The Newcastle upon Tyne Hospitals NHS Foundation Trust

Public Trust Board of Directors
Friday 27 March 2026, 10:00 – 12:00
Piano Room, Royal Victoria Infirmary (RVI)

Agenda

	Time	Item	Purpose	Lead
1.	**Introduction**			
a.	10:00	Apologies for absence and declarations of interest	For discussion	Paul Ennals
b.	10:01	Minutes of the Public Board of Directors meeting held on 30 January 2026 and matters arising	For discussion & approval	Paul Ennals
c.	10:02	Chair's Report	For discussion & assurance	Paul Ennals
d.	10:08	Chief Executive Report	For discussion & assurance	Rob Harrison
2.	**Focus on Fundamentals – Quality, Performance and Finance**			
a.	10:15	Patient and Staff Stories	For assurance	Ian Joy
b.	10:22	Board Visibility Programme	For discussion & assurance	Rachel Carter
c.	10:30	Integrated Board Report (IBR)	For discussion & assurance	Patrick Garner & Executive Leads
d.	10:40	Finance, Activity and Workforce Plan update	For discussion & assurance	Patrick Garner & Jackie Bilcliff
e.	10:48	Joint Medical Directors Report including: i) Mental Health update	For discussion & assurance	Michael Wright & Lucia Pareja-Cebrian
f.	10:56	Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs) Report	For discussion & assurance	Ian Joy
g.	11:05	Maternity: i) Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress report	For discussion & assurance	Jenna Wall
h.	11:12	Aubrey Self-Assessment	For discussion & assurance	Patrick Garner & Rachel Carter
3.	**Make it better for colleagues – IT, People and Estate**			
a.	11:22	NHS staff survey, Workforce Race Equality Standard (WRES) and	For discussion & assurance	Vicky McFarlane-Reid

	Time	Item	Purpose	Lead
		Workforce Disability Equality Standard (WDES) results		
4.	**Look to the future – Strategy, Neighbourhood Teams and GNCH**			
a.	11:30	Shine (Sustainable Healthcare in Newcastle) – Interim Update	For discussion & assurance	Russ Jones
5.	**Items to approve**			
a.	11:35	Board Assurance Framework (BAF)	For approval & assurance	Patrick Garner
b.	11:40	Trust Board and Committee Terms of Reference and Schedules of Business 2026/27	For approval	Kelly Jupp
6.	**Items to receive *[To cover by exception only]***			
a.	11:45	Committee Triple A reports	For receipt	Committee Chairs
b.	11:50	Learning from Deaths Report	For receipt	Rachel Carter
c.	11:55	Meeting Action Log	For receipt	Paul Ennals
7.	**Any other business**			
a.	11:56	Any other business	For discussion	All

Date and Time of Next Meeting: Friday 22nd May 2026, 10:15 – 12:15, Piano Room, Peacock Hall, RVI

Sir Paul Ennals, Chair
Mr Rob Harrison, Acting Chief Executive Officer
Mr Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals
Dr Michael Wright, Joint Medical Director
Dr Lucia Pareja-Cebrian, Joint Medical Director
Dr Vicky McFarlane-Reid, Executive Director of People and Commercial Innovation
Mrs Jackie Bilcliff, Chief Finance Officer
Mr Russ Jones, Deputy Director of Estates, Strategy, Planning & Capital Development
Mrs Rachel Carter, Director of Quality and Safety
Mr Patrick Garner, Director of Performance and Governance
Mrs Jenna Wall, Director of Midwifery
Mrs Kelly Jupp, Trust Secretary

PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 30 JANUARY 2026

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	Interim Director of People & Commercial Development
	Sue Hillyard	Interim Executive Director of Operations
	Bill MacLeod	Non-Executive Director (NED)
	Liz Bromley	NED
	Anna Stabler	NED
	Bernie McCardle	NED
	Hassan Kajee	NED
	Phil Kane	NED
	Wendy Balmain	NED

In attendance:
Nini Adetuberu, Associate NED
Judith McKenna, Associate NED
Paul Hanson, Director of Estates, Facilities and Strategic Partnerships
Caroline Docking, Director of Communications and Corporate Affairs
Rachel Carter, Director of Quality and Safety
Dave Elliott, Chief Digital Officer
Martin Wilson, Director - Great North Healthcare Alliance (GNHA) & Strategy
Patrick Garner, Director of Performance and Governance
Amy Callow, Director for People and Organisation Development
Kelly Jupp, Trust Secretary
Jenna Wall, Director of Midwifery *(for item 26/02 g. i))*
Sam Richardson, Chief Registrar *(for item 26/03 b.)*
Lee-Ann Naidoo, Improvement Programme Manager *(for item 26/03 a.)*
Ilisha Purcell, Equality, Diversity and Inclusion (EDI) Manager *(for item 26/03 a.)*

Observers:
Tania Bell, Member of the public
James Boyle, Enterprise Accounts Manager - Medtronic UK and Ireland

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.

26/01 FORMAL MEETINGS AGENDA:

a. Apologies for Absence and Declarations of Interest

Apologies were received from David Weatherburn, NED.

The Board welcomed Judith McKenna, who formally commenced her role as an Associate NED at the Trust from today.

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

b. Minutes of the previous meeting held on 28 November 2025 and matters arising

The minutes of the meeting held on 28 November 2025 were accepted as a true record of the business transacted.

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

c. Chair's Report

The Chair's Report was received for information.

Paul Ennals highlighted the following points:

- Today was the third day of the Urgent Treatment Centre (UTC) being in operation, with staff demonstrating the high quality of services being provided from the new facility.
- A successful visit to the maternity service was recently undertaken, with the Chair of NHS England (NHSE) Penny Dash.
- The positive work on theatre optimisation, with thanks expressed to all staff involved.
- A ministerial visit to the Clinical Diagnostic Centre (CDC) took place yesterday, with the visit being well received.

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

d. Chief Executive's Report

Rob Harrison highlighted the following points:

- Focus remained on ending the financial year as strongly as possible, building on the progress made during the year to date.

- In relation to the NHS Oversight Framework (NOF) rating, the Trust moved positively from 29th to 22nd, which reflected the commitment and hard work of colleagues across the organisation.
- Appreciation was expressed to all teams for their contributions, particularly during winter pressures and the busy period leading up to Christmas.
- In terms of finance and performance, preparation for quarter 4 was underway, ensuring the organisation was fully prepared for the next phase of plans. There remained a continued focus on financial balance and making the best use of available resources.
- Multiple areas were progressing well following estates developments, which included department openings and new build construction schemes, supported by excellent work from the Estates team.
- Successful delivery of the Royal Victoria Infirmary (RVI) decant project, which included neonate patients. The complexity of undertaking such activity on a live hospital site caring for high-risk patients was acknowledged.
- Planned infrastructure upgrades would support improved quality of care, better performance and access for patients.
- In terms of the recent external Well Led Review, the report recognised significant progress, whilst also identifying areas for further improvement that would inform planning activities for next year.

  Priorities from the Well Led report included strengthening leadership and management, supporting culture and people and enhancing the organisational development approach. Ongoing attention would continue on improving financial discipline and resource utilisation.

  All priorities aligned with the development of the organisation's new five-year strategy.
- There was a key focus on capturing learning from achievements this year to commence the next period from a positive starting point.
- A commitment to ending the current year strongly to position the organisation for future success.

A discussion ensued which covered the following areas:

- Regarding the elective sprint funding, it would be useful to undertake a benefits realisation analysis to ensure the investment delivered the most benefit for patients.
- The need to be clear on what could realistically be delivered in 2025/26, using a rapid process to identify and agree activity levels. It was noted that the elective sprint requirement represented a step-up from quarter 2 and quarter 3, with capacity for up to 8,000 additional patients.
- The importance of delivering as much activity as possible for patients, particularly those facing the longest waits and within cancer pathways, which remained critical priorities. Discussions continued with regional commissioners that any elective sprint activity undertaken in February/March 2026 should maintain a clear focus on patient benefit and must not adversely affect the organisation's year-end financial position.
- The clear processes in place for managing delivery through to year-end.

- The importance of aligning key priorities within the organisational structure to ensure coherent delivery.

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

26/02 FOCUS ON FUNDAMENTALS – QUALITY, PERFORMANCE AND FINANCE:

a. Patient and Staff Stories

Ian Joy advised that patient experience remained a key priority and it was important to share patient and staff insights with the Board of Directors, including those emerging from the real-time feedback programme.

The patient story presented highlighted the organisation's position as both a district general hospital and a tertiary centre, where a patient's experience spanned more than one NHS organisation which can impact their ongoing care and outcomes. The story illustrated the wider system impact of care delivered across multiple providers and reinforced the need for strengthened collaboration with the Alliance and with wider system partners to ensure consistency and improve experience across pathways. The story shared was an example of the broader challenges around communication, pathway complexity, and the lived experience of patients. It demonstrated the importance of ongoing pathway work to improve integration and inform future discussions with partners.

[Jenna Wall joined the meeting at 10.28am].

A discussion ensued which covered the following areas:

- The importance of the Alliance having shared ambitions for a joined-up model of care, recognising that patients move across primary, community and acute pathways.
- That patients expect services to be connected and for information to flow smoothly between organisations.
- National work was underway to develop a single patient record, with NHS England (NHSE) exploring a central repository for core patient information.
- The Great North Care Record (GNCR) continued to support regional information sharing, though it did not yet provide access to full patient records at the bedside, with enhancements being explored.
- Concerns raised about some patients viewing results online/through the NHSApp before having had the chance to discuss with their clinician(s), which highlighted the need for improved communication approaches across organisations.
- A question was raised relating to compliance with National Institute for Health and Care Excellence (NICE) recommendations and best practice guidance on delivering difficult diagnoses, particularly ensuring that such conversations occur face to face rather than by telephone. The importance of patients receiving clear information about next steps was discussed at the Clinical Risk Group, and it was recognised that digital tools such as QR codes were not suitable for all patients. Lucia Pareja-Cebrian agreed to provide assurance on the process regarding the delivery of test results by

clinicians prior to release on NHSApp **[ACTION01]**. It was noted that patients may have different preferences as to whether they engage face to face or via telephone.

- Care navigation and coordination at the point of diagnosis was not always consistent across services and further work was being explored.
- The patient experience detailed within the story was concerning, particularly in relation to appointment cancellations/poor coordination of appointments and communication issues. The importance of identifying specific actions to prevent recurrence of the issues detailed in the story, and to strengthen system-wide working across the Alliance, was noted.

Ian Joy explained that mechanisms were being explored to ascertain how patient and staff stories could be used to inform pathway reviews and improvement work, with updates to be included in the next Board report. Complaints data was monitored through the Quality Committee, and it continued to evidence the significant impact that experiences within services had on overall patient experience.

Ian Joy acknowledged the important contribution of administrative and security colleagues in shaping patient experience and supporting safe effective services. The staff story by Ken Marshall brought to life the role all staff play in delivering high-quality care and demonstrated the meaningful difference staff actions can make.

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

b. <u>Trust response to the Grant Thornton Well Led review</u>

Ian Joy highlighted the following points:

- The report provided an overview of the findings identified in the external well-led review by Grant Thornton and the improvement themes which arose from the 2024 Care Quality Commission (CQC) inspection findings. The resulting CQC action plan has already led to measurable improvements, with progress triangulated and validated by colleagues externally.
- A series of themes, recommendations, and areas for development were discussed previously at a Board Development Workshop, ensuring shared understanding of the required next steps.
- Workstreams addressing the recommendations were already established, and a cohesive, organisation-wide action plan was being developed to draw these together.
- The Provider Capability Assessment had been submitted to NHSE, the results of which would be be triangulated with the Well-Led action plan to ensure alignment and avoid duplication.
- The recommendations would be aligned to specific Executive Team members, who would refine and agree detailed actions by the end of February 2026.
- The governance framework supporting both the Provider Capability Assessment and the Well-Led improvement actions was now in place. Oversight of progress and assurance would be provided through the Audit, Risk and Assurance Committee, ensuring appropriate governance and monitoring.

Anna Stabler noted that the interviews for the well-led report were held in August 2025 and therefore were reflective of that point in time. Many improvements had already been made however it was acknowledged that cultural change would take time to embed. Several Improvement Groups were fully established and reporting into the Quality Committee.

Anna Stabler sought assurance whether the People team had sufficient capacity to support the cultural change needed to which Amy Callow acknowledged that current capacity was constrained. However discussions were underway as to a potential People and Organisational Development (OD) Directorate restructure, with the aim of strengthening resources and capability in this area. It was noted that the issues identified would require longer-term sustainable solutions rather than short-term fixes.

Paul Ennals highlighted that the work had progressed well and that there was a clearer and more structured method for using the outcomes from reviews to inform assurance and decision-making regarding the actions required.

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

c. Board Visibility Programme

Rachel Carter advised that the previously paused stream 1 leadership walkabouts had now been reinstated and were progressing well. Stream 2 activity continued uninterrupted, with NED walkabouts running alongside leadership visits.

A wide range of areas had been visited, including non-clinical departments, reflecting a deliberate effort to gain a broader view of organisational culture and operational issues while maintaining the focus on putting patients at the centre of care. Staff had continued to be open and honest, with any immediate concerns addressed or escalated at the time.

Estates issues raised during visits were either already part of an agreed plan or had a clear route into existing estates programmes, and concerns relating to System One and instances of incivility were dealt with promptly.

Rachel Carter explained that a recommendation had been made in the external well-led report to measure the effectiveness of the programme. A survey had been drafted with the Trust Secretary which would be issued next week to Clinical Boards and senior teams to gather feedback and support further improvements in the Board Visibility Programme. It was agreed that the results of the survey will be included in a future report **[ACTION02]**.

Rob Harrsion noted that the report did not fully reflect the breadth of ad hoc visits undertaken by Executive Team members and senior leaders, as well as the insights gathered through informal conversations. The wider cultural themes were expected to be captured more comprehensively as part of the staff survey.

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

d. Integrated Board Report (IBR)

Patrick Garner highlighted the following points:

- The Emergency Department (ED) admission-to-discharge standard had shifted from showing special cause variation of an improving (low) nature to common cause variation. This change sat against a backdrop of significant operational pressure, and reflected the exceptional work delivered by teams in recent months.
- The 28-Day Faster Diagnosis Standard (FDS) has been formally escalated to the Executive Team through the Quarterly Performance Reviews (QPRs). Although demand had increased, an improvement would typically be expected at this point in the year however this had not yet materialised, prompting escalation.
- In terms of 65 week wait performance, the number of patients waiting over 65 weeks had decreased to 49. The Trust did not meet the NHSE trajectory and recorded 40 remaining breaches however plans remained on track to reduce this to zero by the end of the financial year.
- The total waiting list size decreased significantly in November to 86,575.

[Sam Richardson joined the meeting at 10.53am].

Jackie Bilcliff noted that the report reflected the Month 8 financial position however that at Month 9, the Trust remained on plan and was working collaboratively with other NHS organisations in the region to balance the overall Integrate Care System position. Work was also underway to support financial planning for 2026/27.

Ian Joy highlighted a typographical error in the safeguarding adults training figure. A data cleanse had been completed to correct this, and the accurate compliance rate was 86% (previously reported as 83%).

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

e. <u>Director reports:</u>

i) <u>Joint Medical Directors (JMD) Report</u>

Michael Wright highlighted the following points:

- The Emergency Department continued to experience significant demand, with sustained operational pressure across the service.
- The opening of the UTC had already improved the care environment for patients and was expected to transform patient pathways, with full benefits anticipated over the coming weeks and months.
- Corridor care remained a significant pressure and an area of focus, as highlighted in previous reports.
- Staff continued to show strong commitment and endeavours to improving service delivery despite service pressures.
- Patient experience remained positive, with consistently high levels of satisfaction, particularly regarding waiting experience and quality of care within the Emergency Department.
- Cancer performance continued to be a major concern, with ongoing compliance challenges against the 28-Day FDS and the 62-day target from the point of referral.

Challenges were most evident across Lower GI, Upper GI, Lung, and Urological suspected cancer pathways. Recovery actions were in place, and a meeting would take place next week to progress improvements.

- Work continued on Quality & Safety and Patient Safety Incident Response Framework (PSIRF) plans, particularly focusing on data and procedural elements required to strengthen patient safety processes.
- Concerns remained regarding mandatory training compliance for some Medical & Dental staff. The People Committee had sought assurance in relation to this, and Clinical Boards were developing a targeted improvement plan to support delivery of the targets.

A discussion ensued which covered the following areas:

- The UTC had experienced some queues initially at reception which had extended outside of the building. The situation was being closely monitored to understand the causes of the delays. Daily improvement work was underway to address the reception flow and reduce queueing, and these actions were expected to deliver significant improvement over the next couple of weeks.
- Clarity was requested on the cancer performance trajectory, the impact on patients, potential improvements and expected timescales. It was noted that while achieving compliance was important, the priority was ensuring the best possible outcomes for patients. Each tumour site had a defined improvement plan, which would be referenced at the next Board of Directors meeting. In-depth pathway audits were underway, with targeted interventions (e.g., in the lung cancer pathway) and refreshed action plans. Findings would be reported through the Finance and Performance Committee.
- A query was raised regarding work with system partners to shorten cancer pathways and if the Alliance was working at pace to support improvements. It was highlighted that progress was variable across partners, but this remained a key priority area. Work was underway to identify further opportunities to accelerate pathways. A deep dive into the lung cancer pathway had been completed, with a clearer timeline now established for patients.

  Work continued with partners to ensure a greater proportion of patients move through pathways efficiently, with strong collaboration across organisations. A further update would be provided at a future meeting **[ACTION03]**.

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

ii) Guardian of Safe Working (GoSW) Report

Lucia Pareja-Cebrian highlighted the following points:

- The report highlighted an increase in exception reporting from the Trust's 1,200 resident doctors, with more reports submitted in this period than previously.
- Significant changes that would come into effect next week, which included:
  - Exception reports being routed directly to HR rather than needing to go via the appropriate supervisor.

- Improved identification of resident doctors who repeatedly worked beyond their contracted hours, enabling targeted support to be provided. There was ongoing work to address the concerns raised through the exception reports.

- The increased reporting volume also carried a financial impact, which would be reviewed further. An update would return to the Board of Directors and People Committee in due course.

A discussion ensued which covered the following areas:

- The current reporting system and risks associated with the system readiness. It was advised that the digital system required doctors to submit reports directly, which was a national issue as the system was not yet fully ready.
- Analysis was underway to understand pressure points and ensure reporting was used effectively to manage workload across the organisation. This work would help identify whether resident doctors were deployed in the right areas. Further analysis would continue over the next year to understand patterns, drawing on learning from the nursing establishment review to help balance risk and identify support opportunities.

  A suggestion was made that this may be an area for the Finance and Performance Committee to consider in the future, particularly regarding assurance around controls and trend analysis.

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

f. Executive Director of Nursing, Midwifery and AHPs Report

Ian Joy provided an update on safe staffing, confirming that local mitigations were in place with strong oversight, and that wards and departments continued to be appropriately staffed. He also reported that vaccination uptake had increased to 64%, positioning the Trust 14th nationally however following a data cleanse, the Trust was now ranked 4th, with the final national position to be confirmed in February 2026.

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

g. Maternity

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

Jenna Wall highlighted the following points:

- Positive CQC maternity survey results were received, reflecting strong feedback from service users and improved performance across postnatal and antenatal services.
- The data quality issues previously reported had been resolved, with the quarter 3 dashboard updated to remove duplicate entries.
- The Maternity Incentive Scheme (MIS) was approaching the end of year 7, with a proposal to confirm compliance with all 10 safety actions, supported by the Head of Obstetrics.
- The following was noted in relation to the 10 safety actions:

- Safety action 1 - The Trust Board had received the quarterly Perinatal Mortality Review Tool reports, which outlined compliance with standards. In addition, this would be externally verified by Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBBRACE).
- Safety action 2 - The Trust had received confirmation from NHS Digital of compliance with the standards.
- Safety action 3 - The Trust had provided the required quality improvement project updates to the Safety Champions and Local Maternity and Neonatal Systems (LMNS) who had verified compliance with the standard.
- Safety action 4 - The Board of Directors and Quality Committee had received all of the required audit and workforce information for every staff group and had formally recorded compliance with the relevant standards in the Board of Directors minutes. The only outstanding action related to the Qualified in Specialty (QIS) standards, which had been escalated to the LMNS and Operational Delivery Network (ODN) and were now being monitored through the risk register.
- Safety action 5 - The Board of Directors had received the biannual staffing paper and staffing action plan which outlined compliance with the standard.
- Safety action 6 - The LMNS and ICB had verified compliance with the standard, and the completion of two quality improvement discussions. The ICB tool had been used rather than the national tool, with confirmation received from the ICB of suitability.
- Safety action 7 - The Trust had escalated the absence of an appropriately commissioned and functioning Maternity and Neonatal Voices Partnership (MNVP) via the Perinatal Quality Oversight Model (PQOM) at Trust, ICB and regional level.
- Safety action 8 - The Quality Committee and Board of Directors regularly received the Integrated Board Report (IBR) which outlined the Trust's compliance with this standard. An action plan was not required as 100% of trainees would have completed training within 6 months of joining the organisation by 31 January 2026.
- Safety action 9 - The Board of Directors and Quality Committee received the Perinatal Quality Surveillance Maternity (PQOM) papers, the IBR with perinatal minimum data sets and the Maternity Safety Champion reports. The LMNS, ODN and ICB had verified compliance with this standard as part of the quarterly PQOM meetings with the Trust.
- Safety action 10 - The Board of Directors had received the required information to be compliant with this standard within the AdminControl Reading Room. In addition, this would be externally verified by the Maternity and Newborn Safety Investigations (MNSI) and NHS Resolution.

- The Trust self-assessed position was compliant with all 10 safety actions.

Ian Joy advised that a secondary conversation would take place with Marie Smith, Head of Obstetrics, to confirm consistency with the self-assessed position and the Board of Directors would be updated on the outcome **[ACTION04]**.

Anna Stabler noted that the actions taken through the Quality Committee over the past year had been significant, and congratulated the team on successfully achieving the 10 standards.

The Board of Directors approved, subject to confirmation of appropriate assurance and challenge from the Head of Obstetrics. It was noted that the submission was expected originally to be completed in February however the ICB timetable had recently been brought forward.

It was **resolved**: to **receive** the report and **approve** the self-declaration of compliance with the 10 safety actions subject to the above referenced conversation with the Head of Obstetrics.

ii) Maternity Safety Champion Report

Liz Bomley highlighted the strong culture of putting patients first and prioritising patient safety, noting the effective leadership driving actions that were making a tangible difference. She reported that patients and families had been engaged openly, with staff demonstrating honesty about their experiences during a period of significant change. Estates issues had been appropriately escalated to the relevant departments, recognising that ongoing challenges were inevitable in a large organisation. Despite this, both patient and staff experience continued to show improvement.

Paul Hanson talked through the 2025/26 Capital Plan and reminded the Board that it was closely aligned to a set of clinical priorities which explicitly included investment to improve the experience of babies, parents and colleagues working to care for them.. A £10m programme was underway across the estate, supported by construction partners who remained highly engaged. Of this, £3m was being delivered this year with a further £3m planned in 2026/27, ahead of a wider remodel and reconfiguration planned for 2027/28 as part of the forthcoming five-year capital plan. In addition, £2m of investment was being directed into the delivery suite, with further elements incorporated into the work already in progress. These developments remained a priority, with continued close collaboration with Trust leadership to maintain momentum and ensure delivery.

Ian Joy reported that the gynaecology pathway matter had been escalated to the Quality Committee, where a transformation plan for this service area had now been considered.

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

h. Developing the Service Review Programme in Newcastle Hospitals

Sue Hillyard advised that the document had previously been scrutinised through Private Board of Directors and that a formal, comprehensive service review programme was now in place to support the development of sustainable services. This programme provided a structured, tiered approach to reviewing clinical services amid concerns around future sustainability.

Sue Hillyard noted that further information would be reported to the Private Board of Directors meeting in February 2026, specifically relating to Cardiothoracic and HPB services, which had been under review following escalation through the QPR process. The programme was now moving onto work in ophthalmology, where a formal service review had already been undertaken, but with a more detailed format now being applied.

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

26/03 MAKE IT BETTER FOR COLLEAGUES – IT, PEOPLE AND ESTATE

a. Anti-racism framework

Caroline Docking introduced the item and highlighted the strong senior support for Equality, Diversity and Inclusion (EDI) and anti-racism, particularly through the Trust Management Group (TMG) and the People Committee. The work was largely led by a small task group, which had led to some frustration about the pace of progress.

Lee-Ann Naidoo and Ilisha Purcell highlighted the following points:

- Clarity on what the initiative meant was essential, particularly in ways that resonate with people of colour and reflect lived experience.
- A structured framework was needed and had been developed to guide progress. The framework was focused on four main areas, being:
    - Education – improving understanding, awareness and capability around equity and anti-racism.
    - Representation – ensuring diverse voices were included and influenced decision-making.
    - Culture change – embedding inclusive behaviours and a safe working environment.
    - Action and accountability – shifting from statements of commitment to visible, measurable delivery and assurance.
- Strengthening the framework supported a move from intent to demonstrable action and evidence of impact.
- Inequalities had a direct effect on patients, with people of colour more likely to require care and more likely to report poorer experiences and outcomes.
- Improving equity for marginalised groups ultimately improved care for everyone, benefiting all patients and staff.
- Gaps in healthcare education and research such as under-representation, limited funding, and inadequate training (e.g. recognising pressure ulcers on darker skin) contributed to unequal experiences and outcomes.
- Feedback relating to racism highlighted how discrimination makes both patients and staff feel less safe, less welcome, and less confident in the service.

Caroline Docking explained that colleague evidence had highlighted the need for change and influenced the development of the EDI framework which was presented for Board of Directors approval. Although significant work remained, early actions planned/in progress included an organisation-wide awareness campaign, refreshed EDI structures and

establishing EDI representatives within each Clinical Board. Maternity services were already leading their own anti-racism work. All Clinical Boards had EDI-related actions, and these now needed to be aligned within the wider framework to improve both patient and staff experience.

A discussion ensued which covered the following areas:

- The importance of reminding colleagues that the work was grounded in real experiences, with concerns about race and behaviours evident within some areas of the organisation, and the need for a safe and confidential environment.
- The approach taken was welcomed, noting the collective focus on improving patient and staff experience and its clear links to improved quality, safety, and outcomes.
- A detailed discussion took place at the People Committee, with the anti-racism framework being an important piece of work being delivered with commitment and passion.
- Board members reflected personally on the need to consider their own behaviours and contribution.
- The need for the anti-racism framework to align with the Trust's health inequalities strategy, noting strong links with deprivation and the broader Trust objectives.
- The importance of good practice, such as the work in maternity, being actively shared across the organisation.
- The need for a clear position and meaningful actions.

Hassan Kajee thanked colleagues leading the work and highlighted the personal importance of the agenda. He reinforced that Board members must offer support and invest appropriately to achieve the intended impact.

It was **resolved**: to **receive** the report and **approved** the antiracism framework.

b. <u>Resident Doctors 10 point plan update</u>

[This item was discussed after item 26/02 e. ii)].

Sam Richardson highlighted the following points:

- The weekly Steering Group continued to demonstrate strong engagement and positive energy, with members actively highlighting issues that fall outside the scope of the national 10-Point Plan.
- The Steering Group was meeting the minimum national requirements and was ahead of trajectory in several areas, with progress indicating the potential to deliver more than expected.
- Some areas would benefit from increased pace and further development, though these were dependent on national or regional approaches rather than local control.
- Visible progress was already being made, with physical changes underway and clear action plans in place to support ongoing improvements.
- A particular focus was being placed on facilities and their impact on the working lives of resident doctors, including issues such as locker space, which forms part of the NHSE 10-Point Plan. Further improvements were expected as more physical changes were delivered.

Paul Ennals noted clear evidence of engagement from resident doctors across the organisation and involvement in the development of the plan. Sam Richardson explained that engagement began at the end of November 2025 with a 'you said we did' approach. Several quick wins had already been identified and progressed, while a timeline was being developed for the larger-scale changes.

A discussion ensued which covered the following areas:

- The Steering Group continued to hold positive and constructive discussions that supported the overall programme of work. Preparations were underway for next week's Junior Doctor Induction, with a focus on ensuring a strong start and improving the early experience for new doctors. It was noted that meaningful early engagement such as welcoming communications in advance can significantly enhance initial connections with the organisation, and that with the right attention, improvements in this area could be achieved quickly.
- The importance of learning from other Trusts and sharing information across the Alliance. Sam Richardson advised that this was happening, noting active contact with Northumbria Healthcare NHS Foundation Trust regarding technology, and acknowledged the challenges faced by all trusts in interpreting what new requirements meant operationally. There was a continued national workstream with clear markers, and each Trust had an assigned peer lead. While many regional issues were shared, a Trust of the size of Newcastle Hospitals faces distinct challenges, and links with Education North East remained an important part of the approach.
- The importance of learning that could be taken from the work to date and how the fundamental lessons identified could be rolled out across the wider organisation.
- An update was presented at the most recent People Committee meeting with ongoing updates provided during meetings. During recent NED visits, the close proximity and challenges with facilities for staff was highlighted.

Paul Ennals acknowledged that while progress was being made, there was stil considerable improvement needed, and that strong communication and learning from this experience across the organisation would be essential.

Rob Harrison commended Sam Richardson for his collaborative leadership style and for challenging the Board of Directors appropriately, noting the positive constructive challenge to the organisation. Paul Ennals reiterated the Board of Directors' commitment to the programme of work.

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

[Sam Richardson left the meeting at 11.24am].

26/04 ITEMS TO APPROVE

a. Board Assurance Framework (BAF)

Patrick Garner advised that the BAF had been discussed at the tier 1 Committees in January 2026.

Patrick Garner highlighted the following points:

- Quality Committee risk ID 1.1 had been updated with 10 new actions, and eight controls and associated assurances had been added against the existing threats.
- The People Committee risks had been reviewed by the Interim Director of People and Commercial Development.
- In relation to the Finance and Performance Committee, one risk score had reduced for risk ID 6.1 from 20 to 15 which demonstrated financial discipline and the hard work that had taken place.
- Risk ID 7.1 was overseen by the Board of Directors with the status of actions remaining unchanged. Work continued to refresh the Alliance reporting to ensure the Board received appropriate assurance.

  Martin Wilson advised that the Alliance Joint Committee was a Tier 1 Committee of the Board of Directors. The minutes of this meeting were available in the Admin Control Reading Room for reference. An update on the strategic intent work was scheduled for the March Board of Directors meeting **[ACTION05]**.

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

26/05 ITEMS TO RECEIVE

a. Committee Chairs Meeting Logs

In relation to People Committee, Bernie McCardle highlighted a focused discussion on the Guardian of Safe Working Report.

With regards to the Finance and Performance Committee, Bill MacLeod noted that planning for the medium-term plan was in progress.

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

b. Learning from Deaths

Rachel Carter advised that the Learning from Deaths report has been fully scrutinised at the Quality Committee.

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

c. Meeting Action Log

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

It was **resolved**: to **receive** the action log.

26/06 ANY OTHER BUSINESS

a. Any other business

There was no any other business to discuss.

The meeting closed at 12.02pm.

Meeting action summary:

- Lucia Pareja-Cebrian agreed to provide assurance on the process regarding the delivery of test results by clinicians prior to release on NHSApp **[ACTION01].**
- A survey had been drafted with the Trust Secretary which would be issued next week to Clinical Boards and senior teams to gather feedback and support further improvements in the Board Visibility Programme. It was agreed that the results of the survey will be included in a future report **[ACTION02]**.
- Work continued with partners to ensure a greater proportion of patients move through pathways efficiently, with strong collaboration across organisations. A further update would be provided at a future meeting **[ACTION03]**.
- Ian Joy advised that a secondary conversation would take place with Marie Smith, Head of Obstetrics, to confirm consistency with the self-assessed position and the Board of Directors would be updated on the outcome **[ACTION04].**
- Martin Wilson advised that the Alliance Joint Committee was a Tier 1 Committee of the Board of Directors. The minutes of this meeting were available in the Admin Control Reading Room for reference. An update on the strategic intent work was scheduled for the March Board of Directors meeting **[ACTION05].**

Date of next meeting:
Public Board of Directors – Friday 27 March 2026

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Agenda Item A1(c)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 March 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 Council meeting held in Public in January 2026: • 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 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

Our succession planning for Board continues. Firstly, I am pleased to announce that Ms Judith McKenna formally took up her role as an Associate Non-Executive Director (NED) on 30 January. Judith is an experienced accountant with a 25-year career and a fellow of the Institute of Chartered Accountants in England and Wales. While we welcome Judith, we also bid farewell to Nini Adetuberu, who will be leaving us at the end of March to concentrate on her new NED roles with Tees, Esk and Wear Valleys NHS Foundation Trust and the North East Ambulance Service NHS Foundation Trust. We are currently out to advert for two posts: an Associate NED with people expertise who will work alongside Bernie McCardle until September and then hopefully take on the full NED role, and a Clinical NED to replace Phil Kane, who is starting at County Durham and Darlington NHS Foundation Trust. We have been excellently served by our current group of NEDs but we are now entering a period of a bit more change.

BOARD ACTIVITY

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

1. **Five Year Trust Strategy**
    - An overview was provided on the Strategy development work undertaken to date.
    - Feedback was shared from the Executive Team Development session on aspects of the new Trust 5-year strategy.
    - Board members discussed the Trust vision, values and draft strategy outline/key headlines.

2. **Ambitions regarding Neighbourhood Services and Integrated health models**
    - Discussion centred on current work/thinking/developments regarding neighbourhood services and integrated health models for Newcastle, where we were joined by colleagues from the local authority and from Primary Care.
    - A brief update was shared on Integrated Health Organisation and Advanced Foundation Trust developments.

3. **New Net Zero Plan**
    - Board members were briefed on the Trust current position in relation Net Zero.
    - A discussion took place on the Board vision in relation to environmental sustainability and the new Net Zero Plan.

ACTIVITY WITH GOVERNORS AND MEMBERS

At our Governor Workshop in February, 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 Wendy Balmain, NED and member of the Quality and Charity Committees, and Nini Adetuberu, Associate NED and member of the People Committee.

Pauline Kelso, Director of Community Services and Dr Amanda Kilsby, Consultant Geriatrician, Clinical Director for Older People's Medicine, Palliative Care & Community Services presented an overview of the evolving model for primary care and neighbourhood working. Aligned with the NHS 10-year Plan, the Trust is beginning to map out what services need to look like over the next decade, with a clear focus on transforming care so that more people can be supported safely at home.

The approach will require strengthened system-wide partnerships, including joint planning, shared resources, and collaborative delivery of performance targets and patient flow. The future model emphasises fully integrated, patient-centred pathways that support prevention, early intervention and community-based care. The aim being to ensure services are coordinated, coherent and easier for patients to navigate pathways that make sense for them and supports prevention, early intervention, and community-based care.

I continue to meet with Governors informally, providing a space for them to raise any issues arising between formal meetings and enabling me to update them on key regional and national developments.

We have begun discussions with governors to consider how the Trust might wish to respond to the NHS Ten Year Plan's intent to remove the formal powers of Councils of Governors from March 2027. We greatly value our governing body, and the important role they play in holding our Board to account and bringing the voices and views of the community, patients and staff into the decision-making of the Trust. Along with the other East Coast trusts we hope to prepare a vision for how we believe we can be at the forefront of community participation in the future. As part of this process, my intention regarding changes to the elections process for governors prompted some debate at the recent Council workshop; We are reflecting, bringing a report to the Trust Board, and will return to the matter at the April Council meeting.

Our most recent members' event on 5 March 2025 focused on *Cancer Care, re-imagined*. Dr Wendy Osborne, Consultant Haematologist, outlined significant advances in immunotherapy, particularly the use of patients' own T-cells to identify and destroy cancer cells. She highlighted the increasing cure rates and reduced toxicity associated with these personalised, cell-based treatments, emphasising their growing life-saving potential.
We also heard from Gemma Kindness, Advanced Physiotherapist, and Dr Ben Hood, Cancer Research Nurse Consultant, who presented on the benefits of Prehabilitation. They described this as a needs-based, multi-modal intervention delivered before and during cancer treatment, aimed at optimising physical, nutritional and psychological wellbeing to improve readiness for treatment, enhance tolerance and support recovery and quality of life.

The event was very well attended, and feedback from members was highly positive.

INFORMAL VISITS & EVENTS

I was delighted to open an event at the Institute of Transplantation hosted by Newcastle Hospitals Charity which presented the vision for the new Sir Bobby Robson Institute development, a world-leading centre for cancer trials and research. To mark International Women's Day 2026 and its theme of Give to Gain, Newcastle Hospitals Charity hosted an inspiring evening of conversation and connection to celebrate the power of generosity collaboration and leadership in driving innovation and progress in cancer research. We heard from female leaders from healthcare, business, sport and the wider community to explore how giving – of money, time, knowledge, accelerates impact for all.

At the beginning of Ramadan, I joined an Iftar gathering in the Piano Room at the Royal Victoria Infirmary to share in the occasion with our Muslim colleagues.

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. I am particularly struck by how collaboration on the ground between units and departments seems to be becoming Business as Usual – nothing to shout about because it is just how we work around here. I have asked us to pull together some more detail of how these collaborations are impacting on the work of the trusts and the outcomes for patients, for sharing more widely.

OTHER MEETINGS AND INFORMATION

I participated in the NHS Confederation and NHS Providers Quarterly Shared Leadership Forum which was launched to support the growing number of NHS trusts adopting shared leadership models, with 24 Chairs already participating and further interest emerging. We heard from Glen Burley, CEO of The Foundation Trust Group, NHS England (NHSE) Financial Reset and Accountability Director to talk about the national perspective of Shared Trust Leadership as well as Sir David Nicholson, Chair of Sandwell and West Birmingham NHS Trust, The Dudley Group NHS Foundation Trust, The Royal Wolverhampton NHS Trust, and Walsall Healthcare NHS Trust to share the challenges and opportunities of The Black Country NHS Trusts. Lots of ideas for me to bring to our work here.

I continue to meet with the Chair, CEO and senior officers of the Integrated Care Board (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
17 March 2026

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Agenda item A2(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 March 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 Patient and Staff Experience					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	**Patient experience story:** Over recent months, the Trust has received multiple compliments and letters of thanks from patients who experienced care as inpatients on Ward 46 at the Royal Victoria Infirmary (RVI). Ward 46 participates in the Trust's real-time patient experience programme and was awarded the Silver Accrediting Excellence (ACE) Award in 2025. Through this programme, the team sought to understand the key factors contributing to consistently positive experiences of care. This story highlights Helen's recent experience on the ward and reflects the practices and behaviours that underpin its strong patient feedback. **Staff experience story:** Keith has volunteered in the Emergency Department at the RVI for just over two years. Patients have recently commented on how his thoughtful actions—such as offering reassuring words, making a cup of tea, and providing simple kindness—have helped to ease their anxieties and made challenging situations more manageable. In this story, Keith describes his pathway into volunteering, what contributes to a fulfilling day in the department, and his advice for others considering a volunteer role.					
Recommendation	The Board is asked to: i) receive both stories, for information; and ii) note our commitment to learning from all experiences of receiving and providing care.					
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	Patient and People stories are a recurrent feature of all Public Board meetings.

Patient story

Context: Over the last few months, there have been a number of compliments and letters of thanks received into the Trust from patients regarding the care they experienced whilst an in-patient on Ward 46 at the RVI. This ward is part of our real time patient experience programme and successfully achieved a Silver Accrediting Excellence (ACE) Award in 2025. Through the real time programme, it was important to understand those factors which have led to a positive experience of care.

When I arrived on ward 46 at around 2am, I was immediately struck by how respectfully I was treated. The porter who brought me up was excellent; he advised me to mention an important detail about my condition to the ward staff, which turned out to be very good advice. In fact, every porter I've encountered—whether in Accident & Emergency (A&E) or during trips to x-ray—has been consistently kind and professional.

Shortly after I arrived on the ward, a doctor came to see me. He welcomed me and said, "You're one of Mr X's patients," showing that he'd already looked through my notes. That small detail made me feel reassured and genuinely cared for.

Over the next few days, I noticed how well the ward team worked together. As they grew more comfortable around me, they chatted openly but professionally—never any gossip or negative comments. I always felt they were focused on patient care.

There was one issue during my stay. I had been told I needed to drink some contrast dye six hours before an x-ray. I took the drink, but it immediately made me sick. One of the Healthcare Assistants (HCA) was with me at the time and acted quickly, keeping me safe. When I later arrived for the x-ray, I was told the scan couldn't go ahead because the dye wouldn't have taken effect, so it had to be rescheduled.

Afterwards, one of the ward senior nurses, came to speak to me. He explained that he hadn't been aware of what had happened but reassured me that the HCA had responded exactly as she should in a risky moment. The HCA later came in to apologise that I'd missed the appointment. I really appreciated how the senior nurse supported and validated his staff while still acknowledging my experience.

Being involved in my care has been difficult to judge because I came in as an emergency, but the doctors have taken time to explain things—especially my worries about surgery because of a pre-existing condition. Another doctor came to speak to me when I was very tearful; she actually got down on her knees beside my bed to talk to me, which meant a great deal.

Nursing staff have been really attentive—unhooking my drips when I need the toilet, checking if I'm steady on my feet, and managing my pain well. When I mentioned a new pain, the doctor immediately recognised the likely cause and prescribed something appropriate. I've also been given hot gel packs, with a student nurse helping me regularly. I've noticed how well the first-year student nurses are being supported and integrated into the team.

Food has been fairly good, though my diet is limited at the moment. The ward housekeeper, realised I preferred clear soup, he made a real effort to get it for me. When my diet changed to low-residue, he asked about my preferences and helped suggest options. His knowledge and willingness to help have made a big difference.

Overall, I've seen staff managing a wide range of patients and conditions, and doing so calmly, kindly, and fairly. Despite a few hiccups, I have felt treated with dignity and genuine care throughout my stay.

Staff story

Context: For just over two years, Keith has volunteered in the Emergency Department at the RVI, where he currently works two shifts a week. Patients have recently shared how his simple gestures such as comforting words, offering a cuppa and generally being nice—eased their worries, helped them feel cared for and made a difficult time more bearable.

I first came to this hospital as a patient. I'd had severe carpal tunnel in both wrists, then developed significant back pain. The doctor thought it might be my sciatic nerve, but things escalated quickly. I ended up in the Intensive Care Unit (ICU), and before I knew it, I was having major surgery on my back.

Before the operation, the surgeon said to me, *"Keith, there are three possible outcomes: you may never walk again, you may need strong medication to walk, or you'll be alright."* Afterwards, the nurse helped me to my feet—and I was like a Springbok. That moment made me want to give something back, and that's how I became a volunteer.

When I first started, I was placed on a ward, but that wasn't the right fit for me. Then I found where I belong—A&E. I've now been volunteering in the Emergency Department for just over two years, doing two shifts a week: Wednesday afternoon and Friday night. My daughter worries about the late one, but I'll keep doing it as long as I'm able.

A cup of tea makes a hell of a difference. That's what I've learned. When patients come into A&E and get triaged, they're given a white wristband—but that wristband doesn't tell me if they're nil by mouth. And that's crucial. You can't have tea and biscuits if you're going for certain scans. So, I always make sure to check.

I suppose that instinct comes from my days as a deep-sea diver. When you're in the chamber, you need to know how to help someone. I learned some basics back then—catheterising, suturing wounds, giving medication. It was a long time ago, but the mindset stays with you. So now, until someone tells me otherwise, all I can offer is a sip of water. And I always explain it: *"If I give you something to eat or drink and you miss your scan, you won't give me a Christmas card!"* That usually breaks the ice.

I try to make the rounds as pleasant as I can. I organise my trolley carefully—blackcurrant, lemon and orange squash, tea, coffee, water, biscuits, sandwiches. If you put everything out at once, it disappears. I'll wheel into triage and call, *"Free sandwiches—please don't mob*

me!"

It takes me about 45 minutes to get to everyone. Sometimes people just need a chat, or a kind word. I remember one lady who was in agony—I called the nurse, who came straight away. Her husband thanked me; he didn't want to leave her. I just told him, "Ask—they won't bite your head off. They're here to help."

Some days are overwhelming. I remember one Wednesday when there were over 140 people in the department. I don't know how the doctors and nurses manage it, but they do. I've had a few difficult run-ins, too. One man swore at me four times. I've learned not to react. I'll get security if I need to—but usually a nice cup of tea breaks the ice.

A good day for me is when I see the nurses smiling at shift change. I don't know if I make a difference, but I like to see most of the patients okay. I might be only 5'4", but I stand tall.

To anyone thinking about volunteering, I'd say: get someone to show you around the different departments and try things out. You have to find an area where you feel comfortable. There's a lot volunteers can do. The only thing I'd change is to have more training when I first started—I think a bit of extra training would help, even just for managing the trolley and knowing who to go to for what. I try not to bother clinicians unless I have to.

The way I look at life is: use it or lose it. This hospital saved my life—twice, really, because I had sepsis while I was already volunteering here. So I'll carry on giving back for as long as I can.

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Agenda item A2(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 March 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 22 walkabouts by Non-Executive Directors (n=10) and Executive Directors (n=12) undertaken throughout January and February 2026. An evaluation, via survey, has recently been undertaken to assist in the evaluation of the Board Visibility Programme. The results of this survey are detailed in Appendix 1 and a summary of results, themes and actions is included in the paper.					
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	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	The previous Board Visibility Programme Report was presented to the Trust Board in January 2026.					

BOARD VISIBILITY PROGRAMME

1. INTRODUCTION

This report provides an overview of the findings from the 22 walkabouts by Executive Directors (n=10) and Non-Executive Directors (NEDs) (n=12) undertaken during January and February 2026.

Since 2023, Non-Executive Directors have undertaken 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 22 walkabouts undertaken at the Royal Victoria Infirmary (RVI), Freeman Hospital (FH), and Community Sites throughout January and February 2026. Ten walkabouts were carried out by Executive Directors as part of stream one and twelve 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	Minor Injury Unit	RVI	Director Great North Healthcare Alliance Strategy, Patient Safety Manager	Nurse Practitioners, GP, Receptionist, Senior Emergency Department (ED) Sister
	Musculoskeletal Outpatients	FH	Director of Performance & Governance, Quality Development Manager	Sister, Health Care Assistants
	Estates Performance, Compliance and Administrative Team	RVI	Interim Executive Director of Operations, Clinical Effectiveness Manager	Head of Estates, Quality, Assurance and Risk, Compliance and Risk Manager, Performance Quality Manager, Performance Quality Officer, Asset Officer
	Ward 1	FH	Director of Communications and Corporate Affairs, Health Safety and Risk Lead	Senior Sister/Charge Nurse, Matron, General Manager, Assistant Operational Service Manager
	Sir Bobby Robson Unit	FH	Director of Estates, Facilities and Strategic Partnerships and Patient Safety Manager	Sister, Trial Coordinator, Biomedical Technician, Assistant Lab Manager, Doctor
	Emergency Assessment Suite (EAS)	FH	Director of Pharmacy, Head of Quality Assurance and Clinical Effectiveness	Health Care Assistant, Sister, Charge Nurse, Matron, General Manager

Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
	Atkinson Road Clinic	Community	Executive Director of Nursing, Midwifery and Allied Health Professionals, Patient Safety Manager	Physiotherapy Manager, Administration staff, Senior Physiotherapist, Junior Physiotherapist
	Electronics and Medical Engineering (EME)	RVI	Director of Performance and Governance, Patient Safety Manager	Head of EME, EME Officer, Deputy EME Officer, EME Team Manager, Chief Instrument Curator, EME Senior Technician, EME Technician
	Ward 38	RVI	Director of Quality and Safety, Patient Safety Manager	Matron, Ward Manager, Nursing and Support Staff
	Ward 4	RVI	Director of Improvement and Delivery, Head of Quality Assurance and Clinical Effectiveness	Ward Sister, Nursing Staff, Health Care Assistants, Domestic Assistant
Stream Two	Ward 10 Ear, Nose and Throat (ENT)	FH	Non-Executive Director	Matron, Operational Service Manager
	Wards 2, 3 and 4	FH	Non-Executive Director	Matron, Senior Sister, General Manager, Consultant Otolaryngologist
	Microbiology Labs	FH	Non-Executive Director	Laboratory Manager, Director of Operations, Associate Director of Operations
	Ophthalmology Outpatients, Emergency Department, Ward 20 and Ward 21 Virtual Hub	RVI	Non-Executive Director	Matron, Associate Director of Operations, Optometrists, nursing staff
	Pharmacy	FH	Non-Executive Director	Director of Pharmacy, Deputy Director of Pharmacy, Superintendent Pharmacist, non-specified staff member

Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
	Cardiothoracic Ward 29	FH	Non-Executive Director	Ward Sister, Matron, Staff Nurses, Ward Clerk, Healthcare Assistant (HCA)
	Ward 40	RVI	Non-Executive Director	Matron/Ward Sister
	Occupational Health (OH)	Regent Point	Non- Executive Director	Clinical Services Manager, Lead OH Consultant, OH Management Team, various other staff members
	District Nursing Team	Curve in Newburn	Non- Executive Director	General Manager, non-specified staff
	Trauma Outpatients, Ward 47, Ward 37	RVI	Non- Executive Director	Matron, Business Manager, Sisters, Specialist Nurses, Staff Nurses, Health Care Assistants, Ward Housekeepers
	Freeman Research Unit (FRU)	FH	Non- Executive Director	Newcastle University Honorary Consultant Rheumatologist, Consultant Haematologist, non-specified staff
	NECTAR	RVI	Non- Executive Director	Matron, Nursing team, team assistant, medical staff, ambulance drivers

Key themes identified include:

- Staff were always welcoming, enthusiastic and proud of the work they do.
- There was evidence of Quality Improvement and training opportunities.
- Estates issues, space and storage were a cause of frustration in several areas.
- Outdated Information Technology (IT) Systems and delays in moving to Electronic Patient Records were a concern.
- Staff were not always consulted or clear on plans for refurbishments and moves to new areas.

Issues addressed during the visits:

- An out-of-date policy was on display in one area and removed.

Further action required:

- Follow up Estates issues in several areas.
- Improve communications to staff on refurbishment plans.
- Monitor progress of Electronic Patient Records for NECTAR.
- Consider road repairs and car park security at NECTAR.
- Follow up availability of cleaning equipment for ward 4.
- Consider medical cover on EAS.
- Consider how to capture and evaluate patient feedback on EAS.
- Follow up additional carts for Wards 2,3 and 4.

4. EVALUATION SURVEY

The recent Grant Thornton Well-Led review made a recommendation for the Trust to:

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.

As an initial action, the Director of Quality & Safety and Trust Secretary (as leads for both elements of the Board Visibility Programme) developed a survey that was circulated to the Clinical Board triumvirate with a request to share with their relevant teams. The survey and results are detailed in Appendix 1. Disappointingly there was a response rate of only n=17. However, this data has been analysed and summarised, with proposed actions below:

- Overall, the Board Visibility Programme is positively received, but not universally understood.
- Predominantly positive feedback among those expressing a view, but many offered no view, suggesting inconsistent local engagement or feedback capture.
- Escalation routes exist but are not reliably visible; follow through is not always transparent to services.
- Visits are positively shifting perceptions of NEDs more than the Executive Team (this may be due to lack of clarity between routine Executive visibility and that of the more formalised Board Visibility Programme).

Future proposals to further improve the overall effectiveness of the programme:

- **Coverage and equity**
  - Achieve more than 95% of Clinical Boards visited at least once per quarter; no area to go more than 6 months without a visit (Stream 1 & 2).
  - Publish a coverage schedule with the Clinical Boards (Stream 1).
- **Closing the loop on feedback**
  - Create a template with a summary of the visit to be shared with the area visited and the Clinical Board triumvirate (Stream 1 & 2).
- **Engagement and visibility**
  - Produce a Board Visibility ‘explainer’ to help consistency with the delivery of the programme, help staff and teams have greater understanding of the purpose of the visits and how better to prepare for them.

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.
13 March 2026

Appendix 1: Survey and Results

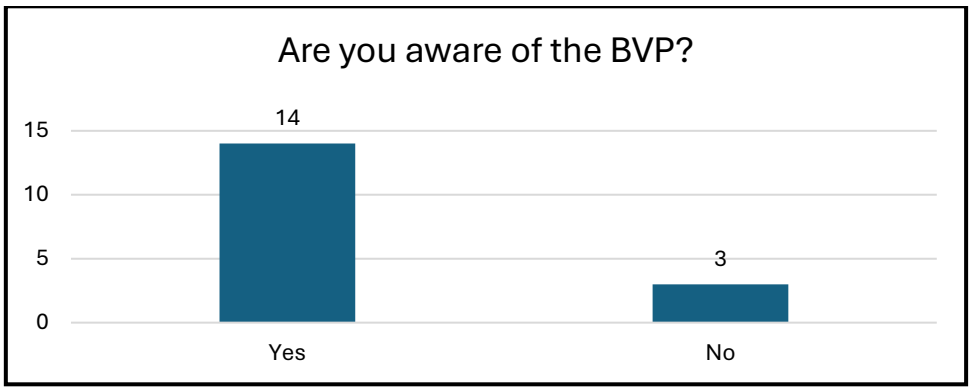
BOARD VISIBILITY PROGRAMME SURVEY RESULTS

A revision to Leadership Walkabouts and NED visits was undertaken following feedback from the CQC Inspection, with the Board Visibility Programme established. The new programme was to identify areas where care delivery can be improved, address difficult issues that may be impacting on the quality and safety of patients and to increase visibility of senior management to staff, thereby supporting staff from Ward to Board.

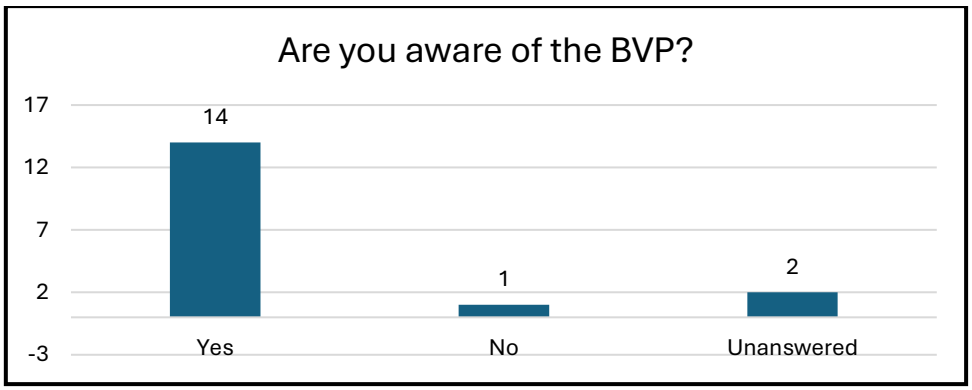
A short survey was conducted in relation to the programme, with the aim of enabling improvements to the programme, including better discussion in the different clinical/corporate areas, potentially escalating any issues and sharing good practice.

Seventeen responses were received to the survey and the results are detailed below:

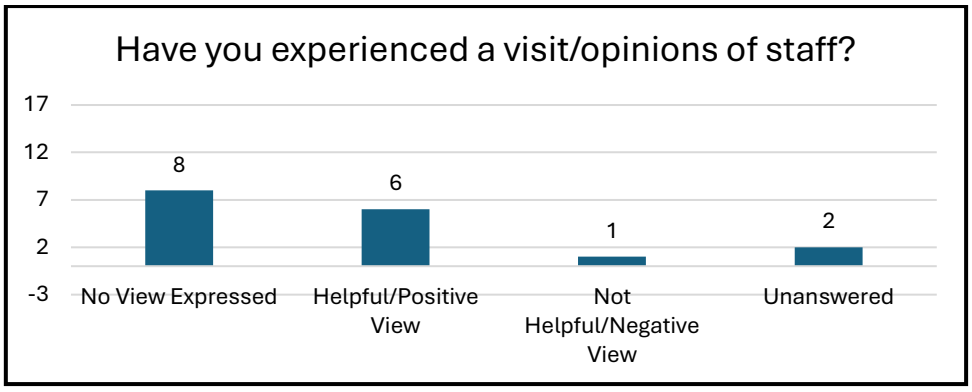
Question 1 - Are you aware of the Board Visibility Programme (BVP) (NB The programme incorporates Leadership Walkabouts and Non-Executive Director (NED) informal visits)?



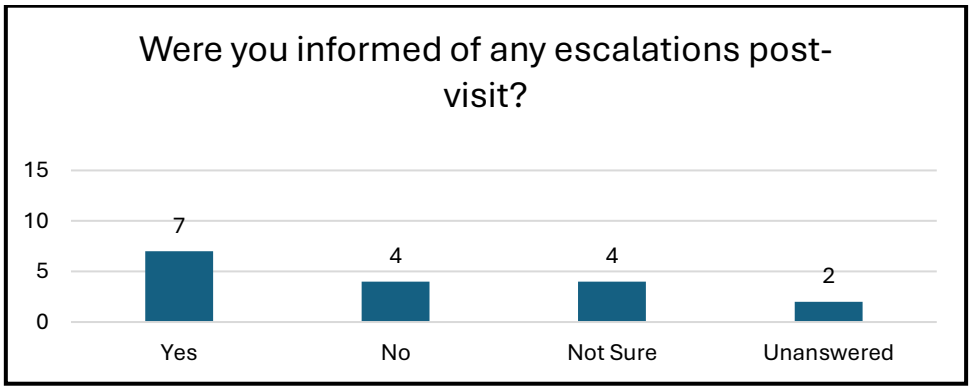
Question 2 - If yes, have any of the areas/services you lead had a leadership walkabout or NED visit in the last 12 months?



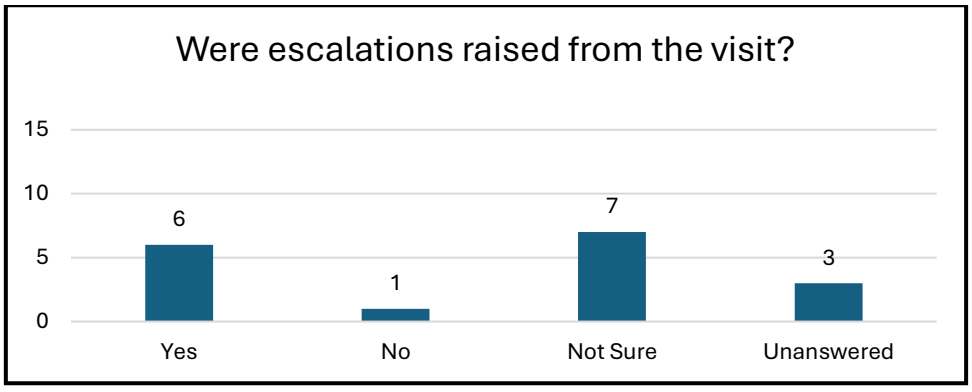
Question 3 - If you have had a walkabout/visit in the area(s) in which you work, how did the staff find the walkabout/visit?



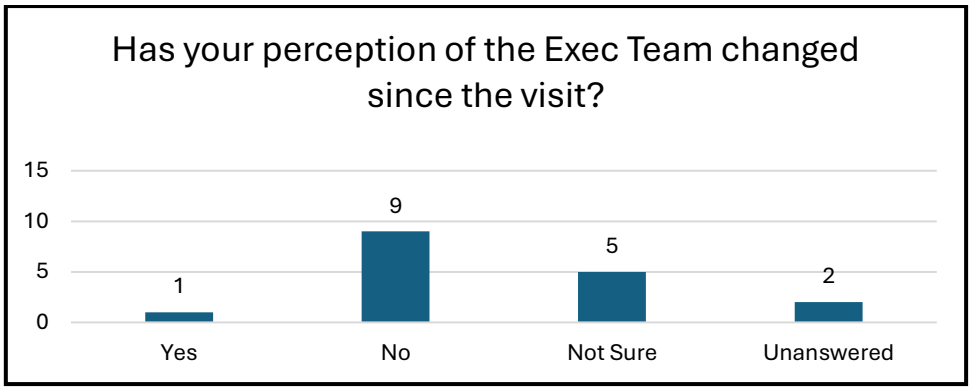
Question 4 - For any walkabouts/visits undertaken in the area(s) in which you work, were you or anyone else in your area informed of any escalations arising from the walkabouts/visits?



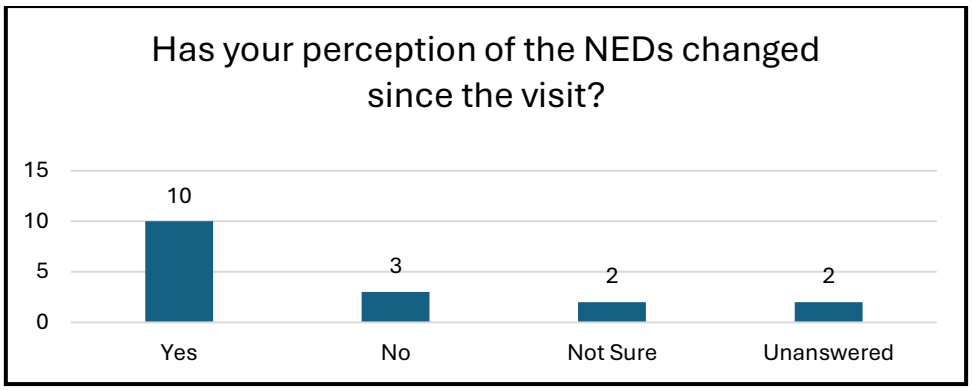
Question 5 - For any walkabouts/visits undertaken in the area(s) in which you work where escalations were raised from the walkabouts/visits, were these acted upon?



Question 6 – For any leadership walkabouts you are aware of, have these led to any changes in your perception of the Executive Team?



Question 7 - For any leadership walkabouts you are aware of, have these led to any changes in your perception of the NEDs?



Question 8 - Can you share an example of where a leadership walkabout/visit has resulted in any improvements? (free text responses)

- Support with Ward 40 pathway changes.
- No - often don't get feedback even as senior management team so unable to act upon it.
- I can't describe a specific improvement, but the teams feel well supported by our NED and issues raised by the Board at Committee level have been well supported by our NED due to the knowledge that he has on our Clinical Board.
- No improvements.
- Raising awareness of our services.
- Difficult to state whether escalations were from NED walkaround or from escalations already highlighted from within the service.
- Use NED visits to contribute to action plans and to provide third party perspectives in clinical areas.
- Support of NEDs voice at committee meeting. Acknowledgement of work and contribution to Trust delivery.

Question 9 - If you have not had a walkabout/visit in any of the areas you lead, please list them here. (free text responses)

- I haven't been in the Clinical Board (CB) for very long so know we have had NEDs in labs (and ongoing commitment to visit more). Radiology but I am not sure of others but as I say, I haven't been here that long.
- Only visits have been NED that I'm familiar with or external visits with escorts.
- Paediatric Medical Specialties.

Question 10 - Please share any further comments or suggestions for improvement. (free text responses)

- Really supportive of the walk arounds - staff always like them and enjoy senior people showing an interest in their work.
- Visibility of walkabouts, learning and improvements across the board of what they have been able to influence may leverage better engagement.

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Agenda item A2(c)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 March 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 on the Trust's performance against key indicators relating to Quality & Safety, Access, People and Finance. **Quality** • Methicillin-susceptible staphylococcus aureus (MSSA) increased in January (11 v 9) compared to the previous month but remains within the parameters of common cause variation. • Clostridioides difficile Infection (CDI) cases decreased in January (10 v15) and remains within the parameters of common cause variation. • Acute (Category 2 & above) Pressure Ulcers (PU) reported in January decreased (45 v 55). • In January there was a continued decrease in falls (206 v 221) and remains within the parameters of common cause variation. **Performance** • January 2026 witnessed a slight increase in >52-week waiters at Newcastle Hospitals, increasing to 930 (+37). This meant 1.1% of the total Referral to Treatment (RTT) waiting list was over 52 weeks - marginally above the national target of 1% by March 2026. • In December, the 80% 28 Faster Diagnosis Standard (FDS) target was not achieved (67.7%) and recent trends show a sustained decline. 31-day performance remained stable at 91.9% in December, whilst 62-day performance continues to show special cause variation of an improving nature (73.4%). **People** • Sickness has moved from showing special cause variation of a concerning nature (high) to common cause variation. • Short-term (Month-only) sickness has moved from showing special cause variation of a concerning nature (high) to common cause variation. **Finance** • At month 10 the Trust is reporting a £2.8m deficit which is in line with the plan, however in delivering this position, the Trust received additional funding and released technical		

<table>
<tr><td></td><td colspan="6">savings to offset pressures and under delivery of the Cost Improvement Programme (CIP). In January, additional income has enabled the reduction of technical mitigations.
• The CIP of £106m is phased over the year with a plan of £83m to month 10. Year to date Clinical Boards and Corporate Services have delivered £34m (of which £24m is recurrent). A further £6m of other recurrent CIP has been actioned as well as £43m of non-recurrent measures, this includes £14m of income mitigating the subsidiary scheme and £29m of technical adjustments (technical adjustments required are now in line with plan).</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>
<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">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>
</table>

Agenda item A2(c)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

March 2026

Healthcare at its best
with people at our heart

Contents

SPC Variation / Assurance – Changes from previous month

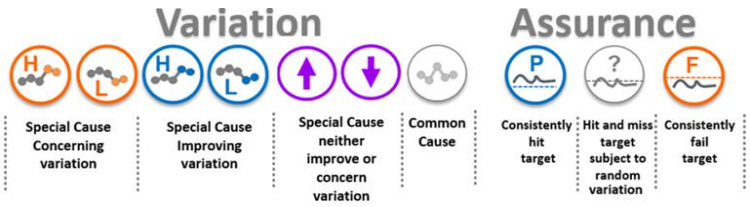
	Dec-25	Jan-25
Sickness		
Short-term (Month only)		

Statistical Process Control (SPC) Variation

- **Two** high level metrics have displayed changes in special cause variation from December 2025 to January 2026.
- **Sickness –** Has moved from showing special cause variation of a deteriorating nature (high) to common cause variation.
- **Short Term Sickness (Month only) –** Has moved from showing special cause variation of a deteriorating nature (high) to common cause variation.

SPC Assurance

- **No** high-level metrics have displayed changes in special cause assurance from December 2025 to January 2026.



Quality

Quality Overview

Metric	Period	Actual	Target	Variation	Assurance
HCAI - MSSA	Jan-26	11	9		
HCAI – C. Diff	Jan-26	10	11		
Harm Free Care – IP Acquired Pressure Ulcers	Jan-26	45	Sustained reduction		
Harm Free Care – Adult Patient Falls	Jan-26	206			
Stillbirths	Jan-26	1			
Blood Loss ≥1500ml (per 1,000)	Jan-26	39 per 1000			
ATAIN	Jan-26	8%	5%		

Health Care Acquired Infections (HCAI)

- Methicillin-susceptible staphylococcus aureus (MSSA) increased in January (11 v 9) compared to the previous month but remains within the parameters of common cause variation.
- *Clostridioides difficile* Infection (CDI) cases decreased in January (10 v15) and remains within the parameters of common cause variation.

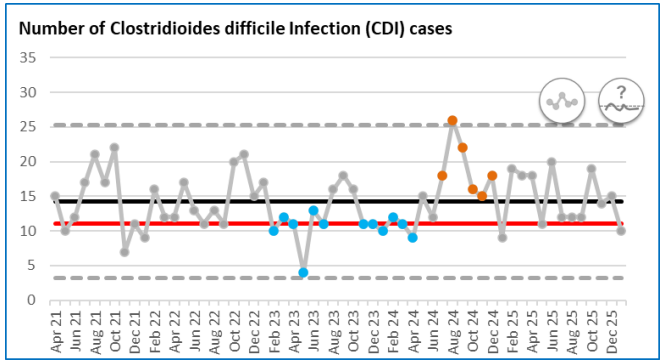
Harm Free Care

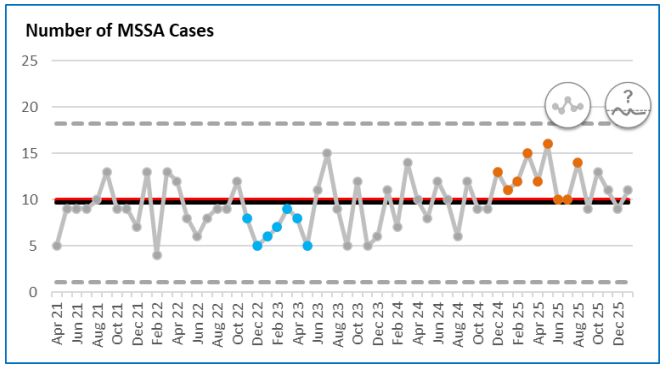
- Acute (Category 2 & above) pressure ulcers (PU) reported in January decreased (45 v 55).
- In January there was a continued decrease in falls (206 v 221) and remains within the parameters of common cause variation.

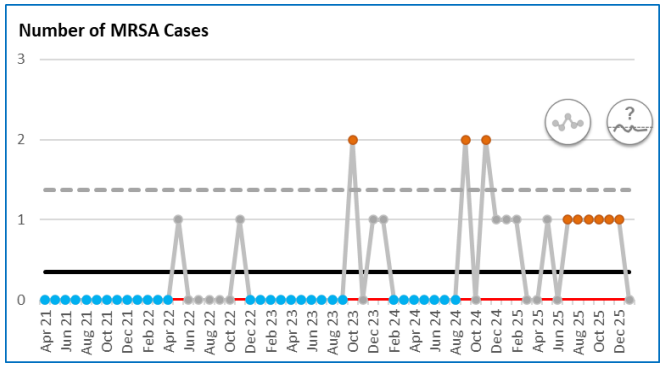
Perinatal Quality Surveillance

- There was one stillbirth in January 2026. There are no emerging themes.
- The National benchmark for term admissions is 5%. The Trust rate remains consistently above the national 5% target with 8% term admission rate in January. Further analysis is in progress of infants born within 37th week of pregnancy as this group represent 40% of admissions.

Healthcare Associated Infections (HCAIs) (1/2)







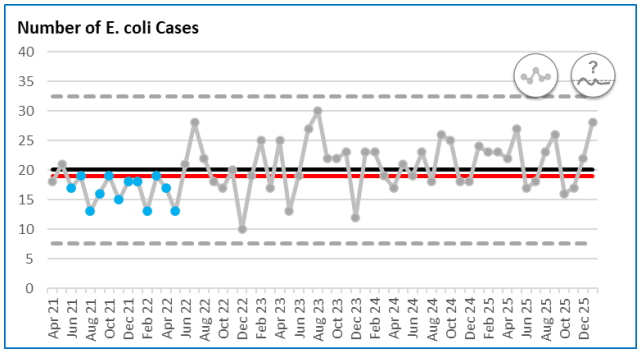
Standards

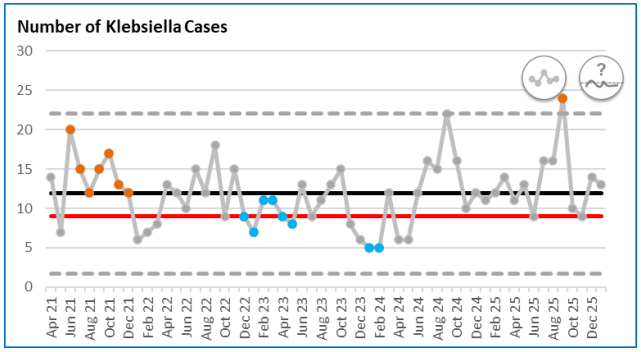
- **Zero Methicillin-Resistant Staphylococcus aureus (MRSA)** cases.
- **No more than 115 MSSA** cases across the financial year (local target - 10% reduction from 2024/25).
- **No more than 136 CDIs, 225 *E. coli*** cases, **108 Klebsiella** cases or **34 Pseudomonas aeruginosa** cases across the financial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

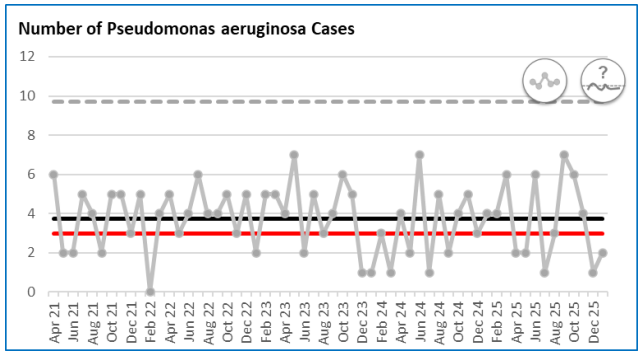
Current Position

- ***Clostridioides difficile* (CDI)** cases decreased in January (10 vs 15) and remain within the parameters of common cause variation. There was 1 Community Onset Healthcare Associated (COHA) case and 9 Hospital Onset Healthcare Associated (HOHA) cases. Investigations remain in progress. Emerging learning themes indicate continued delays in both sample submission and treatment administration.
- **Methicillin-Sensitive Staphylococcus aureus (MSSA)** cases increased in January (11 v 9); however, the rate remains within common cause variation. There was 4 COHA and 7 HOHA cases. Recent findings indicate suboptimal compliance with intravascular device requirements, with deficiencies identified in both device management and associated documentation.
- **Methicillin-Resistant Staphylococcus aureus (MRSA)** there were no cases in January therefore the financial year total remains at 7 and brings the parameters back within common cause variation.
- ***Escherichia coli* (*E. coli*) bacteraemia** cases continued to increase compared to the previous month (28 vs 22) but remains within the parameters of common cause variation. There were 7 COHA and 21 HOHA cases, with 3 HOHA cases attributed to the Hepatobiliary (HPB) service. All cases subject to investigation have been reviewed, and findings indicate that, urinary catheter care has improved, however with these complex patient groups, there are no learning opportunities for the clinical areas.
- **Klebsiella bacteraemia** saw a slight decrease (13 vs 14), with the rate remaining within common cause variation. There was 1 COHA and 12 HOHA. Investigations are ongoing; however, cases reviewed to date have not, at this stage, identified any learning opportunities for the clinical area.
- **Pseudomonas aeruginosa** cases increased (2 vs 1). Of the two cases under review, one remains in progress. The completed investigation identified contributory factors and associated learning in device management, documentation standards, and antimicrobial stewardship.

Healthcare Associated Infections (HCAIs) (2/2)







Themes and Actions

Clinical Board Alignment

Clinical Board alignment for the Infection Prevention and Control Nursing (IPCN) team went live on 9 February, supported by a formal Service Level Agreement. Final sign-off from one Clinical Board is pending.

Audit and Education

The IPCN audit framework has been finalised, establishing regular assurance audits covering:

- Hand hygiene
- Invasive devices
- Cleanliness

This is supported by ongoing education and in-area clinical support to reinforce the importance of effective IPC practice.

Invasive Device Management

Device-related bloodstream infections remain a persistent concern, with IV device management continuing to be a recurring theme hence its priority in the audit and education workstreams.

Current Workstreams

Vascular Access Team

- Providing weekly ward rounds and focused education on central vascular devices within the Northern Cancer Care Centre (NCCC).

B Braun

- Conducting IV surveillance audits and delivering education.

Trust-wide IV Device Task & Finish Group

- Led by the Director of Infection Prevention and Control.
- Focus on improving Aseptic Non-Touch Technique (ANTT) practice and strengthening surveillance.
- Incorporates learning from areas carrying out daily Senior Nurse harm-free care walkarounds.

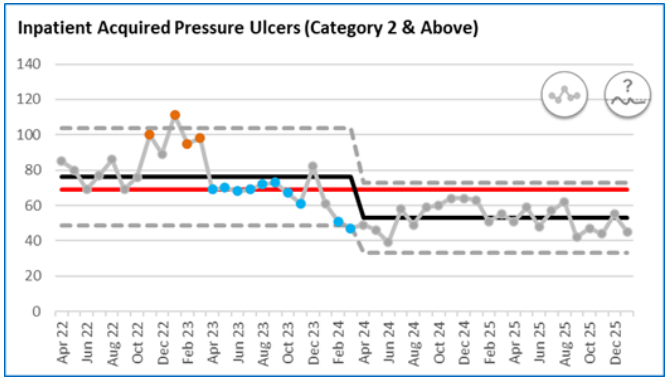
The ***Clostridioides difficile*** **InPhase investigation process** launched on **2 March**. This transition aims to:

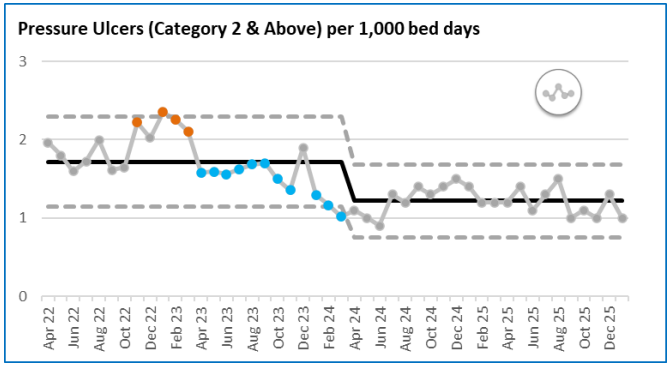
- Strengthening clinical engagement
- Improve learning quality
- Establish clear ownership of actions in line with Patient Safety Incident Response Framework (PSIRF) principles.

Work is now planned to extend this approach to all bloodstream infection (BSI) investigations.

- All clinical areas to fully engage with the InPhase investigation process and prepare for its expansion to BSIs.

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 from 55 in December to 45 in January.
- The rate per 1,000 bed days has decreased in January to 1.0.
- SPC charts indicate a sustained reduction with no special cause variation.

Severity Breakdown

- 1 Category IV pressure ulcer reported.
- 6 Category III pressure ulcers reported.
- All cases are currently under investigation to identify contributory factors and learning.

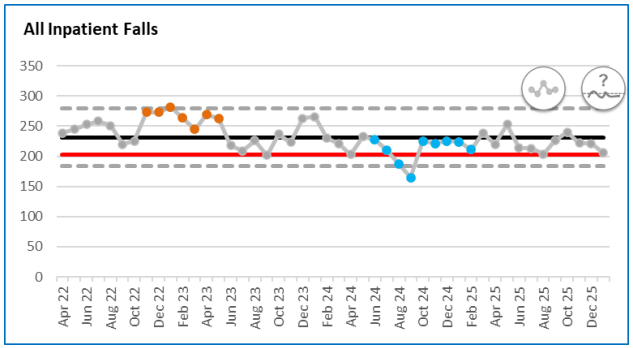
Key Areas for Improvement

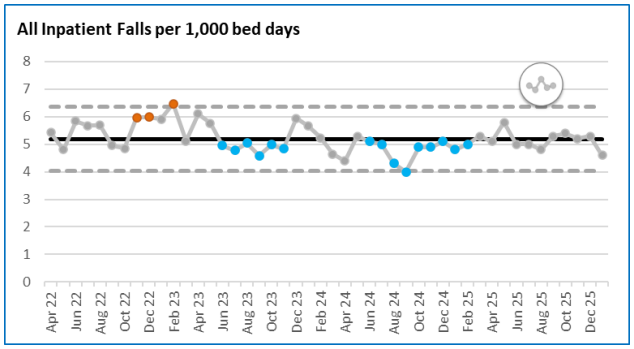
- Timely capture of images for pressure ulcer documentation
- Completion of skin and pressure ulcer risk assessments
- Completion of pressure ulcer prevention and categorisation training
- Implementation of mattress champions and regular mattress audits

Actions Taken

- Induction Training focusing on Pressure Ulcer Prevention continues to evaluate well following the successful pilot teaching on Purpose T. The practical sessions and discussions allow further discussion on pressure ulcer prevention and ongoing care.
- Education is available for Tissue Viability on Learning lab. Recent teaching focused on documentation, practical work, and good verbal feedback from staff to embed knowledge into practice.
- Ongoing collaborative work with the Continence Service and industry for education on pad use on the wards and departments with visits, practical demonstrations and opportunities for questions with staff.

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 206 in January from 221 in December
- Falls per 1,000 bed days decreased from 5.3 to 4.6.
- SPC charts indicate a sustained reduction with no special cause variation.

Harm Levels

- 8 inpatient falls with harm:
  - 4 moderate harm
  - 4 severe harm

Investigations

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

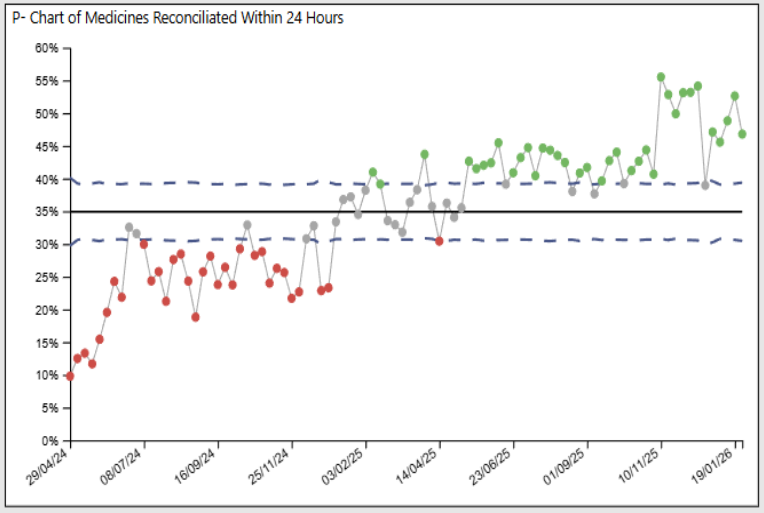
Key Areas for Improvement

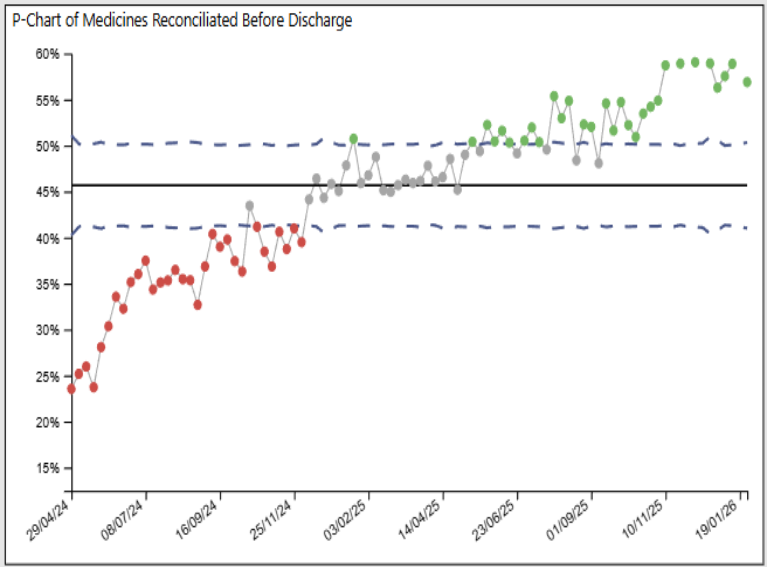
- Completion of multifactorial assessment to optimise safe activity, including:
  - Lying/standing blood pressure
  - 4AT (Delirium screening)
  - Vision checks
  - Medication reviews related to falls

Action Taken

- FPC has implemented a Train-the-Trainer programme for clinical educators, enabling them to deliver high-quality falls training within their directorates and cover Trust induction. As of 13/01/26, 24 clinical educators have completed the programme.
- The FPC and Digital Team are updating the falls assessment, care bundle, care plan and Post-Fall Medical Review. Initial drafts are now ready for staff feedback.
- The IP Post-Fall Protocol is under review, with strong engagement from medical staff.
- The FPC and Ophthalmology have developed three vision-check tool options for staff feedback.

Medicines Reconciliation ('Med Rec')





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

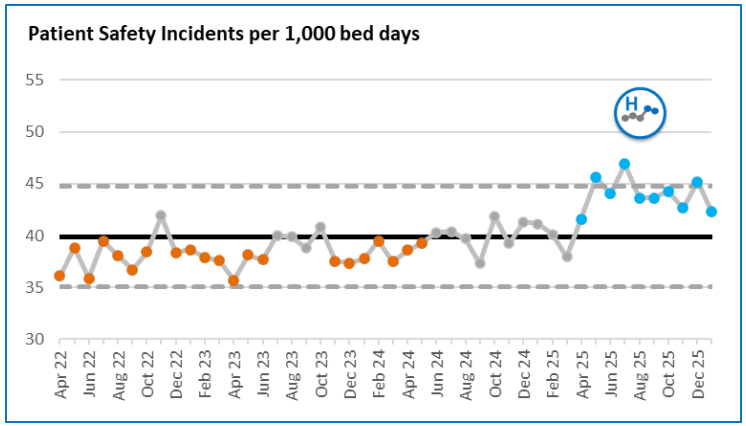
- Maintaining rates above 40% since June 2025.

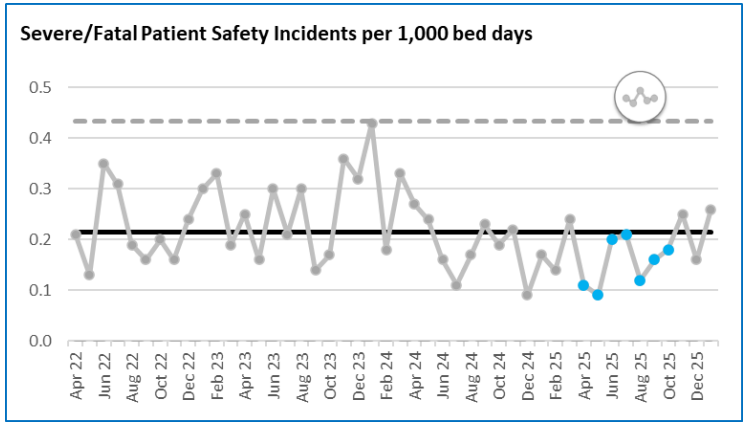
	Med Rec within 24 hours		Total Med Rec before discharge	
	Total Number & %		Total Number & %	
Dec 2024	1280	**27%**	2065	46%
Jan 2025	1696	**34%**	2353	51%
Feb 2025	1718	**39%**	2103	52%
Mar 2025	1692	**34%**	2261	48%
April 2025	1811	**37%**	2305	50%
May 2025	1809	**38%**	2335	52%
June 2025	1974	**42%**	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%
Jan 2026	2362	**48%**	2872	58%

Action taken

- Highest total number of med rec within 24 hours since data collection started (% has dropped as against a background of more admissions).
- Increase in med rec for elective patients; 24% in January 2025 vs 41% in January 2026.
- Increase in emergency admissions; 36% in January 2025 vs 50% in January 2026.

Incident Reporting





Standards

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

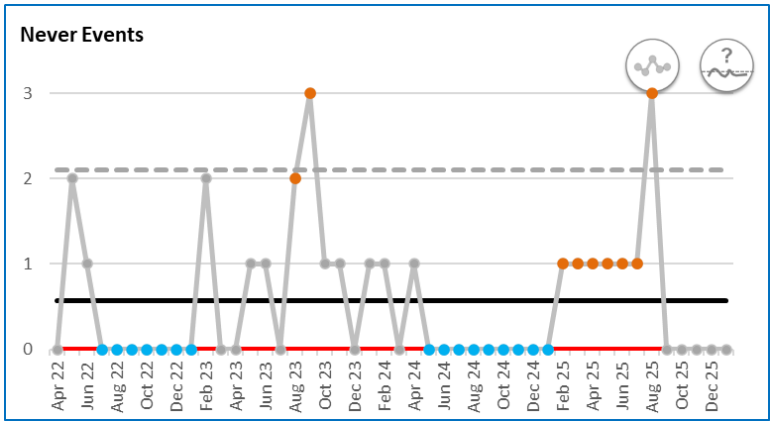
Current Position

- The total number of patient safety incidents per 1,000 bed days reported in January 2026. Decreased compared to December 2025.
- The number of severe/fatal safety incidents per 1,000 bed days increased in January 2026, compared with December 2025.
- Three Patient Safety Incident Investigations and seven After Action Reviews were recorded in January 2026.

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, Safety Spotlights 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

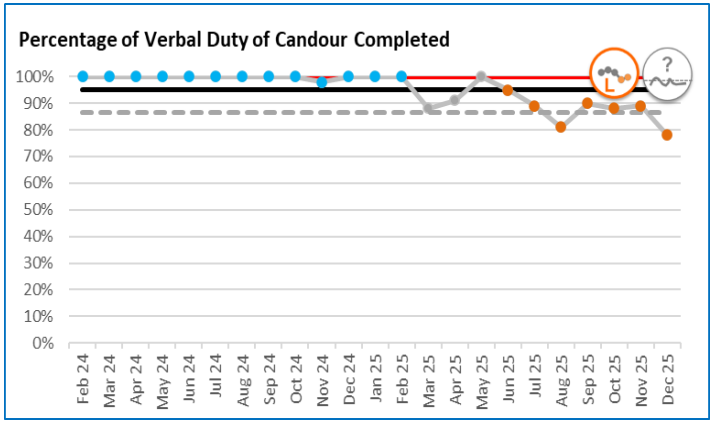
- No Never Events were recorded in January 2026.
- A total of seven Never Events have been recorded for the 25/26 period.

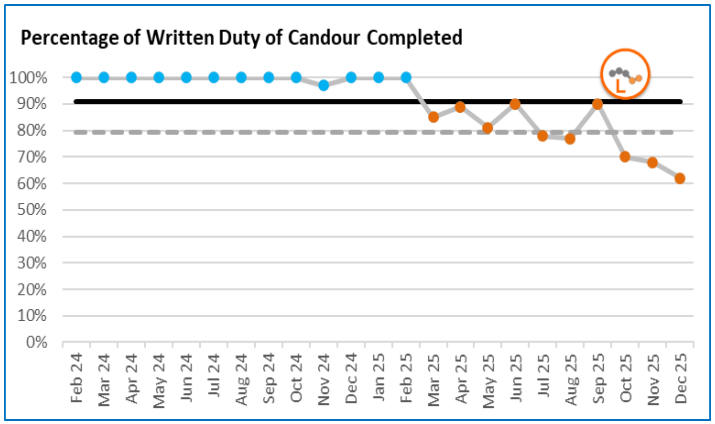
Action taken

- Trust PSRIF priority is being introduced to successfully implement 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.

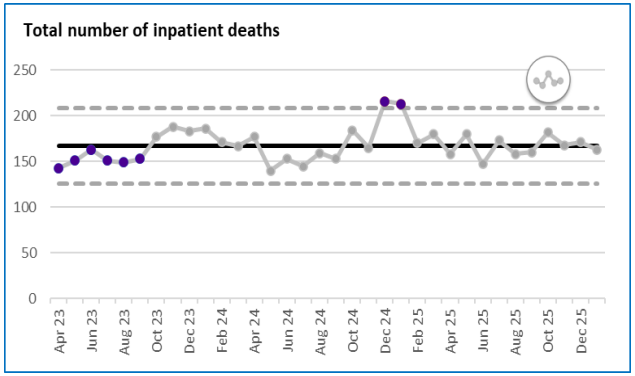
Current Position

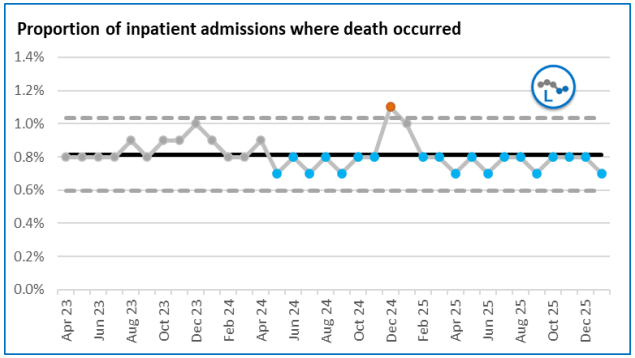
- Data for overall Trust compliance is taken from records of completion in the incident module of InPhase / Datix. Additional assurances for compliance with the statutory requirements of Regulation 20 are undertaken through audits reported to Patient Safety Group and Quality Committee.
- Audit data highlights gaps in some areas of DoC completion, including documentation of verbal discussions. Work is ongoing to support improvements in this area.
- 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 December. Compliance will continue to improve as incidents are reviewed, and investigations completed.
- Changes to the way DoC is recorded since the transition to InPhase has helped to improve the accuracy of the compliance data. This is reflected in the reduction in compliance seen.

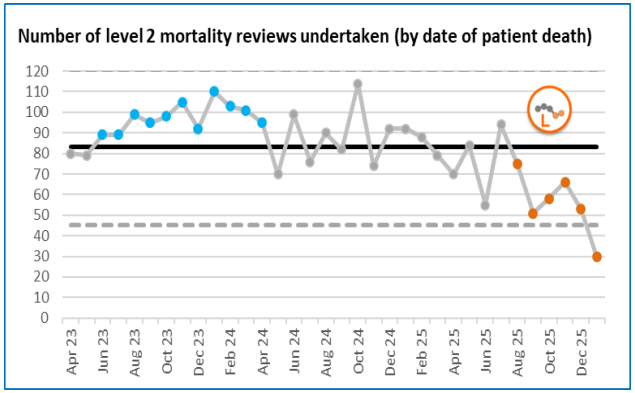
Action taken

- Continuation of newly introduced DoC quality and compliance audit to support improvements in the quality of DoC responses.
- DoC compliance dashboards for Clinical Board oversight have been reestablished in the Reporting Hub. InPhase reports to support oversight of compliance accuracy are also available.

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).

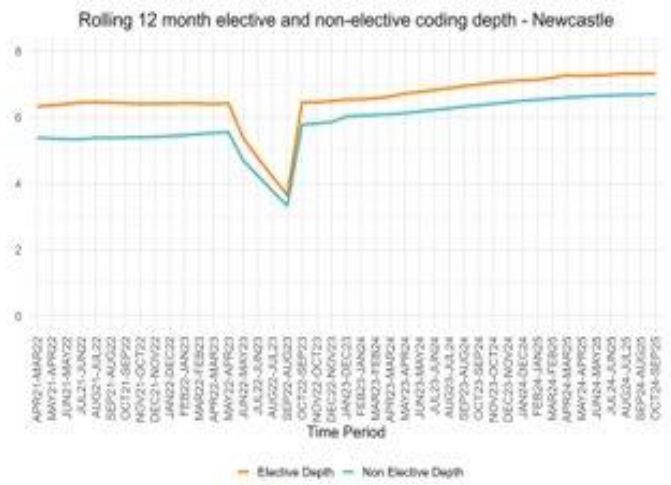
Current Position

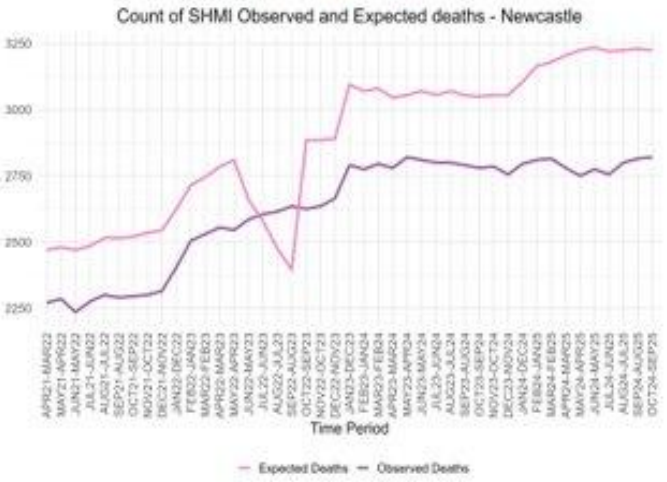
- There were 163 inpatient deaths in total reported in January 2026. This is a decrease of 8 on the previous month and a decrease of 50 on January 2025 which saw a peak in part due to increased circulating respiratory viruses (source: UKHSA).
- The crude mortality rate in January 2026 is 0.7%. This is a decrease of 0.1% on the previous month and is in line with the Trust average.
- Out of the 163 inpatient deaths reported, there are 30 completed level 2 mortality reviews entered into the Trust mortality review database to date.
- 56 Level 2 reviews were also completed in January 2026 for patients who died prior to this date.
- None of the completed reviews undertaken in January have been scored with a high HOGAN score (indicator of preventability of death) or a high NCEPOD score (quality of care provided).
- One patient with a confirmed learning disability died in January 2026.

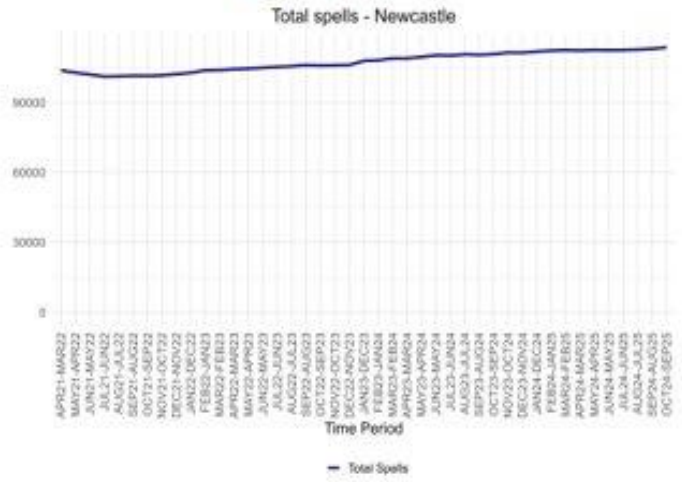
Action taken

- 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 (Oct 2024 – Sept 2025) the Trust SHMI is at 0.87. This is within the 'as expected' category.

Observed & Expected deaths Between Oct 2024 – Sept 2025, the Trust has 2,820 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 Oct 2024 – Sept 2025, the Trust has a 1.9% palliative care coding rate.

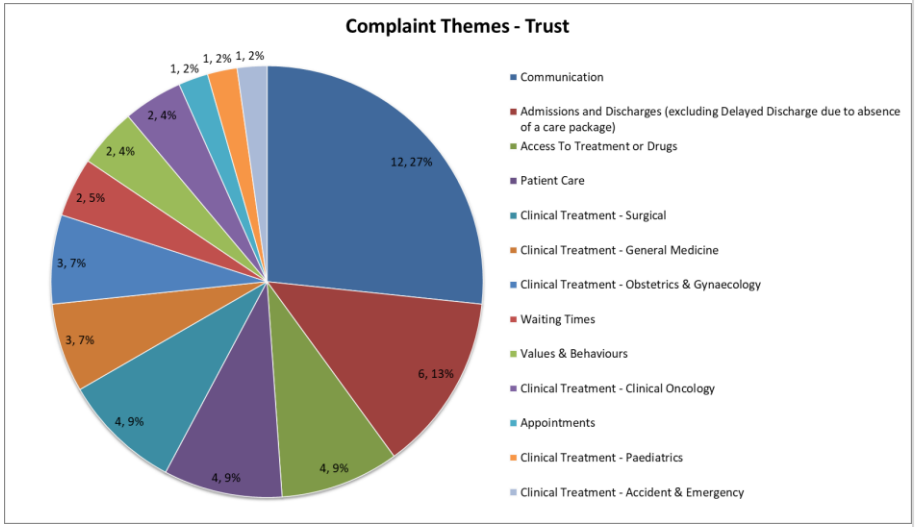
Invalid Primary Diagnosis
The Trust has a 0% rate of invalid primary diagnosis coding.

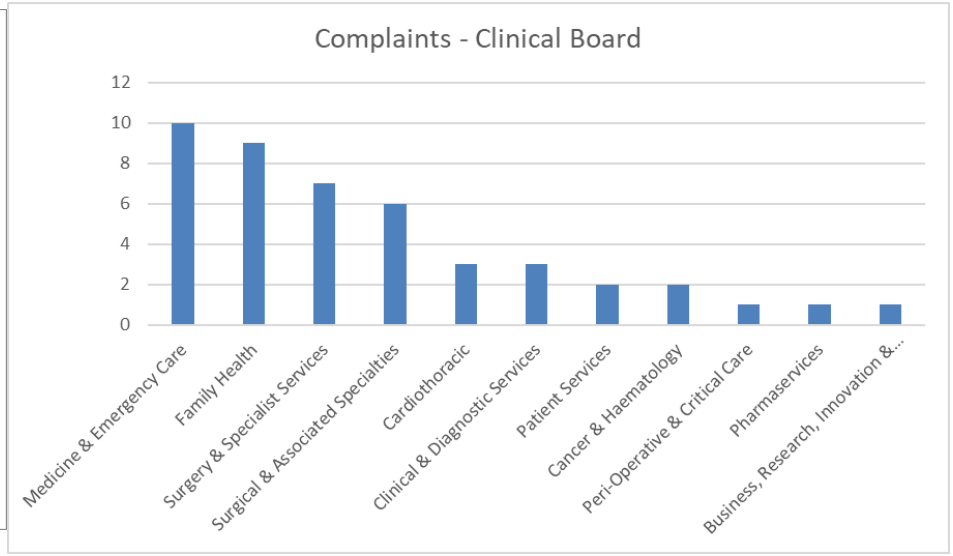
Total Spells
Between Oct 2024 – Sept 2025 the Trust recorded 113,710 spells in total

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).*

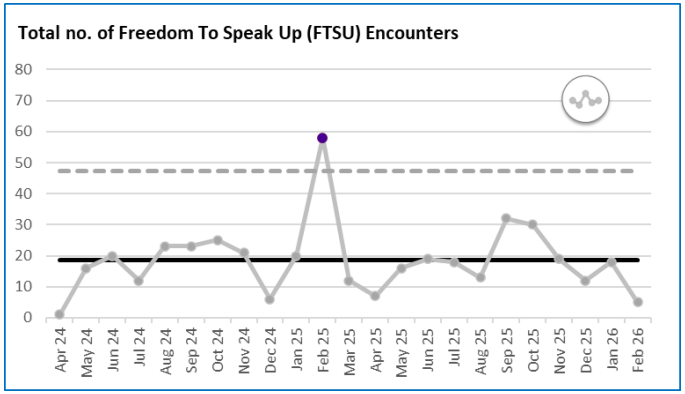
Formal Complaints





- The Trust has had 45 formal complaints In January 2026. The average number of complaints opened for the previous financial year is 54.
- The main theme for complaints this month was Communication, accounting for 27% of the complaints (12).
- Clinical treatment accounts for the most complaints collectively across the specialties with 31% of complaints opened this month (14).
- The most complaints were opened for the following three Clinical Boards, collectively accounting for 66% of complaint this month:
    - Medicine & Emergency Care 10 (22%)
    - Family Health 9 (20%)
    - Surgery & Specialist Services 7 (16%)

Freedom to Speak Up (FTSU)



Standards

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

Current Position

- There were a total of 18 speak up encounters made to the FTSU Guardian (FTSUG) in January 2026. 6 encounters with peri-op, 3 of which related to car parking, and 5 within Clinical and Diagnostic Services (CDS), of which 3 were relating to the same issue.
- 2 speak ups were raised by the Work in Confidence (WIC) software but the staff members subsequently felt able to meet face to face.
- 1 concern was raised via the Cumbria, Northumberland, Tyne and Wear (CNTW) FTSUG (ward 31A, RVI)

Clinical Board	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Grand Total
CB Surgery and Specialist Services RVI						19	20	4	3		46
CB Peri-operative and Critical Care	1	2	5	5			3	1	1	6	24
CB Clinical and Diagnostic Services			2	1	2	3	1	4	2	5	20
CB Family Health	1	2	1	1		1	6	1	2		15
CB Medicine and Emergency Care						7	2	3	1		13
CS Unknown			3							8	11
CB Cardiothoracic Services		1	4	1			1	1		1	9
CB Clinical and Research Services	3	6									9
CS Business Development				1	1	3	1	1	1	1	9
CS Estates		1	2	1	1	1			1		7
(blank)			2	3						1	6
CB Surgical and Specialist Services RVI		1		3	1						5
CB Surgical and Associated Services FH				1	3						4
CS Information Management and Technology		1					1	2			4
CB Cancer and Haematology	1					1		1			3
CS Human Resources						1		1			2
CS Patient Services					1				1	1	3
CB Surgery and Associated Specialities FH										1	1
CS Chief Executive			1								1
CS Hosted Staff										1	1
CS Unkown											0
Grand Total	**6**	**14**	**20**	**17**	**9**	**36**	**35**	**19**	**12**	**25**	**193**

Topic	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Grand Total
Inappropriate behaviour and attitudes		2	7	9	2	17	6	8	6	4	61
Bullying and harassment	2	2	3	1	1	6	18	9	2	5	49
Worker safety and quality		4	2	5	6	11	10	1	3	5	47
Patient safety and quality	2	1	1			2	1	1	1	11	20
Poor management	2	4	5								11
(blank)			1	2							3
Civility		1									1
Disadvantageous demeaning treatment as a result of speaking up			1								1
Grand Total	**6**	**14**	**20**	**17**	**9**	**36**	**35**	**19**	**12**	**25**	**193**

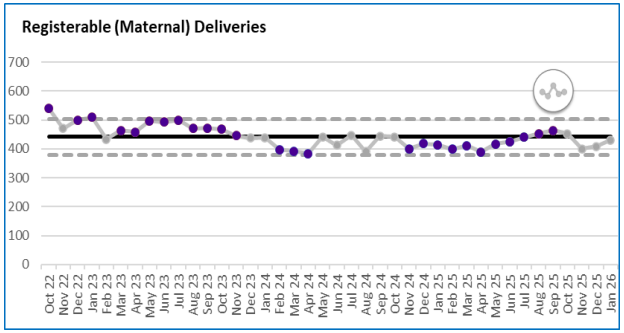
- The most frequently reported category of concern reported was worker safety and quality (12), followed by bullying and harassment (10), patient safety and quality (8) and inappropriate behaviour and attitudes (7). The most frequently reported subcategory was individual behaviour (10).
- There was 1 case of racial discrimination that was being managed within the service area.

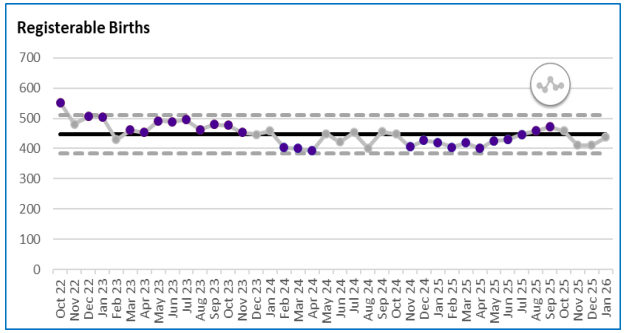
There are currently 29 trained FTSU Champions.

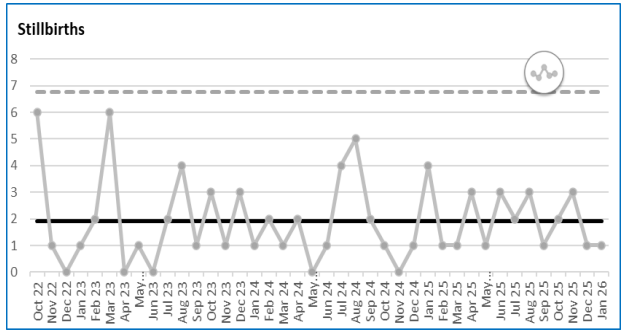
Action Taken

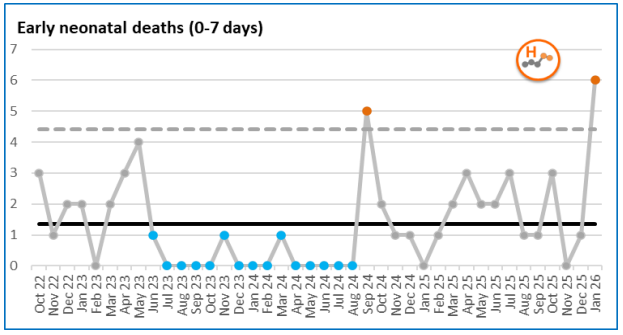
- Meetings with managers to escalate concerns and gain assurance on actions, with scheduled follow ups to ensure action completion.
- Leadership walkabout – Minor injuries.
- Staff engagement sessions – Outpatient (OP) nursing staff, Freeman Hospital (FH) radiology, FH Estates and Facilities.
- Ongoing champion recruitment.

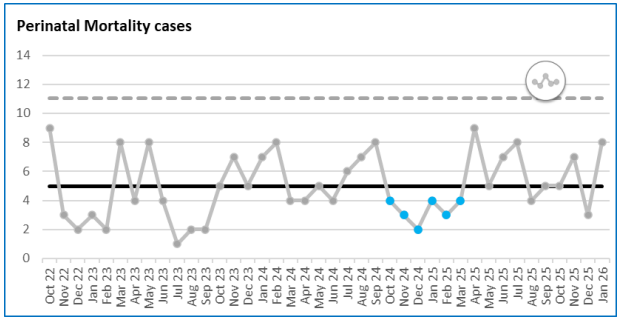
Perinatal Quality Oversight: Births











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.

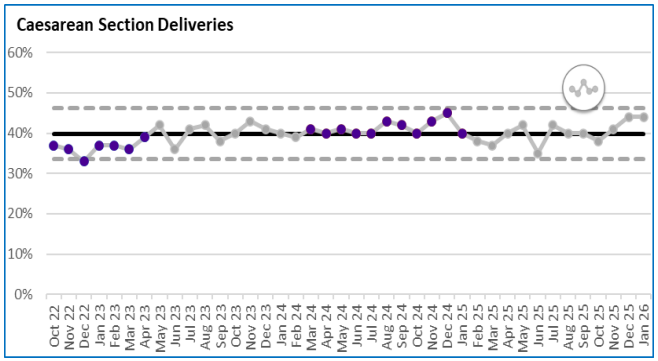
Stillbirths

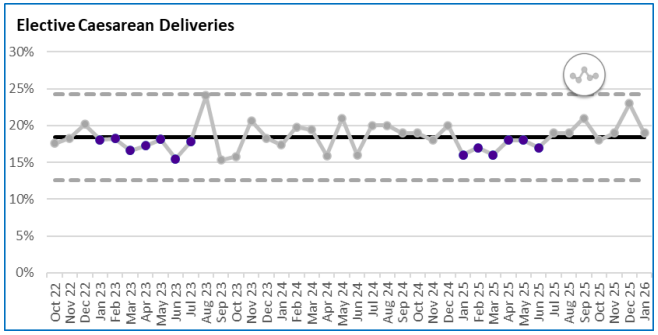
- This data includes termination for fetal anomalies >24 weeks gestation. There was one stillbirth in January 2026, this case meets the criteria for notifying but not reviewing through the Perinatal Mortality Review Tool (PMRT). The PMRT quarterly report is submitted to Trust Board in accordance with the Maternity Incentive Scheme (MIS) requirements. The Trust's previous safety alert has been stood down following further analytics which indicated this was duplicated data, when these cases were removed the Trust returned to within a 95% confidence limit. (Average per 1000 births: England 3.2, North East North Cumbria (NENC) 3.6).

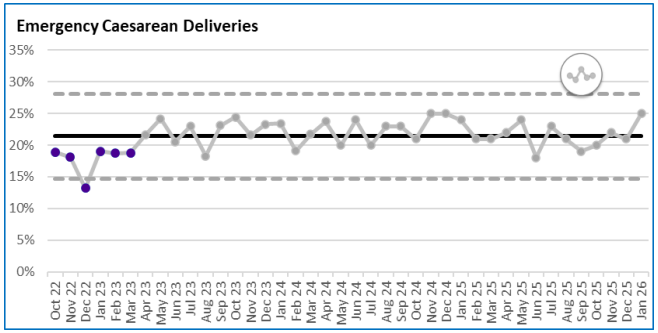
Early Neonatal Deaths

- The Trust has the highest level of neonatal intensive care provision supporting extremely premature babies. Early neonatal deaths are classified as death within 0-7 days of life (late neonatal deaths are those from 7-28 days). These deaths are reported to the Child Death Review panel who will have oversight of the investigation and review process. There were six early neonatal deaths in January 2026. Three of these deaths involved extremely premature infants born before 24 weeks gestation.

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 44.0% in January 2026, 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. A quality case has been submitted, with a comprehensive action plan jointly owned by Peri-operatives and Maternity leadership team.

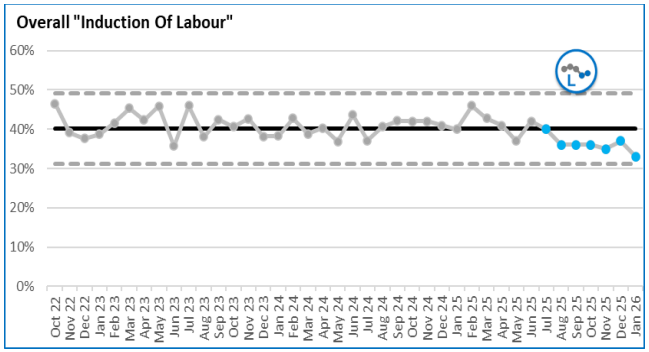
Elective Caesarean section

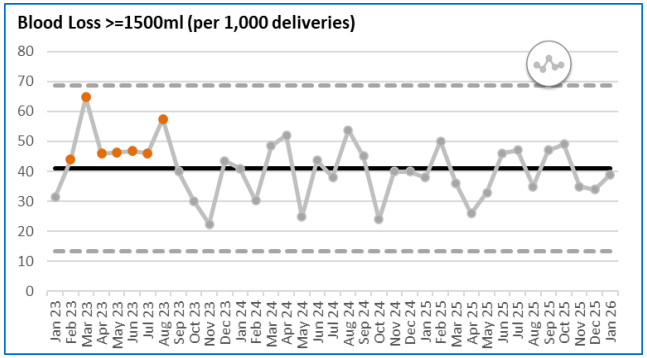
- The average England elective caesarean rate in Q2 was 20.3% and in NENC 20.7%.
- The Trust elective caesarean rate was 19% in January 2026.
- The national rise in elective caesarean rates is partially due to an increasing proportion being undertaken due to maternal request in accordance with the National 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.

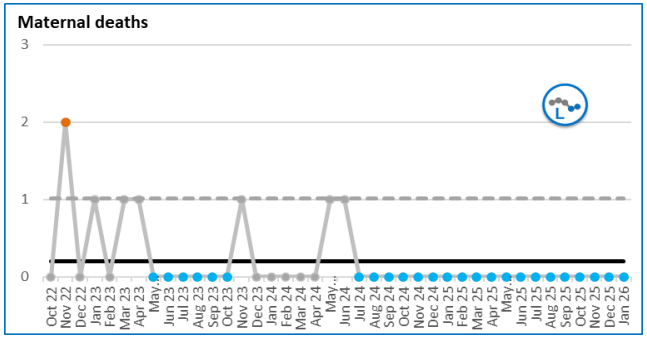
Emergency Caesarean section

- The England average for Q1 2024/25 was 23.6%, and NENC mean 20.5%
- The Trust emergency caesarean rate was 25% in January 2026. 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 Q2 2025/26 was 28.5% and NENC 33.5%. The Trust induction of labour rate for January 2026 is 33% (stable since August).

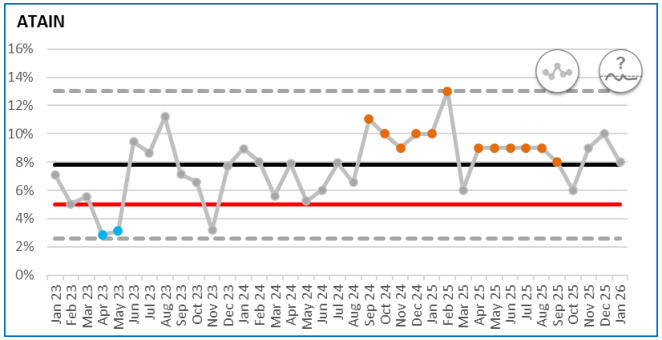
Blood Loss ≥1500ml

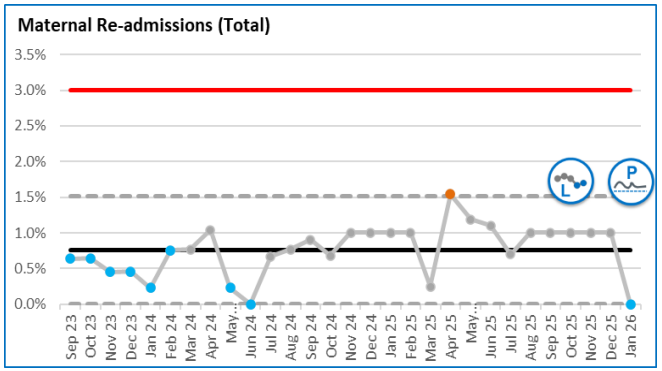
- The average Post Partum Haemorrhage (PPH) rate for Q2 2025/26 in England is 32 per 1000 and NENC average is 30 per 1000. The Trust PPH rate for January 2026 is 39 per 1000. Q1 average was 35 per 1000, Q2 average 43 per 1000 and Q3 average 39 per 1000.
- Higher rates are indicative of the complexities of the high-risk patient group and provision of the Placenta Accreta Spectrum service as confirmed by the previous review.
- Element 5 of the newly published 'The Maternal Care Bundle' (MCB) (NHS England, 2026) requires Trusts to implement safety actions for obstetric blood loss/PPH and ensure multidisciplinary review of cases ≥2000ml . The Trust are currently benchmarking against all elements within the MCB but do not anticipate any significant increase in reporting PPH as many of the required standards are already implemented within the maternity services.

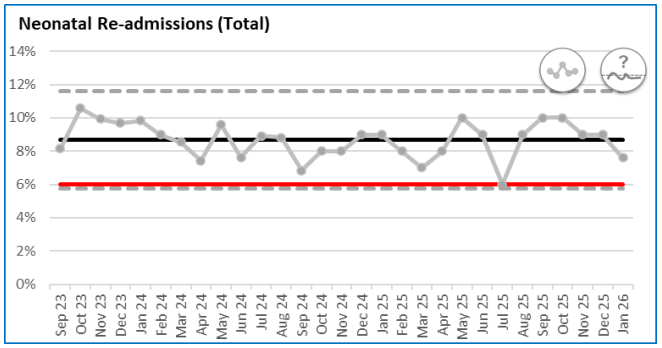
Maternal Deaths

- 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. There have been no maternal deaths reported between July 2024 and January 2026.
- The regional maternity team are currently conducting a thematic review of all maternal deaths across North East and Yorkshire between 2022-2024.
- The Maternal Care Bundle (NHS England, 2026) was published in response to care improvements and disparities in morbidity and mortality outcomes identified by MBRRACE-UK national reports. It establishes a baseline of best practice in 5 areas of care associated with higher rates of maternal mortality and morbidity. The 5 elements are: Venous thromboembolism, Pre-hospital and acute care, Epilepsy in pregnancy, Maternal mental health, Obstetric haemorrhage.

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 January this was 8%. Three quality improvement workstreams are ongoing. The neonatal nurse outreach pilot for theatre recovery commenced in August 2025 and has prevented less than 20 admissions due to the stringent criteria for inclusion. Further analysis is in progress of infants born within the 37th week of pregnancy as this group of patients represent 40% of term admissions, whilst all neonatal admissions were clinically indicated, further analysis of the antenatal care and decision to deliver is required.

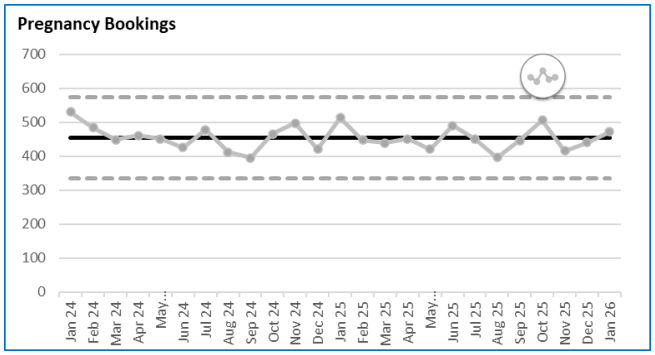
Maternal Readmissions

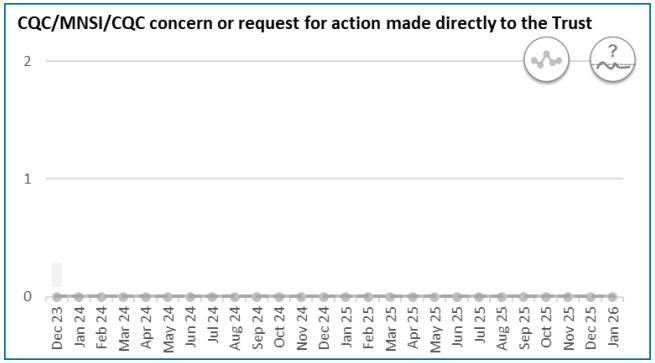
- National Maternity & Perinatal Audit (NMPA) Report (2025) the maternal postnatal readmission rate for England was 3.08% in 2023, rates varied by provider (IQR: 2.57–5.02% in Wales; 2.14–3.59% in England). The LMNS are benchmarking against the national mean readmission rate, hence an internal target 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 January 2026.

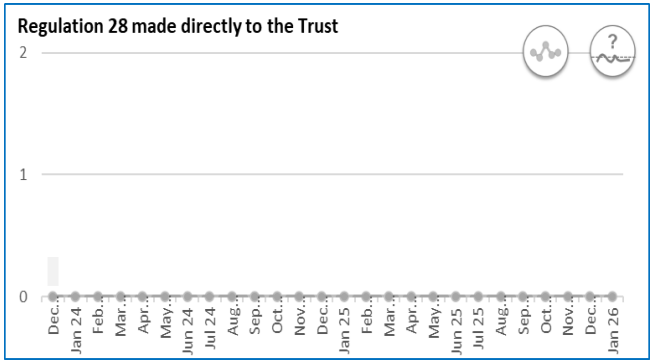
Neonatal Readmissions

- 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 January the readmission rate was 8%, this is currently being reviewed by the lead Neonatologist for Transitional Care services.

Perinatal Quality Oversight: Incidents & Bookings





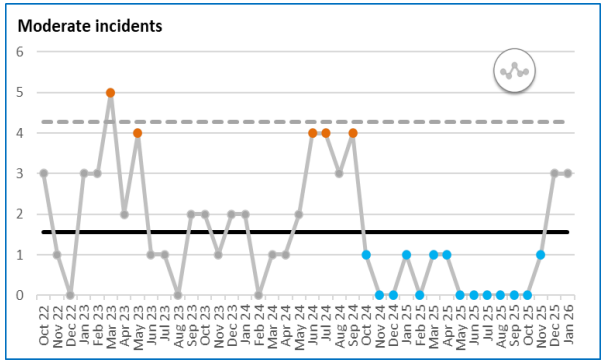


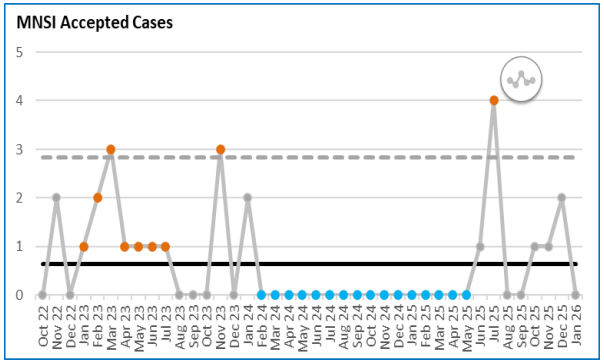
Pregnancy Bookings

- 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.

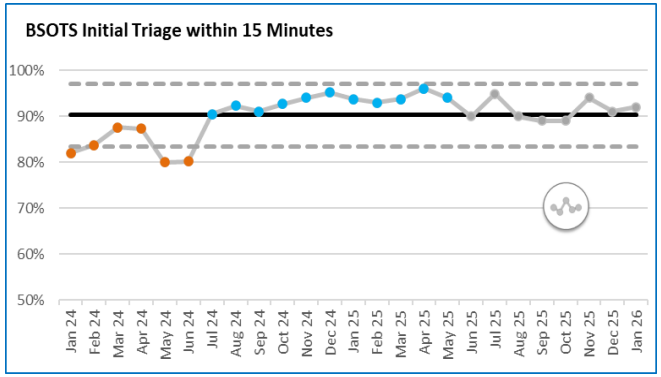
Incidents

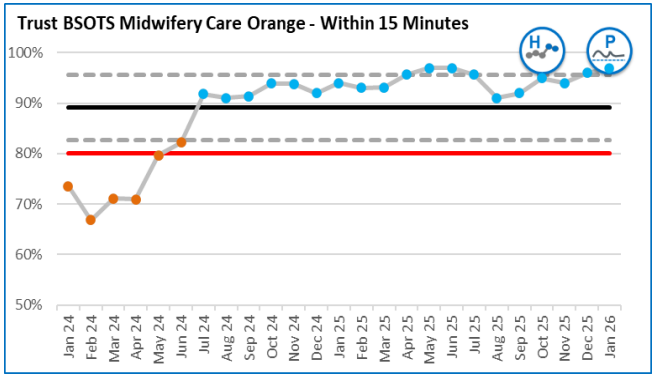
- Moderate incidents are now separated from externally reported MNSI cases which were previously grouped together. There were three moderate or above harm incidents reported in January. Incidents are discussed at a multi disciplinary rapid review and presented to the Trust Response Action Review Meeting (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 no MNSI cases in January.
- 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.

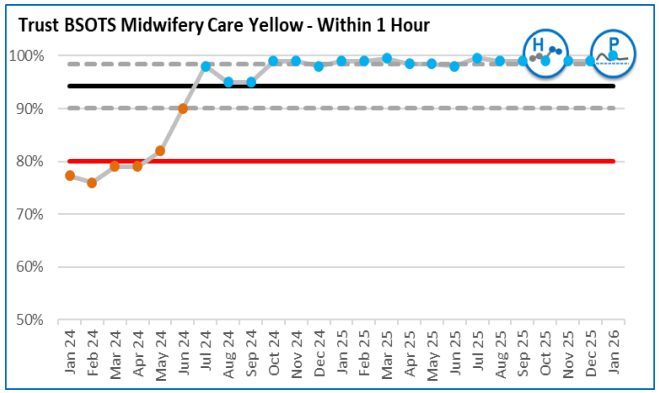


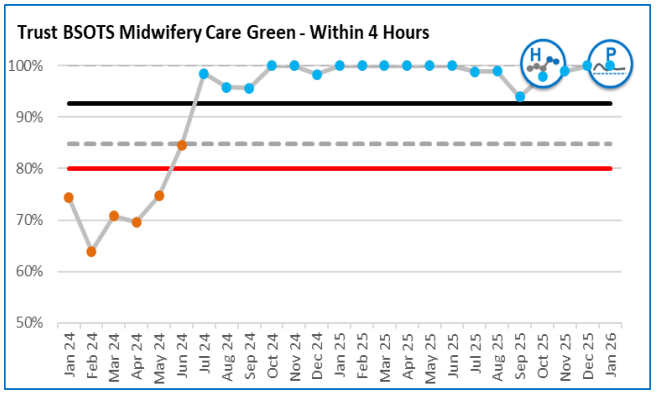


Perinatal Quality Oversight: Triage - Midwifery Care Timings





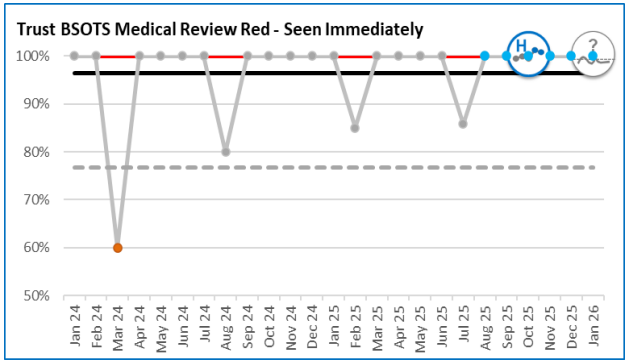


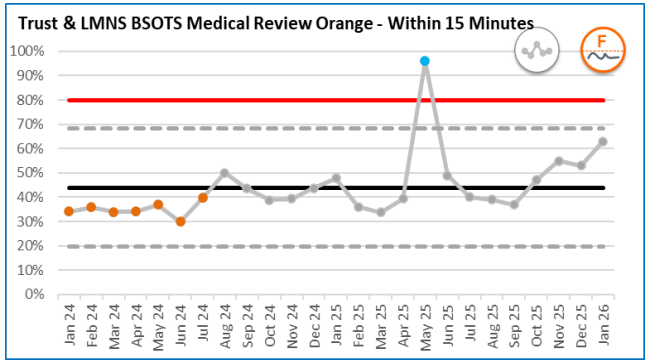


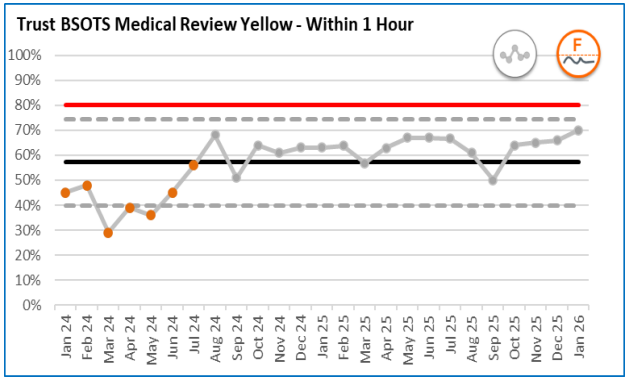
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

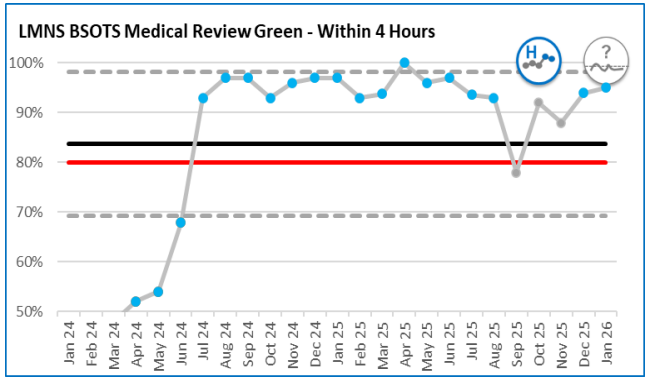
- The Trust implemented the BSOTS triage system in January 2024. Midwifery triage and subsequent review has improved considerably and has exceeded the Trust and LMNS target.
- Good performance continues to be sustained across every category for midwifery review.
- The triage within 15 minutes metric was subject to 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 Emergency Department (ED), analysis has demonstrated there has been no impact.

Perinatal Quality Oversight: Triage - Medical Review Timings





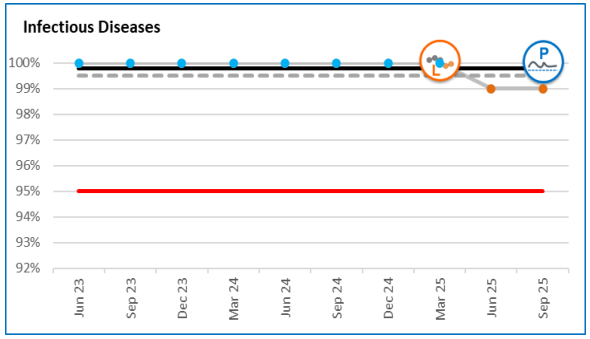


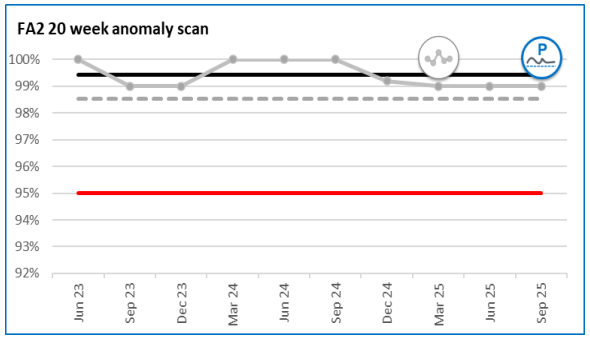


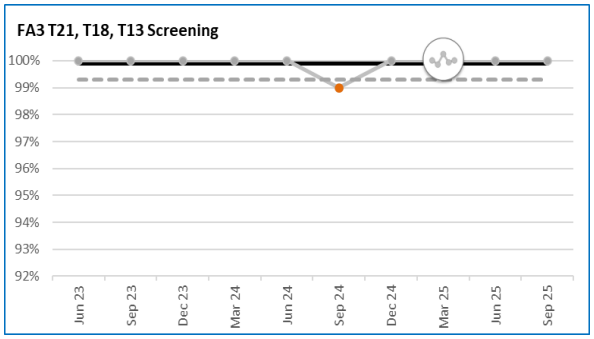
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

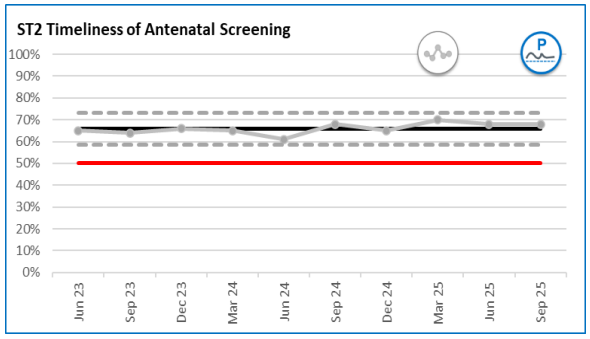
- There has been significant improvement in performance in the last 12 months.
- As previously highlighted, the business case to commence call recording for the triage services has been paused. This remains a risk within the service and is subject to ongoing discussions.
- The national BSOTS team have recommended that women within the ‘orange’ category are further broken down into ‘urgent’ and ‘non-urgent’. The Trust are currently scoping the reporting of this in the Integrated Board Report (IBR).
- However, it should be noted that performance is improving for medical reviews within 15 minutes and 1 hour.

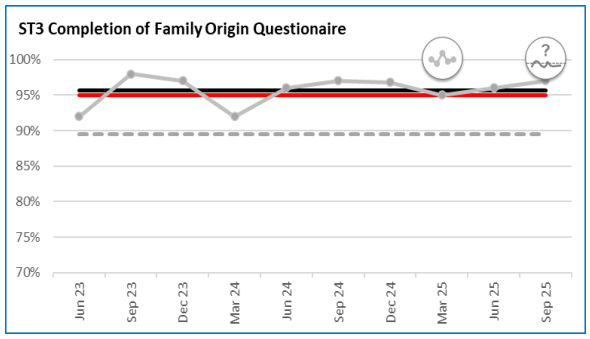
Perinatal Quality Oversight: Antenatal Screening

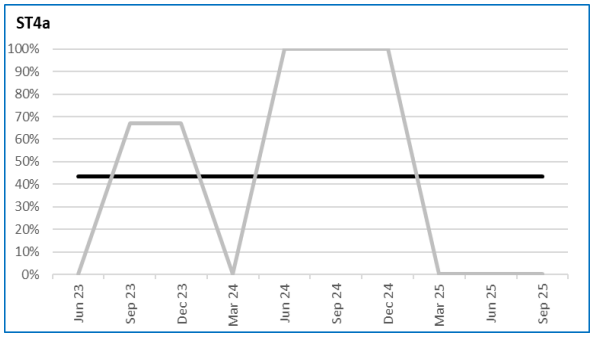


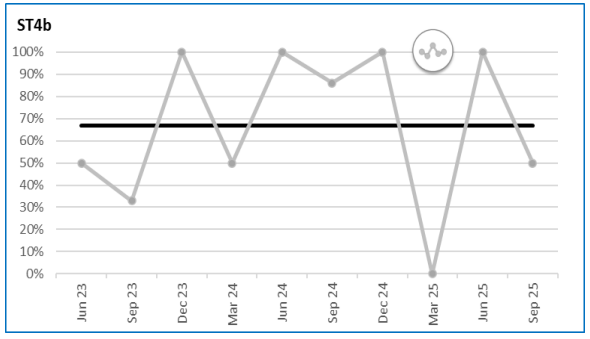


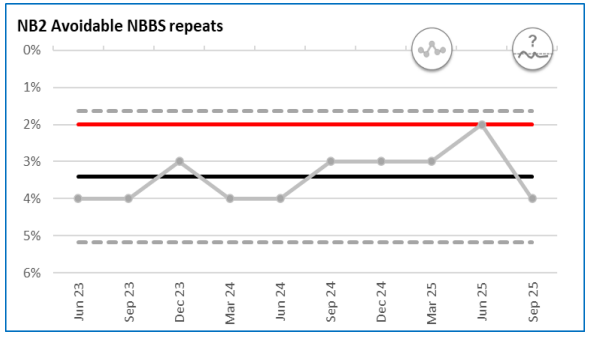








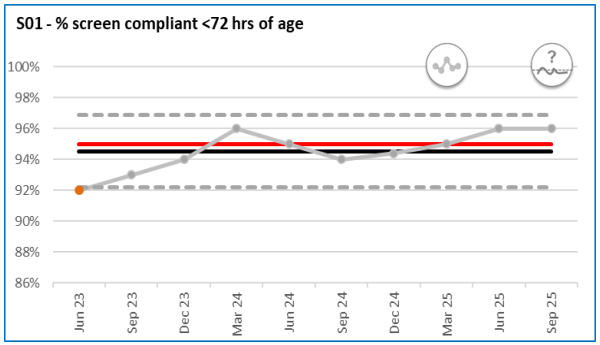


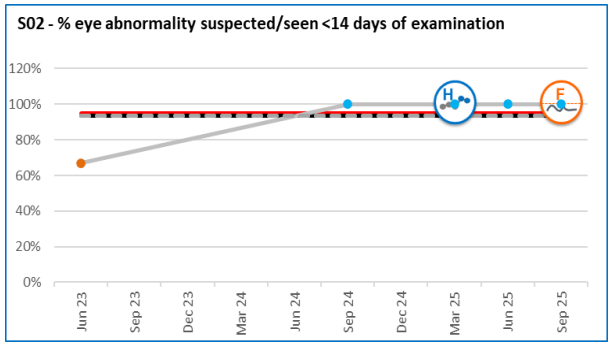


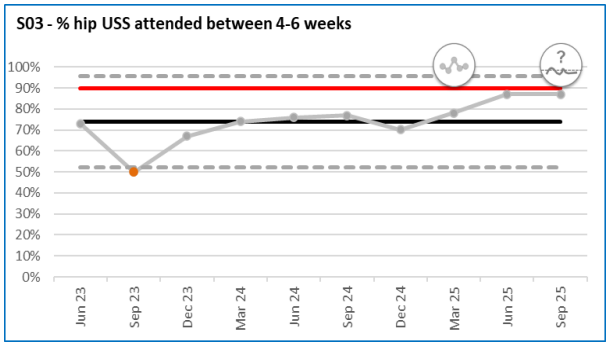
Antenatal Screening

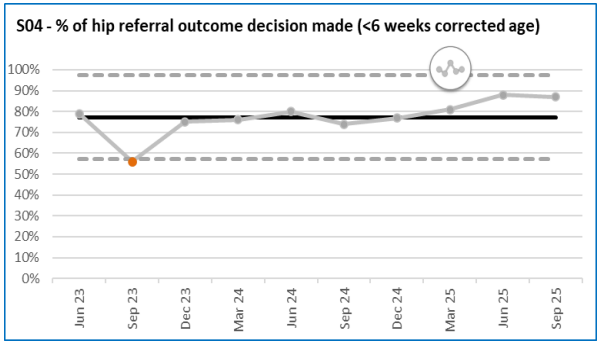
- QIP to review antenatal clinic patient flow, failsafe and administration processes is in place but is impacted by consultant capacity to provide cross cover.
- Screening tracker has been developed by analysts and deployed to support failsafe processes and reporting as per the recommendation in the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

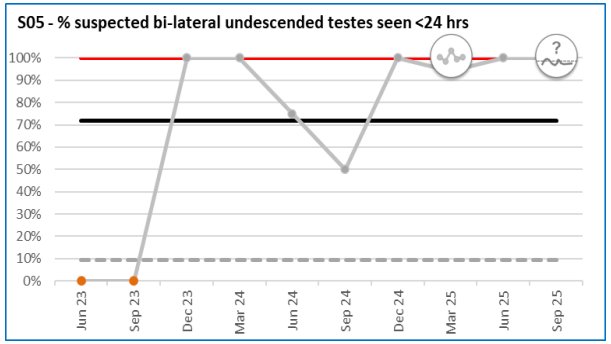
Perinatal Quality Oversight: NIPE Screening







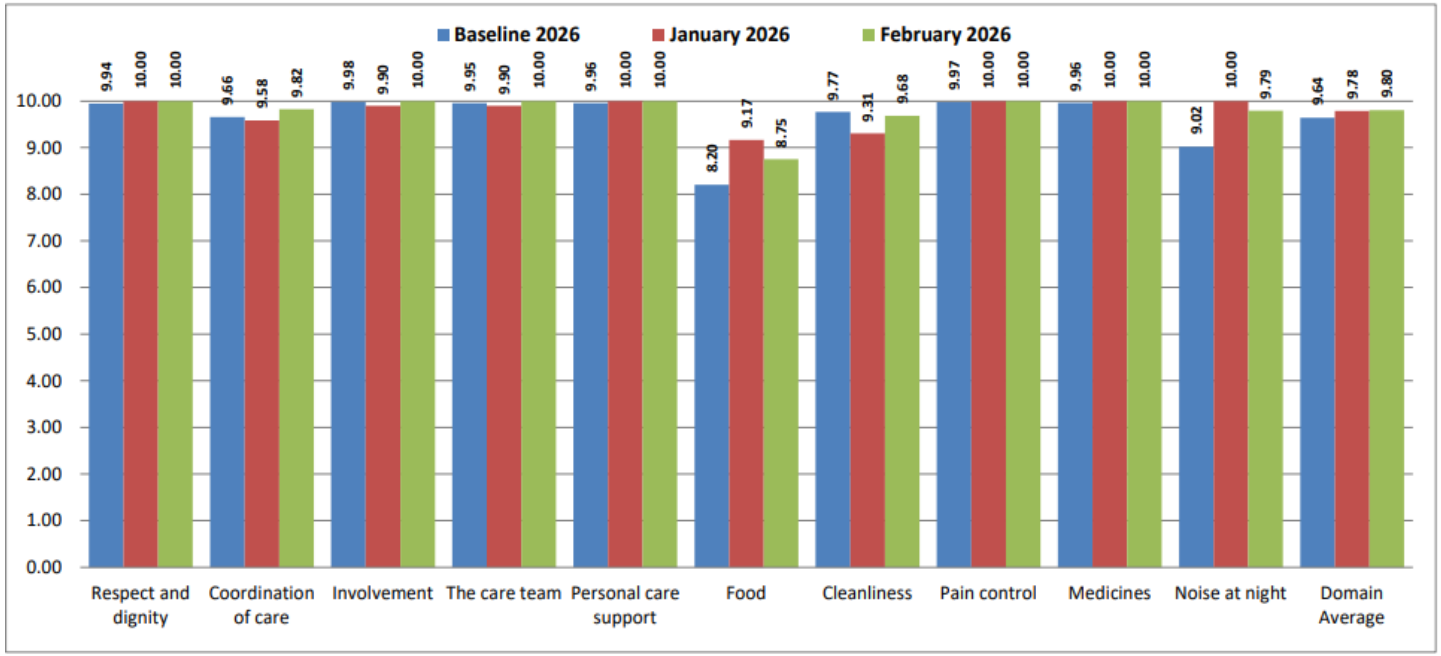




Newborn and Infant Physical Examination

- 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). This is now embedded.
- Focus on hips screening has resulted in month on month improvement

Perinatal Quality Oversight: Patient Experience

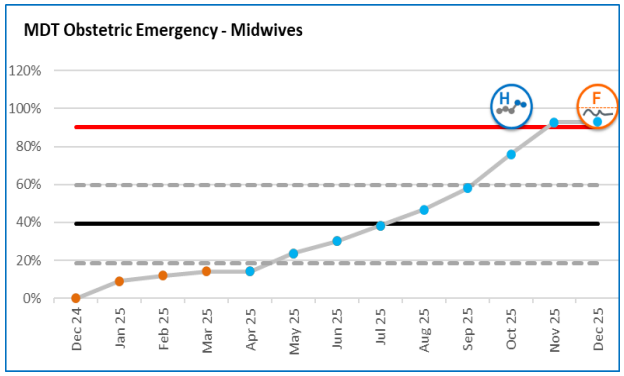


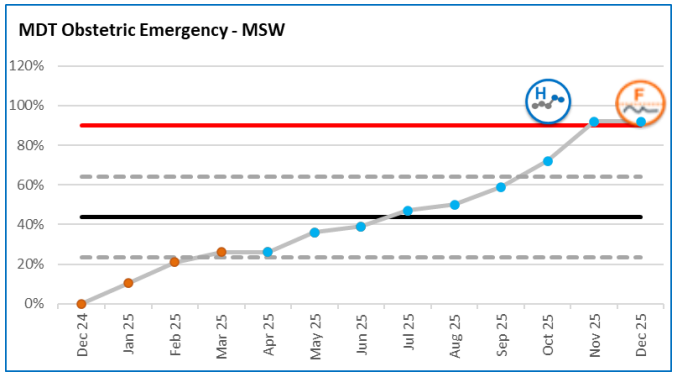
Patient perspective – Delivery Suite

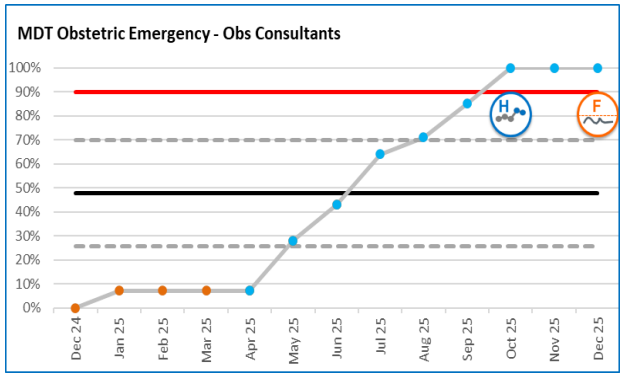
100% of patients surveyed rated their overall experience on the ward as either good or very good.
Number of patients on new medication: 9
Number of respondents: 14

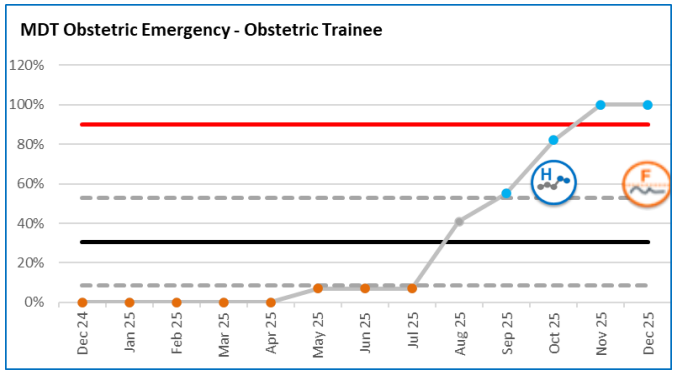
- Everyone has been really consistent. Each member of staff works together really well. I didn't have to wait for anything. Yes, I do have confidence and trust in them. The ward is clean and tidy. I've seen the staff sanitising their hands.
- They've been fine, what they've said is exactly what's happened. I was able to speak to the midwives when I came in. The ward seems to be very clean, and the toilets are nice and clean.
- It has happened where people have said one thing and someone else has said another. The staff work alright together as far as I'm aware. I think they need to work on their communications. I had a bit of an issue today when someone said one thing and it wasn't communicated.
- It's just a lot of waiting really.

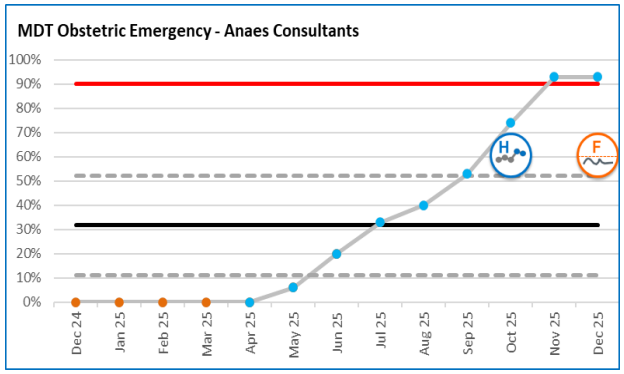
Perinatal Quality Oversight: Training (Maternity Incentive Scheme)

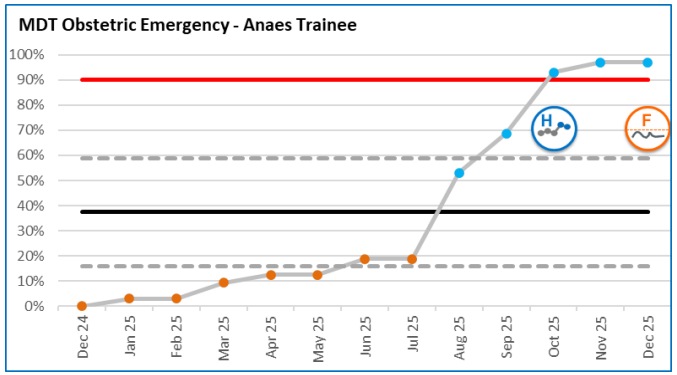












Obstetric Emergency Training by Staff Group:

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:

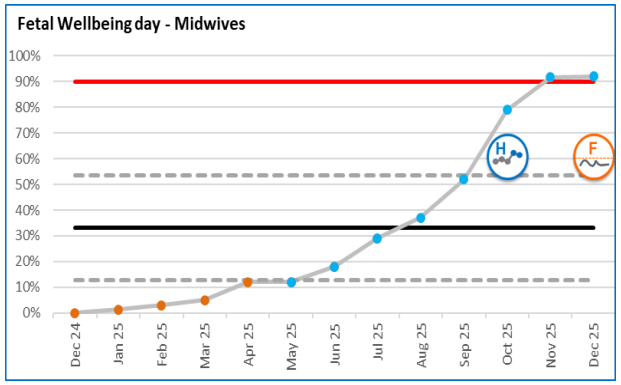
- Multi-professional maternity emergencies training
- Neonatal resuscitation training
- Fetal monitoring training

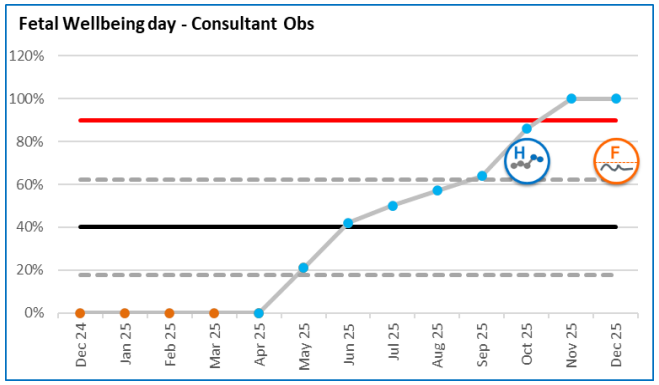
The fetal monitoring and obstetric emergencies training account for one whole day respectively.

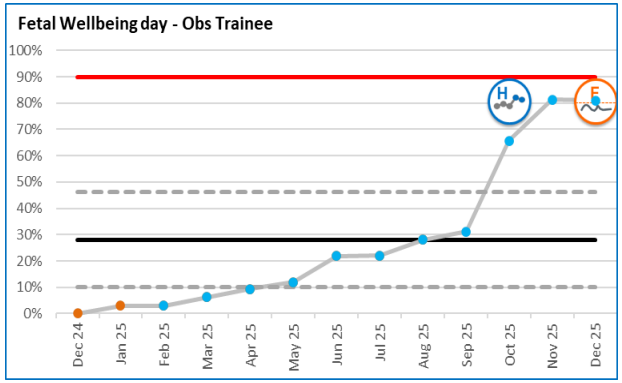
An additional requirement is to ensure at least one emergency simulation is performed within a clinical area (not simulation suite) during the MIS reporting period to capture attendance from the wider professional team, the Trust are compliant with this requirement.

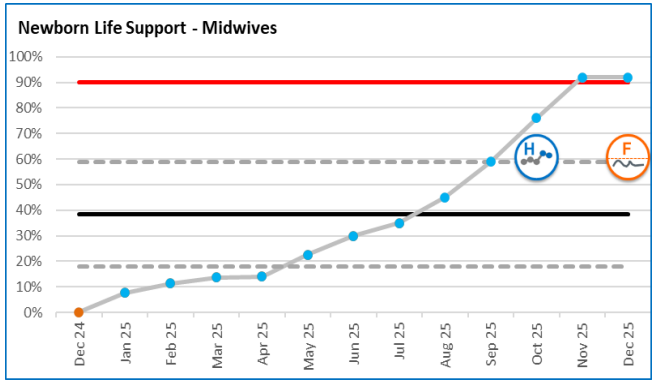
The Trust is compliant with the obstetric emergency training across all staff groups.

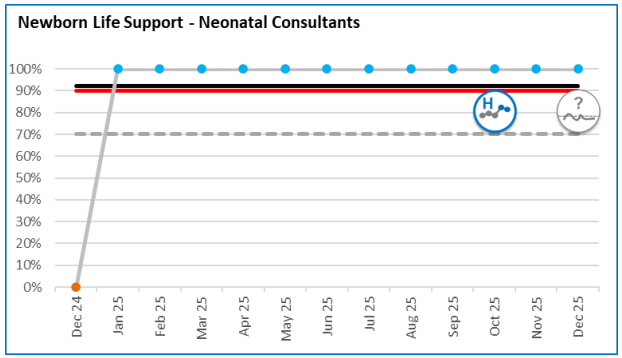
Perinatal Quality Oversight: Training (Maternity Incentive Scheme)

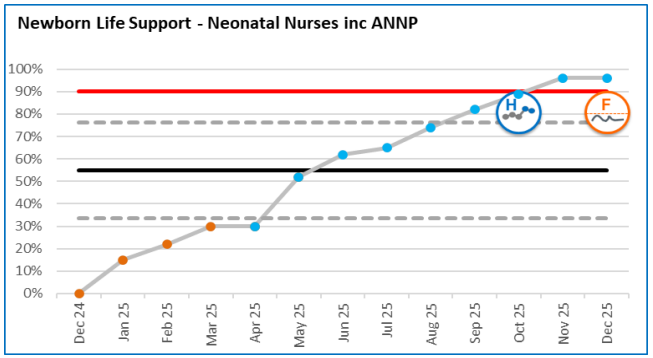


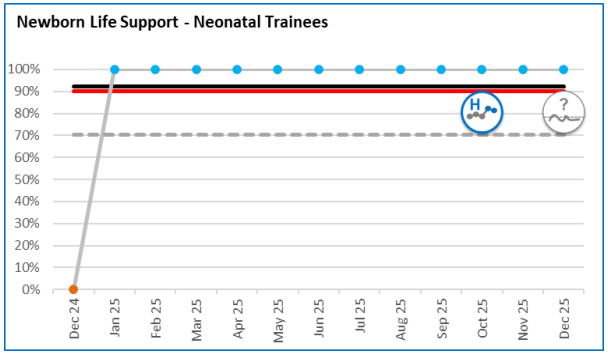












Fetal Wellbeing Training by Staff Group:

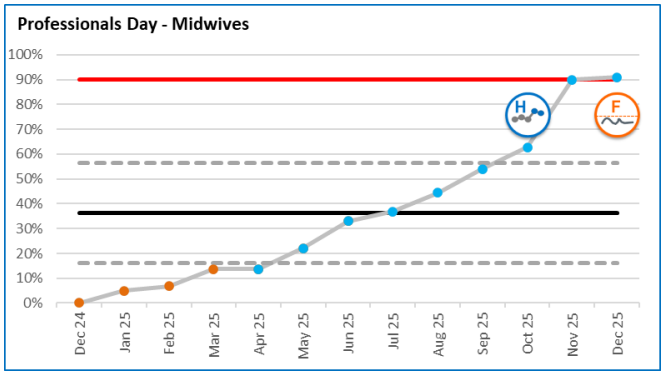
The Fetal Wellbeing training is essential training to ensure compliance with the implementation of the Saving Babies Lives Care Bundle version 3 (SBLCBv3) which aligns to the CNST MIS Year 7 Safety Actions 6 and 8.

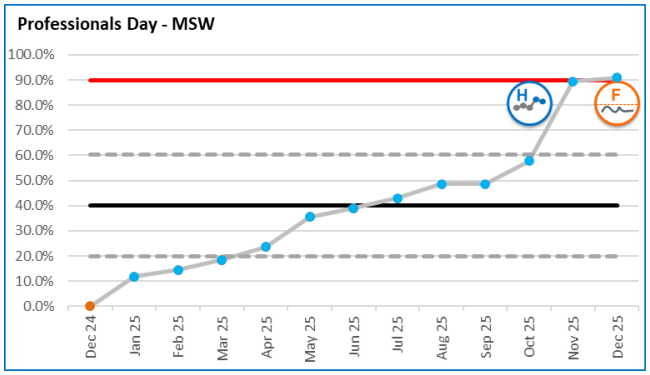
The Trust is compliant across all the required staff groups; as a lower threshold is accepted for trainees who have rotated into the Trust since July 2025.

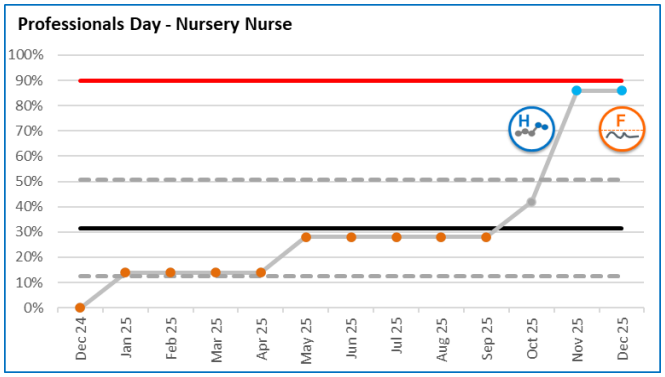
Newborn Life Support by Staff Group:

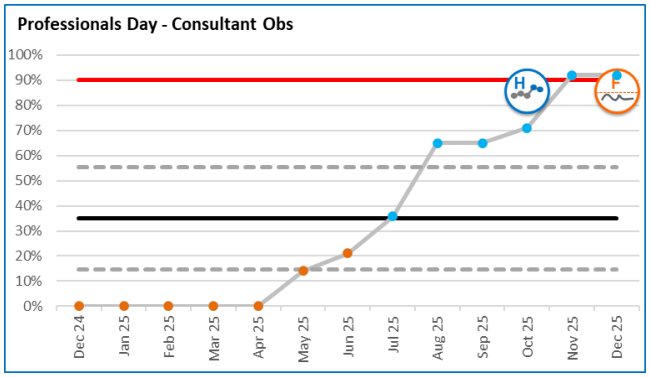
The newborn life support training is essential training to ensure compliance with MIS Year 7 Safety Action 8
The Trust is compliant across all staff groups.

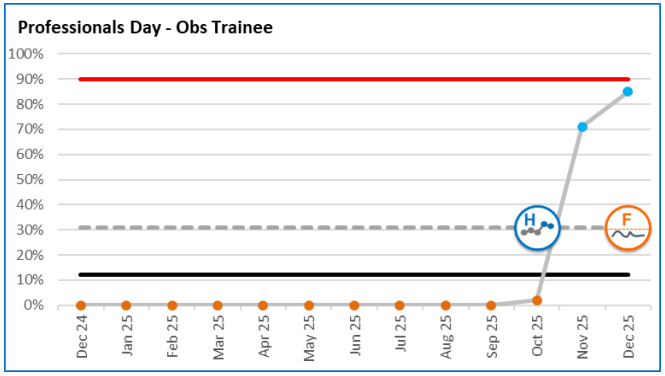
Perinatal Quality Oversight: Training (Maternity Incentive Scheme)









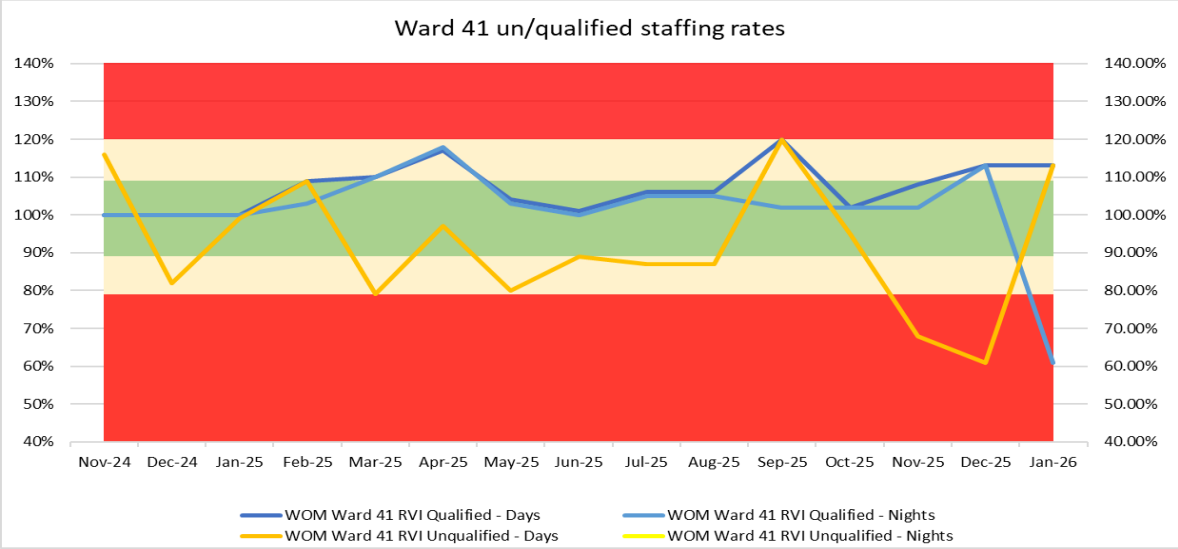


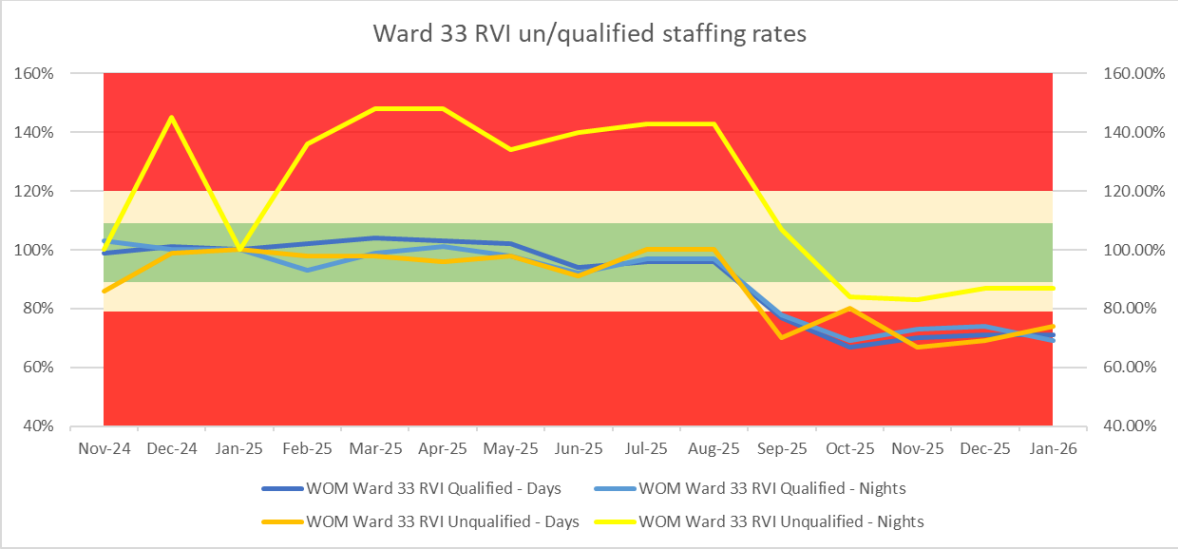
Saving Babies Lives Training by Staff Group:

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





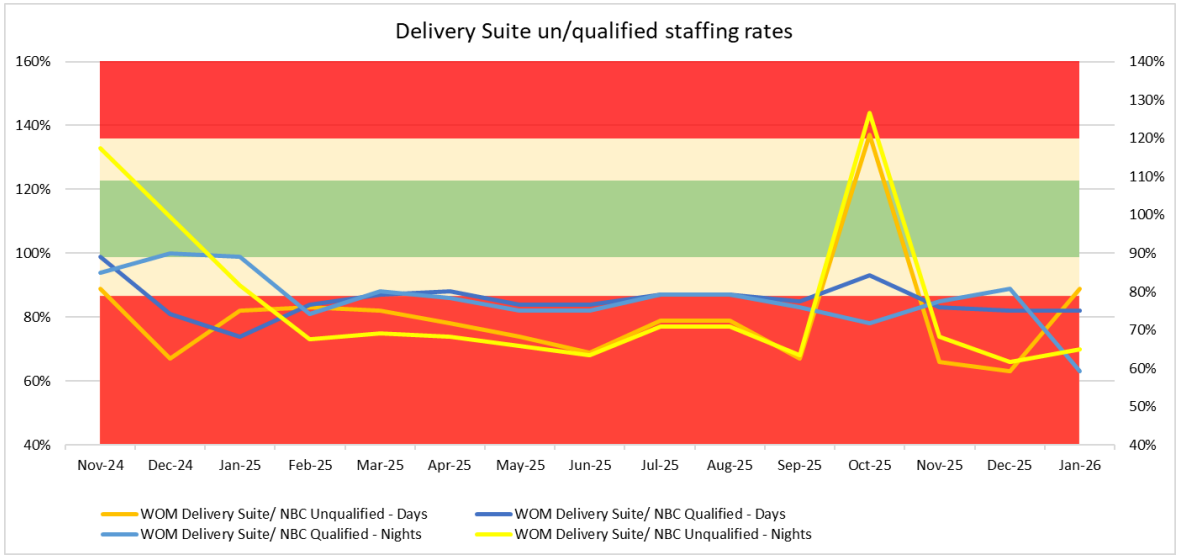
Antenatal Ward (41)

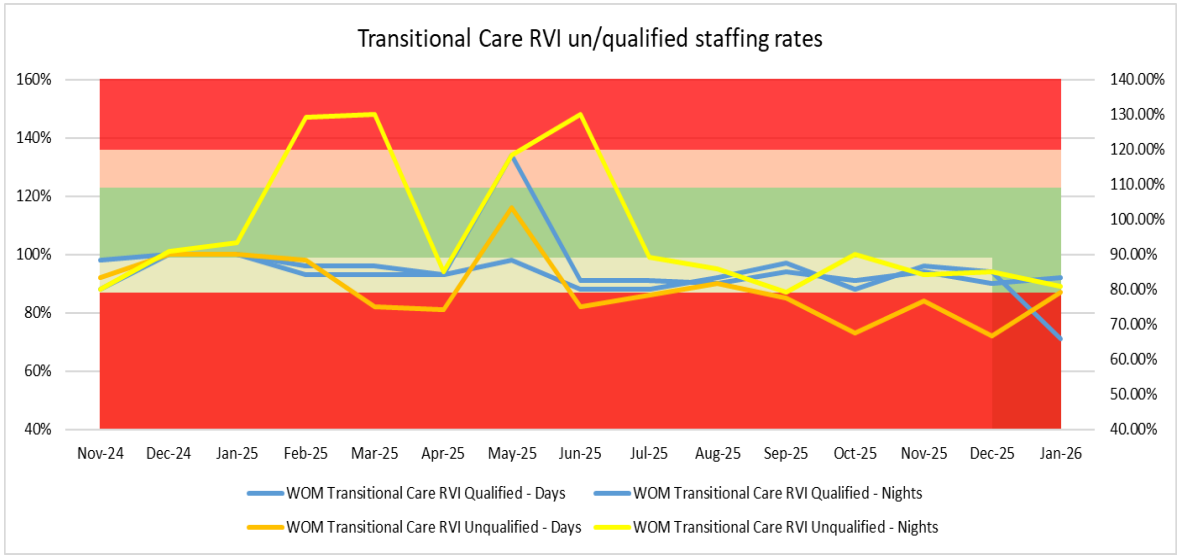
The qualified night and day fill rates have been stable, up to December, there has been a drop in January night shift fill rates due to Birthrate Plus staffing templates for 3 qualified staff on nights which are expected to go live late 2026. When the ward opens escalation beds in an additional bay, midwifery fill rates should exceed the staffing establishment to maintain appropriate staff to patient ratios; this can be seen in January fill rates as there were 19 days in escalation with extra bed spaces open.

Postnatal Ward (33)

The fill rates for the postnatal ward were impacted by sickness and escalation to support antenatal inpatient and intrapartum care in September, however from October the updated Allocate template has 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





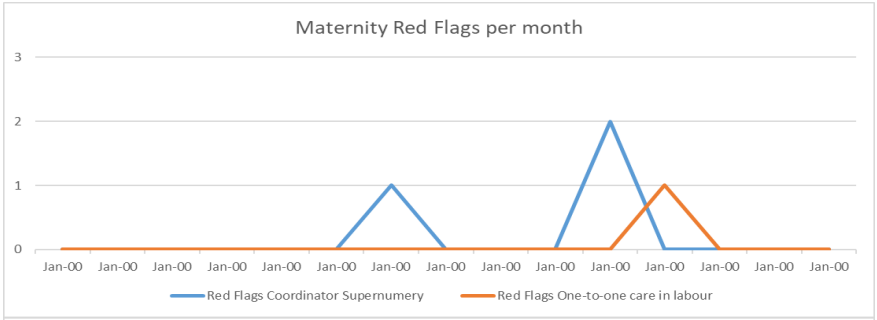
Intrapartum (Delivery Suite and Newcastle Birthing Centre)

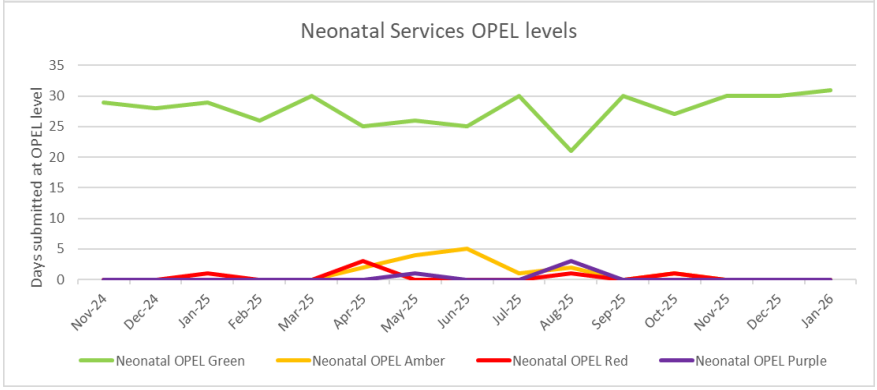
The midwifery fill rates for the intrapartum team remain stable despite the staffing position which is impacted by sickness and maternity leave. There were no red flags relating to the provision of one-to-one care in labour. There were no occasions when the co-ordinator was not supernumerary on Delivery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

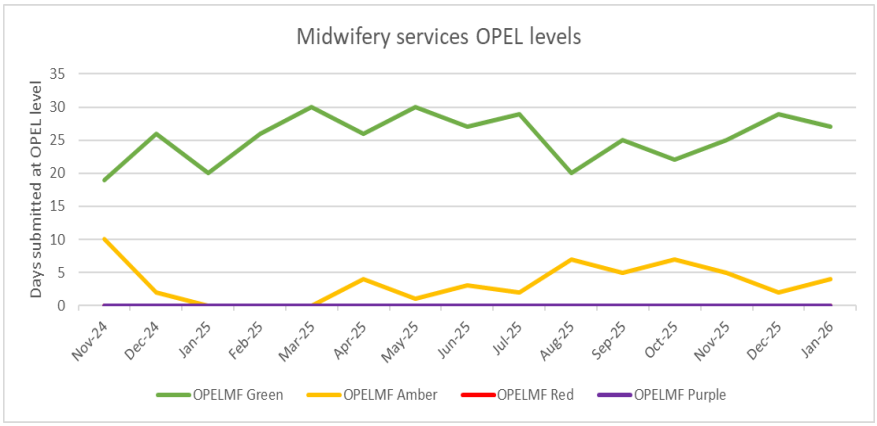
Transitional Care Ward (34)

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 January 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 January when one to one care in labour was not provided.

Operational Pressures Escalation Levels Maternity and Neonatal Framework

The neonatal service maintained Operational Pressures Escalation Level (OPEL) 1 for all 31 days in January. There were no staffing InPhase reports or delays to admissions or transfers out of region.

The maternity service maintained Operational Pressures Escalation Level (OPEL) 1 for 27 days in January, and OPEL 2 for 4 days. There were no staffing InPhase reports and no community escalations to support the acute service.

There were no gaps in obstetric or anaesthetic cover for the Delivery Suite during January 2026.

Performance

Performance Overview

Metric	Period	Actual	Traj.	Target	Variation	Assurance
A&E Arrival to Admission / Discharge	Jan-26	76.0%	82.4%	78%		?
RTT 18 Weeks	Jan-26	71.0%	73.4%	92%	H	F
>52 Week Waiters (% of total PTL)	Jan-26	1.1%	0.3%	1%	L	F
Cancer 28 Day FDS	Dec-25	67.7%	85.3%	80%	L	?
Cancer 31 Day	Dec-25	91.9%	84.1%	96%	H	F
Cancer 62 Day	Dec-25	73.4%	73.8%	75%	H	F
Diagnostic 6 Weeks	Jan-26	21.9%	5.6%	5%	L	F

Emergency Care

- Emergency Department (ED) Performance (All Types) in January was 75.97%, a marginal increase of 0.07% compared to December (75.90%). ED attendances fell slightly in January (21,962) compared to December (21,966), however type 1 performance decreased to 57.25% (58.73% in December).

Elective Waits

- January 2026 witnessed a slight increase in >52-week waiters at Newcastle Hospitals, increasing to 930 (+37). This meant 1.1% of the total RTT waiting list was over 52 weeks - marginally above the national target of 1% by March 2026.
- The total waiting list size decreased further in January to 83,929. The Trust's participation in an NHS England coordinated validation sprint has been key to reductions throughout 2025-26.

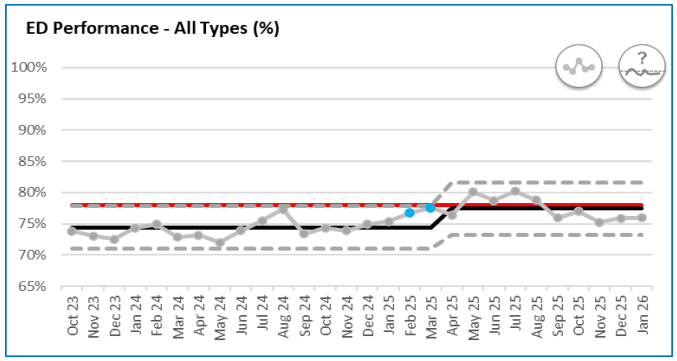
Cancer Care

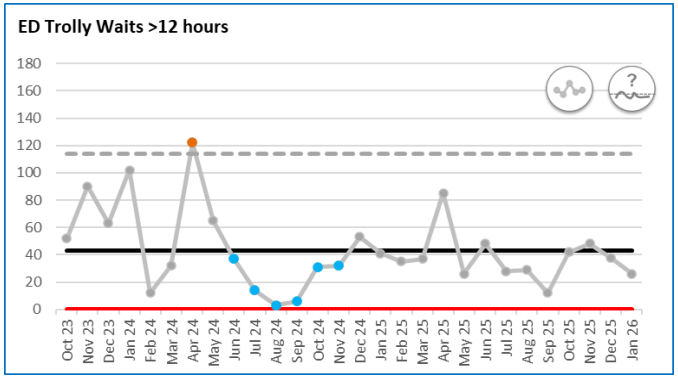
- In December, the 80% 28 Faster Diagnosis Standard (FDS) target was not achieved (67.7%) and recent trends show a sustained decline. 31-day performance remained stable at 91.9% in December, whilst 62-day performance continues to show special cause variation of an improving nature (73.4%).
- There has been a reduction in imaging capacity for Breast Symptomatic patients and also an increase in referrals from Durham, where the local Breast service continues to be heavily impacted.

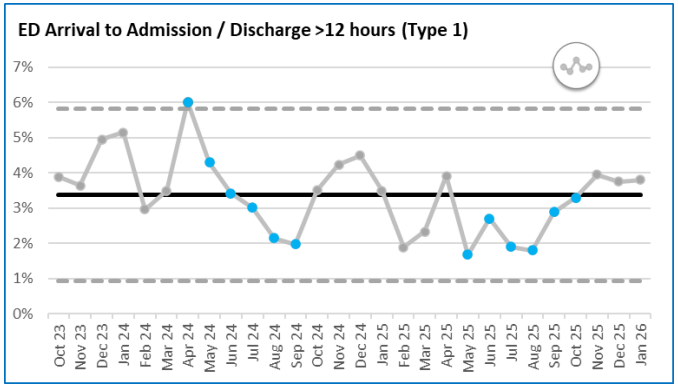
Diagnostics

- Performance against the 5% standard declined in January – 21.9% 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 Accident & Emergency (A&E) exceeding 60 minutes.
- Reduction from 24/25 in waits over 12 hours from A&E arrival to admission/discharge (Type 1).

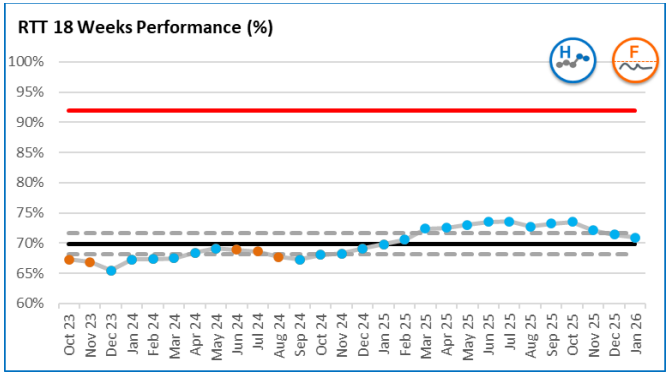
Current position

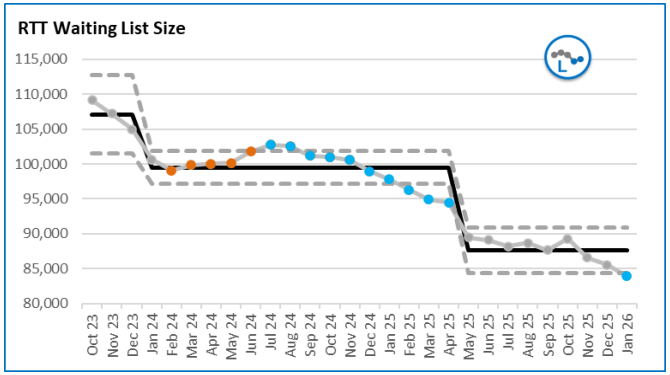
- ED Performance (All Types) in January was 75.90%, a reduction of 0.07% compared to December (75.97%). ED attendances fell slightly in January to 21964, only 4 patients less than December. Paediatric ED 4hr performance for January was 86.38%, an increase of 2.33% from December.
- ED Trolley waits >12 hours reduced from 57 in December to 26 in January.
- ED Arrival to Admission / Discharge > 12 hours (Type 1) in January was 4.12%, a 0.24% increase from the previous month.
- There were 221 handovers > 45 mins in January, this was a decrease from 227 in December. Of those handovers, January had 88 handovers >60mins, down from 109 handovers >60mins.

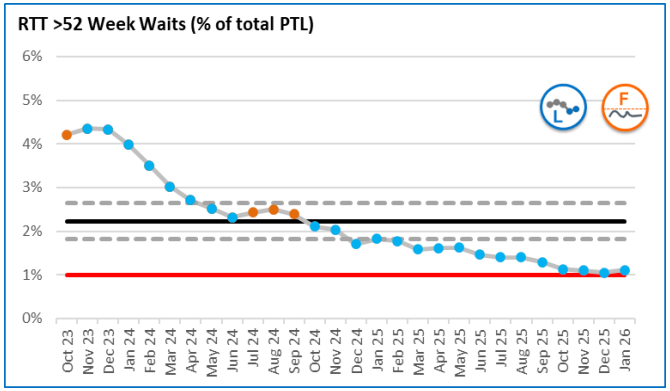
Action taken

- There is ongoing work to improve Urgent Treatment Centre (UTC) performance and triaging criteria between departments.
- Additional space was opened up in the RVI Discharge lounge to facilitate patient flow across sites.
- The Operational and Information Services team are looking into issues between clinical systems when patients are being referred from the UTC to ED back to the UTC.
- The Paediatric Psychiatric Liaison Team went live with their service in and initial feedback from Paediatric ED staff has been positive.
- The winter ward opened on 29th December, increasing the bed stock by 27. This has eased pressures, however the trust continued to see a high number of admissions and high acuity patients, with complex patient discharges.

Elective Waits







Standards

- 92% of patients on incomplete Referral To Treatment (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%).

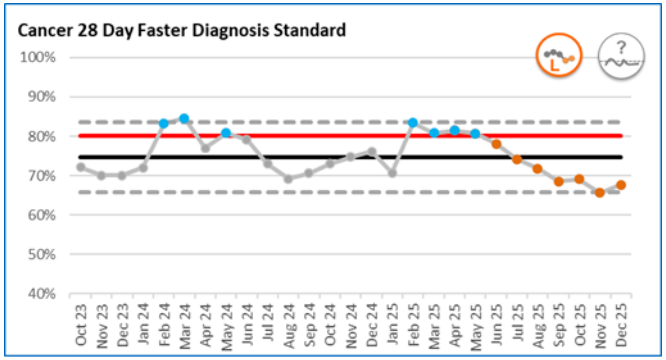
Current position

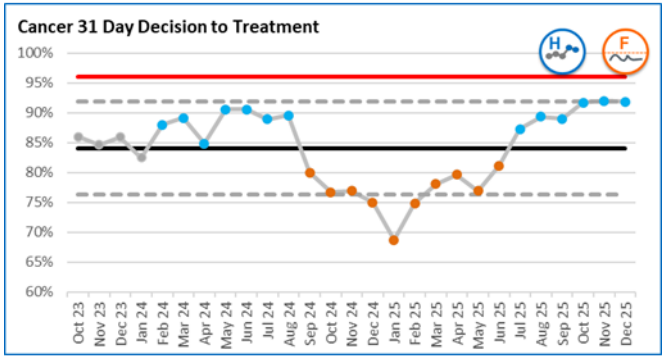
- January 2026 witnessed a slight increase in >52-week waiters at Newcastle Hospitals, increasing to 930 (+37). This meant 1.1% of the total RTT waiting list was over 52 weeks - marginally above the national target of 1% by March 2026.
- 78-week waiters increased to 2 in January after achieving zero in December.
- The number of >65 week waits decreased to 26 (-12). The trust is pushing to clear 65-week waiters by the end of March 2026. Achieving this will allow for further focus on clearing 52-week waiters and making improvements to the front-end of the RTT pathway. Current challenges affecting remaining 65-week waiters at specialty-level include:
    - Adult Deformity patients are highly complex and often require two surgeries with two consultants present, making scheduling appropriate lists very challenging.
    - Ophthalmology continue to manage corneal graft tissue availability alongside capacity pressures for ocular plastics, squint surgery, cataracts and glaucoma.
    - Spinal Neurosciences are currently experiencing capacity constraints exacerbated by surgeon absence.
- The total waiting list size decreased further in January to 83,929. The Trust's participation in an NHS England coordinated validation sprint has been key to reductions throughout 2025-26.

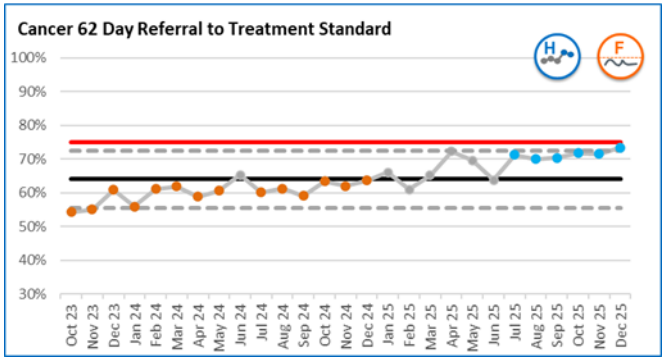
Action taken

- New consultants in the Adult Deformity service are happier to work on pooled lists, allowing quicker treatment for patients.
- Ophthalmology are enhancing use of theatres at the Campus for Aging and Vitality (CAV) and an additional Fellow has been appointed part-time.
- Neurosciences 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).

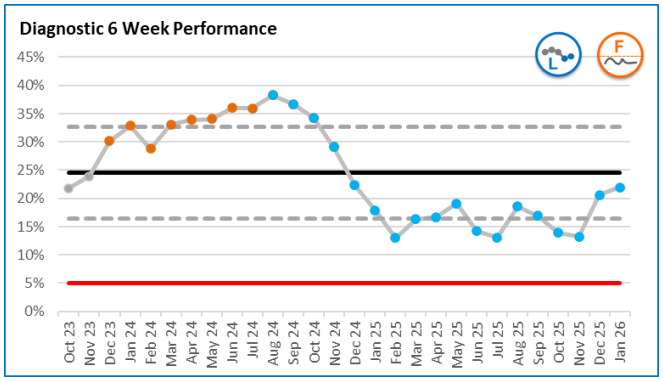
Current position

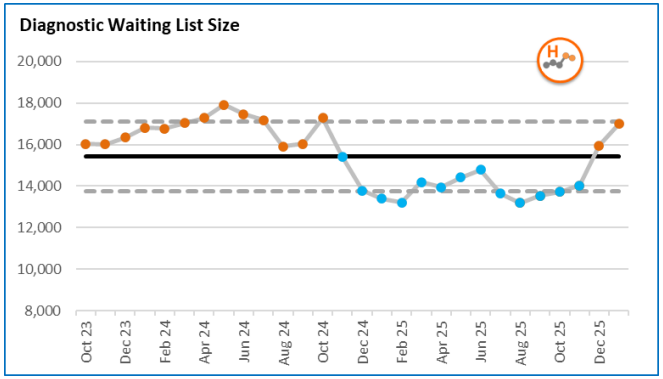
- In December, the 80% 28 FDS target was not achieved (67.7%) and shows a sustained decline. 31-day performance remained stable at 91.9% in December, whilst 62-day performance continues to show special cause variation of an improving nature (73.3% for December).
- Skin - There were 17 lost clinics over Christmas, but the team have put on WLI clinics in January to mitigate this. Looking ahead to March, capacity will be reduced with Annual Leave being used up towards the end of the year.
- Oesophageal – Large drop in provisional February performance due to a significant increase in tertiary referrals. The 1st Oncology appointment is restricting the performance due to limitations in capacity.
- Breast – the team are struggling to manage tertiary referrals, as well as the GP referrals from the Durham area straight to the NuTH team. GP referrals straight to the service have been increasing in recent months.
- Lung – There are bottlenecks in the pathway from the CT scan to Outpatient appointment and then waits for Diagnostics tests which the team have identified and are targeting with QI work.

Action taken

- Skin – The team are focussing on longest waiters in the weekly PTL meetings which is reducing the backlog.
- Urology - Transurethral Resection of Bladder Tumor (TURBT) clinics on Saturdays until June are running weekly with funding from the Cancer Alliance.
- Colorectal – Sprint funding has allowed additional capacity to be made over weekends in March. The allocation process in MDTs, sharing patients between surgeons' lists, has improved the 31 day performance.
- Radiology – new rota to come into effect in the coming months to improve gaps in on-calls and shifts. The team are offering direct CT Colons from failed colonoscopy appointments.
- Lung - A locum consultant post will be made substantive in the next month adding further capacity to the team.

Diagnostics





6 Week Diagnostic Performance by Modality – January 2026			
MRI	16.5%	CT	14.5%
Non-obs US	21.5%	DEXA	15.7%
Audiology	31.3%	ECHO	37.1%
Electrophysiology	27.3%	Neurophysiology	2.0%
Sleep Studies	36.5%	Urodynamics	18.3%
Colonoscopy	35.0%	Flexi-Sig	35.7%
Cystoscopy	10.5%	Gastroscopy	41.9%
Newcastle Hospitals Total			**21.9%**

Standards

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

Current position:

- Performance against the 5% standard declined in January – 21.9% 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 (37.1%) remains a challenged area for performance - Ageing equipment in the department at both sites is at risk of being placed out of use which could further reduce capacity. Capacity is being expanded 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.
- Activity levels increased across the board in January following a decline in December linked to seasonal holidays.

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 has now established an accurate performance baseline, hence the notable increase in overall diagnostic waiting list – These are not new waiters but were previously unreported in the data.
- MRI - Improvement workstreams with prep time and dedicated porter in Neuroradiology has improved productivity by 7% in neuro MRI and CT. This 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 now signed off in Colon/OGD double procedures to provide a long-term sustainable solution to capacity issues.
- 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	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Num.	Den.	25/26 YTD
Activity										
Day Case	**100%** of 25/26 Plan (equivalent to 118% of 19/20 value-weighted activity)	N/A	94.9%	96.0%	98.6%	**96.3%**	**96.5%**	11,014	11,412	**98.6%**
Elective Overnight			88.9%	89.2%	93.7%	**91.6%**	**90.8%**	1,690	1,862	**94.4%**
Outpatient New			93.8%	92.8%	93.7%	**93.5%**	**94.4%**	25,143	26,624	**96.3%**
Outpatient Procedures			94.0%	95.2%	95.5%	**97.7%**	**97.1%**	21,865	22,528	**97.0%**
Outpatient Review	N/A		108.0%	106.5%	111.3%	**118.4%**	**114.5%**	69,724	60,882	**109.8%**
Non-Elective			95.8%	92.3%	90.9%	**87.0%**	**84.6%**	915	1,081	**91.1%**
Emergency			109.4%	108.0%	106.6%	**106.1%**	**108.5%**	6,647	6,128	**105.2%**
Diagnostic Activity	**100%** of 25/26 Plan	N/A	101.8%	98.8%	101.6%	**91.5%**	**98.0%**	21,330	21,772	**101.8%**
PIFU Take-up (%)	>=**5%** of all OP atts. (by Mar-29)	**3.3%**	2.7%	2.8%	2.9%	**2.9%**	**3.0%**	3,644	112,706	**2.7%**
Day case rates (BADS procedures)	**85%**	N/A	86.0%	87.0%	**85.3%**	**TBC**	**TBC**			
Capped Theatre Utilisation	**85%**	N/A	83.4%	81.5%	82.9%	80.9%	**81.4%**			
Urgent Ops. Cancelled Twice	**Zero**	N/A	0	0	0	0	**0**	0		**0**
Cancelled Ops. Rescheduled >28 Days	**Zero**	N/A	2	8	10	9	**7**	7		**53**
Elective Waits										
RTT Waiting List Size	**Reduction** from 24/25	**93,709**	87,666	89,294	86,575	85,552	**83,929**	83,929		
RTT 18 Week Wait	**92%**	**72.5%**	73.2%	73.5%	72.1%	71.4%	**71.0%**	59,559	83,929	**72.9%**
>78 Week Waiters	**Zero**	**0**	1	0	1	0	**2**	2		
>65 Week Waiters	**Zero**	**0**	64	56	49	38	**26**	26		
>52 Week Waiters	N/A	**713**	1,131	1,012	966	893	**930**	930		
>52 Week Waiters (% of Total WL)	**<1% of total WL** (by Mar-26)	**0.8%**	1.3%	1.1%	1.1%	1.0%	**1.1%**	930	930	**1.4%**
>12 Week Waiters Validated	**90%**	N/A	96.2%	96.1%	96.2%	95.9%	**91.4%**	21,388	23,412	**96.3%**
Time to First Outpatient Appointment (18 Weeks)	**72%** (local target of **82.6%**)	**79.4%**	78.3%	79.3%	79.3%	77.8%	**77.0%**	35,116	45,628	**78.7%**
RTT Waiting List (Children & Young Persons <=18 yrs)	N/A	**12,370**	11,819	11,798	11,935	11,632	**12,095**	12,095		
>52 Week Waits (Children & Young Persons <=18 yrs)		**62**	149	117	104	113	**87**	87		
Community Services Waiting List	N/A	N/A	10,973	11,374	11,373	**10,520**	**TBC**	0		
Community Services >52 Week Waiters			1,015	1,081	1,030	**1,027**	**TBC**	0		
Diagnostic 6 week wait	<=**5%** (local target of **<=11.4%**)	**6.5%**	16.9%	13.9%	13.2%	20.6%	**21.9%**	3,725	16,990	**16.3%**

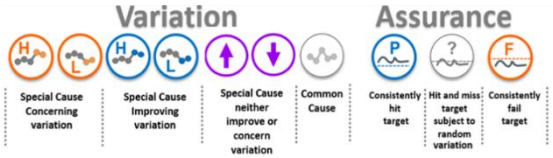
Contractual & Planning Standards (2/2)

Theme	Standard	Trajectory	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Num.	Den.	25/26 YTD
Cancer Care										
28 Day Faster Diagnosis	**80%** (by Mar-26)	**81.8%**	68.5%	69.1%	65.6%	**67.7%**	**TBC**	TBC	TBC	**73.2%**
31 Days (DTT to Treatment)	**96%**	**80.0%**	89.0%	91.7%	92.0%	**91.9%**	**TBC**	TBC	TBC	**86.5%**
62 Days (Referral to Treatment)	**75%** (by Mar-26)	**71.4%**	70.4%	71.7%	71.5%	**73.4%**	**TBC**	TBC	TBC	**70.4%**
>62 Day Cancer Waiters	**N/A**	**N/A**	127	138	139	**144**	**TBC**	TBC		**70.4%**
Urgent & Emergency Care										
A&E Arrival to Admission/Discharge (All types)	**>=78%** under 4 hours (by Mar-26)	**84.0%**	76.0%	77.0%	75.5%	76.0%	**75.9%**	16,670	21,962	**77.6%**
A&E Arrival to Admission/Discharge (Type 1)	**Reduction** from 24/25	**2.5%**	2.9%	3.3%	4.0%	3.9%	**4.1%**	490	11,892	**2.9%**
A&E Decision to Admit to Admission >12 Hours	**Zero** over 12 hours	**N/A**	12	42	48	57	**26**	26		**375**
Adult General & Acute Bed Occupancy	**<=92%**	**89.6%**	88.8%	89.3%	90.1%	85.2%	**87.7%**	1,288	1,468	**88.4%**
Ambulance Handovers <15 mins	**65%**	**N/A**	51.0%	47.8%	49.1%	45.5%	**47.1%**	1,559	3,311	**46.3%**
Ambulance Handovers <30 mins	**95%**		88.0%	83.9%	86.3%	83.9%	**83.3%**	2,759	3,311	**81.4%**
Ambulance Handovers >60 mins	**Zero**		17	100	73	109	**88**	88		**945**
Urgent Community Response Standard	**>=70%** under 2 hours	**N/A**	87.8%	85.6%	87.6%	91.3%	**89.1%**	369	414	**84.5%**
Safe, High Quality Care										
Mixed Sex Acommodation Breach	**Zero**	**N/A**	66	151	121	102	**114**	114		**789**
VTE Risk Assessment	**95%**		96.3%	96.2%	96.1%	**95.9%**	**0.0%**			
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour		**85.0%**	**69.0%**			**TBC**			
Sepsis Screening Treat. (All)			**75.0%**	**63.0%**			**TBC**			

People

People overview

Metric	12-month rolling	Actual	Target	Variation	Assurance
Sickness	Jan-26	5.83%	4.5%		F
Short-term (Month only)	Jan-26	2.22%			
Long-term (Month Only)	Jan-26	4.03%			
Turnover	Jan-26	8.79%	10%		P
Mandatory training	Jan-26	92.43%	90%		P
Appraisal	Jan-26	86.31%	90%		F
Disabled staff	Jan-26	6.62%		H	
Ethnicity (BAME staff)	Jan-26	18.40%		H	



(Data is for period **1 February 2025 to 31 January 2026** unless otherwise stated)

Staff in post

- Total is 15,965.37 Full Time Equivalent (FTE) including Bank/agency
- Total substantive is 15,528.92 FTE, 17,884 headcount
- Above substantive pre-Covid by 2,025.22 FTE (+14.53%)
- Above workforce plan of 15,699.96 FTE by 265.41 FTE (+1.69%)

Sickness – target 4.5%, performance 5.83% (+0.01%)

- Across the rolling 12-month period to January 2026, the Trust recorded an average of 1,022 staff absent per day.
- Top reasons for sickness: anxiety/stress/depression 29.74% (+0.01%); cough, cold, flu – influenza 14.27% (-2.70%); other musculoskeletal problems 9.20% (-0.12%)
- Short-term sickness change in January 2.22% (-0.23%)
- Long term sickness change in January 4.03% (-0.05%)

Retention & Turnover – target 10%, performance 8.79% (+0.01%)

- Increase of 0.01%
- Top reason for leaving: retirement age at 15.67%
- Top destinations: no employment 43.28%; other NHS organisation 30.33% (includes retire-return)

Mandatory training – target 90%, performance 92.43% (+0.39%)

- Increase of 0.39%
- Lowest is Medical and Dental 80.46% (+0.71%)
- Seven courses are below target

Appraisal – target 90%, performance 86.31% (-0.43%)

- Overdue increased to 1,924

Bank & Agency

- Total annual non-medical bank expenditure £18.9m, +£2.0m vs last year
- Total annual non-medical agency expenditure £2.8m, -£0.70m vs last year
- Total annual medical agency expenditure £3.6m, +0.27m vs last year

Equality & Diversity

- Disabled staff change in January +0.03% to 6.62%
- BAME staff change in January +0.03% to 18.40%

Provider workforce return (PWR) – overview as-at January 2026

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	10,081.22	10,675.74	10,060.64	1,376.49	-20.58	-615.10
2. Total Non Medical - Non-Clinical Substantive Staff	2,874.99	3,250.67	3,775.38	3,347.84	472.85	97.17	-427.54
3. Total Medical and Dental Substantive Staff	1,732.92	1,968.52	2,116.39	2,106.84	373.92	138.32	-9.55
4. Any other Staff (substantive staff)	146.48	51.40	11.50	13.60	-132.88	-37.80	2.10
5. Bank	441.22	307.17		412.21	-29.01	105.04	
6. Agency	60.38	40.98		24.23	-36.15	-16.74	
Total	**13,940.15**	**15,699.96**	**16,579.01**	**15,965.37**	**2,025.22**	**265.41**	**-1,050.09**

Current Position:

- Workforce is +2,025.22 FTE (+14.53%) above January 2020 (pre-Covid) position.
- Substantive workforce target at year-end is 15,352 FTE.
- Substantive workforce target at 31st January is 15350.51 FTE.
- Substantive workforce actual position at 31 January is 15,528.92 FTE
- Substantive workforce is currently +265.41 FTE above plan for January.
  (see slide 3, top row, middle graph)
- NHS infrastructure support (substantive) is 97.17 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

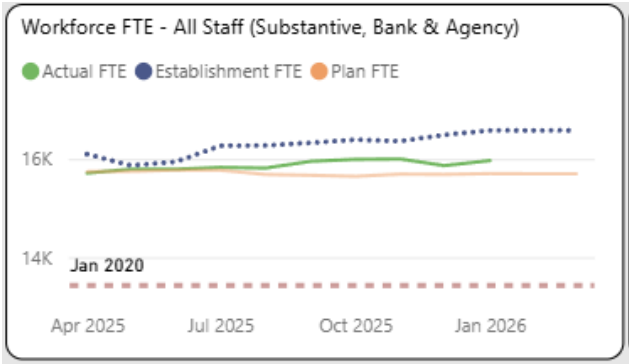
Underlying Issues

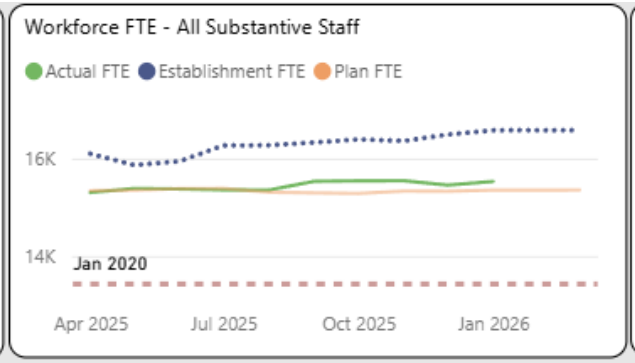
- Bank use due to switching requirements for additional hours from overtime to Bank which is more cost effective.
- Need to maintain safe services (e.g. healthcare assistants for enhanced care). Greater use being made of Bank options to reduce spend on agency.
- Practice of rostering staff may not be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

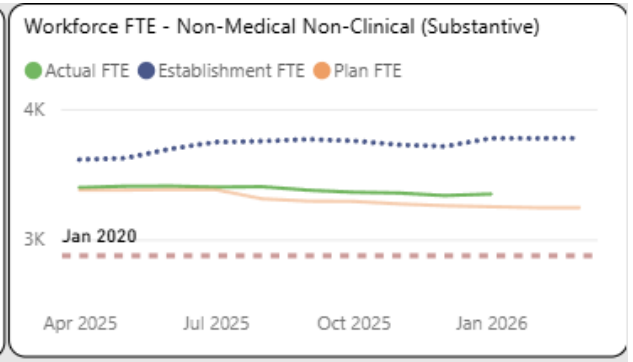
Actions Undertaken:

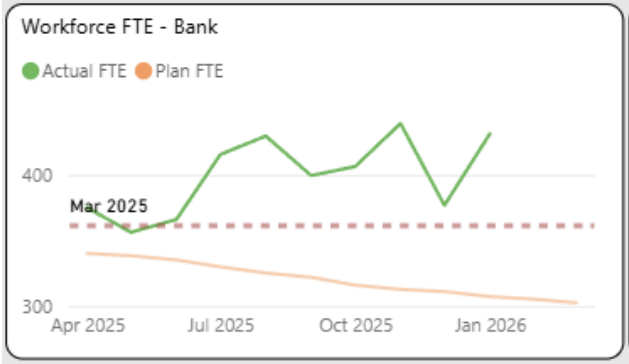
- The 2026/27 Workforce Plan was submitted on schedule in February 2026: all Trusts awaiting approval of submissions by 12th March 2026. The aim of the year one plan is to reduce the substantive workforce by approx. 400 FTE by 31 March 2027, with a 10% reduction for Bank and 30% reduction for Agency by end of March 2027 also.
- A mutually agreed resignation scheme (MARS) was offered to all staff between October and November 2025 and will conclude at the end of March 2026, when the last agreed applicant will leave the organisation.
- Recruitment activity has been resumed; all services are asked to continue to review their recruitment/vacancy position to prioritise and/or replan their needs going forward with a focus on recruiting *internally in first* instance prior to external recruitment.

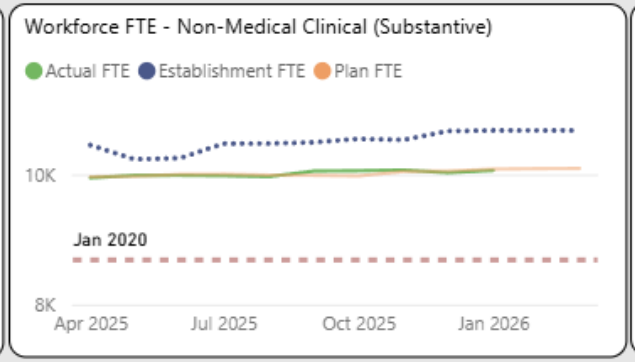
PWR – in-year overview position

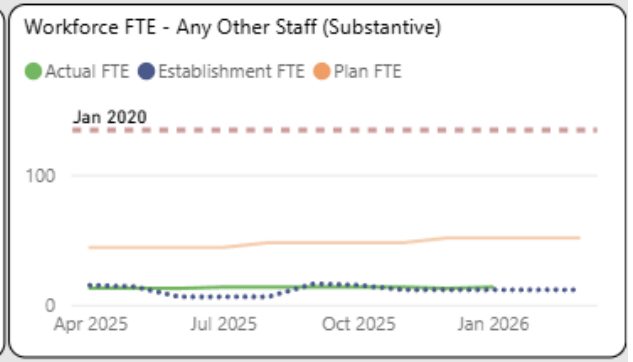


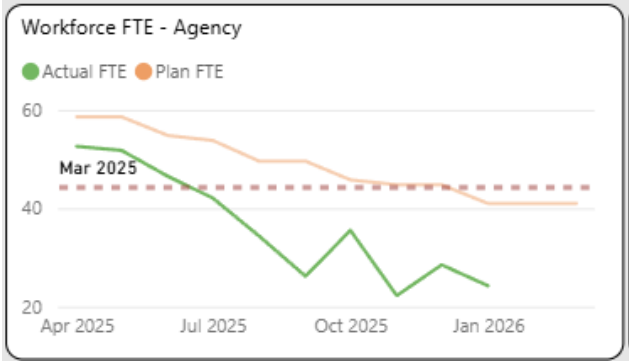


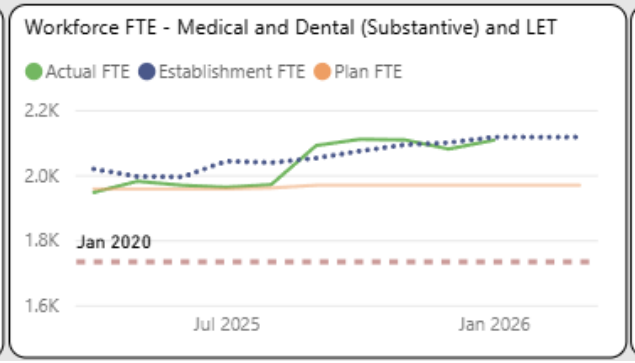


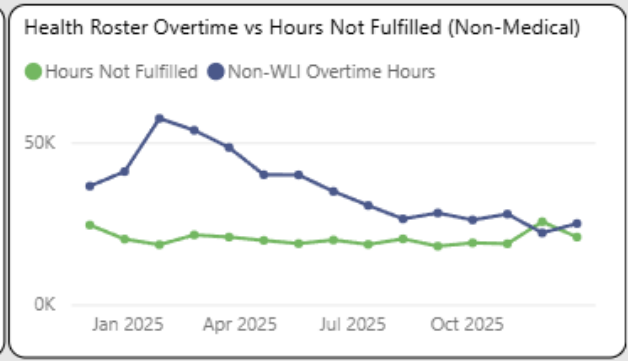










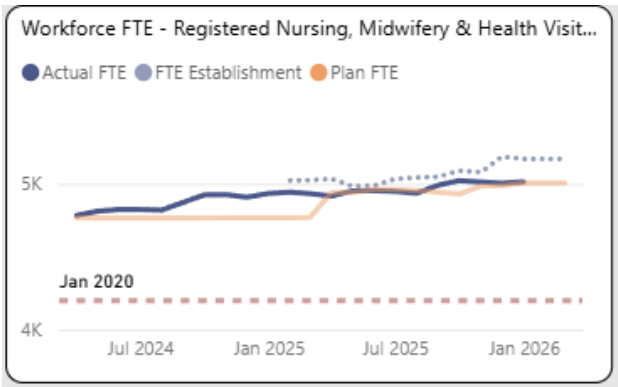


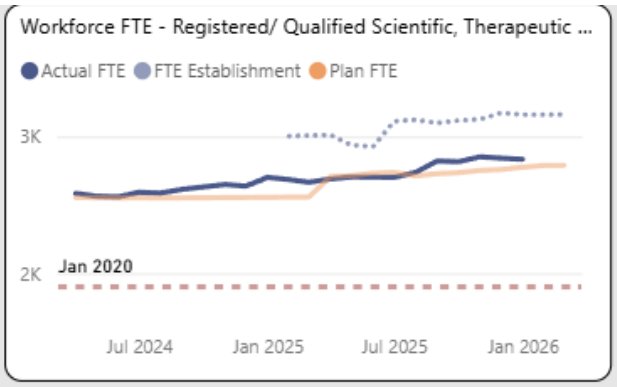
**Please note: The charts on this page include LET data

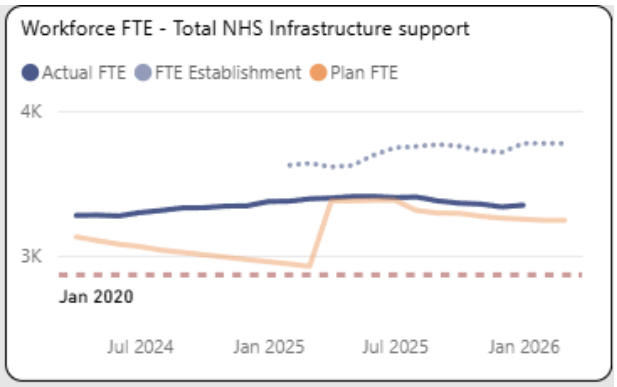
PWR – staff group overview as-at January 2026

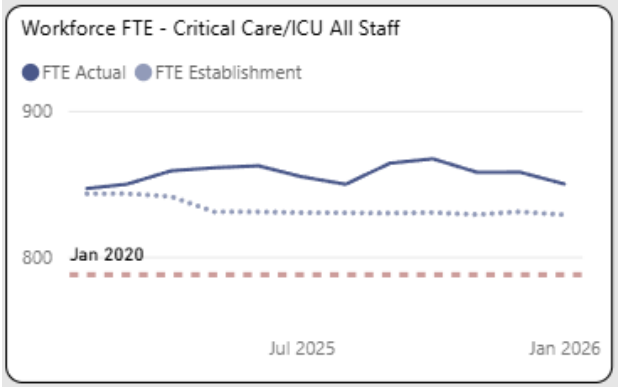
Sub Categories Metric	Jan 2020 FTE	Plan FTE	Establishment	Current FTE	Current FTE v Jan 2020	Current FTE v Plan	Current FTE v Establishment
1. Registered Nursing, Midwifery and Health visiting staff (substantive total)	4,202.08	5,005.17	5,170.20	5,013.49	811.41	8.32	-156.71
2. Registered/ Qualified Scientific, Therapeutic and Technical Staff (substantive total)	1,993.02	2,387.75	2,580.03	2,416.77	423.75	29.02	-163.26
3. Support to Clinical staff (substantive total)	2,489.06	2,688.29	2,925.51	2,630.38	141.33	-57.91	-295.13
4. Total NHS Infrastructure Support (includes A&C, estates, managers) (substantive total)	2,874.99	3,250.67	3,775.38	3,347.84	472.85	97.17	-427.54
5. Total Medical and Dental (substantive total)	1,732.92	1,968.52	2,116.39	2,106.84	373.92	138.32	-9.55
6. Any other Staff (substantive total)	146.48	51.40	11.50	13.60	-132.88	-37.80	2.10
7. Bank Any other staff	0.00	0.00			0.00	0.00	
7. Bank Medical and dental	11.75	15.48		42.17	30.42	26.68	
7. Bank Registered nursing, midwifery and health visiting staff	111.27	78.18		119.40	8.13	41.22	
7. Bank Registered/ Qualified Scientific, Therapeutic and Technical staff	16.41	11.48		14.12	-2.29	2.64	
7. Bank Support to clinical staff	258.10	176.48		221.56	-36.54	45.08	
7. Bank Total NHS infrastructure support	43.69	25.55		14.96	-28.73	-10.59	
8. Agency Any other staff	0.00	0.00			0.00	0.00	
8. Agency Medical and dental	0.87	6.79		1.82	0.95	-4.97	
8. Agency Registered nursing, midwifery and health visiting staff	2.86	3.53		2.61	-0.25	-0.92	
8. Agency Registered scientific, therapeutic and technical staff	17.27	4.16		1.43	-15.84	-2.73	
8. Agency Support to clinical staff	23.68	25.50		14.42	-9.26	-11.08	
8. Agency Total NHS infrastructure support	15.70	1.00		3.95	-11.75	2.95	
Total	**13,940.15**	**15,699.96**	**16,579.01**	**15,965.37**	**2,025.22**	**265.41**	**-1,050.09**

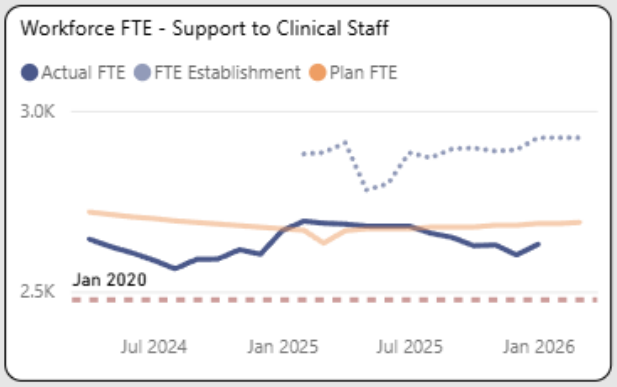
PWR – staff group overview in-year position

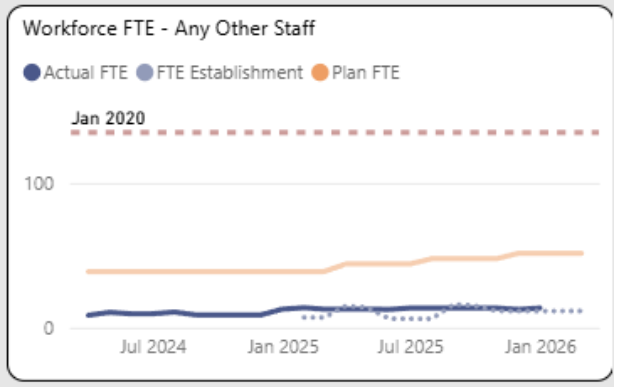


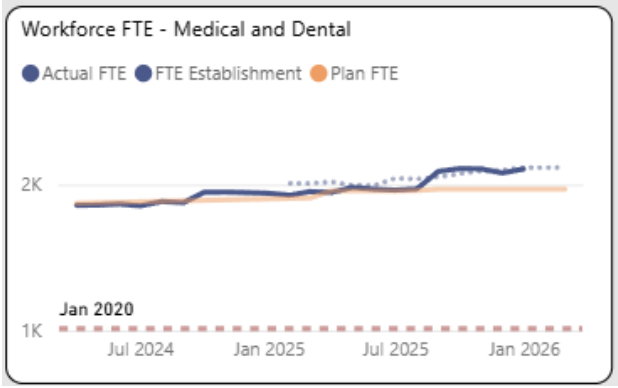










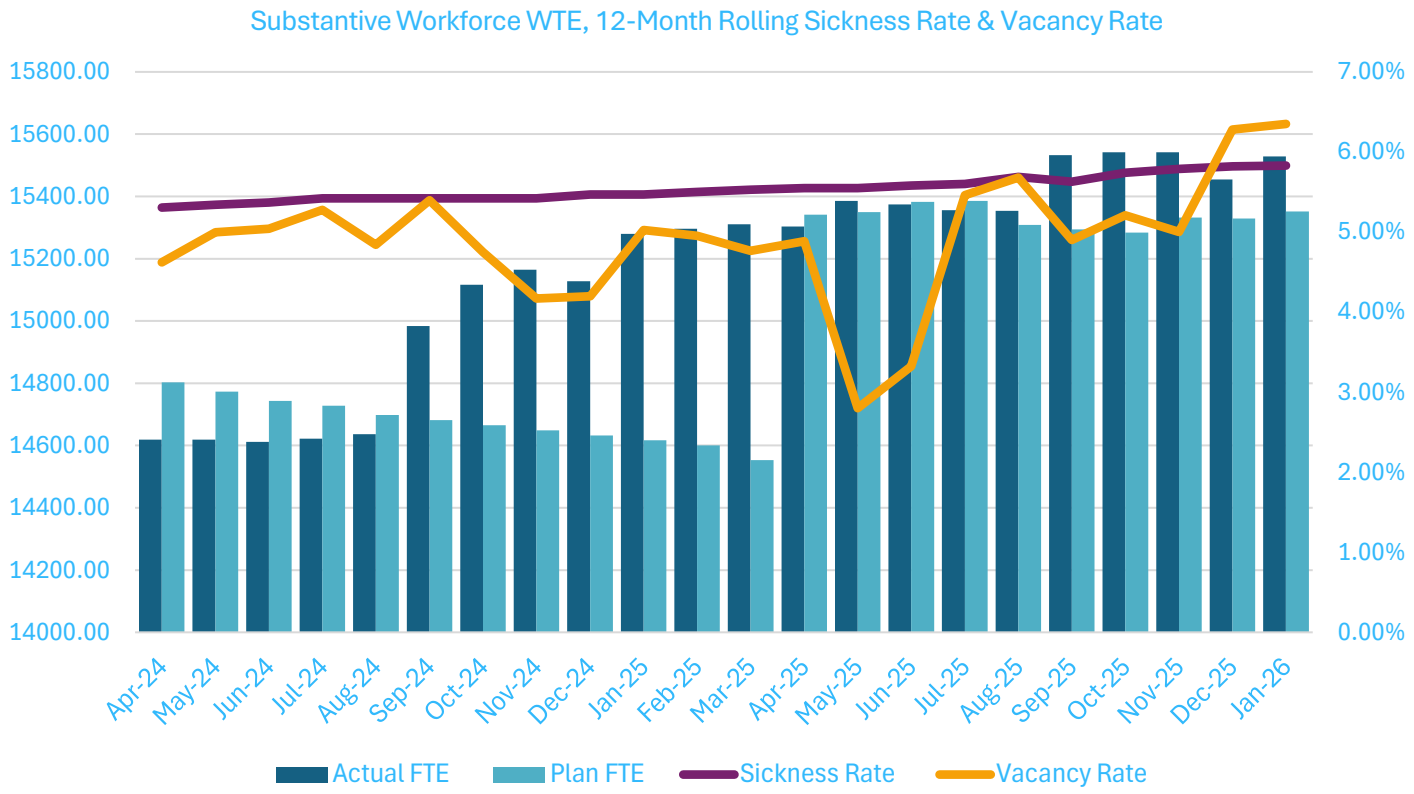


**Please note: The charts on this page include LET data

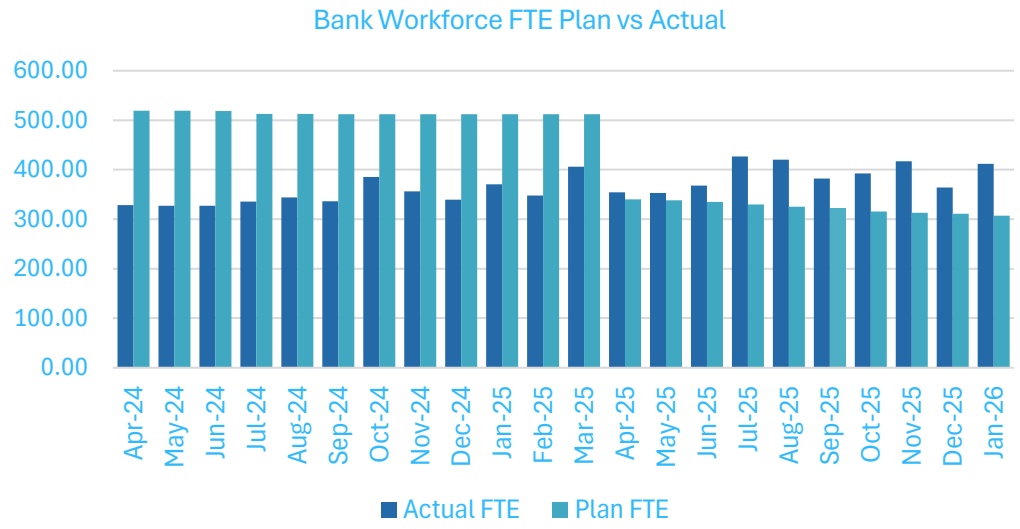
Vacancies

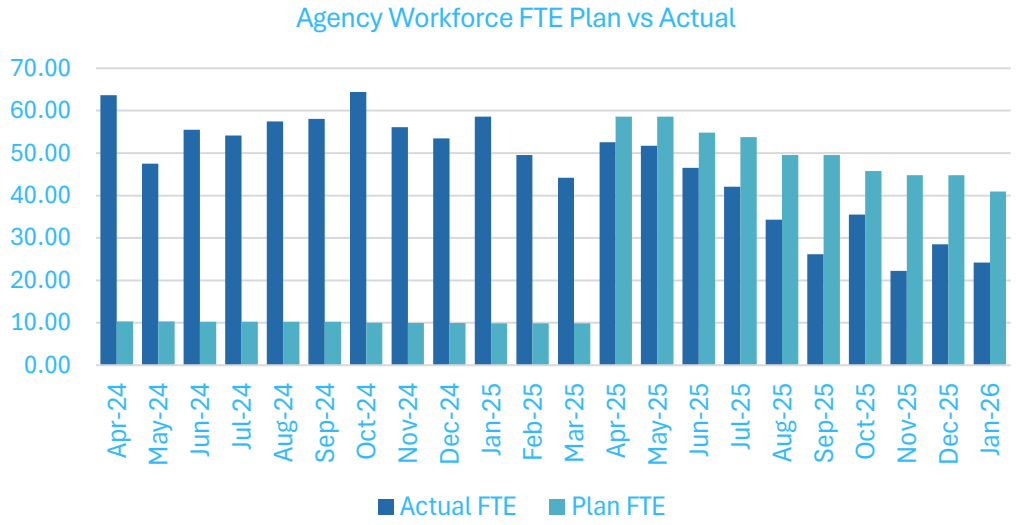
Summary Group	FTE Establishment	Actual FTE	Vacancy FTE	Vacancy FTE %
1. Total Non Medical - Clinical Substantive Staff	10675.74	10060.64	615.10	5.76%
2. Total Non Medical - Non-Clinical Substantive Staff	3775.38	3346.84	428.54	11.35%
3. Medical and Dental	2116.39	2105.84	10.55	0.50%
5. Other	11.50	13.60	-2.10	-18.26%
Total	**16579.01**	**15526.92**	**1052.09**	**6.35%**

Substantive Workforce



Bank and Agency Workforce



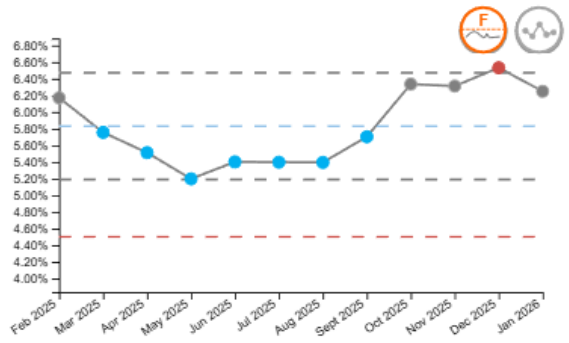


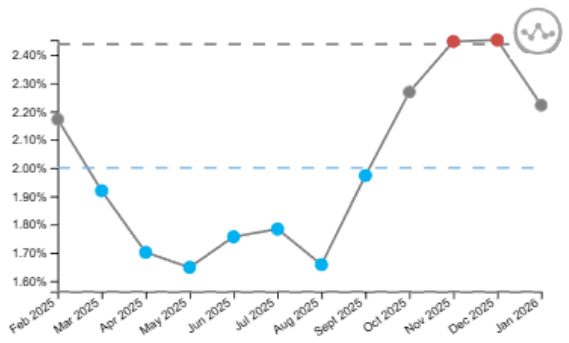
Sickness absence – 12-month average

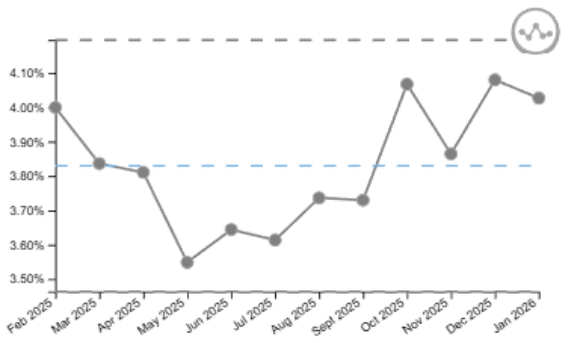
Trust Sickness %	12-Month Rolling	Value	Target
	Jan 26	5.83%	4.50%

Metric	Value
Short Term Sickness %	2.22%

Metric	Value
Long Term Sickness %	4.03%







Current Position:

- Top reasons for sickness:
  - Anxiety/stress/depression (S10) 29.74%
  - Cold, Cough, Flu – Influenza (S13) 14.27%
  - Other musculoskeletal problems (S12) 9.20%
- The 12-month rolling absence rate of 5.83% and the sick pay cost of £35.1m 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: 313,538.19 FTE.
- Average time lost per person: 21 days.
- Total cost of sick pay: £35.1m.
- Variation in sickness rates across Clinical Boards:
  - Lowest – Clinical and Diagnostic Services at 4.43% (short-term 1.84%, long term 2.66%)
  - Highest – Peri-operative and Critical Care at 6.70% (short-term 2.83%, long term 4.27%)

Actions Undertaken:

- Staff Psychological Service offer will be rolling out and scaling up from March. "Working Well" offer and all resources and open access offers will be shared on the intranet and open for self-enrolment via the Learning Lab. Offer designed over four tiers, Preventative, Proactive, Targeted & Restorative. – MHFA training booked until June 2026. 101 colleagues trained as of 20 February 2026. 2 Scaffolding sessions taken place and support resources under development.
- 'Why absence matters' is a Trustwide program focusing on supporting line managers to manage sickness absence. There are 4 key areas of focus, one of which is the use of performance metrics and visibility. The development of a new sickness infographic dashboard allows for key metrics to be triangulated, in a 3 month rolling data capture. The infographic information will also be shared Trustwide via the Intranet on a quarterly basis.

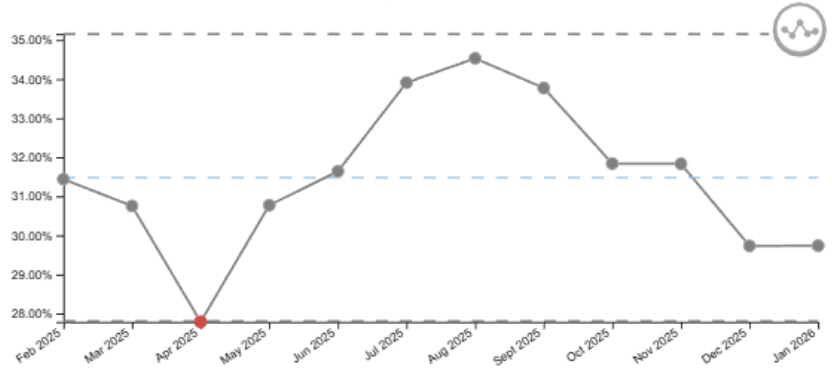
Sickness absence – top absence reasons

Trust Sickness %	12-Month Rolling	Value	Target
	Jan 26	5.83%	4.50%

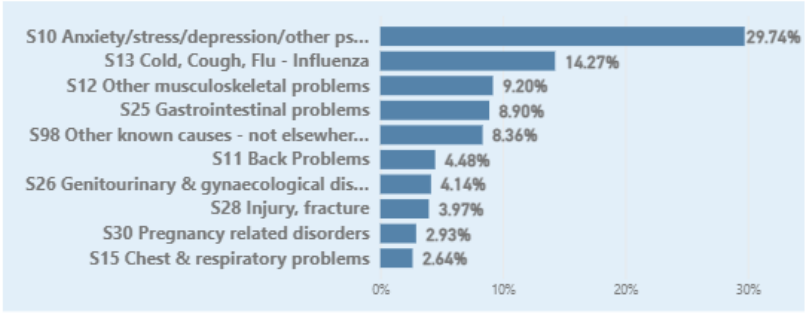
Sickness Reasons - SPC

S10 - Anxiety/stress/depression/ other psychiatric illness

29.74%

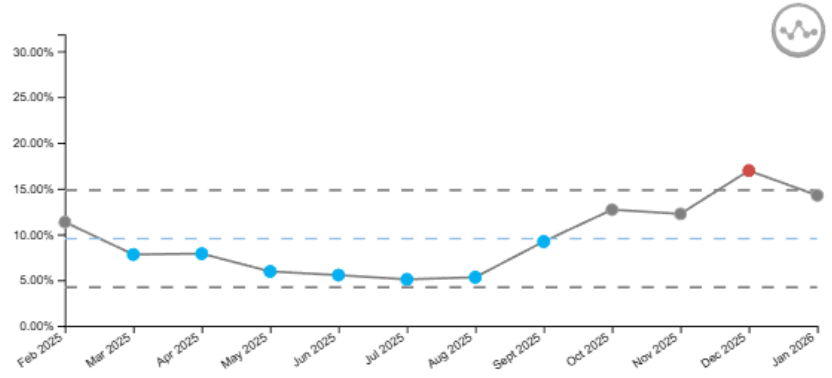


Top 10 Sickness Abscences



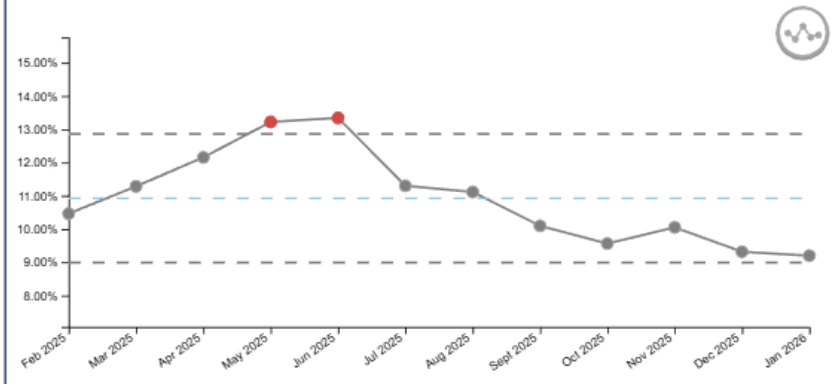
S13 - Cold, Cough, Flu - Influenza

14.27%

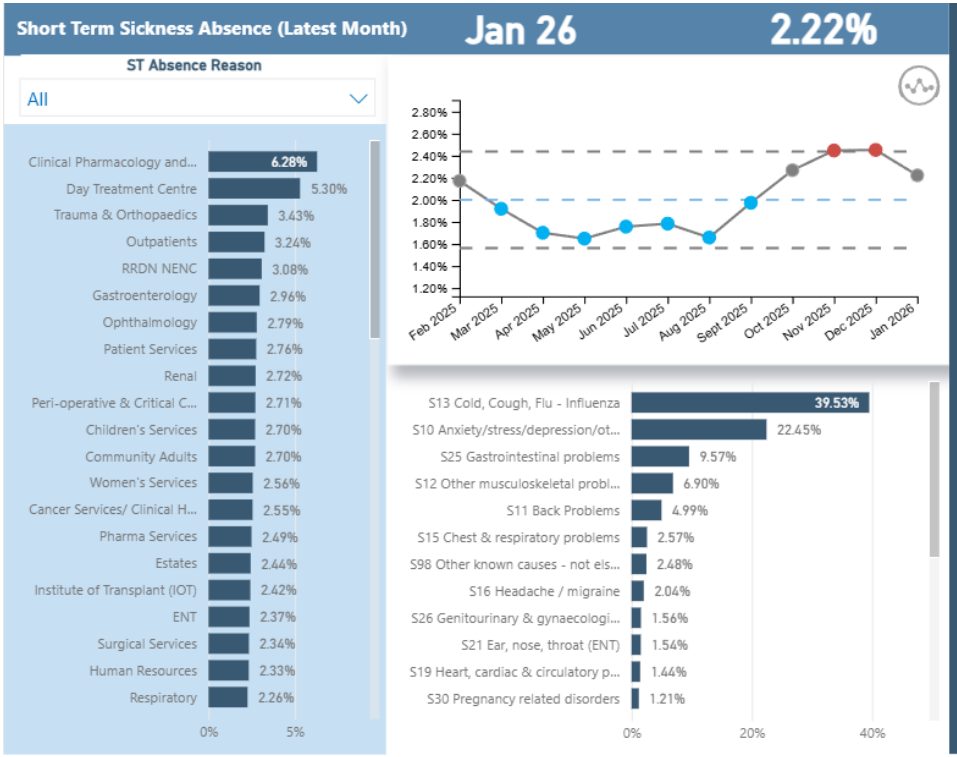


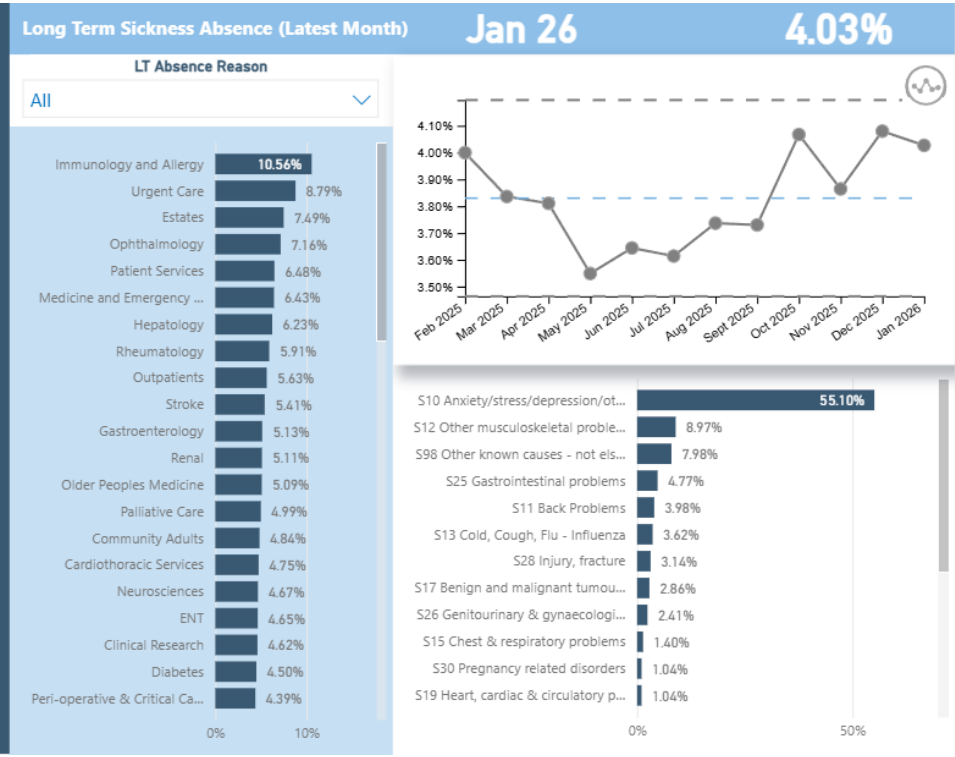
S12 - Other musculoskeletal problems

9.20%



Sickness absence – short & long-term analysis by CB/CS & reason





Sickness – FTE working days lost & formal action activity

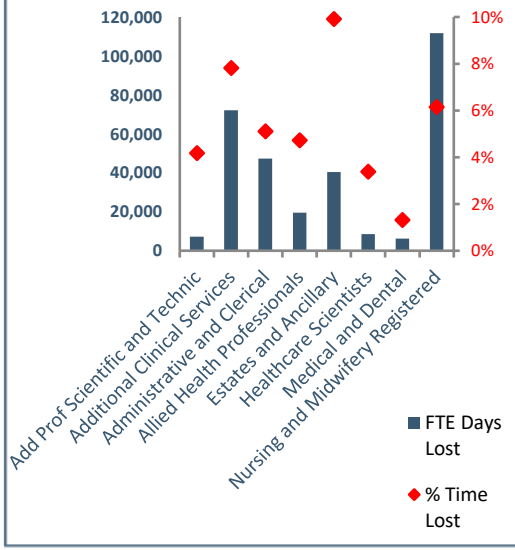
Sickness - FTE working days lost

FTE working days lost due to sickness

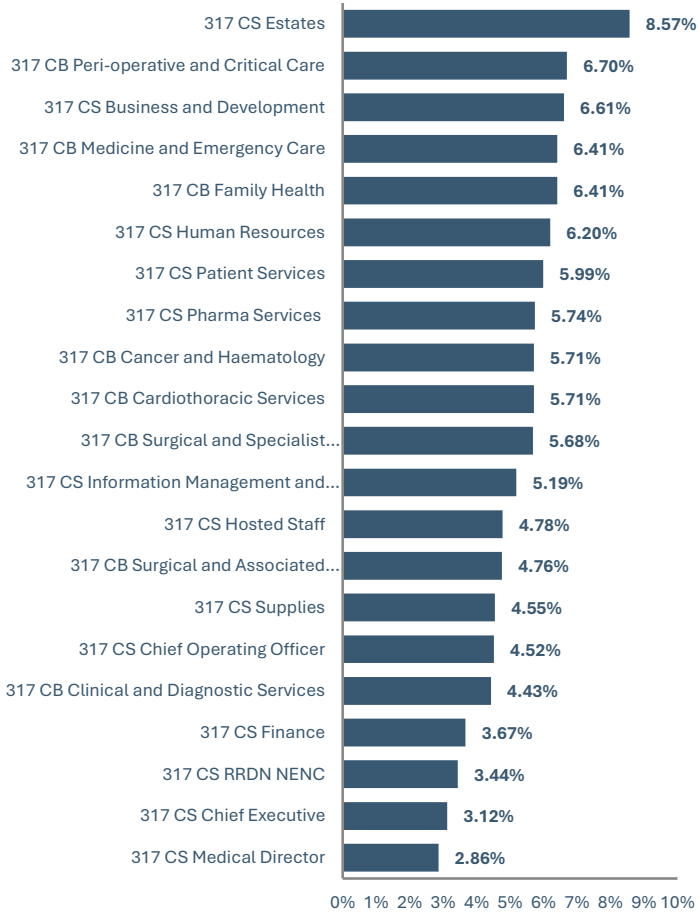
313,538

287,189 compared to the previous year.

Sickness Absence by Staff Group



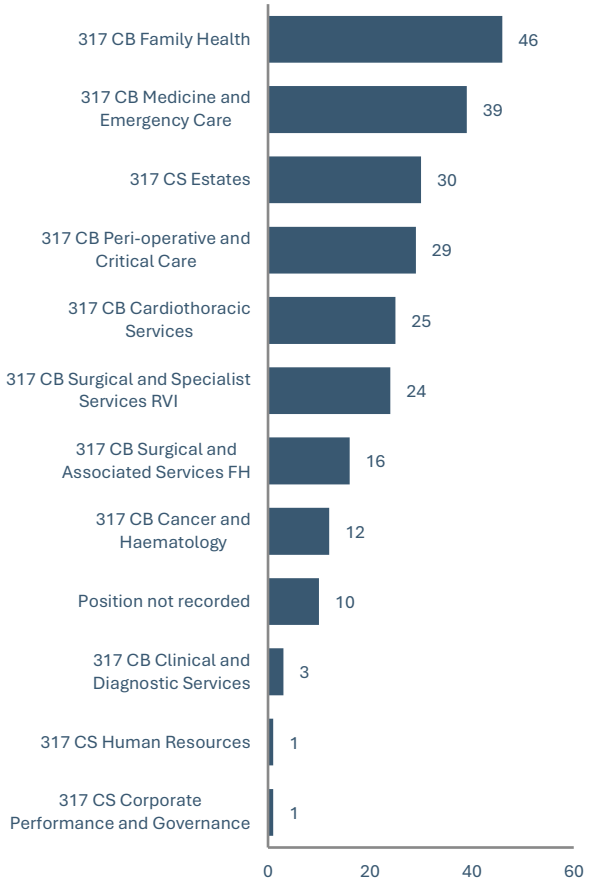
Sickness Absence (% Time Lost) by Clinical Board



Sickness - Formal Action

Latest Data - December 2025

Attendance Management – Formal Action by Clinical Board/ Corporate Service

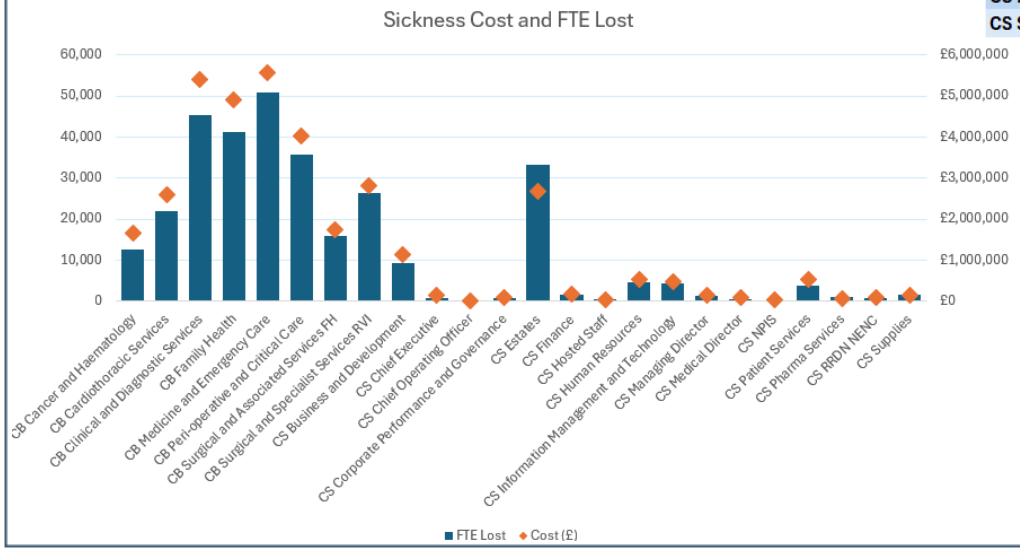


Sickness – FTE working days lost & cost of sick pay

Sickness Absence	12-Month period ending	Cost (£)	FTE Lost	Ave. No of Days Lost per FTE
	Jan 26	£35,096,982	313,538.19	21.22

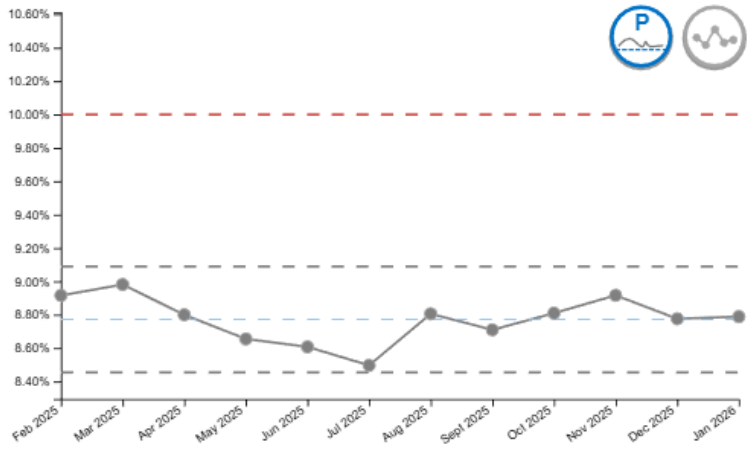
Clinical Board	Cost (£)	FTE Lost	Ave. No of days lost per FTE
CB Cancer and Haematology	1,669,658	12,449.42	20.84
CB Cardiothoracic Services	2,594,484	21,968.44	20.84
CB Clinical and Diagnostic Services	5,392,794	45,450.37	16.15
CB Family Health	4,918,443	41,082.12	23.24
CB Medicine and Emergency Care	5,575,973	50,805.34	23.24
CB Peri-operative and Critical Care	4,034,231	35,638.79	24.52
CB Surgical and Associated Services FH	1,732,129	15,770.23	17.44
CB Surgical and Specialist Services RVI	2,804,770	26,329.93	20.85

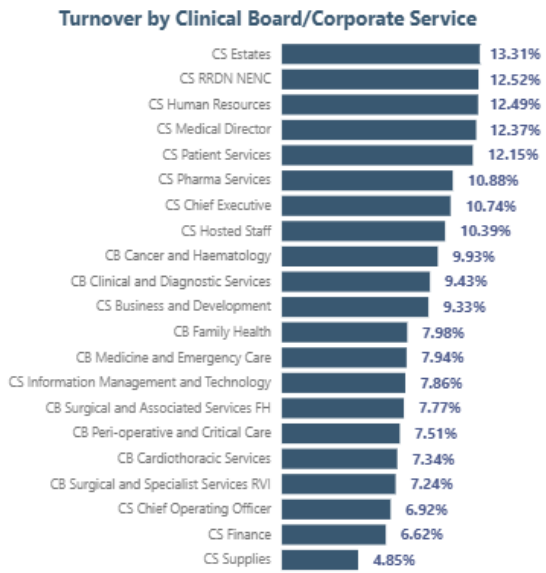
Clinical Board	Cost (£)	FTE Lost	Ave. No of days lost per FTE
CS Business and Development	1,138,975	9,200.50	23.27
CS Chief Executive	138,617	824.03	11.39
CS Chief Operating Officer	0	0.00	0.00
CS Corporate Performance and Governance	100,618	826.87	10.01
CS Estates	2,672,715	33,128.35	31.11
CS Finance	158,303	1,505.69	13.37
CS Hosted Staff	30,511	548.00	17.36
CS Human Resources	538,378	4,576.25	22.57
CS Information Management and Technology	483,086	4,318.77	18.76
CS Managing Director	153,039	1,224.20	15.32
CS Medical Director	88,209	549.24	9.92
CS NPIS	28,470	165.60	8.43
CS Patient Services	529,348	3,833.53	21.18
CS Pharma Services	66,519	1,129.64	21.01
CS RRDN NENC	100,774	732.99	12.48
CS Supplies	146,936	1,479.91	15.94

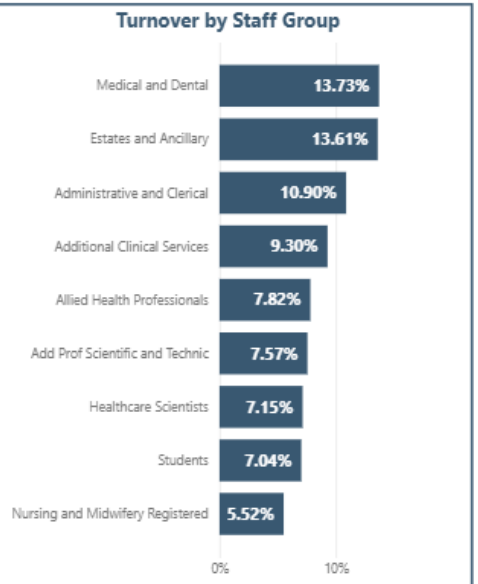


Turnover

Trust Turnover %	12-Month Rolling	Value	Target
	Jan 26	8.79%	10.00%







Current Position:	Underlying Issues	Actions Undertaken:
• 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.	• 1,494 leavers in 12-months to January 2026: 21% Nursing & Midwifery (307), 20% Administrative and Clerical (297). • Top destinations – no employment (645, 43%); other NHS organisation (453, 30%). • Top reasons – retirement age (231, 15%); work-life balance (198, 13%); relocation (182, 12%).	• 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

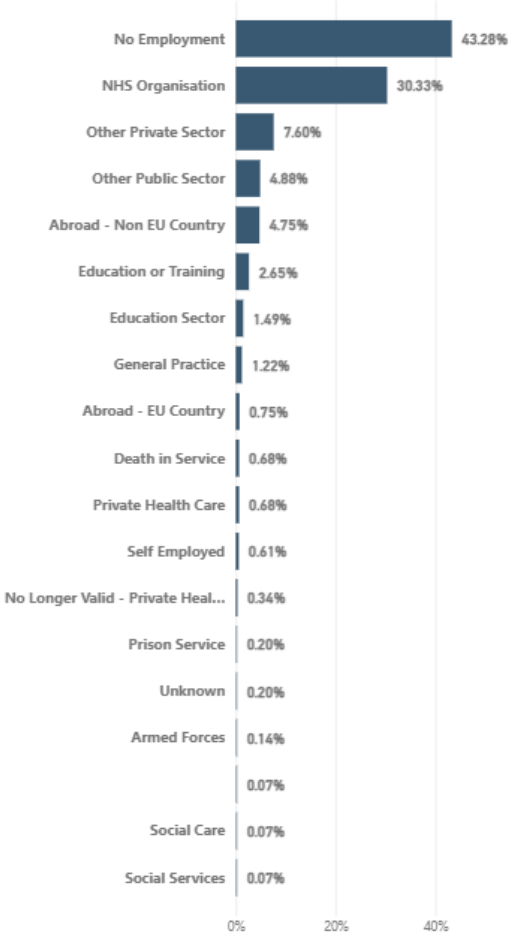
Trust Turnover %	12-Month Rolling	Value	Target
	Jan 26	8.79%	10.00%

Leaving Reasons

Leaving Reasons

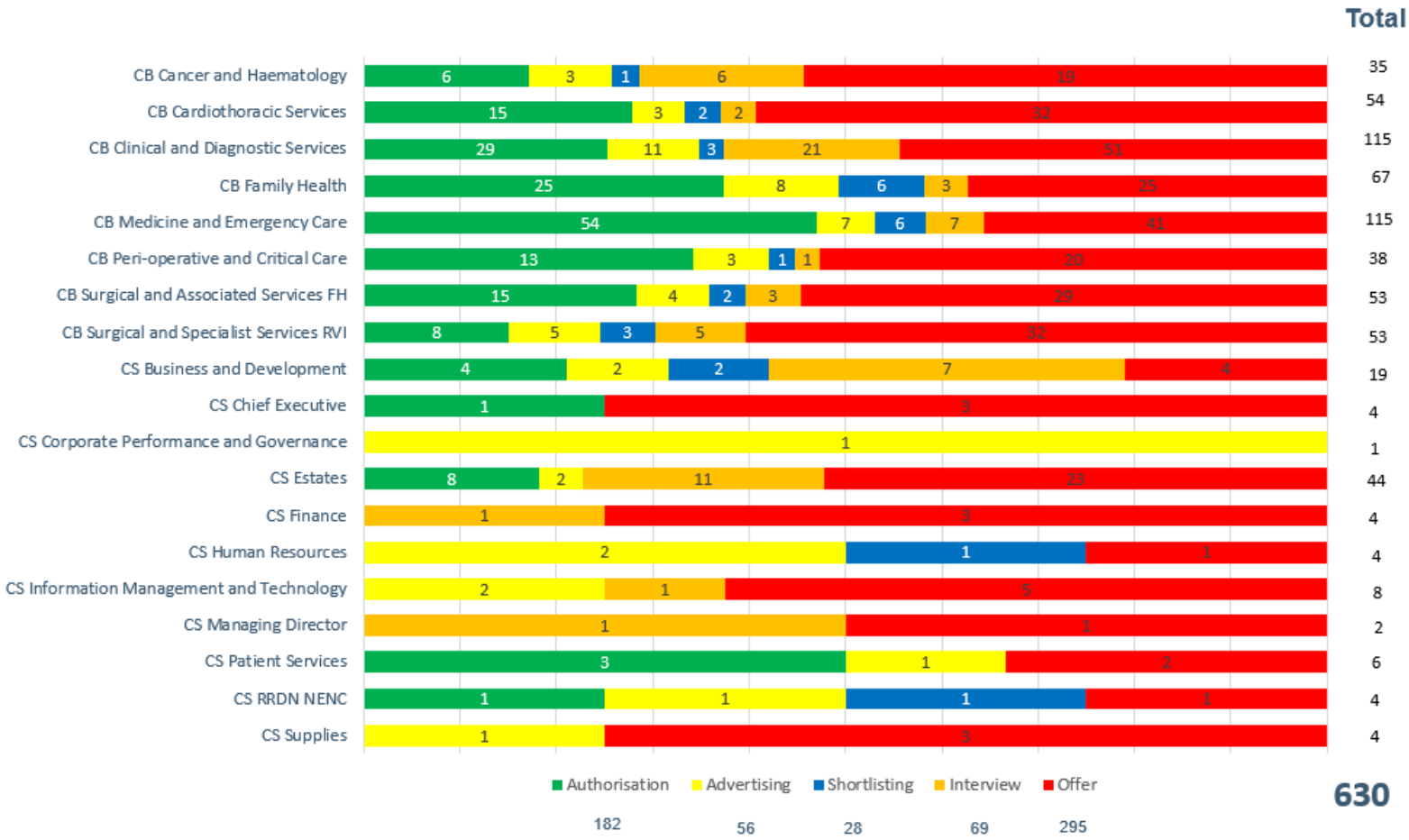
Leaving Reason	Leaving Reason %
Retirement Age	15.67%
Voluntary Resignation - Work Life Balance	13.43%
Voluntary Resignation - Relocation	12.35%
Voluntary Resignation - Promotion	9.70%
End of Fixed Term Contract	8.21%
Flexi Retirement	7.87%
Voluntary Resignation - Health	6.31%
Voluntary Resignation - To undertake further education or training	3.87%
Mutually Agreed Resignation - Local Scheme with Repayment	3.39%
Voluntary Resignation - Incompatible Working Relationships	3.19%
Voluntary Resignation - Lack of Opportunities	2.37%
Dismissal - Capability	2.24%
End of Fixed Term Contract - Completion of Training Scheme	1.90%
Voluntary resignation - Pay and Reward Related	1.49%
End of Fixed Term Contract - Other	1.29%
Voluntary Resignation - Child Dependants	1.02%
Voluntary Early Retirement - with Actuarial Reduction	0.81%
Death in Service	0.68%
Retirement - Ill Health	0.68%
Voluntary Resignation - Other/Not Known	0.68%
Voluntary Early Retirement - no Actuarial Reduction	0.61%
Redundancy - Compulsory	0.47%
Dismissal - Conduct	0.41%
Voluntary Resignation - Adult Dependants	0.41%
Dismissal - Statutory Reason	0.34%
End of Fixed Term Contract - End of Work Requirement	0.27%
End of Fixed Term Contract - External Rotation	0.27%
Redundancy - Voluntary	0.07%

Destination on Leaving



Destination On Leaving	Destination On Leaving %
No Employment	43.28%
NHS Organisation	30.33%
Other Private Sector	7.60%
Other Public Sector	4.88%
Abroad - Non EU Country	4.75%
Education or Training	2.65%
Education Sector	1.49%
General Practice	1.22%
Abroad - EU Country	0.75%
Death in Service	0.68%
Private Health Care	0.68%
Self Employed	0.61%
No Longer Valid - Private Health/Social Care	0.34%
Prison Service	0.20%
Unknown	0.20%
Armed Forces	0.14%
	0.07%
Social Care	0.07%
Social Services	0.07%

Recruitment - Vacancies in progress by stage – 03 February 2026



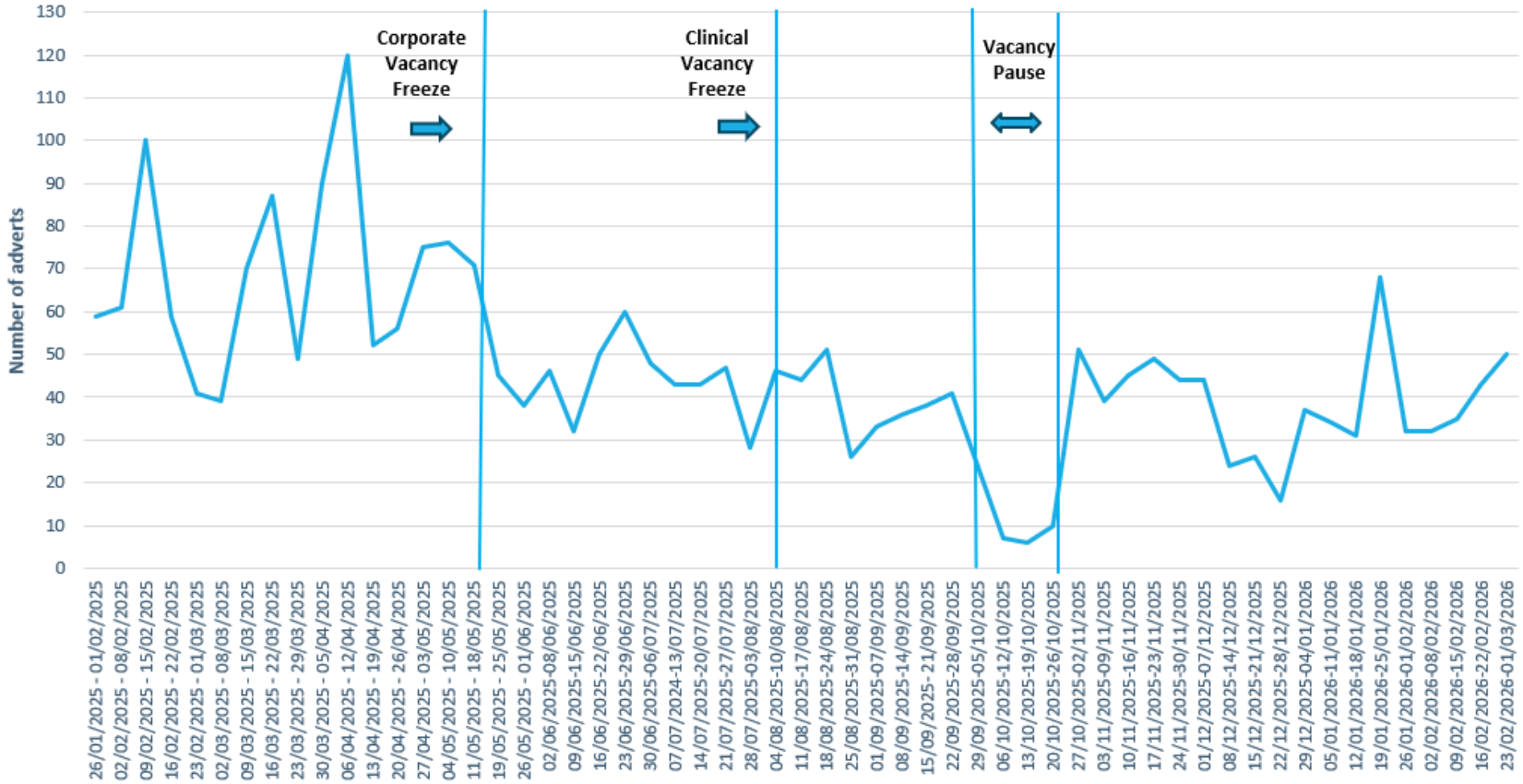
The chart illustrates that as of 02 March 2026, there were 630 adverts/vacancies progressing through the recruitment process—an increase of 47 compared to the previous period. The largest proportion of vacancies were at the conditional offer stage (46%).

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 - Vacancies in progress by stage

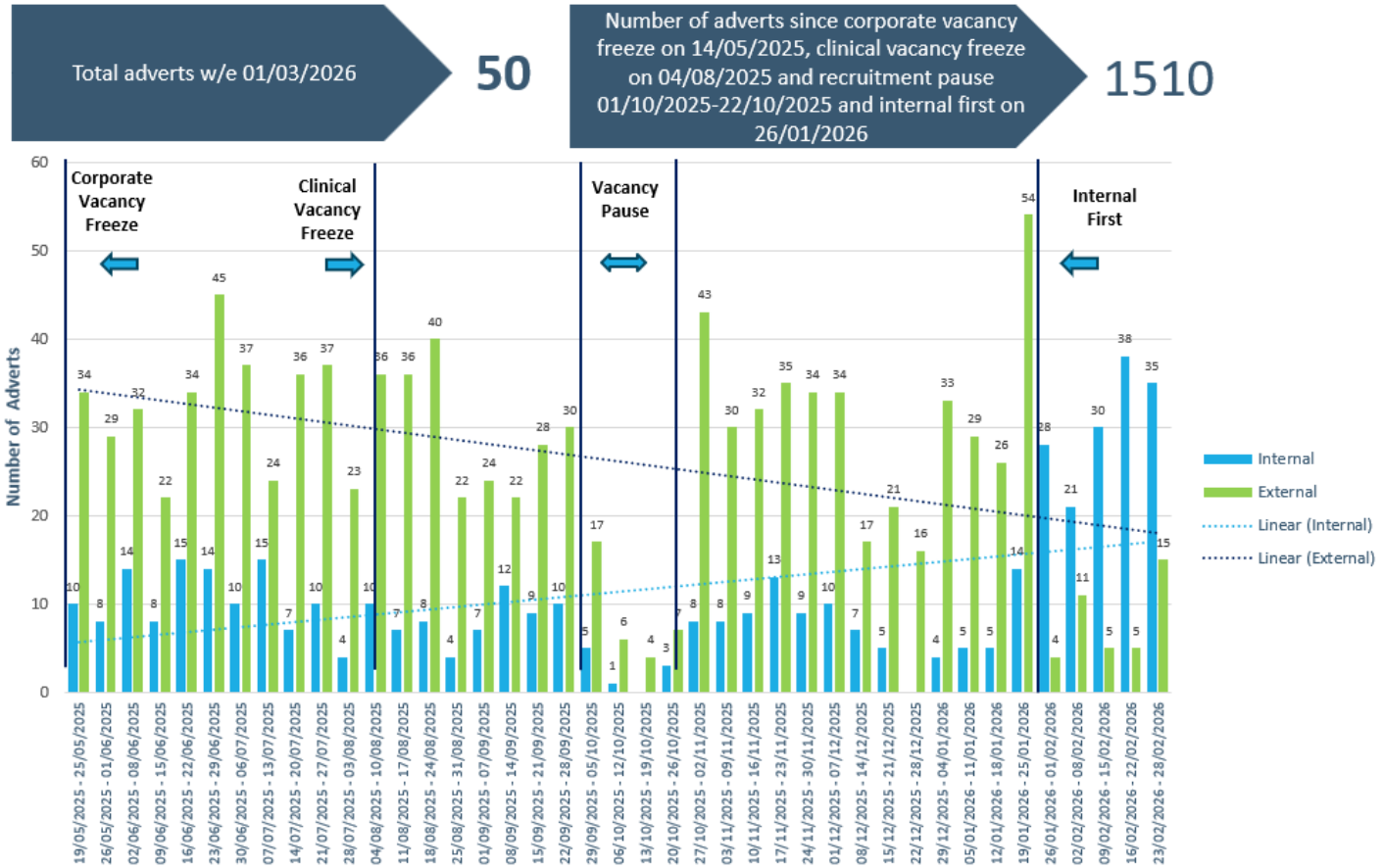
Total adverts w/e 01/03/2026 **50**

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 **1510**



This graph shows a decline in the number of vacancies advertised during the recruitment pause and freezes. Activity increased after the pause ended, reduced during December 2025 and has increased in January 2026 to 68 for 19/01/2026-25/01/2026 and now reduced to 50 for 23/02/2026-01/03/2026. Overall, there are fewer adverts compared to the same period in 2025.

Recruitment – Internal v External Advertising

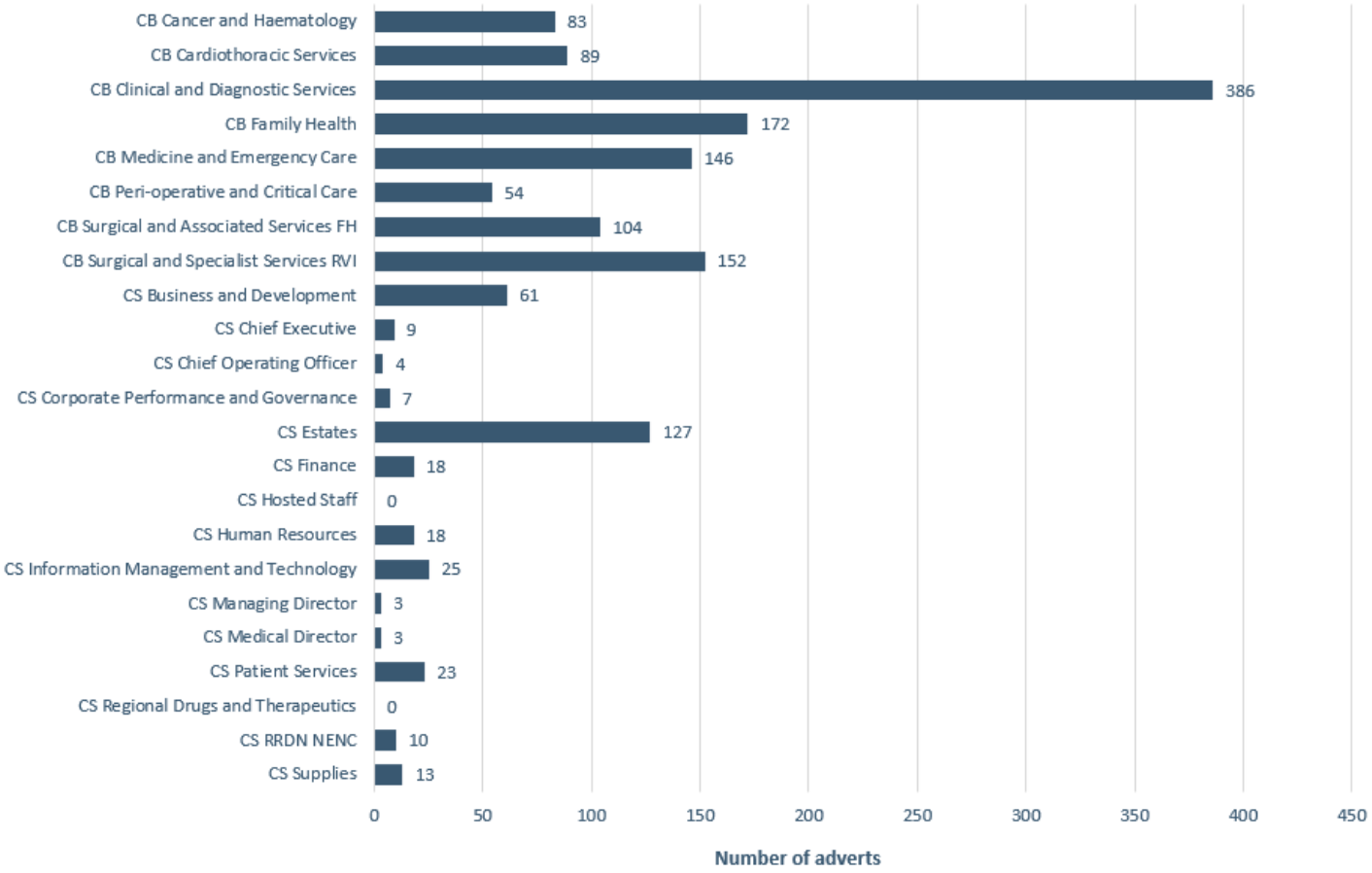


This graph shows an overview of the adverts; those that were advertised internal and external. It shows that most adverts were advertised external to the Trust. The reduction in the external adverts was with effect from 26 January 2026 when the decision was made to advertise vacancies internal first with an exception process for external advertising.

On 3 March 2026 70% of candidates that were at conditional offer stage were external and 30% internal which is a change as of 02 February 2026 when it was 77% external and 23% internal. As part of the Workforce Reduction Group this is being reviewed and reported on a fortnightly basis.

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

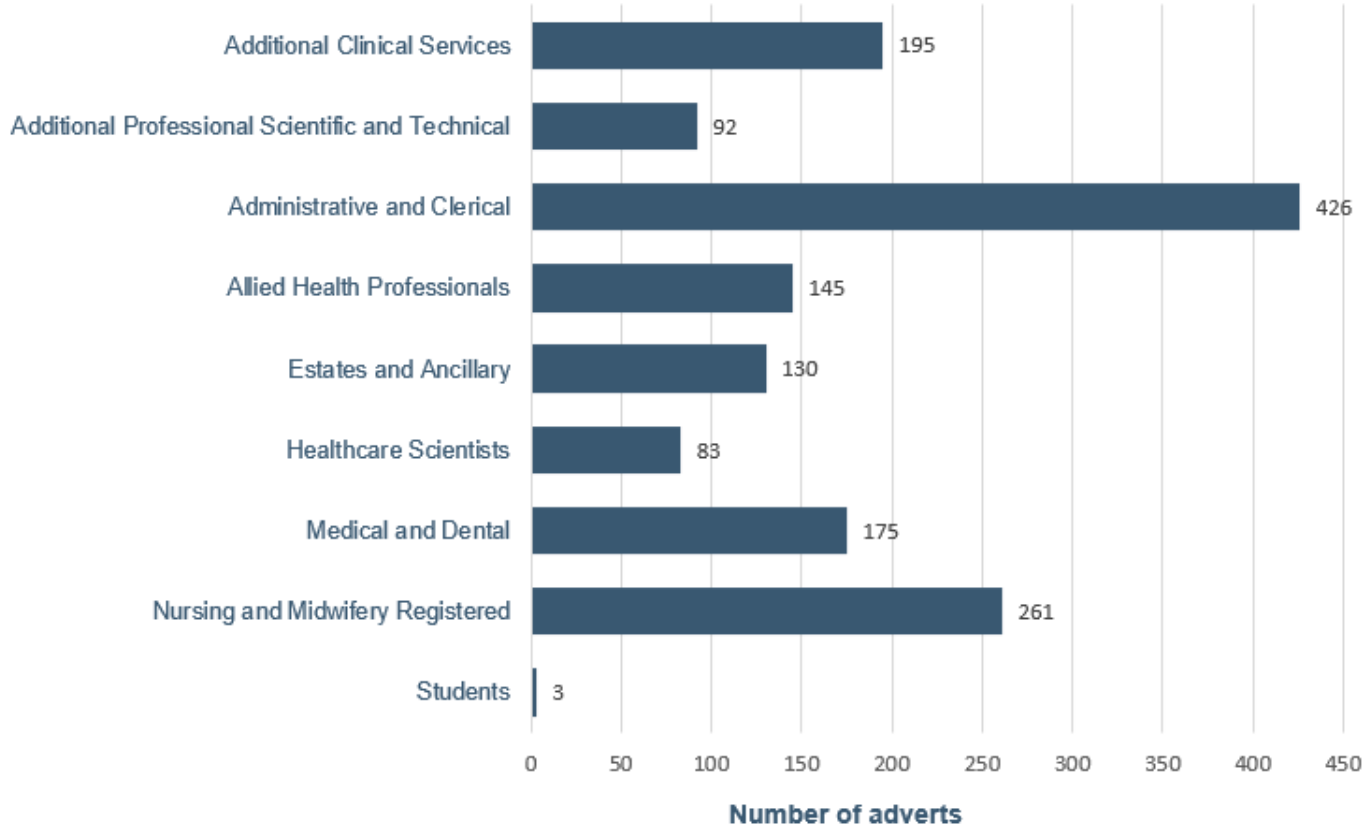


Since 14 May 2025, the highest number of adverts have been for Clinical and Diagnostic Services. However, this should be considered in proportion to the size of the Clinical Board.

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

1510



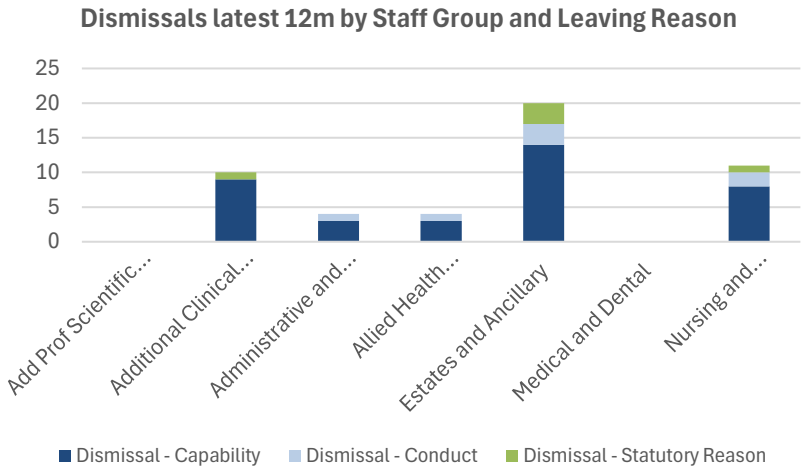
The largest volume of adverts since 14 May 2025 has been in Administrative and Clerical roles, followed by Nursing and Midwifery, with the lowest numbers in Healthcare Scientist positions.

Dismissals – 12 month rolling period ending January 2026

Dismissals	12-Month period ending	Dismissals Headcount	Dismissals FTE
	Jan 26	49	33.07

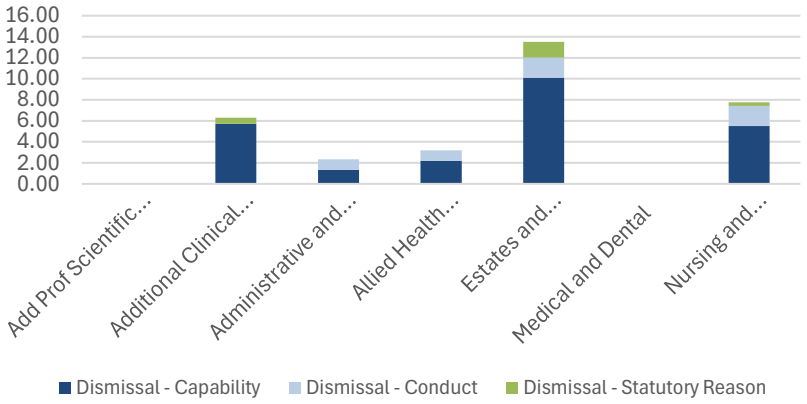
Headcount

Staff Group	Dismissal - Capability	Dismissal - Conduct	Dismissal - Statutory Reason	Total
Add Prof Scientific and Technic				
Additional Clinical Services	9		1	10
Administrative and Clerical	3	1		4
Allied Health Professionals	3	1		4
Estates and Ancillary	14	3	3	20
Medical and Dental				
Nursing and Midwifery Registered	8	2	1	11
Grand Total	37	7	5	49



FTE

Staff Group	Dismissal - Capability	Dismissal - Conduct	Dismissal - Statutory Reason	Total
Add Prof Scientific and Technic				
Additional Clinical Services	5.71		0.60	6.31
Administrative and Clerical	1.34	1.00		2.34
Allied Health Professionals	2.17	1.00		3.17
Estates and Ancillary	10.09	1.93	1.47	13.49
Medical and Dental				
Nursing and Midwifery Registered	5.50	1.91	0.35	7.75
Grand Total	24.81	5.84	2.41	33.07



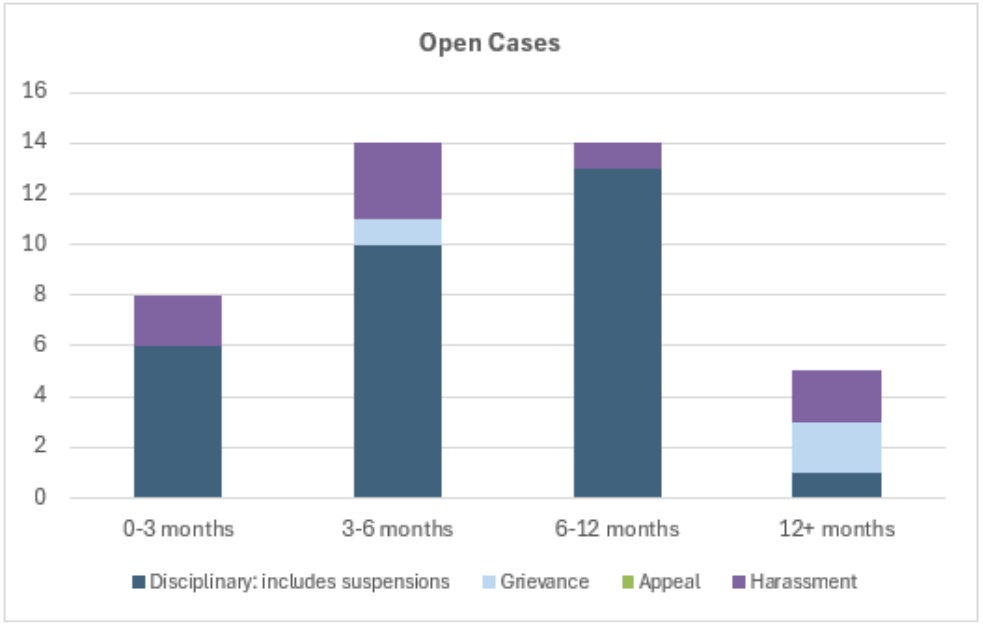
Employee Relations - Open Cases

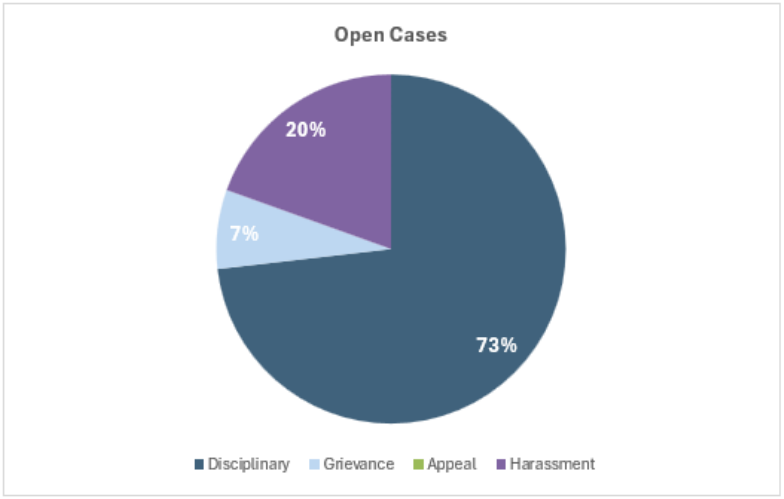
Open Cases	Latest Month	Total Open Cases
	Jan 26	41

Case Type	0-3 months	3-6 months	6-12 months	12+ months	Total
Disciplinary: includes suspensions	6	10	13	1	30
Grievance	0	1	0	2	3
Appeal	0	0	0	0	0
Harassment	2	3	1	2	8
Grand Total	8	14	14	5	41

There are currently 41 open employee relations cases, of 30 are disciplinary (of which 4 suspensions), 8 harassment and 3 grievance.

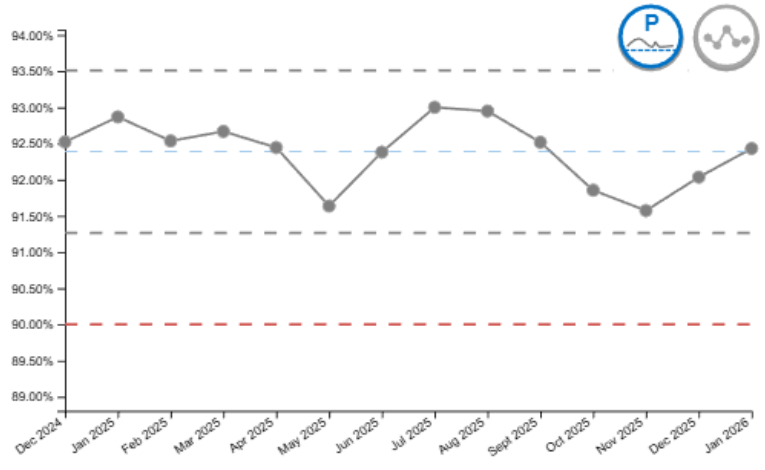
27 of the 41 (65.85%) have been raised between November 2025 to January 2026.

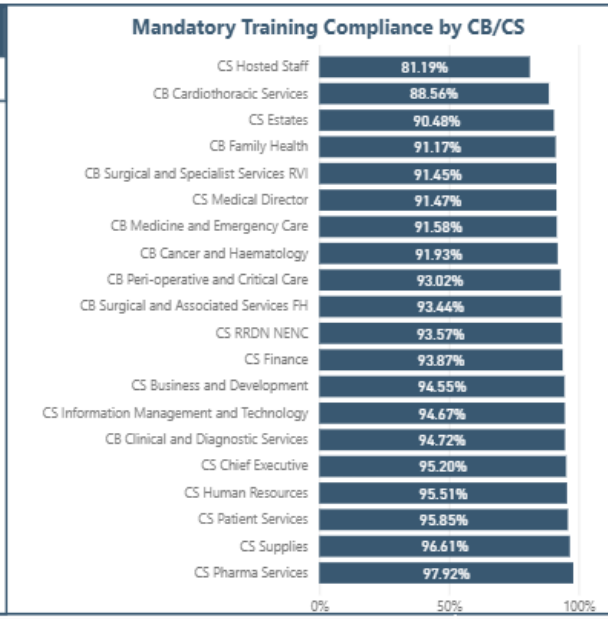


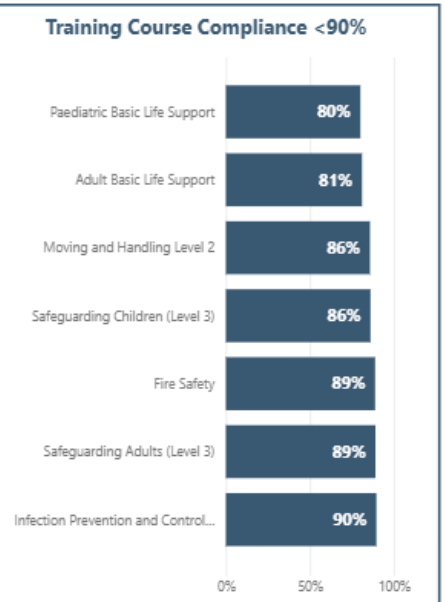


Mandatory training

Mandatory Training Compliance	Month	Value	Target
	Jan 26	92.43%	90.00%







Current Position:

- Overall target is consistently met.
- Certain areas, staff groups and courses are below target.
- Oliver McGowan. Statutory requirement under Health and Care Act 2022 for CQC-registered providers to ensure staff receive learning disability and autism training appropriate to their role. DHSC launched Code of Practice in June 2025 which supports statutory training requirements and sets clear standards for Care Quality Commission (CQC)-registered providers.

Underlying Issues

- Medical and Dental – have lowest overall compliance (80.46%) with low compliance in Adult Basic Life Support (65.17%); Safeguarding Children - Level 3 (67.61%); Paediatric Basic Life support (69.23%).
- 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.

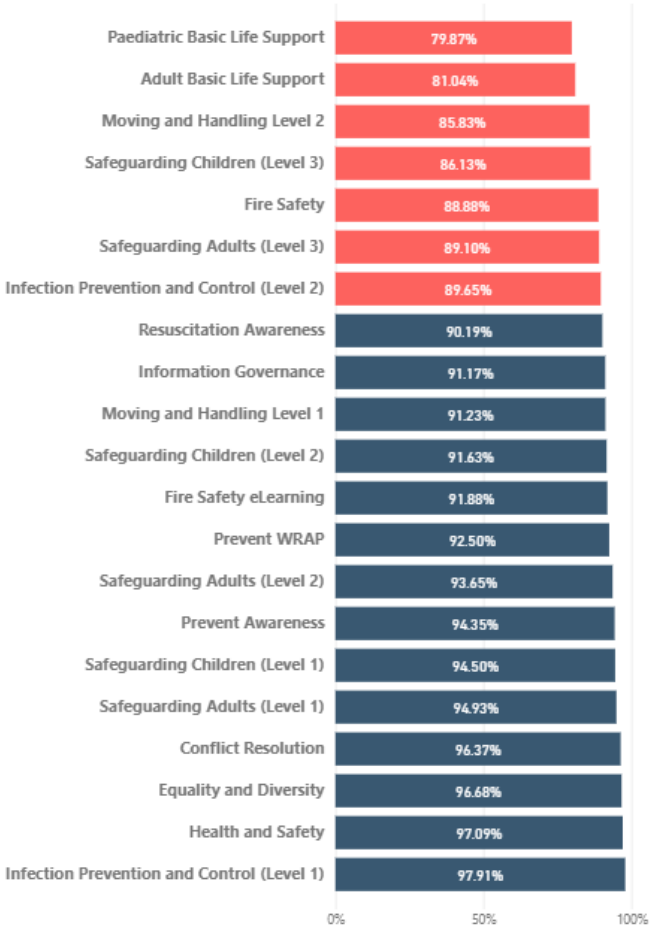
Actions Undertaken:

- 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

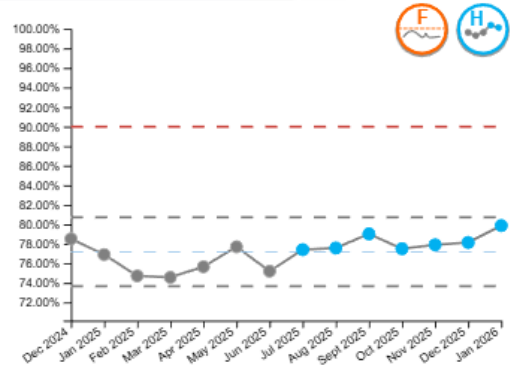
Mandatory Training Compliance	Month	Value	Target
	Jan 26	92.43%	90.00%

Training Course Compliance %

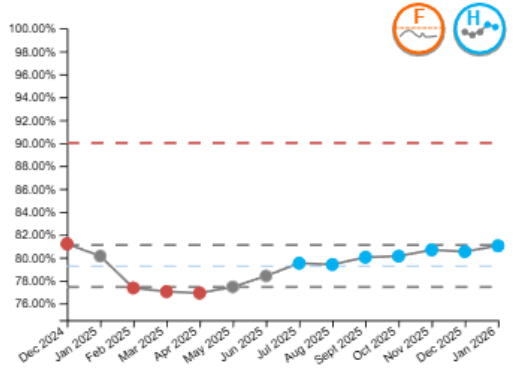


Lowest 4 Mandatory Training Compliance %

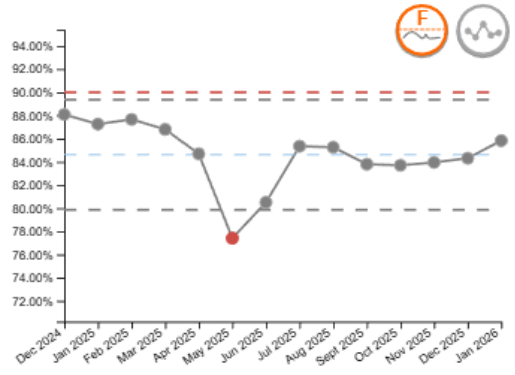
Paediatric Basic Life Support — 80%



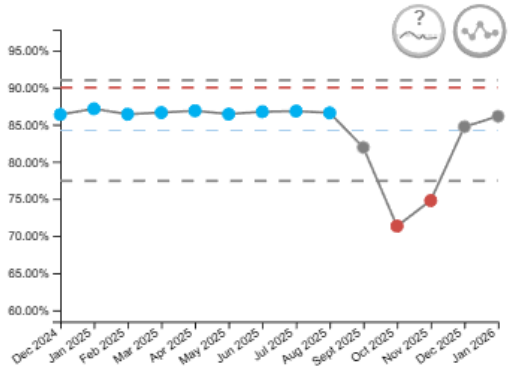
Adult Basic Life Support — 81%



Moving and Handling Level 2 — 86%

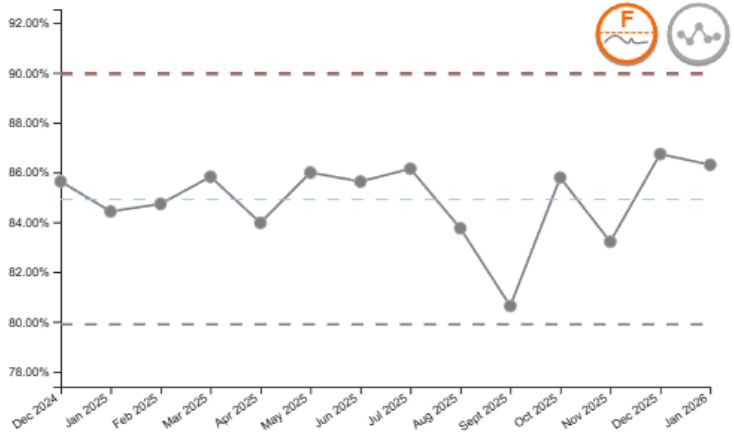


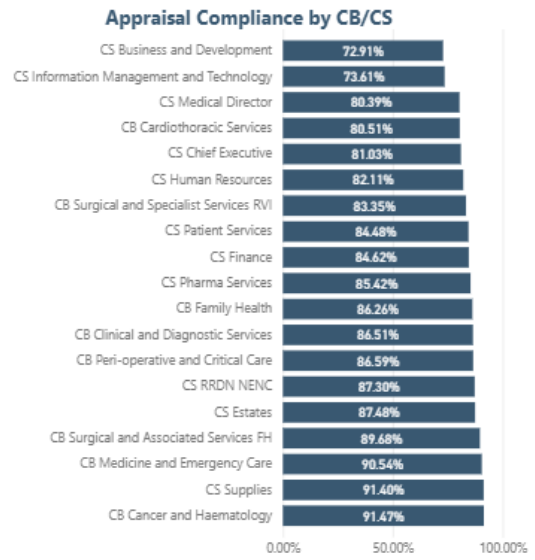
Safeguarding Children Level 3 — 86%

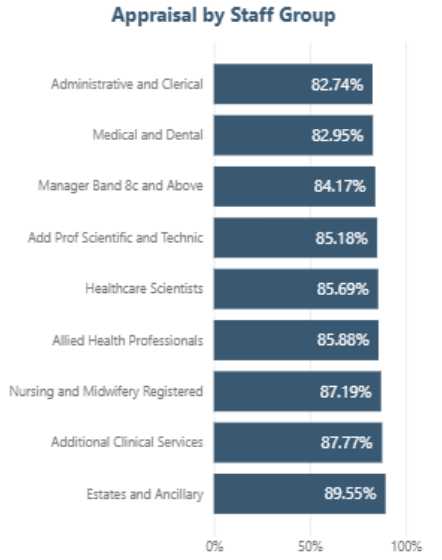


Appraisal compliance

Appraisal Compliance	Month	Value	Target
	Jan 26	86.31%	90.00%







Current Position:

- Overall performance is consistently below target, however, has increased from last month after declining in the autumn
- No area has met the target.

Underlying Issues

- 1,871 appraisals are overdue with highest numbers in Nursing and Midwifery (562) and Admin and Clerical (375).
- Clinical board performance varies between 81.73% (Cardiothoracic Services) to 91.70% (Cancer and Haematology).
- Corporate Service performance varies between 74.29% (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.
- 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 (£)
	Jan 26	£18,851,142	+£2,022,373

Bank Utilisation (£)

Staff Group	Feb 24 - Jan 25	Feb 25 - Jan 26	Difference
Admin & Clerical	£1,089,933	£884,585	-£205,348
Ancillary	£267,295	£340,128	£72,833
Estates			£0
Nursing & Midwifery (Registered)	£5,501,119	£6,549,401	£1,048,282
Nursing & Midwifery (Unregistered)	£9,155,422	£10,305,968	£1,150,545
Professional & Technical	£815,000	£771,060	-£43,940
Total	£16,828,769	£18,851,142	£2,022,373

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.
- Aim to remove HCA agency for enhanced care end of January with exception only via break glass.
- 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 (£)
	Jan 26	£2,785,134	-£703,818

Agency Utilisation (£)

Staff Group	Feb 24 - Jan 25	Feb 25 - Jan 26	Difference
Admin & Clerical	£200,924	£245,104	£44,179
Ancillary	£23,760	£24,679	£919
Estates	£18,736	£54,535	£35,799
Nursing & Midwifery (Registered)	£283,817	£561,329	£277,513
Nursing & Midwifery (Unregistered)	£1,674,639	£1,044,203	-£630,436
Professional & Technical	£1,287,076	£855,284	-£431,792
Total	£3,488,953	£2,785,134	-£703,818

Current Position:

- Costs reduced by c. £0.7m 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
- Aim to remove HCA agency for enhanced care end of January with exception only via break glass.
- Robust management of agency requests with active bank and redeployment

Agency use (£) – medical

Agency Utilisation (£)	12-Month period ending	Total Bank Expenditure (£)	Total Bank Difference (£)
	Jan 26	£3,573,436	+£268,025

Agency Utilisation (£)

Staff Group	Feb 24 - Jan 25	Feb 25 - Jan 26	Difference
Medical - Consultant	£3,010,384	£3,523,417	£513,034
Agency - Career / Staff Grades	£44,909	-£18,772	-£63,681
Medical - Registrar & Senior Registrar	£147,522	-£1,952	-£149,474
Medical - SHO'S and HO'S	£101,655	£65,596	-£36,059
General Practitioner	£942	£5,147	£4,205
Total	£3,305,411	£3,573,436	£268,025

Current Position:

- Costs increased by c. £268,025, on previous year.
- Notable reductions in Registrar/Senior Registrar and SHO's/HO's.
- Significant increase in Consultant spend.
- Consultants collectively working an average of 1,100 hours per month.

Underlying Issues

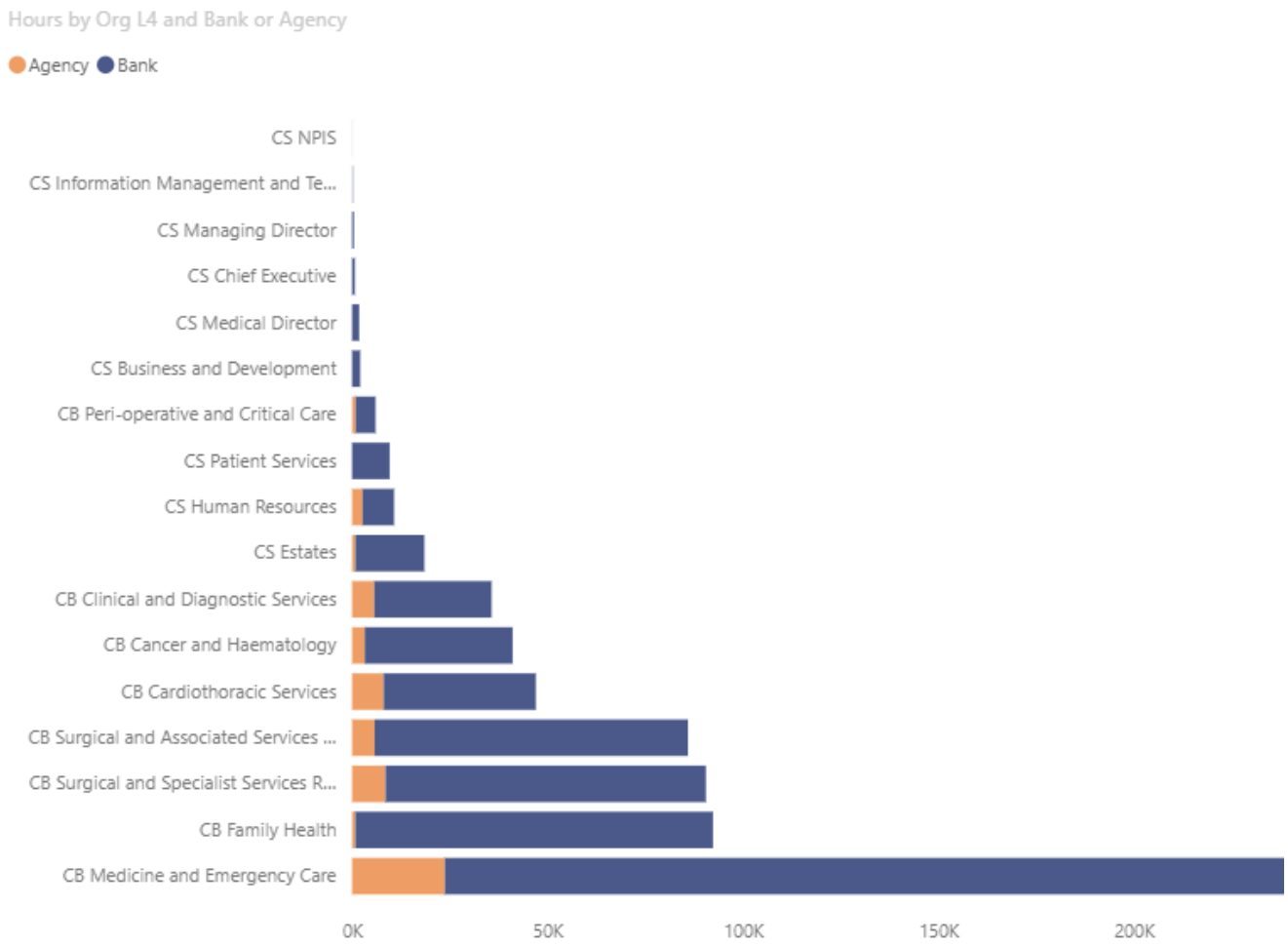
- Consultant spend. Staffing issues in Older People's Medicine and Stroke; off-framework arrangement in PICU due to sickness absence and recruitment; locum in General Medicine as part of Winter Plan 2024/25 ended in April 2025; agency Consultants unwilling to move to a Trust contract.

Actions Undertaken:

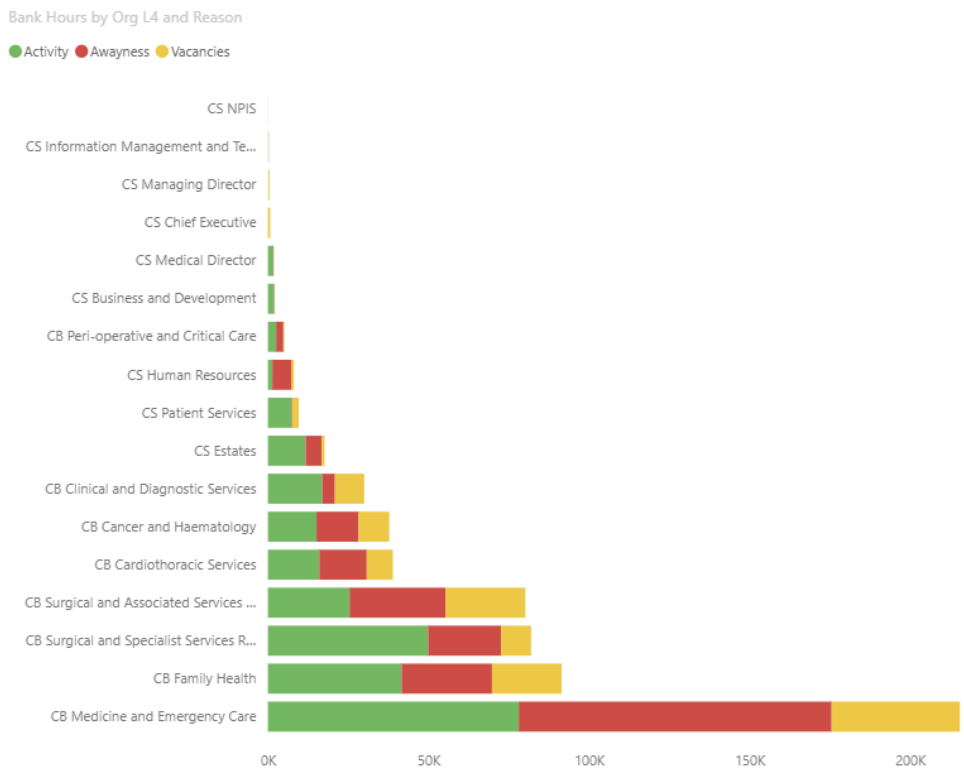
- Consultants. Trust contracts offered and declined; charges and hourly rates renegotiated wherever possible; recent recruitment in PICU has been successful reducing the need for agency.

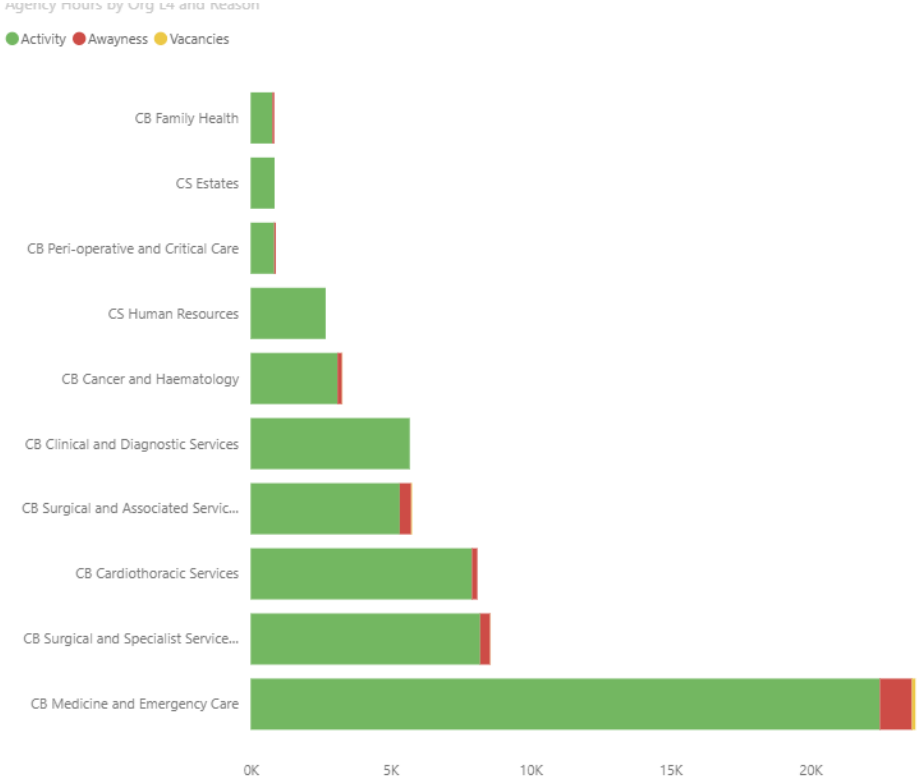
Bank & agency use - hours

Bank & Agency	12-Month period ending	Total Bank and Agency Hours
	Jan 26	682,141



Bank & agency hours (latest 12-month period ending January 2026)

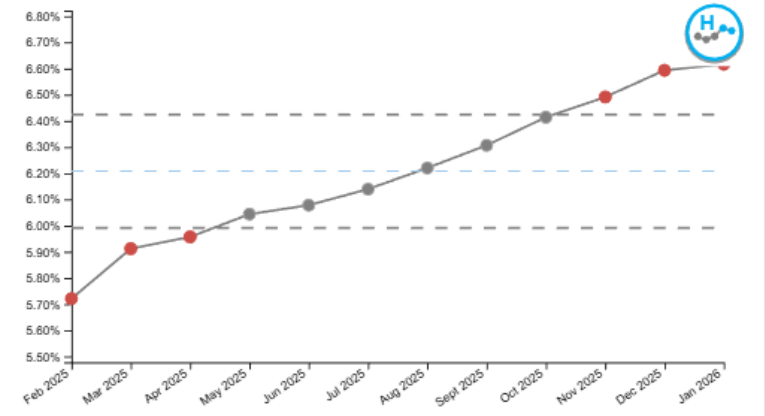


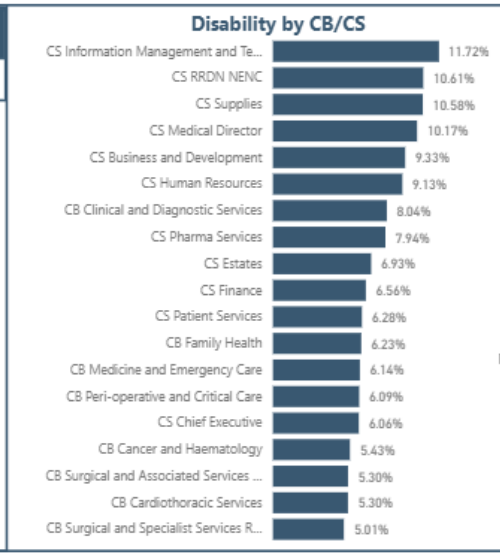


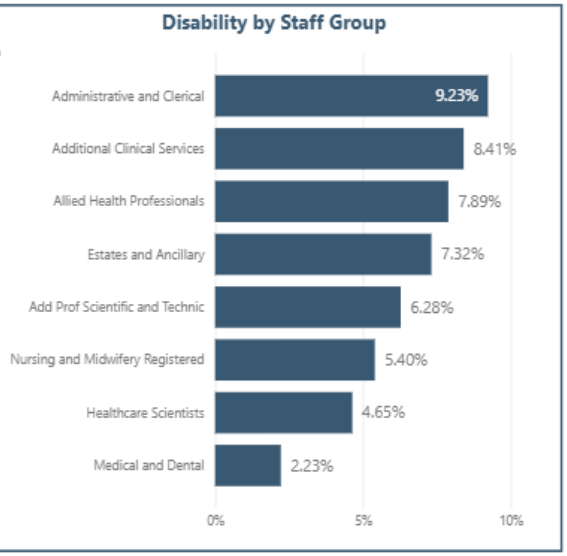
- **awayness**, including sickness, maternity, study leave, industrial action, etc.
- **activity**, including workload, acuity, waiting list initiative, etc.
- **vacancies**

Equality, diversity and inclusion (EDI) - disability

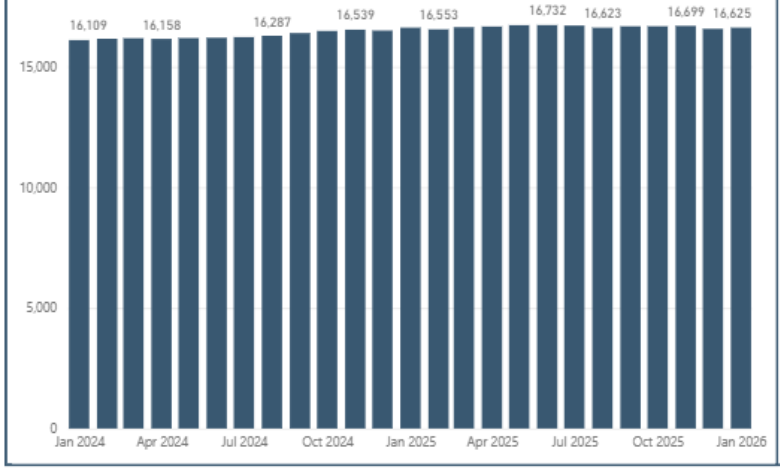
EDI - Disability	Month	Value	Trust Headcount
	Jan 26	6.62%	16,625







Trust Headcount Trend



Age Band

	Age Band	Disability %
1	<=20 Years	8.00%
2	21-25	13.49%
3	26-30	7.81%
4	31-35	6.79%
5	36-40	5.26%
6	41-45	4.90%
7	46-50	5.31%
8	51-55	6.77%
9	56-60	6.00%
10	61-65	6.22%
11	66-70	3.10%
12	>=71 Years	4.92%

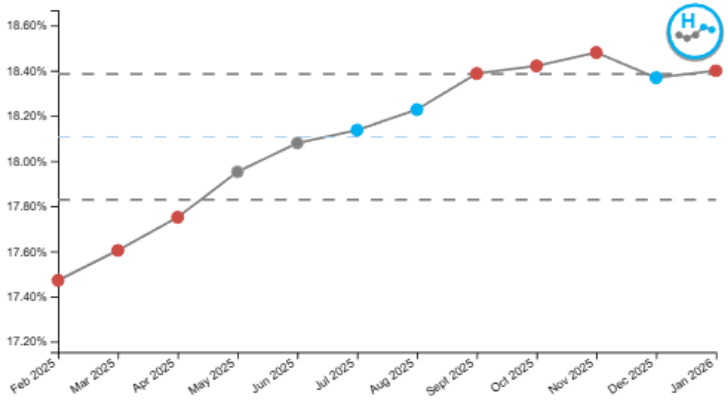
Current Position:

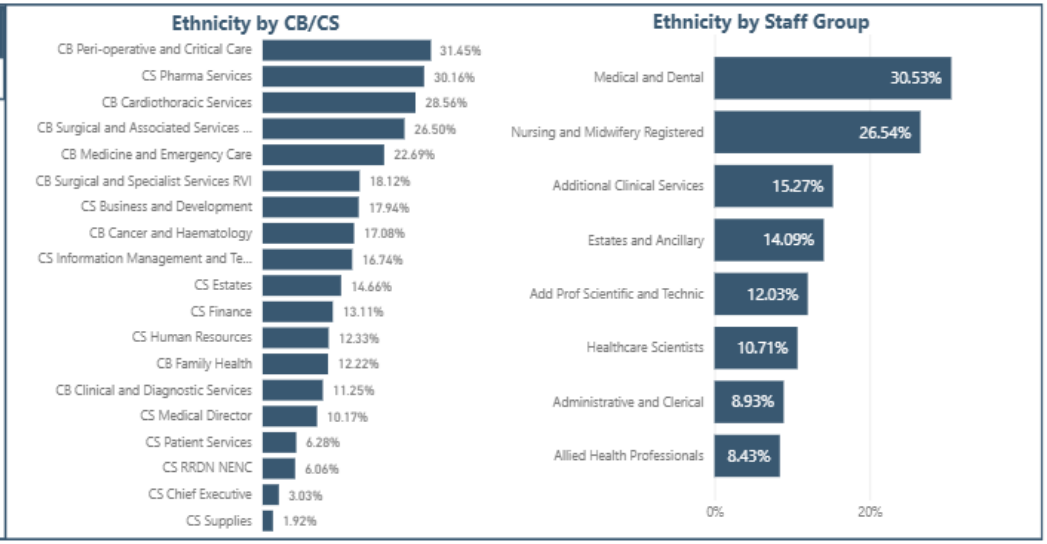
Charts show percentage of staff in post each month by those disclosing a disability.

Percentage of disabled staff continues to grow with the latest position reflecting 6.59% of the workforce.

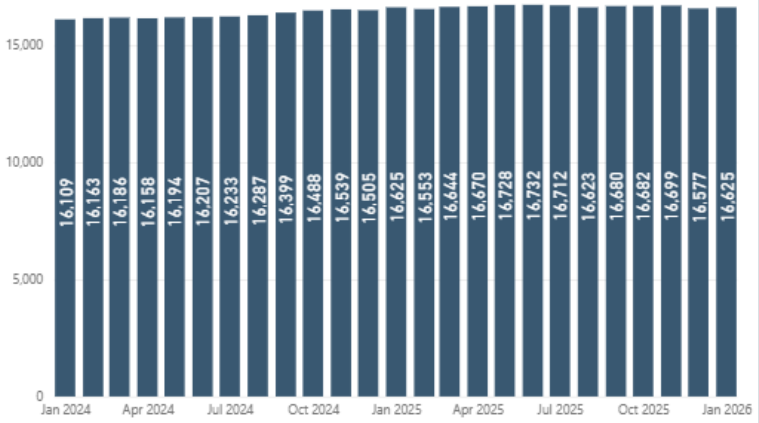
Equality, diversity and inclusion (EDI) - ethnicity

EDI - Ethnicity	Month	Value	Trust Headcount
	Jan 26	18.40%	16,625





Trust Headcount Trend



Age Band

	Age Band	BME %
1	<=20 Years	20.67%
2	21-25	15.53%
3	26-30	27.44%
4	31-35	24.74%
5	36-40	22.78%
6	41-45	16.04%
7	46-50	18.88%
8	51-55	16.04%
9	56-60	10.26%
10	61-65	5.89%
11	66-70	6.98%
12	>=71 Years	3.28%

Current Position:

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

Percentage of BAME staff has reduced slightly with the latest position reflecting 18.37% of the workforce.

Finance

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

January 2026

Financial Health

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

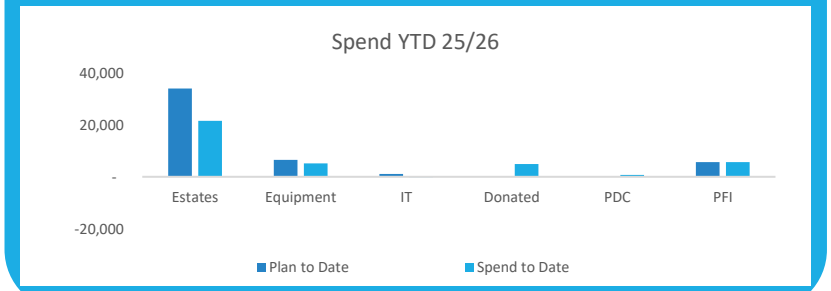
Financial Performance Month 10

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.

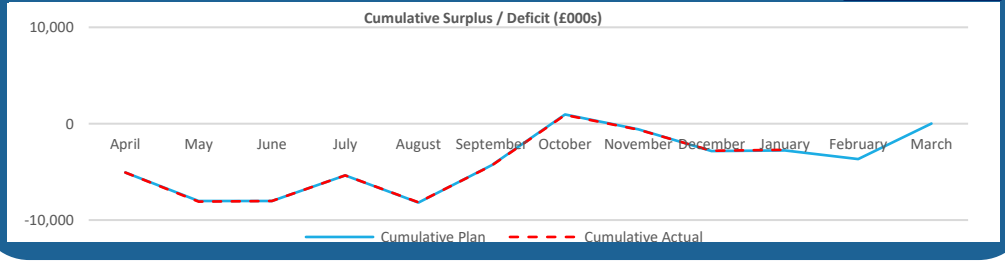
At month 10 the Trust is reporting a £2.8m deficit which is in line with the plan, however in delivering this position, the trust received additional funding and released technical savings to offset pressures and under delivery of CIP. In January, additional income has enabled the reduction of technical mitigations. Key points to note include:

- Unfunded pay award of £2.9m and costs associated with resident doctor industrial action of £2 m (December £0.6m, November £0.6 m and July £0.8m) and the revised job planning policy, are negating some reductions in temporary pay.
- Year to date there is a pressure of £14m on drugs against plan, this is made up of £7m in tariff drugs, £4.2m block and £2.8m pass through (which are matched with additional income). This includes under delivery of £4m against the CIP plan on drugs.
- Clinical Supplies expenditure has settled in January, more in line with the expected run rate, after the increase in December. A number of areas have included stock for the first time such as Periops and the roll out of Genesis continues.
- The CIP of £106m is phased over the year with a plan of £83m to month 10. Year to date Clinical Boards and Corporate Services have delivered £34m (of which £24m is recurrent). A further £6m of other recurrent CIP has been actioned as well as £43m of non recurrent measures, this includes £14m of income mitigating the subsidiary scheme and £29m of technical adjustments (technical adjustments required are now in line with plan).
- Activity which comes under the ERF scheme remains above the cap. This is no longer recognised within the position, being replaced with income secured from commissioners in relation to overperformance. 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.

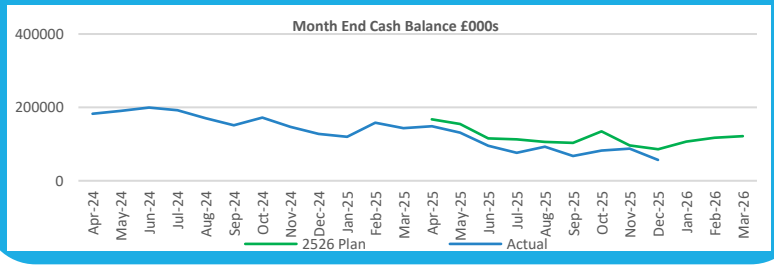
Capital Programme Delivery – Month 10



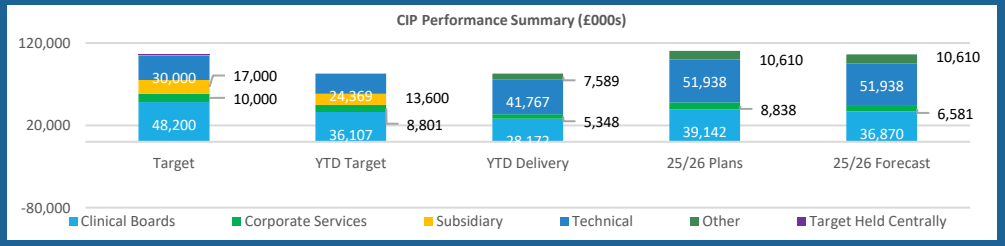
Cumulative Performance Against Plan



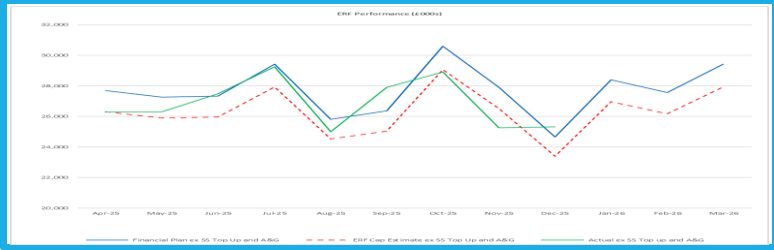
Cash Balance



Cost Improvement Programme Performance



Activity – Elective Recovery Income



A Guide to SPC

SPC Icons & How to Interpret (1/4)

	Variation/Performance Icons		
Icon	**Technical Description**	**What does this mean?**	**What should we do?**
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	**Something's going on!** Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	**Investigate** to find out what is happening/ happened. 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(d)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	27 March 2026		
Title	Integrated Delivery Plan - Public		
Report of	Jackie Bilcliff, Acting Deputy CEO and CFO Patrick Garner, Director of Performance and Governance,		
Prepared by	Patrick Garner, Director of Performance and Governance		
Status of Report	Public	Private	Internal
	☒	☐	☒
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	This document sets out the Trust's Medium Term Plans and outlines the strategic, operational, workforce, financial, transformational and governance arrangements that will underpin delivery over the next planning period. It reflects the Trust's current position, its emerging strategic direction, and the programmes of work required to meet national expectations while improving local service quality, safety, and equity. **By 2031 The Trust will have delivered its new five-year strategy (2026-31)**. This is due for publication in April 2026 and is being informed by comprehensive internal engagement and scheduled external consultation. Although subject to refinement, the emerging strategic pillars align closely with national frameworks, including Fit for the Future: A 10-Year Health Plan for England and the Medium-Term Planning Framework (MTPF). This alignment demonstrates a clear and intentional shift toward prevention, integrated community-based delivery models, digital enablement and strengthened leadership and workforce culture. Collectively, these strategic foundations position the organisation to support system-wide transformation while addressing local priorities and the needs of the populations we serve. **Addressing health inequalities remains a is a priority in our 5 year plan.** The North East continues to experience disproportionately high levels of deprivation, multimorbidity, clustering of high-risk behaviours, lower healthy life expectancy and significant variation in outcomes between communities. In response, the Trust has implemented its interim Health Inequalities Strategy and established the Promoting Equity in Health Group as a formal oversight mechanism. Key priorities include improving access, strengthening reasonable adjustments, enhancing outcomes measurement for ethnically minoritised and disabled groups, improving accessible communication and embedding workforce training. These priorities will be integrated into the forthcoming organisational strategy. The Trust has worked in partnership with Gateshead Health, North Cumbria Integrated Care and Northumbria Healthcare as the **Great North Healthcare Alliance** since 2024. Together, the four organisations provide care for 1.3 million people across a wide geographic footprint, employ 40,000 staff and manage a combined budget of £3.4bn.		

	The Alliance's shared vision—*working together to deliver excellence in healthcare*—guides collaborative efforts to **improve patient outcomes, strengthen secondary and tertiary care, enhance staff experience, drive innovation and research, reduce inequalities, and support a financially sustainable regional health economy.** The refreshed strategic intent focuses on aligning prevention, community, secondary and tertiary services, enabling more patients to receive care closer to home while ensuring specialist services remain high-quality and sustainable. This includes reviewing service pathways and patient flows so that secondary care currently delivered in Newcastle can be provided locally where appropriate, creating capacity for expanded tertiary services. **Improving quality and safety continues to be at the forefront of our plans**, building on progress made following the previous Care Quality Commission (CQC) inspection. Key areas of continuing focus include strengthening quality governance, embedding quality leadership within Clinical Boards, enhancing patient experience measurement, improving risk management, expanding ward accreditation and strengthening learning from incidents and complaints. Additional priorities include improving cancer waiting times, eliminating corridor care, reducing healthcare-associated infections, improving sepsis management, enhancing outcome measurement, developing a city-wide community single point of access, and improving the timeliness and quality of response to complaints. **The Trust has established detailed performance trajectories to restore constitutional standards by 2028/29.** Elective care plans include achieving 81% Referral To Treatment (RTT) performance by March 2027, rising to 92% by 2029, elimination of 52-week waits by 2027, and continued reductions in waiting list size. Cancer trajectories show planned improvements across the main cancer targets, supported by pathway redesign, demand management, and targeted investment. Emergency Care trajectories show improvements in four-hour performance, sustained reductions in 12-hour waits and the elimination of ambulance handovers exceeding 45 minutes. Diagnostic performance is expected to improve significantly through increased capacity, productivity gains and further development of community-based diagnostic models. **Workforce planning has been undertaken in alignment with the MTPF, the Long-Term Workforce Plan and the emerging clinical strategy**. These plans are triangulated with financial and activity assumptions. Key workforce priorities include strengthening substantive staffing, reducing reliance on temporary staffing, modernising consultant job planning, enhancing skill-mix utilisation, expanding advanced practice and supporting digital-enabled roles. A Workforce Reduction Group oversees the implementation of workforce efficiencies, including reductions in overtime, improvements in sickness absence, redesign in theatres and outpatients, digital transformation and service reviews. **The 3-year finance plan is based on the organisation's current financial position and outlines a credible improvement trajectory in each year and eliminates the underlying deficit by the end of the planning period.** The financial plan is supported by aligned workforce and activity assumptions. The plan also sets challenging cost improvement targets of circa 5.5% each year, with 60% of first-year savings expected to be recurrent

	and schemes spread across different risk levels. The plan aligns with commissioner income assumptions and incorporates future benefits from realigning contract values. Delivery depends on significant workforce reductions, alongside targeted quality and safety investments and invest-to-save initiatives, supported by stretching targets for Clinical Boards/Corporate services and wider trust wide transformation programmes. Achieving this scale of change will also require investment in enabling infrastructure, particularly digital. **Transformation and improving productivity form essential components of the delivery plan.** Three strategic improvement groups: Surgical, Diagnostics and Urgent and Emergency Care, are driving redesign of pathways and operational practices. Outpatient transformation is a Board priority, with participation in national programmes to enhance productivity and patient experience. A structured five-year transformation roadmap outlines major shifts in outpatient delivery, elective throughput, urgent care access, diagnostics and community-based care. The Service Review Programme provides a structured mechanism for assessing the operational, clinical and financial sustainability of all Trust services, supporting evidence-based decision-making, cost-improvement planning and service reconfiguration where required. **Digital transformation will be a critical enabler over the next 12 to 18 months.** Priorities include digitisation of elective and peri-operative pathways, enhanced utilisation management, expansion of electronic patient engagement tools, optimisation of the electronic patient record and improved bed management systems. Infrastructure modernisation, particularly migration to cloud-based platforms and reduction of legacy system, will improve resilience, scalability and safety. Digital solutions will also support neighbourhood and community-based models, with improved interoperability, shared records and enhanced connectivity for outreach services. Digital programmes will be tightly aligned with productivity and cost-improvement expectations. **The estates strategy provides a five-year roadmap to address significant infrastructure challenges, modernise clinical areas, rationalise estate utilisation, support Net Zero delivery, and prepare for major developments associated with the Great North Healthcare Alliance**. Key priorities include upgrading critical infrastructure, modernising urgent care, maternity, neonatal, theatres and diagnostics, consolidating office and community estate and supporting major research development through the Sir Bobby Robson Institute. Risks associated with the delivery plan have been assessed and mitigation strategies have been and will continue to be developed. Monitoring and reporting will be governed through the Trust's Accountability Framework.
Recommendation	The Board of Directors are asked to confirm support for the Trust's medium term delivery plan.
Links to Strategic Objectives	Look to the future (interim strategy) The content is also congruent with the new 5 year Trust strategy that is in development.

Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☒	☒	☒
Link to Board Assurance Framework [BAF]	Links to all principle risks.					
Reports previously considered by	Previously agreed as part of the Medium Term Planning process					

SECTION 1: STRATEGIC CONTEXT

This section sets out the strategic context in which the delivery plan has been populated.

2 Trust strategy

The Trust is in the process of developing its new 5-year strategy which will be published early in 2026/27. The strategy has been developed through extensive internal engagement with staff including with the Board. External consultation with key stakeholders is planned for later this month. Whilst still being refined and therefore subject to change, there are three central pillars in the emerging strategy, summarised below.

Figure 1: Three strategic pillars

Joining up care	Improving how we work together	Being our best
Working together to give people better and quicker access to care	Using new ideas, better information and improved training	Having the things in place to support staff to deliver high quality, sustainable care
•Developing community services to support people proactively •Transforming outpatient services moving away from hospital-centred care •Making it easier and faster for people to get the care they need	•Prioritising innovation and research in our work •Using data to make care safer and more effective •Helping staff learn and develop new skills	•Creating a caring and inclusive workplace •Improving our buildings, equipment and digital systems •Using money wisely and protecting the environment

The themes within the pillars resonate with strategic direction set out both Fit for the Future: a 10 year health plan for England and in the Medium Term Planning Framework: delivering change together (2026/27 to 2028/29). Both national frameworks set out shifts toward community based, digitally enabled, preventative care, aiming to reduce pressure on acute services and improve patient outcomes.

The 10-Year Plan emphasises this in three defining shifts: from hospital to community, from analogue to digital, and from treatment to prevention. The Medium Term Planning Framework acts as the operational framework for delivering these ambitions, setting out a three-year roadmap that accelerates neighbourhood care models, sets out a digital-first operating model, strengthens leadership and workforce engagement, and reintroduces rigor around constitutional performance standards, particularly in elective care, cancer, diagnostics, and urgent care.

The themes in the emerging Trust strategy shows clear coherence with both national plans, particularly in the areas of joining up care, embedding prevention,

strengthening digital infrastructure, improving pathways, investing in workforce culture and leadership, and expanding innovation and research. This alignment indicates that the Trust is well positioned to deliver its local ambitions whilst fully supporting the wider NHS transformation agenda.

Figure 2: Strategy theme comparison table

Theme	Fit for the Future – 10-Year Plan	Medium Term Planning Framework	Drafts strategy themes
1. Community-based / Neighbourhood Care	Major shift from hospital to community; Neighbourhood Health Centres	Accelerates community shift through a Neighbourhood Health Service model; enables integrated local care to reduce acute demand	Community/prevention models; neighbourhood delivery central to "Joining up care"
2. Digital Transformation	Major shift from analogue to digital; NHS App as the front door; single record; digital-first access	A digital-first operating model; real-time data, expanded NHS App use; digital urgent care and outpatient redesign.	Digital infrastructure improvement; better use of information; digital innovation & technology adoption
3. Prevention & Population Health	Major shift from treatment to prevention; prediction, prevention, personalised plans	Reinforces prevention as a core strategic shift (e.g., screening, vaccination, Core20PLUS5), aiming to reduce acute demand	Prevention-focused community models and pathway redesign
4. Workforce & Culture	Addresses demotivation, morale crisis, empowering frontline staff	Workforce reconnection; leadership strengthening; enabling local teams to deliver transformation	Focus on compassionate culture, Equality, Diversity & Inclusion (EDI), psychological safety, leadership & workforce planning
5. Innovation & Technology	Technology central to NHS reinvention; science & tech drive new model of care	Strong emphasis on digital, genomics, life sciences, research integration; innovation embedded in new operating model.	Embedding research & innovation; robotics, genomics, future clinical technologies
6. Access & Pathway Improvement	Improved access to GP/dental/diagnostics; faster appointments; reduced waits	Ambitious performance recovery targets (e.g., 18-week RTT, cancer, diagnostics waits)	Outpatient transformation; pathway redesign for efficiency & better access
7. Financial Sustainability	Investment to fund reform; emphasis on efficiency and value delivered nationally.	Multi-year financial framework; productivity drive; reformed payment models; focus on long-term sustainability	Efficiency, productivity and commercial plan to ensure internal sustainability
8. Equity & Health Inequalities	Structural targeting of areas with lowest healthy life expectancy	Tackling inequalities embedded in the operating model (e.g., neighbourhood focus, Core20PLUS5)	Focus on EDI, antiracism and inclusive culture

3 Health Inequalities

The Trust is progressing its work on reducing health inequalities through the implementation of its interim Health Inequalities Strategy, aligned with the wider North East and North Cumbria (NENC) Integrated Care System (ICS) population health strategy.

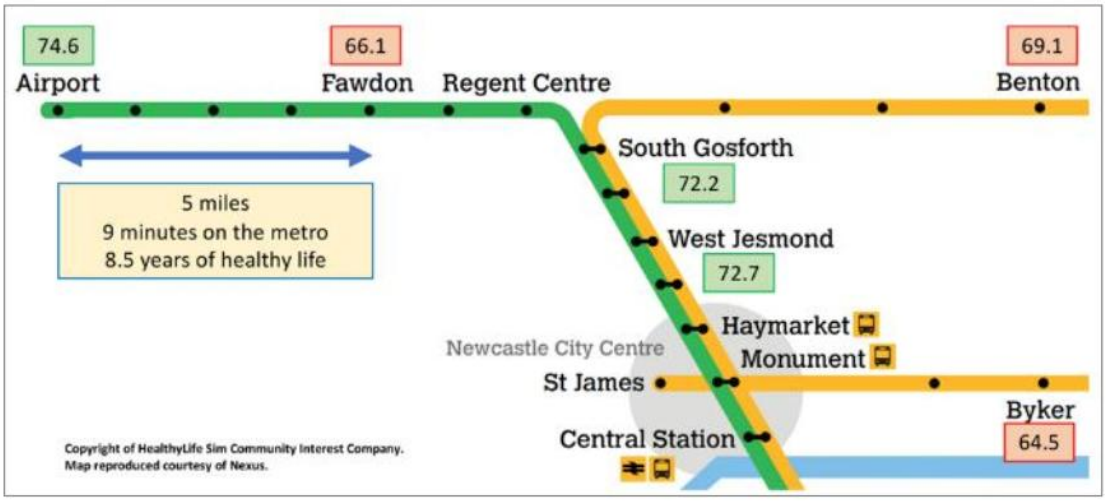
The context in which we work is stark, in the North East:

- 35% of all babies, children and young people live in poverty, the second highest rate in England, with the steepest increases seen over the past decade. Poverty is strongly linked to barriers in accessing healthcare, delayed treatment, and poorer outcomes.
- People in more deprived communities experience higher levels of multimorbidity, with a greater proportion having two or more long-term conditions. This leads to increased hospital admissions and longer hospital stays.
- Socioeconomic deprivation is also associated with increased prevalence of key risk factors such as obesity, smoking, poor diet, physical inactivity and harmful alcohol

consumption, with multiple high-risk behaviours clustering disproportionately in the most deprived areas.

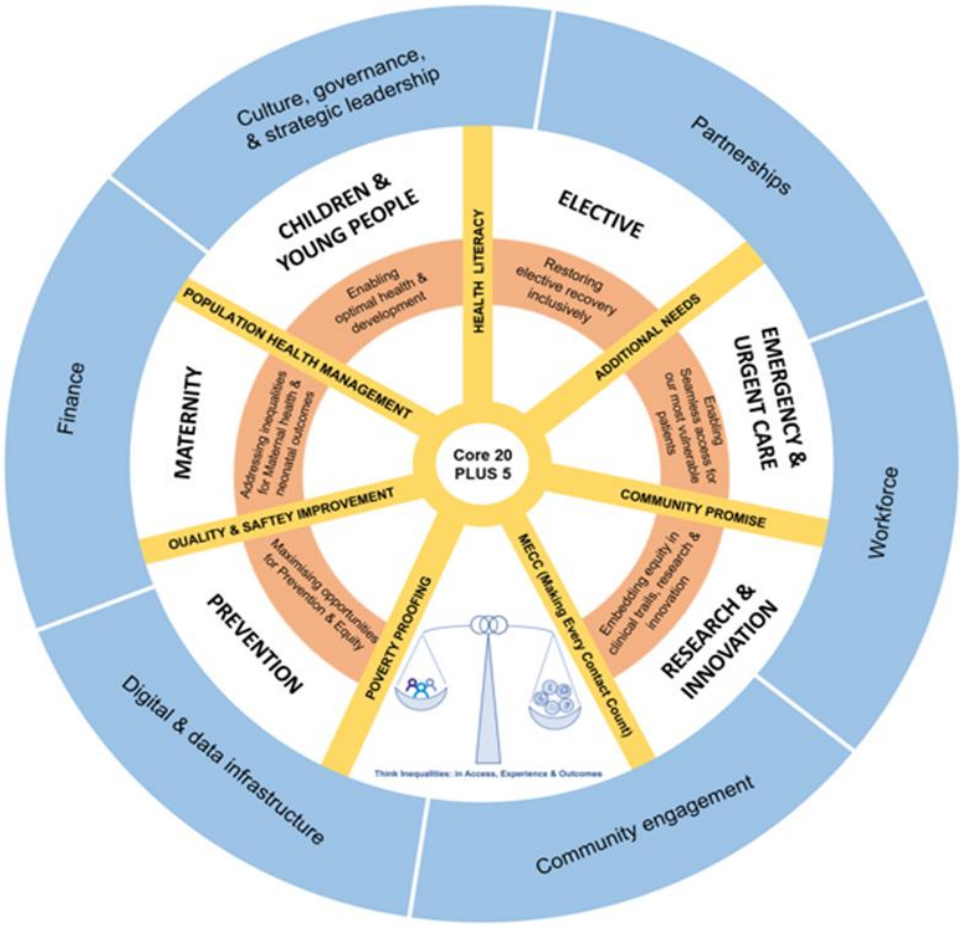
- Newcastle's population has become increasingly diverse, with the 2022 School Census identifying 79 ethnicities across the city's school-aged children. Many ethnic minority groups are more likely to live in deprived areas and experience poorer outcomes.
- Around 62% of adults struggle to understand health information containing words and numbers, and those with low health literacy are 1.5–3 times more likely to be hospitalised.
- Healthy life expectancy in Newcastle is notably lower than in the rest of England. This means that in Newcastle, many people spend a greater proportion of their lives in poor health and die younger than the national average. For example, females are expected to live 82.3 years but spend only 60.7 years in good health.
- There is wide variation in healthy life expectancy between different parts of Newcastle.

Figure 3: Healthy life expectancy for adults aged 55 across Newcastle



To strengthen organisational focus, the Promoting Equity in Health Group (PEHG) was established in July 2025 as an oversight body reporting to the Quality Committee (a formal Tier 1 Board Committee). The Trust's first interim Health Inequalities Strategy was endorsed in September 2025 and health inequalities will be embedded as a cross-cutting priority in the forthcoming five-year Trust Strategy. A summary is included below.

Figure 4: Interim Health Inequalities strategy: strategic priorities, critical enablers & golden threads



The strategy sets out key priority areas and golden threads for ensuring equity in all services, supported by Trust-wide strategic goals. These include improving access by reducing Did Not Attend and Was Not Brought rates among deprived and minoritised groups; improving patient experience through consistent reasonable adjustments; measuring and improving outcomes for ethnically minoritised people and disabled people; ensuring all communication is accessible and meets literacy standards; and strengthening the workforce through expanded Making Every Contact Count training. Together, this work aims to ensure fairer access, better-tailored services, and improved outcomes for the communities most affected by inequality.

4 Great North Healthcare Alliance (GNHA)

The Trust has been working together with Gateshead Health NHS FT, North Cumbria Integrated Care NHS FT and Northumbria Healthcare NHS FT as the Great North Healthcare Alliance since 2024. The Alliance is intended in large part to change ways of working across the four trusts, supplementing existing practice and working more closely in partnership with neighbouring organisations to drive better decision making for the benefit of patients, staff and external partners.

Together the Alliance cares for 1.3 million patients over 4,600 square miles. It collectively employs 40,000 staff and has an annual budget of around £3.4 billion.

The Alliance has the overall vision of "working together to deliver excellence in healthcare" which through working together will:

- Improve patient outcomes and reduce inequalities by strengthening our services and making it easier to access the best clinical care.
- Create great places to work by joining up our recruitment and staff experience offer and by sharing career development opportunities.
- Pioneer innovation, transformation, research and development, making the most of our academic and commercial opportunities.
- Reduce health inequalities and do more for our economy, environment and communities through local and national partnerships.
- Create a financially sustainable value for money health economy that raises revenue by treating as many patients as possible within the resources available, commercial activity and cost reduction.

The Alliance is led by an Alliance Steering Group which is a Committee of each of the four Foundation Trusts and includes the chairs, chief executives and a non-executive director member from each organisation. There are also bilateral meetings between Newcastle Hospitals and each of Gateshead Health, North Cumbria Integrated Care and Northumbria Healthcare Foundation Trusts, which coordinate the delivery of improvement priorities between the respective organisations for the benefit of patients, staff and the taxpayer.

The Alliance has recently refreshed its strategic intent to focus on those things which bind the four trusts together for the benefit of patients, namely the interdependencies of prevention, primary, community / neighbourhood, secondary care hospital and tertiary specialist services, within the Alliance. The Alliance recognises the role of all Trusts in providing excellent secondary care hospital services in their area for local people and communities, and how this supports the provision of the best possible tertiary services.

By working together with a focus 'to deliver excellent tertiary and excellent secondary care hospital services' it is expected that the Alliance will support this Trust to:

- Enable more people / patients to receive their care local to where they live, including by Trusts working differently with each other. Wherever possible this will be done to increase rather than reduce, choice and the range of services provided in each place.

- Provide the right accessible services to the right people in the right environment with patient choice at the heart of this and mindful of health inequalities.
- Work in a way that supports each trust to be successful and for patients to benefit from improved service provision.
- Make progress on the 3 shifts, particularly around moving more hospital care to be provided in hospitals and communities / neighbourhoods closer to where patients live. The shifts from analogue to digital, and from treatment to prevention will also enable the wider success of the Alliance and its proposed strategic intent.
- Strengthen tertiary services as an asset to all patients in the Alliance, and address service fragilities in sub-tertiary services, particularly in North Cumbria, by having these services increasingly provided by Newcastle Hospitals. In doing so the Alliance will ensure services are accessible and adopt the principle that 'we will localise where possible and centralise where necessary to ensure safe, quality, sustainable care'.
- Engage proactively, and where appropriate collectively, in commissioning discussions about how best to organise and provide services.

To achieve this strategic intent requires many things, including reviewing secondary care service pathways and patient flows so that more patients from Gateshead, North Tyneside, Northumbria and North Cumbria that currently receive secondary care hospital care in Newcastle, can choose to be cared for in Gateshead, Northumbria and North Cumbria trusts, releasing capacity for Newcastle to take more of the tertiary care.

A full vision, work plan, milestones and monitoring metrics for the Great North Healthcare Alliance have also been developed.

5 Current performance

5.1 Access targets

Over the past 12–18 months, Emergency Care performance has shown meaningful and sustained improvement. Type 1 12-hour waits have reduced from 4.5% in November 2024 to 3.8% in December 2025, demonstrating steady, monthly progress despite significant activity pressures. This downward trend continues into January 2026 with Type 1 12-hour waits continuing at 3.8%, sustaining the improvement achieved during 2024/25. While the Type 1 four-hour standard remains pressured, the Trust continues to treat or discharge three-quarters of all patients within four hours (75.9% in December, 74.7% in early January), reflecting an improving performance compared to a year earlier despite significantly higher demand.

From an elective perspective the Trust has delivered substantial improvement in overall waiting list size, reversing part of the post-pandemic growth that was seen. The waiting list has fallen to 85,552 in December 2025, representing a 13.6% reduction compared with December 2024. Performance against the 18-week RTT standard has also improved: 71.4% of patients now start treatment within 18 weeks (December 2025) and 79.3% receive their first outpatient appointment within 18 weeks. This compares favourably nationally and reflects 18 months of targeted recovery actions, increased activity, and better pathway management across services.

One of the most significant areas of progress has been in reducing long waits. The Trust achieved zero patients waiting over 78 weeks in October 2025 for the first time since April 2020. The number of 65 week waiters has fallen dramatically with 38 in December 2025, a 71% reduction over the last 12 months. Similarly, >52-week waiters have reduced from 1,683 to 893 over the past year, now representing only 1.0% of the total waiting list. This signifies a near halving of 52 week waits within 12 months showing significant operational recovery.

Cancer performance has also strengthened across multiple standards over the last year, with all three major cancer pathways showing improvement. 31 day Decision to Treat performance remains consistently strong at c.92%, which is a 25% point improvement over the last 12 months. The 62 day standard, has risen from previously much lower performance to 71.5% in November and 72.3% in December 2025, closing the gap to the national March 2026 target of 75%. Pressures still exist in achieving the 28 day Faster Diagnosis Standard, more of which is covered in section 8. Overall, the Trust is demonstrating progress across the cancer standards, reflecting improved diagnostic capacity, more timely decision making, and minimising delays in treatment pathways.

Diagnostic performance has also shown progress since August 2024. The Trust is currently at 20.6% of patients waiting over 6 weeks as of December 2025. This trend indicates a gradual improvement reducing higher backlogs across a number of modalities, supported by improved capacity through targeted investment, and improved utilisation of diagnostic hubs. Though still challenged, the direction of travel in diagnostics performance over the past 12–18 months is positive and continues to underpin improvements in RTT and cancer performance.

5.2 Financial context

Newcastle Hospitals has consistently met its in year financial targets despite a challenging financial environment.

However, the Trust had a reported underlying deficit pre pandemic due to inflationary pressures, the costs of the Private Finance Initiative (PFI) estate, non-elective pressures and drugs, which rose to £104m at the beginning of 2025/26. Pressure on funding, block contracts and cost pressures particularly in relation to drugs and devices compounded the in-year position.

Thus in 2025/26 the Trust has a considerable Cost Improvement Programme (CIP) target of £106m to deliver financial balance. This target has been delegated to clinical boards and corporate services as well as having cross cutting themes within the organisation such as commercial schemes and drugs savings. This significant target has also resulted in a projected workforce reduction of 400 FTE, supported through a voluntary severance and Mutually Agreed Resignation Scheme (MARS) scheme.

As at the end of January 2026, the Trust is forecast to meet the target of year-end financial balance and deliver in the region of £33m recurrent savings, which represents 2% of operating expenditure plus a full year impact of a further £17m savings. This improvement in the position has formed the basis of the plan for 2025/26 and moving forwards.

SECTION 2: WHAT WILL BE DELIVERED

6 Planning approach

The Trust uses a range of evidence to inform the setting of realistic but stretched delivery outcomes to optimise achievement of them. This includes:

- Benchmarking, audit, including model hospital outputs to help set out opportunities across all areas of delivery and inform the setting of key targets and Trust ambitions,
- A comprehensive suite of Trust business intelligence reports to inform trends and forecasts and develop insights to services,
- Population health and health inequality information,
- Commissioning intentions,
- Initiative sharing through various forums including the improvement directors' network, Further Faster and other GIRFT programmes, local, regional and national collaborations.

The rest of this section sets out what will be delivered across the key domains within the plan, namely Quality and Safety, Operational Performance, Workforce and Finance.

7 Quality & Safety

Our focus for the next 3 years is to build on extensive work that has been undertaken over the last 2 years in response to our CQC inspection in 2023 and subsequent report in 2024. The following key areas whilst have been substantially developed over the last 2 years, remain a focus:

- Strengthening and embedding a revised quality governance structure.
- Improved Ward to Board reporting in line with the revised accountability framework.
- Embedding of quality leads in Clinical Boards to support local quality oversight and assurance.
- Implementation of executive led improvement groups to support services in need.
- Implementation of a comprehensive 'real time' patient experience programme rolled out to 40 wards, going above and beyond planning guidance recommendations. Implementation of 'right time' patient experience programme

which has allowed us to capture the lived experience of over 125,000 patients over the last year.

- Implementation of a comprehensive ward accreditation programme to capture and provide assurance and improvement in clinical and professional standards at a ward and departmental level.
- Improvement in risk management processes and risk oversight.
- Embedding of robust Equality and Quality Impact Assessment process to ensure effective decision making for cost improvement and transformational work programmes.
- Clear and measurable Quality Priorities and Patient Safety Incident Response Framework priorities based on local incident data intelligence and learning from incidents.
- Embedding a comprehensive Freedom to Speak Up Guardian programme with measurable work plan.

Whilst all the above remain important areas of focus, there are additional key areas of specific focus which are outlined below.

- Measurable improvement in cancer waiting times and achievement of constitutional standards to reduce avoidable harm to patients.
- Eradication of corridor care in our emergency department. This will be achieved through a combination of revision to existing clinical pathways, extensive estates work to right size the emergency department, system level engagement with stakeholders to address unmet mental health need.
- Reduction in avoidable Healthcare Acquired Infections with a specific focus on screening, antimicrobial stewardship, fundamentals of clinical practice and locally led quality improvement initiatives.
- Improvement in the recognition, screening and response to patient deterioration and sepsis.
- Improvement in the ability to measure and monitor clinical outcomes to inform operational delivery plans.
- Implementation of a comprehensive city-wide community single point of patient access, supported by health and social care stakeholders.

- Improve how the Trust responds to patient complaints and demonstrate a statistical improvement in complaint response times and evidence improvement in quality of responses.

- Demonstrate statistical improvement, evidenced through audit, that patients with a learning disability or those who are autistic have reasonable adjustments documented and care delivered in line with the mental capacity act.

- Strengthen the learning from incidents, complaints and claims with triangulation of data.

- Further develop the Involvement pillar of Patient Safety Incident Response Framework (PSIRF) to ensure patients and relatives are involved in learning from incidents should they choose to be.

All the above areas of focus have oversight through our existing quality governance structure within the Trust, ultimately reporting to Quality Committee.

8 Operational Performance

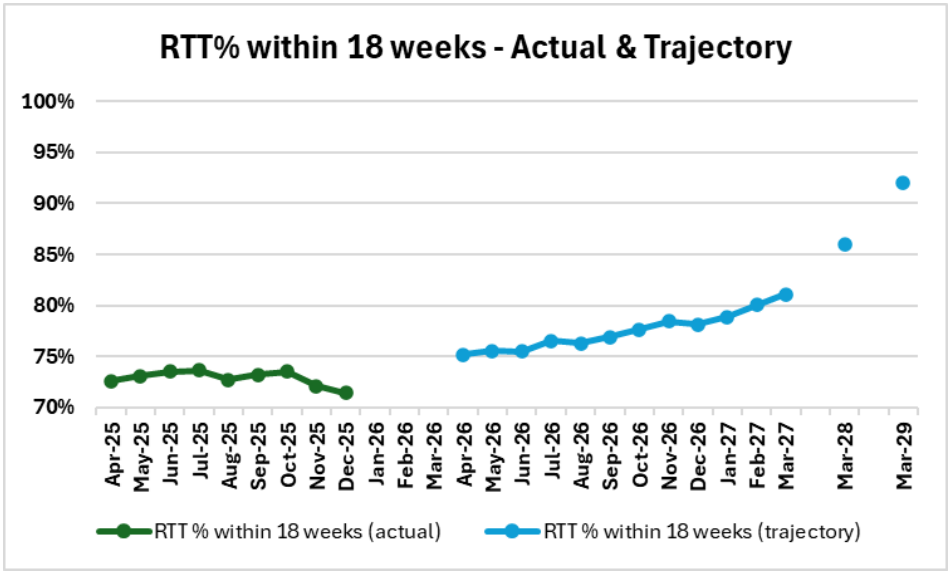
The Trust has developed a three-year set of performance trajectories that progressively return key standards to constitutional levels by 2028/29. Clinical activity plans underpinning these trajectories have been developed with the relevant clinical and operational teams and reflect known developments, capacity changes, and planned pathway improvements. The overarching ambition is to:

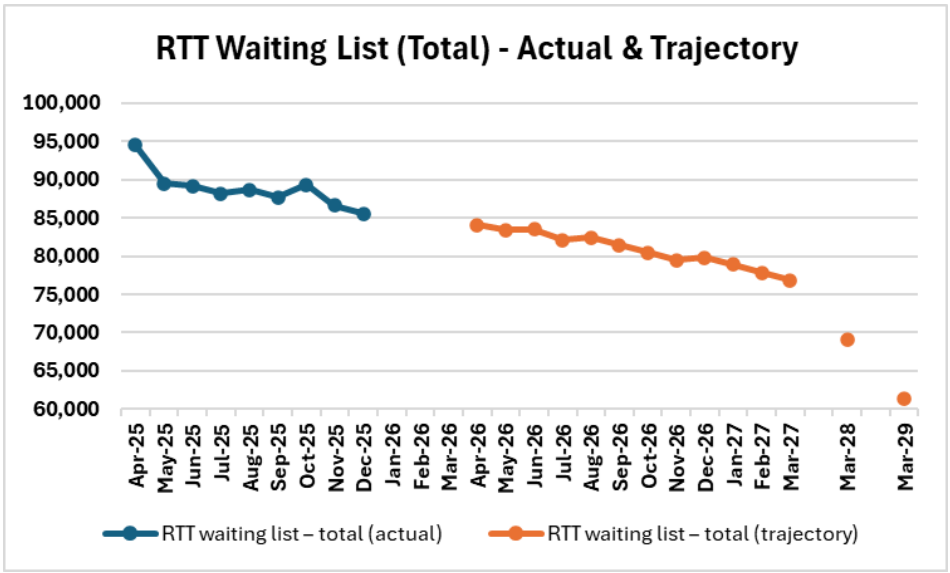
- Significantly improve elective waiting times and eliminate 52 week breaches by March 2027.
- Deliver sustained improvements across all cancer standards supported by pathway redesign and targeted investment.
- Improve Emergency Department (ED) flow, reduce long ED waits, and eliminate prolonged ambulance handovers.
- Reduce diagnostic waiting times to the constitutional 1% standard by 2029.

In relation to **Elective (RTT) Recovery** the performance against the key performance indicators can be seen below:

- 81% of patients treated within 18 weeks by March 27.
- 86% by March 28.
- 92% (constitutional standard) by March 29.
- In addition, the total waiting list will see year on year reduction and 52-week waits are planned to be fully eliminated by March 2027.

Figure 5: 3 year Referral To Treatment (RTT) and waiting list size trajectories.





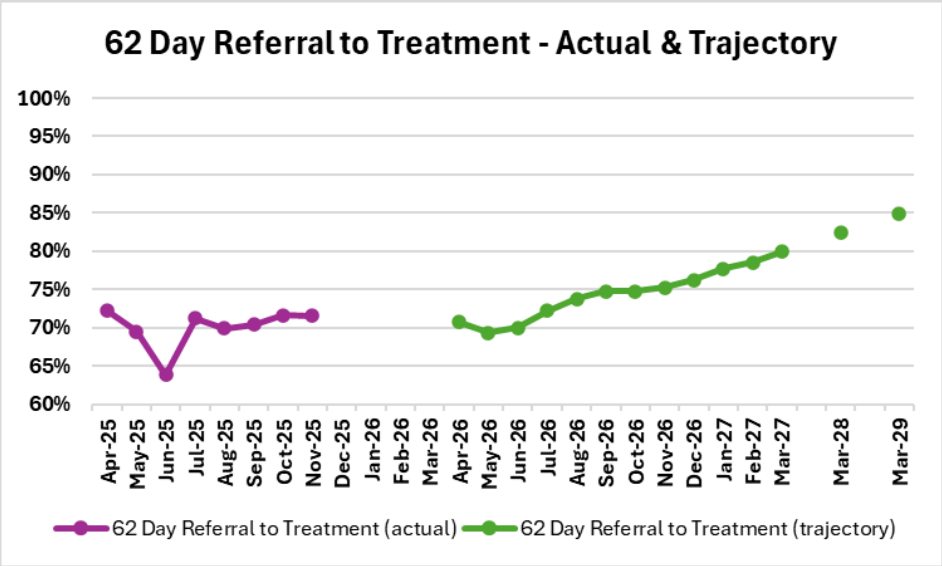
Achieving these trajectories requires sustained elective throughput, optimal theatre utilisation, and agreed productivity gains at specialty level. Section 12 sets out more of this detail.

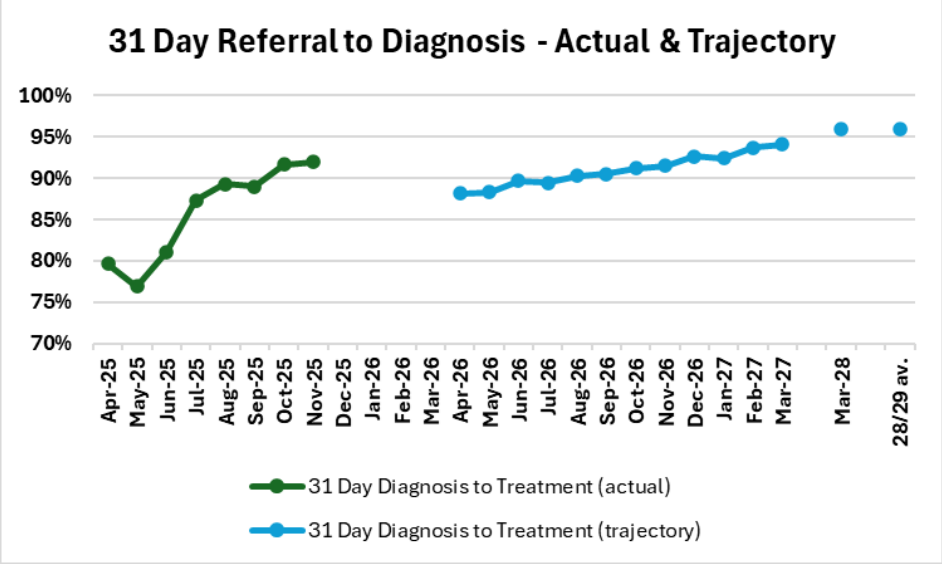
For **cancer performance** our plan sets out the following levels of performance:

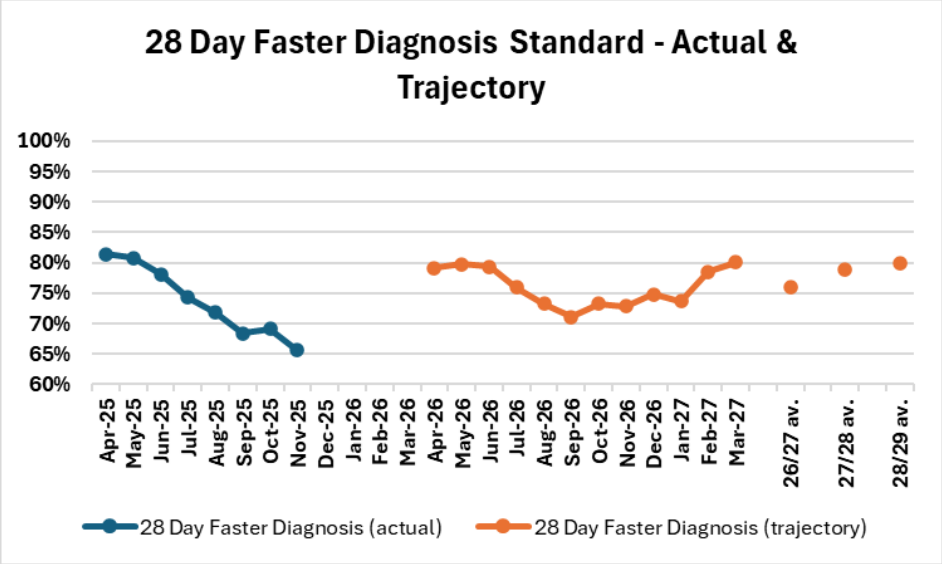
- 28 Day Faster Diagnosis Standard: 76% in 2026/27, 79% in 2027/28 and 80% for 2028/29.

- 31 Day Diagnosis to Treatment: 94% by March 2027, 96% by March 2028 and sustained in following year.
- 62 Day Referral to Treatment: 80% by March 2027, 82.5% by March 2028 and 85% by March 2029.

Figure 6: 3 year cancer KPI trajectories







Key enablers for delivery of the cancer standards include:

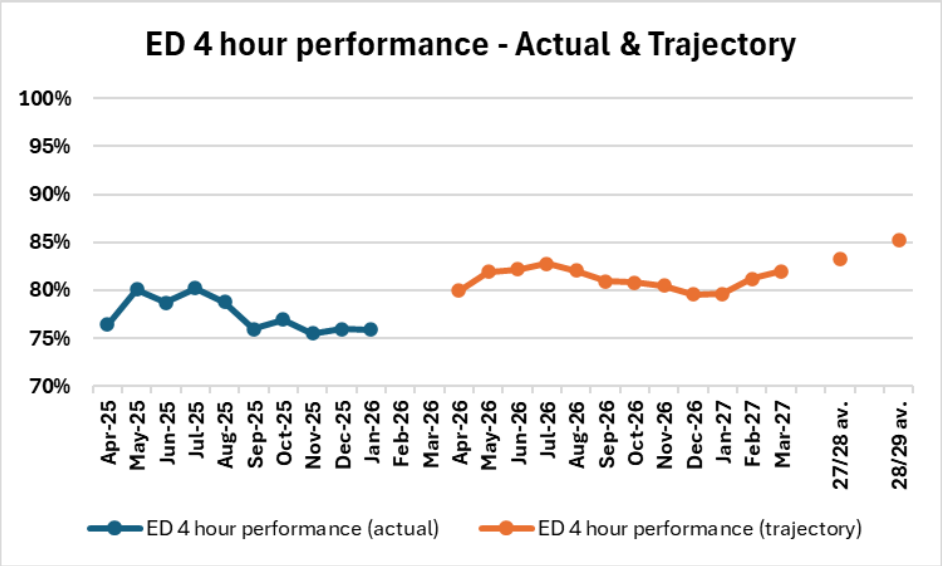
1. better demand management and tele-dermatology (skin) from Q4 2026/27,
2. improved timeliness of tertiary referrals,
3. targeted investment in lung cancer pathways and,
4. comprehensive pathway audits to identify bottlenecks to refine improvement plans.

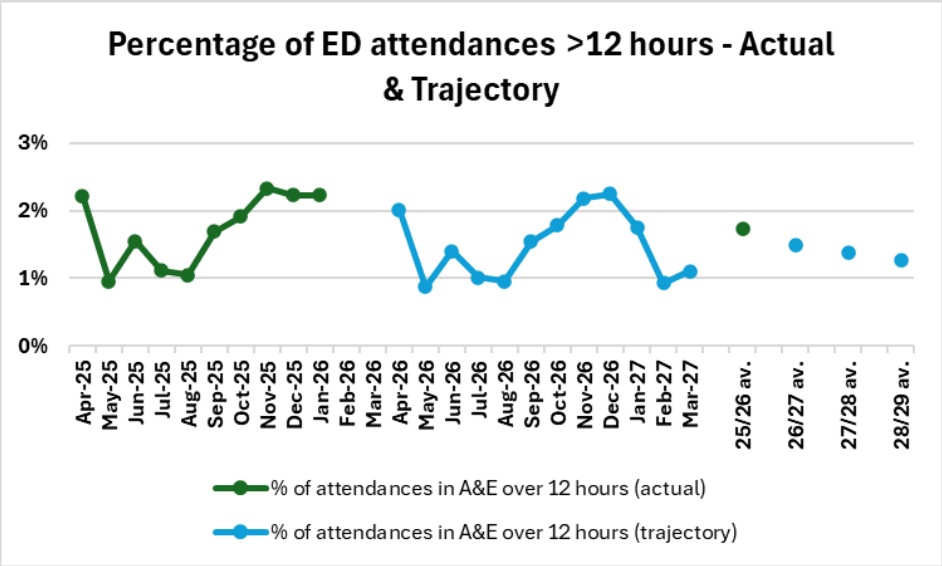
The first of these is contained within the ICB commissioning intentions for the coming year, with this and 2. the timeliness of tertiary referrals, being areas of system support that have been escalated as being essential through the planning process with regional NHS England team and the ICB. Enablers 3. and 4. are more internally focused and will help ensure that we build on the improvements made over the last 12 months.

From an **Emergency Care** perspective, the performance trajectories submitted as part of the planning process are shown below.

- 4-Hour Standard: 82% by March 2027, 83.2% the following year and 85.2% in the final year of numerical plan
- 12-Hour waits: reduction each year: 1.5%, 1.4% and 1.3% respectively over the 3 year period.
- Ambulance Handovers: Zero handovers >45 minutes by March 2027.

Figure 7: 4 and 12 hours ED trajectories



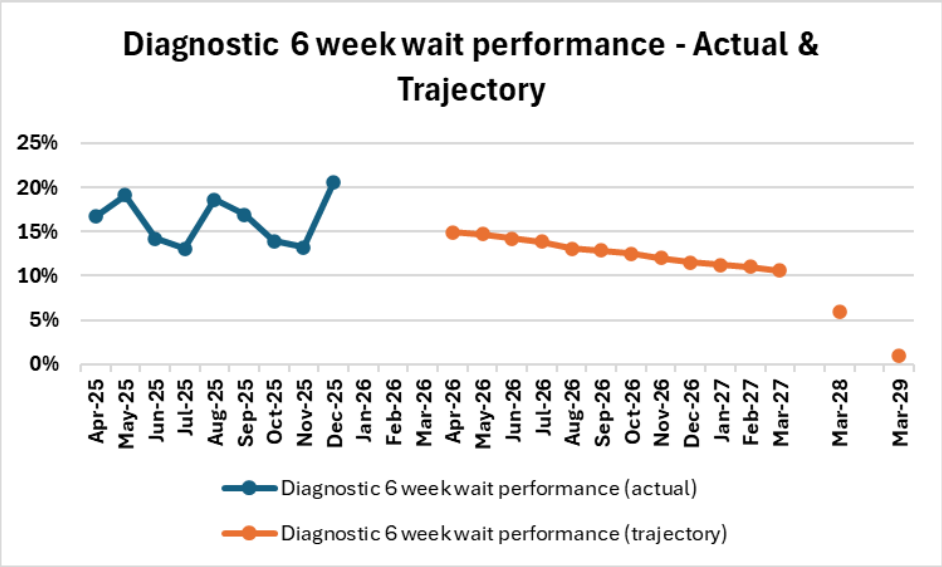


The continued improvements in ED performance are based on targeted interventions including realisation of the benefits of the newly opened co-located Urgent Treatment Centre on the RVI site, Same Day Emergency Care (SDEC) and frailty service expansion and part of the phase 2 ED capital expansion, and a new bed management system facilitating increased operational oversight. Eliminating >45 minute handovers will represent a major operational and patient safety milestone.

For **diagnostics**, the percentage of patients waiting over 6 weeks are planned to be:

- 10.6% by Mar 2027
- 6.0% by March 2028
- 1.0% by March 2029

Figure 8: > 6 week waits for diagnostics trajectory



A step-change is required between 2026/27 and 2027/28 to bridge the gap to the constitutional 1% standard. This will be driven by planned imaging capacity increases, productivity gains (some related to new equipment), and improved demand management.

In summary the planned performance trajectories are credible and balanced, with clear year-on-year improvements and defined enablers. Delivery will be supported by:

- Continued clinical ownership of activity plans.
- Tight operational oversight and performance governance.
- Targeted investment in key diagnostic and cancer pathways.
- Evidence based improvement plans.

9 Workforce

The following section sets out the workforce elements of the plan, i.e. how the plan was constructed and the planned changes to support the workforce agenda over the next 5 years.

The workforce return has been produced using data extracted from Electronic Staff Record (ESR) and temporary staffing recording systems for the M06 baseline snapshot. Staff information was mapped to the Staff Groups required for the return template using Occupation Code, Job Role, Area of Work and Full Time Equivalent (FTE). All collated data was validated internally to ensure accuracy, completeness and alignment with the national workforce dataset.

Following establishment of the M06 baseline, the dataset was separated into Substantive, Bank and Agency groups. Forecasting to March 2026 was undertaken using the following methodology:

- Substantive: Based on the M06 baseline, removing remaining VSS FTE terminating after September 2025, removing projected MARS FTE terminating by March 2026, and adding Business, Quality and CIP-related FTE planned for implementation between October 2025 and March 2026.

- Bank: Maintained at the M06 baseline.

- Agency: Maintained at the M06 baseline.

Monthly and annual workforce projections for 2026/27, 2027/28 and 2028/29 were produced using these assumptions:

- Establishment: March 2026 baseline plus targeted quality investments and FTE reductions based on cost improvement plans where applicable.

- Substantive**:** March 2026 baseline plus targeted quality investments and FTE reductions based on cost improvement plans where applicable

- Bank: March 2026 baseline with a planned 10% reduction year-on-year.

- Agency: March 2026 baseline with a planned 30% reduction year-on-year.

The numerical methodology has been triangulated and corroborated with finance and activity planning assumptions prior to submission, ensuring consistency across workforce, activity and financial trajectories.

Workforce planning assumptions have been developed with consideration of the wider strategic context, including the Trust's commitment to returning to constitutional standards in line with the Medium-Term Planning Framework (MTPF). Workforce requirements within capital business cases, particularly those supporting elective, cancer and urgent care improvement—are aligned to this recovery intent.

The workforce plan has been shaped by emerging clinical strategy development, incorporating expected service redesign, pathway transformation and shifts towards more integrated clinical models. The plan is further informed by ICS, place and neighbourhood strategies, recognising shared workforce priorities, collaborative recruitment opportunities and interdependencies across community, primary and acute services.

Alignment with the national Long-Term Workforce Plan is reflected through the emphasis on the three strategic shifts: strengthening prevention, increasing community-based models of care and utilising digital innovation to support productivity and new ways of working. These shifts influence future workforce composition, deployment and skill-mix assumptions.

Planned workforce reforms have also been incorporated, including consultant job planning modernisation, enhanced skill-mix utilisation, expansion of advanced practice and targeted use of new digital roles. These reforms underpin expected productivity improvements and reductions in temporary staffing reliance, supporting a more efficient and sustainable workforce model.

In developing the numerical workforce plan, careful consideration has been given to potential workforce impacts, including changes in staffing levels linked to service redesign, efficiency requirements arising from cost improvement programmes, and the phasing of new roles aligned to clinical priorities. Where significant changes in FTE

appear in the numerical return, these reflect purposeful redesign, such as MDT expansion, digital-enabled workforce roles, or reductions in agency dependency, rather than unplanned variation.

Triangulation has been central to the planning process. Workforce assumptions have been reconciled with activity-demand forecasts to ensure that changes in FTE align with expected productivity levels. For example, increases in substantive FTE correspond to service expansion or redesigned pathways, where associated improvements in throughput, efficiency or patient flow are expected. Workforce assumptions have also been aligned with financial planning to ensure affordability, including the planned reductions in temporary staffing expenditure and the timing of new workforce investment.

To support and oversee the workforce reduction targets within the plan a Workforce Reduction group has been set up, chaired by the Interim Executive Director of Operations. Areas of focus for the group includes the following, including considering the workforce changes associated with the productivity and transformation work outlined in section 12:

- Reduction of waiting list initiatives to better productivity and efficiency in week.
- Movement of overtime into bank shifts.
- Cost control to reduce overall agency use.
- Improved sickness and absence levels.
- Improvements in Theatre Productivity and associated workforce redesign.
- Transforming the delivery of outpatients.
- Digital transformation.
- Specialist Service review.
- Bed reconfiguration.

The operationalisation of workforce control measures such as vacancy freezes, internal recruitment where possible and if required, redundancy schemes such as VSS and MARS are also overseen by the group.

To support the delivery of the workforce elements of the plan the People Team will undergo wholescale transformation, moving from 34 siloed teams to 4 core elements plus a business partnership team: Talent and Development; Digital Innovation; People Operations; Culture, health, and Wellbeing; and People Partners.

This will in turn:

- Provide People Partners aligned to clinical and corporate teams.

- Offer simple, consistent pathways for staff and managers to access support.
- Strengthen our ability to proactively improve culture and leadership, not only react to issues.
- Build capacity and capability in areas such as workforce planning, change leadership and organisational development.
- Support a shared purpose and consistent standards across all People services.

A key enabler for the transformation of the People Team will be adoption of Robotic Process Automation, a list of the areas of potential improvements in included in appendix 3.

Staff experience is also vitally important to the Executive Team and wider Trust Board, with connection between staff experience, patients and experience and outcome we understood. The Trust's People Plan was developed in 2024, following engagement with over 8000 colleagues, working closely with our staff networks and staff side colleagues to identify the most important priorities to support colleagues and improve how it feels to work at the Trust. The four key themes forming our people plan for 2024-2027 are shown below.

Figure 9: People plan themes.

The plan in the process of being refreshed to ensure it is fit for purpose with a greater emphasis on leadership development being part of this.

The Trust also engages and supports its staff in other ways such as through:

- Staff networks aimed at reducing inequalities and to support staff to help create an organisational culture where everyone feels valued and heard.

- Working to become an anti-racist organisation through delivery of the antiracism framework.
- A revised, comprehensive Health and Wellbeing offer for all staff.
- Acting on data and information gathered through the national staff survey and our local 'Pulse' surveys.
- Speaking up and raising concerns processes including expanded capacity for Freedom to Speak Up.
- Proud2bAdmin and Proud2bOps programmes.
- Staff recognition and awards and a dedicated Staff Social Club.

10 Finance

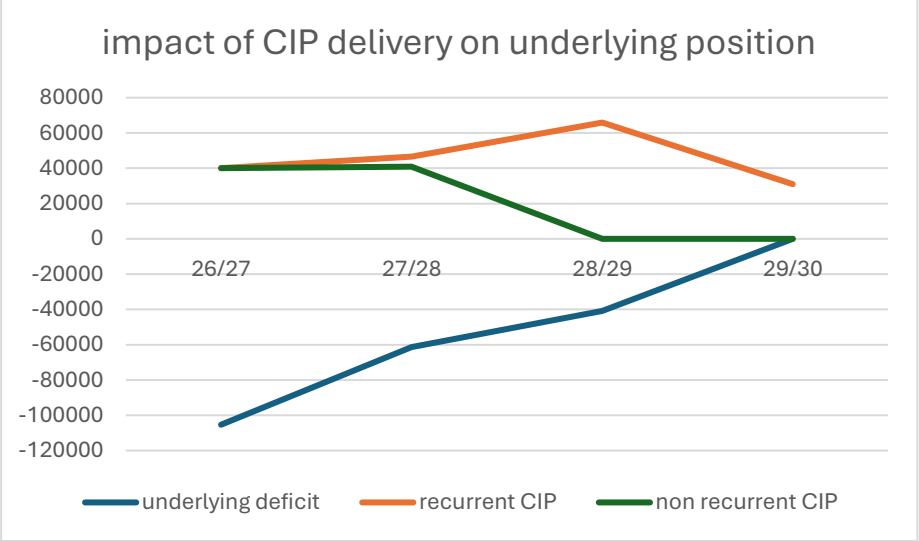
The 3 year finance plan is built from the underlying position and a stretching but credible 3 year improvement plan, underpinned and triangulated with robust workforce and activity planning assumptions.

The overarching ambition is to:

- achieve financial balance in each of the years of the financial plan
- achieve a credible improvement / financial recovery programme, building on the recurrent cost reductions achieved in 2025/26 and utilisation of non-recurrent measures to allow for the development of recurrent and transformational plans
- elimination of the underlying deficit to the end of the planning period.

The impact of the financial plan on the underlying deficit is as follows.

Figure 10: CIP impact



To achieve these aims there is a challenging CIP target set for each year of circa 5.5%. In the first year of the plan 60% of the total is planned to be delivered recurrently.

The plans are consistent with commissioners' income mandates. In future years the additional benefit of the 'deconstructing the block' work has been assumed within the position.

The achievement of the cost improvement targets are dependent on a significant workforce reduction programme, whilst continuing to invest where quality and safety improvements are required and funded or invest to save schemes for example creation of an intestinal failure unit and improvements in medicines management. Stretching CIP targets for Clinical Boards and Corporate departments will be set over a 3-year period to mirror the medium-term plan. Achievement of these targets will also be facilitated via a programme of transformation and improvement led by Executive SROs for example, estates, bed reduction, outpatient reform and drugs and devices.

To deliver a change of this size may also require investment in enablers for example a step change in digital solutions.

There are of course risks which are currently not included within the plan and therefore could have a destabilising impact. The following are known potential issues

- national funding for the Genomics contract
- potential job evaluation impact of band 5 to 6 and
- changes to resident doctors reporting.

The Trust has an operational **capital** limit (excluding centrally funded schemes) of £33m, in addition to this it is required to make payments of £18.8m for PFI liability repayments and £3.8m of net lease repayments. Therefore, it has a total capital cash requirement of £55.6m. In addition to the expenditure above a further £15.9m of capital schemes which are funded via external Estates Safety and Return to Constitutional Standards funds which are cash backed.

The Trust will fund this from planned depreciation plus external capital support PDC cash funding. The Trust's **cash** position is also dependent on the delivery of planned CIP, funding for capital schemes and timing of the receipt of revenue funding from commissioners.

In summary the planned financial improvement is credible and balanced, with clear year-on-year underlying improvement and defined enabling strategies. Delivery will be supported by:

- robust financial control balanced with the delegated autonomy framework
- ownership of the plans and 'themes' by clinical boards and corporate teams
- targeted investment in enablers, in particular digital solutions
- focus on service reform underpinned by benchmarking and other data sources.

11 Impact assessment

A high level Equality Impact Assessment (EQIA) of the planning submission has been undertaken; a copy is included as appendix 2. The EQIA document includes the rationale and justification for scoring of each domain which shows the following:

- Patient, Staff or Public Safety: score of 12 based on moderate impact and possible likelihood.
- Patent Experience: score of 12 based on moderate impact and possible likelihood
- Clinical Effectiveness: score of 9 based on neutral impact and possible likelihood.

The overall rating is amber based on the potential impact of the plan on quality and safety if fully implemented without mitigating factors.

Several of the assumptions outlined in the plan include achievement of, or movement towards delivery of constitutional standards which will positively impact quality. It is therefore difficult to balance positive and potentially negative factors in a singular EQIA.

The plans have included wide engagement with Clinical Boards and Corporate Services to provide assurance that finance, quality, performance and workforce have been appropriately triangulated and balanced. Oversight will continue through monthly performance reviews in line with our accountability framework.

In addition to the EQIA for the planning process each individual scheme relating to cost improvements or transformation if progressed will be subject to an individual EQIA. Any high risk clinical/operational schemes or those relating to reduction in headcount, in line with the Trust's operating procedure, will be reviewed at an EQIA panel attended by senior nursing and medical leadership. Any schemes of concern will be escalated to the Quality Committee or People Committee for overview, scrutiny and sign off.

There are several assurance mechanisms in place to provide robust oversight of the impact of any implemented scheme – positively or negatively. This includes patient experience measurement, staff experience measurement, tracking of core quality metrics through the Integrated Board Report and through Quality Performance Review process (see section 17). This will support revision of plans as required.

SECTION 3: ENABLERS FOR DELIVERY

12 Transformation and productivity

The Trust's approach to Quality Improvement (QI) is well-embedded, having worked with the Institute for Healthcare Innovation over the last few years and trained 100s of employees locally in QI fundamentals. Whilst this work will continue, the Trust's development and improvement journey, like many other NHS organisations, is turning towards significant transformational change, to be able to address the complexities in continuing to provide high quality, responsive and sustainable services.

A recent restructure to the Trust's change management teams places expertise into the heart of operations, working into the eight Clinical Boards to stimulate and enable change, and a central team available to support more strategic programmes at both Trust and system level.

The interim Executive Director of Operations has Board level responsibility for the portfolio, and the Director of Improvement and Delivery leads the team, working alongside clinical and operational teams to transform operational services, allocating resources to best meet the needs of the Trust.

The Access and Improvement Delivery Group was recently established (October 2025), operating as a Tier 2 group, reporting into the Finance and Performance Committee to raise the profile and visibility of the improvement and transformation work that is underway.

12.1 Service improvement groups – focus for 2026/27

There are three strategic service improvement groups in place to support the transformation of Urgent and Emergency Care, elective care through surgical improvement initiatives and diagnostics optimisation. These are long term strategic programmes of work that require a shift from historical embedded practices to

adopting new ways of working and use of new systems. The transformation priorities for 2026/27 are described in the table below.

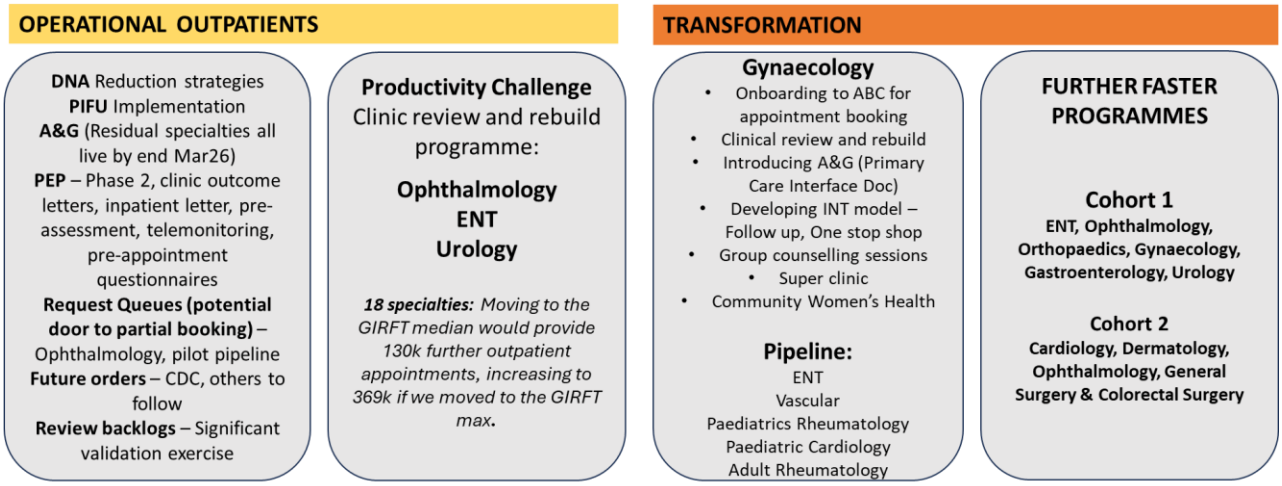
Figure 11: Transformation priorities for 2026/27.

Surgical Improvement Group • *underutilised lists and theatres* • *fallow theatre session* • *high cancellation rates*	**To optimise use of theatres and lists through:** • Trust-wide adoption of 6 4 2 - best practice waiting list scheduling • Standardising Booking and Scheduling – a Trust-wide training and development programme • Digitisation of pre-assessment for low risk patients and waiting list forms • HVLC and HIT lists embedded as BAU
Diagnostics Improvement Group • *High spend on mobile units* • *High volumes of patients **not** seen within 6 weeks*	**To reduce reliance and spend on insourcing and outsourcing and reduce waiting times for patients** **Slow the curve on diagnostic capacity growth requirements** • Improve productivity of diagnostic capacity across all modalities • Increase community diagnostic offer • Harmonise access to diagnostics across the Alliance and start shift into communities to enable access in neighbourhoods
UEC • *4 hour performance sub 80%* • *Ambulance handover delays* • *Low staff morale working in a challenging environment*	**Increase UEC capacity and pathways to minimise overcrowding in the ED and return to constitutional performance standards, through:** • Establish new 'front door' to UEC in Newcastle • Development of alternative streaming pathways • Reconfiguration of the front of house departments to improve clinical workflow and increase capacity **Improved patient flow:**

	• Proactive and streamlined discharge practice • Enhancing digital solutions to improve visible patient tracking and flow • Harnessing of 'at home' technologies and wearables to support early facilitated discharge

In addition to the Trust wide improvement groups, the transformation of Outpatient Services is a Board level priority and is being tackled through several complementary programmes of work, including engagement with national Further Faster programmes and working with Boston Consulting Group and nine other Trusts as part of the national elective recovery team.

Figure 12: Summary of outpatient transformation priorities



All the groups have or are setting their key performance indicators for measurement for the next financial year, reporting the productivity metrics into the Trust's Financial Recovery Steering Group.

12.2 Summary of the 5 year priority programme

Given the breadth of service improvement ongoing in the Trust, the following tables set out the headline ambitions, and 'shifts' expected to be delivered in the next five years, aligned to the expectations set out in the 10 year Health Plan.

Figure 13: 5 year transformation priorities

2026/27	2027/28	2028/29	2029/30	2030/31

OUTPATIENTS	At least 50k more appointments created through efficient delivery. ERS in place for A&G (July 2026)	Scaling of the SPoA model Expansion of PIFU and self-referral model	Patients able to view waiting times, complete questionnaires & access digital Patient Initiated Follow-Up (PIFU)		
	Adoption of NHS Online with 95% of appointments available after triage via the NHS App (April 2026)	All communications available in the Patient Engagement Portal (PEP) /NHS App	Get It Right First Time (GIRFT) pathways fully embedded across all specialties Automated follow ups, where still required Consistent patient experiences		
	SPOA in place for x10 Specialties	Remote monitoring and virtual consults become a standard offer			

	2026/27	2027/28	2028/29	2029/30	2030/31
ELECTIVE	c. 3000 more patients treated per annum - theatre productivity increased through optimisation programme Routine use of High-Volume, Low-Complexity (HVLC)/ High Intensity	No patients waiting longer than 52 weeks for treatment Scaling up commercial offer	Restore NHS constitutional standard of 92% beginning treatment within 18 weeks Post-operative care shift to community		

	Therapist (HIT) sessions		

	2026/27	2027/28	2028/29	2029/30	2030/31
U E C	New front door to access Urgent & Emergency Care (UEC) in the city Embedding of Frailty Same Day Emergency Care	Sustainable delivery of ED 4 hr performances c.83%	Return to constitutional standards 86-95% Patients can book appropriate service via 111 or NHS App		

	2026/27	2027/28	2028/29	2029/30	2030/31
D I A G N O S T I C S	Reduce reliance of insourcing and outsourcing Increased productivity of diagnostic services – across all modalities Community Diagnostic Centre (CDC) Phase 1 Optimisation	<1% of patients waiting more than 6 weeks for a diagnostic Development of self-referral models Patients can access their test results in the Patient Engagement Portal (PEP)/ NHS App	Secondary care supporting remote assessments performed in the community		
	Transitioning to neighbourhood delivery of diagnostics services				

12.3 Service review programme

To support a continuous drive of improvement, effectiveness and efficiency in the Trust, an approach is being developed to systematically review all Trust services for their operational, clinical and financial sustainability. This is known within the Trust as the Service Review Programme. The programme commenced in 2025/26 and has been received positively in the organisation to date, with positive engagement from operational and clinical teams. The cyclical programme of reviews with outputs expected to support service transformation, improvement, efficiency and effectiveness and inform the production of a safe pipeline of cost improvement to ensure financial sustainability in this challenging climate. The process will also support the development of service reconfigurations or exit strategies where sustainability is not viable. There are three levels of review which are described in the figure below.

The approach is based on a structured framework through which the sustainability of a service is evaluated. Criteria are in development to trigger which level of review is required. All services have completed the self-assessment, using a developing service fragility tool as part of the annual planning cycle.

Figure 14: Different levels of review within the programme

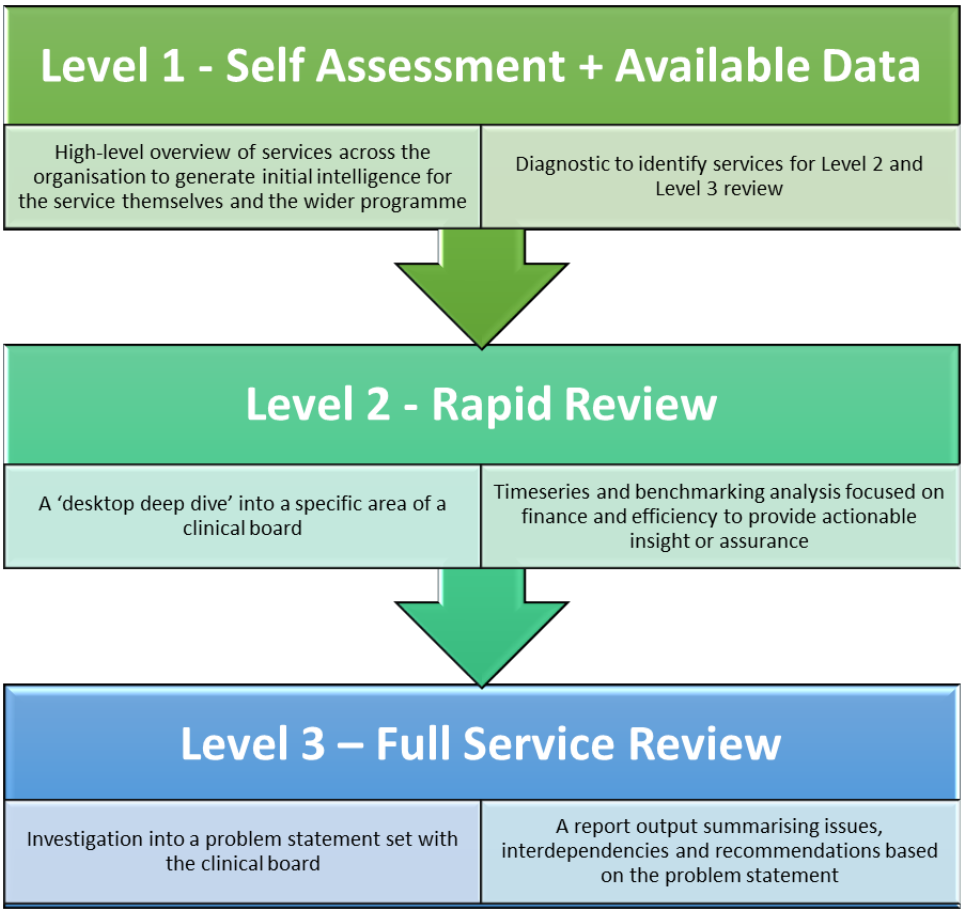
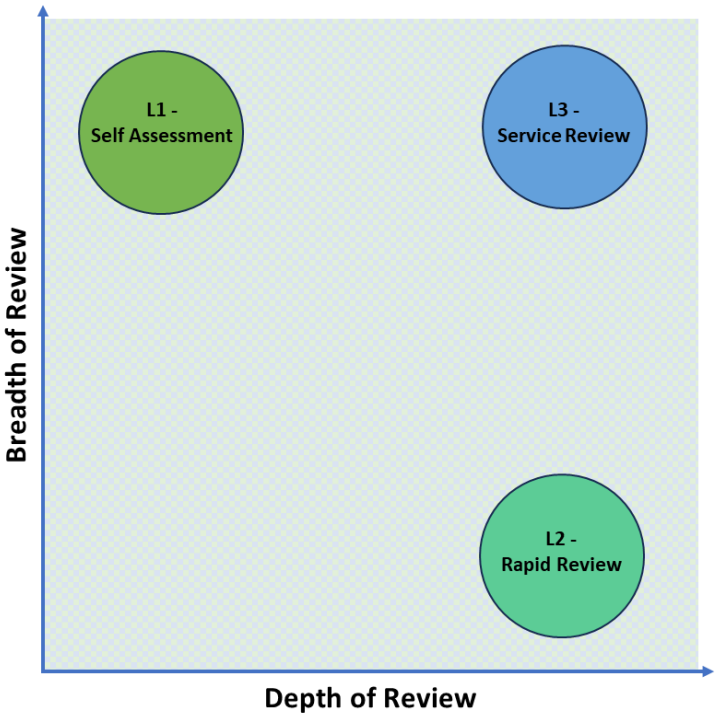


Figure 15: Breadth and depth of review options



13 Innovation

A number of strategic partnerships are in place to support innovation across the Trust including the University of Newcastle, Health Innovation North East and Cumbria, Newcastle Health Innovation Partnership, of which we are one of five organisations, and industry on a global scale supporting our innovation and clinical research activities.

The Trust's innovation team works closely in partnership with industry and academic bodies and plays an active role in collaborating with colleagues throughout the regional and national health and care system, to take forward inventions and support adoption of new solutions and technologies. There are several successful commercial developments generating income growth and a number in pipeline, and we will continue to secure places on the NHS Clinical Entrepreneur programme to support our employees to gain commercial skills, knowledge and experience needed to develop and spread solutions.

The North East Innovation Lab is part of the Trust and works with organisations of all sizes from universities to large international companies, providing access to clinical samples and supporting the development of new diagnostic tests.

A rapidly developing area for the Trust is commercial data partnerships. Through these partnerships the Trust can accelerate healthcare innovations to help make improvements to treatment and care for patients by informing research, service

improvement, drug discovery, medical technology and diagnostic development. Working with technology and data partners helps produce and analyse high quality data, which can help with vital research and unlock new ways to treat people.

14 Digital

Over the next 12 to 18 months, digital transformation will be a core enabler of delivery across access, safety, productivity and financial sustainability. Digital will be used deliberately to change how services operate, rather than as a standalone programme of technology implementation. Delivery will focus on a small number of high-value priorities aligned to clinical, operational and financial pressures, while establishing the foundations for longer-term transformation.

The organisation has an established digital function that provides a strong base from which to deliver the next phase of transformation. However, the scale and nature of the ambition over the next 5 years requires further strengthening of capability and capacity. This will include targeted recruitment and development of new skillsets, particularly in areas such as cloud technologies, automation, data and analytics, and service transformation. Alongside this, a consistent digital front door will continue to be used to ensure early engagement on all digital proposals, providing challenge and assurance on alignment to patient safety, productivity, cost reduction and workforce impact. Each Clinical Board and corporate function will continue to operate to a defined digital roadmap, with regular engagement with nominated digital leads to support prioritisation and delivery.

This approach addresses previous challenges where high-value digital opportunities were obscured by competing demand and ensures that limited digital capacity is deployed where it delivers the greatest benefit.

A significant proportion of delivery over the next 12 to 18 months will focus on improving access to care and reducing waits by digitising and optimising elective and peri-operative pathways. This includes implementation of a single patient tracking list for diagnostics, further development of the FDP Care Coordination System and visualisation of utilisation data at theatre/surgeon level to further target improvement. Digital patient engagement and electronic forms will be expanded across pre-assessment and outpatient pathways to reduce administrative burden, improve data quality and reduce non-attendance. Theatre scheduling and emergency theatre lists will be digitised to improve real-time visibility of utilisation and support safer, more efficient patient flow. These changes will support elective recovery, reduce delays driven by manual processes and improve patient experience.

Digital delivery will also directly support urgent and emergency care performance and patient safety. This includes the rollout of digital observations and deteriorating patient solutions across inpatient and critical care areas, improved bed and capacity management tools, and targeted digital support for high-acuity pathways such as stroke, critical care and cardiothoracic services. These changes will improve early recognition of deterioration, reduce variation and support timely clinical decision-making in high-pressure environments.

Transformation will be delivered primarily through optimisation of the existing electronic patient record rather than the introduction of parallel systems. This includes completion of the planned core system upgrade, rationalisation and standardisation of electronic forms and workflows across pre-assessment, peri-operative care, pain management and specialist services, and expanded use of digital documentation and ordering. This work underpins improvements in productivity, safety and data quality and supports consistent delivery across services.

Alongside application and pathway transformation, there is a clear focus on modernising the underlying digital infrastructure. Over the next 12 to 18 months, the organisation will reduce reliance on legacy, on-premises systems where this is safe and appropriate, and increase use of modern, cloud-based platforms. This will improve resilience, scalability and security, while reducing the operational burden and cost associated with maintaining ageing infrastructure. Reducing technical debt is essential to releasing digital capacity, enabling faster delivery, and supporting more sustainable services over the medium term.

Digital enablement of neighbourhood and community-based care is also a priority over the next 12 to 18 months. Delivery will focus on shared digital records for family health, complex care and community teams, improved connectivity to support outreach clinics and community diagnostics, and better interoperability between acute and community systems. This will support multidisciplinary working, reduce duplication and enable care closer to home.

Digital transformation over this period will be explicitly aligned to productivity and cost improvement delivery. Digital schemes will be differentiated between essential enablement and discretionary demand to allow realistic planning of digital capacity. Where appropriate, digital programmes will be embedded directly within Clinical Board cost improvement plans, with digital resource treated as scheme investment rather than overhead. This approach enables digital to unlock productivity opportunities such as reduced outsourcing, improved utilisation of clinical capacity and removal of manual processes.

Where digital initiatives generate verified savings, these will support an invest-to-save approach, with a defined proportion reinvested into digital delivery capacity and skills development, creating a sustainable cycle of improvement.

Digital solutions are a critical enabler across all Improvement Groups. Over the next 12 to 18 months, Improvement Groups will identify priority schemes where digital is a key dependency and work with digital teams to test assumptions, confirm feasibility and quantify benefits. Where approved, Improvement Groups will oversee delivery and monitor benefits realisation.

Alongside transformation, targeted investment will address digital risk and resilience. This includes replacement of end-of-life infrastructure and devices presenting patient safety or data risks, migration of servers and storage to improve resilience and recovery, and removal of digital constraints that have prevented deployment of existing clinical equipment. This work is essential to maintaining safe services and enabling further transformation.

Digital transformation will deliver tangible improvements in access, safety, productivity and financial sustainability. By strengthening digital capability, recruiting and developing new skillsets, modernising infrastructure, and embedding digital delivery within clinical and corporate improvement plans, the organisation will move from reactive digital delivery to a sustainable operating model that supports both immediate operational pressures and longer-term service transformation.

15 Estates

The Trust is in the process of finalising a five-year estates strategic delivery plan that provides a focused roadmap for modernising, rationalising and future-proofing its estate. The delivery plan responds to significant challenges including ageing infrastructure, rising demand, national policy shifts, environmental commitments, and the emerging Great North Healthcare Alliance construction programme.

The estate across the Trust is extensive but ageing, with major services delivered from the Royal Victoria Infirmary (RVI) and the Freeman Hospital. Many buildings are over 40 years old and carry £182m of backlog maintenance risks. Infrastructure, ventilation, electrical systems and fire safety compliance require significant investment. In the context of rising clinical demand, outdated layouts, poor clinical adjacencies and limited flexibility hinder modern care delivery. Emergency Care, Critical Care, Maternity, Neonatal, Theatres, Wards and Diagnostics no longer meet standards that are expected. A summary of the 5 year capital investment plan is included as appendix 4. The Trust's Net Zero by 2030 commitment requires transition to clean energy. An infographic summarising the route to achieving this is also included (appendix 5).

The Estates strategic delivery plan outlines a vison for the future to improve the estate while preparing for transformational developments. Key priorities include reducing critical infrastructure risks, modernising wards and theatres, improving urgent and emergency care, upgrading maternity and neonatal services, investing in specialist and diagnostic services, and delivering large-scale decarbonisation. This will also include external estate rationalisation to reduce costs and improve utilisation, the Trust plans to consolidate community and office facilities, using Regent Point for community and corporate teams as a central hub and disposing of poor-quality sites.

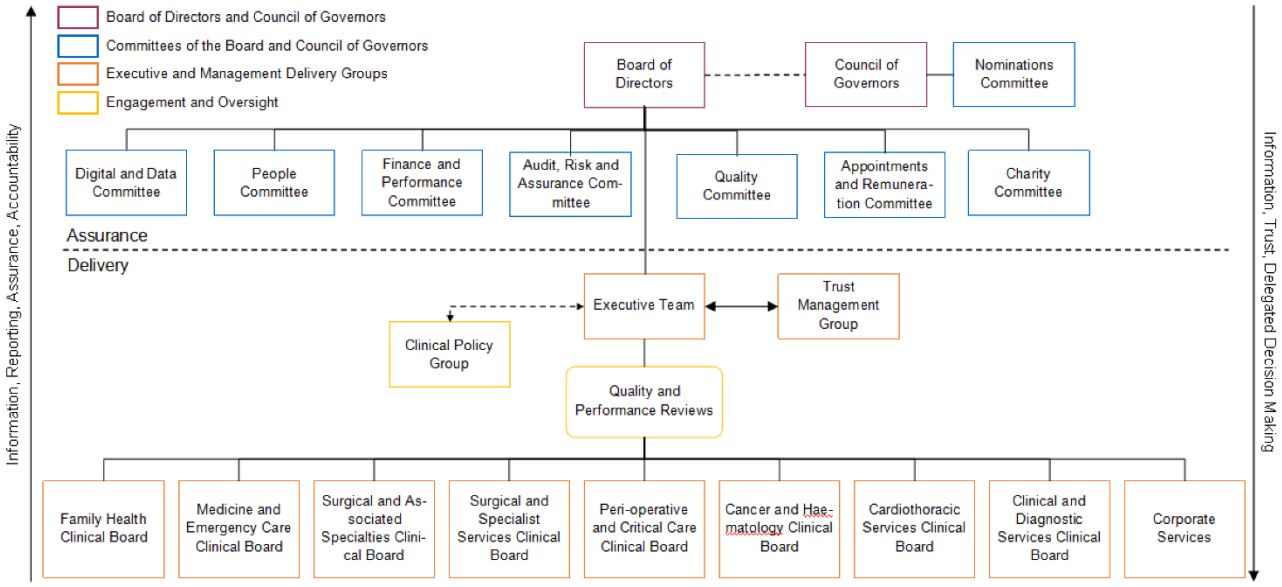
The strategic delivery plan also sets the ground for major regional developments including new centres for trauma, emergency care, cardiothoracic surgery, ophthalmology, women's health and integrated laboratories as part of the emerging Great North Healthcare Alliance construction programme. The Sir Bobby Robson Institute is progressing as a flagship research building project increasing capacity and access for clinical trials at the Freeman site. These developments are not only crucial to improve patient care, but they will also have a positive impact on local economy and help the development of the workforce pipeline for major construction in the North East.

Overall, the strategic delivery provides a structured, risk-led plan to stabilise the estate, modernise patient environments, reduce backlog maintenance, and accelerate energy transformation. It creates the foundations for a future-proof estate aligned with both clinical ambitions and long-term regional redevelopment plans.

16 Engagement

The Trust will engage proactively with service users and local people by strengthening the networks and partnerships that help us understand and respond to community needs. This includes through learning from concerns and complaints raised with us and by engaging with patient groups. This in addition to the Real Time and Right Time patient engagement programmes that continue and part of the quality priorities moving forward (see section 7).

Our Council of Governors will play a central role in representing the views of patients, members and the wider public, helping to shape priorities and hold the Trust to account. As we navigate the new NHS plan and await more information on future models for involvement, we will actively explore opportunities to collaborate with the local authority on community engagement initiatives, aligning our efforts to reach underserved groups and make it easier for people to share what matters to them.



We will work closely with Healthwatch (and successor organisations) to gather independent insights into people's experiences of care, ensuring that diverse voices directly influence service improvement. Through these combined approaches—alongside accessible digital channels, listening events, targeted outreach, and specific work in relation to service change, we will embed meaningful engagement into the way we design, deliver and continually improve our services.

17 Monitoring and reporting

The Trust has several delivery forums within its formal governance and accountability structure to drive forward achievement of its goals and ambitions. These are set out in the Trust's Accountability Framework and are summarised the figure below:

Figure 16: Governance Structure

The eight Clinical Boards (the functional operational units within the Trust) have the primary responsibility for delivering on Trust-wide objectives across devolved performance, finance, people, and quality domains. Performance oversight is through a structured Quality and Performance Review (QPR) process. These are held monthly where success and challenges are discussed with members of the Trust's Executive teams across the four domains. Clinical Board structures replicate the QPR process within their own Directorates and have their own business meetings to maintain oversight of performance, finance and people and quality, safety and clinical effectiveness is managed through Quality Oversight Groups (QOGs) in each Board.

There are several cross Board and Trust wide groups to drive forward transformational programmes, including targeted Trust wide Service Improvement Groups, Trust Management Group (which is the Trust's Senior Leadership Group), and Clinical Policy Group, a forum for clinical leaders.

Board level oversight will be provided by the relevant Tier 1 committees through to Board, using the Trust's Integrated Board Report, as well as other standard and ad hoc reports as required.

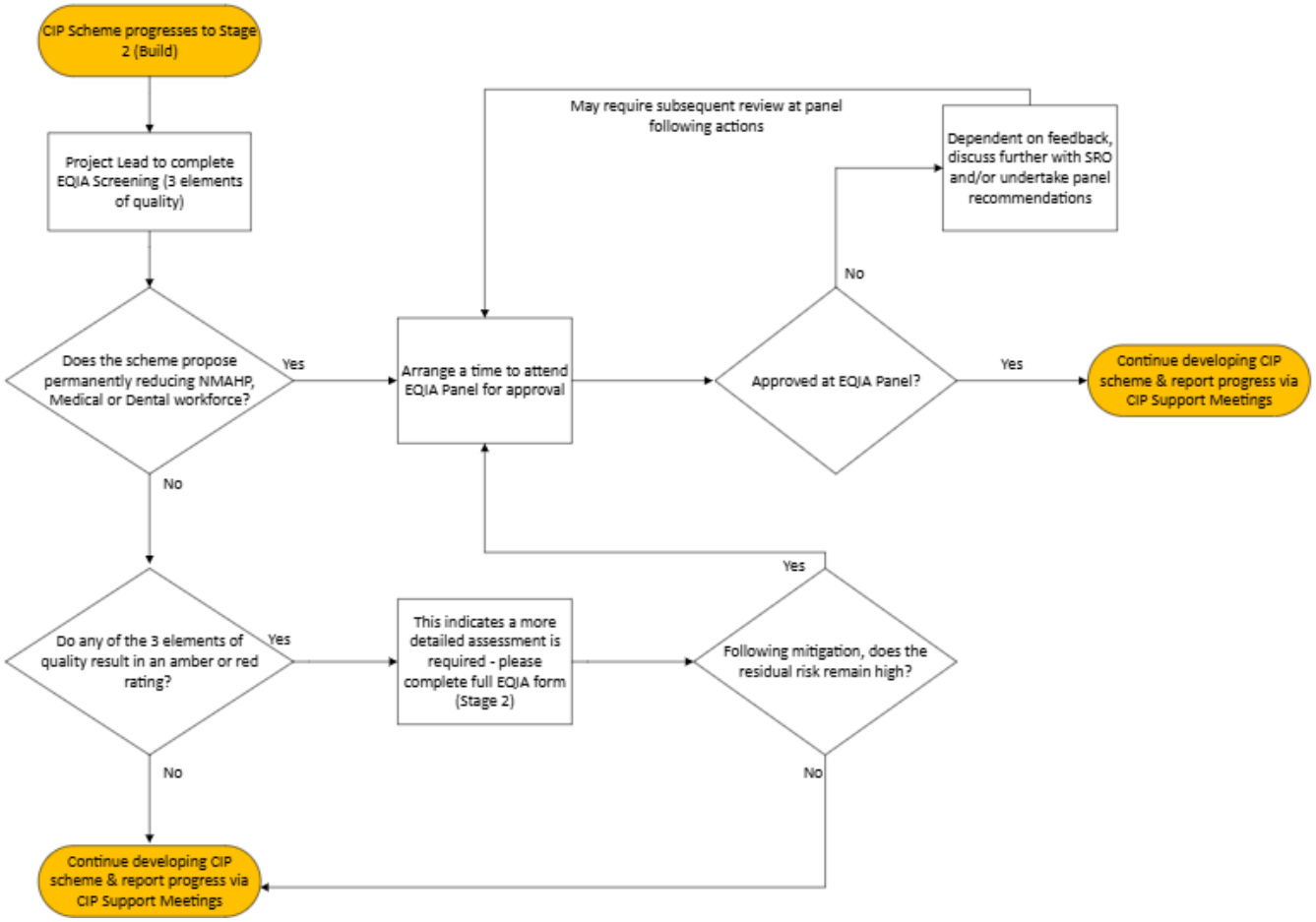
Prepared by Newcastle Upon Tyne Hospitals Executive Team

End

12.02.2026 (revised 24.03.26)

Agenda item A2(d)

Appendix 1: EQIA process



All schemes (regardless of value) undergo initial screening to ensure consideration of quality & safety impacts.

Schemes removing clinical workforce automatically trigger an EQIA panel discussion.

EQIA built into structured stages of CIP planning.

Routine reporting into Clinical Board CIP Support Meetings and Finance Recovery Steering Group.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Quality Impact Assessment (QIA)

This tool requires all projects to undergo an initial assessment (Stage 1) to identify the potential impacts, positive, negative or neutral on the **3 elements of quality** from any proposed changes to the way services are commissioned or delivered.

Where an amber or red assessment of the impact of quality on the matrix is identified, this indicates that a more detailed assessment is required in this area and a full QIA form must be completed (Stage 2). All impact assessments must be signed and dated by the person carrying out the assessment.

Any scheme which results in a substantive reduction in NMAHP, Dental or Medical workforce regardless of value will require EQIA panel review.

1

Scheme Name: *

2026/27 Planning Submission

2

Scheme ID (if known):

Not Applicable

3

Scheme Value *

Not Applicable

Agenda item A2(d)

Patient, Staff or Public Safety

Could the proposal impact any of the following: safety, patient length of stay, systems in place to safeguard patients to prevent harm (inc. infections)?

Impact:
What is the expected impact if the scheme were to be implemented?
*

+ve Major (1)	+ve Moderate (2)	Neutral (3)	-ve Moderate (4)	-ve Major (5)
Prevention of major injury, reduction in LOS by >2 days, excellent management of patient mitigating long term effects	Prevention of minor injury or illness requiring time off work or measureable reduction in LOS Improvement on care of care with short or medium term effects	Creates no change or effect	Minor injury or illness requiring time off work or increased LOS 1-3 days mismanagement of care with short or medium term effects	Major injury or death, increased LOS >14 days, mismanagement of care with long term effects

- ( ) +ve Major (1)
- ( ) +ve Moderate (2)
- ( ) Neutral (3)
- (•) -ve Moderate (4)
- ( ) -ve Major (5)

7

Likelihood:
What is the likelihood of the **impact** occurring? *

- ( ) Very Likely
- ( ) Likely
- (•) Possible
- ( ) Unlikely
- ( ) Very Unlikely

8

Outcome
Using the matrix, where does the scheme score as per the above answers? *

		Likelihood				
		Very likely	Likely	Possible	Unlikely	Very Unlikely
Impact (as per screening tool)	1					
	2					
	3					
	4					
	5					

- ( ) Red (Stage 2 required)
- (•) Amber (Stage 2 required)
- ( ) Green

9

Please provide any justification for your scores above:
*

The planning submission has been undertaken with extensive engagement with Clinical Board and Corporate Service management teams. The requirement to balance quality, operational performance, workforce and financial sustainability means that there is a risk that balance is not achieved which could impact on quality and safety. It is also noted that in the next year it is unlikely that constitutional standards in relation to cancer care will be achieved which will impact on patient safety.

This has been considered throughout the creation of the plan. To mitigate, all CIP schemes and Workforce Schemes will be subject to an individual EQIA to be assured regarding balance and management of risk. Any high risk scheme will be discussed with the Executive Director of Nursing and Medical Directors and escalated to the Quality Committee by exception as required.

Patient Experience

Could the proposal impact complaints, compliance with national standard, survey results, patient choice, personalised and compassionate care?

10

Impact:
What is the expected impact if the scheme were to be implemented?
*

+ve Major (1)	+ve Moderate (2)	Neutral (3)	-ve Moderate (4)	-ve Major (5)
Resolves to comply with national standards where previously there was noncompliance, significant reduction of risk to patients, major reduction in complaints, delivers excellent patient safety across large number of patients	Improvement to meet Internal standards, measureable reduction in formal complaints, minor Improvement for patient safety / performance rating in certain cases	Creates no change or effect	Treatment or service has reduced effectiveness, failure to reduce formal complaints, failure to meet internal standards, patient safety implications if findings are not acted on	Noncompliance with national standards with significant risk to patients if unresolved, multiple complaints/independent review, low performance rating in critical report

- ○ +ve Major (1)
- ○ +ve Moderate (2)
- ○ Neutral (3)
- ◉ -ve Moderate (4)
- ○ -ve Major (5)

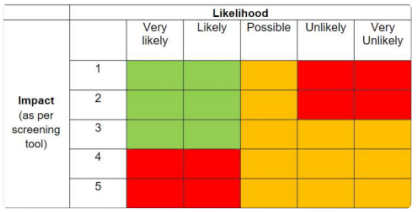
11

Likelihood:
What is the likelihood of the **impact** occurring? *

- ○ Very Likely
- ○ Likely
- ◉ Possible
- ○ Unlikely
- ○ Very Unlikely

12

Outcome
Using the matrix, where does the scheme score as per the above answers? *



- ( ) Red (Stage 2 required)
- (•) Amber (Stage 2 required)
- ( ) Green

13

Please provide any justification for your scores above:
*

To achieve appropriate balance between workforce, performance, finance and quality means that a number of transformational CIP schemes have been identified within the high level plan. This includes a significant headcount reduction and reduction in in-patient capacity. Whilst each scheme will be subject to an independent EQIA a potential impact on patient experience is noted if not mitigated.

It is noted within the plan that there will be a focus on improving ED performance and waiting times for planned surgery which will positively impact on the patient experience. It is also noted that extensive patient experience modelling is now in place to understand any impact on patient experience and be able to course correct if required.

In the creation of the plan, there has been extensive engagement with clinical teams through the organisation.

Clinical Effectiveness

Could the proposal impact evidence based practice, clinical leadership, clinical engagement or quality standards?

14

Impact:
What is the expected impact if the scheme were to be implemented?
*

+ve Major (1)	+ve Moderate (2)	Neutral (3)	-ve Moderate (4)	-ve Major (5)
Addresses multiple statutory breaches, delivers <90% performance rating, ensures high performance in critical report, improves compliance with safe staffing guidance and/or increases workforce cost efficiency	Addresses breach in statutory duty, meets external recommendations or improvement notice	Creates no change or effect	Breach of statutory legislation, reduced performance rating if unresolved.	Risks enforcement notice or improvement notice, multiple breaches in statutory duty, low performance rating in critical report, significant impact on compliance with safe staffing guidance

- ( ) +ve Major (1)
- ( ) +ve Moderate (2)
- (•) Neutral (3)
- ( ) -ve Moderate (4)
- ( ) -ve Major (5)

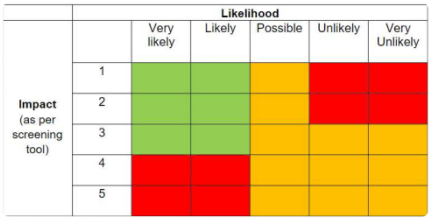
15

Likelihood:
What is the likelihood of the **impact** occurring? *

- ( ) Very Likely
- ( ) Likely
- (•) Possible
- ( ) Unlikely
- ( ) Very Unlikely

16

Outcome
Using the matrix, where does the scheme score as per the above answers? *



		Likelihood				
		Very likely	Likely	Possible	Unlikely	Very Unlikely
Impact (as per screening tool)	1					
	2					
	3					
	4					
	5					

- ( ) Red (Stage 2 required)
- (•) Amber (Stage 2 required)
- ( ) Green

17

Please provide any justification for your scores above:
*

The plan as outlined requires Trust Board approval and without substantial change is likely to be implemented as documented. The plan outlines risks of failure to delivery constitutional standards but also outlines areas of focus to improve care and outcomes for patients. It is therefore difficult to outline with certainty the likely impact on clinical effectiveness and is therefore scored as neutral. This will be monitored through individual EQIA discussions per scheme to be able to determine an overall impact on clinical effectiveness. Oversight will be through the Trust Executive Team and Quality Committee

18

Does the scheme substantively remove or reduce NMAHP, Dental or Medical workforce? *

- (•) Yes - Panel review required
- ( ) No

Matrix Outcome Analysis

Where an amber or red assessment of the impact of quality on the matrix is identified, this indicates that a more detailed assessment is required in this area and a full QIA form must be completed (Stage 2). Please indicate below whether any of the three elements of quality satisfy this requirement.

19

Did any of the elements of quality produce a red or amber score in their respective **matrix**? *

- (●) Yes
- ( ) No

Stage 2 Full Quality Impact Assessment Form

This form is to be completed for **each element of quality** that has been assessed as being amber or red risk from the QIA screening tool in Stage 1.

20

Background and context of the scheme: *

As previously noted

21

What are the benefits? *

As previously noted

22

What are the risks if the scheme is not approved? *

As previously noted

23

What are the high risks that the initial impact assessment indicates to certain groups or quality? *

As previously noted

24

Are there any risks identified that will impact negatively on other services e.g. radiology, labs, therapy services etc. *

As previously noted

25

What is the impact, both positive and negative, on people or groups with protected characteristics? *

As previously noted

26

What plans are in place to ensure identified risks are mitigated? *

As previously noted

27

After mitigation, what are the remaining residual risks? *

As previously noted

28

Recommendations for the Committee to consider: *

As previously noted

Equality Analysis

The Trust is committed to creating an organisation that actively promotes equality of opportunity for all and ensuring that no one receives less favourable treatment on the grounds of their age, disability, gender, gender identity/expression, marital or civil partnership status, maternity or pregnancy status, race (including nationality or culture), religion or belief, sexual orientation, caring responsibilities in any aspect of their employment.

Any development or change to any existing or proposed policy, procedure, strategy or service must be subject to a systematic and thorough Equality Analysis. Full details of the policy can be found below.

Equality Analysis (Section 8) - http://nuth-intranet/apps//policies/personnel/EqualityandDiversity202301.pdf

Please ensure you have read the above policy and have completed and Equality Analysis Form before continuing with the below. The form can be found here https://policies.app/policyprocess.htm titled "Equality Analysis Form".

29

Please confirm you have read and reviewed the Equality Impact Assessment (EIA) using the trust EIA template

The form can be found here https://policies.app/policyprocess.htm titled "Equality Analysis Form". *

- (●) Yes

30

Did this EIA identify any equality implications?

- (●) Yes
- ( ) No

31

Please provide an overview of these implications and how they will be rectified

There is a risk with headcount reduction that there will be a negative impact on the diversity of the workforce. An individual Trust Level EIA will be undertaken for each scheme (MARS/VSS/Headcount Reduction) and overseen by the People Committee for scrutiny and oversight.

Appendix 3: Digital enablers for the People Team transformation

- **Recording Inductions on ESR** A bot can automatically update ESR to confirm that new starters have completed their induction, saving HR time and reducing data entry errors.
- **Recording Probation Outcomes on ESR** Robotic Process Automation (RPA) can enter probation completion details directly into ESR once managers submit the forms, ensuring timely updates and compliance.
- **Updating Appraisals on ESR** A bot can log appraisal dates and outcomes into ESR, keeping records accurate without manual input.
- **Adding Applicant Emails to ESR (Onboarding)** Bots can automatically update applicant emails on ESR so new starters can access Applicant dashboard on ESR.
- **Linking Vacancies Between Trac and ESR (Onboarding)** RPA can link vacancies in Trac and ESR so data stays consistent across systems.
- **Mask Fit Testing Updates** A bot can update completion of mask-fit tests in staff records, helping maintain compliance and audit trails.
- **Recording Flu Vaccinations** RPA can upload flu vaccination data into Record a Vaccination Service (RAVS), keeping vaccination records current without manual data entry.
- **Publishing Vacancies on NHS Jobs (Onboarding)** Bots can take approved vacancy details from Trac and automatically publish them to NHS Jobs, speeding up the recruitment process.
- **Setting Up Interviews on Trac (Onboarding)** RPA can create interview schedules in Trac, populate candidate lists, and send out invites.
- **Checking Professional Registrations for Applicants (Onboarding)** A bot can verify professional registrations (e.g. Nursing and Midwifery Council (NMC), Health and Care Professions Council (HCPC)) and flag any that are expired or missing.
- **RCG Process Support** Bots can move roles through the RCG approval stages, attach documents, and update status changes automatically, send emails to recruiting managers.
- **Adding New Vacancies Through RCG into Trac** Once approved, RPA can create new vacancies in Trac based on the Recruitment Control Group (RCG) request details.

- **Updating Supervisors on ESR** Bots can update supervisor hierarchies in ESR when teams change, reducing admin effort.
- **Updating or Creating New Positions on ESR** RPA can build new positions in ESR or update existing ones based on approved changes.
- **Maintaining Establishment in ESR** A bot can routinely update establishment data in ESR (such as changes in budgeted FTE) to keep workforce information accurate.
- **Removing Duplicate Applicants in ESR** RPA can scan ESR for potential duplicates and tidy up records to ensure clean data.
- **Removing Leavers from Medirota for Medical & Dental (M&D) Staff** Bots can automatically deactivate medical staff from Medirota after their leaving date is confirmed in ESR, keeping rotas tidy and up to date.
- **Submitting Absence Forms via HR Forms to Update Therefore Files** A bot can take absence forms submitted via HR Forms and upload the documents straight into the correct Therefore record, saving manual filing time.
- **Submitting Maternity Forms via HR Forms to Update Therefore Files and HR Files** RPA can pick up submitted maternity forms, file them in Therefore, and also update relevant records or trackers used by the HR team.
- **Formal Absence Review Documents via HR Forms** A bot can collect formal absence review meeting documents from HR Forms and file them in Therefore automatically.
- **Leavers Form via HR Forms — Full Off-boarding Automation** RPA can pick up leavers forms submitted by managers, and trigger downstream off-boarding actions such as notifications, system removals, or ESR updates.
- **HR Chat Bot** RPA and AI can be used to create an HR chat bot to answer queries as a help desk, provide policy details, and direct specific queries to the correct department, saving valuable time allowing teams to focus on more value based work.

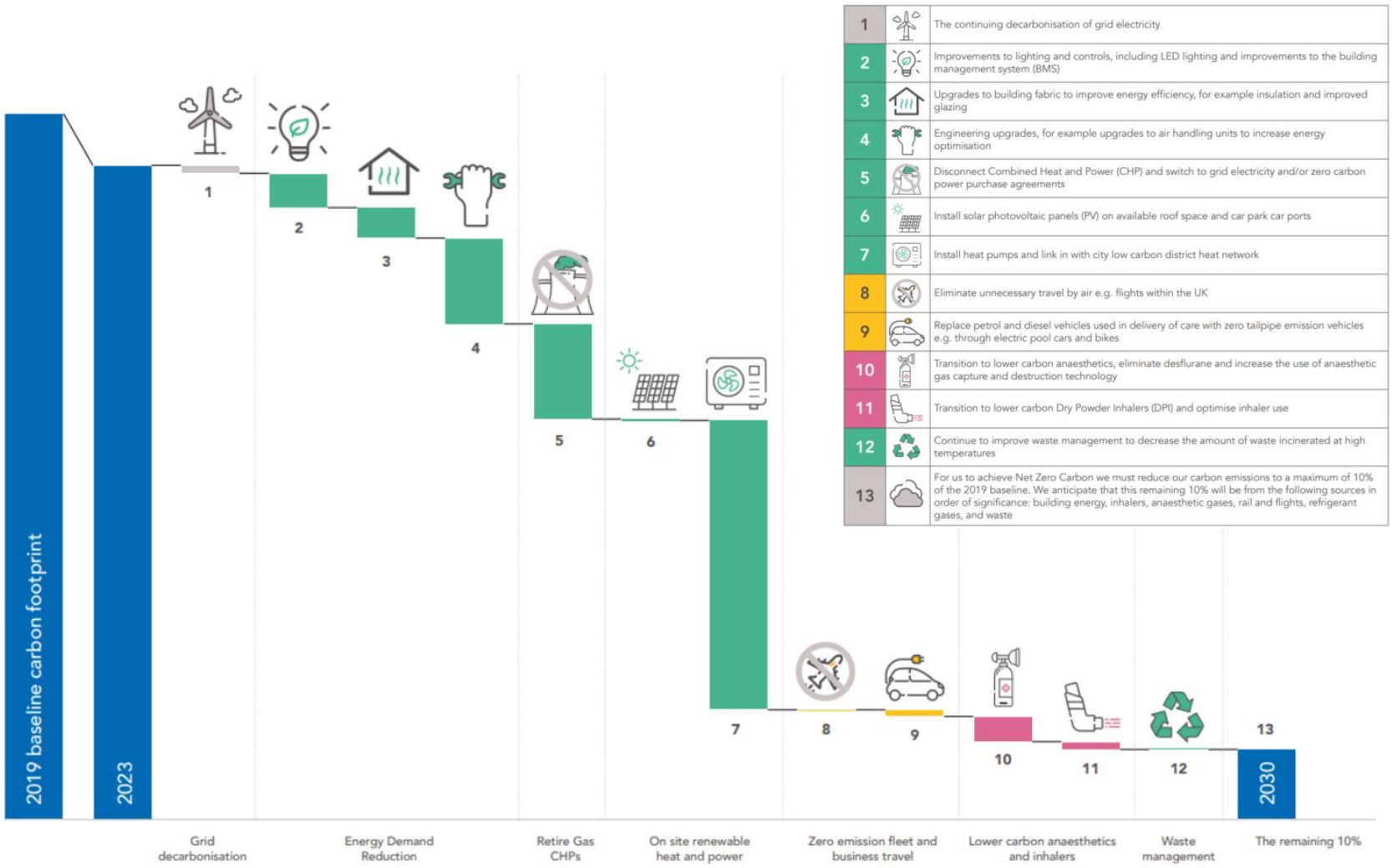
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Appendix 4: 5 year capital plan summary

2025/26 £51.1m	2026/27 £61.6m	2027/28 £64.3m	2028/29 £61.3m	2029/30 £55.9m
ESTATES SCHEMES £29.4m Refurb Med Records (Belsay/FASS) FH Diabetes and Endocrinology FRH NCC Ambulatory Care (PFI) RVI Atrium Balustrades RVI Mortuary (PFI) Gait Lab Relocation to Freeman RVI Urgent Treatment Centre Roche equipment upgrades (blood labs) RVI Ward 38 Improvements Neonates reconfigurations RVI Leazes Staff Changing (50% delivery) Peacock Hall Restoration Freeman & RVI Critical Infrastructure Risk Community Critical Infrastructure Risk Freeman Ward 16 Refurbishment RVI East Atrium Road Improvements FRH Ward 1 Refurbishment SDEC (in-line with NHSE submission) Ward 11 (IF) & Research to DSC ED Front Door (phase 2) design	**ESTATES SCHEMES £34m** Neonates reconfigurations RVI Leazes Staff Changing (50% delivery) ED Front Door (phase 2) Roche equipment upgrades Refurb Med Records (Belsay/FASS) East Atrium Balustrades Cardio Zeal Cultural work Freeman & RVI Critical Infrastructure Risk Community Critical Infrastructure Risk Freeman Ward 16 Refurbishment FRH Ward 1 Refurbishment (design) RVI Claremont Theatre 19 & 16 (50%) Freeman ENT Theatres Enabling (Sustainability Projects (12% PSDS) Claremont Theatres IPS/UPS (50%) Anti-ligature and dementia improvements Regent Point Rationalisation RVI HDU Omnicell (25 cabs) 33%	**ESTATES SCHEMES £35.4m** Neonates reconfigurations Cardio Zeal Cultural work Roche equipment upgrades RVI Claremont Theatre 19 & 16 (50%) Claremont IPS/UPS (50%) Omnicell (25 cabs) 33% Freeman & RVI Critical Infrastructure Risk Community Critical Infrastructure Risk FRH Ward 1 Refurbishment FRH Ward 19 Refurbishment (design only) Freeman Central Ops Recovery Refurb Sustainability Projects (12% PSDS) Leazes Wing Main Entrance Refurb & Cladding (50%) RVI Theatre Phase 5 (1,2,2a) (50%) Site Wide CCTV Upgrades Freeman Main Entrance Refurb Anti-ligature and Dementia improvements SDEC Design Pack	**ESTATES SCHEMES £34.2m** Leazes Wing Main Entrance Refurb & Cladding (50%) RVI Theatre Phase 5 (1,2,2a) (50%) Omnicell (25 cabs) 33% Freeman & RVI Critical Infrastructure Risk Freeman Ward 19 Refurbishment Community Critical Infrastructure Risk FRH Ward 13 Refurbishment (design) Freeman ENT Recovery FRH ENT Theatres 12 & 14 Theatre 9 & 10 IPS/UPS Site Wide CCTV Upgrades Maxs Facs IPS/UPS Cardio Entrance Refurbishment (FRH) (50%) SDEC Refurbishment FRH Ward 13 Refurbishment (design) RVI General IPS/UPS Installations Anti-ligature and Dementia Improvements Sustainability Schemes	**ESTATES SCHEMES £28.2m** Cardio Entrance Refurbishment (FRH) (50%) Freeman & RVI Critical Infrastructure Risk Community Critical Infrastructure Risk Dental Hospital Main Entrance (50%) Ward 13 refurb Ward 20 refurb design Next RVI Theatres Phase (next pair) CRB Enabling of Essential Veolia Supply CRB Secondary Generator Installation Peacock Hall - upgrading/relocation of LV Switchboard Dental Hospital - 3x transformer upgrades FRH ENT Theatre 11 Centre for Life - Cryostore Expansion SJS Touch down office RVI Energy Centre Design Pack Catering equipment replacements Anti-ligature and Dementia improvements Sustainability Schemes
FIRE REMEDIATION £4m	**FIRE REMEDIATION £4.9m**	**FIRE REMEDIATION £5.5m**	**FIRE REMEDIATION £6m**	**FIRE REMEDIATION £6.5m**
MEDICAL EQUIP 'BIG TICKET' £9m Gamma Camera (FH) RVI Radiology ED Room 17 Ponteland Road X-Ray PPU isolators MRI fit-out, ward 39 bi-plane fitout, pharmacy robot Linac Rm 9 Tomotherapy MRI Avanto (NVW RVI)	**MEDICAL EQUIP 'BIG TICKET' £12.5m** PPU Isolators (ESTATES) RVI Radiology ED Room 16 MRI Avanto (RVI) build works Cath Lab 3 (FH) Gamma Cam FH TH38 BiPlane Breast Screening Rm 2 (RVI) Linac Rm8 Tomotherapy (FH) Superficial X-Ray Therapy (SXT)	**MEDICAL EQUIP 'BIG TICKET' £12.5m** PPU Isolators (ESTATES) MRI Aera (RVI) RDR2 (FH) SPECT CT FH NM Breast Screening Rm 3 (RVI) Linac Rm2 Sterotactic with ExacTrac Plain Film Rm6 (RVI) Plain Film Rm8 (RVI) Plain Film Rm9 (FH)	**MEDICAL EQUIP 'BIG TICKET' £12.4m** Interventional Radiology Rm2 (FH) Cath Lab 2 (FH) CT Force (RVI) Plain Film Rm1 (FH) Fluoroscopy Rm11 (RVI) MRI Neuro Aera Linac_Rm4 V3 Varian TrueBeam Plain Film Rm8 (FH)	**MEDICAL EQUIP 'BIG TICKET' £13.4m** CATH LAB 4 (FH) BS RVI Carlisle 1 SPECT CT RVI NM CT Edge Neuro MRI Neuro Skyra Fit BS CAV WI IR Pheno TH9 (FH) PF Benfeild Park Linac_Rm5 V4 Varian TrueBeam
MEDICAL EQUIPMENT LIFE CYCLE £1m	**MEDICAL EQUIPMENT LIFE CYCLE £3m**	**MEDICAL EQUIPMENT LIFE CYCLE £3.2m**	**MEDICAL EQUIPMENT LIFE CYCLE £1.5m**	**MEDICAL EQUIPMENT LIFE CYCLE £1.6m**
IFRS16 LEASES £5.5m	**IFRS16 LEASES £4m**	**IFRS16 LEASES £4m**	**IFRS16 LEASES £4m**	**IFRS16 LEASES £4m**
NON-MEDICAL EQUIPMENT £0.5m	**NON-MEDICAL EQUIPMENT £0.5m**	**NON-MEDICAL EQUIPMENT £0.5m**	**NON-MEDICAL EQUIPMENT £0.5m**	**NON-MEDICAL EQUIPMENT £0.5m**
IT & DIGITAL £1.7m	**IT & DIGITAL £2.7m**	**IT & DIGITAL £3.2m**	**IT & DIGITAL £2.7m**	**IT & DIGITAL £1.7m**

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Appendix 5: Route to Clean Energy by 2030



1	The continuing decarbonisation of grid electricity
2	Improvements to lighting and controls, including LED lighting and improvements to the building management system (BMS)
3	Upgrades to building fabric to improve energy efficiency, for example insulation and improved glazing
4	Engineering upgrades, for example upgrades to air handling units to increase energy optimisation
5	Disconnect Combined Heat and Power (CHP) and switch to grid electricity and/or zero carbon power purchase agreements
6	Install solar photovoltaic panels (PV) on available roof space and car park car ports
7	Install heat pumps and link in with city low carbon district heat network
8	Eliminate unnecessary travel by air e.g. flights within the UK
9	Replace petrol and diesel vehicles used in delivery of care with zero tailpipe emission vehicles e.g. through electric pool cars and bikes
10	Transition to lower carbon anaesthetics, eliminate desflurane and increase the use of anaesthetic gas capture and destruction technology
11	Transition to lower carbon Dry Powder Inhalers (DPI) and optimise inhaler use
12	Continue to improve waste management to decrease the amount of waste incinerated at high temperatures
13	For us to achieve Net Zero Carbon we must reduce our carbon emissions to a maximum of 10% of the 2019 baseline. We anticipate that this remaining 10% will be from the following sources in order of significance: building energy, inhalers, anaesthetic gases, rail and flights, refrigerant gases, and waste


Install LED lighting


Enhance insulation


Install heat pumps


Install solar panels

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Agenda item A2(e)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

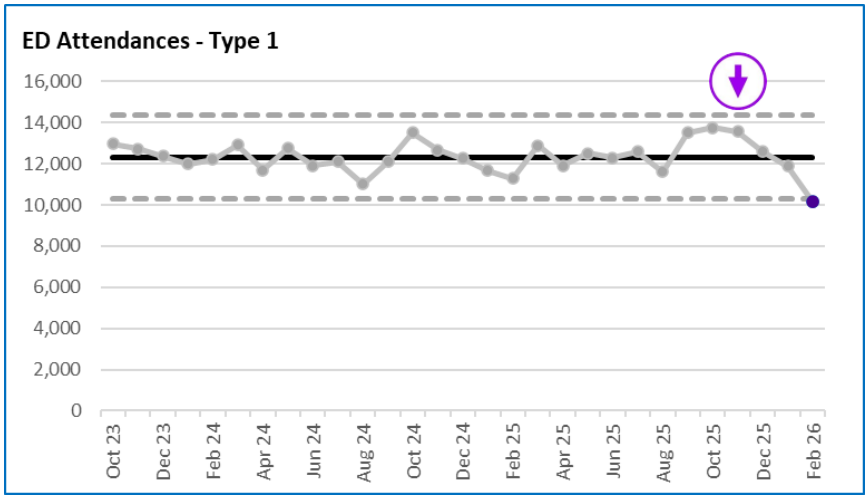
TRUST BOARD

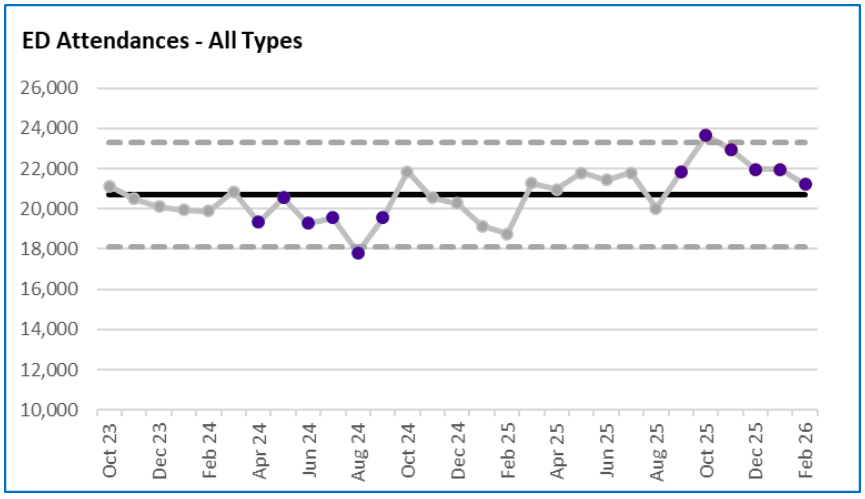
Date of meeting	27 March 2026					
Title	Joint Medical Directors Report					
Report of	Dr Lucia Pareja-Cebrian / Dr Michael Wright					
Prepared by	Associate Medical Directors					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☒		☒	
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 • Job planning update • Statutory Mandatory Training					
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 progress made with job planning for senior medical and dental staff. vi) 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

At the end of February 2026, overall emergency care performance against the 4-hour target was 77.23%. Type 1 performance was 51.59%. This is a drop in performance compared with the same period last year however we have seen escalation in demand which is the main driver. The past 2 months have seen days with the highest attendances ever to the Royal Victoria Infirmary (RVI) Emergency Department (ED) and the greatest number of ambulance conveyances. The team continue to assess the situation and explore changes which could lead to sustainable improvements.





There has been a shift in demand from Type 1 patients with increased numbers of Type 3 following the opening of the RVI Urgent Treatment Centre (UTC). The UTC and reconfigured front door continue to develop as staff training is embedded and processes are refined.

Winter schemes will continue until the end of April when the winter ward will be closed at the Freeman Hospital as planned.

2. CANCER UPDATE

i) Performance

28 Day Faster Diagnosis

		Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Brain/CNS	Actual	100.0%	100.0%	66.7%	100.0%	100.0%		100.0%			100.0%	100.0%		100.0%	100.0%	
Breast	Actual	97.8%	96.0%	94.4%	973.0%	97.1%	95.4%	92.0%	95.4%	95.5%	92.9%	92.8%	94.0%	94.2%	90.5%	89.0%
Breast Symptomatic	Actual	82.7%	61.9%	63.6%	70.9%	54.8%	65.7%	52.2%	55.5%	47.0%	38.7%	33.3%	34.5%	42.8%	44.4%	26.0%
Childrens	Actual	60.0%	0.0%	66.7%	100.0%	66.7%	83.3%	100.0%	46.2%	100.0%	50.0%	100.0%	14.3%	50.0%	50.0%	
Colorectal	Actual	69.5%	71.1%	64.0%	79.6%	73.6%	61.8%	62.0%	71.0%	75.1%	74.5%	71.1%	73.6%	69.8%	74.4%	64.4%
Gynae	Actual	69.5%	71.1%	80.5%	82.0%	81.6%	76.9%	84.0%	75.6%	85.6%	76.3%	81.2%	85.4%	77.7%	81.7%	81.1%
Haematology	Actual	91.7%	89.5%	100.0%	94.4%	70.0%	100.0%	88.2%	80.0%	86.7%	84.6%	100.0%	78.6%	90.0%	33.3%	66.7%
Head & Neck	Actual	87.1%	91.8%	90.8%	93.3%	86.2%	85.7%	87.5%	89.0%	87.0%	90.6%	95.3%	96.4%	94.3%	91.3%	89.8%
Lung	Actual	75.5%	76.3%	86.0%	78.6%	85.0%	68.1%	75.9%	84.8%	74.4%	76.3%	80.0%	76.7%	86.7%	88.0%	63.3%
NSS	Actual	90.9%	85.7%	63.6%				77.8%	90.5%	100.0%	92.9%	84.6%	100.0%	92.9%	76.5%	81.8%
Other	Actual	50.0%	0.0%		100.0%	0.0%	100.0%		0.0%	100.0%			100.0%		100.0%	
Sarcoma	Actual	85.7%	92.9%	100.0%	72.7%	80.0%	90.0%	81.8%	100.0%	84.6%	87.5%	77.8%	92.3%	78.6%	75.0%	81.8%
Skin	Actual	65.2%	68.9%	60.4%	81.3%	79.6%	82.5%	82.1%	74.9%	63.9%	61.6%	53.3%	53.5%	47.3%	44.7%	54.1%
Testicular	Actual	87.5%	93.8%	90.9%	81.8%	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	88.9%			100.0%	100.0%
Upper GI	Actual	76.7%	85.9%	86.4%	88.4%	83.5%	78.5%	84.8%	84.3%	80.0%	93.2%	89.5%	82.2%	82.4%	85.9%	77.9%
Urology	Actual	60.2%	50.9%	31.7%	55.8%	68.0%	78.0%	58.2%	65.4%	69.9%	73.4%	76.3%	81.3%	78.0%	73.6%	62.0%
HPB	Actual	16.7%	66.7%	0.0%	66.7%	58.3%	62.5%	27.3%	60.0%	42.9%	62.5%	70.0%	66.7%	62.5%	42.9%	55.6%
OGD	Actual	82.8%	92.4%	88.5%	90.6%	86.0%	79.2%	88.1%	86.3%	86.0%	91.9%	91.2%	84.4%	82.1%	89.5%	78.9%
Trust Total	Actual	74.7%	76.1%	70.7%	83.4%	80.9%	81.4%	80.3%	78.1%	74.2%	71.9%	68.5%	69.1%	65.6%	67.7%	66.5%
NHSE	Target	77.0%	77.0%	77.0%	77.0%	77.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

62 Day Time to Treatment Target

		Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26
Brain/CNS	Actual	92.6%	100.0%	100.0%	89.5%	100.0%	88.2%	91.7%	100.0%	82.6%	83.3%	100.0%	100.0%	100.0%	92.9%	89.5%
Breast	Actual	90.5%	90.8%	87.9%	88.1%	77.5%	95.1%	87.0%	89.8%	92.1%	83.5%	86.5%	83.1%	78.6%	86.3%	74.5%
Childrens	Actual	100.0%	100.0%	100.0%		100.0%		100.0%		100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Colorectal	Actual	44.1%	31.3%	50.6%	34.5%	71.7%	56.4%	49.1%	38.2%	40.8%	40.0%	53.7%	47.9%	68.2%	48.0%	67.3%
Gynae	Actual	57.7%	35.5%	64.0%	48.0%	61.1%	77.8%	48.3%	79.2%	42.9%	52.0%	50.0%	39.1%	66.7%	70.3%	78.6%
Haematology	Actual	92.1%	83.3%	100.0%	85.3%	82.4%	86.2%	88.4%	81.6%	83.9%	76.1%	64.7%	96.2%	88.2%	85.7%	78.6%
Head & Neck	Actual	75.0%	59.0%	85.4%	80.7%	60.0%	75.8%	92.3%	75.8%	79.7%	76.3%	72.2%	90.7%	82.5%	70.5%	65.0%
Lung	Actual	43.1%	55.1%	45.1%	35.6%	46.2%	47.9%	43.0%	40.7%	63.5%	56.0%	56.9%	58.4%	51.1%	49.1%	43.5%
Other	Actual	63.6%	100.0%	50.0%	45.5%	100.0%	83.3%	63.6%	100.0%	83.3%	50.0%	69.2%	71.4%	100.0%	87.5%	100.0%
Sarcoma	Actual	58.3%	57.1%	69.6%	94.7%	81.3%	100.0%	80.0%	100.0%	63.6%	78.9%	70.0%	88.9%	84.2%	60.0%	66.7%
Skin	Actual	75.4%	77.9%	82.5%	79.2%	83.1%	90.2%	95.8%	89.7%	90.5%	94.7%	90.7%	85.3%	86.5%	87.2%	86.5%
Upper GI	Actual	39.2%	37.6%	42.0%	53.2%	42.3%	40.0%	42.3%	41.8%	49.6%	49.1%	47.4%	50.0%	46.2%	64.9%	37.2%
Urology	Actual	50.0%	58.4%	53.6%	40.5%	62.3%	57.0%	54.0%	40.8%	55.1%	59.8%	51.9%	65.3%	61.1%	54.3%	59.8%
HPB	Actual	41.4%	46.2%	37.0%	47.3%	43.6%	45.8%	47.5%	34.7%	50.7%	45.2%	54.7%	47.4%	47.1%	55.2%	42.9%
OGD	Actual	55.9%	54.2%	50.0%	61.5%	39.4%	34.0%	36.8%	50.0%	47.9%	54.3%	30.4%	58.3%	44.4%	80.6%	37.0%
Trust Total	Actual	62.0%	63.7%	66.4%	60.9%	65.5%	71.9%	69.2%	63.9%	71.1%	70.2%	70.4%	71.7%	71.5%	73.4%	66.7%
NHSE	Target	70.0%	70.0%	70.0%	70.0%	70.0%	75.0%	75.0%	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*

28 Day Performance

Skin - The deterioration in compliance against target in the 28-day faster diagnosis pathways is largely still driven by deterioration in this measure within the skin pathway. Skin referrals make up nearly 50% of patients on this pathway and therefore shifts in performance in this group have a disproportionate effect on overall performance.

Clinical Impact - Clinical triage is ongoing to identify the highest risk patients and because many of the patients are biopsied and treated same day (i.e. lesion removed as both diagnostic and therapeutic procedure) compliance at 62 days remains strong in skin and outcomes for patients are good. There have been no cases of harm due to delay beyond 104 days recorded for skin cancer in the last 18-months.

Action planning both for demand management and managing workload for skin referrals continues and has been discussed at relevant Quality and Performance Reviews (QPR).

Actions include:

- Review of referrals to enable patients are managed closer to home when appropriate to do so, specifically focusing on referrals from Northumberland GPs.
- Consultant recruitment to posts with increased skin cancer component.
- Work with the North East and North Cumbria Integrated Care Board (ICB) to encourage commissioned tele-dermatology in primary care to maximise efficiency.

There has already been a fall in referrals from Northumbria. The impact of these changes on our cancer performance and the performance across the system, including impact on histopathology services, is being monitored.

Breast -There has been a significant drop in 28-day performance in the symptomatic breast service. This is driven in large part by redistribution of work and workforce to support the breast care service at County Durham and Darlington NHS Foundation Trust (CDDFT). There has been an increase in referrals to our breast team (11.5% increase in September 2025 - January 2026; approximately 230 extra referrals). Work is ongoing to confirm the origin of these referrals and understand the change and whether we need to anticipate this as a long-term impact. In addition, some clinical radiology time has been provided in CDDFT and it has not been possible to fully backfill this at Newcastle Hospitals.

Actions include:

- Screening pathway prioritised for staffing with the symptomatic pathway relying heavily on Waiting List Initiative (WLI) sessions which have been hard to staff. This is a very appropriate clinical approach given the pick-up rates for malignancy are 12.5% and 1.5% in the screening pathway and in the symptomatic pathway respectively.
- Maximise WLI activity whenever staff are available.
- Work with CDDFT and the ICB to finalise the arrangements for ongoing support at CDDFT.

Unvalidated data suggests 28-day performance will be over 80% in February 2026

62 Day Performance

This has deteriorated in January. The main shifts driving this change were an increase in referrals to head and neck coinciding with loss of some clinical capacity over Christmas and New Year. The complexity of this pathway, including the need for multi-speciality actions, is adversely affected by Bank Holidays.

The other area of performance change was in upper GI cancer, both oesophagogastric (OG) and HPB but with biggest impact for OG pathways. There were 64.5 patients on 62-day pathways in OG in January as compared to 45.5 in December. This included 17 additional tertiary referrals and is associated with an increased time from inter-provider transfer to treatment at Newcastle Hospitals.

Appropriate equipment and facilities are available to move Endobronchial Ultrasound (EBUS) for lung cancer from the Freeman Hospital to the RVI and commence navigational bronchoscopy alongside it. This should have a positive impact on time to treatment in lung cancer. The first EBUS list has been completed.

As highlighted in the report of January 2026, performance for tertiary referrals is the element that has the biggest negative impact on Newcastle Hospitals performance. There is work to do to reach the NHS England (NHSE) target of 85% compliance by March 2027. The number of patients waiting beyond 62 days on urgent suspected cancer pathways week ending 1 March 2026 was 120, down from 133 in January.

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:

Ablation

- It has not been possible to support the bid, as part of the quality business case process, to create a theatre with a scanner at the Freeman Hospital to allow expansion of ablation work in interventional radiology.
- There is currently a wait of more than 12-weeks for ablation once a decision has been made that this is appropriate treatment for renal cancer, hepatic cancer or metastases.
- The harm review process has been enacted for waits >104 days.
- Almost every case requires additional scanning prior to treatment due to the gap between referral and procedure completion.

Actions include:

- Clinical teams (radiology, surgery and peri-ops) to meet to establish if there are any further efficiencies that can be made with current physical resource to treat more patients.
- Establish whether additional senior nursing (Clinical Nurse Specialise (CNS)) input might help in streamlining process, supporting patients and minimising wasted slots.

- Assess ongoing clinical risks after mitigations.
- Review business case submission to establish if this can be prioritised in the future.

iii) Cancer Governance

Cancer Harm Review Process – The most recent data was included in the January 2026 Board paper, with a further update anticipated for May 2026.

Durham Breast Service - As discussed above, clinical colleagues from Newcastle Hospitals continue to provide input and oversight within the CDDFT breast service, particularly as part of the Multidisciplinary 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, ICB and the Cancer Alliance as to the best long-term strategy to support and/or deliver this service for CDDFT patients.

Skin Referrals to Plastic Surgery in Northumbria - As above review of the pathway locally and across the Great North Healthcare Alliance will be needed once changes are embedded, including impact assessment on pathology. This may be a topic for discussion at the Bilateral Board meetings.

iv) National Cancer Plan (NCP)

It is clear that the immediate focus of the NCP is an improvement in performance, and this is clearly welcomed and critically important for patients. The overall plan is far reaching and aspirational with a focus on 5 big 'bets': data, robotics, Artificial Intelligence (AI), wearable technology and genomics as transformative factors in cancer care that will facilitate the increased performance as well as improved quality of life and patient empowerment in the face of the rising incidence and prevalence of the disease. The fundamental aspiration is to make England a global leader in cancer survival with 75% 5-year survival by 2035.

Newcastle Hospitals should be well placed to roll out changes across the cancer sphere as opportunities develop. We have a strong background in oncology genomics and have implemented AI projects in several areas already. The progress with the Sir Bobby Robson Institute (SBRI) will help build research capacity.

The NCP sets out a strengthened role for the Regional Cancer Alliances with a bigger role in monitoring and challenging performance alongside closer working with individual trusts. The major challenge will be around performance, finding better ways to work at neighbourhood level and working as a genuine system, including with colleagues in primary care, to deliver care and monitoring sustainably.

3. QUALITY AND SAFETY

i) Patient Safety Incident Response Framework (PSIRF) Priority Project – Invasive Procedure - Update

The Trust's priority safety project remains in diagnostic and exploration phase, there has been no great change to the January update.

This comprises:

- A major poster and communications campaign (including a QR code), across the 8 major theatre areas and 12 major procedure areas and labs.
- Webpage – details of project, how to get involved and a survey.
- Coffee room consultations.
- Peri-Ops Board engagement – RVI/Freeman Hospital governance meeting 19 March 2026.

In parallel we are:

- Designing measurable parts of the process to inform progress.
- Engaging national figures involved in the design of National Safety Standards for Invasive Procedures (NatSSIPs) 2, to meet and advise on our process.

We hope to move into testing phase over March to Spring with individual elements.

A full driver diagram to achieve aims has been produced, with implementation in the second half of the year.

Martha's Rule (MR) Update

As the Trust Board is aware, MR is well established throughout Newcastle Hospitals and we have good data demonstrating how it is utilised and in general this has been a beneficial and positive addition to the detection arm of our deteriorating patient system.

We are currently not complying with one element of Martha's Rule, namely recording of a Patient Wellness Score. This element of MR is intended to capture subjective information from a patient (or their family or parent/carer) regarding their wellbeing for example if they have new concerns or feel better or worse compared to 24hrs previous.

This element is not validated but this is now a requirement from NHSE and one which we plan to implement. There exists a model within paeds e-obs charting currently, namely the requirement to document parental concern, and within adults there is a current option (not mandated) to record nursing concern.

We aim to adapt this current functionality existent within our e-obs modules to the Martha's Rule Patient Wellness Requirement. This modification is currently sitting with the digital team for prioritisation and actioning.

ii) 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 – Surgical and Associated Services (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.

Concerns

- Thoracic Surgery – culture, governance process, with clinical board oversight.
- Cardiac Transplant outcomes – benchmarking concerns but working through our specific high-risk profile regarding the adult congenital recipient group – meeting with Chief Executive Officer planned 24 March 2026.

New

- Paediatric Oncology/ Haematology – issues in relation to team health and individual behaviours currently being investigated. No current concerns regarding clinical outcomes.

4. MEDICAL EDUCATION

Undergraduates

- Twenty-four Teaching Fellowship (TF) posts have been approved for recruitment for 2026/27. These are currently being recruited to, internally in the first instance. Recurrent funding has been identified for these posts. This is down from the 29 posts we had last year. The Trust is already a high outlier in terms of student, TF ratio in contrast to other Trusts in the region. The Paediatric team in particular have raised concerns about feasibility of delivering current curriculum with only 2 (rather than) 3 TFs. There is an ongoing piece of work looking at TF provision within the Trust in comparison to curriculum need.
- New appointments to Undergraduate Senior Clinical Team mean we are now at full complement. New remits added ('Learning Environment and Culture Lead' & 'Educator Lead') mapped to General Medical Council (GMC) domains.
- During the current Academic Year, there has been a small number of Newcastle students undergoing Fitness to Practice investigations. These incidents are complex and the Undergraduate team are providing support to those involved along with the Medical School as part of the process.
- Initial student numbers confirmed for 2026/27 are similar to current numbers. We anticipate a challenge to maintain service delivery quality and quantity with reduced TF resource.

Postgraduates

- A number of new changes have been introduced to Exception Reporting (ER) as part of a change in resident doctor contracts. The supervisors are now removed from the ER process. Hours and rest ER go to Human Resources (HR) and the Guardian of Safe Working (GOSW). Education ER go to the medical education team, with all ERs <2

hours automatically signed off. The changes have been communicated to consultants widely by our GOSW at the Clinical Policy Group (CPG) and educational leads meeting. Educational leads have been asked to disseminate the information amongst their consultants. The effect of these changes is being monitored and will be reported via Guardian of Safe Working and Joint Medical Director reports.

- Work is ongoing with the 10-point plan designed to address key concerns raised by resident doctors nationally. Meetings to address progress are held weekly, chaired by one of the Joint Medical Directors.
- We have appointed a tutor for wellbeing. The appointee comes with a wealth of experience and will be very welcome given the increase in doctors with different needs.
- The GMC training survey is open from the 24 March to the 6 May 2026. All resident doctors and consultants will be encouraged to respond.

5. IMPROVING THE LIVES OF RESIDENT DOCTORS

There is an oversight group which meets weekly chaired by one of the Joint Medical Directors, attended by the Chief Registrar, Resident Forum Chair, HR, Medical Education and Estates. A baseline survey led by NHSE followed by a Newcastle Hospitals specific internal survey helped informed an action plan, helping focus the areas which require improvement to meaningfully improve working lives of our Resident doctors.

6. JOB PLANNING

A review of all senior medical and dental staff job plans for 2025-26 has now been completed. Approximately 90% of job plans had been approved and signed off by the beginning of March and it is anticipated that in excess of 95% will have been approved by the end of March.

Analysis of the data generated from the job plans is underway and a full report will be shared when this is complete. Review of the effect of the new job planning guidance and process on total Programmed Activity (PA) allocation to job plans across the Trust and in individual Clinical Board, distribution of PAs to Direct Clinical Care (DCC) and Supporting Professional Activities (SPA), effect on productivity and financial impact of the changes made is currently underway and will be presented in April.

Planning is currently underway for the 2026/27 job planning round. It is hoped that this can be completed in Quarter 1 (Q1) of 2026/27.

7. STATUTORY AND MANDATORY TRAINING

Compliance with statutory and mandatory training amongst both resident and senior medical and dental staff remains a concern. Data on this is presented on a monthly basis to Clinical Boards at their Quality and Performance Reviews. The importance of this has been highlighted to Clinical Board Chairs (CBCs) by the Joint Medical Directors and they have been

asked to develop action plans by the end of March to ensure improved compliance in 2026-27.

8. 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 progress made with job planning for senior medical and dental staff.
vi) 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
20 March 2026

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 March 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, Midwifery and Allied Health Professionals Report. The report covers the following sections: • Section 1: Nurse Staffing Update • Section 2: Safeguarding and Mental Capacity Act Quarter 3 (Q3) Update • Section 3: Learning Disability Quarter 3 (Q3) Update • Section 4: Flu Vaccination Programme The following key points/risks are noted for the Trust Board's attention: **Section 1** • Trust nurse staffing escalation remains at level 1 with appropriate oversight, monitoring and supportive actions in place. There are no new escalations to the Trust Board. • The enhanced therapeutic observation and care task and finish groups focus is on effective leadership, oversight and education to promote safe therapeutic care. Incident themes which occur during the delivery of enhanced therapeutic observation and care shifts will be shared in a future report. • Agency use has seen sustained reduction. The staff bank continues to be the main provider of temporary resource allowing responsive enhanced therapeutic observation and care shifts when required. **Section 2** • Risk 1475 documents the increased activity across the safeguarding teams resulting in the inability to respond to and deliver timely advice due to the demands. Oversight of mitigating actions is provided by the Safeguarding Committee. • Across the safeguarding teams, staffing challenges along with increased volume of work has resulted in audit delays. A full workforce review has been commissioned by the Executive Director of Nursing, Midwifery and Allied Health Professionals with skill mix changes agreed and recruitment expedited. Additional resources will be required and to mitigate the risk, a temporary increase in establishment has been agreed until long term requirements are known. • Level 1 and 2 adult and children compliance is above Trust target. Level 3 adult and children compliance is improving but below the 90% threshold at 88.78% and 86.18% respectively.		

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

- Mental Capacity Act (MCA) Level 1 training is 97.27%. Level 2 stands at 86.66% compared to 81.45% reported in Quarter 2 (Q2), with efforts ongoing to reach the 90% target.

Section 3

- Learning Disability service activity remains high, with many patients requiring multiagency participation and input from the MCA and legal teams.
- Risks associated with staffing capacity and lack of support for autistic patients have now been closed. The team is now fully established following the appointment of the Autism Lead Practitioner role.
- Diamond Standard Training is 94.6%, and above the Trust target of 90%. The Trust is reviewing training plans in line with national expectations of the Oliver McGowan Training. Delivery of this training in acute settings will be challenging financially and organisationally. A proposal has been provided for Executive consideration, and a project plan is being developed.

Section 4

- 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.
- The total number of staff vaccinated against Flu was 10,851, an increase of 1,677 from 2024/25. The Trust recorded the highest number vaccinated and highest percentage vaccine uptake across the Northeast and North Cumbria Integrated Care Board (ICB). Nationally the Trust recorded the highest total number of staff vaccinated and the 8th highest percentage vaccinated for all trusts in England.

</td></tr>
<tr><td>Recommendations</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 risks and mitigations in relation to the Safeguarding Teams.
iv) Note the vaccination programme delivery.</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.

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<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 Executive Director of Nursing, Midwifery and Allied Health Professionals update is a regular comprehensive report bringing together a range of issues to theTrust Board.</td></tr>
</table>

The Newcastle upon Tyne Hospitals NHS Foundation Trust

EXECUTIVE DIRECTOR OF NURSING MIDWIFERY AND ALLIED HEALTH PROFESSIONALS REPORT

1. NURSE STAFFING UPDATE

A guidance document outlining nursing safe staffing metrics and Monthly Safe Staffing Dashboard is available in the Trust Board Reading Room to supplement the information presented in this report.

1.1 Nurse Staffing Escalation

The Trust Nurse Staffing Guidelines provide a robust framework to ensure safe nurse staffing governance and identifies a clear process for safe staffing escalation. 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 opened on 29th December 2025 and is planned to continue until the end of the winter plan. The Head of Nursing continues to sustain safe nurse staffing levels in collaboration with other Clinical Boards and so, the safe staffing escalation level has remained at level one but is reviewed and may be increased responsively.

The following actions are in place and overseen by the Executive Director of Nursing, Midwifery and Allied Health Professionals:

- 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 for the last quarter:

Month	Total	Clinical Board	High level support	Medium level support	Low level support
November 2025	4	Family Health Services		GNCH01a, 01b	GNCH03, 12
	2	Surgical and Specialist Services		RV22, RV16	
	0	Perioperative Services			
	3	Cardiothoracic Services		FH29, FH30	FH21

Month	Total	Clinical Board	High level support	Medium level support	Low level support
	3	Medicine and Emergency Care Services		RVAS	FH18, RV44
	0	Surgical and Associated Services			
	2	Cancer and Clinical Haematology Services		NCCC34	NCCC33
Total	**14**		**0**	**8**	**6**
December 2025	4	Family Health Services		GNCH01a, 01b, 02a	GNCH12
	2	Surgical and Specialist Services		RV16	RV22
	1	Perioperative Services			
	3	Cardiothoracic Services		FH29, FH30	FH21
	4	Medicine and Emergency Care Services		RVAS	RV44, FH13
	1	Surgical and Associated Services			FH08
	2	Cancer and Clinical Haematology Services		NCCC34	NCCC33
Total	**15**		**0**	**8**	**7**
Month	**Total**	**Clinical Board**	**High level support**	**Medium level support**	**Low level support**
January 2026	7	Family Health Services		GNCH01a, 01b, 02a	GNCH12, 03, 09, 11
	3	Surgical and Specialist Services		RV16	RV22, RV20
	0	Perioperative Services			
	4	Cardiothoracic Services		FH29, FH30	FH21, FH24
	7	Medicine and Emergency Care Services		RVAS	RV44, FH13, FH14, FH18, FH20, RV48
	3	Surgical and Associated Services			FH08, FH05, FH07
	2	Cancer and Clinical Haematology Services		NCCC34	NCCC33
Total	**26**		**0**	**8**	**18**

Key:
FH – Freeman Hospital
GNCH – Great North Childrens Hospital
NCCC – Northern Centre for Cancer Care
RV – Royal Victoria Infirmary
RVAS – Royal Victoria Infirmary Assessment Suite
N.B. Numbers disclosed represent the Ward number

The key points to note:

- No wards have required high-level support over the last three months.
- Wards receiving medium-level support for more than two months have formal action plans in place. These are monitored through mid-point meetings to provide governance, oversight, and assurance of progress.
- The number of wards receiving low-level support has increased in the last month. This reflects a review of medication safety assurance and the introduction of a clearer threshold for non-compliance that triggers escalation. The intention is that early escalation through this forum will support timely improvement, enable monitoring, and promote shared learning across all Clinical Boards.
- Key themes driving medium-level support this quarter include:
  – Medication safety assurance
  – e-Observation compliance
  – Ward leadership and culture
  – Infection prevention and control
  These themes inform improvement priorities and targeted support offers.

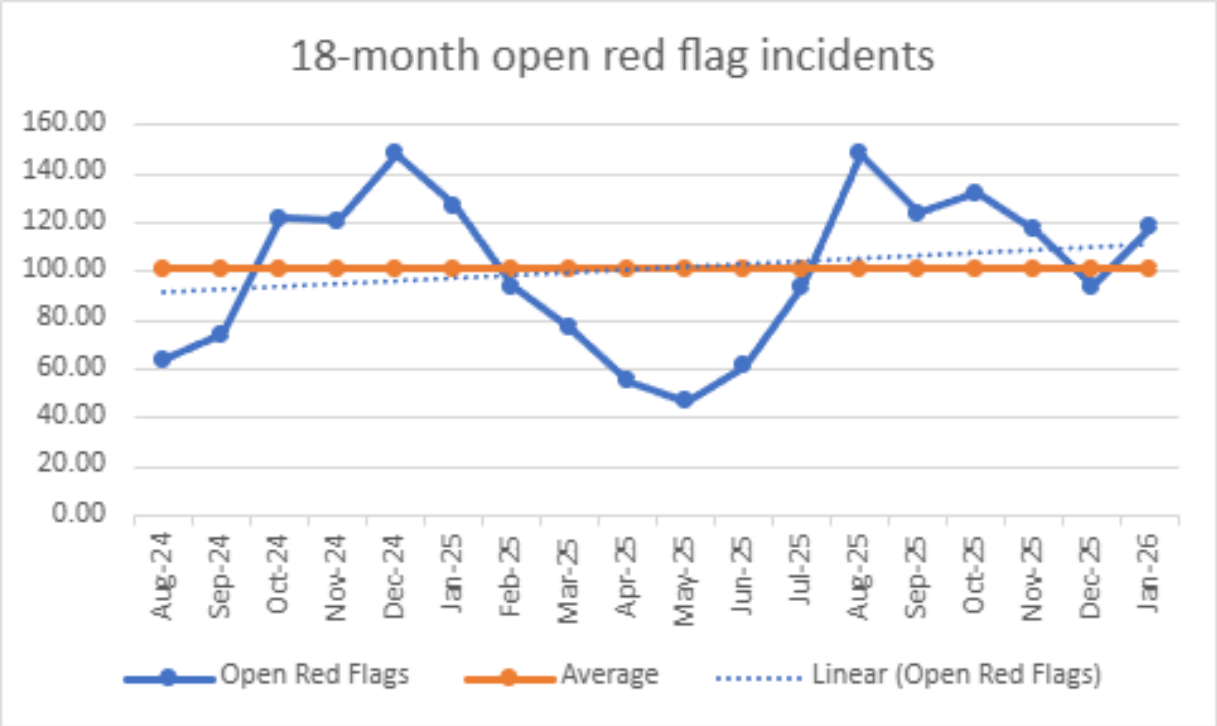
1.3 Incident and Red Flag data

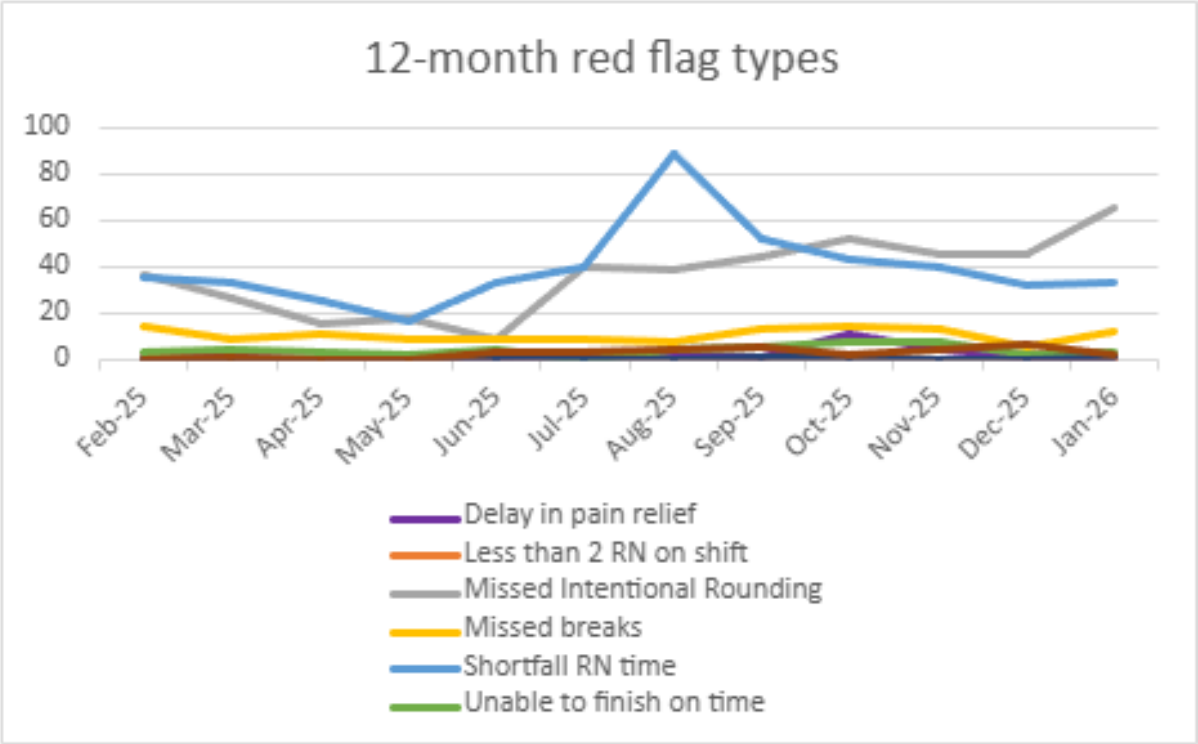
Red flag and incident data are reviewed daily (Monday-Friday) by the senior nursing team and reported as part of the daily staffing briefing and presented to the NSCO Group monthly. Red flag events are triangulated with staffing metrics and nurse sensitive indicators to identify potential risks, the level of support required at NSCO and during nurse staffing reviews. Themes continue to be monitored and reported to Professional Practice Assurance Group (PPAG) and the Quality Committee.

The key points to note:

- Incidents show a clear upward trend over the 18-month period, with a sustained step-up from mid-2025. This is linked to an increase in staffing incidents being reported by non-inpatient areas.
- Some incident reports identify the effects of staffing levels on morale, and delays to care but there were no reports in the last quarter linking staffing levels directly to harm.
- Work has commenced to review incident themes which occur during the delivery of enhanced therapeutic observation and care shifts and will be shared in a future report.
- Red flag incident numbers show variability but have a gradual upward trend over the 18-month period.
- There were no open red flag events of “less than 2 Registered Nurse (RN)” in the last quarter.
- Weekday day-shift red flags are higher than nights and weekends, likely due to greater senior staff presence and temporary staff preference for enhanced-rate shifts. Further analysis using Allocate and bank data will be included in the next report.
- The highest unresolved red flags were “shortfall in RN time” and “missed intentional rounding,” mostly concentrated in medicine wards. The top three reporting wards were all in older people’s medicine, where staffing is impacted by high sickness

absence. The Clinical Board is actively addressing sickness concerns.





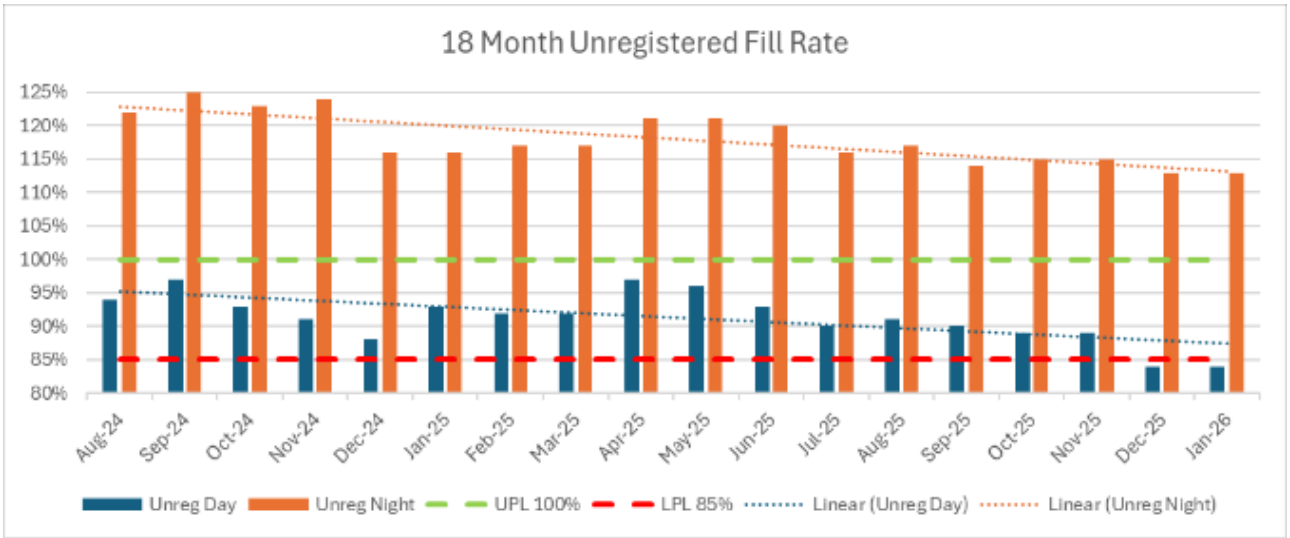
1.4 Care Hours Per Patient Day (CHPPD) data

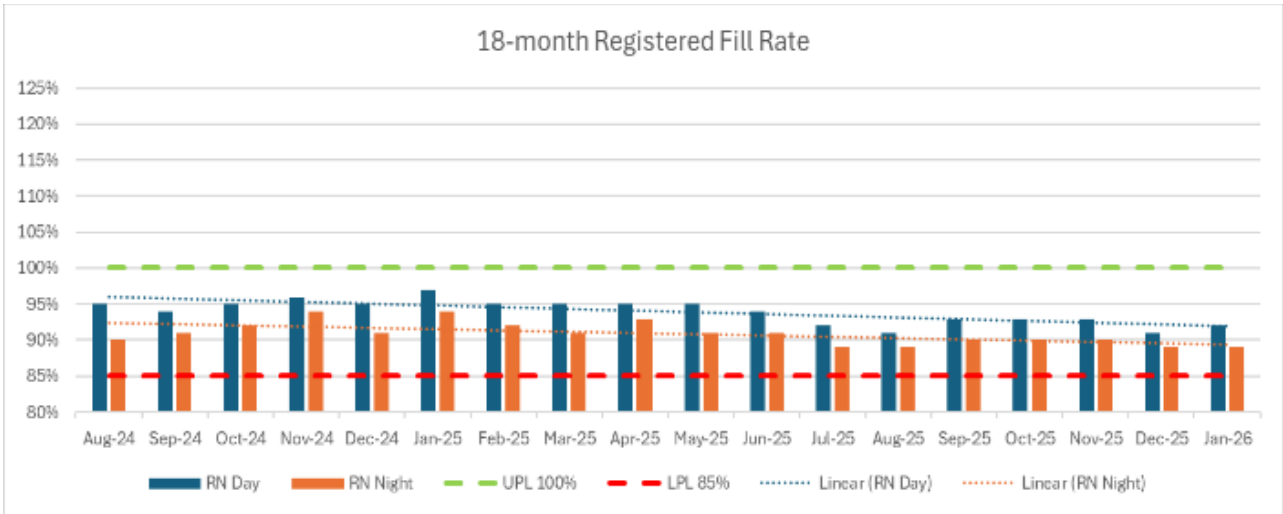
The nurse staffing team monitor ward-specific CHPPD on the safer staffing dashboard which is reviewed at the NSCO Group each month. The Trust CHPPD has remained at around 9.0 for the past 12 months. Non-specialist in-patient wards benchmark lower than the Model Hospitals Dashboard comparator in most 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, Midwifery and Allied Health Professionals each month. Key points to note:

- Wards reporting <85% RN fill rates show a slight upward trend on days, and a slight downward trend on nights over the last 18 months, remaining stable overall.
- During the last quarter, five critical care areas recorded RN staffing levels below the 85% threshold. Bed utilisation and patient acuity continued to be actively reviewed each day, with operational teams adjusting activity and staffing to manage risks promptly. The work of the enhanced therapeutic observation and care task and finish group will allow effective leadership and oversight, promote safe therapeutic care, provide effective education and inform workforce planning.
- Three adult critical care units required staffing escalation risk assessments, and appropriate mitigations and controls were put in place. No staffing-related incident reports were submitted for the same periods.
- Ten of the areas reporting <85% RN fill rates have been receiving low-level support through NSCO; no areas have required medium-level support.





1.6 Temporary Staffing

Newcastle Hospitals Staff Bank supply temporary staffing to wards and departments to fill short-term vacancies or absence. It also allows deployment of enhanced therapeutic observation and care shifts responsively to meet the needs of vulnerable patients. Temporary staffing and agency usage reports are distributed to the senior corporate nursing team and heads of nursing each week, providing additional oversight.

The key points to note:

- Unregistered bank fill has remained stable at 85% over 18 months. A recent dip is due to increased demand, as both requested and filled shifts have risen.
- Registered bank fill is improving, with fill rates rising to 76–81% and the number of filled registered shifts also increasing, in line with growing demand. Some of this could be attributed to a move from overtime to bank in some areas.
- Unregistered agency use is consistently declining, with a sustained steep reduction in agency-filled shifts over the past 18 months. Where enhanced therapeutic observation and care shifts are required, approval is sought through a process agreed with the Executive Director of Nursing, Midwifery and Allied Health

Professionals.

1.7 Recruitment and Retention

- The current RN Turnover is 5.11 % and continues on a downward trajectory. In the same period last year turnover was 5.75%.
- The current RN Vacancy rate is 2.75% which is slightly increased from the previous month.
- The current Healthcare Support worker turnover rate is 5.77% which is a very slight increase on the previous month but has seen an overall reduction since the same period last year when it was 7.31%.
- The current Healthcare Support Worker (HCSW) vacancy rate is 15% which is an increase on the previous month where a rate of 14.39% was reported.
- Recruitment events continue to run successfully on a six-weekly basis for both Band 3 and Band 5 roles, with real-time vacancy data informing decisions on whether adverts are shared internally or externally.
- All adult nursing students due to register in April/May 2026 have now attended interviews and have been successfully appointed to posts.
- Students expected to register in September 2026 have been invited to attend pre-employment preparation sessions, including application and interview skills workshops and the 'Steps to Employment' programme, delivered by the Preceptorship Team. These sessions are intended to support readiness for interview, with formal interviews scheduled for May 2026.

2. SAFEGUARDING

This summary of key points provides a Q3 update of Safeguarding (Adult, Children's and Maternity) and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) activity throughout the Trust. This detail was presented to the Safeguarding Committee (13 January 2026) and to the Quality Committee (19 February 2026).

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

2.1 Activity and Service Capacity

- Risk 1475 documents the increased activity across the safeguarding teams. This risk records the inability to respond to and deliver timely advice due to the demands on the team. Oversight of mitigating actions is provided by the Safeguarding Committee.
- Across the safeguarding teams, staffing challenges along with increased volume of work has resulted in audit delays. Benchmarking is underway to quantify resource gaps in the teams. A full workforce review has been commissioned by the Executive Director of Nursing, Midwifery and Allied Health Professionals with skill mix changes agreed and recruitment expedited. Additional resources will be required and to mitigate the risk, a temporary increase in establishment has been agreed until long term requirements are known.
- Maternity and children's teams are collaborating to develop a standard operating procedure (SOP) for group safeguarding supervision. This mitigates the risk associated

with low supervision compliance and therefore will be added to the risk register whilst a resolution is sought.

- Work is ongoing with the digital health team to improve the visibility of safeguarding information. This is recognised in Risk 1463 with the safeguarding teams participating in the development of a safeguarding module for SystemOne.
- MCA and DoLS case numbers remain high. In Q3 there were 277 reported MCA and DoLS-related enquiries, this is an increase from Q2 where there were 144 reported MCA and DoLS-related enquiries.
- The Trust 2024 internal audit safeguarding governance recommendation relating to Newcastle Safeguarding Adults Board (NSAB) updates to the Safeguarding Committee and Operational meetings has been actioned.
- Policies and the audit schedule are reviewed at the Safeguarding Committee. There is one 0-19 recording keeping audit and the adult policy monitoring audit delayed for due to service capacity. All safeguarding maternity and children's audits are up to date.
- Q3 MCA audit data is under review. Q2 MCA audit data demonstrates improvements in the quality of capacity assessments which is attributed to effective training being delivered and accessed by appropriate staff groups.

2.2 Education and Training

- Safeguarding training is monitored and reviewed at the Safeguarding Committee.
- When it was identified that some staff did not have safeguarding training attached to their roles. Immediate action was taken to rectify this and the Training Needs Analysis (TNA) refreshed. The new e-learning commenced in February 2026 with a 12-month implementation period and robust monitoring mechanisms.
- Safeguarding adults Level 1 is 94.84%, and Level 2 is 93.38%. Level 3 compliance has improved to 88.78% but is below the Trust 90% standard.
- Safeguarding children Level 1 is 94.40% and Level 2 91.34%. Level 3 compliance has improved to 86.18% but is below the required target.
- MCA Level 1 training is 97.27%. Level 2 stands at 86.66% compared to 81.45% reported in Q2, with efforts ongoing to reach the 90% target.

3. LEARNING DISABILITY QUARTER 3 (Q3)

This summary of key points provides a Q3 update of Learning Disabilities activity throughout the Trust. The following key points are noted for the Trust Board's attention:

3.1 Activity and Service Capacity

- Service activity remains high, with many patients requiring multiagency participation and input from the MCA and legal teams. In Q3 there were 572 inpatient and day case attendances which is slightly lower than the 617 inpatient and day case attendances in Q2.
- The risks associated with staffing capacity and lack of support for autistic patients have now been closed and the team is now fully established following the appointment of the Autism Lead Practitioner role.

- Audit and quality improvement work is ongoing to review quality of documentation relating to learning disability and identification of reasonable adjustments and is now detailed in Matron governance reports.
- The LeDeR panel continues to meet monthly to review the deaths of patients with a learning disability.

3.2 Education and Training

- Compliance with the e-learning Diamond Standard Training is 94.6%, and above the Trust target of 90%.
- The Trust continues to review the training plans in line with national expectations of the Oliver McGowan Mandated Training. It is recognised that the delivery of this training in acute settings will be challenging both financially and organisationally. A proposal has been provided for Executive consideration with a pragmatic approach to roll out agreed. Further work is required to develop a clear project plan.

4. FLU VACCINATION PROGRAMME UPDATE

The Trust Staff Vaccination Programme supported staff in making the choice to receive their Flu vaccination in line with national guidance to protect themselves, family and patients. For the 2025/2026 programme the Department of Health and Social Care (DHSC) provided a target for trusts to increase their Flu vaccination uptake by 5%, which has been exceeded.

The Trust programme commenced in early October 2025 with the Flu vaccine only, in line with Joint Committee on Vaccination and Immunisation (JCVI) advice. The programme encompassed a range of opportunities to engage with high volumes of staff and observed robust governance and assurance processes through the Vaccination Steering Group, with fortnightly progress reports published for the Executive Team. The Trust also delivered an inpatient peripatetic Covid and Flu vaccination service, starting from October 2025 and running to March 2026. NHS England will reimburse the vaccine and associated administration costs.

The total number of staff vaccinated against Flu was 10,851, an increase of 1,677 from 2024/25. 10,250 flu vaccines given through the Newcastle Hospitals staff vaccination programme, with 601 notifications from staff of receiving flu vaccine outside of the Trust offer. The Trust recorded the highest number vaccinated and highest percentage vaccine uptake across the Northeast and North Cumbria ICB. Nationally the Trust recorded the highest total number of staff vaccinated and the 8th highest percentage vaccinated for all trusts in England.

5. RECOMMENDATIONS

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 risks and mitigations in relation to the Safeguarding Teams.
iv) Note the vaccination programme delivery.

Report of Ian Joy
Executive Director of Nursing, Midwifery and Allied Health Professionals
9 March 2026

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	27 March 2026		
Title	Perinatal Quality Oversight Report, including Maternity Incentive Scheme update		
Report of	Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals		
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 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: • In the absence of an Integrated Care Board (ICB) commissioned Maternity and Neonatal Voice Partnership (MNVP) model in accordance with the NHS England (NHSE) guidance the Trust continues to develop a comprehensive service user experience programme, collating data from multiple sources, to strengthen the service user experience action plan and support the limited capacity of the MNVP Lead. • The Fetal Medicine service remains fragile and is an area of focus, with concerns being shared by midwifery and medical colleagues regarding the capacity and performance of the service; an enhanced support plan is in place pending the successfully recruited team members joining the service during April, in addition the Trust is currently recruiting into sub-speciality posts. • The Trust is supporting the Independent Maternity and Neonatal Investigation staff experience survey, as of 2 March 2026 62 responses had been received from the Trust. This is in keeping with the 8,000 responses from across 120 Trusts nationally. It is hoped that participation from the perinatal multidisciplinary team will ensure every voice is heard and will inform national recommendations to improve quality, safety, compassion, and equity in maternity and neonatal care. • The Clinical Quality Improvement Metrics (CQIM) for 'babies readmitted to hospital who were under 30 days old' data is used to benchmark the Trust performance against MBRRACE and national performance. In January, the readmission rate was 8%, this is currently being reviewed by the Lead Neonatologist for Transitional Care services and the perinatal patient safety team to understand the drivers. • The Trust developed an action plan to address the provider deliverables outlined in the Three Year Plan for Maternity and Neonatal Services. As we approach the end of the three years, a review of the Trust position and the ongoing business as usual oversight arrangements has been conducted. The Trust has made substantial progress with the actions required and has embedded a governance framework to maintain oversight and traction to ensure the actions are embedded in practice.		

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

- In February 2026, the Interim Independent Investigation into Maternity and Neonatal Services in England Report was published. The report sets out the background and changing context in which maternity and neonatal care is provided and highlights 6 factors which are contributing to the pressures on the maternity and neonatal system. The final report is expected to be published later this year.

The reading room contains three documents for reference:

- A detailed overview of the Trust action plan for the Three-Year Plan for Maternity and Neonatal Services.
- An overview of Maternity and Newborn Safety Investigation Reports and subsequent actions.
- Quarter 3 (Q3) Perinatal Mortality Review Report.
</td></tr>
<tr><td>Recommendations</td><td colspan="6">The Trust Board is asked to:

i. Receive and discuss the report.
ii. Note the progress made to deliver the actions included within the Three Year Plan for Maternity and Neonatal Services.
iii. Note the publication of the Interim Independent Investigation into Maternity and Neonatal Services in England Report.
iv. Note compliance with the Perinatal Quality Surveillance Model (PQOM).</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.</td></tr>
<tr><td rowspan="2">Impact

(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☐</td><td>☐</td><td>☒</td><td>☒</td><td>☐</td><td>☐</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">Principal Risk - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.

Threat - Failure to improve the safety and quality of patient and staff experience in Maternity Services.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Previous reports have been presented to the Quality Committee, Maternity Update, Midwifery staffing paper, Maternity Incentive Scheme (Clinical Negligence Scheme for Trusts (CNST)).</td></tr>
</table>

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 perinatal services team.

2. LISTENING TO WOMEN AND FAMILIES THROUGH SERVICE USER FEEDBACK

In the absence of an Integrated Care Board (ICB) commissioned Maternity and Neonatal Voice Partnership (MNVP) model in accordance with the NHS England (NHSE) guidance the Trust continues to develop a comprehensive service user experience programme, collating data from multiple sources, to strengthen the service user experience action plan and support the limited capacity of the MNVP Lead.

The Perinatal Engagement and Inclusion Group (PEIG) has supported the Trust Patient Experience team with the development of a service user infographic, to translate the data captured by the Real Time Right Time (RTRT) into a format which is meaningful to be displayed in wards and departments to share the experience data and the associated actions instigated by the feedback.

REAL TIME PATIENT SURVEY

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

The Patient Experience Team surveys patients every month, **face-to-face, in the hospital,** asking them to score different parts of their experience, in **real time**. They also ask for descriptions of their care. These are their answers for:

WARD NUMBER AND NAME, XXth MONTH 2026*.

*11 patients surveyed on this date.

100% Good or very good patient rating

9/10 Overall patient score

9/10	10/10	10/10
Food	Medicines	Pain control

Quiet at night 10/10

Cleanliness 9/10

"The staff always include me in the conversation. Yes, I'm able to get help when I need support and they're really quick."

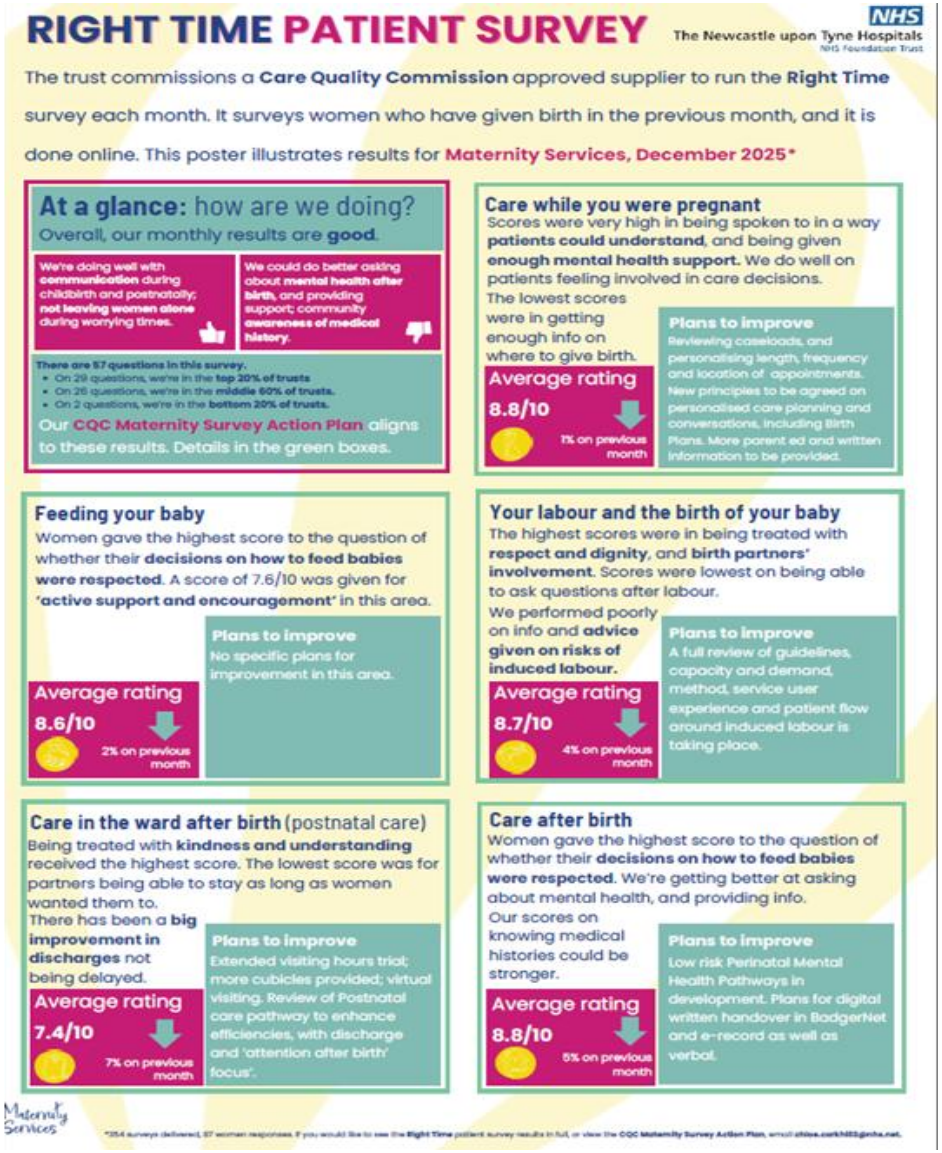
Maternity Services

Respect and dignity	10/10
Coordinated care	9/10
Involvement	10/10
Care team	8/10
Personal care support	10/10

What do patients *say* about their care?

"I didn't have to do any chasing while I've been here. They've been really good to be fair. I've washed and dressed myself, but they did get me towels and stuff. They've helped show me how to change the baby too. The food is actually really nice. They always wash their hands."

"The staff have been good, and I've had a good time here. I've only had the toast. The cleanliness is 10/10. I've never taken any notice about handwashing. The babies are noisy, but it can't be helped."



RIGHT TIME PATIENT SURVEY

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

The trust commissions a **Care Quality Commission** approved supplier to run the **Right Time** survey each month. It surveys women who have given birth in the previous month, and it is done online. This poster illustrates results for **Maternity Services, December 2025***

At a glance: how are we doing?

Overall, our monthly results are **good**.

We're doing well with **communication** during childbirth and postnatally; **not leaving women alone** during worrying times.

We could do better asking about **mental health after birth**, and providing support; community **awareness of medical history**.

There are 57 questions in this survey.
- On 29 questions, we're in the **top 20% of trusts**
- On 26 questions, we're in the **middle 60% of trusts.**
- On 2 questions, we're in the **bottom 20% of trusts.**

Our **CQC Maternity Survey Action Plan** aligns to these results. Details in the green boxes.

Care while you were pregnant

Scores were very high in being spoken to in a way **patients could understand**, and being given **enough mental health support.** We do well on patients feeling involved in care decisions.

The lowest scores were in getting enough info on where to give birth.

Average rating **8.8/10** 1% on previous month

Plans to improve
Reviewing caseloads, and personalising length, frequency and location of appointments. New principles to be agreed on personalised care planning and conversations, including Birth Plans. More parent ed and written information to be provided.

Feeding your baby

Women gave the highest score to the question of whether their **decisions on how to feed babies were respected.** A score of 7.6/10 was given for **'active support and encouragement'** in this area.

Average rating **8.6/10** 2% on previous month

Plans to improve
No specific plans for improvement in this area.

Your labour and the birth of your baby

The highest scores were in being treated with **respect and dignity**, and **birth partners' involvement**. Scores were lowest on being able to ask questions after labour.

We performed poorly on info and **advice given on risks of induced labour.**

Average rating **8.7/10** 4% on previous month

Plans to improve
A full review of guidelines, capacity and demand, method, service user experience and patient flow around induced labour is taking place.

Care in the ward after birth (postnatal care)

Being treated with **kindness and understanding** received the highest score. The lowest score was for partners being able to stay as long as women wanted them to.

There has been a **big improvement in discharges** not being delayed.

Average rating **7.4/10** 7% on previous month

Plans to improve
Extended visiting hours trial; more cubicles provided; virtual visiting. Review of Postnatal care pathway to enhance efficiencies, with discharge and 'attention after birth' focus'.

Care after birth

Women gave the highest score to the question of whether their **decisions on how to feed babies were respected.** We're getting better at asking about mental health, and providing info.

Our scores on knowing medical histories could be stronger.

Average rating **8.8/10** 5% on previous month

Plans to improve
Low risk Perinatal Mental Health Pathways in development. Plans for digital written handover in BadgerNet and e-record as well as verbal.

Maternity Services

*354 surveys delivered, 57 women responses. If you would like to see the **Right Time** patient survey results in full, or view the **CQC Maternity Survey Action Plan**, email [illegible]

The trial of the infographics will be evaluated prior to roll out across other services within the Family Health Clinical Board.

The PEIG has recently completed a triangulation of data from complaints, Patient Advice and Liaison Service (PALS) contacts and MNVP feedback which has been incorporated into the Care Quality Commission (CQC(Maternity Survey Action Plan, along with monthly review of the emerging themes from the RTRT programme.

In Quarter 3 2025/26 16 PALS contacts were received, 2 of which were to celebrate the care provided, and 10 to provide improvement feedback, in addition there were 12 formal complaints. There is an emerging theme regarding the use of BadgerNotes, and information being published to these in a timely manner for the patients to view. Communication regarding care planning and the quality of care remain overarching themes across the perinatal services, with small numbers of complaints for the wards and departments. Complaints breakdown:

- Maternity Assessment Unit 2
- Day Care Unit 1
- Intrapartum services 5
- Postnatal 1
- Transitional Care 2
- Community 1

Whilst there are no immediate trends from a health inequalities perspective further analysis will be conducted in Quarter 4. The patient stories associated with the complaints have been shared widely across the perinatal services and used to inform the educational and development programme.

To ensure the perinatal services hear the voices of women from varied backgrounds MNVP funding has been allocated to the Angelou Centre, which helps black and minoritised women and young people recover after experiencing violence, abuse, and unfair treatment, to understand their experiences of maternity and neonatal care. Listening events are also planned with the organisation ‘Her Circle’ which support women with issues related to complex motherhood and recovery from trauma and abuse. The MNVP Lead will attend these events, supported by specialist midwives, and this valuable experiential information will further inform future engagement and co-production of services.

The MNVP Lead provides PEIG and the Obstetric Board with a monthly update of themes and feedback, again this is shared via internal communications. It is notable that women continue to share that their chosen place of birth is influenced by the facilities, visiting and parking. The extended visiting times across the inpatient wards commenced in February 2026 and will be evaluated via MNVP feedback and the RTRT programme.

Issues continue to be highlighted regarding the quality and accessibility of the interpreting services; this information has been shared with the Trust Experience of Care Group to inform Trust wide improvements.

MNVP Update for MNEG
Date: Dec 25 – Jan 2026
Completed by: Roz Vinton, MNVP Lead for Newcastle

North East and North Cumbria
Local Maternity and Neonatal System

Escalation and risks to take forward	Surveys and listening events undertaken:	Actions/ Improvements undertaken / planned
Awaiting plan for service user engagement and MNVP strategy post March 2026. > Raised at MNEG and flagged as a stakeholder concern on the Regional Heatmap	Christmas Parties in West End of Newcastle in collaboration with **Children North East.** **Neonatal Parent Advisory Group** – Jan Attended **Her Circle** weekly check in session to meet and build relationships before the planned listening event. – Jan 26 Attended **Footsteps** event with parents from the West End. – Jan 26	Self discharge instead of transfer of care for neonatal mums > action to look at this project sitting with the FiCare Moving Around the Network Group.

Perinatal service user feedback themes

Neonatal parents at the PAG raised the issue of maternal health, in particular in relation to self discharge against medical advice in order to be transferred with their babies. This has now been noted at the PAG, at other Newcastle listening events, at Carlisle and at Northumbria. This has been shared with the FiCare Moving Around the Network team as they had also had similar feedback from the NNETS transport team.

Parents from the West End (in the top 10% of deprived areas nationally) spoke overall very positively of the service and care they had received in Newcastle. Several had been teen mams the first time round and spoke of the challenges with being believed and listened to. They were amazed to hear the current continuity now offered to teen mams and felt that would have made a huge difference to their experience of care. One dad from a same sex couple, who had adopted, credits the team at the RVI with saving his daughter's life when the baby's mother was struggling with addiction. He spoke about how the obstetric team had taken extra care to explain the situation with him and his partner. Several years on, all the families talk about how they were spoken to as shaping their experience of care.

Mixed feedback from families of multiple languages. One dad had acted as interpreter for his wife because they felt more comfortable and they had had challenges with the reliability of interpreters, particularly when attending MAU.

Several service users had chosen to give birth at NSECH because of the visiting and parking.

3. WORKFORCE

3.1 Midwifery and nursing workforce

An overview of midwifery staffing fill rates against Birthrate Plus is included within the Integrated Board Report, which also details the red flags recorded monthly and the Operational Pressures Escalation Level (OPEL) status of the service. The Trust is reporting fill rate against Birthrate Plus, whilst acknowledging this will not operationally be delivered until October 2026.

There are no neonatal nursing vacancies, the current over recruitment of nurses on the Neonatal Intensive Care Unit (NICU) is being used to improve nursing staffing ratios on the Transitional Care ward as per the improvement action plan.

3.2 Medical workforce

The Fetal Medicine service remains fragile and is an area of focus, with concerns being shared by midwifery and medical colleagues regarding the capacity and performance of the service; an enhanced support plan is in place pending the successfully recruited team members joining the service during April, in addition the Trust is currently recruiting into sub-speciality posts. There has been month on month reduction in performance with the standard for achieving review of new referrals within 72 hours, this was 31% in January due to the impact of annual leave, as there is limited cross cover for annual leave amongst team due to specialist skills required. Clinical prioritisation of referrals is being conducted to safeguard clinical safety, however there are increased waiting times for appointments leading to a poorer patient and staff experience, despite this there have been no PALS or formal complaints.

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 February.

The Trust is compliant with the British Association of Perinatal Medicine (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 Trust is supporting the Independent Maternity and Neonatal Investigation staff experience survey, as of 2 March 2026 62 responses had been received from the Trust. This is in keeping with the 8,000 responses from across 120 Trusts nationally. It is hoped that participation from the perinatal multidisciplinary team will ensure every voice is heard and will inform national recommendations to improve quality, safety, compassion, and equity in maternity and neonatal care.

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 February 2026.

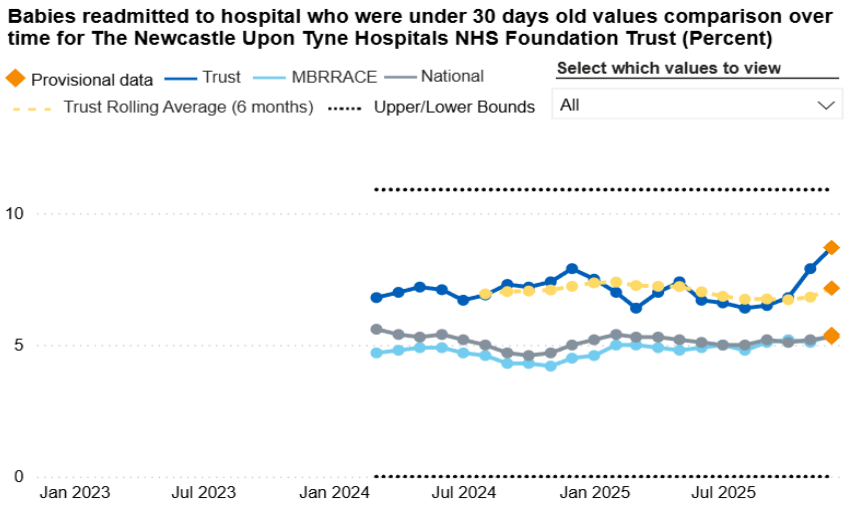
5. STRUCTURES AND STANDARDS UNDERPINNING SAFER, MORE PERSONALISED, EQUITABLE CARE.

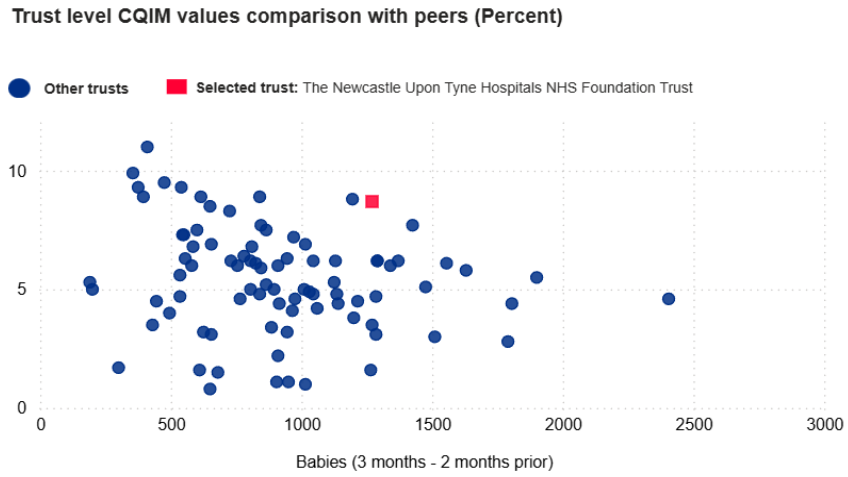
5.1 Clinical Indicator Dashboard

5.1.1 Neonatal Readmissions within 30 days

In addition to the detailed exploration of the factors influencing term admissions to the Neonatal Intensive Care Unit (NICU) the Trust is currently reviewing the neonatal readmission rate. The Clinical Quality Improvement Metrics (CQIM) for ‘babies readmitted to hospital who were under 30 days old’ data is used benchmark the Trust performance against MBRRACE and national performance. In January the readmission rate was 8%, this is currently being reviewed by the Lead Neonatologist for Transitional Care services and the perinatal patient safety team to understand the drivers, it is thought that the stringent management of jaundice guidance introduced following a patient safety incident is influencing the number of babies readmitted for monitoring.

The Trust admits babies from across the ICB into the Great North Children’s Hospital and so a further split of the data to understand the proportion of babies born under the care of the Trust will be considered as part of the review.





5.2 Three Year Plan for Maternity and Neonatal Services

The Three Year Delivery Plan for Maternity and Neonatal Services, published in March 2023, set out how the NHS should make maternity and neonatal care safer, more personalised, and more equitable for women, babies, and families. Services are asked to concentrate on four themes:

1. Listening to and working with women and families, with compassion.
2. Growing, retaining, and supporting our workforce.
3. Developing and sustaining a culture of safety, learning, and support.
4. Standards and structures that underpin safer, more personalised, and more equitable care.

The Trust developed an action plan to address the provider deliverables outlined in the plan and has been tracking progress through a task and finish group, with reporting into Trust Board biannually as part of the Perinatal Quality Oversight Model (PQOM), and to the Local Maternity and Neonatal System (LMNS) via the quarterly PQOM submissions.

As we approach the end of the three years, a review of the Trust position and the ongoing business as usual oversight arrangements has been conducted. (*an updated version of the action plan can be found in the Trust Board Reading Room).*

The Trust has made substantial progress with the actions required and has embedded a governance framework to maintain oversight and traction to ensure the actions are embedded in practice.

Listening to and working with women and families, with compassion

- 25/25 of the actions have been completed and the ongoing monitoring is outlined to maintain process and embed the actions.

Growing, retaining, and supporting our workforce

- 34/35 actions have been completed and the ongoing monitoring is outlined to maintain process and embed the actions.
- 1 action outstanding, administration review to ensure adequate support service wide, updates will be provided to Obstetric Board and Business Group until completion.

Developing and sustaining a culture of safety, learning, and support

- 36/39 actions have been completed and the ongoing monitoring is outlined to maintain process and embed the actions.
- 1 action outstanding, develop Professional Midwifery Advocacy (PMA) model, the People and Culture Group will maintain oversight of the deployment of the PMA model and embedding of hot & cold debrief processes.
- 2 actions abandoned as no longer appropriate.

Standards and structures that underpin safer, more personalised, and more equitable care.

- 12/15 actions have been completed and the ongoing monitoring is outlined to maintain process and embed the actions.
- 1 action outstanding, to complete the national maternity self-assessment tool and use the findings to inform maternity and neonatal safety improvement plans, this will be reported to Obstetric Board in March 2026.
- 2 actions abandoned as no longer appropriate.

6. NATIONAL UPDATES

6.1 Amos review

In February 2026, the Interim Independent Investigation into Maternity and Neonatal Services in England Report was published. The report sets out the background and changing context in which maternity and neonatal care is provided and highlights 6 factors which are contributing to the pressures on the maternity and neonatal system. These are as follows:

1. Capacity pressures
2. Culture and leadership
3. Racism and discrimination

4. Poor responses and lack of accountability when things go wrong
5. The quality of estates
6. Workforce

The PQOM reports to the Trust Board have briefed on these topics, and have highlighted the Trust challenges, successes and associated ongoing workstreams.

Baroness Amos outlined that by taking a whole system approach which understands different perspectives with the intention of developing recommendations which will enable a step change in the provision of maternity and neonatal services in England.

There are a number of additional areas of work which will be taken forward in the next phase of the investigation, which includes concluding analysis of previous recommendations made to improve maternity and neonatal care and evidence from national stakeholder organisations to provide insights into governance and organisational structures, training, regulation and funding pathways for the different elements of maternity and neonatal services. The final report is expected later this year.

7. CONCLUSION

The Trust Board are provided with an update on the main quality and safety considerations of the perinatal service, demonstrating the Trusts compliance with the Perinatal Quality Oversight Model. The Trust is not currently expected to respond to the findings of the Interim Independent Investigation into Maternity and Neonatal Services in England Report and is awaiting further direction following the publication of the final report later this year.

8. RECOMMENDATIONS

The Trust Board is asked to:

i. Receive and discuss the report.
ii. Note the progress made to deliver the actions included within the Three Year Plan for Maternity and Neonatal Services.
iii. Note the publication of the Interim Independent Investigation into Maternity and Neonatal Services in England Report.
iv. Note compliance with the Perinatal Quality Surveillance Model (PQOM).

Report of Ian Joy
Executive Director of Nursing
13 March 2026

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Agenda item A2(h)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	27 March 2026					
Title	Integrated Care Board (ICB) Aubrey Self-Assessment					
Report of	Patrick Garner, Director of Performance and Governance Rachel Carter, Director of Quality & Safety					
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	In November 2025, an Independent External Review of Governance within the Breast Surgery Services at County Durham and Darlington NHS Foundation Trust undertaken by Mary Aubery was published. In response to the serious and longstanding weaknesses identified as part of the review The North East and North Cumbria Integrated Care Board (ICB) have requested that the Trust undertake a structured self-assessment across 4 domains, aligned with the findings from the Aubery report: • Leadership and Governance • Quality of Care • Workforce and Culture • Finance and Contracting Executive Team Members have been aligned to each of the domains and were asked to provide statements in relation to the key lines of enquiry provided by the ICB. All responses have been collated and assurances statement written for each domain to provide a comprehensive self-assessment document as well as detailing any gaps in compliance identified based on the information and evidence provided. The Trust plans to complete a full internal review of governance in response to the Aubery report finding which will be presented to Audit, Risk and Assurance Committee and Public Trust Board in May 2026.					
Recommendation	The Trust Board are asked to: • Discuss and review the information provided in the self-assessment. • Approve the Self-Assessment. • Provide any feedback.					
Links to Strategic Objectives	1. Quality of care will be our main priority.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☒	☒	☐

Link to Board Assurance Framework [BAF]	Failure to implement effective governance systems and processes across the Trust to assess, monitor and drive improvements in quality and safety.
Reports previously considered by	Executive Team Meeting, Audit, Risk and Assurance Committee.

ICB AUBERY SELF ASSESSMENT

1. INTRODUCTION

In November 2025, an Independent External Review of Governance within the Breast Surgery Services at County Durham and Darlington NHS Foundation Trust undertaken by Mary Aubrey was published. The independent external governance review of the Breast Surgery Services was commissioned after informal feedback from the Royal College of Surgeons of England (RCS), following its Invited Service Review in January 2025.

In response to the serious and longstanding weaknesses identified as part of this review The North East and North Cumbria Integrated Care Board (NENC ICB) requested that the Trust undertake a structured self-assessment across 4 domains, aligned with the findings from the Aubery report:

- Leadership and Governance
- Quality of Care
- Workforce and Culture
- Finance and Contracting

2. SELF ASSESSMENT PROCESS AND SUMMARY

Executive leads were aligned to each area and asked to provide information in relation to each key line of enquiry. All information has now been collated, and an assurance statement has been written for each domain to provide a comprehensive self-assessment document with any gaps in compliance identified based on the information provided.

The full self-assessment document is provided in Appendix 1 of this report.

3. IMMEDIATE ACTIONS IDENTIFIED

Following completion of the ICB Aubrey Self-Assessment the following immediate actions have been identified:

Domain	Action
Leadership and Governance	• Full root and branch review of policy management. • Implement mechanisms to improve identification of areas of concern or gaps in operational resilience.
Quality of Care	• Root and branch review of external review and inspections, including Get-It-Right-First-Time (GIRFT). • Implement process for triangulation of incident, claims and complaints data at clinical board level.

Domain	Action
Workforce and Culture	• Further improve leadership development offer. • Embed civility interventions and mediation processes. • Develop and implement integrated well-being support. • Review and update Job planning policy. • Review locum management process, oversight, governance and assurance reporting mechanisms. • Review and update medical appraisal policy. • Finalise medical appraisal quality assurance process with peer organisation.
Finance and Contracting	• Review business case template to ensure workforce training and governance oversight is included. • Complete a full review of contracting and commissioning service provision. • Develop and implement service level contracting and commissioning policies and processes, including governance, oversight and reporting mechanisms. • Implement central repository of all service level contracts. • Implement central repository of all insourcing and outsourcing. • Consider internal audit of contracting to be added to internal audit plan.

The Trust plans to complete a full internal review of governance in response to the Aubrey report finding which will be presented to Audit, Risk and Assurance Committee and Public Trust Board in May 2026.

4. RECOMMENDATIONS

The Trust Board are asked to:

- Discuss and review the information provided in the self-assessment.
- Approval of the Self-Assessment.
- Provide any feedback.

Natalie Yeowart
Head of Corporate Risk and Assurance
17.03.2026

Appendix 1 ICB Aubrey Self-Assessment March 2026

Leadership and Governance		
Domain	**Key Lines of Enquiry**	**Statement**
Governance, Leadership and Assurance Structures	• What arrangements are in place to ensure oversight of good governance at board level? • Who has overall accountability and responsibility for clinical with regards to the provision of clinical services? • Who have overall accountability and responsibility for corporate governance, compliance and assurance. • Can you demonstrate how your Group Board has oversight of clinical quality and safety across your organisation?	Robust arrangements are in place across the Trust to align ward to board governance and assurance. The Trust has a ward to board organisational structure which is underpinned by an overarching Trust governance structure. The Trust Board compromises of Executive and Non-Executive Directors (NEDs), operating as a unitary board and has collective responsibility for the overall performance of the Trust and setting the organisational strategy. The Trust Board has well established assurance Tier 1 committees (Quality, Finance and Performance, People, Digital and Data and Audit, Risk and Assurance) as well as Tier 2 Committee groups in place. Tier 1 committees are chaired by NEDs, and all have an Executive Lead assigned. The Tier 1 Committees have a key role in seeking and providing assurance to the Trust Board. Committees receive written reports and in person updates from Tier 2 groups, senior staff and operational leaders across the Trust. Committees report directly into Trust Board meetings through a newly established triple A assurance and escalation report, minutes and updates from NED chairs and lead Executive Team members, to provide assurance or highlight any gaps in assurance for consideration. The Trust have a clinical Triumvirate in place consisting of the Executive Director of Operations, Joint Medical Directors and the Executive Director of Nursing and AHP, who lead on the delivery of clinical services within the Trust. The Director of Performance and Governance also has accountability and responsibility for corporate assurance, compliance and governance. There is robust oversight of clinical quality and safety across the organisation. Each Clinical Board has a Monthly Quality Oversight Group (QOG) which is led by a Quality and Safety Lead (Senior Consultant) and supported by a non-medical Quality and Safety Lead. There is a standardised terms of reference in place across each QOG. All departmental/ speciality governance meetings feed into the QOG, reporting by exception any quality and patient safety concern or good practice. Robust arrangements are in place across the Trust to align ward to board governance and assurance. The Trust has a ward to board organisational structure which is underpinned by an overarching Trust governance structure. Each Clinical Board then has a monthly Quality and Safety Performance Review (QPR) which is Executive. led and has a schedule of business covering quality and safety, performance, Risk, finance and people. During the QPRs the Clinical Board leadership team present information on the four domains to provide oversight, assurance, seek advice or escalate areas of concern directly to the Executive Team. This is further supplemented by quality and safety management groups attended by both corporate, clinical and operational staff focusing on key areas of quality and safety e.g. Patient Safety Group, Infection Prevention and Control Group, Experience of Care Group, Clinical Outcomes and Effectiveness Group)
Good Governance embedded at every level.	• What structural/meeting arrangements are in place to align ward to board governance and assurance? • Does this enable consistency, transparency and effective challenge across the organisation? • Are escalation pathways for issues clear and responsive? • Does this include plans for example, managing emerging risks, regulatory scrutiny, Patient safety concerns.	There is robust oversight of clinical quality and safety across the organisation. Each Clinical Board has a governance structure in place which cover key Areas of clinical and corporate business including quality and safety, performance, risk, people and finance which report into a Quality and Safety Performance Review (QPR) chaired by a member of the Executive Team. Quality and Safety Performance Reviews, and a formal report is presented to the Trust Board by the Director of Performance and Governance ensuring a ward to board escalation process is in place. These meetings are attended by operational, clinical and corporate representatives, all have clear terms of reference, agenda's, papers and minutes ensuring the Trust can evidence consistent, transparent and effective discussions and challenge takes place across the Trust.
Policies and Procedures	• What arrangements are in place to ensure all Policies and Procedural Documents including Standard Operating Procedures (SOPs), are up to date and have received approval? • Are arrangements clear on the authority to approve or ratify each type of document?	Trust wide arrangements are in place to ensure all policies are up to date and have received approval. All policies have a named individual with overall responsibility for individual policies including review, updates, monitoring and approval. A policy on policies in place to ensure staff comply with Trust standards in relation to the management of policies with a policy template which includes approval date and expiry. Processes and flow charts are in place documenting the arrangements for approval and ratification of policies with initial approval by the parent group/committee prior to final approval and ratification at Clinical Policy Group (CPG). The Trust has a total of 358 policies, of which 80% (285) are compliant, 20% (73) are non-compliant. Processes are in place to support and guide staff to review and update policies, reminder emails are sent to policy authors and responsible group/ committee chairs 6 months prior to, and on expiry.

Appendix 1 ICB Aubery Self-Assessment March 2026

	• Are all policies in date, with a review date and, if extended, a new deadline for completion within policy? • Are overdue policies tracked and escalated to Committee or Board? • Is there a policy/procedural document register which is reviewed at speciality / operational group meetings and by Senior Leadership? • When were these arrangements last reviewed and reported on?	The Trust Compliance and Assurance Group, a tier 2 group of the Audit, Risk and Assurance Committee have responsibility for the monitoring and seeking assurance in relation to policy compliance. The Compliance and Assurance Group have commissioned the establishment of an task and finish group to undertake a full root and branch review of policy management with a view to revising and making improvements to the Trust's policy management approach.
Risk Register Governance	• What arrangements are in place to ensure timely identification, escalation, and resolution of risks? • What arrangements are in place for regular review of all specialty and operational group risk registers? • What arrangements are in place to escalate risks that remain static or overdue? • Is there sufficient consideration and oversight of risks linked to clinical audit findings, NICE non-compliance, and patient safety incidents? • Have audits taken place on the timeliness and quality of risk registers, reporting and updates, with findings reported to the Audit Committee?	The Trust has robust arrangements in place for risk management across the Trust to ensure the identification, reporting, escalation and mitigation of risks. A Risk Management Policy and procedure is in place across the Trust which has clear processes and procedures in place for the identification, management, review and mitigation of risk. Clinical Boards have strong risk management governance processes in place; all risks are reviewed on a quarterly basis by risk owners and reported through speciality governance meeting and then to Clinical Board governance meetings. Each Clinical Board has a Quality and Safety Lead and Governance Lead in place to actively support staff in the management and review of risk. Risks are escalated from Speciality to Clinical Board, any risks of concern are then reported by exception in Quality and Performance Review Meetings, reviewed at Risk Validation Group and reported to Audit, Risk and Assurance Committee. The Risk Validation Group is a tier 2 group reporting to the Audit, Risk and Assurance Committee, chaired by the Director of Performance and Governance, and represented by each clinical board and corporate service, responsible for trust wide oversight of risk management. The Group meets on a monthly basis and validations all new, closed, tolerated risks, action mitigations, risks overdue review and static risks. The Group provides advice and guidance in relation to risk management, monitor key risk performance indicators in relation to risk to ensure compliance with risk management policy and complete risk deep dive's whereby each Clinical Board attends to present and overview of their risk register and associated governance procedures. The risk management process and governance in place allows for the consideration of clinical risks associated with audit finding and NICE non-compliance. The Clinical Audit process includes a risk assessment of each key finding to assess the risks associated, non-compliance with NICE guidance is risk assessed using the risk management framework to determine the level of risk for each non-compliance. Quality and Safety Governance is in place to ensure the Trust has sufficient consideration and oversight of clinical audit and NICE via the Clinical Audit and Guidelines Group, which reports into the Clinical Outcomes and Effectiveness Group and onto Quality Committee. Patient safety incident investigations are completed with consideration of any residual risks as part of the investigation, of which there is oversight at the Patient Safety Incident Forum and Tier 2 Patient Safety Group. Any areas for escalation are raised at other relevant groups or Committees such as Risk Validation Group and Quality Committee as required. AuditOne Internal Auditors complete an annual plan of audit in the Trust, a core audit completed annually within this plan is an audit of risk management. The last Internal audit on risk management completed by AuditOne returned a good level of assurance that governance, risk management and control arrangements are managed effectively and a high level of compliance with the control framework was taking place. The risk management audit report is presented to the Audit, Risk and Assurance Committee annually.
Operational and Service Governance	• What arrangements are in place for accountability, tracking, and feedback for escalated concerns from specialty and operational group, for example care groups / business units etc.? • Are responsibilities and accountability understood set out within an accountability framework? • Are there formal mechanisms for regular evaluation, ensuring	Trust arrangements are in place to ensure accountability, tracking and escalation across the Trust. The Accountability Framework sets out the Trust's approach to performance management, governance and accountability, a key element of the Framework is distributed leadership, which is supported through the accountability and autonomy, ensuring responsibilities are understood in relation to decision making and when escalation is required to the Executive Team. Operational Governance Structures are in place across the Trust. Each Clinical Board has a governance structure in place which cover key areas of clinical and corporate business including quality and safety, risk, people, finance and performance which report into a Quality and Safety performance Review (QPR) chaired by a member of the Executive Team. A report outlining the escalations form the monthly Quality and Safety Performance Reviews is presented to the Trust Board by the Director of Performance and Governance ensuring a ward to board escalation process is in place. Clinical Boards have also been supported by the Trust's external governance partner, The Value Circle who have delivered a full development programme focussing on areas of leadership and governance.

Appendix 1 ICB Aubery Self-Assessment March 2026

	performance measures are actively maintained? • How are significant review findings shared between with the specialty and operational groups, patient safety team and, where appropriate, escalated to executive and the Board? • Do the executive have sufficient operational oversight, including risks of service continuity to ensure safe and effective care for patients? • What arrangements are in place for addressing external concerns/enquiries, for example safeguarding / CQC / NMC / GMC? • What arrangements are in place for joint /multidisciplinary governance frameworks between services? • How are lessons learned, and improvements systematically shared and embedded across all teams, specialties and care groups?	There are structures in place to ensure multidisciplinary / multiple service governance across the Trust where this is required for example the Trust wide Transplantation Committee or Trust Cancer Board in addition, Trust Management Group and Clinical Policy Group also offer Trust wide forums to discuss problems, issues and gain agreement on changes when required. Improvements are driven by our four cross Trust improvement workstreams, Outpatients, Theatres, Urgent and Emergency Care and Diagnostics. Improvements in these areas are tracked by Access and Improvement Delivery Group, a Tier 2 Group feeding into finance and Performance Committee. The Compliance and Assurance Group (CAG), a tier 2 committee of the Audit, Risk and Assurance Committee (ARAC) has responsibility for the oversight and assurance in relation to all external reviews. A compliance report is provided to CAG at each meeting. External reviews and recommendations are part of the Clinical board QOG terms of reference. Any areas for escalation are raised via QPRs and onto Trust Board as required. Exernal concerns and enquiries are triaged to the responsible Executive Team member or deputy, for example NMC concerns/enquires are addressed by the Director of Nursing, recorded and tracked on a central log and supported by HR colleagues. GMC queries are addressed by the Joint Medical Directors, considered at a Clinical Oversight Group, recorded and tracked on a central log and supported by the Medical Workforce Team. CQC queries are addressed by the Executive Director of Nursing and AHP, recorded and tracked on a central log and supported by the Quality and Safety Department.
Quality of Care		
Domain	• **Key Lines of Enquiry**	**Statement**
Clinical Leadership	• What arrangements are in place to explain how the CMO and CNO share clinical leadership? • What arrangements are in place on how clinical governance is managed to provide independence, challenge, and assurance? • How does the Quality Committee actively challenge clinical leadership when patient safety concerns arise?	The CMOs and CNO have joint responsibility for clinical leadership, both are active members of all Quality and Performance Reviews (QPR) and chair tier 2 committees/ groups in relation to quality and safety. There is robust oversight of clinical quality and safety across the organisation. Each Clinical Board has a Monthly Quality Oversight Group (QOG) which is led by a Quality and Safety Lead (Senior Consultant) and supported by a non-medical Quality and Safety Lead. There is a standardised terms of reference in place across each QOG. All departmental/ speciality governance meetings feed into the QOG, reporting by exception any quality and patient safety concern or good practice. Each Clinical Board then has a monthly Quality and Safety performance Review (QPR) which is Exec. led and has a schedule of business covering quality, performance, Risk, finance and people. During the QPRs the Clinical Board leadership team present information on the four domains to provide oversight, assurance, seek advice or escalate areas of concern directly to the Executive Team. This is further supplemented by quality and safety management groups attended by both corporate, clinical and operational staff focusing on key areas of quality and safety e.g. Patient Safety Group, Infection Prevention and Control Committee, Experience of Care Group, Clinical Outcomes and Effectiveness Group) The Quality Committee provide independent oversight, challenge and assurance in relation to clinical governance through monthly review of the Integrated Board Report, monthly/bimonthly reporting from Improvement Groups, deep dives into areas of concern and regular safety and quality reports. Members of the Quality Committee actively discuss, challenge and test the evidence, seeking assurance from clinical leaders to demonstrate understanding of issues, progress and assurance as well as seek out areas of learning and improvement. In addition, a Quality Committee Non-Executive Director (NED) is an active member of the Trust Patient Safety Group, a monthly Tier 2 group reporting into Quality Committee which provides further oversight and scrutiny of Trust wide patient safety issues.
Oversight of Duty of Candour (DoC)	• What arrangements are in place for DoC monitoring, reporting and escalating? • Does the Trust have a system in place which enables DoC to be initiated	All safety events are recorded on Inphase, the Trusts local risk management system (LRMS), for any events that are recorded as moderate physical or psychological harm or above Duty of Candour (DoC) is required. All moderate plus safety events are discussed at a Trust wide safety Multi-Disciplinary Team (MDT) Meeting where an appropriate learning response is agreed. DoC compliance is monitored as part of this MDT meeting and escalated through the relevant clinical governance groups and committees including Patient Safety Group and Quality Committee.

Appendix 1 ICB Aubery Self-Assessment March 2026

	immediately upon identification of harm which meets the statutory threshold? • Are Patient Safety Leads involved from the outset and is the Trust acting in accordance with Regulation 20? • Is compliance with DoC regularly audited and reported through formal governance processes, with clear escalation protocols and accountability for any delay or deviation? • Have all relevant staff received training on recognising and responding to notifiable incidents? • When were DoC arrangements last reviewed and reported on?	The Trust have a DoC dashboard in place for all Clinical Boards (CB) which is accessible via the Trust wide reporting hub providing a ward and department level data in relation to DoC. This data is linked to the Inphase system and is automatically refreshed daily to support timely DoC completion. The dashboards also enable compliance monitoring across a CB to either provide assurance or escalation through individual CB governance processes including the Quality Oversight Groups and Quality and Safety Performance Reviews. Training is provided to staff in relation to patient safety incident management and investigation, guidance is available to staff through policies, procedures and guidance documents on the Trust Intranet page and support is provided by the central Patient Safety Team in relation to compliance with Regulation 20. Compliance with DOC is monitored and escalated though Quality Committee through the Integrated Board Report. In addition to this, a quarterly audit is presented to Quality Committee to review the quality of DoC responses, and to provide further assurance or areas for escalation regarding compliance with the Trust Policy and Regulation 20.
External Reviews and National Audits	• What arrangements are in place to ensure all external reviews, national audits, and patient experience surveys are formally discussed at Board level? • What arrangements are in place to ensure all external reviews have a formal action plan, named clinical and executive leads, and defined reporting timelines through governance arrangements? • Is there an established a framework for responding to external reports, a tracking/updating system in place to ensure delivery and formal sign-off by the Board. • Has the trust commissioned any independent reviews, for example, where quality signals are unclear or concerning? Have these been escalated to and shared with the ICB/ NHSE? • What arrangements are in place to ensure learning and improvement takes place from external benchmarking reports? • What arrangements are in place to ensure clinical and executive leaders have training in interpreting and probing assumptions? • What arrangements are in place to triangulate patient feedback, complaints, and incident data?	External reviews are not formally discussed at Trust Board unless specially required. The Compliance and Assurance Group (CAG), a tier 2 committee of the Audit, Risk and Assurance Committee (ARAC) has responsibility for the oversight and assurance in relation to all external reviews. A compliance report is provided to CAG at each meeting. External reviews and recommendations are part of the Clinical board QOG terms of reference. Any areas for escalation are raised via QPRs and onto Trust Board as required. When the Quality and Safety Department is notified of an external agency visit, it will contact the relevant clinical board to ascertain who the clinical/ operational lead is for the visit. As part of the Clinical Board QOG TOR's external benchmarking reports i.e. external reviews, NCA are part of the cycle of business. Where recommendations are made or outlier status identified these should be discussed, identifying key learning points and improvements for the Clinical Boards. Where appropriate, Trust wide forums such as Clinical Risk Group are also used to share learning widely across the organisation. Each visit is added to a central tracker which logs the date of the visit, the external agency visiting and any recommendations made. Clinical Boards are provided with a monthly 'Directorate Profile' which details all outstanding actions/ action plans arising from external visits and asks for updates where these are available. Additionally, the profile prompts the receipt of any new external review reports and associated recommendations/ actions. The Trust Access and Delivery Group also receives updates on GIRFT recommendations to support oversight, challenge and delivery of the recommendations. As part of Clinical Board QOG and QPRs data is presented in relation to patient feedback, complaints and incidents. This provides an opportunity to triangulate themes across these three domains. In addition, the Integrated Board Report provides data to Trust Board and other reports including the above are regular presented to the Trust Quality Committee. The Trust have commissioned two independent external reviews in recent years relation to CQC Well Led and Cardiothoracic Service both of which were escalated and shared with the ICB and CQC with regular communications and progress reports provided. The Trust have identified that some gaps exist in relation to the external review process and plan to complete a root and branch review of the external review policy, processes and procedures to ensure robust monitoring and reporting is in place. The Trust have a central GIRFT Oversight Group in place reporting to Clinical Outcomes and Effectiveness Group. However, due to the multi-faceted nature of GIRFT, there are now several governance routes monitoring and reporting on areas of GIRFT and review and consideration is needed in relation to the Trust approach going forward. National Clinical Audits (NCAs) are not formally discussed at Trust Board. Clinical Board and departmental baselines assessments are discussed at Clinical Audit and Guidelines Group and escalated to Clinical Outcomes and Effectiveness group), which is a Tier 2 group reporting to Quality Committee. The NCA process is managed centrally by the Clinical Effectiveness Team within the Quality and Safety Department. All NCA results should also be discussed at local clinical governance meetings (speciality level) and escalated up to the Clinical Board QOG where outlier status is identified. Where this cannot be managed by the QOG, Clinical Boards should report by exception into the Quality and Performance Review (QPR) process and complete a risk assessment to identify and consider any risks for addition to the risk register. Each Clinical Board is also required to present audit data annually at CAGG, including NCA activity and results.

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Patient Experience and Patient Safety Data	• What arrangements are in place to ensure oversight of all national patient experience surveys? • Are all national patient experience surveys reported timely to Quality Committee and /or Board? • What arrangements are in place at operational and service level to develop and implement formal action plans in response to Patient Experience Surveys? • How are service and operational groups held to account, and how is non-compliance with plans escalated? • How are patient representatives actively involved in action planning, meaningful engagement and co-production? • How are persistent non-compliance or poor outcomes are raised in Quality Committee and/or to the Board? • What arrangements are in place to triangulate data from complaints, claims, and incidents to identify themes and improve quality and safety, within each specialty and operational group?	The Trust has robust processes in place to ensure the oversight of national patient experience surveys; all national surveys are received into the organisation and co-ordinated through our Patent Experience Team who are aligned to the Director of Quality and Safety with direct links to the Quality and Safety Department. The Patient Experience Team oversee and co-ordinate patient experience data review and analysis, linking with relevant clinical areas based on the focus of the survey. The Executive Director of Nursing, Midwifery and Allied Health Professionals provides executive oversight of this work. This includes data review and analysis. All national patient experience surveys are reported into the Quality Committee. This includes an overview of the results, benchmarking against previous year's results to understand trends and a breakdown of statistically significant movement on individual questions. The national patient surveys compliment the Trust's Real Time and Right Time patient experience programme. The real time and right time programme ensure near real time data capture of 40 in –patient wards monthly and right time programme focusses on all patients, two weeks after their care episode. All information (national and local survey data) is shared with local clinical leaders discussed through local clinical governance routes with local actions agreed. This is overseen by Clinical Board Quality Oversight Groups and discussed through monthly Quality and Performance Reviews. Action plans for specific surveys (Maternity, National Cancer Survey, Palliative and End of Life) are overseen within Clinical Boards. In May 2025, the Trust established a new Partnership and Involvement Panel made up of Involvement Partner volunteers. The panel meets monthly to provide a patient perspective on issues such as research proposals, service improvement ideas and quality improvement initiatives. In addition, Involvement Partners may join working groups within the Trust to offer an ongoing patient voice. Some of the projects presented to the Panel have a patient safety aspect; examples include the Medicines Management Oversight Group and Deciding Right Steering Group, Rapid Action and Review Meeting (RARM), Patient Safety Incident Forum meeting and Patient Safety Group. The Trust Integrated Board Report is used to monitor quality metrics such as incident reporting, Duty of Candour (DoC), complaints dashboard. Recurrent non-compliance is challenged at Quality Committee which has led to the deep dive report for DoC and escalation to improve the complaints dashboard metrics – quality and timeliness of responses. It is recognised that further system development is required to ensure the triangulation of data from complaints, incidents and claims in the Clinical Boards to improve identification of trends and inform future improvements in quality and safety.
Workforce and Culture		
Domain	• **Key Lines of Enquiry**	**Statement**
Culture, Behaviour, and Accountability	• What arrangements are in place to develop an open, transparent and restorative culture and promote a culture where staff feel safe to speak up about behaviour, team and leadership issues? • What arrangements are in place to ensure actions are taken in response to behavioural concerns? • What plans are in place a cultural and/or behavioural improvement programme to drive a values-based approach to leadership? • What arrangements are in place to involve staff with organisational and patient safety priorities?	The Trust has clear newly established arrangements to promote and support an open and transparent culture, underpinned by the development of a Freedom to Speak Up (FTSU) infrastructure, Trust wide Behavioural Standards and Civility Charter, compassionate leadership development, and integrated wellbeing and psychological safety support. Several confidential reporting routes have been created for staff including FTSU, Occupational Health, Staff Psychology/Working Well, Trade Unions, Work in Confidence and Staff Network, ensuring colleagues feel safe to raise concerns and have confidence that issues will be acted on, for example, the enhanced Resolution Service, supported by 54 trained facilitators, now provides early mediation and restorative conversations to prevent escalation. Large scale programmes have been completed by the Trust to ensure behavioural concerns are responded too such as civility training for more than 14,380 colleagues, compassionate leadership development (106 leaders trained, 47 awaiting), and corporate induction for over 5,217 staff help embed values and expectations across the workforce. Regular 1:1s, team check ins, behavioural standards and visible Board level role modelling further reinforce psychological safety. Staff engagement is strengthened through surveys, listening events, Schwartz Rounds and "You Said, We Did" feedback loops, supported by data insight (absence, turnover, ER cases) to identify hotspots requiring targeted cultural support. The Trust has established a Working Well programme which aims to integrates Occupational Health, Staff Psychology and HR to support staff experiencing behavioural or leadership issues through coaching, counselling, restorative meetings and team-based interventions that will rebuild trust and reset culture. This provides targeted support for teams where relationships, behaviour or leadership challenges are impacting safety or wellbeing. While these foundations are established in the Trust it is recognised that there is a need for this to go further to ensure a more consistently embedded approach for our staff. There is ongoing work across leadership development, civility interventions, mediation, integrated wellbeing support and strengthened

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	• How does the trust ensure transparent reporting to maintain staff trust and organisational assurance? • What is in place to embed sustainable workforce practices? • What is in place for workforce planning and succession strategies • Are there clear escalation routes and accountability structures for disputes or non-compliance?	accountability which will continue to build a value based, psychologically safe environments where colleagues feel supported and confident to speak up without hesitation.
Job Planning Governance	• What arrangements are in place for a Trust-wide, system-led, centrally monitored job planning framework? • Does the job planning framework have an annual audit to monitor compliance, quality, consistency, equity, and contractual alignment? • Does the job planning framework have executive oversight, with clear accountability for compliance in line with the NHS England Medical Job Planning Guidance? • Is training provided for all staff involved in job planning and review? • Is job planning and aligned with service needs and integrated into appraisal, revalidation and workforce assurance processes?	Over the last 18 months the Trust has reviewed and updated its job planning framework to ensure that job plans accurately reflect the activity, which is to be delivered, provide adequate time for training and education and SPA activities more broadly and contain clear personal and Directorate level objectives. The new framework and its implementation are in line with National Job Planning Guidance. A Trust-wide job planning framework is in place, led by an Associate Medical Director Lead with Executive Oversight by the Joint Medical Director. The Job Planning Oversight group chaired by a joint Medical Director with HR and LNC representation is responsible for monitoring of implementation and delivery of the job planning policy. A job planning advisory group to monitor consistency of job planning reporting to the oversight group is being established. An appeals panel is also established to allow discussions and consideration where agreement cannot be reached through normal channels. Job planning is carried out between individual doctors and dentists by Clinical Directors with operational manager involvement. All Job Plans are reviewed and approved by the Joint Medical Director and Associate Medical Director. Job planning is monitored and reported through these arrangements to the People Committee, Quality Committee and to Trust Board. The Trust has documented processes and procedure for job planning, guidance documents and detailed user guides are in place to support staff involved in job planning. Training has been provided for Clinical Board Chairs, Clinical Directors and individual clinicians during 2025-2026 and will be updated for 2026-27. The Trust uses the Rotamap product – Medirota for e-rostering of medical and dental staff. This is aligned with payroll cycles and interfaced directly with the Electronic Staff Record (ESR). This allows monitoring of activity which is being delivered from the agreed job plans. A review of the agreed job plan is part of the medical and dental appraisal process which informs recommendations for revalidation. The outputs of appraisal in the personal development plan in turn inform the job planning discussion. Current Trust compliance with Job planning as at March 2026 is approximately 90%. Job Planning is included within the AuditOne Internal Audit Plan and will next be audited as part of the Internal Audit 26/27 plan. In line with the NHS Conflicts of Interest and to ensure compliance with the Health and Care Act the Trust undertakes an annual declaration of interest process, which allows for all decision makers (clinical and non-clinical) to submit any interests or submit a nil return. Declarations are included and considered for those staff subject to job planning and medical appraisal. A Declaration system is in place, declare that supports the coordination of the process, which automates emails to all staff required to submit a declaration of interest with reminders send on a weekly basis. Guidance is available for staff in relation to what must be declared. The 2025/26 process began late February and ends in May, once the process closes in May 2026, the data is collated and a report is written to the Audit, Risk and Assurance Committee to provide assurance on compliance with declaration, any non-compliance is reported within the report and escalated to the Executive lead responsible. The Trust does not currently have an agreed compliance target however in 2024/25 the Trust compliance with declaration of interest was 77%, which was an increase of 9% on the previous year.

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Oversight and Governance of Locum Consultant Contract	• What arrangements are in place for oversight and governance of Locum Consultant Contracts to ensure that no consultant is practicing outside their scope of practice? • Are timely contract reviews, renewals, and regulatory compliance in place for all consultant appointments, including locums? • Are all consultants formally verified against appropriate section of the GMC Specialist Register prior to appointment or contract renewal? • What plans are in place to ensure core requirements under NHS Employers' standards and fundamental safeguards are in place? • If any doctors are appointed to locum consultant positions who are not on the Specialist Register, are they formally recorded as committed to achieving Specialist Registration, with a clear tracking mechanism to monitor progress? • Is this reported/monitored by an executive committee or board?	The Trust has arrangements in place for the oversight and governance of locum consultant contracts. Clinical Boards have a responsibility for establishing locum consultant posts and are responsible for seeking approval from the Clinical Board Chair and Joint Medical Director to recruit to such posts through the established medical recruitment process including a job description, person specification and job plan. Fixed term posts are reviewed regularly with managers who are asked to confirm plans for the posts going forward. General Medical Council (GMC) registration is checked as part of the recruitment process, along with the other NHS Employers' check standards. Reports on GMC registration compliance are run monthly, and any concerns are reported to the Clinical Board. Where a locum consultant is appointed to a post pending achieving specialist registration, progress on this is monitored. This type of appointment only occurs when there is a known date for achieving specialist registration, for example, when an individual is within 6 months of completion of training and they have attained all competencies required for the role. Monitoring of this is currently at Clinical Board level but consolidated reporting of this to People Committee with begin in 2026-27.
Appraisal Framework	• What arrangements are in place to ensure the medical appraisal framework, enables accurate linkage of incidents, complaints and claims to the consultants involved? • What arrangements are in place to ensure objectivity and clinical oversight of medical appraisals? • What arrangements are in place to ensure robust oversight of appraisal performance and compliance, including appraisal compliance reporting by core service and professional group, across both medical and non-medical workforce? • What training is in place for all appraisers to give assurance on consistency and quality of appraisals?	The Trust has a medical appraisal framework in place with to ensure that senior medical and dental staff appraisal is completed in keeping with stipulated time limits. This is monitored by the revalidation team through weekly meetings with the Trust appraisal lead and Joint Medical Director. Supporting information is provided to support to completion of appraisal set out focusing on good medical practice, including information on scope of practice, continued professional development, quality improvement activity, significant events, complaints, compliments and colleague and patient feedback ensuring objectivity through a structured, evidence-based approach. Information on incidents, complaints and claims is provided to individual clinicians in a consolidated form ahead of annual appraisal and is used to inform appraisal discussions. Appraisal performance and compliance is maintained through a set of reporting and governance arrangements covering both the medical and non-medical workforce. Appraisal compliance is monitored daily via a live Power BI Reporting dashboard accessible to staff via the Trust Reporting Hub. The live dashboard data is reported monthly through the Clinical Board governance arrangements ensuring the Board has full visibility of organisational compliance, emerging trends, and areas requiring improvement as well as reported within the Quality and Safety Performance Review (QPR) meetings and assurance provided to Committees of the Board and Trust Board via the monthly integrated board report (IBR). Focused scrutiny and challenge is also provided through review of information at the People Committee, who receive focussed appraisal performance reports and triangulated workforce intelligence. The Trust has guidance documents available on the Trust intranet to support staff in preparing for appraisal, support appraisee's with medical and dental appraisal and revalidation, the use of competency tools and the use of the SARD workforce planning system. Appraisers are recruited and trained and have annual update training overseen by the Trust appraisal lead. Appraisees provide feedback on appraisal process and appraiser performance after each appraisal, and this is fed back to appraisers in an anonymised form. The Trust are currently in discussion with another NHS Organisation to support in the carry out a peer quality assurance process to support the trust in demonstrating consistency and quality of appraisals.

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Finance and Contracting		
Domain	• **Key Lines of Enquiry**	**Statement**
Service Delivery and Equipment Replacement	• What arrangements are in place to ensure patient safety is prioritised in business cases, especially for equipment replacement? • Do business cases explicitly reference national guidance (NICE, Royal Colleges) and include workforce training, governance oversight, and strategic alignment with service improvement goals? • Are associated risks accurately recorded on the risk register and is this regularly reviewed?	The Trust have an annual equipment replacement programme in place which is maintained by the Electronic Medical Equipment Team with Executive Oversight, review and approval by the Joint Medical Director. Equipment replacement is prioritised based on the equipment age and quality and safety impact relating to each piece of equipment. A Medical Device Management policy is in place which clearly describes the management and monitoring of medical equipment. There is an established Medical Device Management Group in place reporting to a Compliance and Assurance Committee, a tier 2 committee of the Trust Board who review regular assurance in relation to medical device management and maintenance. The Trust has a business case process in place which reports into Capital Management Group. There is a business case template in place for replacement equipment which allows for information to be provided in relation to any patient safety considerations required when replacing equipment, where medical equipment is required due to patient safety, this equipment is prioritised and the equipment replacement programme reviewed and updated. Business case templates reference strategic alignment and relevant clinical guidelines however workforce training and governance oversight are not included. Risks associated with medical equipment when identified are risk assessed and added to the Clinical Board risk register as necessary, risks are reviewed on a quarterly basis in line with the risk management policy and procedures.
Integration of systems	• What arrangements are in place to ensure information and digital systems used in clinical services (e.g. EPR, coding, audit, and imaging platforms) promote a seamless and integrated process? • What arrangements are in place to ensure all relevant clinical and operational information is accessible in one place, and enables effective oversight, audit, and learning. • Are associated risks accurately recorded on the risk register and is this regularly reviewed and reported on?	The Trust ensures that digital systems used in clinical services operate in a coordinated and integrated way through clear governance and a consistent digital architecture. Strategic oversight is provided through the Digital and Data Sub Board Committee, supported by established digital governance arrangements that ensure digital developments align with clinical priorities and organisational strategy. The Electronic Patient Record (EPR) acts as the central clinical record, enabling information to be recorded once and accessed across services. Systems used for clinical coding, audit, reporting, and imaging are aligned with the EPR so that information captured during care can also support operational management and performance monitoring. The Trust uses its core Electronic Patient Record as the primary source of clinical information, ensuring that key patient and operational data can be accessed consistently across the organisation. New technologies, including artificial intelligence tools, are considered through a dedicated AI Steering Group to ensure appropriate evaluation, governance, and safe implementation. The Trust also aligns with national digital standards and participates in interoperability initiatives across the Integrated Care System to support safe information sharing. The Trust has gone further with GNCR integrating it within the EPR in patient context access for GNCR and this displays information from other NHS trusts and local providers. Information management and data use are overseen through the Trust's Digital and Data Governance Group, which provides assurance around data quality, reporting, and information use. The Trust internal digital audit plan support the systematic review of clinical activity and operational performance, audit findings, internal reviews, and regulatory feedback are used to inform improvement activity. Data quality and reporting outputs are reviewed routinely to ensure that information used for oversight, audit, and organisational learning remains accurate and reliable. The Trust also has a well-established IT training team who respond and develop to any additional learning requirements through delivery of additional new training materials, and these are made readily available for all staff via the intranet. Digital and information-related risks are formally recorded on the Trust risk register with clear descriptions, controls, and responsible owners. Risks are reviewed on a quarterly basis through established risk management governance processes in line with the risk management policy and procedures.
Insourcing and Outsourcing Contracts	• What arrangements are in place for contract management processes for all insourcing and outsourcing arrangements, ensuring robust controls, quality assurance, and compliance?	The Trust Contracting and Commissioning Team have responsibility for the development and review of contract documentation for clinical services, however it is the clinical boards responsibility to provide oversight and ongoing contract management. A full review of Trust contracting and commissioning is underway to ensure robust governance arrangements can be put in place. The Chief Finance Officer is dedicated contract lead for procurement contracts. The Executive Director of Commercial and Innovation is dedicated contract lead for NHS service level contracts. Any significant subcontracts have a Finance lead involved in discussions and the development of the contract. The Trust is not currently involved in any LLPs.

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	• Is there a dedicated contract lead aligned to the Executive Director of Finance? • Is there an annual contract review schedule, enforce end-of-contract controls, and commissioned independent audits of all LLPs and insourcing arrangements? • What arrangements are in place to ensure full compliance with procurement policies and Standing Financial Instructions? • Has there been an audit of policy compliance, contract management and standards of documentation? • Are associated risks accurately recorded on the risk register and is this regularly reviewed?	Contracting and Commissioning Team are reliant on the Clinical Boards informing the team of any insourcing, at present they are aware of one insourcing arrangement relating an independent provider arrangement. There is no central repository in place for insourcing and outsourcing. Procurement process outcomes and contract award decisions are reported through the Trusts Supplies and Services Procurement Group, Finance & Performance Committee and Trust Board. Monitoring arrangements are in place for procurement related breaches in SFI, these are reported to Audit, Risk and Assurance Committee, however no formal process exist in relation to service level contracts. There has not been an internal audit of policy compliance, contract management and standards of documentation. Any risks in relation to contract and commissioning are entered on the local risk register and reviewed in line with the risk management policy. Any clinical risks associated with a service contract are added to the respective service risk register.
Contract Management and Governance for Insourcing LLPs	• What arrangements are in place to ensure Limited Liability Partnerships (LLPs) and similar contractual arrangements have: • -Robust oversight for all contracts, including regular review and monitoring of compliance with the Trust's Standing Financial Instructions (SFIs), procurement processes, and national • procurement legislation, with the level of compliance proportionate to the value and risk profile of the contract? • -An independent review to assess insourcing and outsourcing arrangements, to ensure compliance with governance • standards and alignment with service priorities? • -Ongoing due diligence and value-for-money assessment, and regular performance reviews? • -Well-documented auditable meetings and reporting?	The Trust is not currently involved in any LLPs.
External Provider Contracts	• What are the arrangements to ensure contracts with external providers explicitly include provisions for clinical governance, quality assurance, and regulatory accountability? • Do contracts specify which organisation's policies and protocols	The Trust uses the NHS Standard Contract where appropriate which have sections and terms and conditions that consider clinical governance, quality assurance and regulatory accountability. The Trust also have a more bespoke contract for where the standard contract is not appropriate, which was developed in conjunction with a legal firm (Sintons) and considers clinical governance, quality assurance and regulatory accountability. For any very specific clinical requirements the clinical services must identify and support the development of the clinical elements of the contract. All contracts are reviewed by the clinical service before proceeding to sign off.

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	apply, and ensure the Trust has rights of access to complaints and incident data, and clarify CQC registration and Responsible Officer arrangements? • Are contracts subject to scheduled review and formal audit, with each review clearly documented and minuted? • Where concerns arise, are escalation pathways clearly defined, consistently applied, and enforceable? • Is there regular Board-level reporting to the Audit Committee and Quality Committee, ensuring visibility of risks and assurance of patient safety?	All contracts specify which organisation's policies and protocols apply, and ensure the Trust has rights of access to complaints and incident data and clarify CQC registration and Responsible Officer arrangements. Contracts are subject to scheduled review in line with the review date specified in the contract but there is no formal governance in place. It is the clinical boards responsibility to provide oversight and ongoing contract management. A full review of Trust contracting and commissioning is underway to ensure robust governance arrangements can be put in place. For the locally developed SLA there is a clear escalation pathway detailed in the contracts with names or staffing levels given for any escalations. For the standard NHS contract there is a clear process contained in the terms and conditions for any concerns. Reporting is in place to the Audit, Risk and Assurance Committee and Quality Committee, ensuring visibility of risks and assurance of patient safety however these are not specific to quality and safety risks and assurance relating to external provider contract.

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Agenda item A3(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 March 2026		
Title	Staff Survey results		
Report of	Victoria McFarlane Reid (Executive Director of People and Commercial Innovation)		
Prepared by	Amy Callow (Director for People and Organisational Development)		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	**Executive summaries:** 3 sub papers for this item: 1. National Staff Survey results 2. NHS Workforce Race Equality Standard (WRES) 3. Workforce Disability Equality Standard (WDES) 1) National Staff Survey: • This year we placed joint **91st out of 121 trusts**, with an average people promise score of **6.21.** Last year we also had an average score of 6.21 and were placed joint 97th out of 122 trusts – essentially static from last year • The data shared in this presentation is aligned to the sector average of Acute and Acute Community Trusts (**Shelford Trusts**) national Staff Survey 2025 data, alongside the scores locally (**North East and North Cumbria (NENC) Regional trusts**). • The NHS Staff Survey is aligned to the 7 NHS **People Promises** and 2 main themes of **Staff Engagement and Morale.** • The staff survey was made up of 85 questions. Following declining response rates between 2021 and 2023, the Trust achieved a step-change improvement in 2024, with response rates increasing to 64%, **sustained at 62%** (10,323 responses) in 2025. • **Next steps**: Review the best practice in Clinical Boards and Corporate Services , aligning the results of this year's staff survey with our People Plan, take time to reflect on the results as a group and as individuals on what these results are showing us, and understand how we can really make an impact that will support our colleagues and change their working lives. 2) The NHS Workforce Race Equality Standard (WRES): The NHS Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) are mandatory frameworks designed to ensure fair treatment, career opportunities, and inclusion for ethnic minority and disabled staff, respectively. They use annual, data-driven metrics to track progress, support staff, and improve patient care. Introduced in 2015, the WRES requires NHS organisations to track nine specific indicators focusing on workforce data and staff survey results.		

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Purpose: To close the gap between the experiences of Black, Asian, and minority ethnic (BME) staff and white staff.
Key Areas: Focuses on board representation, recruitment, disciplinary processes, and access to career development.
Key Finding: While representation of BME members on boards has increased, the gap between BME representation in the workforce and on boards has increased.

For 2025, our WRES data shows

Inequalities widening in harassment and bullying metrics.
Discrimination improving but remains much higher for Global Majority colleagues.
Career progression confidence decreasing, though the race gap slightly narrows.

<u>Workforce Disability Equality Standard (WDES):</u>

The WDES consists of ten specific metrics that enable NHS organisations to compare the workplace and career experiences of disabled and non-disabled staff.

Purpose: To improve inclusion and equality for disabled staff through data-driven action plans.
Key Areas: Tracks metrics on recruitment, retention, career progression, bullying, and staff engagement.
Key Finding: Data often shows lower engagement and feeling of being valued among disabled staff, and it helps highlight gaps in representation at the board level.

For 2025, our WDES data shows

There has been in an increase in reports of allegations of bullying from managers and reporting behaviours.
Worsening experiences relating to colleague behaviour and feeling valued.
Career progression perceptions continue to decline.
Workplace adjustments remain a Trust strength.

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<tr><td>Recommendation</td><td colspan="6">To note to data in the three reports and to reflect as a board on key actions that we could take that will make a difference.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">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">2.1 Failure to improve and maintain an organisational culture, in line with our Trust values and our People Plan.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Annual presentation of staff survey results.</td></tr>
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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

STAFF SURVEY UPDATE

March 2025 survey results

Amy Callow and Vicky McFarlane Reid

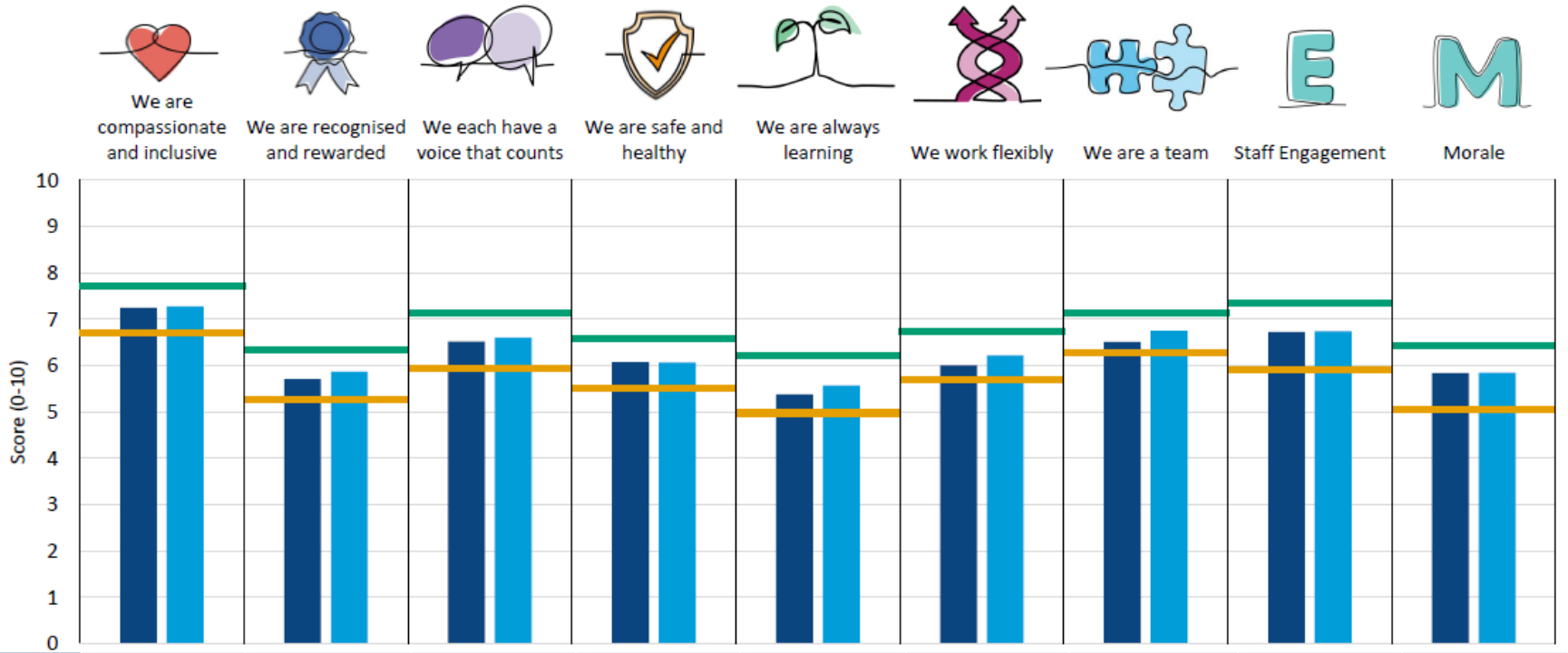
Healthcare at its best
with people at our heart

Overview

- This year we placed joint 91st out of 121 trusts, with an average people promise score of 6.21. Last year we also had an average score of 6.21 and were placed joint 97th out of 122 trusts.
- The data shared in this presentation is aligned to the sector average of Acute and Acute Community Trusts (Shelford Trusts) national Staff Survey 2025 data, alongside the scores locally (North East and North Cumbria (NENC) Regional trusts).
- The NHS Staff Survey is aligned to the 7 NHS **People Promises** and 2 main themes of **Staff Engagement and Morale.**
- The staff survey was made up of 85 questions.
- Following declining response rates between 2021 and 2023, the Trust achieved a step-change improvement in 2024, with response rates increasing to 64%, sustained at 62% (10,323 responses) in 2025.

Our overall results

The Newcastle upon Tyne Hospitals NHS Foundation Trust



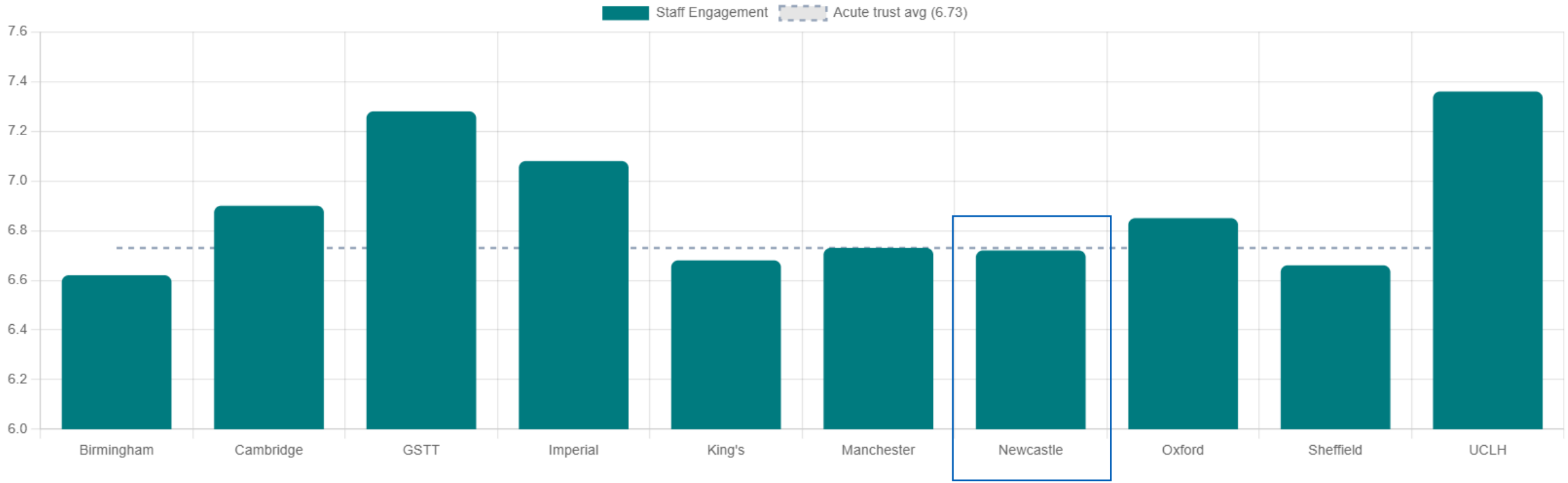
	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.25	5.71	6.52	6.07	5.38	6.01	6.51	6.72	5.84
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	10299	10299	10237	10219	9816	10248	10295	10306	10307

Benchmarking with Shelford

Staff Engagement Score by Trust

Source: NHS Staff Survey 2025. Score on 0–10 scale. Dashed line shows acute trust average (6.73).

A-Z | Highest to Lowest | Lowest to Highest



Benchmarking with Shelford

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Recommend as Place to Work & Happy with Standard of Care

Source: NHS Staff Survey 2025. q25c: "I would recommend my organisation as a place to work"; q25d: "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation." % agree/strongly agree.

Benchmarking with Shelford - People Promise Themes

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Trust	Compassionate & Inclusive	Recognised & Rewarded	Voice that Counts	Safe & Healthy	Always Learning	Work Flexibly	Team Working
Birmingham	7.10	5.75	6.48	6.04	5.53	6.22	6.64
Cambridge	7.35	5.94	6.65	6.13	5.87	6.49	6.81
GSTT	7.58	6.15	7.02	6.32	6.21	6.47	6.97
Imperial	7.39	6.00	6.84	6.21	5.95	6.20	6.83
King's	7.17	5.79	6.51	5.97	5.73	5.86	6.73
Manchester	7.27	5.90	6.63	6.16	5.55	6.15	6.72
Newcastle	7.25	5.71	6.52	6.07	5.38	6.01	6.51
Oxford	7.34	5.93	6.65	6.14	5.73	6.27	6.84
Sheffield	7.30	5.88	6.60	6.08	5.52	6.06	6.70
UCLH	7.64	6.21	7.01	6.31	5.94	6.48	6.99
Acute trust average	**7.27**	**5.88**	**6.60**	**6.07**	**5.59**	**6.22**	**6.74**

Benchmarking with Regional NENC - People Promise Scores

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Trust	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	People Promise Average Score
Northumbria Healthcare NHS Foundation Trust	7.71	6.31	7.05	6.58	5.93	6.23	6.97	6.68
South Tyneside and Sunderland NHS Foundation Trust	7.38	6.00	6.75	6.25	5.76	6.37	6.78	6.47
North Tees and Hartlepool NHS Foundation Trust	7.41	5.94	6.67	6.17	5.54	6.31	6.78	6.40
County Durham and Darlington NHS Foundation Trust	7.17	5.80	6.49	5.98	5.53	6.15	6.67	6.26
North Cumbria Integrated Care NHS Foundation Trust	7.11	5.79	6.43	6.15	5.31	6.07	6.60	6.21
The Newcastle upon Tyne Hospitals NHS Foundation Trust	7.25	5.71	6.52	6.07	5.38	6.01	6.51	6.21
Gateshead Health NHS Foundation Trust	7.18	5.76	6.44	5.95	5.38	5.99	6.55	6.18
South Tees Hospitals NHS Foundation Trust	7.14	5.63	6.46	5.81	5.25	5.70	6.48	6.07

Staff Survey

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Top 5 positive themes

1. Supportive Immediate Teams & Line Managers
2. Pride in Patient Care & Professional Roles
3. Good Experiences for Some New Starters & International Staff
4. Some Positive Organisational Improvements
5. Flexible Working or Adjustments (Where Available)

Top 5 areas for improvement

1. **Management, Leadership & Culture**
2. **Understaffing, Workload Pressure & Burnout**
3. **Unfair Pay, Banding & Limited Career Progression**
4. **Poor Communication, Lack of Transparency & Decisions Made Without Staff Input**
5. **Bullying, Harassment & Discrimination**

Immediate considerations

- Review the best practice that we can clearly see in some of our Clinical Boards and Corporate Services – with a view to understanding what has gone well and how we can mirror this across our teams.
- Aligning the results of this year's staff survey with our People Plan, making sure that we have tangible actions which support improvement.
- Take time to reflect on the results as a group and as individuals on what these results are showing us and understand how we can really make an impact that will support our colleagues and change their working lives.
- Focusing on key areas of development – we know that there is a lot of work to do, and the survey results confirm this. Organisationally we need to agree on the key areas of focus for 2026/27, where we can develop and show impact to our colleagues.

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Work force race equality standard (WRES) and Workforce disability equality standard (WDES)

2025 survey results

Healthcare at its best
with people at our heart

Executive summary

The Newcastle upon Tyne Hospitals NHS Foundation Trust

WRES (Race Equality)

Harassment & bullying inequalities are widening – White colleagues improved slightly, but Global Majority (GM) colleagues worsened, increasing the internal race gap.

Discrimination reduced for both groups, though GM colleagues still experience far higher levels, remaining worse than benchmark but moving in the right direction.

Career progression perceptions declined for White colleagues but improved slightly for GM colleagues, narrowing the gap. Both groups remain below benchmark.

WDES (Disability Equality)

Bullying from managers significantly reduced for both Disabled and Non-Disabled colleagues—one of the biggest positive movements in the dataset.

Colleague behaviour worsened for Non-Disabled colleagues, while Disabled colleagues improved slightly, narrowing the gap but due to deterioration among Non-Disabled colleagues.

Feeling valued continues to fall for both groups, further below benchmark.

Career progression confidence fell to the lowest levels in the dataset for both groups.

Workplace adjustments remain a strong Trust performance area, well above benchmark despite a tiny decline.

Race inequality worsened in 2025 due to deterioration for Global Majority colleagues, while disability inequality showed mixed results with notable improvements in reducing manager-related bullying but continued decline in perceptions of being valued and career equality. Further information is available in the Trust Board Reading Room

Key insights

WRES Race Inequality Key Insights

The Newcastle upon Tyne Hospitals NHS Foundation Trust

1. Harassment & Bullying – from Public (Metric 5)

- White colleagues improved slightly; GM colleagues worsened noticeably.
- Internal race gap widened significantly (from 2.63 to 5.07).

2. Harassment & Bullying – from Managers/Colleagues (Metric 6)

- **White colleagues improved**, but GM colleagues worsened.
- The **inequality gap increased** from 6.03 to 7.50.

3. Equal Opportunities for Progression (Metric 7)

- White colleagues declined; GM colleagues improved slightly.
- Gap narrowed; both groups remain below benchmark.

4. Discrimination (Metric 8)

- Both White and GM colleagues reported **less discrimination** in 2025.
- GM colleagues still much worse than benchmark, but trending positively.

WDES Disability Equality Key Insights

Bullying/Harassment from Public, Managers & Colleagues (Metric 4a)

- Public: Disabled colleagues improved; Non-Disabled worsened slightly. Gap narrowing positively.
- Managers: Strongest improvement across all indicators for both groups. Now better than benchmark. Gap stable.
- Colleagues: Disabled slightly improved; Non-Disabled worsened. Trust now worse than benchmark for both groups. Gap narrowed only because of Non-Disabled deterioration.

Reporting Bullying (Metric 4a – reporting)

- Record-high reporting levels for both groups.
- Disabled colleagues improved markedly, now above benchmark.
- Internal gap widened because Disabled colleagues improved more.

Equal Career Opportunities (Metric 5)

- Declined for both groups to the lowest results in the dataset.
- Both now further below benchmark. Gap stable.

Pressure to Work When Unwell (Metric 6)

- Unchanged from 2024; still worse than benchmark.
- Disabled colleagues experience notably higher pressure. Gap stable.

Feeling Valued (Metric 7)

1. Small decline for both groups.
2. Further below benchmark for both; gap stable with Non-Disabled colleagues still more positive.

Adequate Adjustments (Metric 8) – Trust Strength

- Still well above benchmark, despite a tiny decrease (–0.36).This remains one of the Trust's most positive disability-related metrics.

Engagement (Metric 9)

- Very small dips for both groups.
- Near national averages; gap modest and unchanged

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Agenda item A4(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 March 2026		
Title	Shine (Sustainable Healthcare in Newcastle) – Interim Update		
Report of	Vicky McFarlane Reid, Executive Director Board Lead for Sustainability		
Prepared by	James Dixon, Associate Director – Environmental Sustainability		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☒
Summary	Newcastle Hospitals was the first healthcare organisation in the world to publicly declare the climate emergency as a health emergency and commit to fast-tracking decarbonisation of our services a decade ahead of government targets. The NHS 10-Year Health Plan reiterates government commitments to 'Delivering a Net Zero NHS'. Our Climate Emergency Strategy sets out our vision, long-term goals and five year action plan that runs to the end of this financial year. Work has been undertaken to consult with staff, patients and wider stakeholders on the next iteration of our climate emergency action plan as well as working with Trust leaders to embed sustainability into the new Trust Strategy as a key priority. This report presents an interim six-monthly update to Trust Board on: i) Progress towards the targets in our current climate emergency strategy: ii) Work to embed sustainability into Trust Strategy and to co-create the next iteration of our climate emergency plan; and iii) Risk and key strategic challenges.		
Recommendation	The Board of Directors is recommended to: i) Receive this report for information, noting progress to date; and ii) Approve the proposal to finalise our Climate Emergency Plan 2026-2031 and bring a final version for Board approval in early 2026-27.		
Links to Strategic Objectives	**Focus on fundamentals** – manage our money (reducing waste and saving energy saves cash) **Making it better for colleagues** – improve the estate (efficient, healthy and biodiverse spaces) **Look to the future** – pioneering sustainable healthcare delivery that is kind to patient and planet		

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

Link to Board Assurance Framework [BAF]	None. InPhase Risk Register #950 – Climate Emergency, rated 20.
Reports previously considered by	Interim six-monthly update (previous full report to Board on 18 September 2025).

SHINE (SUSTAINABLE HEALTHCARE IN NEWCASTLE) – INTERIM UPDATE

1. PROGRESS UPDATE

High-level progress towards the targets and actions in our Climate Emergency Strategy 2020-25 is summarised in the **Sustainability High-level Dashboard** (see Appendix 1). The dashboard is based on the Trust High-level Dashboard and presents data up to the end of December 2025 alongside strategic updates in Shine priority action areas. This dashboard format was first presented to the Sustainable Healthcare Committee (SHC) in February 2025 and recommended for sharing with Trust Board. This is now included quarterly in the Integrated Board Report. The following sections outline the detail to support the high-level dashboard.

1.1 Energy (Building Carbon Emissions)

Transitioning from fossil-fuel derived heat and power for our building energy remains our biggest challenge. Significant investment is required to remove our hospitals old and inefficient steam heating systems, so we are heavily reliant on securing external funding for this. Our Estates Net Zero Team helped deliver the decarbonisation of Regent Point (saving 120 tonnes of carbon/year) and secured the second largest NHS grant award from the Public Sector Decarbonisation Scheme (PSDS) to de-steam our Freeman Hospital site, along with full decarbonisation of two community clinics (Benfield Park and Ponteland Road). This PSDS project is nearing the end of the first year of a three-year programme, with work set to conclude in Spring 2028. In 2025-26 we were also successful in securing government funding for installing solar panels and power sub-metering.

Carbon emissions from building energy are likely to rise by the end of this financial year for the first time since our 2021 pandemic-induced increase. This is primarily due to our need to generate more on-site electricity, from gas-fired combined heat and power, at our Freeman Hospital (FH) site following grid supply resilience concerns. The level of increase has been reduced through energy and cost efficiency projects in Estates & Facilities, but the rise is concerning as it takes us further away from our carbon budget targets.

1.2 Journeys (Transport Carbon Emissions)

It is encouraging to see that our operational transport carbon emissions have reduced this year, according to data up to December 2025, following work to rationalise taxi and courier usage. A Trust Travel and Transport Plan is being developed, in consultation with staff, with the aim of improving patient, staff and visitor access to our sites, reduce carbon and air pollution and improve health and wellbeing. Government grant funding was secured to install more electric vehicle charging points at our hospital sites, including support for electric ambulances to rapidly charge outside our new Urgent Treatment Centre. In recognition of all this improvement work our Clean Air Hospital Framework score has risen from 38% to 50%.

1.3 Care (Anaesthetic Gas Carbon Emissions)

Anaesthetic gas emissions continue to track below our carbon reduction target, although we are predicting a slight increase compared to last year. This has been achieved by local

clinician-led projects to ban desflurane (the most environmentally damaging anaesthetic gas), introduce Entonox cracking technology (to safely use this pain-relieving gas in Maternity) and to decommission the unused nitrous oxide pipeline at the FH. This year our nitrous oxide waste mitigation multidisciplinary team met monthly to continue with this improvement work and have secured government grant funding to trial portable nitrous oxide supply manifolds which could lead to further waste reduction (saving money and carbon emissions).

To further support clinical capacity to deliver lower carbon care pathways we have received charity funding for a Clinical Sustainability Fellow in Intensive Care (Dr Sarah Peters) and a Trust wide Clinical Sustainability Lead (Dr Suren Kanagasundaram). We aim to help demonstrate the value of these temporary positions to our triple bottom line (improve patient care, save money and reduce carbon) to make a case for longer term investment in these roles.

1.4 Waste

Total waste volumes are predicted to reduce this year by an estimated 4%, with encouraging reductions in waste segregated as hazardous clinical waste and increases in recycling. Over 75 ward and departmental waste audits have taken place, which ensures legal and policy compliance as well as raising awareness and improving segregation rates. Improvement projects have included new public-facing waste bins, funded by charity, a collaborative Bin the Wipe campaign with Northumbria Water, and rolling out offensive waste (being non-infectious waste which is unpleasant and may cause offence to those coming into contact with it) segregation in our community sites (to further reduce the amount of overtreated, costly, hazardous waste we segregate).

1.5 People

There are now **1,129 staff Green Champions** in the Trust (up from 931 at the end of 2024/25). Engagement by the Sustainability Team at the corporate induction Market Place events is resulting in a surge of interest and support to work on environmental improvement projects. Eight staff-led sustainable quality improvement (SusQI) projects have been awarded a Shine Award by the Sustainability Team. Our Shine Awards app has 1,448 users, recognising and rewarding environmentally sustainable behaviours. Our Shine 10-Step Framework, developed to help embed sustainability into business-as-usual in our Clinical Boards, has been well-adopted by Clinical & Diagnostic Services with staff sustainability leads in 80% of their services and projects such as reusing pre-loved uniforms, switching off paper reports and climate cafes.

1.6 Other Sustainability Achievements

Our work to engage with our suppliers has increased support for our **5 Step Net Zero Supply Chain** work, leading to greater awareness in our supply chain and more accurate procurement carbon emissions calculations. Our **Born Green Generation** partnership with other European hospitals has led to 3.5 tonnes less single use plastic being used in Maternity Services and contributions to financial savings targets. Our externally funded **Nature Recovery Ranger** has been working hard to enhance biodiversity at our hospital

green spaces whilst supporting access to nature for patients, visitors and staff (who in turn benefit from the positive health & wellbeing affects this brings).

2. STRATEGY REFRESH

2.1 National Statutory Guidance

In 2020, the NHS became the world's first health system to commit to reaching net zero emissions. The Health and Care Act 2022 reinforced this commitment, placing new duties on NHS trusts to consider statutory emissions and environmental targets in their decisions. Trusts and Integrated Care Board (ICBs) are expected to meet these duties through the delivery of Board-approved 'green plans'. Our current Climate Emergency Strategy includes a five year 'green plan' that runs until the end of this financial year. At the March 2025 meeting of the Trust Board, it was agreed to continue to its conclusion whilst also consulting with staff and wider stakeholders on our next iteration, at the same time engaging with Trust leaders to embed sustainability into the new Trust Strategy on a similar timeline.

2.2 Newcastle Hospitals' Position

2.2.1 Embedding Sustainability into Trust Strategy

A request from staff Green Champions to ensure that environmental sustainability is included as an explicit commitment in the new Trust Strategy was supported by the Chief Executive in 2024. Since then, our Associate Director – Sustainability has worked with other colleagues on the Trust Strategy Steering Group and sustainability has been included as a key commitment in the final draft of the Trust Strategy (2026-2031) with a 'green thread' weaved throughout the text, demonstrating the co-benefits of caring for patients and planet.

2.2.2 Embedding Sustainability into our Estates Strategic Delivery Plan

The largest portion of our controllable carbon footprint comes from emissions from our buildings and our ability to achieve our net zero carbon target depends on our plans to develop and invest in our estate. To support our work to tackle the climate emergency and improve the environment for our patients, staff and visitors, our Estates Strategic Delivery Plan and accompanying five-year capital investment plan includes a commitment to invest in decarbonisation and sustainability projects to realise this strategic priority.

2.2.3 Developing our new Climate Emergency Plan

The Sustainability Team has undertaken extensive stakeholder consultation to help co-create the next version of our climate emergency action plan (referred to as a 'Green Plan' in national statutory guidance). This engagement has involved almost 300 survey responses (from staff, patients and visitors), awareness stalls, webinars, and presentations at team meetings, patient involvement forums, Clinical Board meetings, Matrons Forum, Trust Management Group and most recently the Board Development Session on 26 February 2026. The collated results of this feedback

demonstrated the continued relevance of our three key goals (see table below) and key enablers for these goals being our need to embed sustainability into business-as-usual and to empower staff to deliver sustainable quality improvement projects.

Priority Rating	Area of Focus Topic	Shine Goal
1	Waste reduction and resource efficiency	Zero Waste
2	Energy efficiency and renewable energy	Zero Carbon Care
3	Clean air and sustainable travel	Clean Air

The next phase of work has begun to produce a refresh of our existing climate emergency strategy document, considering this engagement feedback and following new national guidance. This document is being developed alongside, and informed by, the final draft of the Trust Strategy. We aim to present a final draft for Trust Board approval in early 2026/27.

3. RISKS

The last Shine update report presented to Trust Board (September 2025) highlighted that the climate emergency risk remains one of the highest risks on the Trust risk register (*InPhase reference #950, rated 20*). The risk highlights the risk to patient safety, care quality and our ability to deliver services caused by the Trust failing to adequately mitigate, anticipate, prepare for and adapt to the direct and indirect impacts of climate breakdown. This could result in disruptions in Trust services, compromised patient safety and outcomes, increased operational costs, legal challenges and potential reputational damage. This includes both physical risks (e.g. increased extreme weather events, heatwaves) and transition risks (e.g. critical supply chain resilience, policy changes, carbon pricing/taxation).

This risk is dominated by the challenges in decarbonising our hospital energy and the lack of national funding to support this. Recent success in recruiting additional sustainability engineering capacity within Estates has resulted in the Trust securing significant amounts of grant funding for heat decarbonisation, LED lighting, solar panels and electric vehicle chargers. Delivering these projects is predicted to save over 9,000 tonnes of carbon a year and reduce energy costs by £700,000 a year from 2028 onwards. Further work to mitigate this risk is underway to negotiate our future on-site energy centre contracts, explore the feasibility of city heat networks to supply the Royal Victoria Infirmary (RVI) with low carbon deep geothermal heat and longer-term decarbonisation infrastructure investment that will be realised through the Great North Healthcare Alliance Construction Programme.

The last report to Board also highlighted the two key challenges that hinder progress towards achieving the goals and targets in our Climate Emergency Strategy: lack of dedicated capacity and funding. The following sections provide a brief update on progress to tackle these.

3.1 Lack of Dedicated Capacity

As part of the Newcastle Hospitals strategic commitment to sustainability, we have been successful in receiving funding for targeted capacity building in clinical sustainability

leadership. As highlighted in Section 1.3, we have recruited to the temporary positions of Clinical Sustainability Lead and Clinical Sustainability Fellow who will be working with Sustainability Leads in each Clinical Board to embed sustainability into business-as-usual and to help empower staff to deliver projects that will improve patient care, save money and reduce carbon.

3.2 Lack of Dedicated Finance

As with 3.1, above, the challenging NHS and Trust financial position makes it difficult to ringfence internal funding for delivering Climate Emergency Strategy projects. Despite this challenging context the Trust has been successful in securing over £42m of government grant funding to decarbonise our buildings and install solar panels and electric vehicle charging. Energy efficiency improvement work by our Estates & Facilities colleagues has contributed to over £2m of financial savings this year and our Estates Strategic Delivery Plan includes a commitment to invest in sustainability projects over the next five years.

4. RECOMMENDATIONS

Trust Board of Directors is recommended to:

i) Receive this report for information, noting progress to date; and

ii) Approve the proposal to finalise our Climate Emergency Plan 2026-2031 and bring a final version for Board approval in early 2026-27.

Report of
James Dixon
Associate Director – Environmental Sustainability
16 March 2026

On Behalf of
Dr Vicky McFarlane Reid
Director for Commercial Development & Innovation (Executive Lead for Sustainability)

Appendix 1: Sustainability High-level Dashboard

Sustainability High-level Dashboard - Q3 2025/26 (October - December 2025)

Shine – Sustainable Healthcare in Newcastle

NHS – The Newcastle upon Tyne Hospitals NHS Foundation Trust

STRATEGIC UPDATE

Strategy: Work continues to ensure sustainability is included as a priority in the new Trust Strategy and in parallel the Sustainability Team are consulting with Green Champions to create a new Climate Emergency Action Plan to 2030 (Board Development session in Feb).

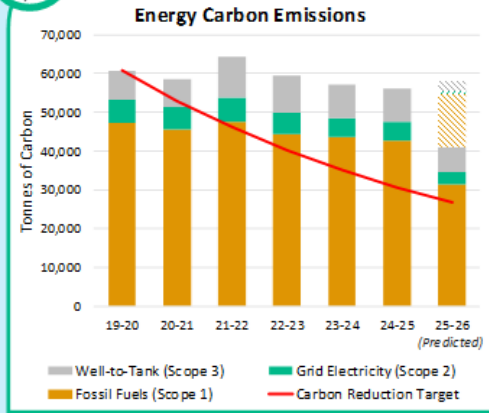
Charity Shine Funding: Team progressing delivery of **£343,195** of Newcastle Hospitals charity funded Shine projects, including clinical sustainability leadership capacity, recycling infrastructure and biodiversity enhancement for patient and staff wellbeing.

PSDS4 £40.5m Grant for Estates Decarbonisation: The Estates Net Zero Team, working with colleagues in Procurement and Capital, have **successfully overcome Cabinet Office spend control challenges** and are back on track for project delivery (currently out for construction partner tender).

Culture: Embedding sustainability into our business as usual: once the new Trust Strategy is agreed we aim to work with Clinical Boards to ensure Shine 10-step delivery is included in their strategic delivery plans (*mirroring the Health Inequalities approach*)

Clinical Sustainability Fellow: with charity support, Dr Sarah Peters is working in ICU on a SusQI project to **reduce unnecessary blood gas analysis that could save over £250,000 Trustwide and staff time equivalent to 256 nursing shifts a year**.

ENERGY — RAG



- Predicted carbon emissions from building energy are expected to be higher than 2024-25, primarily due to increased gas-CHP engine run-time at Freeman in Q1 (due to backup power concerns).
- **£92k funding** secured to improve power monitoring at Freeman.
- PSDS4 project design evolution proposing an **additional 3,000 tCO_2e lifetime savings** (2028+).

PEOPLE — RAG

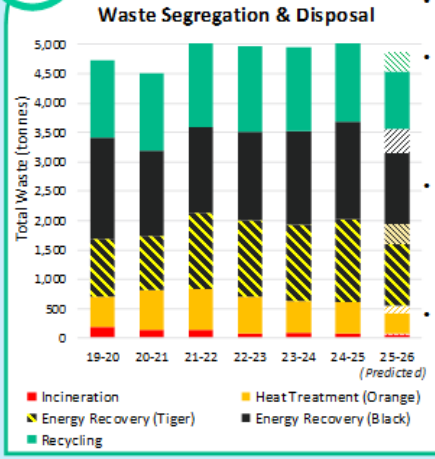
Green Champion Engagement
1,129 Green Champions (3%↑)

SHINE Rewards Staff Benefit Programme and App
402,600 tCO_2e
avoided since launch of programme at end of Q3 through staff actions (1,448 users)

Social Media Communications
605 followers
(11% increase from Q2 to Q3)

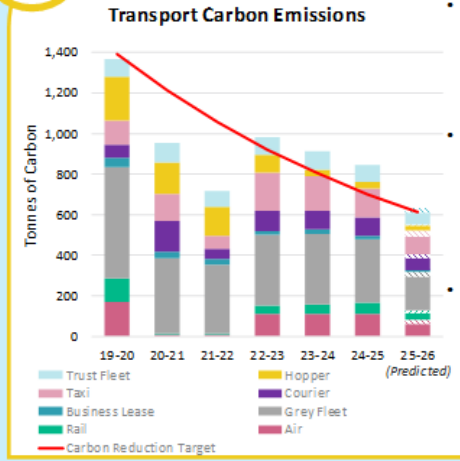
SHINE Awards for SusQI Projects
8 projects
awarded a Shine Award Q1 3

WASTE — RAG



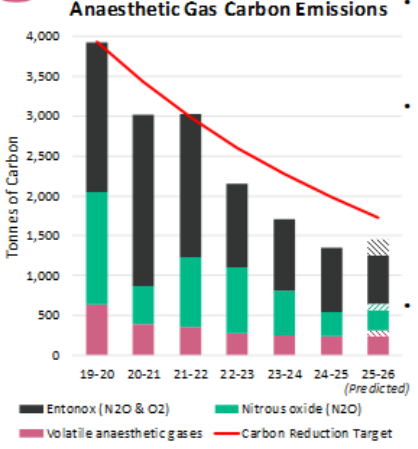
- Total volumes **4% lower** than 2024-25.
- Further reductions in hazardous waste (incineration & heat treatment) - **11.3% is the lowest recorded**.
- Recycling rate has improved slightly - 27% of all waste (45% of non-healthcare waste).
- Charity investment in public-facing bins & signage to comply with new regulations and help improve segregation.

JOURNEYS AND CLEAN AIR — RAG



- Transport carbon emissions predicted to fall from 24-25 (back within carbon target).
- Most significant **decrease in grey fleet emissions** (*CIP-related? or might be late claims in Q4*).
- **£196k funding secured for rapid EV chargers at RVI** for new NEAS all-electric ambulances and our own EVs.

CARE — RAG



- Carbon emissions from anaesthetic gases continue to remain **below carbon target**.
- Slight increase predicted from 24-25 figures (believed to be from previously unaccounted data from cardio at FH - will be reconciled in time for Annual Report).
- **£15k funding secured for trial of portable NO2 supply manifolds** to reduce NO2 waste (saving £ and carbon).

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 March 2026		
Title	Board Assurance Framework (BAF) Report		
Report of	Patrick Garner, Director of Performance and Governance.		
Prepared by	Natalie Yeowart, Head of Corporate Risk and Assurance.		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	This report aims to support the Trust Board to gain assurance that strategic risks aligned to the committees are being managed effectively; that risks have an appropriate action plan in place to mitigate them; and that risk scores are realistic and achievable. **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. • There have been 4 new actions added to existing threats, these relate to: - Phase 3 Care Quality Commission (CQC) action plan. - Review and update all Infection Prevention and Control (IPC) policies. - Develop and approve IPC Clinical Board Service Level Agreement. - Develop IPC culture guiding principles. • Slight wording updates have been made to the Maternity threat relating to changes to operational group names. • Two controls have been added relating to: - Establishment of the CQC Inspection Preparation Forum. - Digital Roadmap and priorities plan 2026/27. • Action timescales have been adjusted on threat 'failure to ensure care is delivered in line with Mental Capacity Act and Mental Health Act' and 'Failure to embed effective systems and processes to recognise and prevent avoidable hospital acquired infections'. • Following a request from the Quality Committee, the medication management threat has been reviewed as a result of the finding following completion of the Quality and Safety Peer Reviews and Clinical Assurance Toolkit (CAT) Tool Audits, it is proposed to reduce the assurance rating from green to amber. **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 People and Commercial Innovation. • BAF Risk Scores remain unchanged. • Assurance levels have changed to amber on the following threats: - Failure to support staff with their health and wellbeing leading to increased sickness absence. - Failure to deliver improvements to leadership and governance across the Trust. - Underdeveloped workforce planning mechanisms impacting on our ability to effectively forecast workforce needs. • Action progress indicators remain unchanged for all threats. • Action timescales have been extended in relation to People Plan Programme Launch, Staff Psychology Support Service and HR restructure completion. • Actions have been completed in relation to: - plans to reduce sickness absence, a Trust Management Group subgroup is now in place to focus plans to reduce sickness absence. - Anti Racism Framework discussed and adopted by Trust Board. **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: • Actions completed: - Enhanced cash reporting to Finance & Performance (F&P) Committee. - Develop actions to mitigate cash position should Cost Improvement Programme (CIP) not deliver for 2025/26. - Review of cash management and control processes. - Development of co-located Urgent Treatment Centre (UTC). • Controls have been added relating to: - Enhanced cash reporting to Finance and Performance Committee. - Review of cash management and control processes. - Co-located Urgent Treatment Centre. - Forecast of Critical Infrastructure Risk (CIR) requirements to 2030 as part of 5-year capital plan. • Two threats have been mitigated: - Reliance on non-cash measures leading to diminished cash balance and reliance on cash support, impacting ability to invest in buildings and equipment – all actions have been taken to consider and mitigate risk to cash position for 2025/26. - Insufficient national capital funding allocation to effectively manage the lifecycle replacement or upgrade of critical medical devices (Imaging assets, Theatre Equipment etc.) – actions are now completed in relation to delivery of 2025/26 plan. • Timescales have been extended on one action relating to dementia friendly estates

<table>
<tr><td></td><td colspan="6">options appraisal.
• Action progress indicators remain unchanged.
• Risk scoring has remained unchanged.
• 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:
• The risk remains largely unchanged.
• 2 actions have been completed in relation to Director of Digital recruitment and Trust-Wide Digital Plan.

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.
• 1 new action has been added in relation to completion of a full internal governance review in response to Aubrey report findings.
• 1 action has been completed relating 2025/26 Board Development Programme.
• 5 action timescales have been extended relating to the accountability framework, governance handbook, Risk Management Strategy and publishment of NHS Oversight Framework (NOF) capability assessment and approval/Sign off of 2026/27 Trust Strategy.
• Progress indicators and assurance levels remain unchanged.

Trust Board
For risk ID 7.1 – inability to sufficiently influence priorities of key partnerships.

Key points to note:
• Risk reviewed by the Director – Great North Healthcare Alliance.
• No updates or changes applied.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Trust Board are asked to:
• Review and 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">Full BAF report.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Executive Leads, Committees of the Trust Board and Audit, Risk and Assurance Committee.</td></tr>
</table>

BOARD ASSURANCE FRAMEWORK MARCH 2025/2026

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	09.03.2026	**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 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. • CQC Delivery Group and CQC Assurance Group oversight. • CQC Inspection Preparation Forum. • 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%	• 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. • Develop and implement phase 3 action plan – April 2026. • Reporting of Duty of Candour 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,	**2- Actions defined – most progressing, where delays are occurring interventions are being taken.**	

		trust compliance with assessment framework. • Freedom To Speak Up biannual report to Trust Board.	aim to recruit minimum of 2 Patient Safety Partners – April 2026. • Implement NAtSIPPS framework Trust-wide by – Oct 2026.		
Failure to ensure care is delivered in line with the Mental Health Act and Mental Capacity Act.	• Mental Health Committee with oversight from, Care for All, Quality Committee • 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. •	• Regular review, audit and appraisal of MCA forms. • Regular review, audit and appraisal of best interest standards. • 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, ICB. National expectation of the Oliver McGowan Training to be confirmed April 2026. • Draft of Learning Disability and Autism Plan completed. Currently working on presentation of the plan and launch – June 2026 • Development and approval of phase 2 Self Harm Programme of Estates work (Medium/Low risk areas) – April 2026. • Develop comprehensive MH audit programme – April 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 GIRFT and 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 ARAC. • GIRFT Oversight Group reports and minutes. • Minutes and reports of New Interventional Procedures including Robotic Surgical Group-reports to COEG. • Quality Oversight Group dashboards. • Initial stocktake of QOG activity completed in May 2024-shared with CB's. • Clinical Board Governance Internal Audit – audit report – reasonable assurance.	• Design and implement a standardised quarterly quality reporting mechanism/dashboard including communications and guidance for clinical boards to report into QPRs. This will include compliance with all metrics e.g. GIRFT/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 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 • Perinatal Operational Assurance Group (POAG) • 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 POAG. • 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. • Obstetric Board. • Reporting and oversight into Quality Committee and Trust Board • Maternity Services Quality Dashboard and NENC Clinical Outcomes Dashboard. • Annual CQC Maternity Survey results – improvement in some domains, no reduction in results, improved position in NENC ranking. • CNST/MIS compliance with oversight via MIS tracker. • Incident data and scorecard reported to 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. • Perinatal quality oversight metrics monitored and reported to Quality Committee. • Midwifery staffing and red flags monitored and • reported to POAG and Quality Committee in Integrated Board Report. • MOSS dashboard reported to Quality and Safety group. • Regional dashboard reported to Quality and Safety group and regional/ICB oversight.	• CQC Maternity Self-Assessment tool completion – March 2026. • Recruitment of midwifery staffing in accordance with approved staffing plan – September 2026.	**Fully on plan across all actions.**	

		• 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. • NUTH 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. • EPR and Digital Induction training. • EPR Optimisation. • Digital road map and priorities work plan.	• 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, IPC, VTE, Lines and Devices. • Nursing documentation audit framework – document standards now in place, aligned to trust guidelines and embedded within clinical standards audits. • Digital Roadmap and priorities plan in place for 26/27. •	• 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. Review and refresh of clinical recording keeping 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 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. • IPC Improvement Group. • IPC Improvement priorities agreed. • IPC Action Plan. • IPC Workflow and job planning.	• 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. • IPC Nursing business partner model approach adopted.	• Develop and implement IPC Nursing handbook, handbook developed, working through implementation with staff via 1:1s – April 2026. • Business continuity plan – April 2026. • Review and update of all IPC related Policies and consider development of IPC SOPs – October 2026. • Develop and approval of clinical Board Service Level Agreement – April 2026. • Develop Culture guiding principles – July 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	13.03.2026	**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. • NOF Trust Capability Self-Assessment • External Well Led review. • NOF capability assessment process. • Board Development programme 25/26	• Terms of Reference – committees of Board. • Minutes of committee meetings. • Committee schedule of business. • Corporate Organograms. • Minutes of QOG/QPR and directorate governance meetings. • Effective governance system report to Trust Board. • CQC delivery group minutes and action plans. • Quality Performance Reviews and summary to Board and relevant committees. • External Tabletop Governance Report. • External leadership and governance review. • Feedback at IQIG • Internal audit of CQC phase one action plan – substantial assurance received. • Internal audit of CQC phase two action plan – reasonable assurance received. • 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 • External well led review completed by Grant Thornton – formal report details good	• Operationalise Accountability Framework including monitoring/governance and review mechanisms – May 2026 • Develop Trust Governance Handbook – May 2026. • Develop 5-year strategy –May 2026. • Complete Review of Governance in response to Aubery report findings –June 2026. • Ensure NOF metrics are captured within accountability and autonomy framework and measured across the Trust – May 2026. • Await publish of NOF Capability Assessment outcome and governance rating – April 2026.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

		assurance. • Process and governance in place to monitor and deliver improvement actions in relation to NOF capability via the well led action plan. • Board Development Programme Documentation, agenda and papers.			
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 – May 2026. • Complete Governance Review in response to Aubery Report findings– June 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 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 information for all staff.	• Develop Risk Management Strategy – May 2026. • Develop Risk Appetite methodology – May 2026. • Further development and improvement of Inphase Risk System, reliant on resource – July 2026.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

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	12.03.2026	**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. • DOPs and Clinical Board Chairs accountability for delivery of activity targets. • Monthly reporting reinstated • IAP introduced as a part of the contracting process/requirement with NHSE and ICB (Indicative Activity Plan). Will be mandated. • IAP agreed. • 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 CIP targets by corporate area and clinical board • Enhanced CIP reporting / CIP organisational lead in place • CIP dashboard in BI • Day to day budget management processes in place including budget holder and DFM attendance/CBFM model and part of senior team • 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 • Purchasing via procurement frameworks where appropriate • DOPs reinforcing financial grip and control. through engagement with teams. • Financial Recovery regular discussion/action planning on TMG. • Annual Internal and External Audit complete • ICB Grip and Control investigation and intervention complete. • Financial communications strategy. • Corporate services CIP targets set. Assessment capability for financial delegation completed - financial indicators developed. • Performance Gap early reporting.	• Budgetary oversight at DOP level • Monthly revenue report at CB and corporate service level. • Deviations from SFIs reported to SSPG committee including action taken. • Regular reporting of compliance through Internal Audit and monitoring of recommendations – Report to ARAC quarterly on Internal audit progress. • HFMA audit of control reported through to ARAC • Reporting framework to ICB / cost control framework implemented. • NHSE/I monthly finance monitoring • Going concern and financial controls audit • Early indication of required targets prior to start of financial year (5% January 2025) • Mazars external audit – satisfactory assurance, no issues re going concern. • First financial specific coms issued in January 2025. • CIP Dashboard on reporting hub, allowing CBs and CDs ability to monitor and view plans. • Revenue reporting and FRP reporting to Finance and Performance Cttee • Integrated Performance Report (IPR, refreshed) to Governors and Public Board of Directors • Monitoring and challenge of delivery of plans by FRSG, fortnightly. • Monthly QIG specifically re financial performance with ICB and NHSE colleagues to give assurance of progress. • Financial indicators contained within the financial revenue report from July. • Early reporting mechanisms and now specifically discussed at each Finance and Performance Committee.	• Delivery of TVC 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 DOFs meeting. • Shelford networking / understanding the environment. • Use of frameworks. • Opportunities through Alliance working. • Engagement with MTPF workstreams (ICS). Annual Internal and External Audit complete. • In year emerging cost pressures identified, discussed and reported through Finance IQUIG (monthly)	• CB and CD finance reporting • Budget sign off and hold to account through accountability framework • ICS updates through Finance report and CEO report to Committees and Board • Finance report to Board, Finance and Performance Committee identifies any unplanned pressures and actions. • Procurement report to Finance and Performance Committee identifies any cost pressures emerging through procurement activity. • Regional finance returns monthly. • Mazars external audit – satisfactory assurance, no issues re going concern. • In year emerging cost pressures identified, discussed and reported through Finance IQUIG (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. • Enhanced cash reporting to Finance and Performance Committee. • Review of cash management and control processes.	• 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.			
Subsidiary company is not formed, and benefits don't accrue due to approvals and/or industrial relations issues.	• Meetings with NHSE • NHSE panel assessment • OBC and FBC • Bi-weekly meetings with staffside • Joint meeting with staffside and NHSE • Staff Side regular engagement meetings. • National financial support.	• NHSE provided with all relevant information 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. • IP Policy developed. • Strengthened commercial governance at Clinical Board Level.	• Strategy document and updates reported to Finance and Performance Committee. • 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 – April 2026. • Establish new Research, Innovation and Commercial Committee – April 2026. • Develop and implement Trust Commercial Strategic plan – 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	12.03.2026	**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.	• 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 A&E Delivery Board, supporting the management of non-elective patients across the system. • Weekly attendance at Provider Collaborative Mutual Support Co-ordination group facilitating patient transfers and collaboration amongst local providers to level demand, make use of system capacity. • Validation of the RTT/non-RTT of long waits. • Implementation of new ED rota. • Targeted cancer improvement plans based on National Cancer Pathway Analyser Tool • Waiting list booking process Training. • Cancer Tiering System Exit. • Outpatient capacity templates. • Service review programme. • Performance Reporting.	• 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 May 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.**	

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 end of 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 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 – end of March 2026. • NOF metrics to form accountability and autonomy framework and measured across the Trust – April 2026. • Await publication of NOF Capability Assessment governance rating – April 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 • Co-located Urgent Treatment Centre.	• TMG Oversight. • Executive Team Oversight. • Quality Performance Reviews. • Monthly IPR to committees and Board. • Clinical Board meeting minutes. • Outpatient Improvement Group actions. • Surgical Improvement Group actions. • Diagnostic Improvement Group actions. • UEC Improvement Group actions. • Cancer Board actions. • Improvement and project management resource reprioritised to support priority actions/service changes. • Trust Winter Plan agreed and in place. • Effective frailty model implemented.	• Pathway changes aimed at improving ED performance including ambulance handovers as part of the GIRFT Further Faster UEC programme – end of 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 – end of 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	12.03.2026	**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”.	• Clearly identify every aspect requiring compliance. • Ongoing engagement with Contractors/HSE. • Engage professional/legal advice. • Discussions with NHSE/DHSC regarding impact on NHS. • Repository of Trust Estate where HRB applies. • DHSC Engagement regarding BSA delays. • Engagement with local MPs who are raising the issue on behalf of the Trust with Ministers.	• 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 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 • Regular review of priority replacement plan and equipment. • Forecast of CIR requirements to 2030 as part of 5-	• Estates Risk Management & Governance Group minutes and action logs. • ERIC/Model Health System. • Estates Investment, Planning, Strategy and Capital Investment Group. • CIR plan 2026/27 Capital programme. • Capital Management Group oversight. • CMG report - Finance and Performance Committee. • ICS Infrastructure Board. • Condition surveys now aligned on CAFM system. • Risk based asset report providing clinical board prioritisation of Backlog Maintenance. • Monitoring priority replacement plans and equipment at Capital Management Group.	• 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.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

	year capital plan.				
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 RVI and 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. • IPCC 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.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Insufficient national capital funding allocation to effectively manage the lifecycle replacement or upgrade of critical medical devices (Imaging assets, Theatre Equipment etc.).	• Condition monitoring of assets is undertaken annually to enable ongoing re-prioritisation of capital replacement programme. • Capital plan includes medical devices. • 5-year Medical Device Capital replacement plan agreed for 2026/27 • Regular review of priority requests by Medical Director and medical device replacement oversight/prioritisation group	• Medical Director medical device replacement oversight/prioritisation group. • Estates Investment, Planning, Strategy and Capital Investment Group. • Medical Device replacement plan 2026/27 Capital programme. • 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 • Trust standard specifications (including dementia standards) finalised. Patient Satisfaction Surveys	• 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 – Q1 2026/27. • 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	**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. • FH Ward 12 used as decant facility for one ward refurbishment per year. • Review of access and impact on patient activity completed for each refurbishment.	• Senior Operational meetings. • Capital Management Group oversight. • Estates Strategy & Capital Investment Group. • Estates Programme Sub Group.	• Use of Alliance Construction Programme aims to delivery decant facilities – Long term – 26/27	**5-Action not yet fully defined.**	
Failure to maintain and invest in the PFI estate to keep it in a suitable and quality condition and at a safe level of compliance.	• Monitoring of PFI annual and 5-year lifecycle plan (Lifecycle investment is included within the Project Agreement and Unitary Charge for the PFI Estate). • Monitoring of PFI annual condition surveys. • Regular zonal and ad hoc inspections of PFI areas. • PFI Performance.	• PFI Monthly Review Meetings. • PFI Liaison Committee. • Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety). • Compliance & Assurance Group. • Trust Internal Audit Programme (AuditOne) • Independent Authorising Engineer annual HTM compliance Audit. • PLACE audits. • Monitor helpdesk reporting. • PFI best practice conditions survey - heads of terms for settlements agreed that include commitments to remedial works, performance improvements and a condition survey.	• Continue zonal inspection processes to identify and remedy any slippage in condition. Checks take place monthly until end of concession in 2043.	**2-Actions defined-most progressing, where delays are occurring 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. • 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	09.03.2026	**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/April 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. • EDI Steering Group. • Health and Wellbeing Steering Group • Trust Behaviours and Civility Charter • NHS England Sexual Safety in Healthcare Charter • New Sexual Misconduct & Sexual Violence Policy • EDI Development Session delivered to TMG/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 MDT Group Established. • Occupational Health Self-Referral Service.	• Health and Wellbeing Steering Group minutes. • People Strategy. • People Strategy Year 1 deliverables. • Safe Staffing Internal audit – Reasonable assurance • Freedom to speak up Internal audit – Reasonable assurance. • F2SUG assurance report to People Committee. • People Committee minutes. • Clinical Board People Oversight Groups. • People Programme Board. • Micro aggression and incivilities training. • 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 – March/April 2026 – to be reviewed in light of Grant Thornton feedback • Staff psychology support service, 2025/26 – March/April 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 – March/April 2026. • Delivery of Year 2 2025/26 EDI Priorities – March 2026.	**4. Actions defined - but largely behind plan.**	

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	09.03.2026	**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 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. • Trust Management Group Task and Finish Group – Sickness absence. • Anti Racism Framework 2025/26.	• 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 & EDI Steering Groups • Behaviours and civilities charter awareness and training in place. • Health and Wellbeing Policy	• 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. • Evaluate learning and sharing from CB People Oversight Groups – due to organisational change in dept this framework is currently in development – review in March/April 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.	• HR consultation on new structure underway, approved at Execs February 2026, expected completion by June/July 2026. • Explore Just learning culture – April 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	09.03.2026	**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. • Workforce triangulation between finance, establishment and budget.	• PWR data. • People dashboard and BI reports. • Clinical Board/Corporate Service workforce plans. • People Programme Board minutes. • People Transformation Group minutes. • Workforce data will be monitored via workforce reduction group with planned increases and decreases in workforce agreed.	• HR consultation on new structure underway, approved at Execs February 2026, expected completion by June/July 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.	• HR consultation on new structure underway, approved at Execs February 2026, expected completion by June/July 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	03.11.2025	**Likelihood**	**4**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	05.03.2026	**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. • Trust-wide Digital Plan in place and delivery timescales confirmed.	• 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.	• 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.	• Recruitment of Director of Digital to strengthen leadership capacity complete.		• 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	03.03.2026	**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 A5(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 March 2026		
Title	Committee Terms of Reference and Schedule of Business Review for 2026/27		
Report of	Kelly Jupp, Trust Secretary		
Prepared by	Lauren Thompson, Corporate Governance Manager/Deputy Trust Secretary		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☐
Summary	The annual review of the Board Committee Terms of Reference (ToR) has been conducted. The Committee ToRs and Schedules of Business (SoB) have been discussed at each respective Committee meeting. Minor changes have been made to the ToRs and SoBs to reflect: - Updated responsibilities, governance arrangements and strategic priorities. - Changes to role titles and membership. - The Finance and Performance Committee, Quality Committee and Audit, Risk and Assurance Committee ToR have been streamlined. - Changes to the scheduling of meetings for the Finance and Performance Committee and Quality Committee from holding a December meeting to holding an August meeting. - The updated process for Triple A reporting. - Minor amendments to reflect consistency when cross-referencing across Committee ToRs. - The Board of Directors Public and Private Schedules of Business have been realigned to the Interim Trust Strategy. This will be further updated once the new Trust 5-year Strategy is approved. The updated Charity Committee ToR and SoB will be submitted to the Trust Board in May 2026.		
Recommendation	The Trust Board is asked to approve the updated Terms of Reference and 2026/27 Schedules of Business.		
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]	1.2 Failure to implement effective governance systems and processes across the Trust to assess, monitor and drive improvements in quality and safety.
Reports previously considered by	Annual Review. Submission to the relevant Committee meetings has taken place in advance of the March Trust Board.

Terms of Reference – Digital and Data Committee

1. Constitution and Authority

1.1 The Digital and Data Committee is a non-statutory Committee established by the Trust Board of Directors to advise and assure the Trust Board on the delivery of the Digital Strategy and significant digital transformation projects and compliance with legislation/relevant regulations relating to information governance and security, data quality and cyber security.

1.2 The Committee reports directly to the Board of Directors and has no executive powers, other than those specifically delegated in these Terms of Reference;

1.3 The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference to:

a) seek any information it requires from any officer of the Trust, and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required; and/or

b) secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Lead of the Committee and / or the Trust Secretary).

1.4 The Committee shall be able, in exceptional circumstances, to establish sub-committees and / or task and finish groups for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders and Scheme of Delegation, the Committee may not delegate powers to a sub-committee or task and finish group unless expressly authorised by the Board of Directors.

1.5 The Terms of Reference must be approved by the Board of Directors and be reviewed annually.

2. Purpose

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors that the:

2.1 Digital Strategy enables improvements in the safety and quality of care for patients, as well as in the efficiency and effectiveness of patient and staff experiences;

2.2 strategic digital priorities are aligned with the Trust strategy and risks are managed effectively;

2.3 reporting of digital performance is being triangulated against agreed plans, progress and performance measures;

2.4 Trust has sufficient digital capability to deliver the Digital Strategy, and that the Trust's digital resources and assets are being used and maintained effectively and efficiently to ensure value for money;

2.5 Trust is complying with current digital statutory and external reporting standards and requirements; as well as with legislation/relevant regulations for clinical safety (digital/system elements), information governance, information security and data quality;

2.6 mitigations and action plans as set out in the Board Assurance Framework specific to the committee purpose and function are reviewed and assessed to gain assurance on their effectiveness; and

2.7 processes and systems for the prioritisation of investments related to the Digital Strategy; as well as any Digital and/or Data incidents, are robust.

3. Duties

3.1 Cycle of Business

The Committee will:

3.1.1 set an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

3.2 Strategies and policies

3.1.2 review the Trust's digital strategy and seek assurance on related delivery plans and transformation programmes. In addition Committee members will provide advice to the Board of Directors on their robustness, comprehensiveness and relevance to the Trust's vision, values, strategic objectives and impact;

3.1.3 provide advice and support to the Trust Board on the development and delivery of the digital aspects of the annual plan; and

3.1.4 provide advice and support on significant digital transformation programmes, including procurements and business cases, prior to their recommendation for approval by the Finance and Performance Committee.

3.3 Risk

3.3.1 receive risks held on the Board Assurance Framework pertaining to the Committees area of focus to review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Audit, Risk and Assurance Committee with assurance on the effectiveness of the management of principal risks relating to the Committees purpose and function.

3.4 Performance and progress reporting

3.4.1 monitor the effectiveness of the Trust's digital performance reporting systems, ensuring that the Board is assured of continued compliance through its annual reporting processes, reporting by exception where required to the Board;

3.4.2 seek assurance on key performance and progress measures relating to the purpose and function of the Committee, including:

- the Trust's strategic digital priorities;
- cyber security;
- exceptions to compliance with national data targets; and
- risk mitigation.

3.4.3 triangulate progress against these measures and seek assurance around any performance issues identified, including proposed corrective actions;

3.4.4 provide regular reports to the Board on assurance around key areas of digital strategy performance, risk, and corrective actions, both retrospectively and prospectively;

3.4.5 be assured of the credibility of sources of evidence and data used for progress reporting to the Committee, and to the Board, in relation to the Committee's purpose and function;

3.4.6 review the formal reports to the Board as listed in the Committee Annual Cycle of Business;

3.4.7 review and approve the Terms of Reference for, and receive the minutes of, the:

- Digital & Data Governance Group; and
- Care Optimisation Group.

3.4.8 receive for information and assurance any Internal Audit reports and external review reports pertaining to the remit of the Committee.

3.5 New technologies and digital innovations

3.5.1 seek assurance on the development and implementation of new technologies and digital innovations, including Artificial Intelligence (AI), as well as any associated policies and strategies.

3.5.2 seek assurance over the implementation of digital transformation/change programmes and associated outcomes/benefits.

3.5.3 assure the Trust Board, on the effectiveness of, and compliance with, any new technologies and innovation strategies and related policies, including the effective prioritisation of innovation projects, the robustness of processes and rigour of decision-making regarding innovations, and report on this as part of the Committee's Annual Report to the Board.

3.6 Data Quality and Security, Cyber Security and Information Governance

3.6.1 seek assurance that the Trust has in place appropriate arrangements for ensuring that technology is secure and up-to-date and that digital systems are protected from cyber threats in accordance with national requirements;

3.6.2 seek assurance on data quality relating to the Trust's systems and processes, including the data quality of mandated and local datasets, Data Protection Impact Assessments, Information Assets and the effectiveness of digital clinical systems;

3.6.3 seek assurance over performance against key information governance standards and requirements, including Freedom of Information requests, data breaches and mandatory information governance training;

3.6.4 provide assurance to the Trust Board that the Trust is compliant with the relevant Data Security and Protection Toolkit standards and national requirements; and

3.6.5 seek assurance over the appropriate storage and processing of records across the Trust including compliance with the General Data Protection Regulation requirements, local policy and subject access requests.

3.7 Investment Prioritisation

3.7.1 consider and review the priorities for digital investment to align with delivery of the Digital Strategy to be included in the 3-year investment plan (to be considered by the Capital Management Group).

3.8 Statutory compliance

3.8.1 ensure, on behalf of the Board, that current digital statutory and regulatory compliance and reporting requirements are met;

3.8.2 ensure future digital legislative and regulatory and reporting requirements are identified and appropriate action taken;

3.8.3 consider any proposed changes to Trust Standing Financial Instructions, Standing Orders and Scheme of Delegation in relation to the Digital Strategy prior to their approval by the Audit, Risk and Assurance Committee; and

3.8.4 consider any reports/correspondence from the Information Commissioner relating to digital technology and information governance.

4. Membership and quorum

4.1 Membership

4.1.1 Members of the Committee shall be appointed by the Trust Board of Directors and shall be made up of at least four members drawn from Non-Executive Directors (two members minimum) and members of the Executive Team (two members minimum).

4.1.2 One of the Non-Executive members will be appointed by the Trust Board of Directors as the Chair of the Committee, and a further Non-Executive member of the Committee will be appointed as Vice-Chair.

4.1.3 In addition to the Non-Executive Chair and Vice Chair of the Committee, the membership of the Committee shall include the:

- Chief Digital Officer (Executive Lead);
- Director of Improvement & Delivery (Operations);
- Joint Medical Directors;
- Senior Information Risk Owner (SIRO);
- Chief Finance Officer;
- Director of Performance and Governance;
- Director of Nursing;
- Chief Clinical Information Officer;
- Clinical Safety Officer;
- Chief Nursing Information Officer;
- Senior Information Manager; and
- Head of Corporate Risk & Assurance.

4.1.4 The Chief Executive, as the Trust's Accountable Officer, shall have the right to attend the Committee at any time. Otherwise, only members of the Committee have the right to attend Committee meetings. Other non-committee members may be invited to observe Committee meetings, or to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.1.5 The Chair of the Board of Directors will not be a member of the Committee but may be in attendance.

4.1.6 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year.

4.1.7 The Chief Digital Officer shall act as Executive Lead for the Committee.

4.1.8 Members are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by either telephone or electronic means will count towards the quorum.

4.1.9 The Council of Governors may nominate one governor to attend Committee meetings on a quarterly cycle by rotation to observe proceedings. The observation of Board assurance committees by governors shall be subject to conditions agreed by the Board of Directors. The Chair of the Committee may, in exceptional circumstances, exclude governors from being present for specific items.

4.1.10 The Trust Secretary, or their designated deputy, shall act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, shall attend all meetings of the Committee.

4.1.11 All members of the Committee shall receive training and development support before joining the committee where required and on a continuing basis to ensure their effectiveness as members, supported by a performance assessment process, as agreed by the Board of Directors.

4.1.12 An attendance record shall be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board.

Quorum

4.1.13 The quorum necessary for the transaction of business shall be four members as defined in 4.1.1 and 4.1.3 above, including the Chair or Vice Chair.

4.1.15 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers, and discretions delegated to the Committee.

5. Committee Administration, Reporting and accountability

5.1 The Committee Chair will report formally to the Trust Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

5.2 The Committee will meet a minimum of six times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

5.3 The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

5.4 The agenda will be set in advance by the Chair, with the Trust Secretary and Executive Lead, reflecting an integrated cycle of meetings and business, which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

5.5 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than three working days before the date of the meeting.

5.6 Committee papers shall include an outline of their purpose and key points in line with the Trust's Committee protocol, and make clear what actions are expected of the Committee.

5.7 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

5.8 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten working days of the meeting.

5.9 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors and produce an Annual

Committee Report outlining how the Committee has discharged its responsibilities and met its Terms of Reference.

Procedural control statement: 3 March 2026
Date approved: 12 March 2026 D&D Committee and 27 March 2026 Trust Board [TBC]
Approved by: D&D Committee and Trust Board
Trust Board Review date: March 2027

Agenda item A5(b)

Committee / Group:	**Data and Digital Committee**
Chair:	**Hassan Kajee**
Annual Cycle Covered:	**2026/27**

	Lead	Authors / contacts of the report	May-26	Jul-26	Sep-26	Nov-26	Jan-27	Mar-27	Notes
Standing Items									
Apologies for absence and Declarations of interest	Lead		✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Hassan Kajee	Mary Bartram	✓	✓	✓	✓	✓	✓	
Action log	Hassan Kajee	Mary Bartram	✓	✓	✓	✓	✓	✓	
Meeting debrief	Hassan Kajee		✓	✓	✓	✓	✓	✓	
Matters requiring escalation and AOB	Hassan Kajee		✓	✓	✓	✓	✓	✓	
Regular Reports									
CIO Report, including digital performance report and partnerships update	Dave Elliott	Rachel Sarginson	✓	✓	✓	✓	✓	✓	To cover any data quality or CQC matters by exception.
Data Security & Protection (DSPT), Information Governance and Cyber Security	Chris Bill / Chris Plummer	Chris Bill / Chris Plummer	✓		✓	✓		✓	To cover any IG breaches/reports to the ICO, any significant sharing agreements etc.
BAF/risk report & emerging risks	Patrick Garner / Natalie Yeowart	Natalie Yeowart	✓(Emerging risks only)	✓(Emerging risks only)	✓	✓	✓(Emerging risks only)	✓	
Digital Transformation Update (projects by rotation)	Dave Elliott	Rachel Sarginson	✓(Digital Change Projects overview)	✓(Tech & AI initiatives)	✓(Tech /Digital Achievements & Challenges)	✓(Updates on two Digital Change Projects)	✓(Updates on two Digital Change Projects)	✓(Examples/ evidence of projects impact on quality, safety, employee/patient experience/digital inclusion)	
Digital/Data incident review	Dave Elliott	Rachel Sarginson	✓	✓	✓	✓	✓	✓	As and when required
Information Services update	Patrick Garner/Joanne Field	Joanne Field	✓	✓	✓	✓	✓	✓	
End of project implementation reviews, to incorporate benefits realisation	**TBC**	**TBC**							
Procurement reports and business cases which require approval from Finance and Performance Committee	**TBC**	**TBC**							
Data Partnerships	Wayne Elliott	Wayne Elliott			✓			✓	
Update from the Clinical Safety Officer	Raman Diddee	Raman Diddee	✓		✓		✓		
Annual Reports (AR) or updates									
Strategic Digital & Data Priorities/Updates	Dave Elliott / Patrick Garner	Rachel Sarginson / Pippa Breakspear Dean	✓	✓	✓	✓	✓	✓	
Annual Digital Workplan/Annual Digital Strategy	Dave Elliott	Rachel Sarginson			✓			✓	
Annual Report of Committee, including review of Schedule of Business and Terms of Reference	Dave Elliott	Kelly Jupp / Lauren Thompson	✓					✓	To include effectiveness consideration. ToR and SoB in March and Committee Annual Report in May
Ad Hoc reports (tabled as required)									
IT service management update including critical incident review	Sanjay Basra	Sanjay Basra							By exception if any issues arise that need reporting
Digital & Data Governance Group Chairs Log	Caroline Docking	Faye Patrick	✓	✓	✓	✓	✓	✓	
Care Optimisation Group Chairs Log	Nichola Kenny	Nichola Kenny	✓	✓	✓	✓	✓	✓	
External/Internal audit/review reports related to Digital & Data	Dave Elliott	Rachel Sarginson	✓	✓	✓	✓	✓	✓	E.g. data quality, penetration testing etc
	✓	On agenda and discussed							
	✓	Item deferred							

Terms Of Reference – Audit, Risk And Assurance Committee

1. Constitution and Authority

1.1 the Audit, Risk and Assurance Committee (ARAC) is a statutory Committee established by the Board of Directors to monitor, review and report to the Board on the suitability and efficacy of the Trust's provisions for governance, risk management and internal control. In addition the Committee will provide assurance to the Trust Board regarding compliance with standards, policies and procedures relating to clinical governance, corporate governance and risk management;

1.2 ARAC is a statutory Non-Executive Committee of the Trust Board of Directors, reporting directly to the Board of Directors, and has no executive powers, other than those specifically delegated in these Terms of Reference;

1.3 ARAC is authorised by the Board to investigate any activity within its Terms of Reference, to seek any information it requires from any officer of the Trust, and to invite any employee to provide information by request at a meeting of the Committee to support its work, as and when required; and

1.4 ARAC is authorised by the Board of Directors to secure the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary for the exercise of its functions, including whatever professional advice it requires (as advised by the Executive Lead of the Committee and / or the Trust Secretary).

2. Purpose

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors:

2.1 monitor the integrity of the financial statements of the Trust and Group, any formal announcements relating to the Trust's financial performance, and review significant financial reporting judgements contained in them;

2.2 monitor, review and report to the Board of Directors on the adequacy of the processes for governance, assurance, and risk management, and facilitate and support the attainment of effective processes through its independence;

2.3 gain assurance that the Trust risk management strategy, associated policies and processes are in place, fit for purpose, working effectively and are regularly reviewed;

2.4 ensure that the Trust, and Group, has appropriate policies in place to seek assurance over compliance with relevant legislation (e.g. Health and Safety, and Emergency

Planning), regulatory standards and the conditions of its licences e.g. Care Quality Commission (CQC) and Human Tissue Authority (HTA), via other tier 2 groups including the Compliance and Assurance Group, HTA Retained Tissue Oversight Group and Risk Validation Group;

2.5 seek assurance from the Compliance and Assurance Group (CAG) that the findings from any External Reviews are reviewed, and the delivery of any required actions is monitored;

2.6 ensure that the process for responding to clinical litigation claims, as reported to/monitored by the CAG, is robust and that appropriate actions are taken to address any areas for improvement, including the identification of any themes and the sharing of lessons learned;

2.7 ensure that the CAG seeks assurance that processes are in place to verify that policies are regularly reviewed and compliance is monitored, in accordance with the Trust policy on writing policies;

2.8 review the effectiveness of the Trust and Group internal audit function, counter fraud services and external audit function;

2.9 provide assurance to the Board of Directors that an appropriate system of internal control is in place to ensure that Trust business is conducted in accordance with legal and regulatory standards, and affairs are managed to secure economic, efficient and effective use of resources with particular regard to value for money;

2.10 report to the Board of Directors on the discharge of its responsibilities as a Committee; and

2.11 provide assurance to the Board of Directors that the Trust, and Group, has policies and procedures in place to protect the organisation from/related to, fraud and corruption.

3. Duties

3.1 undertake the duties detailed in the NHS Audit Committee Handbook (HFMA latest edition) and will have regard to the Code of Audit Practice for NHS Foundation Trusts. The Committee will carry out the duties below for the Foundation Trust and major subsidiary undertakings as a whole, as appropriate. The Committee will set an annual set of objectives and an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

3.2 Financial Reporting

The Committee will:

3.2.1 ensure that the systems for financial reporting to the Board of Directors, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided;

3.2.2 ensure the integrity of the Annual Report and Financial Statements of the Trust and Group before submission to the Board of Directors, and any other formal announcements relating to its financial performance, reviewing significant reporting issues and judgements that they contain, and including the meaning and significance of the figures, notes and significant changes; accounting policies and practices followed, and significant changes; explanation of estimates or provisions having material effect; the schedule of losses and special payments and any reservations and disagreements between internal and external auditors, and the executive directors, which are not resolved. This is done via escalation from the Finance and Performance Committee;

3.2.3 review summary financial statements, Trust Accounts Consolidation (TAC) data/schedules, the Annual Report and Accounts, including the Annual Governance Statement;

3.2.4 review the consistency of, and changes to, accounting policies across the Trust and its subsidiary undertakings including the operation of, and proposed changes to, the Standing Orders, Standing Financial Instructions, Scheme of Delegation and Reservation of Powers, Matters Reserved to the Board, Standards of Business Conduct, the Fit and Proper Persons Policy , maintenance of registers, and the Fraud Response Plan;

3.2.5 review the methods used to account for significant or unusual transactions where different approaches are possible (including unadjusted mis-statements in the financial statements);

3.2.6 receive and review an annual report on special severance payments made during the year via a settlement agreement;

3.2.7 review whether the Trust has followed appropriate accounting standards and made appropriate estimates and judgements, taking into account the views of the External Auditor; and

3.2.8 review the clarity of disclosure in the Trust's financial reports and the context in which statements are made.

3.3 Governance, Risk Management and Internal Control

The Committee will:

3.3.1 review the establishment and maintenance of an effective system of integrated governance, risk management and internal control, across the whole of the Trust's activities (both clinical and non-clinical), that supports the achievement of the organisation's objectives;

3.3.2 review the risk environment of the Trust, and Group, to ensure that the governance system is adequately addressing the full range of current, and potential future, risks;

3.3.3 review the effectiveness of systems and processes for risk management in the Trust, in accordance with the Risk Management Strategy and Policy approved by the Committee, including arrangements for the development and review of the Board Assurance Framework and the Corporate Risk Register;

3.3.4 review the Board Assurance Framework and processes that indicate the degree of the achievement of corporate objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements;

3.3.5 review the adequacy of risk and control related disclosure statements, in particular the Annual Governance Statement, together with the Head of Internal Audit Opinion, External Audit Opinion or other appropriate independent assurances, prior to endorsement by the Board of Directors;

3.3.6 review any changes to the profile and scoring of risks included in the Board Assurance Framework, as well as any proposed new risks or risks proposed for closure, as determined by the Board and the Board Committees;

3.3.7 seek assurance on behalf of the Board of Directors that risks of all types are identified, and managed to an acceptable level, and to undertake a deep dive of significant risks (those with a residual score of 20 or above)/review Clinical Board governance reports;

3.3.8 seek assurance that risk management systems and processes are continually developed and monitored to support high standards of clinical care;

3.3.9 ensure that there is an effective mechanism for reporting, managing and escalating risks to the Board or senior management in accordance with the agreed Risk Management Policy;

3.3.10 receive a report to identify any approved changes to the Board Assurance Framework, as well as summarising assurances received/gaps in assurance in relation to the identification, management and escalation of risks;

3.3.11 advise the Trust Board on defining ‘acceptable’ risk in terms of the Trust Boards risk appetite;

3.3.12 ensure the risk management process is underpinned by a culture of open and honest reporting and management of any situation that may threaten the quality of the patient experience, staff, visitor, or public safety;

3.3.13 ensure there are mechanisms in place for training and the dissemination of information on risk management and issues, to all stakeholders, to raise awareness and understanding of risk management for all Trust employees;

3.3.14 seek assurance from CAG that the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements, any related reporting and self-certifications. Work related to counter fraud and security, as required by the NHS Counter Fraud Authority will be reported directly into the Committee;

3.3.15 via escalation from the Quality Committee, that there are robust processes/policies for managing and investigating complaints and legal claims against the Trust, including referrals to the NHS Resolution; and

3.3.16 seek assurance that a process is in place to update the Register of Directors' Interests; and Register of Gifts and Hospitality on a regular basis, and not less than annually.

3.4. Internal Control and Counter Fraud

The Committee will:

3.4.1 ensure that there is an effective Internal Audit function that meets the *Public Sector Internal Audit Standards* and provides appropriate independent assurance to the Committee, Chief Executive, and Board of Directors;

3.4.2 consider and approve the Internal Audit Strategy and Annual Plan, and ensure it has adequate resources and access to information, including the Board Assurance Framework, to enable it to perform its function effectively and in accordance with the relevant professional standards. The Committee will also ensure the function has adequate standing and is free from management or other restrictions;

3.4.3 review all reports on the Trust from the Internal and External Auditors which identify "limited assurance" or "no assurance";

3.4.4 review and monitor, on a sample basis, the Executive Management's responsiveness to the findings and recommendations of audit reports, and ensure coordination between Internal and External Auditors to optimise use of audit resource;

3.4.5 meet the Head of Internal Audit on a formal basis, at least once a year, without Executive Directors or management, to consider issues arising from the internal audit programme and its scope and impact. The Head of Internal Audit will be given the right of direct access to the Chair of the Committee, Chief Executive, Board of Directors, and to the Committee;

3.4.6 assure itself that the Trust has policies and procedures for all work related to fraud and corruption as required by the NHS Standard Contract and NHS Counter Fraud Authority (NHS CFA);

3.4.7 consider the effectiveness of Counter Fraud services annually;

3.4.8 monitor the implementation of the policy on standards of business conduct for directors and staff (i.e. Codes of Conduct and Accountability) in order to offer assurance to the Board of Directors on probity in the conduct of the Trust's business;

3.4.9 consider and approve the Annual Fraud Plan, and ensure that adequate resources and access to information enables the Fraud Team to perform its work effectively and in accordance with the relevant professional standards and the NHS Counter Fraud Manual; and

3.4.10 approve the contents of the annual Counter Fraud Functional Standard Return prior to submission to the NHS CFA.

3.5. External Audit

The Committee will:

3.5.1 consider and make recommendations to the Council of Governors, in relation to the appointment, re-appointment and removal of the Trust's External Auditor;

3.5.2 work with the Council of Governors to manage the selection process for new auditors. If an auditor resigns, the Committee will investigate the reasons, and make any associated recommendations to the Council of Governors;

3.5.3 obtain assurance of External Auditor compliance with the Code of Audit Practice for NHS Foundation Trusts;

3.5.4 have oversight of the External Auditor's remuneration and terms of engagement (approved by the Council of Governors), including fees for audit or non-audit services and the appropriateness of fees, to enable an adequate audit to be conducted;

3.5.5 agree and review the policy regarding the supply of non-audit services by the External Auditor and monitor that service, taking into account relevant ethical guidance;

3.5.6 review and monitor the External Auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the External Auditors and consider the implications and management's responses to their work;

3.5.7 meet the External Auditor at least once a year, without management being present; to discuss their remit and any issues arising from the audit;

3.5.8 establish with the External Auditors, the nature and scope of the audit, as set out in the annual plan before the audit commences; and

3.5.9 review all External Audit reports for the Trust and Charity, including the reports to those charged with governance (before its submission to the Board of Directors) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses.

3.6 Other Board Assurance Functions

The Committee will:

3.6.1 seek assurance from the CAG on policy compliance and on the maintenance of the policy framework of the Trust and review any significant breaches of the policies (non-financial);

3.6.2 review arrangements by which staff may raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters, ensuring that arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action. The People Committee will receive an annual report on the application of the Trust policy on raising concerns, with any associated matters to be raised for the attention of the Audit, Risk and Assurance Committee by the People Committee Chair;

3.6.3 receive assurance on compliance with the Trust's Speaking Out Policy, via escalation from the Trust People Committee, to ensure that the policy allows for proportionate and independent investigation of such matters and appropriate follow-up action;

3.6.4 seek assurance from the CAG on the review the findings of other significant assurance functions, both internal and external to the Trust, and consider the implications for the governance of the Trust. These will include, but not be limited to, any external reviews undertaken by the Department of Health and Social Care Arms-Length Bodies, Regulators, and professional bodies with responsibility for the performance of staff or functions;

3.6.5 seek assurance from the CAG that the findings from External reviews are acted upon (where required) and that any lessons learned are disseminated;

3.6.6 ensure that the CAG receives regular reports regarding compliance with Business Continuity, Emergency Preparedness and Health and Safety standards/legislation;

3.6.7 review the work, and receive the minutes, of other Committees within the organisation and its subsidiaries, whose work can provide relevant assurance to the Audit, Risk and Assurance Committee's own scope of work and in relation to matters

of quality affecting the Board Assurance Framework, including the Quality Committee, the Finance and Performance Committee and the People Committee;

3.6.8 ensure there is no duplication of effort between the Committees, and that no area of assurance is missed as part of its responsibility for reviewing the Annual Governance Statement prior to submission to the Board of Directors;

3.6.9 receive assurance in relation to work of the Clinical Audit function;

3.6.10 receive information on Single Tender Waivers, as approved by the Chief Executive, to gain assurance that such waivers were appropriate;

3.6.11 receive a schedule of losses and compensations and approve appropriate write-offs;

3.6.12 review registers relating to the Standards of Business Conduct Policy and consider any breaches and action taken; and

3.6.13 review every decision by the Council of Governors or the Board of Directors to suspend their respective Standing Orders.

3.6.14 In fulfilling its responsibilities, the Committee will primarily utilise the work of Internal Audit, External Audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

3.6.15 Consider matters referred to the Audit, Risk and Assurance Committee by the Board, any Board Committee or any Audit, Risk and Assurance Committee sub-committee; and

3.6.16 Refer matters to any committee of the Trust for further consideration/review.

4. Membership And Quorum

Membership

4.01 Members of the Committee will be appointed by the Trust Board of Directors and the Committee will be made up of at least four members.

4.02 All members of the Committee will be independent Non-Executive Directors. One of the members will be appointed by the Trust Board of Directors as the Chair of the Committee and a second member will be appointed as Vice-Chair by the Trust Board of Directors.

4.03 The Committee Chair will have recent relevant financial experience, assessed as being appropriate to the role by the Nominations Committee, on behalf of the Board

of Directors. It is expected that at least one member will have a formally recognised professional accountancy qualification.

4.04 The membership will include, but is not limited to:

- a Non-Executive member of the Finance and Performance Committee;
- a Non-Executive member of the Quality Committee; and
- a Non-Executive member of the People Committee.

4.05 Meeting attendees for specific agenda items will include:

- Chief Finance Officer;
- Deputy Chief Executive Officer;
- Joint Medical Directors;
- Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs);
- Director of Quality and Safety;
- Chief Digital Officer;
- Director of Communications and Corporate Affairs;
- Trust Secretary;
- Head of Corporate Risk and Assurance; and
- Assistant Finance Director – Financial Services.

4.06 The Chair of the Board of Directors will not be a member of the Committee but may be in attendance.

4.07 The Senior Independent Director of the Board of Directors will not be Chair of the Audit, Risk and Assurance Committee.

4.08 Only members of the Committee have the right to attend Committee meetings. Alternate, or substitute, members may be agreed in advance with the Chair of the Committee for a specific meeting but not for more than one and will not count towards the quorum. Other non-Committee members may be invited to observe Committee meetings, or to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.09 In the absence of the Committee Chair, the Vice-Chair will chair the meeting.

4.10 Members are able to attend Committee meetings in person, by telephone, or by other electronic means (all participation formats will count towards the quorum).

4.11 The Chief Finance Officer will act as the Executive lead for the Committee and will attend all meetings or notify the Committee Chair in advance if a nominated Deputy is required to attend the meeting in their absence.

4.12 The Chief Executive and other members of the Executive Team should be invited to attend as appropriate with an expectation that if invited they should attend in person. In addition, the Chief Executive should be required to attend, at least

annually, to discuss the process for assurance that supports the Annual Governance Statement.

4.13 External Audit and Internal Audit representatives, and the Trust Fraud Specialist Manager will be invited to attend meetings of the Committee at the discretion of the Chair. In addition, they will be invited to meet Committee members prior to the formal conduct of the business of the meeting without members of the Executive present.

4.14 The Council of Governors may nominate one Governor to attend Committee meetings on a quarterly cycle by rotation to observe proceedings. The observation of Board assurance Committees by Governors will be subject to conditions agreed by the Board of Directors. The Chair of the Committee may in exceptional circumstances exclude Governors from being present for specific items.

4.15 The Trust Secretary, or their designated deputy, will act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, will attend all meetings of the Committee.

4.16 All members of the Committee will receive training and development support where required before joining the Committee, and on a continuing basis as required, to ensure their effectiveness as members, supported by the process of annual appraisal, as agreed by the Board of Directors.

4.17 An attendance record will be held for each meeting and an annual register of attendance will be included in the annual report of the Committee to the Board of Directors.

Quorum

4.18 The quorum necessary for the transaction of business will be two members, both of whom will therefore be Non-Executive Directors, as specified in 4.02 and 4.04 of these Terms of Reference.

4.19 A duly convened meeting of the Committee at which a quorum is present will be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee.

5. Committee Administration, Reporting and Accountability

5.1 The Committee Chair will report formally to the Trust Board on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

5.2 The Committee will report to the Trust Board annually on its work in support of the Annual Governance Statement. The Annual Report will:

- set out clearly how the committee is discharging its responsibilities;

- include a statement referring to any non-audit services provided by the external auditors, and if so, how auditor objectivity and independence is safeguarded;
- set out details of the full auditor appointment process, and where the Council of Governors decide not to accept the recommendations of the Committee, a statement setting out (a) an explanation of the Committee's recommendation in relation to the appointment, re-appointment or removal of the external auditor and (b) the reasons the Council of Governors has chosen not to accept those reasons;
- provide explanatory details, where during the year the External Auditor's contract is terminated in disputed circumstances, on the removal process and the underlying reasons for removal;
- be signed by the Chair of the Audit, Risk and Assurance Committee; and
- be presented to the Annual General Meeting (as part of the overall Trust Annual Report, with the Chair of the Audit, Risk and Assurance Committee in attendance to respond to any stakeholder questions on the Committee's activities.

5.3 The Chair of the Committee will write to the Independent Regulator of NHS Foundation Trusts (NHS England) in those instances where the services of the External Auditor are terminated in disputed circumstances.

5.4 Where exceptional, serious and improper activities have been revealed by the Committee, the Chair of the Committee will write to NHS England, if insufficient action has been taken by the Board of Directors after being informed of the situation.

5.5 The Chair of the Committee shall provide, as a minimum annually, an update to the Council of Governors on the work of the Committee.

5.6 The Committee shall be able, in exceptional circumstances, to establish sub-committees and / or task and finish groups for the purpose of addressing specific tasks or areas of responsibility. In accordance with the Trust's Standing Orders and Scheme of Delegation, the Committee may not delegate powers to a sub-committee or task and finish group unless expressly authorised by the Board of Directors.

5.7 The Committee will approve the terms of reference and membership of any of its reporting sub-committees (as may be varied from time to time at the discretion of the Committee) and oversee the work of those sub-committees, receiving reports from them as specified by the ARAC in the sub-committees' terms of reference for consideration and action as necessary.

5.8 The Terms of Reference shall be reviewed by the Committee and approved by the Board of Directors annually.

5.9 The Committee will meet a minimum of five times a year and at such other times as the Chair of the Committee, in consultation with the Trust Secretary, will require allowing the Committee to discharge all of its responsibilities.

5.10 The Chairman may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

5.11 The agenda will be set in advance by the Chair, with the Trust Secretary and Executive Lead, reflecting an integrated cycle of meetings and business, which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

5.12 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, will be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers will be made available no later than three working days before the date of the meeting.

5.13 Committee papers will include an outline of their purpose and key points in line with the Trust's committee protocol, and make clear what actions are expected of the Committee.

5.14 The Chair will establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure these are recorded in the minutes accordingly.

5.15 The Committee Secretary will minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings will be made available promptly to all members of the Committee, normally within ten working days of the meeting. A Triple A Report will be produced which will be included in the Public Board of Directors papers.

5.16 The Committee will, at least once a year, review its own performance, using a process agreed for all Board Committees by the Board of Directors and produce an Annual Committee Report outlining how the Committee has discharged its responsibilities and met its Terms of Reference.

Procedural control statement: March 2026
Date approved: 24 March 2026 Audit, Risk and Assurance Committee [TBC] and 27 March 2026 Trust Board [TBC]
Approved by: Trust Board [TBC]
Trust Board Review date: March 2027

Agenda item 5(b)+A1:K65+A1:J20	**Audit, Risk and Assurance Committee (ARAC)**
Chair:	**David Weatherburn**
Annual Cycle Covered:	**2026/27**

Focus:

	Lead	Authors / contacts of the report	May-26	June-26	Jul-26	Sep-26	Nov-26	Jan-27	Mar-27	Notes
Standing Items										
Apologies for absence	David Weatherburn		✓	✓	✓	✓	✓	✓	✓	
Declaration of interests	David Weatherburn		✓	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	David Weatherburn	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	
Action log	David Weatherburn	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	
Committee Triple A Reports - Finance & Performance - Quality - People - Charity - Compliance and Assurance Group - Digital & Data - HTA Retained Tissue Oversight Group - Risk Validation Group	Committee Chairs/members	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	Committee minutes are added to the Admin Control Reading Room
Escalations from other Board Committees to ARAC/Escalations from ARAC to other Committees	Committee Chairs	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	
Escalations to Trust Board	David Weatherburn	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	
Assurance and Risk Management										
Compliance and Assurance Group Chairs Log	Patrick Garner	Patrick Garner	✓	✓		✓	✓		✓	
Risk Register report	Patrick Garner	Natalie Yeowart	✓		✓	✓	✓	✓	✓	
Risk Appetite	Patrick Garner	Natalie Yeowart							✓	
New guidance or mandatory documents	Kelly Jupp	Kelly Jupp								As an when required
Scheme of Delegation/SFIs/SOs	Jackie Bilcliff	Chris Haynes / Kelly Jupp				✓			✓	Bi annual review from July 2024 meeting
Modern Slavery Act Statement	Dan Shelley / Kelly Jupp	Dan Shelley / Kelly Jupp			✓					Review annually as a minimum
Board Assurance Framework (BAF) Report	Patrick Garner	Natalie Yeowart	✓	✓	✓	✓	✓	✓	✓	
Review findings of other significant assurance functions (outwith internal and external audit)	Kelly Jupp/Patrick Garner	Kelly Jupp/Patrick Garner								As and when required - for example the CQC, NHSI and NHS Resolution
Committee Self-Assessment of effectiveness and Audit Committee Annual Report	Kelly Jupp	Kelly Jupp / Lauren Thompson	✓							
Committee Terms of Reference and Schedule of Business	Kelly Jupp	Kelly Jupp / Lauren Thompson							✓	
Committee Annual Report	Kelly Jupp	Kelly Jupp / Lauren Thompson	✓							
Annual Governance Statement	Patrick Garner	Natalie Yeowart	✓ (Draft)	✓(Final)						
Review of the Clinical Audit Process	Rachel Carter	Pippa Breakspear-Dean			✓			✓		

Financial reporting systems	Jackie Bilcliff	Chris Haynes / Jo Mason	✓							
Assurance from the People Committee as to whether arrangements by which staff may raise concerns are operating effectively	Bernie McCardle	Vicky McFarlane-Reid					✓			Annual - in accordance with the Trust policy on raising concerns
SIRO Report	Caroline Docking	Natalie Yeowart		✓			✓			Six-monthly
Designated Individual Mortuary update including: a. Regulatory Compliance b. Mortuary services improvement plans	Nigel Cooper	Nigel Cooper				✓			✓	
7 day service audit	Rachel Carter	Pippa Breakspear-Dean	✓							
Legal claims	Rachel Carter	Pippa Breakspear-Dean	✓				✓			
Third party assurance reports	Chris Haynes	Chris Haynes			✓					ESR, payroll and NEP
Financial Governance										
Financial Statements timetable and plans	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓(Update)					✓		
Review Accounting issues raised as part of the Financial Statements audit	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓	✓						
Trust Annual Financial Statements and TACs	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓(Draft/Update)	✓(Final)						Prior to Board approval
Charity Annual Financial Statements	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity			✓(Draft)	✓(Final)				Prior to Board approval
Annual Report (including Quality Account)	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity		✓						Prior to Board approval
Corporate Governance Manual update	Kelly Jupp	Kelly Jupp								As and when required
Schedule of Losses and Compensation report	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓		✓	✓		✓		
Standards of Business Conduct Annual Report, including the	Natalie Yeowart	Natalie Yeowart		✓						
Chairman's fit & proper persons declaration	Kelly Jupp / Vicky McFarlane-Reid	Kelly Jupp / Vicky McFarlane-Reid			✓					
Annual Report - Register of Directors' Interests	Kelly Jupp	Kelly Jupp / Lauren Thompson		✓ (As part of the Annual Report)						
Annual Review of Special Severance Payments / Settlement Agreements	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓							
Debtors and Creditors balances report	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓		✓	✓		✓		
Schedule of Approval of Single Tender Action	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity	✓		✓	✓		✓		

External/Internal Audit Protocol	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity			✓					
Financial Statements Accounting Policies, Estimates and Judgements	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity		✓					✓	
Going Concern Position	Jackie Bilcliff	Chris Haynes / Jo Mason / Claire Garrity							✓	
Internal Audit										
Annual Plan	Internal Audit	Internal Audit	✓(Final)					✓	✓(Draft)	
Outcome of Audit Work / Progress Update	Internal Audit	Internal Audit	✓	✓	✓		✓	✓	✓	
Head of Internal Audit Opinion	Internal Audit	Internal Audit	✓(Draft)	✓(Final)						Verbal update at April meeting
Annual Report and IA Charter	Internal Audit	Internal Audit			✓					
Internal Auditor performance	Internal Audit	Internal Audit			✓					
External Audit										
Annual Plan and 3-year Strategic Plan	External Audit	External Audit						✓	✓	For approval
Outcome of Audit Work	External Audit	External Audit								As and when required
Management Letter / ISA260 report to the Trust	External Audit	External Audit		✓						
Management Letter / ISA260 report to the Charity	External Audit	External Audit					✓			
Annual Audit Letter	External Audit	External Audit			✓					
External Auditor Performance	External Audit	External Audit			✓					
Counter Fraud										
Annual Plan and Annual Fraud Self Review Tool	Ivan Bradshaw	Ivan Bradshaw							✓	For approval
Fraud Response Log /Fraud register	Ivan Bradshaw	Ivan Bradshaw	✓		✓		✓	✓	✓	
Activity Report	Ivan Bradshaw	Ivan Bradshaw	✓		✓		✓	✓		
Annual Report	Ivan Bradshaw	Ivan Bradshaw	✓		✓					
Counter Fraud Performance	Ivan Bradshaw	Ivan Bradshaw			✓					

✓	On agenda and discussed
✓	Item deferred

Terms of Reference – Finance & Performance Committee

1. Constitution and Authority

1.1 The Finance & Performance (F&P) Committee is a non-statutory Committee established by the Trust Board of Directors to provide assurance to the Board on the delivery of the financial aspects of the Trust's annual Operational Plan, including financial strategy and planning, transformation and sustainability, the financial performance of the Trust, and on commercial and procurement activity, including strategic investments.

1.2 The Committee has no executive powers other than those specifically delegated in these Terms of Reference. It may establish and agree Terms of Reference for sub-committees or task and finish groups to undertake specific tasks, but may not delegate any powers detailed in these Terms of Reference.

1.3 The Committee is authorised by the Board to investigate any activity within its Terms of Reference and to seek any information it requires from any officer of the Trust to support its work, as and when required.

1.4 The Committee is authorised by the Board to obtain external legal or other independent professional advice and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

2. Purpose

The purpose of the Committee is to seek assurance, on behalf of the Board of Directors:

2.1 that the strategic financial priorities, risk and performance considerations are aligned and support the Trust's strategic objectives and its long-term sustainability;

2.2 that there is effective management of financial risk, and any potential to compromise the achievement of the strategic objectives is mitigated against;

2.3 that reporting on the financial and activity performance of the Trust is being triangulated against agreed plans, progress and performance measures, with progress reported to the Trust Board;

2.4 that the Trust's resources and assets are being used and maintained effectively and efficiently;

2.5 on the robustness, credibility and quality of financial management and planning information, which is reviewed and triangulated by the Committee;

2.6 on the Trust's compliance with current statutory and external reporting standards and requirements, including NHS and Treasury policies and procedures;

2.7 on the development, effective management, and delivery of the Trust's capital investment programme, and that this is fit for purpose;

2.8 to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the committee purpose and function; and

2.9 on the robustness of procurement strategies, decision-making and documentation.

2.10 The Committee will provide the Trust Board of Directors with advice and support on the development and delivery of the: Investment Strategy (regarding investments in services and business cases), Commercial Strategy, Procurement Strategy and Sustainability (Shine Report).

3. Duties

3.1 Cycle of Business

The Committee will:

3.1.1 set an annual set of objectives and an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

3.2 Strategies and policies

The Committee will:

3.2.1 review the Trust's financial plans and transformation programmes, and advise the Board on how strong, complete and aligned they are with the Trust's vision and objectives;

3.2.2 review guidance on the financial components of annual planning, including revenue, budgets, capital, targets, and resource use;

3.2.3 review, and recommend to the Board, the Annual Financial Plan, including key financial performance indicators;

3.2.4 advise on key financial and commercial policies including costing, revenue, capital, working capital, treasury, investments, and benefits realisation before Board approval;

3.2.5 seek assurance that financial policies and plans are aligned to the Trust's agreed approach to the development of place-based, systems and regional working, and align with the Trust's strategic approach to commissioners and stakeholders;

3.2.6 identify learning and development needs arising from the work of the Committee for consideration by the People Committee.

3.3 Annual Financial Plan

The Committee will:

3.3.1 review the Trust's Annual Financial Plan for recommendation and approval by the Board;

3.3.2 review progress and performance against the approved plan and any significant supporting plans and targets, and analyse the robustness of any corrective action required to address emerging cost pressures and risks;

3.3.3 review the Trust's Statement of Financial Position, with a particular focus on debtors, creditors, and asset valuations; and

3.3.4 receive and review an overview of financial and service delivery agreements and key contractual arrangements entered into by the Trust.

3.4 Risk

The Committee will:

3.4.1 Receive the risks held on the Board Assurance Framework pertaining to the Committees area of focus to review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Audit, Risk and Assurance Committee with assurance on the effectiveness of the management of principal risks relating to the Committees purpose and function.

3.5 Performance and progress reporting

The Committee will:

3.5.1 monitor the Trust's performance reporting systems, ensuring that the Board is assured of continued compliance through its annual reporting processes, reporting by exception where required to the Board;

3.5.2 agree a succinct set of key performance and progress measures relating to the full assurance purpose of the Committee, including:

- the Trust's strategic financial priorities;
- national performance and statutory targets;
- consolidated financial performance summaries and related budgets;
- statement of financial position;
- working capital performance;
- cash flow status;
- progress on capital investment programme;
- regulatory oversight ratings;
- risk mitigation; and
- information from sub committees / task and finish groups.

3.5.3 triangulate progress against these measures and seek assurance around any performance issues identified, including proposed corrective actions;

3.5.4 provide regular reports to the Board, including as part of the bi-monthly Integrated Board Report, on assurance around key areas of Trust performance, risk, and corrective actions, both retrospectively and prospectively;

3.5.5 agree a programme of benchmarking activities and reference points to inform the understanding and effectiveness of the Committee and its work;

3.5.6 be assured of the credibility of sources of evidence and data used for planning and progress reporting to the Committee, and to the Board, in relation to the Committee's purpose and function;

3.5.7 ensure the alignment and consistency of Board assurances, use of data and intelligence, by working closely with the Audit, Risk and Assurance Committee, Quality Committee, People Committee and Digital and Data Committee;

3.5.8 review the following formal reports to the Board as part of the Annual Cycle of Business:

- Annual Financial Plan;
- Finance Reports; and
- Capital Investment Policy

3.6 Capital, investments, acquisitions and disposals

3.6.1 review the Trust's capital and investment policies against appropriate benchmarks prior to recommendation for Board approval;

3.6.2 agree a consistent and robust methodology for the assessment of proposed capital expenditure, acquisitions, joint ventures, equity stakes, major property transactions, mergers, and formal or informal alliances with other Institutions;

3.6.3 review business cases and proposals over the threshold specified within the Trust Scheme of Delegation, and provide advice to the Board accordingly;

3.6.4 assure the Trust Board, on a regular basis, of the effectiveness of, and compliance with, the capital and investment strategies and related policies, including the effective prioritisation of investment decisions, the robustness of processes and rigour of investment decision-making, and report on this as part of the Committee's Annual Report to the Board;

3.6.5 seek assurance that a process is in place to monitor the performance of investments, which incorporates a review of the benefits realised as part of infrastructure and service improvement investments made; and

3.6.6 exercise delegated responsibility on behalf of the Board in line with the Standing Financial Instructions for proposals for acquisition and disposal of assets in accordance with Trust policy.

3.7 Commercial strategy

3.7.1 provide support and advice on the development and implementation of the commercial strategy for the Trust.

3.7.2 assure the Trust Board, on a regular basis, of the effectiveness of, and compliance with, the commercial strategy and related policies, including the effective prioritisation of commercial decisions, the robustness of processes and rigour of commercial decision-making, and report on this as part of the Committee's Annual Report to the Board.

3.8 Subsidiary company reporting

3.8.1 monitor the effectiveness of subsidiary company/companies financial and operational performance reporting systems, ensuring that the Board is assured of continued compliance through its annual reporting processes, reporting by exception where required to the Board.

3.9 Statutory compliance

3.9.1 ensure, on behalf of the Board, that current statutory and regulatory compliance and reporting requirements are met, including compliance with treasury policies and procedures and the appropriate safeguards for security of the Trust's funds as an NHS Foundation Trust;

3.9.2 ensure the proper reporting of actions deemed "high-risk" by regulators, or actions with an equity component, which entail a potentially significant risk to reputation or to the stability of the business of the Trust, or which create material contingent liabilities;

3.9.3 ensure future legislative and regulatory and reporting requirements are identified and appropriate action taken; and

3.9.4 consider, and recommend for approval by the Audit, Risk & Assurance Committee, any proposed changes to Trust Standing Financial Instructions, Standing Orders and Scheme of Delegation.

4. Membership and quorum

4.1 Membership

4.1 Members of the Committee shall be appointed by the Trust Board of Directors and shall be made up of at least six members drawn from Non-Executive Directors (three members minimum) and members of the Executive Team (three members minimum).

4.2 One of the Non-Executive members will be appointed by the Trust Board of Directors as the Chair of the Committee and another as Vice Chair (who will chair the meeting in the absence of the Committee Chair if required).

4.3 The membership of the Committee shall include:

- a Non-Executive member;
- the Chief Finance Officer;
- the Deputy Chief Executive Officer or nominated Executive Lead;
- the Chief Digital Information Officer
- the Director of Estates, Facilities and Strategic Partnerships; and
- the Director of Performance and Governance

4.4 The Chief Executive, as the Trust's Accountable Officer, shall have the right to attend the Committee at any time. Otherwise, only members of the Committee have the right to attend Committee meetings. Other non-committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.5 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year.

4.6 The Chief Finance Officer shall act as Executive Lead for the Committee.

4.7 Members are able to attend Committee meetings in person, by telephone, or by other electronic means (all participation formats will count towards the quorum).

4.8 The Council of Governors may nominate one Governor to attend Committee meetings on a quarterly cycle by rotation to observe proceedings. The observation of Board assurance Committees by Governors shall be subject to conditions agreed by the Board. The Chair of the Committee may, in exceptional circumstances, exclude governors from being present for specific items.

4.9 The Trust Secretary, or their designated deputy, shall act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, shall attend all meetings of the Committee.

4.10 The Chair of the Board of Directors will not be a member of the Committee but may be in attendance.

Quorum

4.11 The quorum necessary for the transaction of business shall be four members, as defined in 4.2 and 4.3 above, including the Chair or Vice Chair and at least one Non-Executive Director.

4.12 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers, and discretions delegated to the Committee.

5. Committee Administration, Reporting and Accountability

5.1 The Committee Chair will report formally to the Trust Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed and matters requiring escalation after each F&P Committee meeting.

5.2 The terms of reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

5.3 The Committee will meet a minimum of ten times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

5.4 The Chair may at any time convene additional meetings, or Extraordinary meetings of the Committee to consider business that requires urgent attention.

5.5 The agenda will be set in advance by the Chair, with the Trust Secretary and Executive Lead, reflecting an integrated cycle of meetings and business, which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

5.6 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than three working days before the date of the meeting.

5.7 Committee papers shall include an outline of their purpose and key points in line with the Trust's Committee protocol, and make clear what actions are expected of the Committee.

5.8 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

5.9 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten working days of the meeting. A Triple A Report will be produced which will be included in the Public Board of Directors papers.

5.10 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board, and produce an Annual Committee Report outlining how the Committee has discharged its responsibilities and met its Terms of Reference.

Procedural control statement: March 2026
Date approved: 23 March 2026 Finance & Performance Committee [TBC] and 27 March 2026 Trust Board [TBC]
Approved by: Finance & Performance Committee and Trust Board
Trust Board Review date: March 2027

Committee / Group:	**Finance & Performance Committee**
Chair:	**Bill MacLeod**
Annual Cycle Covered:	**2026/27**

	Lead	Authors / contacts of the report	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Jan-27	Feb-27	Mar-27	Notes
Standing Items														
Apologies for absence	Bill MacLeod		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Declaration of interests	Bill MacLeod		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Bill MacLeod	Kelly Jupp / Lauren Thompson		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Action log	Bill MacLeod	Kelly Jupp / Lauren Thompson		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Meeting debrief, matters requiring escalation and AOB	Bill MacLeod	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Regular Reports														
Finance report [Including KPIs, CIP, *cquins,* risks, capital summary, cash and balance sheet updates]	Jackie Bilcliff	Claire Garrity / Jo Mason / Chris Haynes	✓	✓	✓			✓	✓	✓	✓	✓	✓	
Finance Committee Risk Report and New/emerging risks	Natalie Yeowart	Natalie Yeowart		✓				✓			✓		✓	Committee members will discuss any new and emerging risks at each meeting where relevant
Board Assurance Framework (BAF)	Patrick Garner	Natalie Yeowart	✓	✓	✓	✓		✓		✓	✓		✓	
Capital Plan and capital projects update (4 x a year)	Paul Hanson / Jackie Bilcliff	Claire Garrity / Lynsey Allen		✓			✓	✓					✓	
Focused Performance updates	Patrick Garner	Pippa Breakspear-Dean	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	M1 - Elective waits and Children & Young People KPIs M2 - Cancer and Diagnostics M3 - Emergency Care and other supporting updates as required
Procurement Plan/Update [4 x a year]	Dan Shelley	Dan Shelley			✓				✓		✓		✓	
Summary of Internal Audit reports relating to the F&P Committee	Natalie Yeowart	Natalie Yeowart	✓			✓			✓		✓			
Management Group Minutes:														
- Supplies & Service Procurement Group (SSPC) minutes [when available]	Bill MacLeod	Dan Shelley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
- Cash Group (when available)	Jackie Bilcliff	Chris Haynes		✓		✓		✓		✓		✓		
- Revenue Management Group (when available)	Jackie Bilcliff	Claire Garrity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
- Sustainable Healthcare Committee	Bill MacLeod	James Dixon	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
- Capital Management Group (CMG) minutes [when available]	Bill MacLeod	Lynsey Allen	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
- Financial Recovery Steering Group minutes	Jackie Bilcliff	Claire Garrity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
- Any Strategic Oversight Group minutes as required	Bill MacLeod	Kelly Jupp	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Review of Commercial Schemes	Vicky McFarlane-Reid	Wayne Elliott				✓			✓		✓			Quarterly
Clinical Board / Corporate Service Updates	Clinical Board Chairs and Directors of Ops	Clinical Board Chairs and Directors of Ops	✓ SSS CB	✓ CS CB	✓ C&H CB			✓ SAS CB	✓ PO&CC CB	✓ FH CB	✓ C&D CB	✓ MEC CB		
Sustainability (Shine Report)	James Dixon	James Dixon						✓					✓	JD to attend twice a year. Report to Board twice a year.
Annual Reports (AR) or updates														
Annual Accounts Draft/Final	Jackie Bilcliff	Claire Garrity / Jo Mason / Chris Haynes		✓	✓									
Annual Report of Committee, including review of Schedule of Business and Terms of Reference	Kelly Jupp	Kelly Jupp / Lauren Thompson	✓										✓	
Revenue and budget setting	Jackie Bilcliff	Claire Garrity	✓										✓	
Capital expenditure deep dive, including PFI	Paul Hanson / Jackie Bilcliff	Claire Garrity / Lynsey Allen / Russell Jones / Chris Haynes						✓			✓			
Month 12/year-end report	Jackie Bilcliff	Claire Garrity / Jo Mason	✓											
National Cost Collection	Jackie Bilcliff	Claire Garrity / Jo Mason						✓						
Plan /Plan updates (Finance and Activity)	Jackie Bilcliff Patrick Garner Vicky McFarlane Reid	Claire Garrity	✓								✓		✓	
Subsidiary company updates														
NHPL Report (twice a year)	Julie Swaddle	Julie Swaddle						✓					✓	
Ad-hoc reports to be considered														
Waiting List Size Activity and Finance Considerations	Jackie Bilcliff Patrick Garner	Claire Garrity			✓									
Commercial strategy / Updates [twice a year]	Vicky McFarlane-Reid	Wayne Elliott		✓						✓				
Briefing on the new Procurement Act 2023	Dan Shelley	Dan Shelley						✓						

	Lead	Authors / contacts of the report	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Jan-27	Feb-27	Mar-27	Notes
Policies and procedures e.g. Treasury management, Investment management as required in accordance with the SFIs/SoD	All	Dan Shelley / Chris Haynes / Kelly Jupp												
Business cases / investment proposals [as and when required in accordance with the SoD/SFIs/SoD]	Vicky McFarlane-Reid / All	Lisa Jordan/ Dan Shelley	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Schedule of Business Cases to be shared at the March 2025 Committee meeting for 2025/26
GIRFT/Model Hospital [to report by exception as required]	Patrick Garner	Pippa Breakspear-Dean		✓										
ED Business Case Update	Patrick Garner	Marcus Weatherly						✓						

Estates Capital Schemes														
[Capital items to be added once Capital Programme finalised]														

Contracts														Contracts schedule for 2026/27
Medicines Manufacturing Centre	Dan Shelley	Procurement team members												
Taxi Services	Dan Shelley	Procurement team members												
Orthotics Services	Dan Shelley	Procurement team members												
CISCO Licence Support	Dan Shelley	Procurement team members												
Catering - Meals to Go and prepared meals	Dan Shelley	Procurement team members												
Endoscopy Consumables	Dan Shelley	Procurement team members												
Renal Dialysis	Dan Shelley	Procurement team members												
Prosthetics Service	Dan Shelley	Procurement team members												
DaVinci Surgical Robot	Dan Shelley	Procurement team members	✓											
Cyber Back-up solution	Dan Shelley	Procurement team members												
Monthly Update Report Jan - Mar	Dan Shelley	Procurement team members	✓											
MRI Replacement RVI	Dan Shelley	Procurement team members												

Terms of Reference – People Committee

1. Constitution and Authority

1.1. The People Committee is a non-statutory Committee (the Committee) constituted as a standing committee of the Trust Board of Directors (the Board). The Terms of Reference shall be reviewed by the Committee and any changes to these must be approved by the Board of Directors, at least annually.

1.2. The Committee is authorised by the Board of Directors to investigate any activity within its Terms of Reference and to seek any information it requires from any officer of the Trust to support its work, as and when required.

1.3. The Committee is authorised by the Board of Directors to obtain external legal or other independent professional advice and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

2. Purpose

2.1. The purpose of the Committee is to seek assurance, on behalf of the Board that the Trust's People agenda is aligned to the strategic priorities and is delivered through the people plan which includes, but is not limited to:

- equality, diversity and inclusion (EDI)
- culture and staff experience
- workforce plans, recruitment retention
- health and well-being
- education and training
- learning and development
- communications and engagement

3. Duties

3.1. The Committee will provide support and challenge on the development and review of the Trust's People Plan and related workforce strategies to achieve it. Its duties will include, but are not limited to:

a. Receiving regular reports to scrutinise the delivery of the People Plan and related people priorities.

b. Reviewing risks held on the Board Assurance Framework (BAF) pertaining to the Committees area of focus and seeking assurance that these are effectively managed. The Committee will provide assurance to the Audit, Risk and Assurance Committee on the effectiveness of these risks.

c. Reviewing the Trust's priorities and plans against the Workforce Race Equality Standards (WRES); Workforce Disability Standards (WDES); the NHS EDI Improvement Plan; Gender Pay Gap; and the Equality Delivery System.

d. Receiving reports to review performance against key people performance indicators.

e. Monitoring staff experience through staff surveys, pulse surveys and the performance dashboard from the Freedom to Speak Up Guardian.

f. Reviewing the Trust's education strategies and plans and seek assurance on the requirements, reporting and recommendations from external partners, professional bodies and regulators in relation to the standards of education and training provided by or at the Trust.

g. Providing support and challenge on the development of the Trust's engagement and communications strategies and related programmes of work and reviewing the effectiveness of communications and engagement.

h. Reviewing workforce related Internal and External Audit reports/findings and the implementation of any associated audit recommendations.

i. Monitoring Trust compliance against legislative and other regulatory workforce requirements including the NHS People Promise.

j. Reviewing and approving the Terms of Reference for, and receive the Chairs Logs and minutes of, the People Programme Board, Job Planning Oversight Group and Workforce Reduction Group.

k. Provide oversight of the process and progress being made on staff disciplinary and grievances

3.2. The Committee will set an annual Cycle of Business and will report to the Board on its progress, escalating issues of concern where necessary.

4. Membership and quorum

4.1. Members of the Committee shall be appointed by the Trust Board of Directors and include at least three Non-Executive Directors and three Executive Team members.

4.2. One of the non-executive members will be appointed by the Trust Board of Directors as the Chair of the Committee and another as Vice Chair (who will chair the meeting in the absence of the Committee Chair if required).

4.3. The membership of the Committee shall be:

- Three Non-Executive Directors
- The Deputy Chief Executive
- The Executive Director of People and Commercial Innovation
- The Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs)
- A Joint Medical Director
- The Director of Communications & Corporate Affairs
- Interim Executive Director of Operations
- The Director of People and Organisational Development

4.4. The Chair of the Board of Directors shall not be a member of the Committee but may be in attendance.

4.5. Members are expected to attend all meetings. Members unable to attend a meeting of the Committee may by exception nominate a deputy to attend on their behalf, agreed in advance with the Chair of the Committee.

4.6. Only members of the Committee have the right to make decisions in relation to Committee business. Other non-Committee members may be invited attend, with agreement of the Chair, to assist the Committee from time to time, according to particular items being considered and discussed.

4.7. Members are able to attend Committee meetings in person, by telephone, or by other electronic means. Members in attendance by either telephone or electronic means will count towards the quorum.

4.8. The Council of Governors may nominate one Governor to attend Committee meetings on a quarterly cycle by rotation to observe proceedings. The observation of Board assurance Committees by Governors will be subject to conditions agreed by the Board of Directors. The Chair of the Committee may in exceptional circumstances exclude Governors from being present for specific items.

4.9. The Trust Secretary, or their designated deputy, shall act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, shall attend all meetings of the Committee.

Quorum

4.10. The quorum necessary for the transaction of business shall be four members, as defined in 4.3 above, with at least two Non-Executive Directors present. Nominated deputies will count towards the quorum.

4.11. A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee.

5. Committee Administration, Reporting and Accountability

5.1. The Committee shall meet a minimum of six times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

5.2. The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

5.3. The agenda will be set in advance by the Chair, with the Committee Secretary and Executive Lead, reflecting an integrated cycle of meetings and business, which is agreed each year for the Board and its Committees to ensure it fulfils its duties and responsibilities in an open and transparent manner.

5.4. Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than three working days before the date of the meeting.

5.5. Committee papers shall include an outline of their purpose and key points, in line with the Trust's Committee protocol, and make clear what actions are expected of the Committee.

5.6. The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

5.7. The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten working days of the meeting. A Triple A Report will be produced which will be included in the Public Board of Directors papers.

5.8. The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board of Directors, and produce an Annual Committee Report outlining how the Committee has discharged its responsibilities and met its Terms of Reference.

5.9. The Committee Chair will report formally to the Trust Board of Directors on matters requiring escalation after each People Committee meeting.

Procedural control statement: March 2026
Date approved: 17 March 2026 People Committee and 27 March 2026 Trust Board [TBC]
Approved by: People Committee and Trust Board
Trust Board review date: March 2027

Agenda item A5(b)

Committee / Group:	**People Committee**
Chair:	**Bernie McCardle**
Executive Lead:	**Vicky McFarlane-Reid**
Year:	**2026-2027**

	Executive Lead	Authors / contacts of the report	May-26	Jul-26	Sep-26	Nov-26	Jan-27	Mar-27	Notes
Standing Items									
Apologies for absence and Declarations of interest	Bernie McCardle	Lauren Thompson / Gillian Elsender	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Bernie McCardle	Lauren Thompson / Gillian Elsender	✓	✓	✓	✓	✓	✓	
Action log	Vicky McFarlane-Reid	Lauren Thompson / Gillian Elsender	✓	✓	✓	✓	✓	✓	
New and emerging risks	Vicky McFarlane-Reid		✓	✓	✓	✓	✓	✓	
Board Assurance Framework (BAF) Report	Vicky McFarlane-Reid	Natalie Yeowart	✓	✓	✓	✓	✓	✓	Committee to approve the BAF for ratification at Audit, Risk and Assurance Committee and Trust Board
Matters requiring escalation and AOB	Bernie McCardle	Lauren Thompson / Gillian Elsender	✓	✓	✓	✓	✓	✓	
Meeting debrief	Bernie McCardle		✓	✓	✓	✓	✓	✓	
Regular Reports for areas of focus									
People Plan (PP) - Progress Update									
PP overview and Action Plan tracker - all pillars	Vicky McFarlane-Reid	Amy Callow	✓	✓	✓	✓	✓	✓	
People Programme Board Chairs Log and minutes	Vicky McFarlane-Reid	Amy Callow	✓	✓	✓	✓	✓	✓	To incorporate updates from the Learning and Education Group, HWB Group and EDI Steering Group. The People Programme Board minutes will be received in the Admin Control Reading Room.
Health and Wellbeing High Level actions)									
Staff psychology support service	Vicky McFarlane-Reid	Amy Callow	✓		✓		✓		Deep dive / discussion on the delivery of plan priority actions and expected impact measures
Supporting staff attendance to reduce short term and long term sickness	Vicky McFarlane-Reid	Amy Callow		✓		✓		✓	
Behaviours and Civility (High Level actions)									
Plans to tackling racism, sexual misconduct and incivility; this will include both staff facing and patient facing elements	Vicky McFarlane-Reid	Amy Callow	✓		✓		✓		
Valued and Heard (High Level actions)									
Staff engagement - include staff Survey	Vicky McFarlane-Reid	Amy Callow		✓		✓		✓	
Equality Diversity and Inclusion (EDI) high impact action plan	Caroline Docking	Amy Callow	✓		✓		✓		.
Freedom to Speak Up (FTSU)	Paula and Kathryn Smart	Rachel Carter	✓	✓	✓	✓	✓	✓	Including the Freedom to Speak Up (FTSU) delivery plan
Gender Pay Gaps annual return	Vicky McFarlane-Reid	Amy Callow						✓	
Public Sector duty annual return	Vicky McFarlane-Reid	Amy Callow				✓			
Equality Delivery System annual return	Vicky McFarlane-Reid	Amy Callow						✓	
WRES & WDES (oversight)	Vicky McFarlane-Reid	Amy Callow		✓					

Training and education	Vicky McFarlane-Reid	Amy Callow			✓			✓	
Communications strategy/strategic communications and external engagement update	Caroline Docking	Angela Halliday			✓			✓	
Violence & Aggression to staff	Ian Joy	Diane Cree & Tim White			✓				
Leadership and Management (high Level actions)									
Developing line managers	Vicky McFarlane-Reid	Amy Callow				✓			
Integrating the way the People and OD aligns to clinical board and corporate directorate	Vicky McFarlane-Reid	Amy Callow	✓		✓		✓		
Ensure all senior leaders have explicit equality, diversity and inclusion objectives setting out their personal and shared responsibilities to improve culture of the Trust	Vicky McFarlane-Reid	Amy Callow						✓	2 actions
GMC training survey	Michael Wright & Lucia Pareja-Cebrian	Ifti Haq				✓			To receive and be assured the Trust has an action plan to address the poor results in the survey
Resident Doctors 10 point plan	Lucia Pareja-Cebrian	Kerry Leonard	✓		✓		✓		
Leng Review	Michael Wright & Lucia Pareja-Cebrian	Kerry Leonard			✓			✓	Added at the March 2026 Committee meeting
Guardian of Safe Working	Henrietta Dawson	Henrietta Dawson		✓			✓		HD to attend twice a year (July & January). Quarterly Reports. Reports go to Trust Board.
Trade Union Faculty Time Report	Vicky McFarlane-Reid	Amy Callow		✓					
Recruitment update	Vicky McFarlane-Reid	Amy Callow			✓				
Employee Relations dashboard and report	Christine Mann	Deb Stuart	✓			✓			
Fairer deal for nurses	Ian Joy	Diane Cree	✓	✓	✓	✓	✓	✓	Update to be provided when available - added at the March 2026 Committee meeting
Workforce planning									
Workforce reduction group	Sue Hillyard	Ali Greener	✓	✓	✓	✓	✓	✓	Terms of Reference to be received once a year
Annual workforce plan	Patrick Garner	Pippa Breakspear-Dean							
Job Planning update	Michael Wright	Kerry Leonard & Elle Marshall			✓			✓	
Job Planning Oversight Group Chairs Log	Michael Wright	Kerry Leonard & Elle Marshall							To receive when available. Terms of Reference to be received once a year.
Integrated Board Report (IBR) - summary People dashboard and highlight report	Keith Wheldon	Deb Stuart	✓	✓	✓	✓	✓	✓	The full IBR will be included in the Admin Control Reading Room.
General Governance reports									
Annual Report of Committee, including review of Schedule of Business and Terms of Reference	Kelly Jupp & Lauren Thompson	Lauren Thompson	✓					✓	Terms of Reference and Schedule of Business in March Committee Annual Report in May
Summary of Internal Audit reports relating to the People Committee	Patrick Garner	Natalie Yeowart		✓		✓		✓	

Terms of Reference – Quality Committee

1. Constitution and Authority

1.1 The Quality Committee is a non-statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the quality of care to the Trust's patients, specifically in relation to patient safety, clinical effectiveness (including patient outcomes) and patient experience.

1.2 The Committee has no executive powers other than those specifically delegated in these Terms of Reference. It may establish and agree Terms of Reference for sub-committees or task and finish groups to undertake specific tasks, but may not delegate any powers detailed in these Terms of Reference.

1.3 The Committee is authorised by the Board to investigate any activity within its Terms of Reference and to seek any information it requires from any officer of the Trust to support its work, as and when required.

1.4 The Committee is authorised by the Board to obtain external legal or other independent professional advice and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

2. Purpose

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors:

2.1 ensure the Trust's quality governance is sufficiently robust to deliver safe care and meet legal and regulatory obligations;

2.2 on the Trust's approach to, and delivery of, continuous quality improvement;

2.3 that any shortcomings in the quality and safety of care against agreed standards are being identified and addressed in a systematic and effective manner;

2.4 on the quality impact of changing professional and organisational practices, including those involved in increased system-based and partnership working (in collaboration with the People Committee);

2.5 that the Trust fulfils its leadership and influencing role on service quality, standards and practice (in collaboration with the People Committee);

2.6 around current and future statutory and mandatory quality and patient safety standards, such as Care Quality Commission (CQC) Fundamental Standards, and the actions needed to meet them;

2.7 on the effectiveness of mechanisms used for the involvement of patients and the public, staff, partners and other stakeholders in improving quality assurance and patient safety at the Trust; and

2.8 to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the committee purpose and function.

Duties

The Committee will:

3.1 Cycle of Business

3.1.1 set an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

3.2 Strategy

3.2.1 advise and contribute to the strategic quality priorities and investments needed to support high-quality clinical outcomes and improve clinical effectiveness in the Trust, and advise the Board accordingly;

3.2.2 review the Trust's Quality Account and related delivery plans and programmes, and provide informed advice to the Board on their robustness, comprehensiveness and relevance to the Trust's vision, values, strategic objectives and impact;

3.2.3 be assured via Tier2 Committees around the monitoring of the Trust's suite of quality-assurance policies against benchmarks to ensure they are comprehensive, up-to-date and reflect best practice; and

3.2.4 scrutinise and triangulate advice on the development of significant clinical and quality policies prior to their adoption.

3.3 Risk

3.3.1 receive risks held on the Board Assurance Framework pertaining to the Committees area of focus to review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Audit, Risk and Assurance Committee with assurance on the effectiveness of the management of principal risks relating to the Committees purpose and function.

3.4 Outcomes and processes

3.4.1 review the Quality Account and seek assurance that it reflects the integration of clinical quality and patient safety improvement processes;

3.4.2 seek assurance on the integrity of the Trust's control systems, processes and procedures relating to critical areas, to include:

- high quality care (through the Trust's quality review processes);
- compliance with fundamental standards of quality and safety;
- patient safety and harm reduction;
- safeguarding – adults and children

- infection prevention and control;
- clinical audit;
- introduction of new clinical pathways and procedures;
- introduction of new clinical roles (in conjunction with the People Committee);
- dissemination and implementation of statutory guidance;
- escalation and resolution of quality concerns; and
- patient and carer involvement and engagement.

3.4.3 be assured as to the effective operation of processes relating to clinical practice and performance, including early detection of issues and problems, escalation, corrective action and learning.

3.5 Learning and communication

3.5.1 seek assurance that continuous learning, innovation, and quality improvement systems are effective and acted upon;

3.5.2 be assured that robust procedures ensure adverse incidents are identified and openly investigated, with lessons learned quickly applied and shared for the benefit of patients, staff, and the Trust;

3.5.3 be assured that evidence-based practice, ideas, innovations and statutory and best practice guidance are identified, disseminated and applied within the Trust;

3.5.4 be assured of the effectiveness of communication, engagement and development activities designed to support patient safety and improve clinical governance.

3.6 Patient and public engagement

3.6.1 be assured that patient experience is assessed and reported consistently, and that patient engagement processes effectively support the Trust's strategic goals.

3.7 Progress and performance reporting

3.7.1 review a range of evidence and data from multiple sources, including management and executive committees and groups, on which to arrive at informed opinions on:

- the standards of clinical, service quality and patient safety in the Trust;
- compliance with agreed standards of care and national targets and indicators; and
- organisational quality performance measured against specified standards and targets;

3.7.2 review a succinct set of key performance and progress measures relating to the full purpose and function of the Committee and review progress against these measures regularly and seek assurance around any performance issues identified, including proposed corrective actions and reporting any significant issues and trends to the Trust Board;

3.7.3 review and shape the quality-related content of the Integrated Board Reports to the Board;

3.7.4 be assured of the credibility of sources of evidence and data used for planning and progress reporting to the Committee and to the Board in relation to the Committee's purpose and function;

3.7.5 ensure alignment of the Board assurances and consistent use of data and intelligence, by working closely with the other tier 1 Board Committees as appropriate;

3.7.6 review the following formal reports prior to submission to the Trust Board as part of the Annual Cycle of Business:

- an Annual Quality Account to inform and / or accompany the Trust's Annual Report;
- Safeguarding Annual Report; and
- the process for management review of specific service reports.

3.9 Statutory and regulatory compliance

3.9.1 be assured of the arrangements for ensuring maintenance of the Trust's compliance standards specified by the Secretary of State, the CQC, NHS England, and statutory regulators of health care professionals.

4. Membership and quorum

4.1 Membership

4.1.1 Members of the Committee shall be appointed by the Trust Board and shall be made up of least seven members drawn from Non-Executive Directors (three members minimum) and members of the Executive Team (four members).

4.1.2 One of the Non-Executive members will be appointed by the Trust Board of Directors as the Chair of the Committee and another as Vice Chair (who will chair the meeting in the absence of the Committee Chair if required).

4.1.3 The membership shall include:

- the Joint Medical Directors;
- the Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs);
- the Deputy Chief Executive Officer or nominated Executive Lead;
- the Director of Quality and Safety;
- the Associate Medical Director, Patient Safety and Quality;
- the Director of Nursing;
- the Director of Midwifery;
- Associate Director of AHP's and Therapy Services;
- Single Clinical Board Representation at each meeting
- Chairs of the Tier 2 committees reporting to Quality Committee if not previously mentioned above.

4.05 The Chair of the Board of Directors and the Chief Executive shall not be members of the Committee, but may be in attendance.

4.1.4 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Other non-Committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.1.5 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year.

4.1.6 The Executive Director of Nursing, Midwifery and AHPs shall act as the Executive Lead for the Committee.

4.1.7 Members are able to attend Committee meetings in person, by telephone, or by other electronic means (all participation formats will count towards the quorum).

4.1.8 The Council of Governors may nominate one Governor to attend Committee meetings on a quarterly cycle by rotation to observe proceedings. The observation of Board assurance Committees by Governors shall be subject to conditions agreed by the Board of Directors. The Chair of the Committee may, in exceptional circumstances, exclude governors from being present for specific items.

4.1.9 The Trust Secretary, or their designated deputy, shall act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, shall attend all meetings of the Committee.

Quorum

4.1.10 The quorum necessary for the transaction of business shall be four members, as defined in 4.1.1 and 4.1.3 above, including the Chair or Vice Chair, at least one other Non-Executive Director and at least one Executive Team Member of the Committee.

4.1.11 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers and discretions delegated to the Committee.

5. Committee Administration, Reporting and Accountability

5.1 The Committee Chair will report formally to the Trust Board on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed and matters requiring escalation after each Quality Committee meeting.

5.2 The Committee will meet a minimum of ten times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

5.3 The Chair may at any time convene additional meetings, or Extraordinary meetings of the Committee to consider business that requires urgent attention.

5.4 The agenda will be set in advance by the Chair, with the Trust Secretary and Executive Lead, reflecting an integrated cycle of meetings and business, which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

5.5 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than three working days before the date of the meeting.

5.6 Committee papers shall include an outline of their purpose and key points in line with the Trust's Committee protocol, and make clear what actions are expected of the Committee.

5.7 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure these are recorded in the minutes accordingly.

5.8 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten days of the meeting. A Triple A Report will be produced which will be included in the Public Board of Directors papers.

5.9 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board and produce an Annual Committee Report outlining how the Committee has discharged its responsibilities and met its Terms of Reference.

Procedural control statement: March 2026
Date approved: 19 March 2026 Quality Committee and 27 March 2026 Trust Board [TBC]
Approved by: Quality Committee and Trust Board
Trust Board Review date: March 2027

Agenda item A5(b)

Committee / Group:	**Quality Committee**
Chair:	**Committee Chair**
Annual Cycle Covered:	**2026/27**

	Lead	Authors / contacts of the report	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Jan-27	Feb-27	Mar-27	Notes
Standing Items														
Apologies for absence	Committee Chair		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Declaration of interests	Committee Chair		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Committee Chair	Lauren Thompson / Gill Elsender	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Action log	Committee Chair	Lauren Thompson / Gill Elsender	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Meeting debrief and matters requiring escalation	Committee Chair	Lauren Thompson / Gill Elsender	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Regular Reports														
Chairs Logs of Tier 2 Committees	Mike Clarke /Gus Vincent / Ian Joy/Julie Swaddle/Lucia Pareja-Cebrian	As below	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Management Group Chair Reports / Chairs Log														
• Patient Safety Group (PSG)	Mike Clarke	Louise Hall	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
• Experience of Care Group	Ian Joy	Ian Joy / Diane Cree	✓		✓		✓		✓		✓		✓	
• Clinical Outcomes & Effectiveness Group (COEG)	Gus Vincent	Steve Stoker		✓		✓		✓		✓	✓		✓	
• Medicines Management Group	Lucia Pareja-Cebrian	Julie Swaddle		✓				✓			✓		✓	
• Care for all Group	Lucia Pareja-Cebrian	Kerry Leonard												
• Transplantation Committee (for receipt only)	Lucia Pareja-Cebrian	Kerry Leonard	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
•Promoting Equity in Health Group	Patrick Garner	Pippa Breakspear-Dean	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Safeguarding	Ian Joy	Diane Cree			✓(Q4 AR)			✓(Q1)		✓(Q2)			✓(Q3)	
Learning from Deaths	Rachel Carter	Danielle Smith/ Pippa Breakspear-Dean		✓(Q4 AR)				✓(Q1)			✓(Q2)		✓(Q3)	
Learning Disability	Ian Joy	Diane Cree			✓(Q4)			✓(Q1)		✓(Q2)			✓(Q3)	
Perinatal Quality Surveillance Report, including Maternity Incentive Scheme update	Ian Joy	Jenna Wall	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Integrated Board Report	Ian Joy	Elliot Tame / Patrick Garner	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
CQC Updates	Rachel Carter / Ian Joy / Others	Pippa Breakspear-Dean/Diane Cree/Anne-Marie Troy-Smith	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Patient and Staff Experience	Ian Joy	Marilyn Hodges		✓		✓		✓		✓	✓		✓	Bi-Monthly
Quality Committee Board Assurance Framework	Natalie Yeowart	Natalie Yeowart	✓	✓	✓	✓		✓		✓	✓		✓	Bi-Monthly
Legal Update & Learning from Claims	Rachel Carter	Emma Stonehouse / Pippa Breakspear-Dean	✓						✓					Changed to biannually in agreement with Ian and Anna
Wards of concern & Accrediting Excellence (ACE) Progress Report	Ian Joy	Diane Cree		✓		✓			✓		✓	✓		
Summary of Internal Audit Reports relating to the Quality Committee	Natalie Yeowart	Natalie Yeowart	✓			✓			✓		✓			
Duty of Candour	Rachel Carter	Jo Ledger	✓						✓					Biannually
Quality Impact Assessment (QIA)	Ian Joy	Jo McCallum						✓					✓	Biannually
Quality Performance Reviews	Ian Joy	Rachel Carter			✓			✓			✓		✓	Q&S focused QPRs occur quarterly (May, Jul, Nov & Feb) therefore scheduled a report for the following month to Quality Committee.
Six month nurse staffing review deep dive	Ian Joy	Diane Cree		✓						✓				
Quality and Safety Peer Reviews	Ian Joy	Diane Cree	✓			✓			✓		✓			
Health Inequalites Quaterly Report	Patrick Garner	Balsam Ahmad		✓				✓			✓		✓	
Annual/Biannual Reports														
PLACE Inspection Update Report	Paul Hanson	Lynsey Allen			✓									
End of Life and Palliative Care	Jennifer Vidrine	Lizzy Zabrocki		✓						✓				
Quality Account Priorities	Rachel Carter	Louise Hall / Pippa Breakspear-Dean		✓						✓				
Equality Delivery System Annual Report	Ian Joy	Rachel Carter								✓				

Agenda item A5(b)

Committee / Group:	**Quality Committee**
Chair:	**Committee Chair**
Annual Cycle Covered:	**2026/27**

	Lead	Authors / contacts of the report	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26	Oct-26	Nov-26	Jan-27	Feb-27	Mar-27	Notes
Annual Report of Committee, including review of Schedule of Business and Terms of Reference	Kelly Jupp / Lauren Thompson	Kelly Jupp / Lauren Thompson		✓									✓	ToR & SoB in March Committee Annual Report in May
Clinical Audit / Guidelines Report	Rachel Carter	Gavin Snelson / Pippa Breakspear-Dean						✓					✓	
Medicines Management Oversight Group Report	Julie Swaddle	Julie Swaddle				✓					✓			
Strategy														
PSIRF Priority Biannual Report	Rachel Carter	Louise Hall / Pippa Breakspear-Dean				✓						✓		
Quality Priorities Updates	Rachel Carter	Louise Hall / Pippa Breakspear-Dean			Quality Priority 1	Quality Priority 2			Quality Priority 3	Quality Priority 4	Quality Priority 5	Quality Priority 6		
Ad Hoc reports to be considered														
Policies/Internal audit reports [as and when required]	Exec Lead	Exec PA												
Clinical Strategy – AD HOC	Michael Wright/Lucia Pareja-Cebrian	Kerry Leonard												
Patient Safety - update on Marthas rule	Lucia Pareja-Cebrian	Gus Vincent												
Alliance developments	Committee Chair/Others	Committee Chair/Others												
Progress Reports from Any External Reviews i.e. Fuller, GIRFT, RCS	Executive Lead	Executive Leads												

✓	On agenda and discussed
✓	Item deferred

Committee / Group:	**Public Board of Directors**
Chair:	**Sir Paul Ennals**
Annual Cycle Covered:	**2026/27**

Meeting date	**22/05/2026**	**31/07/2026**	**25/09/2026**	**27/11/2026**	**29/01/2027**	**TBC 2027**		
Deadline for papers	**12/05/2026**	**21/07/2026**	**15/09/2026**	**17/11/2026**	**19/01/2027**	**TBC 2027**		

	Lead	Authors / contacts of the report	May-25	Jul-25	Sep-25	Nov-25	Jan-26	Mar-26	Notes
Standing items									
Apologies for absence	Paul Ennals		✓	✓	✓	✓	✓	✓	
Declaration of interests	Paul Ennals		✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Paul Ennals	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	
Action log	Paul Ennals	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	
Any other business	Paul Ennals		✓	✓	✓	✓	✓	✓	
Chair Report	Paul Ennals	Gill Elsender	✓	✓	✓	✓	✓	✓	
Chief Executive Report (Dashboard)	Rob Harrison (Jim Mackey on secondment)	Ellspeth Marshall / Ali Greener (Jackie Sutherland)	✓	✓	✓	✓	✓	✓	
Focus on Fundamentals – Quality, Performance and Finance									
Patient and Staff Story	Ian Joy	Diane Cree	✓	✓	✓	✓	✓	✓	
Joint Medical Directors Report	Michael Wright/Lucia Pareja-Cebrian	Kerry Leonard	✓	✓	✓	✓	✓	✓	
Guardian of Safe Working	Michael Wright/Lucia Pareja-Cebrian	Henrietta Dawson	✓	✓		✓	✓		Quarterly reports go to People Committee (May, July, November and January)
Annual Emergency Preparedness, Resilience and Response (EPRR) Report	Michael Wright/Lucia Pareja-Cebrian	Kerry Leonard				✓			
Annual Mental Health Update	Michael Wright/Lucia Pareja-Cebrian/Sarah Brown	Sarah Brown					✓		
Executive Director of Nursing, Midwifery and AHPs Report including safe staffing	Ian Joy	Diane Cree	✓	✓	✓	✓	✓	✓	
Perinatal Quality Surveillance (formerly named the Maternity Update report) and Maternity Incentive Scheme update Report	Ian Joy / Jenna Wall	Diane Cree / Jenna Wall	✓	✓	✓	✓	✓	✓	From Quality Committee
Maternity Safety Champion Report	Liz Bromley	Liz Bromley	✓	✓	✓	✓	✓	✓	When required
Nurse Staffing Deep Dive	Ian Joy	Diane Cree	✓			✓			
Annual flu checklist	Ian Joy	Diane Cree			✓		✓		
Learning from Deaths Report	Rachel Carter	Pippa Breakspear-Dean	✓		✓		✓	✓	From Quality Committee
Health and Safety Annual Report	Rachel Carter	Pippa Breakspear-Dean				✓			From Quality Committee
Quality Account update	Rachel Carter	Pippa Breakspear-Dean / Anne-Marie Troy-Smith	✓						From Quality Committee
Patient Safety Strategy Bi-annual reports	Rachel Carter	Pippa Breakspear-Dean			✓				From Quality Committee
Board Visibility Programme	Rachel Carter	Pippa Breakspear-Dean	✓	✓	✓	✓	✓	✓	
Planning	Jackie Bilcliff	Claire Garrity	✓					✓	
Strategy / Strategy update / Objectives 2026/27	Patrick Garner	Lisa Jordan	✓			✓			
Quality & Safety Strategy update	Rachel Carter	Pippa Breakspear-Dean			✓				
Winter Plan	Sue Hillyard	Ali Greener	✓	✓					From Finance & Performance Committee
Integrated Board Report	Patrick Garner	Elliott Tame	✓	✓	✓	✓	✓	✓	From all Committees
Sustainability update	Vicky McFarlane-Reid	James Dixon			✓			✓	From Finance and Performance Committee Annual Shine Report - September
Make it better for colleagues – IT, People and Estate									
Gender Pay Gap Report	Vicky McFarlane-Reid / Amy Callow	Karen Pearce / Deb Stuart						✓	From People Committee

Freedom to Speak Up update	Vicky McFarlane-Reid / Amy Callow / Rachel Carter	Deb Stuart / Paula Dimarco / Kathryn Smart	✓			✓			From People Committee
Staff Survey Results	Vicky McFarlane-Reid / Amy Callow	Deb Stuart						✓	From People Committee
Equality, Diversity and Inclusion (EDI) and health inequalities – patients and people	Vicky McFarlane-Reid / Patrick Garner	Deb Stuart / Balsam Ahmad						✓	
Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report/Survey Results	Vicky McFarlane-Reid / Amy Callow	Karen Pearce / Deb Stuart	✓					✓	From People Committee
Annual Revalidation Report	Michael Wright	Kerry Leonard			✓				
Annual Report of the Trust Employer Based Awards Committee	Vicky McFarlane-Reid / Amy Callow	Deb Stuart				✓			When required
Chief Digital Officer Report	Dave Elliott	Rachel Sarginson				✓			
Look to the future – Strategy, Neighbourhood Teams and GNCH									
Alliance update	Martin Wilson	Martin Wilson					✓		
NB Collaborative Newcastle/Provider Collab and other Partnership Updates	Martin Wilson	Martin Wilson				✓			When required
NIHR CRN NENC Annual Report / Research updates	Vicky McFarlane-Reid	John Isaacs				✓			
Business Items / Governance									
Committee Triple A Reports	Committee Chairs	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	
Committee Terms of Reference and Schedules of Business	Kelly Jupp	Kelly Jupp / Lauren Thompson						✓	
Subsidiary Board Terms of Reference	Kelly Jupp	Kelly Jupp / Gillian Elsender						✓	
Committee Annual Reports	Kelly Jupp	Kelly Jupp / Lauren Thompson	✓						
Board Assurance Framework	Patrick Garner	Natalie Yeowart	✓	✓	✓	✓	✓	✓	
Modern Slavery Declaration	Kelly Jupp	Kelly Jupp		✓					From Audit, Risk and Assurance Committee
Annual Governance Statement (in Annual Report and Accounts)	Rob Harrison (Jim Mackey on secondment)	Natalie Yeowart							From Audit, Risk and Assurance Committee Includes annual declarations
Fit and proper persons statement	Paul Ennals	Rachel Cockburn			✓				
Standards of business conduct	Patrick Garner	Natalie Yeowart			✓				

✓	On agenda and discussed
✓	Item deferred

Agenda item A5(b)

Committee / Group:	**Private Board of Directors**
Chair:	**Sir Paul Ennals**
Annual Cycle Covered:	**2026/27**

Meeting date	**30/04/2026**	**22/05/2026**	**25/06/2026**	**31/07/2026**	**25/09/2026**	**29/10/2026**	**27/11/2026**	**17/12/2026**	**29/01/2027**	**25/02/2027**	**TBC 2027**		
Deadline for papers	**21/04/2026**	**12/05/2026**	**15/06/2026**	**21/07/2026**	**15/09/2026**	**20/10/2025**	**17/11/2026**	**10/12/2026**	**19/01/2027**	**16/02/2027**	**TBC 2027**		

	Lead	**Authors / contacts for the reports**	**April**	**May**	**June**	**July**	**September**	**October**	**November**	**December**	**January**	**February**	**March**	**Notes**
Standing items														
Apologies for absence	Paul Ennals		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Declaration of interests	Paul Ennals		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Minutes and matters arising	Paul Ennals	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Action log		Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Any other business	Paul Ennals		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Chair update	Paul Ennals	Gillian Elsender	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Chief Executive update	Rob Harrison (Jim Mackey on secondment)	Ellspeth Marshall / Ali Greener (Jackie Sutherland)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Focus on Fundamentals – Quality, Performance and Finance														
Cardiac Oversight Group update	Michael Wright	Ellspeth Marshall	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	When required
Maternity Incentive Scheme Sign Off Report	Ian Joy	Jenna Wall										✓		
Safeguarding Serious Case Review	Ian Joy	Diane Cree		✓			✓		✓			✓		
Legal Update	Rachel Carter	Pippa Breakspear-Dean	✓					✓						
New Drug Approvals	Michael Wright / Lucia Pareja-Cebrian	Julie Swaddle	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	When required
Finance Report	Jackie Bilcliff	Claire Garrity		✓		✓	✓				✓		✓	
Tenders & Business Cases	Jackie Bilcliff / Dan Shelley	Claire Garrity / Dan Shelley / Lisa Jordan		✓		✓	✓				✓		✓	When required
Finance, activity and workforce plans	Jackie Bilcliff/Patrick Garner	Claire Garrity/Pippa Breakspear-Dean	✓										✓	
Operational & Financial Planning 2025/26:														
- Monthly Finance Report	Jackie Bilcliff	Claire Garrity	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
- Financial Recovery Plan	Jackie Bilcliff	Claire Garrity		✓							✓			
- Capital Programme	Jackie Bilcliff / Paul Hanson	Claire Garrity / Lynsey Allan					✓							
Key Clinical Board Updates	Patrick Garner	Pippa Breakspear-Dean	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Make it better for colleagues – IT, People and Estate														
People Legal Cases	VIcky McFarlane- Reid / Amy Callow	Deb Stuart		✓		✓	✓				✓		✓	When required
Estates Director Report (by exception)	Paul Hanson	Lynsey Allan												
Annual Fire Report	Paul Hanson	Lynsey Allan										✓		
Annual Security Report	Paul Hanson	Lynsey Allan												
Estates Strategic Delivery Plan/5 Year Capital Programme	Paul Hanson	Lynsey Allan												
Premises Assurance Model (PAM) Report	Paul Hanson	Lynsey Allan										✓		
Look to the future – Strategy, Neighbourhood Teams and GNCH														
Commercial Strategy	Vicky McFarlane- Reid	Wayne Elliott					✓							
Trust Strategy	Patrick Garner	Lisa Jordan											✓	When required
Business items / Governance														
Annual Report and Accounts	Jackie Bilcliff / Kelly Jupp	Kelly Jupp / Lauren Thompson		✓										
Risk Appetite	Patrick Garner	Natalie Yeowart		✓										
Review of Board effectiveness	Paul Ennals	Kelly Jupp / Lauren Thompson				✓								
Accountability Framework	Patrick Garner / Kelly Jupp	Lisa Jordan/Natalie Yeowart/Kelly Jupp	✓											
Senior Information Risk Officer Report	Patrick Garner					✓					✓			
Subsidiary annual report and annual accounts	Rob Harrison / Jackie Bilcliff	Chris Haynes					✓							
Reading room														
Committee minutes: - Finance and Performance - Audit, Risk and Assurance - Quality - People - Charity - Digital and Data - Research, Innovation & Commercial	Committee Chairs	Kelly Jupp / Lauren Thompson	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

✓	On agenda and discussed
✓	Item deferred

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Agenda item A6(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 March 2026					
Title	Committee Triple A Reports/Chairs 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 Phil Kane, Chair of the Charity 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 Triple A Reports/Chairs Logs are included since the last Public Trust Board meeting in January 2026: • Digital & Data Committee – 15 January 2026 • Quality Committee – 22 January 2026 & 19 February 2026 • People Committee – 22 January 2026 • Finance & Performance Committee – 26 January 2026 & 23 February 2026 • Audit, Risk & Assurance Committee – 27 January 2026 • Chairty Committee – 29 January 2026 (Funding only) & 2 February 2026					
Recommendation	The Trust Board is asked to note the contents of the Committee Triple A Reports and Chairs 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 January 2026.					

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Digital and Data Committee
Date of Committee / Group:	15 January 2026
Chair of Committee / Group:	Hassan Kajee

Alert
(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group e.g. breaches in legal or regulatory requirements, fraud, significant negative inspection/audit findings, unmitigated risks rated 20+, major changes in funding/commissioning, industrial action or risks to business continuity/emergency preparedness)

- No critical issues requiring urgent attention or action reported.

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

- **PACS - Digital and reporting suite requirements**
  A decision has been made for the award for PACS, this is awaiting final legal advice (should take place over the next two weeks).

- **Laboratory system LIMS**
  The committee discussed the replacement of the lab system LIMS. Options are being explored for a single system for the Trust along with the possibility of regional collaboration, ensuring clinical teams are fully engaged in exploring joint procurement and joint configuration.

- **Door access control system**
  The committee were informed of recent incidents involving the door access control system, outlining the technical issues, interim solutions, and plans for a formal incident report, with discussions of governance and assurance processes.

- **Accessible Information Standards (AIS)**
  The Trust is reviewing the approach to complying to AIS (a legal requirement introduced in 2016) as it was identified there was a gap in providing patient correspondence in alternative formats. The AIS policy has been updated along with a supporting policy in the use of emails for patient correspondence. Once ratified there are plans to roll out a communications and awareness campaign ensuring compliance across all systems/correspondence.

Assure
(key assurances received and any highlights of note such as best practice or innovation)

- **Associate Director of Digital**
  The vacancy of Associate Director of Digital will proceed with an executive search.

- **Artificial Intelligence (AI) Principles**
  The committee held a comprehensive discussion on AI and automation, covering the establishment of governance structures, development of guiding principles, training initiatives and the need for alignment with existing safety and data protection frameworks, emphasizing patient safety, professional judgment and transparency.

- **Accessible Information Standards (AIS)**
  The completed self-assessment framework was reviewed and approved by the committee.

- **Board Assurance Framework (BAF)**
  Updates were presented for the BAF which were reviewed and approved by the committee.

Risks (any new risks / proposed changes to risk scores – include risk ID where known)

- None identified.

Cross-referrals to other Committees / Executive Director Leads

- None identified.

Agreed actions	Responsibility / timescale
1. Door access control system – formal incident report to be shared at the next committee meeting.	1. Chief Digital Information Officer Timescale: Committee meeting 12th March 2026
2. Care Quality Commission (CQC) Feedback – paper to be produced highlighting the overall current position of the Trust against the CQC recommendations.	2. Chief Nursing Information Officer and Head of Corporate Risk & Assurance Manager Timescale: Committee meeting 12th March 2026
3. AI project plan to be shared at the next committee meeting.	3. Chief Clinical Information Officer and Director of Innovation Timescale: Committee meeting 12th March 2026
4. To audit the current processes that are in place using AI against the backdrop of the new principles.	4. Chief Clinical Information Officer and Director of Innovation Timescale: To be confirmed

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Quality Committee
Date of Committee / Group:	22 January 2026
Chair of Committee / Group:	Anna Stabler, Non-Executive Director

Alert
(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group e.g. breaches in legal or regulatory requirements, fraud, significant negative inspection/audit findings, unmitigated risks rated 20+, major changes in funding/commissioning, industrial action or risks to business continuity/emergency preparedness)

- There were no matters requiring escalation.

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

- **Infection Prevention Control (IPC) Improvement Group**
  Overall, the Committee received assurance on the progress being made and is being proactively managed, that appropriate support is in place, acknowledging that further work was required.
- **Ophthalmology Improvement Group**
  The Committee welcomed the progress made within the service, noting the positive impact of the action plan, strengthened processes and triangulation visit, however, it was highlighted that while operational and clinical improvements are moving forward, there remains a gap in Human Resources (HR) and Organisational Development (OD) capacity to support the cultural and people-related elements of the work. It was noted that work is underway to strengthen HR and OD capacity through a revised People and OD structure.
- **Emergency Department Improvement Group**
  The Committee welcomed the progress made and noted the anticipated positive impact of the Urgent Treatment Centre. Members agreed that the position is significantly stronger than at the same point last year, with improved readiness and greater confidence in delivery.
- **Cardiothoracic Improvement Group**
  The Committee welcomed the clear progress against both action plans and the Clinical Board's strong understanding of the required improvements. The key challenge identified for ongoing oversight is ensuring a well-managed transition of this intensive programme of work into business-as-usual arrangements, with clarity on how ongoing assurance will be maintained by the Quality Committee
- **Integrated Board Report**
  The Committee acknowledged that, due to the scale and complexity of the report, it is unlikely that every component will meet the highest standard simultaneously;

however, the Committee reaffirmed the importance of maintaining clear oversight of key escalations and improvement actions. Areas in the Quality section that are not meeting the required standard and being followed through in the committee via improvement group e.g. IPC work or supplementary reporting e.g. Medicines Management.

- **Quality and Safety Peer reviews**
  The quarter 3 programme had focused on the reinspection of areas that had not met the required standards, it was acknowledged that some areas who had received ACE accreditation had deteriorated. Therefore, the broader programme of inspections planned for Quarter 4 will be critical in understanding where progress is not being achieved / or deteriorated and what additional support or intervention is required to strengthen delivery. The Committee emphasised the importance of using these insights to enhance the organisation's offer to teams and drive further improvement.
- **Duty of Candour (DoC)**
  Whilst current compliance with both verbal and written DoC remains below the Trust average, the Committee noted that the quality of DoC responses is being monitored through quarterly audits, and a Trust-wide improvement plan is in place to strengthen compliance and enhance the quality of communication provided to those affected.
- **Gynaecology Emergency Interim Pathway on Maternity Assessment Unit (MAU)**
  Due to changes in service delivery there is a risk to compliance with National Maternity Pregnancy Loss standards. An Equality and Quality Impact Assessment (EQIA) has been completed considering the patient experience, staff experience and clinical risk, balanced with the risk associated with multiple short term pathway changes, which concluded that the current gynaecology emergency interim pathway on the MAU should continue until a decision has been reached regarding the proposal. The committee has sought further assurance that the reconfiguration of the Termination of Pregnancy (TOP) and pregnancy loss service be expedited, and an update be provided.
- **Medicines Management Oversight Group Report**
  The Committee was assured in the significant improvements made in medicines management throughout 2025 in a number of areas including Medicines Reconciliation and Pharmacy Interventions, Cost Improvement Schemes, Education and Training, Medication incident reporting and learning from incidents, Pharmaservices (Outpatient Pharmacy) governance and quality systems and Governance and Clinical Audit Programme. Further improvement was needed in compliance with the core standards of medicines management practice within the clinical areas. To further support the safe use of medicines in the clinical areas it was noted that Matrons and pharmacists will now undertake monthly walk throughs. Further assurance was sought on the trust position regarding Oxygen prescribing.

Assure
(key assurances received and any highlights of note such as best practice or innovation)

- **Hepato-Pancreato-Biliary (HPB) Improvement Group**

The Committee noted that the improvement group was operating effectively and providing strong assurance. The group has demonstrated strong engagement and grip, and much of the ongoing work now reflects activity that would be expected as part of normal governance and operational management within the Clinical Board. Exit criteria would be discussed with a view to transitioning this work back into business-as-usual governance.

- **Quality Priority 5 – Waiting Safely**
  The Committee recognised the clear benefits demonstrated. It was noted, however, that full assurance will require confirmation of how the work will be incorporated into the final Quality Account summary for the year.
- **Perinatal Quality Oversight Report, including Maternity Incentive Scheme update.**
  The Trust has reviewed its current self-assessed position and is compliant with all 10 safety actions and will be seeking the support of the Trust Board to declare this as the final position.
- **Transplant Strategy**
  The Trust Solid Organ Transplant Strategy was approved noting it aligned to the requirements for the NHS Blood and Transplant framework.

Risks (any new risks / proposed changes to risk scores – include risk ID where known)

- No new risks noted.

Cross-referrals to other Committees / Executive Director Leads

- **Hepato-Pancreato-Biliary (HPB)**
  Whilst not a direct cross referral it was suggested that a more detailed performance analysis on pathways could be prepared for Finance & Performance Committee.

Agreed actions	Responsibility / timescale
1. End of Life / Palliative Care paper submitted to the ICB Sub-Committee to be shared with the Committee.	1. Pauline Kelso, Director of Community Services – February Committee
2. To extract patient experience data of those that have received corridor care to understand if there is a disparity in terms of their experience particularly with the respect and dignity.	2. Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals – next ED update to Committee
3. Clarify Corridor Care Measurement and enhance reporting by capturing both patients and time on corridor, with breakdowns by reason and time of day.	3. Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals – next ED update to Committee
4. The Value Circle (TVC) action plan for Cardio - to provide clarification on how associated risks are being managed for	4. Sophie West, Clinical Board Chair

those actions that have been identified as not currently achievable.	
5. More detailed analysis in the next Perinatal Quality Surveillance Report, including whether demographic or clinical factors contribute to higher admission rates and to include age, deprivation and ethnicity.	5. Jenna Wall – Director of Midwifery – Next update for Committee
6. Duty of Candour - Trajectory, along with a supporting improvement plan, will be incorporated into the April deep-dive paper.	6. Rachel Carter – Director of Quality & Safety
7. Gynaecology Overnight Pathway to confirm the expected timeframes for the reconfiguration decision and the associated implementation plan.	7. Ian Joy - Executive Director of Nursing, Midwifery and Allied Health Professionals
8. Update on Oxygen Prescribing.	8. Rachel Carter – Director of Quality & Safety - February
9. Next Medicines Management Update to include how risks in relation to medicines storage are being managed across wards and departments.	9. Julie Swaddle - Director of Pharmacy

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Quality Committee
Date of Committee / Group:	19 February 2026
Chair of Committee / Group:	Anna Stabler, Non-Executive Director

Alert
(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group e.g. breaches in legal or regulatory requirements, fraud, significant negative inspection/audit findings, unmitigated risks rated 20+, major changes in funding/commissioning, industrial action or risks to business continuity/emergency preparedness)

- **Infection Prevention Control Improvement Group** – The Improvement Group was established in September 2025; however, the Committee was not assured by the current pace of progress. A review will be undertaken to assess the governance arrangements and processes in place.

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

- **Ophthalmology Improvement Group –** Committee members were satisfied with the progress to date and noted that robust processes are now in place. Updates will be provided on a bi-monthly basis to allow actions to progress. It was agreed that the next update will include details on the timescales and mitigations for the red-rated actions within the action plan.
- **Deteriorating Child Improvement Group** – Deteriorating Child is presented as a monthly update to the Quality Committee. While plans are currently in place, it was noted that a formal action plan is required, including clearly defined trajectories.
- **Integrated Board Report** – Assurance was provided for the areas within the remit of the Quality Committee; however, further information was requested regarding category 4 pressure ulcers and Level 2 mortality reviews.
- **Safeguarding Quarter 3 Report** - A comprehensive report was received, noting improvements in training. The Committee requested a clearer understanding of the trajectories for compliance in areas not yet achieving 90% for level 3 training. Actions being taken to address capacity were highlighted, along with recognition of the system-wide risks and the impact this may have on staffing reviews across all safeguarding partners.

Assure
(key assurances received and any highlights of note such as best practice or innovation)

- **Patient Safety Incident Response Framework (PSIRF) Priority Biannual Report –** Positive assurance was received on the work to date, however, it was agreed that the next update should include the impact and associated learning.
- **Breast Review Process** – A robust process was outlined, and the final report will be presented for detailed discussion at the March Quality Committee meeting, prior to consideration by the Audit, Risk and Assurance Committee and the Private Board of Directors.
- **Perinatal Quality Surveillance Report including Maternity Incentive Scheme update** – Assurance was provided that appropriate systems and processes are in place. The Committee noted the risks relating to fetal medicine and the use of an alternative growth chart following the letter received from the National Clinical Director and Chief Midwifery Officer for England, along with the planned mitigations. The uncertainty regarding funding for the Maternity and Neonatal Voice Partnership (MNVP) beyond March 2026 was also highlighted.
- **Wards of Concern & Accrediting Excellence (ACE) Progress Report** - The Committee were assured that a robust process is in place, with ongoing development of monitoring arrangements. It was also noted positively that there are currently no wards requiring high-level support, which is an area to celebrate, and that red-flag reporting has returned to average levels.

Risks (any new risks / proposed changes to risk scores – include risk ID where known)

Perinatal Quality Surveillance Report including Maternity Incentive Scheme update – A new risk was identified which has been added to the risk register (1671) relating to the transition from Intergrow (IG21) to the World Health Organisation (WHO) growth charts. Mitigations are in place and the risks will be closely monitored.

A second new risk was identified in relation to the fetal medicine service with a further reduction in performance in December 2025 with 51% of new referrals being seen within 72 hours.

Cross-referrals to other Committees / Executive Director Leads

- No new cross-referrals.

Agreed actions	Responsibility / timescale
1. Infection Prevention Control Improvement Group – the Executive Team to discuss at the Executive Team Meeting on 25 February 2026 and an update will be provided at the March Quality Committee meeting.	1. Michael Wright, Joint Medical Director & Rachel Carter, Director of Quality and Safety / March 2026
2. Deteriorating Child - An example was provided relating to a case on Ward 9, and the Committee requested further	2. Jane Melvin, Director of Operations for Family Health Clinical Board / March 2026

detail regarding the resulting learning and outcomes.	
3. Integrated Board Report – Additional information should be included in the report regarding pressure ulcers, with clear separation between hospital-acquired and community-acquired cases, as well as further detail on Category 4 pressure ulcers and Level 2 mortality reviews.	3. Rachel Carter & Lisa Guthrie, Director of Nursing / March 2026
4. Safeguarding quarter 3 report - Lynn Craig agreed to feed back on the Safeguarding Team restructure at the Integrated Care Board (ICB).	4. Lynn Craig, Deputy Director of Nursing (Quality), ICB / March 2026
5. Safeguarding quarter 3 report – The Committee to receive an update on the emerging risk regarding the transition to SharePoint for document management, which has caused delays in processing Deprivation of Liberty (DoLS) forms which has been escalated to the digital team and Care for All Group.	5. Lisa Guthrie / March 2026

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	People Committee
Date of Committee / Group:	22 January 2026
Chair of Committee / Group:	Bernie McCardle, Non-Executive Director (NED)

Alert
(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group e.g. breaches in legal or regulatory requirements, fraud, significant negative inspection/audit findings, unmitigated risks rated 20+, major changes in funding/commissioning, industrial action or risks to business continuity/emergency preparedness)

- **Guardian of Safe Working (GoSW) report –** The imminent changes to exception reporting which will increase the admin burden and create additional financial costs. The People Committee have been previously updated on the changes and this has been escalated to Trust Board.
- **Violence and Aggression to staff update –** It was noted that during the period of the People Committee meeting, Michael Wright, Joint Medical Director received five red cards to sign off which shows the reality of what staff are dealing with. Further work to improve the experience of staff and patients. This work is complex and multifaceted and there are currently some skill and capacity challenges internally to deliver all aspects of this work at pace against competing priorities. This is understood and under review, overseen by the Executive Team.

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

- **Equality, Diversity and Inclusion (EDI) update –** Committee members agreed that further work is needed to progress the EDI work relating to recruitment and ownership. The People Programme Board will discuss the direction of travel in further detail, and this will be reported to the People Committee.
- **People Plan –** Year 3 of the people plan will be reset in line with actions and feedback received.
- **Violence and Aggression to staff update** – Further work is required to gain a deeper understanding from the data and understand what interventions will be most useful in ensuring a tangible improvement in violence reduction balancing capacity and resource.
- **Integrated Board Report (IBR) –** Sickness absence and statutory and mandatory training were highlighted as areas where further work needs to take place to improve the position.
- **Board Assurance Framework (BAF) –** Vicky McFarlane-Reid, Director of Commercial Development and Innovation & Executive Lead for Organisational

Development agreed to review the RAG (Red-Amber-Green) ratings for the next People Committee meeting.

- **Employee Relations dashboard -** The dashboard was received noting that this is a new report which will evolve.

Assure
(key assurances received and any highlights of note such as best practice or innovation)

- **EDI –** The positive work at all levels (including Trust Board members) was acknowledged. The antiracism work has been exemplar and work is taking place to revise the EDI Steering Group.
- **People Plan –** The Committee acknowledged that there is solid foundation for a medium/long term plan and good progress has been made in year 2 of the people plan.
- **GoSW report –** The robust data, reporting and processes was noted.
- **People learning development update including apprenticeship levy –** The Trust is making best use of the apprenticeship levy opportunities for staff.
- **Violence and Aggression to staff update –** The Committee were assured that the data is captured and monitored, benchmarking against national guidance has taken place and action plans in place to improve compliance.
- **IBR –** The processes of escalation/action through the Quality Performance Reviews (QPRs) and the level of detail provided to Committee members. In terms of statutory and mandatory training, it was noted the People Directorate are actively seeking assurance from the outliers that they have plans in place to address compliance.
- **BAF –** The BAF is regularly reviewed, and a healthy debate took place relating to potential changes.

Risks (any new risks / proposed changes to risk scores – include risk ID where known)

- **BAF –** Potential changes to risk scores may be part of the BAF review.

Cross-referrals to other Committees / Executive Director Leads

- No new cross-referrals however it was highlighted that Organisational Development/HR support was an area of discussion during an Ophthalmology update at Quality Committee earlier that day.

Agreed actions	Responsibility / timescale
1. To scope Organisational Development capacity for immediate demand / future needs.	1. Amy Callow, Associate Director of People and Organisational Development (OD) / March 2026
2. GoSW staff support considerations to be part of the People Directorate staffing review.	2. Amy Callow / March 2026

3. An update on progress from the EDI Steering Group to be incorporated into a future EDI update.	3. Caroline Docking, Director of Communications and Corporate Affairs & Lead on EDI
4. The People Programme Board to review sickness absence and red outliers for statutory and mandatory training.	4. Amy Callow / March 2026
5. A review to take place of the BAF and RAG ratings.	5. Vicky McFarlane-Reid / March 2026
6. An annual strategic recruitment update to be added to the People Committee Schedule of Business.	6. Lauren Thompson, Corporate Governance Manager & Deputy Trust Secretary / March 2026

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Finance and Performance Committee
Date of Committee / Group:	26 January 2026
Chair of Committee / Group:	Bill MacLeod, Non-Executive Director (NED)

Alert

(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group e.g. breaches in legal or regulatory requirements, fraud, significant negative inspection/audit findings, unmitigated risks rated 20+, major changes in funding/commissioning, industrial action or risks to business continuity/emergency preparedness)

- **Medicine & Emergency Care Clinical Board update –** Discussions are ongoing with the Integrated Care Board (ICB) in relation to drug costs and there are pressures with diabetes devices.
- **Cash -** The Trust Board has been fully sighted on the cash position, but the overall position continues to be challenging.
- **Integrated Board Report (IBR) –** Ongoing pressures within the skin cancer pathway, driven by continued high demand, remain a challenge. Collaborative work with the Northern Cancer Alliance is underway to support the development of regional service plans going forward. In terms of elective waits, the 65-week wait trajectory remains a significant challenge, and further review will be undertaken.
- **Finance, Activity and Workforce Plan update –** Work is underway to progress the plan, with a submission deadline of 12 February 2026. This will be resolved by the next Public Board of Directors meeting in March 2026.

Advise

(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee / Group is seeking assurance over and list any decisions made/approvals)

- **Medicine & Emergency Care Clinical Board update –** While notable progress has been achieved in relation to performance and financial management, the overall position continues to present challenges.
- **Capital Expenditure –** The Capital Programme has been well managed with strong equipment gains, but the final quarter of the financial year remains challenging.
- **IBR –** While mitigations have been implemented in all areas and improvements are emerging in several domains, the position remains below the level the Trust aspires to achieve.
- **Job Planning update -** Strong plans are in place to support the Trust in realising the benefits of the work undertaken, with a particularly welcome emphasis on training and education.

Assure

(key assurances received and any highlights of note such as best practice or innovation)
• **Month 9 Finance Report –** At Month 9 there is no reported variance against the planned deficit of £2.9m, and the forecast outturn remains at breakeven, in line with the agreed financial plan for 2025/26. • **Job Planning –** The robust job planning process, engagement and policy in place. • **Commercial Strategy update -** The continued commitment to supporting commercial growth from teams across the organisation and ensuring a strong pipeline for 2026 and beyond.
Risks (any new risks / proposed changes to risk scores – include risk ID where known)
• There were no new or proposed changes to risk scores.
Cross-referrals to other Committees / Executive Director Leads
• People Committee - Encouraging staff to plan and take annual leave evenly across the financial year to improve phasing, reduce end-of-year pressure, and support overall wellbeing.

Agreed actions	Responsibility / timescale
No new actions agreed	Not applicable

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Finance and Performance Committee
Date of Committee / Group:	23 February 2026
Chair of Committee / Group:	Bill MacLeod, Non-Executive Director (NED)

Alert
(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group e.g. breaches in legal or regulatory requirements, fraud, significant negative inspection/audit findings, unmitigated risks rated 20+, major changes in funding/commissioning, industrial action or risks to business continuity/emergency preparedness)

There were no items the Board should be alerted to.

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

The were no items to note.

Assure
(key assurances received and any highlights of note such as best practice or innovation)

Clinical and Diagnostics Services Clinical Board update
The Committee felt highly assured about the progress made by the Clinical Board and the strength of the work presented, particularly the improvement in grip, control and delivery over the year.

Month 10 Finance Report including Cash and Capital Expenditure
The Committee highlighted the significant progress made over recent months, noting the substantial improvement and the strong turnaround in overall financial performance which was worthy of recognition.

Integrated Board Report (Month 8 Performance)
The Committee considered the appropriate Assure / Advise / Alert category noting confidence in the data quality and core validation processes. There were no issues that the Board needed alerting to with assurance provided in sound systems and process however being more proactive in providing assurance particularly around diagnostics was highlighted.

Annual Plan and Budget Setting 2026/27

The Committee acknowledged understandable nervousness entering the new financial year, but took assurance that the organisation now had stronger grip and greater detail behind the plan than at the same point last year.
Risks (any new risks / proposed changes to risk scores – include risk ID where known)
No new risks noted.
Cross-referrals to other Committees / Executive Director Leads
No cross-referrals noted.

Agreed actions	Responsibility / timescale
1. Future iterations of monthly finance report to highlight high-impact programmes with clear finance and performance implications.	Jackie Bilcliff, Chief Finance Officer – March Committee
2. Business cases update to be removed from future agendas / schedule of business	Gill Elsender, PA and Corporate Governance Officer – March Committee

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Audit, Risk and Assurance Committee
Date of Committee / Group:	27 January 2026
Chair of Committee / Group:	David Weatherburn, Non-Executive Director (NED)

Alert
(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group e.g. breaches in legal or regulatory requirements, fraud, significant negative inspection/audit findings, unmitigated risks rated 20+, major changes in funding/commissioning, industrial action or risks to business continuity/emergency preparedness)

No 'alert' items identified during the meeting.

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

- **Clinical audit process –** for local audits, good progress had been made in increasing the number of projects registered on the Clinical Effectiveness Register, and reducing the number of outstanding projects however completion rates remained static. Further work was planned to strengthen oversight and assurance mechanisms at directorate and specialty level, as well as enhancing visibility following the implementation of InPhase.
- **A company debt –** A company had gone into receivership and therefore the Trust had made an application to the liquidators for the total debt value, this created a risk as to the recoverability of the debt owed by the company to the Trust.

Assure
(key assurances received and any highlights of note such as best practice or innovation)

- **Board Assurance Framework (BAF) –** Evidence was provided that the BAF was being used dynamically, with regular reviews within Board Committees, and healthy discussions on strategic risks, threats, mitigations, controls and progress indicators.
- **Risk Management Report –** Assurance provided that risks were actively being managed through changes in scoring, movements in the number of open, closed and tolerated risks, as well as the constructive challenge undertaken within the Risk Validation Group.
- **Internal Audit –** Good assurance ratings provided on two internal audits (patient experience and venous thromboembolisms) and reasonable assurance on the outpatients appointment booking process follow up. Good progress made on implementation of management actions. There were no management actions from

internal audit reports where the original target date had been exceeded by more than one year and none where a revised target date had been requested three or more times.

- **Fraud –** Evidence of review and updating of the Fraud, Bribery and Corruption policy to reflect key changes (with policy updates approved by the Committee). Work was noted to be in progress on moving towards compliance with the Economic Crime and Corporate Transparency Act 2023. Fraud risk assessment regarding Exception Reporting for resident doctors was highlighted as underway.

Risks (any new risks / proposed changes to risk scores – include risk ID where known)

None identified.

Cross-referrals to other Committees / Executive Director Leads

Committee members discussed the appropriate assurance categorisation and governance route for a debtor write-off issue and agreed this was 'Advisory'. It was agreed that the issue should be referred to the Finance & Performance Committee (F&PC) for further scrutiny as a standalone matter. Further, given the nature of the debt (related to Research & Development charges), members also agreed it should be taken through the newly established Research, Innovation & Commercial Committee

Agreed actions	Responsibility / timescale
1. Committee Chair to write to the risk owner for risk 589 (Medicines and Healthcare products Regulatory Authority (MHRA) inspection finding) to request that the risk be reviewed/updated due to the long length of time elapsed since the last risk review date.	1. David Weatherburn, Committee Chair – 24 February 2026
2. Director of Quality and Safety (DQ&S) to follow up the status of the progress for 2 national audits to feedback to Committee members (Quality and Outcomes in Oral and Maxillofacial Surgery (QOMS); and diabetes - adults).	2. Rachel Carter, DQ&S – 24 February 2026
3. Director of Quality and Safety and Joint Medical Director (JMD) to ask the Quality & Safety Lead in the Cardiothoracic Clinical Board to undertake further analysis of the 20 local clinical audits due to be completed by 31 December 2025.	3. Rachel Carter, DQ&S and Michael Wright, JMD – 24 February 2026
4. Head of Quality Assurance and Clinical Effectiveness (HQAE) and Head of Corporate Risk and	4. Vic Smith, HQAE and Natalie Yeowart, HCRA – 24 February 2026

	Assurance (HCRA) to discuss whether an assurance level could be added to the corporate audit programme.	
5.	Confirmation to be provided to Committee members as to the current external audit contract length/term.	5. Jackie Bilcliff, Chief Finance Officer (CFO) – 24 February 2026
6.	CFO to share further information on the Beacon software and subscription cost model with the Committee Chair.	6. Jackie Bilcliff, CFO – 24 February 2026
7.	Process to be facilitated to ensure 'alerts' arising from the Triple A Committee reports are escalated timely.	7. Kelly Jupp, Trust Secretary – 30 January 2026

Agenda item A6(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Charity Committee - Chair's Log

Meeting: Charity Committee – Funding only	**Date of Meeting**: 29 January 2026
Connecting to: Audit, Risk and Assurance Committee / Trust Board	**Date of Meeting**: 24 March 2026 27 March 2026
Key topics discussed in the meeting	
• Funding proposals were discussed and the outcomes were as follows: ○ Surgical and Specialist Services - £48,300 - D SLT Treatment for Glaucoma Patients. The proposal was supported subject to the condition that before any expenditure takes place feedback to be provided to and approved by the Chief Finance Officer regarding revenue cost implications and Clinical Board ability to meet those costs. ○ Cardiothoracic Services - £23,100 – MRI Scans for Pleural Research Study. The proposal was supported. ○ Family Health – Durham Cricket – £45,544 Cricket Based Physical Activities. The proposal was supported. ○ Clinical and Diagnostic Services - £54,470 – MRI Acceleration Software for Paediatric Imaging. The proposal was supported. ○ Surgical and Specialist Services - £53,750 - Improving Patient Experience and Diagnostic Accuracy with Neuromuscular Ultrasound. The proposal was supported, subject to the condition that evaluation includes data on whether or not this equipment resulted in the hoped for efficiencies and increase in productivity detailed in the proposal. ○ Cancer and Haematology - £95,456 - Haematological Cancer Research Fellow. The proposal was deferred. ○ Family Health - £67,032 – Great North Children's Hospital (GNCH) Citizen Advice Service for Patients and Families. The proposal was supported for one year. ○ Clinical and Diagnostic - £98,735.59 - Newcastle Stroke Service Stroke Rehabilitation Resources. The proposal was deferred. ○ Family Health Board - £100,000 - NUF Proposal. The proposal was supported for two years. ○ Cardiothoracic Services - £37,452.85 - Cardiothoracic Theatres Operating Table. The proposal was deferred. • The summary of funding agreed since the last meeting was received (bids up to £20k).	
Actions agreed in the meeting	Responsibility / timescale
No actions from these applications.	Not applicable

Escalation of issues for action by connecting group	Responsibility / timescale
Not applicable	Not applicable
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
Not applicable	Not applicable

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Newcastle Hospitals Charity Committee
Date of Committee / Group:	2 February 2026
Chair of Committee / Group:	Phil Kane, Non-Executive Director (NED)

Alert
(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group e.g. breaches in legal or regulatory requirements, fraud, significant negative inspection/audit findings, unmitigated risks rated 20+, major changes in funding/commissioning, industrial action or risks to business continuity/emergency preparedness)

- None identified.

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

- None identified.

Assure
(key assurances received and any highlights of note such as best practice or innovation)

- **Update on Options Appraisal of Governance Models:** The scheduled meetings between the Charity Director and Trust Board members have now taken place. A paper will be produced and presented at the Trust Board Meeting on 26 February 2026.
- **Fundraising Review:** A review is underway with the More Partnership and interviews have taken place with key members of the Charity Committee and Executive, and the Trust Chair and Acting Chief Executive. Three surveys have

been circulated to supporters, staff and leadership. A final report available in April which will include a set of recommendations.

- **Shared Resources Agreement Update:** The agreement proposes the Charity manages operational procurement up to £12,500, this ensure that the charity complies with public sector procurement regulations. Trust procurement are currently re-checking that the rules apply to the Charity before this section is finalised.
- **Management Accounts:** The Management Accounts were received and discussed.
- **Fund rationalisation and Funds committed but not drawn down:** This is a regular report to Committee to highlight funding that has been awarded but not being spent within the agreed timescale. It was agreed that while progress had been made, further work to be undertaken re returning historical unused awards.
- **Review of Investments and Banking:** Further to previous discussions re change of signatories, the paperwork to be authorised and signed. Update given regarding the tender review of Investment Managers.
- **Charity Risk Statement:** The quarterly report to Committee was received.
- **Summary of Investments to 31 December 2025:** The quarterly report to Committee was received.
- **Draft 2026_27 Schedule of Business:** The paper was approved.
- **Sir Bobby Robson Institute (SBRI) Progress Report:** The report was received and progress noted.
- **Draft Conflict of Interest Policy:** The Policy was received and approved.

Risks (any new risks / proposed changes to risk scores – include risk ID where known)

- Not applicable

Cross-referrals to other Committees / Executive Director Leads

- Not applicable

Agreed actions	Responsibility / timescale
1. An informal Meeting of the Charity Committee to be arranged to discuss the interim report from the Fundraising Review.	1. Amanda Waterfall, Charity Operations Manager – March 2026
2. Rationalisation of Funds - Section 4, paragraph 2 stated some information that required checking / updating.	2. Teri Bayliss, Charity Director – February 2026

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Agenda item A6(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 March 2026		
Title	Learning from Deaths, Quarter 3 (Q3) 2025/26 (October 2025 – December 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 • Level 2 mortality reviews for patients with a recognised learning disability • Maternal deaths • Overview of Level 2 mortality reviews by HOGAN and 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 20 February 2026 and covers data up to the end of Q3 2025/26.		
Recommendation	(i) Receive the report. (ii) Note the actions taken to improve oversight and reporting in relation to continued monitoring as required by national Learning from Death criteria.		
Links to Strategic Objectives	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.

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 in September and December 2025.

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 we identify, investigate and learn from deaths that occur under our 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 our commitment to learning from any deaths where problems in care have been identified so that improvements can be made.

2. REVIEW OF INPATIENT DEATHS

In December 2025 the Quality & Safety Department implemented a new process whereby monthly reports are sent to each Clinical Board triumvirate detailing all outstanding Level 2 reviews. This includes those required as per national or organisational policy, where referred by the Medical Examiner/ other speciality, or where a draft has been started by a speciality in that Clinical Board but not yet finalised. The expectation is that the Clinical Boards will take action to follow these up internally and ensure timely completion. This process replaces the previous method of following up outstanding reviews directly with the governance leads from each specialty. Feedback has been positive from the Clinical Boards as it allows an overarching view of the position. There has been variable impact in the completion of outstanding reviews since the implementation of this process with little to no movement in some Clinical Boards but notable progress in others to clear the backlog, though the impact of December's industrial action and winter pressures has been acknowledged. The Integrated Governance Manager – Patient Safety will incorporate regular reports to Mortality Surveillance Group on the progress and position of this work.

2.1 Level 2 (L2) Reviews

Figure 1 details the number of completed level 2 reviews by month over the previous 12 months up until the end of Q3 2025/26. These are shown by the date the patient died. In some cases, more than one L2 review may have been carried out for the same patient.

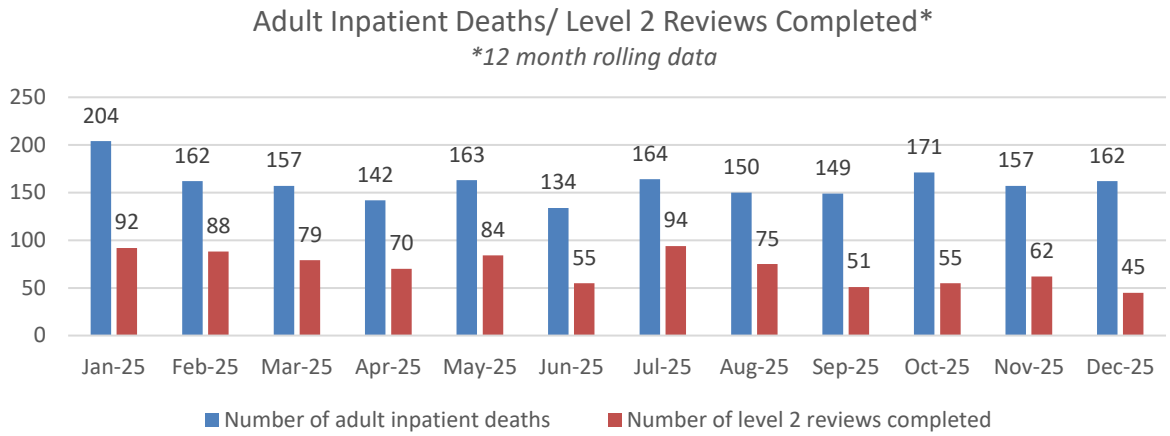

Figure 1: Number of Completed Level 2 Reviews, Jan – Dec 25 (data correct as of 17/02/26)

2.2 Medical Examiner (ME) Initiated Level 2 (L2) Reviews

From January to December 2025, the MEs referred 104 cases for L2 review. At the time of writing, 72 reviews have been completed, seven are in draft, 15 have not yet been started and ten have been discounted due to having been sent in error. Additionally, there is one case outstanding from a referral made in June 2024. This has been escalated to the Medicine & Emergency Care Clinical Board for action within the monthly reports.

Figure 2 details the number of L2 reviews requested by the ME and subsequently completed from January to December 2025, broken down by month:

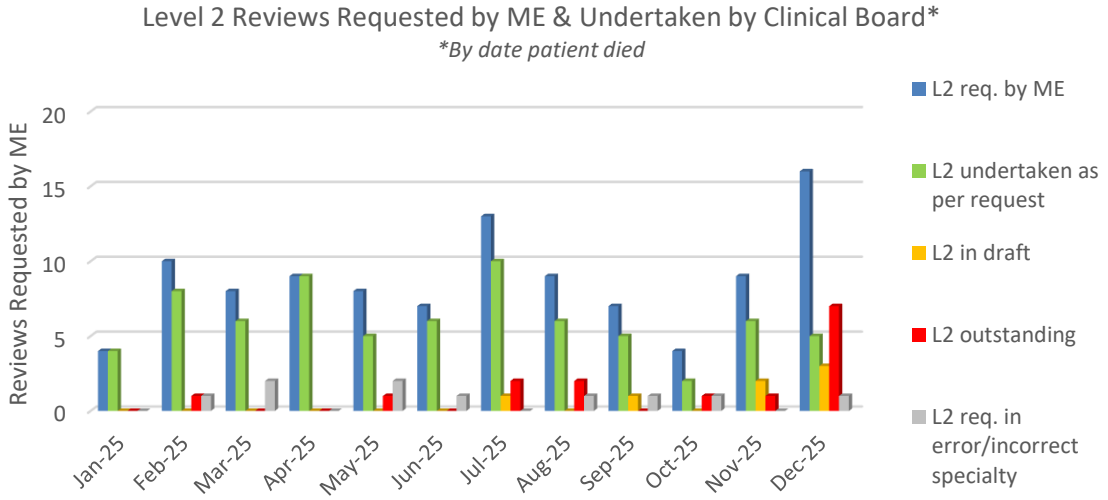

Figure 2: L2 Reviews Requested by ME and Undertaken by Clinical Board, Jan - Dec 25 (data correct as of 17/02/26)

2.3 Patients with Learning Disability

Since January 2025, there have been 41 recorded deaths of adult patients with a recognised learning disability. Of these, 25 have had a Level 2 review completed by the LeDeR Panel. In the same period, 2,618 patients with a confirmed learning disability were admitted to the Trust. This includes daycases, overnight electives and non-elective admissions. This data may include patients 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 Q3 25/26.

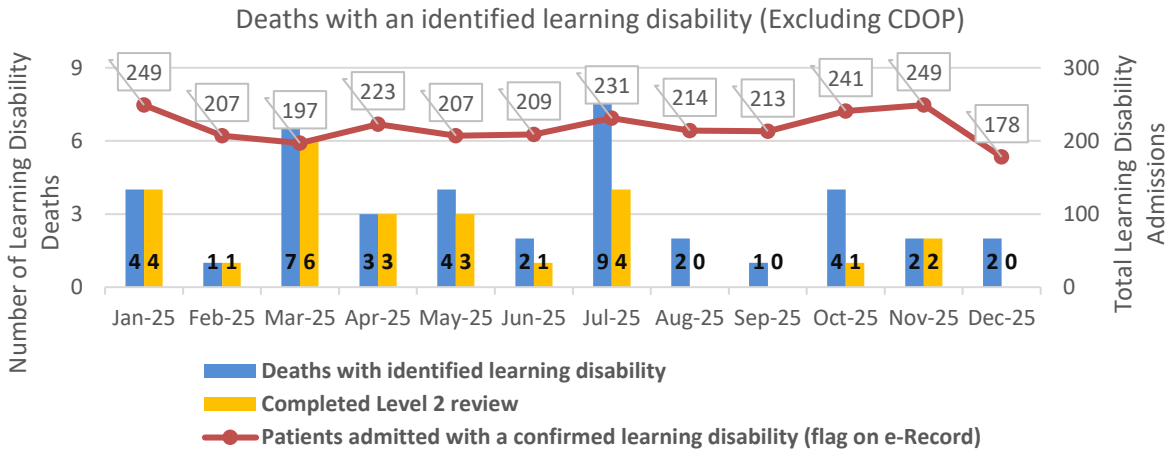

Figure 3: LeDeR Level 2 Reviews Jan - Dec 2025 (data correct as of 18/02/26). CDOP is Child Death Overview Panels.

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:

- Good practice: supportive conversations with families and carers, timely referrals to support services, good examples of Multi-disciplinary Team (MDT) collaborative working.
- Evidence of some gaps in documentation, particularly around reasonable adjustments and whether hospital passport is present/ being used.
- Variable compliance with the compliance of capacity assessments.

2.4 Deaths within 12 Months of Pregnancy

There have been no maternal deaths recorded in the Trust from January to December 2025.

3. LEARNING FROM DEATHS Q3 2025/26

162 level 2 reviews were undertaken of the 490 adult inpatient deaths recorded in the Trust. This equates to 33% 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. An additional 41 draft reviews are currently awaiting completion for deaths from this quarter.

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 for patients who died in Q3 by HOGAN scores for the quarter:

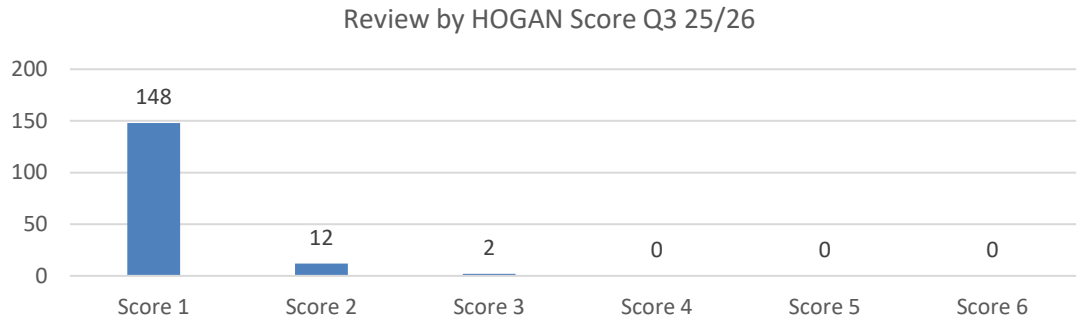

Figure 4: Q3 25/26 Completed L2 Reviews by HOGAN Scores (data correct as of 17/02/26)

At the time of writing, none of the completed Level 2 reviews for deaths in Q3 2025/26 have been given a score of HOGAN 4 or above.

3.2 National Confidential Enquiry into Patient Outcome and Death (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 for patients who died in Q3 by NCEPOD scores for the quarter:

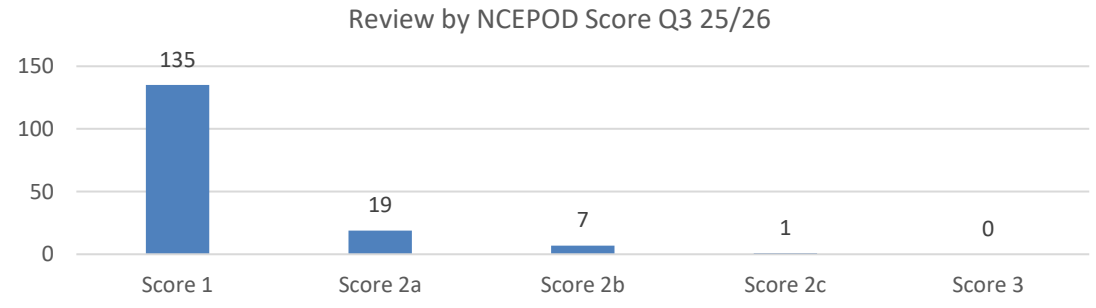

Figure 5: Q3 25/26 Completed L2 Reviews by NCEPOD Scores (data correct as of 17/02/26)

At the time of writing, none of the completed reviews for deaths in Q3 were given an NCEPOD score of 3. 27 reviews were given a score of 2 (either a, b or c respectively). The 27 reviews in total comprise 24 patients as one patient had three reviews and another patient had two in which scores of NCEPOD 2 were allocated.

3.3 Reviews Completed for Deaths Prior to Q3 2025/26

89 reviews were completed in Q3 for deaths that occurred prior to 1 October 2025. Of these;

- 76 were given a score of HOGAN 1
- 9 were scored HOGAN 2
- 3 were scored HOGAN 3
- 1 was given a score of HOGAN 4

- 67 were scored NCEPOD 1
- 13 were scored NCEPOD 2A
- 6 were scored NCEPOD 2B
- 1 was scored NCEPOD 2C
- 2 were scored NCEPOD 3

The case scoring HOGAN 4 was presented at RARM prior to the mortality review being completed following submission of an incident report and declared as an After Action Review.

The two cases scoring NCEPOD 3 arose from learning disability reviews undertaken by the LeDeR panel in which it was considered that there were areas of care from a learning disability perspective which fell below expected standards for this cohort. Neither patient came to actual harm, and both cases were reviewed within the Quality & Safety team with a view to whether further presentation and discussion at the Response Action Review Meeting (RARM) was required, which was deemed not to be the case. The learning points have been fed back by the Chair of the LeDeR Panel to the specialties concerned.

3.4 Thematic Analysis of Learning Points from NCEPOD Scores

This report acknowledges the ongoing limitations of reporting and extracting this data from the current mortality database as previously detailed. For this report, thematic analysis of the learning points has been undertaken via a manual crosschecking process of all 46 reviews that were allocated an NCEPOD score of 2 or 3 (all reviews completed in Q3) with the following themes identified:

Theme	Overview of cases	Actions/ Outcomes
Delayed investigations/ reviews/ treatment/ diagnosis	Five cases identified concerns relating to delays in aspects of care, ranging from senior medical review to administration of medication or completion of safety risk assessment (falls). None were considered to have impacted on the overall outcome (None being scored HOGAN 4 or above).	Four of the five cases have been referred on to other specialities to address the concerns raised and are awaiting completion. The case involving a delay in completing falls risk assessments has been shared at the relevant specialties' Quality & Safety meeting.
Communication	11 cases identified learning in relation to the need for improved communication, either between clinical teams and patients/ families, or between clinical teams within the Trust or between different organisations.	One of the cases is being managed through the Trust complaints process and PSIRF process as there were issues in clinical care that contributed to the patient's death. The investigation is ongoing with the full detail of the learning awaited. The importance of ensuring good communication and documentation of

Theme	Overview of cases	Actions/ Outcomes
		conversations and decisions was discussed at all of the Morbidity & Mortality (M&M) meetings for these cases.
Documentation	Six cases related to themes with poor documentation being a feature. Three of these were learning disability reviews undertaken by the LeDeR panel where gaps were identified in documentation of reasonable adjustments, hospital passports, incorrectly documenting a patient's friends as their Independent Mental Capacity Advocate (IMCA) or Care Manager as their Next of Kin (NOK), for example. The three remaining cases concerned gaps in documentation around clinical decision making, for example where a discussion has been held with a consultant around escalation to the Intensive Treatment Unit (ITU).	The learning points for the learning disability cases have been fed back to the relevant Clinical Boards by the LeDeR Panel chair. In one case, the Clinical Board undertook a thorough review of the points raised, providing feedback on the reflections and actions taken. In the remaining three cases, the importance of ensuring correct documentation was discussed in each M&M meeting. In one case this learning point was taken forward to share at a Cardiothoracic Governance Meeting.
Abnormal results	Three cases involved instances of failing to act on abnormal results (an Electocardiogram (ECG) showing Atrial Fibrillation (AF), a low potassium and a probably missed pubic rami fracture on x-ray from an attendance days prior to final admission). None of these were felt to have impacted on the final outcome.	In the case of the missed ECG and the abnormal low potassium result, these were discussed within the relevant specialty M&M meeting. The case of the probable missed pubic rami fracture was reviewed in a different speciality meeting (who received the patient on final admission) and by the LeDeR Panel. The reviewing specialty did not consider that any different management would have altered the outcome.
Clinical decision making	10 cases identified concerns related to clinical decision making. One of these related to concerns over management of an initial referral to Newcastle Hospitals from a neighbouring trust and differing clinical opinions. Three cases related to decisions on treatment (antibiotics and opioids). Two cases detailed potential learning in relation to timing and appropriateness of patient transfer. One case posed queries around possible discrepancies in radiological versus intraoperative findings. Three cases identified learning in relation to timing/ appropriateness of interventions. None	The aspects of the referral pathway in the case involving the external trust have been discussed with the relevant trust. In relation to the three medication related cases, one has been shared at the relevant clinical governance meeting, one was referred to the home speciality for review on the decisions on antimicrobials and this has been reviewed with no cause for concern found as protocol was followed, and the third has been fed back informally to the admitting specialty with a further referral to another specialty in relation to peri-operative medications which has not yet been completed.

Theme	Overview of cases	Actions/ Outcomes
	were deemed to have impacted on the patient's final outcomes.	The first case concerning patient transfer has been shared with two other specialties for wider learning and the importance of nursing and Allied Health Professionals (AHP) staff feeding into M&M meetings has been identified. The second case was discussed at the M&M meeting. In the three cases related to clinical interventions, learning points have been shared with the wider team in the first case to ensure staff carefully consider appropriateness of lower limb cannula insertion on patients with diabetes and Peripheral Vascular Disease (PVD) and pay attention to early signs of extravasation injury. In the second case, all patients to be listed for heart or lung transplant should be offered elective peripheral vessel scanning at time of listing. In the final case the M&M meeting agreed that consideration should be given where appropriate to quicker revascularisation to offer greater chances of recovery.
Other	Six cases identified other themes including: • Awareness of MCA assessments and the role of the IMCA • Inpatient falls that contributed to deterioration and death • Information Technology (IT) issues creating barriers to delivering effective care • Positioning of frail and elderly patients on the operating table • Difficult management of complex hyperparathyroidism contributing to inpatient fall and surgery • Referral error contributing to patient self-harm	The actions and learning points arising from these cases are: • Education sessions for Cardiothoracics staff on MCA/IMCA • Falls case referred to home specialty for review to address concerns. Not yet complete. Fall investigated via the PSIRF Falls Pathway • IT issues escalated appropriately at time of events. Did not contribute to patients' death – complex case with multiple comorbidities • Reflection and team discussion on how to carefully position patients with severe osteoarthritis on the operating table due to risk of stress fractures • Complex hyperparathyroidism case managed through complaints process due to family concern about aspects of care on ward. Fall investigated through PSIRF Falls process. Death unpreventable. • Referral error incident declared as an After Action Review (AAR)

Theme	Overview of cases	Actions/ Outcomes
Unknown	In five cases it was not possible to determine from the case review what the learning points were.	

3.5 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 criteria, in addition to cases escalated via the mortality review process. In Q3 2025/26, 1 death met these criteria and was reviewed at RARM.

3.6 Completed Investigations and Learning

Completed PSIRF investigations (PSII/AARs) are presented to the Trust's Patient Safety Incident Forum (PSIF) for scrutiny and final approval. This forum meets on a monthly basis. In Q3 2025/26, five completed investigations (four PSIIs and one AAR) relating to cases where a patient had died, were presented for approval.

4. RECOMMENDATIONS

To:

(i) Receive the report
(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
20 February 2026

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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
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. 10.03.2026 - LT sent a reminder email. 16.03.2026 - Added to the Schedule of Business as date to be confirmed. Propose to close action.
161	30 January 2026	26/02 FOCUS ON FUNDAMENTALS – QUALITY, PERFORMANCE AND FINANCE: a. Patient and Staff Stories	Lucia Pareja-Cebrian agreed to provide assurance on the process regarding the delivery of test results by clinicians prior to release on NHSApp [ACTION01].	LPC			11.03.26 - The Trust does not release any results directly to the NHS app - the only way they are included is by being approved/acknowledged by the patient's GP. A presentation that was presented to the Trust Management Group in January is in the Admin Control Reading Room for information. Propose to close action.
162	30 January 2026	26/02 FOCUS ON FUNDAMENTALS – QUALITY, PERFORMANCE AND FINANCE c. Board Visibility Programme	A survey had been drafted with the Trust Secretary which would be issued next week to Clinical Boards and senior teams to gather feedback and support further improvements in the Board Visibility Programme. It was agreed that the results of the survey will be included in a future report [ACTION02].	RC/KJ			10.03.26 - Included on the March Public Board of Directors agenda. Propose to close action.
163	30 January 2026	26/02 FOCUS ON FUNDAMENTALS – QUALITY, PERFORMANCE AND FINANCE e. Director reports: i) Joint Medical Directors (JMD) Report	A query was raised regarding work with system partners to shorten cancer pathways and if the Alliance was working at pace to support improvements. It was highlighted that progress was variable across partners, but this remained a key priority area. Work was underway to identify further opportunities to accelerate pathways. A deep dive into the lung cancer pathway had been completed, with a clearer timeline now established for patients. Work continued with partners to ensure a greater proportion of patients move through pathways efficiently, with strong collaboration across organisations. A further update would be provided at a future meeting [ACTION03].	MWr			11.03.26 - Further details included in the Medical Directors Board Report at the March Trust Board meeting. Propose to close action.

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164	30 January 2026	26/02 FOCUS ON FUNDAMENTALS – QUALITY, PERFORMANCE AND FINANCE g. Maternity i) Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress report	Ian Joy advised that a secondary conversation would take place with Marie Smith, Head of Obstetrics, to confirm consistency with the self-assessed position and the Board of Directors would be updated on the outcome [ACTION04].	IJ			10.03.26 -IJ advised that the self assessment was reviewed and approved by Marie Smith. The document and has been signed by the relevant parties and submitted. Propose to close action.
165	30 January 2026	26/04 ITEMS TO APPROVE a. Board Assurance Framework (BAF)	Martin Wilson advised that the Alliance Joint Committee was a Tier 1 Committee of the Board of Directors. The minutes of this meeting were available in the Admin Control Reading Room for reference. An update on the strategic intent work was scheduled for the March Board of Directors meeting [ACTION05].	MWi			10.03.26 - Included on the March Public Board of Directors agenda. 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.