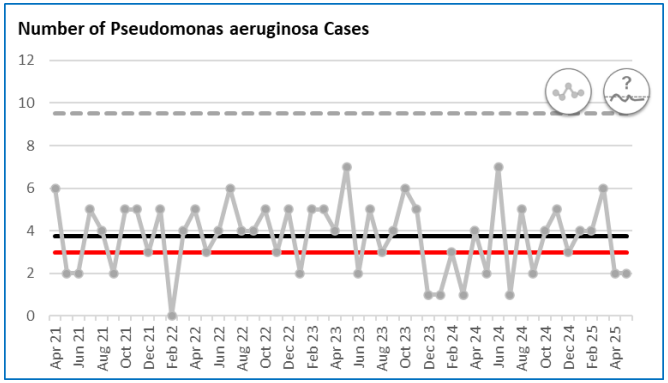
Current Position

- There was a decrease seen in the number of CDI cases compared to the previous month (11 v 18) this remains within the parameters of common cause variation. There were 5 Community Onset Healthcare Associated (COHA) cases and 6 Hospital Onset Healthcare Associated (HOHA) cases, of which 2 were found to have contributory associated factors relating to the infection. Themes identified were poor compliance with antimicrobial stewardship, delay in sending a specimen and delay in the patient receiving treatment.
- There was an increase in the number of MSSA cases compared to the previous month (16 v 12) this is now within the parameters of special cause concerning variation.
- There were 1 HOHA MRSA case in May this remains within the parameters of common cause variation.
- There was an increase in the number of E. coli bacteraemia cases compared to the previous month (27 v 22). There were 3 COHA and 24 HOHA cases, of which 2 were found to have contributory associated factors relating to the infection. Themes identified were poor compliance with device management and documentation.
- The was a slight increase in Klebsiella bacteraemia cases this month compared to the previous month (13 v 12).
- There was no change seen in Pseudomonas aeruginosa cases compared to previous months (2 v 2), this remains in line with common cause variation.
- Themes identified from bloodstream infections include; suboptimal intravenous device and urinary catheter insertion, ongoing management, poor documentation and poor adherence to antiseptic skin washes.

Healthcare Associated Infections (2/2)



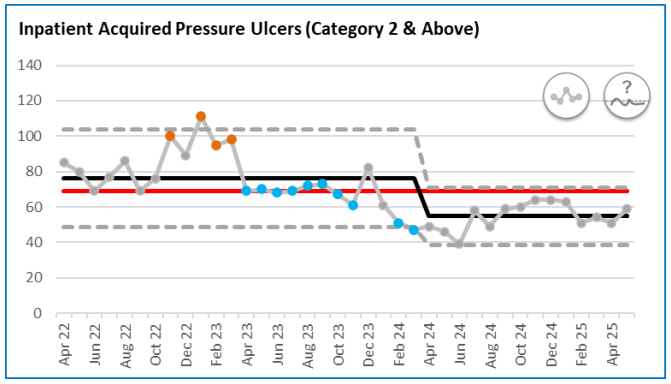


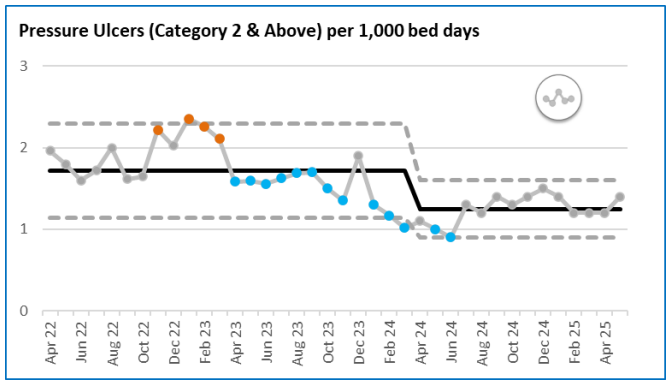


Action taken

- B Braun have completed a Trust wide cannulation audit. The results will be disseminated at various forums with improvement actions to be reported and monitored in Clinical Board Governance meetings. These findings will be triangulated and actioned using our current Trust processes on Aseptic Non-Touch Technique (ANTT) and hand hygiene compliance / assurance processes.
- A designated member of the Infection Prevention and Control (IPC) team is supporting the Accrediting Excellence (ACE) programme to address the concerns around IPC practices identified at ward and department level. This collaborative engagement process will help drive changes at ward level to support ward staff to improve the fundamentals of IPC where required. In addition, this process will be strengthened further by the designated IPC nurse for that area who will support the ward team to help make the required changes.
- A programme to support has increased compliance with hand hygiene and reduced glove use within the organisation. This will help support and strengthen our HCAI reduction strategies.
- IPC are undertaking monthly validation ‘Take 5’ audits (cannulation, urinary catheter and commodes) that will incorporate device management and clinical staff knowledge for all inpatient areas. This will help support and provide education to clinical areas where areas of development have been identified through current IPC processes.

Harm Free Care: Pressure Damage





Standard

- Following the sustained reduction in pressure ulcers over the last two years, targeted reductions have not been set. Instead, a sustained reduction demonstrated through statistical process control will be sought.

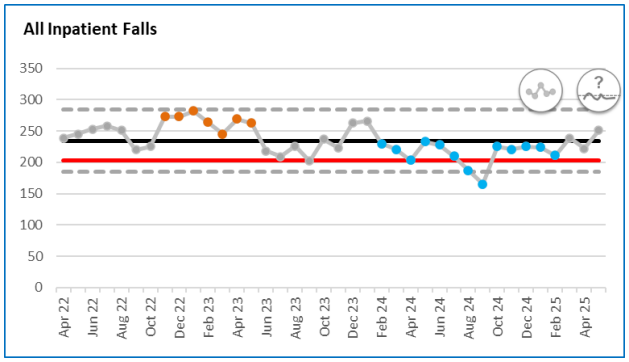
Current position

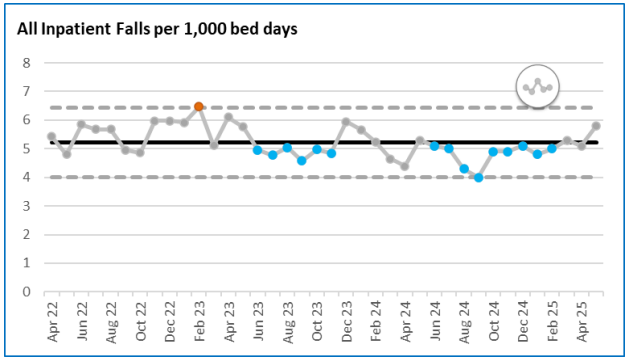
- The graphs for May have been amended to reflect an error that was reported in the April 2025 data.
- The number of acute pressure ulcers (PU) Category II and above reported in April was 75, however this has been validated and corrected to 51. This number slightly increased in May to 59.
- PU per 1,000 bed days has also been corrected for April and was 1.2 this slightly increased in May to 1.4 . The chart has been adapted to reflect a sustained reduction, therefore highlighting no special cause variation.
- The was one category IV pressure ulcer in April and four category III pressure ulcers in May. Investigations are underway into all of these.

Action taken

- The themes and trends from pressure ulcer investigations in March and April reflect those of previous months. Actions required: improved documentation, images to be taken in a timely manner, skin/pressure ulcer risk assessments required completion, completion of pressure ulcer prevention/categorisation training required and implementation of mattress champions/mattress audits.
- As part of the pressure ulcer prevention care plan Purpose T as an Iview band is now being piloted with the aim to roll this out across the Trust by late July 2025.
- The Tissue Viability Team continue to provide a range of education sessions so in the month of July training on Purpose T has been prioritised.
- Royal Victoria Infirmary (RVI) mattress audit will be undertaken in September 2025.

Harm Free Care: Falls





Standard

- Following the sustained reduction in falls over the last two years, targeted reductions have not been set. Instead, a sustained reduction demonstrated through statistical process control will be sought.

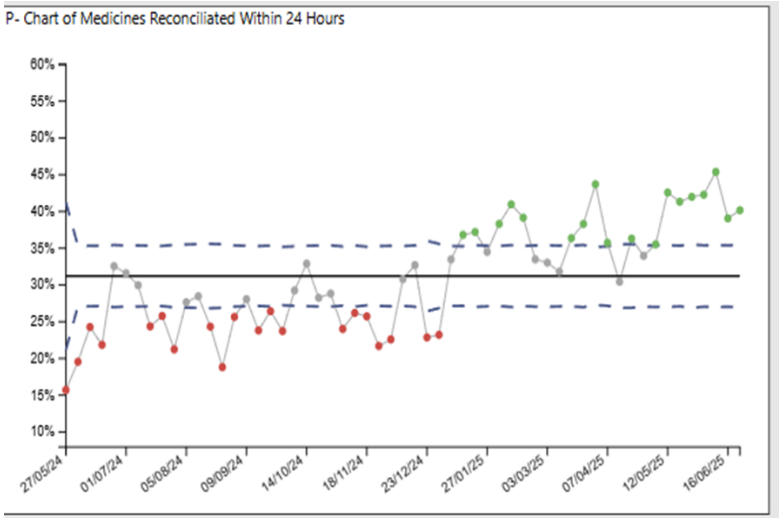
Current position

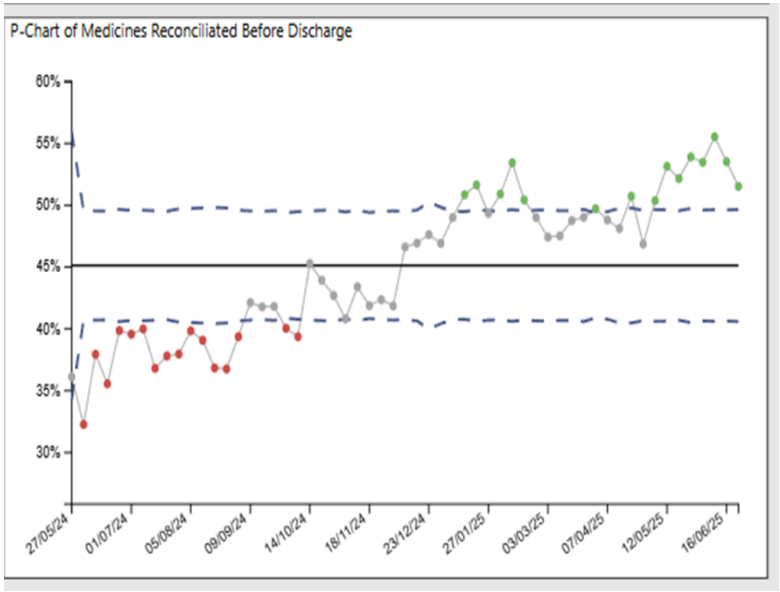
- In May 2025, there was an increase in falls, following a reduction in April (251 vs 222). The Trust falls per 1,000 bed days has also increased to 5.8. There rise in falls seen in both in May 2024 and 2025, has been reviewed but does not seem to be linked to staffing levels and no trends have been identified. There is however an increased visibility and presence on wards and departments of the falls prevention team with education being delivered, which includes encouraging staff to report all falls.
- Falls with moderate or above harm were recorded as 2.8% of falls (7). Injuries sustained were: 2 intercranial haemorrhages, rib, ankle, radius, greater trochanter and neck of femur fractures.

Action taken

- Themes remain consistent with previous months, action plans noted the quality of the multifactorial assessment to optimise safe activity (Lying and Standing blood pressure, 4AT, Vision, Medication, Continence and Mobility) or adherence with the enhanced care observation policy.
- Compliance with mandatory Falls Prevention training remains high at 97.6%.
- Enhanced Care Observation (ECO) training continues to be rolled out across the Trust by the clinical educators, 1,650 staff have now been trained (the previous reported figure has been validated).
- The Trust has been accepted onto NHS England Enhanced Therapeutic Observation and Care programme (ETOC) Cohort 2, with a pilot planned to be undertaken in Older Peoples Medicine.
- The Falls Prevention Coordinator is working with clinical colleagues to respond to the National Institute for Health and Care Excellence (NICE) falls guidance that was published at the end of April.

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 on-going to test different ways of working to improve medicines reconciliation rates without adversely impacting other core services (e.g. patient flow, medicine supply, operational duties).
- Phase 1 of the staffing business case approved with staggered start dates starting from September 2025.

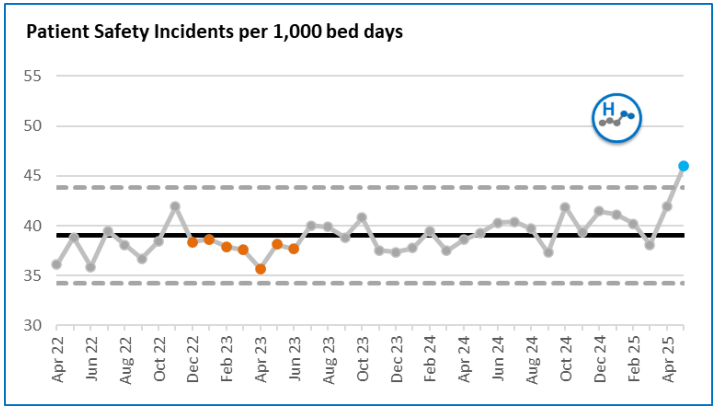
Current Position

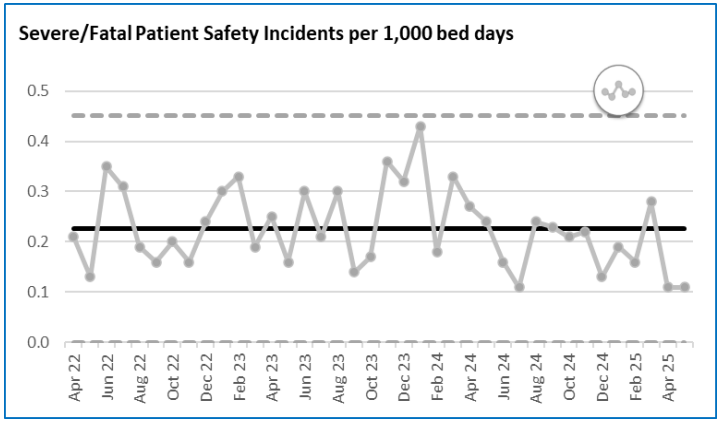
- 40% target within 24 hours achieved for the first time in June 2025.

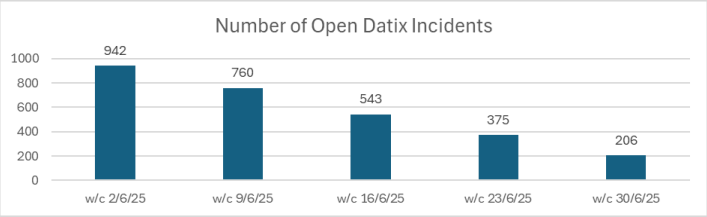
	Med rec within 24 hours	Total Med Rec before discharge
Dec 2024	**27%**	46%
Jan 2025	**34%**	51%
Feb 2025	**39%**	52%
Mar 2025	**34%**	48%
April 2025	**37%**	50%
May 2025	**38%**	52%
June 2025	**42%**	54%

- From May 2025 the Pharmacy team began to call elective surgery patients at home to reconcile medication on the day prior to admission to Freeman Ward 4 (Day of Surgery Admission (DOSA)). This included weekends in preparation for Monday's arrivals.
- On-call service review commenced. Due to be completed by September 2025. It is anticipated this will release staff to provide additional pharmacy support for medicines reconciliation at weekends.

Incident Reporting







Standards

- Continued trend of **increased incident reporting** across the Trust.
- Ensure learning from safety events is shared across the organisation.

Current Position

- The total number of patient safety incidents per 1,000 bed days reported in May 2025 has increased compared to April.
- The number of severe/fatal safety incidents per 1,000 bed days has stayed the same in May 2025, compared with April.
- Two Patient Safety Incident Investigations (PSII) were recorded in May 2025.

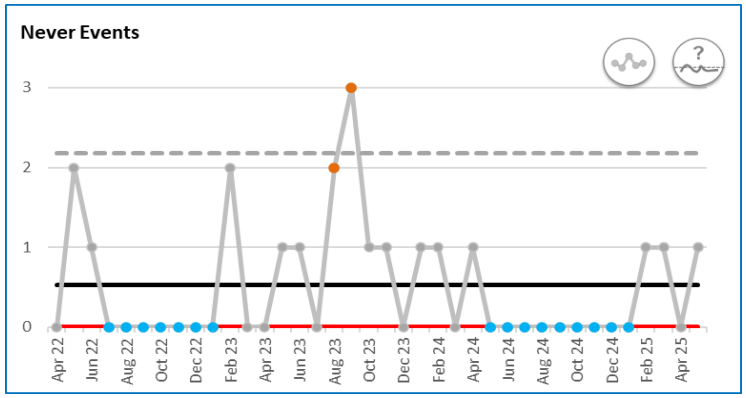
Action taken

- Clinical Boards have access to incident reporting rates and have identified areas of low reporting, implementing targeted plans to address this.
- Raising awareness of incidents and dissemination of learning continues to 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.
- Additional training has been created for staff during the transition from Datix reporting to InPhase.
- Psychological support services being developed to support staff involved with patient safety events.

Open Datix Incidents

- The Trust moved to InPhase for incident reporting on 1st May 2025. Since then, work has been ongoing to reduce the number of incidents that remained open on Datix Cloud IQ.
- Over the last four weeks the number of open incidents on Datix Cloud IQ has fallen from 942 to 206.
- Work is ongoing to support the Clinical Boards in closing the remaining incidents.

Never Events



Standards

- Aim to achieve a target of **zero Never Events**.

Current Position

- One Never Event was declared in April 2025.
- A total of one Never Event has been recorded for the 2025/26 period, the same at this point in 2023/24.

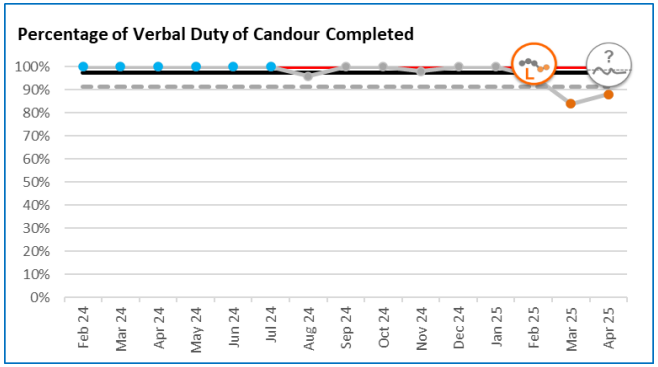
Action taken

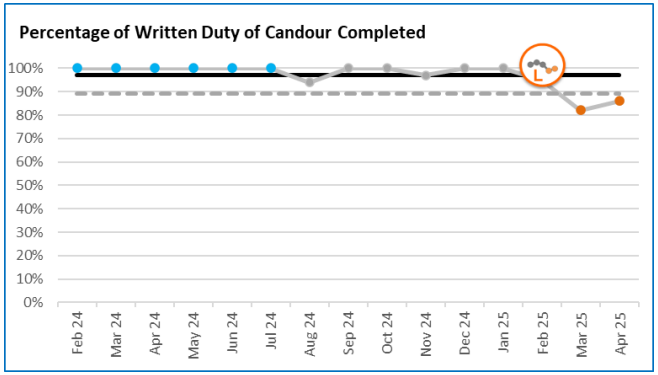
- Patient Safety Incident Investigations undertaken for all Never Events. PSII's support the identification of contributing factors and implementation of system-based actions to prevent reoccurrence.
- Additional focus on the introduction of key safety standards, including NatSSIPS2 across the organisation.
- Consideration of a Patient Safety Incident Response Framework (PSIRF) priority focused on reduction of Never Events.

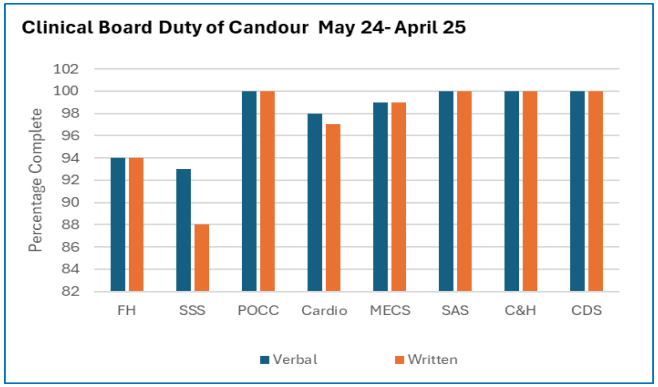
Never Events 2023/24	Clinical Board	Speciality	Never Event
April 2024	Surgery & Specialist Services	Ophthalmology	Wrong implant / prothesis
February 2025	Perioperative & Critical Care	Theatres & recovery	Retained foreign object post procedure
March 2025	Surgical & Associated Specialities	Vascular Surgery	Wrong site surgery

Never Events 2024/25	Clinical Board	Speciality	Never Event
April 2025	Surgery & Specialist Services	Orthopaedics	Wrong Implant / prothesis

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 97% for the reporting period compared with 96% the previous month.
- Clinical Board oversight is monitored through Patient Safety Group, Quality and Performance reviews and Quality Oversight Groups.

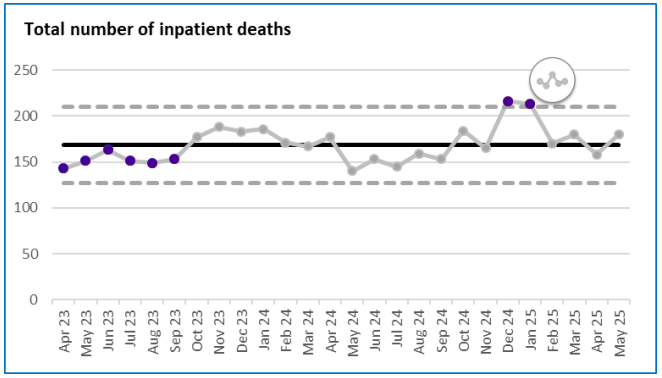
Action taken

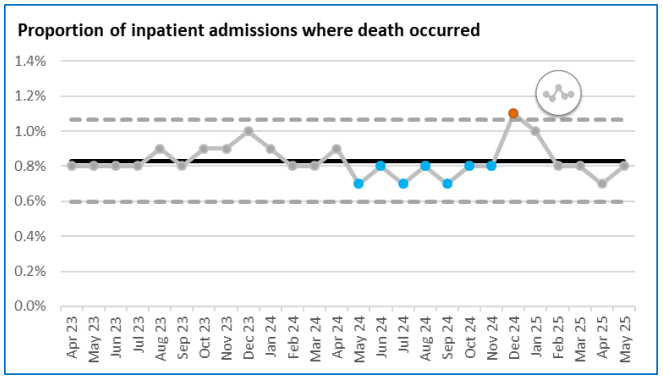
- A focus is being made on the quality of duty of candour responses with a quality audit to include patients being developed.
- Review and update of the duty of candour policy to provide more succinct and relevant guidance. Introduction of 'policy on a page'.
- Ongoing work to introduce Family Liaison roles within the trust to support engagement in safety events and DoC requirements.

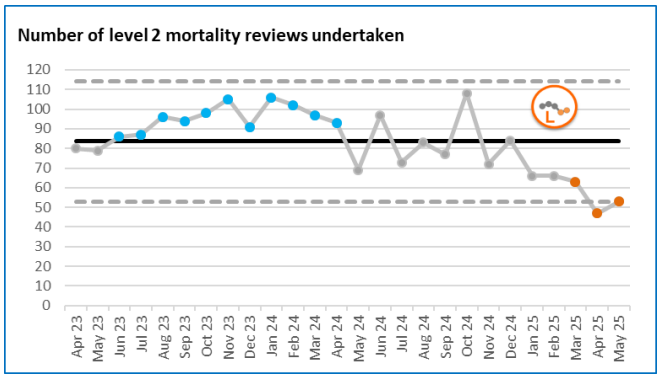
Measures of Success

- 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).

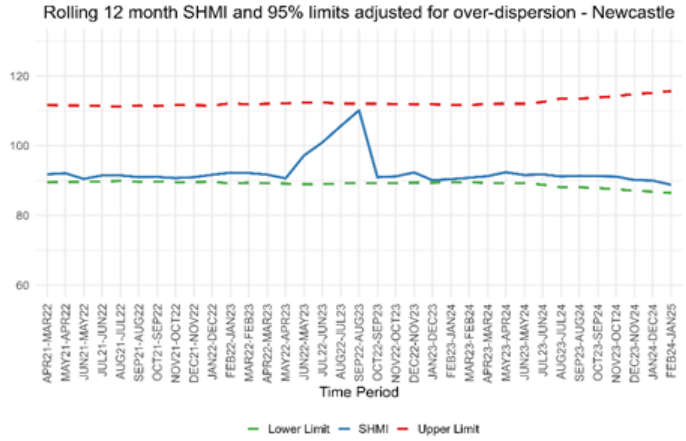
Current Position

- There were 180 inpatient deaths in total reported in May 2025. This is an increase of 22 on the previous month.
- The crude mortality rate in April 2025 is 0.8%. This is an increase of 0.1% from the previous month.
- Out of the 180 inpatient deaths reported, there are 53 completed level 2 mortality reviews entered into the Trust mortality review database to date.
- None of the level 2 reviews completed for patients who died in May 2025 to date have been scored with a high HOGAN or National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading.
- Two level 2 reviews completed in May 2025 for patients who died prior to this date have received a HOGAN 4 score (*probably preventable, more than 50-50 but close call*).
- Four patients with a confirmed learning disability died in May 2025.

Action taken

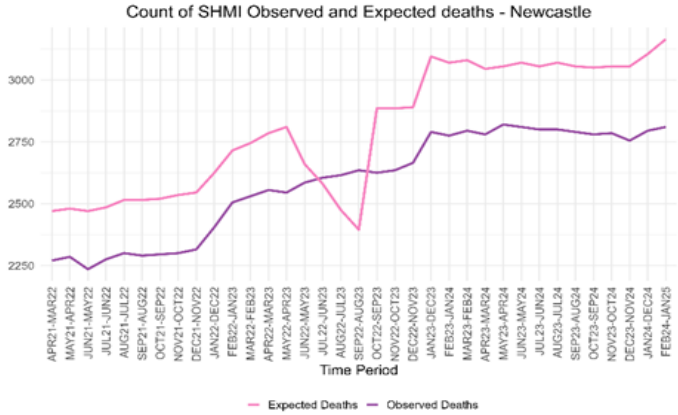
- All inpatient deaths are continually monitored.
- Of the cases that were given a HOGAN 4 score:
    - One case had already been investigated as a PSII. The level 2 was outstanding and was been completed after being followed up by the Integrated Governance Manager.
    - One case was escalated by the Integrated Governance Manager as a potential patient safety incident. The case was reviewed under the PSIRF framework and deemed to be for local investigation by the Trust's Response Action Review Meeting (RARM) Panel.
- 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.

Mortality Indicators (2/2)



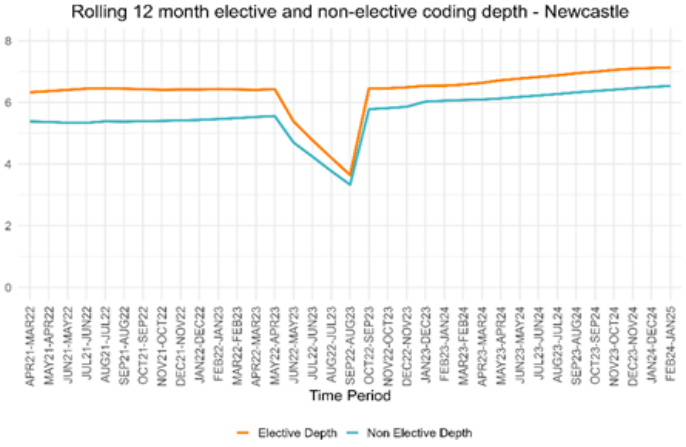
Summary Hospital-level Mortality Indicator (SHMI)
Within the latest published SHMI data (Feb 2024 – Jan 2025) the Trust SHMI is at 0.89. This is within the "as expected" category.

Observed & Expected deaths
Between February 2024 – January 2025, the Trust has 2,810 observed deaths and 3,165 expected deaths.



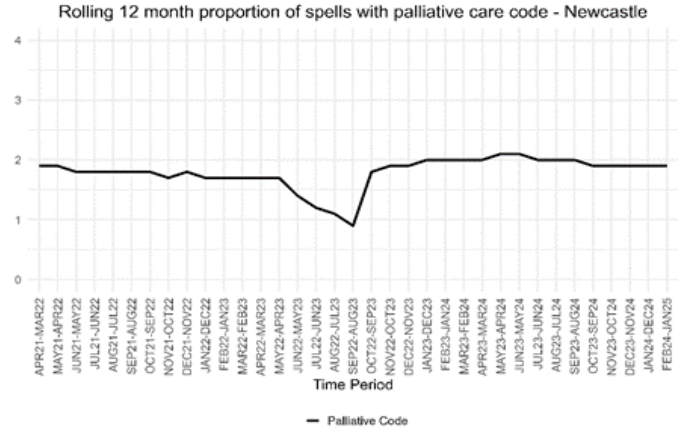
All data rolling 12-month periods. Data as reported by NHS England.

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

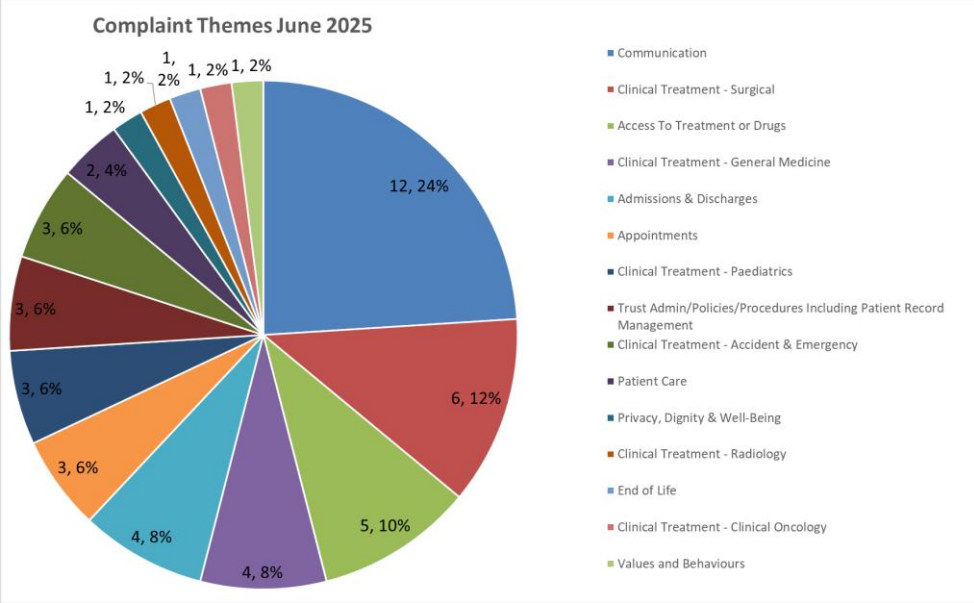


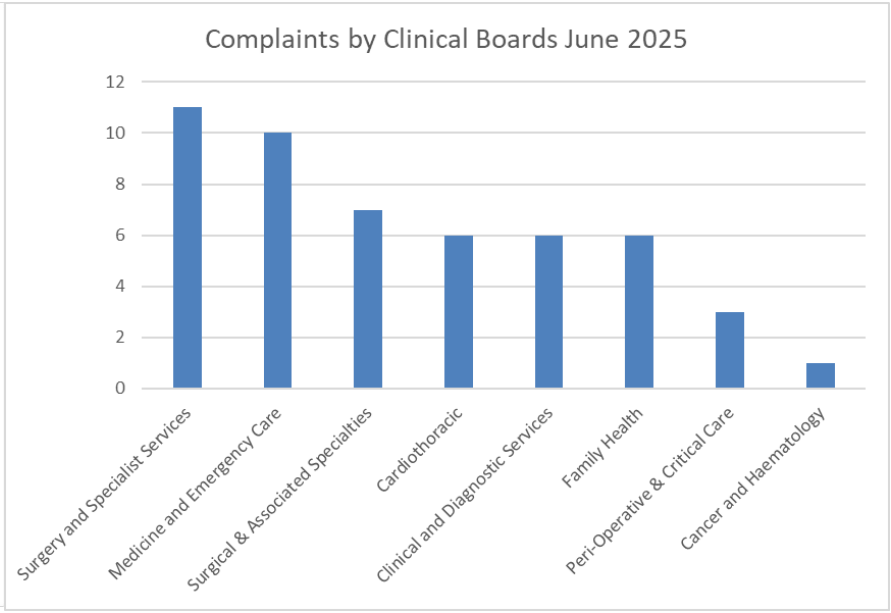
Coding Depth
Coding depth has a substantial impact on mortality indicators. Within the latest published SHMI data the Trust has an elective coding depth of 7.1 and a non-elective coding depth of 6.5*.

Spells with palliative code
Between February 2024 – January 2025, the Trust has a 1.9% palliative care coding rate.



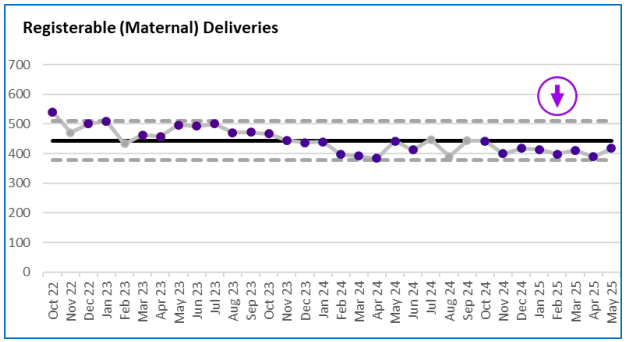
Formal Complaints

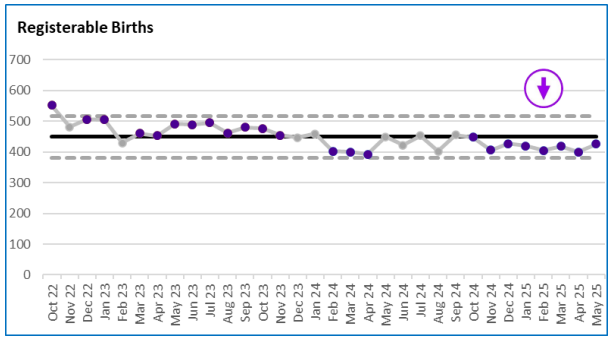


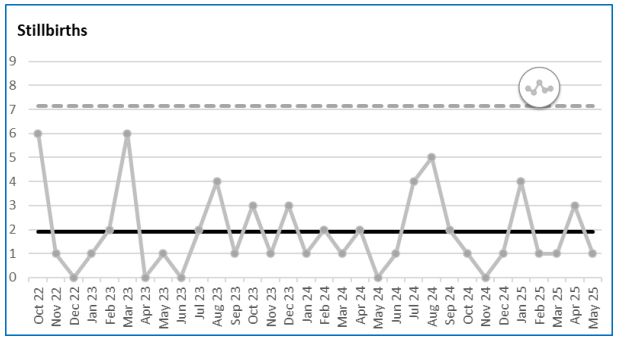


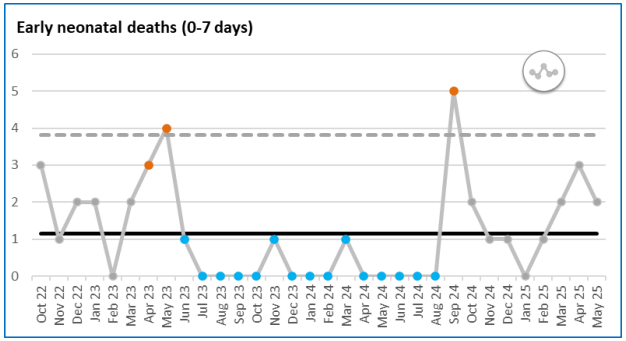
- The Trust has had 50 formal complaints In June 2025. The average number of complaints opened for the previous financial year is 54.
- The main theme for complaints this month was Communication, accounting for 24% of the complaints (12).
- Clinical treatment accounts for the most complaints collectively across the specialties with 36% of complaints opened this month (18).
- The most complaints were opened for the following Clinical Boards:
    - Surgical and specialist Services 11 (22%)
    - Medicine 10 (20%)
    - Surgical & Associated Specialties 7 (14%)

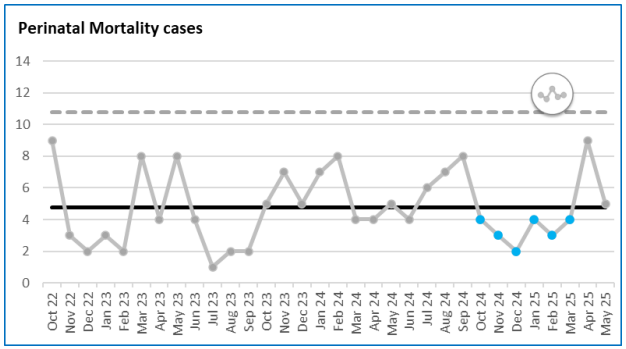
Perinatal Quality Surveillance: Births











Deliveries/Births

- There were 591,072 live births in England and Wales in 2023, a 2.4% decrease from 2022. There has been an overall decline in births since 2012, and this is the lowest number of births since 1977. 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. The NBC was re-opened on the 2 December 2024. Activity will continue to be closely monitored.

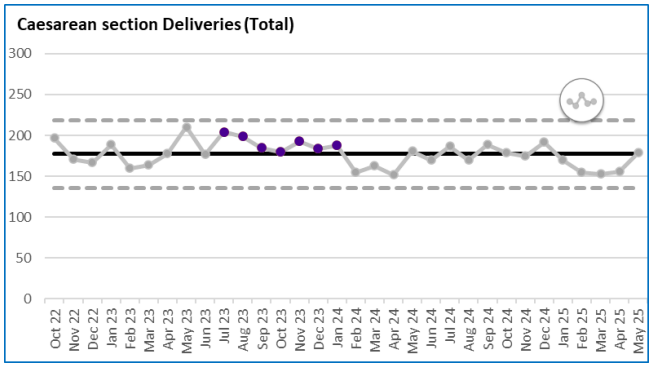
Stillbirths

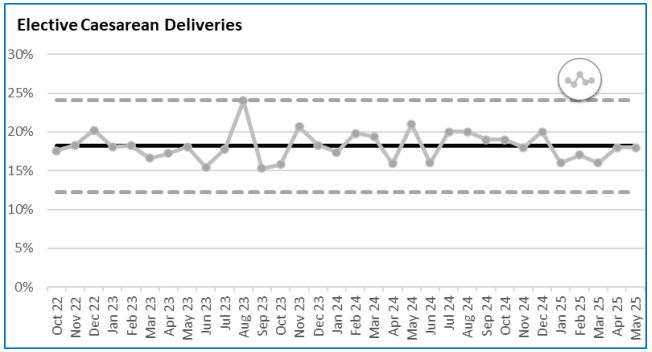
- Newcastle is a tertiary referral Fetal Medicine Unit, providing care to the most complex cases from across NENC. This data includes termination for fetal anomalies >24 weeks gestation. There was 1 stillbirth in May 2025. These will be reviewed via the Perinatal Mortality Review process. (Average per 1,000 births: England 3.2, NENC 3.6). The Trust triggered the second quarterly safety alert for the number of stillbirths on the Clinical Indicators Dashboard in Q3. In accordance with the Local Maternity and Neonatal System (LMNS) safety signal process this was a safety alarm and instigates review. Further analytics have been performed by the NHSE analytics team which indicate duplicate counting, when these cases were removed the Trust returned to within a 95% confidence limit.

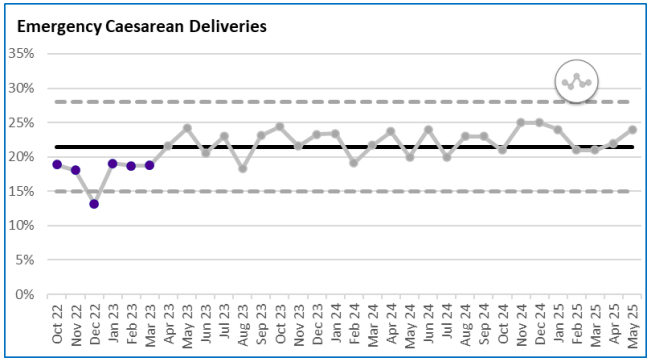
Early Neonatal Deaths

- 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 May 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 improved 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 42% in May 2025, however, it should be noted that the increasing caesarean section rate for the Trust, and nationally, is challenging operationally and there has been an associated impact on the perioperative staffing requirements to maintain a safe service which is being reviewed by the leadership teams.

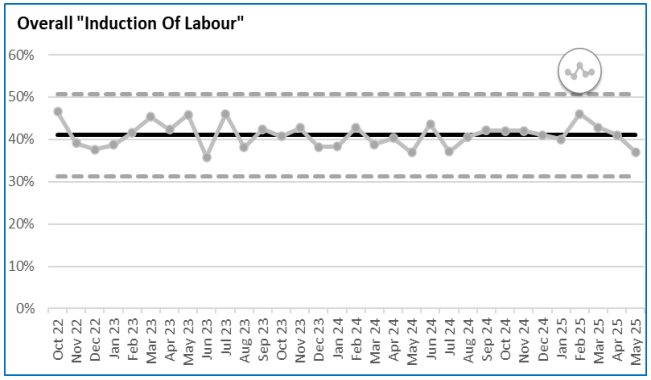
Elective Caesarean section

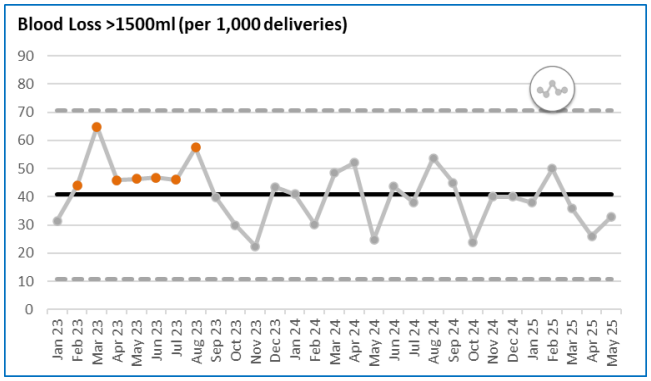
- The average England elective caesarean rate is 18.2%.
- The Trust elective caesarean rate is stable at 18% in May 2025.
- The national rise in elective caesarean rates is partially due to an increasing proportion being undertaken due to maternal request in accordance with the NICE guidance.
- The Trust 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.

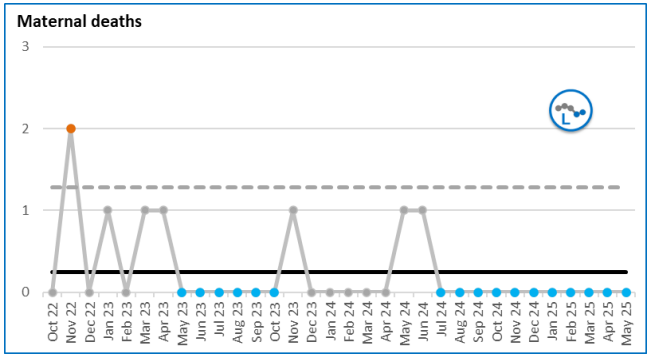
Emergency Caesarean section

- The England average for Q4 2024/25 was 23.5%, and NENC mean 21.6%.
- The Trust emergency caesarean rate was 24%, in keeping with the England average and a reflection of the tertiary service provision and complex case mix.
- 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 Q4 2024-25 29.6% and NENC 35.2%. The Trust induction of labour rate for May 2025 is 37%. The Induction of Labour Quality Improvement Plan (QIP) reviewing pathways and patient experience is making good progress as the Trust is aware that the current facilities offered to women undergoing induction of labour require improvement.

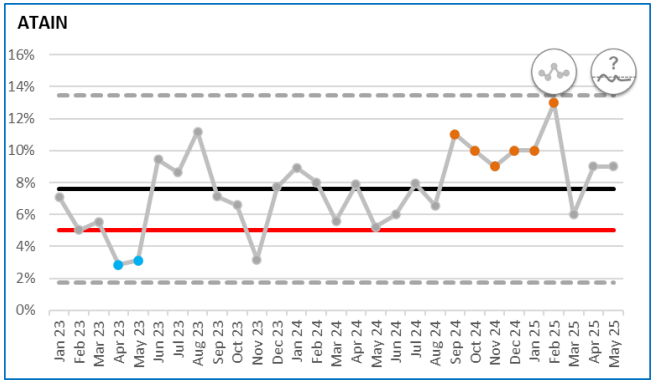
Blood Loss >1500ml

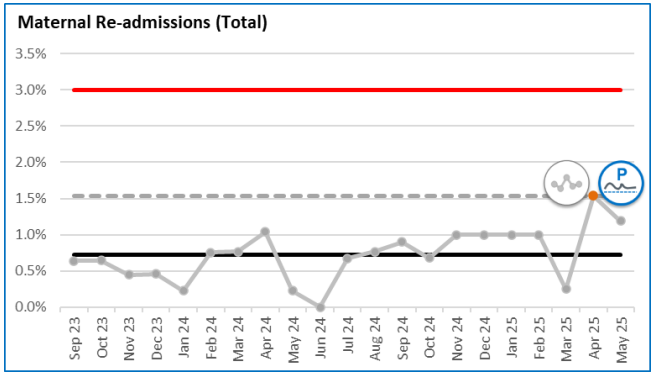
- In 2023 the Trust triggered a safety signal for postpartum haemorrhage (PPH) >1500ml per 1,000 births on the NENC clinical dashboard, which instigated a deep dive and audit. The recommendations of the review were enacted and resulted in a reduction in the PPH rate. The average PPH rate for Q4 2024/25 in England is 33 per 1,000 and NENC average is 29 per 1,000. The Trust PPH rate for May 2025 is 33%, with a mean average of 41%. 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 was undertaken to identify any new or emergent themes; the review identified multiple risk factors already known to add complexity and risk of PPH within the affected patient group.

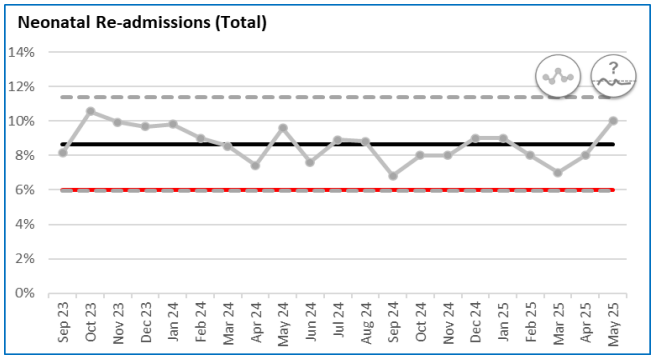
Maternal Deaths

- 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 May 2025.

Perinatal Quality Surveillance: Admissions







Avoiding Term Admission into Neonatal Units (ATAIN)

- The National benchmark for term admissions is 5%. The Trust rate remains consistently above the national 5% target. The Trust Q3 ATAIN rate was 7.45% and the Q4 rate was 6.3% on the NENC Clinical Indicators Dashboard and whilst this does not constitute a safety signal it has instigated internal quality improvement activity. The Local Maternity and Neonatal System (LMNS) have been asked to agree a NENC definition of unplanned admission as most Trusts report admissions of over 4 hours duration whilst the Trust includes all admissions regardless of duration. Three quality improvement workstreams have been identified. The workstreams are care of infants of diabetic mothers, thermoregulation and respiratory issues following delivery by elective caesarean section, progress is monitored by the Quality and Safety Group and is linked to compliance with Safety Action 3 of Maternity Incentive Scheme. The Trust rate for May 2025 was 9%.

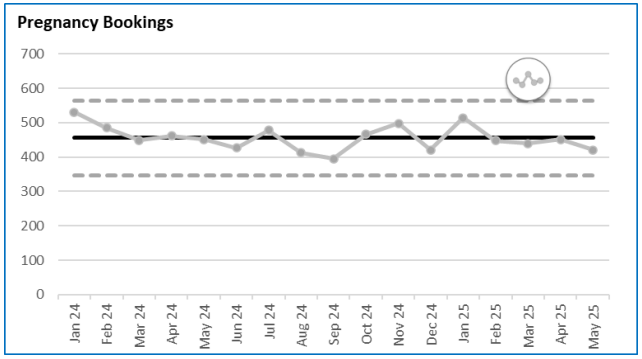
Maternal Readmissions

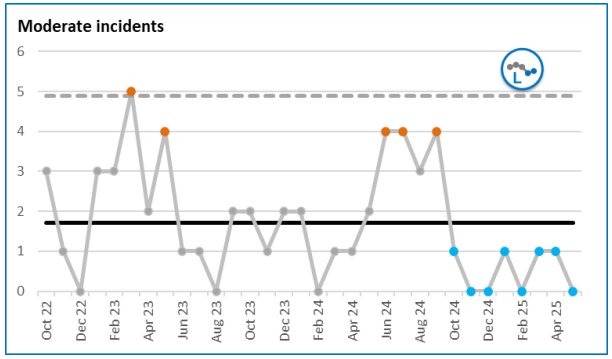
- National Maternity & Perinatal Audit (NMPA) Report (2022) the maternal postnatal readmission rate for England was 3.3%, with rates being higher following caesarean section compared with vaginal birth (4.3% vs 2.9%). The LMNS are working to agree a NENC Key Performance Indicator (KPI) for this metric, in the interim a target against the national average of 3% has been set. Maternal readmission rate for the Trust is consistently below the national average and was 1% in May 2025.

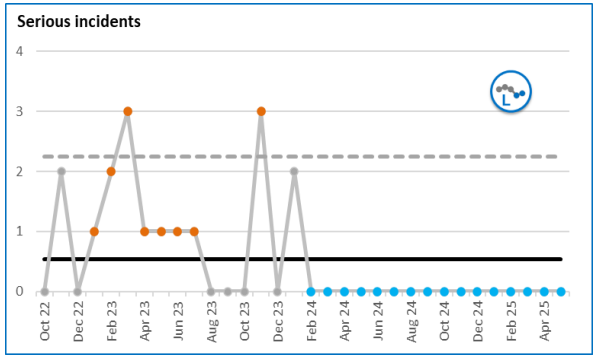
Neonatal Readmissions

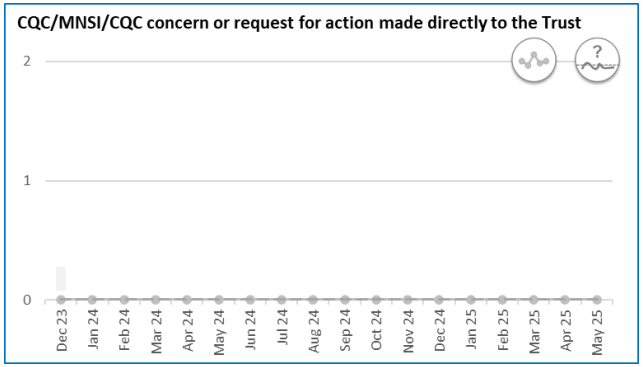
- The Clinical Quality Improvement Metrics (CQIM) for ‘Babies readmitted to hospital who were under 30 days old’ data is used as a comparison to Trust performance, hence the target of 6%. The neonatal team are currently reviewing the management of jaundice guidance which is impacting the readmission rate.

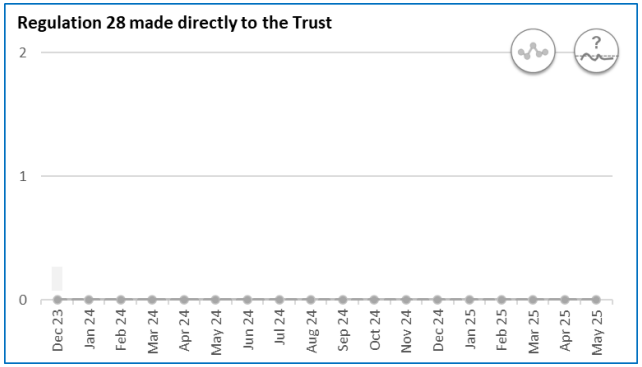
Perinatal Quality Surveillance: Incidents & Bookings











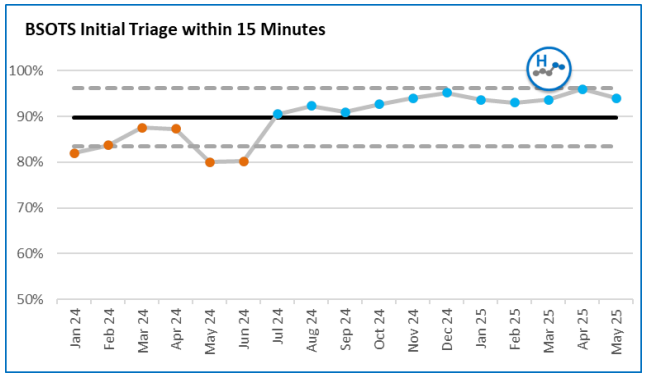
Incidents

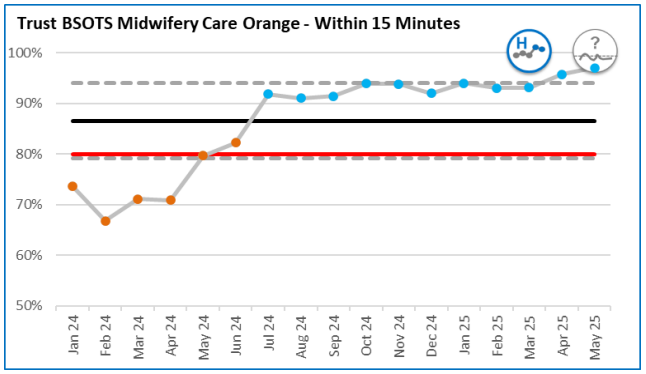
- There has been no moderate (and above) incident reported in perinatal services in May 2025.
- Most moderate incidents fit the criteria for referral to MNSI for external review. These include cases involving neonatal brain injury - Hypoxic Ischaemic Encephalopathy (HIE), Term Intrapartum Stillbirths, Early Neonatal deaths and Maternal deaths.
- There have been no CQC/MNSI concerns or requests for action in the last 12 months.
- There have been no regulation 28 notices in the last 12 months.

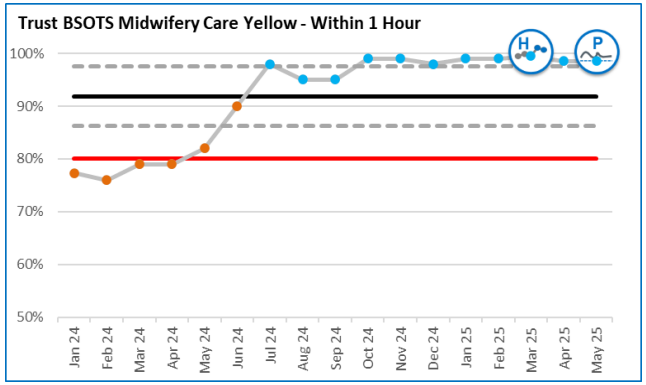
Pregnancy Bookings

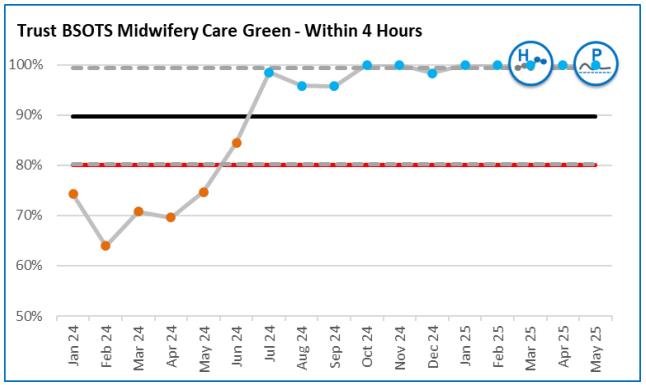
- The number of women choosing to book for care and delivery at the Trust had fallen since January 2024 and although is currently stable there has been no improvement in the number of bookings since the re-opening of the Birthing Centre. The number of bookings is a concern, and whilst reflects the reduced total fertility rate nationally, is also impacted by a reduction in market share. A communication officer will be supporting a project from August 2025 to address this.

Perinatal Quality Surveillance: Triage - Midwifery Care Timings





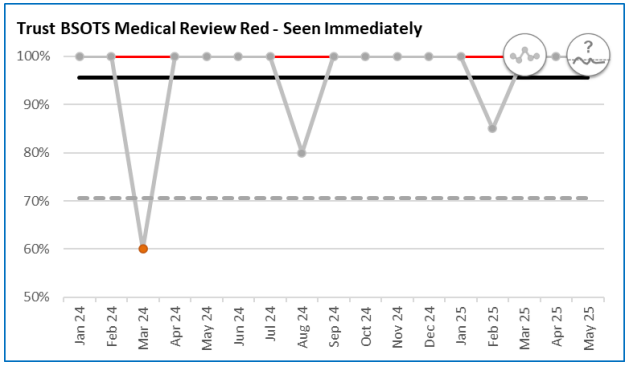


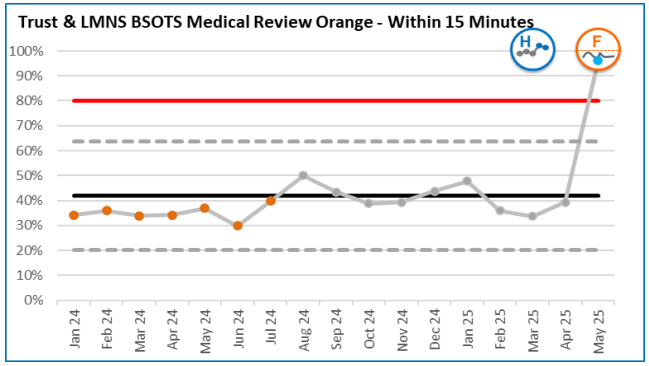


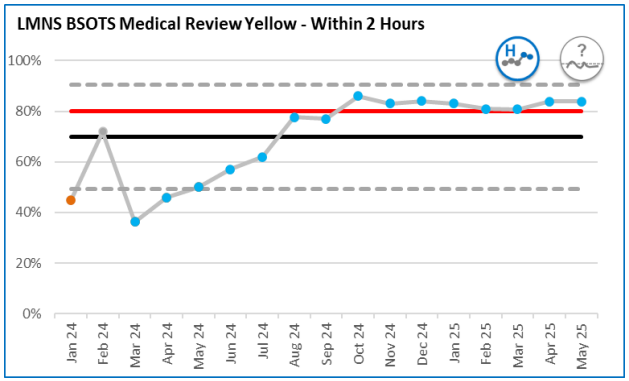
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

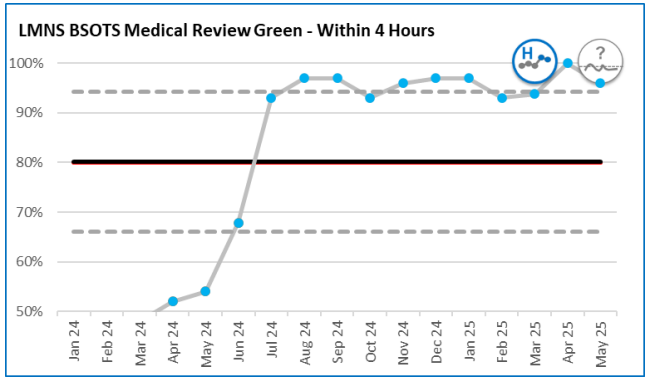
- The Trust implemented the BSOTS triage system in January 2024. Midwifery triage and subsequent review has improved considerably and has exceeded the Trust and LMNS target.
- Good performance continues to be achieved across every category for midwifery review.

Perinatal Quality Surveillance: Triage - Medical Review Timings





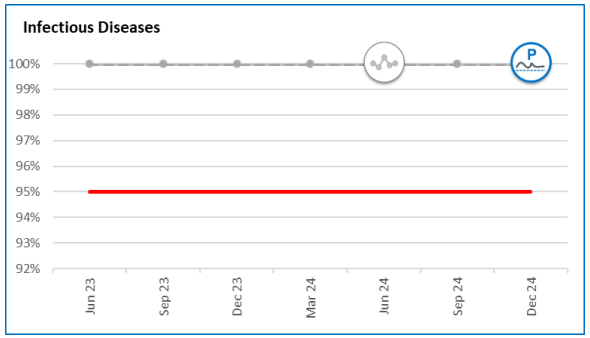


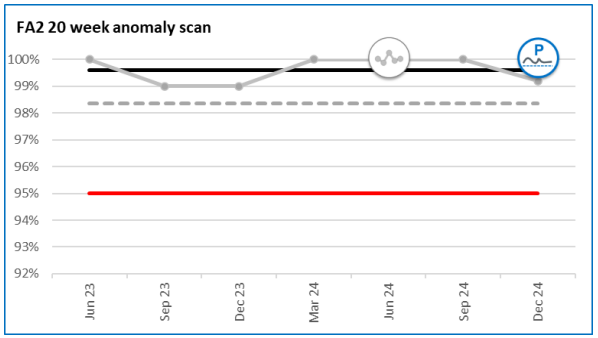


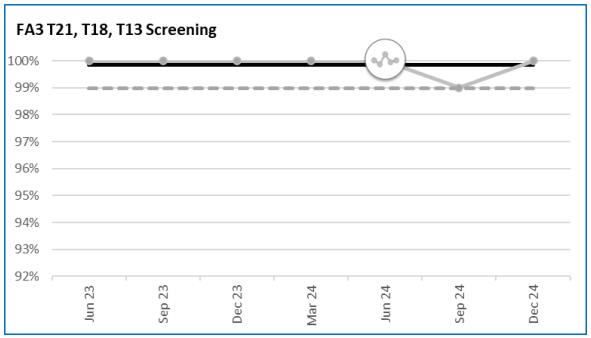
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

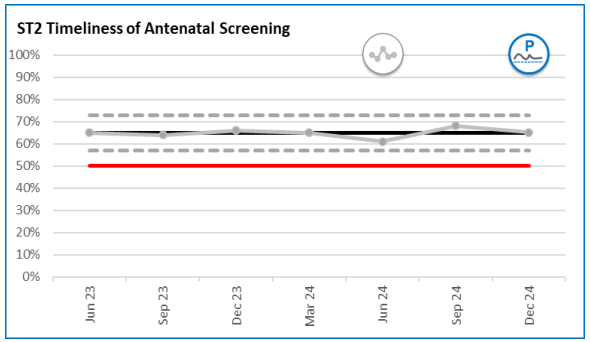
- The Trust has now bench marked performance against the NENC LMNS target for each of the categories. It is worth noting that the timescales for review are longer for women in the yellow category (2 rather than 1 hour) and the targets for compliance lower than those previously set internally.
- The service will continue to aspire to reach the Trust performance target but will be benchmarked against the LMNS target on the NENC Triage Dashboard.
- There has has been significant improvements in performance in the last 12 months.
- A project is underway to commence call recording and capturing patient experience for the triage services.

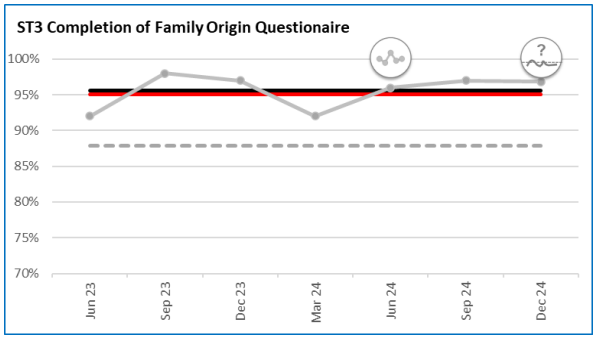
Perinatal Quality Surveillance: Antenatal Screening

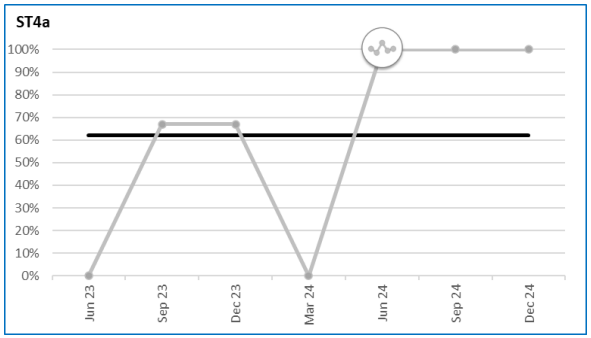


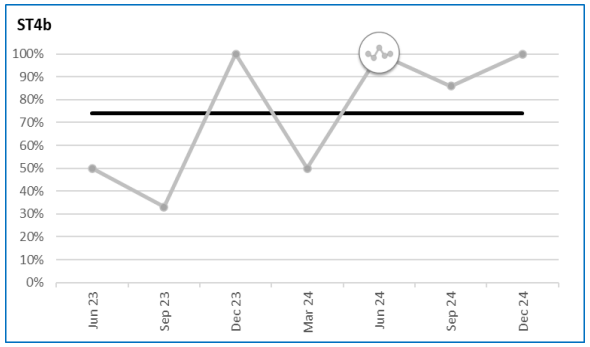


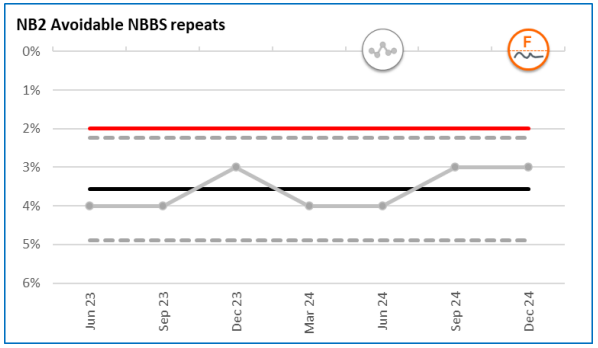








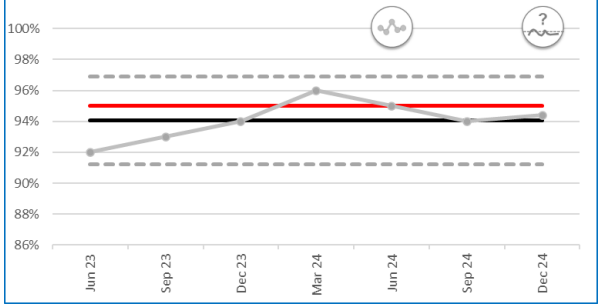




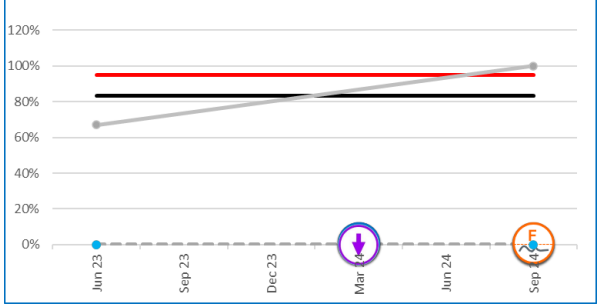
- 3 Patient Safety Incident Investigations (PSII) completed, action plan on track.
- QIP to review antenatal clinic patient flow, failsafe and administration processes underway and making good progress but is impacted by consultant capacity to provide cross cover.

Perinatal Quality Surveillance: NIPE Screening

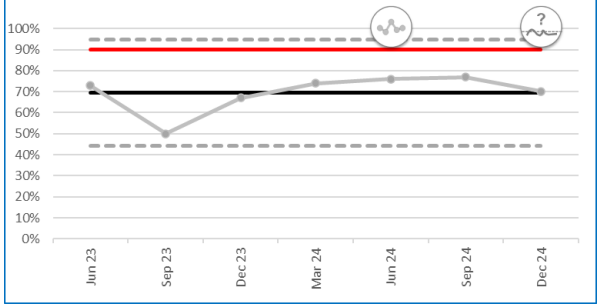
S01 - % screen compliant <72 hrs of age



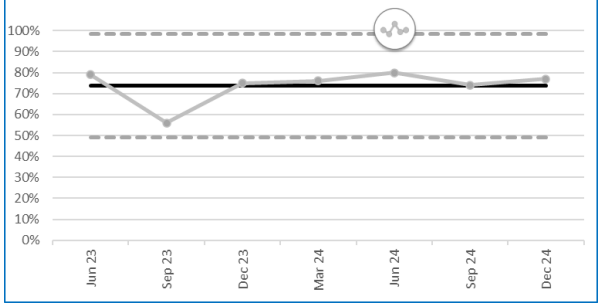
S02 - % eye abnormality suspected/seen <14 days of examination



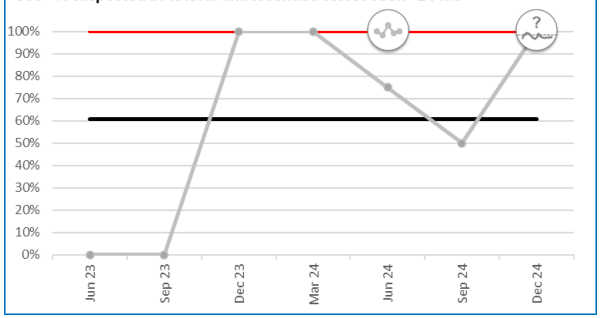
S03 - % hip USS attended between 4-6 weeks



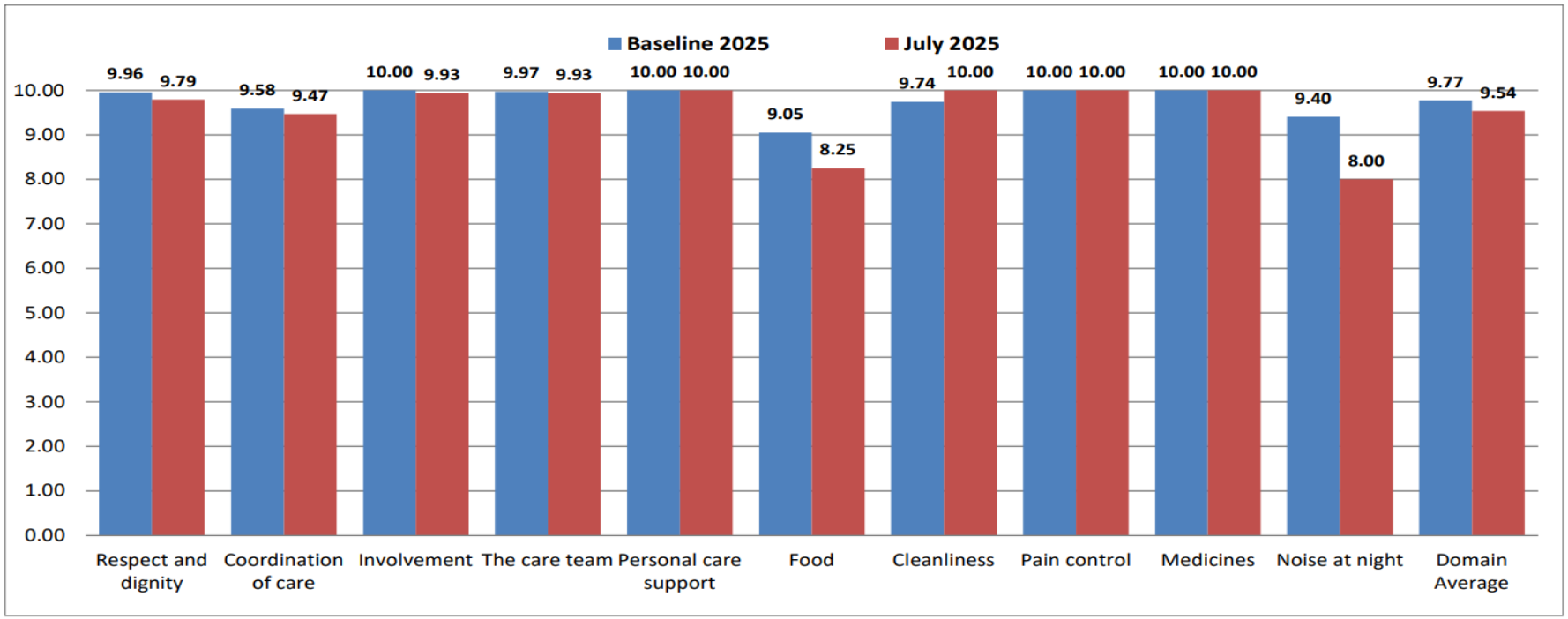
S04 - % of hip referral outcome decision made (<6 weeks corrected age)



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



Perinatal Quality Surveillance: Patient Experience



Patient perspective

- The Real Time patient experience programme has been reintroduced on the Delivery Suite. 92% of patients surveyed rated their overall experience on the ward as either good or very good.

Example comments

- 'I would like more information about timelines with a little more transparency. I understand they have valid constraints though and don't want to promise and then not deliver.'
- 'The care is very consistent. My family have definitely been able to be involved in my care and support. It's been a really positive experience.'
- 'When we first came in it was a little all over the place, but we did arrive during handover. The staff work very well with each other especially after changeover. They're pretty quick at answering the buzzer, they come straight away. They've asked multiple times if I want any more pain relief and they've made sure I'm comfortable. The noise does bother me, but I know it can't be helped.'
- 'The staff have been very consistent.'

Performance

Performance Overview

Metric	Period	Actual	Traj.	Target	Variation	Assurance
A&E Arrival to Admission / Discharge	May-25	79.1%	78.7%	78%	H	?
RTT 18 Weeks	May-25	73.1%	71.1%	92%	H	F
>52 Week Waiters (% of total PTL)	May-25	1.6%	1.5%	1%	L	F
Cancer 28 Day FDS	May-25	80.8%	81.4%	80%		?
Cancer 31 Day	May-25	76.9%	70.1%	96%	L	F
Cancer 62 Day	May-25	69.5%	63.7%	75%	H	F
Diagnostic 6 Weeks	May-25	19.1%	10.6%	5%	L	F

Emergency Care

- Overall 4-hour performance improved in May to 79.1%, the first time the standard has been met since August 2023.
- Emergency Department (ED) Arrival to Discharge >12 hours (Type 1) for May was 1.7%, a significant reduction from the 3.9% recorded in April.

Elective Waits

- May 2025 witnessed a decrease in >52-week waiters at Newcastle Hospitals, falling to 1,455 (-66). The number of >65 week waits also decreased to 108 (-8).
- The total Waiting Lise (WL) size decreased sharply in May, to 89,451, due to participation in an NHS England coordinated validation sprint. The Trust's performance has been one of the strongest nationally. Referral to Treatment (RTT) 18-week performance sat at 73.1%.

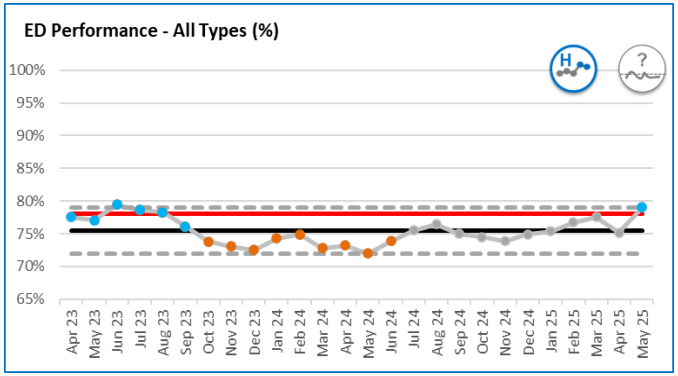
Cancer Care

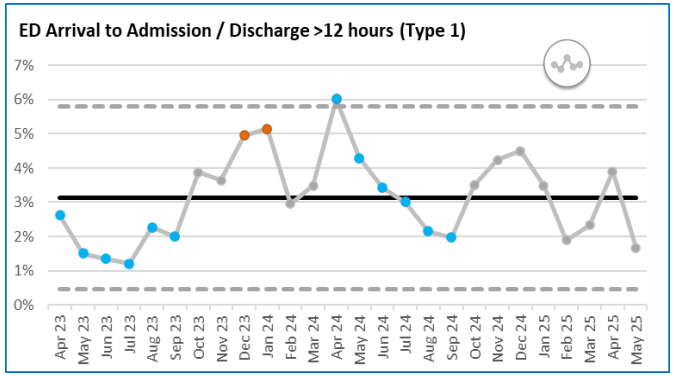
- The 28 Faster Diagnosis Standard (FDS) was achieved for the fourth successive month (80.8%).
- 31 Day performance (76.9%) sustained the marked improvement displayed throughout early 2025 but nonetheless remains outside the control limits and significantly below standard.
- 62 Day compliance for May was 69.5%, consistent with a continuation of improving special cause variation despite an overall consistent failure to hit the target. At the end of May the volume of patients waiting over 62 days for treatment stood at 137.

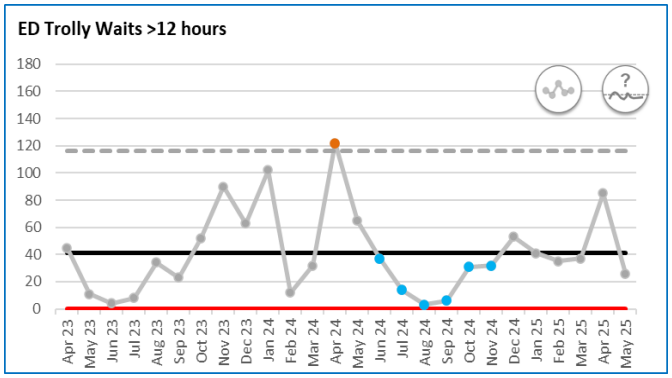
Diagnostics

- Performance against the 5% standard worsened further in May, having improved for the preceding 6 consecutive months. 19.1% of patients were waiting over six weeks at the end of May.

Emergency Care







Standards

- 78% of patients to be admitted/transferred/discharged from Accident and Emergency (A&E) in <4 hours (by March 2026).
- No ambulance handovers to A&E exceeding 60 minutes.
- Reduction from 24/25 in waits over 12 hours from A&E arrival to admission/discharge (Type 1).

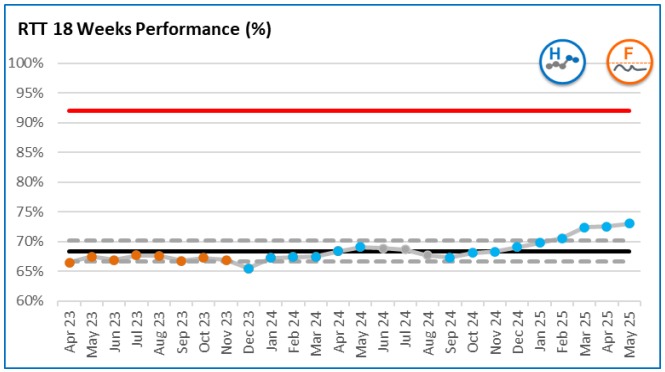
Current position

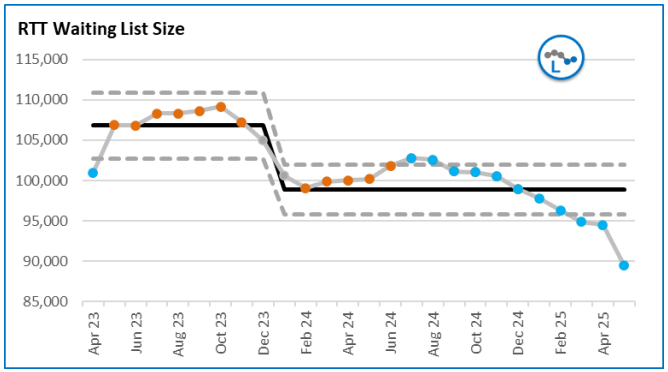
- Whilst April saw a decline in overall performance, this improved in May by increasing to 79.05% (+3.87%). This increase in performance was also impacted by Type 1 breaches, with May reporting 4,128, a reduction of 623 compared to April.
- May also saw a decline in the number of admissions at 8,961. This was a reduction of 94 compared to April 2025.
- Ambulance handovers >60 minutes (mins) in May saw a 3% decrease compared to April at 153, however there was a 6% increase in Ambulance handovers > 30 mins at 623 for May.
- ED trolly waits >12 hours significantly improved in May at 26, compared to April 2025 which was 85 and May 2024 which was 65. This metric remains in line with common cause variation.
- ED Arrival to Admission / Discharge > 12 hours (Type 1) was 1.66% for May, this is a 2.24% improvement in performance compared to April which was 3.90%.

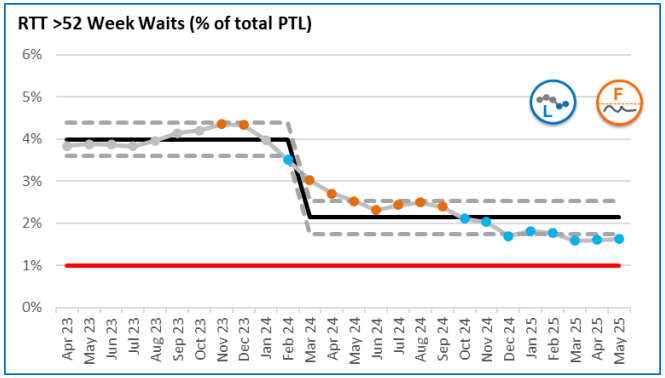
Action taken

- Plans to operationalise the new Urgent Treatment Centre and redesign the front door pathway are ongoing.
- The department are doing work on increasing safety of the waiting room, reducing corridor care and time to nursing assessment continues with oversight from the Emergency Department Quality Improvement Group.
- There is ongoing work around Frailty Same Day Emergency Care to support admission avoidance and utilisation of community services for older people.
- The board has drafted an action plan with regards to improving ambulance handover times and this continues to be monitored.

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.
- <1% of incomplete RTT waits over 52 weeks (by March 2026).
- 72% of patients time to first outpatient appointment <18 weeks (local target of 82.6%).

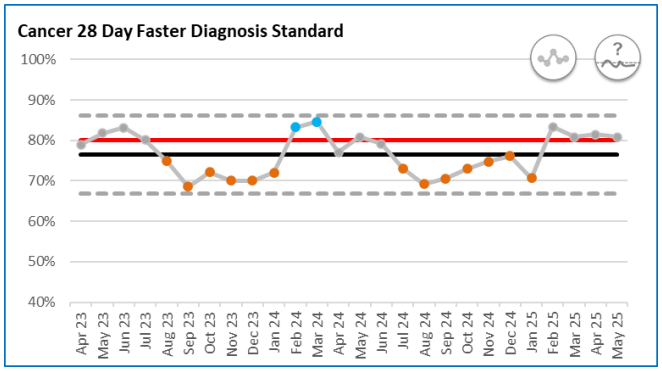
Current position

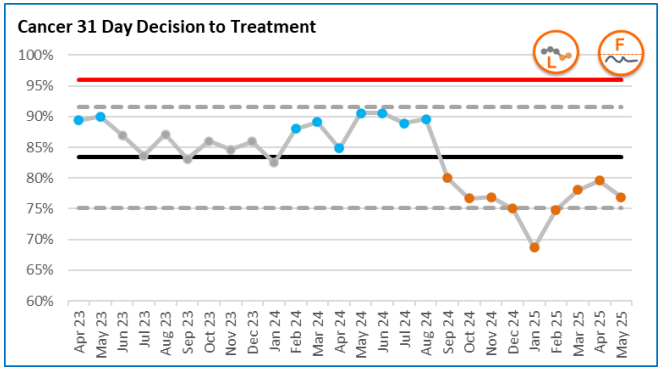
- May 2025 witnessed a decrease in >52-week waiters at Newcastle Hospitals, falling to 1,455 (-66). The number of >65 week waits also decreased to 108 (-8) as the Trust progressed treatment plans for Respiratory Medicine patients who were added to the waiting list following a data error in the Referral Assessment Service (RAS).
- >78-week waiters dropped to 21 (-1) with breaches centred in Spinal Surgery, Trauma & Orthopaedics (T&O), Ophthalmology (corneal grafts) and Respiratory Medicine.
- Despite making huge progress in clearing its longest waiters and now pivoting focus to clearing 52-week waiters and making improvements to the front-end of the RTT pathway, the Trust continues to manage a small number of issues at sub-specialty level impacting 65 and 78-week waiters, including:
    - Capacity issues in North-East Adult Deformity Service exacerbated by a service pause.
    - The Ophthalmology service continue to schedule corneal graft patients in line with tissue availability whilst managing capacity pressures in Squint Surgery and Oculoplastics.
- The total WL size decreased sharply in May, to 89,451, due to participation in an NHS England coordinated validation sprint. The Trust's performance has been one of the strongest nationally.

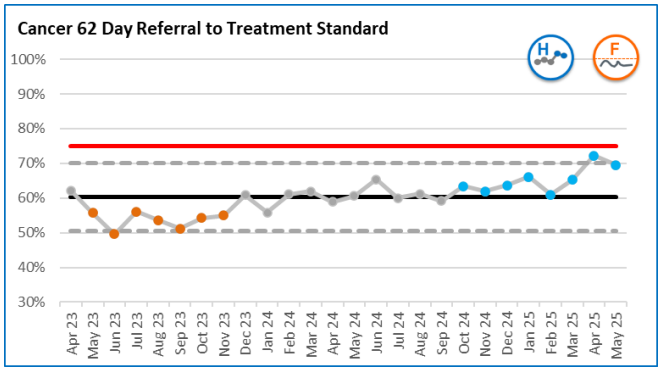
Action taken

- 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.
- Waiting List Initiative (WLI) clinics are in place in Respiratory Medicine to treat long waiters, with harm reviews being completed to evaluate any potential negative impact on patients.
- Ophthalmology are commencing conversations with the Peri-Op & Critical Care clinical board and other specialties to secure additional theatre capacity for Paediatric Squint patients.

Cancer Care







Standards

- FDS - 80% of patients on a suspected cancer or breast symptomatic pathway to receive results/diagnosis within 28 days of referral (by March 2026).
- 96% to wait no more than 31 days from diagnosis to first cancer treatment.
- 75% of patients to wait no more than 62 days from urgent/screening referral to first cancer treatment (by March 2026).

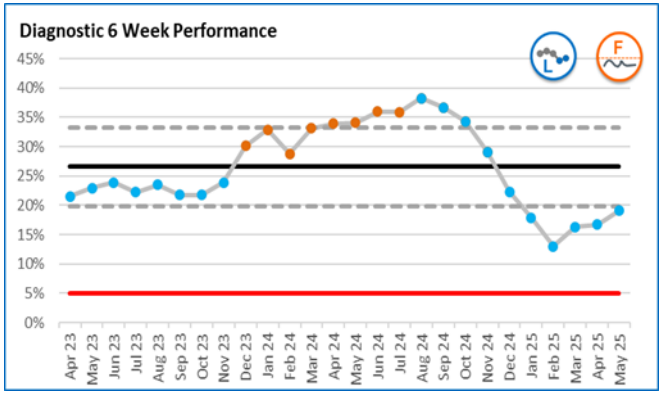
Current position:

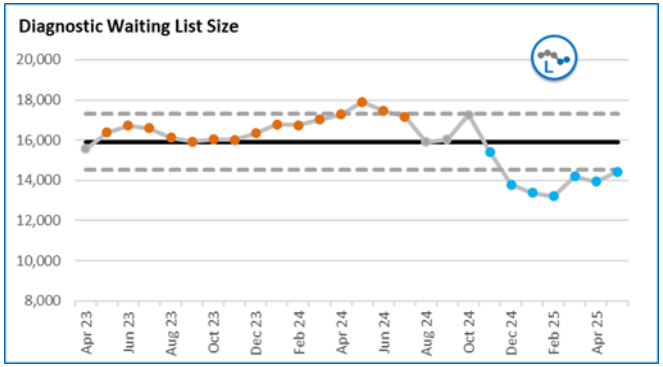
- In May, the 80% 28 FDS was achieved for the fourth successive month (80.8%).
- 31 Days (76.9%) has sustained improvements made over the early part of 2025, but the service continue to recover from increasing referrals and capacity shortfalls due to retirements/turnover.
- 62 Day compliance for May was 69.5%, consistent with a continuation of improving special cause variation despite an overall consistent failure to hit the target. At the end of May the volume of patients waiting over 62 days for treatment stood at 137, an increase compared to previous months.
- Performance against all standards, even where short of the national standard, continues to exceed internal trajectories and Tier 2 exit criteria thresholds.

Action taken

- Breast Symptomatic – mutual aid for Durham patients continue to be managed with resolution expected soon.
- Oesophago-gastro (OG) – combined gastrointestinal (GI) 2 week wait (WW) nurse led service embedded speeding up the beginning of the pathway, existing consultant is being trained in Endoscopic Mucosal Resection (EMR) and a new EMR consultant has started and the positive impact on EMR capacity is expected from July onwards.
- Lung – nodule clinic established to ensure non-cancers are removed from cancer capacity (creates an additional 10 outpatient appointments (OPAs) per week), risk stratification of referrals implemented.
- Radiotherapy - actions to address backlog and scheduling issues include employing an additional scheduler, training for physics staff to enable increased sign off of dosing plans, and a review of protocols to shorten pathways where appropriate. A joint meeting between Getting It Right First Time (GIRFT), Specialised Commissioning and the Cancer Programme will shortly take place to discuss strategies for improving radiotherapy performance.

Diagnostics





6 Week Diagnostic Performance by Modality – May 2025			
MRI	21.0%	CT	10.4%
Non-obs US	11.4%	DEXA	3.1%
Audiology	16.3%	ECHO	65.6%
Electrophysiology	0.0%	Neurophysiology	0.5%
Sleep Studies	77.6%	Urodynamics	44.7%
Colonoscopy	17.2%	Flexi-Sig	14.4%
Cystoscopy	26.9%	Gastroscopy	27.7%
Newcastle Hospitals Total			19.1%

Standards

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

Current position:

- Performance against the 5% standard worsened in May for the third successive month, having improved for the preceding 6 consecutive months. 19.1% of patients were waiting over six weeks at the end of May. The target continues to be consistently failed but there is special cause variation of an improving nature after considerable improvement in the second half of 2024/25.
- Sleep Studies (77.6%) and Echo (65.6%) remain the areas with the most challenged performance.
- Numerous services saw activity impacted in April and May due to bank holidays and staff leave.
- The waiting list grew by 482 patients in May, with Non-obstetric Ultrasound contributing most of this growth. The waiting list is however circa 20% smaller than in May 2024 (3,483 fewer patients).
- There were 632 patients waiting >13 weeks at the end of May, similar to April. Magnetic Resonance Imaging (MRI) (219) and Echo (219) have the most >13 week waiters.

Action taken

- Radiology have successfully recruited 6 radiographers, 3 Radiologists and an Ultrasound Manager
- MRI are looking to utilise additional capacity at the Metrocentre Community Diagnostic Centre (CDC) to keep up with demand.
- Regular weekend Neuroradiology General Anaesthetic (GA) MRI lists are being run to address the >13 week waiters.
- Neuroradiology are piloting numerous improvement schemes including changing booking protocols to sustainably increase the number of patients seen per scanner per day.
- Digital issues for Echo have been escalated through the Quality and Performance review process, with digital colleagues prioritising a resolution to the service.
- More nurse endoscopists are being trained in undertaking Colon & OGD oesophago-gastro duodenoscopy (OGD) double procedures to provide a long term sustainable solution and address a current backlog. In the short term WLI, backfilling of cancelled lists and outsourcing will cover capacity.
- Sleep Studies activity should increase as new equipment has been installed and staff have been trained, particularly with the upcoming school summer holidays when additional activity is being planned.
- A CDC Oversight Group has been established internally at the Trust to strengthen governance and ensure increased utilisation of this capacity. The group includes executive representation, as well as operational managers, IT, Finance, Contracting and Performance. Actions are also being taken to increase the visibility of CDC utilisation data within various Trust forums.

Contractual & Planning Standards (1/2)

Theme	Standard	Trajectory (May-25)	Feb-25	Mar-25	Apr-25	May-25	Num.	Den.	25/26 YTD
Activity									
Day Case	**100%** of 25/26 Plan (equivalent to 118% of 19/20 value-weighted activity)	N/A	100.6%	98.3%	103.3%	**103.0%**	10,934	10,620	**103.1%**
Elective Overnight			95.5%	97.6%	102.4%	**103.2%**	1,789	1,733	**102.8%**
Outpatient New			97.6%	92.8%	100.1%	**100.2%**	24,783	24,724	**100.2%**
Outpatient Procedures			107.7%	105.5%	99.2%	**96.9%**	20,538	21,188	**98.1%**
Outpatient Review	N/A		118.3%	115.0%	111.5%	**112.1%**	65,861	58,758	**111.8%**
Non-Elective			91.4%	91.1%	86.5%	**86.1%**	931	1,081	**86.3%**
Emergency			108.8%	108.3%	105.2%	**105.6%**	6,469	6,128	**105.4%**
Diagnostic Activity	**100%** of 25/26 Plan	N/A	103.9%	103.6%	103.7%	**102.1%**	21,172	20,734	**102.9%**
PIFU Take-up (%)	>=**5%** of all OP atts. (by Mar-29)	**2.8%**	2.4%	2.5%	2.6%	**2.5%**	2,887	117,495	**2.5%**
Day case rates (BADS procedures)	**85%**	N/A	88.3%	88.2%	82.8%	**78.5%**			
Capped Theatre Utilisation	**85%**	N/A	81.3%	**79.7%**	TBC	TBC			
Urgent Ops. Cancelled Twice	**Zero**	N/A	0	0	0	**0**	0		**0**
Cancelled Ops. Rescheduled >28 Days	**Zero**	N/A	11	16	5	**3**	3		**8**
Elective Waits									
RTT Waiting List Size	**Reduction** from 24/25	**95,576**	96,323	94,893	94,496	**89,451**	89,451		
RTT 18 Week Wait	**92%**	**71.1%**	70.6%	72.4%	72.6%	**73.1%**	24,094	89,451	**72.8%**
>78 Week Waiters	**Zero**	**0**	16	13	22	**21**	21		
>65 Week Waiters	**Zero**	**0**	157	88	116	**108**	108		
>52 Week Waiters	N/A	**1423**	1,707	1,505	1,521	**1,455**	1,455		
>52 Week Waiters (% of Total WL)	**<1% of total WL** (by Mar-26)	**1.5%**	1.8%	1.6%	1.6%	**1.6%**	1,455	89,451	**1.6%**
>12 Week Waiters Validated	**90%**	N/A	82.2%	90.3%	96.1%	**96.3%**	23,500	24,396	**96.2%**
Time to First Outpatient Appointment (18 Weeks)	**72%** (local target of **82.6%**)	**77.9%**	77.7%	79.3%	78.3%	**79.0%**	43,454	54,972	**78.7%**
RTT Waiting List (Children & Young Persons <=18 yrs)	N/A	**12,616**	16,298	16,439	16,731	**16,111**	16,111		
>52 Week Waiters (Children & Young Persons <=18 yrs)		**123**	174	170	192	**204**	204		
Community Services Waiting List	N/A	N/A	10,855	11,193	**10,818**	TBC	10,818		
Community Services >52 Week Waiters			623	571	**569**	TBC	569		
Diagnostic 6 week wait	<=**5%** (local target of **<=11.4%**)	**10.6%**	13.0%	16.3%	16.7%	**19.1%**	2,758	14,428	**17.9%**

Contractual & Planning Standards (2/2)

Theme	Standard	Trajectory (May-25)	Feb-25	Mar-25	Apr-25	May-25	Num.	Den.	25/26 YTD
Cancer Care									
28 Day Faster Diagnosis	**80%** (by Mar-26)	**81.1%**	83.4%	80.9%	81.4%	**80.8%**	2,212	2,738	**81.1%**
31 Days (DTT to Treatment)	**96%**	**68.1%**	74.8%	78.1%	79.6%	**76.9%**	1,028	1,337	**78.3%**
62 Days (Referral to Treatment)	**75%** (by Mar-26)	**62.6%**	61.0%	65.2%	72.2%	**69.5%**	283	407	**70.9%**
>62 Day Cancer Waiters	**N/A**	**N/A**	165	112	106	**137**	137		
Urgent & Emergency Care									
A&E Arrival to Admission/Discharge (All types)	**>=78%** under 4 hours (by Mar-26)	**78.7%**	76.7%	77.5%	75.2%	**79.1%**	16,368	20,704	**77.2%**
A&E Arrival to Admission/Discharge (Type 1)	**Reduction** from 24/25	**2.5%**	1.9%	2.3%	3.9%	**1.7%**	209	12,515	**2.8%**
A&E Decision to Admit to Admission >12 Hours	**Zero** over 12 hours	**N/A**	35	37	85	**26**	26		**111**
Adult General & Acute Bed Occupancy	**<=92%**	**93.6%**	91.4%	90.3%	89.9%	**88.4%**	1,255	1,420	**89.1%**
Ambulance Handovers <15 mins	**65%**	**N/A**	45.8%	46.5%	45.5%	**43.3%**	1,456	3,360	**44.4%**
Ambulance Handovers <30 mins	**95%**		82.8%	82.1%	77.2%	**76.9%**	2,584	3,360	**77.1%**
Ambulance Handovers >60 mins	**Zero**		64	97	157	**153**	153		**310**
Urgent Community Response Standard	**>=70%** under 2 hours	**N/A**	74.7%	74.4%	82.9%	**81.1%**	304	375	**82.1%**
Safe, High Quality Care									
Mixed Sex Acommodation Breach	**Zero**	**N/A**	60	90	74	**61**	61		**135**
VTE Risk Assessment	**95%**		**97.9%**		TBC	TBC			
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour		**72.0%**		TBC	TBC			
Sepsis Screening Treat. (All)			**82.0%**		TBC	TBC			

People

People Overview

Metric	12-Month Rolling	Actual	Target	Variation	Assurance
Sickness	May-25	5.55%	4.5%		F
Short-term	May-25	1.65%			
Long term	May-25	3.55%			
Turnover	May-25	8.63%	10%	L	P
Mandatory training	May-25	91.64%	90%	L	P
Appraisal	May-25	85.99%	90%		F
Disabled staff	May-25	6.04%		H	
Ethnicity (BAME staff)	May-25	17.95%		H	

Staff in post (Whole time equivalent (WTE))

- May is 15,833 Full time equivalent (FTE) including bank and agency (15,425 excluded), 16,893 headcount. Above pre-Covid by 2,394 FTE (18%), above workforce plan by 86.21 FTE (0.55%).
- Clinical staff (excluding Medical & Dental) highest increase +1,300 FTE (15%).

Sickness

- 12-month rolling average remained the same at 5.55%.
- Top reasons for sickness: anxiety/stress/depression 31%; other musculoskeletal problems 13%; gastrointestinal problems 10%,
- Short-term sickness improved in May -0.05% to 1.65%.
- Long term sickness improved in May -0.26% to 3.55%.

Retention & Turnover

- 12-month rolling average improved -0.14% to 8.63%.
- Top reason for leaving: relocation at 14.49%.
- Top destinations: no employment 38.68%; other NHS organisation 34.22% (includes retire-return).

Mandatory training

- Performance dropped -0.81% to 91.64%.
- Lowest is Medical and Dental – improved +0.19% to 81.55%.
- Eight courses are below 80%.

Appraisal

- Performance improved 2.01% to 85.99%.

Equality & Diversity

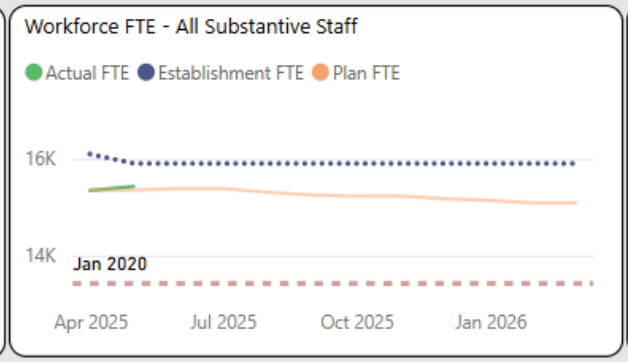
- Disabled staff increased +0.08% to 6.04%, BAME staff +0.20% to 17.95%.

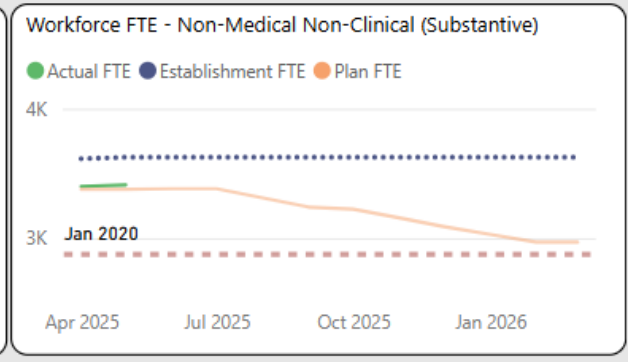
Provider Workforce Return (PWR)

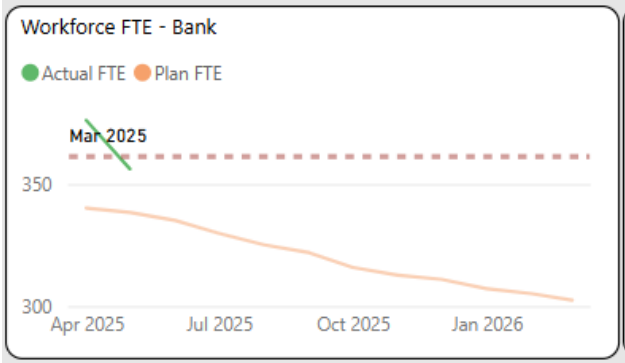
Headline Metric	Jan 2020 FTE	Plan FTE	Establishment	Current FTE	Current FTE v Jan 2020	Current FTE v Plan	Current FTE v Establishment
1. Total Non Medical - Clinical Substantive Staff	8,684.15	9,970.82	10,270.39	9,983.97	1,299.81	13.15	-286.42
2. Total Non Medical - Non-Clinical Substantive Staff	2,874.99	3,377.93	3,625.09	3,411.47	536.48	33.54	-213.62
3. Total Medical and Dental Substantive Staff	1,732.92	1,957.02	1,995.42	1,981.70	248.78	24.68	-13.72
4. Any other Staff (substantive staff)	146.48	44.10	14.00	47.90	-98.58	3.80	33.90
5. Bank		338.33		356.20		17.86	
6. Agency		58.59		51.77		-6.82	
Total	**13,438.55**	**15,746.80**	**15,904.90**	**15,833.01**	**1,986.49**	**86.21**	**-479.86**

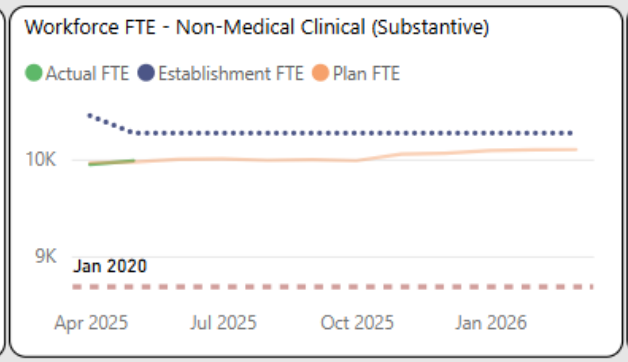
Current Position:	Underlying Issues	Actions Undertaken:
• The workforce is 2,394 FTE above the January 2020 (pre-Covid) position and 86.21 FTE above the 2025-26 workforce plan as-at May. • NHS infrastructure support (substantive) is 33.54 FTE above plan. • All substantive staff metrics are above plan. • Bank is above plan. • Agency is below plan.	• Substantive category staff have grown month on month since July 2024 – from 14,896.67 FTE (July 2024) to 15,425.04 FTE (May 2025). • An increase of 528.37 FTE. • The underlying trend in Bank and agency use is down. • Need to maintain safe services (e.g. Healthcare assistants for enhanced care). • Impact on staffing numbers from awayness due to long term sickness absence and maternity leave.	• Workforce plan for 2025/26 has total target reduction of 2% (320 FTE) split 160 FTE natural wastage and 160 FTE voluntary severance with up to 80 FTE of voluntary severance anticipated from Corporate Services. • A voluntary severance scheme was run 6-20 June 2025. 205 applications were received and are going through the decision-making process. • The outcome of voluntary severance is subject to necessary internal and external approvals being in place which could take up to 8 weeks. • Temporary vacancy freeze on jobs in Corporate Services in place. • Greater scrutiny of staffing, vacancies, systems and practices in place to identify potential opportunities to reduce costs by redesigning services and/or taking advantage of technology whilst protecting quality and safety.

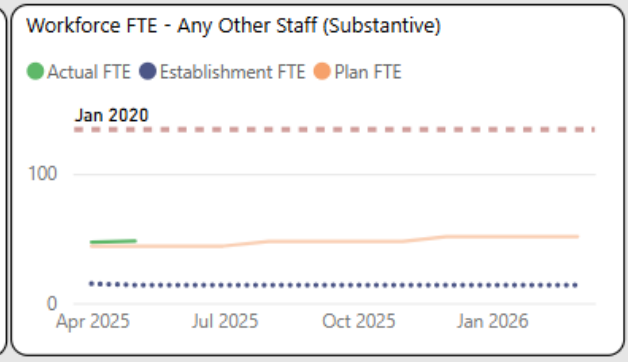
Provider Workforce Return (PWR) – Staff Groups (1/3)

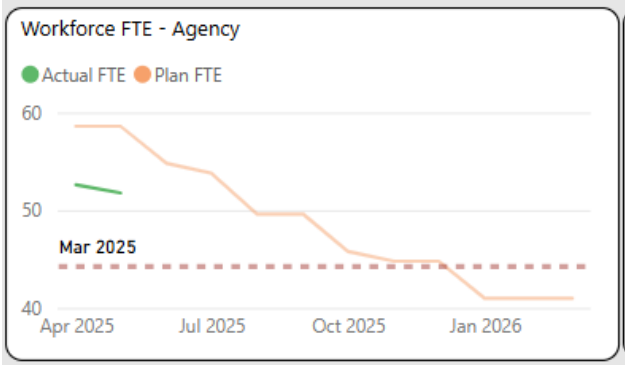


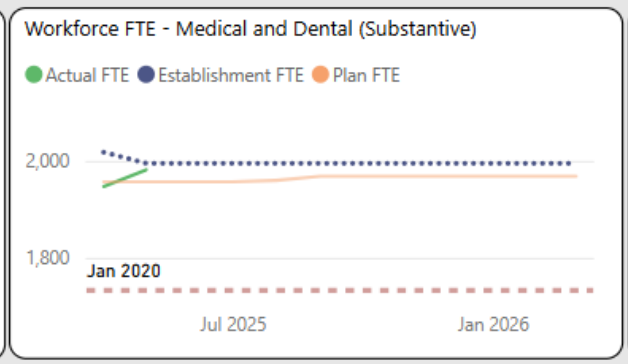


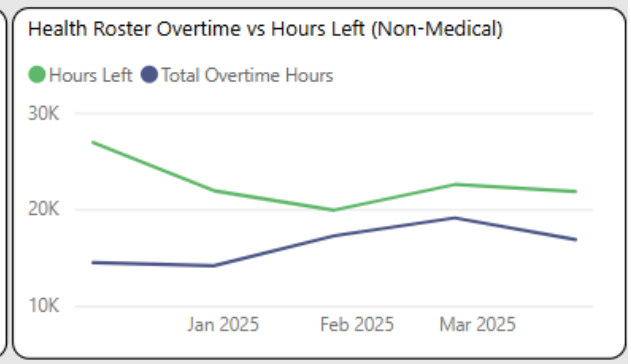










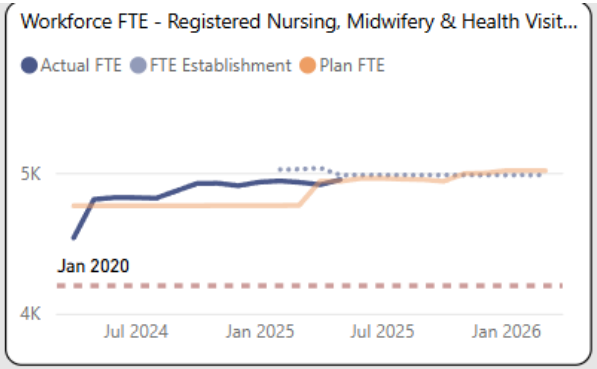


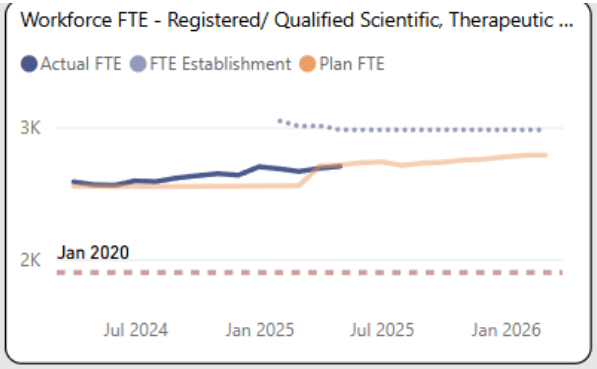
**Please note: The charts on this page include LET data

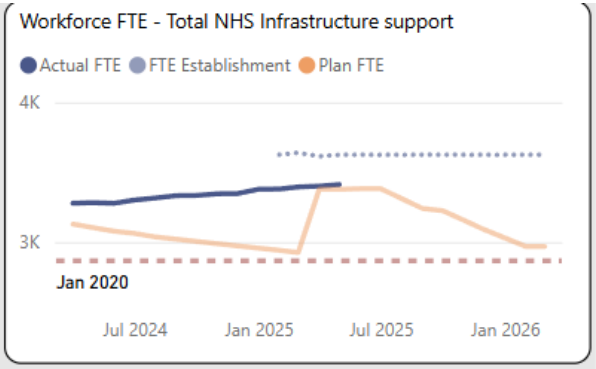
Provider Workforce Return (PWR) – Staff Groups (2/3)

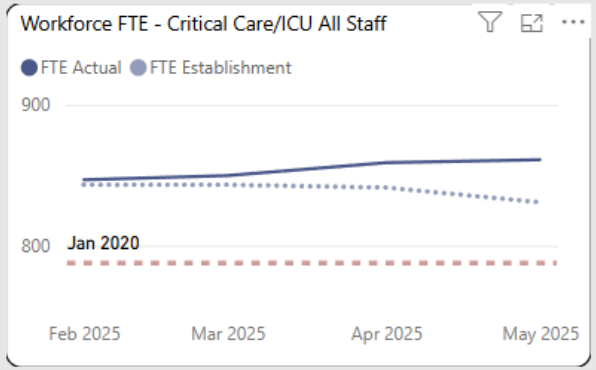
Sub Categories Metric	Jan 2020 FTE	Plan FTE	Establishment	Current FTE	Current FTE v Jan 2020	Current FTE v Plan	Current FTE v Establishment
1. Registered Nursing, Midwifery and Health visiting staff (substantive total)	4,202.08	4,940.17	4,983.74	4,950.92	748.84	10.75	-32.82
2. Registered/ Qualified Scientific, Therapeutic and Technical Staff (substantive total)	1,993.02	2,357.25	2,490.40	2,352.06	359.04	-5.19	-138.34
3. Support to Clinical staff (substantive total)	2,489.06	2,673.40	2,796.25	2,680.99	191.94	7.59	-115.26
4. Total NHS Infrastructure Support (includes A&C, estates, managers) (substantive total)	2,874.99	3,377.93	3,625.09	3,411.47	536.48	33.54	-213.62
5. Total Medical and Dental (substantive total)	1,732.92	1,957.02	1,995.42	1,981.70	248.78	24.68	-13.72
6. Any other Staff (substantive total)	146.48	44.10	14.00	47.90	-98.58	3.80	33.90
7. Bank Any other staff		0.00				0.00	
7. Bank Medical and dental		16.48		42.15		25.67	
7. Bank Registered nursing, midwifery and health visiting staff		86.68		87.34		0.66	
7. Bank Registered/ Qualified Scientific, Therapeutic and Technical staff		11.98		9.95		-2.04	
7. Bank Support to clinical staff		191.56		190.09		-1.47	
7. Bank Total NHS infrastructure support		31.63		26.66		-4.97	
8. Agency Any other staff		0.00				0.00	
8. Agency Medical and dental		7.78		9.24		1.46	
8. Agency Registered nursing, midwifery and health visiting staff		5.53		3.57		-1.96	
8. Agency Registered scientific, therapeutic and technical staff		7.16		4.61		-2.55	
8. Agency Support to clinical staff		36.90		34.35		-2.55	
8. Agency Total NHS infrastructure support		1.22				-1.22	
Total	**13,438.55**	**15,746.80**	**15,904.90**	**15,833.01**	**1,986.49**	**86.21**	**-479.86**

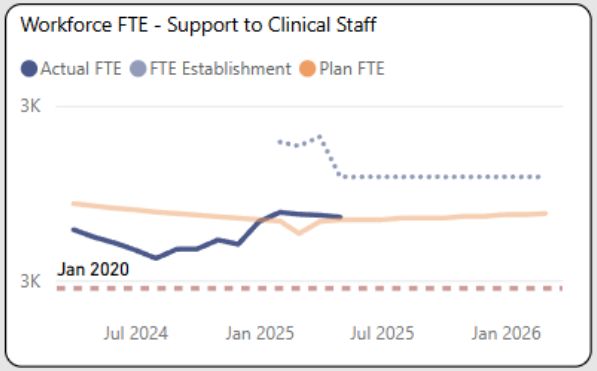
Provider Workforce Return (PWR) – Staff Groups (3/3)

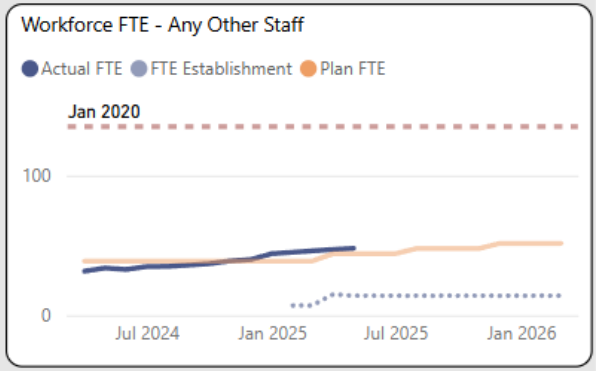


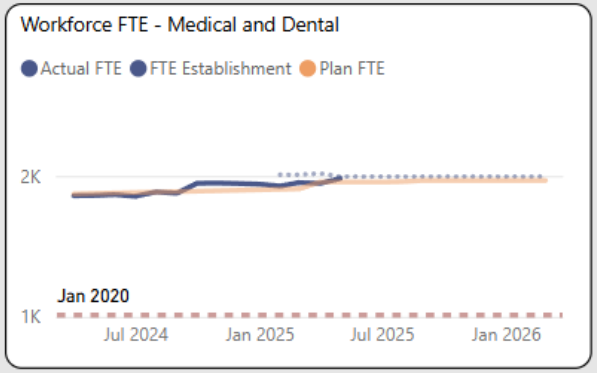












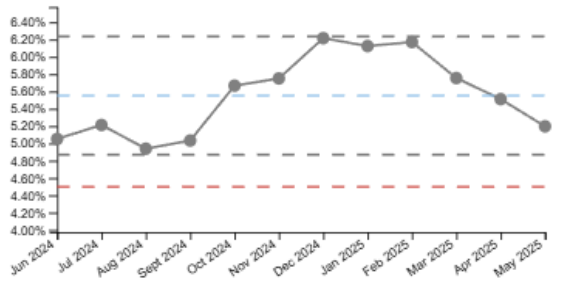
**Please note: The charts on this page include LET data

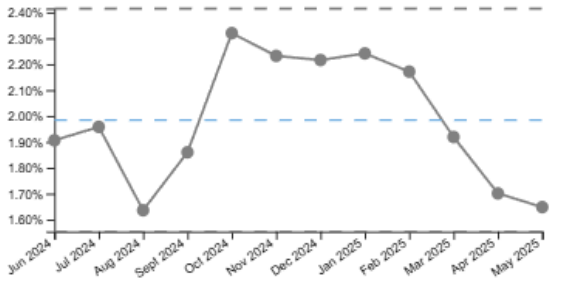
Sickness Absence

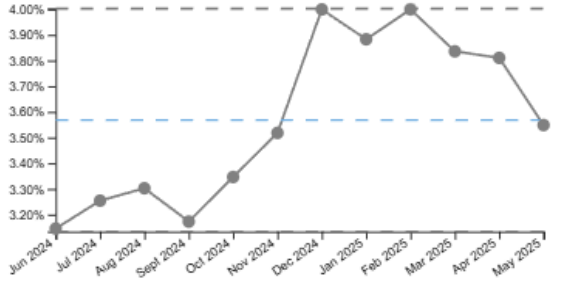
Trust Sickness %	12-Month Rolling	Value	Target
	May 25	5.55%	4.50%

Metric	Value
Short Term Sickness %	1.65%

Metric	Value
Long Term Sickness %	3.55%







Current Position:

- 12-month average to May 5.55%.
- May total sickness 5.20%:
  - short-term 1.65%
  - long-term 3.55%
- Top reasons for sickness:
  - Anxiety/stress/depression (S10) 31%
  - Other musculoskeletal problems 13%
  - Gastrointestinal problems 10%
- Areas with highest levels of S10 in last 12 months: Clinical & Diagnostic Services; Family Health; Medicine/ED; Peri-operative & Critical Care; Estates; Business & Development; Human Resources (HR); Information Technology; Patient Services

Underlying Issues

- Anxiety/stress/depression (S10) is main reason for sickness absence and has had an underlying upward trend since May 2023. Areas report that an amount of S10 is attributed to stressors outside of work.
- Total days lost: 293,543 FTEs.
- Average time lost per person: 20 days.
- Total cost of sick pay: £32.2m.
- Variation in sickness rates across Clinical Boards:
  - Lowest – Clinical and Diagnostic Services at 4.39% (short-term 1.25%, long term 2.68%)
  - Highest – Peri-operative and Critical Care at 6.46% (short-term 1.71%, long term 4.89%)

Actions Undertaken:

- Health and Wellbeing Offer (HAWB) offer – task and finish group in place to operationalise offer. Mental Health First Aider refresher training 7 July with steps in place to recruit/train 300.
- Target number of health champions to be in place for each Clinical Board/Corporate Service.
- New HAWB policy to be implemented.
- Occupational Health – online portal for first day referrals in place and will be expanded for all referrals from August onwards.
- 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.

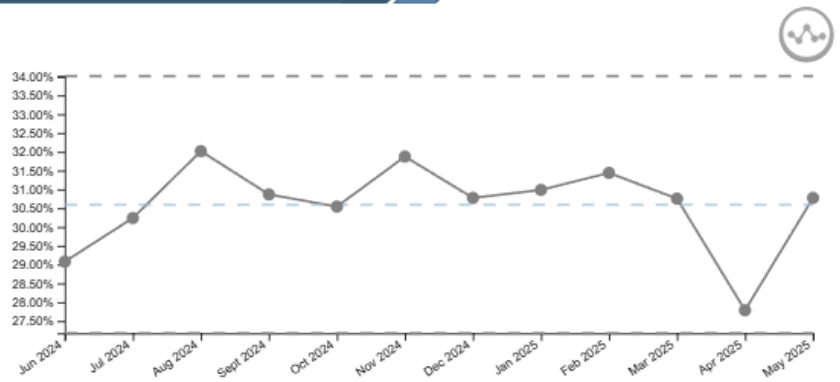
Sickness Absence – Absence reasons (1/2)

Trust Sickness %	12-Month Rolling	Value	Target
	May 25	5.55%	4.50%

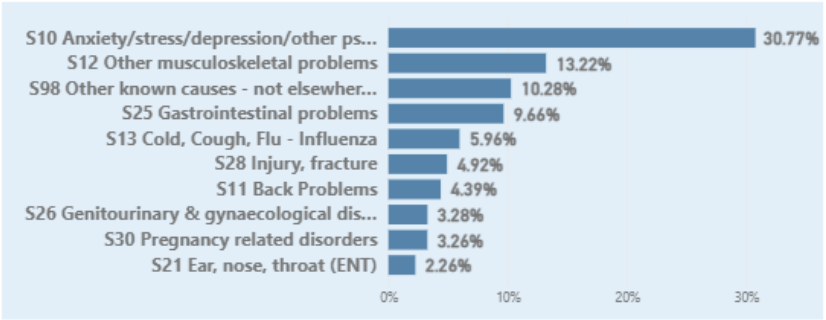
Sickness Reasons - SPC

S10 - Anxiety/stress/depression/ other psychiatric illness

30.77%

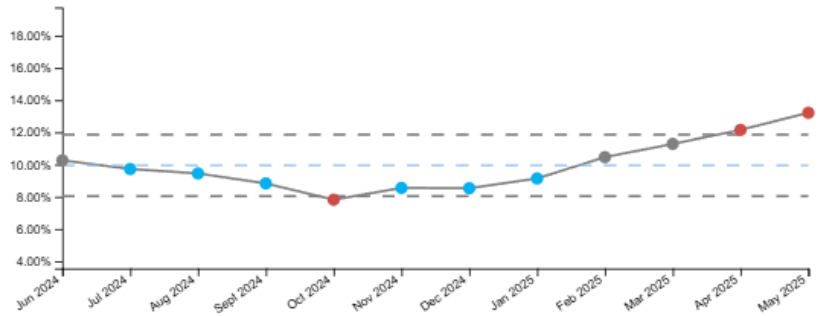


Top 10 Sickness Abscences



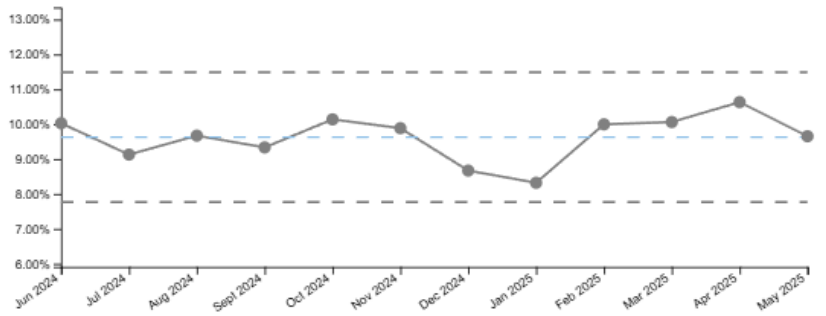
S12 - Other musculoskeletal problems

13.22%

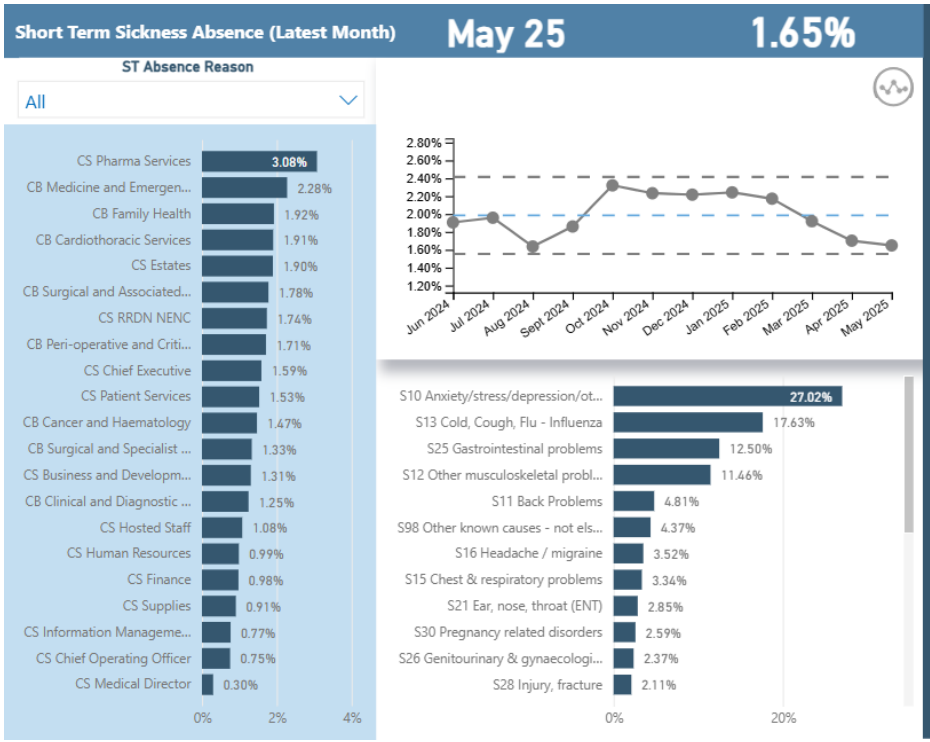


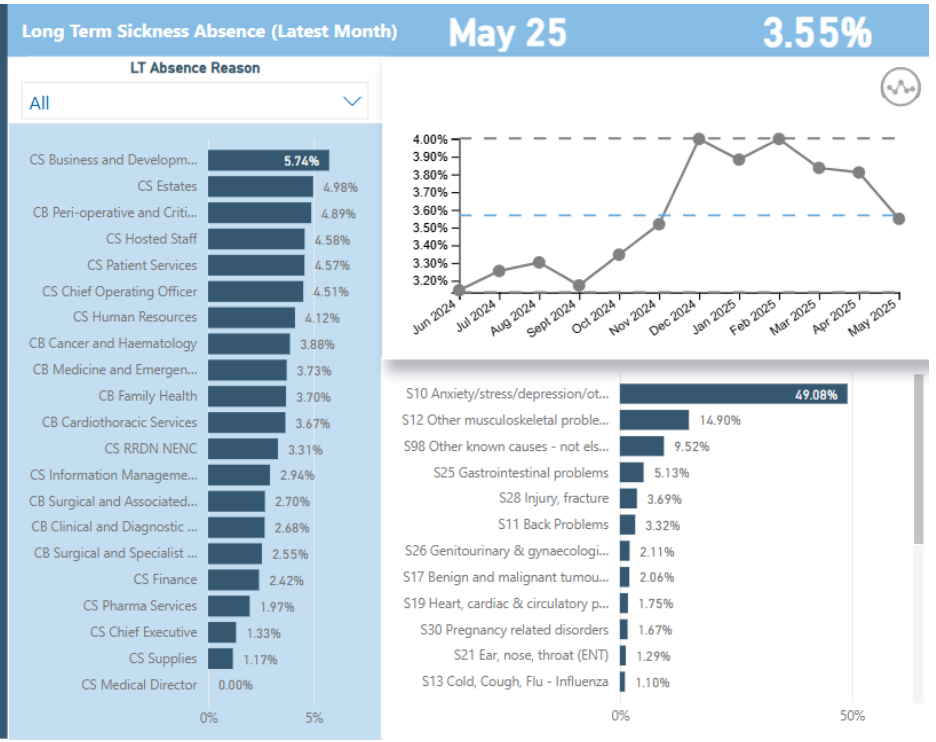
S25 - Gastrointestinal problems

9.66%



Sickness Absence – Absence reasons (2/2)





Sickness – FTE working days lost & Formal Action

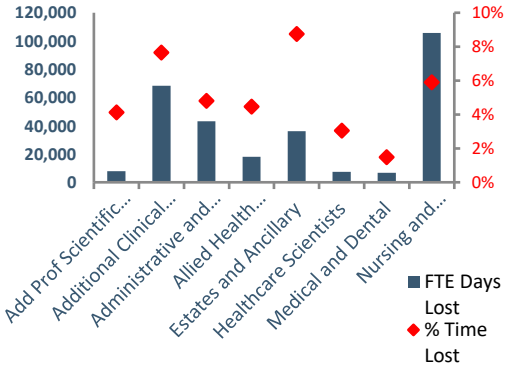
Sickness - FTE working days lost

FTE working days lost due to sickness

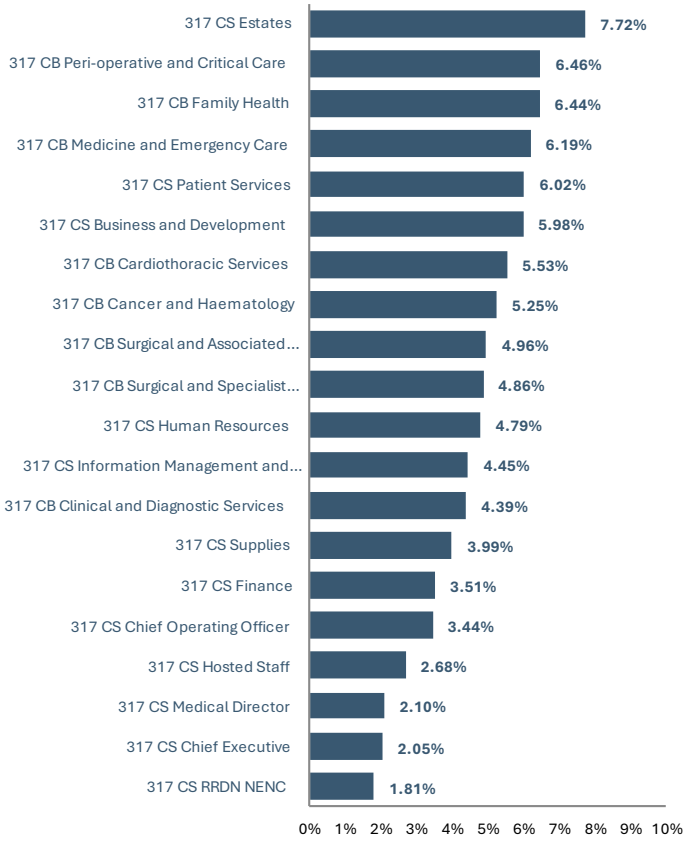
293,543

273,543 compared to the previous year.

Sickness absence by staff group



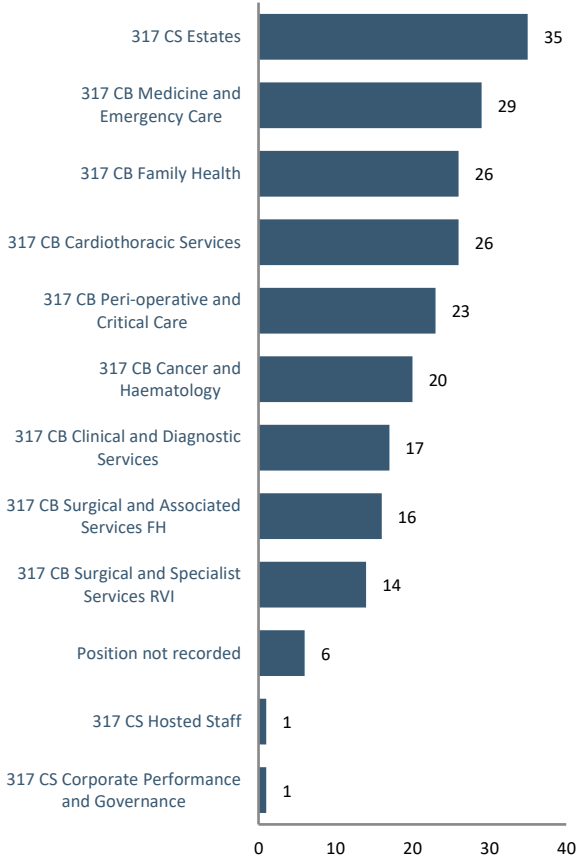
Sickness Absence (% Time Lost) by Clinical Board



Sickness - Formal Action

Latest Data - March 2025

Attendance Management – Formal Action by Clinical Board/ Corporate Service

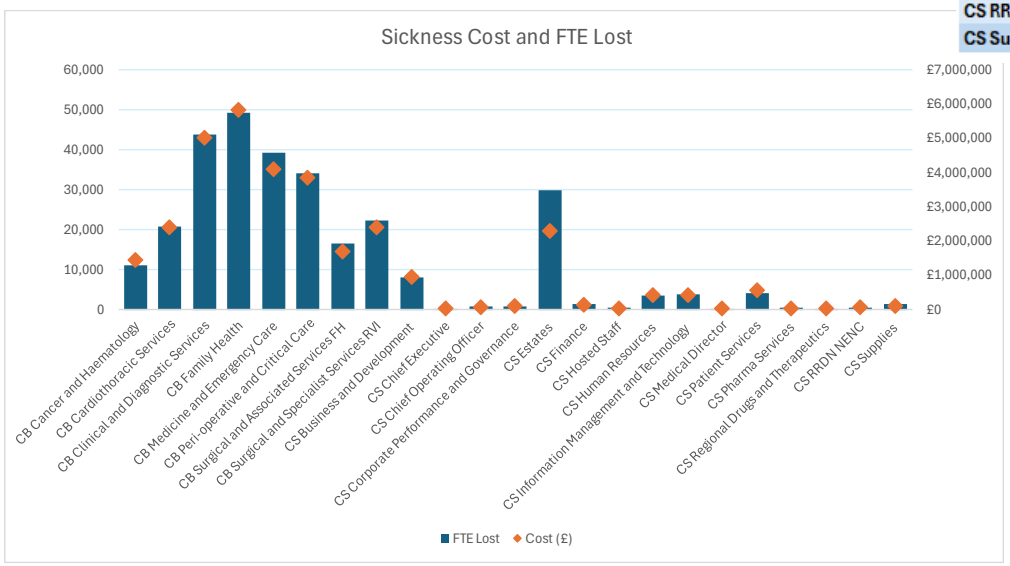


Sickness – FTE working days lost & Cost of sickness

Sickness Absence	12-Month period ending	Cost (£)	FTE Lost	Ave. No of Days Lost per FTE
	May25	£32,224,837	293,543.37	20.25

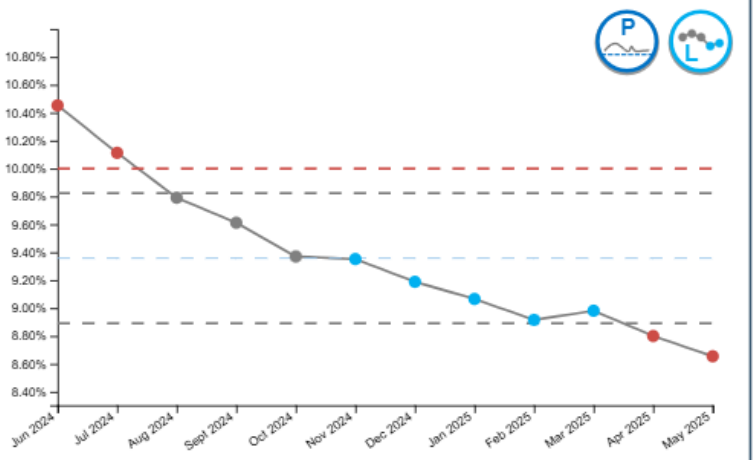
Clinical Board	Cost (£)	FTE Lost	Ave. No of days lost per FTE
CB Cancer and Haematology	1,461,618	11,124.62	19.11
CB Cardiothoracic Services	2,418,729	20,819.53	20.05
CB Clinical and Diagnostic Services	5,041,819	43,912.92	16.02
CB Family Health	5,840,504	49,288.73	23.45
CB Medicine and Emergency Care	4,095,471	39,147.19	22.58
CB Peri-operative and Critical Care	3,842,817	34,068.58	23.62
CB Surgical and Associated Services FH	1,686,472	16,524.56	18.00
CB Surgical and Specialist Services RVI	2,399,789	22,446.42	17.84

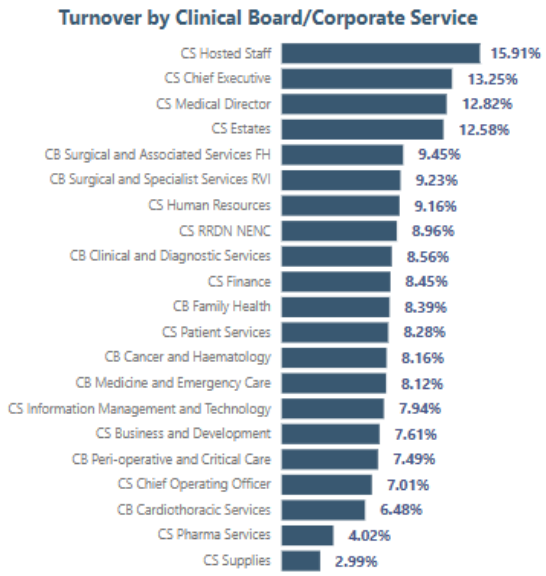
Clinical Board	Cost (£)	FTE Lost	Ave. No of days lost per FTE
CS Business and Development	960,992	8,016.70	20.50
CS Chief Executive	54,182	370.43	5.67
CS Chief Operating Officer	93,755	745.03	12.27
CS Corporate Performance and Governance	101,014	953.99	12.49
CS Estates	2,314,617	29,802.49	28.10
CS Finance	162,701	1,425.59	12.87
CS Hosted Staff	36,498	387.00	9.98
CS Human Resources	434,228	3,629.54	17.46
CS Information Management and Technology	425,503	3,907.11	16.82
CS Medical Director	42,002	265.60	7.68
CS Patient Services	557,288	4,300.93	22.09
CS Pharma Services	29,657	401.45	8.16
CS Regional Drugs and Therapeutics	48,149	272.10	8.47
CS RRDN NENC	65,633	412.59	6.71
CS Supplies	111,399	1,311.27	14.54

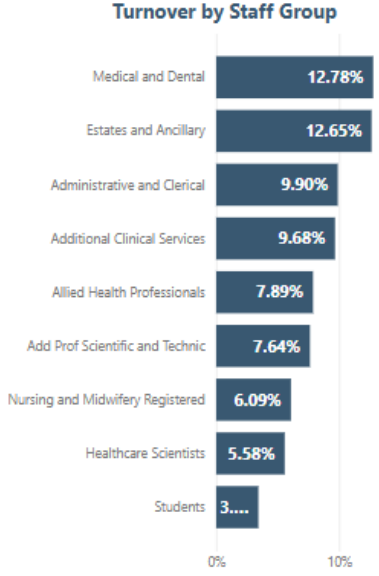


Turnover (1/2)

Trust Turnover %	12-Month Rolling	Value	Target
	May 25	8.63%	10.00%







Current Position:

- Chart shows underlying downward trend in turnover since June 2024.
- Overall target met since August 2024.
- All Clinical Boards are better than target.

Underlying Issues

- 1,437 leavers in 12-months to May 2025: 23% were Nursing & Midwifery (335) and 19% were Additional Clinical Services (279).
- Top destinations – No Employment (557, 39%); Other NHS organisation (492, 34%).
- Top reasons – relocation (208, 14%; Retirement Age (206, 14%) Work life Balance (204, 14%).
- Medical and Dental turnover due in part to Resident Doctors temporary contracts ending rather than resignations.

Actions Undertaken:

- Flexible working – supported and encouraged across the Trust. In 2024-25, 1,390 requests were received, 1,379 were approved (99%).
- Newcastle Hospitals top 3 sources of recruitment from neighbouring Trusts (last 12 months):
  - Northumbria 76 staff, 67.98 FTE
  - Gateshead 47 staff, 42.41 FTE
  - South Tyne/Sland 25 staff, 22.03 FTE
- NUTH top 3 destinations of leavers to neighbouring Trusts (last 12 months):
  - Northumbria 15 staff, 12.36 FTE
  - Gateshead 07 staff, 6.32 FTE
  - South Tyne/Sland 07 staff, 5.40 FTE

Turnover (2/2)

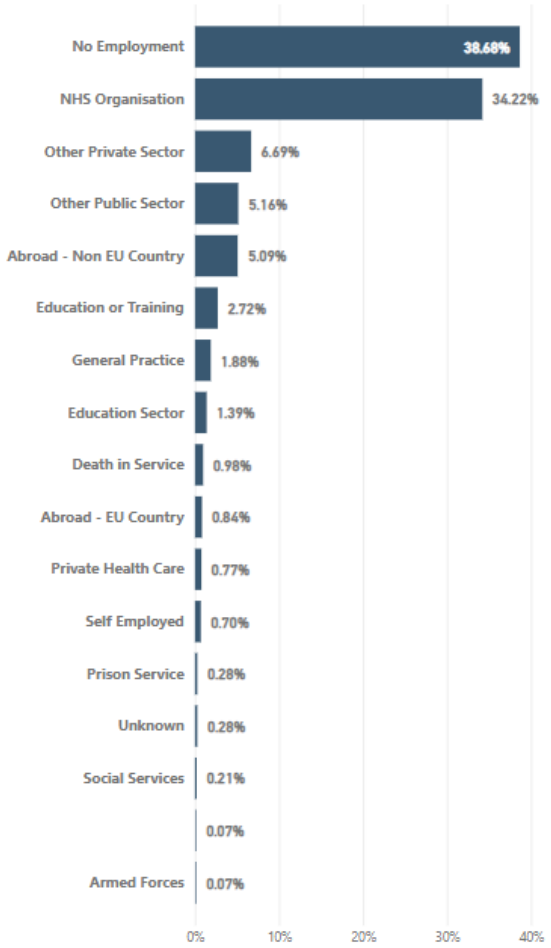
Trust Turnover %	12-Month Rolling	Value	Target
	May 25	8.63%	10.00%

Leaving Reasons

Leaving Reasons

Leaving Reason	Leaving Reason %
Voluntary Resignation - Relocation	14.49%
Retirement Age	14.36%
Voluntary Resignation - Work Life Balance	14.22%
Voluntary Resignation - Promotion	9.76%
Flexi Retirement	9.13%
End of Fixed Term Contract	6.76%
Voluntary Resignation - Health	6.06%
Voluntary Resignation - Incompatible Working Relationships	3.83%
Voluntary Resignation - To undertake further education or training	3.83%
Voluntary resignation - Pay and Reward Related	2.44%
Voluntary Resignation - Lack of Opportunities	2.23%
Voluntary Resignation - Child Dependants	1.74%
Dismissal - Capability	1.67%
End of Fixed Term Contract - Other	1.67%
End of Fixed Term Contract - Completion of Training Scheme	1.18%
Death in Service	1.05%
Retirement - Ill Health	1.05%
Voluntary Resignation - Other/Not Known	0.91%
Voluntary Early Retirement - with Actuarial Reduction	0.63%
Voluntary Resignation - Adult Dependants	0.63%
Redundancy - Compulsory	0.49%
Voluntary Early Retirement - no Actuarial Reduction	0.49%
Dismissal - Conduct	0.42%
End of Fixed Term Contract - End of Work Requirement	0.28%
Dismissal - Statutory Reason	0.21%
End of Fixed Term Contract - External Rotation	0.21%
Redundancy - Voluntary	0.21%
Bank Staff not fulfilled minimum work requirement	0.07%

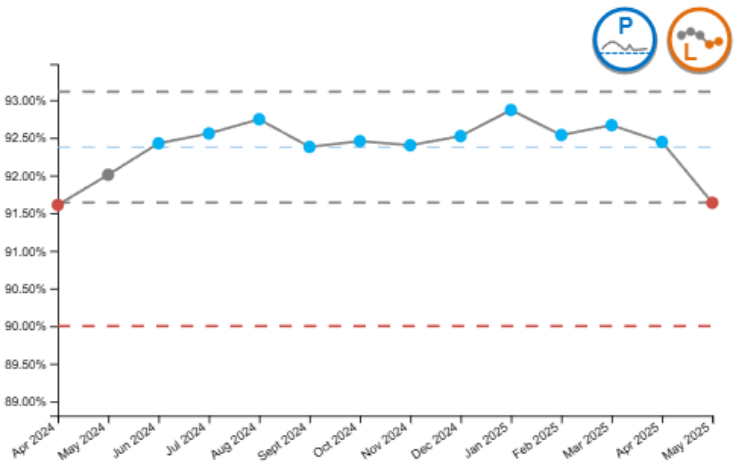
Destination on Leaving

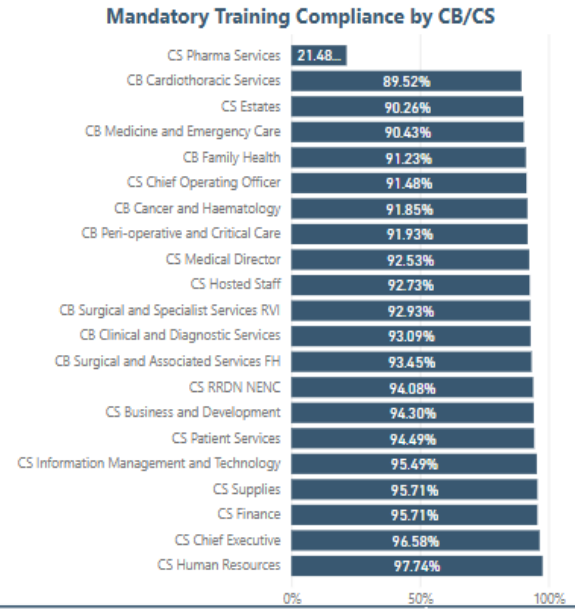


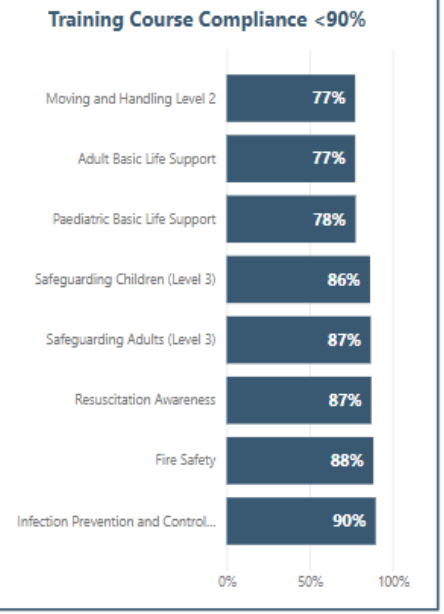
Destination On Leaving	Destination On Leaving %
No Employment	38.68%
NHS Organisation	34.22%
Other Private Sector	6.69%
Other Public Sector	5.16%
Abroad - Non EU Country	5.09%
Education or Training	2.72%
General Practice	1.88%
Education Sector	1.39%
Death in Service	0.98%
Abroad - EU Country	0.84%
Private Health Care	0.77%
Self Employed	0.70%
Prison Service	0.28%
Unknown	0.28%
Social Services	0.21%
	0.07%
Armed Forces	0.07%

Mandatory Training (1/2)

Mandatory Training Compliance	Month	Value	Target
	May 25	91.64%	90.00%







Current Position:

- Chart shows the overall target is consistently met, though compliance has dipped for the second month in a row and by 1% since March.
- Oliver McGowan – statutory requirement under Health and Care Act 2022 for CQC-registered providers to ensure staff receive learning disability and autism training appropriate to their role. Department of Health and Social Care (DHSC) launched Code of Practice in June which supports statutory training requirements and sets clear standards for CQC-registered providers.

Underlying Issues

- Medical and Dental – have lowest overall compliance (81.55%) with low compliance in Resuscitation Awareness (50%); Paediatric Basic Life support (51.48%); Adult Basic Life Support (56.21%).
- Corporate Services - Pharma Services compliance due to being newly created; all staff required to complete all mandatory training.
- Possible dip in compliance impacted by holidays over Easter and May Bank holidays.
- Face-to-face training can take more time away from work compared to online.
- Performance looked at as part of Well-led domain.

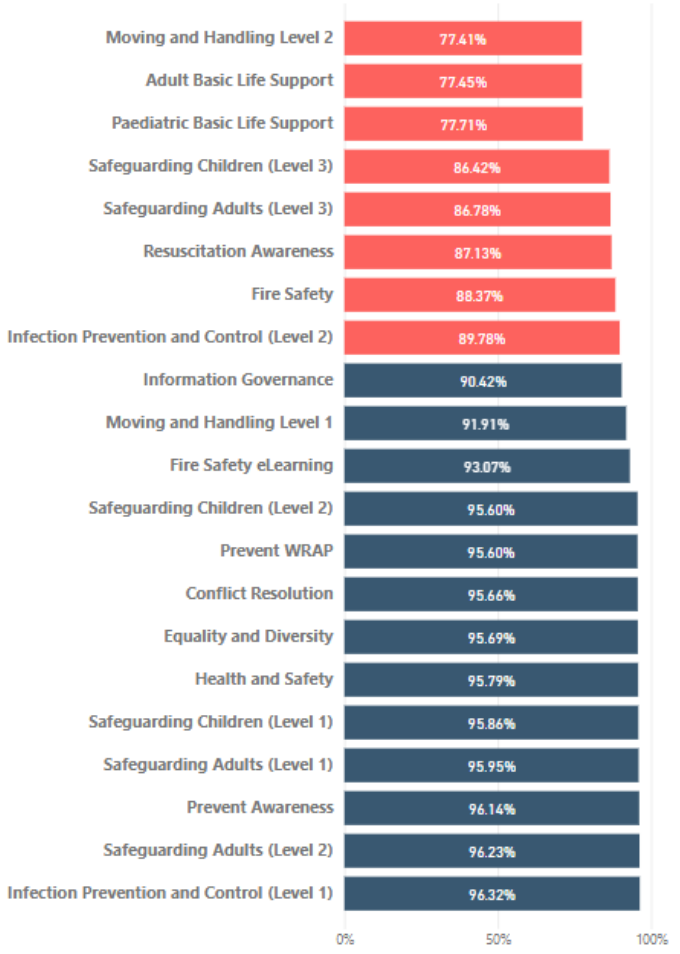
Actions Undertaken:

- Oliver McGowan. Need to translate the recently launched DHSC Code of Practice into action.
- Safeguarding courses:
  - Level 4 trial rolled-out, awaiting feedback.
  - Level 3 Adult e-learning creation half done, awaiting more material.
  - Level 3 Children e-learning awaiting final feedback and amendments, practical set-up awaiting final decision.
  - Audiences for all levels decided, only level 3 children awaiting creation.

Mandatory Training (2/2)

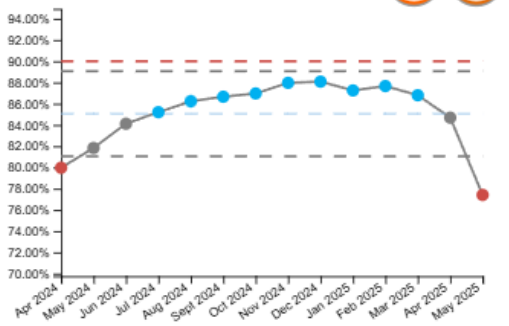
Mandatory Training Compliance	Month	Value	Target
	May 25	91.64%	90.00%

Training Course Compliance %

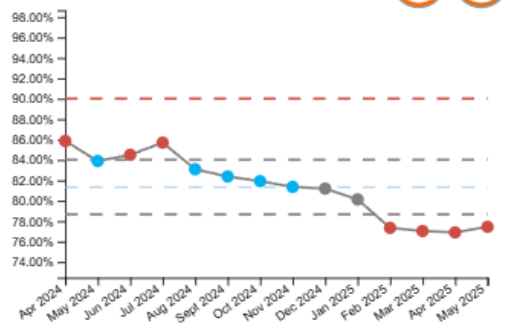


Lowest 4 Mandatory Training Compliance %

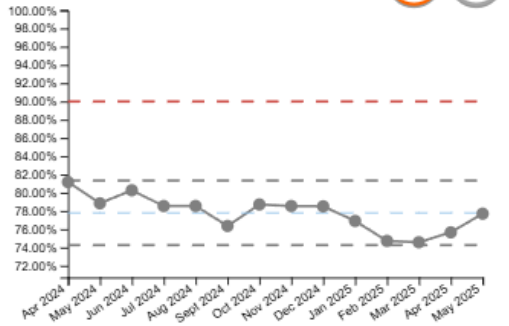
Moving and Handling Level 2 — 77%



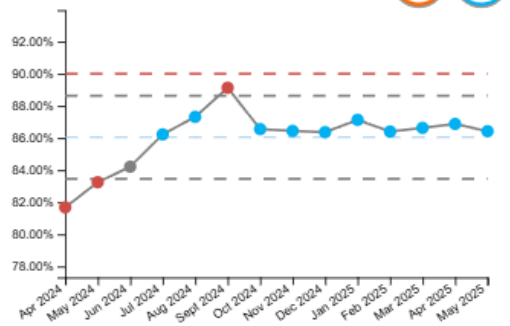
Adult Life Support — 77%



Paediatric Basic Life Support — 78%

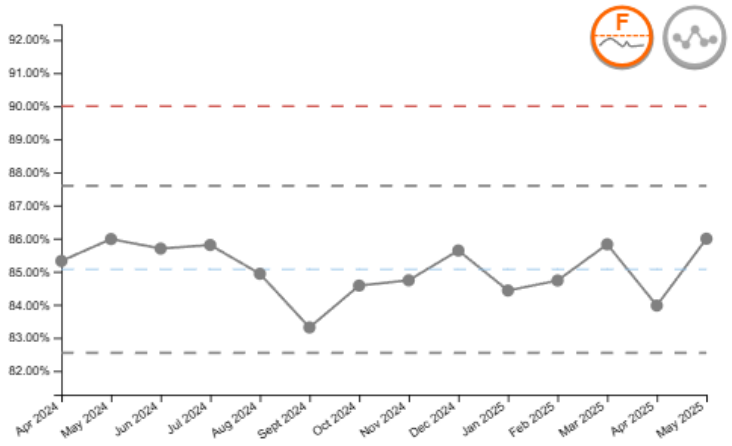


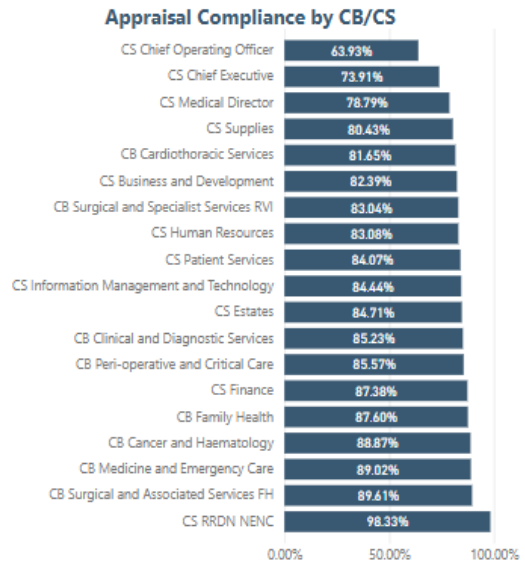
Safeguarding Children (Level 3) — 86%

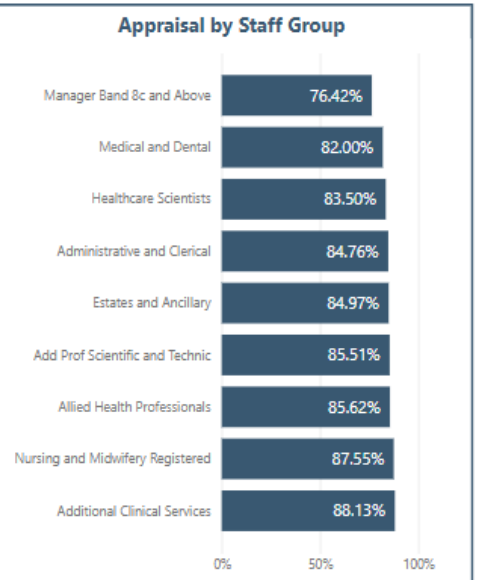


Appraisal Compliance

Appraisal Compliance	Month	Value	Target
	May 25	85.99%	90.00%







Current Position:

- Chart shows overall performance is consistently below target.
- All but one area has not met the target.

Underlying Issues

- 2,024 appraisals are overdue with highest numbers in Nursing and Midwifery (751) and Administrative and Clerical (364).
- Clinical Board performance varies between 81.65% (Cardiothoracic Services) to 89.61% (Surgical and Associated Services Freeman Hospital).
- Corporate Service performance varies between 63.93% (Chief Operating Officer) to 98.33% (Regional Research Delivery Network (RRDN) NENC).
- Time and capacity of managers and staff to complete appraisal process vs service delivery.

Actions Undertaken:

- Options paper with proposals for interventions to improve compliance is currently under discussion.
- Work on-going between Workforce Advisory team and managers to renew focus and double-down on non-compliance.

Bank use (£) – Non-medical

Bank Utilisation (£)	12-Month period ending	Total Bank Expenditure (£)	Total Bank Difference (£)
	May 25	£17,169,994	+£32,749

Bank Utilisation (£)

Staff Group	Jun 23 - May 24	Jun 24 - May 25	Difference
Admin & Clerical	£1,180,339	£289,046	-£891,293
Ancillary	£314,450	£1,100,322	£785,872
Estates			£0
Nursing & Midwifery (Registered)	£5,628,935	£5,599,619	-£29,316
Nursing & Midwifery (Unregistered)	£9,087,270	£9,426,524	£339,254
Professional & Technical	£926,251	£754,483	-£171,768
Total	£17,137,245	£17,169,994	£32,749

Current Position:

- Cost of Bank for year to April 2025 increased +£32,749 on the previous year.
- Underlying trend in number of Bank shifts has been down since August 2024.

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:

- Target reduction in bank staff of 10% set for 2025/26.
- Work continues to reduce bank usage with effective rostering and direction.
- Aiming to reduce agency use of Healthcare Assistants (HCAs) for enhanced care.
- Focus in place to: reduce overtime; reduce sickness absence; make more effective use of rostering.
- Ward staff being fast-tracked on to bank where they can be utilised at a lower rate than overtime.

Agency use (£) – Non-medical

Agency Utilisation (£)	12-Month period ending	Total Agency Expenditure (£)	Total Agency Difference (£)
	May 25	£3,695,727	-£630,180

Agency Utilisation (£)

Staff Group	Jun 23 - May 24	Jun 24 - May 25	Difference
Admin & Clerical	£639,258	£101,632	-£537,626
Ancillary	£10,614	£12,593	£1,979
Estates	£57,548	£28,104	-£29,445
Nursing & Midwifery (Registered)	£92,425	£716,461	£624,036
Nursing & Midwifery (Unregistered)	£2,668,875	£1,501,341	-£1,167,534
Professional & Technical	£857,187	£1,335,597	£478,410
Total	£4,325,907	£3,695,727	-£630,180

Current Position:

- Cost of agency for year to May 2025 reduced by £630,180 on the previous year.
- Underlying trend in number of agency shifts has been down since October 2024.

Underlying Issues

- Notable reductions in Nursing & Midwifery (unregistered) and Administration & Clerical.
- Significant increase in Nursing and Midwifery (registered) and 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.

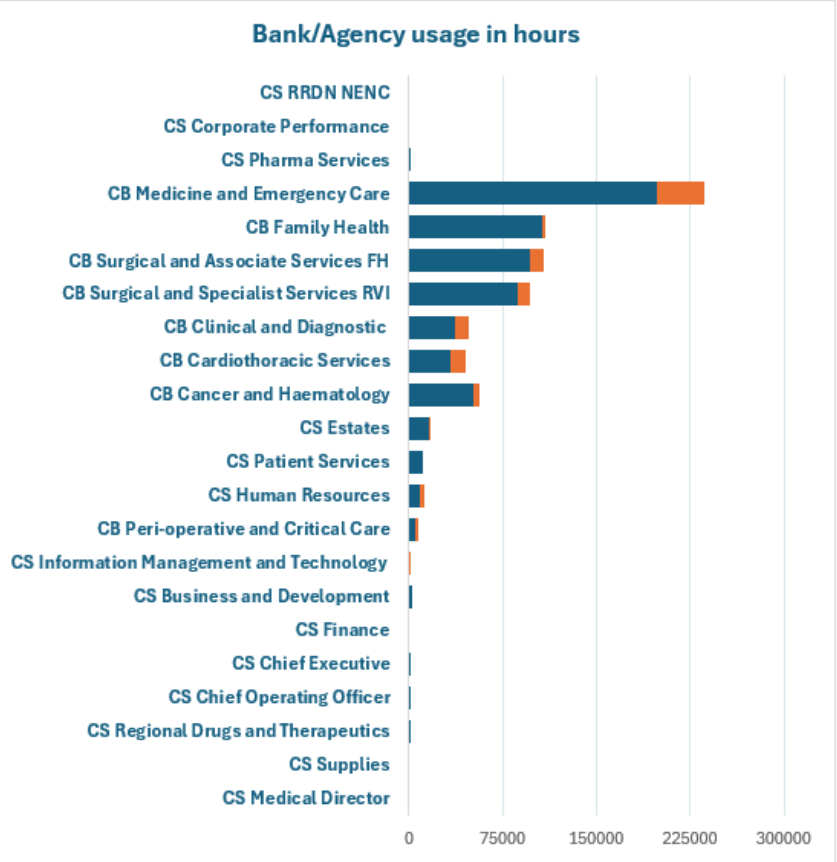
Actions Undertaken:

- Agency cost – target reduction of £2m set for 2025/26.
- Increasing bank availability to reduce agency use.
- Agency usage reviewed and challenged monthly.
- Actively negotiating conversion of agency staff to bank staff to reduce costs where possible.

Bank & agency use - Hours

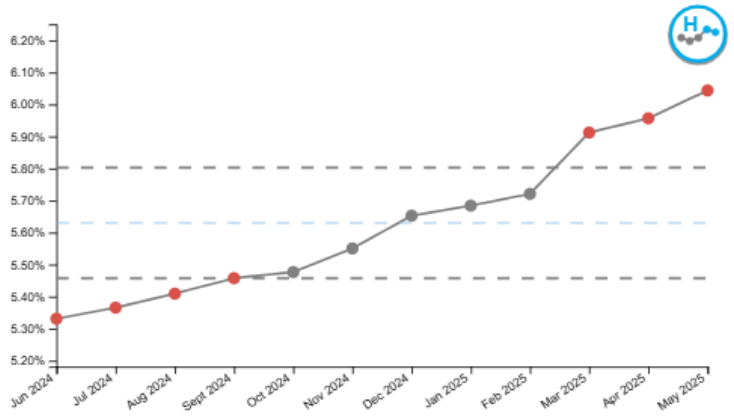
Bank & Agency	12-Month period ending	Total Bank and Agency Hours
	May 25	751,200

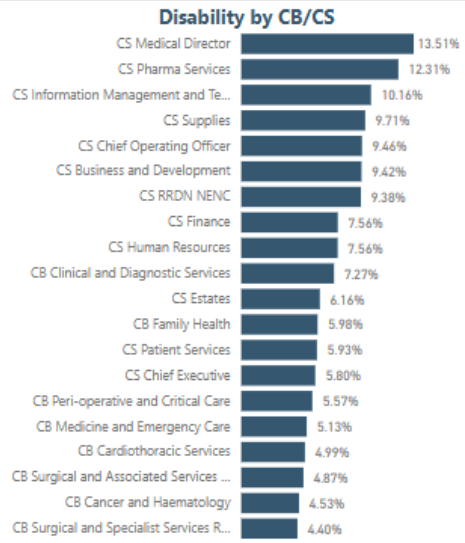
Clinical Board	Bank Hours	Agency Hours	Total Hours
CB Medicine and Emergency Care	198,046	38,200	236,245
CB Family Health	105,978	2,529	108,507
CB Surgical and Associate Services FH	97,241	10,524	107,764
CB Surgical and Specialist Services RVI	86,529	10,716	97,244
CB Clinical and Diagnostic	37,290	11,055	48,345
CB Cancer and Haematology	51,676	4,968	56,645
CB Cardiothoracic Services	33,389	11,505	44,893
CS Estates	16,148	923	17,071
CS Patient Services	11,190	0	11,190
CS Human Resources	8,080	3,737	11,817
CB Peri-operative and Critical Care	5,346	1,592	6,938
CS Business and Development	2,532	0	2,532
CS Information Management and Technology	105	60	165
CS Chief Executive	1,414	0	1,414
CS Finance	0	0	0
CS Chief Operating Officer	379	0	379
CS Regional Drugs and Therapeutics	17	0	17
CS Medical Director	0	0	0
CS Supplies	0	0	0
CS Pharma Services	32	0	32
CS Corporate Performance	0	0	0
CS RRDN NENC	0	0	0

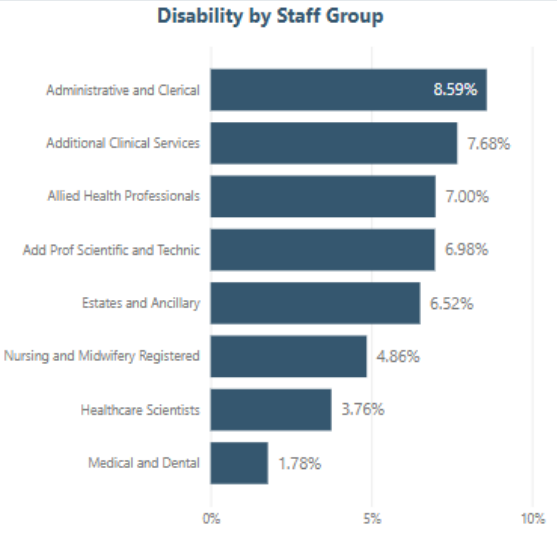


Equality, Diversity and Inclusion (EDI) - Disability

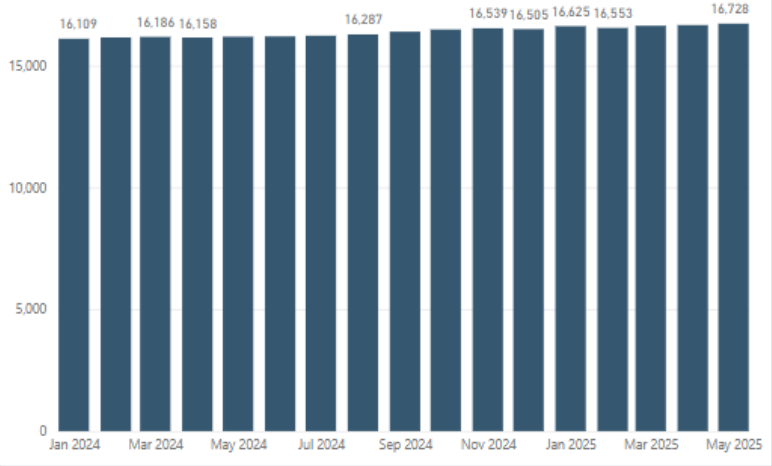
EDI - Disability	Month	Value	Trust Headcount
	May 25	6.04%	16,728







Trust Headcount Trend



Age Band

	Age Band	Disability %
1	<=20 Years	8.67%
2	21-25	12.08%
3	26-30	7.17%
4	31-35	5.95%
5	36-40	4.94%
6	41-45	5.05%
7	46-50	4.11%
8	51-55	5.43%
9	56-60	6.36%
10	61-65	5.36%
11	66-70	4.35%
12	>=71 Years	4.84%

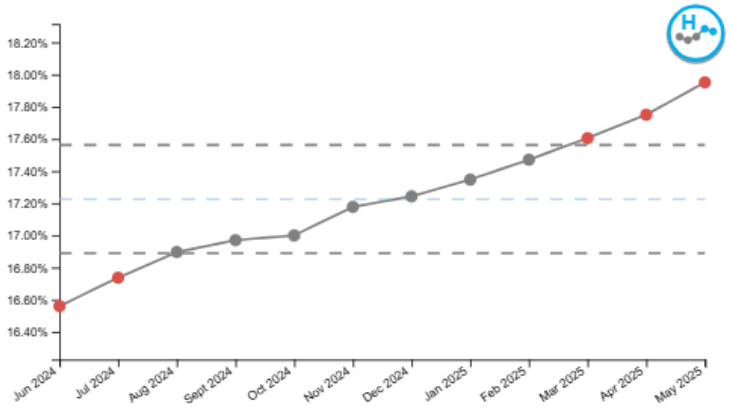
Current Position:

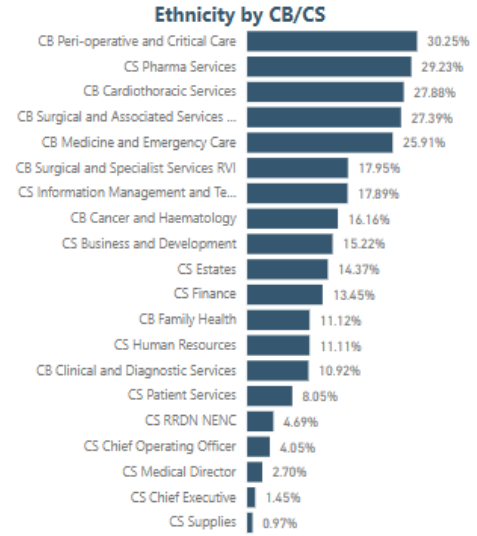
Charts show percentage of staff in post each month by those disclosing a disability.

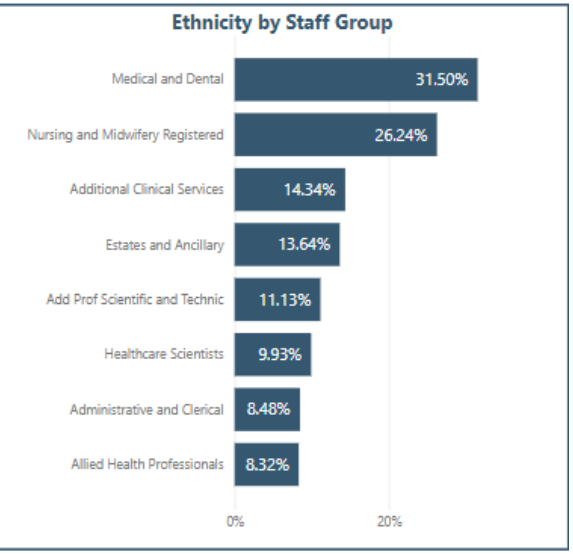
Percentage of staff employed disclosing a disability increased +0.08% in May 2025 to 6.04%

Equality, Diversity and Inclusion (EDI) - Ethnicity

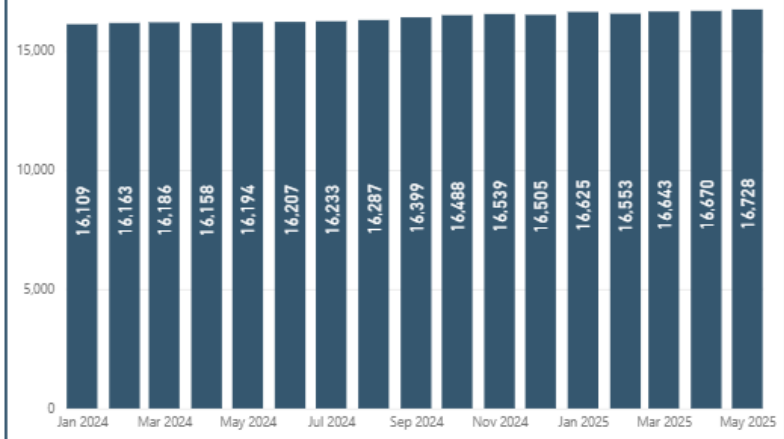
EDI - Ethnicity	Month	Value	Trust Headcount
	May 25	17.95%	16,728







Trust Headcount Trend



Age Band

	Age Band	BME %
1	<=20 Years	17.33%
2	21-25	17.52%
3	26-30	26.53%
4	31-35	24.01%
5	36-40	22.40%
6	41-45	14.61%
7	46-50	19.63%
8	51-55	16.02%
9	56-60	8.83%
10	61-65	5.03%
11	66-70	5.53%
12	>=71 Years	3.23%

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 17.95% of the workforce.

Finance

Finance Overview

May 2025

Financial Health

The Trust needs to take significant actions to deliver its financial objectives and is managing significant financial risk.

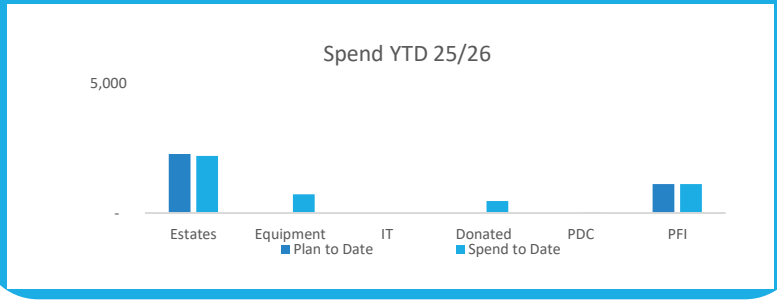
Financial Performance Month 2

The Trust has a plan to break even for the 2025/26 financial plan. To do this, it needs to deliver £106m of savings, manage expenditure within budgets and to deliver Elective Recovery Fund Income of £335m.

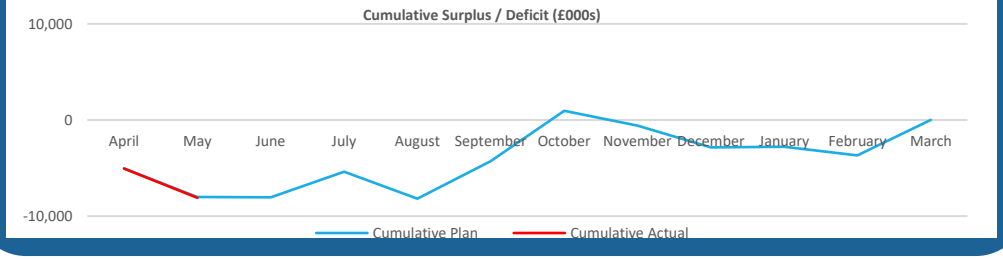
At month 2 the Trust is reporting an £8.1m deficit which is in line with the plan, however in delivering this position, the trust has had to bring forward technical savings to offset new pressures and under delivery of the Cost Improvement Programme (CIP).

- There are new pay pressures in relation to temporary staffing in Medicine and increased staffing costs in Family Health as well as new pressures on Cancer/Haematology drugs.
- The CIP of £106million is phased over the year and £8.1 million to M2. Year to date Clinical Boards and Corporate Services have delivered £1.6m (of which £974k is recurrent) and £7.7m of technical adjustments have been recognised as CIP in order to meet the target.
- Additional technical adjustments of £4.4m have been identified
- Elective Recovery Fund (ERF) delivery has been assumed to be impacted by the cap, with an adverse impact when compared to plan of £2.5m. Actual delivery will be reported between month 2 and month 3 closedown.
- The forecast for the trust is that it will breakeven and deliver the financial plan, however this assumes delivery of the CIP programme and management of any new pressures.

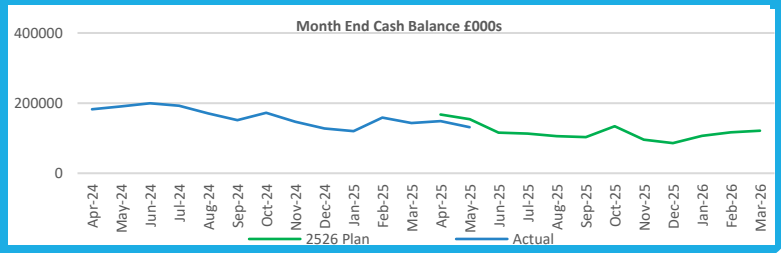
Capital Programme Delivery – Month 2



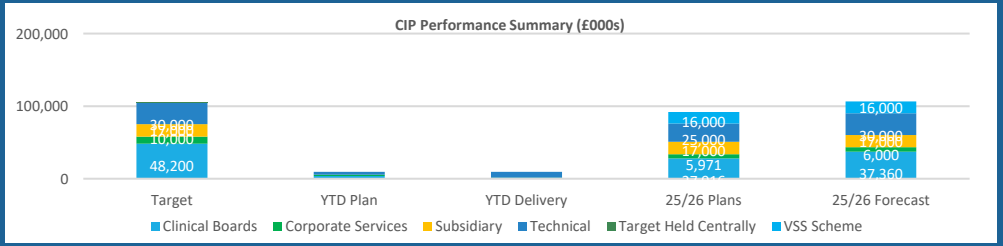
Cumulative Performance Against Plan



Cash Balance



Cost Improvement Programme Performance



Activity – Elective Recovery Income

Health Inequalities

The Health Inequalities reporting program for 2025/26 will commence in Quarter 2 2025.

Sustainability

High-level Dashboard

Shine
Sustainable Healthcare in Newcastle

Sustainability High-level Dashboard – May 2025

Data: March 2025 (end of 24/25)

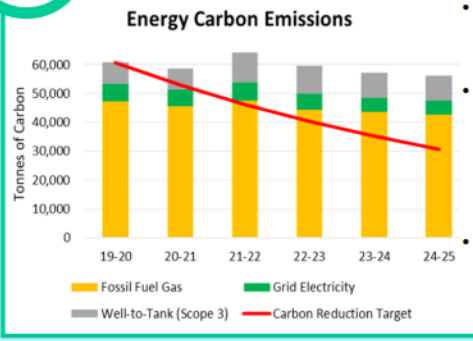
NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

STRATEGIC UPDATE

- **Capacity**: ⊖ one vacancy in Estates Net Zero Team (on hold) ⊕ recruiting Clinical Sustainability capacity (Lead & Fellow) via charity, Nature Recovery Ranger (external £) and Biodiversity PhD
- **Funding**: Net Zero Team have secured £42m in grants (for energy efficiency/carbon saving projects inc. LED, Solar PV & heat pumps)
- **Culture**: slow progress with Clinical Boards embedding Shine 10-steps (Cardio & CDS making most progress)
- **Governance**: Integrated Board Report to include quarterly Shine update
- **Procurement**: 5th annual Net Zero Supplier event held on 14th May, first joint event with NCC, 200+ suppliers = improved data & engagement
- **Born Green Generation**: team working on projects in Maternity to reduce plastics by 3,500kg/yr and save over £22,000/yr

ENERGY

RAG =



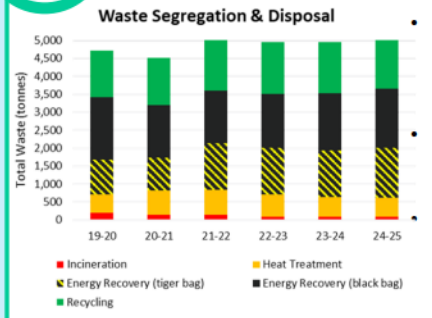
- 2% reduction in energy CO_2 in 24-25 (still off target)
- Energy Team (*now fully established*) have avoided costs of £343k in 24/25 with £202k potential in 25/26.
- 115 MWh of Solar PV in 24/25, increasing to 500 MWh by Mar26 (↑430%)

PEOPLE

- **1,000 Green Champions** (*699 in Q3,* ↑43%)
- Sustainability & Waste embedded in corporate induction
- **65% of staff have completed sustainability training** *('Net Zero NHS' e-module)*
- Schwartz Round held on 'tipping points'

WASTE

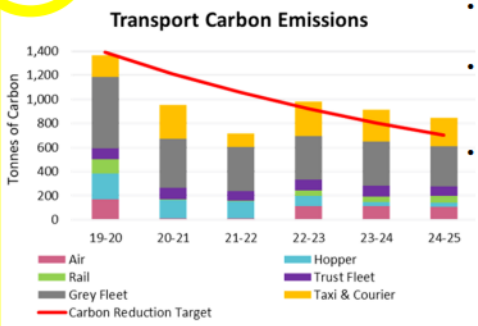
RAG =



- Incineration waste **down to 1.6%** (*was 4% in 19-20*)
- **Recycling rate at 45%** (*non-clinical*)
- Volumes up to 5,060/yr (*highest since Covid*)

JOURNEYS

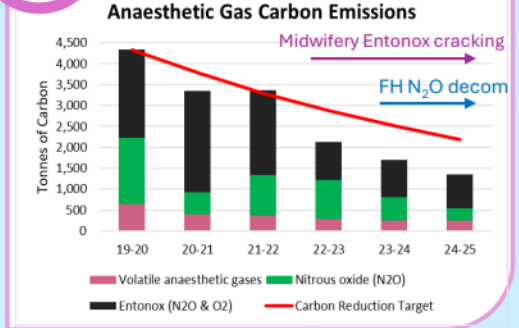
RAG =



- Above CO_2 target
- **EV hopper saving 144 tCO_2e/yr**
- Grey fleet, taxis & courier = biggest challenge (*CIP work may help*)

CARE

RAG =



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(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

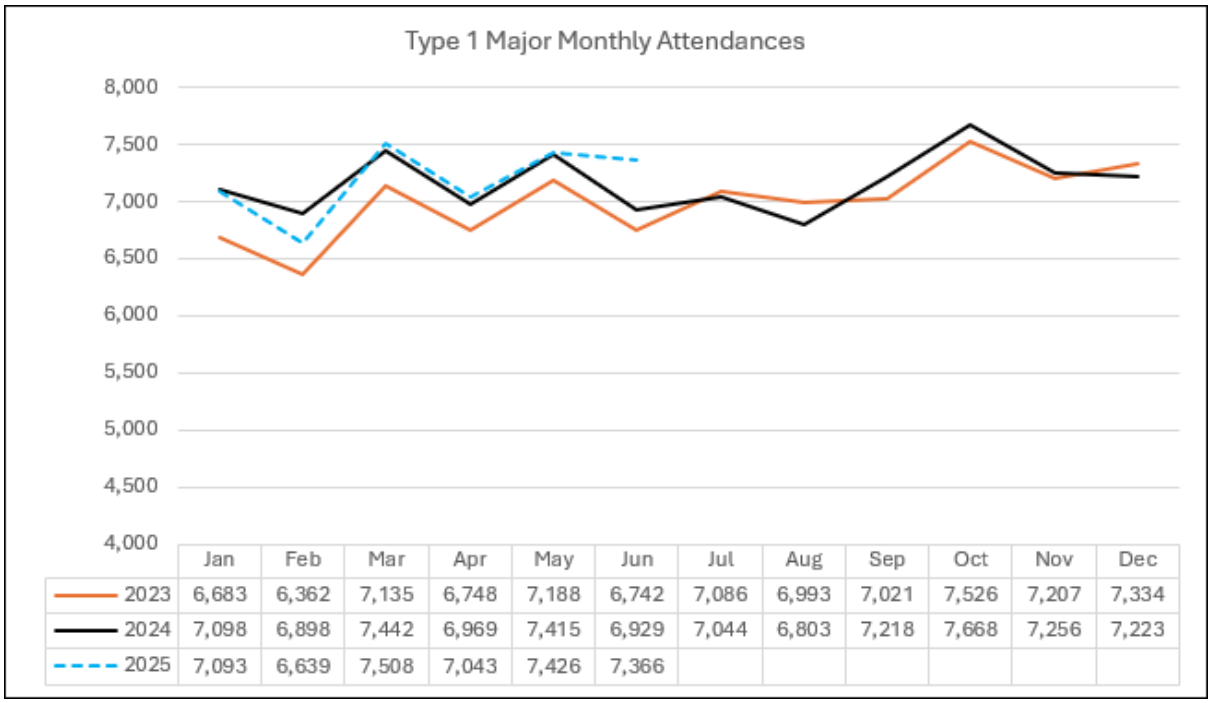
TRUST BOARD

Date of meeting	25 July 2025					
Title	Joint Medical Directors Report					
Report of	Dr Lucia Pareja-Cebrian / Dr Michael Wright					
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 • Medical Education Update • Job Planning Update • Industrial Action The Annual Report of the Guardian of Safe Working for 2024/25 and the Quarter 1 2025/26 report have also been included in the meeting papers.					
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 REPORT

1. URGENT & EMERGENCY CARE UPDATE

June was a challenging month with our highest ever number of majors attendances in 1 day in the middle of the month. Performance which had seen a steady improvement dropped slightly from 79.06% in May to 77.5% in June although Quarter 2 (Q2) performance remains 79.14% as of 16 July 2025. Ambulance handover delays have increased and there is an action plan in place to reduce the target of no ambulance waiting over 45 minutes before handing over. The placement of patients in corridors will now be recorded and available as part of the daily dashboard with action on continuous flow models to reduce this. Progress continues on the Urgent Treatment Centre (UTC) scheduled to open at the end of 2025 with work to redevelop the front door of the hospital and streaming processes. Emergency admission numbers continue to be high, and work continues to develop appropriate community step down models.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	6,683	6,362	7,135	6,748	7,188	6,742	7,086	6,993	7,021	7,526	7,207	7,334
2024	7,098	6,898	7,442	6,969	7,415	6,929	7,044	6,803	7,218	7,668	7,256	7,223
2025	7,093	6,639	7,508	7,043	7,426	7,366						

2. CANCER UPDATE

2.1 Performance

Note data for May 2025 remains provisional.

28 Day Faster Diagnosis 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	Apr-25	May-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%	80.9%	81.4%	80.3%

		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25
Brain/CNS	Actual			50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%		50.0%
Breast	Actual	95.5%	96.4%	95.8%	94.7%	93.9%	96.3%	96.8%	97.8%	96.0%	94.4%	97.0%	97.1%	95.6%	92.5%
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%	56.1%	65.5%	53.3%
Childrens	Actual	100.0%	100.0%	60.0%	66.7%	60.0%	100.0%	100.0%	60.0%	0.0%	66.7%	100.0%	66.7%	83.3%	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%	74.4%	61.8%	61.1%
Gynae	Actual	60.6%	70.0%	65.9%	61.7%	63.5%	59.2%	65.8%	69.5%	71.1%	64.0%	80.2%	74.4%	61.8%	61.1%
Haematology	Actual	72.7%	93.8%	75.0%	81.8%	73.3%	72.7%	100.0%	91.7%	89.5%	100.0%	94.4%	70.0%	100.0%	81.8%
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%	86.2%	85.9%	89.0%
Lung	Actual	85.7%	81.6%	71.0%	60.8%	82.5%	63.0%	78.6%	75.5%	76.3%	86.0%	82.5%	85.4%	72.7%	74.5%
NSS	Actual	80.0%	100.0%	92.3%	92.9%	87.5%	87.5%	86.7%	90.9%	85.7%	63.6%				77.8%
Other	Actual	100.0%		100.0%		0.0%		100.0%	50.0%	0.0%		100.0%	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%	80.0%	90.0%	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%	79.1%	82.5%	82.0%
Testicular	Actual	100.0%	100.0%	91.7%	100.0%	100.0%	90.0%	92.3%	87.5%	93.8%	90.9%	90.0%	100.0%	100.0%	100.0%
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%	83.5%	79.5%	77.5%
Urology	Actual	69.9%	75.7%	77.7%	82.4%	80.9%	80.6%	64.5%	60.2%	50.9%	31.7%	56.3%	68.0%	78.8%	65.2%
HPB	Actual	12.5%	66.7%	0.0%	33.3%	0.0%	20.0%	33.3%	16.7%	66.7%	0.0%	66.7%	58.3%	62.5%	27.3%
OGD	Actual	79.2%	74.1%	61.9%	65.5%	60.3%	59.7%	75.9%	82.8%	92.4%	88.5%	90.6%	86.0%	79.2%	88.1%
NHSE	Target	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	77.0%	80.0%	80.0%

62 Day Time to Treatment 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	Apr-25	May-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%	65.2%	72.2%	69.6%

		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-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%	100.0%	88.2%	91.3%
Breast	Actual	89.9%	93.8%	97.8%	89.7%	89.9%	91.8%	87.5%	90.5%	90.8%	87.7%	88.1%	77.7%	95.1%	88.9%
Childrens	Actual			100.0%			100.0%		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%	72.9%	55.3%	48.2%
Gynae	Actual	45.0%	63.2%	73.7%	60.0%	56.3%	77.8%	76.9%	57.7%	35.5%	64.0%	48.0%	39.3%	77.8%	48.3%
Haematology	Actual	82.1%	66.7%	93.2%	90.0%	90.0%	81.8%	83.0%	92.1%	83.3%	100.0%	85.3%	82.4%	86.7%	88.4%
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%	60.0%	75.8%	92.1%
Lung	Actual	29.3%	46.0%	48.3%	34.8%	29.3%	33.5%	39.2%	43.1%	55.1%	45.1%	36.3%	46.2%	49.6%	42.5%
Other	Actual	77.8%	78.0%	33.3%	28.6%	83.3%	33.3%	62.5%	63.6%	100.0%	50.0%	41.7%	100.0%	83.3%	63.6%
Sarcoma	Actual	71.4%	77.8%	85.7%	53.8%	64.7%	76.9%	81.3%	58.3%	57.1%	68.2%	94.7%	81.3%	100.0%	80.0%
Skin	Actual	80.5%	87.9%	87.9%	83.5%	92.6%	87.0%	89.2%	75.4%	77.9%	82.3%	79.2%	82.9%	90.2%	95.7%
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%	41.3%	40.9%	44.0%
Urology	Actual	47.0%	38.4%	52.4%	46.9%	37.8%	44.6%	50.4%	50.0%	58.4%	66.7%	40.5%	61.3%	56.5%	54.7%
HPB	Actual	44.2%	23.1%	41.7%	58.1%	44.7%	52.4%	37.9%	41.4%	46.2%	41.0%	58.5%	53.4%	45.8%	51.4%
OGD	Actual	47.6%	56.3%	54.5%	38.2%	44.4%	48.4%	59.1%	55.9%	54.2%	61.3%	66.7%	48.1%	35.6%	36.8%
NHSE	Target	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	70.0%	75.0%	75.0%

Key

NSS	Non-specific symptoms
OGD	Oesophagus Gastro Duodenoscopy
HPB	Hepato Pancreato Biliary
CNS	Central Nervous System
GI	Gastro Intestinal

Cancer performance is clearly still below the standard required and that which we would want to see although there has been a progressive improvement in performance against the 28-day faster diagnosis standard. Whilst the 62-day treatment commencement figures have dropped for May (provisional data) the overall performance is still improved in the last quarter. This coincides with a drop in number of patients waiting over 62-days for treatment and thus coincides with a period of more 'real time' working.

The Trust remains in tiering for cancer performance and fortnightly meetings with the regional NHS England (NHSE) team continue, these are focussed on action plans by tumour group. Review is awaited as to whether we can move out of tiering but whether or not that happens does not detract from the need to focus on improvement in meeting the targets and improving patient experience.

The 31-day target data (not shown) continues to be adversely affected by radiotherapy performance. This is being reviewed both internally and at tiering and comprises a specific workstream. As one of the poorest performing Trusts in England for 31-day treatment target performance for radiotherapy, NHSE has proposed a specific working group, through Getting It Right First Time (GIRFT), with several Trusts in a similar position to drive improvements. Our own trajectory does demonstrate anticipated improvement, with month-on-month fall in mean time to treatment. It is, however, likely to take until early 2026 until the 31-day performance returns to >90% despite the month-on-month reduction in mean time to treatment.

The most consistently challenged tumour groups in terms of 62-day performance remain lower GI, upper GI, lung and urology. Regular fortnightly review meetings are in place with the teams to review action plans and to overcome barriers to improvement wherever possible.

Pathway Changes

As per Board report of May 2025, Lung surgery work from Durham, currently done at Newcastle Hospitals, will move under the auspices of the thoracic surgical team at South Tees Hospitals from August 2025. Whilst this will reduce the demand for surgical slots at Newcastle Hospitals this reduction will 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, in itself, result in reduced demand. There is ongoing discussion about the best site to deliver non-surgical oncology services to the Durham population given that delivery of surgery in South Tees would result in a split pathway unless non-surgical oncology services also move to South Tees. The South Tees team do not have capacity to take on this work therefore a split pathway is inevitable at least for a period of time. Newcastle Hospitals oncology team are currently working on a risk assessment and mitigation strategy to maintain safe care through this transition period.

2.2 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. As previously, the main clinical area where harm has been identified in the context of longer treatment pathways is in lung cancer. In addition, there have been 2 episodes of harm recorded in May and June 2025 in respect of patients with liver malignancy who were due to have ablation treatment. Following this review and its recommendations, Radiology, Surgery and Peri-ops are working together to define set weekly lists for ablation in Computed Tomography (CT), in which patients can have predictable procedures under general anaesthetic (GA). This has meant prioritising resource

to this work potentially at the expense of other surgical interventions and the teams are working closely together to co-ordinate this work successfully, minimise impact and to understand the risks/benefits overall, of undertaking prioritisation work when needed. These risks lie both within surgery, if peri-operative resource is prioritised in radiology, and in radiology when a full day of ablation means one CT scanner is unavailable at the Freeman Hospital all day. This becomes particularly problematic if there is any scanner down time.

In terms of requirement for investment from a cancer perspective, priority would be given to the provision of a theatre with a scanner to allow ablations and other interventional radiology procedures to be undertaken in a better, less cramped, environment, close to main theatres, with peri-operative team predictability available whilst preserving access to static CT scanning facilities at the Freeman Hospital.

Flatiron

Patients should start to be contacted during July and August to enquire as to whether they wish to opt out of data capture by Flatiron. All clinical teams have been made aware of the project and of the contact that will be made to patients. In early autumn a meeting with Flatiron and cancer clinicians will be hosted to discuss data collected and how this might be used for the benefit of patients.

2.3 Summary

Progress remains slow in terms of performance improvement, but the Trust is in a better position particularly over the last quarter. Radiotherapy performance (31 days) remains an area of concern, and the Trust was a national outlier. There is improvement in average time to treatment but achieving 31-day target even at 90% compliance is some months away. Alongside tiering, engagement will take place with NHSE via GIRFT to assess any other potential solutions.

3. QUALITY AND SAFETY

3.1 Marthas Rule (MR) Update

Martha' Rule – Paediatrics

After a great deal of work from the Great North Children's Hospital (GNCH) colleagues, Freeman Hospital Paediatric Cardiac Surgical colleagues and the deteriorating patient teams, MR is set to go live across all children's wards at Newcastle Hospitals on 22 July 2025.

The major challenge has been in agreeing the response pathways to a Call for Concern at GNCH. This is primarily due to the lack of paediatric outreach at GNCH. Ward 12 Paediatric Intensive Care Unit (PICU) band 6 and above nursing staff have agreed to take this role on and have been integral in developing the Standard Operating Procedure (SOP) which will guide the response. There is some anxiety about time available to undertake this role in the

context of a busy unit. As such the initial phase following implementation is being treated as a pilot and assessment of demand and capacity to respond.

Martha's Rule – Maternity

This will also commence on 22 July 2025. The response in maternity is potentially complex with both neonatal and maternal patients requiring assessment. The coordinator will be the senior midwife on the labour suite; there has been fantastic engagement from this area.

3.2 PSIRF Priority 2025

As the three initial projects come to a close, the Clinical Governance and Risk Department (CGARD), alongside senior medical and nursing colleagues have determined that the next whole organisation safety project should be *Invasive Procedure Safety*. This has been for the following reasons:

- Ongoing high numbers of patient safety incidents relating to this area (top 5 class of incident), both in theatre and procedure areas.
- Difficulty launching NatSSIPs 2 to this point.
- A major and well-resourced launch to the new Invasive Procedure Safety Group – this met for the first time early in July 2025 – chaired by Rachel Bell Surgery Clinical Director.
- Ability to engage a very large number of staff throughout Newcastle Hospitals with a major safety project.
- A project with less emphasis on digital solutions and thus requirement for digital resource to complete.

This project will have 3 x Programme Activity (PAs) of consultant resource attached for 12-18 months alongside input from the Patient Safety Team.

3.3 Wide Bore Arterial Access for Transcatheter Aortic Valve Implantation (TAVI)

Significant vascular complications related to vessel access for Transcatheter Aortic Valve Implantation occur at a rate of between 2-3%. A series of these complications were reported as a group InPhase incident and reported to the Integrated Care Board (ICB). In addition, an 'After Action' review of one of the most significant of these events took place in May 2025.

As an outcome of these events, a specially convened meeting of the TAVI cardiology group alongside, vascular surgeons and interventional radiologists took place on 7 July 2025. This examined data and additionally allowed a detailed technical discussion about maximally mitigating this complication. There was excellent engagement and understanding of safety principles. A final document summarising this will shortly be released, and a series of actions are now underway.

4. MEDICAL EDUCATION

4.1 Postgraduate

- The medical education administrative team are on minimal staffing, and we are having to necessarily reduce activity, accordingly, including pausing our flagship quality panels.
- The foundation Annual Review of Competency Progressions (ARCPs) are complete. This year, there are four outcome 3s at Foundation Year 1 (FY1) (inadequate progress) which is more than usual. These resident doctors will require additional training time.
- Preparation is underway for shadowing and induction for the new August intake of resident doctors.
- A bespoke International Medical Graduate (IMG) induction has been created for all incoming FY1s (28 doctors) on the 20 August 2025, including an additional procedural skills course.
- The annual General Medical Council (GMC) training survey for 2025 is expected to report at the end of July.

4.2 Undergraduate

- There are currently two vacancies in the undergraduate administrative team which are critical to delivery of a number of undergraduate programmes. Work is being done to ensure that appropriate resource is made available to ensure these programmes are supported.
- All medical students attached to Newcastle Hospitals have passed their final grades for the year and will progress into the next stage of the programme.
- Conversations are currently undergoing with Sunderland Medical School to offer their students SSC placements and exploring supporting elective students. This will not be possible without additional administrative support.

5. JOB PLANNING UPDATE

Implementation of the new job planning policy continues. All of the job plans submitted so far have been reviewed (930 of a total of 1,203 required to achieve 100%). It is anticipated that all job planning meetings will be completed by the 31 August 2025 and all changes in salary will be actioned by the end of September.

The key changes which have been made are introduction of clearly defined personal objectives for both Supporting Professional Activities (SPA) and Direct Clinical Care (DCC) time in job plans, identification of time for clinical and educational supervision, introduction of 1.5PAs of SPA time for most full time and less than full time staff, identification within job plans of additional roles being undertaken and remuneration associated with these. This brings the Trust into line with the majority of local and national organisations. Further work is being carried out in Q2 and Q3 to consider whether changes need to be made to the existing policy ahead of the job planning round for 2026/2027 which it is anticipated will be done in Q4 of 2025/26.

Reconciliation of the financial and activity implications of the change in job plans continues. Initial reports have been provided to the Finance and Performance Committee and a further report will be submitted in September.

A job planning consistency panel to ensure the policy is being implemented fairly and appropriately across the Trust and an appeals panel to hear appeals where agreement cannot be reached between individual members of staff and Clinical Leadership teams, have been established.

6. INDUSTRIAL ACTION

Resident doctors have announced a period of industrial action between 25 and 30 July 2025. Preparations are underway to ensure patient safety over that period. The Trust has a very well-rehearsed planning strategy having covered a total of 44-days over the last 2 years, during which we maintained safe cover of both emergency and inpatient care as well as a significant proportion of our elective programme overall, covering P1 and P2 activity.

Report of
Dr Lucia Pareja-Cebrian/ Dr Michael Wright
Joint Medical Directors
17 July 2025

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 2025					
Title	Guardian of Safe Working Hours Annual Report					
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 a consolidated annual report on rota gaps, and the plan for improvement to reduce these gaps to be included in the Trust's Quality Account. This report addresses the requirement for the year from April 2024 to March 2025 for consideration by the Trust People Committee, prior to submission to the Trust Board.					
Recommendation	The Trust Board is asked to note the content of this report for inclusion in the Trust's Quality Account.					
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. 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	Annual Report of the Guardian of Safe Working Hours. Report submitted to the 21 July 2025 People Committee meeting.					

GUARDIAN OF SAFE WORKING ANNUAL REPORT

1. EXECUTIVE SUMMARY

The purpose of this annual report is to highlight the vacancies in junior doctor rotas and steps taken to resolve these during the year from April 2024 to March 2025.

Rota gaps on actual working rotas are also influenced by sickness absence, individualised working requirements, and changes in working patterns due to changes in educational and rest requirements. These additional factors are not outlined in this report. However, the locum spend may give some indication of the gaps in service coverage.

Where vacancies exist, the gaps in service coverage are mainly addressed by rewriting work schedules, redeployment of doctors to areas of greatest clinical need and the use of locums. The causes of vacancies are multifactorial but include gaps due to lack of doctors on the rotational training scheme, lack of recruitment of locally employed doctors, and less than full time doctors in full time training slots. There are no areas of persistent or recurrent concern for vacancies identified.

The Trust takes a proactive role in recruiting to vacancies where funding is identified. Delays from recruitment to the appointment of overseas candidates were experienced due to visa issues.

The current issues, obstacles, and actions taken to resolve these issues are outlined below.

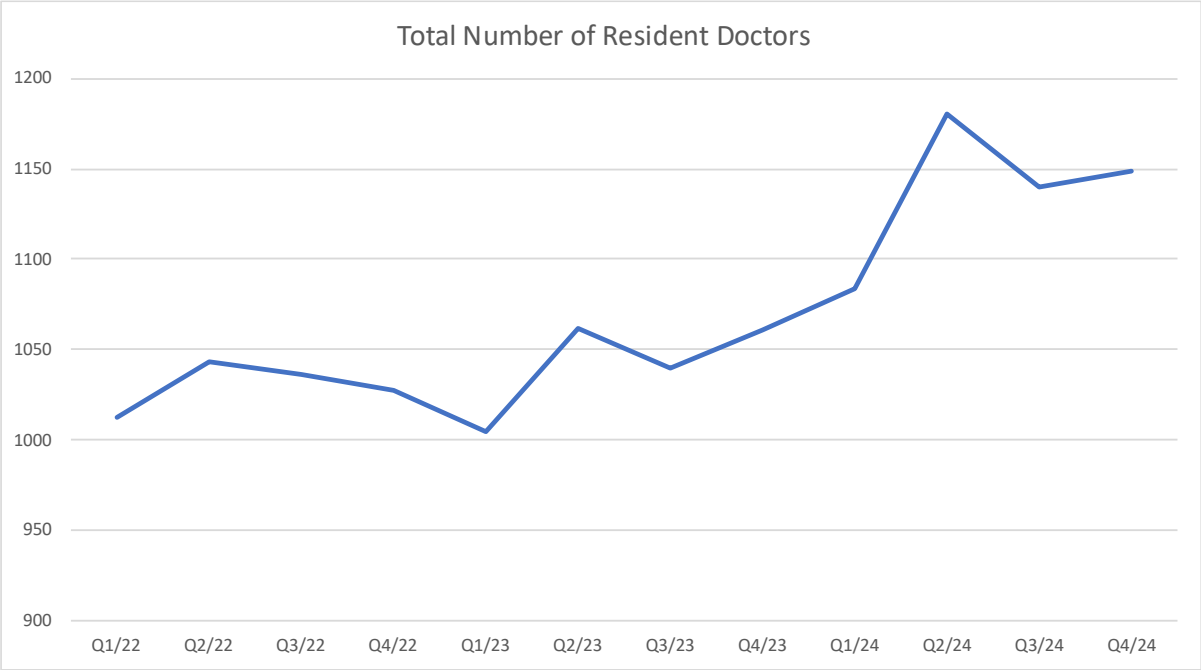
2. INTRODUCTION / BACKGROUND

The 2016 New Junior Doctor Contract came into effect on 3 August 2016. The terms and conditions of service (TCS) require a consolidated annual report on rota gaps, and the plan for improvement to reduce these gaps to be included in the Trust's Quality Account.

3. HIGH LEVEL DATA

Number of postgraduate doctors / dentists in training on 2016 TCS:	1,118
Of which:	
Lead Employer Trust (LET) employed	*898*
Trust Employed	*220*
Number of postgraduate doctors on 2002 TCS:	31
Total number of postgraduate doctors / dentists:	1,149

3.1 Trend of Number of Postgraduate doctors by quarter:



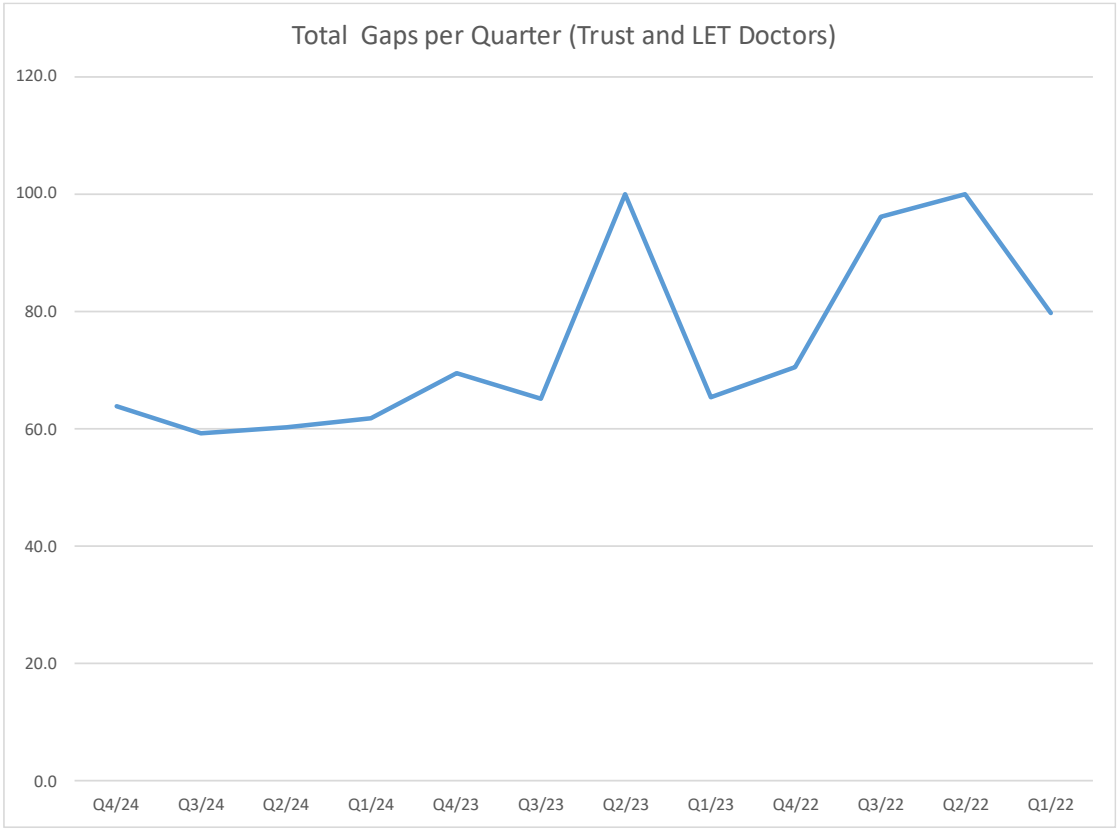
4. ANNUAL VACANCIES DATA SUMMARY BY SPECIALTY AND GRADE PER QUARTER (Q)

Site	Specialty/Sub Specialty	Grade	No. required on rota (at full complement)	Q4	Q3	Q2	Q1
	Cancer and haematology (Freeman Hospital (FH))						
FH	Oncology	ST3+	22	3.5	3.7	4	4.8
FH	Haematology / Oncology	F2/ST1/ST2	12	0.3	1	1	1
FH	Haematology	ST3+	9	1	1.3	1.4	2.1
	Cardiothoracic Services						
FH	Cardiology	ST3+	15	0.1	0.2	0.2	0.2
FH	Cardiothoracic Anaesthesia	ST3+	10	2	2.7	3	2.7
FH	Cardiothoracic Surgery	F2/ST1-2	2	1.3	0	0	0
FH	Cardiothoracic Surgery	ST3+	11	3	2.3	2.3	2.7
FH	Cardiothoracic Transplant	ST3+	3	1	1	1	1
FH	Paediatric Intensive Care Unit (PICU)	ST3+	8	1	1	1	1
FH	Paediatric Cardiology 1st	F2/ST1/ST2	6	0.2	0.2	0.2	0.2
FH	Paediatric Cardiology 2nd	ST3+	9	2	2	1	1
FH	Respiratory Medicine	CMT/ST1-2	5	0.2	0	0	0
FH	Respiratory Medicine	ST3+	8	1	1	0	0
	Family health (Royal Victoria Infirmary (RVI))						
RVI	Paediatrics	F2/ST1/ST2	25	1.4	1.4	1.4	1.3
RVI	General Paediatrics	ST3+	23	0	0	0	0.7

Site	Specialty/Sub Specialty	Grade	No. required on rota (at full complement)	Q4	Q3	Q2	Q1
RVI	Paediatric Oncology	ST3+	6	1	1	1	1
RVI	Obstetrics & Gynaecology	F2/ST1/ST2	14	1.4	1.4	1.4	1.4
RVI	Obstetrics & Gynaecology	ST3+	22	2	2	2	2
RVI	Neonates	F2/ST1/ST2	7	1	1	1	1
RVI	Neonates	ST3+	13	1	1.1	1.2	1.2
RVI	PICU	ST3+	10	1	1	1.3	2
	Surgical & Associated Specialities (FH)						
FH	Ear, Nose and Throat (ENT)	F2 / CST / ST1-2	5	0	0	0.3	0.7
FH	ENT	ST3+	9	0	0.7	1.3	0
RVI	Dermatology	ST3+	7	0.4	0.4	0.4	0.4
FH	General Surgery	F2/ST1/ST2/ST3+	7	1	1	1	1
FH	Vascular	ST3+	10	1.7	1	0.7	0
FH	Hepatobiliary / Transplant	ST3+	11	0	0	0.4	1.2
RVI	General Surgery	ST3+	15	1.8	1.8	0.8	0.8
FH	Urology	F2/ST1/ST2	7	0.7	0	0	0
	Clinical and Diagnostic Services						
RVI	Histopathology	ST3+	16	0	0	0.3	0.9
RVI	Histopathology	ST1/2	8	0.2	0.2	0.2	0.2
RVI	Integrated Medical Microbiology	ST1+	21	1.6	1.6	1.6	1.6
RVI / FH	Radiology On Call	ST2 / ST3+	33	1	1	1	1
	Medicine						
FH	General Internal Medicine	F2/GPVTS/CMT/TF	12	0.6	0.6	0.6	0.6
RVI	CMT Acute - ACU (August 2019)	IMT/CMT	2	1	1	1	1
RVI	ACCS on Assessment Suite Only	ACCS	2	0.2	0.2	0.2	0.2
RVI	General Internal Medicine	ST3+	25	1	1	1.3	1.9
RVI	Clinical Immunology	ST3+	3	1	1	1	1
FH	Gastroenterology	ST3+	6	0	1	0.7	0
FH	Care of the Elderly	ST3+	5	0	1	0.7	0
RVI	Accident & Emergency 1st	ACCS/ST1-2/CT1-2	20	1	1	1	1
RVI	Accident & Emergency 2nd	ST3+	15	2.3	2	2.1	2.4
RVI	Accident & Emergency	F2 GP Placement	12	0	0	0.7	0.2
FH	Rheumatology	ST3+	5	1	1	1	1
FH	Rheumatology	CMT1-2	3	1	0	0	0
FH	Renal Medicine	ST3+	6	0	0.5	1.6	1.6
FH	Palliative Medicine	F2/ST1+	5	0.3	0.8	0.8	0.8

Site	Specialty/Sub Specialty	Grade	No. required on rota (at full complement)	Q4	Q3	Q2	Q1
FH	Respiratory Medicine	CMT/ST1-2	4	0.2	0.1	1	0
FH	Respiratory Medicine	ST3+	5	1	1	0	1
	Surgical & Specialist Services						
RVI/FH	Orthopaedics	ST3+	19	1	1	1	1
RVI	Neurosurgery	F2/ST1/ST2	5	1.9	0.5	0.2	0.2
RVI	Neurosurgery	ST3+	13	1	0.3	0	0
RVI	Neurology	ST3+	13	0.4	0.4	0.4	0.4
RVI	Neurology	IMT/CMT	3	0.2	0.2	0.2	0.2
RVI	Ophthalmology	F2/ST1/ST2	6	1.3	0	0	0
RVI	Ophthalmology	ST3+	25	2	1.7	1.2	1.2
RVI	Plastic Surgery	F2/ST1/ST2	8	0	0.7	0.7	0.2
	Peri-operative						
FH	Critical Care	F2 ST1-7	13	1	1	1	1
FH	Anaesthetics General	ST1-7 CT1-2	27	3.1	3.1	3.1	3.8
RVI	Critical Care	ST1+	16	3.3	2.6	2.6	2.6
RVI	Anaesthetics	ST1-2 / ST3 +	40	3.6	3.6	3.6	3.6

4.1 Trends in rota gaps



5. ISSUES ARISING

The purpose of this report is to highlight any current issues or concerns, including the reasons for the gaps, obstacles in resolving this and actions taken to resolve the issues.

Key:
LED = Locally Employed Doctor
LET = Lead Employer Trust
LTFT = Less Than Full Time

Site	Specialty/Sub Specialty	reason for gap	Obstacles to Recruitment	Actions taken to overcome obstacles
	Cancer and haematology			
FH	Oncology	LET gaps		Accommodating workload within workforce
	Cardiothoracic Services			
FH	Cardiothoracic Anaesthesia	LED not recruited or delays	Overseas candidates. Delays due to visa issues	Proactive recruitment
FH	Cardiothoracic Surgery	Postgraduate trainees removed by LET	Overseas candidates. Delays due to visa issues	Accommodating workload within workforce
FH	Cardiothoracic Transplant	LET gaps		Conversion of posts to LEDs
FH	PICU	LET gaps		Accommodating workload within workforce
FH	Paediatric Cardiology	LET gaps	Difficulty to recruit	Accommodating workload within workforce
	Family health			
RVI	Paediatric Oncology	LED gaps	Overseas candidates. Delays due to visa issues	Accommodating workload within workforce
RVI	Obstetrics & Gynaecology	LTFT in Full Time slots / LET gaps	Funding for further posts	Accommodating workload within workforce
RVI	Neonates	LED gaps	Overseas candidates. Delays due to visa issues	Accommodating workload within workforce
RVI	PICU	LET gaps	Unable to recruit into advertised posts	New LED posts created to add resilience to rotas

	Surgical & Associated Specialities			
FH	General Surgery	LTFT in Full Time slots		Accommodating workload within workforce
FH	Vascular	LED gaps	Overseas candidates. Delays due to visa issues	Proactive recruitment
RVI	General Surgery	LTFT in Full Time slots		Accommodating workload within workforce
	Medicine			
RVI	Accident & Emergency 2nd	LTFT in Full time slots		Extra posts created to add resilience to workforce
FH	Rheumatology	LET gaps		Accommodating workload within workforce
	Surgical & Specialist Services (RVI)			
RVI	Neurosurgery	LED gap	Unable to recruit into advertised posts	
RVI	Ophthalmology	LET and LED gaps		Accommodating workload within workforce
	Peri-operative			
FH	Critical Care	Additional posts created		Accommodating workload within workforce
FH	Anaesthetics	LET gaps and LTFT in Full time slots		Accommodating workload within workforce
RVI	Critical Care	LED gaps		LTFT money pooled to create LED posts
RVI	Anaesthetics	LET gaps and LTFT in Full time slots		Accommodating workload within workforce

5.1 Actions taken to resolve these issues

The Trust takes a proactive role in management of gaps through the work of the Junior Doctor Recruitment and Education Group (JDREG). 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.

Other actions to resolve the issues are rewriting work schedules to reflect the number of available doctors, employing physician associates and advanced care practitioners to assist with junior doctor workload, redeployment of doctors to areas of clinical need, and the use of locums.

5.2 Locum Spend

The purpose of reporting locum spend is as a source of information indicating where there were gaps in service coverage requiring temporary workforce cover. All data shown here is supplied by the finance team and medical staffing.

Locum Spend 01.04.24 – 31.03.25

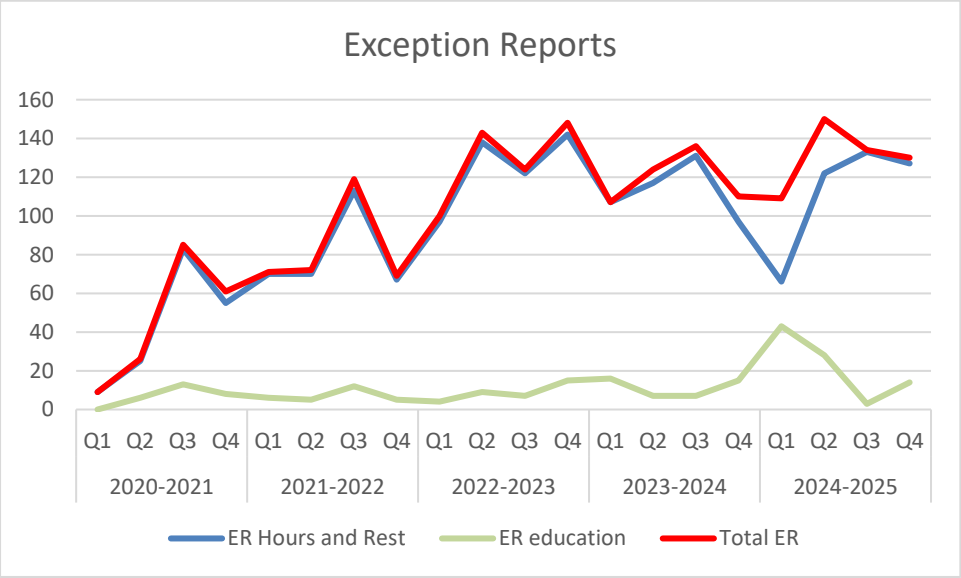
Lead Employer Trust:	£3,624,098
NUTH:	£3,116,531
Total:	£6,740,629

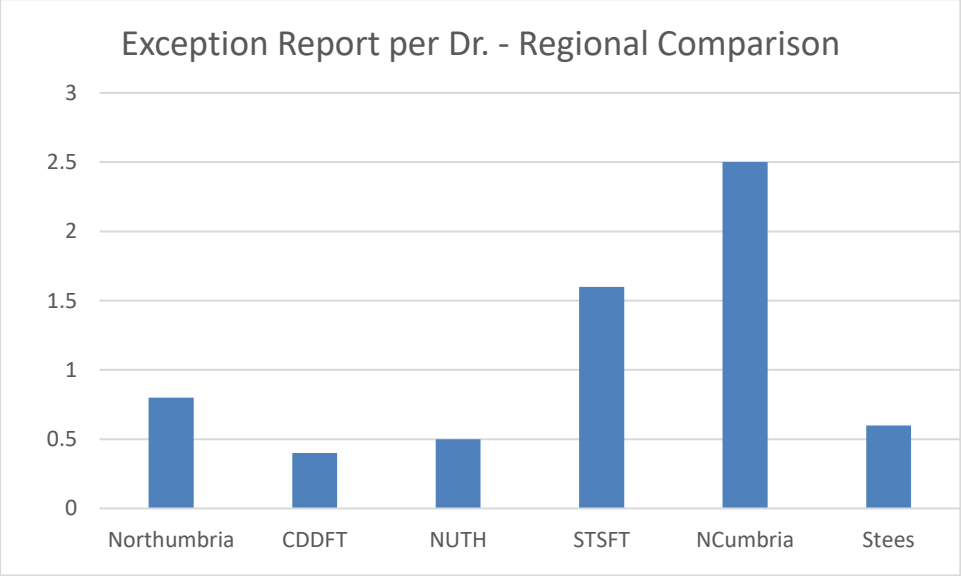
Locum Spend 01.04.23 – 31.03.24

Lead Employer Trust:	£7,156,944
NUTH:	£6,139,785
Total:	£13,296,729

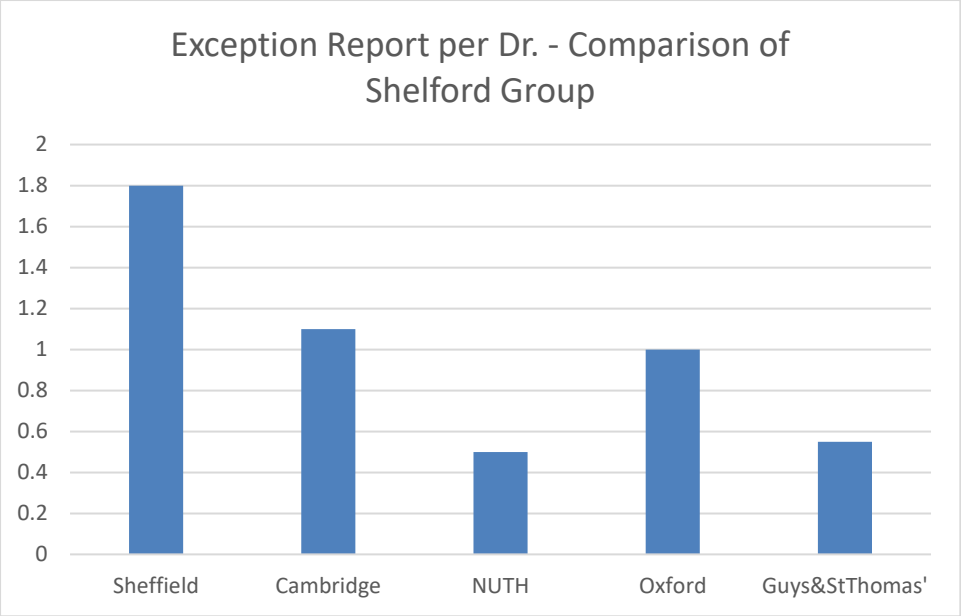
6. EXCEPTION REPORTS

Below is a summary of exception reporting numbers, and comparison with both regional and Shelford group colleagues.





CDDFT – County Durham and Darlington NHS Foundation Trust
NUTH – Newcastle Upon Tyne Hospitals NHS Foundation Trust
STSFT – South Tyneside and Sunderland NHS Foundation Trust
NCumbria – North Cumbria Integrated Care NHS Foundation Trust
Stees – South Tees Hospitals NHS Foundation Trust



7. SUMMARY

Vacancies are present on a number of rotas. This is due to both gaps in the regional training rotations, partial gaps created by less than full time doctors in a full-time training slot, and lack of recruitment of suitable locally employed doctors.

Overseas recruitment often results in a delay between recruitment and appointment due to delays in issuing visas.

The Trust takes a proactive approach to minimising the impact of vacancies by active recruitment, with a clear focus on staff retention to attract the best candidates. Other strategies include the use of advanced nurse practitioners and physician associates, rewriting work schedules to ensure that key areas are covered and the use of locums.

Gaps on actual working rotas are also impacted by short term sickness and changes in working patterns. These gaps are not highlighted in this report.

8. RECOMMENDATIONS

The Trust Board are asked to (i) note the content of this report for inclusion in the Trust's Annual Quality Account; and (ii) to encourage pro-active recruitment of doctors to reduce vacancies and to continue to consider the impact of changes to working patterns on the workforce workload balance in order to provide a resilient workforce.

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

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Agenda item A10(a)(i)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 2025					
Title	Guardian of Safe Working Quarterly Report (Quarter 1 (Q1) 2025-26)					
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 (TCS) 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 March to 26 June 2025 for consideration by the Trust People Committee, prior to submission to the Trust 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. Report submitted to the 21 July 2025 People Committee meeting.					

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

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

There are now 1,116 resident doctors on the TCS of the 2016 contract, and a total of 1,139 resident doctors in the Trust.

There were 118 exception reports in this period. This compares to 130 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. A framework agreement has been published (attached for information – see Trust Board reading room) Changes are expected to be implemented by September 2025. However, we are still awaiting the revised TCS.

The principles of the framework agreement are to improve access, confidentiality and ease of exception reporting. Residents will be able to decide compensation and supervisors will be removed from the exception reporting process.

3. HIGH LEVEL DATA

		(Previous quarter data for comparison)
Number of Resident Doctors on New Contract	1,116	(1,118)
Total Number of Resident Doctors	1,139	(1,149)
Number of Exception reports	118	(130)
Number of Exception reports for Hours Breaches	113	(127)
Number of Exception reports for Educational Breaches	12	(14)

Fines	14	(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	76	(97)
General Surgery	10	(12)
Haematology/Oncology	15	(7)
Ophthalmology	9	(7)

4.2 Exception Report by Rota/Grade

General medicine

Royal Victoria Infirmary (RVI) (F1)	16
RVI (CT/IMT/Trust)	13
Freeman Hospital (FH) (F1)	34
FH (CT/IMT/Trust)	13

General Surgery

FH (F1) including Hepato-Pancreato-Biliary (HPB), colorectal, vascular	9
RVI (F1)	1

Ophthalmology

StR	7
SHO	2

Haematology/Oncology

SHO/Trust	15

4.3 Example Themes from Exception Reports

General Medicine RVI/FH

‘Due to staffing issues across other wards we were reduced to 2 doctors. This has happened in the past but have never felt the need to address it; Unfortunately took no time for breaks; had lunch at desk while dealing with sick patients and left 2hrs late. This unfortunately

happened 3 times in a two week period which forced me to do my first exception reporting. In this instance we had a number of new patients requiring multiple investigations and discussions; which meant the ward round extended to 1pm.'

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

'On minimum staffing; doing meaningful work that could not be left until the next day'

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 microbiology on call hours.

5.2 Fines

14 fines have been issued:

- General Medicine (4 fines): Rule breached "Late finish; Exceeded the maximum 13-hour shift length; Unable to achieve the minimum 11 hours rest between resident shifts" Total fine money £642.27.
- Ophthalmology (4 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 £1,419.99.
- Haematology/Oncology (2 fines): Rule breached "Late finish; Exceeded the maximum 13-hour shift length" Total fine money £178.88.
- Urology (1 fine): Rule breached "Late finish; Exceeded the maximum 13-hour shift length; Unable to achieve the minimum 11 hours rest between resident shifts." Total fine money £87.08. (additional hours worked due to erecord downtime)

The following fines were generated due to exception reporting reduced rest when the clocks went forward:

- Anaesthetics (1 fine): Rule breached "Unable to achieve the minimum 11 hours rest between resident shifts. " Total fine money £47.67.
- Infectious diseases (1 fine): Rule breached "Unable to achieve the minimum 11 hours rest between resident shifts." Total fine money £63.26.
- Neonates (1 fine): Rule breached "Unable to achieve the minimum 11 hours rest between resident shifts. " Total fine money £43.52.

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. ROTA GAPS

Specialties and rotas with vacancies are outlined below.

Site	Specialty/Sub Specialty	Grade	No. required on rota (at full complement)	Jun-25	May-25	Apr-25
	Cancer and haematology					
FH	Oncology	ST3+	22	4.5	4.5	3.5
	Cardiothoracic Services					
FH	Cardiology	ST3+	15	2	2	2
FH	Cardiothoracic Anaesthesia	ST3+	10	1	1	1
FH	Cardiothoracic Surgery	F2/ST1-2	2	2	2	2
FH	Cardiothoracic Surgery	ST3+	11	2	2	3
FH	Cardiothoracic Transplant	ST3+	3	1	1	1
FH	Paediatric Intensive Care Unit (PICU)	ST3+	8	1	1	1
FH	Paediatric Cardiology 1st	F2/ST1/ST2	7	0.2	0.2	1.2
FH	Paediatric Cardiology 2nd	ST3+	9	3	2	2
FH	Respiratory Medicine	CMT/ST1-2	5	0.2	0.2	0.2
	Family health					

Site	Specialty/Sub Specialty	Grade	No. required on rota (at full complement)	Jun-25	May-25	Apr-25
RVI	Paediatrics 1st - ST1/ST2 (now inc Paeds Surgery)	F2/ST1/ST2	25	1.4	1.4	1.4
RVI	Paediatric Oncology	ST3+	6	0	0	1
RVI	PICU	ST3+	10	0	0	1
RVI	Obstetrics & Gynaecology	F2/ST1/ST2	14	1.4	1.4	1.4
RVI	Obstetrics & Gynaecology	ST3+	22	3	3	2
RVI	Neonates	F2/ST1/ST2	7	1	1	1
RVI	Neonates	ST3+	13	0	0	1
	Surgical & Associated Specialities					
RVI	Dermatology	ST3+	7	0.4	0.4	0.4
FH	Vascular	ST3+	10	1.5	1.5	1.5
RVI	General Surgery	ST3+	15	0.8	0.8	1.8
	Clinical and Diagnostic Services					
RVI	Histopathology	ST1/2	8	0.2	0.2	0.2
RVI	MM rota integrated with ID and MV and GIM	ST1+	21	1.6	1.6	1.6
RVI / FH	Radiology On Call	ST2 / ST3+	33	2	2	2
	Medicine					
FH	General Internal Medicine	F2/GPVTS/CMT/TF	12	0.6	0.6	0.6
RVI	CMT Acute- ACU (August 2019)	CMT	2	1	1	1
RVI	ACCS on Assessment Suite Only	ACCS	2	0.2	0.2	0.2
RVI	General Internal Medicine	ST3+	25	1	1	1
FH	Care of the Elderly	ST3+	5	1	1	1
RVI	Accident & Emergency 1st	ACCS/ST1-2/CT1-2	20	1	1	1
RVI	Accident & Emergency 2nd	ST3+	15	2	2	2
	Surgical & Specialist Services					
RVI/FRH	Orthopaedics	ST3+	19	1	1	1
RVI	Neurosurgery	F2/ST1/ST2	5	1.2	1.2	2.2
RVI	Neurosurgery	ST3+	13	1	1	1
RVI	Neurology	IMT/CMT	3	0.2	0.2	0.2
RVI	Ophthalmology	F2/ST1/ST2	6	2	2	2
RVI	Ophthalmology	ST3+	25	1	1	2
	Peri-operative					
FH	Critical Care	F2 ST1-7	13	1	1	1
FH	Anaesthetics General	ST1-7 CT1-2	27	2.8	2.8	2.8
RVI	Critical Care	ST1+	16	4.6	4.6	3.6
RVI	Anaesthetics	ST1-2 / ST3 +	40	3.6	3.6	3.6

8. LOCUM SPEND

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

LET Locum Spend

April to June (Q1 2025-2026)	£550,340
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 a decrease of £138k between Q4 24/25 & Q1 25/26. Of this decrease, £154k was Medicine & Emergency Care.'

Trust Locum Spend

April to June (Q1 2025-2026)	£710,027
January to March (Q4 2024-2025)	£774,552
October to December (Q3 2024-25)	£600,046

Comment from finance team:

'Spend on Trust locums between these periods decreased by £65k. Based on information supplied by Medical Staffing this was made up predominately by decreases in Establishment vacancies (-£183k), increased workload/acuity (-£140k), offset by increases in shifts with no reasons given of £76k, other leave £66k and winter pressures £47k.

Shifts input to Medirota should no longer be able to be input with no reason code, and so the issue above should not impact future shifts.'

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 and short term sickness absence. The predicted changes to the contract are likely to greatly increase exception reporting numbers with possible significant financial implications, although we are awaiting the final details of these changes.

9. RESIDENT DOCTOR FORUM

Issues discussed included concerns around bottlenecks in training and some resident doctors still without employment for August, out of hours medical cover at the Freeman Hospital, and discussions around simplification of nomenclature on ID badges.

10. 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
21 July 2025

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Agenda item A10(b)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 2025		
Title	Executive Director of Nursing (EDoN) Report		
Report of	Ian Joy Executive Director of Nursing		
Prepared by	Lisa Guthrie Deputy Director of Nursing Diane Cree Personal Assistant		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	This paper has been prepared to inform the Board of Directors of key issues, challenges, and information regarding the Executive Director of Nursing areas of responsibility. The content of this report outlines: • Section 1: Nursing and Midwifery Staffing Update • Section 2: Safeguarding and Mental Capacity Act/Deprivation of Liberty Safeguards (DoLS) Quarter 4 highlight report • Section 4: Learning Disability Quarter 4 highlight report The following key points/risks are noted for the Trust Board's attention: • Trust nurse staffing escalation remains at level 2 due to utilisation of surge beds and intermittent sickness absence above 6%. Appropriate oversight, monitoring and supportive actions are in place and there are no new escalations to the Trust Board in this regard. • Several wards have required support in line with our Nurse Staffing and Clinical Outcomes Group criteria with one classified as requiring high level support. Action plans are in place for wards with additional peer support, education and resources provided, overseen by the Executive Director of Nursing team and relevant Clinical Boards. • There are several nurse staffing metrics included in the report with additional detail included in the Board of Directors Reading Room. There are no new escalations to note. • The complexity within adult safeguarding remains and the legal support provided has been increased. The policy and audit schedule is monitored at the Safeguarding Committee with all audits completed in plan but due to capacity in the adult team this remains challenging. • Safeguarding training compliance continues to be monitored. Level 1 and 2 adult and children compliance is above Trust target. Level 3 adult and children compliance is below the 90% threshold with actions in place to improve this. • Capacity to respond to the increased demand in the Learning Disability Liaison Team and the lack of dedicated resources for caring for those who are autistic results in a risk to patient safety and staff experience. This is logged on the risk register, plans have been agreed to increase team capacity and temporary mitigations are in place. Once additional team members are in place, this risk will be reviewed.		

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

- The Learning Disability Care Quality Commission (CQC) Action Plan is overseen by the Learning Disability Steering Group and a phase 2 action plan has been agreed and included the four remaining open actions from the original plan and one new action.

Reference items from this report are available in the Board of Directors Reading Room.
</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Board of Directors is asked
i) Receive and discuss the report.
ii) Note the oversight and reporting of safe staffing which has been prepared in line with national guidance regarding.
iii) Note the risks and mitigations in relation to the Safeguarding and Learning Disability Liaison Teams.</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>
<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">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 EDoN update is a regular comprehensive report bringing together a range of issues to the Trust Board.</td></tr>
</table>

EXECUTIVE DIRECTOR OF NURSING REPORT

1. NURSE STAFFING UPDATE

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

1.1 Nurse Staffing Escalation

The Trust Nurse 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 at level two due to the following thresholds being met:

- Intermittent sickness absence greater than 6% for the registered nursing and midwifery workforce.
- The winter ward de-escalated in April 2025, however, surge beds remain utilised, which creates an increased staffing requirement.

The following actions are in place and 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 (InPhase) reports.
- Staff bank Healthcare Assistant (HCA) pool is reviewed daily, using Safecare to identify areas of shortfall and reduce agency requirement.

Level two escalation will remain in place until the de-escalation criteria has been met.

1.2 Nurse Staffing and Clinical Outcomes

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

Month	Total	Clinical Board	High level support	Medium level support	Low level support
April 2025		Family Health Services	Great North Children's Hospital (GNCH) 3	GNCH 2a	GNCH 12, RVI 40
		Surgical and Specialist Services (Royal Victoria Infirmary (RVI))		RVI 22	RVI 16
		Perioperative Services			
		Cardiothoracic Services		FH Paediatric Intensive Care Unit (PICU), FH 30, FH 21	FH 23, FH 24
		Medicine and Emergency Care Services		RVI Assessment Suite (AS)	
		Surgical and Associated Services (Freeman Hospital (FH))		FH 8	FH 3
		Cancer and Clinical Haematology Services		Northern Centre for Cancer Care (NCCC) 34	NCCC 35
Total	**16**		**1**	**8**	**7**
May 2025		Family Health Services	GNCH3	GNCH 2a	GNCH 1b, GNCH 12, RVI 40
		Surgical and Specialist Services RVI		RVI 22	RVI 16
		Perioperative Services			
		Cardiothoracic Services		FH PICU, FH 21	FH 23, FH 24
		Medicine and Emergency Care Services		RVI AS	
		Surgical and Associated Services FH		FH 8	FH 3, FH 5
		Cancer and Clinical Haematology Services		NCCC 34	
Total	**16**		**1**	**7**	**8**
June 2025		Family Health Services	GNCH3	GNCH 2a, GNCH 1b	GNCH 12, RVI 40
		Surgical and Specialist Services RVI		RVI 22, RVI 16	
		Perioperative Services			
		Cardiothoracic Services		FH PICU, FH 21	FH 23, FH 24, FH 25
		Medicine and Emergency Care Services		RVI AS	FH 14, FH 20
		Surgical and Associated Services FH			FH 3, FH 8
		Cancer and Clinical Haematology Services		NCCC 34	NCCC 33
Total	**19**		**1**	**8**	**10**

The key points to note:

- One ward (GNCH 3) has required high-level support over the last three months.
- Ward 3 GNCH was at high-level support due to staffing levels, related to vacancy and culture concerns. This is being mitigated with a closed bed and a supportive action plan. The ward is fully recruited with start dates for the remaining new starters in September. The staff culture survey has been repeated in June. If the results are positive, the ward will undergo peer review in July with the aim to de-escalate.
- Wards requiring medium level support for more than two months have an action plan in place and themes are reviewed for learning.

1.3 Datix and Red Flag data

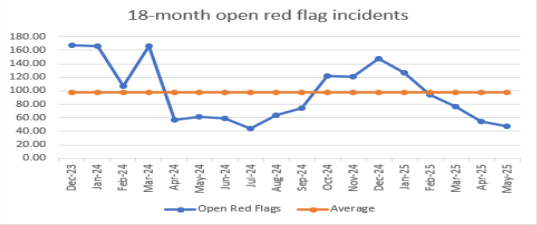
Red flag and incident data is reviewed daily (Monday-Friday) by the senior nursing team and reported as part of the daily staffing briefing and presented to the NSCO Group monthly.

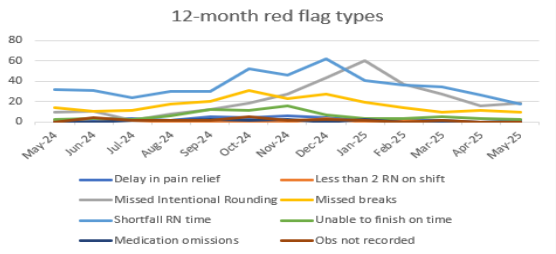
The key points to note:

- The reporting of staffing incidents on InPhase continues to be encouraged, with an upward trend of incident reports seen and a downward trend in unresolved red flag

events. Increased staffing incident reporting in May was related to surge bed capacity along with incident reporting training being supported locally.

- Staffing incidents are being reported most frequently in Medicine and Emergency Care. This is the largest Clinical Board, with the greatest requirement for enhanced care observation and includes front of house services.
- There has been a reduction in unresolved staffing red flags since March 2024. This is expected based on improved fill rates, reduced vacancy and turnover.
- There have been no “less than 2 Registered Nurses (RN)” unresolved red flags in the last quarter.
- The greatest number of unresolved red flag reasons were “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).





1.4 Care Hours Per Patient Day (CHPPD) data

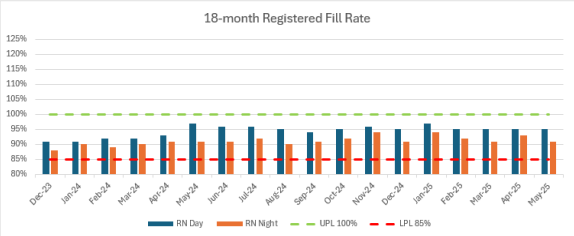
The nurse staffing team monitor ward-specific CHPPD on the safer staffing dashboard which is reviewed at the NSCO Group each month. The Trust CHPPD has remained at around 9.0 for the past 12 months. Non-specialist in-patient wards benchmark lower than the Model Hospitals Dashboard comparator in most services but direct benchmarking is difficult. There are no new areas for escalation.

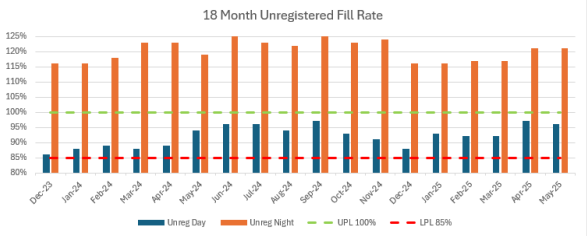
1.5 Planned versus actual hours (fill rates)

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 each month. Key points to note:

- The number of wards reporting <85% RN fill rates has been static over the last six months and remains more prevalent on nightshift where the shortfalls are mitigated by HCA support.
- Six critical care departments reported <85% RN in the last quarter. Bed capacity and patient acuity is monitored in these areas and risk is mitigated locally on a day-by-day basis. No staffing escalation risk assessments have been required and reported to PPAG in the last quarter.

- Five of the areas reporting <85% RN fill rates have been in receipt of low-level support through NSCO Group and three areas have been supported at medium-level with clear actions and mitigations in place.





1.6 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 each week.

Key points to note:

- Temporary staffing spend has fluctuated month-to-month with a gradual increasing trend. This is influenced by pay increases and back-dated pay awards. However, unregistered agency spend continues on a downward trajectory.
- The number of requested temporary staffing shifts for registered and unregistered staff has been on a downward trend over the past 18 months. This is expected based on improvement in vacancy rates but is reassuring to note.
- The Trust is part of cohort 2 of the NHS England (NHSE) enhanced therapeutic observational care improvement programme which aims to reduce patient harm through effective therapeutic observation whilst also reducing the spend on temporary staffing.

2. RECRUITMENT AND RETENTION

Key points to note:

- The current RN turnover is 5.76%. This demonstrates a continued reduction from the previously reported 6.83% in the same period last year.
- The current RN vacancy rate is 0.67%. This remains stable and is below the figure of 1.74% 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 is providing supportive measures in the recruitment of the September adult and paediatric 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. Recruitment for RN with specialty experience continues where required.

- The current Health Care Support Working (HCSW) turnover rate is 8.23% and demonstrates a reduction from 11.22% in the same period last year.
- The HCSW vacancy rate is currently 5.5%. This remains stable and is below the figure of 6.5% reported in the same period last year.
- The HCSW apprentice recruitment continues offering opportunities to those new to care with 11 being appointed in May 2025.

3. SAFEGUARDING AND MENTAL CAPACITY ACT (MCA) QUARTER 4 (Q4)

This summary of key points provides a Q4 update of Safeguarding (Adult, Children's and Maternity) and Mental Capacity activity throughout the Trust. This detail was presented to the Safeguarding Committee (April 2025) and Quality Committee (June 2025).

The following key points are noted for the Trust Board's attention:

3.1 Activity and Audit

- The complexity within adult safeguarding remains, along with the challenge presented by increased activity and is recognised in Risk 4662. Oversight of mitigating actions is provided by the Safeguarding Committee.
- Increased legal support is provided for Safeguarding and MCA Teams to ensure effective escalation and provide a legally robust review of the growing number of complex cases.
- Children's safeguarding activity data shows a 25% reduction in Q4 compared to the same period last year. However, the total activity levels for the whole of 2024-25 are similar to 2023-24. Maternity activity has increased in regard to complex cases in Q4.
- In Q4 there were 104 reported MCA and DoLS related enquiries, with some regarded as complex. This is a decrease from Q3.
- Policies and the yearly audit schedule are discussed as standing agenda items at the Safeguarding Committee with all audits now completed according to plan. It is recognised that compliance with policy audits remains challenging due to capacity in the adult team.
- Q4 audit of compliance with the application of MCA demonstrated that 87% of patients who required an MCA assessment had documented evidence of this (85% in Q3). The quality of assessments and documentation of best interest decisions continues to improve but further education is still required to ensure this is consistently evidenced in practice.

3.2 Education and Training

- Safeguarding adults training compliance is closely monitored at Safeguarding Committee. Currently Level 1 training demonstrates good compliance with 95.98% and Level 2 96.83%. Safeguarding adult Level 3 compliance is 86.99% and below the Trust 90% standard.
- Safeguarding children Level 1 compliance rates are 96.24% and Level 2 100%. Level 3 Children's safeguarding sits at 86.62% 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.

- Work is being undertaken to prioritise level 3 training, with focused work in the Medicine and Emergency Care Clinical Board to improve accessibility and increase compliance.
- The maternity safeguarding team have commenced work on a bespoke training package with the North East North Cumbria Local Maternity & Neonatal System (NENC LMNS) Training Faculty to standardise the regions offer.
- Level 1 MCA mandatory training for all clinical and patient facing staff is in place. Compliance currently sits at 97%. Level 2 MCA and DoLS e-learning was launched in December 2024. The audience, based on a leadership model, is in line with Safeguarding adults and children Level 3. Staff who have been mandated to complete this are medical consultants, nurse managers, district nursing and allied health professionals. The current compliance rate is 76%. Training completion is a key priority documented in the Clinical Board Quality and Safety Priorities action plan.

4. LEARNING DISABILITY QUARTER 4 (Q4)

This summary of key points provides a Q4 update of Learning Disabilities activity throughout the Trust. This detail was presented to the Safeguarding Committee (April 2025) and Quality Committee (June 2025).

The following key points are noted for the Trust Board's attention:

4.1 Activity and Service Pressures

- There continues to be an increase in referrals and contacts with the Learning Disability Liaison Team. Q4 figures demonstrate that there were 557 inpatient and day case attendances. Although there was a reduction in attendances to the Emergency Department in Q4 when compared to Q3.
- To support safety and quality, Matrons review daily information identifying in-patients with a learning disability flag by ward to ensure reasonable adjustments and use of hospitals passports have been discussed and documented.
- There is a risk in providing the appropriate care for autistic patients due to a lack of dedicated resource to lead this work. This is logged on the risk register, and funding for a lead for this work has been identified. Once appointed, this risk will be appropriately reviewed.

4.2 Mandatory training for Learning Disability and Autism

- In Q4 compliance with the e-learning Diamond Standard Training is 86.7% which reflects the recent roll-out to non-clinical staff. For clinical staff, compliance is 95% (Nursing Midwifery and Allied Health Professionals (NMAHP)/Medical and Dental). Compliance will be monitored by the Learning Disability Steering Group.
- The Trust is currently reviewing the training plans in line with national expectations. A delivery plan to sustainably implement the Oliver McGowan Mandatory Training for Learning Disabilities and Autism is in progress and will be presented to the relevant committees in due course for approval. It is recognised that the delivery of

training in acute settings will be challenging, and we are working on this in collaboration with regional colleagues.

4.3 Learning from deaths and lives of people with a learning disability and autism - LeDeR

The Trust LeDeR panel meets monthly to review the deaths of patients with a learning disability, along with representation from the Trust on the Regional LeDeR Panel meetings and the subgroup reviewing themes.

The number of reviewers has been increased but there remain cases which require discussion at panel. Mitigations are in place to minimise the risk of delay in reviewing deaths in the short term along with focused work on the process for uploading information to database. This has resulted in better quality feedback to the Clinical Boards but further work is required to ensure this thematic learning is shared through the Clinical Board monthly governance meetings.

4.4 CQC Action Plan

The Learning Disability CQC Action Plan is overseen by the Learning Disability Steering Group at bi-monthly meetings. A phase 2 action plan has been developed and includes the four remaining open actions from the original plan which have been refined and are:

- The Trust will have a clearly defined, sustainable training plan which is aligned to national best practice. This deadline has been revised to Q3 2025/26.
- The Trust will actively engage with patients with lived experience to ensure services meet their needs and improvements are co-produced. This project remains live and on plan.
- The Trust will have a Learning Disability strategy in place, this action has been delayed due to the need to ensure collaboration with those with lived experience. A draft strategy has been proposed and has been co designed with Skills for People. The draft requires further internal discussion and feedback which will take place over Q2 with the aim of having a finalised document in Q3.
- The reasonable adjustment pilot had been delayed and was behind plan. This was due to the need to ensure collaboration with those with lived experience. The pilot has now commenced and is in week 4 of testing. The pilot will continue throughout the summer with audit and evaluation planned for September.

A further action has been identified for the phase 2 action plan as follows:

- The Trust will have a well-defined audit programme to provide monitoring and oversight of key metrics - use of passports, reasonable adjustments and capacity assessments. An audit schedule has been proposed and agreed.

5. RECOMMENDATION

The Board of Directors is asked to note and discuss the content of this report.

Report of Ian Joy

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Executive Director of Nursing
15 July 2025

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 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 Avoiding Term Admissions into Neonatal Units (ATAIN) rate remains consistently above the national 5% target. The Trust Quarter 3 (Q3) ATAIN rate was 7.45% and the Q4 rate was 6.3% on the North East North Cumbria (NENC) Clinical Indicators Dashboard and whilst this does not constitute a safety signal it has instigated internal quality improvement activity. • The maternity service maintained Operational Pressures Escalation Level (OPEL) 1 for 30 days in May, and OPEL 2 for 1 day. There were no staffing Datix reports and no community escalations to support the acute service. Mutual aid was provided to Northumbria Healthcare NHS Foundation Trust (NHFT), with 9 women planned for induction of labour accommodated. • There is concern that the current Peri-Operative model is impacting on the midwifery staffing meeting acuity. An Equality Impact Assessment (EQIA) is being progressed, and work is ongoing with the Peri-Operative leadership team regarding the future staffing model. Mitigations have been agreed in the short term. • The Culture and Staff Wellbeing action plan is being updated following the publication of the Staff Survey results, and recent introduction of the Right Time staff experience programme across the Perinatal Services, from June 2025, to further inform the actions required to support culture and staff experience and retention. The action plan will be ratified by the People and Culture Group in July 2025. • The required standard for Safety Action 5 is that a systematic and evidence based approach to calculating the midwifery staffing establishment has been completed and the Trust Board have evidenced that the midwifery staffing budget reflects the establishment. The Trust has completed a midwifery staffing review following the Birth Rate Plus assessment in June 2024 and is currently awaiting the costed staffing templates to inform the workforce investment plan. This safety action remains at risk until the workforce investment plan is understood and subsequently agreed. • NHS England (NHSE) Specialised Commissioning Regional Leadership Group (RLG) and the Integrated Care Board (ICB) Sub Committee were asked to endorse the Neonatal Critical Care Review (NCCR) recommendations proposed by the Northern Neonatal Network,		

<table>
<tr><td></td><td colspan="6">one of which was for Newcastle Hospitals to continue as a Neonatal Intensive Care Unit (NICU). Whilst the recommendation for the Trust to maintain a NICU was agreed, not all the proposed recommendations were approved. The Neonatal Network will now produce a revised briefing paper for consideration through commissioning governance, then submission to Joint Overview and Scrutiny Committee, scheduled for 29 September. There is a potential impact to the Trust regarding the number of intrauterine transfers, maternity capacity, parental accommodation and cot occupancy and capacity. This impact and any associated risk is yet to be understood but will be considered as part of the estates plan.
• The Trust had been identified as a potential National Maternity and Perinatal Audit (NMPA) alarm level outlier for Apgar score <7 and postpartum haemorrhage (PPH) >1500mls. The Trust has identified data entry errors and clinical factors which have influenced the potential alarm and responded to NMPA to this effect. The NMPA have confirmed that the Trust outlier status will be removed from the NMPA State of the Nation publication based on 2023 data.
• The Secretary of State for Health and Social Care announced a rapid national independent investigation into maternity services and an independent taskforce to review maternity and neonatal services, alongside immediate actions to improve care on the 23 June 2025. There has been no confirmation as to which Trusts will be included in the investigation. The Chief Executive and Chief Nursing Officer of NHSE wrote to all Trusts asking that in the interim trusts act, referencing five specific activities.</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 risk regarding Safety Action 5.
iv. Note the potential risk associated with the Neonatal Critical Care Review.
v. Consider if the data received from the service is satisfactory to provide assurance regarding outcomes and experience.</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>
</table>

PERINATAL QUALITY SURVEILLANCE REPORT

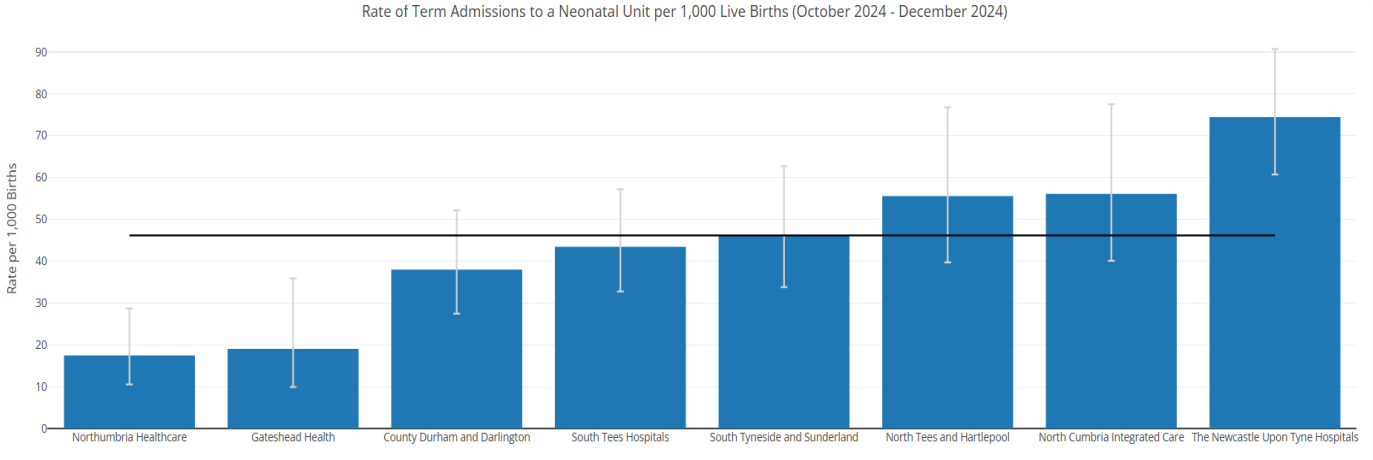
1. INTRODUCTION

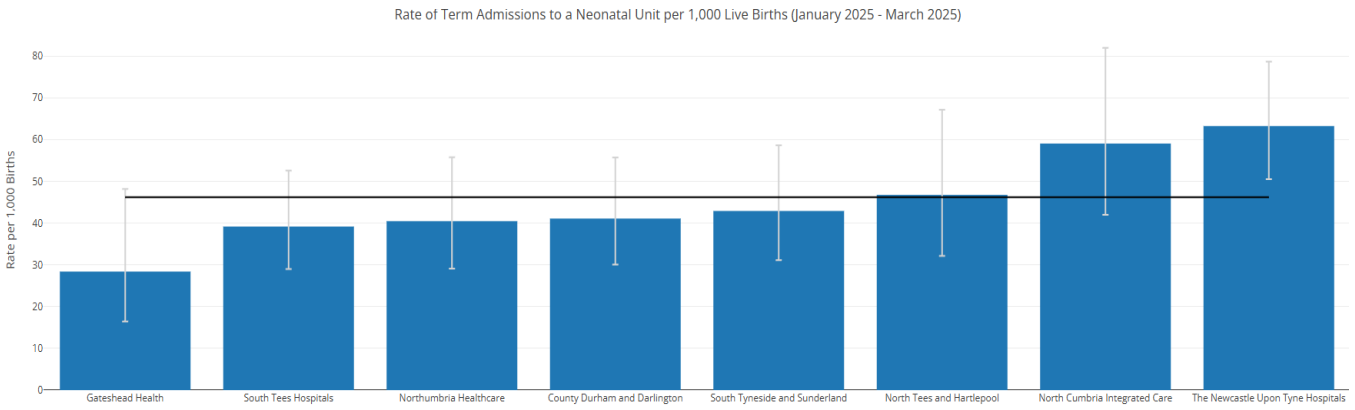
This report provides the Trust Board with an overview of the Maternity Service compliance with the PQSM, based on the locally and nationally agreed measures to monitor maternity and neonatal safety. The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity 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

2.1 Clinical Indicator Dashboard

The Trust ATAIN rate remains consistently above the national 5% target. The Trust Q3 ATAIN rate was 7.45% and the Q4 rate was 6.3% on the NENC Clinical Indicators Dashboard and whilst this does not constitute a safety signal it has instigated internal quality improvement activity. The Local Maternity and Neonatal System (LMNS) have been asked to agree a NENC definition of unplanned admission as most Trusts report admissions of over 4 hours duration whilst the Trust includes all admissions regardless of duration.





All unexpected admissions of term infants are reviewed by the multidisciplinary team and three quality improvement workstreams have been identified. The workstreams are care of infants of diabetic mothers, thermoregulation and respiratory issues following delivery by elective caesarean section, progress is monitored by the Quality and Safety Group and is linked to compliance with Safety Action 3 of Maternity Incentive Scheme.

2.2 Midwifery staffing

Organisational requirements for safe midwifery staffing for maternity settings (NICE 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings. 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 92.5% and Birmingham Symptom Specific Obstetric Triage System (BSOTS) ongoing midwifery care across all categories is above LMNS targets. 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 92% acuity in May 2025.

Fill Rate Midwife Day Shift	Fill Rate Midwife Night Shift	Fill Rate Support Staff Day
104%	103%	80%

There was one red flag recorded in May 2025, relating to a delay in pain relief/missed medication.

Intrapartum care (Delivery Suite and Newcastle Birthing Centre)
The daily BirthRate Plus acuity tool assessment demonstrated that the phase 1 staffing met acuity 80% for Delivery Suite in May 2025 (up from 64% in February 2025) and 94% for Newcastle Birthing Centre (NBC) in May 2025.

Fill Rate Midwife Day Shift	Fill Rate Midwife Night Shift	Fill Rate Support Staff Day	Fill Rate Support Staff Night
84%	82%	74%	71%

There were three red flags in May 2025 for intrapartum care recorded, one brief period when the coordinator provided clinical care, one delayed or cancelled time critical activity, one delay between admission for induction and beginning of process.

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

Work is progressing 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 ongoing concern that the current Peri-Operative nursing staffing model is impacting on the midwifery staffing meeting acuity as midwives are required to provide care in recovery and scrub for theatre cases. A Quality Impact Assessment (QIA) has been drafted, and work is ongoing with the Peri-Operative leadership team regarding the future staffing model. A recent patient safety incident in obstetric theatres and recovery have been considered as part of the QIA risk assessment process and mitigations have been agreed and further explored alongside a staffing review.

Postnatal and transitional care wards

Ward 33

The daily BirthRate Plus acuity tool assessment demonstrated that the phase 1 midwifery staffing met acuity 97% in May 2025. There was no red flags on the postnatal ward reported during May.

Fill Rate Midwife Day Shift	Fill Rate Midwife Night Shift	Fill Rate Support Staff Day	Fill Rate Support Staff Night
102%	98%	98%	134%

Ward 34

The nursing establishment is considered separately. If the ward is staffed as planned there is the capacity to provide care for 6 babies per shift, whilst the bed capacity is 11. There have been no patient safety incidents associated with the nursing staffing model, but there are concerns this is impacting staff experience and wellbeing. An escalation process to support nursing staff is being developed with the Neonatal Intensive Care Unit to be launched in July 2025. The Transitional Care ward was non-compliant with BirthRate plus midwifery staffing in May 2025, with only 41% staffing meeting acuity due to high capacity and complexity. There were no associated patient safety concerns.

Fill Rate Midwife Day Shift	Fill Rate Midwife Night Shift	Fill Rate Support Staff Day	Fill Rate Support Staff Night
134%	98%	116%	134%

Community midwifery teams

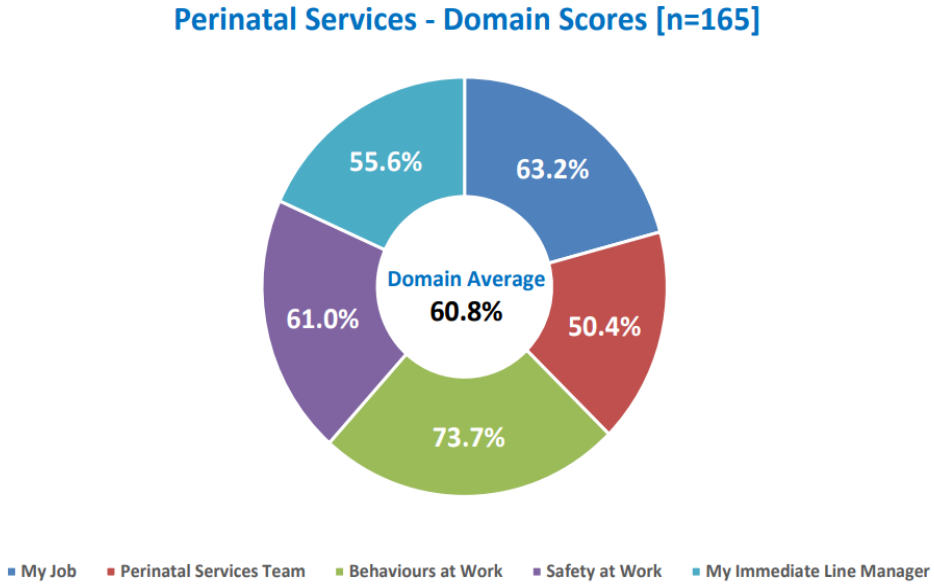
The homebirth service remains fully operational with 100% of on calls covered. Phase 1 midwifery staffing is adequate to maintain safe caseloads across the 4 community teams, although caseloads are currently allocated to two bank members of staff due to maternity leave.

Service overview

The maternity service maintained OPEL 1 for 30 days in May, and OPEL 2 for 1 day. There were no staffing Datix and no community escalations to support the acute service. Mutual aid was provided to NHFT, with 9 women planned for induction of labour accommodated.

2.3 Staff experience

The Culture and Staff Wellbeing action plan is being updated following the publication of the Staff Survey results, and recent introduction of the Right Time staff experience programme across the Perinatal Services from June 2025, to further inform the actions required to support culture and staff experience and retention. The action plan will be ratified by the People and Culture Group in July 2025.



Top 5 Scoring Questions	Score
1. In the last 12 months how many times have you either witnessed or personally experienced physical violence at work from other colleagues? *(% Never)*	100.0%
2. In the last 12 months how many times have you either witnessed or personally experienced physical violence at work from managers? *(% Never)*	100.0%
3. In the last 12 months, how many times have you been the target of unwanted behaviour of a sexual nature in the workplace from staff / colleagues? *(% Never)*	100.0%
4. We are encouraged to report errors, near misses or incidents. *(% Agree/Strongly agree)*	90.3%
5. I always know what my work responsibilities are. *(% Agree/Strongly agree)*	88.8%

Bottom 5 Scoring Questions	Score
1. Relationships at work are strained. *(% Never/Rarely)*	25.2%
2. I am involved in deciding on changes introduced that affect my work area / team / department. *(% Agree/Strongly agree)*	28.8%
3. The team I work in often meets to discuss the team's effectiveness. *(% Agree/Strongly agree)*	30.2%
4. In the last 12 months how many times have you witnessed or personally experienced uncivil behaviour, such as raised voices or inappropriate language, from other colleagues? *(% Never)*	34.7%
5. My immediate manager asks for my opinion before making decisions that affect my work. *(% Agree/Strongly agree)*	37.9%

3. MATERNITY INCENTIVE SCHEME (MIS)

The 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. The Q1 2025/26 update has been provided in accordance with the LMNS guidance.

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?	At Risk
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.	On Track
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 Trust has escalated its concern to the LMNS and ICB regarding the lack of appropriate funding to fully deliver this service and is therefore compliant with the requirements of the scheme.

The required standard for Safety Action 5 is that a systematic and evidence based approach to calculating the midwifery staffing establishment has been completed and the Trust Board have evidenced that the midwifery staffing budget reflects the establishment. The Trust has completed a midwifery staffing review following the Birth Rate Plus assessment in June 2024 and is currently awaiting the costed staffing templates to inform the workforce investment plan. This safety action remains at risk until the workforce investment plan is agreed.

4. NMPA OUTLIER STATUS

The NMPA is preparing to publish its report on outcomes for births that took place in the NHS during 2023 in England, Scotland, and Wales.

The Trust had been identified as a potential alarm level outlier for Apgar score <7 and postpartum haemorrhage >1500mls. The Trust was alerted to safety signals from the NENC Clinical Indicator Dashboard and has completed comprehensive deep dives and audits to understand if there were any safety implications and learning. The review team completing the PPH deep dive discovered the errors in the workflows in the BadgerNet system which allowed for double data entry, and therefore cumulative blood loss, which was often doubled due to midwifery and obstetric data entry. The Trust also provide the Placenta Accreta Spectrum (PAS) service for the ICB, hence care for a more complex case mix which impacts the rates of PPH.

The review team completing the APGAR <7 at 5 minutes review found missing data in records and the incorrect classification of APGAR score when babies are receiving Positive End Expiratory Pressure (PEEP) ventilation with regular respiratory activity.

On this basis the Trust has identified data entry errors and clinical factors which have influenced the potential alarm and responded to NMPA to this effect. The NMPA have confirmed that the Trust outlier status will be removed from the NMPA State of the Nation publication based on 2023 data.

5. NEONATAL CRITICAL CARE REVIEW

The NCCR aims to standardise neonatal services across the UK by aligning units with defined service specifications. This initiative is designed to improve outcomes for babies and families and ensure equitable care; however, it has significant implications for units that have historically operated beyond these specifications.

The Northen Neonatal Network was instructed by NHSE to review the service provision and make recommendations to bring the services in line with both the NCCR recommendations and the neonatal critical service specification in March 2024. The Neonatal Network constituted a task and finish group in 2024 to bring a proposal to the Network Board, LMNS and NHSE.

NHSE Specialised Commissioning RLG and the ICB Sub Committee were asked to endorse the recommendations proposed by the Northern Neonatal Network, one of which was for Newcastle Hospitals to continue as a NICU.

Whilst the recommendation for the Trust to maintain a NICU was agreed, not all the proposed recommendations were approved.

The Neonatal Network will now:

- Complete a data review to highlight impact across the network.
- Produce a revised briefing paper for consideration through commissioning governance, then submission to Joint Overview and Scrutiny Committee, scheduled for 29 September.

There is a potential impact to the Trust regarding the number of intrauterine transfers, maternity capacity, parental accommodation and cot occupancy and capacity. The impact and associated risk is yet to be understood but will be considered as part of the estates plan.

6. NATIONAL MATERNITY INVESTIGATION

The Secretary of State for Health and Social Care announced a rapid national independent investigation into maternity services and an independent taskforce to review maternity and neonatal services, alongside immediate actions to improve care on the 23 June 2025.

Between now and December, the national independent investigation will conduct reviews of 10 trusts where there are specific issues as well as completing a broader systematic review of maternity and neonatal care in England, they will then publish one national set of actions to ensure every woman and baby receives safe, high-quality and compassionate care. The government is also establishing a National Maternity and Neonatal Taskforce, chaired by the Secretary of State for Health and Social Care, which will be made up of a panel of esteemed experts and bereaved families. There has been no confirmation as to which Trusts will be included in the investigation.

The Chief Executive and Chief Nursing Officer of NHSE wrote to all Trusts asking that in the interim Trust Boards take the following action:

i. Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.
ii. Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.

iii. Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.
iv. Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.
v. Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it.

An update will follow in due course. The Trust Board are asked to consider if the data received from the service is satisfactory to provide assurance regarding outcomes and experience.

7. CONCLUSION

The Trust Board 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 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.

There are robust improvement plans to ensure compliance with the Maternity Incentive Scheme and Three Year Plan for Maternity and Neonatal Care; performance is being tracked and progress monitored to ensure the mitigations in place are supporting patient safety.

8. 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 risk regarding Safety Action 5.
iv. Note the risk associated with the Neonatal Critical Care Review.
v. Consider if the data received from the service is satisfactory to provide assurance regarding outcomes and experience.

Report of Ian Joy
Executive Director of Nursing
3 July 2025

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Agenda Item A10(c)(ii)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 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 May 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 23 May 2025.					

MATERNITY SAFETY CHAMPION REPORT - JUNE 2025

I visited the Maternity Department in June and spent some time talking to the very experienced clinician who runs the vaccination service within Maternity services. Pregnant women are advised to get two whooping cough vaccinations to protect their unborn babies when they have their 20 week scan and their 28 week scan. The maternity department has a drop in vaccination clinic (room) on the 4th floor of the Leazes wing, near to the Maternity reception at the Royal Victoria Infirmary (RVI). It is open 5 days a week and is currently getting on average 15-20 visitors per day, despite having capacity for many more.

The communications to pregnant mothers is mixed and not doing a good enough job. Some pregnant women know that they should get the 2 vaccinations but think they can have them at any point during the pregnancy, including towards the end of the 40 weeks. However, vaccinations at times other than at 20 weeks and 28 weeks are ineffective or less effective. Women visiting the department for ante-natal care often do not know that the vaccination centre offers a drop in service, meaning no advance booking is required. They don't know where it is located. The signage is not effective because it is flat against the wall above the door, rather than hanging in the sight line overhead in the corridor (as do all the other signs).

There is a new inoculation against Respiratory Syncytial Virus (RSV) which can be very harmful to new babies, although it would only seem to be a cough and a cold to adults. In the USA both parents are inoculated against RSV as a matter of course. The inoculation was launched in September of last year and if given at 28 weeks into the pregnancy will give protection to the unborn and then the new baby up to age 6 months. Again, communication around this precautionary and welcome vaccine to expectant parents could give vital protection to very young babies.

I was delighted to be able to spend some quality time in the birthing centre and I spoke to a number of staff present there that day. They were all extremely pleased with the service being up and running again; they were pleased the centre is being well used, but they would like to see more patients, and more diverse parents, visiting and using the centre. On the day I visited two maternity support workers (MSWs) were giving tours to prospective parents until 8pm in the evening. One community-based midwife expressed her concern about the cultural differentiators that lead to some parts of the Newcastle community not being interested in using the Birthing Centre. Some families in these areas prefer a more traditional approach to birth with ‘beds’ and ‘doctors’ rather than baths and midwife support. As some members of these communities also tend to be of higher risk during pregnancy, they are also more likely to be steered away from using the birthing centre as a first choice, reinforcing the idea that the Centre is ‘not for them’.

Whilst at the Birthing Centre I had yet another conversation about the untapped potential of the MSWs and how training programmes, particularly part time and flexibly delivered programmes, could free up willing potential which would equate to additional resource for the department. Often highly experienced, but unqualified in terms of midwifery, these colleagues could offer so much more than they currently do, particularly in terms of post-natal support and breastfeeding training. They did say that there is a lot of work ongoing in

terms of reviewing the framework of contracts, and the related training, but it is generally believed that MSWs on the wards do less by way of support, (thereby reducing midwives' workload), than the MSWs who are working in the community. Community staff are given much more responsibility and have more autonomy in terms of doing 5 day visits, jaundice reviews, and breastfeeding training, even though they are contracted on Band 3. Having said that, more flexible working patterns would be greatly welcomed for colleagues working in the community, particularly those who work in very disadvantaged areas.

To be rather downbeat for a moment, the Centre has received some patient feedback about the induction space and related practice. Women being inducted need privacy as the process / intervention can be distressing and painful and personal space divided by curtains does not give the privacy needed at such a time. Both prospective mums and dads have expressed dissatisfaction, or been put off by this element of the birthing process, i.e. the prospect of 'shared space'. Whilst I understand the challenges presented by the accommodation, single rooms offering privacy for women at this particular point would seem vital to improving patient experience.

I met a 'rotational' midwife who told me how very much she enjoyed being assigned to the Birthing Centre where she is kept busy in a very fulfilling environment

The Birthing Centre is run by a small, highly skilled team which works well together and the individuals that I spoke to all thoroughly enjoy the working environment and the patient care that they offer.

As ever, it is clear that the Maternity Department continues to go from strength to strength in terms of its culture, the expectations staff have of themselves and each other, the aspirations that they have for their patients, and this is evidenced in physical form by the reopening of this valued resource.

Report of
Liz Bromley, Non-Executive Director
17 June 2025

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Agenda item A11

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 2025					
Title	Committee Chair Meeting Logs					
Report of	Bill MacLeod, Chair of the Finance and Performance Committee Anna Stabler, Chair of the Quality Committee Hassan Kajee, 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 May 2025: • Finance and Performance Committee – 19 May 2025 and 23 June 2025 • Quality Committee – 13 May 2025 and 17 June 2025 • People Committee – 13 May 2025 • Charity Committee – 10 June 2025 *[Funding only meeting]* • Audit, Risk and Assurance Committee – 20 May 2025 and 25 June 2025 • Digital and Data Committee – 20 March 2025 and 8 May 2025					
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 – May 2025.					

Agenda item A11

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**: 19 May 2025
Connecting to: Audit, Risk and Assurance Committee Trust Board	**Date of Meeting**: 24 June 2025 25 July 2025

Key topics discussed in the meeting

- In relation to the month 1 finance report, the Trust has submitted a breakeven plan for 2025/26 and remains on plan. The report included the risks associated with the delivery however that the focus is to deliver the forecasted breakeven position. The report has been redesigned, and Committee members were asked to provide any feedback.
- At month 1, the total capital expenditure to date was £1.4m against a plan of £1.3m. The Trust's plan currently exceeds the allocation by £7.8m which will be managed in year through both delays in schemes and additional VAT recovery which may be available.
- The month 1 Integrated Board Report was presented. In February 2025, the 77% 28 Day Faster Diagnosis Standard (FDS) was achieved for the first time in eight months at 83.4%. The total waiting list size has decreased further in March 2025 and overall emergency care 4-hour performance improved for the four successive month increasing to 77.48%.
- A comprehensive presentation took place in relation to cancer and diagnostic performance. In March 2025, the Trust delivered performance of 80.9% against the 28-day faster diagnosis standard and tumour groups are meeting or exceeding the standards. In relation to diagnostics, performance against the 5% standard worsened in March 2025 for the first time in seven months. 16.3% of patients were waiting over six weeks at the end of March compared to 13.0% in February however it was noted that this is a considerable improvement from August 2024. Overall challenges and actions taken were discussed in detail for both performance areas.
- The first iteration of the Board Assurance Framework was presented which is still under development. Key changes relate to risk ID 6.1, 6.2 ad 5.1. Committee members were asked to review and provide feedback in relation to the risks/threats.
- The Joint Medical Director provided an update on the new Job Planning process and policy. A total of 617 (51.2%) job plans were submitted by 1 May 2025 of which 540 had sufficient information to allow full review. A job planning advisory group is being established to monitor consistency of application. The aim is to carry out job planning for 2026/27 in Quarter 4 of 2025/26.
- An update on Commercial progress throughout 2024/25 and areas of focus for 2025/26 was provided. A new pillar has been added to the Commercial Strategy which is 'Commercial Research'. The majority of the 2025/26 activity plans have been

drawn up, with most schemes requiring cross departmental delivery, demonstrating a collective effort in the delivery of our commercial activity ambitions.
- A Business Case was approved.
- The Committee received the minutes and Chairs Logs of the Capital Management Group in April and Financial Recovery Steering Group in May.
- The Finance and Performance Committee Annual Report 2024/25 was received and the content noted. The Annual Report 2024/25 will be included in the Public Board of Directors papers.

Actions agreed in the meeting	Responsibility / timescale
No actions agreed.	No actions agreed.

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 – Information Technology (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

Finance and Performance (F&P) Committee - Chair's Log

Meeting: Finance and Performance Committee	**Date of Meeting**: 23 June 2025
Connecting to: Audit, Risk and Assurance Committee Trust Board	**Date of Meeting**: 22 July 2025 25 July 2025

Key topics discussed in the meeting

- The Cancer and Haematology Clinical Board provided a presentation in relation to the Clinical Boards financial position and cost improvement plans. As at month 2 the Clinical Board reported a £999k adverse variance against budget. The Clinical Board has Cost Improvement Programme (CIP) plans totalling £2,590k against a full year target of £3,007k and as at month 2, £571k of CIP has been achieved and transacted.
- In relation to the month 2 finance report, the Trust has submitted a breakeven plan for 2025/26 and remains on plan. The report included monitoring against the planned position and that the planned CIP is currently being met predominantly through technical non-recurrent benefits rather than cost reduction.
- At month 2, the total capital expenditure to date was £6.8m against a plan of £4.3m. The Trust's plan currently exceeds the allocation by £7.8m which will be managed in year through both delays in schemes and additional Value Added Tax (VAT) recovery which may be available.
- The Integrated Board Report (IBR) was presented and the key areas highlighted were in relation to the decline in overall Emergency Care performance in April 2025, Referral to Treatment (RTT) 18-week performance was recorded at an improving 72.6% and 62 day cancer compliance for March 2025 was 65.2%, consistent with a continuation of improving special cause variation despite an overall consistent failure to hit the target.
- A deep dive into Emergency Care took place highlighting the following areas:
  - The Trust has not achieved the national 4-hour standard of 78% since August 2023. Actions being taken to improve the position were discussed.
  - Progress has been seen particularly in relation to type 1 breaches.
  - Challenges within specific services with a key limiting factor across the Trust being inefficient estate, which impacts patient flow and bed delays.
  - Surgical streaming is being relaunched to reduce the number of patients being seen within the Emergency Department.
- An update was provided in relation to the draft Winter Plan for 2025/26 which mirrors last year's plan with the primary objective being to optimise safety of services during times of sustained pressure. The Winter Plan update set out the Urgent and Emergency Care (UEC) plan, specific requirements for NHS Trusts, key planning assumptions, objectives, initiatives and Clinical Board plans. The Winter Plan will be presented at the Public Board of Directors in July 2025.

- The Board Assurance Framework (BAF) including the strategic risks aligned to the Committee was presented with all current risk scores remaining unchanged. One new threat has been added to BAF risk 5.1.
- The Procurement and Supply Chain Director provided a comprehensive presentation in relation to procurement and a briefing on the new Procurement Act 2023. The presentation included the transition in which legislation applies, the impact, procurement objectives, conflict of interest obligations, supplier exclusion provisions, contract performance and Key Performance Indictor (KPI) reporting.
- The Committee ratified the Sustainable Healthcare Committee Terms of Reference.
- The Committee received the Chairs Logs and minutes of the Capital Management Group in May, Financial Recovery Steering Group in May, Supplies and Service Procurement in May, the Sustainable Healthcare Committee in June and the National Cost Collection paper.

Actions agreed in the meeting	Responsibility / timescale
1. Winter Plan - an update on Intermediate Care to be brought back to a future Committee meeting.	1. The Interim Director of Operations / September 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.	Not applicable.

Agenda item A11

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Quality Committee
Chair's Log

Meeting: Quality Committee	**Date of Meeting**: 13 May 2025
Connecting to: Audit Risk & Assurance Committee and Trust Board	**Date of Meeting**: 23 May 2025 25 July 2025
Key topics discussed in the meeting	

- **CQC** – A general update on progress within the following areas were received:
  - Medicines Oversight Group including Medicines Management Action Plan
  - Emergency Department
  - Feedback from Quality Improvement Group (QIG)
- **Management Groups Chairs Logs**
  - **Patient Safety Group (PSG).** Key topics for discussion included:
    - Patient Safety Partners Update
    - Deteriorating Patient Group Annual Report
    - Risk Management
    - Patient Safety Incident Forum
    - Harm Free Care Group
    - Medication Safety Group
  - **Transplantation Committee**. Key topics for discussion included:
    - An update was provided on the National Organ Utilisation Strategy (NOUS).
    - Patient and Public Involvement and Engagement (PPIE) and the approach to take was discussed.
    - An update on the mortality review in heart transplants was presented.
    - A comprehensive discussion with regards to the ExVivo Lung Perfusion (EVLP) service plan took place.
    - The Assessment and Repair Centre (ARC) Development plan was discussed.
    - Sustainability and Certainty in Organ Retrieval (SCORE) programme was discussed.
- **Draft Quality Account 2024/26 for Review.** Each year the Trust is required to produce and publish a Quality Account. Contained within the report was 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. This was noted and it was requested that the final version for approval be received by the Committee.
- **7 Day Services Audit Report.** The report focused on four of the 10 seven-day services standards that were identified as a priority for patients admitted in an emergency. The concerns with compliance were noted, recognising that this was impacted by a

data quality issue. It was requested that an update be brought once the data issues had been resolved

- **Patient & Staff Experience update.** The presentation provided an update on the patient experience based on the feedback of 11,422 individuals. Results for March 2025 were shared. Results remained very good and in the top 20% of all Trusts when benchmarked against national survey results for inpatients, outpatients, and maternity.
- **Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress**. The report provided the Quality Committee with an update 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 to the Committee's attention as outlined in the report summary section. The concerns regarding funding for the Maternity and Neonates Voices Partnership (MNVP) involvement in maternity services and funding allocated by the Integrated Care Board (ICB) for maternal mental health were noted and escalated to the ICB in the meeting. It was agreed to escalate to Trust Board via ARAC by the committee chair.
- **End of Life and Palliative Care update** The report provided an overview of the Palliative Care Service Key Strategic Aims for 2025-2027 as well as an update on
    - Terminally Ill Adults (End of Life) Bill
    - Patient And Carer Experience of Palliative Care Service
    - End Of Life Care Domiciliary Care Provision
    - Deciding Right and Advance Care Planning
    - Caring For the Dying Patient Document - Digital Project
    - Continuous Subcutaneous Infusions Quality and Safety
- **Wards of Concern and Accrediting Excellence (ACE) Progress Report** The report highlighted wards of concern raised via the professional Nurse Staffing and Outcomes Group (NSOG) along with an update on the Accrediting Excellence Programme (ACE).
- **Eden Court Update –** an update on commissioned intermediate care provision was provided. Multiple concerns regarding this provision were noted including the lack of a local/regional intermediate care plan. It was agreed to escalate this to the regional ICB Place meeting
- **Six-month Nurse Staffing Review Deep Dive -** The report comprised of both the Nurse Staffing six-month review (2024/25 Quarters 3 and 4) and the quarterly safe staffing assurance report. It also fulfilled the recommendations of the NHS Improvement 'Developing Workforce Safe guards' 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. All areas or potential risk and mitigation as outlined in the report summary were discussed and noted.
- **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. Infection Prevention and Control (IPC) indicators continue to be closely monitored with a deep dive update planned for the committee in July.
- **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.
- **Quality Committee Annual Report –** The report provided 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 report outlined overall achievements throughout the year and action points for continuing development during the coming year.

Actions agreed in the meeting	Responsibility / timescale
1. Medicines Oversight Group (MOG) now established as a tier 2 committee, therefore update removed from CQC update to business as usual. Quarterly MOG report to come to Quality Committee – schedule to be determined by IJ and JS.	• Executive Director of Nursing (IJ) and Director of Pharmacy (JS)
2. Audits and Standard Operating Procedures (SOPS) from the Emergency Department are to be included in the reading room for future updates as evidence of improvement.	• Director of Operations and Head of Nursing - Medicine and Emergency Care
3. Matron Governance Report and action plan for improvement to be shared with the Committee	• Executive Director of Nursing – July Committee
4. Update to be provided in relation to accountability/ leadership / mentorship of medics	• Joint Medical Director - LPC Date to be determined
5. Digital & Data priorities currently being reviewed by Care Optimisation Group – an update will be provided for the Committee.	• Executive Director of Nursing – July Committee
6. Quality Account - The contents were noted, and it was requested that the final version for approval be received by the Committee in June	• Director of Quality & Safety – June Meeting
7. Seven Day Service Audit Report – update paper to be provided to the Committee following re-audit	• Director of Quality & Safety – September Committee
8. The ICB has a requirement in the 3-year plan to commission a maternal Mental Health Service to give the Trust an opportunity to refer women into a service fit for purpose. This has not been commissioned by the ICB as yet with no funding model. This was to be raised with the ICB as women accessing services in Newcastle were potentially being disadvantaged and what assurances can be given by the ICB being mindful they have been funded to do so.	• Deputy Director of Nursing, North East and North Cumbria (NENC) ICB – update for June Committee
9. The NENC ICB/ Local Maternity and Neonatal System (LMNS) has not commissioned the MNVP in accordance with the national guidance and is therefore not compliant with the requirements of Safety Action 7. The Trust has escalated its concern to the LMNS. This to be raised with the ICB.	• Deputy Director of Nursing, NENC ICB – update for June Committee
10. The Carbapenemase Producing Enterobacteriaceae (CPE) outbreak on the Neonatal Intensive Care Unit is being investigated as a patient safety incident investigation (PSII) with the engagement of ICB and	• Director of Midwifery once report completed.

NHS England colleagues. There have been no further colonisations. The outcome to be shared in the Quality Committee reading room	
11. Impact on discharges following cessation of Bluebird Contact specifically on staff with the number of different forms to be completed due to exaggerated process and whether this is impeding the timeliness of discharges to be raised with the ICB and the PLACE Committee. The scale of the problem to be shared with Deputy Director of Nursing, NENC ICB.	• Deputy Director of Nursing, NENC ICB – update for June Committee
12. Wards of Concern update to include trends / themes and the actions taken for improvement from a quality & safety perspective	• Deputy Director of Nursing – next report in July Committee
13. Eden Court / Intermediate Care update including how the provision is working during summer and what the plans are moving forward in to winter	• Director of Operations – Medicine and Emergency Care – September
14. The next Nurse Staffing Review Report to include the plan / model / process for recruitment being mindful of Government's new migrant policy	• Executive Director of Nursing – next report in November 2025
15. Quality Committee Annual Report – to note under section 5.2 that both the Allied Health Professions (AHP) and Maternity Staffing Reports have been independently shared with Quality Committee.	• PA and Corporate Governance Officer – June Committee
16. Quality Committee Annual Report – to determine if the report should be shared with Governors	• PA and Corporate Governance Officer – June Committee
Escalation of issues for action by connecting group/Trust Board	**Responsibility / timescale**
• The ICB has a requirement in the 3-year plan to commission a maternal Mental Health Service to give the Trust an opportunity to refer women into a service fit for purpose. This has not been commissioned by the ICB as yet with no funding model. This was to be raised with the ICB as women accessing services in Newcastle were potentially being disadvantaged and what assurances can be given by the ICB being mindful they have been funded to do so.	• Anna Stabler to share with Trust Board for oversight.
• The NENC ICB/LMNS has not commissioned the MNVP in accordance with the national guidance and is therefore not compliant with the	• Anna Stabler to escalate to Trust Board for oversight.

requirements of Safety Action 7. The Trust has escalated its concern to the LMNS. This to be raised with the ICB.	
• Longer term strategy and risks in relation to intermediate care beds following the loss of Eden Court	• Anna Stabler to escalate to Trust Board for oversight.
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**: 17 June 2025
Connecting to: Audit Risk & Assurance Committee and Trust Board	**Date of Meeting**: 26 June 2025 25 July 2025
Key topics discussed in the meeting	

- **Care Quality Commission (CQC)** – A general update on progress within the following areas were received details of which are included within the reports:
    - Mental Health
    - NECTAR
    - Emergency Department
    - Feedback from Quality Improvement Group (QIG)
- **Management Groups Chairs Logs**
    - **Transplantation Committee**. Key topics for discussion included an update on European Neuroendocrine Tumour Society (ENETS) Accreditation, discussion around the National Organ Utilisation strategy as well as a performance update. No new escalations to the committee were noted.
    - **Experience of Care Group** Key topics for discussion included AccessAble 2024/25 annual report, annual report from Language Empire, Learning Disability and Autism Quarter 4 (Q4) report, Complaints Improvement plan and an update from the Partnership and Involvement Panel. No new escalations to the committee were noted.
- **Quality Priority 1 Update.** The update provided an overview and assurance to the Quality Committee that plans are in place for Quality Priority 1 (QP1) 2025/26, building on the improvements achieved in 2024/25 which promoted incident reporting by supporting staff to feel confident to report incidents.
- **Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress**. 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 to the Committee's attention as outlined in the report summary section with escalations noted, discussed and further escalation agreed within the meeting.
- **Quarter 4 Reports for:**
    - **Safeguarding** An overview was provided in relation to current activity and any service pressures or emerging risks, Audit and Assurance, Progress with

actions in response to the internal audit report, Education and training, and Practice Development Initiatives
    - **Learning Disability** The update included evidence of action relating to the Quality Account Priority - To ensure reasonable adjustments are made for patients with suspected or known Learning Disability and/or Autism. Appropriate and consistent use of Mental Capacity Assessment & Deprivation of Liberty Safeguards for patients with vulnerabilities.
    - **Learning from Deaths** The update provided 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. This paper also summarises the processes that are in place to provide assurance to the Committee that all deaths are reviewed including those with potentially modifiable factors.
- **Quality Performance Reviews Update** The update provided an overview of the meetings, detailing any areas of risk and matters for escalation to Quality Committee. Areas of good/excellent practice were also detailed for information and sharing. No new escalations were noted for the committee's attention
- **Quality & 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 and commenced in September 2024. A comprehensive overview of the last quarters inspections was provided and discussed.
- **PLACE Inspection Update Report** The Patient Led Assessment of the Care Environment (PLACE) is an NHS mandatory requirement undertaken by all healthcare organisations on an annual basis. This paper provides and overview of the 2024 results. A number of recommendations were discussed and agreed and oversight will be provided by the PLACE Steering Group.
- **Learning from Excellence** A presentation was provided with regard to using artificial intelligence to improve the early management of venous thromboembolism.
- **Health Inequalities Update** The report provided Quality Committee with an update of progress in relation to the Trust Health Inequalities Strategy for the Promoting Equity in Health Group (PEHG), the newly established tier 2 Committee and oversight group for health inequalities.
- **Mental Capacity & Mental Health Screening - Internal Audit Report** As part of the 2024/25 Internal Audit Framework, Audit One undertook two follow-up audits of the application of Mental Capacity and Mental Health Screening in practice: one for the application in the Emergency Department (ED) and one in Inpatients. Both audit reports were received on 21 May 2025 and demonstrated reasonable assurance. It was acknowledged that a significant amount of work had been undertaken since the original report, but also noted areas for further improvement.
- **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. The committee endorsed the changes recommended in the paper.
- **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. Infection Prevention and Control (IPC) indicators continue to be closely monitored with a deep dive update planned for the committee in July.

- **Quality Account** Each year the Trust is required to produce and publish a Quality Account. Contained within, was 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 final version was approved for publication by the committee.

Actions agreed in the meeting	Responsibility / timescale
1. Unplanned Downtime of the APEX Laboratory testing system. Close down report including any incidents of harm and learning to be presented to the Committee.	• Executive Director of Nursing – September 2025.
2. Emergency Department – to included additional detail relating to flow changes at front door as part of future CQC Emergency Department (ED) update report.	• Director of Operations – September
3. Transfer from DATIX to InPhase – 'MopUp' report with any learning from both incidents and the transfer process to be provided for review by the committee.	• Director of Quality & Safety – October 2025
4. ICB requirement in the 3-year plan to commission a maternal Mental Health Service. This had not been commissioned by the ICB yet with no funding model identified. This has been escalated but due to the potential Health Inequalities across the system, an escalation to be prepared and submitted to the PLACE Committee.	• Executive Director of Nursing and Director of Midwifery – July 2025
5. Next Learning Disability Report to include deeper dive into pain management and how it is documented for those patients with a learning disability.	• Executive Director of Nursing – September 2025
6. Learning from Deaths – breakdown of reviews by The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) scores to include any themes in the next report particularly for NCEPOD 2A - Room for improvement: Aspects of clinical care that could have been better and NCEPOD 2B -Room for improvement: Aspects of organisational care that could have been better.	• Director of Quality & Safety
7. One death in Q4 2024/2025 that underwent L2 review received a score of NCEPOD 3. To determine the reason and provide clarification why the level of harm was downgraded.	• Director of Quality & Safety / Joint Medical Director - July 2025

8. Case discussed as part of Learning from Deaths report which highlighted a patient who had waited on a urgent waiting list for 30 weeks and had been lost to follow up. Assurance was sought that learning had been embedded and this is not re-occurring now.	• Director of Quality & Safety / Joint Medical Director - July 2025
9. Learning from Deaths – next report to include clear Key Performance Indicators (KPI's) in relation to the completion of level 2 reviews by the medical examiner.	• Director of Quality & Safety
10. The work of the Nutritional Steering Group (including overview of the progress with electronic meal ordering) to be added to a future agenda.	• Executive Director of Nursing
Escalation of issues for action by connecting group/Trust Board	**Responsibility / timescale**
• NHS England (NHSE) objectives at risk of completion, with eleven specific actions. The most impactful to the Trust being the publication of national postnatal guidance, obstetric workforce modelling and role descriptors and the support for capital neonatal estate and output of the national maternity and neonatal unit infrastructure compliance survey. The Perinatal Leadership team have escalated a request for further information to the Regional Chief Midwife via the Regional Perinatal Quality Surveillance Meeting and have not received any further updates.	• Anna Stabler – June Board
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Detailed within the BAF	• Not applicable

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

People Committee - Chair's Log

Meeting: People	**Date of Meeting**: 13 May 2025
Connecting to: Audit, Risk and Assurance Committee (ARAC) Trust Board	**Date of Meeting**: 24 June 2025 25 July 2025
Key topics discussed in the meeting	

- An update was provided in relation to the new designed people governance structure which incorporates oversight of the people related groups within the Trust alongside the re-introduction of the People Programme Board.
- A comprehensive discussion took place with regards to the Year 2 People Plan including the timeline prior to the launch and engagement plans. The Year 2 People Plan has been directly informed by the 2024 staff survey results/ feedback received and Year 1 People Plan actions.
- The annual Workplace Disability Equality Standard (WDES) and Workplace Race Equality Standard (WRES) reports were presented and ratified for Trust Board approval. It was noted that both WRES and WDES results have improved however they remain a long way from where the Trust would like them to be which is a key focus going forward.
- The Committee welcomed Paula Dimacro, Interim Freedom to Speak Up Guardian (FTSUG).
- The Committee received an update on the Voluntary Redundancy Scheme position.
- The People Integrated Board Report was presented which included information on sickness absence, retention and turnover, statutory and mandatory training and appraisals. The importance of staff members completing statutory and mandatory training and appraisals was noted.
- The first draft of the refreshed People Board Assurance Framework was presented. Further discussions will take place in relation to the content and additions will be included once the Year 2 People Plan has been finalised.
- A summary of Internal Audit Reports was presented which detailed the internal audit plan and associated recommendations aligned to the People Committee areas of focus.
- The Committee considered a Legal update report which had a positive trend.
- The Trade Union Facility Time report was presented, and the content was approved for publishing on the government portal and in the Trust Annual Report and Accounts 2024/25.
- The People Committee annual report was received which outlines overall achievements throughout the year and action points for continuing development during the coming year. The report will be included in the May Public Trust Board papers.

- The People Programme Board Chairs Log from the April meeting was received which included a summary of key topics discussed and agreed actions from the meeting.

Actions agreed in the meeting	Responsibility / timescale
1. The Acting Associate Director of People and Organisational Development (AADPOD) agreed to circulate a graph which provides detail against the national average for behaviours and civilities.	1. The AADPOD / May 2025
2. The Committee asked the People Programme Board to discuss: • The gap in appraisals; • Flexible working requests; and • International recruitment.	2. The AADPOD / July 2025
3. A workforce numbers dashboard, coproduced by the Human Resources (HR) team and Finance team to be presented at the July People Committee.	3. The Head of HR Services / July 2025
4. The Executive Director of Nursing (EDN) agreed to pick up Basic Life Support and Paediatric Basic Life Support Statutory and Mandatory training in the Quality Performance Reviews (QPRs).	4. The EDN / July 2025
5. The Head of Corporate Risk and Assurance (HCRA) to discuss where Equality, Diversity and Inclusion (EDI) sits within the Board Assurance Framework and to reword a sentence in relation to effective workforce planning.	5. The HCRA / July 2025
6. A revised version of the Summary of Internal Audit reports relating to the People Committee with updated management updates to be submitted to the July Committee meeting.	6. The HCRA & AADPOD / July 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.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Charity Committee - Chair's Log

Meeting: Charity Committee – Funding only	**Date of Meeting**: 10 June 2025
Connecting to: Audit, Risk and Assurance Committee / Trust Board	**Date of Meeting**: 22 July 2025 / 25 July 2025
Key topics discussed in the meeting	
• Funding proposals were discussed in relation to: ○ Peri-Operative and Critical Care - £56,376 – Staff Engagement Post – Supported in principle with the conditions to be met. ○ Family Health - £62,632 – Modern Examination Tables – Supported with conditions to be met. ○ Peri-Operative and Critical Care - £28,422 – Peri-ops Office Transformation – Not Supported. ○ Trust-wide - £82,880 — Hospital and Home Exercise Support Project - Supported. ○ Surgical and associated services (Royal Victoria Infirmary)- £36,228 – Home Video Telemetry Equipment – Supported. ○ Family Health - £57,675 – Hoops 4 Health – 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.	
Escalation of issues for action by connecting group	Responsibility / timescale
No matters for escalation.	
Risks (Include ID if currently on risk register)	Responsibility / timescale
None noted.	

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Audit, Risk and Assurance Committee (ARAC) - Chair's Log

Meeting: ARAC	**Date of Meeting**: 20 May 2025
Connecting to: Board	**Date of Meeting**: 25 July 2025
Key topics discussed in the meeting	

- The meeting action log was received and there were no matters requiring attention. The actions proposed for closure were agreed as complete. Action 291 was also agreed as complete [Annual Report content checklist) and it was agreed that an update on action 308 [Capital Plan and residual risks] would be presented at the July Committee meeting.
- Updates from the Quality, Finance & Performance (F&P) and People Committee Chairs were shared – this covered Clinical Negligence Scheme for Trusts (CNST) compliance, mental health services funding, bed closures, appraisal compliance rates and the financial position.
- Board Assurance Framework (BAF) Report – The report provided a first iteration of the 2025/26 BAF and it was noted to be still under development. The main changes were outlined, along with the risks that required further consideration. Committee members reviewed and discussed the proposed principal risks and associated threats, as well as other potential risks e.g. digital (in relation to quality of care). It was requested that the timeline for production of the new BAF be brought forward for next year so that the BAF for 2026/27 is produced before 31 March 2026. Committee members agreed that further work is conducted to provide assurance over the uniformity/consistency of scoring of assurance ratings and progress indicators.
- Risk Report – The report provided an overview of the Trust Risk profile and to provide assurance from the Risk Validation Group (RVG) relating to the areas validated by the Group. Membership of the RVG had been expanded to include Clinical Board representation. Committee members discussed the need for further assurance where mitigations have been put in place but risk scores have remained unchanged or have increased. It was agreed that the Clinical Board risk deep dives be undertaken in the RVG meetings, with the RVG to make a recommendation to ARAC as to any changes to risk scores.
- Senior Information Risk Owner (SIRO) Report – The report provided an update on areas within the SIRO areas of responsibility and accountability. The SIRO role was now being undertaken by the Director of Communications and Corporate Affairs and future iterations of the report would be more assurance focussed. Committee members discussed the Information Asset Owners programme, Information Governance training compliance levels and cyber security.
- The draft Annual Report and Accounts for 2024/25 were received. The report detailed the changes in the Annual Reporting Manual from 2023/24 to 2024/25 and areas that were still to be completed were highlighted. Some Committee members had recently shared feedback directly to the Trust Secretary, which included that the document was particularly lengthy. The Trust Secretary confirmed that the process for production would be reviewed for next year with length restrictions to be implemented for content authors.
- The Annual Report of the Committee 2024/25 was discussed and agreed. The areas of focus for 2025/26 were outlined, which were based on feedback from the effectiveness survey.

Committee members discussed the meeting frequency and agreed that this be reduced to 6 meetings per annum.

- The updated Annual Governance Statement was discussed – Committee members requested that further consideration be given to the wording in the conclusion of the Statement to be more explicit regarding the assurance level.
- The following reports were received for information and the contents noted:
    - Litigation and Legal Cases report – Committee members discussed processes for monitoring/reporting compliance with section 28 notices.
    - Seven-day service clinical standards report – the report had been discussed at the Quality Committee with a further update to be brough back in circa 3 months' time.
- The Committees Chairs Logs were received for the following Committee meetings:
    - Finance and Performance Committee – 22 April 2025
    - Quality Committee – 15 April 2025
    - Charity Committee – 17 April 2025
    - Compliance and Assurance Group – 9 April 2025

Actions agreed in the meeting	Responsibility / timescale
1. The Head of Corporate Risk and Assurance (HCRA) agreed to liaise with the Director of Estates, Facilities and Strategic Partnerships to bring an update on action 308 to the July Committee meeting.	1. HCRA - 22 July 2025
2. The HCRA and the Director of Performance and Governance (DPG) to review uniformity/consistency of scoring of assurance ratings and progress indicators in the BAF and provide an update at the next Committee meeting.	2. HCRA and DPG – 24 June 2025
3. The HCRA and DPG to review and update the content of the risk report to include rationale and decision making around risk scores, specifically those which remain unchanged, where controls are not mitigating the risk, and where current risk scores have increased higher than the initial risk score	3. HCRA and DPG – 24 June 2025
4. The HCRA and Acting Chief Executive (ACEO) to update the conclusion in the Annual Governance Statement based on the feedback from Committee members.	4. HCRA and ACEO – 24 June 2025
5. The Trust Secretary (TS) to update the Schedule of Business to cover six meetings per year and update meeting invites once agreed with the Committee Chair.	5. TS – 24 June 2025

6. Committee Chair to observe a future RVG meeting – the HCRA to facilitate.	6. HCRA – 24 June 2025
7. The TS to liaise with the Digital and Data Committee Chair regarding attendance at future ARAC meetings.	7. TS – 24 June 2025
8. The TS to update the Trust Annual Report based on the feedback received.	8. TS – 24 June 2025
Escalation of issues for action by connecting group	Responsibility / timescale
The Quality Committee Chair gave an update, for information, on the matters agreed for escalation to the Trust Board from the Quality Committee.	N/a
Risks (Include ID if currently on risk register)	Responsibility / timescale
All BAF risks were detailed in the BAF report. The risk report also included Trust risks. All 15+ risks were detailed in the risk report appendices.	N/a

Agenda item A11

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Audit, Risk and Assurance Committee (ARAC) - Chair's Log

Meeting: ARAC	**Date of Meeting**: 24 June 2025
Connecting to: Board	**Date of Meeting**: 25 July 2025
Key topics discussed in the meeting	

- The meeting action log was received and there were no matters requiring attention. The actions proposed for closure were agreed as complete. Action 291 was confirmed as completed previously [Annual Report content checklist) and the Trust Secretary (TS) confirmed that she was liaising with the Digital and Data Committee Chair regarding his attendance at future ARAC meetings (Action 341).
- Updates from the Quality and Finance & Performance (F&P) Chairs were shared (there were no updates of note from the People Committee Chair) – mental health services funding for pregnant women, the national maternity investigation launched and the financial challenges.
- Audit Completion Report and Draft Auditor's Annual Report – audit procedures were substantially complete and a 'clean' audit opinion was anticipated to be issued on the Annual Report and Accounts 2024/25.
  No changes were made to the initial risk assessment and planned audit approach, and no significant control deficiencies were identified.
  The value for money section of the report included a follow up of a previously reported significant weakness in relation to the Care Quality Commission inspection findings.
  The significant audit matters were discussed, along with the updated materiality figure, two unadjusted misstatements, some minor disclosure misstatements and some internal control recommendations.
  Committee members discussed whether a positive external well-led review report would impact positively in removing the significant weakness.
- Board Assurance Framework (BAF) Report – The main changes were outlined including the addition of three new people risks, additional actions and the risk that required further consideration by ARAC (risk 1.2). The assurance rating recommendations proposed for the Quality and Finance Committee risks were agreed. The People Committee and Digital and Data Committee risks would be discussed/considered as part of the July ARAC report.
- Internal Audit (IA) Annual Report, including Head of Internal Audit Opinion 2024/25 – The components used to inform the Head of Internal Opinion were outlined. A 'reasonable' opinion was reported, the same as in the prior year, albeit some improvements had been identified from the previous year. A breakdown of the internal audit reports issued during the year was shared, along with the associated assurance level.
- IA Progress Update 2025/26 – 12 final reports had been issued since the last ARAC (Audit Focus) meeting in April 2025 and six reports were currently at draft/review stage. Three overdue actions were highlighted where an update was required and there were a further ten actions with revised target implementation dates. 13 actions were implemented.

Two limited assurance reports were issued and one audit report was agreed to be carried into quarter 1 of 2025/26 (records management).

- IA Charter for 2025/26 – The document had been updated from the previous year to reflect a small number of amendments to the mandate section. The updated charter was agreed.
- The final Annual Governance Statement was discussed – the conclusion in the Statement had been updated following feedback at the previous Committee meeting. The wording was consistent with both the Internal and External Audit opinions.
- The final Annual Report and Accounts for 2024/25 were discussed and recommended for approval by the Trust Board. The report detailed the changes made since the previous version viewed by Committee members. The year-end financial position was summarised.
- Updated Audit, Risk and Assurance Committee Schedule of Business – The schedule was approved having been updated to reflect a move to bi-monthly meetings.
- Committee self-assessment checklist – The checklist had been updated to incorporate the 6 survey responses received. Actions were identified for completion as detailed in the report.
- Draft Risk Appetite Statement – The statement had been updated following the discussion at the board development session in March 2025 and was approved. Further work was needed to align to key performance indicators and decision making.
- Standards of Business Conduct Annual Report – The report provided an annual review and update on standards of business conduct.
- The Committees Chairs Logs were received for the following Committee meetings:
    - Finance and Performance Committee – 19 May 2025
    - Quality Committee – 13 May 2025
    - People Committee – 13 May 2025
    - Charity Committee – 15 May 2025
- The response to those charged with governance was approved.

Actions agreed in the meeting	Responsibility / timescale
1. Checklist actions: a) ARAC Chair and Trust Chair to discuss succession planning arrangements for the Committee b) The Trust Secretary will discuss the statement regarding reviewing key data against the data quality dimensions with the Executive Lead and the Chair of the Digital and Data Committee before feeding back to Committee members c) Clinical audit assurance – discussion to take place between the Director of Quality and Safety and the Quality Committee and ARAC Chairs d) Assurances from third parties who deliver key functions to the Trust – TS to discuss further with the Assistant Finance Director – Financial Services and Committee Chair before providing an update at a future Committee meeting	1. TS and ARAC Chair – 31 August 2025

2. Further consideration to be given to updating the Board/Committee cover sheet template to incorporate the risk appetite statement	2. TS and Director of Performance and Governance – 22 July 2025
Escalation of issues for action by connecting group	Responsibility / timescale
No specific escalations were identified for the ARAC.	N/a
Risks (Include ID if currently on risk register)	Responsibility / timescale
All BAF risks were detailed in the BAF report.	N/a

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Digital and Data (D&D) Committee Chair's Log

Meeting: Digital and Data Committee	**Date of Meeting**: 20 March 2025
Connecting to: Audit, Risk and Assurance Committee Trust Board	**Date of Meeting**: 22 April 2025 25 July 2025

Key topics discussed in the meeting
Chair - Actions to be taken up at next meeting. Digital & Technology Roadmap – shared with the Clinical Boards and to also share with the Executive Team. Data Security and Protection Toolkit (DPST) – work still to progress through on the action plan to address the remaining evidence to be provided. Oracle Cerner – A discussion took place with regards to challenges with the Oracle Cerner upgrade. A meeting is to be scheduled with Oracle Cerner and Newcastle Hospitals Executives. Community Diagnostic Centre (CDC) MetroCentre – discussion around Phase 2 funding which would help address some of the integration challenges and help the overall functionality of the CDC project. Care Quality Commission (CQC) - Care plans significantly increased throughout the organisation. The Digital Health team are currently reviewing data recorded within the care plans. Patient Engagement Portal – Phase one of the project has now formally closed having met the required deliverables and Outpatient Services have assumed overall management.

Actions agreed in the meeting	Responsibility / timescale
1. CDC MetroCentre - The Acting Chief Executive (ACEO) highlighted the two separate booking systems at the CDC and the need to plan to have staff trained on both systems so that the Trust is optimising the usage whilst seeking out a digital solution. DAT Services to scope out dual systems at CDC and report back to next committee **[ACTION01]**	1. The Chief Nursing Information Officers / 8 May 2025
2. CQC update care plans - It was noted and agreed for triangulation with the Quality Committee and	2. The Chief Nursing Information Officer / 8 May 2025.

ensuring that the actions are lined up for impact and improvement **[ACTION02]** 3. Digital/Data Incidents Review/Cyber updates - Desktop and Server Estate Compliance and the DSPT. It was agreed that the DCCA /SIRO to bring a final submission back through the Committee for final review **[ACTION03]** 4. Oracle Cerner - A discussion took place in relation to the Cerner upgrade. A meeting is to be scheduled for Oracle to meet with Executives at Newcastle Hospitals to talk through how they are going to work with the Trust [**ACTION04]** 5. Data, Security and Protection toolkit - as the DCCA / SIRO requested going forward one paper is brought to the committee meeting so assurance can be given that all of the information is captured. There is a requirement as part of the DSPT and audit to have some additional optional audits. The recommendation is to set out the four optional areas that we would recommend to be included as part of the audit which are included in the committee papers. It was noted and agreed by the committee **[ACTION05]** 6. Information Governance & SARS Update - Discussion around Freedom of Information (FOI) and it was agreed to include FOI data in the annual information governance report to provide a comprehensive view of patient and public information requests **[ACTION06]** 7. Data Incidents – The Chief Nursing Officer confirmed the figures have now reduced and there is opportunities within the next phase to change Datix to ensure report is better and easier for staff to understanding. In response Mr Phil Kane, Non-Executive Director said that it would be useful to include numerator and denominator in next report to give an idea of the percentage of incidents and what the information relates to **[ACTION07]**	3. The Director of Communications and Corporate Affairs / SIRO (DCCA/SIRO) / Future Committee meeting. 4. The Chief Information Officer / 8 May 2025. 5. The DCCA / SIRO / 8 May 2025. 6. The Chief Nursing Information Officers / Future Committee meeting. 7. The Chief Nursing Information Officer / 8 May 2025
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.

Agenda item A11

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Digital & Data (D&D) Committee Chair's Log

Meeting: Digital & Data Committee	**Date of Meeting**: 15 May 2025
Connecting to: ARAC Trust Board	**Date of Meeting**: 22 July 2025 25 July 2025
Key topics discussed in the meeting	

Remote Hosting Organisation (RHO) – Gordon Elder, Interim Operational Director informed the group that RHO is now live. Further information was shared in the Chief Information Officer (CIO) report including the timeline of the go-live weekend and details of the issues encountered including delays in getting the system back up. The committee members thanked staff for their hard work and for the level of commitment and emphasised the dedication and support from staff across the organisation who gave up their Bank Holiday weekend to work on RHO.

Dental Digitalisation - Continues to move forward with good progress being made. Phase 1 is complete. Currently working through bespoke work which is still required.

Promptly Health data sharing- Good progress has been made in relation to the required infrastructure and connections to the data warehouse. Data sharing will commence by the end of this month.

Triangulation of meetings – The Chair advised of the importance of triangulation of the work of this Committee with other Committees, in a systematic way so that matters are escalated as appropriate for Board notice.

Care Plans – Chris Bill, Chief Nursing Information Officer (CNIO), provided an update on Care Plans. Work continues on the requirements for the subsequent 10 Care Plans which hopefully will be released to the organisation mid to end of June. Staff continue to be trained through the clinical educators within the Clinical Boards. There has been no negative impact from the introduction of the care plans.

Community Diagnostic Centre (CDC) Integration – The Committee discussed how Newcastle and Gateshead Trusts currently use separate booking systems. Philips are unable to provide the resource due to completing priorities elsewhere. An operational plan is to be agreed to deliver a solution.

Cyber Attacks – Gordon Elder, Interim Operational Director, shared that Mark Bell, Cyber Security Manager had carried out a risk assessment for the organisation and was keeping an eye on the recent cyber-attacks highlighted in the press. The Chair advised the Committee it is important that the Board are aware via this Committee that the

challenges are understood, the issues are being monitored and that the team is professional and prepared.

Infected Blood Inquiry Support Line – Gordon Elder, Interim Operational Director, informed the Committee this has been put on hold until clinical, operational and technical matters are resolved with NHS England.

Senior Information Risk Owner (SIRO) - Reports to be reintroduced and will be brought to the Committee every 6 months.

Data and Digital Governance Group – This has been reintroduced on a regular basis and feedback will be shared with the Committee.

Digital Change Projects – A list of priorities for the next 6-12 months was shared. The Committee agreed to support this work on the understanding that progress and updates are provided in a regular manner to see and be assured that the priorities stated are being acted upon and monitored.

Roadmap 2025 – Dave Elliott, Chief Digital Information Officer (CDIO), outlined his strategy and vision for the Digital and Technology Services. A formal discussion will be brought to the next meeting. The Committee will ensure operational work in Digital is monitored and will escalate the strategic information that needs to go to the Board for awareness and assurance.

Board Assurance Framework (BAF)/Risk Report and emerging risks – Natalie Yeowart, Head of Corporate Risk and Assurance, and Dave Elliott, CDIO, plan to review risk governance in place in the Digital department and restructure how risk management is conducted which will help to clearly identify high rated risks for consideration. The Chair agreed this on behalf of the committee.

Digital and Data Committee Annual Report – The group approved the annual report.

Actions agreed in the meeting	Responsibility / timescale
Triangulation of meetings 1. Discussion to be arranged regarding triangulation between Committees and removing any potential areas of duplication.	1. Caroline Docking, Director of Communication and Corporate Affairs, Dave Elliott - CDIO, Hassan Kajee, D&D Committee new Chair Kelly Jupp, Trust Secretary Timescale: Next Committee meeting 10th July 2025
Care Plans 2. To bring an update on Care Plan training to the next meeting.	2. Chris Bill, CNIO Timescale: Next Committee meeting on 10th July 2025

3. The training element of Care Plans triangulates with both HR and people issues - Caroline Docking and Dave Elliott to include this in their discussion as agreed in the above action 1. **Phillips CDC Integration** 4. To agree an operational plan and bring back to the next D&D committee. Dave Elliott to meet with Hassan Kajee prior to the Committee meeting to provide a clear understanding of how the decision had been reached, the evidence, any implications that the Committee and Board need to be aware of and if there are any implications for the risk register.	3. Caroline Docking, Director of Communication and Corporate Affairs Dave Elliott, CDIO Timescale: Next Committee meeting 10th July 2025 4. Dave Elliott, CDIO Gordon Elder, Interim Operational Director Hassan Kajee, D&D Committee new Chair Timescale: Next Committee meeting 10th July 2025
Escalation of issues for action by connecting group	Responsibility / timescale
None identified.	
Risks (Include ID if currently on risk register)	Responsibility / timescale
None noted.	

Agenda item A12

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 2025					
Title	Improving Together - Interim Trust Strategy					
Report of	Patrick Garner, Director of Performance and Governance					
Prepared by	Patrick Garner, Director of Performance and Governance Caroline Docking, Director of Communications and Corporate Affairs					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	The previous 5-year Trust Strategy expired at the end of 2024. In response to this the Board approved the development of an interim strategy for the duration of 2025/26. The rationale for this approach was to then allow time for developing a meaningful longer term 5 year strategy for the organisation, in collaboration with staff, patients and other stakeholders. The interim strategy is therefore a deliberately concise document that clearly sets out what success looks like for the next 12 months, i.e. our immediate strategic focus, and a high-level description of how we will get there. The Board has been part of the development of the interim strategy for 2025/26 through updates to Board and part of three separate development sessions. It has also been discussed at the Trust's Planning and Strategy Group, the Trust Management Group and also the Council of Governors. The Board will continue to be kept up to date on the development of the longer term 5-year strategy through the rest of the year, with the aim that this will be published in April 2026.					
Recommendation	The Board of Directors are asked to note the publication of the Interim Strategy.					
Links to Strategic Objectives	The Interim Strategy links to all of the strategic objectives within the previous Trust strategy.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☒	☒	☒
Link to Board Assurance Framework [BAF]	Link to all principal risks within the BAF.					
Reports previously considered by	Previous strategy updates to Board. Interim Strategy approved at the Private Board meeting in June 2025.					

IMPROVING TOGETHER – INTERIM TRUST STRATEGY

1. INTRODUCTION

The previous 5-year Trust Strategy expired at the end of 2024. In response to this the Board approved the development of an interim strategy focussing on smaller number of immediate goals and ambitions to be achieved in 2025/26.

2. INTERIM STRATEGY

2.1 Approach to the interim strategy

A well thought out and written strategy should acknowledge the challenges being faced by an organisation and provide an approach to overcoming them. Strategies (particularly those written in the NHS) can often end up as a wish list of everything that an organisation would want to do, this is not good strategy. A good strategy is about choices; it should focus on a small number of critical issues and then focus on actions and resources to address them. Therefore, the interim strategy is a deliberately concise document that sets out our goals for the next 12 months, i.e. our immediate strategic focus.

2.2 Summary of the interim strategy

In summary the interim strategy covers the following:

- It provides a reminder to the background of the organisation i.e. one of the UK's largest NHS Trusts with ~16,000 staff and £1.6bn budget, that provides local, regional, and national specialist care.
- Reiterates the Trust as a member of the Great North Healthcare Alliance.
- Outlines the current Trust priorities as described in the 'Big Signals'.
- Summarises the Trust's improvement journey in response to a Care Quality Commission (CQC) rating of "Requires Improvement" and "Inadequate" for well-led in 2024, including the rapid improvement efforts that led to removal of CQC licence conditions and a continued focus on improving governance, culture, patient safety and access to care.
- The development of Trust's People Plan.
- A summary of the Clinical Strategy development including incorporation of three national "shifts"; treatment to prevention, hospital to community, and analogue to digital that have subsequently been confirmed in Fit for the Future, the 10 Year Health Plan for the NHS that was published earlier this month.
- It outlines the Quality Account Priorities for 2025/26.
- Summarises a commitment to Research, Innovation & Commercial Growth including a focus on integrating research into routine care, developing private and international healthcare, and data partnerships in collaboration with Newcastle University and the Great North Healthcare Alliance.
- Finally, the interim strategy outlines the annual priorities for each of the eight Clinical Boards which include themes in relation to quality and safety priorities and

improving patient experience, waiting times for treatment, staff wellbeing and financial sustainability.

The interim strategy has been published online to help improve access to the information contained within the strategy, with the Trust website having additional accessibility tools available for those who require it. The published strategy is available at: Our interim strategy - Newcastle Hospitals NHS Foundation Trust: https://www.newcastle-hospitals.nhs.uk/about/our-interim-strategy/. A one-page summary of the main priorities within the strategy is attached as appendix 1.

3. LONGER TERM STRATEGY DEVELOPMENT

This interim strategy provides a 12-month bridge following the end of the previous strategy and leads into the development of a longer-term five-year strategic plan to be published by April 2026. This allows time for developing a meaningful longer term strategic direction for the organisation, in collaboration with staff, patients and other stakeholders throughout 2025/26. It will also need to align with the 10 Year Health Plan, other national policy priorities and local partnership goals.

A Strategy Development Steering Group has been set up to oversee and co-ordinate the longer terms strategy development work. The group has wide range of representatives with the first task of agreeing the longer term strategy engagement plan which will also be provided to Board at a future meeting.

4. RECOMMENDATION

In respect to this report the Board are asked to note the publication of the Interim Strategy.

Report of Patrick Garner
Director of Performance and Governance
18 July 2025

Appendix 1: Interim strategy - one page summary

This year we are focussing on 3 priorities as we address our Big Signals

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Quality of care will be our main priority.

We will be a great place to work where everyone feels supported.

We will focus on excellence in all that we do.

Our technology will support our work and patients' care.

Our buildings will be fit for purpose.

We will take our responsibilities as a public service seriously, carefully managing our money and performance.

We will make sure we deliver our commitments to the communities who depend on us.

We will be honest, open and transparent about our challenges and our progress.

Focus on Fundamentals	• Deliver high quality, safe and compassionate patient care, meet our clinical board and trust quality priorities. • Improve performance – cancer, diagnostics and emergency care. • Manage our money – saving £9m per month.
Make it better for colleagues	• Improve IT kit, digital systems and correspondence with patients. • Support colleagues through our People Plan with better psychology support and greater equality, diversity and inclusion. • Improve the estate for colleagues and patients, including opening the urgent treatment centre.
Look to the Future	• Work with partners to create Neighbourhood teams caring for people closer to home. • Focus on the Great North Children's Hospital as the regional specialist centre providing world class paediatric care. • Develop our Clinical and Trust strategy, as a member of Great North Healthcare Alliance.

Healthcare at its best
with people at our heart

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Agenda item A13

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 2025		
Title	Trade union facility time report 2024-25		
Report of	Vicky McFarlane-Reid, Director of Commercial Development and Innovation/Interim Executive Director for People and Organisational Development		
Prepared by	Paul Turner, Head of HR Services		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☐
Summary	There is a legal requirement under the Trade Union (Facility Time Publication Requirements) Regulations 2017, for public sector organisations to report and publish on an annual basis information on facility time for staff who are trade union representatives. The deadline for reporting is 31 July 2025. The purpose of this paper is to: a) present the data for period 1 April 2024 to 31 March 2025 b) advise that the People Committee on 13 May 2025 approved the data set for publication on the government portal by 31 July, publication on the Trust's website, and publication in the Trust's Annual Report & Accounts for 2024-25 (the reason for this was to meet the deadline for the Annual Report & Accounts) c) ask Trust Board to ratify the decision made by People Committee This report is to comply with the annual requirement under the Trade Union (Facility Time Publication Requirements) Regulations 2017 for public sector employers to collect and publish a specific set of data on the use and spend of TU facility time by their staff. The Regulations provide transparency on the use and spend of facility time in the public sector. The reporting period is 1 April 2024 to 31 March 2025.		
Recommendation	Trust Board is asked to: • ratify the decision of the People Committee on 13 May 2025 to approve the data set for publication on the government portal by 31 July, publication on the Trust's website, and publication in the Trust's Annual Report & Accounts for 2024-25		
Links to Strategic Objectives	People		

Agenda item A13

Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☐	☒	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link. Impact being a failure to comply with legal requirement.					
Reports previously considered by	People Committee 21 June 2024 and 13 May 2025, Trust Board 17 July 2024.					

TRADE UNION FACILITY TIME REPORT 2024-25

1. BACKGROUND

This report is to comply with the annual requirement under the Trade Union (Facility Time Publication Requirements) Regulations 2017 for public sector employers to collect and publish a specific set of data on the use and spend of TU facility time by their staff. The Regulations provide transparency on the use and spend of facility time in the public sector.

The reporting period is 1 April 2024 to 31 March 2025.

Publication of the data set on the government portal is required by 31 July 2025. (This has been actioned).

Publication is also required on the Trust's website and in its Annual Report and Accounts 2024-25. (This has been actioned).

2. FACILITY TIME

We recognise the many benefits of the Trust and Staff Side colleagues working together in partnership. Our Recognition Agreement is the cornerstone of our relationship and sets out the arrangements between the Trust and trade union colleagues for representation, facility time, accommodation and joint consultation and collective bargaining.

Facility time is when staff take time off from their normal role to carry out their *duties* and *activities* as a trade union representative.

A trade union *duty* is paid time off during working hours to carry out recognised trade union duties. The amount of time off must be reasonable. Duties include: taking part in collective bargaining (e.g. terms and conditions and redundancy), consultation and negotiation; participating in disciplinary and grievance cases; and attending training for a trade union role.

Trade union *activity* can be paid or unpaid. Requests for such time off is normally unpaid. Activities include discussing internal union matters and dealing with internal administration of the union, for example answering union correspondence and meetings other than as part of the negotiating or consultation process.

Requests for paid and unpaid time off to attend courses/conferences/meetings are decided centrally by the Head of HR Services and normally paid – they are subject to completion of an application by the trade union representative and signature from their manager.

3. DATA SET FOR REPORT

3.1 RELEVANT UNION OFFICIALS

Total number of staff who were relevant union officials during the relevant period:

Number of staff who were relevant union officials during the relevant period	Full-time equivalent
43	37.21

3.2 PERCENTAGE OF TIME SPENT ON FACILITY TIME

Total number of staff who were relevant union officials employed during the relevant period spent a) 0%, b) 1%-50%, c) 51%-99% or d) 100% of their working hours on facility time:

Percentage of time	Number of employees
0%	23
1-50%	19
51%-99%	0
100%	1

3.3 PERCENTAGE OF PAY BILL SPEND ON FACILITY TIME

Percentage of Trust's total pay bill spent on paying staff who were relevant union officials for facility time during the relevant period:

First Column	Figures
Provide the total cost of facility time	£43,684.98
Provide the total pay bill	*£848,971,600
Provide the % of total pay bill spent on facility time	0.0051%

(*pending audit)

3.4 PAID TRADE UNION ACTIVITIES

Percentage of total paid facility time hours that were spent by staff who were relevant union officials on paid trade union activities?

Time spent on paid trade union activities as percentage of total paid facility time hours	4.80%

4. SUMMARY COMPARISON WITH LAST YEAR'S RETURN

	2024-2025	2023-2024
Number of TU officials	43 (37.21 FTE)	41 (35.88 FTE)
Cost of facility time	£43,684.98	£41,890.30
Percentage of total pay bill	0.0051%	0.0052%
Time spent on paid TU activity as percentage of total paid facility time hours	4.80%	5.17%

5. RECOMMENDATION

The Trust Board is asked to:

- ratify the decision of the People Committee on 13 May 2025 to approve the data set for publication on the government portal by 31 July, publication on the Trust's website, and publication in the Trust's Annual Report & Accounts for 2024-25

Vicky McFarlane Reid
Director of Commercial Development and Innovation/Interim Executive Director for People and Organisational Development

Paul Turner
Head of HR Services

2 July 2025

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Agenda item A14

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 2025					
Title	Annual Statement on behalf of The Newcastle upon Tyne Hospitals NHS Foundation Trust - Modern Slavery and Human Trafficking Act 2015					
Report of	Kelly Jupp, Trust Secretary Dan Shelley, Procurement and Supply Chain Director					
Prepared by	Kelly Jupp, Trust Secretary Dan Shelley, Procurement and Supply Chain Director					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	During the development of the Trust Annual Statement on Modern Slavery and Human Trafficking Act 2015 NHS bodies were notified that following NHS Board approval, a NHS Modern Slavery Statement for 2024/25 for **all NHS bodies** was published in April 2025. This report provides an update on the latest position.					
Recommendation	The Trust Board is asked to: i) Endorse that the wording in section 3(i) be added to the Trust website to replace the existing Annual Statement: ii) Note that once NHS England has produced its Action Plan then the Trust will need to revisit its own Action Plan (aligned to the national plan). A future update will be shared with Audit, Risk and Assurance Committee members.					
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	This is an annual submission. The previous report was approved by the Trust Board on 17 July 2024. The report will also be presented at the 22 July Audit, Risk and Assurance Committee meeting.					

ANNUAL STATEMENT ON BEHALF OF THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

MODERN SLAVERY AND HUMAN TRAFFICKING ACT 2015

1. INTRODUCTION

Historically the Newcastle upon Tyne Hospitals NHS Foundation Trust has prepared an Annual Statement on Modern Slavery and Human Trafficking and published the Statement on the Trust website. This report provides an update on changes for 2025/26.

2. 2025/26 UPDATE

Following NHS Board approval, the NHS modern slavery statement for 2024/25 was published on behalf of **ALL** NHS bodies in April 2025 [see NHS England » NHS England modern slavery and human trafficking statement - https://www.england.nhs.uk/safeguarding/slavery-human-trafficking-statement/].

The statement aligns to Home Office guidance and enables the wider system to demonstrate a consistent commitment to addressing the risk. Integrated Care Boards (ICBs) and trusts are asked to:

1. Publish a commitment to eradicating modern slavery and human trafficking on their website
2. Refer to the NHS statement (there is no need to publish an individual Trust statement)
3. Align to the actions set out in the statement (details to follow from NHS England).

The government has published its response to the recent consultation on new regulations for the health sector - Tackling modern slavery in NHS procurement: government response - https://gbr01.safelinks.protection.outlook.com/?url=https%3A%2F%2Fnhscommercialbulletin.cmail19.com%2Ft%2Fd-l-sulllc-irbyddidu-j&data=05%7C02%7Ck.jupp%40nhs.net%7C9caa1db2092d4f86b9d008ddc088a186%7C37c354b285b047f5b22207b48d774ee3%7C0%7C0%7C638878415239091444%7CUnknown%7CTWFpbGZsb3d8eyJFbXB0eU1hcGkiOnRydWUsIlYiOiIwLjAuMDAwMCIsIlAiOiJXaW4zMiIsIkFOIjoiTWFpbCIsIldUIjoyfQ%3D%3D%7C0%7C%7C%7C&sdata=ES9YE1Oz2NXkgLkvy3V%2BkBfAldMMGXibJNsYxcfgKSs%3D&reserved=0. The updated regulations and guidance will now go to Parliament and are expected to commence early 2026.

Further updates will be provided to the Audit, Risk and Assurance Committee in due course.

3. RECOMMENDATION

The Trust Board are asked to:

i) Endorse the following wording to be added to the Trust website to replace the existing Annual Statement:

The Trust recognises that it has a responsibility to take a robust approach to preventing and addressing any concerns regarding modern slavery and human trafficking and is absolutely committed to eradicating modern slavery and human trafficking.

The Trust is also fully committed to working towards supply chains, and business activities, that are free from ethical and labour standards abuses.

The NHS modern slavery and human trafficking statement can be found here at NHS England » NHS England modern slavery and human trafficking statement - https://www.england.nhs.uk/safeguarding/slavery-human-trafficking-statement/.

ii) Note that once NHS England has produced its Action Plan then the Trust will need to revisit its own Action Plan (aligned to the national plan). A future update will be shared with Audit, Risk and Assurance Committee members.

Report of Kelly Jupp, Trust Secretary, and Dan Shelley Procurement and Supply Chain Director
17 July 2025

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Agenda item A15

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 2025					
Title	Board Assurance Framework (BAF) Report					
Report of	Patrick Garner, Director of Performance and Governance					
Prepared by	Natalie Yeowart, Head of Corporate Risk and Assurance					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☒	☐			
Summary	This report aims to provide the Trust Board with a fully complete Board Assurance Framework. Committees of the Trust Board gain assurance on a monthly basis ensuring that strategic risks aligned to each committee are being managed effectively; that risks have an appropriate action plan in place to mitigate them; and that risk scores are realistic and achievable. Key points to note: • This is the first full iteration of the Board Assurance Framework 2025/26. • There are currently 9 strategic risks held on the BAF. • All BAF risks have been populated and reviewed with the Executive Lead. • All BAF risks have been reviewed, considered and discussed at each Committee of the Board. • The Digital and Data Committee BAF risk which was transferred over from 2024/25 has now been removed from the BAF following review and confirmation that this was not an accurate representation of the digital strategic risk and threats for 2025/26. The Chief Digital Officer (CDO) expects to have an accurate representation of the Digital strategic risks in the next 3 months. • Following review at committees, all BAF risks have been recommended for Trust Board approval.					
Recommendation	The Public Trust Board are asked to: • Review and approve the Board Assurance Framework. • Provide any feedback or comments.					
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]	BAF 2025/26					

Reports previously considered by	Executive Director Leads and Committees of the Trust Board.

Agenda item A15

BOARD ASSURANCE FRAMEWORK 2025/2026 – JULY 2025

The Newcastle upon Tyne Hospitals NHS Foundation Trust

The 2025/2026 BAF

The 2024/25 BAF has been re-designed to ensure it can effectively capture all the relevant information to allow effective discussion and assurance to be received by each committee and Trust Board. This approach informs the agenda and regular management information received by the relevant committees, to enable them to make informed judgements as to the level of assurance that they can take, and which can then be provided to the Trust Board in relation to each Principal Risk and also to identify any further action required to improve the management of those risks.

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, that forms the basis of the Trust's risk framework (with corresponding corporate and operational risks defined at a Trust-wide and service level if available).
- Risk ratings – initial, current and target levels.
- Clear identification of primary strategic threats and opportunities that are considered likely to increase or reduce the Principal Risk, within which they are expected to materialise.
- A statement of risk appetite for each risk.
- Sources of assurance incorporate the three lines of defence: (1) **Management** (those responsible for the area reported on); (2) **Risk and compliance functions** (internal but independent of the area reported on); and (3) **Independent assurance** (Internal audit and other external assurance providers) to demonstrate the assurance and confidence of the control in place.
- Key actions identified for each threat; each assigned a timescale for completion. These will be individually rated by the lead committee noting the level of assurance they can take that the actions will be effective in treating the risk (see below for key)

Committee assurance ratings:

Green (significant) = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity
- no gaps in assurance or control AND current exposure risk rating = target
OR - gaps in control and assurance are being addressed.
Amber (moderate) = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy
Red (limited) = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity.

Action progress Indicators:

One progress indicator should be added in the action progress indicator box for each threat to demonstrate action progress.

1. **Fully on plan across all actions.**
2. **Actions defined- most progressing, where delays are occurring interventions are being taken.**
3. **Actions defined – work started but behind plan.**
4. **Actions defined -but largely behind plan.**
5. **Actions not yet fully defined.**

Agenda item A15

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.	**Strategic objective**	1. Quality of Care will be our main priority.

Lead Committee	Quality Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Nursing	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	
Date Added	01.05.2025	**Likelihood**	**4**	**3**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	07.07.2025	**Risk Score**	**20**	**15**	**5**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Failure to successfully develop and nurture a positive safety culture: including supporting staff to report incidents with an enhanced focus on shared learning and a systems-based approach to improvement, creating a psychologically safe environment and listening to staff and patients.	• Patient Safety Incident Response Framework (PSIRF) went live in January 2024. • Central supportive governance infrastructure to deliver the PSIRF • The Quality Governance Framework underpinned by Quality Oversight Groups (QOG's) in each Clinical Board. • Response Action Review Meetings. • Policies and Procedures. • Patient Safety Incident Forum. • Incident reporting system. • Clinical Risk Group. • Rapid Quality and Safety Peer Reviews.	• Response Action Review Meeting /Patient Safety Incident Forum minutes and actions plans. • Strengthened quality of learning responses by ensure a standardised approval methodology is used. • Monitoring of compliance with PSIRF timeframes for learning responses. Power BI dashboards shared at Clinical Board QOG's and Quality and Performance Reviews. • Regular PSIRF update reports to Patient Safety Group. • Integrated Quality Report to Quality Committee. • Oversight through Clinical Board Quality. Oversight Group, reported into Quality and Performance Reviews and the Executive Team. • CQC Delivery Group and CQC Assurance Group oversight. • Staff Survey – demonstrates increased response rate of 65%. • Clinical Risk Group reports and sharing of learning, national patient safety alerts etc. • Rapid Quality and Safety Peer Review Paper to Quality Committee December – demonstrates 93% trust compliance with assessment framework.	• Develop and embed a positive reporting and safety Culture evidenced by pulse survey and staff survey and monitoring of reporting – January 2026. • Delivery of CQC action plan – Actions on track to be completed by deadline, please see CQC phase 2 action plan document for exact timescales (5 out of 7 actions completed) • Reporting of Duty of Candour improvement to Quality Committee – next paper Sept 2025 to include an audit of quality of DoC written responses. • Deliver 25/26 Quality Priorities. Aim for 3% increase in incident reporting and 90% of all staff will have received training in Patient Safety by 31st March 2026 • Development of Trust-Wide Patient Safety Strategy – July 2025. • PSIRF Annual Report to Quality Committee April 2026. • Recruit Patient Safety Partners from the Trust Participation & Involvement Panel – September 2025.	**2- Actions defined – most progressing, where delays are occurring interventions are being taken.**	

Failure to safeguard and deliver care in line with the Mental Health Act and Mental Capacity Act.	• Mental Capacity Oversight Group. • Mental Health Committee. • PLT meetings with core services. • Restraint Review Group. • MCA Quarterly audit framework. • Health and Safety Committee. • Patient Experience and Engagement Group. • MCA training programmes/compliance. • Learning Disability Steering Group. • LeDeR review group. • Environment review completed on two areas of concerns highlighted in Trust CQC report, along with areas of high risk. • Learning Disabilities and MCA oversight by Safeguarding Committee/Quality Committee/Trust Board. • Mental Health Awareness Training (specific packages for high-risk staff groups e.g. Security staff) • Core quarterly mental health assessment metrics agreed. • Self-Harm Risk Assessment Programme	• Quarterly MCA audit data demonstrating improved compliance with MCA. – Q4 data – 86.6% of patients requiring MCA had documented evidence (85% in Q3) • Increase in DOL's referrals represented of expected volume. • Compliance with MCA Level 1 mandatory training 97% in Q4 (96% in Q3) and bite size training (Learning Disabilities, MCA and MH) • MHA provider review recommendations, action plan and evidence of completion. • Learning Disabilities and MCA reporting and minutes to Safeguarding Committee/Experience of Care Group/Quality Committee and Trust Board. • Compliance with Mental Health Awareness Training (98.1% June 25). • Quarterly mental health assessment audit framework. • Self-Harm Risk Assessment Programme complete, remediation work to commenced in January 25 for high risk areas. • Training Video to support reasonable adjustments launched and documentation of reasonable adjustment pilot commenced June 2025. The Self Harm Risk Assessments are on InPhase	• Level 2 MCA training programme launched and mandated for all relevant staff - compliance currently 72.45% Target of 90% by • Agree long term training framework for Learning Disabilities and Autism, ICB. National expectation of the Oliver McGowan Training confirmed. • Monitoring and delivery of Phase 1 Self Harm Programme of Estates works (High risk areas), work 90% complete, remaining areas of work within PFI to complete – July 2025. • Development and approval of phase 2 Self Harm Programme of Estates works (Medium/Low risk areas – August 2025. • Develop draft of Learning disability and autism 1 year strategy – agreed end of June 2025.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Failure to achieve best practice clinical standards and associated recommendations/actions.	• Clinical Audit and Guidelines Group. • Clinical Outcomes and Effectiveness Group. • GIRFT oversight group. • Clinical Effectiveness metrics. • New Interventional Procedures Group. Review • Stocktake of progress with Clinical Board Quality Oversight Groups completed. • Stocktake of progress with clinical board QoGs. • Review of QoG activity presented to Quality Committee in October 2024.	• Clinical Audit and Guidelines Group minutes and Action plans. • Clinical Outcomes and Effectiveness Group (COEG)minutes and action plans. • Bi-annual Reports to Quality Committee. • Bi-annual Clinical Audit Report to ARAC. • GIRFT Oversight Group reports and minutes. • Minutes and reports of New Interventional Procedures including Robotic Surgical Group-reports to COEG. • Quality Oversight Group dashboards. • Initial stocktake of QOG activity completed in May 2024-shared with CB's.	• Design and implement a standardised quarterly quality reporting mechanism/dashboard including communications and guidance for clinical boards to report into QPRs. This will include compliance with all metrics e.g. GIRFT/NICE via Inphase risk management system – July 2025 • Baseline review of Trust non-compliance with standards/guidelines, propose organisational approach to Quality Committee – September 2025. • Evaluate the implementation of revised integrated governance structure – Clinical Board Governance Internal Audit – audit report expected by July 2025. – report now in draft stages. •	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Gaps in assurance regarding compliance with policy and best practice relating to medication safety, storage, security and learning from medication incidents. This	• Medication Safety Task and Finish Group providing oversight of key improvement actions. • Monthly audit framework measuring. compliance with policy to inform areas for improvement. • Internal peer review process.	• Monthly audit data of ward and department compliance with core standards with dissemination of learning and action. • Policy audits undertaken and reported through medicines management committee. • Datix data and trends relating to medicines management reported and reviewed.	• Actions as outlined in MMOG Action Plan. Spot Check audit framework –review of 6 months data – July 2025	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

could directly impact care quality and safety	• Existing medication governance and oversight structures. • Medicine Management Policies and procedures. • Commissioned and completed expert external review to inform improvement work streams. • CQC Delivery Group. • Completed review of Medicines Reconciliation function across the Trust to identify urgent areas for improvement to attain to national best practice. • Revised medicines management action plan. • Established Medicines Management Oversight Group to ensure delivery of improvements • Increased nursing infrastructure to support medicines safety.	• Peer review and external review reports and audit data. • CQC Delivery Group monitoring, reporting and minutes. • Compliance and Assurance Group reporting and minutes. • Quality Governance Structure via quality committee and Trust Board. • September Rapid Quality and Safety Review Audit Data.			
Failure to improve the safety and quality of patient and staff experience in Maternity Services.	• CQC, Ockenden and Maternity Three-Year action plan in place. These are reported into Quality Committee and Trust Board. • Robust Maternity Governance Team in place • Maternity Operational Oversight Group (MOOG) • Board Maternity Safety Champions • Incident Review Group • Women's Quality and Safety Group • Family Health QOG • Monthly Maternity Staff meetings • Maternity Voices Partnership - Lead quorate member of Quality and Safety Group and Obstetric Board member. • LMNS (Local Maternity and Neonatal System) oversight of Perinatal Quality Surveillance metrics and Maternity Incentive Scheme. • Director of Midwifery appointed and in post. Real time patient/staff experience programme. • Workforce review including outputs of 2024 birthrate plus. • Refreshed perinatal governance structure aligned to themes of Three-Year Plan for Maternity and Neonatal care, reporting into Obstetric Board. • NENC Clinical Outcomes Dashboard and safety signal review process. • Review and refresh of Perinatal Quality Surveillance Metrics.	• Improvement action plan in place covering all core CQC must and should do. • SOF Enhanced Surveillance Exit meeting and review of evidence with ICB and LMNS completed in May 2025, exit agreed with return to routine oversight via LMNS from June 2025 • Staff wellbeing and cultural improvement plan in place and monitored via People and Culture Group drawing insights from the staff experience programmes and SCORE survey results. • Project PROMISE spend plan aligned to staff wellbeing and cultural improvement plan. • Obstetrics Board. • Reporting and oversight into Quality Committee and Trust Board • Maternity Services Quality Dashboard and NENC Clinical Outcomes Dashboard. • Annual CQC Maternity Survey results – improvement in some domains, no reduction in results, improved position in NENC ranking. • CNST/MIS compliance. • Incident data • Incident review group reporting and actions. • Family Health meeting minutes and QOG minutes. • Staff experience programme includes one post-natal maternity ward. • Workforce review outputs and report. • Peri-natal quality surveillance metrics monitored and reported to Quality Committee. • Midwifery staffing and red flags monitored and reported to quality Committee.	• Maternity Services phase 3 investment plan – October 2025 • Update Allocate templates to evidence correct fill rate, skill mix and safe staffing against planned – July 2025, currently with finance to action. • Establish anti racist/cultural programme group – July 2025. • Review and strengthen current escalation processes, to include senior midwifery manager on call - August 2025.	**1.Fully on plan across all actions.**	
Failure to embed the learning from external service reviews.	• Cardiac Oversight Group • Cardiothoracic Improvement plan, including improvement actions from CQC and other external reviews.	• Cardiac Oversight group reporting and minutes. • Reports to Trust Board and Quality Committee • Maintenance of central external review log	• Design and implement a standardised quarterly quality and safety reporting mechanism for clinical boards to report into QPRs to be developed as part of the Inphase	**2-Actions defined-most progressing, where delays are occurring**	

	• NUTH Quality Improvement Group • Quality and Performance Reviews • Review infrastructure of quality oversight and local governance groups.	• Central oversight of implementation of recommendations and monitoring of action plan completion via Quality and Performance Reviews • Compliance and Assurance Group Reports and Minutes.	Risk Management System Role out – July 2025. • Development of dashboard framework for Clinical Board oversight of actions/areas for improvement by July 2025.	**interventions are being taken.**	
Failure to deliver care optimisation improvements impacting on quality and safety.	• IT Town Hall, engagement sessions and Staff Roadshows. • Trust-wide adoption coaches appointed. • Digital Health Team Care optimisation project. • Digital leaders' group. • Care optimisation group. • Care Planning Task and Finish Group. • Review of core care plans. Standardisation of nursing documentation • Care planning training. • Nursing documentation audit framework • Patient correspondence/letters audit to validate Clinical Board processes to maintain oversight of timeliness of completion of correspondence • Secondary review of all systems functionality in relation to patient correspondence/letters. • Digital care planning Reporting to Quality Committee. Digital improvements prioritisation and oversight.	• Presentations slides, staff roadshow sides and feedback from staff. • Supplier assessment based on site visit. • Power BI report of all discharge summaries in all areas in real time. • E-record reminders to clinicians of encounters that require discharge summary. • Care Planning Task and Finish Group Action Plan. • Review of core care plans – 6 core care plans released in to live system – increased usage of care plans since launch 40,265 used as at December 2024. • Standardisation of nursing documentation – end of shift inpatient, critical care and paediatrics introduced into live system. • Care planning training now available within the EPR – delivered to 1149 registered nurses as at December 2024. Nursing documentation audit framework – document standards now in place, aligned to trust guidelines. • Power BI report provided to all clinical boards to all routine validation to take place. • Secondary review of all system functionality in relation to patient correspondence and letters provided positive assurance relating to processes in place. • Digital care planning report received by QC in April 2025. • Digital improvements identified through quality and safety forums into the Care Optimisation Group for prioritisation, oversight and tracking.	• Completion of Care Planning Project – April 2026. • EPR induction training – review of post roll out training has commenced. Two sessions have been completed with more planned in July 2025. • Review of compliance with nursing documentation standards using nursing documentation framework – July 2025. • Standardisation of use of SystmOne commencing with template audit – January 2026	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Failure to embed effective systems and processes to recognise and prevent avoidable Hospital Acquired Infections	• IPC Board Assurance Framework • Operational Group. • Integrated Quality and Performance Report. • IPC Committee and subgroups. • Clinical Board Governance Meetings and Quality Oversight Group. • Local and National Benchmarking. • IPC policies. • Clinical Board Improvement plans. • Clinical Assurance Toolkit Audits. • Accrediting Excellence (ACE) Programme. • Antimicrobial Stewardship Policy and Framework.	• IPC Board Assurance Framework document. • IPC Operational Group and Committee minutes and action logs • Integrated Quality Performance Report with overview ICP and HCAI metrics reporting to Quality Committee. • IPCC minutes and reports. • Reporting and oversight into Quality Committee and Trust Board • Local, regional and national benchmarking data • Clinical Board QOG and Governance meeting minutes and action logs • Clinical Assurance Toolkit results	• ICNET system development underway improve surveillance and timely intervention - Sept 2025	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

	• IPC Corporate Team in place with clear roles and responsibilities to support Clinical Board HCAI reduction strategies.	• Rapid Quality and Safety Peer review results and action plans demonstrates 93% trust compliance with assessment framework. • Screening compliance. • Quality and Performance review minutes and action log • Clinical Board improvement plans in place in areas of high occurrence of CDI.			

Risk ID	1.1
Comments:	

Agenda item A15

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Failure to implement effective governance systems and processes across the Trust to assess, monitor and drive improvements in quality and safety.	**Strategic objective**	1. Quality of care will be our main priority.

Lead Committee	Audit, Risk and Assurance Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Performance and Governance	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	Compliance and Regulatory
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	18.06.2025	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Failure to implement effective integrated governance focused on clinical quality, risk, finance, and performance Ward to Board.	• Revised corporate governance structure and reporting arrangements in place. Clinical Board Governance arrangements established including QOGs/QPRs/directorates. • Audit, Risk and Assurance Committee established. • CQC delivery group established. • Clinical Board Risk Registers. • Risk Validation Group • Recovery Oversight Group • Cardiac Oversight Group • Clinical Assurance Group • Review of QoG activity presented to Quality Committee in October 2024. • CQC phase one action plan. • CQC phase two action plan.	• Terms of Reference – committees of Board. • Minutes of committee meetings. • Committee schedule of business. • Corporate Organograms. • Minutes of QOG/QPR and directorate governance meetings. • Effective governance system report to Trust Board. • CQC delivery group minutes and action plans. • Quality Performance Reviews and summary to Board and relevant committees. • External Tabletop Governance Report. • External leadership and governance review. • Feedback at IQIG • Internal audit of CQC phase one action plan – substantial assurance received. • Internal audit of CQC phase two action plan – reasonable assurance received.	• Evaluate the implementation of revised integrated governance structure – Clinical Board Governance Internal Audit starting in November – audit now complete, initial feedback positive, report expected early July 2025. • Establish Trust Access Board to strengthen governance relating to performance metrics – Terms of Reference now drafted – July 2025. • Deliver Board Development programme 25/26 – March 2026. • Operationalise Accountability Framework including monitoring mechanisms – July 2025. • Develop Trust Governance Handbook – July 2025. • Finalise and implement Trust interim strategy – July 2025. • Develop 5-year strategy – March 2026. • Commission and complete External Well-Led review – tender process underway expected to be completed by end of June 2025.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Failure to embed escalation processes and ensure executive oversight.	• Performance and accountability framework. • Standardised reporting and governance. • Clinical Board development plan in place. • Quality performance review process. • Executive Leads for clinical boards. • Reporting hub dashboards. • Quality Oversight Group Evaluation. Risk Management Dashboard.	• Performance and accountability framework document. • Clinical board reporting and minutes. • Performance review reports and minutes. • Clinical Board Chairs update to Executive Team. • Quality Committee Quality Oversight Evaluation Report, June 2024. • Clinical Board update report presented to Trust Board. • The value circle report on QPR process. • The value circle report on effective governance Audit One Risk Management and Board Assurance Framework Core Audit – Good level of assurance received.	• Review escalation through new governance route to Exec, through Clinical Board Governance/QPR process – July 2025 (part of Clinical Board Governance Audit). • Operationalise Accountability Framework including monitoring mechanisms – July 2025.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Failure to implement effective risk management including clear escalation and accountability.	• New risk management policy. • Refresh of risk management governance and reporting. • Quality and Safety leads appointed. • Risk Validation Group established. • Audit, Risk and Assurance Group established. • Risk management dashboard. • Executive Team lead assigned to CBs. • Refresh of risk management training for risk system users. • Engagement with clinical boards. • Implementation of risk decision tool -risk vs issue. • Risk Management SOP. • Refreshed Board Assurance Framework. Implementation/engagement risk refresher sessions provided to risk system users. • Risk Management and Board Assurance Framework Risk and compliance based internal audit. • Risk management induction video for all staff.	• Risk Management Policy document and associated guidance. • Reporting, accountability, and escalation structure. • Terms of reference and minutes for the risk validation group • Historical risk trajectory. • Risk management dashboard. • Reporting to CQC Delivery Group weekly. • Risk management training TNA. • Clinical board risk presentation. • Embedded into clinical board governance arrangements – qog minutes and reporting. • Audit, Risk and Assurance ToR, minutes, and Reports. • Clinical Risk reporting to Quality Committee. • Quality Performance Reviews and summary report to Board • Risk management and Board Assurance Framework risk and compliance based internal audit – good level of assurance. • Risk Induction Video available on learning lab.	• Implement further strategies to support ward/departmental level risk identification and documentation – Work now underway to roll out Inphase risk management system to include ward and department levels – Go live planned for July-August 2025. • Develop and roll out initial Risk App User training – July – August 2025. • Develop risk appetite statement and associated monitoring metrics – Draft Risk appetite strategy to ARAC June 2025. • Develop Risk Management Strategy – August 2025. • Develop Risk Management Intranet page with key guides, advise, contacts and supporting information – July 2025.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Risk ID	1.2

Comments:

Agenda item A15

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Failure to manage our finances effectively to improve our underlying deficit and deliver long term financial sustainability.	**Strategic objective**	6. We will take our responsibilities as a public service seriously, carefully managing our money and performance.

Lead Committee	Finance	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Chief Finance Officer	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Finance/VfM
Date Added	08.05.2025	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	11.07.2025	**Risk Score**	**25**	**20**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
ERF activity plans do not sufficiently deliver activity targets and therefore increase financial risk to the Trust.	• Activity targets produced for each speciality. • Funding has been delegated at the start of the year for specific areas where identified this is necessary for impact. • DOPs and Clinical Board Chairs accountability for delivery of activity targets. • Monthly reporting reinstated • IAP introduced as a part of the contracting process/requirement with NHSE and ICB (Indicative Activity Plan). Will be mandated. • IAP agreed.	• Activity reporting via monthly performance reviews and corrective action agreed where possible, against IAP. • Monthly reporting of targets, activity and financial impact to Finance and Performance Committee and Trust Board including obstacles and corrective action highlighted through trend analysis. • National reporting back to Trust of validated activity levels (quarterly) – assurance provided around validity of internal reporting • Internal and external audit of income levels • Finance Dashboard. • IAP in place, however at a lower activity level than required to meet standards required.	• Review and discuss ‘performance gap’ re ERF with Finance and Performance Committee once IAP is received and assessed – to be discussed at F&P July 2025. • Develop early reporting mechanisms to enable ‘pull back’ of spend, required – September 2025.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Insufficient capability and capacity to deliver significant change programs to deliver the Financial Recovery Programme including CIP delivery.	• Financial governance framework in place, moving to accountability framework and delegated financial controls • Budget setting principles and budgets in place, including CIP targets by corporate area and clinical board • Enhanced CIP reporting / CIP organisational lead in place • CIP dashboard in BI • Day to day budget management processes in place including budget holder and DFM attendance/CBFM model and part of senior team	• Budgetary oversight at DOP level • Monthly revenue report at CB and corporate service level. • Deviations from SFIs reported to SSPG committee including action taken. • Regular reporting of compliance through Internal Audit and monitoring of recommendations – Report to ARAC quarterly on Internal audit progress. • HFMA audit of control reported through to ARAC • Reporting framework to ICB / cost control framework implemented.	• Delivery of TVC development programme – March 2026. • Delivery and mitigation plan meetings with clinical Boards and Corporate Services – March 2026. • Early mitigation plans reporting to Trust Board in July 2025.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	

	• Monthly performance reviews, one in 3 finance focussed. • Capital Management Group. • Clinical Board sign off of budgets and CIP targets. • Supplies and Services Procurement Cttee • Financial Recovery Plan and Financial Recovery Steering Group • Purchasing via procurement frameworks where appropriate • DOPs reinforcing financial grip and control. through engagement with teams. • Financial Recovery regular discussion/action planning on TMG. • Annual Internal and External Audit complete • ICB Grip and Control investigation and intervention complete. • Financial communications strategy. • Corporate services CIP targets set. Assessment capability for financial delegation completed - financial indicators developed.	• NHSE/I monthly finance monitoring • Going concern and financial controls audit • Early indication of required targets prior to start of financial year (5% January 2025) • Mazars external audit – satisfactory assurance, no issues re going concern. • First financial specific coms issued in January 2025. • CIP Dashboard on reporting hub, allowing CBs and CDs ability to monitor and view plans. • Revenue reporting and FRP reporting to Finance and Performance Cttee • Integrated Performance Report (IPR, refreshed) to Governors and Public Board of Directors • Monitoring and challenge of delivery of plans by FRSG, fortnightly. • Monthly QIG specifically re financial performance with ICB and NHSE colleagues to give assurance of progress. • Financial indicators contained within the financial revenue report from July.			
Unplanned emerging cost pressures not included within the agreed balanced plan	• Horizon scanning • Executive team discussions • Planning and strategy group and financial recovery steering group re business cases and approval • Proactive engagement with suppliers • Supply and procurement committee. • Financial governance framework • ICB DOFs meeting. • Shelford networking / understanding the environment. • Use of frameworks. • Opportunities through Alliance working. • Engagement with MTPF workstreams (ICS). Annual Internal and External Audit complete.	• CB and CD finance reporting • Budget sign off and hold to account through accountability framework • ICS updates through Finance report and CEO report to Committees and Board • Finance report to Board, Finance and Performance Committee identifies any unplanned pressures and actions. • Procurement report to Finance and Performance Committee identifies any cost pressures emerging through procurement activity. • Regional finance returns monthly. Mazars external audit – satisfactory assurance, no issues re going concern.	• Strengthen grip and control measures through financial recovery steering group – March 2026. • Adoption and embedding of financial accountability framework - bimonthly review of position by clinical board – Monthly reviews of position – March 2026. • Strengthen horizon scanning through Alliance DOF and national meetings/updates monthly – ongoing through 25/26 financial year -March 2026.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Reliance on non-cash measures leading to a diminished cash balance and reliance on cash support, impacting our ability to invest in buildings and equipment.	• Financial Recovery Plan • Non cash element of financial recovery defined and identified • Finance committee reporting and discussion • Financial Recovery Plan including cash releasing (CIP) • Other controls as above re management and reporting of CIP achievement • Capital management group • Strengthened discussion of cash position and reporting to finance Committee.	• Cash forecast within regular finance and board reporting • Daily / weekly cash management • Reporting of progress on cash releasing savings through financial recovery steering group and finance committee • Reporting of progress against capital plan to finance committee and Trust board • Reporting of progress against capital plan to Capital Management Group • Increased reporting of cash position via Monthly Finance Report to Finance and Performance Committee.	• Consider and develop actions necessary to mitigate cash position should CIP not deliver - July 2025.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Subsidiary company is not formed, and benefits don't accrue due to approvals and/or industrial relations issues.	• Meetings with NHSE • NHSE panel assessment • OBC and FBC • Bi-weekly meetings with staffside • Joint meeting with staffside and NHSE • Staff Side regular engagement meetings.	• NHSE provided with all information relevant to make an informed decision • Continued thinking on benefits of forming a subsidiary company (risk, seeking) • All engagement material shared with staffside • All comms shared with staffside prior to sending out • Guarantees provided re terms and conditions, pensions issues and recognition agreement for staffside • Staff side engagement meetings 2 weekly.	• Further information to be provided to NHSE to support non-VAT benefit analysis, submitted now awaiting response – August 2025. • Develop collective involvement with staff side to ensure they are involved on 'day one' i.e. how do we work together to fully function – June 2025.	**1.Fully on plan across all actions.**	
Under delivery of commercial income and growth to support financial recovery.	• Commercial Strategy • Commercial Delivery and Innovation Group • Commercial delivery Operational Group • Dedicated Commercial team established. • Commercial Update report. • Data Partnership model. • Data Partnership Group. • Sales force implementation. • Commercial schemes identified by Clinical Boards and Corporate Directorates. • Commercial Dashboards. • IP Policy developed.	• Strategy document and updates reported to Finance and Performance Committee. • Commercial update report to F&P. • Data Partnership Proposal accepted by F&P. under engagement with other committees and groups currently. • Data partnership group reporting to commercial delivery and innovation group. • Tracking commercial pipeline. • Commercial schemes reporting alongside financial recovery plans. • Commercial dashboard data suggests marginal growth, further actions required as per action plan. • Commercial updates presented to Finance and Performance Committee. • First 2 data partnership agreed, and contract signed – Flatiron and Promptly.	• Develop commercial principles for external contracts for full scale adoption in order to maximise potential returns. Phase 1 focus NJRO – July 2025 • Strengthen governance and awareness relating to IP protection and data access – July 2025. • Strengthen our job descriptions for senior staff to include data access alongside IP - March 2026. • Mandate clinical board and commercial team oversight into the sign off of 'co development' contract with external parties where commercial opportunities are available – July 2025. • Develop commercial principles for external contracts for full scale adoption in order to maximise potential returns. Phase 1 focus NJRO – July 2025. • Ensure there is accountability at a clinical board level for commercial income generation – Via planning process – June 2025. • Improve and strengthen governance for commercial income delivery – July 2025.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Risk ID	6.1

Comments:

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care.	**Strategic objective**	6. We will take our responsibilities as a public service seriously, carefully managing our money and performance.

Lead Committee	Finance and Performance Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Performance and Governance	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	Compliance and Regulatory
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	16.06.2025	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Failure to manage capacity and demand.	• PMO supported programme of demand and capacity planning across all surgical specialities completed. • Weekly Stand-up highlighting areas of performance focus. • Daily Site meetings and Site Handover. • Weekly speciality /tumour group PTL meetings for long waits and cancer. • Fortnightly performance meetings with operational leads for long waits and cancer. • Local A&E Delivery Board, supporting the management of non-elective patients across the system. • Weekly attendance at Provider Collaborative Mutual Support Co-ordination group facilitating patient transfers and collaboration amongst local providers to level demand, make use of system capacity. • Validation of the RTT/non-RTT cohort of long waits. • Implementation of new ED rota. • Targeted cancer improvement plans based on National Cancer Pathway Analyser Tool	• Revised Accountability Framework. • Activity and Income reports. • Integrated Quality and Performance Board Report. • Monthly Integrated Quality Performance Reviews. • Theatre Utilisation Data • CEO performance summary TMG including national performance comparisons • Performance Improvement Plans monitored via Finance and Performance Committee, including deep dives incorporated into the cycle of business • Further development of the Integrated Quality and Performance Board Report – reported into Committees and Trust Board. • Implementation of new ED rota, report to Finance and Performance Committee - demonstrating improved safety. • Targeted cancer improvement plans with quarterly updates to F&P Committee • Tier 2 escalation process for cancer performance – positive feedback on progress by NHSE/ICB	• Operationalisation of the Accountability Framework – July 2025 • Develop Clinical Board Level reports – challenges identified in completing – July 2025 • Review current information and performance reports to ensure they are fit for purpose – August 2025 • To improve waiting list booking process through a standardised SOP, training and implementation by July 2025. • Full review of Outpatient capacity templates to be completed by the end of September 2025. • Further development of the Service Review (Health Check) methodology and reviews, first set of reviews to be completed by September 2025 • Cancer performance improvement plans – full update for the end of July 2025.	**2 – Action defined-most progressing, where delays are occurring interventions are being taken.**	

			Cont/…		
Utilising available resource effectively – workforce, estate, and equipment.	• Activity plans developed with Clinical Boards as part of the annual planning process. • Productivity targets set as part of the • Capital planning process through Capital Management Group. • Allocation of growth funding from commissioners to under pressure services, where available. • Revised annual planning process to incorporate approval of business cases for the coming financial year and utilisation. • Operational reports establishing weekly activity and value performance reports. • Diagnostic, Surgical and Outpatient Improvement Groups in place, with organisation wide scope to deliver improvements in effectiveness.	• Integrated Quality and Performance Board Report. • Monthly Integrated Quality Performance Reviews. • TMG Updates. • Clinical Board meeting minutes. • Weekly Activity and ERF (income) reports.	• Improve theatre utilisation to greater than 85% by the end of March 2026. • Develop sustainable workforce plans across histopathology specialisms by July 25. • Longer term capacity modelling for radiology modalities to be completed by September 2025. • Regular reporting on key productivity metrics through Financial Recovery Steering Group to start in July 2025	**2 – Action defined- most progressing, where delays are occurring interventions are being taken.**	
Failure to transform and change service models at pace.	• Clinical Board Improvement Plans. • Winter Plan. • Bespoke programmes of support to critical / fragile services. • Clinical Board Structure in place from April 2023 • Alliance working groups. • GIRFT engagement and sharing of alternatives models, tools, and support. • Outpatient Improvement Group. • Surgical Improvement Group. • Diagnostic Improvement Groups. • Urgent and Emergency Care Improvement Group. • Monthly meetings in place with primary care. Winter planning.	• TMG Oversight. • Executive Team Oversight. • Quality Performance Reviews. • Monthly IPR to committees and Board. • Clinical Board meeting minutes. • Outpatient Improvement Group actions. • Surgical Improvement Group actions. • Diagnostic Improvement Group actions. • UEC Improvement Group actions. • Cancer Board actions. • Improvement and project management resource reprioritised to support priority actions/service changes.	• Develop and implement co-located UTC – December 25. • Establish effective Frailty model trial to be reviewed and longer-term model to be designed by September 2025. • Development of the Winter Plan for 25/26 to be completed by July 2025.	**2 – Action defined- most progressing, where delays are occurring interventions are being taken.**	
Clinical service failure at neighbouring Trusts impacting on NUTH performance – also linked to strategic risk	• Trust based Clinical Strategy work across the Alliance including a focus on vulnerable services. • Attendance at the Provider Collaborative Mutual Support Coordination Group and Alliance groups. • Alliance plans for identified services addressed through Bilateral Board meetings and workstreams.	• Regular updates to TMG. • CEO attendance at Great North Health Care Alliance Steering Group and Minutes. • Monitoring via the Bilateral Boards –First iteration of Alliance performance report complete.		**1.Fully on plan across all actions.**	

Risk ID	6.2
Comments:	

Agenda item A15

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	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.	**Strategic objective**	5.Our building will be fit for purpose.

Lead Committee	Finance and Performance	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Estates	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Compliance and Regulatory
Date Added	01.05.2024	**Likelihood**	**4**	**4**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	16.06.2025	**Risk Score**	**20**	**20**	**5**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Uncertainty and programme risk due to delays in Building Safety Act (BSA) approval will delay delivery and increase costs of construction/ refurbishments projects in “high-risk buildings”.	• Clearly identify every aspect requiring compliance. • Ongoing engagement with Contractors/HSE. • Engage professional/legal advice. • Discussions with NHSE/DHSC regarding impact on NHS.	• BSA applications. • Ongoing correspondence with Contractors/HSE.	• Compile a comprehensive list of the Trust Estate where HRB applies September 2025 • correspondence with Contractors/HSE – project specific timeline -March 2026 • Reporting capital plan and cashflows through CMG and F&PC – March 2026	**4-Actions defined - but largely behind plan.**	
Insufficient national capital funding allocation to effectively manage the lifecycle replacement or upgrade of the Trust Estate, Environment and Critical Infrastructure assets (Backlog Maintenance).	• Condition monitoring of assets undertaken annually to enable ongoing re-prioritisation of backlog maintenance programme. • Annual capital investment plan including estates and medical devices. • Estates Strategy. • ICS Infrastructure plan. • Annual condition survey (20%) to determine condition of infrastructure in accordance with NHS Backlog Methodology. • Alignment of condition surveys.	• Estates Risk Management & Governance Group minutes and action logs. • ERIC/Model Health System. • Estates Investment, Planning, Strategy and Capital Investment Group. • CIR plan 2025/26 Capital programme. • Capital Management Group oversight. • CMG report - Finance and Performance Committee. • ICS Infrastructure Board. • Condition surveys now aligned on CAFM system.	• Develop a risk-based asset report for Clinical Boards to inform risk-based prioritisation of backlog maintenance programme -July 2025. • Develop a detailed 5-year Backlog Maintenance plan to feed into the Estates Strategy -July 2025. • Carry out a condition survey of built environment, critical plant and equipment as part of subsidiary service agreement – December 2025.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Compliance with fire safety regulations & standards - Failure to	• Risk based fire remediation programme. • Condition monitoring of fire safety assets undertaken annually to enable ongoing re-	• Trust Fire Safety Group minutes and action logs. • Oversight by Estates Fire Directors Group. • Estates Risk Management & Governance Group minutes and action logs.	• Complete phase 2 passive fire remediation works to high-risk clinical areas -Q2 2025. -– • Tender/award contract for phase 3 of passive fire remediation works - Incumbent	**3-Action defined-work started but behind plan.**	

deliver fire safety systems remediation programmes.	prioritisation of fire safety remediation programme. • Monthly fire safety remediation programme monitoring reports. • Fire Safety Reports. • Incident reporting system. • Estates Strategy.	• Quarterly report to Compliance & Assurance Group. • Reports to Capital Management Group. • Fire Safety report to Trust Board.	contractor to deliver current phase of works (pending procurement approval). Tender ready to go out for 2026/27 – update in September 2025. • 2024/25 upgrade programme of active fire system – FH complete / RVI delayed L/W Q2, Dental Q3 2025. • Tender/award contract for 2025/26 upgrade of active fire systems – Q2 2025.		
Failure of ageing critical estates M&E engineering infrastructure (Ventilation, Water, Electrical (HV & LV systems), Decontamination and Medical Gas Pipeline Systems).	• Regular planned preventive maintenance programme (PPM) in place in line with the requirements of SFG20 and Health Technical Memoranda (HTM) guidance. • Condition monitoring of assets undertaken annually to enable ongoing re-prioritisation of backlog maintenance programme. • Monthly HTM Compliance Monitoring Reports. • Health & Safety Reports. • Incident reporting system. • Capital Programme. • Estates Strategy. • Trust Policies and Procedures. • Annual condition survey (20%) to determine condition of infrastructure in accordance with NHS Backlog Methodology.	• Estates Operational Management Structures. • Estates Investment, Planning, Strategy and Capital Investment Group. • CIR plan 2024/5 Capital programme. • Oversight via Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety). • Estates Risk Management & Governance Group minutes and action logs. • Quarterly report to Compliance & Assurance Group. • Capital Management Group oversight. • IPCC oversight. • Independent Authorising Engineer annual HTM compliance Audit. • Trust Internal Audit Programme (AuditOne).	• Develop a risk-based asset report for Clinical Boards to inform risk-based prioritisation of backlog maintenance programme -Aug 2025 as part of estates dashboard. • Develop a detailed 5-year Backlog Maintenance plan to feed into the Estates Strategy -July 2025. • Carry out condition survey of built environment, critical plant and equipment as part of subsidiary service agreement – December 2025.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Insufficient national capital funding allocation to effectively manage the lifecycle replacement or upgrade of critical medical devices (Imaging assets, Theatre Equipment etc.).	• Condition monitoring of assets undertaken annually to enable ongoing re-prioritisation of capital replacement programme. • Annual capital plan includes medical devices. • 3-year medical device asset replacement. • 3-year lifecycle replacement plan. • Medical Device replacement plan agreed for 2025/26 Capital programme.	• Medical Director medical device replacement oversight/prioritisation group. • Estates Investment, Planning, Strategy and Capital Investment Group. • Medical Device replacement plan 2025/26 Capital programme. • Capital Management Group oversight. • CMG report - Finance and Performance Committee. • Medical Device Steering Group. • medical device asset replacement monitored via Capital/Financial planning meetings. • Lifecycle replacement plan and programme in place.	• Regular review of priority requests by Medical Director medical device replacement oversight/prioritisation group March 2026.	**1.Fully on plan across all actions.**	
Failure of ageing critical medical devices assets (Imaging assets, Theatre Equipment etc.).	• Regular planned preventive maintenance programme (PPM) in place in line with the requirements of MHRA guidance. • Monthly Compliance Monitoring Reports. • Incident reporting system. • Capital Programme. • Trust Policies and Procedures.	• EME Operational Management Structures. • Annual report to Medical Device Steering Group. • Estates Risk Management & Governance Group minutes and action logs.	• Analysis of CAFM medical device data to identify failure trends -July 2025.	**1.Fully on plan across all actions.**	

Failure to maintain the Quality and Safety of the care environment to meet CQC regulatory standards and deliver Trust priorities and ambitions including environments that are Dementia Friendly and free from Self Harm risks.	• Regular planned preventive maintenance programme (PPM) in place in line with the requirements of SFG20 and Health Technical Memoranda (HTM) guidance. • Health & Safety Audit Reports. • Incident reporting system. • Capital Programme. • Estates Strategy. • Trust Policies and Procedures	• Estates and Facilities Operational Management Structures. • Estates Risk Management & Governance Group minutes and action logs. • Quarterly report to Compliance & Assurance Group. • PLACE Assessments. • NHS Premises Assurance Model (PAM). • IPCC oversight. • CQC Delivery Group. • CQC Standards Assurance Group. • Trust Internal Audit Programme (AuditOne).	• Dementia Friendly Estates options appraisal to be finalised and escalated for approval including any agreed plan of work – August 2025. • Finalise Trust standard specifications (including dementia standards) to follow on any refurbishment programme within capital plans -August 2025 • Phase 2 - Compliance with Self Harm Risk Assessment recommendations 18–24-month programme subject to CMG approval, currently outside of capital plan for 25/26. August 2025. • Review and implement agreed improvements relating to Real Time Patient Satisfaction Surveys -ongoing Q4 2025/2026.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Lack of decant facility compromises the delivery of planned Estates objectives	• Estates Strategy. • Liaison meetings with Patient Services to minimise impact on clinical activity. • Project Management meetings.	• Senior Operational meetings. • Capital Management Group oversight. • Estates Strategy & Capital Investment Group	• Co-ordinate with Patient Services to minimise impact on patient activity-timing project specific throughout the year – March 2026.	**5-Action not yet fully defined.**	
Failure to maintain and invest in the PFI estate to keep it in a suitable and quality condition and at a safe level of compliance.	• Monitoring of PFI annual and 5-year lifecycle plan (Lifecycle investment is included within the Project Agreement and Unitary Charge for the PFI Estate). • Monitoring of PFI annual condition surveys. • Regular zonal and ad hoc inspections of PFI areas.	• PFI Monthly Review Meetings. • PFI Liaison Committee. • Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety). • Compliance & Assurance Group. • Trust Internal Audit Programme (AuditOne) • Independent Authorising Engineer annual HTM compliance Audit. • PLACE audits. • Monitor helpdesk reporting.	• Continue zonal inspection processes to identify and remedy any slippage in condition. Checks to take place monthly until end of concession in 2043. • Performance of the PFI Centre of Best Practice condition survey process – July 2025.	**3-Action defined-work started but behind plan.**	
Failure to effectively manage PFI partners resulting in disruption to clinical service delivery.	• Maintain meeting structures to ensure flow of dialogue. • Communications and correspondence to review matters and highlight and action concerns. • Adherence with contract management requirements outlined within the PFI Project Agreement. • Legal support if required to resolve any disagreements.	• PFI Liaison Committee. • Service Providers meeting. • Performance reports. • Performance report review meetings.	• Execute Settlement Agreement 2 – now due Q3 2025. • Execute Settlement Agreement 3 – now due Q3 2025.	**3-Action defined-work started but behind plan.**	
Failure to manage project delivery within PFI estate will impact the ability to transform services and improve efficiency.	• Follow variation procedure outlined with PFI Project Agreement. • Track works requests and escalate slippage. • Review progress within meeting structures. • Implement alternative routes if required. • Management of works requests.	• Review at monthly Variation meetings. • PFI Liaison Committee. • Track and manage works requests through variation procedure and meeting structure -takes place monthly.	• Deed of variation being prepared for HSN direct delivery – Letter of Intent issued May 2025 Deed to be in place Q2 2025. • Implementation planned June 2025 - On target.	**4-Actions defined - but largely behind plan.**	

Reduced fire compliance during PFI Programme of fire remedial works.	• Obligations to perform and conclude fire remedial works set out in PFI Project Agreement and Settlement Agreement. • Maintain meetings structures to manage progress with the works.	• Independent certification for each zone when completed. • Ongoing compliance requirements contained within PFI Project Agreement. • PFI Fire Steering Group.	• Regular reviews of requirements and progress with the remedial works - April 2026.	**4-Actions defined - but largely behind plan.**	
Non-compliance of elements of PFI Ventilation and Air Conditioning Systems	• Obligations to perform remedial works set out in PFI Project Agreement. • Legal support if required to resolve any disagreements.	• Compliance requirements contained within PFI Project Agreement. • Performance reports. • Performance report review meetings. • PFI Liaison Committee.	• Seek remedial scope and programme from PFI partners - Q1 2026. • Manage terms of the PFI Project Agreement to conclude remedial works through to Dec 2026.	**3-Action defined- work started but behind plan.**	
Non-compliance of elements of PFI Electrical Systems.	• Obligations to perform remedial works set out in PFI Project Agreement. • Legal support if required to resolve any disagreements.	• Compliance requirements contained within PFI Project Agreement. • Performance reports. • Performance report review meetings. • PFI Liaison Committee.	• Seek remedial scope and programme from PFI partners - now due Q2 2025. Manage terms of the PFI Project Agreement to conclude remedial works through to Dec 26 – on track. Commence condition survey of electrical installations to fully define issues and required remedial actions -plan for July 2025.	**5- Actions not yet fully defined.**	

Risk ID	5.1
Comments:	

Agenda item A15

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Failure to improve and maintain an organisational culture, in line with our Trust values and our People Plan.	**Strategic objective**	2. We will be a great place to work where everyone feels supported.

Lead Committee	People Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Commercial Development & Innovation.	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	People & Culture
Date Added	01.05.2025	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	17.06.2025	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Failure to review and improve team working across the Trust following declining staff survey results in relation to 'we work as a team' question.	• Health and Wellbeing Steering Group. • People Programme Board.	• Health and Wellbeing Steering Group minutes. • People Programme Board Minutes.	• Staff psychology support service, 2025/26 – September 2025 • Staff Survey Action Plans – August 2025. • Evaluation and appraisal of Trust Leadership Programme -September 2025.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Failure to foster a supportive and inclusive culture across the Trust to ensure all staff groups feel safe, valued and respected.	• Staff Networks established including Enabled, Race Equality Network, Pride and Women's. • EDI Steering Group. • Health and Wellbeing Steering Group • Developed and launched Trust Behaviour and Civility Charter • NHS England's Sexual Safety in Healthcare Charter • New Sexual Misconduct and Sexual Violence Policy • EDI Development Session delivered at TMG and Trust Board. • Cultural Ambassadors in place. • People dashboard. • Let's Talk Race session with the Trust Board in March 2025.	• Health and Wellbeing Steering Group minutes. • People Strategy. • People Strategy Year 1 deliverables. • Safe Staffing Internal audit – Reasonable assurance • Freedom to speak up Internal audit – Reasonable assurance • F2SUG assurance report to People Committee. • People Committee minutes. • Clinical Board People Oversight Groups. • People Programme Board. • Micro aggression and incivilities training – 88.7% Trust staff compliance with training. • EDI and Let's Talk Race Presentation and slides. • People Dashboard reporting.	• People Plan Year 2 programme launch, July 2025. • Staff psychology support service, 2025/26 – Sept 2025. • Year 2 EDI Plan 2025/2026 – July 2025. • Establish People and Culture MDT Group – July 2025. • Further development of People Oversight Groups in CBs as part of PP Year 2 action plans – Sept 2025.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Failure to foster a supportive and inclusive culture across the Trust to ensure all staff groups feel safe, valued and respected.	• Staff Networks, Enabled, REN, Pride and Women's • EDI Steering Group • Health and Wellbeing Steering Group • Developed and launched Trust Behaviour and Civility Charter • NHS England's Sexual Safety in Healthcare Charter • New Sexual Misconduct and Sexual Violence Policy • Reasonable Adjustment Guide and Neurodiversity Guide • Micro aggressions and incivilities Training. • Let's Talk Race session ran with the Trust Board in March 2025. • Cultural Ambassadors in place. • People dashboard. • EDI Development Session delivered at TMG and Trust Board.	• Health and Wellbeing Steering Group minutes. • People Strategy. • People Strategy Year 1 deliverables. • F2SUG assurance report to People Committee. • People Committee minutes. • Clinical Board People Oversight Groups. • People Programme Board. • Health and Wellbeing and EDI Steering Groups in place • Micro aggression and incivilities training – 88.7% Trust staff compliance with training. • People dashboard reporting.	• People Strategy Year 2 programme launch, July 2025. • Staff psychology support service, 2025/26 – July 2025. • Year 2 EDI Plan 2025/2026 – July 2025. • Establish People and Culture MDT Group – July 2025. • Further development of People Oversight Groups in CBs as part of PP Year 2 action plans – Sept 2025. • Evaluate Civility and Behaviours Programme and Training – report to People committee – July 2025.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	

Risk ID	2.1
Comments:	

Agenda item A15

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Failure to effectively manage organisational change and related leadership and governance required to ensure effective supporting structures with the new Trust operating model.	**Strategic objective**	6.We will take our responsibilities as a public service seriously, carefully managing our money and performance.

Lead Committee	People Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Commercial Development & Innovation.	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	People and Culture
Date Added	01.05.2025	**Likelihood**	**4**	**3**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	17.06.2025	**Risk Score**	**20**	**16**	**4**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Failure to support staff with their health and wellbeing leading to increased sickness absence.	• Health and Wellbeing Steering Group in place. • Better Health at Work Award • Health and Wellbeing policy in place. • People Strategy. • completed including Wellbeing Gap Analysis. • People Programme Board. • Sexual Safety Charter. • Behaviour and civilities charter in place. • Staff Health and Wellbeing offers including Trust travel scheme, financial wellbeing, meal cards, access to helping hands, Staff social club and fitness centres. • EDI – Staff Networks, High Impact Actions, EDI Steering Group, WRES, WDES, EDS Cultural Ambassadors.	• Health and Wellbeing Steering Group minutes. • IBR - People report. Board (mthly); People Committee (bi-mthly); Employment Partnership Forum (mthly). • People Strategy, Year 1 delivery programme • Performance review report for Clinical Boards (mthly). • Sexual safety charter awareness and training in place. • People Strategy Year 1 programmes. • Internal Audit reports (absence management; HAWB initiatives; F2SUG). • People dashboard and reports. • F2SUG reports. • People Committee minutes. • Clinical Board People Oversight Groups. • People Programme Board. • Health and Wellbeing ad EDI Steering Groups in place • Behaviour and civilities charter awareness and training in place – Trust compliance 88.7%	• People Strategy Year 2 programme launch - July 2025. • HAWB policy in place - July 2025. • Staff psychology support service, 2025/26 – Sept 2025. • Target reduction in sickness absence of 0.5% - March 2026. • Anti Racism Framework 2025/26 – July 2025. • Evaluate learning and sharing from CB People Oversight Groups – Sept 2025. • Establish People and Culture MDT Group – July 2025.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Failure to support staff with their health and wellbeing leading to	• Health and Wellbeing Steering Group in place. • Better Health at Work Award • NHS annual staff survey.	• Health and Wellbeing Steering Group minutes.	• People Strategy Year 2 delivery programme launch, July 2025. • New HAWB policy in place, July 2025.	**2.Actions defined- most progressing,**	

increased sickness absence.	• Health and Wellbeing policy in place. • People Strategy in place. Aims to create an environment where our people feel safe and well, experiencing care and compassion from leaders and colleagues. • People Strategy, Year 1 delivery programme completed including Wellbeing Gap Analysis. • People Programme Board. • Living Wage Employer since October 2023. • Sexual Safety Charter in place. • Sexual safety charter awareness and training in place. • Behaviour and civilities charter in place. • Menopause support program delivered. • Menopause-related absence recorded in ESR. • Sleep Well Guidance/Resources • Support in place: meal cards, food fridges, access to 'Helping Hands', travel cards, salary sacrifice schemes including Trust Travel Scheme. Financial wellbeing programs. • Vaccination support in place. • Wellbeing café in place for nurses, midwives, and AHPs. • Annual suite of HAWB awareness sessions in place. • Staff social club and fitness centres in place. • Occupational Health Service in place, including Rapid Access. • Early Access Advice system in place. • New appraisal policy and process in place. • Statutory and mandatory training in place. • F2SUG in place. • EDI – Staff Networks, High Impact Actions, EDI Steering Group, WRES, WDES, EDS • Cultural Ambassadors	• IBR - People report. Board (mthly); People Committee (bi-mthly); Employment Partnership Forum (mthly). • Performance review report for Clinical Boards (mthly). • People Strategy Year 1 programmes. • Internal Audit reports (absence management; HAWB initiatives; F2SUG). • NHS annual staff survey action plans. • Performance review records. • Occupational Health Service dashboard. • People dashboard and BI reports. • F2SUG reports. • People Committee minutes. • Clinical Board People Oversight Groups. • People Programme Board. • Health and Wellbeing ad EDI Steering Groups in place • Behaviour and civilities charter awareness and training in place – Trust compliance 88.7%	• Staff psychology support service, 2025/26. • MHFA 2025/26 • Target reduction in sickness absence of 0.5%, March 2026. • Staff psychology support service to be implemented 2025/26. • Mental Health First Aiders to be refreshed 2025/26. • Anti Racism Framework 2025/26 – July.	**where delays are occurring interventions are being taken.**	
Failure to deliver improvements to leadership and governance across the Trust.	• Organisational Change policy in place. • People Strategy. • SubCo Operational Group in place. • SubCo People Group in place. • People Programme Board. • People Transformation Group. • People Committee. Employment Partnership Forum.	• Project management records. • Internal Audit report. • People Programme Board minutes and actions. • People Transformation Group minutes and actions. • People Committee minutes and actions. • Employment Partnership Forum minutes and actions. • SubCo Operational Group minutes and actions. • SubCo People Group minutes and actions.	• Business Partner Model – Q4. • Develop BP working Group – July 2025. • Explore Just learning culture – Q4.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	

Risk ID	2.2
Comments:	

Agenda item A15

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Failure to deliver effective workforce planning to allow the Trust to forecast and adapt to changing NHS healthcare landscape, financial constraints and address staff shortages and retention.	**Strategic objective**	2. We will be a great place to work where everyone feels supported.

Lead Committee	People Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**
Executive Lead	Director of Commercial Development & Innovation.	**Impact**	**5**	**5**	**5**	**Risk Appetite Category** People & Culture
Date Added	01.05.2025	**Likelihood**	**4**	**3**	**1**	**Risk Appetite Tolerance**
Last Reviewed	17.06.2025	**Risk Score**	**20**	**15**	**5**	**Risk Appetite Rating**

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Trust plans to reduce corporate headcount by 50% of 2019/20 growth potentially destabilising corporate functions.	• Financial Recovery Steering Group. • IBR - People report. Board (mthly); People Committee (bi-mthly); Employment Partnership Forum (mthly). • PWR data mapping with PFR data. • Redeployment policy in place. • Redeployment group meets weekly.	• Voluntary severance scheme drawn up. • Redeployment group minutes and actions. • Workforce reduction data reported to FRSG.	• Evaluate Voluntary Severance Scheme - July 2025. • Workforce transformation programme- Q4.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Underdeveloped workforce planning mechanisms impacting on our ability to effectively forecast workforce needs.	• PWR data (mthly). • Clinical Board People Oversight Groups in place. • People dashboards and BI reports. • People Programme Board.	• PWR data. • People dashboard and BI reports. • Clinical Board/Corporate Service workforce plans. • People Programme Board minutes. • People Transformation Group minutes.	• Business partner model 2025/26 – Q4. • Workforce planning benchmarking exercise – Q4.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Capacity and capability to effectively support workforce planning in the Trust.	• Operational Planning Group in place. • ESR in place, including Establishment. • PWR data. • People dashboards and BI reports. • People Programme Board. • People Transformation Group.	• Operational Planning Group minutes. • ESR reports. • PWR data/reports. • People dashboards and BI reports. • People Programme Board minutes. • People Transformation Group minutes.	Business partner model 2025/26 – Q4.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Risk ID	2.3

Comments:

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Inability to sufficiently influence priorities of key partnerships (including the Great North Healthcare Alliance, the ICB, Provider Collaborative and Newcastle place arrangements) or to deliver on agreed commitments due to capacity or culture, impacting on our ability to effectively deliver sustainable local and regional healthcare commitments.	**Strategic objective**	7. We will make sure we deliver our commitments to the communities who depend on us.

Lead Committee	Trust Board	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Martin Wilson,	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	System and Partnerships
Date Added	Director Great North Healthcare Alliance	**Likelihood**	**4**	**3**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	01.05.2024	**Risk Score**	**16**	**12**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Lack of appropriate Board, Executive and senior clinician capacity to influence the key partnerships and/or culture of the organisation resistant to working in effective partnerships.	• Great North Healthcare Alliance Steering Group Committees in Common • Great North Healthcare Alliance Joint Committee. 3 lead directors in place for delegated functions of financial planning, digital and research and innovation. • Bilateral group between Northumbria and Newcastle established. • Bilateral sub-committee between North Cumbria and Newcastle established. • ICS Board. • Great North Healthcare Alliance Collaboration Agreement based around improving collaboration working whilst retaining organisational independence. • Provider collaborative leadership board. • Newcastle place based ICB sub-committee. • Alliance Vision, Workplan and Milestones. • Alliance Performance Dashboard. • Shared Chair in post across Newcastle, Northumbria, and Gateshead. • Bilateral group between Gateshead and Newcastle established.	• Chair and CEO member of Great North Healthcare Alliance Steering Group Committees in Common and Joint Committee. • CEO member of Provider Collaborative Leadership Board. • Executive Directors leading appropriate Alliance work streams with peers. • Acting CEO chairs Newcastle Place ICB Sub-Committee. • Alliance vision and 3-year work plan approved by Trust Board and supported by Council of Governors and NENC ICB. • Great North Healthcare Alliance Steering Group Committees in Common and Joint Committee Minutes • Great North Healthcare Alliance bi-monthly update to Trust Board and quarterly written update to Council of Governors. • ICB/Provider Collaborative and PLACE Minutes • Legal support to ensure legislative compliance • ICB approval of Alliance Case for Change. • ICB led stakeholder engagement assurance of Alliance plan very positive. • NHSE assured Alliance shared leadership arrangements	• Alliance Construction Programme (“Big Build”) – market engagement with policy makers and potential funders and construction partners – July 2025. • ICB, Alliance Chairs and CEO’s meeting – July 2025. • 2nd Alliance Governor Event – Autumn 2025. • 3rd Alliance Board member event – Winter 2025.	**1-Fully on plan across all actions.**	

	• Director for the Great North Healthcare Alliance and (Trust) Strategy leads Alliance Formation Team.	• Alliance updated Collaboration Agreement. • Alliance and wider partnership working embedded within the Trust interim and draft clinical strategy			

Risk ID	7.1
Comments:	

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Agenda item A16

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 July 2025					
Title	FINAL Risk Appetite Statement 2025-2026					
Report of	Patrick Garner, Director of Performance and Governance					
Prepared by	Natalie Yeowart, Head of Corporate Risk and Assurance					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☐	☐			
Summary	Risk appetite and risk tolerance are critical components of effective risk management. It should aim to support the Trust to understand the capacity to take risk and allow for the establishment of clear boundaries for risk taking. By defining a risk appetite, the Trust will be able to clearly set the optimal and tolerable position in pursuit of the achievement of strategic objectives. The attached statement builds upon the risk appetite board development session in March 2025 where Trust Board members discussed and considered the Trusts collective risk appetite and risk appetite categories. Audit, Risk and Assurance Committee reviewed and considered the draft risk appetite statement at the June Committee meeting and recommend that the Public Trust Board review and approve the final version. Once approved work will start to further align risk appetite to the Trust strategy with the development of a risk appetite approach including clear metrics for risk appetite and tolerance.						
Recommendation	Public Trust Board are asked to: • Review and approve the Final Risk Appetite Statement. • Provide any feedback or comments.					
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]	Links to all of Board Assurance Framework.
Reports previously considered by	Annual Report to the Audit, Risk and Assurance Committee.

The Newcastle upon Tyne Hospitals NHS Foundation Trust Risk Appetite Statement 2025-2026		
Key Risk Category	**Risk Appetite Level**	**Risk Appetite Statement**
Quality and Safety	LOW	We have a **LOW** appetite for risk taking in relation to Quality and Safety. We will take measured risks to improve and deliver quality outcomes where there is potential for long term benefit. We will not take any risk that would compromise the safety of the patients in our care.
Compliance and Regulatory	LOW	We have a **LOW** appetite to risk taking in relation to Compliance and Regulatory. We will take measured risks in relation to compliance and regulatory guidance where it is in the best interest of patient care. We will not take any risks which will impact our ability to meet our legislative requirements.
Finance/VfM	MODERATE	We have a **MODERATE** appetite for risk taking in relation to Finance and Value for Money. We will consider risks to support growth whist making the best use of resources, delivering value for money whilst minimising the possibility of financial loss allowing us to continue to develop and provide highest standards of healthcare. We will not take any material financial risks which will have a negative impact on the overall sustainability of the Trust and will be cognisant of the impact that our decision making may have on Alliance and System Partners.
Performance	MODERATE	We have a **MODERATE** appetite for risk taking in relation to Performance. We will consider all risks and are open to exploring new performance delivery options in pursuit of the achievement of our performance standards, however we will not compromise the quality and safety of the care we provide to do so.
People and Culture	MODERATE	We have a **MODERATE** appetite for risk taking in relation to our People and Culture in the Trust. We will take considered risk to liberate the potential of all of staff, engaging with, supporting and enabling staff to shape the environment and culture of the organisation to enhance staff experience, ensuring staff feel valued and supported at work.
Digital Technology	HIGH	We have a HIGH appetite for risk taking in relation to Digital Technology. We are eager to innovate in relation to digital transformation and new digital key enablers to support and improve better outcomes, operational delivery, productivity and efficiency to support our work and patient care.
Information Security (IG/Cyber)	LOW	We have a **LOW** risk appetite for risk taking in relation to Information governance and Cyber Security.

		Whilst we are eager to innovate and consider digital transformation, we will not take any risk which would compromise patient confidentiality, or the security of healthcare data held by the Trust.
Commercial and Innovation	HIGH	We have a **HIGH** appetite for Commercial and Innovation to maximise commercial and innovative opportunities to improve patient outcomes, transform services and ensures value for money for the Trust.
System and Partnership	HIGH	We have a **HIGH** appetite for systems and partnerships where we believe there is a patient, staff, organisational alliance or system benefit. We believe that by working together we can deliver better care for our local communities including many of the solutions to delivering the three shifts (from sickness to prevention; hospital to community and analogue to digital) nationally expected of us if we work in collaboration.
Please note: The Executive Team may agree to accept a risk that exceeds the Trust Risk Appetite tolerance when it is in the best interest of the Trust. This will be carefully considered and will be reported to the Audit, Risk and Assurance Committee.		

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PUBLIC BOARD MEETINGS - ACTIONS

Agenda item A17

Log No.	BOARD DATE	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
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. 23.05.25 - The Board of Directors agreed to close this action and the EDN will pick up outside of the meeting.
144	23-May-25	25/115 STANDING ITEMS: iii) Chair's Report	The Chair advised that he would share his vision for the Alliance at a future Board meeting or development session [ACTION01].	PE			14.07.25 - Presentation shared at the June Board development session. Propose close action.
145	23-May-25	25/125 STRATEGIC ITEMS: ii) Board Visibility Programme	The DQS agreed to include non-clinical environments/areas in the walkabouts programme and an update to be provided in the next report [ACTION02].	RC			14.07.25 - Included in the Board Visibility Programme report to July 2025 Public Board. Propose to close.
146	23-May-25	25/125 STRATEGIC ITEMS: iv) Winter Plan Review	Mr Kane queried if any concerns had been raised by relatives that patients had been discharged early and whether readmission rates had increased. He referred to staff shortages and queried if staff were offered Respiratory Syncytial Virus (RSV) vaccinations to which the EDN advised that he would follow this up at the Vaccination Steering Group [ACTION03].	IJ			14.07.25 - IJ advised that the national guidance on RSV vaccination has been reviewed regarding eligibility criteria. At the present time the vaccination is recommended for people aged 75 to 79 and for people who are more than 28 weeks pregnant (to help protect the baby from infection after it has been born). Propose to close action.
147	23-May-25	25/130 ITEMS TO RECEIVE i). Guardian of Safe Working (GoSW) Report	Mr Kajee sought clarification with regards to the recommendation in the report on continuing to review the workforce and queried whether the Trust was considered to be safe in terms of working hours. The JMD-W explained the role of the Guardian in ensuring that working conditions were safe and to highlight exception reporting. The JMD-W agreed to ask the GOSW to highlight further information in terms of assurance as to safety in future reports [ACTION04].	MWr			14.07.25 - KJ emailed the GOSW on 14 July.
148	23-May-25	25/130 ITEMS TO RECEIVE i). Guardian of Safe Working (GoSW) Report	The ACEO referred to the increases in resident doctor posts and that it would be useful to include content with regards to the changes that had been made, how this aligned to outcomes within the report and to whether this had a positive or negative impact in those areas from an exception reporting perspective. The JMD-W agreed to follow up [ACTION05].	MWr			14.07.25 - KJ emailed the GOSW 14 July.

Log No.	BOARD DATE	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes

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.