The Newcastle upon Tyne Hospitals
NHS Foundation Trust

QUALITY ACCOUNT 2025/2026

CONTENTS

PART 1
Chief Executive's Statement 4
What is a Quality Account? 6

PART 2
Quality Priorities for Improvement 2026/2027 7
Patient Safety 8
Clinical Effectiveness 9
Patient Experience 10
Statement of Assurance from the Board 13

PART 3
Review of Quality Performance 2025/2026 15
Patient Safety 16
Clinical Effectiveness 21
Patient Experience 23
Information on Participation in National Clinical Audits and National Confidential Enquiries 32
Information on Participation in Clinical Research 38
Information relating to Registration with the Care Quality Commission (CQC) 39
Information on the Quality of Data 41
Key National Priorities 2025/2026 42
Core Set of Quality Indicators 45
Workforce Factors 54
Involvement and Engagement 2025/2026 57

ANNEX 1:
Statement on Behalf of the Newcastle Health Scrutiny Committee 59
Statement on Behalf of Northumberland City Council 61
Statement on Behalf of the Newcastle & Gateshead Integrated Care Board 63
Statement on Behalf of Healthwatch Gateshead,Healthwatch Newcastle, Healthwatch North Tyneside and Healthwatch Northumberland 66

PART 1

CHIEF EXECUTIVE'S STATEMENT

Thank you for taking the time to read our Quality Account for 2025/2026. 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.

However, during 2025/2026, the Trust reported ten Never Events. Each represents a failure in the systems designed to protect patients from avoidable harm, and we are deeply sorry to those affected. Whilst Never Events are, by definition, rare relative to the volume and complexity of care delivered by the Trust, their occurrence is unacceptable and this experience has reinforced our determination to strengthen safety in high-risk areas such as invasive procedures. As a result, reducing the risk of Never Events is a core focus in one of our Quality Account priorities for 2026/2027.

We have taken steps to strengthen 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

To the best of my knowledge the information contained in this document is an accurate reflection of outcome and achievement.

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 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. Strategic Oversight Groups 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 report. 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

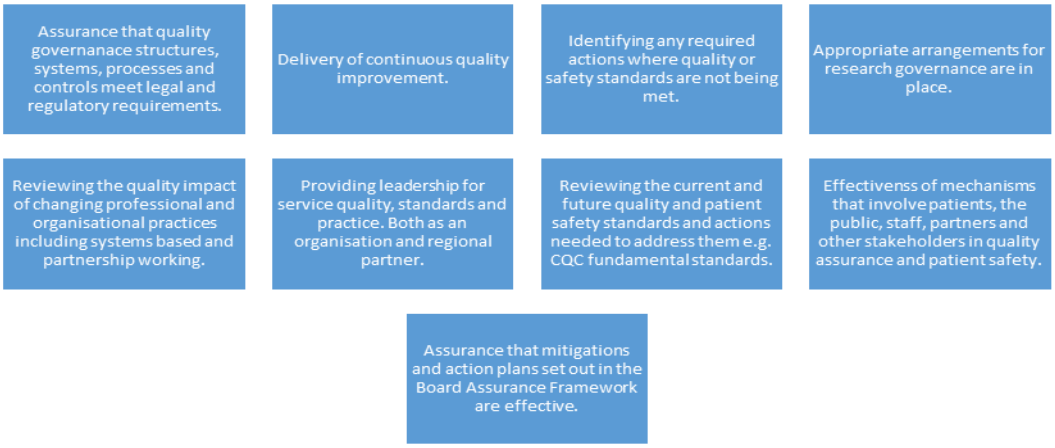
standardised agenda ensures regular review of all domains of quality, including the identification and escalation of risks. This governance structure is being further embedded within directorates and specialties and has been strengthened through the appointment of non-medical Quality and Safety Leads 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

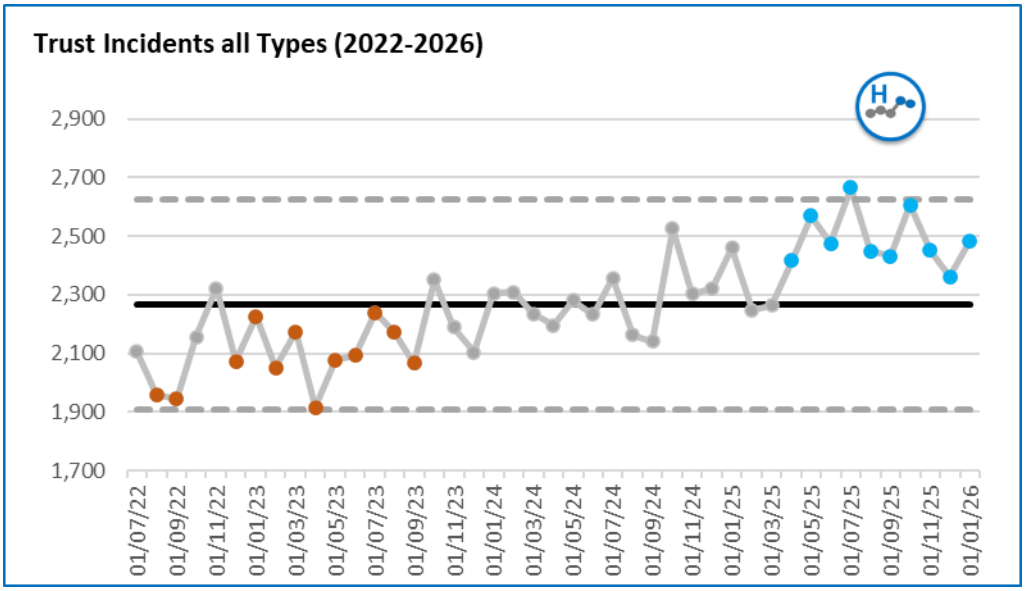


Figure 2: all incident types

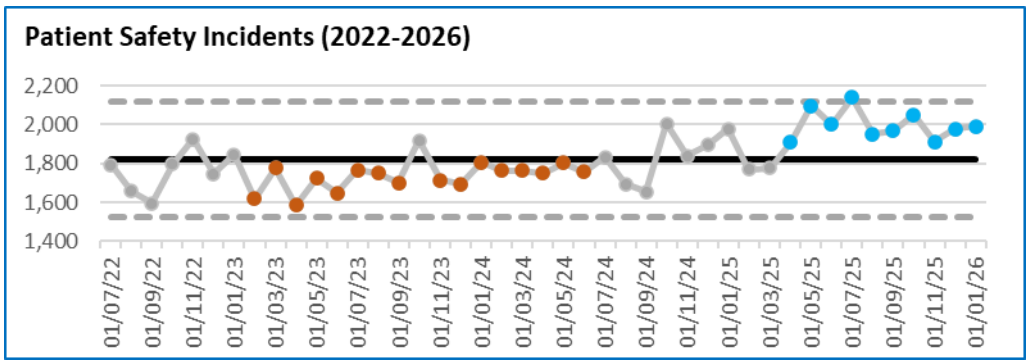
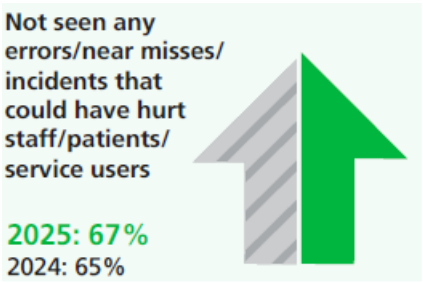


Figure 3: patient safety incidents

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.

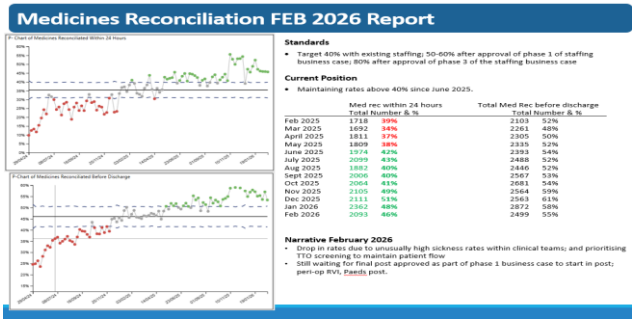
What did we say we would do:

- 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

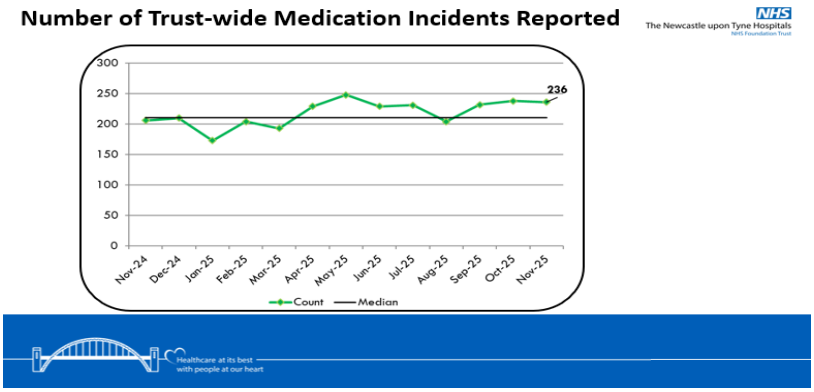
The clinical medicines management audit plan has been completed with action plans in place for areas of non-compliance. The audits completed this year include medicines management at ward level, medicines reconciliation, antimicrobial stewardship, medicines management interventions, FP10 audit, pharmacy 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.

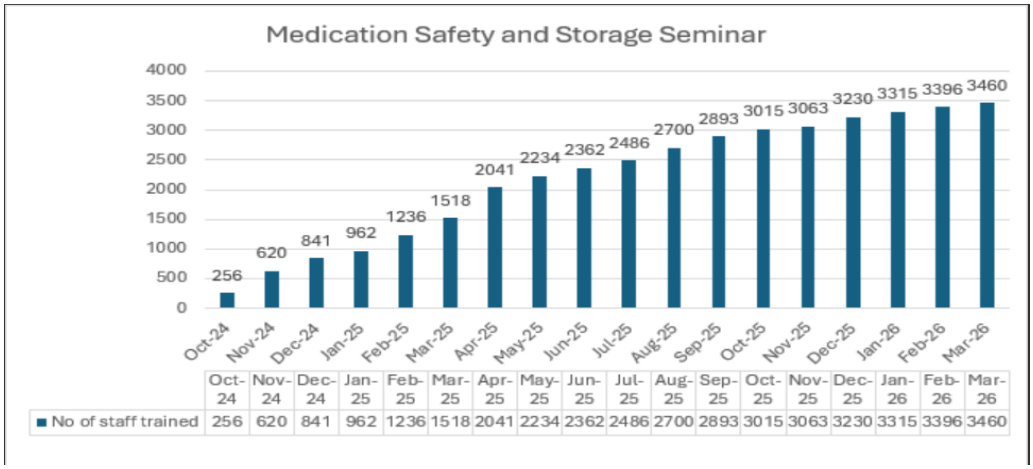


Examples of work to reduce the risk of incidents occurring includes:

- 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

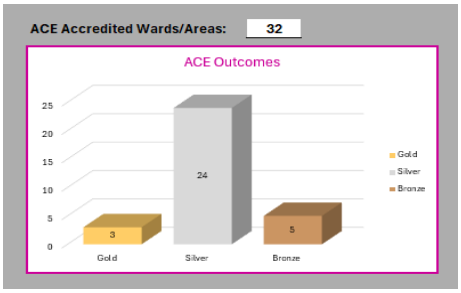
What did we say we would do:

- 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

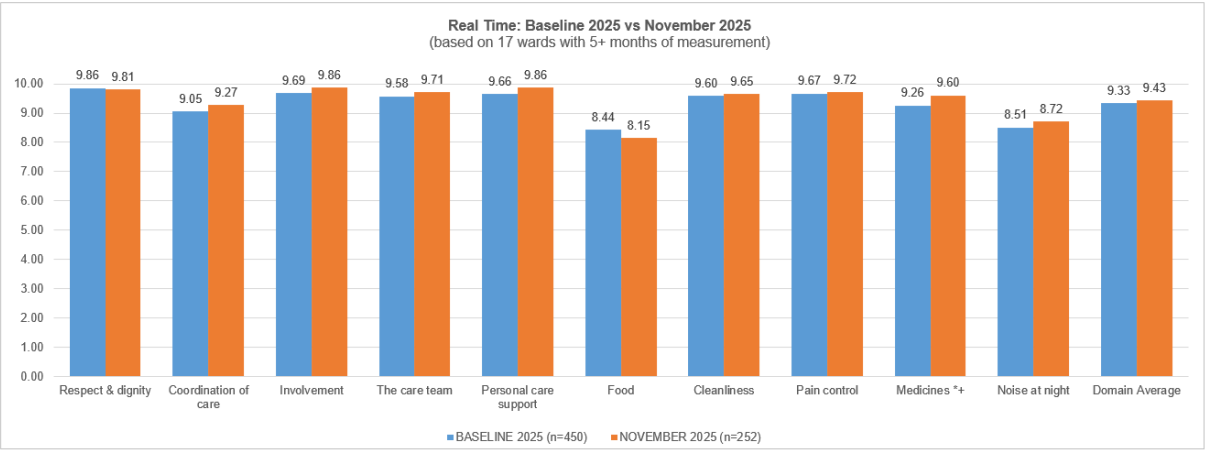
This priority has been achieved

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.

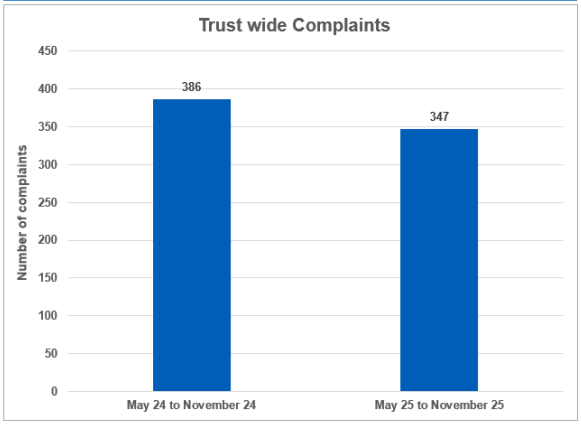
By December 2025, the real time patient experience programme was rolled out to 40 wards across all hospital sites. This comprised of over 3000 bedside conversations with most reporting back to ward teams within 24 hours of completion of final survey. The programme is still in early stages of implementation 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).

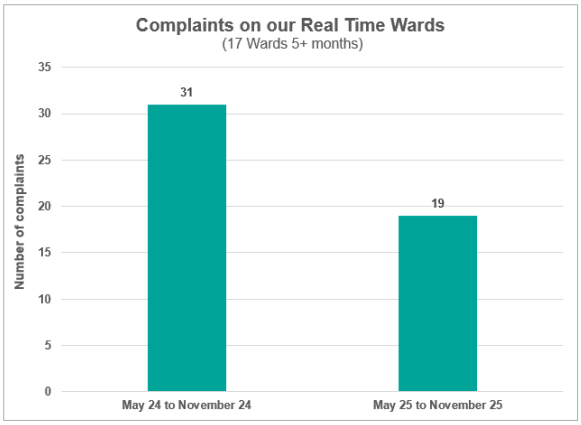


An early review of complaints data from wards that have been receiving real-time feedback for five months suggests a reduction of 39% in complaints between May and November 2025, compared with the same period in 2024. Over the same period, wards not participating in the real-time programme saw a 10% 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 these 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% of all patient deaths in 2024/2025) 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 Care Quality Commission 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 Care Quality Commission 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 Infection Prevention and Control 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

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

Newcastle City Council

21 May 2026

By Email: nuth.qualityaccount@nhs.net

Ms Anne Marie Troy-Smith Quality Development Manager Newcastle upon Tyne Hospitals NHS Foundation Trust

Dear Anne Marie,

NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST DRAFT QUALITY ACCOUNT 2025/26

On behalf of the Health and Social Care Scrutiny Committee I am very pleased to comment on the NUTH draft quality account 2025/26.

The Committee is happy with the progress that NUTH has made over the last two years and the Committee supports your suggested priorities. However the Committee would like some further information about how they will be achieved, in particular we would like to highlight the following:

- **Priority 3: Reduction in Lung Cancer Wait Times**
  The Committee are keen to understand how the targets on faster diagnosis of lung cancer can be achieved.

- **Priority 4: Reducing healthcare associated infection and improving antimicrobial stewardship**
  The Committee would like clarification on how the target to increase low risk antibiotic use to greater than 70%, currently between 50-55%, will achieve a reduction in overall antibiotic use as per national action plan for antimicrobial resistance.

- **Priority 6a: Reduce "did not attend/was not brought" appointments in Maternity services for those with highest risk by 3%**
  The Committee would like to understand how attendance by deprived communities and vaccination rates will be improved.

- **Priority 5: Waiting safely- improving safety for patients who are waiting for treatment.**

The Committee is particularly impressed by the results of the prehabilitation programme for patients needing knee replacement. We would like to know if this will be expanded to other pre-op groups.

- **Priority 6: Roll out of patient experience real time surveys**

  The Committee are concerned at the statistical decline in the experience of accessing the emergency department and would like to receive more information on this.

NHS Staff Survey 2025 – Overview of Results
The Committee is concerned that NUTH continues to score below the national NHS average when compared to other Trusts. We would like to know how you plan to improve the staff survey results.

We have been very grateful for the engagement of NUTH in the work of the Health and Social Care Scrutiny Committee over the last year. We would like to give particular thanks to Caroline Docking, Director of communications and corporate affairs, for her support to the Committee which has included arranging a number of site visits for members.

We look forward to continuing to work with you over the next year and we welcome the contribution of NUTH to Health and Social Care Scrutiny Committee.

Yours sincerely

Cllr Wendy Taylor
Chair, Health and Social Care Scrutiny Committee

STATEMENT ON BEHALF OF NORTHUMBERLAND COUNTY COUNCIL

Northumberland
County Council

Annemarie Troy-Smith
Quality Development Manager

By email to – Annemarie.troy-smith@nuth.uk

Our ref: RG/OSC/QA/2025/26
Enquiries to: Rebecca Greally
Email: democraticservices@northumberland.gov.uk
Tel direct: (01670) 622616
Date: 21 May 2026

Dear Ms Troy-Smith

NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST'S ANNUAL PLAN AND QUALITY ACCOUNT 2025/26

Statement from Northumberland County Council's Health and Wellbeing Overview and Scrutiny Committee

On behalf of the Health and Wellbeing Overview and Scrutiny Committee (OSC), I am writing to formally acknowledge receipt of the Quality Accounts for 2025/26. We appreciate the opportunity to provide commentary and feedback on this important document. The Committee always welcomes your attendance and input at their meetings and believe it is vital to effective scrutiny.

In our recent committee meetings, we have reviewed quality accounts from various local NHS trusts, which has provided us with a comprehensive understanding of healthcare services in Northumberland and their respective priorities.

Upon reviewing the Annual Quality Account 2025/26 and the outlined priorities for 2026/27, I would like to highlight some key comments from the committee and additionally what further information has been requested:

- The Trust's proactive engagement with partners and its eagerness to leverage insights from other organisations. The last year was noted as significant for Newcastle Hospitals, on strengthening quality governance, improving patient safety and experience, and building on the learning from external review and internal scrutiny.
- The approach to patient safety had continued to mature, with the full implementation of the Patient Safety Incident Response Framework helping the Trust 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 remained high, which was deemed as a positive indicator of a developing open and

learning culture, and emphasis was increasingly on learning and improvement.

- The quality oversight arrangements had been strengthened, 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, had helped identify risk earlier and respond more effectively.
- The Accrediting Excellence (ACE) Programme was well under way with 34 wards/areas now being accredited out of a total of 60 inpatient wards.
- We welcomed the news that the focused priority to improve Never Events had started. Actions included ensuring that there was a sustained increase of incident reporting as well as a focus on promoting patient safety in areas where there was a significant risk of harm associated with invasive procedures. The target for 2026/27 was to have 0 Never events.
- The committee felt that overall the picture was still worrying with many of the performance targets set last year not being met, especially cancer witing times. Waiting times regarding cancer referrals was an area of focus which needed everyone to work together on a regional basis. The Committee welcomed assurances around ongoing improvement but will be concerned if this does not materialise in next year's accounts.
- We welcomed the Trust's acknowledgement that it needed to do more but remained committed to openness, learning and partnership with patients, colleagues, Governors and system partners as they continue the improvement journey.

Based on the information shared with us throughout the past year we believe that the contents accurately reflect the services provided by the Trust and resonate with the community's priorities.

If I can be of any further assistance regarding the Committee's response, please do not hesitate to contact me.

Yours sincerely,

Councillor Georgina Hill, Chair of Health & Wellbeing Overview and Scrutiny

STATEMENT ON BEHALF OF THE NEWCASTLE & GATESHEAD INTEGRATED CARE BOARD

NHS
North East and North Cumbria

Commissioner Statement from NHS North East and North Cumbria Integrated Care Board for Newcastle-upon-Tyne Hospitals NHS Foundation Trust Quality Account 2025/26

NHS North East and North Cumbria Integrated Care Board (NENC ICB) is committed to commissioning high quality services from Newcastle-upon-Tyne Hospitals NHS Foundation Trust (NuTHFT). NENC ICB is responsible for ensuring that the healthcare needs of patients that they represent are safe, effective and that the experiences of patients are reflected and acted upon. The ICB welcomes the opportunity to review and provide comment on this 2025/26 Quality Account.

Overview

The ICB would like to thank NuTHFT for the openness and transparency reflected in this year's Quality Account, and to commend all staff for their commitment and dedication demonstrated throughout these challenging times and for striving to ensure that patient care continues to be delivered to a high standard.

Achievements

The ICB would like to congratulate NuTHFT and its staff on the achievements made during this period. The ICB recognises the attainments detailed within the quality account, which include:

- Supporting staff to report incidents, focus on shared learning and take a systems-based approach to improvement. Through this priority incident reporting rates exceeded ambition, the proportion of staff reporting errors/near misses improved, and the 2025 General Medical Council survey showed improvement in trainee experience. NuTHFT implemented the national patient safety syllabus and training programme and developed a patient safety communication plan strengthening shared learning and engagement. Data is triangulated to fully understand the impact of this work.
- Ensuring mental capacity, best interests decision making and deprivation of liberty safeguards are considered appropriately for inpatients with a learning disability. This priority led to mental capacity assessment training levels matching or just below the 90% target, compliance audits continuing as part of routine business, and a three-year roll out of the Oliver McGowan learning disability and autism training. This priority was partially achieved and will continue as 'business as usual'.
- Expanding the Accrediting Excellence Programme to 40 inpatient wards, 32 achieving full accreditation status, 1 critical care area, and 5 day units, exceeding expectation.
- Optimising health before and after a total knee replacement, through improved patient education, including updated resources and delivery of pre-operative education. Enrolling patients with more ‘complex’ needs on a prehabilitation programme which resulted in reduced average hospital stays and measurable improvements suggesting improved cardiovascular fitness and mobility, both associated with better surgical resilience and recovery potential, with high patient satisfaction.

- Rolling out the Real Time patient experience programme to 40 wards across all hospital sites with early indications of meaningful improvement, including medicine communicatior and a reduction in complaints on participating wards. This was successfully introduced to the emergency department, with Great North Healthcare Alliance partners.
- Full implementation of the Patient Safety Incident Response Framework.
- Remaining a leading research organisation in the NHS for the number of individuals recruited to clinical trials provided or hosted by NuTHFT and the number of open studies.
- Participating in all eligible national clinical audits and national confidential enquiries/reviev outcome programmes, with additional audits included in 2026/27's Quality Account. 459 local audit reports were reviewed by NuTHFT in 2025/26.
- Being de-escalated from enhanced oversight by NHS England's Integrated Quality Improvement Group following evidence of sustained improvement. NuTHFT commissioned and completed a Well-led Review, which demonstrated clear improvement compared to the findings of the 2024 Care Quality Commission inspection report. Progress of the action plan is overseen by the Audit, Risk and Assurance Committee.
- Introducing a new local risk management system (InPhase) to record patient safety incidents and duty of candour activity, improving accuracy of recording, reporting, and implementing a quality audit process providing additional assurance that Duty of Candour requirements are met, and that responses are appropriate.
- Improving access to Freedom to Speak Up staff.

Areas for Further Development

The ICB recognises the additional work required which has been identified within the quality account. In particular, work to:

- Use medicines more safely and effectively with improvement seen in medicines reconciliation, ward medicines management audits, development of an omitted doses dashboard and new medication incident report. In 2026/27 the working group to improve communication to primary care will continue, and a digital transcribing solution (MPage) will be reviewed. This will continue as a priority in 2026/27.

Future Priorities

The ICB is fully supportive of the identified Quality Priorities for 2026/27. The ICB welcomes:

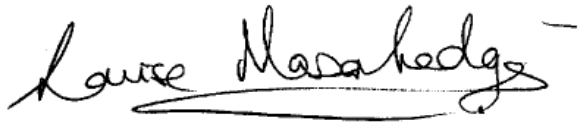
- Continued work to increase incident reporting, reduce incidents resulting in serious harm and reduce invasive procedure never events.
- Safer and more effective use of medicines by minimising drug errors through increased pharmacy reconciliation, prescribing corrections, increasing the number of medicines prescribed by pharmacists and improving the accuracy of information sent to GPs on discharge. This priority is carried forward from 2025/26.
- Reduced lung cancer wait times by achieving the NHS England 28-day faster diagnosis standard.
- Reduced healthcare associated infections, e.g., Methicillin-resistant Staphylococcus Aureus, Clostridium difficile and Escherichia coli, by implementing a range of infection prevention initiatives and improving antimicrobial stewardship to reduce overall antimicrobial use.
- Improved complaint response timescales by establishing clear maximum timeframes, developing quality standards for complaint responses, incorporating key performance indicators in the complaints dashboard and enhancing accountability and governance.
- Reduced 'did not attend/was not brought' appointments in maternity services, particularly among people living in the most deprived and global majority groups, by reducing missed appointments, and improving access and continuity of care.

- Increased maternal vaccination rates, e.g., flu, whooping cough and respiratory syncytial virus, for women who require an interpretation service.

The ICB can confirm that to the best of their ability the information provided within the annual Quality Account is an accurate and fair reflection of NuTHFT's performance for 2025/26. It is clearly presented in the required format, contains information that accurately represents the Trust's quality profile and aspirations for the forthcoming year.

NENC ICB remain committed to working in partnership with NuTHFT to assure the quality of commissioned services in 2026/27.

Yours sincerely



Louise Mason-Lodge
Director of Nursing
NHS North East and North Cumbria Integrated Care Board

STATEMENT ON BEHALF OF HEALTHWATCH GATESHEAD,HEALTHWATCH NEWCASTLE HEALTHWATCH NORTH TYNESIDE AND HEALTHWATCH NORTHUMBERLAND.

Thank you for sharing the draft Quality Account for 2025/26 for comment. We recognise and appreciate the sustained efforts of Trust staff during a challenging period for the NHS, and welcome the Trust's continued commitment to patient safety, learning and engagement. The breadth of activity described demonstrates clear intent to improve quality and experience. As the programme of work continues to develop, clearer articulation of the impact of these changes on patient outcomes, harm reduction and sustained service improvement would further strengthen the account.

We welcome the Trust's ongoing commitment to openness and learning.

Local Healthwatch recognises the scale and complexity of the Trust's services and the wider system pressures. We welcome the progress outlined while encouraging clearer demonstration of impact, stronger acknowledgement of workforce constraints, and more consistent, patient-centred communication, particularly for those waiting for care. We look forward to continuing constructive dialogue to ensure patient, carer and community experience meaningfully informs quality improvement across the Trust.

The NHS 10 Year Plan sets a clear direction for care to move closer to people's homes, with greater emphasis on prevention, early intervention and community-based services. We are disappointed that this shift is not reflected in the future priorities. Aligning priorities with the community agenda would enable the Trust to play an active role in Neighbourhood Health.

We continue to encourage the Trust to engage with communities across Newcastle, Gateshead, North Tyneside and Northumberland, recognising that Newcastle Hospitals act as the local hospital for many residents beyond the city centre. Involving service users and carers in service redesign and

developments will help ensure that services better meet people's needs and that challenges can be jointly understood and tackled.

We welcome the progress outlined in this Quality Account and look forward to continued dialogue and partnership working to ensure that the voices and experiences of patients, carers and communities continue to inform quality improvement.

Progress against 2024/25 Quality Priorities

Local Healthwatch welcomes progress reported against the 2024/25 Quality Priorities, particularly around governance and learning systems. More reports on their own don't prove things are safer. For example, more incident reports under PSIRF don't necessarily mean all incidents are being reported, harms are getting less serious, or actions are stopping problems from happening again. Clearer evidence of what was learned, what was done, and what changed would give more confidence.

- **Priority 3 – Ensuring mental capacity, best interests decision-making and Deprivation of Liberty Safeguards are considered appropriately for inpatients with a learning disability** We welcome the positive progress made in improving Mental Capacity Act training compliance and audit quality. However, we note that Mental Capacity Assessment Level 2 training has not yet reached the Trust standard. We would encourage continued focus in this area and would welcome more information in future reporting on how carers and families are involved in best interest decision making.

- **Priority 5 – Waiting safely: improving safety for patients who are waiting for treatment** Improvements to patient information resources and pre-operative education are welcome. However, patient feedback to local Healthwatch consistently highlights dissatisfaction while waiting. We continue to hear challenges of delays, cancellations, and referral problems, communication issues, uncertainty and perceived lack of support across multiple pathways.

The impact of waiting is shaped not only by duration but by clarity, reassurance and timely updates. The description of support to help people get ready for treatment could be clearer. At the moment, this support seems limited to certain patients and short time periods, and doesn't reflect the wider "Waiting Well" offer.

While we welcome the positive way in which the Trust has engaged with Healthwatch about Audiology services and the improvement actions taken, we believe the Quality Account should acknowledge the on-going challenges this service has and the impact waiting times have for existing patients with hearing loss.

Whilst we recognise the pressures faced by the health system, waiting for care, in Emergency Departments ass well as for planned care, is one of the most common issues people raise with us.

- **Priority 6 – Rollout of real-time patient experience surveys** The rollout of real-time patient experience surveys and the associated reduction in complaints is a positive development. Realtime surveys and the associated reduction in complaints are positive. Their value would be strengthened by ensuring feedback is not collected solely 'in the heat of the moment', particularly where patients remain dependent on the care being evaluated. Follow-up surveys at a later stage are welcome, though response rates and representativeness should be considered.

Priorities for 2026/27

We welcome the priorities for 2026/2027 set out in the Quality Account and the continued emphasis on patient safety, clinical effectiveness and patient experience. In particular, Priority 5 relating to complaints handling stands out as an important area of focus.

- **Improve timescales to respond to complaints** We strongly support the Trust's commitment to delivering a more timely, transparent and learning-focused complaints process. An efficient and compassionate approach to complaints handling can help people feel listened to and valued and may reduce the risk of future interactions being shaped by unresolved dissatisfaction. We particularly welcome the intention to strengthen thematic analysis and learning from complaints to inform service improvement and reduce repeat issues.

- **Medicines management** We recognise the significant improvement in medicines reconciliation rates and the Trust's continued focus on safer and more effective medicines use. While ward-level audit compliance narrowly missed the Trust's target, targeted support for underperforming areas and improvements to discharge communication with primary care would be beneficial in supporting safer transitions of care. Improvements in medicines reconciliation are welcomed, though 'effective use of

medicines' covers a wide and diverse range of issues, from safety and communication to operational pressures. Workforce constraints are notably absent from this discussion; for example, omitted or delayed doses can be linked to staff shortages and skill mix, particularly for intravenous medicines. Better communication with GPs would also help when patients need prescriptions after leaving hospital. Systems only work well if staff record information quickly and consistently.

- **Staff experience** We acknowledge that staff recommendation rates remain above the national average. However, we note a gradual downward trend and encourage the Trust to continue addressing areas of staff experience that fall below NHS averages, including recognition, learning opportunities and flexibility, recognising the link between staff experience, patient safety and patient care.

Summary of Patient and Community Feedback

Local Healthwatch continues to gather a wide range of patient and community feedback about Newcastle Hospitals services, including both positive and critical experiences. Some of the common themes within this feedback are below.

- **Quality of care** Many patients commend the professionalism, compassion and dedication of staff, particularly in emergency and specialist services, and recognise the pressures under which staff are working. However, concerns continue to be raised about care planning, consistency of care and patient experience in specific areas, including emergency departments and outpatient services.

- **Access and waiting times** Long waits for appointments, diagnostics and treatment remain a consistent theme in feedback, with particular concern about extended waits in A&E, audiology, orthopaedics, ENT, and urology. This has impacts on patient wellbeing and confidence in services.

- **Communication and information** While some patients report positive, clear communication, others describe feeling poorly informed about waiting times, next steps in care and who to contact for updates. Improved communication during waiting periods remains a key issue.

- **Involvement of carers and families** Carers continue to report feeling insufficiently recognised or involved, particularly during hospital stays and discharge processes. Opportunities to better identify and support carers, and to involve them more consistently in decision-making, would be

welcome. It is essential that the Trust works with partners and support organisations across your footprint to coordinate support for carers.

- **Travel and access** Travel, transport and parking continue to be raised as barriers to accessing services, particularly for people travelling longer distances or those with mobility issues, with cost increasingly highlighted as an inequalities issue.