The Newcastle upon Tyne Hospitals NHS Foundation Trust

Public Trust Board of Directors
Friday 22 May 2026, 10:15 – 12:45
Piano Room, Royal Victoria Infirmary (RVI)

Agenda

	Time	Item	Purpose	Lead
1.	**Introduction**			
a.	10:15	Apologies for absence and declarations of interest	For discussion	Paul Ennals
b.	10:16	Minutes of the Public Board of Directors meeting held on 27 March 2026 and matters arising	For discussion & approval	Paul Ennals
c.	10:17	Approval of the Trust Strategy ***[Full Strategy to follow]***	For discussion	Patrick Garner
d.	10:25	Chair's Report	For discussion & assurance	Paul Ennals
e.	10:30	Chief Executive Report	For discussion & assurance	Rob Harrison
f.	10:40	Committee Triple A reports	For discussion	Committee Chairs
2.	**Joining up care – working together to give people better, quicker access to effective care**			
a.	10:47	Board Visibility Programme	For discussion & assurance	Rachel Carter
b.	10:52	Integrated Board Report (IBR)	For discussion & assurance	Patrick Garner & Executive Leads
c.	11:00	Winter Plan evaluation	For discussion & assurance	Sue Hillyard & Nichola Kenny
3.	**Advancing Care – improving patient care, effectiveness and quality through innovation, research, improvement and education**			
a.	11:10	Patient and Staff Stories	For discussion & assurance	Ian Joy
b.	11:15	Joint Medical Directors Report including: ***[To follow]*** i) Emergency Preparedness, Resilience and Response (EPRR) ii) Guardian of Safe Working reports	For discussion & assurance	Michael Wright & Lucia Pareja-Cebrian
c.	11:25	Antimicrobial resistance – NHS England (NHSE) response	For discussion & assurance	Ian Joy & Julie Samuel

	Time	Item	Purpose	Lead
d.	11:35	Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs) report including Nurse Staffing Deep Dive	For discussion & assurance	Ian Joy
e.	11:45	Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress report	For discussion & assurance	Ian Joy
11:55 Refreshment break				
4.	**Supporting great care – supporting everyone to do their job to the best of their ability with effective leadership, a just and learning culture and modern digital and physical environments**			
a.	12:00	Resident Doctors 10 Point Plan ***[To follow]***	For discussion & assurance	Sam Richardson
b.	12:10	Freedom to Speak Up (FTSU) update	For discussion & assurance	Rachel Carter, Kathryn Smart & Paula Dimarco
c.	12:20	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report/Survey Results	For discussion & approval	Vicky McFarlane-Reid
d.	12:30	Travel and Transport Plan	For discussion & approval	Paul Hanson
5.	**Items to approve**			
a.	12:35	Quality Account	For discussion & approval	Rachel Carter
b.	12:40	Committee Annual Reports 2025/26 and Charity Committee Terms of Reference and Schedule of Business 2026/27	For approval	Kelly Jupp
6.	**Items to receive *[To cover by exception only]***			
a.	12:42	Learning from Deaths Report	For receipt	Rachel Carter
b.	12:43	Meeting Action Log	For receipt	Paul Ennals
7.	**Any other business**			
a.	12:44	Any other business	For discussion	All

Date and Time of Next Meeting: Friday 31st July 2026, 10:15 – 11:45, 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 Sue Hillyard, Interim Executive Director of Operations
Mr Patrick Garner, Director of Performance and Governance
Mrs Rachel Carter, Director of Quality and Safety
Mrs Nichola Kenny, Director of Improvement and Delivery
Mrs Kelly Jupp, Trust Secretary
Dr Sam Richardson, Peer Representative for Improving Resident Doctors Working Lives
Dr Julie Samuel, Consultant Microbiologist and Director of Infection, Prevention and Control (IPC)
Ms Kathryn Smart, Freedom to Speak Up Guardian (FTSUG)
Ms Paula Dimarco, FTSUG

The Newcastle upon Tyne Hospitals NHS Foundation Trust

PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 27 MARCH 2026

Present:	Paul Ennals *[Chair]*	Chair
	Rob Harrison	Acting Chief Executive Officer (CEO)
	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 Executive Director of People & Commercial Innovation
	Sue Hillyard	Interim Executive Director of Operations
	Bill MacLeod	Non-Executive Director (NED)
	Anna Stabler	NED
	David Weatherburn	NED
	Bernie McCardle	NED
	Hassan Kajee	NED
	Phil Kane	NED
	Wendy Balmain	NED

In attendance:
Nini Adetuberu, Associate NED
Judith McKenna, Associate NED
Caroline Docking, Director of Communications and Corporate Affairs
Rachel Carter, Director of Quality and Safety
Martin Wilson, Director - Great North Healthcare Alliance (GNHA) & Strategy
Patrick Garner, Director of Performance and Governance
Amy Callow, Director for People and Organisation Development
Russ Jones, Deputy Director of Estates & Facilities
Kelly Jupp, Trust Secretary
Jenna Wall, Director of Midwifery *(for item 26/08 g. i) only)*

Observers:
Tania Bell, Member of the public
Andrew Russell, Trainee Healthcare Scientist, Newcastle Hospitals
Sam Volpe, Health Reporter – Chronicle Live
Ankita Bharati, Postgraduate Student – Northumbria University
Laiba Arooj, Master's Student – Northumbria University
Misha Arooj, Master's Student – Queen's University Belfast
Alannah Pepper, General Management Trainee, Newcastle Hospitals

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.

26/07 INTRODUCTION:

Paul Ennals thanked the observers for attending and explained that the pre-election period was in place and the trust was required to adhere to national guidance on communication and activity.

a. Apologies for Absence and Declarations of Interest

Apologies were received from Liz Bromley, NED, Paul Hanson, Director of Estates, Facilities and Strategic Partnerships and Dave Elliott, Chief Digital Officer.

Phil Kane declared that he was now also a NED at County Durham and Darlington NHS Foundation Trust (CDDFT).

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

b. Minutes of the previous meeting held on 30 January 2026 and matters arising

The minutes of the meeting held on 30 January 2026 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:

- Changes within the NED cohort which included:
  - Judith McKenna being welcomed to the Trust Board in January as an Associate NED with finance expertise. Judith was recruited to replace Bill MacLeod, who was scheduled to leave in July due to his term of office coming to an end.
  - Nini Adetuberu's success in the Associate NED role which had resulted in her being recruited to two substantive NED posts. Nini would therefore be leaving Newcastle Hospitals on 31 March 2026.
  - Phil Kane becoming a NED at CDDFT and therefore his planned departure from Newcastle Hospitals in May 2026.
  - Bernie McCardle's planned retirement later in the calendar year.
  - Recruitment was underway to fill the NED roles being vacated by Phil and Bernie.

- The private Trust Board session would focus on strategy, forward planning and long-term ambitions including opportunities to advance medical care for patients in Newcastle and nationally.
- The Trust was no longer under Care Quality Commission (CQC) regulatory oversight.
- Industrial action for resident doctors was planned for next week and practical arrangements were being put in place to ensure clinical cover.

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

d. Chief Executive's Report

Rob Harrison highlighted the following points:

- Appreciation was expressed to all colleagues for their sustained commitment since the previous Public Trust Board meeting in relation to the continued emergency pressures, rising patient attendances and the intensified elective activity being undertaken as part of the year end elective sprint.
- Following the Care Quality Commission (CQC) report in early 2024, regulators had agreed that the organisation was now operating from a more level baseline, reflecting improvement in core processes. Whilst this was positive progress, improvement work was still required to maintain momentum and further strengthen systems, for example Clinical Board teams had been asked to continue strengthening governance arrangements.
- The staff survey results to be covered later in the meeting agenda. There had been a 65% response rate which equated to over 10,000 colleagues having completed the survey. The results were fairly static however Rob Harrison noted the importance of acting on the staff feedback received in the survey.
- The Trust was categorised in Segment 3 of the NHS Oversight Framework (NOF) which was linked to poorer performance against the 28-Day Faster Diagnosis Standard (FDS).
- Waiting times and associated pressures remained, with recent performance discussions held at the Finance and Performance Committee meeting.
- The seasonal increase in high-volume skin tumour cases during the summer months which meant that actions were needed to achieve a more sustainable position next year.
- Infection Prevention and Control (IPC) performance was currently being reviewed, with a focus on progressing towards NOF Segment 2 as soon as possible.
- Preparation had begun regarding the resident doctor's industrial action which was due to take place from 7 April 2026 to 13 April 2026.
- Breaking the ground for the new Sir Bobby Robson Institute was scheduled to take place in April. The Institute was aligned with the organisation's cancer strategy and would enhance capacity to deliver clinical trials at scale. Positive collaboration across the Charity team, Estates team and other teams was noted, with work continuing..

A discussion ensued which covered the following areas:

- The topics discussed at the Integrated Quality Improvement Group (IQIG), and specifically whether this included matters of patient safety. It was advised that patient safety was actively considered within the Group, with clear links to the findings of the recent staff survey.

- CQC re-inspection/future visits and potential changes to oversight arrangements. It was explained that the CQC undertakes inspections/visits on a risk-based approach, and as the Trust's risk level had reduced, a revisit was less likely at the current time. The external Well-Led review had contributed positively to this position.
- The staff survey results, in particular the low rating for 'we are a team', and whether the Executive Team had any insight into the underlying reasons for this lower score. Reflections were currently underway and it was acknowledged that while some areas of the organisation worked well, further understanding was required. The People Committee would receive more detailed analysis, including targeted actions and learning to support improvement. Although the results were more static than hoped for, it was agreed that this provided an opportunity to sharpen priorities and drive progress.

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

26/08 FOCUS ON FUNDAMENTALS – QUALITY, PERFORMANCE AND FINANCE:

a. Patient and Staff Stories

Ian Joy noted a common theme across both stories regarding the importance of small actions that could make a significant positive difference to patient and staff experience. He highlighted Ward 46, where several direct comments were received, and emphasised the need to explore these in the interest of transparency.

The fundamental value of the volunteer role was highlighted, along with an acknowledgement that effective communication from volunteers can have a meaningful impact on overall experience.

Anna Stabler noted that both examples were very positive stories and highlighted the opportunity to use them to promote volunteering across the Trust. Caroline Docking noted that many volunteers had personal experiences within the organisation which motivated them to return and support others through volunteering. She emphasised the importance of encouraging people to volunteer by sharing these stories; in ensuring volunteers are placed in the right roles; and in measuring improvements to ensure the approach was effective.

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

b. Board Visibility Programme

Rachel Carter highlighted the following points:

- The Trust Board was well informed on feedback from visits through the report, with the detailed information available in the Board Reading Room.
- No significant new themes or trends had emerged since the previous report, with any issues identified during visits escalated as appropriate at that time.
- A wide range of areas were visited, including community sites and non-clinical settings.

- Staff were open, honest, and proud of their daily work, whilst also transparent about the challenges they faced.
- A questionnaire was circulated to Clinical Boards in order to aid in evaluating the effectiveness of the programme. Whilst only 17 responses had been received, the feedback generated was useful in identifying areas for improvement.

  Feedback was that the visits were positively received, however it was evident that some staff did not fully understand the purpose of the programme, particularly for those who routinely met with Executive Team members informally.
- Future improvements included providing more consistent visits feedback to Clinical Boards, revising the feedback form to ensure the feedback loop was closed and developing an explainer to clarify the aims of visits and help teams prepare for discussions.

Paul Ennals highlighted the strong evidence of increased visibility across the organisation and observed that Trust Board members were warmly welcomed during their visits.

Nini Adetuberu noted that she had personally enjoyed undertaking the visits, which had prompted interesting conversations and each with a different focus. She queried the overall objective of the Board Visibility Programme to which Rachel Carter advised that one of the key aims was to triangulate information gathered from the visits with the staff survey results for each Clinical Board and Corporate Team. She noted that the Programme was continuing to evolve, and the intention was not to make it overly restrictive.

Bill MacLeod suggested a more targeted and responsive approach to selecting areas for visits be undertaken to which Ian Joy referenced the need to balance between formal and informal visibility. He noted the ongoing challenge of determining what constituted 'meaningful' visibility when evaluating the Board Visibility Programme. It was agreed that the framework should be measurable and clearly articulate the intended purpose and outcomes of Trust Board engagement across the organisation.

Paul Ennals advised that he was assured that a clear and robust process was in place, with appropriate oversight. He emphasised that the approach should not be restrictive but should support effective use of time. The positive feedback received to date was acknowledged, and appreciation was expressed to colleagues for their contributions.

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

c. <u>Integrated Board Report (IBR)</u>

Paul Ennals highlighted that each section of the IBR had been scrutinised at the relevant Board Committee.

Patrick Garner noted the following points:

- There had been a statistically significant improvement in sickness absence, particularly short-term sickness, with the previous decline now stabilised.

Vicky McFarlane-Reid advised that performance was encouraging, though sustained improvement was required with a Trust-wide refreshed approach to managing sickness absence has been initiated.

- The Finance and Performance Committee would receive an update on the elective sprint activity underway. The elective sprint was largely on track, with almost all planned activity expected to be delivered.
- Continued pressures remained within the Emergency Department (ED), however in March 2026 performance had improved and was expected to exceed the 78% target.
- The waiting list was forecast to reach approximately 82,000, a positive improvement against a plan of 84,500.
- The number of 52-week waits had improved and was expected to fall below 700 by month-end.
- Progress towards achieving the 92% Referral To Treatment (RTT) standard had been more limited, and work continued to improve the position.

Paul Ennals noted that overall performance had moved positively compared with the position 12 months ago.

Rob Harrison acknowledged that while progress had been made across several areas, further improvement was still required in cancer and diagnostics performance. A full review with Clinical Boards would take place once all relevant performance information was available.

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

d. <u>Finance, Activity and Workforce Plan update</u>

Patrick Garner highlighted the following points:

- The plans were developed as part of the medium-term planning process and gratitude was expressed to all colleagues who had helped support the development of the plans and the narrative document.
- The document outlined the key headlines and associated governance arrangements.
- NHS England (NHSE) had requested that the Trust revisit its plans, including the Cancer Faster Diagnosis Standard. Work was continuing with the Northern Cancer Alliance and the Integrated Care Board (ICB) regarding skin cancer pathways, as well as with neighbouring Trusts to identify key pathway elements and secure additional capacity during the summer months to support primary care.

  There was an opportunity to resubmit a revised plan at the end of April.

Jackie Bilcliff advised that the financial plan remained compliant, meeting the break-even requirement despite a challenging Cost Improvement Programme (CIP), and set out a trajectory to reduce the underlying deficit over the 3-year period.

Paul Ennals emphasised the Trust's ambition, noting that the plans offered a valuable opportunity to stretch performance, and welcomed the ability to set this out within a 3-year planning framework.

It was **resolved:** to **support** the Trust's medium term delivery plan.

e. Joint Medical Directors (JMD) Report including Mental Health update

Lucia Pareja-Cebrian noted the following points:

- Emergency Department (ED) activity remained challenging.
- With previous rounds of industrial action, the approach had been to plan for the continued delivery of the scheduled elective programme and adjust if required. However the short notice given for the upcoming round of industrial action for resident doctors was particularly challenging, with only six working days' notice provided and the action to take place during the busy Easter holiday period.
- Patient acuity had increased, with ongoing pressures regarding attendance versus admission.
- The Urgent Treatment Centre (UTC) had opened, which required adaptation to new ways of working and a continued quality improvement approach to refine processes.
- Cancer performance remained affected by the disproportionate impact of skin activity on the 28-day pathway, though this was having a positive effect on the 62-day performance.
- Breast cancer referrals had increased and actions to address this were outlined.
- Harm reviews remained ongoing.
- Within the Quality & Safety section, the Invasive Procedures Group was working to integrate its processes into harm-free care reviews.
- Job planning was progressing well, with 96% of plans completed by the end of March 2026. Next steps involved translating job plans into productivity improvements.
- Work on the 10-point plan for resident doctors continued, with weekly meetings and an update to be shared at the May 2026 Public Trust Board meeting.
- The General Medical Council (GMC) survey had recently gone live and was being publicised.
- The Trust's Mental Health Group met yesterday, and an update would be provided to the Trust Board on progress since the last CQC report **[ACTION01]**. Paul Ennals noted that it would be useful to discuss this topic through the Quality Committee.

  [Jenna Wall joined the meeting].

A discussion ensued which covered the following areas:

- Statutory and mandatory training compliance for medical staff and linkage to the job planning process. It was advised that compliance with statutory and mandatory training was a requirement of the job planning process, and this had been discussed with Clinical Directors. A plan was being developed to improve medical and dental statutory and mandatory training compliance. In addition there was an action from the People Committee to establish a task-and-finish group to review barriers to accessing training, with a future update to follow. Oversight would continue through the Quality Performance Reviews (QPR) process.

  A query arose relating to whether training compliance should be/is linked to appraisal and whether a 'satisfactory appraisal' threshold applied. It was clarified that while

completion of mandatory training was required, the medical and dental appraisal process did not follow a pass/fail model.

- The number of teaching fellows compared to previous years and resource implications. It was advised that discussions had taken place with the Clinical Board Chairs, who considered the current number of teaching fellows to be appropriate given available resources.

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

f. Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs) Report

Ian Joy highlighted the following points:

- Safe Staffing Level 1 was noted, with an observed increase in Health Care Assistant (HCA) vacancies.
- An update on safeguarding referrals/capacity from the Safeguarding Committee would be provided to the Quality Committee.
- Safeguarding training compliance remained strong for Levels 1 and 2, with improvement seen for Level 3 compliance. Plans were in place to further increase compliance.
- A review of safeguarding training requirements had been completed and a project plan has been developed to manage the forthcoming changes.
- The Trust was ranked 8th nationally for the number of flu vaccines delivered. Planning for next year's vaccination programme would commence in April 2026.

Paul Ennals highlighted the link between the Trust's strong vaccination performance and reduced staff sickness. He noted that rising HCA vacancies were also being seen regionally to which Ian Joy advised that it appeared to be a national trend influenced by recent visa application changes. Bernie McCardle explained that turnover was routinely reviewed at the People Committee meeting, to which Ian Joy added that a new workforce flag would be reported to the People Committee.

Anna Stabler advised that safeguarding concerns were being tracked more effectively than a year ago, and that a practitioner was now in post to support patients with autism.

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:

- An overview of the Maternity and Newborn Safety Investigation Reports and subsequent actions and Quarter 3 (Q3) Perinatal Mortality Review Report were available in the Private Board Reading Room. In addition an update was added to the Reading Room on progress against the three-year plan, noting that the Trust had

made good progress, with oversight having now transitioned into business-as-usual within maternity services.
- The importance of continuing to listen to, and learn from, service users.
- The currently commissioned maternity and neonatal model did not fully align with national guidance in relation to the maternity and neonatal voices partnership; however voices from hard-to-reach groups were being captured through several engagement mechanisms.
- In fetal medicine, medical staffing did not currently provide 72-hour cover for immediate reviews, although comprehensive clinical risk assessments and triaging was in place. A new Consultant Midwife in fetal medicine had now commenced in post to support a more sustainable workforce model.
- Wider issues relating to the recently published interim independent investigation report into maternity and neonatal services in England. This included areas such as capacity, culture and leadership, racism, estates and workforce.

Anna Stabler queried if the programme remained on track for the upload of the new growth charts planned for the summer to which Jenna Wall advised that the transition to the WHO charts would begin in June, ensuring that the updated patient record became visible as part of the change.

Rob Harrison highlighted that he and Jenna Wall met regularly to review and understand risks within the service, noting this as a key Quality Account priority. The ongoing work to improve vaccination uptake was outlined, particularly to improve uptake amongst ethnic minority communities and those living in deprivation where clear discrepancies existed.

Did Not Attend (DNA) rates were noted to be variable, and it was recognised that communication barriers such as appointment letters being issued in one language (English) may contribute to this. Work was therefore underway to review pathways and to support equitable access for all service users.

It was **resolved**: to **receive** the report and **note** compliance with the Perinatal Quality Surveillance Model.

[Jenna Wall left the meeting].

h. <u>Aubrey Self-Assessment</u>

Paul Ennals noted that, following the external review of governance within breast surgery services at CDDFT, he had asked the Executive Team to review the Trust assurance arrangements in place. Subsequently the North East and North Cumbria ICB had requested that all trusts undertake a self-assessment across four domains, aligned with the findings of the Aubrey report.

Patrick Garner advised that the Trust self-assessment was discussed at the Audit, Risk and Assurance Committee meeting earlier this week, with all trusts required to undertake a similar self-assessment. Executive leads had contributed information to support the assessment and accompanying assurance statements. High-priority actions were detailed in

section 3, and the Audit, Risk and Assurance Committee would consider further at the May Committee meeting.

David Weatherburn emphasised the importance of avoiding duplication with the Well-Led review workstream and highlighted the need for additional data to clearly evidence the actions being taken. He stressed the importance of streamlining effort so that the approach remained clean, simple, easy to follow and measurable.

Paul Ennals noted that the findings in the Trust self-assessment were well-known and reflected the substantial work already undertaken/in progress through the Well-Led review. He emphasised the value of considering the broader lessons that the review offered for the organisation, which would be reported in May 2026.

It was **resolved**: to **receive** the report and **approve** the submission of the self-assessment to the ICB.

26/09 MAKE IT BETTER FOR COLLEAGUES – IT, PEOPLE AND ESTATE

a. NHS staff survey, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) results

Vicky McFarlane-Reid highlighted the following points:

- A presentation was received at the Trust Management Group (TMG) and the People Committee, showing largely unchanged results from the October 2025 staff survey which reflected how staff were feeling at that time.
- Since the survey, notable progress had been made, including development of the anti-racism framework and work to address sickness absence, supported by staff networks.
- Whilst further pace was required in some areas, early evidence showed that actions were beginning to align with the staff feedback.
- The NHS Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES), in place since 2015, provided mandatory frameworks to assess whether ethnic minority and disabled staff experienced fair career progression. The Trust remained committed to improving its performance against these standards.

A discussion ensued which covered the following areas:

- Overall the results were felt to be disappointing given the work undertaken in the previous 12 months. The scores did not reflect our aspirations and demonstrated the need for further significant efforts. Despite this, the positive engagement from Executive Team colleagues provided confidence to NEDs that progress would be made over the next year, supported by detailed work already underway. Key foundations such as a strengthened focus on Equality Diversity and Inclusion (EDI), anti-racism initiatives, and the sexual misconduct framework were now in place, with staff networks playing an important role.
- Ensuring that the People Plan was focused on the right priorities and directed at the areas that would have the greatest impact. It was acknowledged that effective cultural

change would require active involvement from staff at every level and there was an opportunity to reflect and re-focus on the most important issues moving forward.

- The importance of defining what 'good' looks like and how initiatives within the People Plan and EDI work would deliver real progress. The People Committee had been updated on the EDI 12-point plan. The next stage in the development of the People Plan needed greater clarity with clearer milestones and actions to address the more challenging steps required for improvement. Strong foundations were established in year 1 of the People Plan, and significant work was already underway, making the coming year critical for turning these foundations into tangible, embedded change. Shared leadership for the delivery of the People Plan was required across the organisation.
- Linking staff experience with patient experience, and understanding the pressures faced regarding teams, workload and staffing.
- Concerns about bullying, harassment and racist behaviours and the need to address such behaviours.
- The importance of creating a supportive environment so colleagues can deliver the best patient care, alongside improving the workplace, IT, the estate and organisational culture.

Paul Ennals highlighted that the Trust Board understood the issues, but the whole organisation needed to share the same level of understanding for meaningful change to occur. He expressed assurance that the Executive Team was actively addressing the matters raised.

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

26/10 LOOK TO THE FUTURE – STRATEGY, NEIGHBOURHOOD TEAMS AND GNCH

a. Shine (Sustainable Healthcare in Newcastle) – Interim Update

Russ Jones provided an interim update which had been discussed at the recent Finance and Performance Committee meeting. He outlined progress against the climate emergency targets, including the £40m grant award from the Public Sector Decarbonisation Scheme (PSDS) covering energy, travel and patient care. Key risks and challenges were highlighted, and the climate emergency plan would be finalised and reported to the Trust Board in early 2026/27.

Bill MacLeod referred to the £40m PSDS grant, presented at the Finance and Performance Committee meeting on Monday, which would be transformational and reflected strong progress toward the Trust's Net Zero ambitions.

Rob Harrison commended the work of the sustainability champions, noting that staff engagement in smaller actions could collectively make a significant positive difference, complementing the larger schemes such as those related to the PSDS at the Freeman Hospital.

Paul Ennals noted strong engagement across the organisation, referencing the 1,129 members of the Green Champions Network meetings as evidence of staff commitment to sustainability.

It was **resolved**: to **receive** the report and **approve** the proposal to finalise the Climate Emergency Plan 2026/2031 and bring a final version for Board approval in early 2026/27.

26/11 ITEMS TO APPROVE

a. Board Assurance Framework (BAF)

Patrick Garner advised that all recent changes to the BAF were outlined on the report cover sheet. Risk ID 7.1, inability to sufficiently influence priorities of key partnerships, remained unchanged since the last Public Trust Board meeting. It would be reviewed as part of the BAF refresh for the new financial year.

David Weatherburn provided assurance that the current BAF was meeting its objectives through the discussions at the Audit, Risk and Assurance Committee (ARAC) meetings, though substantial updates were anticipated in the coming year to make it more dynamic and reflective of delivery. Paul Ennals added that approval of the new strategy would also significantly influence the BAF work required.

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

b. Trust Board and Committee Terms of Reference and Schedules of Business 2026/27

Kelly Jupp reported that the Terms of Reference (ToR) and Schedules of Business (SoB) had been reviewed through the relevant Committees. Minor amendments were required to update the wording on 'investment strategy' for the Finance and Performance Committee ToR, to add Patrick Garner as an attendee in the ARAC ToR, and to include a bi-monthly Grant Thornton Well-Led update in the ARAC SoB. Kelly Jupp thanked Lauren Thompson for her work in preparing the ToRs and SoBs.

It was **resolved**: to **receive** the report and **approve** the Trust Board and Committee ToRs and SoBs.

26/12 ITEMS TO RECEIVE

a. Committee Triple A reports

In relation to the Digital and Data Committee, Hassan Kajee advised that at the March meeting, the Committee discussed the Laboratory Information Management System (LIMS), in particular the current limitations and challenging timeframe. Committee members discussed and approved the proposed way forward, as well as acknowledging the associated risks.

Anna Stabler reported that at the February meeting of the Quality Committee, Infection Prevention and Control (IPC) had been escalated as an area which required further oversight. However, following the work undertaken by the Executive Team and the subsequent discussion at the March Committee meeting, Committee members received good assurance regarding the systems and processes now in place to improve IPC performance. The matter had therefore been de-escalated, with ongoing monitoring to continue through the Improvement Group and the organisation's continuous improvement processes.

With regards to the People Committee, Bernie McCardle reported on the national major changes to resident doctors' working arrangements, noting the added administrative workload and possible financial impact, with work ongoing to understand these fully. He also highlighted continuing concerns about violence and aggression towards staff, with the Committee assured that significant efforts were underway to address and reduce these incidents.

In relation to the Finance and Performance Committee, Bill MacLeod reported that while concerns remained about the Trust's cash position, positive progress had been made. The year-end cash position was expected to be more favourably than previously anticipated, although challenges were still expected in the new financial year. At the March Committee meeting, a deep dive was undertaken into cancer and diagnostics performance, with a detailed discussion on the Estates five-year capital plan and the strategic delivery plan, both of which would need to align with the new Trust strategy.

David Weatherburn reported that there were no alerts from the recent ARAC meeting, indicating that the other tier 1 Committees were functioning effectively. He noted that many of the items considered by the Committee had already been discussed in other forums, reflecting strong governance processes.

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

b. Learning from Deaths

Rachel Carter advised that the Learning from Deaths report had been fully scrutinised at the Quality Committee. Anna Stabler raised concerns regarding delays in completing level 2 mortality reviews. Rachel Carter and the team were undertaking work to address this and to ensure that learning was captured and acted upon in a timely manner.

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.

26/13 ANY OTHER BUSINESS

a. Any other business

Paul Ennals offered thanks and farewell on behalf of the Trust Board to Nini Adetuberu as she concluded her term as an Associate NED. He noted the freshness, insight and constructive challenge she had brought to discussions, and expressed the Trust Board's hope that she would remain connected with the organisation as she moved into two new substantive NED roles.

Nini Adetuberu expressed her appreciation to the Trust Board and wider team, highlighting the strong commitment and values demonstrated across the Trust, the shared focus on patients and the collaborative way of working. She reflected on how much she had learned from colleagues and, while sad to be leaving, looked forward to remaining part of the wider system.

There was no items of any other business discussed.

Summary of actions:

1. The Trust's Mental Health Group met yesterday, and an update would be provided to the Trust Board on progress since the last CQC report **[ACTION01]**.

The meeting closed at 11:36.

Date of next meeting: Public Board of Directors – Friday 22 May 2026.

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Agenda item A1(c)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 2026		
Title	Caring, Improving and Learning Together – Our Strategy 2026 - 2031		
Report of	Patrick Garner, Director of Performance and Governance, Caroline Docking, Director of Communications and Corporate Affairs		
Prepared by	Caroline Docking, Director of Communications and Corporate Affairs, Lisa Jordan, Assistant Director of Strategy and Planning		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☐
Summary	Following a significant period of engagement and involvement with colleagues, Governors, partners and others, the Board approved our new strategy in April 2026. The final version is now presented for adoption at our public meeting. This strategy sets out a clear and focused direction for the Trust over the next five years, aligning our vision, values and strategic priorities to deliver high-quality, equitable care for our patients and communities. It sets out 3 clear priorities - Joining Up Care, Advancing Care and Supporting Great Care – which provide a framework to guide our work. Our strategy places a strong emphasis on improving outcomes, reducing variation, and strengthening our role within both our neighbourhoods and our region. The approach brings together clinical excellence, improving colleague experience, and sustainability, underpinned by a commitment to compassionate leadership and a just and learning culture. Delivery will be supported through our clear priorities, measurable outcomes and robust governance, ensuring we can track progress, adapt to emerging challenges, and realise our ambition to provide high quality, personalised care for all. The work has begun to embed the strategy – both by sharing it with colleagues and by incorporating it into our processes and practices, including recruitment and induction. Key events include the Chief Executives Roadshows in June, and our Strategy Impact event for senior clinical and operational leaders on 1 July.		
Recommendation	The Board are asked to publicly endorse our strategy.		
Links to Strategic Objectives	This document sets out the strategic objectives for 2026-31.		

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Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☒	☒
Link to Board Assurance Framework [BAF]	The Trust Strategy will help to inform the refreshed BAF.					
Reports previously considered by	The Trust Strategy development has been discussed at several Trust Board meetings and Board Development sessions.					

Caring, Improving and Learning Together
2026 - 2031

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Our Vision

To deliver excellent, compassionate and innovative healthcare, education and research

Our Values

- **Kind**
- **Respectful**
- **Inclusive Team**

Our Ambition

To be an organisation that people are proud to be part of, trust for their care, and value as a partner in improving health outcomes

Our 3 Priorities

1 Joining up care

Working together to give people better, quicker access to effective care

- Easier access to care that works for patients
- More care closer to home
- Services that feel coordinated and are effective

2 Advancing care

Improving patient care, effectiveness and quality through innovation, research, improvement and education

- Consistent, high-quality care every time with fewer avoidable harms
- Using innovation, research and improvement to deliver better outcomes and experience
- Developing a skilled, confident workforce with strong clinical leadership
- Supporting and nurturing our world class specialist services

3 Supporting great care

Supporting colleagues to do their job to the best of their ability with effective leadership, a just and learning culture and modern digital and physical environments

- Feeling valued, safe and respected
- Confident, compassionate and accountable leadership
- Modern, reliable digital systems and physical environments
- Sustainable and responsible use of our financial and environmental resources

Success

What success looks like by 2031

Everyone has a role to play to create:

- Care that feels joined-up and personal
- Better outcomes and experience for patients and communities
- A confident and proud workforce
- Strong partnerships across the city and region
- A sustainable organisation fit for the future

Healthcare at its best
with people at our heart

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Agenda Item A1(d)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 2026					
Title	Chair's Report					
Report of	Sir Paul Ennals, Chair					
Prepared by	Sir Paul Ennals, Chair Gillian Elsender, PA and Corporate Governance Officer					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	This report outlines a summary of the Chair's activity and key areas of recent focus since the previous Board meeting held in Public in March 2026: • Board Succession • Governor Activity • Informal Visits • Alliance • External Meetings					
Recommendation	The Trust Board is asked to note the contents of the report.					
Links to Strategic Objectives	Joining up care – working together to give people better, quicker access to effective care Advancing Care – improving patient care, effectiveness and quality through innovation, research, improvement and education					
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. Following a robust interview process involving governor, executive and external stakeholder representation, and with some healthy competition from candidates, I am pleased to confirm that we have successfully appointed to the posts of Clinical Non-Executive Director (NED) and Associate NED (People) following Council of Governor approval. Candidates are likely to join us in early June subject to normal vetting procedures in line with the NHS England Fit and Proper Person Test Framework for Board members.

ACTIVITY WITH GOVERNORS AND MEMBERS

At our Governor Workshop in April, in addition to our standard reports, we had our regular update on local matters, recent news and achievements, reports on patient and staff experience, performance and finance delivered by Jackie Bilcliff, Deputy Chief Executive. We also heard about the work of Bill MacLeod, Vice Chair and Chair of the Finance & Performance Committee, and Bernie McCardle, NED and Chair of the People Committee.

Akbar Hussain, Consultant Neurosurgeon & Luke Bashford, Senior Clinical Research Fellow delivered a remarkable and insightful presentation on the work undertaken in the National Centre for Neurotechnology and Neurorestoration. The Trust has achieved national lead-centre status across multiple projects, reflecting the rapid growth of neurotechnology as one of the fastest-expanding areas in medical device applications.

Driven by significant unmet patient need and rapid growth in research, innovation and investment, the National Centre for Neurotechnology and Neurorestoration will provide a flagship hub for human research and translation within the NHS. Building on unique expertise, facilities and partnerships, the Centre will lead a national hub-and-spoke ecosystem, accelerating the delivery of transformative neurotechnologies and therapies that restore quality of life, while positioning the NHS as a global leader and living laboratory for neuroscience.

We also heard from Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals, and Russ Jones, Deputy Director Estates, Strategy, Planning & Capital Development, who provided an update on our Food and Drink Strategy, the three strategic aims of which are to meet patient nutrition & hydration needs, promote healthier eating for staff and visitors and deliver sustainable food procurement. We heard about the improvement programmes being undertaken in wards recognising that food is fundamental to physical, psychological and rehabilitative recovery.

We continue our engagement with Governors in relation the NHS Ten Year Plan's intent to remove the formal powers of Councils of Governors from March 2027. Governors will be aware that this has been discussed extensively with the Board who unanimously agree that maintaining a strong public and staff voice is essential in any future engagement model and that work on defining this model should be accelerated to provide clarity and stability.

Work is ongoing to develop a clear process for creating the Trust's future engagement model which will align with the 10-year Health Plan and focus on more dynamic engagement that incorporates patient, staff and stakeholder insight. Work will also take place across the Alliance to identify best-practice engagement models, ensuring Governor input is embedded throughout.

In addition, the Trust Board endorsed the recommendation to pause Governor elections until October 2026. This decision is intended to maintain constitutional compliance, allow time to consider forthcoming legislation expected in May 2026, and provide an opportunity to review progress and anticipated timelines for that legislation. In the meantime, our Council of Governors agreed to the proposal to offer a co-opted governor role to eligible governors whose terms were ending on 31 May 2026.

In addition to our formal meetings, 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.

INFORMAL VISITS & EVENTS

I was delighted to welcome the Princess Royal to the Trust on a recent visit in her role as Patron of The Royal College of Midwives. The Princess Royal commented on the great core spirit and positive work ethic in the Royal Victoria Infirmary Maternity Unit; the range of challenges faced in a unit of this size and how they are dealt with.

I also attended the official 'Groundbreaking' for the construction of the Sir Bobby Robson Institute, a world-leading centre for cancer trials and research. The building will be run as part of our Trust and will join with the Freeman Hospital's cancer and blood disorders research team, as well as the existing Sir Bobby Robson Cancer Trials Research Centre based at the Northern Centre for Cancer Care. The new institute would increase research activity by 50% over five years and lead to more complex and larger trials.

Whilst at the Freeman site I took the opportunity to visit the Pathology Lab within the Integrated Laboratory Medicine function which provides comprehensive routine and specialist laboratory services across the region. It is a major hub for diagnostics, covering areas including blood sciences, microbiology, and cellular pathology.

In addition to the above I also had the opportunity to meet a wide range of teams at Regent Point.

ALLIANCE

There continues to be good progress with Alliance developments with recent discussions focusing on our Strategic Intent. The Alliance Formation Team has reviewed each Trust's existing strategy and confirmed alignment with the Alliance Strategic Intent. As Trust

strategies are refreshed, clearer and more explicit links to the Alliance Strategic Intent will be incorporated.

OTHER MEETINGS AND INFORMATION

Along with other Chief Executives and Chairs from the region I recently attended a North East and Yorkshire Regional Roadshow hosted by NHS England, which provided an opportunity to discuss priorities and ways of working with regional and national colleagues, including newly appointed regional Chair Bill McCarthy, Sir Jim Mackey, Chief Executive of NHS England and Paul Dinkin, Department of Health and Social Care (DHSC) Director General, Strategy and Healthcare Policy.

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
30 April 2026

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Agenda item A1(f)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 2026					
Title	Committee Triple A Reports					
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 Wendy Balmain, 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 March 2026: • Digital & Data Committee – 12 March 2026 • Quality Committee – 19 March 2026 & 23 April 2026 • People Committee – 17 March 2026 • Finance & Performance Committee – 23 March 2026 & 27 April 2026 • Audit, Risk & Assurance Committee – 24 March 2026 • Chairty Committee – 26 March 2026 (Funding only) & 10 April 2026					
Recommendation	The Trust Board is asked to note the contents of the Committee Triple A Reports.					
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 Triple A Reports.					
Reports previously considered by	Public Board meeting in March 2026.					

Agenda item A1(f)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Digital and Data Committee
Date of Committee / Group:	12 March 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)

- **Laboratory Information Management System (LIMS) Roadmap Spotlight**
  The Director of Operations described the risks present regarding the outdated APEX system, including recent outages and formal end-of-life notifications for both software and hardware, necessitating urgent action. The committee reviewed the options presented, with support expressed for the preferred option, while noting the need for due diligence, procurement compliance, and risk assessment. The estimated project cost was significant with a relatively long contract length, committee members highlighted the compressed decision-making window, and discussed the complexities of procurement, legal advice and alignment with national funding and support. The committee agreed on the importance of a robust business case detailing risks, requirements, and governance, with further scrutiny through the Finance and Performance Committee, and acknowledged the urgency imposed by external deadlines.

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)

- **Digital Exclusion**
  The committee raised concerns about digital exclusion, prompting assurances from the Chief Digital Officer that fallback processes are in place for patients unable to use digital platforms, and that a tailored, multi-channel approach is being developed to address diverse patient needs.

- **Change of Senior Information Risk Owner (SIRO)**
  Patrick Garner will take over from Caroline Docking as SIRO on 1 April 2026. The SIRO structure will be reviewed once the new Director of Digital starts.

Assure

(key assurances received and any highlights of note such as best practice or innovation)

No items discussed for the assure section.

Risks (any new risks / proposed changes to risk scores – include risk ID where known)

No new risks.

Cross-referrals to other Committees / Executive Director Leads

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No new cross referrals.	
Agreed actions	**Responsibility / timescale**
1. Future Care Quality Commission (CQC) update reports to provide assurance to the committee that CQC recommendations have been addressed, distinguishing from ongoing continuous improvement.	1. Chief Nursing Information Officer Timescale: Committee meeting May 2026
2. To identify and clarify the real opportunities for Artificial Intelligence (AI) to support productivity gains, and report back to the committee.	2. Director of Innovation Timescale: Committee meeting May 2026

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Quality Committee
Date of Committee / Group:	19 March 2026
Chair of Committee / Group:	Anna Stabler

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 issues for the Board to be alerted on.

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)

- **Emergency Department (ED) Improvement Group** - ED update should remain at "advise" level on the escalation and assurance report, recognising progress but acknowledging further work is needed in terms of strengthening corridor care data, addressing staff concerns at the front door, and providing more detailed assurance on staff engagement in the next report.
- **Infection Prevention Control Improvement Group** - Based on the documentation and pre-meeting discussion, it was agreed to de-escalate from "alert" to "advise", recognising the progress made, while noting that full de-escalation will require consistent, tangible evidence over time.
- **Deteriorating Child Improvement Group** - Based on the information provided and discussions, and recognising the need for clearer data, SMART (Specific, Measurable, Achievable, Realistic and Time-bound) actions and a complete, time-bound action plan, it was agreed that this item should remain in the "advise" section.
- **Learning Disability Quarter 3 Report** - Based on the paper and discussion, it was agreed that while appropriate systems, processes and day to day oversight are in place and improvement is evident, the position should be recorded as advise rather than assure.
- **Learning from Deaths Quarter 3 Report** - Being mindful of mitigations in place it was agreed to place this item at "advise", with a clear caveat that it may escalate to alert if there is not rapid improvement, including timely implementation of the InPhase module and consistent uptake across the Trust as well as improvement in level 2 reviews.
- **Integrated Board Report** - Following review of the Integrated Board Report, a rating of "advise" was agreed.

- **Dental Services Update** - The Committee agreed that there is assurance that appropriate governance processes are in place. However, recognising that the service is on a development journey, particularly in relation to defining metrics and monitoring arrangements, it was agreed to rate the item as "advise".
- **Nutrition & Hydration Strategy – Clinical Workstreams** - Based on the report and agreed recommendations, the Committee agreed to place this item in the "advise" section of the escalation and assurance report, noting that further work was underway to develop and refine appropriate KPIs (Key Performance Indicators).
- **Clinical Audit & Guidelines Report** - the position was noted as "advise" reflecting the fragmented storage and governance of clinical guidelines across multiple systems. Emphasis was placed on the need to see clear evidence of progress and improvement in this area as assurance develops over time.

Assure
(key assurances received and any highlights of note such as best practice or innovation)

- **Perinatal Quality Surveillance Report Including Maternity Incentive Scheme** Despite ongoing staffing gaps, the Committee agreed there was sufficient assurance that processes and mitigations are in place. The report was therefore rated as "assure".
- **Equality Quality Impact Assessment (EQIA)** - the Committee agreed there was good assurance that robust processes were in place and are subject to ongoing review and strengthening. On this basis, the item was rated as "assure".
- **Patient & Staff Experience** - the Committee agreed to assign an "assure" rating to Patient Experience within the Escalation and Assurance Report. It was agreed that the report would move to quarterly reporting rather than bi-monthly.

Risks (any new risks / proposed changes to risk scores – include risk ID where known)

No new risks identified.

Cross-referrals to other Committees / Executive Director Leads

No cross referrals.

Agreed actions	Responsibility / timescale
1. De-escalation from the Integrated Quality Improvement Group (IQIG) – outputs from the work in relation to de-escalation to be made available.	1. Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals – April 2026
2. Meningitis National Patient Safety Alert – An update on the alert and related actions would be brought to the next Committee for noting and assurance.	2. Rachel Carter – Director of Quality & Safety – April 2026

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Quality Committee
Date of Committee / Group:	23 April 2026
Chair of Committee / Group:	Anna Stabler

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)

- **Facilities Management Change Programme** - It was agreed that this change programme should remain a corporate Alert. While mitigations are in place, there are concerns relating to organisational capacity, requirement for future investment, and the degree of leadership development required. Until a detailed action plan is developed with clear assurance of cross-organisational support, the alert status should be maintained
- **Antimicrobial Resistance – Response to NHS England Letter** - While progress was being made, improvements are still required relating to data quality and oversight. The alert status reflected the need to strengthen governance and process issues. It was also agreed that these metrics would be tracked through the Infection Prevention and Control (IPC) Improvement Group reporting to Quality Committee.

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)

- **IPC Improvement Group** – the Committee recognised the long-term nature of this work. While broad principles for de-escalation were already in place, more detailed plans will be developed by June to outline improvement trajectories.
- **Ophthalmology Improvement Group** - Not all issues are resolved but there is now clear understanding of the problems and a comprehensive action plan in place. There is confidence the correct processes are established and progress is being actively managed, marking a significant improvement in recent months.
- **Integrated Board Report** - Following review of the Integrated Board Report, a rating of “advise” was agreed.
- **Duty of Candour –** The committee noted that legacy obligations had been completed but recognised that further improvement in processes and assurance are still required. This remains under close monitoring of the committee with further updates scheduled.
- **Quality and Safety Peer Reviews** – the Committee recognised there was an established assurance process in place and remained iterative, with clear recognition that further improvement was still needed to provide high quality assurance that standards are embedded and maintained.

- **Allied Health Professionals (AHPs) -** There is strong confidence in workforce oversight, actions and controls in some areas. There remains cross-system challenges relating to the AHP workforce. These workforce pressures and demand-capacity gaps are noted in service level risks registers with local improvement actions and mitigations in place but concerns remain regarding care quality and sustainability.

Assure
(key assurances received and any highlights of note such as best practice or innovation)

- **Hepato-Pancreato-Biliary (HPB) Improvement Group -** the Committee was assured by the information presented. There was a strong example of effective escalation through the Quality and Performance Review (QPR) process. A range of issues had been identified, addressed systematically, and supported by strong clinical leadership. The Committee formally recognised the effectiveness of the escalation and improvement process, and agreed to step the item down from the Quality Committee oversight.
- **Cardiothoracic Improvement Group** - There was broad agreement that an Assure rating was appropriate. While the report included a mix of assurance and areas still requiring attention, there were no new alerts or escalations. The committee agreed to move the cultural improvements into the Cardiothoracic People Group, and supported the proposal that those items still in train would be monitored through the QPR process. The Committee agreed to step the improvement group down from Quality Committee oversight.
- **Perinatal Quality Surveillance Report Including Maternity Incentive Scheme** - the Committee agreed there was sufficient assurance that processes and mitigations are in place. There were no new issues requiring escalation.
- **Quality Performance Reviews** - the committee recognised that there is a robust and effective escalation process in place, with issues appropriately identified and managed through the QPR framework.
- **Review of Care Quality Commission (CQC) 'Must Do' Actions –** the Committee rated this as Assure being mindful that the Trust self-assessed overall significant assurance, meeting NHS England thresholds for de-escalation from external oversight, which has been confirmed by external stakeholders.
- **Mortuary Privacy & Dignity Update –** the Committee noted assurance that privacy, dignity, and security are being maintained. No new risks or escalations were identified, all issues are known and managed, and strong controls, oversight, and staff understanding are in place.
- **Legal update and Learning from Claims** - the Committee was assured that that litigation and inquest risks are understood and managed, with clear oversight of increasing claim volumes, no Regulation 28 reports issued, and learning from cases being captured and shared to support improvement.
- **Summary of Internal Audit Reports relating to the Quality Committee -** the Committee was assured that the Internal Audit provides independent, risk-based assurance on internal controls, with a 2025/26 audit plan aligned to key risks, governance priorities, and Board assurance requirements.

(any new risks / proposed changes to risk scores – include risk ID where known)

No new risks identified.	
Cross-referrals to other Committees / Executive Director Leads	
Ophthalmology Improvement Group - Concerns were highlighted in relation to the Human Tissue Act compliance and the Trust had been in direct correspondence with the Human Tissue Authority (HTA). Members were assured that the process had been fully redesigned, and that full compliance with the Human Tissue Act was in place. A cross-referral to the HTA Group was recommended for oversight.	
Agreed actions	**Responsibility / timescale**
1. To re-circulate email feedback regarding Paediatric Integrated Management Group Team Visit.	1. Lucia Pareja-Cebrian – Joint Medial Director, May 2026.
2. Next Ophthalmology update to include specific update in relation to training and the use of MEDISIGHT.	2. Keecia Bailey, Director of Operations, Surgical and Specialist Services Clinical Board – June 2026.
3. Facilities Management Change Programme to be added to schedule of business for 6 months' time.	3. Gill Elsender, PA and Corporate Governance Officer – May 2026.
4. Integrated Board Report – items for next iteration to include additional narrative for the following to be made available in the reading room: • Severe Falls • HOGAN 5 scores • Pressure Ulcers 3 and 4 and split between Hospital and Community pressure ulcers • Medicines Management Reconciliation – trajectory for improvement • Level 2 mortality reviews - trajectory for improvement • Complaints slide – numbers to be included for overdue complaints.	4. Rachel Carter, Director of Quality & Safety and Ian Joy, Executive Director of Nursing, Midwifery and AHPs and Lucia Pareja-Cebrian – Joint Medial Director – May 2026.
5. Internal Audit report – concern at the extension given to the recommendation in relation to NUTH 2024- 25/12 Transfer of Care Transmissions - Conduct a clinical risk assessment for the eRecords (Docstore) system in line with DCB0160 standard to assure the clinical safety of the system. Action to contact Executive Director to seek agreement on the length of the extension.	5. Natalie Yeowart, Head of Corporate Risk and Corporate Assurance to contact, Dave Elliott, Chief Digital Officer – May 2026.

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	People Committee
Date of Committee / Group:	17 March 2026
Chair of Committee / Group:	Wendy Balmain, 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)

- **NHS staff survey** – Committee members reviewed the staff survey results in detail and recognised the need to focus on specific areas for improvement. Deep dives into the data and free-text comments will be undertaken to ensure that priorities are accurately targeted. This work will be aligned with the People Plan, and any required changes to priorities or delivery plans will be made accordingly. A key area of focus will be leadership capacity and development.
- **Fair deal for nurses** – The complexity and sensitivity of the national review were noted, and the Committee agreed to receive updates as they become available.

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)

- **Summary of Internal Audit reports relating to the People Committee –** The Committee received assurance that Internal Audits continue to progress; however, further information was requested regarding one of the outstanding audits concerning bullying and harassment.
- **People Plan including People Plan year 3 action planning and Grant Thornton update –** A comprehensive update was received; however, the Committee requested further information regarding the development of a leadership framework and associated costing. In relation to the Grant Thornton well led review update, the Committee also requested additional detail on how monitoring, measuring, and ensuring improvements will be achieved in relation to Equality, Diversity and Inclusion (EDI).
- **Sexual Safety Charter Assurance Framework Audit update –** Oversight arrangements are in place, though it was recognised that additional work is still required.
- **Leng Review -** Further work is needed to ensure responsibilities are clearly defined. The Committee acknowledged that potential future opportunities related to workforce roles remain to be explored.
- **Integrated Board Report (IBR) –** A detailed discussion took place covering staff sickness, policies and processes, statutory and mandatory training, and workforce numbers. Further work is required to address hotspot areas of non-compliance in

statutory and mandatory training, as well as staff sickness, through the group established to lead this work. • **People Team and Clinical Board Effectiveness Audit** – A discussion took place regarding the phased approach to aligning the People Team with the Clinical Boards, noting that this work remains in progress. • **Workforce Reduction Group –** The Terms of Reference and membership of the group will be reviewed to ensure they incorporate oversight of the costs associated with the workforce element of the Cost Improvement Programme (CIP), as well as staffing numbers, to support a sustainable workforce.
Assure ***(key assurances received and any highlights of note such as best practice or innovation)***
• **Board Assurance Framework (BAF)** – It was noted that the requested changes from the previous People Committee meeting have been reflected in the BAF, and progress has been made regarding the amber-rated risks. The BAF will be refreshed for the new financial year in alignment with the new Trust Strategy. • **Job Planning** – Significant progress has been achieved, and the appropriate processes are firmly established. • **People Team Restructure** – The Committee were assured that the correct plans are in place.
Risks (any new risks / proposed changes to risk scores – include risk ID where known)
• No new risks or prosed changes to risk scores.
Cross-referrals to other Committees / Executive Director Leads
• No new cross-referrals.

	Agreed actions		Responsibility / timescale
1.	People Committee Terms of Reference (ToR) and Schedule of Business (SoB) – to add wording relating to the oversight of disciplinary processes and Sue Hillyard, Interim Executive Director of Operations as a member of the Committee to the Terms of Reference.	1.	Vicky McFarlane Reid, Executive Director of People and Commercial Innovation & Lauren Thompson, Corporate Governance Manager/Deputy Trust Secretary / March 2026
2.	People Programme Board ToR and SoB – to be reviewed in line with the People Committee ToR and SoB and to explicitly reference reporting into People Committee.	2.	Amy Callow, Director of People and Organisational Development (OD) / May 2026
3.	Summary of Internal Audit reports relating to the People Committee - further information was requested	3.	Vicky McFarlane-Reid / May 2026

	regarding one of the outstanding audits concerning bullying and harassment.	
4.	People Plan year 3 action planning – The Committee requested that the next update incorporate the impacts arising from the staff survey results and provide a mapped overview of the resource, funding and delivery elements.	4. Amy Callow / May 2026
5.	People Plan, Grant Thornton well led review update – A discussion to take place on how monitoring, measuring, and ensuring improvements will be achieved in relation to Equality, Diversity and Inclusion (EDI).	5. Amy Callow & Caroline Docking, Director of Communications and Corporate Affairs / May 2026
6.	Leng Review – Further work to take place to define future workforce opportunities.	6. Michael Wright & Lucia Pareja-Cebrian, Joint Medical Directors / July 2026
7.	IBR – A strategic summary to be provided at the next Committee meeting relating to the hotspot areas and actions to tackle non-compliance with statutory and mandatory training.	7. Amy Callow / May 2026
8.	People team and Clinical Board effectiveness audit – An update to be provided in 12 months' time.	8. Vicky McFarlane-Reid / March 2027
9.	Fair deal for nurses – Add to the People Committee SoB as a regular update when required.	9. Lauren Thompson / March 2026

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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 March 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)

The 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)

- **Estates update including the Strategic Delivery Plan and Five Year Capital Plan –** The Committee approved the Strategic Delivery Plan and the Five Year Capital Plan, subject to further work to ensure both are aligned with the new Trust Strategy. Additional work will also be undertaken to strengthen the linkage between community and finance elements in the Five Year Capital Plan.
- **Integrated Board Report (Month 10 Performance) including Cancer and Diagnostics update –** Committee members noted the progress achieved, however challenges remain in certain areas, resulting in an NHS Oversight Framework (NOF) rating of Segment 3 in quarter 3. Operational and corporate teams are continuing to work to improve performance.

Assure

(key assurances received and any highlights of note such as best practice or innovation)

- **Month 11 Finance Report including Cash –** The forecast outturn remains at breakeven, consistent with the agreed financial plan for 2025/26. The Committee received assurance that appropriate grip and control measures are in place, alongside extensive planning for the 2026/27 financial year.
- **Capital –** Committee members received assurance regarding the capital position, including confirmation that appropriate oversight and evaluation processes are being applied throughout the busy year-end period.
- **Sustainability update including Climate Emergency Action Plan –** The Committee highlighted the positive progress being made towards the targets in Newcastle Hospitals' current climate emergency strategy, as well as the ongoing work to embed sustainability within the new Trust Strategy.

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• **Procurement update –** A comprehensive update was received, covering the Procurement Team's contributions to the Cost Improvement Programme (CIP), current supply chain issues, relevant legislation, and ongoing training and professional development.
Risks (any new risks / proposed changes to risk scores – include risk ID where known)
No new or proposed changes to risks noted.
Cross-referrals to other Committees / Executive Director Leads
No cross-referrals noted.

Agreed actions	Responsibility / timescale
1. F&P Committee Terms of Reference (ToR) & Schedule of Business (SoB) – To update the wording relating to the investment strategy in the ToR.	1. Jackie Bilcliff, Chief Finance Officer & Acting Deputy Chief Executive / March 2026

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Finance and Performance Committee
Date of Committee / Group:	27 April 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)

The 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)

- **Finance and Activity Plan update including NHS England (NHSE) 'Plan Close Down' letter -** Work is underway to strengthen the quality of performance discussions, including a review of Tier 2 meetings. Regular updates to the Finance and Performance Committee will be provided.
- **Integrated Board Report (Month 11 Performance) including Emergency Care update –** A positive update was noted for February 2026. Emergency Department (ED) performance showed a slight reduction compared to January 2026, there was a significant reduction in 52-week waiters, and the 28-day Faster Diagnosis Standard (FDS) was achieved. Targeted improvement work continues within cancer services, breast services and areas within Emergency Care with a particular focus on reducing paediatric type 1 breaches, improving length of stay, and strengthening patient flow.

Assure

(key assurances received and any highlights of note such as best practice or innovation)

- **Surgical and Specialist Services Clinical Board update –** Committee members received assurance that the Clinical Board fully delivered its Cost Improvement Programme (CIP) on a recurrent basis during the year and exceeded the recurrent target by £3.8m on a full-year effect. A fortnightly Productivity and Efficiency Group continues to meet, maintaining engagement and oversight of ongoing efficiency and productivity initiatives.
- **Month 12 revenue report including cash –** The outturn revenue position for 2025/26 is a surplus of £5.1m against a planned break-even position. This favourable variance arose late in the year and reflects £4.9m of reallocated deficit

support funding agreed with NHS England (NHSE). The overall position has been delivered through robust performance against the CIP, alongside £17m of national support funding. • **Capital –** The Trust's final capital programme for 2025/26 totalled £75.9m. This compared to overall funding allocated through Capital Departmental Expenditure Limit (CDEL), Public Dividend Capital (PDC) allocations and Private Finance Initiative (PFI) Lifecycle of £76.4m leading to a final underspend of £463k subject to audit, which was highlighted as a positive position.
Risks (any new risks / proposed changes to risk scores – include risk ID where known)
No new or proposed changes to risks noted.
Cross-referrals to other Committees / Executive Director Leads
No cross-referrals noted.

Agreed actions	Responsibility / timescale
1. Jackie Bilcliff agreed to review the corporate performance financial overspend figures within the Month 12 Finance Revenue Report.	1. Jackie Bilcliff, Chief Finance Officer & Acting Deputy Chief Executive / May 2026
2. An Urgent & Emergency Care roadmap to be produced and presented at a future Finance and Performance Committee meeting.	2. Sue Hillyard, Interim Executive Director of Operations, Patrick Garner, Director of Performance and Governance and Marcus Weatherly, Director of Operations – Medicine and Emergency Care Clinical Board / June 2026

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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:	24 March 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)

- **Board Assurance Framework (BAF) –** Evidence was provided that the BAF was being used dynamically, with regular reviews within Board Committees. However one area was identified where further assurance was sought regarding the approach to monitoring external reviews and implementation of associated recommendations.
- **Aubrey Report –** Following a request to all trusts in the region from the North East and North Cumbria Integrated Care Board (ICB), a self-assessment against the 4 domains linked to Aubrey report was undertaken and presented. The self-assessment provided assurance for some areas, with further work needed to provide assurance on others such as insourcing and outsourcing contracts.
- **Well-Led Report –** An update was shared on the development of the well-led action plan and the process for monitoring. Some assurance was noted as to the comprehensive of the plan and the measurable outcomes. Further assurance would be needed as to completion and embeddedness of the actions going forward.
- **Internal Audit –** The Internal Audit Plan for 2026/27 was approved.
- **Fraud –** The Annual Fraud Plan for 2026/27 was approved.
- **Committee Terms of Reference (ToR) and Schedule of Business (SoB) 2026/27 –** The updated ToR and SoB were approved, subject to a minor amendment to add the well-led action plan review into the SoB and to update attendees to include the Director of Performance and Governance (DP&G) and remove the Chief Digital Officer. Board approval would be sought at the 27 March Board meeting.
- **Standing Orders (SOs), Scheme of Delegation (SoD), Standing Financial Instructions (SFIs) –** Minor amendments were made to the SOs, SoD and SFIs which were approved.

• **Going Concern statement –** The statement explained why the Trust should be considered a Going Concern and why the annual accounts for 2025/26 should be prepared on that basis. The statement was approved and Board approval would be sought.
Assure ***(key assurances received and any highlights of note such as best practice or innovation)***
• **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.
Risks (any new risks / proposed changes to risk scores – include risk ID where known)
Committee members discussed the conflict in Iran and whether a new risk should be considered in relation to the potential impacts on the supply chain, energy/fuel costs, cyber incidents, overseas patients and the workforce. See action 3 below.
Cross-referrals to other Committees / Executive Director Leads
Committee members discussed action 358 on the action log [*Trust Charity Customer Relationship Management System subscription costs*] and it was agreed that the action be closed but that David Weatherburn discuss this directly with the Charity Director and refer to the Charity Committee. Committee ToR – Executive Team members to discuss attendees at Committee meetings. Regarding the Assurance and Escalation report from the Digital and Data Committee – Non-Executive Directors Anna Stabler and Hassan Kajee agreed to discuss the clinical implications and risks linked to the paper to the Digital and Data Committee on the digital aspects of the Care Quality Commission (CQC) report. Anna Stabler agreed to consider further regarding reporting to the Quality Committee.

Agreed actions	Responsibility / timescale
1. BAF – Proposal to be developed on the approach to monitoring external reviews and implementation of associated recommendations.	1. Rachel Carter, Director of Quality & Safety (DQ&S), and Patrick Garner, DP&G – 19 May 2026
2. BAF – The DP&G agreed to share the latest report on external reviews that was presented to the Compliance and Assurance Group with Committee members.	2. DP&G – 19 May 2026
3. Risk Report – It was agreed that the wording on the local risk register and	3. Lucia Pareja-Cebrian, Joint Medical Director (JMD), DQ&S and Natalie

the Emergency Preparedness, Resilience and Response regional risk register be reviewed to consider the conflict in Iran.	Yeowart, Head of Corporate Risk and Assurance – 19 May 2026
4. Accountability Framework – Framework to be updated and reported at the May Committee meeting. Specific reference to be made to the escalation/de-escalation process.	4. DP&G and Kelly Jupp, Trust Secretary – 19 May 2026

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

Charity Committee - Chair's Log

Meeting: Charity Committee – Funding only	**Date of Meeting**: 26 March 2026
Connecting to: Trust Board	**Date of Meeting**: 22 May 2026

Key topics discussed in the meeting	

- Funding proposals were discussed and the outcomes were as follows:
  - Cancer and Haematology - Haematological Cancer Research Fellow - £95,456 – Following reassurance regarding all previous queries received, the proposal was supported via email.
  - Family Health – Great North Children's Hospital (GNCH) Yoga and Wellbeing - £33,540 – the proposal was not supported.
  - Surgical & Associated Services - Channelled Laryngoscope - £24,408 - The funding proposal was supported on the condition they are able to provide more information regarding plans to evaluate impact and acknowledge the Charity's support.
  - Family Health - GNCH Youth Workers - £148,946 - The funding proposal was supported on the condition the project can commit to providing more information regarding plans to evaluate impact and acknowledge the Charity's support.
  - Medicine - Oesophageal Physiology Testing - Capital Request for Equipment - £46,868 - The funding proposal was not supported as it was felt that this constituted the delivery of a new service, so they should first submit a business case to the Trust.
  - Family Health - Keepsake Equipment to Support Families of Dying Children - £20,000 – the proposal was supported.

- The summary of funding agreed since the last meeting was received (bids up to £20k).

Actions agreed in the meeting	Responsibility / timescale
No actions from these applications.	

Escalation of issues for action by connecting group	Responsibility / timescale
Not applicable.	

Risks (Include ID if currently on risk register)	Responsibility / timescale
No new risks.	

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Newcastle Hospitals Charity (NHC) Committee
Date of Committee / Group:	10 April 2026
Chair of Committee / Group:	Wendy Balmain, 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 alerts discussed.

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)

- **Charity Governance:**
  - Key discussions underway with Union/staff group.
  - Frequently Asked Question's (FAQs) being developed.
  - A Steering Group to be established.
  - Project management capacity required.

- **Fundraising Review:** Final report due at the end of April. Recruitment for vacant post to commence. Findings to fit into longer term vision and be built into new operating model. Fundraising Feedback Session to be arranged.

Assure

(key assurances received and any highlights of note such as best practice or innovation)

- **Proposed Funding Programmes 2026/27**
  Endorsed in principle subject to Executive Team Feedback and language revisions.
- **Sir Bobby Robson Institute (SBRI) Progress Report:** The report was received and it was noted that good progress was being made and we have almost closed the gap on the required funding through receiving some significant donations.
- **Management Accounts:** The Management Accounts were received and discussed.
- **Update on rationalisation of Funds:** It was noted that work had been carried out to date. More detail required regarding sections 6 and 7 of the report.
- **Quarterly Reporting Funds committed but not drawn down:** Committee were assured that progress had been made and noted that new financial forecasting through the funding proposal mechanism had been put in place.

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- **Review of Investments and Banking:** Assured processes in place**.** Review panel to be established. Committee agreed invitation letters and pack to be sent out.
- **Shared Resources Agreement Update:** The agreement was received and approved.
- **NHC Terms of References (ToR):** The ToR were received and amendments approved.
- **Charity Risk Statement:** The quarterly report to Committee was received.
- **Annual Operating Plan and Key Performance Indicators (KPI's) 2026/27** – The report was received. A simplified report to show progress against key priorities to be brought to future meetings.

Risks (any new risks / proposed changes to risk scores – include risk ID where known)

- 1478 – additional information to be added to this risk following discussions regarding the Charitable Incorporated Organisation (CIO).

Cross-referrals to other Committees / Executive Director Leads

- No new cross referrals.

Agreed actions	Responsibility / timescale
1. Regarding the CIO – Teri Bayliss (TB) to share FAQs with Committee following conversation with the Union.	1. TB/September 2026
2. Committee agreed that project management capacity is essential – TB to explore.	2. TB/September 2026
3. A CIO steering group to be established.	3. TB/Amanda Waterfall (AW)/September 2026
4. Further dates to attend Trust Board to be explored.	4. TB/Caroline Docking (CD)/May 2026
5. Senior engagement meeting to be arranged with Trust Chair/CEO ahead of Trust Board Meeting.	5.AW/ May 2026
6. Fundraising review feedback session to be arranged.	6. AW/May 2026
7. Fundraising Review report highlighted retail as being a considerable expenditure, a full financial retail plan to be brought to the next meeting.	7. Graham Bowers (GMB)/September 2026

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8. Advice from Stoneking regarding classification of funds to be shared ahead of September Committee.	8. GMB/September 2026
9. A more detailed report to be produced including donor intention assurance and brought to September Committee.	9. GMB/September 2026
10. An Investment Tender Review Panel to be established	10. GMB/May 2026

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Agenda item A2(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 2026					
Title	Board Visibility Programme					
Report of	Rachel Carter, Director of Quality & Safety					
Prepared by	Fiona Gladstone, Clinical Effectiveness Advisor Victoria Smith, Head of Quality Assurance and Clinical Effectiveness					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☒	☐			
Summary	The objective of the Board Visibility Programme is to provide a structure that enables identification of areas where care delivery may require improvement, support and expertise to address 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 ten walkabouts by Non-Executive Directors (n=5) and Executive Directors (n=5) undertaken throughout March and April 2026. **Alert** There are no current alerts to Trust Board from the March – April 2026 walkabouts **Advise** - Staff described some pockets of incivility, alongside individual feedback suggesting the potential influence of skin colour on career progression. - Adequate Storage remains a consistent issue across areas visited, alongside capacity and demand issues and other staffing pressures. **Assure** - Providing high quality patient care was a priority for staff across all areas. - Staff generally felt well supported in their roles. - There was evidence of a learning and improving culture with examples of incident reporting, shared learning and engagement in quality improvement projects.					
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. It is also asked to consider an alternative reporting format which can be found in Appendix 1.					
Links to Strategic Objectives	Joining up care – working together to give people better, quicker across to effective care.					
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 March 2026.

BOARD VISIBILITY PROGRAMME

1. INTRODUCTION

This report provides an overview of the findings from the ten walkabouts by Executive Directors (n=5) and Non-Executive Directors (NEDs) (n=5) undertaken during March and April 2026.

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).

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 each visit, members of the walkabout team are asked to provide a qualitative summary highlighting the key themes identified through their conversations with staff. The reporting template also enables the inclusion of brief details of any issues addressed during the visit, along with any actions required. The information is subsequently collated by the Quality and Effectiveness Team and is presented within this report.

In response to feedback from the previous Trust Board meeting, the Quality and Effectiveness Team have reviewed the current reporting template in comparison with that used by Northumbria Healthcare. Two illustrative examples have been developed (Appendix 1) for the Board's consideration to determine whether it would prefer future reporting in this format, or whether the existing report, supplemented by the Reading Room document, should be retained.

In addition, feedback was shared on bringing the report 'more to life', to be more engaging and less detailed in a list format. The revised focus will be on drawing out key themes and

insights to better bring visits to life. To complement this, from July we will also invite one or two Board members to share a brief reflection on their visits at the meeting, providing additional context and lived experience alongside their written reports.

3. SUMMARY OF FINDINGS

The table below summarises the ten walkabouts undertaken throughout March and April 2026. Five walkabouts were carried out by Executive Directors. Six walkabouts were cancelled during this timeframe. Five walkabouts were carried out by NEDs. 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	Ward 39	Royal Victoria Infirmary (RVI)	Joint Medical Director	Nursing staff, Administration staff
	Fracture Clinic	RVI	Integrated Governance Manager, Director Great North Healthcare Alliance Strategy	Receptionist, Outpatient Supervisor, Support Worker (Bank), Orthopaedic Practitioner, Consultant, Staff Nurses, Junior Sister
	Ward 21 (Cardiothoracic Critical Care Unit)	Freeman Hospital (FH)	Director of Estates, Facilities and Strategic Partnerships, and Patient Safety Manager	Matron, Senior Sister, Junior Sister, Staff Nurse, Physiotherapist
	Ward 9	FH	Director of Quality and Safety, Clinical Effectiveness Advisor	Resident Doctor, Dietician, Staff Nurse, Health Care Assistant, Domestic
	Ward 20	FH	Executive Director of Nursing, Midwifery and Allied Health Professionals, Deputy Director Quality and Safety	Sister, Staff Nurse, Occupational Therapist, Physiotherapist, Housekeeper, Student Nurse, Matron
Stream Two	Diabetes Centre	FH	Non-Executive Director	Acting Head of Department, Clinical Director of Medicine, Operational Service Manager
	Wards 22, 23 & Fracture Clinic Outpatients	RVI	Non-Executive Director	Matron, Nursing Teams, Team Assistant, Medical Staff, Operational

Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
				Service Manager, Plaster Technician
	Podiatry	FH	Non-Executive Director	Head of Service, Podiatry Manager
	Ward 23 and Paediatric Intensive Care Unit (PICU)	FH	Non-Executive Director	Head of Nursing, Matron, Deputy Matron, Band 7, 6 & 5 Nurses
	Endoscopy	FH	Non-Executive Director	Matron, Operational Service Manager, Senior Sister

Key themes identified include:

- Patient care was always a priority for staff.
- There was a strong team working ethos and most staff felt supported and enjoyed their work.
- There was evidence of a learning and improving culture with examples of incident reporting, shared learning and engagement in quality improvement projects.
- All areas visited were clean and welcoming. However, storage limitations are impacting on safety and workflow.
- Staffing shortages are impacting on workload and morale, with a reliance on discretionary effort in some areas.
- There are challenges with staff movement across wards, reducing continuity.
- There are capacity and demand pressures in several areas with increasing complexity of workload and evidence of some delays impacting patient flow and discharge (Integrated Care Board (ICB) funding and transport).
- Information Technology (IT) systems are limiting productivity in some areas with duplication.
- Some examples of incivility and poor behaviour were shared, although staff generally felt comfortable to challenge these. The value of staff networks i.e. Race Equality Network was shared by a member of staff who felt career progression had been impacted by skin colour.

Issues addressed during the visits:

- Estates issues on ward 21 were escalated immediately. This was in the process of being dealt with by the Matron who was in regular contact with Estates colleagues.

Further action required:

- Estates work required on Ward 22 in relation to additional power points to undertake administrative work. Damage to the walls in nursing bays was noted. This requires review and painting.
- Repatriation difficulties on Ward 23, specifically linked to ICB funding for transport.
- A review of the cleaning schedule and storage of equipment required in the Gymnasium room on Ward 23.
- Review of Central Sterile Services Department (CSSD) turnaround of equipment to Fracture Clinic

- Funding for treatments in Diabetes Centre and staffing levels in Podiatry.
- Bereavement support for parents to be reviewed on ward 23 and PICU.
- Review Harm Free Care dashboard ward 23.

4. 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. It is also asked to consider the alternative reporting format presented within Appendix 1 and decide if this should be used going forwards as an alternative to the current report and reading room supplement.

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.
7 May 2026

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Appendix 1. Suggested change to reporting template

Board Visibility Programme

Walkabout Stream: Non-Executive Director

Members of the Walkabout Team: Bill MacLeod. Accompanied by Judith McKenna / Nikki Coates (Head of Service) and Philip Dalby (Podiatrist)

Site/ Ward/ Department: Podiatry, Freeman Hospital

Date: 19 March 2026

First Impressions	I had previously visited Podiatry when it was on the Campus for Ageing and Vitality (CAV) so it was great to see its new home at the Freeman. The department has been recently refurbished and is immaculate providing a much better experience for staff and patients.
Observations i.e. Environment/ Staffing/ Patients	Closer links with vascular are beneficial. The consultant I met at CAV has retired, a new doctor is due to join shortly and will hopefully become a consultant. Many underlying challenges with the service remain. Demand continues to grow and there are staffing challenges. All patients are diabetic, this can create an inequality for non-diabetic patients with foot problems as they are not prioritised. *[Note from management - we are aware Patients accessing the service are diabetic, this causes anxiety within the team that they are creating an inequality for non-diabetic patients with foot problems as they are not prioritised. This is being considered by the Clinical Board and has been escalated via the Quality and Performance Review to the Executive Team]* Preventative work is central to reducing hospital admissions and serious complications such as amputations; however, pulling staff from community teams to support clinics weakens early intervention capacity. Community work also presents lone worker safety concerns. A significant number of patients are from out of region, especially Northumberland, and the nature of the service means these patients may well have a weekly visit for the rest of their lives. Staff morale is a factor often relating to workload. We did meet one podiatrist who discussed the workload challenges faced but who was upbeat and positive about their role. They raised challenges with System One where patients have restricted access to other services they receive. I don't understand why we would allow this within NuTH (the Newcastle Upon Tyne Hospitals NHS Foundation Trust) although I understand if different organisations are involved? *[Note from management - Rachel Carter to discuss further with Bill MacLeod to clarify the issue raised. We are aware of the challenges for staff in having to use multiple systems and this is being considered through the digital modernisation plan for the Trust]*

Summary	Much improved environment however further action is required to address cross-boundary demand, review staffing levels, and resolve information-sharing limitations within clinical systems.
Potential Actions Identified	Work to do for out of area patients, especially Northumberland is placing strain on the service. Lucia Pareja-Cebrian has a meeting with Northumbria Healthcare to discuss. In addition, funded staffing levels remain below requirements. Query why can patients restrict access to information on other services within NuTH as it causes prescribing challenges.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Board Visibility Programme

Walkabout Stream: Executive Director

Members of the Walkabout Team: Rachel Carter, Director of Quality and Safety & Fiona Gladstone, Clinical Effectiveness Advisor

Site/ Ward/ Department: Ward 9, Freeman Hospital

Date: 17 March 2026

First Impressions	The ward was quiet and welcoming upon arrival, with many staff preparing to join the Multi-disciplinary Team (MDT) meeting.
Observations i.e. Environment/ Staffing/ Patients	The ward was described as welcoming, supportive, and team-oriented, with good communication and visible, approachable leadership. Staff across roles (Foundation Year 1 doctors, nurses, Healthcare Assistants (HCAs), domestic, dietician, and student nurse) generally felt well supported and valued teamwork and learning culture. Newer staff reported positive experiences integrating into the team, while long-standing staff expressed strong job satisfaction and connection with patients and colleagues. MDT involvement and collaborative working (including physio and dietetics) were highlighted as strengths, alongside a focus on patient safety, incident reporting, and shared learning. There is a display Board, showcasing thank you letters and cards from patients. Key challenges included staffing pressures, being asked to cover other wards, and difficulty providing consistent patient care when stretched, which has contributed to incidents (e.g., falls). Practical issues included limited space for equipment storage and a desire for better bed/bay layout to facilitate an increase in this. Some individual concerns included workload balance, expectation to cover other wards and managing cross-site responsibilities.
Summary	Overall, morale is good, with a strong team culture, but operational pressures and resource constraints remain ongoing concerns.
Potential Actions Identified	There were no issues that required immediate action during the visit. Ongoing improvement work within the ward should focus on minimising staff redeployment across wards to maintain continuity of care, identification of safe, accessible storage of equipment and management of cross-site cover for Allied Health Professionals

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Agenda item A2(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 2026		
Title	Integrated Board Report		
Report of	Patrick Garner, Director of Performance & Governance Rachel Carter, Director of Quality & Safety		
Prepared by	Steven Fraser, Performance Manager		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	This paper is to provide assurance to the committee on the Trust's performance against key indicators relating to Quality & Safety, Access, People and Finance. **Quality** • Methicillin-susceptible staphylococcus aureus (MSSA) reduced (9 v 11) but remains within the parameters of common cause variation. • *Clostridioides difficile* Infection (CDI) cases increased (16 v 10) but remains within the parameters of common cause variation. • Acute (Category 2 & above) pressure ulcers (PU) reported in March increased (47 v 49). • In March there was a decrease in falls (234 v 204). • There were four stillbirths in March 2026. • The National benchmark for term admissions is 5%. The Trust rate remains consistently above the national 5% target with 6% term admission rate in March. Further analysis is in progress of infants born within 37th week of pregnancy as this group represent 40% of admissions. **Performance** • Emergency Department (ED) Performance (All Types) in March was 79.82%, an increase of 4.27% compared to February (75.55%). ED attendances increased in March to 24,132, 2892 patients more than February. • March 2026 witnessed another significant reduction in >52-week waiters at Newcastle Hospitals, dropping to 579 (-198). This meant 0.7% of the total Referral to Treatment (RTT) waiting list was over 52 weeks – comfortably below the national target of 1%. • The trust's RTT 18-week compliance increased to 72.5% in March (+1.5% from February). • In February, the 80% 28 Faster Diagnosis Standard (FDS) target was achieved - performance was at 85.6%. 31-day performance rose to 86.8% in February, whilst 62-day performance rose only slightly to 68.5% in February. • Performance against the 5% standard improved in March – 14.4% 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.		

<table>
<tr><td></td><td colspan="6">People
Top reasons for sickness: anxiety/stress/depression 31.98% (+0.97%); other musculoskeletal problems 10.75% (+1.03%); gastrointestinal problems 10.03% (+0.32%).
Short-term sickness change in March 2.00% (-0.07%). Long-term sickness change in March 3.84% (-0.30%). Average working days lost is 1,028 (headcount) per day for the reporting period. Trust wide initiative to look at ‘why does absence matter’ which is tasked with reducing sickness by 0.5% - lead by Director of Operations for Medicine.
Mandatory training compliance levels have reduced by 0.17%, lowest is Medical and Dental 79.17%. A task & finish group being commissioned to look at ‘process and provision’.
Overdue appraisals increased to 2,074. Senior doctors (consultant and SAS) have had set 1.5 SPA (6 hours a week) in their job plans since job planning began which was designed to cover things including Mandatory Training, and appraisal preparation.
Finance
The Trust planned to deliver £106m of savings (£76m recurrent and £30m non recurrent). While it has met the £106m target, this has been delivered as £40m of savings recurrently in year with £14m of non-recurrent in Clinical Boards and Corporate Services, £2m additional technical than planned and one-off additional subsidiary support funding of £17m. The Trust has significantly under delivered on recurrent Cost Improvement Programme (CIP) in year.
The Trust saw unplanned pressures estimated at £22m, this includes £6m due to job planning, £7.1m on drugs, a pay award pressure of £3.2m, £0.7m pressures due to industrial action (net of funding from NHS England) and other pressures totalling £5m.</td></tr>
<tr><td>Recommendation</td><td colspan="6">For assurance.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Joining up care – working together to give people better, quicker across to effective care.
Advancing Care – Improving patient care, effectiveness and quality through innovation, research, improvement and education.
Supporting great care – supporting everyone to do their job to the best of their ability with effective leadership, a just and learning culture and modern digital and physical environments.</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(b)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

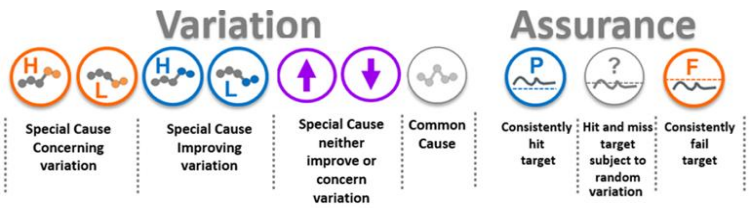
May 2026

Healthcare at its best
with people at our heart

Contents

SPC Variation / Assurance – Changes from previous month

	Feb-26	Mar-26
Turnover		H
Caesarean Section Deliveries	↑	
ED Performance - All Types (%)	L	
ED Arrival to Admission / Discharge >12 hours (Type 1)	H	
Trust BSOTS Medical Review Yellow - Within 1 Hour		H
LMNS BSOTS Medical Review Green - Within 4 Hours		H



Statistical Process Control (SPC) Variation

- **Six** high level metrics have displayed changes in special cause variation from February 2026 to March 2026.
- Special cause variation of a deteriorating nature (high) to common cause variation:
  - Emergency Department (ED) Arrival to Admission / Discharge >12 hours (Type 1)
- Special cause variation of a deteriorating nature (low) to common cause variation:
  - ED Performance – All Types (%)
- Common cause variation to special cause variation of a deteriorating nature (high):
  - Turnover
- Common cause variation to special cause variation of an improving nature (high):
  - Trust Birmingham Symptom Specific Obstetric Triage System (BSOTS) Medical Review Yellow – Within 1 hour
  - Local Maternity and Neonatal System (LMNS) BSOTS Medical Review Green – Within 4 hours
- Special cause neither improve or concern variation to common cause variation:
  - Caesarean Section Deliveries

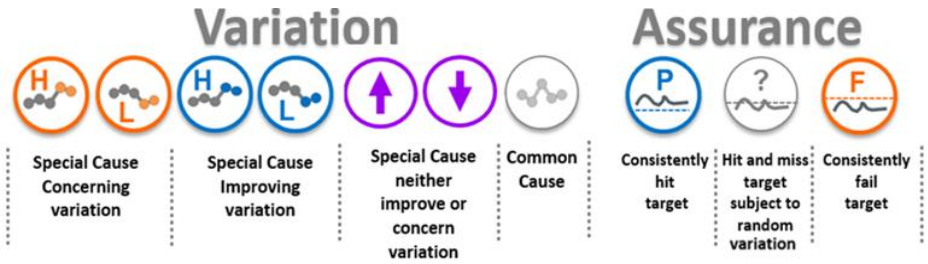
SPC Assurance

- **No** high-level metrics have displayed changes in special cause assurance from February 2026 to March 2026.

Quality

Quality Overview

Metric	Period	Actual	Target	Variation	Assurance
HCAI - MSSA	Mar-26	9	10		
HCAI – C. Diff	Mar-26	16	12		
Harm Free Care – IP Acquired Pressure Ulcers	Mar-26	49	Sustained reduction		
Harm Free Care – Adult Patient Falls	Mar-26	204			
Stillbirths	Mar-26	4			
Blood Loss ≥1500ml (per 1,000)	Mar-26	44 per 1000			
ATAIN	Mar-26	6%	5%		



Health Care Acquired Infections

- Methicillin-susceptible staphylococcus aureus (MSSA) reduced (9 v 11) but remains within the parameters of common cause variation.
- *Clostridioides difficile* Infection (CDI) cases increased (16 v 10) but remains within the parameters of common cause variation.

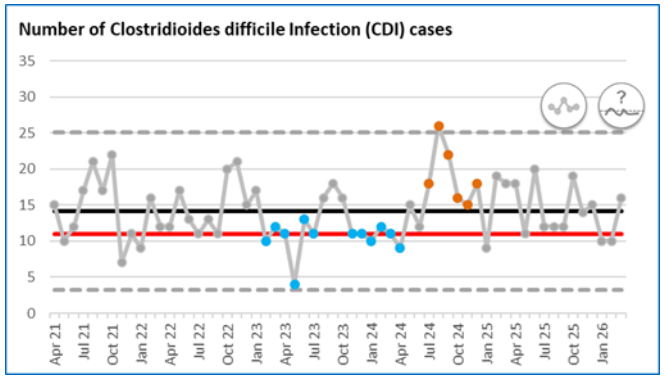
Harm Free Care

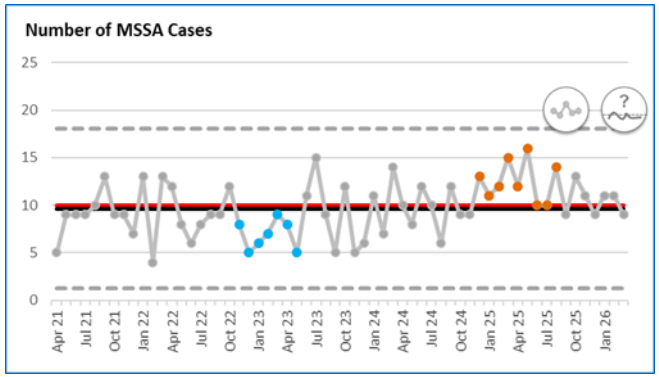
- Acute (Category 2 & above) pressure ulcers (PU) reported in March increased (47 v 49).
- In March there was a decrease in falls (234 v 204).

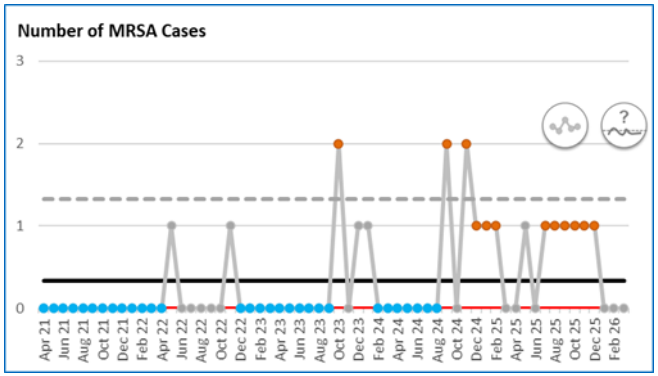
Perinatal Quality Surveillance

- There were four stillbirths in March 2026.
- The National benchmark for term admissions is 5%. The Trust rate remains consistently above the national 5% target with 6% term admission rate in March. 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 MRSA** cases.
- **No more than 115 MSSA** cases across the fiscal 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 fiscal year.

Current Position

- ***Clostridioides difficile* (CDI):** CDI cases increased (16 vs 10) but remained within common cause variation. Of these, three were COHA and 13 were HOHA. Learning continues to focus on delays in testing, initiation of treatment, patient isolation, and completion of stool charts.

- **Methicillin-Sensitive Staphylococcus aureus (MSSA)**:MSSA cases reduced (9 vs 11) and remained within expected variation. There were no COHA cases; all nine were HOHA. Reviews have identified learning opportunities relating to documentation and intravascular device management.

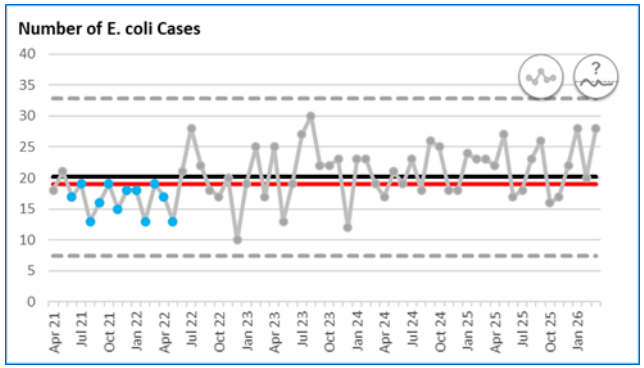
- **Methicillin-Resistant Staphylococcus aureus (MRSA)**:No MRSA cases were reported this month. The year-to-date total remains within common cause variation.

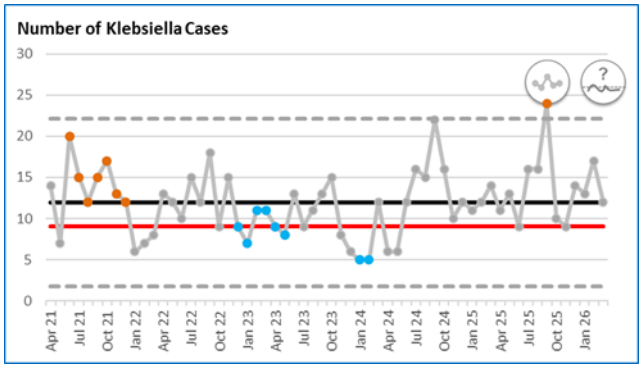
- ***E. coli* bacteraemia:** Cases increased (28 vs 20) but remained within common cause variation. Five cases were COHA and 23 were HOHA. Reviews are under way, with early learning related to documentation and intravascular device management.

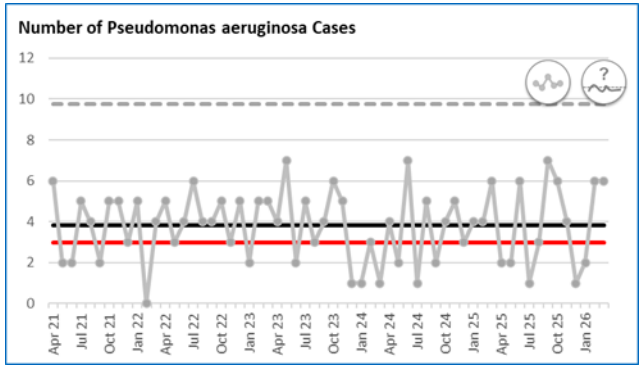
- **Klebsiella bacteraemia:** Klebsiella cases decreased (12 vs 17) and remained within expected variation. Five cases were COHA and seven were HOHA. Ongoing reviews have identified learning around intravascular device documentation.

- **Pseudomonas aeruginosa bacteraemia**: Case numbers were unchanged (six cases). All were reviewed, with one HOHA case requiring further investigation, which remains ongoing.

Healthcare Associated Infections (HCAIs) (2/2)







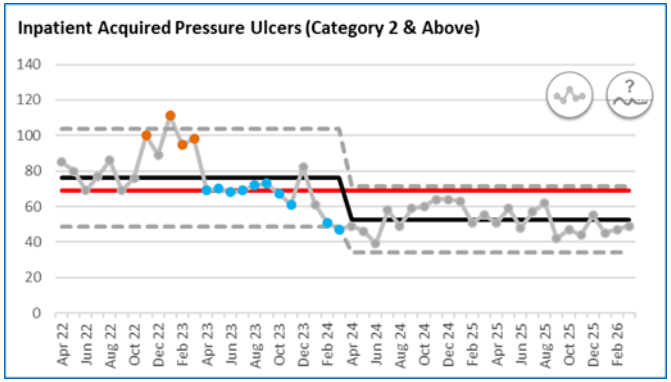
Themes and Actions

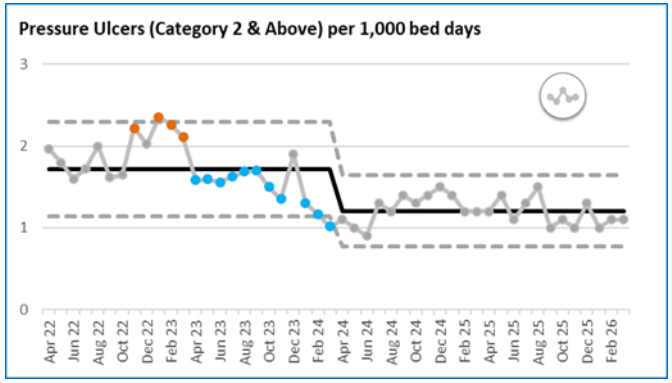
- **Clinical Board Engagement:** Arrangements for enhanced Clinical Board engagement with IPC governance have been finalised. From May 2026, Clinical Boards will attend the Infection Prevention and Control Committee (IPCC) on a rolling basis to present performance, incidents, learning, and actions. This will strengthen Clinical Board-level ownership and support greater system-wide visibility and accountability.
- **Audit, Education and Assurance:** Trust-wide implementation of the IPCN audit and education framework is complete. Early audit intelligence is now being actively used to drive targeted education, in-area support, and real-time coaching. Clinical Boards have access to local audit intelligence via SharePoint, supporting timely oversight and action.
- **Development of standardised Trust-wide audit reporting infrastructure:** progressing, with consolidated reporting functionality planned for May 2026 and Power BI development scheduled to further enhance assurance and performance oversight. Targeted IPC improvement activity will continue into Quarter 1 of 2026/27.

Key Workstreams

- **Invasive Device:** Visibility of Aseptic Non-Touch Technique (ANTT) compliance has been established Trust-wide. The IV Device Task & Finish Group, led by the Director of Infection Prevention and Control (DIPC), is progressing improvements in IV device surveillance and embedding learning from Senior Nurse harm-free care walkarounds. Recommendations are due in May 2026,**.** with implementation to follow in Quarter 1 of 2026/27
- **Vascular Access (NCCC):** Weekly ward-based Vascular Access Team walk rounds within NCCC remain embedded, providing direct clinical support and targeted CVC education, supporting consistency in IV device management and mitigation of device-related infection risk
- **B. Braun Partnership:** Collaborative work with B. Braun continues to support IV therapy improvement through surveillance activity and competency-based training, strengthening assurance around standardised invasive device care
- **Clostridioides difficile & Bloodstream Infection Investigations:** The revised Clostridioides difficile investigation workflow is live within InPhase. Early operational review activity is underway, with formal evaluation scheduled for June 2026 and a full review planned for September 2026.Work is progressing to extend this standardised investigation model to bloodstream infections. Capacity review is underway to confirm delivery timelines, with adoption required across clinical services once available.

Harm Free Care: Pressure Damage





Standard

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

Current Position

- The number of acute pressure ulcers (Category II and above) increased slightly from 47 cases in February to 49 cases in March. The rate per 1,000 bed days remained static at 1.1. Despite this month-on-month increase, SPC charts continue to demonstrate a sustained reduction overall, with no evidence of special cause variation.
- 1 Community acquired category III pressure ulcer was reported in March, this is currently under investigation.
- **Severity Breakdown -** No Category IV pressure ulcers were reported. Six Category III pressure ulcer was reported. All reported cases are currently under investigation to identify contributory factors and to capture learning.

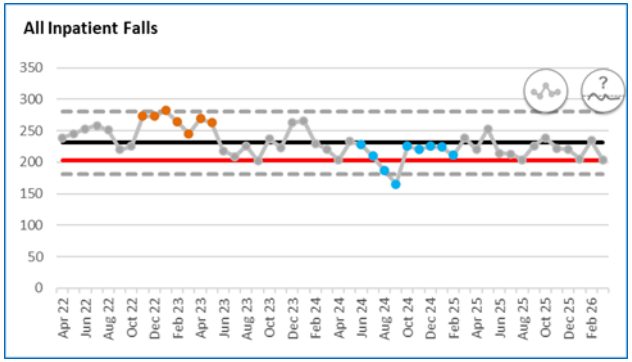
Key Areas for Improvement

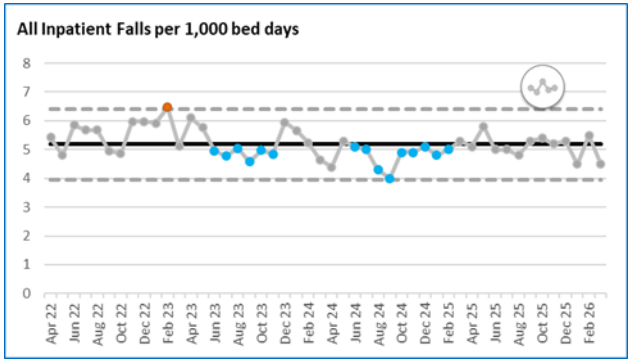
- Timely capture of clinical images to support pressure ulcer documentation. New devices to capture medical photographs are currently being trialled by podiatry, tissue viability and some specialist services. On completion of the trial devices will be rolled out across the clinical areas.
- Improved completion of skin integrity and pressure ulcer risk assessments.
- Enhanced quality and consistency of pressure ulcer descriptions within nursing documentation.

Actions Taken

- The Tissue Viability Team has worked with the ACE Team to review and update accreditation standards.
- Work is underway to review pressure ulcer investigations under the Patient Safety Incident Response Framework (PSIRF). This aims to support wards and departments to identify learning and actions and to ensure improvement activity is progressed by clinical teams.
- Acute and community Tissue Viability Teams are working collaboratively to develop Trust-wide guidance to support staff in selecting appropriate pressure-relieving equipment.

Harm Free Care: Falls





Standard

In light of the sustained reduction in inpatient falls over the past two years, specific numerical reduction targets have not been set. Instead, continued improvement will be monitored through Statistical Process Control (SPC), with the expectation of demonstrating a sustained reduction over time.

Current Position

- The number of inpatient falls decreased from 234 in February to 204 in March. The falls rate per 1,000 bed days also decreased from 5.5 to 4.5.
- SPC charts continue to indicate a sustained overall reduction, with no evidence of special cause variation.
- Harm Levels - three inpatient falls resulting in harm were reported:
    - Three incidents of moderate harm
    - No incidents of severe harm.

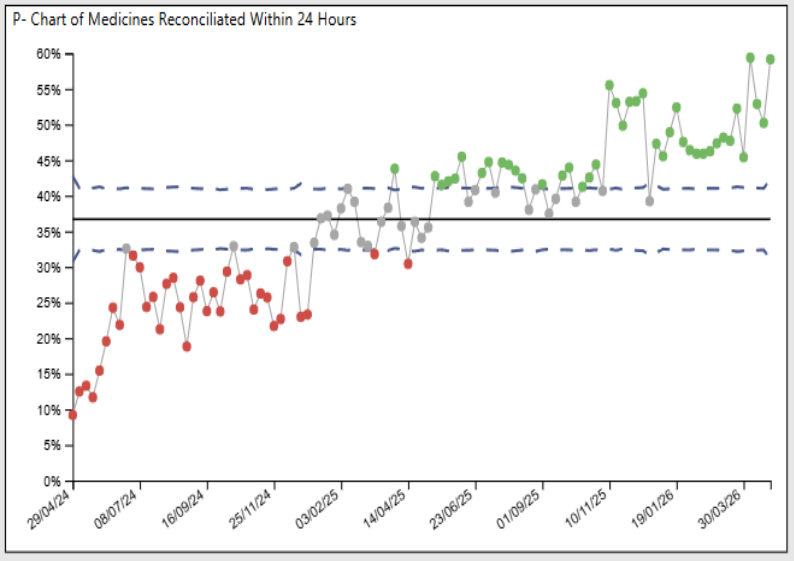
Key Areas for Improvement

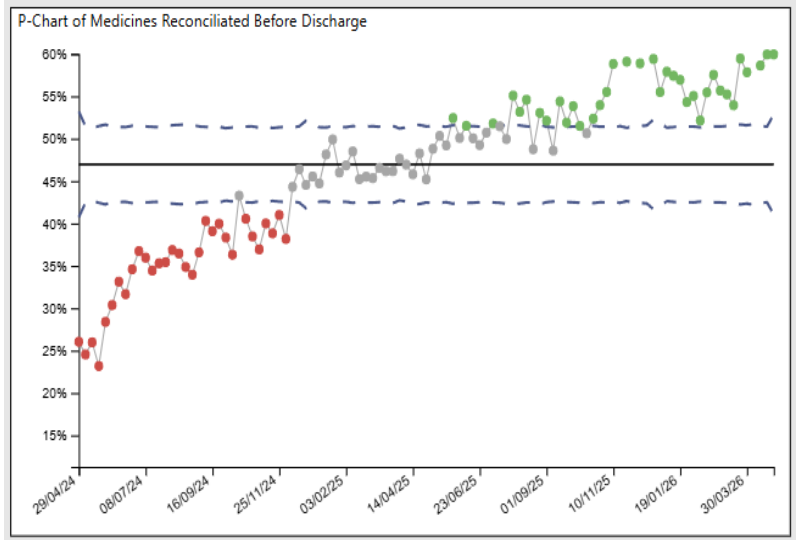
- Remain the same with improved completion of multifactorial falls assessments to optimise safe activity, including:
    - Lying and standing blood pressure measurements
    - 4AT delirium screening
    - Vision checks
    - Medication reviews related to falls risk

Actions Taken

- The Falls Prevention Coordinator is working with the Service Improvement team to develop a falls prevention workbook for clinical staff.
- Work is underway to provide Lying and Standing Blood pressure information; a leaflet and card will be available to wards and departments.
- Updated guidance is now available on the intranet on how to access and order low level beds.

Medicines Reconciliation





Standards

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

Current Position

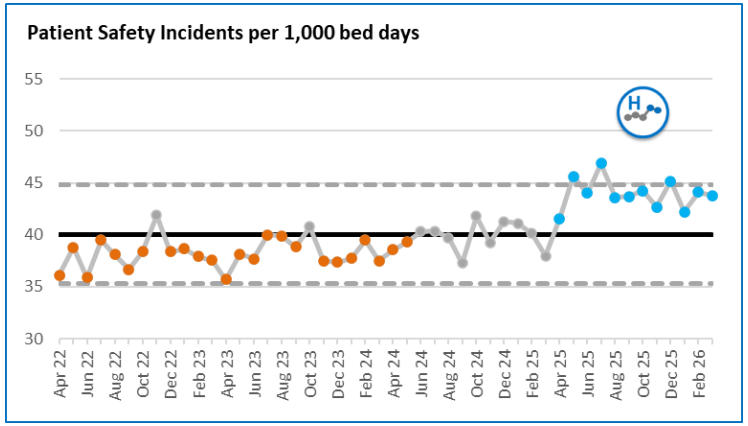
- Consistently between 46% and 52% since November 2025.

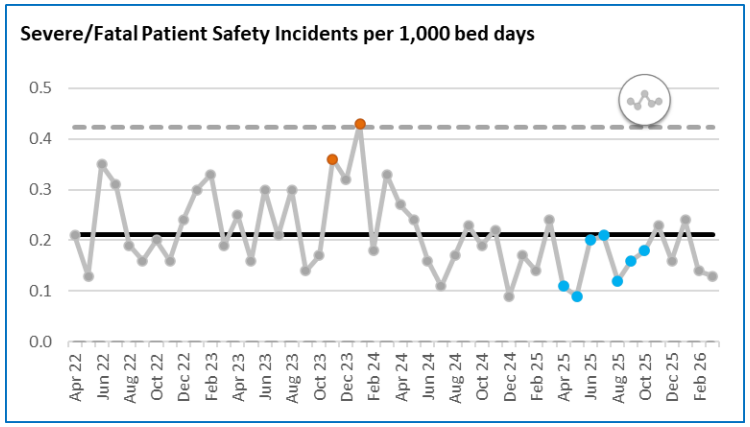
	Med rec within 24 hours Total Number & %		Total Med Rec before discharge Total Number & %	
Mar 2025	1692	**34%**	2261	48%
April 2025	1811	**37%**	2305	50%
May 2025	1809	**38%**	2335	52%
June 2025	1974	**42%**	2393	54%
July 2025	2099	**43%**	2488	52%
Aug 2025	1882	**40%**	2446	52%
Sept 2025	2006	**40%**	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%
Feb 2026	2093	**46%**	2499	55%
Mar 2026	2301	**49%**	2698	57%
Apr 2026	2375	**52%**	2672	59%

Narrative April 2026

- RVI Peri-Op completing induction and rolling out new service at RVI.
- Working with technicians group to move around resource to maximise impact across Trust.

Incident Reporting





Standards

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

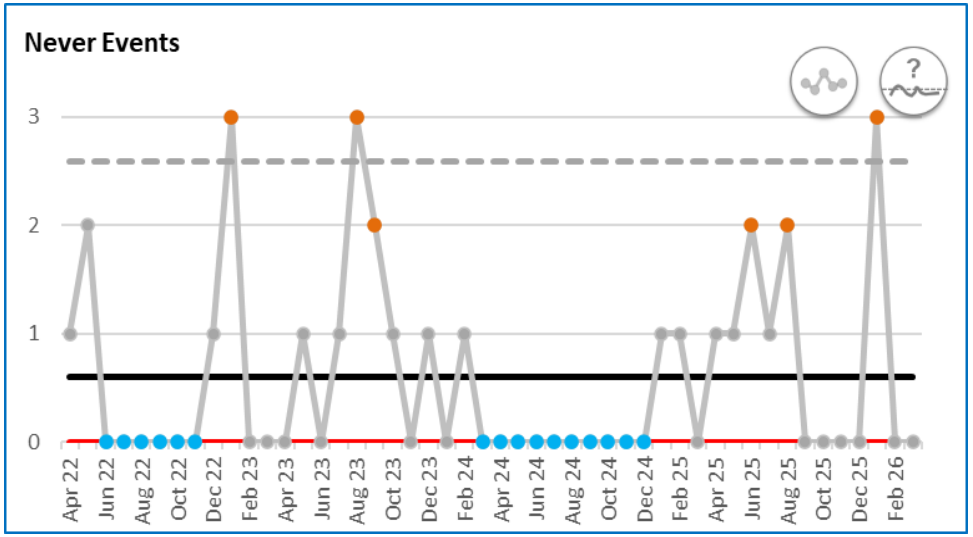
Current Position

- The total number of patient safety incidents per 1,000 bed days reported in March 2026 decreased compared to February 2026.
- The number of severe/fatal safety incidents per 1,000 bed days decreased in March 2026, compared with February 2026.
- Eight After Action Reviews were recorded in March 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



Incident Date	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
June 25	6311	Surgery & Specialist Services	Orthopaedics	Wrong site surgery
July 25	8426	Surgery & Specialist Services	Orthopaedics	Wrong implant / prothesis
August 25	9458	Perio-Operative & Critical Care	Theatres	Wrong implant / prothesis
August 25	10030	Cardiothoracic	Cardio Surgery	Wrong implant / prothesis
January 26	25587	CDS	Nuclear Medicine	Wrong site surgery
January 26	26140	Cardiothoracic	Cardio Theatres	Retained object
January 26	29025	Surgery & Specialist Services	Ophthalmology	Wrong lens

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.

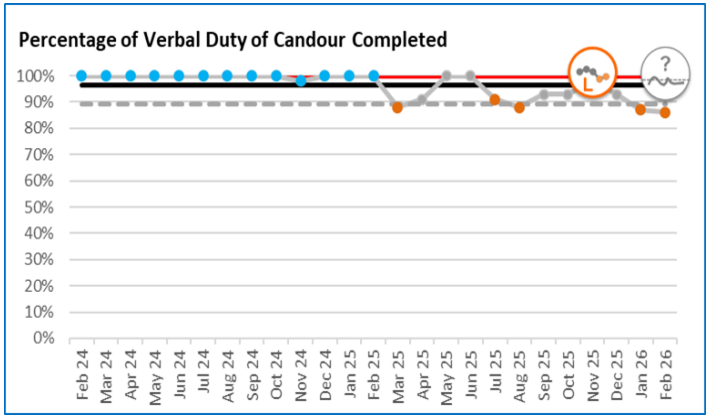
Current Position

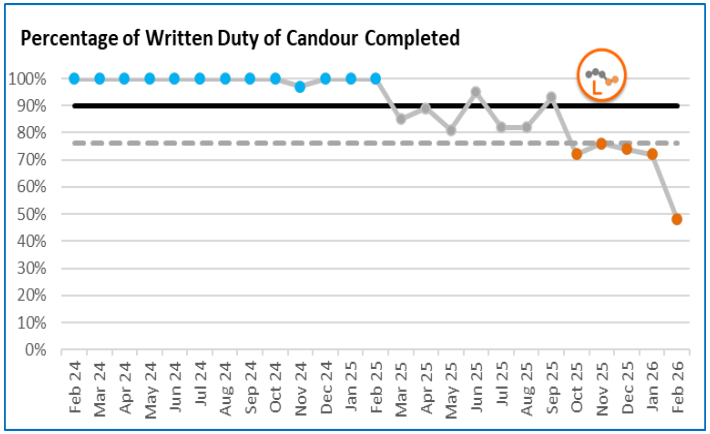
- Reporting of Never Events has been updated, these are now reported by the date the incident occurred. The data has been updated to reflect this change.
- A total of 10 incidents met the Never Events criteria for the 25/26 period.

Action taken

- Trust Patient Safety Incident Response Framework (PSRIF) priority is being introduced to successfully implement National Safety Standards for Invasive Procedures (NatSSIPS2) into the organisation, led by a Project Board with dedicated resources to drive improvement.
- NatSSIPs 2, or the National Safety Standards for Invasive Procedures 2, is a set of guidelines designed to improve patient safety during invasive procedures and to reduce the occurrence of Never Events.
- Project work has commenced with staff engagement sessions (surveys and in-person conversations) to review and amend current checklists to ensure they are relevant and proportionate and allow the project board to identify barriers to compliance with checklist completion. In addition, a sub-group of the project team is looking at improving implant safety using a similar staff engagement methodology and a further subgroup has begun to review and analyse Local Safety Standards for Invasive Procedures (LocSSIPs) that are currently used throughout the Trust
- A newly established Invasive Procedures Group has been introduced to strengthen the governance of invasive procedures and support the PSIRF priority.

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.

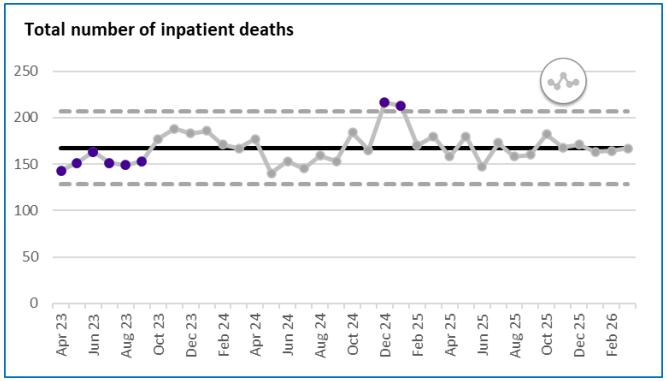
Current Position

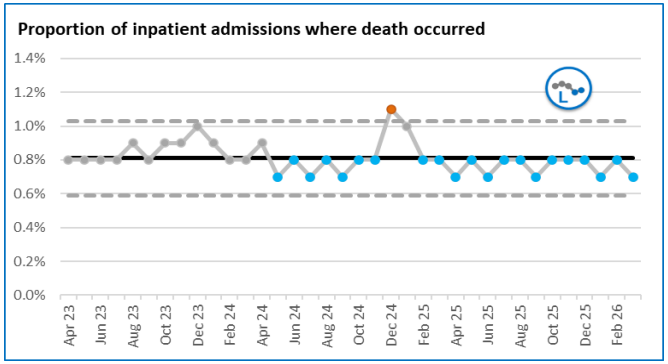
- Data for overall Trust compliance is taken from records of completion in the incident module of InPhase / Datix. Additional assurances for compliance with the statutory requirements of Regulation 20 are undertaken through audits reported to Patient Safety Group and Quality Committee.
- Audit data highlights 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 February.
- 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.

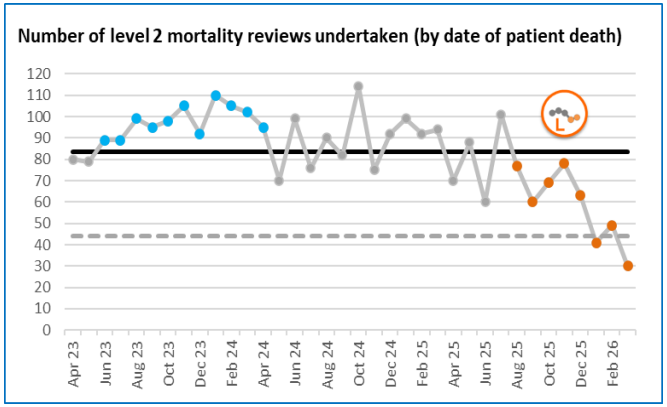
Action taken

- 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.
- Clinical Board compliance is monitored through Quality Performance Reviews.

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).

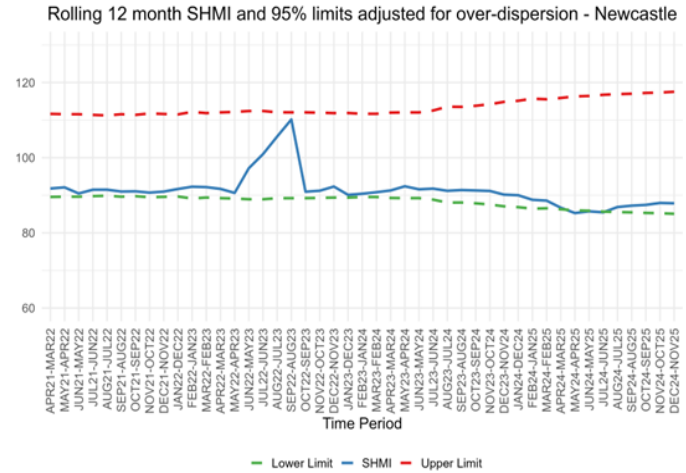
Current Position

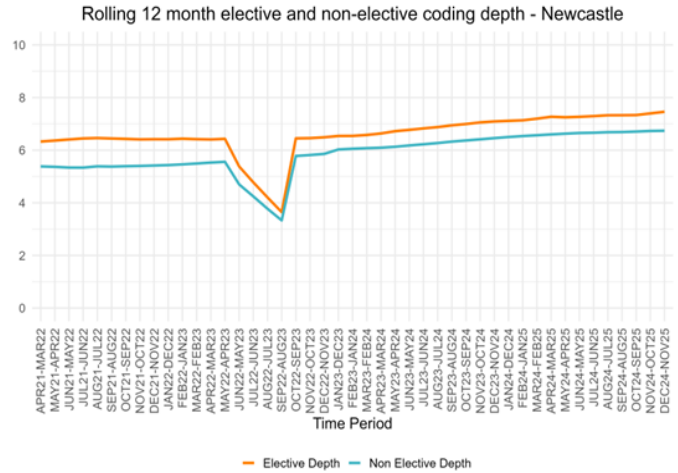
- There were 167 inpatient deaths in total reported in March 2026. This is an increase of 3 on the previous month.
- The crude mortality rate in March 2026 is 0.7%. This is a decrease of 0.1% on the previous month and is in line with the Trust average.
- Out of the 167 inpatient deaths reported, there are 30 completed level 2 mortality reviews entered into the Trust mortality review database to date.
- 63 Level 2 reviews were also completed in March 2026 for patients who died prior to this date.
- One of the completed reviews undertaken in March was scored with an NCEPOD score of 3 (*Less than satisfactory: several aspects of clinical and/or organisational care that were well below that which you would accept from yourself, your trainees and your institution*). At the time of writing, an InPhase incident report has been submitted and is awaiting rapid review by the clinical board to explore the concerns identified in the mortality review with a view to presenting the case at the Trust's Rapid Action Review Meeting (RARM) in line with existing PSIRF processes.
- Three patients with a confirmed learning disability died in March 2026.

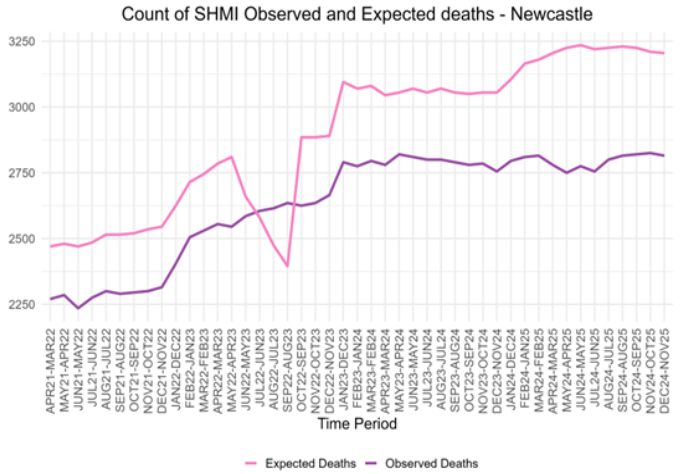
Action taken

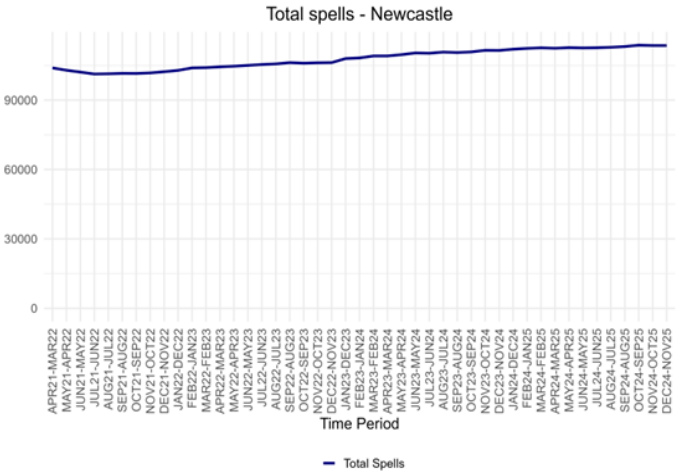
- All inpatient deaths are continually monitored.
- The number of level 2 mortality reviews will rise significantly over the coming months as Morbidity and Mortality (M&M) meetings continue to take place.
- Monthly reports to each Clinical Board detailing the position of outstanding mortality reviews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

Mortality Indicators (2/2)









SHMI (Summary Hospital-level Mortality Indicator)
Within the latest published SHMI data (Dec 2024 – Nov 2025) the Trust SHMI is at 0.88. This is within the 'as expected' category.

Observed & Expected deaths Between Dec 2024 – Nov 2025, the Trust has 2,815 observed deaths and 3,205 expected deaths.

Coding Depth
Coding depth has a substantial impact on mortality indicators. Within the latest published SHMI data the Trust has an elective coding depth of 7.5 and a non-elective coding depth of 6.7*. These are in line with expected averages.

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

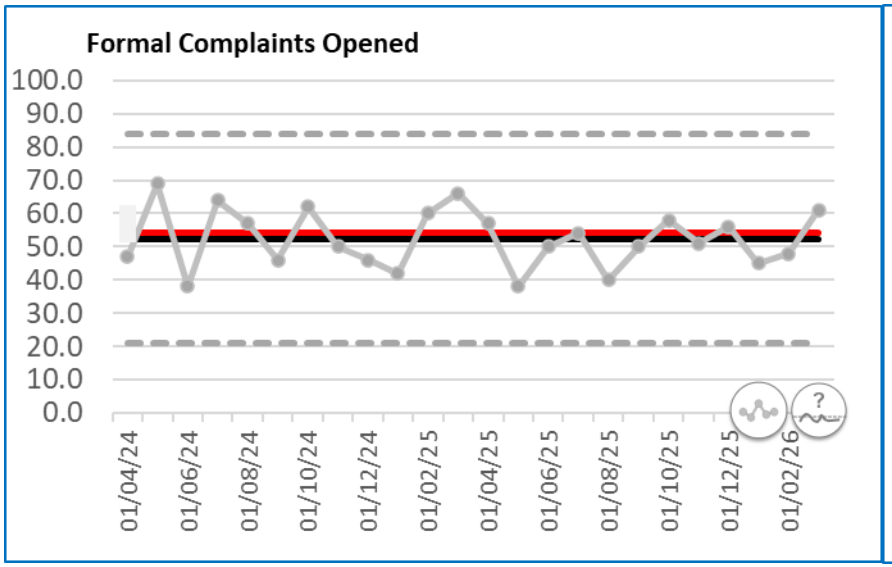
Invalid Primary Diagnosis
The Trust has a 0% rate of invalid primary diagnosis coding.

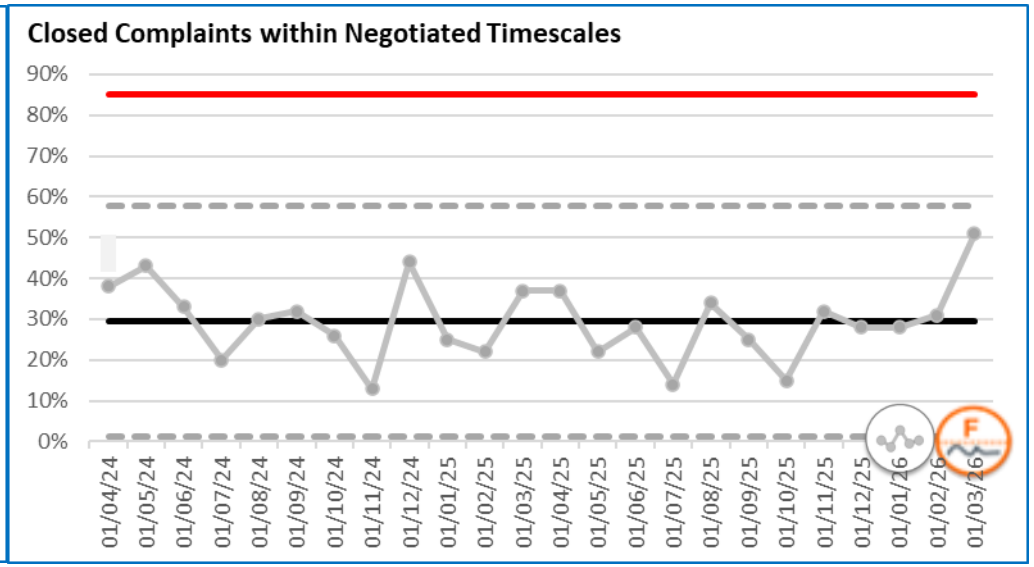
Total Spells
Between Dec 2024 – Nov 2025 the Trust recorded 113,560 spells in total

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 had 61 formal complaints In March 2026. The average number of complaints opened for the previous financial year is 54 and continues to show a fluctuation of variation above and below the target.

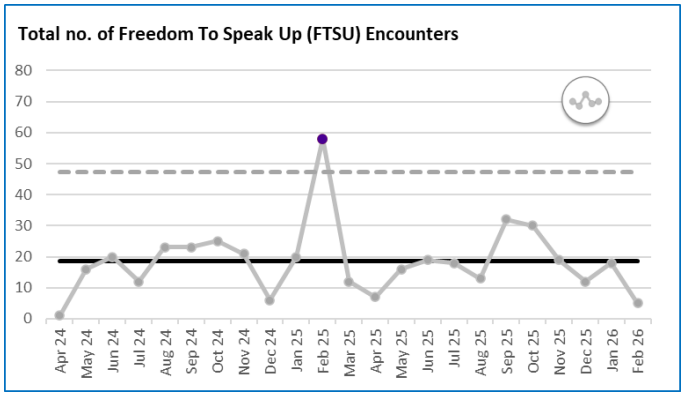
- Clinical treatment accounts for the most complaints collectively across the specialties with 30% of complaints opened this month (18). The top 3 relating to: Surgical 14 (13%); General Medicine 8 (7%); and Accident & Emergency (A&E) 6 (6%).

- The most complaints were opened for the following three Clinical Boards, collectively accounting for 63% of complaints this month:

    - Medicine & Emergency Care 15 (25%)
    - Surgery & Specialist Services 11 (18%)
    - Family Health 11 (18%)

- In March there were 74 formal complaints closed and 38 (51%) were on time, within negotiated timescales This shows a substantial improvement towards the internal Key Performance Indicator (KPI) of 85%, following the introduction of re-negotiated timescales and we will continue to monitoring this alongside further service improvements .

Freedom to Speak Up



	Q1 25/26	Q2 25/26	Q3 25/26	Jan-Feb 2026
CB Cancer and Haematology	1	1	1	0
CB Cardiothoracic Services	3	1	2	1
CB Clinical and Diagnostic Services	2	7	7	7
CB Clinical and Research Services	10	0	0	0
CB Family Health	4	3	4	1
CB Medicine and Emergency Care	0	5	6	0
CB Peri-operative and Critical Care	9	4	5	6
CB Surgery and Associated Specialities FH	0	0	0	2
CB Surgery and Specialist Services RVI	0	16	27	1
CB Surgical and Associated Services FH	0	5	0	0
CB Surgical and Specialist Services RVI	1	4	0	0
CS Business Development	0	6	3	1
CS Chief Executive	0	0	0	0
CS Chief Operating Officer	0	0	0	0
CS Estates	3	3	1	0
CS Hosted Staff	0	0	0	1
CS Human Resources	0	1	0	1
CS Information Management and Technology	1	0	3	0
CS Medical Director	0	0	0	0
CS Occupational health	0	0	0	0
CS Patient Services	0	1	1	1
CS Unknown	3	0	0	1
CS Unkown	1	0	0	0
(blank)	2	3	0	1
Grand Total	40	60	60	24

	Q1 25/26	Q2 25/26	Q3 25/26	Jan-Feb 2026
Bullying and harassment	8	8	24	6
Civility	1	0	0	0
Disadvantageous demeaning treatment as a result of speaking up	1	0	0	0
Inappropriate behaviour and attitudes	7	27	19	7
Patient safety and quality	4	2	3	4
Poor management	13	0	0	0
Worker safety and quality	6	23	14	7
(blank)	0	0	0	0
Grand Total	40	60	60	24

Standards

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

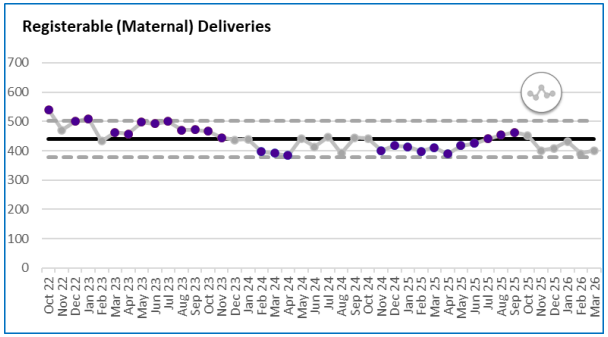
Current Position

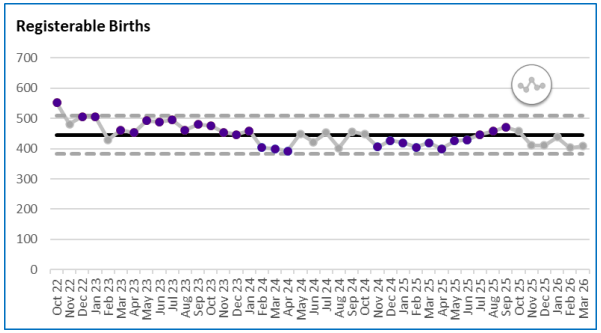
- There were a total of 23 speak up encounters made to the FTSU Guardian in March 2026. (3 times more than February, which could be related to the information shared at the CEO roadshows)
- 2 speak ups were raised anonymously, of which 1 staff member subsequently felt able to meet the Freedom To Speak Up Guardian (FTSUG) face to face
- The most frequently reported category of concern reported was worker safety and quality (19), followed by inappropriate attitudes and behaviours (11), patient safety and quality (7) and bullying and harassment (3)
- 1 case of detriment was reported which is being managed by the Board Chair and Medical Director
- 1 case of racism was raised. This was escalated to HR, and the person has since met with the Head of Workforce Advisory Service
- There are currently 31 trained FTSU Champions

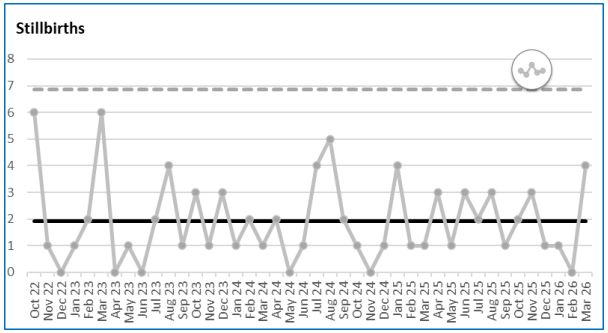
Action Taken

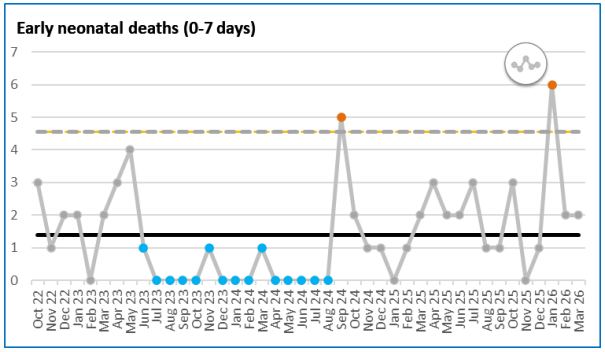
- Meetings with managers to escalate concerns and gain assurance on actions, with scheduled follow ups to ensure action completion
- Ongoing engagement work
- Ongoing champion recruitment – work has commenced to determine if the FTSU and Health and Wellbeing Champions would like to be dual trained.

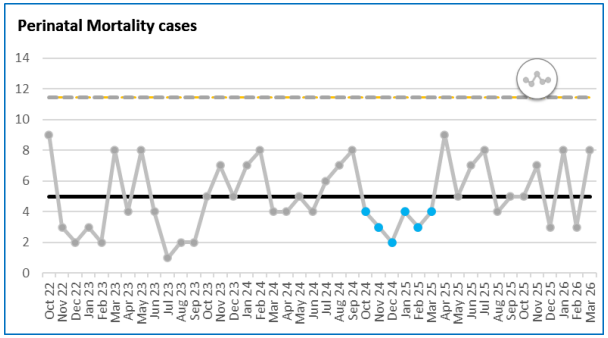
Perinatal Quality Oversight: Births











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.

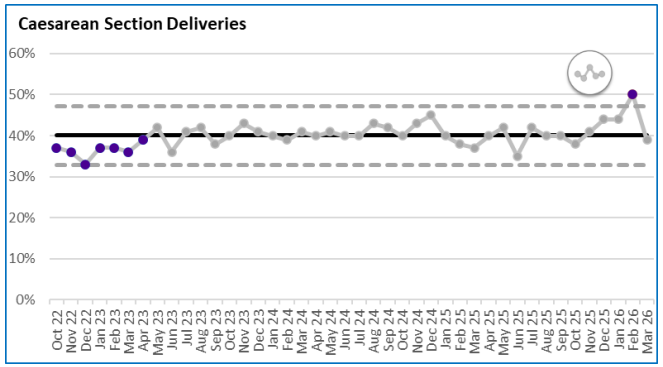
Stillbirths

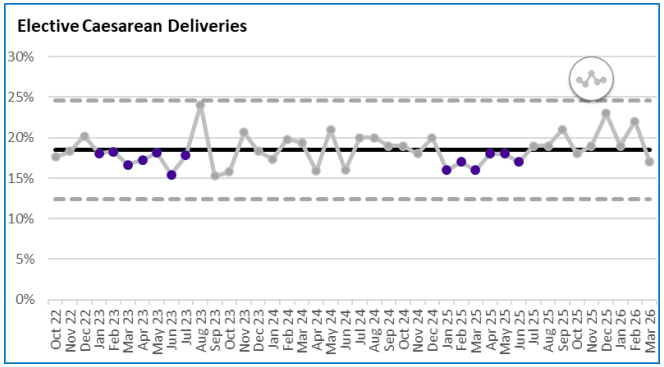
- This data includes termination for fetal anomalies >24 weeks gestation. There were four stillbirths in March 2026; all cases meet criteria for review through the Perinatal Mortality Review Tool (PMRT). The PMRT quarterly report is submitted to Trust Board in accordance with the Maternity Incentive 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, NENC 3).

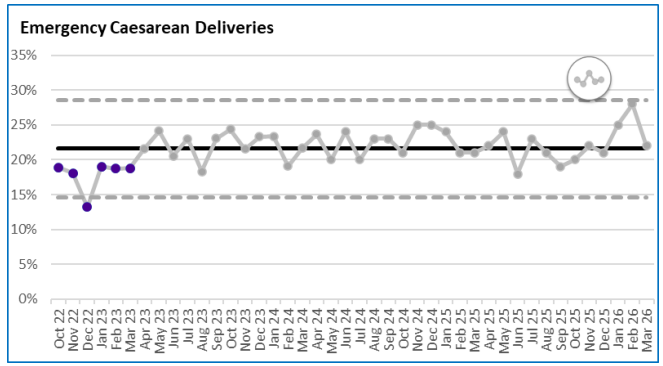
Early Neonatal Deaths

- 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 two early neonatal deaths in March 2026. Early neonatal deaths often include extremely premature infants born before 24 weeks gestation and may also include babies with complex congenital anomalies.

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 Q3 average was 41%, Q2 average was 40.3% and Q1 average was 38.1%.
- The Trust has had a decrease in the caesarean section rate from 50% in February 2026 to 39% in March 2026, a decrease is seen in both planned (elective) and emergency cases. 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.

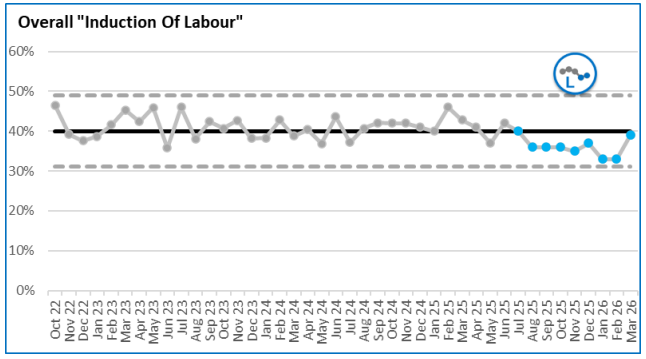
Elective Caesarean section

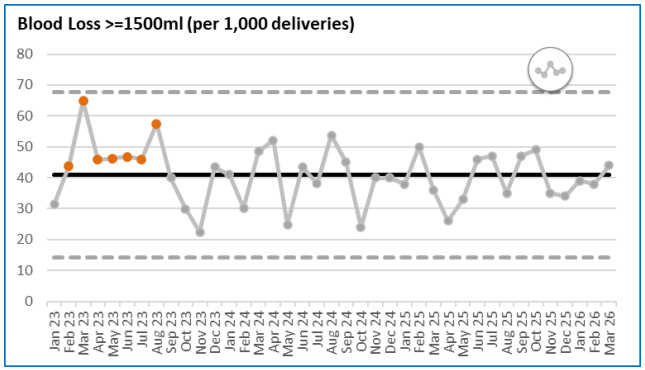
- The average England elective caesarean rate in Q2 was 20.3% and in NENC 20.7%.
- The Trust elective caesarean rate was 22% in February 2026 and 17% in March 2026.
- The national rise in elective caesarean rates is partially due to an increasing proportion being undertaken due to maternal request in 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.

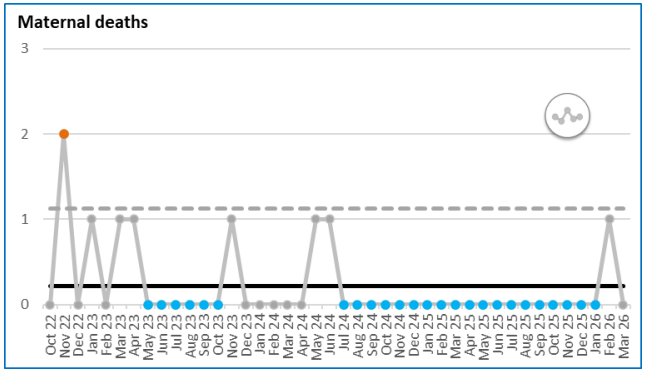
Emergency Caesarean section

- The England average for Q1 2024/25 was 23.6%, and NENC mean 20.5%
- The Trust emergency caesarean rate was 22% in March 2026, a reduction from 28% in February 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 RCOG guidance.
- England average for induction of labour Q3 2025/26 was 28.2% and NENC 33.6%. The Trust induction of labour rate has been stable since August 2025 and was 39% in March 2026.

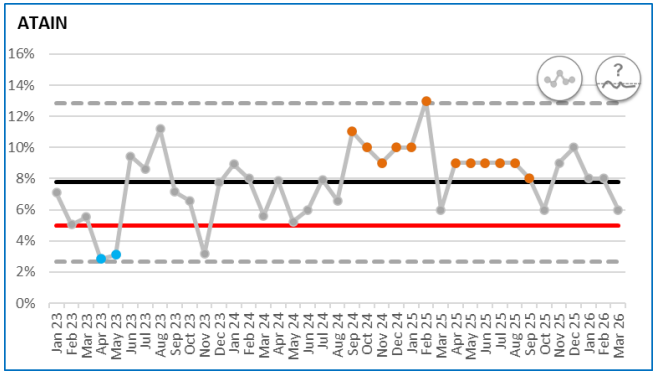
Blood Loss ≥1500ml

- The average Post Partum Haemorrhage (PPH) rate for Q3 2025/26 in England is 32 per 1000 and NENC average is 30 per 1000. The Trust PPH rate for March 2026 is 44 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

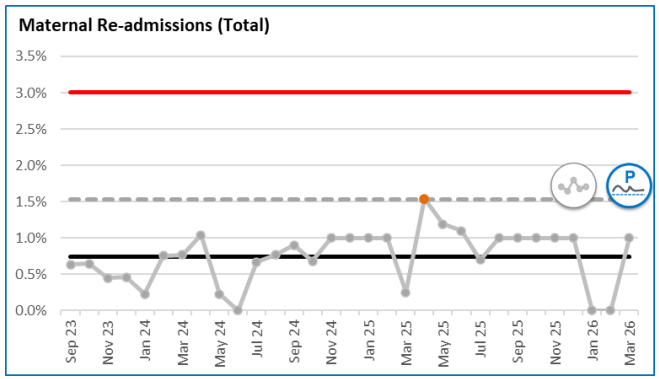
- Maternal deaths are reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) and an annual national report is provided. There were no maternal deaths in March 2026. There was one late maternal death reported in February 2026, having been none since July 2024.
- 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



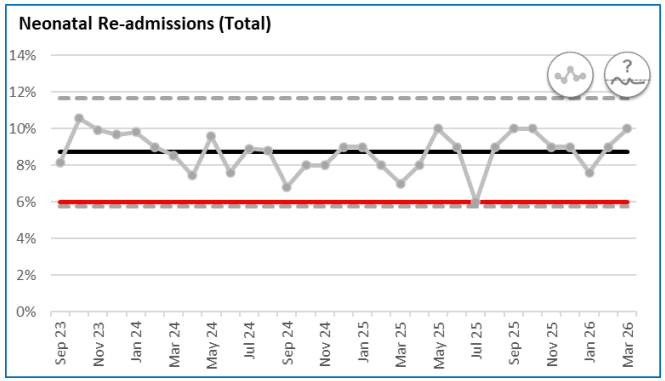
Avoiding Term Admission into Neonatal Units (ATAIN)

- The National benchmark for term admissions is 5%. The Trust rate remains consistently above the national 5% target; in March this was 6%. 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

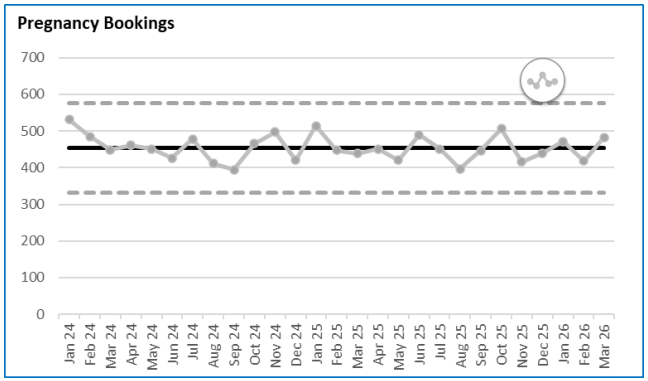
- National Maternity & Perinatal Audit (NMPA) Report (2025) the maternal postnatal readmission rate for England was 3.08% in 2023, rates varied by provider (IQR: 2.57–5.02% in Wales; 2.14–3.59% in England). The LMNS are benchmarking against the national mean readmission rate, hence an internal target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

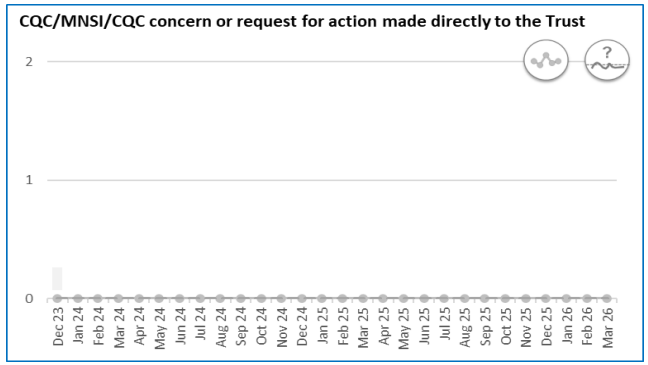


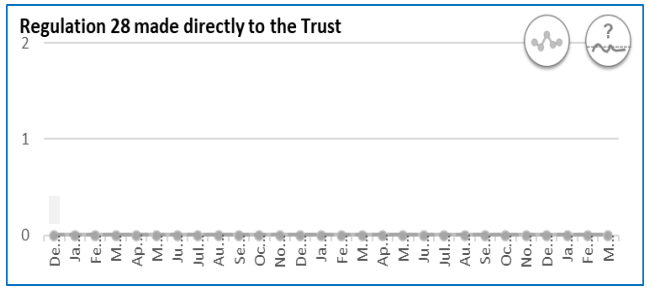
Neonatal Readmissions

- 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 March the readmission rate was 10%. The perinatal patient safety team continue to conduct the analysis on the data.
- Early learning indicates that the current management of jaundice guidance is impacting the number of admissions. The Trust management of jaundice guidance is currently more robust than the national standards as this was amended to incorporate the learning following a case of kernicterus in an infant with brown skin. The NICE guidance (CG98) was published in May 2010 and a revision of this is expected following an amendment made in October 2023 to acknowledge that jaundice may be harder to detect in visually darker skin tones.

Perinatal Quality Oversight: Incidents & Bookings





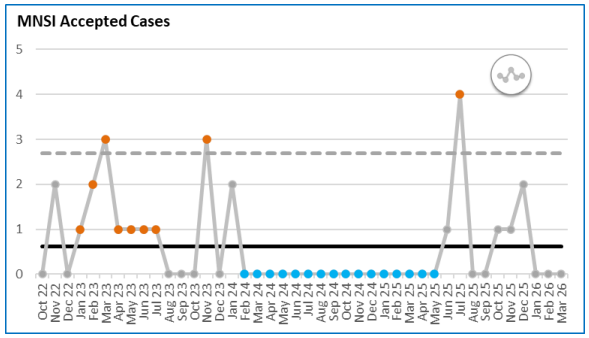


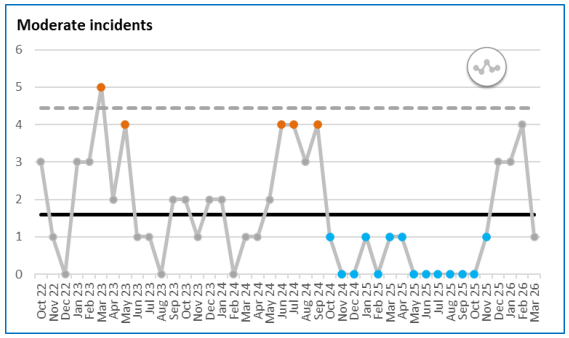
Pregnancy Bookings

- 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.

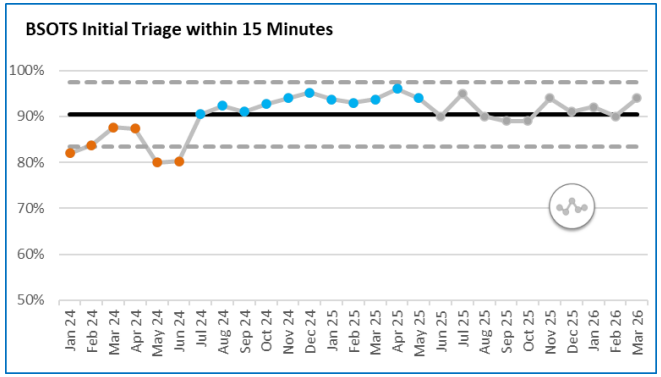
Incidents

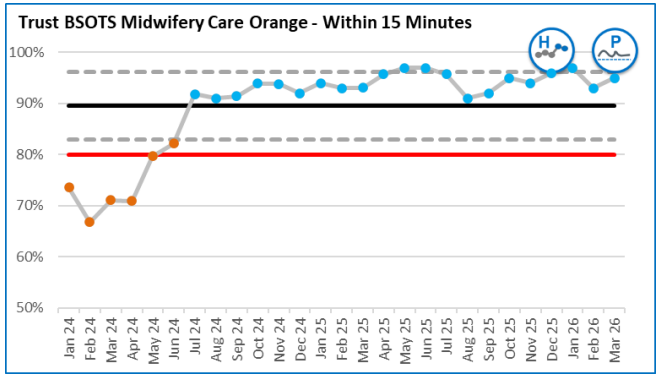
- Moderate incidents are now separated from externally reported MNSI cases which were previously grouped together. There was one moderate or above harm incident reported in March. Incidents are discussed at a multi disciplinary rapid review and presented to the Trust Response Action Review Meeting (RARM) 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 March.
- There have been no Care Quality Commission (CQC)/MNSI concerns or requests for action in the last 12 months.
- There have been no regulation 28 notices in the last 12 months.

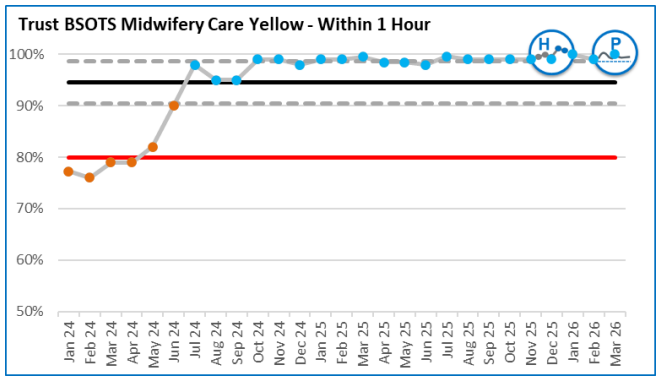


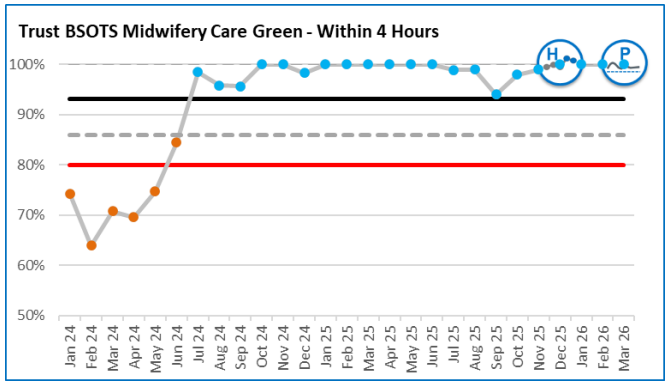


Perinatal Quality Oversight: Triage - Midwifery Care Timings





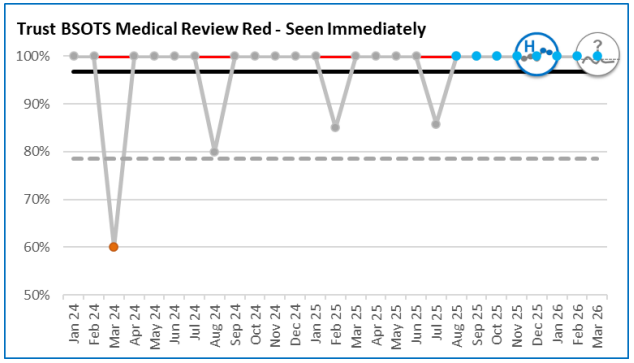


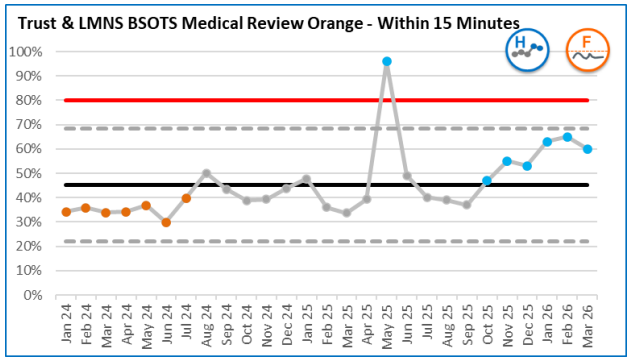


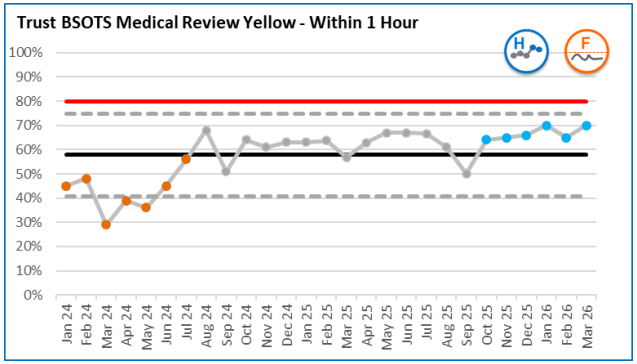
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

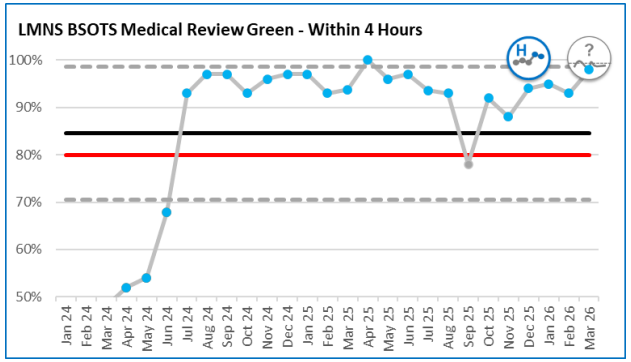
- The Trust implemented the BSOTS triage system in January 2024. Midwifery triage and subsequent review has improved considerably and has exceeded the Trust and LMNS target.
- Good performance continues to be sustained across every category for midwifery review.
- The triage within 15 minutes metric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

Perinatal Quality Oversight: Triage - Medical Review Timings





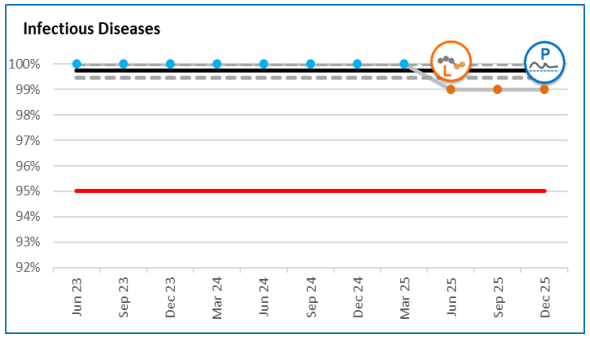


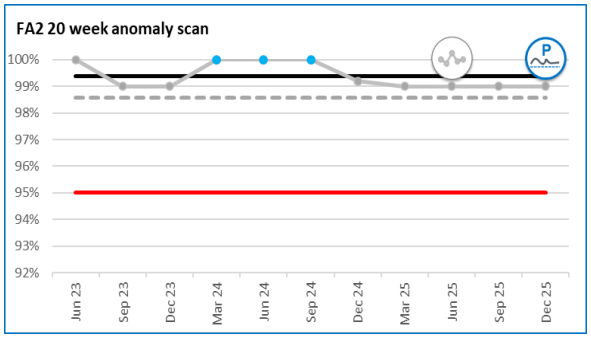


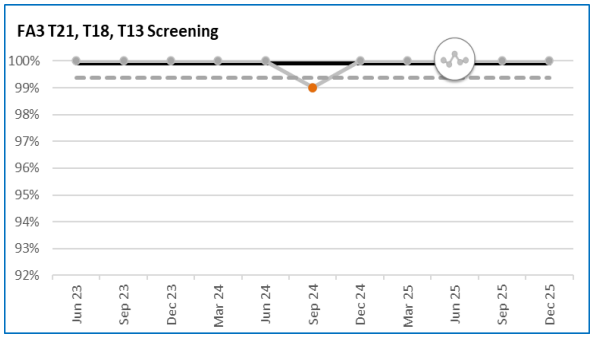
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

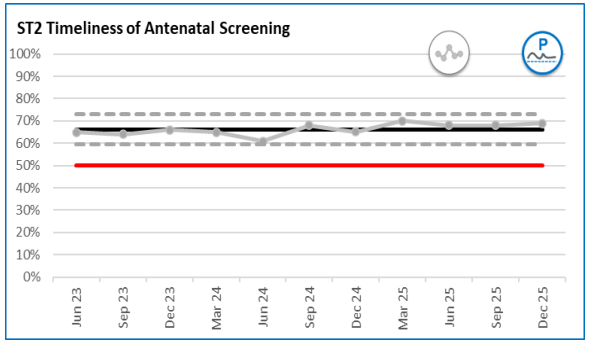
- There has been significant improvement in performance in the last 12 months.
- As previously highlighted, the business case to commence call recording for the triage services has been paused. This remains a risk within the service and is subject to ongoing discussions.
- The national BSOTS team have 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 IBR.
- However, it should be noted that performance is improving for medical reviews within 15 minutes and 1 hour.

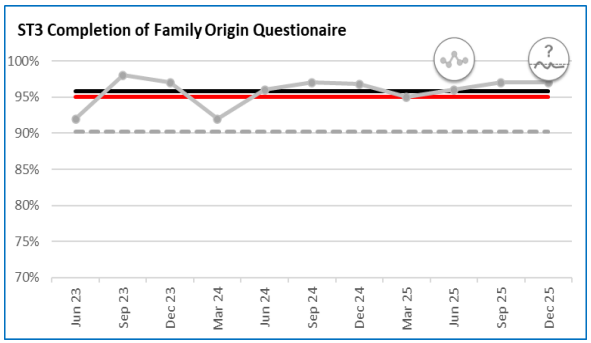
Perinatal Quality Oversight: Antenatal Screening

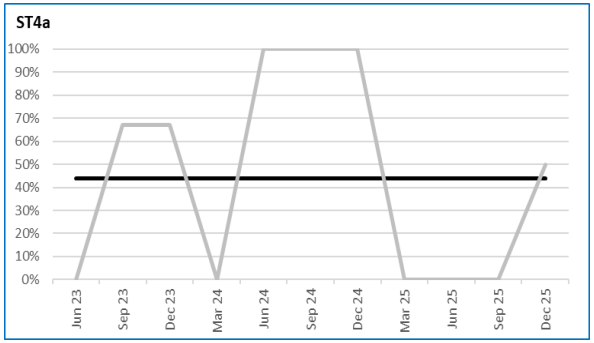


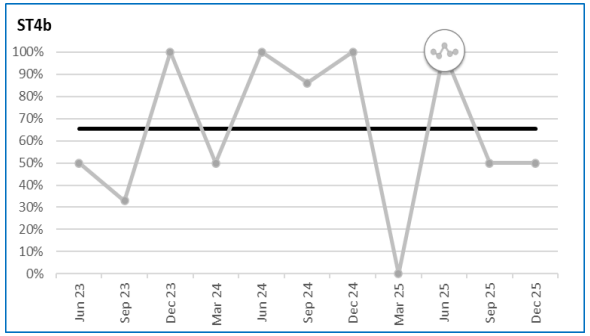


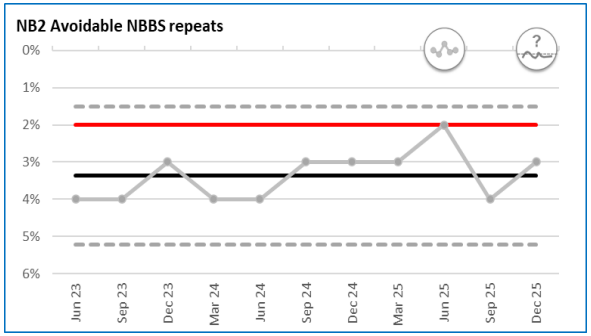








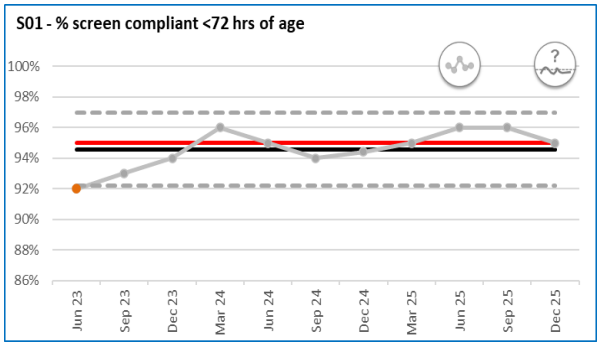


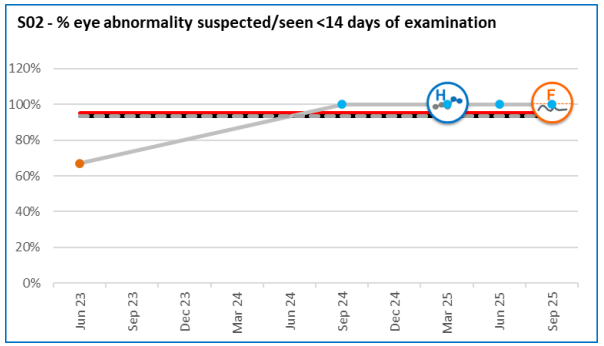


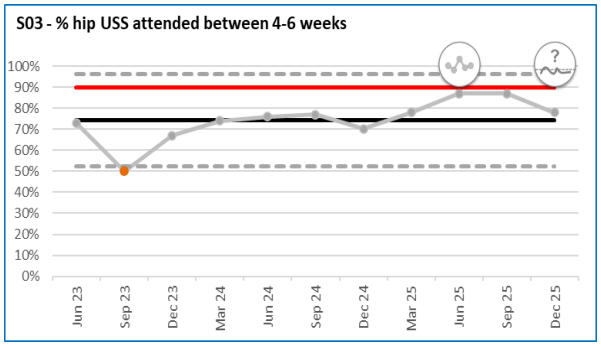
Antenatal Screening

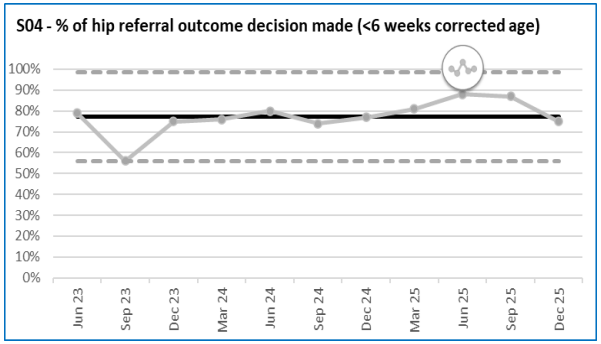
- Screening tracker has been developed by analysts and deployed to support failsafe processes and reporting as per the recommendation in the patient safety incident investigation (PSII)

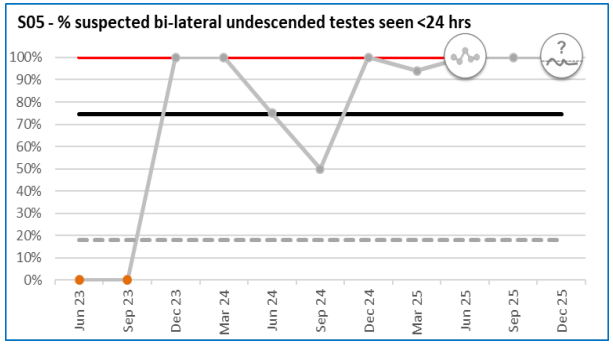
Perinatal Quality Oversight: NIPE Screening







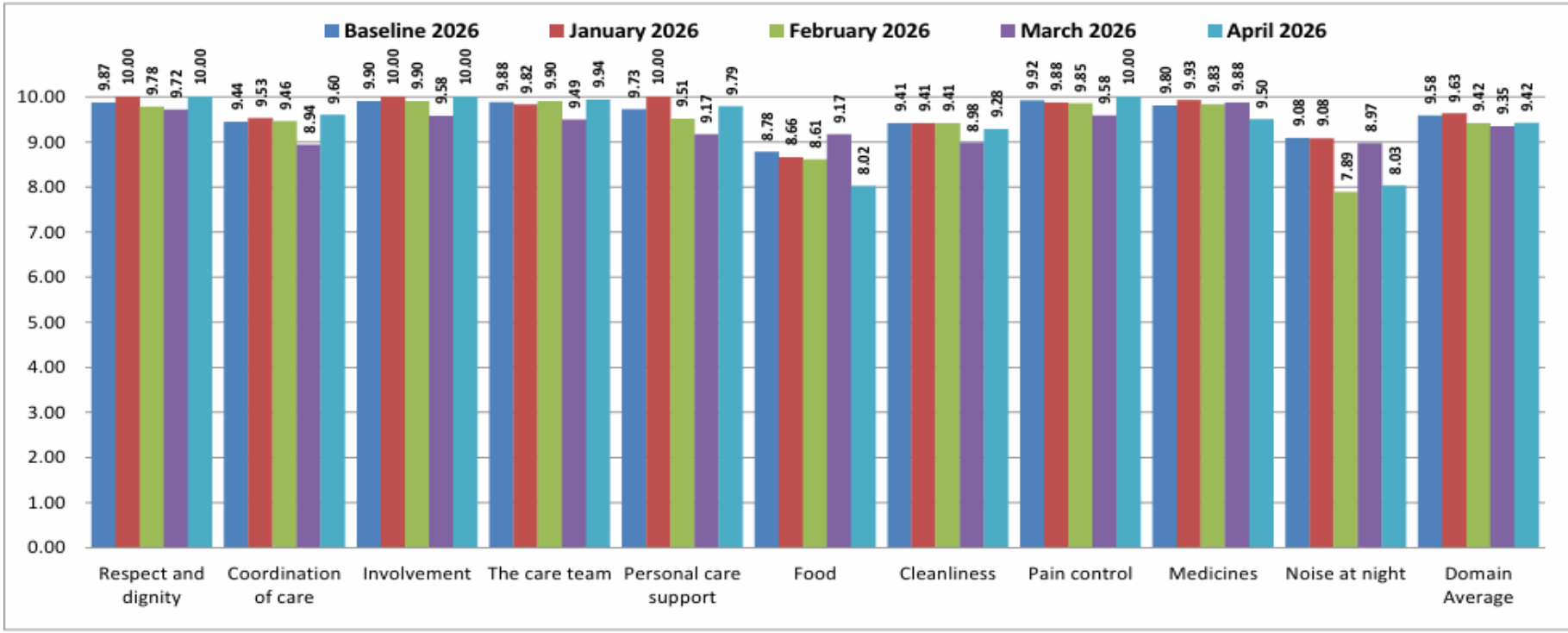




Newborn and Infant Physical Examination

- 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

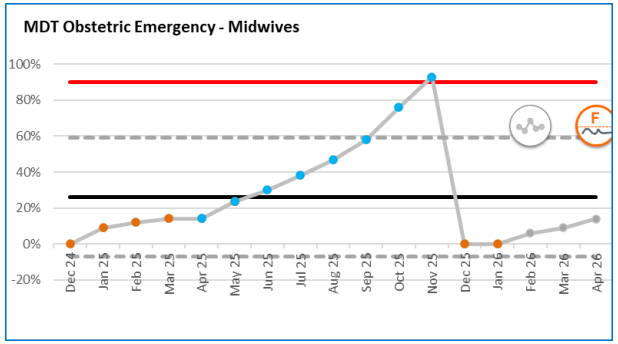


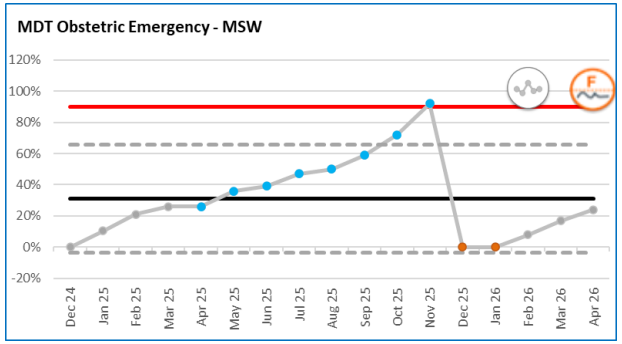
Patient perspective – Postnatal Ward 33

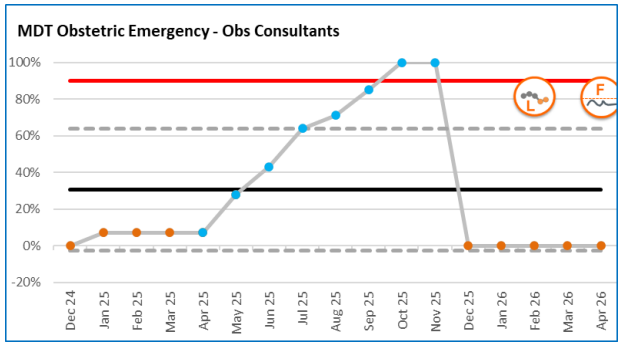
100 % of patients surveyed rated their overall experience on the ward as either good or very good.

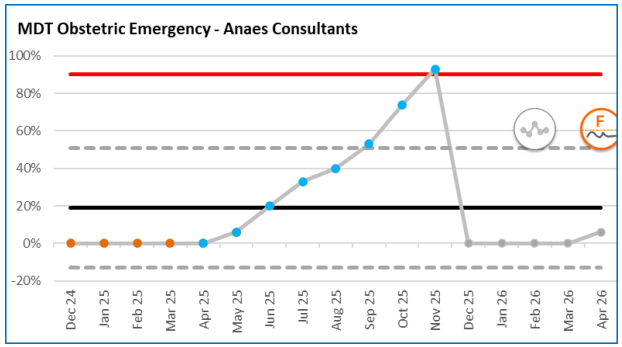
- The care has been great, really brilliant. I trust them more than enough. The food is pretty good actually. I was expecting a lot worse. The staff are all doing amazing jobs. They are so understanding and patient.
- The food is awful. Portion size is ok but very bland. I would say I have been bothered sometimes by noise at night by other patients, it's not that their babies are awake or crying, it's when people are up facetiming at all hours of the night.
- Everything has been really good here. I really enjoyed the breakfast.
- The staff have been great. It can take a while for the buzzer to be answered though, so that can be frustrating. I think I would have liked a bit more information about the antibiotics I am on, I am a bit itchy, and I am not sure if it could be a side effect.
- Everyone has been really kind to me. There has always been someone to talk to and support me when I have needed it. They always explain what they are doing and have been really helpful.

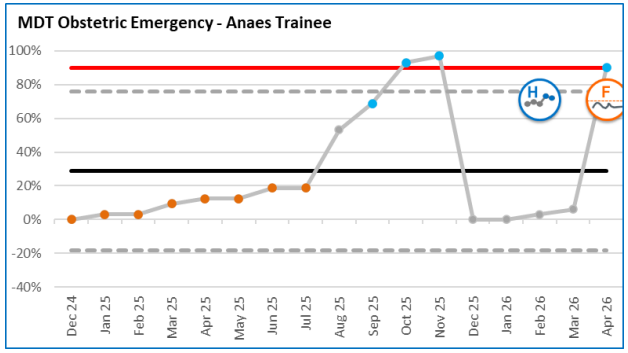
Perinatal Quality Oversight: Training (Maternity Incentive Scheme)

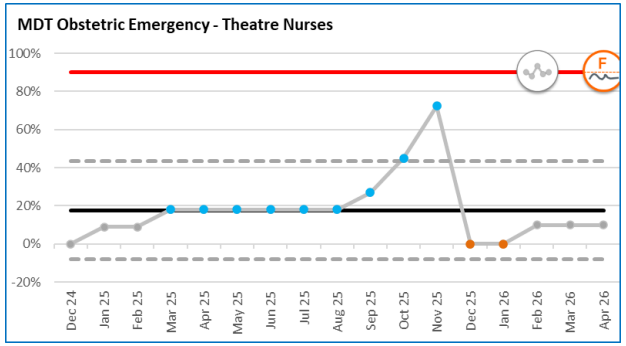












Obstetric Emergency Training by Staff Group:

The Trust were compliant with the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS) Year 7 guidance, safety action 8, Training.

MIS Year 8 guidance has now been published, and the Trust are scoping and working toward the updated requirements for safety action B (Training) which requires a minimum of 90% compliance (working toward expected trajectory of 100% compliance) for every required staff group at two points during the MIS year (April to November 2026, to be agreed locally) for:

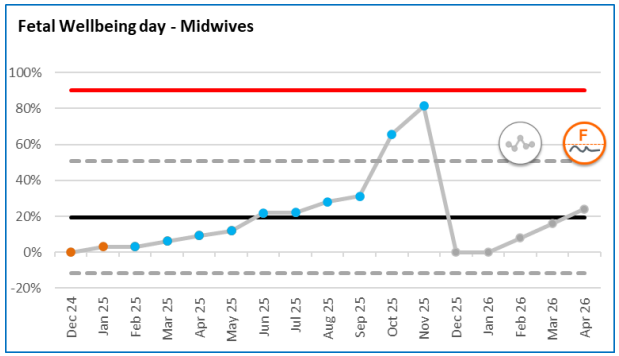
- Multi-professional maternity emergencies training
- Neonatal resuscitation training
- Fetal monitoring training

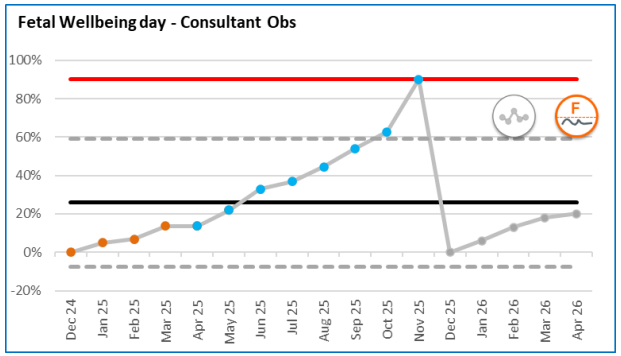
Additional requirement to deliver two in-situ multiprofessional perinatal emergency simulations (one beginning in hospital and one beginning in community).

The statistical drop in December 2025 marks the new period of reporting. Continuation of the SPC allows analysis over subsequent years.

Allocations for the training above have been completed for the Year 8 for Multidisciplinary Team (MDT) Obstetric Emergencies. With projected compliance above 90% in all staff groups.

Perinatal Quality Oversight: Training (Maternity Incentive Scheme)

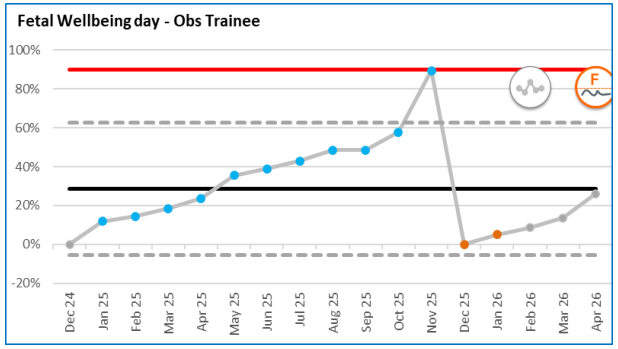


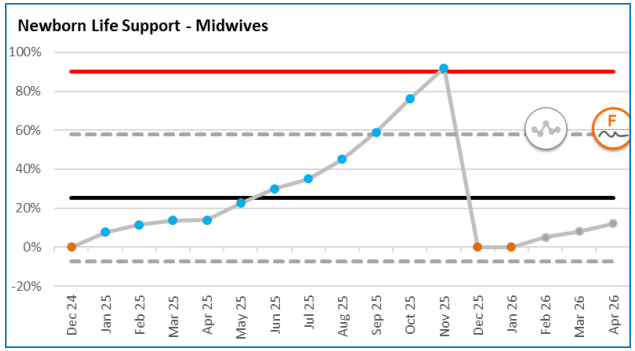


Fetal Wellbeing Training by Staff Group:

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 in Year 7. Allocations for the training above have been completed for the Year 8 for Fetal Wellbeing, with projected compliance above 90% in all staff groups.



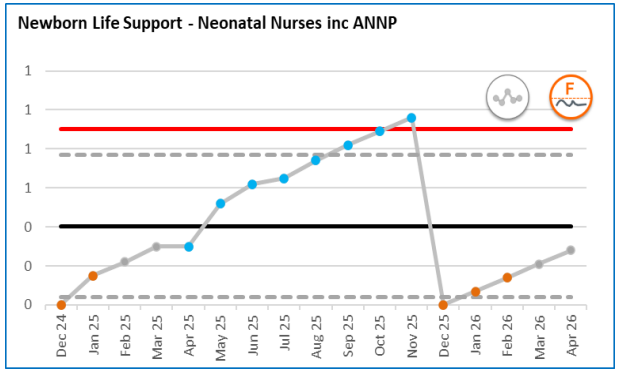


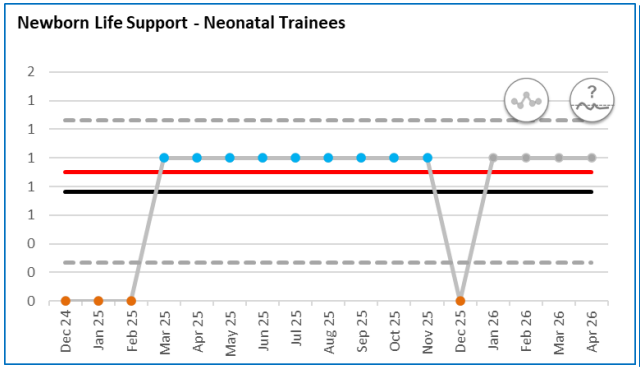
Newborn Life Support by Staff Group:

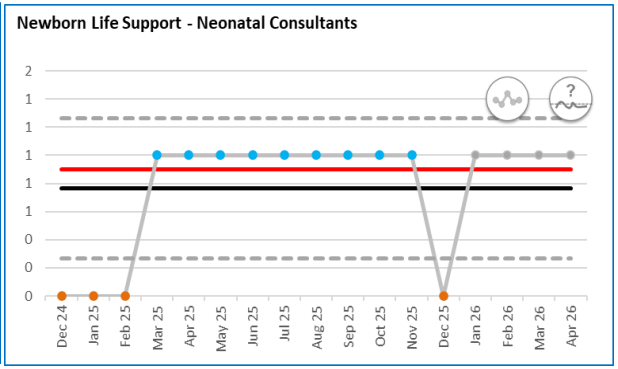
The newborn life support training is essential to ensure compliance with MIS Year 7 Safety Action 8, The Trust was compliant across all staff groups for Year 7.

As above, allocations for MIS Year 8 have been made and projected over 90% compliance for staff groups.

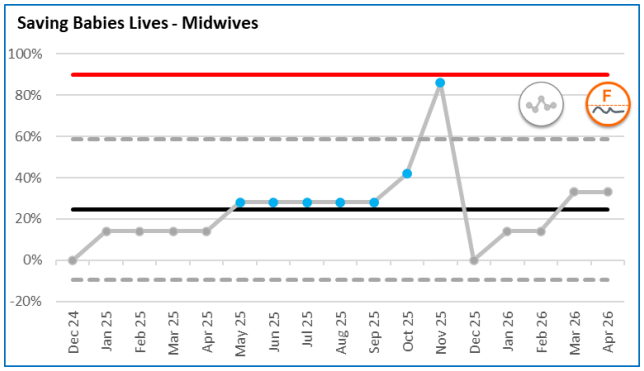
The statistical drop in December 2025 marks the new period of reporting. Continuation of the SPC allows analysis over subsequent years.

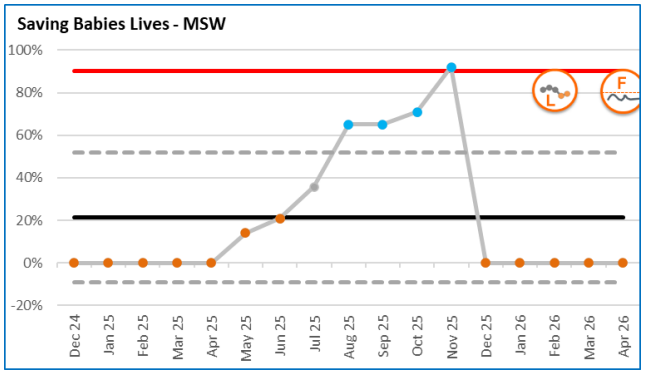


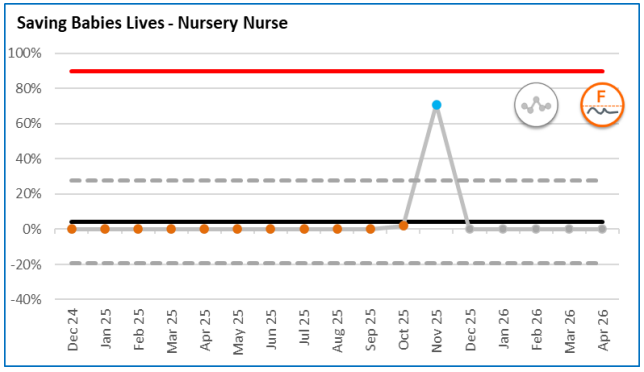


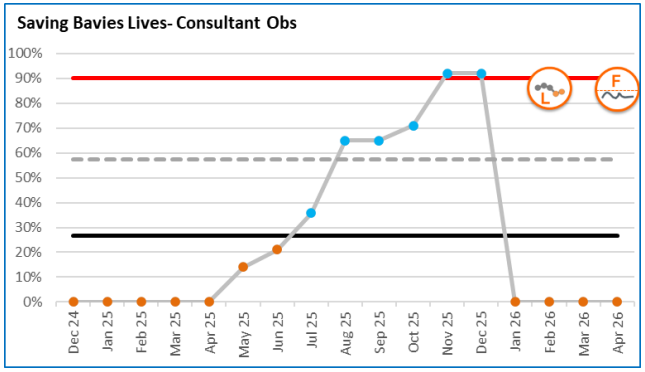


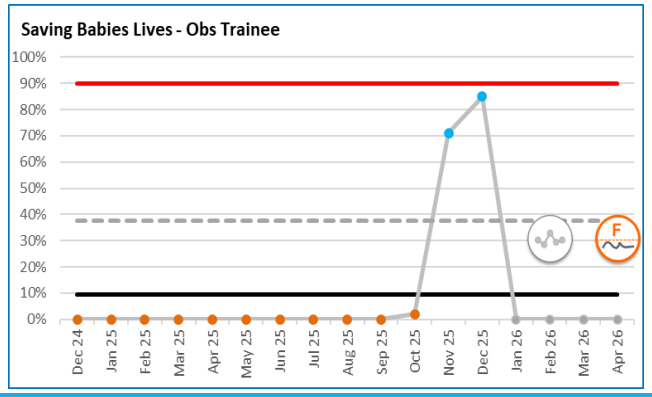
Perinatal Quality Oversight: Training (Maternity Incentive Scheme)











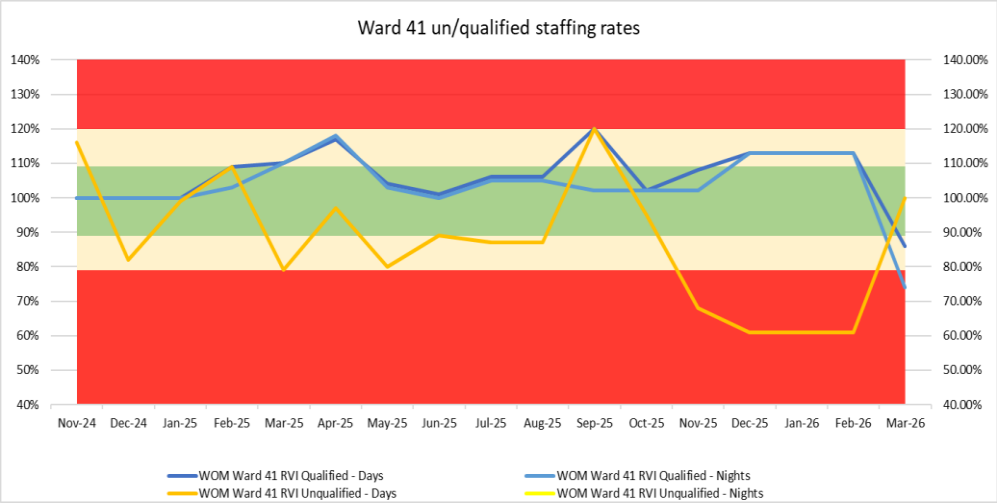
Saving Babies Lives Training by Staff Group:

The 'Saving Babies Lives' 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). This features in Safety Action E Care Bundle.

Pre-April 2026 training was delivered as part of a core 'Professionals day' attended by some staff groups. Training from April 2026 will be accessed by all staff and weekly attendance reporting oversight is in place to ensure progress to compliance at the mid and mandatory checkpoints in MIS Year 8.

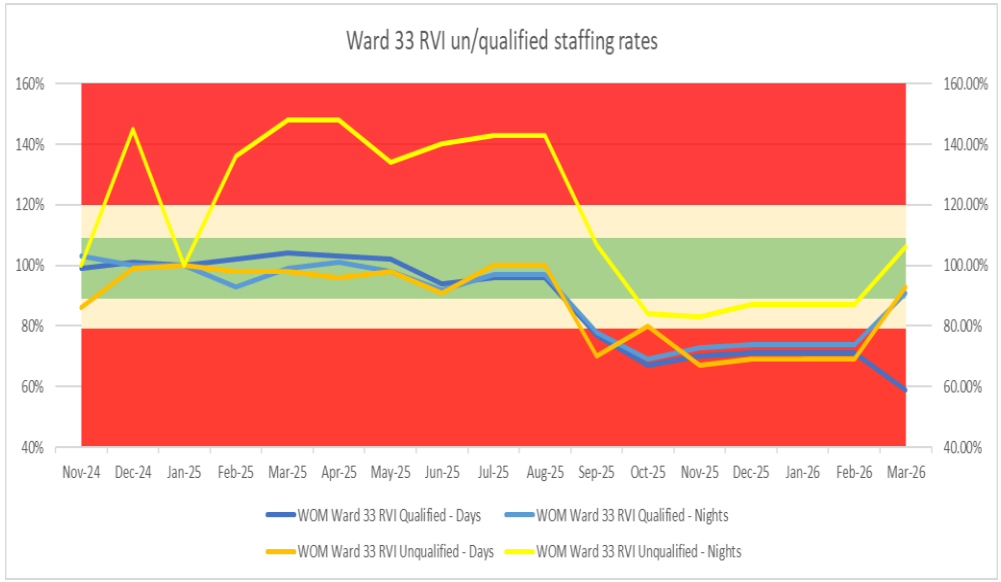
The statistical drop in December 2025 marks the new period of reporting. Continuation of the SPC allows analysis over subsequent years.

Perinatal Quality Oversight: Staffing fill rates



Antenatal Ward (41)

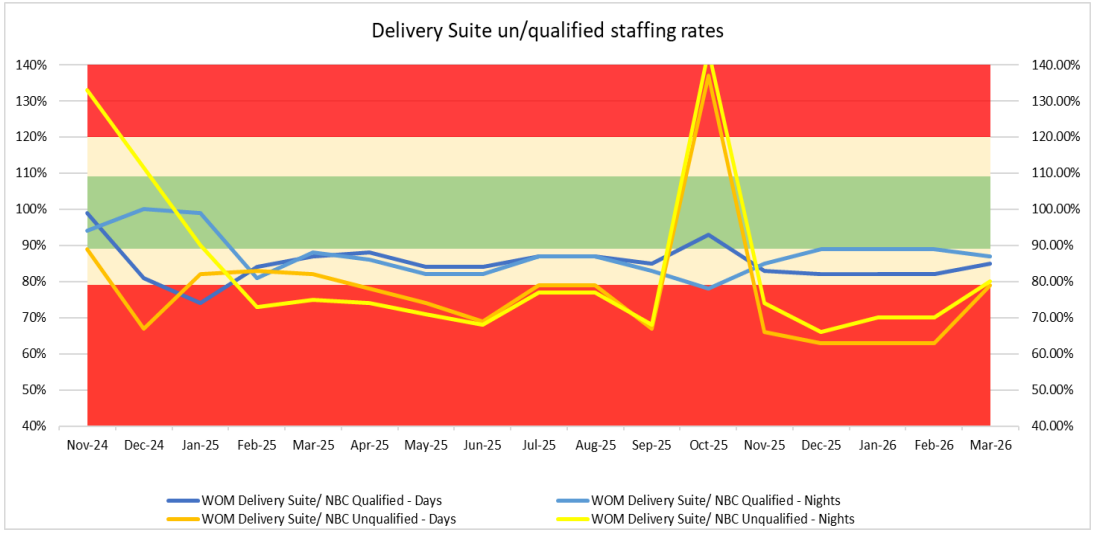
The qualified night and day fill rates have been stable, up to December. Birthrate Plus staffing templates for 3 qualified staff on nights are expected to go live late 2026. When the ward opens escalation beds in an additional bay, midwifery fill rates should exceed the staffing establishment to maintain appropriate staff to patient ratios. There were 18 days in escalation (5 consecutively) with extra bed spaces open in March. Additional unqualified staff were utilised to support the service.



Postnatal Ward (33)

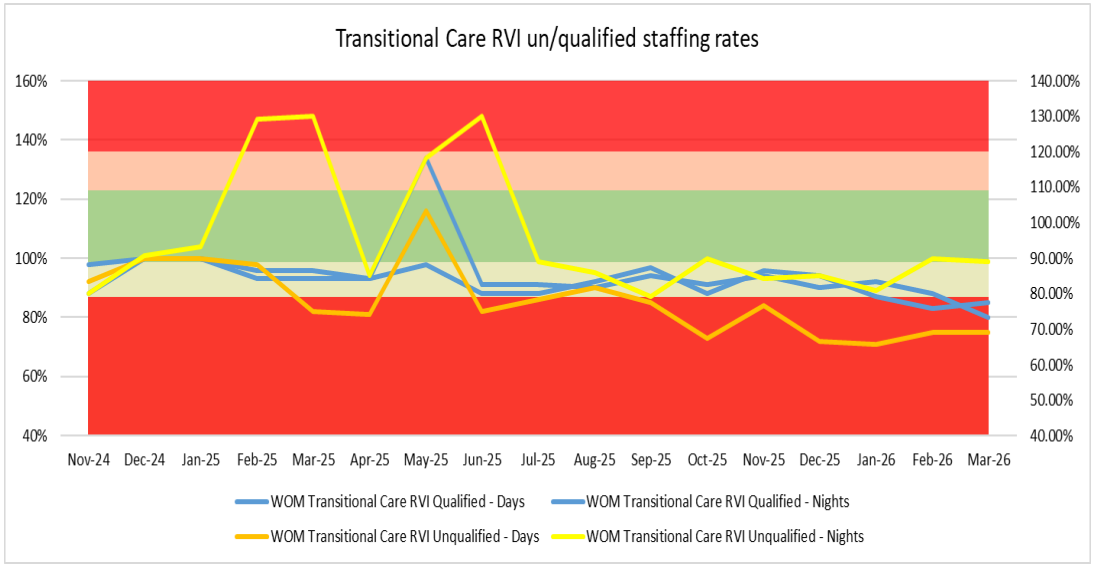
The fill rates for the postnatal ward were impacted by sickness and escalation to support antenatal inpatient and intrapartum care in September, however from October the updated Allocate template has been introduced and the fill rate is measured against Birthrate Plus. There have been no associated patient 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)

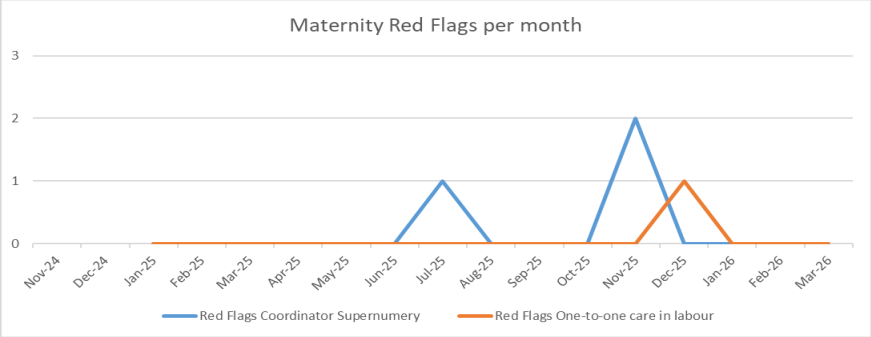
The midwifery fill rates for the intrapartum team remain stable despite the staffing position which is impacted by sickness and maternity leave. There were no red flags relating to the provision of one-to-one care in labour. There were no occasions when the co-ordinator was not supernumerary on Delivery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

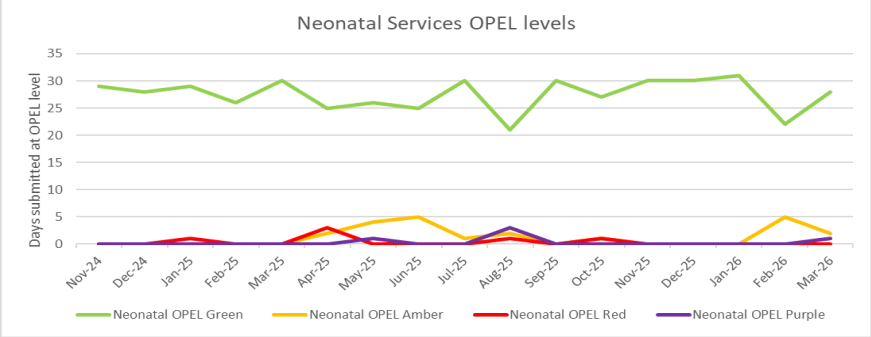


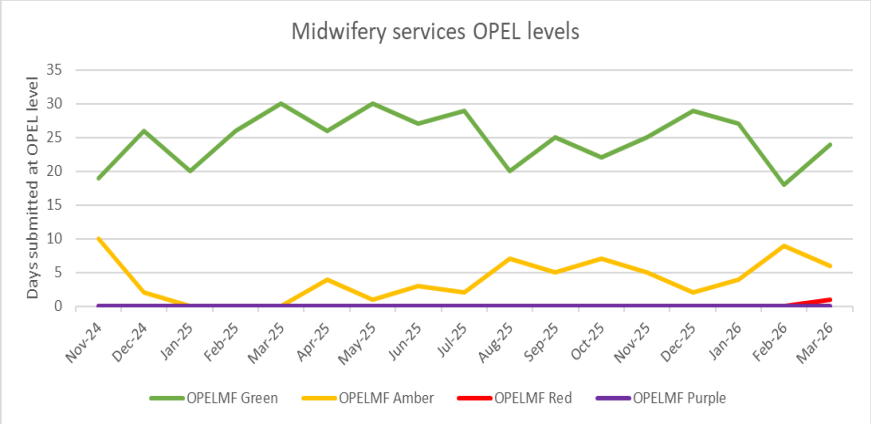
Transitional Care Ward (34)

The fill rates for Transitional Care ward for qualified 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 March 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 March 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 28 days in March, OPEL 2 for two days and OPEL 4 for one day. 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 24 days in March, OPEL 2 for six days and OPEL 3 for one day. 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 March 2026.

Performance

Performance Overview

Metric	Period	Actual	Traj.	Target	Variation	Assurance
A&E Arrival to Admission / Discharge	Mar-26	79.3%	85.0%	78%		?
RTT 18 Weeks	Mar-26	72.5%	74.0%	92%	H	F
>52 Week Waiters (% of total PTL)	Mar-26	0.7%	0%	1%	L	F
Cancer 28 Day FDS	Feb-26	76.2%	85.6%	80%	L	?
Cancer 31 Day	Feb-26	90.1%	88.1%	96%	H	F
Cancer 62 Day	Feb-26	70.3%	77.9%	75%	H	F
Diagnostic 6 Weeks	Mar-26	14.4%	5.0%	5%	L	F

Emergency Care

- ED Performance (All Types) in March was 79.82%, an increase of 4.27% compared to February (75.55%). ED attendances increased in March to 24,132, 2892 patients more than February.

Elective Waits

- March 2026 witnessed another significant reduction in >52-week waiters at Newcastle Hospitals, dropping to 579 (-198). This meant 0.7% of the total Referral To Treatment (RTT) waiting list was over 52 weeks – comfortably below the national target of 1%.
- The total waiting list size decreased further in March to 81,301 (-720). The Trust's participation in an NHS England coordinated validation sprint has been key to reductions throughout 2025-26.
- The trust's RTT 18-week compliance increased to 72.5% in March (+1.5% from February).

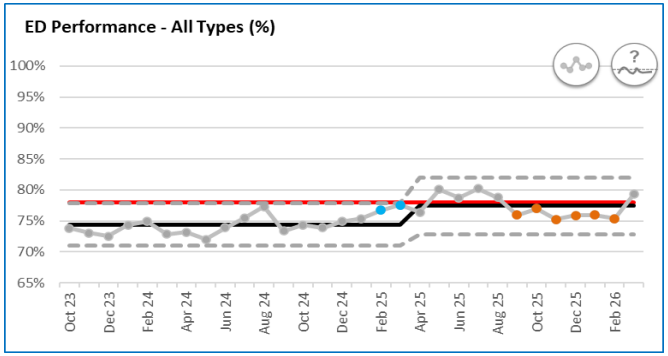
Cancer Care

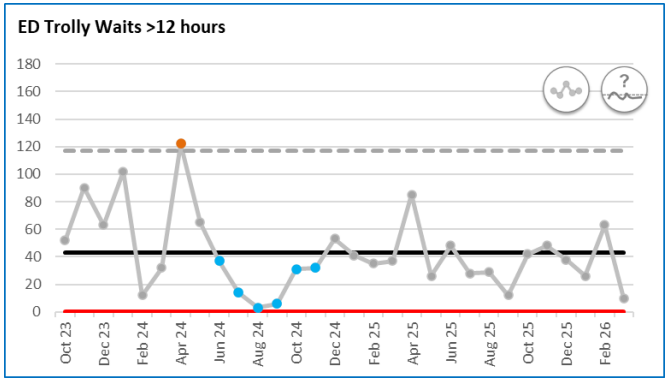
- In February, the 80% 28 Faster Diagnosis Standard (FDS) target was achieved - performance was at 85.6%. 31-day performance rose to 86.8% in February, whilst 62-day performance rose only slightly to 68.5% in February.
- The Breast team are struggling to manage tertiary referrals, as well as the GP referrals from the Durham and Gateshead area that are going straight to the NuTH team.

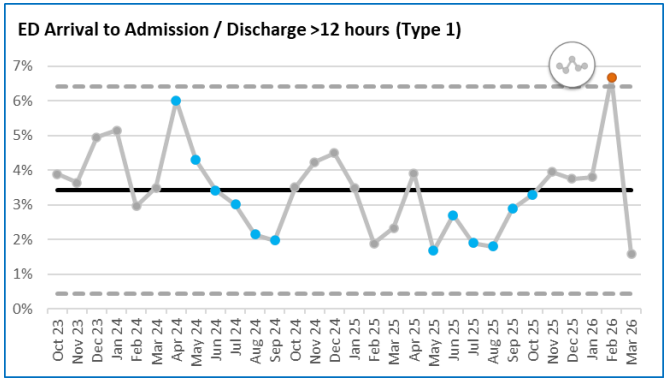
Diagnostics

- Performance against the 5% standard improved in March – 14.4% of patients were waiting over six weeks. The target continues to be consistently failed but there is special cause variation of an improving nature after considerable improvement in 2024/25.

Emergency Care







Standards

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

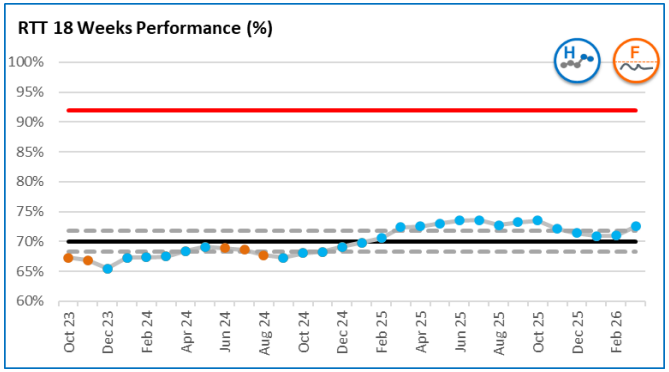
Current position

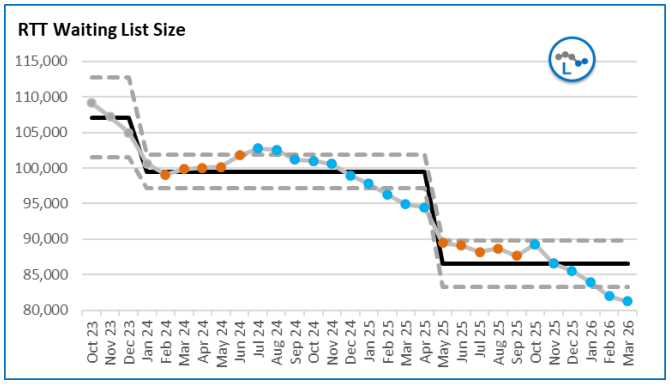
- ED Performance (All Types) in March was 79.82%, an increase of 4.27% compared to February (75.55%). ED attendances increased in March to 24,132, 2892 patients more than February. Paediatric ED 4hr performance for March was 79.73%, a reduction of 0.60% from February.
- ED Trolley waits >12 hours decreased from 63 in February to 11 in March.
- ED Arrival to Admission / Discharge > 12 hours (Type 1) in February was 6.67%, this dropped to 1.57% in March.
- There were 211 handovers > 45 mins in March, this was an decrease of 53 in February. Of those handovers, March had 83 handovers >60mins, down from 116 handovers >60mins in February.

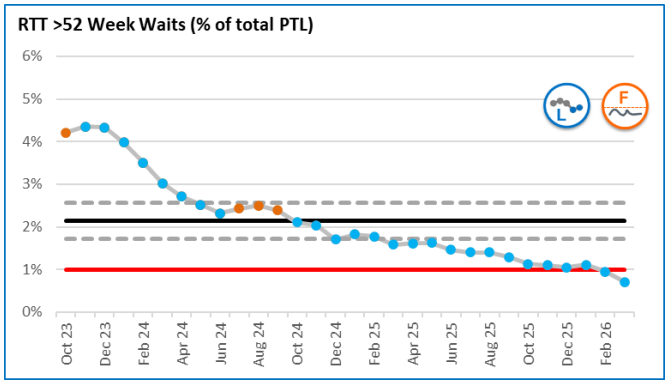
Action taken

- 'Sprint' funding – made available nationally to accelerate departmental flow and waiting time performance improvements - was available in March, paying double for staff overtime. This positively influenced overall and Type 1 performance despite the large number of attendances compared with previous years.
- The team initiated an ED Ambulatory Majors space (EDAM), utilising the old minor injuries space to see and treat anyone that didn't need a bed or could walk. The utilisation of the EDAM space was limited in March due to a high level of sickness within the ED senior medical team.
- The Urgent Treatment Centre (UTC) has a new interim lead for training and development – the Matron for Paediatric ED has met with leads to discuss formal training plans and the possibility of formal supervision for Nurse Practitioners. This would improve UTC staff confidence in treating paediatric patients, rather than streaming them straight to paediatric ED.
- Discharges increased in March, which helped patient flow. This translated into a very low number of medical boarders for the month and impacted other metrics related to patient flow in the Trust.

Elective Waits







Standards

- 92% of patients on incomplete RTT pathways to be waiting less than 18 weeks.
- Zero tolerance on incomplete RTT waits over 65 weeks.
- <1% of incomplete RTT waits over 52 weeks (by Mar-26).
- 72% of patients time to first outpatient appointment <18 weeks (local target of 82.6%).

Current position

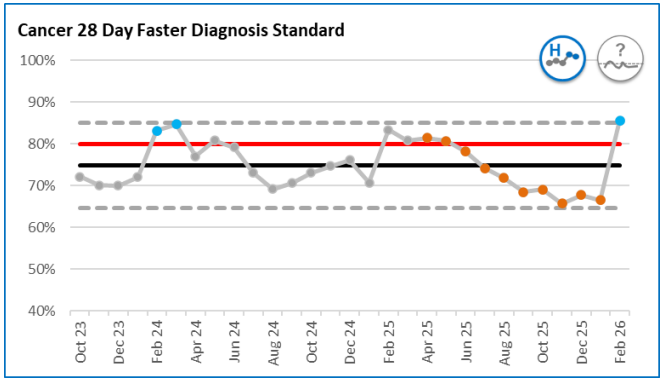
- March 2026 witnessed another significant reduction in >52-week waiters at Newcastle Hospitals, dropping to 579 (-198). This meant 0.7% of the total RTT waiting list was over 52 weeks – comfortably below the national target of 1%.
- 78-week waiters remained at zero.
- The number of >65 week waits decreased to 6 (-11). The trust is pushing to clear 65-week waiters by the end of May 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:
    - Spinal Neurosciences are currently experiencing capacity constraints exacerbated by surgeon absence.
    - Adult Deformity patients are highly complex and often require two surgeries with two consultants present, making scheduling appropriate lists very challenging.
    - Cardiology current have long waiters for Left Atrial Appendage Occlusion procedures (LAAO).
- The total waiting list size decreased further in March to 81,301 (-720). The Trust's participation in an NHS England coordinated validation sprint has been key to reductions throughout 2025-26.
- The trust's RTT 18-week compliance increased to 72.5% in March (+1.5% from February).

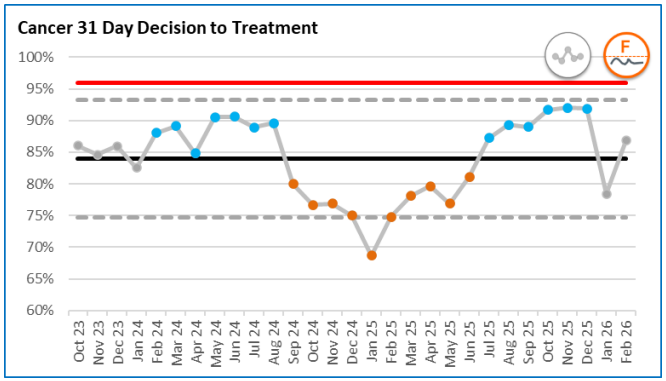
Action taken

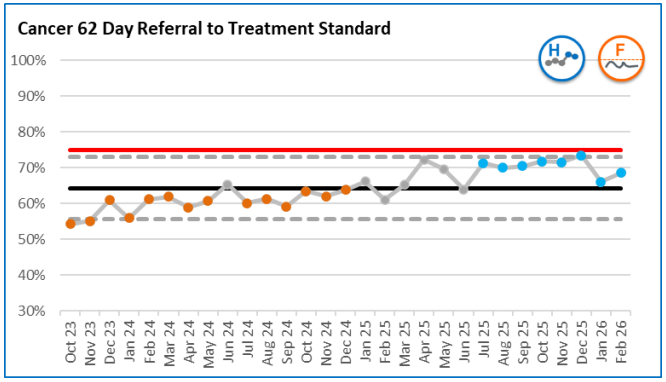
- Neurosciences continue to rigorously validate pathways, ensuring patients remain fit and suitable for surgery and that no individual consultant backlogs occur.
- New consultants in the Adult Deformity service are happier to work on pooled lists, allowing quicker treatment for patients.
- Cardiology have an agreement for Radiology to do CT scans for LAAO patients - meaning lists can be carried out under local anaesthetic rather than general anaesthetic.

Cancer Care

March 2026 cancer performance data has not yet been published.







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).

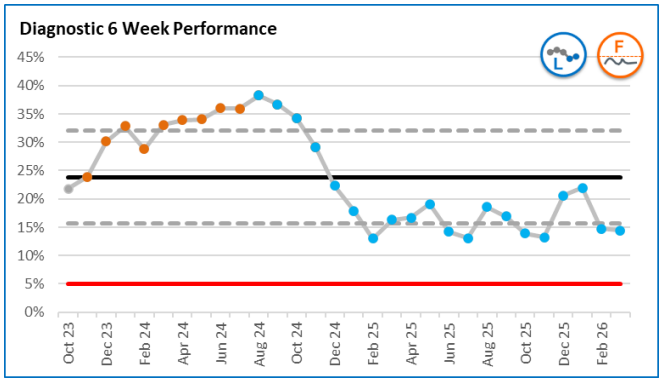
Current position

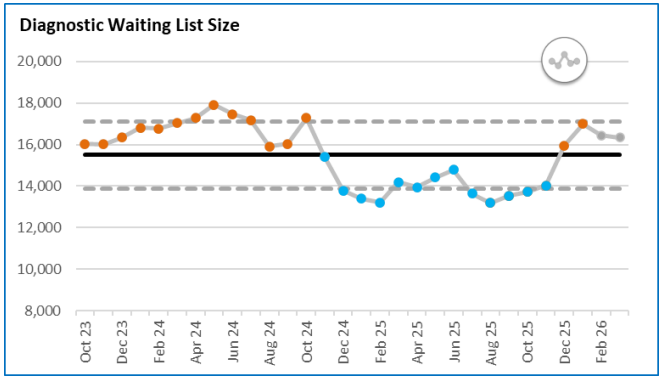
- In February, the 80% 28 FDS target was achieved, performance was at 85.6%. 31-day performance rose to 86.8% in February, whilst 62-day performance rose only slightly 66.0% in January to 68.5% in February.
- Skin – There has been strong 28 and 62 day performance, with 32 day performance not hitting the 92% target.
- OGD – The team are struggling to gain and maintain capacity for clinics.
- Breast – the team are struggling to manage tertiary referrals, as well as the GP referrals from the Durham area straight to the NuTH team.
- Radiology is struggling to recruit radiologists or consultant radiographer and identified increased costs to cope with the demand.
- Lung – NuTH is an outlier in the region for its low 62 day performance. The surgical end of the pathway is contributing to this, as a result the service is focusing on changing the mindset around the waiting list, reducing cancellations and better scheduling.
- Urology – Prostate have struggled to find clinic rooms and struggled to hit the 62 day target for surgery. For bladder, the team have introduced a Nurse led clinic for direct GP referrals. Ablation has become a bottleneck due to consultant and anaesthetist availability.

Action taken

- Skin –A new consultant has been recruited, they are estimated to start in September and will likely have an emphasis on skin cancer in their job plans.
- Radiology – A 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 – the team will be putting in a bid to cover Nav Bronch equipment across the region. The NuTH part of the bid is complete. A workshop is planned for after the Manchester visit, to review how the team adapt the model and improve it for NuTH.

Diagnostics





6 Week Diagnostic Performance by Modality – March 2026			
MRI	18.0%	CT	6.1%
Non-obs US	8.3%	DEXA	6.1%
Audiology	9.1%	ECHO	22.0%
Electrophysiology	12.5%	Neurophysiology	2.3%
Sleep Studies	29.1%	Urodynamics	27.3%
Colonoscopy	29.2%	Flexi-Sig	38.8%
Cystoscopy	13.1%	Gastroscopy	39.1%
Newcastle Hospitals Total			**14.4%**

Standards

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

Current position:

- Performance against the 5% standard improved in March – 14.4% 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.
- Strong performance improvements have been achieved in Audiology, with compliance up to 9.1% in March.
- Despite this, there is a continued need to balance sustainable achievement of the DM01 standard, whilst maintaining sufficient capacity to enable the delivery of phases 4-6 of the Audiology Recovery Plan - with a growing waiting list for re-assess and fits a particular concern.
- The number of completed paediatric endoscopies haven't kept pace with increased listing - the service has become reliant on weekend WLI to avoid long waits. List availability has decreased markedly this financial year and is unlikely to increase soon.
- Inconsistent and unpredictable slot usage in Echo, combined with staffing challenges (vacancy, absence) is reducing throughput and performance.

Action taken

- Insourcing has re-commenced on a weekend for hearing aid fittings. Additionally, following a comprehensive service review and re-structure, the process of appointing to posts has started.
- Paediatric Endoscopy recovery options are currently limited by a small and stretched team of gastroenterologists and a lack of children's theatre appetite for out of hours lists.
- Weekly list oversight meetings with Clinical Director/Service Manager/Sisters/Admin Manager have been established within main Endoscopy to identify if any list can be reopened (even if reduced capacity e.g. 6-point list instead of standard 12 points).
- 24 new Echo machines were delivered in March following a successful funding bid with NHSE. A further 2 were be provided through the Children's Heart Unit Fund (CHUF). This will enable back-to-back appointments, reduce malfunctions and provide more accurate diagnoses.
- Work with Kid Scan has led to 110 paediatric GA long waiters being scanned- thus reducing the waiting list. Main radiology has been using NCCC MRI - mainly out of hours/weekends. The service is exploring taking on staff from third party providers to support Neuro.

Contractual & Planning Standards (1/2)

Theme	Standard	Trajectory	Dec-25	Jan-26	Feb-26	Mar-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	96.4%	97.0%	98.1%	**94.6%**	11,414	12,070	**98.4%**
Elective Overnight			91.5%	89.2%	88.3%	**82.5%**	1,653	2,003	**93.4%**
Outpatient New			93.7%	95.2%	91.8%	**86.7%**	24,652	28,420	**95.8%**
Outpatient Procedures			97.7%	97.1%	94.6%	**94.4%**	22,715	24,060	**96.8%**
Outpatient Review	N/A		118.6%	114.9%	107.4%	**103.1%**	67,358	65,305	**110.1%**
Non-Elective			87.0%	84.6%	90.1%	**82.9%**	896	1,081	**90.4%**
Emergency			106.0%	108.4%	110.6%	**112.7%**	6,908	6,128	**105.9%**
Diagnostic Activity	**100%** of 25/26 Plan	N/A	91.5%	98.0%	102.6%	**99.7%**	22,745	22,808	**101.5%**
PIFU Take-up (%)	>=**5%** of all OP atts. (by Mar-29)	**3.3%**	2.8%	2.9%	2.8%	**2.9%**	3,526	112,646	**2.7%**
Day case rates (BADS procedures)	**85%**	N/A	**87.3%**	TBC	TBC	TBC			
Capped Theatre Utilisation	**85%**	N/A	80.9%	81.4%	82.7%	**82.6%**			
Urgent Ops. Cancelled Twice	**Zero**	N/A	0	0	0	**0**	0		**0**
Cancelled Ops. Rescheduled >28 Days	**Zero**	N/A	9	7	18	**9**	9		**78**
Elective Waits									
RTT Waiting List Size	**Reduction** from 24/25	**93,709**	85,552	83,929	82,021	**81,433**	81,433		
RTT 18 Week Wait	**92%**	**72.5%**	71.4%	71.0%	71.0%	**72.4%**	58,943	81,433	**72.5%**
>78 Week Waiters	**Zero**	**0**	0	2	0	**0**	0		
>65 Week Waiters	**Zero**	**0**	38	26	17	**6**	6		
>52 Week Waiters	N/A	**713**	893	930	777	**579**	579		
>52 Week Waiters (% of Total WL)	**<1% of total WL** (by Mar-26)	**0.8%**	1.0%	1.1%	0.9%	**0.7%**	579	579	**1.3%**
>12 Week Waiters Validated	**90%**	N/A	95.9%	91.4%	96.4%	**97.7%**	20,879	21,363	**95.8%**
Time to First Outpatient Appointment (18 Weeks)	**72%** (local target of **82.6%**)	**79.4%**	77.8%	77.0%	77.5%	**77.2%**	34,929	45,219	**78.5%**
RTT Waiting List (Children & Young Persons <=18 yrs)	N/A	**12,370**	11,414	11,036	11,403	**11,475**	11,475		
>52 Week Waits (Children & Young Persons <=18 yrs)		**62**	113	87	76	**70**	70		
Community Services Waiting List	N/A	N/A	10,520	11,018	11,315	**11,615**	11,615		
Community Services >52 Week Waiters			1,027	1,067	947	**733**	733		
Diagnostic 6 week wait	<=**5%** (local target of **<=11.4%**)	**6.5%**	20.6%	21.9%	14.7%	**14.4%**	2,355	16,331	**16.8%**

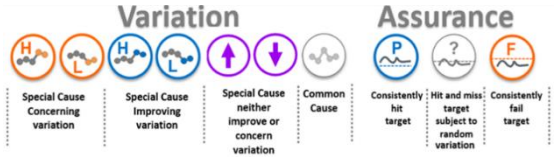
Contractual & Planning Standards (2/2)

Theme	Standard	Trajectory	Dec-25	Jan-26	Feb-26	Mar-26	Num.	Den.	25/26 YTD
Cancer Care									
28 Day Faster Diagnosis	**80%** (by Mar-26)	**81.8%**	67.7%	66.5%	**85.6%**	TBC	TBC	TBC	**73.6%**
31 Days (DTT to Treatment)	**96%**	**80.0%**	91.9%	78.5%	**86.8%**	TBC	TBC	TBC	**85.8%**
62 Days (Referral to Treatment)	**75%** (by Mar-26)	**71.4%**	73.4%	66.0%	**68.5%**	TBC	TBC	TBC	**69.8%**
>62 Day Cancer Waiters	**N/A**	**N/A**	144	131	**123**	TBC	TBC		**69.8%**
Urgent & Emergency Care									
A&E Arrival to Admission/Discharge (All types)	**>=78%** under 4 hours (by Mar-26)	**84.0%**	76.0%	75.9%	75.6%	**79.8%**	19,262	24,132	**77.3%**
A&E Arrival to Admission/Discharge (Type 1)	**Reduction** from 24/25	**2.5%**	3.9%	4.1%	6.7%	**1.6%**	177	11,211	**3.3%**
A&E Decision to Admit to Admission >12 Hours	**Zero** over 12 hours	**N/A**	57	26	63	**11**	11		**464**
Adult General & Acute Bed Occupancy	**<=92%**	**89.6%**	85.2%	87.7%	90.8%	**94.1%**	1,387	1,474	**88.6%**
Ambulance Handovers <15 mins	**65%**	**N/A**	45.5%	47.1%	45.1%	**45.6%**	1,515	3,323	**46.3%**
Ambulance Handovers <30 mins	**95%**		83.9%	83.3%	79.8%	**82.9%**	2,755	3,323	**81.5%**
Ambulance Handovers >60 mins	**Zero**		109	88	116	**83**	83		**1,149**
Urgent Community Response Standard	**>=70%** under 2 hours	**N/A**	91.3%	89.1%	86.3%	**80.5%**	240	298	**85.2%**
Safe, High Quality Care									
Mixed Sex Acommodation Breach	**Zero**	**N/A**	102	114	**146**	**161**	161		**1,049**
VTE Risk Assessment	**95%**		**95.9%**	96.9%	97.3%	96.6%			
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour		**69.0%**	**72.0%**					
Sepsis Screening Treat. (All)			**63.0%**	**73.0%**					

People

People overview

Metric	12-month rolling	Actual	Target	Variation	Assurance
Sickness	Mar-26	5.84%	4.5%		F
Short-term (Month only)	Mar-26	2.00%			
Long-term (Month Only)	Mar-26	3.84%			
Turnover	Mar-26	9.22%	10%	H	P
Mandatory training	Mar-26	92.19%	90%		P
Appraisal	Mar-26	85.27%	90%		F
Disabled staff	Mar-26	6.78%		H	
Ethnicity (BAME staff)	Mar-26	18.89%		H	



(Data is for period **1 April 2025 to 31 March 2026** unless otherwise stated)

Staff in post

- Total is 15,980.60 Full Time Equivalent (FTE) including Bank/agency
- Total substantive is 15,492.98 FTE, 17,773 headcount
- Above substantive pre-Covid by 2,040.45 FTE (+14.64%)
- Above workforce plan of 15,697.15 FTE by 283.45 FTE (+1.81%)

Sickness – target 4.5%, performance 5.84% (+ 0.1%)

- Top reasons for sickness: anxiety/stress/depression 31.98% (+0.97%); other musculoskeletal problems 10.75% (+1.03%); gastrointestinal problems 10.03% (+0.32%)
- Short-term sickness change in March 2.00% (-0.07%)
- Long term sickness change in March 3.84% (-0.30%)
- Average working days lost is 1,028 (headcount) per day for the reporting period
- Trust wide initiative to look at 'why does absence matter' which is tasked with reducing sickness by 0.5% - lead by Director of Operations for Medicine

Retention & Turnover – target 10%, performance 9.22% (+0.12%)

- Increase of 0.12%
- Top reason for leaving; retirement age at 14.09%
- Top destinations: no employment 47.64%; other NHS organisation 27.28% (includes retire-return)

Mandatory training – target 90%, performance 92.19% (-0.17%)

- Reduction of 0.17%
- Lowest is Medical and Dental 79.17% (-0.71%)
- Task & Finish Group is being commissioned to look at 'process and provision'.

Appraisal – target 90%, performance 85.27% (-0.43%)

- Overdue increased to 2,074
- Senior doctors (consultant and SAS) have had set 1.5 SPA (6 hours a week) in their job plans since job planning began which was designed to cover things including Mandatory Training, and appraisal preparation.

- **Bank & Agency**
- Total annual non-medical bank expenditure £19.2m, +£1.2m vs last year
- Total annual non-medical agency expenditure £2.3m, -£1.1m vs last year
- Total annual medical agency expenditure £3.1m, -£0.6m vs last year

As part of the workforce transformation programme, HR is transitioning to a modern, strategic people services model, with People Business Partners embedded within Clinical Boards to strengthen engagement and delivery.

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

Headline Summary	Jan 2020 FTE	Plan FTE	Establishment	Current FTE	Current FTE v Jan 2020	Current FTE v Plan	Current FTE v Establishment
Total Substantive Staff	13,438.55	15,353.75	16,415.38	15,491.42	2,052.87	137.67	-923.96
Total Bank & Agency Staff	501.60	343.40		489.18	-12.42	145.78	
Total	**13,940.15**	**15,697.15**	**16,415.38**	**15,980.60**	**2,040.45**	**283.45**	**-923.96**

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	10,090.75	10,568.13	10,051.23	1,367.08	-39.52	-516.90
2. Total Non Medical - Non-Clinical Substantive Staff	2,874.99	3,243.09	3,711.29	3,306.96	431.97	63.87	-404.33
3. Total Medical and Dental Substantive Staff	1,732.92	1,968.52	2,124.46	2,118.63	385.71	150.11	-5.83
4. Any other Staff (substantive staff)	146.48	51.40	11.50	14.60	-131.88	-36.80	3.10
5. Bank	441.22	302.42		458.59	17.37	156.17	
6. Agency	60.38	40.98		30.59	-29.79	-10.39	
Total	**13,940.15**	**15,697.15**	**16,415.38**	**15,980.60**	**2,040.45**	**283.45**	**-923.96**

Current Position:

- Workforce is +2,040.45 FTE (+14.64%) above January 2020 (pre-Covid) position.
- Substantive workforce target at 31st March is 15,352.45 FTE.
- Substantive workforce actual position at 31st March is 15,492.98 FTE.
- Substantive workforce is currently +140.53 FTE above plan for March.
  (see slide 3, top row, middle graph)
- NHS infrastructure support (substantive) is 63.87 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

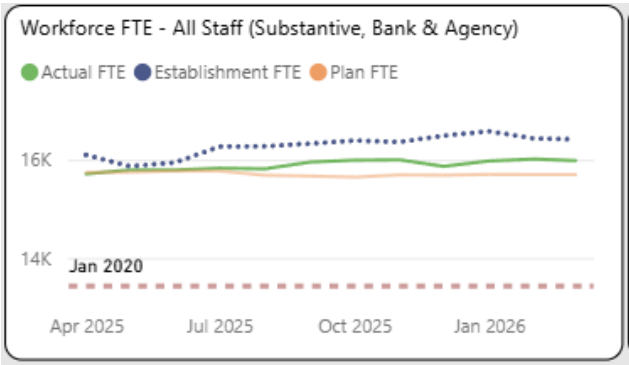
Underlying Issues

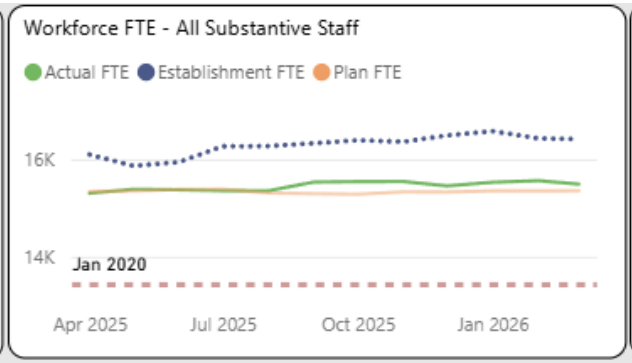
- Bank use due to switching requirements for additional hours from overtime to Bank which is more cost effective.
- Need to maintain safe services (e.g. healthcare assistants for enhanced care). Greater use being made of Bank options to reduce spend on agency.
- Practice of rostering staff may not be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

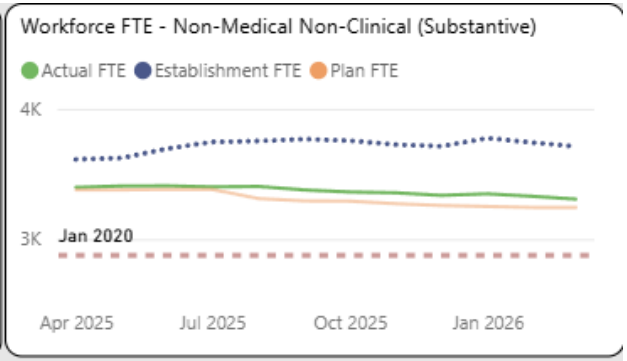
Actions Undertaken:

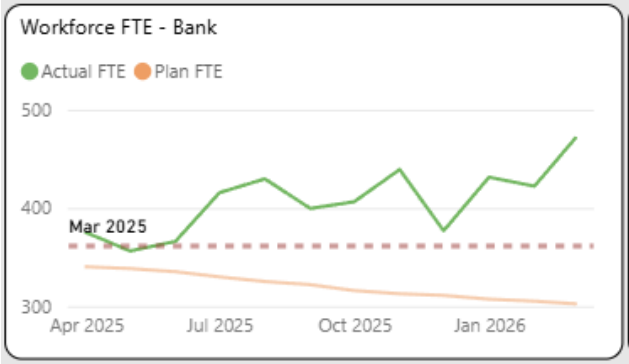
- A mutually agreed resignation scheme was offered to all staff between during October and November 2025. Applications were decided by the Chief Executive and outcomes notified to staff in December. All successful staff have now left the organisation.
- Workforce Reduction Group (WROG) continues to meet bi-weekly, safeguarding the integrity of workforce controls to ultimately support a reduction in organisational headcount. The group functions as a 'gatekeeper' for specific workforce requests i.e. MARS skill mix and external advertising, ensuring all exceptions meet agreed upon criteria.
- To support the shift from overtime to Bank, around 1200 substantive staff have been fast-tracked as additions to the Bank.

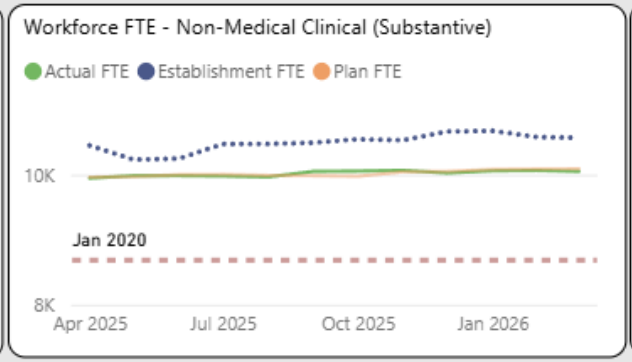
PWR – in-year overview position

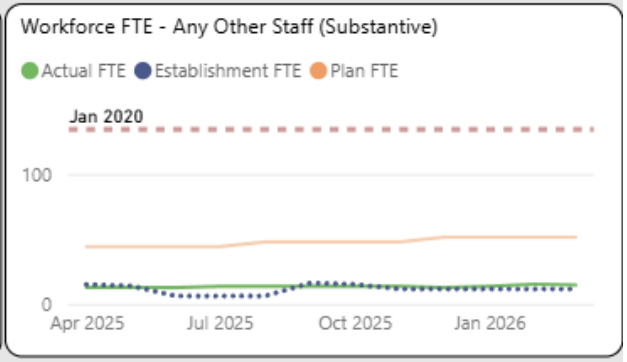


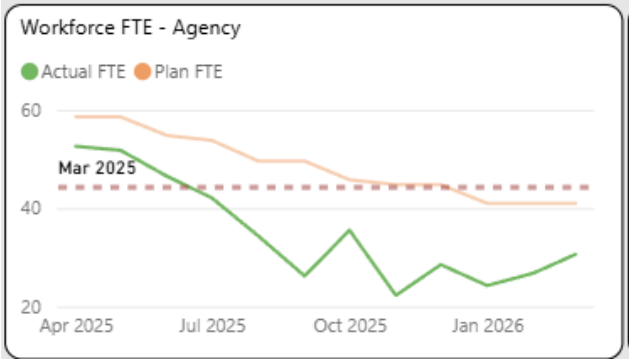


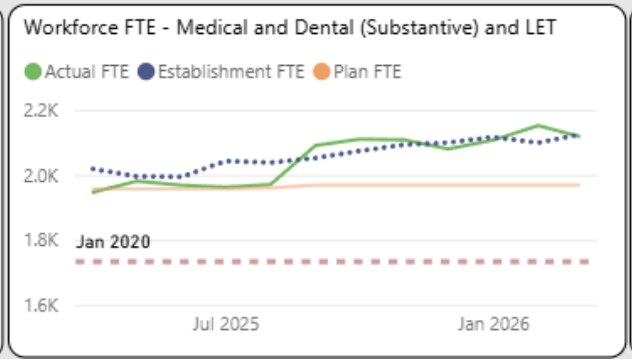


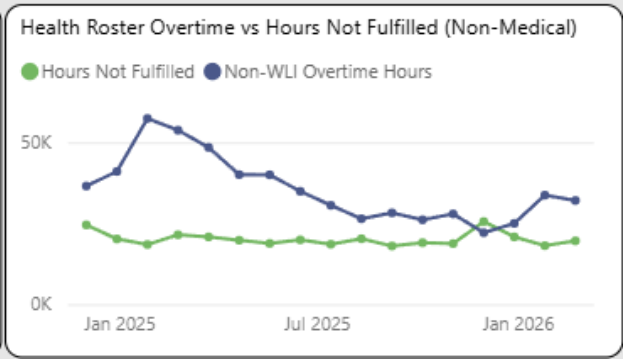










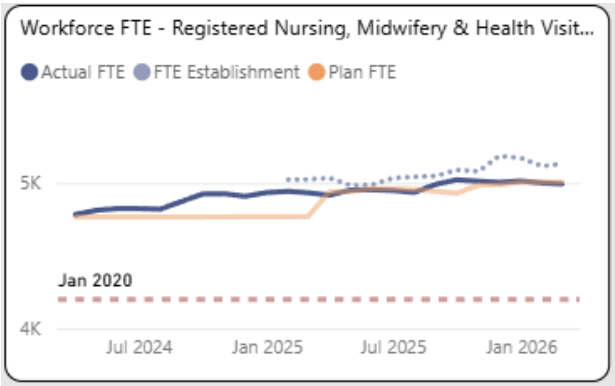


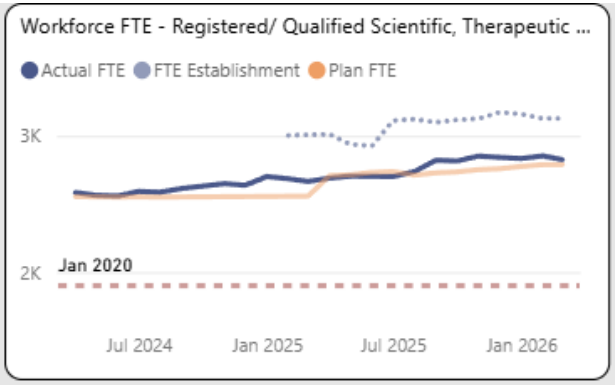
**Please note: The charts on this page include LET data

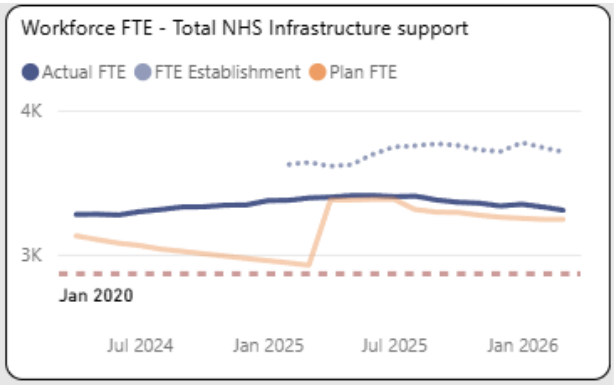
PWR – staff group overview as-at March 2026

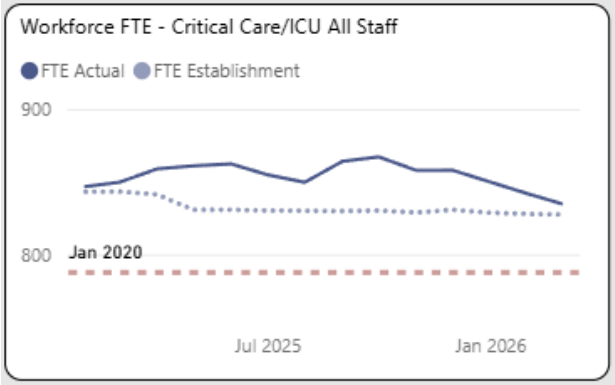
Sub Categories Metric	Jan 2020 FTE	Plan FTE	Establishment	Current FTE	Current FTE v Jan 2020	Current FTE v Plan	Current FTE v Establishment
1. Registered Nursing, Midwifery and Health visiting staff (substantive total)	4,202.08	5,005.17	5,131.58	4,993.07	791.00	-12.10	-138.51
2. Registered/ Qualified Scientific, Therapeutic and Technical Staff (substantive total)	1,993.02	2,394.28	2,564.10	2,412.34	419.32	18.06	-151.76
3. Support to Clinical staff (substantive total)	2,489.06	2,691.29	2,872.45	2,645.82	156.76	-45.47	-226.63
4. Total NHS Infrastructure Support (includes A&C, estates, managers) (substantive total)	2,874.99	3,243.09	3,711.29	3,306.96	431.97	63.87	-404.33
5. Total Medical and Dental (substantive total)	1,732.92	1,968.52	2,124.46	2,118.63	385.71	150.11	-5.83
6. Any other Staff (substantive total)	146.48	51.40	11.50	14.60	-131.88	-36.80	3.10
7. Bank Any other staff	0.00	0.00			0.00	0.00	
7. Bank Medical and dental	11.75	15.48		47.44	35.69	31.96	
7. Bank Registered nursing, midwifery and health visiting staff	111.27	78.18		142.84	31.57	64.66	
7. Bank Registered/ Qualified Scientific, Therapeutic and Technical staff	16.41	11.48		10.48	-5.93	-1.00	
7. Bank Support to clinical staff	258.10	174.43		239.40	-18.70	64.98	
7. Bank Total NHS infrastructure support	43.69	22.85		18.41	-25.28	-4.44	
8. Agency Any other staff	0.00	0.00			0.00	0.00	
8. Agency Medical and dental	0.87	6.79		2.68	1.81	-4.11	
8. Agency Registered nursing, midwifery and health visiting staff	2.86	3.53		4.48	1.62	0.95	
8. Agency Registered scientific, therapeutic and technical staff	17.27	4.16		1.66	-15.61	-2.50	
8. Agency Support to clinical staff	23.68	25.50		21.78	-1.90	-3.72	
8. Agency Total NHS infrastructure support	15.70	1.00			-15.70	-1.00	
Total	**13,940.15**	**15,697.15**	**16,415.38**	**15,980.60**	**2,040.45**	**283.45**	**-923.96**

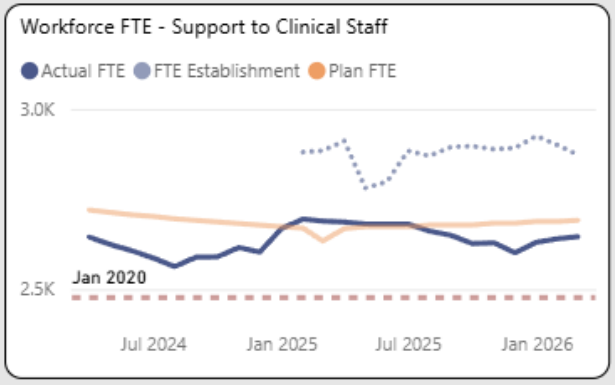
PWR – staff group overview in-year position

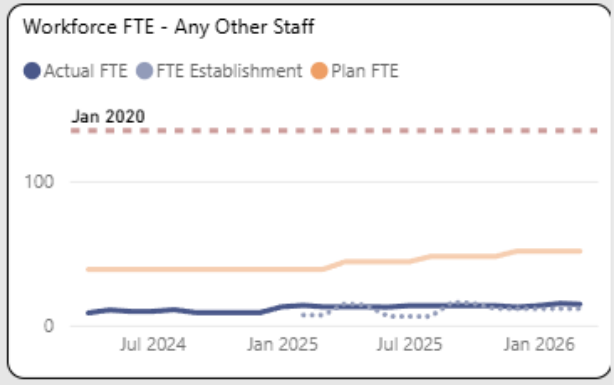


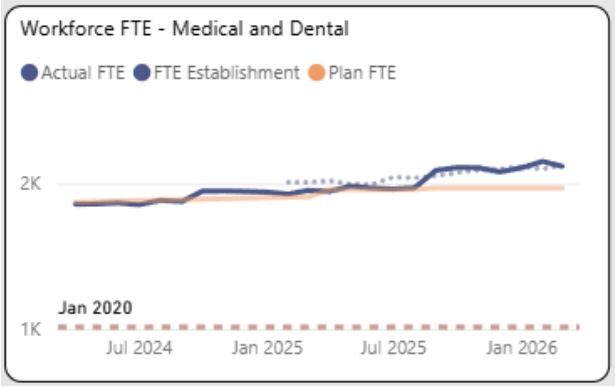










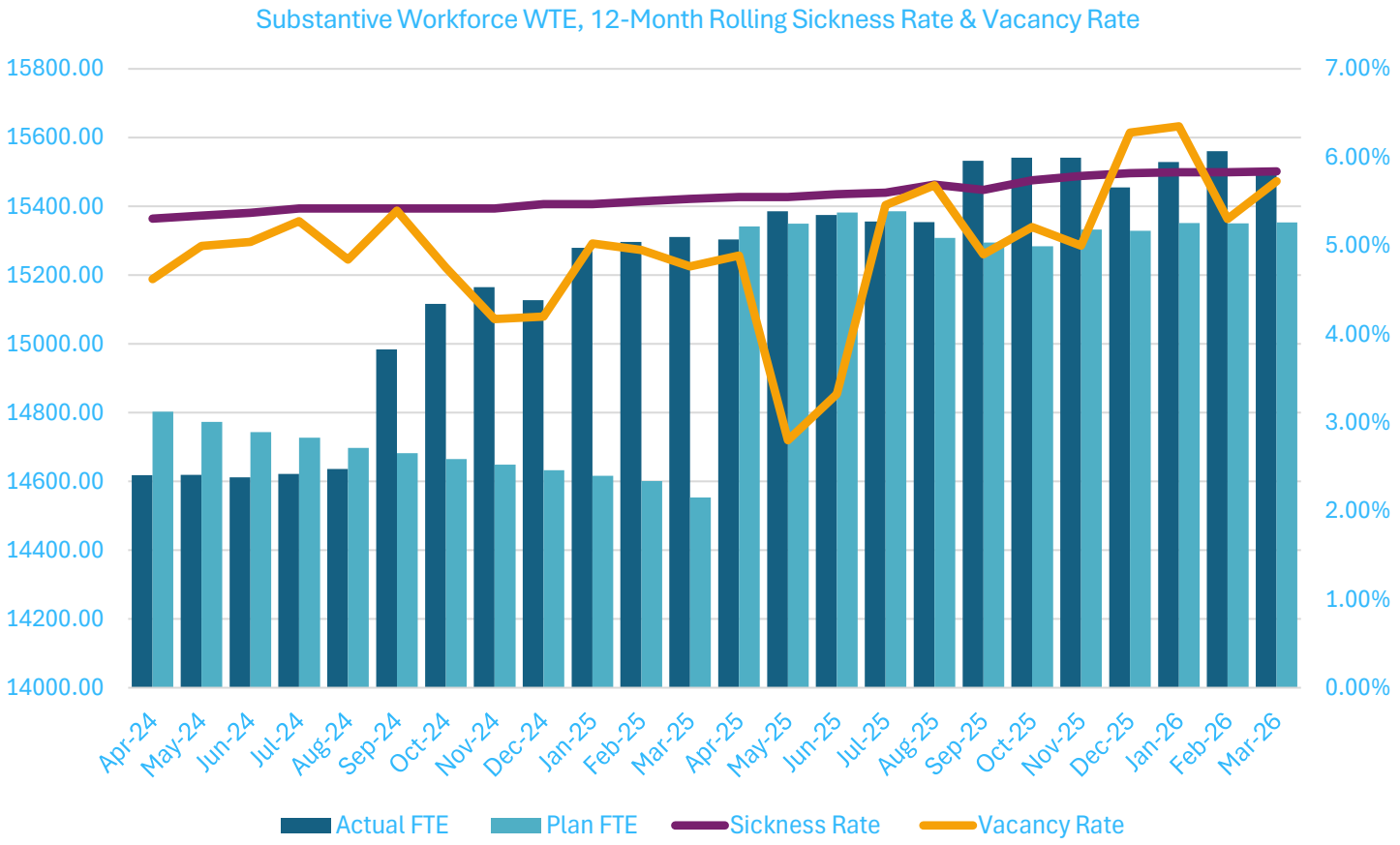


**Please note: The charts on this page include LET data

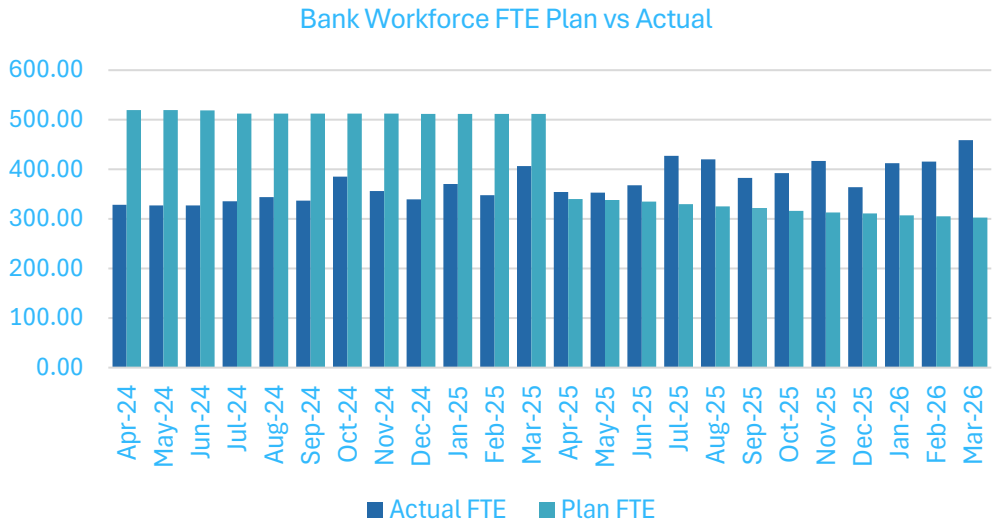
Vacancies

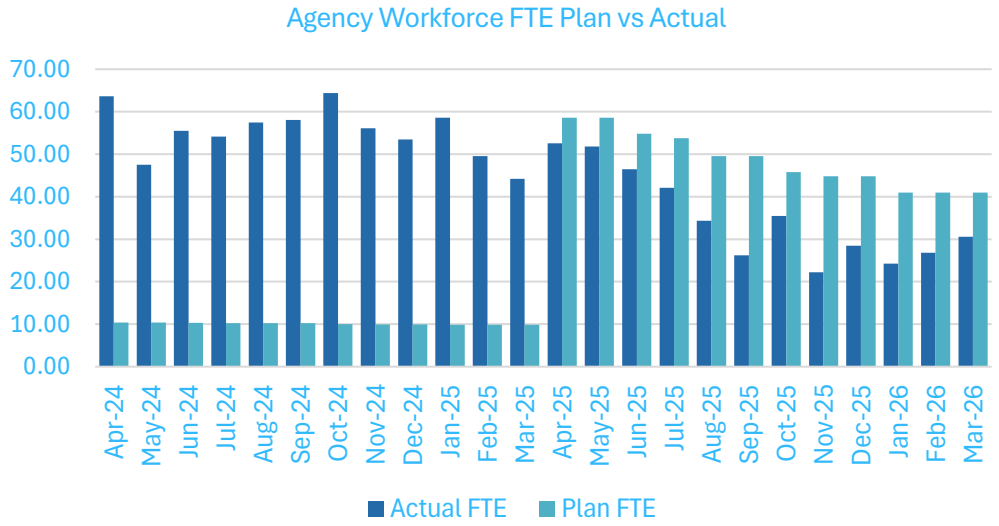
Summary Group	FTE Establishment	Actual FTE	Vacancy FTE	Vacancy FTE %
1. Total Non Medical - Clinical Substantive Staff	10568.13	10052.19	515.94	4.88%
2. Total Non Medical - Non-Clinical Substantive Staff	3711.29	3305.96	405.33	10.92%
3. Medical and Dental	2124.46	2102.73	21.73	1.02%
5. Other	11.50	14.60	-3.10	-26.96%
Total	**16415.38**	**15475.48**	**939.90**	**5.73%**

Substantive Workforce



Bank and Agency Workforce



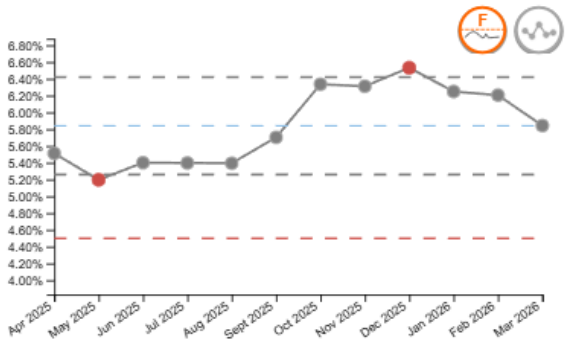


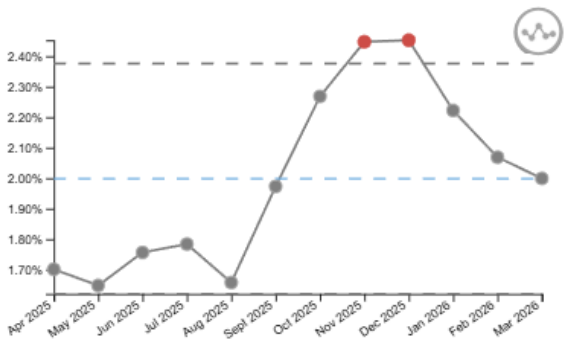
Sickness absence – 12-month average

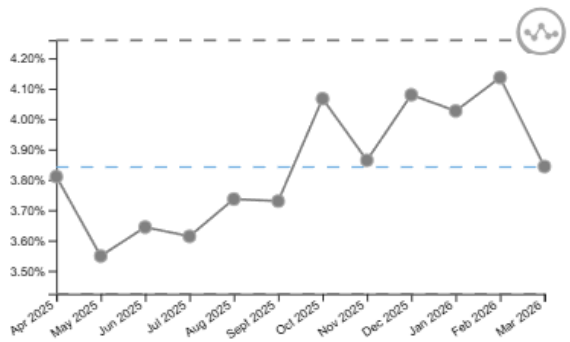
Trust Sickness %	12-Month Rolling	Value	Target
	Mar 26	5.84%	4.50%

Metric	Value
Short Term Sickness %	2.00%

Metric	Value
Long Term Sickness %	3.84%







Current Position:

- Top reasons for sickness:
  - Anxiety/stress/depression (S10) 31.98%
  - Other musculoskeletal problems (S12) 10.75%
  - Gastrointestinal problems (S25) 10.03%
- The 12-month rolling absence rate of 5.84% and the sick pay cost of £35.6m are significantly above the target of 5% and £25m respectively.
- Marked increase in short-term sickness.

Underlying Issues

- Anxiety/stress/depression (S10) is main reason for sickness absence. Some is work-related and some is due to issues outside of work.
- Total days lost: 315,145.13 FTE.
- Average time lost per person: 21 days.
- Total cost of sick pay: £35.6m.
- Variation in sickness rates across Clinical Boards:
  - Lowest – Clinical and Diagnostic Services at 4.40% (short-term 1.61%, long term 2.98%)
  - Highest – Peri-operative and Critical Care at 6.57% (short-term 2.48%, long term 4.53%)

Actions Undertaken:

- 'Why absence matters' is a Trustwide program focusing on supporting line managers to manage sickness absence. The development of a new sickness infographic allows for key metrics to be triangulated, there will be a 3 phased approach with sickness metrics being phase 1. The infographic information will also be shared Trustwide via the Intranet monthly from May 2026.
- 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. 152 colleagues trained as of 31 March 2026. 2 Scaffolding sessions taken place and support resources under development.

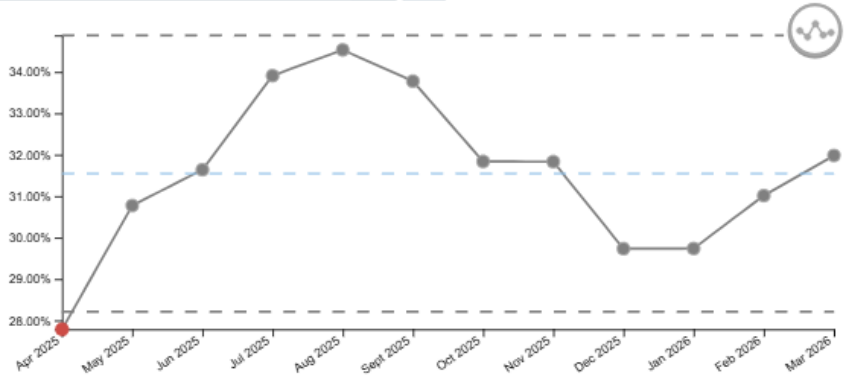
Sickness absence – top absence reasons

Trust Sickness %	12-Month Rolling	Value	Target
	Mar 26	5.84%	4.50%

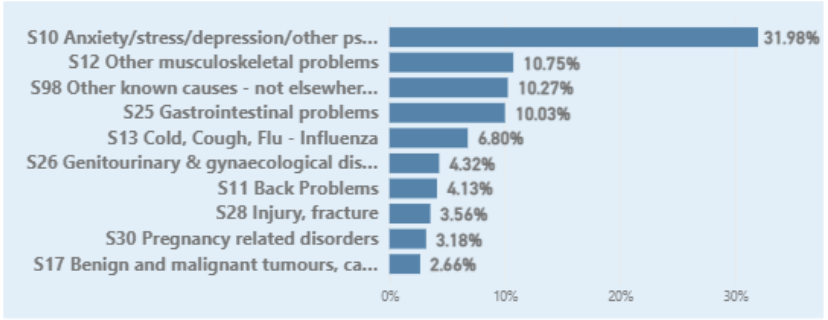
Sickness Reasons - SPC

S10 - Anxiety/stress/depression/ other psychiatric illness

31.98%

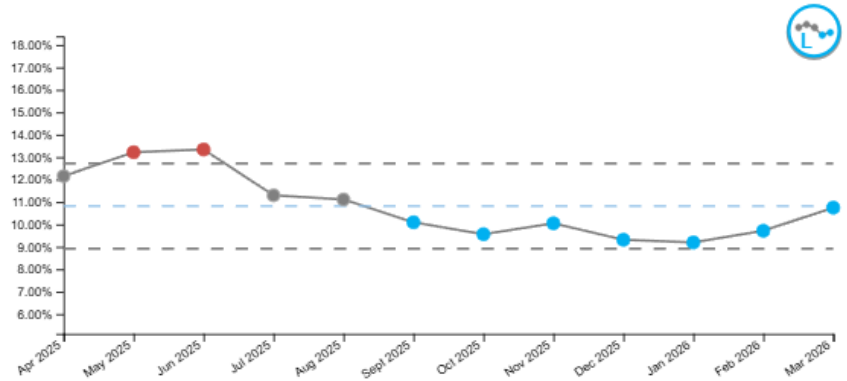


Top 10 Sickness Abscences



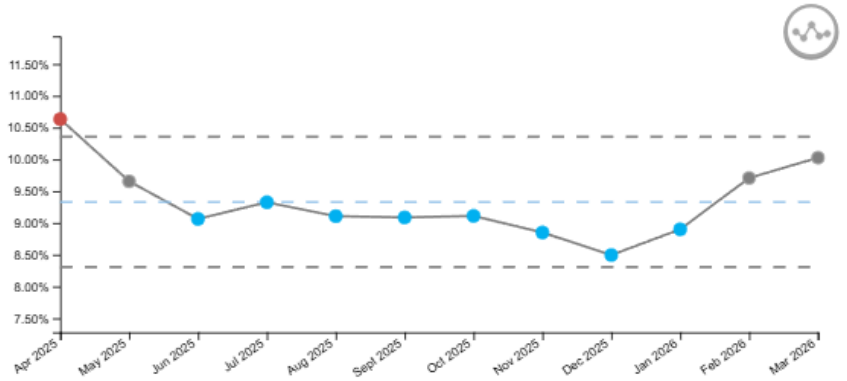
S12 - Other musculoskeletal problems

10.75%

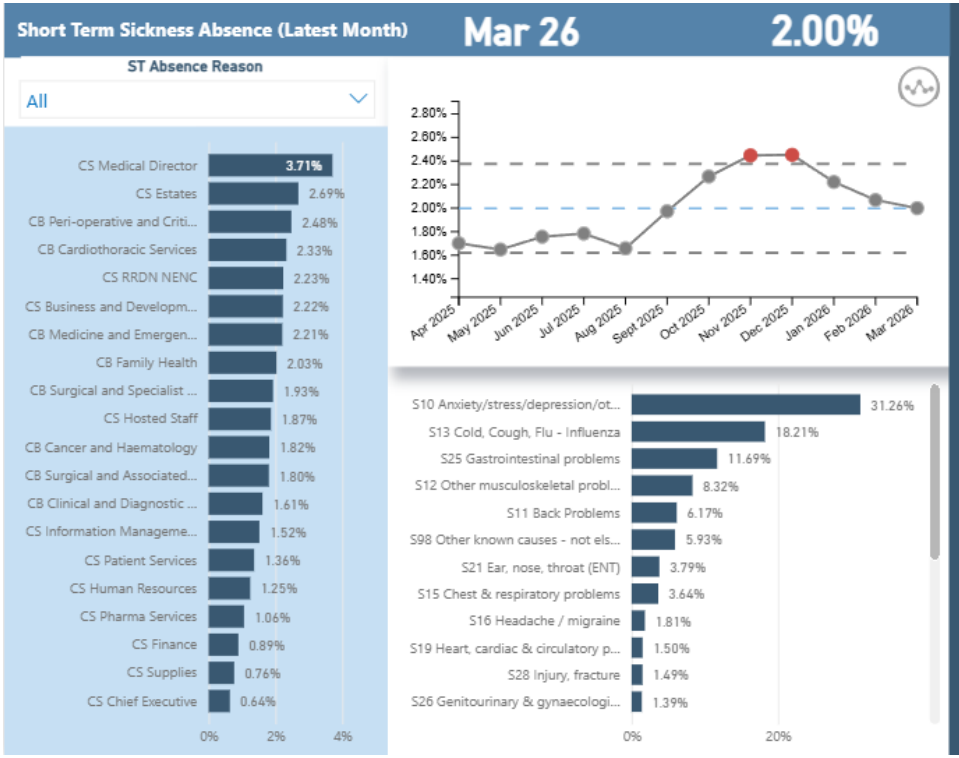


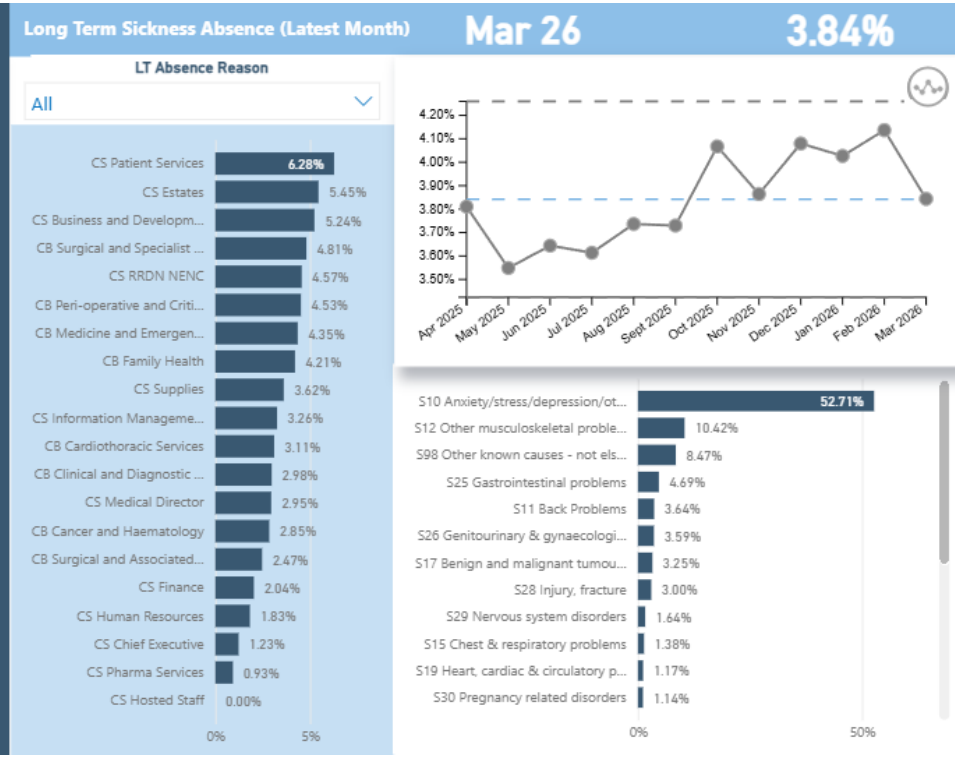
S25 - Gastrointestinal problems

10.03%



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





Sickness – FTE working days lost & formal action activity

Sickness - FTE working days lost

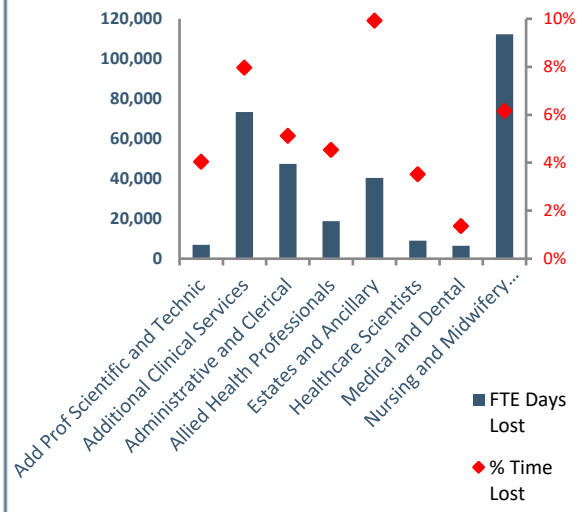
FTE working days lost due to sickness

315,145

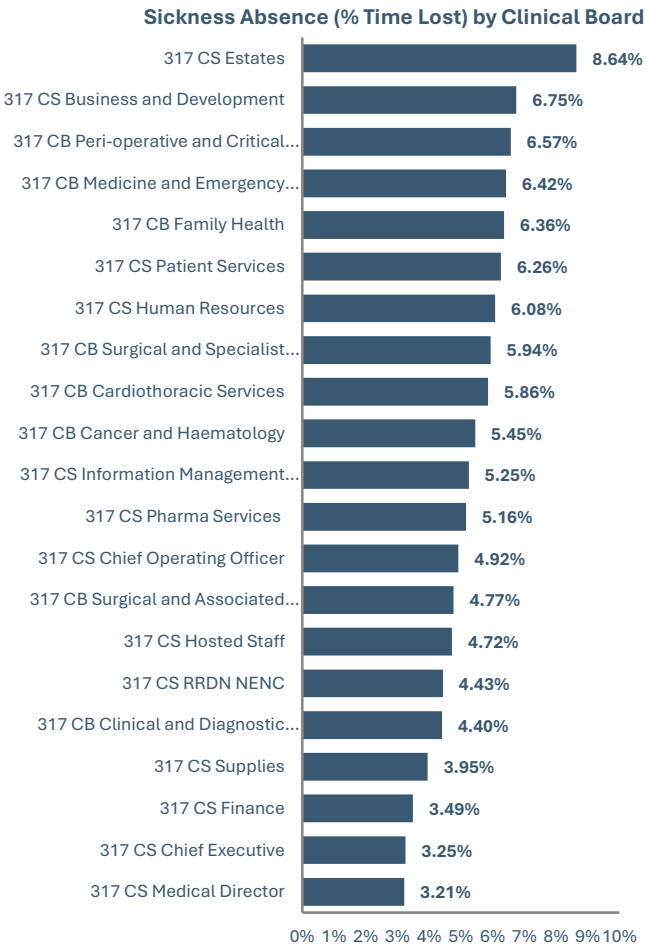
291,130

compared to the previous year.

Sickness Absence by Staff Group



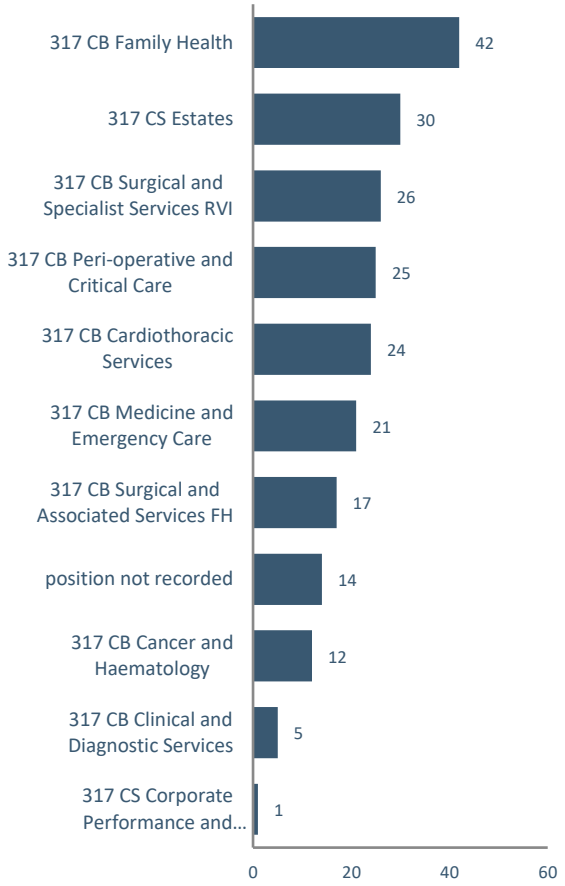
Sickness Absence (% Time Lost) by Clinical Board



Sickness - Formal Action

Latest Data - March 2026

Attendance Management – Formal Action by Clinical Board/ Corporate Service

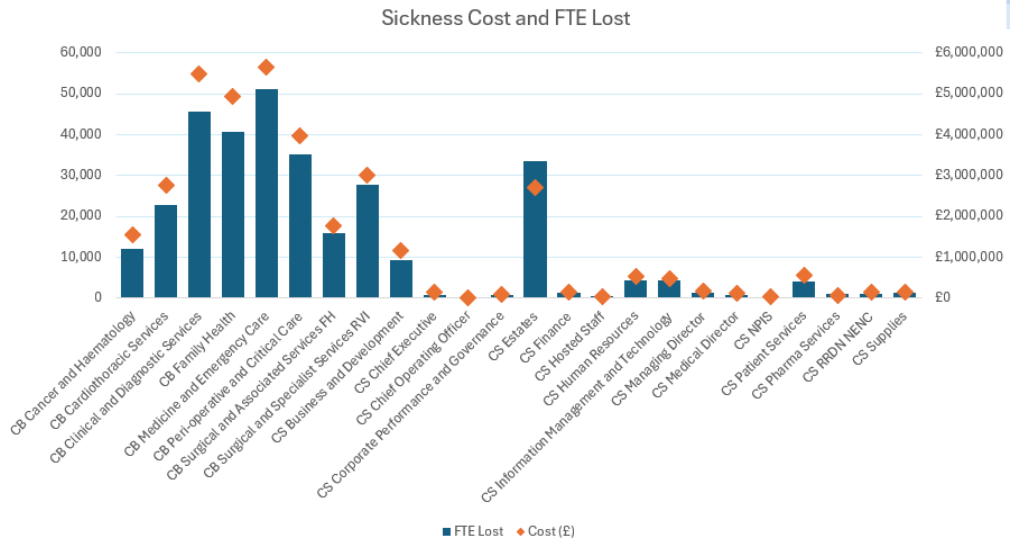


Sickness – FTE working days lost & cost of sick pay

Sickness Absence	12-Month period ending	Cost (£)	FTE Lost	Ave. No of Days Lost per FTE
	Mar 26	£35,618,622	315,145.13	21.30

Clinical Board	Cost (£)	FTE Lost	Ave. No of days lost per FTE
CB Cancer and Haematology	1,557,532	11,971.20	20.00
CB Cardiothoracic Services	2,763,879	22,673.98	21.49
CB Clinical and Diagnostic Services	5,492,223	45,541.83	16.15
CB Family Health	4,932,219	40,795.54	23.01
CB Medicine and Emergency Care	5,640,618	50,988.03	23.36
CB Peri-operative and Critical Care	3,979,975	35,087.96	24.10
CB Surgical and Associated Services FH	1,759,684	15,813.00	17.39
CB Surgical and Specialist Services RVI	3,004,046	27,659.82	21.80

Clinical Board	Cost (£)	FTE Lost	Ave. No of days lost per FTE
CS Business and Development	1,161,699	9,377.83	23.77
CS Chief Executive	144,327	878.43	11.94
CS Chief Operating Officer	0	0.00	0.00
CS Corporate Performance and Governance	95,697	755.12	9.03
CS Estates	2,716,515	33,408.21	31.39
CS Finance	153,409	1,438.33	12.68
CS Hosted Staff	29,741	532.60	16.52
CS Human Resources	521,352	4,424.09	22.20
CS Information Management and Technology	483,141	4,381.64	19.12
CS Managing Director	159,048	1,291.60	16.42
CS Medical Director	104,519	626.12	11.39
CS NPIS	30,406	176.60	8.91
CS Patient Services	565,752	4,031.11	22.34
CS Pharma Services	58,812	1,048.62	18.94
CS RRDN NENC	132,782	954.33	16.07
CS Supplies	131,247	1,289.13	13.82



Sickness – Average working days lost per day

April 2025 to March 2026	Average Working Days Lost per Day*
	1,028

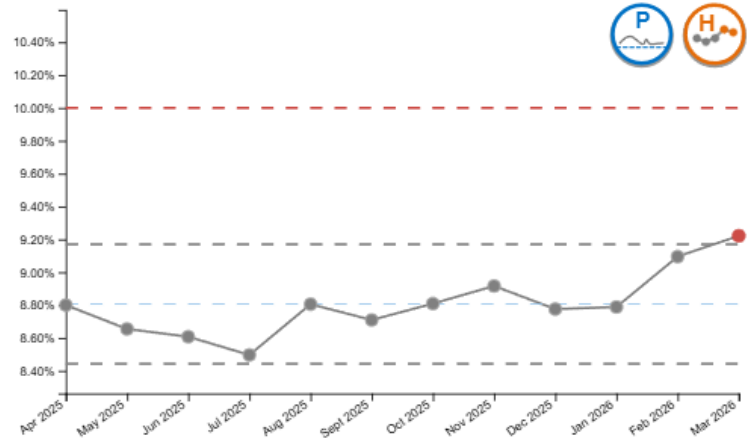
Month	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26	Oct 26	Nov 26	Dec 26
Average Working Days Lost per Day*	1,101	1,092	1,023									

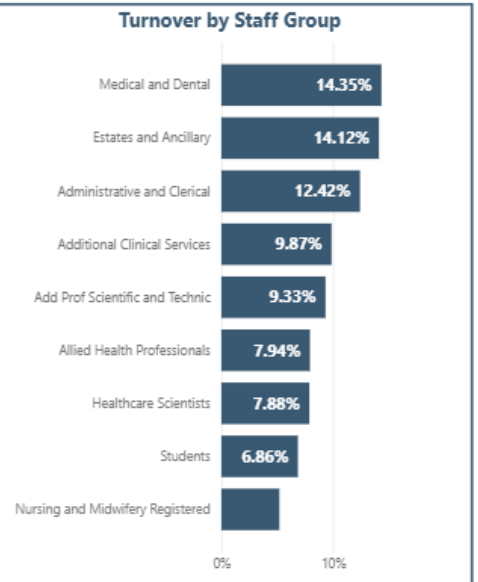
Rolling 12-month daily average

*Headcount

Turnover

Trust Turnover %	12-Month Rolling	Value	Target
	Mar 26	9.22%	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.	• 1,569 leavers in 12-months to March 2026: 21% Administrative and Clerical (337); 19% Additional Clinical Services (293) • Top destinations – no employment (747, 48%); other NHS organisation (427, 27%). • Top reasons – retirement age (218, 14%); work-life balance (209, 14%); mutually agreed resignation (172, 11%)	• Flexible working. Supported and encouraged across the Trust. With consistently 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

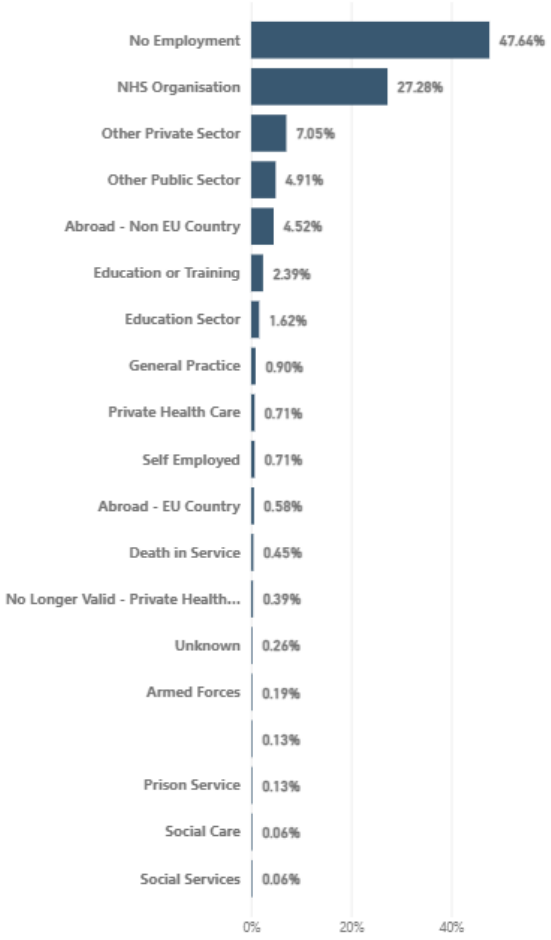
Trust Turnover %	12-Month Rolling	Value	Target
	Mar 26	9.22%	10.00%

Leaving Reasons

Leaving Reasons

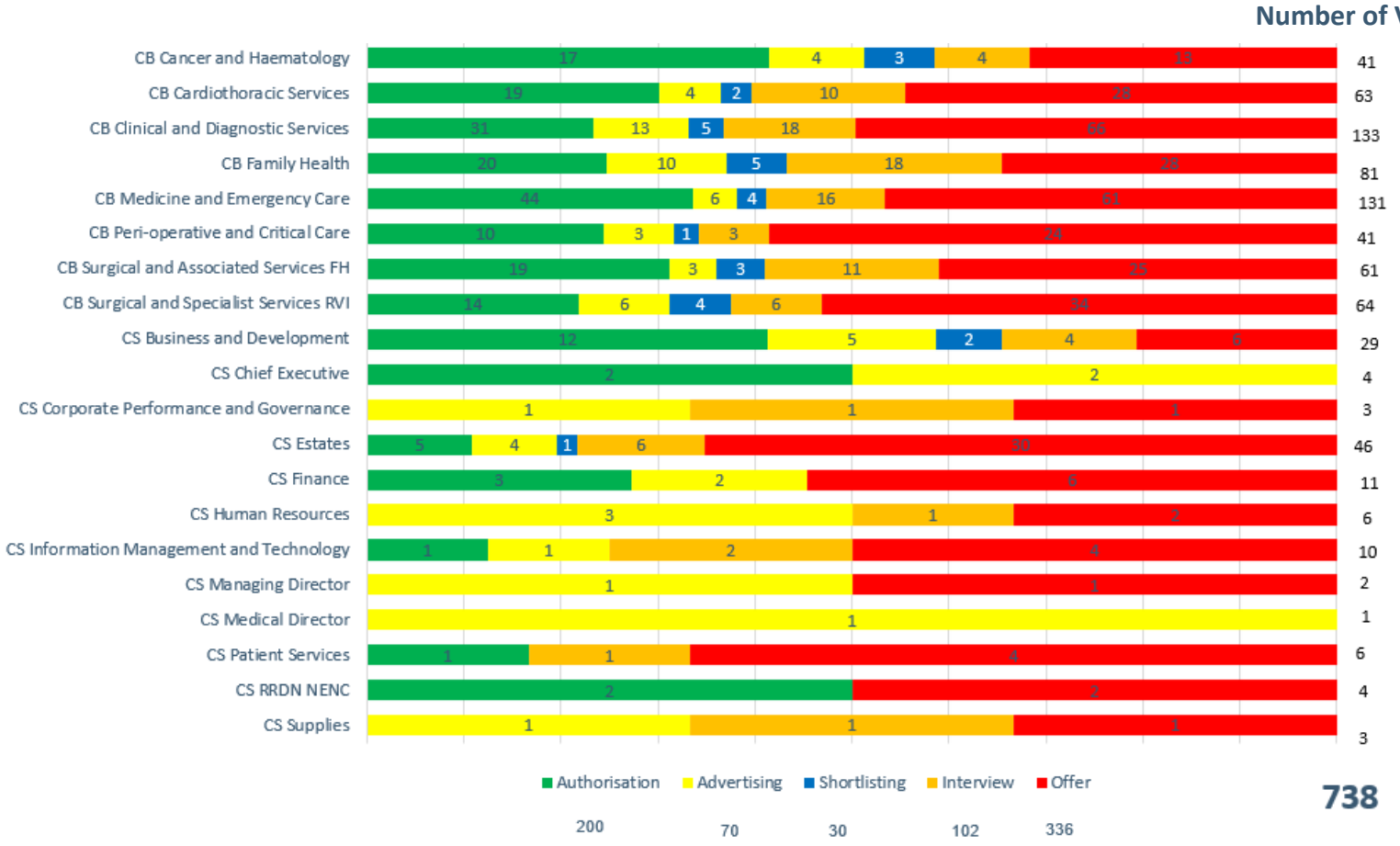
Leaving Reason	Leaving Reason %
Retirement Age	14.09%
Voluntary Resignation - Work Life Balance	13.51%
Mutually Agreed Resignation - Local Scheme with Repayment	11.12%
Voluntary Resignation - Relocation	10.99%
Voluntary Resignation - Promotion	8.73%
End of Fixed Term Contract	7.89%
Flexi Retirement	6.21%
Voluntary Resignation - Health	6.01%
Voluntary Resignation - To undertake further education or training	3.62%
Voluntary Resignation - Incompatible Working Relationships	2.91%
Dismissal - Capability	2.26%
Voluntary Resignation - Lack of Opportunities	2.26%
End of Fixed Term Contract - Completion of Training Scheme	1.87%
Voluntary resignation - Pay and Reward Related	1.36%
End of Fixed Term Contract - Other	1.29%
Voluntary Resignation - Child Dependants	0.97%
Voluntary Early Retirement - with Actuarial Reduction	0.78%
Voluntary Resignation - Other/Not Known	0.78%
Voluntary Early Retirement - no Actuarial Reduction	0.65%
Retirement - Ill Health	0.58%
Death in Service	0.45%
Dismissal - Conduct	0.45%
Voluntary Resignation - Adult Dependants	0.39%
End of Fixed Term Contract - External Rotation	0.32%
Dismissal - Statutory Reason	0.26%
End of Fixed Term Contract - End of Work Requirement	0.26%

Destination on Leaving



Destination On Leaving	Destination On Leaving %
No Employment	47.64%
NHS Organisation	27.28%
Other Private Sector	7.05%
Other Public Sector	4.91%
Abroad - Non EU Country	4.52%
Education or Training	2.39%
Education Sector	1.62%
General Practice	0.90%
Private Health Care	0.71%
Self Employed	0.71%
Abroad - EU Country	0.58%
Death in Service	0.45%
No Longer Valid - Private Health/Social Care	0.39%
Unknown	0.26%
Armed Forces	0.19%
	0.13%
Prison Service	0.13%
Social Care	0.06%
Social Services	0.06%

Recruitment - Vacancies in progress by stage – 27 April 2026

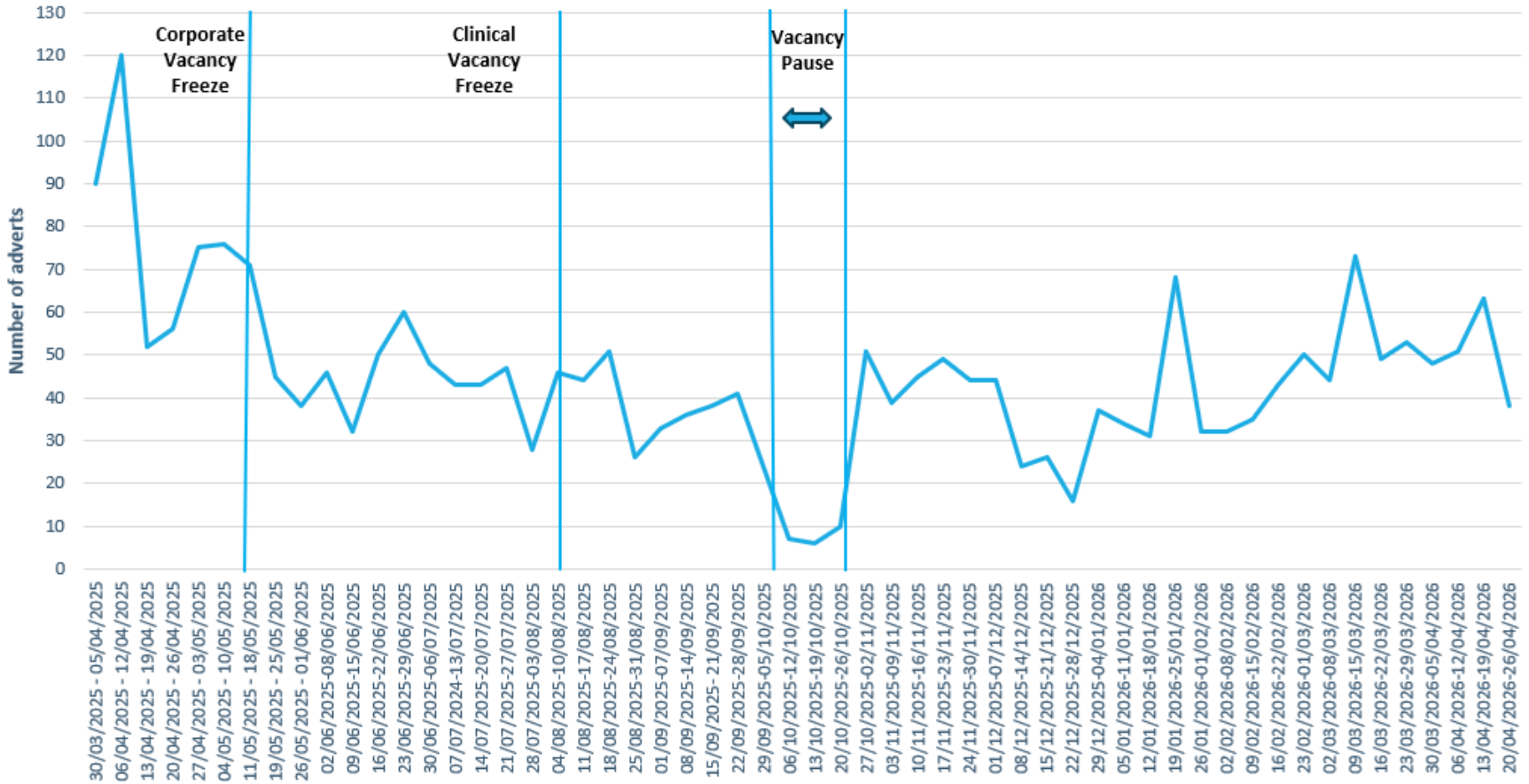


The chart illustrates that as of 27 April 2026, there were 738 adverts/vacancies progressing through the recruitment process—an increase of 33 compared to the previous period. The largest proportion of vacancies were at the conditional offer stage (45%). Following the end of the temporary recruitment pause on 22 October 2025, there has been an increase in positions at the authorisation granted stage, which have progressed to advertising. The numbers in the recruitment process are increasing.

Recruitment - Vacancies in progress by stage

Total adverts w/e 26/04/2026 **38**

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 **1916**

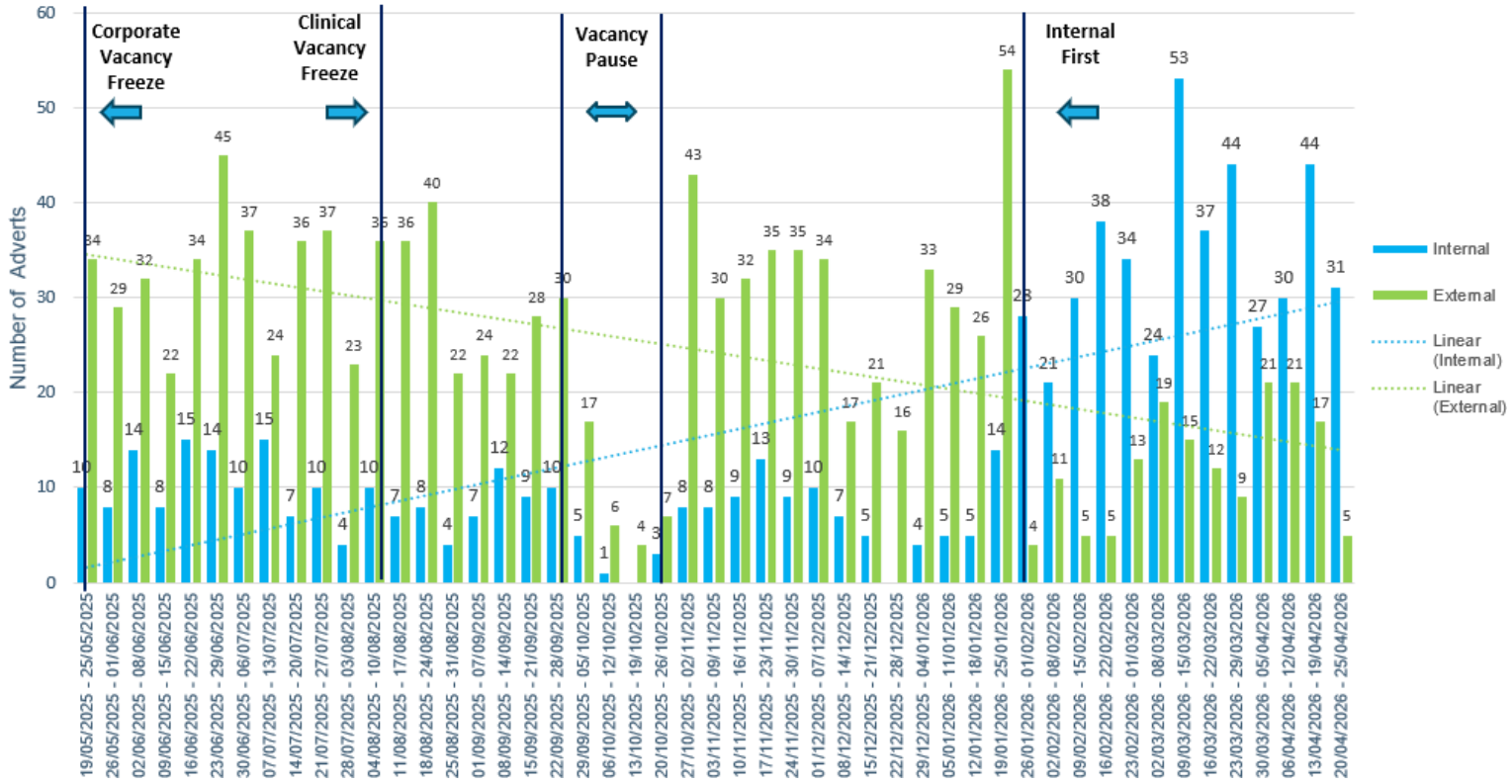


This graph shows a decline in the number of vacancies advertised during the recruitment pause and freezes. There has been increases in January and March 2026 and has decreased for April 2026. Overall, there are fewer adverts compared to the same period in 2025.

Recruitment – Adverts Overview – Internal v External Advertising

Total adverts w/e 26/04/2026 **38**

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 and internal first on 26/01/2026 **1916**

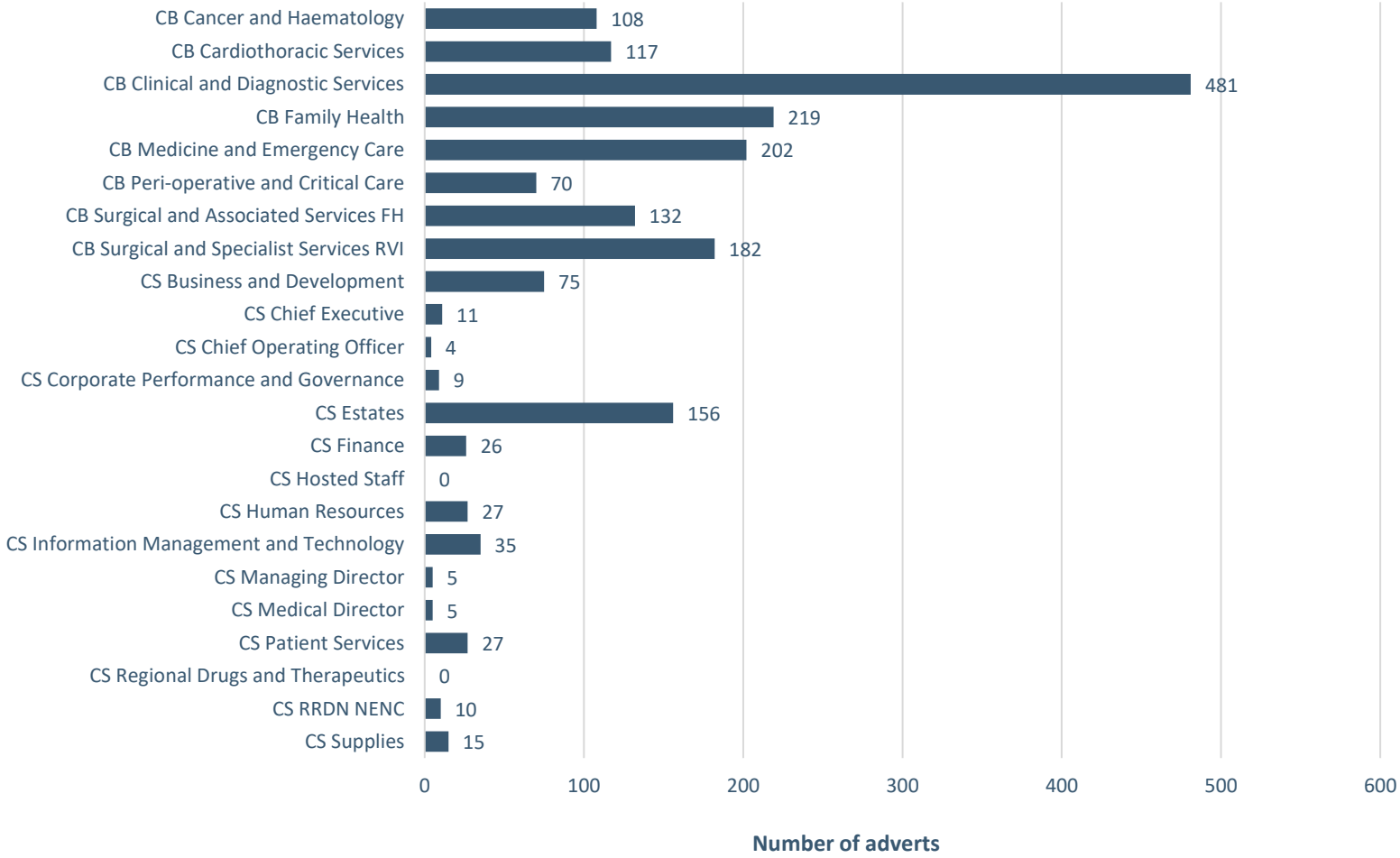


The above chart demonstrates that the majority of adverts were advertised external to the Trust prior to 26/01/2026 when the decision was made to advertise vacancies internal first with an exception process for external advertising. On 20 April 2026, 66% of candidates that were at conditional offer stage were external and 34% internal which is a slight change as of 31 March 2026 when it was 65% external and 35% internal.

There is a slight increase in the number of internal candidates being offer posts compared with the previous month which can be attributed to the internal first advertising process. 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

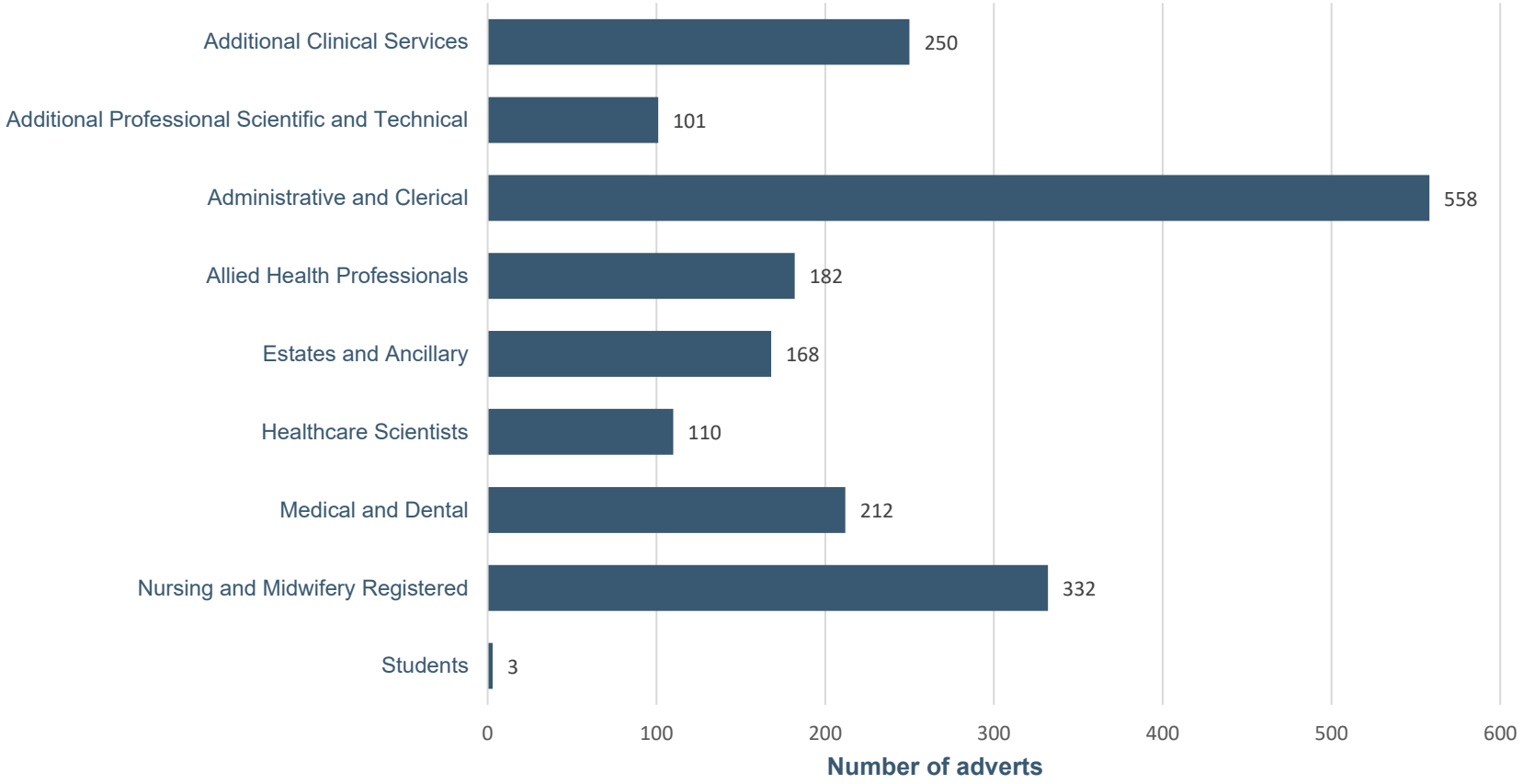


There has been 1916 adverts since 14/05/2026. The highest number of adverts has been for Clinical and Diagnostic Services. However, this should be considered in proportion to the size of the Clinical Board.

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

1,916



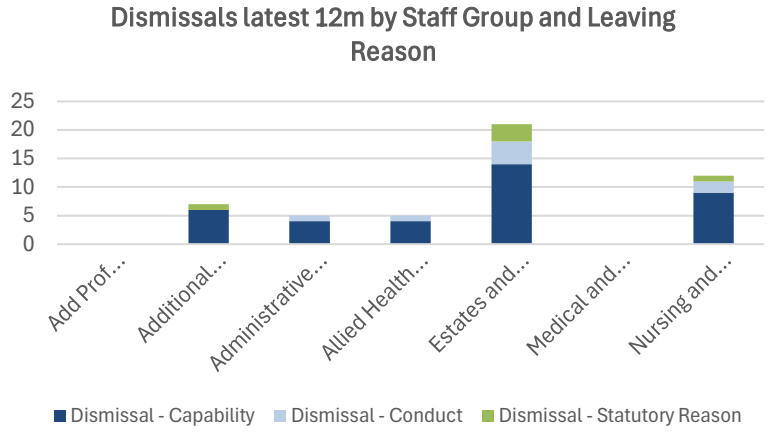
There has been 1916 adverts since 14/05/2026. The largest volume of adverts since 14 May 2025 has been in Administrative and Clerical roles, followed by Nursing and Midwifery, with the lowest numbers in Healthcare Scientist positions with the exception of students.

Dismissals – 12 month rolling period ending March 2026

Dismissals	12-Month period ending	Dismissals Headcount	Dismissals FTE
	Mar 26	50	34.63

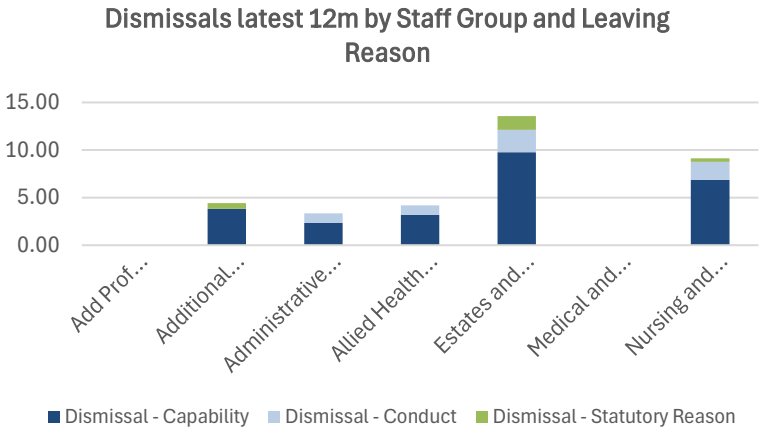
Headcount

Staff Group	Dismissal - Capability	Dismissal - Conduct	Dismissal - Statutory Reason	Total
Add Prof Scientific and Technic				
Additional Clinical Services	6		1	7
Administrative and Clerical	4	1		5
Allied Health Professionals	4	1		5
Estates and Ancillary	14	4	3	21
Medical and Dental				
Nursing and Midwifery Registered	9	2	1	12
Grand Total	37	8	5	50



FTE

Staff Group	Dismissal - Capability	Dismissal - Conduct	Dismissal - Statutory Reason	Total
Add Prof Scientific and Technic				
Additional Clinical Services	3.83		0.60	4.43
Administrative and Clerical	2.34	1.00		3.34
Allied Health Professionals	3.17	1.00		4.17
Estates and Ancillary	9.77	2.35	1.47	13.58
Medical and Dental				
Nursing and Midwifery Registered	6.86	1.91	0.35	9.11
Grand Total	25.97	6.25	2.41	34.63



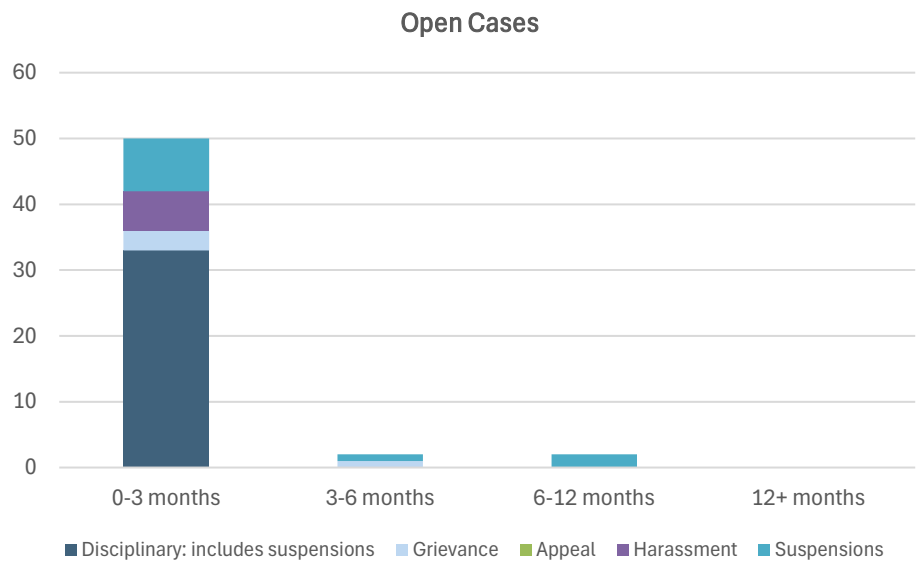
Employee Relations - Open Cases

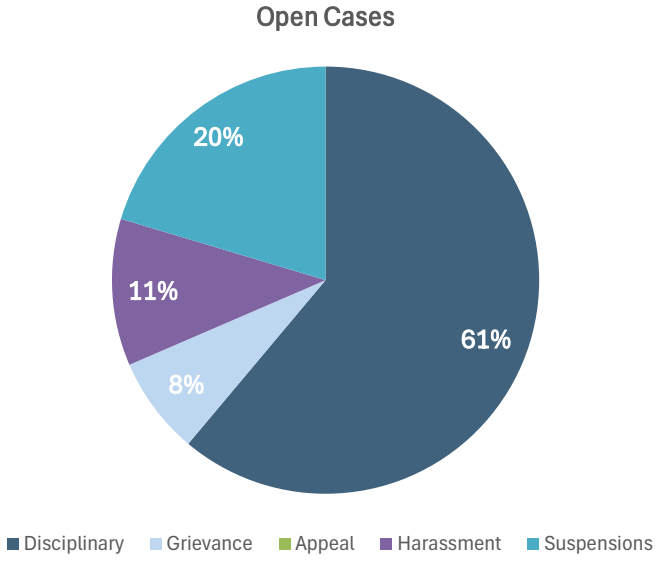
Open Cases	Latest Month	Total Open Cases
	Mar 26	43

Case Type	0-3 months	3-6 months	6-12 months	12+ months	Total
Disciplinary: includes suspensions	33	0	0	0	33
Grievance	3	1	0	0	4
Appeal	0	0	0	0	0
Harassment	6	0	0	0	6
Grand Total	42	1	0	0	43

There are currently 43 open employee relations cases, of 33 are disciplinary (of which 8 suspensions), 6 harassment and 4 grievance.

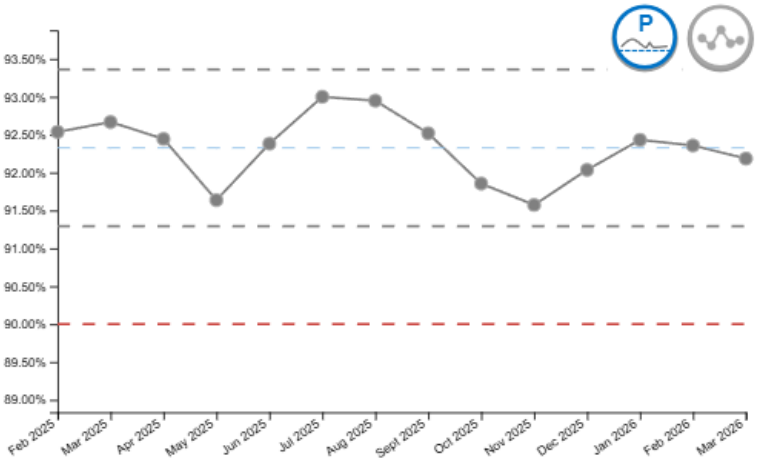
8 of the 46 (17.39%) have been raised since January 2026.

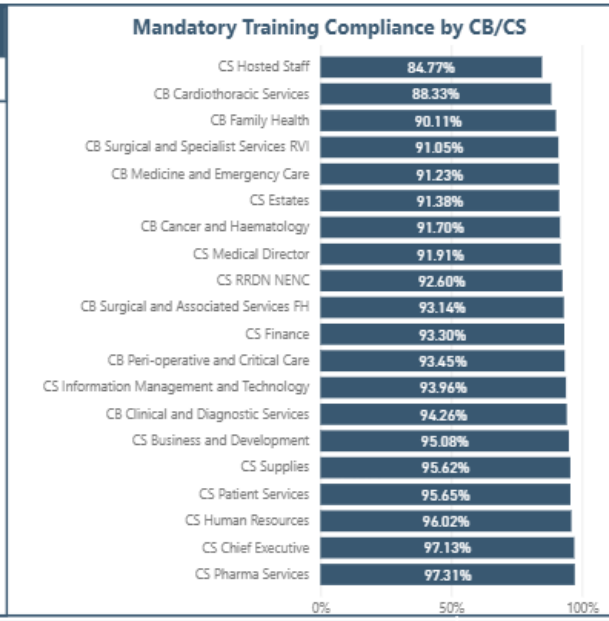


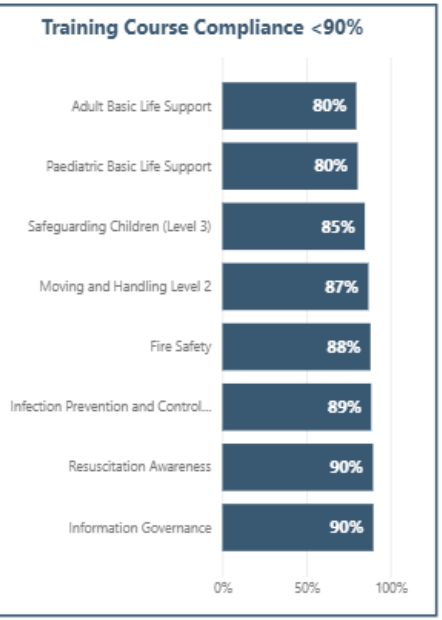


Mandatory training

Mandatory Training Compliance	Month	Value	Target
	Mar 26	92.19%	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 CQC-registered providers.

Underlying Issues

- Medical and Dental – have lowest overall compliance (79.17%) with low compliance in Adult Basic Life Support (63.29%); Safeguarding Children - Level 3 (66.40%); Fire Safety (66.67%).
- Face-to-face training can take more time away from work compared to online.
- Performance looked at as part of Well-led domain.
- Quality Improvement (QI) approach to improve resus compliance had limited impact.
- Oliver McGowan. Trust expected to show CQC how it has met legal requirements.

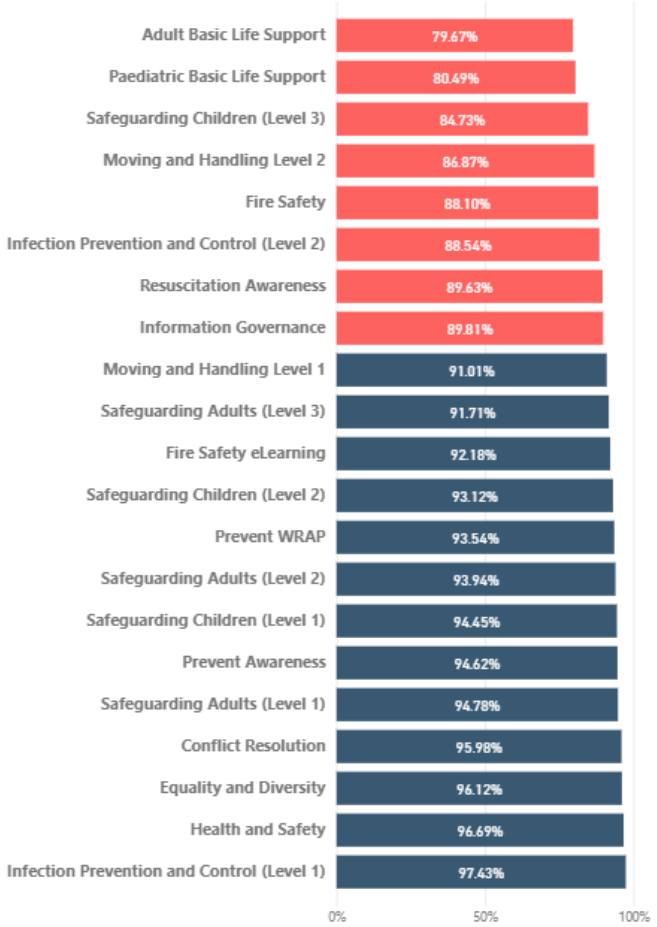
Actions Undertaken:

- Task & Finish Group is being established to look at 'process and provision'.
- Clinical Board (CB) Surgical and Specialist Services are establishing a 2-day bespoke drop-in session for learning lab.
- 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.

Mandatory training

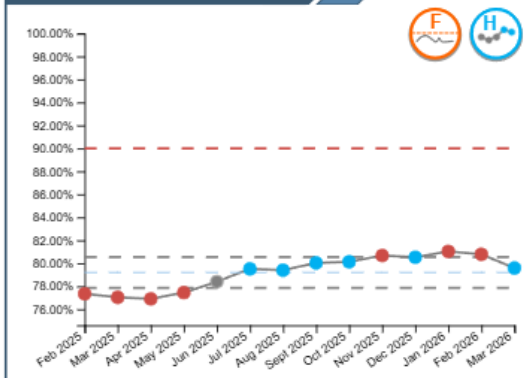
Mandatory Training Compliance	Month	Value	Target
	Mar 26	92.19%	90.00%

Training Course Compliance %

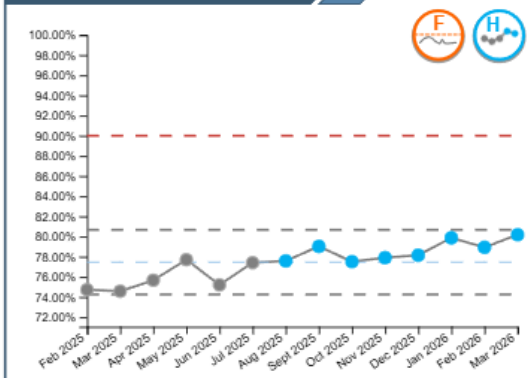


Lowest 4 Mandatory Training Compliance %

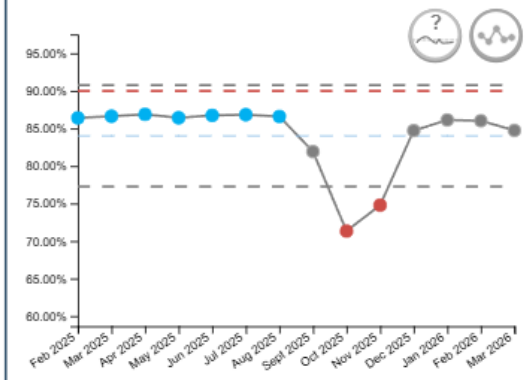
Adult Basic Life Support 80%



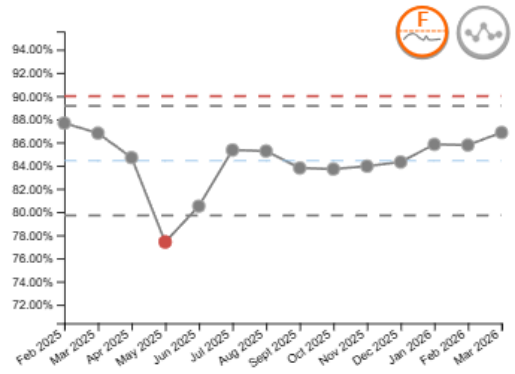
Paediatric Basic Life Support 80%



Safeguarding Children (Level 3) 85%

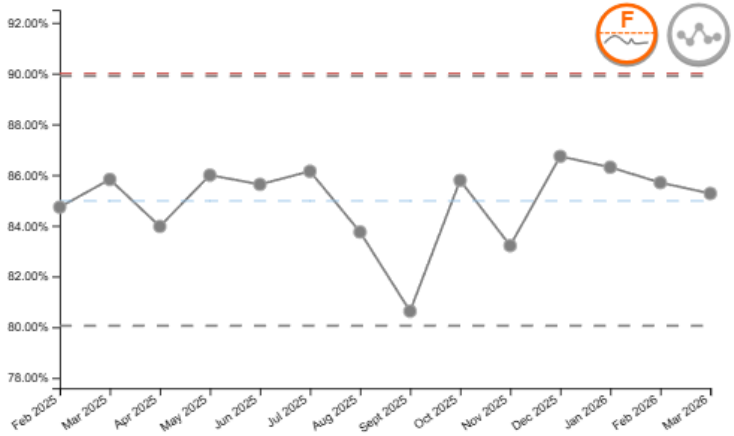


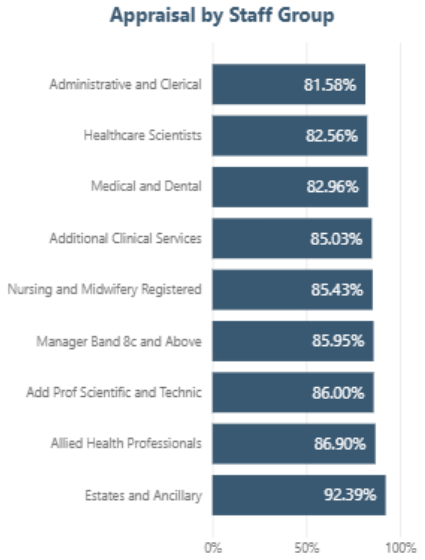
Moving and Handling Level 2 87%



Appraisal compliance

Appraisal Compliance	Month	Value	Target
	Mar 26	85.27%	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

- 2,074 appraisals are overdue with highest numbers in Nursing and Midwifery (681) and Admin and Clerical (410).
- Clinical board performance varies between 76.68% (Cardiothoracic Services) to 88.63% (Medicine and Emergency).
- Corporate Service performance varies between 71.72% (Business and Development) to 94.57% (Supplies).
- Compliance impacted by time and capacity of managers and staff.

Actions Undertaken:

- Senior medical and dental staff (consultant and SAS) now typically have a weekly minimum of 1.5 (6 hours) and 1(4 hours) core SPA (Supporting Professional Activity) respectively in their job plans. Amongst other activities, statutory and mandatory training, and preparation for appraisal would be done within this SPA time. The review of senior medical and dental staff job planning undertaken over the last 12 months recognised the need to increase core SPA time from a minimum of 1 PA for consultant staff to new minimum of 1.5 PA for most staff in this group to support delivery of a number of activities including those highlighted here.

Bank use (£) – non-medical

Bank Utilisation (£)	12-Month period ending	Total Bank Expenditure (£)	Total Bank Difference (£)
	Mar 26	£19,245,920	+£1,217,016

Staff Group	Apr 24 - Mar 25	Apr 25 - Mar 26	Difference
Admin & Clerical	£1,098,506	£744,045	-£354,462
Ancillary	£290,705	£337,040	£46,335
Estates			£0
Nursing & Midwifery (Registered)	£5,635,246	£6,815,900	£1,180,655
Nursing & Midwifery (Unregistered)	£9,704,195	£10,542,788	£838,593
Professional & Technical	£300,251	£806,147	£505,896
Total	£17,028,903	£19,245,920	£2,217,016

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:

- Work continues to reduce bank usage with effective rostering and direction.
- Aiming to reduce agency use of HCAs for enhanced care.
- To support the shift from overtime to Bank, around 1200 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 (£)
	Mar 26	£2,293,780	-£1,115,079

Staff Group	Apr 24 - Mar 25	Apr 25 - Mar 26	Difference
Admin & Clerical	£120,568	£0	-£120,568
Ancillary	£20,733	£0	-£20,733
Estates	£26,346	£206,553	£180,206
Nursing & Midwifery (Registered)	£464,054	£324,797	-£139,257
Nursing & Midwifery (Unregistered)	£1,503,650	£973,978	-£529,672
Professional & Technical	£1,273,508	£788,452	-£485,055
Total	£3,408,859	£2,293,780	-£1,115,079

Current Position:

- Costs reduced by c. £0.1.1m on previous year.
- Notable reductions in Nursing & Midwifery (unregistered) and Professional & Technical.

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:

- Increasing bank availability to reduce agency use including additional recruitment.
- Agency usage reviewed and challenged weekly / monthly.
- Robust management of agency requests with active bank and redeployment

Agency use (£) – medical

Agency Utilisation (£)	12-Month period ending	Total Agency Expenditure (£)	Total Agency Difference (£)
	Mar 26	£3,060,262	-£643,447

Staff Group	Apr 24 - Mar 25	Apr 25 - Mar 26	Difference
Medical - Consultant	£3,508,936	£2,984,966	-£523,970
Agency - Career / Staff Grades	£6,873	-£298	-£7,171
Medical - Registrar & Senior Registrar	£69,600	£68,127	-£1,473
Medical - SHO'S and HO'S	£113,023	£7,467	-£105,556
General Practitioner	£5,278	£0	-£5,278
Total	£3,703,709	£3,060,262	-£643,447

Current Position:

- Costs decreased by c. £643,447, on previous year.
- Notable reductions in Consultant and SHOs/HOs
- Consultants collectively working an average of 1,100 hours per month.

Underlying Issues

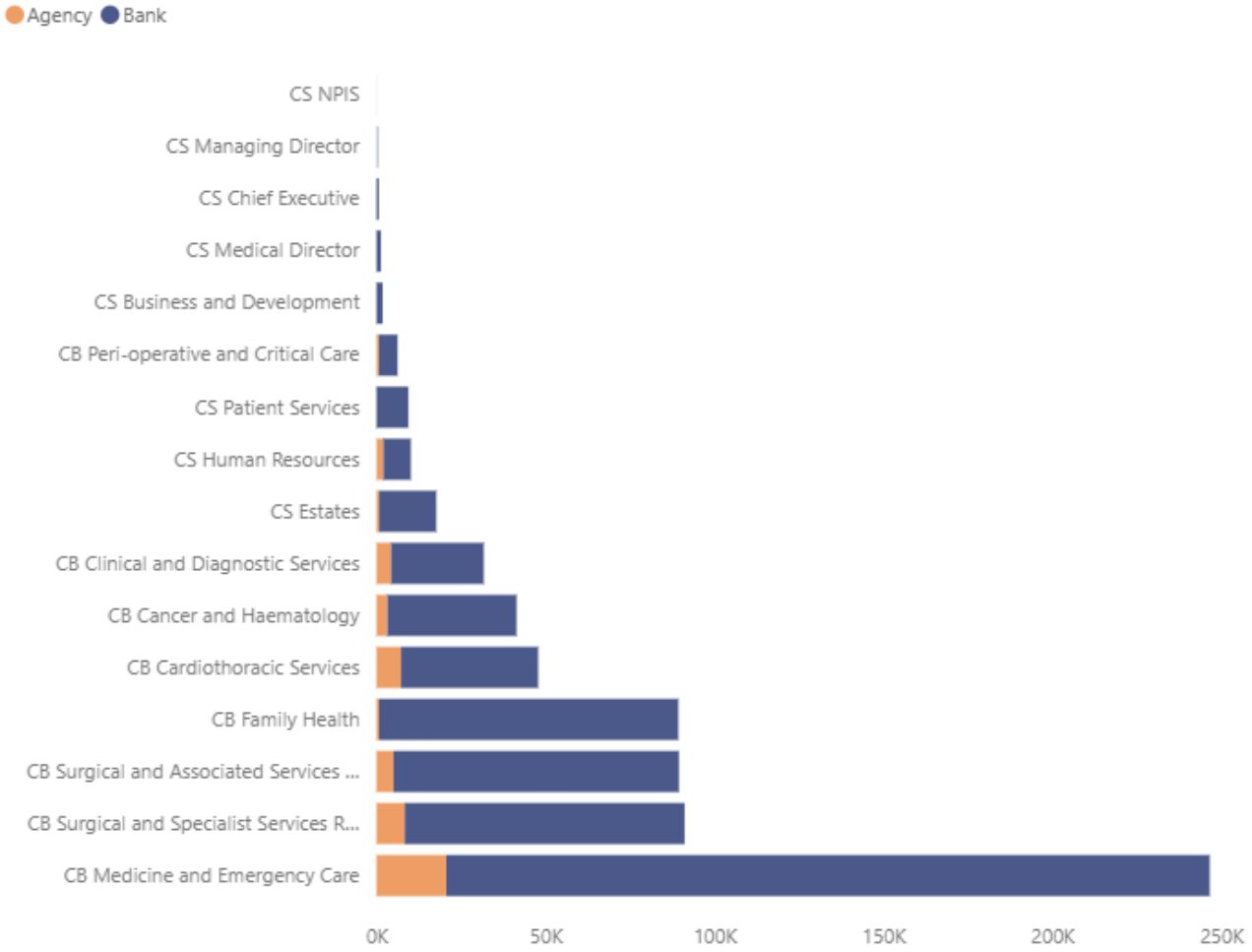
- Consultant spend. Staffing issues in Older People's Medicine and Stroke; off-framework arrangement in PICU due to sickness absence and recruitment; locum in General Medicine as part of Winter Plan 2024/25 ended in April 2025; agency Consultants unwilling to move to a Trust contract.

Actions Undertaken:

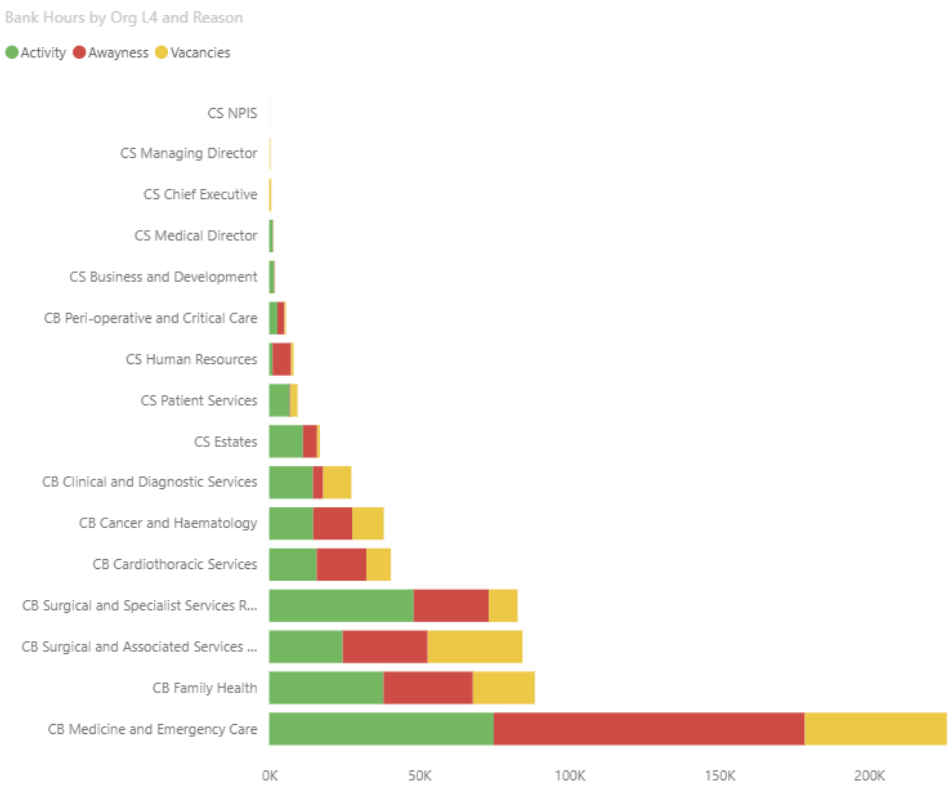
- Consultants. Trust contracts offered and declined; charges and hourly rates renegotiated wherever possible; recent recruitment in PICU has been successful reducing the need for agency.

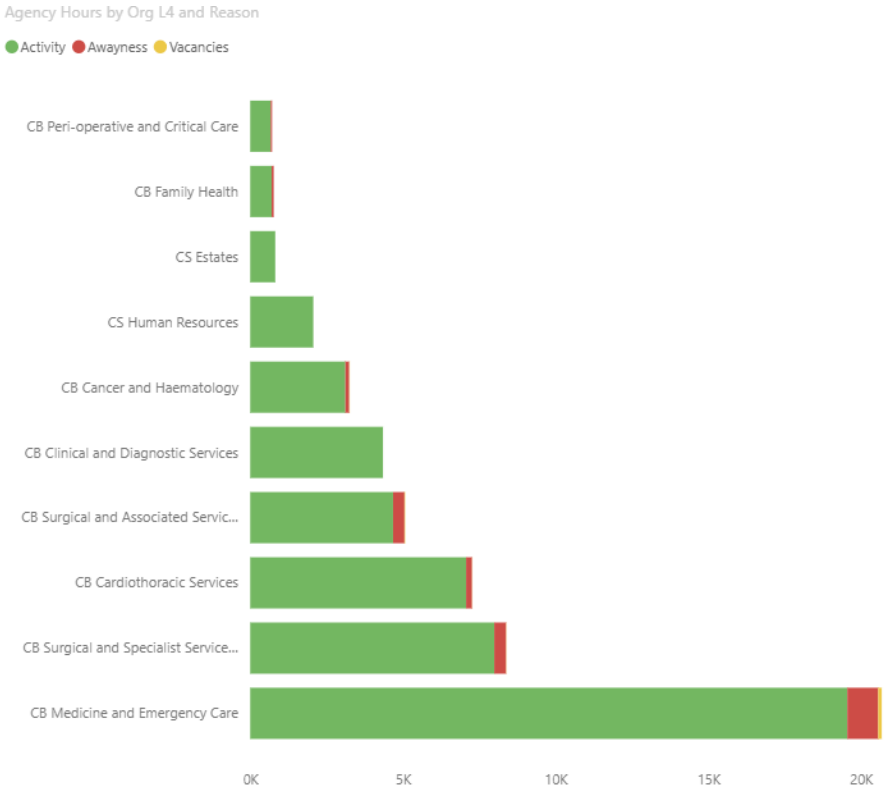
Bank & agency use - hours

Bank & Agency	12-Month period ending	Total Bank and Agency Hours
	Mar 26	685,510



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

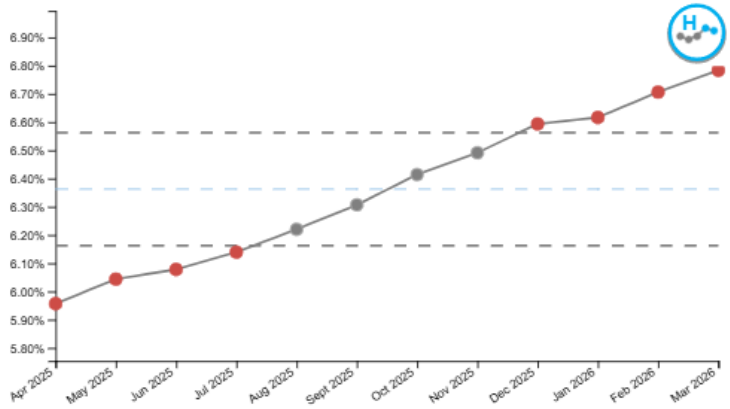


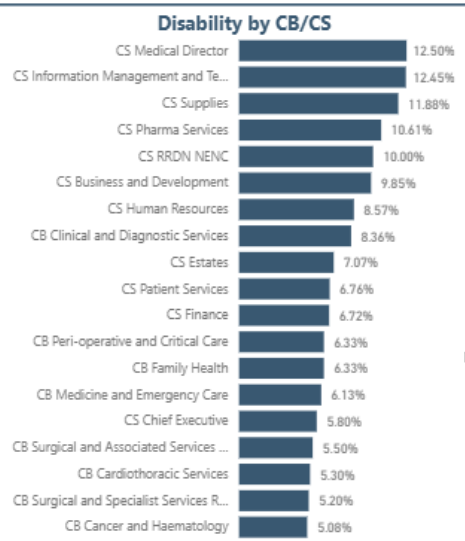


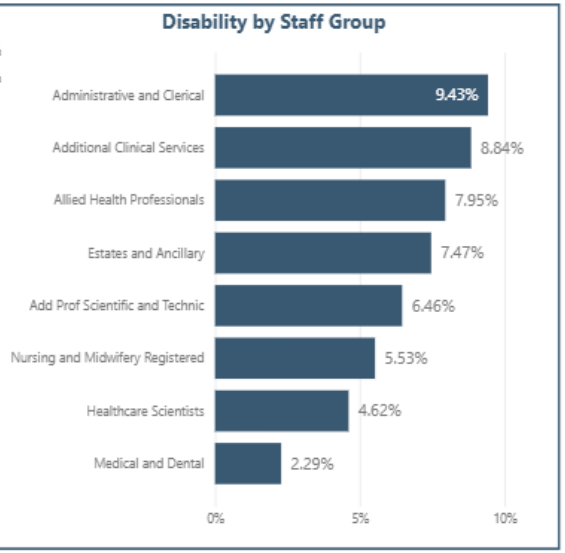
- **awayness**, including sickness, maternity, study leave, industrial action, etc.
- **activity**, including workload, acuity, waiting list initiative, etc.
- **vacancies**

Equality, diversity and inclusion (EDI) - disability

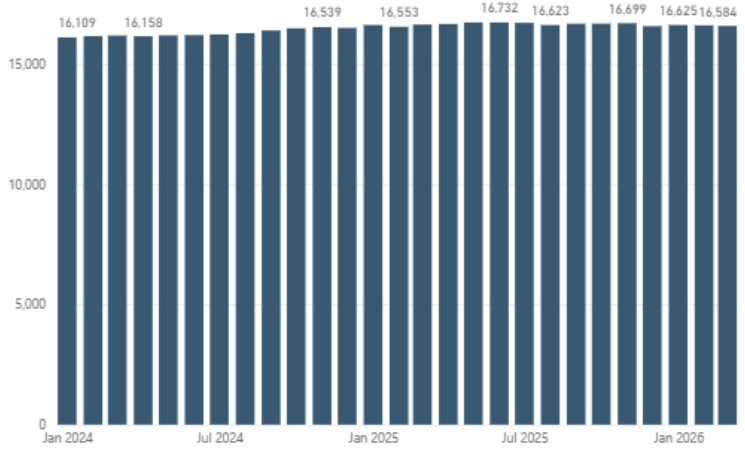
EDI - Disability	Month	Value	Trust Headcount
	Mar 26	6.78%	16,584







Trust Headcount Trend



Age Band

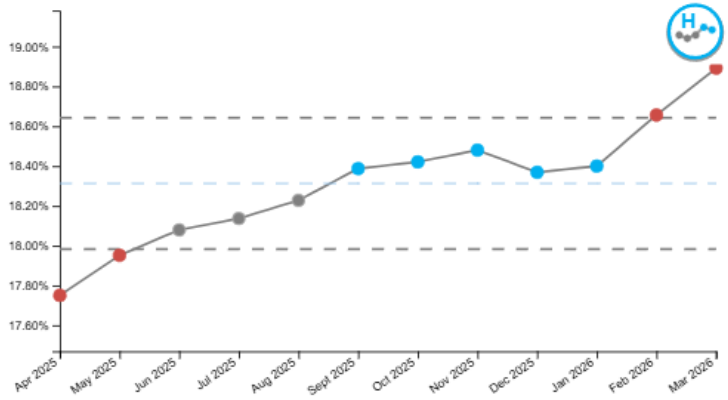
	Age Band	Disability %
1	<=20 Years	9.80%
2	21-25	14.36%
3	26-30	8.17%
4	31-35	6.78%
5	36-40	5.45%
6	41-45	5.12%
7	46-50	4.92%
8	51-55	7.15%
9	56-60	5.84%
10	61-65	6.51%
11	66-70	3.14%
12	>=71 Years	5.17%

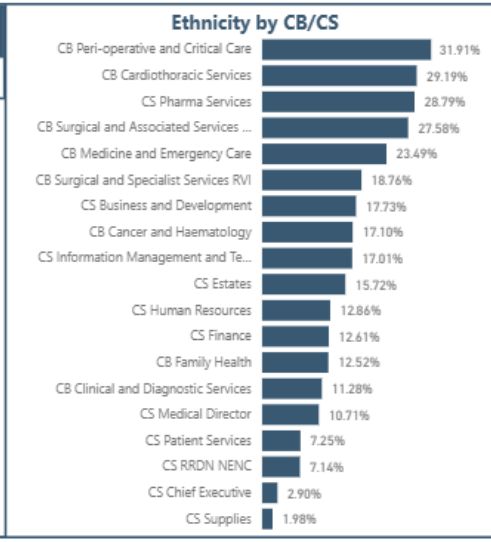
Current Position:

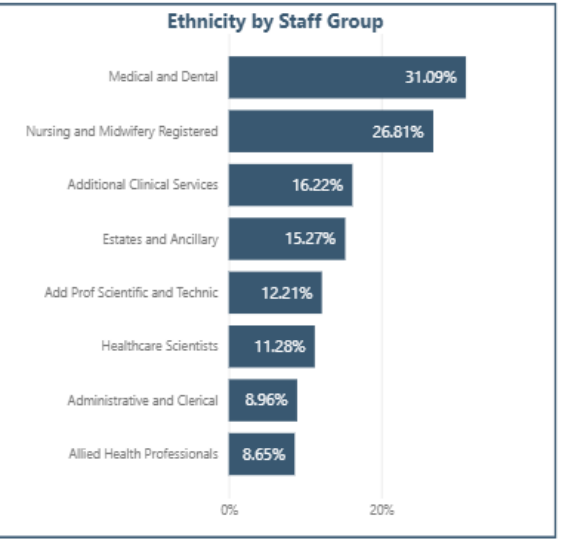
- Charts show percentage of staff in post each month by those disclosing a disability.
- Percentage of disabled staff continues to grow with the latest position reflecting 6.78% of the workforce.
- WDES data from the National Staff Survey will be published at the end of April 2026, with key findings being linked/aligned to the 12-point EDI plan.
- The development of the leadership development program will have EDI integrated throughout.

Equality, diversity and inclusion (EDI) - ethnicity

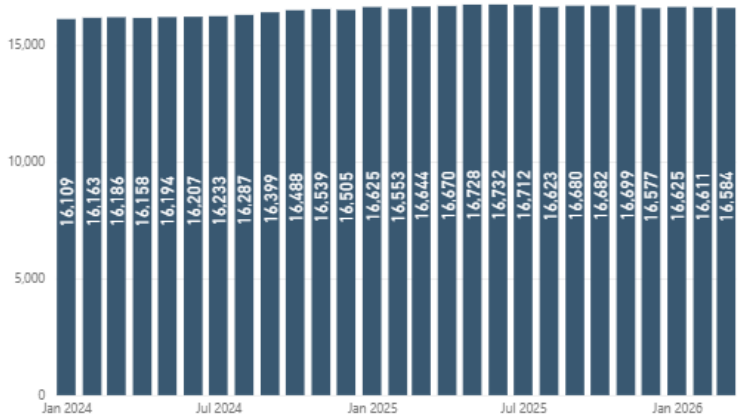
EDI - Ethnicity	Month	Value	Trust Headcount
	Mar 26	18.89%	16,584







Trust Headcount Trend



Age Band

	Age Band	BME %
1	<=20 Years	22.88%
2	21-25	15.54%
3	26-30	28.54%
4	31-35	24.95%
5	36-40	23.46%
6	41-45	16.48%
7	46-50	18.78%
8	51-55	16.60%
9	56-60	10.69%
10	61-65	6.01%
11	66-70	6.67%
12	>=71 Years	3.45%

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 18.89% of the workforce.
- WRES data from the National Staff Survey will be published at the end of April 2026, with key findings being linked/aligned to the 12-point EDI plan.
- The development of the leadership development program will have EDI integrated throughout.

Finance

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

March 2026

Financial Health

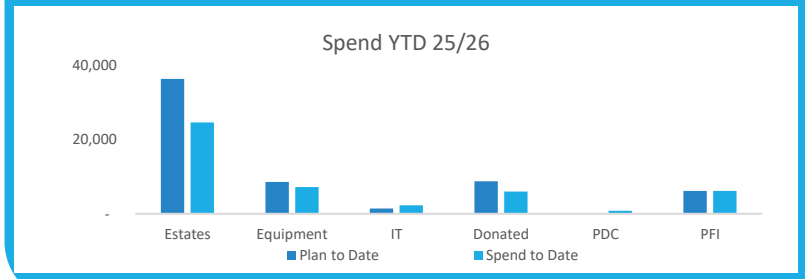
The Trust needs to take significant actions to deliver its financial objectives and is managing significant financial risk.

Financial Performance Month 12

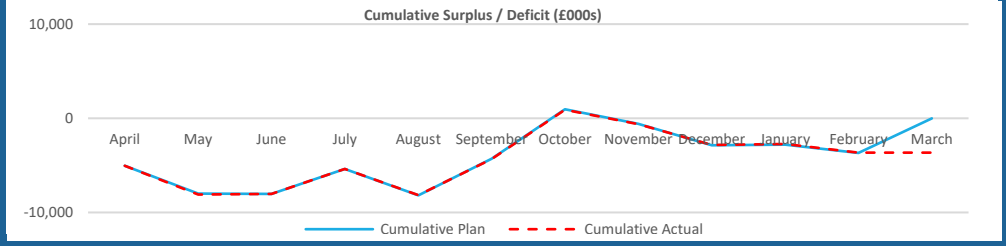
- The trust planned to deliver £106m of savings (£76m recurrent and £30m non recurrent). While it has met the £106m target, this has been delivered as £40m of savings recurrently in year with £14m of non recurrent in Clinical Boards and Corporate Services, £2m additional technical than planned and one-off additional subsidiary support funding of £17m. The trust has significantly under delivered on recurrent CIP in year.
- The trust saw unplanned pressures estimated at £22m, this includes £6m due to job planning, £7.1m on drugs, a pay award pressure of £3.2m, £0.7m pressures due to strikes (net of funding from NHS E) and other pressures totalling £5m.
- The plan also assumed £17m of ERF income above contracted levels which was not delivered due to the ERF cap.
- Unplanned pressures and planned ERF has been mitigated by additional technical adjustments above plan £6m, underspends in reserves £13m, additional Non Recurrent funding from the ICB (£10m winter surge and £2m additional support) and additional funding from NHS England £3.5m.
- The trust also received a £4.9m share of deficit support funding (NHS E recovered and redistributed funding from deficit providers where their financial performance did not meet agreed targets).

The above cost pressures combined with non recurrent CIP delivery and additional one-off support resulted in a £5.1m surplus at year end.

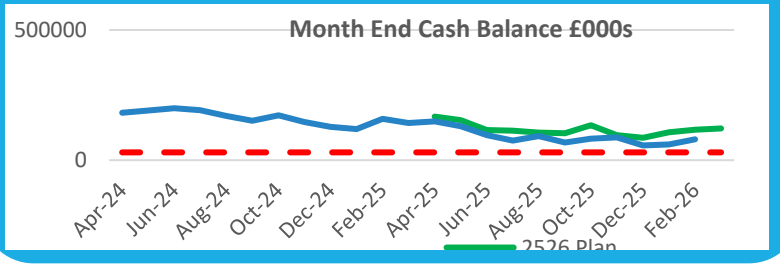
Capital Programme Delivery – Month 11



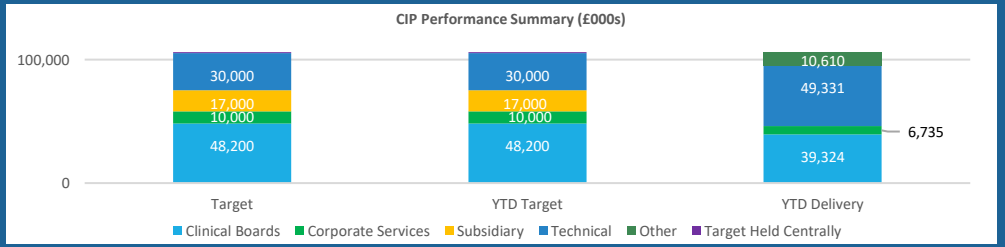
Cumulative Performance Against Plan



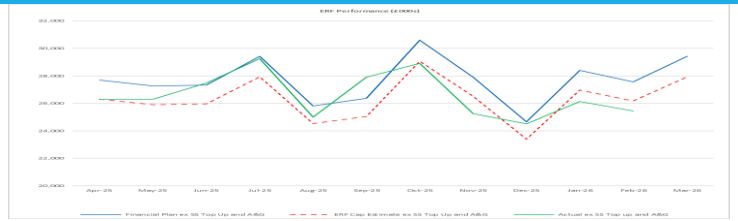
Cash Balance



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(c)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 2026					
Title	Winter Plan Evaluation of 2025/26					
Report of	Sue Hillyard, Interim Executive Director of Operations					
Prepared by	Nichola Kenny, Director of Improvement and Delivery					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☒			
Summary	The main purpose of the winter plan was to ensure optimal quality and safe care provision at a time when services are put under pressure. The Trust's winter plan for 2025/26 was prepared much earlier last year and shared with the Trust Board in July. The plan mirrored the previous year's plan, with the core elements of the plan being additional beds on the Winter Ward 12 at the Freeman Hospital and the bolstering of the workforce front of house and back of house to manage outlying patients. During winter the Integrated Care Board (ICB) funded additional discharge transport which helped ensure timely discharges direct from the discharge lounges, where there was increased utilisation. In the main, the key performance measures demonstrated overall a better winter than the previous year. Whilst admissions had increased overall, key metrics were sustained in line with the previous year, some slightly improved, some slightly deteriorated. As an overall indication of safety, there was no notable increase in patient safety incidents during the period. A datapack has been included in the Trust Board Reading Room to accompany this report.					
Recommendation	Members of the Trust Board are recommended: • To review the report for information and take assurance that the plan had a positive impact in being able to maintain safe services. • Note the plan to conclude an early Winter Plan for 2026/27, building on learning opportunities and feedback through the regional winter debrief.					
Links to Strategic Objectives	Joining up care – working together to give people better, quicker across to effective care. Advancing Care – Improving patient care, effectiveness and quality through innovation, research, improvement and education.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☐	☐	☐

Agenda item A2(c)

Link to Board Assurance Framework [BAF]	• Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients. • Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care.
Reports previously considered by	The Winter Plan 2025/26 was shared with the Trust Board in July 2025.

Agenda item A2(c)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

2025/2026 Winter Plan Debrief

May 2026

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

Recap - Getting ready early for winter

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Annual vaccination programme

Recruitment for peer vaccinators (July)

Additional bed capacity

Winter ward to open from 29 December

Recruitment to commence August

Bolstering of the workforce in key departments

A SAFER start to Winter

Improvement programme of action

Making better use of transport and ensure optimum use of lab analyser capacity

Plan requirements set by NHS England (NHSE)

Specific requirements of NHS Trusts	Outcome
Early winter planning	Plan shared with Board in July and Winter Board Assurance Statement signed off in September
Demonstrate plans to improve vaccination rates in health and care workers	Offer mirrored last year and **achieved 64.2% uptake** (compared to 54.3% in the previous year)
Have an accessible occupational health vaccination offer to staff throughout the entire flu campaign window, including onsite bookable and walk-in appointments	
Acute trusts to establish a defined improvement trajectory towards achieving the 15-minute hospital handover target.	Significant improvement in recording and slight reduction in those <45 mins, but a slight deterioration in the volume >60 mins
To achieve the target of more children being seen within 4hrs, deliver effective utilisation of Urgent Treatment Centres (UTCs), Child & Young People (CYP) specific services and standards.	For the most of 2025/26 more children were seen within 4 hours overall

Plan requirements set by NHSE

Specific requirements of NHS Trusts	Outcome
Acute trusts to set stretching local performance targets for daily pathway 0 discharges and profile them through the week.	Continued focus on teams planning discharge dates for patients - **sustained performance** rather than improvement
Acute trusts and local authorities to set local performance targets for pathway 1, 2 and 3 patients.	System upgrade required to support reporting against improvement targets
Demonstrate effective use of capacity across the full system by reviewing bed usage, returning people to home-based care where possible, and providing surge capacity alongside Infection, Prevention and Control (IPC) cohorting where it is effective and appropriate to do so	**Embedded in daily rhythm** • Daily brief with discharge team and Integrated Discharge Team (IDT), and trust-wide huddles • Daily discharge hub meetings • Weekly system meeting to monitor surge /pressure

What went well?

In terms of plan delivery

- **Early planning and plan** was trailed through various Trust forums and Clinical Board Town Halls – *setting out specific asks of teams to help plan and prepare for winter*
- There was a **Trust-wide focus on occupancy reduction** heading into winter **-** *achieving a significantly reduced occupancy level of 66% by 24 December.*
- The **winter ward was successfully recruited to** and opened as planned on 29 December - *Winter Ward 12 (Freeman) 27 beds*
- **Successful opening of the UTC** 19th January – *currently diverting c100 patients a day away from the main Emergency Department (ED) (3,000 per month)*
- Much **less impacted by system pressure** – *as can be seen from fewer diverts received*
- **Excellent oversight of IPC** and minimal loss of beds due to infection
- **No scaling back of the elective programme**

What went well?

The Newcastle upon Tyne Hospitals NHS Foundation Trust

- **Improved use of the discharge lounges** since they have been made substantive – *throughput has more than doubled*
- **Frailty at the front door -** *Continues to evaluate well, receiving an average of 200 referrals per month and avoiding admission of between 40% and 63% each month*
- **Timely transport for discharge -** supported by additional transport dedicated to Newcastle Hospitals **-** *over 1,300 journeys in 4 months*
- **Call before convey pilot (with care homes) -** *10th February to 17th April there were 31 calls received, 25 accepted for care 6 were triaged to attend hospital. Of those 25, there* ***were 24 admissions avoided***
- **Spend profile in line with budget** and additional funding secured from the Integrated Care Board (ICB) for additional dedicated transport
- **Staffing challenges in Paediatric Intensive Care Unit (PICU) –** *well managed with minimal advanced cancellations and advance planning of Paediatric elective activity to minimise demand for PICU at critical pressure points*
- **Fewer cleaning delays experienced compared to previous year -** *lower levels of infection*
- Consistently **met turnaround times** for Point of Care Testing (POCT) 24/7 – *12,028 tests between October and March*

Over the course of the winter, out-with plan:

- **An Urgent & Emergency Care (UEC) sprint was announced** to take place in March. A number of initiatives were put in place, and all targets set were achieved in the month of March.
- A period of **Industrial Action** was also announced (7-13 April), taking place at end of winter pressures/start of Easter. This was successfully managed as in previous strikes, with 95% of planned activity being maintained.

Opportunities for learning and improvement

- **Corridor Care -** *we continue to experience Corridor Care with c10% of patients attending ED spending time in a corridor space.*
- **Delay in refurbishment of Ward 38 at the Royal Victoria Infirmary (RVI) -** *this resulted in the continuation of a reduction of 6 Intensive Treatment Unit (ITU) beds over the winter period, impacting on patient flow and transfers with only a few advanced Neurosurgery cancellations.*
- **Unable to secure a dedicated transfer team** (ED, Assessment Suite (AS) and wards) *– an initiative still to test out*
- Unable to **measure responsiveness** of domestic services – *working ongoing with Information Team*

Key statistics - How did we perform compared to last winter?

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Overall, ED attendances were fewer than the previous year, however more patients were admitted and there was a sustained increase in ambulance handover delays which have continued throughout 2025. Bed occupancy was reduced and overall, 4-hour performance was improved.

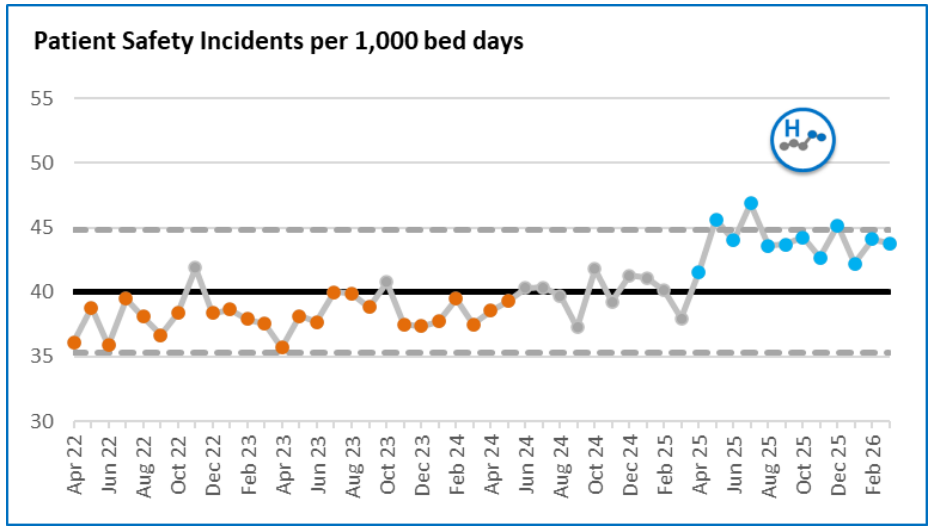
Green Improved
Red Deteriorated

Activity	1 Dec 25 – 31 Mar 26	1 Dec 24 – 31 Mar 25	Variance
ED 4-hour Performance (All Types)	76.89%	76.17%	+0.72%
Type 1 ED Attendances	45,878	48,011	-2,133
ED Ambulance Arrivals	13,082	12,818	+264
ED Walk In Attendances	32,796	35,193	-2,397
Emergency Admissions (Accident & Emergency)	15,547	14,368	+1,179
Ambulance handovers <30 minutes	8,979	8,330	+649
Ambulance Handovers <45 minutes	10,370	10,285	+85
Ambulance handovers >60 minutes	396	366	+30
Patients in ED > 12 hours	1,834	1,471	+363
Patients waiting >12 hours for a bed	157	166	-9
Bed Occupancy (Average)	88.12%	90.78%	-2.66%
Medical Patients Boarded (Max over period) *RVI Ward 44 switched to Medicine June 2025 (bed increase of 29), counted as boarders in 2024/25)	63	120	-57

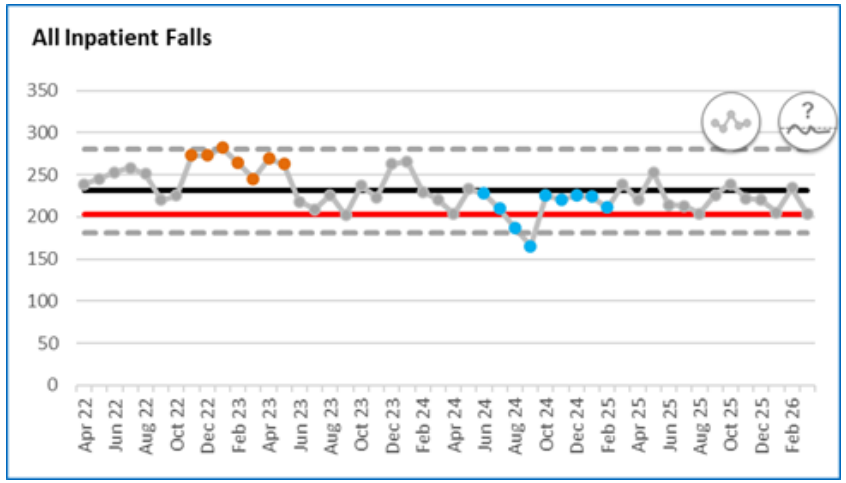
How did we perform compared to last winter?

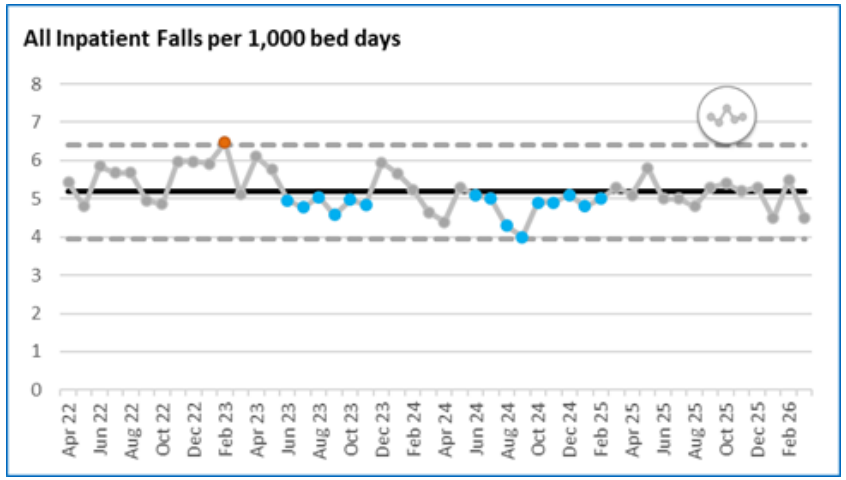
The Newcastle upon Tyne Hospitals NHS Foundation Trust

Safety was maintained with no notable increase in patient safety incidents over the period and inpatient falls per 1,000 bed-days remaining static around the median



* Move to use of Inphase 1st May 2025





Patient experience over winter

- **Patient experience continued to be monitored** throughout winter through the Trust's real-time and right time programmes
- Real time feedback was captured from patients on inpatient wards following an attendance in ED
- Care across Inpatients, Outpatients and Maternity showed a **stable picture across winter**
- Right time feedback relating to Emergency Department care over winter **shows a decline in most areas, particularly in February,** with improvement showing in April. Areas with the lowest domain scores across winter include waiting, information about medicine, consistency and coordination and pain control

Next Steps – Winter 2026/27

Build on the identified contributors to an improved winter delivery

- Earlier planning
- Ongoing collaboration amongst partners and other providers

Development of areas identified through the regional debrief for 2026/27 planning

- Strengthening discharge and repatriation
- Improving alternatives to ED
- Reducing corridor care
- Expansion of short stay and frailty pathways
- Mental health requiring sustained system attention

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Agenda item A3(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 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:** Keith's story builds on his involvement in an evidence-based co-design workshop held last year with recipients of transplants. Afterwards, Keith expressed a strong desire to say more about what it meant to live in hospital for almost a year while waiting for his heart transplant. His story offers a powerful insight into what it means to *live*, rather than simply *wait*, in hospital over an extended period. It describes the physical, emotional and social impact of long stays, the importance of meaningful activity, space, privacy and environment, and how these factors shape both resilience while waiting and recovery afterwards. Keith is clear that this is not a criticism of care — which he describes as exceptional — but a call to recognise that quality of life during long hospital stays matters. **Staff experience story:** Wayne is a diagnostic radiology physicist, Co-Chair of the Trust's Enabled Network, and a kidney transplant recipient. His story highlights the organisational value of recognising and supporting lived experience among staff. Having received his transplant as a young adult, Wayne went on to build the life he hoped for until the COVID-19 pandemic brought renewed isolation and vulnerability for clinically extremely vulnerable people. Through peer connection, counselling and involvement in the Transplant Games, he rebuilt confidence, wellbeing and a sense of possibility. Wayne emphasises that when lived experience is included in decision-making, organisations are better able to identify unintended barriers, support safe disclosure, and create more inclusive environments for both staff and patients.					
Recommendation	The Board is asked to receive both stories for information and to note our commitment to learning from all experiences of receiving and providing care.					
Links to Strategic Objectives	Advancing Care – Improving patient care, effectiveness and quality through innovation, research, improvement and education.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐

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

PATIENT AND STAFF SIDE STORIES

Patient story: When you're waiting for a transplant in hospital, you're not putting life on pause – you're living it, just in a very small space, for a very long time. I spent close to a year in hospital waiting for a transplant. During that time, the care I received was exceptional. The staff went above and beyond, and I will always be grateful for that. What I want to talk about isn't the clinical care – it's the experience of living in hospital while you wait.

Before transplant, there's a lot of focus on hope. Doctors build you up, and that hope is important. But sometimes it can also create expectations that don't quite match reality. You're led to believe that afterwards things will be "back to normal" quickly.

What isn't always explained well enough is how different recovery can be for each person, or how much harder some parts can feel afterwards than before. Many of us have lived with illness for a long time. We've adapted to it. Then transplant comes, and everything changes again – physically, mentally, emotionally. It's an amazing change, but it's also a massive one, and not everyone follows the same path or at the same pace.

While you're waiting, hospital becomes your world. Days stretch out. Time behaves differently. When you're there long-term, the small things stop being small.

Staying active, staying motivated, staying positive – all of that becomes harder over time. Often, walking is the only thing you can do to keep moving, and even that can feel restricted. You become aware of where you're allowed to be, where you're not. I remember being moved on from places simply because we weren't supposed to be sitting there. It might seem minor, but when it happens again and again, it eats away at your sense of independence and dignity.

When you've been in hospital for months, meaningful activity isn't optional – it's essential. Days need some kind of structure. Something to break them up. Something that reminds you that you're more than a patient in a bed.

I was lucky to be part of a group of long-stay patients who tried to create that normality ourselves – movie nights, games, little events that made the days feel less empty. Those moments mattered. They helped us feel human. But they relied on energy, motivation, and connection – things that aren't guaranteed when you're unwell and waiting.

Food becomes another marker of time. When there isn't much else going on, mealtimes are often the highlight of the day. And when those meals become repetitive, unenjoyable, or something you start to dread, it has a bigger impact than you might expect. Over time, it affects your mood, your motivation, and your relationship with the space you're living in.

Privacy also starts to matter more the longer you stay. Living out of a suitcase, worrying about your belongings, lacking a quiet space to make a phone call or see family – those things build a constant, low-level stress. You're sharing everything: noise, light, conversations, emotions. Sometimes all you want is a door you can close, or a corner that feels like it's yours.

You miss home comforts. You miss peace and quiet. You miss your pets. You miss freedom.

And while you're waiting, life outside the hospital doesn't stop. Families are travelling back and forth, juggling work, costs, and worry. Important moments happen without you – births,

weddings, funerals. You're trying to exist in two worlds at once: the one inside the hospital, and the one you're watching carry on without you.

There are places that get this right. Spaces like Maggie's Centre show how powerful the environment can be – what it means to have somewhere calm, private, and human. Somewhere that reminds you what normal life feels like, even for a short while. Those spaces don't fix everything, but they help you breathe.

I want to be clear about something else too. The positives absolutely outweigh the negatives. I wouldn't be here without the people who cared for me. This isn't about criticism of individuals or teams.

It's about recognising that quality of life while living in hospital matters.

How you live while you wait affects how strong you stay – physically and mentally. It shapes how prepared you are for transplant, and how you cope afterwards. Waiting time isn't empty time. It's real life, happening day after day, hour after hour. If we acknowledge that – truly acknowledge it – then we can start to think differently about how hospital stays are designed for people who aren't just passing through.

Because even while you're waiting, you're still living.

A selection of memories from the Transplant games - Shared by Wayne Hartley.

Staff story: I had my kidney transplant when I was 20 years old. Before that, I'd spent much of my teenage years in and out of hospital with infections and complications related to my health. Like many people, once I had my transplant my goal was simple – to be *normal*. To go to university, get a job, and build a career without my health defining me.

For a long time, that worked.

Then COVID hit.

As a transplant patient, I was classed as clinically extremely vulnerable. Almost overnight, everything changed. I felt different again – more visible, more isolated, and more afraid. There was huge uncertainty about what the virus might mean for people like me who are immunosuppressed. Questions about treatment, risk, and the safety of my transplant were suddenly very real again.

Like many others, I struggled with the isolation. I tried to find support online, but much of what I found was understandably negative and anxiety-provoking. Eventually, I realised I needed help to process everything I was carrying. I accessed counselling sessions available to kidney patients, which helped me make sense of my experiences and separate what had happened to me from who I am.

What I still missed was connection with people who truly understood.

I had my transplant at a young age, and the peer support available at the time was largely aimed at much older patients. I never quite felt I fitted in. Because I'd been unwell for so long, sport and exercise were never things I saw as realistic options for me, let alone something I could compete in.

That changed when I discovered the Transplant Games.

What initially drew me in was the donor run – an event focused on thanking donors and raising awareness of organ donation. It felt meaningful, something positive to work towards after the isolation of COVID. At the time, I couldn't run 5km without stopping. Before the pandemic, I'd tried parkrun and hadn't made it round without walking. So I set myself a goal: to one day be able to run the full distance.

I started slowly, going out early in the morning or late at night, building it up bit by bit. Reaching that goal became about much more than physical fitness – it helped my mental health, my confidence, and my sense of what was possible.

At the World Transplant Games in Dresden, I went from not being able to run 5km at all to finishing in 19 minutes and 30 seconds. I came fifth individually, and as part of Team GB we won the team road-racing event. It was an incredible moment – not just because of the result, but because of what it represented.

The Transplant Games community is open, welcoming and non-judgemental. It brings together people who have been through a huge amount, but who focus on what they *can* do rather than what they've lost. Being part of that space helped me become much more open about my own health, including living with a hidden disability and managing long-term conditions.

That openness has shaped how I work today.

I work in diagnostic radiology physics, helping ensure imaging equipment such as X-ray and CT scanners is safe, effective and delivering high-quality images while keeping radiation doses as low as reasonably achievable. Having spent much of my life in hospitals, I'm very aware that not everyone who comes for imaging is there "just once". Some groups – particularly children and people with long-term conditions – can be disproportionately affected if we don't get things right. My lived experience makes this personal, and it motivates me every day.

That same motivation led me to become Co-Chair of the Trust's Enabled Network.

When I joined Newcastle Hospitals, it was the first time I formally disclosed that I am disabled. Having conversations with Occupational Health before I started meant reasonable adjustments were put in place from day one. That took away a lot of anxiety and showed me how powerful openness can be – for individuals and for organisations.

As Co-Chair of the Enabled Network, my aim is simple: to help make work a fairer, more inclusive place for everyone. Many disabled staff and staff with long-term health conditions are disproportionately affected by decisions made without lived experience at the table. Often, barriers aren't created deliberately – they're introduced unintentionally. Our role as a network is to amplify our members' voices, raise awareness, and work with the organisation to help remove those barriers.

I'm passionate about encouraging people to disclose where they feel able to, and about supporting managers to listen, learn, and ask for help when they don't have the answers. Nobody expects perfection – but open, honest conversations make a real difference.

Whether through my day job, my role in the Enabled Network, or my involvement in the Transplant Games, everything I do is connected by a shared purpose: making systems work better for people, especially those whose voices aren't always heard.

I've been given a second chance at life through my transplant. Being able to use that experience to support patients, colleagues and the wider organisation is something I'm incredibly proud of.

Report of Ian Joy
Executive Director of Nursing, Midwifery and
Allied Health Professionals
7 May 2026

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Agenda item A3(b)(ii)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 2026					
Title	Guardian of Safe Working Hours Annual Report					
Report of	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Prepared by	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☐		☒	
Summary	The terms and conditions of service of the new resident doctor contract (2016) require a consolidated annual report on rota gaps, and the plan for improvement to reduce these gaps to be included in the Trust's Quality Account. This report addresses the requirement for the year from April 2025 to March 2026 for consideration by the Trust People Committee, prior to submission to the Trust Board.					
Recommendation	The Trust Board is asked to note the content of this report for inclusion in the Trust's Quality Account.					
Links to Strategic Objectives	Advancing Care – Improving patient care, effectiveness and quality through innovation, research, improvement and education. Supporting great care – supporting everyone to do their job to the best of their ability with effective leadership, a just and learning culture and modern digital and physical environments					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☐	☐	☐
Link to Board Assurance Framework [BAF]	No direct link. In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training.					
Reports previously considered by	Annual Report of the Guardian of Safe Working Hours. Shared at the May People Committee.					

GUARDIAN OF SAFE WORKING ANNUAL REPORT

1. EXECUTIVE SUMMARY

The purpose of this annual report is to highlight the vacancies in resident doctor rotas and steps taken to resolve these during the year from April 2025 to March 2026.

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

Where vacancies exist, the gaps in service coverage are mainly addressed by rewriting work schedules, redeployment of doctors to areas of greatest clinical need and the use of locums. The causes of vacancies are multifactorial but include gaps due to lack of doctors on the rotational training scheme, lack of recruitment of locally employed doctors, and less than full time doctors in full time training slots. The areas of recurrent or residual concern are paediatric cardiology and cardiothoracic anaesthesia.

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

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

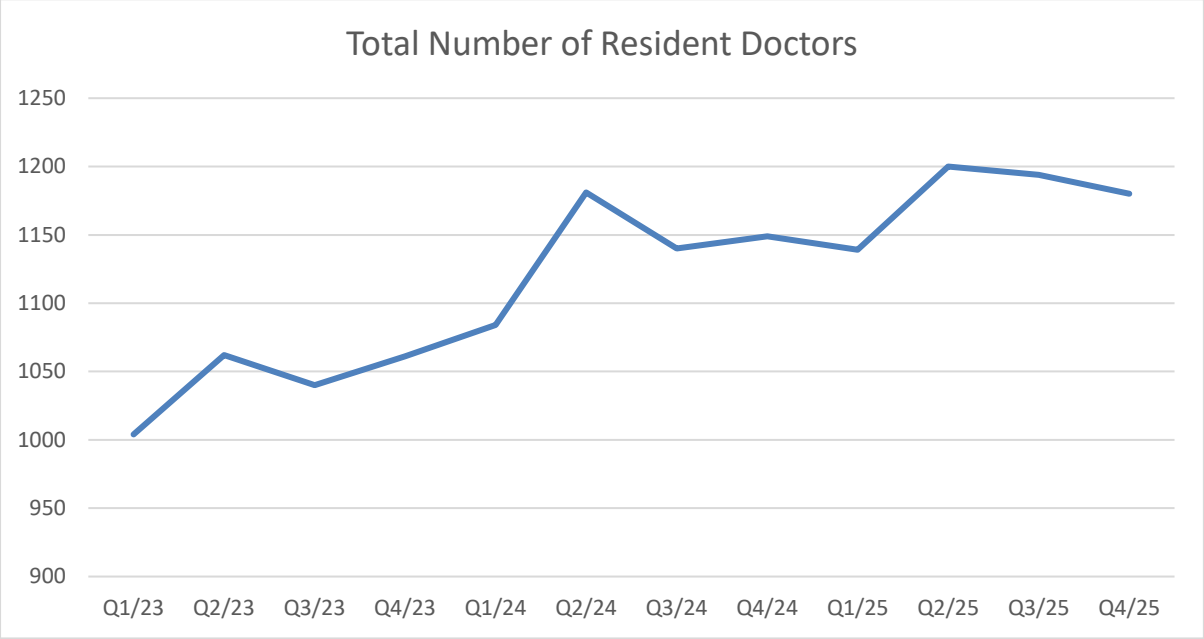
2. INTRODUCTION / BACKGROUND

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

3. HIGH LEVEL DATA

Number of postgraduate doctors / dentists in training on 2016 TCS:	1,163
Of which:	
Lead Employer Trust (LET) employed	*927*
Trust Employed	*236*
Number of postgraduate doctors on 2002 TCS:	17
Total number of postgraduate doctors / dentists:	1,180

3.1 Trend of Number of Postgraduate doctors by quarter:



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

Key:

- ACCS – Acute Care Common Stem
- CMT – Core Medical Training
- CST – Core Surgical Training
- CT – Core Training
- ENT – Ear, Nose and Throat
- F2 – Foundation Year 2GPVTS – GP Vocational Training
- FH – Freeman Hospital
- ICU – Intensive Care Unit
- IMT – Internal Medicine Training
- RVI – Royal Victoria Infirmary
- ST - Specialty Training
- TF – Teaching Fellow

Below is a list of vacancies by specialty. The impact of these vacancies on rotas is variable amongst specialties

Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Q4	Q3	Q2	Q1
	Cancer and haematology						
FH	Oncology	ST3+	22	1.0	1.0	2.2	4.2
	Cardiothoracic Services						
FH	Cardiothoracic Anaesthesia	ST3+	10	2.0	0.0	0.3	1.0
FH	Cardiothoracic Surgery	ST3+	11	2.7	2.0	2.0	2.3
FH	Paediatric ICU (PICU)	ST3+	8	0.0	0.0	0.3	1.0

FH	Paediatric Cardiology 1st	F2/ST1/ST2	7	2.0	0.2	0.2	0.5
FH	Paediatric Cardiology 2nd	ST3+	9	2.0	2.0	1.7	2.3
FH	Respiratory Medicine	CMT/ST1-2	5	0.2	0.2	0.2	0.2
	Family Health						
RVI	Paediatric Surgery 2nd	ST3+	9	1.0	1.0	0.0	0.0
RVI	Paediatrics 1st	F2/ST1/ST2	25	1.4	0.4	1.4	1.4
RVI	Paediatric Oncology	ST3+	6	0.2	0.0	0.0	0.3
RVI	Paediatric ICU (PICU)	ST3+	10	1.0	0.0	0.0	0.3
RVI	Obstetrics & Gynaecology	F2/ST1/ST2	14	0.7	0.0	0.5	1.4
RVI	Obstetrics & Gynaecology	ST3+	22	1.7	1.0	1.7	2.7
RVI	Neonates	ST3+	13	0.7	0.0	0.0	0.3
	Surgical & Associated Specialities (FH)						
FH	ENT	F2 / CST / ST1-2	5	0.0	0.0	0.7	0.0
FH	ENT	ST3+	9	1.0	1.0	0.0	0.0
FH	General Surgery	F2/ST1/ST2/ST3+	7	1.0	1.0	1.0	0.0
FH	Vascular	ST3+	10	0.7	0.0	0.5	1.5
RVI	General Surgery	F2/ST1/ST2	7	0.3	1.0	0.7	0.0
RVI	General Surgery	ST3+	15	0.8	0.8	0.8	1.1
FH	Urology	F2/ST1/ST2	7	0.0	0.0	0.3	1.0
FH	Urology	ST3+	11	0.7	0.0	0.0	0.0
	Clinical and Diagnostic Services						
RVI	Histopathology	ST1/2	8	0.2	0.2	0.2	0.2
RVI	Integrated Medical Microbiology	ST1+	21	0.8	0.8	1.6	1.6
RVI / FH	Radiology On Call	ST2 / ST3+	33	0.0	0.0	0.7	2.0
	Medicine						
FH	General Internal Medicine	F2/GPVTS/CMT/TF	12	1.3	0.6	0.6	0.6
RVI	Core Medical Training	CMT	11	0.3	1.0	0.7	0.0
RVI	Core Medical Training Acute	CMT	2	0.3	1.0	1.0	1.0
RVI	ACCS on Assessment Suite Only	ACCS	2	0.0	0.0	0.1	0.2
RVI	General Internal Medicine	ST3+	25	3.7	3.0	2.3	1.0
FH	Care of the Elderly	ST3+	5	1.3	2.0	1.7	1.0
RVI	Accident & Emergency 1st	ACCS/ST1-2/CT1-2	20	1.0	1.0	1.0	1.0
RVI	Accident & Emergency 2nd	ST3+	15	2.3	3.0	2.7	2.0
RVI	Dermatology	ST3+	7	0.4	0.4	0.4	0.4
FH	Renal Medicine	ST3+	6	1.3	2.0	0.0	0.0
	Surgical & Specialist Services (RVI)						
RVI	Neurosurgery	F2/ST1/ST2	5	0.2	0.2	0.5	1.5
RVI	Neurology	F2/ST1/ST2	2	0.7	0.0	0.0	0.0
RVI	Neurology	IMT/CMT	3	0.2	0.2	0.2	0.2
FH	Orthopaedics	F2/ST1/ST2	4	0.7	2.0	1.3	0.0
RVI	Orthopaedics	F2/ST1/ST2	4	0.7	0.0	0.0	0.0
RVI/FRH	Orthopaedics	ST3+	19	3.0	2.0	1.7	1.0
RVI	Ophthalmology	F2/ST1/ST2	6	1.0	1.0	1.3	2.0
RVI	Ophthalmology	ST3+	25	2.7	3.0	2.3	1.3
	Peri-operative						

FH	Critical Care	F2 ST1-7	13	0.8	0.8	0.9	1.0
FH	Anaesthetics General	ST1-7 CT1-2	27	3.3	2.8	2.5	2.8

5. ISSUES ARISING

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

Key:

- FT = Full Time
- LED = Locally Employed Doctor
- LET = Lead Employer Trust

  LTFT = Less Than Full Time

Site	Specialty/Sub Specialty	Reason for Gap	Obstacles to Recruitment	Action taken to overcome obstacles
	Cardiothoracic Services			
FH	Cardiothoracic Anaesthesia	LED gaps	Overseas candidates. Delays due to visa issues	Additional posts to add resilience. Proactive recruitment and contract extension from clinical team
FH	Cardiothoracic Surgery	LED gaps	Overseas candidates. Delays due to visa issues, difficulty recruiting	Readvertising and accommodating workload within workforce
FH	Paediatric Cardiology 2nd	LED gaps, LTFT in FT post	Overseas candidates. Delays due to visa issues	
	Family health			
RVI	Paediatric ICU (PICU)	LTFT in FT posts		Additional temporary post created
	Surgical & Associated Specialities (FH)			
FH	General Surgery	LED gaps	Difficulty with recruitment	Accommodating workload within workforce
FH	Vascular	LED gaps	Overseas candidates. Delays due to visa issues	Accommodating workload within workforce
	Medicine			
RVI	General Internal Medicine	LET gaps		LED recruitment, internal locums, cross cover within medicine directorate
FH	Care of the Elderly	LET gaps, LTFT in FT	Difficulty with recruitment	Accommodating workload within medicine directorate

	Surgical & Specialist Services (RVI)			
RVI /FRH	Orthopaedics	LET gaps and LTFT in FT post		Accommodating workload within workforce
	Peri-operative FH			
FH	Anaesthetics General	LTFT in FT posts, LET gaps		Accommodating workload within workforce

5.1 Actions taken to resolve these issues

The Trust takes a proactive role in management of gaps through the work of the Junior Doctor Recruitment and Education Group (JDREG). Members of this group include the Director of Medical Education, a Finance Team representative and Medical Staffing personnel.

In addition to recruitment into locally employed doctor posts the Trust runs several successful trust-based training fellowships, a teaching fellow programme and has supported temporary and permanent expansion of the Foundation Training Programme. Due to issues with bottlenecks in training for resident doctors, the Trust has adopted a policy of internal prioritisation for recruitment to ST1 and ST2 equivalent posts. This was requested by resident doctors following growing concerns about job security and lack of training progression.

Other actions to resolve the issues are rewriting work schedules to reflect the number of available doctors, recruitment into less than full time gaps, employing physician associates and advanced care practitioners to assist with resident doctor workload, redeployment of doctors to areas of clinical need, and the use of locums.

5.2 Locum Spend

The purpose of reporting locum spend is as a source of information indicating where there were gaps in service coverage requiring temporary workforce cover. All data shown here is supplied by the finance team and medical staffing. Unfortunately the finance team were unable to supply information for locum spend for Q4, therefore total spend for Q1-Q3 is shown for both years.

Locum Spend 01.04.25 – 31.03.26 Q1-Q3

Lead Employer Trust:	£1,384,029
Newcastle Hospitals:	£2,235,394
Total:	**£3,619,423**

Locum Spend 01.04.24 – 31.03.25 Q1-Q3

Lead Employer Trust:	£2,936,121
Newcastle Hospitals:	£2,341,979
Total:	**£5,278,100**

6. EXCEPTION REPORTS AND FINES

As mentioned in my quarterly report, the changes to the Resident Doctor contract which were enacted in February have seen a small increase in exception reporting numbers compared to the previous months. However it is too early to comment on whether this is due to the change in TCS or natural variations. However, we have seen a marked increase in exception reports submitted where a breach of hours have occurred which incur a financial penalty (fine.)

Total Fine Money £8,093.60

Fine money has been spent this year on cards to increase awareness of exception reporting, a fan for the neonatal doctor rest area and psychology group sessions for paediatric residents. There are further plans to spend the money on improvements to the resident doctor mess facilities with the purchase of coffee machines and a TV.

7. SUMMARY

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

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

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

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

8. RECOMMENDATIONS

The Trust Board are asked to (i) note the content of this report for inclusion in the Trust's Annual Quality Account; and (ii) to encourage pro-active recruitment of doctors to reduce vacancies and provide a resilient workforce.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours
3 May 2026

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Agenda item A3(b)(ii)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 2026					
Title	Guardian of Safe Working Quarterly Report (Quarter 4 (Q4) 2025-26)					
Report of	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Prepared by	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	The terms and conditions of service (TCS) of the new junior doctor contract (2016) require the Guardian of Safe Working (GOSW) Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant. The content of this report outlines the number and main causes of exception reports for the period 27 December 2025 to 26 March 2026 for consideration by the Trust People Committee and the Trust Board.					
Recommendation	The Trust Board is asked to note the contents of this report.					
Links to Strategic Objectives	Advancing Care – Improving patient care, effectiveness and quality through innovation, research, improvement and education. Supporting great care – supporting everyone to do their job to the best of their ability with effective leadership, a just and learning culture and modern digital and physical environments					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link to the BAF. In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training.					
Reports previously considered by	Quarterly report of the Guardian of Safe Working Hours. Shared at the May People Committee meeting.					

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

This quarterly report covers the period 27 December 2025 to 26 March 2026.

There are now 1,163 resident doctors on the TCS of the 2016 contract, and a total of 1,180 resident doctors in the Trust.

There were 160 exception reports in this period. This compares to 126 exception reports in the previous quarter.

The main areas of exception reports are general medicine, general surgery, ENT (ears, nose and throat) and neurosurgery . The main cause is when there is a workforce/workload imbalance.

Changes to exception reporting were introduced on 4 February 2026. This has resulted in a small increase in exception reporting numbers. However the pattern of exception reporting has changed, with an increase in specialties exception reporting, increase in fines, and an increase in exception reports from doctors in specialty training.

2. INTRODUCTION / BACKGROUND

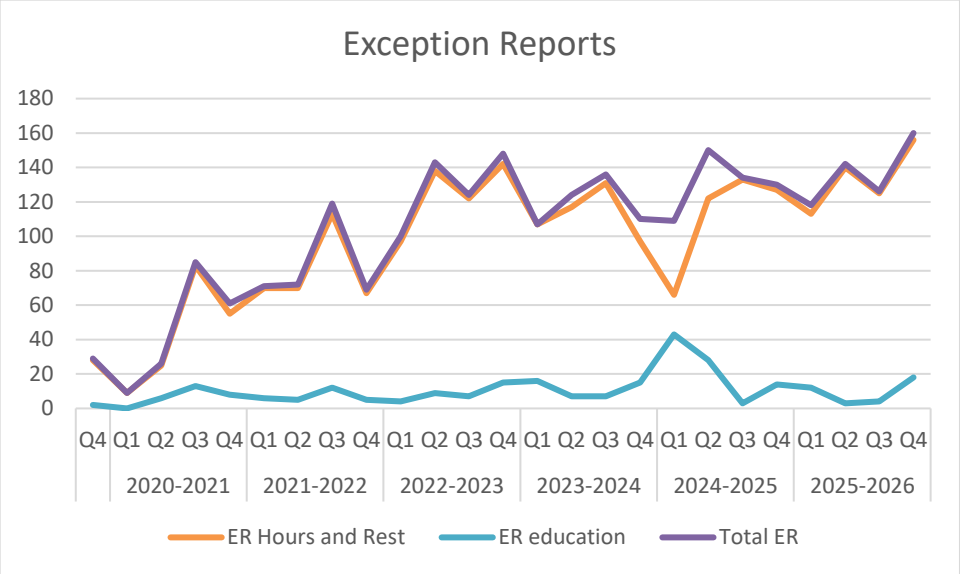
The Resident Doctor Contract came into effect on 3 August 2016. From August 2023 Locally Employed Doctors at Newcastle Hospitals are also employed on a contract which mirrors the 2016 contract. On the 4 February 2026 changes to exception reporting were introduced which aim to improve access, confidentiality and ease of exception reporting.

The TCS of the 2016 contract allows for exception reporting to raise reports on breaches of working hours and educational opportunities. The Guardian of Safe Working Hours must provide a quarterly report to the Trust Board to give assurance to the Board that the doctors' hours are safe and compliant.

3. HIGH LEVEL DATA

		(Previous quarter data for comparison)
Number of Resident Doctors on New Contract	1,163	(1,177)
Total Number of Resident Doctors	1,180	(1,194)
Number of Exception reports	160	(126)
Number of Exception reports for Hours Breaches	156	(125)
Number of Exception reports for Educational Breaches	18	(4)
Fines	25	(6)
Admin Support for Role	Good	

4. EXCEPTION REPORTS



4.1 Exception Report by Speciality (Top 5)

		(Previous quarter for comparison)
General Medicine	26	(34)
General Surgery	27	(46)
ENT	27	(5)
Neurosurgery	17	(0)
Ophthalmology	10	(4)
Paediatrics	10	(10)

4.2 Exception Report by Rota/Grade

General medicine:

Royal Victoria Infirmary (RVI) FY1/FY2/CT1/CT2	13
Freeman Hospital (FH) FY1/FY2/CT1	13

General Surgery:

FH (F1) including Hepato-Pancreato-Biliary (HPB), colorectal, vascular	6
FH (Foundation Level 2 (F2)/SHO/StR))	8
RVI (F1)	13

ENT:

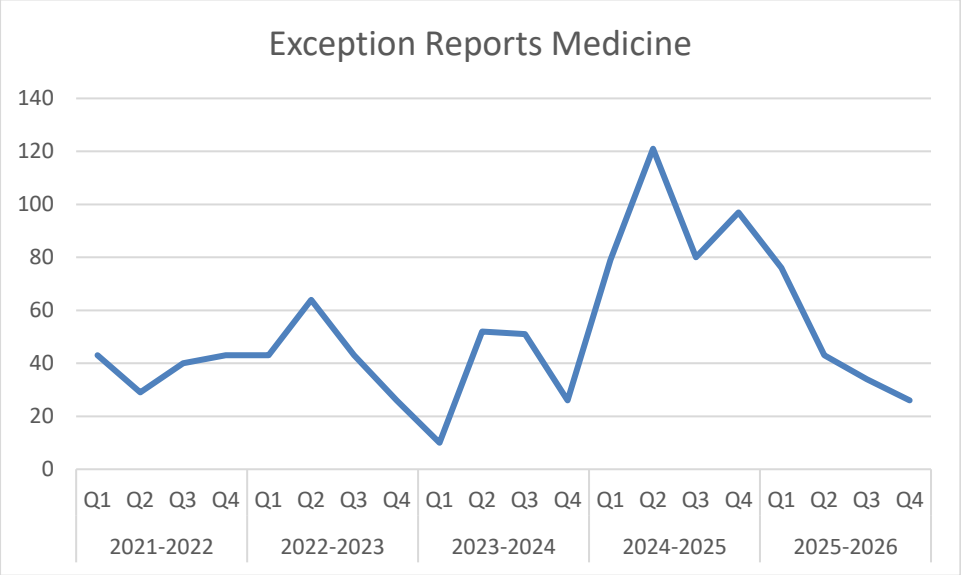
FY1	16
SHO	8
StR	3
Neurosurgery:	
ST2	6
ST3	11
Paediatrics:	
F1/F2	7
SHO/StR	3
Ophthalmology:	
StR	10

4.3 Example Themes from Exception Reports

General Medicine RVI/FH

Exception reports submitted when there was reduced staffing or high workload. Lack of phlebotomy services have been highlighted in a number of exception reports, which contributes to workload.

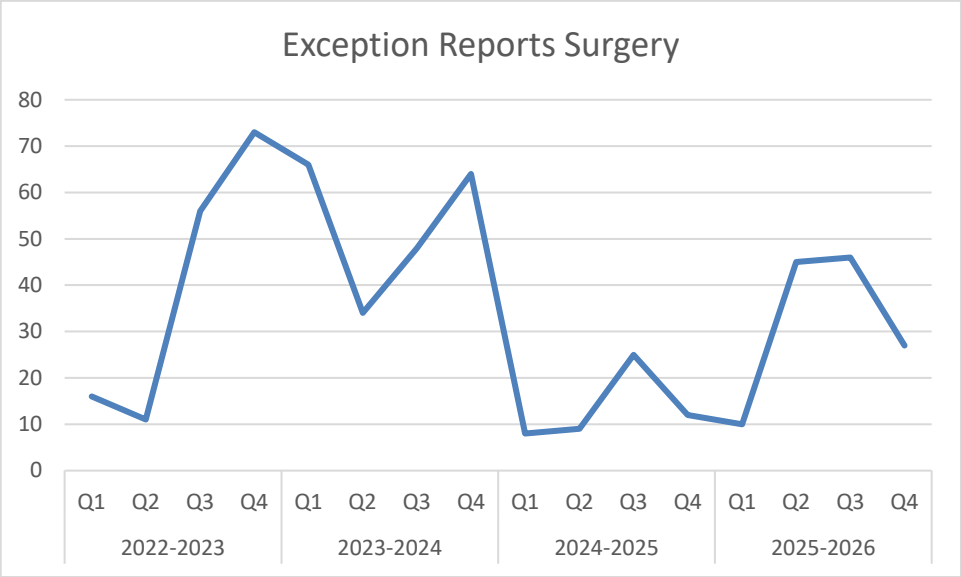
An additional 5 F1s were assigned across FH and RVI in August 2023 (Q2 2023-2024), with a further 5 F1s added to the workforce in August 2024. 2 additional F2s were also added (commenced August 2025). Exception report numbers for medicine are currently lower than previous.



General Surgery

Exception reports submitted for a variety of reasons, including overrun on theatre lists, breaches of hours on non-resident on call, reduced staffing and clinical demand.

F1 workload at Freeman Hospital have previously been an area of concern. Additional doctors were added to improve the workload. Exception Reports from this area have reduced. Following the exception reporting reforms there has been an increase in exception reports from Specialty Registrars.



ENT

Exception reports submitted when there was low staffing or high workload. Due to the increase in exception reporting numbers in this area, I conducted a review. No underlying concerns or issues were highlighted.

Neurosurgery

Doctors stayed late when clinical demand required it. This occurred due to both routine elective work and emergency on call work. A work schedule review is currently being undertaken.

Ophthalmology

Exception reports submitted due to additional hours worked on non-resident on call shifts.

Paediatrics

Exception reports submitted when there was low staffing of high workload. In addition there are issues within paediatric surgery with lack of SHO cover overnight due to short term sickness. Concerns have been escalated and steps are in place to address these.

5. EXCEPTION REPORT OUTCOMES

5.1 Work Schedule Reviews

A work schedule review is currently under discussion with neurosurgery to try to make the work schedules more accurately reflect the working hours.

5.2 Fines

25 fines have been issued:

- Ophthalmology (4 fines): Rule breached "Unable to achieve minimum overnight continuous rest of five hours between 22:00 and 07:00 during a non-resident on-call (NROC); Unable to achieve the minimum 8 hours total rest per 24-hour NROC shift." Total fine money £921.64.
- General Surgery (4 fines): Rule breached "Late finish; Exceeded the maximum 13-hour shift length." Total fine money £381.58.
- Hepatobiliary surgery (2 fines): Rule breached "Unable to achieve minimum overnight continuous rest of five hours between 22:00 and 07:00 during a non-resident on-call (NROC); Unable to achieve the minimum 8 hours total rest per 24-hour NROC shift." Total fine money £906.55.
- Neurosurgery (5 fines): Rule breached "Late finish; Exceeded the maximum 13-hour shift length." Total fine money £982.41.
- ENT (7 fines): Rule breached "Late finish; Exceeded the maximum 13-hour shift length." Total fine money £703.49.
- Trauma and Orthopaedics (2 fines): Rule breached "Late finish; Exceeded the maximum 13-hour shift length." Total fine money £309.50.
- Gastroenterology (1 fine): Rule breached "Unable to achieve minimum overnight continuous rest of five hours between 22:00 and 07:00 during a non-resident on-call (NROC); Unable to achieve the minimum 8 hours total rest per 24-hour NROC shift." Total fine money £866.70.

6. ISSUES ARISING

6.1 Workforce and workload

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

6.2 Administrative Support

Administrative support is currently good.

7. LOCUM SPEND

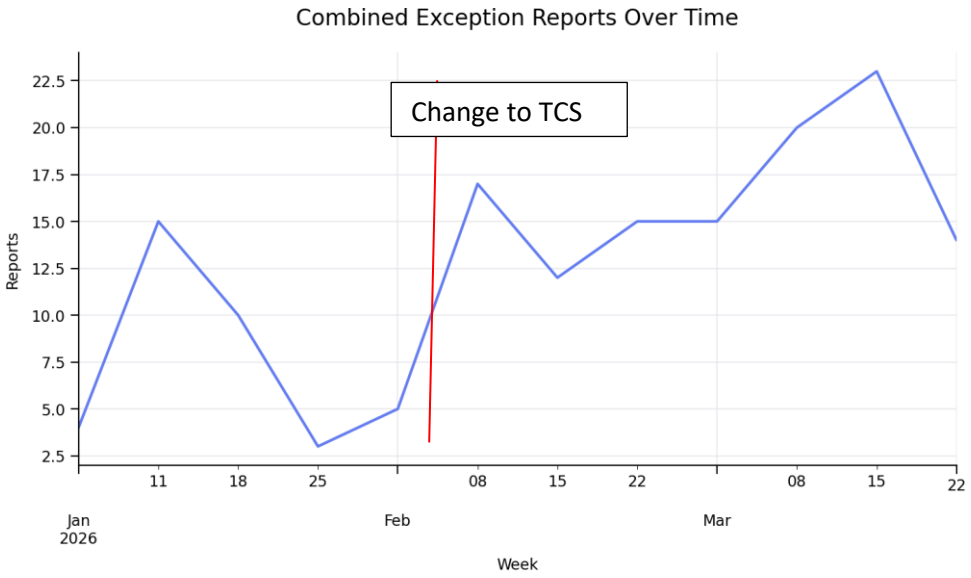
The finance team have been unable to provide this information for this quarter.

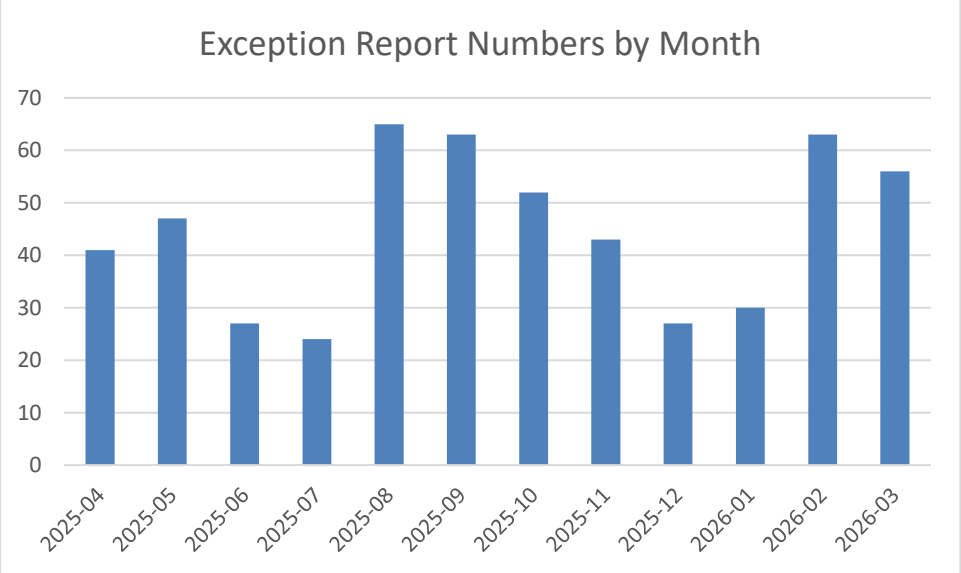
8. RISKS AND MITIGATION

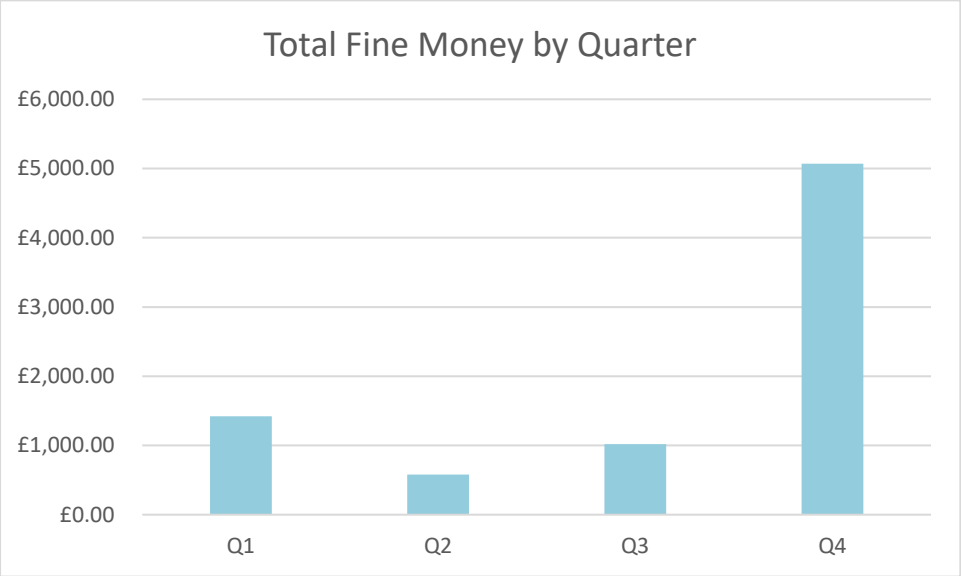
8.1 Changes to the TCS of the Contract

Changes to the TCS of the contract came in in February 2026. Exception reports are signed off by medical staffing with oversight by the GOSW. There is no involvement from supervisors. It was anticipated that this would result in a large increase in exception reporting numbers. There has been some increase in exception reports, but not to the level anticipated and it is difficult at this time to determine whether the increase in number is due to the natural variations that we observe from month to month.

Other Trusts in the region have seen a 1.5 to twofold increase in exception reporting numbers. However, we have seen a change in pattern of exception reports, with an increase in exception reports from specialties which previously did not have high numbers of reports. There has also been an increase in numbers of exception reports from specialty trainees, and a significant increase in exception reports resulting in a fine.







9. RESIDENT DOCTOR FORUM

Issues discussed included concerns around bottlenecks in training with updates on local solutions at Newcastle Hospitals.

NHS England's newly published 10 point plan to improve working conditions for resident doctors was also discussed.

Intermittent lack of phlebotomy cover, and it's impact on workload was also highlighted.

10. RECOMMENDATIONS

I recommend that we continue to review the workforce workload balance to ensure that safe staffing numbers reflect the current workload for individual wards, with consideration of further locally employed doctor posts to accommodate the anticipated number of doctors unable to secure training places.

I also recommend that we continue to monitor the impact of the Resident Doctor Contract changes.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours
28 April 2026

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Agenda item A3(c)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 2026		
Title	Trust Response to NHS England letter regarding Antimicrobial Resistance and Stewardship		
Report of	Lucia Pareja-Cebrian Medical Director		
Prepared by	Dr Julie Samuel, Consultant Microbiologist and Director of Infection Prevention and Control Martin Young, Senior Lead Clinical Pharmacist		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	The NHS England (NHSE) 5-year National Action Plan (2024–2029), titled 'Confronting Antimicrobial Resistance 2024 to 2029' provides a tactical roadmap for NHSE's 20-year vision to contain and control antimicrobial resistance (AMR) by 2040. Within the plan, the key targets for 2029 are: • 5% reduction in total antibiotic use in human populations from the 2019 baseline. • 70% "Access" Category use, aiming for at least 70% of total prescriptions to come from the World Health Organization (WHO) "Access" category (narrow-spectrum antibiotics). • 0% increase in specified drug-resistant and Gram-negative bloodstream infections compared to the 2019/20 baseline. • 10% knowledge boost in public and healthcare professional awareness of AMR. This paper sets out the Trust response to the NHSE November 2025 letter on Antimicrobial AMR, aligning local Antimicrobial Stewardship (AMS) priorities with the National Action Plan 2024–2029. It also adds context to each of the strategic points in the context of the current Trust position and seeks to provide assurance on the delivery of the national strategy within the Trust. The Trust is focusing on three core areas: reducing overall antibiotic prescribing, increasing use of WHO ACCESS antibiotics, and optimising intravenous to oral switch (IVOS) practice. Although Trust antibiotic use has increased by 3.3% from the 2019/20 baseline, Newcastle Hospitals remains among the lowest antibiotic users within the Shelford Group. Performance against national targets shows mixed progress: ACCESS antibiotic usage is currently 53% (below the 70% target), and IV (intravenous) antibiotic use sits at the upper end of benchmarking, indicating clear opportunity for improvement. An assurance framework for 2026 is in place, with defined workstreams, timelines, and executive oversight through the Infection Prevention and Control governance structure. Key actions include strengthened AMS audit processes led by clinical pharmacists, blood culture optimisation pathways, guideline review, and nursing led stewardship to support IVOS. Risks and delivery are overseen through the Infection Prevention and Control (IPC) Board Assurance		

<table>
<tr><td></td><td colspan="6">Framework, with an established Antimicrobial Resistance Steering Group providing multidisciplinary leadership.

Overall, the paper provides assurance that appropriate governance, capability and delivery mechanisms are in place, while acknowledging the scale of change required to meet national AMR targets.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Trust Board is asked to:
i) To note and comment on the detail provided.
ii) Discuss compliance with the national request.
iii) Discuss progress with outstanding actions and agree future reporting frequency and structure.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Advancing Care – Improving patient care, effectiveness and quality through innovation, research, improvement and education.</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">i) Updated detail contained withing the IPC Board Assurance Framework
ii) 1.2 - Failure to implement effective governance systems and processes across the Trust to assess, monitor and drive improvements in quality and safety.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Standalone report with continued oversight via the IPC Improvement group and IPC Committee</td></tr>
</table>

Agenda item A3(c)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Trust Response to NHS England (NHSE) letter regarding Antimicrobial Resistance and Stewardship

April 2026

Act now: protect our present, secure our future

NHSE letter November 2025

Act now: protect our present, secure our future

The World Health Organisation has declared antimicrobial resistance (AMR) as one of the top global public health and development threats, and AMR is listed on the UK government's National Risk Register.

As a senior NHS leader, your commitment is critical to tackling AMR and protecting patient safety.

We are writing to you with a **call to action** – to work with your prescribers and your clinical leads to make the changes required to meet the targets in the national action plan for AMR.

National Action Plan: Confronting antimicrobial resistance 2024 – 2029

#Confronting AMR - The UK's second five-year national action plan. Key actions for provider organisations:

- Target 4a: Reduce combined Primary and Secondary care total antibiotic prescribing by 5% from 2019 / 20 baseline: Note 70 – 80% antibiotic prescribing is in Primary care

- Target 4b: Achieve combined 70% of total antibiotic use from the World Health Organization ACCESS group of antibiotics: ACCESS group: First- or second-line narrow spectrum agents, lower resistance potential, fewer side effects, lower cost options

- Local target: Optimise intravenous to oral switch (IVOS) practice

Key asks for NHS provider organisations

- Ensure board-level review & Executive oversight – Performance against National Standards and benchmarking
- Risk and Capability Assessment – Infection Prevention and Control (IPC) Board Assurance Framework
- Set Priorities and Deliver Improvement

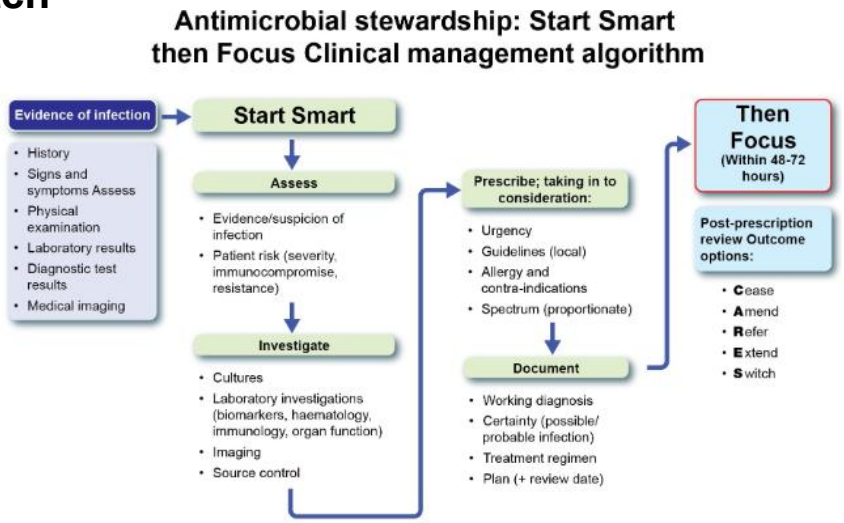
Three priorities for Antimicrobial Stewardship (AMS)

1. **Monitor and where possible reduce antibiotic prescribing**

2. **Increase proportion of ACCESS antibiotics used**

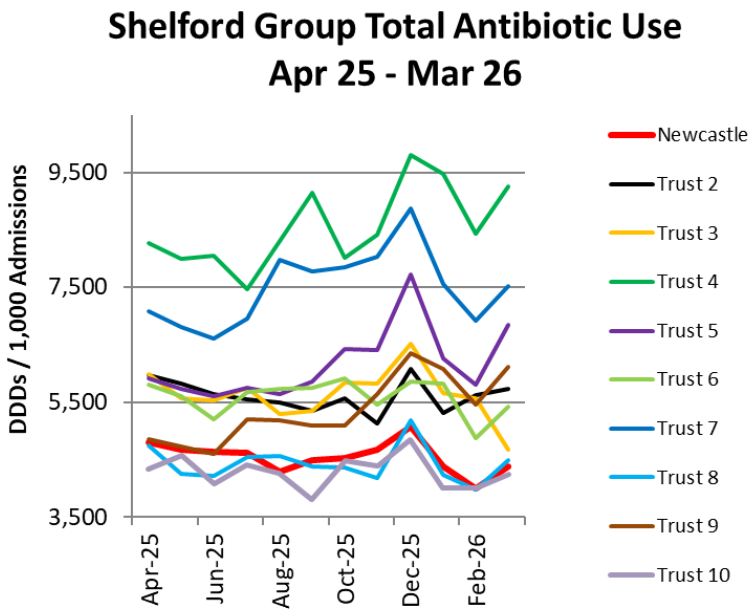
3. **Optimise intravenous to oral antibiotic switch**

Embed the principles of AMS best practice Start Smart, then Focus clinical management algorithm



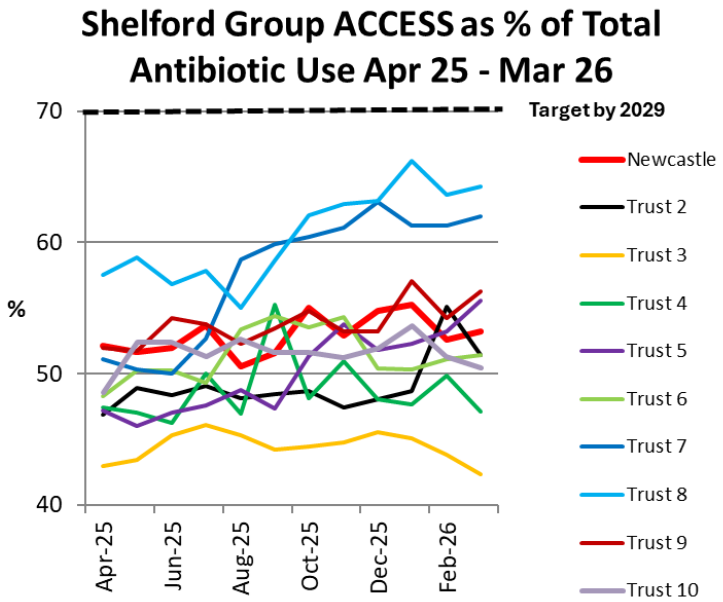
Target 4a: Reduce combined Primary and Secondary care total antibiotic prescribing by 5% from 2019 / 20 baseline

- Primary care initiatives which are already in place indicate that this target will be met, Secondary care has a smaller influence on this target
- Trust antibiotic prescribing has increased by 3.3% against the baseline, but Newcastle Hospitals is amongst the lowest users in the Shelford group
- Challenges for Secondary care:
  - Multiple narrow spectrum agents may be required to replace one broad spectrum agent
  - Increasing bacterial resistance means higher doses are sometimes needed
  - Movement of prescribing from GPs to Urgent Treatment Centre



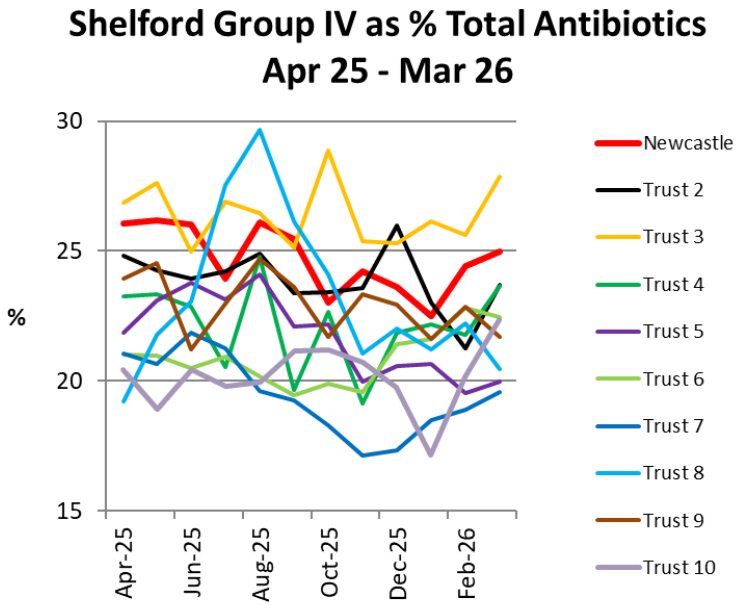
Target 4b: Achieve 70% of antibiotic use from the World Health Organization ACCESS category by 2029

- ACCESS group: First- or second-line narrow spectrum agents, lower resistance potential, fewer side effects, lower cost options
- Newcastle Hospitals at 53%, middle to upper level of Shelford Group but significant changes required to work towards the target
- Higher broad spectrum antibiotic use is associated with using intravenous rather than oral antibiotics, combinations of narrow spectrum antibiotics are sometimes required to achieve the same cover as a single broad spectrum antibiotic



Local target: Optimise intravenous to oral antibiotic switch practice (IVOS)

- Benefits of optimising IVOS practice include reduced patient risk and improved experience, shorter length of stay, saving nursing time, oral agent more likely to be narrow rather than broad spectrum, reduction in cost, reduction in environmental waste
- Newcastle Hospitals proportion of intravenous antibiotics used is in the upper end of Shelford group suggesting there is scope for possible IVOS improvement
- A national IVOS guideline is available to aid decision making in our Trust with support from AMS pharmacists.



Assurance framework for delivering AMS strategies in 2026

Challenges	Key Workstreams	Timelines	Lead /oversight group
Timely de-escalation of antibiotics following identification of sepsis	Blood culture optimisation pathway	End of Quarter 2	IPCC collaboration with Clinical Decision Support (CDS) and Deteriorating sepsis group
AMS audits being undertaken at ward level inconsistently due to workforce challenges	Clinical Pharmacists taking on this role from May 2026 to ensure continuous and sustained audit processes with feedback	Quarter 2	AMSG , Medicine Management Optimisation group and Quality Oversight Group (QOG)
Increase our usage of ACCESS antibiotics (5%)	AMS audits Review of Trust guidelines	End of Quarter 4	AMSG and Clinical Boards QOG
Optimise IVOS	AMS audits Nurse AMS stewardship (Night shift teams flagging patients for review) Reduce Intravascular devices	End of quarter 3	AMSG and Clinical Boards QOG

Additional Actions in place

- Antimicrobial Resistance Steering Group (AMSG) in place with multistakeholder involvement
- Key actions captured within the IPC Board Assurance Framework
- Leadership posts in place from a pharmacy and medical perpsective
- Executive oversight through Infection Prevention and Control Committee (IPCC)

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Agenda item A3(d)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 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 Review Six Month Deep Dive Highlight Report. The full review paper discussed at the Trust Quality Committee can be found in the Trust Board Reading Room for information. • **Section 2**: Accrediting Excellence (ACE) Programme Update • **Section 3**: Allied Health Professionals (AHPs) Workforce Highlight Report. The full review paper discussed at the Trust Quality Committee can be found in the Trust Board Reading Room for information. 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. • Several wards have required support in line with the Nurse Staffing and Clinical Outcomes Group criteria. Action plans are in place with education and resources provided. • Registered nurse fill rates remain above the 85% threshold. Staffing incidents, red flags and Care Hours Per Patient Day (CHPPD) data collectively indicate increased pressure on staffing over the last quarter, consistent with winter demand, sickness absence and service complexity. • Safer Nursing Care Tool (SNCT) and Community Nursing Safe Staffing Tool (CNSST) data captures have been completed in line with national guidance and triangulated with professional judgement; most nursing establishments remain broadly fit for purpose. • A number of services require further detailed review due to complexity and changes in acuity and dependency profiles. Temporary mitigations are in place while sustainable solutions are explored. • Strengthened nurse staffing review (NSR) governance, including enhanced pre-review reporting and Clinical Board action logs, is improving grip, accountability and progress		

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Section 2
• The Accrediting Excellence (ACE) Programme was launched in January 2025, supported by Newcastle Hospitals Charity, to provide a structured, organisation-wide framework for assuring and improving clinical and professional standards.
• Progress to date demonstrates strong engagement and early impact, with a growing number of areas achieving accreditation and measurable improvements seen across compliance, safety and staff engagement.
• There are 60 inpatient wards on the programme, of which 37 have achieved their first accreditation award.

Section 3
• The workforce data highlights the professions that remain ‘at risk’ where there is staff turnover and absence leading to clinical and operational pressures. Local mitigations are in place.
• The standardised job planning framework for all AHP professions commenced in October 2025 and the current position is provided in the report.
• There are broad workforce challenges with a range of capacity and demand issues impacting on clinical and operational performance. Detail can be found in the report.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Board of Directors is asked
i) Receive and discuss the report.
ii) Note the oversight and reporting of safe staffing which has been prepared in line with national guidance.
iii) Note the progress of the ACE Programme.
iv) Note the AHP professional assurance and workforce update.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Advancing Care – Improving patient care, effectiveness and quality through innovation, research, improvement and education.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">BAF risk ID 1.1 - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">The EDoN update is a regular comprehensive report bringing together a range of issues to the Trust Board.</td></tr>
</table>

EXECUTIVE DIRECTOR OF NURSING MIDWIFERY AND ALLIED HEALTH PROFESSIONALS REPORT

1. NURSE STAFFING UPDATE

A guidance document providing an overview of nursing safe staffing metrics along with the ward and department monthly safe staffing dashboard can both be found in the Board Reading Room to complement the details contained within this paper.

1.1 Nurse Staffing Escalation

The Trust Nursing Safe Staffing Guidelines provide a robust framework to ensure safe nurse staffing governance and identifies a clear process for safe staffing escalation. The Trust staffing escalation is currently at level one. The Nurse Staffing and Clinical Outcomes (NSCO) Group continues to provide oversight of safer staffing metrics aligned to clinical outcomes and nurse-sensitive indicators, in line with national guidance. During the last quarter, there were no wards requiring high-level support. The number of wards receiving medium-level support reduced from eight to four, with an increase in wards receiving low-level support. This shift reflects both improvement in some areas and the intentional inclusion of new assurance measures within the NSCO framework.

Registered nurse (RN) fill rates show a gradual downward trend across the 18-month period for both day and night shifts; however, Trust-wide performance remains consistently above the 85% threshold. Unregistered fill rates remain strong across day and night shifts, exceeding upper thresholds in several months, reflecting the use of Healthcare Assistant (HCA) backfill to mitigate RN shortfalls overnight as well as meeting the enhanced therapeutic observation and care (ETOC) task need. Red flag and staffing incident reporting has increased. This increase reflects improved reporting awareness but triangulation with a dip in CHPPD and nursing fill rates suggests pressure on staffing resilience. This pattern is consistent with the impact of winter pressures, including planned and unplanned escalation beds diluting staff-to-patient ratios, alongside increased winter sickness absence. Outside of this winter-related period, variation remains within expected limits and indicates a generally stable staffing position. Mitigation continues through established staffing escalation processes and the use of temporary staffing to maintain service continuity and reduce immediate risk; however, this may carry not eliminate risk of staff fatigue and sickness absence.

1. 2 Nurse Staffing Deep Dive

The corporate nursing team coordinates Nurse Staffing Reviews (NSR) using evidence-based workforce tools, including the Safer Nursing Care Tool (SNCT) and the Community Nursing Safer Staffing Tool (CNSST), triangulated with nurse-sensitive indicators and professional judgement. These reviews inform nursing establishment recommendations in line with national guidance. The full and comprehensive Nurse Staffing Deep Dive paper is contained within the Board Reading Room.

The NSR governance has been strengthened, to include enhanced pre-review reporting and Clinical Board action logs. This is improving grip, accountability and supports informed discussion and decision-making whilst allowing progress tracking across the organisation.

There are a number of areas where the staffing model is broadly fit for purpose. In some areas where there have been budgetary adjustments a Quality Impact Assessment has been completed and agreed by the Executive Director of Nursing. Where budgetary efficiencies have been identified these have supported adjustments within the Clinical Boards. In the Emergency Department, since the last reporting period, SNCT now incorporates the nursing workload associated with patients remaining in the department for 12 hours or more. This data coupled with rising patient attendances, indicates that additional staffing is required to support quality of care and timely triage. Interim mitigation continues using temporary staffing while this work is progressed to conclusion. There are several services where a further detailed review was required due to the complexity of the patient group, patient acuity or service redesign is present. In these services temporary mitigations are in place while sustainable solutions are explored within Clinical Boards and through agreed governance processes.

2. ACCREDITING EXCELEENCE (ACE) PROGRAMME

The Accrediting Excellence (ACE) Programme was launched in January 2025, supported by Newcastle Hospitals Charity, to provide a structured, organisation-wide framework for assuring and improving clinical and professional standards. The programme responded directly to staff feedback for a clear, consistent approach to quality and aligns with NHS England guidance on accreditation as a driver of safer, higher quality care.

ACE is now established as a key enabler of the Trust's focus on fundamentals ambition to support wards and departments to embed high standards, reduce unwarranted variation and strengthen both patient outcomes and staff experience.

Progress to date demonstrates strong engagement and early impact, with a growing number of areas achieving accreditation and measurable improvements seen across compliance, safety and staff engagement. High quality clinical and professional standards are essential to safe and effective care and accreditation brings together multiple measures of care quality into a single, coherent framework that allows teams to understand performance, identify gaps and continuously improve. The ACE programme was developed to provide a clear, structured framework for clinical standards, enable consistent measurement of quality at ward and department level, empower local teams to take ownership of improvement and recognise and celebrate excellence in care delivery.

The ACE process is structured, supportive and improvement-focused, ensuring that teams are prepared and guided throughout their accreditation journey. Key stages include:

1. **Programme onboarding** – wards and departments are invited or self-nominate.

2. **Baseline assessment** – early review of readiness, highlighting strengths and areas for improvement.
3. **Progress reviews** – structured check-ins to monitor improvement and provide targeted support.
4. **15-step visit** – unannounced patient-centred assessment of environment and first impressions.
5. **Staff engagement survey** – contributing to overall accreditation outcomes.
6. **Accreditation assessment period** – formal evaluation within a defined two-week window.
7. **Outcome and feedback** – recognition of achievement and clear guidance for further development.
8. **Celebration and recognition** – formal acknowledgement of success at ward level.
9. **Ongoing assurance and re-accreditation** – cyclical process to sustain standards, 2-3 years.

This structured approach balances assurance with support, enabling teams to improve while maintaining local ownership.

Significant progress has been made in the first phase of delivery, with six core sets of standards having been developed and implemented. Initial accreditations have been completed in day units and in critical care. 37 of 60 inpatient wards on the programme have achieved their first accreditation award. Six wards have achieved gold accreditation, 26 silver and five bronze, with the remaining wards and departments actively progressing toward accreditation.

The forthcoming phase of the ACE programme is strategically focused on several key objectives: finalising and embedding the remaining standards across all service areas, while expanding accreditation coverage to encompass inpatient, community and specialist services. The programme will prioritise strengthening digital capabilities to enhance delivery and reporting mechanisms, ensuring the sustained evidence of impact through measurable improvements in quality and safety to embed long-term engagement at ward and department level.

In summary, the ACE programme is delivering a comprehensive range of organisational and clinical benefits, fundamentally driving improved patient safety through a stronger focus on harm-free care, enhanced risk management and a reduction in service variation. Furthermore, the initiative has enhanced staff experience and culture by fostering increased engagement, developing clinical leadership and cultivating a greater sense of accountability.

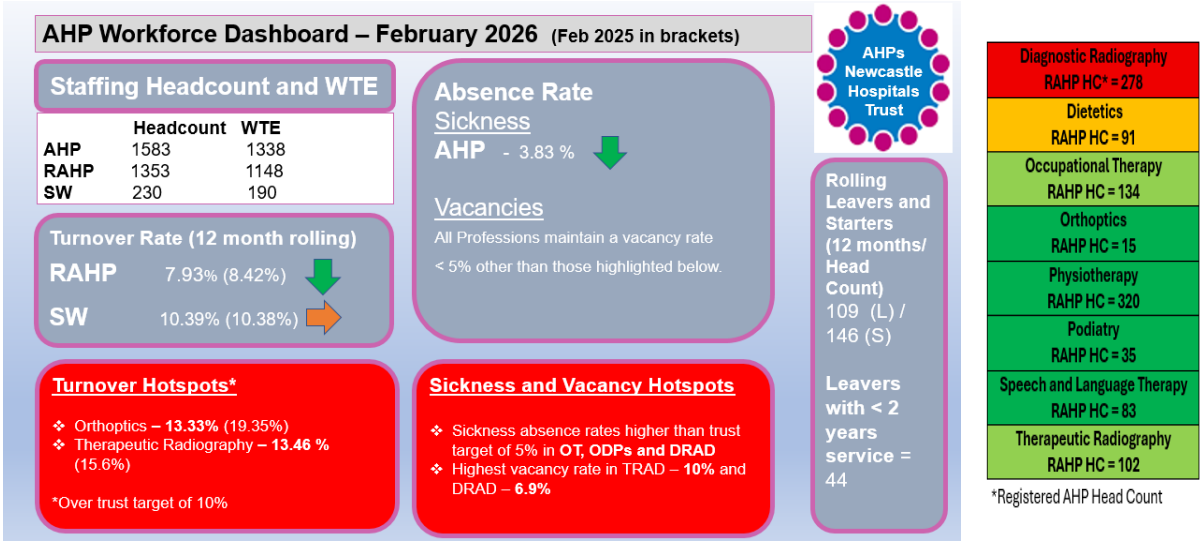
From an organisational perspective, the programme provides strengthened assurance through improved visibility of quality metrics from ward to board, aligning local practices with NHS best practices. Early implementation evidence indicates tangible impact, including improved compliance with clinical standards, notably in medical devices training and has strengthened collaboration between front-line staff and specialist teams, such as Infection Prevention and Control (IPC). Finally, the programme facilitates a greater presence of clinical experts in care environments, supporting real-time improvement and education.

3. ALLIED HEALTH PROFESSIONS PROFESSIONAL ASSURANCE AND WORKFORCE REPORT

A comprehensive overview of the AHP Assurance and Workforce Report was discussed at the Trust Quality Committee in April 2026. This can be found in the Trust Board reading room. The following key areas have been summarised for the Trust Board's awareness:

- **Workforce Overview**

Newcastle Hospitals employs 1,350 registered AHPs (RAHP) and 250 AHP Support Workers (SW) across nine professions: Dietetics, Diagnostic Radiography (DRAD), Occupational Therapy (OT), Operating Department Practitioners (ODP), Orthoptics, Physiotherapy, Podiatry, Speech and Language Therapy (SALT), and Therapeutic Radiography (TRAD).



WTE = whole-time equivalent

- **Vulnerable Professions**

The workforce data analysis identifies several professions that continue to be 'at risk', specifically Podiatry, Orthoptics and Therapeutic Radiography. These professions mirror those nationally recognised as 'vulnerable' due to their relatively small workforce size and persistent recruitment and retention challenges. Contributing factors nationally include, consistently high vacancy rates, higher levels of student attrition, and an ageing workforce.

- **Professional Leadership & Workforce, Education and Practice Development Annual Report 2025/26**

A dedicated AHP Professional Leads Group provides multiprofessional leadership, oversight, and assurance for workforce and professional development priorities. The AHP Workforce, Education and Practice Development Annual Report 2025/26 sets out a comprehensive overview of the AHP workforce priorities and achievements over the past 12 months. A copy can be found in the Board Reading Room.

- **AHP Job Planning at Newcastle Hospitals**

In 2025, Newcastle Hospitals introduced a standardised Job Planning framework for all AHP professions – implementation commenced in October 2025, with full compliance required by 31 March 2026. The accompanying heat map summarises the current position of all AHP professions as of April 2026:

Less than 25% of RAHP have Job Plan
25 – 50% of RAHP have Job Plan
50 – 75% of RAHP have Job Plan
75% + of RAHP have Job Plan

- Significant progress has been achieved over a six-month period, with the majority of professions now demonstrating 50–75% compliance.
- Where full compliance has not yet been realised, targeted discussions are ongoing to identify and address areas requiring further support, with compliance anticipated by the end of June 2026.

- **Capacity, Demand and Productivity**

One key purpose of AHP Job Planning is to enhance organisational understanding of clinical capacity, enabling safer deployment of the AHP workforce and improved alignment of staffing to patient need. Future phases of the programme will focus on correlating capacity with demand (see below) and strengthening assurance around safe and sustainable staffing and productivity; providing a clearer visibility of risks associated with capacity constraints.

- **Productivity**

Current data from Model Hospital is relatively limited for AHP's, as the information is not connected to pathway and subspecialty analysis. The productivity metric used within Model Hospital is *cost per Weighted Activity Unit (WAU)* - the data shows that AHP professions at Newcastle lower cost per WAU, closely aligned with peer Trusts (similar size and clinical output) and below the national value.

Workforce Output	Data period	Provider value	Peer average	National value	method	Chart
Professional, Technical, and Therapies staff cost per WAU	2024/25	£437	£263	£243	Provider median	
(Annual Accounts estimate) AHP cost per WAU	2024/25	£111	£111	£118	Provider median	
(Annual Accounts estimate) Healthcare science and Other STT cost per WAU	2024/25	£326	£166	£126	Provider median	

- **Achievements**

The **AHP Workforce, Education and Practice Development Annual Report for 2025/26** provides a comprehensive and detailed account of the progress, achievements, and impact delivered across the last 12 months. The report outlines key developments across safe

staffing, education, training, supervision, and professional practice, and aligns each workstream to the overarching AHP Workforce Strategy.

In particular, attention is drawn to the sections on the **Therapy Services Supervision Framework, Training Needs Analysis, and AHP Practice Placement Growth**, which collectively highlight the value and impact of this ongoing work.

3. RECOMMENDATIONS

The Trust Board is asked to:

i) Note and discuss the content of this report.
ii) Note the oversight and reporting of safe staffing which has been prepared in line with national guidance.
iii) Note the progress of the ACE Programme.
iv) Note the AHP professional assurance and workforce update.

Report of Ian Joy
Executive Director of Nursing, Midwifery and
Allied Health Professionals
12 May 2026

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 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 the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight. Key points/risks to note: • The Trust has analysed the Right Time Maternity Survey results from January – March 2026. It is reassuring to see, even with a small sample size, improvement in the results for asking women about mental health and providing support during the antenatal and postnatal period, with the Trust is in the top 20% of Trusts overall. • The Trust continues to consult with the Integrated Care Board (ICB) to agree the service specification for the maternal mental health service, unfortunately there has been little progress in April, with no response received thus far to the Trust questions regarding the eligible cohort of women. • The service is currently under pressure due to the ongoing rate of maternity leave; currently 5.15% service wide. This has been a concern for the last 12 months and whilst this is being addressed via appropriate allocation of rotational midwifery staff, the skill mix is subsequently an area of concern which is being monitored closely by the matron team. • The Fetal Medicine service remains fragile and is a continued area of focus; an enhanced support plan is in place, which is expected to continue for the next 6-12 months as the Trust was unfortunately unsuccessful in appointing a Fetal Medicine Consultant. Daily consultant triage of referrals, with clinical prioritisation continues to safeguard clinical safety. The estates work has been completed, the additional scan room will support patient flow through the service, and timely progress is being made to introduce the electronic referral system for oversight and visibility of waiting lists. • The perinatal service has conducted analysis of the latest staff survey results and has been able to obtain a further limited breakdown to focus on specific staff groups and areas of the perinatal service to better inform the Perinatal Culture and Staff Wellbeing action plan. The results have reiterated the importance of the Perinatal Anti-Racism Taskforce (PART), with the compassionate and inclusive people promise scores indicating perinatal staff are experiencing discrimination at work from patients and relatives above that of the Trust average. • Maternity Incentive Scheme Safety Action E is at risk, pending the publication of the national implementation tool and clarity of the ICB co-ordination approach to the system requirements.		

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On 26 March 2026, an advisory notice was received from System C regarding concerns relating to automatic population of the fetal growth and pre-eclampsia risk assessments within the BadgerNet electronic patient record. A local review is in progress to understand clinical impact which will be concluded by the 22 May 2026.
A national patient safety alert (NPSA) was received on 8 April 2026 relating to a shortage of dinoprostone. The Trust switch to cervical ripening balloon induction of labour occurred on the 20 April 2026 following completion of a comprehensive action plan to address the estate and bed capacity issues, midwifery training, changes in guidance and patient information. Despite the control measures it is expected that there will be a considerable increase in delays during the induction of labour pathway.
The perinatal service is under considerable pressure and whilst the leadership team strive to continue to progress the other quality improvement initiatives, the progress of these has been thwarted over the last month due to the capacity of the team, however, comprehensive action plans with established oversight mechanisms to track progress and escalate concerns are in place to ensure that patient safety and staff and patient experience are prioritised.

</td></tr>
<tr><td>Recommendation</td><td>The Trust Board are asked to:

i. Receive and discuss the report.
ii. Note the improvements in the Right Time patient experience results.
iii. Note the ongoing actions to support the fragility of the fetal medicine service.
iv. Note the delay to introducing the maternal mental health service.
v. Note the benchmarking with the Maternity Incentive Scheme requirements.
vi. Note the impact of the digital risk assessments advisory notice and approach of the Trust to complete a comprehensive review.
vii. Note the impact of the National Patient Safety Alert on the induction of labour pathway and performance.
viii. Note compliance with the Perinatal Quality Surveillance Model (PQOM).</td></tr>
<tr><td>Links to Strategic Objectives</td><td>Advancing Care – Improving patient care, effectiveness and quality through innovation, research, improvement and education.</td></tr>
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<tr><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Reputation</td><td>Sustainability</td></tr>
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<tr><td>Link to Board Assurance Framework [BAF]</td><td>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>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>
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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. Future reports will outlines the Trusts current self-assessed position against the Year 8 Maternity Incentive Scheme Safety Actions and any escalations.

2. LISTENING TO WOMEN AND FAMILIES THROUGH SERVICE USER FEEDBACK

The Trust has analysed the Right Time Maternity Survey results from January – March 2026, and whilst the Trust is in the top 20% of Trusts overall, the results must be cautiously interpreted as the response rate of 168 surveys represents only 18% of service users. The surveys have been designed to include all the key questions from the questionnaire used in the Care Quality Commission (CQC) national patient survey programme and the NHS England (NHSE) Friends and Family Test.

A targeted communication strategy with further information provided during pregnancy is planned to increase the response rate and improve confidence in the results.

It is reassuring to see, even with a small sample size, improvement in the results for asking women about mental health and providing support during the antenatal and postnatal period. The Trust continues to consult with the ICB to agree the service specification for the maternal mental health service, unfortunately there has been little progress in April, with no response received thus far to the Trust questions regarding the eligible cohort of women.

The perinatal service has reported this as an escalation to the Local Maternity and Neonatal System (LMNS) leadership team via the Quarter 4 Perinatal Quality Oversight return, in addition this is being escalated through the Family Health Clinical Board. The Trust is meeting with the LMNS on the 28 May 2026 and hopes to receive an update in response to the escalation.

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.

The service is currently under considerable pressure due to the ongoing rate of maternity leave; this has been a concern for the last 12 months but unfortunately shows no sign of abating. The current maternity leave rate is 5.15% service wide; however, this is disproportionate between teams with 9.37% attributed to the intrapartum team, and 8.18% for community midwifery, and whilst this is being addressed via appropriate allocation of rotational midwifery staff, the skill mix is subsequently an area of concern which is being monitored by the matron team. The midwifery leadership team are also depleted, resulting in a 1:6 on call requirement until July 2026.

The peri-operative obstetric theatre staffing business case was agreed in part, and the recruitment for additional nurses commenced in May 2026. The peri-operative and perinatal leadership team are currently reviewing the deployment of the limited additional nursing resource against the current risk, and the impact of the unfunded elements, as there will continue to be a requirement for midwives to scrub for theatre cases overnight and weekends if a second theatre is required, the updated action plan continues to be monitored by both Clinical Boards.

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 a continued area of focus; an enhanced support plan is in place, which is expected to continue for the next 6-12 months as the Trust was unfortunately unsuccessful in appointing a Fetal Medicine Consultant during the recent recruitment round. In the interim the consultant midwife for Fetal Medicine is providing additional clinical capacity, and support to progress the action plan.

The estates work has been completed, the additional scan room will support patient flow through the service, and timely progress is being made to introduce the electronic referral system for oversight and visibility of waiting lists.

Daily consultant triage of referrals, with clinical prioritisation continues to safeguard clinical safety. The service has developed an internal escalation standard operating procedure to support this, with clarity regarding the threshold at which mutual aid will be requested, acknowledging that Fetal Medicine consultant shortfalls are mirrored nationally. This issue has been flagged with the LMNS, and support has been requested to escalate the workforce challenges to the national team.

The Trust has appointed two high risk obstetricians, as well as a locum for a six month period, who will provide much needed additional capacity. This will facilitate the Fetal Medicine consultants to reduce their generic obstetric cover, such as for elective caesarean lists, and increase the number of Fetal Medicine sessions, however, the impact of this will not be felt until November 2026.

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 April.

The Trust is compliant with the British Association of Perinatal Medicine (BAPM) guidance for neonatal medical staffing; there are currently no vacancies following the recent recruitment of a consultant, and no rota gaps.

4. CULTURE OF LEARNING, SAFETY AND SUPPORT

a. Perinatal staff experience

The perinatal service has conducted analysis of the latest staff survey results and has been able to obtain a further limited breakdown to focus on specific staff groups and areas of the perinatal service to better inform the Perinatal Culture and Staff Wellbeing action plan, unfortunately this does not allow for benchmarking with Shelford colleagues and should be a consideration for the Trust for next year.

There were 216 respondents from the perinatal service in 2025, up from 160 in 2024. Results included:

- 8 questions are statistically worse.
- 6 questions are statistically better.

The results regarding leadership and line management have broadly improved, however the results regarding burn out, feeling appreciated and having adequate materials and equipment and enough staff to do their job have deteriorated. The wellbeing champions and perinatal leadership team will co-produce actions to address this, including exploring fixed term contracts to cover midwifery maternity leave cover the next 12 months.

The results have reiterated the importance of the Perinatal Anti-Racism Taskforce (PART), with the compassionate and inclusive people promise scores indicating perinatal staff are experiencing discrimination at work from patients and relatives. The PART has an action plan to address this and ensure that the staff are equipped to manage and escalate concerns, and ensure these are appropriately managed, as well as providing pastoral care and support through the New to Newcastle group and Global Café.

People Promise Questions	Organisation	Maternity	Neonates
Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability, or age (Yes).	54.93%	54.88%	60.38%
In the last 12 months have you personally experienced discrimination at work from patients / service users, their relatives, or other members of the public (Yes).	6.45%	8.92%	11.32%
In the last 12 months have you personally experienced discrimination at work from	7.91%	6.10%	6.67%

a manager / team leader or other colleagues (Yes).			

There was one Freedom to Speak up contact during April 2026 associated with incivility in theatre, this has been appropriately investigated and additional incivility drills are planned in Quarter 1 to support the learning, with senior oversight.

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

5.1 Maternity Incentive Scheme Year 8

The Year 8 Maternity Incentive Scheme was published on 31 March 2026 and unlike previous years focuses on six core safety actions:

Safety Action	Progress
A. Workforce and capacity	On track
B. Training	On track
C. Learning from reviews and investigations	On track
D. Service User Voice and equity	On track
E. Care bundles	At risk
F. Board oversight, governance, culture, and leadership	On track

Safety Action E – Care Bundles

This safety action focuses on the implementation of national maternity and neonatal care bundles, which bring together evidence-based practices to improve outcomes.
The Trust is expected to prioritise implementation based on local safety intelligence, monitor progress through established governance routes, and ensure Board-level oversight of care bundle delivery, this includes both the Saving Babies Lives Care Bundle and the Maternal Care Bundle, published in January 2026.

The Trust was fully compliant with the Saving Babies Lives Care Bundle in Year 7, and will continue to ensure this is embedded, however the audits to demonstrate compliance were centrally produced by the LMNS as part of their assurance and oversight responsibilities for the scheme, it is not clear if this will be continuing in 2026/27 due to the ICB reorganisation, or whether this will need to return to the Trust. If the Trust is required to audit against the various standards this would significantly impact the analytical and perinatal patient midwifery team capacity.

The Trust is yet to complete a benchmarking against the requirements of the Maternal Care Bundle (MCB) but is expected to have an action plan agreed by Trust Board to fully implement by March 2027. The implementation tool to support progress has not been published by NHSE, this was expected in Quarter 4 2025/26. In addition, the MCB requires co-ordinated action across NHS services, including primary care, with an ICB responsibility for ensuring engagement with wider services and strategic commissioning. The Trust has

made the decision to await further guidance from the ICB and NHSE regarding the approach across the North East and North Cumbria. The MCB was published in January 2026 and so the Trust has escalated the lack of an implementation tool and system approach to the LMNS and Regional NHSE maternity team in the Quarter 4 PQOM return.

5.2 Digital electronic patient record risk assessments

On 26 March 2026, an advisory notice was received from System C regarding incorrect automatic population of the fetal growth and pre-eclampsia risk assessments within the BadgerNet electronic patient record. The error was originally thought to only affect the risk assessments for women with a body mass index (BMI) 35.0 and 39.9kg/m2, in that the automatic population did not add the BMI risk to the calculation but it was later found to also affect the risk calculation associated with drug misuse and smoking.

Following a system wide meeting, convened by the LMNS, issues were raised by other Trusts relating to the risk calculation following automatic population for the venous thromboembolism (VTE) assessment, whereby there may be a risk that women who should have commenced antenatal thromboprophylaxis have not.

It was agreed with the LMNS that a clinical harm review should be conducted for all women with open pregnancy with a low or moderate risk status based on the original auto populated assessment. The Trust has taken the approach to review all open pregnancies and review each risk assessment to ensure all women are receiving the appropriate care and are on the correct pathways. A standardised review process has been agreed with the LMNS, who are maintaining oversight of the number of women affected.

The clinical harm reviews of the 2,327 open pregnancies commenced 13 April 2026 and is expected to be completed by 22 May 2026. The reviewers have prioritised women of an earlier gestation where there is still an opportunity for intervention. As yet no harm has been reported, and this will remain under review.

The Trust will also review all stillbirths and neonatal deaths from January 2026 to ensure the risk assessments for these pregnancies were not affected, this will be completed by 8 May 2026.

The midwifery time to complete the reviews is considerable, 1.8 WTE has been allocated to complete the reviews within 6 weeks, and the patient safety team are currently supporting the follow up and duty of candour letters and conversations with all affected women, reducing their capacity to support other patient safety priorities.

6 NATIONAL UPDATES

6.1 National Patient Safety Alert

A national patient safety alert (NPSA) was received on 8 April 2026 relating to a shortage of dinoprostone. This shortage is expected to last until September 2026. The NPSA outlined actions which had to be completed by 20 April and made recommendations of alternatives

during the shortage, of which there are very few. The Trust will receive an extremely limited supply of prostin gel which will be ring fenced for augmentation of labour as per the NPSA.

Following careful clinical consideration, the Trust has switched to mechanical induction of labour using cervical ripening balloons (CRB), with misoprostol tablets as a second line, whilst this is a clinically sound decision, it brings significant operational and patient flow issues.

The Trust is currently the top performing in the region for induction of labour delays, with no delays over 24 hours for more than 18 months up until the end of March 2026. The bed utilisation and patient flow is carefully managed, with the use of prostin (administered 6 hourly to a maximum of 3 doses) reduces the induction of labour (IOL) duration and length of stay, ensuring that the existing 7 IOL beds can accommodate up to 12 women a day.

Unlike prostin, the CRB must be insitu for 24 hours, and whilst some organisations complete this as an outpatient procedure, the Head of Obstetrics did not deem this feasible as part of the Trust's initial rapid transition having considered the home location and complexity of the Trusts patient profile. Data will be collated to inform future decision making around which patient cohorts will be eligible for outpatient IOL.

The Trust switch to CRB IOL occurred on the 20 April 2026 following completion of a comprehensive action plan to address the estate and bed capacity issues, midwifery training, changes in guidance and patient information, however, despite the control measures it is expected that there will be a considerable increase in delays during the induction of labour pathway.

During the first 14 days there have been 10 delays of >24 hours, with the associated patient frustration and complaints, although there have not been any patient safety incidents. This is a dynamic situation and the senior leadership team are supporting patient flow in hours and available out of hours via the perinatal on call to provide support, refine processes and ensure appropriate escalation. Whilst there have been delays, no requests for mutual aid have been made thus far, but it is likely this may occur as the new pathways are embedded. This issue is on the risk register with a score of 20, target of 8.

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 perinatal service continues to balance the national requirements such as the Maternity Incentive Scheme alongside the dynamic operational challenges associated with the digital risk assessments, national patient safety alert and the fragility of the fetal medicine service and has demonstrated agility whilst doing so. The perinatal service is under considerable pressure and whilst the leadership team strive to continue to progress the other quality improvement initiatives, the progress of these has been thwarted over the last month due to the capacity of the team, however, comprehensive action plans with established oversight mechanisms to track progress and escalate concerns are in place to ensure that patient safety and staff and patient experience are prioritised.

8 RECOMMENDATIONS

The Trust Board are asked to:

i. Receive and discuss the report.
ii. Note the improvements in the Right Time patient experience results.
iii. Note the ongoing actions to support the fragility of the fetal medicine service.
iv. Note the delay to introducing the maternal mental health service.
v. Note the benchmarking with the Maternity Incentive Scheme requirements.
vi. Note the impact of the digital risk assessments advisory notice and approach of the Trust to complete a comprehensive review.
vii. Note the impact of the National Patient Safety Alert on the induction of labour pathway and performance.
viii. Note compliance with the Perinatal Quality Surveillance Model (PQOM).

Report of Ian Joy
Executive Director of Nursing
5 May 2026

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Agenda item A4(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 2026					
Title	Freedom to Speak Up Guardian 2025-2026 Annual Report					
Report of	Rachel Carter, Director of Quality and Safety					
Prepared by	Paula Dimarco, Freedom to Speak Up Guardian					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☒			
Summary	This report is the 2025-2026 annual report of the Freedom to Speak Up Guardian.					
Recommendation	The Board is asked to receive the report, reflect on the themes raised in staff concerns and continue to support the Freedom to Speak Up function within the Trust.					
Links to Strategic Objectives	People Plan: Health and Wellbeing, Behaviours and Civility, Valued and Heard and Leadership and Management					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☒	☐
Link to Board Assurance Framework [BAF]	Risks 2.1, 2,2 and 2.3					
Reports previously considered by	This is a bi-annual reported presented to Trust Board					

FREEDOM TO SPEAK UP GUARDIAN (FTSUG) ANNUAL 2025-2026 REPORT

1. INTRODUCTION

This report provides details of the activity undertaken by the Trust's Freedom to Speak Up Guardian (FTSUG) between 1st April 2025 and 31st March 2026, including themes and trends identified in the concerns that have been raised and any learning identified by the Trust. It also includes data from the Work In Confidence anonymous reporting platform.

2. REVIEW OF 2024-2025 RECOMMENDATIONS

1. **Continue to invest in the service by appointing a 1.0 whole-time-equivalent (wte) FTSUG**
   FTSUG 1.0 recruitment undertaken and service commenced in September 2025.
2. **Continue the promotional work so that staff are aware that the service is available, this includes being present at induction and carrying out walkabouts and drop-in sessions as well as collaborating with the Chief Experience Officer to support targeted improvement work**
   Present at Trust and Resident Doctor induction, multiple walkabouts and drop-in sessions carried out and collaboration with Chief Experience Officer undertaken.
3. **Explore options for using a more robust data management tool, such as the FTSU InPhase app, to strengthen the governance and assurance around the FTSU service**
   InPhase app reviewed – does not support a 2-way conversation for anonymous reporters. A price reduction for the Work In Confidence contract was negotiated. Plan to use In-house built inphase module for case notes and data management.
4. **Develop a tool to capture data in relation to the champions**
   Complete and available to champions.
5. **Ensure FTSU dashboard is visible for all staff**
   Available through People section of Power BI.
6. **Ensure FTSU data is included in the monthly Integrated Board Report**
   FTSUG data included in this report.
7. **Improve communication between the FTSUG and Boards by implementing monthly meetings to share data that is then discussed at the Quality Oversight Group (QOG)**
   Not started.
8. **Develop and implement a tool for capturing learning from local teams in relation to FTSU cases**
   In progress.
9. **Amend the pathway by which the FTSUG receives feedback from service users so it goes directly to Guardian**
   User feedback survey data now emailed directly to the FTSU inbox (via MS Forms).
10. **Strengthen and grow the FTSU Champions, including setting up a Teams Channel and facilitating improved communication, meeting admin processes and support for champions as needed**
    Teams Channel in place. Number of Champions has increased to 36.
11. **Ensure relevant staff are aware of the request to complete the Speak Up, Listen Up Follow Up e-learning training – consider the use of face-to-face workshops to enhance and embed this online learning**

E-learning promoted at all engagement sessions. Face to face workshops not started.

3. FREEDOM TO SPEAK UP SERVICE

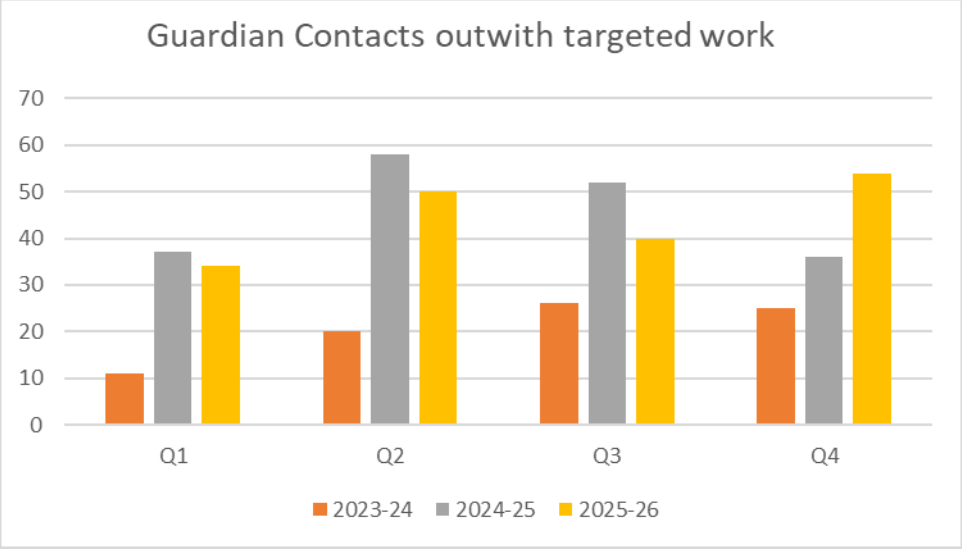
3.1 FTSUG Service provision

There was an increase in the FTSUG service provision from 0.4wte in May 2024 to 1.0wte (2 x 0.5) by September 2025. This increase in resource has meant that as well as being able to respond in a timely manner to all concerns raised, more time is available for case management as well as promotional work. Following a Trust Board development session in August, a FTSU Action Plan was agreed, which subsequently incorporated recommendations made by Grant Thornton as part of the external well led review. Updates on the action plan are provided at the People Programme Board.

3.2 Speak Up Activity

Between 1st April 2025 and 31st March 2026, the FTSUG responded to 225 cases of concern raised by staff members, which is 8 less than the same time period in 2024/25 (233). Of these cases, in 2025/26 43 speak ups were as a result of targeted work in conjunction with the Staff Experience Team, compared to 68 cases in 2024/25. Graph 1 shows a comparison of FTSUG cases raised since 2023/24, excluding cases raised as part of targeted work.

Graph 1:

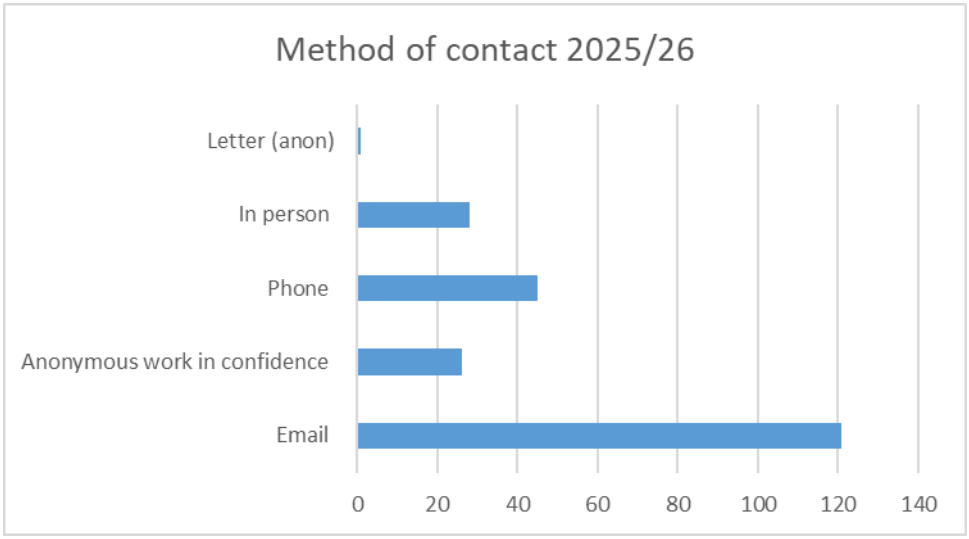


A FTSUG dashboard is available for staff to access on PowerBI, however it is not known how well used this is. Furthermore, aside from Cardiothoracic, who have an internal speak up process that runs alongside the FTSUG service and therefore they discuss speak up cases and learning at their monthly Quality Oversight Group and Quality Performance Reviews, Clinical Boards and Corporate Services are not known to be routinely reviewing and discussing their FTSU data.

3.3 Speak Up Accessibility

There are several ways that staff can contact the FTSUG, the most frequent of which is via email, which is the same as 2024/25. Graph 2 shows the different ways that staff members raised concerns in 2025/26. 26 people initially chose to contact the service anonymously through the Work In Confidence platform. After this initial engagement, 8 people felt able to share their identify and attend a face-to-face meeting with the Guardian. An additional person opted to write anonymously to the FTSUG with their concerns.

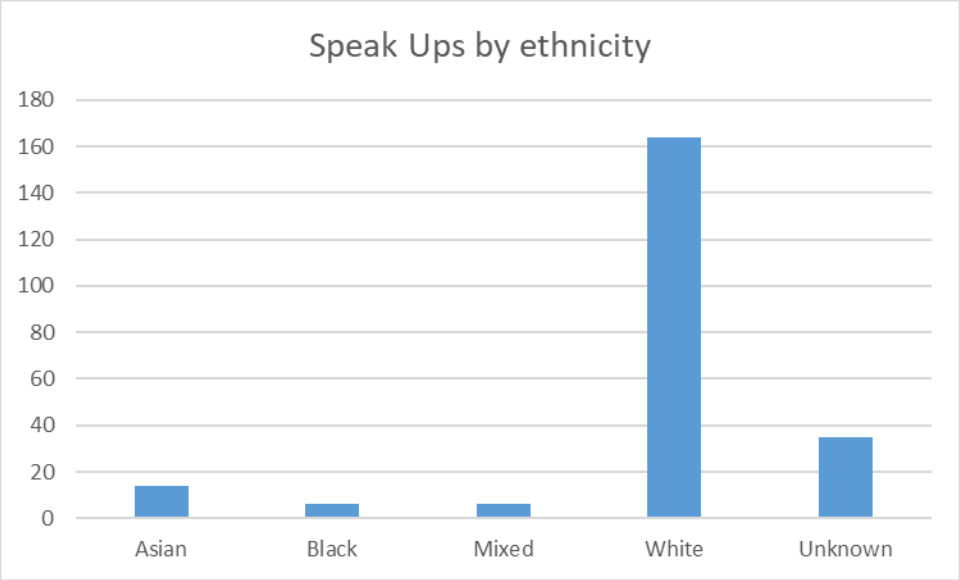
Graph 2:



As per 2024/25, the greatest number of people speaking up are white (73%). 11.5% of people reported their ethnicity as Black and Minority Ethnic (BME). This is significantly lower than the Trust headcount, which was 18.78% in March 2026. Attempts have been made to address this through staff engagement sessions, where this data is explicitly discussed and people are informed that they are able to speak up on behalf of their colleagues if their colleagues feel unable to speak up for themselves. Further work is needed to engage with the Race Equalities Network in addition to ensuring that the appropriate mechanism is in place to capture data from speak ups enacted on behalf of others.

Graph 3 shows the number of people speaking up by ethnicity.

Graph 3:



The FTSUG service does not currently capture any additional information about protected characteristics, and it is intended that this will change in 2026/27.

3.4 Speak Up Categories

The FTSU service must report quarterly stats to the National Guardian Office using the categories in Graph 4. Each speak up can generate more than one category of concern. It is not possible to know for certain that previous Guardians have categorised speak ups in the same way, but the current Guardians have completed a quality assurance check to ensure that the same categories are identified from different speak ups.

Graph 4 shows that issues involving staff experience of being in the workplace continue to far outweigh speak ups involving patient safety concerns. This trend is seen across the whole NHS (see table 2). Where a person has cited patient safety as a concern, this is most frequently due to a perception that something could happen as a result of local culture or behaviours. There have not been any cases of actual patient harm raised to the FTSUG that weren't already known about and reported on InPhase.

Graph 4:

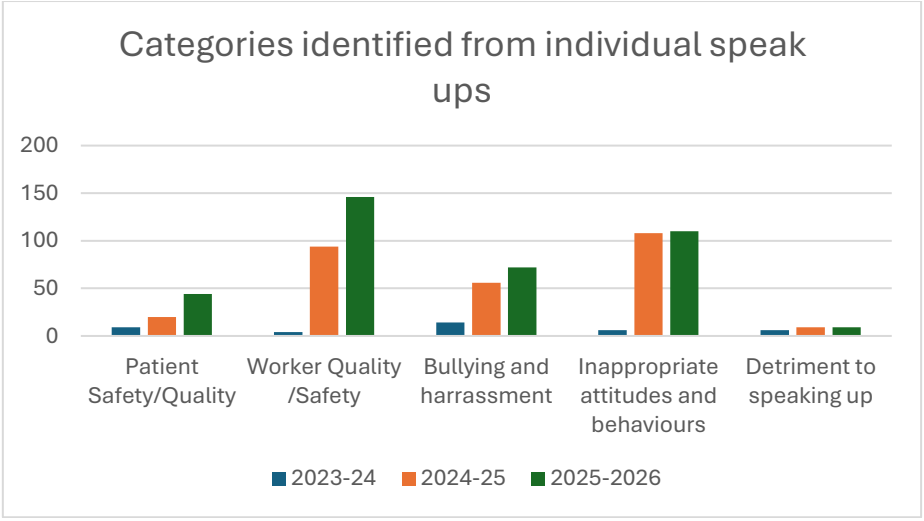


Table 2: FTSUG data for Quarter 3 (2025/26 data not available at the time of writing) benchmarked against other Shelford Group Hospitals.

Category	Newcastle Hospitals	Peer average	National value
Total number of cases reported	58	67	36
Bullying and harassment	25	18	4
Patient Safety and Quality	7	7	5
Worker Safety	31	27	11
Inappropriate attitudes and behaviours	30	34	14
Cases of detriment	0	1	0
Cases reported anonymously	5	4	2

3.5 Speak Up Subcategories

In Quarter 3, the FTSUGs introduced sub-categories in order to gain more meaningful data. This remains work in progress, however the subcategories identified 4 cases of racism, all of which were escalated to Human Resources (HR). 1 case of sexually inappropriate behaviour was also identified. This involved an employee from an external provider and was escalated to the Associate Director of Estates to be managed appropriately. Further work is planned to review and refine these subcategories in partnership with the Newcastle Hospitals Equality, Diversity and Inclusion Team as well as FTSUG colleagues within the Great North Healthcare (GNH) Alliance.

3.6 Detriment

The Trust has zero tolerance to detriment and any cases where a person has stated that they have experienced detriment as a result of speaking up have been escalated to the head of workforce advisory service to agree appropriate action and escalation, excluding cases involving medical staff.

3.7 Learning from Speak Ups

The themes identified from speak ups can be broadly split into 2 categories, which are often interwoven: poor understanding and application of organisational policies and procedures and poor interpersonal relationships between people and people managers. Some examples of these are below:

- **Poor understanding and application of policies and procedures:**

Many staff describe a poor understanding and inconsistent application of policies and procedures, particularly around probation and performance management. A lack of clear objectives, documented reviews, HR involvement, and regular feedback leaves people feeling anxious and unsupported, with uncertainty about expectations and job security. This uncertainty damages working relationships and contributes to stress, mistrust, and disengagement.

- **Poor interpersonal relationships between people and people managers**

Concerns are also raised about investigation processes and people management more broadly. Lengthy investigations with limited communication increase anxiety for all involved, while poor feedback, breaches of confidentiality, and repeated inaction undermine trust in managers. In addition, managers are perceived as lacking knowledge or confidence to implement reasonable adjustments, resulting in unmet needs and people feeling unable to perform to their full potential.

3.8 Sharing the learning

Information relating to data themes and trends is shared at staff engagement sessions. This learning is shared informally as there isn't currently an agreed formal mechanism for sharing learning from speak ups. Future plans include collaborating with the Education and Workforce Development and Organisational Development Teams to ensure these themes inform leadership and other training in addition to providing thematic feedback to the People Programme Board.

3.9 Escalation of risks

A Standard Operating Procedure is in place in relation to escalating risks and the FTSUGs have regular meetings with the Director of Quality and Safety, the Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs) and the Head of Workforce Advisory Service along with ad-hoc contact with the Chief Executive Officer (CEO), who is easily accessible.

3.10 Feedback from service users

When a case is closed, the person who contacted the Guardian is emailed a survey link to service feedback. This feedback was previously collated by the staff experience team, and it is not known how many people provided a response. Since September 2025, the survey responses were returned directly to the Guardians and is known that from that time 15 people provided feedback on the service. All 15 responders stated that they were very satisfied with the service, and all said they would recommend the service to colleagues. Examples of free text feedback include:

- *The Service helped achieve an outcome that would have been impossible to achieve without their assistance.*
- *It's just a relief to be heard.*
- *I only wish I had opted to visit the Speak up Guardian sooner. I felt I could "open up" fully and was given information I didn't know about.*

- *I believe that her involvement supported me in being listened to by HR and I don't think I would have had the resolution I needed without her. I was a bit nervous to contact the service as it didn't involve patient safety however I was quickly reassured.*

3.11 Champions

The Speak up Champions network has grown from 11 to 33 people who work across clinical and corporate services. It is acknowledged that the Champions network does not represent the diversity of people who work in the Trust, and work is being undertaken to address this.

All the Champions have received the training as set out by the NGO. Their role is to raise awareness and signpost staff appropriately for help. Champions do not take any case work. The Champions have received 6 contacts between them. 1 person was requesting support with navigating the Work In Confidence platform, 4 cases were relating to concerns about the behaviours of other people, and these were signposted to their line manager or the FTSUG and one had a concern about an interview process and were signposted to HR.

A Champions meeting is held bi-monthly to talk about learning from cases and to hear from other services around the Trust, e.g. Chaplaincy, and how they interact with the Champion and Guardian role. Following a pilot at North Cumbria Integrated Care, the NUTH FTSUGs approached the NUTH Health and Wellbeing (HAWB) Team to propose amalgamating the role of FTSU and HAWB champions. All relevant champions have completed a survey and the FTSUGs and HAWB lead intend to meet to determine the next steps.

3.12 Engagement activity

The increase in service provision has led to an increase in engagement activity, and the Guardians have undertaken more than 56 bespoke engagement activities across the Trust, such as attendance at Town Halls, business meetings and departmental staff meetings as well as visiting all wards and departments at the Freeman, and most at the RVI (work to continue to ensure all areas have the most up to date poster and contact information). In addition to this, where patient safety learning has been requested, such as at the Harm Free Care meeting, the Clinical Leaders forum, Trust induction and Resident Doctor Induction and study days, information about the FTSU service and learning from cases has also been provided.

A Board engagement session also took place where results from the FTSU framework informed the new FTSUG action plan.

3.13 Training

It is a recommendation from the National Guardian Office (NGO) that all staff complete the Speak Up training, all first line managers complete the Listen Up training and all senior leaders complete the Follow Up training. This training is promoted at all FTSU engagement sessions as well as through Trust comms and the Speak Up section of the Intranet. Between 01/04/2025 and 31/03/2026, training compliance is as follows:

Training title	Number of people trained this reporting period	Total number of people trained
Speak Up	51	198

Listen Up	32	125
Follow up	10	43

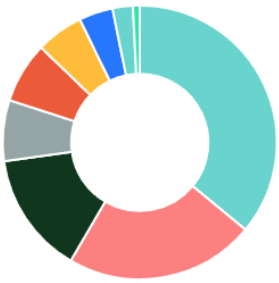
4. WORK IN CONFIDENCE

Work in confidence (WIC) is an online reporting platform that allows people to report concerns anonymously while supporting a two-way conversation.

Between 01/04/2025 and 31/03/2026, 82 new accounts were registered (compared to 126 in 2024/25), 125 (184) conversations were raised, and 100 (160) conversations were closed via the WIC platform. A breakdown of categories can be seen in figure 1. These categories are very similar to those reported in 2024/25, except the percentage of concerns raised that were about patient safety has doubled in 2025/26 (14.4% vs 7.1% in 24/25) The average time to the first response was 3 days (previously 5).

It is noted that the categories that people can choose to report against in WIC do not match the categories that have to be reported to the NGO or those that are available to report against in InPhase. To allow for improved triangulation of data, it is proposed that these categories are amended, and subcategories are added to improve the depth of data and available for comparison. Furthermore, the category 'other' is the most frequently selected category, however it is the most unhelpful in regard to gathering meaningful insight. It is hoped that providing subcategories to the WIC platform will lead to more meaningful data could be captured.

Figure 1: Concerns raised via WIC by category



Other	45	36%
Leadership	28	22.4%
Patient Safety or Quality	18	14.4%
Staff Safety or Quality	9	7.2%
Improvement Ideas	9	7.2%
Finance/Fraud Matters	7	5.6%
Inappropriate attitudes or behaviours	5	4%
Governance	3	2.4%

5. CONCLUSION

Although the increase in FTSUG resource has not led to an increase in the number of spontaneous speak ups, there has been more capacity available to support targeted staff experience work, and a greater amount of staff engagement sessions have been undertaken. In addition, the FTSU champion network continues to grow.

Most people contact the service using email, and the majority of people accessing the Guardian are white, indicating that further engagement work is needed to support global majority colleagues to speak up.

Due to the variation in categories and sub-categories it is not possible to triangulate the FTSUG data with other speak up data, which could mean that emergent risks are missed.

Learning from speak ups continues to be similar to 2024/25, with the focus of concerns being around interpersonal relationships and understanding/application of Trust policies. People who have used the service provide positive feedback.

Less positively, although not essential courses, eLearning training numbers remain low.

Areas of focus/action for 2026/27:

- Use InPhase as the FTSU data management system and in partnership with FTSUGs in the Alliance, develop subcategories to enrich the data available from speak ups to inform learning and improvement and allow for triangulation across the Alliance.
- Ensure Power BI database displaying the above information is available for all people to access across the Trust and is used to inform discussions at Clinical Board QOGs.
- Review the categories available for selection on WIC and add subcategories so that this platform aligns with data collected by the FTSUG – create guidance for all users.
- Capture additional data about protected characteristics in line with EDI guidance.
- Use speak up data to contribute to identification of Trust-wide hotspots and requirement for early intervention (as per Grant Thornton report recommendation).
- Explore the amalgamation of the FTSU Champion and Health and Wellbeing Champion role to enhance individual knowledge and skills and grow the network.
- Undertake a gap analysis of Champions to improve diversity of the Network.
- Strengthen engagement with staff networks.
- Provide quarterly update about learning from speak ups to the Quality and Safety Learning Forum.
- Continue the promotional work so that staff are aware that the service is available Improve communication between the FTSUG and Clinical Boards by implementing monthly meetings to share data that is then discussed at the QOG.
- Develop and implement a tool for capturing learning from local teams in relation to FTSU cases.
- Ensure relevant staff are aware of the request to complete the Speak Up, Listen Up Follow Up training – work with the Education Workforce Development Team to embed these principles into existing leadership training.

6. RECOMMENDATIONS

The Board is asked to receive the report, reflect on the themes raised in staff concerns and continue to support the Freedom to Speak Up function within the Trust.

Rachel Carter, Director of Quality and Safety
8 May 2026

Appendix 1 – Engagement activities (formally recorded, also promoted FTSU at InPhase roll out sessions, and multiple walkabouts updating FTSU posters in wards and departments)

Month	Event
Bi-monthly (was weekly)	Trust induction
April 2025	Drop-in session, North East and Cumbria Transport and Retrieval Team (NECTAR)
	FTSU session for Resident Doctors with General Medical Council (GMC) representative
June	Drop-In session, Ward 18 Royal Victoria Infirmary (RVI)
July	Meeting with Director of Operations, Medicine and Emergency Care (MEC)
August	Resident Doctor Induction
	Renal Business Meeting
September	Surgical and Associated Services (SAS) Leadership Roadshow
	Clinical Leaders Forum
	Drop-in session Manor Walks
October (Speak Up week)	FTSUG Regional Conference
	Drop-In session, Freeman Hospital (FH) canteen
	Pharmacy, FH
	Clinical Educators Meeting
	Ophthalmology drop-in, Royal Victoria Infirmary (RVI)
	Research Team monthly meeting
	Trust Management Group
	Pre-assessment team meeting, FH
	Drop-in session, Regent's Point
	Therapy Services Managers meeting
	Ophthalmology drop-in session, Campus for Ageing and Vitality (CAV)
	Admin Leads meeting
	Out of Hours (OOH) Pharmacy Team meeting
	Drop-in session, Eldon Court
November	Community engagement sessions - Molineux, Kenton
	Drop-In session, Geoffrey Rhodes
	Resident Doctor teaching
	B6/7 Masterclass
	Critical Care Education day session
	Senior Nursing Leaders Forum, MEC
December	Surgical and Specialist Services (SSS) Town Hall
	Leadership Walkabout – Centre for Life
January 2026	Leadership walkabout – Minor Injuries
	Occupational Therapy (OT) staff meeting
	Radiology walkabout at FH and RVI

	Better Doctors Better Patients (x4 sessions)
	Estates and facilities staff meetings, FH
	Centre for Life staff meeting/drop-in session
February	Northern Centre for Cancer Care (NCCC) Sister's Forum
	Major Trauma Rehabilitation meeting
	Physio staff meeting
	Information Technology (IT) staff meeting
	Coding Team meeting
	Hospital At Night Team meeting
	Outpatients (OP) admin team, RVI
	Resident Doctor induction

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Agenda item A4(c)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 2026					
Title	Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES)					
Report of	Vicky McFarlane Reid Executive Director of People and Commercial Innovation					
Prepared by	Karen Pearce Head of Equality, Diversity and Inclusion					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	This update highlights that both **Workforce Race Equality (WRES**) and **Workforce Disability Equality (WDES)** data continue to show **systemic inequality**, with Global Majority and disabled colleagues experiencing the Trust differently from their peers, particularly in relation to bullying and harassment, progression, capability processes and feeling valued at work. While there have been signs of improved reporting, transparency and engagement with learning – including stronger Board ownership of Equality Diversity and Inclusion (EDI), adoption of an Anti-Racism Framework, publication of ethnicity and disability pay gaps, and investment in wellbeing, early Occupational Health access and reasonable adjustments – the data shows that lived experience, especially for Global Majority and disabled colleagues, has not yet improved consistently and, in some areas, has deteriorated. Key risks remain at critical points of power and decision-making, including senior progression, recruitment criteria and the use of formal capability processes. Detailed analysis can also be found in the Board Reading Room.					
Recommendation	The Trust is required to publish this data in the public domain by 31st May 2026. Therefore we are seeking permission to approve the report and proceed with publication.					
Links to Strategic Objectives	Supporting great care – supporting everyone to do their job to the best of their ability with effective leadership, a just and learning culture and modern digital and physical environments.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☐	☒	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	Not applicable.					
Reports previously considered by	Annual report to Trust Board.					

WORKFORCE DISABILITY EQUALITY UPDATE

Executive Summary

This report provides the Trust Board with an update on performance against the **Workforce Disability Equality Standard (WDES) for 2025/26**, ahead of statutory publication by 31 May 2026. The data presents a mixed picture. The Trust demonstrates clear strengths in **reporting culture**, **reasonable adjustments** and **staff engagement** for disabled colleagues, with performance in several areas at or above national benchmark, indicating improved psychological safety and sustained commitment. However, **significant and persistent inequalities remain**. Disabled colleagues continue to experience systematically poorer outcomes than non-disabled staff, particularly in relation to bullying, harassment and abuse, entry into formal capability processes, feeling pressured to attend work when unwell, perceptions of fair progression, and—most critically—**feeling less valued by the organisation**. Fewer than one third of disabled staff report feeling valued, with Trust performance below national benchmark, signalling a cultural rather than procedural challenge. Representation data shows a strong entry pipeline but a sharp drop-off in progression beyond middle grades, with minimal representation at senior and Board levels. While targeted actions over the last year have strengthened leadership accountability, early intervention, wellbeing support and transparency, improvements are not yet being felt equitably. Delivering sustained improvement will require **clear local ownership**, consistent Executive and Board sponsorship, and a continued shift from compliance-based approaches to **relational, inclusive and preventative practice** that improves the lived experience of disabled colleagues across all parts of the organisation.

1. Purpose of the Report

This report summarises progress made, sets out areas of ongoing concern and risk, and outlines the leadership actions required to deliver sustained and equitable improvement for disabled colleagues across the Trust.

The paper is intended to support Board assurance, oversight and challenge in relation to workforce equity, organisational culture and leadership accountability.

2. Workforce Profile, Representation and Leadership

Disability Declaration and Workforce Profile

As at 2025/26:

- 6.81% of the workforce have declared a disability
- 84.17% have declared they do not have a disability
- 9.02% of staff remain undeclared

While clinical workforce representation of disabled staff has increased between 2025 and 2026, non-disclosure levels remain high, particularly in senior roles. This limits confidence in the true picture of representation and progression and remains a data risk.

Representation by Band and Role

Across both clinical and non-clinical workforces:

- Disabled staff representation is concentrated in lower and mid-bands (Bands 2–4 non-clinical; Bands 5–6 clinical)
- Representation drops sharply from Band 6 onwards
- Representation is minimal at Bands 8a and above, Very Senior Manager (VSM) and Board levels
- Disabled staff representation among Medical and Dental Consultants remains very low

Model Employer analysis demonstrates that significant increases in disabled representation would be required at senior bands to achieve equity.

Board Representation

Disabled staff remain under-represented at Board level, particularly in:

- Voting membership
- Executive roles

The gap between Board representation and overall workforce representation has widened since last year, reinforcing the need for leadership visibility, accountability and sponsorship.

3. Key WDES Findings: Strengths and Risks

3.1 Areas of Strength and Progress

Improved reporting culture

- Disabled staff are now more likely than non-disabled staff to report bullying, harassment and abuse
- Trust performance is at or above national benchmark
- Reporting rates have improved steadily over several years, indicating increased psychological safety and trust

Reasonable adjustments

- Around 75% of disabled staff report that reasonable adjustments have been made
- Trust performance has remained consistently above national benchmark since 2021
- This is a sustained organisational strength

Staff engagement

- Disabled staff continue to report higher engagement scores than non-disabled staff
- This suggests resilience and ongoing commitment despite challenges in other areas
- However, engagement scores for disabled staff have declined slightly since 2022 and are now below national benchmark

3.2 Persistent Inequalities and Areas of Risk

Bullying, harassment and abuse

- Disabled staff continue to report higher levels of bullying, harassment and abuse than non-disabled colleagues across all sources
- Although rates have improved over time, inequality gaps remain sizeable
- Some Clinical Boards report significantly worse experiences than the Trust average, requiring local accountability and targeted action

Formal capability processes

- Disabled staff are now over three times more likely than non-disabled staff to enter formal capability procedures
- This represents a significant deterioration compared to last year
- The data suggests variation in management practice and raises concern that capability processes may be acting as a proxy for unmet health needs or delayed adjustments
- This risk is heightened in the context of organisational focus on sickness absence management

Pressure to attend work when unwell

- Disabled staff remain significantly more likely to feel pressured to attend work when not well enough
- Although some improvement has been seen since 2023, the inequality gap persists
- This indicates ongoing challenges in sickness management practice and line-manager capability

Career progression and promotion

- Only around half of disabled staff believe the Trust provides equal opportunities for progression and promotion
- While Trust performance is above national benchmark, the gap with non-disabled staff remains
- Representation data reinforces that progression barriers remain most pronounced at senior levels

Feeling valued

- This is the most concerning indicator
- Fewer than one third of disabled staff feel valued by the organisation
- Trust performance is below national benchmark
- The gap between disabled and non-disabled staff has been sustained over multiple years
- This signals a cultural issue, cutting across leadership behaviours, recognition, inclusion and daily experience

4. Action Taken in the Last 12 Months

Significant actions have been taken to address the issues highlighted through WDES:

- Strengthened leadership accountability for inclusion, including clear executive leadership and alignment with wider EDI priorities

- Launch of the Working Well Staff Psychological Service (April 2026), with strong early uptake, focus on post-incident support, suicide prevention, absence-related pressures and line-manager development
- Re-establishment of Mental Health First Aid, with over 150 colleagues trained, supported by Continuing Professional Development (CPD) and peer-support structures, and commended by MHFA England
- Expansion of Early Access to Occupational Health, supporting earlier intervention for short-term absence and reducing escalation
- First publication of the Disability Pay Gap, improving transparency and organisational learning
- Continuation and success of Choices College, supporting disabled people and those with learning disabilities into sustained employment
- Establishment of a multidisciplinary Reasonable Adjustments Action Team, led by an Executive Sponsor, to improve consistency, data quality, manager capability and staff experience

5. Key Risks and Learning

The data indicates that:

- Improvements in systems and processes are not yet translating consistently into improved lived experience
- Local variation is significant, particularly in experiences of bullying, harassment and abuse
- Capability processes present a material risk of disproportionate impact on disabled staff
- High engagement and reasonable adjustment performance risk masking underlying cultural issues
- Without stronger local ownership, inequality risks becoming normalised

6. Priorities for 2026/27 and Board Oversight

The Trust's focus for the coming year will be on:

1. Strengthening leadership accountability
    - Clear ownership within Clinical Boards and operational leadership
    - Visible executive and Board sponsorship
2. Reducing harm and escalation
    - Embedding earlier, supportive and restorative approaches
    - Ensuring capability and absence management are not acting as proxies for unmet need
3. Improving culture and day-to-day experience
    - Addressing the "feeling valued" gap as a priority cultural issue
    - Focusing leadership development on inclusion, recognition and trust
4. Improving representation and progression
    - Targeted action at senior progression pinch points
    - Improving disclosure rates and data quality
5. Sustaining strengths

- Maintaining high performance in reporting culture and reasonable adjustments
- Protecting staff engagement while addressing declining trends

7. Conclusion

The 2025/26 WDES data demonstrates both progress and persistent challenge. While the Trust has strong foundations in reporting culture, reasonable adjustments and engagement, inequalities in experience remain entrenched, particularly in relation to feeling valued, progression and capability processes.

Delivering meaningful and equitable improvement will require continued Board attention, clear leadership accountability, and a sustained shift from procedural compliance to relational, inclusive and preventative practice that improves the lived experience of disabled colleagues across all parts of the organisation.

WORKFORCE RACE EQUALITY UPDATE

Executive Summary

This paper provides the Trust Board with an update on performance against the **Workforce Race Equality Standard (WRES) for 2025/26**, supporting assurance and oversight of workforce equality, leadership accountability and organisational culture. The data shows that **racial inequality within the Trust remains systemic**. While there has been modest improvement in some indicators – including recruitment outcomes from shortlisting, disciplinary processes and access to non-mandatory training – progress is **limited, inconsistent and not yet embedded**. Global Majority colleagues continue to enter the organisation in significant numbers, particularly in core clinical roles, but **do not progress proportionately into senior and decision-making positions**, resulting in widening representation gaps at Bands 6 and above, VSM and Board level. Staff experience data shows a **divergent trend**, with experiences improving for White colleagues while worsening for Global Majority colleagues in key areas such as bullying, harassment and discrimination from both patients and staff, leading to widening internal gaps. Discrimination remains the most severe and persistent inequality, with Global Majority colleagues several times more likely to report discriminatory treatment. The data indicates these disparities arise from **structural and behavioural factors at key decision points**, rather than attraction or capability. Although important actions have been taken over the last year, including adoption of the Trust's Anti-Racism Framework and strengthened Board accountability, impact on lived experience and senior progression remains limited. Delivering meaningful improvement will require **sustained structural change**, clear local accountability, consistent executive and Board leadership, and visible action to move the organisation from intent to measurable and equitable outcomes.

1. Purpose of the Report

This report supports Board assurance and oversight of workforce equality, leadership accountability and organisational culture, and aligns to the Trust's statutory duties and strategic commitments under the **NHS People Plan**, **People Promise** and the Trust's **Anti-Racism Framework**.

2. Workforce Representation and Progression

2.1 Workforce Profile and Representation

Non-Clinical Workforce

- There has been **no material change** in overall Global Majority representation.
- Representation is concentrated in **Bands 2–4**.
- **Bands 8c–9 and VSM roles show near-zero or zero Global Majority representation**, indicating a persistent leadership gap.

Clinical Workforce

- The ethnic profile of the clinical workforce has remained **static year-on-year**.
- **Band 5** is the largest point of Global Majority representation, reflecting strong entry pipelines in nursing and Allied Health Professionals (AHP) roles.
- Representation **drops sharply at Band 6 and beyond**, with minimal presence at Bands 8a–9 and VSM.
- In the medical workforce, diversity is stronger in **non-consultant grades**, but this does not translate proportionally into consultant or senior medical leadership positions.

Across both workforces, the data shows a **strong entry pipeline but a weak progression pipeline**, particularly into senior leadership and decision-making roles.

2.2 Progression Disparity Ratios

Disparity ratios confirm that **progression inequity is the Trust's most significant structural challenge**.

Across all staff:

- Global Majority colleagues are:
    - **2.7 times less likely** to progress from Bands 1–5 to 6–7
    - **2.27 times less likely** to progress from Bands 6–7 to 8a+
    - **6.33 times less likely** to progress from Bands 1–5 to 8a+

Within nursing specifically:

- Disparities are significantly higher, with Global Majority nurses:
    - **6.63 times less likely** to progress from Bands 1–5 to 6–7
    - **8.45 times less likely** to progress from Bands 6–7 to 8a+
    - **56 times less likely** to progress from Bands 1–5 to 8a+

While there has been some improvement at lower-to-middle transitions, **senior progression remains largely unchanged**, and gains at entry level are not translating into leadership representation.

3. Employment Processes and Opportunities

3.1 Recruitment – Appointment from Shortlisting

- White staff remain **1.63 times more likely** to be appointed from shortlisting.
- This represents a modest improvement from last year, but inequality persists.
- The data indicates barriers at **final decision-making stages**, not at attraction or shortlisting.

3.2 Disciplinary Processes

- Global Majority colleagues are **1.10 times more likely** to enter formal disciplinary processes.
- This sits within the "non-adverse" range nationally and represents improvement on last year.
- However, disproportionate entry persists, reinforcing concerns around variation in management practice and consistency.

3.3 Access to Non-Mandatory Training and CPD

- In 2025/26, Global Majority colleagues are **more likely than White colleagues** to access non-mandatory training and CPD.
- However, long-term trends show **significant volatility**, with periods where access strongly favoured White staff.
- This suggests **instability rather than sustained equity**, and highlights the need for consistent governance and monitoring.

4. Staff Experience: Behaviour, Harassment and Discrimination

4.1 Harassment, Bullying and Abuse from Patients and Public

- Global Majority colleagues continue to report **higher levels of abuse from patients and the public**.
- While experiences for White colleagues have improved year-on-year, experiences for Global Majority colleagues have **worsened**, widening the internal gap to around **5 percentage points**.
- The largest disparities are seen in **high patient-contact clinical areas**, indicating frontline exposure and insufficient protection.

4.2 Harassment, Bullying and Abuse from Staff

- Global Majority colleagues are **7.5% more likely** than White colleagues to experience harassment, bullying or abuse from staff.
- While White colleagues' experience has improved, Global Majority colleagues' experience has deteriorated.
- In several departments, reported rates for Global Majority colleagues exceed **30–40%**, indicating a significant and systemic issue.

4.3 Discrimination at Work

- Discrimination remains the **most severe and persistent inequality**.
- Global Majority colleagues are **several times more likely** to experience discrimination from managers or colleagues.
- Although the gap has narrowed slightly, Trust performance remains **worse than national benchmark**.
- This pattern is consistent across most clinical and corporate areas, including some leadership and people-focused functions, indicating an organisation-wide issue rather than isolated pockets.

5. Perceptions of Career Progression and Fairness

- Only **48.1%** of Global Majority colleagues believe the Trust provides equal opportunities for career progression.
- While the gap has narrowed slightly, confidence remains consistently lower than for White colleagues.
- In some corporate and clinical areas, confidence among Global Majority colleagues is **particularly low**, reinforcing evidence of structural barriers and lack of trust in progression systems.
- The declining confidence of White colleagues also suggests a **wider organisational challenge**, though with disproportionate impact on Global Majority staff.

6. Leadership and Board Representation

- Global Majority representation at **Board and VSM level remains significantly below workforce representation**, with a gap of **-9.3%**.
- Progress towards the **Model Employer ambition** remains slow.
- Increases in Global Majority representation are concentrated in lower bands and have **not yet translated into senior leadership impact**.
- This reinforces the need for **visible leadership accountability**, sponsorship and succession planning.

7. Action Taken in the Last 12 Months

Key actions to date include:

- Strengthened **Board-level accountability**, including individual SMART EDI objectives aligned to the NHS Six High Impact Actions.
- Board participation in **Let's Talk About Race** learning sessions.
- Publication of the **Ethnicity Pay Gap** for a second consecutive year.
- Formal adoption of the Trust's **Anti-Racism Framework** (January 2026), co-designed with Global Majority colleagues.
- Early implementation focusing on education, improved reporting guidance, restorative approaches and alignment across People Services.

These actions have increased awareness, clarity of intent and governance maturity, but **impact on lived experience and senior progression remains limited**.

8. Organisational Priorities Going Forward

The Trust's priorities for 2026/27 are to:

1. **Strengthen leadership accountability**
    - Clear ownership at Clinical Board and divisional level
    - Consistent Executive and Board oversight
2. **Embed the Anti-Racism Framework**
    - Focus on education, representation, culture change, and action with measurable outcomes
3. **Protect safety and psychological wellbeing**
    - Strengthen reporting, Freedom to Speak Up and harm-reduction approaches
4. **Reduce progression and recruitment barriers**
    - Target decision-points in recruitment and promotion
    - Improve transparency and fairness in progression pathways
5. **Work in partnership with staff networks**
    - Particularly the Race Equality Network, as a critical partner in cultural change

9. Conclusion

The WRES data demonstrates that **racial inequality within the Trust is structural and persistent**. While some indicators show improvement, progress is not sustained or

experienced equitably. The most entrenched challenges remain behaviours, discrimination, progression into senior roles, and accountability for equitable outcomes.
Improvement will not be achieved through activity alone. It will require **explicit ownership, consistent leadership behaviour, local accountability and visible commitment**, moving the organisation from intention to impact and from awareness to sustained change.

Report of Vicky McFarlane Reid
Executive Director for People and Commercial Innovation
14 May 2026

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Agenda item A4(d)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 2026					
Title	Travel and Transport Plan					
Report of	Paul Hanson, Director of Estates, Facilities and Strategic Partnerships					
Prepared by	Paul Hanson, Director of Estates, Facilities and Strategic Partnerships					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☒	☐	☐			
Summary	The Trust generates around 9m journeys per year - that has a significant environmental impact, financial cost and contributes to each patient, visitor and colleagues' experience We have therefore worked to plan more strategically, aligning our approach to the North East Combined Authority who is charged with strategic transport planning. Our work has also included engagement with colleagues including our Staff Side, Green Champions, Governors and Matrons. The plan explains the challenges, suggests the Trust lines up against the North East Transport Plan objectives of X, Y and Z. Finally, the plan outlines our response to those challenges and asks the Board to agree the objectives and the proposed action plan This Travel and Transport Plan has been written to align to the agreed Trust Strategy and is an important part of the Climate Emergency Plan which will be agreed by Board later this summer.					
Recommendation	To agree the Travel and Transport plan and support the implementation of the recommendations.					
Links to Strategic Objectives	Supporting great care – supporting everyone to do their job to the best of their ability with effective leadership, a just and learning culture and modern digital and physical environments.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☐	☐	☒	☒	☒	☒
Link to Board Assurance Framework [BAF]	Not applicable.					
Reports previously considered by	Discussed at the Executive Team on 13 May 2026.					

TRAVEL AND TRANSPORT PLAN
2026-2031

Executive Summary

This Travel and Transport Plan sets out the Trust approach to improve accessibility, deliver transport at best value, support colleague wellbeing, reduce environmental impacts and contribute to the commitment to Net Zero.

It focuses on patient and visitor access, staff transport, logistics and sustainability whilst recognising the unique challenges faced and how we will work with local partners such as North East Combined Authority (NECA), local authorities, neighbours and NHS trusts in the region and nationally. The plan provides an explanation of purpose and background. It describes the scope of the plan then goes on to outline the detail of the Trust's transport challenges. It then describes the strategic context set by the North East Combined Authority and the actions to deliver three shared objectives.

- A more inclusive economy
- Contribute to a better environment; and
- A healthier North East.

Finally, the plan is designed to deliver part of the Trust's response to declaring a Climate Emergency and the overall Trust Strategy. The plan explains how governance and reporting will be handled and what engagement has been undertaken to test the thinking behind it.

Purpose

The Newcastle upon Tyne Hospitals NHS Foundation Trust generates in the order of 9m journeys every year. Some of those journeys are short walks, some are from around the world.

Those Journeys involve most forms of transport and are a significant factor in the transport activity in the North East. Journeys also form an integral part of operational activity but there are impacts to health and the environment as a result.

Journeys are defined as the commuting of our team, patient travel to and from our hospitals and services, deliveries of goods from all over the world and logistics generated through our own activities delivering healthcare. There is a constant stream of visitors travelling to see patients, attend meetings or contractors maintaining our estate. The Trust also has a community service portfolio visiting patients at home to keep them out of hospital or delivering their medicines. There is a transport impact to every facet of the organisation.

Having declared a Climate Emergency and planned for Net Zero, the Trust's transport planning is a critical part of day-to-day business and its strategic ambitions. As a health care organisation, the Trust's approach to travel and transport can have a positive or negative impact on the health of our colleagues, our customers and our neighbours.

The Trust needs to be clear on its strategic objectives and plan to inform its transport arrangements as well as being able to clearly articulate its needs to those charged with transport planning in the City, the region and the country. This document defines those objectives and plan.

Background

When the Bishop of Durham laid the foundation stone on the 5th September 1751, Newcastle upon Tyne Infirmary was on Forth Banks, a green space to the west of the city. When the General Hospital opened in 1870 it was as the infirmary for the workhouse on the western boundary of the city. When King Edward VII opened the Royal Victoria Infirmary (RVI) on 11th July 1906 it was on 10 acres of the Town Moor gifted to the City by the Freemen. Again, it was in green space, this time on the northern boundary of the city opposite Kings College Durham. When the Freeman Hospital (the 'Freeman') opened in 1977 it took up a former farm site and space previously used by "The Ministry".

Over time, the Trust's estate has evolved, adding the major site at Regent Point and a network of community buildings. What has also happened is that the urban context for the Trust's estate has changed dramatically. The City has expanded north and west, in a wider context and settlements like Blyth, Ashington, Lemington, Winlaton and Whickham have grown as the population has moved away from the dense terracing along the Tyne.

The transport context has shifted as a result and travel behaviours have changed too. The lifetime of the major hospitals in Newcastle has seen the move away from the horse as a main means of transport other than walking or water. Trams have come and gone and rail which had its origins in the region, continues to matter. Air travel has become common place and buses appeared, thrived, faltered and remain critical in a distressed market, as the most frequently used form of public transport in the North East.

In the post war period, car ownership grew exponentially. In 2023 households in England had an average of 1.2 cars per household. The biggest increase in car ownership per household in the UK has been in the North East where the number of cars per household has grown from 0.86 in 2003 to 1.02 in 2023 and in March 2025 zero emission vehicles accounted for only 3.7% of all licenced road using vehicles. *(1)*

Cycling has transformed and bike use has risen faster than infrastructure has changed.

In the North East, the Tyne and Wear Metro system is the same age as the Freeman Hospital and rolling stock which is the same age has hampered its growth. Only now is that being changed with the arrival of a new fleet and proposed changes to the timetable coming this winter.

1. *Statistics at Department for Transport, - Statistics at DfT - Department for Transport - GOV.UK*

Scope

The Trust's transport scope can be defined as follows

- **Patients, visitors and other customers;** the need to receive advice and treatment and the need to be able to visit loved ones in hospital, as it is proven to aid recovery and reduce hospital stays. *(2)*

- **Colleagues;** the Newcastle Hospitals team need to get to work and get to our patients.

- **Goods, services and samples;** the need to move to and from our sites regionally and nationally and between our hospital sites, some with very high clinical priority. Contractors and other service providers must get to us efficiently; and

- **Healthy Active Travel;** we have an opportunity to support and encourage active travel for everyone we work with and gain long term benefits.

Today in terms of numbers that scope means:

- 17,206 colleagues plus volunteers, providing a service 24 hours a day / 365 days a year and working various shift patterns and over 70% work full-time *(3)*

- Over 2 million patient contacts a year which includes 1.5m outpatient appointments *(3)*

- 2,275 hospital beds and over 245,000 inpatient spells a year and ensuring visitors to patients are able to visit their loved ones in hospital (estimated at 1.7 per patient) *(3)*

- 630,000 patients visited in the community *(3)*

- 44% of staff using single car occupancy as their travel choice to work (an increase of 17% since 2010) *(5)*

- 11,498 tonnes of carbon emissions generated from commuting alone in 2024 *(6)*

- 500 ad-hoc courier jobs per month travelling approximately 200,000 miles and 53 tonnes of carbon in delivery *(6)*

- Over 1m vehicle miles driven in 'grey fleet' (staff driving their own private vehicles) with an approximate cost of £550,000 in 2024/25

- Over £1.25m spent on business travel through rail, bus, air and taxi in 2024/25

2. Royal Voluntary Service, - Lack of visitors has detrimental effect on patient recovery
3. 2024/25 Trust Annual Report
4. North East Combined Authority Local Transport Plan: Delivering Green Transport
5. Mobilityways Trust Transport Team Travel Surveys and CommuteIQ
6. Trust Transport and Travel Team data

Challenges

This section of the plan describes our transport operating environment, our team's current travel patterns, our business requirements and the challenges which arise. They can be summarised as follows.

- **Driving and car parking**; the volume of colleague and patient related car journeys is greater than our capacity for parking and, as such, has an impact on patient experience when attending our healthcare facilities, wellbeing and air quality.

- **Cycling and active travel**; we need to encourage increased cycling and provide the right type and volumes of facilities; we need to improve walking routes and integration with public transport.

- **Fleet**; the use of a range of vehicles needs to be better organised; and

- **Patient Transport**; there are opportunities to improve the patient experience, reduce carbon and save money.

The rest of this section provides more detail.

Driving and Car Parking

The Trust has 2,556 spaces for all users. The RVI has 1,670 and the Freeman has 1,441 spaces. Providing more spaces is not an option available to the Trust and space numbers are dictated by planning regulations and by available land.

The cost of building car parks is around £2,000 per space if it is gravel *(10)* and there is no drainage and the cost per space in the new Leazes Multi-storey at the RVI was around £22,000. This is the original build costs and excludes lighting, CCTV, equipment and maintaining it to the standards expected for safe use. Building extra space often generates more traffic on the road network to those spaces and the local council are therefore mindful of this when determining planning applications.

Site	Staff Spaces including disabled	Public Spaces including disabled	Disabled Spaces	Motorcycles	Notes
RVI	1,285	715	98	17	330 are off-site rented
Freeman	856	585	115	31	
CAV	127	58	22	2	
Regent Point	576	0	4	2	

Table 1: Car park spaces

10. How Much Does It Cost To Build A Car Park in 2025? | Checkatrade

The Trust provides over 6,000 staff parking permits to colleagues. Parking provision for any staff for all their working shifts is through an assessment-based criteria which considers need. There are a range of parking permits available to enable flexible parking when it is deemed essential for example at nights or to support occasional parking which is needed to assist with work-life balance commitments.

Assessment determines need and permits are issued on that basis. Assessments factor distance from work, access to public transport for shifts worked, any business requirement to drive, carer needs and any health conditions.

There are approximately 14,000 free disabled parking concessions issued every month. A further 1,100 other concessions issued to frequent outpatients and long-stay visitors.

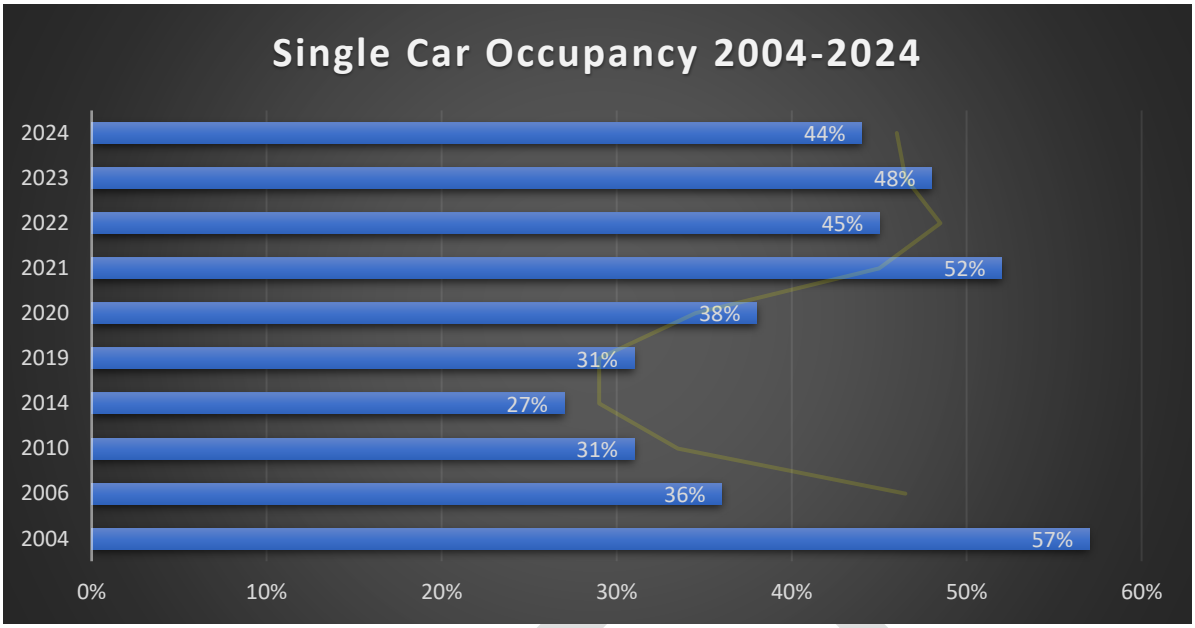
Overall, the Trust sees an average 16,500 vehicle transitions per day across RVI, Freeman, the Campus for Ageing and Vitality (CAV) and Regent Point.

The likelihood of spaces being lost over the next five to ten years is greater than the likelihood of additional spaces being provided and the retention of little remaining green spaces is also of vital importance as they provide necessary biodiversity but also sanctuary for our colleagues, patients and visitors.

In 2024 44% of colleagues commute to work by single occupancy car. A fall from 2023 but up 17% from 2014.

Single-car modal shift occupancy commuting reduced by 30% reduction in the 10 years between 2004 – 2014 due to proactive support with sustainable transport, more robust parking management transport and travel planning.

This reduction reversed by 17% between 2014 and 2024 with the Covid Pandemic a key contributor to the greatest shift in modal travel choice since 2004. However, we know that the shift back to car was already underway primarily due to public transport reliability and its increasing cost, where lower Trust parking charges made driving to work a more affordable option for many.



Graph 1: Newcastle upon Tyne Hospitals NHS Foundation Trust Staff Single Car Occupancy data 2004 - 2024

NHS England have released the Net Zero Transport and Travel Strategy in which a requirement for modal shift from single car use is prominent and includes a 50% reduction target by 2033. This would mean that we should be aiming for 22% of staff to be commuting to work by car in 2033.

There is excessively high demand for limited parking and management of Trust car parking is certainly one of the most sensitive and contentious of impacts. There are a total of 2,556 car parking spaces including disabled spaces across all sites. The Average Commuter Emissions Level (ACEL) recommendation is 5,632 but there is simply no available space to deliver this.

These 2,556 spaces to support parking for staff who are commuting and are essential car users, enable patients to attend for appointments, enable visitors to visit patients or attend meetings and provide for other logistical and essential service contractor vehicles including ambulances and patient transport services

Statutory parking concessions introduced by NHS England provide free parking for Blue Badge holders frequent outpatient attenders, parking for parents of sick children out of hours and staff working nightshift. Free parking naturally increases the demand for space.

Parking charges are essential to ensure operational costs for the provision of parking are not met by budgets intended to fund and deliver patient healthcare. The NHS Confederation 'Fair for all, not free for all' provides a compelling argument for the principles for sustainable hospital car parking.

There is genuine concern that further modal shift reductions are not achievable when the difference between parking at work or travelling via sustainable transport is as great at £4 per day (£80 per month / £960 per year). *(8)*

8. Based on parking rate of Band 2 – 4 staff member and fixed maximum charge of £2.50 each way public transport ticket cap which is subsidised and supported by the North East Combined Authority (NECA)

Public transport costs increased by 80% in the period between 2010/11 and 2018/19 and then increased by a further 67% between 2018 and 2024. In contrast, Trust parking charges increased by 250% in 2008 and remained static until a reduction in 2022 of 50% following a period of free parking for 24 months.

The difference in cost between most public parking charges and staff parking charges is currently, staff parking charges are over 1000% cheaper.

The top three reasons for choosing to travel by single car occupancy in the last three Staff Travel Surveys has been convenience, time and cost.

We generate significant journeys through our business activities as a result of delivering care and the logistics associated with our deliveries both in and out of the Trust. In total the Trust have on average 16,500 vehicle transitions per day across RVI, Freeman, CAV and Regent Point. *(9)*

Cycle Provision, Capacity and Active Travel

The hospital sites are geographically well situated to support active travel. At the Freeman Hospital the historic 19th century Waggonway's Network runs to the rear of the hospital and at the RVI the site has a new dedicated cycle lane on Queen Victoria Road and access to walking and cycling on the surrounding green spaces connecting communities.

The Trust fully encourages and supports staff who commute by cycling. Travel survey data from 2024 showed that cycling is the main form of commuting for staff as follows:

- 6.1% of staff at Freeman Hospital
- 5% of staff at RVI
- 2% at Regent Point

Total average cycling to work modal choice in 2024 was 4.3%. This is a reduction of 2.9% from 7.2% in 2023 and of 5.7% from 2014 when cycling was averaging 10% of staff travel choice. However, there are differences between groups of colleagues where, for example, our Resident Doctors prefer cycling to a greater degree than the average of all colleagues.

The top three Staff Travel Survey responses in 2024 on what measures would encourage colleagues to making cycling to work their main form of commute were:

- Improved shower and changing facilities including drying – 22.4%
- Provision of more secure cycle parking – 16.9%
- Improved storage lockers at work – 12.4%

The Trust currently provide 798 cycle parking spaces across the three main sites:

9. Figures used from automatic number plate recognition cameras provided by Parking Eye Ltd. using vehicle counts or one month from June 2025.

	Gold	Silver	Bronze	Total
Number of spaces.	138	250	410	798

Table 2: Cycle parking spaces

The Trust's cycle parking categorised in three levels and there is a small one-off charge for silver level parking to provide an electronic key and a small monthly rental charge for gold level parking. Income is ring-fenced to re-invest in further provision and infrastructure and maintenance of existing facilities. Defined levels are as follows:

- Gold – secure individual use cycle lockers
- Silver – secure cycle compounds requiring access control fob
- Bronze – 'Sheffield' style cycle stands both covered and uncovered

Only bronze level cycle parking is available for patient and visitor use.

The Trust is an accredited Cycle Friendly Employer achieving the highest award, Gold in January 2025.

In 2025 up to the beginning of October there have been 79 cycles and associated equipment acquired with an average spend of £2,000. This is a positive indication that more colleagues are considering cycling whether for health benefits or active travel to work.

We know our team can utilise an e-bike or e-scooters instead of pedal cycles, but this will require safer routes and cycle proficiency. The Trust are establishing alternative safe parking for these users which meets with fire guidance and battery powered ride storage.

Courier Journeys

The Trust has a courier contract with QE Transport to deliver fixed schedule courier runs which include movement of specimens, pharmaceutical items, collection of general and clinical waste, general 'goods' of stock, furniture and specialist medical and non-medical equipment.

The contract is shared with Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) to reduce replicated journeys and improve financial efficiency. There are a total of 18 fixed route courier schedules totalling approximately 350,000 miles per annum.

The Trust have approximately 500 ad-hoc courier jobs per month regionally and nationally with over 200,000 miles completed and an output of 53 tonnes of carbon for the period September 2024 to September 2025. Over £1m per annum spent on logistics costs for pharmaceutical, pathology, specialist equipment and general 'goods'.

The contract award for courier services includes a requirement for the service provider to transition vehicles to Ultra-Low Emission Vehicles (ULEV) and Electric Vehicles (EV) with 25% of fleet in the first three years to 75% of fleet to EV by 2029 and 100% target for post 2030 with limited exemptions for alternatives beyond this date.

Taxis

The Trust generates approximately 3,500 taxi journeys per month for patients and staff through the service contract. In 2024 over 27,000 taxis were used for transporting of patients costing the organisation over £80,000 and there were 15,300 journeys for staff or goods costing £260,000. Most staff and goods use was for transport out of hours to support on-call commitments or staff visiting patients in the community.

In 2022/23 whilst still supporting Covid projects taxi spend exceeded £800,000 as alternatives were not readily available and in many cases the default solution was to utilise taxis. This changed some business arrangements which are yet to return to the pre-pandemic situation.

Taxis completed 392,341 miles between September 2024 and September 2025 and contributed to 135 tonnes of CO2 on Trust business during this period. In the period from November 2022 to October 2023 over 200 tonnes of CO2 was generated from taxi use.

Deliveries

The Trust have approximately 650 delivery vehicles per week attending the delivery areas at the RVI and Freeman Hospitals. There are an estimated 50 deliveries in smaller vehicles per week using other areas of the hospitals including main entrances. At the RVI approximately 61% of these vehicles are diesel and at the Freeman this increases to 73%.

Grey Fleet

Grey fleet are personal vehicles that are used by employees for business purposes excluding salary sacrifice, business lease and Trust owned vehicles. Whilst grey fleets can be cost effective, they do introduce challenges related to liability, maintenance and ensuring employee safety and regulatory compliance as there is no direct control over these vehicles. In 2024/2025 over 1,000,000 miles were claimed in Grey Fleet costing the organisation approximately £550,000 in expenses.

Fleet, Lease and Hire Cars

Car hire is provided through the Trust Supplies and Procurement team. There are 12 long-term hire vehicles operational with an annual hire cost of £110,000. In the period September 2024 – 2025 there have been 43 short-term hires at a cost of £12,600.

The Trust Leases 32 vehicles for operational service delivery used entirely for business use at annual cost of £146,000. Vehicle categories are as follows:

Fuel Type	No. of vehicles	Vehicle Types	Percentage of Fleet
Diesel	5	3 Luton tail-lift vans, 2 large vans	15.6%
Petrol	1	Car with regional service requirements	3.1%
Hybrid (Petrol)	19		59.4%
Electric	7	5 vans, 2 cars	21.9%

Table 3: Trust Business use only vehicles

The Trust provide a Contract Business Lease Car Scheme providing colleagues who frequently complete more than 3,500 business miles per annum the option to lease a car for business and private use. Colleagues are required to contribute to the cost balance after Trust subsidy and reduced mileage rates are paid.

Vehicles on the Contract Business Lease Car Scheme are limited to ULEV and there are 29 vehicles being used on this scheme. Vehicle categories are as follows:

Fuel Type	No. of vehicles	Vehicle Types	Percentage of Fleet
Diesel	0		0%
Petrol	11	Cars – average engine size is 1200cc	37%
Hybrid (Petrol)	12	12 cars	41.3%
Electric	6	6 cars	21.7%

Table 4: Trust Contract Business Lease Car Scheme (Business and Private use) vehicles

All business lease vehicles are fitted with vehicle tracking and live driver behaviour devices to support safer driving, reduced idling, and fuel / range efficiencies whilst also producing a league table of driving standard by staff / department (see Image 2 Lightfoot Analytics Dashboard).

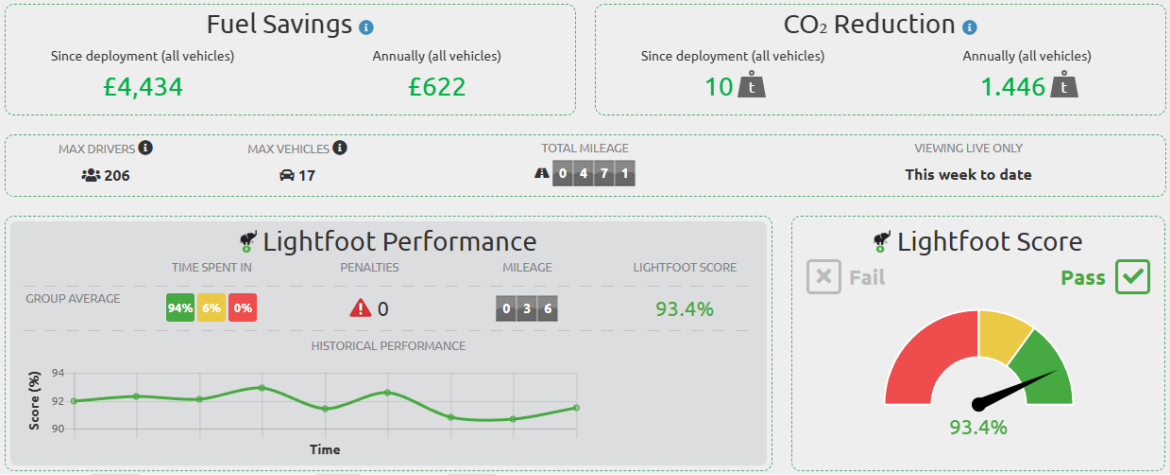


Image 2: Lightfoot Analytics Dashboard

Hopper / Shuttle / Bus Services

The dedicated staff only Hopper service operates Monday to Friday from 0640 – 1940 between the RVI and the Freeman Hospital. The contracted provider Go North East provide an electric powered bus for Service H. 98% of Hopper journeys were completed using the EV bus in 2024/25 covering approximately 66,000 miles per annum and avoiding 130 tonnes of CO2e. The services delivers an average of 11,500 passenger journeys a month.

A Hospital Shuttle is also funded by the Trust and is available for use by colleagues and the wider public and is operated by Arriva North East between Regent Centre and the Freeman Hospital. This service supports sustainable transport of staff between Regent Point.

Service 553 supports a transport gap between buses running from the north of the city towards Newcastle and Freeman Hospital contributing to improved accessibility to the Freeman Hospital with the major bus and Metro interchange at Regent Centre. There is also a Park and Ride at Regent Centre which helps to support partial sustainable transport access for a staff, patients and visitors.

Colleagues may travel free on Service 553 and may also utilise any Arriva bus service travelling between Regent Centre and the Haymarket in the city. This supports a sustainable transport link between Regent Point and the RVI.

The 553 delivers approximately 5,600 journeys a month between Regent Centre and the Freeman Hospital and 7,500 passenger journeys between Regent Point and the city centre. This is a combined 12,500 passenger journeys a month.

The alternative costs of travelling between sites (single journey) is available in Table 5: Single cost journey between sites based on passengers versus contract cost.

Mode Type	Regent Point and RVI	Freeman Hospital and RVI	Freeman Hospital and Regent Point
Taxi	£6.20	£7.80	£6.20
Grey Fleet	£1.77	£2.36	£1.77
Public Transport	£3.00	£3.00	£3.00
Cycle	£0.60	£0.80	£0.60
Hopper		£2.97	
Arriva Shuttle	£1.20		£1.20

Table 5: Single cost journey between hospital sites

Image 3: The Newcastle Hospitals NHS Foundation Trust EV Hopper Service (operated by Go North East)

The combined Hopper and Arriva sustainable transport bus services linking the three main sites exceeds 24,500 passenger journeys and keeps cost per journey to around £1.87 per journey.

Business Travel

The Trust spent £1.25m on business travel through rail, bus, air and taxi in 2024/25. All business travel is arranged through the Trust's Supplies and Procurement Department.

Patient Transport

A significant amount of the Trust's transport requirement arises from the need to support patient transport. This is currently dispersed and different throughout Clinical Boards. Gathering data and insights, particularly with the North East Ambulance Service (NEAS) is underway.

One area where work has been done to understand need and test a different model is patient transport to our Renal Satellite Clinics. This provides some illustrative context to the issues of patient transport.

Renal Satellite Clinics

There is a national requirement to support patients receiving renal dialysis to treatment.

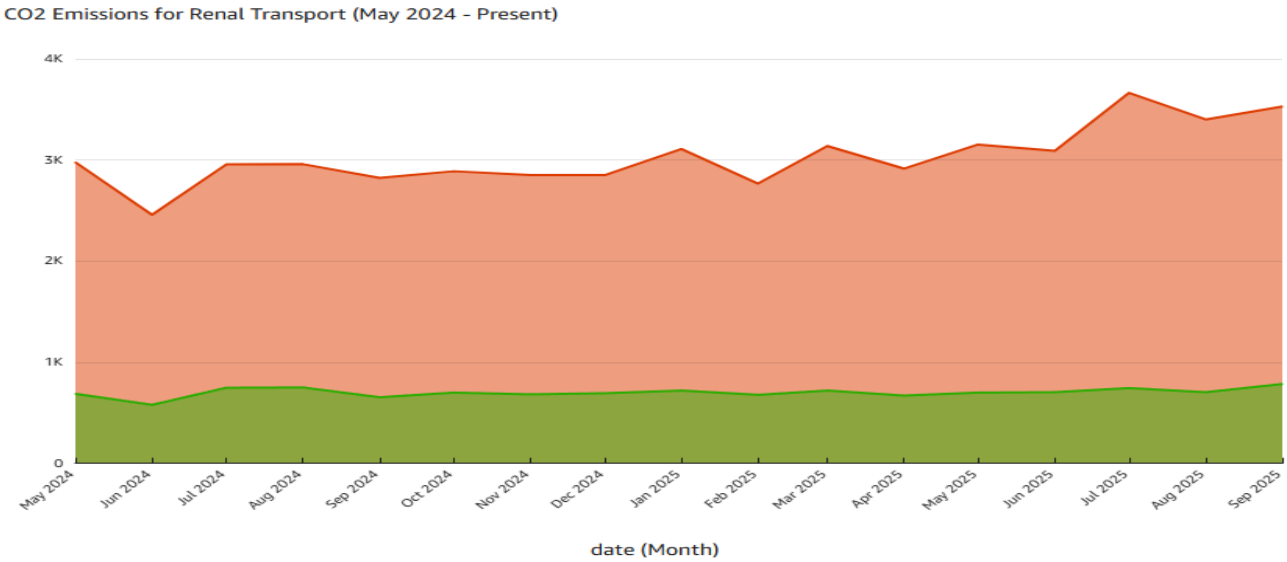
Previously the Trust spent £300k on taxis in 2023/24 for the transport of patients to satellite Dialysis Clinics in North Shields and Gateshead.

A pilot project of 'Flockmobilty' to use EV vehicles and provide shared journeys through an optimised transport booking system was supported by funding from the European Space Agency to deliver improved sustainable transport of patients through shared use transport with reduced emissions and reduced transport costs.

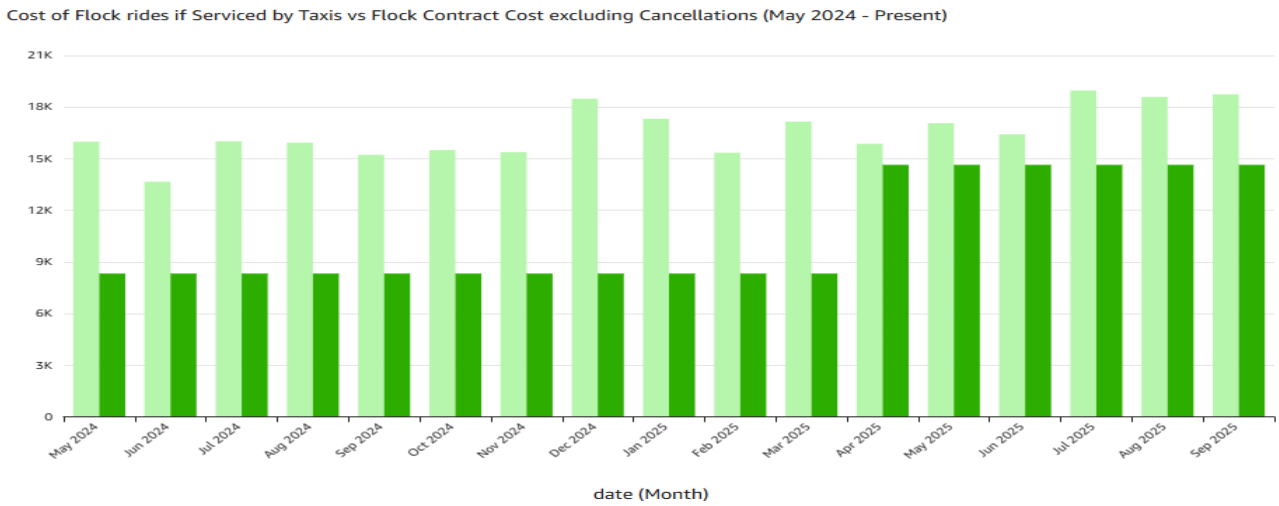
Image 1: Flockmobility electric vehicle

The scheme has contributed to reducing single occupancy taxi journeys, saving approximately 24 tonnes of Co2 per annum (see Graph 2) and reducing costs whilst improving patient experience. 60 patients per day being transported to two renal satellite clinics.

Significant financial saving have been achieved with two demand responsive vehicles replacing individual return taxi journeys (Graph 3) and enabled the vehicles to support other aspects of travel demand in the Trust during downtime from renal transport.



Graph 2: Emissions by Flockmobility (Green) versus comparative emissions by non-electric vehicle



Graph 3: Cost savings achieved in comparison to taxi use

Health and Wellbeing / Work life Balance

Exercise is proven to be beneficial in boosting mood, sleep quality and energy as well as reducing the risks of stress and helping with depression, anxiety and other mental health benefits.*(12)* Inactivity is described by the Department of Health and Social Care as the 'silent killer' and active travel can certainly contribute to achieving the NHS recommended physical activity levels.

12. Benefits of exercise - NHS

Mobilityways uses residential postcodes which assists with future planning, conduct Travel Surveys and produce 'Scoping and CommuteIQ' reports for the Trust. 61% of current employees at the Freeman Hospital, based on mapping residential postcode, whilst not accounting for shifts and work life balance commitments could either walk or cycle to work.

There is a staff led Active Travel group in the Trust who are committed active travel staff and engage with the Trust to support improved active travel initiatives and also network with the local authority. The Trust have a Flexible Working and Agile Working Policy to support staff with work life balance and adapt shifts wherever possible without a clinical impact.

There is a potential 3,228 staff could walk or cycle to work at the Freeman Hospital.

Image 4: Mobilityways Active Travel zone map (2022) for walking and cycling to Freeman scoping.

There is a potential 3,771 of staff to walk or cycle to work at the RVI.

Image 5: Mobilityways Active Travel zone map (2022) for walking and cycling to RVI scoping.

Air Quality

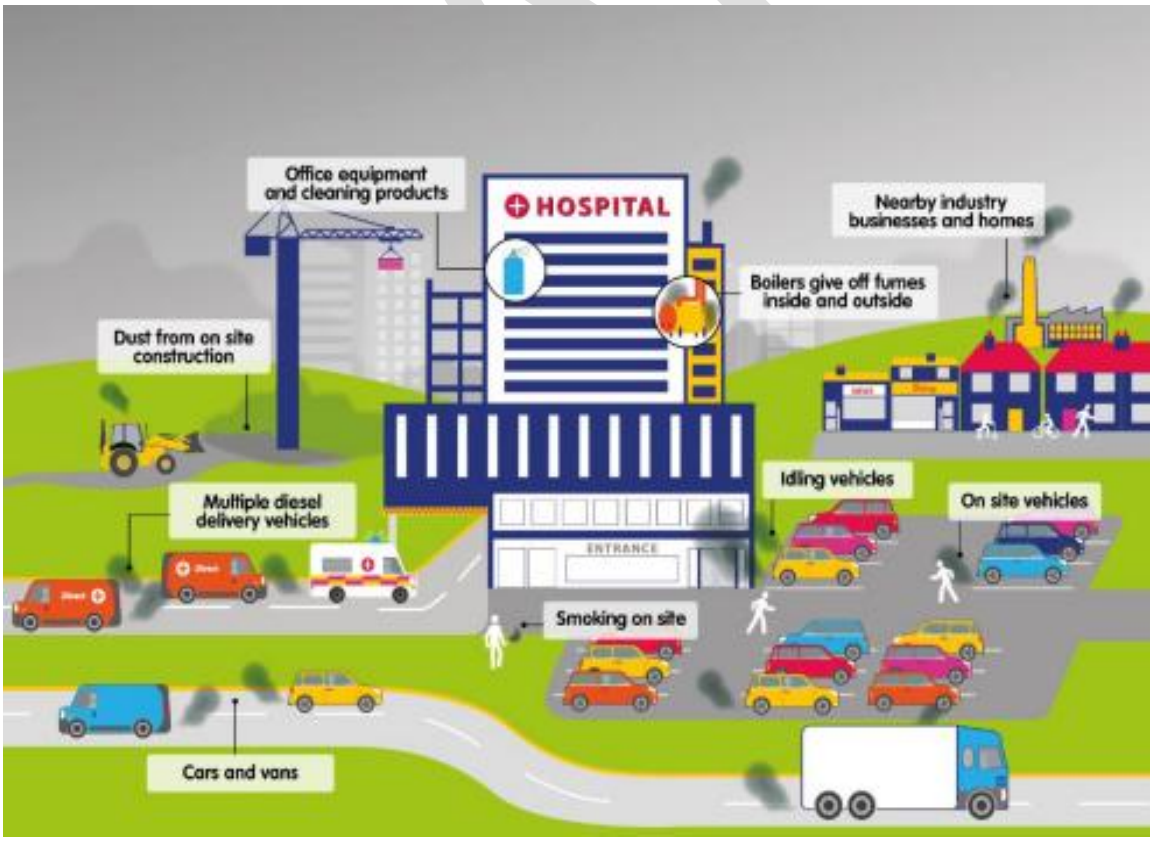


Image 6: Sources of pollution in and around a hospital (www.actionforcleanair.org.uk)

The Trust are committed to the Clean Air Hospital Framework aiming to improve the air quality of our city and wider region through our own activities and influence and in turn contributing to improved health and wellbeing of our staff, patients, visitors, neighbours and wider population. The Trust have set a target to achieve a score of 70% (Excellent) and the rating of 50% (Good) was met in 2025. Actions within the Clean Air Hospital Framework Action Plan with transport a key theme will contribute to the Trust improving the score further.

Travel is the greatest contributing factor to poor air quality within hospitals. This includes influencing Procurement and Supply Chain transport. The framework guidance is available to review full air quality framework requirements.

Responding to the audience and challenges

The rest of the plan explains the strategic context and how the Trust will respond to the evidence and challenges.

North East Transport Plan

Responsibility for transport planning for the North East (in this context the local authority areas of, Durham, Gateshead, Newcastle upon Tyne, North Tyneside, Northumberland, South Tyneside and Sunderland) is shared between the Government, the North East Combined Authority and the local authorities. There are specific provider inputs for the highways, air travel and rail. Overall responsibility for strategic transport planning in the North East lies with the North East Combined Authority, which is led by an Elected Mayor and Cabinet. Local roads are managed by the seven local authorities of County Durham, Gateshead, Newcastle, North Tyneside, Northumberland, South Tyneside and Sunderland whilst the Strategic Road Network in the region comprising the A1, A19, A88 and A69 is managed by National Highways, Nexus own and operate the Tyne and Wear Metro and Shields Ferry, whilst a range of providers operate bus, rail, air and ferry routes serving the region.

The Local Transport Plan (LTP) for the North East can be found here Transport Plan which is a statutory plan which sets out the region's transport priorities up to 2040. It has a primary goal to 'create a green, integrated transport network that works for all'. The plan aims to support people and businesses to make greener journeys describing this against three themes.

- A more inclusive economy
- A better environment; and
- A healthier North East.

We have chosen to base our strategic transport planning on those themes.

The rest of this section explains what we plan against each area and there is a more detailed action plan at Annex A.

A more inclusive economy

In supporting a more inclusive economy, the Trust has the following transport objectives:

- **Integrated transport planning;** working with local government and North East Combined Authority colleagues plus transport operators to ensure our team can get to work across the full range of transport choices. This is particularly true in any plans for active travel and bus reform;

- **Affordability;** while the average earnings at the Trust are higher than the North East average (£32,960 in 2024), a significant number of the team are in lower paid roles. The Trust has an interest in fares and integrated ticketing;

- **Accessibility;** as an organisation which seeks to be inclusive, accessible travel is important to accessing skilled colleagues with different mobility needs. As a health care organisation, our patients often have different mobility requirements; some of which might be temporary or permanent;

- **Green transition;** as a region seeking an economic transition to new, green jobs, based in energy and transport, the Trust can contribute through its own operations to support that economic change examining its supply chain and logistics for local impact; and

- **Value for money;** as it seeks to balance the books and continue and grow its commercial activity the Trust needs to ensure transport planning and operations deliver value for the public purse.

Contribute to a better environment

In supporting a better environment, the Trust has the following transport objectives:

- **Understand and reduce the Carbon impact of Trust transport;** making transport planning a key factor in Trust business planning, strategies and Board-led activity to reach Net Zero.

- **Contribute to improved air quality;** understanding the drivers of poor air quality, support Public Health colleagues with evidence of the impact of poor air quality and review operations to make a positive contribution to efforts to improve air quality around the Trust sites and travel to work area.

- **Achieve modal shift;** In the first instance, return the Trust's staff commuting modal shift to the pre-COVID modal and narrow the gap in cost between public transport and parking which is a key barrier to achieving modal shift away from the car and maintain an aligned commuting cost for all staff. Deliver alternatives to support colleagues to use active travel choices or blended travel which enables car use part of the way and still helps support work life balance.

- **Achieve value for money;** Ensure measures to contribute to a better environment is sustainable and cost analysis and best value is a key component in planning.

A Healthier North East

As the largest health care organisation in the North East Combined Authority area there is a moral imperative that the Trust plans its transport arrangements to support a heathier North East. In supporting a better environment, the Trust has the following transport objectives:

- **Support colleagues and customers to make active travel choices;** building in choices to policies and operations, following active travel;

- **Contribute to active travel infrastructure;** work with local government, combined authority and other stakeholders to develop an attractive and safe environment for walking and wheeling; and

- **Ensure active travel is part of the Trust's health and wellbeing offer;** ensuring that it is presented as a healthy choice.

Governance and Reporting

Following agreement to this plan the governance of travel and transport will be reviewed.

The work will remain accountable to the Board via the People Committee.

Work is required to ensure transport planning is also part of the Trust's response to net zero.

Finally, arrangements are in place but will be reviewed for handling parking appeals.

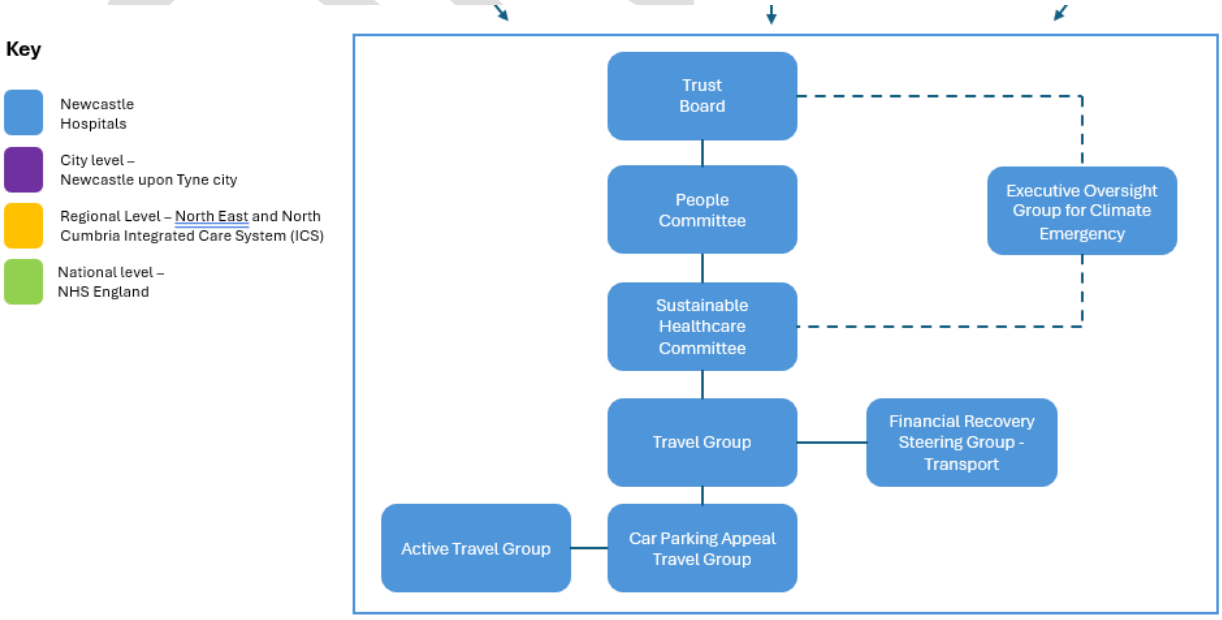


Image 9:Transport Governance and reporting structure

Engagement and communication

Engagement and communication is essential to travel behaviour change. This strategy makes a commitment to actively listen to staff and service users through engagement.

The development of this strategy has been supported by the following engagement:

- **North East Transport Plan;** was developed and agreed following a major engagement exercise across the region;
- **Staff Side advice;** Trade Union colleagues provided important input and views via the Employment Partnership Forum;
- **Green Champions;** the Trusts network of over 1000 Green Champions provided their views; and
- **Governors;** the Governors' Business and Development Group were asked for their views;
- **Trust Management Group;** were briefed and provided views;
- **The Matron's Forum;** were briefed and provided views; and
- **Town Halls;** the team hosted 3 Town Hall sessions, 1 at the RVI, 1 at the Freeman and one online to brief colleagues and listen to views.

Annex A

Within 6 to 12 months **Within 6 to 24 months** **Within 24 to 60 months**

	A more inclusive economy	What is required?	What will we do?
	Integrated Transport Planning	A Trust Transport Plan aligned to regional transport planning.	Engage, develop and agree a plan. Improve the efficiency of estate and transport resources using digital journey planning, centralising expertise, improving wayfinding and reviewing digital booking for parking, staff transport and patient transport.
	Affordability	A view for our workforce on travel choices and any travel to work savings.	Ensure travel planning is available for colleagues. Secure access to discounts and integrated ticketing, consider affordability and sustainability in parking charges.
	Accessibility	An understanding of how accessible our current transport is.	Conduct accessibility tests with our Staff Networks and Patient Representatives.
	Green Transition	A clear plan to manage transport and fleet operations in a manner which reduces carbon and adding value or money.	Understanding fleet management and procured transport services using commercial leverage to reduce carbon.
	Value for money	Better understanding and management of cost.	Implement this plan and manage benefit realisation.

	Contribute to a better environment	What is required?	What will we do?
	Modal-shift and value for money	The cost of parking must align with the cost of public transport to reduce favour for single car occupancy, protect spaces for patients and ensure that staff are provided with full supportive measures for alternative travel where necessary.	Review parking charges and current public transport charges to maintain equitable costs which do not favour commute by the car. Review the Travel Scheme to ensure staff are provided best value. Work with external agencies and businesses to create improved season ticket options for staff working shifts. Promote Park and Ride options. Maintain an annual review and apply inflationary uplifts following annual review.
	Modal-shift Improved Air Quality Reduce Carbon Impact	Recognising that for some colleagues' use of the car to commute is the only option however space is very limited. Patients are more likely to commute by car and space for access is vital. Provide a Board supported and robust parking policy, a process for assessment of need and an online application parking system with suitable systems for supporting need demonstrated parking provision for staff and concessions for patients.	Review the current Parking Policy. Finalise an online parking permit system which enables staff to apply for parking permits and patients to apply for concessions. Provide a range of parking permits to enable a fully flexible parking system which enables provision of parking when needed and maintain infrastructure which ensures space allocation is well controlled, managed and reviewed. Issue idling penalties terms to Trust contractors within Terms and Conditions of any parking provision.
	Review space requirements	Review of parking spaces and utilisation, ensure any rented spaces are cost neutral and produce a plan of alternative under-utilised parking in reasonable proximity to healthcare sites or where Park and Ride is feasible.	Maintain an updated record of occupancy and space. Produce and maintain an alternative parking guide. Seek to support park and ride to Trust sites for staff and others.

	Contribute to a better environment	What is required?	What will we do?
	Contribute to improved air quality and deliver financial and operational efficiencies and value for money	A central point for all transport requests which aim to reduce duplication, maximise use of existing vehicles and resources and ensure the right transport is provided to meet the need.	Seek to centralise all transport provision within a 'Transport Hub'. The Transport Hub to receive all transport enquiries and direct staff and service users to the appropriate mode of transport and avoid unnecessary trips, duplicated emissions and costs. This should include logistics, parking, business travel, patient discharge and transport, shuttle and hopper services, Trust vehicles, pool car services and sustainable transport management.
	Reduce carbon impact, improve air quality, improve health and achieve modal shift	Promote and support an increase in cycling.	Continuously improve facilities on the sites for staff which support active travel with infrastructure including secure cycle parking, drying room facilities, maintenance support and tools to improve skills and confidence.
	Reduce carbon impact, improve air quality, improve health and achieve modal shift and achieve value for money	Increased Demand Responsive Transport (DRT) provision.	Expand the successful Demand Responsive Transport system piloted with Renal (via Flockmobility) to increase volunteer driver support for Trust journeys, support access for staff where public transport does not align with shifts, support patient movement with shared journeys, reduce car dependency and emissions. Trust vehicles will be fitted with suitable management trackers and software. Work closely and be supported by Human Resources to recruit and maintain volunteer drivers.
	Achieve modal shift, improved air quality and value for money	Engage with staff and departments including training to raise awareness of transport options. Embed a Commuting to Work and transport guide with Recruitment to manage expectations and promote our values to potential and new employees.	Work closely with the People Service to produce recruitment information and with Training and Development to develop mandatory training for Transport Awareness. Annual Staff Travel Surveys and analysis of transport usage.
	Reduce carbon impact and	Balanced EV infrastructure to benefit operational need which does not	

	Contribute to a better environment	What is required?	What will we do?
	improve air quality and value for money	produce a negative impact on the estate's electrical outputs.	Produce a five-year EV Infrastructure Plan which will focus on growth where there is business need.
	Reduce carbon impact and achieve value for money	Safer Driving and effective vehicle use	Ensure Trust vehicles are tracked and aligned to a system for allocation and use ensuring they can be utilised by other services if necessary to reduce the need for additional vehicles and avoid low operational use. Staff to be supported with Driver Training if unfamiliar with EV vehicles and provided guidance on charging and effective use of vehicles.
	Reduce carbon, improve air quality and value for money	Increase ULEV / EV usage for all transport provision including contracts.	Trust transport contracts issued with drive to have an EV fleet and support from Trust provided to utilise EV infrastructure and remove barriers to progress. Electrical costs recharged to service provider.
	Reduce carbon impact, improve air quality and achieve value for money	Trust Consolidation Centre Feasibility.	Commission a feasibility study into an off-site 'Consolidation Centre' with local partners to reduce large scale deliveries to the hospital sites, enable 'last green mile' direct department logistics and furniture recycling.
	Reduce carbon impact, improve air quality and achieve value for money	Zonal Appointment Planning Study.	Commission a feasibility study into creating zonal appointment systems for patients which results in improved allocation of appointments to support patients from 'zones' attending at similar times. This supports Patient Transport Service (NEAS), Daft as a Brush and other patient transport providers maximise passenger loadings, improve patient experience and reduce trips.

	Contribute to a better environment	What is required?	What will we do?
	Reduce carbon impact, improve air quality and achieve value for money	Patient Discharge Lounge Feasibility	Commission a study and model of Patient Discharge which will enable patients to be moved to an area for discharge and transport co-ordination to manage final journey with the aim of reduced bed blocking, improved patient experience, fewer failed collections.
	Reduce carbon impact, improve air quality and achieve value for money and support modal shift	Hopper and Shuttle Services.	Trust funded services are to be used to maximum efficiency in improving access to our services not only for colleagues but also the wider public as this contributes to single car occupancy trips. Enable colleagues to travel in uniform to maintain operational efficiency and make these Trust funded services public access to drive efficiencies in access and financially. Conduct robust route planning to ensure the services meet with shift times and exploring opportunities for services to support integration, interchange and possible park and ride options to relieve space pressure on the sites will be explored and implemented.

	A healthier North East	What is required?	What will we do?
	Support colleagues to make active travel choices, promote and ensure why the NHS Active Staff and ensure active travel is part of the Trust wellbeing offer	Facilitate Active Travel Engagement and support. To support reduced sickness absence, enhance staff wellbeing, improve physical activity, mental health and embed active travel into Health and Wellbeing, recruitment and workforce ethos.	Support Occupational Health Services (OHS) and managers to recognise and promote active travel as a means to reduce sickness, manage stress and anxiety and improve overall health. Ensuring a move away from a 'parking pass is the solution.' Promote the Trust's wellbeing and active travel ethos at recruitment and as part of the corporate image of delivering a healthy workforce. All new colleagues to have Personalised Journey Plans. Promote walking and cycling to work, encouraging staff to build physical activity into their daily routines. Support staff to learn how to cycle and provide access to cycle initiatives to encourage greater use of cycles for commuting and working across sites and in the community. Encourage Active Travel Group and Green Champions to promote the benefits of active travel to staff health and the environment. Place an Active Travel exclusion zones around Trust sites with limited exemptions for parking.

	A healthier North East	What is required?	What will we do?
	Contribute to active travel infrastructure	Ensure the Trust is a strong voice and collaborates with wider partners and networks on best practice, shared learning, innovative opportunities and is involved in wider regional transport initiatives and solutions and contributes to national NHS transport matters.	Develop relationships and engage with NECA and local authorities on local transport plan deliverables. Build on partnership with Health Innovation North East and North Cumbria (HINENC) and other regional NHS trusts for regional Travel Planning. Continue work with National Performance Advisory Group (NPAG) Sustainable Transport and Transport Logistics and NHS England Greener Team for active travel and net zero initiatives.
	Ensure active travel is part of the Trust wellbeing offer	Active Travel on Occupational Health and adjustments at work.	Alongside existing Stress Management courses, counselling, promote the benefits of walking and cycling, encouraging activity in workplace adjustments where appropriate. Linking health condition support where evidence promotes exercise as a preventative or supportive measure enable Trust active travel support packages. Engage with OHS to determine if exercise can aid physical and mental health wellbeing. Work with the Integrated Care Board (ICB) to understand if cycle proficiency and led cycle rides could be provided as a tariff based treatment option (see NICE Guidelines) for rehabilitation, preventative measure to avoid hospital admissions, weight loss support programme pre-surgery and aid recovery for patients. Review if Prescribed Active Travel is possible.

Agenda item A4(d)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Travel and Transport Plan

Paul Hanson

Director of Estates, Facilities and Strategic Partnerships

Healthcare at its best
with people at our heart

What I am going to cover

- Why it matters
- Engagement
- Next steps
- Parking Policy Review

Why Transport Matters

The Newcastle upon Tyne Hospitals NHS Foundation Trust

- 9 million (m) journeys
- 35,517 tonnes of carbon per year from car generated journeys
- 1m miles via the "grey fleet" costs £550k
- £4.5m costs for managing car parks
- £1.25m in business travel
- Part of every colleague, patients and visitor’s working day

Why Transport Matters

- Opportunity to
  - Improve patient, visitor and colleague access
  - Reduce carbon
  - Improve air quality
  - Improve health and wellbeing

How we travel

2025 survey results show:

- 44% of colleagues commute by single car occupancy
- 32% of colleagues commute by public transport
- 4% of colleagues commute by cycle
- Rest is made up of walking, running, wheeling, car share or park and ride
- The hopper and 533 carry 12,500 people per month

Mode	%	No
Car	44%	1861
Public Transport	32%	1600
Active Travel	11%	573
Park and Ride	1%	23
Car Share / Lift	7%	329
Other	5%	185
	100%	4571

Engagement

- Trust Management Group (TMG)
- Green Champions
- Matrons' Forum
- Employment Partnership Forum
- Royal Victoria Infirmary (RVI) Town Hall
- Freeman Hospital Town Hall
- MS Teams/online Town Hall
- Briefed the Chair
- and lots of conversations about parking…..

Full slide deck included in the Board Reading Room.

Issues

- Parking spaces
- Cycle storage
- Public transport
- Safe walking
- Clear messaging

Next steps

- Trust Board approval requested in May following Executive approval
- Continue to refresh a Trust Travel Group
- Review the Parking Policy

Highlights

- Cycle Hubs
- Look at more cycle storage
- Engage with the North East Combined Authority (NECA) and NEXUS on affordable public transport access
- Create a Transport Hub for efficiency

Parking Policy Review

- Formal Policy Review process
- Plus
    - Parking-specific survey; principles, criteria, charging
    - Staff side engagement
    - Customer Service changes
- Highlights
    - Objective criteria
    - Time limited permits
    - Regular review
    - Online application
    - Streamlined appeal process
    - Plan for charging

Questions?

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Agenda item A5(a)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 2026		
Title	Quality Account 2025/2026		
Report of	Mrs Rachel Carter Director of Quality & Safety		
Prepared by	Anne Marie Troy-Smith Quality Development Manager		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☐
Summary	Each year the Trust is required to produce and publish a Quality Account. Contained within this is a review of the previous 12-month performance against national targets, the agreed Quality Priorities, as well as a narrative detailing the identified priorities for the coming year. **Alert:** - There have been 10 Never Events reported for the year 2025/26. Key improvement work, via the Quality Priorities and National Safety Standards for Invasive Procedures is currently underway [page 8]. - Cancer performance remains below national targets in relation to 28, 31 and 62-day measures. Lung cancer is a particular area of focus within the 2026/27 Quality Priorities [page 9, 42, 44]. - Incidence of Clostridioides difficile and Methicillin-resistant Staphylococcus aureus bacteraemia remain above the national targets. There are several key improvement actions currently underway, led by senior leaders within the Organisation, including focusing on this work as a Quality Priority for 2025/26 [page 10, 42-44]. **Advise:** - Quality Priorities 1 (increasing incident reporting rates) and 2 (safe and effective medicines use) from 2025/26 have been refreshed and will continue in 2026/27 with a clear focus on continuing improvement. - Whilst work has been undertaken to improve on 2025/26 compliance, achievement of the diagnostic standard remains below the national average in 2025/26 [page 42,44]. - Significant improvements have been made in 2025/26 to improve compliance with the Emergency Department 4-hour wait standard (78%); the Trust is currently just below this at 77.43% [page 42]. **Assure:** - The 2025/2026 Quality Account has been completed and sent out for Consultation to the relevant bodies in time for Trust Board and submission to the Department of Health in June 2026.		
Recommendation	Review and approve the Quality Account for publication.		

Agenda item A5(a)

Links to Strategic Objectives	Advancing Care – improving patient care, effectiveness and quality through innovation, research, improvement and education					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	Not applicable.					
Reports previously considered by	Annual report, progress reported throughout year at Trust Board.					

QUALITY ACCOUNT 2025/2026

1. EXECUTIVE SUMMARY

The Trust Board is asked to review and approve the Quality Account for publication, noting priority detail to date with a change in focus for 2026/2027.

Review of Quality Performance 2025/2026

Patient Safety:

Priority 1 – Supporting staff to report incidents with an enhanced focus on shared learning and a systems-based approach to improvement. This priority was achieved and will now become business as usual.

Incident reporting rates have continued to increase since 2022/2023 on all types of incident and Patient Safety Incidents, exceeding the 3% ambition. The 2025 General Medical Council survey shows improvement in trainee experience, with stronger rankings and fewer outliers, particularly in specialties such as endocrinology, respiratory medicine and core surgery. We have implemented the national patient safety syllabus and training programme.

Priority 2 – Safer and more effective medicines use. This priority was partially achieved and will continue as priority in 2026/2027.

Medicines Reconciliation has increased from 10% to consistently between 40-50%. This is due to new ways of working for pharmacy team members. There has been an increase of over 3,000 pharmacy interventions per month with over 50% of these being with high-risk medicines. Ward medicines management audits have improved to 89% compliance overall slightly below the 90% target. Nursing medicines management training is at 72% and corporate induction medicines management training in place. A working group on discharge letters to improve communication to primary care is in place and will continue through 2026/2027.

Clinical Effectiveness:

Priority 3 – Ensuring mental capacity, best interests decision making and deprivation of liberty safeguards are considered appropriately for inpatients with a learning disability. This priority was Partially Achieved and will now become business as usual.

Face to face supervision, study days and planned training sessions have continued throughout the year reaching 422 staff. Additional situation specific advice and training is delivered as required. Mental capacity assessments e-learning level 1 achieved 90% and Mental capacity assessments e-learning level 2 achieved 87%.

An audit of patients with a learning disability flag took place with results showing an improvement in the quality of mental capacity assessments and best interests' rationale. Work to improve compliance, alongside regular audit will become part of business as usual. The e-learning Diamond Standard training compliance training is 89.5%.

Priority 4 – Expanding the Accrediting Excellence programme for wards and departments. This priority has been achieved and will now become business as usual.

Significant progress was made in expanding and embedding the Accrediting Excellence Programme. A total of 40 inpatient Wards, one critical care area, and five-day units were

introduced to the programme from across all Clinical Boards. By the end of 2025**,** 32 inpatient wards achieved full accreditation status**,** accounting for 53% of all inpatient wards. Four wards have now progressed onto the re-accreditation pathway. All participating areas completed a detailed baseline assessment and received regular progress reviews, along with tailored support to guide improvement. Accredited wards also took part in a celebration event, recognising their efforts and reinforcing a culture of continuous improvement. There has been strong organisational momentum and growing capability which gives a solid foundation for further expansion of the programme.

Patient Experience:
Priority 5 – Waiting safely- improving safety for patients who are waiting for treatment. We will focus on patients who are waiting for a total knee replacement operation, with the aim of optimising health before and after the procedure. **This priority has been achieved and will now become business as usual.**

Work has been undertaken to improve the patient education resources available to patients awaiting total knee replacement surgery. We are currently finalising patient education videos. Formal pre-operative patient education was offered to 733 patients, delivered by our orthopaedic therapy team. Patients with more complex needs are enrolled on a prehabilitation programme. This provides a multi-disciplinary approach to further support. A total of 51 patients have completed the full prehabilitation programme, with 23 patients currently active on the pathway. Analysis of these postoperative outcomes demonstrates a 0.7day reduction in average hospital length of stay. Patients participating in the prehabilitation programme demonstrated measurable improvements in functional capacity and cardiovascular endurance with an average percentage improvement of 32.47% and an average increase in walking distance of 60 metres.

Priority 6 – Roll out of patient experience real time surveys. This priority has been achieved and will now become business as usual.
By December 2025, the real time patient experience programme was rolled out to 40 wards across all hospital sites. This comprised over 3,000 bedside conversations with most reporting back to ward teams within 24 hours of completion of final survey. There are some early indications of meaningful improvement, with a comparison of scores for wards that have been receiving near real time feedback for at least 5 months (n=17), showing a statistically significant improvement in communication about medicines (average baseline score of 9.26 improved to 9.6 in this period).

An early review of complaints data from wards that have been receiving real-time feedback for five months suggests a reduction of 39% in complaints between May and November 2025, compared with the same period in 2024. Over the same period, wards not participating in the real-time programme saw a 10% reduction in complaints. While these early findings are encouraging, they are based on a limited timeframe and wards. As the programme is implemented across a wider range of wards, further monitoring will be required to determine if this encouraging picture continues.

Patient experience of emergency care: Real time measurement has been successfully introduced to our Emergency Department, capturing experience of people who attended within 24 hours. This was implemented along with our partners within the Great North Healthcare Alliance. We have not yet achieved our aim to see ourselves consistently placed

within the top 20% of provider organisations of emergency care – missing the threshold by 0.3%.

Quality Priorities for Improvement 2026/2027

Patient Safety:

Priority 1- Continue to increase incident reporting, reducing the proportion of incidents resulting in serious harm and including an in-year reduction in never events related to invasive procedures

To ensure we achieve a sustained increase of incident reporting. We will also focus on promoting patient safety in areas where there is a significant risk of harm associated with invasive procedures, aiming to reduce the number of related Never Events.

Priority 2 - Safer and more effective medicines use

Carry forward from 2025-26 to achieve original targets which have only been partially met.

Clinical Effectiveness:

Priority 3 – Reduction in lung cancer wait times

Consistently achieve >80% of patients achieving the national 28-day faster diagnosis standard.

Priority 4 - Reducing healthcare associated infection and improving antimicrobial stewardship

Reduction in Methicillin-resistant Staphylococcus aureus, C. diff and E. coli infections. National and trust target to reduce healthcare infection rates to improve patient outcomes and safety.

Patient Experience:

Priority 5 - Improve timescales to respond to complaints

Trust target to improve the quality and timeliness of complaint responses to provide a higher quality of feedback to patients and families.

Priority 6- Reduce 'did not attend/was not brought' appointments by 3%, measured using the index of multiple deprivation 1& 2 & global majority

3% Reduction in Did Not Attend or Was Not Brought episodes in patients with higher levels of social deprivation.

Priority 6a. Increase maternal vaccination rates by 10% for women who require interpretation service. Vaccinations include flu, whooping cough and respiratory syncytial virus.

Increase vaccination rates (10%) for women who require interpretation services.

Report of Rachel Carter
Director of Quality and Safety
28 April 2026

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

QUALITY ACCOUNT 2025/2026

CONTENTS

PART 1

CHIEF EXECUTIVE'S STATEMENT

Thank you for taking the time to read our Quality Account for 2025/26. This report gives us an important opportunity to reflect openly on the quality and safety of the care we provide, to be transparent about where we are doing well, and to be honest about where we still need to improve.

The past year has been a significant one for Newcastle Hospitals. It has been a period of sustained focus on strengthening quality governance, improving patient safety and experience, and building on the learning from external review and internal scrutiny. I am pleased with the progress that has been made, particularly with the work to embed quality and safety in everyday practice across our clinical boards and services.

Over the last 12 months we have seen tangible improvements in a number of key areas. Our approach to patient safety has continued to mature, with the full implementation of the Patient Safety Incident Response Framework helping us to focus much more deliberately on systems-based learning, shared improvement and meaningful engagement with patients and families when things go wrong. Reporting of incidents remains high, which we see as a positive indicator of a developing open and learning culture, and our emphasis is increasingly on learning and improvement.

We have also strengthened our quality oversight arrangements, with clearer lines of accountability from service level through to the Trust Board. Monthly quality oversight at clinical board level, alongside more consistent escalation and assurance, has helped us to identify risk earlier and respond more effectively.

Patients continue to tell us that the care they receive from our staff is compassionate and respectful. Feedback from patient experience surveys and real-time feedback highlights the dedication of our teams and the difference they make every day, often in very pressured circumstances. It is good to see real changes happening because of the feedback we receive.

There has also been important progress in clinical effectiveness and access to care. Teams across the organisation have worked hard to reduce long waits, improve flow and make best use of available capacity. Alongside this, Newcastle Hospitals remains one of the leading research organisations in the NHS, giving patients access to cutting-edge treatments and innovation that directly supports improvements in outcomes and quality.

I want to thank colleagues across every role and profession for their continued commitment, resilience and professionalism. They have remained focused on what matters most: providing safe, high-quality care for patients and supporting one another to do so.

This Quality Account sets out both what we have achieved over the last year and the priorities we have identified for further improvement. We know there is more to do and we remain committed to openness, learning and partnership with patients, colleagues, Governors and our system partners as we continue our improvement journey.

I hope this report gives assurance to patients and the public about the care we provide and our determination to keep improving.

Rob Harrison
Acting Chief Executive
The Newcastle upon Tyne Hospitals NHS Foundation Trust
April 2026

What is a Quality Account?

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

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

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

The account includes additional information required by NHS England.

PART 2
Our Quality Priorities for Improvement 2026/2027

This section of the Quality Account sets out the improvement priorities we have identified for 2026/2027.

We have used a wide range of qualitative and quantitative data, including our current priorities, analysis of patient safety incidents, serious incidents, and risk registers, waiting times and clinical audit results, national and regulatory reports and other feedback from patients and stakeholders.

Process of Selection
Long-listing: A broad list of 17 potential priorities were discussions with team leads for each area and after further consideration list was reduced to eight.
Shortlisting and engagement: internal and external stakeholders reviewed the long list, considering alignment with our strategy, patient safety, effectiveness, and experience. This engagement included meetings with Healthwatch North Tyneside & Healthwatch Newcastle, The Integrated Care Board were invited to be part of the consultation process. Internally there was consultation with Governors and the Executive team.
Governance Approval: The final priorities were considered and approved by the Trust Board and relevant committees.

The quality priorities we have agreed are:

1. Continue to increase incident reporting, reducing the proportion of incidents resulting in serious harm and including an in-year reduction in never events related to invasive procedures
2. Safer and more effective medicines use
3. Reduction in lung cancer wait times
4. Reducing healthcare associated infection and improving antimicrobial stewardship
5. Improve timescales to respond to complaints

6a. Reduce ‘did not attend/was not brought’ appointments by 3%, measured using the index of multiple deprivation 1& 2 & global majority

6b. Increase maternal vaccination rates by 10% for women who require an interpretation service. Vaccinations include flu, whooping cough and respiratory syncytial virus.

Patient Safety

Priority:1	Continue to increase incident reporting, reducing the proportion of incidents resulting in serious harm and including an in-year reduction in Never Events related to invasive procedures.
Why we chose this as a priority and what it means for patients:	To ensure we achieve a sustained increase of incident reporting. We will also focus on promoting patient safety in areas where there is a significant risk of harm associated with invasive procedures, aiming to reduce the number of related Never Events.
What we are planning to do:	We will continue to support all staff to report incidents, promoting a positive safety culture, focussing on learning opportunities and improving our systems. To reduce the risk from incidents and Never Events associated with invasive procedures, we will implement the National Safety Standards for Invasive Procedures. Sharing learning from incident reporting remains a key component and we will improve our methods of sharing learning.

Performance measure:	Proposed Measure	Target
	• Increased incident reporting across all services.	By quarter 4 2026-2027 3% increase in reported incidents compared to average baseline 2025-2026.
	• Improve low/no harm incident ratio of all reported incidents.	By quarter 4 2026-2027 3% increase in low/no harm incidents as a proportion of all incidents.
	• Reduce the number of Never Events related to invasive procedures.	Quarters 3 & 4 2026-2027 – 0 Never Events related to invasive procedures.

Priority:2	Medicines Management
Why we chose this as a priority and what it means for patients:	Medicines are the most widely used intervention in healthcare and medication errors, and adverse drug reactions are common. This can lead to poor patient outcomes, and negatively impact families, staff and organisations.
What we are planning to do:	We want to minimise drug errors by increasing pharmacy medicines reconciliation rates and prescribing corrections (interventions), whilst increasing the number of medicines prescribed by pharmacists. We also want to improve the accuracy of information we send to GPs about their patient's medication changes and monitoring requirements on discharge.

Performance measure:	Proposed Measure	Target
	• Further increase medicines reconciliation rates.	50-60% increase.
	• Increase pharmacy interventions and pharmacist prescribing.	Interventions by 10%, prescribing by 5%.
	• Reduce omitted doses of medicines for patients in hospital.	To <10% (currently around 15%) and <5% for critical medicines.
	• Improve the safe & secure handling & storage of medicines.	90% compliance per ward/clinical area on the medicine's assurance framework.
	• Improve pharmacy prescription turnaround times.	95% of discharge prescriptions will be dispensed within 1.5 hours of receipt.
	• Improve the accuracy of information sent to GPs on discharge.	5% improvement.

Clinical Effectiveness

Priority:3	Reduction in Lung Cancer Wait Times
Why we chose this as a priority and what it means for patients:	The faster diagnosis standard set by NHS England states that 80% of patients should have either a diagnosis of cancer (or cancer ruled out) within 28 days. Over the last 12 months we met this standard in 4 months.
What we are planning to do:	We aim to significantly improve the early stages of the lung cancer pathway, with a focus on faster and more efficient diagnostics.

Performance measure:	Proposed Measure	Target
	Achieve the NHS England 28-day faster diagnosis standard.	Achieve more than 80%. Reduce time from referral to first appointment to 6 days (Currently 17 days as of December 2025). Reduce median wait for endobronchial ultrasound, 85% to have procedure by 7 days (Currently 9 working days). Reduce navigational bronchoscopy wait to 7-14 days (Currently eight weeks).

Priority:4	Reducing healthcare associated infection and improving antimicrobial stewardship
Why we chose this as a priority and what it means for patients:	There is a significant risk from the impact of Antimicrobial Resistance, and it is imperative that we focus on appropriate prescribing and use antimicrobials only when there is an infection for which they are the most appropriate treatment. We aim to reduce patient harm associated with healthcare infections by achieving national targets.
What we are planning to do:	Reduce infections associated with Methicillin-resistant Staphylococcus aureus, C. diff and E. coli. Implement a range of infection prevention and control initiatives to improve patient safety including development of care bundles and promoting hand hygiene. Improve antimicrobial stewardship to reduce overall antimicrobial use and to further develop the antimicrobial audit programme.

Performance measure:	Proposed Measure	Target
	To meet the national targets for Methicillin-resistant Staphylococcus aureus, C. diff and E. coli.	New targets for 2026-2027 will be set in June 2026. Until these are released, we will aim to achieve the 2025 - 2026 targets which are: • 0 Methicillin-resistant Staphylococcus aureus bloodstream infections • Less than 136 C. diff cases • Less than 225 E. coli Blood Stream Infection.
	Reduce overall antibiotic use as per national action plan for antimicrobial resistance.	• Increase low risk antibiotic use to greater than 70% currently between 50-55%.

Patient Experience

Priority:5	Improve timescales to respond to complaints
Why we chose this as a priority and what it means for patients:	The NHS Complaint Standards set out how NHS organisations should approach complaint handling; to provide a quicker, simpler and more streamlined complaint handling processes. The focus is on early resolution and learning. We aim to improve our complaints process by fully aligning with these standards.
What we are planning to do:	Deliver a timely, reliable, transparent and learning focused complaints process.

Performance measure:	Proposed Measure	Target
	Timeliness of complaints	• Establish clear maximum timeframes for each stage of the complaints process • Achieve 90% of complaint responses within agreed timeframes by quarter 4 • Introduce standardised extension principles.
	Strengthen complaint quality and consistency	Develop quality standards for complaint responses, including clarity, empathy, action and demonstrable learning.
	Deliver a robust complaints dashboard	Redesign the complaints dashboard to include Key Performance Indicators covering: • Timeliness • Agreed extensions • Themes and sub themes • Repeat complaints • Actions/learning.
	Enhance accountability and governance	Dashboards circulated to all clinical boards regarding open and overdue complaints. Clinical board deep dive reviews reported to complaints panel to evaluate themes and learning. Establish an escalation process for persistently overdue complaints.

Priority: 6a	Reduce "did not attend/was not brought" appointments in Maternity services for thosewith highest risk by 3%
Why we chose this as a priority and what it means for patients:	The highest rates of 'did not attend/ was not brought' appointments within maternity services occur amongst people living in the following groups: - index of multiple deprivation deciles 1 and 2 (most deprived.) - global majority communities: These population groups experience poorer overall health, worse pregnancy outcomes, and wider health inequalities, alongside known barriers to accessing services.
What we are planning to do:	Reduce missed appointment numbers, improve maternity access, and continuity of care, alongside improved outcomes for mothers and babies within these groups.

Performance measure:	Proposed Measure	Target
	Reduce the number of did not attend /was not brought appointments in the above groups within maternity services.	3% reduction by 31 March 2027, using quarter 3 2025–2026 as the baseline. (50.1% for index of multiple deprivation 1, 14.2% for group 2)

Priority: 6b	Increase maternal vaccination rates by 10% for women who require an interpretation service vaccinations include flu, whooping cough and respiratory syncytial virus.
Why we chose this as a priority and what it means for patients:	A significant number of women who require interpreting services and are from the global majority do not attend maternal vaccination appointments, increasing the risk to maternal health and poor outcomes for babies.
What we are planning to do:	Increase vaccination uptake, reducing health inequalities and improving maternal and population health outcomes.

Performance measure:	**Proposed Measure**	**Target**
	Increase maternal vaccination rates for women who require interpretation services.	10% increase by 31 March 2027, using Quarter 3 2025–2026 as the baseline. (Flu 19.8%, whooping cough 42.9%, respiratory syncytial virus 34.1%.)

Statement of assurance from the Board

The Quality Account is an annual account that providers of NHS services must publish to inform the public of the quality of the services we provide. It also supports us to focus on and to be open about service quality. The following section provides an explanation of our quality governance arrangements which provide assurance to the Board.

Quality is central to the Trust's purpose and is led by the Board of Directors through the Chief Executive Officer and Executive Team. The Board is responsible for ensuring that appropriate governance, oversight and assurance mechanisms are in place to monitor and improve the quality and safety of care.

To support this, the Trust has established a number of Board assurance committees, including the Quality Committee; Finance and Performance Committee; Audit, Risk and Assurance Committee; People Committee; Digital and Data Committee; Charity Committee; and Appointments and Remuneration Committee. Each committee is chaired by a Non-Executive Director and provides independent assurance to the Board on the effective performance and operation of the Trust within its remit.

Where required, the Board establishes Strategic Oversight Groups (SOGs) as time-limited sub-committees of a Board Committee. These groups comprise Non-Executive Directors, Executive Directors and relevant senior staff and are convened to provide focused oversight of significant developments or issues. SOGs are established where the level of risk, complexity, time commitment or cross-cutting impact requires more dedicated scrutiny than can be accommodated within existing committee structures.

In March 2026, the Trust was de-escalated from enhanced oversight by NHS England's Integrated Quality Improvement Group following evidence of sustained improvement across the organisation. As part of this process, the Trust commissioned and completed a Well-led Review, which demonstrated clear improvement compared to the findings of the 2024 Care Quality Commission inspection. Recommendations arising from the review have been translated into a comprehensive action plan, with progress overseen by the Audit, Risk and Assurance Committee. This work aligns with and complements actions identified through the provider capability self-assessment completed in February 2026.

The Trust's quality and safety governance framework continues to mature and strengthen. Quarterly performance reviews are undertaken across the eight Clinical Boards, supported by Trust-wide quality improvement programmes. These include quality and safety peer reviews and the Accreditation of Excellence programme, both of which are embedded within Quality Committee reporting and escalation processes. Together, these arrangements support effective assurance and escalation from ward to Board.

Clinical services are delivered through Clinical Boards, each led by a Clinical Board Chair (medical leader), a Director of Operations, and a Head of Nursing. Each Clinical Board has a monthly Quality Oversight Group, chaired by a senior medical Quality and Safety Lead and attended by key clinical, operational and corporate staff. A standardised agenda ensures regular review of all domains of quality, including the

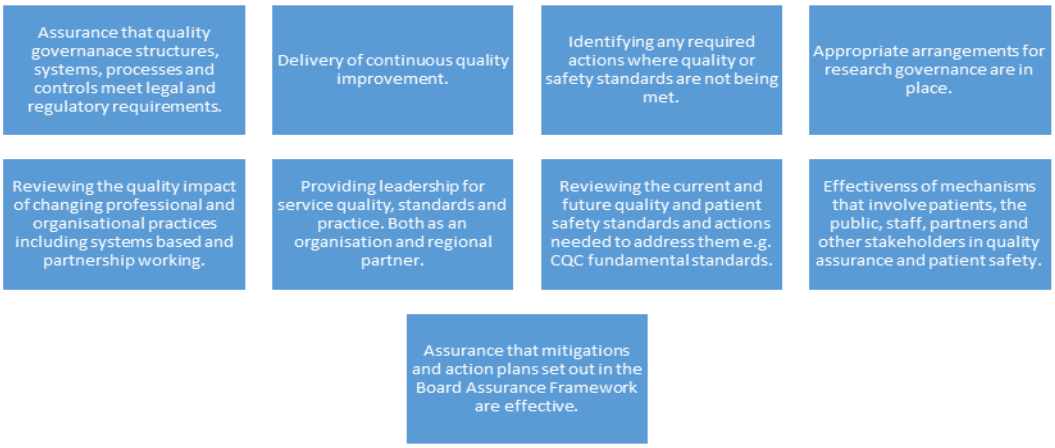
identification and escalation of risks. This governance structure is being further embedded within directorates and specialties and has been strengthened through the appointment of non-medical Quality and Safety Leads to support improvement across all services.

The Board of Directors receives a regular Integrated Board Report, providing a comprehensive overview of performance across the domains of quality, people and finance, supporting informed decision-making and assurance.

The Quality Committee

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

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



Examples of how the Quality Committee has discharged its responsibilities during the year include:

- Ongoing oversight of the Patient Safety Incident Response Framework, including receipt of assurance updates against the Trust's three identified priority areas.
- Commissioning and consideration of in-depth reviews into specific areas of concern, such as Duty of Candour compliance.
- Review and approval of the new Transplantation Strategy, including the development of the Assessment and Recovery Centre to enhance transplant opportunities at a national level.
- Monitoring of key improvement programmes, including infection prevention and control, ophthalmology services and the management of the deteriorating child. Receipt of quarterly assurance reports from the rapid quality and safety review programme, providing oversight against core quality standards. Peer reviews include real-time feedback and coaching, with escalation to the Executive Director of Nursing where required. Findings are triangulated with outputs from the Nurse Staffing and Outcomes Group and the Accreditation of Excellence programme, enabling the Committee to identify areas requiring further improvement and to support enhanced intervention where necessary.

PART 3

Review of quality performance 2025/2026

This section of the Quality Account describes the progress made against priority areas for improvement in the quality of services identified last year. It includes what we hoped to achieve, and what we actually achieved for each priority which has been monitored over the last 12 months by the Trust Board, Council of Governors and the Quality Committee.

Our priorities were:

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

Priority 2 – Safer and more effective medicines use.

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

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

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

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

Most of the account represents information from all eight Clinical Boards presented as total figures for the Trust.

Patient safety

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

This priority was achieved.

What did we say we would do:

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

Evidence:

1. **Incident Reporting Rates**

Incident reporting rates have continued to increase since 2022/2023 on all types of incident and Patient Safety Incidents, exceeding the 3% ambition. A summary of the increase in reporting is detailed in Figure 1 and illustrated in Figures 2 and 3.

	Jan 2023 - Feb 2024	Jan 2024 - Feb 2025	Jan 2025 – Feb 2026	Increase on 2024/2025	Increase on 2023/2024
All Incidents	25654	27523	29413	6.8%	14.6%
Patient safety incidents	20739	21735	23542	8.3%	13.5%

Figure 1: Incident reporting data

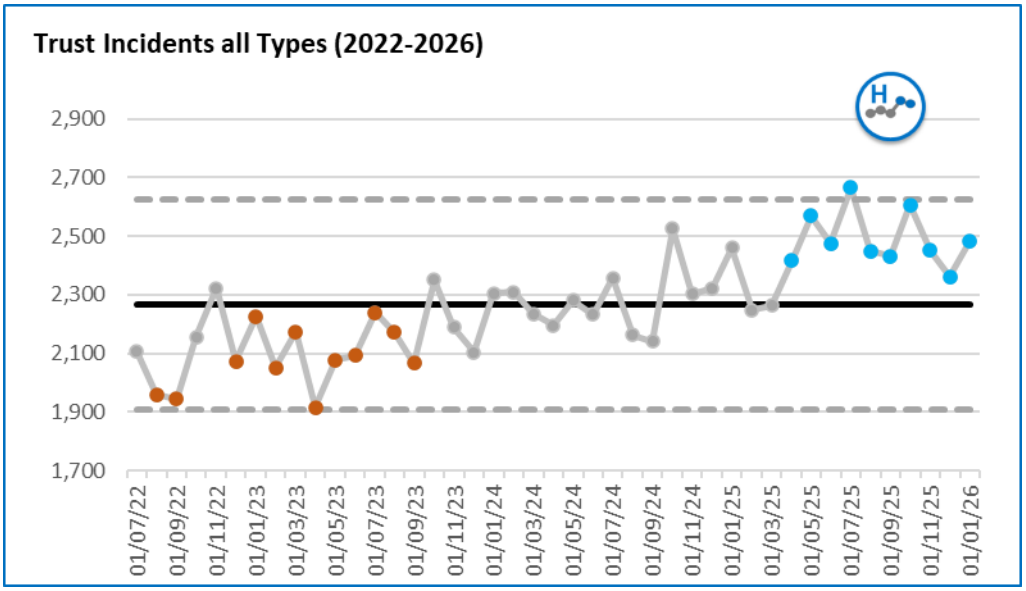


Figure 2: all incident types

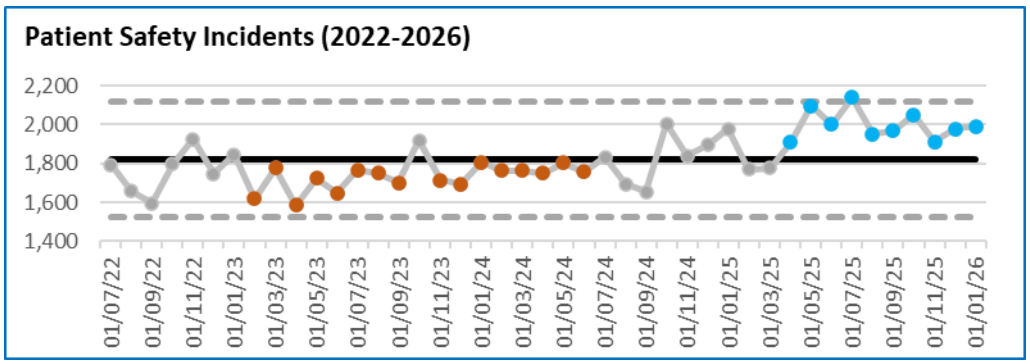
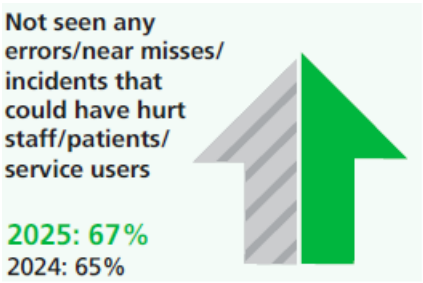


Figure 3: patient safety incidents

2. Staff Survey Results

The proportion of staff reporting they have not seen errors or near misses has improved, and there was also a small uplift in how strongly staff feel the organisation encourages incident reporting.
Most other safety-related responses remained at or above the benchmark-group median. While not all scores increased, the overall profile reflects a maintained and safety culture with signs of improvement in key areas.



3. General Medical Council Survey

The 2025 General Medical Council survey shows improvement in trainee experience, with stronger rankings and fewer outliers, particularly in specialties such as endocrinology, respiratory medicine and core surgery. Challenges remain around facilities and supportive environments in a small number of departments.

4. Staff Training

We have implemented the national patient safety syllabus and training programme. The syllabus has five levels, which build on each other:

- Level 1 - essentials for patient safety – mandatory e-learning for all staff. Current compliance 97%
- Level 2 - access to practice – mandatory e-learning for clinical staff band 6 and above, medical and dental. Current compliance 89.5%
- Level 3 investigator training – in person training provided to meet the patient safety incident response framework requirements for learning response leads. 80 staff have been trained to date, with additional training being sourced externally
- Level 4 & 5 – patient safety specialists - four trust patient safety specialists have completed externally provided training.

5. Communications Plan

A patient safety communication plan has been developed to strengthen shared learning and engagement. This includes a monthly patient safety bulletin providing key updates, learning from incidents and practical safety messages for all colleagues. Alongside this, a focused “Safety Spotlight” offers more targeted learning on emerging themes or priority risks.

To further support openness and collaboration, the Clinical Risk Group - our forum for shared learning - is now open to all staff. A recent review shows strong engagement, with attendance averaging around 60 colleagues from a range of clinical and corporate services, demonstrating growing commitment to collective improvement.

6. Patterns of Harm

To ensure that our improvement work is genuinely reducing harm, we will continue to routinely evaluate patterns and trends in patient safety incidents using both quantitative and qualitative measures. This includes analysing incident themes, severity levels, contributory factors, and any changes in harm profiles over time and following the implementation of specific safety actions.

We will also triangulate this with data from audits, patient experience feedback and clinical outcome measures, to build a fuller picture of impact.

Regular review through governance forums will allow us to identify whether improvements are sustaining, where additional action is required, and how learning can be shared to prevent recurrence and continuously improve the safety of our care.

Priority 2 – Safer and more effective medicines use

This priority was partially achieved and will continue as priority in 2026/7.

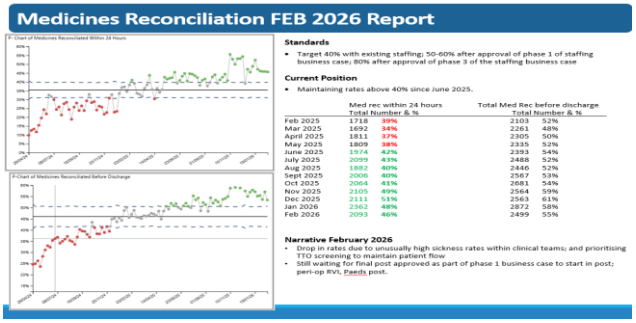
What did we say we would do:

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

Evidence

1. **Medicines Reconciliation**

Medicines Reconciliation has increased from 10% to consistently between 40-50%. This is due to new ways of working for pharmacy team members which includes:



- prioritising patients who have been admitted for less than 24 hours
- additional staff in key areas including accident and emergency, peri-operative care, orthopaedics and trauma,
- an increase in pharmacy technicians on the admissions area and
- an additional pharmacist is onsite until 10.30pm and at weekends to support medicines reconciliation out of hours.

There has been an increase of over 3000 pharmacy interventions per month with over 50% of these being with high-risk medicines.

2. **Medicines Assurance Framework**

Ward medicines management audits have improved to 89% compliance overall slightly below the 90% target. An escalation plan has been developed for areas that have repeated non-compliance over a 3-month audit cycle. Robust actions plans are put in place at the end of every audit cycle.

3. Clinical Audit Plan

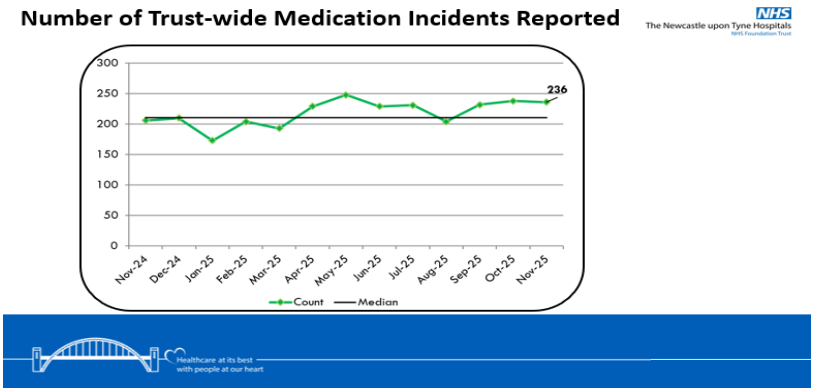
The clinical medicines management audit plan has been completed with action plans in place for areas of non-compliance. The audits completed this year include medicines management at ward level, medicines reconciliation, antimicrobial stewardship, medicines management interventions, FP10 audit, pharmacy turnaround times, patient group direction, omitted doses and oxygen prescribing.

4. Omitted doses

An omitted doses audit/spot check has been undertaken. A new omitted doses dashboard is currently in progress of being built so that it is visible to the clinical services.

5. Medication Incidents & Dashboard

A new medication incident report has been developed which is discussed monthly at the medicines management oversight group with a cycle of business to consider areas such as omitted doses, controlled drugs and chemotherapy with a robust action plan in place for each area. The number of medication incidents are expected to increase with time as efforts continue to encourage reporting and learning from incidents, with the current position shown below.

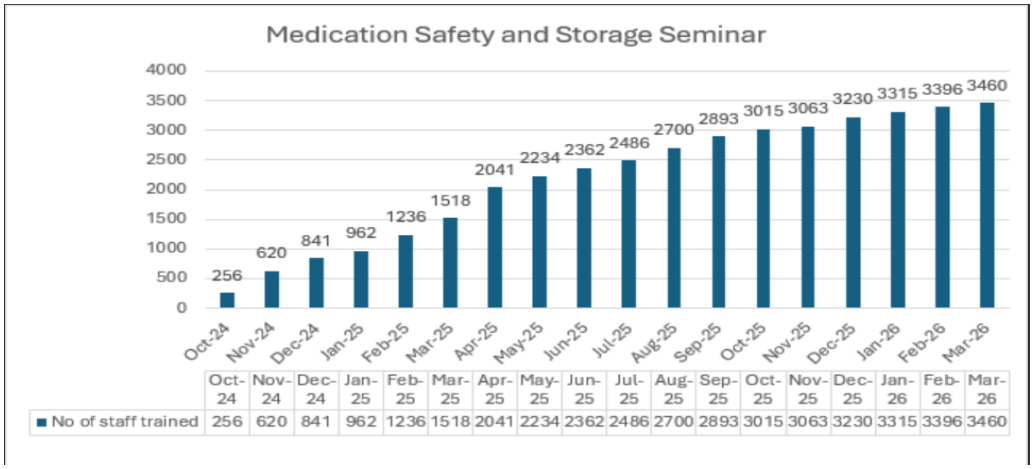


Examples of work to reduce the risk of incidents occurring includes:

- Gap analysis and action plan for the Parkinson's UK national audit with an inpatient Parkinson's disease guideline being created, which is currently undergoing expert review
- Working group established at the Freeman surgical wards for prescribed fluids to move towards National Institute for Health and Care Excellence guidelines compliance
- Critical medicines alert now on e-record for administration of these medicine types.
- Sustained high venous thromboembolism risk assessment completion.

6. Medicines Management training

Nursing medicines management training is at 72% as shown in the graph below and corporate induction medicines management training in place.



	Oct-24	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	Feb-26	Mar-26
No of staff trained	256	620	841	962	1236	1518	2041	2234	2362	2486	2700	2893	3015	3063	3230	3315	3396	3460

7. Communication with Primary Care

A working group on discharge letters to improve communication to primary care is in place and will continue through 2026/2027. There is an IT solution called 'MPage' which would assist in the transcribing of discharges to improve quality of discharges which will be reviewed in 2026/2027.

Clinical Effectiveness

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

This priority was Partially Achieved and will now become business as usual.

What did we say we would do:

- Improve training compliance for Mental Capacity Assessments levels 1 & 2 in line with Trust standard of 90%.
- We will agree a clinical audit programme to ensure actions are demonstrating improvements with clear improvement trajectories.
- Agree long term training framework for Learning Disability and Autism in line with national expectation.

1. Mental Capacity Assessment Training

Face to face supervision, study days and planned training sessions have continued throughout the year reaching 422 staff. Additional situation specific advice and training is delivered as required.

Mental capacity assessments e-learning level 1 – 90%.
Mental capacity assessments e-learning level 2 – 87%.

2. Audit

Audits of 60 patients with a learning disability flag took place with results showing an improvement in the quality of mental capacity assessments and best interests' rationale. Work to improve compliance, alongside regular audit will become part of

business as usual. The findings demonstrate that as time in hospital increases, assessment of capacity and Deprivation of Liberty Standards completion increases. Work continues to improve compliance and regular audits of nursing documentation continues.

3. **Learning Disability and Autism Training**

The e-learning Diamond Standard training compliance training is 89.5%.

A three-year roll out of the Oliver McGowan learning disability and autism training has been agreed and is currently being rolled out with 280-315 funded spaces for tier and 1 and 2 training available between June and October.

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

This priority has been achieved

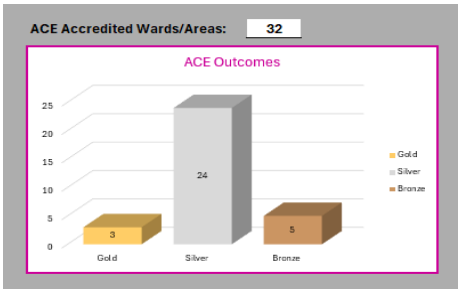
What did we say we would do:

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

Significant progress was made in expanding and embedding the Accrediting Excellence Programme. A total of 40 inpatient Wards**,** one critical care area**,** and five-day units were introduced to the programme from across all clinical boards.

By the end of 2025**,** 32 inpatient wards achieved full accreditation status**,** accounting for 53% of all inpatient wards**.** Four wards have now progressed onto the re-accreditation pathway.

All participating areas completed a detailed baseline assessment and received regular progress reviews, along with tailored support to guide improvement. Accredited wards also took part in a celebration event, recognising their efforts and reinforcing a culture of continuous improvement. There has been strong organisational momentum and growing capability which gives a solid foundation for further expansion of the programme.



Patient Experience

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

This priority has been achieved

What did we say we would do:

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

Work has been undertaken to improve the patient education resources available to patients awaiting total knee replacement surgery including an update of the patient information booklets and providing digital information. We are currently finalising patient education videos.

Formal pre-operative patient education was offered to 733 patients, delivered by our orthopaedic therapy team. This is delivered through group-based sessions with telephone or one-to-one appointments offered to those who need it. The only patients not offered this opportunity were those with urgent or last-minute surgery dates.

Patients with more ‘complex’ needs are enrolled on a prehabilitation programme. This provides a multi-disciplinary approach to further support. A total of 51 patients have completed the full prehabilitation programme, with 23 patients currently active on the pathway. Analysis of postoperative outcomes demonstrates a 0.7day reduction in average hospital length of stay for patients who have completed the prehabilitation pathway. These findings are based on 18 patients, representing a small, early dataset.

Patients participating in the prehabilitation programme demonstrated measurable improvements in functional capacity and cardiovascular endurance with an average percentage improvement of 32.47% and an average increase in walking distance of

60 metres. This suggests improved cardiovascular fitness and mobility, both of which are associated with better surgical resilience and recovery potential.

Feedback captured through post-programme questionnaires indicates high levels of satisfaction. All patients completing the evaluation stated they would recommend the prehabilitation service to others. Many provided positive comments regarding improved confidence, physical ability, and preparedness for surgery reinforcing the value of the programme beyond bed days saved.

We will continue this initiative as business as usual.

Priority 6 – Roll out of patient experience real time surveys

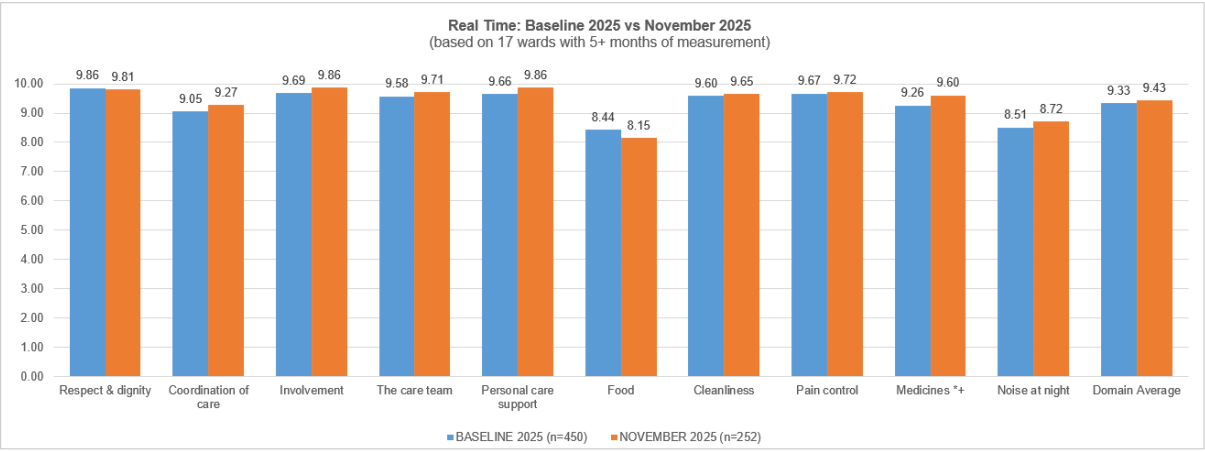
This priority has been achieved

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

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

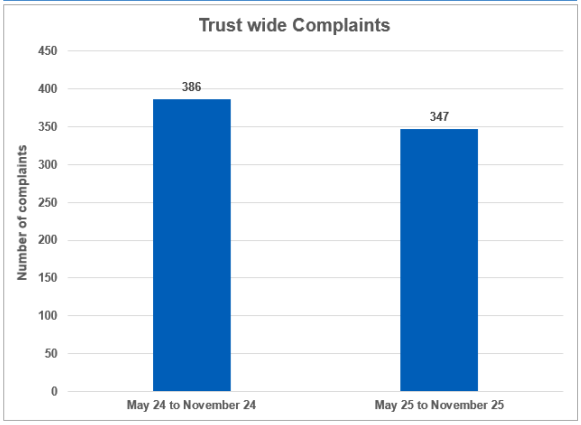
By December 2025, the real time patient experience programme was rolled out to 40 wards across all hospital sites. This comprised of over 3000 bedside conversations with most reporting back to ward teams within 24 hours of completion of final survey. The programme is still in early stages of implementation with future statistical analysis planned as more historic data becomes available.

There are some early indications of meaningful improvement, with a comparison of scores for wards that have been receiving near real time feedback for at least 5 months (n=17), showing a statistically significant improvement in communication about medicines (average baseline score of 9.26 improved to 9.6 in this period).

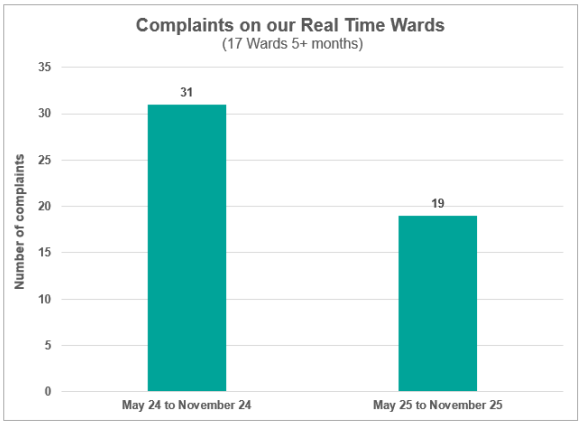


An early review of complaints data from wards that have been receiving real-time feedback for five months suggests a reduction of 39% in complaints between May and November 2025, compared with the same period in 2024. Over the same period, wards not participating in the real-time programme saw a 10% reduction in complaints. While these early findings are encouraging, they are based on a limited timeframe and wards. As the programme is implemented across a wider range of wards, further monitoring will be required to determine if this encouraging picture continues.

Trust wide complaints have seen a 10% reduction



RT ward complaints have seen a 39% reduction



Patient experience of emergency care: Real time measurement has been successfully introduced to our emergency department, capturing experience of people who attended within 24 hours. This was implemented along with our partners within the Great North Healthcare Alliance. We have not yet achieved our aim to see ourselves consistently placed within the top 20% of provider organisations of emergency care – missing the threshold by 0.3%.

Right time patient experience measurement: We continue to capture the experience of patients approximately two weeks after receiving care. Between November 2024 and November 2025, statistical improvement was seen in inpatients and day case, as well as maternity. There is no statistical change in the patient experience of outpatients, and a statistical decline in the experience of accessing the emergency department.

National guidance requires us to include the following updates in the Quality Account:

Update on the statutory duty of candour

Being open and transparent is an essential aspect of patient safety. Promoting a restorative, just and learning culture helps us to ensure we communicate in an open and timely way when things go wrong. If a patient in our care experiences harm or is involved in an incident because of their healthcare treatment, we explain what happened and apologise to patients and/or their family as soon as possible after the event.

There is a statutory requirement to implement Regulation 20 of the Health and Social Act 2008: Duty of Candour. We have a multifaceted approach to providing assurance and monitoring of our adherence to the regulation.

Our Duty of Candour policy supports staff to communicate openly, honestly and sensitively with patients and their families when things do not go as expected. We regularly review how well we are meeting this commitment to ensure we are meeting our statutory requirements and, most importantly, to make sure people receive a timely verbal and written apology, a clear explanation of what happened, and the opportunity to ask questions. Our focus is on helping patients and families feel listened to, supported and fully informed, so they can understand what has happened and what will happen next.

In 2025/2026, we introduced a new local risk management system – InPhase - to record patient safety incidents and duty of candour activity. This has improved the accuracy of our reporting and helps ensure that recorded compliance reflects that conversations, apologies and written communication have genuinely taken place. We also introduced a quality audit process to provide additional assurance that Duty of Candour requirements are met, and that responses are compassionate, clear and focused on the needs of patients and their families.

A key element of the Patient Safety Incident Response Framework is meaningful engagement with patients and families affected by safety incidents.

Duty of Candour expectations are regularly communicated across the organisation and are a standing agenda item at Quality Committee and Patient Safety Group. Overall compliance is reported through the monthly Integrated Board Report.

Clinical Boards have access to compliance dashboards to support local ownership and understanding of their practice, with regular reporting into quarterly performance reviews.

Statement on progress in implementing the priority clinical standards for seven-day hospital services

The Board Assurance Framework for seven-day hospital services submission was updated in 2022, and we are required to produce a report signed off by the Executive Medical Director, at least once a year. This report was presented to the Trust Audit, Risk and Assurance Committee and Quality Committee in May 2025. Work is currently underway in relation to the 2026 audit.

Raising concerns (Ways in which staff can speak up)

The views and experiences of all staff are vital for us to keep our staff and patients safe.
There are a number of ways that staff can raise concerns. These are:

- By contacting their line manager, team leader, nurse or doctor in charge and/or reporting the concern on InPhase.
- Confidentially: by contacting the Freedom to Speak Up Guardian by email, telephone, text message, or in person.
- Anonymously: by using the Work In Confidence platform, which enables staff to anonymously raise concerns or improvement ideas directly with a choice of 15 senior leaders, including the Chief Executive Officer, members of the Executive team and the Freedom to Speak Up Guardian.

Staff are encouraged to raise concerns about quality issues such as patient and staff safety, including leadership, governance matters and inappropriate attitudes and behaviours, as well as share improvement ideas and good practice.

Our Freedom to Speak up Guardians act as an independent, impartial point of contact to support, signpost and advise staff who may wish to raise serious issues or concerns. They are available to all current and previous employees including bank staff and volunteers.

We now have 2 half time staff members who cover the service Monday to Friday 08:30-16:30 but can be flexible and meet staff where and when is convenient to them. There is also a network of Freedom to Speak Up Champions who can signpost colleagues to appropriate support.

When a staff member contacts the Freedom to Speak Up Guardian, they are offered the opportunity to meet in person to discuss their concerns so they can be fully understood. The Guardian will explain how they can support and will agree a plan.

Most frequently, when a staff member raises a concern, the concern is escalated to their line manager, head of department or governance lead. However, where necessary the Guardian can escalate the concern to any of the Executive team, including the Chief Executive Officer.

Colleagues should not experience detriment due to raising concerns and are asked to inform the Guardian if they are concerned.

The Freedom to Speak Up Guardians keep confidential records. High-level data including demographics, staff role, clinical or corporate service, speak up categories and subcategories are recorded to populate a dashboard that mangers can access for information. This high-level data is also included in the monthly Integrated Board Report. An in-depth report that includes themes, trends, learning and user feedback is provided to the Trust Board twice a year. The Trust Board completed a Freedom to Speak Up self-assessment and this was used to develop an action plan. Progress updates against the action plan, which includes growing the champion network and providing a simple road map of different routes for staff to follow when they want to speak up, are provided to the People Committee. Guardians regularly meet with the Director of Quality and Safety, Executive Director of Nursing and Chief Executive Officer to share themes and learning.

The service is included at the staff induction marketplace. New staff also receive information about available routes to raise concerns. Multiple staff engagement sessions to raise awareness of the service have taken place. These include visiting wards and departments (including community sites), posters and business cards, attendance at team meetings and Town Halls and utilising the staff Facebook page and Loop system. eLearning modules that can be accessed via the learning lab.

Union and Staff Representatives: we recognise a number of trade unions and work collaboratively to improve the working environment for all. Staff can engage with these representatives to obtain advice and support if they wish to raise a concern.

Professional Nurse Advocates are available to support nurses, midwives and Allied Health Professionals to reflect on situations in a safe space and to make sense and take forward learning or actions.

Staff Networks exist to support a fairer and more diverse NHS for everyone. They actively engage and contribute towards promoting awareness of equality and inclusion and facilitate peer support, sharing of experiences and development of best practice. These networks can also signpost staff to the best route for raising concerns. Our current staff networks are:

- Armed Forces Network
- Enabled Network (Enhancing Ability, Learning from Disability)
- Pride Network
- Race Equality Network
- Women's Network

We have 10 **cultural ambassadors**, trained to make sure that formal processes are fair, equitable and free from less favourable treatment and bias (conscious or unconscious) and unlawful discrimination. Cultural ambassadors have discretion to challenge bias and are trained to provide independent advice and guidance to investigation and hearing panels and as such ensure that any processes are conducted in a fair and appropriate manner.

A summary of the Guardian of Safe Working Hours Annual Report

This consolidated annual report covers the period April 2025 – March 2026. The aim of the report is to highlight the vacancies in resident doctor rotas and steps taken to resolve these.

Gaps are present on several different rotas; this is due to both gaps in the regional training rotations, challenges recruiting suitable locally employed doctors, delays in incoming overseas resident doctors' arrival in post, and less than full time doctors in full time posts. The main areas of recurrent or residual concern are in paediatric cardiology and cardiothoracic anaesthesia. The trust takes a proactive approach to minimise the impact of gaps by active recruitment; utilisation of locums; and by rewriting work schedules to ensure that key areas are covered.

In addition to the specific actions above, we have taken a proactive role in management of gaps through the work of the resident doctor recruitment and education group. Members of this group include the director of medical education, finance team representative and medical staffing personnel. in addition to recruitment into locally employed doctor posts, there are several trust-based training fellowships, a teaching fellow programme, and has supported temporary and permanent expansion of the foundation training programme. Due to issues with bottlenecks in training for resident doctors, we have adopted a policy of internal prioritisation for recruitment to Specialty Training Year 1and Specialty Training Year 2 equivalent posts. This was requested by resident doctors following growing concerns about job security and lack of training progression.

Learning from deaths

In 2017, the National Quality Board introduced a new national framework to support a consistent and robust approach to identifying, investigating, and learning from deaths occurring within their care. We have established clear processes to monitor and review inpatient deaths and remain committed to identifying any areas where care may not have met expected standards and ensuring that we continuously learn and improve.

Mortality findings are reviewed by the mortality surveillance group, with outcomes reported to the Clinical Outcomes and Effectiveness Group. A quarterly Learning from Deaths report is also presented to the Quality Committee and Trust Board. We actively participate in the Northeast collaborative mortality review group, to share learning, strengthen practice, and promote quality improvement across the region.

During the reporting period April 2025 – March 2026, 2032, patients died. This comprised the following number of deaths which occurred in each quarter of that reporting period:

- 485 in the first quarter
- 500 in the second quarter
- 533 in the third quarter
- 514 in the fourth quarter

3 deaths (representing 0.06% of the patient deaths) were judged to be more likely than not to have been due to problems in the care provided to the patient. In relation to each quarter, this consisted of:

- 0, representing 0% deaths for the first quarter
- 2, representing 0.36% for the second quarter
- 1, representing 0.19% for the third quarter
- 0, representing 0% for the fourth quarter

716 case record reviews and 1 investigation (Patient Safety Incident Investigations and After-Action Reviews) have been carried out in relation to 2031 of the deaths included above. In 1 case, a death was subjected to both a case record review and an investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 214 in the first quarter
- 228 in the second quarter
- 197 in the third quarter
- 78 in the fourth quarter

To date, not all incidents have been fully investigated. Once all investigations have been completed, any death found to have been due to problems in care will be summarised in the Quality Account and reported to Board.

184 case record reviews and 3 investigations were completed after April 2025 which related to deaths which took place before the start of the reporting period. 3 (representing 1.6% of the patient deaths) are judged to be more likely than not to have been due to problems in the care provided to the patient. 8 (representing 0.39%) are judged to be more likely than not to have been due to problems in the care provided to the patient. These numbers have been estimated using the HOGAN evaluation score as well as Patient Safety Incident Response Framework systems-based investigations.

The learning and actions from case record reviews and investigations of cases meeting the criteria is shared at the Patient Safety Incident Forum, Clinical Risk Group, Patient Safety Group and the Mortality Surveillance Group. This information is also reported quarterly as part of the Learning from Deaths report to Quality Committee and Trust Board.

In 2025/2026, the following learning points and actions for improvement from the completed investigations were identified:

- Improvements have been made to patient discharge processes in the vascular surgery service with the creation of a ward discharge checklist, strengthened information in discharge summaries, and a discharge pack for patients with wound care leaflets and patient warning cards containing safety netting information post arterial graft surgery.
- the vascular surgery service and community nursing service have jointly created an agreed standardised operating procedure for referral of vascular surgery patients into community nursing services.

- The neurosurgical service have developed standardised operating procedures for review and documentation of post-operative abdominal x-rays post ventricular peritoneal shunt surgery.
- The emergency department are exploring the development of an electronic triage system for patients and electronic tracking for patient monitoring in the department. Development of a process for corridor oversight, checklists for assessments of patients with head injuries, rapid clinical assessment processes and escalation pathways for staff has also been undertaken. The team have also collaborated with health psychology to develop a support programme for staff.
- Improvements to resident doctor induction, clarity on referral pathways for the psychiatric liaison team and removal of inactive referral forms have also been completed.

INFORMATION ON PARTICIPATION IN NATIONAL CLINICAL AUDITS AND NATIONAL CONFIDENTIAL ENQUIRIES

During 2025/2026, 79 national clinical audits and 5 national confidential enquiry reports / review outcome programmes covered NHS services that the Newcastle upon Tyne Foundation Hospitals NHS Foundation Trust provides.

During that period, the Trust participated in 79 (100%) of the national clinical audits and 100% of the national confidential enquiries / review outcome programmes which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Trust was eligible to participate in during 2025/2026 are listed below.

National Audit issue	Trust participation in 2025/2026	Outcome if participated / If did not participate why, what is the risk to the Trust and what mitigation is in place
British Association of Urological Surgeons Data & Audit Programme: British audit of the investigation and referral of women with recurrent urinary tract infection using recent guidance	Yes	Published report expected August 2026
British Association of Urological Surgeons Data & Audit Programme: Evaluating the management pathway for suspected testicular cancer referrals	Yes	Published report expected November 2026
Breast and Cosmetic Implant Registry	Yes	No publication date yet identified
British Spine Registry	Yes	No publication date yet identified
British Thoracic Society Interstitial Lung Disease Registry	Yes	No publication date yet identified
Case Mix Programme	Yes	No publication date yet identified
Child Health Clinical Outcome Review Programme: Emergency surgery in children and young people	Yes	Report published December 2025. A baseline assessment of the recommendations is currently in progress.
Child Health Clinical Outcome Review Programme: Stabilisation of the critically ill child	Yes	Published report expected December 2026
Cleft Registry and Audit Network Database	Yes	Published report expected December 2026
Emergency Medicine Quality Improvement Programme: Adolescent Mental Health	The Trust is not eligible to participate in this audit as it relates to services not provided by the Trust.	
Emergency Medicine Quality Improvement Project: Care of Older People Year 3	Yes	Published report expected Autumn 2026
Emergency Medicine Quality Improvement Project: Care of Older People Year 4	Yes	Published Report expected Autumn 2027
Emergency Medicine Quality Improvement Project: Mental Health Self Harm	The Trust is not eligible to participate in this audit as it relates to services not provided by the Trust.	
Emergency Medicine Quality Improvement Project: Time Critical Medications Year 2	Yes	Published report expected Autumn 2026
Emergency Medicine Quality Improvement Project: Time Critical Medications Year 3	Yes	Published report expected Autumn 2027
Epilepsy12: National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	Published report expected July 2026

National Audit issue	Trust participation in 2025/2026	Outcome if participated / If did not participate why, what is the risk to the Trust and what mitigation is in place
Falls and Fragility Fracture Audit Programme: Fracture Liaison Service Database	**Yes**	No publication date yet identified
Falls and Fracture Audit Programme: National Audit of Inpatient Falls	Yes	No publication date yet identified
Falls and Fracture Audit Programme: National Hip Fracture Database	Yes	No publication date yet identified
Learning from lives and deaths – People with a learning disability and autistic people	Yes	No publication date yet identified
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal Morbidity Confidential Enquiry	Yes	Published report expected October 2026
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal Mortality Confidential Enquiry	Yes	Published report expected October 2026
Maternal, Newborn and Infant Clinical Outcome Review Programme: Maternal Mortality Surveillance	Yes	Published report expected October 2026
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality and Serious Morbidity	Yes	No publication date yet identified
Maternal, Newborn and Infant Clinical Outcome Review Programme: Perinatal Mortality Surveillance	Yes	Published report expected July 2026
Medical and Surgical Clinical Outcome Review Programme: Managing acute illness in people with a learning disability	Yes	Published report expected Summer 2026
Medical and Surgical Clinical Outcome Review Programme: Pleural procedures	Yes	Published report expected November 2026
Medical and Surgical Clinical Outcome Review Programme: Rib fractures	Yes	Published report expected Spring 2027
Mental Health Clinical Outcome Review Programme: Real-time data collection of probable suicide deaths by mental health in-patients	The Trust is not eligible to participate in this audit as it relates to services not provided by the Trust.	
Mental Health Clinical Outcome Review Programme: Suicide (& homicide) by people under mental health care	The Trust is not eligible to participate in this audit as it relates to services not provided by the Trust.	
National Adult Diabetes Audit: National Diabetes Core Audit	Yes	No publication date yet identified
National Adult Diabetes Audit: Diabetes Prevention Programme Audit	Yes	No publication date yet identified
National Adult Diabetes Audit: National Diabetes Footcare Audit	Yes	No publication date yet identified
National Adult Diabetes Audit: National Diabetes Inpatient Safety Audit	Yes	No publication date yet identified
National Adult Diabetes Audit: National Pregnancy in Diabetes Audit	Yes	No publication date yet identified
National Adult Diabetes Audit: Transition (Adolescents and Young Adults) and Young Type 2 Audit	Yes	No publication date yet identified
National Audit of Cardiac Rehabilitation	Yes	Published reports expected April, July, September and December 2027
National Audit of Cardiovascular Disease Prevention in Primary Care	The Trust is not eligible to participate in this audit as it relates to services not provided by the Trust.	
National Audit of Care at the End of Life	Yes	No publication date yet identified
National Audit of Dementia	Yes	No publication date yet identified
National Audit of Eating Disorders	The Trust is not eligible to participate in this audit as it relates to services not provided by the Trust.	

National Audit issue	Trust participation in 2025/2026	Outcome if participated / If did not participate why, what is the risk to the Trust and what mitigation is in place
National Bariatric Surgery Registry	The Trust is not eligible to participate in this audit as it relates to services not provided by the Trust.	
National Cancer Audit Collaborating Centre: National Audit of Metastatic Breast Cancer	Yes	No publication date yet identified
National Cancer Audit Collaborating Centre: National Audit of Primary Breast Cancer	Yes	Published report expected September 2026
National Cancer Audit Collaborating Centre: National Bowel Cancer Audit	Yes	No publication date yet identified
National Cancer Audit Collaborating Centre: National Kidney Cancer Audit	Yes	No publication date yet identified
National Cancer Audit Collaborating Centre: National Lung Cancer Audit	Yes	No publication date yet identified
National Cancer Audit Collaborating Centre: National Non-Hodgkin Lymphoma Audit	Yes	No publication date yet identified
National Cancer Audit Collaborating Centre: National Oesophago-Gastric Cancer Audit	Yes	No publication date yet identified
National Cancer Audit Collaborating Centre: National Ovarian Cancer Audit	Yes	No publication date yet identified
National Cancer Audit Collaborating Centre: National Pancreatic Cancer Audit	Yes	No publication date yet identified
National Cancer Audit Collaborating Centre: National Prostate Cancer Audit	Yes	No publication date yet identified
National Cardiac Arrest Audit	Yes	No publication date yet identified
National Cardiac Audit Programme: National Adult Cardiac Surgery Audit	Yes	No publication date yet identified
National Cardiac Audit Programme: National Congenital Heart Disease Audit	Yes	No publication date yet identified
National Cardiac Audit Programme: National Heart Failure Audit	Yes	No publication date yet identified
National Cardiac Audit Programme: National Audit of Cardiac Rhythm Management	Yes	No publication date yet identified
National Cardiac Audit Programme: Myocardial Ischaemia National Audit Project	Yes	No publication date yet identified
National Cardiac Audit Programme: National Audit of Percutaneous Coronary Intervention	Yes	No publication date yet identified
National Cardiac Audit Programme: UK Transcatheter Aortic Valve Implantation Registry	Yes	No publication date yet identified
National Cardiac Audit Programme: Left Atrial Appendage Occlusion Registry	Yes	No publication date yet identified
National Cardiac Audit Programme: Patent Foramen Ovale Closure Registry	Yes	No publication date yet identified
National Cardiac Audit Programme: Transcatheter Mitral and Tricuspid Valve Registry	Yes	No publication date yet identified
National Child Mortality Database	Yes	Published reports expected July and December 2026
National Clinical Audit of Psychosis	The Trust is not eligible to participate in this audit as it relates to services not provided by the Trust.	
National Comparative Audit of Blood Transfusion: 2025 Major Haemorrhage	Yes	No publication date yet identified
National Early Inflammatory Arthritis Audit	Yes	Published report expected October 2026
National Emergency Laparotomy Audit: Laparotomy	Yes	Published report expected Autumn 2026

National Audit issue	Trust participation in 2025/2026	Outcome if participated / If did not participate why, what is the risk to the Trust and what mitigation is in place
National Emergency Laparotomy Audit: No Laparotomy	Yes	No publication date yet identified
National Joint Registry	Yes	Published report expected November 2026
National Major Trauma Registry	Yes	No publication date yet identified
National Maternity and Perinatal Audit	Yes	No publication date yet identified
National Neonatal Audit Programme	Yes	No publication date yet identified
National Obesity Audit	Yes	No publication date yet identified
National Ophthalmology Database: Age-related Macular Degeneration Audit	Yes	No publication date yet identified
National Ophthalmology Database: Cataract Audit	Yes	No publication date yet identified
National Paediatric Diabetes Audit	Yes	Published report expected March 2026
National Perinatal Mortality Review Tool	Yes	Published report expected Autumn 2027
National Pulmonary Hypertension Audit	Yes	No publication date yet identified
National Respiratory Audit Programme: Adult Asthma Secondary Care	Yes	Published report expected June 2026
National Respiratory Audit Programme: Children and Young People's Asthma Secondary Care	Yes	Published report expected June 2026
National Respiratory Audit Programme: Chronic Obstructive Pulmonary Disease Secondary Care	Yes	Published report expected June 2026
National Respiratory Audit Programme: Pulmonary Rehabilitation	Yes	Published report expected June 2026
National Vascular Registry	Yes	Published report expected November 2026
Out of Hospital Cardiac Arrest Outcomes	The Trust is not eligible to participate in this audit as it relates to services not provided by the Trust.	
Paediatric Intensive Care Audit Network	Yes	Published report expected December 2026
Perioperative Quality Improvement Programme	Yes	Published report expected August 2026
Prescribing Observatory for Mental Health: Improving the quality of valproate prescribing in adult mental health services	The Trust is not eligible to participate in this audit as it relates to services not provided by the Trust.	
Prescribing Observatory for Mental Health: Use of clozapine	The Trust is not eligible to participate in this audit as it relates to services not provided by the Trust.	
Prescribing Observatory for Mental Health: Use of medicines with anticholinergic (antimuscarinic) properties in older people's mental health services	The Trust is not eligible to participate in this audit as it relates to services not provided by the Trust.	
Sentinel Stroke National Audit Programme	Yes	No publication date yet identified
Serious Hazards of Transfusion: UK National Haemovigilance Scheme	Yes	Published report expected July 2026
UK Cystic Fibrosis Registry	Yes	Published report expected October 2026
UK Parkinson's Audit	Yes	Published report expected March 2026

National Audit issue	Trust participation in 2025/2026	Outcome if participated / If did not participate why, what is the risk to the Trust and what mitigation is in place
UK Renal Registry Chronic Kidney Disease Audit	Yes	Published report expected June 2026
UK Renal Registry National Acute Kidney Injury Audit	Yes	Published report expected June 2027

An additional 17 audits have been added to the list for inclusion in 2026/2027 Quality Account. The audits include:

- British Association of urological Surgeons Data & Audit Programme: Audit of Bladder Cancer Transurethral Laser Ablation Treatment and Evaluation
- British Association of urological Surgeons Data & Audit Programme: Male Bladder Outflow Obstruction Audit
- British Association of urological Surgeons Data & Audit Programme: Stent Time in Endourology: A National Treatment Survey
- British Thoracic Society Endobronchial Ultrasound National Audit
- British Thoracic Society National Tobacco Dependency Audit British Thoracic Society
- Emergency Medicine Quality Improvement Projects: Prioritising Patients Pain
- National Audit of Dementia: Dementia Diagnostic Services Audit
- National Audit of Dementia: Dementia Hospital Care Audit
- National Clinical Audit of Perioperative Care
- National Comparative Audit of Blood Transfusion: National Comparative Audit of NICE Quality Standard QS138
- National Comparative Audit of Platelet Use
- National Comparative Audit of Blood Transfusion: National Comparative Audit of the use of Anti-D Immunoglobulin Prophylaxis
- National Adult Diabetes Audit: National Gestational Diabetes Mellitus Audit
- Prescribing Observatory for Mental Health: Opioid medications in inpatient mental health services
- Prescribing Observatory for Mental Health: Prescribing antipsychotic medication in people with dementia
- Prescribing Observatory for Mental Health: Use of antipsychotic medication for relapse in patients with a diagnosis of schizophrenia
- Prescribing Observatory for Mental Health: Use of propranolol

The reports of national clinical audits were reviewed by the provider in 2025/2026 and the Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

- The Trust has firmly embedded monitoring arrangements for national clinical audits with the identified lead clinician asked to complete suggested action against recommendations and report to Clinical Audit and Guidelines Group as part of the Quality Metrics Report.

- On an annual basis the Group receives a report on the projects in which the Trust participates and requires the lead clinician of each audit programme to identify any potential risk, where there are concerns action plans will be monitored on a regular basis.
- In addition, each Clinical Board is required to present an Annual Clinical Audit Report to the Clinical Audit and Guidelines Group detailing all audit activity undertaken both national and local. Clinicians are required to report all audit activity using the Trust's Clinical Effectiveness Register.
- Clinical Boards are asked to include national clinical audit as a substantive agenda item at their Clinical Governance meetings, to review any areas required for improvement.
- Compliance with National Confidential Enquiries is reported to the Clinical Outcomes and Effectiveness Group and exceptions subject to detailed scrutiny and monitored accordingly.
- Non-compliance with recommendations from National Clinical Audit and National Confidential Enquiries are considered in the Annual Business Planning process.

The reports of 459 local audits were reviewed by the provider in 2025/2026 and the Newcastle upon Tyne Hospitals NHS Foundation Trust intends to take the following action to improve the quality of health care provided:

- Each Clinical Board is required to present an Annual Clinical Audit Report to the Clinical Audit and Guidelines Group detailing all audit activity undertaken both national and local.

Any areas of non-compliance with standards are risk assessed and escalated as appropriate to the Clinical Outcomes and Effectiveness Group.

Information on participation in clinical research

In the last year over 8,452 participants were recruited to clinical trials provided or hosted by Newcastle Hospitals. 7,489 of these studies are part of the National Institute for Health and Care Research Delivery Network portfolio. We continue to be one of the top research trusts in the country for the number of individuals participating in research and for the number of studies open.

A wide range of clinical trials take place, ranging from complex and rare disease to common conditions that affect many of our patients.

A recent trial, led collaboratively with Newcastle University, found that early withdrawal of a treatment (eculizumab) for patients with a rare kidney disease is possible without relapse. Atypical haemolytic uraemic syndrome is a life-threatening condition caused by a defect in the immune system. The study found that most patients can stop eculizumab six months without relapse and can be restarted on the drug if the disease returns. The withdrawal of eculizumab is not only of huge benefit to patients but also represents considerable savings to the NHS of £4.2 million per patient over their lifetime.

Information relating to registration with the care quality commission

Newcastle Hospitals is required to register with the Care Quality Commission to deliver care from seven separate locations and 21 community locations for ten regulated activities and its current registration status is fully registered. Newcastle Hospitals currently has no conditions imposed on its registration.

In 2023, the Care Quality Commission looked at how the organisation was led and assessed some services at the Royal Victoria Infirmary and Freeman Hospital, which included urgent and emergency care, medicine, surgery, maternity, children and young people, as well as NECTAR the regional patient transport service. They also spent some time in the cardiothoracic surgery department. The inspectors found that overall Newcastle Hospitals' 'requires improvement' and highlighted areas for improvement with the way some services are run.

Following this, continued focus has been maintained on strengthening leadership, governance and quality oversight arrangements. An independent Well-led review was commissioned and completed in 2025, which evidenced demonstrable improvement compared with the findings of the 2023 inspection. The outcomes of this review contributed to the Trust's de-escalation from enhanced oversight by NHS England's Integrated Quality Improvement Group in March 2026.

Recommendations arising from the Well-led review have been translated into a comprehensive action plan with clearly defined actions, timescales and accountable leads. Delivery and effectiveness of the plan are monitored through the Trust's established governance framework, with formal assurance provided to the Audit, Risk and Assurance Committee and escalation to the Board of Directors where required.

The Trust continues to work openly and constructively with the Care Quality Commission and system partners, responding promptly to regulatory feedback and inspection activity. Progress against CQC-related actions is routinely monitored through established committee structures to support sustained improvement and ongoing compliance with regulatory requirements.

The Trust remains committed to delivering services that are safe, effective, caring, responsive and well led, and to maintaining full compliance with CQC registration requirements in support of the delivery of high-quality care for patients and service users.

Overview

Latest inspection: 27June 2023 to 28 September 2023 Report published: 24 January 2024

Safe	Requires improvement
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Inadequate

INFORMATION ON THE QUALITY OF DATA

The Newcastle upon Tyne Hospitals NHS Foundation Trust submitted records during 2025/2026 to the Secondary Uses Service for inclusion in the Hospital Episode Statistics which are included in the latest published data. The percentage of records in the published data:

Which included the patient's valid NHS number was:

- 99.6% for admitted patient care.
- 99.8% for outpatient care.
- 99.0% for emergency care.

Which included the patients' valid General Medical Practice Code was:

- 100.0% for admitted patient care.
- 100.0% for outpatient care.
- 100.0% for accident and emergency care.

Clinical Coding Information

Score for 2025/2026 for Information Quality and Records Management, assessed using the Data Security and Protection Toolkit.

Our annual Data Security and Protection Clinical Coding audit for diagnosis and treatment coding of inpatient activity demonstrated an excellent level of attainment and satisfies the requirements of the Data Security and Protection Toolkit Assessment.

200 episodes of care were audited, covering the following three specialties:

- Urology
- Ear Note and Throat
- Upper Gastrointestinal Surgery

The level attained for Data Security Standard 1 Data Quality – Standards Exceeded.
The level attained for Data Security Standard 3 Training – Standard Exceeded.

Table shows the levels of attainment of coding of inpatient activity:

	Levels of Attainment		
	Standards Met	Standards Exceeded	Trust Level
Primary diagnosis	>=90%	>=95%	98.5%
Secondary diagnosis	>=80%	>=90%	97.1%
Primary procedure	>=90%	>=95%	95.4%
Secondary procedure	>=80%	>=90%	90.0%

KEY NATIONAL PRIORITIES 2025/2026

The key national priorities are performance targets for the NHS, which are determined by the Department of Health and Social Care and form part of the Care Quality Commission Intelligent Monitoring Report. A wide range of measures are included and the Trust's performance against the key national priorities for 2025/2026 are detailed in the table below.

Operating and Compliance Framework Target	Target	Annual Performance 2024/2025	Annual Performance 2025/2026
Incidence of *Clostridioides difficile* infections (*C .difficile:* variance from plan)	National Threshold ≤136	197 cases	169 cases
Incidence of Methicillin-resistant *Staphylococcus aureus* bacteraemia	Zero tolerance	7 cases	7 cases
28-day faster diagnosis standard - wait from urgent referral to patient told they have cancer (or cancer is definitively excluded)	80%	76.5%	73.6% (Provisional Apr-Feb 25/26)
31 day (decision to treat to treatment) - wait from a decision to treat/earliest clinically appropriate date to first or subsequent treatment of cancer	96%	86.3%	85.8% (Provisional Apr-Feb 25/26)
62 day (referral to treatment) - wait from an urgent suspected cancer or breast symptomatic referral, or urgent screening referral, or consultant upgrade to a first definitive treatment for cancer	75%	56.7%	69.8% (Provisional Apr-Feb 25/26)
Referral to treatment - incomplete compliance	92%	68.3%	72.5% (Provisional Apr-Feb 25/26)
Maximum 6-week wait for diagnostic procedures	95%	71.3%	83.2% (Provisional Apr-Feb 25/26)
Emergency Department: maximum waiting time of 4 hours from arrival to admission/transfer/discharge	78%	74.9%	77.43%
*Maternity bookings within 9 weeks 6 days	Not Defined	69.25%	70.61%

We have detailed below some of the reasons for not meeting the required standards.

Reducing Healthcare Associated Infections

Newcastle Hospitals continues to prioritise robust Infection Prevention and Control measures to safeguard patients, staff and the wider community. During 2025/2026, both national and regional patterns showed increases in key Healthcare Associated Infections, including Methicillin-resistant *Staphylococcus aureus* bacteraemia and *Clostridioides difficile*. The Trust has taken comprehensive action to identify contributory factors and implement targeted, evidence-based improvements.

Methicillin-resistant *Staphylococcus aureus* bacteraemia

National Methicillin-resistant *Staphylococcus aureus* bacteraemia rates increased during the year, and similar upward trends were observed within the region. Internal investigations identified gaps in screening and decolonisation compliance, variations in wound care, and issues related to antimicrobial stewardship.

Key Improvement Actions

- Introduction of a new Methicillin-resistant *Staphylococcus aureus* Care Plan, supporting structured and consistent delivery of screening, decolonisation and wound management.
- Improved device and line management, with a Trust-wide focus on insertion, documentation and ongoing maintenance. Several incidents highlighted the need for strengthened device safety, prompting targeted interventions.
- Strengthening of Aseptic Non-Touch Technique with refreshed Trust-wide training and competency assessments. Visibility of Aseptic Non-Touch Technique compliance has been significantly improved through incorporation into the Power BI dashboards, enabling all Clinical Boards to monitor performance and address gaps.
- Senior nurse device walk-arounds are being considered as part of strengthening daily line oversight, recognising that clinical areas maintaining *Saving Lives* bundles demonstrate lower device-associated infections.
- Development of a clinical “flag” to alert clinicians when Methicillin-resistant *Staphylococcus aureus* positive patients are prescribed flucloxacillin. Each incident in investigated through the InPhase system.
- Targeted antimicrobial reviews for patients with a known history of Methicillin-resistant *Staphylococcus aureus*, supporting more appropriate and focused antibiotic prescribing.
- Methicillin-resistant *Staphylococcus aureus* screening compliance audits, with themes disseminated to drive improvement.
- The ongoing presence of the Infection Prevention and Control team within clinical areas has supported real-time engagement, advice and escalation, while the Accrediting Excellence Programme has further strengthened clinical involvement through targeted education and improved focus on isolation indicators

National ***Clostridioides difficile*** rates increased during the reporting period, with regional surveillance also showing upward trends that were reflected in Trust figures. Delays in sampling, isolation and treatment were common themes, alongside antimicrobial and Proton Pump Inhibitor stewardship challenges.

Key Improvement Actions

- Introduction of a diarrhoea care plan, providing a structured approach to assessment, isolation decisions, sampling and escalation.
- End-of-shift digital nursing assessment, strengthening stool monitoring and early recognition of *Clostridioides difficile* symptoms.
- Strengthened reporting and escalation processes when isolation cannot be achieved.
- Enhanced antimicrobial pharmacist reviews, offering real-time feedback and rapid improvement actions.

- Weekly multi-disciplinary review of *Clostridioides difficile* and bloodstream infections to identify emerging themes.
- Launch of the InPhase CDI Investigation Workflow (March 2026), improving the quality of learning, strengthening clinical engagement and aligning accountability with Patient Safety Incident Response Framework principles. Work is ongoing to extend this workflow to all blood stream infection investigations

Cancer Wait times
31-day performance has continued to be impacted throughout the year by staff absences but has shown considerable improvement from the previous year. 62-day performance has also significantly improved compared to 2024/2025 but remains short of target due to factors including ongoing delays in the referral of cases from tertiary centres, as well as a shortage of capacity in areas such as Gynae and Lung. 28-day performance has been lower than planned throughout the majority of the year due to a significant increase in skin cancer referrals from out of area – regional organisations are working together to ensure referrals are routed to the appropriate local providers in the first instance.

Referral to Treatment Targets:
Over the last year, the overall referral to treatment incomplete performance has fluctuated at around 70%. The national referral to treatment target is 65% by April 2026 continuing to 92% by March 2029. Newcastle Hospitals remains above the National average currently at 61.5%.

Over the last 12 months the National validation sprint has reduced the overall size of the waiting list from 94,496 to 82,467 patients waiting for first treatment.

There has been an unrelenting focus on treating the longest waiters and a significant achievement to reduce the longest waiting times under 78 weeks for treatment. There has also been a significant reduction in 65 and 52 week waiting. Patients on the waiting list continue to be prioritised by clinical need and longest waits.

Maximum 6-week wait for diagnostic procedures
For diagnostics the national ambition for 2025/2026 remains 5% at the end of March 2026. As a Trust we have maximised utilisation of the Community Diagnostic Centre this year as additional capacity for a variety of diagnostics and have insourced at various points throughout the year to increase capacity in our Audiology and ECHO services – performance for the annual year shows an improving picture but still short of the national target.

Emergency Department: maximum waiting time of 4 hours from arrival to admission/transfer/discharge:
Quality improvement initiatives within the Emergency Department have improved not only our compliance with the 4-hour target there has been a real time improvement in ambulance handover times. A significant increase in Emergency Department attendances coupled with very high occupancy levels has impacted on patient flow.

CORE SET OF QUALITY INDICATORS

Data is compared nationally when available from the NHS Digital Indicator portal. Where national data is not available the Trust has reviewed our own internal data.

Measure	Data Source	Target	Value	2025/2026		2024/2025				2023/2024			
1. The value and banding of the summary hospital-level mortality indicator for the Trust	NHS Digital Indicator Portal https://digital.nhs.uk/data-and-information/publications/statistical/shmi	Band 2 as expected		Oct24 - Sept 25 **NUTH Value:** 0.8744 **NUTH Band 2**	Jul24 - Jun 25 **NUTH Value:** 0.8547 **NUTH Band 3**	Apr24 - Mar 25 **NUTH Value:** 0.8669 **NUTH Band 2**	Jan24 - Dec 24 **NUTH Value:** 0.9001 **NUTH Band 2**	Oct23 - Sept 24 **NUTH Value:** 0.9128 **NUTH Band 2**	Jul23 - Jun 24 **NUTH Value:** 0.9177 **NUTH Band 2**	Apr23 - Mar 24 **NUTH Value:** 0.9128 **NUTH Band 2**	Jan23 - Dec 23 **NUTH Value:** 0.9011 **NUTH Band 2**	Oct22 – Sept 23 **NUTH Value:** 0.9095 **NUTH Band 2**	Jul22 - Jun 23 **NUTH Value:** 1.0095 **NUTH Band 2**
			National Average	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0	1.0
			Highest National	1.3408	1.3106	1.2688	1.3323	1.3094	1.3121	1.3193	1.2548	1.2293	1.2129
			Lowest National	0.7188	0.7173	0.7153	0.6991	0.6968	0.6946	0.7142	0.7202	0.6770	0.7097
2. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust	NHS Digital Indicator Portal https://digital.nhs.uk/data-and-information/publications/statistical/shmi	N/A	Trust	46%	45%	46%	46%	47%	48%	47%	44%	41%	29%
			National Average	44%	45%	45%	44%	44%	44%	43%	42%	42%	41%
			Highest National	71%	70%	68%	66%	67%	69%	67%	67%	66%	66%
			Lowest National	18%	17%	17%	17%	17%	18%	11%	16%	15%	14%

Measure 1. The value and banding of the summary hospital-level mortality indicator for the Trust.

Newcastle Hospitals considers that this data is as described for the following reasons:

The Trust continues to perform well on mortality indicators. Mortality reports are regularly presented to the Trust Board. The Newcastle Hospitals has taken the following actions to improve this indicator, and so the quality of its services by closely monitoring mortality rates and conducting detailed investigations when rates increase. We continue to monitor and discuss mortality findings at the Quarterly Mortality Surveillance Group; representatives attend this group from multiple specialities and scrutinise Trust mortality data to ensure local learning and quality improvement. This group complements the departmental mortality and morbidity meetings within each speciality of all clinical boards.

Measure 2. The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the Trust.

Newcastle Hospitals considers that this data is as described for the following reasons:

The use of palliative care codes in the Trust has remained static and aligned to the national average percentage over recent years. The Newcastle Hospitals continues

to monitor the quality of its services, by involving the Coding team and End of Life team in routine mortality reviews to ensure accuracy and consistency of palliative care coding. We continue to monitor and discuss patients with a palliative care coding at the quarterly Mortality Surveillance Group.

Measure 3. The Patient Reported Outcome Measures scores for groin hernia surgery.

Collection of groin procedure scores ceased on 1 October 2017.

Measure 4. The Patient Reported Outcome Measures scores for varicose vein surgery.

Collection of varicose vein procedure scores ceased on 1 October 2017.

Measure 5. The Patient Reported Outcome Measures scores for hip replacement surgery.

Measure	Value	2024/25	2023/24	2022/23	2021/22	2020/21	2019/20
5. The patient reported outcome measures scores (PROMS) for primary hip replacement surgery (adjusted average health gain – EQ5D)	Trust Score	*	*	**0.52**	**0.47**	**0.52**	**0.46**
	National average:	0.45	0.46	0.46	0.46	0.47	0.46
	Highest national:	0.54	0.58	0.55	0.53	0.57	0.54
	Lowest national:	0.27	0.35	0.36	0.37	0.39	0.35
6. The patient reported outcome measures scores (PROMS) for primary knee replacement surgery (adjusted average health gain – EQ5D)	Trust Score	*	*	**0.38**	*	**0.35**	**0.36**
	National average:	0.32	0.32	0.33	0.32	0.32	0.34
	Highest national:	0.50	0.41	0.41	0.42	0.40	0.42
	Lowest national:	0.23	0.23	0.24	0.25	0.18	0.22

Newcastle Hospitals considers that this data is as described for the following reasons:

Patient Reported Outcome Measures scores are good, and we are committed to increasing our participation rates going forward. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty multidisciplinary team.

Finalised Patient Reported Outcome Measures scores data have now been published for 2024/2025; in 2024/2025 the number of modelled records for both primary hip are less than 30 for NUTH so the health gain figures are not shown for the Trust.

Measure 6. The Patient Reported Outcome Measures scores for knee replacement surgery.

Newcastle Hospitals considers that this data is as described for the following reasons:
Patient Reported Outcome Measures scores are good, and we are committed to increasing our participation rates going forward. We encourage patients to complete these and discuss completion rates and results in the Arthroplasty multidisciplinary team.

Finalised Patient Reported Outcome Measures scores data have now been published for 2024/2025; in 2024/2025 the number of modelled records for both primary knees are less than 30 for NUTH so the health gain figures are not shown for the Trust.

Measure 7. The percentage of patients aged— (i) 0 to 15; and (ii) 16 or over readmitted within 28 days of being discharged from hospital.

7a. Emergency readmissions to hospital within 28 days of discharge from hospital: Children of ages 0-15.

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
2013/2014	32,242	2,648	8.2
2014/2015	34,561	3,570	10.3
2015/2016	38,769	2,875	7.4
2016/2017	35,259	1,983	5.6
2017/2018	35,009	2,077	5.9
2018/2019	36,387	2,003	5.5
2019/2020	42,238	4,609	10.9
2020/2021	29,319	2,643	9.0
2021/2022	34,112	3,080	9.0
2022/2023	33,945	2,859	8.4
2023/2024	33863	2708	7.9
2024/2025	34574	2998	8.6
2025/2026	34805	2829	8.1

7b. Emergency readmissions to hospital within 28 days of being discharged aged 16+.

Year	Total number of admissions/spells	Number of readmissions (all)	Emergency readmission rate (all)
2013/2014	177,867	9,052	5.1
2014/2015	180,380	9,446	5.2
2015/2016	182,668	10,076	5.5
2016/2017	186,999	10,219	5.5
2017/2018	182,535	10,157	5.6

2018/2019	185,967	10,461	5.6
2019/2020	192,365	12,648	6.6
2020/2021	142,629	10,730	7.5
2021/2022	185,434	12,104	6.5
2022/2023	193,003	13,575	7.0
2023/2024	203342	15708	7.7
2024/2025	212116	16536	7.8
2025/2026	214960	17199	8.0

This indicator was last updated in December 2013, and future releases have been suspended pending a methodology review. Therefore, the trust has reviewed its own internal data and used its own methodology of reporting readmissions within 28 days (without Payment by Results exclusions). The Newcastle Hospitals considers that this data is as described for the following reasons: The Trust has a robust reporting system in place and adopts a systematic approach to data quality improvement.

Newcastle Hospitals intends to take the following actions to improve this indicator, and so the quality of its services, by continuing with the use of an electronic system.

Measure 8. The Trust's responsiveness to the personal needs of its patients.

Measure	Data Source	Value	2022/23	2021/22	2020/21	2019/20	2018/19	2017/18
8. The Trust's responsiveness to the personal needs of its patients	NHS Information Centre Portal https://indicators.ic.nhs.uk/	Trust percentage	Ceased Publication August 2020	Ceased Publication August 2020	77.7%	72.6%	73.1%	74.9%
		National Average:			74.5%	67.1%	67.2%	68.6%
		Highest National:			85.4%	84.2%	85.0%	85.0%
		Lowest National:			67.3%	59.5%	58.9%	60.5%

This data used in the table above ceased to be published in August 2020.To assign a score to indicate the patient experience, the table below uses the Care Quality Commission benchmark data from the National Adult Inpatient Survey. The data shows that the Trust scores above the national average in this indicator. The 2024 survey results were published in September 2025.

Measure	Data Source	Value (out of 10)	2024 (Published September 2025)	2023 (Published August 2024)	2022 (Published Sept 2023)	2021 (Published August 2022)
8. Overall rating of experience	CQC Benchmark results for National Adult Inpatient Survey Adult inpatient survey 2022 - Care Quality Commission (cqc.org.uk)	Trust score	8.3	8.3	8.4	8.6
		National Average score:	8.2	8.1	8.1	8.1
		Highest National:	9.4	9.3	9.3	9.4
		Lowest National:	7.4	7.5	7.4	7.4

Measure 9. The percentage of staff employed by, or under contract to, the Trust who would recommend the Trust as a provider of care to their family or friends changed to "If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation" in 2021/2022 survey and has continued to be the same for the 2025/2026 survey. There were no changes to this question between the 2024 and 2025 Staff Survey. The following table has had the results for each year updated as per the benchmarking report received.

Measure	Data Source	Value	2025/26	2024/25	2023/24	2022/23	2021/22
9. The percentage of staff employed by, or under contract to, the trust who would recommend the trust as a provider of care to their family or friends	http://www.nhsstaffsurveys.com/Page/1006/Latest-Results/Results/	Trust percentage	74.1%	76.6%	77.4%	82.6%	85.5%
		National Average	60.8%	61.6%	63.3%	61.8%	66.9%
		Highest National	88.4%	89.6%	88.9%	86.4%	89.5%
		Lowest National	34.7%	39.7%	44.3%	39.2%	43.5%

Newcastle Hospitals considers that this data is as described for the following reasons:
Over the five-year period from 2021 to 2025, the Trust has consistently performed well in relation to this measure, with results remaining substantially above the national average each year. While there has been a gradual downward trend in the Trust's score, from 85.47% in 2021 to 74.10% in 2025, performance continues to compare favourably against the national average, which has also declined over the same period. The Trust's results remain significantly higher than the worst-performing organisations and, although there is a narrowing gap between the Trust and the highest national results, overall performance continues to demonstrate strong staff confidence in the standard of care provided. The increase in response numbers in recent years provides additional assurance that these results reflect a robust and representative staff voice. The Trust remains committed to listening to staff feedback and taking action to sustain and improve staff experience and perceptions of care quality.

Measure 10. The percentage of patients that were admitted to hospital who were risk assessed for Venous thromboembolism

Measure	Data Source	Target	2025/26				2024/25			
10. The percentage of patients that were admitted to hospital who were risk assessed for Venous thromboembolism	https://www.england.nhs.uk/statistics/statistical-work-areas/vte/	Trust %	Q4	Q3 96%	Q2 96%	Q1 97%	Q4 98%	Q3 92%	Q2 89%	Q1 88%
		National Average:	Not available	91%	91%	91%	91%	90%	89%	89%
		Highest National:	Not available	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
		Lowest National:	Not available	**15%**	**15%**	**14%**	**14%**	**14%**	**14%**	**15%**

National data collection has resumed in 2024/2025 post COVID-19 and is available up until Quarter 4 2025/2026.

Measure 11. The number of cases of *Clostridioides difficile* infection reported within the Trust amongst patients aged 2 or over

Measure	Data Source	Target	2025/2026	2024/2025	2023/2024	2022/2023	2021/2022
11. The number of cases of *Clostridioides difficile* infections reported within the Trust amongst patients aged two or over	UKHSA Data Capture System	Trust number of cases	169 HOHA* = 131 COHA* = 38	197 HOHA* = 157 COHA* = 40	144 HOHA* = 114 COHA* = 30	172 HOHA* = 138 COHA* = 34	169 HOHA* = 135 COHA* = 34
		National Average number of cases	HOHA* = 55 COHA* = 22	HOHA* = 63 COHA* = 25	HOHA* = 56 COHA* = 21	HOHA* = 54 COHA* = 19	HOHA* = 45 COHA* = 18
		Highest National number of cases	HOHA* = 283 COHA* = 78	HOHA* = 312 COHA* = 79	HOHA* = 275 COHA* = 82	HOHA* = 212 COHA* = 76	HOHA* = 189 COHA* = 76
		Lowest National number of cases	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0	HOHA* = 0 COHA* = 0

*HOHA = Hospital Onset – Healthcare Associated
*COHA = Community Onset – Healthcare Associated

Taking into account the *Clostridioides difficile* information provided, Newcastle Hospitals is assured that the data presented accurately reflects the Trust's position. The organisation has robust mechanisms for the reporting, investigation and monitoring of healthcare-associated infections, supported by established mitigations that promote patient safety.

To underpin this assurance, the Trust has taken the following actions:

- **Clinical Board–specific action plans** have been developed to address themes identified through *Clostridioides difficile* case reviews. These plans are monitored within each Clinical Board, with overarching oversight from the Infection Prevention and Control Committee.
- **A Trust-wide diarrhoea care plan** has been implemented to support early recognition, isolation, sampling and management of patients with suspected infectious diarrhoea, strengthening frontline practice and improving the reliability of *Clostridioides difficile* case detection.
- **An end-of-shift digital nursing assessment tool** has been introduced to improve stool documentation and support timely identification and escalation of potential *Clostridioides difficile* cases.
- **The IPC team continues to raise awareness of isolation requirements**, encouraging clinical teams to report occasions where isolation cannot be achieved due to capacity constraints. These incidents are reviewed through the Infection Prevention and Control Operational Group, with escalation to the Board as required.
- **A structured antimicrobial review process**, undertaken alongside the antimicrobial pharmacist, ensures real-time feedback to clinical teams and enables rapid optimisation of therapy to maintain safe and effective care.
- **Weekly multidisciplinary IPC reviews** of bloodstream infections and *Clostridioides difficile* remain pivotal in identifying emerging themes and ensuring consistent case classification.

- **The introduction of the InPhase *Clostridioides difficile* Investigation Workflow has further strengthened assurance processes**, providing a consistent and structured approach to case investigation, improving the quality of learning, enhancing clinical engagement and ensuring clear Patient Safety Incident Response Framework-aligned accountability across clinical teams.
- **Proton Pump Inhibitor guidelines published** by the Antimicrobial Stewardship Group in Quarter 3 2025/2026.

Measure 12. The number and rate of patient safety incidents reported

Measure	Data Source	Target	2025/2026	2024/2025	2023/2024	2022/2023
12. The number and rate per 100 admissions of patient safety incidents reported *NB: Changed to rate per 1000 bed days April 2014*	NHS Information Centre Portal https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/	Trust no.	April 2025 – March 2026 24,073	April 2024 – March 2025 21,768	April 2023 – March 2024 20,909	April 2022 – March 2023 20,464
		Trust %	45.19	40.56	39.3	38.7
		National Average	Not available	Not available	Not available	Not available
		Highest National	Not available	Not available	Not available	Not available
		Lowest National	Not available	Not available	Not available	Not available

The Newcastle Hospitals considers that this data is as described for the following reasons:

The Trust adopted the Patient Safety Incident Response Framework in January 2024. This framework advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management. Following the successful conclusion of a Trust priority (reducing the frequency of preventable Hospital Acquired Thrombosis), a thematic review was undertaken to identify a new priority, which is aiming to implement National Safety Standards for Invasive Procedures 2 and therefore improve surgical safety.

In addition, the Trust transitioned to a new local risk management system in May 2025, which has resulted in an increase in patient safety incident reporting.

Clinical Boards continue to strengthen their internal incident oversight processes through the recruitment of quality and safety specialist roles. These roles are supported by the Patient Safety Team who provide in-house education to ensure staff are trained in accordance with NHS England standards. As well as leading on incident investigation, these staff members ensure learning from incidents is shared across wards and directorates in addition to providing oversight of incidents and subsequent actions at the monthly Clinical Board Quality Oversight Groups.

Incident data, themes and organisational learning are reported annually through the Trusts governance structures to Quality Committee and Trust Board.

The Patient Safety Team continue to provide formal and ad-hoc training and education to support staff around the Trust to ensure they understand the importance of incident reporting and how to report incidents. Learning from incidents is also shared through the monthly Patient Safety Bulletin and Safety Spotlight.

Measure 13. The number and percentage of patient safety incidents that resulted in severe harm or death

Measure	Data Source	Target	2025/2026		2024/2025		2023/2024	
13. The number and percentage of patient safety incidents that resulted in severe harm or death	NHS Information Centre Portal https://www.england.nhs.uk/patient-safety/national-patient-safety-incident-reports/	Trust no.	April 2025 – March 2026 **Severe Harm** 93	April 2025 – March 2026 **Death** 20	April 2024 – March 2025 **Severe Harm** 84	April 2024 – March 2025 **Death** 28	April 2023 – March 2024 **Severe Harm** 115	April-2023 March 2024 **Death** 50
		Trust %	0.3%	0.1%	0.1%	0.4%	0.6%	0.2%
		National Average	Not available	Not available	Not available	Not available	Not available	Not available
		Highest National	Not available	Not available	Not available	Not available	Not available	Not available
		Lowest National	Not available	Not available	Not available	Not available	Not available	Not available

The Newcastle Hospitals considers that this data is as described for the following reasons:

Our Patient Safety Incident Response Framework process mandates that all patient safety incidents that are graded as moderate or above harm undergo a rapid review, facilitated by clinical board Quality and Safety leads. Following this review the harm grading may be amended in accordance with Learning From Patient Safety Events definitions. Incidents that remain graded as moderate or above harm are presented for Trust and External (NHS England and Integrated Care Board) oversight at a weekly Response Action Review Meeting.

The learning response outcomes allocated at the Response Action Review Meeting are closely monitored through the Patient Safety Group, and investigation findings are shared at the monthly Patient Safety Incident Forum.

Where appropriate, incident investigations undertaken in collaboration with neighbouring Trusts and findings and recommendations are shared across the Integrated Care Board.

Learning from incidents is shared across the Trust through a number of forums as previously mentioned.
Where appropriate, incident investigations undertaken in collaboration with neighbouring Trusts and findings and recommendations are shared across the Integrated Care Board.
Learning from incidents is shared across the Trust through a number of forums.

WORKFORCE FACTORS

The tables below provide data on the loss of workdays. The table directly below reports on the Trust and regional position rate (data taken from the NHS Information Centre) and the next table provides an update on the Trust number of staff sick days lost to industrial injury or illness caused by work.

This table shows the loss of workdays (rate).

	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sept 2025	Oct 2025	Nov 2025
The Newcastle Upon Tyne Hospitals	6.18	6.13	6.15	5.72	5.49	5.18	5.36	5.39	5.39	5.70	6.31	6.32
South Tyneside and Sunderland	7.25	7.20	6.49	5.83	5.71	5.50	6.00	6.08	6.29	6.25	6.43	6.27
County Durham and Darlington	6.73	6.31	5.70	5.45	5.64	5.53	5.59	5.72	5.52	5.86	6.06	6.29
Gateshead Health	6.69	6.29	5.78	5.52	5.12	4.89	5.10	4.99	4.72	5.28	5.84	5.92
North Tees and Hartlepool	7.04	6.46	6.19	5.84	5.50	5.13	5.90	5.94	5.88	6.18	6.40	6.20
Northumbria Healthcare	6.42	6.41	5.81	5.39	5.31	5.19	5.24	5.31	5.20	5.21	5.30	5.17
South Tees Hospitals	6.85	6.96	6.11	5.81	5.56	5.58	5.92	5.88	6.08	6.28	6.51	6.72
England	5.74	5.71	5.26	4.88	4.79	4.70	4.93	5.08	5.07	5.29	5.67	5.61

Year	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Year Total
2015/2016 no. of days	360	194	365	219	1138
2016/2017 no. of days	230	387	136	84	837
2017/2018 no. of days	137	90	51	122	400
2018/2019 no. of days	214	131	188	326	859
2019/2020 no. of days	249	172	67	123	611
2020/2021 no. of days	65	61	335	212	673
2021/2022 no. of days	318	475	618	409	1820
2022/2023 no. of days	319	119	139	321	898
2023/2024 no. of days	525	381	445	457	1808
2024/2025 no. of days	251	306	557	526	1640
2025/2026 no. of days	599	547	261	352	1759

2025 NHS STAFF SURVEY RESULTS SUMMARY

NHS Staff Survey 2025 – Overview of Results

The past few years have been exceptionally challenging for everyone working within the NHS. Against this backdrop, it remains vital that we listen to our colleagues' experiences, using their feedback to shape improvements to working lives.

A full census NHS Staff Survey was issued to all eligible employees. This was distributed electronically via email, with paper copies sent by post to colleagues on maternity leave and those working within the estates directorate. 16,787 members of staff were invited to take part.

In 2025, 10,323 members of staff responded to the survey, representing a response rate of 62%. This reflects a marginal decrease of 0.46% compared to 2024, when 10,371 staff participated. The response rate remains strong and provides a robust and representative picture of staff experience across the organisation.

The survey is aligned to the NHS People Promise, which sets out the areas that matter most to colleagues in improving their experience of work. The People Promise is structured around seven key elements:

- We are compassionate and inclusive
- We are recognised and rewarded
- We each have a voice that counts
- We are safe and healthy
- We are always learning
- We work flexibly
- We are a team

In addition to these seven elements, the survey also captures two overarching themes: staff engagement and morale.

Newcastle Hospitals People Promise Benchmarked Results:

	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.25	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

People Promise scores between 2024 and 2025 have been stable with no statistically significant change across any of the people promise elements and additional themes.

People Promise Element	2024 Score	2024 Respondent	2025 Score	2025 Respondents	Statistically significant Change
Overall 'We are compassionate and inclusive' score	72.35	10371	72.37	10323	No Significant Difference
Overall 'We are recognised and rewarded' score	56.85	10371	56.91	10323	No Significant Difference
Overall 'We each have a voice that counts' score	65.81	10371	65.07	10323	No Significant Difference
Overall 'We are safe and healthy' score	61.12	10371	60.75	10323	No Significant Difference
Overall 'We are always learning' score	54.72	10371	53.51	10323	No Significant Difference
Overall 'We work flexibly' score	58.97	10371	59.88	10323	No Significant Difference
Overall 'We are a team' score	64.56	10371	65.02	10323	No Significant Difference
Overall 'Staff Engagement' Score	68.14	10371	67.03	10323	No Significant Difference
Overall 'Morale' score	59.25	10371	58.28	10323	No Significant Difference

** Statistical significance is testing using a two-tailed t-test with a 95% level of confidence*

We continue to score below the national NHS average when compared to other Trusts and need a clear focus on narrowing the gap to top-performing organisations through targeted, evidence-led interventions.

2025 Scores vs NHS Average and NHS Best	Northumbria	STSFT	North Tees	CDDFT	North Cumbria Integrated Care NHS Foundation Trust	Newcastle	Gateshead	South Tees	NHS Average	NHS Best
We are compassionate and inclusive	7.71	7.38	7.41	7.17	7.11	7.25	7.18	7.14	7.28	7.71
We are recognised and rewarded	6.31	6.00	5.94	5.80	5.79	5.71	5.76	5.63	5.87	6.34
We each have a voice that counts	7.05	6.75	6.67	6.49	6.43	6.52	6.44	6.46	6.60	7.12
We are safe and healthy	6.58	6.25	6.17	5.98	6.15	6.07	5.95	5.81	6.07	6.58
We are always learning	5.93	5.76	5.54	5.53	5.31	5.38	5.38	5.25	5.57	6.21
We work flexibly	6.23	6.37	6.31	6.15	6.07	6.01	5.99	5.70	6.22	6.74
We are a team	6.97	6.78	6.78	6.67	6.60	6.51	6.55	6.48	6.75	7.14

same as national average
Above National Average
Below National Average
same as NHS Best

2025 Scores vs NHS Average and NHS Best	Northumbria	STSFT	North Tees	CDDFT	North Cumbria Integrated Care NHS Foundation Trust	Newcastle	Gateshead	South Tees	NHS Average	NHS Best
We are compassionate and inclusive	7.71	7.38	7.41	7.17	7.11	7.25	7.18	7.14	7.28	7.71
We are recognised and rewarded	6.31	6.00	5.94	5.80	5.79	5.71	5.76	5.63	5.87	6.34
We each have a voice that counts	7.05	6.75	6.67	6.49	6.43	6.52	6.44	6.46	6.60	7.12
We are safe and healthy	6.58	6.25	6.17	5.98	6.15	6.07	5.95	5.81	6.07	6.58
We are always learning	5.93	5.76	5.54	5.53	5.31	5.38	5.38	5.25	5.57	6.21
We work flexibly	6.23	6.37	6.31	6.15	6.07	6.01	5.99	5.70	6.22	6.74
We are a team	6.97	6.78	6.78	6.67	6.60	6.51	6.55	6.48	6.75	7.14

Involvement and engagement 2025-2026

We are committed to listening to our patients, local communities and to work with community-based organisations to help us meet the needs of the population we serve.

We have continued to work with a wide range of local voluntary community organisations across the region. This helps us to reach and involve our wide and diverse populations in shaping health services. Examples of this work includes:

- The continuing success of the DeafLink Health Navigator Project, in collaboration with Northumbria Healthcare Foundation Trust and Cumbria, Northumberland, Tyne and Wear Foundation Trust. This joined up approach has shown real improvements for people who are D/deaf and need to access a diverse range of services across the region.
- Collaboration work with Skills for People to produce easy read health information and the development and launch of a video written and produced by people with lived experience to explain to staff and patients about the reasonable adjustment flag on the patient record.
- Consultation work with carers, staff, patients and visitors to understand the experience of visiting someone in hospital to inform a full review of the visiting policy and regulations.

In addition, last year we launched our new Partnership and Involvement Panel, recruiting people with lived experiences across the region to become ‘involvement partners’ and give their views on developments.

In 2025-2026, panel members have offered their views and become involved in the work of:

- the deciding right group
- the medicines management oversight group
- scoring of funded research applications
- judging the people at our heart staff awards
- the equality, diversity and inclusion working group
- research around age-friendly hospitals
- reimaging outpatients’ transformation work.

In 2026-2027 the focus will be:

- Further recruitment and embedding of the Partnership and Involvement Panel and work within clinical boards to highlight the benefits and opportunity for involvement
- To ensure involvement and engagement within the patient safety work of the trust including the recruitment of patient safety partners. patient safety partners will represent the patient/family voice by providing a questioning approach in the investigation and learning from patient safety incidents
- continue to work in partnership with local communities on projects and concerns which matter to them
- build our collaborative working across the Great North Healthcare alliance.

ANNEX 1:

STATEMENT ON BEHALF OF THE NEWCASTLE HEALTH SCRUTINY COMMITTEE

STATEMENT ON BEHALF OF NORTHUMBERLAND COUNTY COUNCIL

STATEMENT ON BEHALF OF THE NEWCASTLE & GATESHEAD INTEGRATED CARE BOARD

STATEMENT ON BEHALF OF HEALTHWATCH GATESHEAD,HEALTHWATCH NEWCASTLE HEALTHWATCH NORTH TYNESIDE AND HEALTHWATCH NORTHUMBERLAND.

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Agenda item A5(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 2026		
Title	Committee Annual Reports 2025/26 and Charity Committee Terms of Reference Review and Schedule of Business Review 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 purpose of this report is to provide assurance to the Trust Board that the Audit, Risk and Assurance, Finance and Performance, People, Quality & Digital and Data Committees have met their key responsibilities for 2025/26, in line with their Terms of Reference. The Committee Annual Reports outline overall achievements throughout the year and action points for continuing development during the coming year. The Annual Reports have been considered at the relevant Committee meetings. The Finance and Performance Committee and Audit, Risk and Assurance Committee Annual Reports are in draft and will be discussed at the relevant Committee prior to the Trust Board meeting. The Committee Terms of Reference (ToR) and Schedules of Business (SoB) have been discussed at each respective Committee meeting and approved at the March 2026 Trust Board meeting. The annual review of the Charity Committee ToR and SoB has been conducted and discussed at the most recent Committee meeting. Minor changes have been made to the ToRs and SoBs to reflect: - Updated role titles. - Change of membership from Deputy Chief Executive to Director of Communications and Corporate Affairs. - Members holding multiple titles will be referred to in the Terms of Reference by their primary title. - The responsibility for reporting a serious event lies with the Charity Committee if they have delegated responsibility. - The updated process for Triple A reporting is included.		
Recommendation	The Trust Board is asked to: i) Approve the Committee Annual Reports, outlining 2025/26 work undertaken and note the key areas to revisit during 2026/27; and ii) Approve the updated Charity Committee Terms of Reference and 2026/27 Schedules of Business.		

Links to Strategic Objectives	Links to all Strategic Objectives. The Charity has its own strategic objectives as outlines in the Charity Strategy to 2026. These are aligned and linked to the Strategic Objectives of the Trust.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link.					
Reports previously considered by	Annual Review. Submission to the relevant Committee meetings has taken place in advance of the 22 May 2026 Board meeting.					

AUDIT, RISK AND ASSURANCE COMMITTEE ANNUAL REPORT 2025-2026

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Audit, Risk and Assurance Committee has met its key responsibilities for 2025-26, in line with its terms of reference and the requirements of the updated Audit Committee Handbook republished in December 2025.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. AUDIT COMMITTEE RESPONSIBILITIES

The key purpose of the Audit, Risk and Assurance Committee is to provide the Board with:

- an independent and objective review of financial and organisational controls, the system of integrated governance and risk management systems and practice across the whole of the organisation's activities (both clinical and non-clinical);
- assurance of value for money;
- compliance with relevant and applicable law;
- compliance with all applicable guidance, regulation, codes of conduct and good practice; and
- advice as to the position of the Trust as a "going concern."

It does this through receipt of assurances from auditors, management and other sources.

3. AUDIT, RISK AND ASSURANCE COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board from the Non-Executive Directors of the Trust and consists of at least four members with a quorum being two members.

Eight ordinary meetings were held between 1 April 2025 and 31 March 2026.

	Attendance at ordinary meetings
Mr D Weatherburn, Non-Executive Director and Committee Chair	8 of 8
Mr B MacLeod, Non-Executive Director	8 of 8
Mr B McCardle, Non-Executive Director	8 of 8
Mrs A Stabler, Non-Executive Director	8 of 8

The Committee met the minimum number of five meetings per year and other attendees at the meetings have included:

- External and Internal Audit, as well as the Trust's Fraud Specialist Manager.
- Management, which included the Chief Executive Officer, the Chief Finance Officer, the Director of Communications and Corporate Affairs, the Executive Director of People and Commercial Innovation, the Executive Director of Nursing, Midwifery and Allied Health Professionals (AHP's), the Director of Performance and Governance, the Director of Quality and Safety, the Chief Experience Officer and other Executive Team members.
- The Trust Secretary and team members who provide Secretariat Support to the Committee.
- The Head of Corporate Risk & Assurance.
- Corporate Services representation including senior finance team members.
- The Designated Individual for Mortuary Services.
- The Chair and other NEDs including the Chair of the Digital and Data Committee.
- The external auditor of the Trust Charity.

In addition, Governors Eric Valentine, Judy Carrick, Chris Record and Poonam Singh observed Committee meetings during the financial year.

4. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee is required to review the establishment and maintenance of an effective system of integrated governance, risk management and internal control across the whole of the Trust's activities that supports the achievement of the Trust's objectives, internal control and risk management.

The Audit, Risk and Assurance Committee had a Schedule of Business for the year and uses a rolling programme and action log to track committee actions.

The Committee has reviewed:

- Its Terms of Reference and Schedule of Business.
- The Head of Internal Audit opinion (June 2025).
- The Board Assurance Framework (BAF); being the underlying assurance processes that indicate the achievement of corporate objectives and the effectiveness of management of principal risks.
- Risk management arrangements, the revised Risk Management Policy and the annual BAF Risk Management Annual Report.
- Amendments required to the Scheme of Delegation, Standings Orders and Standing Financial Instructions.
- The Grant Thornton Well Led Review Report.
- The response to the External Auditors on:
    - ISA+240: Audit Committee responsibilities for preventing fraud in the Annual Accounts.

- ISA+250: Audit Committee responsibilities for being satisfied that the Annual Accounts comply with laws and regulations.
- ISA+501: Specific consideration of the potential for, and actual, litigation and claims affecting the financial statements.
- ISA+570: Consideration for the Going Concern Assumption in an audit of financial statements.

Committee members endorsed the response for submission to the External Auditors for the year.

The BAF focuses on the key risks against achievement of the strategic objectives. The BAF is a 'live' document which is continuously reviewed and updated by the Corporate Risk & Assurance Department with regular updates to the Committee.

Each Committee of the Board has a responsibility to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the BAF specific to the Committee purpose and function. Bi-monthly each Committee of the Board receives a report detailing the:

- Executive Lead review undertaken during the previous month and any recommendations for risks held on the Board Assurance Framework aligned to that Committee;
- Assurances received and any areas requiring Committee consideration; and
- Risks held on the BAF and movements in the risks, along with risk mitigations, threats, assurances and any gaps in assurance.

During the early months of 2025/26 (until August 2025), the Trust continued to work with The Value Circle who provided advice and support in ensuring an effective governance system was in place from Ward to Board.

Escalations from other Committees appears as a standing agenda item on the ARAC meeting agendas, with any matters raised for the Committee members' attention by exception.

The Committee is satisfied that the system of risk management in the organisation is adequate in identifying risks and allows the Board of Directors to understand the appropriate management of those risks. The Committee believes there are no areas of significant duplication or omission in the systems of governance (that have come to the Committee's attention) that have not been adequately resolved.

5. INTERNAL AUDIT

The Committee has ensured that there is an effective internal audit function established by management that meets mandatory Internal Audit Standards and provides appropriate independent assurance. The Trust receives its internal audit service from AuditOne.

This was achieved by:

- Reviewing and approving the Internal Audit Plan 2025/2026, including regular updates of performance against the Plan.

- Consideration of the major findings arising from internal audit work and management's responses.
- Receipt of the Internal Audit Annual Report, Head of Internal Audit Opinion and Internal Audit Charter/Protocol.
- Monitoring progress with implementation of agreed audit recommendations.
- Integrated Care Board (ICB) external review of Financial and Workforce controls report.

The Committee received a report from the internal auditor at the majority of its Committee meetings which summarised the audit reports issued since the previous meeting.

The internal audit plan for 2025/26 was based on a risk assessment approach centred on discussions with senior staff and Directors and was linked to the organisation's assurance framework. Assurances from Internal Audit reports are, where possible, mapped to the BAF clearly in the BAF document itself.

Good progress continued to be made during the year in relation to the completion of historic internal audit recommendations.

A number of high priority recommendations were identified by Internal Audit and reported during 2025/26, these covered the following internal audits:

- Compliance review of Care Quality Commission (CQC) action plan (2 recommendations);
- Risk based Audit of Contract Management – Linen (1 recommendation);
- Risk based review of Waiting List Initiative (WLI) payments (6 recommendations);
- Risk Based Audit of Management of Contractors (2 recommendations);
- Risk Based Audit of Performance Targets – 62 Day Cancer Target (1 recommendation);
- Risk Based Audit of Procurement Pharmacy (1 recommendation);
- Risk Based Audit of Medicines Management (1 recommendation);
- Follow up audit of Outpatients appointments booking process (1 recommendation); and
- Waiting List Management – Ophthalmology follow up (3 recommendations).

Regular updates on the progress in relation to high priority recommendations were received by Committee members during the year from management and internal audit.

Internal Audit performance against Plan was discussed regularly during the year.

One Internal Audit Report received limited assurance for Waiting List Management – Ophthalmology Follow Up.

Benchmarking reports were provided by AuditOne on:

- WEB-ICE - around use of the Sunquest Integrated Clinical Environment IT application, commonly referred to the WEB-ICE system.

6. EXTERNAL AUDIT

The Committee has reviewed the work and findings of external audit and considered the implications and management responses to their work.

This was achieved by:

- Discussing and agreeing with the external auditor the nature and scope of the audit as set out in the External Audit Annual Plan.
- Reviewing external audit reports, together with the appropriateness of management responses.
- Reviewing the Audit Strategy Memorandum for 2025/26.
- Receiving the year-end Audit Completion Report (which included the Annual Audit Opinion) and the Annual Audit Report (which referenced the Value for Money audit work).

The Council of Governors has the statutory responsibility for the appointment of the external auditors, and this process is led by a sub-group of public Governors supported by Trust officers and the Chair of the Audit Committee. During 2023/24, a robust procurement and evaluation process was undertaken regarding the external audit contract with Mazars LLP reappointed as the Trust's external auditors for an initial three year term commencing in the 2024/25 financial year – approval from the Trust's Council of Governors was granted in February 2024. This followed a satisfactory review of external audit performance undertaken.

The Forvis Mazars LLP external audit fees for 2025/2026:

- Statutory Accounts £147,500 (excluding VAT) which is an increase on the statutory fee invoiced for 2024/25 (£145,000 excluding VAT). The fees were agreed in 2024 when the Trust entered a three year contract with Forvis Mazars LLP for the provision of external audit services following a competitive tender exercise. The contract is currently in its second year of the contract.

The audit of the Charity Accounts is undertaken separately by Robson Laidler, with a 3-year contract in place.

For 2025/26, there was no mandated requirement to undertake external audit procedures on the Quality Report and therefore no fee was charged in relation to this.

To ensure that the independence of the external auditors is not compromised where work outside the scope of the Audit Code has been procured from the external auditors, the Trust has a policy which requires that no member of the team conducting the external audit may be a member of the team carrying out any additional work and their lines of accountability must be separate.

No additional services/non-audit work was carried out by Mazars LLP during 2025/26.

7. MANAGEMENT

The Committee has challenged the assurance process when appropriate and has requested and received assurance reports/verbal updates from Trust management throughout the year. Examples of areas of challenge have included:

- The Trust InPhase launch.
- The Internal Audit Report recommendations sign off process.
- The Digital and Data Committee Chair attending Committee meetings to update on any escalations/items by exception.
- The establishment of the Human Tissue Authority (HTA) Retained Tissue Oversight Group.
- Oversight of the Grant Thornton Well Led Review action plan.

8. FINANCIAL AREAS OF REVIEW

The Committee has ensured that the systems for financial reporting to the Board are subject to review.

The Committee has achieved this primarily through review and approval of the Annual Accounts, including those of the Newcastle upon Tyne Hospitals NHS Charity. The Committee also reviewed the External Audit Opinion and fed back relevant comments for consideration by the external auditors.

In the course of 2025/26, there were no significant issues that the Committee had to consider in relation to the financial statements. During the year, the Committee reviewed the following key areas of management judgement and significant risks:

- PFI/IFRS 16 transition (Trust);
- Management over-ride of controls (Group and Trust);
- Valuation of property, plant and equipment (Group and Trust); and
- Risk of fraud in revenue recognition (Group and Trust).

Other areas discussed between External Audit and Management during the year, and reported to the Committee (as appropriate), related to the value for money work and subsidiary developments.

These have been considered through the presentation of the external audit plan, associated progress updates and discussions during Committee meetings.

The Committee Chair attends and Chairs the HTA Retained Tissue Oversight Group.

9. OTHER AREAS OF ACTION AND REVIEW

The Committee has:

- Reviewed details of all Losses and Compensation Payments.
- Received reports on approved single tender actions and breaches and waivers where applicable.

- Reviewed regular debtors and creditors reports.
- Received and approved the Counter Fraud annual plan and self review tool, as well as regular updates in the form of the Fraud response log, associated progress reports, and the Annual Report on Counter Fraud.
- Reviewed the content of the statutory Annual Report (including the Annual Governance Statement).
- Received an update from the Designated Individual for the Trust Mortuaries and a subsequent report on regulatory compliance and improvement plans.
- Reviewed and approved changes to the Trust Scheme of Delegation, Standing Financial Instructions and Standing Orders.
- Received the Annual Accounts preparation timetable and subsequently the Annual Accounts and Going Concern Review.
- Considered the findings of an external review undertaken by The Value Circle and the associated action plan.
- Received updates on
    - Changes to the Compliance and Assurance Group;
    - The establishment of the HTA Retained Tissue Oversight Group;
    - An assessment of overdue internal audit recommendations;
    - Standards of Business Conduct, including declarations of interest and the annual review of the register of gifts and hospitality;
    - The Clinical Audit Process and National Clinical audits;
    - External Visits compliance;
    - Fit and proper persons; and
    - The national payroll exercise.
- The Annual Report of the Committee / self-effectiveness review.
- Received an annual report on special severance payments/settlement agreements.
- Approved the Trust's Annual Modern Slavery Act Statement.
- Approved the Integrated Care Board (ICB) Aubrey Self-Assessment.
- Received the Health and Safety Annual Report.
- Received an action log to follow up previous Committee meeting actions.
- Discussed assurance from the People Committee as to whether arrangements by which staff may raise concerns are operating effectively.
- Approved the Internal Audit Charter and Protocol (July 2025).
- Reviewed the performance of Internal Audit, External Audit and Counter Fraud.
- Received the minutes / chairs logs from associated Committees/Groups – Finance and Performance; People; Quality; Charity; Digital and Data; Compliance and Assurance, Risk Validation Group and HTA Retained Tissue Oversight Group.

10. PROGRESS FOR 2025-2026, REVIEW OF EFFECTIVENESS & AREAS OF FOCUS FOR 2026-27

The self-assessment checklist from the HFMA Audit Committee Handbook (the December 2025 version being the latest version) has been completed. Six responses were received and used to populate with the response in Appendix 1. Responses received were very consistent with the previous year.

An annual effectiveness survey was circulated to Committee members – the format of this was agreed with the Chair and used for all Committees. Feedback was received from 3 ARAC Committee members, which highlighted the following:

- Responses were largely positive. Most respondents agreed (as a minimum from 2 out of 3) that:
  - The Committee has a clearly defined role, purpose and objectives (as set out in its Terms of Reference).
  - The meeting is well managed in terms of scheduling, agenda setting and time management.
  - The skill mix and number of people who attend the Committee is appropriate.
  - The purpose of papers being presented is made clear by the author, with actions, issues and assurances clearly defined.
  - Committee members actively participate and make relevant contributions to discussions.
  - The cross-representation of members at Committee meetings enhances the quality and reliability of decisions.
  - There is no unnecessary duplication between Committees.
  - The frequency of the meetings enables business to be conducted effectively.
  - The Chair clearly captures decisions and actions arising throughout the committee meetings.
  - The Chair clearly captures the decision-making process and ensures it is understood by Committee members.
  - It is clear when the Committee needs to escalate matters for the attention of the Board or to another Committee.
  - The Committee Chair effectively addresses conflicts, concerns or issues and manages time allocated to allow discussion on key items.
  - The Committee Chair encourages participation from newer / less experienced members.
  - Committee members and meeting attendees are actively engaged and focussed on the reports under discussion.
  - The Committee effectively considers and weighs the potential risks and benefits associated with the decisions made.
  - The Committee members are given the opportunity to provide input and contribute to the decision making process.
  - The style and quality of meeting papers is appropriate for the meeting.
  - Meeting papers are succinct and set out the key issues, assurances and any gaps in assurances.
  - The Committee values and considers diverse perspectives and opinions when making decisions.
  - The Committee's decision making process is clear, transparent and inclusive.
  - The Committee ensures that processes are in place to create robust action plans with clear ownership, timeframes, and dependencies all of which are monitored and followed up.
  - The Committee receives assurance that identified actions are completed in line with agreed timescales.
  - Decisions are based on and related to the evidence presented to the Committee.
  - Record keeping is prompt and accurate. It is useful in future meetings.

- The Committee's goals, objectives and activities are clearly aligned with the Trust's vision and strategy.
- The Committee's meetings and agendas are focussed on addressing priorities aligned with the Trust's vision and strategy.
- The Committee's decision-making process reflects the Trust's vision and strategy.
- The Committee effectively fosters a culture and environment that supports the pursuit of the Committee's vision and strategy.
- The Committee is actively engaged in discussions and decision-making processes that contribute to the realisation of the Trust's vision and strategy.
- The Committee is effective in communicating and reporting on risks, issues and performance, and escalating these where necessary.
- Where information or risks need to be discussed in more than one committee, there is effective escalation between Committee.
- The Chair provides adequate support and guidance in managing risks, issues and performance.
- Committee members actively discuss the strategic risks in the BAF that are within the remit of the Committee.

- Additional feedback comments were included which covered:
  - Since the post-Care Quality Commission (CQC) 'reset', the Committee has been operating effectively. It would be helpful to reflect on the BAF and risk management processes to ensure they remain current, continue to reflect the Trust's evolving challenges, and are actively used and understood across the organisation, rather than becoming routine or static.
  - The Committee is operating very effectively, and the pre-meeting with Audit One is particularly helpful in supporting well-focused discussion and assurance.

Based on the feedback above the following three areas of focus have been identified for Committee members to consider in 2026/27:

- To reflect on the BAF and risk management processes.

In the 2024/25 annual report of the Committee, the key area of focus for 2025/26 was to review the quality of reports in terms of succinctness and clarity, review the attendees at Committee meetings to consider whether future attendance should continue and revisit the Schedule of Business to ascertain whether the meeting frequency should be reduced. The meeting frequency was reduced to bi-monthly from July 2025 with an updated schedule of business approved at that meeting. Work has been taking place to ensure there is minimal duplication between Committee meetings.

The Terms of Reference and Schedule of Business for the Committee have been reviewed and minor changes agreed at the Committee and the Trust Board in March 2026. In summary the changes were:

- The Terms of Reference were streamlined to enhance clarity, remove duplication and reflect the Committee's current responsibilities and reporting arrangements;
- Updated report leads and authors;

- The change to moving the meeting to bi-monthly (with the exception of June due to the Annual Report and Accounts); and
- Updated report scheduling.

Report of

Kelly Jupp
Trust Secretary

Lauren Thompson
Corporate Governance Manager/Deputy Trust Secretary
24 April 2026

DIGITAL AND DATA COMMITTEE ANNUAL REPORT 2025/26

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Digital and Data Committee has met its key responsibilities for 2025/26. It also outlines overall achievements throughout the year and action points for continuing development during the coming year.

The Terms of Reference and Schedule of Business for the Committee have been reviewed and minor changes were agreed at the Committee meeting in March 2026.

2. COMMITTEE RESPONSIBILITIES

The Digital and Data Committee is a non-statutory Committee established by the 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.

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Director:

- That the Digital Strategy enables improvements in the safety and quality of care for patients, as well as in the efficiency and effectiveness of patient and staff experiences,
- That the strategic digital principles are aligned with the Trust strategy and risks are managed effectively;
- That reporting of the digital performance is being triangulated against agreed plans, progress and performance measures;
- That the 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;
- On the Trust's compliance 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;
- On the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the committee purpose and function; and
- On the robustness of systems and processes for prioritisation of investments related to the Digital Strategy, as well as any Digital and/or Data incidents.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of 19 members (as specified in the Terms of Reference), drawn from the Non-Executive Directors and members of the Executive Team and Management Team.

The Committee's quorum is four members, including the Chair or Vice Chair.

Meetings are held bi-monthly. Six ordinary meetings were held between 1 April 2025 and 31 March 2026.

Attendance at the meetings was as follows:

	Attendance at ordinary meetings
Hassan Kajee, Non-Executive Director (NED) Committee member, and Committee Chair from July 2025	6 out of 6
Liz Bromley, NED Committee member, and Committee Chair until June 2025	4 out of 6
Phil Kane, NED Committee member	5 out of 6
Dave Elliott, Chief Digital Officer (from May 2025)	6 out of 6
Shauna McMahon, Chief Information Officer and Senior Information Risk Owner (SIRO) until April 2025	0 out of 0
Michael Wright / Lucia Pareja-Cebrian, Joint Medical Directors	4 out of 6
John Crossman, Associate Medical Director – Digital	1 out of 6
Vicky McFarlane-Reid, Director for Commercial Development and Innovation (role title changed during the year to Executive Director of People and Commercial Innovation) *	1 out of 6
Jackie Bilcliff, Chief Finance Officer/Acting Deputy Chief Executive	5 out of 6
Patrick Garner, Director of Performance and Governance	4 out of 6
Annie Laverty, Chief Experience Officer (until December 2025)	0 out of 4
Caroline Docking, Director of Communications & Corporate Affairs & Senior Information Risk Owner (SIRO from April 2025)	4 out of 6
Lisa Guthrie, Deputy Director of Nursing (role title changed during the year to Director of Nursing)	6 out of 6
Chris Plummer, Chief Clinical Information Officer	5 out of 6
Gordon Elder / Chris Bill, Chief Nursing Information Officers	3 out of 6
Wasique Chaudry, Director of Operations – Clinical and Diagnostic Services Clinical Board (Committee member until June 2025)	0 out of 1
Claire Pinder, Director of Operations – Clinical and Diagnostic Services Clinical Board (Committee member from June 2025)	1 out of 5
Natalie Yeowart, Head of Corporate Risk & Assurance	4 out of 6
Gary Towns, Head of IT Service Management	4 out of 6

* Wayne Elliott, Associate Director for Commercial Enterprise has attended on behalf of Vicky McFarlane-Reid

Other attendees at meetings have included Acting Chief Executive Officer, Executive Team members, the Chair, a Finance Manager, the Associate Director for Commercial Enterprise, representatives from Northumbria Healthcare, a Clinical Director and Secretariat support.

Governor observers throughout the year included Appointed Governor for Charity, Tracy Armstrong and Public Governors, Claire Watson and Philip Home.

4. REPORTING

i) Regular Reports

Over the course of the year, Committee members received regular reports/updates on:

- Chief Digital Officer report including Care Quality Commission (CQC) update;
- Cyber Security;
- Board Assurance Framework (BAF)/risk report & emerging risks;
- Digital financial plan/position/investments;
- Digital change projects/Care optimisation;
- SIRO report;
- Digital/Data incident review;
- Digital & Data Priorities/Updates including Patient Engagement Portal (PEP) letters;
- IT service management update including critical incident review
- Information Services update;
- End of project implementation reviews, to incorporate benefits realisation;
- Update from the Clinical Safety Officer;
- External/Internal audit/review reports related to Digital & Data; and
- Chairs Logs from the Digital and Data Governance Group and Care Optimisation Group.

ii) Annual Reports

The following Annual Reports were received by the Committee:

- Digital and Data Committee Terms of Reference and Schedule of Business 2025/26; and
- Annual Digital Workplan/Annual Digital Strategy.

iii) Ad-Hoc Reports

In addition to those reports listed above, several reports were received by the Committee. These included:

- Digital Maturity Assessment;
- Information Governance and SARS update;
- Digital Roadmap and EPR optimisation plan;
- Data Security & Protection (DSPT) – optional audit requirements;
- Update on Electronic Patient Record - Adoption Coaches;
- Accessible Information Standard (Improving Patient Experience);
- Oracle Cerner Remote Hosting and EPR Upgrade
- Digital Programme Project Delivery update;
- Data Quality;
- Funding bids;
- Information Standards Notice (ISN) Compliance;
- Accessible Information Standards update;
- LIMS roadmap spotlight;
- Community Diagnostic Centre (CDC) update;

- Artificial Intelligence (AI) update;
- Staff survey results;
- Cost Improvement Programme (CIP);
- Alliance update;
- External/Internal audit/review reports related to Digital & Data; and
- Commercial opportunities – Digital and Cloud solutions, Digital Partnerships Committee.

5. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2025/26 and utilised a rolling programme and action log to track committee actions.

As highlighted in Section 4(i), the Committee receives regular updates on risks recorded on the BAF which related to the Committee's area of focus. During 2025/26, the one risk included in the BAF and regularly discussed at the Committee was:

- *Failure to deliver and improve the digital capability required to support the delivery of safe, effective and efficient patient care.*

Three threats were identified that might cause the principal risk to materialise if not mitigated, being:

- Delivery of foundational digital and operational tasks supersedes strategic digital priorities, resulting in limited ability to deliver digital transformation;
- Lack of staff skill set and resources to deliver digital plans; and
- Insufficient capital and revenue funding to deliver agreed digital priorities and transformation programmes.

The Committee received regular updates on mitigations in place. In addition, at the end of every meeting debriefs are held and matters for escalation to the Trust Board agreed (and captured within the meeting minutes).

6. PROGRESS FOR 2025/26 & REVIEW OF EFFECTIVENESS

An annual effectiveness survey was circulated to Committee members. Of the 19 members, only 4 responses were received. Committee members may wish to discuss whether the current survey format should be amended and/or other formats for reviewing effectiveness be explored to encourage feedback. Feedback received highlighted the following:

- Most respondents agreed or strongly agreed (as a minimum 2 from 4) that:
    - Committee members actively participate and make relevant contributions to discussions.
    - The cross-representation of members at Committee meetings enhances the quality and reliability of decisions.
    - There is no unnecessary duplication between Committees.
    - The frequency of the meetings enables business to be conducted effectively.
    - The Chair clearly captures decisions and actions arising throughout the committee meetings.

- The Chair clearly captures the decision-making process and ensures it is understood by Committee members.
- It is clear when the Committee needs to escalate matters for the attention of the Board or to another Committee.
- The Committee effectively considers and weighs the potential risks and benefits associated with the decisions made.
- The Committee members are given the opportunity to provide input and contribute to the decision making process.
- The Committee values and considers diverse perspectives and opinions when making decisions.
- The Committee's decision making process is clear, transparent and inclusive.
- The Committee ensures that processes are in place to create robust action plans with clear ownership, timeframes, and dependencies all of which are monitored and followed up.
- The Committee receives assurance that identified actions are completed in line with agreed timescales
- Decisions are based on and related to the evidence presented to the Committee.
- Record keeping is prompt and accurate. It is useful in future meetings.
- The Committee's goals, objectives and activities are clearly aligned with the Trust's vision and strategy.
- The Committee's meetings and agendas are focussed on addressing priorities aligned with the Trust's vision and strategy.
- The Committee's decision-making process reflects the Trust's vision and strategy.
- The Committee effectively fosters a culture and environment that supports the pursuit of the Committee's vision and strategy.
- The Committee is actively engaged in discussions and decision-making processes that contribute to the realisation of the Trust's vision and strategy.
- The Committee is effective in communicating and reporting on risks, issues and performance, and escalating these where necessary.
- Where information or risks need to be discussed in more than one committee, there is effective escalation between committees.
- The Chair provides adequate support and guidance in managing risks, issues and performance.
- Committee members actively discuss the strategic risks in the BAF that are within the remit of the Committee.

- The following statements had one respondent included 'disagree':
  - The Committee has a clearly defined role, purpose and objectives (as set out in its Terms of Reference).
  - The skill mix of the Committee's membership is appropriate.
  - The purpose of papers being presented is made clear by the author, with actions, issues and assurances clearly defined.
  - The cross-representation of members at Committee meetings enhances the quality and reliability of decisions
  - The Committee Chair encourages participation from newer / less experienced members.
  - The Committee effectively considers and weighs the potential risks and benefits associated with the decisions made.

- The style and quality of meeting papers is appropriate for the meeting.
- Meeting papers are succinct and set out the key issues, assurances and any gaps in assurances.
- The Committee ensures that processes are in place to create robust action plans with clear ownership, timeframes, and dependencies all of which are monitored and followed up.
- Decisions are based on and related to the evidence presented to the Committee.
- Record keeping is prompt and accurate. It is useful in future meetings.
- The Committee's goals, objectives and activities are clearly aligned with the Trust's vision and strategy.
- The Committee effectively fosters a culture and environment that supports the pursuit of the Committee's vision and strategy.
- The Committee is actively engaged in discussions and decision-making processes that contribute to the realisation of the Trust's vision and strategy.
- Where information or risks need to be discussed in more than one committee, there is effective escalation between committees.

- Additional feedback comments were included which covered:
  - One respondent highlighted that the volume of documentation made it difficult to focus on important issues, and it may be helpful to structure the papers around reports and appendices for additional information.
  - A further respondent noted that representation on the Committee was weighted more towards digital operational roles, while Clinical Board involvement could be increased. Discussions had often centred on operational issues, although this balance was noted to be gradually improving.
  - One respondent highlighted that the Committee would benefit from enhanced Clinical Board representation, mirroring the arrangements within the Quality Committee. Alignment with the Trust's strategy and vision was highlighted to be more straightforward once the new Trust strategy had been developed.
  - The style and quality of meeting papers was highlighted as an area to improve.

7. NEXT STEPS AND ACTIONS FOR 2026/27

During 2025/26 there was a change in the Committee Chair and Executive Lead for the Committee. Despite this, the Committee has progressed well and the survey findings have identified key focus areas for 2026/27 to further embed and strengthen the Committee, being:

- The quality of meeting papers, in particular focussing on succinctness, style, clarity of issues/decisions and assurance. In addition, use of more succinct Executive Summaries in reports would assist the reader is identifying the key points at the start of the report.
- Revisit membership, in particular Clinical Board attendance.
- Refocus meeting agendas around the new strategic objectives.

The Terms of Reference and Schedule of Business for the Committee have been reviewed and minor changes were agreed at the Committee and the Trust Board in March 2026. In summary the changes were:

- Updated report leads and authors;
- Updated reports/agenda items; and
- Updated report scheduling.

Report of Lauren Thompson
Corporate Governance Manager/Deputy Trust Secretary
24 April 2026

QUALITY COMMITTEE ANNUAL REPORT 2025/26

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Quality Committee has met its key responsibilities for 2025/26, in line with its Terms of Reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. COMMITTEE RESPONSIBILITIES

The Quality Committee is a non-statutory Committee established by the Trust Board of Directors to monitor, review and report to the Board on the quality of care to the Trust's patients, specifically in relation to patient safety, clinical effectiveness and patient experience.

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors:

- That the Trust's quality governance is sufficiently robust to deliver safe care and meet legal and regulatory obligations;
- On the Trust's approach to, and delivery of, continuous quality improvement;
- That any shortcomings in the quality and safety of care against agreed standards are identified and addressed;
- On the quality impact of changing professional and organisational practices;
- That the Trust fulfils its leadership and influencing role on service quality, standards and practice;
- 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;
- 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; and
- 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.

It does this through the receipt of assurances from the management groups, the receipt of regular reports relating to areas which impact the quality of care provided to patients and discussions and reports on the management of risks relating to the Committee's area of focus.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of at least 7 members and is required as per the Terms of Reference, drawn from the Non-Executive Directors, members of the Executive Team and other senior staff members.

The Committee's quorum is four members and includes the Committee Chair or Vice-Chair, and at least one other Non-Executive Director and one Executive Team Member.

During 2025/26, the Committee continued to meet monthly in recognition of the improvements needed/assurances required as part of the CQC inspection findings. Eleven ordinary meetings were held between 1 April 2025 and 31 March 2026. Attendance at the ordinary meetings was as follows:

	Attendance at ordinary meetings
Anna Stabler, Non-Executive Director (Committee Chair)	11 out of 11
Bill MacLeod, Non-Executive Director	10 out of 11
Phil Kane, Non-Executive Director	9 out of 11
Wendy Balmain, Non-Executive Director	9 out of 11
Ian Joy, Executive Director of Nursing (title change during the year to Executive Director of Nursing, Midwifery and AHP's)	10 out of 11
Michael Wright and Lucia Pareja-Cebrian, Joint Medical Director	11 out of 11
Rachel Carter, Director of Quality & Safety	8 out of 11
Gus Vincent, Associate Medical Director, Patient Safety & Quality	3 out of 11
Annie Laverty, Chief Experience Officer (until December 2025)	4 out of 8
Lisa Guthrie, Deputy Director of Nursing (title change during the year to Director of Nursing)	9 out of 11
Jenna Wall, Director of Midwifery	10 out of 11
Ewan Dick, Associate Director of AHP's and Therapy Services	7 out of 11

The terms of reference for the Committee included the following Committee members:

1. Single Clinical Board Representation at each meeting; and
2. Chairs of the Tier 2 committees reporting to Quality Committee if not previously mentioned above.

Due to the volume of individuals falling within the two categories above, and the alternating attendance of individuals across Clinical Boards/Corporate leaders, they have not been included in the table above however representation of both 1 and 2 was present at every Committee meeting.

Other attendees at the meetings have included:

- The Chair, other Non-Executive and Associate Non-Executive Directors;
- Acting Chief Executive Officer;
- Other Executive Team members, Directors and Deputy Directors;
- Associate Medical Directors;
- Head of Midwifery;
- The Director of Infection Prevention and Control;
- Clinical Directors;
- Heads of Services;
- Heads of Nursing, Clinical Board Chairs and Directors of Operations;
- Associate Directors of Nursing;

- Quality & Safety Leads;
- Associate Directors of Operations;
- Consultants – Neonatal, Paediatrics, Obstetrician, Palliative Medicine, Cardiologist, Ophthalmologist, Paediatric Cardiologist, Public Health, Dental;
- The Director of Pharmacy;
- The Quality Improvement Programme Manager /Patient Safety & Quality Lead;
- Patient Safety & Quality Leads;
- The Director of Nursing (North) and the Deputy Director of Nursing (Quality), North East and North Cumbria Integrated Care Board;
- Associate Medical Directors;
- The PA / Corporate Governance Administrator and Corporate Governance Manager / Deputy Trust Secretary who provided Secretariat Support to the Committee.

During 2025/26, Public Governors Sandra Mawdesley, Philip Home, Claire Watson, Judy Carrick, Peter Bower and Volunteer Staff Governor, Roger Bishop observed Quality Committee meetings.

4. MANAGEMENT GROUPS

To ensure that the Committee maintained adequate oversight of the management of quality related matters across the Trust, a series of Management and Oversight Groups continued to report into the Committee, with terms of references updated/approved by the Committee during the year as appropriate:

- Patient Safety;
- Experience of Care;
- Clinical Outcomes and Effectiveness including updates from the Clinical Ethics Advisory Group;
- Transplantation Committee;
- Cardiac Oversight Group;
- Promoting Equity in Health Group; and
- Medicines Management Oversight Group.

The Committee receive a report from a minimum of four groups at each meeting, rotating across the course of the year. The reports detail the activities of the Management Groups and any risks/matters requiring escalation to the Committee. Additionally, the minutes or Chairs Logs from the Management Groups are received by the Committee at each meeting.

The Terms of Reference for each of the Management Groups, which clearly define the remit of each of the groups, were approved by the Committee on establishment, with any changes captured in the minutes of the groups shared with the Committee routinely.

5. REPORTING

i. Regular Reports

During the year, the following regular reports/agenda items were discussed by the Committee:

- The Integrated Board Report;
- Regulatory Updates e.g. Care Quality Commission Update Reports;
- Improvement Groups
    - Medicines Oversight Group including Medicines Management Action Plan – De-escalated to business as usual at the May 2025 Committee meeting.
    - Hepato-Pancreato-Biliary (HPB) – escalated at the October 2025 Committee meeting.
    - Infection, Prevention and Control (IPC) – escalated at the September 2025 Committee meeting.
    - Deteriorating Child – escalated at the October 2025 Committee meeting.
    - Ophthalmology – stepped down from monthly to bi-monthly updates at the February 2026 Committee meeting.
    - Emergency Department - stepped down from monthly to bi-monthly updates at the November 2025 Committee meeting.
    - Cardiothoracic – de-escalated from Board Oversight Group to Executive Improvement Group.
    - NECTAR - de-escalated to business as usual at the November 2025 Committee meeting.
- Well Led Progress Update;
- Cardiac Oversight Group;
- New and emerging risks;
- Patient and Staff Experience update;
- Updates from the Executive Director of Nursing, Joint Medical Directors, Managing Director/Deputy CEO, ICB and Committee Chair;
- Maternity Updates / Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress (CNST) and Midwifery Staffing;
- Wards of concern & Accrediting Excellence (ACE) Progress Report;
- Quality and Safety Peer Reviews; and
- Board Assurance Framework review.

ii. Quarterly, Biannual and Annual Reports

The following Quarterly and Annual reports were received by the Committee during 2025/26:

- Safeguarding and Mental Capacity Act;
- Learning Disability;
- Legal Cases and Learning from Claims Update;
- Mortality and Learning from Deaths;
- End of Life and Palliative Care Bi-Annual Report;
- Clinical Audits/Guidelines Report;
- Quality Committee Internal Audit Report;
- Serious Incident Close Out Assurance Report;
- Patient Safety Incident Response Framework (PSIRF) Priorities e.g. internal referrals and updates;
- Quality Oversight Group Terms of Reference (which were approved);

- Audiology updates;
- Allied Health Professionals (AHP) update;
- Duty of Candour, including a deep dive;
- National Patient Safety Strategy & Patient Safety Incident Response Framework update;
- Call for Concern (Marthas Rule);
- Health Inequalities;
- Annual Report of the Quality Committee;
- Nurse Staffing Deep Dive/Six monthly reports;
- Getting it Right First Time (GIRFT) Update Report;
- Equality Quality Impact Assessment (EQIA) Update;
- Quality Account Bi-Annual Report / Quality Priorities updates; and
- Infection Prevention and Control Bi-Annual update.

iii. Ad-Hoc Reports

In addition to those reports listed above, a number of ad-hoc reports have been received by the Committee. These included:

- Cancer and Non-cancer Patient Harm Reviews;
- Performance;
- Internal Audit Reports – all included in the Admin Control Reading Room;
- Mortuary Privacy and Dignity update;
- Dental Hospital update;
- Breast Services update;
- Gynaecology Services Report
- Eden Court / Intermediate Care update;
- Food Provision and Nutrition and Hydration;
- Patient Identity Check Audit;
- Waiting List Management;
- 7-day Services Audit Report;
- Transplantation Strategy;
- Care planning and Care Optimisation;
- Research and Development Overview Report;
- World Health Organisation (WHO) Surgical Safety Checklist to NATSSIPS2 (National Safety Standards for Invasive Procedures);
- PLACE Inspection Update Report;
- Celebrating Excellence reports;
- Clinical Board Quality & Safety Escalation Report; and
- Quality Oversight Group monitoring and evaluation report.

6. GOVERNANCE, INTERNAL CONTROL AND RISK MANAGEMENT

The Committee developed a revised Schedule of Business during 2025/26 and utilised a rolling programme and action log to track committee actions.

As highlighted in Section 5(ii), the Committee received regular updates on risks recorded on the Board Assurance Framework (BAF) which related to the Committee's area of focus. One risk was recorded on the BAF during 2025/26 relating to the Committee in relation to the inability to maintain and improve the quality of care (safety, experience and quality) for our patients. There were 8 threats identified in relation to the risk and the Committee received a detailed report regarding the risk and threats.

The Committee received regular updates on the mitigating actions in relation to the risk above and sought assurance that the risk was being managed effectively.

7. PROGRESS FOR 2025/26 & REVIEW OF EFFECTIVENESS

In the prior year Committee Annual Report, the following area was identified to progress in 2025/26 – updates are shown in italic text below:

- Meeting attendees – review of meeting attendance to ensure best use of time. *This was completed prior to April 2025.*
- Meeting papers – continued work to ensure meeting papers are succinct and clear. *Papers are continuously reviewed and feedback provided if any additions/changes are required.*
- Meeting agendas/time management – continuing focus on ensuring meeting agendas are aligned to risks and do not become overburdened. *Work continues to ensure comprehensive updates are received in a timely manner to allow sufficient time for questions.*

An annual effectiveness survey was circulated to Committee members. Feedback was received from 6 Quality Committee members, which highlighted the following:

- Responses were largely positive. Most respondents agreed or strongly agreed (as a minimum 4 from 6) that:
    - The Committee has a clearly defined role, purpose and objectives (as set out in its Terms of Reference).
    - The meeting is well managed in terms of scheduling, agenda setting and time management.
    - The skill mix and number of people who attend the Committee is appropriate.
    - The purpose of papers being presented is made clear by the author, with actions, issues and assurances clearly defined.
    - Committee members actively participate and make relevant contributions to discussions.
    - The cross-representation of members at Committee meetings enhances the quality and reliability of decisions.
    - There is no unnecessary duplication between Committees.
    - The frequency of the meetings enables business to be conducted effectively.
    - The Chair clearly captures decisions and actions arising throughout the committee meetings.
    - The Chair clearly captures the decision-making process and ensures it is understood by Committee members.
    - It is clear when the Committee needs to escalate matters for the attention of the Board or to another Committee.

- The Committee Chair effectively addresses conflicts, concerns or issues and manages time allocated to allow discussion on key items.
- The Committee Chair encourages participation from newer / less experienced members.
- Committee members and meeting attendees are actively engaged and focussed on the reports under discussion.
- The Committee effectively considers and weighs the potential risks and benefits associated with the decisions made.
- The Committee members are given the opportunity to provide input and contribute to the decision making process.
- The style and quality of meeting papers is appropriate for the meeting.
- Meeting papers are succinct and set out the key issues, assurances and any gaps in assurances.
- The Committee values and considers diverse perspectives and opinions when making decisions.
- The Committee's decision making process is clear, transparent and inclusive.
- The Committee ensures that processes are in place to create robust action plans with clear ownership, timeframes, and dependencies all of which are monitored and followed up.
- The Committee receives assurance that identified actions are completed in line with agreed timescales.
- Decisions are based on and related to the evidence presented to the Committee.
- Record keeping is prompt and accurate. It is useful in future meetings.
- The Committee's goals, objectives and activities are clearly aligned with the Trust's vision and strategy.
- The Committee's meetings and agendas are focussed on addressing priorities aligned with the Trust's vision and strategy.
- The Committee's decision-making process reflects the Trust's vision and strategy.
- The Committee effectively fosters a culture and environment that supports the pursuit of the Committee's vision and strategy.
- The Committee is actively engaged in discussions and decision-making processes that contribute to the realisation of the Trust's vision and strategy.
- The Committee is effective in communicating and reporting on risks, issues and performance, and escalating these where necessary.
- Where information or risks need to be discussed in more than one committee, there is effective escalation between Committee.
- The Chair provides adequate support and guidance in managing risks, issues and performance.
- Committee members actively discuss the strategic risks in the BAF that are within the remit of the Committee.

- One respondent highlighted to support efficient discussion, papers can be taken as read, with presenters highlighting any exceptions or areas that require particular attention.
- A further respondent noted that it may be helpful to review the content of reports presented to the Committee to ensure they align with and support the principles of Triple A Reporting.

- One respondent highlighted that the Committee operates effectively and benefits from wide engagement. Continued progress could be supported by strengthening links with Tier 2 committees and ensuring papers are concise while still containing the required information.

8. NEXT STEPS AND ACTIONS FOR 2026/27

As identified in the survey, the key areas of focus for 2026/27 are:

- Committee papers – to ensure they are aligned with the Triple A Reports and key areas, assurance and recommendations are highlighted within the cover sheet.
- Tier 2 Committees/Groups – continue progress in strengthening links and the Committee receiving the correct assurance/escalations in the updates.

The Terms of Reference and Schedule of Business for the Committee have been reviewed and minor changes agreed at the Committee and the Trust Board in March 2026. In summary the changes were:

- The Terms of Reference were streamlined to enhance clarity, remove duplication and reflect the Committee's current responsibilities and reporting arrangements;
- Updated report leads and authors;
- The change from holding a December meeting to an August meeting; and
- Updated report scheduling.

Report of Lauren Thompson
Corporate Governance Manager/Deputy Trust Secretary
24 April 2026

PEOPLE COMMITTEE ANNUAL REPORT 2025/26

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the People Committee has met its key responsibilities for 2025/26, in line with its Terms of Reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

The Terms of Reference and Schedule of Business for the Committee have been reviewed and changes were agreed at the Committee and Board meetings in March 2026.

2. COMMITTEE RESPONSIBILITIES

The People Committee is a non-statutory Committee constituted as a standing committee of the Trust Board of Directors.

During 2025/26 the purpose and function of the Committee was to gain assurance, on behalf of the Board of Directors, on the development and review of the Trust's People Plan and related workforce strategies to achieve it. The main duties being to:

- Receive regular reports to scrutinise the delivery of the People Plan and related people priorities.
- Review 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.
- Review 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.
- Receive reports to review performance against key people performance indicators.
- Monitor staff experience through staff surveys, pulse surveys and the performance dashboard from the Freedom to Speak Up Guardian.
- Review 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.
- Provide 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.
- Review workforce related Internal and External Audit reports/findings and the implementation of any associated audit recommendations.
- Monitor Trust compliance against legislative and other regulatory workforce requirements including the NHS People Promise.

- Review 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.
- Provide oversight of the process and progress being made on staff disciplinary and grievances.

It does this through the receipt of assurances from management, the receipt of regular reports relating to areas which impact Trust staff and the People Plan, and discussions and reports on the management of risks relating to the Committee's area of focus.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of at least six members (as specified in the Terms of Reference), drawn from the Non-Executive Directors and members of the Executive Team.

The Committee's quorum is four members, with at least two Non-Executive Directors present.

During 2025/26 meetings were held bi-monthly. 6 ordinary meetings were held between 1 April 2025 and 31 March 2026.

Attendance at the meetings was as follows:

	Attendance at ordinary meetings
Bernie McCardle, Non-Executive Director (NED) and Committee Chair	5 out of 6
Liz Bromley, NED	3 out of 6
Wendy Balmain, NED	6 out of 6
Vicky McFarlane-Reid, Director for Commercial Development and Innovation (role title changed during the year to Executive Director of People and Commercial Innovation)	5 out of 6
Ian Joy, Executive Director of Nursing, Midwifery and AHPs	5 out of 6
Lucia Pareja-Cebrian / Michael Wright, Joint Medical Directors	5 out of 6
Caroline Docking, Director of Communications and Corporate Affairs	3 out of 6
Annie Laverty, Chief Experience Officer (until December 2025)	3 out of 4
Amy Callow, Associate Director of People and Organisational Development and Committee member from September 2026 (role title changed during the year to Director of People and Organisational Development)	4 out of 4
Donna Watson, Acting Associate Director of People & Organisational Development (until July 2025)	2 out of 2

Other attendees at meetings have included Acting Chief Executive Officer, Executive Team members, Senior HR team members, the Guardian of Safe Working, the Freedom to Speak Up Guardians, the Chair, an Associate NED, the Director and Deputy Director of Medical

Education, Directors of Operations, Associate Directors of Operations, Heads of Nursing, Assistant Director - Business Strategy & Planning, Improvement Programme Manager and the Corporate Governance Manager/Deputy Trust Secretary as Secretariat Support.

Public Governors Judy Carrick, Peter Bower, Catherine Heslop, Chris Record and Sue Brown observed Committee meetings during the year.

4. REPORTING

i) Regular Reports

Over the course of the year, Committee members received regular reports/updates on:

- The Trust People Strategy/Plan/Priorities:
  - Health and Wellbeing;
  - Leadership and Management;
  - Valued and Heard;
- The Behaviours and Civility Charter;
- An Equality, Diversity and Inclusion (EDI) update;
- Summary of Internal Audit reports relating to the People Committee;
- The People Committee Board Assurance Framework Report;
- The Guardian of Safe Working Hours Quarterly Reports and Annual Report (prior to receipt at the Board of Directors);
- The NHS Staff survey, staff engagement and culture plans/updates;
- Integrated Board Report (IBR) e.g. Statutory and Mandatory Training, Appraisal Compliance, and Education and Training Update;
- Communications;
- Legal Cases/Employee Relations;
- Job Planning update; and
- Freedom to speak up Guardian (FTSUG) reports (bi-annual).

ii) Annual Reports

The following Annual Reports were received by the Committee:

- Workplace Race Equality Standard (WRES) and Workplace Disability Equality Standard (WDES) Data and Action Plan (prior to approval at Trust Board);
- Gender Pay Report;
- Trade Union Faculty Time Report; and
- Annual Report of the Committee, Committee Terms of Reference and Schedule of Business.

iii) Ad-Hoc Reports

In addition to those reports listed above, a number of reports were received by the Committee. These included:

- Violence and Aggression to staff update;
- Leadership Development, Talent and Succession planning;

- People learning and development update including apprenticeships and Newcastle Skills Academy;
- NHS EDI Improvement Plan;
- National Workforce Plan;
- Clinical Board updates;
- Workforce Age Profile and Demographics update;
- Real Living Wage (RLW); and
- Care Quality Commission (CQC) – People updates.

The Committee also received the Chairs Logs and minutes of the Learning and Education Group, the Health and Wellbeing Steering Group, and the EDI Steering Group until July 2025; and from July 2025 the People Programme Board as a standing item.

A further review of the People Committee Terms of Reference and Schedule of Business was undertaken to ensure consistency and alignment following the establishment of the People Programme Board. Both documents were approved at the July 2025 Committee meeting.

5. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2025/26 and utilised a rolling programme and action log to track committee actions.

As highlighted in Section 4(i), the Committee receives regular updates on risks recorded on the BAF which related to the Committee's area of focus. During 2025/26, the three risks included in the BAF and regularly discussed at the Committee were:

- Risk ID 2.1 - Failure to improve and maintain an organisational culture, in line with our Trust values and our People Plan.
- Risk ID 2.2 – Failure to effectively manage organisational change and related leadership and governance required to ensure effective supporting structures with the new Trust operating model.
- Risk ID 2.3 – Failure to deliver effective workforce planning to allow the Trust to forecast and adapt to changing NHS healthcare landscape, financial constraints and address staff shortages and retention.

The Committee received regular updates on mitigations in place and discussed the threats identified which might cause the principal risks to materialise if not mitigated against.

In addition, at the end of every meeting debriefs are held and matters for escalation to the Trust Board agreed (and captured within the meeting minutes).

6. PROGRESS FOR 2025/26 & REVIEW OF EFFECTIVENESS

In the Annual Report of the Committee for 2024/25, five areas were identified as for action during 2025/26, with progress updates highlighted in italic font:

- Membership, attendance and encouraging contributions from those present. *The Chair actively encourages members/attendees to contribute and there is sufficient time for questions during each meeting.*
- Continuing to ensure all meeting papers have succinct Executive summaries, clear recommendations, issues and decisions. *A significant amount of work has taken place to ensure the key areas, assurance and recommendations are including on the cover sheets. Further work is taking place to ensure the papers link to the Triple A reporting.*
- Refinement of the People dashboard. *Work has taken place to refine the People Dashboard and incorporate into the Integrated Board Report (IBR).*
- Reducing duplication across/improving triangulating with Committees as appropriate. *Any cross referrals are picked up through the Chairs Log/Triple A report.*
- Enhancing reporting on priority areas: workforce planning, FTSU, EDI, Leadership and OD. *The Schedule of Business was updated in July 2025 to ensure these areas were captured / regularly reported.*

An annual effectiveness survey was circulated to Committee members. Feedback was received from 4 People Committee members, which highlighted the following:

- Responses were largely positive. Most respondents agreed or strongly agreed (as a minimum 4 from 5) that:
  - The Committee has a clearly defined role, purpose and objectives (as set out in its Terms of Reference).
  - The meeting is well managed in terms of scheduling, agenda setting and time management.
  - The skill mix and number of people who attend is appropriate.
  - The purpose of papers being presented is made clear by the author, with actions, issues and assurances clearly defined.
  - Committee members actively participate and make relevant contributions to discussions.
  - The cross-representation of members at Committee meetings enhances the quality and reliability of decisions.
  - There is no unnecessary duplication between Committees.
  - The frequency of the meetings enables business to be conducted effectively.
  - The Chair clearly captures decisions and actions arising throughout the committee meetings.
  - The Chair clearly captures the decision-making process and ensures it is understood by Committee members.
  - It is clear when the Committee needs to escalate matters for the attention of the Board or to another Committee.
  - The Committee Chair effectively addresses conflicts, concerns or issues that arise within the Committee.
  - The Committee Chair effectively manages time allocated to allow discussion on key items and encourages participation from newer / less experienced members.
  - Committee members and meeting attendees are actively engaged and focussed on the reports under discussion.
  - The Committee effectively considers and weighs the potential risks and benefits associated with the decisions made.

- The Committee members are given the opportunity to provide input and contribute to the decision-making process.
- The style and quality of meeting papers is appropriate for the meeting.
- Meeting papers are succinct and set out the key issues, assurances and any gaps in assurances.
- The Committee values and considers diverse perspectives and opinions when making decisions.
- The Committee's decision-making process is clear, transparent and inclusive.
- The Committee ensures that processes are in place to create robust action plans with clear ownership, timeframes, and dependencies all of which are monitored and followed up.
- The Committee receives assurance that identified actions are completed in line with agreed timescales.
- Decisions are based on and related to the evidence presented to the Committee.
- Record keeping is prompt and accurate.
- The Committee's goals, objectives and activities are clearly aligned with the Trust's vision and strategy.
- Committee's meetings and agendas are focussed on addressing priorities aligned with the Trust's vision and strategy.
- The Committee's decision-making process reflects the Trust's vision and strategy.
- The Committee effectively fosters a culture and environment that supports the pursuit of the Committee's vision and strategy.
- The Committee is actively engaged in discussions and decision-making processes that contribute to the realisation of the Trust's vision and strategy.
- The Committee is effective in communicating and reporting on risks, issues and performance, and escalating these where necessary.
- Where information or risks need to be discussed in more than one committee, there is effective escalation between committees.
- The Chair provides adequate support and guidance in managing risks, issues and performance.
- Committee members actively discuss the strategic risks in the BAF that are within the remit of the Committee.

- There was one statement where one respondent included 'disagree' being:
  - The Committee Chair effectively manages time allocated to allow discussion on key items.

- Additional feedback comments were included which covered:
  - One respondent noted that consideration was often given to process and classification, though there was an opportunity to place greater emphasis on effective discussion and constructive challenge to strengthen decision-making.
  - A further respondent highlighted the need to review Clinical Board membership.
  - One respondent referred to the ongoing development of the Trust Strategy which would help strengthen the effectiveness of the Committee, supported by the use of Triple A Reporting.
  - One respondent noted that there had been a noticeable improvement in papers, which were now shorter and supported by clearer executive summaries however some papers would benefit from further development. The move to a

smaller executive-level core membership was referenced to have positively strengthened discussion and decision-making at the Committee.

7. NEXT STEPS AND ACTIONS FOR 2026/27

The Committee has worked effectively during the year, and the survey findings have identified the following key focus areas for 2026/27 to further strengthen the Committee:

- To review Clinical Board membership. *Please note that the Interim Executive Director of Operations has now been added as a Committee member.*
- Committee papers – to ensure cover sheets/executive summaries are clear and highlight key points, assurance and recommendations. *The Trust Secretary has shared a 'hints and tips' guidance document for writing Executive Summaries with Executive Team members to assist with this (for onward cascade through teams).*
- Refocus meeting agendas around the new strategic objectives. *This will be undertaken following approval of the new Trust Strategy at the Board meeting on 30 April.*

The Terms of Reference and Schedule of Business for the Committee have been reviewed and minor changes were agreed at the Committee and the Trust Board in March 2026. In summary the changes were:

- Updated report leads and authors;
- Updated reports/agenda items; and
- Updated report scheduling.

Report of Lauren Thompson
Corporate Governance Manager/Deputy Trust Secretary
24 April 2026

FINANCE AND PERFORMANCE COMMITTEE ANNUAL REPORT 2025-2026

1. PURPOSE

The purpose of this report is to provide assurance to the Trust Board that the Finance and Performance Committee has met its key responsibilities for 2025/26, in line with its Terms of Reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. COMMITTEE RESPONSIBILITIES

The Finance and Performance Committee is a non-statutory Committee established by the Trust Board of Directors to provide assurance to the Board on the delivery of the financial aspects of the Trust's annual Operational Plan, including financial strategy and planning, transformation and sustainability, the financial performance of the Trust, and on commercial and procurement activity including strategic investments.

The purpose and function of the Committee is to gain assurance, on behalf of the Board of Directors, that:

- The strategic financial priorities, risk and performance considerations are aligned and support the Trust's strategic objectives and its long-term sustainability;
- There is effective management of financial risk, and any potential to compromise the achievement of the strategic objectives is being mitigated against;
- 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;
- The Trust's resources and assets are being used and maintained effectively and efficiently;
- Financial management and planning information is robust, credible and high quality, and that such information is reviewed and triangulated by the Committee;
- The Trust complies with current statutory and external reporting standards and requirements, including NHS and Treasury policies and procedures;
- The Trust's capital investment programme is fully developed, effectively managed and delivered, and that it is fit for purpose;
- Mitigations and action plans as set out in the Board Assurance Framework specific to the Committee purpose and function are effective;
- Procurement strategies, decision-making and documentation is robust; and
- The procedure for managing investments is fit for purpose and Committee associated strategies are developed and delivered.

It does this through the receipt of assurances from management groups in the form of updates from Executive Team members and receipt of Triple A reports, chairs logs/minutes from management groups such as the Capital Management Group, the Supplies and Services Procurement Group, the Financial Recovery Steering Group, the Sustainable Healthcare Committee and the Access & Improvement Delivery Group. In addition, the

Committee receives regular reports relating to areas which impact the financial position of the Trust, performance areas of focus and considers reports on the management of risks relating to the Committee's remit.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board of Directors and consists of a minimum of six members, drawn from the Non-Executive Directors and members of the Executive Team.

The Committee's quorum is four members and include the Chair or Vice-Chair and at least one other Non-Executive Director.

Eleven meetings were held between 1 April 2025 and 31 March 2026 and one extraordinary meeting in August 2025. The extraordinary meeting was held to discuss the financial position, the Voluntary Severance Scheme (VSS), the Private Finance Initiative (PFI) Commercial Strategy and the Capital Programme.

The attendance during the year was as follows:

	Attendance at ordinary meetings	Attendance at extraordinary meeting
Bill MacLeod, Non-Executive Director (NED) and Committee Chair	11 out of 11	1 out of 1
Bernie McCardle, NED	10 out of 11	1 out of 1
Hassan Kajee, NED	10 out of 11	1 out of 1
Jackie Bilcliff, Chief Finance Officer/Acting Deputy Chief Executive	11 out of 11	1 out of 1
Paul Hanson, Director of Estates, Facilities and Strategic Partnerships – Committee member from February 2025	8 out of 11	1 out of 1
Vicky McFarlane-Reid, Executive Director of People and Commercial Innovation	10 out of 11	1 out of 1
Dave Elliott, Chief Digital Officer (from May 2025)	1 out of 10	0 out of 1
Shauna McMahon, Chief Information Officer (until April 2025)	1 out of 1	0 out of 0

The Committee met for the minimum number of ten meetings per year and other attendees at the meetings have included the Acting Chief Executive Officer, other Executive Team members, the Chair, an Associate Non-Executive Director; a NED from Northumbria Healthcare Foundation Trust, the Procurement and Supply Chain Director, Deputy Directors, Associate Directors, Assistant Directors and Heads of Services, Senior Performance Managers, Clinical Board Chairs, Directors of Operations and Finance Managers, the Trust Secretary and the Corporate Governance Manager/Deputy Trust Secretary who provided Secretariat Support to the Committee.

Throughout the year Public Governors Eric Valentine, Philip Home, and Hugh McKendrick and Staff Governor, David Bull observed meetings of the Finance and Performance Committee.

4. REPORTING & AREAS OF REVIEW

During the year, the Committee:

- Received, and constructively challenged the content of the regular reports on the Trust financial position and Cost Improvement Programme (CIP).
- Discussed:
  - The 2025/26 Finance and Activity Planning submission.
  - Subsidiary Company options.
  - CIP schemes – equality and quality impact assessments.
  - Data Partnerships.
  - Planning guidance for 2026/27 and the financial and activity plans which were approved.
  - The Financial Plan and Budgets for 2026/27 which were approved.
- Received regular finance and performance reports, and the Annual Report of the Committee.
- Deep dives into key areas of performance e.g. Cancer and Diagnostics, Emergency Care, Elective Waits, Children & Young People Key Performance Indicators (KPIs) and reporting turnaround times for Cancer Pathways.
- Sought assurance over the financial and performance management arrangements regarding:
  - The Medium Term Plan;
  - The Capital Plan;
  - The Winter Plan;
  - The Integrated Care Board (ICB) external review of Financial and Workforce controls;
  - Development of the Financial and Activity Plans for 2025/26; and
  - The Commercial Strategy.
- Finance and Performance Clinical Board deep dives (Clinical Boards present once a year on rotation).
- A Sustainability update including the SHINE Annual Report.
- Updates on the Job Planning policy and process.
- Considered the Newcastle Hospitals Pharma Services Limited Business Plan.
- Sought and received regular updates from the Procurement and Supply Chain Director regarding the Procurement Plan, the Provider Selection Regime and the new Procurement Act 2023.
- Updates on Commercial Schemes/Activity and the Intellectual Property (IP) policy.
- Discussed and ratified the Board Assurance Framework (BAF).
- Approved tenders, investments and business cases (BC) in accordance with the delegated authority of the Committee e.g. the Public Sector Decarbonisation Scheme Funding and the Sir Bobby Robson Institute construction.
- Approved the Terms of Reference for the Capital Management Group, the Sustainable Healthcare Committee, the Access and Improvement Delivery Group and Cash Group.
- Endorsed the Annual National Cost Collection Exercise.

- Received an update on business cases not approved and utilisation of the Community Diagnostic Centre (CDC).
- Updates on the Voluntary Severance Scheme (VSS) and Mutually Agreed Resignation Scheme (MARS).
- Received a report on Internal Audits relating to the Committee.

5. GOVERNANCE, INTERNAL CONTROL AND RISK MANGEMENT

The Committee had a Schedule of Business for 2025/26 and utilised a rolling programme and action log to track committee actions.

The Committee received regular updates on risks recorded on the Board Assurance Framework which relate to the Committee's area of focus. There were three risks recorded on the BAF during 2025/26 relating to the Committee being:

- Risk ID 6.1 - Failure to manage our finances effectively to improve our underlying deficit and deliver long-term financial sustainability.
- Risk ID 6.2 - Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care.
- Risk ID 5.1 - Failure to maintain the standard of the Trust estate, environment, and infrastructure could result in a disruption to clinical activities and impact on the quality of care delivered.

An annual effectiveness survey was circulated to Committee members. Feedback was received from 4 Finance and Performance Committee members, which highlighted the following:

- Responses were largely positive. Most respondents agreed or strongly agreed (as a minimum 3 from 4) that:
    - The Committee has a clearly defined role, purpose and objectives (as set out in its Terms of Reference).
    - The meeting is well managed in terms of scheduling, agenda setting and time management.
    - The skill mix and number of people who attend the Committee is appropriate.
    - The purpose of papers being presented is made clear by the author, with actions, issues and assurances clearly defined.
    - Committee members actively participate and make relevant contributions to discussions.
    - The cross-representation of members at Committee meetings enhances the quality and reliability of decisions.
    - There is no unnecessary duplication between Committees.
    - The frequency of the meetings enables business to be conducted effectively.
    - The Chair clearly captures decisions and actions arising throughout the committee meetings.
    - The Chair clearly captures the decision-making process and ensures it is understood by Committee members.
    - It is clear when the Committee needs to escalate matters for the attention of the Board or to another Committee.

- The Committee Chair effectively addresses conflicts, concerns or issues and manages time allocated to allow discussion on key items.
- The Committee Chair encourages participation from newer / less experienced members.
- Committee members and meeting attendees are actively engaged and focussed on the reports under discussion.
- The Committee effectively considers and weighs the potential risks and benefits associated with the decisions made.
- The Committee members are given the opportunity to provide input and contribute to the decision making process.
- The style and quality of meeting papers is appropriate for the meeting.
- Meeting papers are succinct and set out the key issues, assurances and any gaps in assurances.
- The Committee values and considers diverse perspectives and opinions when making decisions.
- The Committee's decision making process is clear, transparent and inclusive.
- The Committee ensures that processes are in place to create robust action plans with clear ownership, timeframes, and dependencies all of which are monitored and followed up.
- The Committee receives assurance that identified actions are completed in line with agreed timescales.
- Decisions are based on and related to the evidence presented to the Committee.
- Record keeping is prompt and accurate. It is useful in future meetings.
- The Committee's goals, objectives and activities are clearly aligned with the Trust's vision and strategy.
- The Committee's meetings and agendas are focussed on addressing priorities aligned with the Trust's vision and strategy.
- The Committee's decision-making process reflects the Trust's vision and strategy.
- The Committee effectively fosters a culture and environment that supports the pursuit of the Committee's vision and strategy.
- The Committee is actively engaged in discussions and decision-making processes that contribute to the realisation of the Trust's vision and strategy.
- The Committee is effective in communicating and reporting on risks, issues and performance, and escalating these where necessary.
- Where information or risks need to be discussed in more than one committee, there is effective escalation between Committee.
- The Chair provides adequate support and guidance in managing risks, issues and performance.
- Committee members actively discuss the strategic risks in the BAF that are within the remit of the Committee.

- There was one statement where one respondent included 'disagree' being:
  - The Committee is actively engaged in discussions and decision-making processes that contribute to the realisation of the Trust's vision and strategy.
- Additional feedback comments were included which covered:
  - One respondent noted that the development of the new Trust Strategy and Medium Term Financial Plan offers a timely opportunity to strengthen

programme management, ensuring delivery is focused on a small number of key priorities and underpinned by clear, outcome-focused metrics.

- A further respondent highlighted that there is an opportunity to streamline finance and Clinical Board papers to focus on key issues, improve consistency across Clinical Boards, and create more space for robust challenge on performance, including service reviews, opportunities for Alliance working, and decisions about what should change or stop.
- A further comment was included which referenced that Committee papers have improved however there remains further scope to reduce their length. While Clinical Board representatives are appropriately present for their items, there may be an opportunity to encourage broader participation from other representatives, who currently tend to adopt more of an observing role, to support richer discussion and challenge.

6. MANAGEMENT

The Committee has challenged the assurance process when appropriate and has requested and received assurance reports/verbal updates from Trust management throughout the year.

7. PROGRESS FOR 2025/26 & REVIEW OF EFFECTIVENESS

In the prior year Committee Annual Report, the following areas were identified to progress in 2025/26 – updates are shown in italic text below:

- Corporate Governance Team to review Committee meeting agendas collectively to ensure duplication is limited/eradicated. *Work carried out to reduce duplication.*
- Committee membership to be reviewed to ensure skill mix is sufficient for the purpose of the Committee. *Committee membership reviewed and the correct skill mix of membership/attendees attend each Committee meeting.*
- Attendees to be revisited to ensure best use of people's time. *Committee attendees attend for their items only or are the one representative attending for their Clinical Board.*
- Continued development of Committee meeting papers in terms of succinctness and clarity. *A significant amount of work has taken place to ensure cover sheets/executive summaries highlighted key points, assurance, recommendations and are linked to the Triple A reporting.*

8. NEXT STEPS AND ACTIONS FOR 2026/27

The survey results have identified the following areas of focus for 2026/27:

- Committee papers – to streamline and ensure they are aligned with the Triple A Reports and key areas, assurance and recommendations are highlighted within the cover sheet. This is an area of continued focus. Guidance has been circulated to report

authors regarding the completion of Triple A reports and in producing effective Executive summaries within reports.

- Attendee input – to ensure attendees, particularly Clinical Board representatives participate during relevant agenda items.
- That decision-making processes contribute to the realisation of the Trust's new vision and strategy. The cover sheet template will be updated to align to the new strategy.

The Terms of Reference and Schedule of Business for the Committee have been reviewed and minor changes agreed at the Committee and the Trust Board in March 2026. In summary the changes were:

- The Terms of Reference were streamlined to enhance clarity, remove duplication and reflect the Committee's current responsibilities and reporting arrangements;
- Updated report leads and authors;
- The change from holding a December meeting to an August meeting; and
- Updated report scheduling.

Report of Lauren Thompson
Corporate Governance Manager/Deputy Trust Secretary
24 April 2026

DRAFT TERMS OF REFERENCE – CHARITY COMMITTEE

1. CONSTITUTION OF THE COMMITTEE

The Charity Committee is a statutory Committee established by the Board of Directors of The Newcastle upon Tyne Hospitals NHS Foundation Trust (the Board) to manage, on behalf of the Board, the governance and decision making / recommendations relating to the charitable funds of Newcastle Hospitals Charity, reflecting the requirements and regulations of the Department of Health and Social Care and the Charity Commission for England and Wales.

2. PURPOSE AND FUNCTION

2.1 The Committee does not diminish in any respect the overall responsibility of the Board of Directors in terms of Corporate Trusteeship and accountability, and the Charity Committee is responsible for scrutiny and providing assurance to the Trust Board on key issues delegated to them by the Board.

2.2 Agendas are set to enable the Board in its capacity as Corporate Trustee of the charity to be assured that robust processes are in place to enable statutory duties to be discharged, to enable the Trust and Charity's strategic objectives to be met and to address and mitigate risk.

2.3 The purpose and function of the Committee is to:

2.3.1 ensure that there is a robust process in place to consider charity strategy; governance and effective operations; and the application of charity funds in accordance with their respective governing documents. To ensure that funds are used in accordance with the charity's objectives (see Appendix 1) – all with the budget, priorities and spending criteria consistent with the responsibilities of Trustees as defined in the Charities Act 2022 and the Charities (Protection and Social Investment) Act 2016 (the 'PSI Act 2016');

2.3.2 provide oversight to ensure that charity funds are managed in accordance with statutory requirements of the Charity Commission, Department of Health & Social Care guidance and the relevant Standing Orders of the Trust, Reservation of Powers to the Board and Delegation of Powers, the Scheme of Delegation and Standing Financial Instructions; and

2.3.3 make decisions, on behalf of the Corporate Trustee, involving the sound investment of charity funds in line with the approved investment strategy and ensures compliance with the Charities Act 2022, the PSI Act 2016 and Charity Commission regulations.

3. AUTHORITY

The Committee is:

3.1 a Committee of the Board, reporting directly to the Board, and has no executive powers, other than those specifically delegated in these Terms of Reference;

3.2 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;

3.3 authorised by the Board 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 Chair of the Committee, Executive Lead of the Committee, Charity Director and / or the Trust Secretary).

3.4 In line with the Trust's Standard Financial Instruction's, the Chief Finance Officer has prime responsibility for:

- treasury management and Trust banking services;
- cash management;
- investment strategy of the Charity, and oversight of Charity investments;
- overall accountability for the Charity Annual Accounts;
- ensuring all receipts relating to the Charity are credited to the proper accounts.

3.5 The Chief Finance Officer has prime responsibility for the Trust's Charitable Funds with the specific powers, duties and responsibilities delegated to a member of the Executive Team:

to adopt and ensure a professional approach to the administration of all charity funds;

- line management of the Charity Director.

3.6 The specific duties and responsibilities delegated to the Charity Director are:

- provision of policy, process and guidelines, and ensure the appropriate treatment of, donations, legacies and bequests, fundraising and trading income;
- set and deliver Charity income projections;
- preparation of the Charity Annual Report and Accounts;
- provision of secure and appropriate receipting arrangements for donations, legacies and bequests;
- where necessary, obtain grant of probate, or make application for grant of letters of administration, where this organisation is the beneficiary;
- be empowered, on behalf of this organisation, to negotiate arrangements regarding the administration of a will with executors and to discharge them from their duty;
- lead and manage all arrangements for professional standards of fund-raising; and
- preparation of reports to the Board including the Charity annual review.

3.7 Under Chairs Action, the Chair can sanction up to £30k of funding. Over this amount and where approval is sought for funding outwith Charity Committee meeting due to extraordinary circumstances (e.g. to meet a particular deadline or opportunity), the proposal is discussed either in person or electronically between the Chair, Vice Chair, Charity Director, Executive Lead for the Charity and Chief Finance Officer before a final decision is made.

4. MEMBERSHIP AND QUORUM

Membership

4.1 Members of the Committee will be appointed by the Board and will be made up of at least five members of the Board.

4.2 The Committee's membership will comprise at minimum:

- three Non-Executive Directors;
- A Joint Medical Director;
- the Executive Director of Nursing, Midwifery and Allied Health Professionals (AHP);
- the Chief Finance Officer and;
- the Director of Communications and Corporate Affairs;

4.3 A lay member can be appointed where a particular area of expertise strengthens the skillset of the Committee.

4.4 One of the Non-Executive members will be appointed by the Board as the Chair of the Committee.

4.5 A further Non-Executive member of the Committee shall be appointed as Vice-Chair, by the Charity Committee, then ratified by Trust Board.

4.6 A nominated Executive Director shall act as the Executive Lead for the Committee.

4.7 Members holding multiple titles will be referred to in the Terms of Reference by their primary title.

4.7 The Charity Director and the Charity Head of Finance will attend the Committee. 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.

4.8 The Chair of the Trust Board of Directors will not be a member of the Committee but may be in attendance.

4.9 Other than as specified above, only members of the Committee have the right to attend Committee meetings. Alternate, or substitute, members may be agreed in advance with the Chair for a specific meeting but not for more than one.

4.10 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.

4.11 Members are able to attend Committee meetings in person or virtually (e.g. by telephone or online). Members in attendance by these means will count towards the quorum.

4.12 All members of the Committee will receive an induction session and pack, to include the Charity Corporate Trustee Handbook; Charity Strategy; Annual Report; Impact reports and any other relevant information. An annual programme of training and development will be included in the schedule of business, as will regular briefings from regulatory bodies on a continuing basis to ensure their effectiveness as members, supported by the process of annual appraisal, as agreed by the Board.

4.13 The Council of Governors may nominate a governor to attend each meeting of the main Committee 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 confidential matters.

4.14 The Charity Operations Manager or designated deputy will act as the Committee Secretary.

4.15 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.

Quorum

4.15 The quorum necessary for the transaction of business will be three members, including the Chair or Vice Chair.

4.16 Members unable to attend a meeting of the Committee may nominate a deputy to attend on their behalf, agreed with the Chair of the Committee. Nominated deputies will not count towards the quorum.

4.17 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. DUTIES

5.1 Financial management and control

The Committee will:

5.1.1 ensure that a process is in place to review the arrangements for the registration of restricted funds with the Charity Commission and ensure that all -funds comply with the objects of the charity and the existing registrations reviewed and managed by the Charity Director and Charity Head of Finance;

5.1.2 ensure that all funds within the Charity umbrella are properly managed by the Head of Charity Finance through the implementation of sound financial controls in accordance with the Charity Commission regulations, the appropriate Standing Financial Instructions of the Trust, and meet the requirements of H.M. Revenue & Customs;

5.1.3 ensure that funds are effectively managed and utilised in accordance with the objects of the charity and where stipulated, purposes for which they are given by the donors;

5.1.4 agree banking arrangements;

5.1.5 provide assurance that the Charity Director has protocols in place for the receipt of all income due to the Charity, and ensure that the annual external audit reviews this;

5.1.6 provide assurance that all expenditure and grants are properly authorised and reviewed by the Charity Director and Head of Charity Finance through established procedures in accordance with delegated levels;

5.1.7 seek assurance that processes are in place for assets funded by the Charity to be recorded on the Trust asset log to ensure that the location of any assets purchased with Charity funds is known; and

5.1.8 ensure a process is in place for the Charity Director and Head of Charity Finance to review the usage of funds in accordance with their objects, and subsequently rationalise funds within the powers granted by the Charity Commission where the original objects have failed or are no longer relevant.

5.2 Strategy, Fundraising, Funding and Investments

The Committee will:

5.2.1 recommend an overall strategy for the Charity to the Trust Board; to be reviewed every 3-5 years, with the process to develop the strategy managed by the Charity Director;

5.2.2 recommend annual funding programmes aligned with Trust priorities (e.g. Capital Management Group requirements) as developed by the Charity Director, Head of Charity Finance and the Trust;

5.2.3 oversee the strategy for liaising with benefactors/donors with regard to potential sources of income and how it is applied;

5.2.4 establish and regularly review an investment strategy including the appointment of specialist advisors, to be led by the Head of Charity Finance every 3 years; and

5.2.5 agree recommendations from the Head of Charity Finance for the basis for apportioning of dividends/interest from investments and administrative charges.

5.3 Financial reporting

The Committee will:

5.3.1 review quarterly financial statements prepared by the Head of Charity Finance including Statement of Financial Activities and Balance Sheet: analysis of income; Investment reports; target spend and reserves; and schedule of all grants made in accordance with the Scheme of Delegation;

5.3.2 request/review any report on an ad-hoc basis, which the Committee feel is necessary;

5.3.3 ensure that the Charity Annual Report & Accounts are produced by the Charity Director and the Head of Charity Finance in accordance with the latest accountancy practice and policy as laid down by the Charity Commission for England and Wales; and

5.3.4 review the Charity Annual Report & Accounts prior to submission to the Trust Board for approval and adoption and subsequent circulation to the Charity Commission and other agencies (as required).

5.4 Governance, risk management and internal control

The Committee will:

5.4.1 agree and approve Audit (Internal/External) services provided to the Charity;

5.4.2 liaise with the Charity Commission on all matters affecting the governance of charitable funds and takes advice from supporting agencies (e.g. NHS Charities Together)) and appropriate legal advice where necessary;

5.4.3 The responsibility for reporting a serious event lies with the Charity Committee if they have delegated responsibility.

5.4.4 agree Terms of Reference for advisory committees to inform strategically important areas e.g. strategy development; Sir Bobby Robson Foundation. To consider the minutes of aforesaid meetings and review / approve recommendations. Maintain general oversight of these groups;

5.4.5 ensure that the Annual Return required by the Charity Commission in respect of all charitable funds held by the Charity is completed and submitted on time by the Charity Director;

5.4.6 confirm agreement of the overall structure of the Charity team and agree annual management and administrative charges levied by the Trust;

5.4.7 establish and monitor a risk register for the Charity, covering all potential areas of risk and agree controls aimed at mitigating such risks. To review/agree on an annual basis;

6. REPORTING AND ACCOUNTABILITY

6.1 The Committee Chair will report formally to the Board on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed.

6.2 The Terms of Reference will be reviewed by the Committee and approved by the Board annually.

6.3 The Committee will review its effectiveness and compliance with these Terms of Reference annually, and report the outcomes of this review to the Board.

7. COMMITTEE ADMINISTRATION

7.1 The Committee will:

- meet formally for a schedule of full Charity business a minimum of four times a year
- meet monthly (virtually) to consider funding proposals, funding proposals will not be considered at the main committee meetings.
- The annual meeting cycle will be set and diarised for the full 12 months, following a regular pattern identified by the Operations Manager by the end of quarter 2.

7.2 The Chair may at any time convene additional meetings of the Committee to consider business that requires urgent attention.

7.3 The formal meeting agenda will be set in advance by the Chair and Charity Director, 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.

7.4 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.

7.5 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.

7.6 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.

7.7 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.

7.8 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.

Procedural control statement:
Date approved: [May 2026 – TBC]
Approved by: Charity Committee and Trust Board
Review date: [May 2027 – TBC]

Charity Committee Draft Schedule of Business 2026/27

Committee / Group:	**Charity Committee**
Chair:	**Wendy Balmain**
Annual Cycle Covered:	**2026/27**

Item	Lead	Authors / contacts of the report	May-26	Sep-26	Nov-26	Feb-27	Notes
Standing Business Items							
Apologies for absence	Wendy Balmain	Amanda Waterfall	✓	✓	✓	✓	
Declaration of interests	Wendy Balmain	Amanda Waterfall	✓	✓	✓	✓	
Minutes and matters arising	Wendy Balmain	Teri Bayliss/Amanda Waterfall	✓	✓	✓	✓	
Action log	Wendy Balmain	Teri Bayliss/Amanda Waterfall	✓	✓	✓	✓	
Committee Triple A Report	Wendy Balmain	Amanda Waterfall	✓	✓	✓	✓	
Advisory Committee minutes: - Great North Children's Foundation - Sir Bobby Robson Foundation - Trust Board Meeting as a Corporate Trustee	Wendy Balmain	Teri Bayliss/Amanda Waterfall	✓	✓	✓	✓	
Charity Strategy & Governance							
Charity Director's Update	Teri Bayliss	Teri Bayliss	✓	✓	✓	✓	
Charity Risk Statement	Natalie Yeowart	Amanda Waterfall	✓	✓	✓	✓	
Committee Terms of Reference (ToR), Committee Review and Schedule of Business	Teri Bayliss	Amanda Waterfall				✓	Terms of Reference and Schedule of Business to be reviewed at February Charity Committee Meeting and March Trust Board. Annual Committee Review to be reviewed at May Charity Committee and July Trust Board.
Newcastle Hospitals Charity Annual Operating Plan and Key Performance Indicators (KPI's) 2026_27	Teri Bayliss	Amanda Waterfall	✓	✓	✓	✓	
Charity Commission Connected Charities Checklist	Teri Bayliss	Teri Bayliss/Amanda Waterfall			✓		Annual review for assurance
Policies and Procedures	Teri Bayliss	Teri Bayliss/Amanda Waterfall					As and when required
Impact Report	Teri Bayliss	Michelle Davies/Kelly Belmont	✓				
Sir Bobby Robson Institute (SBRI) Progress update	Teri Bayliss	Kate Bradley	✓	✓	✓	✓	
Charity Funding and Monitoring							
Funding Proposals for decision	Richard Haigh	Richard Haigh/Kelly Belmont					Additional funding meetings held monthly outside of full Committee meetings to consider proposals.
Summary of under £20k funding proposals agreed since last meeting	Richard Haigh	Teri Bayliss/Richard Haigh/Gordon Burns/Kelly Belmont					Additional funding meetings held monthly outside of full Committee meetings to consider proposals.

Bi-annual monitoring and evaluation of funded proposals	Richard Haigh	Richard Haigh/Fay Darville/Kelly Belmont			✓		
Quarterly Funding Variance Report	Richard Haigh	Richard Haigh/Fay Darville/Kelly Belmont					Included in monthly funding only meetings.

Item	Lead	Authors / contacts of the report	May-26	Sep - 26	Nov-26	Feb-27	Notes
Annual review of criteria and guidance	Teri Bayliss	Teri Bayliss/Richard Haigh	✓				Annually
Finance							
Finance Report - to include Statement of Financial Activities (SoFA), Target Spend Report, & Income Report	Gordon Burns	Gordon Burns	✓	✓	✓	✓	
Summary of Investment Performance/Investment Reports	Gordon Burns	Gordon Burns	✓	✓	✓	✓	
Annual Report and Accounts	Teri Bayliss	Gordon Burns/Michelle Davies		✓(Draft)	✓(Final)		Externally audited accounts reviewed by (1) Charity Committee; (2) Audit, Risk and Assurance Committee then (3) Corporate Trustee (Trust Board)
Investment Management Annual Update and Review	Teri Bayliss/Gordon Burns	Teri Bayliss/ Gordon Burns				✓	As and when required – good practice to re-tender every 3 years.
Investment Managers to attend Charity Committee every 6 months.	Teri Bayliss/ Gordon Burns	Amanda Waterfall		✓		✓	
Annual Investment Benchmarking	Teri Bayliss	Gordon Burns	✓				
Tender for new Investment Manager	Gordon Burns	Gordon Burns	✓				
Review of Bank Accounts	Gordon Burns	Teri Bayliss/Gordon Burns	✓	✓	✓	✓	
Quarterly Report regarding Liabilities	Gordon Burns	Gordon Burns/Richard Haigh	✓	✓	✓	✓	

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Agenda item A6(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	22 May 2026					
Title	Learning from Deaths, Quarter 4 2025/26 (January – March 2026)					
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 that the processes for Learning from Deaths across the organisation follow 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. The report is correct as of 29 April 2026 and covers data up to the end of Quarter 4 (Q4) 2025/26. This paper details the Trust position with regards to: • Project plan for improvement of the mortality review process • 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					
Recommendation	(i) Receive the report (ii) Discuss and note the proposed mortality review improvement project plan activity (iii) 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	Joining up care – working together to give people better, quicker access to effective care					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☐	☐	☒	☐
Link to Board Assurance Framework [BAF]	Inability to maintain and improve the quality of care for our patients					
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 December 2025 and March 2026.					

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 Trust Board 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. MORTALITY REVIEW IMPROVEMENT PROJECT

The Mortality Surveillance Group met in April 2026 as part of the regular meeting schedule. The proposed timeline for development of the InPhase mortality application being on the agenda for discussion. Development of this application has been delayed due to prioritisation of other applications requiring development, availability of InPhase consultant time and additional quality assurance work required in the transition from Datix. As part of the discussion, it was recognised that, to be able to build an effective application to support the mortality monitoring activity across the Trust, it was imperative to understand the whole mortality review process and agree what this should look like going forward. This effectively translates the initial work of moving from the Mortality Database to InPhase into a much bigger piece of work.

The Group agreed the following:

- Quality & Safety representatives to undertake process mapping exercise (planned May 2026)
- Agree estimated timeline for improvement work and implementation of interventions to be presented to July Mortality Surveillance Group meeting
- Creation of Task & Finish Group with named medical lead with oversight of all individual mortality improvement projects reporting to Mortality Surveillance Group
- InPhase build late Summer/ early Autumn subject to project plan development and InPhase consultant availability

3. REVIEW OF INPATIENT DEATHS

3.1 Level 2 (L2) Reviews

Figure 1 (below) details the number of completed level 2 reviews by month over the previous 12 months up until the end of Q4 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.

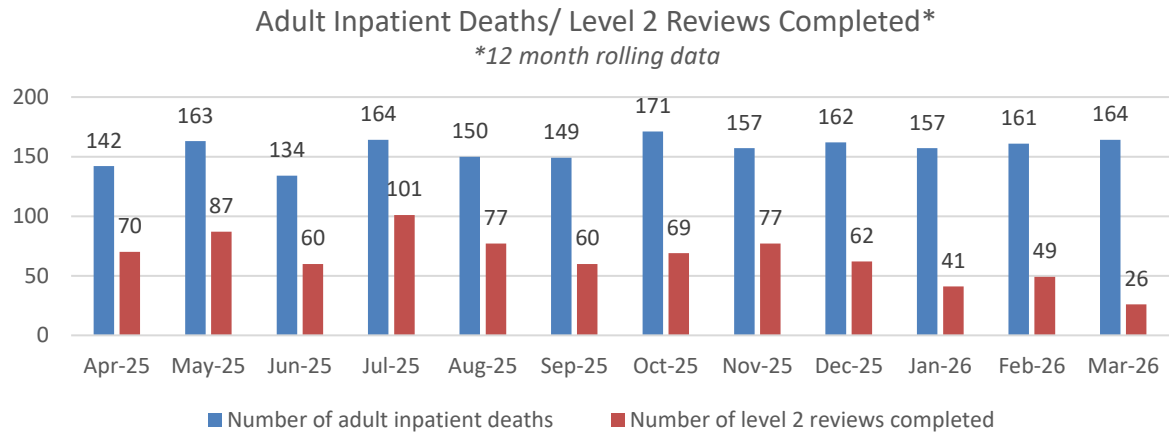

Figure 1: Number of Completed Level 2 Reviews, Apr 25 – Mar 26 (data correct as of 28/04/26)

3.2 Medical Examiner Initiated Level 2 Reviews

From April 2025 to March 2026, the Medical Examiners (MEs) referred 97 cases for L2 review. At the time of writing, 69 reviews have been completed, five are in draft, 15 have not yet been started and eight have been discounted due to having been sent in error. One case remains outstanding from a referral made in June 2024. This continues to be escalated to the Medicine & Emergency Care Clinical Board for action within the monthly reports and by the Director for Quality and Safety with the Director of Operations of the Medicine and Emergency Care Clinical Board. Following the meeting of the Mortality Surveillance Group on 22 April 2026, the Joint Medical Director resolved to escalate the issue of persistently outstanding L2 reviews for discussion at the Clinical Policy Group on 28 April 2026.

Figure 2 details the number of L2 reviews requested by the ME and subsequently completed for deaths from April 2025 to March 2026, broken down by month:

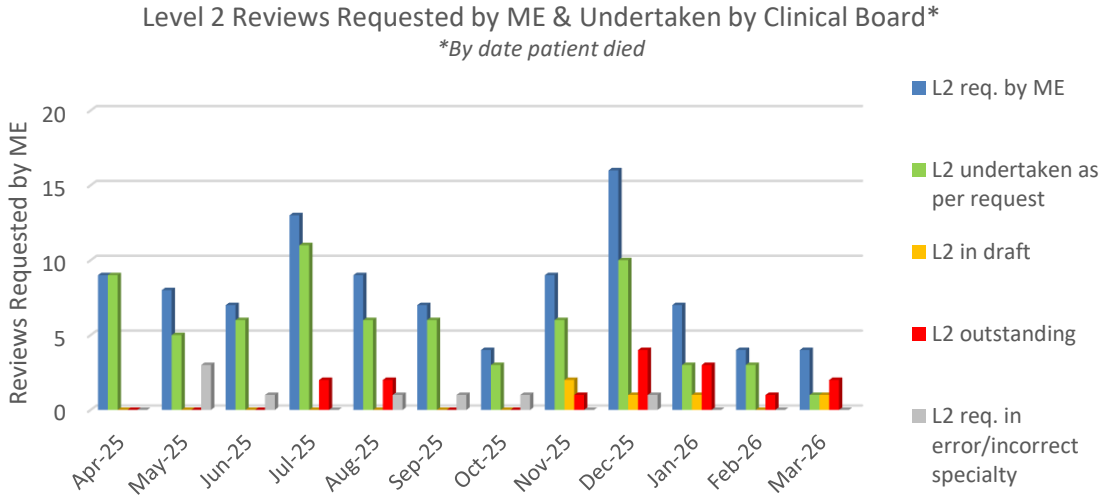

Figure 2: L2 Reviews Requested by ME and Undertaken by Clinical Board, Apr 25 – Mar 26 (data correct as of 28/04/26)

3.3 Patients with Learning Disability

Since April 2025, there have been 33 recorded deaths of adult patients with a recognised learning disability. Of these, 27 have had a Level 2 review completed by the LeDeR Panel. In the same

period, 2621 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 Q4 25/26.

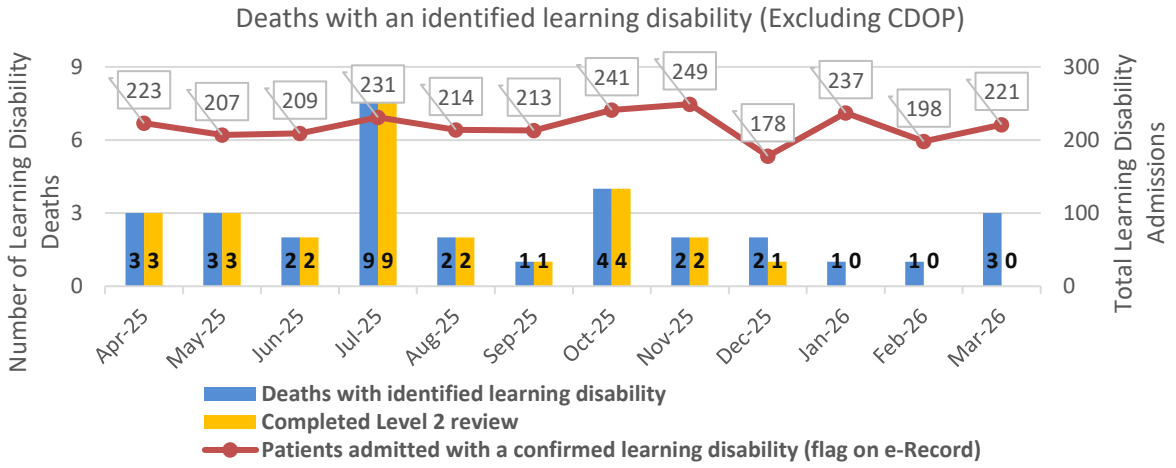

Figure 3: LeDeR Level 2 Reviews Apr 25 – Mar 26 (data correct as of 28/04/26)

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 Chair of the LeDeR Panel also provides a quarterly update to Mortality Surveillance Group. Learning themes and areas of good practice from recent reviews include:

- Staff perceptions that a prescription for anticipatory medications is a trigger for automatic referral to the Palliative Care team. This is not the case, and a referral is still required, however the Palliative Care team are now pro-actively reviewing the alerts where anticipatory medications are prescribing and contacting relevant wards.
- Instances of Learning Disability passports being mislaid/ going missing, particularly on transfer between wards. The Learning Disability team are collaborating with Digital Health to explore digitisation of the passport as these are currently still on paper.
- Learning around terminology, for example instances of the Liverpool Care Pathway being noted in patient notes, or learning difficulties being used instead of learning disability.
- New pilot of pain free blood bottles for needle phobic patients for certain blood samples.
- Understanding the use of Mental Capacity Assessments (MCA) and Lasting Power of Attorney (LPA) – a Trustwide Patient Safety Bulletin has recently been issued to help staff understand LPAs and the requirements for documentation of these.
- Exploring the use of an alternative to the Estimated Date of Discharge in e-Record when a patient is end of life and will not be planned for discharge.
- Learning has been identified around documentation, examples of poor documentation of reasonable adjustments, pain assessments or capacity. However, the LeDeR Panel also highlighted some areas where documentation was excellent.
- Multi-disciplinary Team (MDT) approach to reviews with the LeDeR Chair being invited to a local specialty debrief and desire from the specialty to participate in the LeDeR review.

3.4 Deaths within 12 Months of Pregnancy

A maternal death includes the death of any woman who has been pregnant within the 12 months prior to death regardless of the outcome of the pregnancy (live birth, pregnancy loss or termination). The Trust recorded one maternal death in Q4 2025/26 in line with national reporting criteria. In this case the patient died six months post-natal for reasons unrelated to service provision. The death has been reported to MBRRACE-UK as per reporting requirements. To date no further external investigation has been notified and the case does not meet any internal mortality review criteria.

4. LEARNING FROM DEATHS Q4 2025/26

At the time of writing, 116 level 2 reviews had been undertaken of the 482 adult inpatient deaths recorded in the Trust. This equates to 24.1% of all adult deaths recorded in the quarter. Some patients may have more than one level 2 review recorded. An additional 58 draft reviews are currently awaiting completion for deaths from this quarter.

All cases undergoing a Level 2 review are given both a HOGAN and NCEPOD score. Cases given a HOGAN score of 4 or above, or an NCEPOD score of 3 are identified in line with Trust policy for further review and consideration of a patient safety learning response as appropriate in line with the Patient Safety Incident Response Framework (PSIRF).

4.1 HOGAN Scores

HOGAN scores are a guide as to the preventability of the patient's death and are defined as:

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 Q4 by HOGAN scores for the quarter:

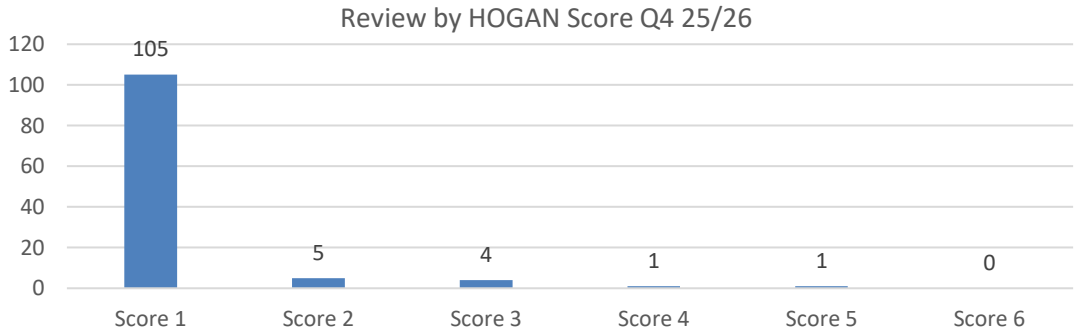

Figure 4: Q4 25/26 Completed L2 Reviews by HOGAN Scores (data correct as of 28/04/26)

The case scored as HOGAN 4 had already been presented to the Trust's weekly Rapid Action Review Meeting (RARM) prior to completion of the mortality review and declared as an After Action Review (AAR). The case scored as HOGAN 5 had been reviewed at RARM prior to completion of the

mortality review and declared an AAR but has since been upgraded to a Patient Safety Incident Investigation (PSII) on further review. Both investigations are ongoing at the time of writing and the learning and outcomes from these will be shared in due course.

4.2 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 Q4 by NCEPOD scores for the quarter:

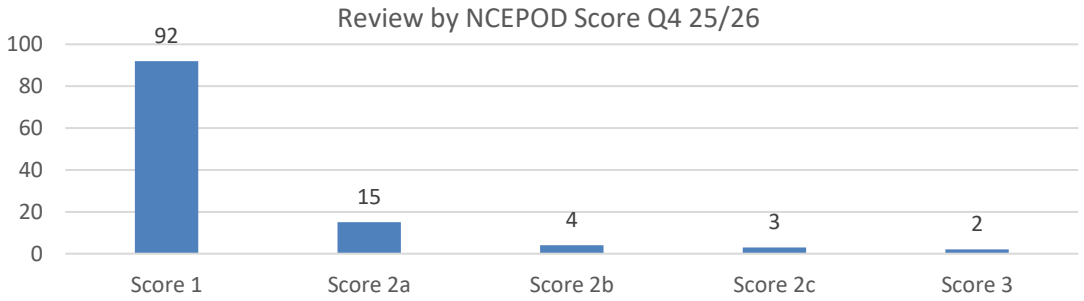

Figure 5: Q4 25/26 Completed L2 Reviews by NCEPOD Scores (data correct as of 28/04/26)

Of the cases scored NCEPOD 3 in this quarter, one corresponds to the case scored HOGAN 5 above which has since been declared a PSII. The second case is, at the time of writing, awaiting the outcome of a rapid review and presentation at RARM in line with PSIRF criteria to determine a proportionate learning response. 22 reviews were given a score of 2 (either a, b or c respectively). The 22 reviews comprise 18 patients as two patients had two reviews each respectively where scores of NCEPOD 2 were allocated.

4.3 Reviews Completed for Deaths Prior to Q4 2025/26

108 reviews were completed in Q4 for deaths that occurred prior to 1 January 2026. Of these;

- 93 were given a score of HOGAN 1
- 11 were scored HOGAN 2
- 3 were scored HOGAN 3
- 1 was given a score of HOGAN 4

- 76 were scored NCEPOD 1
- 23 were scored NCEPOD 2A
- 8 were scored NCEPOD 2B
- 1 was scored NCEPOD 3

The case scored HOGAN 4 was presented at RARM prior to the mortality review being completed following submission of an incident report and declared as a PSII which is now under investigation.

The case scored NCEPOD 3 pertains to a learning disability review undertaken by the LeDeR panel. An incident report has been submitted to enable the clinical team to review concerns identified in relation to the care provided and at the time of writing, is awaiting a rapid review to be undertaken in line with PSIRF processes.

4.4 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 56 reviews (50 patients due to 4 patients having more than one review) that were allocated an NCEPOD score of 2 or 3 (all reviews completed in Q4) with the following themes identified:

Theme	Overview of cases	Actions/ Outcomes
Delayed investigations/ reviews/ treatment/ diagnosis	13 cases identified concerns relating to delays in aspects of care, including referral to other teams for review, delays or omissions in medication, reviewing patients following high NEWS score, completing investigations (bloods/ imaging), patient scheduling for surgery or lost to follow up. Four cases identified concerns that may have impacted the patient's outcomes.	Three of the 13 cases are being investigated via the PSIRF process with two AARs and one PSII being declared. One further case is awaiting a rapid review by the Clinical Board. In the remaining nine cases, learning has been identified locally within the relevant specialties in relation to the importance of correct referral pathways, timely prescribing and administration of medication, timely investigations and reviews to support patient management and education on the use of correct red blood sample bags for urgent blood results.
Communication	Four cases identified learning in relation to the need for improved communication, both between clinical teams, and patients and their families. None of these were felt to have impacted the patient's outcomes.	The importance of ensuring good, civil communication between teams, with clarity on roles and responsibilities. To ensure that timely, compassionate discussions are held with patients and families around DNACPR decision making.
Documentation	Eight cases related to the theme of poor documentation, including: documentation of clinical decisions, discussions and treatment plans; poor documentation of capacity assessments and MCAs, and documentation of DNACPR on transfer from another trust not documented promptly. None of these were felt to	The learning points for the learning disability cases have been fed back to the relevant clinical boards by the LeDeR Panel chair. In the remaining cases, learning has been identified locally within the relevant specialties in relation to the importance of clear documentation of clinical decisions, discussions, escalation plans, insertion of lines and cannulae and the need to reconfirm DNACPR status on transfer from other hospitals.

Theme	Overview of cases	Actions/ Outcomes
	have impacted the patient's outcomes.	
Abnormal results	Four reviews (three patients) related to delay/ failure to act on abnormal results, including imaging, ECG, bloods and other patient symptoms. In one of these cases, failure to act on results was felt to have impacted on the final outcome (HOGAN 4).	The case scored HOGAN 4 is being investigated as a PSII via the PSIRF framework. In the remaining cases, the Morbidity & Mortality reviews (M&Ms) identified learning in relation to ensuring haemolysed samples are repeated, or if not required, the rationale is clearly documented so that information is available to senior decision makers pre-discharge. Subtle radiology findings may not always be identified in the first instance but were appropriately escalated once identified via a report addendum. The identified case will be presented to the Radiology learning meeting as a case study.
Clinical decision making	Eight cases identified concerns related to clinical decision making, including: management of initial referral from another trust, discharge management, decision making regarding surgical intervention, radiological reporting, medication management and post-operative patient management. There were no cases where it was felt the patient's final outcomes had been affected.	The relevant specialities have all identified local learning in relation to: • The importance of clear clinical decision making and documentation of rationale • Recognition of MDT opinion and forward planning for high-risk interventions • Considering the appropriateness of whether a patient who is end of life should remain detained under the Mental Health Act (MHA) • Importance of thorough discussion with peers • Consider, if appropriate to do so, earlier revascularisation • Undertaking education with junior medical staff on anticoagulation prescribing and monitoring
Other	Six cases identified other themes including: use of correct terminology and nursing forms, concerns in relation to standards of nursing care, little evidence of reasonable adjustments documented throughout records, surgical postponements (though	The points identified in the LeDeR reviews have been fed back to the Clinical Boards by the LeDeR Chair. One of these is awaiting a rapid review by the clinical board to explore the concerns raised in relation to the care provided though the patient did not come to significant harm. Neurosurgery are working with PatientPass to develop solutions to identified concerns.

Theme	Overview of cases	Actions/ Outcomes
	unrelated to the post-operative infection that patient developed), other post-operative complications, issues with PatientPass referral system	Nursing care standards being addressed by Associate Director of Nursing (AND). The post-operative complications were identified as recognised complications
Unknown	In twelve cases it was not possible to determine from the case review what the learning points were.	

4.5 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 Q4 2025/26, 3 deaths met these criteria and was received at RARM.

4.6 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 monthly. In Q4 2025/26, no completed investigations relating to events where a patient had died were submitted to PSIF for approval.

5. RECOMMENDATIONS

To:

(i) Receive the report
(ii) Discuss and note the proposed mortality review improvement project plan activity
(iii) 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
29 April 2026

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PUBLIC BOARD MEETINGS - ACTIONS

Agenda item A6(b)

Log No.	BOARD DATE	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
166	27 March 2026	26/08 FOCUS ON FUNDAMENTALS – QUALITY, PERFORMANCE AND FINANCE: e. Joint Medical Directors (JMD) Report including Mental Health update	The Trust's Mental Health Group met yesterday, and an update would be provided to the Trust Board on progress since the last CQC report [ACTION01]. Paul Ennals noted that it would be useful to discuss this topic through the Quality Committee.	LPC/MWr			14.05.26 - Joint Medical Director (LPC) will discuss with Rachael Gregory, Associate Director of Nursing, and an update paper on Mental Health will be brought to the Quality Committee and Trust Board in June.

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.