The Newcastle upon Tyne Hospitals NHS Foundation Trust

Public Trust Board of Directors
Friday 30 January 2026, 10:15 – 12:00
Piano Room, Royal Victoria Infirmary (RVI)

Agenda

	Time	Item	Purpose	Lead
1.	**Formal meeting agenda**			
a.	10:15	Apologies for absence and declarations of interest	For discussion	Paul Ennals
b.	10:16	Minutes of the Public Board of Directors meeting held on 28 November 2025 and matters arising	For discussion & approval	Paul Ennals
c.	10:17	Chair's Report	For discussion & assurance	Paul Ennals
d.	10:23	Chief Executive Report	For discussion & assurance	Rob Harrison
2.	**Focus on Fundamentals – Quality, Performance and Finance**			
a.	10:30	Patient and Staff Stories	For assurance	Ian Joy
b.	10:35	Trust response to the Grant Thornton Well Led review	For discussion & assurance	Ian Joy
c.	10:40	Board Visibility Programme	For discussion & assurance	Rachel Carter
d.	10:45	Integrated Board Report	For discussion & assurance	Patrick Garner & Executive Leads
e.	10:55	Joint Medical Directors Report including: i) Guardian of Safe Working Report	For discussion & assurance	Michael Wright & Lucia Pareja-Cebrian
f.	11:05	Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs) Report	For discussion & assurance	Ian Joy
g.	11:12	Maternity: i) Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress report ii) Maternity Safety Champion Report	For discussion & assurance	Jenna Wall Liz Bromley
h.	11:18	Developing the Service Review Programme in Newcastle Hospitals	For assurance	Sue Hillyard

	Time	Item	Purpose	Lead
3.	**Make it better for colleagues – IT, People and Estate**			
a.	11:24	Anti-racism framework	For approval & assurance	Caroline Docking, Lee-Ann Naidoo & Ilisha Purcell
b.	11:32	Resident Doctors 10 point plan update	For assurance	Sam Richardson
4.	**Look to the future – Strategy, Neighbourhood Teams and GNCH**			
5.	**Items to approve**			
a.	11:42	Board Assurance Framework (BAF)	For approval & assurance	Patrick Garner
6.	**Items to receive *[To cover by exception only]***			
a.	11:48	Committee Chairs Meeting Logs	For receipt	Committee Chairs
b.	11:53	Learning from Deaths	For receipt	Rachel Carter
c.	11:56	Meeting Action Log	For receipt	Paul Ennals
7.	**Any other business**			
a.	11:57	Any other business	For discussion	All

Date and Time of Next Meeting: Friday 27th March 10:15 – 12:15, Piano Room, Peacock Hall, RVI

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
Dr Lucia Pareja-Cebrian, Joint Medical Director
Mrs Sue Hillyard, Interim Executive Director of Operations
Mrs Rachel Carter, Director of Quality and Safety
Mr Patrick Garner, Director of Performance and Governance
Mrs Caroline Docking, Director of Communications and Corporate Affairs
Mrs Jenna Wall, Director of Midwifery
Lee-Ann Naidoo, Improvement Programme Manager
Ilisha Purcell, Equality, Diversity and Inclusion (EDI) Manager
Sam Richardson, Chief Registrar

PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 28 NOVEMBER 2025

Present:	Paul Ennals *[Chair]*	Chair
	Rob Harrison	Acting Chief Executive Officer
	Lucia Pareja-Cebrian	Joint Medical Director [JMD]
	Michael Wright	JMD
	Jackie Bilcliff	Chief Finance Officer
	Ian Joy	Executive Director of Nursing, Midwifery & Allied Health Professionals (AHPs)
	Vicky McFarlane Reid	Director for Commercial Development & Innovation / Interim Executive Lead for People & Organisational Development
	Sue Hillyard	Interim Director of Operations
	Bill MacLeod	Non-Executive Director (NED)
	Liz Bromley	NED *(joined from 10:31 to 11:38)*
	David Weatherburn	NED
	Anna Stabler	NED
	Bernie McCardle	NED
	Hassan Kajee	NED
	Phil Kane	NED
	Wendy Balmain	NED

In attendance:
Nini Adetuberu, Associate NED
Paul Hanson, Director of Estates, Facilities and Strategic Partnerships
Caroline Docking, Director of Communications and Corporate Affairs
Martin Wilson, Director - Great North Healthcare Alliance (GNHA) & Strategy
Patrick Garner, Director of Performance and Governance
Annie Laverty, Chief Experience Officer
Kelly Jupp, Trust Secretary
Jenna Wall, Director of Midwifery *(for item 25/2 i) c))*

Observers:
Hugh McKendrick, Public Governor
Dan Frend, Management Trainee – Newcastle Hospitals
Mark Oxley, Videographer, Newcastle Hospitals
Loredana Trevi, Trainee Healthcare Scientist: Visual Electrodiagnostics Service Newcastle Hospitals
Tania Bell, Member of the public
Paul Watson, Member of the public

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.

25/26 STANDING ITEMS:

i) Apologies for Absence and Declarations of Interest

Paul Ennals welcomed all attendees to the meeting and advised that some agenda items had already been discussed at length in previous Board Committee meetings and therefore may not be covered in as much detail today.

Apologies were received from attendees Rachel Carter, Director of Quality and Safety, Dave Elliott, Chief Digital Officer, and Amy Callow, Associate Director for People and Organisation Development.

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 26 September 2025 and matters arising

The minutes of the meeting held on 26 September 2025 were accepted as a true record of the business transacted.

Paul Ennals commended the Board of Directors for achieving 100% compliance with flu vaccinations.

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 highlighted the following points:

- Despite the ongoing industrial action, delivery of almost all elective activity had continued. Appreciation was expressed to staff and resident doctors for their support during this period.
- A report had recently been published into breast services at County Durham and Darlington NHS Foundation Trust (CDDFT) and the trust had issued an apology to those let down by those services. A review of processes within Newcastle Hospitals was underway in the light of learning from CDDFT, and any lessons learned or actions required would be acted upon.

Bill MacLeod raised a question regarding the recent Supreme Court Judgment definition of biological sex to which Martin Wilson emphasised the need to prepare for potential developments, recognising their implications and confirming that staff were being fully supported. He noted that a Code of Practice was expected to be published which was

expected to prompt public and political debate, and stressed the importance of ensuring readiness for these discussions. Meetings were underway with several organisations to focus on sharing learning and best practice. Strong engagement and constructive conversations had taken place with staff and Governors.

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

iv) Chief Executive's Report, including Care Quality Commission (CQC) update

Rob Harrison highlighted the following points:

- Continued improvements on Referral to Treatment (RTT) performance, while focussed on addressing the ongoing challenges in cancer pathways.
- The importance of creating the right conditions for colleagues to deliver high-quality care, ensuring a supportive and effective working environment. Positive feedback had been received regarding the roll out of new IT equipment. This had enabled enhanced system speed and hardware performance, providing staff with reliable IT equipment to enable them to carry out their roles more efficiently.
- Newcastle 'Place' work was ongoing through the Integrated Care Board (ICB) sub-committee. This was focussed on understanding and mapping existing community services and fostering collaborative working through neighbourhood models.

  Delivery plan information and further guidance was awaited. Martin Wilson was scheduled to join the next sub-committee meeting to assist with governance and decision-making.

  A comprehensive spreadsheet mapping current services and community assets was being developed to provide clarity and to support planning.
- As part of the Medium Term Planning Framework, detailed work was underway to develop several plans which included a three-year revenue plan and a four-year capital plan. The deadlines for submission were short and work was progressing across the organisation to understand the delivery expectations and associated implications for the Trust.

  Focus was also placed on understanding the expected year-end financial position and the impact on the next financial year.

  Collaboration continued with the Trust Management Group (TMG) on planning requirements and transformation opportunities.

  Patrick Garner referenced the ongoing significant internal work regarding the planning submission and outlined the submission expectations with the draft submission due in December 2025 and the final submission due in February 2026. Robust governance arrangements had been established which included the initiation of weekly multi-disciplinary team (MDT) meetings and updates to the Executive Team.

  A vast amount of planning information and guidance had now been published, with further detail awaited on the financial allocations and performance baselines.

Paul Ennals noted that it was expected that the first draft submission would be submitted to the Board of Directors for sign-off. Rob Harrison highlighted the significant number of national changes and reiterated the challenges associated with the tight submission deadlines.

Jackie Bilcliff advised that at month 7 the Trust was reporting on plan and was forecasting to achieve the financial targets set. Workforce planning was underway, along with work to support achievement of Cost Improvement Programme (CIP) targets. Major changes had been made to the financial framework which would mean that an internal stretch target would be required, along with exploring commercial opportunities and engaging with commissioners regarding financial allocations.

Bill MacLeod commended Rob Harrison, Jackie Bilcliff, and all involved for the progress made on financial recovery, however noted that the cash position remained challenging for 2026/27 and would require careful management.

- The Integrated Quality Improvement Group oversight meetings continued bi-monthly, having been stood down from monthly meetings due to positive progress. To meet the exit criteria from the oversight meetings, the Trust was required to receive a satisfactory report from an independent external Well-Led review or a CQC reinspection. However, as a CQC visit was not expected in the near future it had been agreed that an external Well-Led review be undertaken. The review had now been completed with the draft report being checked for factual accuracy and the final report to be presented at the January Public Board of Directors meeting alongside a response to any recommendations and actions going forward.
- As referred to in the earlier Chair's update, the outcomes from the report into breast services at CDDFT would be mapped against the revised Trust governance system in Newcastle Hospitals to ascertain whether any further improvements were needed. Patrick Garner and Rachel Carter had been asked to undertake a joint piece of work in relation to this, with their findings to be presented to the Quality Committee in February 2026 **[ACTION01]**. This exercise would be a valuable test regarding the effectiveness of the Trusts' governance framework.
- The launch of the national centre for neurotechnology and neuro restoration, being the first centre of its kind in the United Kingdom (UK). The collaboration with researchers from the United States, and the benefits of being co-located with Newcastle University, were expected to deliver significant benefits to patients, creating a unique relationship. Gratitude was expressed to all involved and a detailed update would be shared with the Board **[ACTION02]**.
- The Trust had been selected as one of the pilot Assessment and Recovery Centre (ARC) locations for lung, liver and kidney transplants, being the only centre designated for all three organs. The aim was to increase organ transplant opportunities through improved organ management. Governance processes were being enacted, and it was noted that the Trust Transplantation Committee was established circa 12 months ago to lead the development of the organ utilisation strategy.

  Anna Stabler queried whether there would be any challenges in maintaining elective performance given the increased demand for transplantation and intensive care beds. She noted the importance of having a clear strategy to balance routine work with

transplantation activity. A discussion ensued regarding balancing capacity with demand, theatre utilisation and service reviews e.g. Cardiothoracic. Rob Harrison outlined that the purpose of the ARC was to preserve organs, therefore the transplants could take place in other locations which would have a lesser impact on Trust elective activity.

Annie Laverty reported that in October, 16 patients and carers participated in an experience-based workshop focused on transplant care.

Paul Ennals emphasised the practical implications in relation to governance arrangements and the need to reduce costs while continuing to grow areas of strength.

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

25/27 STRATEGIC ITEMS:

i) Patient and Staff Stories

Paul Ennals reminded members of the importance of maintaining a balance between positive and more negative stories, for consideration at the Board.

Annie Laverty shared a patient story highlighting the importance of seeing the person behind the patient. The story described how the patient felt that their care had become depersonalised and the patient, a retired nurse, provided valuable learning around fragmentation of care and the need for personalised approaches to avoid similar challenges in the future.

Ian Joy reflected on the patient story, noting his concern on reading the patients' experience and emphasised that personalised care was fundamental to professional practice. He highlighted the importance of learning from the story and sharing it more widely across the organisation. Further consideration was needed as to how issues could be addressed more promptly in 'real-time' and he highlighted that the patient voice was fundamental in the delivery of personalised and compassionate care. He advised that consideration would be given to how the lessons learnt could be incorporated into the governance framework e.g. through the Accrediting Excellence programme.

A discussion ensued covering the following areas:

- Recognition that compassionate care was everyone's responsibility, including NEDs during visits, and the importance of asking patients how they felt when appearing distressed and listening carefully to understand patients' conditions, experience and care. An example of a patient going to theatre was provided and how compassion and context should be built into that experience, whether it be a first or repeated procedure.
- The need for learning to be shared e.g. with universities to influence nurse training, and reflected on in professional processes.

- The importance of the real-time patient experience programme in making immediate adjustments where necessary.
- The reasons as to why the patients' experience occurred and the learning undertaken by the team involved in the delivery of the patients' care.

Anna Stabler queried if assurance was sought from managers and matrons on what the data and patient feedback indicated, and whether any further concerns had been raised to which Annie Laverty advised there had been improvements on the ward regarding patient experience, noting the ward was included in formal evaluation and audit processes.

Rob Harrison stressed the importance of focussing on compassionate care given that the patient experience programmes were embedded and could now highlight areas where patient experience was not as good as expected. He referred to the ACE programme, personal accountability, and the importance of improving and embedding good practice.

Annie Laverty highlighted the staff story which demonstrated accountability in managing patient experience and safety, noting the staff pride in their daily work and the power of clinical leadership.

Paul Ennals noted it was Annie Laverty's last Public Board meeting before she moved on to a new role out with the Trust and thanked Annie for her work on establishing the patient experience programmes within the Trust.

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

[Liz Bromley joined the meeting]

ii) Board Visibility Programme

Ian Joy explained that the Board Visibility Programme provided an informal sense check across wards and departments, identifying good practices and escalation points.

There were no formal leadership walkabouts undertaken by Executive Team members and senior members from the Quality and Safety Team during the reporting period as the programme transitioned to the new model described in the paper presented to Trust Board in September 2025.

Eleven informal visits were undertaken by NEDs during September and October. Ian Joy advised that any issues raised by the NEDs were addressed directly by Executive Directors, or through the Clinical Boards, with additional detail available in the Board Reading Room on AdminControl.

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

iii) Cardiac Surgery update

Michael Wright highlighted the following points:

- Work continued to address concerns previously raised by the CQC, particularly around departmental culture, with good progress being made. A detailed update would be provided at a future Board of Directors meeting.
- A review of clinical services was underway, with positive team engagement, to ensure services were delivered in the best way to maximise patient care.
- Recent BBC news coverage regarding the use of complex mechanical assisted devices both historically and currently within cardiac services. Such devices were noted to support critically ill patients, particularly those awaiting transplantation.

  A response had been submitted to the BBC to advise that the Trust had stopped using the devices in question as soon as a safety notification had been issued. The decision making had been reviewed, and assurance was provided that appropriate decisions were made based on good evidence available at the time, as well as in the best interests of the patient involved.

  Michael Wright advised that the organisation remained open to discussions with any concerned families/patients and noted that such matters were taken seriously.

  Paul Ennals sought clarification regarding the robustness of the Conflict of Interest policy to which Michael Wright advised that the standards of business conduct policy had been in place, and the appropriate guidance had been followed but the policy would be revisited in light of the recent concerns being raised.

  Rob Harrison stressed the importance of transparent decision-making.

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

iv) <u>Integrated Board Report (IBR)</u>

Patrick Garner highlighted that the Statistical Process Control (SPC) variation / assurance slide within the IBR included changes from the previous month's report, with eight negative and two positive changes in special cause variation noted. An overview of the ten changes was provided.

A discussion ensued which covered the following areas:

- An Infection Prevention and Control (IPC) Improvement Group had been established in response to the deterioration in Health Care Associated Infection (HCAI) performance. Compounding reasons had been identified for the performance deterioration which included nursing challenges, increased patient acuity and personal protective equipment perceptions. Focus had been placed on highlighting the importance of hand hygiene and associated training.

  It was noted that there had been a significant increase in Klebsiella bacteraemia cases since the previous month and these cases were being actively reviewed. The aged nature of some of the Trust estate impacted on the Klebsiella position.
- Never events. Ian Joy highlighted that the never events had been discussed previously at Quality Committee and Board meetings. Clinical Boards had been asked to provide

an update on outstanding mortality reviews at the recent Quality Performance Review (QPR) meetings, with a focus on shared learning. As Quality Committee Chair, Anna Stabler advised that she was comfortable with the oversight and regular reports received.

- Increased sickness absence, whereby Vicky McFarlane-Reid advised that sickness reviews were taking place within the Clinical Boards and Corporate Services. Reporting would be amended from next month to include the number of staff absent per day. It was noted that on average there were 885 staff absent each day.
- Appraisal rates had decreased, and work was underway to review the areas where improvements were required such as for medical and dental staff.
- Staff turnover and the need to consider the external environment, as well as availability of opportunities, both internally and externally.
- The processes for ACE accreditation and whether these were being modified to reflect learnings regarding IPC. Ian Joy advised that acceptable levels were outlined as part of the ACE accreditation framework, with baseline assessments triangulating IPC information at the time of the assessment.
- Avoiding Term Admission into Neonatal Units (ATAIN) had moved from showing 'common cause variation' to 'special cause variation of a concerning nature' (high). Three maternity quality improvement workstreams had been identified, with the thermoregulation workstream brought forward to commence earlier. In addition, the neonatal nurse outreach pilot for theatre recovery started in August.
- The impact on Trust delivery and on patients in terms of sickness absence and how this was measured. Sue Hillyard agreed to ascertain whether a report could be generated/data collated relating to when clinics/appointments were cancelled due to staff sickness absence to identify the impact on patients **[ACTION03].**
- The increased volume of type 1 Emergency Department (ED) patients was noted to be of concern. This had resulted in a deterioration in performance despite significant efforts from staff members managing the situation. The Get It Right First Time (GIRFT) programme and improvement work continued.
- Ambulance conveyances and whether assurance could be provided that where appropriate, patients were supported to stay at home when hospital admission was not deemed necessary. Sue Hillyard advised that circa 50% of ambulance arrivals did not result in admission. Work was taking place with the North East Ambulance Service NHS Foundation Trust (NEAS) and community response team to review the position. It was acknowledged that the opening of the Urgent Treatment Centre (UTC) would assist with appropriate patient streaming, however further work was needed on neighbourhood health.
- The challenges faced regarding lung cancer performance, which included complex patient pathways and in some cases, difficulties with patient engagement. There was scope for improvement through streamlining pathways to reduce pathway length.

  It was noted that the Finance and Performance Committee received a deep dive into cancer performance 3-monthly. Annie Laverty suggested carrying out a patient engagement piece of work with cancer patients and it was agreed to discuss through the Executive Team meeting **[ACTION04]**.
  Work continued collaboratively with the Northern Cancer Alliance on the timeliness of referrals and pathways for out of area referrals.

- The need to use data to identify key areas of change for the benefit of the patients and staff members. Curated cancer data would be provided by Flatiron in early 2026 as part of the data partnership in place. This would support an increased focus on outcomes.

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

v) <u>The big picture – national and local perspectives on the 10 year plan</u>

Morag Burton highlighted the following points:

- The changing research landscape which included research considerations in the NHS 10 Year Plan and the Life Science Sector Plan.
- Clinical trials generated £1.2 billion revenue for the NHS and supported circa 13,000 NHS jobs nationwide. Research was known to improve patient care, provide access to innovative medicines and reduce sickness absence.
- The UK was 5th nationally in the global rankings for clinical trials initiated and an investment programme was launched to improve the UK position further with 75% of funding allocated to expedite trial delivery.
- There were 21 Commercial Research Delivery Centres (CRDCs) across the UK, with one in Newcastle. The aim being to increase participant recruitment, increase access to medicines, grow investment and enable larger-scale studies.
- A key strategic ambition for the new National Institute for Health and Care Research (NIHR) Research Delivery Network (RDN) was to grow the amount of clinical research. Research inclusion and delivery of the right research in the right settings were priorities.
- The Department of Health and Social Care (DHSC) has a 150-day timeline for trial setup and delivery, with a penalty regime in place for organisations failing to meet the timelines e.g. removal of funding and enforcement letters. The current Trust position was discussed, with an aim to improve.
- The role of the Regional Delivery Network (RDN) and benefits for the Trust, which included contribution to job creation and workforce development, and enhanced patient care through early access to treatments.

John Isaacs noted the following points:

- Newcastle Hospitals was one of the UK's leading Trusts for clinical trial delivery however achieving the 150-day target was challenging.
- Strong partnerships were in place across the City, supported by high quality infrastructure within Newcastle.
- Newcastle was aspiring to match/challenge leading collaborations such as King's Health Partnership.
- The current challenge of consultant numbers increasing while clinical academics were declining.
- Resources were restricted which meant that time allocated to research was constrained, however highly skilled colleagues were present with innovative ideas that required support and development. Leadership and middle management training was critical.

- Research income supported the Trust's financial position, with efficiency being essential.
- The potential solutions being to maximise value from the existing infrastructure, invest in training for future NHS research leaders, strengthen partnerships and streamline processes.
- Newcastle Hospitals was performing well but had significant opportunity to improve.

Vicky McFarlane-Reid explained that a Research, Innovation and Commercial Committee was being established in the new year which would be chaired by Phil Kane, NED.

A discussion ensued which covered:

- The national 150-day target and barriers to achievement.
- An area of focus for the new Research, Innovation and Commercial Committee would be relating to receipt of financial income from research.
- The benefits of sharing/communicating patient stories from successful trials to aid learning.
- The importance of research and utilising research to aid transformation.
- The potential for future Alliance benefits and opportunities, wider collaboration and academic connections.
- The important research relationship between Newcastle Hospitals and Newcastle University.

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

[Liz Bromley left the meeting].

25/28 ITEMS TO RECEIVE

Paul Ennals highlighted that information included in this section has been discussed thoroughly within Committee meetings.

i) Director reports:

a. Joint Medical Directors (JMD) Report

Lucia Pareja-Cebrian highlighted the following points:

- Urgent and Emergency Care demand continued to rise, being an area of concern. Rising influenza and Covid cases were adding additional flow challenges with the need for isolation and estates cleaning.
- In terms of industrial action, elective care was maintained with 95% of planned activity being delivered across the period of the industrial action.
- With regards to the Patient Safety Incident Response Framework (PSIRF) Priority Project – Invasive Procedure, with a large proportion of the project being to refresh and overhaul of the major components of the National Safety Standards for Invasive Procedures.

- The resident doctors 10 point plan was progressing well, along with the actions for improvement identified from the General Medical Council (GMC) trainee and trainer survey.

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

i) Guardian of Safe Working (GoSW) Report

Lucia Pareja-Cebrian advised that the GoSW Report had been discussed at the latest People Committee meeting, and specific areas included within the report at the Quality Committee meetings. Forthcoming changes to the terms and conditions of service from February 2026 were expected to result in an increase in exception reports.

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

b. Executive Director of Nursing Report

Ian Joy highlighted the following points:

- The Department of Health and Social Care (DHSC) target was to increase staff flu vaccination uptake by 5% compared to 2018–19 with an aim to achieve 72% overall. The Trust was expected to move to 55 – 60% once the figures for staff vaccinated elsewhere were added, which represented a significant improvement compared to last year.
- The receipt of a Nursing Times workforce award.

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

i) Nurse staffing review - deep dive

Ian Joy noted the points below:

- Safe staffing updates were required to be presented to the Board of Directors to provide assurance regarding nurse staffing levels.
- Staffing levels were monitored locally, with effective day to day operational oversight.
- Several areas remained under review. Despite the challenges, staffing establishments were broadly fit for purpose.
- Actions were in place and workstreams outlined within the report.

Anna Stabler referred to a recent Quality Committee discussion on the increase in red flags whereby Committee members had sought assurance on the management of red flag escalations.

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

[Jenna Wall joined the meeting].

c. Maternity

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

Jenna Wall highlighted the following points:

- A Qualified in Speciality (QIS) options paper was discussed at the Northern Neonatal Network (NNN) Board meeting in October 2025, however due to a lack of clarity regarding funding a decision was not made. In the interim the NNN would commence a QIS element of the pathway via an e-learning platform from January 2026. To date, over 500 staff had been trained, which included all consultants.
- The Trust has been impacted by three separate System C (BadgerNet) issues during August to October 2025, with some issues taking longer to resolve than desired.
- The Trust had sought clarification on the Maternity and Neonatal Safety Investigations (MNSI) triage process as an increased number of cases had been accepted for investigation by MNSI. The matter had been escalated to the Integrated Care Board via the Quality Committee.
- The Northern Neonatal Network (NNN) proposal to enact the recommendations of the Neonatal Critical Care Review (NCCR) was agreed at the NNN Board in October 2025. Sunderland Royal Hospital would be redesignated as a Local Neonatal Unit (LNU) and would no longer provide therapeutic cooling or long-term ventilation. Modelling indicated that 26 babies per year will need to be transferred to the Royal Victoria Infirmary (RVI) and the James Cook University Hospital, this increased activity could be accommodated within the existing commissioned cot capacity.

A discussion ensued which covered the following areas:

- The challenges in and impact of achieving the QIS requirements.
- Ongoing monitoring and collaboration to address workforce and specialty gaps.
- Concerns regarding the mixed economy model in place and the impact on personalised care for patients potentially suffering from a miscarriage being seen in the Maternity Assessment Unit (MAU). Jenna Wall advised that women continued to receive personalised care in individual cubicles in the MAU.
- The patient experience programme response rate had been low and further work was needed on gynaecology pathways, with a gynaecology service review underway. Further work is required within gynaecology services which will be addressed through a future Quality Committee **[ACTION05]**.
- There was a commitment to ensuring the patient voice was heard throughout.

Jenna Wall highlighted the value of the Maternity Safety Champion role in driving improvements. Ian Joy referred to the Maternity Safety Champion Report and advised that the learnings from the report had been taken forward.

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

ii) Maternity Safety Champion Report

This item was discussed during the Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress report (item 25/2 i) c))

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

d. People Update: Sexual Safety Audit

Vicky McFarlane-Reid advised that the report included the audit results, a proposal to develop a People Review Panel and a request to carry out an additional questionnaire incorporating the 'Surviving in Scrubs' questions, which was discussed at the latest People Committee meeting.

Annie Laverty highlighted this work was a priority and offered the services of the Experience Team to facilitate the survey. A discussion ensued regarding the importance of having a zero-tolerance approach.

Anna Stabler raised difficulty in finding the lead for Sexual Safety on the staff intranet to which Vicky McFarlane-Reid agreed to ensure the intranet was updated to show the correct lead **[ACTION06]**.

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

ii) Provider Capability Assessment

Patrick Garner advised that the Provider Capability Assessment declaration had been submitted confirming compliance with each of the six domains. Formal feedback was awaited.

Rob Harrison explained that there were learning opportunities from the self-assessment exercise. He highlighted the benefit in reviewing how NHS England and the Trust were interpreting the framework and assessments, which would be a useful in strengthening understanding and consistency in future assessments.

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

iii) Committee Updates

a. Chair Meeting Logs

The Trust Board received the Committee Chair Meeting Logs for information. The following additional points were noted:

- Triple A reporting would be implemented in Board Committees from January 2026.
- Charity Committee - Wendy Balmain explained that the Committee discussed development of the new Charity strategy which would be aligned to the Trust Strategy.
- Digital and Data Committee - Hassan Kajee noted the positive direction of travel to ensure a more strategic focus and to ensure prioritisation.
- Quality Committee - Anna Stabler advised that at the most recent meeting food and nutrition was discussed, along with an update on the Dental Hospital and complaints.

- People Committee - Bernie McCardle explained that appraisal rates, sickness absence rates, and statutory and mandatory training outliers were discussed in detail.
- Finance and Performance Committee - Bill MacLeod highlighted that the Committee received an update on the Community Diagnostic Centre (CDC).
- Audit, Risk and Assurance Committee - David Weatherburn advised that a comprehensive discussion took place relating to the risk validation group and good practice regarding learning which was encouraging. He noted that following receipt of the well-led report there may be a requirement for further refinement of processes.

It was **resolved**: to **receive** the report and the associated verbal updates.

b. Alliance Committees Update on progress

The report noted the steady progress that had been made, with positive discussions underway amongst the Chairs and CEOs regarding strategic intent and making a collective difference for patients. All agreed that the Alliance represented a significant opportunity for Trusts to collaborate and achieve more together.

A positive workshop had been held recently with clinical leaders across the Alliance.

Martin Wilson advised that when the Joint Committee was established in January 2025 individual NED attendance was due to be reviewed after 12 months. Whilst no substantive changes to the membership formulation of the Committee were proposed, a proposal was supported by the Alliance Steering Group that the attending NED members be updated to be Vice Chairs of the three 'East Coast' trusts. Gratitude was expressed to Anna Stabler for her attendance at the Joint Committee, with Bill MacLeod to attend the future Joint Committee meetings.

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

iv) Health and Safety Annual Report

Ian Joy explained that the report was reviewed at the recent Audit, Risk and Assurance Committee meeting, and all requested date amendments had now been validated and accurately updated.

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

25/29 ITEMS TO APPROVE

i) Board Assurance Framework (BAF)

Patrick Garner explained that the BAF had been discussed at each Board Committee meeting. In relation to Digital and Data Committee, a new strategic principal risk was

proposed and agreed on 'Failure to deliver and improve the digital capability required to support the delivery of safe, effective and efficient patient care', and it was noted that there was further work to be done in relation to the risk.

Patrick Garner advised that principle risk 7.1 actions relating to partnerships and the Alliance formation team had now been completed.

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

25/30 ANY OTHER BUSINESS

i) Meeting Action Log

The action log was received and the content noted. The actions proposed for closure were agreed as completed.

ii) Any other business

Rob Harrison expressed appreciation on behalf of the Board of Directors to Annie Laverty for her significant contribution to advancing patient and staff experience, noting the inclusion of this in the national planning guidance and the 10 Year NHS Plan. He highlighted Annie Laverty's national work would further develop the approach to patient experience, leaving a valuable legacy in Newcastle Hospitals. Ian Joy would assume Executive leadership responsibilities for patient experience.

The meeting closed at 12.18pm.

Date of next meeting:
Public Board of Directors – Friday 30 January 2026

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Agenda Item A1(c)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Trust Board

Date of meeting	30 January 2026					
Title	Chair's Report					
Report of	Sir Paul Ennals, Chair					
Prepared by	Sir Paul Ennals, Chair 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 Board meeting held in Public in November 2025: • Board Activity • Governor Activity • Informal Visits • Alliance • External Meetings					
Recommendation	The Trust Board is asked to note the contents of the report.					
Links to Strategic Objectives	Focus on Fundamentals – Deliver high quality, safe and compassionate patient care, meet our Clinical Board and Trust quality priorities. Look to the Future – Develop our Clinical and Trust strategy, as a member of the Great North Healthcare Alliance.					
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 Public meeting.					

CHAIR'S REPORT

Happy New Year.

I was lucky enough to join our first Alliance Christmas carol service in the beautiful surroundings of Newcastle Cathedral. The first of what we hope will be an annual event.

As part of our succession planning for Board, in early December we held interviews for an Associate Non-Executive Director with financial expertise. I am pleased that following a robust interview process, which included additional Nominations Committee meetings in November and December, and Council of Governor approval on 17 December, we have offered the position to Ms Judith McKenna. Judith is likely to join us in early February subject to normal vetting procedures in line with the NHS England Fit and Proper Person Test Framework for Board members.

BOARD ACTIVITY

Our Board Development session in December focussed on three main areas:

1. **Finance & Productivity**
   Reflections on draft planning, path towards financial sustainability, transformation and improvements in productivity/performance which covered:
   - A brief overview of our planning submission;
   - The finance and performance challenge moving forward; and
   - Transformation and productivity schemes.

2. **People Plan**
   Stocktake on the current People Plan status, pre-mortem and agreement of priorities/next steps regarding the remainder of 2025/26 and into 2026/27.

3. **Well-Led**
   Initial feedback from Board members on the Grant Thornton well-led report.

ACTIVITY WITH GOVERNORS AND MEMBERS

At our Governor Workshop in December, in addition to our standard reports, we had our regular update from Rob Harrison, Chief Executive Officer (CEO), on local matters, recent news and achievements, reports on patient and staff experience, performance and finance. We also heard about the work of two of our Non-Executive Directors (NED) from David Weatherburn, NED Chair of the Audit, Risk & Assurance Committee and Phil Kane, NED Chair of the Charity Committee and member of the Quality Committee.

Lisa Jordan, Assistant Director of Strategy and Planning, provided an overview of the 2026-29 Medium Term Planning Framework where we have been asked to prepare credible, integrated three-year plans and demonstrate how financial sustainability will be secured over the medium term.

It is the first time in many years that the NHS has re-introduced planning over a timeframe longer than a year. This is complex, but a welcome challenge, since it allows us to think more strategically about how we might change and develop some of our activities. We have recently been going through an Assurance process with the Integrated Care Board (ICB_ and NHS England, to demonstrate that our Board has been fully engaged in the complexities of the plan, that we are compliant in our financial plans and making good progress in our performance, and that we are balancing the demands of finance, quality and safety.

Patrick Garner, Director of Performance & Governance also joined the meeting to present an overview of the Board Assurance Framework (BAF) process and its importance which is used as a strategic planning tool underpinning governance. I am pleased to report that a recent audit of our BAF confirmed that governance, risk management and control arrangements for the BAF provided a good level of assurance that the risks identified are managed effectively. A high level of compliance with the control framework was found.

Our latest members' event held on 4 December 2025 focussed on diabetes and technology. At the event we shared information on the latest technology being used to improve health outcomes and quality of life for people living with type 1 diabetes, particularly for pregnant women. We also heard from two patients with lived experience. The event was well attended with positive feedback received.

INFORMAL VISITS & EVENTS

I have continued with my informal visits across the organisation to meet with staff. Unfortunately, due to infection I had to postpone my normal Christmas ward visits (sharing my bugs might not have been the most welcome gift to staff or patients); however, I did have the opportunity to meet with Pauline Kelso, Director of Community services and join her and colleagues at the Kenton Centre for a community adult staff engagement session.
Pauline is leading on some pivotal work with the potential to look at Intermediate Care from an Alliance perspective. This fits very clearly into 'Standardising Community Services' which is a key priority and core component of the 10 Year Plan.

I attended the opening of Sycamore Place, which is a paediatric Sexual Assault Referral Centre based in our Great North Children's Hospital at the Royal Victoria Infirmary (RVI). This is a very meaningful name for us in the North East as it speaks of resilience and regrowth which is particularly important for the very ethos of this service, and for the children, young people and families that the team supports in providing sensitive, holistic assessment and support following sexual abuse or sexual assault.

On Wednesday 21 January, together with Northumbria Healthcare NHS Foundation Trust, we hosted a visit for Dr Penny Dash, Chair of NHS England who has focused her career on improving the quality and efficiency of health and care services in order to enhance life expectancy and quality of life.

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.

Frequent 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 workstreams (IT, finance and research), and consider progress on the range of bilateral collaborations. The Chief Executives have been working on developing an ambitious "strategic intent" for the Alliance over the coming period – focussing on ensuring we have outstanding tertiary services supported by outstanding local secondary services.

OTHER MEETINGS AND INFORMATION

I participated in the NHS Providers Chairs and Chief Executive's Network where:

- We heard from their Chief Executive Daniel Elkeles who provided an overview of key policy issues impacting providers, including the recent Budget and its relation to healthcare, realities from the frontline including record demand going into winter and unprecedented levels of activity, finance performance and NHS reform.
- We explored how trust leaders are taking meaningful action to tackle racism and build more inclusive cultures across the NHS.

  This coincides with the development of our own Anti Racism Framework which will set out how we will embed anti-racism into our culture, services, systems, and everyday behaviours. It is both a statement of intent and a plan for measurable change, co-produced with staff and community voices.
- Colleagues from NHS England provided an overview of recent financial performance, discussing financial transparency, board-level focus of costings, current spending trends and the national costing dashboard. They also explored NHS England's two "north stars" - the spending resettlement and the 10-year plan - before discussing the Medium-Term Planning Framework and understanding the cost of delivering services for accountability and public confidence.
- Care Quality Commission (CQC)'s Chief Inspector of Hospitals, Dr Toli Onon, reflected on CQC's recent changes, and highlighted the key proposals in their open consultation on improving the way they assess and rate providers.

I continue to meet with the Chair, CEO and senior officers of the ICB, along with other Foundation Trust Chairs, monthly to discuss issues of common interest. There is also a strong informal network between Chairs in recognition that some colleagues elsewhere in the region are facing some real organisational challenges.

I continue my role representing the NHS on the Net Zero North East England Board. I have also retained my engagement and contributions to the work of the North East Child Poverty Commission, again on behalf of the NHS.

RECOMMENDATION

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

Report of Sir Paul Ennals
Chair
22 January 2026

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 January 2026		
Title	Patient and Staff Stories		
Report of	Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals		
Prepared by	Marilyn Hodges – Associate Director Service Improvement		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☐	☒
Summary	**Patient experience story:** Gillian initially shared her experience as part of the Real Time Patient Experience Programme at the Royal Victoria Infirmary (RVI). In her patient story, Gillian highlights the emotional toll of navigating what she experienced as a fragmented healthcare system. After discovering a lump, she faced months of delays, repeated referrals across multiple hospitals, and conflicting information that left her feeling lost and powerless. Despite eventually receiving surgery at the RVI, the journey was marked by uncertainty, poor communication between trusts, and overwhelming anxiety. Her story underscores the impact of complex pathways and inconsistent communication. It is important that as we move forward, we use stories such as Gillian's to frame our improvement work. As an organisation who cares for patients from across the region and nationally, many of our patients will have been through other trusts prior to receiving care here within Newcastle Hospitals and it is important to ensure that patient pathways are clear, communication is effective and the patient remains in control of their health and care journey. Using stories such as Gillian's in pathway review and improvement work is extremely important and mechanisms to do this are being explored. This story also reflects the importance of meaningful discussion through the real time programme which often captures learning and experiences which are much broader than the care being received in that specific ward or department. **Staff experience story:** Our staff story is from Ken Marshall, who reflects on 21 years in his role as a Security Officer at the RVI. Ken highlights the importance of compassion, communication, and teamwork. From calming a distressed autistic child to supporting vulnerable adults, he emphasizes that talking and kindness go a long way. Ken advocates for the 'We Can Talk' training, urging new staff not to judge, and reminds us that every patient is a human being deserving respect. For him, the job is never about fear—it's about care and making people feel safe. Ken's story reminds us of the fundamental role all staff play in the delivery of high-quality care and the impact we can all have on the experience for patients and their relatives.		
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.		

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Links to Strategic Objectives	Focus on Fundamentals - Deliver high quality, safe and compassionate patient care, meet our Clinical Board and Trust quality priorities.					
	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

Context: Gillian shared her story whilst an inpatient at the RVI. Originally her experience was captured as part of the Real Time Patient Experience Programme, and the powerful message she shared around the impact of navigating a complex healthcare system is important to share.

'I first noticed a lump and, feeling concerned, made an appointment with my GP. The practice had recently merged with another, so I ended up at a different medical centre on a Saturday morning. The doctor suspected a Bartholin's cyst and said he would arrange a gynae appointment at a local hospital.

In May, I received a text asking if I still wanted the referral. I replied yes. Then, at the beginning of August - after more than eleven weeks - I got another text asking the same question. By then, the lump had grown, so of course I said yes and explained that in my message.

Finally, in early September, I was given an appointment at my local hospital with a gynaecology consultant. The doctor examined me and called for a second opinion as the lump was hard. The outcome was a referral to the specialist gynae team at a different hospital. That was unsettling - another hospital, another wait.

In late October, I got a call from the hospital. The team were kind and reassuring, which helped, but the constant changes were unsettling. They booked me for an investigation the next day, then arranged a CT scan. I was also told I'd need a pre-operative assessment and a biopsy. Because I live alone, they said I'd have to stay overnight after the biopsy.

The night before, I got a call from the hospital saying not to come until 11a.m. instead of 07:15. I followed those instructions, but then at 09:15 on the day I got another call asking why I hadn't arrived at 07:15. That moment was overwhelming - I felt completely lost in the system.

After the biopsy, the consultant said they suspected cancer but didn't know the origin. They hoped to have results by mid-November for the MDT [Multi-disciplinary Team] meeting, but then I learned the results weren't ready. Later, nurses confirmed it was cancer and said I'd need a PET scan at the Freeman Hospital to find the origin. They promised to fast-track it, but even that felt uncertain.

Then, on 28th November, I got a call from a Consultant Surgeon's secretary at the RVI which I was not expecting saying that a consultant would call me that morning. When they did, they told me I needed major surgery with radiotherapy and chemotherapy. After that call I was shell shocked - I felt sick. Thirty minutes later, another call came from a different trust asking me to attend an appointment at one of the local hospitals. I had to explain I'd literally just been told I was going to the RVI for surgery. The conflicting messages were overwhelming - I felt pulled in every direction.

Now, four weeks after my biopsy, I've had surgery at the RVI, and as of 4th December, no one has sat down to explain exactly what they found. I'm told a consultant will see me tomorrow. I also felt a tugging sensation and was worried, but a nurse said it was a dissolvable stitch that can take up to six weeks. I'm also worried about the PET scan - a different trust was arranging it, but I'm in hospital and afraid I'll miss it. Today a nurse said there's a backlog for PET scans, so I hope I haven't missed it. A doctor admitted communication between different trusts at times isn't as good as it should be and that was hard to hear. Finally, on 5th December, I had two one-to-one consultations and at last have some clarity.

This whole experience has been emotionally draining weeks of waiting, conflicting information, and constant uncertainty. Every new message or call brings anxiety. I've felt lost, powerless, and exhausted by the lack of clear communication between different organisations. It's not just the illness - it's navigating a system that feels fragmented and overwhelming.'

Staff story

Context: Our staff story is from Ken Marshall, who has worked for Newcastle Hospitals for twenty-one years as a security officer. Ken has particularly been praised for his kind and compassionate approach to supporting patients with additional needs and behaviours that might challenge.

'My favourite day was probably my start date. I never had a clue what this job entailed, but I've worked here twenty-one years now. Every day is different - I've never once got up for work and thought "oh no, I'm going back in there again" even after the more difficult days. There was this one day when we met a young autistic boy whose mother was frantic, as the little man was so scared and distressed in the car. I just talked to them like I would with my own grandbairns. I said, "are you going to come into this hospital and see all these lovely doctors and nurses with me?", and then "well, if you come with me, I'll get you an ice cream!". He let me open the door, even took my hand, and walked with me onto the ward. Talking goes a long way. I like connecting with people. With adults, too, if someone's distressed, I will always say "Hello, I'm Ken" and then ask, "can I approach you?". Sometimes they'll say no, and I just explain "if I can't approach you, then I can't help you". I'll ask "Do you want a brew?" - a lot of people start talking over a cuppa, not just about what's brought them here, but about themselves.

I've had many situations with vulnerable adult patients needing secure transport or support to safely access care. We met a vulnerable patient whose carers were worried about them absconding. They asked to go out for fresh air, so I spoke with them about going outside for just fifteen minutes in a wheelchair - they "pinky promised" that they'd stay with us, and they did! They were distressed having blood taken, so I said, "look at me, this doctor is a lovely doctor, they won't hurt you, you squeeze my hand" and spoke to them gently. It turned out from speaking to them that they'd travelled a long distance, and their comfort

item had been left behind – I went to the shop and brought them a cuddly toy for after their procedure. Their carer said “that means they trust you, and they feel safe with you”.

My advice to people new to a security role would be ‘don’t judge people’. You’ll come into contact with so many people, with different needs, addictions, fears - you need to understand nobody wants to be in that position in the first place. You can’t do the job without compassion - it doesn’t matter what ward someone’s on or where they’re going to, everyone we meet is a human being. It takes nothing to be kind. I also think the ‘We Can Talk’ training should be mandatory. It’s especially important for young people who have been brave enough to tell their family they’re not well, then have to explain again and again in triage - they only want to say it once.

I do hear people say sometimes “oh no, not them again” about particular patients, but I feel there are always two sides to a story. Just because someone might present with behaviour that challenges doesn’t mean they’ll be the same the next day. Just because someone has [hand]cuffs on doesn’t make them a bad person, they may have just made the wrong choice. I don’t think I’ve ever been scared on the job though - even the times I got hurt. We always work in teams - that helps. You might sometimes be more cautious, but I don’t change how I treat people. The way I see it is - if I’m not trying to look after people, I may as well not be here.’

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 January 2026		
Title	Trust Response to the Grant Thornton External Well Led Review		
Report of	Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals		
Prepared by	Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☒
Summary	This report provides an overview of the Grant Thornton Well Led Review and proposes how to take the recommendations forward as part of the overall approach to ensuring the Trust is very well led. The following key points are noted: • The review has highlighted areas of improvement in the well-led domain since the Care Quality Commission (CQC) 2023 inspection findings. Detail is found within the report. • The review identifies 4 broad themes for development moving forward. These were discussed and agreed as part of a Board of Directors Development Session on the 23 October 2025. • The report outlines 26 recommendations over the 9 key lines of enquiry. 11 are rated as red (high priority), 12 as amber (medium priority) and 3 as green (low priority). These have been aligned to relevant Executive Directors and other Directors with the aim of agreeing clearly defined and measurable actions by the end of February. • The report outlines a recommended governance structure to ensure actions lead to evidenced improvement as the Trust continues on its journey to become very well led. • Since the review was completed and before the report was finalised, the Trust Board submitted its first Provider Capability Self-Assessment Declaration to NHS England (NHSE) and is awaiting feedback. The Board of Directors identified some areas for continued development in the self-assessment and there are several overlapping key lines of enquiry with the well-led review. These will be reviewed and amalgamated to produce a single overarching improvement plan. • It is important to recognise and thank internal and external stakeholders for their contributions during this review.		
Recommendation	The Board of Directors is asked to: • Review and comment on this report and the review findings.		

	• Discuss and endorse the recommended governance structures outlined in this report. • Approve aligning this work with the NHSE Provider Capability Assessment Framework to deliver a single overarching improvement plan.					
Links to Strategic Objectives	• Focus on Fundamentals - Deliver high quality, safe and compassionate patient care, meet our Clinical Board and Trust quality priorities. • Make it better for colleagues - 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]	BAF risk ID 1.1 - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.					
Reports previously considered by	Standalone report.					

TRUST RESPONSE TO THE GRANT THORNTON EXTERNAL WELL LED REVIEW

1. INTRODUCTION

This paper provides a high-level overview of the Grant Thornton Developmental Well Led Review final report which was received by the Trust in January 2026. The report is an outcome of a review which was commissioned by the Trust and fieldwork undertaken between July and September 2025.

The paper provides a high-level summary of the Trust response to the report and recommendations, including an overview of next steps as part of the overall approach to ensuring the Trust is very well led.

The intention is that the Executive Team and Board use this report to take stock of progress and agree on priorities and timescales for further improving the organisation.

2. BACKGROUND

In response to the CQC inspection in 2023 and subsequent report received in January 2024, significant work has been undertaken to address the concerns raised. Intensive external oversight of progress and action plans has been in place through an Integrated Quality Improvement Group, supported by colleagues from the Integrated Care Board (ICB), NHSE and the CQC.

In the spring of 2025, nearly 18 months into this process, it was agreed by all parties that it was timely to commission an external well led review to understand progress with elements of the well led actions outlined in the Trust CQC action plan and provide a helpful external review to frame future improvement actions. This was driven by factors including:

- The Trust wanting independent feedback on what progress had been made and where to focus effort going forward.
- CQC indicating that they would not be prioritising the Trust for an early re-inspection due to their perception of reduced risk within the organisation and their need to focus their capacities on other trusts and their own internal organisational transformation.
- A recognition that both CQC and NHSE were changing their approaches to assuring the quality of leadership and governance in organisations and therefore benefit in the Trust being better assured of well led governance across a range of domains.

Following a Trust procurement process, Grant Thornton was commissioned to undertake a well led review.

As noted on page 7 of the final report, the review was undertaken using the NHSE developmental well led framework (June 2017). The report also provides rationale for not utilising the CQC single assessment framework and instead ensuring alignment in the key lines of enquiry and findings.

A number of internal and external stakeholders were interviewed as part of this process alongside an extensive document review and observation of committees and meetings. The insights from a recent anonymous Trust pulse survey with feedback from over 4,000 staff fed into the report, recognising that culture and staff experience was a key finding during the original CQC inspection. The review also included interviewing and engaging with the Council of Governors which has provided valuable insight and reflection.

3. SUMMARY OF FINDINGS

The review has identified that substantial progress has been made since the 2023 CQC inspection. The review identified many areas of improvement and good practice across the framework including:

- Renewed leadership that has driven significant, positive change from the top of the organisation.
- A cohesive, professional and collegiate Board which focuses on ensuring psychological safety and constructive challenge.
- Non-Executive Directors (NED) that have a broad range of complementary skills and experience.
- A clear focus on improving Board visibility.
- Strong staff engagement in relation to development of the forthcoming Trust strategy.
- Increased embedding of clinical leadership through the Clinical Board structure.
- Strengthened risk management processes and supporting infrastructure.
- A more open and transparent approach to engagement with partners.
- Many core governance processes are coherent and generally functioning as we would expect.
- Positive foundations in place to drive quality improvement.
- Clear focus on staff engagement and strong response rates to recent staff surveys.
- Accrediting Excellence (ACE) programme provides a strong foundation for improvement at ward level.
- Commitment to patient engagement and feedback.
- A strong strategic narrative in relation to environmental sustainability supported by strong staff engagement with around 1,000 Green Champions recruited.

A full overview of areas of improvement aligned to the key lines of enquiry can be found in Section 2 (Summary Findings) of the report.

The review identifies and justifies 4 key areas for development going forward:

- **Culture, line management and psychological safety**

'Leadership clearly recognises the need for an environment where colleagues feel supported and safe to speak up. However, cultural change is not yet embedded in the organisation's 'muscle'. Development should include strengthening line management capability and leadership development, prioritising good basics such as 1:1s and 360 feedback, and ensuring appraisals assess how well managers know and engage their teams. There also needs to be clear accountability for poor leadership behaviours, and celebration of positive behaviours that promote the Trust's values.'

- **Strategy**

  'The interim 2025–26 strategy was a pragmatic approach, but the Trust recognises its longer-term plan needs to articulate its vision more clearly and embed golden thread from strategic aims through governance and frontline delivery. Quick wins include structuring agendas and papers around the strategy. The Trust should also accelerate work on the digital strategy.'

- **Governance, management and performance**

  'Board and Committee remits and agendas should explicitly support strategy delivery. Supporting papers should adopt a consistent format focused on assurance and escalation, such 'AAA' reporting. Escalation and de-escalation processes need refreshing, particularly to and from 'Tier 2' Committees (sub-Committee level), to clarify decision-making and maintain 'Tier 1' Board Committees' strategic focus. There is also scope to strengthen ownership and narrative around efficiency programmes and recurrent CIP delivery.'*

  **AAA - A Triple 'A' Report is a concise summary for reporting from a meeting or committee to its Board of Directors using an Alerting/Advising/Assuring approach.*

- **Leadership**

  'Board relationships are positive and collegiate despite significant change. Clarifying leadership of key portfolios (notably People) and communicating this clearly will reinforce the Trust's commitment to culture change.'

A full overview of areas for development aligned to the key lines of enquiry can be found in Section 2 (Summary Findings) of the report.

4. REVIEW RECOMMENDATIONS

Section 3 of the report provides a comprehensive list of 26 recommendations over 9 key lines of enquiry. 11 are rated as red (high priority), 12 as amber (medium priority) and 3 as green (low priority).

The recommendations were discussed with the Trust Board at a Board Development session on 23rd October 2025. This development session provided an opportunity for the Trust Board to discuss and challenge key areas of development identified during the review and discuss practical recommendations to address these findings.

5. TRUST RESPONSE TO THE REVIEW RECOMMENDATIONS AND FINDINGS

The Trust Board fully accept the contents of the report and the rationale provided for the areas for development. The following key points were noted:

- Several of the recommendations were in tune with other feedback sources and relate to improvement work which is already underway. Examples include recommendations related to Freedom to Speak Up, Equality Diversity and Inclusion, Implementation of triple A reporting, Complaint Resolution and Sharing Learning from Incidents.
- As we approach the end of Year Two of our People Plan, work has commenced to review and agree key areas of focus for year 3. The planned areas of focus align to several of the well-led review recommendations and work is already underway to ensure any additional learning from the external review informs this work.
- It is noted that 9 of the recommendations relate to the future Trust strategy and how it will be embedded in governance structures. The new Trust strategy is due to be launched in April 2026 and therefore any agreed actions on the back of these recommendations will be to commence once the strategy is launched.
- Recommendation 2.3 relates to the refresh of the Trust values and requires further discussion as part of the finalisation of the Trust strategy.

Since the review was completed and before the report was finalised, the Trust Board submitted its first Provider Capability Self-Assessment Declaration to NHS England and is awaiting feedback. The Trust Board identified some areas for continued development in the self-assessment and there are several overlapping key lines of enquiry with the well-led review.

6. NEXT STEPS AND AGREED ACTIONS

Whilst the Grant Thornton recommendations have been fully accepted, they need to be cross referenced against open actions captured on existing improvement plans. Once external feedback is received on the Provider Capability Self-Assessment, this will be combined with the internally identified areas for development and the recommendations from the Grant Thornton review in a single overarching Well Led Improvement Action Plan.

It is expected that this will be developed by the relevant Executives by the end of February.

It is important to note that the actions will naturally align to a number of the Board Committees such as People, Quality, Digital and Data, and Audit, Risk and Assurance. Actions will be aligned to key Executives and Directors as outlined below and overseen by the appropriate Board Committee.

- Chief Executive Officer – 1.1, 2.1
- Trust Chair – 1.3
- Executive Director of Nursing, Midwifery and Allied Health Professionals – 5.1, 7.1, 8.1
- Trust Secretary – 4.1, 4.2, 4.3, 4.6
- Director of Quality and Safety – 1.2, 3.4, 7.2, 8.2
- Director of Performance and Governance - 2.2, 4.4, 5.2, 6.1, 9.1
- Director for Commercial Development and Innovation and Interim Executive Lead for the People Directorate – 3.1, 3.2, 3.3, 3.5
- Chief Digital Officer – 4.5 (in collaboration with other Directors), 6.2

It is expected that the Audit, Risk and Assurance Committee provides oversight and assurance for delivery of the entirety of the Well Led Improvement Action Plan.

7. SUMMARY

The Trust has welcomed the Grant Thornton Well Led Review of progress over the past 18 months and their recommendations. The Trust Board recognises that there is more work to do with workstreams already underway, including ensuring all staff feel valued, safe to speak up and have a positive staff experience.

The review will help provide focus for a revised Well Led Improvement Action Plan which will be monitored through appropriate Board committees.

Report of Ian Joy
Executive Director of Nursing, Midwifery and Allied Health Professionals
20 January 2026

Grant Thornton

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Developmental Well-Led Review

Final Report - January 13th 2026

Grant Thornton

FAO Rob Harrison, Interim Chief Executive
The Newcastle Upon Tyne Hospitals NHS Foundation Trust
Royal Victoria Infirmary
Queen Victoria Road
Newcastle Upon Tyne
NE1 4LP

Grant Thornton UK Advisory & Tax LLP
8 Finsbury Circus
London EC2M 7EA
+44 (0)20 7383 5100
+44 (0)20 7184 4301
grantthornton.co.uk

13th January 2026

Dear Rob

We have pleasure in enclosing a copy of our report in accordance with your instructions. This document (the Report) has been prepared by Grant Thornton UK LLP (Grant Thornton) for Newcastle Upon Tyne Hospitals NHS Foundation Trust (the Addressee) in connection with the Well Led Governance review (the Purpose).

We stress that the Report is confidential and prepared for the Addressee only. We agree that an Addressee may disclose our Report to its professional advisers in relation to the Purpose, or as required by law or regulation, the rules or order of a stock exchange, court or supervisory, regulatory, governmental or judicial authority without our prior written consent but in each case strictly on the basis that prior to disclosure you inform such parties that (i) disclosure by them is not permitted without our prior written consent, and (ii) to the fullest extent permitted by law we accept no responsibility or liability to them or to any person other than the Addressee.

The Report should not be used, reproduced or circulated for any other purpose, in whole or in part, without our prior written consent, such consent will only be given after full consideration of the circumstances at the time. These requirements do not apply to any information, which is, or becomes, publicly available or is shown to have been made so available (otherwise than through a breach of a confidentiality obligation).

To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Addressee for our work, our Report and other communications, or for any opinions we have formed. We do not accept any responsibility for any loss or damages arising out of the use of the Report by the Addressee(s) for any purpose other than in relation to the Purpose.

The data used in the provision of our services to you and incorporated into the Report has been provided by third parties. We will not verify the accuracy or completeness of any such data. There may therefore be errors in such data which could impact on the content of the Report. No warranty or representation as to the accuracy or completeness of any such data or of the content of the Report relating to such data is given nor can any responsibility be accepted for any loss arising therefrom.

We have shared the Report with Ian Joy on 11th November 2025 who confirmed its factual accuracy in all material respects.

Our fieldwork was performed in the period between July 2025 and September 2025. We have not performed any fieldwork since 30th September 2025 and, in agreement with the addressees of this Report, our Report may not take into account matters that have arisen since then. If you have any concerns in this regard, please do not hesitate to let us know.

Scope of work and limitations

Our work focused on the areas set out in the scope of work agreed with you. Our assessment of the affairs of the Trust does not constitute an audit in accordance with Auditing Standards and no verification work has been carried out by us; consequently we do not express an opinion on the figures included in the Report. The scope of our work has been limited both in terms of the areas of the business and operations which we have assessed and the extent to which we have assessed them. There may be matters, other than those noted in the Report, which might be relevant in the context of the Purpose and which a wider scope assessment might uncover.

Forms of report

For your convenience, the Report may have been made available to you in electronic as well as hard copy format, multiple copies and versions of the Report may therefore exist in different media and in the case of any discrepancy the final signed hard copy should be regarded as definitive.

General

The Report is issued on the understanding that the management of the Trust have drawn our attention to all matters, financial or otherwise, of which they are aware which may have an impact on our Report up to the date of signature of this Report. Events and circumstances occurring after the date of our Report will, in due course, render our Report out of date and, accordingly, we will not accept a duty of care nor assume a responsibility for decisions and actions which are based upon such an out-of-date Report. Additionally, we have no responsibility to update this Report for events and circumstances occurring after this date.

Notwithstanding the scope of this engagement, responsibility for management decisions will remain solely with the directors of the Trust and not Grant Thornton. The directors should perform a credible review of the recommendations and options in order to determine which to implement following our advice.

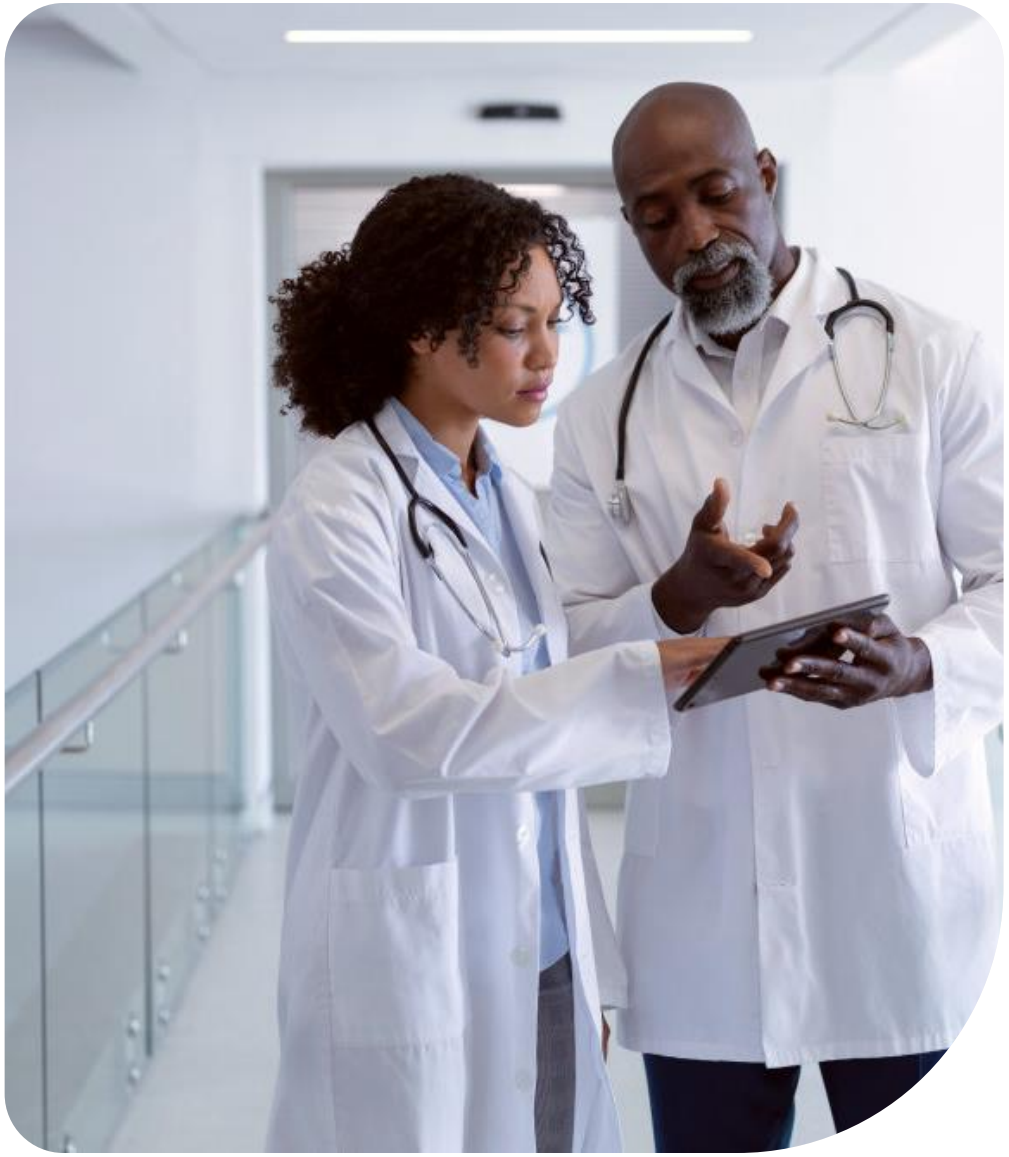
Contacts

If there are any matters upon which you require clarification or further information, please contact Peter Saunders.

Yours sincerely

Grant Thornton Uk Advisory and Tax LLP

Grant Thornton UK Advisory & Tax LLP



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1. Executive Summary

Summary findings

Overall conclusions

The Trust has made substantial progress since its CQC inspection, particularly at senior leadership level. During our review we identified many areas of improvement and good practice areas across the framework including:

- ✓ Renewed leadership that has driven significant, positive change from the top of the organisation.
- ✓ A cohesive, professional and collegiate Board which focuses on psychological safety and constructive challenge.
- ✓ NEDs that have a broad range of complementary skills and experience.
- ✓ A clear focus on improving Board visibility.
- ✓ Strong staff engagement in relation to development of the forthcoming Trust strategy.
- ✓ Increased embedding of clinical leadership through the Clinical Board structure.
- ✓ Strengthened risk management processes and supporting infrastructure.
- ✓ A more open and transparent approach to engagement with partners.
- ✓ Many core governance processes are coherent and generally functioning as we would expect.
- ✓ Positive foundations in place to drive quality improvement.
- ✓ Clear focus on staff engagement and strong response rates to recent staff surveys.
- ✓ 'ACE' accreditation programme provides a strong foundation for improvement at ward level.
- ✓ Commitment to patient engagement and feedback.
- ✓ A strong strategic narrative in relation to environmental sustainability supported by strong staff engagement with around 1,000 Green Champions recruited.

The Trust's key areas of development areas relate to driving culture change throughout the organisation to ensure all staff are supported by their managers and feel safe to raise concerns. This needs to be supported by a clear strategic narrative for the organisation, with governance processes fully aligned to delivering on its objectives, creating a clear golden thread of reporting and accountability from ward to Board.

1. **Culture** – embedding a positive and inclusive culture at all levels of the organisation is a key challenge for the Trust. The Trust has made a good start in building this culture at Board level but there is, at this stage, less evidence that this is embedded throughout the organisation. The Trust needs to improve the quality of line management and staff's trust in the revised speaking up processes, and act to promote greater diversity and inclusion.
2. **Strategy** – the Trust's pragmatic decision to have a 1-year, interim strategy inevitably left a gap in terms of the medium-term vision for the Trust, and development of the Trust strategy is key to enabling all staff to articulate the outcomes the Trust is seeking over the next 5 years. Development of the strategy is a clear opportunity to ensure the remits of the Trust's Tier 1 Committees are aligned to the outcomes it is seeking. There is also scope to develop a more complete digital and data strategy to prioritise improvement and investment.
3. **Governance, risk and performance** – relatedly, the Trust's governance and accountability structures would benefit from clearer alignment to the Trust's strategy. This will ensure that, more generally, the Trust's reporting to Tier 1 Committees would benefit from a sharper focus on assurance against achievement of outcomes, clearer and more consistent executive summaries.
4. **Leadership** – while the Trust has made significant progress in improving leadership and the Board is developing well, the Trust's leadership of some portfolios could be clearer. During conversations with stakeholders, a lack of clarity around the distributed roles and responsibilities for the people and culture agenda at executive level was highlighted as a risk, potentially sending an unclear message about the longer-term priority placed on this agenda.

Well-Led reviews

An introduction to Well-Led reviews

Well-Led reviews

Boards are responsible for all aspects of performance and governance of the organisation. The role of the Board is to set strategy, lead the organisation, oversee operations, and to be accountable to stakeholders in an open and effective manner.

The Francis report led to major changes in the regulatory regime. It has also resulted in even closer working relationships between the bodies responsible for regulation and oversight of Foundation Trusts, particularly around the sharing of information and intelligence.

It is in this spirit regulators committed to developing an aligned framework for making judgements about how well led NHS providers are.

The Well-Led framework for governance reviews considers 8 key lines of enquiry (KLOE):

1. Is there the leadership capacity and capability to deliver high quality, sustainable care?
2. Is there a clear vision and credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?
3. Is there a culture of high quality, sustainable care?
4. Are there clear responsibilities, roles and systems of accountability to support good governance and management?
5. Are there clear and effective processes for managing risks, issues and performance?
6. Is appropriate and accurate information being effectively processed, challenged and acted on?
7. Are the people who use services, the public, staff and external partners engaged and involved to support high quality, sustainable services?
8. Are there robust systems and processes for learning, continuous improvement and innovation?

It is important to note that the Care Quality Commission (CQC) have updated the well-led framework under its Single Assessment Framework (SAF) in April 2024. At the time of undertaking the review, the developmental well-led framework and guidance had not been updated by NHS England (NHSE). The review did not therefore follow the CQC SAF. As part of the set-up of the review, we mapped the revised SAF with the developmental guidance to ensure areas were aligned and could be used to support any assessment CQC may undertake using the SAF. To ensure coverage of the CQC SAF areas an additional KLOE around environmental sustainability has been included as part of this review.

Background

Trust overview and important context to this review

Overview of the Trust

The Newcastle Upon Tyne Hospitals NHS Foundation Trust (the Trust) is one of the largest NHS teaching hospital trusts in the UK. It provides a comprehensive range of acute, specialist, and community services to patients across Newcastle, the wider North East region, and beyond. The Trust operates two major hospital sites—Royal Victoria Infirmary (RVI) and Freeman Hospital—and is internationally recognised for its research-led clinical care, particularly in areas such as cancer, transplantation, and neurosciences. It has a workforce of over 16,000 staff and serves a population of approximately 1.5 million people. It has a strong academic partnership with Newcastle University and is a leading centre for medical education and innovation. The Trust managed an annual budget exceeding £1.7bn in 2024/25.

Key context - Summary of recent CQC inspections

Following inspections between June and December 2023, the Care Quality Commission (CQC) downgraded the Trust's overall rating from **Outstanding** to **Requires Improvement**, with the Well-led domain rated **Inadequate**.

The inspections covered services at both Freeman Hospital and RVI, including surgery, medicine, maternity, critical care, and children's services. While staff were consistently praised for their compassion and dedication, the CQC identified serious concerns around governance, leadership culture, and compliance with the Mental Capacity Act and Mental Health Act.

Key issues included poor documentation and oversight of patients with mental health needs, unsafe medicines management, and a lack of effective risk escalation.

The Trust was also criticised for failing to foster a culture where staff felt safe to raise concerns, with reports of bullying and harassment.

Despite these challenges, some services—particularly those for children and young people—were commended for outstanding practice.

In response to CQC's findings, the Trust **developed a comprehensive improvement programme under new executive leadership**. This included the implementation of a revised governance framework, enhanced training on mental health legislation that focused on the Mental Capacity Act and strengthened incident reporting mechanisms. Monthly progress reports were submitted to the CQC, and conditions placed on the Trust's licence have now been lifted. The Trust was placed in National Oversight Framework (NOF) segment 2 at the time of our review.

Key context – the national picture

There are some important broader contextual points to consider:

- There is currently significant uncertainty across the NHS, resulting in a lack of clarity regarding the impact this will have on the system; including how this will be configured and how this will operate going forwards.
- Trusts across the NHS are operating in the context of extreme financial pressure. This has been a significant challenge for the Trust during 2024/25 and continues to be a significant challenge across the sector in 2025/26. As guidance emerges on plans for future financial settlements the Trust and other NHS bodies will be able to make longer term plans.
- NHS organisations continue to face operational challenges including waiting list backlogs and staff shortages, in the context of the financial challenges and with an ageing population with evolving healthcare needs.

References

1. Newcastle Upon Tyne Hospitals Annual Report and accounts 2024-2025
2. CQC inspection report January 2024

Our approach

An overview of our approach in conducting this Well-Led review

This report sets out the findings from our independent review of leadership and governance arrangements at the Trust against NHSE's developmental Well-Led Framework (June 2017). In addition, we have assessed the Trust against the environmental sustainability domain within the CQC Well-led guidance and framework. We emphasise that our review of KLOEs 1-8 was limited to the scope outlined in the NHSE Framework and did not assess whether clinical services provided by the Trust are safe, effective, caring or responsive.

For each of the 8 Well-Led framework key questions, and the additional KLOE on environmental sustainability, we have assessed the Trust and assigned a rating using the NHSE four-point scoring methodology. Definitions of the ratings are shown in the diagram 1 on the right. These developmental ratings provide an assessment to help guide the Trust on where development actions should be prioritised. They do not represent an indicative inspection rating.

We undertook our work between July and September 2025, and followed the approach outlined below:

Project set up:

- Confirmation of areas to be covered in review.
- Set up of regular meetings to share emerging findings and monitor progress.
- Identification of key stakeholders for interview and sharing of document request list.

Field work:

- Over 40 internal and external 60–90-minute structured interviews, some involving multiple individuals, including Governor, partner trust, ICB, regional and other stakeholder input.
- Review of documents shared by the Trust.
- Review of survey data shared by the Trust.
- Observing private and public Board, Board Committees and Clinical Board quality and performance reviews (QPRs).

Feedback and reporting:

- Emerging themes shared at mid-point and towards the end of review with Chair and CEO.
- Development session with full Board including sharing key themes and co-development of actions.
- Formal reporting with factual accuracy check.

Note, we have summarised our evidence base on the next page, which we have used to triangulate our findings and determine our ratings.

Rating	Definition	Evidence
GREEN	Meets or exceeds expectations.	Many elements of good practice and there are no major omissions.
AMBER/GREEN	Partially meets expectations but confident in management's capacity to deliver 'Green' performance within a reasonable timeframe.	Some elements of good practice, has no major omissions. Robust action plans to address perceived shortfalls with proven track record of delivery.
AMBER/RED	Partially meets expectations, but with some concerns on capacity to deliver within a reasonable timeframe.	Some elements of good practice, has no major omissions. Action plans to address perceived short falls are in an early stage of development with limited evidence of track record of delivery.
RED	Does not meet expectations.	Major omissions in quality governance identified. Significant volume of action plans required and concerns on management capacity to deliver.

Our approach

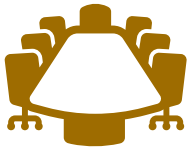
Below is a summary of the evidence base we have gathered to support our developmental Well-Led review during the fieldwork phase. We have only raised issues and recommendations where these have been confirmed through multiple sources and triangulated with evidence. During the review, we have communicated emerging themes with key stakeholders and co-developed actions for improvement with members of the Board as part of a Board development session in October 2025.

We would like to thank all of the individuals at the Trust who supported the completion of this review.

Over 40 interviews with internal stakeholders including the Executive Team, Non-executive Directors and individuals in specialist roles.

Interviews with external stakeholders including ICB, partner Trusts and region.

Face to face observation of Public Board, Private Board and Board development.

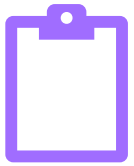


Over 100 documents, including committee papers and minutes reviewed.

Mid-project feedback with key individuals to test emerging themes.

Virtual observation of Board committees.

Observation of Executive Performance Reviews of Clinical Boards.



Review of Trust Pulse Survey focusing on key areas which had been flagged through both internal and external interviews.

Face to Face Board development session co-developing actions.

Summary KLOE ratings

Overall, The Newcastle Upon Tyne Hospitals NHS Foundation Trust (the Trust) has made substantial leadership and performance improvements since its CQC inspection. The changes at the top of the organisation have been positive, reflected in a more open and transparent engagement with partners. However, embedding a consistently positive culture across all staff groups remains the most significant and challenging priority. This requires a clear strategy for leadership development, and visible accountability for leadership behaviours.

The key areas for development based on our review are:

1. **Culture, line management and psychological safety** – leadership clearly recognises the need for an environment where colleagues feel supported and safe to speak up. However, cultural change is not yet embedded in the organisation's 'muscle'. Development should include strengthening line management capability and leadership development, prioritising good basics such as 1:1s and 360 feedback, and ensuring appraisals assess how well managers know and engage their teams. There also needs to be clear accountability for poor leadership behaviours, and celebration of positive behaviours that promote the Trust's values.
2. **Strategy** – the interim 2025–26 strategy was a pragmatic approach, but the Trust recognises its longer-term plan needs to articulate its vision more clearly and embed golden thread from strategic aims through governance and frontline delivery. Quick wins include structuring agendas and papers around the strategy. The Trust should also accelerate work on the digital strategy, now being progressed through its NED-led Digital and Data Committee.
3. **Governance, management and performance** – Board and Committee remits and agendas should explicitly support strategy delivery. Supporting papers should adopt a consistent format focused on assurance and escalation, such 'AAA' reporting. Escalation and de-escalation processes need refreshing, particularly to and from 'Tier 2' Committees (sub-Committee level), to clarify decision-making and maintain 'Tier 1' Board Committees' strategic focus. There is also scope to strengthen ownership and narrative around efficiency programmes and recurrent CIP delivery.
4. **Leadership** – Board relationships are positive and collegiate despite significant change. Clarifying leadership of key portfolios (notably People) and communicating this clearly will reinforce the Trust's commitment to culture change.

These key developments resonated with Trust leaders. For some areas, plans were already being put into place to address these issues, although we have not been able to assess the impact of these. The table to the right summarises our assessment of the Trust's performance against the 8 KLOEs outlined in the Well-Led framework, and the additional KLOE of Environmental Sustainability. Our summary of findings against each KLOE are presented in section 2.

NHS Well-Led framework			CQC SAF
#	KLOE	Provisional rating	CQC Well Led category
1	Leadership	Amber/Green	Capable, compassionate and inclusive leaders
2	Vision and Strategy	Amber/Green	Shared direction and culture
3	Culture	Amber/Red	Freedom to speak up Workforce equality, diversity and inclusion
4	Governance and management	Amber/Red	Governance, management and sustainability
5	Risk and performance management	Amber/Green	
6	Information and data quality	Amber/Green	
7	Engagement – Patients, public and staff	Amber/Green	
7	Engagement – Partnership working	Amber/Green	Partnerships and communities
8	Improvement and innovation	Amber/Green	Learning, improvement and innovation
9	Environmental sustainability	Amber/Green	Environmental Sustainability

2. Summary findings

KLOE 1: Leadership

Is there the leadership capacity and capability to deliver high quality, sustainable care?

Overview

The Trust has undergone a period of significant leadership transformation and renewal since 2024. Despite this, the Board is cohesive. Both the Executive and Non-Executive teams have well-balanced and complementary skills, with expertise across clinical, financial, commercial, digital, and partnership domains. The Trust's substantive Chief Executive is currently on secondment to NHS England, and some staff expressed a desire for clarity over future leadership arrangements, though feedback on the leadership transition to the interim Chief Executive was positive.

Relationships across the Board were consistently professional and constructive in the meetings and interactions we observed. There is a growing culture of psychological safety and supportive challenge, particularly at the Executive and Board levels. The Trust's Chair – who also chairs two other Trusts within the system – sets a positive 'tone from the top' which has helped foster an environment where respectful debate is encouraged. As we set out below, there is scope to sharpen the Board's focus through improving submissions to the Board, as well as to Tier 1 Committees. This will help the Trust demonstrate that time is allocated on Board agendas as effectively as possible.

Board development is in place and covers relevant material. Members recognise more time is needed to fully embed a high-performing team dynamic given the degree of turnover since 2024 and, over the next 12 months, there is a commitment to further strengthen Board cohesion and enhance collective leadership.

The Trust has prioritised increasing Board visibility but needs to be sure this is having the effect needed. There is an active Board visibility programme of Executive and NED visits and walkabouts, reported to the Board and this is supported by initiatives such as the Chief Executive roadshows. The Trust would benefit from structured evaluation of the effectiveness of this in improving perceptions of Executive and Non-Executive visibility among frontline staff.

The Trust needs to ensure clarity over executive leadership of the people and culture agenda. Executive responsibility for HR rests with the Director of Commercial Development and Innovation, who is also Executive Lead for People and Organisational Development. Key elements of the people agenda also rest with the Chief Experience Officer who has led development of processes to provide data, intelligence and insight and is one of two Joint Leads on Equality, Diversity and Inclusion (EDI). The Director of Communications and Corporate Affairs, is also Joint Lead for EDI. The Trust has appointed a new Associate Director with a formal HR background to support this agenda. The Trust needs to ensure that the leadership arrangements are clear to ensure appropriate accountability and signal the high priority placed on this key developmental challenge. It would also be beneficial to ensure clarity and stability in leadership arrangements across all portfolios, including Digital/Data.

Actions to address key areas of development

Capacity

- Clarify the leadership of the people and culture agenda and communicate this clearly to staff and external stakeholders.
- Clarify the leadership of shared portfolios - including digital and strategy.

Cohesion of the Board

- Ensure Board agenda setting clearly demonstrates how the Board agenda is aligned to the Trust strategy and how time is allocated in a way that allows appropriate time for discussion and debate.
- Align Board development to longer-term strategy and related skills requirements at Board level (including succession planning).

Visibility

- Assess the effectiveness of the Board visibility programme.

KLOE 2: Vision and strategy

Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

Overview

The Trust has an interim strategy for the period 2025–2026, following the conclusion of its previous five-year strategy in 2024. The Trust's current vision is "achieving local excellence and global reach through compassionate and innovative healthcare, education and research." The interim strategy itself is coherent and structured around eight "big signals," aligned with four overarching strategic aims: improving safety, quality, and experience; delivering performance; ensuring effective governance; and strengthening systems and partnerships. The current strategy does not include a dedicated section on population health, though work is underway to address health inequalities through initiatives in prevention, maternity, children's services, elective and urgent care, and research.

The development of an interim strategy was a deliberate and pragmatic step that allowed the Trust to focus on core performance at a challenging time. The interim strategy allowed the Trust to focus on immediate priorities following the CQC report, while engaging staff, patients, and stakeholders in the development of a longer-term strategy.

However, the sense from those we spoke to was that the current strategy did not always convey a unique vision for the Trust. The absence of a fully-bespoke, longer-term strategy has made it harder for staff at all levels to articulate the longer-term outcomes the Trust is seeking. For less mature portfolios, such as digital, the absence of an organisational strategy makes defining strategic goals, aligned to strategic aims, more challenging.

The Trust is currently developing a five-year strategy, which is scheduled for publication in April 2026. The Trust is developing the strategy based on an extensive consultation process with staff and partners. There is also a need to ensure all supporting strategies are in place and clearly linked to the developing organisational and clinical strategies. The Trust should also refresh its values, which were developed in 2018/19. The Trust has undergone significant strategic and cultural shifts since then. At present, there is no dedicated workforce strategy, and limited reference to environmental sustainability within the interim strategy (although a Green Plan is in place).

The Board engages with the strategy through regular updates and development sessions. Progress against the eight big signals is monitored through monthly CEO reports. However, the Trust's annual report currently does not track strategic progress. Leadership responsibility for corporate strategy development lies with the Director of Performance and Governance, supported by the Director of Communications and Corporate Affairs, with Clinical Strategy the responsibility of the Director of the Great North Healthcare Alliance and strategy.

Actions to address key areas of development

Strategy development

Finalise development of the Trust 5-year Strategy.

Refresh the Trust's values.

Leadership and accountability for strategy

Implement clear monitoring of Trust progress against the strategy and use this methodology to support the monitoring of other strategies within the organisation.

Making use of the Trust strategy across the organisation

Create a targeted communications and engagement strategy for the new strategy, to ensure staff understand how it fits in with their day to day.

Support service lines to link their own strategies to the ambitions of the Trust strategy.

KLOE 3: Culture

Is there a culture of high quality, sustainable care?

Overview

The cultural improvement evident at Board level is not yet embedded throughout the organisation. Leadership and line management development needs to be a key priority for the Trust. The 2024 NHS Staff Survey and internal reviews highlighted line management quality as a key area for improvement, particularly within the Cardiothoracic clinical board. Concerns raised via the FTSU Guardian often relate to staff-manager interactions, and the 2025 Pulse Survey showed no significant progress in satisfaction with line management. The Trust needs a clear plan to strengthen line management capability and leadership development, prioritising good basics such as 1:1s and 360 feedback, and ensuring appraisals assess how well managers know and engage their teams. There also needs to be clear accountability for poor leadership behaviours, and celebration of positive behaviours that promote the Trust's values.

The organisation has developed a 3-year People Plan (now in Year 2) but measuring the impact of this is a challenge. The Trust has developed an Impact Framework, but not all indicators are outcome-focused. The Trust has improved the response rate to its staff surveys, and this provides reliable data, but survey data have inherent limitations including time-lags and a lack of granularity at ward level. More leading indicators and robust evaluation are needed to assess the effectiveness of interventions under the plan. The Plan is overseen by the Non-Executive-led People Committee. Initiatives include a Civility Charter and training to embed respect and kindness across recruitment, induction, appraisal, and other processes.

Staff confidence in raising concerns remains mixed and needs improvement. The 2024 NHS Staff Survey showed average results, and the July 2025 internal survey showed no notable improvement. The Trust has invested in Speaking Up arrangements, increasing Guardian capacity and appointing of FTSU Champions. However, the champion network is not yet fully embedded or representative of all staff groups, and monitoring of Champions' activity needs formalising. The Trust seeks to identify and report on staff who experience detriment for speaking up, but processes are not standardised or documented in policy, limiting assurance. Reporting of FTSU themes and concerns is established, but there is little evidence that data on protected characteristics is collated and reported.

The Trust needs to accelerate progress in relation to diversity and inclusion. The 2023/24 NHS Staff Survey shows the Trust scores below average on indicators linked to equality, diversity and inclusion, with limited progress over the past year. WRES and WDES compliance remains variable. Leaders acknowledge this and have increased focus through initiatives such as: Two Executive EDI leads, Board development sessions, and EDI objectives for Board members; An EDI action plan monitored by the EDI Steering Group, development of an Anti-Racism Policy; Active Staff Networks with direct Board engagement. Despite this, the 2025 Pulse Survey indicates declining staff confidence that the Trust is serious about improving EDI, suggesting a gap in communicating progress.

Areas for development

Line management

Develop a strategic and measurable plan for line management improvement. Create a dedicated improvement plan aligned with People Plan objectives. Include targeted interventions for key staff groups and clarify support/development needs.

People plan

Invest in robust evaluation of the People Plan and interventions. Assess pre-implementation logic and post-implementation outcomes.

Increase staff confidence that concerns will be addressed.

Strengthen communication and training on Freedom to Speak Up (FTSU) processes. Enhance participation via FTSU Champions and improve Board oversight.

Build momentum on Equality, Diversity, and Inclusion (EDI) initiatives.

Embed EDI clearly within Trust strategy and make leadership support visible. Ensure behaviours contrary to EDI are not tolerated and promote diversity in Champion networks. Leaders should share objectives and hold each other accountable for progress.

KLOE 4: Governance and management

Are there clear responsibilities, roles and systems of accountability to support good governance and management?

Overview

The Trust has established a governance framework based on a distributed leadership model. Significant operational and leadership responsibilities sit with eight Clinical Boards, while strategic oversight remains with the Board of Directors. Governance operates across four tiers: the Board of Directors, Council of Governors, Board Committees, and the Executive Team, with defined reporting lines. The Board retains ultimate accountability for strategic direction, performance, and compliance, while the Council of Governors provides public oversight. These arrangements are underpinned by a Performance and Accountability Framework.

Based on our observations, Tier 1 Committees function well with appropriate cross-membership of Executive and Non-Executive Directors. Committees all operate under current Terms of Reference and undertake annual effectiveness reviews. Meetings we observed were quorate, and Board papers followed a standard format. However, some could have been summarised more effectively to support discussion. Aligned to our observations under KLOE2, escalation and de-escalation processes need refreshing, particularly to and from 'Tier 2' Committees (sub-Committee level), to clarify decision-making and maintain 'Tier 1' Board Committees' strategic focus. There is also scope to strengthen ownership and narrative around efficiency programmes and recurrent CIP delivery.

To strengthen governance, clearer alignment between Tier 1 remits, reporting structures, and strategic priorities is needed, alongside a more standardised focus on assurance. This includes defined thresholds for escalation and de-escalation to sharpen Tier 1's focus on strategic assurance rather than operational detail. Paper quality is variable—for example, an IPC paper focused on activity rather than outcomes, leaving gaps in assurance (which were appropriately) challenged. Executive summaries lack consistency, and some Committees remain more operational than strategic, reflecting a residual challenge transitioning from 'grip and control' post-CQC.

Quality and Performance Reviews (QPRs) are a key accountability mechanism for Clinical Boards, covering five domains: quality and safety, performance, people, finance, and strategy. Our observations showed QPRs foster constructive dialogue and identify performance issues, but we heard effectiveness of meetings can vary at times. Clinical Board leaders demonstrated clarity on core responsibilities but were less confident regarding information governance and data quality. Strengthening QPR consistency, clarifying escalation, and ensuring Clinical Board accountabilities fully reflect all strategic priorities would strengthen their role further.

Areas for development

Strategic alignment

Tier 1 Committees' remit and reporting should be linked to oversight of delivery of strategic goals once defined.

The Strategy should be more clearly used to drive the Board's agenda and key supporting tools such as the BAF.

Sharper focus on assurance and strategic oversight

Committees would benefit from a sharper focus on assurance using a consistent structure (such as 'AAA'), supported by clear criteria for escalation and de-escalation to and from Board, Tier 1 and Tier 2 Committees. Similar structures and principles should also apply to Clinical Boards.

Embedding Clinical Board leadership

Ensuring all QPRs are equally effective and aligned to key areas of assurance at Board level, and that local leaders are clear on their responsibilities regarding the digital and data agenda.

Action tracking

Action tracking could be improved further, by including a log of all new actions (rather than just the ongoing action log).

KLOE 5: Risk and performance management

Are there clear and effective processes for managing risks, issues and performance?

Overview

The Trust has established a clear risk management framework underpinned by a Risk Management Policy, effective from April 2025 to April 2027. Governance of risk is overseen by the Audit Risk and Assurance Committee (ARAC), which provides assurance on the Trust's approach to risk management. The committee is chaired effectively and has transparent discussions, though there is some scope to clarify escalation points and actions required. Below this, risk identification begins at individual or team level, with directorate risk registers maintained locally. Risks are assessed using a decision tool and reviewed by governance leads, with escalation to the Quality Oversight Group or Board as necessary. However, in meetings we were unable to independently confirm if this was carried out.

Mechanisms exist to track progress against Care Quality Commission (CQC) actions, with updates monitored through dedicated groups and committees. Clinical and internal audit processes are embedded, with audits monitored through the Clinical Audit and Effectiveness Group and ARAC. Internal audit services, provided by AuditOne, align with strategic objectives and the Assurance Framework, with regular updates on progress and implementation of recommendations. As noted above, Quality Performance Reviews (QPRs) are used to hold Clinical Boards to account, but there is scope to make escalation of issues and risks more consistent.

The Board Assurance Framework (BAF) is well-used and maintained but could be more useful in supporting delivery of the Trust's strategy. The BAF was redesigned in April 2024 and is currently based around strategic risks, which are then mapped to strategic objectives. Some objectives have more risks, and others less coverage, and the Trust should consider aligning the BAF primarily to strategic objectives before identifying the key risks to delivery of those objectives. The BAF includes detailed assurance lines, ratings, and action plans. However, some committees could improve clarity on action ownership versus items for escalation.

There is scope to develop a more positive narrative on the Trust's efficiency agenda. The Trust plans to break even in 2025/26 with a £106m Cost Improvement Programme (CIP). Historical delivery of recurrent savings has not been an area of strength, and cultural challenges persist around normalising financial discussions throughout the organisation. Senior leaders we spoke to attributed declining staff feedback in the 2025 pulse survey on perceptions of 'quality being the Trust's top priority' to higher-profile leadership messaging around finance and this sense was replicated in our interactions with other stakeholders. The Trust needs to communicate clearly how such risks are managed. Public board reporting on finance is high-level, and greater transparency could help embed a clearer narrative around necessary savings.

Areas for development

Balancing financial pressures and quality of care

- Support a culture shift to create a more positive culture around efficiency and savings delivery throughout the Trust.
- Financial training to support financial fluency at all levels of the organisation could help to deliver savings goals, including training in the processes used to ensure efficiency is balanced with quality and safety.

Focus on assurance

- Clarify around what is for escalation and what is for assurance. Make explicit in the BAF what is a gap in control vs. a gap in assurance. Align BAF more to strategic objectives to ensure even coverage and focus.

KLOE 6: Information and data quality

Is appropriate and accurate information being effectively processed, challenged and acted on?

Overview

The Board IBR itself has significantly improved in recent months following collaboration with NHSE through the making data count programme. An Integrated Board Report (IBR) covering performance quality, and finance and people is presented to the Board. It was positive to see an intent to report on population health in the report, but this dimension was not yet populated at the time of our observation. The IBR is now more closely aligned to recognised good practice. Statistical Process Control (SPC) indicators are used appropriately within the IBR to distinguish statistically significant changes, whether positive or concerning, from routine variations in data. Tight Board agendas limited the opportunity for thorough interrogation of the information presented at the Board meetings we observed. In common with other Board papers, the IBR would benefit from a more effective overall summary, including a 'heat map' of indicators of concern or showing positive assurance as used by other Trusts. Benchmarking is used in Clinical Board reporting and at service level. The Trust also plans to include FTSU data within the IBR in future.

There was a recognition that the Digital and Data Tier 1 Committee and portfolio leadership were still developing, and this extends to Clinical Boards' leadership role. The Trust's Chief Digital Officer post is a new role and has responsibility for 3 of the 4 trusts in the Alliance. Responsibility for information governance, meanwhile, rests with the Director of Performance and Governance and the Trust's SIRO is the Director of Communications and Corporate Affairs. Clinical Boards would not be confident that they would know what action would follow from any breach reporting, or how lessons would be communicated. The Trust could develop clearer mechanisms to ensure effective feedback loops are in place and clearly communicated.

There is a wealth of data available within the Trust and senior leaderships discussions show the Trust is aware of the opportunities and challenges of using data as an asset. The Trust clearly takes data quality seriously and a strong programme of assurance over data quality including multiple Internal Audit reviews, to back up its policies and procedures. Data Quality Assurance Indicators in the IBR would enhance the focus on assurance at Board and Committee level, as part of continued development of Integrated Reporting.

Areas for development

Integrated Board reporting

Consider introducing data quality assurance indicators within the IBR

Digital and data leadership and education

Clarify and communicate the roles and responsibilities of digital leadership, both at Board/Tier 1 and Clinical Board level

Benchmarking

Add more benchmarking to performance reporting to provide a comparative perspective

KLOE 7: Engagement

Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

Overview

The Trust has worked hard to improve staff engagement. The 2024 NHS Staff Survey showed improved staff engagement with a response rate of 64%, compared to 42% in 2023. The 2024 report also shows there has been improvements made against all areas of the 9 People Promises. However, the Trust's scores remained slightly below average compared with other Trusts in 8 of the 9 themed areas and it is acknowledged there is still significant work to be undertaken to regain the Trusts previous status. Our findings in relation to KLOE3 reflect this.

External partners highlighted the improved engagement and transparency of communication with the Trust. The appointment of the Shared Chair provides a good opportunity to identify share and adopt good practice with partners. This marks a significant shift in the Trust's approach to engaging with its partners locally.

The Trust actively engages with staff and patients through the "Real Time" programme of structured ward visits and "Right Time" post-care survey programme. These programmes are well designed, have executive-level leadership and results are reported to the Quality and People Committees. The Real Time programme has not yet been fully embedded across all 45 of the clinical areas originally proposed, however. There has been positive engagement with the Right Time experience programme, which provides clear comparative insight into patient experience. Monthly Friend and Family Test (FFT) data is also collected - since the introduction of the 'Right Time Programme there has also been a 500% increase in FFT responses. The Trust should clarify the sustainability of funding for these programmes.

The Trust has processes for collecting complaints and compliments but needs to deal with complaints more promptly and effectively. The Trust reports the number of complaints, prevalent themes and location through its Integrated Board Report. However, the Annual Complaints report indicates low complainant satisfaction in the current year, and it is recognised at both Board and Clinical Board level that current processes need to be updated to ensure the Trust can deal effectively with complaints first time. In the most recent year only 30% of complaints are closed in line with the agreed timeframe with some Clinical Boards having over 100 overdue complaints waiting to be closed. This may impact the Trust's ability to maximise learning, and this is also linked to embedding a speaking up culture (KLOE3). The Trust recognises that improvement is required to strengthen their arrangements and a complaints improvement group has been established to monitor and report progress on this work.

Areas for development

Patient and Staff Experience

- Fully embed the Real Time Experience process across all proposed clinical areas to allow regular assurance of patient experience allowing trust wide themes for improvement to be identified in a timely manner.
- Confirm the future funding arrangements for the Real Time and Right Time programmes.

Complaints

- Prioritise the development and introduction of new complaints management arrangements that will strengthen the quality assurance process of complaint investigations and support the timely closure of complaints in line with Trust target.

The Trust's Governors are passionate about their roles and are keen to engage with the Trust - both the Trust and Governors need to continue working together to ensure this adds as much value as possible. Relationships between the Board of Directors and Council of Governors are generally constructive. The way in which Governors' work is changing in line with working practices more widely, and we heard a degree of nervousness among some Governors about the increase of virtual meetings, while others were positive about the increased efficiency and opportunities for others to engage. The Trust and Governors will need to work together effectively, to ensure that forums allow all participants equal opportunity to contribute their perspectives and expertise.

KLOE 8: Improvement and innovation

Are there robust systems and processes for learning, continuous improvement and innovation?

Overview

There is a commitment at Board level to embed continuous improvement and an intent to develop a culture of learning over blame. The National Staff Survey demonstrates improvement made by the Trust to support learning and we heard of a wide variety of forums where learning is being shared.

The Trust has improved its capacity to share learning across the organisation but needs to improve participation. The Trust has a Quality Improvement methodology but not all staff we spoke to were aware of it or spoke confidently about it. Work is in progress to triangulate learning from multiple sources, following the introduction of the People & Culture MDT Group and the development of the In-Phase risk management system to allow the triangulation of risk, incidents, audit, external inspection and patient experience feedback to assists the identification of common themes and trends. It was reported to us by staff that the introduction of the Clinical Board model had reduced silo working, and we heard evidence of learning being share across services. However, a number of Executives highlighted the need to further strengthen learning arrangements and participation, within areas such as Mortality Reviews and improved engagement with national clinical audits.

The Trust has invested in Quality Improvement Training for staff to improvement capacity and capabilities. Innovation is celebrated and promoted through the ACE ward accreditation programme, which provides a strong foundation for improvement activity, and at events such as the 'People at our Heart' and 'Celebrating Excellence' awards.

Areas for development

QI approach and skills

- The Trust should consider documenting and publicising its Quality Improvement approach and develop a toolkit to equip staff to drive improvement with a standardised approach.

Increase collaboration and shared learning

- Prioritise the introduction of Structured Judgement Reviews to allow a standardised approach to assessment and identification of improvement
- Formalise the dissemination of sharing learning/improvement on a Trust-wide and system wide basis and improve participation in national clinical audits.

Additional KLOE: Environmental sustainability

Overview

In 2019, The Trust was the first healthcare organisation in the world to declare a climate emergency. The Trust also participates in a wider Newcastle civic partnership with Newcastle City Council and Newcastle University, which is jointly committed to achieving carbon neutrality by 2040.

The Trust has a Green Plan in place covering the period to 2026 and has established a Sustainable Healthcare in Newcastle (SHINE) group which has an annual strategy, renewed by the Board. The Trust's Executive Director of Commercial Development and Innovation is the Board level sponsor for the Trust's Net Zero agenda, and we understand this agenda will be co-sponsored in future by the Director of Estates, Facilities and Strategic Partnerships. The Trust's work is led by a dedicated Associate Director for Sustainability, who has relevant professional expertise.

Sustainability is considered within governance and clinical pathways, and staff awareness is supported through a network of around 1,000 green champions and initiatives that help individuals understand their carbon footprint. The Trust has implemented a range of initiatives, including energy efficiency measures, waste reduction, and the removal of single-use plastics in perinatal and postnatal care. For example:

- Teleclinics and PEP have been introduced to reduce paper use and travel.
- Local projects such as the Green Endoscopy Group have replaced single-use plastics with reusable alternatives and are exploring greener medical gases, while the Theatre Sustainability Group focuses on reducing waste in operating theatres.
- The ENT department is transitioning to more environmentally friendly cleaning systems.

The Trust is currently not on track to deliver its net zero goals. It attributes this primarily to an absence of capital funding. Like many Trusts, there is a challenge in reducing the environmental impact of the Trust's legacy estate, with the opportunities arising primarily when new facilities are built. However, the Trust was recently successful in bidding for a significant (c£40m) capital grant to convert the gas heating system at the Freeman site to Heat Pump technology. Transport also remains a challenge, partly due to low parking costs discouraging sustainable travel.

Areas for development

- Promote sustainability priorities by making sustainability more prominent in the forthcoming Trust Strategy.

3. Recommendations

Introduction to recommendations

This section of the report details our recommendations based on the findings from our developmental review.

The recommendations were co-developed by Grant Thornton alongside the Trust's Board at a Board development session in October 2025. This session provided an opportunity for key stakeholders to discuss and challenge key areas of development identified during our review and agree practical actions to enable the Trust to address these findings.

Ownership has been applied to these by the Trust during the factual accuracy stage of reporting.

The pages that follow include a brief summary of the background to, and rationale for, each recommendation followed by a clear recommendation to address the challenge identified.

These have been RAG rated to enable the Trust to focus its time in the areas of highest priority as shown in the table below:

Priority rating for recommendation raised
High Findings that are fundamental to the management of risk in the business area, representing a weakness in the design or application of activities or control that requires the immediate attention of management. Those identified with an asterisk (*) are those we feel the Trust should prioritise.
Medium Findings that are important to the management of risk in the business area, representing a moderate weakness in the design or application of activities or control that requires the immediate attention of management.
Low Findings that identify non-compliance with established procedures, or which identify changes that could improve the efficiency and/or effectiveness of the activity or control but which are not vital to the management of risk in the business area.

Recommendations (1 of 12)

KLOE	Reference	Development area	Recommendation and supporting detail	Priority	Responsibility
1 - Leadership	1.1	Leadership capacity	**Strengthen Leadership Clarity Across Shared Portfolios** While the current distribution of responsibilities across People and Digital/Data portfolios has supported transitional continuity, it risks diluting accountability and strategic focus in some areas. A lack of clarity around leadership of the people and culture agenda could dilute accountability and/or lead to a perception of a gap in leadership capacity in this key area. **Recommendation** The Trust should clarify and stabilise leadership arrangements in these areas to ensure clear ownership and accountability, reduce ambiguity, and support delivery of strategic priorities.	High	
1 - Leadership	1.2	Visibility of the Board throughout the Trust	**Evaluate the Effectiveness of the Board Visibility Programme** The Trust has made notable progress in prioritising Board visibility and cohesion. This includes an active Board Visibility Programme, on which activity is routinely reported to Board. The Trust needs to assess whether this is translating into improved perceptions of Board visibility - and perceptions of Board cohesion - among frontline staff. **Recommendation** Embed a structured evaluation of Board visibility—particularly in relation to visibility and impact on frontline staff—to help assess progress, identify areas for improvement, and reinforce a culture of continuous learning and development.	Medium	
1 - Leadership	1.3	Board development	**Evolve the Board Development Programme to Align with Strategy and Succession Planning** Linking the Board's development agenda to the strategy will support strategic coherence, strengthen future leadership capacity, and reinforce the Trust's commitment to inclusive and forward-looking governance. **Recommendation** Building on the Trust's commitment to Board development, the current programme should be evolved to align closely with the longer-term organisational strategy. This should include a structured approach to succession planning across both Executive and Non-Executive roles, ensuring leadership continuity and resilience.	Medium	

Recommendations (2 of 12)

KLOE	Reference	Development area	Recommendation and supporting detail	Priority	Responsibility
2 - Strategy	2.1	Strategic focus	**Agree the strategic focus of the organisation and communicate this clearly to staff on an ongoing basis** Given current changes in the NHS landscape the development of the Trust's strategy is a key opportunity for the Trust to confirm its strategic direction both externally through its improving external relationships, and internally. **Recommendation** Linked to the leadership capacity recommendation 1.1, the identification of a dedicated senior leader (and additional short- and long-term support) with accountability for strategy delivery is important to ensure this receives sufficient Board level focus. The Trust should also develop a comprehensive communication plan to ensure the staff engagement is maintained as the strategy moves from development to implementation.	High	
2 - Strategy	2.2	Monitoring strategic progress	**Implement clear monitoring of progress against the Trust's strategy, and use this to support the monitoring of other strategies within the organisation** Whilst objectives are reviewed and reported through via CEO updates and the BAF, the Trust lacks alignment of monitoring to these objectives or the strategy. Further there was limited evidence of this in other supporting strategies and plans. **Recommendation** We recommend the Trust identify key performance indicators for tracking progress against the strategy. These should be supported with regular monitoring and discussion and aligned to the IBR. At lower levels of the organisation service lines should be supported to consider how they achieve and monitor progress against their own strategies.	Medium	

Recommendations (3 of 12)

KLOE	Reference	Development area	Recommendation and supporting detail	Priority	Responsibility
2 - Strategy	2.3	Values	**Refresh the Trust's values** The Trust's vision and values were last refreshed in 2018/19 following extensive engagement. Since then, the organisation has undergone significant strategic and cultural shifts. **Recommendation** Update the Trust's vision and values shortly after finalizing the new strategy to ensure alignment and relevance. Build on the successful engagement methods used for the People Plan and strategy development to involve staff and stakeholders widely. Communicate the refreshed values clearly and embed them through leadership behaviours, performance frameworks, and recognition programs.	Medium	
3 – Culture	3.1	Responding to concerns raised	**Focus the Trust's Year 2 People Plan agenda around developing a clear, strategic and measurable plan to improve line management throughout the organisation.** The Trust recognises that improving line management is fundamental to promoting and embedding an improved culture at all levels of the organisation. There is a concern that the activity in this area in year 1 of the People Plan, while welcome, may not have been sufficiently well targeted. **Recommendation** We recommend the Trust makes clear that the second year of its people plan is focus on developing and implementing a dedicated line management improvement plan to supplement – and support delivery of - the People Plan objectives. This should include a clear strategy (such as focusing on 'hot spots' of poor performance) and ensuring there is a programme of interventions that are targeted specifically at the support and development needs of staff in key groups, including medical staff. The Trust should also clarify its support and development offer where it finds instances of poor line management at both individual and Ward level (for example through Speaking Up or Ward Accreditation arrangements).	High*	

Recommendations (4 of 12)

KLOE	Reference	Development area	Recommendation and supporting detail	Priority	Responsibility
3 – Culture	3.2	Responding to concerns raised	**Develop HR processes to ensure clearer accountability and support where leadership and management behaviours do not reflect the Trust's values** Aligned to the need for a clear improvement strategy, the Trust needs to refresh and develop its core processes provide effective accountability and support where these are necessary. **Recommendation** We recommend the Trust develops clear statements of the line management and leadership behaviours that are expected at all levels. It should also clarify the support offer at both individual and team/Ward level to support those areas that do not exhibit these behaviours to support improvement and ensure there is accountability. The Trust should also develop ways to ensure there are ways to celebrate and promote positive and effective management and leadership and review its recruitment, promotion and appraisal processes to place a sufficient emphasis on leadership and development behaviours.	High	
3 – Culture	3.3	Improve EDI outcomes	**Invest in robust evaluation of the People Plan and supporting interventions** Aligned to recommendation 3.1, above, the Trust needs to be assured that the interventions it is putting in place through its People Plan are the right ones to deliver the outcomes intended. Robust evaluation would assess the pre-implementation logic model and evidence base for individual interventions (whether they should work), as well as the post-implementation impact (whether they did work). **Recommendation** We recommend the Trust commissions ongoing, professional evaluation support for the People Plan to provide both formative learning for improvement and refinement, and evidence of the impact of interventions.	High	

Recommendations (5 of 12)

KLOE	Reference	Development area	Recommendation and supporting detail	Priority	Responsibility
3 – Culture	3.4	Responding to concerns raised	**Increase confidence amongst staff that concerns raised will be addressed** The Trust has invested in its FTSU processes, but this has not yet been fully embedded and there remains significant work required around promotion of a safe culture, and the response to concerns and the reporting. **Recommendation** Implement a structured communication and training programme to raise awareness of FTSU routes and outcomes. Include case studies and feedback loops to demonstrate action taken and build trust in the system. Enhance participation and diversity among FTSU Champions, and reflect this role in the FTSU policy Enhance Board oversight by integrating FTSU data with staff survey results, incident reports, and whistleblowing concerns into a consolidated dashboard. Ensure regular review and challenge at Board and Clinical Boards to identify emerging risks early.	High	
3 – Culture	3.5	Improve EDI outcomes	**Build momentum in supporting, promoting and delivering EDI initiatives to ensure progress to drive better EDI outcomes** The NHS Staff survey highlighted that, while not an outlier nationally, the Trust showed limited progress in improving diversity, equality and inclusion. This is also evident in the Trust's WRES and WDES data. Leaders are aware of this, and the Trust has initiatives in place to address this moving forward. **Recommendation** The Trust should clearly embed EDI within its strategy and support leaders to ensure the EDI agenda is actively promoted and visible to staff. For example, leaders should ensure that it is understood across that Trust that behaviours which do not support EDI will not be tolerated. The Trust should also monitor diversity among its Champion networks, such as FTSU Champions. We also recommend that leaders hold one another to account on progress made to support this agenda, for example, by sharing their EDI objectives with one another and monitoring the impact.	High	

Recommendations (6 of 12)

KLOE	Reference	Development area	Recommendation and supporting detail	Priority	Responsibility
4 – Governance and management	4.1	Clarity, purpose and effectiveness of meetings	**Refresh the Trust's Board and Tier 1 committee terms of reference and align them to the Trust's strategy, when developed** The Trust should align Tier 1 Committees' remits and accountabilities should align to allocated strategic goals, and their reporting should reflect this. This should also be reflected in Clinical Board and lower-tier committees' reporting. **Recommendation** We recommend that the Terms of Reference and agendas for all Board-level meetings be reviewed alongside development of the Strategy, to clarify the purpose of each forum in terms of strategic oversight. Strategic goals should be assigned to the relevant committee. The agenda and frequency meetings should be aligned to ensure they remain purposeful and facilitate constructive challenge among Board members, fostering public accountability.	High	
4 – Governance and management	4.2	Clarity, purpose and effectiveness of meetings	**Sharpen Board and Tier 1 committees' focus on strategic assurance** A more consistent and standardised focus on assurance at Board Committees would support strategic oversight. This includes defined thresholds for escalation and de-escalation (both up to the Board and down to lower-tier committee) to sharpen the Tier 1 Committees' focus on strategic assurance rather than operational detail. **Recommendation** The Trust should introduce a standardised form of assurance reporting throughout the organisation and particularly for escalations to the Board and Tier 1 Committees. A format such as 'AAA', now used at many Trusts may be appropriate.	High	

Recommendations (7 of 12)

KLOE	Reference	Development area	Recommendation and supporting detail	Priority	Responsibility
4 – Governance and management	4.3	Clarity, purpose and effectiveness of meetings	**Refresh the interface between Tier 2 and Tier 1 committee terms reference to support appropriate escalation and focus** To strengthen governance, clearer protocols for escalation and de-escalation from Tier 1 Committees is required. **Recommendation** We recommend the Trust establishes clear thresholds for escalation and de-escalation, so that Board Committees are fully supported in maintaining strategic oversight and key risks and are delegating more operational matters and lower-risk matters to Tier 2 committees. Tier 2 committees will need to be appropriately trained and supported to implement this approach and empowered to manage issues within their remit.	High	
4 – Governance and management	4.4	Clarity, purpose and effectiveness of meetings	**Maintain focus on QPR effectiveness** While QPR meetings we observed were well chaired and promoted and effective two-way conversation, the effectiveness of QPRs is ultimately dependent on the level of preparation and participation by clinical board leadership. Inconsistent engagement across boards could lead to uneven scrutiny of performance, missed improvement opportunities, and weaker assurance to the Finance and Performance Committee. The Trust needs to be assured this is working well across all Committees and over time. **Recommendation** We recommend the Trust Introduce a standardised pre-QPR preparation checklist and timeline for all clinical boards, supported by clear expectations from leadership. Consider implementing a light-touch peer review or feedback mechanism between boards to share best practices and promote consistency in engagement.	Medium	

Recommendations (8 of 12)

KLOE	Reference	Development area	Recommendation and supporting detail	Priority	Responsibility
4 – Governance and management	4.5	Shared accountability	**Continue to develop Clinical Board leadership** The Trust needs to ensure Clinical Board leaders are clear on their responsibilities around the digital agenda, data and information governance. **Recommendation** The Trust should refresh its accountability framework alongside development of the Strategy and Tier 1 Committee remits to ensure adequate coverage of digital leadership, data quality and information governance.	Medium	
4 – Governance and management	4.6	Papers, action logs and risks	**Refine the use and writing of executive summaries and action summaries** To help ensure key points within papers and the purpose of papers are clear to readers there has been a concerted effort to introduce executive summaries at the start of papers. The use and format of these varies across meetings. Actions are generally captured and tracked appropriately, but a summary table of new actions identified would make this even clearer. **Recommendation** The Trust should provide guidance and training for report writers on writing effective executive summaries. Additionally, review cover sheets to identify any appropriate enhancements, such as linking papers to relevant strategic pillars or risks. Introduce a standard table summarising new actions within Committee minutes.	Low	
5 – Risk and performance	5.1	Balancing financial pressures and quality of care	**Promote a positive and informed culture around efficiency and financial savings without compromising quality of care** The Financial Turnaround team have been fundamental in enabling the Trust to achieve a small surplus in 2024/25. However, this was reliant on key individuals across the Trust leveraging their knowledge, experience and relationships to drive change at pace. **Recommendation** We recommend the Trust reviews its processes for engaging with staff on the efficiency agenda to reduce the perception that savings are necessarily at odds with quality of care. To ensure that quality of care is not compromised, the QIA process must be embedded across the Trust and consistently applied.	Medium	

Recommendations (9 of 12)

KLOE	Reference	Development area	Recommendation and supporting detail	Priority	Responsibility
5 – Risk and performance	5.2	Board assurance framework	**Align the BAF to the strategy** Risks on the BAF are aligned to a number of principal risks (what may stop the Trust from achieving their strategic objective) and these are in turn aligned to the Trust's strategic objectives for the current year. The BAF is aligned primarily to risks, with links then made to the relevant strategic objectives. **Recommendation** the Trust could consider aligning the BAF directly to its strategic objectives to support the focus on assurance and accountability for delivery we have recommended in KLOEs 2 and 4.	Medium	
6 – Information and data quality	6.1	Integrated Board reporting	**Evolve integrated board reporting** The Trust has improved integrated board reporting with a clear focus on improving this over the last year. As with other Board-level reports there is scope to continue improvement to maximise the usefulness of this report. **Recommendation** We recommend the Trust introduce a heat-map at the front of its IBR as part of a clearer executive summary focused on summarising assurance and escalations. The Trust could also include Data Quality Assurance Indicators or commentary as part of this, drawing on findings from relation internal audits, for example. Once this has been established at a Trust level these principles should be used to within Clinical Board reporting.	Low	

Recommendations (10 of 12)

KLOE	Reference	Development area	Recommendation and supporting detail	Priority	Responsibility
6 – Information and data quality	6.2	Digital strategy	**Clarify the Trust's Digital and Data strategy to prioritise improvement and investment** The Trust is aware it needs to invest in the digital agenda to support staff in accessing the data they need on a timely basis. However, the lack of a current strategy makes it harder to prioritise investment and effort effectively. **Recommendation -** Aligned to other recommendations, the Trust should progress development of its digital and data strategy to support effective prioritisation of digital and data project, support clarity in leadership of this agenda, set the strategic focus of the Digital and Data Committee and prioritise investment in digital infrastructure and skills.	High	
7 – Engagement	7.1	Patient engagement	**Embed the Real Time and Right Time Experience process.** Fully embedding the Real Time and Right Time Experience process provides valuable and actionable insight across clinical areas and the Trust should ensure this has the full coverage it originally planned. **Recommendation** Fully embed the Real Time Experience process across all proposed clinical areas to allow regular assurance of patient experience allowing trust wide themes for improvement to be identified in a timely manner. The Trust should also confirm the future funding arrangements for the Real Time and Right Time programmes.	Medium	
7 – Engagement	7.2	Complaint resolution	**Improve Complaints-resolution Performance** Delays in resolving complaints and lack of robust assurance processes could undermine compliance with Well-Led standards on openness, transparency, and responsiveness. **Recommendation** Prioritise the work of the complaints improvement group in strengthening complaints management arrangements, including clear escalation routes and monitoring of overdue cases, to ensure timely closure and assurance reporting to the Board.	Medium	

Recommendations (11 of 12)

KLOE	Reference	Development area	Recommendation and supporting detail	Priority	Responsibility
8 - Learning, continuous improvement and innovation	8.1	QI approach and skills	**Formalise the Trust's Quality Improvement approach** The Trust has good foundations for quality improvement building on its engagement methodologies and the ACE Ward Accreditation programme. However, while the Trust has an improvement methodology not all staff we spoke to were aware of this or spoke confidently about it. **Recommendation** We recommend that the Trust clearly documents and promotes it QI approach, allowing more staff the opportunity to implement improvements. We also recommend that the Trust publicises to staff the outcomes of completed QI projects. This will raise confidence in the approach and empower more staff to take part.	Medium	
8 - Learning, continuous improvement and innovation	8.2	Sharing learning	**Share learning from incidents more consistently** The Trust continues to report to the Quality Committee on learning from deaths and serious incidents. However, learning is not consistently shared at all levels across the Trust which limits the opportunity to share learning on a Trust-wide basis. **Recommendation** We recommend that the Trust establishes an appropriate forum (or makes better use of an existing forums such as the cross-cutting Boards) to share learning more widely. We recommend that the Trust establishes effective ways to disseminate learning/improvement on a Trust-wide basis.	Medium	

Recommendations (12 of 12)

KLOE	Reference	Development area	Recommendation and supporting detail	Priority	Responsibility
9 - Environmental sustainability	9.1	Set a clear strategic direction	**Reiterate the strategic direction for environmental sustainability** The Trust has a Climate Emergency Strategy in place, but its current (interim) organisational strategy does not specifically include sustainability among its top-level commitments (big signals). **Recommendation** We recommend that the Trust use the opportunity presented in publishing its strategy in 2026 to refresh reiterate its strategic commitment to its environmental sustainability goals.	Low	

4. Detailed findings

KLOE 1: Is there the leadership capacity and capability to deliver high quality, sustainable care?

1.1 - Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed.

Board composition

The Board consists of the Chair, Vice Chair, seven further NEDs, and two Associate NEDs (who do not have voting rights) and 14 executive roles as listed below:

Individual	Role	Voting Member
Rob Harrison	Acting Chief Executive	✓
Ian Joy	Executive Director of Nursing	✓
Dr Lucia Pareja-Cebrian	Joint Medical Director	✓
Dr Michael Wright	Joint Medical Director	
Jackie Bilcliff	Acting Deputy CEO and Chief Finance Officer	✓
Dr Victoria McFarlane Reid	Director of Commercial Development and Innovation/Exec Lead for People and Organisational Development	✓
Sue Hillyard	Interim Executive Director of Operations	✓
Annie Laverty	Chief Experience Officer and Joint Lead on Equality, Diversity and Inclusion	
Caroline Docking	Director of Communications and Corporate Affairs and Joint Lead on Equality, Diversity and Inclusion	
Martin Wilson	Director of the Great North Healthcare Alliance Strategy	
Paul Hanson	Director of Estates and Facilities and Strategic Partnerships	
Rachel Carter	Director of Quality and Safety	
Dave Elliott	Chief Digital Officer for the Great North Healthcare Alliance	
Patrick Garner	Director of Performance and Governance	
Kelly Jupp	Trust Secretary	

Board turnover

The **Executive Team has had a significant degree of turnover in recent months.** The Trust's acting Chief Executive, Rob Harrison, has been in post as interim CEO since March 2025 having previously been appointed as deputy Chief Executive in February 2024. The current substantive Chief Executive, Sir Jim Mackey, is on secondment to NHS England having joined the Trust in January 2024.

The **NED team has also had significant change.** Trust's Chair, Sir Paul Ennals, was appointed permanently July 2025 (having been interim since October 2024) and is also now Chair of two of the Trust's key partners within the Great North Healthcare Alliance (Northumbria Healthcare NHS Foundation Trust and Gateshead Health Foundation Trust). A significant number of the other Non-executive have also either joined the Trust or been appointed to their current roles since the Trust's last CQC report.

At the time of our review, the Trust's substantive Chief Executive Officer, Sir Jim Mackey, was on secondment to NHS England.

Skills, Experience, Capacity and Cohesion

Despite the degree of change in the leadership team as a whole, the Board is united. We heard from Board members and observed directly a professional and constructive environment within Public and Private Board and Tier 1 Committee meetings. Perceptions of psychological safety at this level have significantly improved since the CQC review and this is an area the Board actively focuses on. The Board continues to evolve supported to by a clear development programme. Executives spoke highly of their peers, and of the substantive and acting Chief Executives and the Trust Chair. External partners noted the high calibre of recent appointments to the Trust

There is a **diverse range of skills and experience present within the NED group**, who come from backgrounds including: finance, audit, construction, nursing, medicine, HR, education, and legal professions. This was evident in the contributions each brough to Boards discussion and the challenge and support offered at meetings observed during our review.

KLOE 1: Is there the leadership capacity and capability to deliver high quality, sustainable care?

1.1 - Leaders have the experience, capacity, capability and integrity to ensure that the strategy can be delivered and risks to performance addressed. (continued)

A consistent messages we received was of the **immediate and significant positive impact the substantive CEO's arrival had on the Trust**. This is triangulated by the uplift in many areas of the Trust's NHS Staff Survey. It was equally clear that **the Acting Chief Executive is also held in high regard throughout the organisation and by external stakeholders**. Overall feedback was positive about the smooth transition between the Substantive and Acting Chief Executive Officers. Some stakeholders commented that clarity over the future arrangements would help ensure the pace of change was sustained, though others did not perceive a tangible difference. The Trust could, however, consider how to manage any uncertainty externally to ensure barriers to the pace of further progress at a strategic level, including in relation to the Alliance, are minimised.

We noted **some concern – both internally and externally - that the leadership and scope of some key portfolios require clarification or further development**. It is important to note that this feedback did not reflect issues with the individual executive and non-executive leaders in post, but with the leadership structures and arrangements more widely. In particular, partners noted that the Trust's executive leadership arrangements for the people and culture agenda were not clear, particularly to an outside observer. Executive responsibility for HR rests with the Director of Commercial Development and Innovation, who is also Executive Lead for People and Organisational Development. Key elements of the people agenda also rest with the Chief Experience Officer who has led development of processes to provides data, intelligence and insight and is one of two Joint Lead on Equality, Diversity and Inclusion (EDI). The Director of Communications and Corporate Affairs, is also Joint Lead for EDI. The Trust has appointed a new Associate Director with a formal HR background to support this agenda. This has led to some confusion around the permanence of current arrangements and concern among partners that **current arrangements risk not sending a strong enough message about the Trust's commitment to addressing its cultural challenges** (see KLOE 3).

1.2 The leadership is knowledgeable about issues and priorities for the quality and sustainability of services, understands what the challenges are and takes action to address them.

During our interviews, Board members were **consistent in their understanding of the priorities for the Trust** and the areas where challenges were prominent. These included managing the Trust's financial challenges, accelerating progress in cultural change, continuing to move toward a more distributed leadership model in which the Clinical Boards take more ownership of decision-making, the development of the Trust's longer-term vision and strategy and, linked to this, a clear strategy to maximise of the benefits of the Alliance model.

Consistent with a number of NHS providers, we heard of current challenges in aligning operational, clinical, and financial pressures. The Trust has struggled to deliver significant recurrent savings in recent years, delivering only £11m of £107m savings recurrently (10% of savings or 0.6% of expenditure) in 2024/25 at a point where recurrent savings of 2% of expenditure has become the norm for many Trusts. The Trust has a CIP target of £106m to support its financial plan for 2025/26.

Our work indicated that **Executives felt supported by their colleagues and that decisions were made equally**. There was a positive and constructive tone within Committees and Chairs or Committees, and this generally ensured all voices were heard allowing a wide range of perspectives to be heard and provided opportunity to influence discussions.

KLOE 1: Is there the leadership capacity and capability to deliver high quality, sustainable care?

1.3 Compassionate, inclusive and effective leadership is sustained through a leadership strategy and development programme and effective selection, development, deployment and support processes and succession-planning.

There is evidence of some **investment in leadership training among the Governing Body and among staff in Networks** who told us that the Trust had invested in Leadership training with the provision of the LEO Couse, Compassionate Leadership Training.

The Trust's People Plan is underpinned by 4 pillars which in Year one included Leadership and Management. A review of the progress in Year 1 Of the People Plan was presented to the People Committee in July indicated that all of the actions had been agreed as completed, including an assessment of current Leadership and Management offer. However, line management and leadership development more generally remains a key development area for the Trust – see KLOE 3.

In recognition of recent changes, with new Executives, NEDs and Associate NEDs joining, the Board has established **an active programme of Board development**, supported by external consultants (the Value Circle). We heard good feedback from the Board in relation to the development sessions; individuals found the insights work particularly helpful in developing a better understand their colleagues and their different approaches.

1.4 Leaders at every level are visible and approachable.

The 2024 CQC Inspection Report for the Trust highlighted a lack of visibility of the Trust's senior Executive as a key issue, noting that sentiment from staff feedback was "overwhelmingly negative". Since the last inspection, however, the Trust has implemented an active, formal Board Visibility Programme, comprising:

- **Leadership walkabouts** which include two senior leaders (who may or may not be a Board members) and
- **NED informal visits** to specific areas or Clinical Board. During our observations of the Trust's Board a number of NEDs spoke positively about this process. Each NED is also assigned to a particular service area.

During the period of June 2024 to May 2025, a total of 262 leadership visits took place throughout the Trust, of which 59 were leadership walkabouts.

Regular **updates on the Board Visibility Programme are presented directly to the Board**. The July 2025 Board reported an overview of 15 walkabouts and visits in May and June. Based on these reports we note that of the nine leadership walkabouts reported, none were attended by members of the Executive Team, though reports from previous periods showed more executive team participation.

During formal and informal interactions with staff we heard positive feedback about the improved visibility of NEDs both generally and as a result of the walkabouts. **It is important that the Trust is also assured that the activity in this area is leading to improved perceptions of the Executive Team** among frontline staff. The Trust should include specific questioning on this area in Pulse surveys and **consider an evaluation of the current visibility programme** to identify successes and areas for improvement.

KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

2.1 There is a clear statement of vision and values, driven by quality and sustainability. It has been translated into a robust and realistic strategy and well-defined objectives that are achievable and relevant.

Trust strategy and values

The Trust has an interim strategy that covers **the 12-month period from 2025-2026**. The previous 5-year strategy expired in 2024, and the Trust is currently using an interim 12-month strategy to focus on immediate priorities. The Trust Board chose to implement an interim strategy to allow time to collaboratively develop a meaningful new 5-year strategy with staff, patients, and stakeholders.

Within the strategy are eight "big signals" which serve as the underpinning pillars for the strategy, which were based on feedback from over 1,000 staff. The big signals are the key issues for improvement that staff can use to hold leadership accountable. Progress on these signals is reported monthly by the Chief Executive at public Board meetings and through internal dashboards. The pillars are summarised below:

1. **Quality of care will be our main priority.**
2. **We will be a great place to work where everyone feels supported.**
3. **We will focus on excellence in all that we do.**
4. **Our technology will support our work and patients' care.**
5. **Our buildings will be fit for purpose.**
6. **We will take our responsibilities as a public service seriously, carefully managing our money and performance.**
7. **We will make sure we deliver our commitments to the communities who depend on us.**
8. **We will be honest, open, and transparent about our challenges and our progress.**

Each big signal maps to the Trust's strategic aims (below) and defines what success would look like and how the Trust would get there:

1. **Improving safety, quality, and experience**
2. **Performance delivery**
3. **Effective governance**
4. **Systems and partnerships**

In alignment with national plans, there is a focus on community healthcare and neighbourhood models. Broadly the strategy covers the areas expected, however there is **minimal mention of commitments to environmental sustainability** though the Trust overall has a positive narrative on sustainability and Net Zero (see KLOE 9).

The Trust's current vision is "achieving local excellence and global reach through compassionate and innovative healthcare, education and research."

The value statements are:

1. **We care and are kind:** we care for our patients and their families, and we care for each other as colleagues.
2. **We have high standards**: we work hard to make sure that we deliver the very best standards of care in the NHS. We are constantly seeking to improve.
3. **We are inclusive:** everyone is welcome here. We value and celebrate diversity, challenge discrimination and support equality. We actively listen to different voices.
4. **We are innovative:** we value research, we seek to learn and to create and apply new knowledge.
5. **We are proud:** we take huge pride in working here and we all contribute to our ongoing success.

References

1. June 2025 clinical strategy paper 0.3

KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

Strategy leadership

The Trust's Director of Performance and Governance, supported by the Director of Communications and Corporate Affairs, are responsible for corporate strategy, while the Director of the Great North Healthcare Alliance and strategy is responsible for developing the Trust's clinical strategy and wider strategy development in relation to the Alliance (see KLOE 7).

The **Board was engaged with the development of the interim strategy** through regular updates and three separate development sessions. The Strategy was also developed through the Trust's Planning and Strategy Group, the Trust Management Group and the Council of Governors. The Board will continue to be kept up to date on the development of the longer-term 5-year strategy through the rest of the 2025/26 financial year, with the strategy itself scheduled for publication in April 2026.

The Trust has launched a major 'conversation' around the development of its longer-term strategy. It has established the foundation of a broad clinical strategy outline and has begun testing this with the senior clinical team. The next step is a comprehensive, six-month engagement exercise to further develop the strategy. There has been a **significant and positive shift** in recognising Newcastle as both the core community and District General Hospital (DGH) provider for the Newcastle locality, as well as a leading tertiary centre.

Collaboration with partners is a key element of ongoing strategy development. This includes developing the Trust's relationship with the ICB in its evolving role and understanding how this aligns with place-based priorities. Specific chapters on the development of community services will be co-authored with the ICB. The Trust has also applied to become a pilot site for this work; preparing the submission and securing the necessary approvals has been an important milestone.

Strategic focus

2.2 The strategy is aligned to local plans in the wider health and social care economy, and services are planned to meet the needs of the relevant population.

Seven out of the eight "big signals" in the current strategy are externally facing. The interim strategy notes that one of the Trust's key deliverables is working with partners to streamline pathways, ICB and local authority work around carers, and Urgent Treatment Centre/Emergency Department ongoing work, and alliance and regional work.

The key deliverables for 2025/26 include: culture, communication and engagement, digital, estates, workforce, quality improvement, finance, performance, and service development. There do not appear to be any notable omissions in the strategy. It was too early for us to assess whether the Trust's longer-term strategy was similarly broad in scope but based on our interviews with senior leaders we would expect this to be the case.

There is currently no dedicated workforce strategy in place and it is recognised that **the current People Plan is not a replacement for a workforce strategy**.

The Trust's current strategy does not have a dedicated section on population health, though the section on the Great Northern Healthcare Alliance notes at multiple points the Trust's aspirations to improve patient outcomes and reduce inequalities, and for the Trust to do more for their economy, environment, and communities through local and national partnerships.

The Trust has clearly signalled an intent to ensure its forward strategy is focused on the needs of its population and recognises the role the Trust plays within its place. There has been a recognition at Board level of the key roe the Trust plays within the Newcastle are the core community and District General Hospital (DGH) provider for the Newcastle locality, as well as a major tertiary care centre.

References

1. June 2025 clinical strategy paper 0.3 and July Board Papers

KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

The Trust is currently **developing a Clinical Strategy aligned with the NHS England 10-year plan,** while operating under an interim strategy during finalisation. A key priority is addressing health inequalities, led by a dedicated group chaired by the Joint Medical Director. Initiatives include improving ethnicity data capture, tackling diabetes and cardiovascular health, and promoting prevention and self-management programmes for patients on waiting lists. The Trust is also engaging with the local authority, embedding a public health consultant, and working with the ICB and NHS England to ensure system alignment.

2.3 Staff in all areas know, understand and support the vision, values and strategic goals and how their role helps in achieving them.

Understanding the Trust vision, values and goals

The development of an interim strategy was generally recognised by leaders we spoke to as a pragmatic approach that allowed the Trust to focus on improving the fundamental issues identified within the 2024 CQC report.

However, some leaders we spoke to also expressed a view that, as a result of its broad focus and short time-span the interim strategy **does not convey a unique vision for the Trust** though we note others were more positive about the interim strategy and the plans for the full strategy.

The Trust's pulse survey indicated that **just under half of staff (49%) agreed or strongly agreed that "the Trust's vision and goals are clear to me", substantively unchanged from a year before.** While this may reflect the current strategy's interim status, it is clearly important that the Trust builds on its current engagement exercise and articulates the refreshed strategic narrative clearly and consistently to staff.

Helping to achieve the goals

The Trust is currently working on a **refresh of its clinical strategy** and in the meantime using a document called "Towards a clinical strategy" which has been endorsed, though not formally approved, by the Board, and will form part of the new strategy by the end of the financial year. The document states that the final clinical strategy will be "the central tenet on which the other Trust plans are built" and is clearly intended as a long-term (10-15 year) strategy. This indicates **an intent to use clinical strategy as the foundation of broader organisational strategy.**

Clinical Boards have also been asked to **engage with their teams as part of strategy development** and involvement of frontline clinical staff in the strategy development. It also mentions the involvement of a Clinical Strategy Steering Group that is composed of various stakeholders, indicating a multidisciplinary approach that integrates clinical perspectives into organisational decision-making.

References

1. June 2025 clinical strategy paper 0.3 and Newcastle Hospitals People Plan

KLOE 2: Is there a clear vision and a credible strategy to deliver high quality, sustainable care to people, and robust plans to deliver?

Communication of the strategy occurs through staff bulletins, executive roadshows, and Clinical Board reviews, with executive performance monitoring linked to strategic objectives. While progress has been made, further work is needed to fully align the Trust's strategy with wider system plans.

2.4 The vision, values and strategy have been developed through a structured planning process in collaboration with people who use the service, staff and external partners.

The Trust's existing vision and values were set following extensive staff and stakeholder engagement in 2018/19. **Our engagement with Board members indicated that these should be updated as, or shortly after, the Trust sets its new Strategy**. As noted above, the eight "big signals" in the 2025/26 strategy were based on feedback from over 1,000 staff. Over 8,000 staff also contributed to shaping the Trust's People Plan by sharing their experiences through a variety of engagement channels including CEO roadshows, focus groups, collaboration with staff networks and staff-side representatives, input from the Freedom to Speak Up Guardian, as well as feedback from both the NHS Staff Survey and the Trust's internal staff survey.

The Trust has recently l**aunched a major 'conversation' around the development of its longer-term strategy**. This is a comprehensive, six-month engagement exercise to further develop the strategy. **Collaboration with partners is a key element of this work.** This includes developing the Trust's relationship with the ICB in its evolving role and understanding how this aligns with place-based priorities. Specific chapters on the development of community services will be co-authored with the ICB. The Trust has also applied to become a pilot site for this work; preparing the submission and securing the necessary buy-in from has been an important milestone.

Communications

The Trust does not currently have a dedicated communications strategy, but anticipate addressing this once the Interim Trust Strategy is replaced. In the meantime, an agreed communication approach is in place to support organisational objectives.

2.5 Progress against delivery of the strategy and local plans is monitored and reviewed, and there is evidence of this. Quantifiable and measurable outcomes support strategic objectives, which are cascaded throughout the organisation. The challenges to achieving the strategy, including relevant local health economy factors, are understood and an action plan is in place.

Annual report

The CEO provides an update on progress against the eight big signals regularly at the Board meetings held in public, and other management meetings. **It does not appear however that the annual report tracks progress against the strategy.** We recommend clarifying reporting arrangemetns to provide clear view of progress against the strategy each year.

Other strategies

Environmental sustainability is underpinned by a five-year strategy concluding in 2026, which has driven significant progress in energy use, waste management, and carbon reduction, although transport remains a challenge. These insights reflect a multi-faceted strategic focus spanning commercial, operational, and environmental domains. Further detail is covered in the environmental sustainability section. The Trust has co-produced a **mental health strategy** for acute care patients and is collaborating with system partners to shape future strategic direction.

KLOE 3: Is there a culture of high quality, sustainable care

3.1 Leaders at every level live the vision and embody shared values, prioritise high quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services. Behaviour and performance inconsistent with the vision and values are acted on regardless of seniority.

In response to the CQC report, the Trust **developed a Three-Year People Plan in collaboration with staff**. The Plan incorporates four: **Health & Wellbeing**, **Behaviours & Civility**, **Valued & Heard** and **Leadership & Management.** Each year a set of annual objectives are developed based on progress against the milestones. Progress is reported from the People Programme Board through the People Committee and Trust Board.

Tone from the top

We saw **substantial evidence of positive leadership at Board level with a clear focus on quality**. It was also evident from our interviews with Clinical Board Leaders and observations of Clinical Boards' monthly Quality Performance Reviews (QPR) that **quality underpins the daily business of the Clinical Boards**. The chairing responsibilities of the monthly QPR meetings for each Clinical Board are rotated between the Executives and were observed to follow a standardised agenda. **The meetings we observed were well attended and outcome focused**, seeking outcomes that would improve both patient safety and experience.

Civility

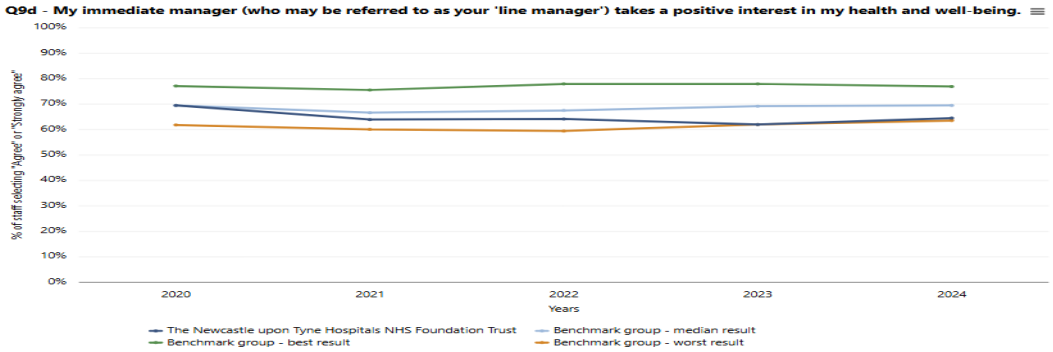
In response to the Regulator's findings, the Trust has **undertaken significant work to improve staff behaviours with the introduction of a Civility Charter**. The Charter was co-produced with staff and outlines clear expectations of how staff are required treat one another with the aim of promoting a culture where respect and kindness are non-negotiable. The Charter has been embedded through training, and team discussions and work is ongoing to embed the Charter's principles into wider practices, policies and procedures, such as recruitment, induction, appraisal, training and celebration. Incivility training is reported to have been rolled out to over 13,000 between Nov 2024 and June 25.

However, **inappropriate attitudes and behaviours remained a theme in an overwhelming majority of the concerns raised with the FTSU Guardian** particularly between staff and their direct line manager in the last 12 months (see below).

Line management

The quality of line management below the Trust's top management tiers was a key theme in the CQC's 2024 report and remains a key challenge for the Trust. The Trust's own reviews into aspects of poor culture, such as those within the Cardiothoracic Clinical Board, highlighted that line management quality is key to individuals' daily experience at work and that this, in turn, directly influences individual and organisational performance. The "tipping point" at which improvement in perceptions of line management translate into more positive outcomes is not reached until individuals' experience of line management is generally good.

The NHS Staff survey 2024 showed results consistently below the national average and, on some indicators close to the worst-performing trusts. The Trust's Pulse survey from 2025 showed no significant improvement from the year prior in relation to the line management dimensions included. While these two data points are not directly comparable, **the Trust is clear that there needs to be more visible progress in this area.**



1. The Equality Diversity and Inclusion Action Plan.
2. NHS Staff Survey 2024.

KLOE 3: Is there a culture of high quality, sustainable care

3.1 Leaders at every level live the vision and embody shared values, prioritise high quality, sustainable and compassionate care, and promote equality and diversity. They encourage pride and positivity in the organisation and focus attention on the needs and experiences of people who use services. Behaviour and performance inconsistent with the vision and values are acted on regardless of seniority (continued)

Feedback from the Trust's 2025 Pulse Survey indicates that some staff also continue to feel that there is a **disconnect between managers and clinical staff**, though the focus of this may have shifted to confusion around the role of clinical board and clarity of management roles.

Overall, it is clear that the Trust has **prioritised positive culture change** and put in place tangible measures to improve line management. **However, at the time of our reviews there was not enough measurable progress for us to conclude at this point - that the Trust's People Plan and its related interventions are having the effect required.** This may reflect the relatively early stage in delivery of the Trust's People Plan at the time of the most recent Staff surveys, but it is critical that the Trust assures itself that the interventions it is making should lead to the outcomes it is seeking, and the depth and reach into the organisation required to make a measurable impact. Some leaders we spoke to suggested that some service leads in their areas may not have received foundational training in line management, and that the focus of some the Trust's training in compassionate leadership, for example, may be 'too much too soon' for those needing more fundamental support in their leadership roles.

People Plan measurement and reporting

Measuring the impact of the People Plan more generally is a challenge. The Trust has an Impact Framework though at the time of our review, not all the indicators were aligned to outcome measures. Impact measurement also relies significantly on staff survey data. While good quality survey data are producing reliable data which are key to outcome measurement, there are inherent limitations to survey data in terms time-lags and sensitivity to changes at sub-Clinical Board level. The Trust needs more leading indicators to show where its interventions are having the intended effect.

A professional evaluation could support the Trust assess the logic model for the People Plan and assessing the impact of individual interventions robustly.

The Trust is aware of – and accepts - these issues. Improving culture - and specifically line management - was consistently highlighted by stakeholders we spoke to – both internally and externally, as the most pressing and also the most difficult challenge the Trust currently faced. The Trust acknowledges that shifting the culture of the organisation could take several years.

References

1. NHS Staff Survey 2024.

KLOE 3: Is there a culture of high quality, sustainable care

3.2 Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.

Raising concerns – Freedom to Speak Up (FTSU)

There is **evidence the number of concerns being raised through the FTSU process are increasing however remain low for the size of the organisation.** The Trust has a **FTSU policy** aligned to the National Guardian guidance, which outlines its FTSU systems and processes. Speaking up is also **well embedded within the wider People Plan**.

The Trust has recently **increased its provision of FTSU Guardian capacity** now supports 1 WTE post, shared between two individuals. The Trust has also introduced a network of **Speak Up champions** to promote and increase the visibility of the service (though this is not reflected in its Policy). The Champions receive formal training - however **Champions are not currently embedded within every Clinical Board**, and it is recognised **work is needed to improve the representation and diversity among Champions** in terms of ethnicity, staff grade and professional group to further assist with accessibility. In addition, there are no arrangements in place to capture the activity of champions.

The FTSU service is promoted through a variety of routes such as staff inductions, regular teaching slots at the harm free care forum, attendance at Clinical Boards and the Clinical Risk Group and ad-hoc walk rounds

Between April 2024 and January 2025, the FTSU Guardian managed 142 cases which required intervention beyond advice and support being given to the complainant. This was an **increase of 67% against the same period in the previous year** (57 cases in 2023 Q1-Q3 compared to 142 cases in Q1-Q3 2024). This increase is encouraging, given the need to develop a more positive Speaking Up culture, though it was also noted that the majority of the concerns raised continued to reflect working relationships such as concerns around mismanagement and fairness in the application of policies and procedures, and a lack of trust in management and formal processes to resolve issues.

The Freedom to Speak Up Guardian provides a **quarterly update to the People Committee** and has recently started to provide a quarterly report to the Patient Safety meeting. The Board receives a biannual Freedom to Speak Up report. The reports provide oversight on the total number of speak up incidents raised and reflects the theme of the concerns being raised.

A biannual report to Board provides detail on the number of anonymous speak up referrals, the staff group and the clinical board where the concerns were raised. This allows the Trust to target support and training more appropriately and alerts them to potentially emerging issues.

A **Freedom to Speak Up dashboard** has been established though until recently visibility was restricted to minimise risk of identifying the individual who had raised concerns in smaller areas. However, the dashboard is now visible to Clinical Boards and managers. FTSU data is currently **not incorporated into the Integrated Board Report**. It was also identified that current data does not accurately capture concerns related to race and it was seen as to challenge to ask. The FTSU Guardian does not currently attend network meetings, and this may assist to promoting the service and improving links with the EDI agenda. In addition, we were informed that, to strengthen triangulation and bring together the various strands of the People & Culture agenda, an MDT group has been established which includes Patient Safety, FTUS Guardian and Human Resources. This is supported by a draft terms of reference and sources information about people that includes but is not limited to: anecdotal concerns, staff engagement, F2SPU, staff experience networks, case management, mediators, Work in Confidence.

KLOE 3: Is there a culture of high quality, sustainable care

3.2 Candour, openness, honesty, transparency and challenges to poor practice are the norm. The leadership actively promotes staff empowerment to drive improvement, and raising concerns is encouraged and valued. Staff actively raise concerns and those who do (including external whistleblowers) are supported. Concerns are investigated sensitively and confidentially, and lessons are shared and acted on. When something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again (continued)

Guardian of safe working hours

The Trust **has an established Guardian of Safe Working Hours**. This role is undertaken by a medical staff representative. The Guardian is responsible for overseeing compliance with the safeguards outlined in the terms and conditions of service (TCS) for doctors in training. The role is to identify and either resolve or escalate problems, and act as a champion of safe working hours for junior doctors. The Guardian **provides assurance to People Committee**, that issues of compliance with safe working hours are being addressed, as they arise. The Guardian is accountable to the Board and reports on key issues as required. It was identified by the Freedom to Speak that Junior Doctors may be more likely to raise issues with the Guardian for Safe Working Hours.

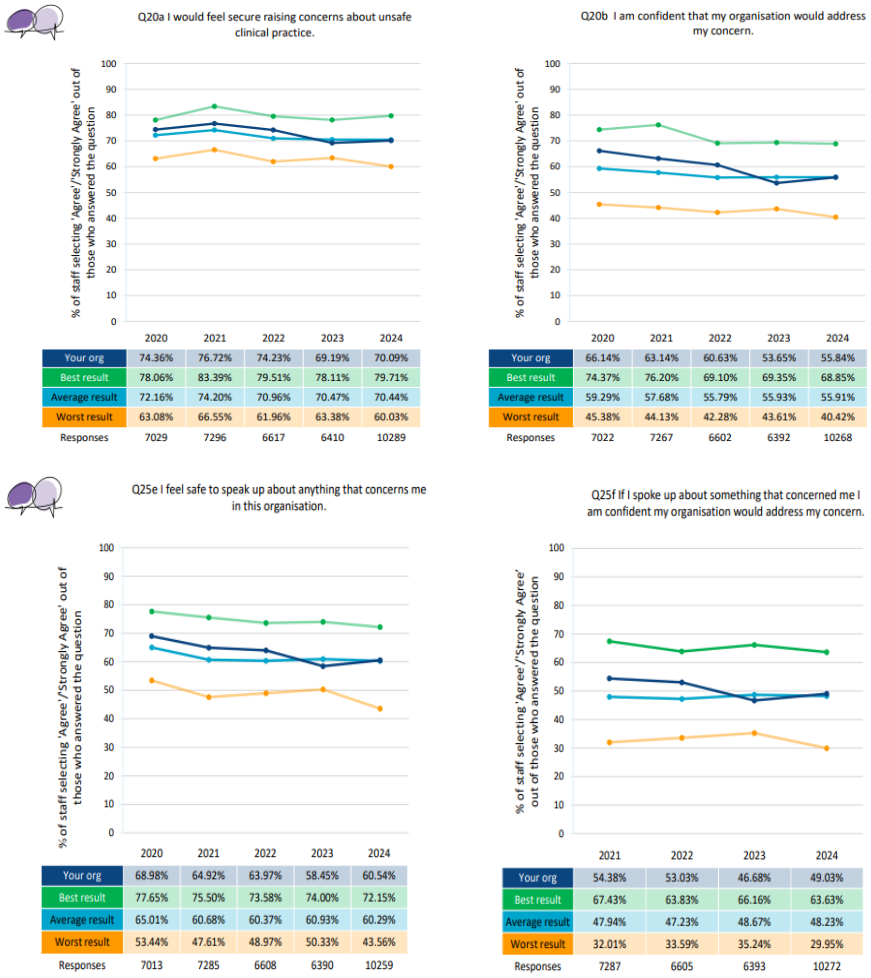
The FTSU Guardian and the Guardian of Safe Working Hours both have important but unique roles however they work separately. There are benefits in networking to share and capture important data, and regular meetings should be scheduled.

National staff survey

The most recent (2024) NHS Staff Survey results **showed signs of improvement in relation to staff's perception of Speaking Up** in 2024. Scores across the four key indicators (see opposite show a reversing the broad trend of worsening score from 2021 to 2023 and moving toward the average benchmark. However, **staff remained less confident that those concerns will be addressed**. The lack of confidence that the Trust would address concerns raised by staff was also highlighted the Trust's 2025 Pulse survey which indicated **only 29.7% of the staff who responded to the survey expressed confidence the Trust would address concerns they raised**, although a breakdown of data to clinical boards indicated better confidence in arrangements in the Family Health Clinical Board.

In addition, the FUTSG's annual report to Board indicated that one of the identified themes associated with the concerns raised through FTSU arrangements was that staff did not feel heard. The Trust **needs to ensure that there is communication of actions and outcomes when a concern is raised to build confidence that the system is working effectively**.

NHS Staff Survey results in respect of raising concerns shown below:



Q20a	2020	2021	2022	2023	2024
Your org	74.36%	76.72%	74.23%	69.19%	70.09%
Best result	78.06%	83.39%	79.51%	78.11%	79.71%
Average result	72.16%	74.20%	70.96%	70.47%	70.44%
Worst result	63.08%	66.55%	61.96%	63.38%	60.03%
Responses	7029	7296	6617	6410	10289

Q20b	2020	2021	2022	2023	2024
Your org	66.14%	63.14%	60.63%	53.65%	55.84%
Best result	74.37%	76.20%	69.10%	69.35%	68.85%
Average result	59.29%	57.68%	55.79%	55.93%	55.91%
Worst result	45.38%	44.13%	42.28%	43.61%	40.42%
Responses	7022	7267	6602	6392	10268

Q25e	2020	2021	2022	2023	2024
Your org	68.98%	64.92%	63.97%	58.45%	60.54%
Best result	77.65%	75.50%	73.58%	74.00%	72.15%
Average result	65.01%	60.68%	60.37%	60.93%	60.29%
Worst result	53.44%	47.61%	48.97%	50.33%	43.56%
Responses	7013	7285	6608	6390	10259

Q25f	2021	2022	2023	2024
Your org	54.38%	53.03%	46.68%	49.03%
Best result	67.43%	63.83%	66.16%	63.63%
Average result	47.94%	47.23%	48.67%	48.23%
Worst result	32.01%	33.59%	35.24%	29.95%
Responses	7287	6605	6393	10272

References: NHS Staff Survey 2024.

KLOE 3: Is there a culture of high quality, sustainable care

3.3 There are processes for providing all staff at every level with the development they need, including high-quality appraisal and career development conversations.

Appraisal rates

The NHS Staff Survey results for 2024 indicated that **87.72% of staff had had an appraisal, annual review, development review or Knowledge and Skills Framework (KSF) development review in the previous 12 months**. This shows an improving trajectory and remains slightly above the national average of 85.08% though short of the Trust target of 90%.

In line with its People Plan, the Trust has **redesigned and piloted a new appraisal process across a number of clinical boards** with the aim of improving the value and impact of the annual review. It was recognised the previous tool was not linked to wider Trust objectives. The new appraisal tool has been simplified and is centred on values, behaviours and meaningful conversations about personal and professional development. It was reported to have been evaluated well at the July 2025 People Committee.

Oversight of appraisal compliance is monitored through the Clinical Boards and there was evidence from the meetings we observed that **non-compliance with the agreed target is challenged** to understand what mitigations have been put in place to address challenges with staffing capacity raised in a Family Health QPR meeting. This metric is also incorporated in the Integrated Board Report and escalated through the People Committee and workforce oversight Committee to Board.

Mandatory training

The Trust **monitors and reports mandatory training levels at Clinical Board level via the monthly Quality Performance Reviews**. Training compliance data is included in the Integrated Board Report that is reviewed at each Quality Committee. During 2024/25, the Trust's systems and processes associated with Statutory and Mandatory training were reviewed by Internal Audit provider and received an assurance rating of 'Good'.

Our observation of Clinical Boards' Quality Performance Review indicates training compliance is a standard agenda item reviewed and escalated as appropriate.

The Trust reported in its July 2012 IBR that 12-month rolling compliance with mandatory training was 91.64%. We note this aligns with the regional benchmark and compliance with the Trust's target of 90%. However, level of compliance with mandatory training appeared in some cases to be on a downward trajectory with the IBR highlighting in June two mandatory courses (Paediatric and Adult basic life support) were below 80% compliance and in July the number of mandatory courses below 80% compliance had increased to eight.

Career development

There is evidence of **some investment in leadership training** among the Governing Body and among staff in Networks who told us the Trust invested in Leadership training with the provision of the LEO Couse and Compassionate Leadership Training.

A review of the progress in Year 1 Of the People Plan that was presented to the People Committee in July indicated all of the actions had been agreed as completed, This suggests the Trust has completed an assessment of current Leadership and Management offer completed to inform future development programme, explored leadership and development tools to support leaders such as coaching and 360 leadership feedback and implemented value- based recruitment with a focus on Leadership competency for leadership roles.

Many of the Trust's leaders that we spoke to identified that further focus was needed to support the development of some Service level managers (as set out above). In addition, we note that the Pulse survey reflected that **some staff felt the opportunities for staff development and progression were limited** and were concerned that the current financial climate may further impact this.

KLOE 3: Is there a culture of high quality, sustainable care

3.4 Leaders model and encourage compassionate, inclusive and supportive relationships among staff so that they feel respected, valued and supported. There are processes to support staff and promote their positive wellbeing.

Health and wellbeing

The Trust has **various initiatives in place to address a range of health and wellbeing issues**, including both formal and informal methods:

- Occupational Health Service: that provides staff with support for mental health, physiotherapy, and other health concerns.
- Sickness Support Programme: to better support staff during sick leave and those staff with high levels of absence
- Better Health at Work (BHAW): that promotes various schemes and activities, such as running groups and mental health training various benefits, including salary sacrifice schemes, car and cycle-to-work schemes, and discounts on various service such as food, travel, childcare and
- Provision of Wellbeing education sessions that staff can access independently addresses areas such as anxiety, sleep and low mood
- Free access for Eye tests
- Benefits Everyone: A program that offers
- Counselling services and the planned introduction of Staff Psychological support services that is aimed a specifically improving staff well-being.

3.5 Equality and diversity are actively promoted, and the causes of any workforce inequality are identified and action taken to address these. Staff, including those with protected characteristics under the Equality Act, feel they are treated equitably.

The Trust has recently increased activity and focus on the EDI but there remains more to do in this area. A recent Board report on the Trust's Equality Delivery System provided an overall assessment the Trusts performance against the National EDS as 'developing'.

NHS Staff Survey 2024

56.3% of respondents to the NHS Staff Survey in 2024 felt that the Trust acts fairly with regard to career progression/promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age, compared with an average of 56.02%.

6.02% of respondents to the NHS Staff survey in 2024 had experienced discrimination at work from patients/ service users, their relatives or other members of the public, compared with an average of 8.75%. 8.42% had personally experienced discrimination at work from manager/ team leader or other colleagues in the last 12 months, which reflected a positive reduction in numbers (9.17%) compared to 2023.

These metrics highlight that the Trust is generally slightly above the average but needs to maintain its focus on EDI matters to ensure this position does not deteriorate. Staff will need to see actionable change if the Trust is to see improvements in this area.

Trust 2025 pulse survey

The most recent results showed 53.7%of staff completing the survey agreed the Trust was serious about improving equality, diversity and inclusion compared to 56% a year earlier.

The Trust has recently appointed **two joint Executive Leads on Equality, Diversity & Inclusion (EDI)** who are now leading work to address recognised workforce inequalities across the Trust.

In line with the guidance from the NHS Equality Diversity & Inclusion Improvement Plan, **the CEO, Chair and board members each have a specific and measurable EDI objective** that are aligned to the 6 high impact actions outlined in the NHS EDI Improvement Plan. Executives are individually and collectively accountable for the delivery of these objectives and provide updates through the EDI Steering Group that has representation from all the Networks.

KLOE 3: Is there a culture of high quality, sustainable care

Executive sponsors are allocated to each of the Trust's staff networks to allow timely oversight of the networks emerging issues and staff networks are promoted at staff induction and on the Trust's intranet. There has been an EDI update recent CEO 'roadshow' updates to staff and all staff have received a communication from the CEO on the Trusts commitment to tackle racism following Trust-wide anti-racism workshops. In addition, there has been Executive representation at a 'Blue Light Breakfast' network event and Executive attendance at the Northern Pride Parade in July 2025.

To assist in maintaining the Board focus on EDI the Trust are currently **agreeing a Board reporting schedule** to ensure EDI becomes a feature of all Board business. The Trust is also developing an EDI Framework incorporating **Education**, **Representation**, **Cultural Change** and **Actions and Accountability**. An EDI Development plan has also been developed in collaboration with the Network Groups and monitored through the EDI Steering Group and regular updates against the EDIs six high impact actions. EDI updates are reported into the People Programme Board and the People Committee on a quarterly basis.

Staff networks

The Trust **has established 5 EDI network meetings for: Armed Forces, Women, Race Equality, Pride** and **Enabled**. Each network has an **executive sponsor** who routinely attends the meetings. The **Chairs of each network meet and collaborate regularly on an informal basis.** There is a monthly meeting with the CEO to share updates. Network leads we spoke to felt that this showed progress and a genuine sense that the Board wanted to hear their perspective and were supportive of improvement to the EDI agenda. The network groups are promoted to new employees at induction and advertised via the intranet and Attendance at each network is variable.

The Race Equality Network has led a Board Development session: 'Let's Talk about Race' which was reported to be well attended by both Executives and Non-Executives. There have also been presentations to the Clinical Board leadership and to Governors. The Race Equality Network Chair is also part of a wider EDI group 'Anti Racism Cumbria' that provides an external lens to anti-racism actions.

The Trust considers its WRES and WDES data at its People Committee and publishes EDI action plan on the Trusts website. The Trusts Networks are in the process of developing a formal report that will feed into the People Committee and Trust Board annually. The summary of the latest data, for 2024, was presented to the Trust Board in July and In relation to WRES, data it was noted that six out of nine indictors had improved however indicators two and three were of concern. Demonstrating the need for the Trust to maintain on going EDI focus to allow sustained and demonstratable evidence to be provided

Workforce Race Equality Standard (WRES)

The annual Workplace Race Equality Standard (WRES) reports were presented and ratified for Trust Board approval in May 2025. It was noted that **WDES results have improved, but there remains significant scope for improvement**. The Trust measures its performance against nine indicators. The areas of more limited or declining progress related to the relative likelihood of staff being appointed from shortlisting across all posts (which showed white staff are 1.81 times more likely to be appointed to a role). In addition, BAME staff are 1.50 times more likely to likely to enter formal disciplinary processes.

Workforce Disability Standard (WDES)

Since the introduction of WDES, the Trust recognise that, **although there has been some progress there is no evidence yet of sustained overall improvement.** The Board received an annual Workforce Disability Equality Update in May 2025, which indicated that the Trust had seen improvement in nine of the ten indicators, the most significant of which was a reduction in the percentage of Disabled staff compared to non-disabled staff entering the formal capability process on the grounds of performance. However, there **remains scope for further improvement on equity for disabled staff**. For example, the percentage of Disabled staff who believe the trust provides equal opportunities for career progression or promotion is 51.15% which is 6.57% lower than non-disabled staff and 0.15% lower than benchmark data.

KLOE 3: Is there a culture of high quality, sustainable care

3.6 There is a culture of collective responsibility between teams and services. There are positive relationships between staff and teams, where conflicts are resolved quickly and constructively and responsibility is shared.

Many interviewees - both internal and external - commented on **an improving culture within the organisation indicating a greater openness to share their challenges and to hear and address emerging issues**.

There was widespread **recognition of key risks** within the organisation at both Executive and Clinical Board level and the interviews with the Clinical Boards reflected their awareness of their individual ownership and responsibility to monitor and address issues within the Clinical Board and escalate as needed.

The **introduction of the Clinical Board structure has also supported an improved the culture of collective responsibility**, and was reported to have allowed the breakdown in individual services working in silos. An example of this was described by staff in the Family Health Clinical Board that has looked to share learning the improvement in arrangements for recognising and escalating the deterioration in children's experiences with those specialist services which also see children, such as dental, ophthalmology and cardiothoracic. In addition, we heard of the collaborative approach taken by clinical boards to support those clinical areas that struggled to meet the Trust's 'ACE' ward accreditation standards.

Recent Pulse survey results showed that **a majority (62.4%) of staff completing the survey felt a strong attachment to their team** – though this was a slight deterioration on the prior year's result. This indicates that the Trust cannot afford to take progress for granted, in line with our recommendations in this area.

KLOE 4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?

4.1 Structures, processes and systems of accountability, including the governance and management of partnerships, joint working arrangements and shared services, are clearly set out, understood and effective.

The Trust has **a governance framework in place, supported by an accountability framework** (the Performance and Accountability framework) which reflects the Trust's move to a distributed leadership model which places substantial leadership responsibility with eight Clinical Boards. We observed the following Committee meetings:

- ✓ Board (Public and Private)
- ✓ Audit, Risk and Assurance Committee (ARAC)
- ✓ Finance, and Performance Committee
- ✓ Quality Committee
- ✓ People Committee
- ✓ Quarterly Performance Review – Family Health Clinical Board
- ✓ Quarterly Performance Review

Common observations across Committees

Papers for the committees are generally shared a week ahead of the committee meeting. One NED raised a concern regarding the timeliness of some of the reports ahead of the Quality Committee specifically, but this was not a widespread concern.

All the Committees we observed had a cross-membership of Executive and Non – Executive Directors. This assisted with ensuring consideration of the impact of decisions on adjacent portfolios.

An annual effectiveness assessment is undertaken for each Committee. All Committees were quorate and had current Terms of Reference and had been allocated appropriate areas to review and monitor. We were told significant work had been undertaken to review and update the Terms of Reference for the Quality Committee to allow improved oversight and focus on quality issues.

It was **not always clear from our observations of committees how items were identified for escalation to Committees or Boards**, or whether papers were offering assurance and to what extent.

Chair's Logs accurately summarised issues discussed by each committee. However, it was not clear what issues, if any were being formally escalated to the Board. Similarly, during the observation of the ARAC "items for escalation" was noted to provide a useful update from Committee chairs but it was unclear what if any items were actually escalated.

Some Committees remain more operational than strategic in focus. The Chair of the Digital and Data committee made this observation in respect of their own committee. It was acknowledged that following the CQC inspection the trust had place increased focus on strengthening the Committees oversight and effectiveness of quality and that now that they had regained improved grip and control, they were in the process of transitioning to a more sustainable approach where the Committee was focusing on assurance and strategic issues. It was acknowledged there had been progress in this area but continued to evolve. Some papers particularly to the Quality Committee did not provide the assurance sought by the Committee. Specifically, a paper on Infection Prevention and Control presented to a Committee we observed **focused on activity, rather than outcomes, leaving gaps in assurance**. This was challenged robustly by the Chair of the Committee.

To strengthen governance, **clearer alignment between Committee's remits, reporting structures, and strategic priorities is needed**, alongside a more standardised assurance style of reporting. When its longer-term strategy is developed, the Trust should ensure that the remits and focus of the Tier 1 Committees is aligned directly to the delivery of defined strategic goals. **A structured approach to reporting and escalation, such as 'Alert, Assure, Advise' would support this, alongside includes defined thresholds for escalation and de-escalation to sharpen Tier 1's focus on strategic assurance rather than operational detail.**

KLOE 4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?

4.2 The board and other levels of governance in the organisation function effectively and interact with each other appropriately.

The governance of the Trust is organised into four main tiers, each with distinct responsibilities and reporting relationships. **The Board of Directors holds ultimate accountability for the Trust's strategic direction, performance and compliance**, and receives reports from all Board Committees and the Executive Team. The **Council of Governors provides oversight and represents the interests of members and the public**. Governors work alongside the Board of Directors and observe some Board Committees. The committees report directly to the Board of Directors, with the exception of the Nominations Committee which reports only to the Council of Governors.

The Executive Team reports into the Board of Directors and oversees the operational delivery. They also receive input from the Clinical Policy Group, Quality and Performance Reviews, and Trust Management Group allowing clear and timely oversight of emerging issues.

The individual Clinical Boards report into monthly Quality and Performance Reviews that are chaired by a Board Executive and attended by the Board's triumvirate Executives. This again provides timely oversight and promotes local ownership of the Clinical Boards issues, cutting across all services and feeding directly into the Executive Team.

From our observations and engagement with stakeholders, the **Quality and Performance Reviews appears to provide an effective means of governance and reporting,** and an Internal Audit review of these arrangements and provided a good level of assurance of the controls and process in place. There was however an action raised for the Trust to refresh risk appetite statements in a timely manner.

Quality Performance Reviews (QPRs)

QPRs are the key mechanism through which the Trust executive holds clinical boards to account for quality and performance. They enable a two-way dialogue and tailored performance discussions between the clinical boards and the Trust leadership. They are used as a tool to flag performance 'hotspots' and drive improvement.

We observed the Quality and Performance Review for Family Health on the 18th of September 2025 and the Quality and Performance Review for SAS on the 19th of September 2025.

We made the following observations in relation to these meetings:

- **Both meetings were well chaired** and ensured time was available to recap discussion and where it was important to reiterate the agreed decision. The meetings ran to time; however, some agenda items were skirted through more quickly than would be ideal.
- Attendees engaged by **asking questions and challenging where appropriate**.
- Time was devoted to the financial position within each QPR; and our observation of the Family & Health QPR dedicated a focused session on finances. We were told that the area of focus would rotate across each of the domain to periodically provide a greater insight into performance and local areas of potential concern.
- The slides noted items for escalation and emerging issues that required discussion. The slide format could be further strengthened by noting the action required.

The QPRs follow a standard agenda but allow for flexibility as needed. There are 8 clinical boards and the QPRs are unique to each Board. From our engagement, it was noted that the Boards that prepare more thoroughly tend to benefit more from the process. The QPRs sit above the Patient Tracking List meetings which handle the operational detail. The results of QPRs are fed into the Finance and Performance Committee (F&PC), with a highlight report presented to Board. The Tier 2 groups (for example: trust wide improvement groups for surgery, emergency care, diagnostics, and cancer) now also report formally in the F&PC.

KLOE 4: Are there clear responsibilities, roles and systems of accountability to support good governance and management?

The strength of the QPR process **is in promoting a two-way conversation**, with the Chair providing feedback and challenge on the reports presented in terms of the mitigations put in place and the impact on outcome. This leads to continuous improvement. Areas for future development was acknowledged to be the variability in QPR effectiveness across the clinical boards based on the maturity of the Clinical Board and the level of engagement. It was noted by one of the members, that the QPR is **as "effective as its members' participation."**

4.3 Staff are clear on their roles and accountabilities.

Staff we interviewed at all levels were **generally clear on their roles and accountabilities**, though as set out above there was scope for more clarity in relation to the People and Digital portfolios at executive level. We observed a good understanding of the delineation between Executive and Non-Executive Director roles. The Board and its Committees have up-to-date and appropriate terms of reference.

Each Clinical Board has a clearly defined leadership team comprising the operational, nursing and clinical director triumvirate. Each Clinical Board has in place its own governance structure to support the performance management and oversight – which includes quality, finance, workforce and risk. There are a host of Core Services, for example, pathology, pharmacy, HR and Finance that centrally support each Clinical board.

At Clinical Board level, leaders were **clear on responsibilities for performance, quality, and finance, people and staff and public engagement matters within their domain.** This reflects the QPRs domains of quality and safety, performance – including activity and access targets, people issues and progress in the implementation of the People Plan, finance including current year position and financial recovery and strategy and service developments. Based on our conversations, leaders were less clear on their responsibilities regarding information governance and data quality. Ensuring Clinical Board remits reflect all areas of the Trust's strategy and Tier 1 committees would support consistency of leadership and oversight across all key areas in which the Board requires assurance.

KLOE 5: Are there clear and effective processes for managing risks, issues and performance?

5.1 There is an effective and comprehensive process to identify, understand, monitor and address current and future risks.

The Trust has a refreshed **Risk Management Policy** in place that sets out key duties, accountabilities and responsibilities in relation to risk management. The policy also sets out the Trust's governance of risk and how risk is managed through the Committee structure. This was originally ratified in April 2025 and is effective until April 2027. Under this scheme, risk identification, escalation and monitoring functions as follows:

1. Any individual who identifies a potential or actual risk can report their concerns directly to the quality committee.
2. Depending on the need for escalation and continued monitoring, these may feed into extraordinary meetings, feed into the BAF, or remain on the quality committee risk register.
3. ARAC is used as a risk monitor of last resort. ARAC requires reassurance of risk management, rather than providing the assurance that risks are managed. The primary risk management is done by the quality committee.

There is an established **Audit and Risk Committee (ARAC)** that has overall responsibility to for providing assurance for the Trust's approach to risk management. The current Chair has worked to streamline the Committee's terms of reference and frameworks used for the ARAC meetings, and reduce the number of people attending ARAC, as it was previously noted that the large amount of people attending ARAC could make it intimidating, particularly clinical attendees, to speak up, especially when less familiar with the language used.

Representatives from all Tier 1 committees attend ARAC and the BAF is a standing agenda item. Our observation of this committee indicated that it was well chaired, kept to the agenda and time, and there was appropriate challenge from the members. The Committee spent time discussing the risk management policy, noting its importance in the Trust's overall governance structure.

The 2024/25 risk management internal audit report provided a good assurance rating, with no high-risk recommendations

As with other Committees, and as noted above, though there was allocated time for escalations to the Committee, it was unclear what points, if any were tabled for formal escalation - as opposed to general updating or flagging issues that were being raised by Committees to the Board - and any action was required from ARAC. A sharper focus on assurance and clarity on what is being escalated and what is for assurance would clarify this, as set out in KLOE 4, above.

The Trust moved from Datix to InPhase for incident reporting on 1st May 2025 and this has supported improved. As at the time of our review, work is ongoing to support the Clinical Boards in closing the remaining incidents on the legacy system, but recent months had shown rapid progress in closing these down.

Directorate level risk registers

Through our engagement Clinical Boards, we were made aware that local risk registers are in place. Risks are initially identified by individual staff members or teams operating within the Directorate. Upon identification, the Risk Register Decision Tool is used to assess the nature, severity, and potential impact of the risk. Once a risk has been assessed using the decision tool, it is reviewed by the Clinical Governance Lead or Matron. At this stage, a decision is made regarding whether the risk can be resolved within the Directorate. If the risk is deemed manageable internally, a risk rating is assigned and a proposed action plan is developed. The outcome of this review is then communicated back to the Clinical Governance Lead. If the risk cannot be resolved at this level, it is escalated to the next tier of governance, the Quality Oversight Group (QOG). The QOG evaluates the grading and determines whether the risk should be added to the Risk Register. An action plan is proposed to address the risk. New risks were presented and discussed at the SAS Board Meeting we observed. The Board reviewed the proposed actions and determines whether further escalation is required. Decisions made at this level are documented and communicated to ensure alignment with strategic objectives and regulatory requirements.

KLOE 5: Are there clear and effective processes for managing risks, issues and performance?

Board Assurance Framework

The Board Assurance Framework is, overall, appropriately presented and well-maintained. The BAF was re-designed in April 2024 to improve capture of relevant information and to allow for effective discussion to take place at Committees, to allow them in turn to make informed judgements as to the level of assurance they recommend to the Audit, Risk and Assurance Committee and Trust Board.

Risks on the BAF are aligned to a number of principal risks (what could stop the Trust from achieving their strategic objective) and these are in turn aligned to the Trust's strategic objectives for the current year. The BAF is aligned primarily to risks, with links then made to the relevant strategic objective and, while this is an approach we see at other organisation, the Trust could consider aligning the BAF directly to its strategic objectives to support the focus on assurance and accountability for delivery we have recommended in KLOEs 2 and 4.

The BAF sets out:

- The risk, including description of the risk
- Risk appetite
- Initial, current and target rating on a 5x5 risk assessment scale
- Associated strategic objective
- First, second and third lines of assurance
- Executive Lead
- Action plan to address gaps in control/assurance.

As with risk management, the 2024/25 and BAF internal audit reports received a good assurance rating, with no high-risk recommendations.

5.2 Financial pressures are managed so that they do not compromise the quality of care. Service developments and efficiency changes are developed and assessed with input from clinicians so that their impact on the quality of care is understood.

The Trust has **struggled to deliver significant recurrent savings in recent years**, delivering only £11m of £107m savings recurrently (10% of savings or 0.6% of expenditure) in 2024/25 at a point where recurrent savings of 2% of expenditure has become the norm for many Trusts. The Trust has a CIP target of £106m to support its financial plan for 2025/26. The target includes savings of £48m in Clinical Board savings, £10m in Corporate Services savings, £17m of Subsidiary savings and £30m in non-recurrent measures to support the Trust's overall financial position. At the end of M6 (September 2025), £42m of savings had been delivered, Clinical Boards delivering £12m against their target of £17m, Corporate Services have £3m against their target of £5m. £26m of technical adjustments had been actioned to close the gap on Clinical Boards, Corporate Service and Subsidiaries, suggesting an ongoing challenge.

There is **work required to embed a more positive culture around efficiency and savings delivery throughout the organisation**. We heard from leaders at multiple levels that normalising discussions around finances has been difficult for the Trust. For example, during some interviews it was noted that it was "only within the last two years" the Trust has been in a challenging financial situation, however, others were clear that the Trust has had an underlying deficit for a longer period and it is only recently that staff beyond Executive level have had to engage with the topic. Some interviewees also noted that the associated charity has historically supported with operational challenges. This was reflected in a statistically-significant decline in the proportion of staff who agreed that "Care of patients/service users was the organisations ' top priority" between the Trust's April 2024 and July 2025 Pulse surveys – a finding that was widely attributed by senior leaders to the increased focus on finance and efficiency in corporate messaging.

Financial information presented to public board is relatively limited and high level within the Integrated Board Report. More information and discussion were evident at Private Board but more prominent reporting and discussion in public would help normalise this agenda. CIP is clearly recognised as a strategic risk on the BAF - but this received limited discussion time at the Board and Tier 1 Committees we observed. More prominent reporting and discussion in public – including positive case studies – could help normalise the savings and efficiency challenge.

KLOE 5: Are there clear and effective processes for managing risks, issues and performance?

5.3 The organisation has the processes to manage current and future performance.

Performance issues are escalated from Clinical Boards via the Quality Performance Reviews (QPRs) and an appropriate Integrated Board Report (IBR) covering performance quality, and finance and people is presented to the Board. We make observations on the QPR process under KLOE4, above, and on integrated reporting under KLOE 6, below.

5.4 Performance issues are escalated to the appropriate committees and the board through clear structures and processes.

The Trust has strengthened its performance management arrangements in recent years. However, there remain areas for further development to ensure there is consistent visibility and escalation of performance issues.

Quality Performance Reviews (QPRs) are the primary mechanism for holding Clinical Boards to account, providing a forum for discussion of operational and quality performance. As set out above, these reviews have standard agendas and allow for two-way dialogue, but we heard the effectiveness of the QPR can vary at times and is recognised as an area for further improvement.

The Finance and Performance Committee (F&PC) undertakes cyclical deep dives into key performance areas (e.g., cancer, diagnostics, emergency care) but the links between these and specific escalations QPRs could be clearer.

Tracking progress against CQC actions

The Trust has mechanisms in place to monitor their progress against its CQC actions. Examples include the Cardiac Oversight Group and the CQC Compliance Group, which recently reviewed progress against the Learning Disability and Autism Action Plan in May 2025. Updates are also tracked through the Quality Committee. The June 2025 Quality Committee shows progress against the CQC plans for Mental Health, Nectar, Emergency Department, and incorporates feedback from the Integrated Quality Group.

To gain additional assurance the progress reported against CQC actions is being embedded and sustained a Peer review programme has been developed and rolled out.

5.5 Clinical and internal audit processes function well and have a positive impact on quality governance, with clear evidence of action to resolve concerns.

The Trust actively participates in clinical audit, monitored through the clinical audit programme, which reports into the Audit, Risk, and Assurance Committee (ARAC).

A Clinical Audit and Effectiveness Group is in place, which reports into broader governance structures such as the Quality Governance and Clinical Governance Committees. Clinical audit responsibilities are embedded within the Quality Governance Team. The Trust's Quality Account summarises its participation in clinical audit, as well as quality improvements identified and, where appropriate, implemented.

At the July 2025 Quality Committee, which we observed, it was reported there had been limited resource available to support the participation in National Clinical Audits, which had resulted in clinicians being unable to collect the required data. It was agreed that moving forward, high consequent audits should be prioritised. A limited capacity to engage with the programme of National clinical audits may impact the Trust's ability to maximise learning opportunities.

Internal Audit services are provided to the Trust by Audit One. **The internal audit programme is aligned to the strategic objectives of the Trust and Assurance Framework and includes a range of clinical and non-clinical areas.** The July 2025 ARAC papers provided an update on the internal audit progress, detailing that two final reports were issued for the 2024/25 internal audit plan since the last ARAC meeting in June and four audits are currently in draft/review stage. Five audits at fieldwork/planning stage were carried forward into the 2025/26 internal audit plan. One final report has been issued from the 2025/26 internal audit plan so far. There were only a small number of higher-priority recommendations outstanding.

KLOE 6: Is appropriate and accurate information being effectively processed, challenged and acted on?

6.1 Quality and sustainability both receive sufficient coverage in relevant meetings at all levels. Staff receive helpful data on a daily basis, which supports them to adjust and improve performance as necessary.

We observed a **clear focus on quality at Board level**. **An Integrated Board Report (IBR) covering performance quality, and finance and people is presented to the Board.** While the population health dimension was not yet populated at the time of our review, it was positive to see health inequalities explicitly covered as a core dimension in the report. The Board meeting we observed demonstrated **clear discussion of the related nature of different dimensions of performance**, with active contributions from both NEDs and the Executive Team aligned to each individual's areas of responsibility and expertise. Where appropriate we noted triangulation of clinical, performance, people and finance perspectives ahead of approval of particular items. Quality issues are also **discussed frequently at other committees of the Board including ARAC and the People Committee**.

It was also evident from our interviews with Clinical Board Leaders and observations of Clinical Boards' monthly Quality Performance Reviews (QPR) that **quality underpins the daily business of the Clinical Boards.** The chairing responsibilities of the monthly QPR meetings for each Clinical Board are rotated between the Executives and were observed to follow a standardised agenda. The meetings we observed were well attended and outcome focused, seeking outcomes that would improve both patient safety and experience.

At Clinical Board level, reporting we reviewed **covered performance, quality, and finance, people and staff and public engagement matters** in line with the Trust's accountability framework. As noted above in relation to KLOE5, recent staff survey have indicated that there may be a tension in the Trust's necessary increased focus on efficiency, and staff perceptions of the balance between finance and quality in decision-making.

6.2 Integrated reporting supports effective decision-making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people, with quality, operational and financial information.

Integrated reporting

The Trust has an Integrated Board Report (IBR). The Integrated Board Report (IBR) has recently been refreshed to provide a more holistic view of Trust-wide performance, incorporating financial, operational, and quality metrics. This is a positive development, supported by feedback loops from Committee Chairs, and reflects a shift towards a more integrated approach. The Director of Performance and Governance has also expressed an ambition to embed benchmarking and align the IBR with the new oversight framework, which would strengthen external comparability and internal accountability.

There is also consideration for the future incorporation of FTSU data within the IBR. This will allow increased opportunity for Executive and the Clinical Board triumvirate to triangulate metrics and identify potentially emerging areas of concern.

Interviewees noted that the data quality and format of IBRs has improved, making the information more useful. The IBR is **broadly aligned to recognised good practice**. **Statistical Process Control (SPC) indicators** are used appropriately within the IBR to distinguish statistically significant changes, whether positive or concerning, from routine variations in data.

In common with other Board papers, the IBR would benefit from a more effective overall summary and clarity over any action requested from Board, potentially including a 'heat map' of indicators of concern or showing positive assurance as used by other Trusts.

KLOE 6: Is appropriate and accurate information being effectively processed, challenged and acted on?

6.2 Integrated reporting supports effective decision-making. There is a holistic understanding of performance, which sufficiently covers and integrates the views of people, with quality, operational and financial information (continued)

There is use of benchmarking, for example Model Hospital, within the organisation. We were shown multiple examples of benchmarking reports both at Trust level and benchmarking integrated into Clinical Boards' reporting via the QPR process.

The Trust employs a mixed approach to data presentation, with some reports (such as the IBR) using Statistical Process Control (SPC) while others use different formats, such as run rates, or a mix.

6.3 Performance information is used to hold management and staff to account.

As noted in KLOE 5, Quality Performance Reviews (QPRs) are the primary mechanism for holding Clinical Boards to account, providing a forum for discussion of operational and quality performance. As discussed earlier in KLOE 5, the current approach to QPRs lacks a fully standardised structure, resulting in some variability in the information presented and its use within meetings. A significant amount of data is included in meeting papers, which can make it difficult for stakeholders to locate key information quickly. To address this issue, efforts have been made to implement and improve executive summaries. While some progress has been made, the effectiveness of the summaries remains varied.

In addition to significant work to develop the IBR and QPR processes, there has been an emphasis on using information to hold staff to account at Tier 1 Committees. An example of this is the response to the quarterly Infection Control Report presented in July 2025, which provided no assurance of the actions and mitigations being taken to deterioration in Infection Control Performance. This is a key performance metric, yet the report presented to the Quality Committee provided limited assurance on actions taken to address the recognised performance issues. In response an IPC Oversight Group has been established chaired by the Medical Director who was previously the DIPC. This will allow increased scrutiny on the deteriorating IPC rates and will provide assurance to the Quality Committee on the impact of the actions being taken.

The Quality Committee now meets for 3 hours each month indicating the focus the Trust has placed on gaining assurance on the quality of care. There is acknowledgement that the focus of the reports presented at the Committee remains variable with some focus on detail rather highlighting the key issues and escalations. We address this under KLOE 4, above.

KLOE 6: Is appropriate and accurate information being effectively processed, challenged and acted on?

6.4 The information used in reporting, performance management and delivering quality care is usually accurate, valid, reliable, timely and relevant, with plans to address any weaknesses.

Data quality is integrated into the Trust's governance, with assurance spanning the 3 lines of defence. The Trust has a dedicated Data Quality function within its Trust Information Services Department that leads routine and ad-hoc data quality analysis, reporting and root cause analysis. The Trust's non-statutory, Non-Executive-led **Digital and Data Committee has an explicit responsibility to provide assurance to the Trust's Board in relation to the governance of the Trust's data quality**.

The Committee receives reports from the Executive-led Digital and Data Governance Group, which is chaired by the Director of Communications and Corporate Affairs, who is the Trust's Senior Information Risk Officer (SIRO). There is both a Chief Clinical Information Officer and a Chief Nurse Information Officer currently in post at the Trust.

Internal Audit covers data quality as a specific audit category and has a number of reviews of data quality planned as part of the 2025/26 Internal Audit Plan. These cover patient experience, diagnostics, Waiting List Management, Patient Level Tracking Data Validation and Theatre Utilisation data.

The Trust **does not currently use data quality assurance indicators within its within key reports** such as the IBR and including these would these would could inform users about any data quality risks and assurances that impact decision-making.

6.5 Information technology systems are used effectively to monitor and improve the quality of care.

At times, **staff can experience problems accessing the information they need efficiently.** Operational inefficiencies were evident, for example, reports of laptops taking up to two hours to start. These delays could directly impact productivity and patient care and may reflect problems with system operability and infrastructure.

During the September 2025 ARAC meeting, it was noted that Digital services were experiencing a backlog of requests (upwards of 500 requests are sitting in the queue). This was flagged as a risk from the Chief Digital Officer to the committee.

At present, there is **no single, overarching data strategy** that defines how data should be used, governed, and maintained. In the absence of this, the Trust's scheme of prioritisation for its investment in digital projects is unclear. The Trust needs to set a clear digital strategy to support and prioritise necessary investment.

KLOE 6: Is appropriate and accurate information being effectively processed, challenged and acted on?

6.6 Data or notifications are consistently submitted to external organisations as required

Currently, not all elements of data submissions within the Trust are automated. Efforts are underway to reduce the amount of manual work involved in these processes. The degree of automation varies depending on the specific requirements of each return. Additionally, weekend data returns are quality-assured during the working week before the final submission. There are occasional gaps in the data submissions, which are typically identified by the Integrated Care Board (ICB) or regional authorities. However, it is anticipated that these gaps will decrease as automation efforts progress. By streamlining these submissions and increasing automation, the Trust aims to enhance efficiency and reduce the potential for human error.

The Trust is also focused on maintaining compliance with the Data Security and Protection Toolkit, which is essential for safeguarding sensitive information.

6.7 There are robust arrangements for the availability, integrity and confidentiality of patient identifiable data, records and data management systems.

The Trust's Director of Communications and Corporate Affairs, assumed responsibility as SIRO in March 2025. The Head of Risk and Corporate Assurance is the Deputy SIRO.

Responsibility for assuring the Board over compliance with legislation and regulations for information governance, cyber security and information security rests with **the Digital and Data Committee.** As noted above, the Committee has a specific responsibility for assuring the board over the Trust's governance in relation to data quality.

It was reported to the Digital and Data Committee in May 2025 that all the of the Trust's Information Asset Owners (IAOs) have completed online IAO training provided by Templar Executives.

The Digital and Data Committee receives assurance on the performance of data security and integrity from the Digital Health and information governance teams

Data breaches are reported on the Datix system, and the Trust reported 414 data incidents in 2024-25. This is noted to be a small decline since 2023-24, four less data incidents reported. Of the 414 incidents, 265 were reported with the 72 hours timescale set by UK GDPR, providing a compliance rate of 64%. Seven data incidents met the criteria for the Trust to report to the external incident portal. No incident met the threshold to self-report to the Information Commissioner.

In June 2024 the Trust's internal auditors completed the annual independent assessment of the Data Security and Protection Toolkit with findings submitted to NHS England. A substantial level of assurance was reported to NHS England.

KLOE 7: Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

7.1 A full and diverse range of people's views and concerns is encouraged, heard and acted on to shape services and culture.

Patient and public engagement

Patient and staff stories feature at all public Board meetings. Patient and staff experience results are reported to the Council of Governors and are shared at the Chief Executive roadshows for staff, Management Groups, and Quality Committee. The Trust has an Experience of Care Team, led at Executive-level by the Chief Experience Officer.

The Trust has an active program to engage with both staff and its service users to gain insight in a number of formal and informal ways. Some recent and regular activities are summarised below:

- **Real Time Programme** – members from the Experience of Care team visit wards bimonthly and speak to 50% of the patients on the ward using a standardised tool to assess the patients experience of their stay in hospital. The outcome of the visit is shared with the ward team immediately, to enable them to address issues in a timely manner. As at July 2025 work had been undertaken on 30 wards out of the 45 originally proposed and two additional Feedback Facilitators had been appointed to increase capacity for real time measurement.
- **Right Time** questionnaires are also sent to both inpatients and outpatients two weeks after they are seen or discharged to gain the patient reflection on their experience of care and use it to inform learning. Data from both activities are shared with the Clinical Board and discussed through the QPR process.
- Monthly **Friend and Family** data is collected and shows that since the introduction of the 'Right Time Programme there has been a 500% increase in FFT responses. This indicates increased confidence by patients that the Trust wants to hear and improve experiences for their patients
- During the Trust's **'Perfect Week' initiative** in September 2024, all patients receiving care during that week were asked to complete a survey in relation to their experience of care in either inpatient/outpatient services or the emergency department and resulted in feedback from 2,903 individuals.

There are formal routes for compliments, complaints and PALS to be reported at both a Clinical Board and Board level. However, it is recognised further work is needed around complaints management arrangements as the Trust has seen an increased backlog in the number of delayed responses to complaints. To address this a monthly Task& Finish Group has been introduced that has the timely completion of complaints as one of the quality workstreams to improve arrangements. There has been a 13% increase in the number of new complaints and in the number of complaints that have been reopened in 2024/25 along with delays in providing response times in line with targets.

Governors

Currently, there are **34 Governors within the Trust**, who convene at bi-monthly with at the Council of Governors (COG) meeting and this alternates with a bi-monthly Governors workshop meeting. The Lead Governor participates in agenda-setting meetings for the Council of Governors, incorporating input from Governors and Trust members. **However, some Governors noted that the breadth of the Council's agenda can lead to important items being overlooked, and the Governors may wish to have oversight of the recommendations we make more widely about aligning agendas to the Trust Strategy to help prioritise.** Governors also observe some Board Committees and conduct service walkabouts, completing observation sheets that feed into discussions at Working Groups and inform the Lead Governor's report to the Council.

Governors do not hold formal constituency meetings but gather public views through informal discussions, community forums such as Healthwatch, patient practice groups, member events, emails and the Annual Members meeting. To support the Trust's Equality, Diversity, and Inclusion (EDI) agenda the People, Engagement and Membership working group goes into community networks to try and increase engagement and membership among less well represented groups within the community with the aim of increasing the recruitment of members from diverse backgrounds. There are also efforts underway to establish regular meetings of Lead Governors across the Great North Healthcare Alliance to strengthen the collaboration among partner organisations.

KLOE 7: Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

The Governors we spoke to reported that there has been noticeable improvement in the visibility and the communications with the Trust's non–executives and the relationships with the Board are more positive. Some governors referred to ongoing challenges with workforce culture in pockets of the organisation. We address this under KLOE 3.

There are three Governor Working Groups that are aligned to Tier 1 Committees. The working groups are open to all Governors and are attended by NEDs. Governors observe Tier 1 & 2 Committees and the Trust Board. The new Lead Governor assumed her role in March 2025 and reports receiving strong support from both the Chair and the CEO during her transition into the position.

Governors' work is changing in line with working practices more widely, and we heard a degree of nervousness among some Governors about the increase remote meetings, for example, with others positive about the increased efficiency and opportunities for other to engage. The Trust and Governors will need to **work together effectively to ensure that forums allow all participants equal opportunity to contribute their perspectives and expertise**.

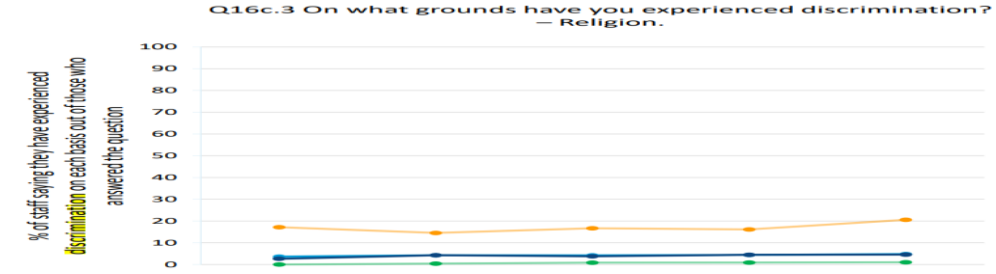
7.2 The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture.

NHS Staff Survey

In 2024, 10,371 individuals completed questionnaires in both paper and electronic form, giving the Trust a response rate of **64%.** This response rate is significantly higher than the median of 49 % and demonstrated a **50% increase** to the response rate on the prior year. There is evidence of **statistical gains across all elements of the People promises however the Trust still falls below the national average when compared to other NHS Trusts**. The previous pattern experience by the Trust of a year-on-year decline seen in many of the Trust's responses was reversed and in the 2024 survey there were improved scores seen in 83% of questions staff responded to.

Feedback from the survey has been used to directly informed the Trust's People Plan actions and there is evidence that the results of National staff survey have been fed back to staff via the CEO Roadshows and service specific results shared back through the Clinical Board structure.

One area highlighted by the survey for additional focus related to the **percentage of staff that report experiencing discrimination and unwanted behaviour from members of the public.** Between 2023 to 2024 an increased percentage of staff reported that 'in the last 12 months they had personally experience discrimination at work from patients/service users, their relatives or other members of the public'. The data showed that the discrimination against white members of staff had improved there had been a 2.51% increase among BME staff. This is further enforced with the notable rise of 7.43% in reports of discrimination specifically related to ethnicity. Increasing from 35.21% in 2023 to 42.64% in 2024. Smaller rises were also reported in staff experiencing discrimination on the basis of gender and religion.



	2020	2021	2022	2023	2024
Your org	2.61%	4.25%	3.80%	4.48%	4.56%
Best result	0.00%	0.42%	0.84%	0.92%	1.04%
Average result	3.64%	4.24%	4.21%	4.43%	4.81%
Worst result	17.17%	14.52%	16.64%	16.12%	20.56%

References

1. National Staff Survey 2024 NHS Staff Survey 2024 Benchmark Report

KLOE 7: Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

7.2 The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture (continued)

In addition to the annual National Staff Survey the Trust has carried out **an internal Pulse survey** in both 2024 and 2025. This provides the Trust additional insight on the impact of the work being implemented on staff and their general morale. Approximately **4,500** staff completed the most recent survey, and the results have been analysed and compared with prior year results. While the scores in both surveys were similar for motivation and teamwork, there was a slight but statistically significant decline reported in 2025 in four of the 14 comparable questions. The most concerning of these was the 7.9% deterioration in confidence staff had that patient care was a top priority for the Trust – we cover this under KLOE 6. In addition, the 2025 survey does not identify any areas where the Trust performance has statistically improved on the prior year (see KLOE 3).

Other staff communication and engagement events

Beyond the National Staff Survey the Trust seeks to engage staff through a number of events and channels including:

- Programme of Executive and Non-Executive walk rounds
- Tri annual all-staff CEO Roadshows chaired by the Chief Executive. These are live events but can also be accessed via MS Teams and allow anonymous staff feedback
- CEO does a monthly Business Briefing to Service managers that includes key information on finance and performance from these briefings is cascade back into the Clinical Boards.
- Townhall meetings
- an established programme of walkarounds undertaken by both the Executive and Non-Executives both in and outside of normal working hours (see KLOE 1).

KLOE 7: Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

7.2 The service proactively engages and involves all staff (including those with protected equality characteristics) and ensures that the voices of all staff are heard and acted on to shape services and culture (continued)

Staff networks

The Trust proactively engages with its staff through a variety of forums networks to support Armed Forces, Women, LGBTQ and BAME and Disabled communities. Each network has an Executive Sponsor who attends the meetings that generally, happen bimonthly apart from the Race Equality Network meets biweekly. Following the CQC report arrangements to engage with staff networks has strengthened and improved lines of communication have been established with the Trust Board, Network meetings are reported to have structured agendas, but meetings are not minuted.

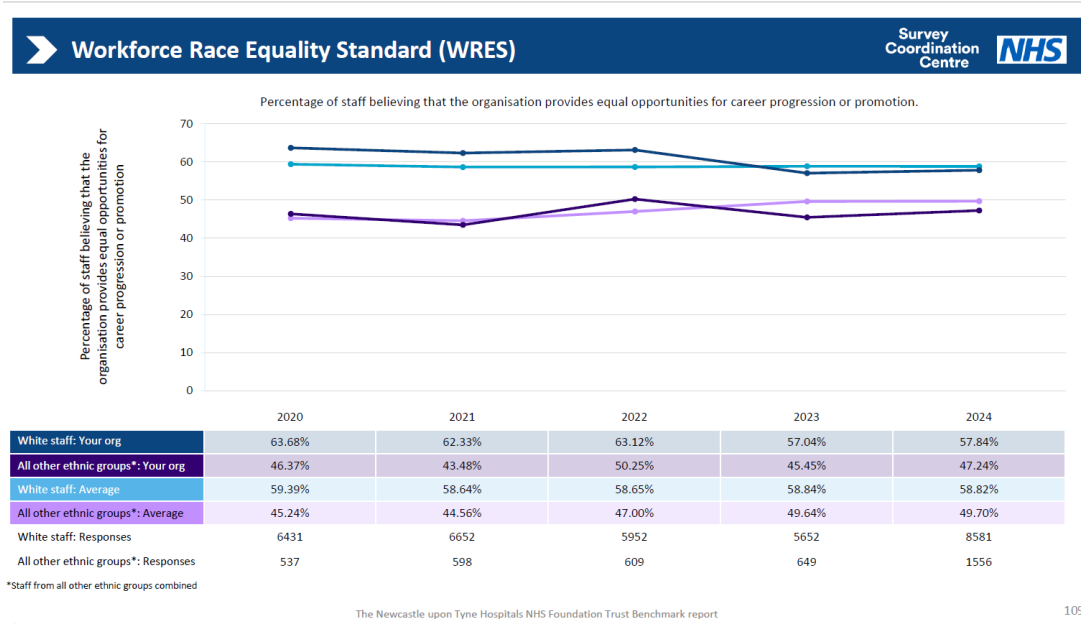
As set out under KLOE 3, The Trust does not currently have an EDI Strategy. However, they are currently working collaboratively with the Race Equality Network to develop an Anti-Racism framework. In addition, there is an EDI Improvement Plan that is updated annually to ensure it reflects current areas for development as highlighted by the national staff survey and is mapped to the work being undertaken in the People Plan. Progress against the Improvement Plan are reported through the EDI Sterring Group Network this is also discussed in KLOE 3.

It was highlighted by several Executives and Non-Executive that in prior years the EDI agenda has not received sufficient focus. However, following the most recent National Staff Survey the Trust has appointed two executive EDI Leads and all the Executives on the Board have EDI objective to increase ownership and visibility of the EDI agenda at Board level. I

In addition, we have been told of initiatives within Clinical Boards such as the Family Health Board, which has established an anti-racism task force and undertaken work to improve to access to translation services and introduce Cultural Competency training for all maternity staff demonstrating a commitment to improving staff knowledge and help address inequalities quality-of-service provision.

The National Staff Survey also highlighted concern that career progression is not always equitable. In the 2024 NHS staff survey 47.2% of staff that identified themselves as from an ethnic background agreed with the statement 'Does your organisation act fairly with regard to career progression / promotion. While there is an improvement from the 2023 NSS results to the same question, the Trust's responses remains below the average result of 49.7% that is seen in similar organisations.

Graph 7: NHS 2024 Staff Survey results: Career Progression



	2020	2021	2022	2023	2024
White staff: Your org	63.68%	62.33%	63.12%	57.04%	57.84%
All other ethnic groups*: Your org	46.37%	43.48%	50.25%	45.45%	47.24%
White staff: Average	59.39%	58.64%	58.65%	58.84%	58.82%
All other ethnic groups*: Average	45.24%	44.56%	47.00%	49.64%	49.70%
White staff: Responses	6431	6652	5952	5652	8581
All other ethnic groups*: Responses	537	598	609	649	1556

*Staff from all other ethnic groups combined

References

1. NHS Staff Survey Benchmark report 2024

KLOE 7: Are the people who use services, the public, staff and external partners engaged and involved to support high quality sustainable services?

There is an awareness that **the Trust Board and the Council of Governors does not fully represent the diversity of the local community**. Recently the Trust has appointed a Non-Executive Director and an Associate Non-Executive Director from diverse backgrounds, marking a positive step toward enhancing representation at the leadership level and as previously mentioned to support the Trust's Equality, Diversity, and Inclusion (EDI) agenda the People, Engagement and Membership working group continue to access community networks to try and engage and increase membership among less well represented groups of the community.

7.3 The service is transparent, collaborative and open with all relevant stakeholders about performance, to build a shared understanding of challenges to the system and the needs of the population and to design improvements to meet them.

The Trust recently appointed a new Chairman of the Board who is shared with neighbouring trusts, Northumbria Healthcare NHS FT and Gateshead Health NHS FT, two other key acute partners in the Alliance. In addition, there are some shared back-office processes associated with the use of bank and agency staff and a shared Chief Digital Officer for the Alliance has been appointed.

The Trust is a part of the Great North Healthcare Alliance, a partnership between the NHS Trusts in Gateshead, Newcastle, Northumbria and North Cumbria. We heard from Trust leaders that there was now a higher degree of trust between the partners, and partners all reported significant improvement in the working relationships with Newcastle and the other organisations in the Alliance and wider system.

In addition, there **are individual connections between members of the Trust Board and the wider system such as education and police**. However, the strength of the relationships is recognised to vary and the relationship with the Local Authority needs additional focus. It is recognised each contact provides an opportunity to explore potential collaborative projects that will further enrich the Trust future impact across the wider system.

External leadership visibility

There is an embedded programme of NEDs walkarounds of clinical services. We cover the Board Visibility Programme further under KLOE 1, above.

The NEDs are allocated as a Champion to specific specialities such as Maternity and Cardiothoracic services. This consistency of oversight can help to build relationships and trust and allows increased assurance that progress and improvements are being addressed in services It has also provided clinical staff an increased opportunity to raise concerns allowing greater confidence among Board members that they are sighted on service level concerns.

There is evidence of attendance by external leaders such as CQC and the ICB at the Trusts Public Board and examples of observations of Public Board from representatives of the neighbouring Trusts and professional media reporters. This indicates a willingness to be transparent in terms of the Trusts challenges and to share the plans they have agreed to address them.

We heard from some external stakeholders that while the roles of the Chief Executive, Director of Nursing and Chief Finance Officer are visible, engagement at service level was less well established in comparison to similar positions in other organisations and would further strengthen clinical leadership.

References

1. Workforce Committee meeting book June 2024

KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?

8.1 There is a strong focus on continuous learning and improvement at all levels of the organisation, including through appropriate use of external accreditation and participation in research.

During our engagement with internal stakeholders, a commitment to sharing learning and to strengthen existing processes was evident. In January 2024 the Trust introduced the Patient Safety Incident Response framework that outlined processes for the review and escalation of incidents. The data themes and learning from the incidents is reported annually through the Quality Committee and Trust Board

There is evidence from interviews that incident reports and associated learning are discussed at monthly Clinical Board Quality Oversight Groups and there is evidence that in some areas learning is also incorporated in monthly newsletter and staff briefings.

There are Patient Safety communications, such as the Patient Safety Bulletin and Patient Safety Briefing, that incorporate learning of both good practice and areas for improvement, and these are disseminated Trust wide. However, we were told the attendance at some learning forums is low and it is recognised this could impact the Trust's ability to effectively cascade learning.

The 2024 NSS results indicate some improvement in the People's Promise 'We are always learning' and in the recent internal Pule Survey 50.8% of staff who responded indicated that they received feedback regarding changes that were made in response to reported errors, near misses and incidents suggesting there are processes in place that need further embedding.

Supporting staff to report incidents, with enhanced focus on shared learning is one of the Trusts Quality Priorities and to help guide this a new Communication Plan is being developed as part of QP1 requirement for (2025/26). It is anticipated this will allow processes to share learning to embed and become standardised across the Clinical Boards.

Learning from Deaths

The Trust is currently reviewing and monitoring Mortality Policy for Adult and executives reported that there was improvement work to strengthen under way to strengthen the existing Learning from Deaths arrangements.

There is a quarterly Mortality Surveillance Group that allows a systematic approach to mortality monitoring and to sharing learning around mortality associated to all Trust inpatient deaths with a recently reviewed Terms of Reference. In addition, mortality data is presented monthly within the Trust Integrated Board Report.

The Quality Committee receives a quarterly Learning from Deaths Report that provides details on mortality quality metrics from inpatient deaths to provide assurance to the Quality Committee and Trust Board of the monitoring and review processes in place, and this incorporates identified learning from those deaths where problems in care are identified. A review of the report indicates mortality reviews are undertaken in 2 stages, and the progress of reviews and identified learning is incorporated in the quarterly report. The Trust has not yet introduced structured judgement reviews but has invested in an In-phase app that going forward will provided improved oversight of mortality performance and will support the development of a mortality dashboard.

Where concerns in care are currently identified, the cases are escalated to the Trust's weekly Rapid Action Review Meeting (RARM) for review, and since May 2025 any patient death is recorded as a patient safety event via Datix or In-Phase and completed PSII investigations are presented to the Trust's monthly Patient Safety Incident Forum (PSIF) for scrutiny and final report approval. These arrangements should provide timely oversight pf emerging themes and concerns

KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?

8.2 There is knowledge of improvement methods and the skills to use them at all levels of the organisation.

The Trust is seeking to promote a culture where improvement is everyone's business. There is a lack of clarity among some staff as to whether the Trust has a single Quality Improvement (QI) methodology. The Trust does not have a single QI methodology however it does advocate the use of a PDSA approach to improvement and has invested in Quality Improvement training for staff. In addition, the Trust has merged its Programme Management Office and QI Team into a single Service Improvement team. This refreshed operating model has integrated QI team members into the eight Clinical Boards who are responsible for embedding a culture of improvement across the organisation via training, education and support. Discussion with Clinical Board leaders indicated that a variety of tool are used to drive improvement.

In addition, there is a Trust intranet page that has documents and guidance for staff undertaking improvement projects. However, there is no central document pulling this information together. We were told this would be incorporated within the Trust strategy.

Oversight of QI is undertaken by the Quality Committee via a variety of Management and Oversight Groups such as:

- Patient Safety
- Patient Experience and Engagement
- Clinical Outcomes and Effectiveness including updates from the Clinical Ethics Advisory Group
- People Committee receive a Learning and Development update

In addition, there are multiple Improvement Groups such as the one introduced to address quality issues within the NECTAR service

The Trust has identified its quality priorities, such as the safer and more effective use of medicines. In addition, our observation of the Family Health Clinical Board indicated that Clinical Boards have their own quality priorities such as the improvement of the Paediatric Early Warning Score (PEWS) and Martha's Rule seeking to ensure babies, children and young people are safely cared for with monitoring in place and the safe, timely escalation and response to concerns.

Engagement with improvement in clinical effectiveness was evident in discussion with the Clinical Boards who report that this underpins the work of the Quality Oversight Group and is considered within the ACE Ward Accreditation Framework which includes 'Engagement for Improvement' as one of the 5 pillars, with the aim of embedding continuous quality improvement (QI) staff engagement in locally created and owned quality improvement projects.

8.3 The service makes effective use of internal and external reviews, and learning is shared effectively and used to make improvements.

National Clinical Audit

At the Quality Committee observed in July 2025 is was reported is that, in terms of support for participation in National Clinical Audit there had been limited resource which had resulted in o clinicians being unable to collect data, usually with very large date sets. It was agreed that moving forward, high consequence audits would be prioritised and that the Quality Committee would be provided with increased oversight of nonparticipation to provide additional assurance. Limited capacity to engage with the programme of National clinical audits may impact the Trust's ability to maximise learning opportunities.

We heard of a variety of internal initiatives employed by the Trust to encourage learning, some examples include:

- Ward accreditation process to improve up standards where the accredited wards support those wards working towards accreditation.
- Patient safety bulletin.
- Patient Safety Incident Response Framework which allows scrutiny of every clinical incident.
- Clinical Risk Group
- Learning slides shared in Clinical Boards Quality Oversight Groups

There are also communication channels for sharing learning, for example, Roadshows and patient safety meetings and a ward sister in one area has developed a Blog to share learning with staff.

KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?

CQC Arrangements

In response to the 2024 CQC report, an action plan was developed in collaboration with services to ensure actions to be realistic and relevant. The service specific actions were shared with staff and progress in addressing actions was reviewed at a fortnightly CQC Quality Delivery Group

A compliance review was completed of the original action plan by internal audit which received substantial assurance that arrangements provided evidence actions had been implemented and evidence to demonstrate they had been appropriately addressed.

Phase 1 of the action plan has now been closed, and Phase 2 is focused on ensuring actions remain sustained and embedded. We were told it was anticipated a further action plan would evolve to incorporate actions to address further learning associated with external reviews or incidents

A Peer Review Process has been developed that is monitored centrally. These arrangements provide additional assurance improvement is being embedded and sustained and allows timely identification of slippage. The Clinical Boards are provided with an overview of compliance following a Peer Review and areas for further improvement that they monitor through the Clinical Boards Quality Oversight Group.

We heard examples within the Clinical Boards of improvements being shared within the services such as the work to improve Paediatric Early Warning Scores (PEWS) and the sharing of this learning with the specialist services who treat children e.g. Cardio thoracic Board and Dental services.

8.4 Staff are encouraged to use information and regularly take time out to review individual and team objectives, processes and performance. This is used to make improvements.

The observation and interviews with the Clinical Boards indicated that leaders of the Clinical Boards have access to appropriate sufficient, accurate, and timely data that informs the day-to-day decision making. As noted under KLOE6, there are some operational barriers to front-line staff accessing data in a timely way. It was reported that developments to further improve oversight are on-going with the increased utilisation of the IN-Phase tool and the development and introduction of dashboards at a service level such as the Freedom to Speak Up dashboard. However, it was acknowledged access will be strengthened with further digital investment such as the work to further develop IN Phase so it can triangulate risk, incidents, complaints, audit results and external inspections.

Following incidents a rapid quality and safety peer reviews are undertaken and reported back to the Quality Committee. These arrangements provide individuals or ward teams an opportunity to review their processes and performance and consider areas for future improvement or development, it can also provide quality assurance of arrangements in place at the time of the incident.

KLOE 8: Are there robust systems and processes for learning, continuous improvement and innovation?

8.5 There are organisational systems to support improvement and innovation work, including staff objectives, rewards, data systems and ways of sharing improvement work.

The Trust has a range of systems to promote improvement. Key to this is the "Accrediting Excellence" (ACE) program for wards and departments. This was launched in 2024 and is a six-step assessment of clinical areas that focuses on quality of care and continuous improvement in patient outcomes. It is designed to support staff to take pride in their work and to recognise and celebrate the care delivered. It is reported to have been positively received by staff in the Board Visibility Report in September 2025.

Staff recognition and reward is proactively promoted by the Trust and there are individual recognition rewards awarded by the Trust such as :

Celebrating Excellence Awards: that are have a dedicated page on the Trust's website and includes categories such as:

- Team of the Year
- Quality Improvement and Patient Safety
- Unsung Hero Award (Support and Corporate Services)
- Clinician of the Year; and
- Innovation, Transformation and Research award which in 2025 by the AI work to improve the identification and management of thromboembolism

People at our Heart Awards: This is a separate program from the main "Celebrating Excellence" awards but also recognises staff and help to identify and celebrate colleagues who are considered to best represent the Trust values The judging panel is made up of clinical and non-clinical staff, patient and governor representatives each quarter.

We were told innovation projects had previously been fed back to the Quality Committee but are now being reported separately to Board.

Some Executives considered more work is needed to support innovation and, as set out above, it is recognised that there the arrangements to embed trust wide learning arrangements need strengthening as indicated in the recent internal staff survey that highlights the need for better development opportunities for ENT nurse practitioners, particularly in relation to their link with ENT outpatient services.

Environmental sustainability

9.1 - The trust's leaders demonstrate a commitment to environmental sustainability. The trust has appropriate governance and support from leaders, with a board member who is responsible for approving and delivering their net zero targets and Green Plan. These targets are also represented in the Integrated Care Board Green Plan.

Leadership

The Trust has demonstrated a clear commitment to environmental sustainability at a leadership level. In 2019, it was the first healthcare organisation globally to declare a climate emergency. Environmental progress is reviewed twice a year at board level, indicating that sustainability is embedded within the Trust's governance structures. The confirmed that he has an environmental professional in place to support the delivery of this agenda, further reinforcing the Trust's commitment.

The Trust's Executive Director of Operations is the Board level sponsor for the Trust's Net Zero agenda, and we understand this agenda will be co-sponsored in future by the Director of Estates, Facilities and Strategic Partnerships. The Trust's work is led by a dedicated Associate Director for Sustainability, who has relevant professional expertise.

Strategy and Governance

The Trust has a Green Plan in place covering the period to 2026 and has established a Sustainable Healthcare in Newcastle (SHINE) group which has an annual strategy, renewed by the Board. The Trust's Executive Director of Operations is the Board level sponsor for the Trust's Net Zero agenda, and we understand this agenda will be co-sponsored in future by the Director of Estates, Facilities and Strategic Partnerships. The Trust's work is led by a dedicated Associate Director for Sustainability, who has relevant professional expertise.

While the Trust is performing well in areas such as energy and waste, transport remains a challenge. One issue identified is the low cost of parking at the hospital, which may discourage staff and visitors from choosing more sustainable travel options. The presence of green champions within the organisation supports the governance framework by promoting sustainability across operational teams.

9.2 - The trust can demonstrate that it has taken all reasonable steps to minimise the adverse impact of climate change on health. It does this through processes and interventions to simultaneously improve patient care and reduce carbon emissions and environmental harm, while tracking their progress. The trust communicates these actions to its workforce, patients and partners in the system.

The Trust has integrated sustainability considerations into its clinical pathways, such as the removal of single-use plastics from perinatal and postnatal care. Beyond system wide initiatives within the Trust, there are local level initiatives in place within the Trust. For example:

- The Green Endoscopy Group has made several changes to reduce environmental impact. They have stopped using plastic bags for patients' clothing and have introduced reusable baskets instead. The group has also replaced single-use plastic valve baskets with reusable metal baskets. Furthermore, they are exploring the possibility of switching from Entonox to Pentorex, which may help reduce the use of environmentally harmful medical gases.
- A Theatre Sustainability Group has been established to lead improvements in operating theatre practices, focusing on reducing waste and promoting greener alternatives.
- In the ENT department, the team is transitioning away from Tristel wipes and chemical sterilisation methods, moving towards the use of Sterad cleaning systems, which are more environmentally friendly.
- The Trust is also promoting the use of PEP and teleclinics, which help reduce paper usage and minimise travel, contributing to a lower carbon footprint.

9.3 - The trust makes its workforce aware of their individual carbon footprint in the context of their role and enables and supports them to reduce this.

Staff awareness of environmental sustainability is supported through the use of Green Champions, who help promote understanding and engagement across the workforce. Recent reporting indicates that there are now over 1,000 Green Champions. Environmental progress is reviewed at board level, with sustainability included in the IBR.

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Agenda item A2(c)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 January 2026					
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. This report provides an overview of the findings from seventeen walkabouts by Non-Executive Directors (n=9) and Executive Directors (n=8) undertaken throughout November and December 2025. An evaluation, via survey, is currently underway to evaluate the outcomes and effectiveness of the Board Visibility Programme.					
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	Focus on Fundamentals - Deliver high quality, safe and compassionate patient care, meet our Clinical Board and Trust quality priorities. Make it better for colleagues - 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]	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 Board Visibility Programme Report was presented to the Trust Board in November 2025.					

BOARD VISIBILITY PROGRAMME

1. INTRODUCTION

This report provides an overview of the findings from the seventeen walkabouts by Executive Directors (n=8) and Non-Executive Directors (NEDs) (n=9) undertaken during November and December 2025.

Since 2023, Non-Executive Directors 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, supported by the Quality and Safety Department.

2. PROCESS

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

Stream 1 [Leadership Walkabouts]: Executive Team members and senior managers from the Quality and Safety Department participate in a one-hour joint visit to a pre-defined clinical or corporate 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 seventeen walkabouts undertaken at the Royal Victoria Infirmary (RVI), Freeman Hospital (FH), and community sites throughout November and December 2025. Eight walkabouts were carried out by Executive Directors as part of stream one and nine walkabouts were carried out by Non-Executive Directors 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	Birthing Centre	RVI	Director of Quality and Safety, Clinical Effectiveness Advisor	Band 6 midwife (shift lead), maternity support worker, domestic assistant, band 7 senior sister, band 5 midwife
	Institute of Human Genetics	Centre for Life	Chief Experience Officer, Patient Safety Manager	Head of laboratory, consultant clinical geneticist, business manager, clinical scientists, admin support
	Renal Services and Outpatients	FH	Director of Estates, Facilities and Strategic Partnerships, Health, Safety and Risk Lead	Senior sister, charge nurse, matron, consultant nephrologist
	Plastics Outpatients	RVI	Director of Communications and Corporate Affairs, Head of Risk, Compliance and Assurance	Sister, nurse specialist, physiotherapist, reception staff
	Same Day Urgent Response Team/Frailty Force	Community	Director of Finance, Integrated Governance Manager – Patient Safety	Head of Nursing, administration staff, call handlers, staff nurse, physiotherapist, team lead
	Ward 15	RVI	Director of Improvement and Delivery, Clinical Effectiveness Advisor	Sister, staff nurse, healthcare assistants, student physiotherapist
	Ward 20	RVI	Director of Pharmacy, Quality Development Manager	Healthcare assistant, staff nurse, sister, domestic
	Ward 31	RVI	Director of Quality and Safety Head of Quality Assurance and Clinical Effectiveness	Senior sister, band 5 staff nurses, student nurse, healthcare assistants, ward clerk, housekeeper, physiotherapist
	Sterile Services	FH	Non-Executive Director	Operational service manager, deputy manager, sterile services technician, housekeeper
	Outpatients	RVI	Non-Executive Director	Outpatient manager, sister, others not specified
	Ward 30 and 48	RVI	Non-Executive Director	Operational service manager, deputy

Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
Stream Two				matron, sister/charge nurse
	Outpatients	FH	Non-Executive Director	General manager, assistant operational service manager, matron, sister, staff nurse, assistant medical records manager, administration team, volunteer
	Catering	FH	Non-Executive Director	Chef, assistant chef, assistant manager, deputy manager
	Community Heart Failure Team	Arthurs Hill	Non-Executive Director	Nursing team band 6 and 7, administrative team
	Paediatric Theatre	FH	Non-Executive Director	Consultant anaesthetist, surgeon, fellow, nursing staff, perfusionist, recovery team, housekeeper
	Community Services	The Curve	Non- Executive Director	Matron, head of nursing, team lead
	Cancer and Haematology	Cumbria Cancer Centre	Non- Executive Director	Director of operations, therapeutic radiography team, administrative manager, receptionist, senior chemotherapy nurse

Key themes identified include:

- Overall staff enjoy their jobs. They are proud of the work they do and proud to work for the Trust.
- Staff feel supported and confident to raise concerns.
- Staff are eager access development opportunities within their roles.
- Staff are enthusiastic about the Accrediting Excellence (ACE) programme.
- All area's visited gave a warm welcome and patient care was a priority.
- Reports of incivility were received in some areas. These were acted on during the visit.
- Lack of space and storage remains challenging for teams. In addition to an aging estate across areas at the Freeman Hospital in particular.
- Frustration with some Trust systems was reported for example the volume of scanned documents in outpatients and the ability to send text messages to patients using SystmOne.
- There were reports of estates issues which have been reported and remain unresolved, as well as security concerns were raised in different areas.
- Patient transport issues were a concern in some areas.
- Staff were anxious in relation to winter pressures and having the right knowledge, skills and equipment to provide safe care for patients. This also extended to patients who were boarded away from their speciality ward.

Issues addressed during the visits:

- Where examples of incivility were raised the visiting Executive/Non-Executive Directors ensured that action was either underway or raised to the appropriate leadership team at the time. Advice where required, was also provided.
- Security concerns in Renal Services were escalated to the Associate Director of Estates.
- Advice was given on Ward 15 in relation to seeking advice and support for a Quality Improvement (QI) project.
- Head of Nursing (Medicine) contacted regarding communication of leadership changes at matron level.

Further action required:

Where it was identified that further action was needed following the visit, this was highlighted to the relevant Clinical Board or Corporate Services Leadership team to consider next steps. This included:

- Review progression opportunities for Healthcare Assistants such as Nursing Associate Roles.
- Investigate opportunities to improve the functionality of Trust systems such as E-Obs implementation, single label printing and text message communication with patients.
- Explore opportunities to reduce inefficiencies in areas such as room bookings and clinic cancellations.
- Reports of incivility to be reviewed and monitored.
- Review of security and safety controls for both in-hospital and community staff in areas that have reported concerns.
- Reports of delays to discharge involving patient transport, repatriation and administration to be reviewed.
- Ensure where patients are boarded away from their speciality ward that a contact number is provided for medical advice and review.

4. EVALUATION OF THE BOARD VISIBILITY PROGRAMME

In response to the Care Quality Commission inspections in 2022 to 2023 several changes were made to the Leadership Walkabout Programme, including a refocus to a Board Visibility Programme that included Non-Executive Director visits. Following the recent well-led review by Grant Thornton it has been agreed that it is important to evaluate the impact and outcome of this programme. As a result, a survey has been designed by the Trust Secretary, Director of Quality and Safety and Head of Quality Assurance and Clinical Effectiveness, to seek the views of senior leaders in relation to the programme, in addition to gathering ideas for improvements. The survey is currently in the design phase. The results and any suggested changes will be reported in future Board Visibility Programme reports.

5. RECOMMENDATION

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

Report of Rachel Carter, Director of Quality & Safety
Prepared by Fiona Gladstone, Clinical Effectiveness Advisor and Victoria Smith, Head of Quality Assurance and Clinical Effectiveness.
19 January 2026

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Agenda item A2(d)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 January 2026		
Title	Integrated Board Report		
Report of	Patrick Garner, Director of Performance & Governance Rachel Carter, Director of Quality & Safety		
Prepared by	Elliot Tame, Head of Performance		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	This paper is to provide assurance to the Board of Directors on the Trust's performance against key indicators relating to Quality & Safety, Access, People and Finance. **Quality** • Methicillin-susceptible staphylococcus aureus (MSSA) increased in October (13 v 9) compared to the previous month, but the rate remains within the parameters of common cause variation. An Infection Prevention and Control (IPC) improvement group has been established to provide oversight and reports to the Quality Committee. • Klebsiella cases have moved from showing special cause variation of a concerning nature (high) to common cause variation. The Surgery and Associated Specialties (SAS) Board is reviewing hepatobiliary infections associated with Gram-Negative Bloodstream Infections (GNBSI), focusing particularly on post-ERCP pancreatitis. The Assessment Suite at the Royal Victoria Infirmary (RVI) has also shown great improvement in in stool documentation. **Performance** • November 2025 witnessed a further decrease in >52-week waiters at Newcastle Hospitals, falling to 966 (-46). The number of >65 week waits also decreased to 49 (-7). The total waiting list size decreased significantly in November, to 86,575 (-2,719). • In November, the 80% 28 Faster Diagnosis Standard (FDS) target was not achieved (65.6%) and shows a sustained decline. 31-day performance remains stable at 92.0% in November, whilst 62-day performance continues to show special cause variation of an improving nature (71.5% for November). Work is ongoing with the Northern Cancer Alliance to facilitate development of a regional plans for skin services going forward. **People** • Short-term sickness has moved from showing special cause variation of a concerning nature (high) to common cause variation. • Turnover has moved from showing special cause variation of an improving nature (low) to common cause variation.		

<table>
<tr><td></td><td colspan="6">Finance
At month 8 the Trust is reporting a £0.6m deficit which is in line with the plan, however in delivering this position, the Trust has had to bring forward technical savings to offset new pressures and under delivery of the Cost Improvement Programme (CIP).
The CIP of £106m is phased over the year with a plan of £61.7m to month 8. Year to date Clinical Boards and Corporate Services have delivered £26.9m (of which £23.7m is recurrent). A further £6m of other CIP has been actioned as well as £29m of non-recurrent technical measures which is £10m more than planned for and required as a result of slippage on CIP plans including the impact of the subsidiary company.</td></tr>
<tr><td>Recommendation</td><td colspan="6">For assurance.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Focus on Fundamentals – Improve performance, cancer, diagnostics and emergency care; and Deliver high quality, safe and compassionate patient care, meet out Clinical Board and Trust Quality Priorities.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
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<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">6.2 Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">This is a regular paper provided to Trust Board.</td></tr>
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Agenda item A2(d)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

January 2026

Healthcare at its best
with people at our heart

Contents

SPC Variation / Assurance – Changes from previous month

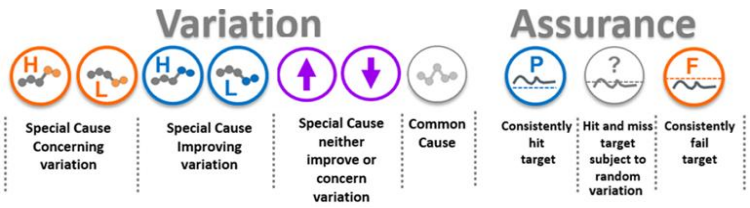
	Oct-25	Nov-25
NB2 Avoidable NBBS repeats	L	
NB2 Avoidable NBBS repeats	F	?
ED Arrival to Admission / Discharge >12 hours (Type 1)	L	
Short-term Sickness	H	
Turnover	L	

Statistical Process Control (SPC) Variation

- **Four** high level metrics have displayed changes in special cause variation from October to November 2025.
- **NB2 Avoidable Newborn Blood Spot (NBBS) repeats –** has moved from showing special cause variation of an improving nature (low) to common cause variation.
- **Emergency Department (ED) Arrival to Admission /Discharge >12 hours (Type 1) –** has moved from showing special cause variation of an improving nature (low) to common cause variation.
- **Short-term sickness –** has moved from showing special cause variation of a concerning nature (high) to common cause variation.
- **Turnover –** has moved from showing special cause variation of an improving nature (low) to common cause variation.

SPC Assurance

- **One** high level metric has displayed changes in special cause assurance from October to November 2025.
- **NB2 Avoidable NBBS repeats –** has moved from showing special cause assurance of a negative nature (consistently failing the target) to random variation in compliance.



Quality

Quality Overview

Metric	Period	Actual	Target	Variation	Assurance
HCAI - MSSA	Nov-25	11	9		
HCAI – C. Diff	Nov-25	14	11		
Harm Free Care – IP Acquired Pressure Ulcers	Nov-25	44	Sustained reduction		
Harm Free Care – Adult Patient Falls	Nov-25	220			
Stillbirths	Nov-25	3			
Blood Loss ≥1500ml (per 1,000)	Nov-25	35 per 1000			
Avoiding Term Admission into Neonatal Units ATAIN	Nov-25	9%	5%		

Health Care Acquired Infections

- Methicillin-susceptible staphylococcus aureus (MSSA) decreased in November (11 v 13) compared to the previous month, remaining within the parameters of common cause variation.
- *Clostridioides difficile (C.Diff)* Infection (CDI) cases decreased in November (14 v19), again remaining within the parameters of common cause variation.

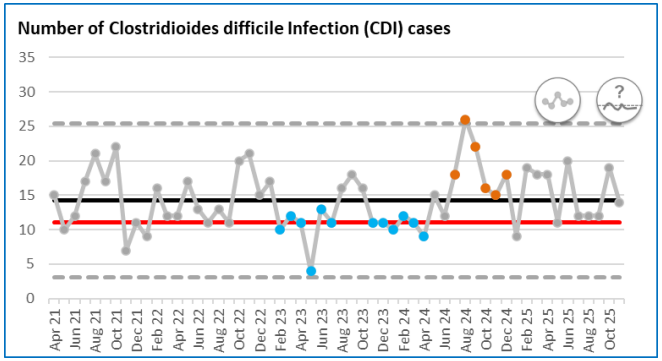
Harm Free Care

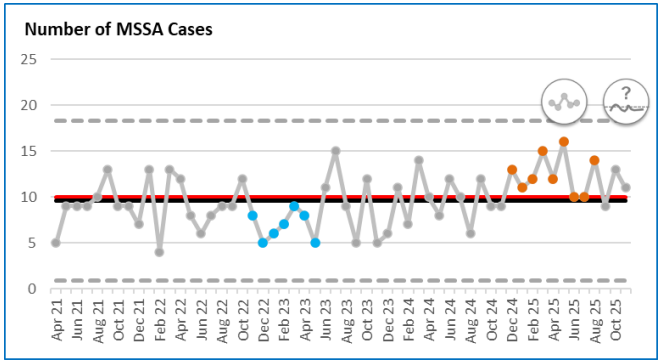
- Acute (Category 2 & above) pressure ulcers (PU) reported in November decreased (44 v 46).
- In November there was a decrease in falls (220 v 241).

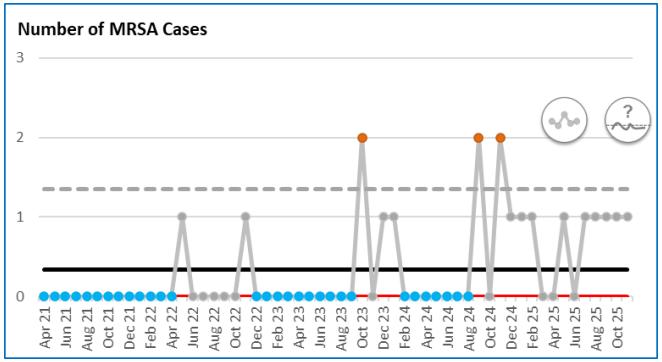
Perinatal Quality Surveillance

- There were 3 stillbirths in November 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 with 9% term admission rate in November. 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)







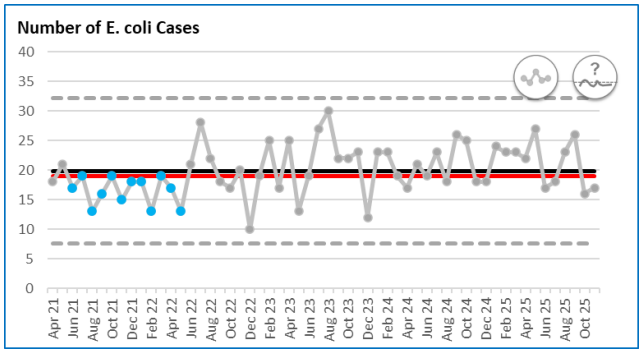
Standards

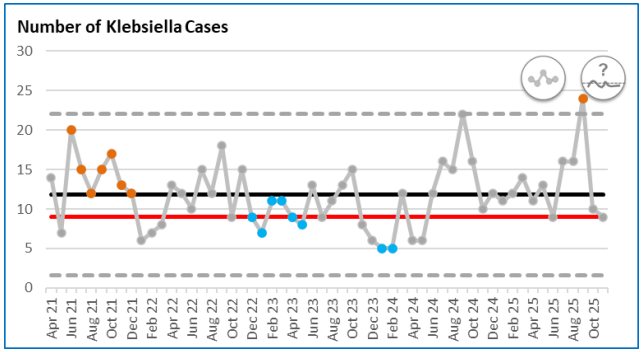
- **Zero MRSA** cases.
- **No more than 115 MSSA** cases across the financial year (local target - 10% reduction from 2024/25).
- **No more than 136 CDIs, 225 *E. coli*** cases, **108 Klebsiella** cases or **34 Pseudomonas aeruginosa** cases across the financial year.

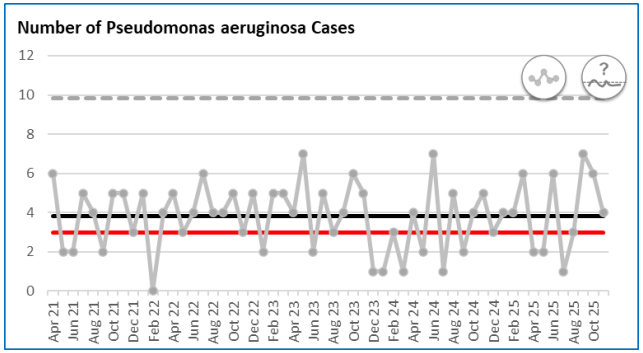
Current Position

- ***Clostridioides difficile* (CDI)** cases decreased in November (14 vs 19) but remain within the parameters of common cause variation. There were 2 Community Onset Healthcare Associated (COHA) cases and 12 Hospital Onset Healthcare Associated (HOHA) cases. Investigations are still ongoing. Identified themes for learning in previous months: delay/absence of appropriate medical reviews of patients with diarrhoea, delays in treatment administration and antibiotic stewardship.
- **Methicillin-Sensitive Staphylococcus aureus (MSSA)** cases decreased in November (11 v 13), but the rate is within common cause variation. There were 2 COHA and 9 HOHA cases. Themes identified were poor compliance with intravascular devices .
- **Methicillin-Resistant Staphylococcus aureus (MRSA)** there was 1 case in November, bringing the financial year total to 6. Identified gaps: Admission screen completed but no screen of clinical sites taken.
- ***Escherichia coli* (*E. coli*) bacteraemia** cases increased compared to the previous month (17 vs 16). There were 3 COHA and 14 HOHA cases, with 3 HOHA cases attributed to the Hepatobiliary (HPB) service. Investigations are still ongoing.
- **Klebsiella bacteraemia** a decrease was seen (9 vs 10), with the rate remaining within common cause variation. There were 0 COHA and 9 HOHA. 5 out of the 9 cases were device related. 1 investigation showed potential intravenous line involvement.
- **Pseudomonas aeruginosa c**ases decreased (4 vs 6), 1 HOHA required investigation and was deemed unavoidable.

Healthcare Associated Infections (HCAIs) (2/2)







Action taken

- Hand Hygiene & Glove Use: An ongoing program is in place to improve hand hygiene compliance and reduce unnecessary glove use, supporting healthcare-associated infection(HCAI) reduction strategies.
- Quarterly Infection, Prevention and Control (IPC) audits continue for wards that have completed the Accrediting Excellence (ACE) Programme to provide assurance in high standards of IPC in practice.
- A new structure aligning IPC nurses to Clinical Boards has been agreed and will take effect in mid-January 2026.

Incident Management

- The IPC team is collaborating with the InPhase team to strengthen incident management processes. This aims to improve HCAI investigations, ensuring timely conclusions and effective reconciliation of themes and actions.

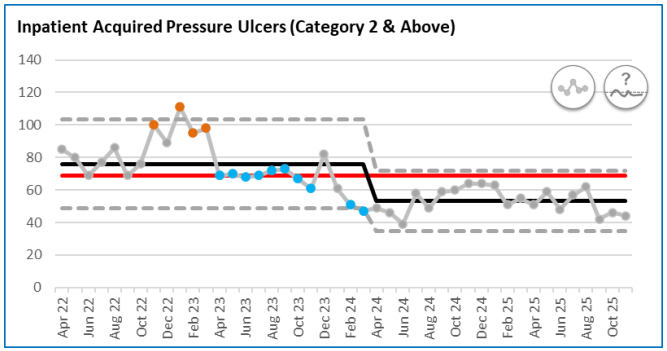
Policy and Implementation

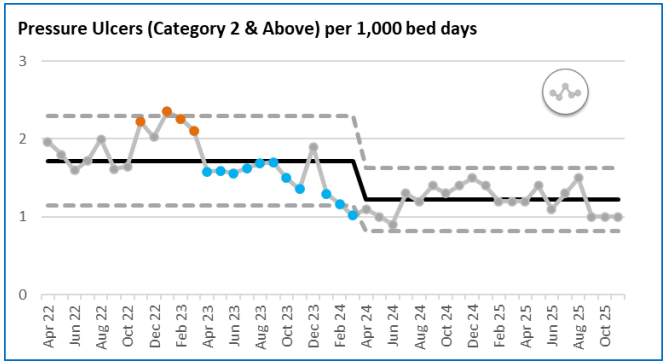
- IPC policies and guidelines are under review, and concise “Policy on a page” summaries are being developed to simplify key messages and enhance staff knowledge in IPC.
- An updated Trustwide screen saver display is being developed to highlight key IPC messages, particularly invasive device management.
- The blood culture (BC) collection policy has been finalised and ratified by the Clinical Policy Group (CPG), with implementation scheduled to begin soon.
- A new Practice Development Nurse has been appointed for IPC, with a plan to identify key areas of focus across the organisation..
- Work is underway to optimise the ICNET system for invasive device monitoring and Surgical Site Infection (SSI) surveillance.

Specific Clinical Reviews

- Targeted hand hygiene and ANTT education delivered by RVED IPC and Practice Development Nurse (PDN) teams has contributed to reducing blood culture contamination rates from **4.9% (May 2025)** to **4.3% (November 2025)**. This initiative remains ongoing, with the current goal to reduce the contamination rate to **2–3%**.

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

Reduction in Cases:

- Acute pressure ulcers (Category II and above) decreased slightly from 46 in October to 44 in November.
- The rate per 1,000 bed days has remained stable at 1.0 for the third consecutive month.
- SPC charts indicate a sustained reduction with no special cause variation.

Severity Breakdown

- No Category Intravenous (IV) pressure ulcers reported.
- Five Category III pressure ulcers reported.
- All cases are currently under investigation to identify contributory factors and learning.

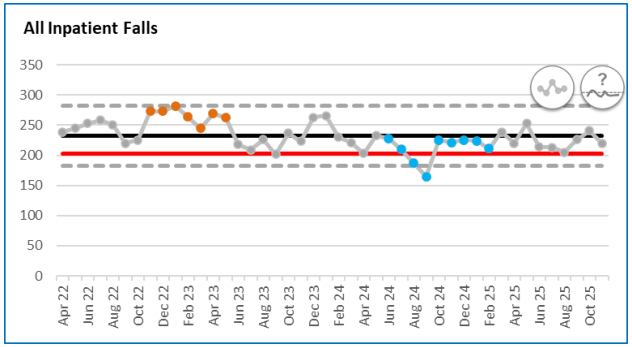
Key Areas for Improvement

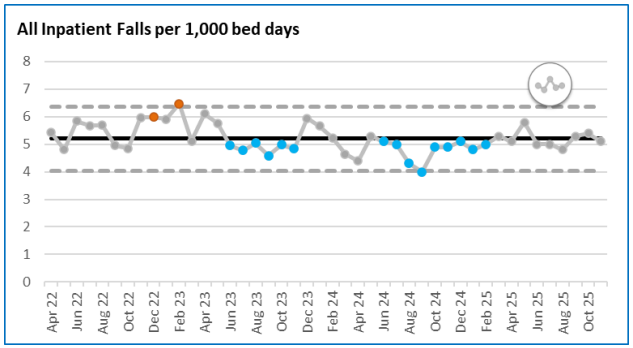
- Timely capture of images for pressure ulcer documentation
- Completion of skin and pressure ulcer risk assessments
- Completion of pressure ulcer prevention and categorisation training
- Implementation of mattress champions and regular mattress audits

Actions Taken

- World Stop Pressure Ulcer Day (20th November 2025): The Tissue Viability Team delivered multiple events, including mattress champion training and a pressure ulcer masterclass.
- Methods of Wound Debridement Training was held in November, attracting participants from both the Trust and external providers.
- The Tissue Viability Team collaborated with other Harm-Free Care teams to plan training and education initiatives for 2026.

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

- Inpatient falls reduced to 220 from 241 in October
- Falls per 1,000 bed days decreased from 5.4 to 5.1

Harm Levels

- 6 inpatient falls (3%):
  - 5 moderate harm within inpatient areas
  - 1 severe harm within inpatient areas
- Additional incidents:
  - 1 moderate harm in Medical Outpatients Department (MOPD) areas
  - 1 moderate harm in ED
  - 1 severe harm in Royal Victoria Infirmary (RVI) Building Services

Investigations

- All moderate and above harm falls investigated on InPhase via the Patient Safety Incident Response Framework (PSIRF) process
- Falls Prevention Coordinator supports teams to identify learning and implement actions
- Trust-wide themes and trends from PSIRF reviews monitored bi-annually, directly influencing improvement projects

Key Areas for Improvement

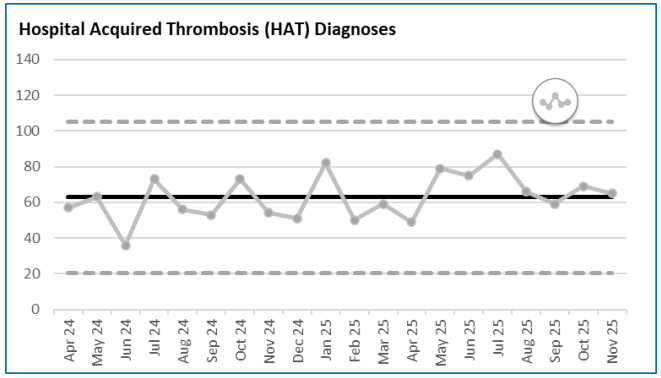
Completion of multifactorial assessment to optimise safe activity, including:

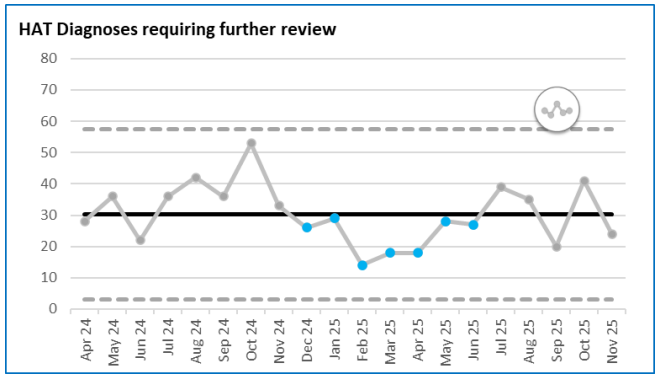
- Lying/standing blood pressure
- 4AT (Delirium screening)
- Vision checks
- Medication reviews related to falls

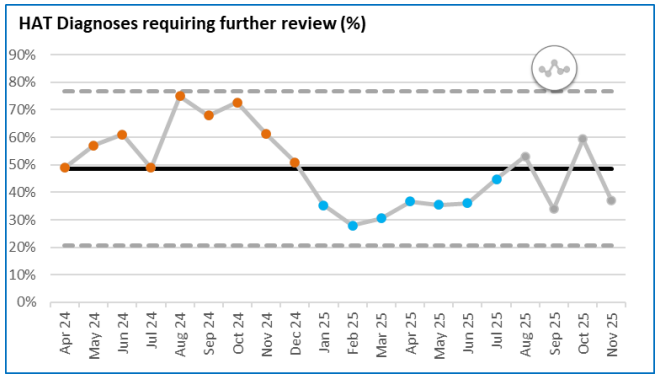
Actions Taken

- Falls Prevention Coordinator (FPC) working with Digital Team to update falls assessment, care bundle and care plan
- FPC is working in collaboration with Ophthalmology to design a Trust-specific process for vision checks
- Post-fall protocol currently under review

Harm Free Care: Hospital Acquired Thrombosis (HAT)







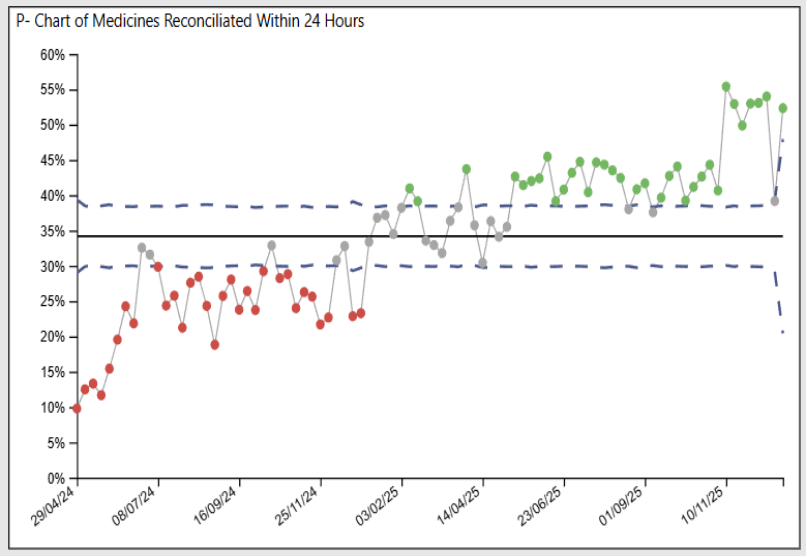
Standards

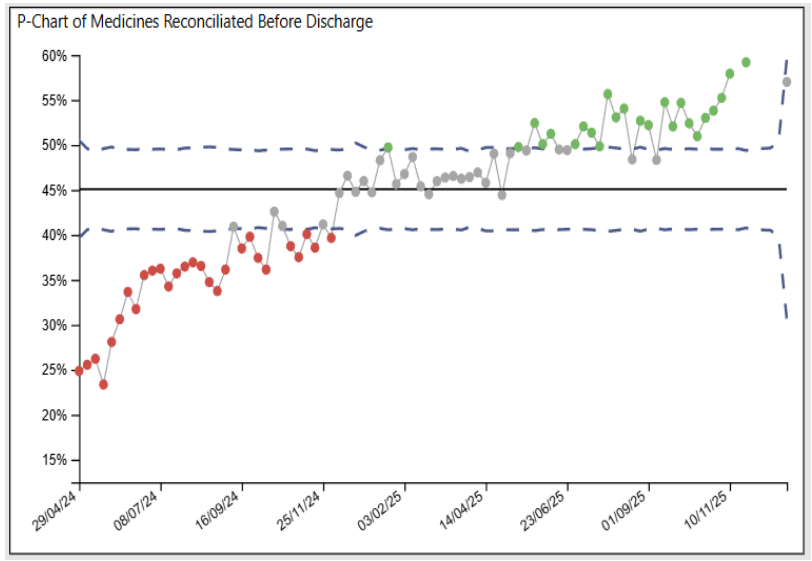
- **95%** of VTE (Venous Thromboembolism) assessments undertaken within 24 hours of admission (external target).
- **To reduce** the number of HATs (Hospital Acquired Thrombosis) for review (these are HATs that have been associated with sub-optimal VTE prevention)

Current Position

- 37% of HATs were identified as needing further review in November 2025.

Medicines Reconciliation





Standards

- Target 40% with existing staffing; 50-60% after approval of phase 1 of staffing business case; 80% after approval of phase 3 of the staffing business case

Current Position

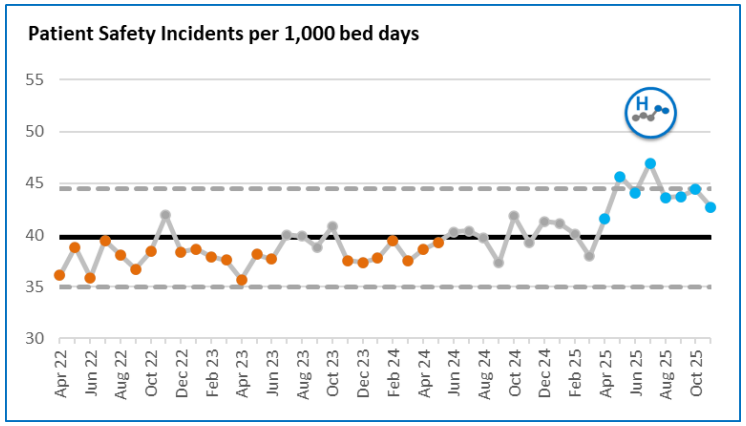
- Maintaining rates above 40% since June 2025.

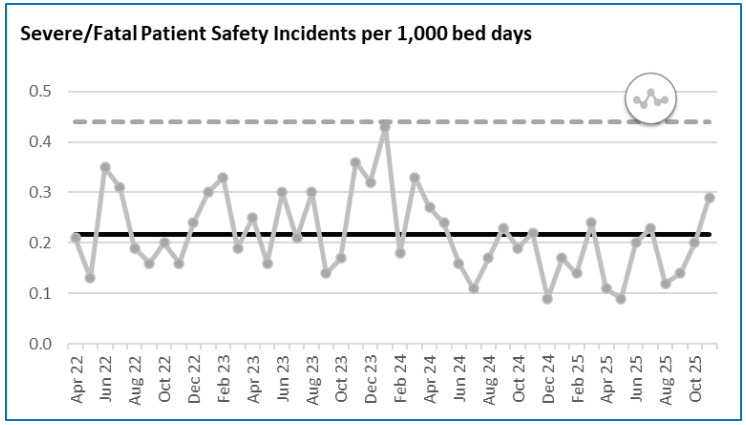
	Med rec within 24 hours Total Number / %		Total Med Rec before discharge Total Number / %	
Dec 2024	1280	**27%**	2065	46%
Jan 2025	1696	**34%**	2353	51%
Feb 2025	1718	**39%**	2103	52%
Mar 2025	1692	**34%**	2261	48%
April 2025	1811	**37%**	2305	50%
May 2025	1809	**38%**	2335	52%
June 2025	1974	**42%**	2393	54%
July 2025	2099	**43%**	2488	52%
Aug 2025	1882	**40%**	2446	52%
Sept 2025	2006	**40%**	2567	53%
Oct 2025	2064	**41%**	2681	54%
Nov 2025	2105	**49%**	2564	59%
Dec 2025	2111	**51%**	2563	61%

Action taken

- New on-call / out of hours service started 7th Nov; 1 extra person around until 10.30 at night and at weekends to support med rec out of hours
- Staff establishing in new posts approved as phase 1 in business case (Accident & Emergency, Peri-op, O&T)

Incident Reporting





Standards

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

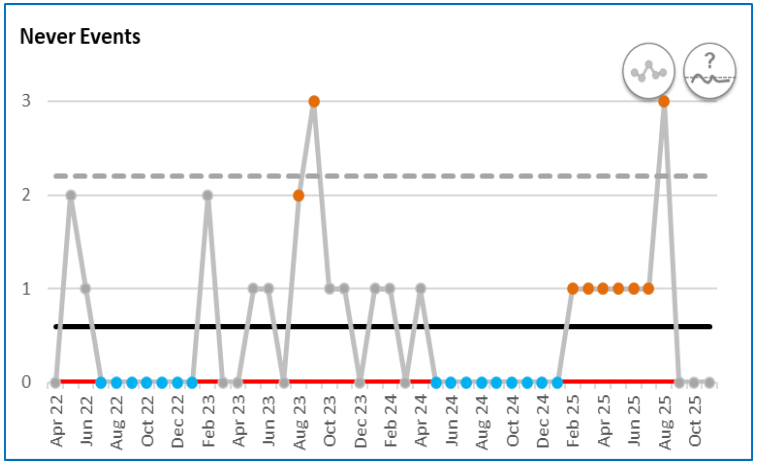
Current Position

- The total number of patient safety incidents per 1,000 bed days reported in November 2025 decreased compared to October 2025.
- The number of severe/fatal safety incidents per 1,000 bed days increased in November 2025, compared with October 2025.
- Five After Action Reviews and three Patient Safety Incident Investigations were recorded in November 2025.

Action taken

- Incident reporting dashboards are now available in the reporting hub providing daily updates to all Clinical Boards and departments on key incident reporting metrics, including incident rates.
- Raising awareness of incidents and dissemination of learning continues to through the Patient Safety Bulletin 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

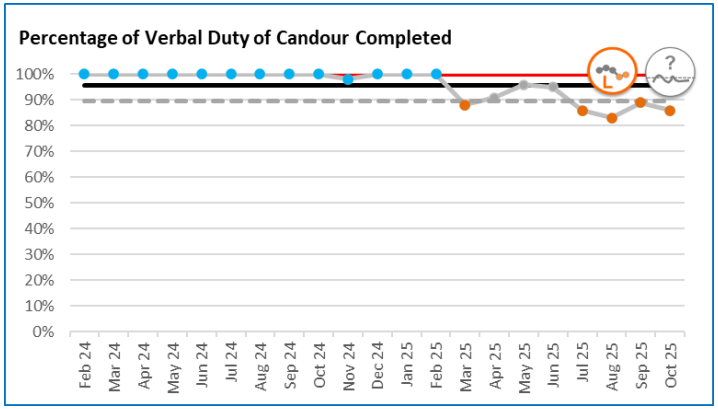
- No Never Events were recorded in November.
- A total of seven Never Events have been recorded for the 25/26 period.

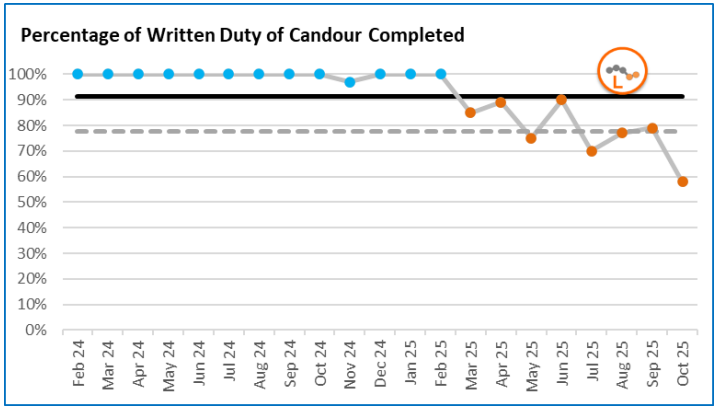
Action taken

- Trust PSRIF priority is being introduced to successfully implement National Safety Standards for Invasive Procedures (NatSSIPS2) into the organisation, led by a Project Board with dedicated resources to drive improvement.
- NatSSIPs 2, or the National Safety Standards for Invasive Procedures 2, is a set of guidelines designed to improve patient safety during invasive procedures and to reduce the occurrence of Never Events.
- A newly established Invasive Procedures Group has been introduced to strengthen the governance of invasive procedures and support the PSIRF priority.

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
August 25	8426	Surgery & Specialist Services	Orthopaedics	Wrong implant / prothesis
August 25	9458	Perio-Operative & Critical Care	Theatres	Wrong implant / prothesis
August 25	10030	Cardiothoracic	Cardiothoracic Surgery	Wrong implant / prothesis

Duty of Candour





Standards

- Statutory Duty of Candour (DoC) 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.

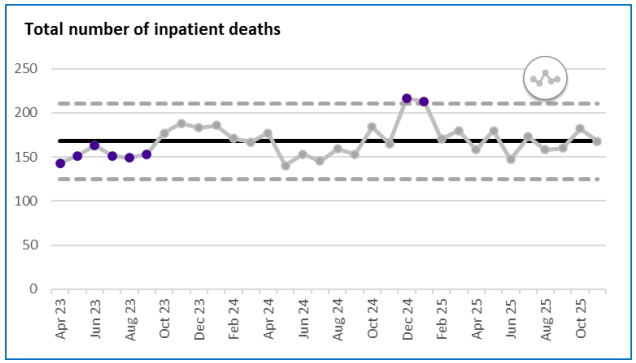
Current Position

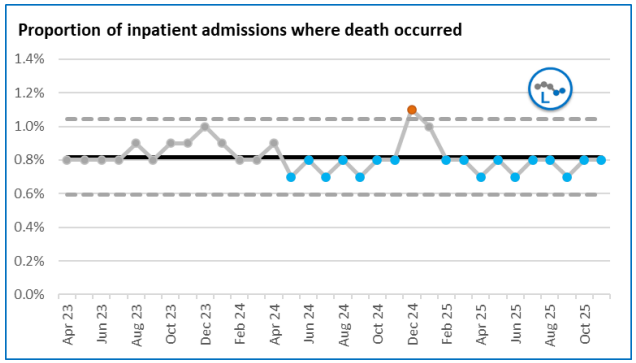
- Data for overall Trust compliance is taken from records of completion in the incident module of InPhase / Datix. Additional assurances for compliance with the statutory requirements of Regulation 20 are undertaken through audits reported to Patient Safety Group and Quality Committee.
- Audit data highlights gaps in some areas of DoC completion, including documentation of verbal discussions. Work is ongoing to support improvements in this.
- Incident reporting moved to InPhase in May 2025 and Datix was changed to read only from 14th July 2025 to allow data migration to take place. Any updates to DoC compliance for datix incidents prior to July 2025 will not be represented in the graphs until migration to InPhase has been completed.
- Compliance with verbal and written DoC was below the trust average in October. Compliance will continue to improve as incidents are reviewed, and investigations completed.

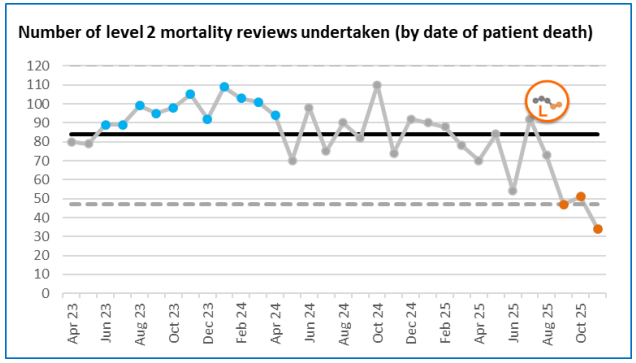
Action taken

- Ongoing work to update and reintroduce DoC compliance dashboards across the trust.
- Changes implemented to InPhase to support more accurate compliance recording.
- Continuation of newly introduced DoC quality and compliance audit to support improvements in the quality of DoC responses.

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)

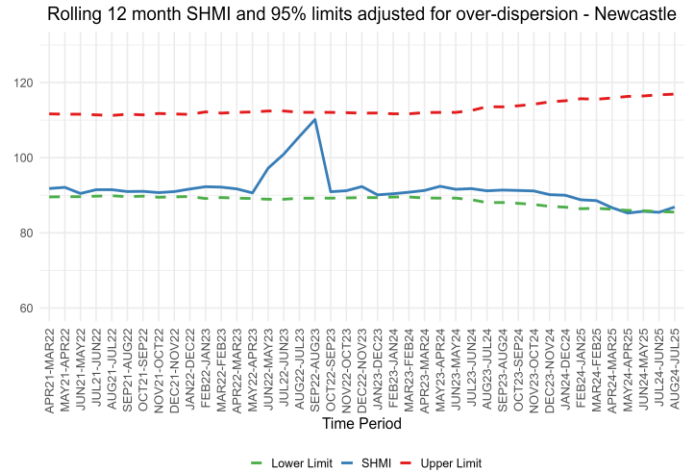
Current Position

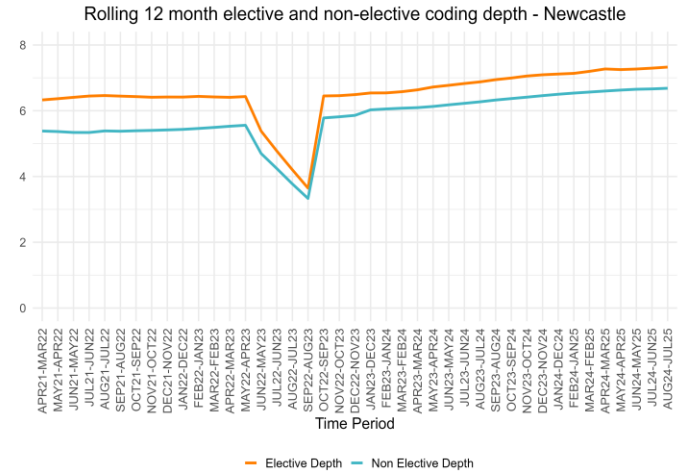
- There were 168 inpatient deaths in total reported in November 2025. This is a decrease of 14 on the previous month
- The crude mortality rate in November 2025 is 0.8%. This is unchanged from the previous month and is in line with the Trust average
- Out of the 168 inpatient deaths reported, there are 34 completed level 2 mortality reviews entered into the Trust mortality review database to date
- 55 Level 2 reviews were completed in November 2025 for patients who died prior to this date
- None of the completed reviews undertaken in November have been scored with a high HOGAN score (indicator of preventability of death) or a high National Confidential Enquiry into Patient Outcome and Death (NCEPOD) score (quality of care provided)
- Two patients with a confirmed learning disability died in November 2025

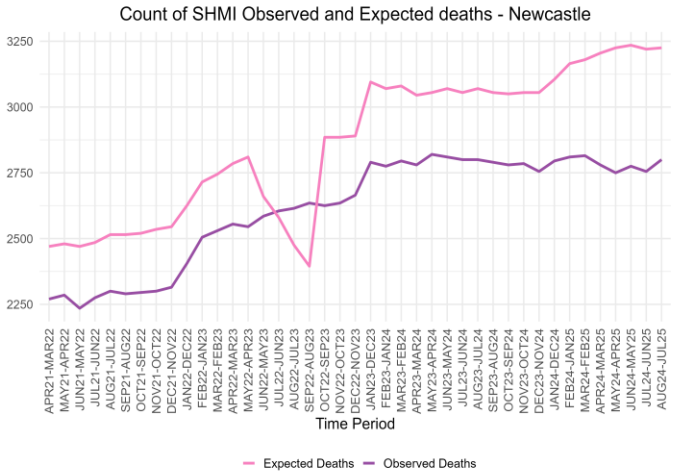
Action taken

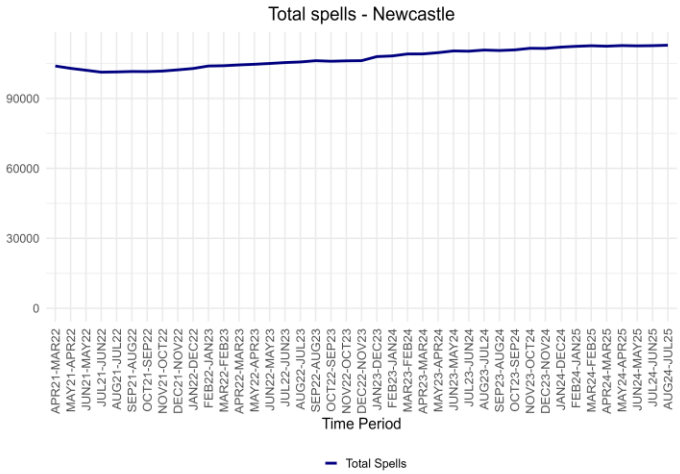
- All inpatient deaths are continually monitored
- The number of level 2 mortality reviews will rise significantly over the coming months as Morbidity and Mortality (M&M) meetings continue to take place
- Monthly reports to each Clinical Board detailing the position of outstanding mortality reviews have now been implemented

Mortality Indicators (2/2)









SHMI (Summary Hospital-level Mortality Indicator)
Within the latest published SHMI data (August 2024 – July 2025) the Trust SHMI is at 0.87. This is within the 'as expected' category.

Observed & Expected deaths Between August 2024 – July 2025, the Trust has 2,800 observed deaths and 3,225 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 6.7*.

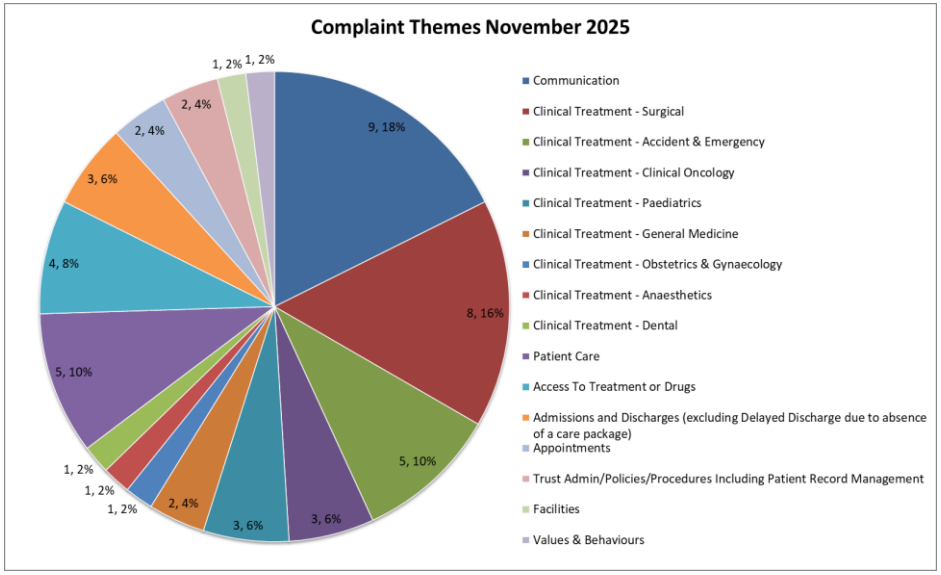
Spells with palliative code
Between August 2024 – July 2025, the Trust has a 1.8% palliative care coding rate.

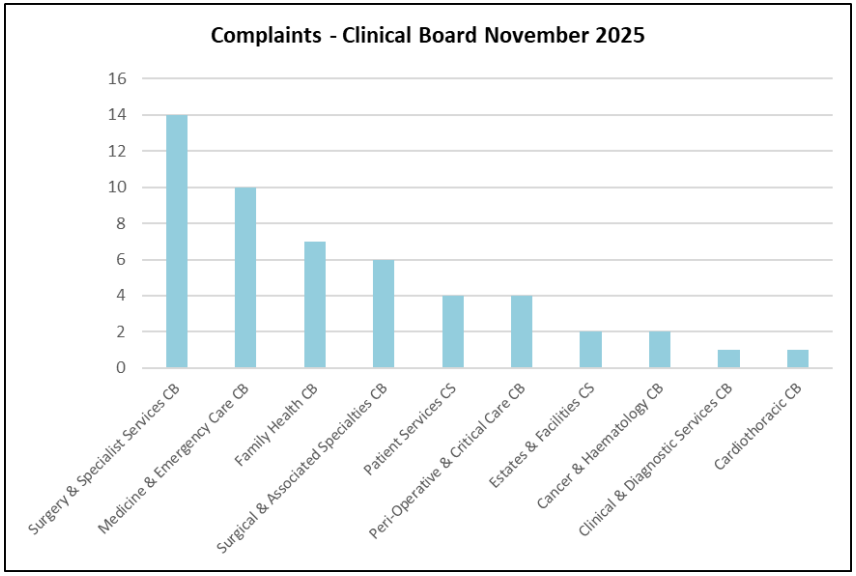
Invalid Primary Diagnosis
SHMI is calculated based on the primary diagnosis coded from admission. The Trust has a 0% invalid primary diagnosis rate, indicating excellent and timely coding accuracy.

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

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

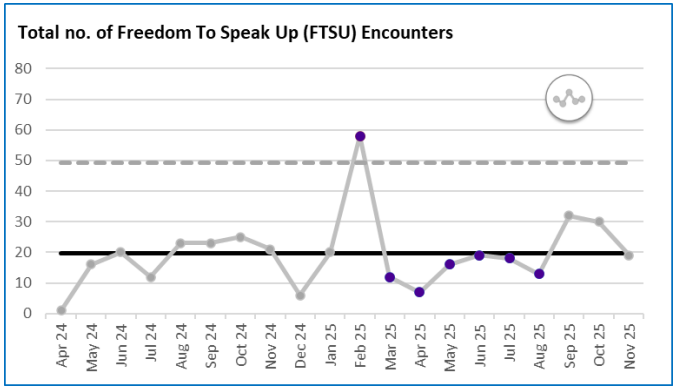
Formal Complaints





- The Trust has had 51 formal complaints In November 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 18% of the complaints (9).
- Clinical treatment accounts for the most complaints collectively across the specialties with 47% of complaints opened this month (24).
- The most complaints were opened for the following three Clinical Boards, collectively accounting for 61% of complaint this month:
    - Surgery & Specialist Services 14 (27%)
    - Medicine & Emergency Care 10 (20%)
    - Family Health 7 (14%)

Freedom to Speak Up (FTSU)



Row Labels	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Total
CB Surgery and Specialist Services RVI						16	20	4	40
CB Peri-operative and Critical Care	1	3	5	5			3	1	18
CB Clinical and Diagnostic Services			2	1	3	3	1	4	14
CB Medicine and Emergency Care						5	2	3	10
CB Clinical and Research Services	3	6							9
CB Family Health	1	2	1	1	1	1	1	1	9
CS Business Development				1	1	4	1	1	8
CB Cardiothoracic Services		1	3	1			1	1	7
(blank)			2	3	2				7
CS Estates		1	2	1	1	1			6
CB Surgical and Associated Services FH				2	3				5
CB Surgical and Specialist Services RVI		1		3	1				5
CS Information Management and Technology		1					1	2	4
CB Cancer and Haematology	1					1		1	3
CS Unknown			3						3
CS Human Resources						1		1	2
CS Chief Executive			1						1
CS Patient Services					1				1
CS Unkown		1							1
Grand Total	6	16	19	18	13	32	30	19	153

Standards

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

Current Position

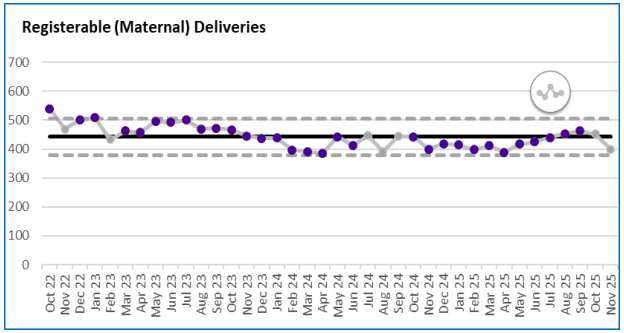
- There were a total of 19 speak up encounters made to the FTSU Guardian in November, of which 2 were as a result of the targeted staff experience work being carried out in ophthalmology (SSS).
- 3 speak ups were raised anonymously.
- The most frequently reported category of concern reported was worker quality and safety (18), followed by inappropriate attitudes and behaviours (12) bullying and harassment (10) and patient safety and quality (1). No cases of detriment, racism or sexual harassment were reported to the Guardian.
- There are currently 25 trained FTSU Champions.

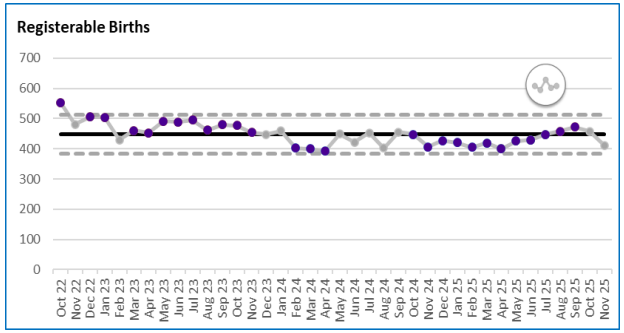
Action Taken

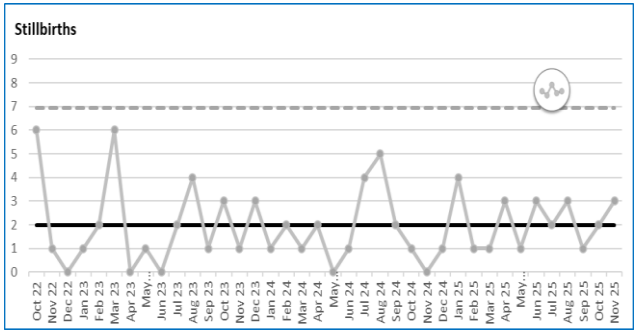
- Attendance and presentation at community engagement sessions at Molineux and Kenton.
- Informal visit to community services at Geoffrey Rhodes, including loan equipment services.
- Presented at admin managers meeting, Newcastle Hospitals critical care study day and MEC clinical leaders forum.
- Attended first meeting with other FTSUG in the Great North Alliance – learning in relation to service development shared and peer support given.
- Adhoc meetings with Execs to escalate concerns where appropriate.
- Guidance and support for managers to help resolve staff issues.
- Ongoing champion recruitment.
- HR concerns escalated directly to Head of Workforce Advisory Service where appropriate.

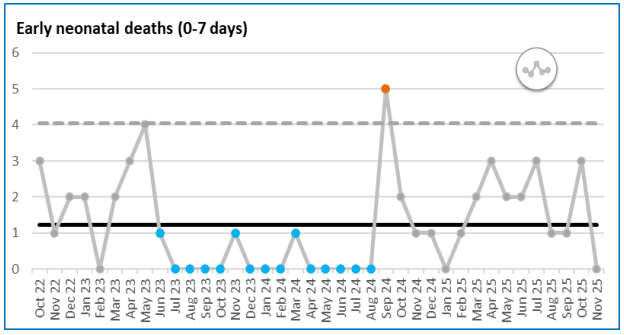
Row Labels	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Total
Inappropriate behaviour and attitudes		2	5	10	4	13	6	8	48
Worker safety and quality		4	2	5	7	11	10	1	40
Bullying and harassment	2	3	3	1	1	6	13	9	38
Poor management	2	5	5						12
Patient safety and quality	2	1	1			2	1	1	8
(blank)			2	2	1				5
Civility		1							1
Disadvantageous demeaning treatment as a result of speaking up			1						1
Grand Total	6	16	19	18	13	32	30	19	153

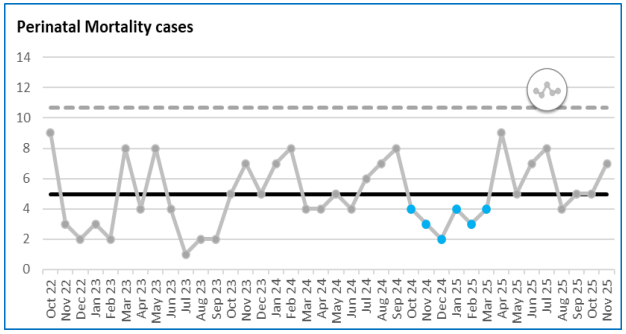
Perinatal Quality Oversight: Births











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 North-East, saw a decline in live births, the overall increase in births has been 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 in development to increase booking numbers.

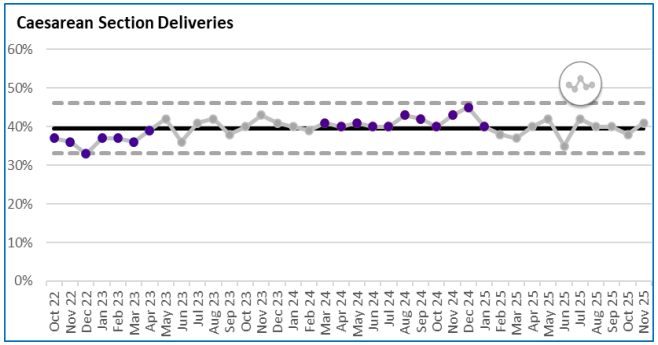
Stillbirths

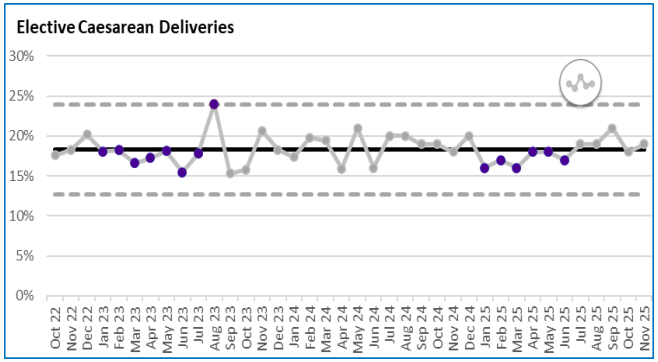
- This data includes termination for fetal anomalies >24 weeks gestation. There were three stillbirths in November 2025. Two cases meet the criteria for review using the Perinatal Mortality Review Tool (PMRT) process. The Trust has triggered a safety alert for the number of stillbirths on the Clinical 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. (Average per 1000 births: England 3.2, North East and North Cumbria (NENC) 3.6).

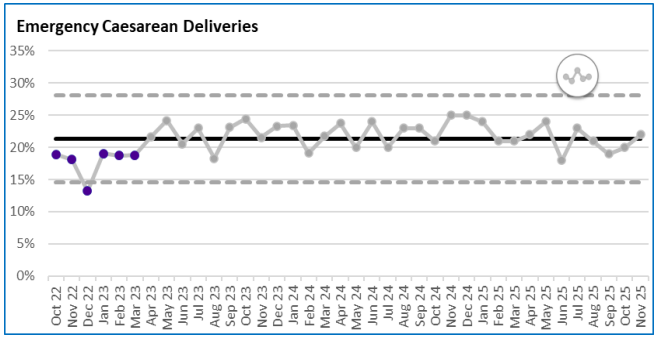
Early Neonatal Deaths

- The Trust has the highest level of neonatal intensive care provision supporting extremely premature babies. These deaths are reported to the Child Death Review panel who will have oversight of the investigation and review process. There were no early neonatal deaths in November 2025.

Perinatal Quality Oversight: Deliveries







Caesarean section deliveries

- In England 42.9% of births are caesarean section, in the NENC for Q1 this was 43.4%. There is no defined national metric for caesarean section rates.
- The Trust Q2 average was 40.3% and Q1 average was 38.1%.
- The Trust has had a comparable caesarean section rate of 41.0% in November 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.

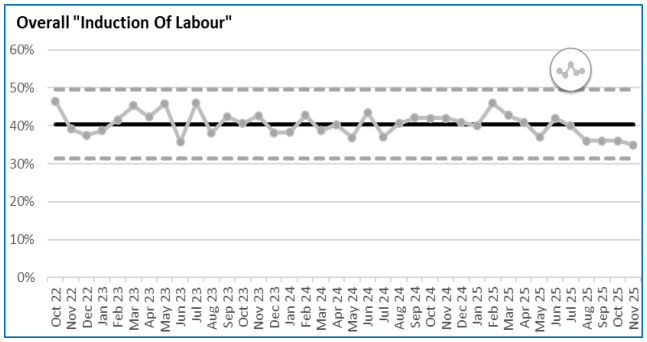
Elective Caesarean section

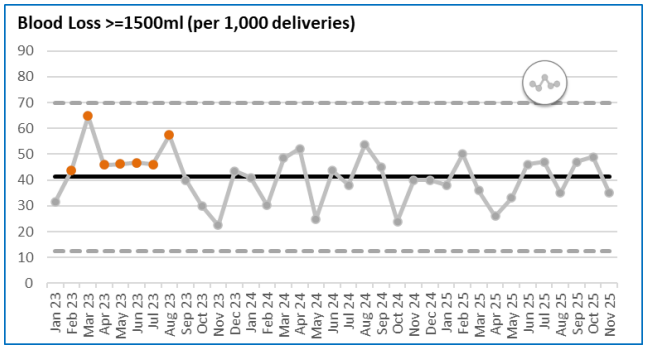
- The average England elective caesarean rate in Q1 was 19.8% and in NENC 20.2%.
- The Trust elective caesarean rate is stable at 19% in November 2025.
- The national rise in elective caesarean rates is partially due to an increasing proportion being undertaken due to maternal request in accordance with the 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.

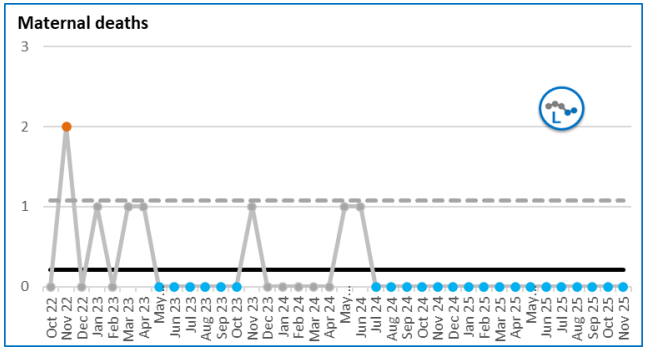
Emergency Caesarean section

- The England average for Q1 2024/25 was 23.6%, and NENC mean 20.5%
- The Trust emergency caesarean rate was 22% in November. There is dedicated consultant presence on Labour Ward 8am-10pm daily, consultant led multi-disciplinary ward rounds occur twice daily. Most obstetric consultants remain onsite overnight, from 10pm-8am and are involved with all decisions for emergency caesarean section births.

Perinatal Quality Oversight: 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 and Gynaecologists (RCOG) guidance.
- England average for induction of labour Q1 2025/26 was 29.3% and NENC 35.3%. The Trust induction of labour rate for November is 35% (stable since August). 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.

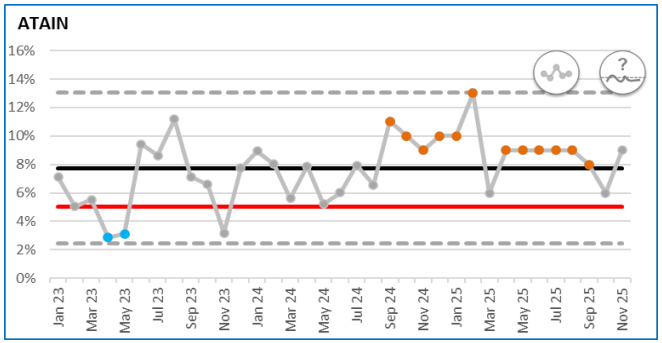
Blood Loss ≥1500ml

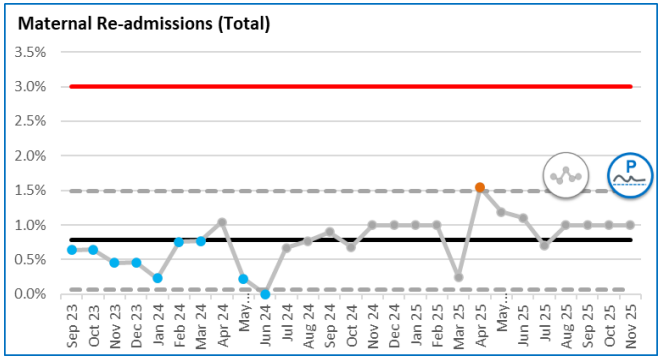
- The average Post Partum Haemorrhage (PPH) rate for Q1 2025/26 in England is 32 per 1000 and NENC average is 26 per 1000. The Trust PPH rate for November is 35 per 1000. Q1 average was 35 per 1000 and Q2 average 43 per 1000.
- Higher rates are indicative of the complexities of the high-risk patient group and provision of the Placenta Accreta Spectrum service as confirmed by the previous review.

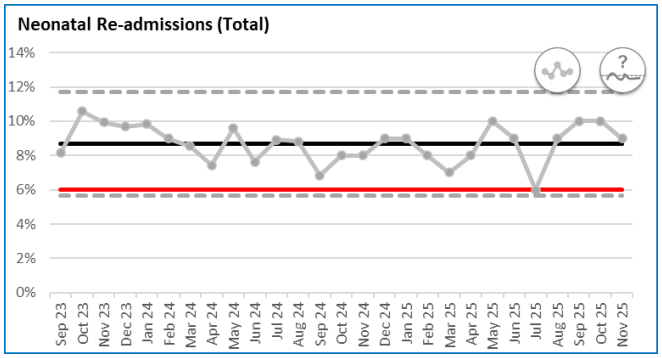
Maternal Deaths

- 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 November 2025.

Perinatal Quality Oversight: 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 November this was 9%. Three quality improvement workstreams are ongoing. 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 commenced in August 2025 and has prevented 5 admissions.

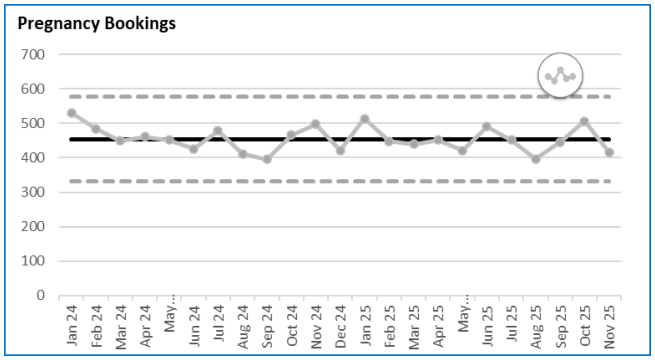
Maternal Readmissions

- National Maternity & Perinatal Audit (NMPA) Report (2025) the maternal postnatal readmission rate for England was 3.08% in 2023, rates varied by provider (Inter-Quartile Range (IQR): 2.57–5.02% in Wales; 2.14–3.59% in England). The LMNS are benchmarking against the national mean readmission rate, hence an internal target against the national average of 3% has been set. Maternal readmission rate for the Trust is consistently below the national average and has been 1% or less from June to November 2025.

Neonatal Readmissions

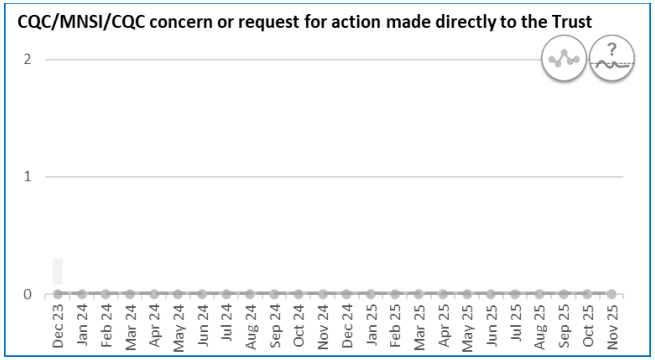
- The Clinical Quality Improvement Metrics (CQIM) for ‘Babies readmitted to hospital who were under 30 days old’ data is used as a comparison to Trust performance, hence the target of 6%.
- In November the readmission rate was 9%.
- The neonatal team are currently reviewing the management of jaundice guidance which is impacting the readmission rate and exploring the coding for the cases.

Perinatal Quality Oversight: Incidents & Bookings



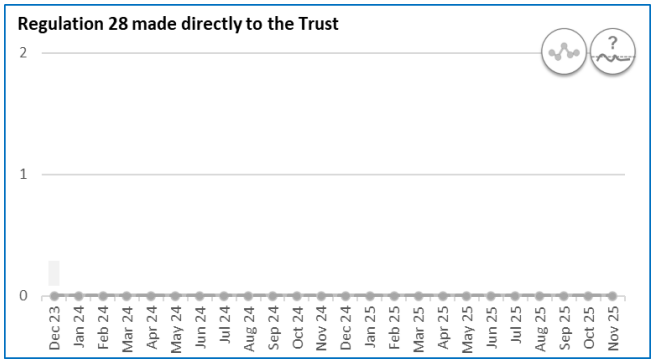
Pregnancy Bookings

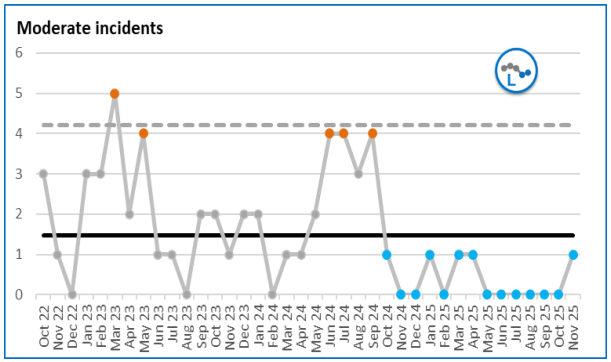
- The number of women choosing to book for care and delivery at the Trust had fallen since January 2024 and although is currently stable there has been no improvement in the number of bookings since the re-opening of the Birthing Centre. The number of bookings is a concern, and whilst reflects the reduced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

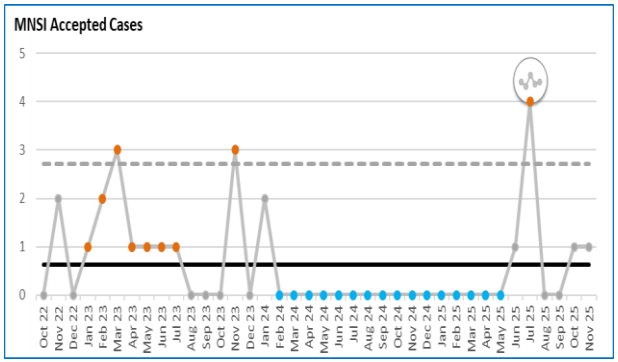


Incidents

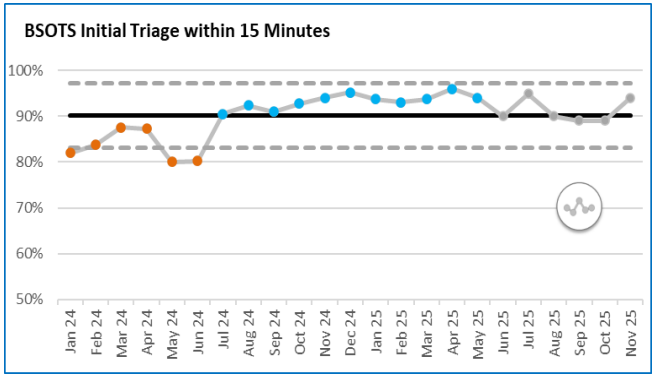
- Moderate incidents are now separated from externally reported MNSI cases which were previously grouped together. There was one moderate or above harm incident reported in November. Incidents are discussed at a multi disciplinary rapid review and presented to the Trust Response Action Review Meeting (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 two cases involving HIE in November. One case was accepted for MNSI review, the other case has not yet progressed due to lack of parental consent. MNSI reviews are usually completed within 6 months from referral.
- There have been no CQC/MNSI concerns or requests for action in the last 12 months.
- There have been no regulation 28 notices in the last 12 months.

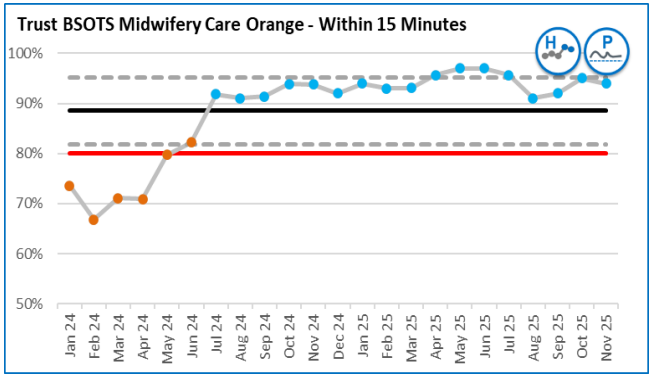


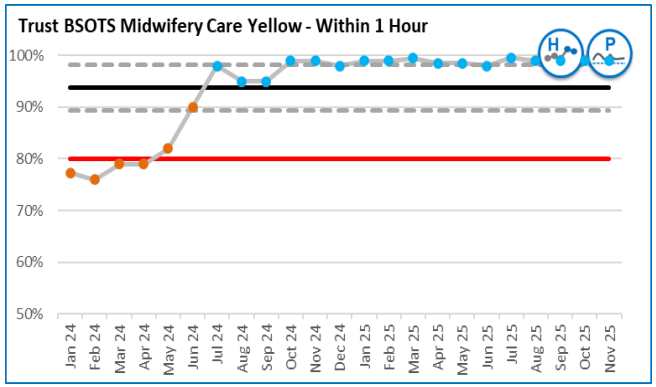


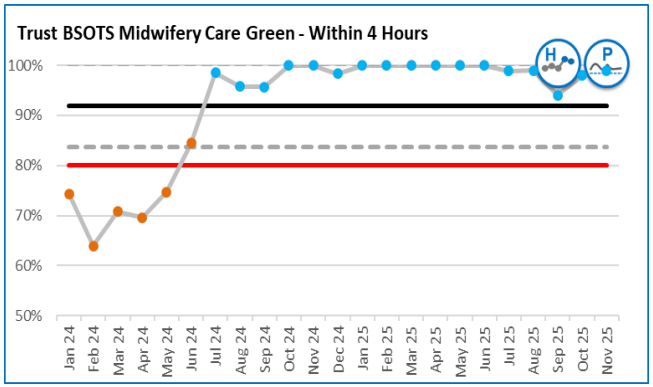


Perinatal Quality Oversight: Triage - Midwifery Care Timings





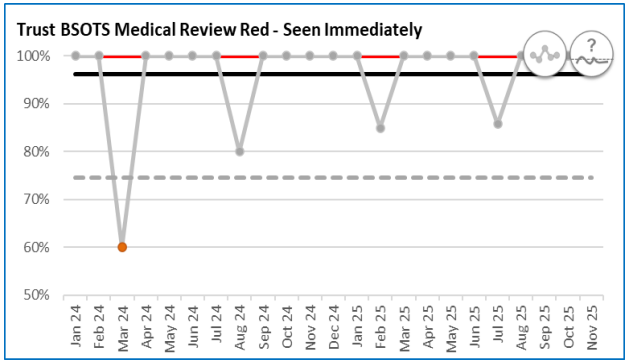


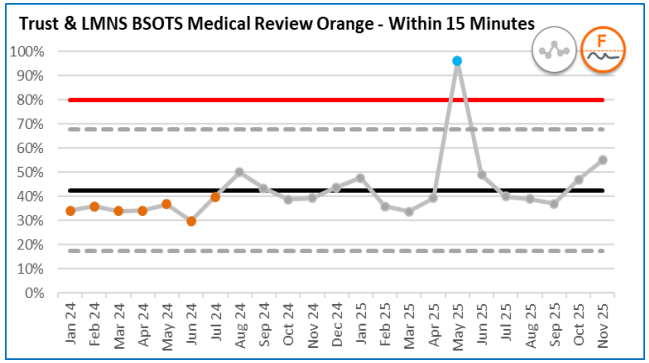


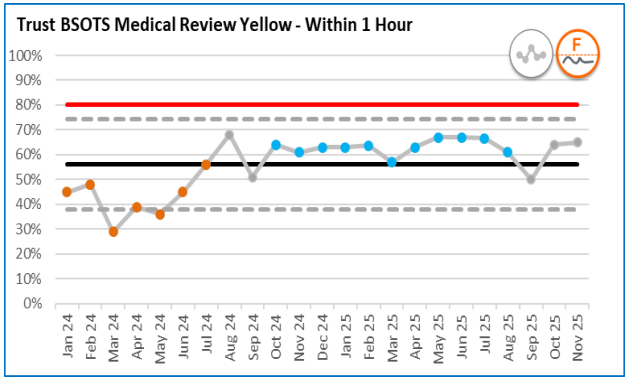
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

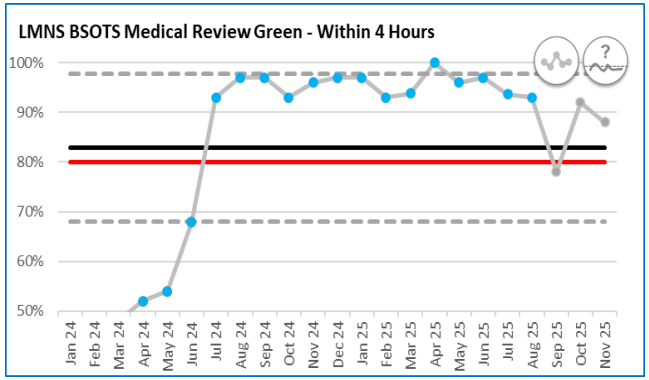
- The Trust implemented the BSOTS triage system in January 2024. Midwifery triage and subsequent review has improved considerably and has exceeded the Trust and LMNS target.
- Good performance continues to be sustained across every category for midwifery review.
- The triage within 15 minutes metric is subject to close scrutiny to monitor the impact of early pregnancy referrals from Emergency Department being supported by Maternity Assessment Unit following the cessation of the gynae overnight pathway from ED.

Perinatal Quality Oversight: Triage - Medical Review Timings





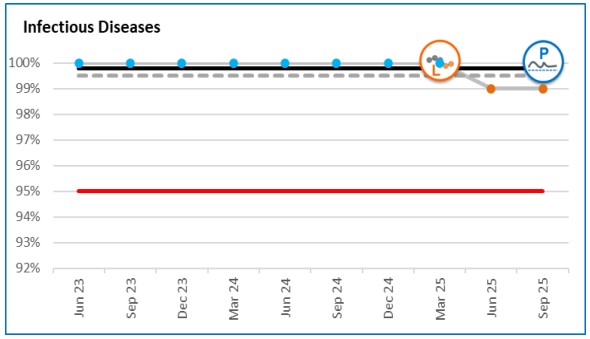


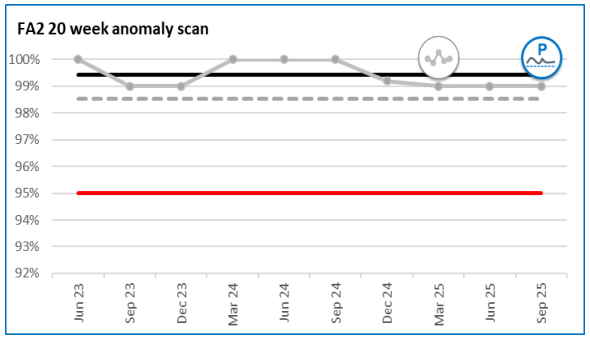


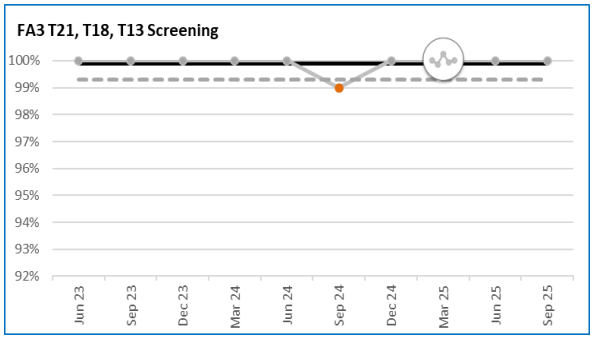
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

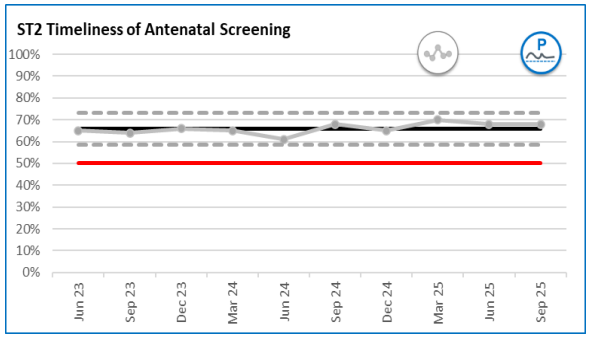
- There has been significant improvement in performance in the last 12 months.
- Unfortunately, the business case for a project to commence call recording and capturing patient experience for the triage services has been paused. This has been a safety recommendation from MNSI and PMRT investigations.
- Medical review for women in the orange category remains challenging, performance has remained at baseline level throughout Q2 2025. Further assurance regarding time interval for review, and the reason for attendance, is reviewed monthly at Q&S.

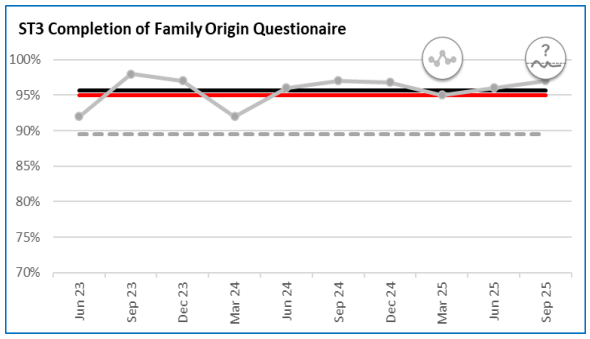
Perinatal Quality Oversight: Antenatal Screening

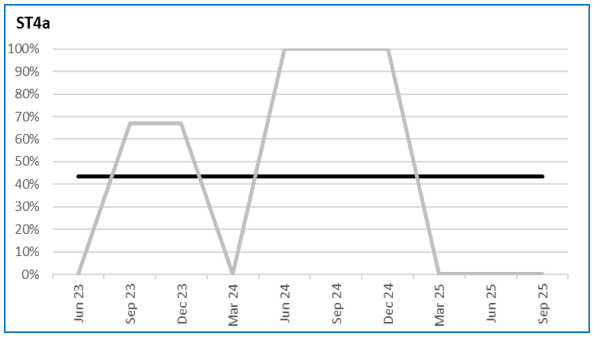


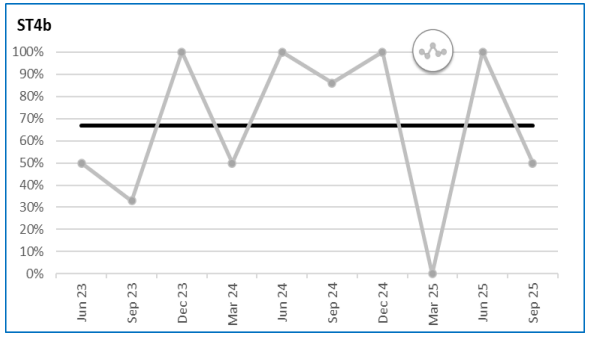


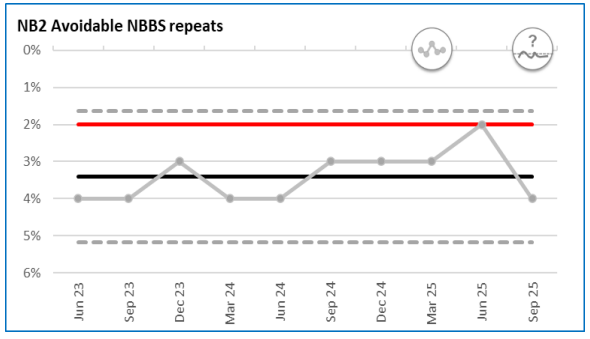








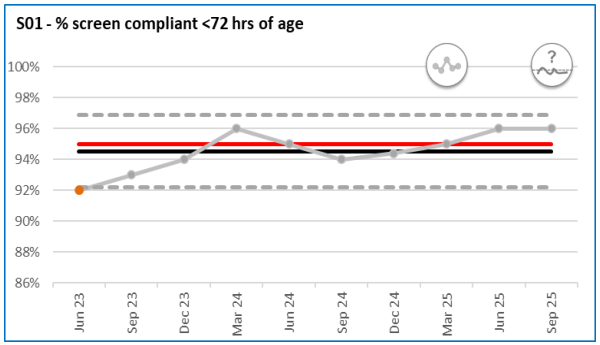


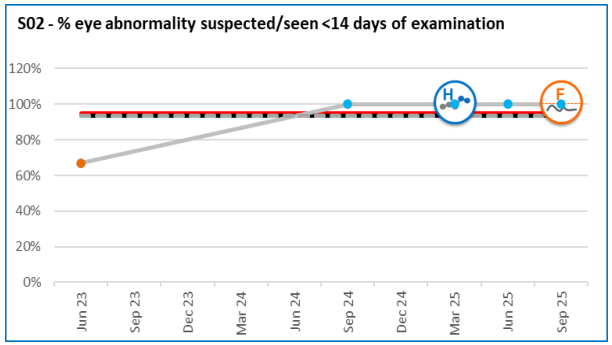


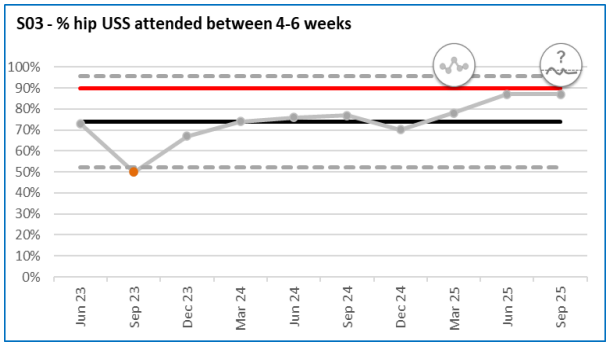
Antenatal Screening

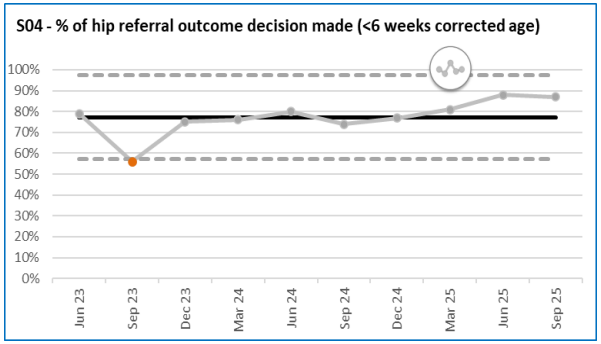
- QIP to review antenatal clinic patient flow, failsafe and administration processes is making good progress but is impacted by consultant capacity to provide cross cover.
- Improvement in newborn blood spot repeats.
- Screening tracker has been developed by analysts and deployed to support failsafe processes and reporting as per the recommendation in the patient safety incident investigation (PSII)

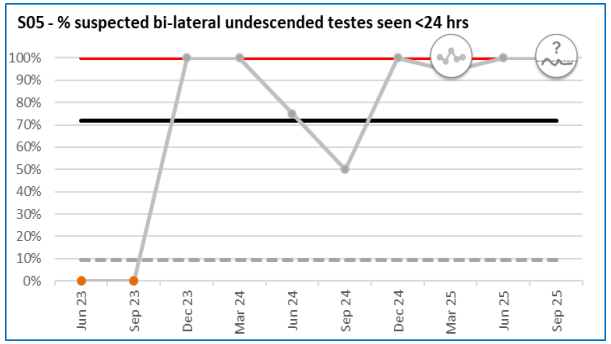
Perinatal Quality Oversight: NIPE Screening







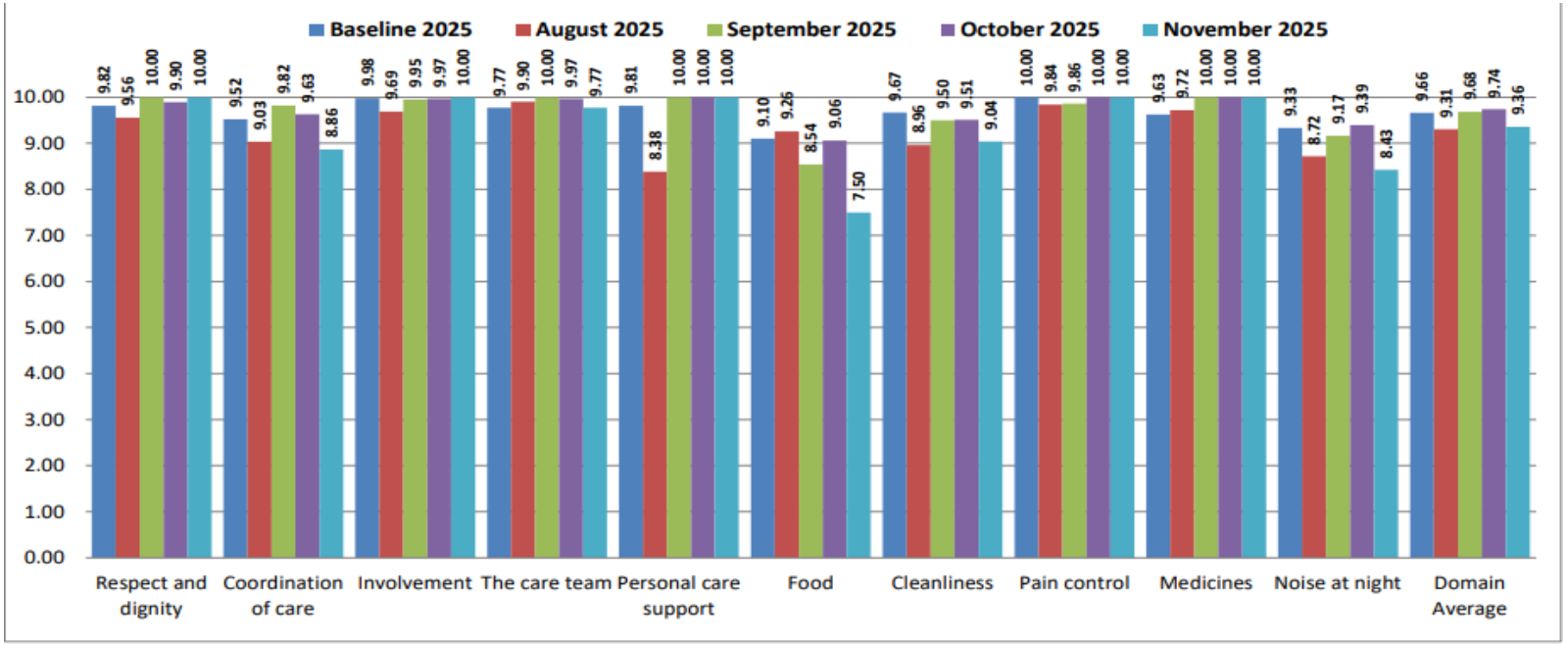




Newborn and Infant Physical Examination

- Improved performance across all elements.
- Screening tracker has been developed by analysts and deployed to support failsafe processes and reporting as per the recommendation in the patient safety incident investigation (PSII)
- Focus on hips screening has resulted in month on month improvement

Perinatal Quality Oversight: Patient Experience

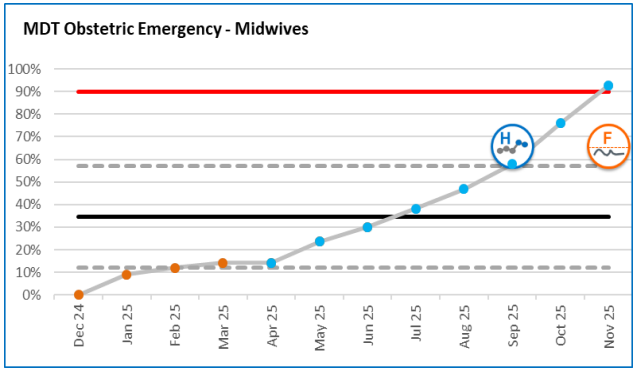


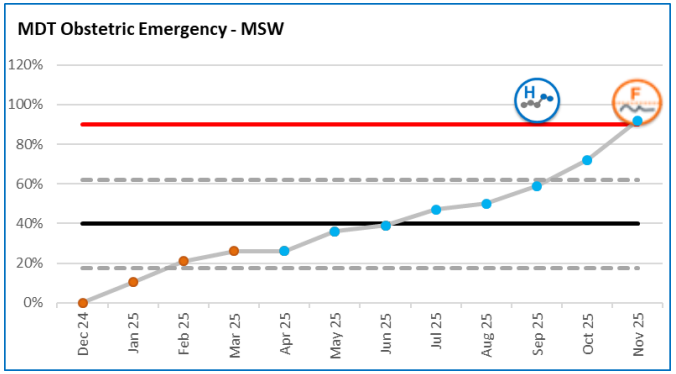
Patient perspective – Ward 33, Postnatal

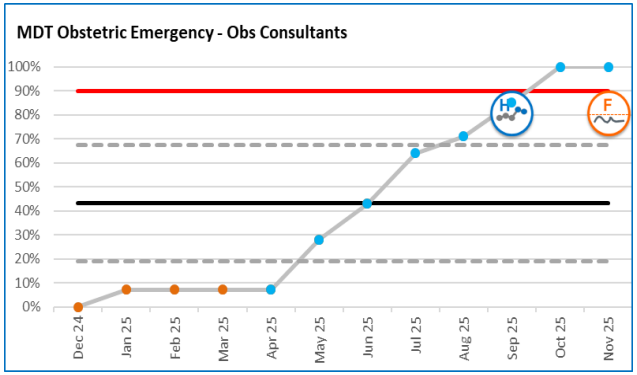
82% of patients surveyed rated their overall experience on the ward as either good or very good.
Number of patients on new medication: 4
Number of respondents: 11

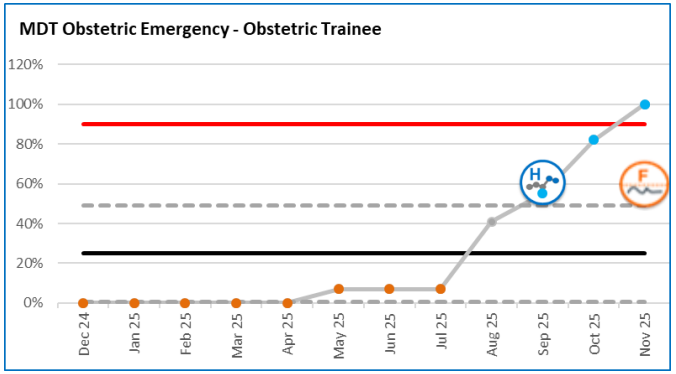
- Everything has all been the same and consistent. The staff work very well together; I've been really looked after. With the cleanliness, there's a lot of stains around. Last night got a little noisier, but not too bad.
- Things have been inconsistent once or twice. The day shift work well together, and the night shift work well together. I find there's a slight lack of communication between the two shifts with handover and things. I've heard people say, "that's a day shift/night shift problem". It's things like I asked a member of staff one night for some support socks and they couldn't find them, but when I asked the day shift, they were able to find them in 10 minutes. I've been able to speak to staff, and they've all been lovely about it. The staff have been really good with me and the baby, so I do have confidence in them. The food has no flavour. I had the honey and mustard chicken and it looked disgusting. There are a lot of babies crying, and it's quite hard when I think it's my baby crying. Everything has been absolutely fine.
- Definitely [respect and dignity]. There have been no inconsistencies yet. The staff work very well together from what I can see. Yes, I've been able to talk about my concerns, they've been very good about that. Yes definitely [attention when needed].

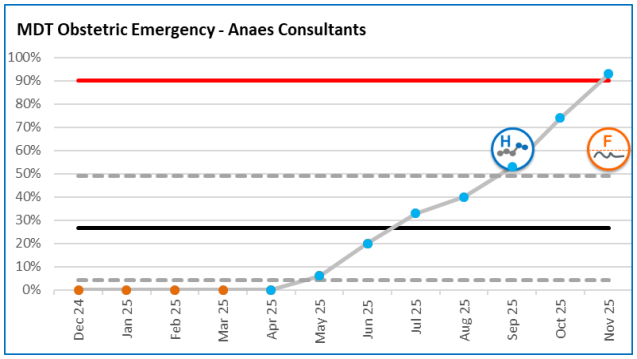
Perinatal Quality Oversight: Training (Maternity Incentive Scheme)

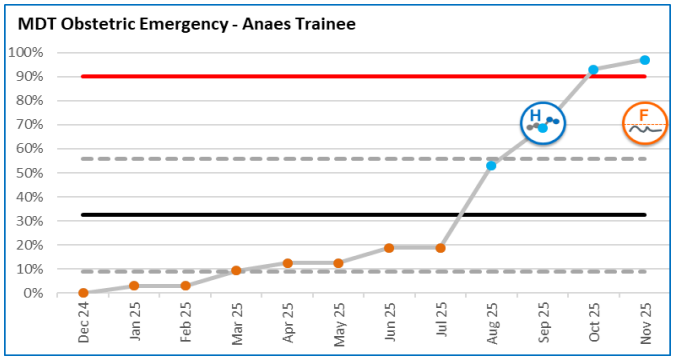












Obstetric Emergency Training by Staff Group:

In accordance with the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS) Year 7 guidance, safety action 8 requires 90% attendance in each relevant staff group at:

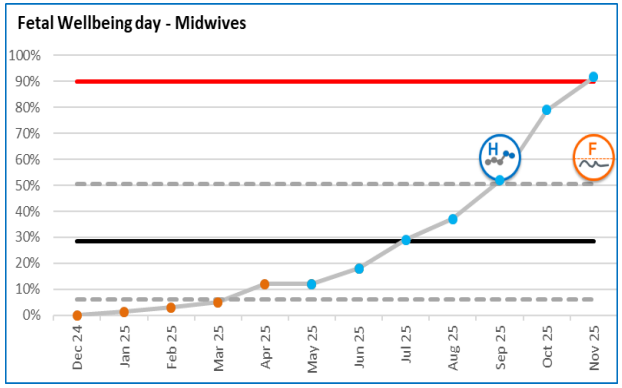
- Multi-professional maternity emergencies training
- Neonatal resuscitation training
- Fetal monitoring training

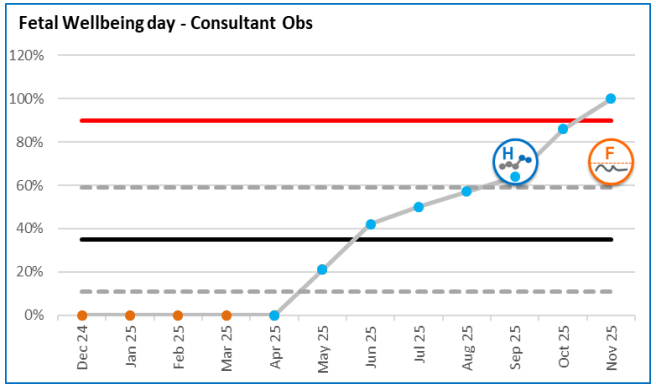
The fetal monitoring and obstetric emergencies training account for one whole day respectively.

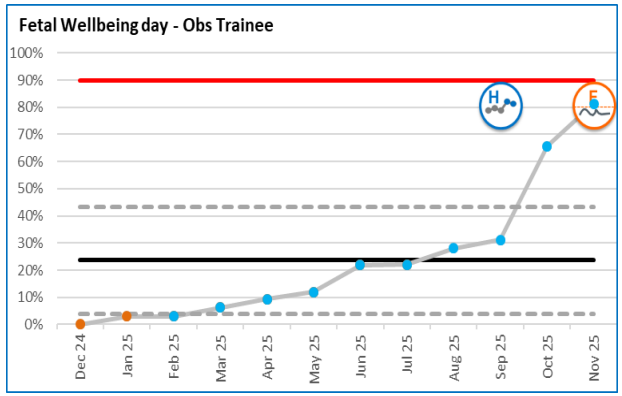
An additional requirement is to ensure at least one emergency simulation is performed within a clinical area (not simulation suite) during the MIS reporting period to capture attendance from the wider professional team, the Trust are compliant with this requirement.

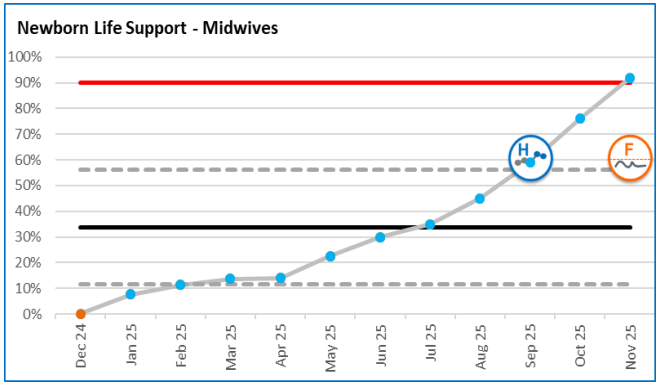
The Trust is compliant with the obstetric emergency training across all staff groups.

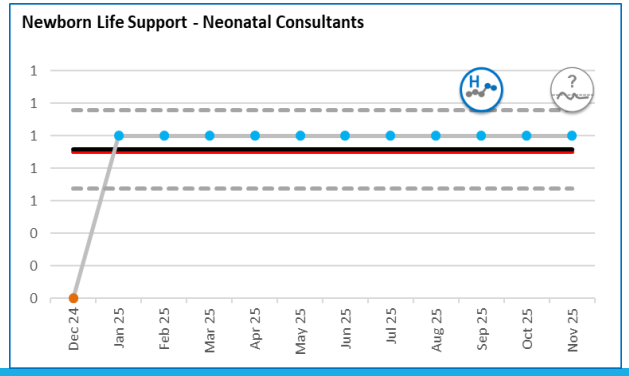
Perinatal Quality Oversight: Training (Maternity Incentive Scheme)

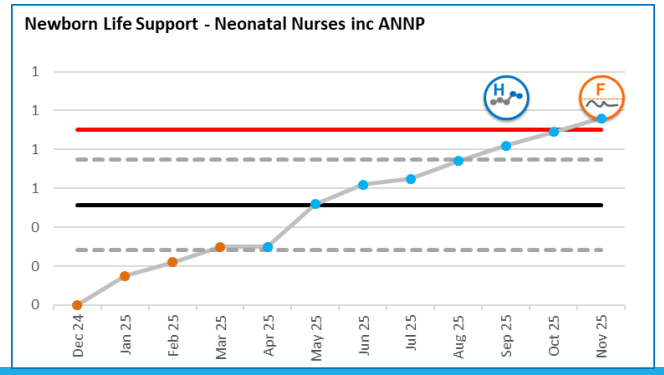


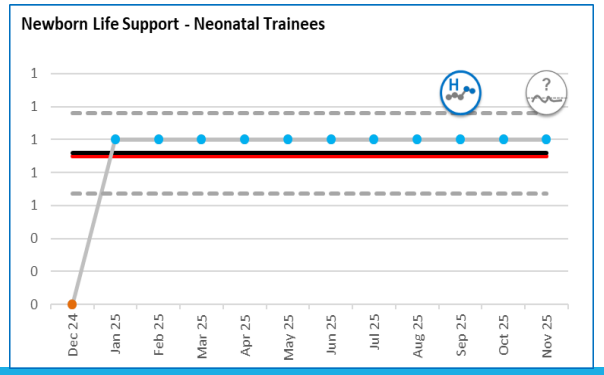












Fetal Wellbeing Training by Staff Group:

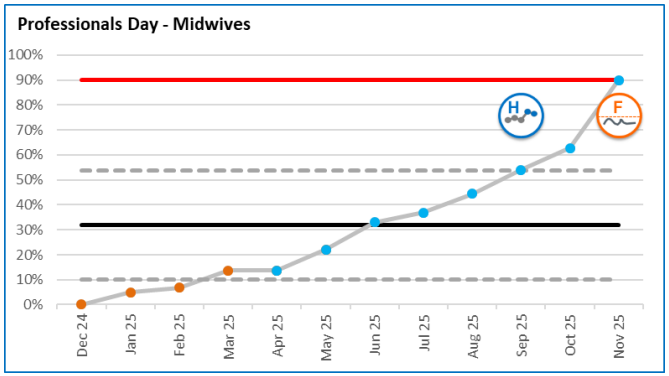
The Fetal Wellbeing training is essential training to ensure compliance with the implementation of the Saving Babies Lives Care Bundle version 3 (SBLCBv3) which aligns to the CNST MIS Year 7 Safety Actions 6 and 8.

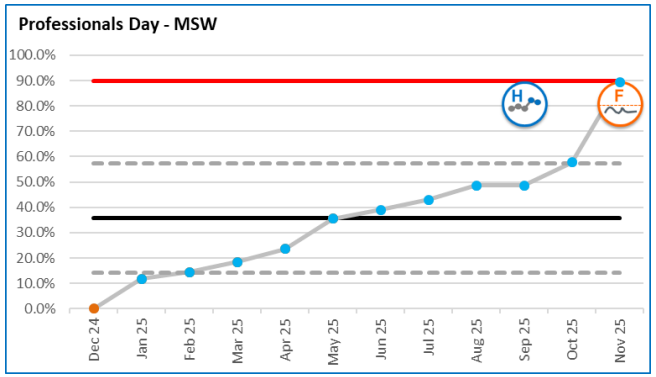
The Trust is compliant across all the required staff groups; as a lower threshold is accepted for trainees who have rotated into the Trust since July 2025.

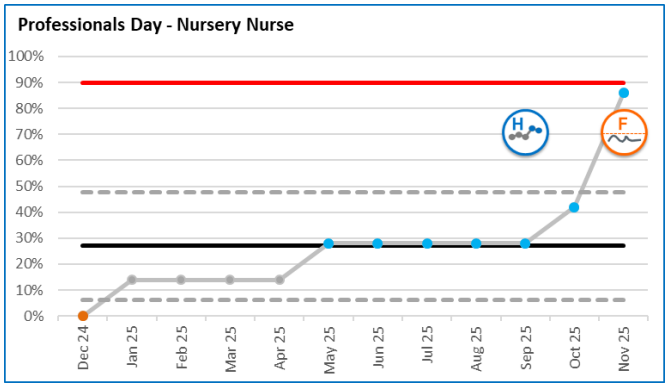
Newborn Life Support by Staff Group:

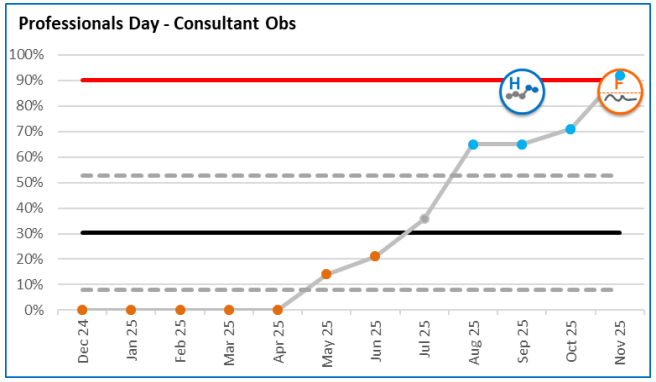
The newborn life support training is essential training to ensure compliance with MIS Year 7 Safety Action 8
The Trust is compliant across all staff groups.

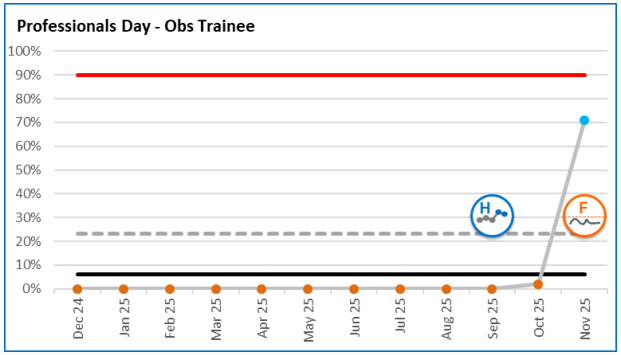
Perinatal Quality Oversight: Training (Maternity Incentive Scheme)









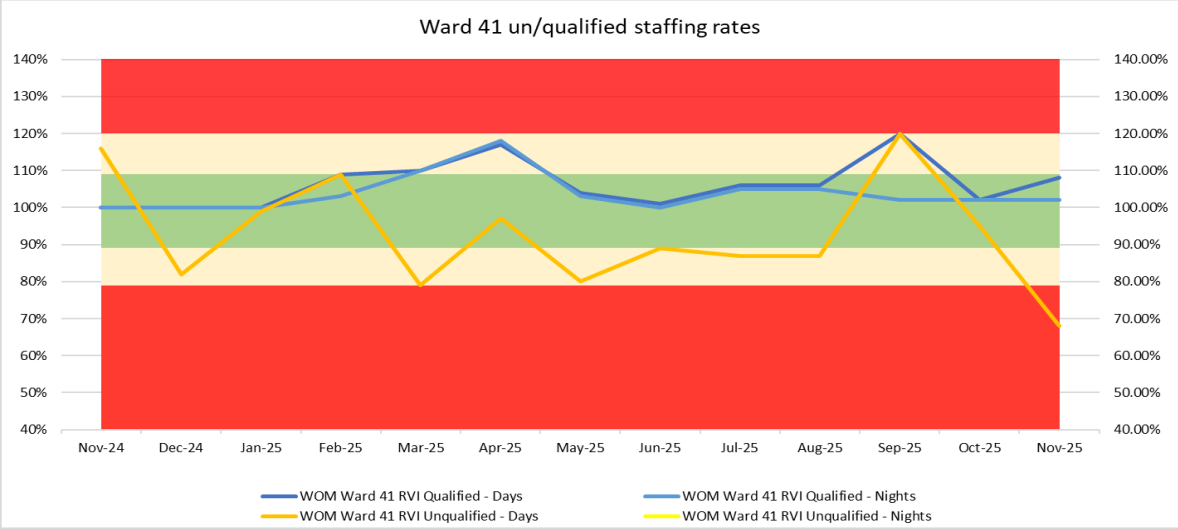


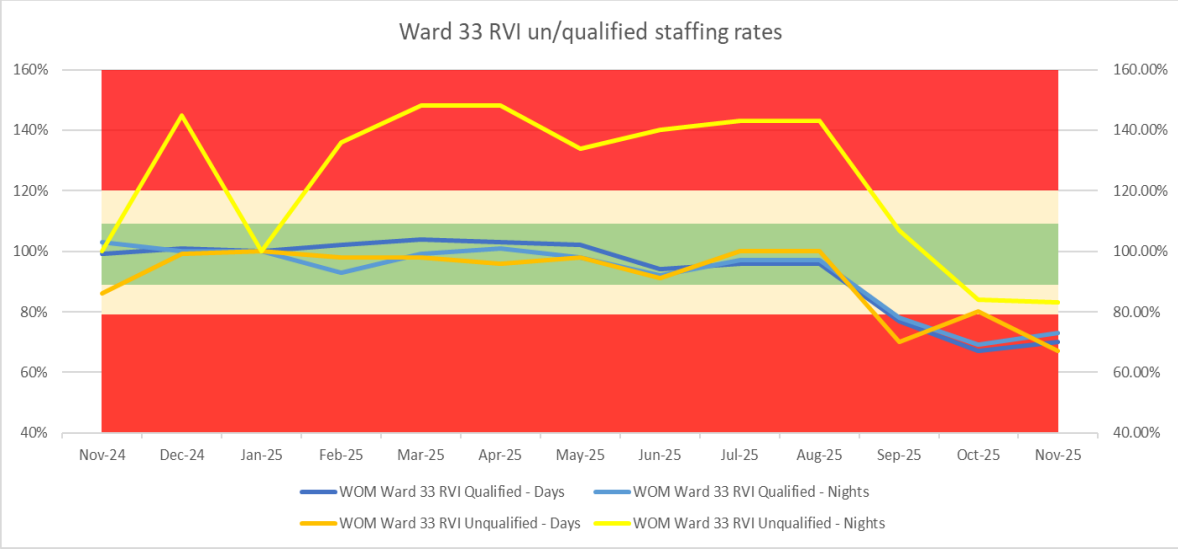
Saving Babies Lives Training by Staff Group:

The 'Professional' training encompasses essential training, such as smoking cessation and preterm birth to ensure compliance with the implementation of the Saving Babies Lives Care Bundle version 3 (SBLCBv3) which aligns to the CNST MIS Year 7 Safety Action 6.

The Trust is compliant with all staff groups; a lower threshold is accepted for trainees who have rotated into the Trust since July 2025.

Perinatal Quality Oversight: Staffing fill rates





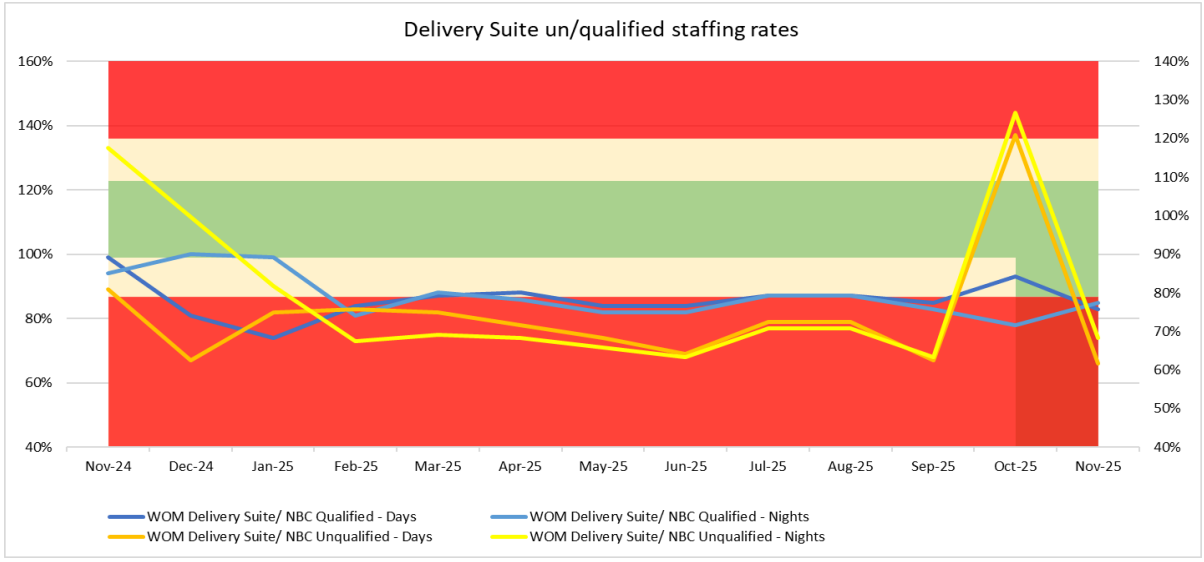
Antenatal Ward (41)

The qualified night and day fill rates are stable, and achieving 100%. During September Ward 41 admitted an increased number of high-risk antenatal patients, some of whom required enhanced observations, hence an increase in the number of unqualified staff on night shift to support safety. The ward opened escalation beds in the additional bay; hence the midwifery fill rates exceeded the staffing establishment to maintain appropriate ratios. During October and November there were less escalation beds open, hence an appropriate fill rate. November shows a reduction in unqualified staffing due to gaps requiring recruitment.

Postnatal Ward (33)

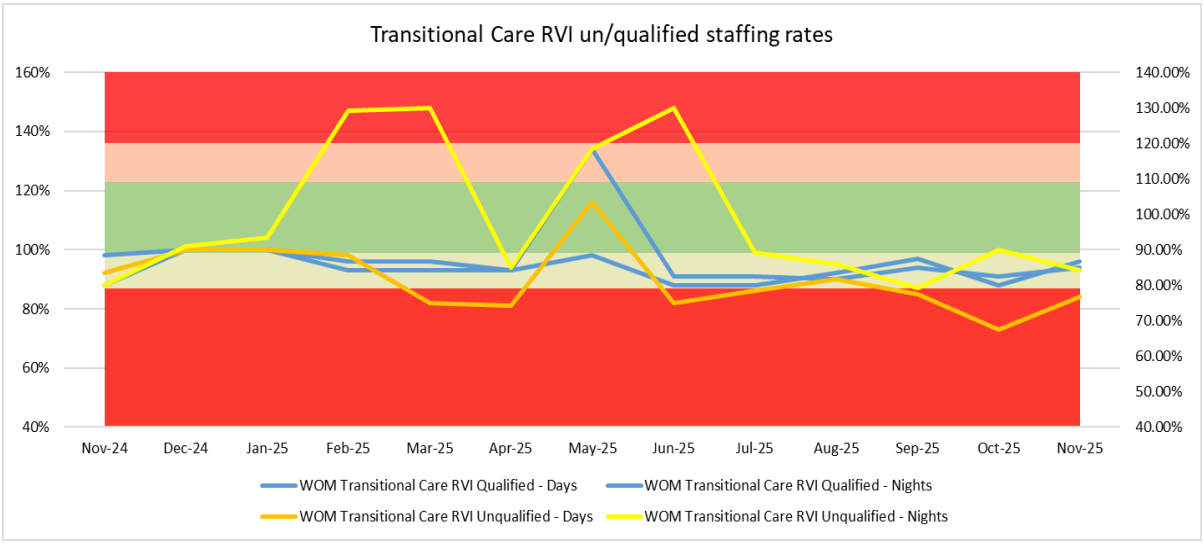
The fill rates for the postnatal ward have been impacted by sickness and escalation to support antenatal inpatient and intrapartum care during September, however from October the updated Allocate template have been introduced and the fill rate is measured against Birthrate Plus. There have been no associated patient safety incidents nor an impact on the patient experience metrics, but staff experience has been impacted by the increased activity and staffing fill rates. The safety huddle process is used to support redeployment of staff based on risk or clinical need.

Perinatal Quality Oversight: Staffing fill rates



Intrapartum (Delivery Suite and Newcastle Birthing Centre)

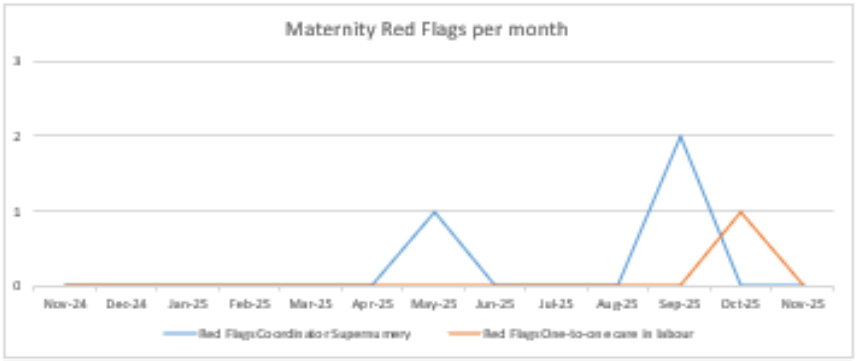
The midwifery fill rates for the intrapartum team remain stable despite the staffing position which is impacted by sickness and maternity leave. There were no red flags relating to the provision of one-to-one care in labour. There were no occasions when the co-ordinator was not supernumerary on Delivery Suite. The updated Allocate staffing template is now measuring fill rate against Birthrate Plus staffing recommendations.

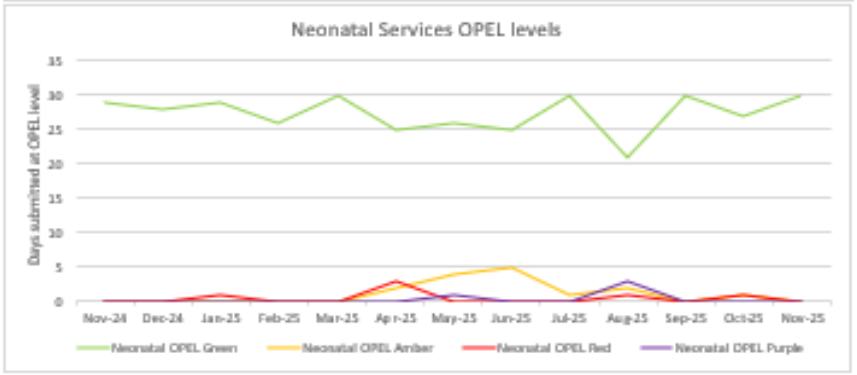


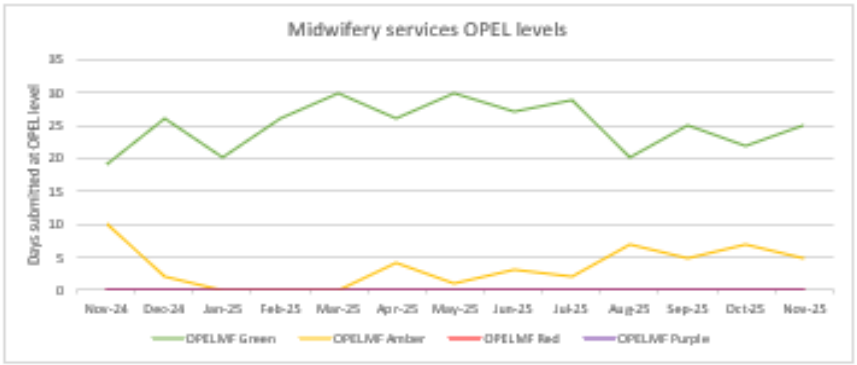
Transitional Care Ward (34)

The fill rates for Transitional Care ward for qualified and unqualified staff are stable. The escalation standard operating procedure to support appropriate nursing ratios has been agreed with the Neonatal Intensive Care Unit. The variance in fill rates above 100% is as a result of staff redeployment to support increased activity and acuity.

Perinatal Quality Oversight: OPEL







NICE Red Flags

There were no occasions in November when the co-ordinator was not supernumerary, secondary to operational pressures, for part of a shift, the Trust remains compliant with the MIS safety action 5 guidance as the co-ordinator was supernumerary for the beginning of the shift.

There were no occasions in November when one to one care in labour was not provided.

Operational Pressures Escalation Levels Maternity and Neonatal Framework

The maternity service maintained Operational Pressures Escalation Level (OPEL) 1 for 25 days in November, and OPEL 2 for 5 days. There were no staffing InPhase reports and no community escalations to support the acute service.

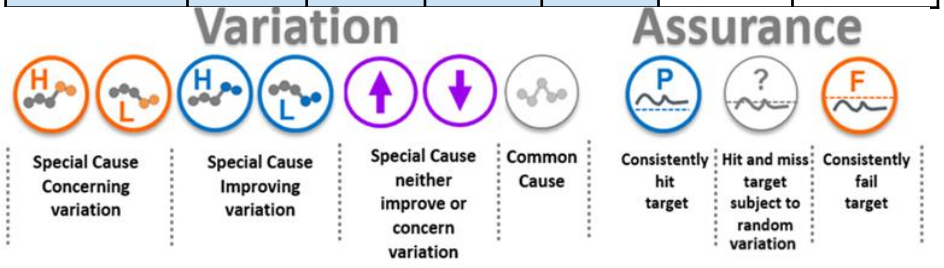
The neonatal service maintained Operational Pressures Escalation Level (OPEL) 1 for all 30 days in November. There were no staffing InPhase reports or delays to admissions or transfers out of region.

There were no gaps in obstetric or anaesthetic cover for the Delivery Suite during November 2025.

Performance

Performance Overview

Metric	Period	Actual	Traj.	Target	Variation	Assurance
A&E Arrival to Admission / Discharge	Nov-25	75.3%	83.8%	78%		?
Referral to Treatment (RTT) 18 Weeks	Nov-25	72.1%	72.8%	92%	H	F
>52 Week Waiters (% of total PTL)	Nov-25	1.1%	0.6%	1%	L	F
Cancer 28 Day FDS	Nov-25	65.6%	83.8%	80%	L	?
Cancer 31 Day	Nov-25	92.0%	82.1%	96%	H	F
Cancer 62 Day	Nov-25	71.5%	73.4%	75%	H	F
Diagnostic 6 Weeks	Nov-25	13.2%	6.2%	5%	L	F



Emergency Care

- Emergency Department (ED) Performance (All Types) in November was 75.48%, a drop of 1.47% compared to October (76.95%). ED attendances fell slightly in November compared to October, the proportion of Type 1 Major decreased again from 59.34% in October to 58.78% in November.
- Paediatric ED suffered due to an early start to the flu season, the 4hr performance for November was 80.85%, a decrease of 9.25% in October.

Elective Waits

- November 2025 witnessed a further decrease in >52-week waiters at Newcastle Hospitals, falling to 966 (-46). The number of >65 week waits also decreased to 49 (-7).
- The total waiting list size decreased significantly in November, to 86,575 (-2,719). The Trust's participation in an NHS England coordinated validation sprint recommenced in this period- accounting for much of the improvement. Further reductions are anticipated in the coming months.

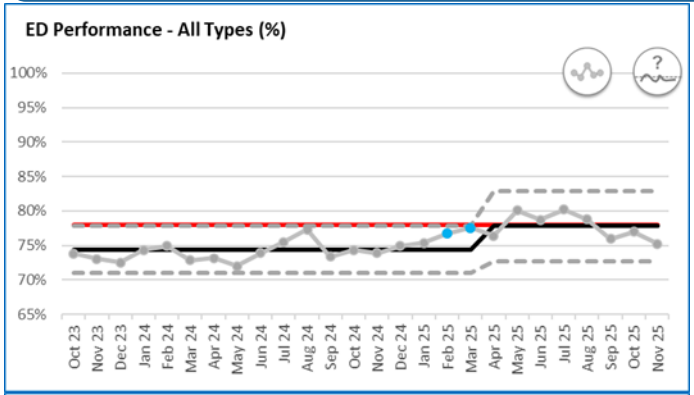
Cancer Care

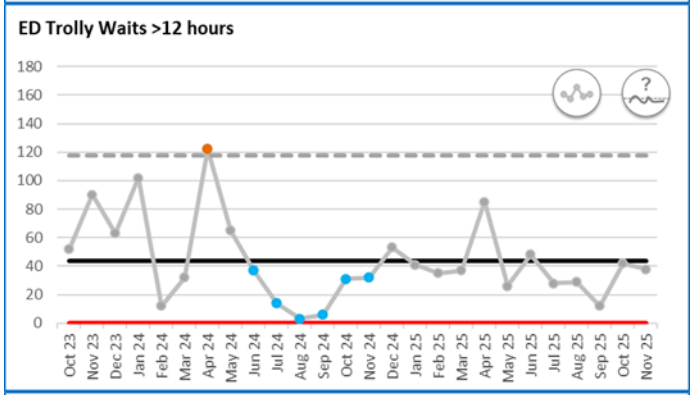
- In November, the 80% 28 Faster Diagnosis Standard (FDS) target was not achieved (65.6%) and shows a sustained decline. 31-day performance remains stable at 92.0% in November, whilst 62-day performance continues to show special cause variation of an improving nature (71.5% for November).
- Work is ongoing with the Northern Cancer Alliance to facilitate development of a regional plans for skin services going forward.

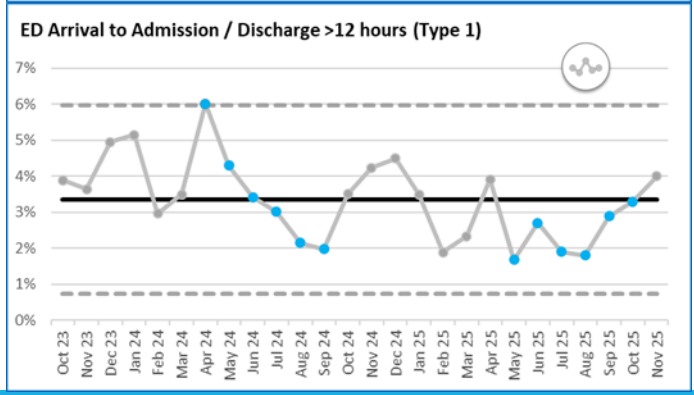
Diagnostics

- Performance against the 5% standard improved in November – 13.2% of patients were waiting over six weeks. The target continues to be consistently failed but there is special cause variation of an improving nature after considerable improvement in 2024/25.

Emergency Care







Standards

- 78% of patients to be admitted/transferred/discharged from Accident & Emergency (A&E) in <4 hours (by Mar-26).
- No ambulance handovers to A&E exceeding 60 minutes.
- Reduction from 24/25 in waits over 12 hours from A&E arrival to admission/discharge (Type 1).

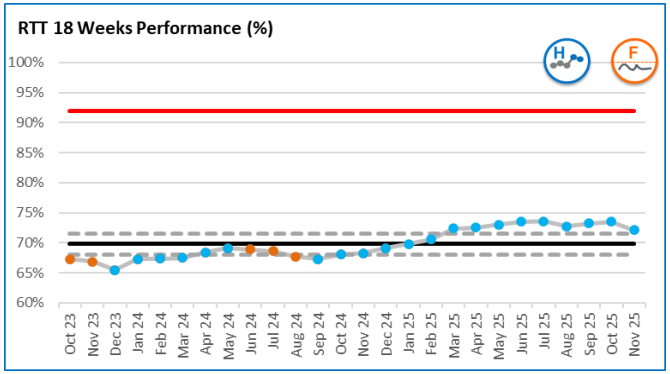
Current position

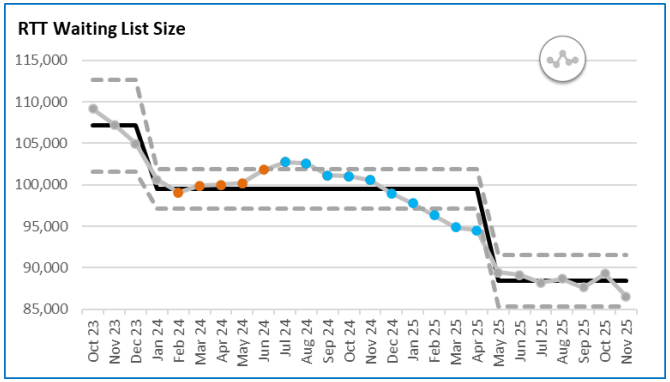
- ED Performance (All Types) in November was 75.48%, a drop of 1.47% compared to October (76.95%). ED attendances fell slightly in November compared to October, the proportion of Type 1 Major decreased again from 59.34% in October to 58.78% in November.
- Paediatric ED suffered due to an early start to the flu season, the 4hr performance for November was 80.85%, a decrease of 9.25% in October.
- ED Trolley waits >12 hours reduced, dropping to 38 in November from 42 in October.
- ED Arrival to Admission / Discharge > 12 hours (Type 1) in November was 3.95%, a 0.66% increase from the previous month. This is in part due to the increase General & Acute (G&A) Bed Occupancy, which was 90.15%, up 0.91% from October. This is still 2.04% lower than November 2024.
- The number of Ambulance Handovers >60 mins reduced, down to 73 in November from 100 in October.

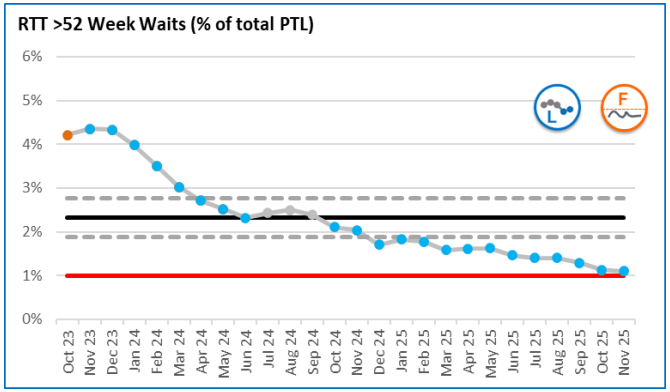
Action taken

- There is ongoing work to open the new front door and co-located UTC from 19/01/26.
- A new model has been implemented with additional staffing to support ambulance handover. This has been successful September to November, with performance meeting plan trajectory for each month. The number of handovers >30 minutes was the lowest of 2025 excluding August.
- A trial to improve time to nurse assessment is underway to improve patient safety.
- Joint work between the Emergency Department and the Older People's Medicine team intends to increase the throughput of the front of house frailty service.
- Additional transport for discharge lounges have been secured to support patient flow.

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 Mar-26).
- 72% of patients time to first outpatient appointment <18 weeks (local target of 82.6%).

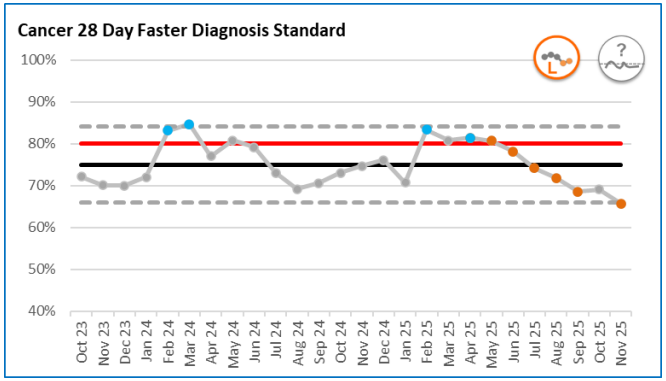
Current position

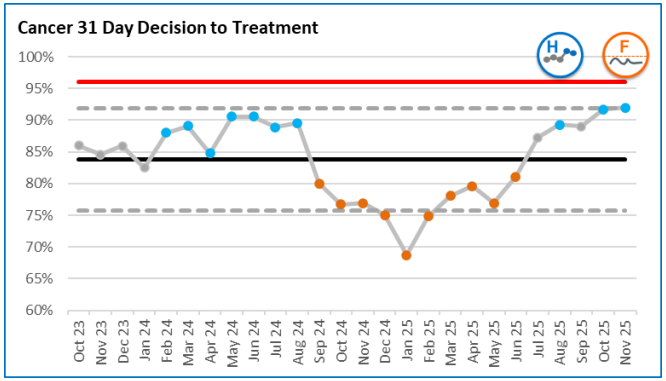
- November 2025 witnessed a further decrease in >52-week waiters at Newcastle Hospitals, falling to 966 (-46). The number of >65 week waits also decreased to 49 (-7).
- There was a single 78-week breach following the Trust reaching zero in October.
- Whilst the Trust is now pivoting focus to clearing 52-week waiters and making improvements to the front-end of the RTT pathway, it continues to manage issues at sub-specialty level impacting its remaining 65-week waiters, amidst increased national scrutiny. Current challenges include:
    - ENT are unable to offer vestibular/cortical testing due to sickness & maternity leave. This represents the largest risk, with a growing number of long waiters in the service.
    - Ophthalmology continue to manage corneal graft tissue availability alongside capacity pressures for ocular plastics, squint surgery, cataracts and glaucoma.
    - Pressures due to increased referrals and outpatient waits for Functional Urology.
- The total waiting list size decreased significantly in November, to 86,575 (-2,719). The Trust's participation in an NHS England coordinated validation sprint recommenced in this period- accounting for the improvement. Further reductions are anticipated in the coming months.

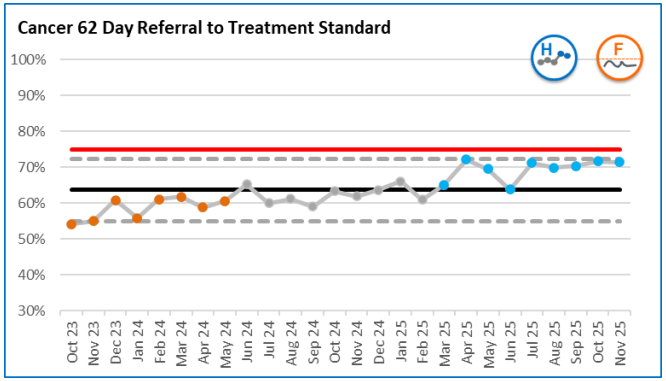
Action taken

- ENT have reached out mutual aid for vestibular/cortical testing from regional providers to alleviate long-waits pressures until the NuTH service can re-commence. However, support to date has been limited and significant pressures remain.
- Ophthalmology are enhancing use of theatres at the Campus for Aging and Vitality (CAV) and an additional Fellow has been appointed part-time.
- Urology are providing increased availability for diagnostics and follow-up appointments to give patients more flexibility and improve waiting times.
- Orthopaedics continue to rigorously validate pathways, ensuring patients remain fit and suitable for surgery and that no individual consultant backlogs occur.

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 Mar-26).
- 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 Mar-26).

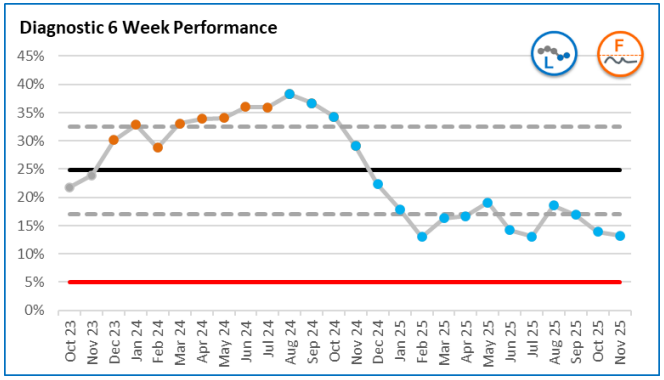
Current position

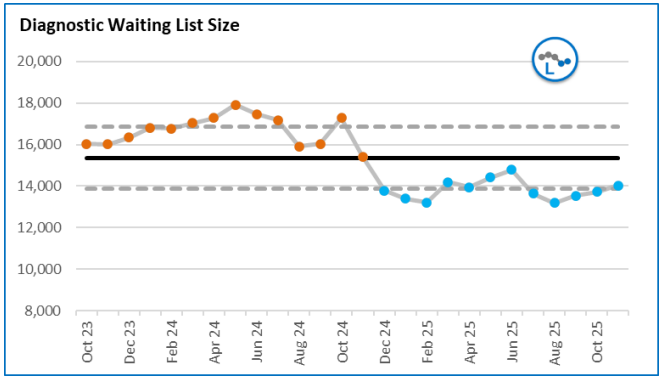
- In November, the 80% 28 FDS target was not achieved (65.6%) and shows a sustained decline. 31-day performance remains stable at 92.0% in November, whilst 62-day performance continues to show special cause variation of an improving nature (71.5% for November).
- Referrals to skin have continued to increase through the summer months. Although referral numbers are gradually reducing, demand outstrips capacity.
- Breast Symptomatic – there has been a reduction in imaging capacity and also an increase in referrals from Durham.
- Radiotherapy are seeing increased staffing vacancies, maternity and reluctance to do overtime.
- For 62 day pathways, demand has outstripped capacity in Gynae and HPB continue to tackle complex liver pathway management. Extended waits for EBUS and navigational endoscopy are affecting timeliness of care in the Lung service, with surgeon absence also impacting capacity available.

Action taken

- Skin – Work is underway with GPs in Northumberland to educate them on pathways available at local hospitals with shorter waiting times. Work is ongoing with the Northern Cancer Alliance to facilitate development of a regional plans for skin services going forward.
- Breast Symptomatic – we will continue to struggle at NUTH and regionally due to the increased workload from redirected referrals from Durham to NUTH. Increased radiology capacity (expected January 2026) will improve wait times, but not to the levels required to cope with the additional demand from Durham/region. Regional work is ongoing with the Northern Cancer Alliance to address this.
- Oncology – escalation process in place to man-mark pathway delays.
- 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.

Diagnostics





6 Week Diagnostic Performance by Modality – November 2025			
MRI	16.6%	CT	3.7%
Non-obs US	10.2%	DEXA	7.2%
Audiology	23.8%	ECHO	27.1%
Electrophysiology	0%	Neurophysiology	5.8%
Sleep Studies	16.7%	Urodynamics	17.5%
Colonoscopy	20.2%	Flexi-Sig	22.0%
Cystoscopy	24.6%	Gastroscopy	21.9%
Newcastle Hospitals Total			**13.2%**

Standards

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

Current position:

- Performance against the 5% standard improved in November – 13.2% of patients were waiting over six weeks. The target continues to be consistently failed but there is special cause variation of an improving nature after considerable improvement in 2024/25.
- Echo (27.1%) remains the area with the most challenged performance. Aging equipment in the department at both sites is at risk of being out of use which could further reduce capacity. Capacity is being provided through insourcing with work ongoing to improve waiting list function.
- Capacity shortages in MRI – one scanner at Freeman required significant repairs over three months (now operational), whilst an approved new MRI scanner to be installed at RVI has been delayed due to Building Safety Act approval and is incurring cost of storage.
- Vacancies have continued to impact both Gastroscopy and Colonoscopy. Backfill lists were 69% full in October 2025 in comparison to 93% in January, and also continue to create a capacity challenge for double procedures - this had led to some patients having to attend twice.

Action taken

- A new echo machine is now in use at the RVI after the previous machine failed quality assurance process. Extensive validation of the waiting list has taken place since the implementation of “Future Orders” which will give the most accurate performance baseline to date.
- MRI - Improvement workstreams with prep time and dedicated porter in Neuroradiology has improved productivity by 7% in neuro MRI and CTT is to be replicated in main radiology, and a dedicated porter will begin working in CT on Tuesday and Friday for 2 weeks. Work with a play specialist has significantly improved waiting times and volumes for paediatric GA.
- 3x Nurse Endoscopists are being trained in Colon/OGD double procedures to provide a long term sustainable solution to capacity issues – all should be signed off by the end of January 2026.
- The endoscopy service has made a concerted effort to appropriately match capacity to demand, flexing timetables according to the most-pressing needs - this has included ringfencing slots for 2WW patients to prioritise those with the highest clinical needs.
- Ongoing Integrated Care Board (ICB) monthly meetings remain in place to provide assurance for the Paediatric Auditory Brain-stem Response review. Consultation of staff for new structure has been completed and recruitment ongoing.

Contractual & Planning Standards (1/2)

Theme	Standard	Trajectory (Oct-25)	Aug-25	Sep-25	Oct-25	Nov-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	97.9%	94.5%	95.6%	**97.8%**	10,729	10,973	**98.7%**
Elective Overnight			98.8%	89.3%	89.7%	**93.5%**	1,702	1,821	**94.8%**
Outpatient New			94.1%	95.8%	96.8%	**97.4%**	25,170	25,836	**98.1%**
Outpatient Procedures			92.9%	84.1%	70.4%	**73.6%**	16,096	21,872	**88.6%**
Outpatient Review	N/A		105.5%	108.9%	110.0%	**112.9%**	67,036	59,368	**109.5%**
Non-Elective			96.8%	95.8%	92.5%	**89.1%**	932	1,046	**91.5%**
Emergency			97.7%	109.6%	108.2%	**104.3%**	6,188	5,931	**104.9%**
Diagnostic Activity	**100%** of 25/26 Plan	N/A	112.3%	101.8%	98.8%	**101.6%**	21,073	20,734	**103.1%**
PIFU Take-up (%)	>=**5%** of all OP atts. (by Mar-29)	**3.3%**	2.7%	2.5%	2.2%	**2.9%**	3,417	129,918	**2.6%**
Day case rates (BADS procedures)	**85%**	N/A	85.2%	**86.0%**	TBC	TBC			
Capped Theatre Utilisation	**85%**	N/A	82.0%	83.4%	81.5%	**82.9%**			
Urgent Ops. Cancelled Twice	**Zero**	N/A	0	0	0	**0**	0		**0**
Cancelled Ops. Rescheduled >28 Days	**Zero**	N/A	9	2	8	**10**	10		**44**
Elective Waits									
RTT Waiting List Size	**Reduction** from 24/25	**93,709**	88,675	87,666	**89,294**	**86,575**	86,575		
RTT 18 Week Wait	**92%**	**72.5%**	72.7%	73.2%	**73.5%**	**72.1%**	62,410	89,294	**73.0%**
>78 Week Waiters	**Zero**	**0**	9	1	**0**	**1**	1		
>65 Week Waiters	**Zero**	**0**	89	64	**56**	**49**	49		
>52 Week Waiters	N/A	**713**	1,245	1,131	**1,012**	**966**	966		
>52 Week Waiters (% of Total WL)	**<1% of total WL** (by Mar-26)	**0.8%**	1.4%	1.3%	**1.1%**	**1.1%**	966	89,294	**1.4%**
>12 Week Waiters Validated	**90%**	N/A	99.3%	96.2%	**96.1%**	**96.2%**	20,511	22,500	**96.3%**
Time to First Outpatient Appointment (18 Weeks)	**72%** (local target of **82.6%**)	**79.4%**	78.2%	78.3%	**79.3%**	**79.3%**	39,479	50,755	**78.8%**
RTT Waiting List (Children & Young Persons <=18 yrs)	N/A	**12,370**	12,233	11,783	**11,771**	**11,203**	11,203		
>52 Week Waits (Children & Young Persons <=18 yrs)		**62**	144	149	**117**	**95**	95		
Community Services Waiting List	N/A	N/A	10,444	10,973	11,374	**11,373**	11,373		
Community Services >52 Week Waiters			694	771	826	**764**	764		
Diagnostic 6 week wait	<=**5%** (local target of **<=11.4%**)	**6.5%**	18.6%	16.9%	13.9%	**13.2%**	1,857	14,030	**15.7%**

Contractual & Planning Standards (2/2)

Theme	Standard	Trajectory (Oct-25)	Aug-25	Sep-25	Oct-25	Nov-25	Num.	Den.	25/26 YTD
Cancer Care									
28 Day Faster Diagnosis	**80%** (by Mar-26)	**81.8%**	71.9%	68.5%	69.1%	**65.6%**	1,716	2,614	**73.8%**
31 Days (DTT to Treatment)	**96%**	**80.0%**	89.3%	89.0%	91.7%	**92.0%**	1,219	1,325	**85.9%**
62 Days (Referral to Treatment)	**75%** (by Mar-26)	**71.4%**	69.9%	70.4%	71.7%	**71.5%**	297	415	**70.1%**
>62 Day Cancer Waiters	**N/A**	**N/A**	120	127	138	**139**	139		**70.1%**
Urgent & Emergency Care									
A&E Arrival to Admission/Discharge (All types)	**>=78%** under 4 hours (by Mar-26)	**84.0%**	78.8%	76.0%	76.9%	**75.5%**	17,325	22,952	**77.8%**
A&E Arrival to Admission/Discharge (Type 1)	**Reduction** from 24/25	**2.5%**	1.8%	2.9%	3.3%	**4.0%**	536	13,567	**2.8%**
A&E Decision to Admit to Admission >12 Hours	**Zero** over 12 hours	**N/A**	29	12	42	**48**	48		**318**
Adult General & Acute Bed Occupancy	**<=92%**	**89.6%**	86.4%	88.8%	89.3%	**90.1%**	1,287	1,428	**88.8%**
Ambulance Handovers <15 mins	**65%**	**N/A**	42.5%	51.0%	47.8%	**49.1%**	1,673	3,407	**46.4%**
Ambulance Handovers <30 mins	**95%**		79.3%	88.0%	83.9%	**86.3%**	2,940	3,407	**81.1%**
Ambulance Handovers >60 mins	**Zero**		92	17	100	**73**	73		**836**
Urgent Community Response Standard	**>=70%** under 2 hours	**N/A**	84.5%	87.8%	85.6%	**87.6%**	304	347	**83.6%**
Safe, High Quality Care									
Mixed Sex Acommodation Breach	**Zero**	**N/A**	61	66	151	**121**	121		**687**
VTE Risk Assessment	**95%**		95.7%	**96.3%**	TBC	TBC			
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour		**85.0%**		TBC	TBC			
Sepsis Screening Treat. (All)			**75.0%**		TBC	TBC			

NHS Oversight Framework Q2 2025/26 (1/2)

		THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST (RTD) - Quarter 2 2025/26							Quarter 1 2025/26		Difference	
Domain	Sub-domain	Metric	Time period	Raw measure	Ranking	Raw score derived	Final Score	Domain Score	Raw measure	Raw score derived	Raw measure	Raw score derived
Access to Services	Elective Care	Proportion of incomplete patient pathways waiting over 52 weeks	Sep-25	1.28%		2.06	2.06		1.46%	2.16	-0.18%	-0.10
		Proportion of incomplete patient pathways waiting less than 18 weeks (gap to plan)	Sep-25	1.01%		1.00	1.00		2.14%	1.00	-1.13%	0.00
		Proportion of incomplete patient pathways waiting less than 18 weeks (absolute performance)	Sep-25	73.24%		1.18	1.18		73.53%	1.12	-0.29%	0.07
		Percentage of community services waiting list waiting over 52 weeks	Sep-25	9.25%		3.45	3.45		6.12%	3.23	3.13%	0.22
	Cancer Care	Proportion of urgent referrals to receive a definitive diagnosis within 4 weeks	Q2 25/26	71.68%		3.46	3.46		80.04%	1.00	-8.35%	2.46
		Proportion of patients treated for cancer within 62 days of referral	Q2 25/26	70.54%		2.42	2.42		68.48%	3.01	2.06%	-0.59
	Urgent & Emergency Care	% of patients managed in under 4 hours in ED	Q2 25/26	78.30%		1.00	1.00		77.30%	2.22	1.00%	-1.22
		% of patients spending over 12 hours in ED	Sep-25	1.86%		1.31	1.31		2.32%	1.37	-0.46%	-0.06
	Overall	**DOMAIN SCORE - Access to Services**						1.98				
Effectiveness & Experience	Patient Experience	National CQC inpatient survey overall experience rating	2023	As expected		2.00	2.00		As expected	2.00	No change	0.00
		Summary Hospital Mortality Indicator	Jul 24 - Jun 25	Lower than expected		1.00	1.00		As expected	2.00	Improved	-1.00
	Effective out of hosptial care	Urgent Community Response % achieving 2hr standard	Q2 25/26	79.40%		2.56	2.56		70%	3.00	9.03%	-0.44
	Effective flow and discharge	Average number of days between discharge ready date and actual date of discharge	Measure excluded for Q2						0.60	1.91		
	Overall	**DOMAIN SCORE - Effectiveness and Experience**						1.85				

Assessments against the NHS Oversignt Framework for Quarter 2 2025/26 have now been published with the following summary findings:

- Newcastle Hospitals remain in segment 2 of 4 (segment 1 containing Trusts deemed as 'high performing' whilst those in segment 4 are described as 'significantly off-track').
- Once all metrics are aggregated and all comparable national Trusts placed in a league table, the Trust places 22nd overall – an improvement of 4 places from Q1. Our average score improved from 2.29 to 2.19.
- Specific metrics displaying particular improvement include the proportion of patients managed in under 4 hours in ED (following a correction to reported information which included a number of booked appointments previously excluded from performance data), the summary hospital mortality indicator, and implied rates of productivity.
- Deteriorating or continually low scoring metrics include performance against 28 day cancer standard, community waits and HCAI rates.

NHS Oversight Framework Q2 2025/26 (2/2)

		THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST (RTD) - Quarter 2 2025/26							Quarter 1 2025/26		Difference	
Domain	**Sub-domain**	**Metric**	**Time period**	**Raw measure**	**Ranking**	**Raw score derived**	**Final Score**	**Domain Score**	**Raw measure**	**Raw score derived**	**Raw measure**	**Raw score derived**
Patient Safety	Patient Safety	NHS Staff Survey raising concerns sub-score (PRV)	2024	6.37		2.76	2.76		6.37	2.76	No change	0.00
		HCAI measure 1: 12 month rolling count of MRSA cases	Oct 24 - Sep 25	9.00		3.84	1.27		8.00	3.72	1.00	0.12
		HCAI measure 2: 12 month rolling count of C.Difficile cases as a proportion of trust threshold	Oct 24 - Sep 25	1.32		3.28	1.08		1.54	3.71	-0.22	-0.43
		HCAI measure 3: 12 month rolling count of e.coli cases as a proportion of trust threshold	Oct 24 - Sep 25	1.17		2.76	0.91		1.17	2.97	0.00	-0.21
		CQC safe domain inspection rating	Current	Requires improvement		3.00	3.00		Requires improvement	3.00	No change	0.00
	Overall	**DOMAIN SCORE - Patient Safety**						3.01				
People and Workforce	Retention and culture	Sickness absence rate	Q1 25/26	5.34%		3.10	3.10		6.01%	3.28	-0.67%	-0.18
		NHS Staff Survey engagement sub-score (PRV)	2024	6.83		2.69	2.69		6.83	2.69	No change	0.00
	Overall	**DOMAIN SCORE - People and Workforce**						2.90				
Finance	Finance	Planned surplus / deficit as a proportion of turnover	25/26	0.0%		1.00			0.0%	1.00	No change	0.00
		YTD surplus / deficit	25/26 YTD	0.0%		1.00			0.0%	1.00	No change	0.00
		Aggregated finance score					1.00					
	Productivity	Implied rate of productivity compared with baseline	24/25 vs 23/24	3.10%		2.15	2.15		0.3%	3.28	2.84%	-1.13
	Overall	**DOMAIN SCORE - Productivity & value for money**						1.58				
		Finance Override						NO		NO		No change
		OVERALL SCORE				47.02	39.40	2.19		51.42		-4.40
		FINAL SEGMENTATION						**2**		**2**		

People

People Overview

Metric	12-month rolling	Actual	Target	Variation	Assurance
Sickness	Nov-25	5.79%	4.5%		F
Short-term (Month only)	Nov-25	2.45%		H	
Long-term (Month Only)	Nov-25	3.86%			
Turnover	Nov-25	8.92%	10%		P
Mandatory training	Nov-25	91.57%	90%		P
Appraisal	Nov-25	83.22%	90%		F
Disabled staff	Nov-25	6.49%		H	
Ethnicity (BAME staff)	Nov-25	18.48%		H	

Staff in post

- Total is 15,982.85 Full Time Equivalent (FTE) including Bank/agency.
- Total substantive is 15,545.69 FTE, 17,816 headcount.
- Above substantive pre-Covid by 2,105.15 FTE (+15.7%).
- Above workforce plan of 15,689.91 FTE by 292.94 FTE (+1.87%).

Sickness

- Top reasons for sickness: anxiety/stress/depression 31.83% (-0.01%); cough, cold, flu – influenza 12.25% (-0.46%); other MSK problems 10.05% (+0.49%).
- Short-term sickness change in November 2.45% (+0.17%).
- Long term sickness change in November 3.86% (-0.21%).

Retention & Turnover

- Increase of 0.10%. Top reason for leaving: retirement age at 15.18%.
- Top destinations: no employment 42.01%; other NHS organisation 31.10% (includes retire-return).

Mandatory training

- Reduction of 0.29%. Lowest is Medical and Dental 79.80% (-0.64%).
- Nine courses are below target.

Appraisal

- Overdue increased to 2,388.

Bank & Agency

- Total annual non-medical bank expenditure £18.3m, +£1.2m vs last year.
- Total annual non-medical agency expenditure £3.0m, -£0.77m vs last year.
- Total annual medical agency expenditure £3.8m, +0.68m vs last year.

Equality & Diversity

- Disabled staff change in November +0.08% to 6.49%.
- BAME staff change in November +0.06% to 18.48%.

Provider workforce return (PWR) – overview as-at November 2025

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	10,044.30	10,530.69	10,066.54	1,382.39	22.24	-464.15
2. Total Non Medical - Non-Clinical Substantive Staff	2,874.99	3,271.87	3,725.24	3,355.61	480.61	83.74	-369.63
3. Total Medical and Dental Substantive Staff	1,732.92	1,968.52	2,093.06	2,107.95	375.03	139.43	14.89
4. Any other Staff (substantive staff)	146.48	47.75	11.50	13.60	-132.88	-34.15	2.10
5. Bank	441.22	312.69		416.92	-24.30	104.23	
6. Agency	60.38	44.78		22.24	-38.14	-22.54	
Total	**13,940.15**	**15,689.91**	**16,360.49**	**15,982.85**	**2,042.70**	**292.94**	**-816.80**

Current Position:

- Workforce is +2,042.7 FTE (14.7%) above January 2020 (pre-Covid) position.
- Substantive workforce target at year-end is 15,352 FTE.
- Substantive workforce target at 30 November is 15,332.44 FTE.
- Substantive workforce actual position at 30 November is 15,545.69 FTE
- Substantive workforce is currently +211.25 FTE above plan for November.
  (see slide 3, top row, middle graph)
- NHS infrastructure support (substantive) is 83.74 FTE above plan.
- Bank is above plan.
- Agency is better than plan.
- Agency usage reviewed and challenged weekly / monthly.
- Robust management of agency requests with active bank and redeployment

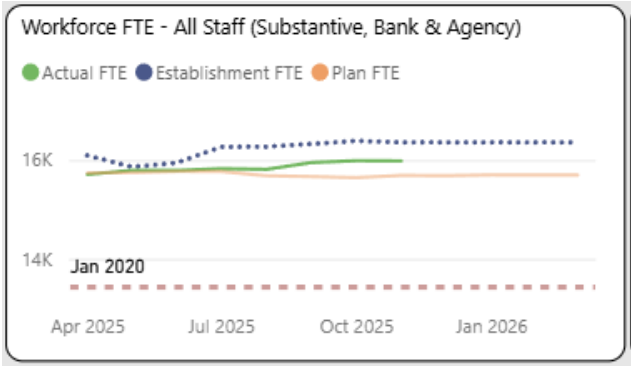
Underlying Issues

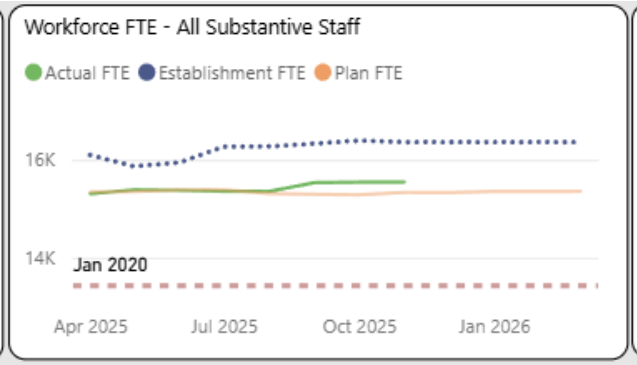
- Bank use due to switching requirements for additional hours from overtime to Bank which is more cost effective.
- Need to maintain safe services (e.g. healthcare assistants for enhanced care). Greater use being made of Bank options to reduce spend on agency.
- Practice of rostering staff may not be optimal in some areas. Potential need for some refresher training.
- Mid-term financial review in October led to adjustment of our workforce plan predictions for the second half of the year to reflect the impact of the following: approved business cases in-year; outcome of voluntary severance scheme; outcome of wholly-owned subsidiary.

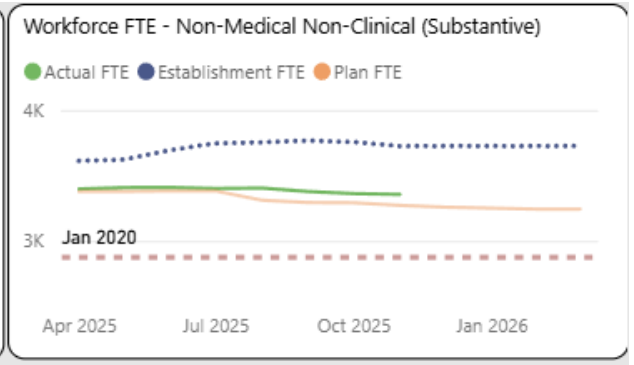
Actions Undertaken:

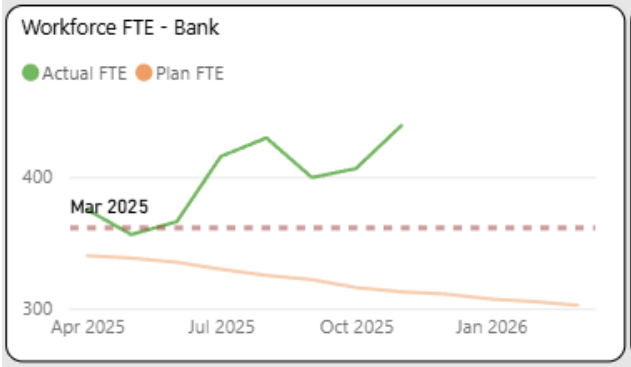
- The aim is to reduce the workforce by 400 FTE by 31 March 2026 through various measures:
  - A mutually agreed resignation scheme was offered to all staff between 13 October and 2 November. Applications will be decided by the Chief Executive and outcomes notified to staff in December. Notice periods will run from December until March.
  - Recruitment activity was temporarily paused in October, and all services were asked to review their recruitment/vacancy position to prioritise and/or replan their needs going forward.
- To support the shift from overtime to Bank, around 800 substantive staff have been fast-tracked as additions to the Bank.

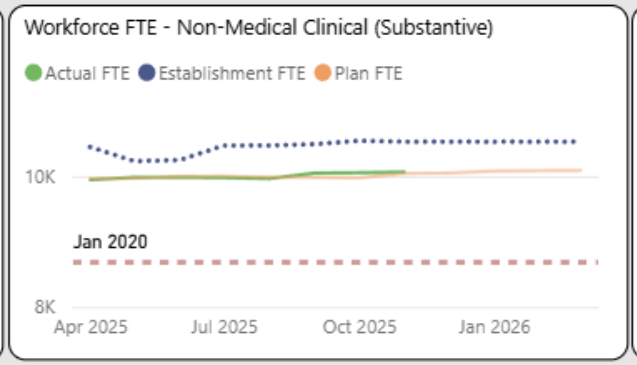
PWR – in-year overview position

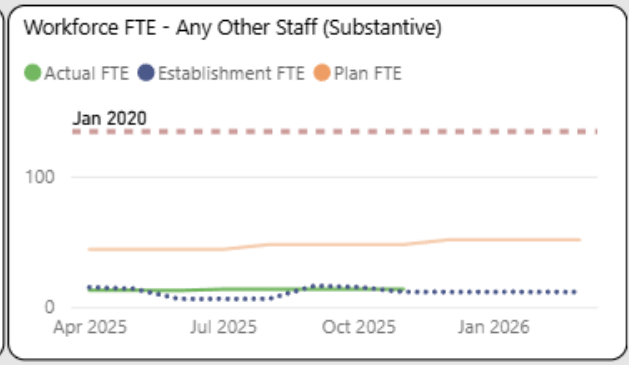


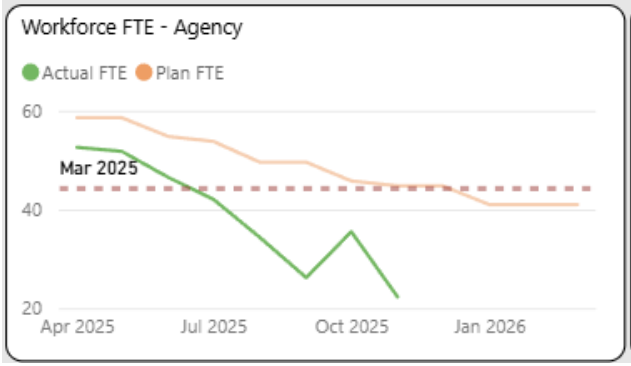


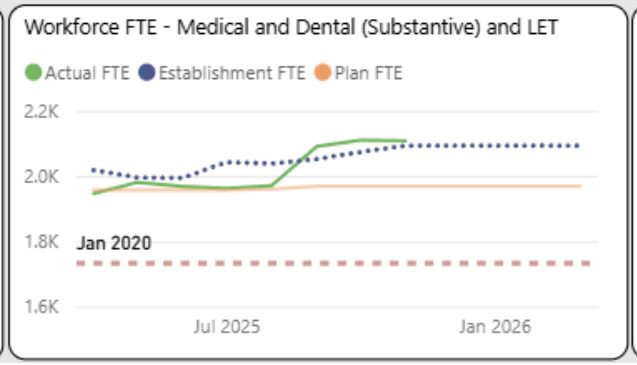


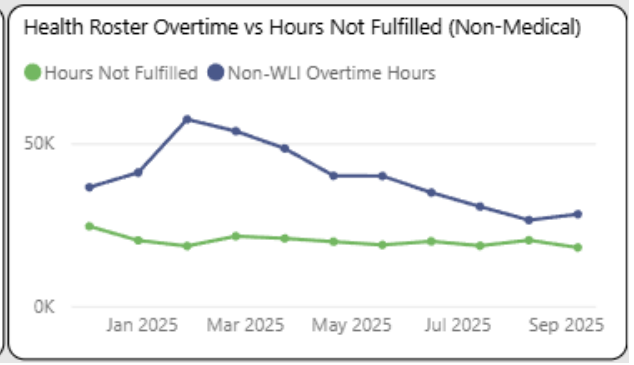










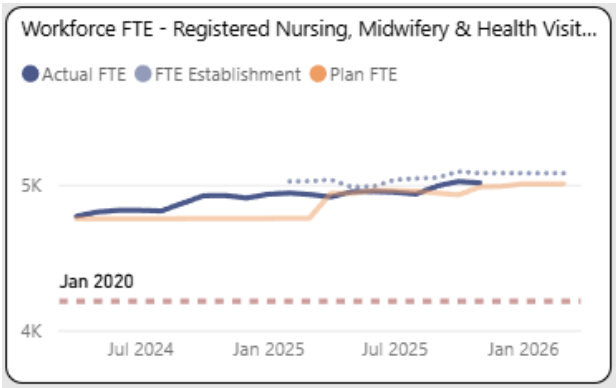


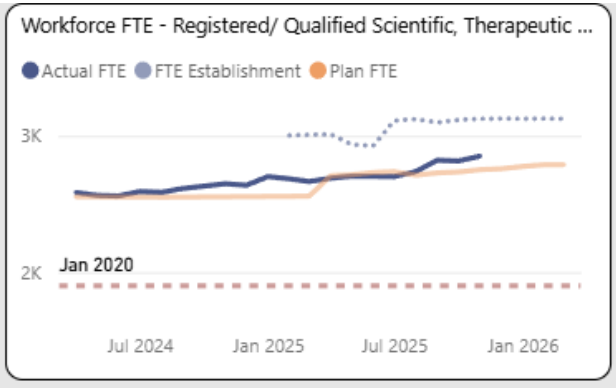
**Please note: The charts on this page include LET data

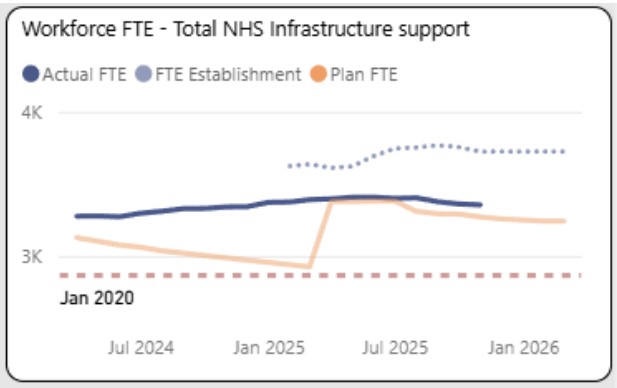
PWR – staff group overview as-at November 2025

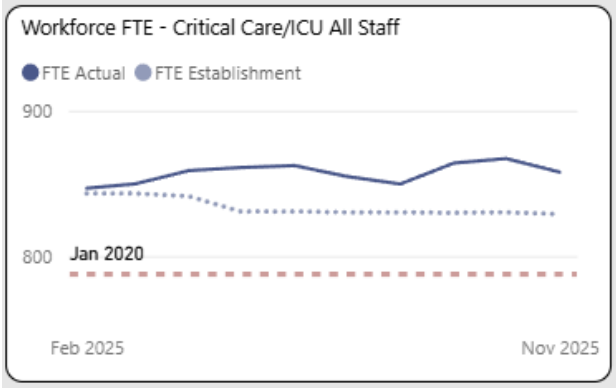
Sub Categories Metric	Jan 2020 FTE	Plan FTE	Establishment	Current FTE	Current FTE v Jan 2020	Current FTE v Plan	Current FTE v Establishment
1. Registered Nursing, Midwifery and Health visiting staff (substantive total)	4,202.08	4,984.90	5,079.26	5,012.09	810.01	27.18	-67.17
2. Registered/ Qualified Scientific, Therapeutic and Technical Staff (substantive total)	1,993.02	2,376.07	2,563.16	2,425.75	432.73	49.68	-137.41
3. Support to Clinical staff (substantive total)	2,489.06	2,683.32	2,888.27	2,628.70	139.65	-54.62	-259.57
4. Total NHS Infrastructure Support (includes A&C, estates, managers) (substantive total)	2,874.99	3,271.87	3,725.24	3,355.61	480.61	83.74	-369.63
5. Total Medical and Dental (substantive total)	1,732.92	1,968.52	2,093.06	2,107.95	375.03	139.43	14.89
6. Any other Staff (substantive total)	146.48	47.75	11.50	13.60	-132.88	-34.15	2.10
7. Bank Any other staff	0.00	0.00			0.00	0.00	
7. Bank Medical and dental	11.75	15.48		54.88	43.13	39.39	
7. Bank Registered nursing, midwifery and health visiting staff	111.27	78.18		122.72	11.45	44.54	
7. Bank Registered/ Qualified Scientific, Therapeutic and Technical staff	16.41	11.48		16.75	0.34	5.27	
7. Bank Support to clinical staff	258.10	179.98		207.35	-50.75	27.37	
7. Bank Total NHS infrastructure support	43.69	27.57		15.22	-28.47	-12.35	
8. Agency Any other staff	0.00	0.00			0.00	0.00	
8. Agency Medical and dental	0.87	6.79		1.87	1.00	-4.92	
8. Agency Registered nursing, midwifery and health visiting staff	2.86	3.53		2.38	-0.48	-1.15	
8. Agency Registered scientific, therapeutic and technical staff	17.27	4.16		0.48	-16.79	-3.68	
8. Agency Support to clinical staff	23.68	29.30		17.08	-6.60	-12.22	
8. Agency Total NHS infrastructure support	15.70	1.00		0.43	-15.27	-0.57	
Total	**13,940.15**	**15,689.91**	**16,360.49**	**15,982.85**	**2,042.70**	**292.94**	**-816.80**

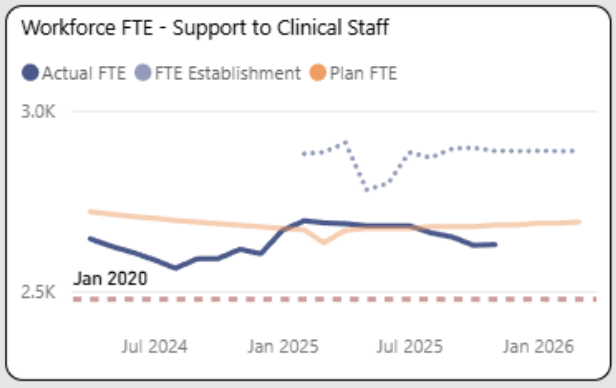
PWR – staff group overview in-year position

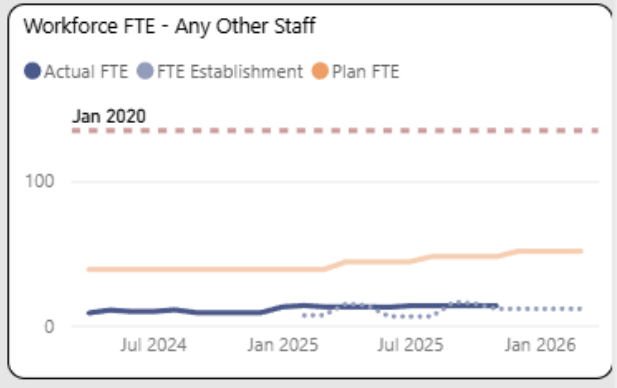


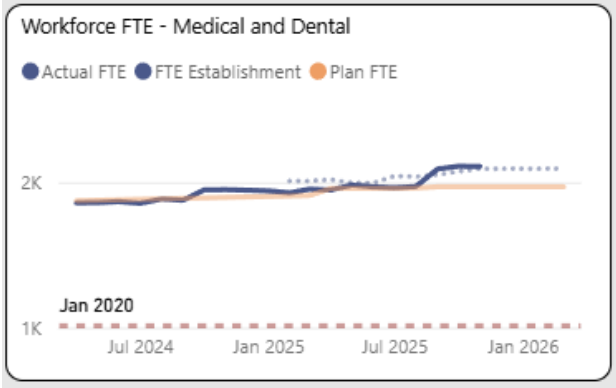










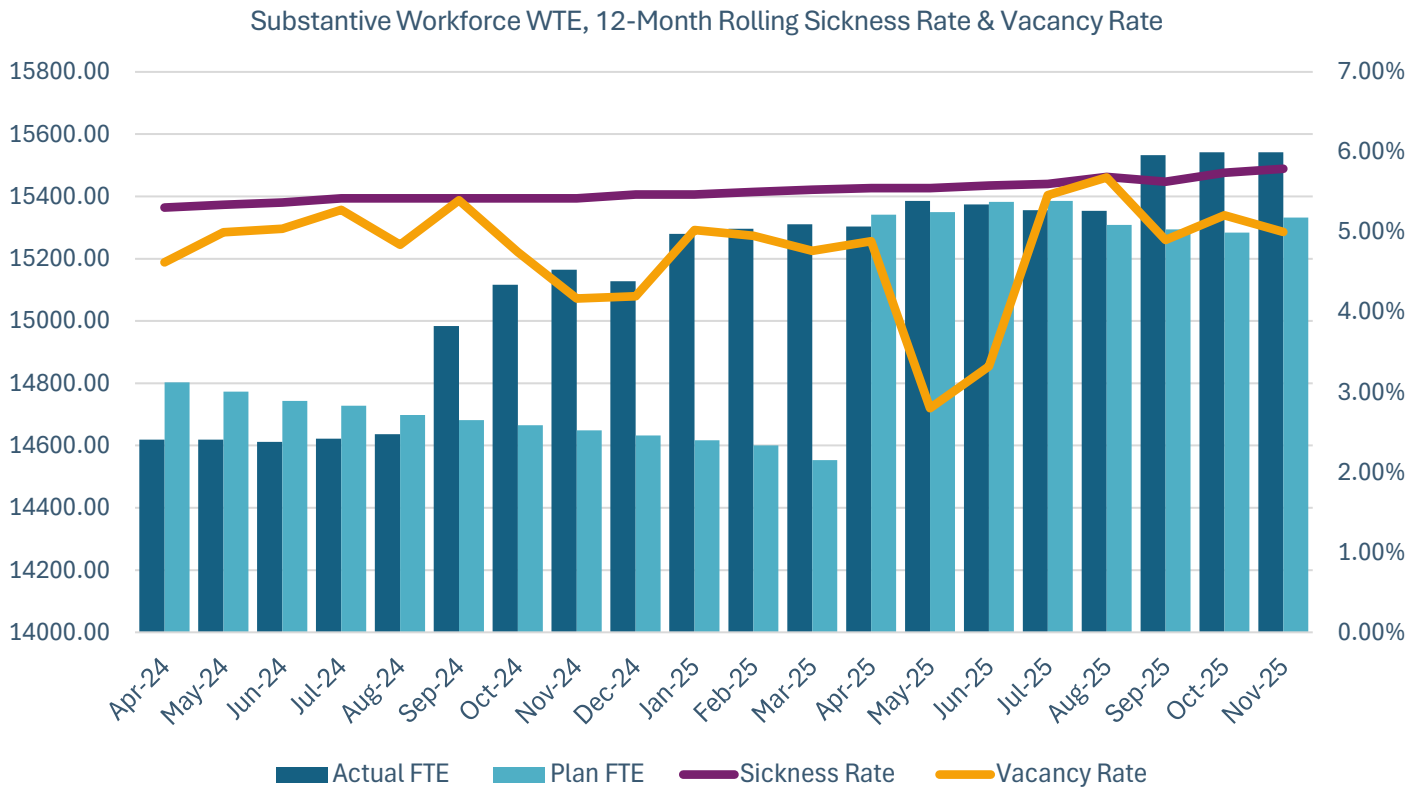


**Please note: The charts on this page include LET data

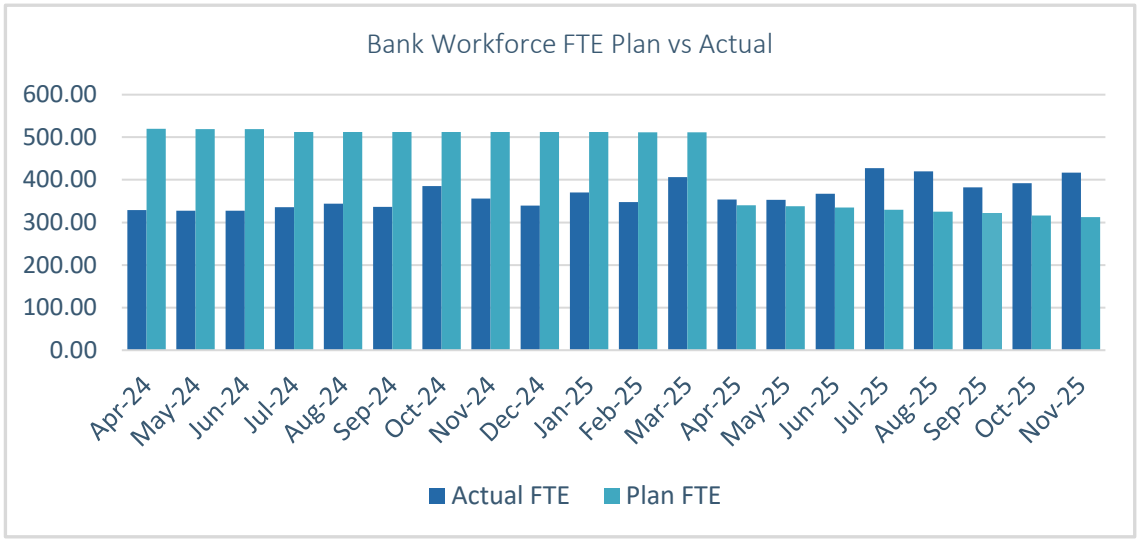
Vacancies

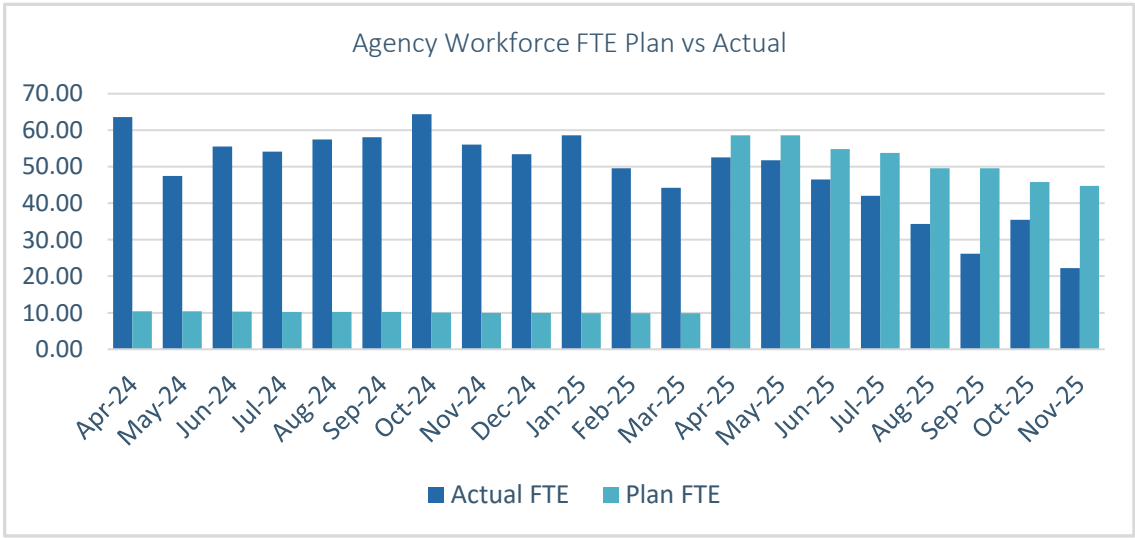
Summary Group	FTE Establishment	Actual FTE	Vacancy FTE	Vacancy FTE %
1. Total Non Medical - Clinical Substantive Staff	10530.69	10065.94	464.75	4.41%
2. Total Non Medical - Non-Clinical Substantive Staff	3725.24	3356.21	369.03	9.91%
3. Medical and Dental	2093.06	2105.95	-12.89	-0.62%
5. Other	11.50	13.60	-2.10	-18.26%
Total	**16360.49**	**15541.69**	**818.80**	**5.00%**

Substantive Workforce



Bank and Agency Workforce



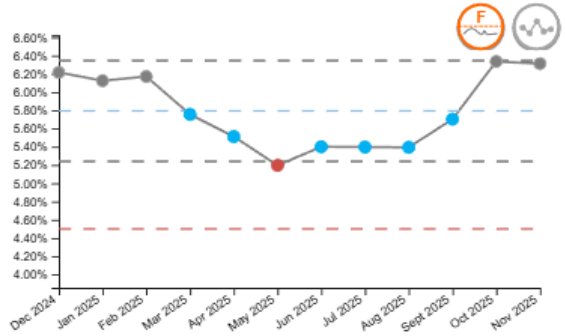


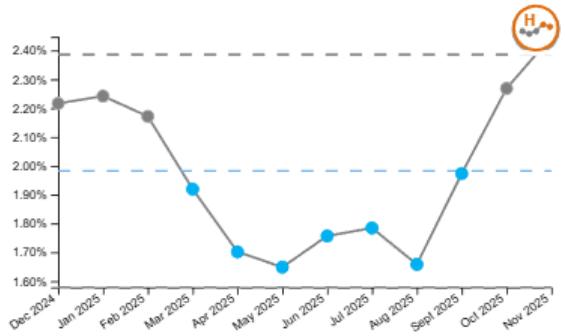
Sickness absence – 12-month average

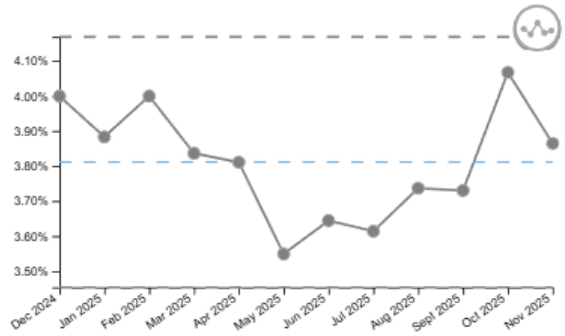
Trust Sickness %	12-Month Rolling	Value	Target
	Nov 25	5.79%	4.50%

Metric	Value
Short Term Sickness %	2.45%

Metric	Value
Long Term Sickness %	3.86%







Current Position:

- Top reasons for sickness:
  - Anxiety/stress/depression (S10) 31.83%
  - Cold, Cough, Flu – Influenza (S13) 12.25%
  - Other musculoskeletal problems (S12) 10.05%
- The 12-month rolling absence rate of 5.79% and the sick pay cost of £34.6m are significantly above the target of 5% and £25m respectively.
- Marked increase in short-term sickness.

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.
- Uptick in short-term sickness due to cold/flu.
- Total days lost: 310,157 FTE.
- Average time lost per person: 21 days.
- Total cost of sick pay: £34.6m.
- Variation in sickness rates across Clinical Boards:
  - Lowest – Clinical and Diagnostic Services at 4.48% (short-term 1.98%, long term 2.65%)
  - Highest – Peri-operative and Critical Care at 6.60% (short-term 2.47%, long term 3.62%)

Actions Undertaken:

- Health and Wellbeing Offer (HAWB) offer – 57 MHFA in place, 13 completed the refresher training and/or produce an in-date certificate. 44 people have completed the two-day course, over 4 cohorts. First scaffolding session has taken place. Two senior Psychologists in place and Psychology assistant commences early in the new Year. TMG update took place on 10 December with pilot areas being identified.
- Occ Health. Flu vaccination program in place.
- Accountability – monthly performance reviews held with Clinical Boards; monthly meetings held between HR and Clinical Boards/Corporate Services. Associate Director of People & Organisational Development (OD) and Head of Workforce Advisory Services meeting with DOPs to discuss and support attendance management.

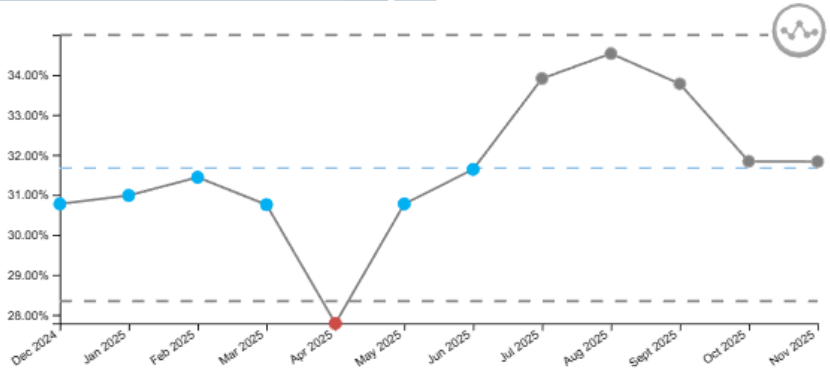
Sickness absence – top absence reasons

Trust Sickness %	12-Month Rolling	Value	Target
	Nov 25	5.79%	4.50%

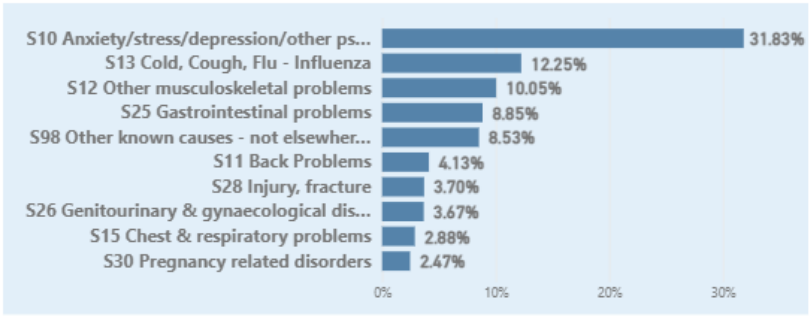
Sickness Reasons - SPC

S10 - Anxiety/stress/depression/ other psychiatric illness

31.83%

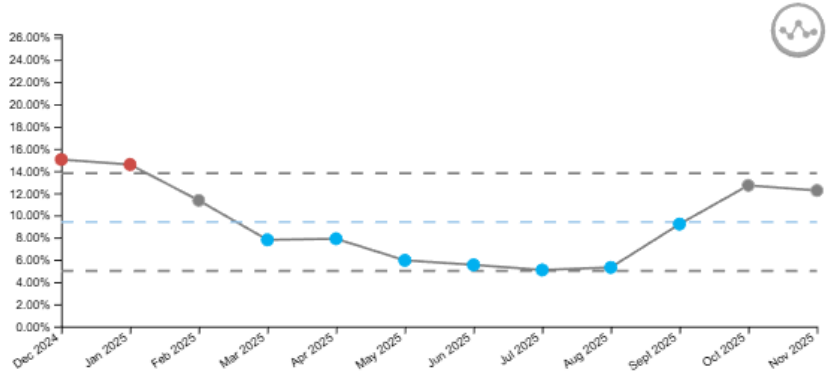


Top 10 Sickness Abscences



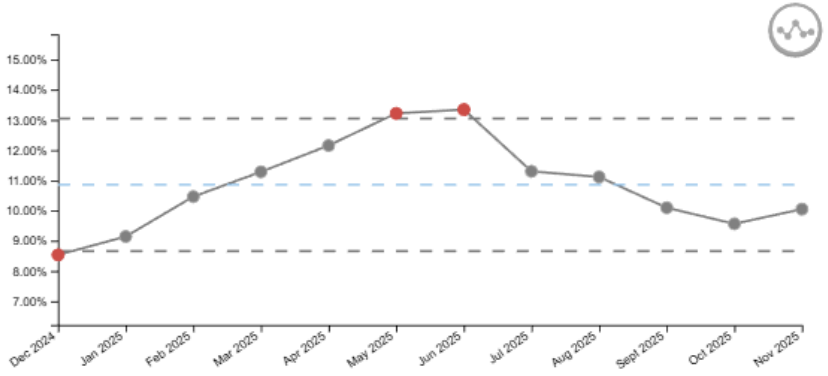
S13 - Cold, Cough, Flu - Influenza

12.25%

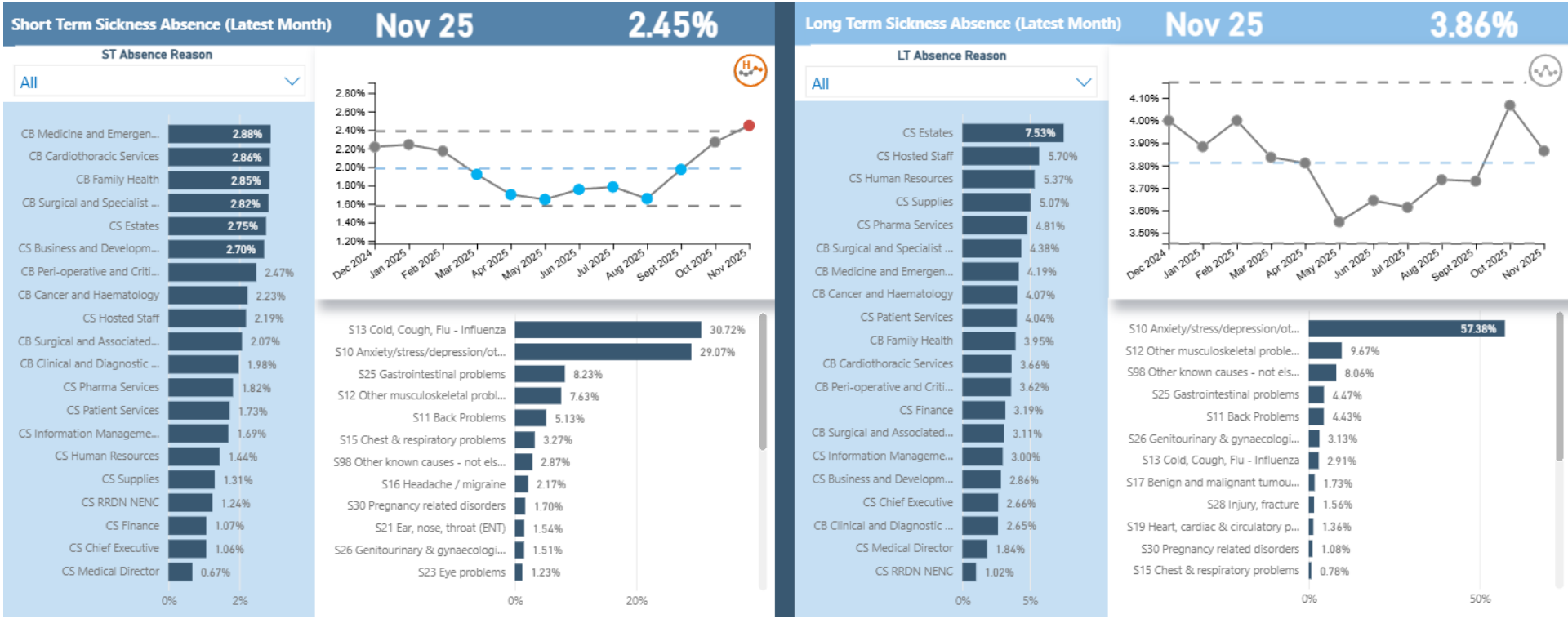


S12 - Other musculoskeletal problems

10.05%



Sickness absence – short & long-term analysis by CB/CS & reason



Sickness – FTE working days lost & formal action activity

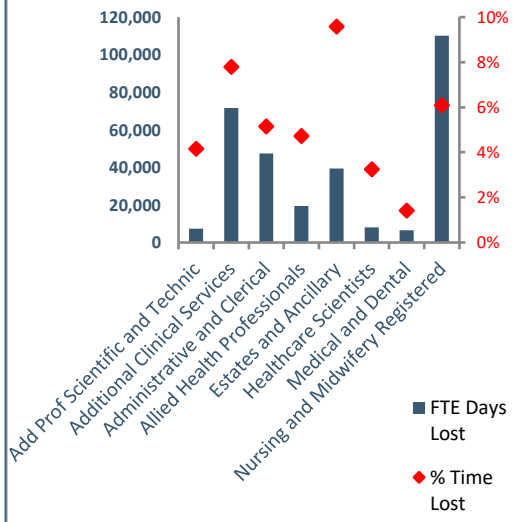
Sickness - FTE working days lost

FTE working days lost due to sickness

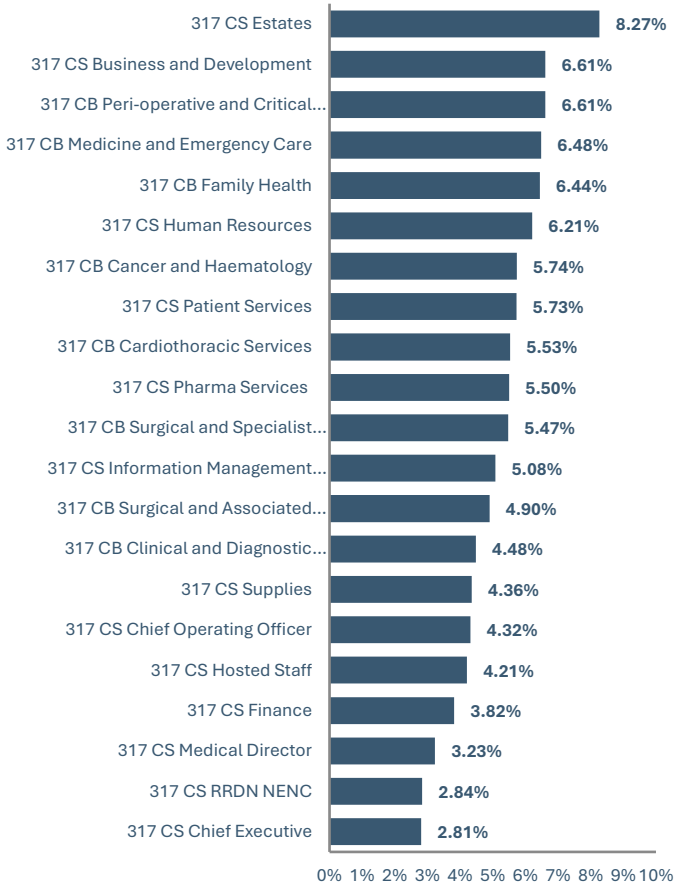
310,157

282,059 compared to the previous year.

Sickness Absence by Staff Group



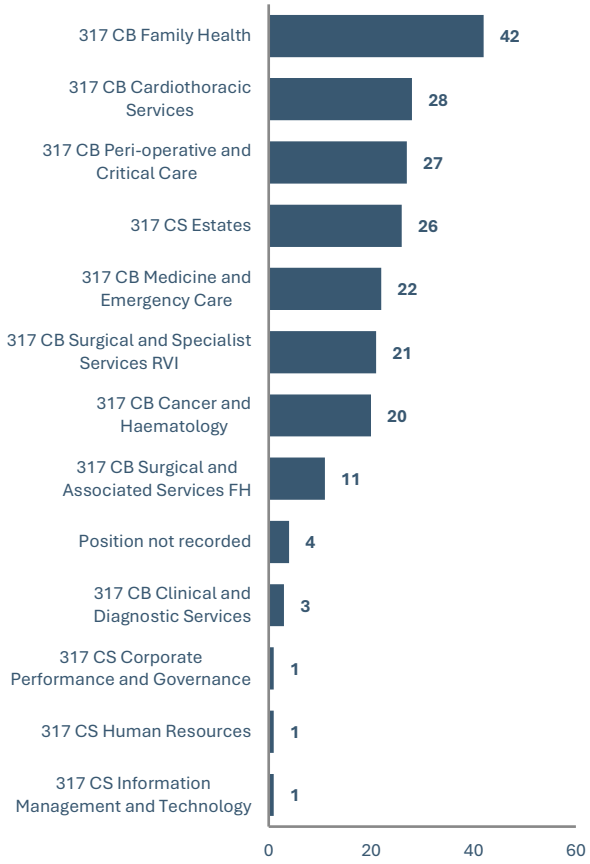
Sickness Absence (% Time Lost) by Clinical Board



Sickness - Formal Action

Latest Data - September 2025

Attendance Management – Formal Action by Clinical Board/ Corporate Service

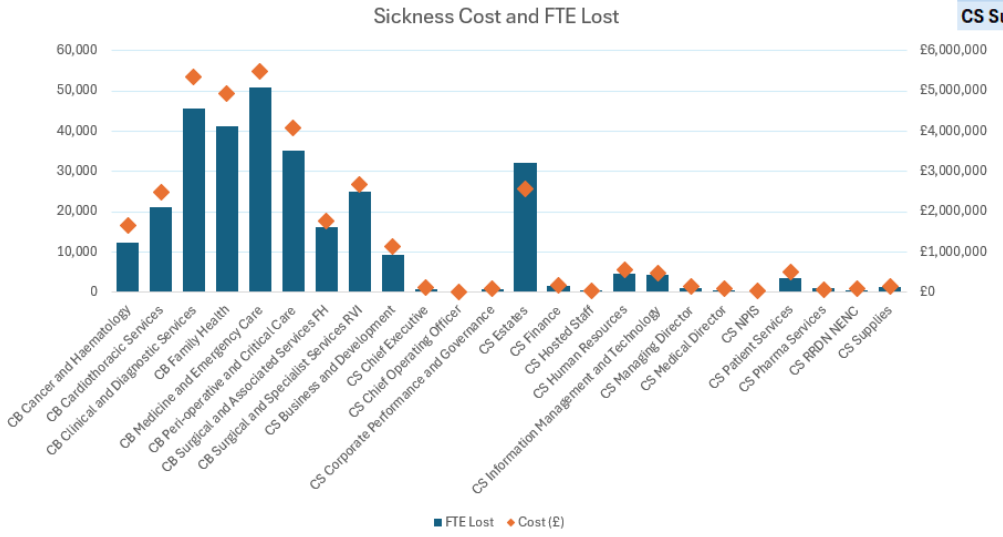


Sickness – FTE working days lost & cost of sick pay

Sickness Absence	12-Month period ending	Cost (£)	FTE Lost	Ave. No of Days Lost per FTE
	Nov 25	£34,573,123	310,157.90	21.05

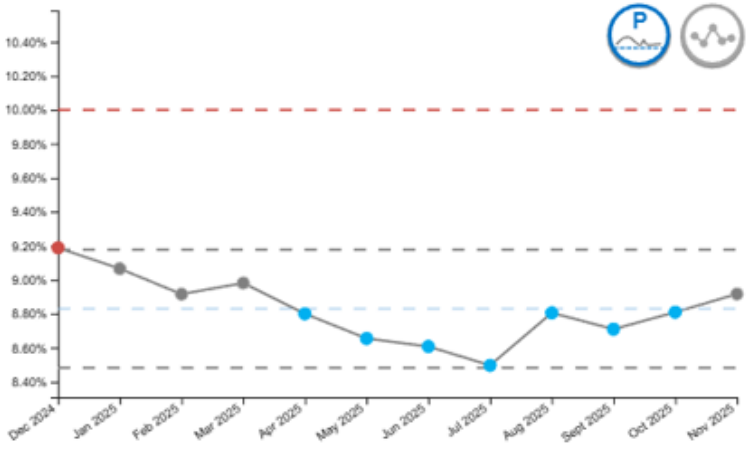
Clinical Board	Cost (£)	FTE Lost	Ave. No of days lost per FTE
CB Cancer and Haematology	1,669,540	12,445.46	20.94
CB Cardiothoracic Services	2,480,042	21,034.89	20.01
CB Clinical and Diagnostic Services	5,346,551	45,601.44	16.28
CB Family Health	4,943,858	41,118.68	23.37
CB Medicine and Emergency Care	5,474,793	50,964.04	23.38
CB Peri-operative and Critical Care	4,068,120	35,168.11	24.25
CB Surgical and Associated Services FH	1,765,308	16,241.75	18.02
CB Surgical and Specialist Services RVI	2,662,286	25,011.75	20.03

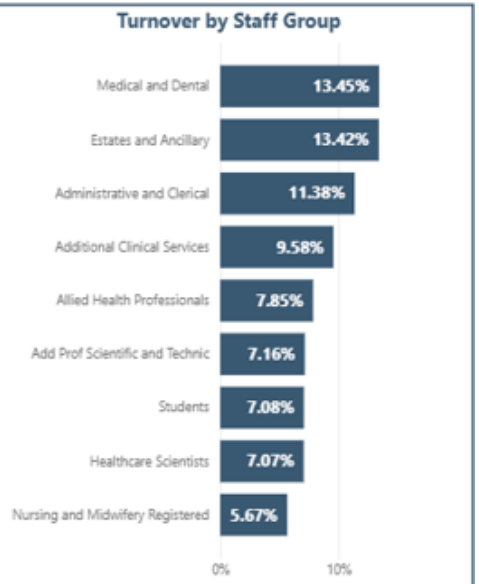
Clinical Board	Cost (£)	FTE Lost	Ave. No of days lost per FTE
CS Business and Development	1,136,365	9,189.83	23.24
CS Chief Executive	109,978	662.03	9.44
CS Chief Operating Officer	0	0.00	0.00
CS Corporate Performance and Governance	89,318	755.81	9.18
CS Estates	2,560,055	32,009.37	30.08
CS Finance	159,474	1,561.85	13.99
CS Hosted Staff	25,922	474.00	15.36
CS Human Resources	558,789	4,663.47	22.59
CS Information Management and Technology	482,740	4,344.05	18.78
CS Managing Director	138,334	1,107.80	13.87
CS Medical Director	92,735	604.47	10.90
CS NPIS	29,861	170.60	8.78
CS Patient Services	492,282	3,631.45	20.01
CS Pharma Services	64,883	1,026.51	19.54
CS RRDN NENC	89,246	608.63	10.29
CS Supplies	132,642	1,408.39	15.24



Turnover

Trust Turnover %	12-Month Rolling	Value	Target
	Nov 25	8.92%	10.00%





Current Position:

- All Clinical Boards are better than target.
- Main reasons for staff leaving to a local Trust in last 12 months are promotion, work-life balance and relocation.

Underlying Issues

- 1,511 leavers in 12-months to November 2025: 20.8% Nursing & Midwifery (315), 20.6% Administrative and Clerical (312).
- Top destinations – no employment (635, 42%); other NHS organisation (470, 31%).
- Top reasons – retirement age (227, 15%); relocation (195, 13%); work-life balance (195, 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

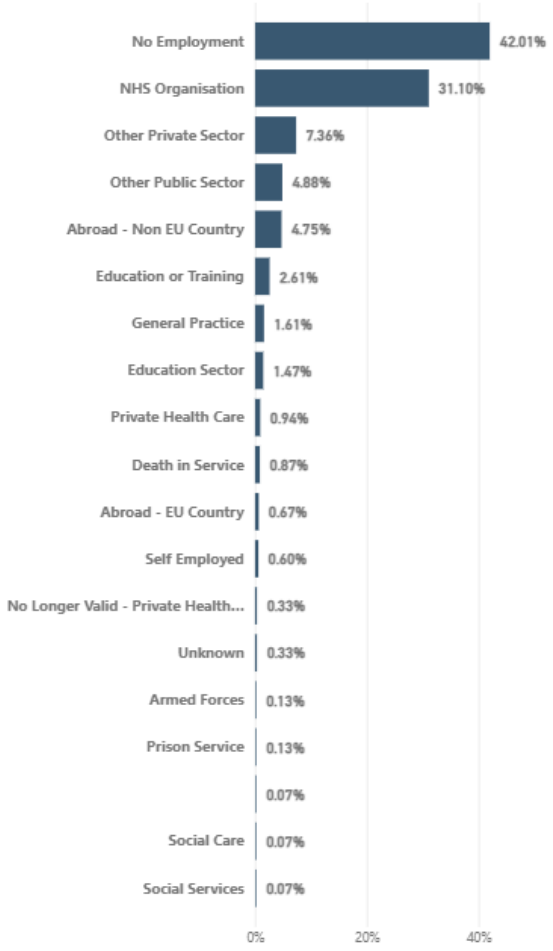
Trust Turnover %	12-Month Rolling	Value	Target
	Nov 25	8.92%	10.00%

Leaving Reasons

Leaving Reasons

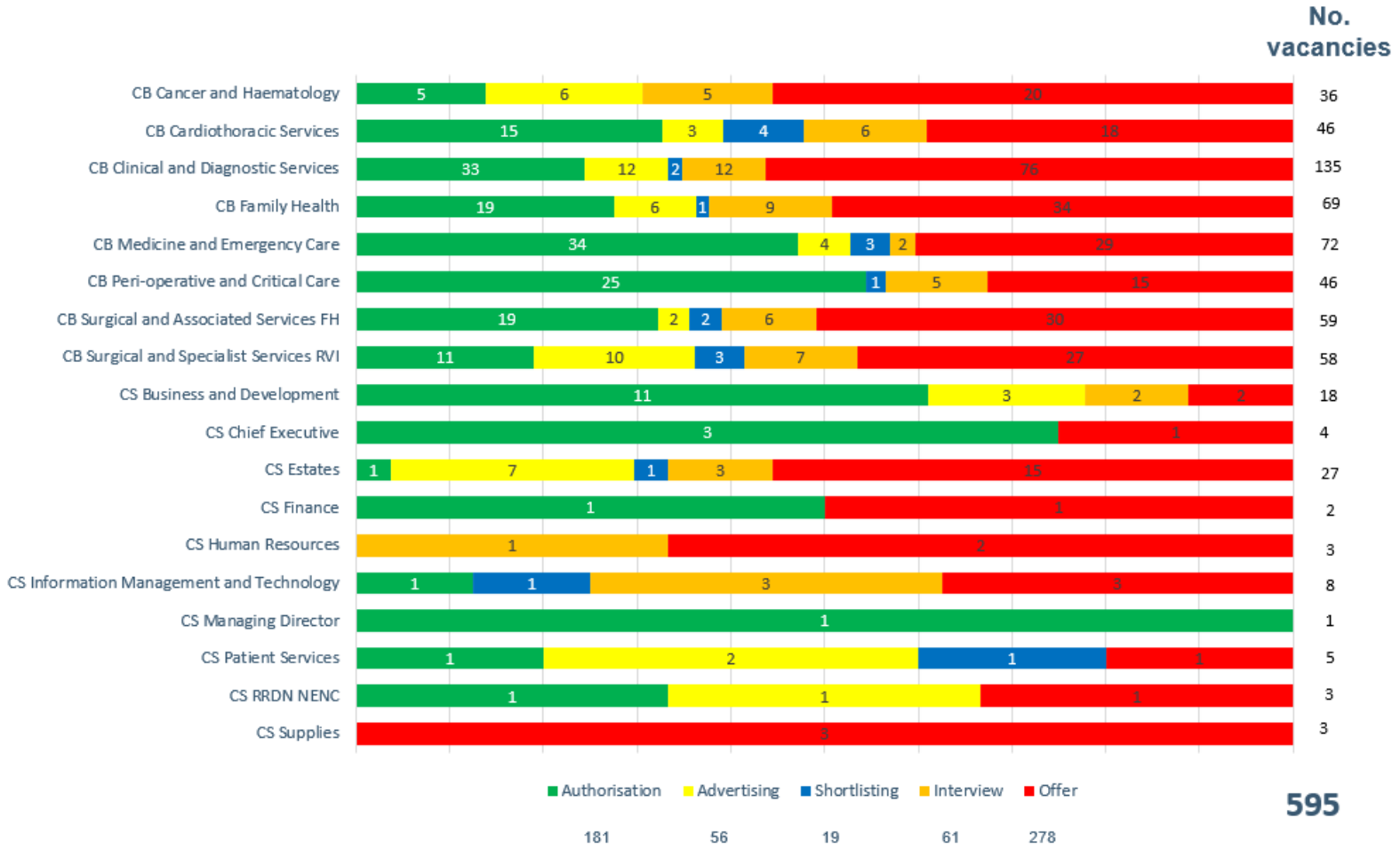
Leaving Reason	Leaving Reason %
Retirement Age	15.18%
Voluntary Resignation - Relocation	13.04%
Voluntary Resignation - Work Life Balance	13.04%
Voluntary Resignation - Promotion	9.57%
Flexi Retirement	8.43%
End of Fixed Term Contract	7.83%
Voluntary Resignation - Health	6.49%
Voluntary Resignation - To undertake further education or training	4.01%
Voluntary Resignation - Incompatible Working Relationships	3.28%
Mutually Agreed Resignation - Local Scheme with Repayment	3.01%
Voluntary Resignation - Lack of Opportunities	2.27%
Dismissal - Capability	2.07%
End of Fixed Term Contract - Completion of Training Scheme	1.74%
End of Fixed Term Contract - Other	1.54%
Voluntary resignation - Pay and Reward Related	1.34%
Voluntary Resignation - Child Dependants	1.20%
Death in Service	0.87%
Voluntary Resignation - Other/Not Known	0.87%
Voluntary Early Retirement - with Actuarial Reduction	0.74%
Retirement - Ill Health	0.67%
Voluntary Early Retirement - no Actuarial Reduction	0.67%
Redundancy - Compulsory	0.47%
Voluntary Resignation - Adult Dependants	0.47%
Dismissal - Conduct	0.33%
End of Fixed Term Contract - External Rotation	0.33%
End of Fixed Term Contract - End of Work Requirement	0.27%
Dismissal - Statutory Reason	0.20%
Redundancy - Voluntary	0.07%

Destination on Leaving



Destination On Leaving	Destination On Leaving %
No Employment	42.01%
NHS Organisation	31.10%
Other Private Sector	7.36%
Other Public Sector	4.88%
Abroad - Non EU Country	4.75%
Education or Training	2.61%
General Practice	1.61%
Education Sector	1.47%
Private Health Care	0.94%
Death in Service	0.87%
Abroad - EU Country	0.67%
Self Employed	0.60%
No Longer Valid - Private Health/Social Care	0.33%
Unknown	0.33%
Armed Forces	0.13%
Prison Service	0.13%
	0.07%
Social Care	0.07%
Social Services	0.07%

Recruitment - Vacancies in progress by stage – 29 December 2025



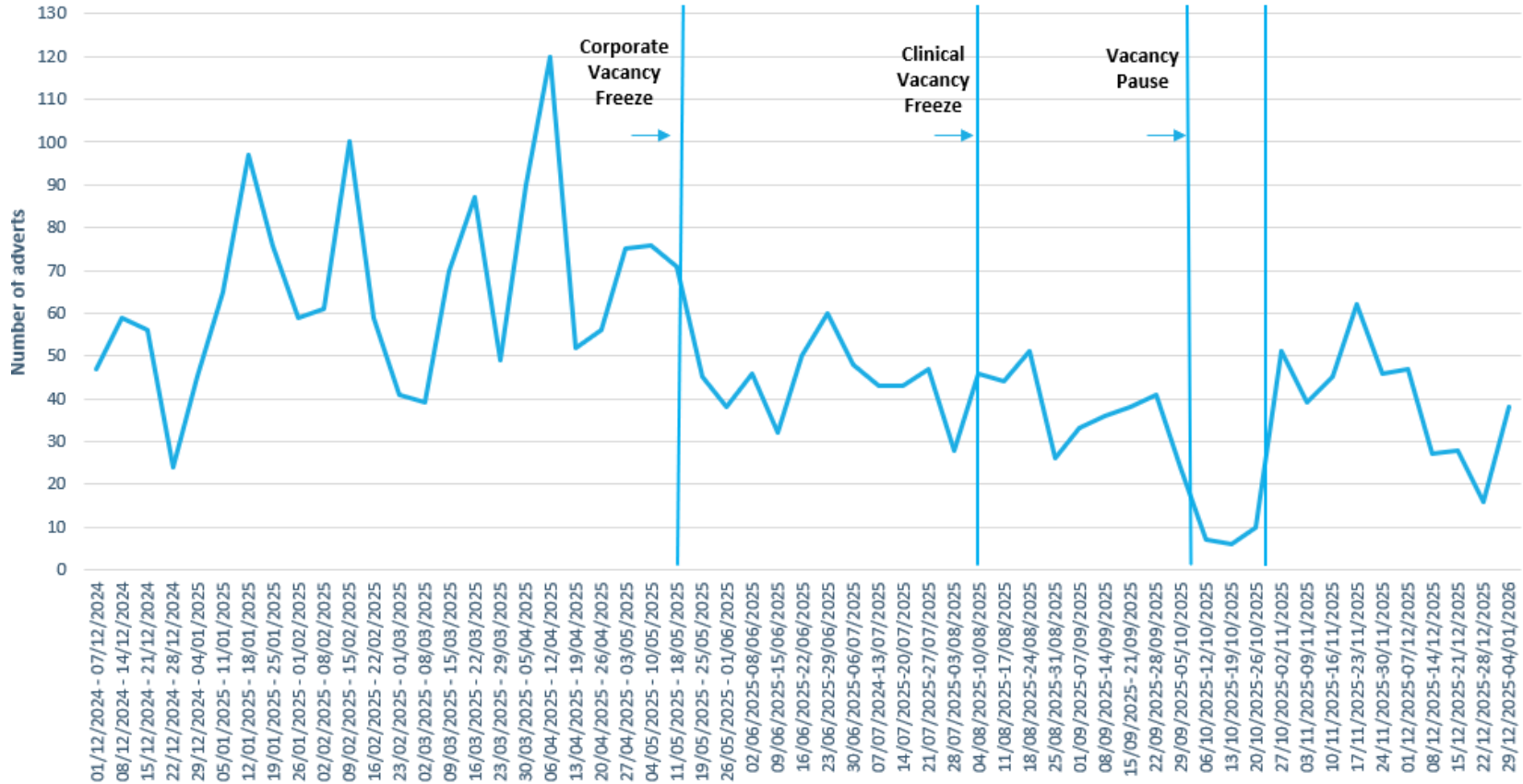
The chart illustrates that as of 29 December 2025, there were 595 adverts progressing through the recruitment process—an increase of 16 compared to the previous period.

The largest proportion of vacancies were at the conditional offer stage (46%). Following the end of the temporary recruitment pause on 22 October 2025, there has been an increase in positions at the authorisation granted stage, which will soon progress to advertising.

Recruitment – Adverts overview

Total adverts w/e 22/12/2025 **51**

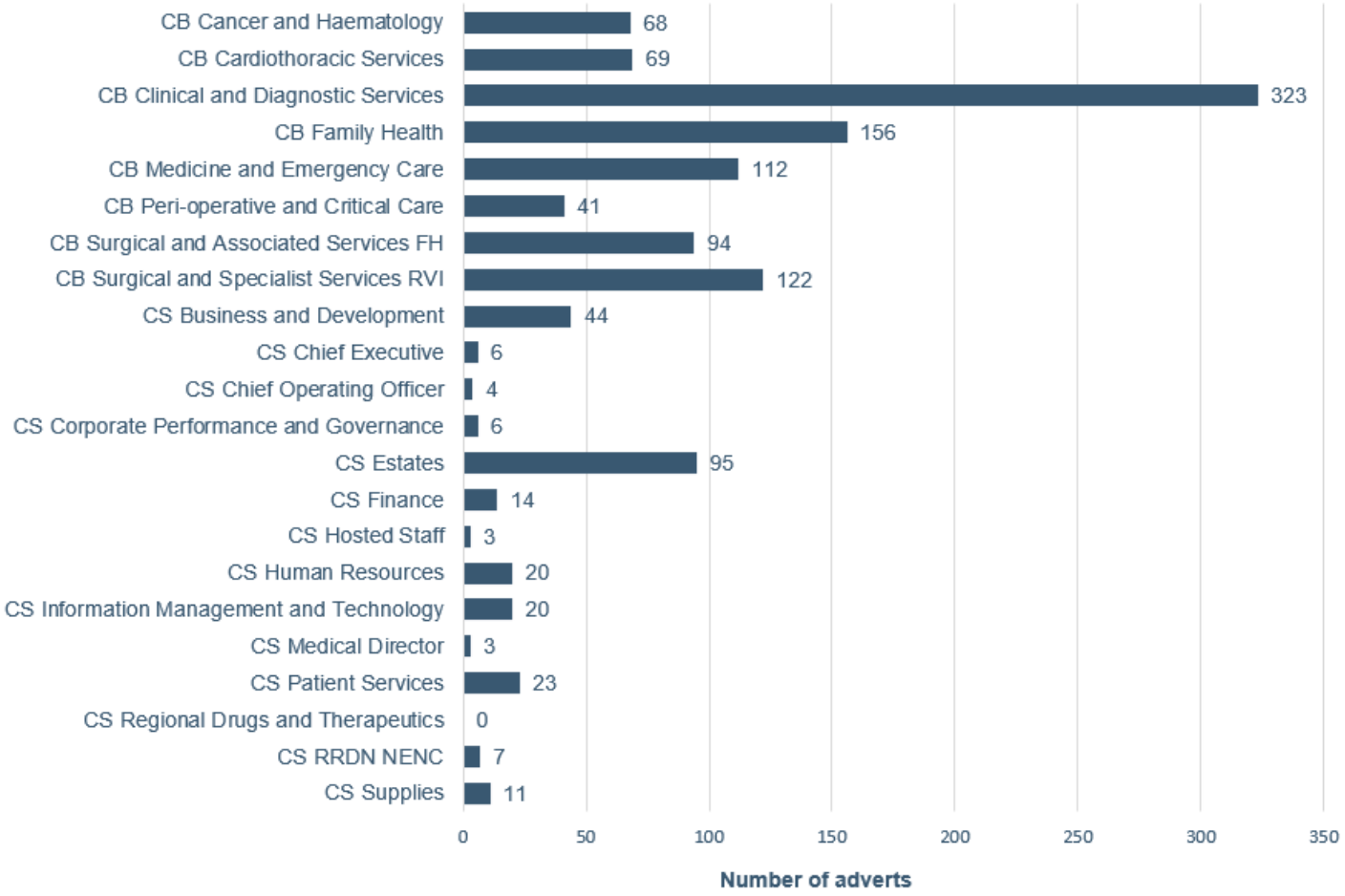
Number of adverts since corporate vacancy freeze on 14/05/2025, clinical vacancy freeze on 04/08/2025 and recruitment pause 01/10/2025-22/10/2025 **1241**



This graph shows a decline in the number of vacancies advertised during the recruitment pause and freezes. Activity increased after the pause ended and has now beginning to taper off in December, leading up to the Christmas period. Overall, there are fewer adverts compared to the same period in 2025.

Recruitment - Adverts

Adverts by CB/CS since corporate vacancy freeze on 14/05/2025, clinical vacancy freeze on 04/08/2025 and recruitment pause 01/10/2025 to 22/10/2025

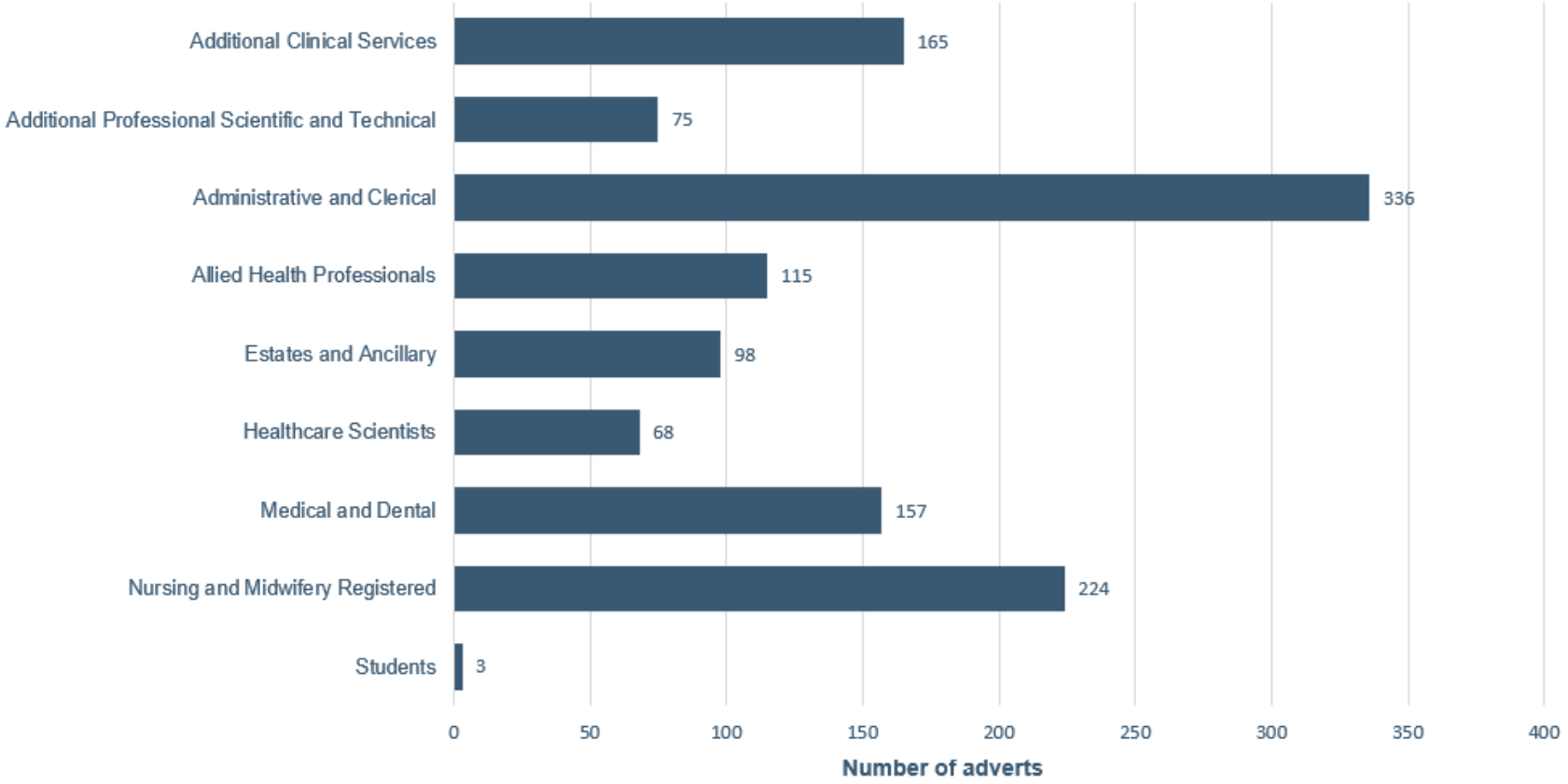


Since 14 May 2025, the highest number of adverts have been for Clinical and Diagnostic Services. However, this should be considered in proportion to the size of the Clinical Board.

Recruitment - Adverts

Number of adverts since corporate vacancy freeze on 14/05/2025 and clinical vacancy freeze on 04/08/2025 and recruitment pause 01/10/2025 to 22/10/2025

1241



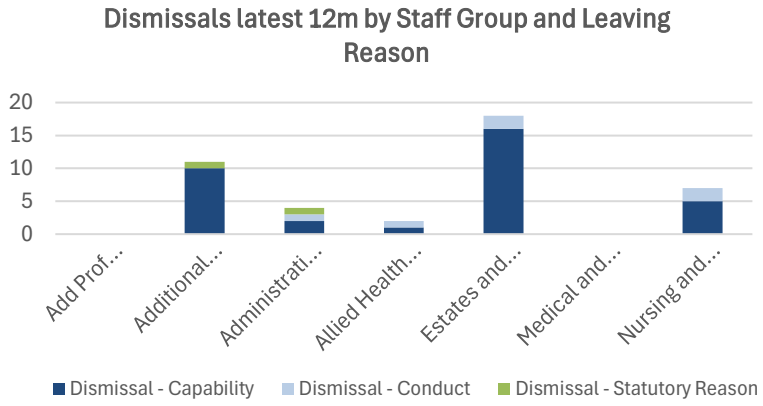
The largest volume of adverts since 14 May 2025 has been in Administrative and Clerical roles, followed by Nursing and Midwifery, with the lowest numbers in Healthcare Scientist positions.

Dismissals – 12 month rolling period ending November 2025

Dismissals	12-Month period ending	Dismissals Headcount	Dismissals FTE
	Nov 25	42	32.02

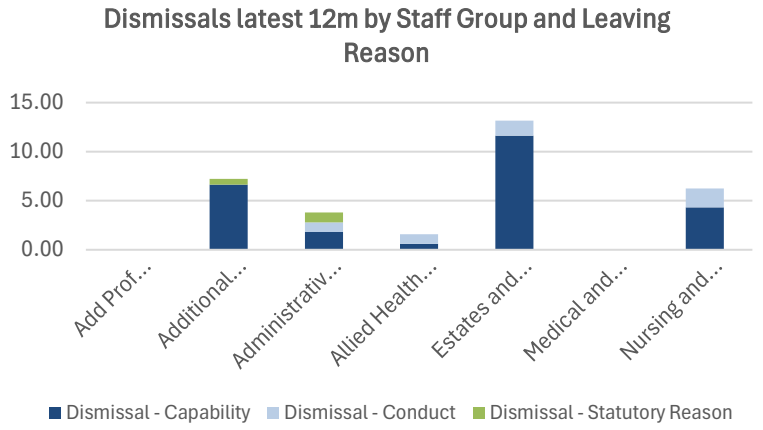
Headcount

Staff Group	Dismissal - Capability	Dismissal - Conduct	Dismissal - Statutory Reason	Total
Add Prof Scientific and Technic				0
Additional Clinical Services	10		1	11
Administrative and Clerical	2	1	1	4
Allied Health Professionals	1	1		2
Estates and Ancillary	16	2		18
Medical and Dental				0
Nursing and Midwifery Registered	5	2		7
Grand Total	34	6	2	42



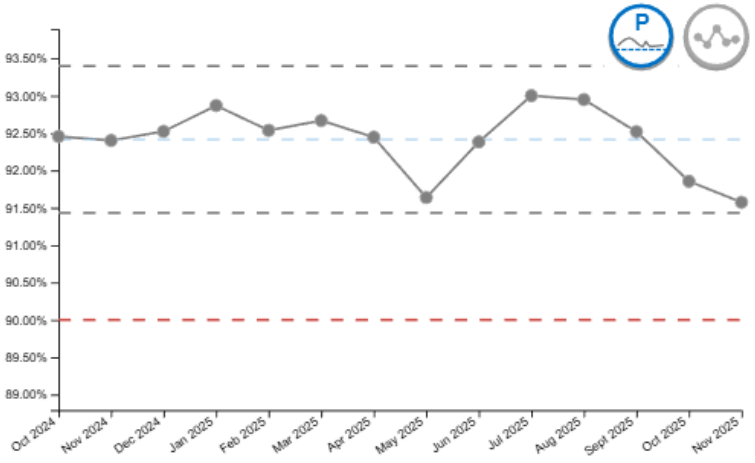
FTE

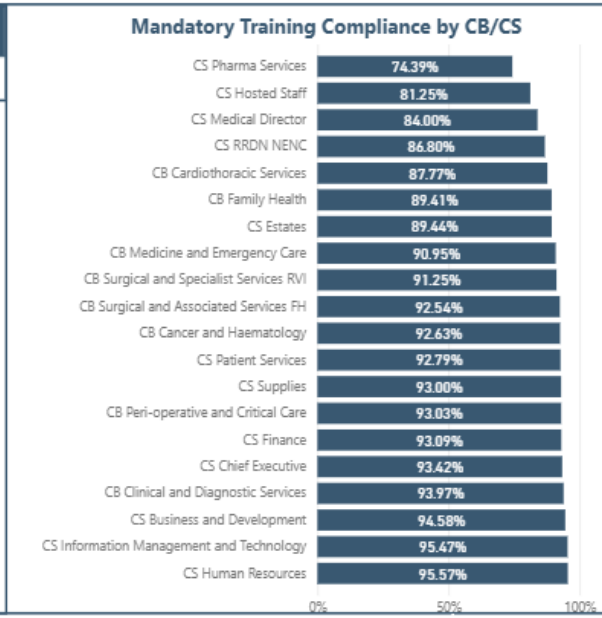
Staff Group	Dismissal - Capability	Dismissal - Conduct	Dismissal - Statutory Reason	Total
Add Prof Scientific and Technic				0.00
Additional Clinical Services	6.63		0.60	7.23
Administrative and Clerical	1.80	1.00	1.00	3.80
Allied Health Professionals	0.60	1.00		1.60
Estates and Ancillary	11.63	1.53		13.16
Medical and Dental				0.00
Nursing and Midwifery Registered	4.33	1.91		6.23
Grand Total	24.98	5.44	1.60	32.02

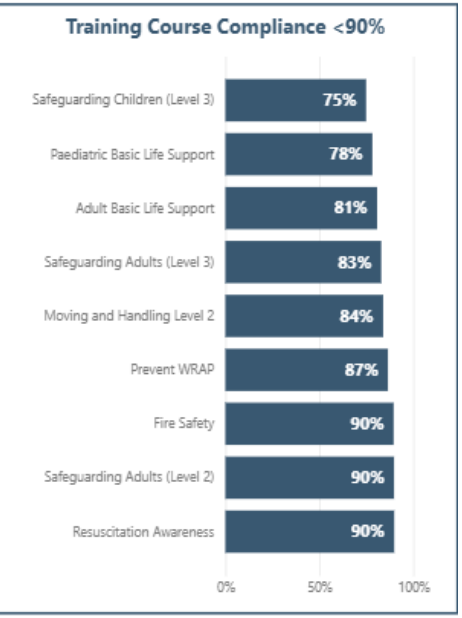


Mandatory training

Mandatory Training Compliance	Month	Value	Target
	Nov 25	91.57%	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 Care Quality Commission (CQC)-registered providers to ensure staff receive learning disability and autism training appropriate to their role. 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 (79.80%) with low compliance in Safeguarding Children - Level 3 (58.47%); Adult Basic Life Support (62.69%); Paediatric Basic Life support (65.77%).
- 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.

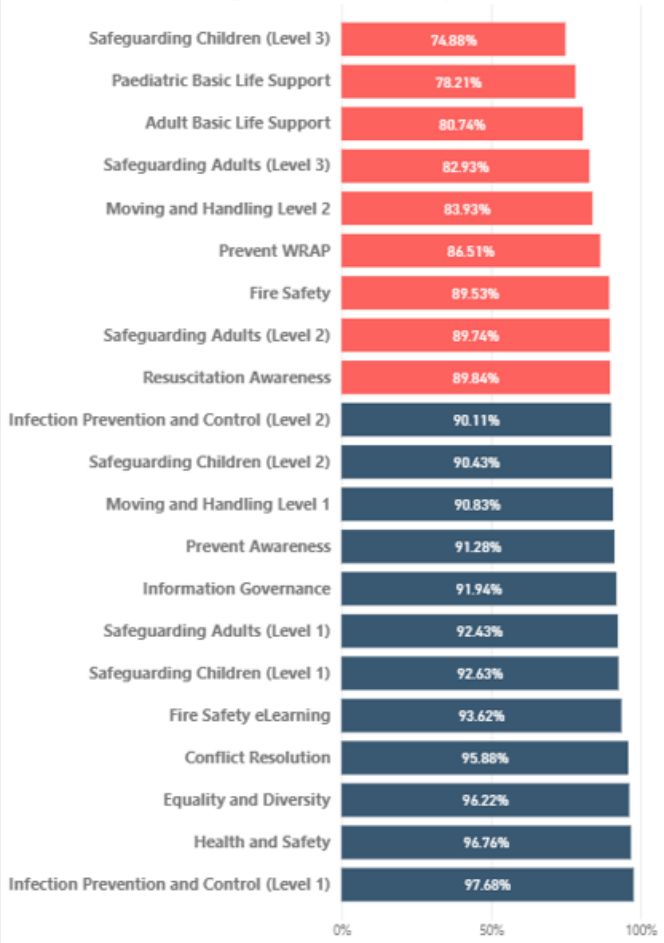
Actions Undertaken:

- Infection prevention & control – in line with national guidelines, level 1 training to be allocated to all staff. In agreement with IPC team, staff will be awarded compliance where they have completed level 2 in the last 3 years, therefore no immediate negative impact expected.
- Adult and children's safeguarding – audience changes have started to address those with no safeguarding attached.
- HR actively seeking assurance from outliers that they have plans in place to address compliance. Accountability will be addressed on a monthly basis.

Mandatory training

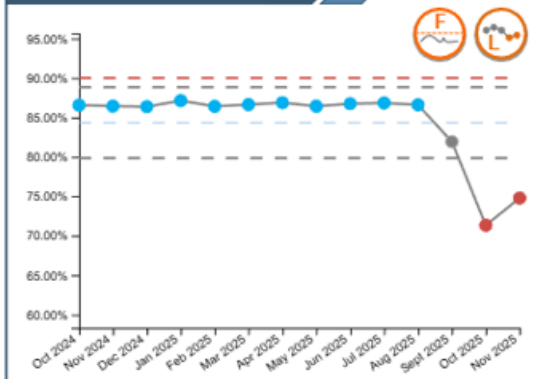
Mandatory Training Compliance	Month	Value	Target
	Nov 25	91.57%	90.00%

Training Course Compliance %

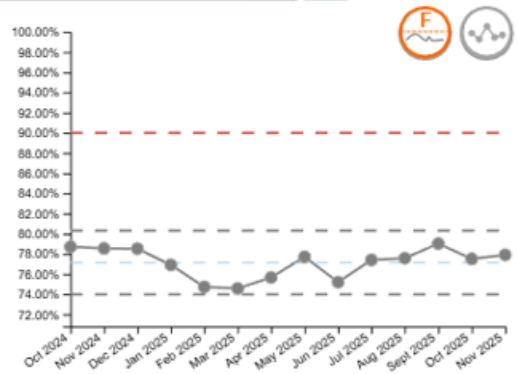


Lowest 4 Mandatory Training Compliance %

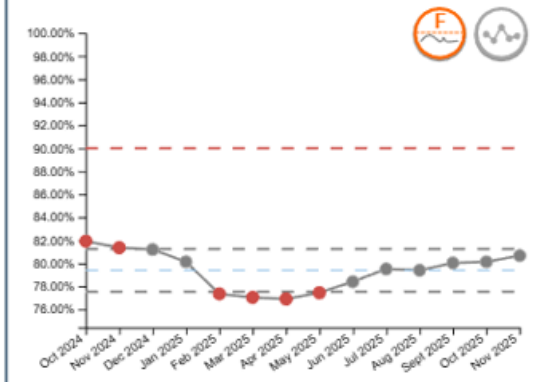
Safeguarding Children (Level 3) 75%



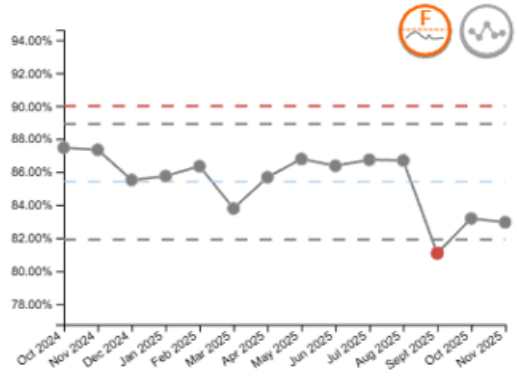
Paediatric Basic Life Support 78%



Adult Basic Life Support 81%

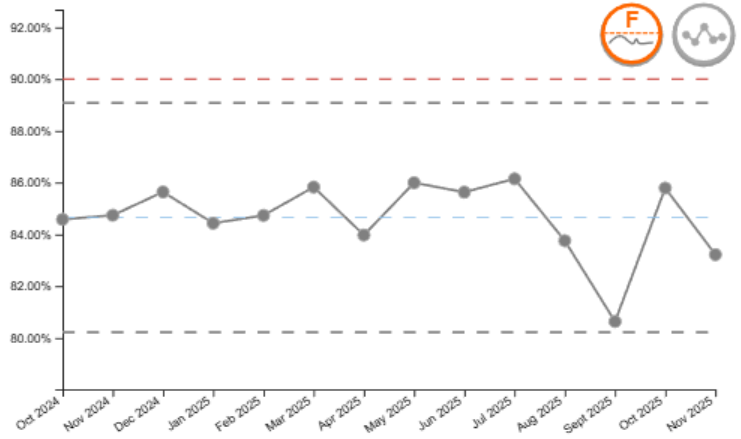


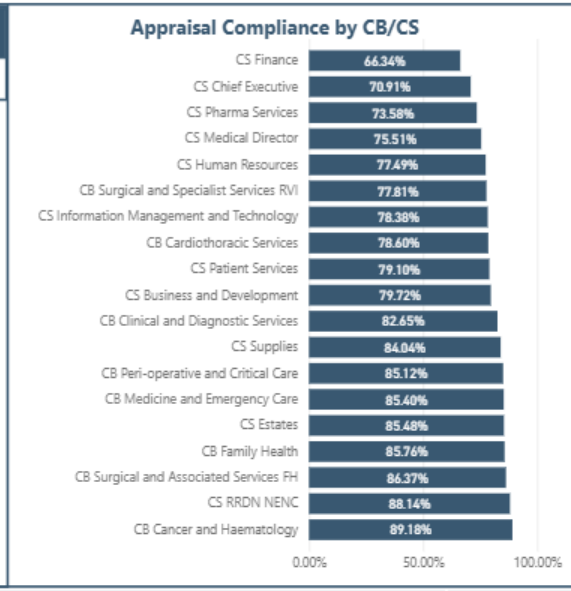
Safeguarding Adults (Level 3) 83%

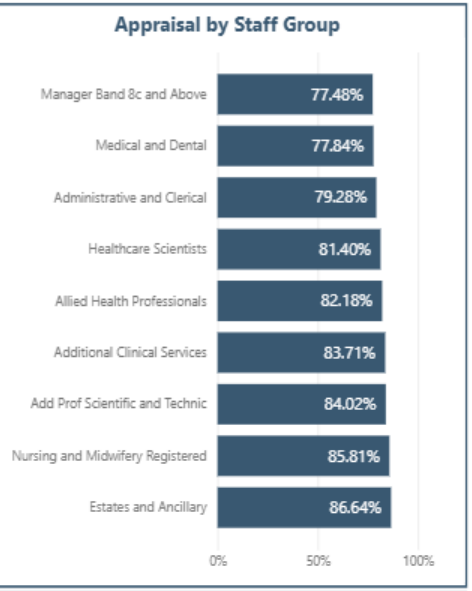


Appraisal compliance

Appraisal Compliance	Month	Value	Target
	Nov 25	83.22%	90.00%







Current Position:

- Overall performance is consistently below target however, has increased from last month after declining for the previous two months.
- No area has met the target.

Underlying Issues

- 2,388 appraisals are overdue with highest numbers in Nursing and Midwifery (672) and Admin and Clerical (492).
- Clinical board performance varies between 77.81% (Surgical and Specialist Services) to 89.18% (Cancer and Haematology).
- Corporate Service performance varies between 66.34% (Finance) to 94.44% (Hosted Staff).
- Compliance impacted by time and capacity of managers and staff.

Actions Undertaken:

- HR continues to actively seek assurance from outliers that they have plans in place to address compliance.
- Accountability will be addressed on a monthly basis.
- Medical & Dental (M&D) staff. Quarterly updates continue to be sent to clinical board chairs.

Bank use (£) – non-medical

Bank Utilisation (£)	12-Month period ending	Total Bank Expenditure (£)	Total Bank Difference (£)
	Nov 25	£18,315,174	+£1,247,298

Bank Utilisation (£)

Staff Group	Dec 23 - Nov 24	Dec 24 - Nov 25	Difference
Admin & Clerical	£1,172,087	£1,001,233	-£170,854
Ancillary	£260,109	£351,425	£91,316
Estates			£0
Nursing & Midwifery (Registered)	£5,574,715	£6,548,381	£973,666
Nursing & Midwifery (Unregistered)	£9,213,317	£9,726,296	£512,979
Professional & Technical	£847,647	£687,838	-£159,808
Total	£17,067,875	£18,315,174	£1,247,298

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 HCAs for enhanced care.
- To support the shift from overtime to Bank, around 800 substantive staff have been fast-tracked as additions to the Bank.

Agency use (£) – non-medical

Agency Utilisation (£)	12-Month period ending	Total Agency Expenditure (£)	Total Agency Difference (£)
	Nov 25	£3,015,391	-£767,997

Agency Utilisation (£)

Staff Group	Dec 23 - Nov 24	Dec 24 - Nov 25	Difference
Admin & Clerical	£267,604	£189,900	-£77,704
Ancillary	£21,315	£0	-£21,315
Estates	£16,291	£28,029	£11,738
Nursing & Midwifery (Registered)	£255,611	£621,167	£365,556
Nursing & Midwifery (Unregistered)	£2,104,204	£1,196,726	-£907,478
Professional & Technical	£1,118,363	£979,570	-£138,793
Total	£3,783,388	£3,015,391	-£767,997

Current Position:

- Costs reduced by c. £0.77m 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.
- Ongoing additional recruitment
- Agency usage reviewed and challenged weekly / monthly.
- Robust management of agency requests with active bank and redeployment

Agency use (£) – medical

Agency Utilisation (£)	12-Month period ending	Total Agency Expenditure (£)	Total Agency Difference (£)
	Nov 25	£3,844,491	+£677,275

Agency Utilisation (£)

Staff Group	Dec 23 - Nov 24	Dec 24 - Nov 25	Difference
Medical - Consultant	£2,770,157	£3,772,306	£1,002,149
Agency - Career / Staff Grades	£78,566	-£8,834	-£87,401
Medical - Registrar & Senior Registrar	£223,655	£7,180	-£216,475
Medical - SHO'S and HO'S	£94,372	£68,879	-£25,493
General Practitioner	£466	£4,961	£4,495
Total	£3,167,216	£3,844,491	£677,275

Current Position:

- Costs increased by c. £677,275 on previous year.
- Notable reductions in Registrar/Senior Registrar and Career/Staff Grades.
- Significant increase in Consultant spend.
- Consultants collectively working an average of 1,100 hours per month.

Underlying Issues

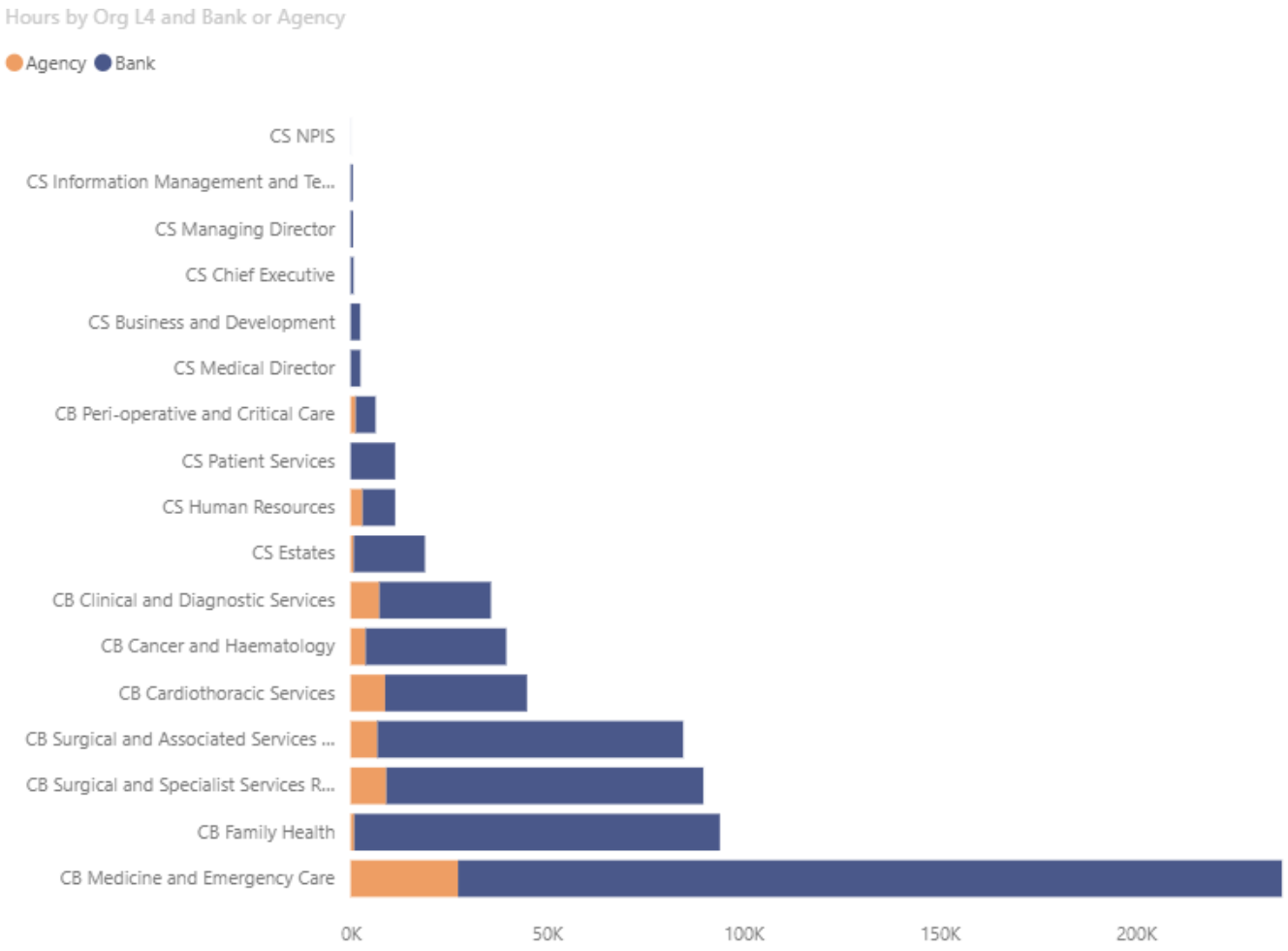
- Consultant spend. Staffing issues in Older People's Medicine and Stroke; off-framework arrangement in Paediatric Intensive Care Unit (PICU) due to sickness absence and recruitment; locum in General Medicine as part of Winter Plan 2024/25 ended in April 2025; agency Consultants unwilling to move to a Trust contract.

Actions Undertaken:

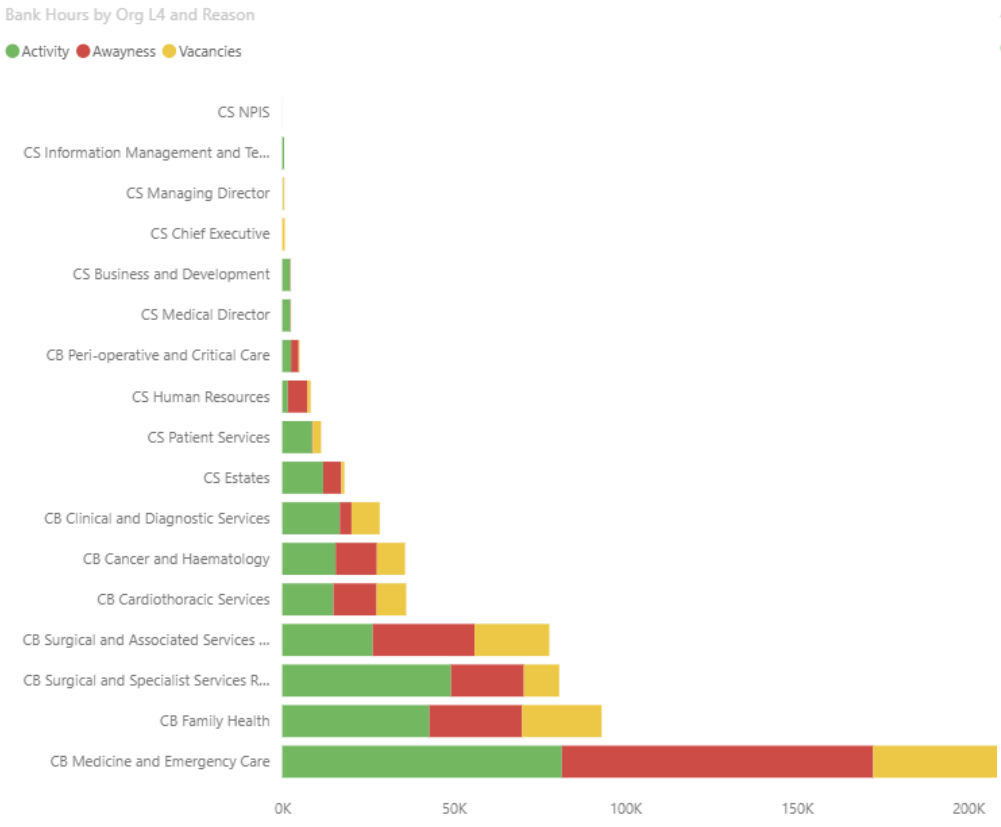
- Consultants. Trust contracts offered and declined; charges and hourly rates renegotiated wherever possible; recent recruitment in PICU has been successful reducing the need for agency.

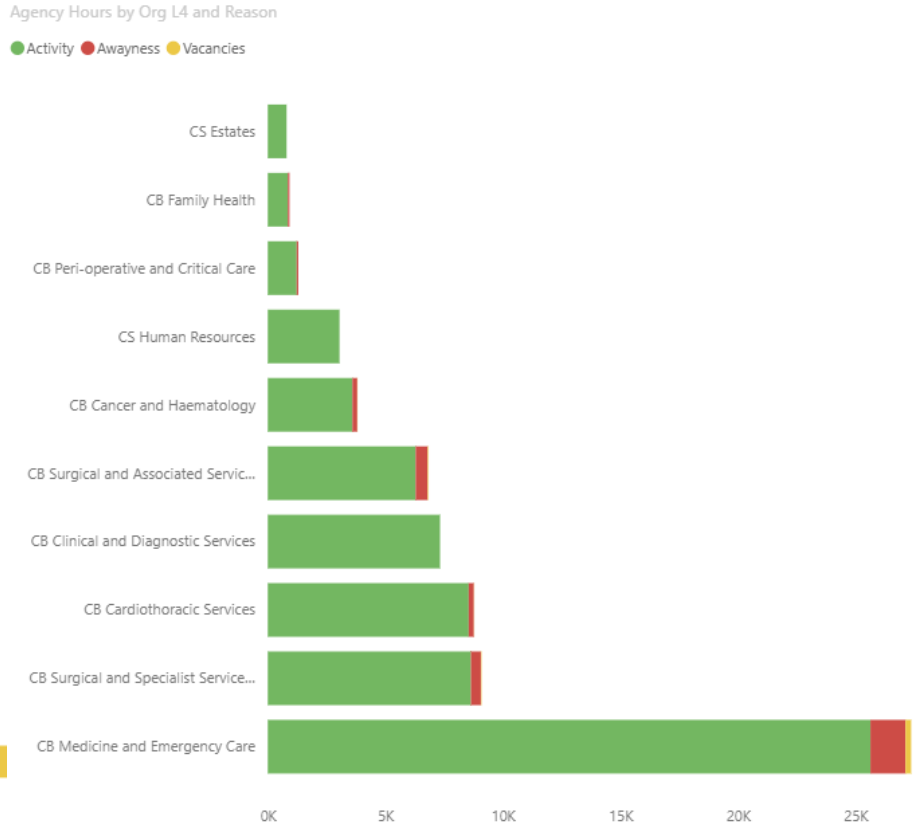
Bank & agency use - hours

Bank & Agency	12-Month period ending	Total Bank and Agency Hours
	Nov 25	680,946



Bank & agency hours (latest 12-month period ending November 2025)

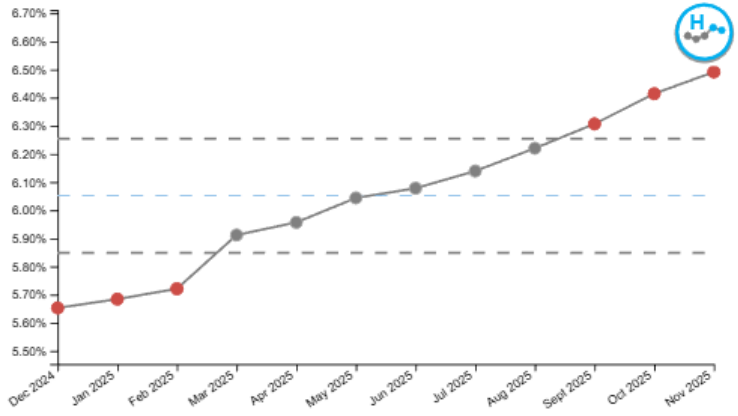


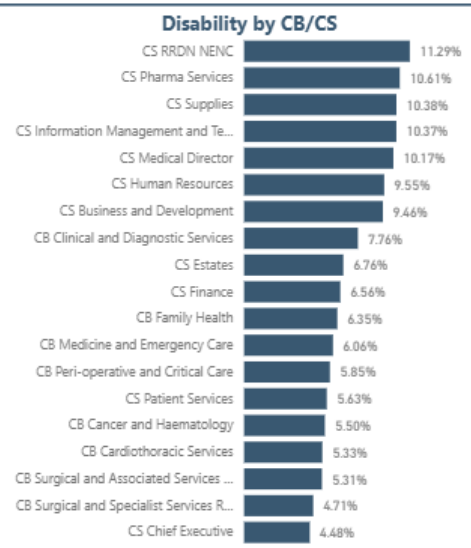


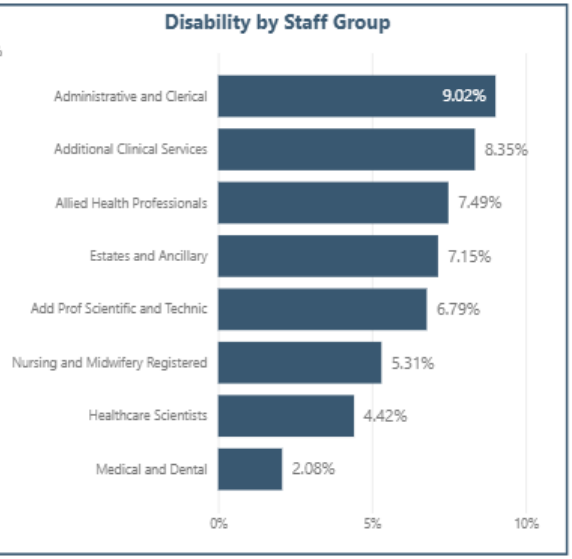
- **awayness**, including sickness, maternity, study leave, industrial action, etc.
- **activity**, including workload, acuity, waiting list initiative, etc.
- **vacancies**

Equality, diversity and inclusion (EDI) - disability

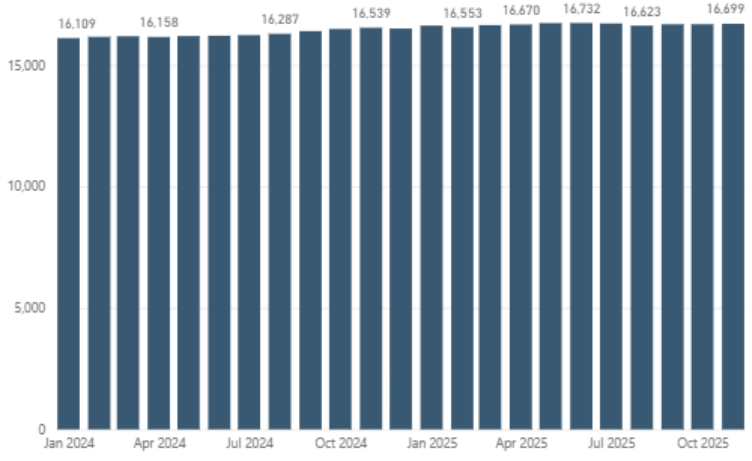
EDI - Disability	Month	Value	Trust Headcount
	Nov 25	6.49%	16,699







Trust Headcount Trend



Age Band

	Age Band	Disability %
1	<=20 Years	7.84%
2	21-25	13.43%
3	26-30	7.71%
4	31-35	6.71%
5	36-40	5.16%
6	41-45	4.89%
7	46-50	5.31%
8	51-55	6.17%
9	56-60	5.79%
10	61-65	6.13%
11	66-70	3.92%
12	>=71 Years	3.39%

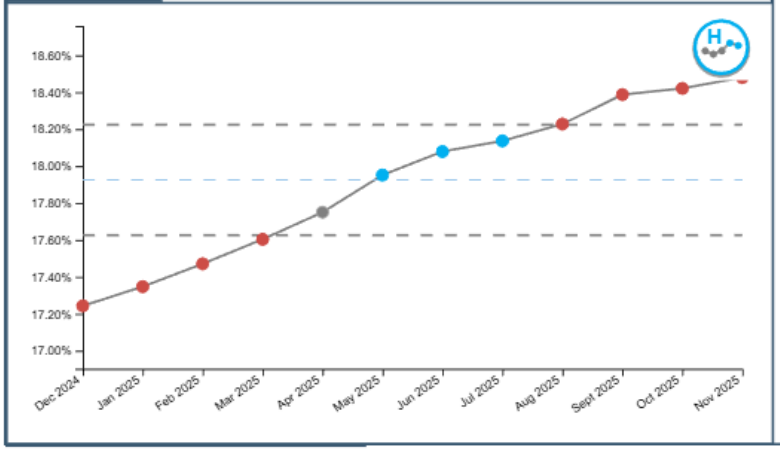
Current Position:

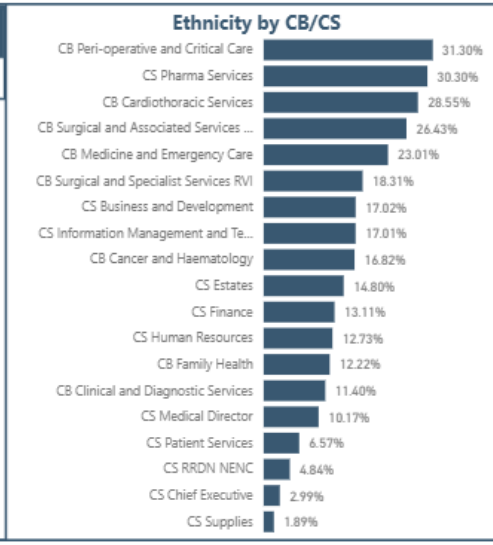
Charts show percentage of staff in post each month by those disclosing a disability.

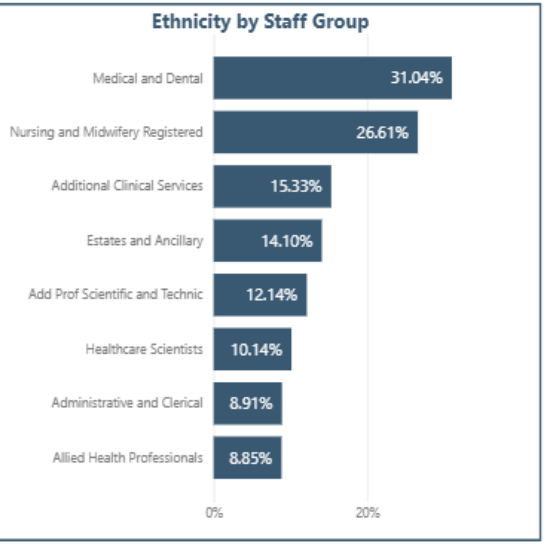
Percentage of disabled staff continues to grow with the latest position reflecting 6.49% of the workforce.

Equality, diversity and inclusion (EDI) - ethnicity

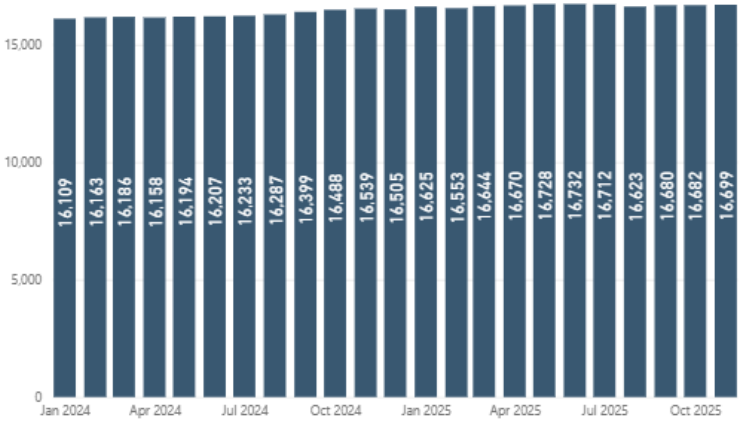
EDI - Ethnicity	Month	Value	Trust Headcount
	Nov 25	18.48%	16,699







Trust Headcount Trend



Age Band

	Age Band	BME %
1	<=20 Years	19.61%
2	21-25	16.08%
3	26-30	27.40%
4	31-35	24.52%
5	36-40	23.06%
6	41-45	16.01%
7	46-50	18.94%
8	51-55	16.75%
9	56-60	9.79%
10	61-65	5.88%
11	66-70	5.88%
12	>=71 Years	3.39%

Current Position:

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

Percentage of BAME staff continues to grow with the latest position reflecting 18.48% of the workforce.

Finance

Overview Dashboard

November 2025

Financial Health

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

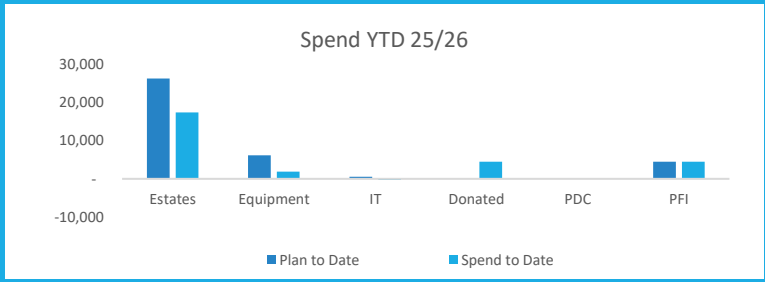
Financial Performance Month 8

The trust has a plan to break even for 25/26. To do this, it needs to deliver £106m of savings, manage expenditure within budgets and to deliver Elective Recovery Fund Income of £351m.

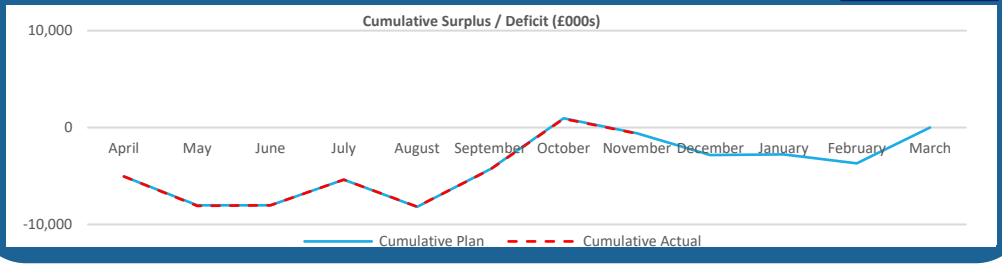
At month 8 the Trust is reporting a £0.6m deficit which is in line with the plan, however in delivering this position, the trust has had to bring forward technical savings to offset new pressures and under delivery of Cost Improvement Programme (CIP). Key points to note include:

- Unfunded pay award of £2.4m and costs associated with resident doctor industrial action of £1.4 m (November £0.6 m and July £0.8m) are negating some reductions in temporary pay.
- Year to date there is a pressure of £13.1m on drugs against plan, this is made up of £5m in tariff drugs, £4.3m block and £3.3m pass through (which are matched with additional income). This includes under delivery of £3m against the CIP plan on drugs.
- The CIP of £106m is phased over the year with a plan of £61.7m to month 8. Year to date Clinical Boards and Corporate Services have delivered £26.9m (of which £23.7m is recurrent). A further £6m of other CIP has been actioned as well as £29m of non recurrent technical measures which is £10m more than planned for and required as a result of slippage on CIP plans including the impact of the subsidiary company.
- There is a pressure related ICB depreciation funding, which has been mitigated by a prospective revenue to capital transfer in Estates of £1.2m (reduced from £2.2m last month).
- Activity which comes under the ERF scheme translates to £4.8m of additional income above the cap and is recognised within the position.
- 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.

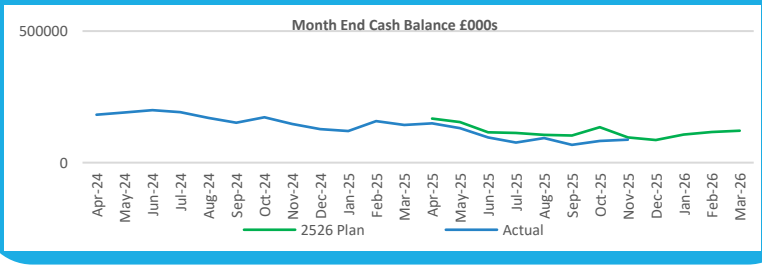
Capital Programme Delivery – Month 8



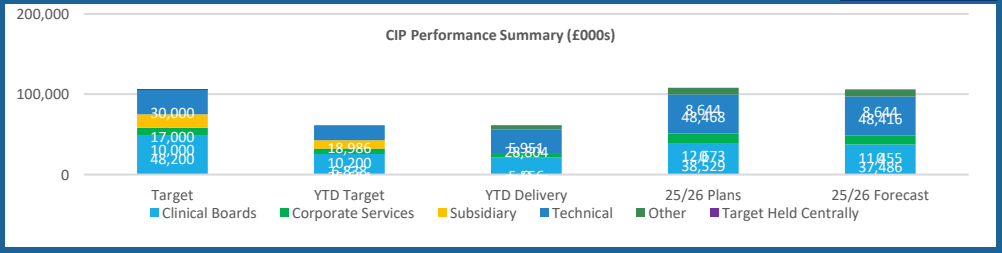
Cumulative Performance Against Plan



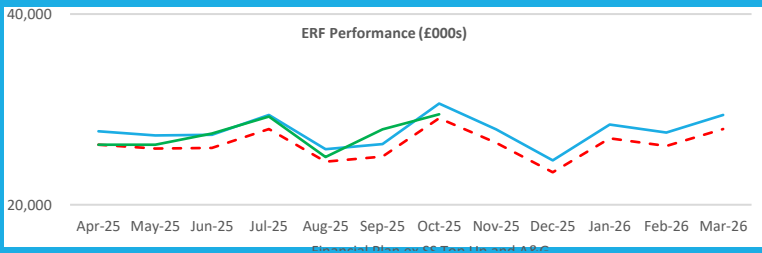
Cash Balance



Cost Improvement Programme Performance



Activity – Elective Recovery Income



Health Inequalities

Referral to Treatment (RTT) Waiting Times Pathways

Background

- Elective care covers a broad range of planned, non-emergency, consultant-led services including diagnostic tests, scans, outpatient appointments and surgery.
- Reducing the NHS elective waiting list is a national priority. In January 2025, the government published a new elective care reform plan which included a pledge that by March 2029, 92% of patients in England on an elective pathway should start hospital treatment within 18 weeks of referral (1). This also includes measures to address health inequalities among those on the waiting list.
- The recently updated NHS England's statement on information on health inequalities describes the powers available to NHS organisations to collect, analyse and publish information on health inequalities (2). The statement includes a set of core measures aligned to national priorities which include:
    - inequalities in the percentage of people waiting 18 weeks or less for elective treatment;
    - inequalities in the percentage of people waiting over 52 weeks for elective treatment
- Analysis undertaken by the King's Fund of national waiting times data found that in August 2022, people who lived in the most deprived parts of England were twice as likely to wait more than a year for elective treatment as people who lived in the most affluent areas (3). More recent analysis of data published by NHS England in July 2025 show patients in the most socioeconomically deprived areas and those from an Asian or Asian British background are more likely to be waiting longer than 18 weeks than any other group (4).
- A recent publication looking at the prevalence of socioeconomic deprivation and risk factors in 78 571 patients with linked primary and secondary care on the elective surgery waiting lists in the North East and North Cumbria shows people living in areas of higher socioeconomic deprivation appear at a younger adult age on surgery waiting lists and live with significantly more comorbidities which impact access to surgery and surgical outcomes (5).
- The national priority and success measure in the operational planning guidance 2025/2026 is improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every trust expected to deliver a minimum 5% point improvement against the November 2024 baseline (6).
- The data source used in this report is the Referral to Treatment (RTT) Waiting Times from the Waiting List Minimum Dataset (WLMDS) (7). From April 2024, data from the WLMDS is being published alongside the monthly RTT data.
- The metric used is percentage (%) of incomplete pathways (admitted and non-admitted) where a patient is waiting 18 weeks or less for elective treatment. Incomplete pathways refer to where patients are still waiting to start treatment at the end of the reporting period.
- The data presented in this report is a snapshot dated 28th December 2025 so more recent than that published in the national dataset.

Aim of this report

The Health Inequality report is a quarterly one. For this report, metrics such as percentage of incomplete pathways (admitted and non-admitted) where a patient is waiting up to 18 weeks; 18 weeks and more and over 52 weeks has been segmented by local authority of residence, socioeconomic status (IMD quintiles), sex, age and ethnicity.

RTT Waiting Times Incomplete Pathways (Age)

Figure 1

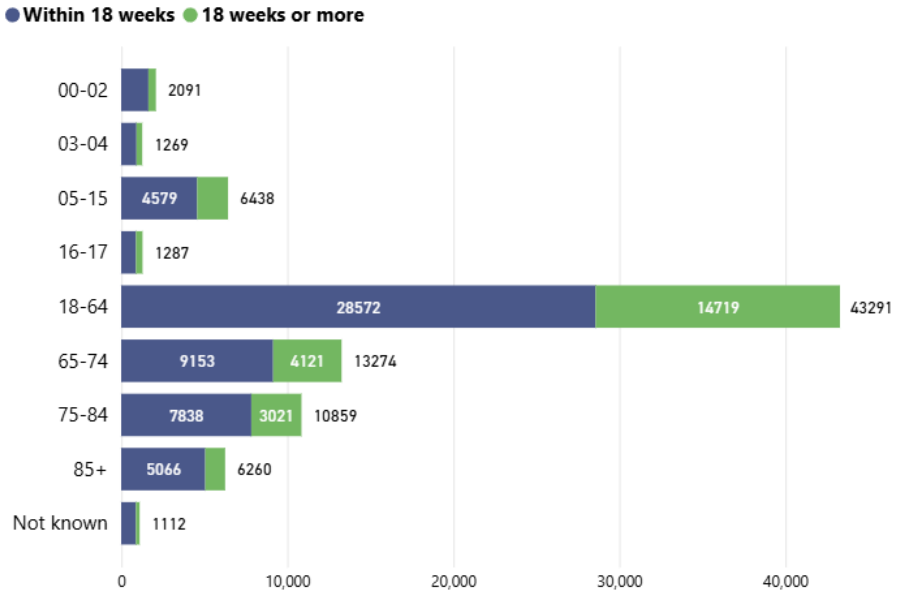
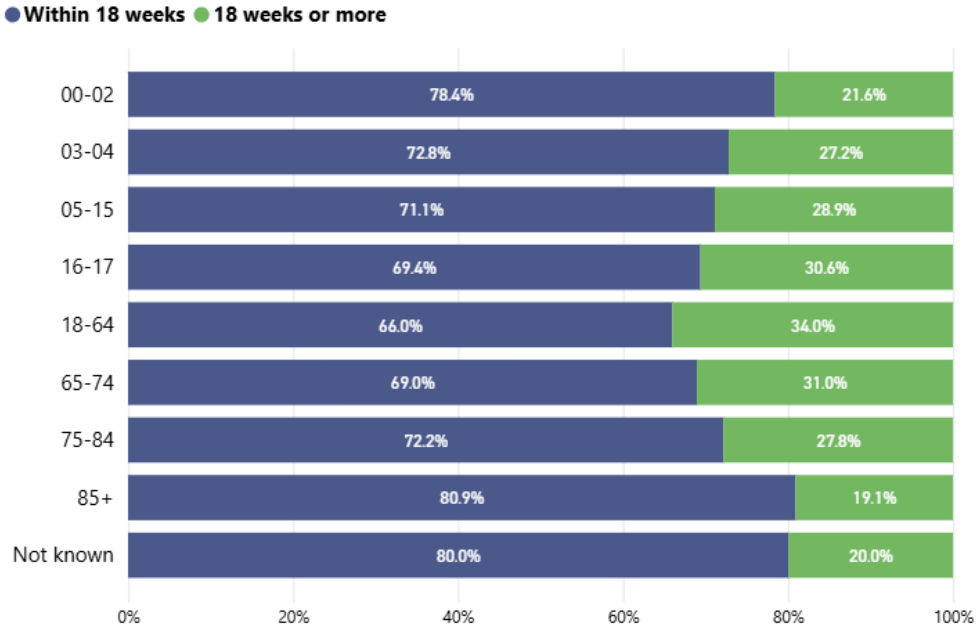


Figure 2



RTT Waiting Times Incomplete Pathways (Local Authority of Residence)

Figure 3

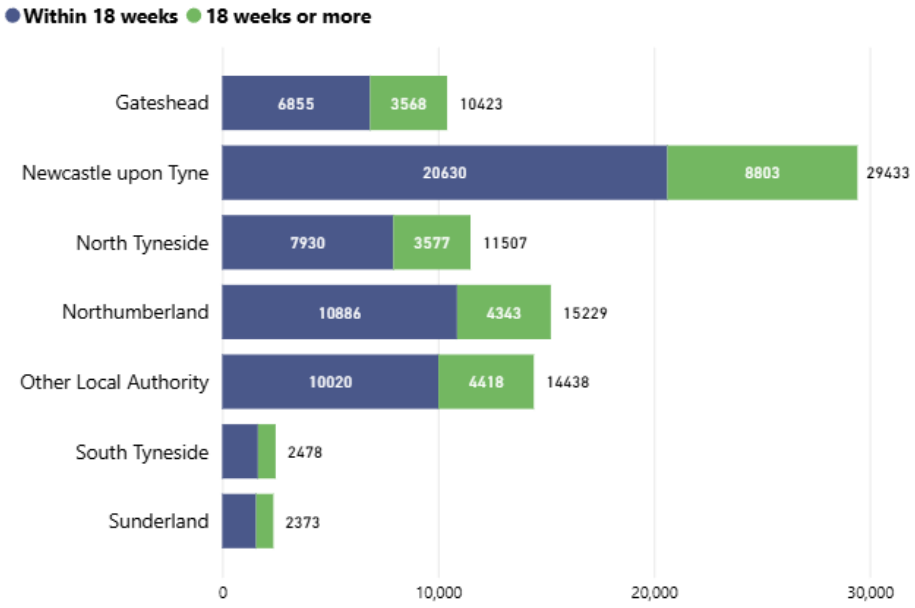
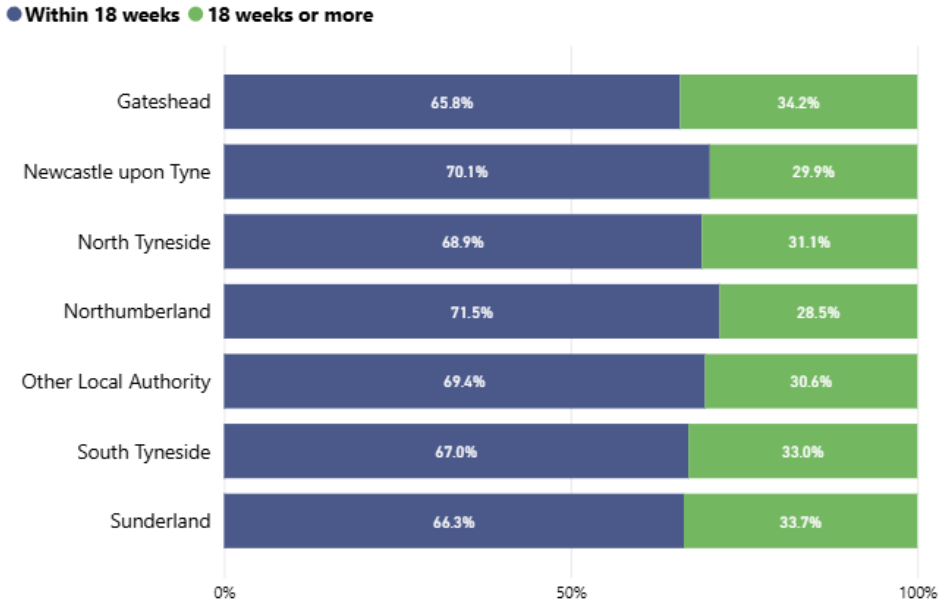


Figure 4



RTT Waiting Times Incomplete Pathways (IMD Quintiles)

Figure 5

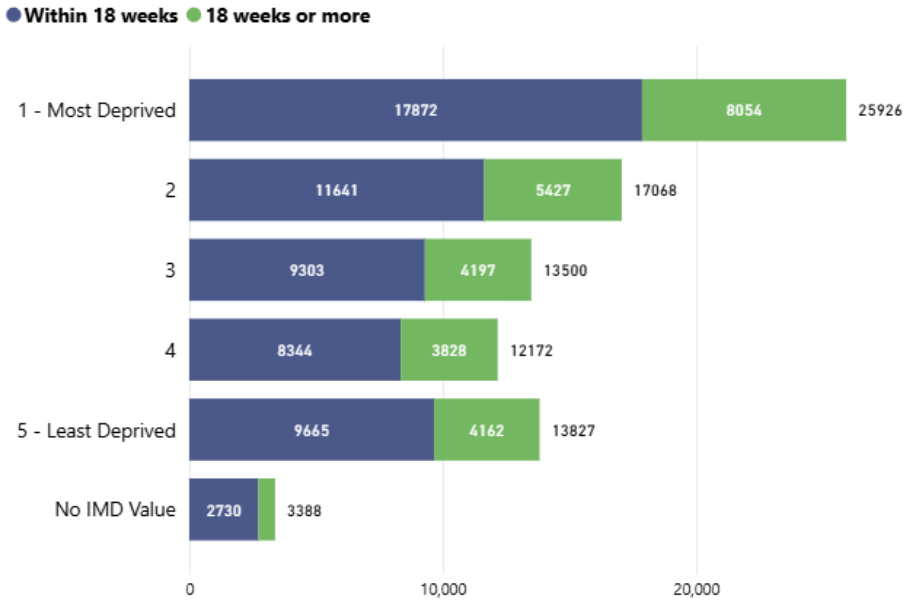
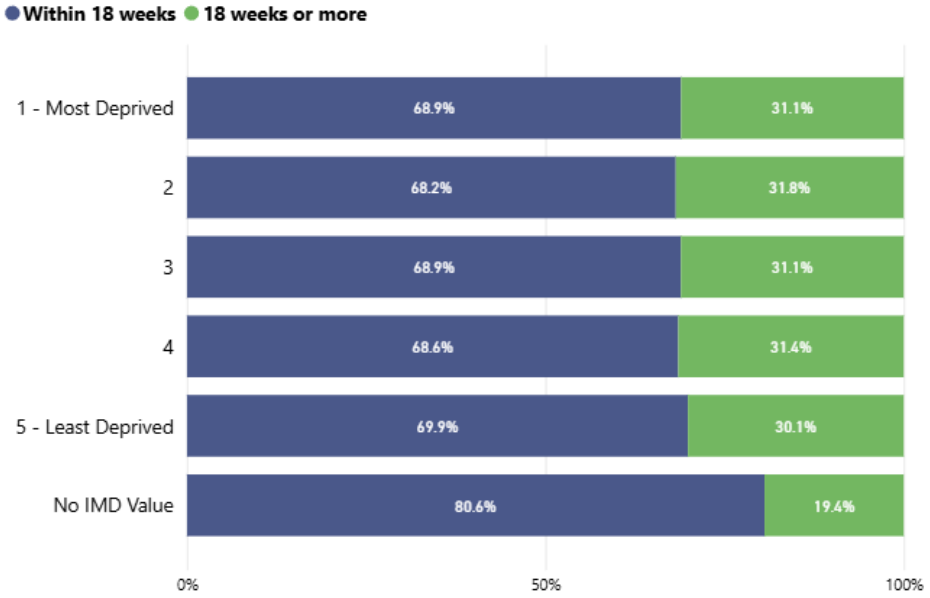


Figure 6



RTT Waiting Times Incomplete Pathways (Ethnicity)

Figure 7

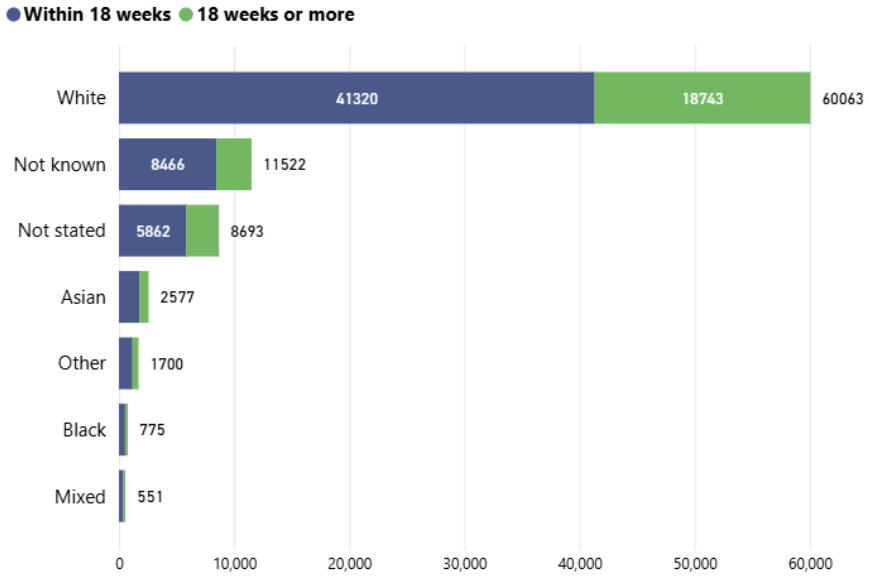
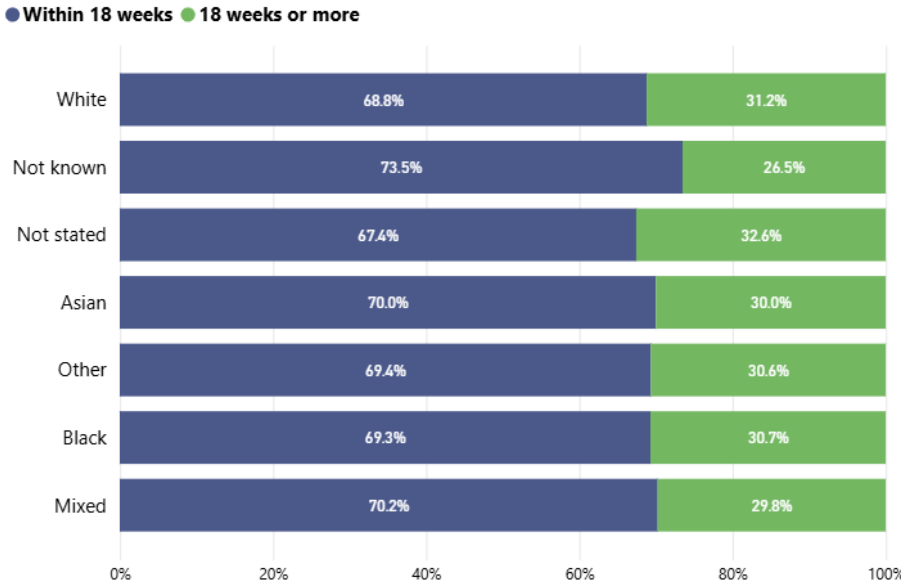


Figure 8



RTT Waiting Times Incomplete Pathways (>52 Week Waits)

Figure 9

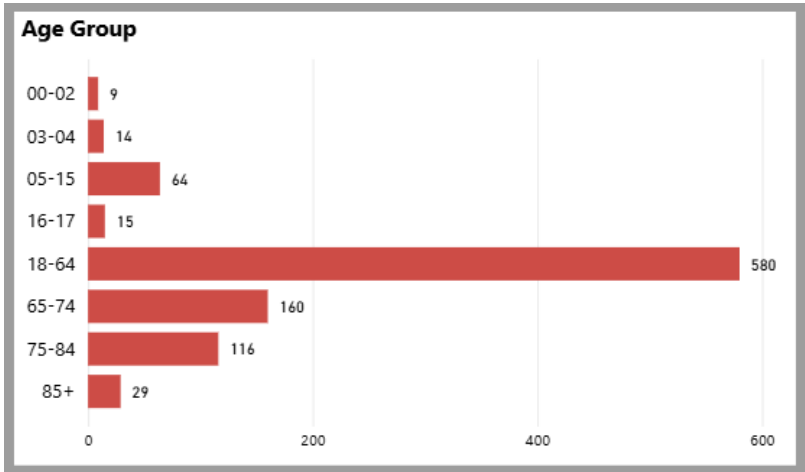


Figure 10

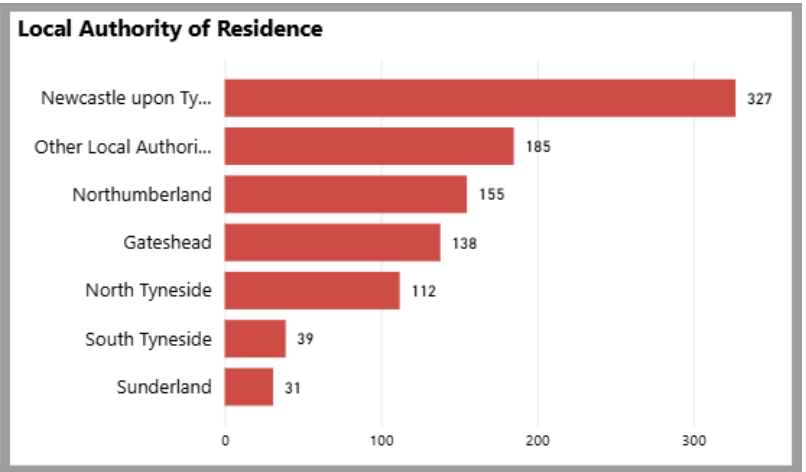


Figure 11

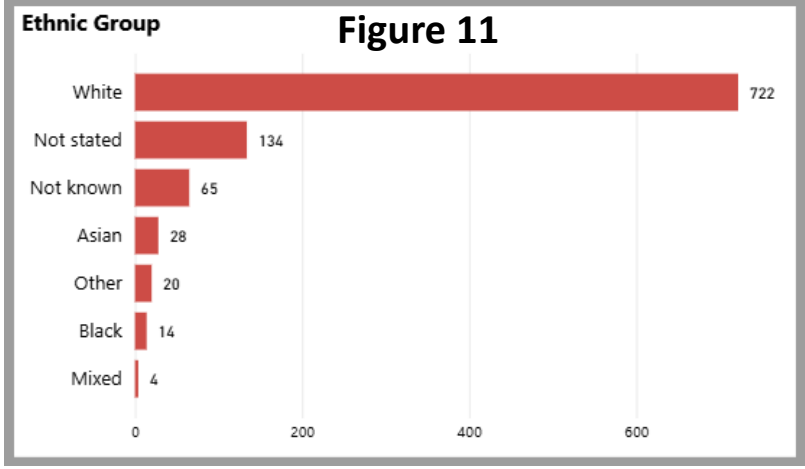
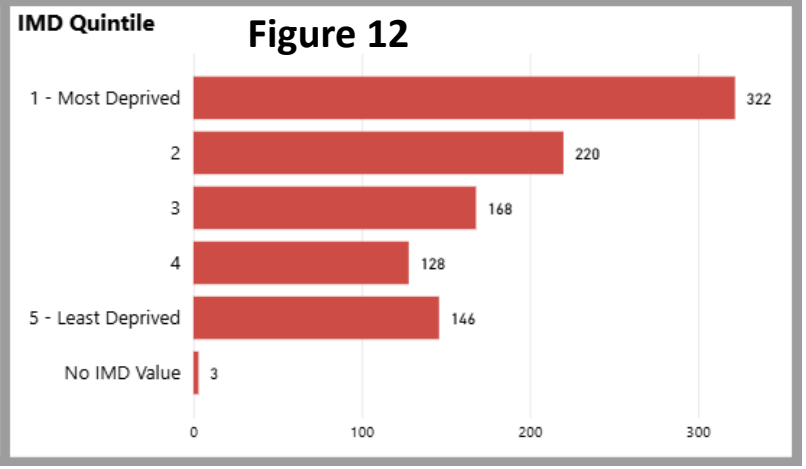


Figure 12



Referral to Treatment (RTT) Waiting Times Pathways

Current position (snapshot of 28 December 2025)

- Among all age categories the percentage of pathways within 18 weeks is higher than the national target noted in the most recent Operational Planning Guidance (i.e. 65% by March 2026). However, there is some variation seen with the lowest proportion of pathways within 18 weeks seen among working age 16-64 category and the highest in the 85+ age category (66 and 80.9% respectively-Figures 1 and 2).
- The highest proportion of pathways within 18 weeks are for patients who are residents within Northumberland followed by that linked to Newcastle upon Tyne residents (Figure 4). However, the largest absolute number of elective pathways (admitted or non-admitted) within 18 weeks is for residents of Newcastle which is twice that of Northumberland that comes second (Figure 3).
- The proportion of RTT Waiting list pathways within 18 weeks for patients across all Index of Multiple Deprivation Quintiles 1-5 categories are almost similar and each is higher than the national target (i.e. 65% by March 2026).
- Of all pathways of 18 weeks and over with a valid IMD value, over a third (31.3%) are those for patients living in the most deprived socioeconomic quintile whereas 21.1% are pathways for patients living in the second most deprived quintile (Q2) so over 50% are pathways relevant to patients living in the two most socioeconomically deprived quintiles. Of all pathways of 18 weeks and over only 16.2% are for patients living in the least deprived areas (Q5). These figures seem to be almost in line with the proportions seen in the Trust catchment population (elective admissions) (8) that has 13.5% living in the least deprived quintile and 32.8% and 23.34% of patients living in the most deprived IMD quintiles (Q1 and Q2 retrospectively) (data not shown).
- In all ethnic categories excluding not known and not stated, the proportions of pathways within 18 weeks as of 28 December 2025 are almost similar and all are above the national target. The proportion of White British and Asian ethnicities in pathways 18 weeks and over is 91% and 3.7% retrospectively (Figures 7 and 8). This deviates a little from the ethnic composition in the trust catchment population for elective admissions (95.79% and 2.56%). Given that the proportion of RTT waiting list pathways in the 'not known' or 'not stated' categories is high (24% within 18 weeks and 22% in 18 weeks and over), this makes it challenging to draw a valid conclusion of any inequalities observed linked to ethnicity.
- Of all 987 pathways over 52 weeks, the highest absolute numbers were observed in the working age population 18-64 (580), those living in the most deprived IMD quintile (322); females compared to males (589 vs. 397); residents of Newcastle (327) and White British ethnicity (722). The findings here suggest potential differences between patients on pathways over 52 weeks and the trust catchment population for elective admissions. There is caveat for this comparison as the elective pathways in this report are incomplete (admitted and non-admitted).

Conclusions and Recommendations

- The descriptive analysis in this report shows no evidence of inequalities in elective pathways within 18 weeks. However, nationally reviewed evidence shows that people with the same clinical needs waiting similar times on elective waiting lists might experience differences in the impact of waiting on their health and quality of life. For example, there is evidence that people from more deprived areas are more likely to have multiple health conditions, develop complications, deteriorate quicker while they wait and hence experience worse health outcomes and quality of life (9). The same report by the Health Foundation makes the case that traditional prioritisation in the NHS by clinical urgency or first-come-first-served principles do not fully address complexities in patients' needs nor optimise health care efficiency.

Referral to Treatment (RTT) Waiting Times Pathways

Conclusions and Recommendations (Continued)

- Examples of inclusive initiatives that have been used to address inequalities in tackling the elective care backlog include pre-surgery and prehabilitation targeted interventions such as Waiting Well to improve people health while on the elective waiting lists for surgery as well as targeted interventions to reduce Did not Attend and Was Not Brought and the use of AI to prioritise people on the waiting list.
- Although the Trust has made significant progress in improving the quality of ethnicity data, there is more work to be done to improve its quality by improving coding (both completeness and accuracy).
- Future health inequality reports relevant to referral to treatment (RTT) waiting times elective pathways may include a spotlight analysis focused on one or more clinical specialities and linked to improvement targets.

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1) NHSE. Reforming elective care for patients; https://www.england.nhs.uk/publication/reforming-elective-care-for-patients/
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3) The King's Fund. Tackling health inequalities on NHS waiting lists. learning from local case studies; 8 Nov 2023 https://www.kingsfund.org.uk/insight-and-analysis/reports/health-inequalities-nhs-waiting-lists
4) NHS England. NHS publishes waiting list breakdowns to tackle health inequalities; 17 July 2025; https://www.england.nhs.uk/2025/07/nhs-publishes-waiting-list-breakdowns-to-tackle-health-inequalities/
5) Madigan CD, Prentis J, Kunonga E, et al. Prevalence of socioeconomic deprivation and risk factors in patients on the elective surgery waiting list in the North East and North Cumbria region of England: a cross-sectional study. BMJ Open 2025;15:e097440
6) NHS England, 2025/26 priorities and operational planning guidance; 30 January 2025; https://www.england.nhs.uk/long-read/2025-26-priorities-and-operational-planning-guidance/#our-national-priorities-for-2025-26
7) NHS England; Waiting List Minimum Data Set (WLMDS) Information; https://www.england.nhs.uk/statistics/statistical-work-areas/rtt-waiting-times/wlmds/
8) OHID, 2022. NHS Acute (hospital) trust catchment population (Elective Admissions) https://app.powerbi.com/view?r=eyJrIjoiODZmNGQ0YzItZDAwZi00MzFiLWE4NzAtMzVmNTUwMThmMTVlIiwidCI6ImVlNGUxNDk5LTRhMzUtNGIyZS1hZDQ3LTVmM2NmOWRlODY2NiIsImMiOjh9
9) The Health Foundation; The elective care waiting list: insights from linked data'; July 2025; https://www.health.org.uk/reports-and-analysis/briefings/the-elective-care-waiting-list-insights-from-linked-data

A Guide to SPC

SPC Icons & How to Interpret (1/4)

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

SPC Icons & How to Interpret (2/4)

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

SPC Icons & How to Interpret (3/4)

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

SPC Icons & How to Interpret (4/4)

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

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Agenda item A2(e)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 January 2026					
Title	Joint Medical Directors Report					
Report of	Dr Lucia Pareja-Cebrian / Dr Michael Wright					
Prepared by	Associate Medical Directors					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☒			
Summary	This report highlights issues the Joint Medical Directors wish the Board to be made aware of. The following items are described in more detail within this report: • Urgent and Emergency Care Update • Cancer Update • Quality & Safety • Medical Education Update					
Recommendation	The Trust Board is asked to: i) Note the contents of the report. ii) Note the ongoing challenges with demand on urgent and emergency care services. iii) Note the work done to ensure successful opening of the RVI UTC. iv) Note the ongoing work to improve performance against cancer care targets and the particular challenges in specific tumour groups. v) Note the work being undertaken to ensure improved compliance with statutory and mandatory training.					
Links to Strategic Objectives	Focus on Fundamentals - deliver high quality, safe and compassionate care, meet out Clinical Board and Trust quality priorities					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	1.1 Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.					
Reports previously considered by	This is a regular report to Board. Previous similar reports have been submitted.					

JOINT MEDICAL DIRECTORS REPORT

1. URGENT & EMERGENCY CARE UPDATE

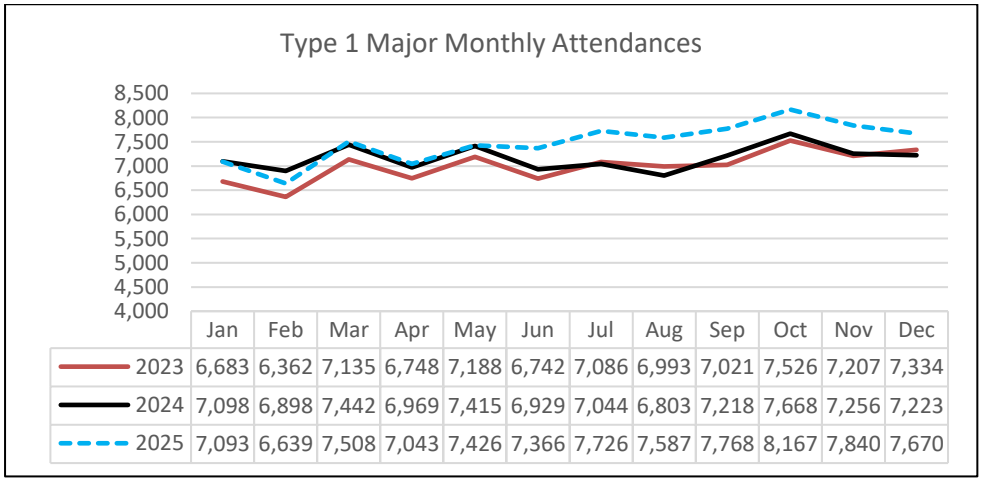
Type 1 Monthly attendances

Attendance figures at both the Royal Victoria Infirmary (RVI) Emergency Department (ED) and Urgent Treatment Centres (UTC) are higher than previous years and ambulance conveyances are at record levels. Emergency admissions are also at higher levels than previous years.

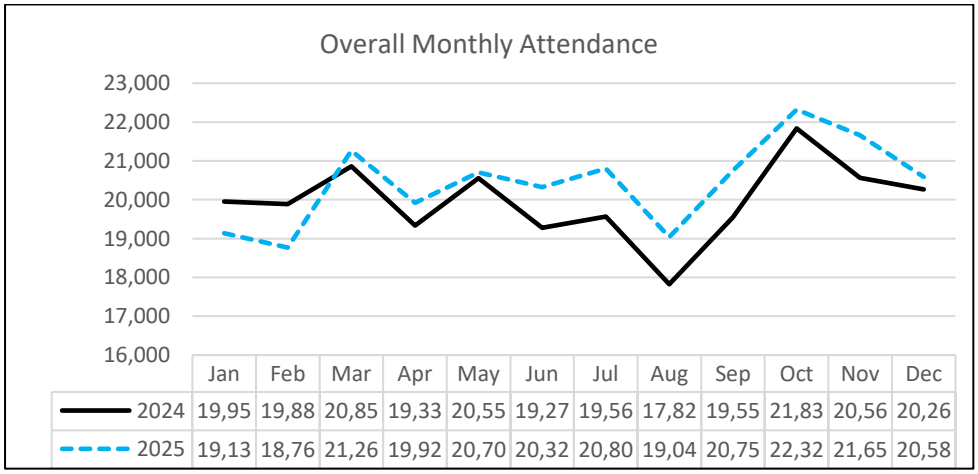
Winter pressure plans were implemented from 29th December with expanded bed capacity at the Freeman Hospital (FH), Boarder team, increased transport to facilitate discharge and enhanced domestic services capacity.

Influenza and Norovirus have put significant strain on the system, but flu admission rates have reduced as of mid-January.

There are ongoing conversations with Northumbria Healthcare NHS Foundation Trust ('Northumbria Healthcare') about the impact of ambulances from the Tyne Valley corridor.

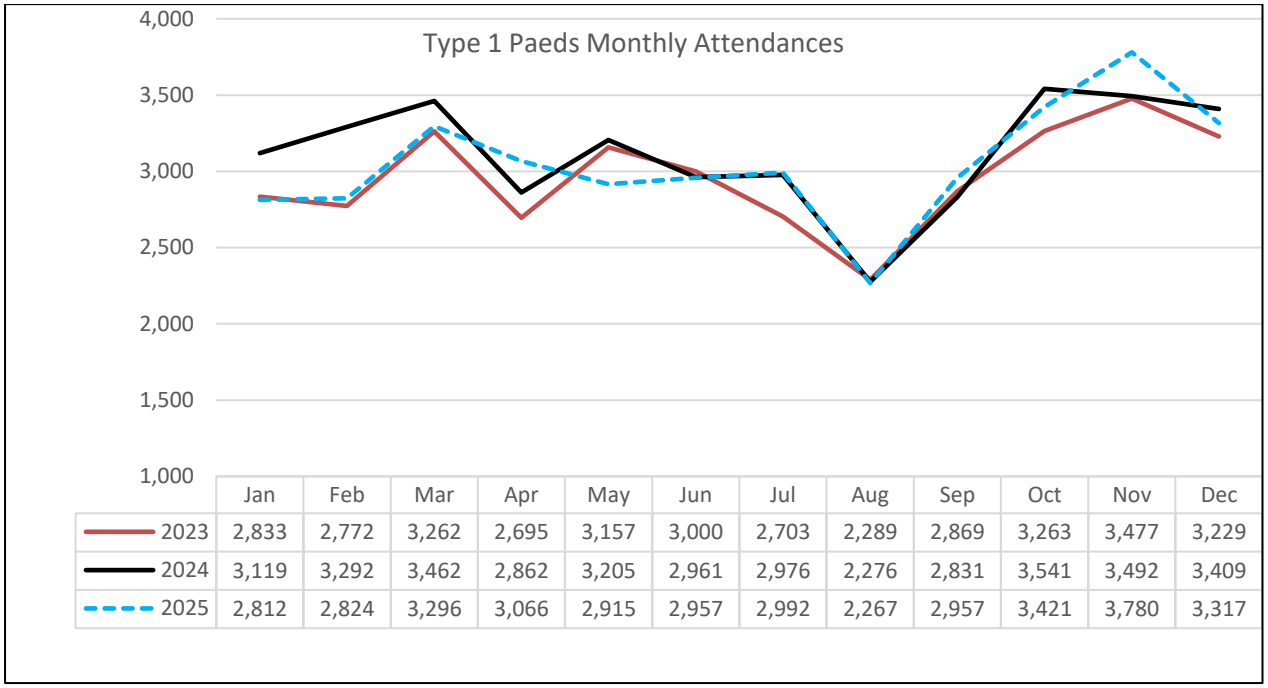


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	6,683	6,362	7,135	6,748	7,188	6,742	7,086	6,993	7,021	7,526	7,207	7,334
2024	7,098	6,898	7,442	6,969	7,415	6,929	7,044	6,803	7,218	7,668	7,256	7,223
2025	7,093	6,639	7,508	7,043	7,426	7,366	7,726	7,587	7,768	8,167	7,840	7,670



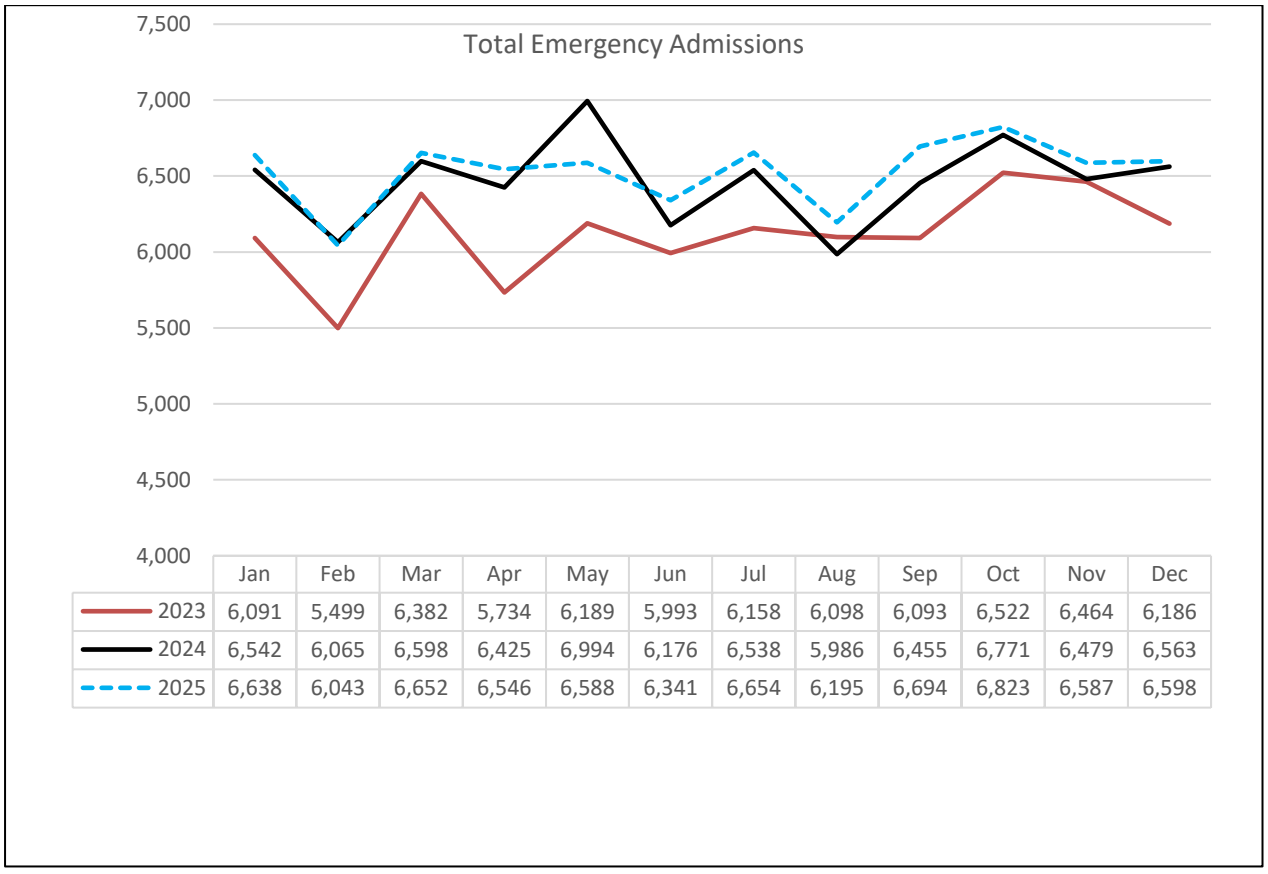
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2024	19,95	19,88	20,85	19,33	20,55	19,27	19,56	17,82	19,55	21,83	20,56	20,26
2025	19,13	18,76	21,26	19,92	20,70	20,32	20,80	19,04	20,75	22,32	21,65	20,58

Type 1 Paediatric ('Paeds') Monthly Attendances

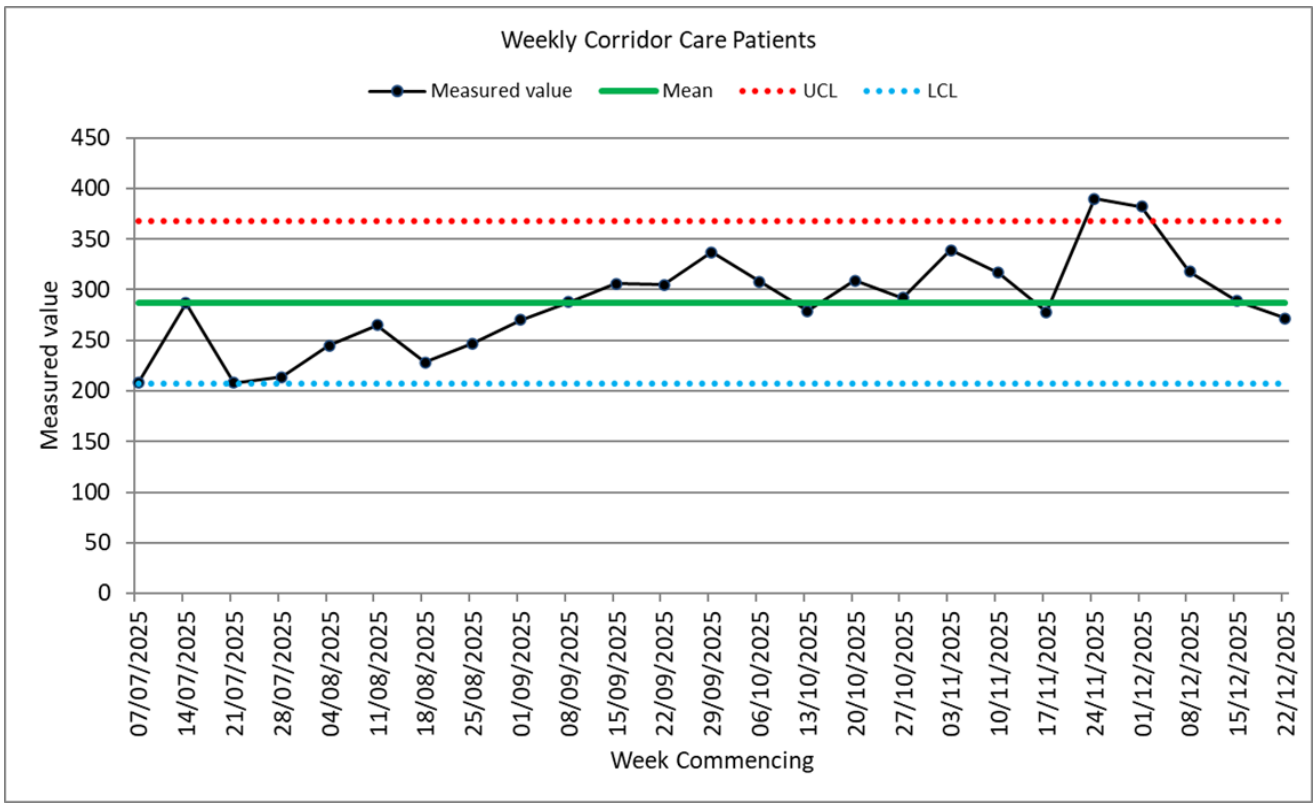


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	2,833	2,772	3,262	2,695	3,157	3,000	2,703	2,289	2,869	3,263	3,477	3,229
2024	3,119	3,292	3,462	2,862	3,205	2,961	2,976	2,276	2,831	3,541	3,492	3,409
2025	2,812	2,824	3,296	3,066	2,915	2,957	2,992	2,267	2,957	3,421	3,780	3,317

Total Emergency Admissions

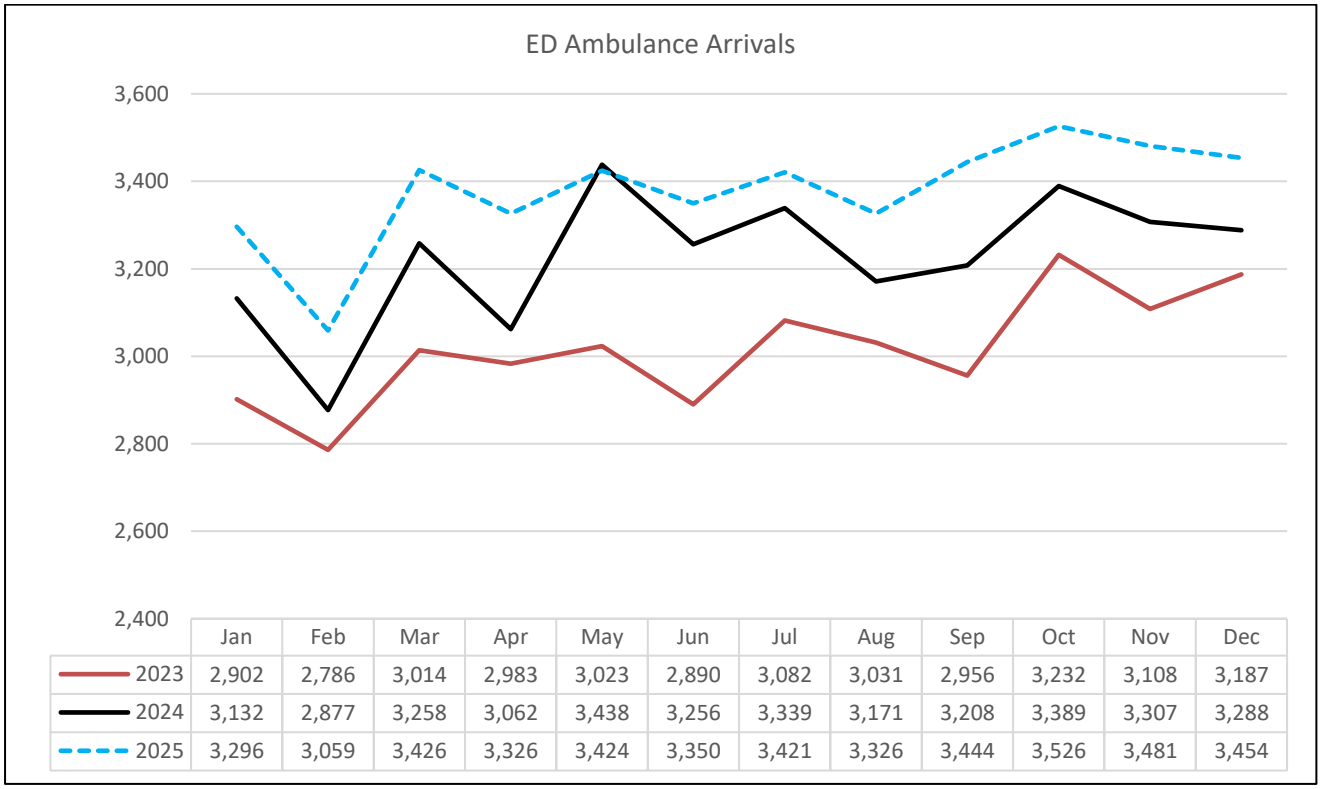


	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	6,091	5,499	6,382	5,734	6,189	5,993	6,158	6,098	6,093	6,522	6,464	6,186
2024	6,542	6,065	6,598	6,425	6,994	6,176	6,538	5,986	6,455	6,771	6,479	6,563
2025	6,638	6,043	6,652	6,546	6,588	6,341	6,654	6,195	6,694	6,823	6,587	6,598

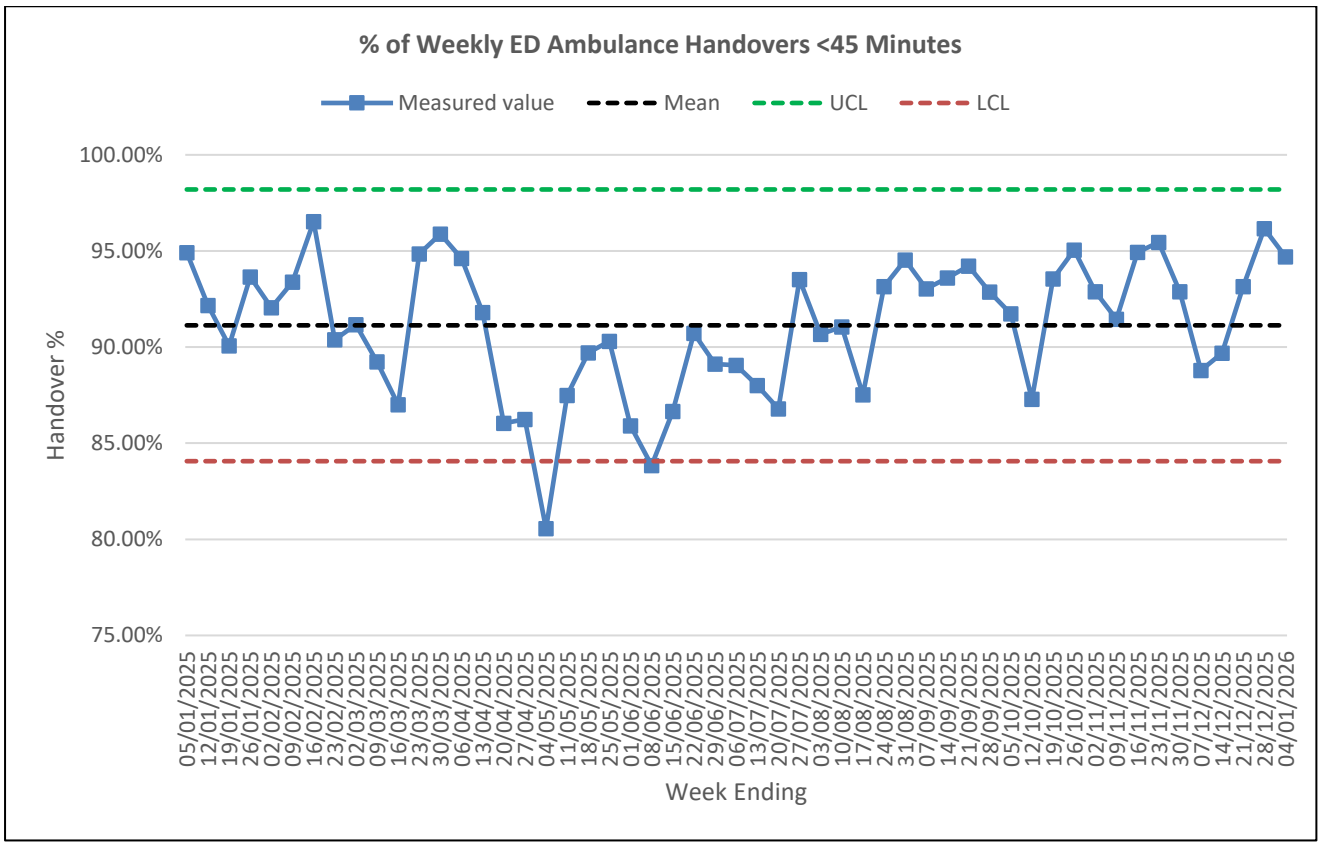


NB. UCL = Upper Control Limit and LCL = Lower Control Limit

Ambulance arrivals and handovers



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	2,902	2,786	3,014	2,983	3,023	2,890	3,082	3,031	2,956	3,232	3,108	3,187
2024	3,132	2,877	3,258	3,062	3,438	3,256	3,339	3,171	3,208	3,389	3,307	3,288
2025	3,296	3,059	3,426	3,326	3,424	3,350	3,421	3,326	3,444	3,526	3,481	3,454


% of Weekly ED Ambulance Handovers <45 Minutes
Measured value
Mean
UCL
LCL
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
Handover %
05/01/2025
12/01/2025
19/01/2025
26/01/2025
02/02/2025
09/02/2025
16/02/2025
23/02/2025
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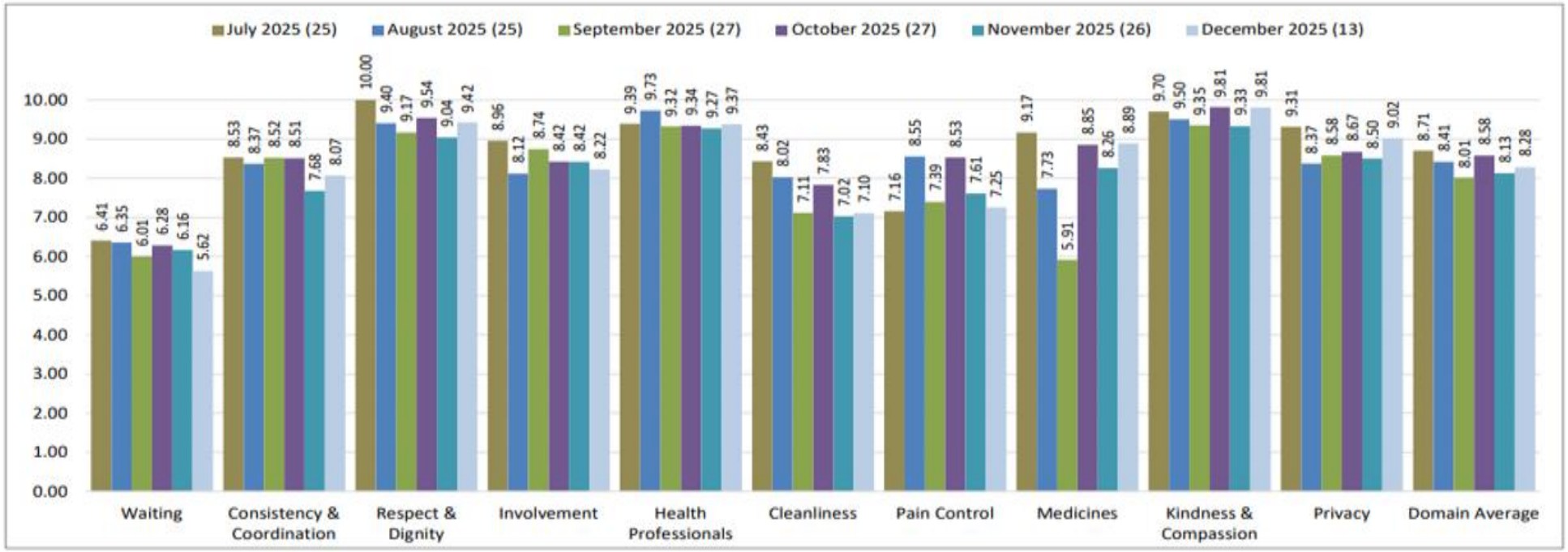
23/11/2025
30/11/2025
07/12/2025
14/12/2025
21/12/2025
28/12/2025
04/01/2026
Week Ending

Patient Experience

Patient experience in the ED continues to be positive overall.

Emergency Department, Royal Victoria Infirmary as at 04/12/2025

Patient Experience
Surveys and Reports



85% of patients surveyed rated their overall experience as either good or very good.

Number of patients on new medication 7

All patients surveyed attended the Emergency Department on 03/12/2025

	N	%
Patients with pain less than 72 hours	6	46%
Patients with pain longer than 72 hours	4	31%
Patients with no pain	3	23%

Corridor care in the ED continues to be a concern for the clinical team and reducing this is a specific focus for the Clinical Board. This occurs partly because of challenges with flow into the hospital and in order to improve patient flow, the Winter Plan has enabled opening more capacity; ward 12 at the FH will be open between 29th January until end of April 2026. There will also be an additional team for RVI outliers, enhanced transport arrangements for discharges and transfers. In addition to this, additional shifts by domestic services have contributed to easing patient flow.

Additional nursing shifts to tackle delays to assessment, additional medical shifts in ED, expansion of RVI discharge lounge will contribute to flow of patients through the department as well as increase patient safety.

Urgent Treatment Centre (UTC)

The RVI UTC opened successfully as planned on 19th January. There has been an immediate improvement in the quality of the environment within the department for patients and staff within the department with many people commenting positively on this. The permanent link with the main department is likely to be completed in the summer, leading to the move onto Phase 2, reconfiguring the space within the ED.

There are some logistical aspects to conclude for the temporary link to ensure that it provides a satisfactory environment for staff and patients. Initial workforce training was completed prior to the UTC opening and further training is ongoing. The next round of recruitment for Nurse Practitioners (NP) is planned. IT training sessions have been completed with further sessions scheduled for Nurse Practitioners and Admin staff.

There will be significant initial learning and a robust operational, clinical and IT rota is in place to help for the initial period of operation. The implementation of the electronic triage system will be completed as soon as possible and will further enhance the efficiency of the department.

The staff of the department and the Clinical Board should be commended for the huge amount of work which has been done to ensure that the opening of the new department has been achieved quickly and efficiently.

2. CANCER UPDATE

i) Performance

28 Day Faster Diagnosis

		Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Trust Total	Actual	76.1%	70.7%	83.4%	80.9%	81.4%	80.7%	78.1%	74.2%	71.9%	68.5%	69.1%	65.6%
NHSE	Target	77.0%	77.0%	77.0%	77.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

		Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Brain/CNS	Actual	100.0%	66.7%	100.0%	100.0%		50.0%		100.0%	100.0%	100.0%		100.0%
Breast	Actual	96.0%	94.4%	97.0%	97.1%	95.6%	92.5%	95.4%	95.5%	92.9%	92.7%	94.0%	94.2%
Breast Symptomatic	Actual	61.9%	63.6%	70.9%	56.1%	65.5%	52.8%	55.5%	47.0%	38.7%	33.3%	34.5%	42.8%
Childrens	Actual	0.0%	66.7%	100.0%	66.7%	83.3%	80.0%	50.0%	100.0%	50.0%	100.0%	14.3%	50.0%
Colorectal	Actual	71.1%	64.0%	80.2%	74.4%	61.8%	63.3%	70.5%	75.7%	74.5%	71.1%	73.6%	69.8%
Gynae	Actual	71.6%	80.4%	82.0%	81.4%	79.3%	84.8%	74.8%	85.5%	76.1%	81.1%	85.4%	77.7%
Haematology	Actual	89.5%	100.0%	94.4%	70.0%	100.0%	87.5%	80.0%	86.7%	84.6%	100.0%	78.6%	90.0%
Head & Neck	Actual	91.8%	90.9%	93.3%	86.2%	85.9%	88.0%	89.0%	87.0%	90.5%	95.3%	96.4%	94.3%
Lung	Actual	76.3%	86.0%	82.5%	85.4%	72.7%	74.5%	87.8%	75.7%	76.3%	82.4%	76.7%	86.7%
NSS	Actual	87.5%	63.6%	72.7%	100.0%	76.9%	77.8%	94.7%	100.0%	92.9%	84.6%	100.0%	100.0%
Other	Actual	0.0%		100.0%	0.0%	100.0%		0.0%	100.0%				
Sarcoma	Actual	92.9%	100.0%	72.7%	80.0%	90.0%	80.0%	100.0%	83.3%	87.5%	85.7%	92.3%	78.6%
Skin	Actual	68.9%	60.9%	81.5%	79.1%	82.5%	82.3%	74.9%	64.0%	61.6%	52.9%	53.5%	47.3%
Testicular	Actual	93.8%	90.9%	90.0%	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	88.9%	88.9%	88.9%
Upper GI	Actual	85.9%	86.5%	88.2%	83.5%	79.5%	85.7%	84.3%	80.0%	91.9%	89.5%	82.2%	82.4%
Urology	Actual	50.9%	31.7%	56.3%	68.0%	78.8%	58.8%	67.3%	71.4%	73.1%	77.5%	81.3%	78.0%
HPB	Actual	66.7%	0.0%	80.0%	53.8%	62.5%	27.3%	60.0%	33.3%	66.7%	71.4%	66.7%	62.5%
OGD	Actual	92.4%	87.4%	90.6%	86.0%	79.2%	88.1%	86.3%	86.0%	91.9%	91.2%	84.4%	82.1%
NHSE	Target	77.0%	77.0%	77.0%	77.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

62 Day Time to Treatment Target

		Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Trust Total	Actual	63.7%	66.1%	61.0%	65.2%	72.2%	69.6%	63.8%	71.2%	69.9%	70.4%	71.7%	71.5%
NHSE	Target	70.0%	70.0%	70.0%	70.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

		Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25
Brain/CNS	Actual	100.0%	100.0%	90.0%	100.0%	88.2%	91.3%	100.0%	82.6%	83.3%	100.0%	100.0%	100.0%
Breast	Actual	90.8%	87.7%	88.1%	77.7%	95.1%	88.9%	89.8%	92.1%	83.5%	86.5%	83.1%	78.6%
Childrens	Actual	100.0%	100.0%		100.0%		100.0%		100.0%	100.0%	100.0%	100.0%	100.0%
Colorectal	Actual	31.3%	50.6%	34.5%	72.9%	55.3%	32.1%	38.7%	34.9%	37.7%	53.7%	47.9%	68.2%
Gynae	Actual	35.5%	64.0%	48.0%	61.1%	77.8%	48.3%	77.3%	41.4%	53.8%	50.0%	39.1%	66.7%
Haematology	Actual	83.3%	100.0%	85.3%	82.4%	86.7%	88.4%	81.6%	83.9%	75.6%	64.7%	96.2%	88.2%
Head & Neck	Actual	59.0%	85.4%	80.7%	60.0%	75.8%	92.3%	75.8%	79.7%	75.0%	72.2%	90.7%	82.5%
Lung	Actual	55.1%	45.1%	36.3%	46.2%	49.6%	42.5%	40.7%	63.7%	54.1%	56.9%	58.4%	51.1%
Other	Actual	100.0%	50.0%	41.7%	100.0%	83.3%	63.6%	100.0%	83.3%	50.0%	69.2%	71.4%	100.0%
Sarcoma	Actual	57.1%	68.2%	94.7%	81.3%	100.0%	80.0%	100.0%	63.6%	78.9%	70.0%	88.9%	84.2%
Skin	Actual	77.9%	82.3%	79.2%	82.9%	90.2%	95.7%	89.7%	90.5%	94.7%	90.7%	85.3%	86.5%
Testicular	Actual	#DIV/0!	#DIV/0!			100.0%		100.0%	100.0%	100.0%	50.0%	100.0%	100.0%
Upper GI	Actual	37.6%	40.4%	53.2%	41.3%	40.9%	44.0%	41.8%	49.6%	48.6%	47.4%	50.0%	46.2%
Urology	Actual	58.4%	66.7%	40.5%	61.3%	56.5%	54.5%	40.2%	55.5%	59.6%	51.4%	65.3%	61.1%
HPB	Actual	47.6%	42.5%	58.5%	53.4%	58.1%	51.4%	40.0%	54.9%	44.2%	52.1%	49.3%	44.4%
OGD	Actual	54.2%	61.3%	66.7%	48.1%	40.5%	36.8%	52.4%	46.9%	58.1%	29.2%	58.3%	48.4%
NHSE	Target	70.0%	70.0%	70.0%	70.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%	75.0%

Key:

- *NHSE - NHS England*
- *CNS – Central Nervous System*
- *NSS – Non Specific Symptoms*
- *Gynae – Gynaecology*
- *GI – Gastrointestinal*
- *HPB – Hepatobiliary*
- *OGD - Oesophago-Gastro-Duodenoscopy*

Cancer performance remains below the standard required and that which we want to see. Validated performance data submitted for November 2025 show that the 28 day compliance has fallen to 65.6%. As described in this paper in November 2025, the main reason for the deterioration in performance on the 28 day faster diagnosis pathway is a deterioration in the 28 day performance within the skin pathway; driven by the large numerical contribution of patients referred with suspected skin cancer. If patients on the skin pathway were excluded from 28-day analysis the performance would be 79.4%. The reasons for deterioration in skin pathway performance were included in November 2025. There is a plan for further consultant recruitment when trainees are ready, and discussions are ongoing with Northumbria Healthcare regarding using plastic surgery capacity there as a route for urgent suspected cancer GP referral.

In terms of patient impact and outcomes, the skin pathway has high compliance at 62 days (86.5% in November 2025); the risk to patient safety associated with a delay to diagnosis at 28 days is very low on this pathway (though this doesn't account for anxiety caused in the waiting period of course). This is because for many skin lesions an excision biopsy both allows a diagnosis to be reached, and a lesion treated at one visit, and this happens within 62 days but less frequently within 28 days. Considerable work has been undertaken and continues to ensure accuracy in tracking these patients as the flow is different from that of other tumours.

The overall performance on 62-day pathways continues to slowly improve. There is still work to do to reach the NHSE target of 85% by March 2027. The number of patients waiting beyond 62-days on urgent suspected cancer pathways in the week ending 11/01/26 is 133 which is static in recent months.

Radiotherapy performance, which 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 Newcastle Hospitals service has now moved back into the top 25% nationally in a league table of time to treatment. There is still significant fragility within the service, and we believe there may be a drop in performance in December, but the finalised data are awaited.

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.

Using the data we have available it is notable that the 62-day cancer performance across all tumours would be 82.7% if only direct referrals were included. The performance for tertiary care referrals is only 41.9%. This often relates to additional investigations and assessments that are needed when a patient is referred from another centre for intervention. If we could treat these patients within 24-days of transfer that would improve the patient pathway significantly. We are a considerable distance from hitting that 24-day target in the major tumour types: colorectal, OGD, HPB, lung and urology. This continues to be a major focus for the fortnightly recovery meetings. The streamlining and parallel planning of pathways is a focus both locally and through regional tumour-specific pathway groups. A Newcastle

Hospitals urologist is now visiting North Cumbria Integrated Care (NCIC) with a view to streamlining referrals where appropriate.

Performance over the next few months will be monitored for impact and improving performance against the 62-day target remains a key focus for the clinical teams, Clinical Board leadership teams, corporate cancer teams and the members of the Medical Directors' team involved in supporting improvement.

ii) Tumour Group Issues

There remain regular tumour group clinical and operational meetings to highlight risks and try to remove barriers when there are challenging situations. Significant current issues are:

- Navigational Bronchoscopy and Endobronchial Ultrasound (EBUS): We are finalising navigational bronchoscopy kit delivery, theatre capacity at the RVI has been identified along with capacity for EBUS. Aim to commence navigational bronchoscopy by the end of January 2026 and release capacity in FH endoscopy for additional Endoscopic Retrograde Cholangio-Pancreatography (ERCP) list for HPB because of EBUS transition to the RVI. This will improve both lung and HPB pathways. Sustainability beyond 1 year requires work but is part of Clinical Board plans for 2026/27.
- Harm reviews for patients waiting over 104-days on a cancer pathway demonstrate that lung cancer patients still have the highest risk of harm of any tumour group underlining the importance of stabilising this service and developing a sustainable plan. Current wait for navigational bronchoscopy outside Newcastle (all done at North Tees) is 6-8 weeks.
- Creating a theatre with a scanner at the FH to allow expansion of tumour ablation work in interventional radiology with routine general anaesthetic lists and preservation of access to static CT facilities at the FH is important and the outcome of a quality business case is awaited. There is significant clinical risk if this project cannot proceed. Tumour progression with a move from potentially curative therapy to palliative therapy has been repeatedly demonstrated for patients in this group as part of the cancer harm review process.
- Dermatology issues as highlighted above; these have a clear impact on Trust performance but have not been shown to impact patient outcome as part of the cancer harm review process.
- Robotic access is currently being reviewed by Surgical and Associated Services (SAS) Board as access is restricted due to capacity issues.

iii) Cancer Governance

Cancer Harm Review Process

Cancer harm review outputs are reported through the Patient Safety Group. Most recent data 01/06/25-31/08/25 showed 100% capture with 213 reviews and 5 episodes of harm (4 for lung cancer patients and 1 for an HPB patient). There were 4 episodes where treatment intent changed from curative to palliative and 1 where additional chemotherapy had to be delivered in order to retain the potential for cure. There is a trend to a reduction in the number of harm reviews required over time but clearly further improvements in time to treatment are necessary.

Durham Breast Service

Clinical colleagues from Newcastle Hospitals continue to provide input and oversight within the County Durham and Darlington NHS Foundation Trust (CDDFT) breast service, particularly as part of the Multi-disciplinary Team (MDT). Some patients are choosing to come to Newcastle Hospitals for treatment, and this has had some impact on breast service referral numbers but is manageable. Discussions continue between trusts, the Northern Cancer Alliance and the Integrated Care Board (ICB) on the best long-term strategy to support and/or deliver this service for County Durham patients are ongoing.

3. QUALITY AND SAFETY

i) Patient Safety Incident Response Framework (PSIRF) Priority Project – Invasive Procedures

The Trust's priority safety project focussing on invasive procedures is underway and currently in the diagnostic phase.

This will comprise:

- A poster and communications campaign across the 8 major theatre areas and 12 major procedure areas.
- Webpage – details of the project, how to get involved and a survey.
- Coffee room consultations.
- Peri-Ops Board staff engagement.

In parallel:

- We are designing measurable parts of the process to inform progress.
- We are engaging national figures involved in design of National Safety Standards for Invasive Procedures (NatSSIPs 2) to meet and advise our process.

We hope to move into the testing phase beginning in March with individual elements.
A full driver diagram describing how to achieve aims will be developed with implementation in the 2nd half of year.

ii) Consent

Closely related to procedural safety is our consent process project.

Complaints and legal process related to consent are of high frequency. Our expected standards across elective and emergency procedures are not always followed as we would wish and provision of high quality, bespoke information to patients is often missing from consultations.

Shared decision making cannot always be demonstrated particularly in relation to other treatment options.

The paper consent form is becoming obsolete and there have been a number of incidents where the information available from the form has lacked clarity.

We have identified funding for a consultant Programmed Activities (PA) for 12 months from within existing budgets to allow consultant Ear, Nose and Throat (ENT) surgeon David Hamilton to work on these issues. This will likely involve a limited pilot in elective surgery of an electronic patient information and consent system.

Digital systems will not provide an immediate solution and would be an expensive solution and a major implementation project. Behavioural, policies and standards should be addressed in parallel.

iii) Other specific trust wide projects in development

- Peripheral cannula associated infection reduction:
    - Great North Children's Hospital (GNCH) testing ground
    - Learning from high performing wards – SAS Board
    - Harm free care rounds (Cheryl Teasdale, Associate Director of Nursing involvement)
    - Working group – Director of Infection Prevention and Control (DIPC), Associate Medical Director (AMD), Clinical Director (CD) Quality & Safety (Q&S), Associate Nursing Director (AND) leads
- Fluid Prescribing and Charting.
- Deteriorating Patient.
- Martha's Rule in the GNCH.

4. MEDICAL EDUCATION

Undergraduates

Trust Fellow Recruitment for 2026/27 to start in the coming weeks. In parallel, we are exploring the possibility to support Sunderland Medical School elective students in Newcastle which would be really positive.

Postgraduates

There is good progress on Self-Assessment Report (SAR) and Quality Improvement Projects (QIP) now at advanced stage. An initial meeting with NHSE was held on 20th January and was very positive.

There is ongoing work on the 10-point plan, with a weekly steering group led by one of the Joint Medical Directors. Discussions include practical steps being taken following results of facilities survey with Director of Estates, and preliminary work looking at locally employed doctor posts to look at feasibility of creating local rotations.

Exception Reporting

The Secretary of State for Health and Social Care has asked for the new exception reporting process for resident doctors to be fully implemented by Wednesday 4 February 2026. The new reporting process is simpler for resident doctors. It will ensure they are fairly compensated for the additional hours they are required to work and will support the safety of their working hours. This process is part of the reforms agreed by the Secretary of State and British Medical Association (BMA) Resident Doctor Committee following the 2024 Resident Doctor Deal. It is one of the most important elements of the 10 Point Plan to improve resident doctors' working lives.

Ongoing work has brought together Finance, Payroll, Clinical Board Chairs, Fraud and Information Governance.

Appropriate information will be available for the doctors rotating into the Trust in February:

- Creation of a "what you need to do on day 1" document for resident doctors in relation to exception reporting.
- Confirmation creation of a video guide for the DRS app for exception reporting.

The greatest concern is the reporting system and how ready and robust it will be by the go live date. We are not an outlier on this – it has been a challenge for all system providers.

5. JOB PLANNING

All job plans for 2025/2026 have now been submitted under the new job planning policy and reviewed by one of the AMDs or Medical Directors (MDs). It is anticipated that more than 90% of these will have been finally agreed by the end of February with the remainder agreed before the end of the financial year. Prospective job planning for 2026/2027 will begin in March.

A full review of the financial and performance implications of the implementation of the new job planning policy is underway with a report to the Finance and Performance committee in January. Key priorities for the job planning round for 2026/2027 will be identified by the end of February to ensure that there is clarity in objective setting during the coming round.

6. STATUTORY AND MANDATORY TRAINING

Compliance with this amongst medical and dental staff remains a concern. Clinical Board Chairs have been asked to work with Clinical Directors to ensure all training is up to date by the end of February 2026. This will be reviewed during the forthcoming job planning round, and progress will be shared with the Trust Board in reports over the coming months.

7. RECOMMENDATIONS

The Trust Board is asked to:

i) Note the contents of the report.
ii) Note the ongoing challenges with demand on urgent and emergency care services.
iii) Note the work done to ensure successful opening of the RVI UTC.
iv) Note the ongoing work to improve performance against cancer care targets and the particular challenges in specific tumour groups.
v) Note the work being undertaken to ensure improved compliance with statutory and mandatory training.

Report of
Dr Lucia Pareja-Cebrian/ Dr Michael Wright
Joint Medical Directors
23 January 2026

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Agenda item A2(e)(i)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	30 January 2026					
Title	Guardian of Safe Working Quarterly Report (Quarter 3 (Q3) 2025-26)					
Report of	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Prepared by	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	The terms and conditions of service (TCS) of the new junior doctor contract (2016) require the Guardian of Safe Working Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant. The content of this report outlines the number and main causes of exception reports for the period 27 September to 26 December 2025 for consideration by the Trust People Committee, prior to submission to the Trust Board.					
Recommendation	The Trust Board is asked to note the contents of this report.					
Links to Strategic Objectives	Focus on Fundamentals - Deliver high quality, safe and compassionate patient care, meet our Clinical Board and Trust quality priorities. Make it better for colleagues - 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]	No direct link to the BAF. In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training.					
Reports previously considered by	Quarterly report of the Guardian of Safe Working Hours. Report considered at the People Committee on 22 January 2026.					

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

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

There are now 1,177 resident doctors on the TCS of the 2016 contract, and a total of 1,194 resident doctors in the Trust.

There were 126 exception reports in this period. This compares to 142 exception reports in the previous quarter.

The main areas of exception reports are general medicine and general surgery and the main cause is when there is a workforce/workload imbalance.

2. INTRODUCTION / BACKGROUND

The Resident Doctor Contract came into effect on 3 August 2016, reviewed in August 2019, with further changes due to be implemented by February 2026. From August 2023 Locally Employed Doctors at Newcastle Hospitals are also employed on a contract which mirrors the 2016 contract allowing for exception reporting for hours breaches, but not educational ones.

The TCS of the 2016 contract allows for exception reporting to raise reports on breaches of working hours and educational opportunities. The Guardian of Safe Working Hours must provide a quarterly report to the Trust Board to give assurance to the Board that the doctors' hours are safe and compliant. The revised TCS of the contract and exception reporting changes will be implemented in February 2026.

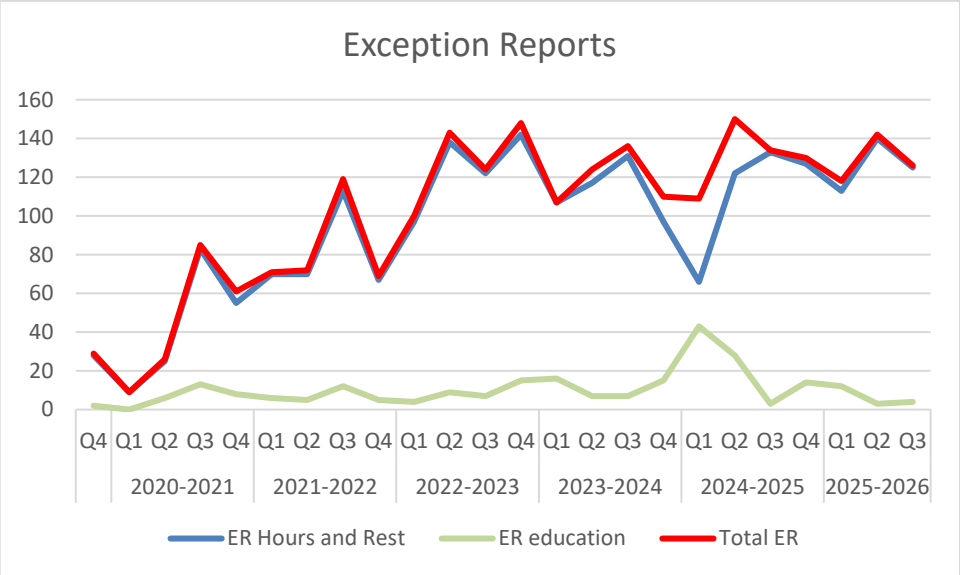
The principles of the framework agreement are to improve access, confidentiality and ease of exception reporting. Resident doctors will be able to decide compensation and supervisors will be removed from the exception reporting process. Other changes which have been suggested include standardisation of Board reporting to enable national benchmarking.

3. HIGH LEVEL DATA

		(Previous quarter data for comparison)
Number of Resident Doctors on New Contract	1,177	(1,182)
Total Number of Resident Doctors	1,194	(1,200)
Number of Exception reports	126	(142)
Number of Exception reports for Hours Breaches	125	(140)
Number of Exception reports for Educational Breaches	4	(3)
Fines	6	(14)

Admin Support for Role	Good
Job Planned time for supervisors	Good

4. EXCEPTION REPORTS



4.1 Exception Report by Speciality (Top 5)

		(Previous quarter for comparison)
General Medicine	34	(43)
General Surgery	46	(45)
Urology	10	(5)
Paediatrics	10	(2)
Haematology/Oncology	7	(4)

4.2 Exception Report by Rota/Grade

General medicine:

Royal Victoria Infirmary (RVI) (Foundation Level 1 (F1))	5
RVI (Trust)	1
Freeman Hospital (FH) (F1)	10
FH Senior House Officer / Specialty Registrar (SHO/StR)	18

General Surgery:

FH (F1) including Hepato-Pancreato-Biliary (HPB), colorectal, vascular	35
FH (Foundation Level 2 (F2)/SHO/StR))	3
RVI (F1)	8

Paediatrics:

F1	1
SHO/StR	9

Urology:

F1	4
SHO	6

Haematology/Oncology:

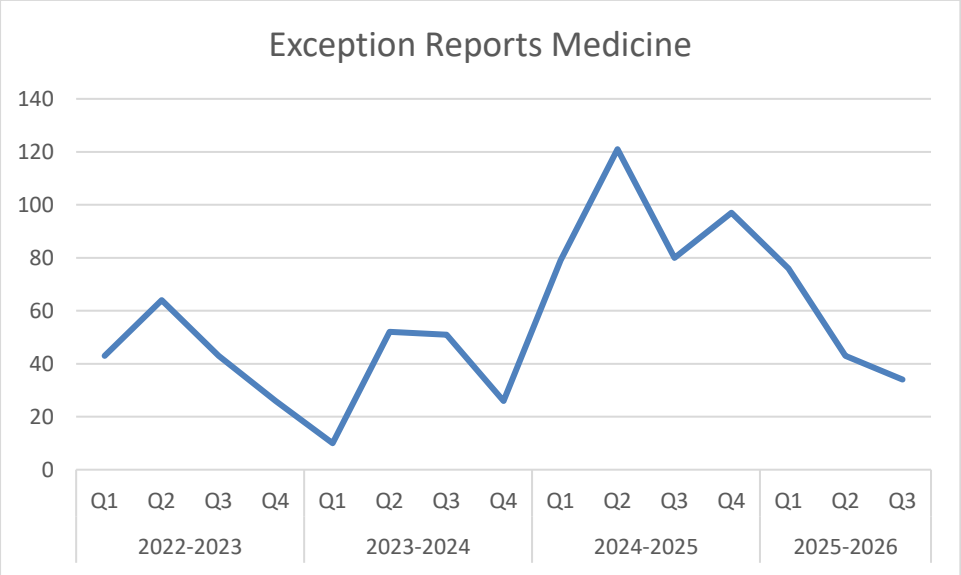
SHO	7

4.3 Example Themes from Exception Reports

General Medicine RVI/FH

'High workload unable to complete in working time.'

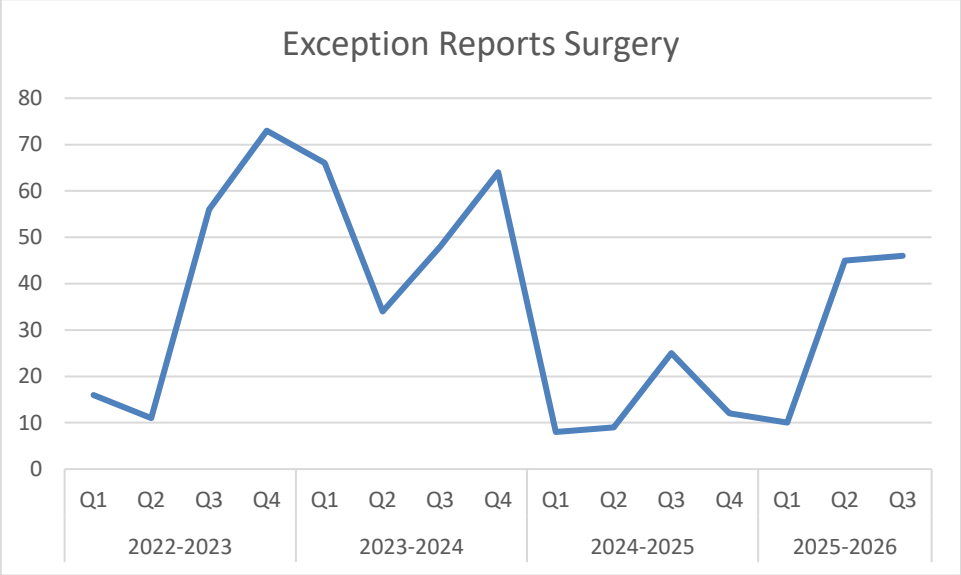
An additional 5 F1s were assigned across FH and RVI in August 2023 (Q2 2023-2024), with a further 5 F1s added to the workforce in August 2024. 2 additional F2s were also added (commenced August 2025). Exception report numbers for medicine are currently lower than previous.



General Surgery FH

'Stayed back to attend sick patients.'

This area has previously been an area of concern with additional doctors added to improve the workload. There were some improvements in exception reporting numbers, but these have now increased for the last 6 months. This rise has been escalated to the department and the medical education team. I will continue to monitor exception reports and their content.



Paediatrics

Exception reports submitted when the clinical workload was high. There were also some issues with rota gaps and lack of locum cover. These issues are being escalated within the Clinical Board.

Urology

Exception reports submitted when there was low staffing due to rota gaps or sickness requiring doctors to stay late.

Haematolgy/Oncology

Doctors stayed late when clinical demand required it.

5. EXCEPTION REPORT OUTCOMES

5.1 Work Schedule Reviews

No work schedule reviews were completed on the back of exception reports.

5.2 Fines

6 fines have been issued:

- Ophthalmology (2 fines): Rule breached “Unable to achieve minimum overnight continuous rest of five hours between 22:00 and 07:00 during a non-resident on-call (NROC); Unable to achieve the minimum 8 hours total rest per 24-hour NROC shift.” Total fine money £603.22.
- General Surgery (FH) (2 fines): Rule breached “Late finish; Exceeded the maximum 13-hour shift length.” Total fine money £118.86.

- Urology (1 fine): Rule breached "Late finish; Exceeded the maximum 13-hour shift length." Total fine money £119.25
- Paediatrics (1 fine): Rule breached "Late finish; Exceeded the maximum 13-hour shift length." Total fine money £178.88

6. ISSUES ARISING

6.1 Workforce and workload

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

6.2 Supervisor Engagement

Supervisor engagement is generally good.

6.3 Administrative Support

Administrative support is currently good.

7. ROTA GAPS

Specialties and rotas with vacancies are outlined below.

Directorate	Site	Specialty/Sub Specialty	Grade	No. required on rota (at full complement)	Dec-25	Nov-25	Oct-25
		Cancer Services					
Cancer Services	FH	Oncology	ST3+	22	1	1	1
		Cardiothoracic Services					
Cardiothoracic Services	FH	Cardiology	ST3+	15	2	1	1
Cardiothoracic Services	FH	Cardiothoracic Surgery	F2/ST1-2	2	2	2	2
Cardiothoracic Services	FH	Cardiothoracic Surgery	ST3+	11	2	2	2
Cardiothoracic Services	FH	Cardiothoracic Transplant	ST3+	3	1	1	1
Cardiothoracic Services	FH	Paediatric Cardiology 1st	F2/ST1/ST2	7	0.2	0.2	0.2
Cardiothoracic Services	FH	Paediatric Cardiology 2nd	ST3+	9	2	2	2
Cardiothoracic Services	FH	Respiratory Medicine	CMT/ST1-2	5	0.2	0.2	0.2

Directorate	Site	Specialty/Sub Specialty	Grade	No. required on rota (at full complement)	Dec-25	Nov-25	Oct-25
		Family Health					
Children's Services	RVI	Paediatric Surgery 2nd	ST3+	9	1	1	1
Children's Services	RVI	Paediatrics 1st - ST1/ST2 (now including Paediatric Surgery)	F2/ST1/ST2	25	0.4	0.4	0.4
Women's Services	RVI	Obstetrics & Gynaecology	ST3+	22	1	1	1
		Surgical & Associated Specialities (FH)					
Surgical Services	RVI	General Surgery	F2/ST1/ST2	7	1	1	1
Surgical Services	RVI	General Surgery	ST3+	15	0.8	0.8	0.8
ENT, Plastics, Ophthalmology & Dermatology (EPOD)	FH	Ear, Nose and Throat (ENT)	ST3+	9	1	1	1
Urology	FH	Renal Medicine	ST3+	6	2	2	2
		Clinical and Diagnostic Services					
Integrated Laboratory Medicine	RVI	Histopathology	ST1/2	8	0.2	0.2	0.2
Integrated Laboratory Medicine	RVI	Medical Microbiology integrated with Medicine	ST1+	21	0.8	0.8	0.8
		Medicine					
Medicine	FH	General Internal Medicine	F2/GPVTS/CMT/TF	12	0.6	0.6	0.6
Medicine	RVI	CMT	CMT	11	1	1	1
Medicine	RVI	CMT Acute	CMT	2	1	1	1
Medicine	RVI	General Internal Medicine	ST3+	25	3	3	3
Medicine	FH	Care of the Elderly	ST3+	5	2	2	2
Medicine	RVI	Accident & Emergency 1st	ACCS/ST1-2/CT1-2	20	1	1	1
Medicine	RVI	Accident & Emergency 2nd	ST3+	15	3	3	3
EPOD	RVI	Dermatology	ST3+	7	0.4	0.4	0.4

Directorate	Site	Specialty/Sub Specialty	Grade	No. required on rota (at full complement)	Dec-25	Nov-25	Oct-25
		Surgical & Specialist Services (RVI)					
EPOD	RVI	Ophthalmology	F2/ST1/ST2	6	1	1	1
EPOD	RVI	Ophthalmology	ST3+	25	3	3	3
Musculoskeletal	FH	Orthopaedics	F2/ST1/ST2	4	2	2	2
Musculoskeletal	RVI/FH	Orthopaedics	ST3+	19	2	2	2
Neurosciences	RVI	Neurosurgery	F2/ST1/ST2	5	0.2	0.2	0.2
Neurosciences	RVI	Neurosurgery	ST3+	13	1	1	1
Neurosciences	RVI	Neurology	IMT/CMT	3	0.2	0.2	0.2
		Peri-operative					
Peri-operative & Critical Care	FH	Critical Care	F2 ST1-7	13	0.8	0.8	0.8
Peri-operative & Critical Care	FH	Anaesthetics General	ST1-7 CT1-2	27	2.8	2.8	2.8
Peri-operative & Critical Care	RVI	Critical Care	ST1+	16	3.6	2.6	2.6
Peri-operative & Critical Care	RVI	Anaesthetics	ST1-2 / ST3 +	40	3.2	3.2	2.2

Key:
CMT – Core Medical Trainee
IMT – Internal Medicine Trainee
CT – Core Trainee
CST – Core Surgical Trainee
ACCS – Acute Care Common Stem (CT equivalent)
ST – Specialist Trainee
GPVTS – GP Vocational Training Scheme
TF – Teaching Fellow

8. LOCUM SPEND

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

Lead Employer Trust (LET) Locum Spend

October to December (Q3 2025-2026)	£399,971
July to September (Q2 2025-2026)	£433,718
April to June (Q1 2025-2026)	£550,340

Trust Locum Spend

October to December (Q3 2025-2026)	£785,609
July to September (Q2 2025-2026)	£739,758
April to June (Q1 2025-2026)	£710,027

Comment from finance team:

'Spend on Trust locums between these periods increased by £46k. This was mainly driven by an increase in Industrial Action Cover (£172k), partly offset by a decrease in Establishment Vacancies (-£86k).'

9. RISKS AND MITIGATION

9.1 Changes to the TCS of the Contract

As previously indicated, changes to the TCS of the contract are due to come in in February 2026. Exception reports will be signed off by medical staffing with oversight by the GOSW. There will be no involvement from supervisors. It is anticipated this will increase exception reporting and result in a significant cost in additional hours remuneration.

The changes will also result in considerable increases in work for both medical staffing and the GOSW. Additional fines will be applicable for delays in access to the exception reporting framework and breaches in confidentiality. Medical staffing will be required to action all exception reports within 10 days. Work is ongoing to implement these changes, including communication, software changes, and changes to operational procedures.

10. RESIDENT DOCTOR FORUM

Issues discussed included concerns around bottlenecks in training and potential lack of employment for doctors.

NHS England's newly published 10 point plan to improve working conditions for resident doctors was also discussed.

11. RECOMMENDATIONS

I recommend that we continue to review the workforce workload balance to ensure that safe staffing numbers reflect the current workload for individual wards, with consideration of further locally employed doctor posts to accommodate the anticipated number of doctors unable to secure training places.

I also recommend that we consider the implications of the changes to the TCS of the Resident Doctor Contract both in terms of the financial implications and the increase in administrative workload. I recommend that the Board considers appointment of a safe working hours administrator similar to other Trusts nationally and regionally.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours
12 January 2026

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Agenda item A2(f)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	30 January 2026		
Title	Executive Director of Nursing, Midwifery and Allied Health Professionals Report		
Report of	Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals		
Prepared by	Lisa Guthrie, Director of Nursing Diane Cree, Personal Assistant		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	This paper has been prepared to inform the Board of Directors of key issues, challenges, and information regarding the Executive Director of Nursing (EDON), Midwifery and Allied Health Professionals areas of responsibility. The report covers the following sections: • Section 1: Nursing Staffing Update • Section 2: Practice Education Update • Section 3: Flu Vaccination Programme The following key points/risks are noted for the Trust Board's attention: • Trust nurse staffing escalation remains at level 1 with appropriate oversight, monitoring and supportive actions in place and there are no new escalations to the Trust Board. • Several wards have required support in line with the Nurse Staffing and Clinical Outcomes Group criteria. Action plans are in place for wards with education and resources provided, overseen by the Executive Director of Nursing team and relevant Clinical Boards. • There are several nurse staffing metrics included in the report with additional detail in the Trust Board Reading Room on AdminControl. • An update on the Practice Education Team support to undergraduate practice placements of Nursing Midwifery and Allied Health Professionals is provided, highlighting the Trust commitment to ensuring students have access to high-quality learning opportunities within safe and effective learning environments. There are no new escalations to note. • The vaccination programme was launched in October 2025 with only Flu vaccinations delivered in line with national guidance. • The Trust has an inpatient peripatetic Covid and Flu vaccination service for patients in vulnerable groups which will run to the end of March 2026. • In the North East and Yorkshire (NEY) region the Trust has the highest compliance for organisations employing over 10,000 staff and overall sits 6th across all NEY Trusts. • The Vaccination Steering Group provides activity reports to the Executive Team weekly. Reference items from this report are available in the Board of Directors Reading Room.		

Agenda item A2(f)

<table>
<tr><td>Recommendation</td><td colspan="6">The Board of Directors is asked
i) Receive and discuss the report.
ii) Note the oversight and reporting of safe staffing which has been prepared in line with national guidance.
iii) Note the vaccination programme compliance and plan in line with best practice guidance.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">• Focus on Fundamentals - Deliver high quality, safe and compassionate patient care, meet our Clinical Board and Trust quality priorities.
• Make it better for colleagues - Support colleagues through our People Plan with better psychology support and greater equality, diversity and inclusion.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">BAF risk ID 1.1 - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">The EDoN update is a regular comprehensive report bringing together a range of issues to the Trust Board.</td></tr>
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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

EXECUTIVE DIRECTOR OF NURSING REPORT

1. NURSE STAFFING UPDATE

A guidance document providing an overview of nursing safe staffing metrics along with the monthly safe staffing dashboard can both be found in the Reading Room to accompany the information contained within this paper.

1.1 Nurse Staffing Escalation

The Trust Nurse Staffing Guidelines - Ensuring Safe Staffing Levels in Wards and Departments provides a robust framework to ensure safe nurse staffing governance and identifies a clear process for safe nurse staffing escalation. The Trust staffing escalation level is currently at level one, as business-as-usual processes are sufficient to maintain safe staffing levels.

The winter ward at the Freeman Hospital has opened on 29th December 2025. These surge beds form part of the winter plan and have an established, successful workforce model with the nursing leadership provided by the Medicine and Emergency Care Clinical Board. As the Head of Nursing can sustain safe nurse staffing levels in collaboration with other Clinical Boards and the surge capacity is planned, the safe staffing escalation level has remained at level one but is subject to review and increase responsively.

The following actions are in place and overseen by the senior nursing team:

- 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) Operational Group. Below is an overview of wards/areas and the level of escalation for the last quarter:

Month	Total	Clinical Board	High level	Medium level	Low level
Sep-25	4	Family Health Services		GNCH01a, GNCH01b, GNCH3	GNCH12
	2	Surgical and Specialist Services, Royal Victoria Infirmary (RVI)		RV22, RV16	
	1	Perioperative Services			RV38
	4	Cardiothoracic Services		FH30	FH21, FH25, FH29
	2	Medicine and Emergency Care Services		RVAS	FH18
	0	Surgical and Associated Services, Freeman Hospital (FH)			
	2	Cancer and Clinical Haematology Services		NCCC34	NCCC33
Total	**15**		**0**	**8**	**7**
Oct-25	4	Family Health Services		GNCH01a, GNCH01b, GNCH3	GNCH12
	3	Surgical and Specialist Services, RVI		RV22, RV16	RV23
	1	Perioperative Services			RV38
	4	Cardiothoracic Services		FH30	FH21, FH25, FH29
	2	Medicine and Emergency Care Services		RVAS	FH18
	0	Surgical and Associated Services, FH			
	2	Cancer and Clinical Haematology Services		NCCC34	NCCC33
Total	**16**		**0**	**8**	**8**
Nov-25	4	Family Health Services		GNCH01a, GNCH01b	GNCH03, GNCH12
	2	Surgical and Specialist Services, RVI		RV22, RV16	
	0	Perioperative Services			
	3	Cardiothoracic Services		FH29, FH30	FH21
	3	Medicine and Emergency Care Services		RVAS	FH18, RV44
	0	Surgical and Associated Services, FH			
	2	Cancer and Clinical Haematology Services		NCCC34	NCCC33
Total	**14**		**0**	**8**	**6**

Key:
GNCH - Great North Children's Hospital
NCCC - Northern Centre for Cancer Care
RV - Royal Victoria Infirmary
AS – Assessment Suite

The key points to note:

- No wards have required high-level support over the last three months.

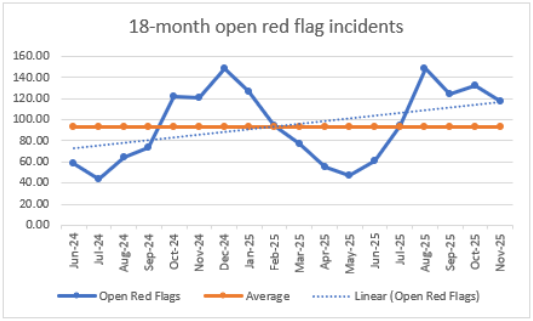
- Wards requiring medium level support for more than two months have an action plan in place and themes are reviewed for learning.
- The main themes for medium level support over the past quarter are infection prevention and control challenges, staffing levels (vacancy and sickness) and harm-free care documentation standards.

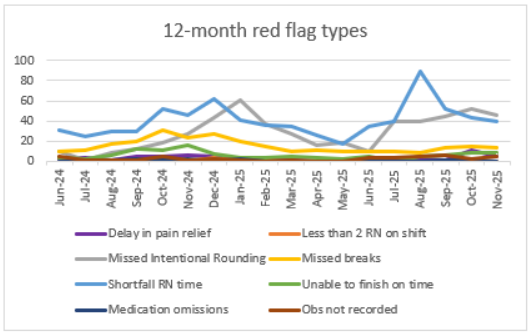
1.3 Datix and Red Flag data

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 past six months.
- There was a significant decrease of both incident reports and red flags in November. This follows the anticipated reduction of vacancy with recruitment of newly registered nurses commencing employment in September and October.
- Incidents are monitored and themes reported to the Professional Practice Assurance Group (PPAG).
- There were no red flag events of “less than 2 Registered Nurse (RN)” in the last quarter.
- The greatest number of unresolved red flag reasons were “shortfall in RN time” and “missed intentional rounding”. This continues to be closely monitored, with data and themes reported to PPAG.





1.4 Care Hours Per Patient Day (CHPPD) data

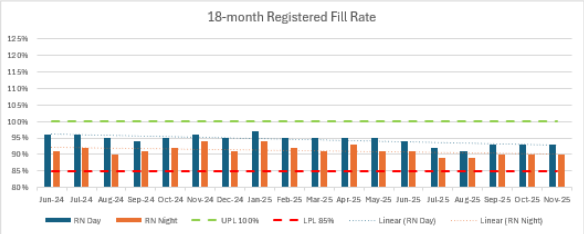
The nurse staffing team monitor ward-specific CHPPD on the safer staffing dashboard which is reviewed at the NSCO Group each month. The Trust CHPPD has remained at around 9.0

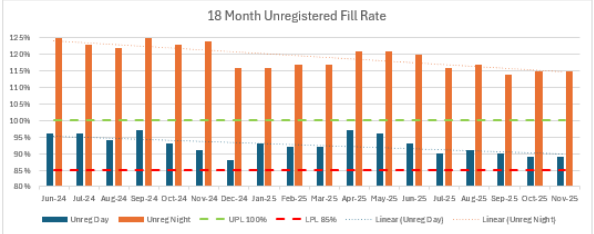
for the past 12 months. Non-specialist in-patient wards benchmark lower than the Model Hospitals Dashboard comparator in most services but direct benchmarking is difficult. There are no new areas for escalation.

1.5 Planned versus actual hours (fill rates)

The planned and actual staffing hours are converted into percentage "fill rates" which are entered onto the safer staffing dashboard, RAG (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 shown a minimally increasing trend on dayshift, and a minimal decreasing trend on nightshift over the last 18 months.
- Six critical care units fell below 85% RN staffing last quarter. Bed capacity and patient acuity are actively managed daily, with local teams mitigating risk in real time. An escalation risk assessment was triggered for one department, with risk mitigations and control measures in place. There were no corresponding staffing incident reports indicating any patient harm because of this escalation.
- Six of the areas reporting <85% RN fill rates have been in receipt of low-level support through NSCO, and two areas have been supported at medium-level with actions and mitigations in place.





1.6 Temporary Staffing

Newcastle Hospitals Staff Bank supply temporary staffing to wards and departments to fill short-term vacancies or absence. Temporary staffing and agency usage reports are distributed to the senior corporate nursing team and heads of nursing each week, providing additional oversight.

The total temporary staffing spend has remained stable over the past six months for both registered and unregistered staff. Registered agency costs have stayed consistently low, while unregistered agency spend continues to decline. Unregistered bank requests have remained static, although the fill rate has decreased. In contrast, registered nurse bank shift requests and their fill rates show an upward trend.

The NHS England "Agency Rules" guidance was updated in October 2025, advising that all NHS Trusts achieve zero use of Band 2 and 3 agency workers by the end of January 2026, unless an exceptional patient safety risk is approved through a "break glass" process signed off by an executive director. Current data indicates a shortfall

in unregistered bank staff to cover enhanced therapeutic observation and care shifts, which are partly filled by agency workers. A task and finish group with an associated action log has been initiated to work through strategies to bridge this gap and achieve zero use of Band 2 and 3 agency workers. Oversight and sign off of any break glass requirements will sit with the Executive Director of Nursing, Midwifery and Allied Health Professionals.

1.7 Recruitment and Retention

Key points to note:

- The current RN turnover is 5.29%. This demonstrates a continued reduction from the previously reported 5.79% in the same period last year.
- The current RN vacancy rate is 1%. This vacancy rate is consistent with the rate reported for the same period last year.
- The current Healthcare Support Worker (HCSW) turnover rate is currently 5.69% and demonstrates a reduction from 7.65% in the same period last year.
- The HCSW vacancy rate has reduced slightly and is currently 10%, a decrease to the figure of 11% reported in the same period last year.
- Band 5 Recruitment has continued over the last year, predominantly recruiting internally and for home Trust students. All students who graduated in September 2025 and applied for a post in the Trust have been recruited into positions, having been placed on a reserve list initially until available posts arose.
- Only two graduates from December 2025/January 2026 are awaiting appointment into their preferred specialities. These are likely to be confirmed in the next month. Regular contact is maintained with candidates during the process.

2. PRACTICE EDUCATION UPDATE

The Practice Education Team oversees all aspects of Nursing Midwifery and Allied Health Professional (NMAHP) undergraduate practice placements, ensuring students have access to high-quality learning opportunities and experiences within safe and effective learning environments.

The team maintain strong partnerships with education providers across the region, including Higher Education Institutions (HEIs), colleges, and schools. The main collaboration is with the three North East HEIs, offering placements across diverse programmes for learners at different stages. We also offer placements to students from other HEIs studying programmes not delivered locally. The Trust remains the largest provider of undergraduate nursing placements in the region and was recently shortlisted, alongside a local HEI, for Partnership of the Year at the Student Nursing Times Awards.

Meeting placement demand can be challenging in some areas, but the team continues to expand the range of opportunities available to learners and to maintain high-quality learning environments, the Practice Education Team conducts regular educational audits aligned to the NHS England Education Quality Framework and the Safe Learning Environment Charter (SLEC). The SLEC priorities are actively promoted, which are underpinned by the principles of equality, diversity, and inclusion. There has been positive

engagement from learners, who have been actively encouraged to share their thoughts on the priorities through the student voice forums.

Students continue to benefit from bespoke education sessions delivered by clinical experts, and student voice forums have provided a psychologically safe space for learners to discuss placement experiences, with an emphasis on wellbeing and feeling valued. Pre-preceptorship workshops, delivered by the Allied Health Professional (AHP) Practice Development and Preceptorship teams, have been incorporated into these forums to encourage early conversations about transitioning to registered practice. The Practice Education Team also promotes career development through positive career conversations within the Trust and externally in schools and colleges.

3. FLU VACCINATION PROGRAMME

The Trust flu vaccination programme launched on 3rd October 2025 and aims to maximise vaccine uptake, ensure staff are well-informed and is in line with national guidance. The Covid vaccination was removed from the staff programme following a government decision in June 2025 and is now offered to the most vulnerable patient populations only. The Trust inpatient vaccinations commenced in November 2025 and will continue to March 2026. The programme is supported by robust governance and assurance processes through the Vaccination Steering Group.

The Department of Health and Social Care (DHSC) target is to increase staff flu vaccination uptake by 5% compared to 2024/25 with an aim to achieve 55% overall. Current compliance reporting is supported by real-time digital recording with weekly updates provided to the Executive Team.

The Trust performance, as of 8th January 2026, is 58%. 10,779 of staff have received their flu vaccination. This is 10,779 doses of vaccine given from 18,623 staff; these figures are an increase on the 2024/25 performance with the compliance at this point in the 2024/25 programme being 52.88%. In the North East and Yorkshire (NEY) region the Trust has the highest compliance for organisations employing over 10,000 staff and overall sits 6th across all NEY organisations.

The 5% uptake target has been met, and it is anticipated that the uptake percentage will rise further through the data cleanse process. Also, it is anticipated that there will be some adjustment of figures for staff who have received their vaccination outside of the Trust. Processes are in place to capture this information to reach a final percentage figure.

4. RECOMMENDATION

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

Report of Ian Joy
Executive Director of Nursing
21 January 2026

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Agenda item A2(g)(i)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 January 2026		
Title	Perinatal Quality Oversight 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. Key points/risks to note: • The Care Quality Commission (CQC) Maternity Survey 2025 Benchmark report was published in December 2025. The Trust scored 'better than expected' for 7 questions, 'somewhat better than expected' for 4 questions, 'about the same' for 45 questions and 'much worse than expected' for 1 question related to partner access and visiting on the postnatal ward. A pilot of extended visiting will commence in January 2026. • The Fetal Medicine service remains fragile; this has been exacerbated by the career break of the Head of Fetal Medicine from January 2026 for 12 months. Mutual aid is being provided by Sunderland and South Tyneside NHS Foundation Trust who are releasing a consultant for 2 Programmed Activity sessions (PA) per week to support the lower acuity cases. In addition, the Trust has recruited a Fetal Medicine Consultant Midwife. A robust triage process is in place to maintain safety and delivery of the tertiary services. • Concerns remain regarding the data quality issues of duplicated records, highlighted by the stillbirth rate analytics, which are being replicated with other metrics where care is provided across multiple trusts. These issues were escalated to the NHS England (NHSE) analytics team and the Local Maternity and Neonatal System (LMNS) in November 2025, a response is awaited and therefore an escalation has been made to the Regional Maternity Team via the Regional Perinatal Quality Oversight Meeting. • The Specialised Commissioning Team have now established a Regional Neonatal Critical Care Review Implementation Group. This group will function as a high-level project board who will have oversight and assurance of the implementation process. The Trust has appropriate representation to support the implementation, oversight, and scrutiny of the plans. • The current self-assessed position has been reviewed and the Trust is compliant with all 10 safety actions. The support of the Trust Board will be sought to declare this as the final position, pending agreement of the midwifery staffing action plan included within the paper.		

Recommendation	The Board of Directors is asked to: i. Receive and discuss the report. ii. Note compliance with the Perinatal Quality Oversight Model (PQOM). iii. Note compliance with the required standard for Safety Action 10. iv. Support the midwifery staffing action plan and timescales. v. Agree compliance with the Maternity Incentive Scheme 10 Safety Actions.						
Links to Strategic Objectives	Focus on Fundamentals - Deliver high quality, safe and compassionate patient care, meet our Clinical Board and Trust quality priorities.						
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☐	☒	☒	☐	☐	☐
Link to Board Assurance Framework [BAF]	Principal Risk - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients. Threat - Failure to improve the safety and quality of patient and staff experience in Maternity Services.						
Reports previously considered by	Previous reports have been presented to the Quality Committee, Maternity Update, Midwifery staffing paper, Maternity Incentive Scheme (Clinical Negligence Scheme for Trusts (CNST)).						

PERINATAL QUALITY OVERSIGHT REPORT

1. INTRODUCTION

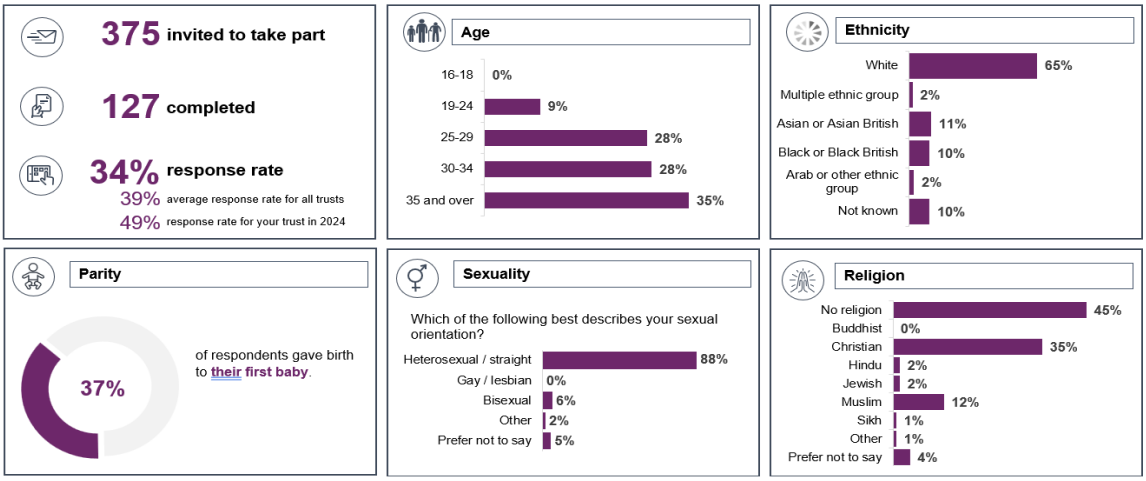
This report provides the Trust Board with an overview of the Maternity Service compliance with the Perinatal Quality Oversight Model (PQOM), based on the locally and nationally agreed measures to monitor maternity and neonatal safety.

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 final self-assessed position against the Year 7 Maternity Incentive Scheme 10 Safety Actions and any escalations.

2. LISTENING TO WOMEN AND FAMILIES THROUGH SERVICE USER FEEDBACK

The CQC Maternity Survey 2025 Benchmark report was published in December 2025. The Maternity Survey is split into seven sections which asks questions about:

- Antenatal Care
- Labour and Birth
- Care in the ward after birth
- Postnatal Care
- Triage: Assessment and Evaluation
- Complaints



Where service user experience is best

- ✓ **Care in the Ward:** Being able to get help from staff when needed
- ✓ **Labour and Birth: Your labour and birth:** Feeling that healthcare professionals did everything they could to help manage pain
- ✓ **Labour and Birth: Staff caring for you:** Feeling that if a concern was raised, it was taken seriously
- ✓ **Labour and Birth: Staff caring for you:** Having the opportunity to ask questions about the labour and birth
- ✓ **Triage: Assessment and Evaluation:** Feelings about the length of time they waited before being seen by a midwife

Where service user experience could improve

- ○ **Care in the Ward:** Partner or someone else close to them being able to stay as much as they wanted
- ○ **Postnatal Care: Care at home after birth:** Being told who to contact if advice needed about potential changes to mental health after birth
- ○ **Postnatal Care: Care at home after birth:** Being given information about possible changes to mental health
- ○ **Postnatal Care: Care at home after birth:** Being asked about mental health by midwife
- ○ **Postnatal Care: Care at home after birth:** Midwife/midwifery team being aware of their and their baby's medical history

It is reassuring to see improvements in the responses relating to postnatal care on the postnatal ward, and experience of triage, as these have been areas of focus for improvement over the last 12 months.

The theme relating to mental health support after birth continues, this is a core quality improvement initiative for 2026, with the introduction of a maternal mental health service in Quarter 1 (Q1). The impact of this will be evaluated through the Right Time programme and via the Maternity and Neonatal Voice Partnership (MNVP) service user feedback.

The number of questions in which the Trust performed better, worse or about the same compared with all other Trusts is outlined below.

Trust rating	Number of questions
Much better than expected	0
Better than expected	7
Somewhat better than expected	4
About the same	45
Somewhat worse than expected	0
Worse than expected	0
Much worse than expected	1

The better than, and somewhat better than questions all related to labour and birth, with the exception of the question relating to care and attention on the postnatal ward after birth which also scored better than expected.

The much worse than expected response was to the question related to care in the postnatal ward after birth, '*Thinking about your stay in hospital, if your partner was involved in your care, were they are able to stay with you as much as you wanted?*'

This question has scored below the national average for five consecutive years and reflects the estate and facilities which mean the Trust are unable to offer accommodation for partners during the postnatal period. The decant of services to support the Neonatal Intensive Care Unit (NICU) estate work means that from December 2025 there are eight postnatal beds accommodated within the Newcastle Birthing Centre (NBC). Whilst this improves access for partners for the woman receiving postnatal care on the NBC, it drives further inequity in the provision of postnatal care and visiting. The Trust is seeking to address this by extending the visiting times for partners on the postnatal ward from January as part of a pilot. The impact will be measured via the Real and Right Time patient

experience programmes and reported to the Perinatal Engagement and Inclusion Group (PEIG).

3. WORKFORCE

3.1 Qualified in Speciality (QIS) training

To comply with British Association of Perinatal Medicine (BAPM) standards, 70% or more of the qualified nursing workforce within a neonatal service must hold a qualified in speciality (QIS) qualification. This figure increases with activity and acuity, based on the services the Trust provides the expectation is 80% of nurses working in intensive and high dependency should be qualified in speciality, currently 64% of Band 5-7 nursing establishment is QIS trained, this is recorded on the risk register and regularly reviewed in accordance with the requirements of Safety Action 4, and BAPM standards for nurse staffing.

A QIS training options paper was discussed at the Northern Neonatal Network (NNN) Board meeting in October 2025 unfortunately, due to a lack of clarity regarding funding, a decision was not made. In the interim the NNN has commenced the QIS F element of the pathway via an e-learning platform from this month, with Trust nurses enrolled to attend. An update on the next steps is expected at the NNN Board in January 2026.

3.2 Midwifery and nursing workforce

The Birthrate Plus staffing business case was approved by the Obstetric Board and the Family Health Clinical Board in December 2025 and subsequently escalated to the Trust Executive Team for review and approval. It has been agreed that the additional investment required to achieve Birthrate Plus compliant funded establishment, required from October 2026 to enact Phase 3 of the staffing review, will be funded by the Maternity Incentive Scheme 10% rebate received as a result of achieving all 10 safety actions in Year 7.

A staffing action plan is included in section 5.2 which outlines the timescales for achieving the appropriate uplift in funded establishment to ensure compliance with Safety Action 5. An overview of midwifery staffing fill rates against Birthrate Plus is included within the Integrated Board Report, which also details the red flags recorded on a monthly basis, and the Operational Pressures Escalation Levels (OPEL) status of the service.

There are no neonatal nursing vacancies, the current over recruitment of nurses on the Neonatal Intensive Care Unit (NICU) is being utilised to improve nursing staffing ratios on the Transitional Care ward as per the improvement action plan. The Trust plans to explore the commissioning model for neonatal and transitional care cots in 2026.

3.3 Medical workforce

The Fetal Medicine service remains fragile; this has been exacerbated by the career break of the Head of Fetal Medicine from January 2026 for 12 months. Mutual aid is being provided

by Sunderland and South Tyneside NHS Foundation Trust who are releasing a consultant for 2 PA sessions per week to support the lower acuity cases. In addition, the Trust has

recruited a Fetal Medicine Consultant Midwife to support clinical activity and pathway reviews. A robust triage process is in place to maintain safety and the delivery of tertiary services, however in November there was a reduction in performance with only 64% of new referrals reviewed within 72 hours, whilst there was no clinical safety impact of this, it is an unsatisfactory patient experience. Fluctuations in the number of new referrals impact performance and this is being closely monitored by the Obstetric Board.

There are currently two obstetric consultant vacancies which are unfilled, despite this the flexibility and dedication of the consultant workforce means that during the industrial action there were no rota gaps in November or December and the Trust maintained compliance with the Royal College of Obstetricians & Gynaecologists (RCOG) guidance in relation to compensatory rest and consultant attendance.

The Trust remains compliant with the Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1 with a duty anaesthetist immediately available for the obstetric unit 24 hours a day with an on call consultant anaesthetist available at all times. There were no rota gaps in November or December, despite the industrial action.

The Trust is compliant with the BAPM guidance for neonatal medical staffing; there is currently one vacancy and no rota gaps.

4. CULTURE OF LEARNING, SAFETY AND SUPPORT

4.1 Perinatal staff experience

The Perinatal Culture and Staff Wellbeing action plan and progress is a standing item on each staff forum. The action plan and staff experience results are monitored by the Perinatal People and Culture Group, chaired by the Head of Midwifery and Associate Director of Operations. There were no Freedom to Speak up contacts during November or December 2025. The Non-Executive Director Safety Champion has conducted walkabouts in November and December, there were no escalations regarding staff experience or feedback.

5. STRUCTURES AND STANDARDS UNDERPINNING SAFER, MORE PERSONALISED, EQUITABLE CARE.

5.1 Clinical Indicator Dashboard

The Trust has triggered safety alerts on North East North Cumbria Clinical Indicators Quarter 1 and 2 Dashboard for the number of preterm births and the number of babies born with an APGAR* <7 at 5 minutes of age. The Trust is concerned that the data quality issues of duplicated records, highlighted by the stillbirth rate analytics, are being replicated with other metrics where care is provided across multiple Trusts. These issues were escalated to the NHSE analytics team and LMNS in November 2025, a response is awaited and therefore an escalation has been made to the Regional Maternity Team via the Regional Perinatal Quality Oversight Meeting.

** The AGPAR score is a simple assessment of a newborn's health against five criteria at 1 and 5 minutes after birth - Appearance, Pulse, Grimace, Activity and Respiration.*

5.2 Maternity Incentive Scheme

The final submission date to NHS Resolution (NHSR) is 3 March 2026, the current self-assessed position has been reviewed and the Trust is compliant with all 10 safety actions. The support of the Trust Board will be sought to declare this as the final position, pending agreement of the midwifery staffing action plan included within this paper.

The LMNS and Northern Neonatal Network on behalf of the North East and North Cumbria (NENC) Integrated Care Board (ICB) are required to verify evidence for safety actions 3,4,5, 7 and 9. The Perinatal Quality Oversight Model quarterly meetings are utilised to share key safety and quality information and compliance with the safety actions are monitored via this meeting.

The Q1 and Q2 2025/26 update has been provided in accordance with the LMNS guidance and the evidence verified as satisfactory. In addition, the ICB and LMNS have confirmed in December 2025 that the Trust is compliant with all requirements of the Saving Babies Lives Care Bundle v3 and has achieved the required standard for safety action 6.

The evidence of compliance with Safety Action 10 is included in the Trust Board Reading Room on AdminControl.

Safety Action	Governance	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?	The Trust Board have received the quarterly Perinatal Mortality Review Tool reports, which outline compliance with standards. In addition, this will be externally verified by MBBRACE.	Compliant
Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	The Trust have received confirmation from NHS Digital of compliance with the standards.	Compliant
Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?	The Trust has provided the required quality improvement project updates to the Safety Champions and LMNS who have verified compliance with the standard.	Compliant
Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?	The Trust Board and the Quality Committee have received the required audit and workforce information for all staff groups and have recorded in the Trust Board minutes compliance with the standards. An escalation regarding the QIS standards have been made to the LMNS and Operational Delivery Network (ODN) and this is recorded and monitored via the risk register.	Compliant
Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	The Trust Board have received the biannual staffing paper and staffing action plan which outline compliance with the standard.	Pending confirmation of compliance

Safety Action	Governance	Trust self-assessed position
Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version 3.2?	The LMNS and ICB have verified compliance with the standard, and the completion of two quality improvement discussions.	Compliant
Safety action 7: Listen to women, parents & families using maternity and neonatal services & co-produce services with users.	The Trust have escalated the absence of an appropriately commissioned and functioning MNVP via the PQOM at Trust, ICB and regional level hence is compliant with the standard.	Compliant
Safety action 8: Can you evidence the following three elements of local training plans and 'in-house', 1 day multi professional training?	The Quality Committee and Trust Board receive the Integrated Board Report (IBR) which outlines the Trusts compliance with this standard. An action plan is not required as 100% of trainees will have completed training within 6 months of joining the organisation by 31st January 2026.	Compliant
Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	The Trust Board and Quality Committee receive the PQOM paper, the IBR with perinatal minimum data set and the Safety Champion reports. The LMNS, ODN and ICB have verified compliance with this standard as part of the quarterly PQOM meetings with the Trust.	Compliant
Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025	The Trust Board have received the required information to be compliant with this standard within the Reading Room. In addition, this will be externally verified by MNSI and NHSR.	Compliant

Safety Action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?

Midwifery staffing action plan:

Action	Progress update	Lead	Completion date
Enact phase 2 of the staffing review in April 2026.	No investment required. Midwifery recruitment complete. Recruit into existing funded vacancy for maternity support workers and maternity care assistants within acute services.	Lucy Patterson, Head of Midwifery	30.3.2026
Agree required investment in midwifery funded establishment to achieve Birthrate Plus funded establishment and compliance with Safety Action 5 from Maternity Incentive Scheme rebate.	Quality business case submitted following agreement at the Obstetric Board and the Family Health Clinical Board. Agreed by the Executive Team. Action plan to be discussed at Trust Board January 2026.	Trust Board	30.1.2026
Enact phase 3 of the staffing review in October 2026 to achieve Birthrate Plus staffing across the maternity services.	On track.	Jenna Wall, Director of Midwifery	30.9.2026
Submit biannual perinatal staffing Q3&4 2025/26 paper to Trust Board to track progress, to include data in accordance with Safety Action 5 requirements.	On track.	Jenna Wall	30.6.2026
Submit midwifery staff data monthly into IBR to track effectiveness of staffing.	Established and ongoing.	Lucy Patterson	31.1.2026
Monitor red flags of one to one care in labour and co-ordinator being supernumerary via the IBR.	Established and ongoing.	Lucy Patterson	31.1.2026

6. NEONATAL CRITICAL CARE REVIEW

The NNN proposal to enact the recommendations of the Neonatal Critical Care Review (NCCR) was agreed at the NNN Board in October 2025. The Specialised Commissioning Team have now established a Regional NCCR Implementation Group. This group will function as a high-level project board who will have oversight and assurance of the implementation process. There is an expectation that the group will commence early February 2026, following a presentation at the Joint North East Overview and Scrutiny Committee (OSC) on the 26 January 2025. The Trust has appropriate representation to support the implementation, oversight, and scrutiny of the plans.

7. NATIONAL UPDATES

A paper has been included within the Reading Room provide an overview of the current direction of travel for maternity and neonatal services in England including the national maternity and neonatal investigation, emerging national maternity and neonatal priorities and the maternity and neonatal priorities in the recently published NHS Medium Term Planning Framework.

8. CONCLUSION

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

The evidence and audits required for compliance with the Maternity Incentive Scheme have been presented to the Quality Committee, Trust Board, LMNS, ODN and ICB within the appropriate time period and as such the Trust will declare compliance with the 10 Safety Actions in Year 7 should the staffing action plan be agreed.

9. RECOMMENDATIONS

The Board of Directors is asked to:

i. Receive and discuss the report.
ii. Note compliance with the Perinatal Quality Surveillance Model (PQOM)
iii. Note compliance with the required standard for Safety Action 10.
iv. Support the midwifery staffing action plan and timescales.
v. Agree compliance with the Maternity Incentive Scheme 10 Safety Actions.

Report of Ian Joy
Executive Director of Nursing
20 January 2026

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Agenda item A2(g)(ii)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	30 January 2026					
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 November 2025 Trust Board meeting.					
Recommendation	The Trust Board is asked to receive the report and consider/discuss the content.					
Links to Strategic Objectives	Focus on Fundamentals – Delivery high quality, safe and compassionate patient care, meet our Clinical Board and Trust quality priorities.					
Impact (Please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐
Link to Board Assurance Framework (BAF)	1.1 Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.					
Reports previously considered by	Last report presented at the Public Board meeting on 28 November 2025.					

MATERNITY SAFETY CHAMPION REPORT – DECEMBER 2025

Usually my reports are a result of departmental visits and ward walkabouts. It seems only fair that every now and then such a visit and report should include the senior management of the department to find out how things are working for them and how it feels to be a senior manager in a very busy department at a challenging time for the NHS generally and for Maternity Service specifically.

It was my pleasure to spend time in December with Jenna Wall, Director of Midwifery, and Lucy Patterson, Head of Midwifery, discussing their perspectives on the department, and indeed how effective the role of the Maternity Safety Champion is for them. It was felt that the long term nature of a maternity champion being in role gave the service a visible, consistent, and familiar presence with whom staff feel able to speak up and engage in a meaningful way. I will continue to try to build on these expectations.

We also discussed staffing structures and the impact of getting internal structures right for quality and patient safety, staff engagement, operational matters, and local governance. We discussed the significant pressures put upon maternity services' management from central government. Examples of the pressures are expectations for the delivery of national dashboards, as well as the local data recording systems, implementing and recording a national escalation process, and an urgent national review on the safety of home births. This is on top of the operational priorities in Newcastle and the 'national ask' will need to be balanced alongside local improvements.

Having said that, the restructures, including the change of reporting line for the matrons in gynaecology services into maternity services, seem to be adding real value. This could support real improvements for patients in early stage pregnancy, and for those who have to face complex termination processes. The example of women's services benefiting from joint clinical leadership shows that this can improve both staff and patient experience. This has enhanced clear communications for midwives and neonatal staff.

The business case for additional midwives is progressing and already the department is feeling the benefit of an improving skills mix. A 24/7 senior manager on call has been introduced and has been very warmly welcomed by midwives working overnight and at weekends. This is not proving to be particularly onerous on the on-call managers because midwives are feeling more confident just knowing that the support is there.

In operational terms everyone is pleased that the decant in neonates was taking place before Christmas. The maternity estates work will start in the summer and will bring an additional sense of relief that positive change is happening. However, the estates work, which is expected to last for up to 2 years, will bring with it a lot of noise and disruption, which will undoubtedly create some unhappiness and inconvenience for service users. There is a concern that there will be a difference in the postnatal care provision provided between the Newcastle Birthing Centre and the postnatal ward. Extended visiting hours on the postnatal ward will be arranged to allow partners to have better access to mothers and babies and to be able to give them additional support. This will be especially important for first time parents. Decisions will be made on the basis of individual risk assessment to

determine the most appropriate admissions to each ward environment. It will be important to explain this clearly to mothers and families. The service has invested in a dedicated communications officer which means that careful and clear communications will be written and shared with service users, emphasising that the standard of care will remain the same.

It has to be noted that the estates work is an interim solution for maternity services, to improve patient and staff safety. A long term solution continues to be an essential requirement for the future.

We had a full discussion about the alignment of gynaecology services with midwifery. Our discussions included the challenges of supporting patients who have been given bad news and treatments for terminated or failed pregnancies, along with those who are in the early stages of pregnancy and pregnancy assessment. We spoke of the challenges of having limited inpatient beds, some of which are needed for up to six days at a time. This and other pressures can unfortunately have an impact.

The concerns that have been expressed by staff working in the Maternity Assessment Unit (MAU) which I have reported on previously mean a restructure is under consideration. I have asked for this to be concluded quickly.

Revisioning the pathways, aligning decisions to estates developments, and staffing need, should be prioritised so that they can deliver a positive impact on the patient experience.

I visited again in January and was pleased to see that the vaccinations service for pregnant women is doing well. 20 to 30 women visit on a daily basis normally, although there had been a couple of very quiet days with only eight or nine women attending. It is clear that this service has become much more established than when I first visited and I had an interesting conversation with the practitioner who was on duty that day about improving the communication system with women who are close to a 20 week scan. It is felt that an appointment based system would ensure that the service gets greater take up. I understand that there is an issue getting appointment letters out. It's possible to send something out with generalised information but not with specific dates for an appointment to coincide with a 20 week scan.

It would be so much better if the little space used by the vaccinations team could be improved and I have asked the estates team to consider this.

I visited the Midwifery Assessment Unit and was disappointed that the request for a door or a safety screen is outstanding. I have ensured that this has been escalated to the Director of Midwifery and the Director of Estates for their attention due to the operational and information governance risks associated.

The service is very busy in the afternoons at the moment. There is a feeling that patients get through the night, phone the hospital in the morning, then come in to the MAU during the afternoon or after they have finished work. Colleagues recognise that it is very easy for them to ask for extra help, but question the value of safety huddles because they take someone ‘from the shop floor’ and need to be more focussed on providing solutions.

The MAU continues to support overnight admissions from the Emergency Department. As described in women's services, women may be undergoing miscarriage, or be women who are in labour, or may have had a new baby. This can lead to a poor patient experience, compounded by having a long period in the waiting room which is not in direct sight of the staff.

Staff complained that iPads were unreliable, making it very frustrating to have spent time during a busy period ensuring that records are up to date, only to lose all the documentation. PCs have been promised for every room but have not yet been delivered. The MAU has also requested a water cooler that could be used by patients and a private area or a coffee room for staff..

We had a discussion about translation services and the challenge of trying to communicate with a woman through her husband, and the particular difficulty if they come from a place where Female Genital Mutilation (FGM) may come into play. Translators can be hard to find for some languages such as Oromo, Tigranian and some Eastern European languages.

I went on to visit the delivery suite where the corridors were very busy, and where there were lots of clinical staff and midwives who did not seem to have an appropriate workstation. Everyone was very cheerful and welcoming to me. They reported that ward computers which had been overhauled recently are working much better at the moment, however printers are temperamental.

All of the staff that I met did their best to make the case for a ward clerk based on the amount of time that midwives spend sorting out stationary and notes, filing papers and booking inductions. I was given a lengthy explanation of how system changes had made the induction list difficult to print off. I was given a demonstration of the Schappbook Diary so that I could see for myself how challenging it was to book inductions in alongside a theatre list. One midwife explained the duplication in the administration systems. A ward clerk would be able to manage the multiplicity of systems from badgernet to surginet, including transcribing the information. Midwives also explained that completing notes at the end of a 12 hour shift when they were tired was a pressure.

Notes of visits to ward 40, Gynaecological Services, also known as Women's Health – December 2025

I visited Women's Health in December and was shown around the service delivered by Ward 40 by Becky Wood who has been acting as both matron and sister since November, and will continue to do so until the middle of February. I learned about the range of services covered by this team and the delivery of services including uro-gynaecology services, investigative colposcopy and hysteroscopy.

This department also administers the HPV vaccine to more than 1,600 women each year. However there have been years when up to 6,000 vaccinations have been given - a clear indication that there could be significantly more access to this service if funding was available. (Cost Improvement Programme (CIP) demand on this ward may require a

restructure.) The service has some ideas that could offer better use of space & improve user experience.

The service has to have 'eyes on' patients presenting with an emergency. Patients showing difficulty in early pregnancy are redirected to the MAU. Day case surgery is delivered under local anaesthetic but there are insufficient rooms available to offer sedation. There has been a 20% increase in the number of patients using the service, which is great in that people have an awareness of what is on offer, but the downside is that no additional resource has been invested in the service.

It was clear from the start of the visit that more effective and patient-centric space is needed to deliver this comprehensive and impressive service to more women in our region. In particular, the single toilet and hand wash basin seem inadequate and should be urgently reviewed. Consideration could also be given to repurposing adjacent clinical areas to minimise the estates issues caused by the limitations of the environment.

I really enjoyed the visit, meeting staff, and learning about the range of services on offer to the women of Newcastle that are being delivered by this small and highly professional team.

Report of
Liz Bromley, Non-Executive Director
22 January 2026

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Agenda item A2(h)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	30 January 2026					
Title	Developing the Service Review Programme in Newcastle Hospitals					
Report of	Sue Hilyard, Interim Executive Director of Operations					
Prepared by	Nichola Kenny, Director of Improvement and Delivery (Operations)					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☐		☒	
Summary	To support a continuous drive of improvement, effectiveness and efficiency in the Trust, an approach is being developed to systematically review all Trust services. The presentation describes the purpose of the review programme and the approach being taken setting out three levels of review 1) self-assessment/ diagnostic, 2) rapid review and 3) full-service review. It also sets out a framework to follow, which includes 12 different potential lenses through which the sustainability of a service can be evaluated. The programme has commenced in 2025/26 and has been received positively in the organisation to date, with positive engagement from operational and clinical teams.					
Recommendation	Members of the Trust Board are recommended to note and support the developing Service Review Programme.					
Links to Strategic Objectives	Focus on Fundamentals - Deliver high quality, safe and compassionate patient care, meet our Clinical Board and Trust quality priorities.					
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	New report for Public Board.					

Introducing a Service Review Programme in Newcastle Hospitals

A programme to shape strategy through continuous improvement, clinical effectiveness and operational efficiency

Purpose of the Service Review Programme

The Newcastle upon Tyne Hospitals NHS Foundation Trust

The NHS has a responsibility to ensure that services are **high quality, sustainable and provide value for money** to the taxpayer

The programme provides a **structured approach** to completing service reviews across the organisation

It will adopt (and evolve) the use of a **framework to help analyse services** for their sustainability, their effectiveness, efficiency and alignment with strategic goals and available resources

Each review will draw on **appropriate methodologies** – process mapping, gap analysis and other tools and available **benchmarking** to comprehensively review a service

The **deliverables** for the Board and Clinical Boards will include:
- Health Check at-a-glance score cards for all services identifying key strengths, challenges and areas of concern, that provides a 'health status'. These will inform the need for further in-depth reviews
- Rapid reviews focussing on a specific area of concern
- Full comprehensive service reviews producing short, medium and longer term actions and strategies to be taken forward by the Clinical Board

The service review methodology is focussed on operational, clinical and financial sustainability

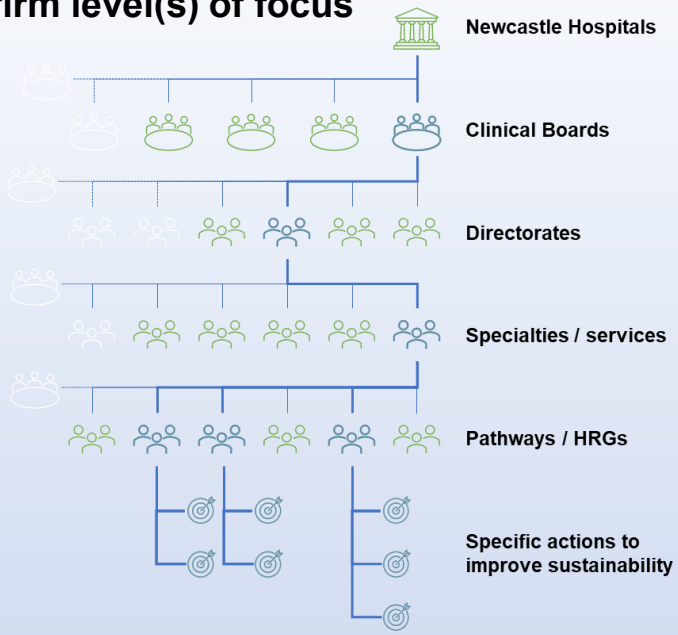
The Newcastle upon Tyne Hospitals NHS Foundation Trust

- There are **multiple lenses** through which services can be reviewed as we look to evaluate their sustainability, such as quality, workforce, finance, commissioner priorities etc.
- We will then used **local intelligence to identify the issues** that are believed to be most impacting sustainability in those services and test them through a process of **focussed analysis alongside clinical and operational engagement**. This will enable the **identification of some of the key actions** to be taken to improve overall service sustainability.
- This is a **learning process for the Trust**. We are building on experiences from elsewhere and adapting our approach as we work through what works best in the Newcastle context.

Lenses through which sustainability can be evaluated

Clinical quality & outcomes	Contribution margin	Workforce sustainability
Patient experience & access	Productivity & efficiency - clinical and operational	Culture & engagement
Equity & health impact	Demand & demographic trends	Environmental sustainability
Alignment with Trust/ICS priorities	Commissioner & funder prioritisation, commercial opportunities	Resilience & risk

Confirm level(s) of focus



Service Review 3 Levels

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Level 1 - Self Assessment + Available Data

High-level overview of services across the organisation to generate initial intelligence for the service themselves and the wider programme	Diagnostic to identify services for Level 2 and Level 3 review

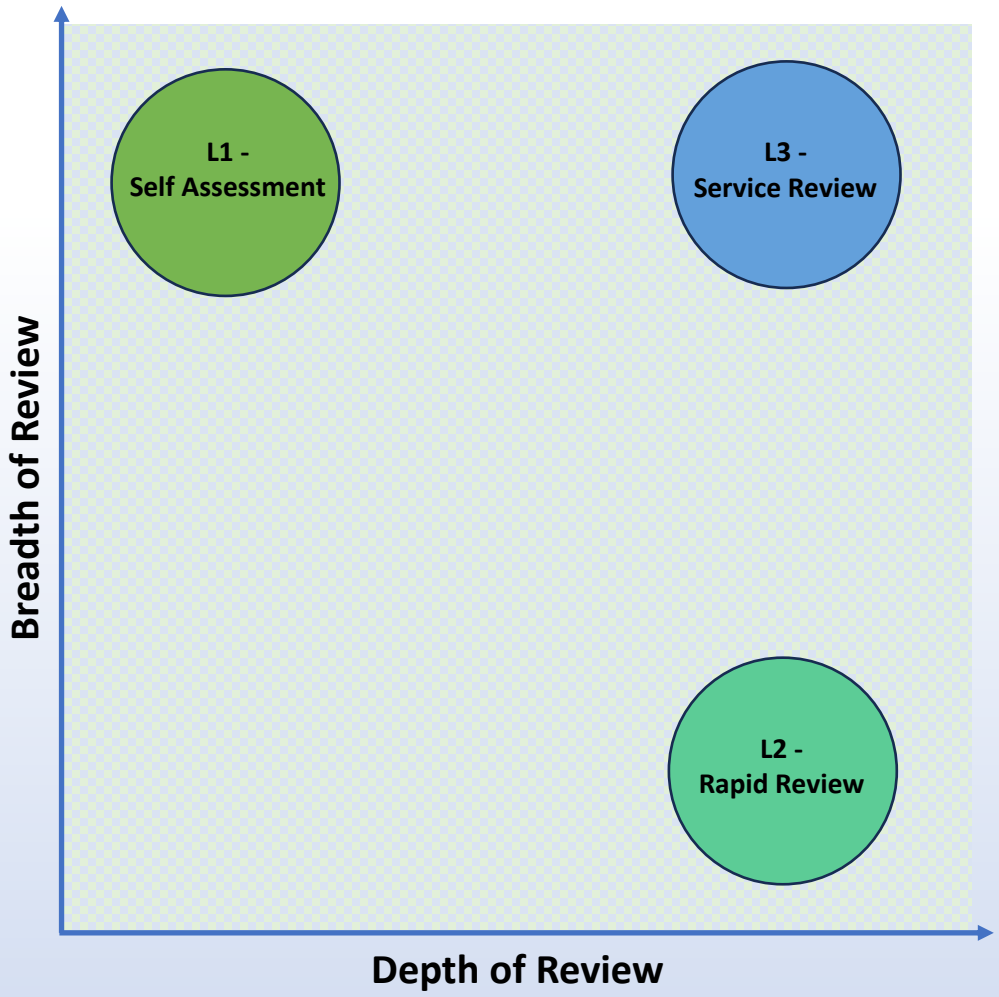
Level 2 - Rapid Review

A 'desktop deep dive' into a specific area of a clinical board	Timeseries and benchmarking analysis focused on finance and efficiency to provide actionable insight or assurance

Level 3 – Full Service Review

Investigation into a problem statement set with the clinical board	A report output summarising issues, interdependencies and recommendations based on the problem statement

Breadth and depth of review options



Programme pipeline

'castle upon Tyne Hospitals NHS Foundation Trust

Areas of work	Fragile Services Review	Level 1 Assessment	Level 2 Rapid Review	Level 3 Service Review
Cardiothoracic Services - Clinical Board	Completed	Completed	Level 1 Assessments and Service Fragility will be used to trigger any Level 2 Rapid Reviews	Underway
Hepato-Pancreato-Biliary (HPB) Services	Completed	Ongoing		Underway
Ophthalmology Services	Completed	Commence end of Quarter 4		
Level 1 Roll-Out programme	Will be completed for all Major Specialty Services as part of the 2026/27 planning round	All Services April 2026 - March 2027		
Agree further next 5-6 Service Reviews for 2026/27	Criteria in development to be used to trigger Level 3 Service Reviews			April 2026 – March 2027

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Agenda item A3(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 January 2026					
Title	Adopting our Anti Racism Framework					
Report of	Caroline Docking, Director of Communications and Corporate Affairs					
Prepared by	Lee-Ann Naidoo on behalf of the Race Equality Network and Anti Racism Taskforce					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☒		☐		☐	
Summary	Newcastle Hospitals is committed to becoming an actively anti-racist organisation, one where every member of staff, every patient, and every community partner is treated with dignity, fairness, and respect. This framework has been developed by representatives of our global majority staff, who have asked the trust to take a more proactive approach to tackling racism within our hospitals and services. The framework sets out how we will embed anti-racism into our culture, services, systems, and everyday behaviours. It is both a statement of intent and a plan for measurable change, co-produced with staff and community voices. In talking about anti-racism, we are explicitly including all groups who have historically experienced racial discrimination or systemic inequalities this includes islamophobia and antisemitism (and alongside this we will adopt the international definitions of antisemitism and islamophobia). The actions we will take to make progress will be overseen by our Antiracism taskforce who will report to our Equality and Diversity Steering Group and People Committee.					
Recommendation	The Board is asked to approve the antiracism framework and support the taskforce to take forward actions which will help to tackle racism in the trust.					
Links to Strategic Objectives	Make it better for colleagues - 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]	Failure to improve and maintain an organisational culture, in line with our Trust values and our People Plan to improve behaviours and civility, health and wellbeing and ensuring our staff feel valued and heard.					
Reports previously considered by	Standalone report.					

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

No Place for Racism:
Our Anti Racist Framework

Healthcare at its best
with people at our heart

Anti-racist
what does it mean?

It is not just “not being racist”, it requires deliberate action.

It means naming racism where it exists and working to dismantle it.

It involves creating systems and cultures where equity, representation, and inclusion are the norm.

It is both an individual responsibility (e.g., speaking up, self-reflection) and an institutional commitment (e.g., changing policies, collecting data, holding leadership accountable).

Providing high quality learning and development opportunities on race, racism, allyship and being anti-racist

In healthcare, anti-racism means ensuring that no patient or staff member is disadvantaged because of race, ethnicity, or cultural background.

Where might racism be showing up in our hospital systems?

Racism is very real, both in society and across our NHS organisations. Yet, despite a large number of reports and pledges over the years we have seen inequalities persist and some areas get even worse.

Guiding drivers

Barriers and Opportunities

01 EDUCATION

Knowledge & confidence to name racism

02 REPRESENTATION

Diverse voices shaping decisions

03 CULTURE CHANGE

Shifting behaviours, policies, assumptions

04 ACTION AND ACCOUNTABILITY

Turning intentions into measurable progress

The impact on patients and patient feedback

- Racism is a determinant of health and health care.
- Newcastle City Council, *Ethnic Minority Needs Assessment 2023* "highlights the increasing diversity of Newcastle's population and in particular the increasingly diverse younger population. There remain, however, inequalities in health, access to services, and the wider determinants of health stratified by ethnicity."
- Local example: Patient Perspective 2024 report – Arabic, Asian, Black – African, and Mixed respondents reported significantly worse experiences of pain control.
- Patient feedback 2022-2025 referencing racism:
  - Complaints - 9
  - Patient Advice and Liaison Service (PALS) - 8

Next Steps to developing our framework

- Anti racism steering group has written our framework – using the four pillars described (education, representation, culture change, action and accountability).
- Work will be led through the Anti Racism group and reporting to the refreshed Equality, Diversity and Inclusion (EDI) steering group.
- Our year one actions will include:
  - Awareness campaign (thanks to the Race Equality Network) will launch January/February 2026.
  - Work in individual directorates/departments (Maternity are trailblazers).
  - Clear reporting mechanisms and analysis of data to inform our actions.
  - Meaningful pledges – from senior leaders.
  - Promotion of the actions we take to challenge racism.
  - Consideration of what effective and impactful training and awareness would look like – followed by delivery.
  - Reminders that we need to consider both the experience of staff and patients from the global majority – a long-term piece of work.

No place for Racism – Our Anti Racism Framework
Published January 2026

1. Introduction

Newcastle Hospitals is committed to becoming an actively anti-racist organisation, one where every member of staff, every patient, and every community partner is treated with dignity, fairness, and respect.

This framework sets out how we will embed anti-racism into our culture, services, systems, and everyday behaviours. It is both a statement of intent and a plan for measurable change, co-produced with staff and community voices.

In talking about anti-racism, we are explicitly including all groups who have historically experienced racial discrimination or systemic inequalities this includes islamophobia and antisemitism.

2. Grounded in Staff Voice

This framework is shaped by the voices of our people.

Global majority colleagues have been asking us for some time to take clear action over racism. In September 2025, colleagues from across the Trust came together for an Anti-Racism workshop to discuss barriers, fears, and opportunities. The experience and insight of our Race Equality Network has been instrumental. Their honesty has guided this framework and we are grateful for their courage in speaking up. We have also been positively supported by unions and staffside colleagues.

What we heard:

- Colleagues want **visible, courageous leadership** - anti-racism must be owned at Board level and throughout the organisation.
- Racism is **gross misconduct** and must be treated as such.
- **Colleagues should not have to experience racism at work.**
- People want **psychological safety** to speak up without fear.
- Education must be **bold, reflective and practical** - helping staff act, not just listen.
- **Representation at every level** must be visible and intentional.
- Staff asked for **consistency, accountability, and transparency** across the organisation.

These insights have been integrated into every section of this framework, ensuring that our work is not just strategic, but lived and felt.

3. Our Vision and Principles

Vision

‘To be a Trust where anti-racism is embedded in every decision, interaction, and system ensuring equity, belonging, and dignity for all.’

Principles

1. **Lived Experience at the Centre** - Co-produce, co-lead, and co-evaluate with those who experience racism.
2. **Transparency and Accountability** - Commit to open data, visible leadership, and honest communication.
3. **Courage and Care** - Engage with discomfort respectfully; growth comes through challenge.
4. **Continuous Learning** - Anti-racism is an ongoing practice, not a project.
5. **Equity in Action** - Move from statements to measurable change.

4. The Four Guiding Drivers

Driver 1: Education – Knowledge & Confidence to Name Racism

We want to build racial literacy, confidence, and competence across the organisation.

Commitments
Agree the best way to ensure staff understand Anti-Racism and their responsibilities. This will include:

- Provide reflective, creative, and lived-experience-led education that encourages courageous conversations.
- Develop Safe-to-Learn Spaces and peer reflection opportunities.
- Embed anti-racism learning in leadership programmes, induction, and appraisal.
  Highlight the benefits of diversity moving beyond compliance, to curiosity and celebration.

Driver 2: Representation – Diverse Voices Shaping Decisions

We want to ensure diversity and lived experience inform leadership, governance, and everyday decision-making.

Commitments

- Establish a Race Equity Taskforce.
- Set and publish representation targets aligned to Workforce Race Equality Standard (WRES) data and local demographics.
- Introduce Inclusive Recruitment Standards and diverse interview panels.
- Build patient and community voice through a Community Advisory Panel.
- Challenge institutional bias and systematic barriers to progression.

Driver 3: Culture Change – Shifting Behaviours, Policies & Assumptions

We want to foster a culture of safety, trust, and accountability where anti-racism is normalised.

Commitments

- Acknowledge and address fear, denial, and covert behaviours.
- Embed psychological safety as a key cultural measure.
- Introduce restorative approaches alongside formal processes.
- Reinforce that racism is gross misconduct and will be acted on.
- Maintain consistent anti-racism messaging and standards across all services.
- Create environments where staff can confidently say: “We are an anti-racism organisation.”

Driver 4: Action & Accountability – Turning Intentions into Measurable Progress

We want to ensure anti-racism outcomes are visible, measurable, and acted upon.

Commitments

- Improve our data collection in relation to race and launch a Race Equity Dashboard (workforce, patient experience, incident data).
- Publish an Annual Anti-Racism Report with data and lived-experience insights.
- Build accountability objectives into executive and managerial appraisals.
- Introduce clear consequence management, racism treated as gross misconduct.
- Strengthen the use of Freedom to Speak Up (FTSU) and InPhase as core accountability mechanisms for reporting and addressing racism.
- “Find the story in the data”, combine quantitative evidence with narrative voice.
- Maintain regular reporting to the People Committee and Trust Board and open progress updates to staff.

5. Implementation and Governance

In the first year of our Framework (2025/6) we will focus on 2 key issues:

1. Supporting staff who experience racism, and
2. Acting consistently when people show racist behaviours.

Detailed actions to address these 2 issues will be developed, based on the principles included in this framework. These will be incorporated into our Equality, Diversity and Inclusion action plan.

The Anti-Racism taskforce (formerly the anti-racism policy group) will meet monthly to have oversight, ownership and challenge of the framework and actions. They will report to the Equality Diversity and Inclusion (EDI) Steering Group and onto the People Committee and Trust Board.

The Director of Communications and Corporate Affairs will be the Executive Sponsor, working closely with the Executive lead for People and the Executive Director of Nursing and Medical Directors to ensure progress for both our patients and our people. All members of the Board and leadership team have a responsibility to make our Antiracism framework a reality.

Our partnership with Anti Racism Cumbria and other Anti racism organisations will provide external challenge, learning, and evaluation.

6. Monitoring & Evaluation

Progress will be reviewed quarterly by the Anti Racism task force and EDI steering group.

Performance will be assessed using:

- Quantitative data: WRES, staff survey, Electronic Staff Record (ESR), incident data.
- Qualitative data: lived-experience feedback, listening events, patient stories.

A “You Said – We Did” update will be published annually to demonstrate transparency and responsiveness.

7. Sustaining Culture Change

To embed anti-racism long-term we will:

- Keep it visible in leadership discussions, team meetings, and strategy.
- Create safe spaces for continued learning and reflection.
- Celebrate progress and role models.

- Partner with staff networks and communities to ensure continued challenge and growth.

8. Next Steps for the Taskforce

1. Continue to provide feedback and challenge, advising on alignment, practicality, impact and language.
2. Prioritise: Identify which specific actions can deliver the biggest cultural impact in the first 12 months.
3. Validate Metrics: Confirm meaningful measures for each action.
4. Co-Design Education: Shape content for learning pathways.
5. Plan Launch: Agree communications and staff engagement strategy for Quarter 1 2026.

"We're not just challenging racism, we're building an organisation where anti-racism is the norm." Lee-Ann Naidoo, Chair, Race Equality Network

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Agenda item A3(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 January 2026					
Title	Resident Doctors 10 Point Plan					
Report of	Lucia Pareja-Cebrian					
Prepared by	Sam Richardson					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☐		☒	
Summary	This paper provides an update on the Trust's position on NHS England's (NHSE) 10 Point Plan to improve resident doctors' working lives. Resident Doctor Peer Leads are at the heart of this programme – shaping local delivery plans, involving colleagues, and ensuring accountability against these commitments. As part of the plan, the Resident Doctor Peer lead (Chief Registrar at Newcastle Hospitals) will provide regular updates on progress against the plan to the Trust Board. Additional information is provided in the reading room with regards to the survey undertaken.					
Recommendation	To receive the report and support the continuing work towards achieving the improvements set out in the 10 point plan.					
Links to Strategic Objectives	• Focus on Fundamentals - Deliver high quality, safe and compassionate patient care, meet our Clinical Board and Trust quality priorities. • Make it better for colleagues - 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]	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. 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.					
Reports previously considered by	Previous report presented at the Trust Board meeting on 23 October 2025.					

RESIDENT DOCTORS 10 POINT PLAN

1. BACKGROUND

Resident doctors are fundamental to the delivery of safe, effective patient care across the NHS, yet their working lives have become increasingly challenging. Persistent issues such as high workload, rota gaps, inadequate rest facilities, limited access to training opportunities, and concerns around wellbeing and morale have contributed to rising levels of burnout, reduced job satisfaction, and difficulties with recruitment and retention. These pressures have been exacerbated by sustained workforce shortages, increasing service demand, and the lasting impact of the COVID-19 pandemic.

In response, NHSE developed the 10 Point Plan to Improve Resident Doctors' working lives. The plan provides a coordinated, system-wide approach to addressing the practical and cultural factors that affect doctors' day-to-day experience at work. It focuses on improving working conditions, ensuring safe and sustainable rotas, supporting education and training, promoting wellbeing, and strengthening leadership, engagement, and accountability, with 10 clear priorities to achieve those goals:

- Workplace wellbeing – Rest areas, parking, food, flexibility
- Rota transparency – 8-week schedules, 6-week rotas
- Annual leave reform – Fair and equitable access
- Board-level leadership – Senior leads and peer representatives
- Payroll accuracy – Eliminate rotation-related errors
- Mandatory training – No unnecessary duplication
- Exception reporting – New national framework
- Expense reimbursement – Fast-track course costs
- Rotation reform – Pilot new approaches
- Lead employer expansion – Reduce administrative burden

By setting out clear priorities and expectations for NHS organisations, the 10 Point Plan aims to create a more supportive, inclusive, and sustainable working environment for resident doctors. Improving their working lives is critical not only for staff wellbeing, but also for patient safety, quality of care, and the long-term resilience of the NHS workforce.

2. NEWCASTLE HOSPITALS' TIMELINE

To date the following actions have been undertaken:

- The Plan was introduced on **29th August 2025** with guidance on rapid implementation given to Trusts across England.
- Senior Leader (Lucia Pareja-Cebrian, joint Medical Director) appointed **September 2025** and Peer Lead (Sam Richardson, Chief Registrar) appointed **October 2025.**
- Agreement with Lead Employer Trust (LET) that they are regionally responsible for aspects of the 10 Point Plan (e.g. Point 8) **October 2025.**
- Initial baseline assessment survey sent to NHSE outlined perceived state of Newcastle Hospitals in reference to 10-point plan standard in **September 2025.**
- Weekly Steering Group commenced **8 December 2025- Current.**

- Facilities Survey sent to all Resident Doctors to evaluate how the Trust facilities help or hinder resident doctors working lives sent and completed - **13 December 2025.**
- 12 Week Follow Up National Survey to assess progress submitted to NHSE with Support of Peer Lead **10 December 2025** with results returned **22 December 2025.**
- Live Action Plan formulated **19 January 2026** for all aspects, incorporating areas for improvement identified within the NHSE survey as well as Newcastle Hospitals' specific areas for improvement. Added to the Trust Board Reading Room.
- Weekly steering group meetings to track progress chaired by the Executive Lead.

Included in the Trust Board Reading Room for information is the NHSE and the Department of Health and Social Care (DHSC) North Easy & Yorkshire 12-week Progress Survey Overview.

3. 10 POINT PLAN FOR IMPROVING DOCTORS WORKING LIVES

The plan is underpinned by a commitment to addressing inherent issues that have for a long time got in the way of a good experience for resident doctors. At Newcastle Hospitals the improvement plan is aimed at both Locally Employed Doctors as well as Locally Employed Trainees.

The overarching aims include:

- Trusts should take action to improve the working environment and wellbeing of resident doctors.
- Resident doctors must receive work schedules and rota information in line with the Code of Practice.
- Resident doctors should be able to take annual leave in a fair and equitable way which enables wellbeing.
- All NHS trust boards should appoint 2 named leads: one senior leader responsible for resident doctor issues, and one peer representative who is a resident doctor. Both should report to trust boards.
- Resident doctors should never experience payroll errors due to rotations.
- No resident doctor will unnecessarily repeat statutory and mandatory training when rotating.
- Resident doctors must be enabled and encouraged to Exception Report to better support doctors working beyond their contracted hours.
- Resident doctors should receive reimbursement of course related expenses as soon as possible.
- We will reduce the impact of rotations upon resident doctors' lives while maintaining service delivery.
- We will minimise the practical impact upon resident doctors of having to move employers when they rotate.

4. RECOMMENDATIONS

The Trust Board is asked to:
i) Receive and discuss the contents of this report.
ii) Support the continued work of the group

Report of Sam Richardson
Chief Registrar
22 January 2026

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 January 2026		
Title	Board Assurance Framework 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 Committees and Board are being managed effectively; that risks have an appropriate action plan in place to mitigate them; and that risk scores are realistic and achievable. **Quality Committee** **For 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.** Key points to note: • The current risk score remains at a score of 15 (5x3). • Action progress indicators remain unchanged. • Threat assurance levels remain unchanged. • There have been 10 new actions added to existing threats, these relate to: - embedding and evidencing a trust safety culture. - completion of Care Quality Commission (CQC) maternity self-assessment tool. - recruitment of midwifery staff. - Infection Prevention and Control (IPC) workflow and job planning. - IPC nursing handbook. - Business continuity plan. - Review of IPC policies. - Review of ICNET results. - Review of use of flags. • 8 controls and associated assurance have been added to existing threats, these relate to: - Incident reporting, statistical improvement in incident reporting. - Freedom to Speak Up Guardian plan in place. - Level 2 Mental Capacity Act (MCA) training compliance now above Trust target of 90%. - Maternity Outcomes Signal System live - Regional Maternity dashboard in place. - IPC Improvement Group established. - IPC Improvement Priorities agreed. - IPC action plan in place. • Following discussion at the last Quality Committee the Digital quality of care threat has been revised in its entirety to ensure the threat concentrates on the lack of adoption of		

digital initiatives designed to improve quality of care.

People Committee
For Risk ID -
2.1 Failure to improve and maintain an organisational culture, in line with our Trust values and our People Plan.
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.
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.

Key points to note:

- The risk has been reviewed by the Director of Commercial Development and Innovation and Head of Corporate Risk and Assurance.
- Assurance levels have reduced on the following threats:
  - Failure to support staff with their health and wellbeing leading to increased sickness absence, this threat has moved from Amber to Red.
  - Failure to deliver improvements to leadership and governance across the Trust has moved from Amber to Red.
  - Underdeveloped workforce planning mechanisms impacting on our ability to effectively forecast workforce needs has moved from Amber to Red.
- Action progress indicators have changed for the following threats:
  - Failure to foster a supportive and inclusive culture across the Trust to ensure all staff groups feel safe, valued and respected. This progress indicator has moved from 2. action defined- most progressing to 4. action defined but largely behind plan.
  - Failure to support staff with their health and wellbeing leading to increased sickness absence. This progress indicator has moved from 2. action defined – most progressing to 3. action defined but behind plan.
  - Failure to deliver improvements to leadership and governance across the Trust. This action progress indicator has moved from 2. action defined – most progressing to 3. action defined but behind plan.
  - Underdeveloped workforce planning mechanisms impacting on our ability to effectively forecast workforce needs. This action progress indicator has moved from 2. action defined – most progressing to 3. Action defined but behind plan.
  - Trust plans to reduce corporate headcount by 50% of 2019/20 growth potentially destabilising corporate functions. This action progress indicator has moved from 2. action defined – most progressing to 1. Fully on plan across all actions.
- Action timescales have been extended in relation to People Plan Programme Launch, and Staff Psychology Support Service.
- New actions have been added in relation to completion of the Mutually Agreed Resignation Scheme (MARS) scheme, review of corporate functions and reintroduction of required posts and workforce triangulation between finance, establishment and budget.

Finance Committee
For Risk ID –
6.1 Failure to manage our finances effectively to improve our underlying deficit and deliver long-term financial sustainability.
6.2 Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care.
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.

Key points to note:

- One risks score has reduced, risk 6.1 failure to manage our finances effectively to improve underlying deficit. This risk has reduced from 20 to 15.
- Two threats have been mitigated:
  - Elective Recovery Fund (ERF) activity plans do not sufficiently deliver activity targets and therefore increase financial risk to the Trust, funding has been received to close the financial gap in relation to 2025/26 ERF activity plans.
  - Subsidiary company is not formed, and benefits don't accrue due to approvals and/or industrial relations issues – Subsidiary plans are now paused, national funding has been received to recover financial saving assumed for 2025/26.
- Actions have been completed relating to 5-year medical device capital replacement plan.
- Timescales have been extended on actions relating to accountability framework, capacity and demand templates, capacity modeling, forecasting models, NHS Oversight Framework (NOF) capability assessment outcome, review of cancer pathways, Building Safety application, alliance bid for national estates funding and forecasting critical infrastructure risk.
- Action progress indicators have improved on threats relating to failure to maintain Private Finance Initiative (PFI) and managing PFI project delivery.
- No new actions have been added.

Digital and Data Committee
For Risk ID 2.2 – Failure to deliver and improve the digital capability required to support the delivery of safe, effective and efficient patient care.

Key points to note:

- There has been minor changes to the wording of two threats, delivery of foundational and operational tasks and insufficient capital and revenue. The wording changes do not change the original threat.
- Two controls have been added in relation to Clinical Board digital priorities, these are now complete and included within the digital roadmap and also completion of financial planning assumptions and digital investment plans, digital priorities are now being considered as part of the Trust capital planning process.
- One action timescale has been extended relating to recruitment of Associate Director of Digital, further targeted recruitment is required and therefore timescale for recruitment extended to April 2026.
- One action has been re-worded to capture the required action effectively – this relates to the review of the capital plan outline to determine opportunities to switch between capital and revenue funding for digital transformation.

Audit, Risk and Assurance Committee
For Risk ID 1.2 – Failure to implement effective governance systems and processes across the **Trust to assess, monitor and drive improvements in quality and safety.**
Key points to note:

- Risk scores remain unchanged.
- 2 Actions have been completed relating NHS Oversight Framework Capability Assessment monitoring process and completion of external well led review.
- 3 action timescales have been extended relating to the accountability framework, governance handbook and ward to board governance review.
- Progress indicators and assurance levels remain unchanged.

Trust Board
For risk ID 7.1 – inability to sufficiently influence priorities of key partnerships.

<table>
<tr><td></td><td colspan="6">Key points of note:
• Risk scores remain unchanged.
• 4 new actions have been added relating to:
- refreshed Alliance strategic intent.
- establishment of a clinical framework group.
- review, simplify and strengthen Alliance governance.
- approval of Alliance construction programme.
• Action progress indicators remain unchanged.
• Assurance rating remains unchanged.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Public Trust Board are asked to:
• Discuss the Board Assurance Framework and seek feedback from Committee Chairs and Audit, Risk and Assurance Committee.
• Review and approve risk ID 1.2 aligned to the Audit, Risk and Assurance Committee.
• Approve the Board Assurance Framework.
• Provide any feedback or comments.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Links to all strategic objectives.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td><td>☐</td><td>☒</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">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 (BAF)
2025/2026 – JANUARY 2026

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

Principal Risk (what could stop us from achieving our strategic objective)	Inability to maintain and improve the quality of care (Safety, experience and quality) for our patients.	**Strategic objective**	1. Quality of Care will be our main priority.

Lead Committee	Quality Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Nursing	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Quality and Safety
Date Added	01.05.2025	**Likelihood**	**4**	**3**	**1**	**Risk Appetite Tolerance**	Low
Last Reviewed	13.01.2026	**Risk Score**	**20**	**15**	**5**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Failure to successfully develop and nurture a positive safety culture: including supporting staff to report incidents with an enhanced focus on shared learning and a systems-based approach to improvement.	• Patient Safety Incident Response Framework (PSIRF) went live in January 2024. • Central supportive governance infrastructure to deliver the Patient Safety Incident Response Framework (PSIRF) • The Quality Governance Framework is underpinned by Quality Oversight Groups (QOG's) in each Clinical Board. • Rapid Response Action Review Meetings. • Policies and Procedures. • Patient Safety Incident Forum. • Incident reporting (Inphase). • Clinical Risk Group. • Rapid Quality and Safety Peer Reviews. • Freedom To Speak Up Guardian. • Trustwide Patient Safety Incident Response Framework (PSIRF) priority working group. • Freedom to Speak Up Guardian Plan in place.	• Rapid Response Action Review Weekly Meeting /Patient Safety Incident Forum minutes and actions plans. • Strengthened quality of learning responses by ensuring a standardised approval methodology is used. • Monitoring of compliance with PSIRF timeframes for learning responses. Power BI dashboards shared at Clinical Board QOG's and Quality and Performance Reviews. • Regular PSIRF update reports to Patient Safety Group. • Incident reporting data is demonstrates a statistical proven improvement in incident reporting. • Integrated Quality Report to Quality Committee. • Oversight through Clinical Board Quality. Oversight Group, reported into Quality and Performance Reviews and the Executive Team. • Care Quality Commission (CQC) Delivery Group and CQC Assurance Group oversight. • Staff Survey – demonstrates increased response rate of 65%. • Clinical Risk Group reports and sharing of learning, national patient safety alerts etc. • Rapid Quality and Safety Peer Review Paper to Quality Committee December – demonstrates 93% trust compliance with assessment framework.	• Embed and improve Trust safety culture evidenced by improved scores in relation to safety culture and staff confidence to report using pulse surveys and annual staff survey – July 2026. • Delivery of CQC action plan – Actions on track to be completed by deadline, please see CQC phase 2 action plan document for exact timescales. • Reporting of Duty of Candour (DoC) improvement to Quality Committee – actions required to support staff to improve documentation of verbal DoC and improve quality of DoC letters. Update to Quality Committee Jan 2026, formal report April 2026. • Deliver 25/26 Quality Priorities. Aim for 3% increase in incident reporting and 90% of all staff will have received training in Patient Safety by 31st March 2026 • Development of Trust-Wide Quality and Safety plan – in draft, working group in place to ensure engagement, launch April 2026. • Recruit Patient Safety Partners from the Trust Participation & Involvement Panel – 1 in post. Refresh of model in progress, aim to recruit minimum of 2 Patient Safety Partners – April 2026.	**2- Actions defined – most progressing, where delays are occurring interventions are being taken.**	

		• Freedom To Speak Up biannual report to Trust Board.	• Implement NAtSIPPS framework Trust-wide by – Oct 2026.		

Failure to ensure care is delivered in line with the Mental Health Act (MHA) and Mental Capacity Act (MCA).	• Mental Health (MH) Committee with oversight from, Care for All, Quality Committee • Psychiatric Liaison Team (PLT) meetings with core services. • Mental Health Awareness Training (specific packages for high-risk staff groups e.g. Security staff) • Core quarterly mental health assessment metrics agreed. • Self-Harm Risk Assessment Programme • Mental Capacity Act Steering Group with oversight from Safeguarding Committee, Care for All, Quality Committee • MCA Quarterly audit framework. • MCA training programmes/compliance. • Restraint Review Group, with oversight from Safeguarding Committee, Care for All, Quality Committee • Learning Disability Steering Group and LeDeR Review Panel with oversight by Experience of Care Group, Quality Committee • Health and Safety Committee. • Patient Experience and Engagement Group. • Level 2 MCA training compliance.	• The number of MCA forms being completed before DoLS form submissions remains relatively static from Q1 at 91.3%. An increase in comparison to Q4 24-25 which was 86.6% • Evidenced switch between sub-standard and minimal requirements of MCA quality, which has increased from 27% (Q1) to 50% Q2 with good quality assessments at 39.1% Q2 Sub-standard assessments have from 59% (Q1) to 16.3% Q2 • Learning Disabilities and MCA reporting and minutes to Safeguarding Committee/Experience of Care Group/Quality Committee and Trust Board. • Training Video to support reasonable adjustments launched and documentation of reasonable adjustment pilot commenced June 2025. • Pilot in paper format now to be digitized. • MHA provider review recommendations, action plan and evidence of completion. • Compliance with Mental Health Awareness Training (98.1% June 25). • The Self Harm Risk Assessments are on InPhase • Quarterly mental health assessment audit framework • Self-Harm Risk Assessment Programme for high risk areas complete. Level 2 MCA training compliance achieved (90%)	• Agree long term training framework for Learning Disabilities and Autism, Integrated Care Board (ICB). National expectation of the Oliver McGowan Training confirmed. Ongoing audit of nursing documentation in relation to learning disability and reasonable adjustments • Draft of Learning Disability and Autism Plan completed. Currently working on presentation of the plan and launch • Development and approval of phase 2 Self Harm Programme of Estates work (Medium/Low risk areas) – January 2026. Develop comprehensive MH audit programme in development – February 2026.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Failure to improve compliance with clinical effectiveness and outcome standards including Getting It Right First Time (GIRFT) and National Institute for Health and Care Excellence (NICE) guidelines.	• Clinical Audit and Guidelines Group. • Clinical Outcomes and Effectiveness Group. • GIRFT oversight group. • Clinical Effectiveness metrics. • New Interventional Procedures Group. Review • Stocktake of progress with Clinical Board Quality Oversight Groups completed. • Stocktake of progress with clinical board QoGs. • Review of QoG activity presented to Quality Committee in October 2024.	• Clinical Audit and Guidelines Group minutes and Action plans. • Clinical Outcomes and Effectiveness Group (COEG)minutes and action plans. • Bi-annual Reports to Quality Committee. • Bi-annual Clinical Audit Report to the Audit, Risk and Assurance Committee (ARAC). • GIRFT Oversight Group reports and minutes. • Minutes and reports of New Interventional Procedures including Robotic Surgical Group-reports to COEG. • Quality Oversight Group dashboards. • Initial stocktake of QOG activity completed in May 2024-shared with Clinical Boards (CB's). • 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 Quality and Performance Reviews (QPRs). This will include compliance with all metrics e.g. GIRFT/NICE via Inphase risk management system – April 2026. • Review and develop new processes for management of Trust non-compliance with standards/guidelines - propose organisational approach to Quality Committee – report to Quality Committee April 2026.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Gaps in assurance regarding compliance with policy and best practice relating to medication safety, storage, security and learning from medication incidents. This	• Medication Safety Task and Finish Group providing oversight of key improvement actions. • Monthly audit framework measuring. compliance with policy to inform areas for improvement. • Internal peer review process. • Existing medication governance and oversight	• Bi-Monthly audit data of ward and department compliance with core standards with dissemination of learning and action. • Policy audits undertaken and reported through medicines management committee. • Datix data and trends relating to medicines	• Actions as outlined in Medicines Management Oversight Group (MMOG) Action Plan.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

could directly impact care quality and safety	structures. • Medicine Management Policies and procedures. • Commissioned and completed expert external review to inform improvement work streams. • CQC Delivery Group. • Completed review of Medicines Reconciliation function across the Trust to identify urgent areas for improvement to attain to national best practice. • Revised medicines management action plan. • Established Medicines Management Oversight Group to ensure delivery of improvements • Increased nursing infrastructure to support • Medicines safety.	management reported and reviewed. • Peer review and external review reports and audit data. • CQC Delivery Group monitoring, reporting and minutes. • Compliance and Assurance Group reporting and minutes. • Quality Governance Structure via quality committee and Trust Board. • September Rapid Quality and Safety Review Audit Data. • Medicines Management (NUTH 2024/25-17) internal audit – Reasonable level of assurance.			
Failure to improve and sustain quality of care in Maternity Services.	• Maternity Incentive Scheme and Three-Year action plan in place. These are reported into Quality Committee and Trust Board. • Robust Perinatal Patient Safety Team in place • Maternity Operational Oversight Group (MOOG) • Board Maternity Safety Champions • Incident Review Group • Women's Quality and Safety Group • Family Health QOG • Monthly Maternity Staff meetings • Maternity Voices Partnership - Lead quorate member of Quality and Safety Group and Obstetric Board member. • LMNS (Local Maternity and Neonatal System) oversight of Quality Oversight Model (PQOM) metrics and Maternity Incentive Scheme. • Real time patient/staff experience programme. • Workforce review including outputs of 2024 birthrate plus. • Refreshed perinatal governance structure aligned to themes of Three-Year Plan for Maternity and Neonatal care, reporting into Obstetric Board. • NENC Clinical Outcomes Dashboard and safety signal review process. • Review and refresh of Perinatal Quality Oversight Metrics. • Perinatal Anti-Racism Taskforce (PART) and associated action plan. • Staff wellbeing and cultural improvement plan. • Perinatal senior nurse/midwife on call introduced August 2025. • Maternity Outcomes Signal System (MOSS) data and associated standard operating procedures. • Regional Maternity Dashboard.	• Improvement action plan in place covering all core CQC must and should do moved to business as usual with reporting via MOOG. • Single Oversight Framework (SOF) Enhanced Surveillance Exit meeting and review of evidence with ICB and LMNS completed in May 2025, exit agreed with return to routine oversight via LMNS from June 2025. • Staff wellbeing and cultural improvement plan in place and monitored via People and Culture Group drawing insights from the staff experience programmes and SCORE survey results. • Project PROMISE spend plan aligned to staff wellbeing and cultural improvement plan. • Obstetrics Board. • Reporting and oversight into Quality Committee and Trust Board • Maternity Services Quality Dashboard and North East and North Cumbria (NENC) Clinical Outcomes Dashboard. • Annual CQC Maternity Survey results – improvement in some domains, no reduction in results, improved position in NENC ranking. • Clinical Negligence Scheme for Trusts (CNST)/Maternity Incentive Scheme (MIS) compliance with oversight via MIS tracker. • Incident data and scorecard reported to Quality & Safety (Q&S) group. • Incident review group reporting and actions. • Family Health meeting minutes and QOG minutes. • Perinatal staff experience programme. • Workforce review outputs and report. • Peri-natal quality oversight metrics monitored and reported to Quality Committee. • Midwifery staffing and red flags monitored and • reported to MOOG and Quality Committee in Integrated Board Report.	• CQC Maternity Self-Assessment tool completion – March 2026. • Recruitment of midwifery staffing in accordance with approved staffing plan – September 2026.	**1. Fully on plan across all actions.**	

		• MOSS dashboard reported to Quality and Safety group. • Regional dashboard reported to Quality and Safety group and regional/ICB oversight. • Midwifery staffing phase 3 (Birthrate Plus) business case agreed and action plan in place to achieve.			
Failure to embed the learning from external service reviews.	• Cardiac Oversight Group • Cardiothoracic Improvement plan, including improvement actions from CQC and other external reviews. • Quality Improvement Group • Quality and Performance Reviews • Review infrastructure of quality oversight and local governance groups.	• Cardiac Oversight group reporting and minutes. • Reports to Trust Board and Quality Committee • Maintenance of central external review log • Central oversight of implementation of recommendations and monitoring of action plan completion via Quality and Performance Reviews • Compliance and Assurance Group Reports and Minutes.	• Development of dashboard framework for Clinical Board oversight of actions/areas for improvement by April 2026. • 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 – April 2026.	**2-Actions defined-most progressing, where delays are Occurring interventions are being taken.**	
Lack of adoption of the digital initiatives designed to improve quality of care.	• Digital and Data Committee providing oversight to Trust Board • Digital Health Team. • Monthly clinical board digital leaders' group. • Care Optimisation Group. • Minimum Nursing Documentation Standards in place. • Patient correspondence/letters visible within Power BI dashboard for Clinical Boards. • Electronic Patient Record (EPR) and Digital Induction training. • EPR Optimisation.	• Lights on data available through Oracle to understand staff adoption and use of the EPR. • Power BI report of all discharge summaries in all areas in real time. • Digital Health Team embedded and working Trust wide to support optimisation, and adoption, currently based on both sites 5 days a week. • Care Optimisation Group provides operational oversight and prioritisation of clinical digital initiatives. • Clinical Records Group established • E-record reminders to clinicians of encounters that require discharge summary. • Interface within the EPR improved along with the reduction of positions removing complexity. • Power BI report is 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. • Nursing documentation audit framework – document standards now in place, aligned to trust guidelines and embedded within clinical standards audits.	• Clinical hardware refresh to be undertaken. – Starting Sept 25, completed by March 26 • Imprivata optimisation ongoing to make it easier and safer to access the EPRs – July 2026. • Digital road map and priorities work plan to Trust Management Group – March 26. Review and refresh of clinical recording keeping and documentation policy – April 26	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Failure to embed effective systems and processes to recognise and prevent avoidable Hospital Acquired Infections	• IPC Board Assurance Framework • Integrated Quality and Performance Report. • IPC Committee and subgroups. • Clinical Board Governance Meetings and Quality Oversight Group. • Local and National Benchmarking. • IPC policies. • Clinical Board Improvement plans. • Clinical Assurance Toolkit Audits. • Accrediting Excellence (ACE) Programme. • Antimicrobial Stewardship Policy and Framework. • IPC Corporate Team in place with clear roles and responsibilities to support Clinical Board Healthcare Associated Infection (HCAI) reduction strategies. • IPC investigation process in place for every hospital associated with HCAI. Moderate and above HCAI incidents, serious incidents and outbreaks with identifiable contributory factors reviewed through the PSIRF framework. • IPC Corporate Team in place with clear roles and responsibilities to support Clinical Board HCAI reduction strategies. 1. IPC Improvement Group. 2. IPC Improvement priorities agreed. • IPC Action Plan.	• IPC Board Assurance Framework document. • IPC Operational Group and Committee minutes and action logs • Integrated Quality Performance Report with an overview of IPC and HCAI metrics reporting to Committees of the Trust Board. • IPC Committee minutes and reports. • Local, regional and national benchmarking data • Clinical Board QOG and Governance meeting minutes and action logs. • Clinical Assurance Tool results • Rapid Quality and Safety Peer review results and action plans demonstrates 93% trust compliance with assessment framework. • Quality and Performance review minutes and action log • Clinical Board improvement plans in place in areas of high occurrence of HCAI. • IPC Improvement Group minutes and action plan – updates provided to Quality Committee.	• Develop IPC workflow and job planning – January 2026. • Develop and implement IPC Nursing handbook – January 2026. • Business continuity plan – January 2026. • Adopt IPC Nursing business partner model approach - February 2026. • Review and update of all IPC related Policies and consider development of IPC Standard Operating Procedures (SOPs) – February 2026. • Review of ICNET results to reduce workflow – February 2026. • Review and analysis of use of flags – February 2026.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Risk ID	1.1

Comments:

Board Assurance Framework 2025/2026

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

Lead Committee	Audit, Risk and Assurance Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Performance and Governance	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	Compliance and Regulatory
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	19.01.2026	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Failure to implement effective integrated governance focused on clinical quality, risk, finance, and performance Ward to Board.	• Revised corporate governance structure and reporting arrangements in place. Clinical Board Governance arrangements established including QOGs/QPRs/directorates. • Audit, Risk and Assurance Committee established. • CQC delivery group established. • Clinical Board Risk Registers. • Risk Validation Group • Recovery Oversight Group • Cardiac Oversight Group • Clinical Assurance Group • Review of QoG activity presented to Quality Committee in October 2024. • CQC phase one action plan. • CQC phase two action plan. • Clinical Board Governance Audit. • Access and Improvement Delivery Group Established to provide greater oversight and governance in relation to performance and productivity metrics. • Trust Interim Strategy. • NHS Oversight Framework (NOF) Trust Capability Self-Assessment • External Well Led review. • NOF capability assessment process.	• Terms of Reference – committees of Board. • Minutes of committee meetings. • Committee schedule of business. • Corporate Organograms. • Minutes of QOG/QPR and directorate governance meetings. • Effective governance system report to Trust Board. • CQC delivery group minutes and action plans. • Quality Performance Reviews and summary to Board and relevant committees. • External Tabletop Governance Report. • External leadership and governance review. • Feedback at Integrated Quality Improvement Group (IQIG). • Internal audit of CQC phase one action plan – substantial assurance received. • Internal audit of CQC phase two action plan – reasonable assurance received. • Clinical Board Governance Audit – reasonable assurance received. • Access and Improvement Group ToR and minutes. • Trust Interim Strategy in place, plan on a page accessible to staff on Intranet. • NOF Trust Capability Self-Assessment completed, and Trust Board Development Session delivered to review assurances and agree final self-assessment rating –	• Deliver Board Development programme 25/26 – March 2026. • Operationalise Accountability Framework including monitoring/governance and review mechanisms – April 2026 • Develop Trust Governance Handbook – April 2026. • Develop 5-year strategy –April 2026. • Complete Ward to Board Review of Governance – April 2026. • Ensure NOF metrics are captured within accountability and autonomy framework and measured across the Trust – April 2026. • Await NOF Capability Assessment outcome and governance rating – February 2026.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

		Compliant agreed. • External well led review completed by Grant Thornton – formal report details good assurance. • Process and governance in place to monitor and deliver improvement actions in relation to NOF capability via the well led action plan.			
Failure to embed escalation processes and ensure executive oversight.	• Performance and accountability framework. • Standardised reporting and governance. • Clinical Board development plan in place. • Quality performance review process. • Executive Leads for clinical boards. • Reporting hub dashboards. • Quality Oversight Group Evaluation. Risk Management Dashboard. • Clinical Board Governance Audit.	• Performance and accountability framework document. • Clinical Board reporting and minutes. • Performance review reports and minutes. • Clinical Board Chairs update to Executive Team. • Quality Committee Quality Oversight Evaluation Report, June 2024. • Clinical Board update report presented to Trust Board. • The value circle report on QPR process. • The value circle report on effective governance Audit One Risk Management and Board Assurance Framework Core Audit – Good level of assurance received. • Clinical Board Governance Audit – reasonable assurance received. •	• Operationalise Accountability Framework and Autonomy framework including monitoring/governance and review mechanisms – April 2026. • Complete Ward to Board review of Governance – April 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. • Refresh of risk management governance and reporting. • Quality and Safety leads appointed. • Risk Validation Group established. • Audit, Risk and Assurance Group established. • Risk management dashboard. • Executive Team lead assigned to CBs. • Refresh of risk management training for risk system users. • Engagement with clinical boards. • Implementation of risk decision tool -risk vs issue. • Risk Management SOP. • Refreshed Board Assurance Framework. Implementation/engagement risk refresher sessions provided to risk system users. • Risk Management and Board Assurance Framework Risk and compliance based internal audit. • Risk management induction video for all staff. • Inphase Risk Application Training. • Risk Appetite Statement. • Risk Management Intranet page.	• Risk Management Policy document and associated guidance. • Reporting, accountability, and escalation structure. • Terms of reference and minutes for the risk validation group • Historical risk trajectory. • Risk management dashboard. • Reporting to CQC Delivery Group weekly. • Risk management Training Needs Analysis (TNA). • Clinical board risk presentation. • Embedded into clinical board governance arrangements – qog minutes and reporting. • Audit, Risk and Assurance ToR, minutes, and Reports. • Clinical Risk reporting to Quality Committee. • Quality Performance Reviews and summary report • Risk management and Board Assurance Framework risk and compliance based internal audit – good level of assurance. • Risk Induction Video available on learning lab. • Inphase Risk Application Training now rolled out to all existing users. • Risk Appetite Statement Approved at Trust Board. • Risk Management intranet created with key guides, advise, contacts and supporting	• 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. • Develop Risk Management Strategy – March 2026. • Develop Risk Appetite methodology – April 2026. • Further development and improvement of Inphase Risk System, reliant on resource – April 2026.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

		information for all staff.			

Risk ID	1.2

Comments:

Board Assurance Framework 2025/2026

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

Lead Committee	Finance	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Chief Finance Officer	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Finance/VfM
Date Added	08.05.2025	**Likelihood**	**5**	**3**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	20.01.2026	**Risk Score**	**25**	**15**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
ERF activity plans do not sufficiently deliver activity targets and therefore increase financial risk to the Trust.	• Activity targets produced for each specialty. • Funding has been delegated at the start of the year for specific areas where identified this is necessary for impact. • Directors of Operations (DOPs) and Clinical Board Chairs accountability for delivery of activity targets. • Monthly reporting reinstated • IAP introduced as a part of the contracting process/requirement with NHS England (NHSE) and ICB (Indicative Activity Plan). Will be mandated. • IAP agreed. • Performance Gap early reporting.	• Activity reporting via monthly performance reviews and corrective action agreed where possible, against IAP. • Monthly reporting of targets, activity and financial impact to Finance and Performance Committee and Trust Board including obstacles and corrective action highlighted through trend analysis. • National reporting back to Trust of validated activity levels (quarterly) – assurance provided around validity of internal reporting • Internal and external audit of income levels • Finance Dashboard. • IAP in place, however at a lower activity level than required to meet standards required. Early reporting mechanisms and now specifically discussed at each Finance and Performance Committee. • Commissioners have provided additional funds which has resulted in reduction of risk to Trust year end position.			

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

Unplanned emerging cost pressures not included within the agreed balanced plan	• Horizon scanning • Executive team discussions • Planning and strategy group and financial recovery steering group re business cases and approval • Proactive engagement with suppliers • Supply and procurement committee. • Financial governance framework • ICB Directors of Finance (DOFs) meeting. • Shelford networking / understanding the environment. • Use of frameworks. • Opportunities through Alliance working. • Engagement with Medium-Term Planning Framework (MTPF) workstreams Integrated Care System (ICS). Annual Internal and External Audit complete. • In year emerging cost pressures identified, discussed and reported through Finance IQIG (monthly)	• CB and CD finance reporting • Budget sign off and hold to account through accountability framework • ICS updates through Finance report and Chief Executive Officer (CEO) report to Committees and Board • Finance report to Board, Finance and Performance Committee identifies any unplanned pressures and actions. • Procurement report to Finance and Performance Committee identifies any cost pressures emerging through procurement activity. • Regional finance returns monthly. • Mazars external audit – satisfactory assurance, no issues re going concern. • 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. • Adoption and embedding of financial accountability framework - bimonthly review of position by clinical board – Monthly reviews of position – March 2026. • Strengthen horizon scanning through Alliance DOF and national meetings/updates monthly – ongoing through 25/26 financial year -March 2026.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Reliance on non-cash measures leading to a diminished cash balance and reliance on cash support, impacting our ability to invest in buildings and equipment.	• Financial Recovery Plan • Non cash element of financial recovery defined and identified • Finance committee reporting and discussion • Financial Recovery Plan including cash releasing (CIP) • Other controls as above re management and reporting of CIP achievement • Capital management group • Strengthened discussion of cash position and reporting to finance Committee. • Enhanced cash reporting. • ICB cash payment request.	• Cash forecast within regular finance and board reporting • Daily / weekly cash management • Reporting of progress on cash releasing savings through financial recovery steering group and finance committee • Reporting of progress against capital plan to finance committee and Trust board • Reporting of progress against capital plan to Capital Management Group • Increased reporting of cash position via Monthly Finance Report to Finance and Performance • Committee. Enhanced cash reporting to Finance and Performance Committee. • ICB agreed to earlier than planned cash payment of specific items before end of December.	• Consider and develop actions necessary to mitigate cash position should CIP not deliver - July 2025. Enhanced cash reporting to Finance and Performance Committee completed • To consider cash management guidance from NHSE at Finance and Performance Committee – on November agenda. • Review of cash management and control processes and consider introduction of cash committee as a sub meeting of the finance committee to ensure actions required in advance of any cash support application are followed - March/April 2026	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Subsidiary company is not formed, and benefits don't accrue due to approvals and/or industrial relations issues.	• Meetings with NHSE • NHSE panel assessment • Outline Business Case (OBC) and Full Business Case (FBC) • Bi-weekly meetings with staffside • Joint meeting with staffside and NHSE • Staff Side regular engagement meetings. • National financial support.	• NHSE provided with all information relevant to make an informed decision • Continued thinking on benefits of forming a subsidiary company (risk, seeking) • All engagement material shared with staffside • All comms shared with staffside prior to sending out • Guarantees provided re terms and conditions, pensions issues and recognition agreement for staffside • Staff side engagement meetings 2 weekly. • National financial support has now been received to mitigate the financial value of savings in 25/26 assumed through establishment of the subsidiary company.			

Under delivery of commercial income and growth to support financial recovery.	• Commercial Strategy • Dedicated Commercial team established. • Commercial Update report. • Data Partnership model. • Data Partnership Group. • Sales force implementation. • Commercial schemes identified by Clinical Boards and Corporate Directorates. • Commercial Dashboards. • Intellectual Property (IP) Policy developed. • Strengthened commercial governance at Clinical Board Level.	• Strategy document and updates reported to Finance and Performance Committee (F&P). • Commercial update report to F&P. • Data Partnership Proposal accepted by F&P. • Data partnership group reporting to commercial delivery and innovation group. • Tracking commercial pipeline. • Commercial schemes reporting alongside financial recovery plans. • Commercial dashboard data suggests marginal growth. • Commercial updates presented to Finance and Performance Committee. • First 2 data partnership agreed, and contract signed – Flatiron and Promptly. • Commercial representative at clinical board cost improvement meetings. • Strengthened governance and awareness relating to IP protection and data access - IP policy updated and SoP socialised.	• Develop commercial principles for external contracts for full scale adoption in order to maximise potential returns. Commercial contracting course to be delivered – February 2026. • Establish new Research, Innovation and Commercial Committee – April 2026.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	

Risk ID	6.1

Comments:

Board Assurance Framework 2025/2026

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

Lead Committee	Finance and Performance Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**
Executive Lead	Director of Performance and Governance	**Impact**	**4**	**4**	**4**	**Risk Appetite Category** Compliance and Regulatory
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**
Last Reviewed	19.01.2026	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Rating**

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Failure to manage capacity and demand.	• Programme Management Office (PMO) supported programme of demand and capacity planning across all surgical specialties completed. • Weekly Stand-up highlighting areas of performance focus. • Daily Site meetings and Site Handover. • Weekly specialty /tumour group PTL meetings for long waits and cancer. • Fortnightly performance meetings with operational leads for long waits and cancer. • Local Accident & Emergency (A&E) Delivery Board, supporting the management of non-elective patients across the system. • Weekly attendance at Provider Collaborative Mutual Support Co-ordination group facilitating patient transfers and collaboration amongst local providers to level demand, make use of system capacity. • Validation of the Referral to Treatment (RTT)/non-RTT of long waits. • Implementation of new Emergency Department (ED) rota. • Targeted cancer improvement plans based on National Cancer Pathway Analyser Tool • Waiting list booking process Training. • Cancer Tiering System Exit.	• Revised Accountability Framework. • Activity and Income reports. • Integrated Quality and Performance Board Report. • Monthly Integrated Quality Performance Reviews. • Theatre Utilisation Data • CEO performance summary TMG including national performance comparisons • Performance Improvement Plans monitored via Finance and Performance Committee, including deep dives incorporated into the cycle of business • Further development of the Integrated Quality and Performance Board Report – reported to Committees and Trust Board. • Implementation of new ED rota, report to Finance and Performance Committee - improved safety. • Targeted cancer improvement plans with quarterly updates to F&P Committee • Tier 2 escalation process for cancer performance – positive feedback on progress by NHSE/ICB • Trust has successfully exited Cancer Tiering System. • Full review of outpatient capacity templates undertaken. • Service review process and methodology confirmed and service review programme in place. • Review and update of performance reporting information complete and updated in reporting	• Operationalisation of the Accountability Framework in progress – to be delivered by April 2026 • Capacity and demand templates being completed for pressurised services as part of the medium-term planning framework, to be completed by the end of April 2026.	**2 – Action defined-most progressing, where delays are occurring interventions are being taken.**	

	• Outpatient capacity templates. • Service review programme. • Performance Reporting.				
Utilising available resource effectively – workforce, estate, and equipment.	• Activity plans developed with Clinical Boards as part of the annual planning process. • Productivity targets set as part of the • Capital planning process through Capital Management Group. • Allocation of growth funding from commissioners to under pressure services, where available. • Revised annual planning process to incorporate approval of business cases for the coming financial year and utilisation. • Operational reports establishing weekly activity and value performance reports. • Diagnostic, Surgical and Outpatient Improvement Groups in place, with organisation wide scope to deliver improvements in effectiveness. Histopathology Turnaround times reporting. Productivity metrics established.	• Integrated Quality and Performance Board Report. • Monthly Integrated Quality Performance Reviews. • TMG Updates. • Clinical Board meeting minutes. • Weekly Activity and ERF (income) reports. • Histopathology turnaround times reported and discussed at QPR. • Productivity metrics reported through Financial Recovery Steering Group.	• Improve theatre utilisation to greater than 85% by the end of March 2026. • Longer term capacity modelling for radiology modalities to be completed by March 2026 – 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 • Access and Improvement Group Established. • NOF methodology. • Trust currently in NOF segmentation 2. • Initial NOF provider capability assessment completed.	• Analysis completed looking at drivers of the NOF segmentation for Quarter 1 (Q1). • NOF Segmentation discussed and reported through Access and Improvement Group. • NOF methodology reported and discussed at Trust Board. • Trust Board development session regarding NOF Self-assessment submission and review of evidence/assurances – Trust self-assessment rating amber/green.	• Develop forecasting model to get early sight of potential future segmentation at the end of each quarter – March 2026. • NOF metrics to form accountability and autonomy framework and measured across the Trust – April 2026. • Await NOF Capability Assessment outcome and governance rating – February 2026.	**2 – Action defined-most progressing, where delays are occurring interventions are being taken.**	
Failure to transform and change service models at pace.	• Clinical Board Improvement Plans. • Winter Plan. • Bespoke programmes of support to critical / fragile services. • Clinical Board Structure in place from April 2023 • Alliance working groups. • GIRFT engagement and sharing of alternatives models, tools, and support. • Outpatient Improvement Group. • Surgical Improvement Group. • Diagnostic Improvement Groups. • Urgent and Emergency Care Improvement Group. • Monthly meetings in place with primary care. • Trust Winter Plan 2025/26. • Medicine and Emergency Care Frailty Model	• TMG Oversight. • Executive Team Oversight. • Quality Performance Reviews. • Monthly IPR to committees and Board. • Clinical Board meeting minutes. • Outpatient Improvement Group actions. • Surgical Improvement Group actions. • Diagnostic Improvement Group actions. • Urgent and Emergency Care (UEC) Improvement Group actions. • Cancer Board actions. • Improvement and project management resource reprioritised to support priority actions/service changes. • Trust Winter Plan agreed and in place. • Effective frailty model implemented.	• Develop and implement co-located Urgent Treatment Centre (UTC) – Opening January 2026 • Pathway changes aimed at improving ED performance including ambulance handovers as part of the GIRFT Further Faster UEC programme – March 2026 • Further round of reviewing cancer pathways to identify 'bottlenecks' and areas of improvement being carried out as part of the planning submission for 2026/27 – March 2026.	**2 – Action defined-most progressing, where delays are occurring interventions are being taken.**	
Clinical service failure at neighbouring Trusts impacting NUTH performance – also linked to strategic risk	• Trust based Clinical Strategy work across the Alliance including a focus on vulnerable services. • Attendance at the Provider Collaborative Mutual Support Coordination Group and Alliance groups. • Alliance plans for identified services addressed through Bilateral Board meetings and workstreams.	• Regular updates to TMG. • CEO attendance at Great North Health Care Alliance Steering Group and Minutes. • Monitoring via the Bilateral Boards –First iteration of Alliance performance report complete.			

Risk ID	6.2
Comments:	

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Failure to maintain the standard of the Trust estate, environment, and infrastructure could result in a disruption to clinical activities and impact on the quality of care delivered.	**Strategic objective**	5.Our building will be fit for purpose.

Lead Committee	Finance and Performance	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Estates, 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	16.01.2026	**Risk Score**	**20**	**20**	**5**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Uncertainty and programme risk due to delays in Building Safety Act (BSA) approval will delay delivery and increase costs of construction/ refurbishments projects in “high-risk buildings” (HRB).	• Clearly identify every aspect requiring compliance. • Ongoing engagement with Contractors/Health & Safety Executive (HSE). • Engage professional/legal advice. • Discussions with NHSE/Department of Health and Social Care (DHSC) regarding impact on NHS. • Repository of Trust Estate where HRB applies. • DHSC Engagement regarding BSA delays. • Engagement with local MPs who plan to raise impact of BSA delays with the Parliamentary Under-Secretary of State in the Ministry of Housing, Communities and Local Government	• BSA applications. • Ongoing correspondence with Contractors/HSE. • HRB repository now in place. • Enhanced understanding of BSA linked projects and application requirements.	• Correspondence with Contractors/HSE – project specific timeline - March 2026. • Reporting capital plan and cashflows through Capital Management Group (CMG) and F&PC – March 2026. • Now assuming protracted BSA application periods and 2026/27 capital programme is being planned to accommodate BSA lead time - March 2026.	**4-Actions defined - but largely behind plan.**	

Insufficient national capital funding allocation to effectively manage the lifecycle replacement or upgrade of the Trust Estate, Environment and Critical Infrastructure assets (Backlog Maintenance).	• Condition monitoring of assets undertaken annually to enable ongoing re-prioritisation of backlog maintenance programme. • Annual capital investment plan including estates and medical devices. • Estates Strategy. • ICS Infrastructure plan. • Annual condition survey (20%) to determine condition of infrastructure in accordance with NHS Backlog Methodology. • Alignment of condition surveys. • Risk based asset plan and report	• Estates Risk Management & Governance Group minutes and action logs. • Estates Returns Information Collection (ERIC)/Model Health System. • Estates Investment, Planning, Strategy and Capital Investment Group. • Critical Infrastructure Risk (CIR) plan 2026/27 Capital programme. • Capital Management Group oversight. • CMG report - Finance and Performance Committee. • ICS Infrastructure Board. • Condition surveys now aligned on Computer-Aided Facilities Management (CAFM) system. • Risk based asset report providing clinical board prioritisation of Backlog Maintenance.	• Carry out a 6-facet condition survey of the built environment, critical plant and equipment Pending funding discussion with NHS England which will include a potential combined Alliance bid for national funding – April 2026. • Regular review of priority replacement plant and equipment requests by CMG - March 2026. • Forecasting of CIR requirements to 2030 as part of 5-year capital plan - March 2026. • Highlighting of complete CIR requirement as part of RtCS submission (NHSE) – March 2026	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**	
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. • Monthly fire safety remediation programme monitoring reports. • Fire Safety Reports. • Incident reporting system. • Estates Strategy.	• Trust Fire Safety Group minutes and action logs. • Oversight by Estates Fire Directors Group. • Estates Risk Management & Governance Group minutes and action logs. • Quarterly report to Compliance & Assurance Group. • Reports to Capital Management Group. • Fire Safety report to Trust Board.	• Fire Remediation works continue in line with the agreed 2025/26 Plan as a workstream as part of the wider Capital Plan – March 2026 • Re-procurement of the Fire Remediation Contractor still planned with tender award in place by April 2026 • A small number of High Risk areas still remain across both Royal Victoria Infirmary (RVI) and Freeman Hospital (FH) due to access constraints. These are included within 2026/27 plan to be completed (pending access) by March 2027.	**3-Action defined- work started but behind plan.**	
Failure of ageing critical estates M&E engineering infrastructure (Ventilation, Water, Electrical (HV & LV systems), Decontamination and Medical Gas Pipeline Systems).	• Regular planned preventive maintenance programme (PPM) in place in line with the requirements of SFG20 and Health Technical Memoranda (HTM) guidance. • Condition monitoring of assets undertaken annually to enable ongoing re-prioritisation of backlog maintenance programme. • Monthly HTM Compliance Monitoring Reports. • Health & Safety Reports. • Incident reporting system. • Capital Programme. • Estates Strategy. • Trust Policies and Procedures. • Annual condition survey (20%) to determine condition of infrastructure in accordance with NHS Backlog Methodology. • Risk based asset plan and report	• Estates Operational Management Structures. • Estates Investment, Planning, Strategy and Capital Investment Group. • CIR plan 2026/27 Capital programme. • Oversight via Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety). • Estates Risk Management & Governance Group minutes and action logs. • Quarterly report to Compliance & Assurance Group. • Capital Management Group oversight. • IPC Committee oversight. • Independent Authorising Engineer annual HTM compliance Audit. • Trust Internal Audit Programme (AuditOne). • Risk based asset report providing clinical board prioritisation of Backlog Maintenance.	• Carry out a 6-facet condition survey of the built environment, critical plant and equipment Pending funding discussion with NHS England which will include a potential combined Alliance bid for national funding – April 2026. • Regular review of priority replacement plant and equipment requests by CMG - March 2026.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Insufficient national capital funding allocation to effectively manage	• Condition monitoring of assets undertaken annually to enable ongoing re-prioritisation of capital replacement programme. • Capital plan includes medical devices.	• Medical Director medical device replacement oversight/prioritisation group. • Estates Investment, Planning, Strategy and Capital Investment Group.	• Regular review of priority requests by Medical Director and medical device replacement oversight/prioritisation group - March 2026.	**1.Fully on plan across all actions.**	

the lifecycle replacement or upgrade of critical medical devices (Imaging assets, Theatre Equipment etc.).	• 5-year Medical Device Capital replacement plan agreed for 2026/27	• Medical Device replacement plan 2026/27 Capital programme. • Capital Management Group oversight. • CMG report - Finance and Performance Committee. • Medical Device Steering Group. • medical device asset replacement monitored via Capital/Financial planning meetings. • Lifecycle replacement plan and programme in place.			

Failure of ageing critical medical devices assets (Imaging assets, Theatre Equipment etc.).	• Regular planned preventive maintenance programme (PPM) in place in line with the requirements of MHRA guidance. • Monthly Compliance Monitoring Reports. • Incident reporting system. • Capital Programme. • Trust Policies and Procedures. • Analysis of CAFM medical device data to identify failure trends.	• EME Operational Management Structures. • Annual report to Medical Device Steering Group. • Estates Risk Management & Governance Group minutes and action logs. • Incident reports discussed at Medical Devices Steering Group.	• 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. • Health & Safety Audit Reports. • Incident reporting system. • Capital Programme. • Estates Strategy. • Trust Policies and Procedures	• Estates and Facilities Operational Management Structures. • Estates Risk Management & Governance Group minutes and action logs. • Quarterly report to Compliance & Assurance Group. • PLACE Assessments. • NHS Premises Assurance Model (PAM). • IPCC oversight. • CQC Delivery Group. • CQC Standards Assurance Group. • Trust Internal Audit Programme (AuditOne).	• Dementia Friendly Estates options appraisal to be finalised and escalated for approval including any agreed plan of work – Q4 2025/26. • Finalise Trust standard specifications (including dementia standards) to follow on any refurbishment programme within capital plans - Q4 2025/26 • Phase 2 - Compliance with Self Harm Risk Assessment recommendations 18–24-month programme subject to funding approval – Q4 2025/26.. • Review and implement agreed improvements relating to Real Time Patient Satisfaction Surveys - ongoing Q4 2025/26.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Lack of decant facility compromises the delivery of planned Estates objectives including ward refurbishment programme, fire remediation works and critical infrastructure replacement.	• Estates Strategy. • Liaison meetings with Patient Services to minimise impact on clinical activity. • Project Management meetings. • Review by Estates Programme Sub Group.	• Senior Operational meetings. • Capital Management Group oversight. • Estates Strategy & Capital Investment Group. • Estates Programme Sub Group.	• FH Ward 12 used as decant facility for one ward refurbishment per year subject to available Capital funding – March 2026. • Co-ordinate with Patient Services to negotiate access and minimise impact on patient activity - timing project specific throughout the year to March 2026. • Alliance Construction Programme aims to delivery decant facilities – Long term.	**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	• Monitoring of PFI annual and 5-year lifecycle plan (Lifecycle investment is included within the Project Agreement and Unitary Charge for the PFI Estate).	• PFI Monthly Review Meetings. • PFI Liaison Committee. • Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety).	• Continue zonal inspection processes to identify and remedy any slippage in condition. Checks to take place monthly until end of concession in 2043.	**2-Actions defined-most progressing, where delays are occurring**	

safe level of compliance.	• Monitoring of PFI annual condition surveys. • Regular zonal and ad hoc inspections of PFI areas. • PFI Performance.	• Compliance & Assurance Group. • Trust Internal Audit Programme (AuditOne) • Independent Authorising Engineer annual HTM compliance Audit. • PLACE audits. • Monitor helpdesk reporting. • PFI best practice conditions survey - heads of terms for settlements agreed that include commitments to remedial works, performance improvements and a condition survey.		**interventions are being taken.(3)**	
Failure to manage project delivery within PFI estate will impact the ability to transform services and improve efficiency.	• Follow variation procedure outlined with PFI Project Agreement. • Track works requests and escalate slippage. • Review progress within meeting structures. • Implement alternative routes if required. • Management of works requests. • SARC Project.	• Review at monthly Variation meetings. • PFI Liaison Committee. • Track and manage works requests through variation procedure and meeting structure -takes place monthly. • Agreement now in place to allow big ticket projects to be delivered by turn-key providers with HSN contribution to lifecycle work's. This has unlocked a number of medical equipment replacement projects • SARC Project now complete.	• Completion of deed of variation for HSN delivery – Delayed, though agreement has been reached to complete the first project whilst this is being prepared – April 2026 • First project completed during Q3 2025 - SARC Project - Complete. • Delivery of Medical equipment replacement projects – Q3 2026. •	**2-Actions defined- most progressing, where delays are occurring interventions are being taken (4).**	
Reduced fire compliance during PFI Programme of fire remedial works.	• Obligations to perform and conclude fire remedial works set out in PFI Project Agreement and Settlement Agreement. • Maintain meetings structures to manage progress with the works.	• Independent certification for each zone when completed. • Ongoing compliance requirements contained within PFI Project Agreement. • PFI Fire Steering Group.	• Regular reviews of requirements and progress with the remedial works – reviewed monthly for 2025/26. • Completion of fully integrated programme of PFI Fire works has been agreed and is to be implemented from January 2026 through to Spring 2027.	**4-Actions defined - but largely behind plan.**	
Non-compliance of elements of PFI Ventilation and Air Conditioning Systems	• Obligations to perform remedial works set out in PFI Project Agreement. • Legal support if required to resolve any disagreements.	• Compliance requirements contained within PFI Project Agreement. • Performance reports. • Performance report review meetings. • PFI Liaison Committee.	• Seek remedial scope and programme from PFI partners - Q1 2026 - On plan. • Manage terms of the PFI Project Agreement to conclude remedial works through to Dec 2026 - On plan. • PFI final settlement to be agreed by April 2026.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Non-compliance of elements of PFI Electrical Systems.	• Obligations to perform remedial works set out in PFI Project Agreement. • Legal support if required to resolve any disagreements.	• Compliance requirements contained within PFI Project Agreement. • Performance reports. • Performance report review meetings. • PFI Liaison Committee.	• Seek remedial scope and programme from PFI partners – delayed, full condition survey of required works is now to be undertaken - June 2026.Manage terms of the PFI Project Agreement to conclude remedial works through to Dec 2026 – on plan. •	**4-Actions defined - but largely behind plan**	

Risk ID	5.1

Comments:

Board Assurance Framework 2025/2026

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

Lead Committee	People Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Commercial Development & Innovation.	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	People & Culture
Date Added	01.05.2025	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	06.01.2026	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Failure to review and improve team working across the Trust following declining staff survey results in relation to 'we work as a team' question.	• Health and Wellbeing Steering Group. • People Programme Board. • Occupational Health Self-Referral Service. • Evaluation and appraisal of Trust Compassionate Leadership Programme.	• Health and Wellbeing Steering Group minutes. • People Programme Board Minutes. • Live in August 2025. • Evaluation of Trust Compassionate Leadership Programme completed August 2025. • Occupational Health Self-Referral Service live.	• Staff psychology support service, 2025/26 – March 2026. • 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. • Equality, Diversity & Inclusion (EDI) Steering Group. • Health and Wellbeing Steering Group • Developed and launched Trust Behaviours and Civility Charter • NHS England's Sexual Safety in Healthcare Charter • New Sexual Misconduct and Sexual Violence Policy • EDI Development Session delivered at TMG and Trust Board. • Cultural Ambassadors in place. • People dashboard. • Let's Talk Race session with the Trust Board in March 2025. • Sexual safety and misconduct audit. • Year 2 EDI 2025/26 priorities developed. • People and Culture Multi-disciplinary Team	• Health and Wellbeing Steering Group minutes. • People Strategy. • People Strategy Year 1 deliverables. • Safe Staffing Internal audit – Reasonable assurance • Freedom to speak up (FTSU) Internal audit – Reasonable assurance. • F2SU Guardian assurance report to People Committee. • People Committee minutes. • Clinical Board People Oversight Groups. • People Programme Board. • Micro aggression and incivilities training. • EDI and Let's Talk Race Presentation and slides. • People Dashboard reporting. • Completed and priority actions/finding to PC November. • Year 2 EDI 2025/26 priorities paper to People Committee July 2025. • Occupational Health Self-Referral Service live.	• People Plan Year 2 programme launch – January 2026 – to be reviewed in light of Grant Thornton feedback • Staff psychology support service, 2025/26 – March 2026. • Further development of People Oversight Groups in CBs as part of PP Year 2 action plans – due to organisational change in dept this framework is currently in development – review in January 2026. • Delivery of Year 2 2025/26 EDI Priorities – March 2026.	**4. Actions defined - but largely behind plan.**	

	(MDT) Group Established. • Occupational Health Self-Referral Service.				

Risk ID	2.1
Comments:	

Board Assurance Framework 2025/2026

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

Lead Committee	People Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Commercial Development & Innovation.	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	People and Culture
Date Added	01.05.2025	**Likelihood**	**4**	**3**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	06.01.2026	**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**
Failure to support staff with their health and wellbeing leading to increased sickness absence.	• Health and Wellbeing Steering Group in place. • Better Health at Work Award • Health and Wellbeing policy in place. • People Strategy. • completed including Wellbeing Gap Analysis. • People Programme Board. • Sexual Safety Charter. • Behaviours and civilities charter in place. • Staff Health and Wellbeing (HAWB) offers including Trust travel scheme, financial wellbeing, meal cards, access to helping hands, Staff social club and fitness centres. • EDI – Staff Networks, High Impact Actions, EDI Steering Group, WRES, WDES, EDS • Cultural Ambassadors. • Health and Wellbeing Policy in place. • People and Culture MDT Group Established.	• Health and Wellbeing Steering Group minutes. • IBR - People report. Board (mthly); People Committee (bi-mthly); Employment Partnership Forum (mthly). • People Strategy, Year 1 delivery programme • Performance review report for Clinical Boards (mthly). • Sexual safety charter awareness and training in place. • People Strategy Year 1 programmes. • Internal Audit reports (absence management; HAWB initiatives; F2SUG). • People dashboard and reports. • F2SUG reports. • People Committee minutes. • Clinical Board People Oversight Groups. • People Programme Board. • Health and Wellbeing ad EDI Steering Groups in place • Behaviours and civilities charter awareness and training in place – Trust compliance 88.7% • Health and Wellbeing Policy ratified August 2025.	• People Plan Year 2 programme launch – January 2026 – to be reviewed in light of Grant Thornton feedback. • Staff psychology support service, 2025/26 – March 2026. • Target reduction in sickness absence of 0.5% - March 2026. • Anti Racism Framework 2025/26 to be discussed and adopted at Trust Board In January 2026. • Evaluate learning and sharing from CB People Oversight Groups – due to organisational change in dept this framework is currently in development – review in January 2026.	**3. Actions defined – work started but behind plan.**	

Failure to deliver improvements to leadership and governance across the Trust.	• Organisational Change policy in place. • People Strategy. • SubCo Operational Group in place. • SubCo People Group in place. • People Programme Board. • People Transformation Group. Employment Partnership Forum.	• Project management records. • Internal Audit report. • People Programme Board minutes and actions. • People Transformation Group minutes and actions. • People Committee minutes and actions. • Employment Partnership Forum minutes and actions. • SubCo Operational Group minutes and actions. • SubCo People Group minutes and actions.	• Business Partner Model – January 2026. • Develop BP working Group – January 2026. – complete, additional support added. • Explore Just learning culture – January 2026	**3. Actions defined – work started but behind plan.**	

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.

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	06.01.2026	**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. • IBR - People report. Board (mthly); People Committee (bi-mthly); Employment Partnership Forum (mthly). • PWR data mapping with PFR data. • Redeployment policy in place. • Redeployment group meets weekly. • Local Vacancy Freeze. • Voluntary Severance Scheme complete • MARS opened to all staff 13th October to 2nd November. • Workforce reduction oversight group established October 2025. SH as SRO. • Workforce reduction targets allocated to each Clinical Board and each Corporate service. Target is to reduce WTE by 400. • Vacancy freeze from 1st Oct – 22nd Oct. • MARS workforce reduction scheme.	• Voluntary severance scheme drawn up and actioned. • Redeployment group minutes and actions. • Workforce reduction data reported to FRSG. • SIT REP to Execs on vacancy hold.	• Completion of 25/26 MARS scheme – March 2026. • Review of corporate functions and re-introduction of required posts whilst still ensuring cost saving, monitored via newly established working group – April 2026.	**1. Fully on plan across all actions.**	
Underdeveloped workforce planning mechanisms impacting on our ability to effectively forecast workforce needs.	• PWR data (mthly). • Clinical Board People Oversight Groups in place. • People dashboards and BI reports. • People Programme Board.	• PWR data. • People dashboard and BI reports. • Clinical Board/Corporate Service workforce plans. • People Programme Board minutes. • People Transformation Group minutes.	• Agree Business partner model 2025/26 – February 2026. • Workforce triangulation between finance, establishment and budget exercise – January 2026.	**3. Actions defined – work started but behind plan.**	

Capacity and capability to effectively support workforce planning in the Trust.	• Operational Planning Group in place. • ESR in place, including Establishment. • PWR data. • People dashboards and BI reports. • People Programme Board.	• Operational Planning Group minutes. • ESR reports. • PWR data/reports. • People dashboards and BI reports. • People Programme Board minutes. • People Transformation Group minutes.	Business partner model 2025/26 – January 2026	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Risk ID	2.3
Comments:	

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Failure to deliver and improve the digital capability required to support the delivery of safe, effective and efficient patient care.	**Strategic objective**	4. Our technology will support our work and patients' care.

Lead Committee	Digital and Data Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	David Elliott	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Digital Technology
Date Added	09.01.2026	**Likelihood**	**4**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	09.01.2026	**Risk Score**	**20**	**20**	**10**	**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**
Delivery of foundational digital and operational tasks supersedes strategic digital priorities, resulting in limited ability to deliver digital transformation.	• Care Optimisation Group providing prioritisation, sequencing and governance of digital initiatives. • Digital Senior Management Team (SMT) meeting weekly to oversee delivery, capacity and emerging risks and issues. • Digital and Data Committee (DDC) • Clinical board digital priorities.	• Care Optimisation Group Terms of Reference, agendas, minutes and Chair's logs to Digital and Data Committee. • Weekly Digital SMT meeting notes and action logs. • Digital and Data Committee ToR, agendas, papers, minutes and escalation reports to Trust Board. • Trust Board assurance via DDC reporting and delivery against the agreed digital roadmap. • Clinical Board digital priorities confirmed and added to digital roadmap.	• Review operational digital demands not currently overseen by the Care Optimisation Group and ensure alignment within agreed priorities – February 2026. • Complete a baseline digital resource and capability review to ensure systems are adequately supported and maintained – March 2026.	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	

Lack of staff skill set and resources to deliver digital plans.			• Recruit Associate Director of Digital to strengthen leadership capacity – Interviews held in January 2026, further recruitment required timescale extended – April 2026. • Undertake a baseline skills and capability review across the Digital workforce to identify gaps and future needs – March 2026. • Implement a new Digital organisational structure aligned to required skills and delivery priorities – May 2026. • Implement planned redesign of the Digital operating model – June 2026.	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Insufficient capital and revenue funding to deliver agreed digital priorities and transformation programmes.	• Financial planning assumptions and Digital investment plans.	• Digital investment plans in place with Inclusion of digital priorities within Trust financial and capital planning processes.	Review 2026 capital plan outline to determine opportunities to switch between capital and revenue funding to enable digital transformation – April 2026.	**5. Actions not yet fully defined.**	

Risk ID	4.1

Comments:

Board Assurance Framework 2025/2026

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

Lead Committee	Trust Board	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Martin Wilson,	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	System and Partnerships
Date Added	Director Great North Healthcare Alliance	**Likelihood**	**4**	**3**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	20.01.2026	**Risk Score**	**16**	**12**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Lack of appropriate Board, Executive and senior clinician capacity to influence the key partnerships and/or culture of the organisation resistant to working in effective partnerships.	• Great North Healthcare Alliance Steering Group Committees in Common • Great North Healthcare Alliance Joint Committee. 3 lead directors in place for delegated functions of financial planning, digital and research and innovation. • Bilateral group between Northumbria and Newcastle meeting monthly. • Bilateral sub-committee between North Cumbria and Newcastle meeting monthly. • Bilateral sub-committee between Gateshead and Newcastle meeting monthly. • Great North Healthcare Alliance Director and Alliance Formation Team in place. • ICS Board. • Great North Healthcare Alliance Collaboration Agreement based around improving collaborative working whilst retaining organisational independence. • Provider collaborative leadership board. • Newcastle place based ICB sub-committee. • Alliance Vision, Workplan and Milestones. • Alliance Performance Dashboard. • Shared Chair in post across Newcastle, Northumbria, and Gateshead.	• Chair and CEO member of Great North Healthcare Alliance Steering Group Committees in Common and Joint Committee. • CEO member of Provider Collaborative Leadership Board. • Executive Directors leading appropriate Alliance work streams with peers. • Acting CEO chairs Newcastle Place ICB Sub-Committee. • Alliance vision and 3-year work plan approved by Trust Board and supported by Council of Governors and NENC ICB. • Great North Healthcare Alliance Steering Group Committees in Common and Joint Committee Minutes • Great North Healthcare Alliance written updates to Trust Board and Council of Governors. • Joint Alliance Governor event was held in October 2025. • ICB/Provider Collaborative and PLACE Minutes • Legal support to ensure legislative compliance • ICB approval of Alliance Case for Change. • ICB led stakeholder engagement assurance of Alliance plan very positive. • NHSE assured Alliance shared leadership arrangements	• Develop refreshed Alliance strategic intent. First draft co-produced with CEOs and discussed at Alliance Steering Group January 2026, Further refinements to be made before being considered by Alliance Steering Group and Trust Boards – March 2026. • Establishment of Clinical Framework Group, • Review, simplify and strengthen Alliance governance and bilateral boards – March 2026. • Alliance Construction Programme (“Big Build”) – full market engagement undertaken. Plan to be approved by Alliance Steering Group in January 2026 and to go to Boards – March 2026.	**1-Fully on plan across all actions.**	

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

Risk ID	7.1
Comments:	

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Agenda item A6(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 January 2026					
Title	Committee Chair Meeting Logs					
Report of	Hassan Kajee, Chair of the Digital and Data Committee Anna Stabler, Chair of the Quality Committee Bernie McCardle, Chair of the People Committee Bill MacLeod, Chair of the Finance and Performance Committee David Weatherburn, Chair of the Audit, Risk and Assurance Committee					
Prepared by	Lauren Thomspon, Corporate Governance Manager/Deputy Trust Secretary					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☐			
Summary	The following Committee Chairs Logs are included since the last Public Trust Board meeting in November 2025: • Digital & Data Committee – 13 November 2025 • Quality Committee – 18 November 2025 and 9 December 2025 • People Committee - 18 November 2025 • Finance & Performance Committee – 24 November 2025 and 15 December 2025 • Audit, Risk & Assurance Committee – 25 November 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 November 2025.					

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

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

Meeting: Digital & Data Committee	**Date of Meeting**: 13/11/2025
Connecting to: Audit, Risk and Assurance Committee Trust Board	**Date of Meeting**: 27/01/2026 30/01/2026
Key topics discussed in the meeting	

- **Chief Digital Information Officer (CDIO) Presentation** – The CDIO presented the current digital workstreams along with the alignment of ongoing digital projects linked to the NHS 10 year plan, providing assurance that current priorities and operational requirements are reflected and updates are provided to the committee.
- **Artificial Intelligence (AI) -** The committee debated the adoption of ambient voice and AI technologies, referencing experiences from other trusts, the need for compatibility, risk management and the importance of a clear organisational position on AI implementation.
- **Strategic Digital & Data Priorities Update** – The Head of IT Programmes described the process for collecting, prioritising, and managing over 500 digital requests from Clinical Boards, focusing on transparency, equity, and alignment with organisational priorities.
- **Digital Transformation Projects Update** – The Head of IT Programmes provided an update on the key digital projects, partnerships, and the implementation of new clinical and patient engagement systems, highlighting successes, challenges, and lessons learned.
- **Information Services Update** – The Director of Performance and Governance presented a summary of the Information Services report, reflecting on the five year plan developed in 2020/21. The report outlines the background, key themes, and delivery of major milestones.
- **Information Standards Notice (ISN) Compliance -** ISN is a legal requirement to ensure health and care data is captured consistently and exchanged digitally. The Director of Performance and Governance informed the group that there are 133 areas for this organisation, with four areas currently non-compliant. An update on the ongoing work to achieve compliance in these areas was shared with the group.
- **Information Governance (IG) –** The Deputy Chief Nursing Information Officer reported on information governance incidents, trends in reporting, and actions taken to address data sharing errors, including the implementation of a communications plan and ongoing review of processes
- **Cyber Security Update –** The Head of IT Service Management provided an update on compliance which are measured again the Data Security & Protection toolkit, the update included the successful upgrade of legacy systems, ongoing migration projects, and the management of technical debt and associated risks. In relation to Cyber Security the group were informed there has been five high severity cyber security updates since last reporting. Two were not applicable to the Trust, the three which were, have been addressed within the 14 day requirement.
- **Community Diagnostic Centre (CDC) Update –** Head of IT Programmes presented lessons learned from the CDC project, a collaboration with Gateshead, focusing on the challenges of implementing a single Electronic Patient Record (EPR), the need for clinical engagement, and the importance of realistic planning.
- **Board Assurance Framework (BAF)/Risk Report and emerging risks** – The Head of Corporate Risk & Assurance Manager and the CDIO informed the group of the

development of a strategic risk and assurance framework for digital and technology, identifying principal risks and threats and agreeing to further refine the framework.

- **Approval –** The committee approved the terms of reference for the Digital & Data Governance Group and the Care Optimisation Group.

Actions agreed in the meeting	Responsibility / timescale
1. Artificial Intelligence (AI) It was agreed to bring back a strategic paper outlining the organisation's position on AI and ambient voice technology, including feasibility, obstacles, and a roadmap for adoption, ensuring alignment with the medium-term plan.	**1.** Timescale: Committee meeting 15th January 2026.
2. Artificial Intelligence (AI) The committee were asked for any feedback on the AI Principles document to be shared with the Chief Clinical Information Officer.	**2.** Committee members: Timescale: Next Committee meeting 15th January 2026
3. Digital Transformation Projects Update The Chair requested including in the next report what the project is transforming and the difference in the impact this will make.	**3.** Head of IT Programme Management Timescale: Next Committee meeting 15th January 2026
4. Information Governance Incident Reporting The Alliance Lead for Digital Governance and Risk Lead agreed to conduct an exercise across the Alliance to review the number and categories of incidents reported to the Information Commissioner's Office (ICO), to assess whether individual Trusts are outliers.	**4.** Alliance Lead for Digital Governance and Risk Timescale: Next Committee meeting 15th January 2026
5. The Chair requested for future meetings to include a clear assessment of security risk levels attached to residual devices and systems to support board and audit, risk and assurance committee assurance.	**5.** Head of IT Service Management. Timescale: Next Committee meeting 15th January 2026.
6. The committee members were asked to read the draft Strategic Risk and Assurance Framework for Digital and Technology and share any feedback with Natalie Yeowart, Head of Corporate Risk and Assurance.	**6.** Committee members Timescale: Committee meeting 15th January 2026.

Escalation of issues for action by connecting group	Responsibility / timescale
No issues reported.	

Risks (Include ID if currently on risk register)	Responsibility / timescale
No risks reported.	

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Quality Committee
Chair's Log

Meeting: Quality Committee	**Date of Meeting**: 18 November 2025
Connecting to: Audit Risk & Assurance Committee and Trust Board	**Date of Meeting**: 27 and 30 January 2026
Key topics discussed in the meeting	

- **Care Quality Commission (CQC)** – A general update on progress within the following areas were received, details of which were included within the reports:
    - Emergency Department
    - Well Led progress
    - Infection Prevention and Control (IPC) Improvement Group
    - North East & Cumbria Transport and Retrieval (NECTAR)
    - Cardiothoracic
    - Ophthalmology
- **Food Provision and Nutrition and Hydration** The report provided the Quality Committee with an overview of nutrition, hydration and food provision within the organisation. It was noted from previous patient experience results, that work is required to improve the provision of food for our patients. The report brings together an overview of nutrition and hydration governance, key workstreams, recent patient experience data and an overview of catering operations including results from a recent external peer review.
- **NICE (National Institute for Health and Care Excellence) Drugs** The Quality Committee supported the ongoing work of the Medicines Value, Access and CIP (Cost Improvement Programme) group and will continue to be informed if there are any additional areas of non-compliance via the Medicines Management Oversight Group.
- **Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress** The report provided the Quality Committee of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. A number of items were brought to the Committee's attention as outlined in the report summary section with escalations noted, discussed and further escalation agreed within the meeting.
- **Quarter 2 Reports:**
    - **Safeguarding** The paper presented an Executive Summary of the Quarter 2 (Q2) 2025/26 Safeguarding and Mental Capacity Act reports presented to the Trust Safeguarding Committee on 7 October 2025. Key points to note were the

increased activity across the safeguarding teams. Adult safeguarding case complexity is evident, and is reflected in the region.
    - **Learning Disability** The Learning Disability Q2 report showed that activity remains high, with complex patients being referred to the Learning Disability Liaison Team. A dedicated resource has recently been appointed to lead on work for appropriate care for autistic patients. The Trust continues to review the training plans in line with national expectations of the Oliver McGowan Training. A proposed implementation plan detailing a programme of incremental roll out over a three-year period has been developed
- **Six-Month Nurse Staffing Review Deep Dive** The report comprised both the Nurse Staffing six-month review (2025/26 Quarters 1 and 2) and the quarterly safe staffing assurance report. The report fulfils the recommendations of the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) and adheres to the recommendations set out by the National Quality Board (NQB 2016): How to ensure the right people, with the right skills, are in the right place at the right time.
- **End of Life and Palliative Care update** The report recognised the successes and progress of the Palliative and End of Life Care Service, as well as the risks and mitigations in place. The Quality Committee noted the high numbers of Palliative Care referrals and activity across the Trust. Discharge of patients at end of life (EOL) continued to bring challenges, with impact on bed days and patient experience.
- **Dental Hospital Update** The Quality Committee received a presentation highlighting an overview of Dental Services provided by the Trust which included a summary of current challenges, opportunities, and areas of success. An overview on the recent peer review process was provided with assurance on actions, actions remaining, and brief overview of current risks.
- **Complaints Improvement Plan** A review of the 12 NHS Complaint Standards, developed by the Parliamentary and Health Service Ombudsman (PHSO) was undertaken to help better understand areas of good practice and identify any gaps to prioritise across the Trust's end to end complaint handling process. Four standards were recognised as requiring improvement. As such a Task & Finish Group has been established to deliver the improvement plan.
- **Quality Account Priorities Update** The paper outlined a six-month review of progress for all 2025/2026 Quality Account Priorities and included results where available. The Quality Committee noted the progress to date which provided assurance that improvements are being made and, where necessary, appropriate measures are in place to address any deviation from the anticipated mid-year position.
- **Getting It Right First Time (GIRFT) Update Report** Getting It Right First Time is a national programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. Whilst significant progress has been made in the engagement and visibility of GIRFT workstreams within the trust and wider system the programme is not yet fully embedded. As such, to reinvigorate the GIRFT agenda and ensure synergy with strategic challenges, there would be a move towards relevant GIRFT workstreams feeding into all improvement boards, with regular reporting on further faster and other GIRFT outputs to inform programme priorities.
- **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.

- **Quality Committee Board Assurance Framework (BAF)** The report provided the Quality Committee with assurance that strategic risks aligned to the committee are being managed effectively; that risks have an appropriate action plan in place to mitigate them; and that risk scores are realistic and achievable. Discussion centred on the description, rating and mitigations in place for the threat of a Failure to deliver and adopt digital optimisation initiatives that drive measurable improvements in patient safety and quality of care.
- **Management Group Chairs Logs were received for the following:**
    - Patient Safety Group
    - Medicines Management Oversight Group
    - Promoting Equity in Health Group including Terms of Reference which were approved.
    - Transplantation Committee
    - Care for All
    - Clinical Outcomes and Effectiveness
- **Equality Delivery System Annual Report** Implementation of the Equality Delivery System (EDS) is a requirement on both NHS commissioners and NHS providers. The report contained the EDS1 (Patients) which has been discussed, reviewed and finalised at the Equality Diversity and Inclusion Working Group meeting held on the 19 August 2025 and the Experience of Care Group meeting held on 15 September 2025. The report was endorsed for publication.

Actions agreed in the meeting	Responsibility / timescale
1. Ophthalmology – agreed that monthly updates would come to the Quality Committee. Future updates to include overview of the harm review process and also what wider support is required to deliver the improvement plan.	• Sue Hillyard, Interim Executive Director of Operations. December & January Committees
2. Food Provision and Nutrition & Hydration – next update to be scheduled for March 2026 and to focus on Nutrition and Hydration Strategy and the work overseen by the Nutrition and Hydration Steering Group	• Paul Hanson, Director of Estates & Facilities and Strategic Partnerships and Ian Joy, Executive Director of Nursing. March 2026
3. Maternity and Neonatal Safety Investigations (MNSI) – to escalate that MNSI are only completing 40% of qualifying cases submitted by the Trust within the necessary timescales as well as the risk associated with the MNSI triage process due to COMET Trial.	• Ian Joy, Executive Director of Nursing - December Committee
4. End of Life (EOL) / Palliative Care – to understand the impact of the funding ending for EOL Managers and to escalate through the ICB Sub-Committee as required.	• Ian Joy – next ICB Sub Committee meets on 27 November 2025.

5. Dental Services – Standard Operating Procedure (SOP) for Sedated Patients to be reviewed and finalised.	• Rachel Carter, Director of Quality & Safety
6. Dental Services – Assurance paper to be provided in relation to systems and processes for clinical oversight together with benchmarking data including health inequalities and patient experience.	• Ian Joy, Rachel Carter, and Graham Walton, Clinical Director of Dental Services - February 2026.
7. Formal Complaints – Page in the Integrated Board Report to be reviewed to provide a more comprehensive position of the complaint process.	• Ian Joy – To update in January Quality Committee
8. Board Assurance Framework - to review the threat of *Failure to deliver and adopt digital optimisation initiatives that drive measurable improvements in patient safety and quality of care* – cross referencing with Digital & Data risks.	• Ian Joy – January Committee
Escalation of issues for action by connecting group/Trust Board	**Responsibility / timescale**
• None	• N/A
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Detailed within the BAF	• N/A

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Quality Committee
Chair's Log

Meeting: Quality Committee	**Date of Meeting**: 09 December 2025
Connecting to: Audit Risk & Assurance Committee and Trust Board	**Date of Meeting**: 27 and 30 January 2026
Key topics discussed in the meeting	

- **Care Quality Commission (CQC)** – A general update on progress within the following areas were received, details of which were included within the reports:
  - Well Led progress
  - Infection Prevention and Control (IPC) Improvement Group
  - Ophthalmology
- **Learning From Deaths Report** The report provided assurance to the Committee that the processes for Learning from Deaths across the organisation are in line with best practice as defined in the national guidance issued by the National Quality Board (NQB) on Learning from Deaths (March 2017). The paper provided a summary of the processes in place for the oversight of monitoring, reporting, learning and improvement from the review of inpatient deaths particularly those with modifiable factors
- **Patient and Staff Experience Update** The Patient Experience Programme has significantly advanced the Trust's ambition to embed patient voice at the heart of care delivery. The report outlined progress during the last 6 months against strategic objectives, highlighted early signs of impact, and sets out some priorities for 2026**.**
- **Audiology Update** The report provided an update on the Trusts response to Paediatric Hearing Services Improvement Programme which was established by NHS England to support providers and Integrated Care Boards (ICBs) to gain assurance around all paediatric audiology services.
- **Wards of Concern & Accrediting Excellence** The report highlighted wards of concern raised via the professional Nurse Staffing and Clinical Outcomes Group (NSOG) along with an update on the Accrediting Excellence Programme (ACE).
- **Quality & Performance Reviews – Quality Summary** The report provided assurance following the Quality & Safety Quality Performance Reviews (QPRs) held in November 2025. The paper included a summary for each Clinical Board and areas of concern/for improvement. There were no significant areas of concern that were not already known to the Executive Team and plans are in place to mitigate risks. It was noted that the Quality & Safety functions in all Clinical Boards were improving with progression of the quality governance frameworks.
- **Management Group Chairs Logs were received for the following:**

- Patient Safety Group
- Medicines Management Oversight Group
- Promoting Equity in Health Group including Terms of Reference which were approved.
- Transplantation Committee
- Experience of Care Group

- **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.

Actions agreed in the meeting	Responsibility / timescale
1. Next update from the IPC Improvement Group to include IPC Board Assurance Framework in order to track progress of actions etc.	• Lucia Pareja-Cebrian, Joint Medical Director – January Committee
2. Next update for Ophthalmology to include comprehensive action plan with clear visibility of progress, including which actions are on or off track and reasons for variance	• Sue Hillyard, Interim Director of Operations – January Committee
3. Information in relation to harm review updates would be included in future updates from the Ophthalmology Improvement Group rather than a standalone report.	• Sue Hillyard - January Committee
4. Audiology - waiting times to be posted on the Trust Website and to include waiting times for reassessments and device upgrades	• Helen Whittaker - Associate Director of Operations, Surgical and Associated Specialties
5. Human Medicines Regulations 2012 - specific question on staff risk will be raised at the next QPRs for clarification	• Ian Joy - February meeting
Escalation of issues for action by connecting group/Trust Board	**Responsibility / timescale**
• It was felt that current arrangements in relation to palliative and end-of-life care were not acceptable and fell short of expected standards and should be escalated to Trust Board.	• Anna Stabler – December Board
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Detailed within the Board Assurance Framework	• N/A

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

People Committee - Chair's Log

Meeting: People Committee	**Date of Meeting**: 18 November 2025
Connecting to: Audit, Risk and Assurance Committee (ARAC) Trust Board	**Date of Meeting**: 27 January 2026 30 January 2026
Key topics discussed in the meeting	

- An update was provided on the year 2 people plan which included carrying out a full scope review of the people plan, the importance of ensuring triangulation between data from multiple sources and middle leadership development.
- The Committee received a Culture and Equality, Diversity and Inclusion (EDI) update which included the following items:
  - NHS England (NHSE) Sexual Safety Charter Assurance Framework Audit – The People team are working to improve the handling of sexual safety incidents and serious conduct matters, aiming for more efficient processes and a comprehensive framework in place.
  - Strategy Plan for Freedom to Speak Up (FTSU) – The plan outlined the aims and vision of the FTSU along with specific actions to achieve this. The Committee agreed to name this item a 'delivery plan'. Efforts are underway to map current FTSU champion coverage and to update the dashboard to provide clearer data on engagement and confidence, and to incorporate feedback from recent engagement events and network activities.
  - EDI update – This included an update on the Medium-Term Planning Framework for 2026/29 which embeds EDI across strategic priorities, the Integrated EDI Strategy, Equality Delivery System (EDS) and the Pay Gap reporting. The Committee approved the integration of Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES), and the EDI Improvement Plan into the Trust's people plan to streamline governance and embed EDI into the workforce strategy.
  - Anti Racism Framework – An update was provided on the anti-racism initiatives, including the involvement of Staff Networks. The importance of impactful training and awareness, as well as understanding unconscious bias at all levels, was emphasised.
- A Job Planning update was received, with final Programmed Activity (PA) change forms to be submitted to payroll by December deadline. An appeals panel has been established following receipt of job plans where agreement has not been reached by normal channels. Further guidance from the proposed national job planning strategy has been received and will be included in the planning for the rest of this year where applicable with a focus for 2026/27 planning round.
- A comprehensive updated was provided in relation to the Integrated Board Report including Workforce Profile & Demographics update. Discussions ensued regarding statutory and mandatory training, appraisals and sickness absence. It was noted that performance has decreased by -0.43% in statutory

and mandatory training and appraisal rates by -3.13% despite significant efforts.

- An update on the People Committee Board Assurance Framework (BAF) Report was provided with all current risk scores remaining unchanged. Additional controls added in relation to the Mutually Agreed Resignation Scheme (MARS) scheme, workforce reduction oversight group establishment, workforce reduction targets allocated to each Clinical Board and each Corporate service and the vacancy freeze from 1 October 2025 to 22 October 2025. The Committee ratified the BAF for Trust Board approval.
- A summary of Internal Audit reports relating to the People Committee was discussed. There are five internal audits within the Trust's 2025/26 Internal Audit Plan relating to the People Committees area of focus. Five of the internal audits are yet to be completed, assurance levels will be updated as and when the final reports are produced.
- The People Programme Board Chairs Log for October 2025 was received.
- The Guardian of Safe Working (GoSW) Report was discussed noting the expected changes to exception reporting and recognition of the increased workload and workforce capacity.
- There were no new and emerging risks.
- A discussion took place with regards to the MARS and next steps and the sickness improvement plan with Committee members.

Actions agreed in the meeting	Responsibility / timescale
1. Sexual Safety Charter Assurance Framework Audit – it was agreed that the next Committee update would include an action plan focussing on progress and impact. Lucia Pareja-Cebrian, Joint Medical Director said that it would be useful to incorporate the Surviving in Scrubs survey results into this work.	1. Amy Callow, Associate Director of People and Organisational Development (OD) / January 2026
2. Sexual Safety Charter Assurance Framework Audit (Communication) - Vicky McFarlane-Reid, Director of Commercial Development and Innovation and Executive Lead for People and OD agreed to carry out an audit of how embedded the local people team are into the Clinical Boards to assess their effectiveness in addressing people matters.	2. Vicky McFarlane-Reid / February 2025
3. EDI update – it was agreed that the Equality Duty Data set including actions would be brought back to a future Committee.	3. Karen Pearce Head of Equality, Diversity and Inclusion (People) / January 2026
4. Job Planning - Rob Harrison, Acting Chief Executive Officer, suggested bringing back an impact assessment alongside the changes to study leave, cost benefits and report findings.	4. Michael Wright, Joint Medical Director / January 2026

Escalation of issues for action by connecting group	Responsibility / timescale
• Statutory and mandatory training and appraisal rates. • Resident doctor strikes.	Bernie McCardle, Non-Executive Director & Committee Chair / November 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. 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. 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.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

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

Meeting: Finance and Performance Committee	**Date of Meeting**: 24 November 2025
Connecting to: Audit, Risk and Assurance Committee Trust Board	**Date of Meeting**: 27 January 2026 30 January 2026

Key topics discussed in the meeting

- The Family Health Clinical Board provided an update on their financial position. The Clinical Board are forecasting a £3.6m overspend for the year, primarily due to unachieved Cost Improvement Programme (CIP) targets, high nursing and midwifery spend, and unpredictable drug costs, especially in paediatric oncology. The Clinical Board is in financial escalation however robust plans are in place to address performance and financial challenges.
- Month 7 Finance report - At month 7 there is no reported variance against the planned surplus of £0.9m, with financial pressures relating to Industrial Action, the Pay Award, Drugs and an increase in costs in Clinical Supplies. The forecast outturn remains at a breakeven position.
- In relation to Capital Expenditure, at month 7 the total capital expenditure to date was £23.1m against a plan of £35.2m. In addition to this there had been £4.3m of expenditure relating to donated funds.
- The Committee received a comprehensive update on the current cash position, including the main factors influencing it, as well as cash flow forecasts to the end of the financial year and the mitigating actions being implemented to address the challenges.
- An update was provided on the commissioned independent review into the financial position and forecast outturn for 2025/26.
- The Integrated Board Report was discussed with updates on cancer targets, elective and community waiting lists, and actions being taken to address capacity constraints, particularly in Ear Nose and Throat (ENT), podiatry and children's services. In September, the 80% 28 Faster Diagnosis Standard (FDS) target was not achieved and is now showing special cause variation of a concerning nature. Emergency Department (ED) performance in September was 75.9%, a drop of 1.8% compared to August.
- A deep dive into elective waits and children & young people key performance indicators (KPIs) took place. It was noted that community waiting lists, particularly for podiatry, occupational therapy, and speech and language therapy, remain a concern. Additional capacity is being added, and service redesigns are underway, but long waits persist. The Trust is working with the Integrated Care Board (ICB) to review eligibility criteria for certain services and seeking mutual aid for diagnostic capacity. There is recognition that some issues, such as long waits for neurodivergent assessments, require system-wide solutions.

• The Board Assurance Framework (BAF) was discussed, with all risk scores remaining unchanged for risks aligned to the Committee and several new actions were added. The BAF was ratified for Trust Board approval. • An update on the Job Planning position was provided with the aim to complete all job plan reviews by the end of the calendar year, with a full review and agreement for 2026/27 job plans expected in February and March 2026. Committee members acknowledged the complexity of the process. • Procurement reports were ratified and a business case discussed. • The Committee received the Chairs Logs and minutes from the October meetings of the Capital Management Group, the Financial Recovery Steering Group, the Supplies and Service Procurement and the Access and Improvement Delivery Group. • A discussion took place with Committee members regarding the headcount position.	
Actions agreed in the meeting	**Responsibility / timescale**
1. Cash update - It was agreed that the Committee would receive a monthly cash update.	1. Jackie Bilcliff, Chief Finance Officer / December 2025
2. Procurement Report – An update to be provided with regards to the controls in place for different levels of continuous positive airway pressure (CPAP) machines adapted to patient needs and commissioning conversations.	2. Jackie Bilcliff & Dan Shelley, Procurement and Supply Chain Director / December 2025
3. Procurement Report – the Executive Team to discuss the robotics strategy.	3. Executive Team members / December 2025
4. Job Planning update to be added to the Committee Schedule of Business for December 2025 or January 2026.	4. Michael Wright, Joint Medical Director / December 2025
Escalation of issues for action by connecting group	**Responsibility / timescale**
No new escalations.	Not applicable.
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• 6.1 - Failure to manage our finances effectively to improve our underlying deficit and deliver long term financial sustainability. • 6.2 - Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care. • 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.	F&P Committee

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

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

Meeting: Finance and Performance Committee	**Date of Meeting**: 15 December 2025
Connecting to: Audit, Risk and Assurance Committee Trust Board	**Date of Meeting**: 27 January 2026 30 January 2026

Key topics discussed in the meeting

- Month 8 Finance report - At month 8 there was no reported variance against the planned deficit of £0.6m, with financial pressures relating to Industrial Action, the Pay Award, Drugs and an increase in costs in Clinical Supplies. The forecast outturn remains at a breakeven position. The recurrent and non-recurrent CIP actual position against the Plan was discussed, along with cash management controls.
- The Integrated Board Report was discussed with positive performance improvements noted in the Emergency Department (ED) arrival to admission/discharge performance indicator and the Referral To Treatment (RTT) waiting list size indicator. The Trust's participation in an NHS England coordinated validation sprint had recommenced with further reductions in the waiting list size anticipated in the third quarter.
- A deep dive into cancer and diagnostics performance indicators (KPIs) took place. It was noted that In October, the Trust delivered performance of 69.1% against the 28-day faster diagnosis standard (FDS), which was below both the national standard and the Trust trajectory. Trust compliance was heavily weighted by Skin cancer performance due to large referral numbers, with significant work underway e.g. on referral pathways, to improve the position. Improvements were made in several other performance indicators e.g. the 31 day diagnosis to treatment standard for cancer and the diagnostics 6 weeks wait standard.

  The Winter Plan and planned resident doctor industrial action were briefly discussed, with an update on the Winter Plan to be brought to the January Committee meeting.
- The Planning Framework first submission was discussed and Committee members agreed the Board Assurance Statements which had been delegated to the Committee for approval from the Trust Board. Changes from the plans (activity, finance and workforce) presented to the Trust Board on 9 December 2025 were outlined and agreed, with ongoing work and next steps summarised (with an update scheduled for both the Board Development session on 17 December and the January Committee meeting).
- The Director of Estates, Facilities and Strategic Partnerships provided a verbal update on Photo-voltaic grant funding utilisation.
- The Committee received the Chairs Logs and minutes from the November meetings of the Capital Management Group, the Supplies and Service Procurement, the Access and Improvement Delivery Group and the Sustainable Healthcare Committee.
- The Business Cases update was received for information.

Actions agreed in the meeting	Responsibility / timescale
1. Report from Rob Cooper - it was agreed that an update on progress against the recommendations be shared at the January Committee meeting.	1. Jackie Bilcliff, Chief Finance Officer / January 2026
2. Update on the Winter Plan, including the Urgent Treatment Centre (UTC) to be added to the January Committee meeting agenda.	2. Sue Hillyard, Chief Operating Officer / January 2026
Escalation of issues for action by connecting group	**Responsibility / timescale**
No new escalations [Medium Plan to be discussed at the Board Development and January Committee meetings].	Not applicable.
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
Board Assurance Framework (BAF) report scheduled for the January Committee meeting.	Not applicable.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

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

Meeting: ARAC	**Date of Meeting**: 25 September 2025
Connecting to: Trust Board	**Date of Meeting**: 30 January 2026
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:
  - Quality – there were no escalations for the ARAC. The Committee Chair provided an update on the three areas of focus at the previous Quality Committee meeting being food and nutrition, the Dental Hospital (in particular oversight of processes) and oversight of service reviews. Quality Committee members also discussed the Digital risk on the Board Assurance Framework (ARAC).
  - People – there were no escalations for the ARAC. The Committee Chair noted the challenges with some aspects of People performance, including statutory and mandatory training compliance, sickness absence and appraisal completion rates. ARAC members discussed the barriers and enablers for increasing compliance rates.
  - F&P – there were no escalations for the ARAC. The challenging financial position and mitigation plans, as well as cash management were discussed at length. Committee members discussed the deep dive into Family Health and in particular community waits for children.
  - D&D – there were no escalations for the ARAC. D&D Committee members discussed the strategic risk for the BAF, capacity to prioritise digital initiatives, the progress regarding prioritisation of digital asks, updates on information governance and data security, device upgrades and unsupported devices. Work was underway to transition the D&D Committee to having a more strategic focus.
- BAF – Updates to the BAF included the completion of actions, addition of new actions, and revisions to the timescales for some actions. A new strategic principal risk was proposed by the D&D Committee regarding digital capability. Committee members approved the assurance rating recommendations proposed. The specific risk aligned to the Committee was discussed, with two actions completed and three new actions added.
- Risk Report – As at 13 November 2025, the Trust held 381 risks (317 Open and 64 tolerated). An improvement in compliance with the quarterly risk reviews had been observed within Clinical Boards, following actions taken. ARAC members discussed the frequency of risk reviews and the work needed as part of such reviews, as well as risk training. The updated Risk Validation Group Terms of Reference were approved.
- Internal audit (AuditOne) Progress Report – 9 internal audit reports had been issues since the ARAC meeting in July, of which 4 related to the 2024/25 internal audit plan. Regarding assurance ratings – 4 were good, 4 were reasonable and 1 was an advisory report. 78% of the 2025/26 plan had commenced compared to the same point last year at 66%. An update was

shared on management actions. ARAC members were informed that the revised internal audit approach to actions was working well.

- Counter Fraud Activity Report – An update was shared on the NHS Counter Fraud Authority national review of Counter Fraud Functional Standard Returns (CFFSR) that were submitted showing full compliance. The counter fraud arrangements for PharmaServices would be consolidated into the Trust's wider work, although some bespoke work around fraud risk assessments and compliance with the Failure to Prevent Fraud offence would be required. The review of the Fraud Policy had been delayed slightly due to the introduction and implications of Conditional Cautions (low level criminal sanctions provide a new, more proportionate and less resource intensive opportunity for dealing with fraud). The Chief Executive Officer (CEO) statement on the Trust's approach to tackling fraud was approved. ARAC members discussed different considerations regarding the new Conditional Cautions. Updates on fraud cases were shared.
- Assurance was received from the People Committee that arrangements by which staff may raise concerns were operating effectively – The People Committee Chair outlined the mechanisms in place and actions taken in the previous 6-12 months e.g. an updated Speaking Up Strategy and reporting directly to Trust Board.
- Review of the Scheme of Delegation, Standing Orders and Standing Financial Instructions – minor changes were proposed and approved.
- Legal Claims – an overview of legal activity and costs in the period was provided. Data accuracy was discussed, along with complexity of cases and the work underway to review legal spend in light of the CIP.
- The Debtors and Creditors and the Losses and Compensation reports were received.
- Further work would be undertaken on the Committee self-assessment.
- Committees Chairs Logs were received for the following Committee meetings:
    - F&PC – 22 September 2025 & 20 October 2025
    - Quality Committee – 16 September 2025 & 14 October 2025
    - People Committee – 23 September 2025
    - D&D Committee – 11 September 2025
    - Compliance and Assurance Group – 6 November 2025
    - Charity Committee – 9 September 2025 & 10 November 2025
    - HTA Retained Tissue Oversight Group – 10 October 2025 & 27 October 2025
    - Risk Validation Group – 6 November 2025

Actions agreed in the meeting	Responsibility / timescale
None identified.	Not applicable.
Escalation of issues for action by connecting group	**Responsibility / timescale**
No specific escalations were identified for the ARAC.	Not applicable.
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
All BAF risks were detailed in the BAF report.	Not applicable.

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Agenda item A6(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	30 January 2026		
Title	Learning from Deaths, Quarter 2 (Q2) 2025/26 (July 2025 – September 2025)		
Report of	Rachel Carter, Director of Quality and Safety		
Prepared by	Danielle Smith, Integrated Governance Manager – Patient Safety		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	This paper aims to provide assurance to the Trust Board that the processes for Learning from Deaths across the organisation are in line with best practice as defined in the national guidance issued by the National Quality Board (NQB) on Learning From Deaths (March 2017). The paper provides a summary of the processes in place for the oversight of monitoring, reporting, learning and improvement from the review of inpatient deaths particularly those with modifiable factors. This paper details the Trust position with regards to: • Completion of Level 2 mortality reviews. • Level 2 mortality reviews requested by the Medical Examiner and those for patients with a recognised learning disability. • Maternal deaths. • Overview of Level 2 mortality reviews by HOGAN and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) scoring with analysis of learning themes. • New cases being investigated under the Patient Safety Incident Response Framework (PSIRF) where Learning from Death criteria may be met. • Summary of learning from any completed investigations during the quarter. The report is correct as of 26 November 2025 and covers data for Q2 of 2025/26.		
Recommendation	The Board of Directors are asked to: (i) Receive the report; and (ii) Note the actions taken to improve oversight and reporting in relation to continued monitoring as required by national Learning from Deaths criteria.		
Links to Strategic Objectives	Focus on Fundamentals – Deliver high quality, safe and compassionate patient care, meet our Clinical Board and Trust quality priorities.		

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

Link to Board Assurance Framework [BAF]	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.

Agenda item A6(b)

Reports previously considered by	This report forms part of the regular quarterly reporting cycle for Learning from Deaths. Previous reports were presented to the Trust Board.

LEARNING FROM DEATHS

1. INTRODUCTION

In April 2017, following the Care Quality Commission's (CQC's) recommendations on how the NHS investigates patient deaths, the National Quality Board (NQB) published a new national framework for NHS trusts, 'National Guidance on Learning from Deaths'. The purpose of this framework was to provide a more standardised approach to the way organisations identify, investigate and learn from deaths that occur under its care.

The Newcastle upon Tyne Hospitals NHS Foundation Trust publishes this quarterly report, in line with the NQB guidance, that details mortality quality metrics from inpatient deaths to provide assurance to the Quality Committee and Trust Board of the monitoring and review processes in place and the Trust commitment to learning from any deaths where problems in care have been identified so that improvements can be made.

2. REVIEW OF INPATIENT DEATHS

The Trust's Reviewing and Monitoring Mortality Policy for Adults outlines the expectation that all clinical areas adopt the overarching principles of routine and systematic mortality review, including a review of all inpatient deaths. Reviews are undertaken in two stages:

- **Level 1**: Every adult inpatient death is assessed by the clinical team to determine whether this should be referred directly to H.M. Coroner for further investigation or to the Medical Examiner (ME) for independent scrutiny and agreement of the Medical Certificate of Cause of Death (MCCD) in line with statutory requirements.
- **Level 2**: Where a need for additional review is identified due to meeting national guidance or policy criteria, or due to concerns in care identified at Level 1, clinical teams will be required to undertake a Level 2 review and record this on the Trust's Mortality Database.

Patients under the age of 18 are reviewed as part of the statutory Child Death Review (CDR) process on behalf of the local Safeguarding Board. The requirements of this process are detailed in the Reviewing and Monitoring Mortality Policy for Children and Young People Less than 18 Years.

2.1 Level 2 Reviews

On average, approximately 38% of deaths in 2024/25 received a Level 2 review (Newcastle Hospitals Quality Account 2024/25). A recent benchmarking exercise against the Shelford Group trusts and against the North East and North Cumbria trusts using data reported in each 2024/25 Quality Account found that Newcastle Hospitals placed second in both instances for reviews undertaken based on raw figures reported. However the methodologies for review, recording and reporting used in each individual trust vary significantly and therefore a true comparison cannot be made. There is no single methodology specified in the national guidance.

Figure 1 details the number of completed level 2 reviews by month over the previous 12 months up until the end of Q2 2025/26. These are shown by the date the patient died and in some cases, may include more than one Level 2 (L2) review for the same patient.

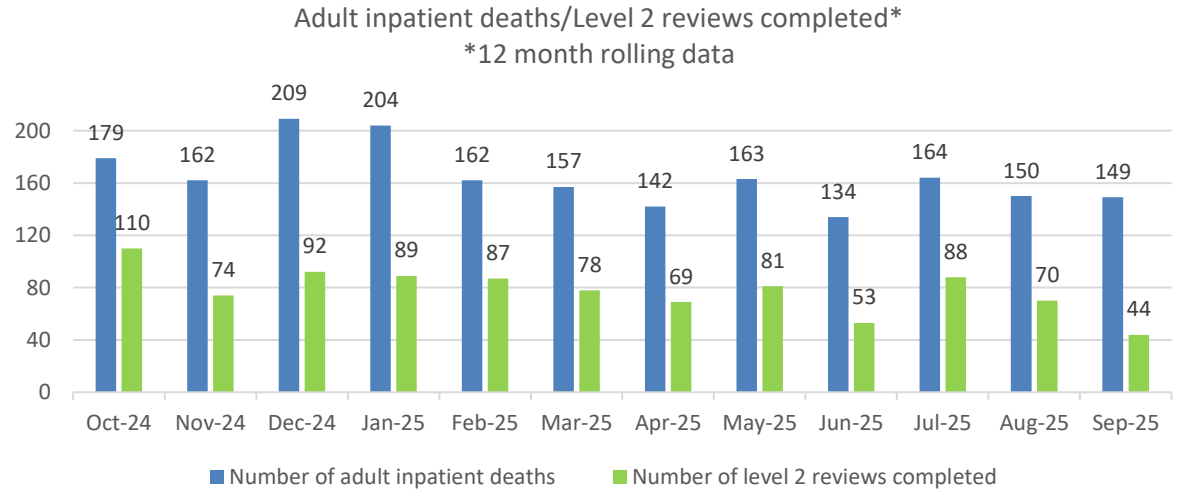

Figure 1: Number of Completed Level 2 Reviews, Oct 24 – Sep 25 (data correct as of 26/11/2025)

2.2 Medical Examiner Initiated Level 2 Reviews

From October 2024 to September 2025, the MEs referred 101 cases for L2 review. At the time of writing, 81 reviews have been completed, two are in draft, eight have not yet been started and ten have been discounted due to having been sent in error. Additionally, there are a further two cases in draft and two cases not yet started from referrals made by the MEs prior to October 2024.

Following the October 2025 meeting of the Mortality Surveillance Group in which it was noted that despite multiple reminders to the relevant clinical governance leads and escalation to Clinical Boards, there were still 32 L2 mortality reviews awaiting completion from 2024 (including those requested by the MEs), the Executive Director of Nursing requested that outstanding mortality reviews be included in each Clinical Board's November Quality and Performance Review with the expectation that these will be prioritised and a timeframe for completion to be implemented by each Clinical Board.

Figure 2 details the number of L2 reviews requested by the ME and subsequently completed from October 2024 to September 2025, broken down by month:

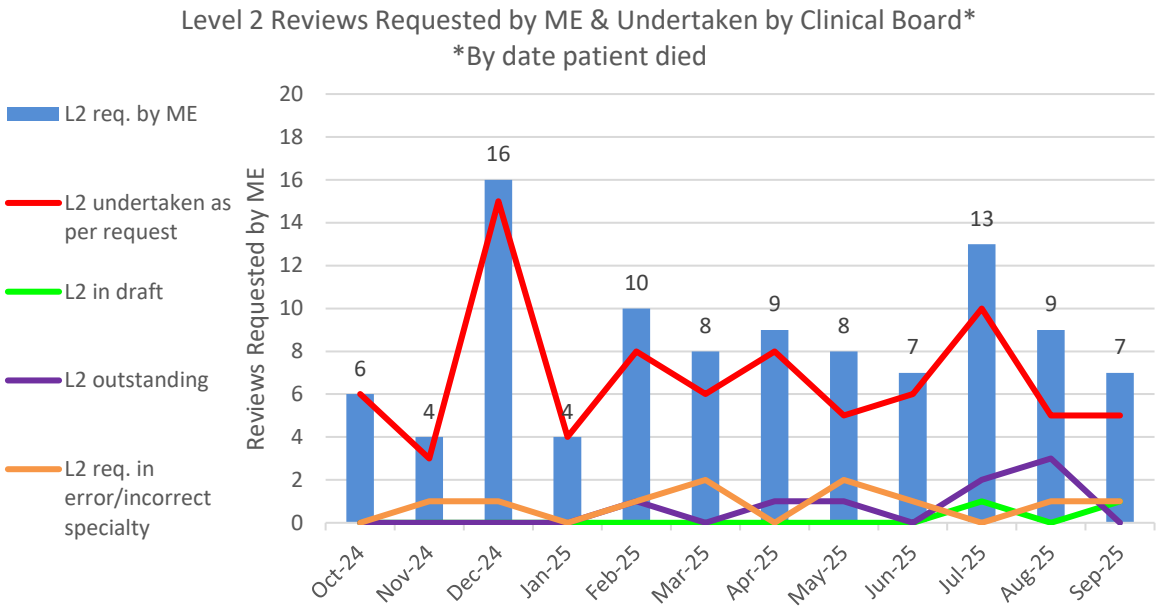

Figure 2: L2 Reviews Requested by ME and Undertaken by Clinical Board, Oct 24 – Sep 25 (data correct as of 26/11/2025)

2.3 Patients with Learning Disability

Since October 2024, there have been 40 recorded deaths of adult patients with a recognised learning disability. Of the 40 recorded adult deaths, 28 have had a Level 2 review completed by the LeDeR [Learning from Lives and Deaths – People with a Learning Disability and Autistic People] Panel. The data excludes children who are reviewed by the Child Death Overview Panel (CDOP), as was agreed nationally to avoid duplication.

In the same period, data obtained from Information Services shows that 2,601 patients with a confirmed learning disability flag on e-Record have been admitted to the Trust. This includes daycases, overnight electives and non-elective admissions. It should be noted that this data may include patients who have been counted more than once if they have had multiple admissions during the period covered.

Figure 3 provides a month by month breakdown of patient admissions, deaths and completed reviews over the past 12 months up to the end of Q2 2025/26. There is an evident increase in deaths in the first two quarters of 2025. This is partly attributable to improvements in the recognition of patients with learning disabilities and recording of these in e-Record. Data provided by the Learning Disability team shows there has been a 5% increase in the number of alerts generated to the team across all demographics and attendance types (e.g. outpatient, inpatient, Emergency Department) from Q1 and Q2 2024/25 to the same period for 2025/26.

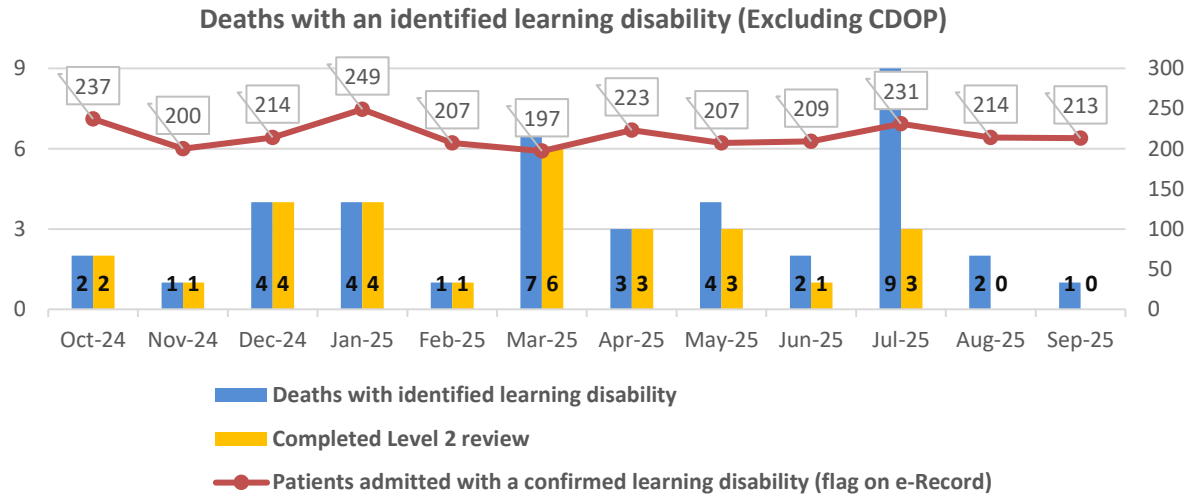

Figure 3: LeDeR Level 2 Reviews Oct 2024 – Sep 2025 (data correct as of 26/11/2025)

Each LeDeR review identifies areas of good practice and learning points. Following each LeDeR meeting these outcomes are shared with the relevant Clinical Board for onward dissemination and awareness. The recurrent key themes are as follows:

- Person centred care: Multiple examples of compassionate, person-centred care and good communication with families.
- Awareness of the Learning Disability Team and referral for input is generally good.
- Reasonable adjustments: documentation of where/ which reasonable adjustments are made for patients (or if required) is variable.
- Hospital passport: documentation of whether the patient has a hospital passport remains variable.
- Variable compliance with the compliance of capacity assessments.

2.4 Deaths within 12 Months of Pregnancy

In line with national guidance, the Trust is required to report the death of any patient who has been pregnant within the 12 months prior to death, regardless of the outcome of the pregnancy (e.g. termination, pregnancy loss or live birth) for reporting to MBRRACE-UK (Mothers and Babies: Reducing Risk Through Audits and Confidential Enquiries).

Every month, the Integrated Governance Manager – Patient Safety receives a list of all inpatient deaths from Information Services. All patients of female gender between the ages of 15 – 55 at the time of death are extracted and their hospital record number is manually cross checked both on e-Record (for terminations under Gynaecology) and on the Trust's maternity records system, Badgernet (for all other pregnancy related records), to ascertain if the patient has a record of pregnancy dated within the previous 12 months. Any cases of maternal death identified are reported in line with national reporting requirements to MBRRACE-UK and the Health Services Safety Investigation Body (HSSIB) for consideration of external independent investigation. Where a case of maternal death is referred to, and accepted by HSSIB for investigation, the case will be presented at the Trust's weekly Rapid Action Review Meeting (RARM) for recording of a Patient Safety Incident Investigation (PSII) in line with national Patient Safety Incident Response Framework (PSIRF) reporting criteria.

There have been no maternal deaths recorded in the Trust from October 2024 to September 2025.

3. LEARNING FROM DEATHS Q2 2025/26

National Learning from Death criteria indicates that, where the patient's death is more likely than not due to problems with the delivery of care, the Trust should report the case as a PSII. Where a level 2 review identifies concerns or problems with the care provided to the patient during their final admission, and is given a HOGAN score of 4 or above, or an NCEPOD score of 3, this may potentially meet the requirements for incident reporting and investigation. Such cases are escalated to RARM for review, and consideration of recording of a PSII. All HOGAN and NCEPOD gradings are presented collectively to the quarterly Mortality Surveillance Group, whilst all HOGAN ≥4 and NCEPOD 3 are discussed by the group on an individual basis.

202 level 2 reviews were undertaken of the 463 adult inpatient deaths recorded in the Trust. This equates to 43.6% of all adult deaths recorded in the quarter however it should be noted that one patient may have more than one level 2 review recorded.

3.1 HOGAN Scores

HOGAN scores are a guide as to the preventability of the patient's death and are defined as follows:

HOGAN 1	Definitely not preventable
HOGAN 2	Slight evidence for preventability
HOGAN 3	Possibly preventable but not very likely, less than 50-50 but close call
HOGAN 4	Probably preventable, more than 50-50 but close call
HOGAN 5	Strong evidence for preventability
HOGAN 6	Definitely preventable

Figure 4 provides a breakdown of reviews by HOGAN scores for the quarter:

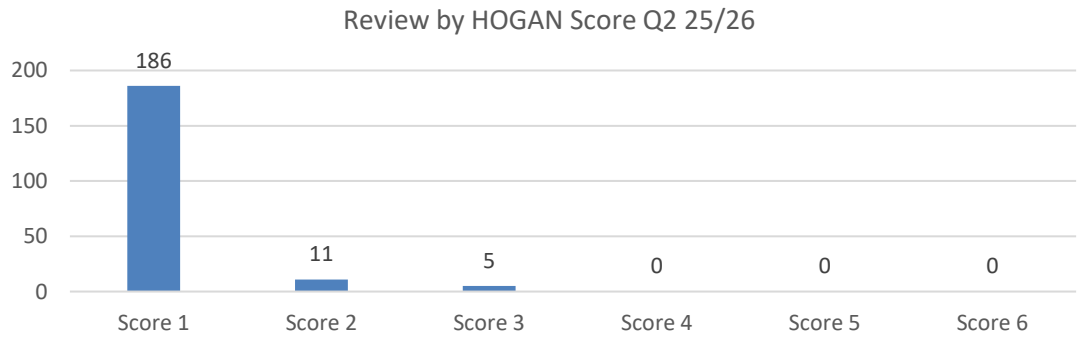

Figure 4: Q2 25/26 Completed L2 Reviews by HOGAN Scores (data correct as of 26/11/2025)

At the time of writing, none of the completed Level 2 reviews for deaths in Q2 2025/26 have been given a score of HOGAN 4 or above.

3.2 NCEPOD Scores

NCEPOD scores are a guide as to the quality of care provided to the patient during their final admission, and are defined as per the following scale:

NCEPOD 1	Good practice: A standard you would accept from yourself, your trainees and your institution
NCEPOD 2A	Room for improvement: Aspects of clinical care that could have been better
NCEPOD 2B	Room for improvement: Aspects of organisational care that could have been better
NCEPOD 2C	Room for improvement: Aspects of clinical and organisational care that could have been better
NCEPOD 3	Less than satisfactory: Several aspects of clinical and/ or organisational care that were well below what you would accept from yourself, your trainees and your organisation

Figure 5 details the breakdown of reviews by NCEPOD scores for the quarter:

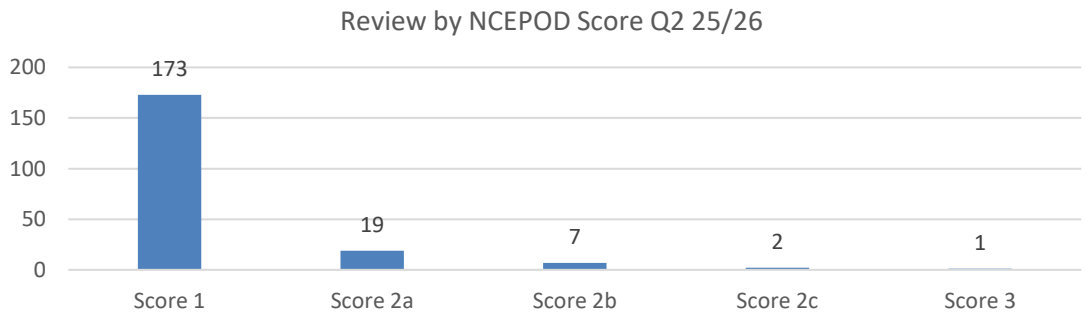

Figure 5: Q2 25/26 Completed L2 Reviews by NCEPOD Scores (data correct as of 26/11/2025)

One completed Level 2 review for a death in Q2 2025/26 has been given an NCEPOD score of 3. A further 28 reviews were given a score of 2 (either a, b or c respectively). The 29 reviews in total comprise 25 patients as 4 of the patients have had two reviews each.

The review scored NCEPOD3 related to a review undertaken by the LeDeR Panel for a patient with known cancer and learning disability. The patient died of a cardiac arrest whilst in the Trust care and the review found that the care delivered was less than satisfactory and several aspects of clinical care could have been better. The LeDeR Panel identified several learning points.

Following submission of an InPhase report by the Integrated Governance Manager – Patient Safety after the LeDeR review, a Rapid Review was undertaken by the Clinical Board in which the above learning points have been addressed locally. The Rapid Review findings were subsequently considered by the Clinical Directors – Patient Safety and Quality and RARM Chair who agreed that further discussion of the case at RARM was not required and the NCEPOD scoring should be downgraded.

3.3 Thematic Analysis of Learning Points from NCEPOD Scores

At present, documentation of learning points and actions within the mortality database is not consistently undertaken by the reviewing teams and the quality of completed reviews is variable. The fields within the review form for completion of learning points are not mandatory and the database does not offer the option to report on or track any actions that may be added. Often the reviewing team will free text the learning identified within the discussion section without documenting the specific learning points or follow up actions in

the fields provided. The database's reporting functions are limited and automated reporting from the free text is not currently viable. Improved recording and reporting is recognised as a key area for improvement within the project work to move the mortality monitoring and reporting function to InPhase in early 2026.

For the purposes of this paper, due to the limited information available in the specific learning point fields, all 29 reviews that were allocated an NCEPOD score of 2 or 3 were manually reviewed to identify any learning points contained within the free text narrative to provide additional detail, where available. In addition to the above NCEPOD3 case, of the 28 reviews in Q2 given an NCEPOD score of 2, the following recurrent themes have been identified from analysis of the completed reviews and learning points:

Theme	Overview of cases	Actions/ Outcomes
Delayed investigations/ reviews/ treatment/diagnosis	Nine of the reviewed cases identified potential concerns regarding delays during the patient's admission in undertaking investigations (gallbladder drainage, colonoscopy, etc.), medical review, diagnosis or escalation. None of these potential delays was felt to have ultimately impacted the patient outcomes (none being scored HOGAN 4 or above).	Two of the cases have been referred on for secondary review by the home specialty to address the concerns raised. (The initial L2 having been carried out by another specialty who cared for the patient during their admission) and completion is awaited. Three of the cases were referred to the home specialty for secondary review and the concerns have been addressed accordingly where either no delay was proven or action has been taken to prevent similar occurrence. The remaining four cases had local learning points identified including awareness of red flag symptoms for bowel cancer, the need to ensure good communication between medical and nursing staff, raising awareness of the use of Message Centre and ensuring documentation of follow up by surgical teams.
Communication	One case (also given an NCEPOD3 score when reviewed by LeDeR) identified learning in relation to communication with families and the need for appropriate DNACPR discussions.	To prompt at handover of ward patients.
Documentation	Four cases reviewed identified concerns related to poor quality documentation including failure to send discharge	The importance of correct documentation was discussed in all of the Morbidity and Mortality

Theme	Overview of cases	Actions/ Outcomes
	summaries to GPs, failure to submit InPhase reports for safety events, switching antibiotics without documented rationale, poor documentation following admission and postoperatively.	(M&M) meetings for each of the cases reviewed. In the case concerning the antibiotic management an action has been taken forward to present the case as further learning at the specialty governance meeting for resident doctors and Allied Health Professionals (AHPs).
Abnormal results	Two of the reviewed cases identified learning in relation to pathology results being acted on, blood antibodies in admission sample not being acted on and a low potassium level not being treated. In each case the patient's outcome was unaffected.	A comprehensive admission order set for bloods is available which teams are encouraged to use and have been reminded of correct processes to follow. Importance of following up on actions as part of planned active management.
Clinical decision making	Three of the reviewed cases identified possible learning in relation to the clinical decision making during admission. None were felt to have impacted the patient outcomes. One case queried the antimicrobial choices made at presentation in a patient subsequently confirmed post-mortem to have had legionella and whether additional cover would have been appropriate. One case considered the monitoring and treatment of hypoglycaemia in the Emergency Department (ED) and safety of transfer to another ward with low blood glucose and the third queried the decision making around not escalating to the Intensive Treatment Unit (ITU) and treatment with midodrine.	All three of the cases were referred for onward review by the relevant specialities with whom the queries were raised. Two have been completed and the concerns addressed accordingly with no further learning identified. The final case (hypoglycaemia) is awaiting completion – referred 31/10/25.
Unknown	Six cases did not have sufficient information in the review or any documented learning points completed.	Not applicable.

3.4 Other Cases Reviewed Under the Learning from Death Criteria

The Trust's RARM panel reviews any patient deaths recorded as a patient safety event via InPhase to be considered under the Learning from Deaths (LfD) criteria, in addition to cases escalated via the mortality review process. In Q2 2025/26, the RARM panel reviewed the following deaths and determined the following learning responses:

InPhase Ref	Case Summary	Date Presented RARM	Agreed Learning Response
13527	Patient high risk for self-harm died following suicide. Delayed referral to Psychiatric Liaison Team (PLT) due to unclear referral processes (now resolved).	29/09/2025	After Action Review (not considered to meet LfD criteria)
13679	Repeated clotting of Continuous Veno-Venous Haemofiltration (CVVH) filters leading to inability to establish adequate renal replacement therapy contributed to patient experiencing hyperkalaemic cardiac arrest and subsequent death.	29/09/2025	PSII (meets LfD criteria)

3.5 Completed Investigations and Learning

Completed PSII investigations are presented to the Trust's monthly Patient Safety Incident Forum (PSIF) for scrutiny and final report approval. No completed investigations relating to cases concerning deceased patients were presented in Q2 2025/26. The September 2025 meeting of PSIF was stood down due to there being no cases due for presentation.

4. RECOMMENDATIONS

The Board of Directors are asked to:

(i) Receive the report; and
(ii) Note the actions taken to improve oversight and reporting in relation to continued monitoring as required by national Learning from Death criteria.

Report of Rachel Carter
Director of Quality and Safety
26 November 2025

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PUBLIC BOARD MEETINGS - ACTIONS

Agenda item A6(c)

Log No.	BOARD DATE	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
155	28 November 2025	25/26 STANDING ITEMS iv) Chief Executive's Report, including Care Quality Commission (CQC) update	As referred to in the earlier Chair's update, the outcomes from the scrutiny/review at CDDFT would be mapped against the revised Trust governance system in Newcastle Hospitals to ascertain whether any further improvements were needed. Patrick Garner and Rachel Carter had been asked to undertake a joint piece of work in relation to this, with their findings to be presented to the Quality Committee in February 2026 [ACTION01].	PG/RC			13/01/2026 - Item added to the February Quality Committee agenda. Propose to close action.
156	28 November 2025	25/26 STANDING ITEMS iv) Chief Executive's Report, including Care Quality Commission (CQC) update	The launch of the national centre for neurotechnology and neuro restoration, being the first centre of its kind in the United Kingdom (UK). The collaboration with researchers from the United States, and the benefits of being co-located with Newcastle University, were expected to deliver significant benefits to patients, creating a unique relationship. Gratitude was expressed to all involved and a detailed update would be shared with the Board [ACTION02].	KJ/LT			20/01/2026 - LT emailed Akbar Hussain to arrange.
157	28 November 2025	25/26 STANDING ITEMS iv) Integrated Board Report (IBR)	The impact on Trust delivery and on patients in terms of sickness absence and how this was measured. Sue Hillyard agreed to ascertain whether a report could be generated/data collated relating to when clinics/appointments were cancelled due to staff sickness absence to identify the impact on patients [ACTION03].	SH			22/01/2026 - SH confirmed that clinical cancellation reasons by staff sickness is not collected. Propose to close action.
158	28 November 2025	25/26 STANDING ITEMS iv) Integrated Board Report (IBR)	It was noted that the Finance and Performance Committee received a deep dive into cancer performance 3-monthly. Annie Laverty suggested carrying out a patient engagement piece of work with cancer patients and it was agreed to discuss through the Executive Team meeting [ACTION04].	AL			22/01/2026 - Discussed at the Executive Team meeting on 17 December 2025. Wards 33, 24 and 35 (Northern Centre for Cancer Care) included in the Real Time Patient Experience Programme. No further action proposed.
159	28 November 2025	25/28 ITEMS TO RECEIVE i) Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress report	The patient experience programme response rate had been low and further work was needed on gynaecology pathways, with a gynaecology service review underway. Further work is required within gynaecology services which will be addressed through a future Quality Committee [ACTION05].	IJ/JW			13/01/2026 - Item added to the January Quality Committee agenda. Propose to close action.

Log No.	BOARD DATE	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
160	28 November 2025	25/28 ITEMS TO RECEIVE d. People Update: Sexual Safety Audit	Anna Stabler raised difficulty in finding the lead for Sexual Safety on the staff intranet to which Vicky McFarlane-Reid agreed to ensure the intranet was updated to show the correct lead [ACTION06].	VMR			20/01/2026 - Website updated with the correct lead, Tracy Mitchell. Propose to close action.

KEY

NEW ACTION	To be included to indicate when an action has been added to the log.
ON HOLD	Action on hold.
OVERDUE	When an action has reached or exceeded its agreed completion date. Owners will be asked to address the action at the next meeting.
IN PROGRESS	Action is progressing inline with its anticipated completion date. Information included to track progress.
COMPLETE	Action has been completed to the satisfaction of the Committee and will be kept on the 'in progress' log until the next meeting to demonstrate completion before being moved to the 'complete' log.