The Newcastle upon Tyne Hospitals
NHS Foundation Trust

# Public Trust Board of Directors' Meeting

Friday 26 September 2025, 10.15 – 12.15

Venue: Culture Centre Boardroom, Royal Victoria Infirmary (RVI)

## 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 25 July 2025 and Matters Arising | Paul Ennals | Attached | 10:16 – 10:17 |
| 3. | Chair's Report | Paul Ennals | Attached | 10:17 – 10:22 |
| 4. | Chief Executive's Report, including CQC update | Rob Harrison | Presentation | 10:22 – 10:42 |
| **Strategic items:** | | | | |
| 5. | Patient and Staff Stories | Annie Laverty | Attached | 10:42 – 10:49 |
| 6. | NHS Staff Survey update | Vicky McFarlane-Reid & Annie Laverty | Attached | 10:49 – 11:00 |
| 7. | Board Visibility Programme | Rachel Carter | Attached & Reading Room | 11:00 – 11:05 |
| 8. | Sustainability update | James Dixon | Verbal | 11:05 – 11:22 |
| 9. | Integrated Board Report | Patrick Garner | Attached | 11:22 – 11:35 |
| **Items to receive *[NB for information – matters to be raised by exception only]*:** | | | | |
| 10. | Director reports: | | | 11:35 – 12:00 |
| | a. Joint Medical Directors Report | Lucia Pareja-Cebrian | Attached | |
| | b. Executive Director of Nursing Report | Ian Joy | Attached & Reading Room | |
| | c. Maternity: | | | |
| | i) Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress report | Ian Joy & Jenna Wall | Attached & Reading Room | |
| | ii) Maternity Safety Champion Report | Liz Bromley | Attached | |
| | d. People Plan Update | Amy Callow | Verbal | |
| 11. | Committee Chair Meeting Logs | Committee Chairs | Attached | |
| **Items to approve:** | | | | 12:00 – 12:10 |
| 12. | Board Assurance Framework (BAF) | Patrick Garner | Attached | |

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|---|---|---|---|
| **Any other business:** | | | 12:10 – 12:15 |
| 13. | Meeting Action Log | Paul Ennals | Attached |
| 14. | Any other business | All | Verbal |

**Date of next meeting:**
Public Board of Directors – Friday 28 November 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 Annie Laverty, Chief Experience Officer*

*Mrs Rachel Carter, Director of Quality and Safety*

*Ms Amy Callow, Associate Director of People and Organisational Development*

*Mr James Dixon, Associate Director Sustainability*

*Mrs Jenna Wall, Director of Midwifery*

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# PUBLIC TRUST BOARD OF DIRECTORS MEETING

## DRAFT MINUTES OF THE MEETING HELD 25 JULY 2025

| | | |
|---|---|---|
| **Present:** | Paul Ennals *[Chair]* | Chair |
| | Rob Harrison | Acting Chief Executive Officer |
| | Michael Wright | Joint Medical Director |
| | Lucia Pareja-Cebrian | Joint Medical Director |
| | Jackie Bilcliff | Chief Finance Officer |
| | Ian Joy | Executive Director of Nursing |
| | Vicky McFarlane Reid | Director for Commercial Development & Innovation |
| | Sue Hillyard | Interim Director of Operations |
| | Bill MacLeod | Non-Executive Director (NED) |
| | Liz Bromley | NED |
| | David Weatherburn | NED |
| | Anna Stabler | NED |
| | Bernie McCardle | NED |
| | Phil Kane | NED |
| | Wendy Balmain | NED |

**In attendance:**
Caroline Docking, Director of Communications and Corporate Affairs
Rachel Carter, Director of Quality and Safety
Patrick Garner, Director of Performance and Governance
Annie Laverty, Chief Experience Officer
Kelly Jupp, Trust Secretary
Russell Jones, Deputy Director of Estates
Amy Callow, Associate Director for People and Organisation Development
Jenna Wall, Director of Midwifery *(for item 25/18 c) i))*
Nichola Kenny, Director of Improvement and Delivery *(for item 25/17 iv))*

**Observers:**
Lisa Hall, Care Quality Commission (CQC)
Andy Nichols, Grant Thornton
Andy Smith, Grant Thornton
Alastair Bailey, Market Access Manager, Uniphar Commercial
David Fletcher, Market Access Manager, Uniphar Commercial
Sam Volpe, Health Reporter, Chronicle Live
Andy Roughan, Videographer, Northumbria Healthcare NHS Foundation Trust

**Secretary:** Lauren Thompson Corporate Governance Manager / Deputy Trust Secretary

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

## 25/16 STANDING ITEMS:

Paul Ennals welcomed all to the meeting, and specifically to Amy Callow in her first meeting as the new Associate Director for People and Organisation Development. He highlighted that the meeting was being filmed and would be available on YouTube, and this was supplemented through moving a greater number of reports from the Private to the Public Board meetings.

In relation to industrial action, Rob Harrison advised that teams within the Trust had done a fantastic job to support the continued delivery of and access to patient care. The action is bad for patients and adds pressure on clinical services. Some staff members had made significant changes to their personal arrangements to make themselves available to support the delivery of safe urgent and elective care during the period of industrial action.

Rob Harrison thanked Lucia Pareja-Cebrian, Michael Wright and all involved for dedicating their time to prioritising patient safety and ensuring continuity of services during the industrial action. Paul Ennals agreed and advised that he had visited the Emergency Department earlier in the day and observed calmness and professionalism throughout.

### i) Apologies for Absence and Declarations of Interest

Apologies were received from Hassan Kajee, NED, Nini Adetuberu, Associate NED, Martin Wilson, Director - Great North Healthcare Alliance (GNHA) & Strategy and Paul Hanson, Director of Estates, Facilities and Strategic Partnerships.

**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 May 2025 and matters arising

The minutes of the meeting held on 28 May 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.

Paul Ennals advised that the Annual Members Meeting (AMM) that took place on 23 July 2025 had gone well with a good level of attendance from members. The meeting was positive, looking into the future and celebrating achievements throughout the year 2024/25.

The Trust was moving out of a difficult phase and the organisation remains focussed on further improvement.

Paul Ennals welcomed representatives from Grant Thornton to the meeting as part of carrying out the independent external well led review.

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

**iv) <u>Acting Chief Executive's Report, including:</u>**

**a. <u>10-year Health Plan for England</u>**

Rob Harrison highlighted the following points:

- The 10-year Health Plan would be discussed in detail at the August Board Development Session and in particular what it means for the Trust.
- The big signals and three priority areas for 2025/26.
- An independent well-led review had been commissioned to test the improvements made since the last Care Quality Commission (CQC) report. Lisa Hall was welcomed as the new Trust engagement lead from CQC.
- In relation to the NHS Oversight Framework (NOF), the Trust was categorised in segment 3 and further discussions on this would take place at the Private Board of Directors' meeting. There was a focus on continuous improvement and the aim was to move to segment 2 in this financial year.
- With regards to the financial position, the Trust continued to be on plan however it was an area of significant focus for all members of staff.

  Jackie Bilcliff highlighted that a challenging plan was set with a significant Cost Improvement Programme (CIP) target to achieve. Difficult decisions may be needed to meet the challenge. Robust challenge was in place regarding use of resources and identification of longer term transformational savings were noted to be crucial in terms of financial sustainability.
- The Dr Penny Dash review of patient safety across the health and care landscape highlighted the link between patient safety, effectiveness and patient/user experience in ensuring the best possible outcomes for patients with the most efficient use resources.
- There was an opportunity to redirect resources and further develop services in line with the 10-year Health Plan. Work was taking place with partners in the city with regards to neighbourhood health services.
- Good progress had been made on elective recovery however the aim was to restore the constitutional standard of 92% for Referral to Treatment (RTT).
- The Urgent Treatment Centre (UTC) on the Royal Victoria Infirmary (RVI) site would be completed by the end of the calendar year with improvements to the Same Day Emergency Care (SDEC) footprint planned.
- The investment made in measuring and developing patient experience had been beneficial in identifying areas for improvement and provided greater use of patient outcome and experience measures across the organisation.
- A new Quality Strategy was under development.
- In relation to areas of development, there was a need to redirect resources into the community, digital transformation and ending corridor care.

The life sciences sector plan was published shortly after the 10-year plan and Michael Wright highlighted the important connections for Newcastle Hospitals. Six core actions were detailed in the presentation and the commercial elements were in progress, which including increasing the speed of clinical trials where appropriate. There was also a need to streamline regulation. Life sciences would be discussed in more detail along with the 10-year Health Plan at the next Board Development Workshop **[ACTION01]**. The development of fertility treatment to prevent mitochondrial diseases was an example of a science discovery which had led to the delivery of new treatment for patients and families. There was a need to use data in an efficient way and the development of the neighbourhood genomics health service would be a positive step.

Rob Harrison advised that early work was taking place regarding 'fixing the fundamentals' priority which included access to care/treatment, patient experience and quality.

Bernie McCardle highlighted the importance of reviewing and assessing the implications of the 10-year Health Plan regarding workforce and noted that this would be considered through the strengthened governance framework implemented through the People Programme Board into the People Committee.

Anna Stabler referred to her previous visits to the Genetics service at the Centre for Life and queried if there was sufficient space and capacity in the building to which Michael Wright explained that space was available however it was not space currently occupied by the Trust. There was the potential to occupy and use the space differently. Paul Ennals sought clarification with regards to a timeline for the review of space utilisation within the Centre for Life to which Rob Harrison advised that a further update would be available in the Autumn.

Bill MacLeod sought clarification as to the role of the Alliance in addressing specific objectives in the Plan to which Rob Harrison explained that this was being discussed at the Alliance Committee in Common meetings and with key stakeholders in the city to improve pathways. Providing efficient care pathways across different trusts was a positive step and progress was moving in the right direction. This would be discussed further at a meeting with Paul Ennals, Rob Harrison and the Chair and Chief Executive Officer of the Integrated Care Board (ICB) next week.

Wendy Balmain noted her interest in the development of the neighbourhood teams and the need to rethink community service provision considering the 10-year Health Plan. She queried the partnership arrangements in place to which Rob Harrison advised that a great deal of work was taking place, with workshops held with different partners across Newcastle on the ICB blueprint and development of a bid to be a national pilot site for Neighbourhood Health.

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

**25/17** **STRATEGIC ITEMS:**

## i) Patient and Staff Stories

Rob Harrison advised that he had visited Ward 3 recently to meet the patient referred to in the report and outlined the challenges with the provision of highly specialist care and treatment within the Ward.

Annie Laverty highlighted the following points:

- The patient experience and staff experience stories were great examples of the roll out of the real time patient experience programme and the commitment from staff and patients. The programme provided opportunities to gain meaningful feedback for continuous improvement.
- Regarding the patient experience story, Lexi had spent significant time in Newcastle Hospitals and was able to name wards and how many times she had attended for surgery.
- Lexi had written a letter to help improve the patient experience and Children and Young Peoples Services. Discussions were underway as to how best to share Lexi's advice in a creative way.
- The staff experience story provided an understanding of the impact of the real time patient experience programme which was designed with patients in mind and impacted staff morale.
- Ward 8 at the Freeman Hospital had challenges due to increased patient acuity which affected staff experience.

The challenge personally and professionally for staff members and as an organisation was highlighted. It was important to encourage and challenge through stories and capture in a supportive way to ensure improvements were made.

Anna Stabler commented that she has visited both areas recently and there was positive feedback received from staff in relation to experience measures.

Bernie McCardle noted that he was moved by the patient experience in Lexi's letter and that it would be beneficial to work with Lexi and family to move experience forward. This was noted to be in progress currently.

Information on patient experience was captured and in some cases wards/departments were revisited to ascertain whether any changes had been made and what actions the teams had put in place. This would also be considered as part of audit processes.

The positive impact that Newcastle Hospitals Charity has had in funding the patient experience programme was acknowledged, which included the provision of IT and resources to conduct the work.

Bill MacLeod noted the difficulties for patients being treated in 'sealed' rooms (specially designed isolation rooms to protect against infectious air-borne pathogens) and for staff working on such wards. He acknowledged that the nurse was passionate and humbling and

highlighted the importance of supporting staff members. Work was taking place regarding staff wellbeing and a trauma informed approach.

The powerful content in Lexi and her mums letters was noted and gratitude was expressed from Board members to both for sharing their stories.

Paul Ennals requested a future update on the actions taken in response to Lexi and her Mum's letters and agreed to send a thankyou card on behalf of the Board of Directors **[ACTION02]**.

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

**ii) Board Visibility Programme**

Rachel Carter highlighted the following points:

- Further information was available in the Board Reading Room on AdminControl which provided an update on all visits held in the last 12 months and feedback received.
- The Board Visibility Programme was an opportunity to capture staff experience and could lead to escalations for action if necessary.
- The aim was for staff to feel comfortable to share their views and to witness positive improvements made from the programme, as well as ensuring staff feel supported.
- There were still issues in specific areas which were being worked through.
- Communications in relation to InPhase continued to be widely shared and the Patient Safety Team were carrying out walkabouts as part of the programme.

*[Nichola Kenny joined the meeting at 10.54am]*

Ian Joy noted that internal staff were not always specifying the staff groups met on the visits to which Rachel Carter advised that there was a question on the form however this was not always completed. The move to using digital forms would allow the question field to be made mandatory.

A request was made to encourage discussions with Allied Healthcare Professionals (AHPs) to capture their views.

David Weatherburn commented that the visits were valuable and time well spent to allow the NEDs to triangulate information and test assurances previously given.

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

**iii) Care Quality Commission (CQC) update**

Ian Joy presented the report and noted the following points:

- In relation to the phase 2 improvement plan, there were two overdue actions due to transactional elements and staff coming into post. Both were scheduled to be completed by the end of September 2025.

- The Trust was still under enhanced oversight with NHS England (NHSE) and the ICB. At the Integrated Quality Improvement Group (IQIG) meeting held on 2 July 2025, the de-escalation criteria were agreed, and the frequency of the meetings would be reduced to bi-monthly going forward.
- Since the May Trust Board meeting, the CQC had conducted an inspection at the Sexual Assault Referral Centre (SARC) on 2 July 2025. No regulatory concerns were noted and there were seven improvement areas to consider. Once the final report was received, a review would take place to ensure to cross reference the actions taken.

Detailed discussions took place at the Quality Committee with no matters to escalate from the CQC Oversight Group.

Sue Hillyard advised that a Get It Right First Time (GIRFT) review had taken place in the ED and the final report was awaited which would be discussed at the Quality Committee.

Paul Ennals noted it was evident that the improvements were becoming 'business as usual' and thanked all colleagues for their work in this area.

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

**iv) Winter Plan [FOR APPROVAL]**

The Winter Plan had been discussed at the most recent Board of Directors meeting, the Board Development Workshop and the Finance and Performance Committee (F&PC).

Nichola Kenny highlighted the following points:

- The Winter Plan has been produced earlier than normal and therefore included some assumptions. Monthly meetings were underway to engage all required teams in the planning and delivery process.
- Activity had been reviewed which had been relatively static for the last few years.
- Intermediate care provision was a valued step down resource to ensure a safe interim transfer of care. Reprovision of the 20 beds lost from Eden Court Care Home into an alternative community setting had been enacted and the Medicine and Emergency Care Clinical Board were leading on this in discussion with the ICB.
- An additional 27 bed capacity would be provided on Winter Ward 12 at the Freeman Hospital, operational from 29 December 2025 until 26 April 2026.
- Planning for the vaccination programme was underway, and recruitment was taking place to ensure an improvement was delivered in terms of uptake by 5%.
- The UTC build was on track for handover on the 15 December 2025, however there was work to be conducted following handover in relation to refurbishment and IT systems. The aim was for the UTC to open in mid-January.
- The Medicine and Emergency Care Clinical Board were leading on the Pharmacy first pathways.
- Representatives from the Trust had contributed to a readiness checklist, meetings and webinars to navigate winter planning with other organisations.
- Early discharge initiatives were under development.

- Winter escalation actions cards were being expanded to other departments and being updated to ensure surge capacity was optimised.
- The draft Winter Planning 2025/26 Board Assurance Statement (BAS) had been included for assurance which would require Trust Board sign off in September 2025.
- A transport review was underway which may negate or lessen the requirement for additional transport.
- Engagement was taking place with staff - for example town hall events - which included discussions on staff health and wellbeing.

Liz Bromley highlighted that in relation to the risks there was no mention of ongoing industrial action, to which Lucia Pareja-Cebrian advised that it was added to Risk Register yesterday. Nichola Kenny agreed to update the Winter Plan regarding the industrial action risks/impact **[ACTION03]**.

Wendy Balmain queried the go live date for the UTC as January was usually one of the busiest periods and if there were any associated risks and mitigations in place. Nichola Kenny referred to the work underway with the Medicine and Emergency Care Clinical Board to streamline pathways and with the estates team to improve flow through the hospital. It was a risk however the teams were fully involved in the mobilisation plan for go live in January 2026. The UTC building work was on plan and the contractors were aware how critical the building was.

Sue Hillyard explained that the teams were testing new ways of working with a focus on screening at the front door. Testing would take place before December 2025 to allow scope for new opportunities and addressing space difficulties.

Rob Harrison noted the importance of the UTC and the better experience patients will have in the new building. Having additional space in January 2026 was critical to improving emergency care.

*[Jenna Wall joined the meeting at 11.13am]*

The Board of Directors agreed to delegate final sign off of the BAS to the F&PC, however if there were any fundamental changes this would be presented to the Board **[ACTION04]**.

In relation to the loss of beds at Eden Court, Anna Stabler sought clarification regarding if the Trust has assurance that the beds received back can be used and contingency plans. Nichola Kenny explained that the beds would not be the same type and work was ongoing in terms of intermediate care provision and supporting patients in their own home.

It was **resolved:** to **receive** the report and **approved** the Winter Plan.

**v) <u>Integrated Board Report (IBR)</u>**

Patrick Garner highlighted the following points:

- Learning had taken place through making data count and the Insightful Board guidance, this included use of Statistical Process Control (SPC) charts in the IBR.

- In terms of Accident & Emergency (A&E), the 4-hour performance improved in May, achieving 79.1% for the first time since August 2023.
- Trends of incident reporting had continued to increase which would help improve patient safety.
- Regarding mandatory training, performance had dropped to 91.46% which had been picked up through the Quality Performance Review (QPR) process with all Clinical Boards.
- A deterioration had been seen regarding healthcare acquired infections and this had been discussed in detail at the Quality Committee. Ian Joy noted the concerns which continued to be a focus, specifically in terms of patient harm that could be avoided. Trust wide action was taking place through the Infection Prevention Control Committee to ensure sustainable improvement was made.

Rachel Carter referred to the new summary table of never events which provided better oversight in terms of themes and trends.

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

**25/18 ITEMS TO RECEIVE**

**i) Director reports:**

**a. Joint Medical Directors (JMD) Report**

Michael Wright noted the following points:

- Regarding Urgent and Emergency Care, performance which had seen a steady improvement dropped slightly from 79.06% in May to 77.5% in June although quarter 2 performance remained 79.14% as at 16 July 2025.
- There was a great deal of focus in relation to corridor care whereby discussions had taken place with the Clinical Policy Group (CPG) and Trust Management Group (TMG). The importance of staff being committed to help improve the situation was noted.
- In relation to cancer performance, there had been an overall improvement in the 62-day time to treatment target. There was a strong commitment from the clinical teams to improve this position further.
- There had been two episodes of harm recorded in May and June 2025 in respect of patients with liver malignancy who were due to have ablation treatment. Computed Tomography (CT) availability was critical for this type of treatment and regular access to equipment would reduce patient harm.
- 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, Martha's rule was set to go live across all children's wards on 22 July 2025. Thanks were given to all the teams involved in the work.
- In relation to never events, a review was taking place of the priorities for this year particularly regarding invasive procedure quality.
- Staffing challenges within the medical education administrative team which was being actively being reviewed to ensure there was appropriate staffing.
- The new foundation doctors would be starting with the Trust imminently.

- A Job Planning update was included within the report and a final update would be provided at the September Board of Directors meeting.

Michael Wright referred to the Leng Review, an independent review focussed on the Physician Associate (PA) and Anaesthesia Associate (AA) professions in England. The review assessed safety, training, support and responsibilities conducted. A meeting would be held with staff to discuss the implications, however the report provided an opportunity for the Trust to look more broadly regarding workforce in the future to deliver the best quality of care.

Paul Ennals noted that PAs and AAs were significant contributors to the Trust's work and were valued staff members.

In relation to industrial action, Lucia Pareja-Cebrian advised that a great deal of effort had taken place to ensure all patients were receiving safe care. Senior clinicians had volunteered to conduct overnight shifts in areas where there were gaps. Paul Ennals asked for the gratitude of the Board of Directors to be fed back to those clinicians covering the shifts.

Phil Kane referred to the four foundation doctors who failed to progress in training and queried if this was an isolated event or a recurrent event. Michael Wright explained that it is not a recurrent event and was unusual, with no specific themes identified.

Annie Laverty said that in terms of Martha's rule/cause for concern, there was a commitment to follow up with all patients who used the phone number regarding the quality of care overall and obtaining learning.

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

**i) <u>Guardian of Safe Working (GoSW) Annual Report 2024/25 and Quarter 1 2025/26 Report</u>**

Paul Ennals referred to actions 147 and 148 on the action log which related to the GoSW report and advised that the required information would be included in the next report.

Michael Wright explained that changes were being made to the report which would help to provide further assurance on safety, staffing levels and exception reporting. The predicted changes to the contract were likely to increase exception reporting however further information was awaited.

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

**b. <u>Executive Director of Nursing Report</u>**

Ian Joy highlighted the following points:

- Incident reporting had increased on InPhase, with staff encouraged to report. Incidents were reviewed and learning takes place to provide tangible change.

- From a registered nurse staffing perspective, the position was strong and the teams were accommodating students who were due to complete their studies in September 2025.
- The Safeguarding and Mental Capacity Act Quarter 4 report had been discussed in detail at the Safeguarding and Quality Committees. The complexity within adult safeguarding remained, along with the challenge presented by increased activity however assurance was provided in relation to case work and clinical activity outcomes.
- The Learning Disability Quarter 4 report had also been discussed in detail at the Safeguarding and Quality Committees. Ongoing work was taking place by the multidisciplinary team in terms of planning.

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

**c. Maternity**

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

Jenna Wall noted the following points:

- The maternity workforce position was positive and the service maintained Operational Pressures Escalation Level (OPEL) 1 for 30 days in May and OPEL 2 for 1 day.
- There was concern that the current Peri-Operative model was impacting on the midwifery staffing meeting acuity. An Equality Impact Assessment (EQIA) was being progressed, and work was ongoing with the Peri-Operative leadership team regarding the future staffing model. Mitigations had been agreed in the short term.
- The required standard for Safety Action 5 was that a systematic and evidence based approach to calculating the midwifery staffing establishment had been completed and the Trust Board have evidenced that the midwifery staffing budget reflects the establishment. Three recommendations had been made to the ICB with two being agreed.
- The Trust had embedded the six requirements to strengthen and optimise board oversight of perinatal safety, this had been supported by the further development of the IBR metrics and the visibility of the performance metrics included in this report.

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

**ii) Maternity Safety Champion Report**

Liz Bromley explained that oversight of data included in the Perinatal Quality Surveillance Report was triangulated with the Maternity Safety Champion visits and talking to staff. She felt assured in relation to management and the quality of data provided.

Anna Stabler highlighted that a discussion took place at the most recent Quality Committee meeting with regards to data submitted within the report.

Ian Joy advised that maternity information was included in the IBR and historically the previous numerous separate reports had been amalgamated to ensure all required

information was captured in one report. Positive challenge took place at the Quality Committee to ensure mechanisms were in place and data was robust to provide appropriate assurance.

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

**ii) Committee Chair Meeting Logs**

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

In relation to the Finance and Performance Committee, Bill MacLeod highlighted that in depth discussions were taking place with regards to the financial challenges and this would continue in the Private Board of Directors' meeting later today.

With regards to the recent Quality Committee meeting, Anna Stabler advised that a robust discussion took place in relation to Infection Prevention Control (IPC). Lucia Pareja-Cebrian explained that an improvement group had been established in line with the improvement framework for IPC and the teams were aware that changes needed to be made to improve IPC performance.

Anna Stabler highlighted that the Quality Committee had asked for a further update with regards to care optimisation and patient correspondence as further assurance was needed in this area.

In relation to the Audit, Risk and Assurance Committee, David Weatherburn explained that positive work is taking place at the other tier one Committee meetings with a review of the tier two groups to improve the information flow.

With regards to the Digital and Data Committee, Liz Bromley advised that there had been a smooth transition to the new Chair, Hassan Kajee, and at the latest Committee meeting a comprehensive discussion took place with regards to the Digital Strategy.

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

**25/19 ITEMS TO APPROVE:**

**i) Interim Strategy**

The Interim Strategy had been discussed at length in previous Board meetings and Development Sessions. Patrick Garner explained that the Interim Strategy was available to the public on the Trust website.

It was **resolved**: to **receive** the report and **endorse** the Interim Strategy.

**ii) Trade Union Report**

The Trade Union Report had been approved by the People Committee, which included agreeing 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.

It was **resolved**: to **receive** the report and **approve** the Trade Union Report.

**iii) Modern Slavery Declaration**

Changes to the Modern Slavery Declaration had been considered and supported by the Audit, Risk and Assurance Committee.

It was **resolved**: to **receive** the report and **approve** the updated Modern Slavery Declaration.

**iv) Board Assurance Framework (BAF)**

Patrick Garner advised that the BAF had been discussed at each Board Committee meeting. Further work would be taking place with Dave Elliott, Chief Digital Officer, in relation to the Digital and Data Committee risks.

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

**v) Risk Appetite Statement**

Paul Ennals highlighted that a full discussion had taken place at a previous Board Development Session with feedback incorporated into the updated Statement presented for approval today.

It was **resolved**: to **receive** the report and **approve** the Risk Appetite Statement.

**25/20 ANY OTHER BUSINESS:**

**i) Meeting Action Log**

The action log was received and the content noted.

Paul Ennals advised that actions 147 and 148 in relation to the GoSW report would be actioned for the next report.

**ii) Any other business**

There was no any other business discussed and the meeting closed at 11.49am.

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

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Agenda Item A3

The Newcastle upon Tyne Hospitals NHS Foundation Trust

# TRUST BOARD

| | | | | | | |
|---|---|---|---|---|---|---|
| Date of meeting | 26 September 2025 | | | | | |
| Title | Chair's Report | | | | | |
| Report of | Sir Paul Ennals, Chair | | | | | |
| Prepared by | Sir Paul Ennals, Chair<br>Gillian Elsender PA and Corporate Governance Officer | | | | | |
| 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 July 2025:<br>• Board Activity<br>• Governor Activity<br>• Informal Visits<br>• Alliance<br>• 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.<br>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

I hope that everyone has had an enjoyable summer and had the opportunity to take advantage of some of the glorious weather we have experienced.

We recently concluded a Governor-led process to appoint a permanent Vice Chair. Following a robust interview process with some healthy competition I am delighted to welcome Bill MacLeod to the role.

Over the last few weeks, I have continued my period of induction at Gateshead Health NHS Foundation Trust - meeting with Executive and Non-Executive colleagues and the Lead and Deputy Lead Governors, visiting services, observing some Committee meetings, and meeting key local partners - ahead of commencing substantively in the role from 1 October 2025.

## BOARD ACTIVITY

Our Board Development session in August focussed on:

- Freedom to Speak Up (FTSU), where we had a detailed discussion to agree the top 3 FTSU priorities and associated key actions for 2025/26.
- The NHS 10-year Health Plan and how this linked to the development of the Trust Strategy. In groups we explored the 5/6 priority areas for the Trust and what actions will be taken in the short, medium and long term to ensure the priorities are progressed.
- Our Board Development Programme, which continues to support our preparation for Care Quality Commission (CQC) re-inspection, and particularly the well-led domain, through the agreement of a robust Board Development Programme for the 12 months from September 2025. A framework was agreed being mindful of how the plan is communicated to provide added assurance to staff and colleagues about the openness of the process. For transparency, the Framework has been appended to this report (Appendix A).

## ACTIVITY WITH GOVERNORS AND MEMBERS

At our Governor Workshop in July, in addition to our standard reports, we had a focussed session on Equality, Diversity and Inclusion (EDI) facilitated by our Executive Leads Caroline Docking and Annie Laverty who provided an update on this area of work noting that:

- Each Board member has a clear EDI objective.
- Priority has been to engage, and importantly to build trust, with our staff network leads and members.
- A deep dive had taken place into Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data alongside the staff survey results.
- Discussions have taken place at the People Committee, Governor People, Engagement and Membership (PEM) Working Group, Trust Management Group and the Trust Board to ensure that there is appropriate focus on EDI improvements.

- The EDI focussed actions are aligned to the People Plan Year 2.
- An action plan for EDI has been co-created for 2025/26 which is framed around the six national high impact actions and extensive feedback.

We also held our Annual Members Meeting in July. Whilst this meeting is held to fulfil the statutory requirement to approve our Annual Report and Accounts for 2024/25, it also allows an opportunity for staff to come together and showcase the pioneering and innovative work being undertaken across the organisation.

Our members' event in August focussed on Sustainable Healthcare in Newcastle (Shine) where we heard about the programme of work our Eco Influencers have been involved in on ward 2B of the Great North Children Hospital as well as the plans in place for resource management and to reduce waste within Newcastle Hospitals.

**INFORMAL VISITS**

I have continued with my informal visits across all parts of the organisation to meet with staff. To pick out some examples –

- I visited the Ophthalmology Department at the RVI, where I met with Wasique Chaudhry, Director of Operations and colleagues from the department, to discuss current challenges and achievements.
- I met with Amanda Kilsby, Consultant Physician and other members of the Frailty Team, to understand more fully the opportunities for significant expansion of this work, and to see how it contributes to the wider Urgent and Emergency Care work.
- I visited the Centre for Life where Dr Michael Wright, Joint Medical Director introduced me to the speciality of Genomics. The Genomics Diagnostics Laboratory provides molecular diagnosis for people with inherited or heritable conditions and recently, and more commonly now, common diseases including cancer. The collaboration between the Genomics Diagnostic Laboratory and laboratories elsewhere in the country, has really helped improve quality of life and outcomes for patients. This work may well feature large in our future plans in response to the NHS 10 Year Plan, where the potential of genomics is emphasised.
- I visited the new facilities on our cardiology day case and long stay patients in Wards 25 and 27 at the Freeman Hospital.

**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. There continues to be good progress with Alliance developments, in terms of closer organisational working, particularly around clinical pathways, but also some of our corporate functions - for example IT, finance and research.

Monthly meetings of the Joint Committee (of the 3 East Coast trusts) and the Committee in Common (all 4 partners) continue, where we receive regular reports on progress in the three areas of delegated authority listed above, and consider progress on the range of bilateral

collaborations. We recently met also with the Chair and CEO of the Integrated Care Board (ICB), who are very encouraging of our progress.

The mutual trust between partners has made possible the various secondments of recent months – Gateshead's CEO is currently seconded to fill a gap at North Cumbria Integrated Care, and her role has been filled in turn by the secondment of the Chief Operating Officer from South Tyneside & Sunderland NHS Foundation Trust. It is noticeable that three out of the four CEOs in the Alliance are interim.

I spoke at an Estates Alliance Event on 9 September where the senior leadership teams from the estates functions across the 4 Alliance partners considered ways in which the teams can work more effectively together.

## OTHER MEETINGS

Monthly I meet with the Chair, CEO and senior officers of the ICB, along with other Foundation Trust Chairs, to discuss issues of common interest.

Latterly, focus has been on the challenging financial position together with the medium-term plan for 2026/27 with specific reference to the ICB's clinical strategy to ensure it is up to date and aligned to the NHS 10 Year Plan. The future roles of the ICB and regional NHS England, the operating framework, the implementation for the NHS 10 Year plan – all have featured in our discussions, along with constructive information sharing on the issues confronting each trust.

I also attended a private dinner with NHS Providers Chief Executive, Daniel Elkeles and Chair of County Durham and Darlington NHS Foundation Trust, Professor Richard Scothon, along with colleagues and chairs from across the patch. This provided an opportunity to share insight and help shape the conversations that will guide us through the next period of change as we focus on the NHS 10 Year Plan next steps, financial and operational challenges.

I remain on the Board of Net Zero North East England, and the Board of the North East Child Poverty Commission.

One highlight of this last period was joining the runners at the end of the Great North Run. Nearly 500 people had run in aid of the Newcastle Hospitals Charity, including several staff. It was a privilege to meet many of them in our hospitality tent beyond the finishing line. The charity staff did a great job, and it was good to see governor attendance too, all in the presence of the race founder, Sir Brendan Foster CBE.

## RECOMMENDATION

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

**Report of Sir Paul Ennals**
**Chair**
**15 September 2025**

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Appendix A

*The draft Board Development programme was discussed at the 28 August 2025 Board Development session and agreed subject to the following amendments which have been incorporated into this final version:*

- *Linking to the NHS 10 Year Health Plan, and ensuring that across the 12-month period the six areas identified as Trust areas for opportunity from the NHS 10 Year Health Plan are incorporated into the Programme;*
- *Building in flexibility for additional topics and their order; and inviting other colleagues to attend where appropriate;*
- *Referencing the month in which session topics plan to be covered; and*
- *Additional narrative for session 1 to incorporate the requirements of the Provider Capability Assessment and include feedback from the external well-led review.*

# Board Development 2025-2026

## The Newcastle upon Tyne Hospitals NHS Foundation Trust

Will.Crookes@thevaluecircle.co.uk September, 2025



thevaluecircle
Change makers
Value creators
Code breakers

# Contents

# Introduction

This document sets out a 12-month Board Development Programme for the Trust from September 2025. The programme sets out clear areas of development to strengthen Board effectiveness, improve governance maturity, and support collective leadership.

The programme has been developed in collaboration with the Chair and Chief Executive. It directly supports the Board's role in delivering is statutory duties, strategic objectives, and high-quality, safe, and equitable care.

It is built on NHS England's The Insightful Provider Board (2024) guidance. It also aligns with the Trust's People Plan, its associated leadership and organisational development (OD) frameworks, and the Trust's values.

Appendix A sets out the previous development work undertaken by the Board, which informed and shaped the forward plan for Board development.

## Integration with Trust Frameworks and Values

The programme is designed to work within existing Trust frameworks. The Board will ensure it explicitly connects to:

- The People Plan and its leadership development frameworks.
- The Trust's behavioural frameworks which guide expectations for all leaders.
- The Trust's values, which will underpin all development activities:
    - **We care and are kind** – fostering respectful, compassionate leadership within the Board.
    - **We have high standards** – committing to robust governance and high-quality oversight.
    - **We are inclusive** – ensuring all voices are heard, challenging bias, and valuing diversity in Board debate.
    - **We are innovative** – encouraging curiosity, learning, and improvement in how the Board works.
    - **We are proud** – reinforcing commitment to the Trust's purpose and service to patients and staff.
- The 10-year Health Plan for the NHS.

## Alignment with Strategy and External Requirements

This programme will strengthen the Board's ability to deliver the Trust's strategy, ensuring collective clarity on priorities and effective oversight. It aligns with:

- The Trust's strategic objectives and operational delivery.

- The new oversight framework and 10 Year Health Plan for England, supporting assurance, accountability, and delivery of national priorities.
- The Well-Led Framework, promoting clear roles, strong leadership, and continuous improvement.

The blended programme builds on the work undertaken on the Board's structures and culture together to ensure that the Board is:

- Confident in its governance mechanics.
- Skilled at using meaningful information for assurance.
- Open, curious, and problem-sensing.
- Cohesive, trusting, and effective as a unitary team.
- Committed to delivering high-quality, safe, sustainable care.

# Board Development Overview

## Development Objectives

- Enhance the Board's capability to govern as a unitary body.
- Support reflection on governance structures and processes put in place in 2024, identifying refinements based on experience to date.
- Use continuous improvement to refine systems and reporting processes (Mechanics).
- Build trust, psychological safety, and open, constructive, and curious challenge (Dynamics).
- Reflect upon and develop our existing data in line with our strategy and performance objectives to ensure the use of meaningful information for assurance.
- Continuously develop the behaviours and style needed for effective Board conversations.
- Support strategy oversight and the Board's role as a partner in the wider system, including addressing how to approach difficult trade-offs for the collective good.

## Development Outcomes

Through undertaking time out as a Board to focus on development as a team, the Board will seek to:

- Have reflected on and refined governance structures and processes to support effective decision-making.
- Be confident in triangulating data and using meaningful assurance.
- Role-model transparent, problem-sensing, learning-focused culture.
- Test and improve the effectiveness of the governance framework on Board oversight of strategy, quality, people, finance and risk.
- Strengthen its approach to system partnership, including handling collective trade-offs.
- Operate as a high-performing, cohesive, unitary Board.

## Programme Structure

The Trust Secretary and Chair will agree the development structure with the Board. The programme will have built in flexibility regarding the order of the sessions and topics covered; in addition other colleagues may be invited to attend where appropriate. This will be set outside of formal Board business to protect dedicated development time. It typically includes:

- 6 development workshops over 12 months (one every two months).
- Participation from the full unitary Board (Executive and Non-Executive Directors).
- External insights and facilitation as required.
- Scenario-based discussion, including use of real Board examples and case studies.
- Structured review of good and poor practice.
- Action planning and review.

# Development areas of focus for 2025-2026

The following outline sets out the focus for each Board development session over the 12-month cycle. This structure provides a clear framework while remaining adaptable to the Board's evolving needs and priorities. Each session will be tailored by the Trust to ensure relevance and impact.

---

## Session 1: Governance Foundations and Board Culture [October 2025]

**Theme:** Setting expectations for effective Board working.

**Mechanics:**

- Review statutory roles, unitary Board responsibilities, committee structures, escalation processes.
- Reflect on structures established in 2024 and identify refinements.
- External well-led review findings shared by Grant-Thornton.
- Review and discuss draft Provider Capability Self-Assessment.

**Dynamics:**

- Explore Board culture, psychological safety, leadership behaviours.
- Commit to open, problem-sensing, learning-focused approaches.

**Outputs:**

- Action plan for well-led, to include strengthening structures and culture.
- Agree/finalise Provider Capability Self-Assessment
- Board behavioural commitments.

---

## Session 2: Finance, Productivity and Risk [December 2025]

**Theme:** Integrating finance, quality, and strategic risk.

**Mechanics:**

- Explore innovation and commercialisation as a Board.
- Review financial governance and committee integration.
- Link finance to quality, workforce, strategy.

**Dynamics:**

- Build collective accountability.
- Trust in financial and commercial discussions.
- Encourage open debate on prioritisation and trade-offs.
- Develop our approach to innovation.

**Outputs:**

- Improved finance reporting and oversight.
- agreed approach to balancing resources and quality.

---

## Session 3: Strategy and System Leadership [February 2026]

**Theme:** Developing and delivering strategy in a system context.

**Mechanics:**

- Review strategic objectives, ICS alignment, Board cycle priorities.
- Consider the opportunities and ambitions regarding neighbourhood services and integrated health models.
- Understand Capital Development, the digital strategy, and wider estates strategy for Newcastle Hospitals.
- Explore how the Board utilises and addresses health inequalities.

**Dynamics:**

- Strengthen understanding of the Board's role as a system partner, including how to handle trade-offs for collective benefit.
- Build collaborative behaviours and partnership mindset.
- Understanding the Great North Healthcare Alliance and the role of the Board within system leadership.

**Outputs:**

- Clarity over the long-term future for Newcastle upon Tyne Hospitals NHS Foundation Trust and who we are as an organisation.
- Agree next steps for two key areas from the 10-year Health Plan: Neighbourhood services and the Integrated Healthcare Organisation models.
- Strategic oversight plan.
- Understand what the Great North Healthcare Alliance means for Newcastle Hospitals.

---

## Session 4: Information, Assurance and Effective Challenge [April 2026]

**Theme:** Moving from reassurance to true assurance while improving Board conversation.

**Mechanics:**

- Review reporting quality and escalation, linking to the asks in the 10-year Health Plan.
- Analyse real examples (case study approach) of weak and strong assurance.

**Dynamics:**

- Build skills in constructive and curious challenge as a dedicated focus.
- Strengthen trust and collective responsibility.

**Outputs:**

- Agreed improvements to reporting.
- Commitments to support open, challenging discussion.

## Session 5: Quality, Safety and Patient Voice [June 2026]

**Theme:** Strengthening quality oversight and patient-centred care.

**Mechanics:**

- Review quality metrics, reporting, escalation, data triangulation.
- Analyse work undertaken to date on outpatient transformation.

**Dynamics:**

- Build empathy for patient and staff voice.
- Promote learning from incidents and complaints.

**Outputs:**

- Improved quality assurance approach
- Board commitments to hearing patient and staff voices.

## Session 6: Innovation, People, Workforce and Culture [October 2026]

**Theme:** Transforming through innovation and leading and supporting the workforce.

**Mechanics:**

- Review workforce reporting, escalation, Board role in people governance.
- Strengthen FTSU processes.
- Discuss work progressed in line with the 10-year Health Plan on transforming through innovation and workforce modernisation.

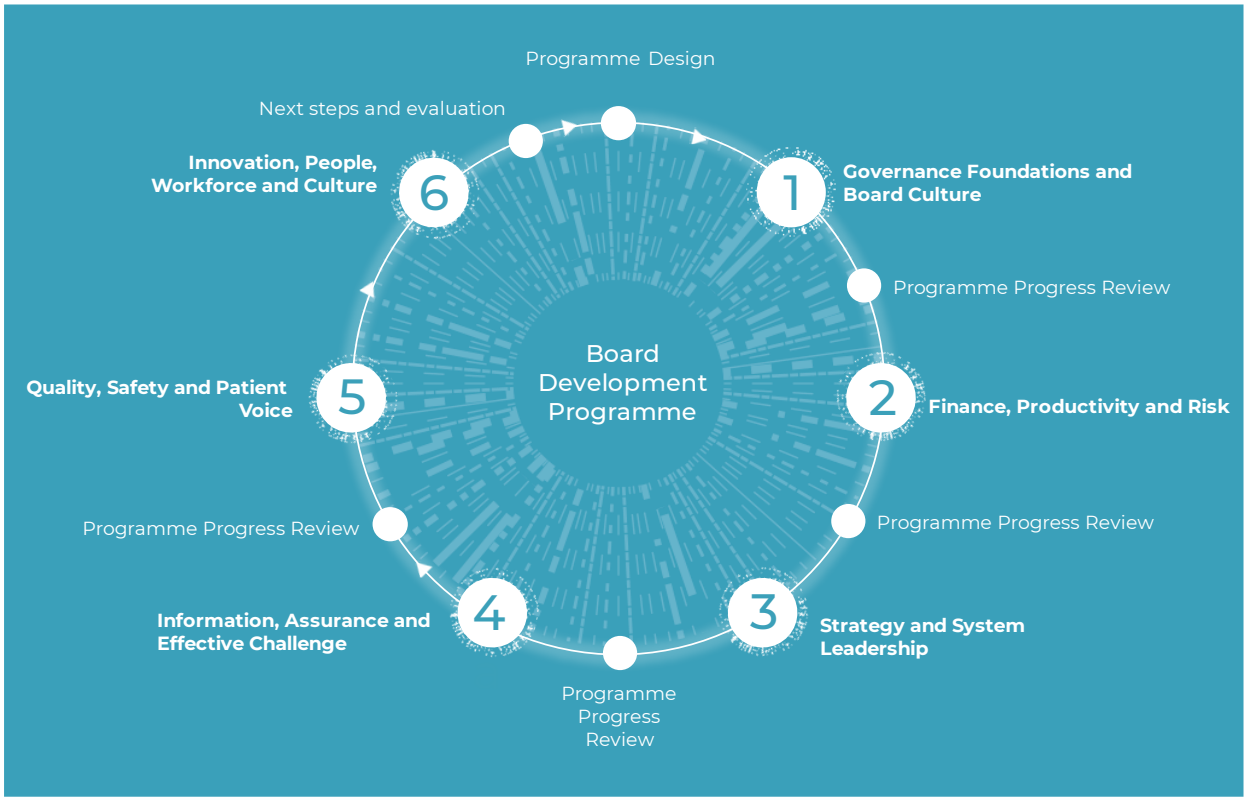
**Dynamics:**

- Build trust and psychological safety.
- Address inequalities and diversity.
- Improve Board visibility and staff engagement.

**Outputs:**

- Workforce assurance improvements
- Staff engagement commitments.

# 2025-2026 Overview



# Appendix A: Previous Board Development 2024-2025

The following table sets out key Board development activities undertaken previously. This work provides an important foundation and informs the design of the forward development plan.

| **Area of focus** | **Description** |
|---|---|
| Exploration of learning from previous CQC Inspection (February 2024) | Reflections on the Board's current context and identification of key actions, changes, and commitments to drive as a unitary board. |
| Skills Matrix Self-Assessment (Spring 2024) | Board members completed an individual skills matrix to identify strengths, gaps, and development needs in the Board's composition. |
| Risk management and Board Assurance Framework (March 2024) | Reviewing and updating the Board's approach to risk management and the Board Assurance Framework (BAF) to strengthen oversight and accountability. |
| Insightful Board Self-Assessment (December 2024) | Collective feedback on the board self-assessment undertaken with agreed areas of priority for development, |
| Developmental Well-Led Interviews (January 2025) | External review and facilitated sessions to reflect on Well-Led Framework domains and Board effectiveness. |
| Equality, Diversity, Inclusion (May 2025) | Dedicated time to establish what good looks like from a Board perspective in relation to EDI, with reflections on the Newcastle Hospitals current position. |
| Strategy (June 2025) | Board-level sessions to explore current strategies including presentation on the vision for the Great North Healthcare Alliance, update on the EDI plan, and update on strategy development. |
| Freedom to Speak up and 10-year Plan (August 2025) | A deep dive into freedom to speak up and development of a draft action plan.<br>Discussion and debate on the 10 year health plan and the impact and considerations for the Board at Newcastle Hospitals. |

Agenda item A5

The Newcastle upon Tyne Hospitals NHS Foundation Trust

# TRUST BOARD

| | | | | | | |
|---|---|---|---|---|---|---|
| Date of meeting | 26 September 2025 | | | | | |
| Title | Patient and Staff Stories | | | | | |
| Report of | Annie Laverty – Chief Experience Officer | | | | | |
| Prepared by | Alice Millican – Senior Communication Officer and Lee-Ann Naidoo – Improvement Manager | | | | | |
| Status of Report | Public | Private | Internal | | | |
| | ☒ | ☐ | ☐ | | | |
| Purpose of Report | For Decision | For Assurance | For Information | | | |
| | ☐ | ☐ | ☒ | | | |
| Summary | **Patient experience story:** Kelly has been receiving treatment for breast cancer at Newcastle Hospitals since 2019. In January 2023, her cancer metastasized to her liver, lungs, spine and brain. While undergoing treatment, Kelly initiated and launched a Christmas pyjama appeal. Together with Ward 35, she helped collect over 800 sets of pyjamas for adult inpatients, spreading festive joy throughout the hospital. In her story, Kelly highlights the importance of human connection when living with cancer.<br><br>**Staff Experience Story:** Rachael qualified as a midwife in 2013 and has worked across both inpatient and community settings. Her career has been shaped by diverse experiences, including meaningful work with the Jewish community. She reflects on the value of cultural exploration and the importance of truly listening to women about what it means to have choice and control. Now Deputy Matron at Newcastle Hospitals, Rachael champions staff wellbeing and morale, firmly believing that staff who feel valued and heard provide better care for women and families. She shares examples of how staff experience measures inform Perinatal Wellbeing Plans. | | | | | |
| Recommendation | The Board is asked to receive both stories 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. | | | | | |
| Impact (please mark as appropriate) | Quality | Legal | Finance | Human Resources | Equality & Diversity | Sustainability |
| | ☒ | ☐ | ☐ | ☒ | ☒ | ☐ |
| Link to Board Assurance Framework [BAF] | Linked to key areas in the BAF relating to 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:

It all began in 2019; I found a large lump in my breast. When they confirmed I had breast cancer, it felt like the rug had been pulled from under me. Surgery, chemotherapy, radiotherapy, and 14 cycles of immunotherapy later, I was eventually deemed to be in remission.

But in January 2023, just seven months after finishing treatment, the cancer came back. And this time, it had spread — to my liver, lungs, spine and eventually my brain. In June 2025, I had brain radiation and lost my hair again. I'm still recovering from the treatment. The cognitive effects — confusion, fatigue — those are hard.

Most of my treatment is on Ward 35 — where I feel safe. The staff know you — not just as a patient, but as a person. It's different here — they ask questions, they listen, and they make you feel welcome. Staff like Nicki, Carmel, Cerys, Sophie, Henry, and Wayne. Gail, the housekeeper, is one of the happiest people I have ever met. And Stella, who sat with me during one of my treatment sessions, asking about my children — that meant everything when I felt alone. My children — they are 16 and 10 now. All I want is to see them happy, playing, just being children...

This brings me to the Christmas Pyjama Appeal. Christmas is a really important time for my family — especially the 1st of December. We each get a Christmas box, including pyjamas to wear all month. Last October, I was in hospital for a week and got talking to a fellow patient who was wearing hospital-issued pyjamas. All I could think was that I wanted to buy him some nice pyjamas — and that sparked an idea. Kids have Santa and footballers visiting their ward, but I wanted to do something nice for adults.

I started an appeal to collect pyjamas, and Ward 35 helped spread the word. We received over 800 pairs of pyjamas last year, shared with patients across the Freeman and RVI. The number of people who got involved was amazing — and we've already started preparing for this year! Through the appeal, we've even been able to fund a coffee machine for the ward to help patients and staff save money. It's really the little things that make a big difference.

Looking back on my whole experience, I feel incredibly lucky to have received the care I have. Ward 35 is amazing. I'm now speaking to other women going through similar experiences. I tell them: when it feels like the rug's been pulled from under you, take time to process. Once you've done that, you realise that family is everything.


**Picture 1**: Kelly pictured with her family on Christmas Day in 2024.


**Picture 2:** Kelly and her children promoting the 2024 Christmas pyjama appeal.

## STAFF STORY:

When I joined midwifery, it wasn't the path I originally imagined. I'd planned to study law or accountancy until my aunt, a midwife herself, inspired me to follow her.

One of the most meaningful chapters of my career was caring for women in the Jewish community. Growing up in a small village, I never experienced much diversity.

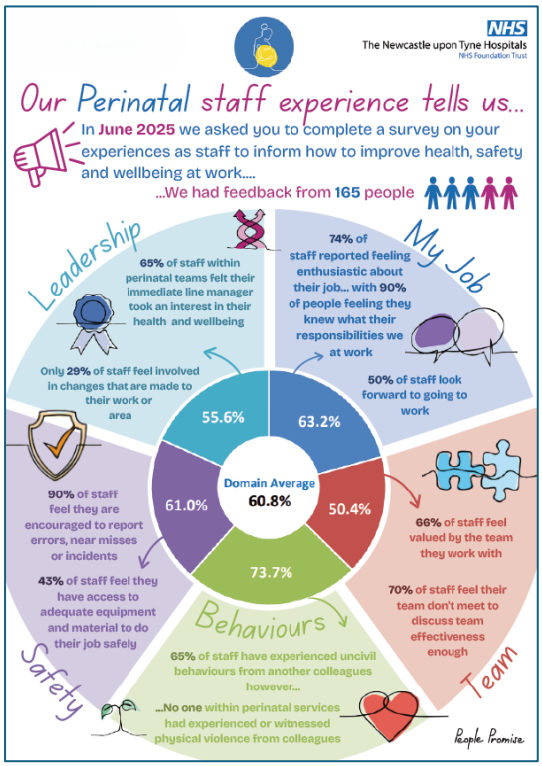
I am so grateful for the time working as a midwife in this community — it opened my eyes and changed the way I care for women to this day. It wasn't just about care; it was about cultural connection. I was welcomed with warmth and curiosity. For the first time, I was truly immersed in diversity. The women I supported were thoughtfully involved in their care, led conversations on breastfeeding, contraception, and family traditions. That openness shaped my approach: midwifery isn't just about procedures; it's about empowering women with information so they can make choices that feel right for them.

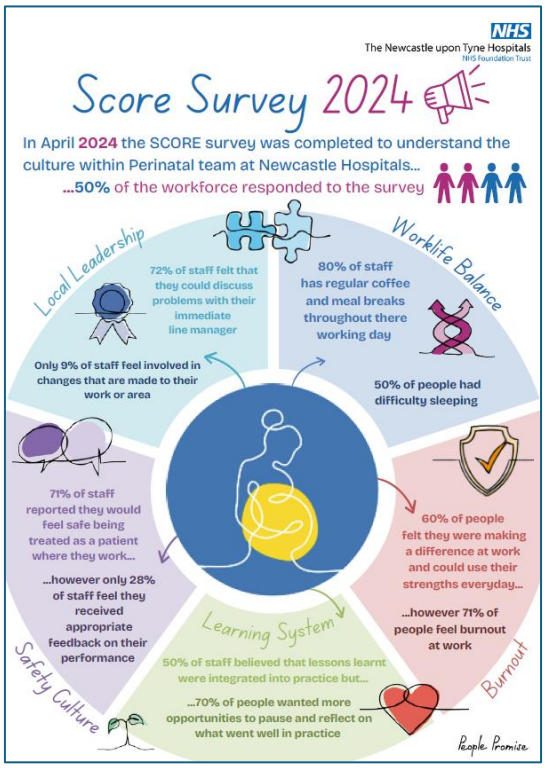
My most vivid memory is of a home birth I supported in a birth pool. It was quick, natural, and deeply moving. Helping bring a small baby into the family was a privilege — I'll never forget it. On the flip side, I also recall supporting a deeply religious couple through a stillbirth. The mother showed no emotion — her faith said this was part of God's plan — while the father grieved openly. I found myself asking: could I hold that space again? It challenged me to acknowledge the emotional toll of our work and reaffirmed why compassionate care matters.

As I moved into a leadership role, and especially during COVID-19, that question carried even more weight. Leading isn't just about managing processes — it's about ensuring staff feel informed, supported, and understood to deliver compassionate care, particularly when feeling anxious and vulnerable themselves.

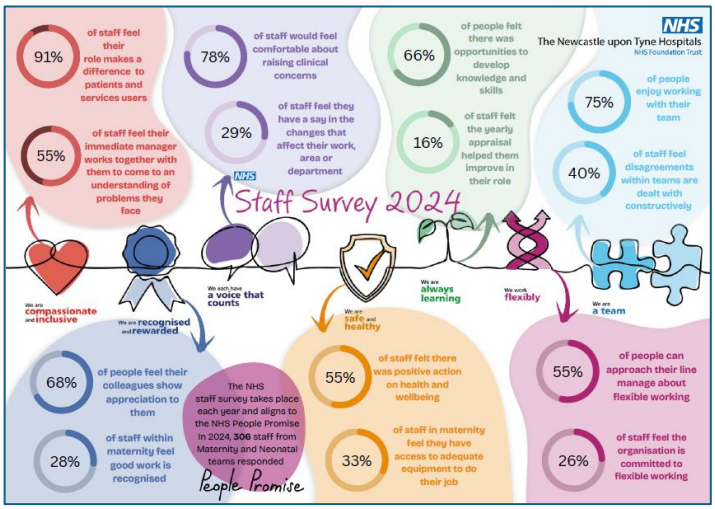
In my current role, I champion staff wellbeing and morale because if staff feel valued, they care better for women and families. I advocate for the right tools, clear communication, and a culture where feedback flows in both directions. It's about listening, responding, and making sure staff feel heard. Staff surveys are one of the tools for this.

At its heart, my midwifery philosophy remains simple: every woman deserves choice and control. My job is to give them the information, time, and respect to make that happen — helping them feel empowered so they can make choices that feel right for them. And as a leader, my duty is similar: to make sure midwives and staff are treated and supported in a way that makes them feel listened to and equipped with the knowledge, skills, and belief in choice and control. Paying attention to staff is key to delivering personalised care.








**Pictures 4-7:** Examples of staff engagement communication by Rachael within Maternity Services.

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Agenda item A6(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

# TRUST BOARD

| | | | | | | |
|---|---|---|---|---|---|---|
| Date of meeting | 26 September 2025 | | | | | |
| Title | Staff Survey update | | | | | |
| Report of | Vicky McFarlane-Reid, Director of Commercial Development and Innovation/Interim Executive Director for People and Organisational Development and Annie Laverty, Chief Experience Officer | | | | | |
| Prepared by | Alice Millican, Senior Communications Officer, Patient and Staff Experience. | | | | | |
| Status of Report | Public | Private | Internal | | | |
| | ☒ | ☐ | ☐ | | | |
| Purpose of Report | For Decision | For Assurance | For Information | | | |
| | ☐ | ☐ | ☒ | | | |
| Summary | We are in the final stages of planning and preparation for launching the annual staff survey.<br><br>As with last year's survey, there is an opportunity to include some of our own local questions – we have opted to use the same as were included last year so that we can see any progress that has been achieved.<br><br>We continue to explore innovative and inclusive approaches to maximising completion.<br><br>The target this year is for 75% completion which would be ~12,000 staff.<br><br>The slides attached share further information on key messaging, survey delivery and communications/engagement. | | | | | |
| Recommendation | The Board of Directors is asked to receive the update. | | | | | |
| Links to Strategic Objectives | People – We will be a great place to work where everyone feels supported.<br><br>Support colleagues through our People Plan with better psychology support and greater equality, diversity and inclusion. | | | | | |
| Impact (please mark as appropriate) | Quality | Legal | Finance | Human Resources | Equality & Diversity | Sustainability |
| | ☒ | ☐ | ☒ | ☒ | ☒ | ☒ |
| Link to Board Assurance Framework [BAF] | Risk 2.1 - Failure to improve and maintain an organisational culture, in line with our Trust values and our People Plan. | | | | | |
| Reports previously considered by | New report. | | | | | |

# 2025 NHS Staff Survey

The Newcastle upon Tyne Hospitals NHS Foundation Trust


**PROJECT AIM:** To achieve a 75% response rate

## SURVEY LIVE DATES

- **TBC Launch Date: Monday 22nd September**
- **Closes: Friday 28th November**

## HOW STAFF CAN TAKE PART

- **Most staff will receive their survey via email**
- **Staff who have more limited access to digital resources will receive a paper copy**

## KEY MESSAGES

| | |
|---|---|
| | **We each have a voice which matters -** everyone can fill in the survey and each voice is important. |
| | **It's confidential for a reason** – we want you to be open and honest in your responses. No-one in the trust can identify individual responses. |
| | **We are listening and we will act – you said, we did** Staff survey is the key barometer for improvement across the trust and informs key areas of further development |
| | **Quick to complete** - it takes just 15 minutes of your working day |
| | **We know your time is precious, so we've added a few thank yous for responding** – your views really make a difference |
| | **We'll tell you about results clearly and simply** We don't just drop data, we'll tell stories and help you understand |

# 2025 NHS Staff Survey

The Newcastle upon Tyne Hospitals NHS Foundation Trust

## COMMUNICATIONS AND ENGAGEMENT

**Multi-channel communications and engagement approach to maximise awareness and power staff response rate.**

### MASS AWARENESS

- Dedicated Intranet hub, In Brief, Staff Facebook group, screen savers/desktop backgrounds, email signatures, Staff Network/Forums meeting presentations
- Downloadable Word/PDF toolkits for Teams to promote survey locally
- Physical Stalls across all Trust sites and CEO roadshows
- Printed assets including posters and leaflets – canteens, gyms, Hopper bus, central Staff areas
- Digital Response Rate trackers and leaderboards – cascaded to senior leaders and available for managers to see how their teams are responding

### LOCALISED ENGAGEMENT

- Smaller Staff forum communications (Residents Doctors groups etc)
- Physical visit to wards (Real Time Patient Experience programme participants and beyond)
- Personal phone calls/communications to low response rate groups (led by Patient and Staff Experience team)
- Empower teams to share what they've actioned (You Said, We Did) to encourage responses at a local level

## A THANK YOU TO ALL STAFF WHO RESPOND

- **Partnership with Greggs**
- **Every respondent will receive a thank you voucher for a Breakfast Roll deal, redeemable at any Greggs store.**
- **This will be issued digitally and physically**

GREGGS

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Agenda item A7

The Newcastle upon Tyne Hospitals NHS Foundation Trust

# TRUST BOARD

| | | | | | | |
|---|---|---|---|---|---|---|
| Date of meeting | 26 September 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 the more difficult issues that may be impacting on the 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.<br><br>This report provides an overview of the findings from the 19 walkabouts and visits undertaken during June, July and August 2025. | | | | | |
| Recommendation | The Trust Board is asked to note the contents of this report in relation to both positive feedback from Trust staff, and concerns/suggestions raised for improvements. | | | | | |
| Links to Strategic Objectives | Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality. | | | | | |
| Impact (please mark as appropriate) | Quality | Legal | Finance | Human Resources | Equality & Diversity | Sustainability |
| | ☒ | ☐ | ☐ | ☒ | ☐ | ☐ |
| Link to Board Assurance Framework [BAF] | Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients. | | | | | |
| Reports previously considered by | The previous Leadership Walkabouts and NED Informal Visits Report was presented to the Trust Board in July 2025. | | | | | |

# BOARD VISIBILITY PROGRAMME

## 1. INTRODUCTION

This report provides an overview of the findings from the 19 walkabouts and visits undertaken during June, July and August 2025.

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

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

Management of the Leadership Walkabout schedule is co-ordinated by the Quality and Safety Department (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 19 walkabouts undertaken at the Royal Victoria Infirmary (RVI), Freeman Hospital (FH), Regent Point (RP) and Community sites, eight within stream one and eleven by the NEDs as part of stream two. Further detail is provided in the Summary of Findings Report in the Board of Directors Reading Room.

| Stream | Area visited | Site | Membership of Walkabout Team | Staff who took part in the conversations |
|---|---|---|---|---|
| Stream One | Wards 25, 26, 29 and 30 | FH | Head of Nursing, Matron | Ward Sisters, Staff Nurses |
| | Ophthalmology Administration | RVI | Director of Operations, Operational Service Manager | Administration Team Lead, Clerical Officer |
| | Trauma and Orthopaedics Surgery | RVI | Associate Director of Operations, Matron | Sister, Ear, Nose and Throat (ENT) Lead |
| | Ward 19 | RVI | Director of Operations | Sister, Staff Nurses |
| | Wards 5, 6, 7 and 8 | FH | Clinical Board Chair, Associate Director of Operations, Head of Nursing, | Matron, Assistant Operational Service Manager |
| | Wards 5, 6, 7 and 8 | FH | Operational Service Manager, Matron | Senior Sister, Charge Nurse |
| | Ward 37 | RVI | Associate Director of Operations, Matron | Matron, Ward Manager, Staff Nurses |
| | Ward 47 | RVI | Associate Director of Operations, Matron | Ward Manager, Clinical Nurse Specialist |
| | Ward 30 | RVI | Non-Executive Director Trust Secretary | Operational Service Manager, Sister |
| | Emergency Department, Assessment Suite, Same Day Emergency Care | RVI | Non-Executive Director, General Manager | Consultant Psychiatric Liaison, Consultant, Sister, Ward Clerk |
| | aHUS – Atypical Haemolytic Uraemic Syndrome Research Unit | RVI | Non-Executive Director | Honorary Consultant Nephrologist, Nurse Consultant, Associate Director of Operations |

| Stream | Area visited | Site | Membership of Walkabout Team | Staff who took part in the conversations |
|---|---|---|---|---|
| **Stream Two** | Stent Laboratory | FH | Non-Executive Director | Staff Nurse, Healthcare Assistant |
| | Community Services | RP | Non-Executive Director General Manager | Not specified |
| | Ward 25, 25a | FH | Non-Executive Director | Band 5,6 and 7 nurses, Healthcare Assistant, Ward Clerk, Nurse Practitioners |
| | Radiology | FH | Non-Executive Director | Clinical Board Chair, Associate Director of Operations, Consultant Radiologist |
| | Dermatology | RVI | Non- Executive Director | Administration Manager, not specified |
| | Endocrinology | RVI | Non-Executive Director | Consultants, Operational Service Manager, Band 6 Sister, Administrator |
| | Community Cardio Team | Arthurs Hill Clinic | Non-Executive Director | Nurses, Administration team |
| | Cardiothoracic Theatres | FH | Non-Executive Director | Consultants, Nursing staff, Perfusionists, Transplant Coordinators |

**Key themes identified include:**

- Overall, there was a positive culture, staff feel supported and are comfortable raising concerns.
- Staff are enthusiastic about the ACE Accreditation process. It has had a positive impact on morale.
- Staff described the Trust as being a good place to work.
- Dealing with difficult patients and reports of incivility between staff in specific areas were identified.
- High temperatures on wards during summer months were a concern.
- Equipment shortages were a frustration in several areas.

**Issues for escalation include:**

- Estates issues; delays in removal of baths, high temperatures in wards, lock on sluice door, poor signage, soft door closures.
- Reports of incivility between staff in a specific area.
- Aggression towards staff from patients.
- Electronic porter booking system affecting the process of bringing patients for scans.

- Reported pause on nursing education opportunities, due to financial constraints.

## 4. NEXT STEPS

The Non-Executive Director informal visits (stream 2) continue to work well, with a number of visits taking place and rich feedback gathered from the areas visited. Where escalation is required, this is actioned.

As the Clinical Boards (CB) are now established throughout the organisation, it is evident that regular walkabouts and visits are undertaken by the CB leadership teams very regularly. In addition, the Trust has strengthened its process of escalation and risk management, meaning that when any areas of concern are raised on a walkabout/ visit, these are dealt with at the time or escalated appropriately by the CB Leaders. As the visits are informal and take place frequently, there is little feedback shared with the Quality and Effectiveness Team as part of a formal walkabout visit by this group of staff.

Moving forwards, it is recommended that stream one of the Board Visibility Programme focuses on the visibility of Directors and Executive Directors across all areas of the organisation (community sites, outpatient and inpatient areas) as the most senior leaders in the organisation. Whilst Clinical Board Leadership Teams continue to regularly visit their wards and departments on an informal/ ad-hoc basis, it is suggested that these visits are no longer recorded as part of the Leadership Walkabout programme (stream one).

As part of the programme refresh it is recommended that four leadership walkabouts are undertaken per month, co-ordinated by the Quality and Effectiveness Team. Each Director/ Executive Director will be accompanied by a member of the Quality and Safety Department who, as part of their role will take notes and transcribe these for inclusion in future reports.

## 5. RECOMMENDATION

The Trust Board is asked to note the contents of this report in relation to positive feedback from Trust staff, concerns/suggestions raised for improvements and the proposed changes to participation in the Leadership Walkabout Programme.

**Report of Rachel Carter, Director of Quality & Safety**
**Prepared by Fiona Gladstone, Clinical Effectiveness Advisor**
**15 September 2025**

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Agenda item A9

The Newcastle upon Tyne Hospitals NHS Foundation Trust

# TRUST BOARD

| | | | |
|---|---|---|---|
| Date of meeting | 26 September 2025 | | |
| Title | Integrated Board Report | | |
| Report of | Patrick Garner, Director of Performance & Governance<br>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 Trust Board on the Trust's performance against key indicators relating to Quality & Safety, Access, People, Finance and Health Inequalities.<br><br>**Quality**<br>• Clostridioides difficile Infection (CDI) cases for July decreased (12 v 20) compared to the previous month. This rate remains within the parameters of common cause variation.<br>• There were 2 stillbirths in July 2025. The Trust has triggered a safety alert for the number of stillbirths on the Clinical Indicators Dashboard. In accordance with the Local Maternity and Neonatal System (LMNS) safety signal process this instigated a review of the data - further analytics have been performed by the NHS England (NHSE) analytics team which indicate duplicate counting - when these cases were removed the Trust returned to within a 95% confidence limit.<br>• Never Events have moved from showing common cause variation to special cause variation of a concerning nature. We have noted a theme in a number of recent Never Events reported in the organisation, specifically surgical events including wrong site surgery and wrong implant. All teams are being urged to ensure that checklists are implemented in their areas, including a check of any implantable device and audit against these standards.<br><br>**Performance**<br>• Emergency Department Performance (All Types) in July was 79.3%, an improvement of 1.8% compared to June (77.5%), meaning this metric is now demonstrating improving variation.<br>• Cancer 31 Days (87.3%) has progressively recovered throughout 2025 and has now returned to within the previous limits of standard variation.<br>• Cancer 62 Day compliance for July was 71.2%, consistent with a continuation of improving special cause variation despite an overall consistent failure to hit the target. In February, the 77% 28 Day Faster Diagnosis Standard (FDS) was achieved for the first time in eight months (83.4%). This follows the deployment of additional resource into pathway tracking within Skin. | | |

<table>
<tr><td></td><td colspan="6">People<ul><li>The substantive workforce is 1,968 Full-Time Equivalent (FTE) (15%) above the January 2020 (pre-Covid) substantive position and 11 FTE (0.07%) above the 2025/26 workforce plan for substantive staff as-at July.</li><li>The 12-month rolling absence rate of 5.6% and the sick pay cost of £32.9m are significantly above the target of 5% and £25m respectively.</li><li>Appraisal compliance increased by 0.52% but rates are consistently failing the target.</li></ul>Finance<ul><li>At month 5 the Trust is reporting an £8.2m 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).</li><li>The CIP of £106 million is phased over the year with a plan of £33million to month 5. Year to date Clinical Boards and Corporate Services have delivered £11.6m (of which £5.7m is recurrent). To mitigate the CIP on Clinical Boards and Corporate Services delivery, £21.7m of non-recurrent technical measures have been actioned (£17.1m more technical adjustments than plan).</li></ul></td></tr>
<tr><td>Recommendation</td><td colspan="6">For assurance.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality.<br><br>Performance – Being outstanding now and in the future.</td></tr>
<tr><td rowspan="2">Impact<br>(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">Links to all strategic risks in the BAF.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">This is a regular paper provided to Trust Board.</td></tr>
</table>

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

# Integrated Board Report

## September 2025

Healthcare at its best
with people at our heart

# Contents

# NHS Oversight Framework (1/2)

## Concept and Implementation

- The new NHS Oversight Framework 2025/26 sets out how NHS England will assess providers and ICBs alongside a range of agreed metrics. These are presented alongside wider contextual metrics that reflect medium-term goals in areas such as inequalities and outcomes. The contextual metrics do not constitute part of the score but will inform how NHS England responds to segmentation.
- 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. Raw measures of performance, derived within set time-periods will then benchmarked against comparable Trusts, with scores issued based on our ranking against other applicable providers. Scores are consolidated to then issue an overall ranking, which will in turn 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).
- High performing providers can obtain increased freedoms, but poor performance can lead to intervention. Providers rated low for both performance and capability assessments will be considered for entry into the Provider Improvement Programme (PIP) and placed into a fifth segment.
- Crucially, there is an expectation that every Integrated Care Board (ICB) and provider must deliver a balanced net system financial position – and unless providers are delivering a surplus or breakeven position, their segmentation will be limited to no better than 3.

## Workings in Detail

- The detail behind segmentation is in places rather complex. Differing scoring systems are deployed, with metrics split to either provide a score:
    - based entirely on ranking compared to other organisations in terms of crude value (regardless of meeting/exceeding a standard) from 1.00 – 4.00
    - or in some cases where default scores of 1.00 or 4.00 are awarded if you are meeting/failing the requirement. Strong performance against these metrics has the potential to hold greater influence on an overall score and ranking.
- Time periods vary for different metrics but generally look at either the most recent in-month performance or rolling three- or twelve-month positions. The Trust will be compared against different organisations for different metrics (e.g. some are applicable only to acute, community or mental health Trusts).
- Segments 1-4 will typically contain 50 Trusts each, with the overall system set-up designed to encourage competition. This does mean that all organisations could be achieving a national target but some would still be ascribed segment 4 for that metric.

## First published rankings – September 2025 (referencing Quarter 1 2025/26 performance)

- The Trust quarter 1 position is included in detail on the next page, listing all comprising metrics, raw measures, competitive ranking, final derived scores and subsequent segmentation. The Newcastle upon Tyne NHS Foundation Trust has been places in **segment 2** for this quarter, indicating that the organisation has good performance across most domains but that specific issues exist. Our placement is in part assisted by recent positive performance against the 28 day cancer Faster Diagnosis Standard (FDS), as well as 18 weeks Referral To Treatment (RTT) performance and financial delivery versus plan.
- Newcastle Hospitals placed 26$^{th}$ overall in this set of rankings, but 34 other organisations have so far been downgraded to segment 3 based on a current financial deficit – many would have been ranked above the Trust based on scoring alone.
- Specific metrics displaying performance that individually rank within lower segments (3 or 4) are indicated in orange and red.
- The Trust is working to develop a forward-looking model that can predict future segmentation as best possible ahead of publication.

# NHS Oversight Framework (2/2)

| THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST (RTD) - Quarter 1 2025/26 | | | | | | |
|---|---|---|---|---|---|---|
| | | **Raw measure** | **Ranking** | **Raw score derived** | **Final Score** | **Group Score** |
| **DOMAIN SCORE - Access to Services** | | | | | | |
| Proportion of incomplete patient pathways waiting over 52 weeks | | 1.46% | 38/131 | 2.16 | 2.16 | |
| Proportion of incomplete patient pathways waiting less than 18 weeks (Gap to plan) | | 2.14% | Meet / exceed plan | 1.00 | 1.00 | |
| Proportion of incomplete patient pathways waiting less than 18 weeks (scored absolute performance) | | 73.53% | 6/131 | 1.12 | 1.12 | |
| Percentage of community services waiting list waiting over 52 weeks | | 6.12% | 90/121 | 3.23 | 3.23 | |
| Proportion of urgent referrals to receive a definitive diagnosis within 4 weeks | | 80.04% | Meet / exceed target | 1.00 | 1.00 | |
| Proportion of patients treated for cancer within 62 days of referral | | 68.48% | 76/118 | 3.01 | 3.01 | |
| % of patients managed in under 4 hours in ED | | 77.30% | 49/123 | 2.22 | 2.22 | |
| % of patients spending over 12 hours in ED | | 2.32% | 16/123 | 1.37 | 1.37 | |
| **DOMAIN SCORE - Access to Services** | | | | | | 1.89 |
| National CQC inpatient survey overall experience rating | | As expected | As expected | 2.00 | 2.00 | |
| Summary Hospital Mortality Indicator | | As expected | As expected | 2.00 | 2.00 | |
| Urgent Community Response % achieving 2hr standard | | 70.61% | 59/63 | 3.00 | 3.00 | |
| Average number of days between discharge ready date and actual date of discharge | | 0.60 | 39/126 | 1.91 | 1.91 | |
| **DOMAIN SCORE - Effectiveness and Experience** | | | | | | 2.23 |
| NHS Staff Survey raising concerns sub-score (PRV) | | 6.37 | 79/134 | 2.76 | 2.76 | |
| HCAI measure 1: 12 month rolling count of MRSA cases | | 8.00 | 118/134 | 3.72 | 1.23 | |
| HCAI measure 2: 12 month rolling count of C.Difficile cases as a proportion of trust threshold | | 154.41% | 116/134 | 3.71 | 1.22 | |
| HCAI measure 3: 12 month rolling count of e.coli cases as a proportion of trust threshold | | 117.33% | 76/134 | 2.97 | 0.98 | |
| CQC safe domain inspection rating | | Requires improvement | Requires improvement | 3.00 | 3.00 | |
| **DOMAIN SCORE - Patient Safety** | | | | | | 3.07 |
| Sickness absence rate | | 6.01% | 156/205 | 3.28 | 3.28 | |
| NHS Staff Survey engagement sub-score (PRV) | | 6.83 | 76/134 | 2.69 | 2.69 | |
| **DOMAIN SCORE - People and Workforce** | | | | | | 2.99 |
| Planned surplus / deficit as a proportion of turnover | | 0.0% | Planned surplus/deficit | 1.00 | | |
| YTD surplus / deficit | | 0.0% | Meet / exceed plan | 1.00 | | |
| Aggregated finance score | | | | | 1.00 | |
| Implied rate of productivity compared with baseline | | 0.26% | 102/134 | 3.28 | 3.28 | |
| **DOMAIN SCORE - Productivity & value for money** | | | | | | 2.14 |
| | | | | | | |
| **Finance Override** | | | | | | NO |
| | | | | | | |
| **OVERALL AVERAGE SCORE** | | | | 51.42 | 43.451 | 2.29 |
| | | | | | | |
| | | **FINAL SEGMENTATION** | | | | **2** |

# SPC Variation / Assurance – Changes from previous month

| | Jun-25 | Jul-25 |
|---|---|---|
| Never Events | | H |
| Proportion of Inpatient Admissions where death occurred | | L |
| BSOTS Initial Triage within 15 minutes | H | |
| A&E Arrival to Admission/Discharge (4 hours) | | H |
| Cancer 31 Day Standard | L | |


## SPC Variation

- Five high level metrics have displayed changes in special cause variation from June to July 2025.
- **Never Events** – has moved from showing common cause variation to special cause variation of a concerning nature. We have noted a theme in a number of recent Never Events reported in the organisation, specifically surgical events including wrong site surgery and wrong implant. All teams are being urged to ensure that checklists are implemented in their areas, including a check of any implantable device and audit against these standards.
- **Proportion of inpatient admissions where death occurred** – has moved from showing common cause variation to special cause improving variation, following a run of data below the long-term monthly average.
- **BSOTS initial triage within 15 minutes -** has changed from showing special cause variation of an improving nature to common cause variation.
- **Accident & Emergency (A&E) arrival to admission/discharge** – the 4-hour target has displayed special cause variation of an improving nature, with performance exceeding the standard levels of deviation recorded between April 2023 and the present day.
- **Cancer 31 day standard -** performance has positively shifted from showing special cause variation of a concerning nature to common cause variation, having recovered to normal levels of historical compliance after a period of deterioration.

## SPC Assurance

- No changes have been noted in SPC assurance levels this month.

# Quality

# Quality Overview

| Metric | Period | Actual | Target | Variation | Assurance |
|---|---|---|---|---|---|
| Health Care Associated Infection (HCAI) - MSSA | Jul-25 | 10 | 9 | H | ? |
| HCAI – C. Diff | Jul-25 | 12 | 11 | | ? |
| Harm Free Care – Inpatient (IP) Acquired Pressure Ulcers | Jul-25 | 57 | Sustained reduction | | ? |
| Harm Free Care – Adult Patient Falls | Jul-25 | 206 | | | ? |
| Stillbirths | Jul-25 | 2 | | | |
| Blood Loss >1500ml (per 1,000) | Jul-25 | 47 per 1000 | | | |
| ATAIN | Jul-25 | 9% | 5% | | ? |


## Health Care Acquired Infections

- Methicillin-susceptible staphylococcus aureus (MSSA) remained the same in July (10 v 10). This rate remains within the parameters of special cause concerning variation.
- *Clostridioides difficile* Infection (CDI) cases for July decreased (12 v 20) compared to the previous month. This rate remains within the parameters of common cause variation.

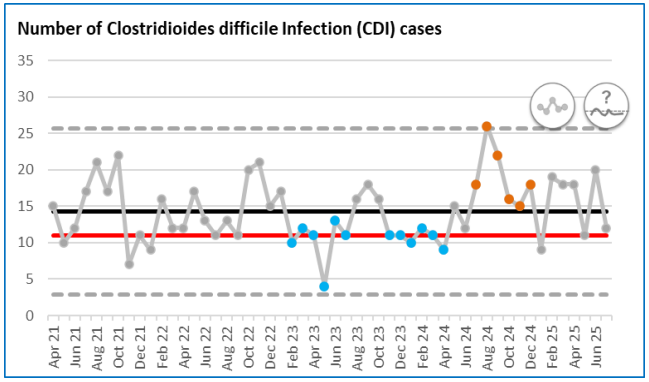
## Harm Free Care

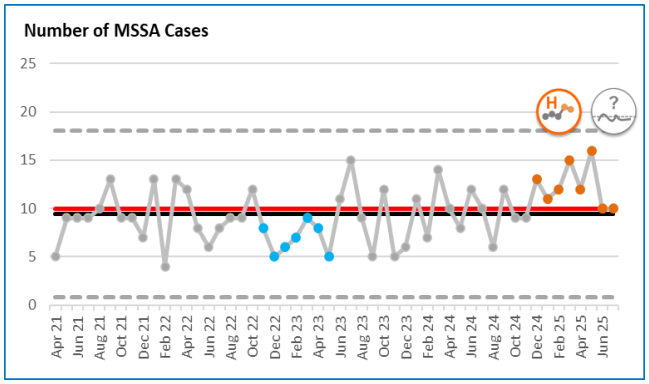
- There has been sustained reduction in falls and pressure ulcers over the last two years, therefore, targeted reductions have not been set. Rather, a reduction demonstrated through statistical process control is sought.
- Acute pressure ulcers (PU) reported in July increased (57 v 48), a seasonal increase is often noted in the summer months.
- In July there was a reduction in falls (206 v 215), but no special cause variation has been highlighted.

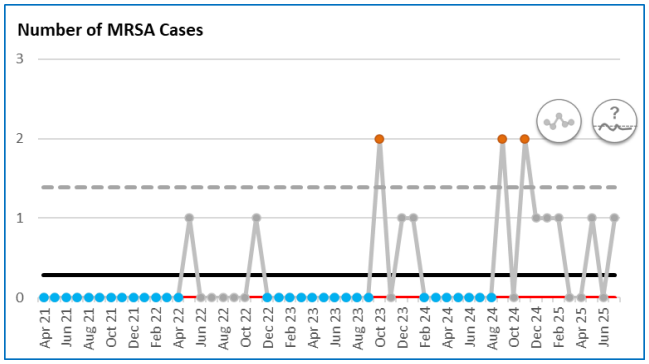
## Perinatal Quality Surveillance

- There were 2 stillbirths in July 2025. The Trust has triggered a safety alert for the number of stillbirths on the Clinical Indicators Dashboard. In accordance with the Local Maternity and Neonatal System (LMNS) safety signal process this instigated a review of the data - further analytics have been performed by the NHS England (NHSE) analytics team which indicate duplicate counting - when these cases were removed the Trust returned to within a 95% confidence limit.
- The National benchmark for term admissions is 5%. The Trust rate remains consistently above the national 5% target; in June and July this was 9%. Three quality improvement workstreams have been identified - 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.

# Healthcare Associated Infections (HCAIs) (1/2)



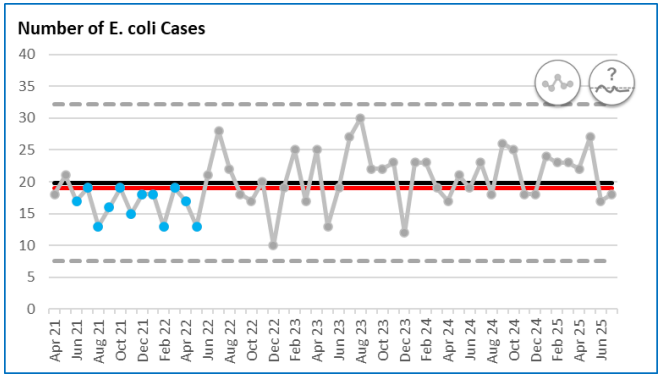

## Standards

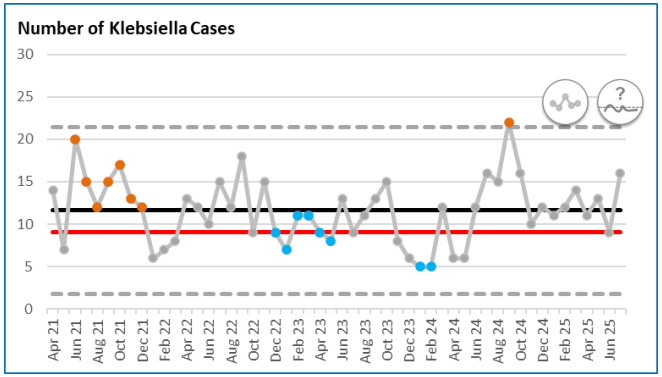
- **Zero MRSA** cases.
- **No more than 115 MSSA** cases across the financial year (local target - 10% reduction from 2024/25).
- **No more than 136 CDIs, 225 E. coli** cases, **108 Klebsiella** cases or **34 Pseudomonas aeruginosa** cases across the financial year.

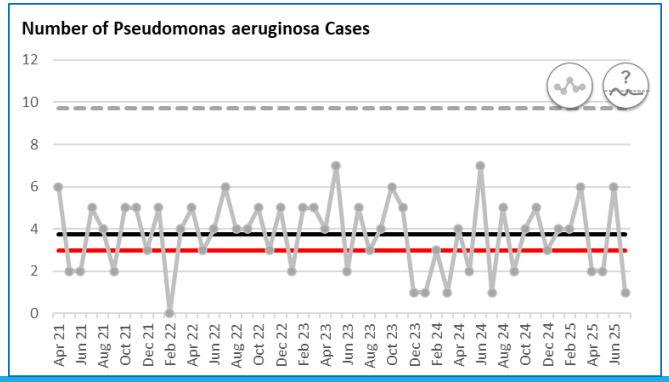
## Current Position

- There was a decrease seen in the number of CDI cases compared to the previous month (12 v 20) this remains within the parameters of common cause variation. There were 4 Community Onset Healthcare Associated (COHA) cases and 8 Hospital Onset Healthcare Associated (HOHA) cases, of which 1 was found to have identified contributory factors relating to the infection. Themes identified were poor compliance with medical management and stool documentation, in addition delays in sending a specimen, isolation and treatment administration were evident.
- The number of MSSA cases was static this month (10 v 10) but this remains within the parameters of special cause concerning variation.
- There was one Methicillin-Resistant Staphylococcus aureus (MRSA) case in July, taking the total for this financial year to 2 cases but this remains within the parameters of common cause variation. Themes identified were poor compliance with Intravenous (IV) device management and documentation, alert flag identification and administering of standard eradication therapy.
- There was a slight increase in the number of *Escherichia coli* (*E. coli*) bacteraemia cases compared to the previous month (18 v 17).
- The was a significant increase in Klebsiella bacteraemia cases this month compared to the previous month (16 v 9).
- There was a decrease seen in Pseudomonas aeruginosa cases compared to previous month (1 v 6) and remains in line with common cause variation.
- Themes identified from bloodstream infections include; suboptimal intravenous device documentation and management, and poor adherence to antiseptic skin washes.

# Healthcare Associated Infections (HCAIs) (2/2)



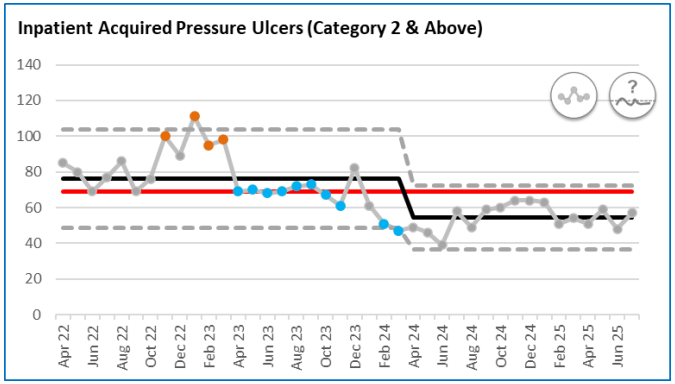



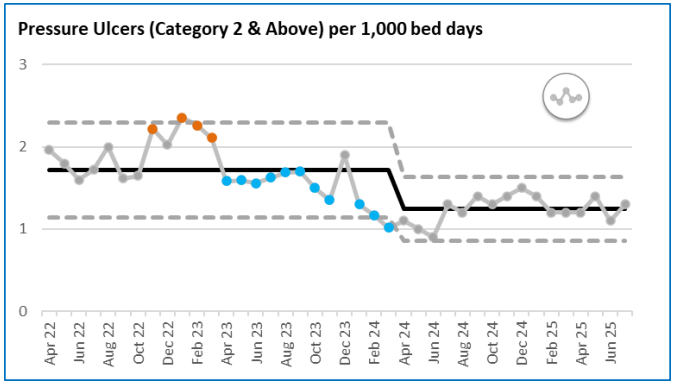




## Action taken

- The themes identified from investigations, indicate improvements required at ward and department level with hand hygiene compliance, decontamination of equipment, invasive device management, stool monitoring, antimicrobial washes, MRSA screening & eradication.
- A number of actions are in progress as follows:
    - Policies and guidelines have been updated.
    - The programme of work to increase compliance with hand hygiene and to reduce glove use within the Trust is ongoing. This will help support and strengthen the HCAI reduction strategies.
    - The IPC validation 'Take 5' (cannulation, urinary catheter) and toilet aid audits continue. These audits incorporate device management, decontamination and clinical staff knowledge for all inpatient areas. This will help support and provide education to clinical areas where additional assurance is required in respect of IPC processes.
    - Invasive device bundles are being revised and will be shared for implementation to all Clinical Boards.
    - Clinical Boards continue to receive patient level data on MRSA screening compliance, and inappropriate antibiotic prescriptions for MRSA from the Clinical Informatics Microbiology Lead.
- The IPC collaboration supporting the Accrediting Excellence Programme (ACE) at ward level continues. The support provided to ward staff will improve the fundamentals of IPC through a coaching approach. The visibility of the IPC nurses has improved with clear areas of responsibility/ward links.
- Work will commence in August 2025 with the InPhase team to build HCAI incident investigations (Post Infection Reviews) in the system; this will enable identification of themes, robust action planning and follow up owned by Clinical Boards wards and departments.

# 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.

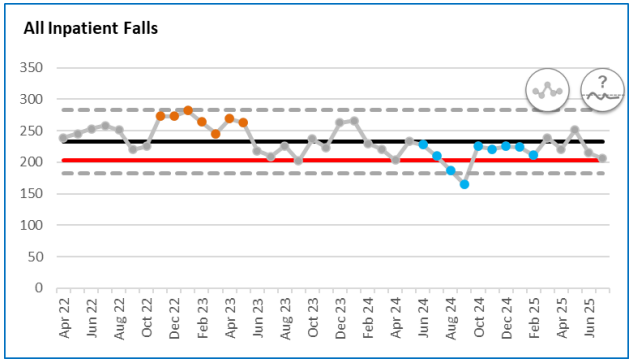
## Current position

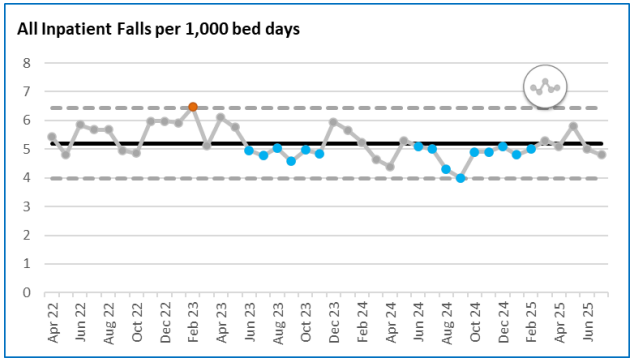
- The number of acute pressure ulcers (PU) Category II and above reported in July has increased from 48 in June to 57 in July, a seasonal increase is often noted in the summer months.
- PU per 1000 bed days also increased in July to 1.3 from 1.1 in June. The chart has been adapted to reflect a sustained reduction, therefore highlighting no special cause variation.
- There were no acute category IV and five category III pressure ulcers in July. Investigations are underway.

## Action taken

- The themes and trends from pressure ulcer investigations in July, 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.
- Education is available on Learning Lab, from the Tissue Viability Team and via the Clinical Educators on Purpose T.
- Purpose T will go live across in patient areas on the 29 September 2025. There will a period of overlap before the Braden assessment ceases.
- The Royal Victoria Infirmary (RVI) mattress audit that was planned for September 2025, however this is to be rearranged for a suitable future date.

# 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.

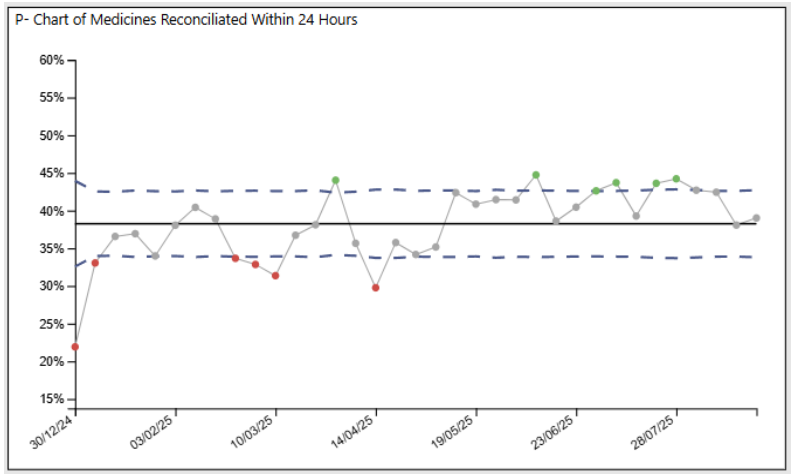
## Current position

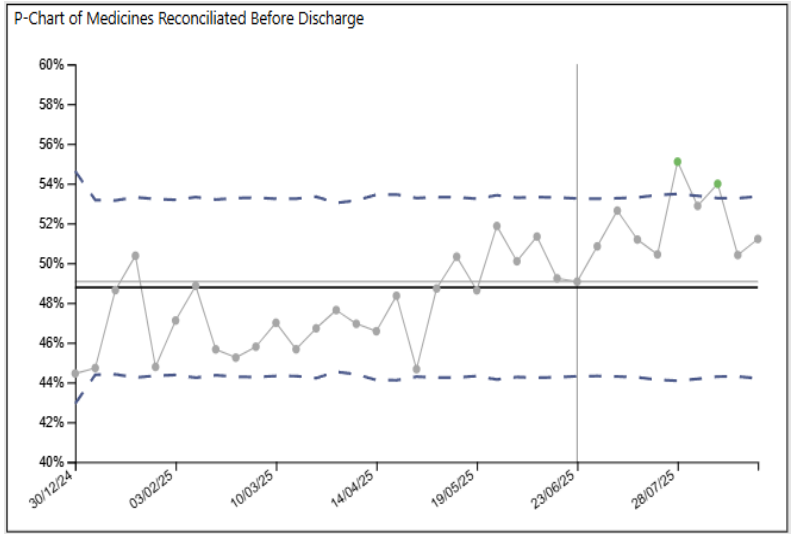
- In July 2025, there was a continued decrease in falls (206 vs 215). The Trust falls per 1000 bed days decreased from 5.0 in June to 4.8.
- Falls with moderate or above harm were recorded as 1% of falls (2) which were both classed as moderate harm incidents.
- All falls moderate and above are investigated on InPhase, clinical teams are supported by the Falls Prevention Coordinator for the investigation to identify learning and actions to help prevent further falls.

## Action taken

- Themes continue to be consistent with previous months, action plans noted the quality of the multifactorial assessment to optimise safe activity (4AT, Vision and Medication) or adherence with the Enhanced Care Observation policy.
- Positive feedback has been received regarding the falls induction session, with the highest number of votes from attendees as best session of day 2 (39%). The documented reasons why included the session being 'interactive', 'exciting', 'engaging' and 'presented well'.
- The second round of the 'Go Decaf' project is due to commence 1 September 2025. Meetings are also taking place with Northumbria and Gateshead Foundation Trusts regarding an Alliance Trust collaboration.
- Falls Awareness Week this year is taking place week commencing 15 September 2025. Public engagement stalls and ward trolley dashes will take place throughout the week and at alternating locations.

# 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.

## Current Position

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

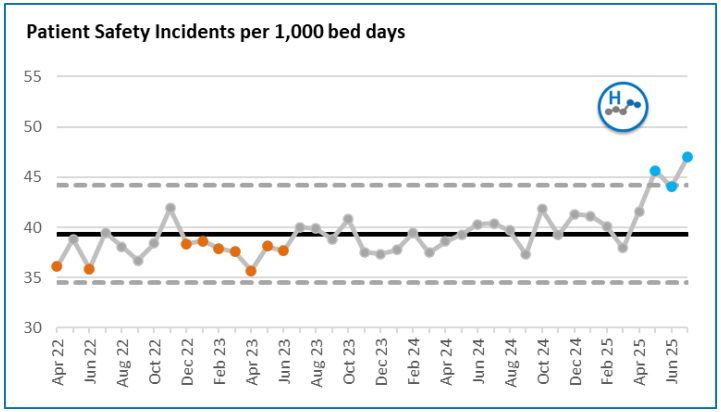
| | Med rec within 24 hours | Total Med Rec before discharge |
|---|---|---|
| Dec 2024 | **27%** | 46% |
| Jan 2025 | **34%** | 51% |
| Feb 2025 | **39%** | 52% |
| Mar 2025 | **34%** | 48% |
| April 2025 | **37%** | 50% |
| May 2025 | **38%** | 52% |
| June 2025 | **42%** | 54% |
| July 2025 | **43%** | 52% |

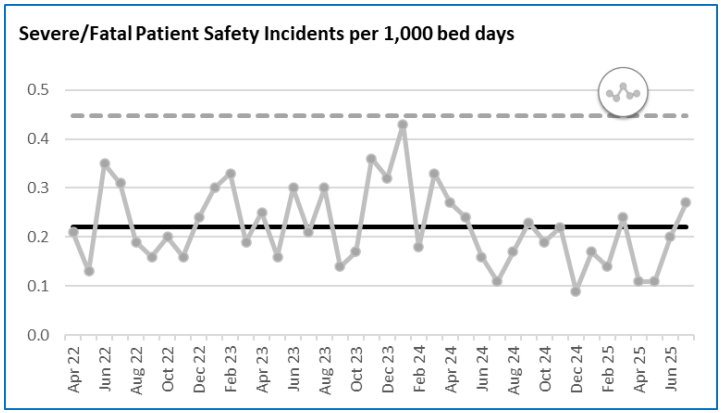
- Target rates sustained in July.

## 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.
- On-call service review starting September. 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.

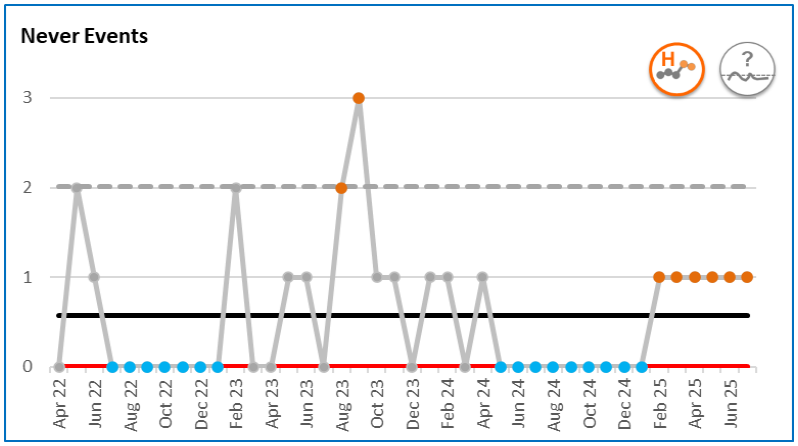
## Current Position

- The total number of patient safety incidents per 1,000 bed days reported in July 2025 has increased compared to June.
- The number of severe/fatal safety incidents per 1,000 bed days has increased in July 2025, compared with June.
- Seven Patient Safety Incident Investigations (five Maternity & Newborn Safety Investigations (MNSI)) and two After Action Reviews were recorded in July 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.
- Psychological support services being developed to support staff involved with patient safety events.

# Never Events




### Standards

- Never Events are serious, preventable patient safety incidents that should never occur if existing guidance and safety recommendations are followed. The Trust target is for **zero** Never Events to occur.

### Current Position

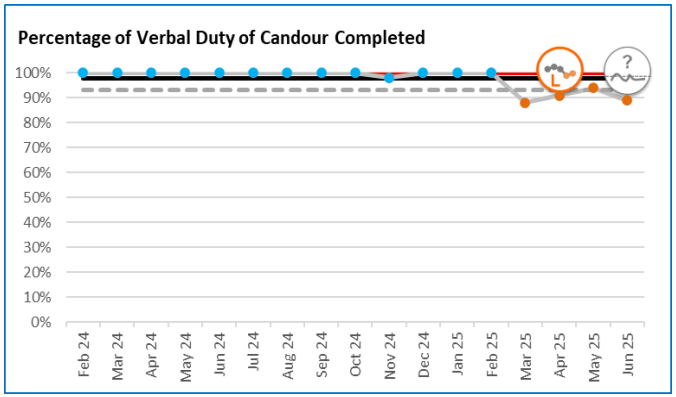
- One Never Event was declared in July.
- A total of four Never Events have been recorded for the 2025/26 period.

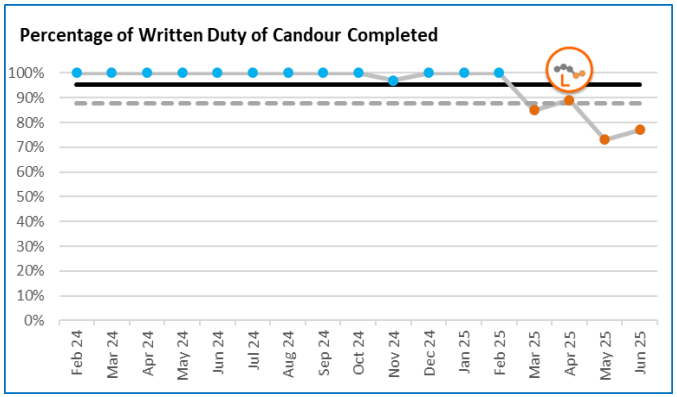
### Action taken

- Patient Safety Incident Investigations (PSII) undertaken for all Never Events (NE). 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, overseen by newly established Invasive Procedures Group.
- New PSRIF priority to support the successful introduction of NatSSIPS2 into the organisation, with an accelerated approach to review the use of current trust safety barriers within orthopaedics.

| Never Events 25/26 | Ref | Clinical Board | Speciality | Never Event |
|---|---|---|---|---|
| April 25 | 9031 | Surgery & Specialist Services | Orthopaedics | Wrong site surgery |
| May 25 | 983 | Surgery & Specialist Services | Orthopaedics | Wrong implant /prothesis |
| June 25 | 3168 | Cardiothoracic | Cardiology | Wrong site surgery |
| July 25 | 6311 | Surgery & Specialist Services | Orthopaedics | Wrong site surgery |

# 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

- Trust compliance for verbal duty of candour, for the period February 2024 to June 2025 has increased to 97%, compared with 96% for the previous month.
- Trust compliance for written duty of candour, for the period February 2024 to June 2025 has decreased to 94%, compared with 96% the previous month.
- Datix was changed to read only from 14th July 2025 to allow data migration to InPhase to take place. Any updates to DoC compliance for the period prior to May 2025 will not be represented in the graphs until migration to InPhase has been completed.

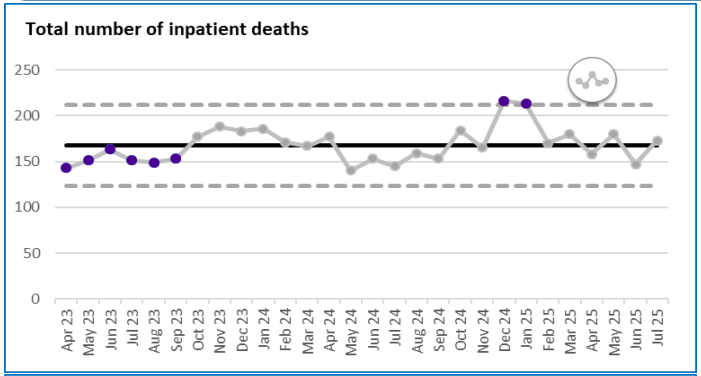
## Action taken

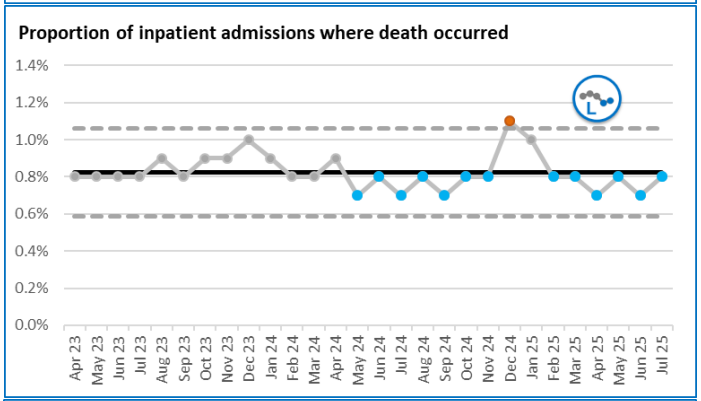
- Review and update of the duty of candour policy to provide more succinct and relevant guidance. Introduction of 'policy on a page'.
- Ongoing work to update and reintroduce DoC compliance dashboards across the trust.
- Changes implemented to InPhase to support more accurate compliance recording.

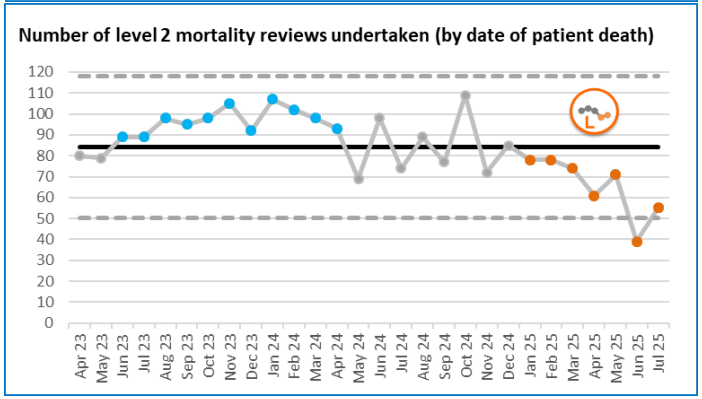
## Measures of Success

- All patients involved in a notifiable patient safety incident resulting in moderate or above harm to receive a 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).

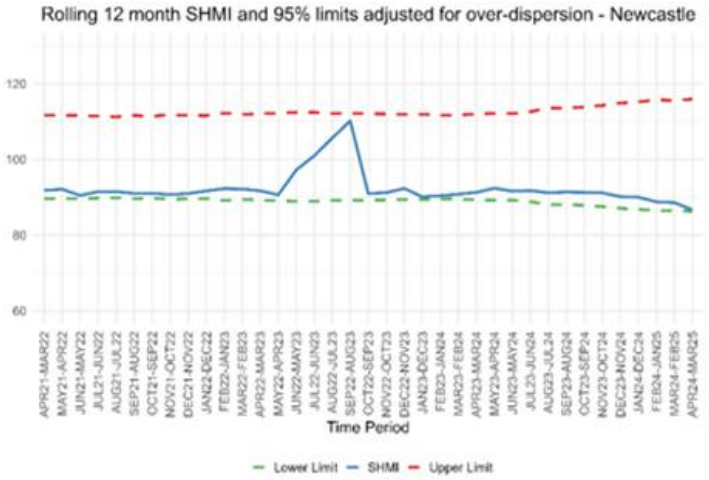
## Current Position

- There were 173 inpatient deaths in total reported in July 2025. This is an increase of 26 on the previous month.
- The crude mortality rate in July 2025 is 0.8%. This is an increase of 0.1% from the previous month and remains well within the average for the Trust.
- Out of the 173 inpatient deaths reported, there are 55 completed level 2 mortality reviews entered into the Trust mortality review database to date. None of the completed reviews have been scored with a high HOGAN or National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading.
- Additionally, a further 61 Level 2 reviews were completed in July 2025 for patients who died prior to this date. None of the completed reviews have been scored with a high HOGAN or National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading.
- Nine patients with a confirmed learning disability died in July 2025.

## Action taken

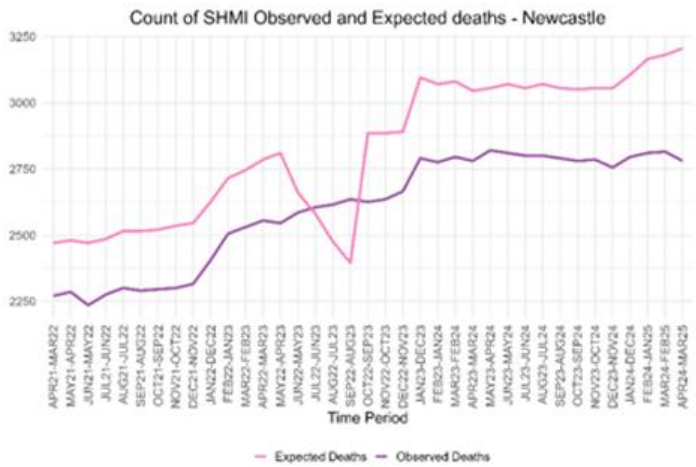
- All inpatient deaths are continually monitored.
- The number of level 2 mortality reviews will rise significantly over the coming months as Morbidity and Mortality (M&M) meetings continue to take place.

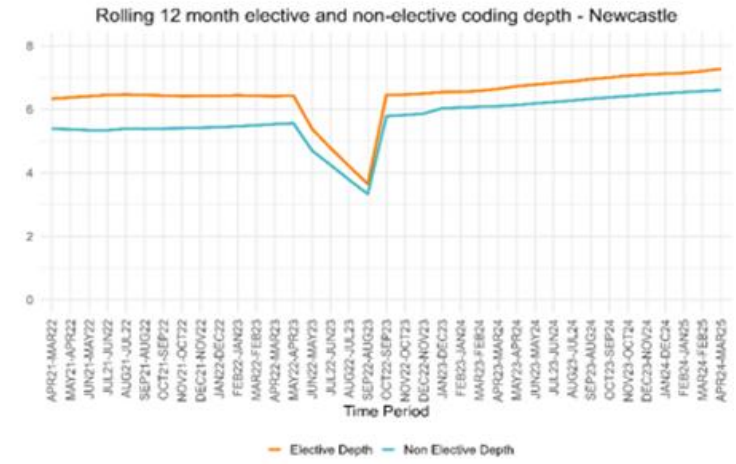
# Mortality Indicators (2/2)




**SHMI (Summary Hospital-level Mortality Indicator)**
Within the latest published SHMI data (Apr 2024 – Mar 2025) the Trust SHMI is at 0.88. This is within the "as expected" category.

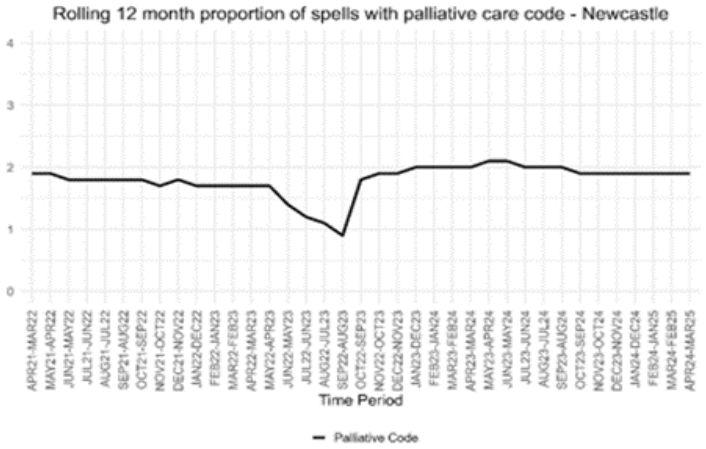
**Observed & Expected deaths**
Between April 2024 – March 2025, the Trust has 2,780 observed deaths and 3,205 expected deaths.




**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 7.3 and a non-elective coding depth of 6.6*.

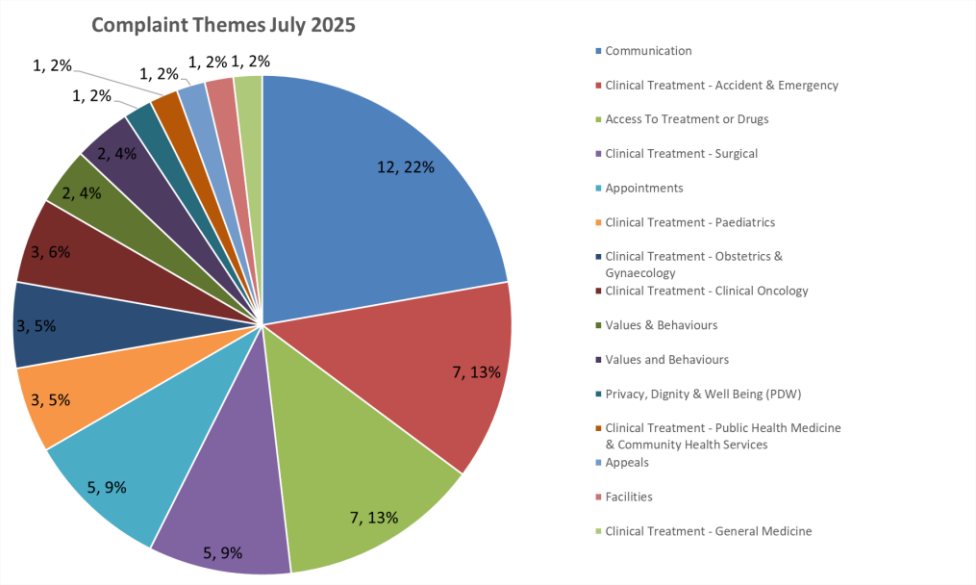
**Spells with palliative code**
Between April 2024 – March 2025, the Trust has a 1.9% palliative care coding rate.

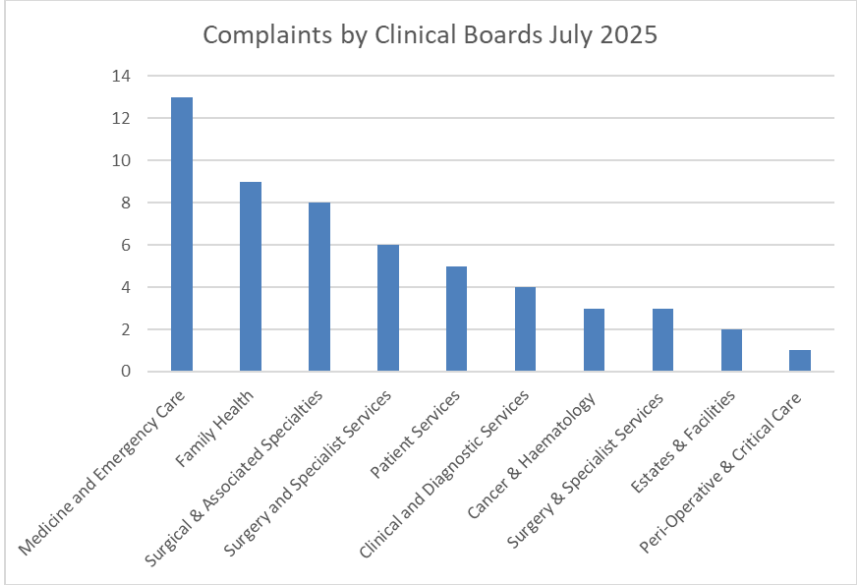



* An issue with the Trust's Secondary Uses Service (SUS) data flow affected clinical coding completeness (now resolved).

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

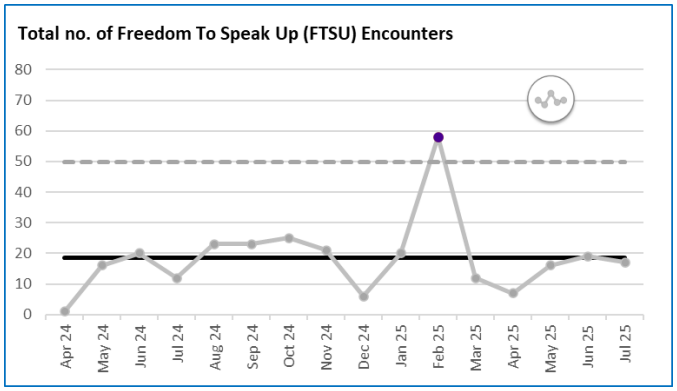
# Formal Complaints




- The Trust has had 54 formal complaints in July 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 22% of the complaints (12).
- Clinical treatment accounts for the most complaints collectively across the specialties with 43% of complaints opened this month (23).
- The most complaints were opened for the following Clinical Boards:
    - Medicine 13 (24%)
    - Surgery and Specialist Services 9 (17%)
    - Family Health 9 (17%)

# Freedom to Speak Up




| Primary topic given for FTSU | Apr-25 | May-25 | Jun-25 | Jul-25 |
|---|---|---|---|---|
| Inappropriate behaviour and attitudes | | 2 | 5 | 10 |
| Poor management | 3 | 5 | 5 | |
| Worker safety and quality | | 4 | 2 | 5 |
| Bullying and harassment | 2 | 3 | 3 | 1 |
| Patient safety and quality | 2 | 1 | 1 | |
| Unknown | | | 2 | 2 |
| Civility | | 1 | | |
| Disadvantageous demeaning treatment as a result of speaking up | | | 1 | |

| FTSU by Clinical Board | Apr-25 | May-25 | Jun-25 | Jul-25 |
|---|---|---|---|---|
| CB Peri-operative and Critical Care | 1 | 3 | 5 | 5 |
| CB Clinical and Research Services | 4 | 6 | | |
| CB Cardiothoracic Services | | 1 | 3 | 1 |
| CB Family Health | 1 | 2 | 1 | 1 |
| Unknown | | 1 | 5 | 3 |
| CB Surgical and Specialist Services RVI | | 1 | | 3 |
| CS Estates | | 1 | 2 | 1 |
| CB Clinical and Diagnostic Services | | | 2 | 1 |
| CB Surgical and Associated Services FH | | | | 2 |
| CB Cancer and Haematology | 1 | | | |
| CS Business Development | | | | 1 |
| CS Chief Executive | | | 1 | |
| CS Information Management and Technology | | 1 | | |

## Standards

- There is **zero tolerance** to detriment.

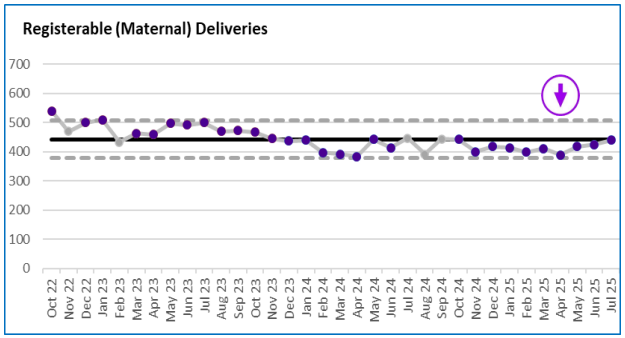
## Current Position

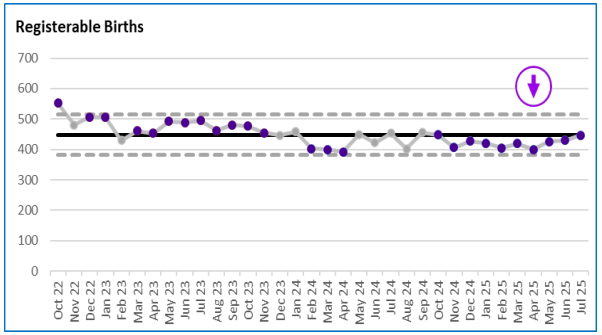
- There were 18 speak ups made to the Freedom To Speak Up Guardian (FTSUG) in July. Three of these were as a result of targeted staff experience work and 2 were reported anonymously through the Work In Confidence platform.
- The most frequently reported category of concern reported in July 2025 was worker quality and safety (14), followed by inappropriate attitudes and behaviours (11), bullying and harassment (5) and patient safety (1).
- No cases of detriment were reported in July 2025.

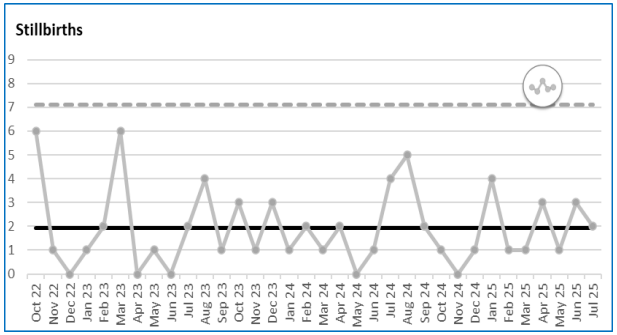
## Action Taken

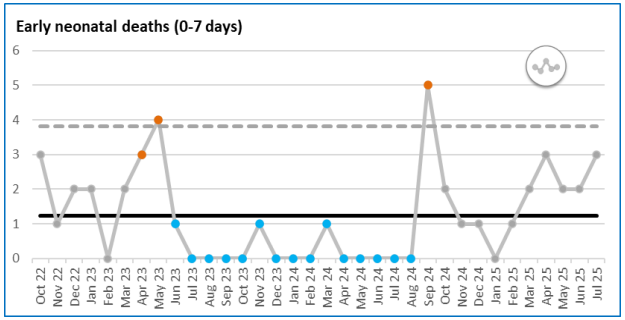
- Recruitment of 2 x 0.5 whole-time-equivalent (wte) FTSUG.
- Completion of staff experience targeted work on Ward 18, RVI.
- Attendance at Cardio cultural steering group.
- Training of 2 additional champions, bringing the total number of champions to 15.

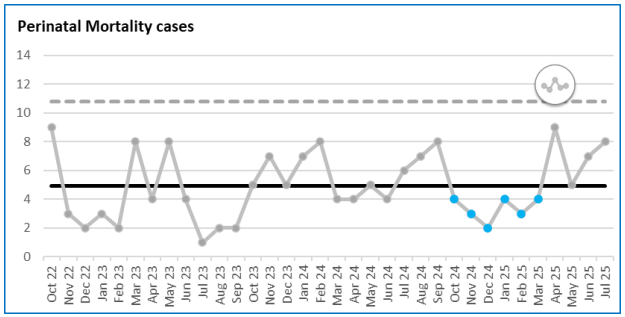
# Perinatal Quality Surveillance: Births




## Deliveries/Births

- There were 594,677 live births in England and Wales in 2024, a 0.6% increase from 2023. This is the first increase since 2021. Several regions, including the Northeast, saw a decline in live births, the overall increase in births appears to be primarily caused by the number of births in the West Midlands and London. There is concern that there has been a reduction in the market share of the Trust following the long-term suspension of the Birthing Centre, the current birth rate is stable, but a communication plan is required to potentially increase booking numbers.

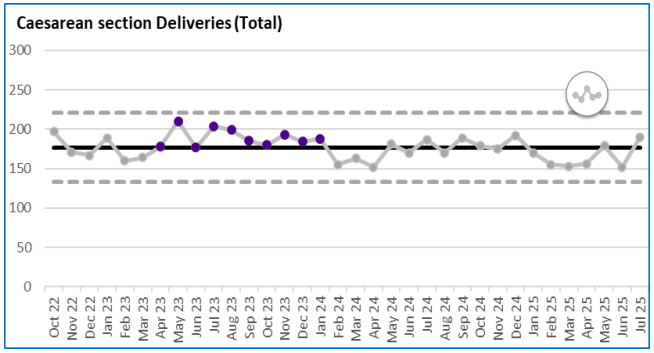
## Stillbirths

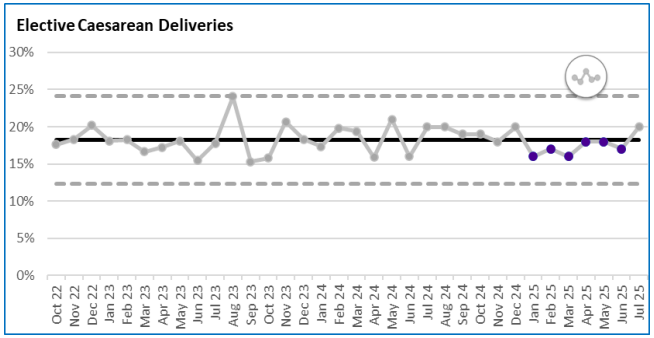
- This data includes termination for fetal anomalies >24 weeks gestation. There were 2 stillbirths in July 2025. These will be reviewed via the Perinatal Mortality Review process. (Average per 1000 births: England 3.2, North East and North Cumbria (NENC) 3.6). The Trust has triggered a safety alert for the number of stillbirths on the Clinical Indicators Dashboard. In accordance with the Local Maternity and Neonatal System (LMNS) safety signal process this instigated a review of the data. 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.

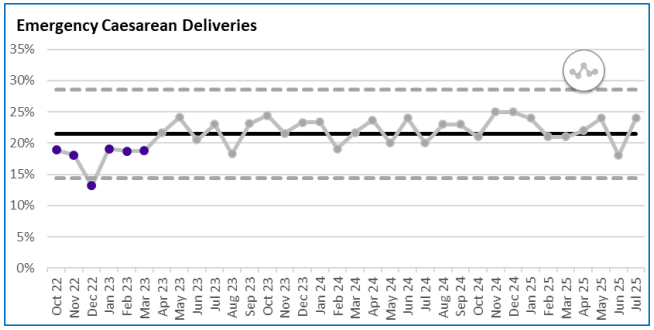
## Early Neonatal Deaths

- 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 3 early neonatal deaths in July 2025. There were no themes associated with care.

# Perinatal Quality Surveillance: Deliveries




## Caesarean section deliveries

- In England 42.9% of births are caesarean section, in the NENC for Q4 this was 43.2%. There is no defined national metric for caesarean section rates.
- The Trust Q4 average was 36.6%. The Q1 average was 38.1%.
- The Trust had a comparable caesarean section rate of 42% in July 2025, however, it should be noted that the 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.
- 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.

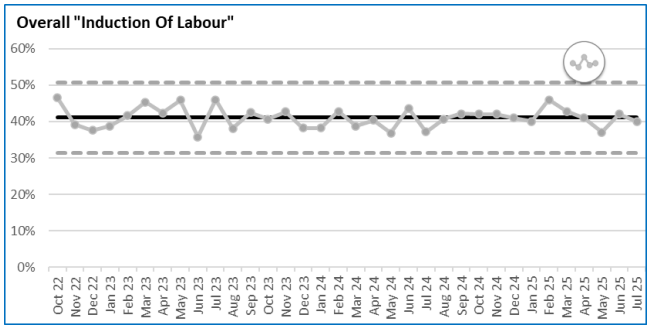
## Elective Caesarean section

- The average England elective caesarean rate in Q4 was 19.7% and in the NENC 18.4%.
- The Trust elective caesarean rate is stable at 18.9% in July 2025 (increase from 17% in June).
- The national rise in elective caesarean rates is partially due to an increasing proportion being undertaken due to maternal request in accordance with the National Institute for Health and Care Excellence (NICE) guidance.
- The Trust has a shared decision-making philosophy and offers informed, non-directive counselling for women over mode of delivery. There is an obstetrician/midwifery specialised clinic to facilitate this counselling and patient choice.

## Emergency Caesarean section

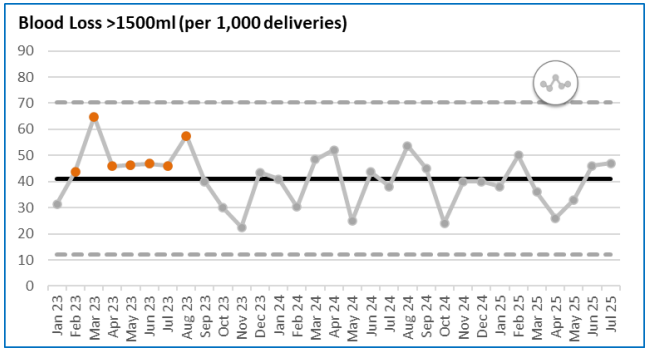
- The England average for Q4 2024/25 was 23.5%, and the NENC mean was 21.6%.
- The Trust emergency caesarean rate was lower than anticipated in June but has returned to 22.3% in July. There is dedicated consultant presence on Labour Ward 8am-10pm daily, consultant led multi-disciplinary ward rounds occur 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



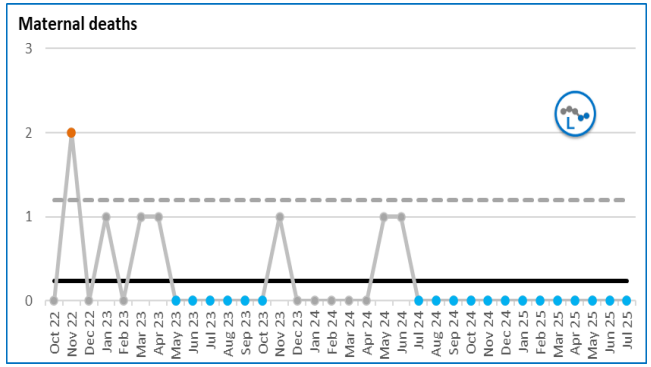

## Induction of Labour

- The number of women being induced during pregnancy has increased due to changes in national guidelines as part of the Saving Babies Lives Care Bundle and other NICE and Royal College of Obstetricians & Gynaecologists (RCOG) guidance.
- England average for induction of labour Q4 2024-25 29.6% and NENC 35.2%. The Trust induction of labour rate for July is 40%. 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

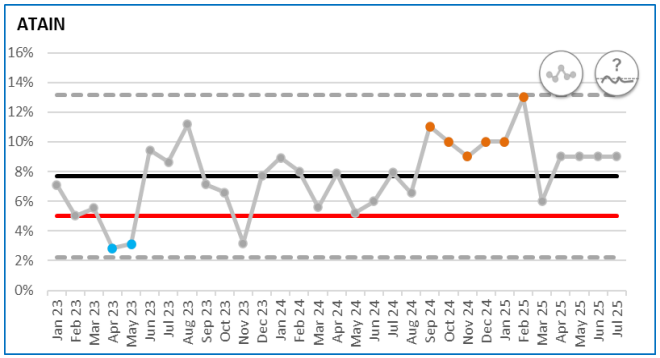
- The average Postpartum Haemorrhage (PPH) rate for Q4 2024/25 in England is 31 per 1000 and NENC average is 29 per 1000. The Trust PPH rate for July 2025 is 47 per 1000. The Trust Q4 average was 29 per 1000.
- Higher rates are indicative of the complexities of the high-risk patient group and provision of the Placenta Accreta Spectrum service as confirmed by the previous review.




## Maternal Deaths

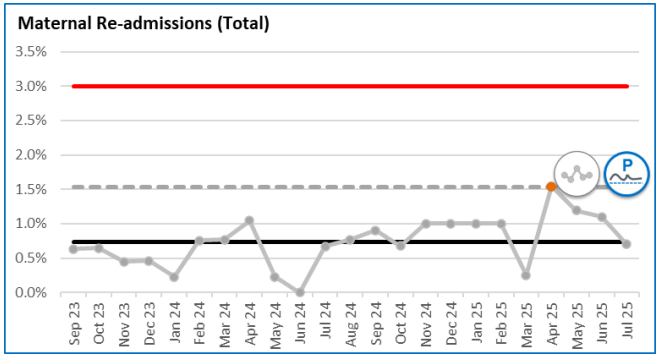
- Maternal deaths are reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) and an annual national report is provided. Early maternal deaths are the death of a woman while pregnant or within 42 days of pregnancy (including termination of pregnancy). 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 July 2025.

# Perinatal Quality Surveillance: Admissions



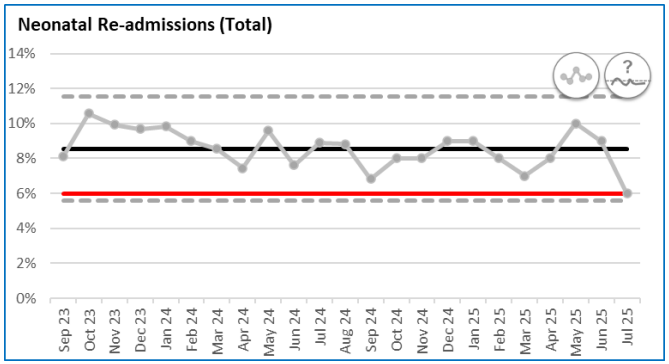

## Avoiding Term Admission into Neonatal Units (ATAIN)

- The National benchmark for term admissions is 5%. The Trust rate remains consistently above the national 5% target; in June and July this was 9%. 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 neonatal nurse outreach pilot for theatre recovery will commence in August 2025.




## Maternal Readmissions

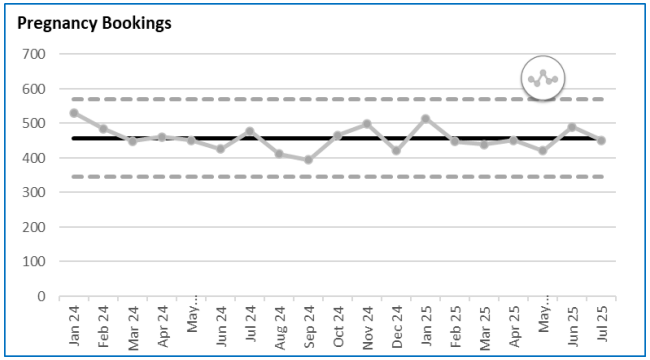
- National Maternity & Perinatal Audit (NMPA) Report (2022) - the maternal postnatal readmission rate for England was 3.3%, with rates being higher following caesarean section compared with vaginal birth (4.3% vs 2.9%). The LMNS are working to agree a NENC key performance indicator (KPI) for this metric, 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 June 2025 and less than 1% in July 2025.

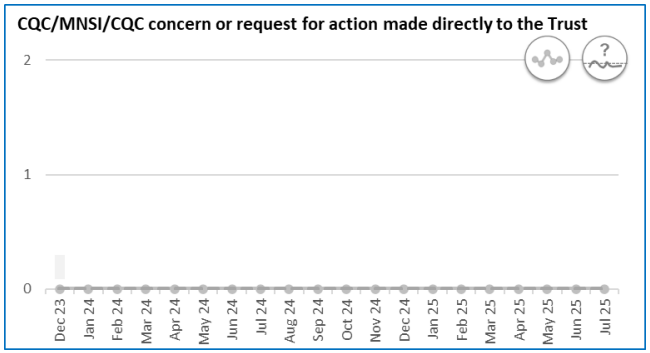


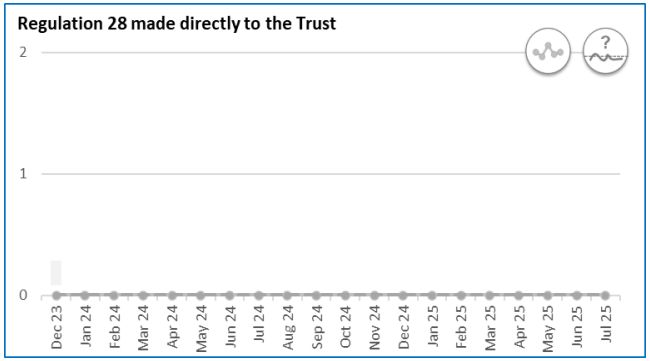

## Neonatal Readmissions

- 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%.
- In June 2025 the readmission rate was 9%, there was some concern this data included babies reviewed on the Transitional Care ward in addition to the babies readmitted due to clinical coding. In July 2025 the readmission rate was 6%.
- The neonatal team are currently reviewing the management of jaundice guidance which is impacting the readmission rate and exploring the coding for the cases.

# Perinatal Quality Surveillance: Incidents & Bookings



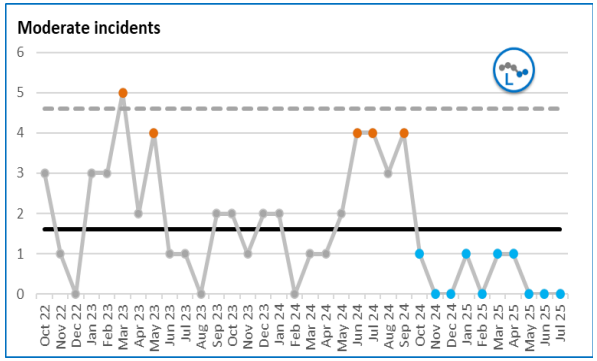



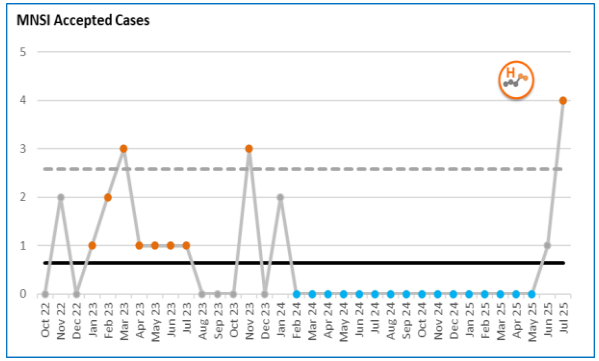

## Pregnancy Bookings

- The number of women choosing to book for care and delivery at the Trust has 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.

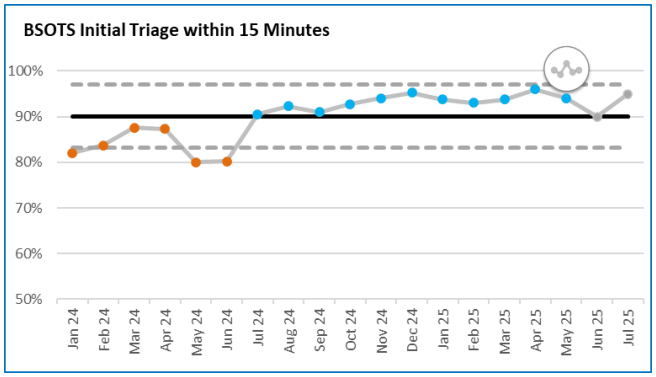
## Incidents

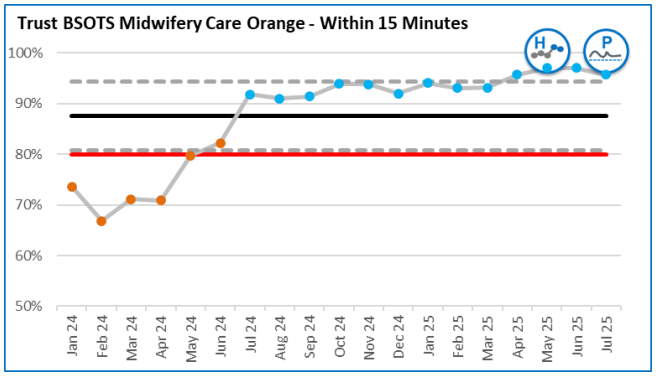
- This month we have separated moderate incidents from externally reported MNSI cases which were previously grouped together. There were no moderate or above harm incidents reported in July, these incidents are discussed at a multi disciplinary rapid review and presented to the Trust Response Action Review Meeting (RARM) to agree a proportionate learning response.
- Perinatal incidents referred to MNSI for external review are now detailed separately. These include cases involving neonatal brain injury - Hypoxic Ischaemic Encephalopathy (HIE), Term Intrapartum Stillbirths, Early Neonatal deaths and Maternal deaths. There were 4 cases in July and 1 in June 2025 which were referred and accepted by MNSI for external review. MNSI reviews are usually completed within 6 months from referral.
- There have been no Care Quality Commission (CQC)/MNSI concerns or requests for action in the last 12 months.
- There have been no regulation 28 notices in the last 12 months.

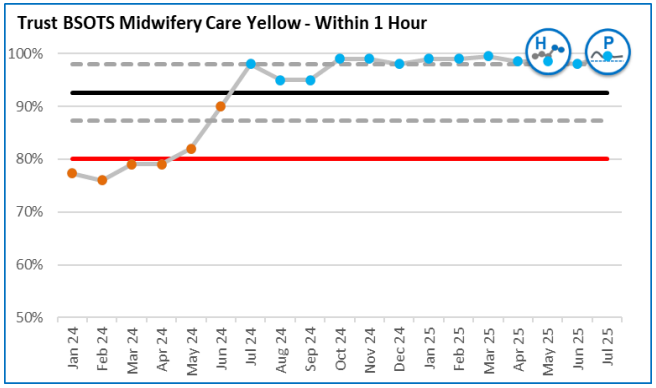


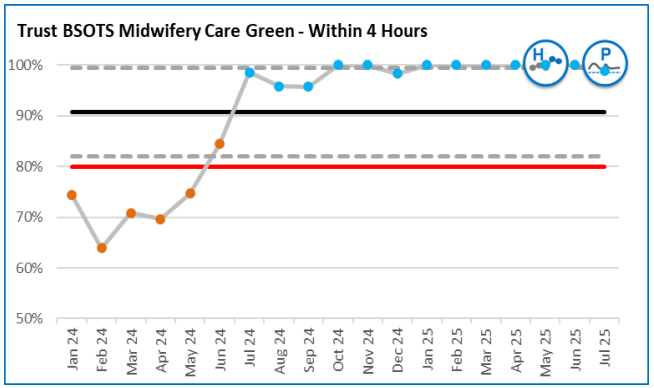



# Perinatal Quality Surveillance: Triage - Midwifery Care Timings



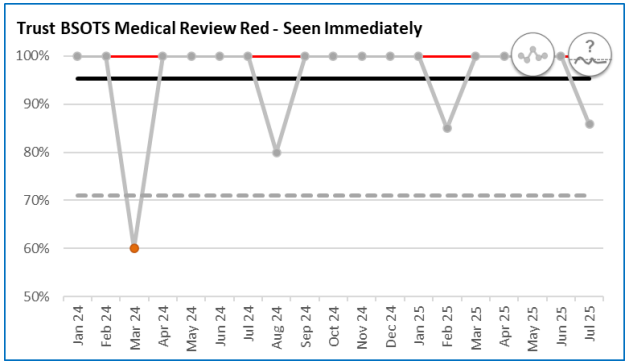



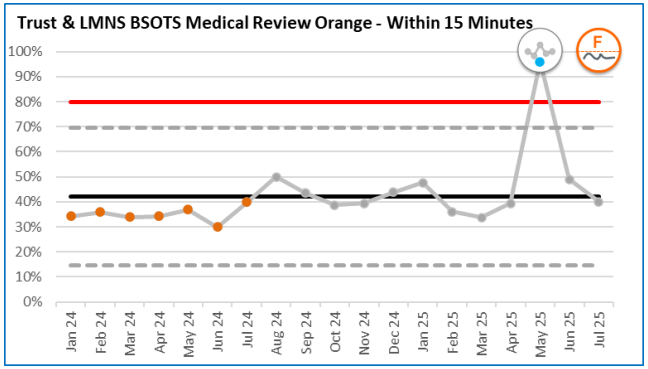



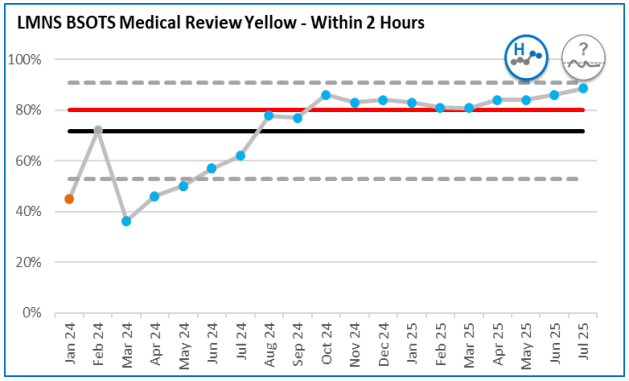

**Birmingham Symptom Specific Obstetric Triage System (BSOTS)**

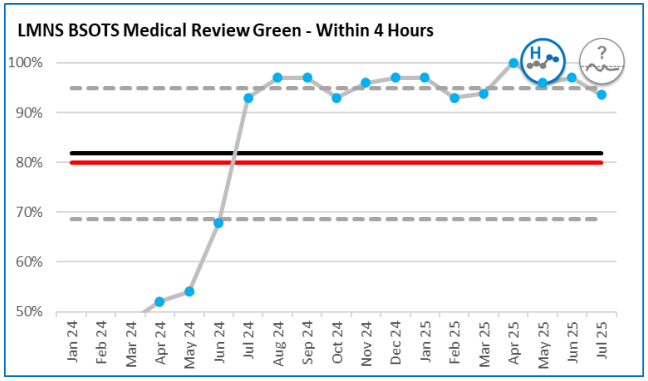
- The Trust implemented the BSOTS triage system in January 2024. Midwifery triage and subsequent review has improved considerably and has exceeded the Trust and LMNS target.
- Good performance continues to be sustained across every category for midwifery review.

# Perinatal Quality Surveillance: Triage - Medical Review Timings



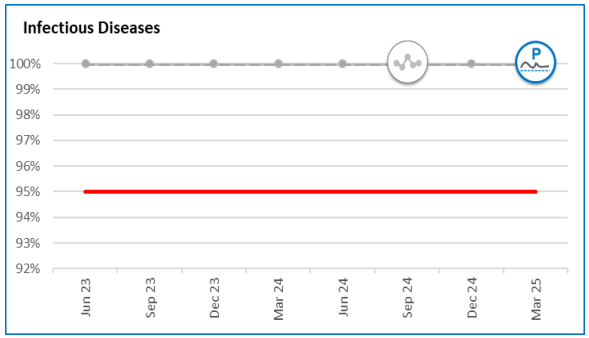



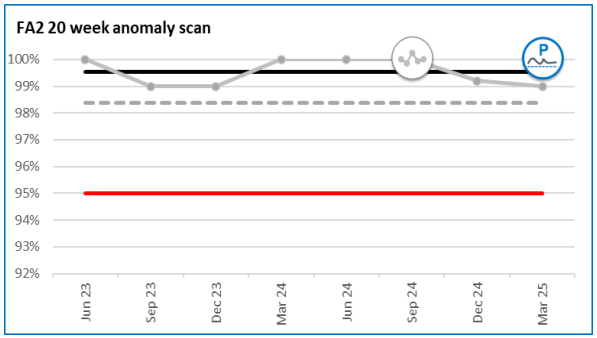



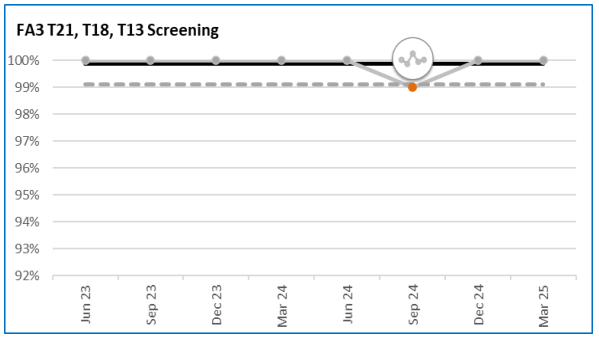

**Birmingham Symptom Specific Obstetric Triage System (BSOTS)**

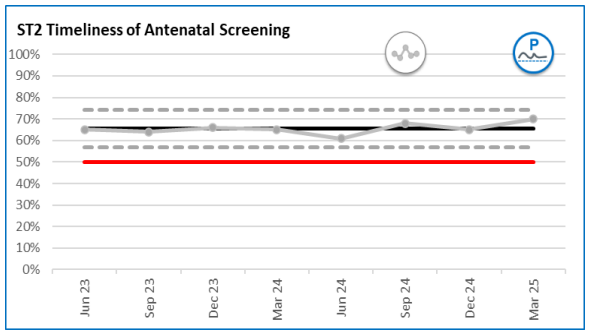
- The Trust has now bench marked performance against the NENC LMNS target for each of the categories.
- There has has been significant improvements in performance in the last 12 months.
- A project is underway to commence call recording and capturing patient experience for the triage services.
- Medical review for women in the orange category remains challenging, performance has remained at baseline level for July 2025. Further assurance regarding time interval for review, and the reason for attendance, is reviewed monthly at Quality & Safety meetings.

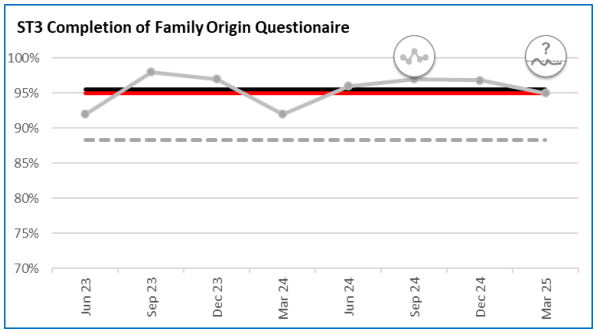
# Perinatal Quality Surveillance: Antenatal Screening

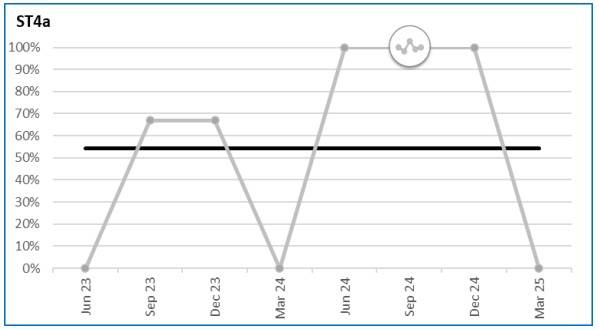


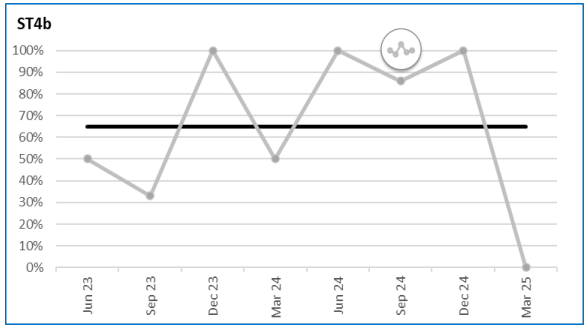



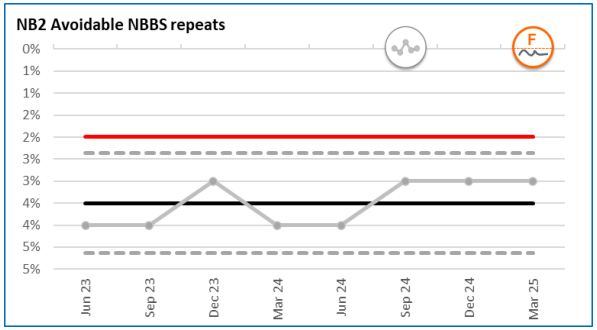



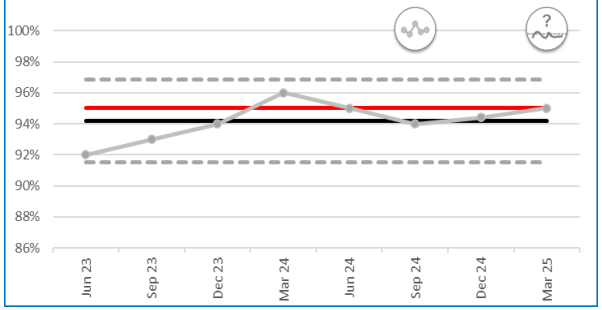



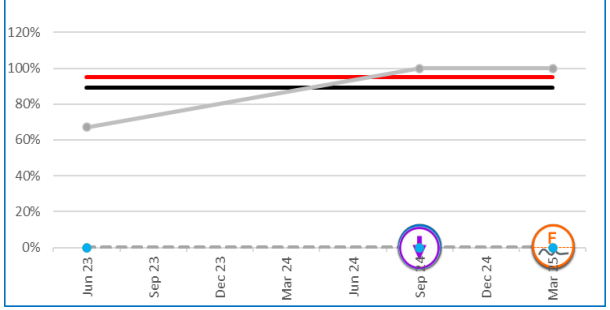

- QIP to review antenatal clinic patient flow, failsafe and administration processes is making good progress but is impacted by consultant capacity to provide cross cover.

# Perinatal Quality Surveillance: NIPE Screening

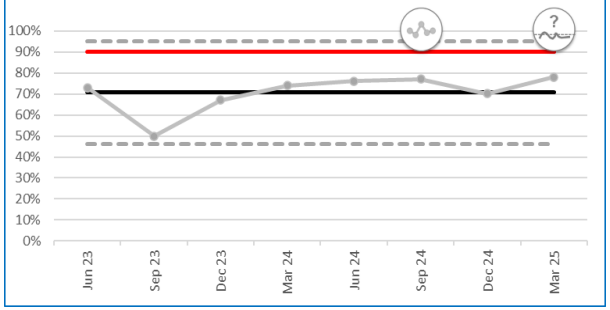
**S01 - % screen compliant <72 hrs of age**



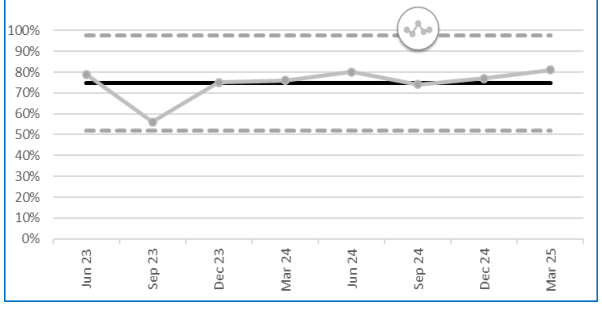

**S02 - % eye abnormality suspected/seen <14 days of examination**



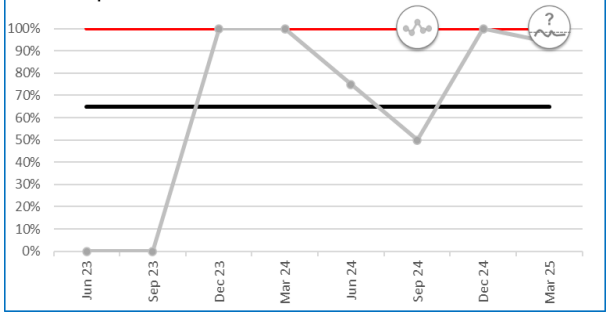

**S03 - % hip USS attended between 4-6 weeks**



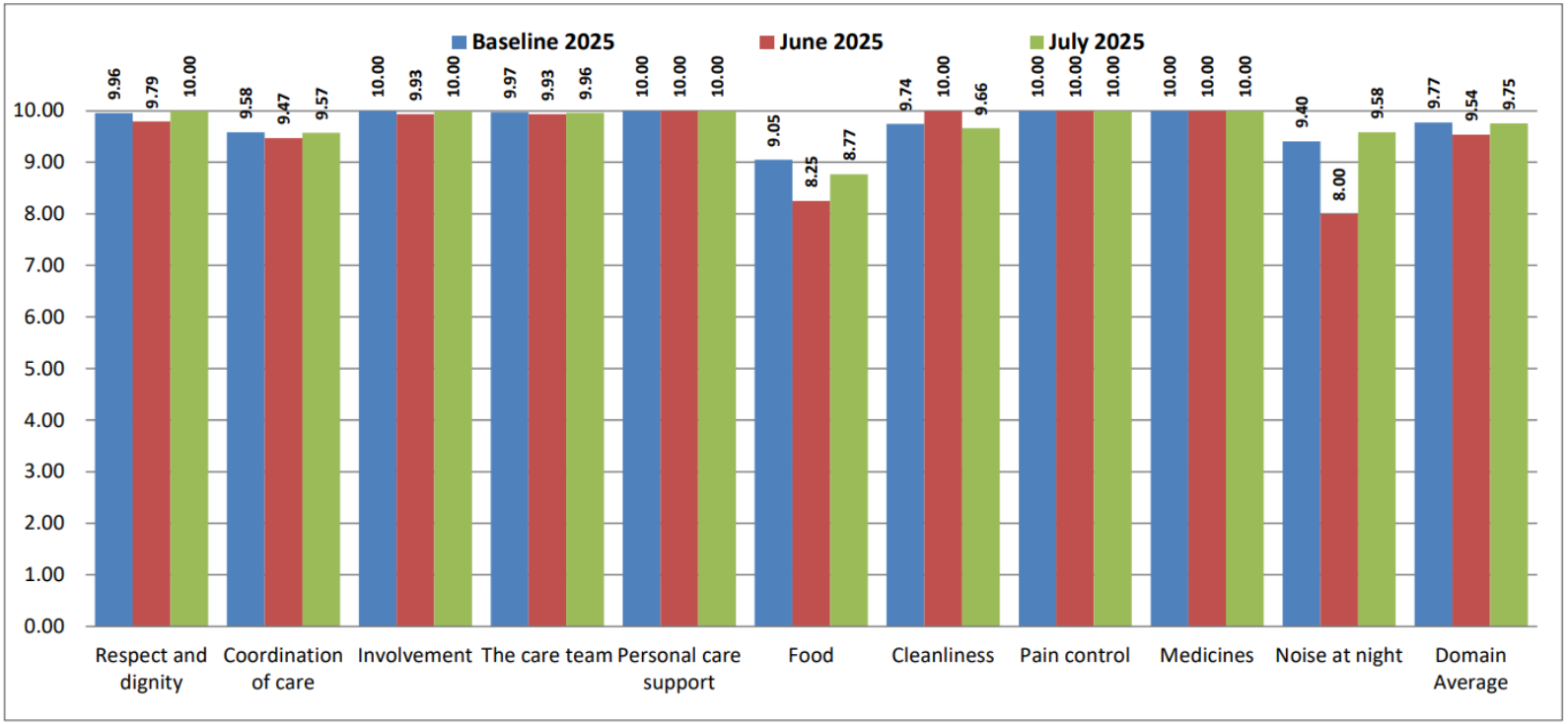

**S04 - % of hip referral outcome decision made (<6 weeks corrected age)**




**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. 95% of patients surveyed rated their overall experience on the ward as either good or very good (number of respondents 21 (88% of available patients).

**Example comments**

- 'I've 100% been treated with respect and dignity while on the ward. The staff have all been consistent. I've been quite open about my needs and they've been very supportive. The staff are very specific with giving me information, they let me ask lots of questions and they explain things well'.
- 'The staff have been great'.
- 'The staff are excellent. It's slightly cold in the room'.
- 'The staff have been pretty consistent the whole way through. When something is planned, it absolutely happens when they say it will. This is mainly with the pain medications, when I ask for them, they just finish what they're doing and then sort them out straight away. I've absolutely been involved in my care and treatment'.

# Performance

# Performance Overview

| Metric | Period | Actual | Traj. | Target | Variation | Assurance |
|---|---|---|---|---|---|---|
| A&E Arrival to Admission / Discharge | Jul-25 | 79.3% | 79.2% | 78% | H | ? |
| RTT 18 Weeks | Jul-25 | 73.6% | 71.7% | 92% | H | F |
| >52 Week Waiters (% of total Patient Tracking List (PTL)) | Jul-25 | 1.4% | 1.2% | 1% | L | F |
| Cancer 28 Day FDS | Jul-25 | 74.2% | 80.2% | 80% | | ? |
| Cancer 31 Day | Jul-25 | 87.3% | 74.1% | 96% | | F |
| Cancer 62 Day | Jul-25 | 71.2% | 64.6% | 75% | H | F |
| Diagnostic 6 Weeks | Jul-25 | 13.1% | 9.0% | 5% | L | F |


## Emergency Care

- Emergency Department (ED) Performance (All Types) in July was 79.3%, an improvement of 1.8% compared to June (77.5%), meaning this metric is now demonstrating improving variation.
- ED Arrival to Admission / Discharge > 12 hours (Type 1) in July was 1.9%, a 0.8% improvement from June's performance of 2.7%.

## Elective Waits

- July 2025 witnessed a small decrease in >52-week waiters at Newcastle Hospitals, falling to 1,275 (-32). The number of >65 week waits also decreased marginally to 68 (-3).
- The total waiting list size reduced again in July to 88,211. The Trust's participation in an NHS England coordinated validation sprint has been key to improvements – with performance at Newcastle amongst the strongest nationally.

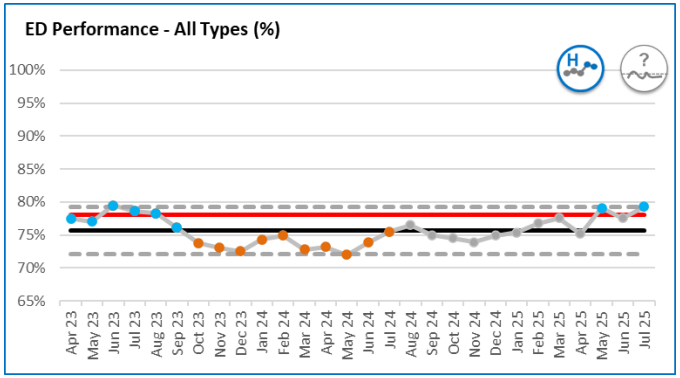
## Cancer Care

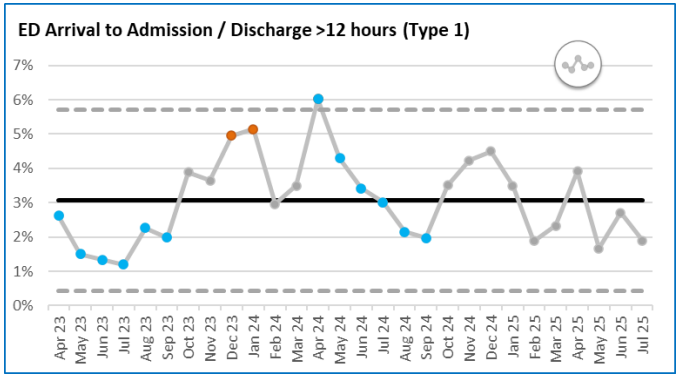
- In July the 28 FDS was missed for a second successive month (74.2%).
- 31 Days (87.3%) has progressively recovered throughout 2025 and has now returned to within the previous limits of standard variation.
- 62 Day compliance for July was 71.2%, consistent with a continuation of improving special cause variation despite an overall consistent failure to hit the target.

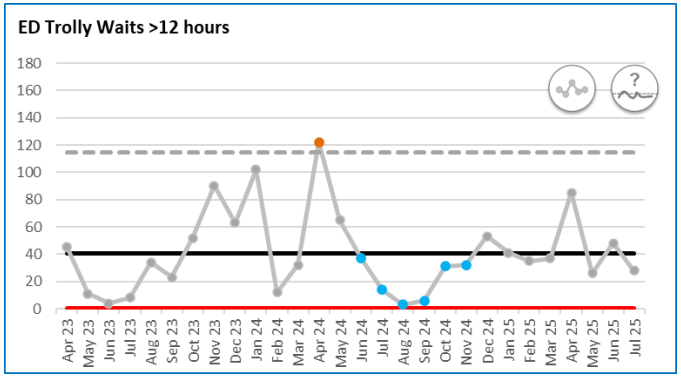
## Diagnostics

- Performance against the 5% standard improved in July for the second successive month - 13.1% of patients were waiting over six weeks.
- The waiting list decreased by 1,140 patients in July, with Non-obs Ultrasound, ECHO and Gastroscopy contributing most of this growth.

# Emergency Care




## Standards

- 78% of patients to be admitted/transferred/discharged from A&E in <4 hours (by March 2026).
- No ambulance handovers to Accident & Emergency (A&E) exceeding 60 minutes.
- Reduction from 2024/25 in waits over 12 hours from A&E arrival to admission/discharge (Type 1).

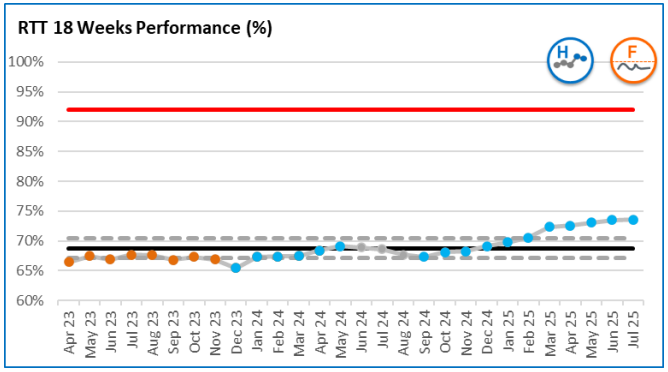
## Current position

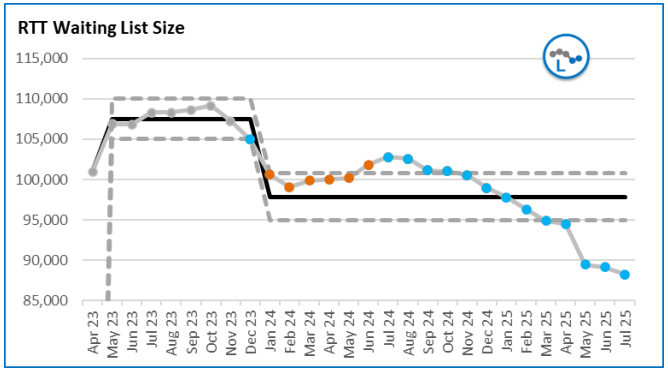
- ED Performance (All Types) in July was 79.3%, an improvement of 1.8% compared to June (77.5%), meaning this metric is now demonstrating improving variation. This improvement in performance is also reflected in the decrease of Type 1 breaches. July witnessed a total of 4,243 which was an 5% reduction compared to June.
- ED Trolley waits >12 hours significantly decreased in July to 28, a reduction of 20 compared to June.
- ED Arrival to Admission / Discharge > 12 hours (Type 1) in July was 1.9%, a 0.8% improvement from June's performance of 2.7%.
- The number of Ambulance Handovers > 60 mins improved in July to 108, a reduction of 28 patients from June, though still above average levels seen in previous financial years.
- ED Discharges were also up in July at 8,909, an increase of 588 from the previous month.

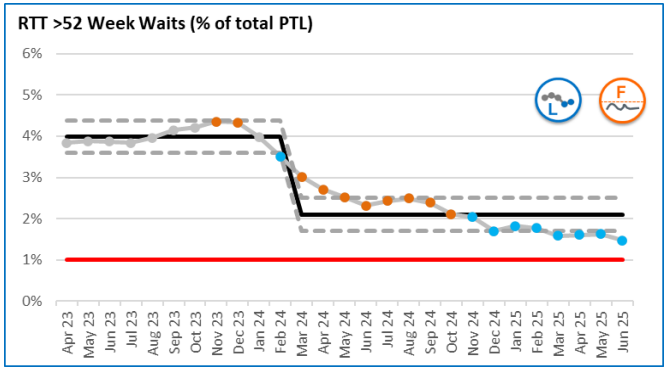
## Action taken

- Positive performance against plan for July at 79.3%.
- Plans to operationalise the new Urgent Treatment Centre and redesign of the front door continue. The trust continue to test streaming opportunities to help inform the new model.
- Continue to monitor patient safety in the waiting room and are driving improvements with time to be seen and time to assessment.
- There is an improvement week planned in relation to patient flow from the Emergency Department to admission in September to understand bottlenecks and inform escalation action plans.
- Temporary funding has been secured to support timely ambulance handovers in line with the regionally agreed principles.

# 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%).

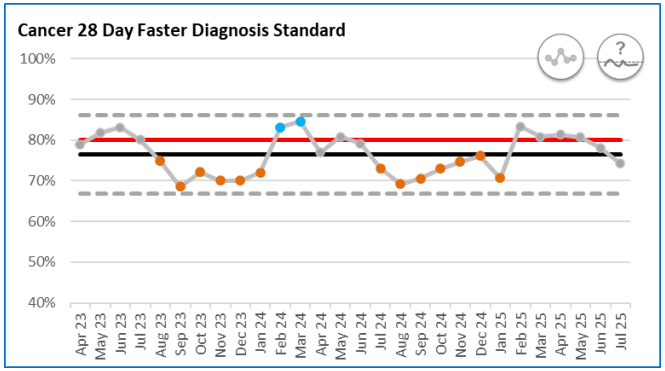
## Current position

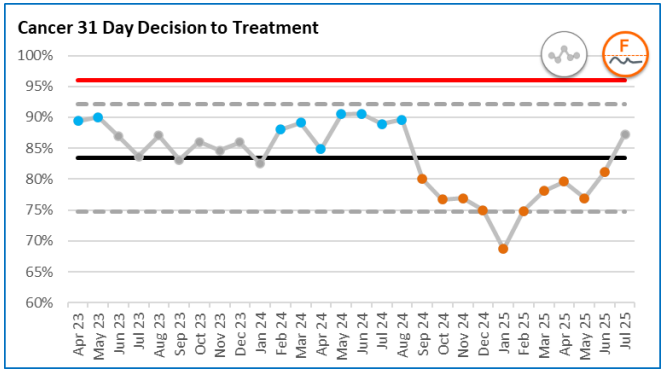
- July 2025 witnessed a small decrease in >52-week waiters at Newcastle Hospitals, falling to 1,275 (-32). The number of >65 week waits also decreased marginally to 68 (-3).
- >78-week waiters reduced further to 9 (-3) with breaches centred in Spinal Surgery, Ophthalmology (corneal grafts), Ear, nose and throat (ENT), Cardiology and Gynaecology.
- Despite making progress in clearing its longest waiters, 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 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 waiting list size reduced again in July to 88,211. The Trust's participation in an NHS England coordinated validation sprint has been key to improvements – with performance at Newcastle amongst the strongest nationally.

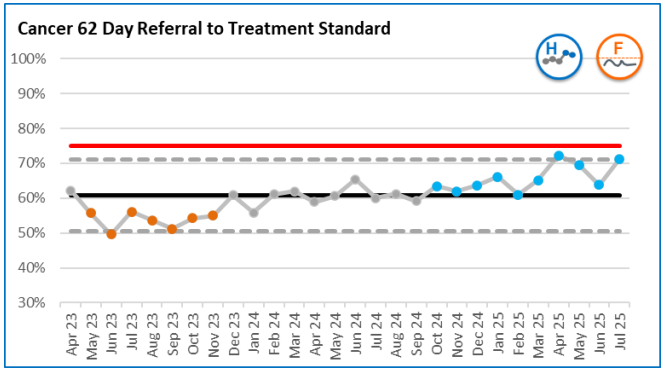
## Action taken

- A new clinical lead is in place for the Orthopaedic Spinal Service, with weekly Multidisciplinary 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. An additional spinal surgeon has also recently been appointed.
- External funding has been approved in Gynaecology to address issues with long waiters- further improvements are expected. A permanent consultant is also due to start in September.
- Specialty-level Path to Zero trajectories and action plans for 52-week waiters have been developed for stringent monitoring through the Trust's Fortnightly RTT meeting, with specialties now regularly sharing learning from successes and collaboratively solving challenges.

# Cancer Care




## Standards

- Faster Diagnosis Standard (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).

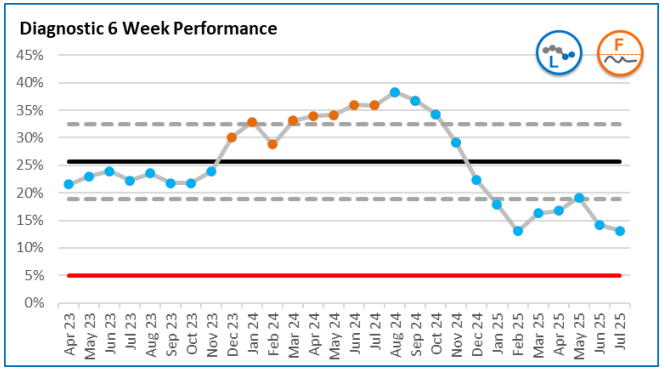
## Current position:

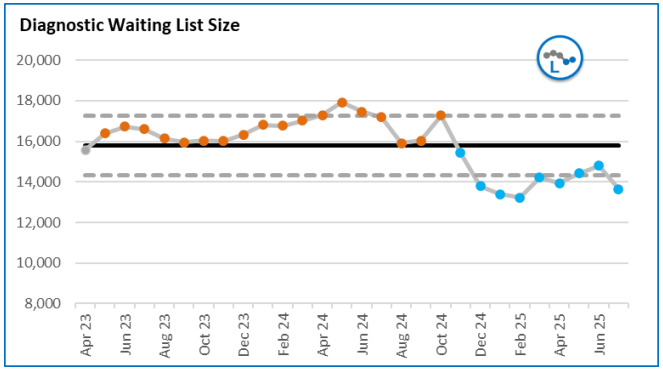
- In July, the 80% 28 FDS was missed for the second successive month (74.2%).
- 31 Days (87.3%) has progressively recovered throughout 2025 following a period of increased referrals and capacity shortfalls due to retirements/turnover, and has now returned to within the previous limits of standard variation.
- 62 Day compliance for July was 71.2%, consistent with a continuation of improving special cause variation despite an overall consistent failure to hit the target. At the end of July the volume of patients waiting over 62 days for treatment stood at 137, on par with the previous month.
- Performance against all standards, even where short of the national standard, has continued to exceed internal trajectories and Tier 2 exit criteria thresholds, and the Trust was formally de-escalated from Tier 2 regulatory oversight on 13th August.

## Action taken

- 28 day Skin – direct to Plastics referrals have been implemented, robust annual leave cover is now in place and clinic times have been extended. General Dermatology clinics have been converted as necessary to cancer clinics and plans are underway with Northumbria NHS Foundation Trust to provide mutual aid. NHSE recognise that skin performance, due to extreme seasonal demand, is a wider problem that cannot be solved by the Trust alone. Although the Trust is now out of tiering, informal meetings will continue with a particular focus on skin.
- Breast Symptomatic – reduction in Radiology capacity has now been resolved, and plans are in place to resolve the backlog of patients.
- 62 day Gynae – new consultant posts are now in place and increased theatre capacity is being phased in with expected capacity expected to be operational by January 2026.
- 62 day Oesophageal – an existing consultant has been trained in Endoscopic mucosal resection (EMR) and a new EMR consultant has started - the positive impact on capacity is being seen.

# Diagnostics




| 6 Week Diagnostic Performance by Modality – July 2025 | | | |
|---|---|---|---|
| MRI | 16.0% | CT | 4.0% |
| Non-obs US | 9.1% | DEXA | 6.1% |
| Audiology | 17.6% | ECHO | 33.2% |
| Electrophysiology | 33.2% | Neurophysiology | 0.9% |
| Sleep Studies | 40.8% | Urodynamics | 41.4% |
| Colonoscopy | 16.9% | Flexi-Sig | 16.4% |
| Cystoscopy | 23.4% | Gastroscopy | 28.5% |
| **Newcastle Hospitals Total** | | | **13.1%** |

## Standards

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

## Current position:

- Performance against the 5% standard improved in July for the second successive month - 13.1% of patients were waiting over six weeks. Performance in Magnetic Resonance Imaging (MRI) and ECHO particularly improved. The target continues to be consistently failed but there is special cause variation of an improving nature after considerable improvement in 2024/25.
- Sleep Studies (59.2%) and Echo (33.2%) remain the areas with the most challenged performance. Echo have had IT issues which have prevented the service's Metrocentre Community Diagnostic Centre (CDC) capacity from being utilised.
- The waiting list decreased by 1,140 patients in July, with Non-obs Ultrasound, ECHO and Gastroscopy contributing most of this growth.
- There were 363 patients waiting >13 weeks at the end of July, which is a 33% reduction from June. MRI (175) have the most >13 week waiters.

## Action taken

- MRI have begun targeted work to significantly reduce the longest periods of downtime between scans – a recent assessment showed the average time between scans was 17 minutes, but that this is significantly exacerbated by the longest waits.
- Neuroradiology have used Acceleration Software to increase capacity by reducing scan times per patient. The service have also changed booking processes to reduce capacity lost through Did Not Attends (DNAs).
- Regular weekend Neuroradiology GA MRI lists are being run to address the >13 week waiters.
- Echo have worked with CDC and QE Gateshead staff to solve IT/Digital issues and consequently Newcastle Hospitals will be able to utilise CDC capacity for Echo patients from late August 2025.
- Echo are also undertaking focused waiting list validation and are improving validation processes.
- Endoscopy have successfully recruited staff to enable all rooms to be staffed more consistently.
- As well as improving DM01 compliance, Audiology are focusing on the next phases of their recovery plan such as reducing waiting lists for hearing aid fittings and reassessments. This will be enacted through numerous schemes including insourcing, weekend working and group clinics.
- A CDC Oversight Group has been established internally at the Trust to strengthen governance and ensure increased utilisation of capacity. A Joint Operations Group with Gateshead NHS Foundation Trust has also been refreshed, assessing real time delivery as well as future developments / provision.

# Contractual & Planning Standards (1/2)

| Theme | Standard | Trajectory (Jul-25) | Apr-25 | May-25 | Jun-25 | Jul-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 | 103.7% | 103.0% | 99.7% | **98.5%** | 11,965 | 12,152 | **101.1%** |
| Elective Overnight | | | 101.6% | 102.0% | 93.5% | **92.5%** | 1,850 | 2,001 | **97.1%** |
| Outpatient New | | | 101.1% | 100.6% | 101.2% | **98.6%** | 27,942 | 28,342 | **100.3%** |
| Outpatient Procedures | | | 99.1% | 97.1% | 96.3% | **97.6%** | 23,685 | 24,272 | **97.5%** |
| Outpatient Review | N/A | | 112.0% | 112.4% | 108.2% | **106.5%** | 71,296 | 66,938 | **109.6%** |
| Non-Elective | | | 86.5% | 86.2% | 91.2% | **93.5%** | 1,011 | 1,081 | **89.4%** |
| Emergency | | | 105.1% | 105.6% | 102.9% | **105.7%** | 6,479 | 6,128 | **104.8%** |
| Diagnostic Activity | **100%** of 25/26 Plan | N/A | 103.7% | 102.1% | 103.4% | **101.7%** | 24,249 | 23,844 | **102.7%** |
| PIFU Take-up (%) | >=**5%** of all OP atts. (by Mar-29) | **3.0%** | 2.6% | 2.5% | 2.7% | **2.7%** | 3,516 | 130,522 | **2.6%** |
| Day case rates (BADS procedures) | **85%** | N/A | 82.8% | **78.5%** | TBC | TBC | | | |
| Capped Theatre Utilisation | **85%** | N/A | 79.8% | 81.4% | 81.9% | **81.0%** | | | |
| Urgent Ops. Cancelled Twice | **Zero** | N/A | 0 | 0 | 0 | **0** | 0 | | **0** |
| Cancelled Ops. Rescheduled >28 Days | **Zero** | N/A | 5 | 3 | 2 | **5** | 5 | | **15** |
| **Elective Waits** | | | | | | | | | |
| RTT Waiting List Size | **Reduction** from 24/25 | **94,829** | 94,496 | 89,451 | 89,130 | **88,211** | 88,211 | | |
| RTT 18 Week Wait | **92%** | **71.7%** | 72.6% | 73.1% | 73.5% | **73.6%** | 64,941 | 88,211 | **73.2%** |
| >78 Week Waiters | **Zero** | **0** | 22 | 21 | 12 | **9** | 9 | | |
| >65 Week Waiters | **Zero** | **0** | 116 | 108 | 71 | **68** | 68 | | |
| >52 Week Waiters | **N/A** | **1139** | 1,521 | 1,455 | 1,307 | **1,275** | 1,275 | | |
| >52 Week Waiters (% of Total WL) | **<1% of total WL** (by Mar-26) | **1.2%** | 1.6% | 1.6% | 1.5% | **1.4%** | 1,275 | 88,211 | **1.5%** |
| >12 Week Waiters Validated | **90%** | N/A | 96.1% | 96.3% | 94.7% | **95.9%** | 21,807 | 22,729 | **95.8%** |
| Time to First Outpatient Appointment (18 Weeks) | **72%** (local target of **82.6%**) | **78.4%** | 78.3% | 79.0% | 78.8% | **79.6%** | 42,012 | 52,800 | **78.9%** |
| RTT Waiting List (Children & Young Persons <=18 yrs) | N/A | **12,517** | 13,445 | 13,224 | 12,538 | **12,330** | 12,330 | | |
| >52 Week Waits (Children & Young Persons <=18 yrs) | | **98** | 192 | 209 | 201 | **162** | 162 | | |
| Community Services Waiting List | N/A | N/A | 10,818 | 11,347 | 11,349 | **11,135** | 11,135 | | |
| Community Services >52 Week Waiters | | | 569 | 605 | 694 | **837** | 837 | | |
| Diagnostic 6 week wait | <=**5%** (local target of **<=11.4%**) | **9.0%** | 16.7% | 19.1% | 14.2% | **13.1%** | 1,787 | 13,651 | **15.8%** |

# Contractual & Planning Standards (2/2)

| Theme | Standard | Trajectory (Jul-25) | Apr-25 | May-25 | Jun-25 | Jul-25 | Num. | Den. | 25/26 YTD |
|---|---|---|---|---|---|---|---|---|---|
| **Cancer Care** | | | | | | | | | |
| 28 Day Faster Diagnosis | **80%** (by Mar-26) | **80.3%** | 81.4% | 80.8% | 78.1% | **74.2%** | 2,419 | 3,258 | **78.4%** |
| 31 Days (DTT to Treatment) | **96%** | **74.1%** | 79.6% | 76.9% | 81.1% | **87.3%** | 1,339 | 1,534 | **81.4%** |
| 62 Days (Referral to Treatment) | **75%** (by Mar-26) | **64.6%** | 72.2% | 69.5% | 63.8% | **71.2%** | 359 | 504 | **69.2%** |
| >62 Day Cancer Waiters | **N/A** | **N/A** | 106 | 137 | 135 | **137** | 137 | | |
| **Urgent & Emergency Care** | | | | | | | | | |
| A&E Arrival to Admission/Discharge (All types) | **>=78%** under 4 hours (by Mar-26) | **79.2%** | 75.2% | 79.1% | 77.5% | **79.3%** | 16,498 | 20,325 | **77.8%** |
| A&E Arrival to Admission/Discharge (Type 1) | **Reduction** from 24/25 | **2.0%** | 3.9% | 1.7% | 2.7% | **1.9%** | 242 | 12,588 | **2.5%** |
| A&E Decision to Admit to Admission >12 Hours | **Zero** over 12 hours | **N/A** | 85 | 26 | 48 | **28** | 28 | | **187** |
| Adult General & Acute Bed Occupancy | **<=92%** | **93.2%** | 89.9% | 88.4% | 90.1% | **87.3%** | 1,242 | 1,422 | **88.9%** |
| Ambulance Handovers <15 mins | **65%** | **N/A** | 45.5% | 43.3% | 47.6% | **44.4%** | 1,500 | 3,375 | **45.2%** |
| Ambulance Handovers <30 mins | **95%** | | 77.2% | 76.9% | 77.9% | **78.9%** | 2,664 | 3,375 | **77.8%** |
| Ambulance Handovers >60 mins | **Zero** | | 157 | 153 | 136 | **108** | 108 | | **554** |
| Urgent Community Response Standard | **>=70%** under 2 hours | **N/A** | 82.9% | 81.1% | 78.3% | **80.8%** | 274 | 339 | **81.0%** |
| **Safe, High Quality Care** | | | | | | | | | |
| Mixed Sex Acommodation Breach | **Zero** | **N/A** | 74 | 61 | 74 | **79** | 79 | | **288** |
| VTE Risk Assessment | **95%** | | 96.8% | 97.0% | 97.6% | **97.1%** | | | |
| Sepsis Screening Treat. (Emergency) | **>=90%** (of sample) under 1 hour | | **70.0%** | | | TBC | | | |
| Sepsis Screening Treat. (All) | | | **79.0%** | | | TBC | | | |

# People

# People Overview

| Metric | 12-month rolling | Actual | Target | Variation | Assurance |
|---|---|---|---|---|---|
| Sickness | Jul-25 | 5.60% | 4.5% | | F |
| *Short-term* | Jul-25 | 1.78% | | | |
| *Long term* | Jul-25 | 3.61% | | | |
| Turnover | Jul-25 | 8.47% | 10% | L | P |
| Mandatory training | Jul-25 | 93.00% | 90% | | P |
| Appraisal | Jul-25 | 86.15% | 90% | | F |
| Disabled staff | Jul-25 | 6.14% | | H | |
| Ethnicity (BAME staff) | Jul-25 | 18.14% | | H | |


## Staff in post

- Total is 15,845 Full Time Equivalent (FTE) including Bank/agency
- Total substantive is 15,397 FTE, 17,715 headcount
- Above substantive pre-Covid of 13,429 by 1,968 FTE (15%)
- Above substantive plan of 15,386 FTE by 11 FTE (0.07%)

## Sickness

- Top reasons for sickness: anxiety/stress/depression 34% (+2%); other musculoskeletal problems 11% (-2%); gastro problems 9% (no change)
- Short-term sickness change in July +0.02% to 1.78%
- Long term sickness change in July -0.03% to 3.61%

## Retention & Turnover

- Improved -0.11%. Top reason for leaving: retirement age ( 14.98%)
- Top destinations: no employment 40.28%; other NHS organisation 33.50% (includes retire-return)

## Mandatory training (MT) & Appraisal

- MT increase of 0.62%. Six courses are below target.
- Lowest is Medical and Dental, *increased* 1.74% to 84.04%
- Appraisal compliance Increased by 0.52%

## Bank & Agency

- Total annual non-medical bank expenditure £18.1m, +£1.15m vs 24/25
- Total annual non-medical agency expenditure £4.0m, -£0.46m vs 24/25
- Total annual medical agency expenditure £4.0m, -£0.46m vs 24/25.

## Equality & Diversity

- Disabled staff 6.14% (+0.06%). BAME staff up +0.06% to 18.14%

# Provider Workforce Return (PWR) – July 2025 overview

| 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 | 10,002.76 | 10,472.50 | 9,979.28 | 1,295.13 | -23.47 | -493.22 |
| 2. Total Non Medical - Non-Clinical Substantive Staff | 2,874.99 | 3,381.93 | 3,746.24 | 3,404.97 | 529.98 | 23.03 | -341.27 |
| 3. Total Medical and Dental Substantive Staff | 1,732.92 | 1,957.02 | 2,042.64 | 1,962.40 | 229.48 | 5.38 | -80.24 |
| 4. Any other Staff (substantive staff) | 146.48 | 44.10 | 6.16 | 49.90 | -96.58 | 5.80 | 43.74 |
| 5. Bank | 441.22 | 329.86 | | 415.55 | -25.67 | 85.69 | |
| 6. Agency | 60.38 | 53.79 | | 42.08 | -18.30 | -11.71 | |
| **Total** | **13,940.15** | **15,769.47** | **16,267.54** | **15,854.19** | **1,914.04** | **84.72** | **-870.99** |

## Current Position:

- The substantive workforce is 1,968 FTE (15%) above the January 2020 (pre-Covid) substantive position and 11 FTE (0.07%) above the 2025/26 workforce plan for substantive staff as-at July.
- NHS infrastructure support (substantive) is 23.03 FTE above plan.
- Bank is off plan.
- Agency is better than plan.
- Additional hours are being worked as overtime rather than Bank which is a more costly option.
- Overtime appears to be being used despite contract hours being unfilled.

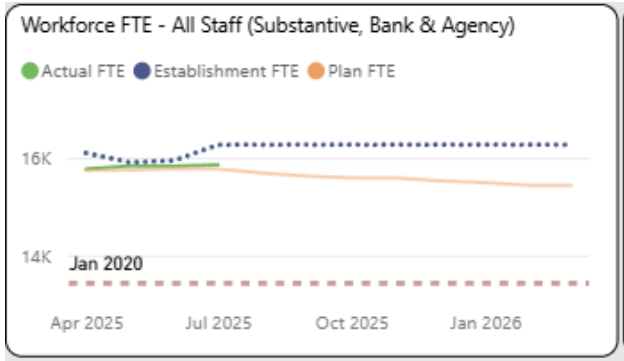
## Underlying Issues

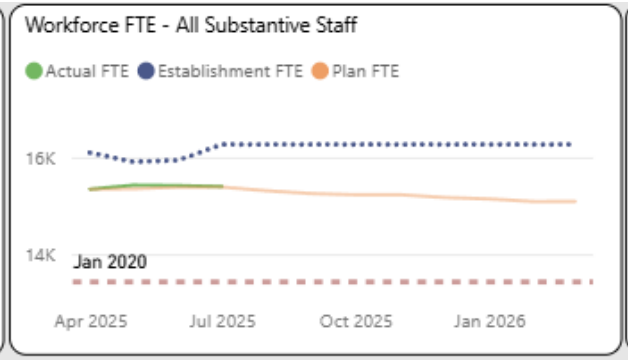
- Uptick in Bank use due to switching requirements for additional hours from overtime to Bank which is more cost effective.
- Need to maintain safe services (e.g. healthcare assistants (HCA) for enhanced care). Greater use being made of Bank options to reduce spend on agency.
- Practice of rostering staff may not be optimal in some areas. Potential need for some refresher training.

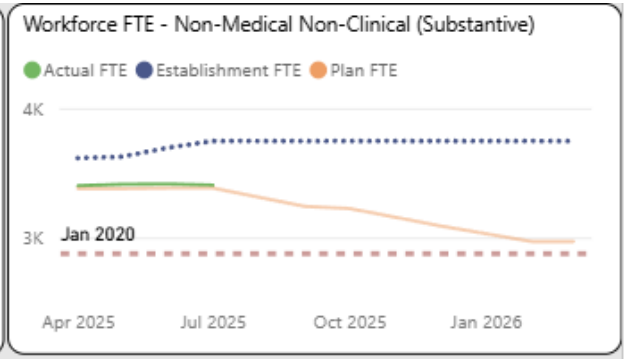
## Actions Undertaken:

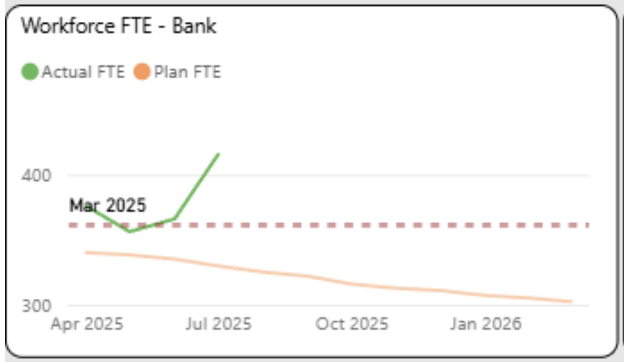
- Workforce plan for 2025/26 has total target reduction of 2% (320 FTE).
- Voluntary severance scheme will result in a workforce reduction of 50 (36.68 FTE) staff between 31 August and 3 November. 35 (70%) are admin and clerical.
- Greater scrutiny of vacancies and recruitment in place in all areas to reduce or delay spend wherever possible.
- Rate card shared with areas to show cost comparison per hour between additional basic hours, Bank and overtime. Where additional hours are required, areas are using additional basic hours and/or switching from overtime to Bank wherever possible to keep costs down.
- Allocate Team and managers looking at rostering data from July to understand the situation and resolve any issues.

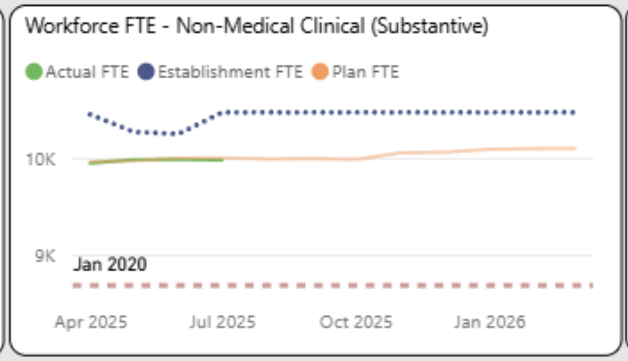
# PWR – in-year overview position

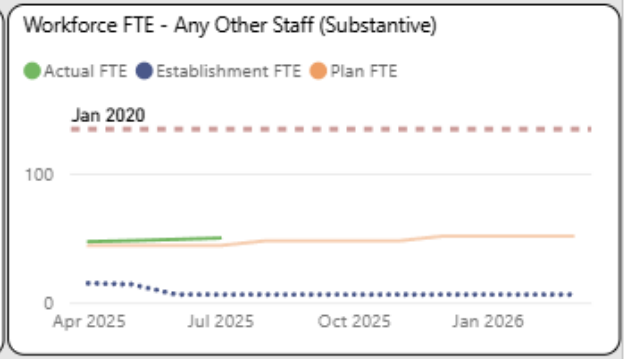


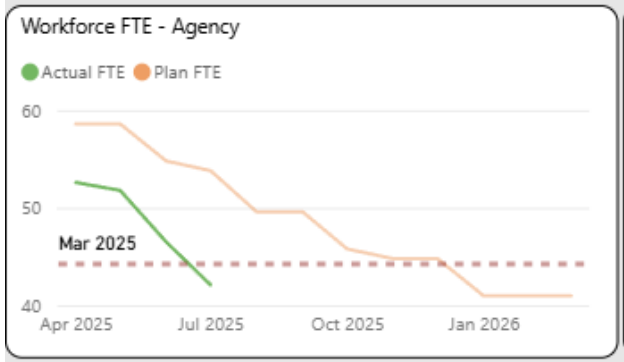



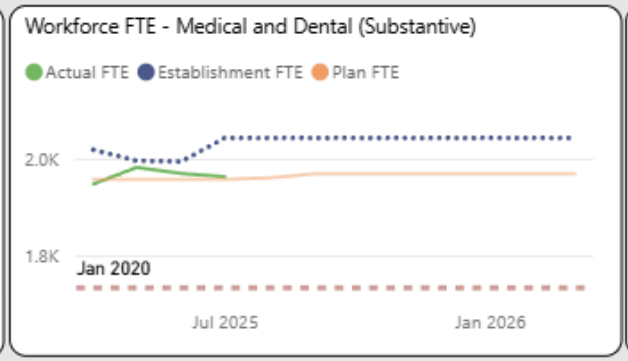



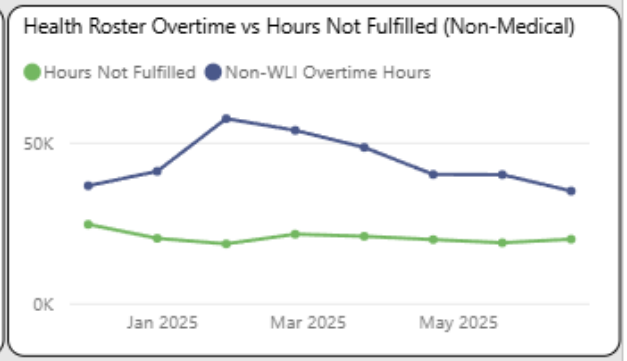



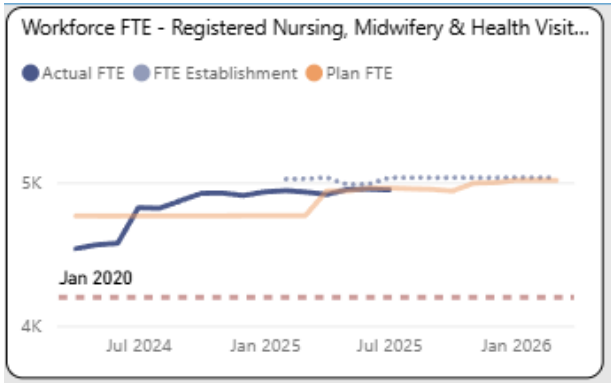



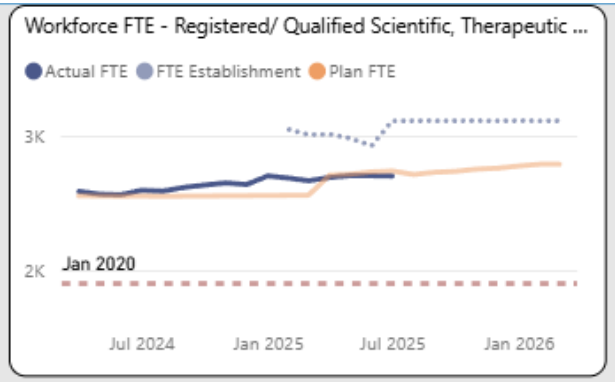

**Please note: The charts on this page include LET data

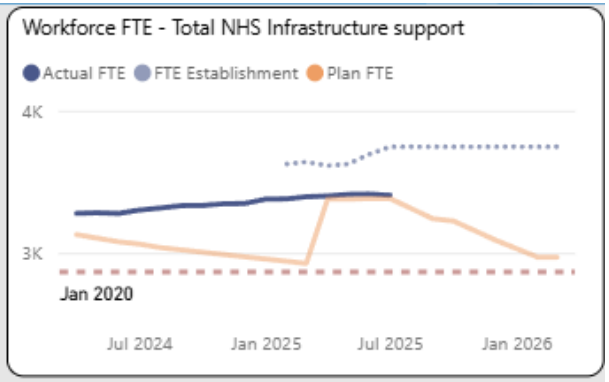
# PWR – July 2025 staff group overview

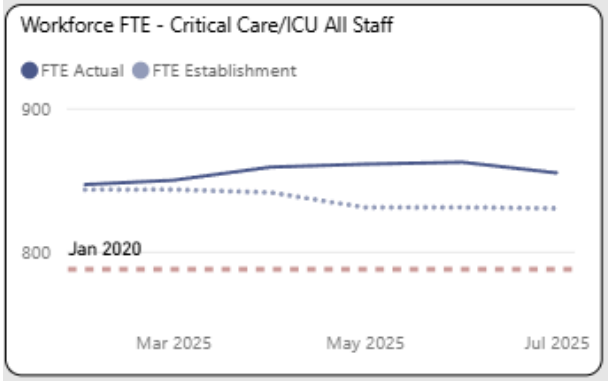
| Sub Categories Metric | Jan 2020 FTE | Plan FTE | Establishment | Current FTE | Current FTE v Jan 2020 | Current FTE v Plan | Current FTE v Establishment |
|---|---|---|---|---|---|---|---|
| 1. Registered Nursing, Midwifery and Health visiting staff (substantive total) | 4,202.08 | 4,960.41 | 5,032.70 | 4,947.84 | 745.77 | -12.57 | -84.86 |
| 2. Registered/ Qualified Scientific, Therapeutic and Technical Staff (substantive total) | 1,993.02 | 2,368.94 | 2,555.78 | 2,350.49 | 357.47 | -18.45 | -205.29 |
| 3. Support to Clinical staff (substantive total) | 2,489.06 | 2,673.40 | 2,884.02 | 2,680.95 | 191.90 | 7.55 | -203.07 |
| 4. Total NHS Infrastructure Support (includes A&C, estates, managers) (substantive total) | 2,874.99 | 3,381.93 | 3,746.24 | 3,404.97 | 529.98 | 23.03 | -341.27 |
| 5. Total Medical and Dental (substantive total) | 1,732.92 | 1,957.02 | 2,042.64 | 1,962.40 | 229.48 | 5.38 | -80.24 |
| 6. Any other Staff (substantive total) | 146.48 | 44.10 | 6.16 | 49.90 | -96.58 | 5.80 | 43.74 |
| 7. Bank Any other staff | 0.00 | 0.00 | | | 0.00 | 0.00 | |
| 7. Bank Medical and dental | 11.75 | 16.48 | | 64.47 | 52.72 | 47.99 | |
| 7. Bank Registered nursing, midwifery and health visiting staff | 111.27 | 83.84 | | 105.36 | -5.91 | 21.52 | |
| 7. Bank Registered/ Qualified Scientific, Therapeutic and Technical staff | 16.41 | 11.98 | | 12.02 | -4.39 | 0.04 | |
| 7. Bank Support to clinical staff | 258.10 | 187.96 | | 207.55 | -50.55 | 19.59 | |
| 7. Bank Total NHS infrastructure support | 43.69 | 29.60 | | 26.16 | -17.53 | -3.44 | |
| 8. Agency Any other staff | 0.00 | 0.00 | | | 0.00 | 0.00 | |
| 8. Agency Medical and dental | 0.87 | 7.78 | | 7.56 | 6.69 | -0.22 | |
| 8. Agency Registered nursing, midwifery and health visiting staff | 2.86 | 4.53 | | 3.50 | 0.64 | -1.03 | |
| 8. Agency Registered scientific, therapeutic and technical staff | 17.27 | 7.16 | | 6.43 | -10.84 | -0.73 | |
| 8. Agency Support to clinical staff | 23.68 | 33.10 | | 24.59 | 0.91 | -8.51 | |
| 8. Agency Total NHS infrastructure support | 15.70 | 1.22 | | | -15.70 | -1.22 | |
| **Total** | **13,940.15** | **15,769.47** | **16,267.54** | **15,854.19** | **1,914.04** | **84.72** | **-870.99** |

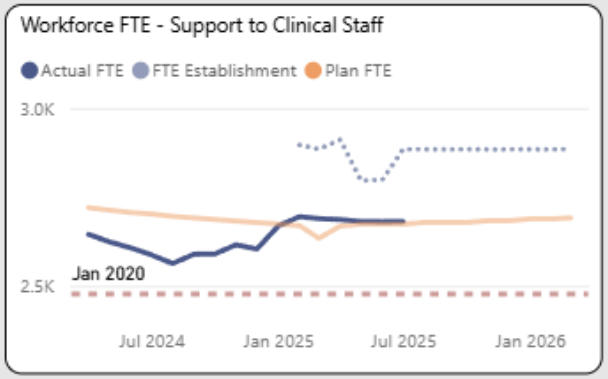
# PWR – staff group overview in-year position

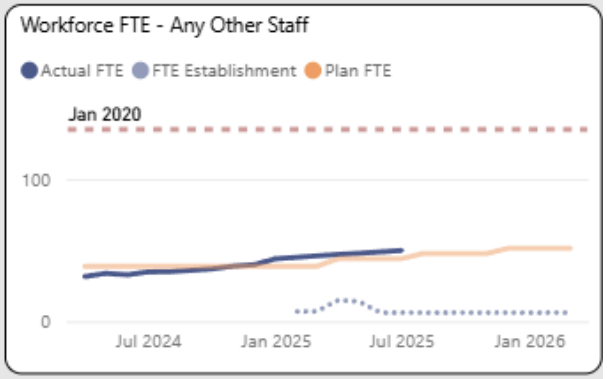


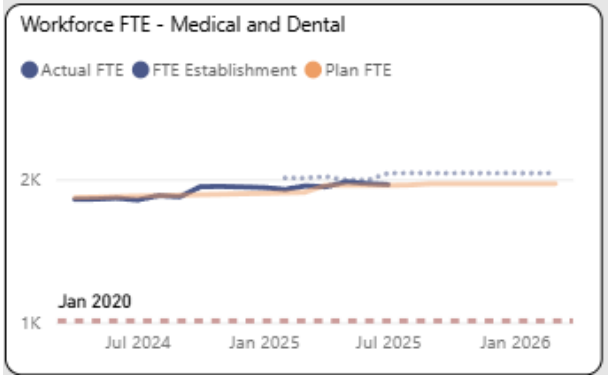




**Please note: The charts on this page include LET data

# PWR – Vacancies

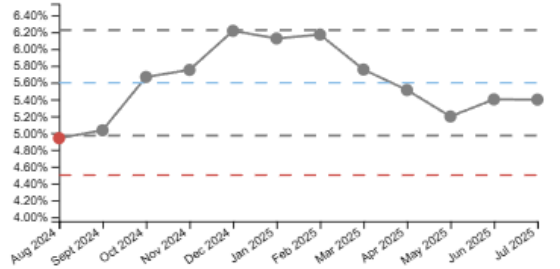
| Summary Group | FTE Establishment | Actual FTE | Vacancy FTE | Vacancy FTE % |
|---|---|---|---|---|
| 2. Total Non Medical - Non-Clinical Substantive Staff | 3746.24 | 3403.97 | 342.27 | 9.14% |
| 1. Total Non Medical - Clinical Substantive Staff | 10472.50 | 9977.28 | 495.22 | 4.73% |
| 3. Medical and Dental | 2042.64 | 1960.40 | 82.24 | 4.03% |
| 5. Other | 6.16 | 49.90 | -43.74 | -710.06% |
| **Total** | **16267.54** | **15391.55** | **875.99** | **5.38%** |

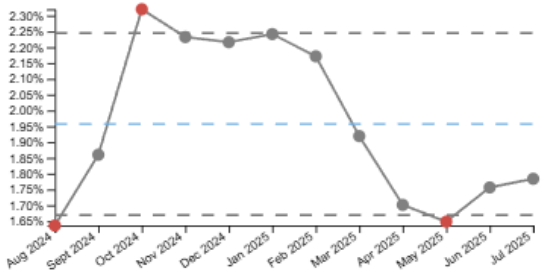
# Sickness absence – 12-month average

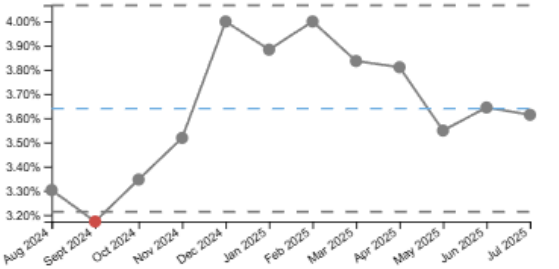
| Trust Sickness % | 12-Month Rolling | Value | Target |
|---|---|---|---|
| | Jul 25 | 5.60% | 4.50% |

| Metric | Value |
|---|---|
| Short Term Sickness % | 1.78% |

| Metric | Value |
|---|---|
| Long Term Sickness % | 3.61% |




## Current Position:

- Top reasons for sickness:
  - Anxiety/stress/depression (S10) 33.91%
  - Other musculoskeletal problems (S12) 11.30%
  - Gastrointestinal problems (S25) 9.33%
- Latest available sickness absence data for Trusts in North East North Cumbria (NENC) (May 2025) showed this Trust had the second lowest rate at 5.2%. The lowest was Gateshead at 4.9%; the highest was Cumbria, Northumberland, Tyne and Wear at 6.5%; average was 5.6%.
- The 12-month rolling absence rate of 5.6% and the sick pay cost of £32.9m are significantly above the target of 5% and £25m respectively.

## Underlying Issues

- Anxiety/stress/depression (S10) is main reason for sickness absence. Some is work-related and some is due to issues outside of work.
- Total days lost: 296,150 FTEs.
- Average time lost per person: 20 days.
- Total cost of sick pay: £32.9m.
- Variation in sickness rates across Clinical Boards:
  - Lowest – Clinical and Diagnostic Services at 4.43% (short-term 1.47%, long term 2.39%)
  - Highest – Peri-operative and Critical Care at 6.54% (short-term 1.98%, long term 4.71%)

## Actions Undertaken:

- Health and Wellbeing offer – funding from Charities for staff psychology service for two years and reintroduce Mental Health First Aiders.
- Occupational Health. On-line service live for early access referrals, management referrals and self-referrals. Developing a PowerBI dashboard.
- Sickness. Target reductions in place this year:
  - sickness absence -0.5% (to 5%)
  - sick pay -£5m (to £25m)
- Accountability – monthly performance reviews held with Clinical Boards; monthly meetings held between HR and Clinical Boards/Corporate Services. All areas focussed on supporting staff and reducing sickness absence.

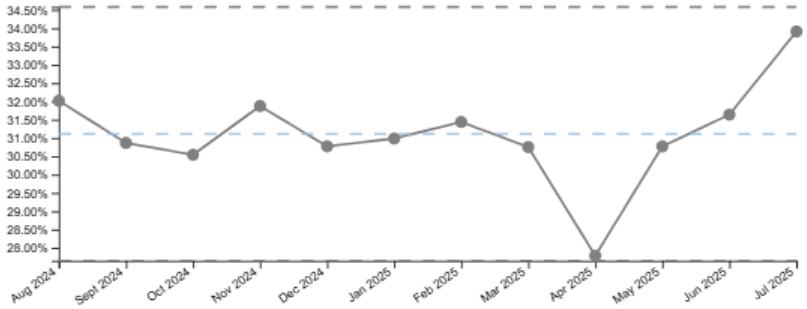
# Sickness absence – top absence reasons

| Trust Sickness % | 12-Month Rolling | Value | Target |
|---|---|---|---|
| | Jul 25 | 5.60% | 4.50% |

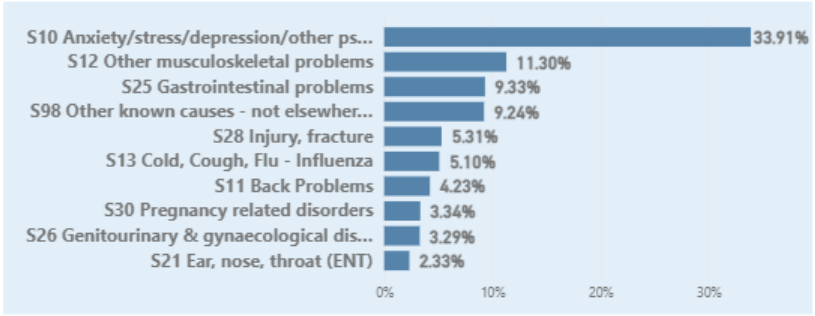
## Sickness Reasons - SPC

### S10 - Anxiety/stress/depression/ other psychiatric illness

33.91%

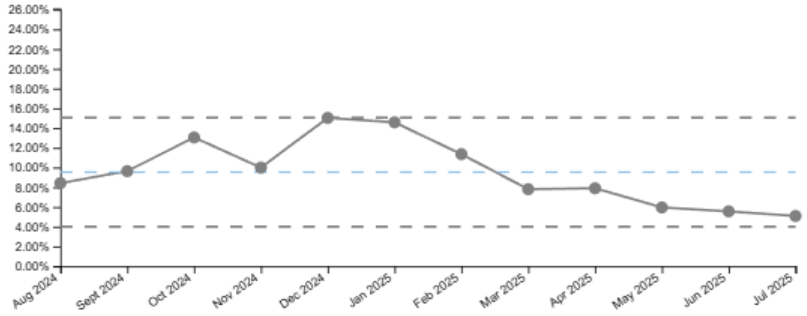



### Top 10 Sickness Abscences



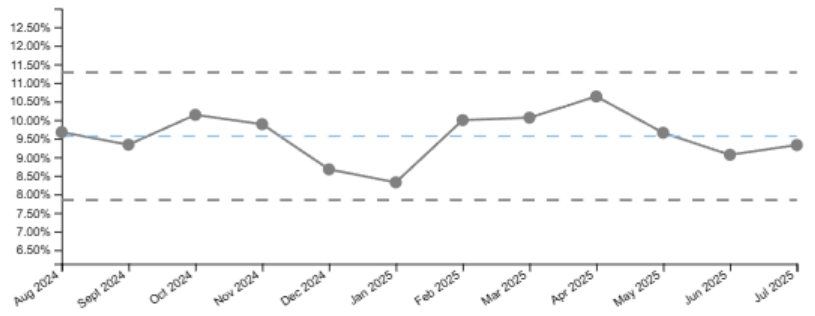

### S12 - Other musculoskeletal problems

11.30%

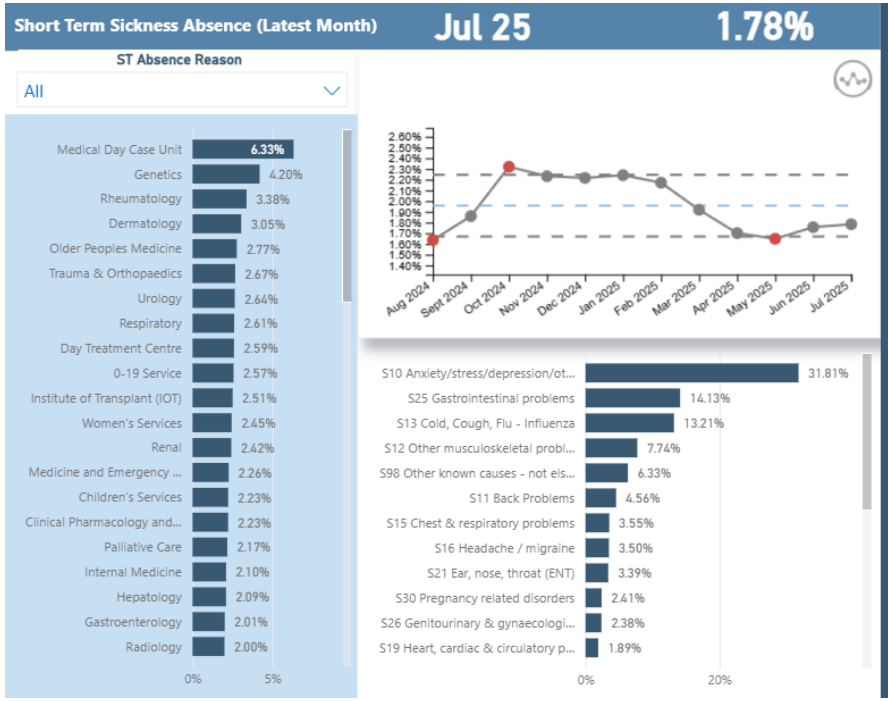


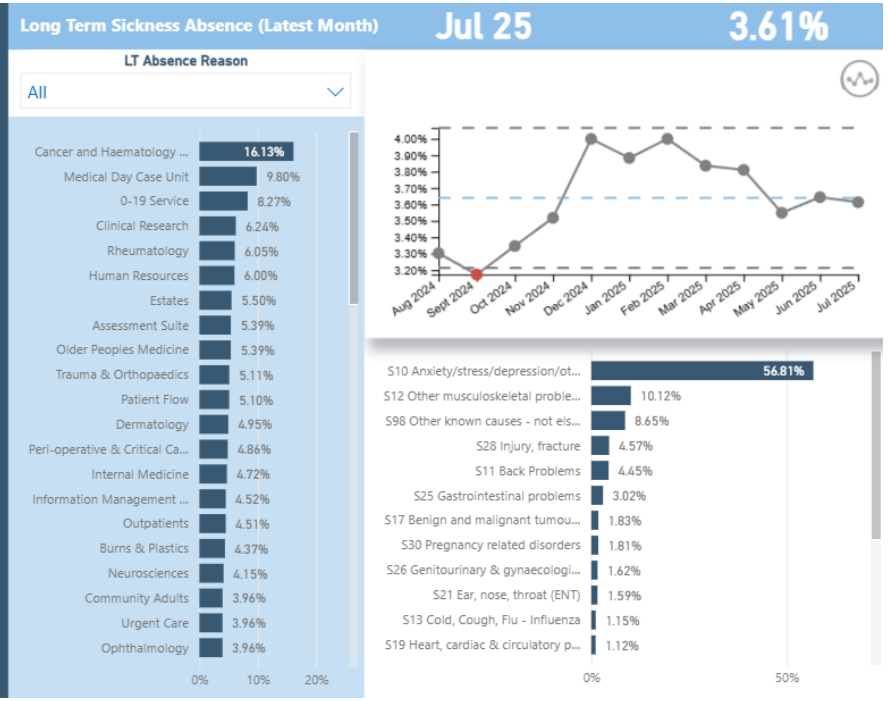

### S25 - Gastrointestinal problems

9.33%



# Sickness absence – short & long term analysis by Clinical Board (CB)/Corporate Services (CS) & reason



# Sickness – FTE working days lost & formal action activity

## Sickness - FTE working days lost

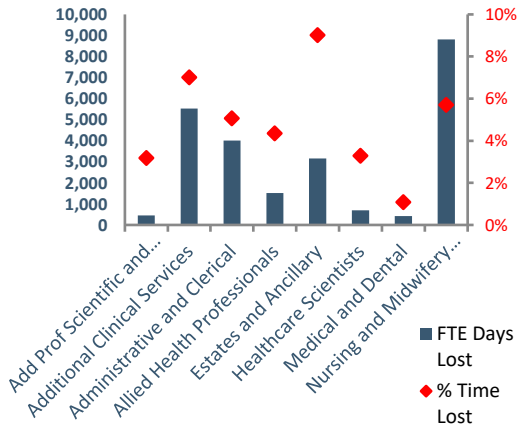
FTE working days lost due to sickness

**297,438**

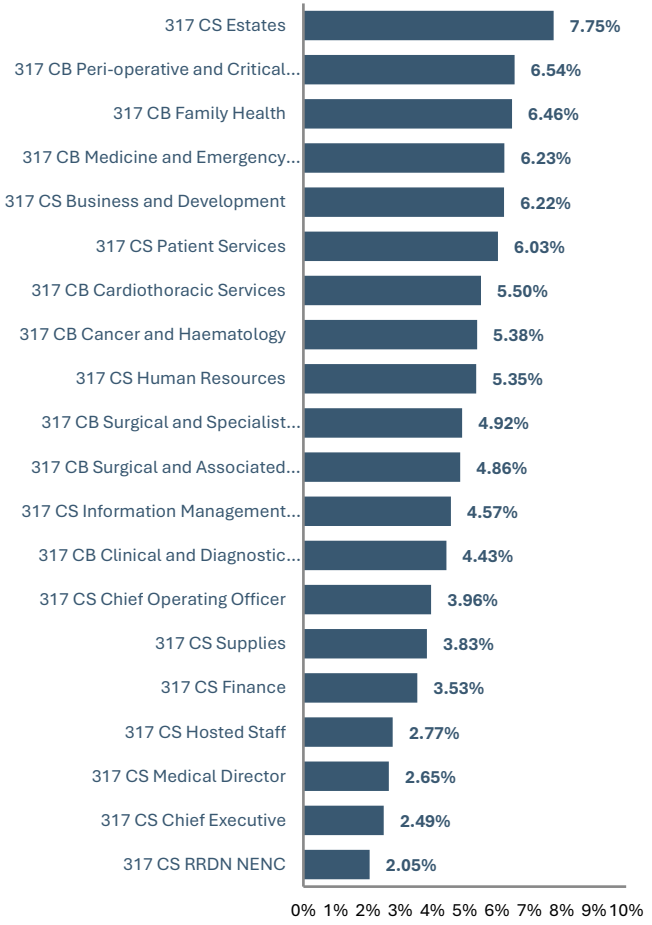
**277,198**

compared to the previous year.

### Sickness Absence by Staff Group



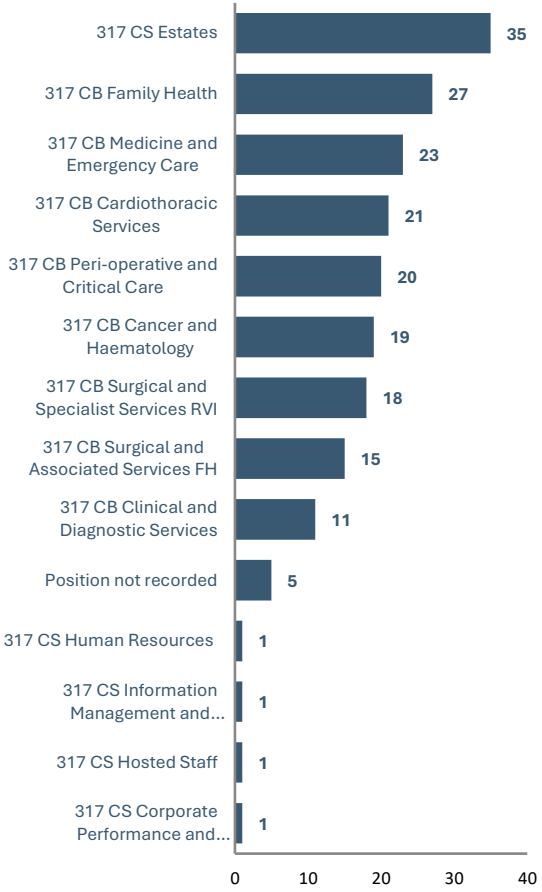

### Sickness Absence (% Time Lost) by Clinical Board




## Sickness - Formal Action

Latest Data - June 2025

### Attendance Management – Formal Action by Clinical Board/ Corporate Service

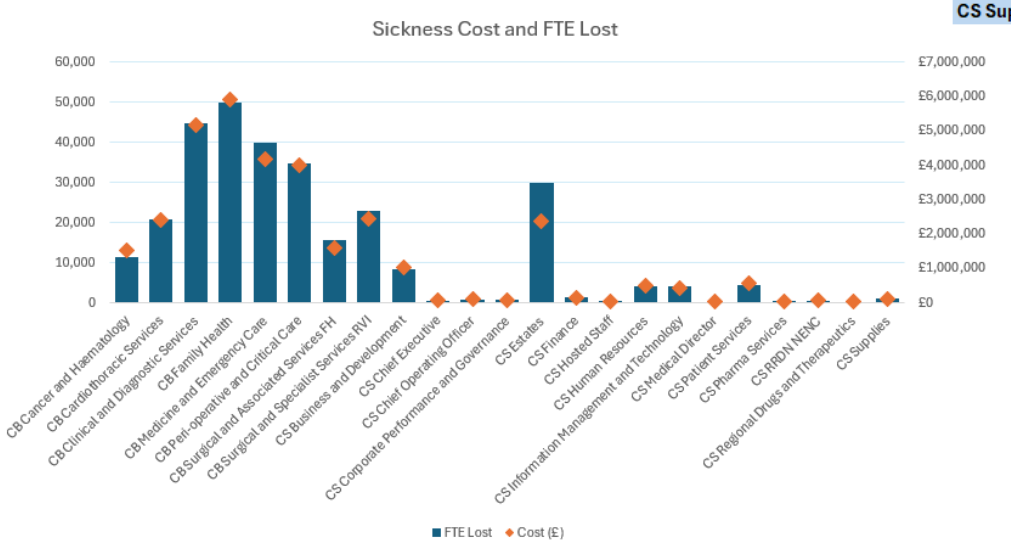


# Sickness – FTE working days lost & cost of sick pay

| Sickness Absence | 12-Month period ending | Cost (£) | FTE Lost | Ave. No of Days Lost per FTE |
|---|---|---|---|---|
| | Jul 25 | £32,917,347 | 297,437.87 | 20.37 |

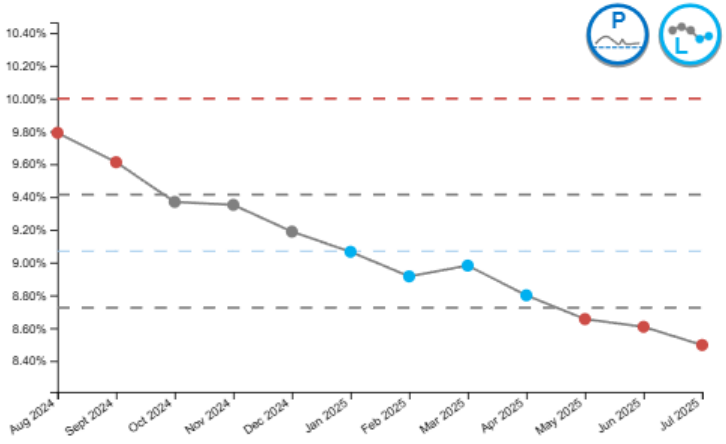
| Clinical Board | Cost (£) | FTE Lost | Ave. No of days lost per FTE |
|---|---|---|---|
| CB Cancer and Haematology | 1,513,460 | 11,537.81 | 19.47 |
| CB Cardiothoracic Services | 2,420,726 | 20,841.88 | 19.94 |
| CB Clinical and Diagnostic Services | 5,169,594 | 44,595.40 | 16.12 |
| CB Family Health | 5,920,772 | 49,760.06 | 23.46 |
| CB Medicine and Emergency Care | 4,159,658 | 39,834.61 | 22.43 |
| CB Peri-operative and Critical Care | 3,998,222 | 34,679.04 | 24.00 |
| CB Surgical and Associated Services FH | 1,614,089 | 15,642.21 | 17.53 |
| CB Surgical and Specialist Services RVI | 2,449,491 | 22,798.08 | 18.07 |

| Clinical Board | Cost (£) | FTE Lost | Ave. No of days lost per FTE |
|---|---|---|---|
| CS Business and Development | 1,048,418 | 8,512.86 | 21.68 |
| CS Chief Executive | 77,712 | 518.33 | 7.59 |
| CS Chief Operating Officer | 104,109 | 876.13 | 14.14 |
| CS Corporate Performance and Governance | 89,268 | 832.19 | 10.81 |
| CS Estates | 2,357,588 | 29,967.96 | 28.16 |
| CS Finance | 162,467 | 1,433.41 | 12.93 |
| CS Hosted Staff | 31,493 | 395.89 | 10.29 |
| CS Human Resources | 493,204 | 4,025.45 | 19.49 |
| CS Information Management and Technology | 430,606 | 4,016.67 | 17.27 |
| CS Medical Director | 49,526 | 327.55 | 9.67 |
| CS Patient Services | 563,037 | 4,314.84 | 22.08 |
| CS Pharma Services | 35,345 | 532.90 | 10.58 |
| CS Regional Drugs and Therapeutics | 54,953 | 320.90 | 9.95 |
| CS RRDN NENC | 69,269 | 458.19 | 7.56 |
| CS Supplies | 104,339 | 1,215.49 | 13.32 |

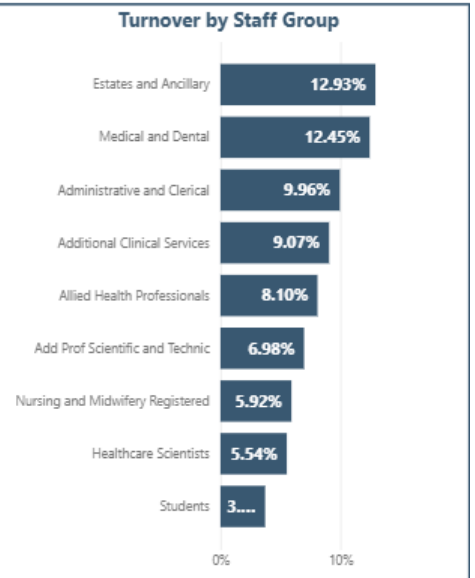


# Turnover (1/2)

| Trust Turnover % | 12-Month Rolling | Value | Target |
|---|---|---|---|
| | Jul 25 | 8.47% | 10.00% |








## Current Position:

- All Clinical Boards are performing better than target.
- Exit questionnaire response rate 20%.
- Main reasons for staff leaving to a local Trust in last 12 months are promotion, work-life balance and relocation.
- Percentage of leavers to local Trusts in last 12 months: Northumbria 5.20% (61.68 FTE); S Tyne/Sunderland 2.52% (29.87 FTE); Gateshead 1.63% (19.37 FTE).
- Percentage of recruits from local Trusts in last 12 months: Northumbria 4.43% (76.27 FTE); Gateshead 2.67% (46.03 FTE); S Tyne/Sunderland 1.16% (20.03 FTE).

## Underlying Issues

- 1,419 leavers in 12-months to June 2025: 23% Nursing & Midwifery (327), 20% Administrative and Clerical (272).
- Top destinations – no employment (572, 40%); Other NHS organisation (476, 31%).
- Top reasons – retirement age (212, 15%); relocation (203, 14%); work-life balance (189, 13%).

## Actions Undertaken:

- Flexible working. Supported and encouraged across the Trust. Over 98% of applications are approved.
- Monitoring – daily information available to managers via People Dashboard; monthly performance reviews held with Clinical Boards; monthly meetings held between HR and Clinical Boards/Corporate Services.

# Turnover (2/2)

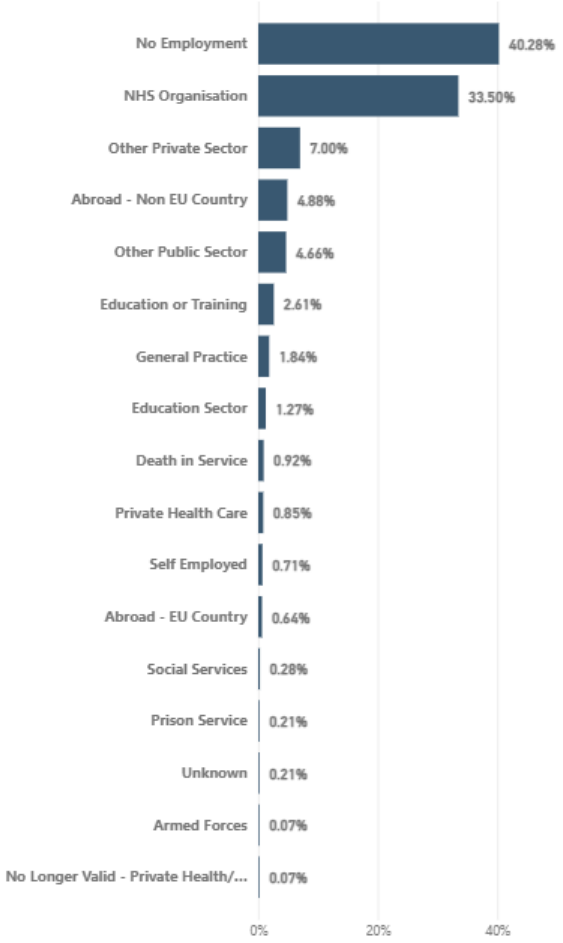
| Trust Turnover % | 12-Month Rolling | Value | Target |
|---|---|---|---|
| | Jul 25 | 8.47% | 10.00% |

## Leaving Reasons

### Leaving Reasons

| Leaving Reason | Leaving Reason % |
|---|---|
| Retirement Age | 14.98% |
| Voluntary Resignation - Relocation | 14.35% |
| Voluntary Resignation - Work Life Balance | 13.36% |
| Voluntary Resignation - Promotion | 9.82% |
| Flexi Retirement | 9.40% |
| Voluntary Resignation - Health | 6.78% |
| End of Fixed Term Contract | 6.64% |
| Voluntary Resignation - To undertake further education or training | 3.96% |
| Voluntary Resignation - Incompatible Working Relationships | 3.89% |
| Voluntary Resignation - Lack of Opportunities | 2.26% |
| Voluntary resignation - Pay and Reward Related | 2.05% |
| Dismissal - Capability | 1.98% |
| End of Fixed Term Contract - Other | 1.63% |
| Voluntary Resignation - Child Dependants | 1.55% |
| End of Fixed Term Contract - Completion of Training Scheme | 1.13% |
| Death in Service | 0.99% |
| Voluntary Resignation - Other/Not Known | 0.99% |
| Retirement - Ill Health | 0.78% |
| Voluntary Early Retirement - with Actuarial Reduction | 0.78% |
| Voluntary Early Retirement - no Actuarial Reduction | 0.57% |
| Redundancy - Compulsory | 0.49% |
| Voluntary Resignation - Adult Dependants | 0.49% |
| Dismissal - Conduct | 0.35% |
| Dismissal - Statutory Reason | 0.21% |
| End of Fixed Term Contract - End of Work Requirement | 0.21% |
| End of Fixed Term Contract - External Rotation | 0.21% |
| Bank Staff not fulfilled minimum work requirement | 0.07% |
| Redundancy - Voluntary | 0.07% |

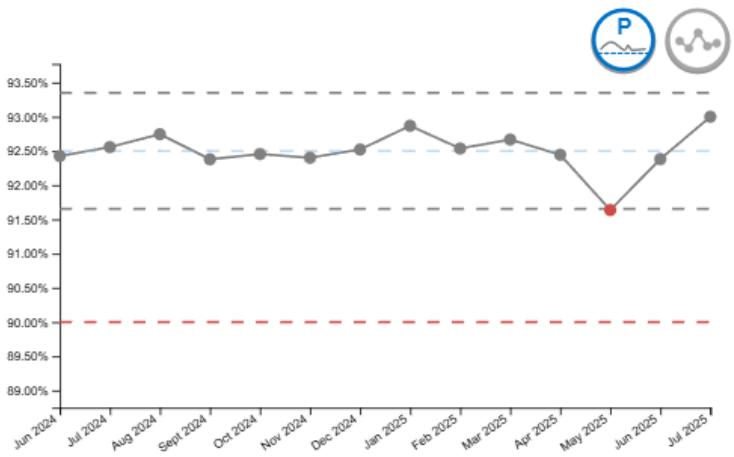
### Destination on Leaving

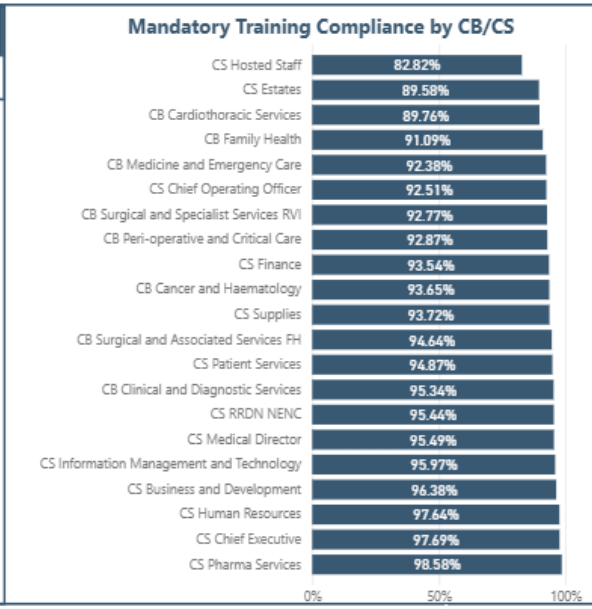


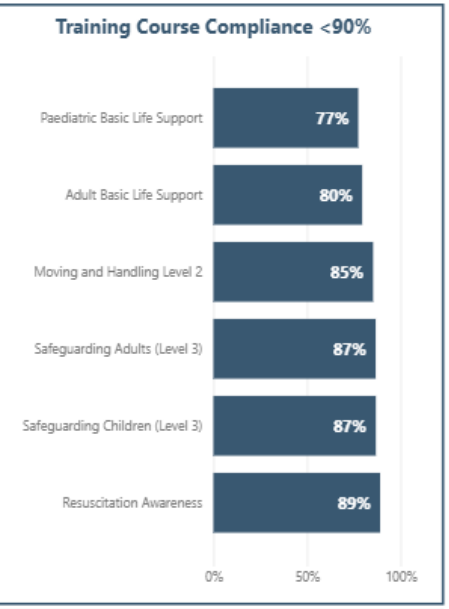

| Destination On Leaving | Destination On Leaving % |
|---|---|
| No Employment | 40.28% |
| NHS Organisation | 33.50% |
| Other Private Sector | 7.00% |
| Abroad - Non EU Country | 4.88% |
| Other Public Sector | 4.66% |
| Education or Training | 2.61% |
| General Practice | 1.84% |
| Education Sector | 1.27% |
| Death in Service | 0.92% |
| Private Health Care | 0.85% |
| Self Employed | 0.71% |
| Abroad - EU Country | 0.64% |
| Social Services | 0.28% |
| Prison Service | 0.21% |
| Unknown | 0.21% |
| Armed Forces | 0.07% |
| No Longer Valid - Private Health/Social Care | 0.07% |

# Mandatory training (1/2)

| Mandatory Training Compliance | Month | Value | Target |
|---|---|---|---|
| | Jul 25 | 93.00% | 90.00% |




## Current Position:

- Overall target is consistently met.
- Certain areas, staff groups and courses are below target.
- 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 2025 which supports statutory training requirements and sets clear standards for CQC-registered providers.

## Underlying Issues

- Medical and Dental – have lowest overall compliance (84.04%) with low compliance in Moving and Handling Level 2 (50%); Paediatric Basic Life support (60.94%); Adult Basic Life Support (62.92%).
- Face-to-face training can take more time away from work compared to online.
- Performance looked at as part of Well-led domain.
- QI approach to improve resus compliance had limited impact.
- Oliver McGowan. Trust expected to show CQC how it has met legal requirements.

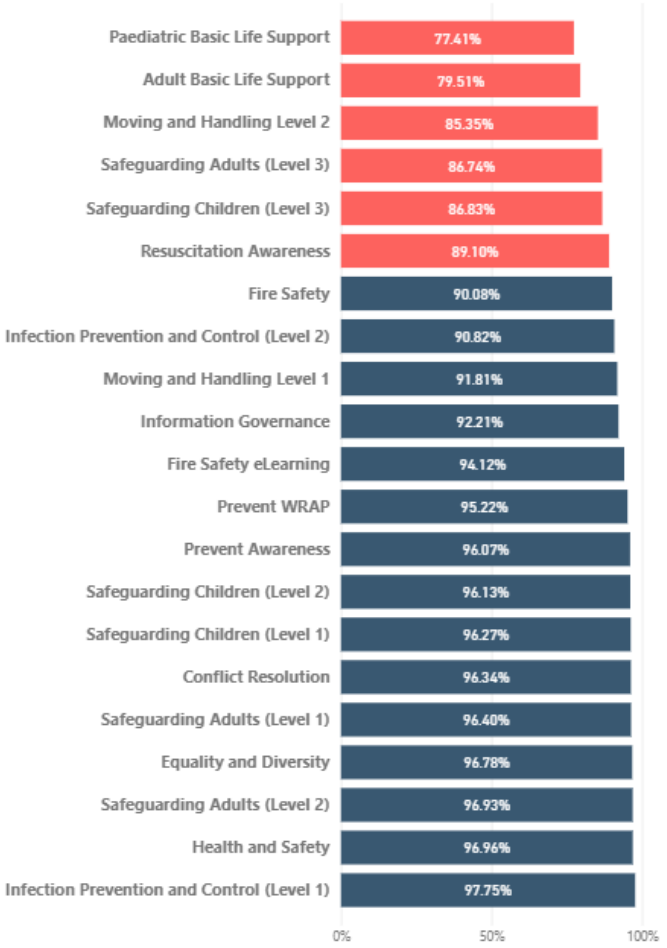
## Actions Undertaken:

- Resus. Further engagement with corporate nursing team to increase clinical oversight of delivery. Work continues to develop alternative approaches e.g. taking training into clinical areas, use of In Situ simulation.
- Adult and children's safeguarding. Training to be amalgamated in a joint package at all levels in line with national review. A further redesign of e-learning packages now required.
- Oliver McGowan. Plan to introduce training for new recruits as phase 1 of roll-out by Quarter 4. Further phases to be identified and implemented following evaluation of phase 1.

# Mandatory training (2/2)

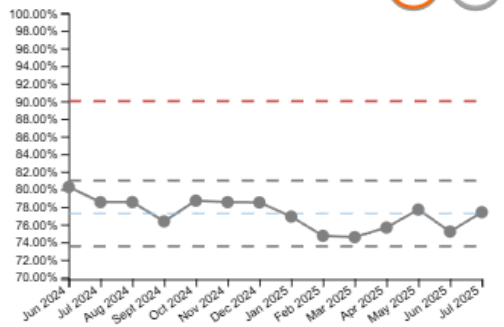
| Mandatory Training Compliance | Month | Value | Target |
|---|---|---|---|
| | Jul 25 | 93.00% | 90.00% |

## Training Course Compliance %

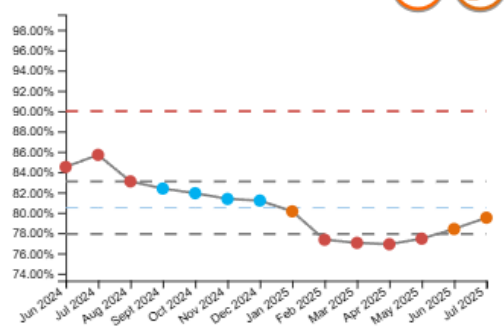



## Lowest 4 Mandatory Training Compliance %

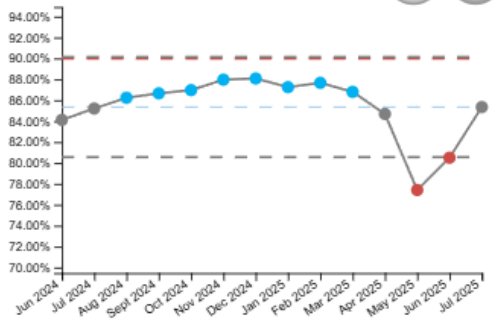
### Paediatric Life Support 77%



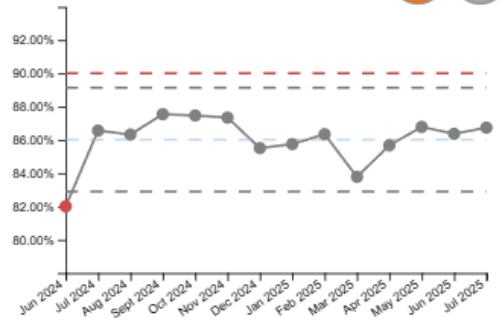

### Adult Life Support 80%




### Moving and Handling Level 2 85%

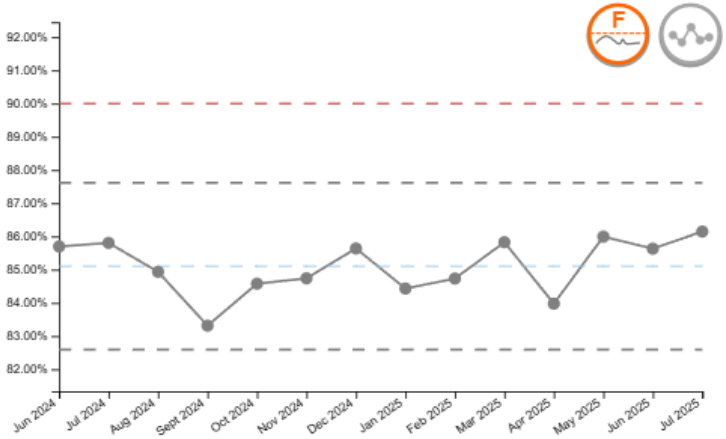


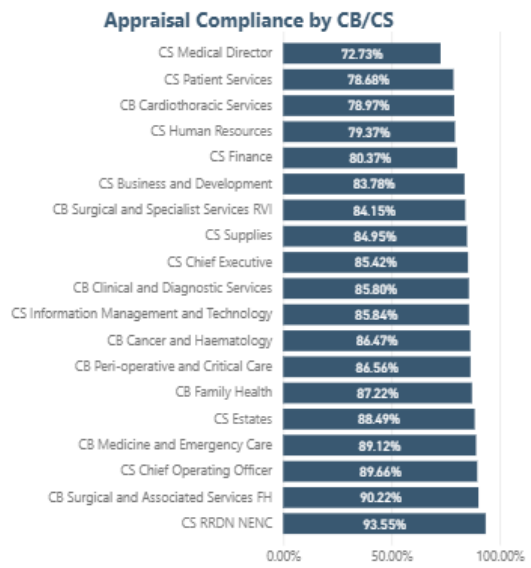

### Safeguarding Adults Level 3 87%

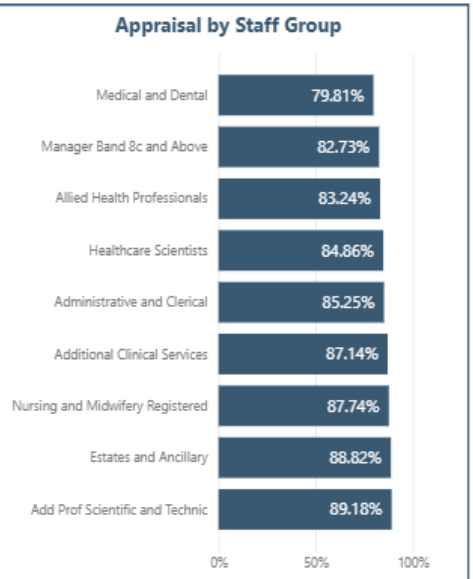


# Appraisal compliance

| Appraisal Compliance | Month | Value | Target |
|---|---|---|---|
| | Jul 25 | 86.15% | 90.00% |




| Current Position: | Underlying Issues | Actions Undertaken: |
|---|---|---|
| • Overall performance is consistently below target.<br>• All but one area has not met the target. | • 1,932 appraisals are overdue with highest numbers in Nursing and Midwifery (568) and Admin and Clerical (349).<br>• Clinical Board performance varies between 78.97% (Cardiothoracic Services) to 90.22% (Surgical and Associated Services).<br>• Corporate Service performance varies between 72.73% (Medical Director) to 93.55% (Regional Research Delivery Network).<br>• Compliance impacted by time and capacity of managers and staff. | • Accountability – monthly performance reviews held with Clinical Boards; monthly meetings held between HR and Clinical Boards/Corporate Services.<br>• All areas focussed on improving compliance. |

# Bank use (£) – non-medical

| Bank Utilisation (£) | 12-Month period ending | Total Bank Expenditure (£) | Total Bank Difference (£) |
|---|---|---|---|
| | Jul 25 | £18,076,424 | +£1,146,446 |

## Bank Utilisation (£)

| Staff Group | Aug 23 - Jul 24 | Aug 24 - Jul 25 | Difference |
|---|---|---|---|
| Admin & Clerical | £1,162,533 | £1,136,895 | -£25,638 |
| Ancillary | £284,348 | £330,947 | £46,599 |
| Estates | | | £0 |
| Nursing & Midwifery (Registered) | £5,577,355 | £5,321,804 | -£255,551 |
| Nursing & Midwifery (Unregistered) | £9,034,315 | £10,539,267 | £1,504,952 |
| Professional & Technical | £871,427 | £747,512 | -£123,915 |
| Total | £16,929,978 | £18,076,424 | £1,146,446 |

### Current Position:

- Cost of Bank has increased for Nursing & Midwifery (N&M) unregistered due to service need for enhanced care.
- Ancillary increase is due to challenges from turnover, vacancies and sickness absence.

### Underlying Issues

- N&M unregistered increase due to service need for enhanced care.
- Ancillary increase due to challenges from turnover, vacancies and sickness absence.
- Additional hours are being worked as overtime rather than Bank which is a more costly option.

### 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 Health Care Assistants (HCAs) for enhanced care.
- Rate card shared with areas to show cost comparison per hour between additional basic hours, Bank and overtime. Where additional hours are required, areas are using additional basic hours and/or switching from overtime to Bank wherever possible to keep costs down.

# Agency use (£) – non-medical

| Agency Utilisation (£) | 12-Month period ending | Total Agency Expenditure (£) | Total Agency Difference (£) |
|---|---|---|---|
| | Jul 25 | £3,509,993 | -£461,947 |

## Agency Utilisation (£)

| Staff Group | Aug 23 - Jul 24 | Aug 24 - Jul 25 | Difference |
|---|---|---|---|
| Admin & Clerical | £540,094 | £150,639 | -£389,455 |
| Ancillary | £14,918 | £6,499 | -£8,418 |
| Estates | £45,372 | £30,869 | -£14,502 |
| Nursing & Midwifery (Registered) | £118,461 | £722,647 | £604,186 |
| Nursing & Midwifery (Unregistered) | £2,390,003 | £1,395,271 | -£994,732 |
| Professional & Technical | £863,093 | £1,204,068 | £340,974 |
| Total | £3,971,940 | £3,509,993 | -£461,947 |

**Current Position:**

- Costs reduced by c. £0.5m on previous year.
- Notable reductions in Nursing & Midwifery (unregistered) and Admin & Clerical.

**Underlying Issues**

- 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.
- Reduced agency use of HCAs for enhanced care shifts by switching to Bank.

# Agency use (£) – medical

| Agency Utilisation (£) | 12-Month period ending | Total Agency Expenditure (£) | Total Agency Difference (£) |
|---|---|---|---|
| | Jul 25 | £4,377,555 | +£1,559,363 |

## Agency Utilisation (£)

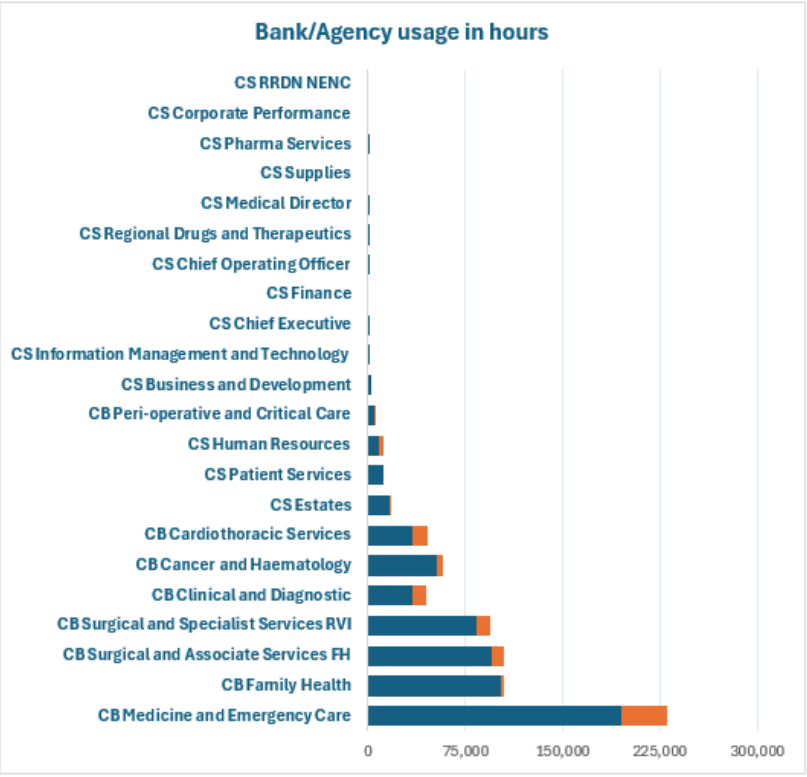
| Staff Group | Aug 23 - Jul 24 | Aug 24 - Jul 25 | Difference |
|---|---|---|---|
| Medical - Consultant | £2,380,842 | £4,306,153 | £1,925,311 |
| Agency - Career / Staff Grades | £90,894 | -£5,731 | -£96,626 |
| Medical - Registrar & Senior Registrar | £277,955 | £1,140 | -£276,815 |
| Medical - SHO'S and HO'S | £68,034 | £71,033 | £2,998 |
| General Practitioner | £466 | £4,961 | £4,495 |
| Total | £2,818,192 | £4,377,555 | £1,559,363 |

| Current Position: | Underlying Issues | Actions Undertaken: |
|---|---|---|
| • Costs increased by c. £1.6m on previous year.<br>• Notable reductions in Career/Staff Grades and Registrar/Snr Registrar.<br>• Significant increase in Consultant spend.<br>• Consultants collectively working an average of 1,100 hours per month. | • Consultant spend. Staffing issues in Older People's Medicine and Stroke; off-framework arrangement in Paediatric Intensive Care Unit (PICU) due to sickness absence and recruitment; locum in General Medicine as part of Winter Plan 2024/25 ended in April 2025; agency Consultants unwilling to move to a Trust contract. | • Consultants. Trust contracts offered and declined; charges and hourly rates renegotiated wherever possible; recent recruitment in PICU has been successful reducing the need for agency; |

# Bank & Agency use - hours

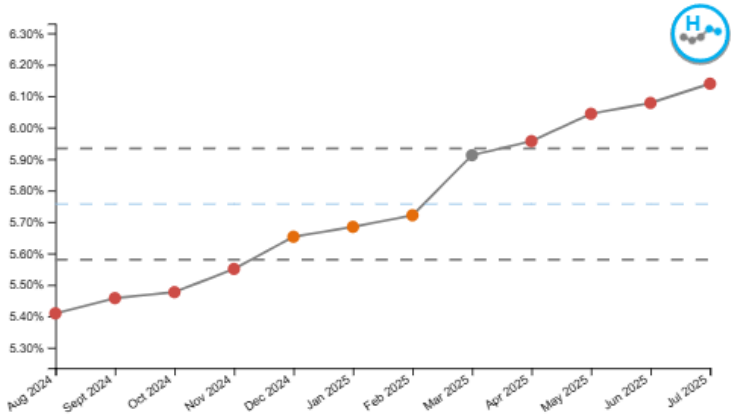
| Bank & Agency | 12-Month period ending | Total Bank and Agency Hours |
|---|---|---|
| | Jul 25 | 733,835 |

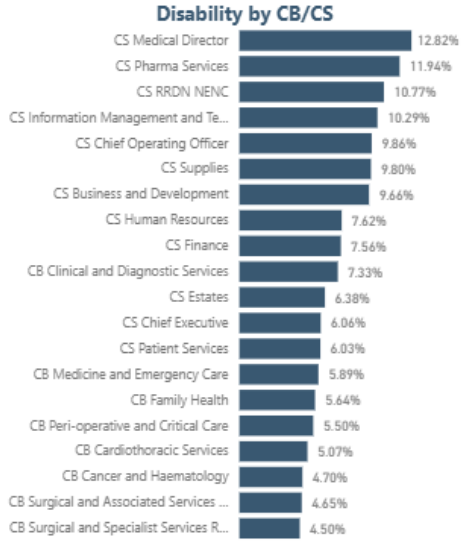
| Clinical Board | Bank Hours | Agency Hours | Total Hours |
|---|---|---|---|
| CB Medicine and Emergency Care | 194,891 | 35,023 | 229,914 |
| CB Family Health | 102,209 | 2,300 | 104,509 |
| CB Surgical and Associate Services FH | 94,765 | 10,189 | 104,954 |
| CB Surgical and Specialist Services RVI | 83,553 | 9,966 | 93,519 |
| CB Clinical and Diagnostic | 33,819 | 10,726 | 44,545 |
| CB Cancer and Haematology | 52,697 | 4,729 | 57,425 |
| CB Cardiothoracic Services | 34,672 | 11,707 | 46,380 |
| CS Estates | 16,817 | 923 | 17,740 |
| CS Patient Services | 11,498 | 0 | 11,498 |
| CS Human Resources | 8,435 | 3,709 | 12,145 |
| CB Peri-operative and Critical Care | 4,897 | 1,408 | 6,305 |
| CS Business and Development | 2,712 | 0 | 2,712 |
| CS Information Management and Technology | 105 | 0 | 105 |
| CS Chief Executive | 1,451 | 0 | 1,451 |
| CS Finance | 0 | 0 | 0 |
| CS Chief Operating Officer | 373 | 0 | 373 |
| CS Regional Drugs and Therapeutics | 58 | 0 | 58 |
| CS Medical Director | 26 | 0 | 26 |
| CS Supplies | 0 | 0 | 0 |
| CS Pharma Services | 178 | 0 | 178 |
| CS Corporate Performance | 0 | 0 | 0 |
| CS RRDN NENC | 0 | 0 | 0 |

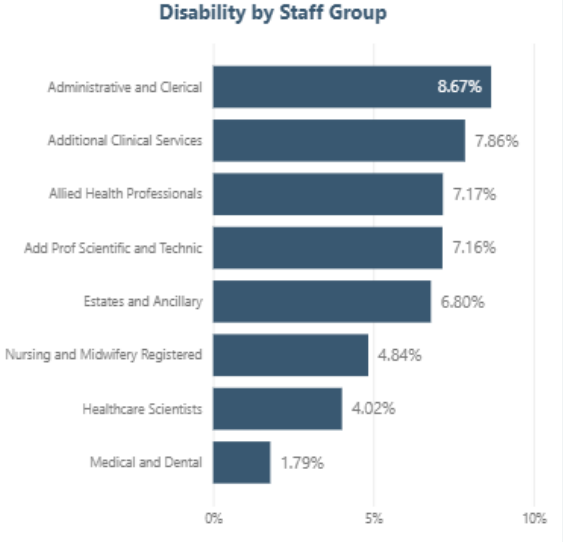


# Equality, Diversity and Inclusion (EDI) - Disability

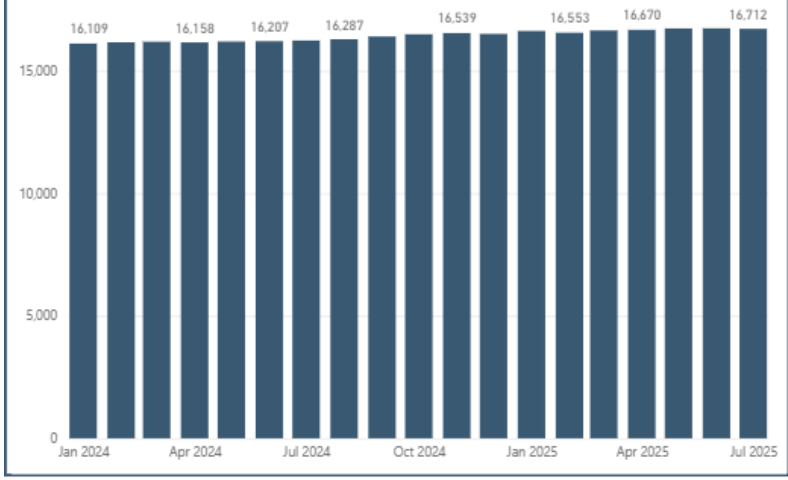
| EDI - Disability | Month | Value | Trust Headcount |
|---|---|---|---|
| | Jul 25 | 6.14% | 16,712 |




## Trust Headcount Trend




## Age Band

| | Age Band | Disability % |
|---|---|---|
| 1 | <=20 Years | 7.80% |
| 2 | 21-25 | 12.48% |
| 3 | 26-30 | 7.21% |
| 4 | 31-35 | 6.08% |
| 5 | 36-40 | 4.96% |
| 6 | 41-45 | 4.88% |
| 7 | 46-50 | 4.52% |
| 8 | 51-55 | 5.57% |
| 9 | 56-60 | 6.33% |
| 10 | 61-65 | 5.89% |
| 11 | 66-70 | 4.12% |
| 12 | >=71 Years | 4.92% |

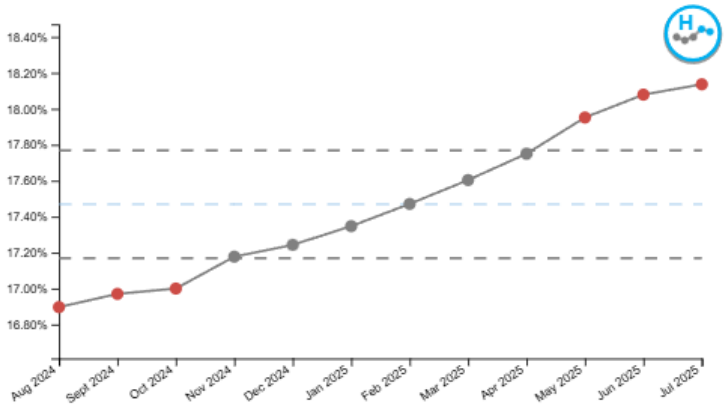
## Current Position:

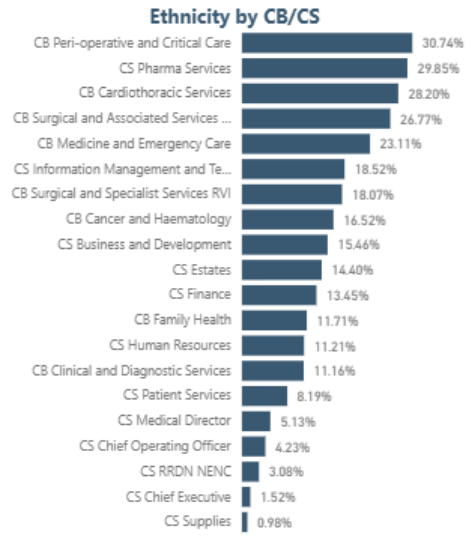
Charts show percentage of staff in post each month by those disclosing a disability.

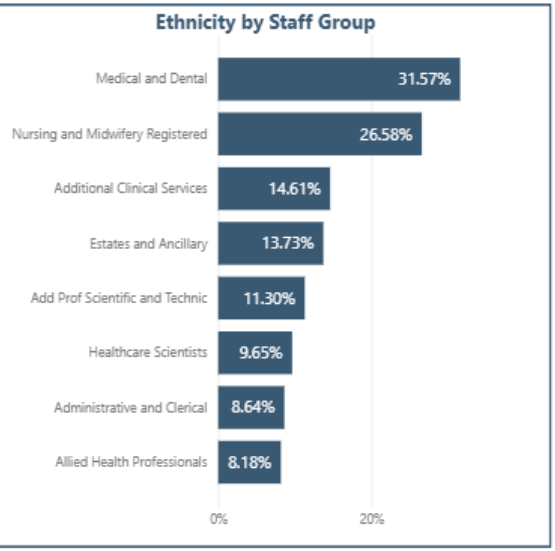
Percentage of staff employed disclosing a disability increased +0.06% to 6.14%

# Equality, Diversity and Inclusion (EDI) - Ethnicity

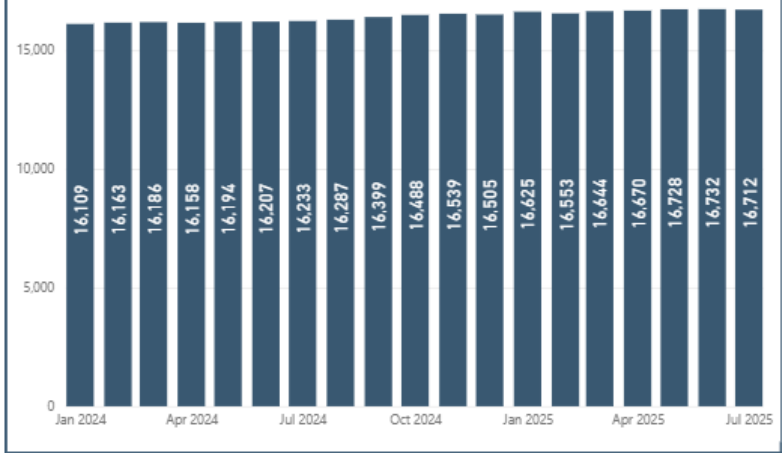
| EDI - Ethnicity | Month | Value | Trust Headcount |
|---|---|---|---|
| | Jul 25 | 18.14% | 16,712 |




## Trust Headcount Trend




## Age Band

| | Age Band | BME % |
|---|---|---|
| 1 | <=20 Years | 18.44% |
| 2 | 21-25 | 18.04% |
| 3 | 26-30 | 26.76% |
| 4 | 31-35 | 24.03% |
| 5 | 36-40 | 22.71% |
| 6 | 41-45 | 14.74% |
| 7 | 46-50 | 19.46% |
| 8 | 51-55 | 16.38% |
| 9 | 56-60 | 8.99% |
| 10 | 61-65 | 5.48% |
| 11 | 66-70 | 5.24% |
| 12 | >=71 Years | 3.28% |

## Current Position:

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

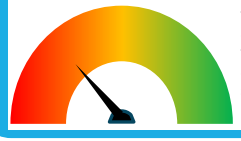
Percentage of BAME staff continues to demonstrate a month-on-month increase with the latest position reflecting BAME staff at 18.14% of the workforce.

# Finance

# The Newcastle Upon Tyne Hospitals NHS Foundation Trust Finance Dashboard 2025/26

## July 2025

### Financial Health



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

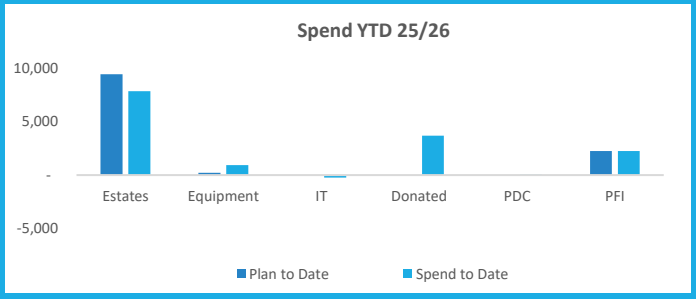
### Financial Performance Month 4

The trust has a plan to break even for 2025/26. To do this, it needs to deliver £106m of savings, manage expenditure within budgets and to deliver Elective Recovery Fund Income of £351m.

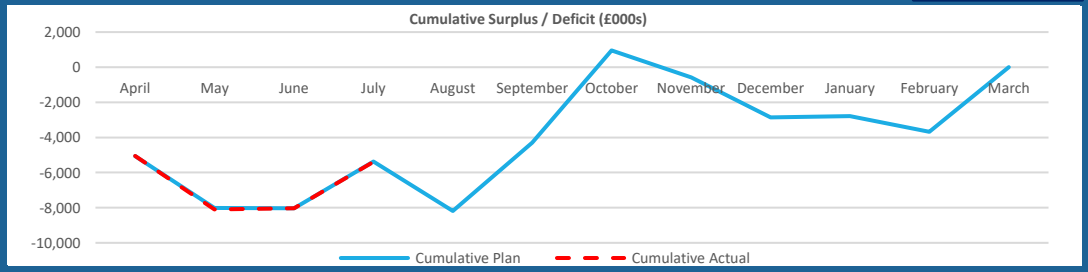
At month 4 the Trust is reporting an £5.4m deficit which is in line with the plan, however in delivering this position, the Trust has had to bring forward technical savings to offset new pressures and under delivery of Cost Improvement Programme (CIP).

- There are new pay pressures at month 4 due to unfunded pay award £1.1 million and cost associated with junior doctor industrial action of £420k which are negating some reductions in temporary pay
- Pressures in relation to block drugs are continuing to increase. At month 4 further increase of £2.6 million, mainly within the Medicine Clinical Board.
- The CIP of £106 million is phased over the year with a plan of £25 million to M4. Year to date Clinical Boards and Corporate Services have delivered £8.4m (of which £4.0m is recurrent). To mitigate the CIP on Clinical Boards and Corporate Services delivery, £16m of non recurrent technical measures have been actioned which is £8m more than planned for.
- Other technical adjustments of £0.5m have been recognised in the year-to-date position.
- Activity which comes under the ERF scheme translates to £2.5m of additional income above the cap and is recognised within the position, albeit adverse (£3.1m) to plan at month 4.
- The forecast for the Trust is that it will breakeven and deliver the financial plan, the risks identified to delivering this position are explored further in the report.

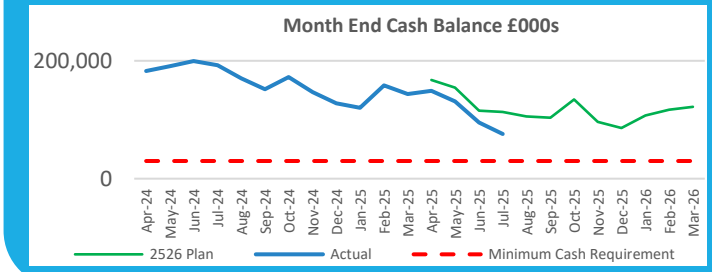
### Capital Programme Delivery – Month 4



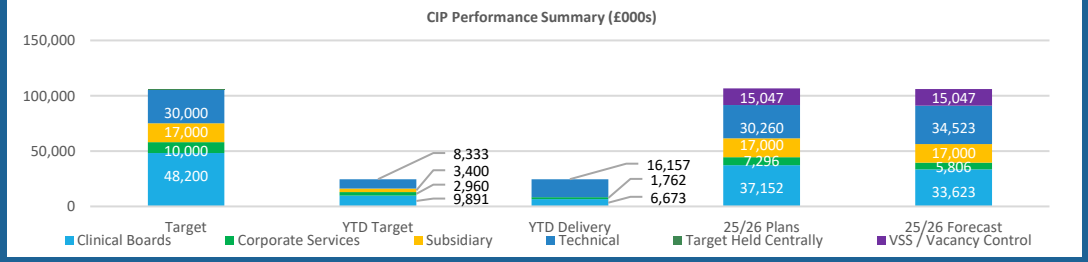

### Cumulative Performance Against Plan



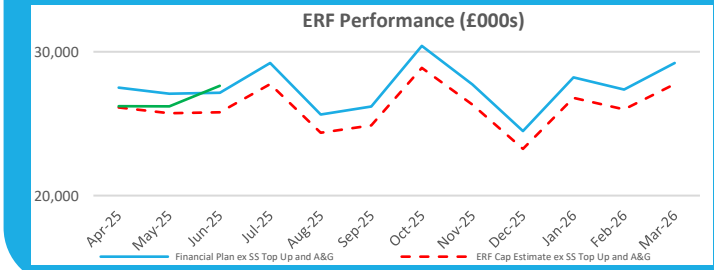

### Cash Balance




### Cost Improvement Programme Performance




### Activity – Elective Recovery Income



# 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.<br>Is it a one off event that you can explain?<br>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.<br>**Celebrate** the improvement or success.<br>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.<br>Is it a one off event that you can explain?<br>Do you need to change something?<br>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**<br>**Celebrate and Learn**<br>• This metric is improving.<br>• Your aim is high numbers and you have some.<br>• You are consistently achieving the target because the current range of performance is above the target. | **Good**<br>**Celebrate and Understand**<br>• This metric is improving.<br>• Your aim is high numbers and you have some.<br>• Your target lies within the process limits so we know that the target may or may not be achieved. | **Concerning**<br>**Celebrate but Take Action**<br>• This metric is improving.<br>• Your aim is high numbers and you have some.<br>• HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change. | **Excellent**<br>**Celebrate**<br>• This metric is improving.<br>• Your aim is high numbers and you have some.<br>• There is currently no target set for this metric. |
| L | **Excellent**<br>**Celebrate and Learn**<br>• This metric is improving.<br>• Your aim is low numbers and you have some.<br>• You are consistently achieving the target because the current range of performance is below the target. | **Good**<br>**Celebrate and Understand**<br>• This metric is improving.<br>• Your aim is low numbers and you have some.<br>• Your target lies within the process limits so we know that the target may or may not be achieved. | **Concerning**<br>**Celebrate but Take Action**<br>• This metric is improving.<br>• Your aim is low numbers and you have some.<br>• HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change. | **Excellent**<br>**Celebrate**<br>• This metric is improving.<br>• Your aim is low numbers and you have some.<br>• There is currently no target set for this metric. |
| (blank) | **Good**<br>**Celebrate and Understand**<br>• This metric is currently not changing significantly.<br>• It shows the level of natural variation you can expect to see.<br>• HOWEVER you are consistently achieving the target because the current range of performance exceeds the target. | **Average**<br>**Investigate and Understand**<br>• This metric is currently not changing significantly.<br>• It shows the level of natural variation you can expect to see.<br>• Your target lies within the process limits so we know that the target may or may not be achieved. | **Concerning**<br>**Investigate and Take Action**<br>• This metric is currently not changing significantly.<br>• It shows the level of natural variation you can expect to see.<br>• HOWEVER your target lies outside the current process limits and the target will not be achieved without change. | **Average**<br>**Understand**<br>• This metric is currently not changing significantly.<br>• It shows the level of natural variation you can expect to see.<br>• There is currently no target set for this metric. |
| H | **Concerning**<br>**Investigate and Understand**<br>• This metric is deteriorating.<br>• Your aim is low numbers and you have some high numbers.<br>• HOWEVER you are consistently achieving the target because the current range of performance is below the target. | **Concerning**<br>**Investigate and Take Action**<br>• This metric is deteriorating.<br>• Your aim is low numbers and you have some high numbers.<br>• Your target lies within the process limits so we know that the target may or may not be missed. | **Very Concerning**<br>**Investigate and Take Action**<br>• This metric is deteriorating.<br>• Your aim is low numbers and you have some high numbers.<br>• Your target lies below the current process limits so we know that the target will not be achieved without change | **Concerning**<br>**Investigate**<br>• This metric is deteriorating.<br>• Your aim is low numbers and you have some high numbers.<br>• 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**<br>**Investigate and Understand**<br>• This metric is deteriorating.<br>• Your aim is high numbers and you have some low numbers.<br>• HOWEVER you are consistently achieving the target because the current range of performance is above the target. | **Concerning**<br>**Investigate and Take Action**<br>• This metric is deteriorating.<br>• Your aim is high numbers and you have some low numbers.<br>• Your target lies within the process limits so we know that the target may or may not be missed. | **Very Concerning**<br>**Investigate and Take Action**<br>• This metric is deteriorating.<br>• Your aim is high numbers and you have some low numbers.<br>• Your target lies above the current process limits so we know that the target will not be achieved without change | **Concerning**<br>**Investigate**<br>• This metric is deteriorating.<br>• Your aim is high numbers and you have some low numbers.<br>• There is currently no target set for this metric. |
| Improving | | | | **Unsure**<br>**Investigate and Understand**<br>• This metric is showing a statistically significant variation.<br>• There has been a one off event above the upper process limits; a continued upward trend or shift above the mean.<br>• There is no target set for this metric. |
| Deteriorating | | | | **Unsure**<br>**Investigate and Understand**<br>• This metric is showing a statistically significant variation.<br>• There has been a one off event below the lower process limits; a continued downward trend or shift below the mean.<br>• There is no target set for this metric. |
| (blank) | | | | **Unknown**<br>**Watch and Learn**<br>• There is insufficient data to create a SPC chart.<br>• At the moment we cannot determine either special or common cause.<br>• 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 | 26 September 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:<br>• Urgent and Emergency Care (UEC) Update<br>• Cancer Update<br>• Quality & Safety<br>• Medical Education Update including GMC survey results<br>• Job Planning Update | | | | | |
| Recommendation | The Board are asked to note the contents of this report and:<br>• Note the performance against cancer targets and the actions being taken to improve this.<br>• Note the results of the GMC trainee and trainer survey. | | | | | |
| 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

In July and August 2025, there was an increased demand on UEC services with 24,111 Emergency Department (ED) attendances and 12,849 Emergency Admissions. This is a 4.3% increase in ED attendances when compared with the same period in 2024 and a 2.5% increase in emergency admissions.

Overall emergency care performance was 79.03% in July (75.51% July 2024) and 77.68% in August (76.49% in August 2024).

Major challenges remain with an escalating number of ambulance arrivals. In July 2025, there were 3,421 ambulance conveyances to the Royal Victoria Infirmary (RVI) ED, which is 82 more than in July 2024. Despite this, PIN compliance has improved to around 90% and the number of ambulances waiting more than 45 minutes has reduced to 5.47% in the week ending 31 August 2025. This is a significant improvement and using money from the Getting-It-Right-First-Time (GIRFT) Faster Further scheme, we will be extending a pilot to maintain this improvement by a further 4 months. The term "PIN" refers to the numeric code used by both paramedics and ED staff to formally acknowledge the transfer of patient care during an ambulance handover. The timing of these dual PIN handovers helps generate data to monitor and improve the timeliness of ambulance handovers.

There remain significant operational challenges with patient flow related to bed capacity, discharge delays, cleaning of isolation rooms, and transport home for patients.

Looking ahead to winter, we expect to create additional bed capacity by opening ward 12 at the Freeman Hospital at the end of December for 4 months and implement the additional winter schemes to increase resilience in the busiest period of the year.

## 2. CANCER UPDATE

### *2.1 Cancer Performance*

Cancer performance remains below the standard required despite an improvement in performance against the 28-day Faster Diagnosis Standard (FDS). Whilst the 62-day treatment commencement figures are still low, there is an upward trend and provision data for July suggest we will see a further improvement. The number of patients waiting beyond 62 days on urgent suspected cancer pathways as at the week ending 31 August 2025 is 120, demonstrating an ongoing downward trend from over 300 in December 2023.

After significant ongoing engagement with NHS England (NHSE) along with the described improvement in performance, the Trust was de-escalated from tiering for cancer performance in the Quarter 2 review. Whilst this is clearly a good reflection on the

improvements underway, our focus on cancer must remain so that those improvements are sustained.

Fig 1: 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 | Jun-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% | 95.4% |
| 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% | 52.8% | 55.5% |
| 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% | 80.0% | 50.0% |
| 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% | 63.3% | 70.8% |
| Gynae | Actual | 59.7% | 72.4% | 69.4% | 70.5% | 50.0% | 59.3% | 60.5% | 73.1% | 71.6% | 80.4% | 82.0% | 81.4% | 79.3% | 84.8% | 74.8% |
| 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% | 87.5% | 80.0% |
| 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% | 88.0% | 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% | 87.8% |
| NSS | Actual | 100.0% | 100.0% | 91.7% | 77.8% | 92.9% | 88.9% | 83.3% | 90.9% | 87.5% | 63.6% | 72.7% | 100.0% | 76.9% | 77.8% | |
| Other | Actual | 100.0% | | 100.0% | | 0.0% | | 100.0% | 50.0% | 0.0% | | 100.0% | 0.0% | 100.0% | 100.0% | 0.0% |
| 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% | 80.0% | 100.0% |
| 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% | 82.3% | 74.9% |
| 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% | 90.0% |
| Upper GI | Actual | 73.2% | 76.0% | 62.6% | 65.9% | 59.3% | 60.8% | 74.3% | 76.7% | 85.9% | 86.5% | 88.2% | 83.5% | 79.5% | 85.7% | 84.3% |
| 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% | 58.8% | 67.3% |
| | | | | | | | | | | | | | | | | |
| | | 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 | Jun-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% | 80.7% | 78.1% |

Fig 2: 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 | Jun-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% | 100.0% |
| Breast | Actual | 89.9% | 93.8% | 97.8% | 89.7% | 89.9% | 91.8% | 87.5% | 90.5% | 90.8% | 87.7% | 88.1% | 77.7% | 95.1% | 88.9% | 89.8% |
| 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% | 32.1% | 38.7% |
| Gynae | Actual | 45.0% | 63.2% | 73.7% | 60.0% | 56.3% | 77.8% | 76.9% | 57.7% | 35.5% | 64.0% | 48.0% | 61.1% | 77.8% | 48.3% | 77.3% |
| 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% | 81.6% |
| 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% | 92.3% | 75.8% |
| 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% | 40.7% |
| 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% | 100.0% |
| 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% | 100.0% |
| 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% | 89.7% |
| Testicular | Actual | - | - | - | - | - | - | - | - | - | - | - | - | 100.0% | - | 100.0% |
| Upper GI | Actual | 45.1% | 42.9% | 40.4% | 36.7% | 51.1% | 39.8% | 46.5% | 39.2% | 37.6% | 40.4% | 53.2% | 41.3% | 40.9% | 44.0% | 41.8% |
| 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% | 54.5% | 40.2% |
| | | | | | | | | | | | | | | | | |
| | | 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 | Jun-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% | 63.8% |

*Key:*
*CNS – Central Nervous System*
*NSS – Non-specific symptoms*
*GI – Gastrointestinal*
*Gynae - Gynaecology*

Radiotherapy performance, which in terms of targets principally impacts the 31 day treatment target, continues to improve month on month as assessed by mean time from referral to commencement of treatment. The team have engaged with GIRFT alongside South Tees Hospitals NHS Foundation Trust and the team at Hull University NHS Foundation Trust. The fragility of the workforce across all three geographies and critical staff groups (therapy radiography, dosimetry and radiotherapy physics) was highlighted alongside our view that ongoing funding for Artificial Intelligence (AI) packages currently in use for radiotherapy planning are critical to current and therefore future performance.

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.

### *2.2 Tumour Group Issues*

Operationally there are regular reviews of performance for individual cancer teams alongside reviews of action plans agreed for performance improvement. In the medium term, current issues are:

- Establishing physical capacity for navigational bronchoscopy, currently supported by the Northern Cancer Alliance (NCA), and developing a business case to sustain this work long term.
- Increasing endoscopy capacity to facilitate endobronchial ultrasound (EBUS), navigational bronchoscopy and hepatobiliary endoscopy procedures.
- Creating a theatre with a scanner at the Freeman Hospital to allow expansion of ablation work in interventional radiology with routine general anaesthetic lists and preservation of access to static Computerised Tomography (CT) facilities at the Freeman Hospital.

There are also significant capacity constraints in dermatology currently, at least in part driven by an increase in referrals over the summer. Due to the pressures on the team, it is becoming increasingly challenging to secure extra service on a Waiting List Initiative (WLI) basis. Negotiations are ongoing as to whether Northumbria Healthcare NHS Foundation Trust can see some local patients, as currently 36% of our referrals are from Northumbria postcodes. At Newcastle Hospitals we are working to ensure that plastics can see patients where clinically appropriate. The role of AI in the diagnosis of skin lesions is likely to expand and change this field significantly but it will require provision of high-quality photographs; the method of best providing such images is the subject of current work.

### *2.3 Pathway Changes*

As per the Trust Board report of May 2025, lung surgery work from Durham, previously done at Newcastle Hospitals, moved under the auspices of the thoracic surgical team at South Tees Hospitals NHS Foundation Trust ('South Tees') from 1 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. As described previously, 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 under the South Tees team. 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.

The Trust is also currently providing support to County Durham and Darlington NHS Foundation Trust breast cancer services both to the surgical side and the radiology side of the pathway.

### *2.4 Cancer Governance*

#### *2.4.1 Harm Reviews*

The harm review process continues, and a full report was submitted to the Quality Committee for discussion at the 16 September meeting. To summarise, 466 patients breached 104 days to treatment on a cancer pathway between 1 October 2024 and 31 May 2025.

*2.4.2 National Cancer Patient Experience Survey (NCPES)*

NCPES results from the survey undertaken in 2024 have recently been released. There were 1,255 responses (53% response rate). Newcastle Hospitals performance appears steady over time, but we have moved from 20th in the national table in 2023 to 49th this year. We are the 4th highest placed local trust after Northumbria Healthcare NHS Foundation Trust (1st), Gateshead Health NHS Foundation Trust (8th) and South Tyneside and Sunderland NHS Foundation Trust (44th). Comparing to Shelford Trusts we are ranked joint 3rd with Sheffield and University College London Hospitals NHS Foundation Trust, with Cambridge University Hospitals NHS Foundation Trust performing best at 12th nationally and Oxford University Hospitals NHS Foundation Trust 33rd nationally. We await individual patient comments that are usually released on a tumour-by-tumour basis later in the year.

All of our tumour groups have been asked to consider an area that they want to specifically impact this year and develop a relevant action plan. It is clear that the ethnic diversity of the responders to the survey is low and this is something that may need focus group work rather than reliance on this survey. In a similar vein, the feedback that comes from this national survey is fairly generic so if patients have had treatment in various places as part of their care programme, it is not possible to tease this out from the survey. We need to consider whether tumour-specific and Newcastle Hospitals-specific approaches may allow us to better understand how we can best serve our patients.

*2.4.3 Flatiron*

The commencement of the Flatiron data project has been delayed into September/October, the first tranche of letters has now gone out to patients asking whether they wish to opt out of this data collaboration project. It will be important to establish early, once communication has gone out to patients, whether further communication is needed and whether more work needs to be done to improve the communication provided.

*2.4.4 High Consequences Infectious Diseases Unit (HCIDU)*

NHSE has granted funding to upgrade the HCIDU over a two-year program of works. This is a significant achievement which will bring the facilities on a par to its sister unit based at the Royal Free Hospital in London.

Exercise Pegasus - the government's large pandemic preparedness exercise is planned to go ahead this Autumn. It will look at the emergence of a novel pathogen and considers the response across the whole of government, not just the NHS. A key date on which our Trust will be asked to take part is Thursday 18 September. This corresponds with 'Phase 1' of the “pandemic” which is the point at which HCID centres would be most involved - containment of initial cases.

During the table-top simulation, the Trust will be asked to join an in-house HCID activation call and there may be further asks to report e.g. bed capacity and staffing levels on that day and will be considering how to run Business as Usual as part of the scenario. The Board of Directors will be updated on the findings and recommendations following the exercise.

## 3. QUALITY AND SAFETY

### *3.1 Martha's Rule*

Call for concern launched in the Great North Children's Hospital (GNCH), Freeman Hospital ward 23 (Paediatric cardio) and Maternity on July 22nd successfully. The GNCH system of call receiving and response remains as a pilot, relying on Paediatric Intensive Care Unit (PICU) nursing and medical staff.

Data was presented to the Quality Committee regarding activity. In Summary:

- Adult - launched 18 February 2025. To date 38 calls received, of which 6 were true calls (patient deterioration) and 32 were other calls.
- GNCH/Freeman Hospital Paediatrics - 3 calls received, of which 1 was a true call and 2 were other calls.
- Maternity - No calls received to date.

Thus, similar to national data, our experience reflects a relatively small call volume with the majority of calls relating to aspects of care and patient experience that are not true deterioration.

#### *3.1.1 Learning*

Learning from this activity is in two parts:

- True calls – All these generate a report on the incident reporting system (In Phase)and are looked at as part of our Patient Safety Systems. Ultimately a true Martha's Rule deterioration call represents a failure in our usual detection systems.
- Other calls – It is a reasonable assumption that a patient or family calling the Martha's Rule line has experienced negative aspects of care, for example, a breakdown in expected relations with their ward staff and caring team. All patients and families in this group will be approached after their in-patient stay by our Patient Experience Team as part of their Right Time assessment process, allowing us to capture and theme any learning in specific areas.

### *3.2 Patient Safety Incident Response Framework (PSIRF) Priority 2025 – Invasive Procedures – Update*

This project is advancing in set up stage with Trust wide advert for senior medical staff involvement imminent and a working party established.

A high number of surgery associated never events (7) – wrong implant, wrong site – in the last 5 months highlights the need for work in this area.

### *3.3 Training*

We are offering high quality safety training to quality and safety (Q&S) active staff in all Clinical Boards in the form of five modules. This will be delivered by Dr Dawn Benson, previous National Investigator for the Healthcare Safety Investigation Branch (HSIB) and renowned safety scientist in the field of Human Factors. These sessions will run from October to January 2026.

### *3.4 Structures*

We are establishing a new forum for how senior Board Q&S staff and the Q&S Department (previously the Clinical Governance and Risk Department (CGARD)) meet and interact.

This will be a quarterly all afternoon session termed the Q&S Community of Practice Events.

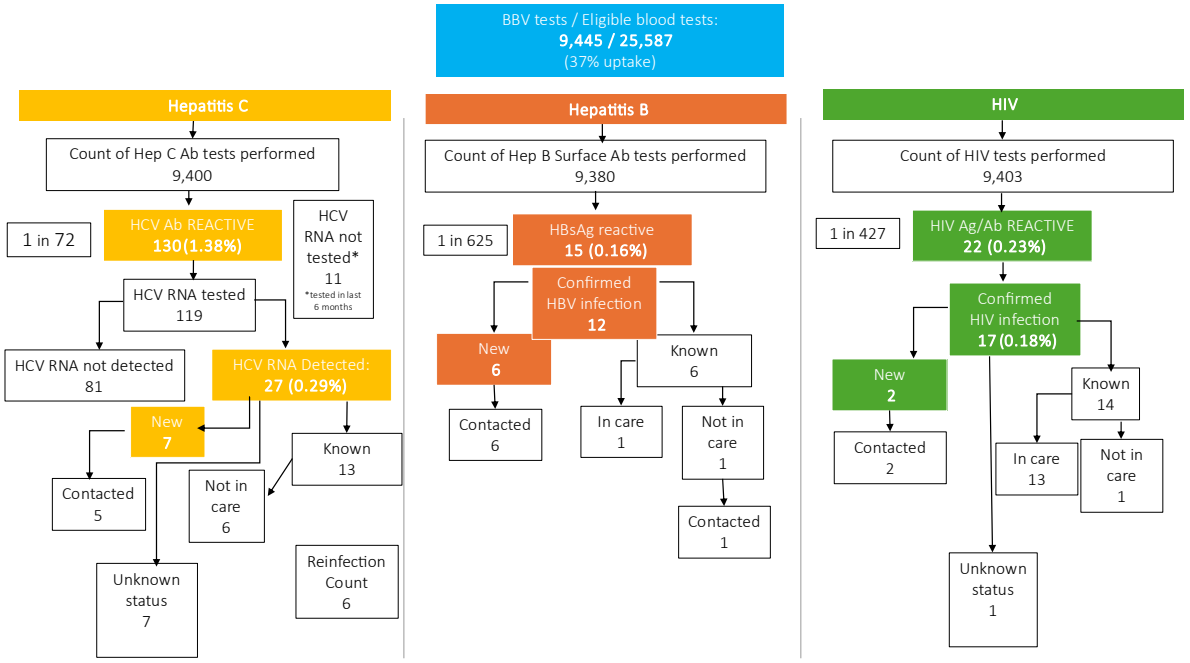
Their purpose will be:

- Two way conversation – corporate to Board
- Agreeing strategy
- Operational aspects
- Continuing Professional Development
- Community building and culture setting

### *3.5 Blood Borne Virus (BBV) testing*

The Trust introduced an Opt-Out initiative for BBV in the Emergency Department (ED) in March. The programme has been successful in identifying patients with active HIV, Hepatitis C, or Hepatitis B infections who may have otherwise not received a diagnosis. A total of 56 patients with active infections have been identified. Of these, 15 patients have been identified with new infections and the teams have had an 87% success rate in contacting these to date.

The project continues to progress well, and our focus is on increasing the number of patients who receive a BBV test, which is currently around 40-50% of eligible patients.




## 4. MEDICAL EDUCATION AND UPDATE INCLUDING GMC SURVEY RESULTS

The General Medical Council (GMC) National Training Survey (NTS) is the largest annual survey of doctors in the UK. Trainees are asked about the quality of training and the environments where they work, and trainers about their experience as a clinical and/or educational supervisor.

### *4.1 Trainee survey*

The response rate for Newcastle Hospitals was 66.4% (n=496 to 500) which is 0.6 percentage points down from the response rate in 2024, compared to a national response rate of 70% (n=50, 637), down 6 percentage points from 2024. Trainees respond to a number of questions which are themed into indicators which map onto the following GMC domains:

- Learning environment and culture: this includes questions on handover, rota design, whether the training is delivered in a supportive environment, teamwork and workload.
- Educational governance and leadership: this includes clinical supervision in and out of hours, educational governance, educational supervision, induction and the robustness of reporting systems
- Developing and supporting learners: this includes facilities, local and regional teaching, and study leave.
- Delivering curricula and assessments: this includes whether the trainees receive adequate experience, feedback and overall satisfaction.

Compared to the 9 other Trusts within the Shelford Group Newcastle Hospitals was the third ranking Trust. This is an improvement from fifth rank in 2024. Newcastle Hospitals ranked first for study leave, second for adequate experience, and third for workload, educational governance, reporting systems, regional teaching and feedback. It was at or above the

median for rota design, teamwork, clinical supervision, clinical supervision out of hours, overall satisfaction and local teaching. It performed below the median for handover, induction, educational supervision and facilities. None of the indicators were outliers. The survey provides granular detail on specialty specific areas for improvement as well as information on positive outliers, that is, specialties which are providing good experiences for trainees.

Newcastle Hospitals ranked lowest among the Shelford Group for facilities (10th out of 10), as it did in 2024, and has consistently ranked poorly. This indicator is based on questions relating to the mess facilities, Wi-Fi connectivity, online resources offered by the library, showers/locker/food preparation areas etc. subsequent to the survey, the RVI resident mess facilities were upgraded, which has improved the experience of trainees and is expected to be reflected in next year's survey.

NHSE has published a 10-point plan to improve the lives of resident doctors which covers some of the aspects referred to in the GMC survey, such as timely rotations, ease of transfer between organisations, car parking and environment. Work is already underway to understand where the gaps remain and where the organisation can make improvements. There is a requirement to name an Executive lead (Dr Lucia Pareja-Cebrian, Joint Medical Director) and a Peer Lead (Dr Henrietta Dawson, Guardian of Safe Working).

### *4.2 Trainer survey results 2025*

Newcastle Hospitals remained last position out of the 10 hospitals in the Shelford group, as it has for three consecutive years.

Time to train is a below outlier nationally. This has been a recurrent theme in Newcastle Hospitals over several years. The Trust reviewed job planning policy has focused among other things on improving the time available for training. It is hoped that those changes will lead to improvements on next year's survey.

## 5. JOB PLANNING UPDATE

We continue to work with Clinical Board Chairs and Clinical Directors to complete the final stage of the job planning process. All of the job plans which have been submitted have been reviewed and where possible changes have been agreed. Where further information is required, feedback has been given to the Clinical Directors and further reviews of job plans will be completed once this information has been provided. It is expected that this process will be finalised by the end of September. This is the largest job planning review that the Trust has ever undertaken. It has been a complex process but will provide significant benefit to the Trust and to individual doctors.

A full detailed report of the outcomes of the process will be provided to the October Trust Board.

## 6. RECOMMENDATION

The Board of Directors is asked to:

i. Note the performance against cancer targets and the actions being taken to improve this.
ii. Note the results of the GMC trainee and trainer survey.

**Report of**
**Dr Lucia Pareja-Cebrian/ Dr Michael Wright**
**Joint Medical Directors**
**18 September 2025**

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Agenda item A10(b)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

# TRUST BOARD

| | | | |
|---|---|---|---|
| Date of meeting | 26 September 2025 | | |
| Title | Executive Director of Nursing (EDoN) Report | | |
| Report of | Ian Joy, Executive Director of Nursing | | |
| Prepared by | Lisa Guthrie, Deputy Director of Nursing<br>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:<br><br>• Section 1: Nursing and Midwifery Staffing Update<br>• Section 2: Safeguarding and Mental Capacity Act/Deprivation of Liberty Safeguards (DoLS) Quarter 1 highlight report<br>• Section 3: Learning Disability Quarter 1 Highlight Report<br>• Section 4: Flu Vaccination Programme<br><br>The following key points/risks are noted for the Trust Board's attention:<br>• Trust nurse staffing escalation has been stepped down to level 1. Appropriate oversight, monitoring and supportive actions are in place and there are no new escalations to the Trust Board.<br>• Several wards have required support in line with the Nurse Staffing and Clinical Outcomes Group criteria. The ward requiring high level support has been de-escalated to medium level support. Action plans are in place for wards with education and resources provided, overseen by the Executive Director of Nursing team and relevant Clinical Boards.<br>• There are several nurse staffing metrics included in the report with additional detail in the Trust Board Reading Room. There are no new escalations to note.<br>• The complexity within adult safeguarding remains and this is reflected in the region. Work continues with the digital health team to improve visibility of safeguarding information and is recognised in Risk 1463. The policy and audit schedule is monitored at the Safeguarding Committee, some audits have been delayed in children and adult safeguarding with plans in place to rectify.<br>• 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 at 85.81% and 86.66% respectively with improvement actions in place.<br>• Level 1 Mental Capacity Act (MCA) training which is mandatory for all staff is 97%. Level 2 MCA and DoLS e-learning, launched in December 2024 is 81% which is an increase from 76% in Quarter 4. | | |

<table>
<tr><td></td><td colspan="6">
<ul>
<li>The Learning Disability Liaison Team continues to see increased demand and patient complexity which impacts patient safety and staff experience. This is logged on the risk register with work underway to increase team capacity.</li>
<li>The Learning Disability Care Quality Commission (CQC) Action Plan is overseen by the Learning Disability Steering Group. An overview of the phase 2 action plan has been developed and is contained within the Trust Board Reading Room.</li>
<li>The vaccination programme will be launched at the beginning of October 2025. In line with national guidance, only Flu vaccinations will be delivered.</li>
<li>There is currently high population immunity to Covid, so additional doses will provide limited protection against infection.</li>
<li>The Trust will provide an inpatient peripatetic Covid and Flu vaccination service for patients in vulnerable groups.</li>
<li>Actions proposed to improve uptake, and further detail is contained within the report. The Vaccination Steering Group will provide reports to the Executive Team fortnightly</li>
</ul>
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<br>i) Receive and discuss the report.<br>ii) Note the oversight and reporting of safe staffing which has been prepared in line with national guidance regarding.<br>iii) Note the risks and mitigations in relation to the Safeguarding, MCA and Learning Disability Liaison Teams.<br>iv) Note the vaccination programme plan in line with best practice guidance.</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<br>(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
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<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">BAF risk ID 1.1 - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">The 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. NURSING AND MIDWIFERY STAFFING UPDATE

A guidance document outlining nursing safe staffing metrics and the monthly Safe Staffing Dashboard is available in the reading room to supplement the information presented in 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. These guidelines have been updated in August 2025, to reflect national guidance and external audit recommendations and were approved by the Professional Practice Assurance Group (PPAG) in September 2025. The criteria to step down the Trust staffing escalation level, to level one, has been met as business-as-usual processes are sufficient to maintain safe staffing levels. This was formally agreed at the September 2025 PPAG meeting.

The following actions are in place for level one and overseen by the Executive Director of Nursing:

- Senior nursing team provide a once 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.

Level one escalation will remain in place unless 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) Group. Below is an overview for the last quarter:

| Month | Total | Clinical Board | High level support | Medium level support | Low level support |
|---|---|---|---|---|---|
| Jun-25 | 5 | Family Health Services | Great North Children's Hospital (GNCH) ward 3 | GNCH ward 2a, GNCH ward 1b | GNCH ward 12, RVI ward 40 |
| | 2 | Surgical and Specialist Services, Royal Victoria infirmary (RVI) | | RVI wards 16 & 22 | |
| | 0 | Perioperative Services | | | |
| | 5 | Cardiothoracic Services | | FH Paediatric Intensive Care Unit (PICU), FH ward 21 | FH wards 23, 24 & 25 |
| | 3 | Medicine and Emergency Care Services | | RVI Assessment Suite (AS) | FH wards 14 & 20 |
| | 2 | Surgical and Associated Services, Freeman Hospital (FH) | | | FH wards 3 & 8 |

| Month | Total | Clinical Board | High level support | Medium level support | Low level support |
|---|---|---|---|---|---|
| | 2 | Cancer and Clinical Haematology Services | | Northern Centre for Cancer Care (NCCC) ward 34 | NCCC ward 33 |
| **Total** | **19** | | **1** | **8** | **10** |
| Jul-25 | 5 | Family Health Services | GNCH ward 3 | GNCH wards 1a, 1b & 2a | GNCH ward 12 |
| | 2 | Surgical and Specialist Services RVI | | RVI wards 16 & 22 | |
| | 0 | Perioperative Services | | | |
| | 4 | Cardiothoracic Services | | | FH PICU, FH wards 21, 24 & 25 |
| | 2 | Medicine and Emergency Care Services | | RVI AS | FH ward 17 |
| | 0 | Surgical and Associated Services FH | | | |
| | 2 | Cancer and Clinical Haematology Services | | NCCC ward 34 | NCCC ward 33 |
| **Total** | **15** | | **1** | **7** | **7** |
| Aug-25 | 3 | Family Health Services | | GNCH, 1a, 1b & 3 | |
| | 2 | Surgical and Specialist Services RVI | | RVI wards 16 & 22 | |
| | 1 | Perioperative Services | | | RVI 38 |
| | 5 | Cardiothoracic Services | | FH ward 30 | FH wards 21, 24, 25 & 29 |
| | 2 | Medicine and Emergency Care Services | | RVI AS | FH ward 17 |
| | 0 | Surgical and Associated Services FH | | | |
| | 2 | Cancer and Clinical Haematology Services | | NCCC ward 34 | NCCC ward 33 |
| **Total** | **15** | | **0** | **8** | **7** |

The key points to note:

- One ward (GNCH ward 3) has required high-level support in the last three months but was de-escalated to medium-level support in August 2025, following successful peer review in July 2025. The ward has progressed to the accrediting excellence (ACE) programme.
- Wards requiring medium level support for more than two months have an action plan in place and themes are reviewed for learning.
- No wards currently require high-level support.

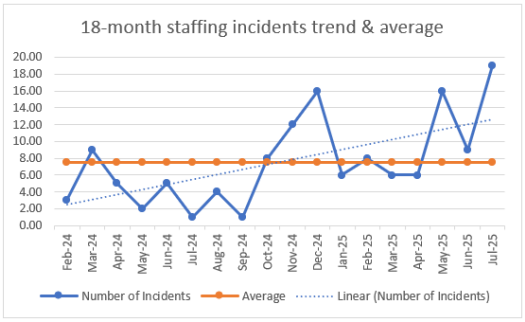
### 1.3 Datix and Red Flag data

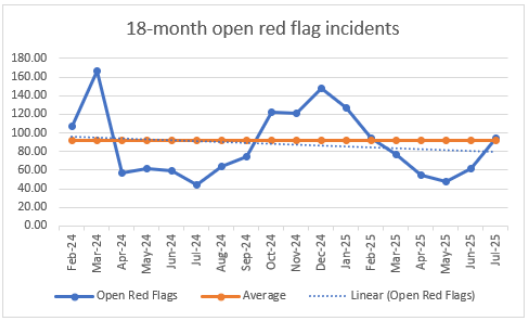
Red flag and incident data is reviewed daily (Monday-Friday) by the senior nursing team and reported as part of the daily staffing briefing and presented to the NSCO Group monthly.

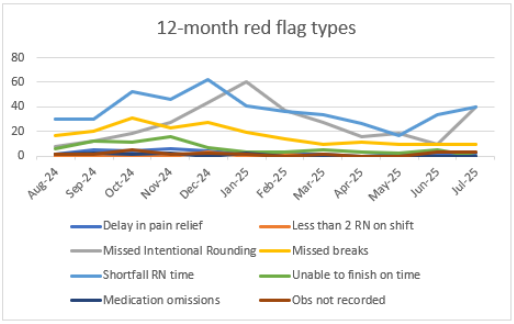
The key points to note:

- Staffing incident reporting via InPhase continues to be encouraged, with a noticeable increased trend in reports in the last quarter. Contributing factors include acute short-term staffing gaps in specific departments, training needs around incident reporting and escalation bed capacity pressures. Incidents are monitored and themes reported to the PPAG.

- Staffing red flag events have remained at average levels over the last quarter, with no red flags of “less than 2 registered nurses (RN)”.
- 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 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 remains difficult. There are no new areas for escalation.

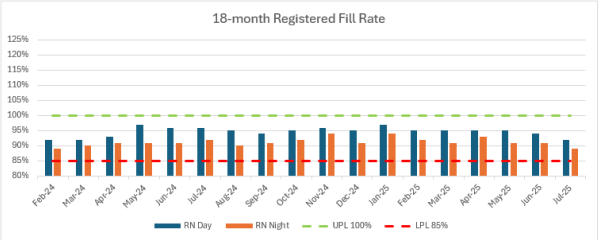
## 1.5 Planned versus actual hours (fill rates)

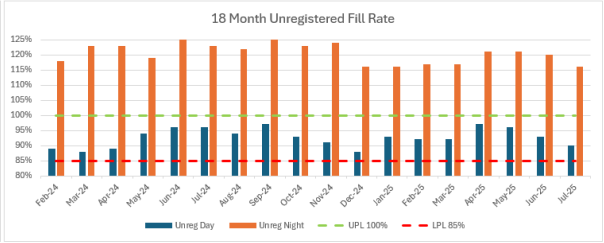
The planned and actual staffing hours are converted into percentage “fill rates” which are entered onto the safer staffing dashboard, RAG (red-amber-green) rated and reviewed monthly by the NSCO Group. RN fill rates <85% are reported to the Executive Director of Nursing each month.

Key points to note:

- The number of wards reporting <85% RN fill rates has remained static over the last six months and continues to be more prevalent on nightshift where the shortfalls are mitigated by Healthcare Assistant (HCA) support.
- Five 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.
- Six of the areas reporting <85% RN fill rates have been in receipt of low-level support through the NSCO Group, and three areas have been supported at medium-level

with actions plans 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. Temporary staffing and agency usage reports are distributed to the senior corporate nursing team and heads of nursing each week, providing additional oversight.

Key points to note:

- Temporary staffing spend has gradually increased over the past 12 months, influenced by pay increases and back-dated pay awards.
- The overall number of temporary staffing shifts continue to decline, reflecting improvements in vacancy rates. This reduction has correspondingly led to an increase in fill rates.

## 2. RECRUITMENT AND RETENTION

Key points to note:

- The current RN turnover is 5.58%. This demonstrates a continued reduction from the previously reported 6.66% in the same period last year.
- The current RN vacancy rate is 0.58%. This remains stable and is below the figure 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.
- The current Healthcare Support Worker (HCSW) turnover rate is currently 8.19% and demonstrates a reduction from 10.09% in the same period last year.
- The HCSW vacancy rate is currently 10.5%. This is increased from the figure of 8.5% reported in the same period last year. Recruitment and retention work continues with the Trust being shortlisted for a Nursing Times Workforce Award.
- To support staff retention a new internal transfer process will be introduced. This will allow transfers throughout the year for staff wishing to gain experience. The process has been developed with heads or nursing, matrons and clinical leaders with support from human resources colleagues. This will complement the generic and bespoke recruitment offers.

## 3. STUDENT NURSES

- Final year nursing students have been supported to interview from May 2025.
- Priority has been given to those students who have completed their clinical placements at Newcastle Hospitals and those successful at interview have been held on a reserve list, with vacancies being reviewed regularly in order to match the students to their preferred area of employment.

- As of 1 September 2025, we have appointed 55 Paediatric and 103 Adult final year nursing students into posts, with three Paediatric and 19 Adult nursing students remaining on the reserve list.
- Moving forward we will be considering several other initiatives, such as working with the staff bank to support new graduates into post.

## 4. SAFEGUARDING AND MENTAL CAPACITY ACT (MCA) QUARTER 1 (Q1)

This summary of key points provides a Q1 update of Safeguarding (Adult, Children's and Maternity) and Mental Capacity activity throughout the Trust. This detail was presented to the Safeguarding Committee (July 2025) and to the Quality Committee (September 2025).

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

### 4.1 Activity and Audit

- The increased activity across the safeguarding teams is recognised in Risk 1475. This risk highlights the inability to respond to and deliver timely advice due to the current demands. Oversight of mitigations is provided by the Safeguarding Committee.
- Work is ongoing with the digital health team to improve the visibility of safeguarding information. This is recognised in Risk 1463.
- Children's safeguarding activity data for Q1 shows a 12% increase of Cause for Concerns (CfC) when compared to the same period last year. In maternity there continues to be an increase in these complex cases in Q1 with 37 reported.
- There continues to be an increase in Multi-Agency Safeguarding Hub (MASH) activity with an overall increase in Q1 of 89% in comparison to the same period in 2024. This will continue to be monitored, as there is no additional resource available to absorb the increase in activity.
- In Q1 there were 247 reported MCA and DoLS-related enquiries, with some regarded as complex and appropriately escalated within the Trust. This is an increase from Q4.
- The Trust internal audit report in 2024 in relation to Safeguarding governance and risk management had ten recommended actions. Following a review, the action relating to Newcastle Safeguarding Adults Board (NSAB) meetings was reopened to ensure changes are embedded and recommendations comprehensively addressed.
- The completion of policy monitoring audits has been delayed in children and adults. These are to be reviewed and will be reported to the next Safeguarding Committee meeting. All safeguarding maternity audits are up to date.
- In Q1 there was an audit of 60 inpatients with a learning disability flag requiring Mental Capacity Act (MCA) assessment, best interests decisions and who were subject to DoLS. The audit demonstrated an improvement in the quality of MCAs and best interests rationale. It was noted that there continues to be some gaps when assessment of capacity should have been completed but was not. Actions are in place to address this.

### 4.2 Education and Training

- Safeguarding adults training compliance is closely monitored at the Safeguarding Committee. There is good compliance with Level 1 training at 96.26% and Level 2 at 96.70%. Safeguarding adult Level 3 compliance is 85.81% and is below the Trust 90% standard.
- Safeguarding children Level 1 compliance rates are 96.07% and Level 2 95.90%. Level 3 Children's safeguarding sits at 86.66% which is below the required target. Work to prioritise level 3 training, with the eLearning module is nearing completion. Children and adult level 4 training for Specialist Professionals has been launched for 28 staff in Learning Lab in line with the intercollegiate document.
- Q1 Level 1 MCA training is 97%. Level 2 MCA and DoLS e-learning was launched in December 2024, current compliance is 81% which is an increase from Q4 where it was reported as 76%.

## 5. LEARNING DISABILITY QUARTER 1 (Q1)

This summary of key points provides a Q1 update of Learning Disabilities activity throughout the Trust. This detail was presented to the Experience of Care Group and Quality Committee (September 2025).

### 5.1 Activity and Service Pressures

- Activity remains high, with complex referrals being made to the Learning Disability team. In Q1 there were 549 inpatient and day case attendances. These figures demonstrate that activity is consistent with Q4.
- To support safety and quality, a fortnightly improvement group for clinical leaders has been initiated, to share audit results and examples of good practice.
- Staffing challenges remain with temporary support being provided, this is logged on the risk register. Once the substantive Band 8a Learning Disability lead and a Band 7 for people with autism are appointed this risk will be reviewed. Dr Hilary Tedd, Consultant Respiratory Physician is now the dedicated medical lead for learning disability.

### 5.2 Mandatory training for Learning Disability and Autism

- In Q1 compliance has increased to 89.89 % just short of the Trust target of 90%. For clinical staff, compliance is 96.45% (Nursing, Midwifery and Allied Health Professions (NMAHP)/Medical and Dental). Training compliance is monitored by the Learning Disability Steering Group.
- The Trust continues to review training plans in line with national expectations of the Oliver McGowan Mandatory Training for Learning Disabilities and Autism, acknowledging that training delivery of which will be challenging in the acute setting and the Learning Disability Network are leading regional discussions.

### 5.3 CQC Action Plan

The Learning Disability CQC Action Plan is overseen by the Learning Disability Steering Group. The phase 2 action plan 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. The revised deadline is Q3 2025/26 as the training provision will be complex for acute organisations and requires consideration with regional colleagues. Mitigation is provided with mandating of Diamond Standards training for all staff and additional awareness sessions.
- 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 through collaboration with Skills for People.
- The Trust will have a Learning Disability strategy in place. This action was delayed due to the need to ensure collaboration with those with lived experience. The strategy has been developed with Skills for People and is now in draft format.
- The reasonable adjustment pilot had been delayed to ensure collaboration with those with lived experience. The revised deadline for Q1 2025/26 has been met.

A further action for the phase 2 action plan is:

- 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 agreed and is reviewed at the Learning Disability Steering group.

## 6. FLU VACCINATION PROGRAMME

The Trust vaccination programme aims to maximise vaccine uptake and ensure staff are well-informed, to support them in making the choice to receive their vaccinations in line with national guidance. The programme is supported by robust governance and assurance processes. Following the 2024/2025 programme, the uptake for vaccine was 67% for Flu and 54% for Covid. This was slightly lower than the previous year but comparable nationally. The Trust had the highest percentage delivery of vaccine in Trusts who employed more than 10,000 staff.

On 26 June 2025, the government decided, in line with Joint Committee on Vaccination and Immunisation (JCVI) advice, that the Covid vaccine will only be offered to those in the population who are most vulnerable. Frontline health and social care workers will not be eligible for the Covid vaccination under the national programme for autumn 2025. This is following an extensive review of the scientific evidence surrounding the impact of vaccination on transmission of the virus from health workers to patients, protection of health workers against symptoms of the disease and staff sickness absences.

The JVCI recommends an inpatient Covid and Flu offer targeting vulnerable long-term inpatients and patients before discharge to care homes. The Trust will provide a Registered Nurse to deliver an inpatient peripatetic Covid and Flu vaccination service, starting from

October 2025 and running to March 2026. NHS England will reimburse the vaccine and associated administration costs.

The Department of Health and Social Care (DHSC) has provided a target for Trusts to increase their Flu vaccination uptake by 5%. The vaccination programme is scheduled to launch in line with national guidance at the beginning of October 2025, delivering Flu vaccinations only.

The new 'National minimum standards and core curriculum for vaccination training' (UK Health Security Agency June 2025) will be implemented ahead of the planned launch which encompasses a range of opportunities to engage with high volumes of staff and oversight will be provided by the Vaccination Steering Group. Digital recording and reporting tools have been refreshed and a progress report with uptake will be provided to the Executive Team on a fortnightly basis.

## 7. RECOMMENDATION

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

**Report of Ian Joy**
**Executive Director of Nursing**
**26 September 2025**

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Agenda item A10(c)(i)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

# TRUST BOARD

| | | | |
|---|---|---|---|
| Date of meeting | 26 September 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.<br><br>Key points/risks to note:<br>• The Trust Avoiding Term Admissions into Neonatal Units (ATAIN) rate remains consistently above the national 5% target. The pilot of an innovative care model with neonatal nursing staff supporting neonatal care in obstetric theatre recovery commenced in August 2025. The impact of this on admissions will be evaluated.<br>• The Trust triggered a further safety alert for the number of stillbirths on the North East North Cumbria Clinical Indicators Dashboard in Quarter 1. Analytics have been performed by the NHS England (NHSE) analytics team which indicate duplicate counting and rounded numbers, when these cases were removed the Trust returned to within a 95% confidence limit. This issue has been highlighted to the national team, however there is no timeline or agreement that these issues will be addressed on a national level.<br>• The maternity service maintained Operational Pressures Escalation Level (OPEL) 1 for 29 days in July, and OPEL 2 for 2 days. The neonatal service maintained OPEL 1 for 30 days and OPEL 2 for 1 day. There were no staffing incident reports required or submitted.<br>• The recent patient safety incidents in obstetric theatres and recovery have been considered as part of the Quality Impact Assessment (QIA) risk assessment process and mitigations have been agreed, with an additional nurse available out of hours and on weekends to reduce the number of occasions midwives are required to provide care in recovery and scrub in theatre.<br>• The Trust is compliant with Royal College of Obstetrics and Gynaecology (RCOG) guidance on the engagement of short and long term locums and compensatory rest and audit of consultant attendance.<br>• The perinatal Culture and Wellbeing action plan has been ratified by the People and Culture Group, with a plan to monitor progress and impact on a quarterly basis. There has been strong staff engagement with the development of the action plan, which will be a key area of focus during September's Patient Safety month.<br>• The Trust has escalated its concern to the Local Maternity and Neonatal System (LMNS) and Integrated Care Board (ICB) regarding Safety Action 7 and is therefore compliant with the requirements of the scheme. In response to this escalation the LMNS/ICB has | | |

<table>
<tr><td></td><td colspan="6">instigated a benchmarking exercise and is meeting with the Trust in October 2025 to review the additional investment and infrastructure required.<br>• The Trust has completed a midwifery staffing review and is awaiting the updated Allocate templates to be published to inform the workforce investment plan. Safety action 5 remains at risk until the workforce investment plan is agreed, although it is expected that the in-year investment required will not be a prohibitive factor in achieving compliance.<br>• The claims scorecard has been reviewed at the Obstetric Board in August. Historical claims were categorised and reviewed alongside Quarter 1 (Q1) incidents and complaints to enable the identification of potential themes or trends, the impact of any learning, and ensure proportionate action is being taken to improve safety and experience.<br>• The Northern Neonatal Network (NNN) is submitting an updated Neonatal Critical Care Review (NCCR) proposal to the Joint Overview and Scrutiny Committee in September. Due to absence within the NNN leadership team this has not yet been shared with partners, nor ratified by the NNN Board, this has been escalated to the LMNS as a risk.</td></tr>
<tr><td>Recommendation</td><td colspan="6">Trust Board is asked to:<br>i. Receive and discuss the report.<br>ii. Note compliance with the Perinatal Quality Surveillance Model (PQSM) and the receipt of the minimum data measures in accordance with Safety Action 9.<br>iii. Evidence in the Trust Board minutes that the safety champions are meeting with the perinatal leadership team and Maternity and Neonatal Voices Partnership (MNVP) Lead a minimum of bimonthly.<br>iv. Evidence in the Trust Board minutes that progress with the perinatal cultural improvement plan is being monitored and any identified support has been implemented.<br>v. Evidence in the Trust Board minutes the Trusts compliant position with the obstetric workforce elements of Safety Action 4.<br>vi. Note the risk regarding Safety Action 5.<br>vii. Note the risk associated with the Neonatal Critical Care Review.<br>viii. Note the receipt of the Q1 Perinatal Mortality Review Tool report in the reading room.<br>ix. Note and receive the six-monthly deep dive staffing report on the reading room.</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>
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<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.<br><br>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 Perinatal Quality Surveillance Model (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 Avoiding Term Admissions into Neonatal Units (ATAIN) rate remains consistently above the national 5% target, this has instigated three quality improvement (QI) workstreams, care of infants of diabetic mothers, thermoregulation and respiratory issues following delivery by elective caesarean section. The pilot of an innovative care model with neonatal nursing staff supporting neonatal care in obstetric theatre recovery commenced in August 2025, the impact of this on admissions for respiratory issues will be evaluated over the next three months. It is hoped that the estates work on Delivery Suite will support improvements regarding thermoregulation.

The Trust triggered a further quarterly safety alert for the number of stillbirths on the North East North Cumbria Clinical Indicators Dashboard in Quarter 1. In accordance with the Local Maternity and Neonatal System (LMNS) safety signal process this was a safety alarm and instigates further review. Further analytics have been performed by the North East Yorkshire NHSE analytics team which indicate duplicate counting and rounded numbers, when these cases were removed the Trust returned to within a 95% confidence limit. This issue has been highlighted to the national team, however there is no timeline or agreement that these issues will be addressed on a national level.

### 2.2 Midwifery staffing

Organisational requirements for safe midwifery staffing for maternity settings (National Institute for Health and Care Excellence (NICE) 2017) states that midwifery staffing establishments develop procedures to ensure that a systematic process is used to set the midwifery staffing establishment to maintain continuity of maternity services and to always provide safe care to women and babies in all settings. Midwifery staffing is reported separately to the Quality Committee and Trust Board biannually to meet the requirements for the maternity incentive scheme. The bi-annual staffing report can be found in the Board of Directors Reading Room.

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 has evidenced that the midwifery staffing budget reflects the establishment. The Trust has completed a midwifery staffing review and is unfortunately still awaiting the updated Allocate templates to be published to inform fill rates against Birthrate Plus establishment. This was expected to go live from the September roster period; however, it has been delayed and will not be enacted until October, hence the fill rates reported currently are against the previous staffing templates. The leadership team is using Birthrate Plus daily acuity tool data to measure the appropriateness of the midwifery staffing, alongside red flags, other clinical outcomes measures and the current fill rates. This safety action remains at risk until the workforce investment plan is agreed, although it is expected that in the in-year investment required will not be a prohibitive factor in achieving compliance.

### 2.2.1 Maternity Assessment Unit

Midwifery initial triage within 15 minutes is 95% 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.

### 2.2.2 Antenatal inpatient ward and Day Care Unit

The daily BirthRate Plus acuity tool assessment demonstrated that phase 1 midwifery staffing met 88% acuity in July 2025. There were no red flags.

| Fill Rate Midwife Day Shift | Fill Rate Midwife Night Shift | Fill Rate Support Staff Day |
|---|---|---|
| 106% | 105% | 87% |

### 2.2.3 Intrapartum care (Delivery Suite and Newcastle Birthing Centre)

The daily BirthRate Plus acuity tool assessment demonstrated that the phase 1 staffing met acuity 74% for Delivery Suite July 2025 (up from 64% in February 2025) and 95% for Newcastle Birthing Centre (NBC) in July 2025.

There were no red flags in July 2025 for intrapartum care recorded. 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.

| Fill Rate Midwife Day Shift | Fill Rate Midwife Night Shift | Fill Rate Support Staff Day | Fill Rate Support Staff Night |
|---|---|---|---|
| 87% | 87% | 79% | 77% |

The recent patient safety incidents in obstetric theatres and recovery have been considered as part of the QIA risk assessment process and mitigations have been agreed, with an additional nurse available out of hours and on weekends to reduce the number of occasions midwives are required to provide care in recovery and scrub for theatre cases. Work is ongoing with the Peri-Operative leadership team regarding the future staffing model as the

scrub staff transition to the Peri-Operative and Critical Care Clinical Board leadership in September 2025.

### 2.2.4 Ward 33

The daily BirthRate Plus acuity tool assessment demonstrated that the phase 1 midwifery staffing met acuity 87% in July 2025. There was no red flags on the postnatal ward reported during July.

| Fill Rate Midwife Day Shift | Fill Rate Midwife Night Shift | Fill Rate Support Staff Day | Fill Rate Support Staff Night |
|---|---|---|---|
| 96% | 97% | 100% | 143% |

### 2.2.5 Ward 34

The nursing establishment is considered separately. The ratio of nursing staff for babies receiving transitional care should be 1:4. An escalation process to support nursing staff has been developed with the Neonatal Intensive Care Unit (NICU) to maintain these ratios.

| Fill Rate Midwife Day Shift | Fill Rate Midwife Night Shift | Fill Rate Support Staff Day | Fill Rate Support Staff Night |
|---|---|---|---|
| 91% | 88% | 86% | 99% |

### 2.2.6 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.

### 2.2.7 Service overview

Maternity leave continues to impact bank and overtime usage with 18.17 whole-time-equivalent (WTE) currently on leave. The recruitment of early career midwives will support a reduction in bank and overtime usage from October 2025 but will need to be carefully managed with preceptorship and supernumerary induction.

The maternity service maintained Operational Pressures Escalation Level (OPEL) 1 for 29 days in July, and OPEL 2 for 2 days. There were no staffing InPhase reports and no community escalations to support the acute service. Mutual aid was provided to Sunderland and South Tyneside NHS Foundation Trust, with 1 woman planned for induction of labour accommodated.

The neonatal service maintained Operational Pressures Escalation Level (OPEL) 1 for 30 days in July, and OPEL 2 for 1 day. There were no staffing InPhase reports or delays to admissions or transfers.

## 2.3 Obstetric medical workforce

Trusts are required to evidence compliance with Royal College of Obstetrics and Gynaecology (RCOG) guidance on the engagement of short and long term locums and

compensatory rest where consultants are working non-resident on-call out of hours and audit consultant attendance at specific clinical situations (minimum 80%) in accordance with the 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'.

The Trust did not employ any short term locums within the reporting period, and only one long term locum who the medical staffing department have confirmed was employed in accordance with the RCOG guidance.

The service acknowledges the importance of compensatory rest and actively support the principles set by the British Medical Association (BMA) and the RCOG of 11-hour rest period between shifts including disruptions whilst on call. This is facilitated by job planning to demonstrate on call duties and the removal of professional activities following an on-call period, this is evidenced by the MediRota for the consultants. The obstetric consultants are contractually required to be on site until 10pm but 11 of 12 consultants chose to remain resident in the unit for the full 24-hour shift due to increasing complexity of clinical activity and expectations of midwifery colleagues, trainees and service users. The Trust provides 98-hour Consultant resident presence for the acute obstetric service, from August 2025 this is a rota of 1 in 12, 24-hour on call residency shifts (followed by a day of compensatory rest). There is currently a 3.8WTE consultant shortfall and this has resulted in 1:12 24-hour on call model which has a significant impact on service provision.

The consultant presence audit for Q1 demonstrated 92% (22 of 24 cases) compliance for attendance in clinical situations where the consultant must be present with appropriate reasons why this was not achieved in the remaining two cases.

## 2.4 Staff experience

The Perinatal Culture and Staff Wellbeing action plan has been developed 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, cross referencing the SCORE survey results from 2024. The action plan has been ratified by the People and Culture Group, with a plan to monitor progress and impact on a quarterly basis. There has been strong staff engagement with the development of the action plan, which will be a key area of focus during September's Patient Safety month.


- PMA – Professional Midwifery Advocate

## 3. MATERNITY INCENTIVE SCHEME

The Maternity Incentive Scheme Year 7 was launched by NHS Resolution on 2 April 2025. The final submission date to NHS Resolution (NHSR) is 3 March 2026. The LMNS and Northern Neonatal Network on behalf of the North East & North Cumbria (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 Quarter 1 (Q1) 2025/26 update has been provided in accordance with the LMNS guidance. The Q1 Perinatal Mortality Review Report can also be found in the Board of Directors reading room for information.

| 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 | On track |

| Safety Action | Trust self-assessed position |
|---|---|
| place and are undertaking quality improvement to minimise separation of parents and their babies? | |
| 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 robust processes provide assurance to the Board on perinatal safety & quality issues? | On track |
| Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigation Special Health Authority & NHS Resolution's Early Notification Scheme? | 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 including the supporting infrastructure. The Trust has escalated its concern to the LMNS and ICB and is therefore compliant with the requirements of the scheme, in response to this escalation the LMNS/ICB has instigated a benchmarking exercise and is meeting with the Trust in October 2025 to review the additional investment and infrastructure required.

## 4. NHS RESOLUTION SCORECARD

Safety Action 9 requires that the Trust claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting. Scorecard data is triangulated with other quality and safety metrics to inform targeted interventions aimed at improving patient safety and reflected in the Trusts Patient Safety Incident Response Plan. These quarterly discussions must be held at least twice in the MIS reporting period at a Board or directorate level quality meeting.

The claims scorecard has been reviewed at Obstetric Board in August, historical claims were categorised and reviewed alongside Q1 incidents and complaints to enable the identification of potential themes or trends, the impact of any learning, and ensure proportionate action is being taken to improve safety and experience.

The score card enhances understanding of the common causes and injuries relating to obstetric claims and the financial implications these have for the Trust and importantly triangulation can demonstrate emerging trends and improvement.

## 5. NEONATAL CRITICAL CARE REVIEW

In response to the National Critical Care Review (NCCR) 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 Northern Neonatal Network (NNN) constituted a task and finish group to bring a proposal to the Network Board, LMNS and NHSE.

The recommendation to endorse Sunderland NICU as a Local Neonatal Unit (LNU) with a hybrid model providing some aspects of intensive care outside of LNU service specification was not approved by the ICB. This decision will increase the number of admissions to the NICU in Newcastle and South Tees, which is yet to be quantified.

The NNN is submitting an updated proposal to the Joint Overview and Scrutiny Committee on the 29 September. Due to absence within the NNN leadership team this has not yet been shared with partners, nor ratified by the NNN Board, this has been escalated to the LMNS as a risk.

## 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.

On 14 August 2025 the Health and Social Care Secretary announced the appointment of Baroness Valerie Amos to chair the independent investigation into NHS maternity and neonatal care. 14 Trusts have now been identified as part of this investigation.

The investigation is separate from the National Maternity and Neonatal Taskforce, which will be made up of a panel of esteemed experts and families, and chaired by the Secretary of State for Health and Social Care, to keep up momentum and deliver change, no further information has been shared regarding the programme of work.

The Chief Executive and Chief Nursing Officer of NHSE wrote to all Trusts asking that in the interim Trust Boards take the following action. The perinatal service has benchmarked against these actions and is satisfied that adequate oversight and workstreams are in progress.

## 7. CONCLUSION

The Trust Board are provided with an update on the Perinatal 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.

There are robust improvement plans, and evidence included within this report, 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 Perinatal Quality Surveillance Model (PQSM) and the receipt of the minimum data measures in accordance with Safety Action 9.
iii. Evidence in the Trust Board minutes that the safety champions are meeting with the perinatal leadership team and MNVP Lead a minimum of bimonthly.
iv. Evidence in the Trust Board minutes that progress with the perinatal cultural improvement plan is being monitored and any identified support has been implemented.
v. Evidence in the Trust Board minutes the Trusts compliant position with the obstetric workforce elements of Safety Action 4.
vi. Note the risk regarding Safety Action 5.
vii. Note the risk associated with the Neonatal Critical Care Review.
viii. Note the receipt of the Q1 Perinatal Mortality Review Tool report in the reading room.

**Report of Ian Joy**
**Executive Director of Nursing**
**5 September 2025**

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Agenda Item A10(c)(ii)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

# TRUST BOARD

| | | | | | | |
|---|---|---|---|---|---|---|
| Date of meeting | 26 September 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 July 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.<br><br>Risks are detailed within the main body of the report. | | | | | |
| Reports previously considered by | Last report presented at the Public Board meeting on 25 July 2025. | | | | | |

# MATERNITY SAFETY CHAMPION REPORT - SUMMER 2025

This report covers visits to the Maternity Department during both August and September. Additionally, on the 13th of August, I chaired the Maternity and Neonatal Safety Champion Group meeting. Issues had been raised about Non-Executive Director (NED) capacity to ensure 100% NED attendance at these meetings in line with national expectations and how we can assure that. In addition, the Group discussed the value of having continuity and consistency in the Maternity Safety Champion role but also recognised that a second person becoming familiar with the department would be extremely useful in terms of additional NED engagement and succession planning.

The meeting discussed four Maternity and Newborn Safety Investigation (MNSI) cases in which issues of senior clinician/anaesthetist presence at birth were raised, and additional concerns around non-English speaking patients and interpretation services, which had led to both poor patient experience and potentially avoidable term admissions.

There was discussion around Perinatal Mortality Review Tool (PMRT) - reduced fetal movement - and discussion about the efficacy of the themed 'trolley dash' and the 'shine a light' model combined with greater service user engagement. Staffing challenges continue to give rise for concern particularly in the neonatal department to complete PMRT in a timely manner particularly when babies have sadly died outside of the neonatal department.

The above discussions demonstrated the need for effective engagement, clear communications, and informed stakeholder voices being heard and listened to. The incoming new post of Communications Officer will be of significant importance in better management of both these challenges.

Strict safety measures in relation to Glycopeptide-Resistant Enterococci (GRE) and Carbapenem Resistant Enterobacteriaceae (CRE) outbreaks have worked well and are mitigating infection risks. The start of the delivery of the estates plan will further mitigate risk.

The meeting noted that the data around stillbirths includes termination for fetal abnormalities, which skews the data profile, making it look as though it is more of a cause for concern than it is. Newcastle Hospitals receives a high proportion of mothers whose unborn babies are seriously unwell and will not survive, and it is important to remember this context when reviewing data. Were these data excluded, stillbirth numbers would be within tolerance levels.

The new perinatal on call model of working which puts senior midwives/nurse on call overnight and at weekends has been implemented and is working well. Colleagues are getting used to this new way of working and it has been very well received.

I chaired the meeting as an interim measure, owing to Summer holidays/absence of the usual chair who was on leave. However, it was a great opportunity for me to triangulate things that I hear on walkrounds with the practitioners who are engaged with and managing the real operational challenges.

Getting our strategy right in relation to Equality, Diversity and Inclusion (EDI) within the maternity services department is going to be a key objective for the Maternity Safety Champion personally, and will be a daily issue for everybody working in the area. It would be foolish not to acknowledge the real challenges of answering all the diverse and particular cultural expectations surrounding childbirth. The history, demography, and current make up off the patients and families whom we serve all contribute to the scale of challenge in delivering an effective and meaningful EDI plan.

We know that racism and discrimination are present in healthcare systems and structures, and these disproportionately affect Black and minoritised groups. This particularly affects Black and Brown women in maternity as well as mothers from different Eastern European communities.

The service has responsibility to actively work to dismantle these barriers in all forms, whether conscious or unconscious, for all the people we serve.

Our workforce reflects a range of backgrounds, training experiences and cultural perspectives. This richness strengthens care but requires us to ensure that equitable standards, inclusive practice and EDI values are consistently embedded across the department and the wider Trust. Nationally, there is growing awareness of the harmful stereotypes affecting Black women in maternity care. Much of the national rhetoric around misplaced expectations of black mothers in labour such as the false belief that “strong black women can take more pain”.  These stereotypes, which are rooted in racism, contribute to poorer health outcomes and disparities in pain management. These narratives have been echoed in conversations with Black mothers, many of whom are now challenging these assumptions within their communities. A new generation of women, supported by their families, is rejecting the expectation to endure pain silently. Embedding culturally sensitive pain management practices and addressing unconscious bias will take time, but each step forward demonstrates meaningful progress.

The service recognises that both conscious, unconscious and structural bias exists. Tackling this requires ongoing reflection, improved anti-racism training and development, and meaningful engagement with diverse communities—including those who are non-white, non-British, and from minority faith groups.

A strong example of inclusive practice is the department’s engagement with the Jewish community in Gateshead. The service has built trusted relationships with influential community members, including Doulas and the hospital chaplain, to better understand and meet the needs of Jewish mothers. This approach—working through belief systems, trusted networks, and bridge-builders—has created a model of care that is both respectful and responsive to cultural needs during childbirth.

Another example of health inequality affecting maternity service users is the financial barrier to travel. Some patients struggle to afford transport to and from the hospital. A government-funded scheme aims to cover these costs through prepaid taxis or direct payments for bus fares. When national funding caps are exceeded, Trusts may need to bridge the gap and

Northumbria Healthcare NHS Foundation Trust is already doing so. The scheme is means-tested and requires form completion, so the Trust must ensure equitable access for non-English speaking patients. While this represents an additional cost, it may also contribute to the Cost Improvement Programme (CIP) by reducing emergency taxi bookings.

Another effort to be both responsive and inclusive is that of Cardiac Medic, an initiative being piloted in Maternity. Pre-recorded videos in various languages should mean that frequently used explanations and questions can be accessed through small iPads to better engage with non-English speaking mothers. We are exploring whether the challenge of interpretation services within the maternity department might possibly be alleviated by closer working with Newcastle College's English for Speakers of Other Languages (ESOL) provision.

**Report of**
**Liz Bromley, Non-Executive Director**
**18 September 2025**

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Agenda item A11

The Newcastle upon Tyne Hospitals NHS Foundation Trust

# TRUST BOARD

| | | | | | | |
|---|---|---|---|---|---|---|
| Date of meeting | 26 September 2025 | | | | | |
| Title | Committee Chair Meeting Logs | | | | | |
| Report of | Phil Kane, Chair of the Charity Committee<br>Hassan Kajee, Chair of the Digital and Data Committee<br>Anna Stabler, Chair of the Quality Committee<br>Bernie McCardle, Chair of the People Committee<br>Bill MacLeod, Chair of the Finance and Performance Committee<br>David Weatherburn, Chair of the Audit, Risk and Assurance Committee | | | | | |
| Prepared by | Gillian Elsender, PA and Corporate Governance Officer | | | | | |
| 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 July 2025:<br>• Charity Committee (funding only meeting) - 8 July 2025 and 9 September 2025<br>• Digital & Data Committee - 10 July 2025<br>• Quality Committee - 15 July 2025<br>• People Committee - 21 July 2025<br>• Finance & Performance Committee - 21 July 2025<br>• Audit, Risk & Assurance Committee - 22 July 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 in July 2025. | | | | | |

Agenda item A11

The Newcastle upon Tyne Hospitals NHS Foundation Trust

# Charity Committee - Chair's Log

| | |
|---|---|
| **Meeting**: Charity Committee – Funding only | **Date of Meeting**: 8 July 2025 |
| **Connecting to**: Audit Committee /Trust Board | **Date of Meeting**: 26 September 2025 |

| Key topics discussed in the meeting | |
|---|---|
| • Funding proposals were discussed in relation to:<br>○ Surgical and Associated Services - £70,460.00 – Periflux 6000 Vascular Assessment System – Supported in principle.<br>○ Surgical and Associated Services - £37,657.94 – Digital Dentistry Project – Supported.<br>○ Cardiothoracic Services - £150,000 – Paediatric Hearts Retrieval Programme – Conditionally Supported.<br>○ Cardiothoracic Services -£76,626.56 – Paediatric Echocardiology Reporting Package for Change Healthcare – Supported.<br>○ Cardiothoracic Services -£74,000.00 – Tricuspid Valve X 3 – On Hold.<br>○ Cancer and Haematology – £52,859.00, Clinical Sustainability Fellowships: Oncology – On Hold.<br>○ Christmas events - £184,554.99, Corporate – Supported.<br><br>• The summary of funding agreed since the last meeting was received (bids up to £20k). | |
| **Actions agreed in the meeting** | **Responsibility / timescale** |
| No actions from these applications. | Not applicable |
| **Escalation of issues for action by connecting group** | **Responsibility / timescale** |
| Not applicable | Not applicable |
| **Risks (Include ID if currently on risk register)** | **Responsibility / timescale** |
| Not applicable | Not applicable |

Agenda item A11

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

# Charity Committee - Chair's Log

| | |
|---|---|
| **Meeting**: Charity Committee | **Date of Meeting**: 9 September 2025 |
| **Connecting to**: Audit, Risk and Assurance Committee and Trust Board | **Date of Meeting**: 23 and 26 September 2025 |
| Key topics discussed in the meeting | |

- The minutes of the previous meetings held on 17 April, 10 June and 8 July 2025 were discussed and it was recommended that they were received as an accurate record. The minutes of the previous meeting held on 15 May was agreed to be an accurate account of the meeting with a minor change to those recorded as present, change Wendy Balmain DW to Wendy Balmain WB.
- The action log was reviewed and discussed.
- The management accounts to 31 March 2025 were discussed and it was recommended that:
  - A review be undertaken of the Fundraising Team to identify any gaps and identify clear recommendations e.g. development plans; capacity gaps.
  - A meeting of the Directors of the Newcastle Hospitals Charity (NHC) Retail Company Limited is required soon.
  - Discussions with Clinical Board regarding rationalisation of funds ongoing.
- The cash-flow paper was received.
- The Funds committed and not yet drawn down quarterly report was received.
- The Shared Resources Agreement was discussed. Once additional information was received relating to the procurement the paper could be sent to Trust Board.
- The Draft Annual Report and Accounts was discussed, and it was agreed to accept the Auditors recommendation to not restate the accounts, and the paper would be submitted to the Audit, Risk and Assurance Committee and Trust Board for ratification.
- Funding Proposals were discussed in relation to:
  - SA2983 – Peri-ops Office Transformation - £28,422 - Supported on condition that a suitable method of evaluating the impact on wellbeing.
  - SA3068 – Cardiothoracic Services - Charity Funded youth worker - congenital heart disease, cardiology service - £77,618 - Supported with the condition that the Clinical Board support the use of Cardio funds for this purpose and an exit strategy is put in place.
  - GA085 – Cancer & Haematology- Pump-Priming a Dedicated Research Consultant to Expand Commercial Haematology Research Capacity in the North East - £270,756 – Not Supported.
  - SA3133 – Cancer & Haematology - Complimentary Therapies Service – Northern Centre for Cancer Care North Cumbria (NCCCNC) - £79,752 – Supported.
- The Summary of funding agreed since the last Committee was received.
- The Sir Bobby Robson Institute update was received.
- A presentation on the Charity Strategy beyond 2026 was received.
- The Charity Arts Programme Update was received; the Committee were supportive of the expansion of the programme but were currently unable to identify the funds to take this forward.
- The Charity Risk Statement was received.

- The summary of investments be received.
- The Connected Charities Checklist was received.
- The 2024/25 Funding Programme Summary and 2025/26 Funding Programme Update were received.
- The Charity Key Performance Indicators (KPI's) 2025/26 were received.
- The Sir Bobby Robson Institute Gift Agreement was received.
- The minutes of the Great North Children's Advisory Committee were received.

| Actions agreed in the meeting | Responsibility / timescale |
|---|---|
| 1. Updates on previous funding proposals put on hold be actioned outside of the meeting. | RH |
| 2. Review/action plan around fundraising capacity and capability to be shared at next meeting. | TB |
| 3. Negotiation of bank credit card charges, currently 5% and should be between 1% and 3%. | Gordon Burns (GMB) |
| 4. An Annual General Meeting (AGM) of the directors of the NHC Retail Company Limited Directors is to take place. | Amanda Waterfall (AW) |
| 5. Charity recharges to be re-assessed in new financial year. | GMB |
| 6. RH to obtain further information regarding proposal SA300 for Carmedic Translation. | Richard Haigh (RH) |
| 7. Further discussion re expansion of Arts Programme to take place outside of the meeting as to how to take this forward, in the context of the next Charity Strategy. | Katie Newell (KN)/AW |
| 8. GMB to provide an estimate of increased pay costs for the forthcoming year at next Committee. | All |
| 9. Phil Kane (PK)/Teri Bayliss (TB) to discuss the addition of a lay member or someone from Voluntary Sector to join the committee. | PK/TB |

| Escalation of issues for action by connecting group | Responsibility / timescale |
|---|---|
| For the Audit, Risk and Assurance Committee to receive<br>• Draft Annual Report and Accounts<br><br>For the Trust Board to receive:<br>• Draft Annual Report and Accounts<br>• SBRI Gift Agreement | |

| Risks (Include ID if currently on risk register) | Responsibility / timescale |
|---|---|

| | |
|---|---|
| The Charity Risk Statement was shared – three tolerated risks and one managed risk. | |

Agenda Item A11

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

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

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|---|---|
| **Meeting**: Digital & Data Committee | **Date of Meeting**: 10 July 2025 |
| **Connecting to**: Trust Board | **Date of Meeting**: 26 September 2025 |
| Key topics discussed in the meeting | |

- **Team Culture and Structure:** Dave Elliott, Chief Digital Officer, provided an update on the team culture and structure, highlighting the need for a reset in the Digital team. The importance of flexible working was discussed, with a proposal for a minimum of three days a week in the office to maintain work-life balance and team interaction.

- **Expectations:** The group discussed the digital priorities and requests for the next 6 to 12 months. There is a current list of 400 projects which need to be prioritised. The decision of where the resources should go will need to come from a clinical and operational point of view. Dave Elliott confirmed that work is taking place on the current list and the plan is to capture everything and to take to the Trust Board a list of work over the next 12 months.

- **Oracle Reset Meeting:** Gordon Elder, Interim Operational Director, provided an update on the Oracle reset meeting, to improve relationships and discuss the new functionalities coming in the near future.

- **Mobile Device Strategy:** The group discussed the importance of a mobile device strategy for clinical staff. This would allow staff to be more flexible, efficient, increase compliance with documentation and would have patient safety benefits. Discussions are taking place on what this would look like.

- **Community Diagnostic Centre and Patient Capacity:** The group discussed the Community Diagnostic Centre (CDC) and patient capacity, highlighting the need for a new solution to free up capacity and improve patient flow.

- **Data Security and Protection Toolkit (DSPT) and Cyber security Accreditation:** The group were informed how the organisation met the new DSPT framework standards and received a low-risk assurance level. The Trust has also been recertified with Cyber Security accreditation.

- **Digital Transformation Projects:** Richard Atkinson, Head of IT Programmes, provided updates on various digital transformation projects, including Portering Services device tracking, ICNet and a national service hosted by the Trust on behalf of NHS England for the Infected Blood Inquiry. Richard highlighted the progress made and the challenges faced.
- **IT Service Management:** Gary Towns, Head of IT Service Management, provided an update to the committee. The desktop and server state remains compliant and this has

| | |
|---|---|
| fed into the DSPT and the positive outcome. There are a number of devices outside these requirements which are being closely managed and risks managed by the IT Risk Register. Windows 11 rollout is on track for October 2025. There is a plan to move the Trust to Office 365. | |
| **Actions agreed in the meeting** | **Responsibility / timescale** |
| **1. Update on CQC Requests**<br>To add 'Update on CQC Requests' as a quarterly standing agenda item to monitor the progress. | 1. D&D Committee Chair<br>Trust Secretary<br>Timescale: Committee meeting 11th September 2025 |
| **2. Charity Funding for Digital Requests.**<br>Meeting to be arranged with IT senior managers, Phil Kane, Non-Executive Director and Teri Bayliss, Charity Director to gain a better understanding of the Digital process. | 2. Interim Operational Director<br>Timescale: Before the next Committee meeting on 11th September 2025 |
| **3. Infected Blood Inquiry**<br>Jackie Bilcliff, Acting Deputy CEO, agreed to raise the Infected Blood Inquiry with Michael Wright to ask if there is an emerging risk and where it is being discussed. | 3. Acting Deputy CEO<br>Timescale: Next Committee meeting 11th September 2025 |
| **4. Data Partnerships and Commercial update**<br>To add to the agenda of the next meeting an update of wider data partnerships, an update on the Alliance conversations due to take place over the summer and a commercial update and the progress on this. | 4. Associate Director for Commercial Enterprise<br>Timescale: Next Committee meeting 11th September 2025 |
| **5. Information Services**<br>To arrange via the Corporate Team, for Jo Field, Head of Information Services, and Patrick Garner, Director of Performance and Risk to attend the agenda planning meeting for the Digital and Data Committee. | 5. Head of Information Services<br>Timescale: Next Committee meeting 11th September 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** |
| Dave Elliott informed the group a review of the strategic risks will be held over the next three months. There would be benefits from splitting out the risks with a more focused strategic way. | |

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

# Quality Committee
# Chair's Log

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|---|---|
| **Meeting**: Quality Committee | **Date of Meeting**: 15 July 2025 |
| **Connecting to**: Audit Risk & Assurance Committee and Trust Board | **Date of Meeting**: 23 and 26 September 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:
  - Emergency Department
  - Feedback from Quality Improvement Group (QIG)
  - Cardiac Oversight Group
- **Management Groups Chairs Logs**
  - **Clinical Outcomes & Effectiveness Group -** Key topics for discussion included: approval of a new procedure in relation to Embolic protection during TAVI (Transcatheter Aortic Valve Implantation) procedures, Status of NCEPOD (National Confidential Enquiry into Patient Outcome and Death) Studies, National Clinical Audits, CQUIN (Commissioning for Quality and Innovation) Update and Terms of Reference for the Clinical Outcomes and Effectiveness Group and the Mortality Surveillance Group.
  - **Patient Safety Group** - Key topics for discussion included the increase in incident reporting, improving Duty of Candour compliance, PSIRF (Patient Safety Incident Response Framework) Priorities for 2025/26 and the role of the Freedom to Speak Up (FTSU) Guardian in terms of visibility in relation to patient safety.
  - **Transplantation Committee -** Key topics for discussion included the National Organ Utilisation Strategy, nursing capacity, cardiothoracic mortality and performance.
- **Quality Priority 2 Update.** *[Improve medicines reconciliation rates, reduce omitted doses for inpatients, reduce medicine related waste, improve accuracy of information to GP on patient discharge].* The update provided an overview and assurance to the Quality Committee that plans were in place for Quality Priority 2. There had been an improvement since January in medicines reconciliation from 10% to 38%. The Clinical Audit Tool for medicines management was now being completed by the pharmacy teams with robust action plans in place for areas of non-compliance and a clear escalation pathway for those that were not meeting targets. Medicines management training continued to improve.
- **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.
- **Gynaecology Services Report.** The report detailed the findings of a review of a historical investigation undertaken in the department. A conclusion was made that several positive changes have been put in place across the organisation since the investigation was initially

conducted and a confidence that if these concerns were raised now there would not be a recurrence.

- **Patient & Staff Experience Update.** The update provided an update on learning about the care experience from patient, service user, carer and family feedback for May and June 2025. At Trustwide level, early results showed an overall domain average score of 9.3 out of 10. The lowest scoring domains related to food (8.22 out of 10) and noise at night (8.54 out of 10).
- **Infection Prevention Control (IPC) Six-month Deep Dive.** The report informed the Quality Committee of the Trust's current position in relation to IPC. The report detailed current rates of Health Care Associated Infections (HCAIs), and the IPC Board Assurance Framework (BAF), highlighting compliance, areas of risk, and the mitigations in place. It complemented the regular Integrated Board Report (IBR) and summarised the current position for the Trust up to the end of May 2025.
- An update on the roll out of **'Call for Concern' (Martha's Rule)** in paediatrics was provided.
- An **Audiology Update Paediatric Hearing Services Improvement Programme** has been established by NHS England to support providers and Integrated Care Boards (ICBs) to gain assurance around all paediatric audiology services. Following an assessment, the Paediatric Audiology service triggered an ICB Incident Management (May 2024). There have been monthly meetings between the ICB and subject matter experts and Newcastle Hospitals with a view to review and monitor progress on the Trust action plan, gain assurance on ABR (Auditory Brainstem Response) screening competence and review all historic ABR testing records for potential harm.
- **Care Optimisation** An update was provided in relation to patient correspondence, current digital requests impacting on quality, prioritisation process, an overview of workstreams as well as governance and escalation processes.
- **Wards of Concern, Accrediting Excellence (ACE) & Progress on Matron Governance Reporting Update -** 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).
- **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.
- **Summary of Internal Audit Reports relating to the Quality Committee.** The report aimed to support the Quality Committee to monitor and seek assurance relating to the internal audit plan and associated recommendations aligned to the Quality Committee area of focus. An update on recommendations and completed actions was provided.
- The **Integrated Quality & Performance Report** was presented which provided assurance to the committee on the Trust's performance against key Indicators relating to Quality & Safety, Access, People, Finance and Health Inequalities.
- **Celebrating Excellence – Paediatric Rheumatology GIRFT (Getting it Right First Time) Update.** A presentation was delivered in relation to data-driven improvements in order to provide better pathways into paediatric rheumatology care, provide prompt access to paediatric rheumatology Multi-disciplinary Team care and better provision of developmentally appropriate Adolescent and Young Adult care.
- The **Quality Oversight Group (QOG) Terms of Reference** were approved.

| Actions agreed in the meeting | Responsibility / timescale |
|---|---|
| 1. More analysis on cleanliness in the Emergency Department (ED) to be looked at via the real time survey. | • Annie Laverty, Chief Experience Officer – October 2025 |
| 2. Assurance paper to be provided in relation to the move from the World Health Organization (WHO) Surgical Safety Checklist to NATSSIPS2 (National Safety Standards for Invasive Procedures) | • Rachel Carter, Director of Quality & Safety – September 2025 |

| | |
|---|---|
| 3. HR support during the speaking up of safety concerns. To be discussed as part of the Executive Team review with any escalations referred into the People Committee. | • Rob Harrison – Acting CEO / Lucia Pareja-Cebrian, Joint Medical Director |
| 4. Assurance paper to be provided following a full audit of all Multi-Disciplinary Team (MDT) meetings across the organization. | • Rachel Carter, Director of Quality & Safety - Quarter 4 2025/26 |
| 5. Care Optimisation – to reinvigorate that work that has been undertaken previously with the expectation of significant improvement. | • Lucia Pareja-Cebrian and Michael Wright, Joint Medical Directors – January 2026 |
| 6. Patient Experience – next report to include details on food provision and how it can be improved as well as an update on the new pieces of work being launched in relation to waiting lists and orthopaedics. | • Annie Laverty, Chief Experience Officer – October 2025 |
| 7. Call for Concern (Martha's Rule) update paper to be provided for the Committee. | • Gus Vincent, Associate Medical Director for Quality & Safety - October 2025 |
| 8. Audiology – update paper to be provided following the next round of reviews and then yearly update thereafter. | • Chris Wright, Director of Operations – November 2025 then yearly update |
| 9. Board Assurance Framework actions to be reviewed being mindful of the digital and IPC risks. | • Rachel Carter, Director of Quality & Safety & Ian Joy Executive Director of Nursing – September 2025 |
| 10. To add a specific update / oversight paper to the schedule of business in relation to the Dental Hospital. | • Ian Joy Executive Director of Nursing – November 2025 |
| 11. Review the timetable for paper submissions to ensure timely delivery and thorough review before meetings. | • Ian Joy Executive Director of Nursing |
| **Escalation of issues for action by connecting group/Trust Board** | **Responsibility / timescale** |
| • Care Optimisation – to reinvigorate the work that has been undertaken previously with the expectation of significant improvement. To escalate to Board that the Quality Committee has asked for this piece of work to be undertaken.<br>• The risks that the rise in IPC infections pose to the organisation and the impact on the NHS Oversight Framework rating. | • Anna Stabler – July Board |
| **Risks (Include ID if currently on risk register)** | **Responsibility / timescale** |
| • Detailed within the BAF. | • N/A |

Agenda Item A11

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

# People Committee - Chair's Log

| | |
|---|---|
| **Meeting**: People | **Date of Meeting**: 21 July 2025 |
| **Connecting to**:<br>Audit, Risk and Assurance Committee (ARAC)<br>Trust Board | **Date of Meeting**:<br>23 September 2025<br>26 September 2025 |
| Key topics discussed in the meeting | |

- The Committee received a comprehensive update on the Proud2B admin and operational development and networks which have been launched across the Trust. It was noted that administrative roles have evolved significantly and the need to support, develop and invest in administrative teams and structures.
- An update was provided on the People Plan Year 1 status and the development of the People Plan Year 2 which included key outcomes and impact measures.
- A Health and Wellbeing update was received which included updates on the Staff Psychology service and emerging operating model, mental health first aid, AuditOne and better health at work recommendations, in work poverty via society matters and men's mental health.
- The Committee received a progress update with regards to Equality, Diversity and Inclusion (EDI) and the six high impact actions. Each Board member has a clear EDI objective, and it was highlighted that the EDI plan has been informed by extensive feedback received during engagement sessions, through the staff survey and from the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) data.

  A discussion ensued with regards to the Supreme Court Judgement dated 16 April 2025 noting that the Trust is awaiting guidance from NHS England (NHSE) however work is underway to understand the implications and support staff. This is led by the Executive Team and supported by the Women's and Pride networks so that the Trust can listen to and support staff, patients and families.
- A People Learning and Development update including compassionate leadership offer was received noting that the Compassionate Leadership programme is currently being evaluated and the refreshed offers in Organisational Development incorporating the Insights Discovery Model.
- A detailed discussion took place on the Integrated Board Report (IBR) which included a deep dive on sickness absence, recruitment, retention and appraisals. Occupational Health are promoting an early access advice system. There has been a 2.01% improvement seen with regards to appraisal rates and mandatory training performance is at 91.64% which is above target.
- An update on the People Committee Board Assurance Framework (BAF) was provided, noting that three new strategic risks have been added, with threats being identified for these and all risk scores, controls, assurances, assurance ratings, actions and action indicators have been populated. The Committee ratified the BAF for Trust Board approval.
- A summary of Internal Audit reports was received with eight internal audits and 25 open recommendations aligned to the People Committees area of focus. 10 were recommended to be completed as they have been actioned and closed within the last month.
- The Guardian of Safe Working Annual Report 2024/25 and Quarter one report for 2025/26 were discussed in detail. It was noted that all issues are managed and actioned in a timely manner and that there will be changes to exception reporting to increase numbers which may

result in a financial implication. In quarter one, there were 118 exception reports with the main area being general medicine and the main cause being staffing levels available are insufficient for the workload.

- The People Programme Board Chairs Log from the June meeting was received which included a summary of key topics discussed and agreed actions from the meeting.
- The updated People Committee Schedule of Business was ratified. Changes included new section titles and job planning updates.
- A discussion took place with regards to the Voluntary Severance Scheme (VSS) and next steps with Committee members.

| Actions agreed in the meeting | Responsibility / timescale |
|---|---|
| 1. In relation to Health and Wellbeing, it was agreed that the next update would include the strategy of the service, actions status and progress made. | 1. Karen Pearce, Head of Equality, Diversity and Inclusion (People) / November 2025 |
| 2. Integrated Board Report - Ian Joy, Executive Director of Nursing said that it would be useful to compare temporary staffing spend and total hours worked from the previous 12 months. | 2. Paul Turner, Head of HR Services / September 2025 |
| 3. Integrated Board Report – Paul Ennals, Chair said that it would be useful to include the proportion of staff who are moving into a new role at an Alliance organisation. | 3. Paul Turner, Head of HR Services / September 2025 |
| 4. Integrated Board Report – Bernie McCardle suggested incorporating the number of staff members working flexibly into the dashboard. | 4. Paul Turner, Head of HR Services / September 2025 |
| 5. Board Assurance Framework (BAF) – Vicky McFarlane-Reid agreed to review the ratings outside of the meeting. | 5. Vicky McFarlane-Reid, Director of Commercial Development and Innovation / September 2025 |
| **Escalation of issues for action by connecting group** | **Responsibility / timescale** |
| 1. Supreme Court Judgement – 16 April 2025 | 1. Caroline Docking, Director of Communications and Corporate Affairs & Annie Lavery, Chief Experience Officer / September 2025 |
| 2. Resident Doctor Stikes | 2. Michael Wright & Lucia Pareja-Cebrian, Joint Medical Directors / September 2025 |
| 3. Exception reporting reform for resident doctors | 3. Henrietta Dawson, Guardian of Safe Working / September 2025 |
| **Risks (Include ID if currently on risk register)** | **Responsibility / timescale** |

| | |
|---|---|
| Risk ID 2.1 - Failure to improve and maintain an organisational culture, in line with our Trust values and our People Plan.<br><br>Risk ID 2.2 - Failure to effectively manage organisational change and related leadership and governance required to ensure effective supporting structures with the new Trust operating model.<br><br>Risk ID 2.3 - 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. | Not applicable. |

Agenda Item A11

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

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

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|---|---|
| **Meeting**:<br>Finance and Performance Committee | **Date of Meeting**:<br>21 July 2025 |
| **Connecting to**:<br>Audit, Risk and Assurance Committee<br>Trust Board | **Date of Meeting**:<br>23 September 2025<br>26 September 2025 |

## Key topics discussed in the meeting

- The Peri-operative and Critical Care Clinical Board provided an update on their financial and Cost Improvement Programme (CIP) position. At month 3, a full budget rebase was completed on pay and non-pay, and work is taking place with regards to understanding this position across the Clinical Board with all budget holders. The Clinical Board has an underspend of £347k excluding CIP and the target for CIP is £5.9m.
- In relation to the month 3 finance report, the Trust has agreed a breakeven plan for 2025/26 and remains on plan. The planned CIP level is currently being met predominantly through technical non recurrent benefits rather than cost reduction. The Trust remains focused on delivering the forecasted breakeven position through recurrent measures however it was noted that this will be a challenge.
- At month 3, the total capital expenditure to date was £10.7m against a plan of £9m. In addition to this, there had been £3.7m of expenditure relating to donated funds.
- An update on the Trust performance requirements and activity plan was provided which included investments, current performance and the anticipated increase in activity still required to achieve the performance standards within the Trust annual plan. Several investments in the most challenged specialities were approved as part of the planning process to increase activity to deliver the national standards.
- The Integrated Board Report (IBR) was presented and the key areas highlighted were in relation to the overall 4-hour performance which improved in May 2025 to 79.1%, the 28 day faster diagnosis standard (FDS) for cancer was achieved for the fourth successive month and the 31 day performance sustained its position at 76.9%.
- A deep dive into elective waits took place highlighting the following areas:
    - Continued progress in relation to 78-week waiters which has reduced from 22 in May 2024 to 21 in May 2025.
    - The Trust had 108 65-week waiters in May 2025, in comparison to 476 in May 2024.
    - Community waits are an area of focus.
- A deep dive into Children and Young Peoples Key Performance Indicators (KPIs) took place highlighting the following areas:
    - Improvements have been seen with regards to Paediatric Emergency Department (ED) with performance being 91.4% in May 2025.
    - In relation to the 0-19 service positive performance being evidenced across arrange of metrics.
- The Board Assurance Framework (BAF) including the strategic risks aligned to the Committee was presented with the risk scores remaining unchanged and a new action has been added

relating to the ongoing financial delivery and mitigation meetings, deep dives and early mitigation plan reporting to the Trust Board and a decision regarding the subsidiary. The Committee ratified the BAF for Trust Board approval.

- A summary of Internal Audit reports relating to the F&P Committee was received noting that there are 11 internal audits relating to the Committees area of focus, five of the 11 are yet to be completed however assurance levels will be updated when the final reports are produced. There are currently 21 open recommendations aligned to the Committee.
- The Committee received a Job Planning update, and it was noted that 950 of 1,203 job plans have been received since April 2025. A Job Planning Advisory Group is being established to monitor consistency of application with the first meeting planned for August 2025. Work against the mitigation actions to reduce financial impact is underway and a further update will be provided at the September F&P Committee meeting.
- A number of procurement reports were approved.
- The Committee received the Chairs Logs and minutes of the Capital Management Group in June, Financial Recovery Steering Group in June and Supplies and Service Procurement in June.

| Actions agreed in the meeting | Responsibility / timescale |
|---|---|
| 1. Bill MacLeod, Committee Chair & Non-Executive Director (NED) said that it would be useful to include further information on Health Inequalities for Community data in the next Children and Young Peoples KPIs deep dive. | 1. Patrick Garner, Director of Performance and Governance / November 2025 |
| 2. In relation to the summary of Internal Audit reports relating to the F&P Committee, Bernie McCardle, NED suggested to include information with regards to when due dates have been revised to future reports. | 2. Patrick Garner, Director of Performance and Governance / October 2025 |
| **Escalation of issues for action by connecting group** | **Responsibility / timescale** |
| 1. The Trust Board is sighted on the challenging financial position and the risks to achieving the CIP target however it was agreed that further discussions will take place at the Private Trust Board meeting. | 1. Jackie Bilcliff, Chief Finance Officer / July & August 2025 |
| **Risks (Include ID if currently on risk register)** | **Responsibility / timescale** |
| • Risk ID 6.1 - Failure to manage our finances effectively to improve our underlying deficit and deliver long term financial sustainability.<br>• Risk ID 6.2 - Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care.<br>• 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. |

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

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

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|---|---|
| **Meeting**: ARAC | **Date of Meeting**: 22 July 2025 |
| **Connecting to**: Trust Board | **Date of Meeting**: 25 July 2025 (verbal)<br>26 September 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.
- Key updates from the Digital & Data (D&D), Quality, Finance & Performance (F&P) and People Committee Chairs were shared:
  - D&D - The Data Security and Protection Toolkit (DSPT) compliance was achieved. Committee members had discussed the challenges associated with prioritisation of the vast number of digital projects. Further work was noted to be underway to increase the prominence of 'data' related matters on the D&D Committee agendas.
  - Quality - Infection prevention and control and the timely issuing of discharge letters.
  - F&P - The challenging financial position and mitigation plans.
  - People - the Guardian of Safe Working briefed members on changes to the exception reporting framework and the recent Supreme Court Judgement on the definition of a woman.
- Board Assurance Framework (BAF) - three new People risks were added for 2025/26 and reviewed at the People Committee. The Chief Digital Officer was reviewing digital strategic risks, with the BAF to be updated as appropriate within the next 3 months. Other updates to the BAF included the completion of actions, addition of new actions and updates to the assurance sections for one threat. Committee members approved the assurance rating recommendations proposed.
- Risk Report – report deferred to the next Committee meeting to allow further work to be undertaken through the Risk Validation Group on higher rated risks.
- Review of the Clinical Audit Process – update shared which detailed the process improvements made during the previous 6 months and audit compliance levels.
- Internal Audit Progress Update – two final reports had been issued from the 2024/25 internal audit plan since the last Committee meeting and four audits were currently at draft / review stage. Five audits at fieldwork / planning stage were carried forward into the 2025/26 internal audit plan and one final report had been issued from the 2025/26 internal audit plan. Regarding the follow up of previously agreed actions one overdue action was awaiting update at the time of the meeting and 11 actions had received a revised target implementation date. Future internal audit reports would no longer include recommendations but refer to findings and actions only.
- Counter Fraud Activity Report including Fraud Response Log / Fraud register – an update was shared on the Trust's preparations for the introduction of the corporate offence of failing to prevent fraud as part of the Economic Crime and Corporate Transparency Act 2023. An initial review of the NHS Counter Fraud Authority (NHSCFA) guidance had been undertaken with full

compliance at 55% to date and areas for further action identified e.g. risk appetite and Chief Executive Officer statement. Update to be shared at the next Committee meeting. Committee members discussed communications on the outcomes of fraud cases.

- Counter Fraud Annual plan and annual fraud self-review tool – the Annual Report was received. The Trust had self assessed as being fully compliant with all of the components of the Government Functional Standards: Counter Fraud.
- Modern Slavery and Human Trafficking Act Statement - An NHS Modern Slavery Statement for 2024/25 for all NHS bodies was published by NHS England in April 2025. Committee members agreed that new wording be added to the Trust website to replace the existing Annual Statement with the national NHS statement.
- Annual Fit & Proper Persons Test report – the report gave an update on the annual checks undertaken for 2024/25 and provided assurance that the requirements had been met. Learning had been identified and would be incorporated into the 2025/26 process.
- The Charity Annual Financial Statements were deferred to the next Committee meeting.
- The following reports were received - review of:
  - Schedule of approval of single tender action and breaches and waivers exception report.
  - Debtors and creditors balances. Work was noted to be underway with the Newcastle University research team regarding aged debtor/creditor balances.
  - Schedule of losses and Compensation. Some new processes were to be implemented regarding overseas visitors payment/debt management.
- Committees Chairs Logs were received for the following Committee meetings:
  - Finance and Performance Committee – 23 June 2025
  - Quality Committee – 17 June 2025
  - Digital & Data Committee – 8 May 2025
  - Compliance and Assurance Group – 11 July 2025
- Third party assurance reports were received for information: Payroll, Electronic Staff Record (ESR) and North East Patches (NEP).
- A review of performance was discussed with no issues noted regarding:
  - Internal Audit
  - Counter Fraud
  - External Audit
- Regarding any other business, the tier two management groups and associated Chairs Log reporting was being considered by the Executive Team.

| Actions agreed in the meeting | Responsibility / timescale |
|---|---|
| 1. Ian Joy, Executive Director of Nursing to liaise with the Digital Health triumvirate regarding completion of an Equality and Quality Impact Assessment for the digital prioritisation exercise. | 1. Ian Joy – 23 September 2025 |
| 2. Jackie Bilcliff, Chief Finance Officer to review the wording in the BAF regarding the potential impact of the financial position on the delivery of services. | 2. Jackie Bilcliff – 23 September 2025 |
| 3. Patrick Garner, Director of Performance and Governance to consider whether threat assurance levels rated as green should be shown/grouped separately. | 3. Patrick Garner – 23 September 2025 |
| 4. Rachel Carter, Director of Quality & Safety agreed to check whether there was a typographical error within the | 4. Rachel Carter – 23 September 2025 |

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| review of Clinical Audit Process report which referenced November 2024. | |
| 5. Ian Joy and Wayne Brown, Associate Director of Internal Audit agreed to meet to discuss the change in approach to not including recommendations and the process for agreement of deliverable actions to ascertain whether further training was needed for staff. | 5. Ian Joy & Wayne Brown – 23 September 2025 |
| 6. Rachel Cockburn, People Resourcing Manager agreed to follow up a specific query regarding one Non-Executive Director (AS) not receiving regular automated reminder emails for training due for completion and the interface between Learning Lab and ESR. | 6. Rachel Cockburn - 23 September 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 |

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

# TRUST BOARD

| | | | |
|---|---|---|---|
| Date of meeting | 26 September 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 support the Trust Board to gain assurance that strategic risks aligned to the Board/Committees are being managed effectively; that risks have an appropriate action plan in place to mitigate them; and that risk scores are realistic and achievable.<br><br>**Key points to note:**<br><br>**Quality Committee**<br>• The risk has been reviewed by the Executive Director of Nursing.<br>• The current risk score remains at a score of 15 (5x3).<br>• Eight new actions have been added on threats: Implementation of the National Safety Standards for Invasive Procedures (NatSSIPS) Framework, review and strengthen maternity escalation processes, sharing digital priorities, define digital capacity, digital communications plans, review digital optimisation, clinical hardware refresh and implementation of the Infection Prevention and Control (IPC) Improvement Group.<br>• 6 actions are currently behind plan and new timescales have been added: Develop Trust-wide Patient Safety Strategy, recruit patient safety partners, achieve 90% target for level 2 Mental Capacity Act (MCA) training, design and implement standardised quality reporting mechanisms, Clinical Board (CB) dashboard framework for areas of improvement and update allocate templates for maternity fill rate, skill mix and safe staffing.<br>• Further controls have been added to the Quality Digital Threat: digital clinical educators appointed, nursing documentation framework and digital improvements prioritisation and oversight via Care Optimisation Group.<br>• A review of the IPC threat has taken place, and a decision has been taken to comprehensively review Healthcare Associated Infection (HCAI) reduction strategies as well as the level of compliance and assurance with policy and procedure via the newly implemented IPC Improvement Group.<br><br>**People Committee**<br>• The risk has been reviewed by the Director of Commercial Development and Innovation.<br>• All current risk scores remain unchanged.<br>• 2 new actions have been added on threats, these relate to the delivery of 2025/26 Equality, Diversity and Inclusion (EDI) priorities and consideration of additional workforce reduction schemes. | | |

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| | • 6 actions are currently behind plan and new timescales have been added to: delivery of staff psychology service, staff survey results, people plan programme launch, further development of CB People Oversight Groups, explore just culture and implementation of Business Partner Model.<br>• 4 controls have been added relating to the establishment of a People and Culture Multi-Disciplinary Team (MDT) Group, Health and Wellbeing Policy, evaluation and appraisal of Trust Compassionate Leadership Programme and establishment of an Occupational Health Self-Referral Service.<br>• Threat assurance levels have been updated to amber from red on the following threats:<br>- Trust plans to reduce corporate headcount by 50% of 2019/20 growth.<br>- Underdeveloped workforce planning mechanisms impacting on our ability to effectively forecast workforce needs.<br>- Failure to deliver improvements to leadership and governance.<br>- Failure to review and improve team working across the Trust following declining staff survey results in relation to 'we work as a team' question.<br><br>**Finance & Performance Committee**<br>• Risk scores remain unchanged.<br>• 8 actions have been completed in relation to in year emerging costs, enhanced cash reporting, waiting list booking process training, cancer tiering exit, histopathology productivity metrics, risk-based asset plan and report, analysis of medical Device Data and Private Finance Initiative (PFI) executive settlement agreement.<br>• 3 new actions have been added relating to consideration of cash management guidance from NHS England, development of forecasting models and NHS Oversight Framework (NOF) Metrics.<br>• 1 new threat and associated controls, assurances and actions have been added – Failure to achieve NOF standards/ratings to ensure the Trust receives strengthened local autonomy.<br><br>**Audit Committee**<br>For Risk ID 1.2 – Failure to implement effective governance systems and processes.<br>• Risk scores remain unchanged.<br>• 6 Actions have been completed relating to the CB governance audit, establishment of an Access and Improvement Delivery group, establishment of enhanced oversight and governance of performance and productivity metrics, development of the interim Trust Strategy, roll out of the InPhase risk application and training and development of the risk appetite statement.<br>• 6 new actions have been added relating to the ward to board governance review, await outcome of external well-led review, complete trust capability self-assessment, develop operational risk appetite approach, develop risk management strategy and further development and improvement of the InPhase Risk Management System.<br>• 3 action timescales are currently behind plan and new timescales have been added, relating to the Accountability and Autonomy Framework, governance handbook and roll out of ward/departmental level InPhase risk management system.<br><br>**Trust Board (due for review in September Trust Board)**<br>For risk ID 7.1 – inability to sufficiently influence priorities of key partnerships.<br>• Risk scores remain unchanged.<br>• All threats are fully on plan across all actions and threat assurance ratings are green.<br>• One new action has been added in relation to the commencement of a Shared Chair to extend the remit to include Gateshead from 1 October 2025. |

<table>
<tr><td>Recommendation</td><td colspan="6">The Trust Board are asked to:<ul><li>Review and approve the Board Assurance Framework.</li><li>Provide any feedback or comments.</li></ul></td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Links to all strategic objectives.</td></tr>
<tr><td rowspan="2">Impact<br>(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">N/A</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Executive Leads and Committees of the Trust Board.</td></tr>
</table>

# BOARD ASSURANCE FRAMEWORK
# 2025/2026 – SEPTEMBER 2025

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

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.**

# Board Assurance Framework 2025/2026

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| **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. |

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| **Lead Committee** | Quality Committee | **Risk Rating** | **Initial** | **Current** | **Target** | **Risk Appetite** | |
| **Executive Lead** | Director of Nursing | **Impact** | **5** | **5** | **5** | **Risk Appetite Category** | Quality and Safety |
| **Date Added** | 01.05.2025 | **Likelihood** | **4** | **3** | **1** | **Risk Appetite Tolerance** | LOW |
| **Last Reviewed** | 08.09.2025 | **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** |
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| 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.<br>• Central supportive governance infrastructure to deliver the PSIRF.<br>• The Quality Governance Framework underpinned by Quality Oversight Groups (QOG's) in each Clinical Board (CB).<br>• Response Action Review Meetings.<br>• Policies and Procedures.<br>• Patient Safety Incident Forum.<br>• Incident reporting system.<br>• Clinical Risk Group.<br>• Rapid Quality and Safety Peer Reviews. | • Response Action Review Meeting /Patient Safety Incident Forum minutes and actions plans.<br>• Strengthened quality of learning responses by ensuring a standardised approval methodology is used.<br>• Monitoring of compliance with PSIRF timeframes for learning responses. Power BI dashboards shared at Clinical Board QOG's and Quality and Performance Reviews.<br>• Regular PSIRF update reports to Patient Safety Group.<br>• Integrated Quality Report to Quality Committee.<br>• Oversight through Clinical Board Quality. Oversight Group, reported into Quality and Performance Reviews (QPR) and the Executive Team.<br>• Care Quality Commission (CQC) Delivery Group and CQC Assurance Group oversight.<br>• Staff Survey – demonstrates increased response rate of 65%.<br>• Clinical Risk Group reports and sharing of learning, national patient safety alerts etc.<br>• 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.<br>• Delivery of CQC action plan – Actions on track to be completed by deadline, please see CQC phase 2 action plan document for exact timescales.<br>• Reporting of Duty of Candour (DoC) improvement to Quality Committee – next paper October 2025 to include an audit of quality of DoC written responses.<br>• Deliver 2025/26 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.<br>• Development of Trust-Wide Patient Safety plan – in draft, working group in place to ensure engagement, launch April 2026.<br>• PSIRF Annual Report to Quality Committee April 2026.<br>• Recruit Patient Safety Partners from the Trust Participation & Involvement Panel – December 2025. 1 in post.<br>• Implement NATSSIPS framework Trust-wide by – October 2026. | **2- Actions defined – most progressing, where delays are occurring interventions are being taken.** | |

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| Failure to safeguard and deliver care in line with the Mental Health Act (MHA) and Mental Capacity Act. | • Mental Capacity Oversight Group.<br>• Mental Health (MH) Committee.<br>• PLT meetings with core services.<br>• Restraint Review Group.<br>• MCA Quarterly audit framework.<br>• Health and Safety Committee.<br>• Patient Experience and Engagement Group.<br>• MCA training programmes/compliance.<br>• Learning Disability Steering Group.<br>• Learning from lives and deaths – people with a learning disability and autistic people (LeDeR review group.<br>• Environment review completed on two areas of concerns highlighted in Trust CQC report, along with areas of high risk.<br>• Learning Disabilities and MCA oversight by Safeguarding Committee/Quality Committee/Trust Board.<br>• Mental Health Awareness Training (specific packages for high-risk staff groups e.g. Security staff).<br>• Core quarterly mental health assessment metrics agreed.<br>• 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).<br>• Increase in Deprivation of Liberty Standards (DOLS) referrals represented of expected volume.<br>• Compliance with MCA Level 1 mandatory training 97% in Q4 (96% in Q3) and bite size training (Learning Disabilities, MCA and MH)<br>• MHA provider review recommendations, action plan and evidence of completion.<br>• Learning Disabilities and MCA reporting and minutes to Safeguarding Committee/Experience of Care Group/Quality Committee and Trust Board.<br>• Compliance with Mental Health Awareness Training (98.1% June 25).<br>• Quarterly mental health assessment audit framework.<br>• Self-Harm Risk Assessment Programme complete, remediation work commenced in January 2025 for high risk areas.<br>• Training Video to support reasonable adjustments launched and documentation of reasonable adjustment pilot commenced June 2025.<br>• The Self Harm Risk Assessments are on InPhase. | • Level 2 MCA training programme launched and mandated for all relevant staff - compliance to 90% by June was not achieved. Current compliance 81% with aim to achieve 90% target in Q3.<br>• Agree long term training framework for Learning Disabilities and Autism, Integrated Care Board (ICB). National expectation of the Oliver McGowan Training confirmed.<br>• Development and approval of phase 2 Self Harm Programme of Estates works (Medium/Low risk areas – September 2025.)<br>• Draft of Learning Disability and Autism Strategy completed. To consult and finalise by end of Q3. | **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.<br>• Clinical Outcomes and Effectiveness Group.<br>• Getting-It-Right-First-Time (GIRFT) oversight group.<br>• Clinical Effectiveness metrics.<br>• New Interventional Procedures Group Review.<br>• Stocktake of progress with Clinical Board Quality Oversight Groups completed.<br>• Stocktake of progress with clinical board QOGs.<br>• Review of QOG activity presented to Quality Committee in October 2024. | • Clinical Audit and Guidelines Group minutes and Action plans.<br>• Clinical Outcomes and Effectiveness Group (COEG) minutes and action plans.<br>• Bi-annual Reports to Quality Committee.<br>• Bi-annual Clinical Audit Report to the Audit, Risk and Assurance Committee (ARAC).<br>• GIRFT Oversight Group reports and minutes.<br>• Minutes and reports of New Interventional Procedures including Robotic Surgical Group-reports to COEG.<br>• Quality Oversight Group dashboards.<br>• Initial stocktake of QOG activity completed in May 2024 - shared with CB's.<br>• Clinical Board Governance Internal Audit – audit report – reasonable assurance. | • 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/National Institute for Health and Care Excellence (NICE) via InPhase risk management system – April 2026.<br>• Baseline review of Trust non-compliance with standards/guidelines, propose organisational approach to Quality Committee – report to Quality Committee September 2025. | **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.<br>• Monthly audit framework measuring. compliance with policy to inform areas for improvement.<br>• Internal peer review process. | • Monthly audit data of ward and department compliance with core standards with dissemination of learning and action.<br>• Policy audits undertaken and reported through medicines management committee.<br>• Datix data and trends relating to medicines management reported and reviewed. | • Actions as outlined in MMOG Action Plan. | **2-Actions defined-most progressing, where delays are occurring interventions are being taken.** | |

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| could directly impact care quality and safety | • Existing medication governance and oversight structures.<br>• Medicine Management Policies and procedures.<br>• Commissioned and completed expert external review to inform improvement work streams.<br>• CQC Delivery Group.<br>• Completed review of Medicines Reconciliation function across the Trust to identify urgent areas for improvement to attain to national best practice.<br>• Revised medicines management action plan.<br>• Established Medicines Management Oversight Group (MMOG) to ensure delivery of improvements.<br>• Increased nursing infrastructure to support medicines safety. | • Peer review and external review reports and audit data.<br>• CQC Delivery Group monitoring, reporting and minutes.<br>• Compliance and Assurance Group reporting and minutes.<br>• Quality Governance Structure via quality committee and Trust Board.<br>• September Rapid Quality and Safety Review Audit Data. | | | |
| Failure to improve the safety and quality of patient and staff experience in Maternity Services. | • Maternity Incentive Scheme and Three-Year action plan in place. These are reported into Quality Committee and Trust Board.<br>• Robust Maternity Governance Team in place.<br>• Maternity Operational Oversight Group (MOOG).<br>• Board Maternity Safety Champion.<br>• Incident Review Group.<br>• Women's Quality and Safety Group.<br>• Family Health QOG.<br>• Monthly Maternity Staff meetings.<br>• Maternity Voices Partnership - Lead quorate member of Quality and Safety Group and Obstetric Board member.<br>• LMNS (Local Maternity and Neonatal System) oversight of Perinatal Quality Surveillance metrics and Maternity Incentive Scheme.<br>• Real time patient/staff experience programme.<br>• Workforce review including outputs of 2024 birthrate plus.<br>• Refreshed perinatal governance structure aligned to themes of Three-Year Plan for Maternity and Neonatal care, reporting into Obstetric Board.<br>• North East and North Cumbria (NENC) Clinical Outcomes Dashboard and safety signal review process.<br>• Review and refresh of Perinatal Quality Surveillance Metrics.<br>• Perinatal Anti-Racism Taskforce (PART) and associated action plan.<br>• Staff wellbeing and cultural improvement plan.<br>• Perinatal senior nurse/midwife on call introduced August 2025. | • Improvement action plan in place covering all core CQC must and should do moved to business as usual with reporting via MOOG.<br>• NHS Oversight Framework (NOF) 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.<br>• 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.<br>• Project PROMISE spend plan aligned to staff wellbeing and cultural improvement plan.<br>• Obstetrics Board.<br>• Reporting and oversight into Quality Committee and Trust Board<br>• Maternity Services Quality Dashboard and NENC Clinical Outcomes Dashboard.<br>• Annual CQC Maternity Survey results – improvement in some domains, no reduction in results, improved position in NENC ranking.<br>• Clinical Negligence Scheme for Trusts/Maternity Incentive Scheme (CNST/MIS) compliance.<br>• Incident data.<br>• Incident review group reporting and actions.<br>• Family Health meeting minutes and Quality Oversight Group (QOG) minutes.<br>• Perinatal staff experience programme.<br>• Workforce review outputs and report.<br>• Peri-natal quality surveillance metrics monitored and reported to Quality Committee.<br>• Midwifery staffing and red flags monitored and reported to MOOG and Quality Committee. | • Maternity Services phase 3 investment plan – October 2025.<br>• Update Allocate templates to evidence correct fill rate, skill mix and safe staffing against planned – currently delayed with finance. September 2025.<br>• Review and strengthen current escalation processes - October 2025. | **2-Actions defined-most progressing, where delays are occurring interventions are being taken.** | |

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| Failure to embed the learning from external service reviews. | • Cardiac Oversight Group.<br>• Cardiothoracic Improvement plan, including improvement actions from CQC and other external reviews.<br>• Newcastle Hospitals Quality Improvement Group.<br>• Quality and Performance Reviews.<br>• Review infrastructure of quality oversight and local governance groups. | • Cardiac Oversight group reporting and minutes.<br>• Reports to Trust Board and Quality Committee.<br>• Maintenance of central external review log.<br>• Central oversight of implementation of recommendations and monitoring of action plan completion via Quality and Performance Reviews.<br>• Compliance and Assurance Group Reports and Minutes. | • Development of dashboard framework for Clinical Board oversight of actions/areas for improvement by April 2026.<br>• 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 project – April 2026. | **2-Actions defined-most progressing, where delays are Occurring interventions are being taken.** | |
| Failure to deliver and adopt digital optimisation initiatives that drive measurable improvements in patient safety and quality of care. | • IT Town Hall, engagement sessions and Staff Roadshows.<br>• Trust-wide adoption coaches appointed.<br>• Digital Health Team Care optimisation project.<br>• Digital leaders' group.<br>• Care optimisation group.<br>• Care Planning Task and Finish Group.<br>• Minimum Nursing Documentation Standard.<br>• Care planning training.<br>• Nursing documentation audit framework.<br>• Patient correspondence/letters audit to validate Clinical Board processes to maintain oversight of timeliness of completion of correspondence.<br>• Secondary review of all systems' functionality in relation to patient correspondence/letters.<br>• Digital care planning Reporting to Quality Committee.<br>• Digital Clinical Educators appointed.<br>• Refreshed induction training for all staff when onboarding into the organization.<br>• Digital and Data Committee providing oversight to Trust Board.<br>• Digital improvements prioritisation and oversight. | • Presentations slides, staff roadshow slides and feedback from staff.<br>• Supplier assessment based on site visit. Regular main Electronic Patient Record (EPR) supplier engagement.<br>• Power BI report of all discharge summaries in all areas in real time.<br>• E-record reminders to clinicians of encounters that require discharge summary.<br>• Care Planning Task and Finish Group Action Plan.<br>• 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.<br>• Standardisation of nursing documentation – end of shift inpatient, critical care and paediatrics introduced into live system.<br>• Care planning training now available within the EPR.<br>• Nursing documentation audit framework – document standards now in place, aligned to trust guidelines.<br>• Power BI report available to all clinical boards for routine validation of various aspects of care including safety assessments, dementia and delirium, Infection Prevention and Control (IPC), Venous thromboembolism (VTE), Lines and Devices.<br>• Secondary review of all system functionality in relation to patient correspondence and letters provided positive assurance relating to processes in place.<br>• Digital care planning report received by Quality Committee in April 2025.<br>• 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.<br>• Standardisation of use of SystmOne commencing with template audit – January 2026.<br>• Care optimisation group to share priorities for the next 12 months – September 2025.<br>• Define the organisation digital capacity to inform structured delivery plan. Refining capability for optimisation, enabling timely implementation of change – December 2025.<br>• Development of regular communication cycles to the organisation to inform staff of the planned work – October 2025.<br>• Review and optimisation of current systems used to create and send clinical correspondence, including discharge summaries, operation notes, clinical letters – March 2026.<br>• Clinical hardware refresh to be undertaken. – Starting Sept 2025, completed by March 2026. | **2-Actions defined-most progressing, where delays are occurring interventions are being taken.** | |

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| Failure to embed effective systems and processes to recognise and prevent avoidable Hospital Acquired Infections | • IPC Board Assurance Framework.<br>• Integrated Quality and Performance Report.<br>• IPC Committee and subgroups.<br>• Clinical Board Governance Meetings and Quality Oversight Group.<br>• Local and National Benchmarking.<br>• IPC policies.<br>• Clinical Board Improvement plans.<br>• Clinical Assurance Toolkit Audits.<br>• Accrediting Excellence (ACE) Programme.<br>• Antimicrobial Stewardship Policy and Framework.<br>• IPC Corporate Team in place with clear roles and responsibilities to support Clinical Board Healthcare Associated Infection (HCAI) reduction strategies.<br>• IPC investigation process in place for every hospital associated HCAI. Moderate and above HCAI incidents, serious incidents and outbreaks with identifiable contributory factors reviewed through the PSIRF framework.<br>• IPC Corporate Team in place with clear roles and responsibilities to support Clinical Board HCAI reduction strategies. | • IPC Board Assurance Framework document.<br>• IPC Operational Group and Committee minutes and action logs.<br>• Integrated Quality Performance Report with an overview of IPC and HCAI metrics reporting to Committees of the Trust Board.<br>• IPC Committee minutes and reports.<br>• Local, regional and national benchmarking data.<br>• Clinical Board QOG and Governance meeting minutes and action logs.<br>• Clinical Assurance Tool results.<br>• Rapid Quality and Safety Peer review results and action plans demonstrates 93% trust compliance with assessment framework.<br>• Quality and Performance review minutes and action log.<br>• Clinical Board improvement plans in place in areas of high occurrence of HCAI. | • Implementation of IPC Improvement Group to provide oversight of HCAI reduction strategies and assess level of assurance of compliance with policy and procedural standards – group to be implemented by September 2025 and action plan and reporting framework to be in place by November 2025. | **2-Actions defined-most progressing, where delays are occurring interventions are being taken.** | |

| Risk ID | 1.1 |
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**Comments:**

# Board Assurance Framework 2025/2026

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| **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. |

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| **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** | 16.09.2025 | **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** |
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| 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.<br>• Audit, Risk and Assurance Committee established.<br>• CQC delivery group established.<br>• Clinical Board Risk Registers.<br>• Risk Validation Group.<br>• Recovery Oversight Group.<br>• Cardiac Oversight Group.<br>• Clinical Assurance Group.<br>• Review of QoG activity presented to Quality Committee in October 2024.<br>• CQC phase one action plan.<br>• CQC phase two action plan.<br>• Clinical Board Governance Audit.<br>• Access and Improvement Delivery Group established to provide greater oversight and governance in relation to performance and productivity metrics.<br>• Trust Interim Strategy. | • Terms of Reference (ToR) – committees of Board.<br>• Minutes of committee meetings.<br>• Committee schedule of business.<br>• Corporate Organograms.<br>• Minutes of QOG/QPR and directorate governance meetings.<br>• Effective governance system report to Trust Board.<br>• CQC delivery group minutes and action plans.<br>• Quality Performance Reviews and summary to Board and relevant committees.<br>• External Tabletop Governance Report.<br>• External leadership and governance review.<br>• Feedback at Integrated Quality Improvement Group (IQIG).<br>• Internal audit of CQC phase one action plan – substantial assurance received.<br>• Internal audit of CQC phase two action plan – reasonable assurance received.<br>• Clinical Board Governance Audit – reasonable assurance received.<br>• Access and Improvement Group ToR and minutes.<br>• Trust Interim Strategy in place, plan on a page accessible to staff on Intranet. | • Deliver Board Development programme 2025/26 – March 2026.<br>• Operationalise Accountability Framework including monitoring/governance and review mechanisms – January 2026.<br>• Develop Trust Governance Handbook – February 2026.<br>• Develop 5-year strategy – March 2026.<br>• Commission and complete External Well-Led review - Underway, expected to be complete by November 2025.<br>• Completion of Trust Capability Self Assessment – October 2025.<br>• Complete Ward to Board Review of Governance – March 2026.<br>• Await outcome of External Grant Thornton Well Led review – November 2025. | **2-Actions defined-most progressing, where delays are occurring interventions are being taken.** | |

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| Failure to embed escalation processes and ensure executive oversight. | • Performance and accountability framework.<br>• Standardised reporting and governance.<br>• Clinical Board development plan in place.<br>• Quality performance review process.<br>• Executive Leads for clinical boards.<br>• Reporting hub dashboards.<br>• Quality Oversight Group Evaluation.<br>Risk Management Dashboard.<br>• Clinical Board Governance Audit. | • Performance and accountability framework document.<br>• Clinical board reporting and minutes.<br>• Performance review reports and minutes.<br>• Clinical Board Chairs update to Executive Team.<br>• Quality Committee Quality Oversight Evaluation Report, June 2024.<br>• Clinical Board update report presented to Trust Board.<br>• The value circle report on QPR process.<br>• The value circle report on effective governance.<br>• Audit One Risk Management and Board Assurance Framework Core Audit – Good level of assurance received.<br>• Clinical Board Governance Audit – reasonable assurance received. | • Operationalise Accountability Framework and Autonomy framework including monitoring/governance and review mechanisms – January 2026.<br>• Complete Ward to Board review of Governance – March 2026. | **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.<br>• Refresh of risk management governance and reporting.<br>• Quality and Safety leads appointed.<br>• Risk Validation Group established.<br>• Audit, Risk and Assurance Group established.<br>• Risk management dashboard.<br>• Executive Team lead assigned to CBs.<br>• Refresh of risk management training for risk system users.<br>• Engagement with clinical boards.<br>• Implementation of risk decision tool -risk vs issue.<br>• Risk Management Standard Operating Procedure (SOP).<br>• Refreshed Board Assurance Framework. Implementation/engagement risk refresher sessions provided to risk system users.<br>• Risk Management and Board Assurance Framework Risk and compliance based internal audit.<br>• Risk management induction video for all staff.<br>• InPhase Risk Application Training.<br>• Risk Appetite Statement. | • Risk Management Policy document and associated guidance.<br>• Reporting, accountability, and escalation structure.<br>• Terms of reference and minutes for the risk validation group.<br>• Historical risk trajectory.<br>• Risk management dashboard.<br>• Reporting to CQC Delivery Group weekly.<br>• Risk management training Training Needs Analysis (TNA).<br>• Clinical board risk presentation.<br>• Embedded into clinical board governance arrangements – QOG minutes and reporting.<br>• Audit, Risk and Assurance ToR, minutes, and Reports.<br>• Clinical Risk reporting to Quality Committee.<br>• Quality Performance Reviews and summary report to Board.<br>• Risk management and Board Assurance Framework risk and compliance based internal audit – good level of assurance.<br>• Risk Induction Video available on learning lab.<br>• InPhase Risk Application Training now rolled out to all existing users.<br>• Risk Appetite Statement Approved at Trust Board. | • Implement further strategies to support ward/departmental level risk identification and documentation – work now underway to roll out InPhase system, delayed due to resource April 2026.<br>• Develop Risk Management Strategy – March 2026.<br>• Develop Risk Management Intranet page with key guides, advice, contacts and supporting information – October 2025.<br>• Develop Operational Risk Appetite Approach – April 2026.<br>• Further development and improvement of InPhase Risk System – March 2026. | **2-Actions defined-most progressing, where delays are occurring interventions are being taken.** | |

| Risk ID | 1.2 |
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**Comments:**

# Board Assurance Framework 2025/2026

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| **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. |

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| **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** | 17.09.2025 | **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** |
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| Elective Recovery Fund (ERF) activity plans do not sufficiently deliver activity targets and therefore increase financial risk to the Trust. | • Activity targets produced for each specialty.<br>• Funding has been delegated at the start of the year for specific areas where identified this is necessary for impact.<br>• Directors of Operations (DOPs) and Clinical Board Chairs accountability for delivery of activity targets.<br>• Monthly reporting reinstated.<br>• IAP (Indicative Activity Plan) introduced as a part of the contracting process/requirement with NHS England (NHSE) and ICB. Will be mandated.<br>• IAP agreed.<br>• Performance Gap early reporting. | • Activity reporting via monthly performance reviews and corrective action agreed where possible, against IAP.<br>• 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.<br>• National reporting back to Trust of validated activity levels (quarterly) – assurance provided around validity of internal reporting.<br>• Internal and external audit of income levels.<br>• Finance Dashboard.<br>• IAP in place, however at a lower activity level than required to meet standards required.<br>Early reporting mechanisms and now specifically discussed at each Finance and Performance Committee. | • Conversations ongoing with commissioners re-funding available to pay for ERF activity above cap.<br>National policy awaited (no timescale) but monthly updates provided. | **2.Actions defined-most progressing, where delays are occurring interventions are being taken.** | |

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| Insufficient capability and capacity to deliver significant change programs to deliver the Financial Recovery Programme (FRP) including Cost Improvement Programme (CIP) delivery. | • Financial governance framework in place, moving to accountability framework and delegated financial controls.<br>• Budget setting principles and budgets in place, including CIP targets by corporate area and clinical board.<br>• Enhanced CIP reporting / CIP organisational lead in place.<br>• CIP dashboard in Power BI.<br>• Day to day budget management processes in place including budget holder and Directorate Finance Manager (FM) attendance/CBFM model and part of senior team<br>• Monthly performance reviews, one in 3 finance focussed.<br>• Capital Management Group (CMG).<br>• Clinical Board sign off of budgets and CIP targets.<br>• Supplies and Services Procurement Committee.<br>• Financial Recovery Plan and Financial Recovery Steering Group (FRSG).<br>• Purchasing via procurement frameworks where appropriate.<br>• DOPs reinforcing financial grip and control. through engagement with teams.<br>• Financial Recovery regular discussion/action planning on Trust Management Group (TMG).<br>• Annual Internal and External Audit complete.<br>• ICB Grip and Control investigation and intervention complete.<br>• Financial communications strategy.<br>• Corporate services CIP targets set. Assessment capability for financial delegation completed - financial indicators developed.<br>• Performance Gap early reporting. | • Budgetary oversight at DOP level.<br>• Monthly revenue report at CB and corporate service level.<br>• Deviations from Standing Financial Instructions (SFIs) reported to Supplies and Services Procurement Group (SSPG) committee including action taken.<br>• Regular reporting of compliance through Internal Audit and monitoring of recommendations – Report to ARAC quarterly on Internal audit progress.<br>• Healthcare Financial Management Association (HFMA) audit of control reported through to ARAC.<br>• Reporting framework to ICB / cost control framework implemented.<br>• NHS England/Improvement monthly finance monitoring.<br>• Going concern and financial controls audit.<br>• Early indication of required targets prior to start of financial year (5% January 2025).<br>• Mazars external audit – satisfactory assurance, no issues regarding going concern.<br>• First financial specific communication issued in January 2025.<br>• CIP Dashboard on reporting hub, allowing CBs and Clinical Directors (CDs) ability to monitor and view plans.<br>• Revenue reporting and FRP reporting to Finance and Performance Committee.<br>• Integrated Performance Report (IPR), refreshed, to Governors and Public Board of Directors.<br>• Monitoring and challenge of delivery of plans by FRSG, fortnightly.<br>• Monthly QIG specifically regarding financial performance with ICB and NHSE colleagues to give assurance of progress.<br>• Financial indicators contained within the financial revenue report from July.<br>• Early reporting mechanisms and now specifically discussed at each Finance and Performance Committee. | • Delivery of The Value Circle (TVC) development programme – March 2026.<br>• Delivery and mitigation plan meetings with clinical Boards and Corporate Services – March 2026. | **2.Actions defined- most progressing, where delays are occurring interventions are being taken.** | |

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| Unplanned emerging cost pressures not included within the agreed balanced plan | • Horizon scanning.<br>• Executive team discussions.<br>• Planning and strategy group and financial recovery steering group regarding business cases and approval.<br>• Proactive engagement with suppliers.<br>• Supplies and services procurement committee.<br>• Financial governance framework.<br>• ICB Directors of Finance (DOFs) meeting.<br>• Shelford networking / understanding the environment.<br>• Use of frameworks.<br>• Opportunities through Alliance working.<br>• Engagement with Medium-Term Financial Plan (MTPF) workstreams (ICS). Annual Internal and External Audit complete.<br>• In year emerging cost pressures identified, discussed and reported through Finance IQIG (monthly). | • CB and CD finance reporting.<br>• Budget sign off and hold to account through accountability framework.<br>• ICS updates through Finance report and CEO report to Committees and Board.<br>• Finance report to Board, Finance and Performance Committee identifies any unplanned pressures and actions.<br>• Procurement report to Finance and Performance Committee identifies any cost pressures emerging through procurement activity.<br>• Regional finance returns monthly.<br>• Mazars external audit – satisfactory assurance, no issues re going concern.<br>• In year emerging cost pressures identified, discussed and reported through Finance IQIG (monthly) | • Strengthen grip and control measures through financial recovery steering group – March 2026.<br>• Adoption and embedding of financial accountability framework - bimonthly review of position by clinical board – Monthly reviews of position – March 2026.<br>• Strengthen horizon scanning through Alliance DOF and national meetings/updates monthly – ongoing through 2025/26 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.<br>• Non cash element of financial recovery defined and identified.<br>• Finance committee reporting and discussion.<br>• Financial Recovery Plan including cash releasing (CIP).<br>• Other controls as above regarding management and reporting of CIP achievement.<br>• Capital management group.<br>• Strengthened discussion of cash position and reporting to finance Committee.<br>• Enhanced cash reporting. | • Cash forecast within regular finance and board reporting.<br>• Daily / weekly cash management.<br>• Reporting of progress on cash releasing savings through financial recovery steering group and finance committee.<br>• Reporting of progress against capital plan to finance committee and Trust Board.<br>• Reporting of progress against capital plan to Capital Management Group.<br>• Increased reporting of cash position via Monthly Finance Report to Finance and Performance Committee.<br>• Enhanced cash reporting to Finance and Performance Committee. | • Consider and develop actions necessary to mitigate cash position should CIP not deliver - July 2025. Enhanced cash reporting to Finance and Performance Committee completed.<br>• To consider cash management guidance from NHSE at Finance and Performance Committee in September. | **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.<br>• NHSE panel assessment.<br>• Outline Business Case (OBC) and Full Business Case (FBC)<br>• Bi-weekly meetings with staffside.<br>• Joint meeting with staffside and NHSE.<br>• Staff Side regular engagement meetings. | • NHSE provided with all information relevant to make an informed decision.<br>• Continued thinking on benefits of forming a subsidiary company (risk, seeking).<br>• All engagement material shared with staffside.<br>• All communications shared with staffside prior to sending out.<br>• Guarantees provided regarding terms and conditions, pensions issues and recognition agreement for staffside.<br>• 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.<br>• 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.<br>• Further actions currently unavailable due to pause in progress / NHSE approval. | **1.Fully on plan across all actions.** | |

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| Under delivery of commercial income and growth to support financial recovery. | • Commercial Strategy.<br>• Commercial Delivery and Innovation Group.<br>• Commercial delivery Operational Group.<br>• Dedicated Commercial team established.<br>• Commercial Update report.<br>• Data Partnership model.<br>• Data Partnership Group.<br>• Sales force implementation.<br>• Commercial schemes identified by Clinical Boards and Corporate Directorates.<br>• Commercial Dashboards.<br>• IP Policy developed.<br>• Strengthened commercial governance at Clinical Board Level. | • Strategy document and updates reported to Finance and Performance Committee.<br>• Commercial update report to F&P.<br>• Data Partnership Proposal accepted by F&P. under engagement with other committees and groups currently.<br>• Data partnership group reporting to commercial delivery and innovation group.<br>• Tracking commercial pipeline.<br>• Commercial schemes reporting alongside financial recovery plans.<br>• Commercial dashboard data suggests marginal growth, further actions required as per action plan.<br>• Commercial updates presented to Finance and Performance Committee.<br>• First 2 data partnership agreed, and contract signed – Flatiron and Promptly.<br>• Commercial representative at clinical board cost improvement meetings. | • Develop commercial principles for external contracts for full scale adoption in order to maximise potential returns. Commercial contracting course to be delivered – October 2025.<br>• Strengthen governance and awareness relating to Intellectual Property (IP) protection and data access - IP policy updated. Online course currently being built with Newcastle hospitals academy. Data partnership group continues drive awareness of value of data – November 2025.<br>• Strengthen our job descriptions for senior staff to include data access alongside IP - March 2026. | **2.Actions defined- most progressing, where delays are occurring interventions are being taken.** | |

| Risk ID | 6.1 |
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**Comments:**

# Board Assurance Framework 2025/2026

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| **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. |

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| **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** | 16.09.2025 | **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** |
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| Failure to manage capacity and demand. | • Programme Management Office (PMO) supported programme of demand and capacity planning across all surgical specialties completed.<br>• Weekly Stand-up highlighting areas of performance focus.<br>• Daily Site meetings and Site Handover.<br>• Weekly specialty /tumour group Patient Tracking List (PTL) meetings for long waits and cancer.<br>• Fortnightly performance meetings with operational leads for long waits and cancer.<br>• Local Accident & Emergency (A&E) Delivery Board, supporting the management of non-elective patients across the system.<br>• 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.<br>• Validation of the Referral to Treatment (RTT)/non-RTT cohort of long waits.<br>• Implementation of new Emergency Department (ED) rota.<br>• Targeted cancer improvement plans based on National Cancer Pathway Analyser Tool.<br>• Waiting list booking process Training.<br>• Cancer Tiering System Exit. | • Revised Accountability Framework.<br>• Activity and Income reports.<br>• Integrated Quality and Performance Board Report.<br>• Monthly Integrated Quality Performance Reviews.<br>• Theatre Utilisation Data.<br>• Chief Executive Officer (CEO) performance summary TMG including national performance comparisons.<br>• Performance Improvement Plans monitored via Finance and Performance Committee, including deep dives incorporated into the cycle of business.<br>• Further development of the Integrated Quality and Performance Board Report – reported into Committees and Trust Board.<br>• Implementation of new ED rota, report to Finance and Performance Committee - demonstrating improved safety.<br>• Targeted cancer improvement plans with quarterly updates to F&P Committee.<br>• Tier 2 escalation process for cancer performance – positive feedback on progress by NHSE/ICB.<br>• Waiting List booking process Training commended in August 2025.<br>• Trust has successfully exited Cancer Tiering System. | • Operationalisation of the Accountability Framework in progress – to be delivered by January 2026.<br>• Review current information and performance reports to ensure they are fit for purpose – complete, changes to reporting hub to be completed by October 2025.<br>• Full review of Outpatient capacity templates to be completed by the end of September 2025.<br>• Further development of the Service Review (Health Check) methodology and reviews, first set of reviews to be completed by September 2025 | **2 – Action defined-most progressing, where delays are occurring interventions are being taken.** | |

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| Utilising available resource effectively – workforce, estate, and equipment. | • Activity plans developed with Clinical Boards as part of the annual planning process.<br>• Productivity targets set as part of the Capital planning process through Capital Management Group.<br>• Allocation of growth funding from commissioners to under pressure services, where available.<br>• Revised annual planning process to incorporate approval of business cases for the coming financial year and utilisation.<br>• Operational reports establishing weekly activity and value performance reports.<br>• Diagnostic, Surgical and Outpatient Improvement Groups in place, with organisation wide scope to deliver improvements in effectiveness.<br>• Histopathology Turnaround times reporting.<br>• Productivity metrics established. | • Integrated Quality and Performance Board Report.<br>• Monthly Integrated Quality Performance Reviews.<br>• TMG Updates.<br>• Clinical Board meeting minutes.<br>• Weekly Activity and ERF (income) reports.<br>• Histopathology turnaround times reported and discussed at QPR.<br>• Productivity metrics reported through Financial Recovery Steering Group. | • Improve theatre utilisation to greater than 85% by the end of March 2026.<br>• Longer term capacity modelling for radiology modalities to be completed by December 2025 – delayed due to organisational change. | **2 – Action defined- most progressing, where delays are occurring interventions are being taken.** | |
| Failure to achieve NHS Oversight Framework (NOF) standards/ratings to ensure Trust receives strengthened local autonomy. | • NOF Segmentation review.<br>• Access and Improvement Group Established.<br>• NOF methodology.<br>• Trust currently in NOF segmentation 2. | • Analysis completed looking at drivers of the NOF segmentation for Q1.<br>• NOF Segmentation discussed and reported through Access and Improvement Group.<br>• NOF methodology reported and discussed at Trust Board. | • Develop forecasting model to get early sight of potential future segmentation at the end of each quarter – November 2025.<br>• NOF metrics to form accountability and autonomy framework and measured across the Trust – January 2025. | **2 – Action defined- most progressing, where delays are occurring interventions are being taken.** | |

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| Failure to transform and change service models at pace. | • Clinical Board Improvement Plans.<br>• Winter Plan.<br>• Bespoke programmes of support to critical / fragile services.<br>• Clinical Board Structure in place from April 2023.<br>• Alliance working groups.<br>• GIRFT engagement and sharing of alternatives models, tools, and support.<br>• Outpatient Improvement Group.<br>• Surgical Improvement Group.<br>• Diagnostic Improvement Groups.<br>• Urgent and Emergency Care Improvement Group.<br>• Monthly meetings in place with primary care.<br>• Winter planning.<br>• Trust Winter Plan 2025/26. | • TMG Oversight.<br>• Executive Team Oversight.<br>• Quality Performance Reviews.<br>• Monthly IPR to committees and Board.<br>• Clinical Board meeting minutes.<br>• Outpatient Improvement Group actions.<br>• Surgical Improvement Group actions.<br>• Diagnostic Improvement Group actions.<br>• Urgent and Emergency Care (UEC) Improvement Group actions.<br>• Cancer Board actions.<br>• Improvement and project management resource reprioritised to support priority actions/service changes.<br>• Trust Winter Plan agreed and in place. | • Develop and implement co-located Urgent Treatment Centre (UTC) – December 2025.<br>• Establish effective Frailty model trial to be reviewed and longer-term model to be designed by September 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.<br>• Attendance at the Provider Collaborative Mutual Support Coordination Group and Alliance groups.<br>• Alliance plans for identified services addressed through Bilateral Board meetings and workstreams. | • Regular updates to TMG.<br>• CEO attendance at Great North Health Care Alliance Steering Group and Minutes.<br>• Monitoring via the Bilateral Boards –First iteration of Alliance performance report complete. | | **1.Fully on plan across all actions.** | |

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| Risk ID | 6.2 |

**Comments:**

# Board Assurance Framework 2025/2026

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| **Principal Risk**<br><br>(what could stop us from achieving our strategic objective) | Failure to maintain the standard of the Trust Estate, Environment, and<br><br>Infrastructure could result in a disruption to clinical activities and impact on the quality of care delivered. | **Strategic objective** | 5.Our buildings will be fit for purpose. |

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| **Lead Committee** | Finance and Performance | **Risk Rating** | **Initial** | **Current** | **Target** | **Risk Appetite** | |
| **Executive Lead** | Director of Estates, Facilities & Strategic Partnerships | **Impact** | **5** | **5** | **5** | **Risk Appetite Category** | Compliance and Regulatory |
| **Date Added** | 01.05.2024 | **Likelihood** | **4** | **4** | **1** | **Risk Appetite Tolerance** | |
| **Last Reviewed** | 15.09.2025 | **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** |
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| 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” (HRB). | • Clearly identify every aspect requiring compliance.<br>• Ongoing engagement with Contractors/Health and Safety Executive (HSE).<br>• Engage professional/legal advice.<br>• Discussions with NHSE/Department of Health and Social Care (DHSC) regarding impact on NHS. | • BSA applications.<br>• Ongoing correspondence with Contractors/HSE. | • Compile a comprehensive list of the Trust Estate where HRB applies September 2025.<br>• Correspondence with Contractors/HSE – project specific timeline - March 2026.<br>• 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.<br>• Annual capital investment plan including estates and medical devices.<br>• Estates Strategy.<br>• Integrated Care System (ICS) Infrastructure plan.<br>• Annual condition survey (20%) to determine condition of infrastructure in accordance with NHS Backlog Methodology.<br>• Alignment of condition surveys.<br>• Risk based asset plan and report. | • Estates Risk Management & Governance Group minutes and action logs.<br>• Estates Return Information Collection (ERIC)/Model Health System.<br>• Estates Investment, Planning, Strategy and Capital Investment Group.<br>• Capital Infrastructure Risk (CIR) plan 2025/26 Capital programme.<br>• Capital Management Group oversight.<br>• CMG report - Finance and Performance Committee.<br>• ICS Infrastructure Board.<br>• Condition surveys now aligned on (Computer Aided Facility Management) CAFM system.<br>• Risk based asset report providing clinical board prioritisation of Backlog Maintenance. | • 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.** | |

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| Compliance with fire safety regulations & standards - Failure to deliver fire safety systems remediation programmes | • Risk based fire remediation programme. Condition monitoring of fire safety assets undertaken annually to enable ongoing re-prioritisation of fire safety remediation programme.<br>• Monthly fire safety remediation programme monitoring reports.<br>• Fire Safety Reports.<br>• Incident reporting system.<br>• Estates Strategy. | • Trust Fire Safety Group minutes and action logs.<br>• Oversight by Estates Fire Directors Group.<br>• Estates Risk Management & Governance Group minutes and action logs.<br>• Quarterly report to Compliance & Assurance Group.<br>• Reports to Capital Management Group.<br>• Fire Safety report to Trust Board. | • Complete phase 2 passive fire remediation works to high-risk clinical areas - March 2026 .<br>• Tender/award contract for phase 3 of passive fire remediation works - Incumbent contractor to deliver current phase of works (pending procurement approval). Tender ready to go out for 2026/27 – update in September 2025. Supplies and Services Procurement Committee (SSPC) approved phase 3 tender award March 2026.<br>• 2024/25 upgrade programme of active fire system – Freeman Hospital (FH) complete / RVI delayed Leazes Wing Q3, Dental on programme December 2025 .<br>• Tender/award contract for 2026/27 upgrade of active fire systems – paused awaiting decision on funding. | **3-Action defined-work started but behind plan.** | |
| Failure of ageing critical estates M&E engineering infrastructure (Ventilation, Water, Electrical (High Voltage & Low Voltage 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.<br>• Condition monitoring of assets undertaken annually to enable ongoing re-prioritisation of backlog maintenance programme.<br>• Monthly HTM Compliance Monitoring Reports.<br>• Health & Safety Reports.<br>• Incident reporting system.<br>• Capital Programme.<br>• Estates Strategy.<br>• Trust Policies and Procedures.<br>• Annual condition survey (20%) to determine condition of infrastructure in accordance with NHS Backlog Methodology.<br>• Risk based asset plan and report. | • Estates Operational Management Structures.<br>• Estates Investment, Planning, Strategy and Capital Investment Group.<br>• CIR plan 2024/5 Capital programme.<br>• Oversight via Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety).<br>• Estates Risk Management & Governance Group minutes and action logs.<br>• Quarterly report to Compliance & Assurance Group.<br>• Capital Management Group oversight.<br>• IPC Committee oversight.<br>• Independent Authorising Engineer annual HTM compliance Audit.<br>• Trust Internal Audit Programme (AuditOne).<br>• Risk based asset report providing clinical board prioritisation of Backlog Maintenance. | • 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.<br>• Annual capital plan includes medical devices.<br>• 3-year medical device asset replacement.<br>• 3-year lifecycle replacement plan.<br>• Medical Device replacement plan agreed for 2025/26 Capital programme. | • Medical Director medical device replacement oversight/prioritisation group.<br>• Estates Investment, Planning, Strategy and Capital Investment Group.<br>• Medical Device replacement plan 2025/26 Capital programme.<br>• Capital Management Group oversight.<br>• CMG report - Finance and Performance Committee.<br>• Medical Device Steering Group.<br>• Medical device asset replacement monitored via Capital/Financial planning meetings.<br>• Lifecycle replacement plan and programme in place. | • Regular review of priority requests by Medical Director and medical device replacement oversight/prioritisation group March 2026. | **1.Fully on plan across all actions.** | |

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| 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 Medicines and Healthcare products Regulatory Agency (MHRA) guidance.<br>• Monthly Compliance Monitoring Reports.<br>• Incident reporting system.<br>• Capital Programme.<br>• Trust Policies and Procedures.<br>• Analysis of CAFM medical device data to identify failure trends. | • EME Operational Management Structures.<br>• Annual report to Medical Device Steering Group.<br>• Estates Risk Management & Governance Group minutes and action logs. | • Regular review of priority requests by Medical Director and medical device replacement oversight/prioritisation group March 2026. | **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.<br>• Health & Safety Audit Reports.<br>• Incident reporting system.<br>• Capital Programme.<br>• Estates Strategy.<br>• Trust Policies and Procedures | • Estates and Facilities Operational Management Structures.<br>• Estates Risk Management & Governance Group minutes and action logs.<br>• Quarterly report to Compliance & Assurance Group.<br>• Patient Led Assessment of the Care Environment (PLACE) Assessments.<br>• NHS Premises Assurance Model (PAM).<br>• IPC Committee oversight.<br>• CQC Delivery Group.<br>• CQC Standards Assurance Group.<br>• Trust Internal Audit Programme (AuditOne). | • Dementia Friendly Estates options appraisal to be finalised and escalated for approval including any agreed plan of work – Q4 2025.<br>• Finalise Trust standard specifications (including dementia standards) to follow on any refurbishment programme within capital plans- Q4 2025<br>• Phase 2 - Compliance with Self Harm Risk Assessment recommendations 18–24-month programme subject to CMG approval, currently outside of capital plan for 2025/26. Q3 2025.<br>• Review and implementation 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.<br>• Liaison meetings with Patient Services to minimise impact on clinical activity.<br>• Project Management meetings. | • Senior Operational meetings.<br>• Capital Management Group oversight.<br>• Estates Strategy & Capital Investment Group. | • Co-ordinate with Patient Services to<br>• 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).<br>• Monitoring of PFI annual condition surveys.<br>• Regular zonal and ad hoc inspections of PFI areas. | • PFI Monthly Review Meetings.<br>• PFI Liaison Committee.<br>• Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety).<br>• Compliance & Assurance Group.<br>• Trust Internal Audit Programme (AuditOne).<br>• Independent Authorising Engineer annual HTM compliance Audit.<br>• PLACE audits.<br>• 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.<br>• Performance of the PFI Centre of Best Practice condition survey process – delayed by settlements and commercial negotiation, now due in Q1 2026-27. | **3-Action defined-work started but behind plan.** | |

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| 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.<br>• Track works requests and escalate slippage.<br>• Review progress within meeting structures.<br>• Implement alternative routes if required.<br>• Management of works requests. | • Review at monthly Variation meetings.<br>• PFI Liaison Committee.<br>• 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 yet to be in place, now due Q4 2025.<br>• Implemented June 2025 as targeted with first scheme completed during Q3 2025. | **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.<br>• Maintain meetings structures to manage progress with the works. | • Independent certification for each zone when completed.<br>• Ongoing compliance requirements contained within PFI Project Agreement.<br>• PFI Fire Steering Group. | • Regular reviews of requirements and progress with the remedial works – still targeted for 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.<br>• Legal support if required to resolve any disagreements. | • Compliance requirements contained within PFI Project Agreement.<br>• Performance reports.<br>• Performance report review meetings.<br>• PFI Liaison Committee. | • Seek remedial scope and programme from PFI partners - Q1 2026. On plan.<br>• Manage terms of the PFI Project Agreement to conclude remedial works through to December 2026. On plan. | **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.<br>• Legal support if required to resolve any disagreements. | • Compliance requirements contained within PFI Project Agreement.<br>• Performance reports.<br>• Performance report review meetings.<br>• PFI Liaison Committee. | • Seek remedial scope and programme from PFI partners – slightly delayed due to design of remedials required, now due Q4 2025.<br>• Manage terms of the PFI Project Agreement to conclude remedial works through to December 2026 – on plan.<br>• Commence condition survey of electrical installations to fully define issues and required remedial actions - plan for Q4 2025. | **5- Actions not yet fully defined.** | |

| Risk ID | 5.1 |
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**Comments:**

# Board Assurance Framework 2025/2026

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| **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. |

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| **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** | 11.09.2025 | **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** |
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| 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.<br>• People Programme Board.<br>• Occupational Health Self-Referral Service.<br>• Evaluation and appraisal of Trust Compassionate Leadership Programme. | • Health and Wellbeing Steering Group minutes.<br>• People Programme Board Minutes.<br>• Live in August 2025.<br>• Evaluation of Trust Compassionate Leadership Programme completed August 2025.<br>• Occupational Health Self-Referral Service live. | • Staff psychology support service, 2025/26 – December 2025.<br>• Staff Survey results – March/April 2026. | **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.<br>• Equality, Diversity and Inclusion (EDI) Steering Group.<br>• Health and Wellbeing Steering Group.<br>• Developed and launched Trust Behaviours and Civility Charter.<br>• NHS England's Sexual Safety in Healthcare Charter.<br>• New Sexual Misconduct and Sexual Violence Policy.<br>• EDI Development Session delivered at TMG and Trust Board.<br>• Cultural Ambassadors in place.<br>• People dashboard.<br>• Let's Talk Race session with the Trust Board in March 2025.<br>• Sexual safety and misconduct audit.<br>• Year 2 EDI 2025/26 priorities developed.<br>• People and Culture MDT Group Established. | • Health and Wellbeing Steering Group minutes.<br>• People Strategy.<br>• People Strategy Year 1 deliverables.<br>• Safe Staffing Internal audit – Reasonable assurance<br>• Freedom to speak up (F2SU) Internal audit – Reasonable assurance.<br>• F2SU Guardian assurance report to People Committee.<br>• People Committee minutes.<br>• Clinical Board People Oversight Groups.<br>• People Programme Board.<br>• Micro aggression and incivilities training – 88.7% Trust staff compliance with training.<br>• EDI and Let's Talk Race Presentation and slides.<br>• People Dashboard reporting.<br>• Completed and priority actions/finding to People Committee (PC) November.<br>• Year 2 EDI 2025/26 priorities paper to People Committee July 2025.<br>• Occupational Health Self-Referral Service live. | • People Plan Year 2 programme launch – November 2025.<br>• Staff psychology support service, 2025/26 – Sept 2025.<br>• Further development of People Oversight Groups in CBs as part of PP Year 2 action plans – due to organisational change in the department this framework is currently in development – review in January 2026.<br>• Delivery of Year 2 2025/26 EDI Priorities – March 2026. | **2.Actions defined-most progressing, where delays are occurring interventions are being taken.** | |

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| | • Occupational Health Self-Referral Service. | | | | |

| Risk ID | 2.1 |
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**Comments:**

# Board Assurance Framework 2025/2026

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| **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. |

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| **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** | 11.09.2025 | **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.<br>• Better Health at Work Award<br>• Health and Wellbeing policy in place.<br>• People Strategy completed including Wellbeing Gap Analysis.<br>• People Programme Board.<br>• Sexual Safety Charter.<br>• Behaviours and civilities charter in place.<br>• Staff Health and Wellbeing offers including Trust travel scheme, financial wellbeing, meal cards, access to helping hands, Staff social club and fitness centres.<br>• EDI – Staff Networks, High Impact Actions, EDI Steering Group, Workforce Race Equality Standard, Workforce Disability Equality Standard and Equality Delivery System (WRES, WDES, EDS)<br>• Cultural Ambassadors.<br>• Health and Wellbeing Policy in place.<br>• People and Culture MDT Group Established. | • Health and Wellbeing Steering Group minutes.<br>• IBR - People report. Board (mthly); People Committee (bi-mthly); Employment Partnership Forum (mthly).<br>• People Strategy, Year 1 delivery programme<br>• Performance review report for Clinical Boards (mthly).<br>• Sexual safety charter awareness and training in place.<br>• People Strategy Year 1 programmes.<br>• Internal Audit reports (absence management; HAWB initiatives; F2SUG).<br>• People dashboard and reports.<br>• F2SUG reports.<br>• People Committee minutes.<br>• Clinical Board People Oversight Groups.<br>• People Programme Board.<br>• Health and Wellbeing ad EDI Steering Groups in place<br>• Behaviours and civilities charter awareness and training in place – Trust compliance 88.7%<br>• Health and Wellbeing Policy ratified August 2025. | • People Strategy Year 2 programme launch - November 2025.<br>• Staff psychology support service, 2025/26 – December2025.<br>• Target reduction in sickness absence of 0.5% - March 2026.<br>• Anti Racism Framework 2025/26 – November 2025.<br>• Evaluate learning and sharing from CB People Oversight Groups – due to organisational change in department this framework is currently in development – review in December/January 2026. | **2.Actions defined- most progressing, where delays are occurring interventions are being taken.** | |

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|---|---|---|---|---|---|
| Failure to deliver improvements to leadership and governance across the Trust. | • Organisational Change policy in place.<br>• People Strategy.<br>• SubCo Operational Group in place.<br>• SubCo People Group in place.<br>• People Programme Board.<br>• People Transformation Group.<br>• Employment Partnership Forum. | • Project management records.<br>• Internal Audit report.<br>• People Programme Board minutes and actions.<br>• People Transformation Group minutes and actions.<br>• People Committee minutes and actions.<br>• Employment Partnership Forum minutes and actions.<br>• SubCo Operational Group minutes and actions.<br>• SubCo People Group minutes and actions. | • Business Partner (BP) Model – January 2025.<br>• Develop BP working Group – July 2025 – complete, additional support added.<br>• Explore Just learning culture – January 2026 | **2.Actions defined- most progressing, where delays are occurring interventions are being taken.** | |

| Risk ID | 2.2 |
|---|---|
| **Comments:** | |

# 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. |

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| **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** | 11.09.2025 | **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 de-stabilising corporate functions. | • Financial Recovery Steering Group.<br>• IBR - People report. Board (monthly); People Committee (bi-monthly); Employment Partnership Forum (monthly).<br>• Provider Workforce Return (PWR) data mapping with Provider Finance Return (PFR) data.<br>• Redeployment policy in place.<br>• Redeployment group meets weekly.<br>• Local Vacancy Freeze.<br>• Voluntary Severance Scheme complete. | • Voluntary severance scheme drawn up.<br>• Redeployment group minutes and actions.<br>• Workforce reduction data reported to FRSG.<br>• Situation report (SIT REP) to Executives on vacancy hold. | • Consider additional workforce reduction schemes – December 2025.<br>• Workforce transformation programme- January 2026. | **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 (monthly).<br>• Clinical Board People Oversight Groups in place.<br>• People dashboards and BI reports.<br>• People Programme Board. | • PWR data.<br>• People dashboard and BI reports.<br>• Clinical Board/Corporate Service workforce plans.<br>• People Programme Board minutes.<br>• People Transformation Group minutes. | • Business partner model 2025/26 – January 2026.<br>• Workforce planning benchmarking exercise – January 2026. | **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.<br>• Electronic Staff Record (ESR) in place, including Establishment.<br>• PWR data.<br>• People dashboards and BI reports.<br>• People Programme Board.<br>• People Transformation Group. | • Operational Planning Group minutes.<br>• ESR reports.<br>• PWR data/reports.<br>• People dashboards and BI reports.<br>• People Programme Board minutes.<br>• People Transformation Group minutes. | Business partner model 2025/26 – January 2026 | **2.Actions defined-most progressing, where delays are occurring interventions are being taken.** | |

| Risk ID | 2.3 |
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**Comments:**

# Board Assurance Framework 2025/2026

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| **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. |

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| **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** | 21.08.2024 | **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.<br>• Great North Healthcare Alliance Joint Committee. 3 lead directors in place for delegated functions of financial planning, digital and research and innovation.<br>• Bilateral group between Northumbria and Newcastle Foundation Trusts meeting monthly.<br>• Bilateral sub-committee between North Cumbria and Newcastle Foundation Trusts meeting monthly.<br>• Bilateral sub-committee between Gateshead and Newcastle Foundation Trusts meeting monthly.<br>• ICS Board.<br>• Great North Healthcare Alliance Collaboration Agreement based around improving collaboration working whilst retaining organisational independence.<br>• Provider collaborative leadership board.<br>• Newcastle place based ICB sub-committee.<br>• Alliance Vision, Workplan and Milestones.<br>• Alliance Performance Dashboard.<br>• Shared Chair in post across Newcastle, Northumbria, (and Gateshead from 1st October 2025). | • Chair and CEO member of Great North Healthcare Alliance Steering Group Committees in Common and Joint Committee.<br>• CEO member of Provider Collaborative Leadership Board.<br>• Executive Directors leading appropriate Alliance work streams with peers.<br>• Acting CEO chairs Newcastle Place ICB Sub-Committee.<br>• Alliance vision and 3-year work plan approved by Trust Board and supported by Council of Governors and NENC ICB.<br>• Great North Healthcare Alliance Steering Group Committees in Common and Joint Committee Minutes<br>• Great North Healthcare Alliance bi-monthly update to Trust Board and quarterly written update to Council of Governors.<br>• ICB/Provider Collaborative and PLACE Minutes<br>• Legal support to ensure legislative compliance<br>• ICB approval of Alliance Case for Change and ongoing progress as at July 2025.<br>• ICB led stakeholder engagement assurance of Alliance plan very positive.<br>• NHSE assured Alliance shared leadership arrangements | • Work underway to develop refreshed Alliance Strategic Intent for consideration by CEOs, Chairs and Alliance Steering Group – October 2025.<br>• Alliance Construction Programme (“Big Build”) – full market engagement to be undertaken following the successful event with policy makers and potential funders and construction partners held in December 2025.<br>• 2nd Alliance Governor Event – Autumn 2025.<br>• 3rd Alliance Board member event – Winter 2025.<br>• Shared Chair to extend remit to include Gateshead Foundation Trust from 1st October 2025. | **1-Fully on plan across all actions.** | |

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

| Risk ID | 7.1 |
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| **Comments:** | |

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**PUBLIC BOARD MEETINGS - ACTIONS**

Agenda item A13

| Log No. | BOARD DATE | AGENDA ITEM | ACTION | ACTION BY | Previous meeting status | Current meeting status | Notes |
|---|---|---|---|---|---|---|---|
| 147 | 23-May-25 | 25/137 ITEMS TO RECEIVE<br>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.<br>25.07.25- Paul Ennals referred to actions 147 and 148 on the action log which related to the GoSW report and advised that the required information would be included in the next report.<br>18.09.25 - Information to be included at the November Public Board of Directors meeting. |
| 148 | 23-May-25 | 25/137 ITEMS TO RECEIVE<br>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.<br>25.07.25- Paul Ennals referred to actions 147 and 148 on the action log which related to the GoSW report and advised that the required information would be included in the next report.<br>18.09.25 - Information to be included at the November Public Board of Directors meeting. |
| 149 | 25-Jul-25 | 25/165 STANDING ITEMS:<br>iv) Acting Chief Executive's Report, including:<br><br>a. 10-year Health Plan for England | Life sciences will be discussed in more detail along with the 10-year health plan at the next Board Development Workshop [ACTION01]. | KJ | | | 18.09.25 - Discussed at the August Board Development session. Propose close action. |
| 150 | 25-Jul-25 | 25/175 STRATEGIC ITEMS:<br><br>i) Patient and Staff Stories | Paul Ennals requested a future update on the actions taken in response to Lexi and her Mum's letters and agreed to send a thankyou card on behalf of the Board of Directors [ACTION02]. | AL | | | 18.09.25 - Thank you card sent on behalf of the Board of Directors. Lexi sadly passed away in September 2025. The Trust will be represented at the Celebration of Life event on 27 September 2025. Annie Laverty, Chief Experience Officer, and the team will continue to work with Lexi's parents to develop her letter as a training resource in line with her wishes. Propose to close action. |
| 151 | 25-Jul-25 | 25/175 STRATEGIC ITEMS:<br>iv) Winter Plan [FOR APPROVAL] | Nichola Kenny agreed to update the winter plan regarding the industrial action risks/impact [ACTION03]. | NK | | | 18.09.25 - NK advised that section 7 in the winter plan has been updated. Propose to close action. |
| 152 | 25-Jul-25 | 25/175 STRATEGIC ITEMS:<br>iv) Winter Plan [FOR APPROVAL] | The Board of Directors agreed to delegate final sign off of the BAS to the F&PC however if there were any fundamental changes this would be presented to the Board [ACTION04]. | NK | | | 18.09.25 - The BAS has been completed for sign off by the Finance and Performance Committee as there were no fundamental changes required to be made to the plan to necessitate a return to the Board. Propose to close action. |

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