

Public Trust Board of Directors

Friday 31 July 2026, 10:00 – 11:45

Piano Room, Royal Victoria Infirmary (RVI)

Agenda

	Time	Item	Purpose	Lead
1. Introduction				
a.	10:00	Apologies for absence and declarations of interest	For discussion	Paul Ennals
b.	10:01	Minutes of the Public Board of Directors meeting held on 22 May 2026 and matters arising	For discussion & approval	Paul Ennals
c.	10:02	Chair's Report	For discussion & assurance	Paul Ennals
d.	10:10	Chief Executive Report	For discussion & assurance	Jackie Bilcliff
e.	10:20	Committee Triple A reports	For discussion	Committee Chairs
2. Joining up care – working together to give people better, quicker access to effective care				
a.	10:25	Board Visibility Programme	For discussion & assurance	Ian Joy
b.	10:32	Integrated Board Report (IBR)	For discussion & assurance	Patrick Garner & Executive Leads
3. Advancing Care – improving patient care, effectiveness and quality through innovation, research, improvement and education				
a.	10:40	Patient and Colleague Experiences	For discussion & assurance	Ian Joy
b.	10:45	Joint Medical Directors Report, including: i) Guardian of Safe Working report	For discussion & assurance	Michael Wright & Lucia Pareja-Cebrian
c.	10:55	Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs) report including Nurse Staffing Deep Dive	For discussion & assurance	Ian Joy
d.	11:05	Maternity update including: i) Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress report	For discussion & assurance	Jenna Wall

	Time	Item	Purpose	Lead
		ii) Maternity Safety Champion Report		Liz Bromley
4. Supporting great care – supporting everyone to do their job to the best of their ability with effective leadership, a just and learning culture and modern digital and physical environments				
a.	11:15	Lord Mann Review – Trust response	For discussion & approval	Caroline Docking & Lee-Ann Naidoo
b.	11:22	Climate Emergency Plan	For discussion & approval	Vicky McFarlane-Reid and James Dixon
5. Items to approve				
a.	11:30	Accountability Framework	For discussion & approval	Patrick Garner & Kelly Jupp
b.	11:35	Modern Slavery Declaration	For approval	Kelly Jupp
c.	11:38	Charity Committee Annual Report	For approval	Caroline Docking
d.	11:40	NHS England (NHSE) Post Death Care Board Assurance Statement	For discussion & approval	Michael Wright
6. Items to receive [To cover by exception only]				
a.	11:43	Meeting Action Log	For receipt	Paul Ennals
7. Any other business				
a.	11:44	Any other business	For discussion	All

Date and Time of Next Meeting: Friday 25 September 2026, 10:15 – 12:15, Piano Room, Peacock Hall, RVI

Sir Paul Ennals, Chair

Mrs Liz Bromley, Non-Executive Director & Senior Independent Director (SID)

Mrs Jackie Bilcliff, Acting Deputy Chief Executive Officer/Chief Finance Officer

Mr Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals

Dr Michael Wright, Joint Medical Director

Dr Lucia Pareja-Cebrian, Joint Medical Director

Mr Patrick Garner, Director of Performance and Governance

Mrs Jenna Wall, Director of Midwifery

Mrs Kelly Jupp, Trust Secretary

Mrs Caroline Docking, Director of Communications and Corporate Affairs and Executive Lead on Equality, Diversity and Inclusion

Ms Lee-Ann Naidoo, Improvement Programme Manager

Mr James Dixon, Associate Director, Sustainability

PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 22 MAY 2026

Present:	Paul Ennals [<i>Chair</i>]	Chair
	Rob Harrison	Acting Chief Executive Officer (CEO)
	Lucia Pareja-Cebrian	Joint Medical Director (JMD)
	Michael Wright	JMD
	Jackie Bilcliff	Chief Finance Officer
	Ian Joy	Executive Director of Nursing, Midwifery & Allied Health Professionals (AHPs)
	Vicky McFarlane Reid	Interim Executive Director of People & Commercial Innovation
	Sue Hillyard	Interim Executive Director of Operations
	Anna Stabler	Non-Executive Director (NED)
	David Weatherburn	NED
	Liz Bromley	NED (<i>left the meeting at 11.02</i>)
	Bernie McCardle	NED
	Phil Kane	NED
	Wendy Balmain	NED

In attendance:

Judith McKenna, Associate NED
 Paul Hanson, Director of Estates, Facilities and Strategic Partnerships
 Caroline Docking, Director of Communications and Corporate Affairs
 Rachel Carter, Director of Quality and Safety
 Martin Wilson, Director - Great North Healthcare Alliance (GNHA) & Strategy
 Patrick Garner, Director of Performance and Governance
 Amy Callow, Director for People and Organisation Development
 Kelly Jupp, Trust Secretary
 Jenna Wall, Director of Midwifery (*for item 26/16 e. only*)
 Nichola Kenny, Director of Improvement and Delivery (*for item 26/15 c. only*)
 Sam Richardson, Peer Representative for Improving Resident Doctors Working Lives (*for item 26/17 a. only*)
 Kathryn Smart, Freedom to Speak Up Guardian (FTSUG) (*for item 26/17 b. only*)
 Paula Dimarco, FTSUG (*for item 26/17 b. only*)

Observers:

Joanne Race, incoming Associate NED for People
 Tania Bell, Member of the Public
 Philip Home, Public Governor
 Andrew Scott, Access and Integrated Healthcare Manager, Almirall Ltd

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

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

26/14 INTRODUCTION:

a. Apologies for Absence and Declarations of Interest

Apologies were received from NED's Bill MacLeod and Hassan Kajee, and attendee Dave Elliott, Chief Digital Officer.

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

b. Minutes of the previous meeting held on 27 March 2026 and matters arising

The minutes of the meeting held on 27 March 2026 were accepted as a true record of the business transacted.

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

c. Approval of the Trust Strategy

Patrick Garner reported that a "plan on a page" summarising the Trust Strategy had been circulated, with the full strategy included within the meeting papers. Board members approved the strategy in April 2026, and it was being formally launched today as a public document, with publication on the Trust website.

The strategy sets out a clear and focused direction for the organisation and includes the vision, values, and strategic priorities. These were refreshed to ensure they remained relevant and meaningful. The document also outlined tangible actions to be taken, which would, over time, be supported by detailed delivery plans. A key priority was to embed the strategy across the organisation as this would form an important part of any forthcoming Well-Led review by the Care Quality Commission (CQC).

The strategy would be incorporated into governance processes, for example through Board and Committee agendas. Further work was underway to ensure alignment with the Board Assurance Framework (BAF) and wider governance processes.

Patrick Garner thanked colleagues for their contributions to the development of the strategy, with particular recognition to Lisa Jordan, Assistant Director – Business, Planning and Strategy Management, Caroline Docking and Martin Wilson for their support.

A discussion ensued which covered the following areas:

- Strong positive feedback on the Trust Strategy, which provided a clear direction, good design, and a consistent focus on care.

- The need to embed the strategy across the organisation, particularly through governance processes, committee agendas, and clear delivery plans, with Clinical Board and Corporate Department leaders playing a key role.
- Ensuring alignment of other plans with the strategy, and making these easier to understand and connect.
- Improving visibility and accessibility for staff and the public, supported by roadshows and communications.
- Reviewing strategy delivery over time, including a 12-month check to assess understanding, impact and embeddedness across the organisation.

It was **resolved**: to **receive** the Trust Strategy and **approve** to publicly endorse the Strategy.

d. Chair's Report

The Chair's Report was received for information.

Paul Ennals thanked Gillian Elsander, PA to the Chair for drafting the report in his absence and noted the following points:

- The Health Bill proposed the removal of formal roles for Governors and Members. The majority of the responsibilities would transfer to the Secretary of State for Health and Social Care.

Emphasis was placed on developing more dynamic engagement models to complement forward-looking governance and decision-making processes. The approach aligned with and endorsed the Trust Board's current direction of travel.

- There was a need to strengthen future models for community engagement and staff involvement. Plans were to be developed by autumn to respond to these changes. This proactive approach would mean a smoother transition to the new arrangements when required.

A suggestion was raised to ensure this was communicated to the Governors, particularly in response to feedback received following the decision to pause the 2026 elections. This was scheduled to be discussed at a future Governor workshop.

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

e. Chief Executive's Report

Rob Harrison highlighted the following points:

- Progress against the findings of the independent Well-Led Review which included notable improvements in quality priority processes, providing a stronger foundation for consistent future performance.
- Ongoing challenges included addressing the longest elective waits and considering the resultant impact on patients and the wider system.
- Strong performance in patient surveys, supported by the real-time and right-time patient experience programme and associated improvement work.

- Successful step-down from all enhanced oversight arrangements with the Integrated Care Board (ICB).
- Continued ambition to stretch performance, with a focus on ensuring appropriate resourcing, including for specialised services such as severe intestinal failure.
- Progress on key clinical developments, including delivery of 24/7 mechanical thrombectomy by the year-end and increased transplant activity through the Organ Assessment and Recovery Centre (ARC).
- Infrastructure and service expansions, including the Urgent Treatment Centre (UTC) and Emergency Department (ED) developments.
- Longer-term improvements were underway in maternity and neonatal services.
- Advancement of major initiatives such as the Sir Bobby Robson Institute, supported by charitable contributions.
- Focus on improving colleague experience as part of the strategy, including expansion of the Accrediting Excellence (ACE) Programme to corporate teams.
- Enhancements to patient experience, including work on patient food, with updates shared at the Quality Committee.
- Redesign of outpatient models to improve access and move care closer to home.
- Continued development of neighbourhood care and urgent and emergency care pathways.
- Collectively, these programmes and improvements had informed and shaped the development of the Trust strategy.

A discussion ensued which covered the following areas:

- Concerns raised regarding securing appropriate commissioning and resources to support delivery of a 24/7 mechanical thrombectomy service. Sue Hillyard advised that the service opened on 8 June 2026, with full 24/7 provision anticipated by November 2026, supported by ongoing recruitment and regional collaboration. Communications would be issued once full arrangements were in place.
- The Sentinel Stroke National Audit Programme (SSNAP) audit rating (Grade C), with recognition of changes in guidance affecting scoring and a need to improve standards.
- Emphasis on collaborative, multidisciplinary working across Clinical Boards to drive improvement.
- Recognition and thanks to colleagues for progress made during 2025/26, including exiting from enhanced regulatory oversight.
- The importance of aligning resources appropriately to deliver strategic priorities, with further work underway by executive colleagues.
- Launch of a Trust-wide communication to support the strategy, helping staff understand their role and contribution.
- The need for clarity on deliverables for the current year and a phased approach to implementation.
- Identification of potential risks, including feedback from ward visits.

Paul Ennals noted that following the secondment of the Chief Executive to NHS England (NHSE), a remarkable amount of work had taken place. Formal thanks were expressed to the Executive Team and wider staff for their work and achievements over the past 12 months.

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

f. Committee Triple A reports

Paul Ennals advised that an experimental approach was being taken to position this item earlier in the agenda to support effective discussion.

Jackie Bilcliff advised that there had been extensive discussion at the Digital and Data Committee and Trust Board in the previous month in relation to the Laboratory Information Management System. Work was underway to agree a Memorandum of Understanding (MoU) with Northumbria Healthcare, with an Expression of Interest document now issued to support progression to the next stage.

In relation to the April Quality Committee, Anna Stabler referred to the strong presentation of the Facilities Management Change Programme. A significant, long-term transformation was underway, with six-monthly progress updates planned as part of a wider ambition to modernise and improve facilities. A letter from NHSE regarding antimicrobial resistance was also noted, which would be monitored through the Committee going forward. For the May Committee, there were no new alerts required for reporting.

At the March People Committee, Bernie McCardle advised the staff survey results update provided good assurance that staff feedback was being taken seriously, with deep dives and actions being progressed through Clinical Boards and ongoing oversight by the Committee. He also noted the national developments regarding the “fair deal” for nursing, including possible revaluation and re-banding, which may have an impact, although full details were not yet known.

Judith McKenna advised that 62 day cancer performance was raised as an alert to the Trust Board from the May Finance and Performance Committee (F&PC).

David Weatherburn reported that the Audit, Risk and Assurance Committee (ARAC) had held a constructive discussion on the Board Assurance Framework (BAF) and risk appetite framework. The discussion also reflected on CQC feedback and findings from the Well-Led Review. Further work was underway on mapping risks to committees in relation to the new strategy. It was clarified that the previous BAF remained in place whilst the new BAF was being developed.

Wendy Balmain reported that the Charity Committee had no alerts to escalate. Approval in principle had been given to move towards charity independence, with due diligence work underway to support this transition. A session was planned for the end of June to build full understanding, including engagement with staff and trade unions. Thanks were also extended to the charity for its support, particularly in relation to the Sir Bobby Robson Institute funding.

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

26/15 JOINING UP CARE – WORKING TOGETHER TO GIVE PEOPLE BETTER, QUICKER ACCESS TO EFFECTIVE CARE:

a. Board Visibility Programme

Rachel Carter reported that the data presented covered March and April 2026, during which 10 walkabouts were undertaken, being slightly more than usual, across inpatient, outpatient, and corporate areas. Whilst the report followed the usual format, consideration had been given to making it more engaging and impactful. Learning had been taken from Northumbria Healthcare colleagues, with their format replicated for discussion. The intention was to provide a richer account of discussions and resulting actions, and the Trust Board's views were sought on reporting arrangements going forward.

A discussion ensued which covered the following areas:

- Positive feedback on the revised proforma, with recognition that elements of the current approach could be retained, including clarity on escalation routes.
- Suggestion to present a small number of detailed walkabout reports, with remaining information made available in the reading room.
- Value noted in identifying both common themes across visits and providing deeper insight into individual visits to inform improvements.
- Example highlighted of a strong visit to Ward 9, with a positive environment, alongside a recurring theme of staff movement.
- Importance of naming the visiting Board member to strengthen accountability and ensure issues raised were clearly followed up and assurance was received.

It was **resolved**: to **receive** the report and **approve** the use of the alternative reporting format.

b. Integrated Board Report (IBR)

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

Patrick Garner noted the following points:

- Statistical process control (SPC) changes were formally highlighted.
- Notable improvements in performance were recorded.
- Two obstetric triage metrics were reviewed and discussed.
- Headcount reduction schemes were currently below target however; this position was not unexpected at this point in the year.
- F&PC members reviewed performance against the 62-day cancer target; this was also referenced within the Joint Medical Director's report.

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

c. Winter Plan evaluation

Nichola Kenny highlighted the following points:

- Overall attendances had increased, reflecting growth across the wider system.
- In the context of winter pressures, maintaining protection of the elective programme remained a priority.
- Marginal improvements had been observed in key performance indicators (KPIs), including the ED 4-hour performance and ambulance handover times.
- A range of initiatives had been sustained throughout the year, alongside the core operating model, to support patient flow.
- Key challenges anticipated for the coming year included improving uptake of the vaccination programme, with uptake of 64% achieved in the prior year, with further improvement required.
- Ongoing challenges remained in relation to corridor care, as well as mental health demand and ED waiting times. These issues had also been highlighted through regional debrief processes.

Sue Hillyard highlighted that the UTC was opened during the peak winter period however, subsequent analysis of performance data had highlighted some areas of performance concerns, prompting a reassessment of the actions currently in place. In response, targeted plans were being developed to recover approximately 5% performance, with a focus on strengthening delivery and addressing identified gaps.

A discussion ensued which covered the following areas:

- Whether expectations for the UTC had been realistic. It was noted that the current position reflected only phase one of the plan, with phase two incorporating system links and additional discharge capacity expected to drive significant improvement. The UTC remained one element of a wider ED model, with further work required on staff training and competencies, alongside mitigations such as ED support for paediatric demand. A full lessons learned report would inform the next phase, but slower-than-anticipated progress was currently impacting performance, which stood at 88–89%.
- There had been an increase in overall attendances, reflecting both the opening of the UTC and a broader upward trend in demand. The availability of improved clinical space had supported the management of higher patient volumes, and overall, this indicated a positive direction of travel.
- The impact of the corridor link and wider building works on the forthcoming winter plan, including expected progress. Planning for the corridor link had commenced, with a target start date in November, with further preparatory work to continue ahead of winter. Whilst the works were not expected to impact the UTC space directly, they would affect the connecting corridor between areas. Plans included the addition of four triage rooms, with phase two focused on optimising use of the overall space while maintaining service continuity. It was also noted that delays to Ward 38 have had a consequential impact on plans for the Paediatric Intensive Care Unit (PICU).

This had created challenges for both patients and staff, with quality and safety a key priority. Enhanced support had been provided to staff, and patient feedback had highlighted the impact, with key learning identified to inform improvements in patient experience going forward.

- Winter planning discussions focused on improving patient flow across pathways, from admission through to discharge, with recognition of contributions to this work. The 'call before you convey' pilot was viewed as important despite currently low volumes, though there were questions around consistency of use, coverage across care homes, and the level of partner engagement. Work was ongoing to embed a more consistent, collaborative system approach, supported by developing business cases.
- Support for staff between summer and the next winter period. It was noted that joint working had enabled significant change to be implemented under considerable seasonal pressures, with further efforts needed to strengthen staff engagement in the next phase. Additional investment had been made to enhance assessment capacity, though this presented challenges in balancing impact on staff morale while ensuring staff safety was maintained.
- Alongside patient experience, consideration should also be given to staff experience, with teams encouraged to share and discuss plans through local forums such as town halls to help identify opportunities for further support.

Paul Ennals noted the assurance provided and the commitment to learning, alongside recognition of the challenges faced by staff working under pressure. He acknowledged that, despite performing well in difficult circumstances, staff may feel they are not achieving the standard of care they aspire to deliver. Structural issues remained, some requiring collaboration with community partners, with evidence of progress and potential for further development in the coming year.

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

[Nichola Kenny left the meeting]

26/16 ADVANCING CARE – IMPROVING PATIENT CARE, EFFECTIVENESS AND QUALITY THROUGH INNOVATION, RESEARCH, IMPROVEMENT AND EDUCATION:

a. Patient and Staff Stories

Ian Joy explained that the strategy would be launched publicly with a focus on advancing care and showcasing flagship services, supported by powerful patient insight into lived experience within hospital settings. This perspective would be shared with staff to encourage new ways of thinking, reinforcing the importance of keeping patient experience at the heart of all activity, while recognising that staff themselves may also be patients.

Paul Ennals reflected on Lexi's Story, a previous story shared by a patient named Lexi.

Anna Stabler noted the positive stories, including the opening of Ward 24a for longer-term patients, which provided an improved and more appropriate environment for their care.

Vicky McFarlane-Reid highlighted that as Chair of the Enabled Network, she reinforced that the staff member detailed in the story made a positive contribution to the organisation, bringing enthusiasm to the role and giving back meaningfully through his involvement.

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

b. Joint Medical Directors Report including:

Michael Wright and Lucia Pareja-Cebrian highlighted the following points:

- Ongoing concerns regarding cancer performance, with an emphasis on maintaining a strong organisational focus. Close working continued with the performance team and clinical leadership, including the reappointment of the Associate Medical Director for cancer services.
- The 28-day faster diagnosis standard (FDS) remained a priority, with challenges noted in skin and breast pathways.
- Significant improvements had been achieved in skin cancer pathways through collaboration with Northumbria Healthcare however, further work was required to secure long-term solutions.
- Continued partnership working with County Durham and Darlington NHS Foundation Trust, particularly in breast care services.
- The above challenges had driven a shift in approach, with ongoing monitoring required.
- The 62-day standard remained a key performance concern, particularly in lung cancer.
- While some improvements in radiotherapy had been seen over the past year, these had not been sustained, with workforce and demand pressures impacting delivery.
- Focus remained on maximising existing capacity and understanding increasing service demand.
- Delays in treatments such as ablation persisted, primarily due to equipment and workforce capacity constraints.
- Extensive discussion relating to the above areas had taken place at the F&PC with future updates planned.
- Work was ongoing to align with national standards for invasive procedures, incorporating learning from recent incidents to identify improvement opportunities.
- Job planning has been completed, with the next annual cycle already underway.
- An Associate Medical Director (AMD) restructure had been implemented, aligning roles to Tier 1 Board Committees, with five portfolios assigned to a combination of new and existing postholders. Appreciation was expressed to those AMDs who had stepped down for their valuable contributions.
- Robotic surgery continued to be a significant area of strategic focus, with active involvement in the Shelford Group.
- The ARC continued to support the assessment and recovery of organs for transplantation.
- In response to the recent international alert regarding an outbreak of Andes Hantavirus on a cruise ship as had been reported in national media, the organisation had played an active role in the national response.

A discussion ensued which covered the following areas:

- Ablation, with ablation capacity currently managed within the Northern Centre for Cancer Care (NCCC) at the Freeman Hospital site, with rising demand including

referrals from other centres. Whilst short-term solutions existed without capital investment, longer-term sustainability would require both capital funding and ongoing support, with options for national funding being explored.

- Improving lung cancer performance and the potential wider impact on other services. It was acknowledged that anticipated improvements over the past 12 months had not materialised, alongside an increase in demand, and that current performance remained below expectations. Lung cancer pathways therefore remained a key area of concern, with improvement expected towards the end of Quarter 2.

The timeline for the business case would be firmed up, with confirmation provided that Radiology colleagues had developed an initial proposal to support this work.

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

i) Emergency Preparedness, Resilience and Response (EPRR)

Lucia Pareja-Cebrian advised that the EPRR annual report would be available in November. She noted that there were no significant changes at present; however, new standards published in August 2026 would prompt an assessment of any gaps and associated risks. Current focus was on strengthening business continuity plans.

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

ii) Guardian of Safe Working (GoSW) reports

Lucia Pareja-Cebrian explained that the GoSW reports were reviewed at the most recent People Committee meeting, with assurance received. Whilst national changes had occurred since February 2026, these had not been as significant as may have been anticipated, with a positive shift towards increased exception reporting.

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

c. Antimicrobial resistance – NHS England (NHSE) response

Lucia Pareja-Cebrian advised that a detailed discussion took place at the last Quality Committee meeting on the delivery plan. Anna Stabler noted that the Quality Committee would monitor progress throughout the year.

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

d. Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs) report including Nurse Staffing Deep Dive

Ian Joy highlighted the following points:

- There was a collective responsibility to ensure the right staffing is in place at the right time.
- Staffing reports were available within the Admin Control reading room.

- The six-month deep dive had been completed and formed part of a continual review process.
- A triangulated approach to data and professional judgement was used to inform decisions.
- Overall, the nursing establishment was broadly fit for purpose, with actions implemented where required.
- Some areas required further improvement, with short-term mitigations in place.
- Additional funding would be required to achieve full compliance.

A discussion ensued which covered the following areas:

- Quality Committee members had discussed that the 85% staffing standard had not consistently been met, primarily due to short-term sickness and limited ability to flex staffing levels overnight. Whilst appropriate ward-level structures were in place to support improvement, the importance of ongoing work to address staff absence was emphasised as a key factor in achieving compliance.
- Feedback from NED visits indicated positive engagement from nursing staff, with teams actively preparing for assessments and demonstrating strong involvement in improvement work through the Accrediting Excellence (ACE) programme.
- Engagement extended beyond nursing staff to include all clinical and multi-professional groups, as well as non-clinical areas. A recent conference brought together 450 nurses, midwives and AHPs, featuring both external speakers and internal staff showcasing quality improvement work, with thanks expressed for Board member attendance and support.

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

e. **Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress report**

Ian Joy highlighted the following points:

- The fetal medicine service continued to face staffing pressures, with ongoing challenges in recruiting to key consultant roles.
- A comprehensive action plan was in place, including estates improvements and enhanced electronic systems to support triage and patient risk management.
- The Quality Committee had received updates regarding referral pathways and activity.
- In response to a national alert, further actions were underway to maximise patient flow, including estates work. Some delays had been identified in the induction of labour pathway for example balloon catheter use, with improvements being made through staff competency development.
- Digital risk assessment processes within the Electronic Patient Record (EPR) had been strengthened.

[Sam Richardson joined the meeting]

- A robust review of all open pregnancy records had been undertaken to ensure appropriate prescribing of aspirin; affected patients had been contacted, and a Duty of Candour review was being completed to confirm no harm.
- The Maternity Incentive Scheme (MIS) year 8 was progressing broadly on track under a revised framework, with one safety action currently at risk pending national guidance, and actions actively being tracked.
- Updates would continue to be reported through the Quality Committee and to the Trust Board.

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

26/17 SUPPORTING GREAT CARE – SUPPORTING EVERYONE TO DO THEIR JOB TO THE BEST OF THEIR ABILITY WITH EFFECTIVE LEADERSHIP, A JUST AND LEARNING CULTURE AND MODERN DIGITAL AND PHYSICAL ENVIRONMENTS:

a. Resident Doctors 10 Point Plan

Sam Richardson highlighted the following points:

- The programme requirements were being progressed through the steering group, transitioning from initial mobilisation to delivery and action.
- Early progress had been achieved, with some quick wins gaining traction.
- Key challenges remained, including estates and facilities constraints, particularly identifying suitable space for Multi-Disciplinary Team (MDT) working.
- Variability existed in processes such as annual leave and rota coordination, with partial use of systems such as Medirota and ongoing work to identify a digital solution.
- Engagement challenges had been noted, including survey fatigue and the need to manage communications effectively to avoid over-saturation. Most engagement had been through the resident doctor forum, supported by surveys, recognising that some improvements would take time.
- Additional team support was now in place to assist with delivery.
- Appreciation was expressed for the work undertaken to date.

A discussion ensued which covered the following areas:

- People Committee members had received assurance regarding progress, noting strong work and effective processes in place.
- Similar engagement challenges were being experienced across other trusts, particularly with rotational resident doctors who may not see changes materialise during placements.
- Whilst progress was being made, engagement remained variable, and some staff were beginning to experience the impact of improvements.
- Medirota was highlighted as a key enabler, with ongoing rollout to additional areas (including paediatrics), and confidence expressed in continued progress. No significant barriers to implementation had been identified.
- The importance of identifying ‘hotspots’, where targeted Board-level focus may be required to improve the experience for resident doctors.

- Feedback from the General Medical Council (GMC) survey was being used to inform targeted improvement actions, supported by focus groups and ongoing communication efforts.
- Broader observations included the complexity of delivery, competing operational pressures, and the need to balance engagement with day-to-day service demands.
- Opportunities to gather feedback through wider forums and alternative communication channels were being explored.

Paul Ennals highlighted that overall, good progress was being made, although further work was required to achieve the desired position.

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

[Sam Richardson left the meeting. Paula Dimarco and Kathryn Smart joined the meeting]

b. Freedom to Speak Up (FTSU) update

Paula Dimarco and Kathryn Smart highlighted the following key points:

- A significant programme of work had been undertaken to embed improved working practices and further develop the FTSU Guardian offer.
- Progress had been made in strengthening governance around data, including the introduction of InPhase as a case management system.
- Work was ongoing to improve data quality through refinement of subcategories and more consistent classification.
- Collaboration with partners across the alliance was supporting alignment of categories and the sharing of improvement approaches.
- Reporting routes had been formalised, with a clear line of sight through the People Committee to the Trust Board.
- Some staff remained uncertain about how to access support or raise concerns, highlighting the need to strengthen visibility and trust. Improving organisational culture was recognised as a key enabler in addressing this.
- Mechanisms for distributing themes and learning across the organisation were still developing and remained a work in progress.

Bernie McCardle advised that People Committee members had received a FTSU update which highlighted significant development within the Speaking Up service, including the expansion from one part-time Guardian to two full-time Guardians to support a workforce of circa 16,000. Regular engagement with senior leaders was in place, and despite the relatively small team, the service was recognised as having a positive and valued impact. A strategic delivery plan was progressing well, although some challenges remained. A key priority was to strengthen confidence among staff to speak up, with recent staff survey results identifying areas for improvement, which were being explored further through detailed review and targeted improvement work.

A discussion ensued which covered the following areas:

- The importance of understanding workforce diversity, particularly in supporting staff from global majority backgrounds to feel confident in speaking up, including exploring

barriers that may prevent this. Engagement with the Race Equality Network was identified as a key mechanism to support this work, alongside recruitment into Speak Up champion roles.

- The need to ensure data accuracy and representation, including consideration of 'work in confidence' reporting and whether this reflected the wider organisation.
- Direct contact with senior leaders was not currently captured, and consideration was being given to recording this to provide a more complete picture of engagement. The importance of capturing all forms of contact was highlighted, and ensuring trusted reporting routes, including the role of staff networks.
- Organisational culture and confidence in speaking up remained central to this work.
- People and OD partners were closely aligned with the FTSU function, providing oversight and enabling early intervention.
- Collaborative working across the alliance, with support offered to organisations at earlier stages of maturity, particularly in championing recruitment and data management. This was a key element of the Alliance's strategic intent.

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

[Paula Dimarco and Kathryn Smart left the meeting]

c. Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report/Survey Results

Vicky McFarlane-Reid highlighted the following points:

- The WRES and WDES data would be published on 31 May 2026 which showed performance not aligned with intended targets.
- Evidence suggested staff experiences differed significantly, and negatively, compared to peers, with key areas of concern noted to include bullying, harassment, and inequitable progression opportunities.
- Board members had approved the 12-point EDI action plan which was a positive step but did not fully capture the scale and breadth of the issues.
- Additional detail was available within the full report in the AdminControl Reading Room.
- The WRES report highlighted concerns around whether the organisation was truly representative for example global majority colleagues were 6.33 times less likely to progress from bands 1-5 to band 8a+ (lower to upper).

Bernie McCardle noted that the data had been subject to thorough and robust challenge through the People Committee. There was a clear expectation to demonstrate tangible impact from the actions taken, with a focus on targeted priority areas and the strengthening of leadership development. Greater commitment and visibility was required at Executive level, alongside a stronger emphasis on identifying and implementing positive, practical actions to effectively address and reduce the issues identified.

A discussion ensued which covered the following areas:

- EDI priorities needed to be embedded within Clinical Boards, with the People team restructure and Business Partner model identified as a key opportunity to support this.

- Examples of good practice, including work in Maternity to challenge and improve quality approaches, should be scaled to support wider improvement across Boards.
- Objectives relating to this work should be clearly reflected within senior management priorities.
- Confidence was expressed in the rigour of improvement processes and the importance of using accurate information.
- Ensuring that more complex cases received appropriate and consistent support.
- Progress on the People restructure was estimated at 30–40%, with a deliberate and careful approach being taken to appointments despite challenges. A need was identified for greater assurance that current plans and resources would be sufficient to deliver a meaningful cultural reset **[ACTION01]**. Resource discussions were difficult, though some reallocation had already taken place, particularly within leadership.

Whilst good foundations and building blocks were in place, this remained an active and ongoing area of focus.

- Although improvements were being seen in some areas, the organisation was not yet where it aimed to be and must strengthen assurance around delivery and resourcing.

It was **resolved**: to **receive** the report and **approve** the publication of the data in the public domain by 31 May 2026.

d. Travel and Transport Plan

Paul Hanson highlighted the following points:

- A Trust-wide Travel and Transport Plan was being proposed following agreement of the Trust strategy, setting out a clear strategic direction for transport and travel needs. Approval was sought to support the plan, including its strategic context and associated delivery approach.
- Transport was noted to be a significant issue, with the organisation generating approximately 9 million journeys per year and incurring around £4.4m in car park management costs, operating at a loss rather than generating profit.
- Survey results from 2025 highlighted key challenges, particularly that public transport was perceived by some as unreliable and unaffordable.
- Extensive engagement had been undertaken, including with Trust Management Group (TMG), Green Champions, Matrons Forum, Employment Partnership Forum, Town Halls, Brief the Chair sessions, and wider discussions on parking.
- There was a recognised shortage of parking spaces across sites.
- Active travel improvements were underway, including development of a cycle hub at the RVI and further enhancements at the Freeman Hospital site.
- Work was ongoing with partners to improve public transport, including increased Metro frequency, though bus provision remained a national challenge.
- Safe walking routes were in place, with continued collaboration with local authorities to enhance accessibility.
- Key actions included refreshing the Trust Travel Group and undertaking a comprehensive review of the parking policy.

- Planned priorities included expanding cycle storage, engaging with North East Combined Authority (NECA) and Nexus to improve affordability and access to public transport, and creating a Transport Hub to improve efficiency.
- Parking policy proposals included a formal review process with robust engagement, clear objective criteria, planned charging approach, regular review, time-limited permits, an online application system, and a streamlined appeals process.

Rob Harrison noted that the overall package should take into account the full cost of travel for staff. Paul Hanson advised that consideration should be given to the financial impact of travel, particularly for more junior and lower-paid colleagues. Further work was needed with the People team to better understand and assess the daily cost of commuting to work for these staff groups.

It was **resolved**: to **receive** the report and **approve** the Travel and Transport plan and support the implementation of the recommendations.

26/18 ITEMS TO APPROVE:

a. Quality Account

Rachel Carter advised that following a 30-day consultation period, all feedback had now been received to inform the final draft.

Anna Stabler highlighted that the Quality Account been reviewed through the Quality Committee and was being recommended to the Trust Board for approval.

It was **resolved**: to **receive** the report and **approve** the Quality Account.

b. Committee Annual Reports 2025/26 and Charity Committee Terms of Reference and Schedule of Business 2026/27

Kelly Jupp explained that the Committee Annual Reports and the Charity Committee Terms of Reference (ToR) and Scheme of Business (SoB) had been reviewed across all relevant committees, with key updates highlighted in the cover sheet, including changes to the Charity Committee ToR and SoB. The Trust Annual Report was currently undergoing external audit review.

It was **resolved**: to **receive** the report and **approve** the Committee Annual Reports 2025/26 and Charity Committee Terms of Reference and Schedule of Business 2026/27.

26/19 ITEMS TO RECEIVE:

a. Learning from Deaths Report

Rachel Carter advised that the Learning from Deaths Report and presentation of data was discussed in detail at the most recent Quality Committee meeting.

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

b. Meeting Action Log

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

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

26/20 ANY OTHER BUSINESS:

a. Any other business

Martin Wilson highlighted the recent Equality and Human Rights Commission (EHRC) announcement, emphasising the importance of treating individuals with dignity and respect. A new code of practice had been published following the Supreme Court ruling, with wider implications for organisations, and was due to become official in 39 days. Further guidance was expected from NHSE. Initial work in this area began last year, with plans now to reaccelerate activity through the relevant working group to fully understand and implement the implications, alongside continued liaison with Alliance partners to ensure alignment.

On behalf of the Trust Board, David Weatherburn noted that this was Phil Kane's final meeting and recognised his significant contributions over the past two years. His experience, confidence, and strong regional insight were particularly valued, especially in relation to the Charity Committee. His approach brought energy and authenticity to discussions, and his leadership and impact across the organisation were highly appreciated.

Phil Kane reflected on the changes achieved during his tenure and emphasised the importance of carrying forward key learning into future roles. He acknowledged the substantial work undertaken within the Quality Committee and Tier 2 groups, and expressed appreciation for the charity team, recognising their impact and progress towards independence.

The meeting closed at 12.54.

Date of next meeting: Public Board of Directors – Friday 31 July 2026.

Summary of actions:

1. Progress on the People restructure is estimated at 30–40%, with a deliberate and careful approach being taken to appointments despite challenges. A need was identified for greater assurance that current plans and resources will be sufficient to deliver a meaningful cultural reset [**ACTION01**].

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TRUST BOARD

Date of meeting	31 July 2026						
Title	Chair's Report						
Report of	Sir Paul Ennals, Chair						
Prepared by	Sir Paul Ennals, Chair Gillian Elsender, PA and Corporate Governance Officer						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☐		☒		
Summary	This report outlines a summary of the Chair's activity and key areas of recent focus since the previous Trust Board meeting held in Public in May 2026: • Board Succession • Governor Activity • Informal Visits • External Meetings						
Recommendation	The Board is asked to note the contents of the report.						
Links to Strategic Priorities	Joining up Care		Advancing Care		Supporting great Care		
	☐		☐		☒		
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability	
	☒	☒	☐	☐	☐	☐	
Link to the Board Assurance Framework [BAF]	No direct link however provides an update on key matters.						
Reports previously considered by	Previous reports presented at each Public meeting.						

CHAIR'S REPORT

Our succession planning for Board continues and I am pleased to welcome Joanne Race, Associate Non-Executive Director (NED) for People and Jeff Perring Clinical (NED) who both joined the Trust on 6 July following a robust interview process and compliance with all NED onboarding procedures in line with the NHS England Fit and Proper Person Test Framework for Board members.

Joanne brings over 35 years of senior Human Resources (HR) and Organisational Development (OD) experience, most recently as Director of HR and OD at Durham University. Joanne holds an MA (Master of Arts) in Strategic HR Management and is a Chartered Fellow of the CIPD (FCIPD).

Jeff is a Consultant Intensivist in Paediatric Critical Care with Sheffield's Children's NHS Foundation Trust. He became their Executive Medical Director and Responsible Officer in July 2018, with responsibility for patient safety, medical workforce standards, appraisal and revalidation and is also the Trust's executive lead for quality, patient safety and mental health.

Board Activity

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

- Outpatients Transformation – We discussed establishing a clear vision for outpatient transformation focused on improving access, quality and financial sustainability. Areas of focus include oversight of key outcomes, including waiting times, patient experience and productivity, while ensuring the necessary digital, workforce and partnership arrangements are in place.
- Board Assurance Framework (BAF) - Discussions highlighted opportunities to simplify and strengthen the new BAF, including clearer risk descriptions, reducing overlap between committees, addressing gaps in areas such as digital and research, and improving oversight of transformation and change.
- Risk Appetite Statement (RAS) - The annual review of the Risk Appetite Statement identified a greater willingness to accept risk in areas such as people, culture and digital innovation, while recognising ongoing tensions between regulatory requirements, organisational capability and transformation ambitions. There was agreement that the RAS should be used more actively in decision-making and that governance and risk frameworks should be simplified where appropriate, and more closely aligned to the Trust's strategic priorities and transformation programme.

The annual round of appraisals of NEDs has now been completed for 2025/2026. Performance against the corporate and personal objectives for each NED were discussed. In addition, NEDs were asked to self-assess themselves using the self-assessment form within the NHS Leadership Competency Framework, and 360-degree feedback was obtained for each NED. I am delighted to advise that all NEDs have met, or exceeded, their objectives.

In June I completed the Annual Fit and Proper Persons return and this was submitted to the

NHS England Regional Director by the 30 June 2026 deadline. Testing was conducted in accordance with the NHS England Fit and Proper Person Framework and the outcomes of the testing enabled me to submit a return which provided full assurance that all Board members were 'fit and proper'. Board member references were completed for all leavers as appropriate and a detailed report will be considered at the Audit, Risk and Assurance Committee meeting on 28 July 2025.

ACTIVITY WITH GOVERNORS AND MEMBERS

At our Governor Workshop in June, in addition to our standard reports, we had our regular update on local matters, recent news and achievements, reports on patient and staff experience, performance and finance delivered by Rob Harrison, Acting Chief Executive. We also heard about the work of Anna Stabler (NED) and Chair of the Quality Committee, and Liz Bromley, Senior Independent Director and Maternity Safety Champion.

Anna highlighted that the Quality Committee continues to oversee several improvement programmes and is developing approaches to better understand and monitor clinical outcomes. Liz shared the positive changes in maternity patient experience, improvements in service environments and noted encouraging progress in creating an open and supportive culture for both staff and families using our maternity services.

Martin Wilson, Director - Great North Healthcare Alliance & Strategy, provided an update on the Great North Healthcare Alliance ('the Alliance'), which reviewed achievements from the previous year and outlined future priorities. The Alliance's renewed strategic focus is on improving secondary and tertiary care services, bringing care closer to patients where possible, and strengthening collaboration across partner organisations. Cancer services have been identified as a priority area for joint working. Examples of the benefits delivered through the Alliance included improvements in audiology services, the development of Community Diagnostic Centres and the sharing of best practice to enhance patient experience.

Vicky McFarlane Reid provided an opportunity for discussion on the results of the latest NHS Staff Survey. While response rates remained stable, there had been little overall improvement in staff engagement scores, and a notable gap remains between staff recommending the Trust as a place to receive care and recommending it as a place to work.

She outlined plans to build on the new Trust strategy by focusing on culture, leadership development, recognition and reward, and the creation of a more open and learning-focused environment. Governors emphasised the importance of listening directly to staff, ensuring colleagues feel heard and addressing concerns that affect their day-to-day experience at work.

We continue our engagement with Governors in relation the NHS Ten-Year Plan's intent to remove the formal powers of Councils of Governors from March 2027. As part of our ongoing work to develop a clear process for creating the Trust's future engagement model, we held a workshop with Governors on 9 July which focused on the current status of the

Agenda Item A1(c)

Health Bill 2026 and potential future models of public accountability, engagement and involvement.

Discussions focused on how the Trust can maintain strong public accountability and meaningful engagement in the future. Draft engagement principles emphasised co-production, inclusivity, transparency, listening to feedback and engaging under-represented communities.

Further work will be undertaken to develop possible engagement models, with consideration given to representation, accountability, recruitment, partnership working and wider community involvement. Feedback from the workshop will help shape proposals to be developed with stakeholders and the Alliance.

In addition to our formal meetings, I continue to meet with Governors informally, the latest being on 2 June, providing a space for them to raise any issues arising between formal meetings and enabling me to update them on key regional and national developments.

INFORMAL VISITS & EVENTS

On 10 and 11 June I attended NHS ConfedExpo 2026 which focused on the challenge of turning NHS strategy into action. Key themes included the shift towards prevention and neighbourhood-based care, with greater emphasis on supporting people closer to home and improving population health.

Digital transformation remained a priority, with discussions centred on the practical implementation of technologies such as Artificial Intelligence (AI) and data sharing to improve patient care and operational efficiency. Overall, the conference highlighted that while the NHS has a clear vision for the future, success will depend on effective delivery, collaboration and demonstrating measurable impact.

On 16 June, I had the pleasure to welcome more than 30 of the Trust's charity partners, many of whom have supported patients, families and services for many years. The event provided an opportunity to recognise and celebrate the significant contribution charities make through funding, volunteering and wider support, all of which play a vital role in enhancing patient and staff experiences across Newcastle Hospitals. Guests were thanked for their continued commitment and partnership, with the afternoon highlighting the strength of collaboration between the Trust and its charity partners.

I received an invitation from the Vicar of Thockrington Church, Northumberland, where Lord William Beveridge is buried, to attend a service marking the 800th anniversary of the church's link with York Minster and the dedication of a new stained-glass window celebrating Beveridge's legacy and contribution to the founding principles of the NHS. Given the significance of the occasion, NHS representatives were invited to attend. Unfortunately, due to a prior commitment I was unable to do so; however, our Vice Chair, Bill MacLeod, attended on behalf of the Trust.

OTHER MEETINGS AND INFORMATION

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

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

RECOMMENDATION

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

Report of Sir Paul Ennals
Chair
20 July 2026

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 July 2026					
Title	Committee Triple A Reports					
Report of	Hassan Kajee, Chair of the Digital and Data Committee Anna Stabler, Chair of the Quality Committee Bernie McCardle, Chair of the People Committee Bill MacLeod, Chair of the Finance and Performance Committee David Weatherburn, Chair of the Audit, Risk and Assurance Committee Wendy Balmain, Chair of the Charity Committee					
Prepared by	Lauren Thomspson, Corporate Governance Manager/Deputy Trust Secretary					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☒		☐	
Summary	The following Committee Triple A Reports/Chairs Logs are included since the last Public Trust Board meeting in May 2026: - Digital & Data Committee – 7 May 2026 - Quality Committee – 14 May & 18 June 2026 - People Committee – 12 May 2026 - Finance & Performance Committee – 18 May & 22 June 2026 - Audit, Risk & Assurance Committee – 19 May & 23 June 2026 - Charity Committee – 7 May (Funding only)					
Recommendation	The Trust Board is asked to note the contents of the Committee Triple A Reports/Chairs Logs.					
Links to Strategic Priorities	Joining up care		Advancing care		Supporting great care	
	☒		☒		☒	
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	Detailed in the individual Committee Triple A Reports/Chairs Logs.					
Reports previously considered by	Public Board meeting in May 2026.					

Escalation and Assurance Report

Name of Committee / Group:	Digital and Data Committee
Date of Committee / Group:	7 th May 2026
Chair of Committee / Group:	Hassan Kajee

Alert

(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group e.g. breaches in legal or regulatory requirements, fraud, significant negative inspection/audit findings, unmitigated risks rated 20+, major changes in funding/commissioning, industrial action or risks to business continuity/emergency preparedness)

No alerts were reported.

Advise

(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee / Group is seeking assurance over and list any decisions made/approvals)

Director of Digital

The Chief Nursing Information Officer (CNIO) informed the committee of the appointment of Joanne Todd as the new Director of Digital. Joanne is due to commence in late June. The Committee noted the appointment and welcomed her anticipated contribution to the Trust.

Clinical Safety

The Committee reviewed clinical safety arrangements for new and legacy systems. While assurance for new systems at implementation was considered robust, members agreed that oversight of legacy systems requires further strengthening. This led to an agreed action to provide a complete list of existing digital systems, outstanding clinical safety risk assessments and technical debt, together with a prioritised plan for addressing these risks.

GLIMS

The Committee received an update on the Genomics Laboratory Information Management System (GLIMS), a significant digital programme to support genomics laboratory processes. Members noted that the project has experienced delivery challenges over a number of years, including an earlier supplier-led approach that did not achieve the expected outcome. The Committee was advised that supplier engagement has strengthened, including senior executive involvement, and that confidence in delivery has improved. The current financial position remains indicative and will be subject to further validation through the business case process. The Committee was supportive of the proposed direction of travel, subject to the usual governance and assurance processes.

Assure

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

Project Completions

The Chief Digital Information Officer reported that the recent Millennium upgrade has been successfully completed. While similar upgrades have been undertaken previously on other platforms, this implementation resulted in minimal disruption. User impact was limited to a simple log out and log in, representing a significant improvement compared to earlier upgrades where downtime was more noticeable. The Digital Health and Technical teams were commended for delivering the upgrade effectively, drawing on previous experience while improving the approach and outcome. The Trust were the first in the country to implement the Millennium upgrade.

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The Operational Director, Digital & Technology Services reported that a major Health Information Exchange upgrade was completed, representing one of the largest code changes undertaken. A minor issue was identified post-implementation, where data from Cumberland Infirmary and West Cumberland was not displaying in the Great North Care Record, this was quickly resolved. It was also noted that due to the Trust Board agreeing to the move to Oracle Cloud, one of the key benefits of this investment is the increased ability to undertake system upgrades with significantly reduced disruption to the organisation.	
Risks (any new risks / proposed changes to risk scores – include risk ID where known)	
No new risks.	
Cross-referrals to other Committees / Executive Director Leads	
No cross referrals.	
Agreed actions	Responsibility / timescale
Alliance Key Performance Indicator (KPI) document To present the Alliance KPI dashboard at the next committee meeting.	Alliance Lead for Digital Governance and Risk Timescale: Committee meeting July 2026
Care Quality Commission (CQC) Update To set out clear outcome measures and thresholds for CQC related actions, define what "good" looks like, and determine at what point CQC specific reporting can transition to business as usual, then report back to the committee.	Chief Nursing Information Officer. Timescale: Committee meeting July 2026
Clinical Safety Risk To compile and present a complete list of existing digital systems, indicating outstanding clinical safety risk assessments and technical debt, and propose a prioritised plan for addressing these risks to the committee.	Clinical Safety Officer and Chief Digital Information Officer Timescale: Committee meeting July 2026
Data Security and Protection Toolkit To raise at the Policy Review Group that a clear statement is needed, potentially within the Policy for Policies document, to confirm that policies currently under review remain valid and in force.	Head of Corporate Risk and Assurance Timescale: Before next committee meeting July 2026

Escalation and Assurance Report

Name of Committee / Group:	Quality Committee
Date of Committee / Group:	14 May 2026
Chair of Committee / Group:	Anna Stabler

Alert

(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group e.g. breaches in legal or regulatory requirements, fraud, significant negative inspection/audit findings, unmitigated risks rated 20+, major changes in funding/commissioning, industrial action or risks to business continuity/emergency preparedness)

No issues for the Board to be alerted on.

Advise

(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee / Group is seeking assurance over and list any decisions made/approvals)

- Deteriorating Child Improvement Group** The Committee noted strong progress in bringing together key work areas and establishing actions, though measurable outcomes and timelines remain difficult to define. Transition to business-as-usual has begun, but further clarity is needed on digital developments. While progress was welcomed, reporting should focus less on transactional detail and better demonstrate risks, outcomes, and impact. Reporting will move to quarterly, with improved distinction between operational updates and assurance-level reporting
- Emergency Department (ED) Improvement Group** The Committee noted good progress in the Emergency Department Improvement Group, with strengthened governance, a targeted Quality Improvement approach, and steps toward business-as-usual. While some delays and estate-related problems remain, improvements in pathways, patient information, and experience were recognised. Clearer assurance reporting is needed, with a fuller update planned for September to support de-escalation and transition to routine reporting.
- Integrated Board Report (IBR)** The report provided assurance on performance across Quality & Safety, Access, People, and Finance, highlighting the need for improved data presentation. Key points included improved pressure ulcer reporting, no severe harm falls, and enhanced complaints data with ongoing KPI (Key Performance Indicators) development. Overall, the IBR continues to offer advisory insight, supported by SPC (Statistical Process Control) data to identify variation and emerging issues.
- Invasive Procedures and Consent Update** Progress on a PSIRF (Patient Safety Incident Response Framework) safety priority programme responding to previous never events was discussed. While early work has identified variation, gaps in standardisation, and engagement challenges, interim safety measures are in place and longer-term improvements are underway. The importance of standardisation, staff engagement, and a strong safety culture alongside clear accountability was noted.

- **Learning from Deaths** The Committee recognised the strong governance framework with progress evident, but residual risks remain in staffing levels, national compliance, and completion of review work.
- **Six-Month Nurse Staffing Review Deep Dive** The report was presented, confirming it supports statutory assurance on staffing, safety, and quality, with models broadly fit for purpose and aligned to patient need. While there has been progress in recruitment, governance, and innovative approaches, pressures remain in areas such as the Emergency Department, specialist services, and overall staffing levels. The Committee noted strong progress acknowledging some risks in areas still in development.
- **Health Inequalities Annual Report** Overall, good progress was acknowledged, with assurance that governance and engagement were strengthening, though further work is required to embed and sustain delivery.
- **Board Assurance Framework (BAF)** Plans to refresh the BAF to better align with the Trust strategy and strengthen its role in assurance were noted, though challenges remain around risk alignment and governance. The Committee welcomed the progress but acknowledged further refinement was needed.
- **Quality Committee Annual Report** The Committee reviewed and approved the Quality Committee Annual Report, noting it provided a comprehensive overview of responsibilities, activity, and performance over the past year.

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

- **Perinatal Quality Surveillance Report Including Maternity Incentive Scheme** Ongoing service pressures from demand, staffing and supply issues, were highlighted but assurance was provided that safety is being maintained through active oversight. Despite challenges such as the national prostaglandin shortage and digital workload, patient experience remains broadly positive and progress continues on workforce and inclusion initiatives with recognition of strong leadership.
- **Quality Account Priorities** The draft Quality Account was presented, noting that it provides a comprehensive overview of performance, improvements, and ongoing challenges, with priorities set for 2026/27. All statutory requirements have been met and external feedback has been positive.
- **End of Life and Palliative Care** Significant progress in reshaping palliative and end-of-life care services, aligned to neighbourhood working, was noted. Work is underway to strengthen community pathways, improve coordination, and reduce avoidable admissions. Committee recognised strong leadership and progress, applying while noting some risks remain as developments continue.
- **Medicines Reconciliation** There was consensus that the organisation can be considered assured on progress to date, reflecting confidence in the processes and improvements achieved, whilst acknowledging that further work is still required, but this is primarily a matter of ongoing progress rather than deficiencies in process.
- **Wards of Concern and Accrediting Excellence (ACE) Progress Report** While ongoing operational pressures were acknowledged, these were recognised as challenges within normal operational delivery rather than systemic issues. Overall, the Committee agreed it was assured, noting that strong processes,

governance, and oversight are in place across wards and departments despite these pressures.	
(any new risks / proposed changes to risk scores – include risk ID where known)	
No new risks identified.	
Cross-referrals to other Committees / Executive Director Leads	
No cross-referrals.	
Agreed actions	Responsibility / timescale
1. A more comprehensive update will be scheduled for September to support decisions on de-escalation of the ED Improvement Group and transition to routine reporting.	1. Catherine Carr head of Nursing – Medicine & Emergency Care – September Committee.
2. End of Life and Palliative Care - future updates to include data on the number of patients with learning disabilities receiving earlier, face-to-face advance care planning assessments, to better understand impact and progress	2. Jennifer Vidrine, Clinical Director and Consultant in Palliative Medicine – November Committee.

Escalation and Assurance Report

Name of Committee / Group:	Quality Committee
Date of Committee / Group:	18 June 2026
Chair of Committee / Group:	Anna Stabler

Alert

(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group e.g. breaches in legal or regulatory requirements, fraud, significant negative inspection/audit findings, unmitigated risks rated 20+, major changes in funding/commissioning, industrial action or risks to business continuity/emergency preparedness)

There were no alerts discussed.

Advise

(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee / Group is seeking assurance over and list any decisions made/approvals)

- **Improvement Group update Infection, Prevention and Control (IPC)** – The Committee was assured of the robustness of the processes in place and the progress achieved; however, it was emphasised that these initiatives now require measurable outcomes which will support the process of de-escalation. This will be progressed by the group and an update provided in future reports.
- **Improvement Group update Ophthalmology** – Tight control and governance arrangements were confirmed to be in place with additional information provided in the comprehensive action plan. It was agreed that de-escalation criteria would be considered ahead of the next update.
- **Mental Health update** - A substantial programme of work has been undertaken to strengthen mental health governance and structural arrangements since the CQC inspection in 2023. A number of key workstreams in place focus on estate, education and patient assessment. Appropriate mitigations are in place to manage environmental challenges and there are clear objectives for the year ahead. It was agreed that the committee would receive a 6 monthly report.
- **Integrated Board Report (IBR)** – It was highlighted that a section on Harm Free Care - Venous Thromboembolism (VTE) assessments, has now been incorporated, with further detail to be provided at future meetings. One incident meeting the Never Events criteria occurred in April 2026, categorised as the administration of incorrect routine medication. In response, project work and staff engagement initiatives have commenced, and a patient safety incident investigation is currently underway.
- **Quality Priority 1 - Supporting staff to report incidents with an enhanced focus on shared learning and a systems-based approach to improvement** – A reduction in reported incidents was noted in April 2026, likely influenced by bank holidays and junior doctor industrial action however efforts will continue to encourage comprehensive reporting. Patient Safety Incident Response Framework (PSIRF) work, including the invasive procedures priority group, is ongoing,

alongside a strong focus on strengthening safety culture through expanded training, with central coordination supported by Quality and Safety Leads. • Patient-Led Assessment of the Care Environment (PLACE) Inspection Update Report – The PLACE assessment was completed in October/November 2025, with oversight from the Steering Group and Estates team. A cross-organisational workplan is in place, and although volunteer participation was lower than in previous years, no new escalations were identified. Ongoing monitoring will continue. • Learning Disability and Safeguarding Quarter 4 reports – It was highlighted that referrals have increased however workforce risks have been mitigated with all posts filled. Progress continues in embedding the documentation of reasonable adjustments and the use hospital passport with a quarterly audit framework agreed, A phased rollout of the Oliver McGowan training has commenced, with ongoing monitoring to support improved understanding and patient care, despite implementation challenges at scale. Safeguarding capacity and workforce remain a concern, although mitigations are in place pending further assessment to inform future planning. A safeguarding governance review has been completed. The committee was informed regarding a recent change to the legal framework relating to Deprivation of Liberty Safeguards with work in place to understand the impact on clinical care and staff education.

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

• Perinatal Quality Surveillance Report Including Maternity Incentive Scheme – The Trust is on track to meet the Maternity Incentive Scheme (MIS); however, risks remain in relation to medical staffing within fetal medicine. Some progress has been made through developments in the job planning process. Further work is underway to review referral pathways and explore opportunities to enhance local support.

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

No new risks identified.

Cross-referrals to other Committees / Executive Director Leads

• Improvement Group update IPC - Power BI/ SharePoint, ICNet implementation to be discussed at the Digital and Data Committee. • Board Assurance Framework (BAF) - The first iteration of the 2026/27 BAF was discussed in detail, including potential shared objectives and principal risks. It was noted that the BAF is scheduled for further discussion at the June Board Development Workshop.
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Agreed actions	Responsibility / timescale
1. Improvement Group update IPC – The Quality Committee to receive an update	1. Lucia Pareja-Cebrian, Joint Medical Director / August 2026

as to when the Power BI/ SharePoint, ICNet will be implemented in Clinical areas.	
2. Mental Health update – It was agreed that the Quality Committee will receive a further update in 6 months' time.	2. Lucia Pareja-Cebrian & Rachel Gregory, Associate Director of Nursing / January 2027

Escalation and Assurance Report

Name of Committee / Group:	People Committee
Date of Committee / Group:	12 May 2026
Chair of Committee / Group:	Bernie McCardle, Non-Executive Director (NED)

Alert <i>(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group e.g. breaches in legal or regulatory requirements, fraud, significant negative inspection/audit findings, unmitigated risks rated 20+, major changes in funding/commissioning, industrial action or risks to business continuity/emergency preparedness)</i>	
• Freedom to Speak Up (FTSU) – The Staff survey indicators for speaking up have decreased across all relevant measures between 2024/25 and 2025/26. While this mirrors national trends, it represents an ongoing cultural risk requiring targeted intervention, particularly in low scoring departments.	
Advise <i>(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee / Group is seeking assurance over and list any decisions made/approvals)</i>	
• People Plan overview and action plan tracker – The Committee suggested a refocus to help ensure the programme remains meaningful and impactful, with support from the People Programme Board. It was noted that clearer messaging and accountability for delivering actions would be beneficial. Some further clarity around terminology and timelines would also support delivery. Alignment between the new Trust Strategy and Year 3 of the People Plan was encouraged. • Leadership Development Programme – The Committee received good assurance and noted that the direction of travel is appropriate, with progress underway. However, further progress is required, and greater clarity, including defined timescales. • Equality Diversity and Inclusion (EDI) high impact action plan – The Committee noted the inclusion of EDI as a positive step, with continued progress in embedding it within organisational objectives and values. An update was provided on the people restructure and the evolving role of HR Business Partners (HRBPs), which are expected to support EDI work. The support of the Executive Team was acknowledged, and the importance of aligning EDI, WRES, and WDES reporting with the new Trust Strategy and People Plan was highlighted to support a more integrated overview. • Freedom to Speak Up (FTSU) – The Committee noted the significant work undertaken in line with FTSU requirements and governance arrangements, including the development of an enhanced dashboard. However, further work is ongoing in relation to the implementation of the FTSU Guardian Service Delivery Plan and staff engagement. Reported concerns continue to centre on safety,	

inappropriate behaviours, bullying, and harassment, all of which are being taken seriously. • Resident doctor 10 point plan – Significant progress has been made, with bi-weekly meetings in place to discuss emerging matters. Work is ongoing with NHS England (NHSE) and the Deanery in relation to rotas. It was noted that the Chief Resident Registrar will attend the May 2026 Public Trust Board meeting to provide a further update. • Integrated Board Report – The Committee received good assurance and noted that performance is being regularly reviewed, with particular focus on areas of low compliance in statutory and mandatory training. Areas of concern remain in relation to appraisal compliance and sickness absence, which continue to be closely monitored. • Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) - The Committee was assured that reporting is compliant; however, performance data is not yet at the expected level and will be addressed through ongoing monitoring and oversight. The Committee ratified the reports for Trust Board approval.	
Assure <i>(key assurances received and any highlights of note such as best practice or innovation)</i>	
• Staff psychology support service – The Committee were assured of the progress that has been made however there is an element of risk in relation to funding. Evaluation and alignment of some existing structures are still required to ensure maximum impact.	
Risks (any new risks / proposed changes to risk scores – include risk ID where known)	
• No new risks or proposed changes to risk scores.	
Cross-referrals to other Committees / Executive Director Leads	
• No new cross-referrals.	
Agreed actions	Responsibility / timescale
1. Staff psychology support services - An update will be provided at the November Committee meeting, including further detail on the service's needs, available data, and triangulation across Psychology, Human Resources (HR), and Occupational Health.	1. Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs) & Ashley Tiplady, Consultant Clinical Psychologist, Working Well / November 2026

Escalation and Assurance Report

Name of Committee / Group:	Finance and Performance Committee
Date of Committee / Group:	18 May 2026
Chair of Committee / Group:	Hassan Kajee, Non-Executive Director (NED)

Alert

(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group e.g. breaches in legal or regulatory requirements, fraud, significant negative inspection/audit findings, unmitigated risks rated 20+, major changes in funding/commissioning, industrial action or risks to business continuity/emergency preparedness)

- **Integrated Board Report (IBR)** – Concerns were noted in relation to 62-day cancer metric with the latest unvalidated data showing a 10% deterioration since December 2025. Outliers include Lung, Urology, Upper Gastrointestinal (GI) and Lower GI. Pathway analysis, supported by targeted actions, is being undertaken to drive measurable improvements in performance and reduce waiting times. An escalation meeting led by the Executive Lead for Cancer is being set up.

Advise

(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee / Group is seeking assurance over and list any decisions made/approvals)

- **Cardiothoracic and Haematology Clinical Board update** – A comprehensive update on financial performance was received; however, it was noted that the 2026/27 Cost Improvement Programme (CIP) target of 5.32% (£5.77m) remains stretching. While CIP schemes are underway and continuing to develop across multiple areas, including commercial procurement and pharmacy, there is an ongoing need to strengthen delivery plans to ensure the target is achieved.
- **Month 1 revenue report including Cash** - The month 1 position shows a £391k deficit, which is in line with the financial plan. However, there is a £1,577k shortfall against Clinical Board and Corporate Services CIP in month 1 compared to plan. Additional pressures arising from industrial action and increased drug costs have been identified, although these have been mitigated through the use of non-recurrent measures.
- **Capital** - The Trust's capital allocation for 2026/27 was £54.7m including private finance initiative (PFI) Lifecycle costs. As at month 1, the Trust had spent £1m against a plan of £3.9m. The forecast for the year is currently £72.5m once adjusted for schemes funded from donations this mean the capital programme is currently over-committed by £13.1m.
- **Veolia** – The Committee received an update on future energy provision for the Trust. Engagement with providers, discussion with partners and comparisons across the NHS have informed a set of recommendations which were discussed in detail prior to the May Private Trust Board meeting.

- **IBR – Emergency Department (ED) performance** across all types reached 79.82% in March 2026, representing a 4.27% improvement compared to February 2026. There was also a significant reduction in 52-week waits, decreasing by 198, resulting in only 0.7% of the total Referral to Treatment (RTT) waiting list exceeding 52 weeks and remaining comfortably below the national target of 1%. Performance against the 5% standard improved in March 2026, and the 28-day Faster Diagnosis Standard (FDS) was achieved in February 2026. However, the 62-day cancer metric continues to be highlighted as an area of concern.
- **Winter Plan Evaluation –** The Committee received an update on the 2025/26 winter plan which was developed earlier than in previous years and presented to the Trust Board in July 2025. The plan largely mirrored the previous year's approach, with key elements including the provision of additional bed capacity on Winter Ward 12 at the Freeman, alongside strengthened workforce support both front of house and back of house to effectively manage outlying patients. Key successes and lessons learned from this years' experience will be reviewed and incorporated into the planning for winter 2026/27 to support continuous improvement.

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

There were no items categorised as assure.

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

No new or proposed changes to risks noted.

Cross-referrals to other Committees / Executive Director Leads

No cross-referrals noted.

Agreed actions	Responsibility / timescale
1. Cardiology Service Review will be presented to the Finance and Performance Committee & Trust Board at a future meeting.	1. Sue Hillyard, Interim Executive Director of Operations & Chris Wright, Director of Operations / Date to be confirmed (TBC)
2. To check the governance route and oversight for Children's Weight Management Services.	2. Patrick Garner, Director of Performance and Governance / June 2026

Escalation and Assurance Report

Name of Committee / Group:	Finance and Performance Committee
Date of Committee / Group:	22 June 2026
Chair of Committee / Group:	Bill MacLeod, Non-Executive Director (NED)

Alert

(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group e.g. breaches in legal or regulatory requirements, fraud, significant negative inspection/audit findings, unmitigated risks rated 20+, major changes in funding/commissioning, industrial action or risks to business continuity/emergency preparedness)

- **Cancer Performance** – In April 2026, performance against the 62-day standard was 65.0%, below both trajectory and standard, with recent deterioration driven by multiple factors, particularly within Lung pathways, and with most backlog in Lung, Upper Gastrointestinal (GI), Lower GI, and Urology services. The Committee was updated on the immediate key actions aimed at reducing the 62 day patients backlog and improving performance.

Advise

(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee / Group is seeking assurance over and list any decisions made/approvals)

- **Cancer and Haematology Clinical Board update** – A comprehensive update was received and at month 2 the Clinical Board reported a £398k adverse variance against the budget. At the start of 2026/27 the Clinical Board had Cost Improvement Programme (CIP) plans totalling £2,345k against a full year target of £2,974k. Work is ongoing to improve the CIP position and investigate medical overspend.
- **Month 2 revenue report including Cash** - The month 2 position reflects a £1.2m deficit, which is broadly in line with the financial plan. There is a £1,645k shortfall against the Clinical Board and Corporate Services CIP in Month 2 compared to plan, alongside pressures relating to industrial action and drugs. These have been partly offset through non-recurrent measures and a reduction in the run rate of clinical supplies. Key actions will focus on further developing and strengthening CIP delivery plans to support delivery of the overall financial plan.
- **Capital** - The Trust's capital allocation for 2026/27 was £54.7m including Private Finance Initiative (PFI) lifecycle costs. As at month 2, the Trust had spent £3.1m against a plan of £6.2m. There is a significant amount of work underway, although a couple of more complex areas remain.
- **Integrated Board Report (IBR)** – Performance has declined across key areas including the 62-day cancer standard, Referral To Treatment (RTT), and diagnostics, with Emergency Department (ED) also worsening slightly in May 2026 due to increased demand. While RTT and Faster Diagnosis Standard (FDS) show

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some improvement, the year has started challenging for ED and RTT. Focus is on strengthening recovery plans, particularly for 62-day performance and ED pressures. • A number of business cases and procurement reports were approved.	
Assure <i>(key assurances received and any highlights of note such as best practice or innovation)</i>	
There were no items categorised as assure.	
Risks (any new risks / proposed changes to risk scores – include risk ID where known)	
No new or proposed changes to risks noted.	
Cross-referrals to other Committees / Executive Director Leads	
Cancer Performance – This matter is already included within the Quality Committee's Schedule of Business; however, it would be appropriate to highlight its possible implications for patient harm.	
Agreed actions	Responsibility / timescale
1. Quarter 4 NHS Oversight Framework outcome – A further update to be provided at the July Finance and Performance Committee meeting.	1. Patrick Garner, Director of Performance and Governance / July 2026

Escalation and Assurance Report

Name of Committee / Group:	Audit, Risk and Assurance Committee
Date of Committee / Group:	19 May 2026
Chair of Committee / Group:	David Weatherburn, Non-Executive Director (NED)

Alert

(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group e.g. breaches in legal or regulatory requirements, fraud, significant negative inspection/audit findings, unmitigated risks rated 20+, major changes in funding/commissioning, industrial action or risks to business continuity/emergency preparedness)

No 'alert' items identified during the meeting.

Advise

(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee / Group is seeking assurance over and list any decisions made/approvals)

- **Board Assurance Framework (BAF)** – In terms of triple A reporting Committee members agreed an "Advise" position with the new BAF approach agreed however further work needed to finalise the new 2026/27 BAF with input from all Tier 1 committees.
- **Risk Appetite** – recorded as Advise pending further development of the Risk Appetite Statement.
- **Grant Thornton Well-Led Review** – A triple A rating of Advise was recorded, reflecting ongoing progress with no immediate concerns but work not yet complete. The work was positively received as comprehensive and well-structured, supporting wider governance improvements. Committee members approved the updated plan.
- **External Review Process and Governance** - A triple A rating of Advise was recorded reflecting strong work in progress requiring further development and implementation.
- **Draft Trust Annual Financial Statements and Trust Accounts Consolidation (TACs) including financial details of accounting estimates and key judgements** - In terms of triple A reporting a rating of Advise was recorded being mindful that the audit was ongoing with active discussion with external auditors.
- **Internal Audit Progress Report** - A triple A rating of Advise was recorded being mindful of the ongoing work required in relation to the internal audit plan, including further discussion and refinement (particularly around HR audits), and optimisation of resources to address backlog and programme delivery.
- **Internal Audit Charter** - The document was considered clear, standard, and appropriate, with no concerns raised and was approved by the Committee. In terms of triple A reporting a rating of "Advise" was recorded to notify the Board that the Charter had been approved.

- **Committee Self-Assessment of Effectiveness and Audit Committee Annual Report** - Overall, the committee was content with the findings and agreed to approve the self-assessment. In terms of triple A reporting a rating of “Advise” was recorded to notify the Board that the self-assessment and Committee Annual Report had been approved.
- **TCWG Response (Those Charged with Governance)** - No concerns or issues were raised by members, and the Committee members confirmed its satisfaction and approved the document for submission to the external auditors. In terms of triple A reporting a rating of “Advise” was recorded to notify the Board that the TCWG response had been approved.

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

- **Risk Management Report** – A triple A rating of Assure was recorded, recognising a well-evidenced process with ongoing refinement as part of business as usual.

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

No new risks identified.

Cross-referrals to other Committees / Executive Director Leads

No cross referrals.

Agreed actions	Responsibility / timescale
1. Progress update in relation to new External Review Process and Governance to be added to agenda and schedule of business for every second month starting July 2026.	1. Kelly Jupp, Trust Secretary – June 2026
2. Review and adjustment of the audit plan for 2026/27 following deferral of 3 HR audits	2. Jackie Bicliff, Chief Finance Officer – June 2026
3. To provide further details in relation to historical breach of Standing Financial Instructions	3. Jackie Bicliff, Chief Finance Officer – June 2026
4. Health Research Authority contracts – write off report alongside proposals for managing this risk in future to be prepared for future Committee	4. Chris Haynes - Assistant Finance Director, Financial Services

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Escalation and Assurance Report

Name of Committee / Group:	Audit, Risk and Assurance Committee
Date of Committee / Group:	23 June 2026
Chair of Committee / Group:	David Weatherburn, Non-Executive Director (NED)

Alert

(matters of significant concern requiring escalation for further action or to bring to the attention of the full Board / Committee / Group e.g. breaches in legal or regulatory requirements, fraud, significant negative inspection/audit findings, unmitigated risks rated 20+, major changes in funding/commissioning, industrial action or risks to business continuity/emergency preparedness)

No 'alert' items identified during the meeting.

Advise

(areas subject to ongoing monitoring where some assurance has been noted / further assurance sought or emerging developments that the Committee / Group is seeking assurance over and list any decisions made/approvals)

- **Board Assurance Framework (BAF)** – Committee members recognised that the BAF remained at an early stage of development and that further refinement was required to ensure risks, controls, mitigations and Committee ownership were appropriately aligned, particularly where risks spanned multiple Committees. Committee members took assurance from the progress made to date and noted the AAA rating of "Advise", recognising that development of the BAF remained ongoing.
- **Standards of Business Conduct Report** – Committee members noted improved compliance with declarations of interests, gifts and hospitality. While assurance was taken from this progress and no significant concerns were identified, members recognised the need to strengthen understanding of declaration requirements, improve oversight of potential conflicts of interest and clarify arrangements for managing non-compliance. Ongoing work to enhance transparency and assurance was noted, and the item remained rated "Advise".
- **Annual Accounts 2025/26** – Committee members received assurance on the 2025/26 Annual Accounts. Members noted that the Trust had delivered a strong financial performance, exceeding its planned break-even position, supported by additional deficit funding linked to achievement of financial targets. Following review by the Finance & Performance Committee and completion of the external audit process, Committee members agreed to recommend the Annual Accounts to the Trust Board for approval.
- **Internal Audit Progress Report** - Committee members received assurance from the Internal Audit Progress Report, noting an improved trend in audit outcomes compared with previous years. Lessons from audit findings would be applied across the organisation and monitored through established governance processes.

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• Annual Governance Statement – Committee members received assurance from the Annual Governance Statement 2025/26, noting that it was supported by a range of evidence, including Internal and External Audit findings, regulatory reviews and external assessments. Members were assured by the Trust’s governance arrangements, the Head of Internal Audit’s Reasonable Assurance opinion, and the progress made in addressing outstanding actions. Committee members approved the statement and noted that no significant control issues had been identified during the year. • Annual Report 2025/26 – Committee members reviewed the Annual Report 2025/26, noting that only minor amendments had been made following the external audit process. Members welcomed the report as a comprehensive and balanced reflection of the Trust’s achievements, challenges and commitment to continuous improvement, recognising the significant contribution of all those involved in its preparation. Committee members agreed to recommend the Annual Report 2025/26 to the Trust Board for approval.	
Assure <i>(key assurances received and any highlights of note such as best practice or innovation)</i>	
• Final Head of Internal Audit Opinion - The Committee received assurance from the Head of Internal Audit Opinion, which concluded that the Trust had a Reasonable Assurance framework in place. Members noted positive progress in audit outcomes, and a high rate of implementation of agreed audit actions. Committee members agreed that the opinion provided a fair reflection of the Trust’s current position and was assured that further progress would be made during 2026/27. • Management Letter / ISA260 Report to the Trust - Committee members received assurance from the External Audit Completion Report, noting that an unqualified audit opinion was expected and that no significant issues had been identified in relation to the financial statements, key audit risks or internal controls. Members welcomed the positive findings, which reflected the significant governance and quality improvements made by the Trust, and agreed to place the report in the “Assure” category, subject to completion of the final audit procedures.	
Risks (any new risks / proposed changes to risk scores – include risk ID where known)	
No new risks identified.	
Cross-referrals to other Committees / Executive Director Leads	
It was suggested to strengthen the reporting framework for Quality and Equality Impact Assessments associated with service reviews, including consideration of routine reporting to the Quality Committee and the role of Clinical Boards in oversight and implementation.	
Agreed actions	Responsibility / timescale
1. Standards of Business Conduct Annual Report / Declarations - The report was noted, with further work to be undertaken through executive routes to	1. Natalie Yeowart, Head of Corporate Risk and Assurance – July meeting

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consider the process for non-compliance with declaration requirements and learning from others to seek assurance that declarations were captured appropriately. Natalie Yeowart agreed to provide an update at a future Committee meeting.	
2. An update on proposed contract management arrangements would be brought back to the Committee by Jackie Bilcliff later in the calendar year.	2. Jackie Bilcliff, Chief Finance Officer – November meeting
3. Tracking of alerts/escalations - whilst escalation arrangements were already in place to Trust Board through existing governance processes, further discussion would take place outside the meeting regarding how tracking of alerts could be strengthened. Kelly Jupp agreed to follow up.	3. Kelly Jupp, Trust Secretary – July Committee

Charity Committee - Chair's Log

Meeting: Charity Committee – Funding only	Date of Meeting: 7 May 2026
Connecting to: Audit, Risk & Assurance Committee / Trust Board	Date of Meeting: 23 June 2026 / 31 July 2026
Key topics discussed in the meeting	
- Funding proposals were discussed and the outcomes were as follows: - Trustwide/Corporate - Upgrade to breast feeding/expressing spaces and moving baby changing stations - £94,273 – the proposal was deferred pending feedback from Clinical Boards regarding collaborative use of funds. - Trustwide/Corporate - Beechwood House Furniture - £104,457 – the proposal was supported with conditions of seeking external funding. - Trustwide/Corporate - Accrediting Excellence Programme - £266,583 – the proposal was deferred pending feedback from Clinical Boards regarding collaborative use of funds. - Trustwide/Corporate - Deciding Right: Advanced Care Planning Clinical Educator (Band 7), 12 Month Fixed Term - £70,384 - the proposal was deferred pending feedback from Clinical Boards regarding collaborative use of funds. - Family Health – TYA/Rare Tumours Nurse Specialist - £140,768 – the proposal was supported with conditions. - Peri-op - Purchase Equipment to Allow Continuous EEG Monitoring for Critically Ill Patients - £30,000 - the proposal was supported. - Cardiothoracic Services – XVIVO EVLP Servicing - £22,000 – the proposal was supported with conditions as suggested in the assessment, including the acknowledgement of the Charity's support. - Family Health - Resident Parent Snack Bags as part of Sophie's Legacy - £89,863 – the proposal was supported with conditions suggested in the assessment including work to begin with regard to the future funding position - as well as acknowledgement of Newcastle Hospitals Charity's support and data around sustainability. - Medicine – Living well with HIV Project - £25,000 – the proposal was supported. - The summary of funding agreed since the last meeting was received (bids up to £20k).	
Actions agreed in the meeting	Responsibility / timescale
No actions from these applications.	
Escalation of issues for action by connecting group	Responsibility / timescale
Not applicable.	
Risks (Include ID if currently on risk register)	Responsibility / timescale

None identified.	
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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 July 2026		
Title	Board Visibility Programme		
Report of	Rachel Carter, Director of Quality & Safety		
Prepared by	Anne Marie Troy-Smith, Quality Development Manager		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	The objective of the Board Visibility Programme is to provide a structure that enables identification of areas where care delivery may require improvement, support and expertise to address the more difficult issues that may be impacting on the quality and safety of patients and staff. The walkabouts raise awareness of front-line issues and support the visibility and accessibility of senior leaders within the organisation. This report provides an overview of the findings from the twenty-four walkabouts by Executive Directors (n=10) and Non-Executive Directors (NEDs) (n=14) undertaken during May and June 2026. Alert - There are no current alerts to Trust Board from the May – June 2026 walkabouts Advise - The strongest positive themes were high staff engagement, compassionate care, excellent teamwork, visible & positive leadership, pride in delivering patient care, a commitment to continuous improvement. There were also consistent themes relating to Multidisciplinary Team (MDT) collaboration, and a proactive focus on innovation and patient flow improvement. - Where any concerns were raised which required further action, these were shared with relevant executives and service leads, detail is provided within this report. Assure - The most common areas of concern or improvement related to continued workforce pressures, infrastructure limitations, and ensuring concerns raised by staff lead to visible action and organisational support. There were also consistent themes related to space constraints, service integration, and operational pressures associated with delivering increasingly complex care.		

Recommendation	The Trust Board is asked to note the contents of this report in relation to both positive feedback from Trust staff, and concerns/suggestions raised for improvements. It is also asked to review the new reporting format which has now been implemented.					
Links to Strategic Priorities	Joining up care		Advancing care		Supporting great care	
	☒		☒		☐	
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.					
Reports previously considered by	The previous Board Visibility Programme Report was presented to the Trust Board in May 2026.					

BOARD VISIBILITY PROGRAMME

1. INTRODUCTION

This report provides an overview of the findings from the twenty-four walkabouts by Executive Directors (n=10) and Non-Executive Directors (NEDs) (n=14) undertaken during May and June 2026.

2. PROCESS

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

Stream 1 [Leadership Walkabouts]: Executive Team members and senior managers from the Quality and Safety Department participate in a one-hour joint visit to a pre-defined clinical or corporate area.

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

Management of the Leadership Walkabout schedule is co-ordinated by the Quality and Safety Department (stream one) and the Corporate Governance Team (stream two).

After consideration by Trust Board in May 2026, a new Board visibility template, based on a similar proforma from Northumbria Healthcare was introduced in June 2026. This offers a summary of the purpose of the visit and includes prompts to facilitate informal productive conversations. The walkabout teams/NEDs also use this as a guide to undertake their visits and capture:

- First impressions
- Observations of staffing, patients, environment
- Summary
- Potential actions identified.

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

As part of the new reporting process one Executive Team Member and one NED will present their walkabout findings at the Trust Board meeting (Appendix 1 & 2).

All other reports are collated by month and can be found in the Reading Room for consideration. As the new format was not introduced until June 2026 some reports remain in the old format for May/early June.

3. SUMMARY OF FINDINGS

The table below summarises the walkabouts undertaken throughout May and June 2026. Six walkabouts were carried out by Executive Directors in May and four in June. Nine walkabouts were carried out by Non- Executive Directors in May and five in June. In total 24 Leadership Walkabouts were undertaken with a further two cancelled during this timeframe due to staff availability and competing pressures. Four reports have not yet been received and are therefore not included in this report.

Further detail is provided in the Summary of Findings Report in the Board of Directors Reading Room.

Stream	Area visited	Date	Site	Membership of Walkabout Team	Staff who took part in the conversations
Stream One	Dental Hospital– Radiology	01.05.2026	Royal Victoria Infirmary (RVI)	Director of Quality and Safety, Patient Safety & Risk Manager.	Operational Service Manager, Administration staff, Radiographer, Assistant Practitioner
	Ward 12 Great North Children’s Hospital (GNCH)	05.05.2026	RVI	Director Great North Healthcare Alliance & Strategy, Quality Development Manager	Nursing staff, Ward Sister, Administration staff, Domestic staff, Physiotherapists x2, Registrar x1.
	Ward 17	06.05.2026	FH	Director of Pharmacy, Clinical Effectiveness Advisor	Staff Nurse, Healthcare Assistant, Matron, Operational Manager
	Ward 17	07.05.2026	RVI	Director of Communications and Corporate Affairs, Clinical Effectiveness Advisor	Sister, Staff Nurse, Domestic

Stream	Area visited	Date	Site	Membership of Walkabout Team	Staff who took part in the conversations
	Neuroradiology	22.05.2026	RVI	Director of Improvement and Delivery, Clinical Effectiveness Manager	MRI Technician, Student Radiographer, Senior Radiographer, Reporting Radiographer, Fellow – CT Control Room, Neuroradiology Registrar, Rotational Registrars
	Newcastle Loan Equipment Service	28.05.2026	Geoffrey Rhodes Centre	Executive Director of Finance/Acting Deputy Chief Executive Officer, Patient Safety Manager	Head Occupational Therapist, Loan Equipment lead, Loan Equipment operational and secretarial staff
	Community Diagnostics Centre (CDC) Metrocentre	Cancelled due to lack of staff availability at the CDC.			
	Assessment Suite	01.06.2026	RVI	Director of Performance and Governance, Clinical Effectiveness Advisor	Staff Nurse, Healthcare Assistant, Pharmacy Technician, F1
	Chest Clinic	04.06.2026	RVI	Director of Estates, Facilities and Strategic Partnerships, Integrated Governance Manager	Sister, Lung Cancer Nurses, Respiratory Nurse
	Ward 7 GNCH	09.06.2026	RVI	Executive Director of Nursing, Midwifery and Allied Health Professionals, Quality Development Manager	Sister, Staff Nurse, Student Nurse

Stream	Area visited	Date	Site	Membership of Walkabout Team	Staff who took part in the conversations
	Ward 19	16.06.2026	Freeman Hospital (FH)	Director Great North Healthcare Alliance & Strategy, Quality Development Manager	Sisters x2, Staff Nurses x2, Physiotherapist, Associate Practitioner, Occupational Therapist, Resident Doctor, Nurse Practitioners x2, Ward Clerk
	Ward 35 RVI	Cancelled by Executive due to urgent meeting.			
Stream Two	Children's Weight Management	06.05.2026	RVI	Non-Executive Director	Consultant, Dietician, Psychologist, Patients
	Ward 42	06.05.2026	RVI	Non-Executive Director	Sister, Operational Service Manager
	Ward 49	06.05.2026	RVI	Non-Executive Director	Sister, Matron, Operational Service Manager, Consultant
	Renal Outpatients, Wards 31&32	07.05.2026	FH	Non-Executive Director	Consultant, Department Head, Matron, Operational Service Manager
	Sterile Services Department	11.05.2026	RVI	Non-Executive Director	Quality Manager, Manager
	Newcastle Hospitals In-House Tobacco Dependency Treatment Service	13.05.2026	FH	Non-Executive Director	Report awaited
	Wards 21,24,24A & 30	14.05.2026	FH	Non-Executive Director	Matron, Nursing staff

Stream	Area visited	Date	Site	Membership of Walkabout Team	Staff who took part in the conversations
	Great North Children's Hospital	18.05.2026	RVI	Non-Executive Director	Director of Operations
	Estates	18.05.2026	RVI	Non-Executive Director	Management Team Presentation
	Human Resources	04.06.2026	Regent Point	Non-Executive Director	Not specified
	Cardio Theatres	19.06.2026	FH	Non-Executive Director	Nursing staff, Matron, Operational Services Manager
	Out-Patients Desk areas	29.06.2026	FH & Cramlington	Non-Executive Director	Report awaited
	Palliative Care	30.06.2026	FH	Non-Executive Director	Report awaited
	Wards 13,14 & 15	30.06.2026	FH	Non-Executive Director	Report awaited

Key themes identified include:

- The strongest positive themes were high staff engagement, compassionate care, excellent teamwork, visible & positive leadership, pride in delivering patient care, a commitment to continuous improvement. There were also consistent themes relating to Multidisciplinary Team (MDT) collaboration, and a proactive focus on innovation and patient flow improvement.
- The most common areas of concern or improvement related to continued workforce pressures, infrastructure limitations, and ensuring concerns raised by staff lead to visible action and organisational support. There were also consistent themes related to space constraints, service integration, and operational pressures associated with delivering increasingly complex care.

Where any concerns were raised which required further action, these were shared with relevant Executives and Service Leads. A number are noted below for reference.

- Radiology Dental Department require clarification from Estates in relation to an unknown/unpleasant smell of sulphur in department – what is it and how it will be resolved. Estates team investigating.

- In the Chest Clinic at the RVI there is a smoky smell entering vents from the roadworks on Leazes Road. There is a concern amongst some staff that the hydrogenated vegetable oil condenser behind the Urgent Treatment Centre could cause emission issues to the Clinic when it is in use. Estates are currently involved and working on a solution.
- The Walkabout Team suggested that Ward 17 FH take forward “over recruitment” as a strategy to mitigate against the challenges of staff shortages. This is in place for Band 5 and band 3 staff and will be discussed further with the local leadership teams.
- A review of discharge prescription turnaround times was expressed as a concern on ward 19 FH. The Quality Development manager contacted pharmacy who are reviewing the turnaround times issues with ward 19.
- Repatriation issues regionally with some staff concerned regarding the impact on beds and delays to treatment. This is continuously being monitored and actioned by the operational team.

4. RECOMMENDATION

The Trust Board is asked to note the contents of this report in relation to the positive feedback from Trust staff and concerns escalated/suggestions raised for improvements. It is also asked to review the alternative reporting format used this month.

Report of Rachel Carter, Director of Quality & Safety
Prepared by Anne Marie Troy-Smith, Quality Development Manager.
13 July 2026

Appendix 1. Non-Executive Director walkabout overview

Walkabout Stream: Non-Executive Director

Members of the Walkabout Team: Anna Stabler

Site/ Ward/ Department: Cardio Theatres FH

Job Title of staff spoken to (staff names are not required): Band 7, Matron, Band 6, Operating Department Practitioner (ODP), Consultants

First Impressions

Area was well organised, clean. Work ongoing to facilitate more storage space.

Observations i.e. Environment/ Staffing/ Patients

Morning Safety Huddle- Very well attended by staff, discussion regarding the theatre cases today clear and made all aware of the proposed running order and lists that had been stood down. The huddle provided updates regarding any Infection Prevention and Control (IPC) issues, complaints and incidents. Staff were also asked for volunteers to cover the transplant list later in the day. Staff told me they valued the meeting, however that due to ongoing bed / staffing issues things could change throughout the day.

8am Consultant meeting – Frustration regarding consultants due to lack of beds therefore patient cancellations, negotiation between them as to who was doing what when. Consideration given to wait times and cancer diagnosis, linked to Intensive Treatment Unit (ITU) / High Dependency Unit (HDU) bed availability. Nursing staff remain concerned that patients are sometimes waiting a long time for procedures.

Observation theatre 4 – Staff voiced concerns regarding the delays in start times in theatre but noted this was surgeon dependant. They also raised issues about not having access to IT, to assist them in their role since work went on the cloud (need to type up assessments) also access to systems to do audits and not having to pull data manually. World Health Organisation (WHO) checklist observed, error noted with patient ID and they stopped the proceedings until it was sorted. In phase completed.

Summary

Frustrations remain regarding staffing and bed availability; this has not changed in the two years I have been visiting. Staff remain committed and proud to work there.

Potential Actions Identified

Were there any issues you needed to address during your visit? ☐ Yes ☒ No

If yes, what was the issue(s)? Not applicable

Responsible person: Not applicable

When should this action be completed by: Not applicable

Appendix 2: Executive Director walkabout overview

Walkabout Stream: Executive Director

Members of the Walkabout Team: Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals & Anne Marie Troy-Smith, Quality Development Manager

Site/ Ward/ Department: Ward 7 GNCH RVI

Job Title of staff spoken to (staff names are not required): Ward Sister, Staff Nurse and student nurse.

Date: 09/06/2026

First Impressions

The ward was quiet with one patient at the time following a very busy morning clinic. Area clean, tidy and well kept. Staff were welcoming and willing to engage.

Observations i.e. Environment/ Staffing/ Patients

The ward was described as welcoming, supportive, and very patient-oriented, with good communication and visible, approachable leadership. Staff across roles (Sister, staff nurse and student nurse) generally felt well supported and valued teamwork and learning culture.

For the delivery of high-quality care, close working relationships with the nurse specialist team was described as essential, collaborative and highlighted as a strength. It was noted that as a small and highly specialised unit, local successes can often be missed and the Sister plans to celebrate success in a different way moving forward which was discussed. Staff are encouraged to attend Nursing Roadshow with plans in place to enable staff time to attend.

Ward Sister explained a clear pathway for patient transition from paediatric to adult services which starts at aged 14 supported by 'Ready Steady Go' programme supported by a Young Adult Co-Ordinator. The Ward on list to undertake Accrediting Excellence (ACE) (awaiting completion of estates work to create new treatment room space, currently treatment room and drug room in one space).

Key challenges included:

- Scheduling of patient care – mornings can be very busy with afternoons less so, ward sister is working on this currently with key stakeholders.
- Feeling connected to the wider Board and Trust. As area is so specialised can at times feel isolated. Not part of staff rotation programme due to complexity of care and training needed for dialysis. Work is underway to address this locally.
- Training for Paediatric Dialysis takes six months. Base inpatient ward for this patient group is ward 1a. Patients on ward 1a come to Dialysis unit if needing dialysis. Due to nature of ward 1a being general care as opposed to Renal there is not an opportunity for staff to rotate into the Dialysis unit to gain experience in dialysis.

Summary

Overall, morale is good, with a strong team culture. Areas of challenge were noted and in the process of being addressed and supported locally. No areas of escalation.

**Potential
Actions
Identified**

There were no issues that required immediate action during the visit.
Estates improvement work is planned this has stopped ACE accreditation which I Joy feels could be managed and will discuss with the ACE Lead.

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 July 2026		
Title	Integrated Board Report		
Report of	Patrick Garner, Director of Performance & Governance Rachel Carter, Director of Quality & Safety		
Prepared by	Elliot Tame, Head of Performance		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	Quality - Methicillin-Sensitive Staphylococcus aureus (MSSA) cases increased (17 vs 14) but remained within common cause variation. There were 2 Community-Onset, Healthcare-Associated (COHA) cases and 15 were Hospital-Onset, Healthcare-Associated (HOHA). Of the 14 cases, nine were selected for investigation. To date, learning opportunities have been identified in two cases, with contributory factors relating to intravascular device documentation and management noted in one case. - Clostridioides difficile Infection (CDI) cases decreased (12 v 15) and remains within the parameters of common cause variation. A system-based investigation process has been implemented within InPhase, with early insights currently under review ahead of formal evaluation. - There were three stillbirths in May 2026. - The National benchmark for term admissions is 5%. The Trust rate remains consistently above the national 5% target with 6% term admission rate in May. Further analysis is in progress of infants born within 37th week of pregnancy as this group represent 40% of admissions. Performance - Emergency Department (ED) Performance (All Types) in May was 76.5%, a decrease of 2.1% compared to April (79.0%). ED attendances increased in May to 24,767, 1,650 patients more than April, with Type 1 Major attendances at 9,507, also the highest seen in years. - Referral to Treatment (RTT) 18-week compliance increased to 73.5% in May (+1.2% from April). Performance improvement was linked to a further rebound in the waiting list size following the conclusion of the Trust's participation in an NHS England sponsored validation sprint at the end of March. - In May, the 80% 28 Faster Diagnosis Standard (FDS) target was achieved, performance sat at 85.0% and demonstrates special cause variation of an improving nature. People - Staff in post - total is 15,884.94 Full-Time-Equivalent (FTE) including bank/agency. Total substantive is 15,470.75 FTE, 17,691 headcount. - Top reasons for sickness: anxiety/stress/depression 32.85% (-0.58%); other musculoskeletal problems 11.24% (+0.71%); gastrointestinal 9.70% (-0.02%).		

	• Average working days lost is 1,036 (headcount) per day for the reporting period. • Mandatory training completion reduction of 0.05%. Lowest is Medical and Dental 79.91% (+0.74%). A Task & Finish Group has been commissioned to look at 'process and provision'. Finance • The Trust delivered a deficit of £1.1 million in month 2, in line with the financial plan. The deficit is anticipated to grow until Cost Improvement Programme (CIP) delivery increases from month 4 onwards. • There is a shortfall of £1,645k on Clinical Board and Corporate Services CIP in month 2 when compared to financial plan. • Due to a higher than planned cash balance, interest receivable is higher than plan by £724k. • There is an overspend on Block and tariff drugs, offset by an underspend on matched drugs and overspends on pay emerging, however in May this has been offset by underspends on Clinical Supplies, which is due to lower patient activity.					
Recommendation	This paper is received to provide assurance to the Board on the Trust's performance against key indicators relating to Quality & Safety, Access, People and Finance, and actions ongoing to address key issues preventing the recovery or sustainability of performance delivery.					
Link to Strategic Priorities	Joining up care		Advancing care		Supporting great care	
	☒		☒		☒	
Impact	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	6.2 Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care.					
Reports previously considered by	This report is delivered on a monthly frequency.					

Integrated Board Report

July 2026



Healthcare at its best
with people at our heart

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SPC Variation / Assurance – Changes from previous month

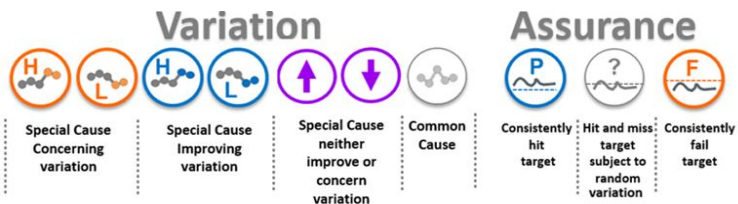
	Apr-26	May-26
Inpatient Falls per 1,000 bed days		
ED Arrival to Admission/Discharge <12hrs		
Maternal deaths		
Neonatal Re-admissions (Total)		
RTT 18 Weeks Performance		

SPC Variation

- **Five** high level metrics have displayed changes in special cause variation from April 2026 to May 2026.
- Special cause variation of an improving nature (low) to common cause variation):
 - Inpatient Falls per 1,000 bed days
 - Emergency Department (ED) Arrival to Admission/Discharge <12hrs
- Special cause variation of an improving nature (high) to common cause variation:
 - Maternal deaths
 - Neonatal re-admissions
- Common cause variation to special cause variation of an improving nature (high):
 - Referral To Treatment (RTT) 18 weeks performance

SPC Assurance

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



Quality

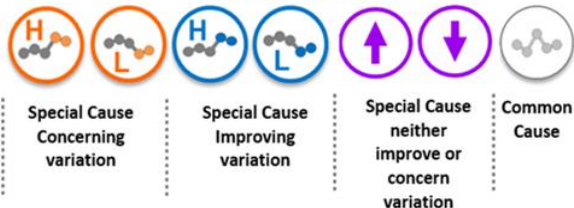


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Quality Overview

Metric	Period	Actual	Target	Variation	Assurance
HCAI - MSSA	May-26	17	10		
HCAI – C. Diff	May-26	12	TBC		
Harm Free Care – Inpatient (IP) Acquired Pressure Ulcers	May-26	54	Sustained reduction		
Harm Free Care – Adult Patient Falls	May-26	226			
Stillbirths	May-26	3			
Blood Loss ≥1500ml (per 1,000)	May-26	22 per 1000			
ATAIN	May-26	6%	5%		

Variation



Assurance



Health Care Acquired Infections

- Methicillin-Sensitive Staphylococcus aureus (MSSA) cases increased (17 vs 14) but remained within common cause variation. There were 2 Community-Onset Healthcare-Associated (COHA) cases and 15 were Hospital-Onset Healthcare-Associated (HOHA). Of the 14 cases, nine were selected for investigation. To date, learning opportunities have been identified in two cases, with contributory factors relating to intravascular device documentation and management noted in one case.
- Clostridioides difficile Infection (CDI) cases decreased (12 v 15) and remains within the parameters of common cause variation. A system-based investigation process has been implemented within InPhase, with early insights currently under review ahead of formal evaluation.

Harm Free Care

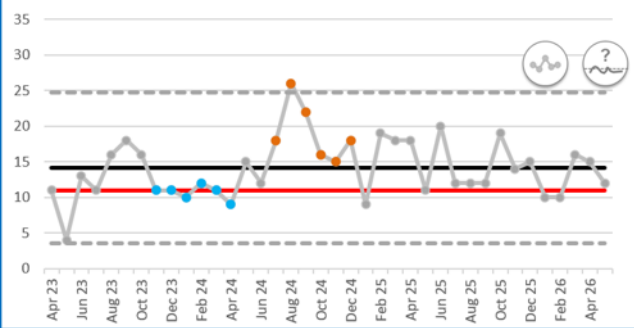
- Acute (Category 2 & above) pressure ulcers (PU) reported in May increased (54 v 46).
- In May there was an increase in falls (226 v 177) and has returned to common cause variation.

Perinatal Quality Surveillance

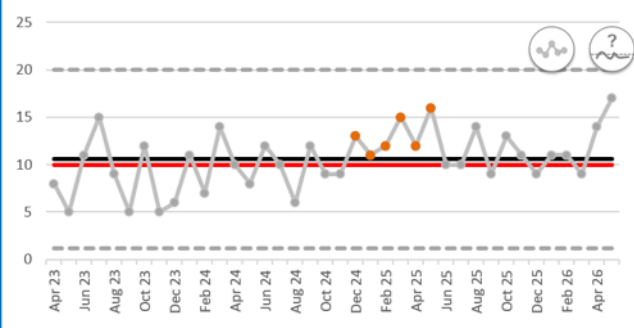
- There were three stillbirths in May 2026.
- The National benchmark for term admissions is 5%. The Trust rate remains consistently above the national 5% target with 6% term admission rate in May. Further analysis is in progress of infants born within 37th week of pregnancy as this group represent 40% of admissions.

Healthcare Associated Infections (HCAIs) (1/2)

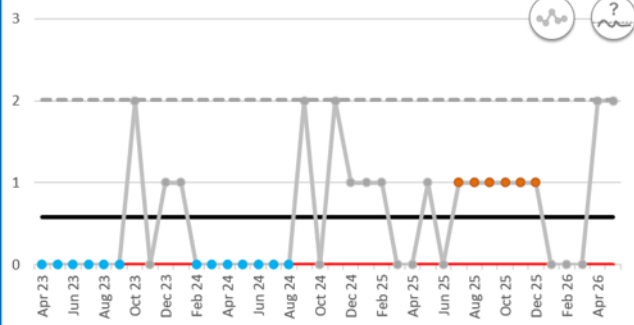
Number of *Clostridioides difficile* Infection (CDI) cases



Number of MSSA Cases



Number of MRSA Cases



Standards

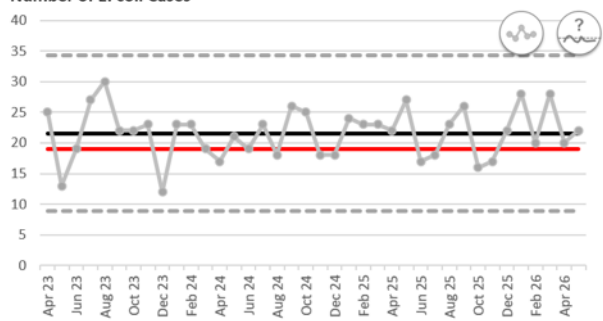
- **Zero MRSA cases.**
- **No more than 122 MSSA cases** across the fiscal year (local target - 10% reduction from 2025/26).
- **No national thresholds for 2026/27 as yet for CDIs, *E. coli* cases, *Klebsiella* cases or *Pseudomonas aeruginosa* cases.**

Current Position

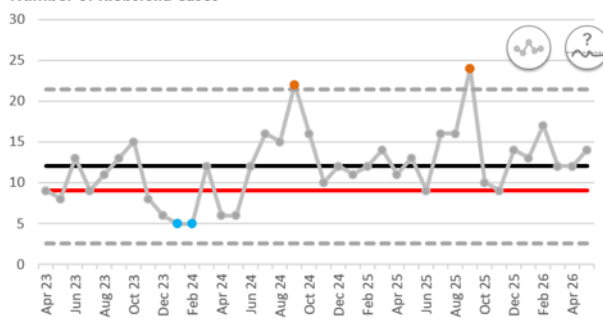
- ***Clostridioides difficile* (CDI):** CDI cases decreased (12 vs 15) and remained within common cause variation. Of these, five were COHA and seven were HOHA. Ongoing learning highlights delays in testing, treatment initiation, patient isolation, and stool chart completion.
- **Methicillin-Sensitive *Staphylococcus aureus* (MSSA):** MSSA cases increased (17 vs 14) but remained within expected variation. There were two COHA cases and 15 were HOHA. An initial review of five of the 10 MSSA cases has been undertaken. Whilst further assessment is ongoing, with learning identified in relation to intravascular device documentation and management.
- **Methicillin-Resistant *Staphylococcus aureus* (MRSA):** Two MRSA cases were reported in month, both cases were HOHA. The year-to-date total remains within common cause variation. The first case identified contributory factors relating to vascular access device care and documentation, together with incomplete MRSA decolonisation treatment. The second case identified some learning in relation to intravascular device documentation; however, this was not deemed contributory to the bacteraemia.
- ***E. coli* bacteraemia:** Cases increased (22 vs 20) but remained within common cause variation. Six cases were COHA and 16 were HOHA. Of the 22 cases, six have been identified for further review and are progressing through the investigation process.
- ***Klebsiella* bacteraemia:** *Klebsiella* cases were increased (14 vs 12) but remained within common cause variation. Four cases were COHA and 10 were HOHA. Reviews have been completed; final outcomes are currently awaited. Of the 14 cases, three have been identified for further investigation and; one has been completed and is awaiting final review.
- ***Pseudomonas aeruginosa* bacteraemia:** Case numbers decreased (2 vs 3). Both cases have been reviewed, with no further investigation required.

Healthcare Associated Infections (HCAIs) (2/2)

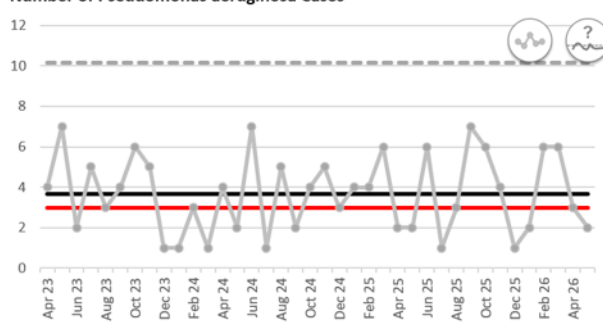
Number of E. coli Cases



Number of Klebsiella Cases



Number of Pseudomonas aeruginosa Cases



Themes and Actions

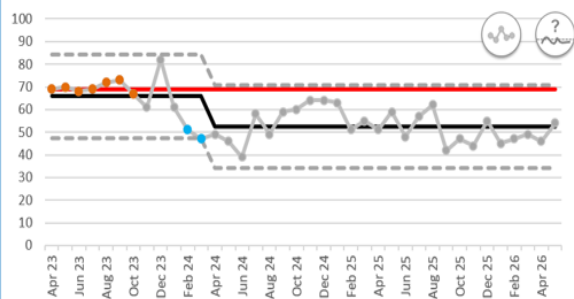
- **Clinical Board Engagement** - Clinical Board involvement in Infection Prevention and Control (IPC) governance is now established, with Infection Prevention and Control Committee (IPCC) participation embedded. Engagement and collaboration have improved, with increasing Board-level ownership, though further embedding is required.
- **Audit, Education and Assurance** - The Infection Prevention and Control Nurse (IPCN) audit framework is fully implemented. Audit insights are informing targeted education, ward support, and real-time coaching. Access to data via SharePoint is in place, though utilisation remains variable. Development of a standardised Trust-wide reporting approach is progressing. Planned Power BI dashboards will strengthen assurance and performance oversight. Improvement activity will continue into Quarter 1 (Q1) 2026/27.
- **MRSA Screening** - Work is underway to integrate MRSA screening data into Power BI, enabling real-time ward-level visibility to support timely screening, early detection, and antimicrobial stewardship.

Key Workstreams

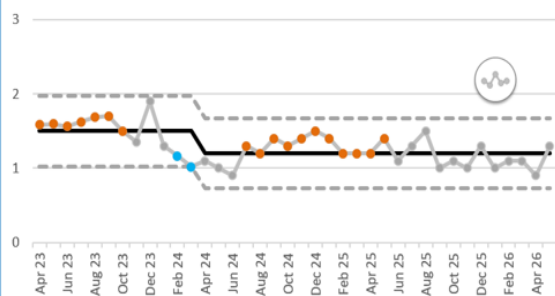
- **Invasive Devices** - Surveillance and standardisation of intravascular device care are being strengthened, supported by ICNET. A wider programme includes policy consolidation, product review, and education development. A Quality Improvement (QI) pilot to support IV-to-oral antimicrobial switch is also in progress.
- ***Clostridioides difficile* and Bloodstream Infection (BSI) Investigations** - The *Clostridioides difficile* investigation process is established within InPhase. Development of a BSI investigation model will follow, informed by this learning.
- **Harm-Free Care Rounds** - Rollout of harm-free care rounds has commenced, with structured patient safety reviews, and a clear focus on invasive devices. Supporting documentation is being finalised ahead of full implementation in late June.

Harm Free Care: Pressure Damage

Inpatient Acquired Pressure Ulcers (Category 2 & Above)



Pressure Ulcers (Category 2 & Above) per 1,000 bed days



Standard

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

Current Position

- The number of acute pressure ulcers (Category II and above) increased from 46 cases in April to 54 cases in May. The rate per 1,000 bed days rose from 0.9 to 1.3.
- Two Category III and two Category IV community-acquired pressure ulcers were reported in April. Following investigation, it was identified there were missed opportunities in completing risk assessments, reduced frequency of skin inspection and some limitations in documentation.
- Severity breakdown: No Category IV pressure ulcers were reported, seven Category III pressure ulcers were reported. All cases are under investigation to identify contributory factors and inform organisational learning.

Key Areas for Improvement

Clinical photography: Timely capture of clinical images remains an area for improvement to support accurate documentation. A required software update has delayed wider rollout of a new photographing device across the Trust.

Pressure ulcers affecting the feet: There has been a noted increase in pressure ulcers affecting the feet. Targeted work is being undertaken by the Podiatry and Tissue Viability teams with specific clinical areas, focusing on:

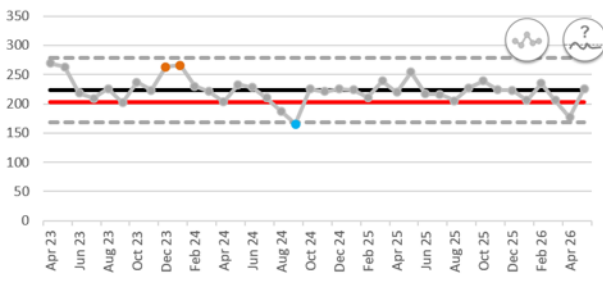
- o Improved skin assessment
- o Enhanced use of heel offloading techniques

Action Taken

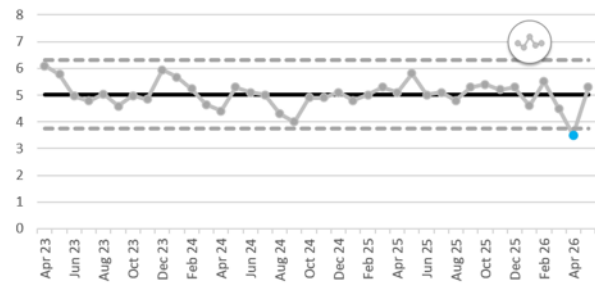
- Senior Tissue Viability Specialist Nurses are actively contributing to a regional Tissue Viability professional forum and are leading the development of regional care pathways for skin care and pressure damage prevention and management.
- A procurement process has commenced to review both standard and specialist mattresses across the Trust. The Tissue Viability Team are currently developing a detailed mattress specification to inform the tender process.
- The Tissue Viability Team delivered a paediatric-specific pressure ulcer prevention session for Paediatric Harm Free Care Leaders. Although attendance was limited, feedback from attendees was positive.

Harm Free Care: Falls

All Inpatient Falls



All Inpatient Falls per 1,000 bed days



Standard

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

Current Position

- The number of inpatient falls increased from **177 in April** to **226 in May**, with the falls rate increasing from **3.5 to 5.3 per 1,000 bed days**.
- This remains a reduction compared to May 2025, which saw **251 falls** and **5.8 per 1,000 bed days**.
- SPC charts now demonstrate **common cause variation**.
- **Harm summary:**
 - **4 inpatient falls** resulting in significant harm were reported, all categorised as a **moderate harm**. Injuries included upper and lower limb fractures (tibia, pubic rami and phalanx) and intracranial haemorrhages (subdural and subarachnoid).
 - **2 outpatient falls** resulting in **moderate harm** were also reported.

Key Areas for Improvement

Focus remains on improving the **completion and quality of multifactorial falls assessments** to optimise safe patient activity, including:

- Vision assessments
- Delirium screening (4AT)
- Lying and standing blood pressure
- Enhanced Care Observations (ECO)
- Digital falls assessment and care bundle

Actions Taken

- Falls Prevention Coordinator (FPC) presented *non-slip slipper socks* and “*decaf by default*” initiatives at the Nursing, Midwifery and Allied Health Professionals (NMAHP) Conference, supporting the rethinking of falls prevention.
- FPC co-delivered an interactive session at the Trust Dementia Conference with the Continence Nurse Consultant, promoting collaborative falls prevention and harm-free care.

Harm Free Care: VTE Assessments

Standards

- **95%** of Venous Thromboembolism (VTE) assessments undertaken within 24 hours of admission (external target).

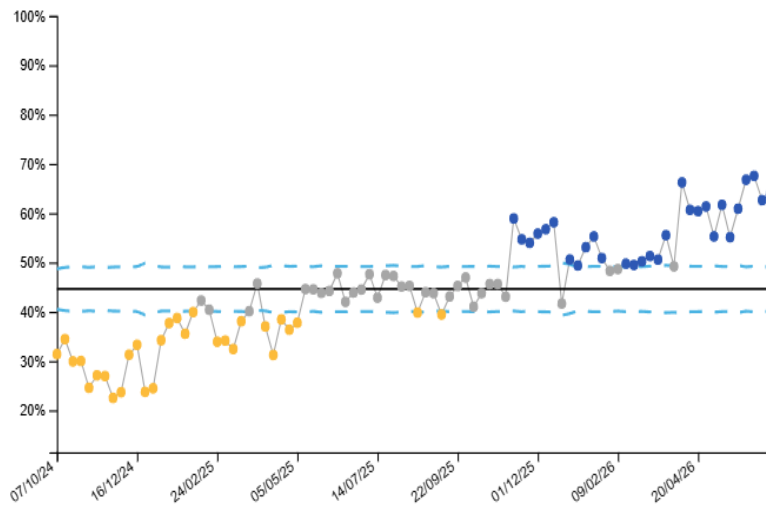
Current Position

- 96% VTE risk assessment completion during admission.
- 87% VTE risk assessment completion within 24 hours of an admission
- 77% VTE risk assessment completion within 14 hours of an admission.
- The accuracy of the VTE risk assessment compliance data is limited as:
 - It provides only a snapshot view and does not allow analysis over time.
 - Inclusion of inappropriate patient groups that should be excluded (e.g. dental hospital patients).
- A test version of a VTE dashboard has been created that allows a review of VTE risk assessment over time.
- We are awaiting an update to the Hospital-Acquired Thrombosis (HAT) identification system so we can begin reporting how many Inphases are reported each month.

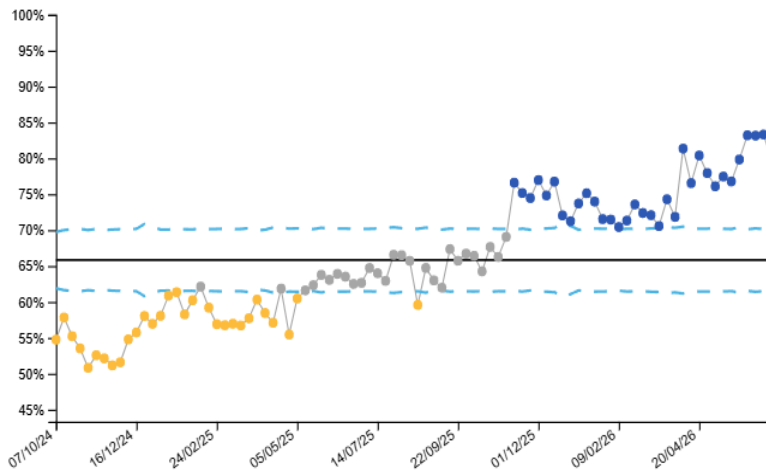
Clinical Board	VTE risk assessment compliance at 24 hrs
Cancer and haematology	73.69%
Cardiothoracic services	78.51%
Family health	66.67%
Medicine and emergency care	93.42%
Perioperative and critical care	84.33%
Surgical and associated services	85.5%
Surgical and specialist services	87.42%

Medicines Reconciliation

P-Chart of Medicines Reconciliated Within 24 Hours



P-Chart of Medicines Reconciliated Before Discharge



Standards

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

Current Position

- All Phase 1 staff now in post; new target of 50-60%

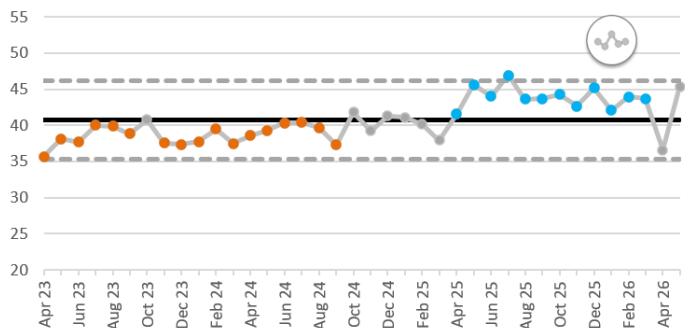
	Med rec within 24 hours		Total Med Rec before discharge	
	Total Number & %		Total Number & %	
Mar 2025	1692	34%	2261	48%
April 2025	1811	37%	2305	50%
May 2025	1809	38%	2335	52%
June 2025	1974	42%	2393	54%
July 2025	2099	43%	2488	52%
Aug 2025	1882	40%	2446	52%
Sept 2025	2006	40%	2567	53%
Oct 2025	2064	41%	2681	54%
Nov 2025	2105	49%	2564	59%
Dec 2025	2111	51%	2563	61%
Jan 2026	2362	48%	2872	58%
Feb 2026	2093	46%	2499	55%
Mar 2026	2301	49%	2698	57%
Apr 2026	2375	52%	2672	59%
May 2026	2549	57%	3412	76%
June 2026	2880	65%	3636	82%

Action taken

- New ways of working with our clinical technicians fully implemented and having impact.
- We have started to analyse weekends to understand the gap and how we can plan a future 7-day service.

Incident Reporting

Patient Safety Incidents per 1,000 bed days



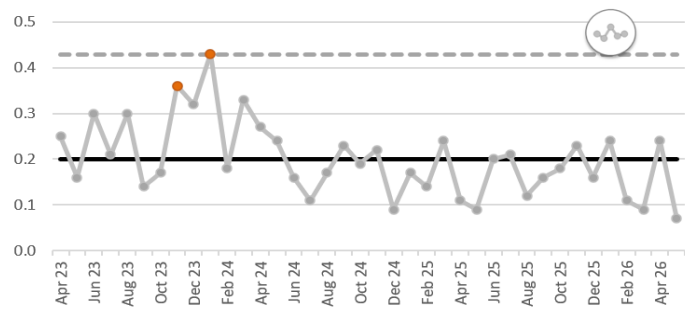
Standards

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

Current Position

- The total number of patient safety incidents per 1,000 bed days reported in May 2026 increased compared to April 2026.
- The number of severe/fatal safety incidents per 1,000 bed days decreased in May 2026, compared with April 2026.
- Two After Action Reviews and four Patient Safety Incident Investigations were recorded in April 2026.

Severe/Fatal Patient Safety Incidents per 1,000 bed days

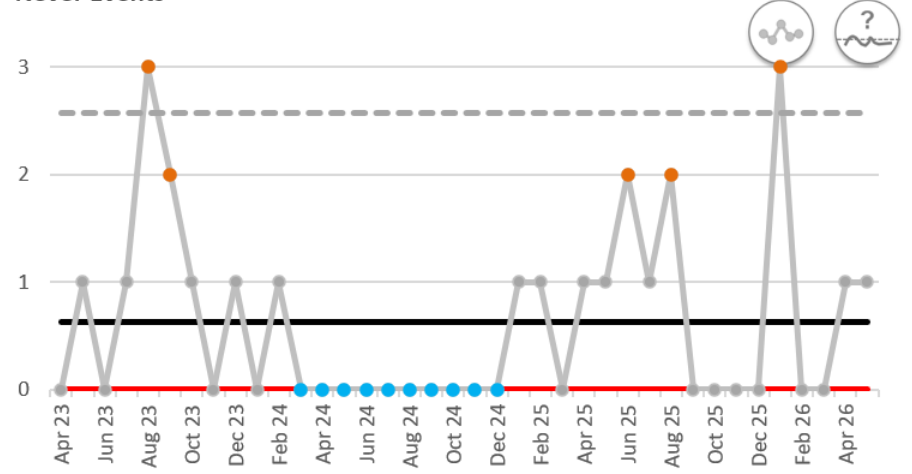


Action taken

- Incident reporting dashboards are available in the reporting hub providing daily updates to all Clinical Boards and departments on key incident reporting metrics, including incident rates.
- Raising awareness of incidents and dissemination of learning continues to through the Patient Safety Bulletin, Safety Spotlights and The Quality, Safety and Learning Forum.
- Questions relating to patient safety are included in the Trustwide peer reviews and the Accrediting Excellence Programme.
- Psychological support services are being developed to support staff involved with patient safety events.

Never Events

Never Events



Incident Date	Ref	Clinical Board	Speciality	Never Event Category
April 26	33286	Medicine & Emergency Care	Acute Medicine	Wrong route medication administration
May 26	36916	Surgery & Specialist Services	Major Trauma	Unintentional connection of a patient requiring oxygen to an air flowmeter

Standards

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

Current Position

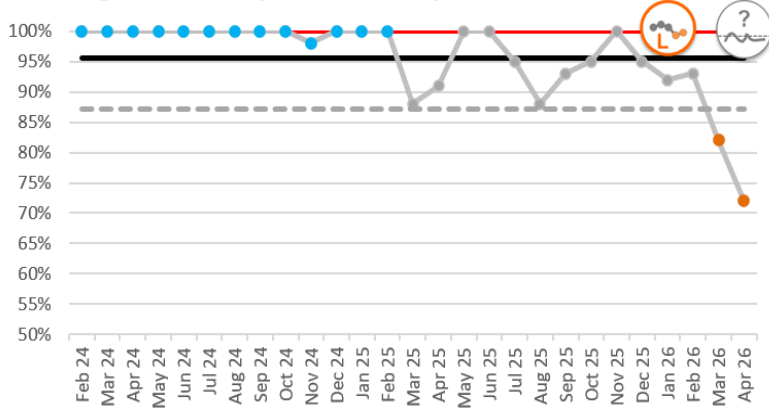
- Reporting of Never Events has been updated; these are now reported by the date the incident occurred. The data has been updated to reflect this change.
- A total of one incident met the Never Events criteria in May 2026. An After-Action review is being completed to learn from this event.
- Two Never Events have been recorded in 26/27, 10 Never Events were recorded in 25/26.

Action taken

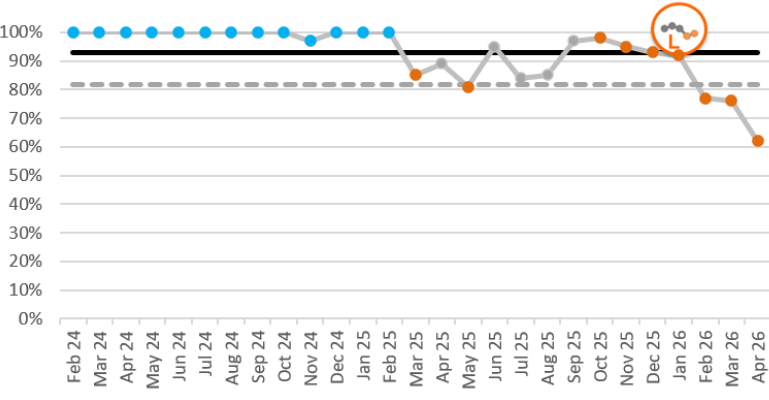
- Trust Patient Safety Incident Response Framework (PSRIF) priority is being introduced to successfully implement National Safety Standards for Invasive Procedures (NatSSIPS2) into the organisation, led by a Project Board with dedicated resources to drive improvement.
- Project work has commenced with staff engagement sessions (surveys and in-person conversations) to review and amend current checklists to ensure they are relevant and proportionate and allow the project board to identify barriers to compliance with checklist completion.
- A sub-group of the project team is looking at improving implant safety using a similar staff engagement methodology and a further subgroup has begun to review and analyse Local Safety Standards for Invasive Procedures (LocSSIPs) that are currently used throughout the Trust.

Duty of Candour

Percentage of Verbal Duty of Candour Completed



Percentage of Written Duty of Candour Completed



Standards

- Statutory Duty of Candour (DoC) to be undertaken for all notifiable safety incidents.
- To encourage openness and a timely apology, the Trust's policy outlines verbal and written duty of candour should be completed as soon as reasonably practicable.

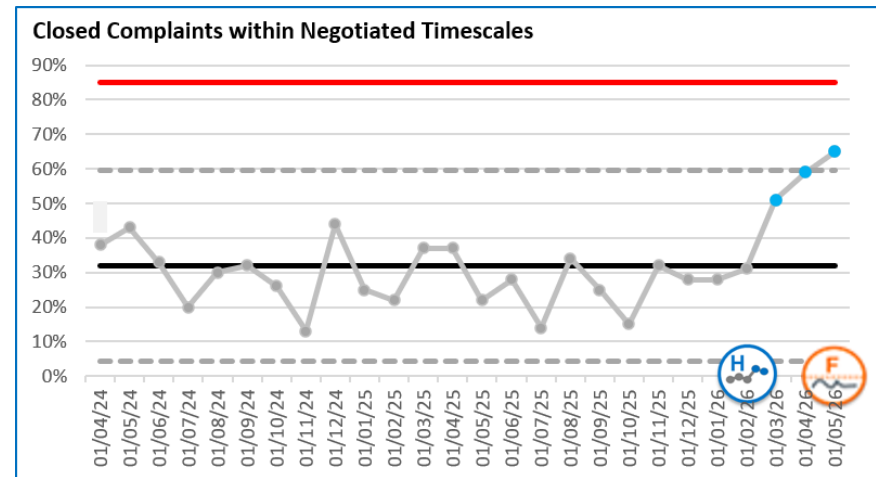
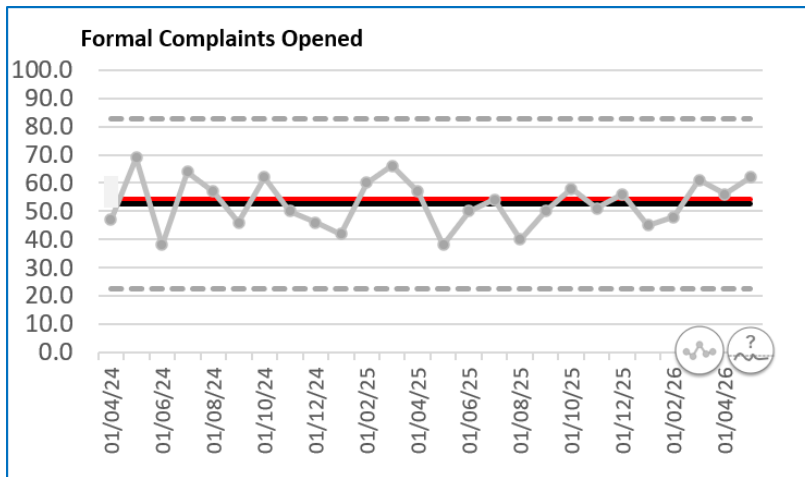
Current Position

- Data for overall Trust compliance is taken from records of completion in the incident module of InPhase / Datix. Additional assurances for compliance with the statutory requirements of Regulation 20 are undertaken through audits reported to Patient Safety Group and Quality Committee.
- Compliance with verbal and written DoC was below the trust average in April 2026.
- Changes to the way DoC is recorded since the transition to InPhase has helped to improve the accuracy of the compliance data. This is likely to be reflected in the reduction in compliance seen.

Action taken

- Clinical Board compliance is monitored through Quality Performance Reviews.
- Work is underway with the IPC team to ensure accuracy of harm grading and more timely review of incidents to support improvements in the Trusts duty of candour position.

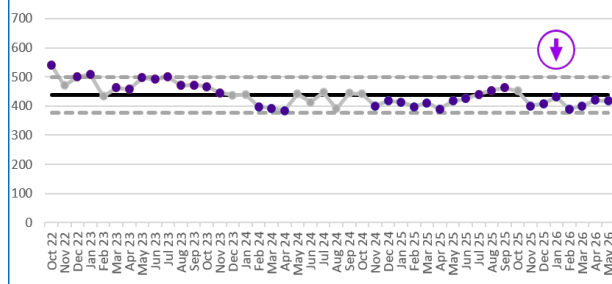
Formal Complaints



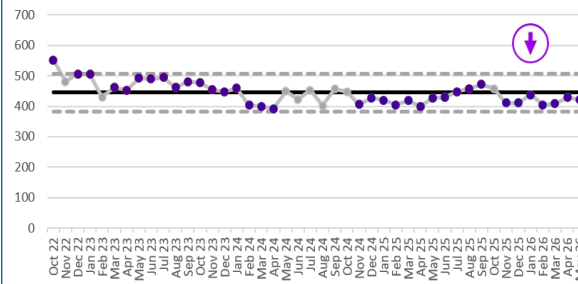
- The Trust had 62 formal complaints In May 2026. The average number of complaints opened for the previous financial year is 54 and continues to show a fluctuation of variation above and below the target.
- Clinical treatment accounts for the most complaints collectively across the specialties with 42% of complaints opened this month (26). The top 3 relating to: Surgical 8 (13%); Accident & Emergency (A&E) 5 (8%); and Obstetrics & Gynaecology 5 (8%);
- The most complaints were opened for the following three Clinical Boards, collectively accounting for 66% of complaints this month:
 - Surgery & Specialist Services 18 (29%)
 - Medicine & Emergency Care 12 (19%)
 - Surgery & Associated Specialties 11 (18%)
- In May there were 55 formal complaints closed and 36 (65%) were on time, within negotiated timescales This shows continuing substantial improvement towards the internal Key Performance Indicator (KPI) of 85% with 5 positive moves in percentages, following the introduction of re-negotiated timescales and we will continue to monitoring this alongside further service improvements .

Perinatal Quality Oversight: Births

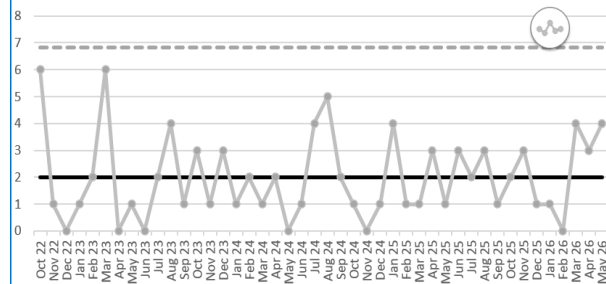
Registerable (Maternal) Deliveries



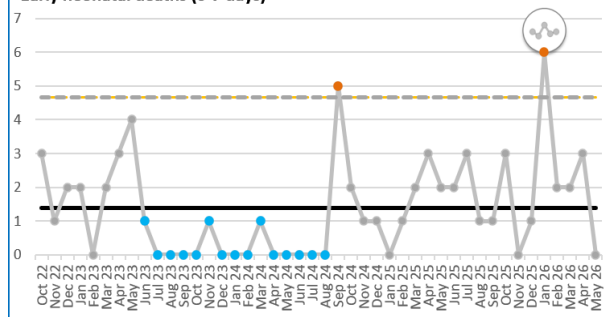
Registerable Births



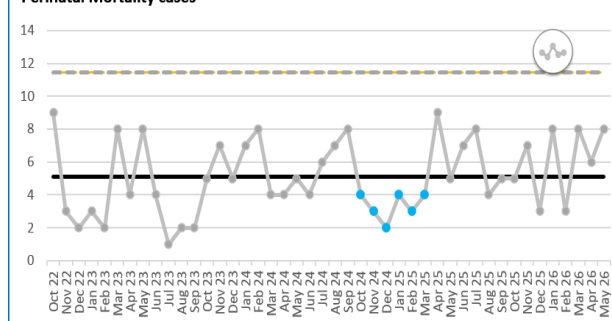
Stillbirths



Early neonatal deaths (0-7 days)



Perinatal Mortality cases



Deliveries/Births

- There were 594,677 live births in England and Wales in 2024, a 0.6% increase from 2023. This is the first increase since 2021. Several regions, including the North-East, saw a decline in live births, the overall increase in births has been in the West Midlands and London.

Stillbirths

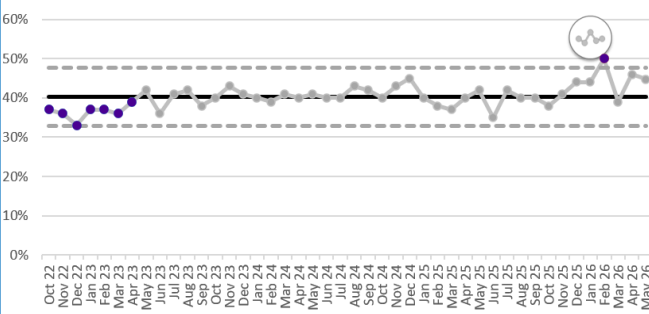
- This data includes termination for fetal anomalies >24 weeks gestation. There were three stillbirths in May 2026; all cases meet criteria for review through the Perinatal Mortality Review Tool (PMRT). The PMRT quarterly report is submitted to Trust Board in accordance with the Maternity Incentive Scheme (MIS) requirements. The Trust's previous safety alert has been stood down following further analytics which indicated this was duplicated data, when these cases were removed the Trust returned to within a 95% confidence limit. (Average per 1000 births: England 3, North East North Cumbria (NENC) 3).

Early Neonatal Deaths

- The Trust has the highest level of neonatal intensive care provision supporting extremely premature babies. Early neonatal deaths are classified as death within 0-7 days of life (late neonatal deaths are those from 7-28 days). These deaths are reported to the Child Death Review panel who will have oversight of the investigation and review process. There were no early neonatal deaths in May 2026. Early neonatal deaths often include extremely premature infants born before 24 weeks gestation and may also include babies with complex congenital anomalies.

Perinatal Quality Oversight: Deliveries

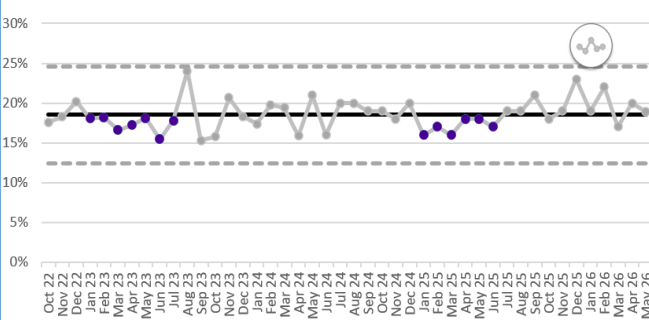
Caesarean Section Deliveries



Caesarean section deliveries

- In England 42.9% of births are caesarean section, in the NENC for Q1 this was 43.4%. There is no defined national metric for caesarean section rates.
- The Trust Q3 average was 41%, Q2 average was 40.3% and Q1 average was 38.1%.
- The Trust had a caesarean section rate of 45% in May. It should be noted that the caesarean section rate for the Trust, and nationally, is challenging operationally and there has been an associated impact on the perioperative staffing requirements to maintain a safe service which is being reviewed by the leadership teams. A quality case has been submitted, with a comprehensive action plan jointly owned by Peri-operatives and Maternity leadership team.

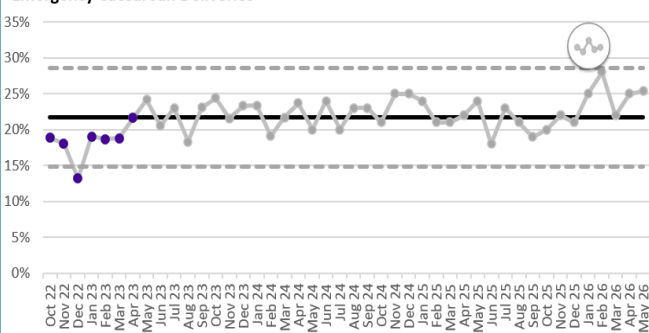
Elective Caesarean Deliveries



Elective Caesarean section

- The average England elective caesarean rate in Q4 2025/26 was 20.9% and in NENC 21.3%.
- The Trust elective caesarean rate was 19% in May.
- The national rise in elective caesarean rates is partially due to an increasing proportion being undertaken due to maternal request in accordance with the National Institute for Health and Care Excellence (NICE) guidance.
- The Trust has a shared decision-making philosophy and offers informed, non-directive counselling for women over mode of delivery. There is an obstetrician/midwifery specialised clinic to facilitate this counselling and patient choice.

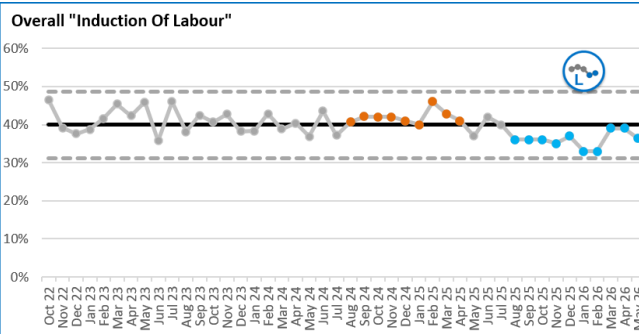
Emergency Caesarean Deliveries



Emergency Caesarean section

- The England average for Q1 2025/26 was 23.6%, and NENC mean 20.5%.
- The Trust emergency caesarean rate was 25% in May 2026. There is dedicated consultant presence on Labour Ward 8am-10pm daily, consultant led multi-disciplinary ward rounds occur twice daily. Most obstetric consultants remain onsite overnight, from 10pm-8am and are involved with all decisions for emergency caesarean section births.

Perinatal Quality Oversight: Labour

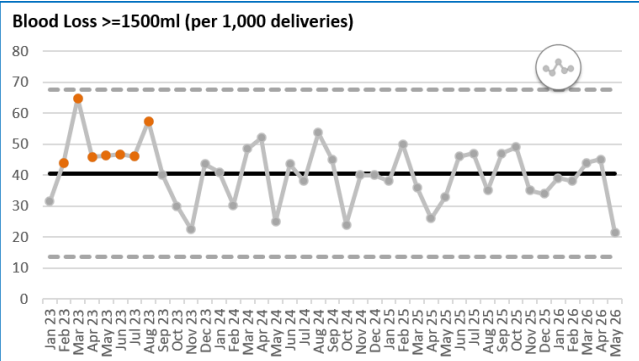


Induction of Labour

- The number of women being induced during pregnancy has increased due to changes in national guidelines as part of the Saving Babies Lives Care Bundle and other NICE and Royal College of Obstetricians and Gynaecologists (RCOG) guidance.
- England average for induction of labour (IOL) Q4 2025/26 was 28.5% and NENC 35.3%. The Trust induction of labour rate has been stable since August 2025 and was 36% in May 2026.
- There has been significant revision of the Trust IOL pathways following the national patient safety alert regarding the shortage of prostaglandins, the impact is being closely monitored.

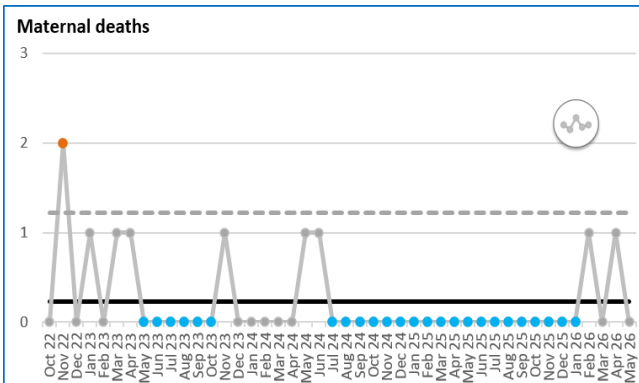
Blood Loss $\geq 1500\text{ml}$

- The average Post Partum Haemorrhage (PPH) rate for Q4 2025/26 in England is 30 per 1000 and NENC average is 27 per 1000. The Trust PPH rate for May 2026 is 22 per 1000. Q1 average was 35 per 1000, Q2 average 43 per 1000 and Q3 average 39 per 1000.
- Higher rates are indicative of the complexities of the high-risk patient group and provision of the Placenta Accreta Spectrum service as confirmed by the previous review.
- Element 5 of the newly published 'The Maternal Care Bundle' (MCB) (NHS England, 2026) requires Trusts to implement safety actions for obstetric blood loss/PPH and ensure multidisciplinary review of cases $\geq 2000\text{ml}$. The Trust are currently benchmarking against all elements within the MCB but do not anticipate any significant increase in reporting PPH as many of the required standards are already implemented within the maternity services.

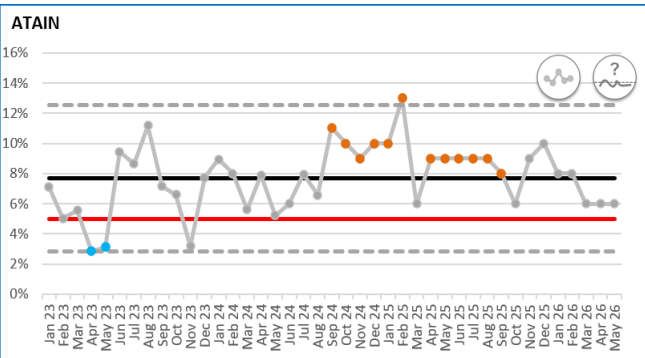


Maternal Deaths

- Maternal deaths are reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) and an annual national report is provided. There was one late maternal death in April 2026. This has been subject to a Rapid Review and further detailed review ongoing through a Patient Safety Incident Investigation (PSII).
- There were no maternal deaths in May 2026.
- The regional maternity team are continuing thematic review of all maternal deaths across North East and Yorkshire between 2022-2024.
- The Maternal Care Bundle (NHS England, 2026) was published in response to care improvements and disparities in morbidity and mortality outcomes identified by Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) national reports. It establishes a baseline of best practice in 5 areas of care associated with higher rates of maternal mortality and morbidity.

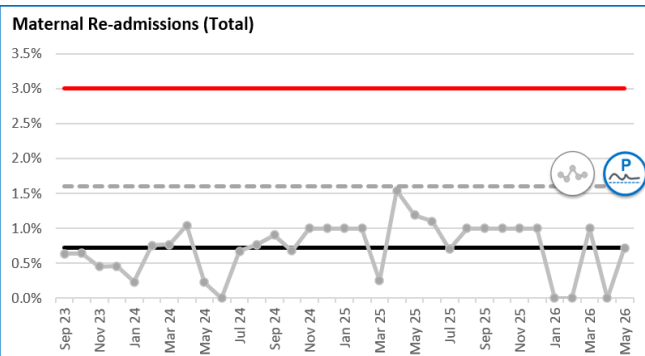


Perinatal Quality Oversight: Admissions



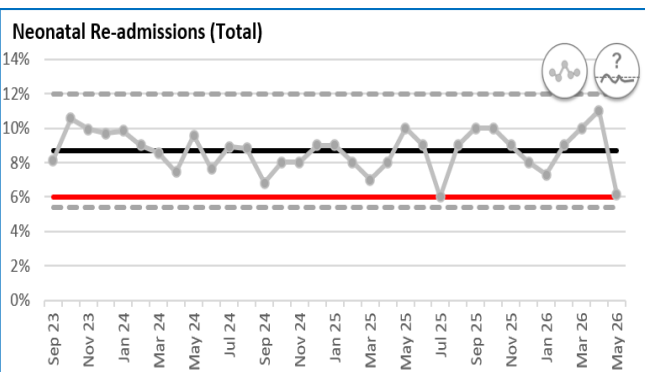
Avoiding Term Admission into Neonatal Units (ATAIN)

- The National benchmark for term admissions is 5%. The Trust rate remains consistently above the national 5% target; in March, April and May, this was 6%. Three quality improvement workstreams are ongoing. The neonatal nurse outreach pilot for theatre recovery commenced in August 2025 and has prevented less than 20 admissions in the first 6 months due to the stringent criteria for inclusion. Further analysis is in progress of infants born within the 37th week of pregnancy as this group of patients represent 40% of term admissions, whilst all neonatal admissions were clinically indicated, further analysis of the antenatal care and decision to deliver is ongoing.



Maternal Readmissions

- National Maternity & Perinatal Audit (NMPA) Report (2025) the maternal postnatal readmission rate for England was 3.08% in 2023, rates varied by provider (IQR: 2.57–5.02% in Wales; 2.14–3.59% in England). The Local Maternity and Neonatal System (LMNS) are benchmarking against the national mean readmission rate, hence an internal target against the national average of 3% has been set. Maternal readmission rate for the Trust is consistently below the national average and has been 1% or less from June to May 2026.

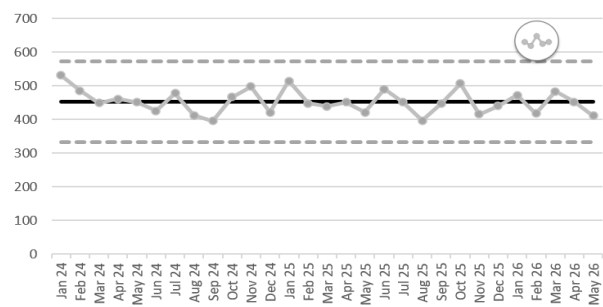


Neonatal Readmissions

- The Clinical Quality Improvement Metrics (CQIM) for 'Babies readmitted to hospital who were under 30 days old' data is used as a comparison to Trust performance, hence the target of 6%.
- The perinatal patient safety team are working with the data analyst to understand the reason for readmission; whether this is a true reflection of this metric or related to coding and data extraction. Early learning indicates that readmissions within this metric include well babies admitted with their mother or twin sibling and transfers from another special care baby unit, as well as planned admissions to the Great North Childrens Hospital. Review of jaundice readmissions as previously reported also continues.
- In May the readmission rate was 6%.

Perinatal Quality Oversight: Incidents & Bookings

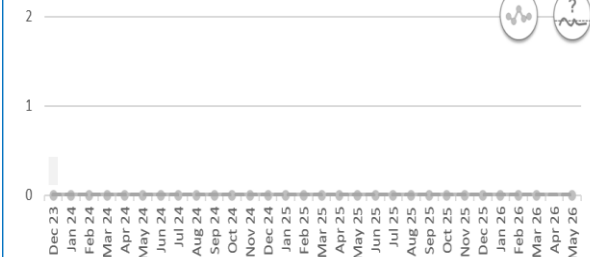
Pregnancy Bookings



Pregnancy Bookings

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

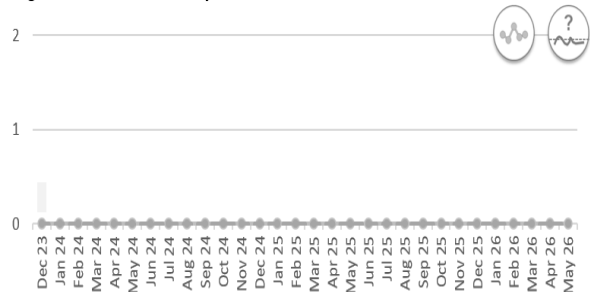
CQC/MNSI/CQC concern or request for action made directly to the Trust



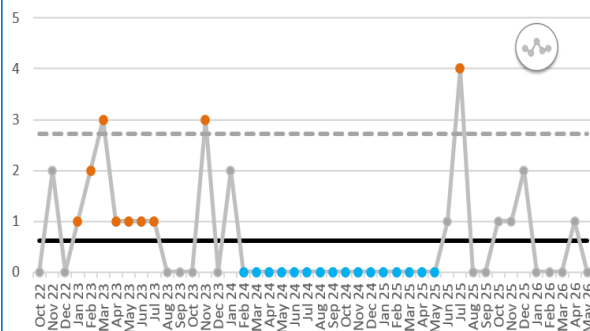
Incidents

- Moderate incidents are now separated from externally reported MNSI cases which were previously grouped together. There was one moderate or above harm incident reported in May. Incidents are discussed at a multi disciplinary rapid review and presented to the Trust Response Action Review Meeting (RARM) to agree a proportionate learning response.
- Perinatal incidents referred to MNSI for external review include cases involving neonatal brain injury - Hypoxic Ischaemic Encephalopathy (HIE), Term Intrapartum Stillbirths, Early Neonatal deaths and Maternal deaths. There were no MNSI cases in May.
- There have been no regulation 28 notices in the last 12 months.

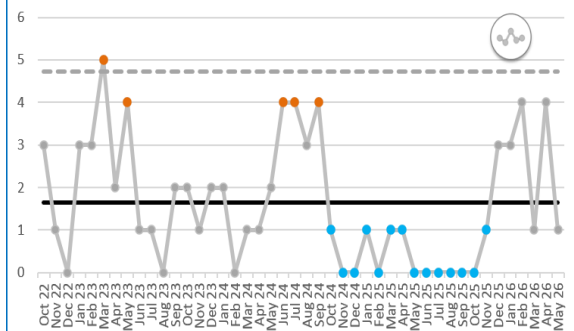
Regulation 28 made directly to the Trust



MNSI Accepted Cases

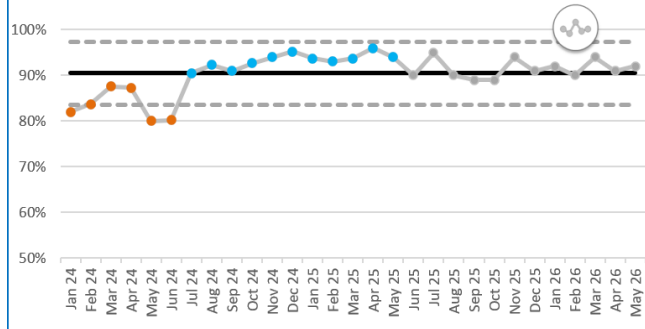


Moderate incidents

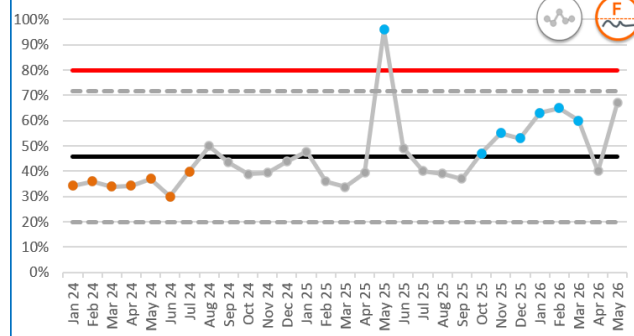


Perinatal Quality Oversight: Triage - Midwifery Care Timings

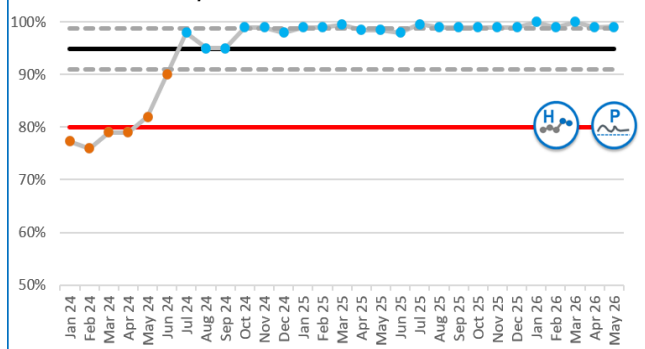
BSOTS Initial Triage within 15 Minutes



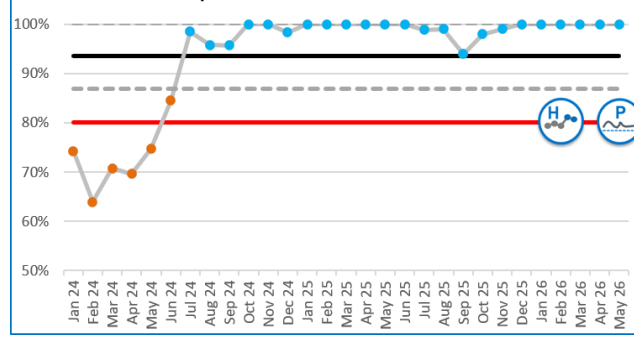
Trust & LMNS BSOTS Medical Review Orange - Within 15 Minutes



Trust BSOTS Midwifery Care Yellow - Within 1 Hour



Trust BSOTS Midwifery Care Green - Within 4 Hours

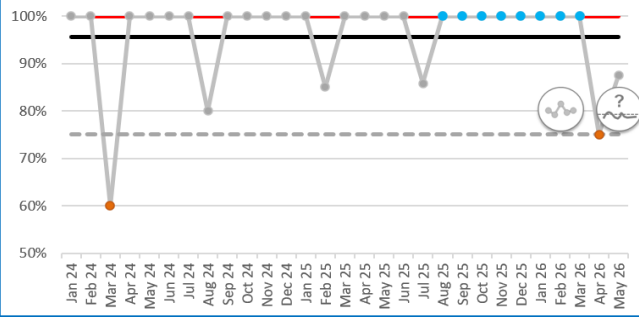


Birmingham Symptom Specific Obstetric Triage System (BSOTS)

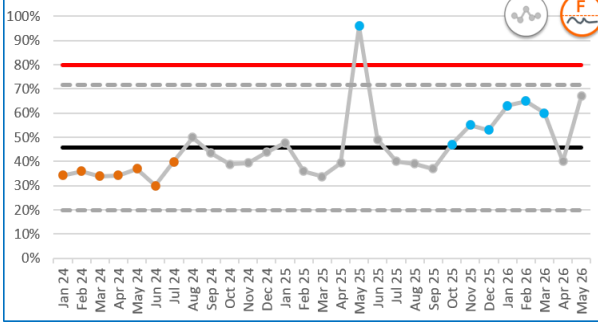
- The Trust implemented the BSOTS triage system in January 2024. Midwifery triage and subsequent review has improved considerably and has exceeded the Trust and LMNS target.
- Good performance continues to be sustained across every category for midwifery review.
- The triage within 15 minutes metric was subject to scrutiny to monitor the impact of early pregnancy referrals from Emergency Department (ED) being supported by Maternity Assessment Unit following the cessation of the gynae overnight pathway from ED, analysis has demonstrated there has been no impact, this subsequently returned to the Gynaecology service in May 2026.

Perinatal Quality Oversight: Triage - Medical Review Timings

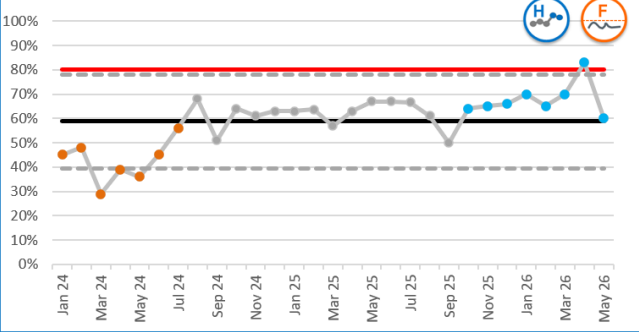
Trust BSOTS Medical Review Red - Seen Immediately



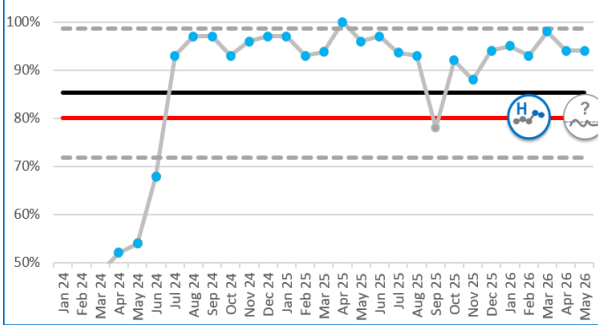
Trust & LMNS BSOTS Medical Review Orange - Within 15 Minutes



Trust BSOTS Medical Review Yellow - Within 1 Hour



LMNS BSOTS Medical Review Green - Within 4 Hours

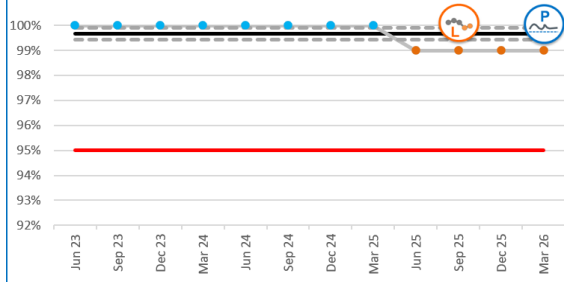


Birmingham Symptom Specific Obstetric Triage System (BSOTS)

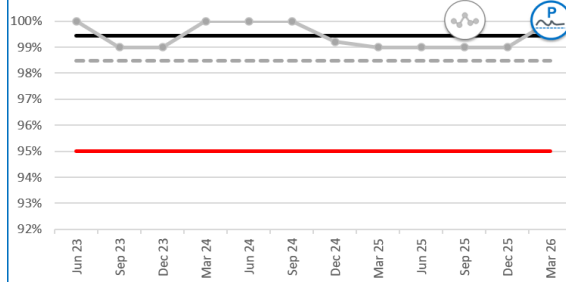
- There has been significant improvement in performance in the last 12 months.
- As previously highlighted, the business case to commence call recording for the triage services has been paused. This remains a risk within the service and is subject to ongoing discussions.
- The national BSOTS team have recommended that women within the 'orange' category are further broken down into 'urgent' and 'non-urgent'. The Trust are currently scoping the reporting of this in the IBR.
- A national toolkit was published in July 2026, benchmarking against the standards are underway.

Perinatal Quality Oversight: Antenatal Screening

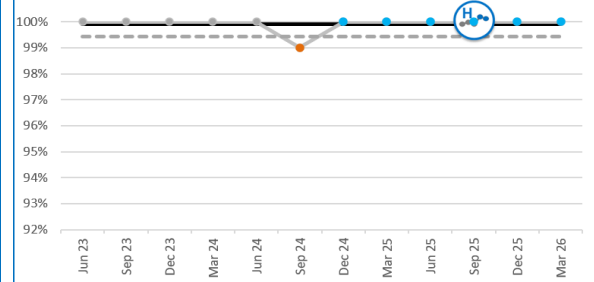
Infectious Diseases



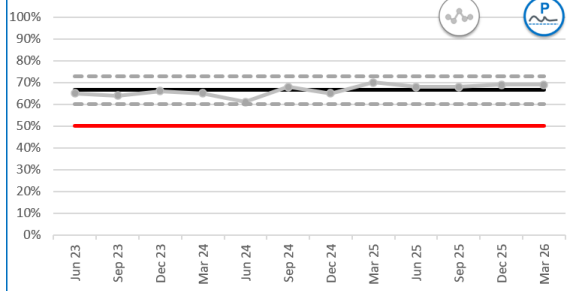
FA2 20 week anomaly scan



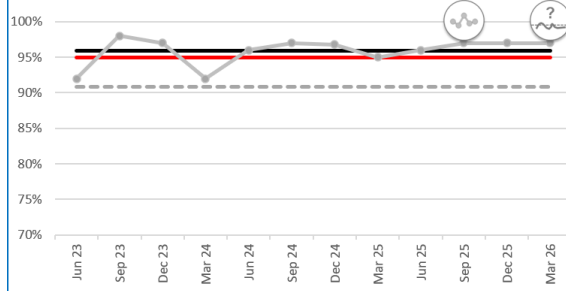
FA3 T21, T18, T13 Screening



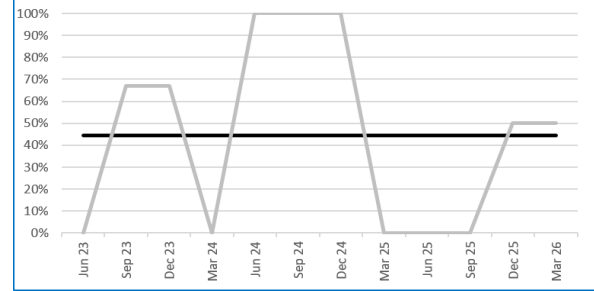
ST2 Timeliness of Antenatal Screening



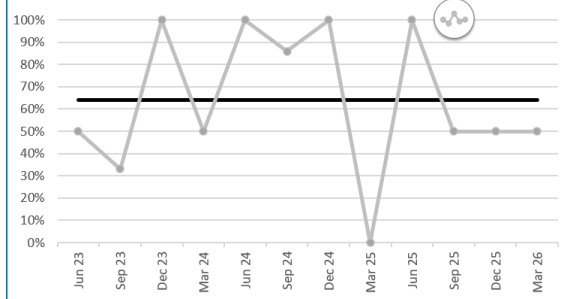
ST3 Completion of Family Origin Questionnaire



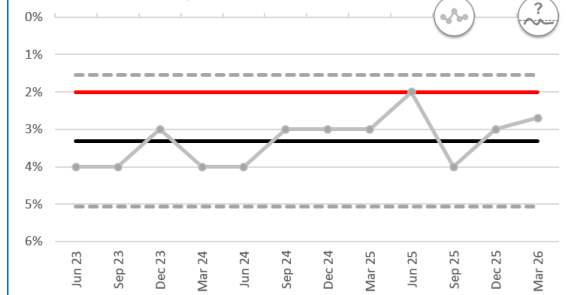
ST4a



ST4b



NB2 Avoidable NBBS repeats

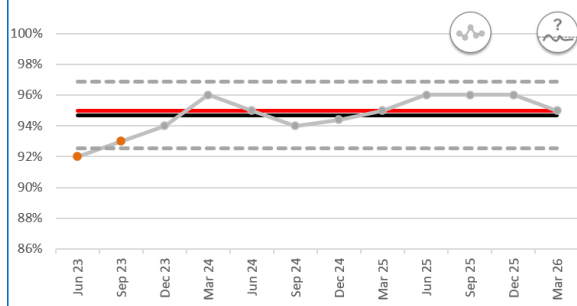


Antenatal Screening

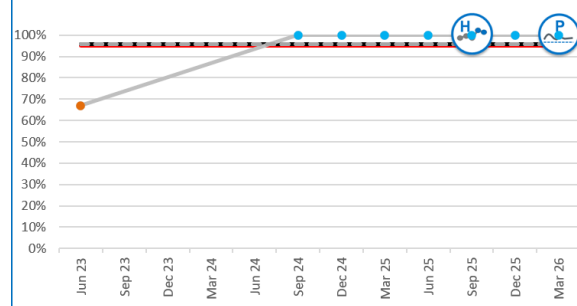
- A screening tracker has been developed by analysts and deployed to support failsafe processes and reporting as per the recommendation in the patient safety incident investigation (PSII). The screening KPI tracker supports visibility and oversight of performance and regional returns.

Perinatal Quality Oversight: Newborn and Infant Physical Examination (NIPE) Screening

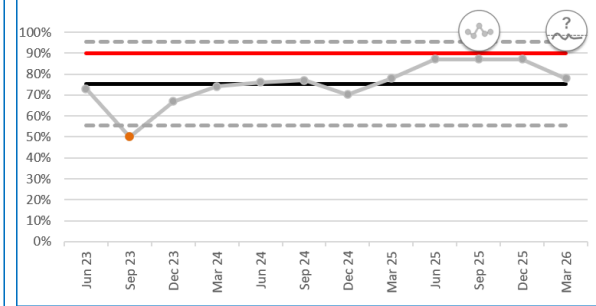
S01 - % screen compliant <72 hrs of age



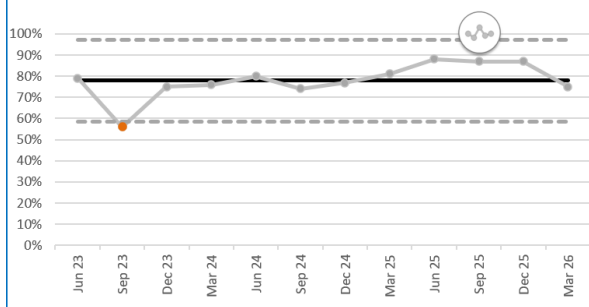
S02 - % eye abnormality suspected/seen <14 days of examination



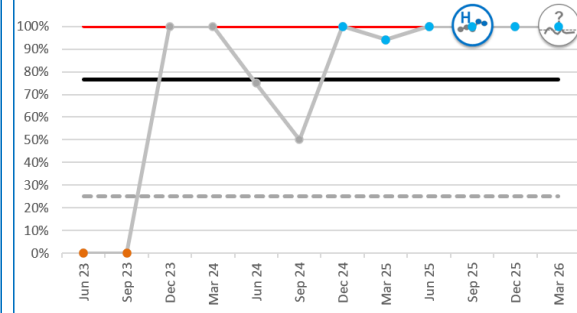
S03 - % hip USS attended between 4-6 weeks



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



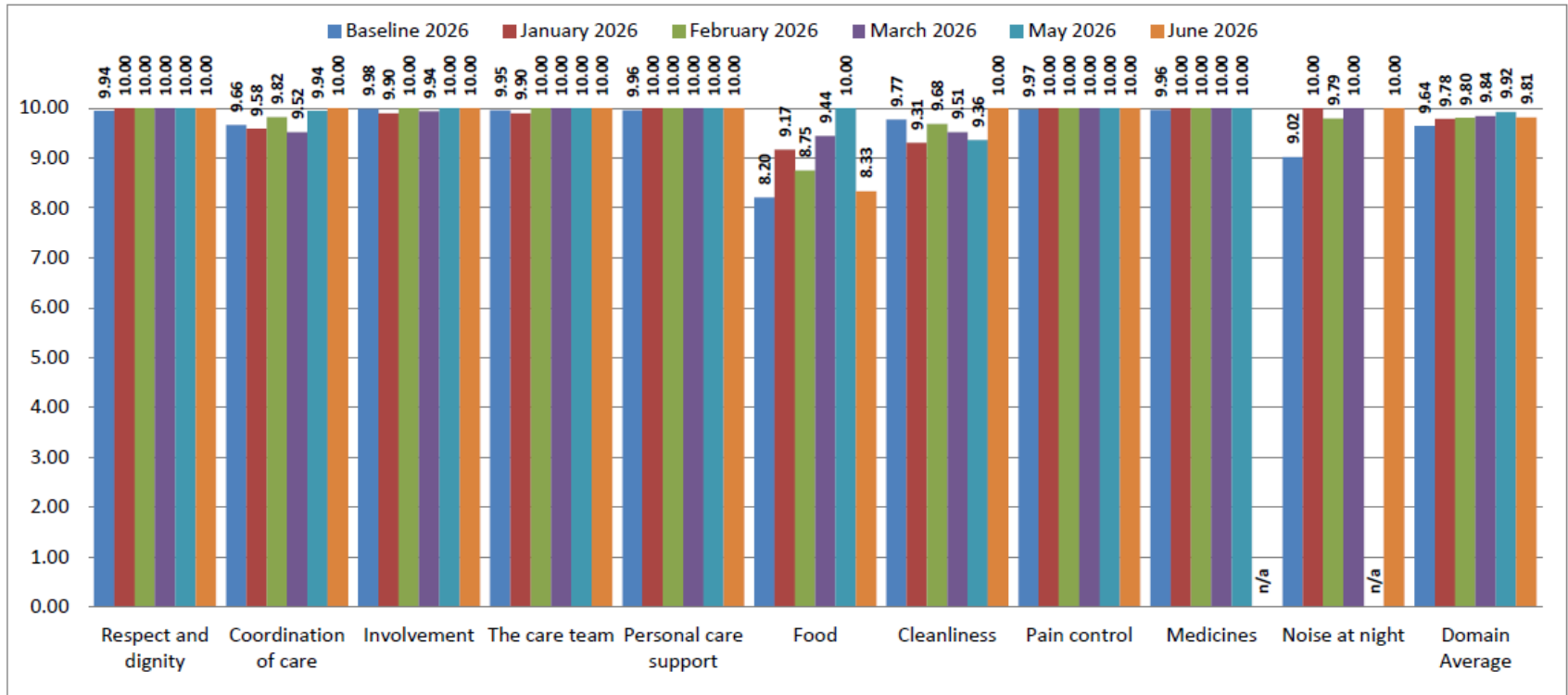
S05 - % suspected bi-lateral undescended testes seen <24 hrs



Newborn and Infant Physical Examination

- A screening tracker has been developed by analysts and deployed to support failsafe processes and reporting as per the recommendation in the patient safety incident investigation (PSII).
- A deep dive into S03 and S04 has been undertaken to understand reduction in compliance with a trial of appointment reminders introduced to improve Did Not Attend (DNA)/Was Not Brought (WNB) rate.

Perinatal Quality Oversight: Patient Experience



Patient perspective – Delivery Suite

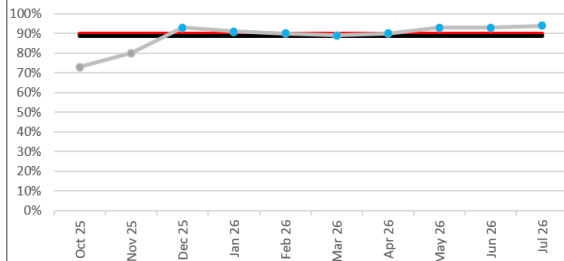
100 % of patients surveyed rated their overall experience on the ward as either good or very good.

The midwives have literally gone over and beyond when it comes to respectfulness, they always ask permission before they do anything, they keep me covered as much as possible, they are absolutely amazing. Our midwife Alex was a dream, so kind and caring. The Dr was very clear this morning with explaining what the plan was, totally put my mind at ease. Now we just have to wait for baby to arrive.

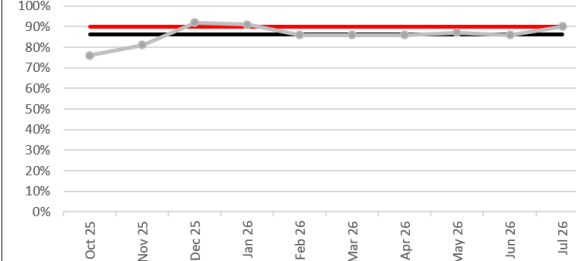
We had a really good experience here when we had our other child. So, I feel in safe hands. We have been here 24 hours now and our overnight stay was really quiet. I have been offered loads of snacks which has been great. All of the staff have been lovely and supportive.

Perinatal Quality Oversight: Training (Maternity Incentive Scheme)

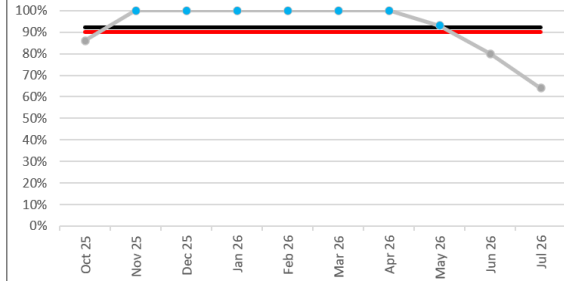
MDT Obstetric Emergency - Midwives



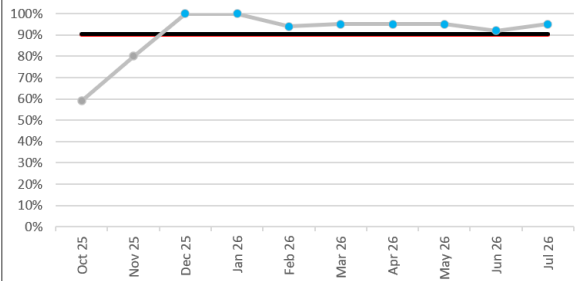
MDT Obstetric Emergency - MSW



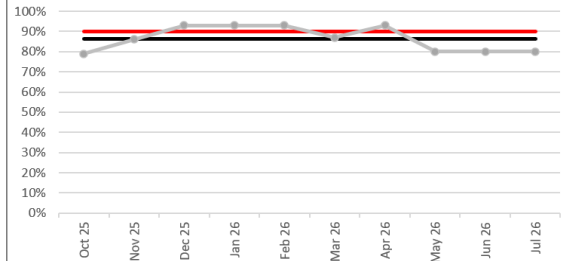
MDT Obstetric Emergency - Obs Consultants



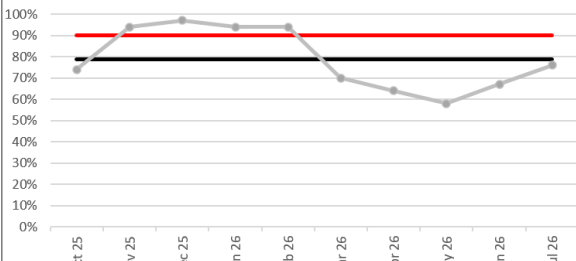
MDT Obstetric Emergency - Obstetric Trainee



MDT Obstetric Emergency - Anaes Consultants



MDT Obstetric Emergency - Anaes Trainee



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

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

Due to the requirement to report above 90% compliance at 2 points in MIS year 8, SPC charts have been changed to show a rolling monthly compliance to ensure detailed oversight of the % of compliance every month. The first checkpoint is to be agreed locally by the Training Group in July 2026.

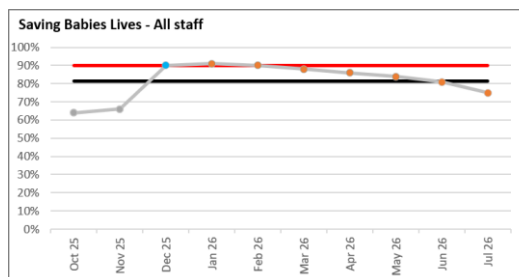
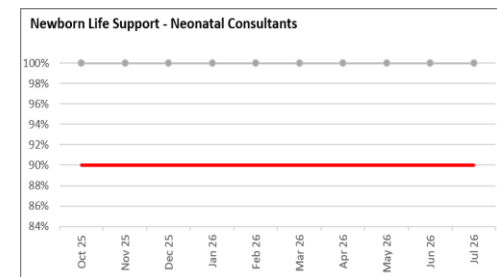
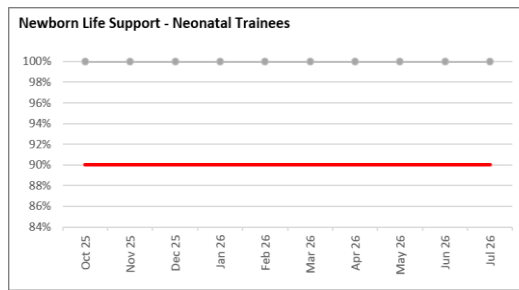
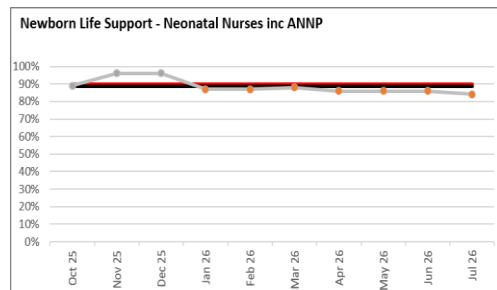
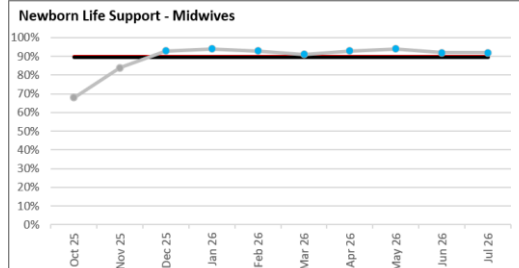
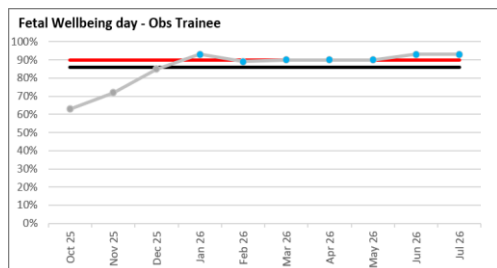
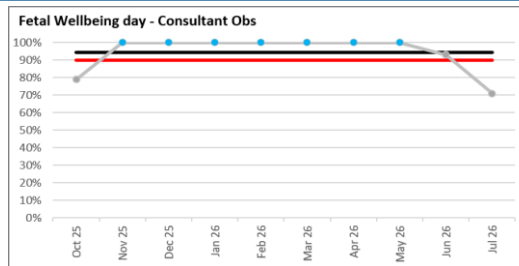
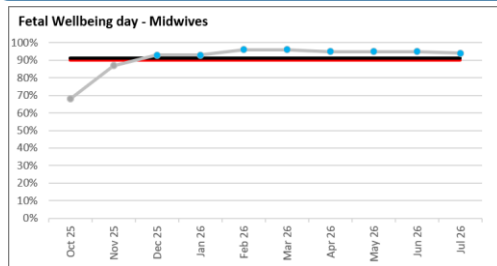
Obstetric Emergency Training by Staff Group:

Compliance above 90% and continuous on track for Midwives and Maternity Support Workers (MSW).

Action plan in place to ensure recovery to 90% compliance for Consultant Obstetricians and Anaesthetics and Anaesthetic Trainees in line with MIS requirements.

Planning in place for mandatory training for new Medical trainees' in August rotation, to ensure the Trust remain compliant.

Perinatal Quality Oversight: Training (Maternity Incentive Scheme)



Fetal Wellbeing Training by Staff Group:

The Fetal Wellbeing training is essential training to ensure compliance with the implementation of the Saving Babies Lives Care Bundle version 3 (SBLCBv3) which aligns to the Clinical Negligence Scheme for Trusts (CNST)/MIS.

Rolling monthly compliance for Midwives and Obstetric Trainees above 90%.

Action plan in place to ensure recovery to 90% compliance for Consultant Obstetricians, in line with MIS requirements.

Planning in place for mandatory training for new Medical trainees in August rotation, to ensure we remain compliant.

Newborn Life Support by Staff Group:

The newborn life support training is essential to ensure compliance with MIS Year 8.

Rolling monthly compliance for Midwives and Neonatal Consultants and Trainees are above 90%.

Action plan in place to ensure recovery to 90% compliance for Neonatal Nurses, in line with MIS requirements.

Saving Babies Lives Training by Staff Group:

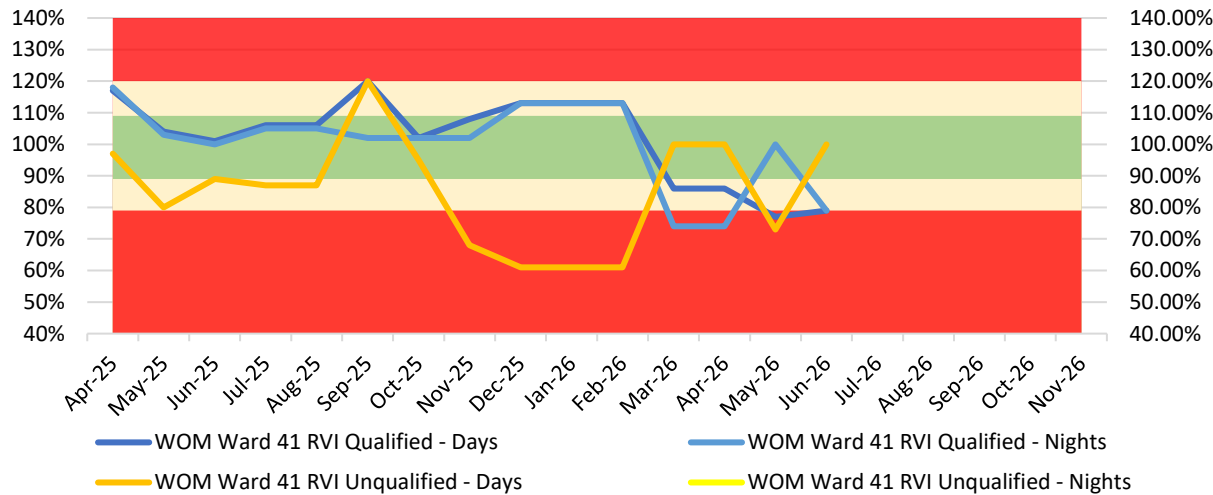
The 'Saving Babies Lives' training encompasses essential training, such as smoking cessation and preterm birth to ensure compliance with the implementation of the Saving Babies Lives Care Bundle version 3 (SBLCBv3). This features in Safety Action E Care Bundle.

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

Action plan in place to ensure recovery to 90% compliance for all staff, in line with MIS requirements.

Perinatal Quality Oversight: Staffing fill rates

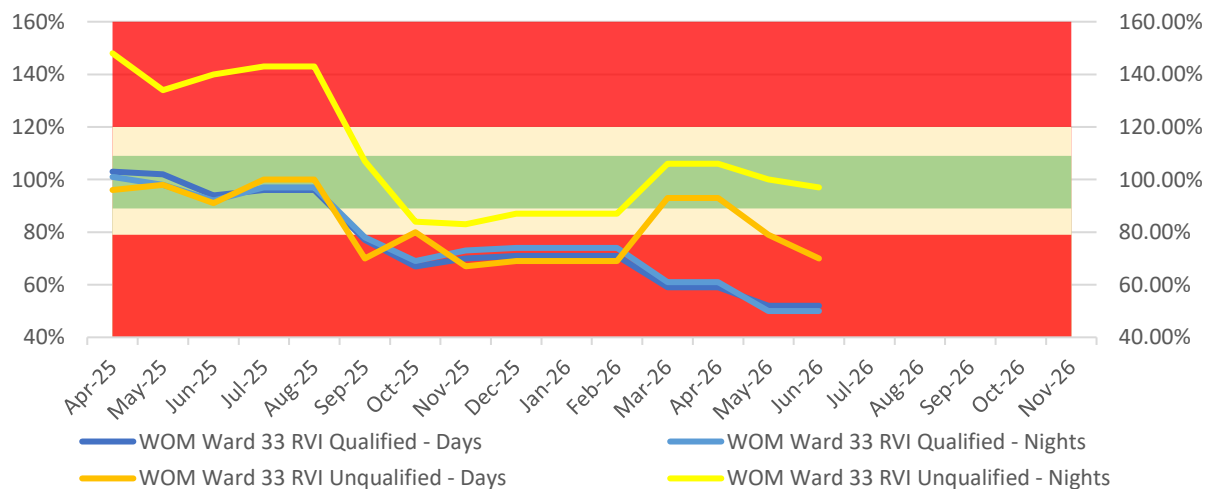
Ward 41 un/qualified staffing rates



Antenatal Ward (41)

The qualified night and day fill rates have been stable, up to December. Birthrate Plus staffing templates for 3 qualified staff on nights are expected to go live late 2026. The ward opened escalation beds in an additional bay on 11 occasions in May with midwifery fill rates exceeding the staffing establishment to maintain appropriate staff to patient ratios.

Ward 33 RVI un/qualified staffing rates

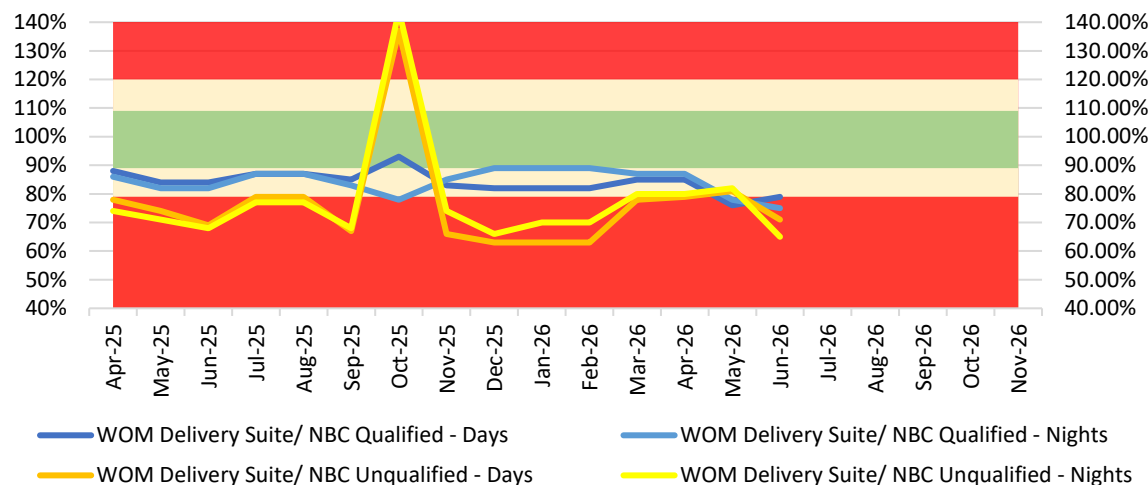


Postnatal Ward (33)

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

Perinatal Quality Oversight: Staffing fill rates

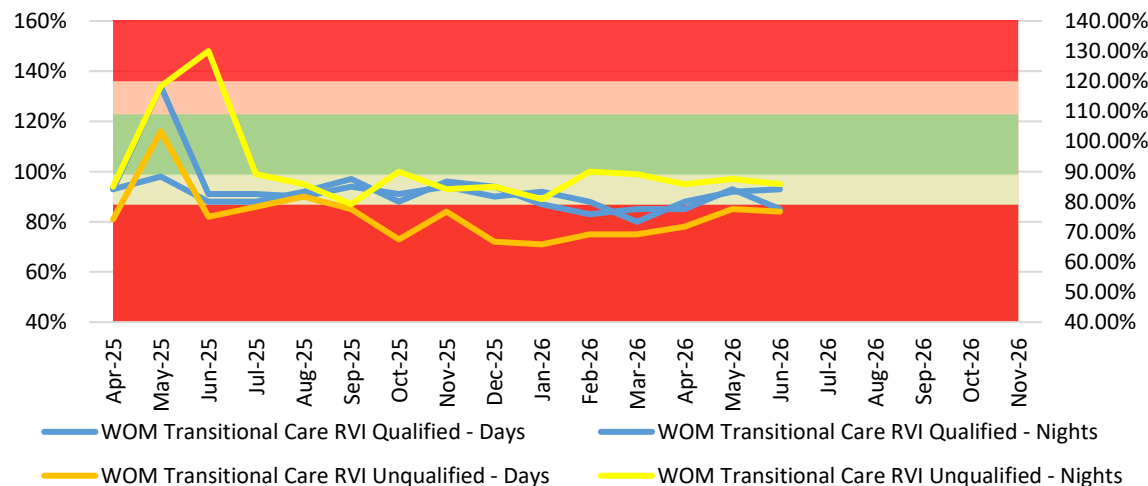
Delivery Suite un/qualified staffing rates



Intrapartum (Delivery Suite and Newcastle Birthing Centre)

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

Transitional Care RVI un/qualified staffing rates

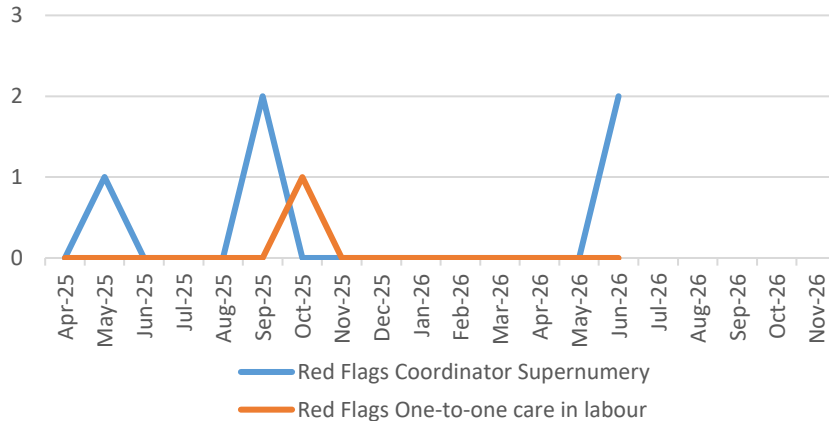


Transitional Care Ward (34)

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

Perinatal Quality Oversight: OPEL

Maternity Red Flags per month



NICE Red Flags

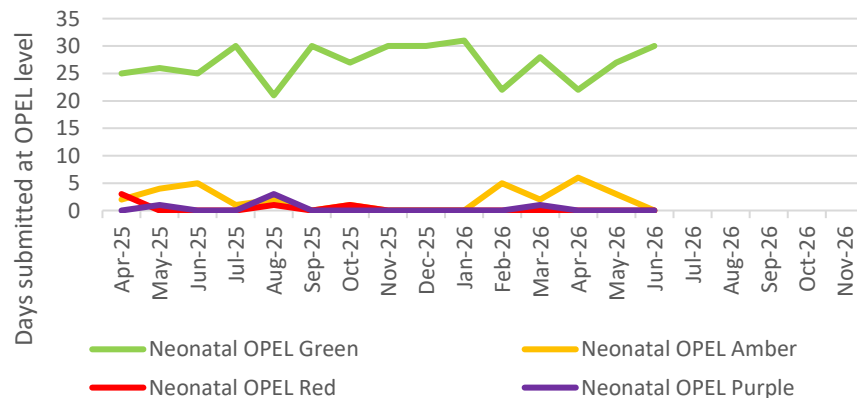
There were no occasions in May when the co-ordinator was not supernumerary, secondary to operational pressures. There were no occasions in May when one to one care in labour was not provided.

Operational Pressures Escalation Levels (OPEL) Maternity and Neonatal Framework

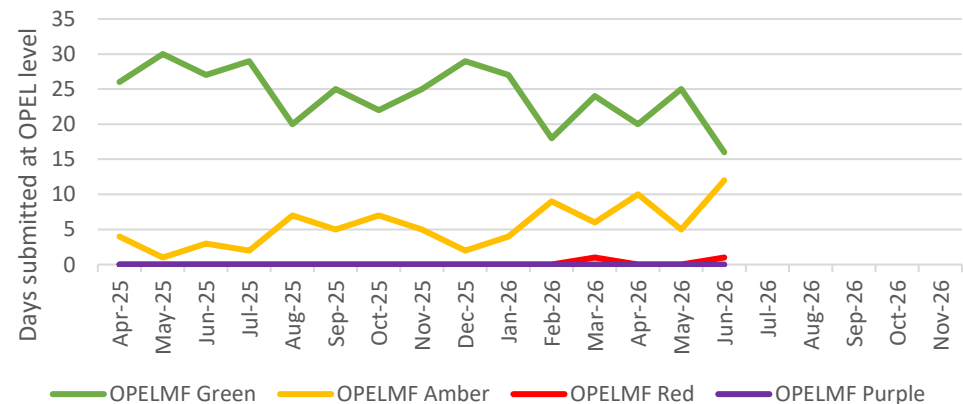
The neonatal service maintained Operational Pressures Escalation Level (OPEL) 1 for 27 days in May and OPEL 2 for 3 days, OPEL status was not submitted for 1 day due to technical issues. There were no staffing InPhase reports or delays to admissions or transfers out of region.

The maternity service maintained Operational Pressures Escalation Level (OPEL) 1 for 25 days in May and OPEL 2 for five days. There were no staffing InPhase reports and no community escalations to support the acute service. There were no gaps in obstetric or anaesthetic cover for the Delivery Suite during May 2026.

Neonatal Services OPEL levels



Midwifery services OPEL levels



Performance

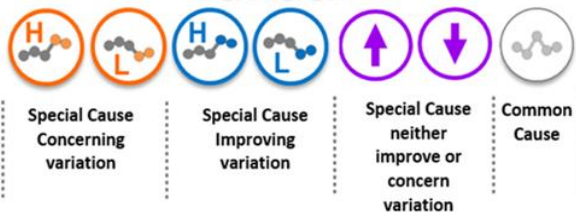


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Performance Overview

Metric	Period	Actual	Traj.	Target (by Mar-27)	Variation	Assurance
A&E Arrival to Admission / Discharge	May-26	76.5%	81.9%	82%		
RTT 18 Weeks	May-26	73.5%	75.5%	81.1%		
>52 Week Waiters	May-26	693	485	0		
Cancer 28 Day FDS	May-26	85.0%	79.5%	80%		
Cancer 31 Day	May-26	83.4%	88.3%	94%		
Cancer 62 Day	May-26	65.1%	69.3%	80%		
Diagnostic 6 Weeks	May-26	20.5%	14.7%	2.1%		

Variation



Assurance



Emergency Care

- Emergency Department (ED) Performance (All Types) in May was 76.5%, a decrease of 2.1% compared to April (79.0%). ED attendances increased in May to 24,767, 1,650 patients more than April, with type 1 Major attendances at 9,507, also the highest seen in years.
- ED Arrival to Admission / Discharge > 12 hours (Type 1) in April was 1.17%, this rose to 2.03% in May.

Elective Waits

- Referral To Treatment (RTT) 18-week compliance increased to 73.5% in May (+1.2% from April). Performance improvement was linked to a further rebound in the waiting list size following the conclusion of the Trust's participation in an NHS England sponsored validation sprint at the end of March.
- The waiting list increased to 86,198 in May (+2,989). Training to stop errors at source has been provided across specialties to mitigate against further waiting list increases.

Cancer Care

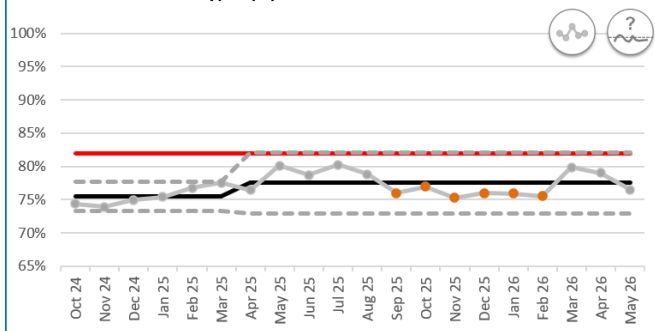
- In May, the 80% 28 Faster Diagnosis Standard (FDS) target was achieved, performance sat at 85.0% and demonstrates special cause variation of an improving nature.
- 31-day performance rose slightly to 83.4% in May, whilst 62-day performance rose slightly to 65.1%. It is too soon to tell whether the slight rises against 31-day and 62-day performance are a trend or natural variation.

Diagnostics

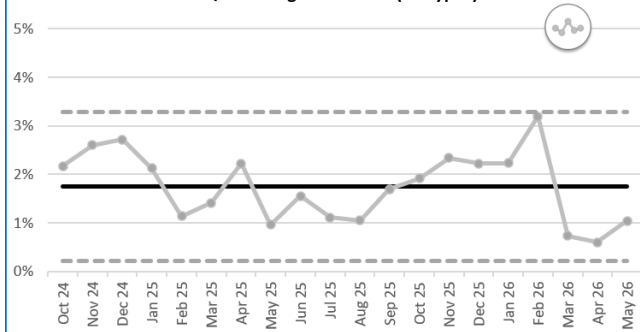
- Performance against the 5% standard declined in May – 20.5% of patients were waiting over six weeks. The target continues to be consistently failed but performance remains within common cause variation.

Emergency Care

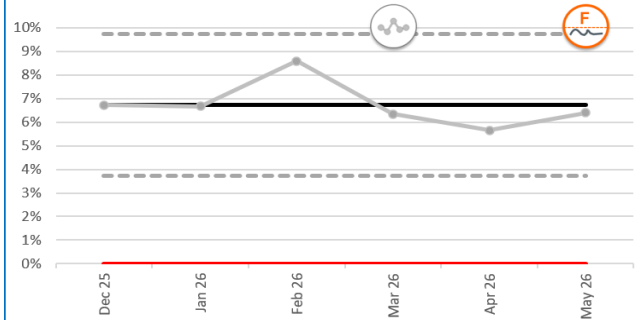
ED Performance - All Types (%)



ED Arrival to Admission / Discharge >12 hours (All types)



Ambulance Handovers >45 mins



Standards

- 82% of patients to be admitted/transferred/discharged from Accident & Emergency (A&E) in <4 hours (by Mar-27).
- No ambulance handovers to A&E exceeding 45 minutes (by Mar-27).
- Reduction from 25/26 in waits over 12 hours from A&E arrival to admission/discharge.

Current position

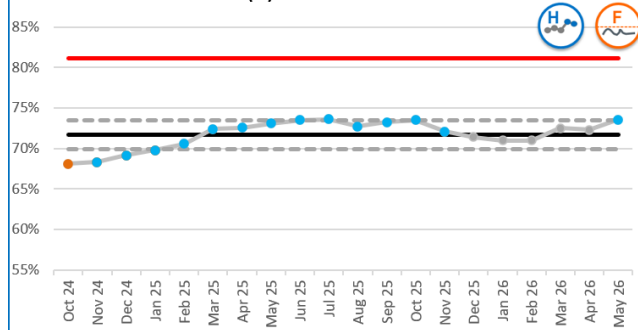
- ED Performance (All Types) in May was 76.5%, a decrease of 2.1% compared to April (79.0%). ED attendances increased in May to 24,767, 1,650 patients more than April. This was the highest number of patients seen in many years. Type 1 Major attendances, 9,507, were also the highest seen in years. Paediatric ED 4hr performance for May was 81.3%, a decrease of 2.2% from April.
- ED Trolley waits >12 hours increased from 7 in April to 11 in May.
- ED Arrival to Admission / Discharge > 12 hours (Type 1) in April was 1.17%, this rose to 2.03% in May.
- There were 217 handovers > 45 mins in May, this was an increase of 36 from April (181). Of those handovers, May had 74 handovers >60 minutes, up from 58 handovers >60 minutes in April.

Action taken

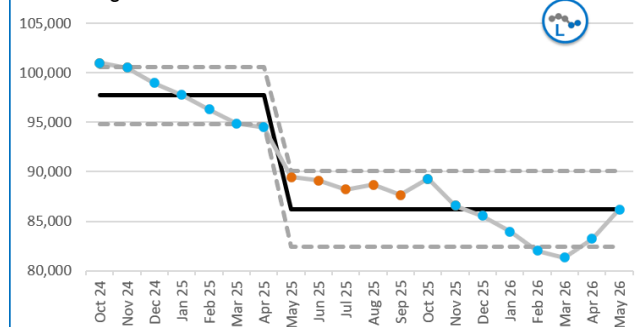
- The team are in the process of building up the ED Ambulatory Majors space (EDAM), utilising the old Minor Injuries space to see and treat anyone that doesn't need a bed or could walk. Staffing will be based on additional nursing and medical shifts only.
- Extra staff for the joint work between ED and the Older People's Medicine team will be funded substantially from September 2026. This has been implemented to increase the throughput of the front of house frailty service. As a result of the pilot, discharge turnaround has improved, with medics, nurses and therapists from Older People's Medicine working in ED to identify any patients to be discharged quickly - the team aim to identify 10 patients a day.
- "Enhanced week" was run during w/c 29th June, dedicated Patient Safety Coordinators for ED were used looking where patient flow could be improved. They chased bed availability in the assessment suite and ensures that patients were moved quickly between areas.
- The department is running a Corridor care improvement group, reviewing a Mental Health "Get It Right First Time" Assessment for ED. The Urgent and Emergency Care (UEC) Recovery Action Plan has been reviewed for discussions with NHSE regarding the Trust's ED Performance versus the Plan.

Elective Waits

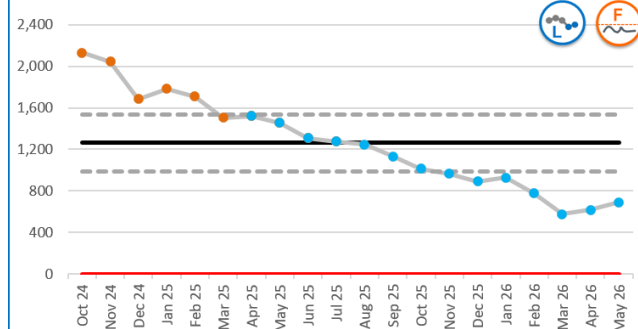
RTT 18 Weeks Performance (%)



RTT Waiting List Size



RTT >52 Week Waits



Standards

- 81.1% of patients on incomplete RTT pathways to be waiting less than 18 weeks (by March 2027, interim local target – constitutional standard remains 92%).
- Reduction in RTT waiting list size compared to 2025/26.

Current position

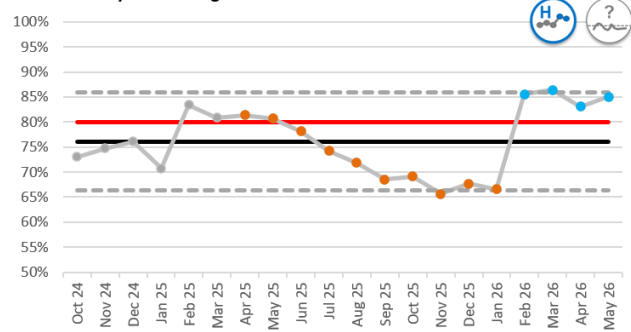
- RTT 18-week compliance increased to 73.5% in May (+1.2% from April). Performance improvement was linked to a further rebound in the waiting list size following the conclusion of the Trust's participation in an NHS England sponsored validation sprint at the end of March.
- The waiting list increased to 86,198 in May (+2,989). Training to stop errors at source has been provided across specialties to mitigate against further waiting list increases.
- Outpatient capacity challenges remain with the average wait to first appointment above or close to 18 weeks in key specialties. There has been a gradual increase in Patient-Initiated Follow-Up (PIFU) uptake (c. 3%) but this remains below internal ambitions.
- May 2026 witnessed an increase in >52-week waiters at Newcastle Hospitals, rising to 693 (+77). Current challenges affecting specialties with long waiters include:
 - Adult Deformity patients are highly complex and often require two surgeries with two consultants present, making scheduling appropriate lists very challenging.
 - Cardiology have long waiters for Left Atrial Appendage Occlusion (LAAO) – Compounded by a skills match issue where only one consultant can provide this procedure.
 - Spinal Neurosciences are experiencing capacity constraints due to surgeon absence.

Action taken

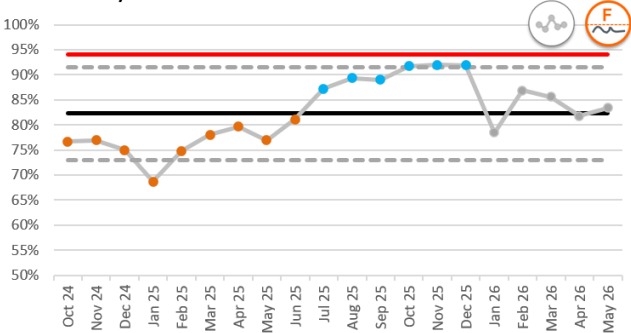
- The Trust is targeting high volume, lower-performing specialties such as Dermatology to increase overall RTT compliance. Dermatology's action plan aims to further develop the alternative workforce, such as Advanced Care Practitioners (ACPs), Physicians Associates (PAs), Specialist Nurses and Nurse Practitioners; and increased off-site provision to improve performance and reduce backlogs.
- Planned validation cycles are now well-established in the orthopaedics service, ensuring only patients who are fit for surgery remain on the waiting list.
- Substantial improvements have been made in Clinical Immunology and Allergy through focused work on reducing the waiting list size and improvement administrative management. RTT performance has increased by 26% in the last six months, with 52-week waiters also eliminated.

Cancer Care

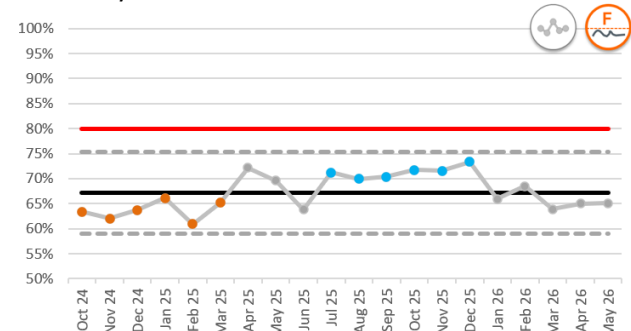
Cancer 28 Day Faster Diagnosis Standard



Cancer 31 Day Decision to Treatment



Cancer 62 Day Referral to Treatment Standard



Standards

- Faster Diagnosis Standard (FDS) - 80% of patients on a suspected cancer or breast symptomatic pathway to receive results/diagnosis within 28 days of referral (annual average by Mar-27).
- 94% to wait no more than 31 days from diagnosis to first cancer treatment (by Mar-27).
- 80% of patients to wait no more than 62 days from urgent/screening referral to first cancer treatment (by Mar-27).

Current position

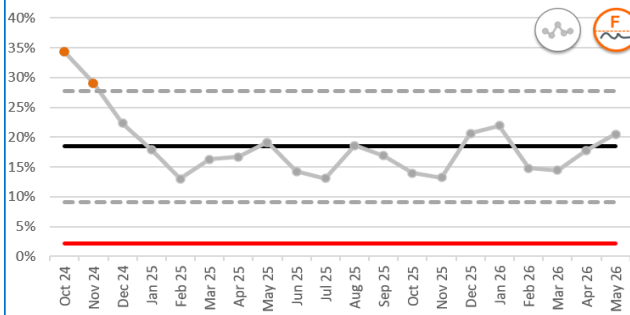
- In May, the 80% 28 FDS target was achieved, performance sat at 85.0% and demonstrates special cause variation of an improving nature. 31-day performance rose slightly to 83.4% in May, whilst 62-day performance rose slightly to 65.1%. It is too soon to tell whether the slight rises against 31-day and 62-day performance are a trend or natural variation.
- Strong performance against the FDS has been driven by improvements on the skin pathway. The Dermatology service have set out a plan for additional lists across the breadth of the summer to meet increasing demand.
- Radiology capacity continues to impact waiting times in the Breast service.
- Newcastle Hospitals is an outlier in the region for its low Lung 62-day performance. The treatment end of the pathway is contributing to this, as a result the service is focusing firstly on reducing cancellations and better scheduling in surgery. Work is underway to develop an additional, focused Patient Tracking List (PTL) meeting to improve tracking of lung cancer patients referred for radiotherapy or chemotherapy.

Action taken

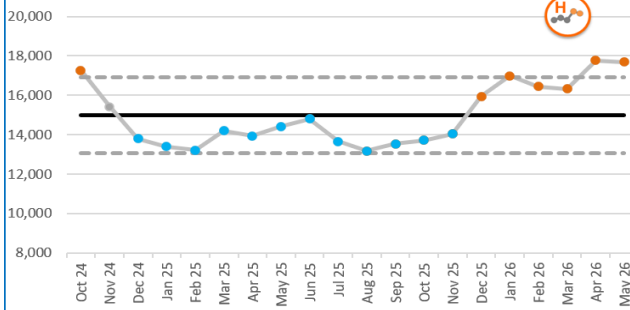
- Our targeted approach to reduce the backlog of patients waiting more than 62 days for treatment continues, focusing on key actions within the top 4 contributing tumour groups – Lung, Upper Gastrointestinal (GI), Urology and Lower GI. Lung and Hepato-Pancreato-Biliary (HPB) aim to reduce their 2 Week Wait (2WW) backlog to less than 10 patients waiting more than 62 days
- Breast – Short-term plan developed to increase one-stop clinic capacity at the front of the pathway within breast radiology.
- Provisional funding has been agreed for a pilot scheme to incentivise GPs to improve the quality of skin cancer referrals, including funding for an additional staff member, whilst discussions about regional pathway integration are also ongoing.

Diagnostics

Diagnostic 6 Week Performance



Diagnostic Waiting List Size



6 Week Diagnostic Performance by Modality – May 2026

MRI	23.3%	CT	5.4%
Non-obs US	8.6%	DEXA	21.0%
Audiology	12.2%	ECHO	46.0%
Electrophysiology	16.0%	Neurophysiology	1.6%
Sleep Studies	45.2%	Urodynamics	19.6%
Colonoscopy	36.2%	Flexi-Sig	37.8%
Cystoscopy	12.0%	Gastroscopy	35.6%
Newcastle Hospitals Total			20.5%

Standards

- $\leq 2.1\%$ of patients on incomplete diagnostic pathways waiting six weeks or longer (by March 2027).

Current position:

- Performance against the 5% standard declined in May – 20.5% of patients were waiting over six weeks. The target continues to be consistently failed but performance remains within common cause variation.
- Strong performance improvements in Audiology were sustained in May with compliance at 12.2%. Despite this, there is a continued need to balance sustainable achievement of the DM01 standard, whilst maintaining sufficient capacity to enable the delivery of phases 4-6 of the Audiology Recovery Plan – with a stubbornly high waiting list for re-assess and fits of particular concern.
- MRI performance reduced to 23.3% in May (-3.8%). Radiology is currently experiencing issues with scanner downtime at the RVI, which is having an impact on activity and performance.
- Performance worsened in Echo in April to 46% over 6 weeks. Inconsistent and unpredictable slot usage, combined with staffing challenges (vacancy, absence) is reducing throughput.

Action taken

- 24 new Echo machines were delivered in March following a successful funding bid with NHS England (NHSE). A further 2 were provided through the Children's Heart Unit Fund (CHUF). All of these machines are now in full operation. This is enabling back-to-back appointments, reducing malfunctions and providing more accurate diagnoses.
- A Radiology waiting list group has been established with waiting lists for neuro and surgery combined. This collaborative approach is ensuring that the longest waiters are prioritised for available capacity. A temporary scanner is also in place to alleviate issues with the permanent scanner, focused on appointments for the most complex patients.
- A group focused on MRI and Ultrasound is established in the Clinical & Diagnostic Services Clinical Board to oversee implementation of improvement action plans.
- Insourcing is in place in Audiology on a weekend for hearing aid fittings. Additionally, following a comprehensive service review and re-structure, appointments have been made, including the appointment of clinical leads and a service manager.

Contractual & Planning Standards (1/2)

Theme	Standard	Trajectory		Feb-26	Mar-26	Apr-26	May-26		Num.	Den.		26/27 YTD
Activity												
Day Case	100% of 26/27 Plan	N/A		98.1%	94.5%	101.7%	102.8%		10,574	10,283		102.3%
Elective Overnight				88.3%	82.5%	93.2%	98.7%		1,635	1,657		95.9%
Outpatient New				91.8%	87.1%	96.1%	94.0%		22,711	24,161		95.1%
Outpatient Procedures				94.6%	95.0%	99.0%	97.5%		20,688	21,228		98.2%
Outpatient Review	N/A			107.4%	104.1%	104.1%	100.2%		60,839	60,737		102.2%
Non-Elective				90.1%	82.4%	99.2%	97.1%		963	992		98.1%
Emergency				110.6%	112.6%	103.2%	103.0%		6,641	6,450		103.1%
PIFU Take-up (%)	N/A	3.6%		2.8%	2.9%	3.4%	3.2%		3,560	110,567		3.3%
Urgent Ops. Cancelled Twice	Zero	N/A		0	0	0	0		0			0
Cancelled Ops. Rescheduled >28 Days	Zero	N/A		18	9	7	7		7			14
Elective Waits												
RTT Waiting List Size	Reduction from 25/26	83,446		82,021	81,433	83,207	86,198		86,198			
	Constitutional: 92%											
RTT <18 Week Wait	Interim: 81.1% by Mar-27 (local target)	75.5%		71.0%	72.4%	72.3%	73.5%		63,391	86,198		72.9%
>52 Week Waiters	N/A	485		777	579	616	693		693			
Time to First Outpatient Appointment (18 Weeks)	N/A	79.9%		77.5%	77.2%	77.1%	79.6%		41,494	52,098		78.4%
Diagnostic Waiting List Size	N/A	14,115		16,441	16,331	17,766	17,682		17,682			
Diagnostic >6 week wait	Constitutional: 1% Interim: 2.1% by Mar-27 (local target)	14.7%		14.7%	14.4%	17.8%	20.5%		3,632	17,682		19.2%
Community Services Waiting List	N/A	N/A		11,315	11,615	11,369	11,412		11,412			
Community Services >18 Week Wait	78% by Mar-27 (ICB target)			75.3%	77.2%	78.0%	79.6%		2,331	11,412		
Community Services >52 Week Waiters	N/A			947	733	729	657		657			

Contractual & Planning Standards (2/2)

Theme	Standard	Trajectory		Feb-26	Mar-26	Apr-26	May-26		Num.	Den.		26/27 YTD
Cancer Care												
28 Day Faster Diagnosis	80% Annual Average (by Mar-27)	79.8%		85.6%	86.4%	83.1%	85.0%		2,012	2,367		84.0%
31 Days (DTT to Treatment)	94%	88.3%		86.8%	85.6%	81.8%	83.4%		1,047	1,255		82.6%
62 Days (Referral to Treatment)	80% (by Mar-27)	69.3%		68.6%	63.9%	65.0%	65.1%		301	462		65.1%
>62 Day Cancer Waiters	N/A	N/A		243	258	260	280		280			
Urgent & Emergency Care												
A&E Arrival to Admission/Discharge (All types)	82% under 4 hours (by Mar-27)	81.9%		75.6%	79.8%	79.0%	76.5%		18,943	24,767		77.7%
A&E Arrival to Admission/Discharge <12 hours	Increase from 25/26 Average	99.1%		96.8%	99.3%	99.4%	99.0%		257	24,767		99.2%
Adult General & Acute Bed Occupancy	N/A	89.6%		90.8%	94.1%	86.2%	88.5%		1,279	1,445		87.4%
Ambulance Handovers >15 mins	N/A	40.0%		45.1%	45.6%	52.0%	53.3%		1,806	3,390		52.6%
Ambulance Handovers >45 mins	Zero (by Mar-27)	8.3%		8.6%	6.3%	5.6%	6.4%		217	3,390		94.0%
Urgent Community Response Standard	>=70% under 2 hours	N/A		86.3%	80.5%	89.1%	89.4%		262	293		89.3%
Safe, High Quality Care												
Mixed Sex Accommodation Breach	Zero	N/A		146	161	95	126		126			221
VTE Risk Assessment	95%			97.3%	96.6%	TBC	TBC					
Sepsis Screening Treat. (Emergency)	>=90% (of sample) under 1 hour			72.0%		TBC	TBC					
Sepsis Screening Treat. (All)				73.0%		TBC	TBC					

People



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People overview

Metric	12-month rolling	Actual	Target	Variation	Assurance
Sickness	May-26	5.90%	4.5%		
Short-term (Month only)	May-26	1.82%			
Long-term (Month Only)	May-26	3.85%			
Turnover	May-26	9.35%	10%		
Mandatory training	May-26	92.08%	90%		
Appraisal	May-26	85.39%	90%		
Disabled staff	May-26	6.90%			
Ethnicity (BAME staff)	May-26	19.18%			



Staff in post

- Total is 15,884.94 Full Time Equivalent (FTE) including Bank/agency
- Total substantive is 15,470.75 FTE, 17,691 headcount
- Above substantive pre-Covid by 1,944.00 FTE (+13.95%)
- Below workforce plan of 15,947.25 FTE by 62.31 FTE (-0.39%)

Sickness

- Top reasons for sickness: anxiety/stress/depression 32.85% (-0.58%); other musculoskeletal problems 11.24% (+0.71%); gastrointestinal 9.70% (-0.02%)
- Short-term sickness in May 1.82% (+0.07%), long term sickness 3.85% (-0.10%)
- Average working days lost is **1,036** (headcount) per day for the reporting period.
- Trust wide initiative to look at 'why does absence matter' which is tasked with reducing sickness by 0.5% - lead by Director of Operations for Medicine

Retention & Turnover

- Increase of 0.12%. Top reason for leaving; retirement age at 14.03%
- Top destinations: no employment 48.60%; other NHS organisation 26.47%

Mandatory training / Appraisal

- Reduction of 0.05%. Lowest is Medical and Dental 79.91% (+0.74%)
- Task & Finish Group has been commissioned to look at 'process and provision'.
- Overdue appraisals increased to 2,068
- Senior doctors (consultant and SAS) have had set 1.5 Supporting Professional Activities (SPA) (6 hours a week) in their job plans since job planning began which was designed to cover things including Mandatory Training, and appraisal preparation.

Bank & Agency

- Total annual non-medical bank expenditure £19.5m, +£2.3m vs last year
- Total annual non-medical agency expenditure £2.1m, -£1.6m vs last year
- Total annual medical bank (locum) expenditure £12.8m, +£1.0m vs last year
- Total annual medical agency expenditure £2.5m, -£1.7m vs last year

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

Headline Metric	Jan 2020 FTE	Plan FTE	Establishment	Current FTE	Current FTE v Jan 2020	Current FTE v Plan	Current FTE v Establishment
Total Substantive Staff	13,438.55	15,548.91	16,294.51	15,470.85	2,032.30	-78.06	-823.66
Total Bank & Agency Staff	501.60	398.34		414.09	-87.51	15.75	
Total	13,940.15	15,947.25	16,294.51	15,884.94	1,944.79	-62.31	-823.66

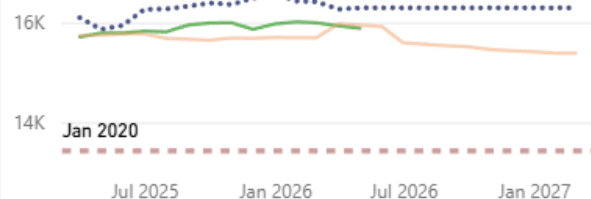
Headline Metric	Jan 2020 FTE	Plan FTE	Establishment	Current FTE	Current FTE v Jan 2020	Current FTE v Plan	Current FTE v Establishment
1. Total Non Medical - Clinical Substantive Staff	9,322.71	10,858.97	11,288.72	10,721.22	1,398.51	-137.75	-567.50
2. Total Non Medical - Non-Clinical Substantive Staff	2,226.73	2,604.82	2,873.26	2,612.59	385.86	7.77	-260.67
3. Total Medical and Dental Substantive Staff	1,732.92	2,071.16	2,123.03	2,123.53	390.61	52.37	0.50
4. Any other Staff (substantive staff)	156.19	13.96	9.50	13.51	-142.68	-0.45	4.01
5. Bank	441.22	373.91		391.31	-49.91	17.40	
6. Agency	60.38	24.43		22.78	-37.60	-1.66	
Total	13,940.15	15,947.25	16,294.51	15,884.94	1,944.79	-62.31	-823.66

Current Position:	Underlying Issues	Actions Undertaken:
- Workforce is +1,944.79 FTE (+13.95%) above January 2020 (pre-Covid) position. - Substantive workforce target at 31st May is 15,548.91 FTE. - Substantive workforce actual position at 31st May is 15,470.85 FTE. - Substantive workforce is currently -78.06 FTE below for May. (see slide 3, top row, middle graph) - NHS infrastructure support (substantive) is 7.77 FTE above plan. - Bank is above plan. - Agency is below plan. - Agency usage reviewed and challenged weekly / monthly. - Robust management of agency requests with active bank and redeployment	- Bank use due to switching requirements for additional hours from overtime to Bank which is more cost effective. - Need to maintain safe services (e.g. healthcare assistants for enhanced care). Greater use being made of Bank options to reduce spend on agency. - Practice of rostering staff may not be optimal in some areas. Potential need for some refresher training. - Changes should be noted regarding Plan FTE and Current FTE for 'Total Non-Medical – Clinical Substantive Staff' and 'Total Non-Medical – Non-Clinical Substantive Staff', due to staff movement within the Provider Workforce Return (PWR) commencing in April 2026. This relates to those within 'Support to Clinical – central functions, hotel services, property and estates', which have been reclassified from 'Total NHS Infrastructure Support' to 'Support to Clinical'.	- New Trust wide Mutually Agreed Resignation Scheme (MARS) running from 22 June to 19 July. - Workforce Reduction Group (WROG) continues to meet bi-weekly, safeguarding the integrity of workforce controls to ultimately support a reduction in organisational headcount. The group functions as a 'gatekeeper' for specific workforce requests i.e. MARS skill mix and external advertising, ensuring all exceptions meet agreed upon criteria. - To support the shift from overtime to Bank, around 1,200 substantive staff have been fast-tracked as additions to the Bank.

PWR – in-year overview position

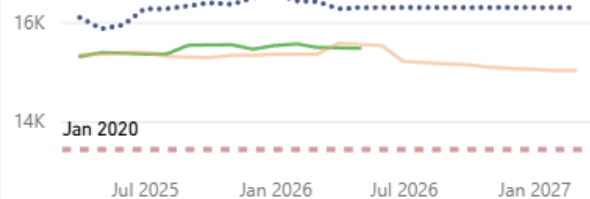
Workforce FTE - All Staff (Substantive, Bank & Agency)

● Actual FTE ● Establishment FTE ● Plan FTE



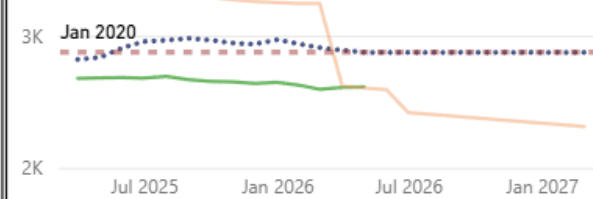
Workforce FTE - All Substantive Staff

● Actual FTE ● Establishment FTE ● Plan FTE



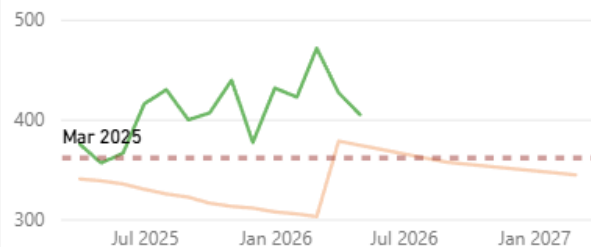
Workforce FTE - Non-Medical Non-Clinical (Substantive)

● Actual FTE ● Establishment FTE ● Plan FTE



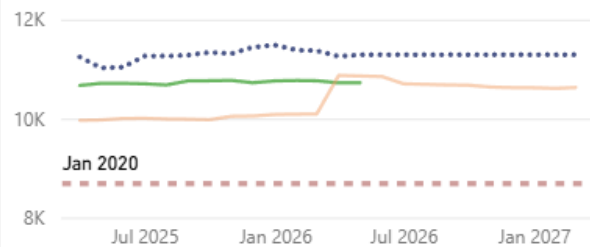
Workforce FTE - Bank

● Actual FTE ● Plan FTE



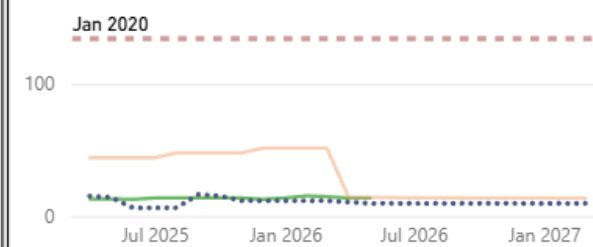
Workforce FTE - Non-Medical Clinical (Substantive)

● Actual FTE ● Establishment FTE ● Plan FTE



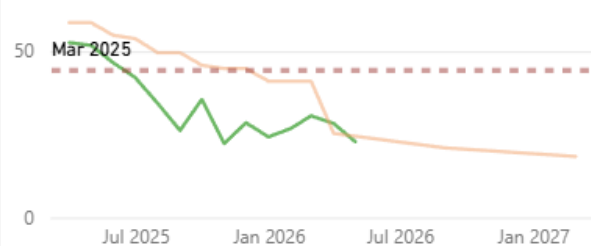
Workforce FTE - Any Other Staff (Substantive)

● Actual FTE ● Establishment FTE ● Plan FTE



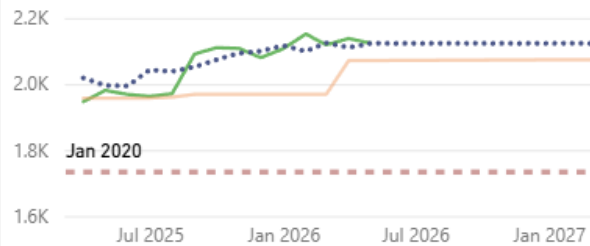
Workforce FTE - Agency

● Actual FTE ● Plan FTE



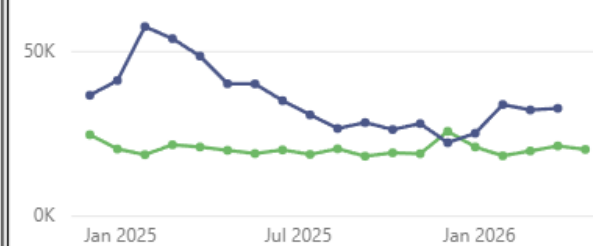
Workforce FTE - Medical and Dental (Substantive) and LET

● Actual FTE ● Establishment FTE ● Plan FTE



Health Roster Overtime vs Hours Not Fulfilled (Non-Medical)

● Hours Not Fulfilled ● Non-WLI Overtime Hours



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

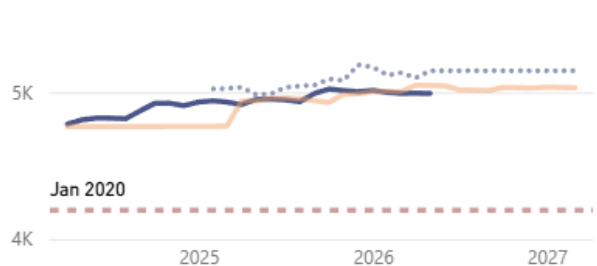
PWR – staff group overview as-at May 2026

Sub Categories Metric	Jan 2020 FTE	Plan FTE	Establishment	Current FTE	Current FTE v Jan 2020	Current FTE v Plan	Current FTE v Establishment
1. Registered Nursing, Midwifery and Health visiting staff (substantive total)	4,200.28	5,045.26	5,146.01	4,991.75	791.47	-53.51	-154.26
2. Registered/ Qualified Scientific, Therapeutic and Technical Staff (substantive total)	1,994.12	2,442.04	2,530.48	2,402.89	408.78	-39.15	-127.59
3. Support to Clinical staff (substantive total)	3,128.32	3,371.67	3,612.23	3,326.58	198.26	-45.09	-285.65
4. Total NHS Infrastructure Support (includes A&C, estates, managers) (substantive total)	2,226.73	2,604.82	2,873.26	2,612.59	385.86	7.77	-260.67
5. Total Medical and Dental (substantive total)	1,732.92	2,071.16	2,123.03	2,123.53	390.61	52.37	0.50
6. Any other Staff (substantive total)	156.19	13.96	9.50	13.51	-142.68	-0.45	4.01
7. Bank Any other staff	0.00	0.00			0.00	0.00	
7. Bank Medical and dental	11.75	27.96		40.57	28.82	12.61	
7. Bank Registered nursing, midwifery and health visiting staff	111.27	107.72		111.55	0.28	3.83	
7. Bank Registered/ Qualified Scientific, Therapeutic and Technical staff	16.41	10.31		13.18	-3.23	2.87	
7. Bank Support to clinical staff	258.10	207.01		216.67	-41.43	9.66	
7. Bank Total NHS infrastructure support	43.69	20.91		9.34	-34.35	-11.57	
8. Agency Any other staff	0.00	0.00			0.00	0.00	
8. Agency Medical and dental	0.87	3.18		3.44	2.57	0.25	
8. Agency Registered nursing, midwifery and health visiting staff	2.86	4.22		2.38	-0.48	-1.84	
8. Agency Registered scientific, therapeutic and technical staff	17.27	4.48		1.61	-15.66	-2.87	
8. Agency Support to clinical staff	23.68	12.55		15.35	-8.33	2.80	
8. Agency Total NHS infrastructure support	15.70	0.00			-15.70	0.00	
Total	13,940.15	15,947.25	16,294.51	15,884.94	1,944.79	-62.31	-823.66

PWR – staff group overview in-year position

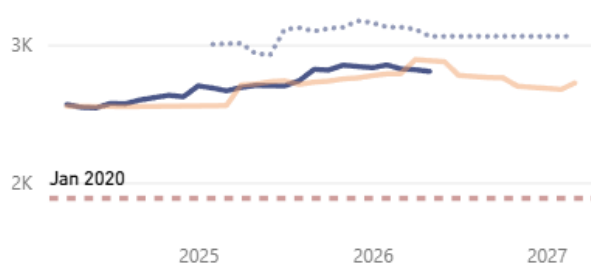
Workforce FTE - Registered Nursing, Midwifery & Health Visits

Actual FTE FTE Establishment Plan FTE



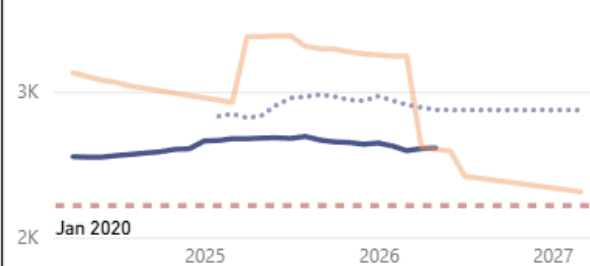
Workforce FTE - Registered/ Qualified Scientific, Therapeutic ...

Actual FTE FTE Establishment Plan FTE



Workforce FTE - Total NHS Infrastructure support

Actual FTE FTE Establishment Plan FTE



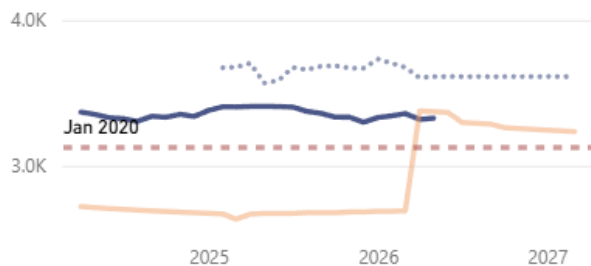
Workforce FTE - Critical Care/ICU All Staff

FTE Actual FTE Establishment



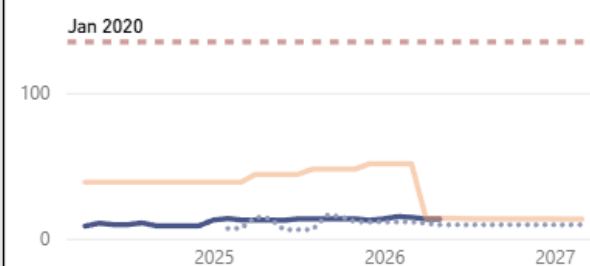
Workforce FTE - Support to Clinical Staff

Actual FTE FTE Establishment Plan FTE



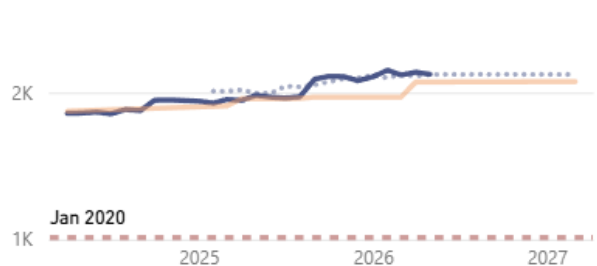
Workforce FTE - Any Other Staff

Actual FTE FTE Establishment Plan FTE



Workforce FTE - Medical and Dental

Actual FTE FTE Establishment Plan FTE

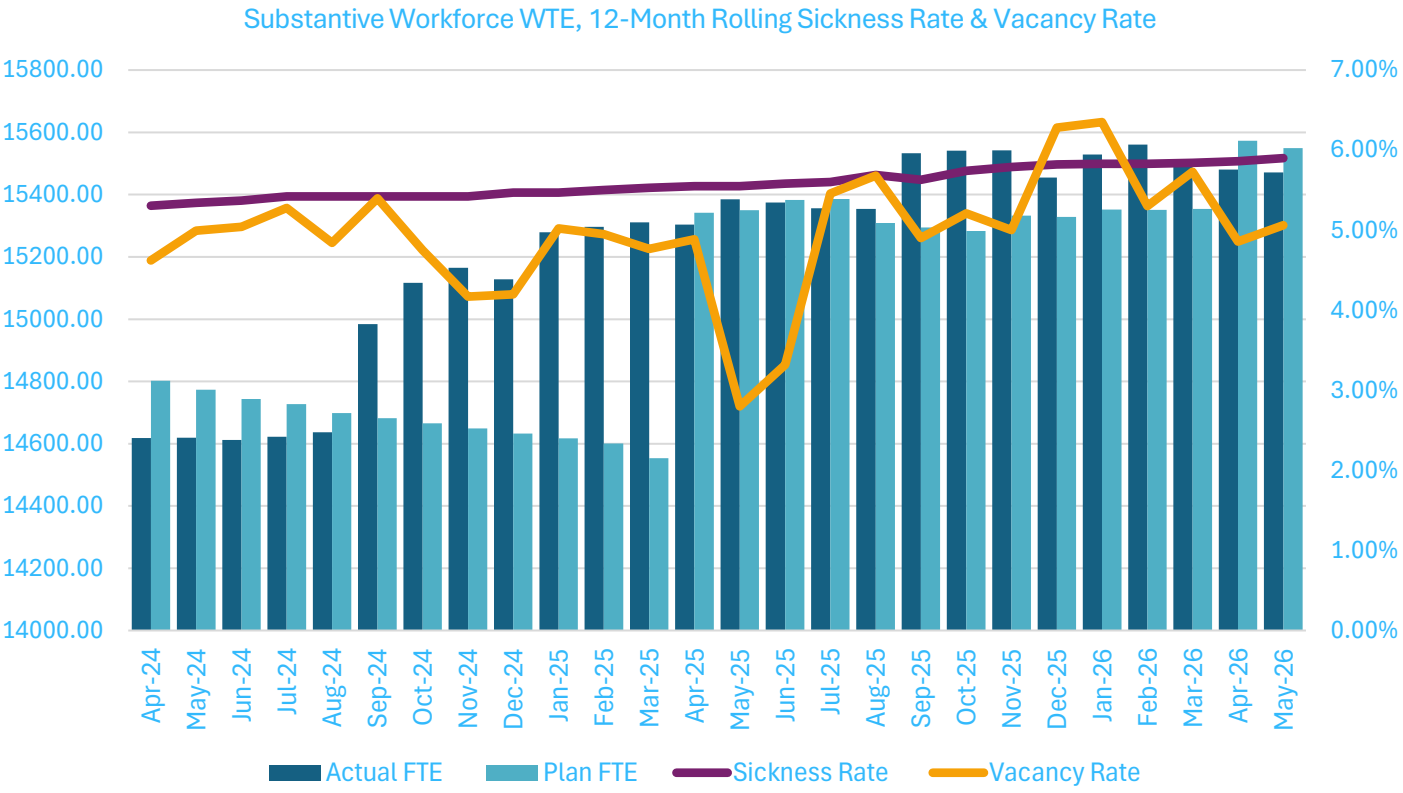


Vacancies

Summary Group	FTE Establishment	Actual FTE	Vacancy FTE	Vacancy FTE %
1. Total Non Medical - Clinical Substantive Staff	11288.72	10722.13	566.59	5.02%
2. Total Non Medical - Non-Clinical Substantive Staff	2873.26	2611.59	261.67	9.11%
3. Medical and Dental	2123.03	2122.53	0.50	0.02%
5. Other	9.50	13.51	-4.01	-42.18%
Total	16294.51	15469.75	824.76	5.06%

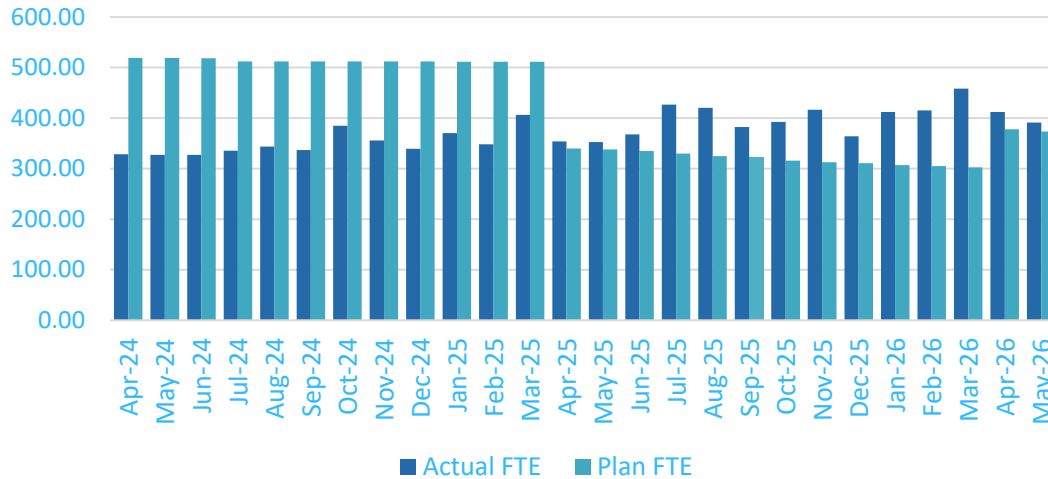
**Please note: The charts on this page include LET data

Substantive Workforce

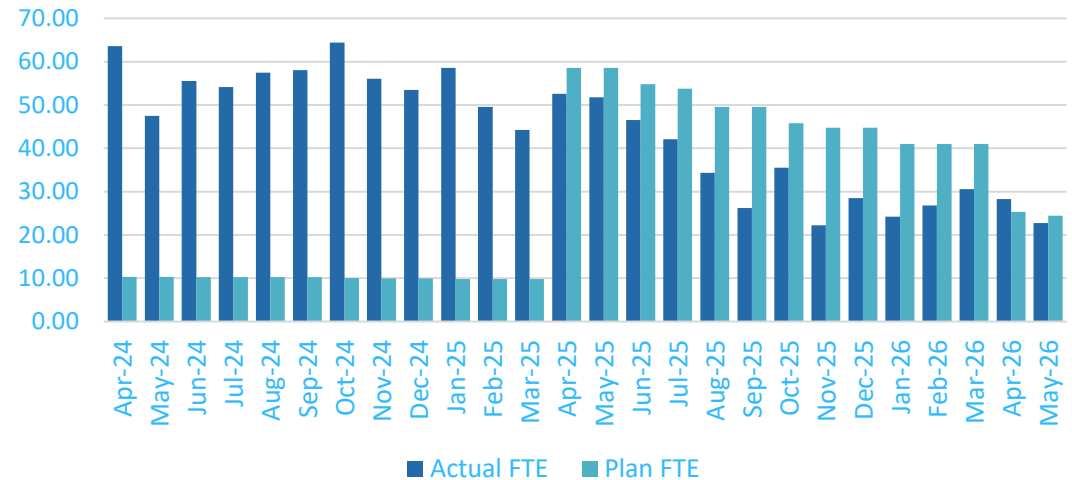


Bank and Agency Workforce

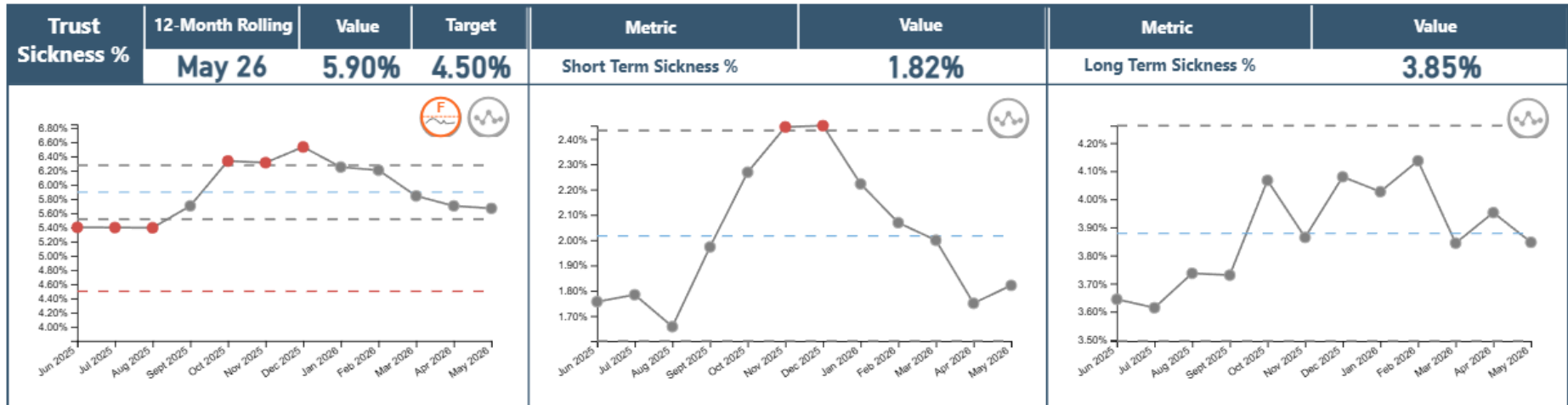
Bank Workforce FTE Plan vs Actual



Agency Workforce FTE Plan vs Actual



Sickness absence – 12-month average



Current Position:

- Top reasons for sickness:
 - Anxiety/stress/depression (S10) 32.85%
 - Other musculoskeletal problems (S12) 11.24%
 - Gastrointestinal problems (S25) 9.70%
- The 12-month rolling absence rate of 5.90% and the sick pay cost of £36.2m are significantly above the target of 5% and £25m respectively.

Underlying Issues

- Anxiety/stress/depression (S10) is main reason for sickness absence. Some is work-related and some is due to issues outside of work.
- Total days lost: 318,804.83 FTE.
- Average time lost per person: 22 days.
- Total cost of sick pay: £36.2m.
- Variation in sickness rates across Clinical Boards:
 - Lowest – Clinical and Diagnostic Services at 4.39% (short-term 1.46%, long term 2.63%)
 - Highest – Peri-operative and Critical Care at 6.56% (short-term 2.57%, long term 4.12%)

Actions Undertaken:

- 'Why absence matters' is a Trustwide program focusing on supporting line managers to manage sickness absence. The development of a new sickness infographic allows for key metrics to be triangulated, there will be a 3 phased approach with sickness metrics being phase 1. The infographic information will also be shared Trustwide via the Intranet monthly from May 2026.
- Staff Psychological Service offer will be rolling out and scaling up from March. "Working Well" offer and all resources and open access offers will be shared on the intranet and open for self-enrolment via the Learning Lab. Offer designed over four tiers, Preventative, Proactive, Targeted & Restorative. – Mental Health First Aid (MHFA) training booked until June 2026.

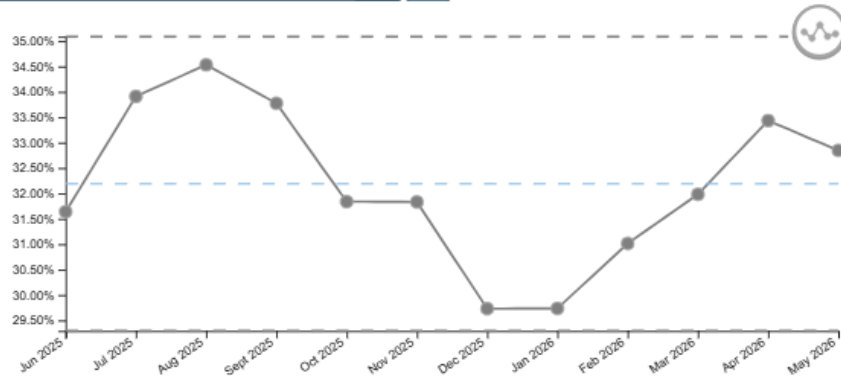
Sickness absence – top absence reasons

Trust Sickness %	12-Month Rolling	Value	Target
	May 26	5.90%	4.50%

Sickness Reasons - SPC

S10 - Anxiety/stress/depression/other psychiatric illness

32.85%

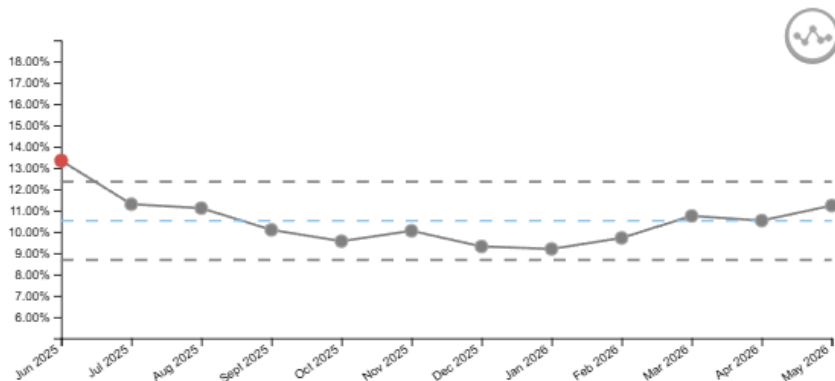


Top 10 Sickness Absences



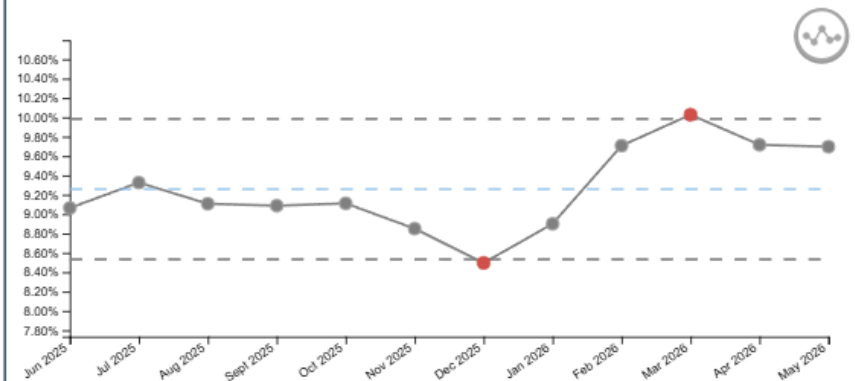
S12 - Other musculoskeletal problems

11.24%



S25 - Gastrointestinal problems

9.70%



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

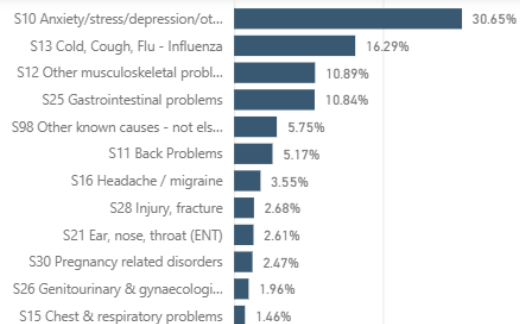
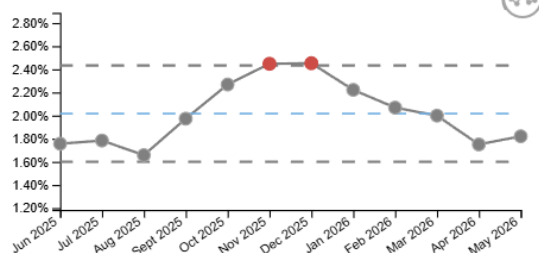
Short Term Sickness Absence (Latest Month)

May 26

1.82%

ST Absence Reason

All



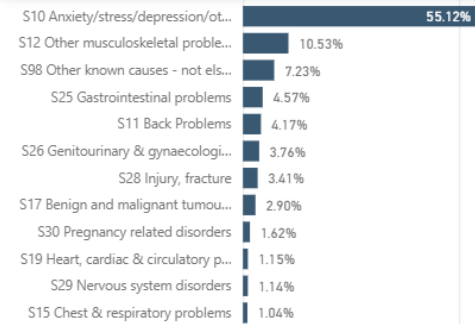
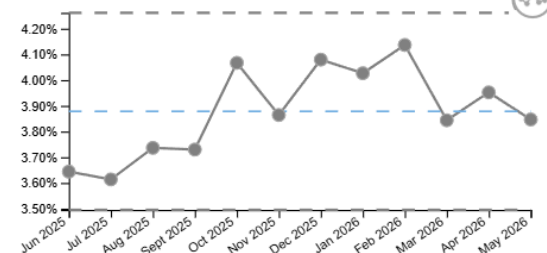
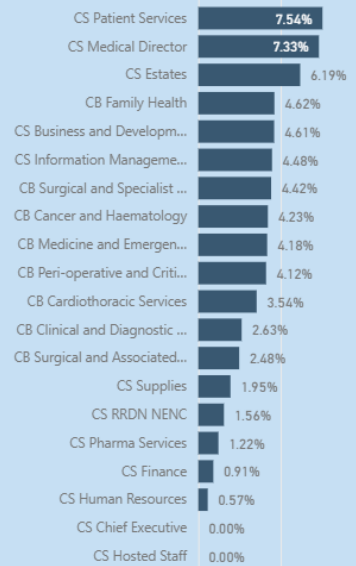
Long Term Sickness Absence (Latest Month)

May 26

3.85%

LT Absence Reason

All



Sickness – FTE working days lost & formal action activity

Sickness - FTE working days lost

FTE working days lost
due to sickness

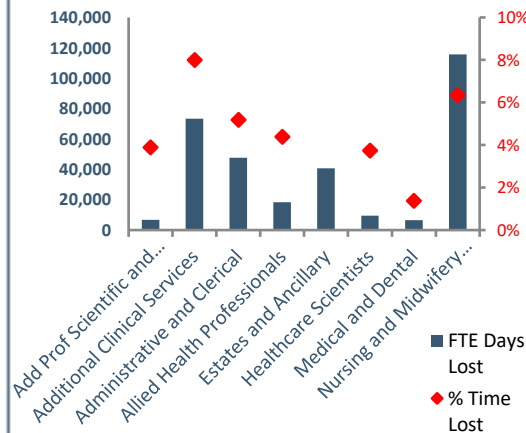
318,511



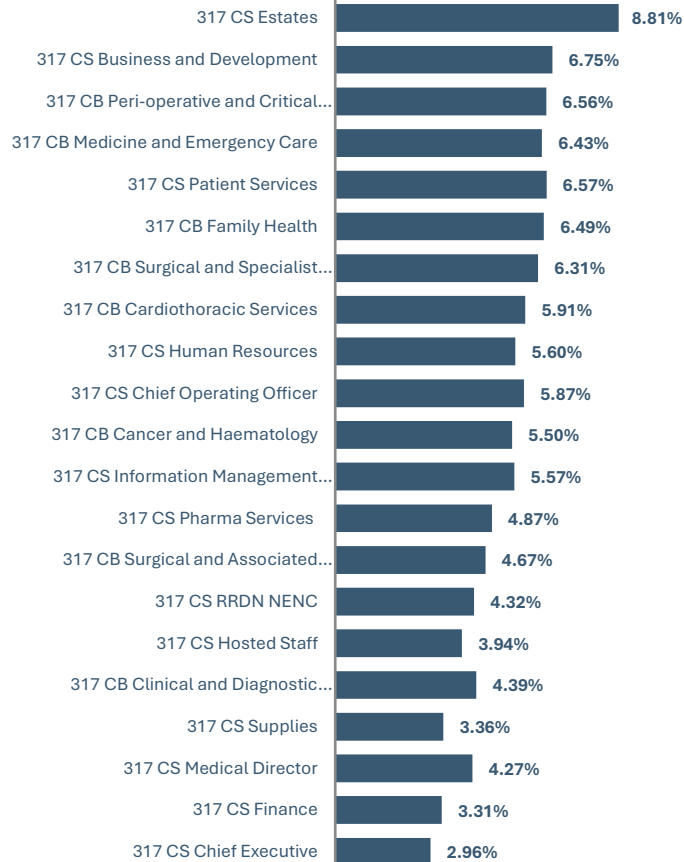
293,462

compared to the
previous year.

Sickness Absence by Staff Group



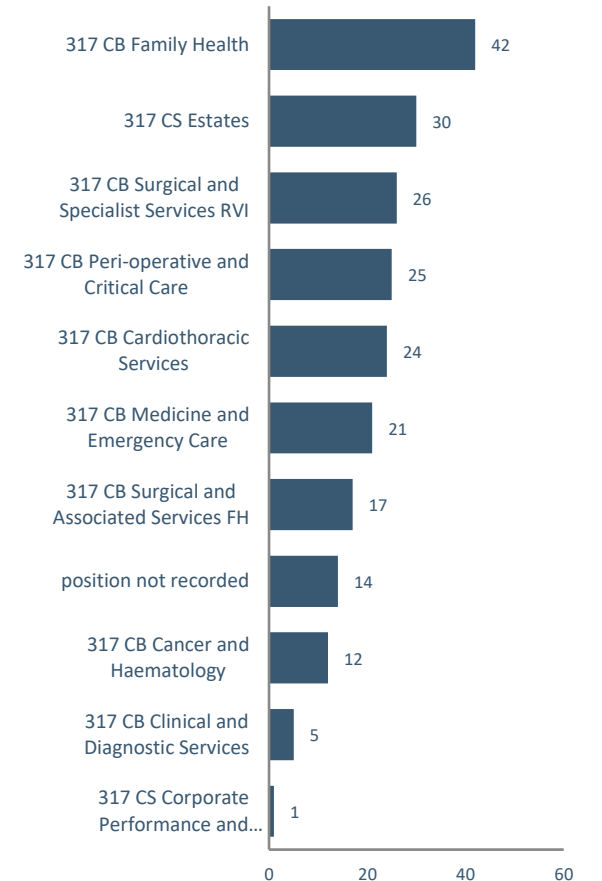
Sickness Absence (% Time Lost) by Clinical Board



Sickness - Formal Action

Latest Data - March 2026

Attendance Management – Formal Action
by Clinical Board/ Corporate Service



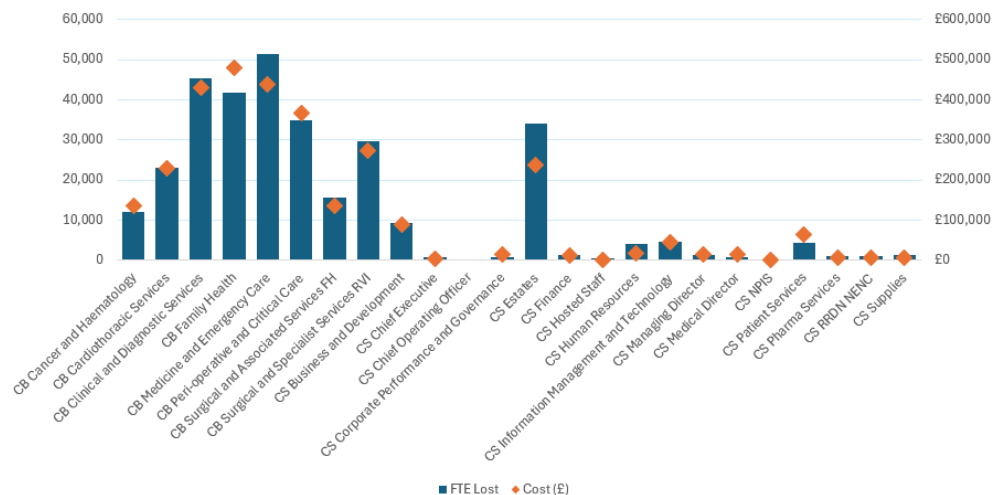
Sickness – FTE working days lost & cost of sick pay

Sickness Absence	12-Month period ending	Cost (£)	FTE Lost	Ave. No of Days Lost per FTE
	May 26	£36,201,206	318,804.83	21.54

Clinical Board	Cost (£)	FTE Lost	Ave. No of days lost per FTE
CB Cancer and Haematology	136,560	12,081.24	20.21
CB Cardiothoracic Services	229,425	22,994.46	21.80
CB Clinical and Diagnostic Services	429,023	45,453.64	16.11
CB Family Health	479,665	41,687.49	23.49
CB Medicine and Emergency Care	438,817	51,271.56	23.52
CB Peri-operative and Critical Care	366,081	34,994.96	23.99
CB Surgical and Associated Services FH	135,439	15,555.53	17.01
CB Surgical and Specialist Services RVI	272,389	29,556.68	23.20

Clinical Board	Cost (£)	FTE Lost	Ave. No of days lost per FTE
CS Business and Development	87,909	9,355.51	23.76
CS Chief Executive	2,669	804.90	10.85
CS Chief Operating Officer	0	0.00	0.00
CS Corporate Performance and Governance	14,075	767.68	9.05
CS Estates	236,390	33,949.66	31.98
CS Finance	10,955	1,372.69	12.07
CS Hosted Staff	0	469.60	14.17
CS Human Resources	16,583	3,979.55	20.35
CS Information Management and Technology	44,868	4,646.97	20.36
CS Managing Director	15,052	1,343.10	17.53
CS Medical Director	13,138	863.75	15.87
CS NPIS	750	153.40	7.71
CS Patient Services	63,918	4,249.33	23.69
CS Pharma Services	5,026	1,013.66	17.90
CS RRD NENC	5,878	942.31	15.62
CS Supplies	6,767	1,297.17	13.88

Sickness Cost and FTE Lost

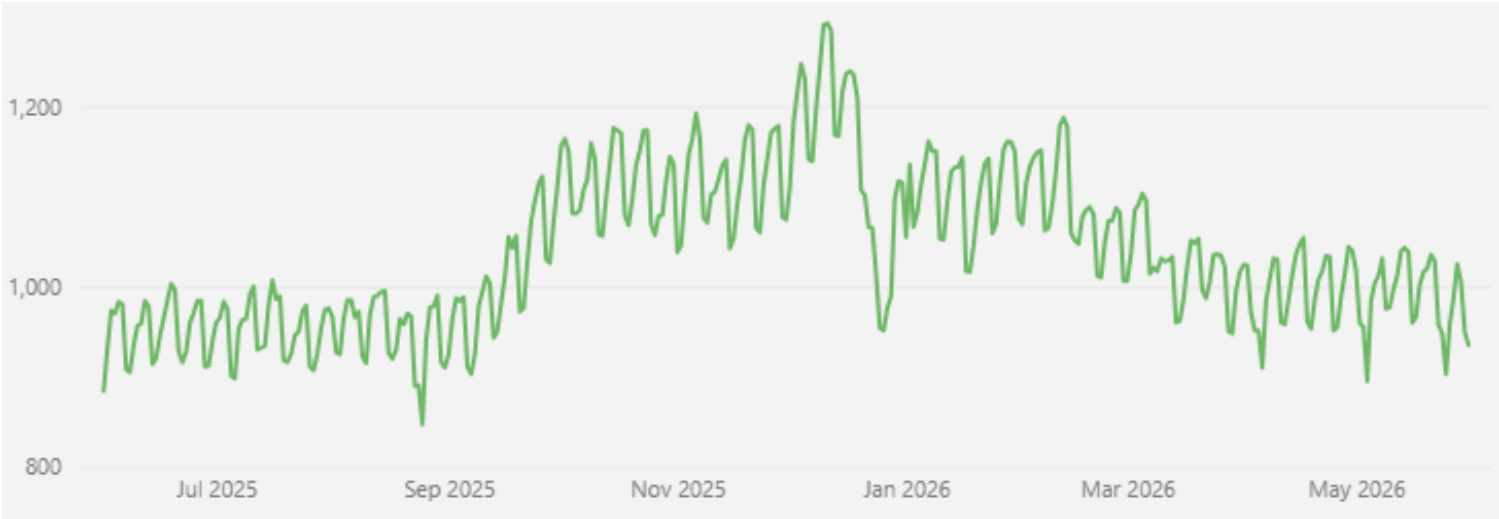


Sickness – Average working days lost per day

June 2025 to May 2026	Average Working Days Lost per Day*
	1,036

Month	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26	Oct 26	Nov 26	Dec 26
Average Working Days Lost per Day*	1,101	1,092	1,023	993	988							

Rolling 12-month daily average



*Headcount

Sickness – Average working days lost per day

Rolling 12-month daily average

Long Term June 2025 to May 2026	Average Working Days Lost per Day*
	724

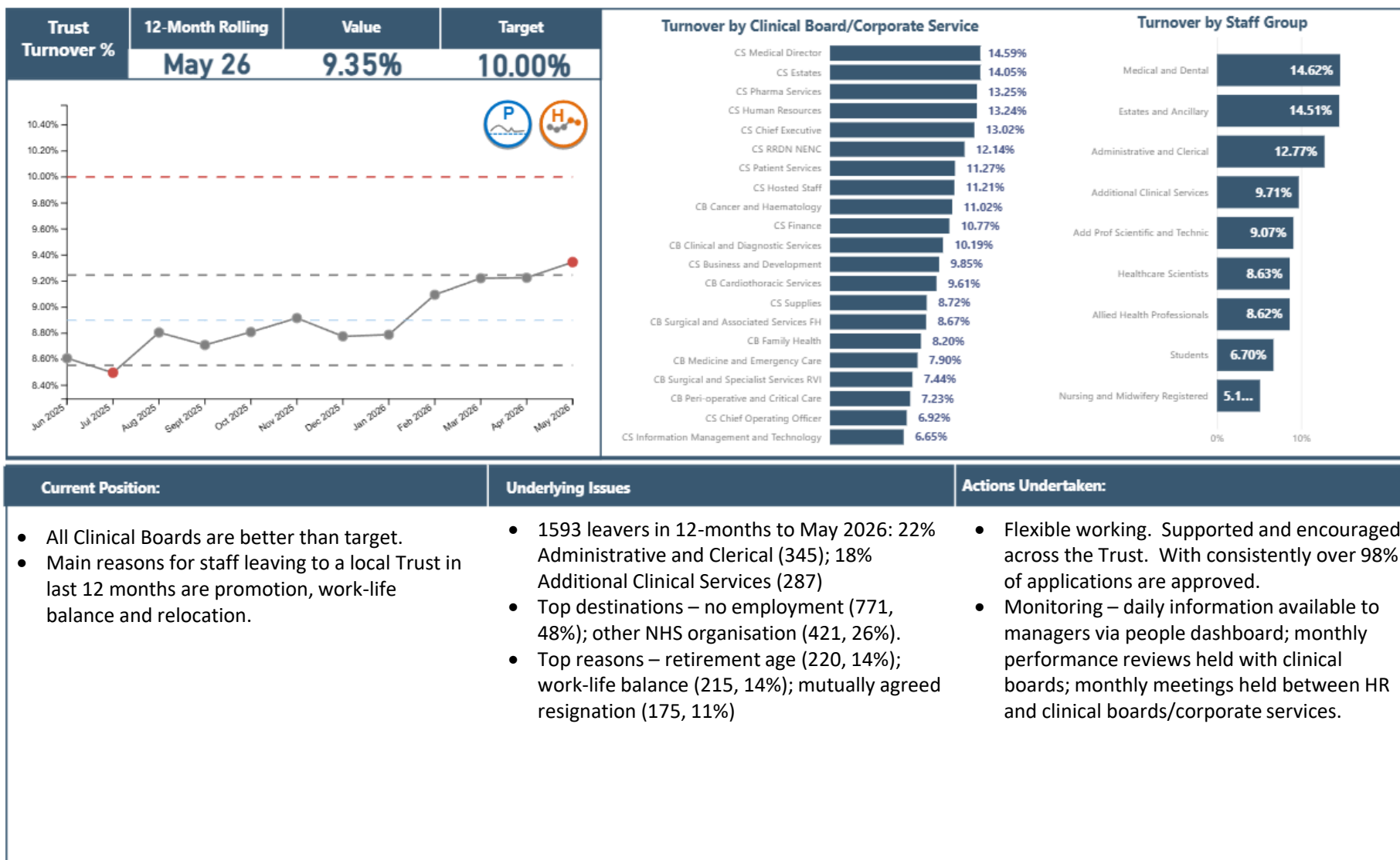
Month	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26	Oct 26	Nov 26	Dec 26
Average Working Days Lost per Day*	649	647	639	649	613							

Short Term June 2025 to May 2026	Average Working Days Lost per Day*
	313

Month	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26	Oct 26	Nov 26	Dec 26
Average Working Days Lost per Day*	451	445	384	344	375							

*Headcount

Turnover



Turnover

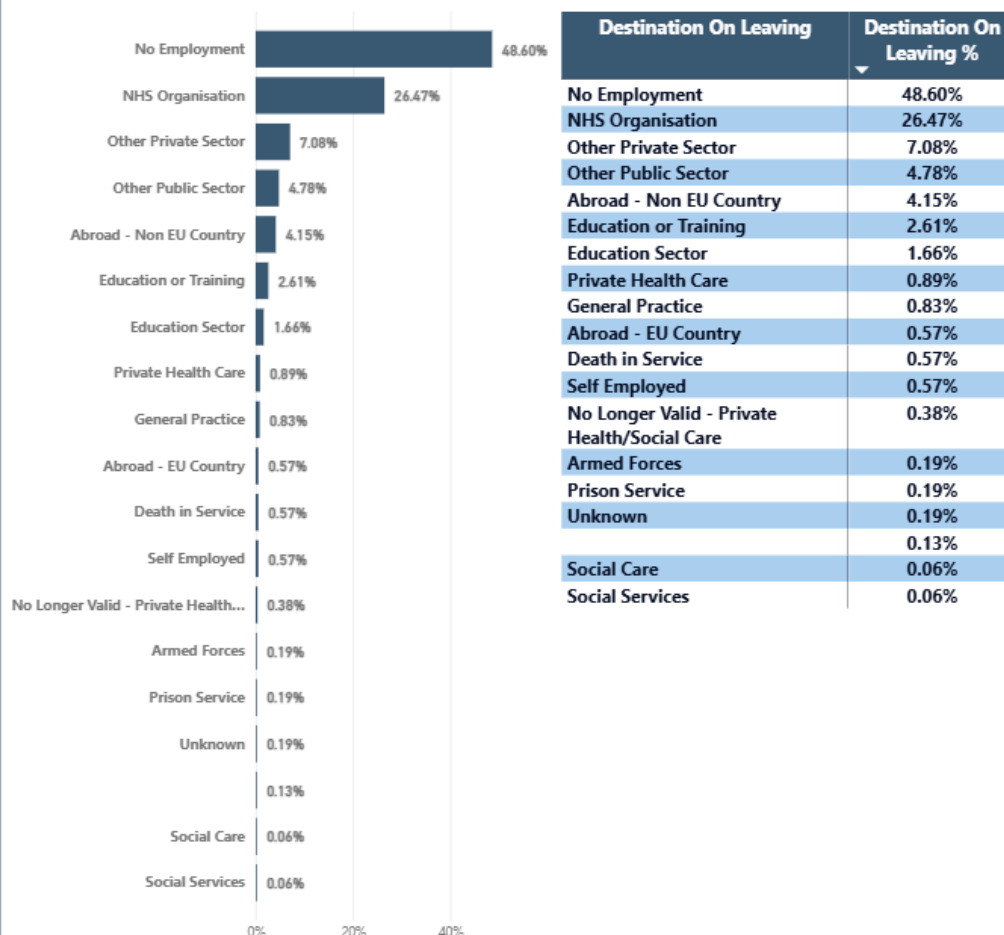
Trust Turnover %	12-Month Rolling	Value	Target
	May 26	9.35%	10.00%

Leaving Reasons

Leaving Reason	Leaving Reason %
Retirement Age	14.03%
Voluntary Resignation - Work Life Balance	13.90%
Mutually Agreed Resignation - Local Scheme with Repayment	11.29%
Voluntary Resignation - Relocation	10.91%
End of Fixed Term Contract	8.23%
Voluntary Resignation - Promotion	7.84%
Voluntary Resignation - Health	5.93%
Flexi Retirement	5.55%
Voluntary Resignation - To undertake further education or training	3.95%
Voluntary Resignation - Incompatible Working Relationships	2.81%
Dismissal - Capability	2.42%
Voluntary Resignation - Lack of Opportunities	2.23%
End of Fixed Term Contract - Completion of Training Scheme	1.85%
Voluntary resignation - Pay and Reward Related	1.66%
End of Fixed Term Contract - Other	1.28%
Voluntary Resignation - Child Dependants	1.02%
Voluntary Early Retirement - no Actuarial Reduction	0.77%
Voluntary Early Retirement - with Actuarial Reduction	0.77%
Voluntary Resignation - Other/Not Known	0.77%
Death in Service	0.57%
Retirement - Ill Health	0.51%
Dismissal - Conduct	0.45%
Voluntary Resignation - Adult Dependants	0.38%
Dismissal - Statutory Reason	0.32%
End of Fixed Term Contract - External Rotation	0.32%
End of Fixed Term Contract - End of Work Requirement	0.26%

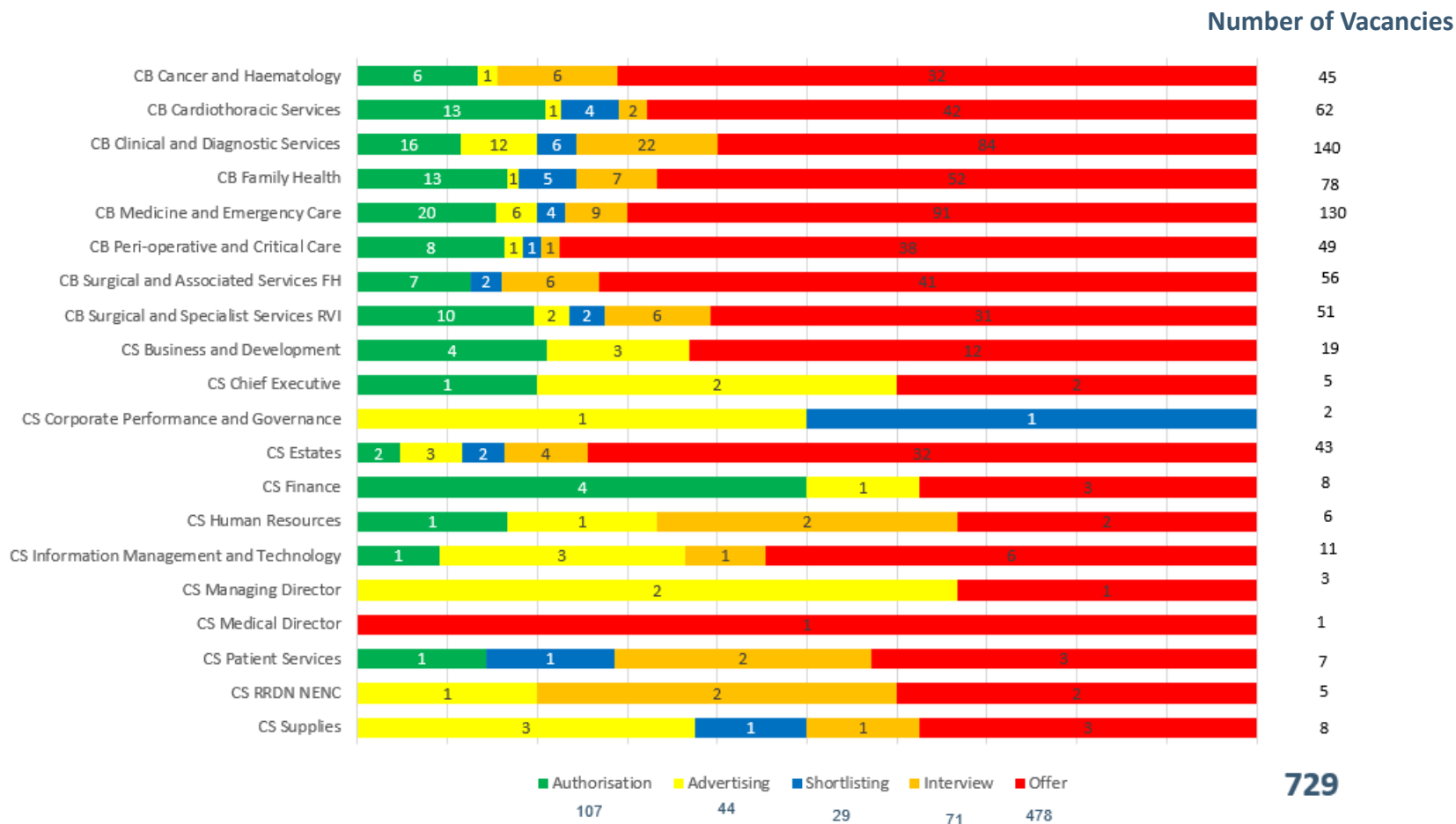
Leaving Reasons

Destination on Leaving



Destination On Leaving	Destination On Leaving %
No Employment	48.60%
NHS Organisation	26.47%
Other Private Sector	7.08%
Other Public Sector	4.78%
Abroad - Non EU Country	4.15%
Education or Training	2.61%
Education Sector	1.66%
Private Health Care	0.89%
General Practice	0.83%
Abroad - EU Country	0.57%
Death in Service	0.57%
Self Employed	0.57%
No Longer Valid - Private Health/Social Care	0.38%
Armed Forces	0.19%
Prison Service	0.19%
Unknown	0.13%
Social Care	0.06%
Social Services	0.06%

Recruitment - Vacancies in progress by stage – 30 June 2026



The chart illustrates that as of 30 June 2026, there were 729 vacancies progressing through the recruitment process—a decrease of 55 compared to the previous period. The largest proportion of vacancies were at the conditional offer stage (65%). Following the end of the temporary recruitment pause on 22 October 2025, there has been an increase in positions at the authorisation granted stage, which have progressed to advertising. The numbers in the recruitment process are increasing.

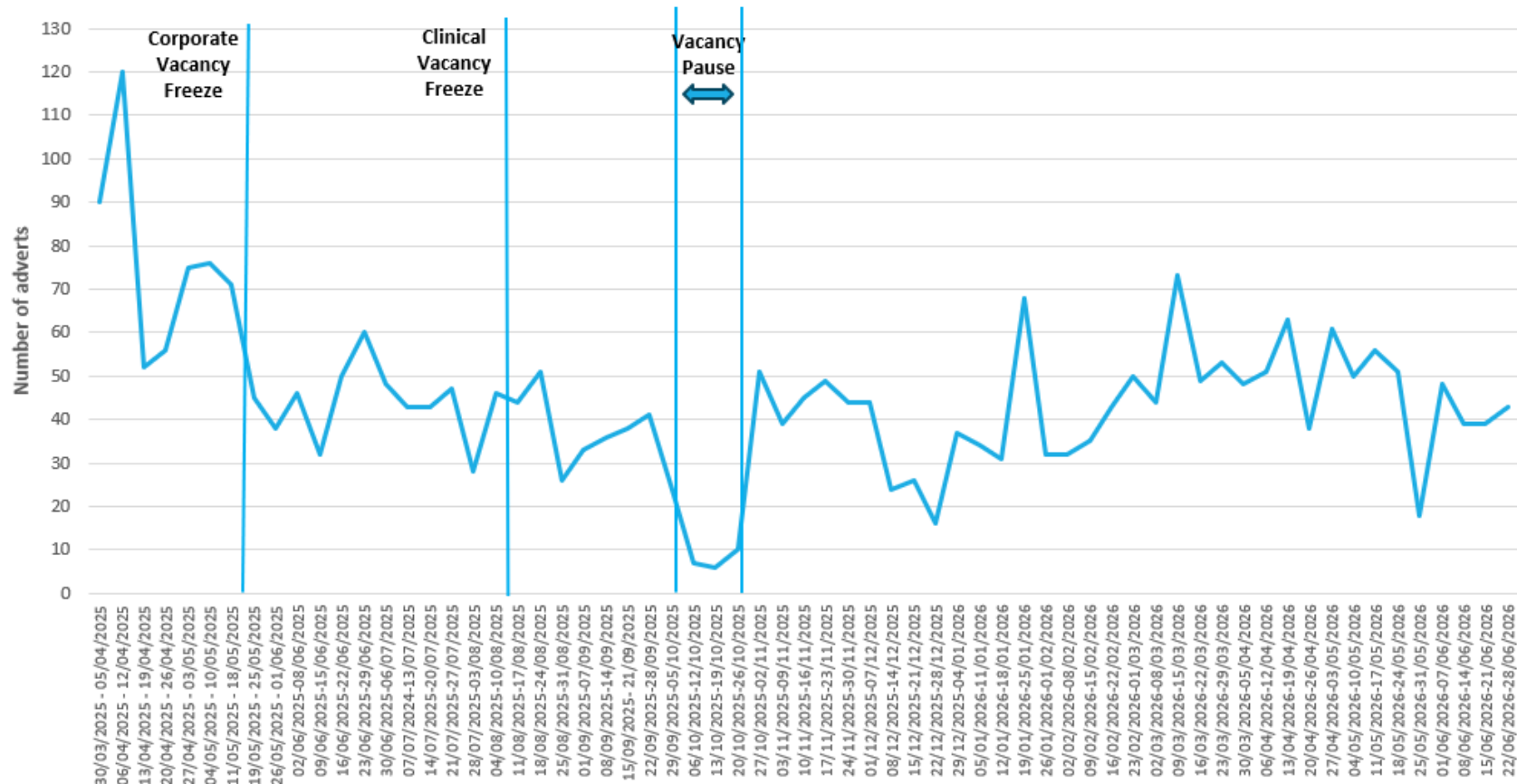
Recruitment - Vacancies in progress by stage

Total adverts w/e 28/06/2026

43

Number of adverts since corporate vacancy freeze on 14/05/2025, clinical vacancy freeze on 04/08/2025 and recruitment pause 01/10/2025-22/10/2025

2,320



This graph shows a decline in the number of vacancies advertised during the recruitment pause and freezes. There has been increases in January and March 2026. Overall, in 2026 there are fewer adverts compared to the same period in 2025 with recent weeks at similar levels to 2026 (This could be attributed to annual recruitments that take place in this period of time).

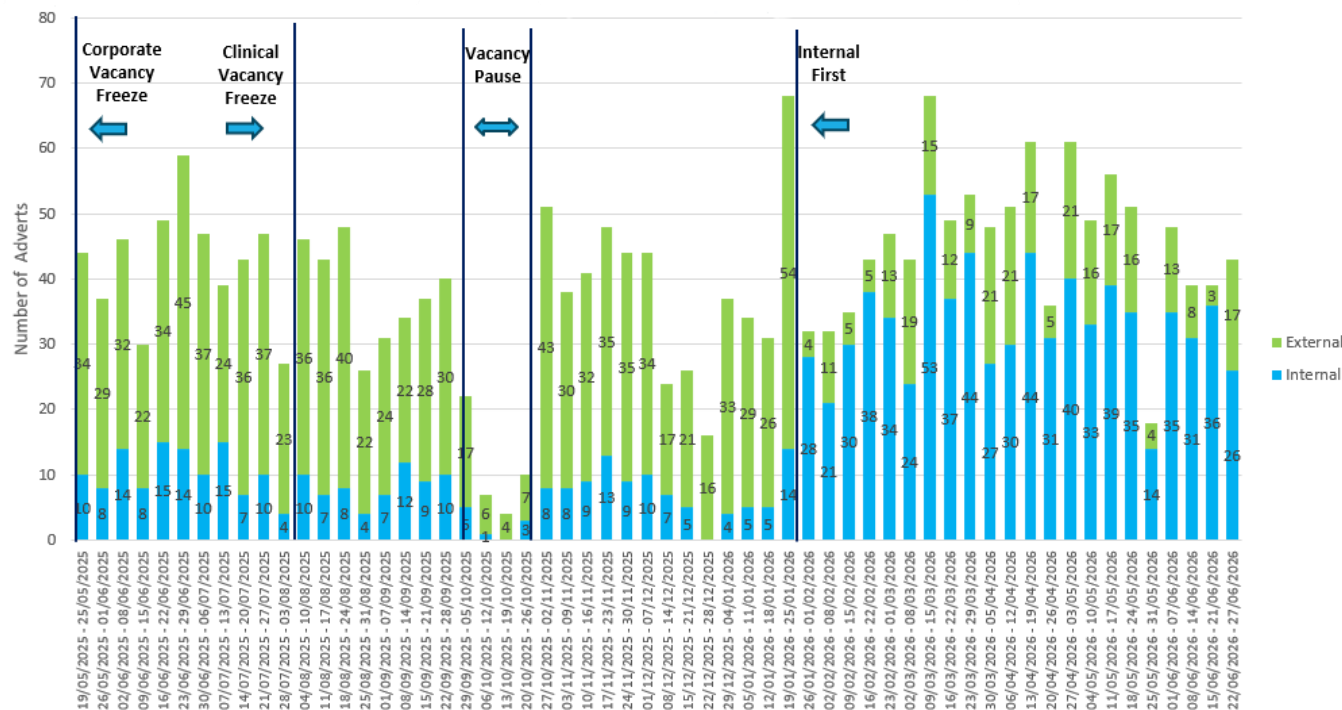
Recruitment – Adverts Overview – Internal v External Advertising

Total adverts w/e 28/06/2026

43

Number of adverts since corporate vacancy freeze on 14/05/2025, clinical vacancy freeze on 04/08/2025 and recruitment pause 01/10/2025-22/10/2025 and internal first on 26/01/2026

2,320

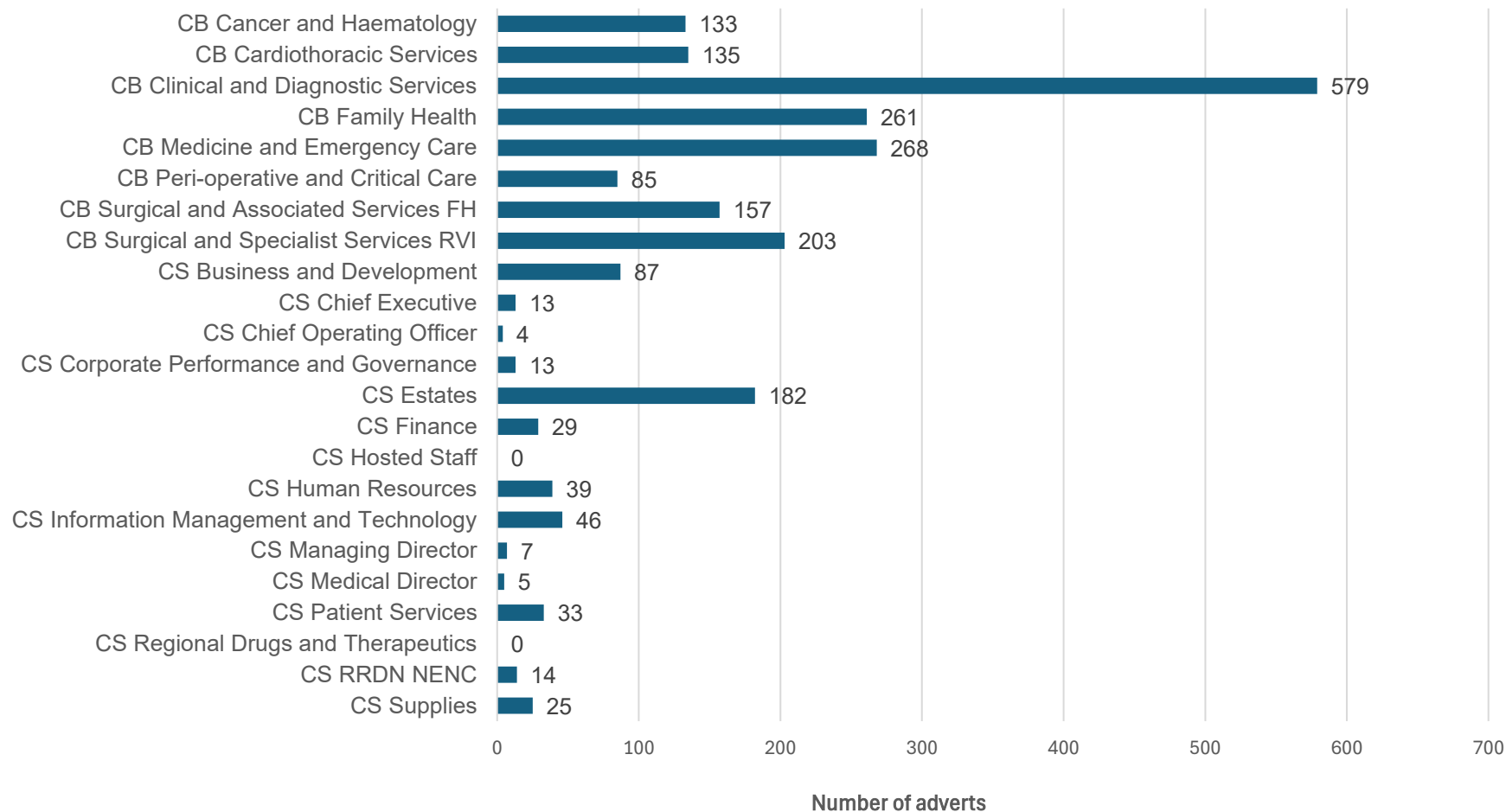


This graph shows an overview of the adverts; those that were advertised internal and external. It shows that most adverts were advertised external to the Trust prior to 26/01/2026 when the decision was made to advertise vacancies internal first with an exception process for external advertising. On 30 June 2026 70% of candidates that were at conditional offer stage were external and 30% internal which is a change of 5% when it was 65% external and 35% internal on 31 March 2026.

This is showing that there is an increase in the number of external candidates being offered posts compared with the previous month which can be mainly attributed to the posts that are being advertised internal first and then if not filled being advertised externally. As part of the Workforce Reduction Group this is being reviewed and reported on a fortnightly basis.

Recruitment - Adverts

Adverts by CB/CS since corporate vacancy freeze on 14/05/2025, clinical vacancy freeze on 04/08/2025 and recruitment pause 01/10/2025 to 22/10/2025

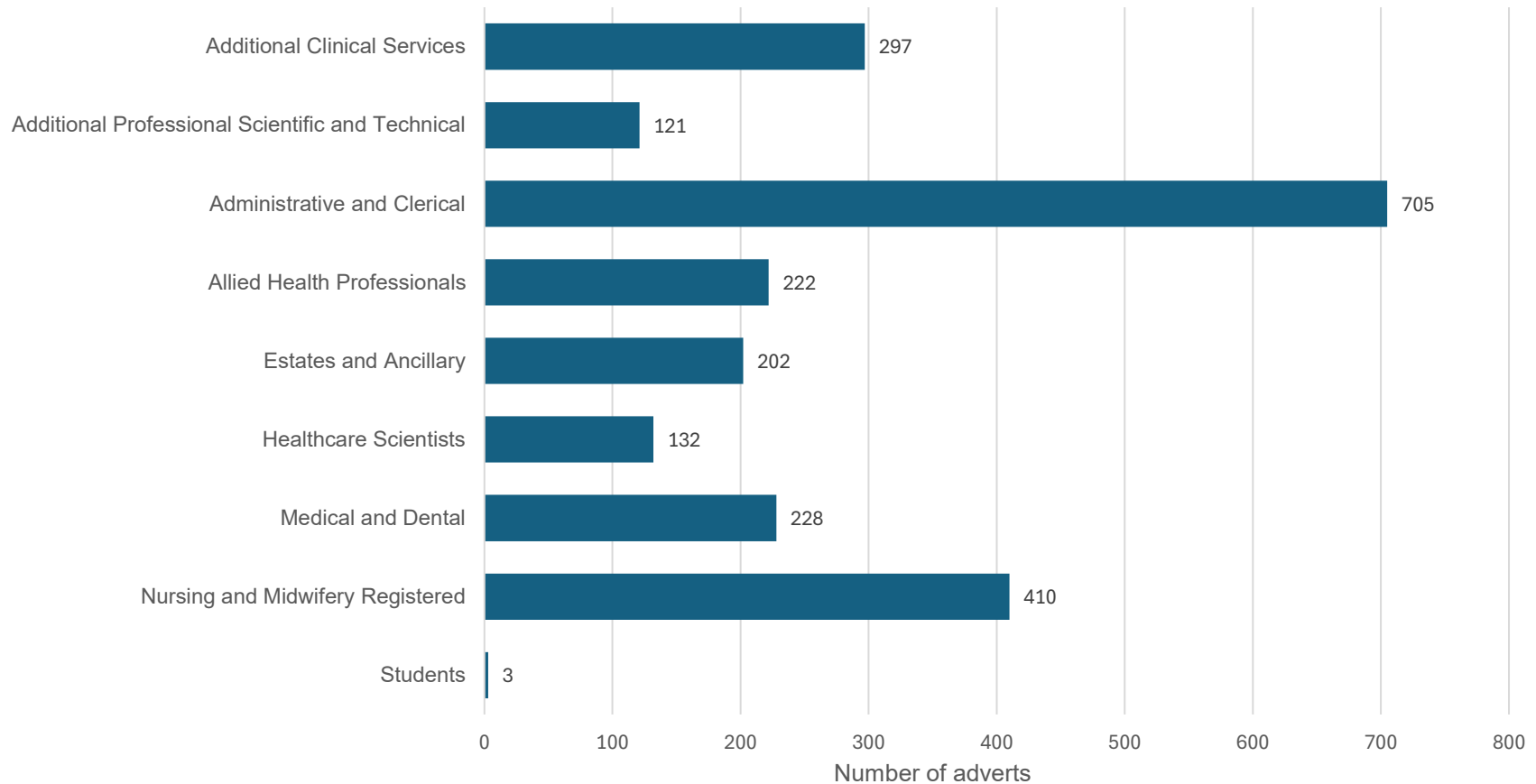


There has been 2,320 adverts since 14/05/2025. The highest number of adverts has been for Clinical and Diagnostic Services. However, this should be considered in proportion to the size of the Clinical Board.

Recruitment - Adverts

Number of adverts since corporate vacancy freeze on 14/05/2025 and clinical vacancy freeze on 04/08/2025 and recruitment pause 01/10/2025 to 22/10/2025

2,320



There has been 2320 adverts since 14/05/2025. The largest volume of adverts since 14 May 2025 has been in Administrative and Clerical roles, followed by Nursing and Midwifery, with the lowest numbers in Additional Professional and Scientific positions with the exception of students.

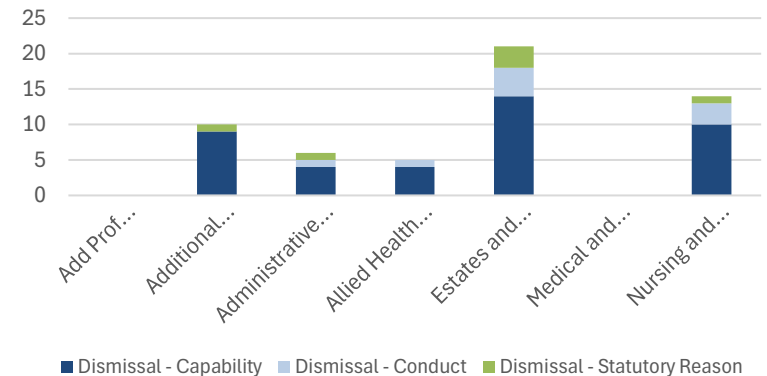
Dismissals – 12-month rolling period ending May 2026

Dismissals	12-Month period ending	Dismissals Headcount	Dismissals FTE
	May 26	56	40.11

Headcount

Staff Group	Dismissal - Capability	Dismissal - Conduct	Dismissal - Statutory Reason	Total
Add Prof Scientific and Technic				
Additional Clinical Services	9		1	10
Administrative and Clerical	4	1	1	6
Allied Health Professionals	4	1		5
Estates and Ancillary	14	4	3	21
Medical and Dental				
Nursing and Midwifery Registered	10	3	1	14
Grand Total	41	9	6	56

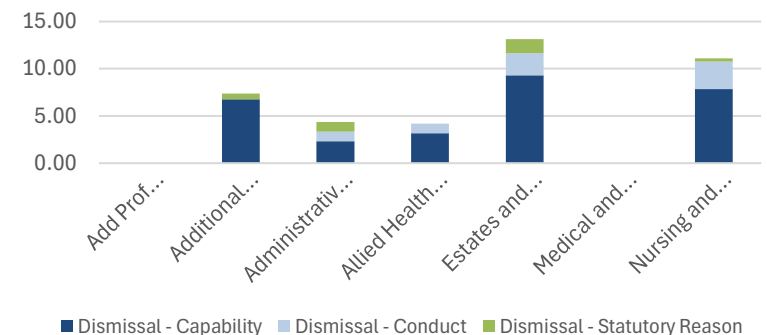
Dismissals latest 12m by Staff Group and Leaving Reason



FTE

Staff Group	Dismissal - Capability	Dismissal - Conduct	Dismissal - Statutory Reason	Total
Add Prof Scientific and Technic				
Additional Clinical Services	6.76		0.60	7.36
Administrative and Clerical	2.34	1.00	1.00	4.34
Allied Health Professionals	3.17	1.00		4.17
Estates and Ancillary	9.31	2.35	1.47	13.13
Medical and Dental				
Nursing and Midwifery Registered	7.86	2.91	0.35	11.11
Grand Total	29.45	7.25	3.41	40.11

Dismissals latest 12m by Staff Group and Leaving Reason



Employee Relations - Open Cases

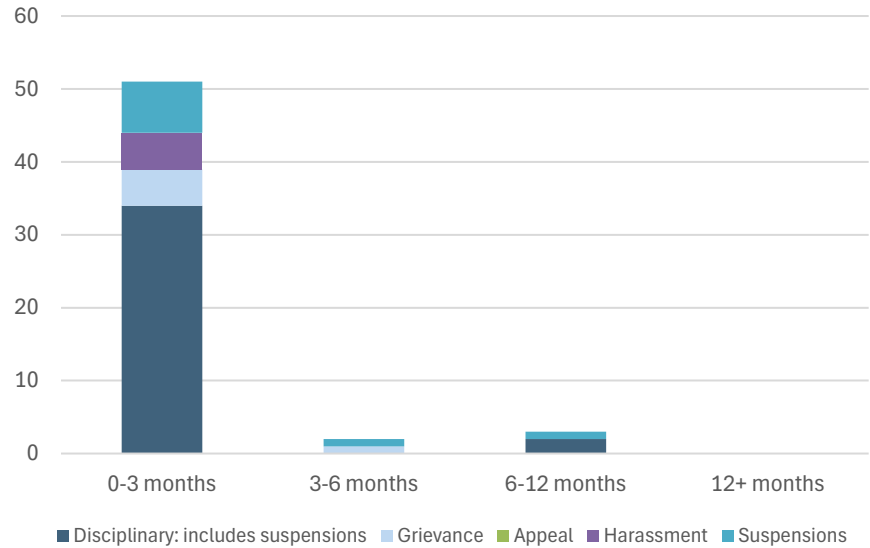
Open Cases	Latest Month	Total Open Cases
	May 26	47

Case Type	0-3 months	3-6 months	6-12 months	12+ months	Total
Disciplinary	34	0	2	0	36
Grievance	5	1	0	0	6
Appeal	0	0	0	0	0
Harassment	5	0	0	0	5
Grand Total	44	1	2	0	47

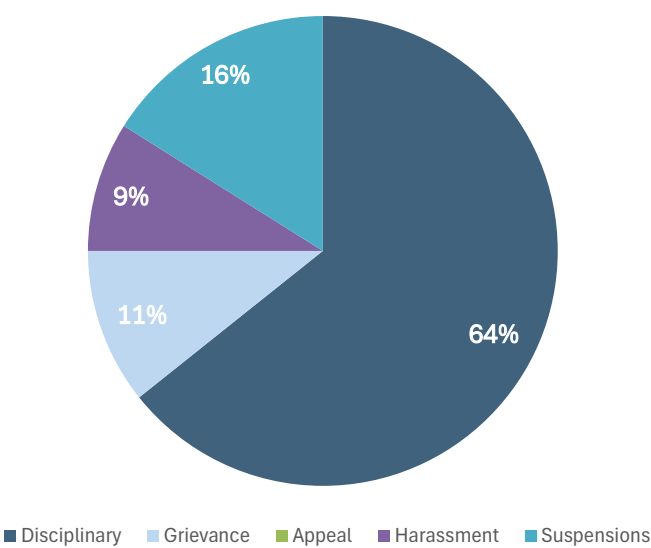
There are currently 47 open employee relations cases, of 36 are disciplinary (of which 9 suspensions), 5 harassment and 6 grievance.

6 of the 47 (12.77%) have been raised since April 2026.

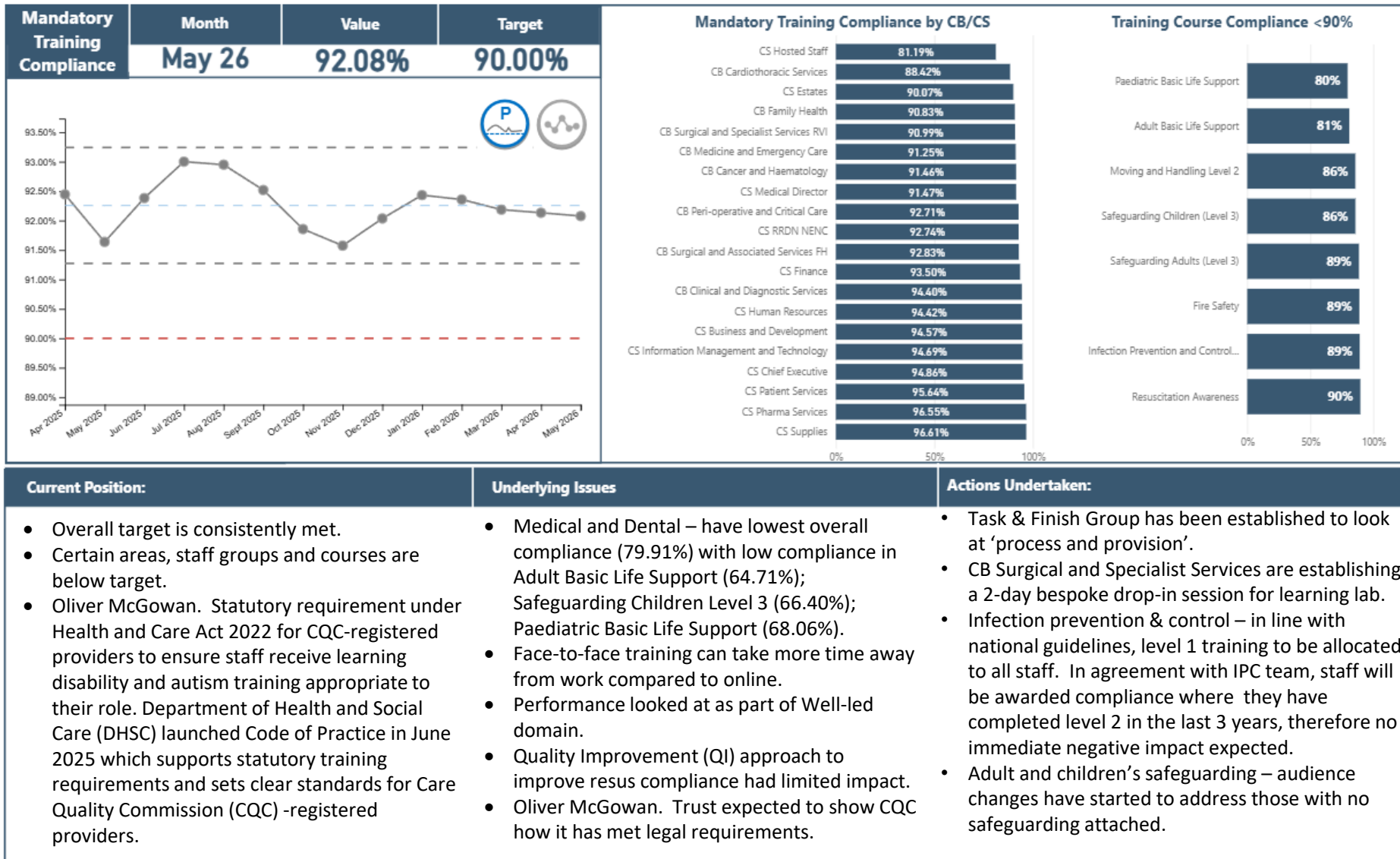
Open Cases



Open Cases



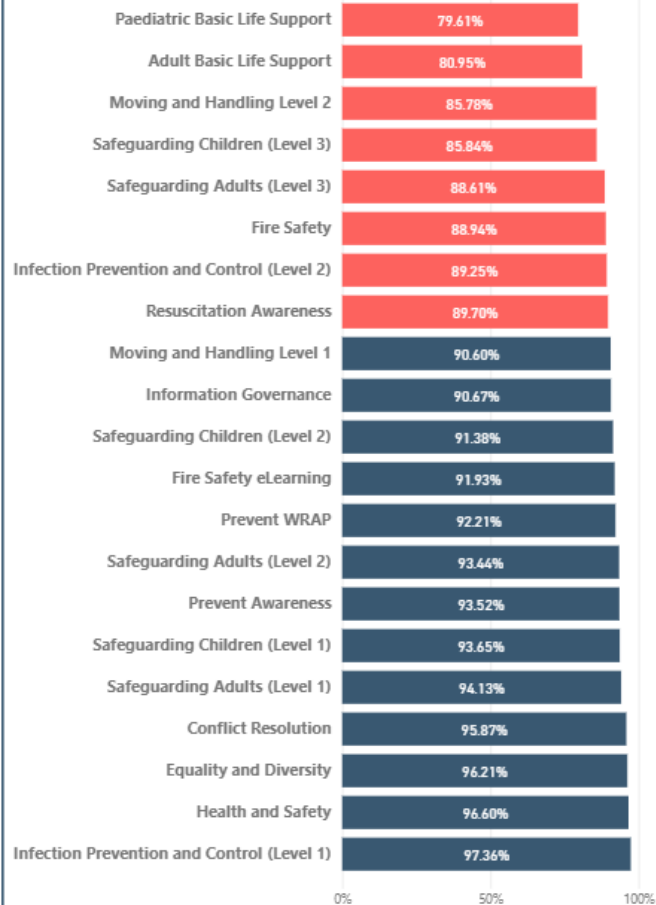
Mandatory training



Mandatory training

Mandatory Training Compliance	Month	Value	Target
	May 26	92.08%	90.00%

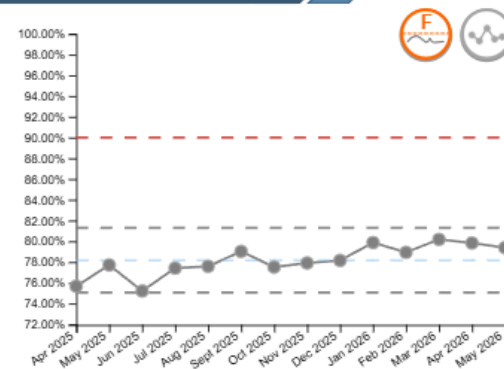
Training Course Compliance %



Lowest 4 Mandatory Training Compliance %

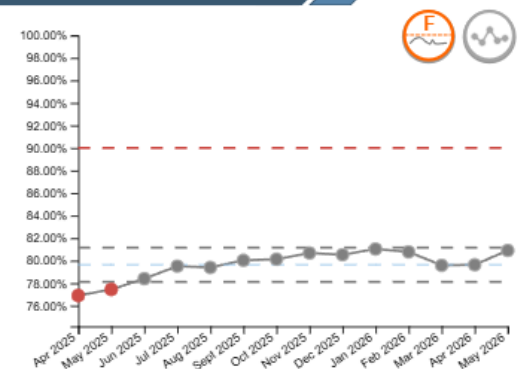
Paediatric Basic Life Support

79%



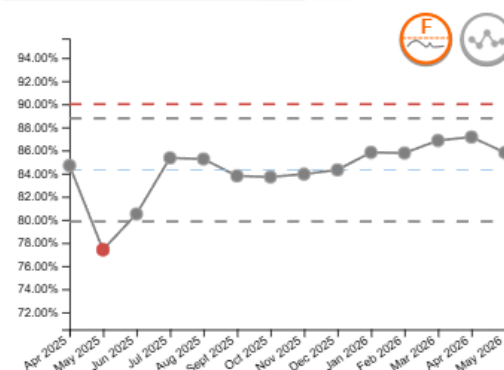
Adult Life Support

81%



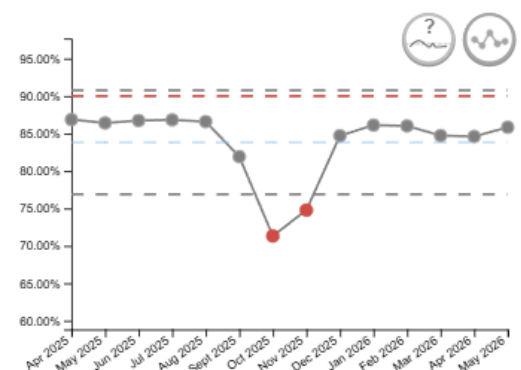
Moving and Handling Level 2

86%

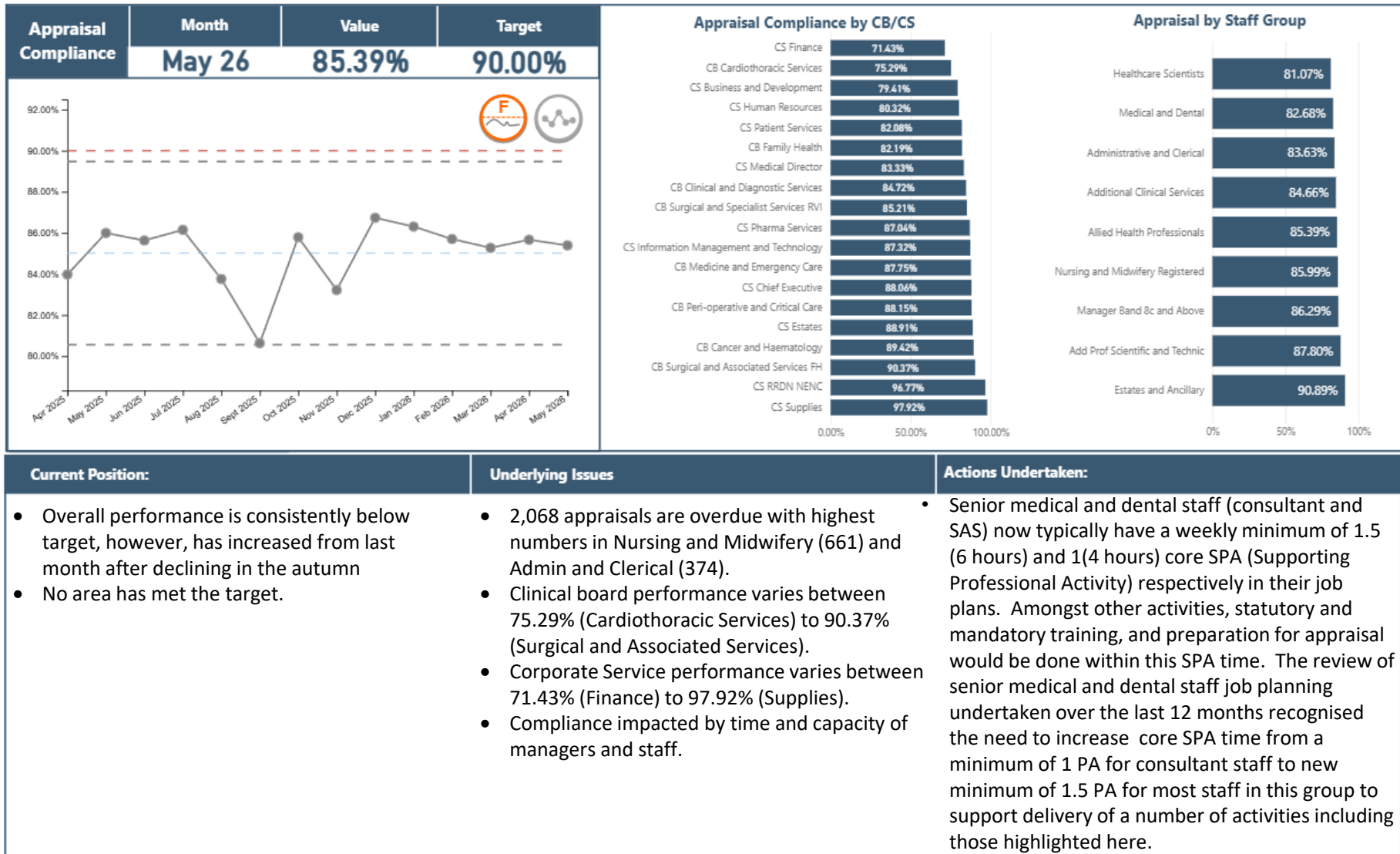


Safeguarding Children (Level 3)

86%



Appraisal compliance



Bank use (£) – non-medical

Bank Utilisation (£)	12-Month period ending	Total Bank Expenditure (£)	Total Bank Difference (£)
	May 26	£19,470,852	+£2,300,858

Bank Utilisation (£)

Staff Group	Jun 24 - May 25	Jun 25 - May 26	Difference
Admin & Clerical	£1,100,322	£637,185	-£463,137
Ancillary	£289,046	£329,888	£40,842
Estates			£0
Nursing & Midwifery (Registered)	£5,599,619	£7,149,975	£1,550,357
Nursing & Midwifery (Unregistered)	£9,426,524	£10,500,352	£1,073,828
Professional & Technical	£754,483	£853,452	£98,969
Total	£17,169,994	£19,470,852	£2,300,858

Current Position:	Underlying Issues	Actions Undertaken:
- Cost of Bank has increased for Nursing & Midwifery (N&M) unregistered due to service need for enhanced care. - Ancillary increase is due to challenges from turnover, vacancies and sickness absence.	- N&M unregistered increase due to service need for enhanced care. - Ancillary increase due to challenges from turnover, vacancies and sickness absence. - Additional hours are being worked as overtime rather than Bank which is a more costly option.	- Work continues to reduce bank usage with effective rostering and direction. - Aiming to reduce agency use of HCAs for enhanced care. - To support the shift from overtime to Bank, around 1200 substantive staff have been fast-tracked as additions to the Bank.

Agency use (£) – non-medical

Agency Utilisation (£)	12-Month period ending	Total Agency Expenditure (£)	Total Agency Difference (£)
	May 26	£2,080,078	-£1,637,114

Agency Utilisation (£)

Staff Group	Jun 24 - May 25	Jun 25 - May 26	Difference
Admin & Clerical	£107,352	£185,898	£78,546
Ancillary	£12,593	£29,789	£17,196
Estates	£28,104	£59,541	£31,437
Nursing & Midwifery (Registered)	£737,926	£287,985	-£449,941
Nursing & Midwifery (Unregistered)	£1,495,621	£847,891	-£647,731
Professional & Technical	£1,335,597	£668,975	-£666,621
Total	£3,717,192	£2,080,078	-£1,637,114

Current Position:	Underlying Issues	Actions Undertaken:
- Costs reduced by c. £0.1.6m on previous year. - Notable reductions in Nursing & Midwifery (unregistered) and Professional & Technical.	Registered nurse agency use – hotspots in Theatres and Cardiothoracic Services for scrub and anaesthetic nurses. Pressures also continue for Nurse Practitioners.	- Increasing bank availability to reduce agency use including additional recruitment. - Agency usage reviewed and challenged weekly / monthly. - Robust management of agency requests with active bank and redeployment

Agency use (£) – medical

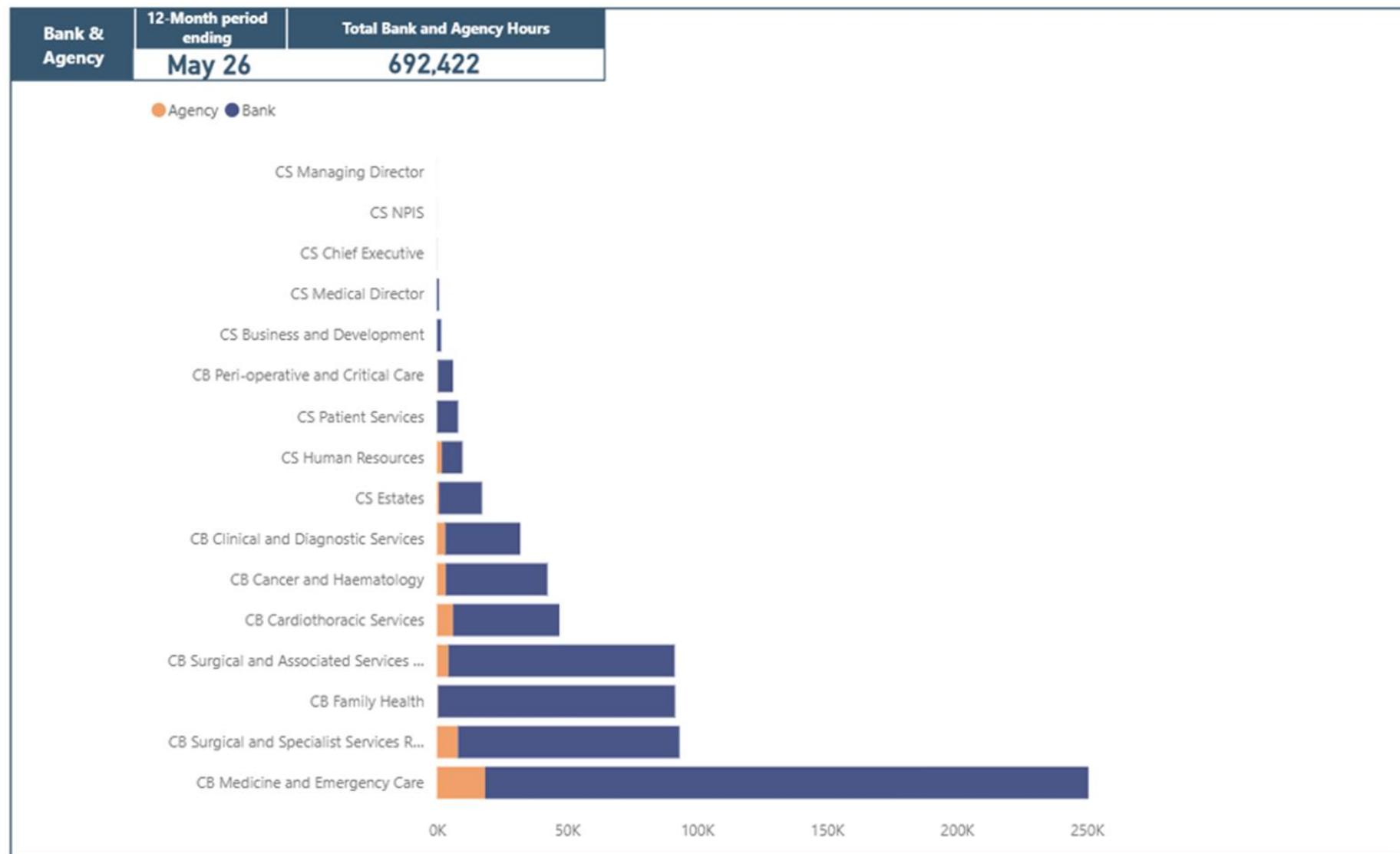
Agency Utilisation (£)	12-Month period ending	Total Agency Expenditure (£)	Total Agency Difference (£)
	May 26	£2,461,288	-£1,727,765

Agency Utilisation (£)

Staff Group	Jun 24 - May 25	Jun 25 - May 26	Difference
Medical - Consultant	£4,044,128	£2,446,979	-£1,597,149
Agency - Career / Staff Grades	£47,315	-£33,250	-£80,565
Medical - Registrar & Senior Registrar	-£6,851	-£1,111	£5,741
Medical - SHO'S and HO'S	£99,089	£48,417	-£50,672
General Practitioner	£5,371	£253	-£5,119
Total	£4,189,052	£2,461,288	-£1,727,765

Current Position:	Underlying Issues	Actions Undertaken:
- Costs decreased by c. £1,727,765, on previous year. - Notable reductions in Consultant and Senior House Officer (SHOs)/House Officers (HOs) - Consultants collectively working an average of 1,100 hours per month.	Consultant spend. Staffing issues in Older People's Medicine and Stroke; off-framework arrangement in Paediatric Intensive Care Unit (PICU) due to sickness absence and recruitment; locum in General Medicine as part of Winter Plan 2024/25 ended in April 2025; agency Consultants unwilling to move to a Trust contract.	Consultants. Trust contracts offered and declined; charges and hourly rates renegotiated wherever possible; recent recruitment in PICU has been successful reducing the need for agency.

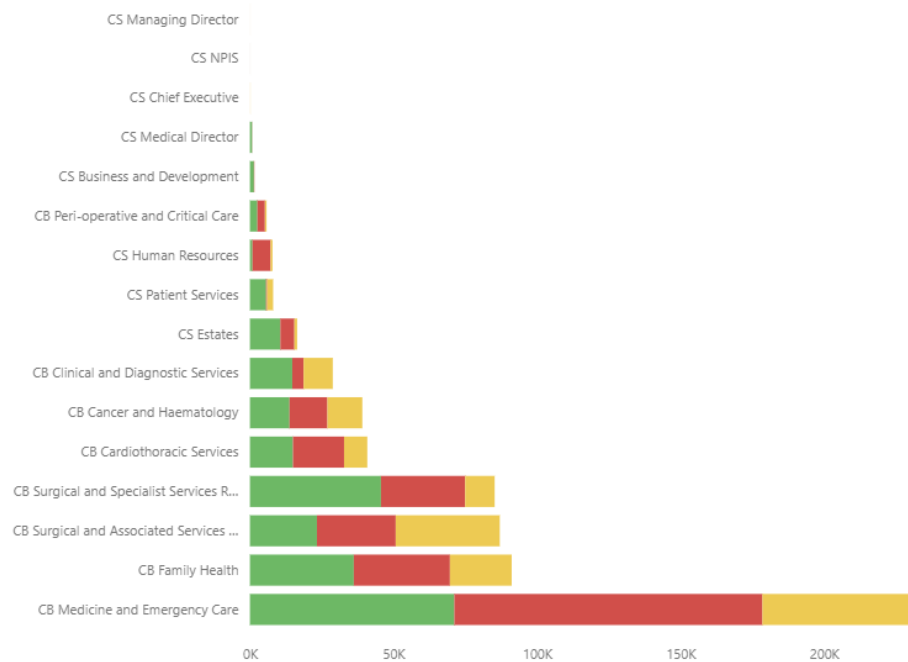
Bank & agency use - hours



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

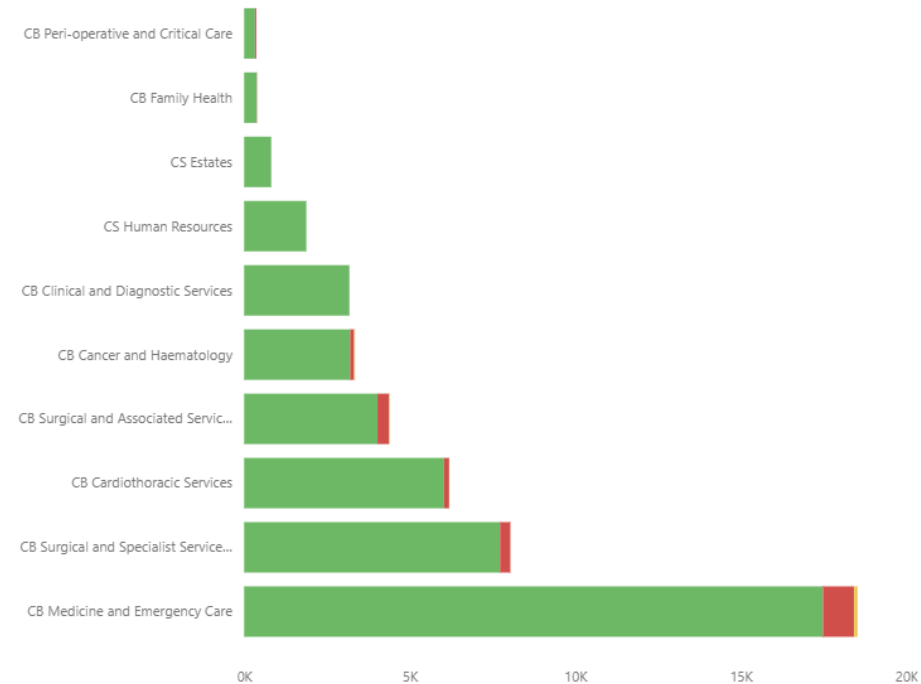
Bank Hours by Org L4 and Reason

● Activity ● Awayness ● Vacancies



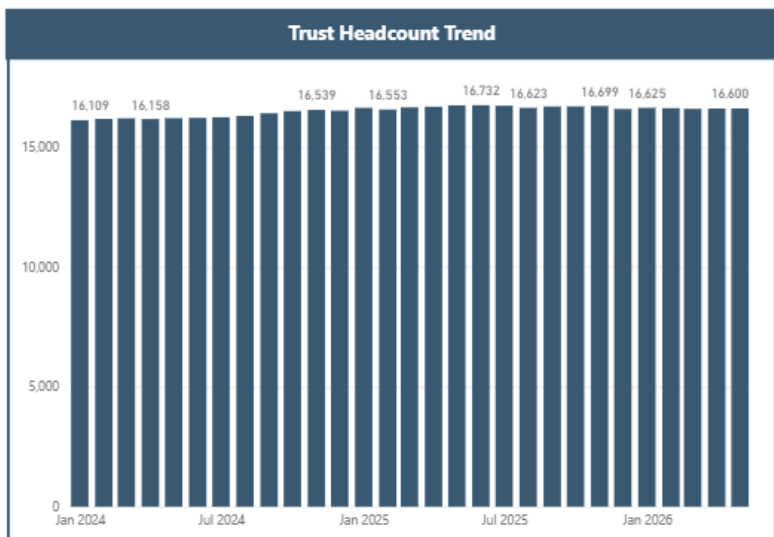
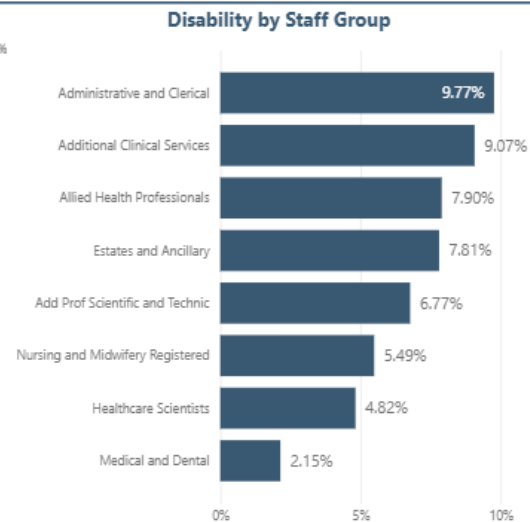
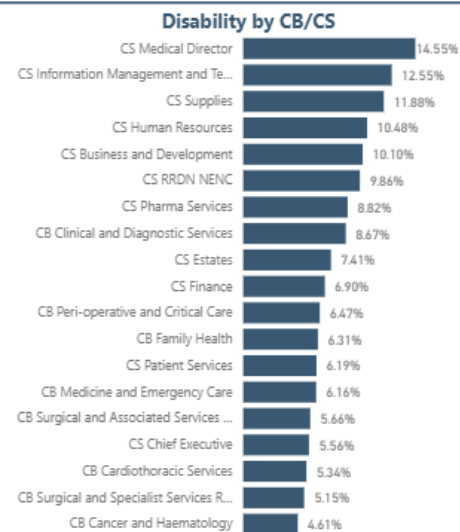
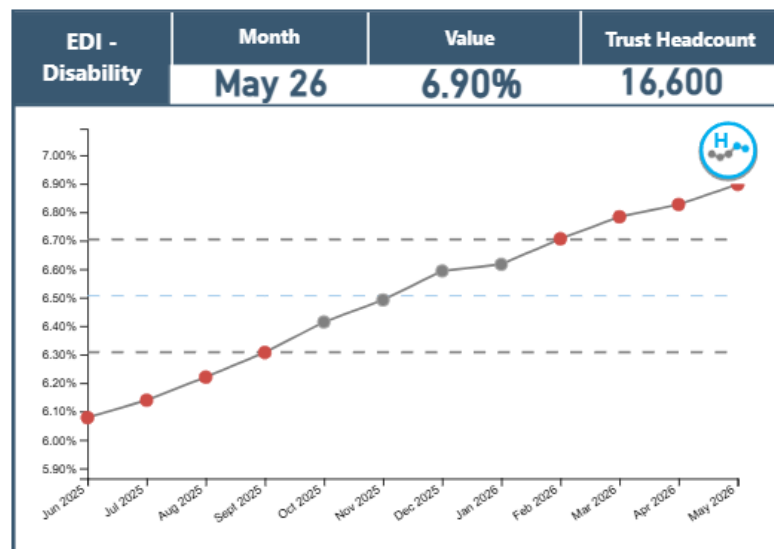
Agency Hours by Org L4 and Reason

● Activity ● Awayness ● Vacancies



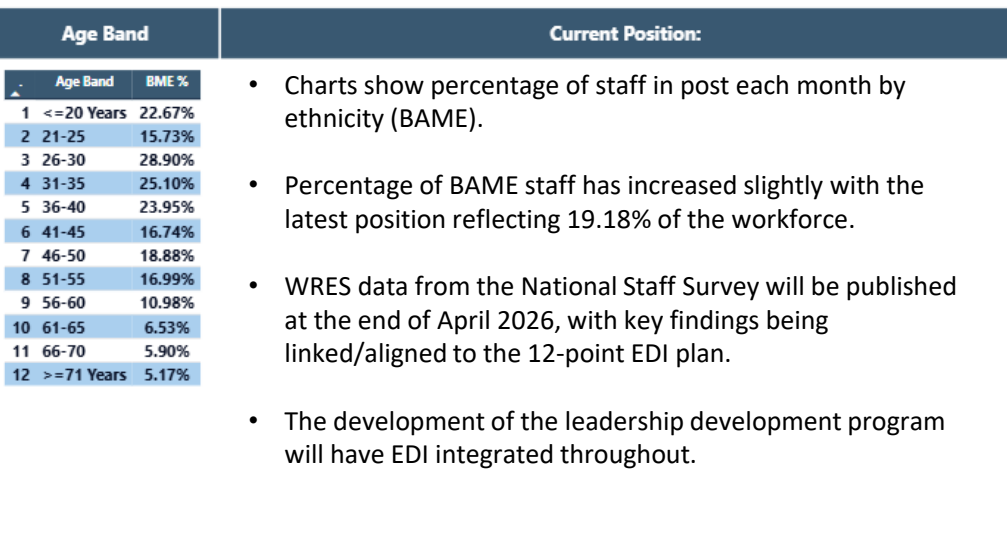
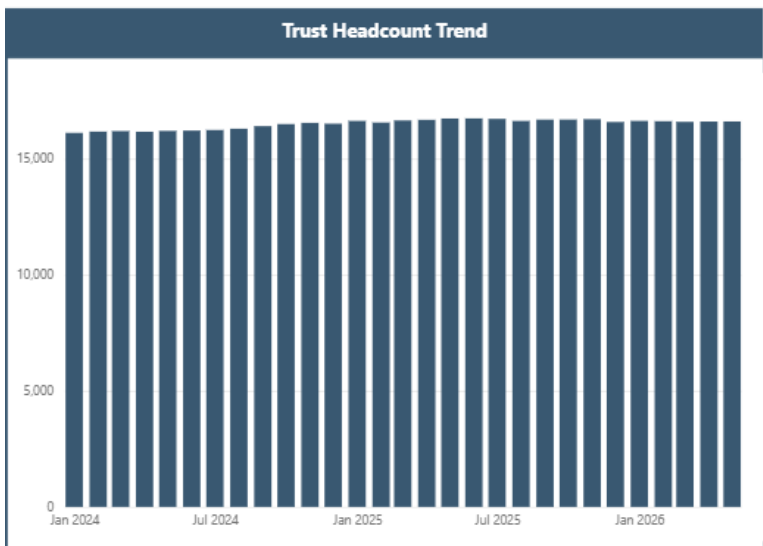
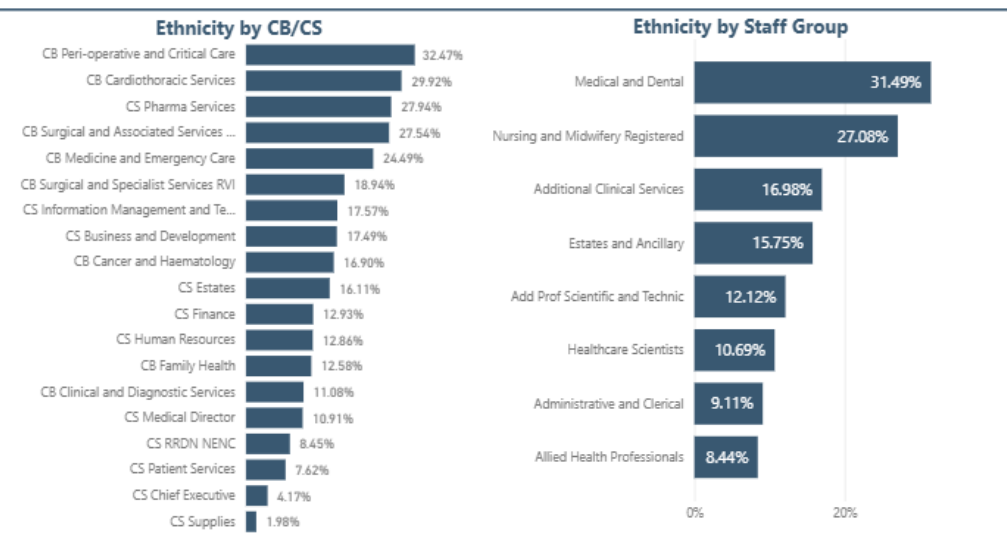
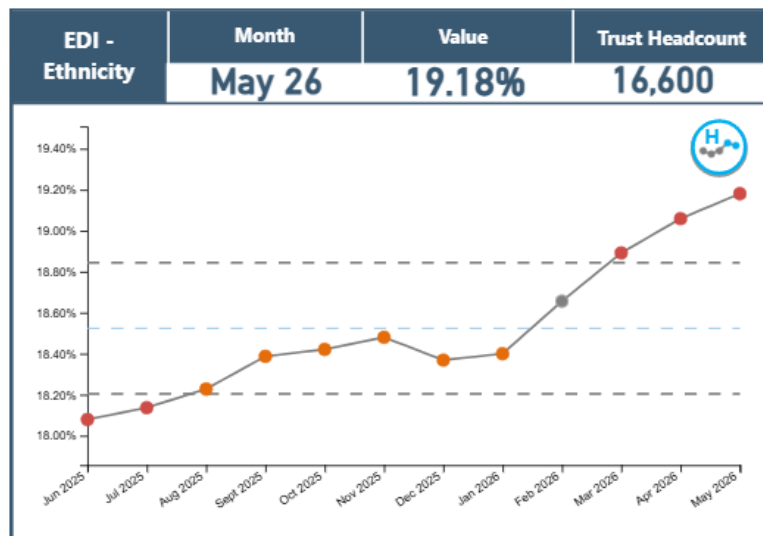
- **awayness**, including sickness, maternity, study leave, industrial action, etc.
- **activity**, including workload, acuity, waiting list initiative, etc.
- **vacancies**

Equality, diversity and inclusion (EDI) - disability



Age Band		Current Position:
Age Band	Disability %	- Charts show percentage of staff in post each month by those disclosing a disability. - Percentage of disabled staff continues to grow with the latest position reflecting 6.90% of the workforce. - Workforce Disability Equality Standard (WDES) data from the National Staff Survey will be published at the end of April 2026, with key findings being linked/aligned to the 12-point EDI plan. - The development of the leadership development program will have EDI integrated throughout.
1 <=20 Years	10.67%	
2 21-25	14.43%	
3 26-30	8.39%	
4 31-35	6.78%	
5 36-40	5.43%	
6 41-45	5.18%	
7 46-50	5.05%	
8 51-55	6.96%	
9 56-60	6.22%	
10 61-65	7.20%	
11 66-70	3.69%	
12 >=71 Years	5.17%	

Equality, diversity and inclusion (EDI) - ethnicity



Finance

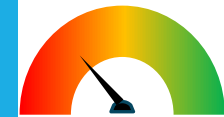


Healthcare at its best
with people at our heart

High-level Dashboard

May 2026

Financial Health



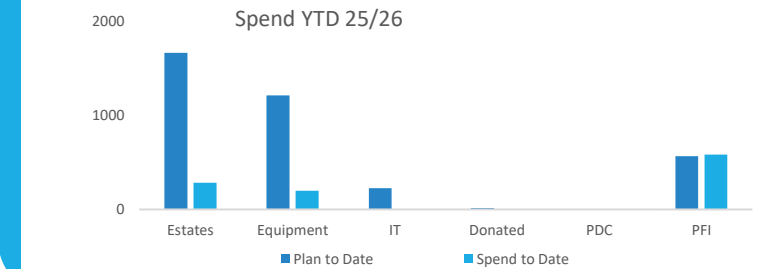
The Trust needs to take significant actions to deliver its financial objectives and is managing significant financial risk.

Financial Performance Month 2

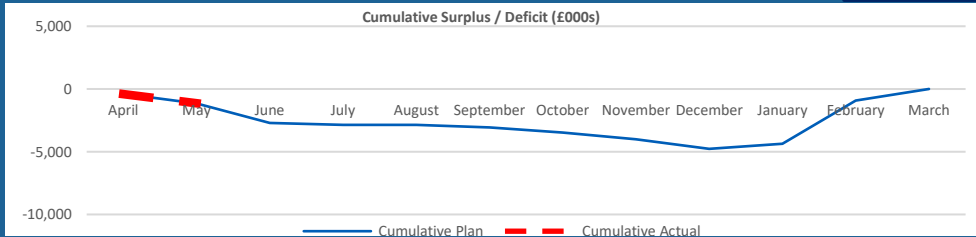


- The trust delivered a deficit of £1.1 million in month 2, in line with the financial plan. The deficit is anticipated to grow until Cost Improvement Programme (CIP) delivery increases from month 4 onwards.
- Industrial action costs in month 1 are £627k, no funding has been allocated by NHS E to cover as there has been in previous years.
- On the NENC Integrated Care Board (ICB) contract, there has been a reduction in income value compared to income expected in plan.
- There is a shortfall of £1,645k on Clinical Board and Corporate Services CIP in month 2 when compared to financial plan.
- Due to a higher than planned cash balance, interest receivable is higher than plan by £724k.
- There is an overspend on Block and tariff drugs, off-set by an underspend on matched drugs and overspends on pay emerging, however in May this has been offset by underspends on Clinical Supplies, which is due to lower patient activity.

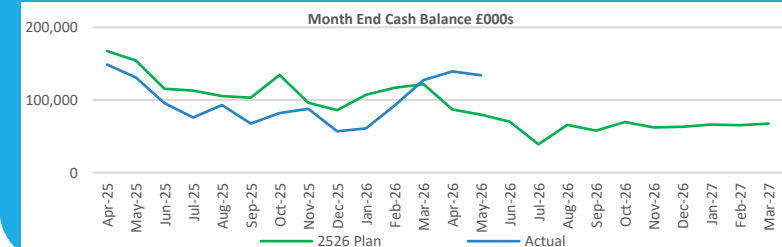
Capital Programme Delivery – Month 2



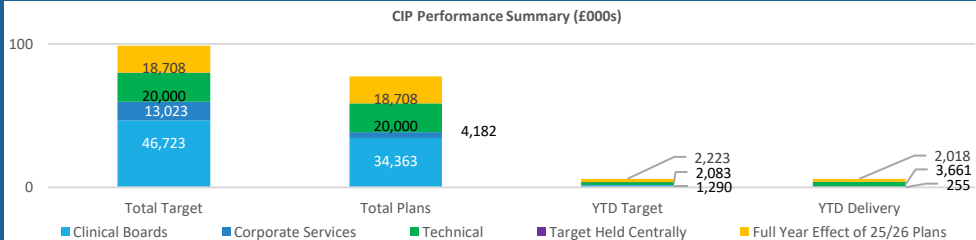
Cumulative Performance Against Plan



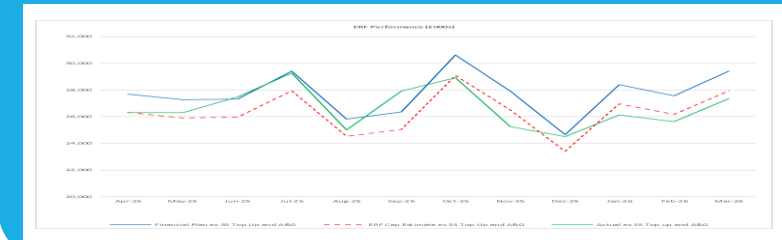
Cash Balance



Cost Improvement Programme Performance



Activity – Elective Recovery Income (25-26 Freeze)



Health Inequalities



Healthcare at its best
with people at our heart

The In-House Tobacco Dependency Treatment Service (TDTS) in Inpatient Pathways

Background

- Smoking is a leading cause of morbidity and mortality and a key driver of health inequality in our population.
- The current smoking rate in adults in the North East Region is 10.2%. That is the percentage of adults aged 18 and over who currently smoke cigarettes. (1). This average masks inequalities in smoking prevalence with higher rates observed in certain population groups such as people living in areas of socioeconomic deprivation, those diagnosed with a mental health condition and people in contact with the criminal justice system to name a few.
- Nationally the Northeast Region had seen the largest fall in adult smoking rates of any region in England with a 65% reduction in smoking prevalence since 2005 when smoking prevalence in adults was the highest of any region in the country (2). This is a testimony to the concerted effort, collective leadership and collaboration between Fresh, local authorities, the NHS and the Office for Health Improvement and Disparities. Launched in 2005, Fresh is the UK's first regional tobacco control programme dedicated to reducing the harm caused by tobacco.
- In 2023 Fresh launched the Declaration for a Smokefree Future (2). It aims to reduce adult smoking rates to 5% or less by 2030 and eliminate tobacco-related death and disease across the North East and North Cumbria (NENC). This has been supported by the NENC NHS Integrated Care Board, all NENC NHS Trusts and local authorities demonstrating commitment to improving population health, reducing health inequalities, and delivering evidence-based treatment for tobacco dependency treatment. The Declaration aligns with the landmark UK Tobacco and Vapes Bill which became law in April 2026 (3).
- Delivering tobacco dependency treatment services in provider trusts is underpinned by strong evidence and national standards, including NICE guidelines NG209 (4); NICE Quality Standards (QS43) (5) and Saving Babies Lives Care Bundle for reducing perinatal mortality (6). Tobacco dependency treatment also aligns with the national shift to prevention in the NHS 10 year plan (7) positioning it as a core element of NHS activity rather than an optional add-on. Offering evidence based smoking cessation and tobacco dependency services for all smokers in the local population is a priority in the recently published Cardiovascular disease (CVD) Modern Service Framework (MSF) (8).
- In October 2021 funding received from NHSE and the ICB (top up funding) supported the establishment and delivery of in-house tobacco dependence treatment services (TDTS) in both maternity and in inpatient pathways in trusts in 2022. This is in line with the NHS Long Term Plan (LTP) (9) commitments around prevention. The focus of this report is on the delivery of the In-House TDTS in inpatient pathways. These according to the NHSE guidance includes 'ordinary' admissions (i.e. overnight stays) and the data guidance outlines which patients are excluded and who need to be included (10).
- At Newcastle Hospitals, Smoke Free Hospitals and Treating Tobacco Dependency are priorities for prevention and addressing health inequalities, both are considered as cross cutting themes under 'Joining up Care' in the newly ratified Five Year Trust Strategy (11). The Executive lead for smoke free is the Director of Communications and Corporate Affairs. An updated version of a trust wide Smoke Free Policy was ratified in August 2025. The smoke free Steering Group in the Trust provides assurance and oversight on delivery of contractual mandates in relation to treating tobacco dependency and implementation of the Trust Smoke Free policy. It is chaired by the Consultant in Public Health in the Trust and reports into Promoting Equity of Health Group (PEHG), chaired by the Director of Performance and Governance who is the trust Executive Lead on health inequalities.
- The NHSE statement on Health Inequalities duty under section 13SA of the NHS Act 2006 (12) requires NHS providers to publish in their annual reports key metrics such as Tobacco Dependency Treatment data disaggregated by age, sex, ethnicity and deprivation. Additionally, the only population health (scoring) metric for NHS Trusts in the NHS Oversight Framework 2026/2027 (13) focuses on % of inpatients making a supported quit attempt with an inhouse Tobacco Dependency Service. The equity profile of this metric is the focus of this report.

TDTS in Inpatient Pathways

Summary / Current Position

- The total number of inpatient smokers who were seen in the service and who set a quit date in 2025/2026 was 1156. That was approximately 4 out of 10 inpatient smokers. These were inpatient smokers seen by the advisors in the service who went on to set a quit date. Advisors in the in-house TDTS give these patients a discharge plan. Patients are also prescribed Nicotine Replacement Therapy for one week and are given the contact information of the relevant community stop smoking service in their local area. Patients who set a quit date are followed up by advisors in the in-House TDTS at Days 3 & 10, 28 to determine quit status and at 12 weeks.
- The findings from the equity profiling of inpatient smokers who set a quit date show that half of inpatient smokers (57%) who engaged with the service in 2025/2026 and who set a quit date lived in the most deprived areas (IMD Q1) (Figure 1). This compares to 52.6% of inpatient smokers living in IMD Q1 (most deprived) (data not shown). Over three quarters of inpatient smokers seen by the service who set a quit date in 2025/26 lived in the two most deprived quintiles nationally (IMD Q1 and IMD Q2) (i.e. 76%). This is slightly higher than the equivalent proportion among inpatient smokers (72.6%) (data not shown) suggesting the uptake of the service is slightly higher among inpatient smokers living in the most socioeconomically disadvantaged groups. Smoking status is socioeconomically patterned with more smokers living in areas of deprivation. The Tobacco Dependency Treatment Advisors in the in-house service also support smokers who are referred to the service remain smoke free during their admission.
- Half of admitted smokers who set a quit date lived in Newcastle (51%). This is almost similar to the proportion seen in inpatient smokers in 2025/26 (52.3%) (data not shown).
- The majority of inpatient smokers seen in the TDTS who set a quit date were White British (89.8%) which is slightly higher than that in inpatient smokers (87.3%) (Figure 2) suggesting a more ethnically diverse group in both groups compared to that observed in the trust catchment population (i.e. 93% White British) (14).
- Using the total number of inpatient smokers who set a quit date in 2025/26 (total 1156 in 2025/26) in the Action on Smoking and Health (ASH) Calculator (15) the results show 71 lives saved in one year alone as a result of interventions offered by the in-house TDTS in Inpatients.
- A quality improvement project in 2024/2025 aimed at reducing smoking episodes at the maternity/neonatal entrance found that TDTS advisors approaching smokers on site was the most effective intervention in reducing smoking episodes at the entrance (16). The contract for the TDTS was subsequently modified to include a requirement for TDTS advisors to approach smokers on hospital site, especially near the entrances when advisors come and leave the hospitals. In 2025/2026 the number of people smoking on hospital sites who were approached by the TDTS advisors was 829.
- The lead for the Service is also training security staff on approaching smokers. The total number of security staff trained since October 2025 was 16 in the Freeman and 21 in the RVI. The security staff training focuses on providing a making Every Contact Count (MECC) approach offering very brief advice on the best ways to quit smoking and providing a business card with both inpatient and community service information included.

Equity Profiling of Inpatient smokers seen by the in-House TDTs who set a quit date (2025/26)

Figure 1: supported quit attempts by Index of Multiple Deprivation (IMD quintiles)

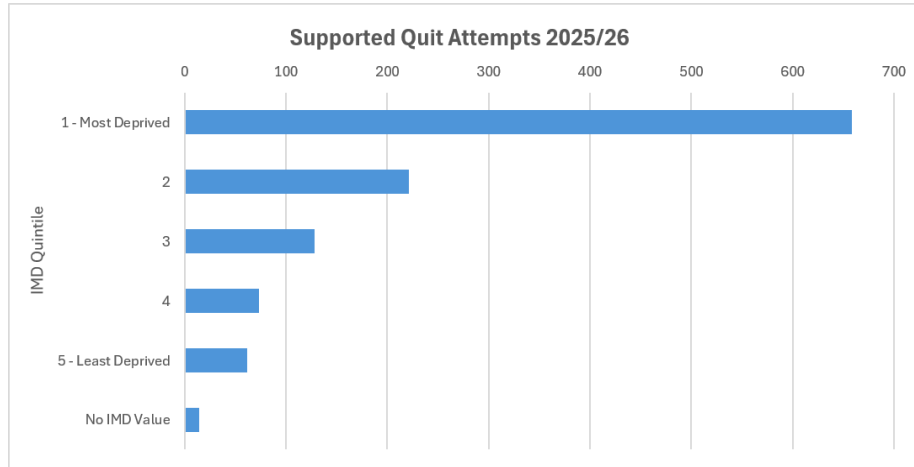
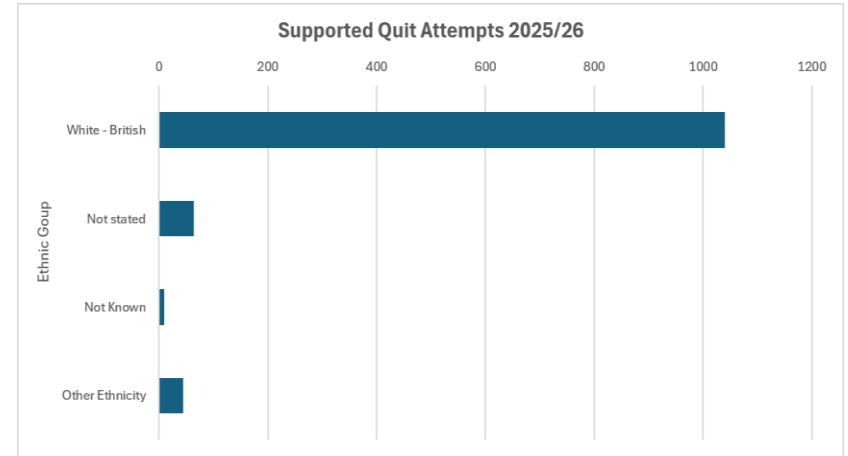


Figure 2: Supported quit attempts by ethnicity (% White British)



Data source: Commissioning Data Set (CDS); 2025/2026

TDTS in Inpatient Pathways

Conclusions / Recommendations

- The descriptive analysis in this report provides evidence that the in-house Tobacco Dependency Treatment Service (TDTS) in inpatient pathways is effective in terms of reach and uptake from inpatient smokers living in the most disadvantaged areas. Hence, this analysis highlights opportunities to embed secondary prevention services in clinical pathways of care and reduce health inequalities. More could be done to improve engagement with the in-house TDTS as measured by percentage of inpatient smokers who set a quit date. This is the focus of current quality improvement work in the service, for example, by targeting interventions to wards or clinical specialities where there is greatest need and high smoking prevalence (e.g. Vascular wards).
- A better understanding of the demographic profile of smokers supported by the service and who set a quit date and comparing it to the profile of all inpatient smokers in the same year enables us to judge that interventions provided by the in-house TDTS are not widening existing health inequalities. Applying an equity lens to business- as -usual performance metrics also helps inform future delivery of the service and prioritisation of resources.
- There is ongoing work to link the in-House TDTS in inpatients to the implementation of the Trust Health Inequalities Strategic Plan and develop improvement projects linked to priority health inequality actions in clinical boards, especially those embedding prevention in existing pathways of care.

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A Guide to SPC



Healthcare at its best
with people at our heart

SPC Icons & How to Interpret (1/4)

Variation/Performance Icons			
Icon	Technical Description	What does this mean?	What should we do?
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is currently not changing significantly . It shows the level of natural variation you can expect from the process or system itself.	Consider if the level/range of variation is acceptable. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of an CONCERNING nature where the measure is significantly HIGHER.	Something's going on! Your aim is to have low numbers but you have some high numbers – something one-off, or a continued trend or shift of high numbers.	Investigate to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an CONCERNING nature where the measure is significantly LOWER.	Something's going on! Your aim is to have high numbers but you have some low numbers - something one-off, or a continued trend or shift of low numbers.	
	Special cause variation of an IMPROVING nature where the measure is significantly HIGHER.	Something good is happening! Your aim is high numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	Find out what is happening/ happened. Celebrate the improvement or success. Is there learning that can be shared to other areas?
	Special cause variation of an IMPROVING nature where the measure is significantly LOWER.	Something good is happening! Your aim is low numbers and you have some - either something one-off, or a continued trend or shift of low numbers. Well done!	
	Special cause variation of an increasing nature where UP is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of high numbers.	Investigate to find out what is happening/ happened. Is it a one off event that you can explain? Do you need to change something? Or can you celebrate a success or improvement?
	Special cause variation of an increasing nature where DOWN is not necessarily improving nor concerning.	Something's going on! This system or process is currently showing an unexpected level of variation – something one-off, or a continued trend or shift of low numbers.	

SPC Icons & How to Interpret (2/4)

Assurance Icons			
Icon	Technical Description	What does this mean?	What should we do?
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies within those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies outside of those limits in the wrong direction then you know that the target cannot be achieved.	You need to change something in the system or process if you want to meet the target. The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies outside of those limits in the right direction then you know that the target can consistently be achieved.	Celebrate the achievement. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

SPC Icons & How to Interpret (3/4)

Assurance				
Variation/Performance				
	 Excellent Celebrate and Learn - This metric is improving. - Your aim is high numbers and you have some. - You are consistently achieving the target because the current range of performance is above the target.	Good Celebrate and Understand - This metric is improving. - Your aim is high numbers and you have some. - Your target lies within the process limits so we know that the target may or may not be achieved.	Concerning Celebrate but Take Action - This metric is improving. - Your aim is high numbers and you have some. - HOWEVER your target lies above the current process limits so we know that the target will not be achieved without change.	Excellent Celebrate - This metric is improving. - Your aim is high numbers and you have some. - There is currently no target set for this metric.
	 Excellent Celebrate and Learn - This metric is improving. - Your aim is low numbers and you have some. - You are consistently achieving the target because the current range of performance is below the target.	Good Celebrate and Understand - This metric is improving. - Your aim is low numbers and you have some. - Your target lies within the process limits so we know that the target may or may not be achieved.	Concerning Celebrate but Take Action - This metric is improving. - Your aim is low numbers and you have some. - HOWEVER your target lies below the current process limits so we know that the target will not be achieved without change.	Excellent Celebrate - This metric is improving. - Your aim is low numbers and you have some. - There is currently no target set for this metric.
	 Good Celebrate and Understand - This metric is currently not changing significantly. - It shows the level of natural variation you can expect to see. - HOWEVER you are consistently achieving the target because the current range of performance exceeds the target.	Average Investigate and Understand - This metric is currently not changing significantly. - It shows the level of natural variation you can expect to see. - Your target lies within the process limits so we know that the target may or may not be achieved.	Concerning Investigate and Take Action - This metric is currently not changing significantly. - It shows the level of natural variation you can expect to see. - HOWEVER your target lies outside the current process limits and the target will not be achieved without change.	Average Understand - This metric is currently not changing significantly. - It shows the level of natural variation you can expect to see. - There is currently no target set for this metric.
	 Concerning Investigate and Understand - This metric is deteriorating. - Your aim is low numbers and you have some high numbers. - HOWEVER you are consistently achieving the target because the current range of performance is below the target.	Concerning Investigate and Take Action - This metric is deteriorating. - Your aim is low numbers and you have some high numbers. - Your target lies within the process limits so we know that the target may or may not be missed.	Very Concerning Investigate and Take Action - This metric is deteriorating. - Your aim is low numbers and you have some high numbers. - Your target lies below the current process limits so we know that the target will not be achieved without change.	Concerning Investigate - This metric is deteriorating. - Your aim is low numbers and you have some high numbers. - There is currently no target set for this metric.

SPC Icons & How to Interpret (4/4)

Assurance				
Variation/Performance				
	 Concerning Investigate and Understand - This metric is deteriorating. - Your aim is high numbers and you have some low numbers. - HOWEVER you are consistently achieving the target because the current range of performance is above the target.	Concerning Investigate and Take Action - This metric is deteriorating. - Your aim is high numbers and you have some low numbers. - Your target lies within the process limits so we know that the target may or may not be missed.	Very Concerning Investigate and Take Action - This metric is deteriorating. - Your aim is high numbers and you have some low numbers. - Your target lies above the current process limits so we know that the target will not be achieved without change	Concerning Investigate - This metric is deteriorating. - Your aim is high numbers and you have some low numbers. - There is currently no target set for this metric.
				
				
				
				Unsure Investigate and Understand - This metric is showing a statistically significant variation. - There has been a one off event above the upper process limits; a continued upward trend or shift above the mean. - There is no target set for this metric.
				Unsure Investigate and Understand - This metric is showing a statistically significant variation. - There has been a one off event below the lower process limits; a continued downward trend or shift below the mean. - There is no target set for this metric.
				Unknown Watch and Learn - There is insufficient data to create a SPC chart. - At the moment we cannot determine either special or common cause. - There is currently no target set for this metric

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TRUST BOARD

Date of meeting	31 July 2026					
Title	Patient and Colleague Experiences					
Report of	Ian Joy – Executive Director of Nursing, Midwifery and Allied Health Professionals					
Prepared by	Ian Joy – Executive Director of Nursing, Midwifery and Allied Health Professionals					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	These stories illustrate the powerful link between colleague experience and patient experience, a key principle of our strategy Caring, Learning and Improving Together. In one reflection, a patient shared their experience of not initially feeling involved in decisions around their care and the impact this had on them. This was captured during a discussion with one of our Patient Experience Facilitators as part of the Real Time Patient Experience Programme. This allowed timely escalation, ensuring their voice was heard and a plan of care adapted accordingly, resulting in a more positive experience. In the second reflection, a colleague shares their experience of being empowered through the Accrediting Excellence (ACE) programme to improve standards, strengthen teamwork and achieve accreditation. Together, the experiences demonstrate how creating an environment where people feel heard, valued and involved drives better experiences, stronger engagement and improved outcomes for patients and colleagues alike.					
Recommendation	The Board is asked to receive both stories for information and to note our commitment to learning from all experiences of receiving and providing care.					
Links to Strategic Priorities	Advancing Care - improving patient care, effectiveness and quality through innovation, research, improvement and education Supporting Great Care - Supporting colleagues to do their job to the best of their ability with effective leadership, a just and learning culture and modern digital and physical environments					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	Linked to key areas in the BAF relating to the quality and safety of care and workforce.					
Reports previously considered by	Patient and Colleague Experiences are a recurrent feature of all Public Board meetings.					

PATIENT AND COLLEAGUE EXPERIENCES

Patient Experience

Context:

This patient was admitted to the ward for ongoing treatment and investigations. During their admission, discussions took place about transferring them to another hospital. Having previously had a distressing experience in this mentioned hospital, the prospect of returning there caused significant anxiety. This was captured in real time by one of the Patient Experience Facilitators as part of the Real Time Patient Experience programme. Following discussions with the patient, the Patient Experience Facilitator shared their concerns with the ward team, Ward Manager and senior nursing staff. The patient's anxieties regarding the proposed transfer were escalated to the Executive Director of Nursing to ensure their wishes and previous experiences were fully considered. Following further review, an alternative plan was agreed, and the patient was transferred to preferred choice of hospital.

Reflections:

'I didn't feel involved in what was happening to me. It felt as though decisions were being made around me rather than with me, and that was frightening.

When I was told I might be transferred to another hospital, I became very anxious. I had been there before and had such a difficult experience that I arranged my own discharge because I didn't want to stay. The thought of going back brought all those feelings flooding back. I couldn't understand why another hospital closer to home couldn't be considered, and I didn't feel anyone was really hearing why this mattered so much to me.

There were also lots of unanswered questions. I was told I would be having a scan on my leg and that someone from the plastics team would come to change the dressing on my face, but I spent much of the time waiting without knowing when anything would happen. Not knowing what was going on made me feel even more anxious.

What made the biggest difference was the kindness shown by the nursing staff. They always listened to me when I spoke about my worries and never made me feel like I was asking too much. Whenever I needed help, someone came quickly. My pain relief was managed well and, when I asked for fruit, staff went out of their way to bring me apples. These may seem like small things, but they made me feel cared for.

One member of staff stood out in particular. Stephen, one of the healthcare assistants, always took the time to stop and talk to me. He treated me as a person, not just another patient. His kindness, patience and reassurance helped me through some very difficult days.

Although my experience with the ward staff was overwhelmingly positive, one conversation with a clinician left me feeling upset. The discussion about my transfer felt abrupt, and I didn't feel my previous experiences had been taken seriously. I wasn't expecting everything to go my way, but I wanted someone to understand why I was so frightened and to involve me in

the decision.

Looking back, I am incredibly grateful for the care I received from the nurses and healthcare assistants. Their compassion made a real difference to my stay. What I found most difficult wasn't the treatment I received but feeling that an important decision about my care was happening without my voice being heard.'

Colleague Experience

Context:

As part of the Accrediting Excellence (ACE) Programme, the Ward Sister/Charge Nurse and Matron are asked for feedback after a ward has gone through the accreditation process. This is to ensure we learn and identify any areas for improvement in the process or support. Nuala Smith, Matron in Surgery at the Freeman Hospital shared her experience of supporting a ward through the ACE programme.

Reflections:

'I was appointed as a Matron one year ago, with oversight of two directorates, the Institute of Transplant (IOT) and Ear Nose and Throat (ENT), both completely new clinical areas for me. Stepping into the role was both exciting and challenging, and it required a huge personal and professional commitment as I worked to understand not only my responsibilities and expectations, but also the teams, the wards, and the complexities of each specialty.

With over 20 years of nursing experience, from staff nurse through to now matron, I have always held myself to high standards and have a strong drive to do the very best for patients and staff. It was clear early on that although both directorates had dedicated teams and solid foundations, there was variation in practice and real opportunities to strengthen consistency and standards. I knew this wouldn't be a quick fix and it would take time, persistence, and often "banging the drum" to embed meaningful and lasting change.

These areas had not previously had consistent matron oversight, meaning there was more work needed to meet Trust standards compared to others. One example was electronic observations (e-obs), where one ward initially sat at 78% compliance. Through focused work, visible leadership, and strong team engagement, we have now consistently sustained compliance above the 90% Trust target.

The introduction of the ACE accreditation programme for one of the wards came at exactly the right time. It gave us a clear framework, structure, and direction, aligning our work with Trust priorities across quality, patient experience, leadership, and engagement. More importantly, it provided the team with the tools, clarity, and focus needed to drive forward improvements that we all already knew were needed.

From the very beginning, our experience with Keri as the ACE lead and the ACE team was incredibly positive. They were approachable, encouraging, and genuinely understood the realities of working on busy wards, the pressures, constraints, and the fact that improvement isn't always "one size fits all." This immediately helped put the team at ease and created a sense of trust and partnership.

Throughout the journey, their ongoing support, feedback, and encouragement kept us on track and helped maintain momentum. We took a multidisciplinary approach, involving all staff, some more enthusiastic at first than others and also welcomed input from colleagues outside the ward, bringing in fresh perspectives.

One of the things that made a real difference was recognising the strengths within our own team. By giving individuals ownership of different areas, we were able to empower staff and make the most of the skills we already had. It became clear that we had everything we needed, we just needed the right direction and support to bring it all together.

As the process progressed, you could really feel a shift. Morale began to lift as changes became visible, and staff started to take pride in what they were achieving. It wasn't just about what needed to improve, we made a conscious effort to celebrate what was already working well, which helped build confidence and engagement across the team. It was also lovely to see patients becoming part of that journey, whether through contributing to a wellbeing board in the day room or simply showing interest in the changes happening around them. It reinforced just how much of a difference this work was making to the overall patient experience.

A particularly special part of this journey was that it coincided with the retirement of our Band 7 Sister, who had led that ward since it opened in 2012 and had nearly 30 years' experience in transplant nursing. Achieving ACE accreditation became a meaningful and well-deserved milestone for her, a legacy to leave behind and a strong foundation for the next leader.

There were moments of doubt, especially at the beginning, but the team showed real resilience. Despite a slightly delayed start, everyone pulled together, embraced the process, and supported one another. That collective effort resulted in the ward achieving a **Gold ACE Award**, something I always believed was possible, but knew would only be achieved with full team commitment, and the right guidance and support.

I am incredibly proud of the Ward 38 team and everyone who supported us along the way. Their dedication, openness to change, and hard work have been truly inspiring.

Finally, I would like to sincerely thank Keri ACE Lead and the ACE team. Their kindness, support, and expertise have been there from the very beginning, throughout the journey, and beyond and they have made a lasting difference not just to our outcomes, but to the confidence and pride within the team.'

Report of Ian Joy
Executive Director of Nursing, Midwifery and
Allied Health Professionals
23 July 2026

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 July 2026					
Title	Joint Medical Directors Report					
Report of	Dr Lucia Pareja-Cebrian / Dr Michael Wright					
Prepared by	Associate Medical Directors					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☒		☒	
Summary	This report highlights issues the Joint Medical Directors wish the Board to be made aware of. The following items are described in more detail within this report: • Operational update including Urgent and Emergency Care • Cancer • Quality & Safety • Mental Health update • People – Medical Workforce Update • Partnerships update • Medical Education – Post Graduate Review • 10 Point Plan Update • Improvement Groups update • Alliance Clinical Framework Group The Guardian of Safe Working (GoSW) report is included as a separate paper and has been discussed at the People Committee on 21 July 2026.					
Recommendation	The Trust Board is asked to: i) Note the contents of the report. ii) Note the ongoing challenges with demand on urgent and emergency care services. iii) Note the ongoing work to improve performance against cancer care targets and the particular challenges in specific tumour groups.					
Link to Strategic Priorities	Joining up care		Advancing care		Supporting great care	
	☒		☐		☒	
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☒	☐	☐

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Link to Board Assurance Framework [BAF]	1.1 Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.
Reports previously considered by	This is a regular report to Board. Previous similar reports have been submitted.

JOINT MEDICAL DIRECTORS REPORT

1. OPERATIONAL UPDATE

i) Urgent & Emergency Care

Overall performance for 2026/27 currently stands at 77.26% against the target for patients to be admitted, transferred or discharged within 4 hours. This is almost identical to the 77.50% achieved at the same point in 2025/26. Attendances are currently running at 2,500-3,000 additional each month compared to last year since the Urgent Treatment Centre (UTC) opened and this additional demand is being primarily experienced in Type 1 adult majors attendances. Emergency admissions are also running at higher levels than recent years for the same period. Within Newcastle Hospitals, in June 2026, an average of 44 patients per day experienced a period of their Emergency Department (ED) care in a corridor. Discussion of the actions being taken to eliminate 'corridor care' is included in the report of Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs).

Building work commenced in July 2026 to construct the link between the ED and the UTC and plans are at an advanced stage for phase 2 redevelopment of ED. The completion of this work is essential to improving the environment for patients and staff in the ED and to provide realisation of the full benefits of the opening of the UTC.

Pre-hospital admission avoidance pilots such as Call before Convey, where North East Ambulance Service NHS Foundation Trust staff discuss patients living in nursing or residential care homes with Newcastle Hospitals' staff before bringing them to the hospital, enhancing the community Urgent Care Response and modifications to Bed Bureau to redirect more care towards Community services.

Work continues with Northumbria Healthcare NHS Foundation Trust to ensure the best pathways are used for patients residing in the Tyne Valley who require admission to hospital.

ii) Digital & Data Update

Chris Gibbins has been appointed as Associate Medical Director (AMD) with responsibility for operational and performance issues at AMD level working in close collaboration with the Director of Operations and her team and for Digital and Data issues working in collaboration with the Chief Digital Officer, the Director of Digital and Data, the Chief Clinical Information Officer and their teams. A more detailed update on clinical digital and data issues will be given in our next report.

iii) Outpatient update

Outpatient services are responsible for is the highest volume of activity undertaken in the Trust where the majority of consultations between Trust staff from all professional groups and patients takes place. There is a vast array of outpatient service types across the Trust. There are therefore many opportunities to improve the quality and efficiency of care

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delivery in outpatients, and a major programme of work is underway to transform outpatient services.

This work has been separated into 3 pillars:

1. Operational basics
2. Single Point of Access (SPOA)/Advice and Guidance Implementation
3. Innovative schemes

The operational basics workstream is focused on updating clinic templates to ensure accurate data and consistent capacity within a service and maximising the efficiency of the utilisation of outpatient facilities.

SPOA is being mandated nationally for 10 specialities from Autumn 2026, and teams are working to determine how they will deliver the Advice and Guidance process that will be an essential part of this.

A number of teams are keen to pilot the use of Ambient Voice Technology to document consultations, shifting clinical activity to the community, utilising patient communication platforms and group education clinics to maximise patient satisfaction and production. The 3rd pillar of work will focus on supporting these innovative approaches to maximising the effectiveness of outpatient activity for patients and allowing staff to deliver these consultations in the most efficient way.

2. CANCER

Gail Jones has been reappointed to the role of AMD with responsibility for Cancer services.

i) Performance

28 Day Faster Diagnosis

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28 Day	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Brain/CNS			100.0%	100.0%		100.0%	100.0%			100.0%	50.0%	100.0%	0.0%
Breast	95.4%	95.5%	92.9%	92.8%	94.1%	94.2%	90.5%	89.0%	96.1%	91.6%	86.2%	88.7%	83.5%
Breast Symptomatic	55.5%	47.0%	38.7%	33.3%	34.5%	42.8%	44.4%	26.0%	49.3%	47.3%	30.4%	22.7%	41.2%
Childrens	50.0%	100.0%	50.0%	100.0%	14.3%	50.0%	50.0%		100.0%	100.0%	100.0%	85.7%	0.0%
Colorectal	71.0%	75.1%	74.5%	71.1%	73.2%	69.6%	74.0%	64.8%	76.2%	69.9%	61.9%	66.8%	71.7%
Gynae	75.6%	85.6%	76.3%	81.2%	85.5%	77.9%	81.7%	81.0%	84.1%	83.7%	86.2%	90.9%	78.8%
Haematology	80.0%	86.7%	84.6%	100.0%	81.3%	90.9%	50.0%	66.7%	77.8%	68.8%	66.7%	84.6%	100.0%
Head & Neck	89.0%	87.0%	90.6%	95.3%	95.4%	93.9%	91.0%	89.8%	92.6%	92.3%	88.2%	91.5%	86.4%
Lung	84.8%	74.4%	76.3%	80.0%	81.3%	84.8%	89.3%	62.5%	85.3%	92.6%	75.0%	74.2%	70.3%
NSS	90.5%	100.0%	92.9%	91.7%	100.0%	100.0%	76.5%	81.8%	91.7%	83.3%	88.9%	81.3%	84.6%
Other	0.0%	100.0%			100.0%		100.0%		0.0%	100.0%			0.0%
Sarcoma	100.0%	84.6%	87.5%	77.8%	92.9%	78.6%	80.0%	81.8%	80.0%	88.9%	87.5%	92.9%	100.0%
Skin	74.9%	63.9%	61.6%	53.3%	53.4%	47.0%	46.1%	54.1%	90.5%	96.9%	94.8%	96.9%	96.7%
Testicular	90.0%	100.0%	100.0%	88.9%			100.0%		100.0%	87.5%	100.0%	90.0%	90.0%
Upper GI	84.3%	80.0%	93.2%	89.5%	82.2%	80.6%	85.9%	77.9%	85.2%	88.4%	81.5%	84.6%	81.3%
Urology	65.4%	69.9%	73.4%	76.3%	79.0%	75.5%	74.1%	62.0%	69.7%	71.9%	69.9%	72.1%	59.2%
HPB	60.0%	42.9%	62.5%	70.0%	66.7%	62.5%	42.9%	55.6%	60.0%	88.9%	50.0%	57.1%	66.7%
OGD	86.3%	86.0%	91.9%	91.2%	84.4%	82.1%	89.5%	78.9%	86.8%	84.4%	82.8%	87.1%	83.3%
Trust Total	78.1%	74.1%	72.0%	68.6%	69.1%	65.5%	68.3%	66.5%	85.6%	86.4%	83.1%	85.0%	84.2%
NHSE	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

Agenda item A3(b)

2 Day Time to Treatment Target

62 Day	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26
Brain/CNS	100.0%	82.6%	83.3%	100.0%	100.0%	100.0%	92.9%	89.5%	81.8%	85.7%	85.7%	83.3%	81.8%
Breast	89.8%	92.1%	83.5%	86.5%	82.8%	78.6%	86.3%	74.8%	78.8%	76.4%	77.5%	71.4%	79.4%
Childrens	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	60.0%	100.0%	100.0%	100.0%
Colorectal	38.2%	40.8%	40.0%	53.7%	48.6%	68.7%	44.4%	59.1%	42.9%	32.3%	58.3%	35.8%	42.2%
Gynae	79.2%	42.9%	52.0%	50.0%	39.1%	71.4%	70.3%	83.3%	84.2%	78.6%	84.2%	56.3%	53.8%
Haematology	81.6%	83.9%	76.1%	64.7%	96.2%	88.2%	86.4%	77.4%	90.9%	82.9%	72.3%	79.4%	82.3%
Head & Neck	75.8%	79.7%	76.3%	72.2%	90.7%	82.5%	70.5%	65.8%	80.5%	86.5%	76.8%	64.3%	73.2%
Lung	40.7%	63.5%	56.0%	56.9%	58.6%	49.6%	48.2%	44.1%	39.1%	38.6%	37.0%	41.1%	39.9%
Other	100.0%	83.3%	50.0%	69.2%	71.4%	100.0%	87.5%	50.0%	100.0%	83.3%	44.4%	50.0%	
Sarcoma	100.0%	63.6%	78.9%	70.0%	88.9%	84.2%	60.0%	57.1%	86.7%	66.7%	56.0%	100.0%	64.3%
Skin	89.7%	90.5%	94.7%	90.7%	85.3%	86.5%	87.2%	87.8%	88.1%	93.2%	94.9%	96.5%	96.2%
Upper GI	41.8%	49.6%	49.1%	47.4%	49.5%	44.4%	64.3%	38.1%	41.7%	43.6%	29.5%	35.0%	34.0%
Urology	41.3%	55.1%	60.2%	52.3%	67.0%	61.1%	56.5%	58.7%	51.8%	52.9%	47.0%	56.9%	47.7%
HPB	34.7%	50.7%	45.2%	54.7%	46.8%	45.3%	54.8%	40.0%	42.1%	37.7%	15.1%	31.1%	38.5%
OGD	50.0%	47.9%	54.3%	30.4%	58.3%	42.9%	80.6%	35.7%	40.6%	52.1%	44.2%	41.0%	40.0%
Trust Total	63.9%	71.1%	70.2%	70.4%	71.6%	71.1%	72.9%	66.1%	68.6%	63.9%	65.0%	65.1%	63.9%
NHSE	75.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%	85.0%

Key:

- NHSE - NHS England
- CNS – Central Nervous System
- NSS – Non Specific Symptoms
- Gynae – Gynaecology
- GI – Gastrointestinal
- HPB – Hepatobiliary
- OGD - Oesophago-Gastro-Duodenoscopy

28 Day Performance

i) Skin

28-day performance continues to be good overall. This is largely driven by changes in the skin pathway. June and July have seen the expected seasonal increase in skin referrals with 1,400 referrals in June. An action plan is in place to mitigate the effect of this variance in referral numbers including Saturday ‘super clinics’ to provide increased capacity for face-to-face consultations.

ii) Breast

Challenges remain in the symptomatic breast service (28-day performance in particular). There has been a gradually increasing gap between capacity and demand in this pathway which has, over time, been addressed with Waiting List Initiative (WLI) activity. The increased pressure of additional referrals from outside the Trust’s immediate catchment area has emphasised and worsened this gap. A business case has been submitted to the Integrated Care Board (ICB) outlining a phased approach for additional investment in this service including radiology, surgery, pathology and oncology resource. The screening pathway continues to be prioritised over the symptomatic pathway due to the variance in cancer detection rates on the two pathways (12.5% vs 1.5% respectively).

62 Day (62D) Performance

62-day performance remains strong in skin. There are concerns in other areas, including all of the major tumour groups – lung, urology, upper GI and colorectal. Action plans are in place for these tumour groups alongside focussed operational and clinical leadership to address specific issues, reduce the backlog of patients waiting more than 62-days for treatment, and improve performance against the standard.

Specific issues are highlighted below:

- **Radiotherapy**

Radiotherapy performance continues to deteriorate. Unfortunately, we anticipate that the Trust is likely to be one of the poorest performers for 31-day treatments nationally in this month's performance data. Inevitably there are multiple potential bottlenecks in a complex radiotherapy pathway, but the current fundamental problem is a lack of therapy radiographers both in Newcastle and Cumbria. Eleven new colleagues have been recruited to start September 2026 but will require training in the role as they are recent graduates. Currently Linear Accelerators (LINACs) have spare capacity in both Newcastle and Cumbria because of staff shortages, this situation will be alleviated by the recruitment of the new staff. Referrals continue to be clinically prioritised to minimise risk of patient harm.

62Day Referral to Treatment Breaches Mapped by First Treatment Modality (May 2026)

Modality	Performance 62D	Number Accountable	Breaches Accountable
Surgery	80%	257.5	51
Radiotherapy	23.3%	75	57.5
Chemotherapy	51.2%	63.5	32.5

Across the tumour groups it is clear that radiotherapy is the treatment modality accounting for most breaches across all tumour pathways. This is particularly prominent in tertiary referrals with radiotherapy accounting for 43/79 breaches (14.5 related to chemotherapy and 21.5 to surgery). By the nature of the tumour sites, the pathways seeing the biggest impact are lung and colorectal accounting for 13/21 and 31/49.5 breaches in these two pathways respectively.

Whilst it is critical that we work to improve radiotherapy performance, this requires training of newly recruited staff and so it is unlikely that a significant improvement in radiotherapy performance is deliverable over the next 6-months. In terms of improvements in performance, we therefore need to focus on minimising breaches in chemotherapy and surgical treatments across all tumour groups.

- Lung Cancer Performance

In terms of improvements across the lung cancer pathway, the team are building on learning they observed on a recent visit to Manchester. Plans are being made to develop a more active Patient Tracking List (PTL) system where the lists are reviewed repeatedly, throughout the week to minimise delays in the early phase of the pathway. Consideration is being given to piloting combined clinics with physicians, surgeons and oncologists to assess whether this reduces time to treatment. The challenge is in not losing capacity in other areas by following this approach; clearly careful evaluation will be essential.

The surgical team are visiting a London site in July to assess opportunities for HIT (high intensity theatre) lists to deal with surgical backlogs. Even without HIT lists we have seen the highest monthly number of operations for lung cancer in June 2026. Ongoing work to dovetail High Dependency Unit capacity with surgical activity is part of the development plan. A funding bid for recurrent support for navigational bronchoscopy has been approved by the ICB. Further development of this technique will improve speed and accuracy of diagnosis of lung cancer.

- Ablation

Negotiations to secure the required funding for the development of a 'theatre with a scanner' within interventional radiology. This will both create capacity for tumour ablation alongside other interventional procedures as well as releasing capacity for diagnostic CT scanning.

This is an excellent development, but we are conscious that the build will take time and capacity does not meet demand currently. We continue to try to manage this mismatch with careful triage. Additional Clinical Nurse Specialist time has been agreed to facilitate efficiencies within existing estate use, and WLI lists can be undertaken when staffing allows.

3. QUALITY AND SAFETY

Jason Ramsingh has been appointed as AMD for Quality and Safety succeeding Angus Vincent who has taken over as the AMD for People and workforce (see below). Work is ongoing on the Trust's Patient Safety Incident Response Framework (PSIRF) priority of implementation of National Safety Standards for Invasive Procedures (NatSSIPs2). There has been a consultation period with all stakeholders across the Trust allowing feedback around the implementation of NatSSIPs2. The Trust continues to experience never events, and it is hoped that the percentage of never events will reduce following its implementation.

The Quality Strategy for NHS funded care in England was released on 14th July 2026 with a focus on high-quality care around the 3 core domains of safety, effectiveness and experience. This aligns with the Trust's strategy on quality and safety. There will be a focus on outcome measures across Clinical Boards, aiming for higher visibility and quality improvement initiatives.

The Amos and Ockenden reports were published in July, with shared ownership between nursing and midwifery and medical teams. NHSE's "100-Day Maternity and Neonatal Sprint" focuses on strengthening patient voice, safety, leadership accountability, equity, learning from incidents and 24/7 (24 hours a day / 7 days a week) high-quality maternity and neonatal care to improve outcomes for women, babies and families. Further detail is included in the Executive Director of Nursing, Midwifery & AHPs paper.

4. MENTAL HEALTH

Significant progress has been made in strengthening the Trust's approach to mental health care following the Care Quality Commission (CQC) inspection, including enhanced governance arrangements, improved access to specialist mental health support, workforce development initiatives, and the establishment of more systematic quality improvement processes. A paper summarising progress made since the last CQC inspection was discussed at the Quality Committee meeting in June. The positive progress achieved across adult and paediatric pathways was recognised, whilst noting that there is still work to do to improve acute mental health pathways within Emergency Care, increasing demand and complexity of presentations, environmental constraints, and the need for continued partnership working across the wider health and care system. The Committee received assurance regarding current mitigation measures and supported continued oversight of this agenda, agreeing to receive a further update in six months' time.

5. PEOPLE – MEDICAL WORKFORCE UPDATE

i) Job Planning Oversight

Angus Vincent was appointed as the AMD of People as of the 1st July 2026. He will have oversight of the of job planning process alongside the Joint Medical Directors.

Acknowledging the huge amount of work undertaken on this so far, ongoing issues include:

- Supporting Clinical Directors (CDs) with good quality capacity and demand mapping informing the job planning process.
- Supporting joint process with Director of Operations (DoPs) and Assistant DoPs.
- Supporting data availability and presentation to optimise the job planning process.
- Clarifying and monitoring Supporting Professional Activities (SPA) activity.
- Complete the shift to Medirota.
- Supporting dispute areas pro-actively.

ii) Training & Development

CD / Heads of Department Training Programme

This will be delivered over 6 half-day sessions running from October to December this year and is in the planning stage with dates and venues established and CD colleagues enrolled. We have agreed funding with The Value Circle who will co-deliver the course with us. The provisional programme will include:

- Job Planning including Software for Appraisal and Revalidation of Doctors (SARD) Masterclass, capacity and demand planning, Additional Direct Clinical Care Activity (ADAs).
- People management – concerns process, interaction with national guidance, occupational health, team health and prevention of conflict, conflict management.
- Finance including Patient Level Information and Costing System (PLICS), business planning, strategy development, Trust strategy
- ‘Nuts and bolts’ operational management, appointments.
- Leadership models – compassionate leadership.
- Quality and Safety – Directorate + Clinical Board responsibilities and process.

New Consultant development

Introducing development streams for new consultants in 1 of 4 – 6 areas, running cohorts over 12-months led by established consultants. Benefits to include fast tracking new colleagues into areas of interest, networking with their peers and senior colleagues.

Likely areas – digital, research as an NHS consultant, quality and safety, education, leadership and management. Further activities includes:

- Oversight of our offer in mentoring, coaching, well-being – working with colleagues and established systems in Human Resources (HR).
- Working with our Organisational Development department and considering how they might be optimally used to address issues within clinical teams.

Responding to Concerns Process

Building on the current established processes and policies within the Trust, strengthening our processes particularly at Clinical Director/Heads of Department level in effectively dealing with issues relating to medics conduct and capabilities.

Incorporating relevant national guidance, including:

- NHS Resolution/ Practitioner Performance Advice (PPA) – “A practical guide for responding to concerns about medical practice”
- Principles and Framework for Fairness and Proportionality – NHS Resolution
- Maintaining High Professional Standards (MHPS)
- Just Culture/Being Fair
- Being Fair 2

Establishing clear expectations and process with particular emphasis on early intervention and effective resolution where appropriate and avoiding harm to all parties.

With People colleagues, establishing training in this area for CDs/Heads of Departments (HoDs).

Responsible Officer duties

Agenda item A3(b)

Supporting the Joint Medical Directors in the Responsible Officer role including support and oversight of the Medical Revalidation and appraisal processes.

Resident Doctors

Supporting the Joint Medical Directors in oversight of this group of colleagues, including the delivery of the 10-point plan (see below), and interaction with medical education.

Non-consultant staff groups – Specialty and Specialist (SAS) doctors / Locally Employed Doctors (LEDs)

Understanding and supporting issues involving these groups.

6. PARTNERSHIPS

Philip Yates has been appointed as AMD for partnerships.

A joint meeting was held with colleagues from Newcastle and North Tyneside Local Medical Committee (NTLMC) and primary care with Trust clinical teams to consider how best to develop pathways to support implementation of the single point of access development (see above), further similar meetings are planned.

A meeting has been held with Newcastle GP Services and NTLMC to review existing communication between primary and secondary care teams and to develop approaches to improve this.

There are ongoing discussions about the development of the 'Neighbourhood Model' as described in the NHS 10-year plan in which Philip will represent the Joint Medical Directors.

7. MEDICAL EDUCATION

i) National increase in training places

Up to 4,500 training places for resident medical staff are expected to be introduced nationally over the next three years, with an initial cohort of 250 posts commencing in 2027. These initial posts will attract tariff funding, including both a placement fee and a salary contribution.

For August 2027, 750 posts are anticipated to receive placement fee funding only in addition to associated study leave and educational costs. As a result, most of the funding required to support any additional training numbers will need to be identified and absorbed within the Trust.

Consultation with Clinical Boards is currently underway to assess capacity, funding implications, and potential allocation of posts.

ii) LEDs

Agenda item A3(b)

The latest government proposal to resident doctors includes an expectation that the training opportunities and support provided to LEDs should align more closely with those available to doctors holding formal training numbers.

Should this proposal be implemented, it is likely to have significant implications for educational supervision arrangements, training oversight, and portfolio requirements, with potential consequences for both educational capacity and resource allocation across the Trust.

iii) International Medical Graduates

There has been a notable reduction in the number of International Medical Graduate (IMG) applications following recent legislative changes.

Departments that are particularly reliant on Internal Medicine Training (IMT)-level doctors have been made aware of the potential impact and are proactively developing alternative workforce plans to mitigate any risks to service delivery and maintain training capacity.

iv) Annual Review of Competence Progressions (ARCPs)

The Foundation Annual Review of Competence Progression process has now been completed. Feedback from participants described the process as efficient, well organised, and professionally delivered, reflecting the commitment and diligence of all those involved.

v) Annual Deanery Quality Meeting (ADQM)

The ADQM took place on 11 June 2026 and was well attended by staff. The event was successful and was received positively. The formal report is currently awaited.

vi) General Medical Council (GMC) Trainee survey results

The final report is anticipated by the end of July. A total of four free-text comments were submitted, comprising two concerns relating to undermining and two relating to patient safety. Each has been thoroughly reviewed and addressed, with appropriate actions taken and further work continuing where necessary.

vii) Medical Education Team

The medical education team are planning educational supervisor updates available to all trainers. The first of these is expected to be delivered in September 2026.

A wellbeing Tutor has been appointed, with several initiatives already planned.

5. 10 POINT PLAN

i) Programme Developments

Agenda item A3(b)

Since the previous Board update, the Resident Doctors 10 Point Plan has evolved from delivery of individual actions into a series of strategic quality improvement programmes focused on delivering sustainable improvements to resident doctors' working lives. Alongside this, NHSE's Annual Leave guidance is being incorporated into the Trust's Annual Leave Policy to improve consistency and transparency across specialties, and the programme has been aligned with the Trust Board Assurance Framework to strengthen governance, oversight and assurance reporting.

Current quality improvement programmes include:

- ***Resident Doctor Workspace Programme*** – a Trust-wide review of hot-desking capacity and need, clinical workspace and Information Technology (IT) provision, with priorities aligned to the Trust's Estates and Digital Capital Programmes.
- ***Resident Doctor Facilities Programme*** – improving locker provision and resident facilities across Trust sites to better support doctors working across multiple specialties and locations.
- ***Resident Doctor Scrubs Programme*** – developing a standardised scrubs offer and single scrubs colour for all resident doctors to improve professional identity, visibility and consistency across the resident doctor workforce, while supporting wider Alliance ambitions.

A refreshed communications and engagement strategy has also been introduced, including a dedicated Resident Doctors 10 Point Plan intranet site, a central email address for resident doctor feedback, and regular programme updates. Enhancing rota design and delivery is also being supported through a dedicated workstream with rota coordinators, providing updated guidance on national changes, clear escalation pathways where rota issues cannot be resolved locally, and exploration of future self-rostering capability with the Trust's current e-rostering provider. To support sustainability, the Resident Doctor Peer Lead (RDPL) model is being expanded to include the incoming Medical Leadership and Management Fellow and two incoming Chief Specialist Registrars, strengthening resident doctor representation and ensuring continuity of programme leadership.

ii) Ongoing Challenges

The programme continues to face several challenges, many of which are reflected nationally. These include maintaining meaningful engagement with resident doctors, developing and delivering larger-scale quality improvement projects within the scope of the 10-Point Plan, and progressing actions that remain dependent on further national guidance from NHSE. As the programme matures, there is an increasing focus on developing meaningful outcome measures to demonstrate the impact of improvements and provide robust assurance to the Trust Board.

6. IMPROVEMENT GROUPS

Deteriorating Child

Significant progress has been made in strengthening the Trust's approach to the recognition and management of deteriorating children. A dedicated multidisciplinary improvement

Agenda item A3(b)

group and operational workstream provides enhanced oversight, data review and action tracking. Key deliverables include pathway mapping to improve consistency of escalation processes, continued implementation of electronic observation systems and digital deterioration alerts, development of outcome measures aligned to Martha's Rule, and enhanced staff education and training programmes in paediatric deterioration, sepsis recognition and escalation. The Group has also progressed plans for a paediatric critical care outreach service and strengthened governance arrangements, with the Quality Committee currently receiving assurance that improvement actions are being delivered and embedded.

Infection Prevention Control (IPC)

The Infection Prevention and Control Improvement Group continues to provide oversight of the Trust's programme to address healthcare-associated infections and strengthen compliance with infection prevention and control standards. Progress has been made through enhanced governance and assurance arrangements, implementation of a structured audit programme, development of improved data and dashboard reporting, strengthened support to Clinical Boards through dedicated IPC leadership, and increased focus on local ownership of infection prevention practices. The Group is providing ongoing assurance through the Quality Committee that actions are being implemented and embedded to support sustainable improvement in infection prevention and control performance.

Transplant Committee

The Committee continues to provide strategic oversight of the Trust's transplantation programme, with a particular focus on organ utilisation, service development, governance and quality outcomes. During the reporting period, the Trust completed and submitted its Organ Utilisation Strategy, becoming one of the first centres nationally to do so, and has continued to work with regional and national partners to develop sustainable transplant pathways and improve access to transplantation services. The Committee maintains oversight of performance, safety, workforce and service development priorities, supporting the Trust's ambition to remain a leading national transplantation centre while ensuring high standards of patient care and clinical governance.

The ARC (Assessment and Recovery Centre) Steering Group continues to support the national NHS Blood and Transplant programme to improve organ utilisation and transplantation outcomes. Significant progress has been made in establishing pilot liver, kidney and lung ARC pathways, developing operational processes, workforce plans, governance arrangements and infrastructure requirements. The programme has identified Newcastle as being in a strong strategic position nationally, with pilots across multiple organ programmes and the potential to become a future multi-organ ARC centre. Ongoing work is focused on workforce sustainability, permanent facility development, equipment and environmental requirements, and ensuring long-term resilience to support expansion of transplantation activity and research opportunities.

An NHS England visit was undertaken in July as part of the ongoing development of the national ARC programme. The visit provided an opportunity to discuss progress, future ambitions and the requirements for a sustainable multi-organ ARC model, with further programme development continuing through the ARC Steering Group.

7. ALLIANCE CLINICAL FRAMEWORK GROUP

The Alliance Clinical Framework Group has been established to provide clinical leadership and strategic oversight for collaborative service improvement across the four Alliance trusts. The group has agreed a framework for identifying and prioritising areas where alliance-wide action can improve patient outcomes, reduce unwarranted variation, support health inequalities objectives and strengthen service resilience. Cancer has been selected as the first priority workstream, with the group focusing on opportunities to standardise pathways, improve diagnostic processes, share best practice, reduce duplication and support consistent performance across the Alliance. The Group is also considering future priorities aligned to population need, including frailty, end-of-life care, community-based models of care and workforce development, supporting delivery of the wider Alliance clinical strategy. The work is founded on a principle of collective improvement for the population served by the Alliance, rather than individual organisational priorities.

8. RECOMMENDATIONS

The Trust Board is asked to:

- i) Note the contents of the report.
- ii) Note the ongoing challenges with demand on urgent and emergency care services.
- iii) Note the ongoing work to improve performance against cancer care targets and the challenges in specific tumour groups.

Report of
Dr Lucia Pareja-Cebrian/ Dr Michael Wright
Joint Medical Directors
24 July 2026

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 July 2026					
Title	Guardian of Safe Working Quarterly Report (Quarter 1 (Q1) 2026-27)					
Report of	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Prepared by	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Status of Report	Public ☒	Private ☐	Internal ☐			
Purpose of Report	For Decision ☐	For Assurance ☐	For Information ☒			
Summary	The terms and conditions of service (TCS) of the new junior doctor contract (2016) require the Guardian of Safe Working (GOSW) Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant. The content of this report outlines the number and main causes of exception reports for the period 27 March to 26 June 2026 for consideration by the Trust People Committee, prior to submission to the Trust Board.					
Recommendation	The Trust Board is asked to note the contents of this report.					
Links to Strategic Objectives	Supporting great care – supporting everyone to do their job to the best of their ability with effective leadership, a just and learning culture and modern digital and physical environments					
Impact (please mark as appropriate)	Quality ☒	Legal ☐	Finance ☐	Human Resources ☒	Equality & Diversity ☐	Sustainability ☐
Link to Board Assurance Framework [BAF]	No direct link to the BAF. In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training.					
Reports previously considered by	Quarterly report of the Guardian of Safe Working Hours (GoSWH). Discussed at the People Committee on 21 July.					

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

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

There are now 1,154 resident doctors on the TCS of the 2016 contract, and a total of 1,166 resident doctors in the Trust.

There were 284 exception reports in this period. This compares to 160 exception reports in the previous quarter.

Changes to exception reporting were introduced on 4 February 2026. This has resulted in a 1.75 increase in exception reporting numbers and an increase in fines. The pattern of exception reporting has also changed, with an increase in specialties exception reporting, increase in fines, and an increase in exception reports from doctors in specialty training.

2. INTRODUCTION / BACKGROUND

The Resident Doctor Contract came into effect on 3 August 2016. From August 2023 Locally Employed Doctors at Newcastle Hospitals are also employed on a contract which mirrors the 2016 contract. The TCS of the 2016 contract allows for exception reporting to raise reports on breaches of working hours and educational opportunities. The purpose is to ensure prompt resolution and/ or remedial action to ensure safe working hours are maintained, secure patient safety, and safeguard the delivery of agreed educational opportunities. Exception reporting is also the mechanism used by doctors to ensure compensation for all work performed.

On the 4 February 2026 changes to exception reporting were introduced which aim to improve access, confidentiality and ease of exception reporting.

The GoSWH quarterly report and annual summary reports were standardised to a national template to allow central data processing.

3. QUARTERLY REPORTING DATA

3.1 Number of exception reports submitted

Number of exception reports submitted over the last quarter:	284
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3.2 Categories of exception reports submitted

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start	14	1	0		15
Additional hours an unscheduled late finish	201	10	29		211
Breaches of non-resident on-call patterns	37	3	24		40
The inability to take contractual breaks			0	23	23
Inadequacy of clinical support				1	1
Inadequacy of rostered skills mix				1	0
Raising concerns of a suspected non-compliant rota pattern				0	0
Detriment or threat of detriment related to exception reporting				0	0
Information breach			0		0
Access and completion resolved in time					2
Access and completion breaches			0		0
Access and completion test				25	25
Other: optional free text box					
Total					

3.3 Experiences of actual or threatened detriment

Quarterly survey response rate	0.69%
Doctors experiencing actual detriment as a result of exception reporting	16%
Doctors feeling that they are not discouraged from exception reporting	82%

3.4 Withdrawals

Number of exception reports withdrawn over the last quarter	4
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3.5 Access to individual doctors' exception reporting data

Personally identifiable data related to exception reporting must not be shared without the doctors' specific consent, except where a senior manager or member of the board of directors is presented with an overriding public interest or has a legal obligation.

Number of exception reports disclosures over the last quarter	0
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3.6 Work schedule reviews related to exception reporting pattern/instances

Number work schedules reviews related to exception reporting patterns or instances	2
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4. ROTA GAPS ON ALL SHIFTS

Total number of rota gaps on all shifts over the last quarter	Data not available
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5. ESCALATIONS

The GoSWH is required to report any escalated issues in relation to working hours, raised in exception reports, to the relevant executive director, or equivalent, for decision and action, where these have not been addressed at departmental level.

No escalations

The GoSWH is required to report issues, with certain posts, that cannot be remedied locally and require a system-wide solution. The Board is required to raise the system-wide issue with partner organisations (for example, NHS England) to find a solution.

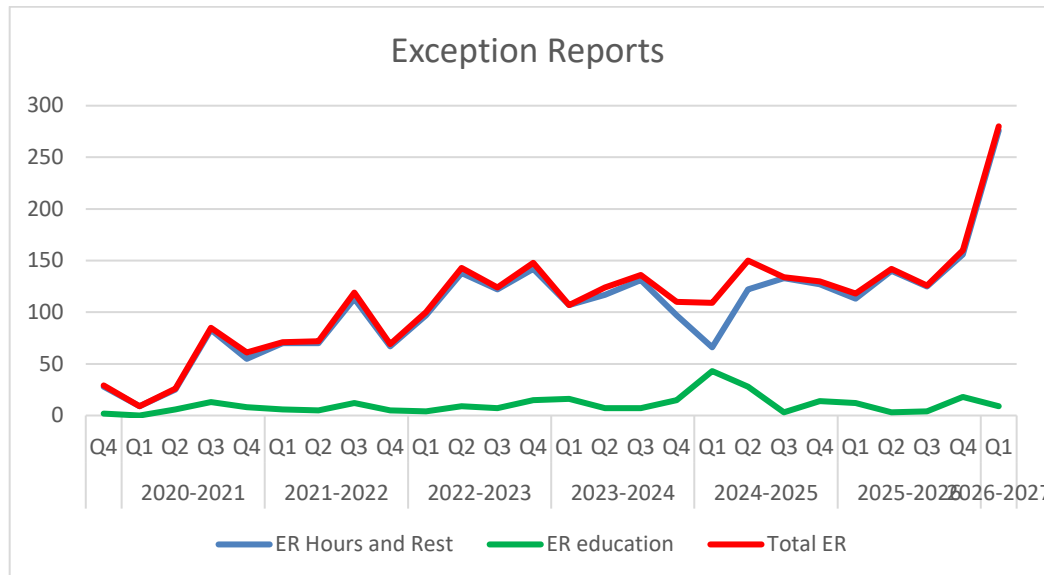
N/A

6. ADDITIONAL INFORMATION

		Previous quarter data for comparison)
Number of Resident Doctors on New Contract	1,154	(1,163)
Total Number of Resident Doctors	1,166	(1,180)
Number of Exception reports	284	(160)
Number of Exception reports for Hours Breaches	280	(157)

Number of Exception reports for Educational Breaches	9	(18)
Fines	53	(25)

7. EXCEPTION REPORTS



7.1 Exception Reports by Board

Surgical and Specialist Services	107
Surgical and Associated Specialties	79
Medicine and Emergency Care	64
Clinical and Diagnostic Services	8
Cardiothoracic Services	6
Family Health	6
Cancer and Haematology	5
Perioperative Care	1

7.2 Example Themes from Exception Reports

Surgical and Specialist Services

The main area of exception reporting was from neurosurgery highlighting excessive hours worked both on routine theatre days and during on call shifts. A work schedule review has been carried out to ensure the work schedule more accurately reflects the working hours. Suggestions regarding intensity of out of hours work are being reviewed by the directorate.

Surgical and Associated Specialties

The reasons for exception reporting were both staying late after a routine shift – particularly on theatre days, and non-resident on call shifts. Other sources of exception reporting were excessive workload on the wards or acutely unwell patients.

Medicine and Emergency Care

Exception reports were submitted when there was excessive workload or low staffing numbers meaning that doctors stayed late.

8 EXCEPTION REPORT OUTCOMES

8.1 Work Schedule Reviews

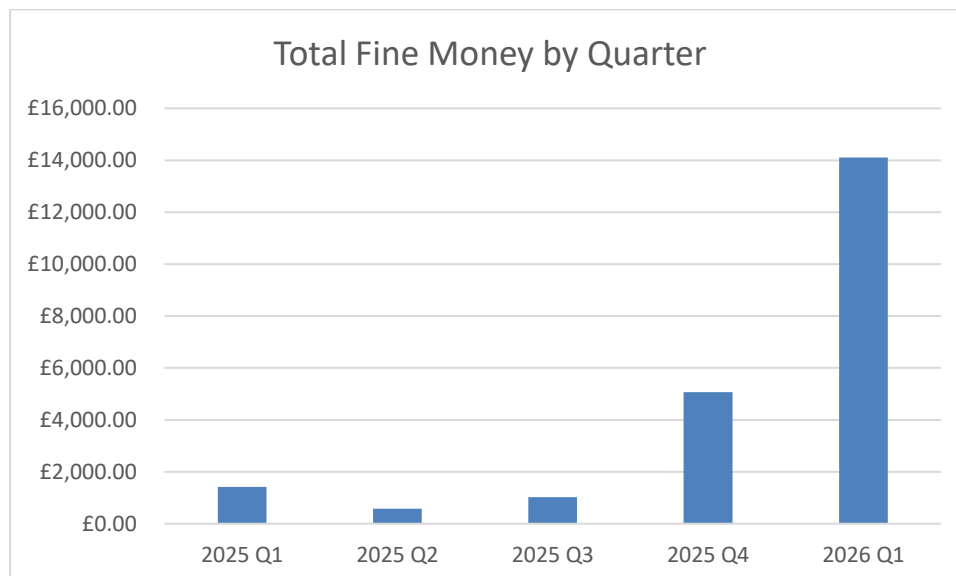
A work schedule was carried out for neurosurgery.

A work schedule review was requested via exception reporting in cardiology, but no changes were required.

8.2 Fines

53 fines have been issued: Total fine money £14,107.80

- Surgical and Specialist Services: 28 fines. Total fine money £5,568.25
- Surgical and Associated Specialties: 22 fines. Total fine money £7,986.97
- Medicine and Emergency Care: 2 fines. Total fine money £75.58
- Family Health 1 fine. Total fine money £477.00



9. ISSUES ARISING

9.1 Workforce and workload

The main increase in exception reports has been within the surgical specialties – particularly among higher grades of training, who previously had not exception reported. The other pattern is within rotas with non-resident on call working.

9.2 Administrative Support

Administrative support is currently good although a dedicated safe working hours administrator has yet to be appointed.

10 ROTA GAPS

Specialties and rotas with vacancies are outlined below.

Directorate	Site	Specialty/Sub Specialty	Grade	No. required on rota (at full complement)	Jun-26	May-26	Apr-26
		<u>Cancer and haematology</u>					
Cancer Services	FH	Oncology	ST3+	22	1	1	1
		<u>Cardiothoracic Services</u>					
Cardiothoracic Services	FH	Cardiology	ST3+	15	2	2	2
Cardiothoracic Services	FH	Cardiothoracic Anaesthesia	ST3+	10	4	4	3
Cardiothoracic Services	FH	Cardiothoracic Surgery	F2/ST1-2	2	1	1	1
Cardiothoracic Services	FH	Cardiothoracic Surgery	ST3+	11	4	4	3
Cardiothoracic Services	FH	Paediatric Cardiology 2nd	ST3+	9	3	3	2
Cardiothoracic Services	FH	Respiratory Medicine	CMT/ST1-2	5	0.2	0.2	0.2
		<u>Family Health</u>					
Children's Services	RVI	Paediatric Surgery 2nd	ST3+	9	1	1	1
Children's Services	RVI	Paediatrics 1st - ST1/ST2	F2/ST1/ST2	25	0.8	0.8	1.4
Children's Services	RVI	Paediatric Oncology	ST3+	6	0.4	0.4	0.4
Children's Services	RVI	Paediatric ICU (PICU)	ST3+	10	1	1	1
Women's Services	RVI	Obstetrics & Gynaecology	F2/ST1/ST2	14	1	1	1
Women's Services	RVI	Obstetrics & Gynaecology	ST3+	22	2	2	2
Women's Services	RVI	Neonates	F2/ST1/ST2	7	1	1	1
		<u>Surgical & Associated Specialities (FH)</u>					
EPOD	FH	Ear, Nose & Throat (ENT)	ST3+	9	1	1	1
EPOD	RVI	Dermatology	ST3+	7	0.4	0.4	0.4
Surgical Services	FH	General Surgery	F2/ST1/ST2/ST3+	7	2	2	2
Surgical Services	FH	Vascular	ST3+	10	1	1	1
Surgical Services	RVI	General Surgery	ST3+	15	0.8	0.8	0.8

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Directorate	Site	Specialty/Sub Specialty	Grade	No. required on rota (at full complement)	Jun-26	May-26	Apr-26
Urology	FH	Urology	ST3+	11	1	1	1
Clinical and Diagnostic Services							
Integrated Lab Medicine	RVI	Histopathology	ST1/2	8	0.2	0.2	0.2
Integrated Lab Medicine	RVI	Medical microbiology integrated with medicine	ST1+	21	0.8	0.8	0.8
Medicine							
Medicine	FH	General Internal Medicine	F2/GPVTs/CT MT/TF	12	1.6	1.6	1.6
Medicine	RVI	General Internal Medicine	ST3+	25	4	4	4
Medicine	FH	Care of the Elderly	ST3+	5	1	1	1
Medicine	RVI	Accident & Emergency 1st	ACCs/ST1-2/CT1-2	20	1	1	1
Medicine	RVI	Accident & Emergency 2nd	ST3+	15	2	2	2
Urology	FH	Renal Medicine	ST3+	6	1	1	1
Surgical & Specialist Services (RVI)							
Musculoskeletal	RVI	Orthopaedics	F2/ST1/ST2	4	1	1	1
Musculoskeletal	RVI/FH	Orthopaedics	ST3+	19	2	2	3
Neurosciences	RVI	Neurosurgery	F2/ST1/ST2	5	0.2	0.2	0.2
Neurosciences	RVI	Neurosurgery	ST3+	13	1	1	1
Neurosciences	RVI	Neurology	F2/ST1/ST2	2	1	1	1
EPOD	RVI	Ophthalmology	ST3+	25	3	3	3
Peri-operative FH							
Peri-operative & Critical Care	FH	Critical Care	F2 ST1-7	13	0.8	0.8	0.8
Peri-operative & Critical Care	FH	Anaesthetics General	ST1-7 CT1-2	27	3.6	3.6	3.6
Peri-operative RVI							
Peri-operative & Critical Care	RVI	Critical Care	ST1+	16	2.8	2.8	2.8
Peri-operative & Critical Care	RVI	Anaesthetics	ST1-2 / ST3 +	40	1.4	2.2	2.2

Key:

ACCS – Acute Care Common Stem (CT equivalent)

CMT – Core Medical Trainee

CST – Core Surgical Trainee

CT – Core Trainee

EPOD – ENT, Plastics, Ophthalmology, Dermatology

FH – Freeman Hospital

GPVTs – GP Vocational Training Scheme

ICU – Intensive Care Unit
IMT – Internal Medicine Trainee
ST – Specialist Trainee
RVI – Royal Victoria Infirmary
TF – Teaching Fellow

11. LOCUM SPEND

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

12. RISKS AND MITIGATION

12.1 Changes to the TCS of the Contract

Changes to the TCS of the contract came in in February 2026. Exception reports are signed off by medical staffing with oversight by the GOSW. There is no involvement from supervisors. There has been an almost twofold increase in exception reporting numbers. This is similar to what has been observed in other Trusts in the region.

13. RESIDENT DOCTOR FORUM

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

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

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

14. ACTIONS

The following actions are those mandated by NHS Employers:

- All quarterly reports must be publicly accessible online within one month after the report has been created.

Information to be shared	Recipient(s) of board reports	Frequency
Quarterly reports	• This report must be sent directly to: • the Joint Local Negotiating Committee (JLNC) • the Local Negotiating Committee (LNC) chair • at least one nominated LNC resident doctor, and relevant Resident Doctor Forum representatives upon completion.	Quarterly

	• This report must be made available to NHS England (Local office), the Care Quality Commission, the General Medical Council and the General Dental Council, the British Medical Association (BMA) or other recognised trade unions. • In addition, all quarterly reports must be publicly accessible online within one month after the report has been created.	
Issues identified as a result of exception reporting that cannot be remedied locally and require a system-wide solution	LNC The board will raise the system-wide issue with partner organisations (e.g. NHS England) to find a solution.	Ad hoc

15. RECOMMENDATIONS

I recommend that we comply with NHS Employers newly published recommendations on the standardisation of Board reports and distribution. I also recommend that we continue to review the workforce workload balance to ensure that safe staffing numbers are maintained and to monitor the impact of the Resident Doctor Contract changes.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours
9 July 2026

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 July 2026		
Title	Executive Director of Nursing, Midwifery and Allied Health Professionals Report		
Report of	Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals		
Prepared by	Lisa Guthrie, Director of Nursing Diane Cree, Personal Assistant		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☐
Summary	This paper has been prepared to inform the Board of Directors of key issues, challenges, and information regarding the Executive Director of Nursing, Midwifery and Allied Health Professionals Report. The report covers the following sections: • Section 1: Nursing and Midwifery Staffing • Section 2: 'Fairer Deal for Nursing' Band 5 Job Evaluation Role Review Programme • Section 3: Vaccination Update • Section 4: Care in non-designated spaces (Corridor Care) The following key points/risks are noted for the Trust Board's attention: Alert: • At present, the organisation faces a significant challenge to reduce the number of patients who are receiving care in non-designated clinical areas usually referred to as 'corridor care'. This means patients are waiting or needing to be observed in a corridor in the Emergency Department. The report outlines some of the challenges faced by the team and work on-going to reduce care in non-designated spaces. (Section 4). Advise: • Staffing incidents, red flags and Care Hours Per Patient Day remain within expected limits. No deterioration in patient safety indicators associated with staffing levels has been identified, although localised workforce and leadership challenges continue to be actively managed through established governance processes. (Section 1) • Registered Nurse (RN) fill rates remain above the 85% threshold; however, a sustained downward trend continues, particularly on night shifts. Increasing numbers of wards are reporting fill rates below 85%, indicating ongoing pressure within the RN workforce. These remain closely monitored. (Section 1) • The Band 5 Job Evaluation Role Review Programme supports the Government's commitment to fair pay by aligning nursing roles with revised national job profiles, with all Band 5 roles to be reviewed by October 2028. Preparatory work is underway, including increasing job matching capacity, identifying staff in scope, financial modelling, and developing an agreed staff engagement plan. The delivery plan requested by NHS England		

	prior to the 31 July has been completed, approved for submission by the People Committee and can be found in the Board Reading Room for reference. (Section 2) - The Staff Vaccination 2026/27 campaign preparation has commenced with monitoring through the Staff Vaccination Steering Group. A delivery plan has been submitted to NHS England ahead of a 31st July deadline. There is an expected target for 60–65% vaccine uptake with a focus on addressing vaccine hesitancy. Plans are in place to deliver this expected target. (Section 4) Assure: - Trust nurse staffing escalation remains at Level 1, with established governance, oversight and mitigation in place to support safe staffing. No wards have required high-level support through the Nurse Staffing and Clinical Outcomes process during the reporting period. (Section 1) - Recruitment and retention remain positive, with reduced turnover rates, low RN vacancy rates and continued recruitment activity supporting workforce sustainability. (Section 1)					
Recommendation	The Board of Directors is asked - Note and discuss the content of this report. - Note the oversight and reporting of safe staffing which has been prepared in line with national guidance. - Note the progress of the Band 5 Job Evaluation Role Review Programme. - Note the progress of the Vaccination Programme. - Note and discuss the alert relating to care delivered in non-designated spaces.					
Link to Strategic Priorities	Joining up care		Advancing care		Supporting great care	
	☐		☒		☒	
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☐	☒	☐
Link to Board Assurance Framework [BAF]	Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.					
Reports previously considered by	The Executive Director of Nursing, Midwifery and Allied Health Professionals Report is a regular comprehensive report bringing together a range of issues to the Trust Board.					

EXECUTIVE DIRECTOR OF NURSING MIDWIFERY AND ALLIED HEALTH PROFESSIONALS REPORT

1. NURSE STAFFING UPDATE

A guidance document outlining nursing safe staffing metrics is available in the Board Reading Room to supplement the information presented in this report. Metrics previously RAG (red-amber-green) rated on the Nurse Staffing Metrics Dashboard is now reported live in the Nurse Staffing Metrics Dashboard in the Newcastle Hospitals reporting hub. This is notable progress in live monitoring and reporting.

1.1 Nurse Staffing Escalation

The Trust Nurse Staffing Guidelines provide a robust framework to ensure safe nurse staffing governance and identify a clear process for safe staffing escalation. The Trust staffing escalation is currently at level one, as business-as-usual processes are sufficient to maintain safe staffing levels. Operational changes, including temporary reconfiguration of adult and paediatric critical care services, have been managed through established safe staffing processes. While these changes have created additional staffing pressures in some areas, mitigations are in place and safe staffing levels continue to be maintained.

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

- The senior nursing team provides a daily staffing review which is reported into the Trust tactical control team.
- SafeCare (daily deployment tool) is utilised to deploy staff within and across Clinical Boards.
- Daily review of staffing red flags and incident (InPhase) reports.

Level one escalation will remain in place unless escalation criteria has been met.

1.2 Nurse Staffing and Clinical Outcomes

The monitoring of staffing metrics against clinical outcomes and nurse-sensitive indicators, in line with national guidance, continues through the Nurse Staffing and Clinical Outcomes (NSCO) Group. An overview for the last quarter is provided below:

Month	Total	Clinical Board	High level support	Medium level support	Low level support
Apr-26	61	Family Health Services Great North Children's Hospital (GNCH)		GNCH Ward 01b	GNCH Wards 01a, 02a, 09, 11 & 12

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Month	Total	Clinical Board	High level support	Medium level support	Low level support
		Family Health Services Women's (WOM)			Royal Victoria Infirmary (RVI) Ward 40
	6	Surgical and Specialist Services RVI		RVI Ward 16	RVI Wards 20, 22, 23, 43 & RVI Park Suite
	0	Perioperative Services			
	3	Cardiothoracic Services			Freeman Hospital (FH) Wards 24, 29 & 30
	6	Medicine and Emergency Care Services		RVI Assessment Suite (AS)	RVI Wards 31, 44, & 48 FH Wards 13 & 20
	0	Surgical and Associated Services FH			
	1	Cancer and Clinical Haematology Services		Northern Centre for Cancer Care (NCCC) Ward 34	
	23		0	4	19
May-26	6	Family Health Services GNCH Family Health Services Women's		GNCH Ward 01b	GNCH Wards 01a, 02, 06, 09 & 12
	5	Surgical and Specialist Services RVI			RVI Wards 16, 20, 22, 23 & 43
	1	Perioperative Services			RVI Ward 18
	1	Cardiothoracic Services			FH Ward 21
	5	Medicine and Emergency Care Services			RVI AS, RVI Wards 31, 44 & 48 FH Ward 13
	2	Surgical and Associated Services FH			FH Wards 03 & 08
	1	Cancer and Clinical Haematology Services		NCCC Ward 34	
	21		0	2	19
Jun-26	5	Family Health Services GNCH Family Health Services WOM			GNCH Wards 01a, 01b, 02, 09 & 12
	6	Surgical and Specialist Services RVI			RVI Wards 15, 16, 20, 22, 23 & 43
	1	Perioperative Services			FH Ward 37

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Month	Total	Clinical Board	High level support	Medium level support	Low level support
	1	Cardiothoracic Services			FH Ward 21
	4	Medicine and Emergency Care Services			RVI AS, RVI Wards 44 & 48, FH Ward 13
	2	Surgical and Associated Services FH			FH Wards 03 & 08
	1	Cancer and Clinical Haematology Services		NCCC Ward 34	
	20		0	1	19

The key points to note:

- No wards have required high-level support across the reporting period, indicating sustained stability.
- There has been a continued reduction in the number of wards requiring medium-level support for more than two months, with de-escalation achieved where action plans have been implemented and progressed.
- Wards requiring medium-level support for greater than two months continue to have formal action plans in place, with ongoing oversight through NSCO Group to provide assurance of progress.
- Key themes remain consistent and continue to drive improvement activity, including:
 - Infection prevention and control (IPC).
 - Medication safety.
 - Leadership factors, including vacancy, absence and capability, continue to underpin areas of support and represent an ongoing risk to sustained improvement.
 - eObservations / deteriorating patient (less frequent).

1.3 Inphase staffing incident reports and Red Flag data

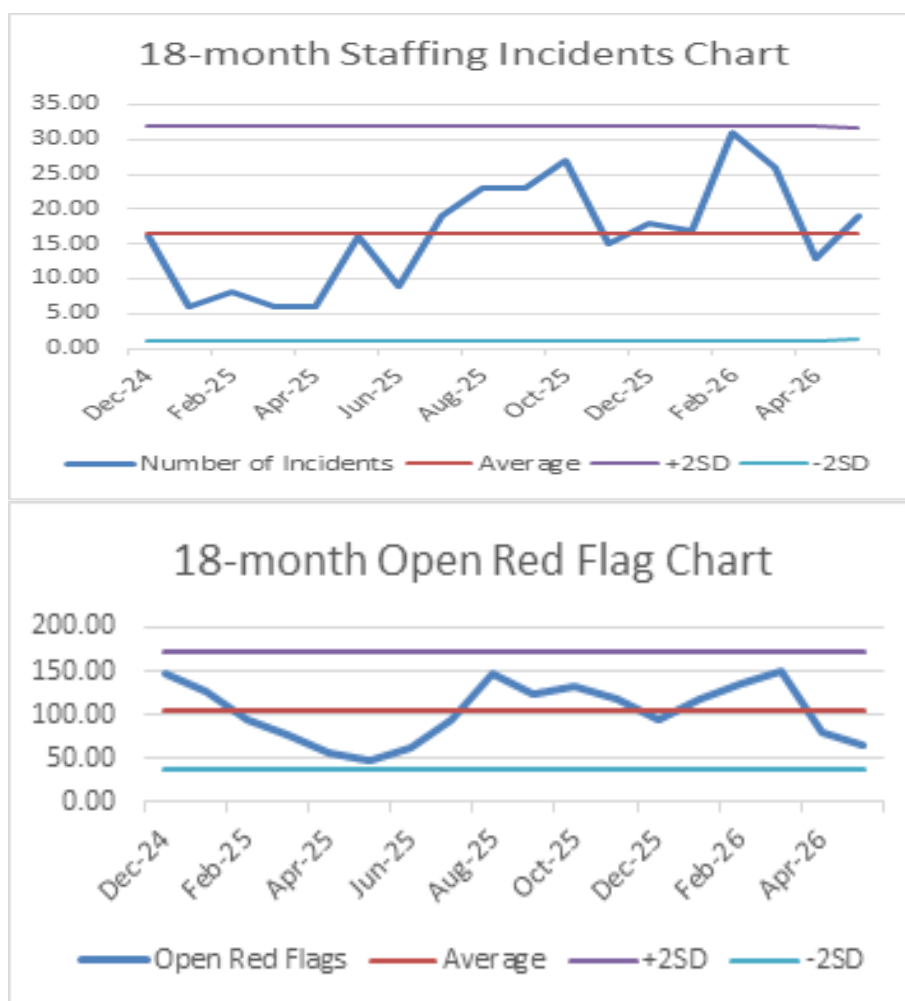
Red flag and incident data is reviewed daily (Monday–Friday) by the senior nursing team, reported through the daily staffing briefing, and presented monthly to the NSCO Group. Red flag events are triangulated with staffing metrics and nurse-sensitive indicators to identify potential risks and inform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

The key points to note:

- Staffing incidents demonstrate continued month-to-month variation, remaining within expected limits, with a recent increase above the 18-month average, primarily driven by unfilled shifts and sickness absence.
- One incident of low-level harm was reported in the last quarter (minor physical injury), involving a high falls risk patient receiving enhanced observation.

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- Open red flag reporting has reduced over the quarter and remains within expected variation; however, elevated reporting in specific areas highlights persistent localised workforce and leadership challenges, which are known and actively managed through the NSCO Group, with targeted support in place to address vacancy, sickness absence and leadership factors.
- There is an increasing proportion of staffing incidents reported from non-inpatient services, indicating a shift in pressure beyond ward-based settings.
- The most common red flags continue to relate to missed intentional rounding and there were no open red flag events of “less than 2 RN” in the last quarter.
- Taken together, incidents and red flags indicate underlying workforce pressures, despite reductions in red flag reporting, reinforcing the need for continued triangulation with staffing metrics through the NSCO Group and nurse staffing review, to inform risk and targeted support.
- A review of incidents occurring during the delivery of Enhanced Therapeutic Observation and Care (ETOC) identified medication incidents, acquired pressure ulcers and patient falls as the most frequently reported patient safety themes; aggression and violence accounted for the majority of non-patient safety incidents. This mirrors the Trust-wide incident profile. Overall incident levels have remained stable throughout the reporting period; however, it is too early to evaluate the impact of the Medicine ETOC pilot, which will be monitored through future reports.



1.4 Care Hours Per Patient Day (CHPPD) data

The CHPPD average of 8.9 over the past 18 months demonstrates stable performance, with variation in expected limits. This suggests overall staffing stability at Trust level. However, CHPPD is not interpreted in isolation and is considered alongside other workforce and quality indicators in line with national staffing guidance. The NSCO Group monitor ward-specific CHPPD every month via the safer staffing dashboard, where CHPPD is evaluated alongside staffing metrics, clinical outcomes and nurse-sensitive indicators, with the appropriate level of support in place.

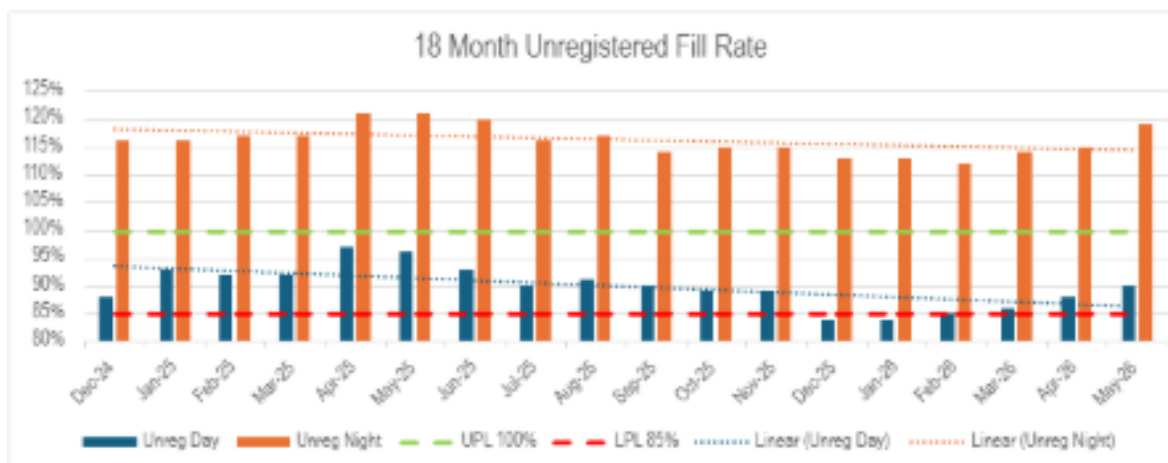
1.5 Planned versus actual hours (fill rates)

The planned and actual staffing hours are converted into percentage “fill rates” which are entered onto the safer staffing dashboard, RAG rated and reviewed monthly by the NSCO Group. RN fill rates <85% are reported to the PPAG or the Quality Committee each month.

Key points to note:

- Registered nurse (RN) fill rates show a sustained downward trend over the 18-month period, although remain above the 85% threshold.
- Over the last quarter, day shift RN fill rates have stabilised at just above 90%, reflecting short-term variation rather than a clear improvement. In contrast, night shift fill rates have remained consistently lower at around 87%.
- The number of wards reporting <85% RN fill rates has increased and remained above average over the last quarter; while still within expected limits, values are approaching the upper control limit, indicating increasing workforce pressure.
- Unregistered fill rates show variable day shift performance alongside sustained overfill on night shifts, aligning with increased RN shortfall overnight and indicating targeted but incomplete mitigation.
- Current RN stability is supported by temporary staffing and increased Healthcare Assistant (HCA) provision, which does not fully mitigate RN shortfall. Further short-term reduction in RN fill rates is anticipated due to vacancy lag due to a delay in new registrants entering the workforce. This is a known and expected pressure point over the next 2-3 months.





1.6 Temporary Staffing

Newcastle Hospitals Staff Bank supply temporary staffing to wards and departments to fill short-term vacancies or absence. Temporary staffing and agency usage reports are distributed to the Senior Corporate Nursing Team and Heads of Nursing each week, providing additional oversight. ETOC hours are monitored monthly through the NHS England (NHSE) Provider Workforce Return to support oversight of demand, workforce utilisation, and quality of care.

The key points to note:

- Registered temporary staffing demand has increased over the past 18-months, with increased bank utilisation meeting much of this demand. Fill rates have remained relatively stable at around 74%.
- Unregistered temporary staffing demand has reduced overall, with fill rates remaining broadly stable at around 83%, despite greater month-to-month variability.
- Agency utilisation has reduced across both the registered and unregistered staffing groups and remains low relative to bank staffing, indicating continued reliance on bank as the primary source of temporary staffing cover.
- The increase in RN/Registered Midwife (RM) temporary staffing requests, alongside declining substantive RN fill rates, increasing wards below 85% fill, and sustained night shift pressures, suggests growing pressure within the registered workforce. This is being partially mitigated through utilisation of bank staffing and continued control of agency usage, while demand for temporary HCA/Maternity Care Assistants (MCA) staffing has reduced over the same period.
- ETOC hours have continued to decrease across both registered and unregistered staff groups, with unregistered ETOC hours reducing by approximately 25% since monitoring commenced. This reflects improvements in education, data quality and rostering accuracy, alongside reduced reliance on temporary staffing to support enhanced observation requirements.
- “ETOC” and “Unregistered agency reduction” Task and Finish Groups continue to provide oversight. A substantive ETOC pilot within Medicine is evaluating the impact of a dedicated workforce model on patient safety, patient experience and workforce outcomes, with learning informing future service development.

1.7 Recruitment and Retention

- The current RN turnover is 4.98%. This demonstrates a continued reduction from the previously reported 5.86 in the same period last year.
- The Healthcare Support Worker (HCSW) turnover rate is currently 6.15% and demonstrates a reduction from approximately 7.7% in the same period last year.
- The current RN vacancy rate is approximately 3.5%, with HCSW vacancy rate higher at 11.1%.
- Both band 3 and Band 5 Recruitment has been taking place 6 weekly from January 2026, alternating between internal and external adverts for Band 5s.
- Final-year nursing students due to graduate in September 2026 were invited to interview during May and June 2026 to enable timely onboarding into appropriate vacancies as they arise. Priority has been given to students who have completed clinical placements at Newcastle Hospitals, supporting both recruitment and retention within the Trust. Successful candidates are held on a reserve list, with vacancies reviewed regularly to align candidates with their preferred areas of employment wherever possible. Regular communication is maintained with candidates throughout the process to ensure engagement and provide updates on available opportunities.

2. FAIRER DEAL FOR NURSING BAND 5 JOB EVALUATION ROLE REVIEW PROGRAMME

Work is underway to deliver the Ministerial commitment declared in February 2026. The commitment included the following:

- Making sure every nurse is in the right band, and reviewing all band 5 nurse job descriptions, with additional funding available to support this review process.
- Making graduate pay a priority as part of ongoing reforms to Agenda for Change staff pay structure.
- Launching a national nursing preceptorship to ensure every nurse has the best start to their career, wherever they work.
- Reviewing the evidence from the review of band 5 nursing roles to determine whether any further action is required.

The commitment relating to Band 5 job description review aims to align current job roles within the Trust to revised national job profiles published in June 2025, and ensure all nurses are being paid correctly for the work they are undertaking. NHSE subsequently wrote to all trusts at the end of June to provide additional guidance which included the following:

- Employer-led review of all Band 5 nursing roles is mandated, with delivery plans due to be submitted by 31 July 2026 with completion of the process by October 2028.

The work is being delivered in partnership with staff side colleagues and is subject to quarterly national reporting. An oversight group has been established and has been meeting regularly to oversee this work. The first national submission has been completed and presented to the People Committee on the 21 July for approval prior to submission. The

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completed document, including an overview of the delivery plan and risk log can be found in the Board Reading Room.

Regular updates will be provided to the People Committee throughout this programme of work.

3. VACCINATION UPDATE

The Staff Vaccination 2026/27 campaign preparation has commenced with workstreams overseen by the Staff Vaccination Steering Group. Confirmation of programme parameters and key workstreams are underway, with a delivery plan submitted to NHSE which can be seen in the Board Reading Room for reference. The proposed model aligns with the successful approach from previous Trust vaccination campaigns.

A regional update has highlighted expectations for vaccine uptake of 60–65%, with confidence that this target is achievable if sufficient workforce capacity is secured. NHSE's focus on addressing vaccine hesitancy is noted, and locally developed resources are in place to support staff engagement. Training remains a key priority, with guidance expected in August 2026. Training sessions have been scheduled across the RVI, Freeman Hospital and Regent Point.

The Trust is expecting delivery of 12,500 flu vaccines from 31 August 2026. There will be no adjuvanted vaccine available this year, removing the need for dedicated clinics for staff aged over 65. Communication planning is progressing, with local adaptation of the regional "Be Wise – Immunise" campaign. Regular Executive updates with digital data reported on the dashboard will be provided throughout the campaign.

4. CARE IN NON-DESIGNATED SPACES (CORRIDOR CARE)

At present, the organisation faces a significant challenge to reduce the number of patients who are receiving care in non-designated clinical areas usually referred to as 'corridor care'. This means patients are waiting or needing to be observed in a corridor in the Emergency Department. Corridor care figures are captured nationally with the Trust reporting some of the highest figures locally and nationally. This is not the level of care we want any of our patients to experience or the environment we want any of our staff to experience working in.

There are a number of factors influencing this position:

- The Emergency Department has one of the smallest footprints per head of population nationally.
- Our emergency admissions and emergency attendances remain on an upward trajectory increasing pressure on the available space.
- There is further work required to validate the data submission nationally to ensure consistency in benchmarking locally and nationally to accurately measure improvement. We know however that this is a significant problem in our hospital.

Despite these challenges it is important that we focus on making tangible improvements to reduce the need for care on a corridor. Focused work is in place with oversight and escalation through to the Trust's Quality Committee. A number of actions are in place, but key developments include:

- Estates work to increase capacity in the Emergency Department now that the Urgent Treatment Centre (UTC) has been opened.
- Introduction of revised clinical pathways to ensure some of our most frail patients are cared for in a more suitable environment.
- Increasing capacity in our urgent community response to reduce the number of patients conveyed to the Emergency Department.
- Staff commitment to ensure that all patients are cared for appropriately, maintaining fundamental clinical and professional standards and maintaining privacy and dignity regardless of where care takes place. Regular audits are underway to measure compliance with this and make changes where necessary.

This work will continue to be closely monitored at a Clinical Board and Board Committee level.

5. RECOMMENDATIONS

The Trust Board is asked to:

- i) Note and discuss the content of this report.
- ii) Note the oversight and reporting of safe staffing which has been prepared in line with national guidance.
- iii) Note the progress of the Band 5 Job Evaluation Role Review Programme.
- iv) Note the progress of the Vaccination Programme.
- v) Note and discuss the alert relating to care delivered in non-designated spaces.

Report of Ian Joy

Executive Director of Nursing, Midwifery and Allied Health Professionals

23 July 2026

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 July 2026		
Title	Perinatal Quality Oversight Report, including Maternity Incentive Scheme update		
Report of	Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals		
Prepared by	Jenna Wall, Director of Midwifery		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight. Alert: - There are no new alerts to note. Advise: - In December 2025, the Integrated Care Board (ICB) published a position statement on medication supply for maternity patients in the community following concerns from primary care colleagues that GP practices are not commissioned to provide prescriptions for maternity related reasons. The Trust infrastructure to support outpatient prescribing for obstetric patients is not in place. This issue has been escalated to the Family Health Clinical Board Quality and Performance Review for discussion, in the interim the service has established a working group to consider solutions. - Following escalation to the Family Health Clinical Board Quality and Performance Review in June the Trust and ICB Executive Directors of Nursing progressed the discussion and the ICB subsequently agreed the amendments to the service specification and additional funding to enable service delivery in July 2026. Work will now continue at pace to operationalise the service during Quarter 3 (Q3) once the final funding allocation is clear. - The completion rate for the Right Time survey has reduced to less than 20%, in response to this a campaign was launched in June 2026 to improve uptake and patient awareness of the opportunities to provide feedback to the service. The impact of this will be evaluated in Q2. - The peri-operative and perinatal leadership team are currently reviewing the deployment of the nursing resource against the obstetric theatre staffing risk; the discussions regarding the deployment of nursing staff will be supported by the Associate Director of Nursing for workforce and the Director of Nursing, and a plan agreed in July 2026. - Benchmarking against the 10-Point Plan is underway and the Trust is committed to learning from the Amos and Ockenden reports to ensure any opportunities for improvement are identified. There are no immediate areas of concern, with each of the 10 points relating to a previous or current improvement workstream.		

	Assure: - The number of inductions of labour delays peaked following the pathway revision following the introduction of cervical ripening balloon catheter in April. This position has stabilised, and the number of delays of over 24 hours have reduced to zero in June 2026. - The Maternity Incentive Scheme is on track to achieve compliance, the required information is included within this report and the Integrated Board Report. - The NHS Race and Health Observatory (RHO) in collaboration with NHS England (NHSE) are rolling out the Perinatal Equity and Anti-Discrimination programme (PEADP) during 2026/27. The Trust has met with the PEADP leadership team as part of the onboarding process and shared the Trust activity currently underway as part of the Perinatal Anti-Racism Taskforce (PART) and were reassured to hear that this work would be considered as part of the new national programme and not superseded.					
Recommendation	The Trust Board is asked to: - Receive and discuss the report. - Note the alert regarding outpatient prescribing infrastructure and the impact on the obstetric service. - Note the progress regarding the commissioning of the Maternal Mental Health Service. - Note the Trust is on track to achieve the Maternity Incentive Scheme requirements. - Note the benchmarking against the 10-Point Plan is underway and there are no immediate areas of concern, with each of the 10 points relating to a previous or current improvement workstream. - Note the inclusion of the Q3&4 Perinatal Workforce paper in the Board Reading Room to satisfy the Developing Workforce Safeguards and Maternity Incentive Scheme requirements. - Note the inclusion of the Q4 Perinatal Mortality Review Tool report in the Reading Room. - Note compliance with the Perinatal Quality Surveillance Model (PQOM).					
Links to Strategic Priorities	Advancing care - Improving patient care, effectiveness and quality through innovation, research, improvement and education					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	Principal Risk - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients. Threat - Failure to improve the safety and quality of patient and staff experience in Maternity Services.					
Reports previously considered by	Previous reports have been presented to the Trust Board, Maternity Update, Midwifery staffing paper.					

PERINATAL QUALITY OVERSIGHT REPORT

1. INTRODUCTION

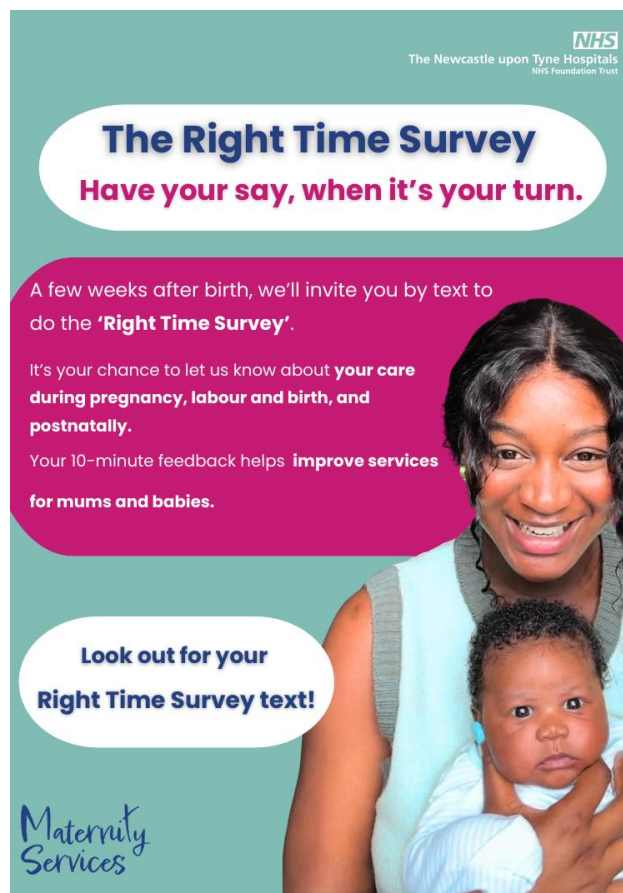
This report provides the Trust Board with an overview of the Maternity Service compliance with the Perinatal Quality Oversight Model (PQOM), based on the locally and nationally agreed measures to monitor maternity and neonatal safety.

The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional perinatal services team. The report outlines the Trusts current self-assessed position against the Year 8 Maternity Incentive Scheme Safety Actions and any escalations.

2. LISTENING TO WOMEN AND FAMILIES THROUGH SERVICE USER FEEDBACK

The Trust continues to triangulate patient experience received through via various mechanisms which are reported to the Perinatal Engagement and Inclusion Group (PEIG).

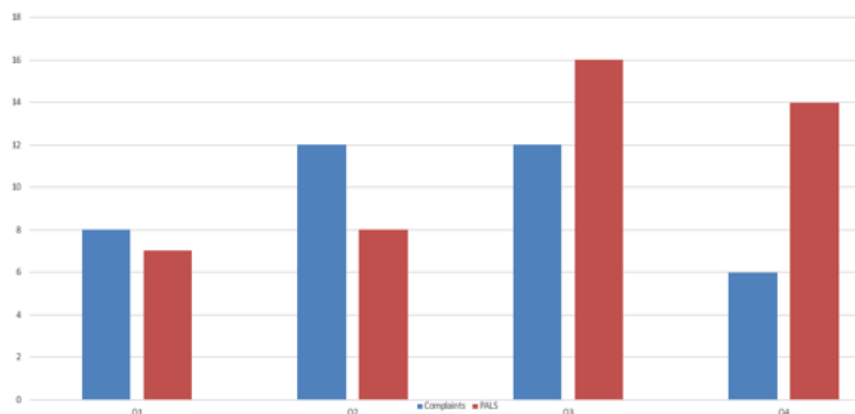
As reported previously, the completion rate for the Right Time survey has reduced to less than 20%, in response to this a campaign was launched in June 2026 to improve uptake and patient awareness of the opportunities to provide feedback to the service. The impact of this will be evaluated in Q2. The Trust continues to explore with the Patient Experience Team the ability to report patient experience by ethnic group and language.



The PEIG has recently completed a triangulation of Q4 data from complaints, Patient Advice and Liaison Service (PALS) contacts and the birth reflections service.

In Quarter 4 2025/26 14 PALS contacts were received, 3 of which were to celebrate the care provided, and 11 to provide improvement feedback, in addition there were 5 formal complaints and 1 informal complaint.

PALS and complaints - 2025/26 summary



Communication regarding care planning remains the overarching theme across the perinatal services. PALS feedback has been received by patients regarding the cancellation of ultrasound appointments as their child was present, in response to this the service has introduced a 'Children at Obstetric Ultrasound' standard operating procedure (SOP) to ensure information is shared during pregnancy and the expectations are understood by staff and service users in advance of appointments.

The patient stories associated with the complaints and compliments have been shared widely across the perinatal services and used to inform the educational and development programme.

Issues continue to be highlighted regarding the quality and accessibility of the interpreting services via InPhase reports and so an audit of compliance with the Interpreting SOP is currently underway; the results of this will be shared with the Trust Experience of Care Group to inform Trust wide improvements.

As reported previously the Trust was concerned it did not have an agreed service specification and adequate funding from the ICB to enable delivery of the Maternal Mental Health Service. Following escalation to the Family Health Clinical Board Quality and Performance Review in June the Trust and ICB Executive Directors of Nursing progressed the discussion and the ICB subsequently agreed the amendments to the service specification and additional funding to enable service delivery in July 2026. Work will now continue at pace to operationalise the service during Q3 once the final funding allocation is clear.

3. WORKFORCE

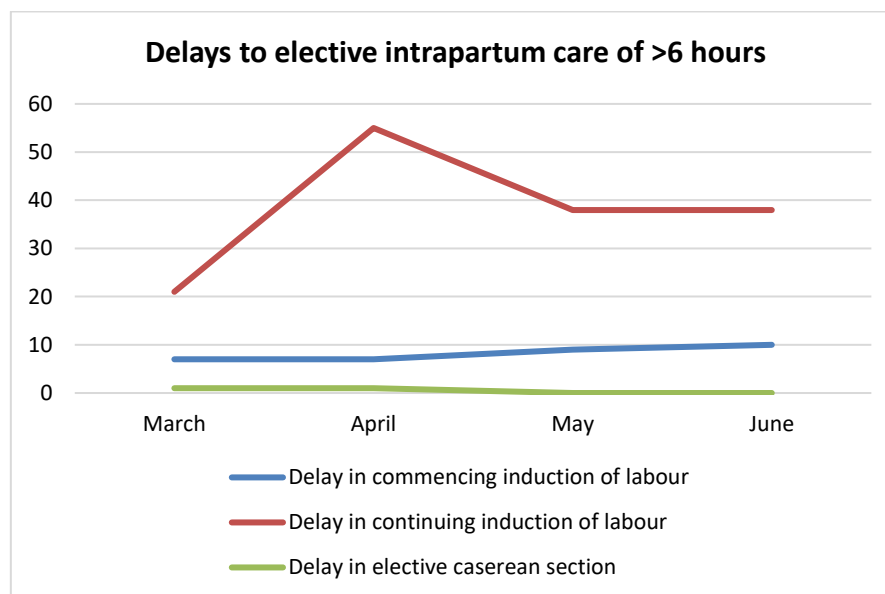
3.1 Midwifery and nursing workforce

An overview of midwifery staffing fill rates against Birthrate Plus is included within the Integrated Board Report, which also details the red flags recorded monthly and the Operational Pressures Escalation Level (OPEL) status of the service. The Trust is reporting fill rate against Birthrate Plus, whilst acknowledging this will not operationally be delivered until October 2026. The fill rates continues to be impacted by the high rates of maternity leave, close operational monitoring and management of skill mix and red flags continues with senior oversight.

The intrapartum midwifery team continues to support the peri-operative obstetric theatre scrub team, with core team midwives required to scrub in the second theatre out of hours and at weekends, reducing the number of midwives available to provide intrapartum care, which also contributes to the delays in induction of labour (IOL).

The peri-operative and perinatal leadership team are currently reviewing the deployment of the nursing resource against the current risk; the discussions regarding the deployment of nursing staff will be supported by the Associate Director of Nursing for workforce and the Director of Nursing, and a plan agreed in July 2026.

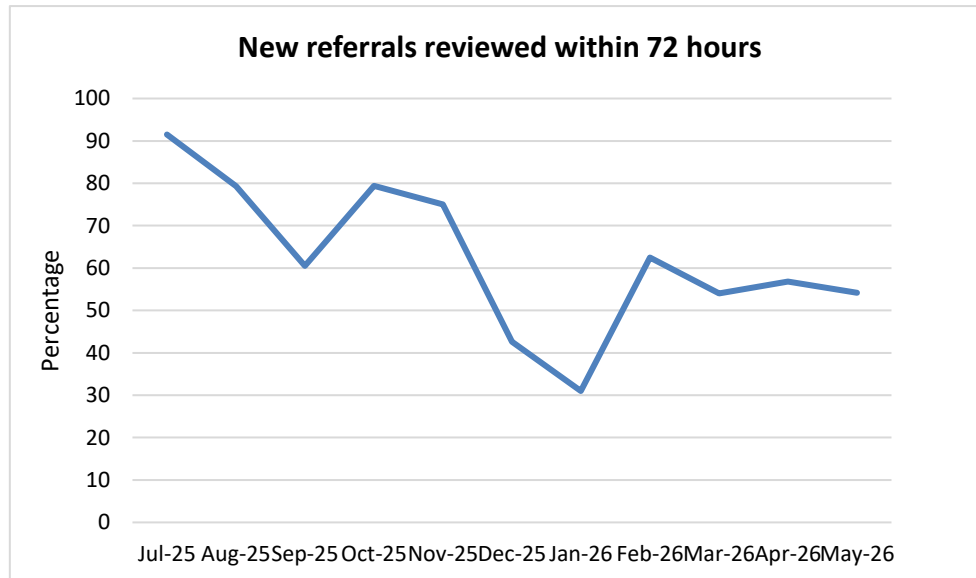
As reported last month the number of inductions of labour delays peaked following the pathway revision following the introduction of cervical ripening balloon catheter in April. This position has stabilised, and the number of delays of over 24 hours have reduced to zero in June 2026.



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

3.2 Medical workforce

The Fetal Medicine service remains fragile, but stable, with daily consultant triage and clinical prioritisation of referrals. Further work is ongoing to develop the regional escalation processes if urgent referrals cannot be accommodated. NENC Connect deployment in August 2026 will support the referral processes and oversight of activity to ensure timely escalations. The improvement action plan is making satisfactory progress. There have been no patient safety concerns associated with the current performance.



The Trust remains compliant with the Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1 with a duty anaesthetist immediately available for the obstetric unit 24 hours a day with an on call consultant anaesthetist available at all times. There were no rota gaps in June.

The Trust is compliant with the British Association of Perinatal Medicine (BAPM) guidance for neonatal medical staffing; there are no current vacancies.

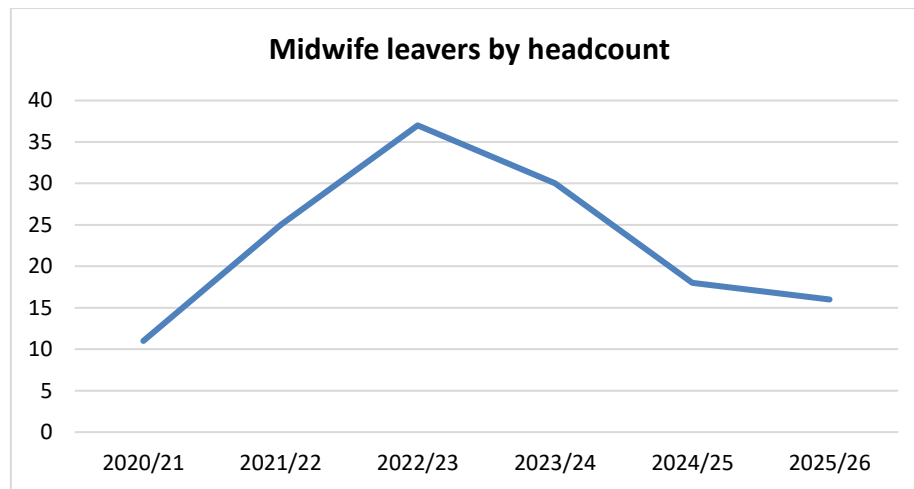
The detailed Perinatal Workforce Q3&4 paper is included within the Board Reading Room to satisfy the Developing Workforce Safeguards and the requirements of the Maternity Incentive Scheme.

4. CULTURE OF LEARNING, SAFETY AND SUPPORT

4.1 Midwifery turnover

The perinatal service has completed a review of all midwifery 'leavers' during 2025/26 to understand the drivers for this, and any opportunities for improvement. There has been a steady reduction in the midwifery turnover in the last 2 years, which is currently 6%. The four reasons for leaving in 2025/26 were cited as work/life balance, retirement, ill health, and relocation.

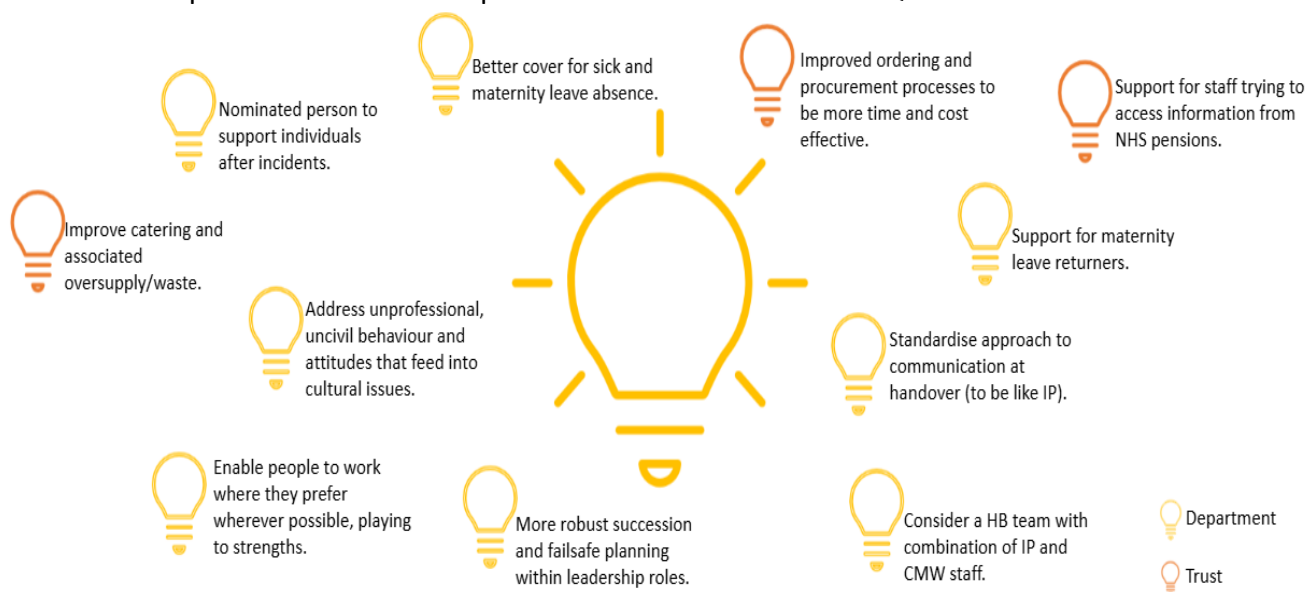
- 15 were offered and 12 accepted an exit interview (60% up from 28% last year).
- Of the 12 leavers to complete exit interviews, 10 had been offered a 'stay' conversation.



The thematic review into the midwifery leavers data provides an understanding of the drivers and insights into opportunities for improvement.

	Yes	No		Yes	No
Able to deliver care I aspire to	50%	50%	Satisfactory pay	58%	42%
Able to make suggestions	67%	33%	Receive recognition for your work	50%	50%
Clear work responsibilities	83%	17%	Staff Benefits/Staff Social club	67%	33%
Development opportunities	83%	17%	Regular, effective communication within the department	25%	75%
Empowered to make a difference	50%	50%	Regular, effective communication within the Trust	42%	58%
Positive working environment	50%	50%	Supportive team/colleagues	92%	8%
Gaining qualifications	58%	42%	Supportive direct manager	50%	50%
Involved in deciding on changes	42%	58%	Supportive senior leadership	50%	50%
Making a difference to patients	75%	25%	Trusted to do my job	83%	17%
Opportunities for flexible working	67%	33%	Valued within my team	92%	8%
Opportunities to show initiative	67%	33%	Valued by the Trust	42%	58%
Opportunities to use your skills	92%	8%	Valued within my department	75%	25%
Satisfactory working hours	67%	33%			

The improvement ideas have been incorporated into the broader Perinatal Staff Wellbeing and Culture Improvement and the impact and themes monitored in Q1.



Key:

- CMW = Community midwife
- IP = Intrapartum
- HB = Home birth

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

5.1 **Maternity Incentive Scheme Year 8**

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

The Q4 Perinatal Mortality Review Tool (PMRT) report is included in the Board Reading Room, updated Maternity (Perinatal) Incentive Scheme (MIS) Year 8 standards place emphasis on triangulation of reviews with wider safety intelligence, aiming for early identification of themes and meaningful family involvement, hence the learning from PMRT reviews will be incorporated into the Perinatal Quality Oversight Report on a quarterly basis and therefore this is the last standalone PMRT update.

There are no escalations and the scheme is on track to achieve compliance, the required information is included within the Perinatal Quality Surveillance report and Integrated Board Report.

5.2 **Outpatient prescribing**

In December 2025, the ICB published a position statement on medication supply for maternity patients in community, this was produced by the ICB Medicines Safety Portfolio Group following concerns from primary care colleagues that GP practices are not commissioned to provide prescriptions for maternity related reasons. The rationale for this is that the cost of all maternity related healthcare activities for pregnant women are included in the maternity pathway payments.

Whilst the Trust agree with the rationale for change, the Trust infrastructure to support outpatient prescribing for obstetric patients is not in place, additional prescribing pharmacist capacity and a SystmOne build would be required and even with this in place there would be a significant impact on obstetric and midwifery staffing resource. This issue has been escalated to the Family Health Clinical Board Quality and Performance View for discussion, in the interim the service has established a working group to consider solutions.

6. NATIONAL UPDATES

6.1 Nottingham and national review

The publication of the Ockenden review into the maternity services at Nottingham University Hospitals NHS Trust on 24 June 2026 followed by Baroness Amos' independent investigation into maternity and neonatal services in England on 30 June 2026, detailing the failings and harm experienced by women, babies and families in maternity units across the UK makes for harrowing reading and has understandably increased scrutiny of services and the assurance required to satisfy the perinatal quality oversight requirements of Trust Boards and system partners.

In response to the publication of both reports the national maternity team have produced a 10-Point Plan for maternity and neonatal services taking elements from Baroness Amos' national investigation and the most recent Ockenden review and have asked every Trust to respond to the actions within this plan. The broader recommendations within both reports will then be considered by the National Maternity and Neonatal Taskforce and it is expected a national improvement plan will then follow.

Benchmarking against the 10-Point Plan is underway and the Trust is committed to learning from these reports to ensure any opportunities for improvement are identified. There are no immediate areas of concern, with each of the 10 points relating to a previous or current improvement workstream.

To support staff wellbeing 6 listening sessions have been scheduled throughout July to hear from staff and ensure there is a shared understanding of the findings of the reports, and the expectations for the Trust, as well as support wellbeing and signpost to colleagues and services.

6.2 Perinatal Equity and Anti-Discrimination Programme (PEADP)

The NHS Race and Health Observatory (RHO) in collaboration with NHSE are rolling out the Perinatal Equity and Anti-Discrimination programme (PEADP) during 2026/27 in response to

the Amos and Ockenden reports; a new programme to challenge racism and discrimination faced by mothers, babies, and staff in perinatal services. The Trust has met with the PEADP leadership team as part of the onboarding process and shared the Trust activity currently underway as part of the Perinatal Anti-Racism Taskforce (PART) and was reassured to hear that this work would be considered as part of the new national programme and not superseded. The Trust welcome the national programme and remain committed to addressing ethnic inequalities.

7. CONCLUSION

The Trust Board are provided with an update on the main quality and safety considerations of the perinatal service, demonstrating the Trusts compliance with the Perinatal Quality Oversight Model. The perinatal service continues to balance the national requirements such as the Maternity Incentive Scheme alongside the dynamic operational challenges and ever increasing national programmes in response to recent publications.

The perinatal leadership team will complete a considered benchmarking against the 10-Point Plan and collaborate with the Executive Team and Safety Champions to agree any additional actions required in response to this. In the interim the Trust will continue to track the existing comprehensive action plans with established oversight and reporting mechanisms.

7. RECOMMENDATIONS

The Trust Board is asked to:

- i. Receive and discuss the report.
- ii. Note the alert regarding outpatient prescribing infrastructure and the impact on the obstetric service.
- iii. Note the progress regarding the commissioning of the Maternal Mental Health Service.
- iv. Note the Trust is on track to achieve the Maternity Incentive Scheme requirements.
- v. Note the benchmarking against the 10-Point Plan is underway and there are no immediate areas of concern, with each of the 10 points relating to a previous or current improvement workstream.
- vi. Note the inclusion of the Q3&4 Perinatal Workforce paper in the Board Reading Room to satisfy the Developing Workforce Safeguards and Maternity Incentive Scheme requirements.
- vii. Note the inclusion of the Q4 Perinatal Mortality Review Tool report in the Board Reading Room.
- viii. Note compliance with the Perinatal Quality Surveillance Model (PQOM).

Report of Ian Joy
Executive Director of Nursing
10 July 2026

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 July 2026					
Title	Maternity Safety Champion Report					
Report of	Liz Bromley, Non-Executive Director (NED) and Trust Maternity Safety Champion					
Prepared by	Liz Bromley, NED and Trust Maternity Safety Champion					
Status of Report	Public	Private			Internal	
	☒	☐			☐	
Purpose of Report	For Decision	For Assurance			For Information	
	☐	☒			☒	
Summary	This report summarises feedback from the Maternity Safety Champion since the last report shared at the January 2026 Trust Board meeting.					
Recommendation	The Trust Board is asked to receive the report and consider/discuss the content.					
Links to Strategic Objectives	Joining up care		Advancing care		Supporting great care	
	☒		☒		☐	
Impact (Please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐
Link to Board Assurance Framework (BAF)	1.1 Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.					
Reports previously considered by	Last report presented at the Public Board meeting on 30 January 2026.					

MATERNITY SAFETY CHAMPION REPORT – JUNE 2026

I had a good visit to the Royal Victoria Infirmary (RVI) in June and was able to spend time with some members of management, and with members of staff.

My report reflects the views of the individual colleagues that I spoke to during the visit.

I visited the ante natal department where I met a new colleague who has been made to feel very welcome in their new role, with a very approachable Senior Leadership Team (SLT) and a set of very engaged consultants. I learned how stretched the team has been as a result of a lack of a senior midwife for some 12 months, despite having great leaders. People are working very hard but have missed that support, and would like some professional TLC (Tender Loving Care). I was told that the level of resource is not bad at all but there is a desire for change, with colleagues coming up with great ideas that need to be heard and acted upon as appropriate. Simple things like the addition of a fridge in the staff room can make a great difference in how people feel.

Yet again I have heard about the need for an electronic record system that is integrated across NHS services and gives accurate information to the user, and only requires the patient to share their information once. Paper processes need to be high on the risk register as they create so many points of failure and room for human error.

Separately I heard about the challenges presented by staff requiring more training to use e-record correctly, and the consequences for storing expressed breast milk, as an example, without a tracking system leading to errors. There has also been an issue (quickly resolved) with the signing off of weekend letters, and we discussed the impact that such errors can have.

Similarly, I heard about the challenges of finding appropriate interpretation services for patients. I was told that the situation in London hospitals is as bad, if not worse. There are however other hospital practices which are very sound and could be introduced to Newcastle Hospitals quite easily by new staff coming from other trusts. During a conversation I was having with one member of staff, we were approached by a colleague who was having terrible trouble finding a Kurdish interpreter for a woman who had the option of her husband or brother in law translating for her in the absence of a translator. This is not good for patient safety, or female dignity, but is a legitimate challenge for which there are no easy answers. A female translation service would be a wonderful asset and we discussed whether there might be an option for college based English for Speakers of Other Languages (ESOL) services to develop short courses in interpretation for females with a specific focus on medical interpretation.

I was given some perceptions about the diversity of the training materials at Trust level induction (i.e. not departmental induction which is delivered by colleagues providing appropriate representation),. There is ongoing concern that the staff base does not reflect the patient demographic, but also a recognition that this is the same in London which has a much broader population base to find staff. It was suggested that interview panels which are

Agenda item A2(g)(ii)

non-white might make a difference, this is being progressed by the Perinatal Anti-Racism Taskforce.

I met a transitional care nurse who complimented the changes to ward 32, giving more space and a feeding room for new mothers. I heard of the risk of ward 34 (with just 11 beds) creating some outliers for post-natal care, which may need to be managed. The care provided is better than the previous set up though.

Colleagues would appreciate more input to planning for days and nights as there is a feeling that there are not enough transitional care cover when people go off sick. A change in shift times would offer 24/7 (24 hours a day, seven days a week) specialist cover, which would be a real improvement to patient safety, this is currently being modelled by the leadership team to understand how the service can achieve British Association of Perinatal Medicine (BAPM) ratios. On the Transitional Care Ward consistently very positive comments were made in relation to a very supportive and professional Matron.

Staff do not enjoy getting caught up in 'politics' and the feeling can create low morale which should be watched for by management. I heard some comments about over-delegation and colleagues who could do more to help hands-on when the service is very busy. I have heard again how useful it could be if Healthcare Assistants (HCAs) could be trained up to give additional support to the midwives, this training is planned for July and August, and how invaluable nursery nurses are to the service.

I also had a very interesting discussion about the role of the neo-natal nurse practitioner and how helpful this could be to stretched doctors. There was discussion about the option of an outreach service in which post-natal nurse practitioners could review babies and refer them up when required. They could cover off bloods and canulation and help out on the delivery and birthing suites. I am always impressed by the good ideas that come from discussions with staff on the wards.

I heard some very positive feedback about the work of Tiny Lives, and the work they do with classes for families and building up a support network for parents.

I met with Jenna Wall, Director of Midwifery, for a catch up and heard about the welcome progress on Estates work and was reassured that changes to the Maternity Assessment Unit (MAU) service are listed as a priority which will be very welcome to the team. I heard about an internal promotion to Matron to cover sick leave, and was assured that the leadership is stable. Staff who have been off sick have been welcomed back to the team. There are still more than 18 midwives on maternity leave at the moment.

The changes to Ward 40 have improved the patient experience for those parents who don't have their first choice of service due to the Estates work ongoing.

One colleague with whom I spoke loved the idea of having the opportunity to visit other hospitals as an informal continuing professional development (CPD) opportunity – I would like to see this being considered as an option, not least as we have the Alliance structures which could offer these opportunities.

Over my time as Maternity Safety Champion I have been encouraged as to how the level of discussion has changed, people are not making general statements about concerns or cultural issues any more. The things that they raise are specific and always pointing in the direction of future improvements, showing how the workforce is getting a little more space to think and reflect on improving practice and processes for greater patient safety and staff support and development.

Suggested actions:

1. Ongoing review of electronic patient record system, focusing on, in particular, a single source of information, and better joining up between neo and post-natal systems.
2. Review of the signing of weekend discharge letters for new babies going into care.
3. Consider development of short course to encourage females studying ESOL to become female interpreters for maternity services.
4. Look at EDI / anti-racism trainers and training materials.
5. Consider how we deal with claims of racist behaviour to ensure a fair process.
6. Encourage the sharing of ideas from the floor to improve process and practice, e.g. transitional care cover planning.
7. Consider CPD for nurse practitioner development, and for HCAs, also whether visiting other hospitals in the Alliance would be a good way of providing informal CPD.

The actions above will be shared with the Clinical Board Quadrumvirate for consideration and discussion through the Maternity Safety Champions Meeting.

Report of

Liz Bromley, Maternity Safety Champion and Senior Independent Director (SID)

June 2026

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 July 2026		
Title	Actions arising from the Lord Mann Review on antisemitism and other forms of racism in the NHS		
Report of	Caroline Docking, Executive Lead for Equality, Diversity and Inclusion (EDI)		
Prepared by	Caroline Docking		
Status of Report	Public ☐	Private ☐	Internal ☒
Purpose of Report	For Decision ☒	For Assurance ☐	For Information ☐
Summary	The Lord Mann Review was published in June 2026 and highlights the ongoing responsibility of NHS organisations to tackle racism, antisemitism, Islamophobia and all forms of discrimination. This was followed by a letter setting out the response from NHS England, and identifying immediate actions that provider organisations are asked to take. Newcastle Hospitals welcomes the review and strongly supports the ambition to create a culture where every colleague, patient and community member is treated with kindness and respect. Through our work to develop and adopt an Anti-racism framework, the trust has already made a public commitment to Anti-racism and while there is significant work to undertake, we are well positioned to understand and quickly adopt these recommendations. This paper includes a position statement against each of the requirements. The Board is asked to note the actions already underway and endorse a small number of further actions to ensure full alignment with the recommendations. The appendices referenced have been added to the Board Reading Room on AdminControl.		
Recommendation	The Board is asked to 1. Note the publication of the Lord Mann Review and the actions requested of NHS organisations which are in line with our current approach. 2. Approve the formal adoption of the NHS Race and Health Observatory Seven Anti-Racism Principles. 3. Support the approach of aligning with the Government definition of anti-Muslim hostility; and the IHRA definition of antisemitism alongside further work to ensure that our policies and practices appropriately reflect our approach to equally address discrimination of all forms. 4. Support Board level training as this becomes available. 5. Continue to support our Anti racism approach and ongoing work, including with the North East Anti-racism coalition. 6. Support the review of the trusts EDI Improvement Plan to incorporate newly published requirements arising from this and other national publications.		

Agenda item A4(a)

Link to Strategic Priorities	Joining up care		Advancing care		Supporting great care	
	☐		☐		☒	
Impact	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☒	☐
Link to Board Assurance Framework [BAF]	People and patient care related risks.					
Reports previously considered by	New report.					

ACTIONS ARISING FROM THE LORD MANN REVIEW ON ANTISEMITISM AND OTHER FORMS OF RACISM IN THE NHS

Introduction

The [Lord Mann Review](#) was published in June 2026 and highlights the ongoing responsibility of NHS organisations to tackle racism, antisemitism, Islamophobia and all forms of discrimination. This was followed by a letter (Appendix 1) setting out the response from NHS England, and identifying immediate actions that provider organisations are asked to take. This reminds us that:

‘Antisemitism and all forms of racism have no place in the NHS. Patients should never feel anxious when receiving care and no member of staff should ever feel isolated, intimidated or unwelcome in their workplace. The Lord Mann review gives us the opportunity to raise our standards and expectations about what we will accept and put our professional values, care, compassion and clinical excellence first. It is part of every leader’s role to actively begin to dismantle the structural discrimination which exists’.

Newcastle Hospitals welcomes the review and strongly supports the ambition to create a culture where every colleague, patient and community member is treated with kindness and respect.

Through our work to develop and adopt an Anti-racism framework, the trust has already made a public commitment to Anti-racism and while there is significant work to undertake, we are well positioned to understand and quickly adopt these recommendations. This paper includes a position statement against each of the requirements.

The Board is asked to note the actions already underway and endorse a small number of further actions to ensure full alignment with the recommendations.

Recommended response against each requirement

1. Adopt the NHS Race and Health Observatory Seven Anti-Racism Principles (included in Appendix 2)

Our Anti-Racism Framework already reflects these principles through its focus on leadership accountability, inclusive culture, listening to and learning from lived experience, addressing structural racism, tackling inequalities in patient and colleague outcomes, and transparent reporting and improvement.

Recommendation

The Board is asked to formally adopt the Anti-Racism Principles as part of our framework. We will then ensure that we map existing commitments against each principle and include them in our refreshed EDI improvement plan. We will provide annual assurance to the People Committee and the Board about progress.

2. Ensure implementation of the Violence Prevention and Reduction Standard

The Trust has a violence and aggression strategy, working group and reporting systems through InPhase, and People Committee has been updated on progress. However, this remains a significant issue within society and the racial dimension of abuse of staff by patients and the public requires further visibility and action. This is currently being reviewed by the executive leads Paul Hanson, Director of Estates, Facilities and Strategic Partnerships, and Rachel Carter, Director of Quality and Safety, with the immediate priorities being:

- Ensuring our policy is reflective of new guidance and applies to all staff groups (previously this has made less reference to community teams).
- Ensuring we are consistent in applying risk assessments when required.
- Reviewing the governance around reducing violence and aggression.

3. Prepare to implement the NHS Staff Standards

The NHS staff standards were published by the Department of Health and Social Care on 6th July 2026 and further information is expected. Work is underway to consider the implementation requirements, led by the People Team, and a further update will be provided to People Committee in due course. There is a specific Staff Standard on ‘tackling racism’ which includes 9 specific requirements for organisations.

4. Adopt the new Government definition of Anti-Muslim Hostility and the IHRA definition of antisemitism hostility and confirm this to NHS England by 31st July (Appendix 3)

The IHRA definition of antisemitism is: ‘Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities.’ The full text including illustrative examples is included in the reading room.

The governments definition of anti-Muslim hostility is: ‘Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts – including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance. It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance, and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals. It is engaging in unlawful discrimination where the relevant conduct – including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life.’

There is a requirement to report our position by 31st July.

Recommendation

Following discussion at People Committee and the EDI steering group, the Board is asked to support the approach of aligning with these definitions and reviewing our relevant policies to ensure that all types of discrimination are considered with equal weight.

5. Ensure all staff have completed the NHS Core Skills Framework module on Equality, Diversity and Human Rights (EDHR), which includes content on antisemitism and Islamophobia.

The Trust already requires this as mandatory EDI learning. Performance is reported to Board as part of the Integrated Board Report.

6. Ensure all staff complete the new bitesize module co-created with faith leaders in the NHS when it becomes available (with the exception of those who have completed EDHR mandatory training in the last 6 months).

This will be considered as soon as the training is available.

7. Ensure Board agreement to undertake new anti-racism training when it becomes available.

Board members are asked to confirm their intention to take part in anti-racism training when it becomes available. Note: we are already in discussion with 'Show racism the red card' through our anti racism framework to consider appropriate training for senior colleagues.

8. Ensure colleagues, staff representatives, patients and communities are aware of your actions through your internal and external communications channels and are appropriately engaged in further developments to address antisemitism and all forms of racism locally.

Anti racism work has been a feature of our communications this year, and is embedded within our strategy. Our Anti racism taskforce and Race Equality network have shaped and supported our internal communications campaign and accompanying information, and there has been strong messaging from the interim Chief Executive (and Executive Team) through the roadshows and Chief executive Officer (CEO) messages. This has included practical advice about how to address racism in the workplace as well as guidance from professional bodies. We will continue to prioritise and develop this through our existing anti racism taskforce.

Work is also underway with local expert organisations to support our progress including arranging high profile events to support black history month (October) and through joining the 'Become the Bridge' campaign of the North East Anti racism coalition.

Recommendation

The Board is asked to support this ongoing work.

9. Ensure your Board and its relevant committees fully understand your staff survey data on the experience of racism in your organisation and are taking appropriate action on key problem areas related to this issue and monitoring progress.

The experience of global majority colleagues has been a focus of Board development sessions and formal Board reporting over the past 18 months including the Workforce Race Equality Standards and Staff Survey results. Changes to our People Services provide an

opportunity to consider how we report data, actions and improvements to colleague experience to ensure this is meaningful and leads to sustained improvement.

Additional points

Since the publication of the Mann Review, the Amos Report into maternity and neonatal services has been published. This also includes requirement for NHS board and organisations in relation to racism and inequalities for maternity services.

Given this, the requirements of the staff standards, the changes to our People Services and the developments achieved in the last 12 – 18 months as part of our culture change, it is proposed that we fully review our EDI Improvement Plan with reporting to the People Programme Board and People Committee, so that we can capture progress so far, and agree our next priority actions.

Recommendations

1. Note the publication of the Lord Mann Review and the actions requested of NHS organisations which are in line with our current approach.
2. Approve the formal adoption of the NHS Race and Health Observatory Seven Anti-Racism Principles.
3. Support the approach of aligning with the Government definition of anti-Muslim hostility; and the IHRA definition of antisemitism alongside further work to ensure that our policies and practices appropriately reflect our approach to equally address discrimination of all forms.
4. Support Board level training as this becomes available.
5. Continue to support our Anti racism approach and ongoing work, including with the North East Anti-racism coalition.
6. Support the review of the trusts EDI Improvement Plan to incorporate newly published requirements arising from this and other national publications.

Caroline Docking**Director of Communications and Corporate Affairs and Executive Lead for EDI****16 July 2026**

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

BOARD OF DIRECTORS

Date of meeting	31 July 2026		
Title	Climate Emergency Plan 2026-2031		
Report of	Vicky McFarlane Reid, Executive Lead for Sustainability		
Prepared by	James Dixon, Associate Director – Environmental Sustainability		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☐
Summary	The draft Climate Emergency Plan 2026–2031 sets out the next phase of the Trust’s response to the climate emergency, aligned to the Trust Strategy 2026–2031 and NHS Net Zero targets. The Plan builds on the foundations established through the previous Climate Emergency Strategy (2020–2025), during which the Trust made measurable progress in reducing emissions, improving air quality, reducing waste and embedding sustainability across key areas of delivery. However, as outlined in the Introduction, the pace and scale of transformation required to meet the original target of a 90% reduction in controllable emissions by 2030 has not been achievable within current operational, financial and system constraints. The Plan is therefore explicit in setting a revised and more deliverable target of a 50% reduction in controllable emissions by 2031, maintaining ambition while aligning to what can be achieved through sustained organisational and system-wide change. This represents a key decision for Board approval. The Plan positions sustainability as integral to delivering high-quality care and sets out a shift from foundations to transformation, embedding sustainability into clinical care, estates, procurement, workforce behaviours and decision-making through the Trust’s Shine (Sustainable Healthcare in Newcastle) programme. Key risks include: • Infrastructure constraints and capital investment requirements to decarbonise the estate. • Increasing demand for care driving resource use and emissions. • Dependence on wider system partners and national policy for supply chain and infrastructure change. These risks are mitigated through strengthened governance, alignment with the Trust Strategy and Estates Plan, and partnership working at local, regional, national and international levels. Financial implications include the requirement for continued capital investment (e.g. estate energy efficiency and decarbonisation programmes) and revenue support for delivery capacity, alongside opportunities for cost savings through improved efficiency and reduced waste.		

Agenda item A4(b)

	There are no adverse quality or safety impacts identified; on the contrary, the Plan supports improved patient outcomes, reduced health inequalities, operational resilience and service efficiency.					
Recommendation	Trust Board of Directors is recommended to: i) Receive and discuss the Climate Emergency Plan 2026-2031. ii) Approve for publication, subject to any suggested amendments.					
Link to Strategic Priorities	Joining up care		Advancing care		Supporting great care	
	☐		☐		☒	
Impact	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☐	☒
Link to Board Assurance Framework [BAF]	InPhase Risk Register #950 – Climate Emergency, Trustwide risk, rated 20.					
Reports previously considered by	New five-year Climate Emergency Plan, following on from the previous Board-approved Climate Emergency Strategy. Draft has been discussed at Sustainable Healthcare Committee (21 May 2026) then at Private Board of Directors (25 June 2026) and is now presented to Board for discussion/final approval.					

CLIMATE EMERGENCY PLAN 2026-2031

1. INTRODUCTION

1.1 Context and Purpose

The draft Climate Emergency Plan 2026–2031 sets out how the Trust will deliver the next phase of its response to the health emergency that is the climate emergency, aligned to the Trust Strategy 2026–2031 and national NHS commitments on Net Zero.

Since declaring a climate emergency in 2019, the Trust has taken a proactive and consistent approach to embedding sustainability within its core activities. The previous Climate Emergency Strategy (2020–2025) established ambitious targets aligned with the Paris Agreement and a science-based carbon budget.

Significant progress has been made, including reductions in carbon emissions, improvements in air quality, strengthened governance arrangements and widespread staff engagement through the Shine programme. However, as highlighted in the Plan, delivery of the original target — a 90% reduction in controllable emissions by 2030 — has proven more challenging than anticipated.

1.2 Learning and Revised Ambition

The Plan is explicit about the lessons learned over the past five years. These include:

- The scale and complexity of transforming healthcare delivery models.
- The impact of increasing demand, ageing infrastructure and financial pressures.
- The extent to which emissions are embedded in system-wide factors beyond the direct control of the Trust.

In response, the Plan sets a revised targets for our long term goals:

- **Zero Carbon Care** - we have retained the target of achieving Net Zero Carbon by 2040 for all emissions (our Carbon Footprint Plus) but have revised our target for our controllable emissions from Net Zero Carbon by 2030 (a reduction of 90% from our 2019/20 baseline) to a 50% reduction in these emissions by 2031. Whilst still ambitious, this represents a more deliverable trajectory while maintaining alignment with long-term Net Zero ambitions (net zero carbon by 2040).
- **Clean Air** – both targets are similar to those in our original strategy, but the wording has been refined for clarity. Our previous 2030 target of ‘operational transport activities generate no harmful air pollution’ was intended to support our transition to zero tailpipe emission vehicles but even these vehicles generate harmful air pollution from their brake dust and tyre wear. The new 2040 target now emphasises a reduction in air pollution achieved through a transition to active or sustainable travel to our sites.
- **Zero Waste** – we have retained the 2040 target, but with more concise wording. The original 2030 target of reusing and repairing everything that can be reused or

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repaired proved too difficult to monitor and record progress. Whilst reuse remains a key priority in our Waste & Resources Shine workstream, we have proposed a new 2031 target to focus on overall waste reduction (which will be achieved by buying less, buying better and increasing reuse where clinically feasible).

1.3 **Strategic Approach**

The Plan supports delivery of the Trust Strategy, positions sustainability as integral to delivering high-quality care and outlines a shift:

- From individual initiatives to whole-system transformation.
- From ambition to delivery and accountability.
- From isolated projects to embedded organisational practice.

Delivery is structured through our Shine (Sustainable Healthcare in Newcastle) programme across eight priority action areas (People, Care, Energy & Water, Journeys, Waste & Resources, Procurement, Buildings, Biodiversity). Each includes an action plan that highlights why it is important (including alignment with the NHS 10-year plan and NHS England Green Plan guidance), what we want to achieve, how we will achieve it and who is accountable.

2 **RISKS**

Key risks include:

- Infrastructure constraints limiting pace of estate decarbonisation.
- Financial pressures impacting investment capacity.
- System dependencies including supply chain, transport infrastructure and national policy.
- Workforce capacity and competing priorities.

Mitigations include:

- Strong governance via the Sustainable Healthcare Committee.
- Integration with Trust Strategy priorities.
- Partnership working (e.g. Great North Healthcare Alliance, Integrated Care System (ICS), national networks).
- Focus on high-impact, deliverable interventions that provide triple benefits (improve patient care, reduce costs and reduce environmental impact).

The overall risk to the organisation is recorded and managed within the InPhase system – risk register entry #950 (Climate Emergency).

3 **FINANCE AND RESOURCE IMPLICATIONS**

Delivery of the Plan will require:

- Continued capital investment in estate energy efficiency and decarbonisation projects (e.g. LED lighting and Public Sector Decarbonisation Scheme funding) – *this has been incorporated into the Estates Strategic Delivery Plan and five-year Capital Plan.*
- Revenue support for programme delivery and staff engagement.

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- Procurement and service redesign to reduce long-term costs and carbon emissions.

The Plan also identifies opportunities to:

- Deliver better care and outcomes for our patients.
- Reduce waste and inefficiencies.
- Lower energy costs over time.

4 QUALITY AND SAFETY

There are no adverse quality or safety concerns identified. The Plan supports: improved patient outcomes; reduced health inequalities (e.g. air quality improvements); enhanced organisational resilience to climate risks; and more efficient and effective care delivery

5 NEXT STEPS

Feedback from the June Board of Directors' meeting has been incorporated into the final version for approval at the July Public Board meeting. Publication on the Trust website will follow, with implementation progress reported quarterly via Integrated Board Reports and six-monthly through formal reports to Board.

6 RECOMMENDATIONS

The Trust Board of Directors is requested to:

1. Receive and discuss the Climate Emergency Plan 2026–2031.
2. Approve for publication, subject to any suggested amendments.

Report of Vicky Mc Farlane Reid
Executive Lead for Sustainability

By James Dixon
Associate Director – Environmental Sustainability
21 July 2026



The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Urgent & Emergency Care

Climate Emergency Plan

2026-2031

Caring for People and Planet





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Foreword

At Newcastle Hospitals, caring for people has always been at the heart of what we do. Every day, our staff provide high-quality care that saves lives, improves wellbeing and supports our communities. Today, that commitment must extend further. To provide high quality care for people now and in the future, we must also care for the planet on which our health depends. This commitment is reflected in our Trust Strategy, **Caring, Improving and Learning Together 2026-2031**, which sets out how we will deliver excellent, compassionate and innovative healthcare in a sustainable organisation fit for the future.

Caring for People and Planet

The climate crisis is the greatest threat to health and care this century. It is already affecting the health of our population, increasing inequality, driving demand and placing pressure on the systems that enable safe, effective care. As a large and complex healthcare organisation, we also recognise our own environmental impact — and our responsibility to reduce it. As an anchor institution within our city and region, we have a unique role to play, working alongside partners across local government, academia and the voluntary sector to support a coordinated response to the climate emergency that improves both environmental and population health. This Climate Emergency Plan 2026–2031 sets out how Newcastle Hospitals will respond. It describes how we will continue to deliver

excellent patient care while reducing our environmental impact, increasing resilience and supporting the long-term future of the NHS. It reflects our belief that sustainability is not separate from our core purpose, but integral to it. The Plan is also a key enabler of our strategic priorities. By helping us reduce environmental impact, strengthen resilience and deliver better value, sustainability supports our ambition to join up care, advance care and support great care across our organisation and the wider health and care system.

Sustainability as Part of High-Quality Care

A sustainable healthcare system is one that delivers high quality outcomes for patients today while safeguarding the ability to meet future needs. It is preventive rather than reactive, uses resources wisely, and is resilient to shocks and change.

These principles align closely with the NHS 10-year vision and its three critical shifts: moving care closer to home, focusing on prevention rather than treatment, and using digital innovation to improve access and efficiency. When designed well, these shifts benefit both people and planet.

At Newcastle Hospitals, sustainability means delivering care that is clinically excellent, financially affordable and environmentally responsible — improving value while reducing harm. By **joining up care**, we can reduce unnecessary journeys and deliver services closer to home. By **advancing care**, we can use innovation, improvement and research to develop more sustainable models of care. By **supporting great care**, we can make better use of our resources, create healthier environments and empower our people to contribute to a more sustainable future.

Caring for People and Planet: Our Organisational DNA

To achieve this, sustainability must be embedded into how we work every day. It cannot sit alongside our priorities; it must be woven through them.

We describe this as **Caring for People and Planet**.

The Plan adopts a DNA metaphor (as illustrated in the top right of this page) to reflect this approach:

- A **blue strand**, representing our core NHS purpose: caring for people through quality, safety, experience and outcomes.
- A **green strand**, representing our responsibility to care for the planet by reducing carbon emissions, using resources efficiently and building resilience.

These strands are interdependent. Together, they form the DNA of sustainable healthcare. Our Shine (Sustainable Healthcare in Newcastle) themes connect the two, ensuring that environmental sustainability strengthens — rather than distracts from — our ability to deliver excellent patient care.

From Commitment to Action

Since declaring a climate emergency in 2019, Newcastle Hospitals has made important progress, learned

valuable lessons and built strong foundations. **We have also been clear about the scale of the challenge, and the need to translate ambition into deliverable, system-wide change.** This Climate Emergency Plan moves us from commitment to embedded action, setting out how sustainability will be integrated into decision making, governance, clinical practice and culture over the next five years. It will help ensure that the way we join up care, advance care and support great care delivers benefits not only for today's patients but also for future generations.

As part of the NHS — one of the most respected public institutions in the UK — we recognise our moral responsibility to lead by example. We will use our influence and reputation to support and empower our staff to make more sustainable choices, both at work and at home, helping to build a culture where environmental responsibility is a core component of delivering high quality care.

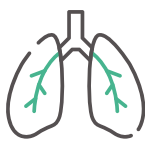
Above all, the Plan reflects a simple but powerful commitment: to deliver excellent care today without compromising the health of future generations. By caring for people and planet together, and working in partnership across our city and region, we will help create a healthier, fairer and more sustainable future for our patients, our staff and our communities.

Rob Harrison
Acting Chief Executive,
Newcastle Hospitals

Sir Paul Ennals
Chair,
Newcastle Hospitals



Climate Emergency Plan 2026-2031 – Plan on a Page

Our Vision for Sustainability			
Delivering Sustainable Healthcare for People and Planet			
Our 3 Goals			
ZERO CARBON CARE		CLEAN AIR HOSPITAL FRAMEWORK (CAHF) PROGRESS	
	Halve our carbon footprint by 2031 Net Zero Carbon (carbon footprint plus) by 2040		100% ultra low emission fleet by 2031 All journeys to our sites to be active or sustainable by 2040
ZERO WASTE			
			Reduce waste by 10% by 2031 All our waste becomes a resource in a circular economy by 2040
Shine Priority Action Areas			
PEOPLE		CARE	
	Inspire, inform and empower our people to deliver sustainable healthcare		Develop low carbon care pathways adapted to a changing climate
JOURNEYS		PROCUREMENT	
	Embed active, clean, low carbon travel		Buy less and buy better, working with our supply chain to decarbonise
ENERGY & WATER		WASTE & RESOURCES	
	Reduce energy and water use whilst transitioning from fossil fuels to clean energy sources		Dispose of less, reuse and recycle more
BUILDINGS		BIODIVERSITY	
	Provide healthy, resilient and sustainable estates		Develop therapeutic green space to support patient recovery and staff wellbeing
Strategic Alignment		How We Measure Success	
Aligned to Trust Strategy 2026-2031 : - Supporting Great Care → sustainable use of our resources - Advancing Care → clinically-led sustainable quality improvement - Joining Up Care → efficient, preventative care models		Aligned to wider strategic priorities : - NHS 10-year plan → delivering a Net Zero NHS, reducing health inequalities - Integrated Care System and Newcastle City Council net zero targets	
Key metrics: - Carbon emissions (tCO₂e) trajectory vs carbon budget - Clean Air Hospital Framework score - Staff commute modal split		- Waste and recycling rates - Energy and water consumption - Supplier engagement (5 Step Net Zero framework) - Staff engagement (Green Champions, SusQI projects)	

Delivering Sustainable Healthcare at scale – caring for People and Planet in everything we do

Introduction

The Next Phase of Our Climate Emergency Response

This Climate Emergency Plan 2026–2031 sets out the next phase of Newcastle Hospitals’ response to the climate emergency and supports delivery of our over-arching Trust Strategy 2026–2031.

In 2019, we were the first healthcare organisation in the world to publicly declare the climate emergency as a health emergency, and we committed to act accordingly. Our first Climate Emergency Strategy (2020–2025) established a clear ambition: to align with the Paris Agreement and limit our organisational contribution to global warming to 1.5°C. This included adopting a science-based carbon budget, developed with the Tyndall Centre, which defined the scale and pace of emissions reduction required. It also set ambitious targets to reduce air pollution and waste.

We deliberately set our ambition high — reflecting both the urgency of the climate crisis and our responsibility as a large and influential healthcare organisation, and our role as an anchor institution within our city and region, working in partnership to improve both population health and environmental sustainability.

Progress and Reality

We have made real progress — but we are not on track to meet our original ambition.

Over the past six years, we have made meaningful progress. We have established strong foundations through our Shine programme,

strengthened leadership and governance, and embedded sustainability across key areas including clinical practice, estates, travel and procurement. We have delivered measurable improvements in carbon reduction, air quality and waste, while building staff engagement and capability across the organisation.

These achievements demonstrate that caring for people and planet can go hand in hand — improving patient care, productivity and environmental performance together.

However, we must also be clear about what we have learned. While our original ambition — to achieve a 90% reduction in controllable emissions by 2030 — was grounded in climate science, it assumed a rate and scale of transformation that has proven more challenging to deliver in practice within the constraints we face. Many of the pressures outlined in our Trust Strategy — including increasing demand, ageing infrastructure, fragmented pathways and financial constraints — have limited the pace at which emissions can be reduced. We have also learned that a significant proportion of our emissions is embedded in the way healthcare is currently designed and delivered, requiring system-wide change, long-term capital investment, national policy alignment and supply chain transformation — much of which sits beyond the direct control of a single organisation.

How we deliver care today shapes both patient outcomes and planetary health. In some areas, the way care is currently delivered drives unnecessary activity, duplication and waste, increasing both cost and

environmental impact. Without redesigning how we provide care, our models will remain both financially and environmentally unsustainable.

In light of this, we are resetting our trajectory. This Plan introduces a revised and more deliverable target: a 50% reduction in our controllable emissions by 2031 (the next key milestone for our Zero Carbon Care goal). This reflects what we have learned over the past five years — maintaining ambition while aligning it more clearly with what can be achieved through our own actions and through sustained, system-wide transformation.

Recognising this gap provides clarity on what must change over the next phase of our climate emergency response.

From Foundations to Transformation

This Plan moves us from establishing the foundations of change to delivering transformation.

It builds directly on what we have learned since 2019 and aligns with our strategic priority of supporting great care through the sustainable and responsible use of resources.

It marks a shift:

- from establishing foundations to delivering transformation at scale
- from individual initiatives to whole-system change across pathways, infrastructure and behaviours
- from ambition to clear accountability for delivery and measurable impact



This shift is underpinned by a clearer understanding of where we can have the greatest impact, and how quickly change can be delivered in practice — enabling us to focus effort where it will drive the most meaningful and sustained reductions in emissions. This reflects the broader direction of our Trust Strategy: improving how care is designed, reducing inefficiency and waste, and ensuring that resources are used to deliver maximum value for patients.

Embedding Sustainability into How We Deliver Care

Sustainability is how we deliver better care — not an additional priority. Environmental sustainability is not separate from our core purpose; it is integral to it.

The Trust Strategy makes clear that delivering high-quality care depends on how effectively we design pathways, use resources and support our people and systems.

Sustainability is part of this — enabling better outcomes, better value and more resilient services.

Through our Shine programme, we are embedding sustainability across:

- clinical care and quality improvement
- estates, infrastructure and digital systems
- procurement and supply chains
- workforce engagement and behaviours

As part of this, we recognise that our workforce is central to delivering change. As part of the NHS — one of the most trusted and respected public institutions in the UK — we have a responsibility to lead by example, supporting our staff to understand the impact of their choices and empowering them to act sustainably in their daily work and in their lives beyond the workplace.

This supports the shift described in our Trust Strategy towards:

- more joined-up, efficient and preventative care
- reduced duplication, delay and avoidable activity
- improved productivity and value for money
- a resilient organisation fit for the future

Reducing carbon, waste and pollution is a direct outcome of better designed, higher-value care. In this context, caring for people and planet means delivering care that is not only clinically excellent, but also efficient, responsible and sustainable for the future.



Looking Ahead

The next five years are critical to accelerating change. We have established the leadership, capability and commitment to act.

The challenge now is to accelerate progress by addressing the systemic barriers identified in our Trust Strategy — including infrastructure constraints, service design and resource pressures.

Working as an anchor institution, in partnership with organisations across our city and region, will be fundamental to achieving this — recognising that many of the changes required extend beyond the boundaries of our organisation.

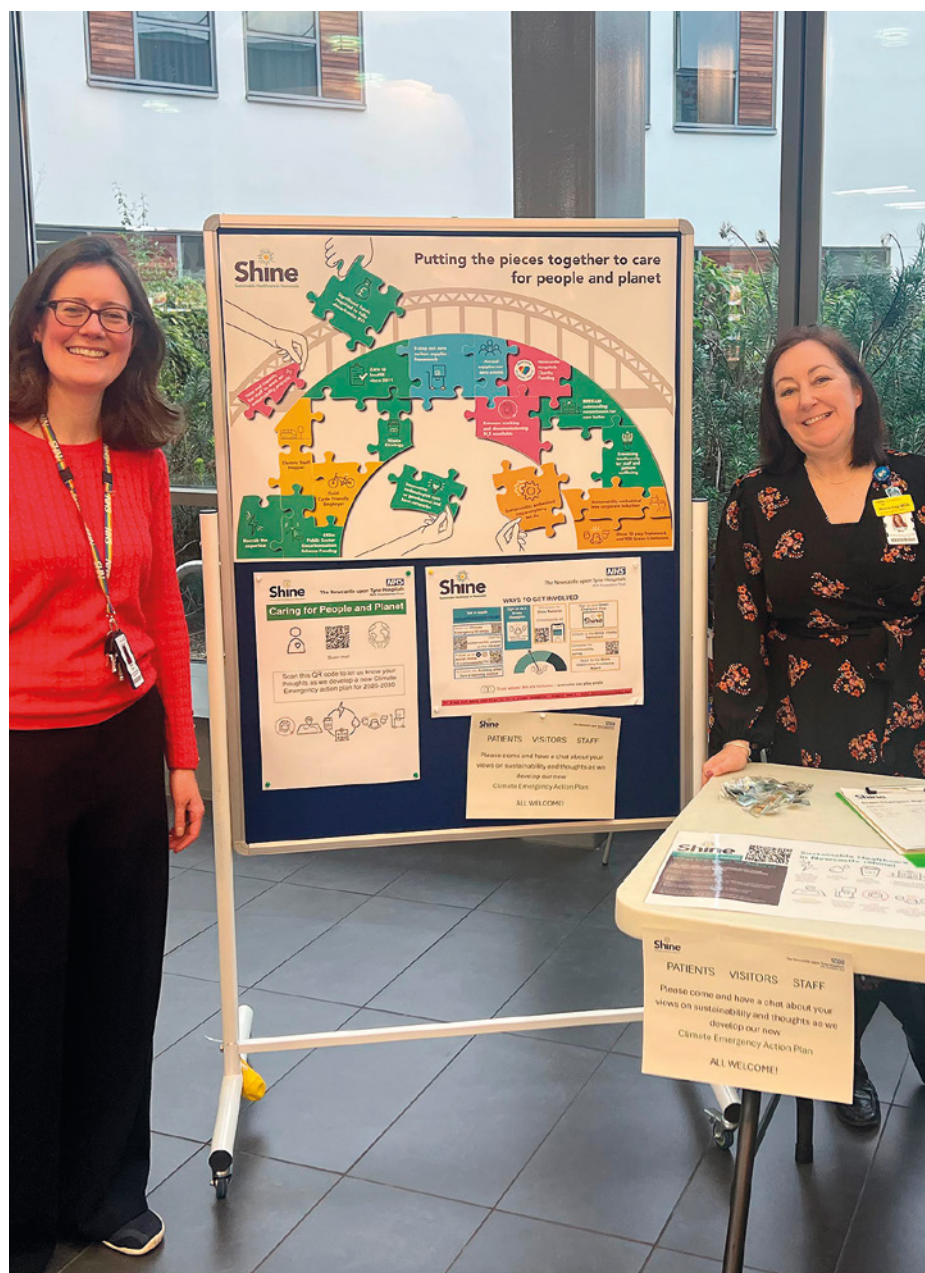
Our revised target does not reduce our commitment — it strengthens it by providing a clear, deliverable pathway for action. It enables us to embed sustainability in core decision-making, scale proven approaches, and drive the structural changes required to deliver lasting impact.

This Climate Emergency Plan provides a clear and aligned framework for doing so:

- supporting delivery of our strategic priorities
- improving efficiency and reducing waste
- strengthening organisational resilience
- and contributing to better health outcomes for our population

By embedding environmental sustainability into how we deliver care, we will bring **our vision of delivering sustainable healthcare in Newcastle for people and planet** to

life — supporting our ambition to be an organisation that people trust for their care, are proud to be part of, and value as a partner in improving health outcomes.



Developing Our Climate Emergency Plan

Our previous Climate Emergency Strategy included an action plan that ran from October 2020 to March 2026. During 2025/26 we worked with Trust senior leaders to include environmental sustainability as a key priority in the new Trust Strategy 2026-2031. Our Climate Emergency Plan is included as a key strategic delivery plan that supports delivery of the overall Trust Strategy.

In developing this Climate Emergency Plan we have consulted with staff, patients, visitors and our partners across the city, region, nationally and internationally.

Our annual staff surveys show that 98% of staff think it is important for the Trust to work in a more environmentally sustainable way

Our most recent engagement survey asked what we should prioritise in this plan – we received almost 300 responses which highlighted (in order of preference): waste reduction; energy efficiency & renewables; clean air & sustainable travel; sustainable food & nutrition; resource efficiency and sustainable suppliers. All of which have been incorporated into the refresh of our vision, goals and Shine priority area actions in this Climate Emergency Plan.

Direct engagement with our patients, carers and local residents, via our Partnership and Involvement Panel (PIP), generated positive feedback and suggestions to further emphasise the direct benefits to patients that will

be achieved through delivering the plan. We have incorporated this feedback into our plan and committed to providing regular updates on this benefits realisation to PIP.

Our collaborative work with other anchor institutions in Newcastle, our regional partners in the Great North Healthcare Alliance and North East and North Cumbria Integrated Care System, have helped inform local and regional sustainability priorities as well as honing the content of this plan. As members of the Shelford Group, and Health Care Without Harm's Global Green and Healthy Hospitals, we have helped steer national and international policy commitments for climate action, as well as ensuring our own strategy helps others in our sector to chart a course for healthcare that cares for both people and planet.

"Looks good. It would be helpful to make more explicit how this will improve the day-to-day experience for patients and visitors."

PIP member feedback on draft version of this plan



Sustainable Healthcare in Newcastle (Shine)

Our Shine (Sustainable Healthcare in Newcastle) programme is the organisational framework through which we deliver this Climate Emergency Plan. Developed over the past decade, Shine has evolved from an early focus on environmental performance into a comprehensive approach for delivering sustainable healthcare — caring for people and planet together.

Shine provides a clear and practical method for embedding sustainability across everything we do. It connects our environmental ambitions with clinical quality, operational efficiency and staff engagement, ensuring that sustainability supports — rather than sits alongside — the delivery of excellent patient care.

Through the eight Shine priority areas shown below, we translate strategy into action. These themes reflect the key areas where we can reduce our environmental impact while improving health outcomes, experience and value. Together, they provide a structured, whole-organisation approach to delivering our Climate Emergency Plan and driving long-term, sustainable change. You can read the detailed action plans for each Shine priority area at page 22 of this Plan.



Energy & Water

Minimise energy and water use and replace fossil fuels with clean energy sources



Buildings

Provide healthy, resilient and sustainable estates



Waste & Resources

Dispose of less, reuse and recycle more



Biodiversity

Develop therapeutic green space to support patient recovery and staff wellbeing



Journeys

Embed active, clean, low carbon travel



Procurement

Buy less and buy better, working with our supply chain to decarbonise



Care

Develop low carbon care pathways adapted to a changing climate



People

Inspire, inform and empower our people to deliver sustainable healthcare



Our Progress So Far

This provides a high-level summary of progress towards our three long-term goals, the following page describes our progress towards embedding Shine into our DNA.

Zero Carbon Care

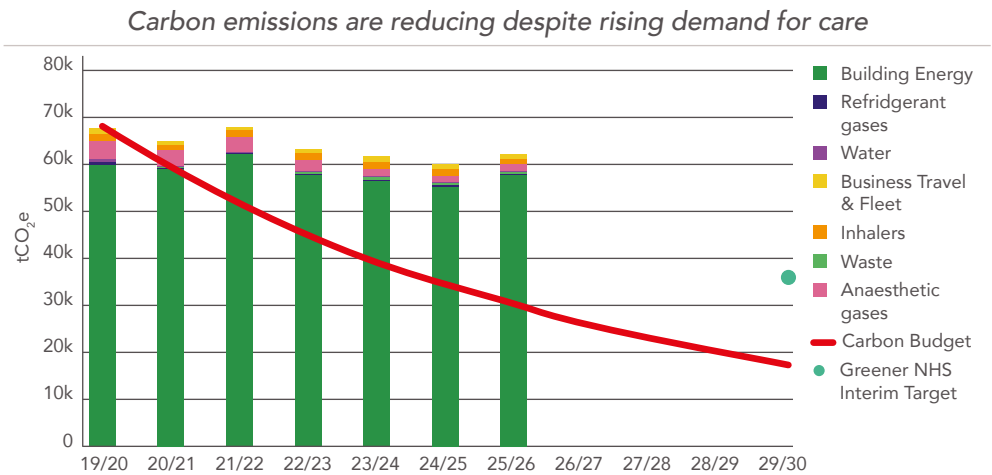


Figure 1: Newcastle Hospitals Carbon Footprint

We have reduced our carbon footprint from our 2019/20 baseline while continuing to deliver increasing levels of healthcare activity.

This progress reflects a combination of estate decarbonisation, clinical change and service redesign.

What we have achieved

- Delivery of major estate decarbonisation projects, including PSDS-funded investment
- Significant reductions in anaesthetic gas emissions, including the phase-out of desflurane
- Expansion of digital and remote care, reducing unnecessary travel
- Improved energy efficiency across parts of the estate

These achievements demonstrate that caring for people and planet can be delivered together — improving outcomes while reducing environmental impact.

What the data shows

- A downward trend in total carbon emissions
- Progress broadly aligned with early-stage carbon budget expectations, with more significant savings projected in the next phase

Challenges we must address

- Ageing infrastructure and reliance on fossil fuel-based energy systems
- Increasing demand for care driving higher energy use
- Scale and pace of capital investment required for heat decarbonisation

Progress to date is positive – but not yet at the pace required

Clean Air

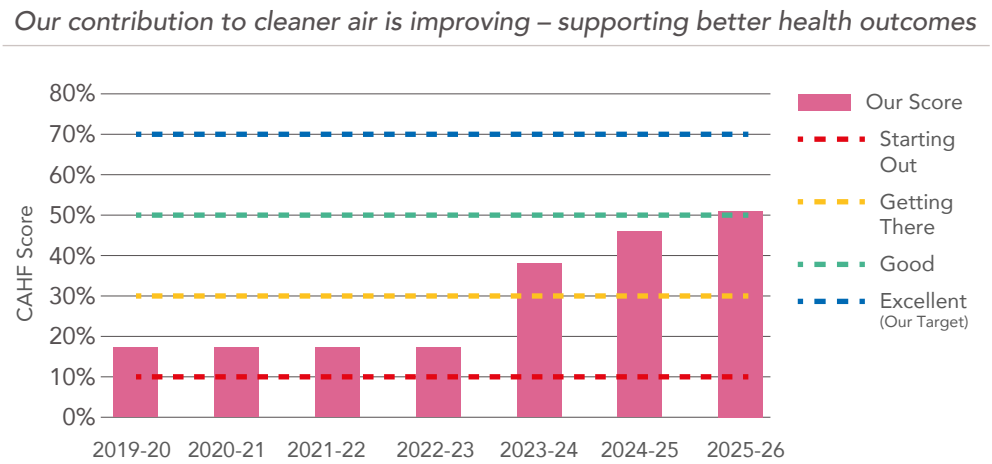


Figure 2: Our Clean Air Hospital Framework (CAHF) Progress

We have made strong progress in improving air quality across our sites and services. Our Clean Air Hospital Framework (CAHF) score has increased significantly from 17% (Starting Out) in 2019/20 to 50% (Good) in 2025/26.

What we have achieved

- Transition towards ultra-low emission and electric fleet vehicles
- Measures to reduce vehicle idling and improve site access
- Promotion of active and sustainable travel
- Increased use of virtual care reducing avoidable journeys

This progress reflects the direct link between air quality and population health, particularly for our most vulnerable patients.

What the data shows

- Significant improvement in CAHF score since baseline
- Growing maturity across multiple components

Challenges we must address

- Accelerating transition to electric fleet vehicles
- Infrastructure and space constraints across sites
- Dependence on wider system factors (transport, city infrastructure)

Achieving a CAHF score of 'Excellent' will require faster progress and stronger system-wide collaboration

Zero Waste

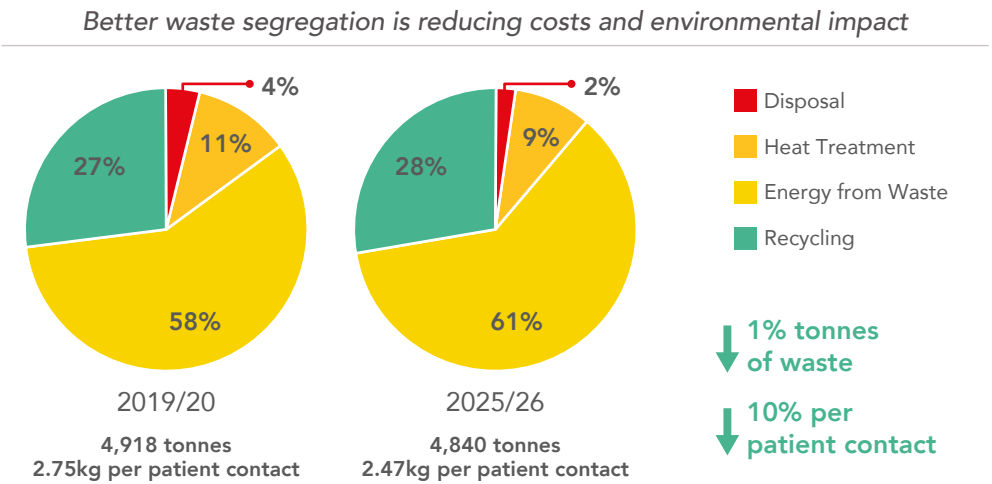


Figure 3: Waste Performance

We have improved how we manage waste and resources, with less waste produced and more materials reused, recycled or recovered.

What we have achieved

- Improved segregation, reducing reliance on the need for high-cost high-environmental impact hazardous waste treatment
- Increased recycling rates
- Strong staff engagement through training and audits
- Early adoption of reuse and circular approaches

These improvements support safer care, lower costs and reduced environmental impact as well as ensuring our compliance with developing legislation.

What the data shows

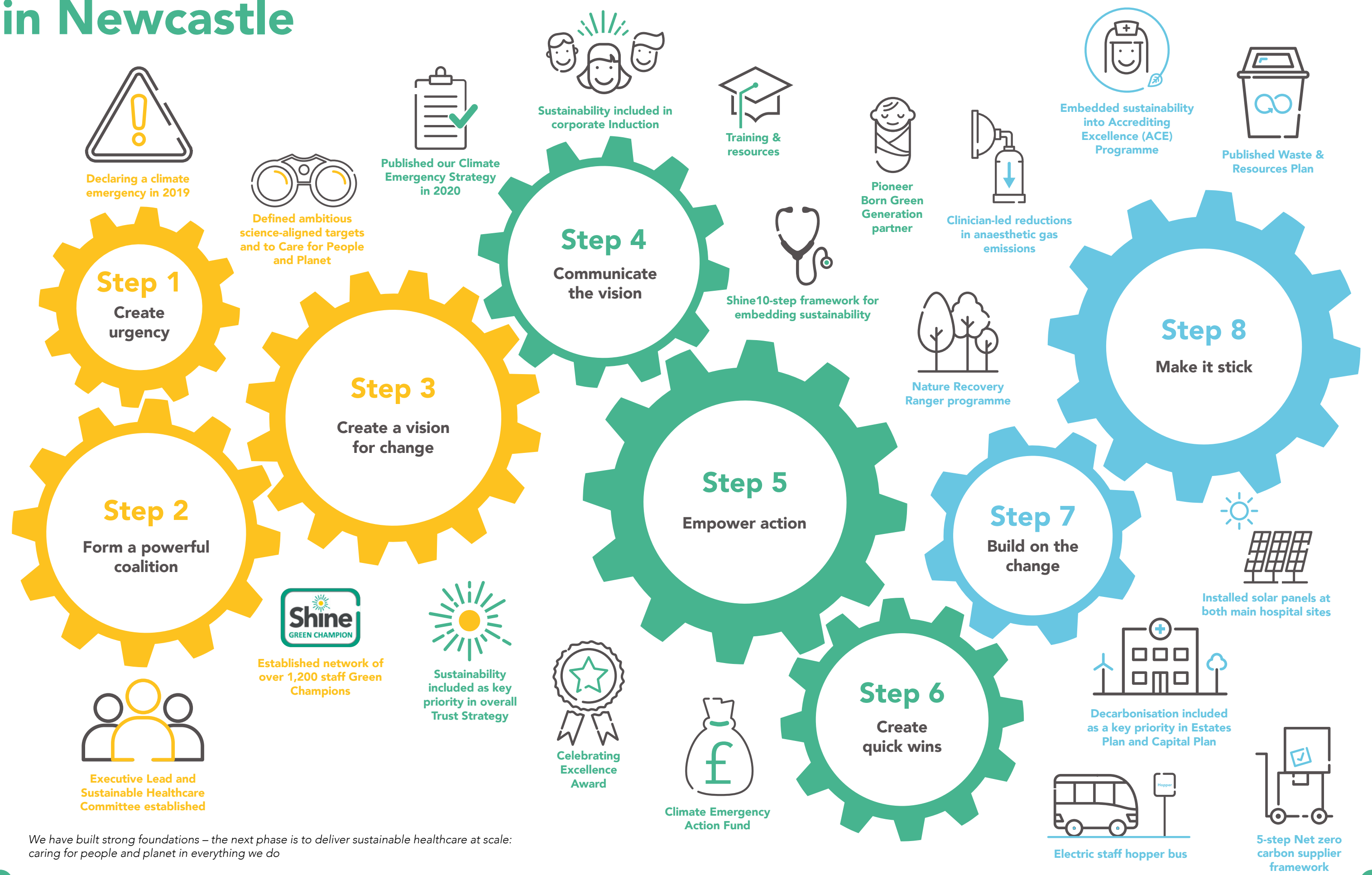
- Increasing proportion of waste managed higher up the waste hierarchy
- Stabilisation of total waste produced despite rising clinical activity levels

Challenges we must address

- Reducing total waste generation
- Embedding consistent behaviours across services
- Reducing reliance on single-use products and packaging and increasing reuse where clinically feasible

The next phase requires a culture shift from managing waste to preventing it

Progress Towards Embedding Sustainable Healthcare in Newcastle





Our Impact So Far (2020-2026)



Saved over **£2.75m** through staff-led sustainability projects



Recognised **32 staff sustainability projects** with Shine Awards



1,320 tonnes of carbon avoided through our use of **nitrous cracking technology** in maternity services



Implemented **25 green space projects** across our estates



Over **2,000 suppliers engaged in carbon reduction** through six annual events



Supported **830 members of staff to actively commute** through our cycle to work scheme



Awarded **6 Celebrating Excellence 'Shine' category winners** in our annual staff awards



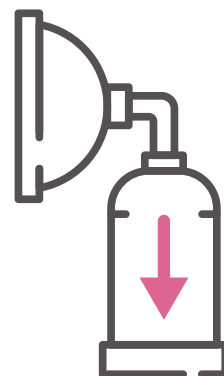
Delivered **sustainability and waste training to 3,700 staff** at corporate inductions



Secured over **£46m to decarbonise our estate** and included further investment in our five-year capital plan



Developed a network of over **1,200 staff Green Champions**



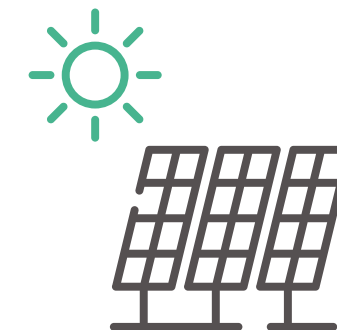
64% reduction in anaesthetic gas carbon emissions



Recycled over **9,750 tonnes** of waste and continued to send zero waste to landfill



350 Meat Free Mondays in our bistros and restaurants



Installed **1,293 solar panels** that now generate almost **350 MWh of clean energy** each year



Avoided **310 tonnes of carbon** and associated air pollution with our **electric staff hopper buses**

What We Want To Achieve

Our Climate Emergency Plan will deliver benefits for patients and local communities, save money that can be used for frontline care, and improve our environmental performance.

Our Vision

Delivering Sustainable Healthcare in Newcastle (Shine) for People and Planet.

Our Goals

To achieve our vision we have set three long-term goals:

1. Zero Carbon Care

- By 2031 our Carbon Footprint will be reduced by half
- By 2040 our Carbon Footprint Plus will be net zero

2. Clean Air

- By 2031 the vehicles we own will generate ultra low levels of air pollution
- By 2040 all travel to our sites will be active or sustainable, generating lower levels of air pollution

3. Zero Waste

- By 2031 we will reduce the amount of waste we dispose of by 10%
- By 2040 all our waste will become a resource within a circular economy



How We Plan To Achieve It

The following section of our strategy outlines what we want to achieve in each Shine priority area, during the life of this five year strategy, as well as how we aim to achieve it and how we will measure it.

To provide high quality care for people now and in the future, we must also care for the planet on which our health depends

Rob Harrison
Acting Chief Executive,
Newcastle Hospitals

Sir Paul Ennals
Chair,
Newcastle Hospitals



People



WHY?	Why this theme matters	Our workforce is central to delivering sustainable healthcare. Staff wellbeing, skills, engagement and empowerment are essential to providing high quality care while reducing environmental impact. The PEOPLE priority area focuses on enabling and supporting our workforce to embed sustainable practice into everyday roles, strengthening care delivery while contributing to environmental sustainability.
	NHS 10 Year Plan alignment (three shifts)	Hospital → Community: Flexible working and place based roles support new models of care. Treatment → Prevention: A healthy, supported workforce is better able to promote prevention and wellbeing. Analogue → Digital: Digitally confident staff can adopt new models of care and ways of working.
	NHS England Green Plan alignment	Primary Green Plan action area: Workforce and Leadership . Secondary links: Net Zero Clinical Transformation, Digital Transformation, Transport and Travel (commuting and flexible working).
	What we learned from 2020–2025	Engagement and leadership at all levels are critical enablers of sustainable change. Sustainability is most effective when framed around patient benefit, staff wellbeing, cost saving and quality improvement. Competing pressures and limited time can be barriers without clear organisational support.
WHAT?	Outcomes we want to achieve by 2031	Environmental sustainability will be a shared responsibility across the Trust, with staff supported, skilled and empowered to care for people and planet as part of their roles.
HOW?	Priority actions 2026–2031	1. Embed environmental sustainability into how we run our organisation 2. Educate and support our Green Champions to deliver environmentally sustainable healthcare 3. Advocate for climate emergency action beyond our boundaries
	Measuring success	• Number of business processes with sustainability embedded (i.e. Clinical Board performance reviews, Accrediting Excellence (ACE) Programme, business case Sustainability Impact Assessments (SIAs) etc.) • Number of staff Green Champions • Number of staff-led sustainability projects that receive a Shine Award • Number of engagement and education events
WHO?	Leadership & governance	Executive Lead: Executive Director of People & Commercial Innovation (working with the Director of People and Organisational Development) Delivery through: HR Sustainability Group (liaison with Sustainability Team, Staff Networks, Trust Education Group, Employment Partnership Forum and Patient Engagement Forum). Oversight via: Sustainable Healthcare Committee, Finance & Performance Committee and Trust Board of Directors.

Care



WHY?	Why this theme matters	How we design and deliver care has the greatest influence on both health outcomes and environmental impact. Clinical decisions shape carbon emissions, resource use, patient experience and value. By embedding sustainability into models of care, we can improve quality, reduce harm and support the long term resilience of the NHS. The CARE priority area ensures that delivering excellent patient care and reducing environmental impact go hand in hand.
	NHS 10 Year Plan alignment (three shifts)	Hospital → Community: Redesigning pathways to deliver care closer to home reduces unnecessary hospital activity and travel while improving patient experience. Treatment → Prevention: Sustainable care prioritises prevention, support for self management, reducing avoidable illness and demand for resource-intensive acute care. Analogue → Digital: Digital and virtual care options support timely access, more personalised care and reduce travel emissions.
	NHS England Green Plan alignment	Primary Green Plan action area: Net Zero Clinical Transformation . Secondary links: Medicines, Transport and Travel, Digital Transformation, Workforce and Leadership .
	What we learned from 2020–2025	Clinically led initiatives deliver the greatest and most durable carbon reductions. Sustainable care is most successful when aligned with quality improvement and patient benefit. Data, engagement and clinical leadership are critical enablers, while time, awareness and system complexity can be barriers.
WHAT?	Outcomes we want to achieve by 2031	We will embed environmental sustainability into all our Quality Improvement processes and deliver over 100 staff-led sustainable quality improvement (SusQI) projects , with every Clinical Board reporting quarterly on reductions in their environmental impact.
HOW?	Priority actions 2026–2031	1. Continue to reduce emissions from anaesthetic gases, with a focus on nitrous oxide waste mitigation 2. Ensure SusQI is embedded in our quality improvement processes and engage with Clinical Boards to implement projects with triple bottom line improvements 3. Implement a Climate Adaptation Plan to ensure our patients receive excellent care in a changing climate
	Measuring success	• Carbon emissions from anesthetic gases and inhalers (tCO2e). • Number of Quality Improvement projects with sustainability co benefits. • Number of Clinical Boards regularly reporting on reductions in their environmental impact. • NHS Climate Adaptation Framework maturity progress.
WHO?	Leadership & governance	Executive Lead: Medical Director and Executive Director of Nursing, Midwifery & AHPs Delivery through: Models of Care Group (liaison with Clinical Boards, Digital, Pharmacy and Transformation programmes). Oversight via: Sustainable Healthcare Committee, Finance & Performance Committee and Trust Board of Directors.

Energy and Water



WHY?	Why this theme matters	The provision of energy and water are fundamental to safe, effective healthcare and are major contributors to the financial cost and environmental impact of delivery. Efficient, low-carbon energy and water provision supports patient safety, staff wellbeing and system resilience while reducing harmful emissions and resource pressures. The ENERGY AND WATER priority area focuses on ensuring our estate uses energy and water efficiently and responsibly, supporting high quality patient care while transitioning to low carbon, resilient systems that are fit for the future.
	NHS 10 Year Plan alignment (three shifts)	Hospital → Community: Efficient infrastructure enables modern, fit-for-the-future models of care delivered in the right setting. Treatment → Prevention: Reliable, climate resilient environments support healthy recovery for patients and wellbeing for staff. Analogue → Digital: Smart systems with data driven monitoring and digital controls reduce waste and optimise performance.
	NHS England Green Plan alignment	Primary Green Plan alignment: Estates and Facilities . Secondary links: Clinical Transformation (resilient environments), Workforce and Leadership (skills, engagement), Digital Transformation (energy and water metering, data and controls).
	What we learned from 2020–2025	Investment in energy and water efficiency delivers multiple benefits: lower operating costs, reduced emissions and improved estate resilience. Demand for energy and water has increased year-on-year and ageing infrastructure remain key resilience risks. Generating electricity at our hospitals, via fossil gas combined heat and power (CHP) engines, has limited our ability to benefit from UK grid electricity decarbonisation. Significant external capital funding for de-steaming has been secured at Freeman Hospital but remains a challenge for the Royal Victoria Infirmary (RVI).
WHAT?	Outcomes we want to achieve by 2031	We will reduce our building energy carbon emissions by at least 50% from our 2019/20 baseline through capital investment in energy efficiency and delivery of our £46m PSDS 4 decarbonisation project .
HOW?	Priority actions 2026–2031	1. Implement automated energy and water metering and digital controls across the estate. 2. Reduce energy demand through capital investment in building fabric, efficiency upgrades and optimisation. 3. Deliver a phased heat decarbonisation programme, including renewable energy generation, aligned to the Trust net zero pathway.
	Measuring success	• Total energy (kWh) and water (m3) consumption. • Total on site renewable generation (kWh). • Energy and water carbon emissions (tCO2e).
WHO?	Leadership & governance	Executive Lead: Director of Estates, Facilities & Strategic Partnerships. Delivery through: Estates Decarbonisation Group (liaison with Estates Strategy Group, Capital Management Group, Emergency Preparedness, Resilience & Response (EPRR)). Oversight via: Sustainable Healthcare Committee, Finance & Performance Committee and Trust Board of Directors.

Journeys



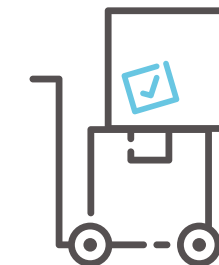
WHY?	Why this theme matters	How patients, staff and visitors travel to, from and between our sites has a significant impact on access to care, experience, health outcomes and carbon emissions. Travel contributes to congestion, air pollution and inequality, while also affecting staff wellbeing and productivity. The JOURNEYS priority area focuses on enabling safe, convenient and sustainable travel choices that support high quality care and healthier communities, while reducing environmental impact.
	NHS 10 Year Plan alignment (three shifts)	Hospital → Community: Care closer to home reduces unnecessary travel and support more equitable access to services. Treatment → Prevention: Active travel and cleaner air support physical and mental health, contributing to prevention aims. Analogue → Digital: Virtual appointments and digital communication reduce the need for travel while improving flexibility and access.
	NHS England Green Plan alignment	Primary Green Plan action area: Transport and Travel . Secondary links: Net Zero Clinical Transformation (virtual care, closer to home), Workforce and Leadership (staff travel), Estates and Facilities (site planning and access).
	What we learned from 2020–2025	Travel demand is closely linked to how services are designed and scheduled. Digital and remote options can significantly reduce journeys when clinically appropriate. Behaviour change is most successful when sustainable options are convenient, affordable and clearly supported by the organisation. Partnership working is critical to enable wider system change and reduce health inequalities.
WHAT?	Outcomes we want to achieve by 2031	We will aim for 100% of our Trust fleet vehicles to be electric and deliver on commitments in our Travel and Transport Plan that enable 70% of our people to commute to work by active or sustainable modes (walking, cycling or public transport) and achieve a score of Excellent on the Clean Air Hospital Framework .
HOW?	Priority actions 2026–2031	1. Reduce carbon emissions from our Trust fleet by transitioning to electric vehicles 2. Support staff to commute by active or sustainable travel through improved infrastructure and discount schemes 3. Improve our Clean Air Hospital Framework score to minimise pollution and protect public health
	Measuring success	• Carbon emissions from transport and travel (tCO2e) • Percentage of Trust vehicles that are ultra-low emission • Staff travel survey data (active and sustainable commuting modal split %) • Clean Air Hospital Framework maturity score
WHO?	Leadership & governance	Executive Lead: Director of Estates, Facilities & Strategic Partnerships. Delivery through: Trust Travel Group (liaison with Clinical Boards, Digital, Estates and HR Teams). Oversight via: Sustainable Healthcare Committee, Finance & Performance Committee and Trust Board of Directors.

Waste and Resources



WHY?	Why this theme matters	Waste is a highly visible and costly by product of healthcare delivery. Reducing waste improves efficiency and safety, reduces costs and environmental impact while supporting high quality care. The WASTE AND RESOURCES priority area focuses on prevention, reuse and improved resource efficiency, supporting safer, more sustainable care and better value for patients and the organisation.
	NHS 10 Year Plan alignment (three shifts)	Hospital → Community: Reduced waste through redesigned pathways. Treatment → Prevention: Preventing waste mirrors preventing avoidable illness and harm. Analogue → Digital: Digital systems reduce paper and resource use.
	NHS England Green Plan alignment	Primary Green Plan action area: Waste and Resources . Secondary links: Net Zero Clinical Transformation, Procurement, Workforce and Leadership .
	What we learned from 2020–2025	Waste reduction is most effective when staff understand the clinical, financial and environmental benefits. Correct segregation is essential to delivering safe healthcare, and collaboration with Procurement and Clinical Boards supports long term reduction in consumables spend, disposal costs and environmental impact.
WHAT?	Outcomes we want to achieve by 2031	We will reduce total waste by 10% from our 2019/20 baseline and achieve a recycling rate of 35%, through buying less and buying better, increasing reuse, and further improving waste segregation.
HOW?	Priority actions 2026–2031	Reduce waste by buying less, buying better, and reusing more Improve our recycling rate, with a focus on food waste recycling - Focus on staff training and engagement to achieve waste hierarchy improvement, with cost and carbon savings
	Measuring success	- Total waste (tonnes) and waste per unit of activity (kg per patient contact). - Recycling rate (both as a % of all waste and a % of non-clinical waste). - Improvements in ward waste audit scores (number of wards improving waste audit scores over the period of this Climate Emergency Plan (CEP)).
WHO?	Leadership & governance	Executive Lead: Director of Estates, Facilities and Strategic Partnerships. Delivery through: Waste Management Group (liaison with Estates, Infection Control, Clinical Boards and Procurement). Oversight via: Sustainable Healthcare Committee, Finance & Performance Committee and Trust Board of Directors.

Procurement



WHY?	Why this theme matters	Purchased goods and services are a major source of emissions and resource use. Sustainable procurement reduces carbon, waste and cost while supporting quality, resilience and ethical supply chains. The PROCUREMENT priority area focuses on ensuring that procurement decisions support high quality patient care while reducing environmental impact and strengthening sustainable, resilient supply chains.
	NHS 10 Year Plan alignment (three shifts)	Hospital → Community: Supporting suppliers that enable community based and place based care. Treatment → Prevention: Procuring products and services that reduce avoidable harm and waste. Analogue → Digital: Digital procurement improves transparency, efficiency and demand management.
	NHS England Green Plan alignment	Primary Green Plan action area: Supply Chain and Procurement . Secondary links: Medicines, Estates and Facilities, Net Zero Clinical Transformation .
	What we learned from 2020–2025	Engagement with suppliers drives the greatest impact. Collaboration with other public sector procurement organisations increases supplier engagement. Clear standards and specifications support environmentally sustainable choices without compromising care quality. Data availability and market readiness vary across goods and services categories. Our suppliers are keen to support our net zero ambitions but some require help and guidance to improve.
WHAT?	Outcomes we want to achieve by 2031	We want to buy less and buy better , by further embedding sustainability into our procurement processes , procuring 90% of goods and services from suppliers engaged in our 5 Step Net Zero Supply Chain framework and promote sustainable food choices on our menus .
HOW?	Priority actions 2026–2031	Embed sustainable procurement into our procurement processes Actively engage with our suppliers to influence a reduction in our procurement carbon emissions Promote sustainable food choices and reduce the carbon footprint of the food we provide to our patients, staff and visitors
	Measuring success	- Procurement carbon emissions (tCO2e) - Number of suppliers engaged at each stage of our 5 Step Net Zero framework (and % of procurement with those suppliers) - Food carbon emissions (tCO2e)
WHO?	Leadership & governance	Executive Lead: Chief Finance Officer (working with Procurement & Supply Chain Director). Delivery through: Sustainable Procurement Steering Group and Food and Drink Sustainability Group (liaison with Clinical Boards, Capital Management Group and Supplies & Services Procurement Group). Oversight via: Sustainable Healthcare Committee, Finance & Performance Committee and Trust Board of Directors.

Buildings



WHY?	Why this theme matters	Our buildings are fundamental to delivering safe, effective and high quality healthcare. Well designed, modern environments support better patient outcomes, improved experience and staff wellbeing. They also play a critical role in reducing energy use, carbon emissions and operational costs. The BUILDINGS priority area focuses on ensuring our estate enables excellent clinical care while transitioning to energy efficient, low carbon and resilient infrastructure that is fit for the future.
	NHS 10 Year Plan alignment (three shifts)	Hospital → Community: Flexible, adaptable buildings support evolving models of care and integration with community services. Treatment → Prevention: High quality internal environments (e.g. air quality, thermal comfort) support recovery, reduce risk and promote wellbeing. Analogue → Digital: Modern infrastructure enables digitally enabled care, advanced diagnostics and more efficient service delivery.
	NHS England Green Plan alignment	Primary Green Plan action area: Estates and Facilities . Secondary links: Transport & Travel, Digital Transformation, Climate Adaptation .
	What we learned from 2020–2025	Embedding environmental sustainability early in capital planning delivers long term benefits for both patient and planetary care. Upgrading ageing infrastructure with modern energy efficient, low-carbon technologies improves patient and staff wellbeing, safety and operational resilience in a changing climate.
WHAT?	Outcomes we want to achieve by 2031	Our buildings will consistently support high quality care delivery with modern, energy efficient and low carbon environments. The estate will be more environmentally sustainable, better aligned to clinical need and more resilient to a changing climate.
HOW?	Priority actions 2026–2031	1. Deliver our Estates Strategic Delivery Plan with targeted investment in energy efficiency and decarbonisation projects. 2. Embed the NHS Net Zero Building Standard and a BREEAM Outstanding design-brief into all new build capital projects. 3. Adapt our estate for the predicted increase in extreme weather events due to our changing climate.
	Measuring success	• Number of capital schemes achieving the NHS Net Zero Building Standard and BREEAM. • Capital investment in energy efficiency and net zero carbon estates projects (£ annually). • Estate condition and energy performance metrics. • Estates Climate Adaptation Plan measures implemented.
WHO?	Leadership & governance	Executive Lead: Director of Estates, Facilities & Strategic Partnerships. Delivery through: Capital Management Group (liaison with Estates, Clinical Boards, Capital and Sustainability Teams). Oversight via: Sustainable Healthcare Committee, Finance & Performance Committee and Trust Board of Directors.

Biodiversity



WHY?	Why this theme matters	Nature and biodiversity are fundamental to health and wellbeing. Access to green space supports recovery, mental health, staff wellbeing and more positive care environments. At the same time, protecting and enhancing biodiversity strengthens climate resilience and contributes to wider environmental recovery. The BIODIVERSITY priority area ensures our estate and green spaces actively support both nature and people, contributing to healthier environments and improved wellbeing for patients, staff and communities.
	NHS 10 Year Plan alignment (three shifts)	Hospital → Community: Welcoming, accessible green spaces support community engagement and wellbeing beyond clinical settings. Treatment → Prevention: Access to nature supports physical and mental health, contributing to prevention and recovery. Analogue → Digital: Digital mapping, planning and monitoring tools support smarter land use and biodiversity management as well as patient and staff engagement and education.
	NHS England Green Plan alignment	Primary Green Plan action area: Estates and Facilities (including biodiversity and green space). Secondary links: Workforce and Leadership (wellbeing), Net Zero Clinical Transformation (therapeutic environments), Climate Adaptation and Resilience .
	What we learned from 2020–2025	Green spaces deliver clear benefits for patients, staff and visitors when they are accessible, well designed and maintained. Small scale interventions can have meaningful impact. Partnerships and staff engagement are key enablers, while competing estate pressures can limit progress without clear prioritisation.
WHAT?	Outcomes we want to achieve by 2031	We will improve biodiversity at our hospitals by 20% and ensure all patients, staff and visitors have access to wildlife-friendly therapeutic green spaces to support their health, wellbeing and connection with nature.
HOW?	Priority actions 2026–2031	1. Create and promote the use of therapeutic green spaces to benefit the health and wellbeing of patients, staff and visitors 2. Enhance biodiversity of our green spaces to support nature recovery and infrastructure resilience 3. Deliver nature-based engagement events to promote the health and wellbeing benefits of spending time in nature
	Measuring success	• Total green space area (m2) and quality (annual biodiversity assessment score) for our hospital sites. • Number of participants in nature engagement events • Number of species identified within our site boundaries via citizen science projects (i.e. BioBlitz/iNaturalist)
WHO?	Leadership & governance	Executive Lead: Director of Estates, Facilities & Strategic Partnerships. Delivery through: Green Spaces Group (liaison with Estates, Clinical Boards, Capital Planning and Sustainability Teams). Oversight via: Sustainable Healthcare Committee, Finance & Performance Committee and Trust Board of Directors.



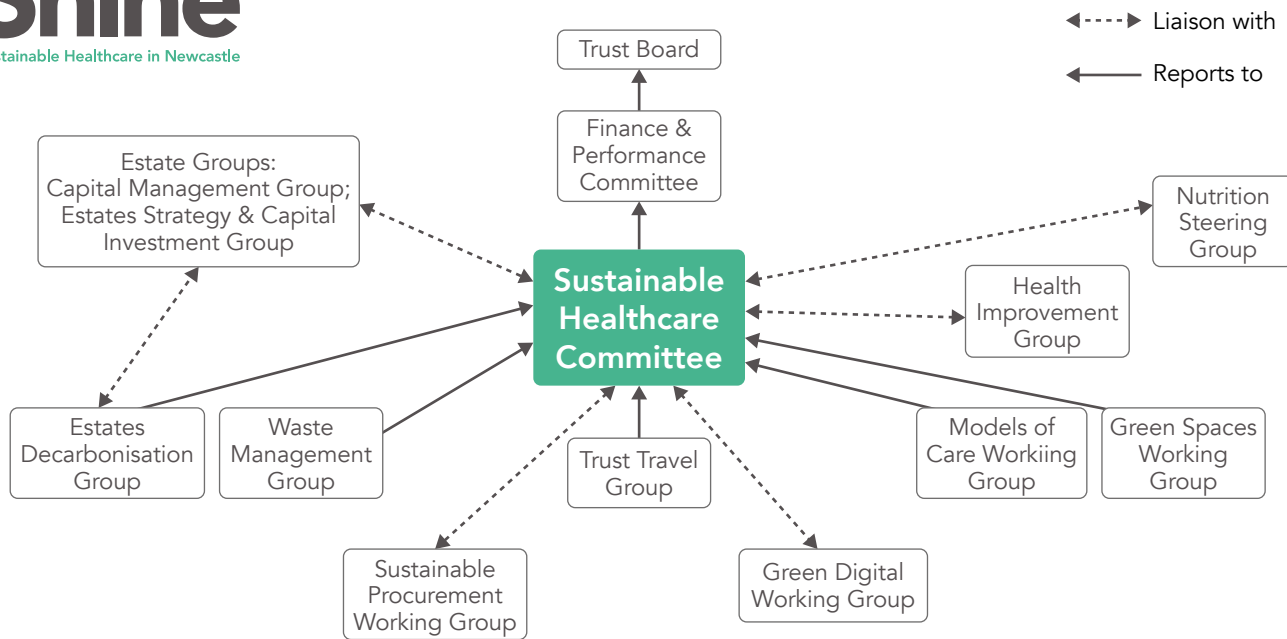
Governance and Accountability

A clear governance structure for accountability and reporting on progress towards this strategic delivery plan is vital.

Our **CEO and Chair** are both highly committed to climate emergency action, and they are aided at Board level by our **Executive Lead for Sustainability**, the Executive Director of People and Commercial Innovation. Our Executive Lead chairs our Sustainable Healthcare Committee (SHC), which reports into the Trust Board of Directors via the Finance & Performance Committee (see diagram below).

The SHC is a multi-disciplinary committee with senior representatives from: nursing, medical, estates & facilities, procurement, human resources, IT, pharmacy, business continuity and a patient representative. Our **Associate Director of Environmental Sustainability** is our strategic lead for sustainability and heads up our in-house team of sustainability professionals who help coordinate the Sustainable Healthcare in Newcastle (Shine) programme of work to deliver on our Climate Emergency Plan commitments.

- ### Reporting Progress
- We will report progress towards the commitments in this strategic delivery plan to our Trust Board of Directors:
- Quarterly, in a Shine high-level dashboard included in the Integrated Board Report
 - Six-monthly, in formal progress reports
 - Annually, in our comprehensive Shine Report, with a summary included in our Trust Annual Report (available publicly on our Trust website)



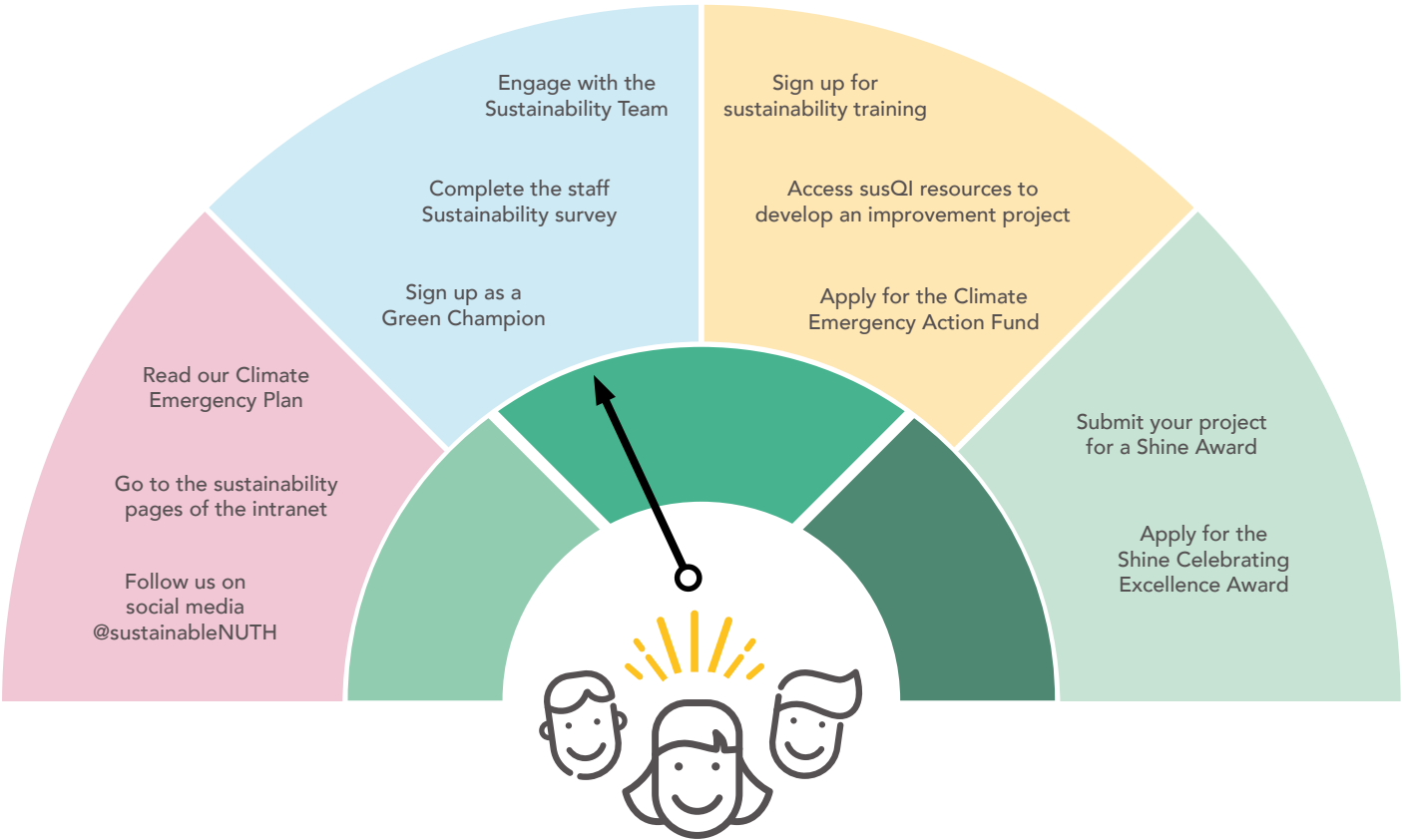


Working Together

To achieve the vision and goals set out in this strategic delivery plan, we need to create a culture and working environment for our people to be empowered and able to act. Tackling the climate emergency can seem overwhelming so we have developed tools and support to enable quick and simple actions to help deliver improvement.

Each of these tools, shown in the diagram below, will help us get one step closer to achieving our vision. All of these tools and other supporting resources can be accessed from the Sustainability pages of the Trust intranet or can be requested from the Sustainability Team at nuth.environment@nhs.net.

Helping us all to Shine



There are already over 1,200 enthusiastic **Green Champions** across the Trust and we are always looking for more. Staff who join the group are added to a network chat group, receive regular emails and newsletters, can attend Green Champion staff network meetings and are educated and empowered on how to support delivery of our Climate Emergency Plan in their everyday roles.

Sometimes sustainability projects require a small amount of funding to get them off the ground, before recurring costs and environmental savings are realised. Applications to our **Climate Emergency Action Fund** are welcome from any member of staff with a sustainability idea that they would like to try in their area of work. Application forms and guidance can be found on our Sustainability intranet page.

If a project is shown to have made a positive impact on one of the key

areas of sustainability it can be submitted for a **Shine Award** and added to our bank of Shine impact stories. Our **Trust Celebrating Excellence Awards** includes a **special annual Shine Award** available for a team, or individual member of staff, that has successfully demonstrated a reduction in the environmental impact of their service or the wider organisation.

Beyond Our Boundaries

Delivering this Plan will also rely on strong collaboration beyond our organisation. As an **anchor institution** within our city and region, we are working alongside other major employers and partners — including local authorities, universities, colleges and businesses — to support a coordinated, place-based response to the climate emergency that improves both environmental and population health.

We are also strengthening our collaboration through the **Great**

North Healthcare Alliance, where addressing the climate emergency is a shared priority. Through this partnership, we are working collectively to deliver meaningful change at scale, sharing learning, aligning approaches and accelerating progress across the North East and North Cumbria through our Provider Collaborative.

At a national level, our work is supported through collaboration with the **Shelford Group** and Greener NHS, enabling us to share best practice, benchmark progress and contribute to system-wide leadership on sustainable healthcare across the NHS. Internationally, we are longstanding members of **Health Care Without Harm's** Global Green and Healthy Hospitals network - a growing global movement of hospitals and health systems dedicated to reducing their environmental impact and promoting both public and planetary health.





Conclusion

This Climate Emergency Plan sets out a clear and credible pathway for the next phase of our response. It reflects what we have learned, the progress we have made, and the scale of the challenge ahead.

At its heart is a simple principle: **caring for people and planet must go hand in hand**. Sustainability is not separate from how we deliver healthcare — it is fundamental to delivering high-quality, efficient and resilient services for our patients now and in the future.

We have been honest about where we are. We have made meaningful progress and built strong foundations, but we know that delivering the pace and scale of change required will demand a sustained, whole-system effort. This Plan sets out how we will move from ambition to action — embedding sustainability into decision-making, redesigning how care is delivered, and working more closely with partners across our city, region and beyond.

As an anchor institution, and as part of one of the most trusted public institutions in the UK, we have both an opportunity and a responsibility to lead. By working collaboratively — with our staff, our partners and our communities — we can help shape a healthier, more sustainable future.

Every member of staff has a role to play. Whether through clinical practice, operational decision-making, or the choices we make every day, small actions can combine to deliver significant impact. Through our Shine programme, we will continue to support and empower our people to act — making sustainable healthcare part of how we work, not something extra we do.

The next five years are critical. By focusing our efforts where they will have the greatest impact, scaling what works, and continuing to learn and adapt, we can deliver meaningful and lasting change.



Glossary

Accrediting Excellence (ACE) programme	A framework that provides a comprehensive view of the quality of care delivered across our wards and departments.
Born Green Generation	A Health Care Without Harm (HCWH) Europe initiative, working in partnership with hospitals and universities in Europe to protect current and future generations from the harmful effects of certain plastics and chemicals, while reducing unnecessary plastic waste.
BREEAM	Building Research Establishment Environmental Assessment Method used to assess, rate and certify the sustainability of buildings.
Carbon dioxide equivalent (CO2 e)	A carbon dioxide equivalent or CO2 e, is a metric measure used to compare the emissions from various greenhouse gases on the basis of their global-warming potential (GWP), by converting amounts of other gases to the equivalent amount of carbon dioxide with the same global warming potential.
Circular economy	A regenerative economic model designed to eliminate waste and pollution by keeping products and materials in continuous circulation.
Clean Air Hospital Framework (CAHF)	A self-assessment tool designed to improve air quality across the hospital site, and in the local community.
Climate adaptation	The process of adjusting to actual or expected climate change and its effects.
Climate emergency	A climate emergency declaration is action taken to acknowledge that humanity is in a climate emergency, and urgent action is required to reduce or halt climate change and avoid potentially irreversible damage resulting from it.
Commuting modal split	The percentage of commuters using different transport modes (e.g., car, public transport, walking, cycling, wheeling).
Great North Healthcare Alliance	The Great North Healthcare Alliance is a partnership between the NHS trusts in Gateshead, Newcastle, Northumbria and North Cumbria.
Green plan	Under the Health and Care Act 2022 all NHS Trusts are required to have a Board approved green plan. The Climate Emergency Plan is Newcastle Hospital's Green Plan
Greener NHS	Via NHS England the Greener NHS team works with staff, organisations and suppliers to support the NHS's world leading ambition to become a net zero national health service.
Integrated Care System (ICS)	A statutory committee jointly convened by Local Authorities and the NHS, comprised of a broad alliance of organisations and other representatives as equal partners concerned with improving the health, public health and social care services provided to their population.
Net zero carbon	Having a balance between the amount of carbon emitted and the amount of carbon absorbed from the atmosphere.
PSDS	The Public Sector Decarbonisation Scheme (PSDS) provides grants for public sector bodies to fund heat decarbonisation and energy efficiency measures.
Carbon budget	The cumulative amount of carbon dioxide emissions permitted over a period of time to keep within a certain temperature threshold.
Shelford Group	The Shelford Group is a collaboration between ten of the largest teaching and research NHS hospital trusts in England.
SusQI	Sustainability in Quality Improvement (SusQI) is a method to drive incremental change towards and more ethical and sustainable health system.
Ultra-low emission vehicles	As defined by UK Department for Transport at time of writing vehicles with less than 75 grams of CO2 per kilometre (g/km) from the tail pipe.
Waste hierarchy	The waste hierarchy ranks waste management options according to what is best for the environment.

Contact Details

This Climate Emergency Plan has been produced by the Sustainability Team at Newcastle Hospitals but reflects work taking place across the Trust. All information contained within it is, to the best of our knowledge, accurate at the time of publishing.

If you wish to contact the Sustainability Team please email nuth.environment@nhs.net

Or write to us at: Sustainability Team (Estates Department)
Royal Victoria Infirmary
Queen Victoria Road
Newcastle upon Tyne
Tyne and Wear
NE1 4LP

You can follow us on:

- : [Sustainable healthcare at Newcastle Hospitals: About | LinkedIn](#)
- : [Sustainable NUTH \(@sustainablenuth\) • Instagram photos and videos](#)
- Website: [Sustainable healthcare - Newcastle Hospitals NHS Foundation Trust \(newcastle-hospitals.nhs.uk\)](#)





Together, we will deliver
sustainable healthcare in
Newcastle — improving
outcomes, reducing harm,
and ensuring that we care
for people and planet in
everything we do.



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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 July 2026					
Title	Performance and Accountability Framework					
Report of	Patrick Garner, Director of Performance and Governance Kelly Jupp, Trust Secretary					
Prepared by	Patrick Garner, Director of Performance and Governance Kelly Jupp, Trust Secretary Lisa Jordan, Assistant Director of Strategy and Planning					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☒		☐		☐	
Summary	The Performance and Accountability Framework was due for review in March 2026 as part of the annual review cycle however the review was delayed to allow alignment with the new 5-year Strategy for the Trust. The Framework has therefore been reviewed by the Trust Secretary, the Director of Performance and Governance, the Assistant Director of Strategy and Planning and the Executive Director of Nursing, Midwifery and Allied Health Professionals. It was also circulated to Executive Team members for comments. In summary, the main changes are: • Updated references to reflect changes in role titles and consistency of referencing. • Revised narrative on the Quality and Performance review process, information reported and a new escalation/oversight framework table. • Additional wording regarding use of the Triple A reporting concept. • Updated structure and other charts. • Inclusion of a reference to the establishment of Executive led improvement groups where appropriate. • Links to other key documents/priorities e.g. Quality Account priorities. • Updated references to the new values, vision and strategic priorities, as well as the new Trust Strategy more broadly. This document sits with the 'Alert' category as requires action in the form of Board approval.					
Recommendation	The Trust Board is asked to approve the changes to the Performance and Accountability Framework.					
Links to Strategic Priorities	Joining up care		Advancing care		Supporting great care	
	☐		☐		☒	
Impact	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability

Agenda item A5(a)

(please mark as appropriate)	☒	☐	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	Not applicable.					
Reports previously considered by	Annual review. Last presented to the Trust Board, and approved, in March 2025. Considered at the Audit, Risk and Assurance Committee meeting on 28 July 2026.					

Performance and Accountability Framework

Version: 3.0

This version issued: 20 July 2026

Executive Team approved: July 2026

Trust Board approved: [TBA – July 2026]

Review date: July 2027

Owner: Patrick Garner, Director of Performance and Governance

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Scope

- 1.1 This document sets out the overarching approach to performance management and the accountability arrangements in place within Newcastle Hospitals. This performance and accountability framework is a Trust-wide document which applies equally to all members of staff.

Purpose and key aims

- 1.2 The purpose of this Performance and Accountability Framework (the 'Framework') is to support the achievement of the Trust's objectives in a way which is consistent with the strategy and organisational values, by providing clarity on how the Trust is organised, where responsibilities for decision making lie, how issues and risks are escalated, and how progress is reported and monitored in an open and transparent way.
- 1.3 It is the framework by which the Board, Executive Team, the Clinical Boards and Corporate Departments are held to account for their performance.
- 1.4 The key aims of the Framework are to promote good governance to support the Trust in:
 - Assessing performance against clear standards, goals and targets.
 - Driving and supporting successful and sustainable delivery of national standards for performance, contractual targets and quality requirements as set out in the Quality Account priorities.
 - Predicting future performance and forecast outturn.
 - Informing strategic decisions and supporting continuous improvement.
 - Focussing resources and improvement efforts in required areas.
 - Holding effective Quality and Performance Reviews (QPRs) that include escalation/intervention as necessary and appropriate, or enabling the use of available autonomy.

Introduction

- 1.5 At Newcastle Hospitals our vision is **'to deliver excellent, compassionate and innovative healthcare, education and research'**. This is supported by our ambition **'to be an organisation that people are proud to be part of, trust for their care, and value as a partner in improving health outcomes'** and three strategic priorities, being:
 1. **Joining up care** – Working together to give people better, quicker access to effective care.

2. **Advancing care** – Improving patient care, effectiveness and quality through innovation, research, improvement and education.
3. **Supporting great care** – Supporting colleagues to do their job to the best of their ability with effective leadership, a just and learning culture and modern digital and physical environments.

- 1.6 The way in which we work as an organisation to achieve this vision and deliver the strategy will be driven by our values of:

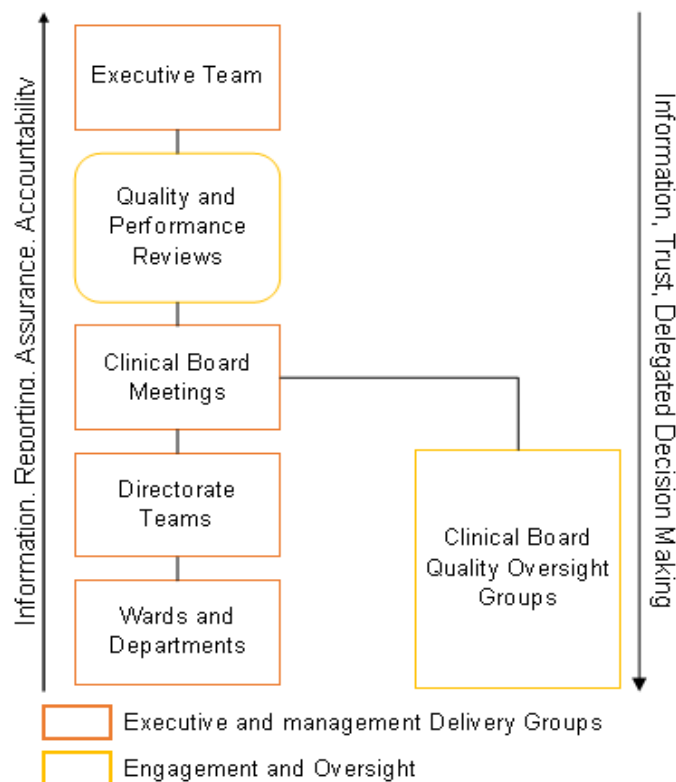


These values define how we will behave towards our patients, our partners and each other.

- 1.7 The Trust's 5-year Strategy, 'Caring, Improving and Learning Together' will be underpinned by strategic delivery plans that describe the areas of focus for 2026/27 and beyond what success will look like and how we will get there.
- 1.8 A key element of the Framework is distributed leadership which is supported through accountability and autonomy – being clear about where there is authority to make decisions independently within Clinical Boards and Corporate Departments, where decisions must be escalated to the Executive Team and under what circumstances this may be reviewed and changed accordingly.
- 1.9 As important as the framework and process itself is the organisational culture within which it operates. The Trust continues to invest in leadership development, to strengthen leadership capacity and capability and drive a culture where staff feel empowered and supported to take responsibility.

Organisational and governance structure

- 1.10 As part of the Trust's planning cycle the Trust Board sets the strategic direction and key deliverables for the organisation, utilising a range of intelligence including current performance. The diagram below shows the accountability structure. There should be a clear alignment to the strategic direction of what teams and individuals are required to do.



- 1.11 The Ward to Board organisational structure is underpinned by the overarching governance structure, to support and ensure that all patients, staff and key stakeholders have the opportunity to influence and inform the way in which the organisation works and its future vision and strategy.
- 1.12 The organisational structure is included in Appendix 1 and Appendix 2 shows the governance structure.
- 1.13 The Terms of Reference of the Clinical Boards, the QPR meetings and the Trust Management Group are included in appendices 3 to 5.

Trust Board of Directors

- 1.14 The Board of Directors (Trust Board) has overall responsibility for leadership, strategic direction and delivery of the Trust Strategy, control and risk management. It is accountable, through our Chair and Chief Executive Officer (CEO), as the

accountable officer, to NHS England (NHSE), the Care Quality Commission (CQC) and the Secretary of State for Health and Social Care.

- 1.15 The Trust Board, comprising Executive and Non-Executive Directors (NEDs), operating as a Unitary Board, has collective responsibility for the overall performance of the Trust and setting the organisational strategy. The key roles and responsibilities of the Board of Directors are set out in the Standing Orders of the Board of Directors. While reserving responsibility for certain specific matters, many functions and responsibilities are delegated by the Board to the CEO and other Executive Directors through the Scheme of Delegation. The Scheme of Delegation also specifies the delegated authority levels. These documents can be found in the policies database on the Trust intranet.
- 1.16 The Trust Board has established several assurance committees (Quality; Finance and Performance; Audit, Risk and Assurance; People; Digital & Data; Charity and Appointments and Remuneration), chaired by NEDs, the key roles of which are to provide **assurance** to the Board on the effective performance and operation of the Trust. The Board Committees oversee key strategic Board level risks. Committees provide more space and time for issues to be considered in further detail than can be achieved in full Board meetings. Committees receive written reports and in-person updates from senior staff who chair relevant management groups. Committees report directly into Trust Board meetings via 'Triple A' reports*, minutes and updates from NED chairs and lead Executive Team members, to provide assurance or highlight any gaps in assurance for consideration. The Appointments and Remuneration Committee is responsible for overseeing the appointment and remuneration of the CEO, Executive Directors and other Very Senior Managers.

**A 'Triple A' report is a concise summary for reporting from a meeting or committee to its governing body e.g. the Trust Board, focusing on three key areas:*

- **Alerting** the Board to critical issues requiring urgent attention or action
- **Advising** the Board of ongoing developments or areas needing monitoring
- **Assuring** the Board of positive confirmations of control effectiveness

- 1.17 When necessary or needed Strategic Oversight Groups (SOGs) may be set up as time limited sub committees of a Trust Board Committee comprising NEDs, Executive Team and other staff members who are convened to oversee a specific significant development or matter. Such Groups are established by the Board where it is identified that the nature of the development/matter requires more dedicated oversight than can be met by an existing Committee either due to time commitment, level of risk or that the development/matter requires a cross committee membership due to its impact on several committees. SOGs are chaired by a NED and often include NED members from more than one Committee. SOGs typically receive written reports and in-person updates from the appropriate Executive Team member and other staff. SOGs report directly into one or more Board Committees

and where appropriate provide updates to Board Meetings via the relevant NED and Executive Director leads.

- 1.18 If required, Executive led Improvement Groups will be established where quality and/or safety concerns are identified in specific areas. Structured Improvement Plans will be agreed, with the Improvement Groups reporting and providing assurance to the Quality Committee or another committee if deemed more appropriate.

Council of Governors

- 1.19 The Council of Governors represents the interests of members and partner organisations in the local community and holds the Board of Directors to account for the performance of the Trust (primarily through the NEDs). Governors exercise this function of holding to account through several channels including the work of the Council of Governors and the Governor Working Groups and observing the work of Board Committees.
- 1.20 The Council of Governors also have several specific statutory duties, as set out in the Trust's Constitution and Standing Orders of the Council of Governors (these can be found on the Trust website).
- 1.21 The Council of Governors meets regularly, with a minimum of 6 formal meetings a year, and are chaired by the Trust Chair with Governors and Board members in attendance. The meetings provide an opportunity for the Governors to seek assurance and provide independent challenge to the Board of Directors. Their overriding statutory duty is to hold the NEDs to account for the performance of the Board.
- 1.22 The Trust has 36 Governor seats. NHS Foundation Trust Governors are the direct representatives of local communities and do not manage the operations of the Trust.
- 1.23 The Trust has three Governor Working Groups (WG), being: Business and Development (B&D) [Aligned to the Finance and Performance Committee, the Digital and Data Committee and the Audit, Risk and Assurance Committee]; People, Engagement and Membership (PEM) [Aligned to the People Committee]; and Quality of Patient Experience (QPE) [Aligned to the Quality Committee]. The Governor WGs are aligned to the Board Committees and are a forum for Governors to obtain assurance and information on specific areas relevant to their statutory roles e.g. the appointment of the external auditor.

Chief Executive Officer (CEO)

- 1.24 The CEO is the Accountable Officer, responsible for the overall running of the organisation. This includes ensuring that the Trust meets all quality, operational performance and financial requirements.

Executive Team

- 1.25 The Executive Team supports the CEO in delivering the Trust's strategic objectives and has overall responsibility for the approval, and implementation, of the Performance and Accountability Framework.
- 1.26 The Executive Team consists of Executive Directors and other Directors who attend the Trust Board meetings.
- 1.27 The Executive Team is responsible for ensuring appropriate oversight mechanisms and processes for the management of performance, including the application of corrective actions in relation to:
- Delivery of strategic priorities, including focused improvements, Trust programmes, and task and finish projects.
 - Operational, quality and financial performance.
 - Organisational capability and capacity to deliver the priorities, including an appropriately skilled and supported workforce.
 - Compliance with statutory, mandatory and regulatory requirements.
- 1.28 The Executive Team is the senior executive decision-making body of the Trust and is accountable to the Trust Board of Directors for the executive oversight and performance of the organisation. Meetings are held weekly and are chaired by the CEO. The Executive Team are responsible for executive oversight of the Trust and are accountable through the CEO to the Trust Board.

Trust Management Group (TMG)

- 1.29 The TMG meets every 2 weeks to bring together senior leaders of the Trust (as defined in the Terms of Reference in Appendix 5) to maintain the overall effectiveness of the Trust by ensuring the robust, effective and efficient operational management.

Executive led management groups – such as the Clinical Policy Group

- 1.30 Executive led management groups are subgroups of the Executive Team where either the CEO or a member of the Executive Team oversees progress and

management of key organisational priorities or tasks. Accountability is through the chair of the meeting with issues escalated to the Executive Team as required. NED input is not directly required as these groups focus on operational matters. Board-level oversight is maintained through the Committee structure and/or regular Board reporting.

Management Groups – e.g. Clinical Outcomes and Effectiveness Group, Supplies and Services Procurement Group

- 1.31 Management Groups are regular groups consisting of a range of staff including senior members of staff who oversee significant issues and themes. They are chaired by Executive Team members or appropriate deputies/senior leaders and are not attended by NEDs.
- 1.32 The Groups report operationally to their lead Executive Director who is accountable for their work programme. Where relevant the Groups provide assurance updates to the Executive Team, and then if required to Board Committees via a Triple A report, minutes and/or verbal updates from the Management Group chair or relevant Executive Director.

Risk Validation Group

- 1.33 The Risk Validation Group provides an additional check and challenge of changes to risks in the Trust. This includes considering risks proposed for acceptance and/or closure based on the Trust Risk Appetite and attainment of the Target Risk Score. The Group validates information which is then presented to the Executive Team and Audit, Risk and Assurance Committee.

Strategic command

- 1.34 This is a function utilised by the Executive Team to allow directors to focus on significant issues of business continuity linked to extreme operational pressure or incidents. The meetings are held when necessary or needed and are chaired by the assigned Medical Director who is the Accountable Emergency Officer. Meetings can also be convened by the Strategic On-Call Director acting within the Emergency Preparedness, Resilience and Response (EPRR) policy, and are administered by the Head of Business Continuity and Emergency Planning. Accountability of this subgroup is through the chair of the meeting with issues escalated to the Executive Team/CEO/Board as required.

Tactical command

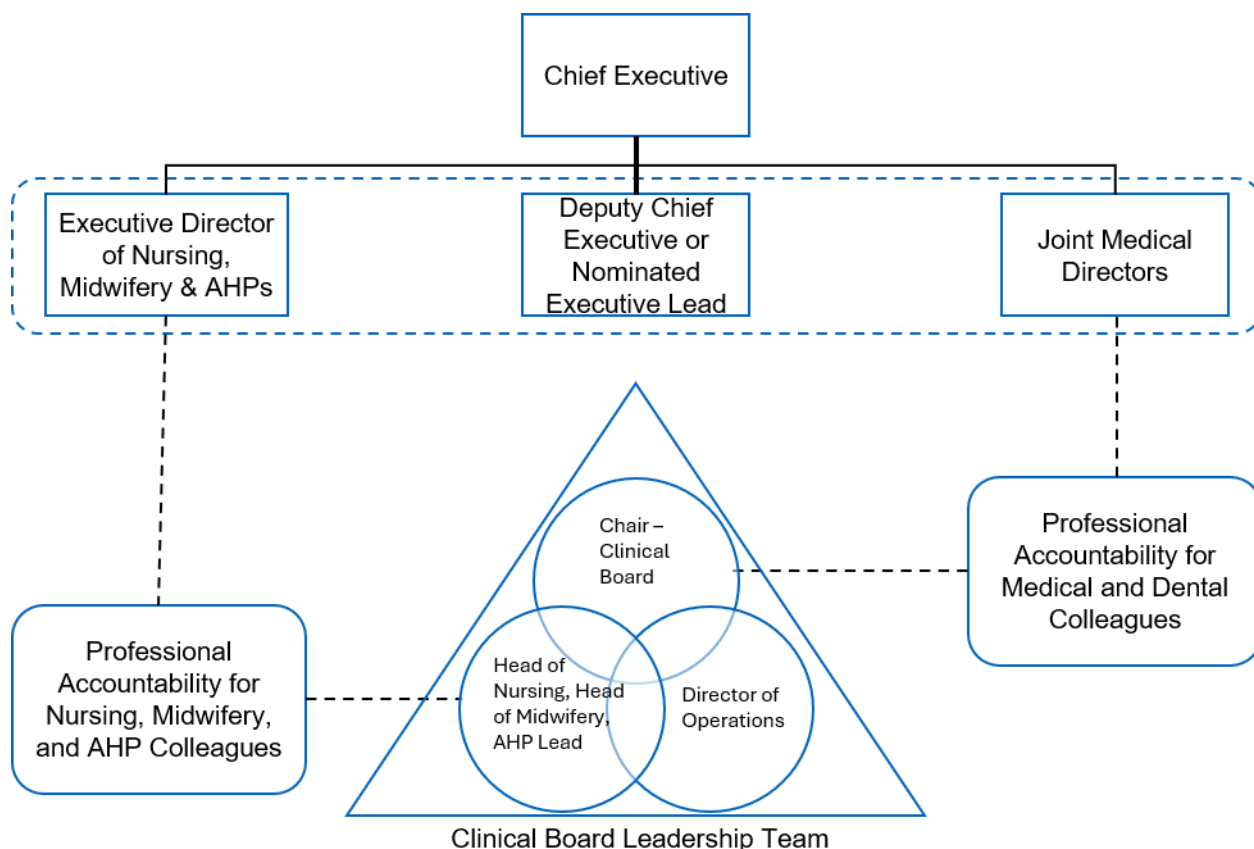
- 1.35 Convened when necessary and needed, tactical command is a daily meeting of senior operational and clinical leads or in the case of major incidents to provide short term strategic leadership as per the EPRR policy. Chaired by the Director of Improvement & Delivery (Operations), the Executive Director of Operations or equivalent. Accountable to Strategic command and the Executive Team via the Joint Medical Directors or the Deputy Chief Executive/Nominated Executive Lead.

Clinical Policy Group

- 1.36 A regular monthly meeting chaired by the Joint Medical Directors and including all Associate Medical Directors, Clinical Board Chairs, Heads of Nursing Corporate Clinical Directors, Senior Corporate Nursing Teams and selected senior clinical leaders. Attended by Executive Team members. Responsible for developing and implementing clinical policy across the Trust. Accountability is through the chair of the meeting with issues escalated to Executive Team as required.

Clinical Boards and directorates

- 1.37 The Board of Directors is committed to a model of strong clinical and distributed leadership, and the eight Clinical Boards are the vehicle for ensuring delivery of operational priorities.
- 1.38 Clinical services operated by the Trust are organised across eight Clinical Boards. The Trust is committed to a clinical leadership model and each Clinical Board is led by a Clinical Board Chair who is a senior clinician and is accountable to the Executive Team (via the Deputy Chief Executive/Nominated Executive Lead, the Joint Medical Directors and the Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs)) for the performance of the Clinical Board across all aspects of its agreed Clinical Board delivery plan.
- 1.39 Clinical Board Accountability Structure:



- 1.40 The Clinical Board Chair is responsible for leadership of the Clinical Board to support the delivery of patient care according to the Trust vision and strategy and is responsible for ensuring that quality and safety of patient care remains the primary objective of all staff of the Clinical Board. The Clinical Board Chair is also responsible for ensuring robust quality and safety arrangements are in place.
- 1.41 As agreed with the Executive Team, Clinical Boards may also provide corporate organisational leadership for specific strategic areas, such as Urgent and Emergency Care, Elective Care, Out of Hospital Care, Cancer and Diagnostic Care.
- 1.42 The Clinical Board Chair is accountable for all aspects of the performance of the Clinical Board and chairs the Clinical Board meetings. They also have line management responsibility for the Director of Operations and Clinical Directors.
- 1.43 Reporting to the Clinical Board Chair and Deputy Chief Executive Officer/Nominated Executive Lead, the Director of Operations is responsible for overall operational delivery, interpreting and delivering overall health service policy and strategy, and has a key role in supporting the Clinical Board Chair in the leadership of a group of Specialties and Directorates. The Director of Operations is also responsible for providing high-level operational and strategic business planning and leadership to ensure that the Clinical Board provides high quality patient care and achieves its performance objectives.

- 1.44 The Clinical Board Director of Operations has line management responsibility for the Head of Nursing (with professional accountability to the Executive Director of Nursing, Midwifery and AHPs).
- 1.45 The Clinical Directors within each Clinical Board are accountable to the Clinical Board Chair for the performance of the Specialties and Directorates in their sphere of responsibility. The Clinical Directors, who are members of the Clinical Board, have line management responsibility for the specialty leads within their clinical directorate and have access to appropriate resources to support necessary performance and governance outputs. This includes responsibility for the budget of the clinical directorate.
- 1.46 The Clinical Board triumvirate (the Clinical Board Chair, the Director of Operations and the Head of Nursing/AHP leadership) is responsible for overseeing effective operation and delivery of services across all the Clinical Board's activities including operational performance, quality, workforce and finance. It is also responsible for ensuring that there are robust governance arrangements in place throughout the Clinical Board (including within clinical directorates and specialties) to ensure that key issues and risks are identified, managed and escalated as necessary in an effective way.
- 1.47 Each Clinical Board is managed in accordance with a common governance framework, specifically in relation to arrangements for quality governance. The following section outlines how the Clinical Boards are held to account for the delivery of their delivery plans.

Corporate departments

- 1.48 Members of the Executive Team lead corporate departments comprising teams with functional responsibilities for providing corporate support on decisions to the organisation as a whole. The Executive Team is accountable to the CEO for the performance of their Corporate Departments.
- 1.49 While this Framework focuses on the levels of the organisational structure outlined above, it is important to recognise that clarity of accountability is vital at all levels of the organisation, including teams and individuals within Newcastle Hospitals who should all have clear objectives which are linked to the organisational objectives.
- 1.50 Corporate Departments have organised their teams to align to each of the Clinical Boards where possible, to ensure that the Clinical Boards have support to deliver their functions.

Holding to account

- 1.51 The primary means by which the Executive Team holds the Clinical Board and Corporate Departments to account for progress against contractual and national performance requirements is through regular QPRs (up to 12 per year depending on the autonomy level assigned to the Clinical Board). These meetings are equally an important mechanism through which Clinical Board and Corporate Departments can escalate issues to and seek support from the management executive.
- 1.52 QPR meetings take place with each of the eight Clinical Boards. For Corporate Departments, a QPR cycle will be developed during 2026/27. They are chaired, and administered, by a Nominated Executive Lead, with an expectation that the following Executive Directors are present as a minimum: Executive Director of Nursing, Midwifery and AHPs, Joint Medical Directors, Chief Finance Officer, Director of Performance and Governance, Director of Quality & Safety, Director of People and Organisational Development and Executive Director of People and Commercial Innovation. From each Clinical Board, it is expected that the Clinical Board representation will be led by the Clinical Board Chair and will comprise of the Director of Operations, Head of Nursing/AHP Lead, as well as the quality and safety, finance, information, performance and workforce leads. Clinical Directors and Associate Directors of Operations /General Managers will also be invited to attend as appropriate. Other members of the clinical leadership team are also free to attend where appropriate.
- 1.53 Other members of the Executive Team are free to attend all meetings. Core attendees should prioritise these meetings but, if they are not available, they should send a representative who is appropriately briefed in order to participate fully in the meeting. It is expected that core members of each QPR (as outlined above) should attend a minimum of 70% of meetings a year.
- 1.54 The QPRs focus on five domains (including any risks associated with each):
 - Quality and safety.
 - Performance – including activity and access targets.
 - People metrics.
 - Finance including current year position and financial recovery.
 - Strategy and service developments.
- 1.55 Key summary metrics within each of these domains are used to track progress. This underpins the key principle of distributed leadership and autonomy.
- 1.56 The focus of the QPRs is on issues and metrics that need to be raised by exception for discussion, with the information and data provided for reference at the meeting taken as read. To get the most from QPRs, the leadership team are required to prepare a pack of information circulated 3 working days in advance to enable the

QPR attendees to have the information required to undertake the review to the appropriate depth. This is supported by Corporate Teams as required and covers all aspects of the agenda. Notes and action points are circulated in a timely way by the Corporate Performance Team and the nominated action owners are responsible for following up their actions ahead of the next meeting.

- 1.57 A comprehensive action log is maintained, and this is supported by an active risk register for each QPR.
- 1.58 It is expected that each Clinical Board and Corporate Department will have in place a formal structure for regular QPR review meetings with their directorates and this should report directly into their Clinical Board/Corporate Department.
- 1.59 For the QPRs, Clinical Boards and Corporate Departments will:
 - Report on recruitment decisions
 - Report Business Case decisions (including updates on consultation where appropriate)
 - Provide assurance on establishment changes (within allocated budget) to transfer resources between budget lines, skill mix
 - Be prepared to unwind decisions if required
- 1.60 Following each round of QPRs, the key quality and performance issues arising from the meetings will be drawn together by the Chair of the QPRs into a Triple A report. This provides an opportunity for key issues to be escalated, particularly where they might involve or impact on more than one Clinical Board. The QPRs follow the triple A reporting method, and a summary is provided to the Executive Team and Trust Board via the Director of Performance and Governance monthly. This in turn will help inform the discussion of quality and performance by the relevant Board Committees, and/or the Trust Board. A Triple A report from the QPRs will be produced/maintained which will be included with the papers for the Quality and Finance and Performance Committees.
- 1.61 The Executive Team will monitor and review the need for additional training, support and capacity to facilitate the effective operation of the Performance and Accountability Framework.

Performance Management and Reporting

- 1.62 Monthly performance reports, finance, quality and people information form the basis of the QPRs. The key performance indicators (KPIs) are based on the annual planning requirements. These reports are regularly updated as performance expectations change, and new targets set as appropriate.

- 1.63 Where Clinical Boards demonstrate an ability to maintain high levels of achievement against the domains of quality and safety, finance, performance and people, the principle of maximum autonomy and minimum oversight will apply.
- 1.64 Where Clinical Boards are failing to maintain the required levels of achievement across the four domains, there will be varying levels of escalation and oversight, depending on how far off plan they are.
- 1.65 Achievement against the domains will be reviewed quarterly by the Executive Team, and escalation will be stepped up or down in accordance with quarterly achievement.
- 1.66 The table below outlines the level of oversight based on achievement against the four domains:

Level and Criteria*	Oversight and autonomy
Level 1: The Clinical Board is consistently high performing across all domains, delivering against plans, or performance is challenged in one domain however robust plans are in place to improve performance.	Full autonomy within the scope of the Framework, Standing Financial Instructions and Standing Orders, including: Recruitment decisions within budget Bi-monthly QPRs (light touch exception reporting). In the month where the QPR isn't held, the Clinical Board leadership triumvirate will have the opportunity to meet with link Executives to discuss any matters which the Clinical Board would like to raise.
Level 2: The Clinical Board is on track for financial metrics and has good performance across most domains. Specific issues exist in two domains with plans being developed to rectify the position.	The Clinical Board has full autonomy: - Recruitment decisions within budget Bi-monthly QPRs and oversight of specific issues which may include: - establishment of a time limited oversight group - specific and targeted intervention In the month where the QPR isn't held, the Clinical Board leadership triumvirate will have the opportunity to meet with link Executives to discuss any matters which the Clinical Board would like to raise.
Level 3: The Clinical Board are off-track in a range of domains or are in financial deficit.	The Clinical Board has limited autonomy, approved investments will be paused if not yet drawn down, monthly QPRs as well as targeted specific oversight which may include: - establishment of a time limited oversight group - specific and targeted intervention - removal of autonomy on all recruitment

Level 4: The Clinical Board is significantly off-track in all or most domains.	The Clinical Board has very limited autonomy, monthly QPRs and focussed interventions with the Executive Team. There will be a requirement to meet with Executives more frequently. Additional support and oversight across all domains with enhanced input from improvement teams, finance and performance teams, with additional oversight of recruitment, establishment changes, investment proposals and quality oversight. If the Clinical Board has remained at level 4 for two consecutive quarters, then the Executive Team will consider whether leadership change is required to turnaround the position.
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**A similar approach will be adopted for Corporate Departments during 2026/27.*

Principles of Autonomy and Accountability

1.67 The following are principles that the Clinical Board and Corporate Department teams should have regard to when decision making:

- Consider the impact on other Clinical Boards/Corporate Departments, as well as on Patients and Staff.
- Determine who are the relevant stakeholders and identify whether they have been consulted.
- Act in the overall interests of the organisation.
- Ensure effective resource management.
- Avoid setting new precedent without Executive level agreement.
- Put in place good governance arrangements locally.
- Commit to sharing learning to improve wider organisational decision making.
- Contribute to external reporting assurance as necessary.
- Ensure compliance with the Trust Standing Orders, Scheme of Delegation and Standing Financial Instructions.

Triggering and managing performance escalations

1.68 There are several layers and routes of escalation:

1.69 Increased routine oversight:

- Clinical Board and Corporate Departments to escalate in-month of any deterioration across any of the KPIs that impacts on their level of autonomy.
- Trust-wide oversight and performance monitoring identifies a concern.
- Review of KPIs identifies a need for a focussed review of finance, workforce, quality and patient safety or operational performance.

1.70 Escalation to the Executive Team:

- Specific items of escalation for the Executive Team to note i.e. breach of a national requirement however assurance can be provided that a recovery action plan is place and will no longer be an issue within a specified time-frame.
- Specific items of escalation for the Executive Team to action i.e. breach of a national requirement and there is no credible recovery plan in place and support is required. The Executive Team will agree the next course of action directly with the Clinical Board.
- Clinical Boards and other corporate leadership teams can make a direct escalation to an appropriate forum, i.e. a Senior Leadership Forum or directly into the Executive Team rather than wait for a QPR / review of KPIs.
- If there is ongoing slippage against the action plan, there will be a further escalation to a Nominated Executive Lead pending the nature of the escalation.
- A further escalation can be made to include the CEO to mediate a resolution or set out the next steps.

1.71 As the framework relies on robust governance arrangements being in place, any governance concerns can and should be highlighted through other routes including, the Risk Validation Group and Clinical Effectiveness and Audit Group as examples. Members in attendance are expected to triangulate information and raise concerns if there is contradictory information presented. In this instance, the Executive Team will review and determine whether a governance review of the Clinical Board is required.

Reserved Matters for the Executive Team

1.72 The following matters are reserved for Executive Team discussion and decision:

- Capital spend to be centrally controlled given the Capital Departmental Expenditure Limit (CDEL) and cash flow.
- Minimum Performance and Quality ambitions.

- Pay Terms and Conditions, the regrading and job evaluation process, and the job planning policy.
- Use of the Very Senior Manager (VSM) grade.
- Redundancy.
- Changes to ward based Safer Nursing Care Toolkit (SNCT) levels.
- Use of Agency staff for non-clinical roles, above cap and off framework.
- Business cases where there is no funding / income available.
- Procurement of Digital Systems.
- Overall decision making on financial requirements and Trust wide policy decisions.

Risk Management

- 1.73 This Framework aims to align with the Risk Management Policy and Strategy. The Trust recognises that there are unavoidable and inherent risks to providing healthcare services and are committed to supporting a dynamic, proactive, and transparent approach to risk management throughout the organisation.
- 1.74 The Board of Directors with the support from its Committees of the Board have a key role in ensuring robust risk management systems and processes are effectively implemented, and maintained, as well as to promote a culture whereby risk management is fully embedded across all Trust activities through its policy, strategy and management plans.
- 1.75 All Clinical Board and Corporate Department leadership teams are responsible for ensuring the implementation of the Risk Management Policy within their areas, including establishing effective risk management governance to support the continual management of risks and risk registers as set out within the Risk Management Policy which can be found in the Trust policy directory.
- 1.76 All staff play a vital role in considering risk and helping to ensure it does not prevent the delivery of care. Effective risk management is the responsibility of every member of staff and the escalation of risk should be encouraged and managed separately using an appreciative enquiry approach.

Monitoring compliance with and the effectiveness of this document

- 1.77 The Framework will be reviewed annually.

Equality and diversity statement

1.78 This document complies with the Newcastle Hospitals equality and diversity statement.

Disclaimer

It is the responsibility of the individual to ensure that the most recent version of this document is being used. This can be checked in the electronic library version control section.

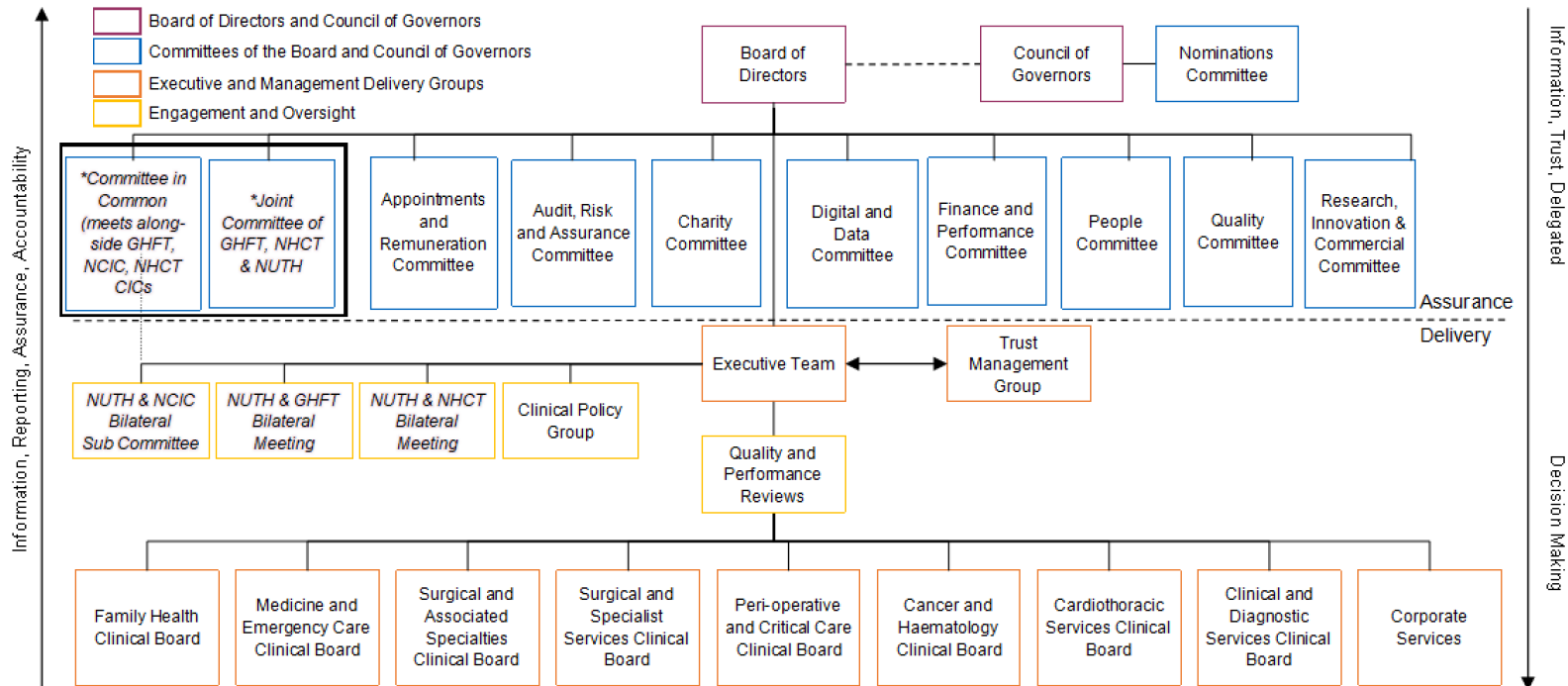
Who, what and where of Newcastle Hospitals

The organizational chart for NHS Wales is structured as follows:

- Chief Executive**: Currently an appointment to NHS England, Sir John Horgan.
- Chair**: Sir Paul Davies CBE.
- Non-Executive Directors**: A group of seven individuals providing strategic guidance.
- Operational**: Includes the Interim Executive Director of Operations, Sir Hilary, and the Acting Chief Executive, Neil Horgan.
- Performance, Governance and Information**: Led by the Director of Performance and Governance, Patricia Gower.
- Clinical Boards**: A central hub connecting various clinical boards, including Family Health Clinical Board, Medicine and Emergency Care Clinical Board, Surgical and Specialist Services Clinical Board, Surgical and Associated Services Clinical Board, Peri-operative and Critical Care Clinical Board, Cancer and Haematology Clinical Board, Cardiothoracic Services Clinical Board, and Clinical and Diagnostic Services Clinical Board.
- Medical**: Led by the Medical Director, Dr. David Williams.
- Nursing and Patient Services**: Led by the Executive Director of Nursing, Midwifery and Allied Healthcare Professionals, Dr. Jane Griffiths.
- Finance**: Led by the Acting Deputy Chief Finance Officer, Dr. Jane Griffiths.
- People & Commercial Innovation**: Led by the Executive Director of People and Commercial Innovation, Dr. Jane Griffiths.
- Alliance and Strategy**: Led by the Director of the Great North Healthcare Alliance and Strategic Partnerships, Dr. Jane Griffiths.
- Communications and Corporate Affairs**: Led by the Director of Communications and Corporate Affairs and Joint Lead on Equality, Diversity and Inclusion, Dr. Jane Griffiths.
- Estate**: Led by the Director of Estate and Facilities, Dr. Jane Griffiths.
- Digital and Technology**: Led by the Chief Digital Officer for the Great North Healthcare Alliance, Dr. Jane Griffiths.
- Trustwide Services**: A collection of services provided across all trusts, including Hospital at Night, Digital Health Team, Occupational Health Services, Learning Disability Liaison Team, Warranties, Practice Education and Practice Development Teams, NCHP Research Team, Infection, Prevention and Control Team, Heart Free Care Team, Quality and Safety, and Patient and Self-Care Support Team.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Appendix 2 – Governance structure



Key:

* Alliance Steering Group

GHFT—Gateshead Health NHS Foundation Trust

NCIC—North Cumbria Integrated Care NHS Foundation Trust

NHCT—Northumbria Healthcare NHS Foundation Trust

NUTH—The Newcastle upon Tyne Hospitals NHS Foundation Trust

CIC—Committee in Common

Appendix 3 – Clinical Board Terms of Reference

CLINICAL BOARD

TERMS OF REFERENCE

1. CONSTITUTION

- 1.1 All clinical services in the Trust are part of one of eight Clinical Boards, which is led by a Clinical Board Chair (a senior clinician), a Director of Operations (a senior manager) and a Head of Nursing (referred to as the leadership triumvirate). Each of these Clinical Boards have been established for the purpose of bringing together its most senior leaders to create a culture of collective leadership, to role model the Trust values and to work in an integrated way to deliver conditions that support staff to deliver the strategic objectives of the Trust.
- 1.2 The Clinical Board is accountable to the Executive Team through the Clinical Board Chair and Director of Operations who are accountable to the Deputy Chief Executive Officer/Nominated Executive Lead. The Joint Medical Directors and the Executive Director of Nursing, Midwifery and AHPs have professional accountability in relation to all aspects of medical and nursing care.

2. DUTIES

- 2.1 In particular the Clinical Board will:
 - a) Oversee and facilitate delivery of Trust objectives, incorporating the annual objectives/goals set each year along with the Clinical Board and Directorate / specialty business plans by:
 - Delivering the agreed Clinical Board strategy.
 - Providing assurance on action plans for variances that are either serious in extent or common across the Clinical Board.
 - Maintaining and reviewing an action tracker.
 - Identifying, managing and escalating (as appropriate) risks in line with the risk management policy.
 - b) Facilitate learning across Clinical Boards from successful initiatives and the review of adverse events utilising the Patient Safety Incident Response Framework.
 - c) Ensure robust management and monitoring of performance metrics, quality and safety issues within the Clinical Board until they are resolved.
 - d) Discuss the Clinical Board's quality and performance and agree actions where necessary to address any issues arising.

- e) Ensure the Clinical Board's financial position remains within the agreed budget, delivering the Cost Improvement target set and take action where necessary when variances occur to minimise the impact.
- f) Manage key workforce issues and agree actions where necessary.
- g) Collaborate with clinical and corporate teams on developments in the wider Trust to deliver the Trust strategic objectives.
- h) Agree and implement research and education priorities and activities within the Clinical Board.
- i) Report to the Executive Team matters by exception (noting that performance and finance are routinely reported through Trust information packs).
- j) Agree a communication plan within the Clinical Board on significant matters and initiatives.

3. MEMBERSHIP & ATTENDANCE

3.1 The Clinical Board will include the following members:

- a) Clinical Board Chair (Chair)
- b) Director of Operations
- c) Associate Directors of Operations
- d) Associate Medical Director
- e) Head of Nursing
- f) Clinical Directors (CD)
- g) Clinical Board finance lead
- h) Clinical Board workforce lead
- i) Clinical Board information lead
- j) Quality and Safety lead

3.2 The members will meet monthly, and an appropriate member of the admin team will be in attendance to take notes of the Clinical Board meetings. Other personnel may be invited by the Chair to attend the meetings on an ad-hoc basis as appropriate.

3.3 Deputies may be nominated to attend prior to the meeting, with the Chair's approval.

4. RESPONSIBILITY OF MEMBERS AND ATTENDEES

Members of the Clinical Board have a responsibility to:

- a) attend meetings, having read all papers beforehand;
- b) when matters are discussed in confidence at the meeting, maintain such confidences;

- c) at the start of the meeting, declare any conflicts of interest / potential conflicts of interest in respect of specific agenda items (even if such a declaration has previously been made in accordance with the Trust's policies and procedures);
- d) produce and maintain a Clinical Board Chairs log/Triple A report to be used as part of the QPRs.

5. QUORUM

- 5.1 Quorum for the monthly Clinical Board meetings will be six members. Of which, two should be members of the triumvirate and there should be at least three Senior Clinical Leaders e.g. CD and Q&S lead in attendance.
- 5.2 When considering if the meeting is quorate, only those individuals who are voting members as listed in 3.1 above can be counted.
- 5.3 Meetings will normally take place monthly on a [day to be inserted].

6. AUTHORITY

The Clinical Board is authorised to: i) act within the Standing Orders, Standing Financial Instructions and Scheme of Delegation, ii) carry out activities and receive assurance on any activity within these terms of reference, iii) make recommendations to the Executive Team; iv) seek any information is requires from any member of staff and v) promote a learning culture, which is open and transparent.

7. REVIEW

The Terms of Reference will be reviewed at least every three years by the Trust Secretary and Deputy Chief Executive/Nominated Executive Lead, with recommendations on changes submitted to the Executive Team for approval.

Date Approved and issued	[TBA - July 2026]
Version Number:	Version 5
Next Review:	[TBA – July 2029]
To be approved by:	Executive Team
Executive Responsibility:	Deputy Chief Executive/Nominated Executive
Lead	

Appendix 4 – Quality & Performance Review Meetings Terms of Reference

QUALITY AND PERFORMANCE REVIEW MEETINGS

TERMS OF REFERENCE

1. **PURPOSE**

- 1.1 The purpose of Quality and Performance Reviews (QPRs) are to ensure that Clinical Boards and Corporate Departments are progressing in line with their strategic aims and objectives, national and local reporting requirements, as well as addressing areas of under-performance and acknowledging areas of strong performance.
- 1.2 The Clinical Board/Corporate Department leadership team will prepare a pack of information circulated 3 working days in advance to enable the QPR attendees to have the information required to undertake the review to the appropriate depth. This will be supported by Corporate Teams as required and cover all aspects of the agenda. The process will ensure that key issues and risks are being appropriately managed.
- 1.3 As well as playing an important role in the overall Performance and Accountability Framework for the Trust, the QPR process provides Clinical Boards/Corporate Departments an opportunity to discuss and escalate updates and concerns to members of the Executive Team and other Senior Managers as part of the review.

2. **DUTIES**

- 2.1 QPR meetings take place (at a frequency determined in accordance with the autonomy level assigned) with each of the eight Clinical Board and the Corporate Departments.
- 2.2 The QPRs focus on five domains:
 - Quality and safety.
 - Performance – including activity and access targets.
 - People metrics.
 - Finance including current year position and financial recovery.
 - Strategy and service developments.

3. **MEMBERSHIP & ATTENDANCE**

- 3.1 QPR Meetings will include the following members:

- a) Deputy Chief Executive/Nominated Executive Lead (Chair)
- b) Joint Medical Directors
- c) Executive Director of Nursing, Midwifery & AHPs
- d) Chief Finance Officer
- e) Director of Performance & Governance
- f) Director of Quality & Safety
- g) Director for People and Organisational Development
- h) Executive Director of People and Commercial Innovation
- i) Clinical Board Chair
- j) Director of Operations
- k) Head of Nursing
- l) Associate Directors of Operations (optional)
- m) Clinical Directors (optional)
- n) Clinical Board finance lead
- o) Clinical Board workforce lead
- p) Clinical Board information lead
- q) Clinical Board quality lead
- r) Performance Lead

- 3.2 An appropriate member of the performance team will be in attendance to take notes of the meetings.
- 3.3 Deputies may be nominated to attend prior to the meeting, with the Chair's approval.
- 3.4 The Deputy Chief Executive/Nominated Executive Lead will chair all QPRs in the first instance, with a member of the Executive Team nominated to act as Vice Chair. Additionally, the Director of Improvement & Delivery (Operations) will endeavour to attend in these circumstances to ensure consistency and representation from the Executive Team across all reviews.

4 **RESPONSIBILITY OF MEMBERS AND ATTENDEES**

- 4.1 Members of the QPR Meetings have a responsibility to:
 - attend meetings, having read all papers beforehand;
 - when matters are discussed in confidence at the meeting, to maintain such confidences; and
 - at the start of the meeting, declare any conflicts of interest / potential conflicts of interest in respect of specific agenda items (even if such a declaration has previously been made in accordance with the Trust's policies and procedures).
- 4.2 If unable to attend, members must inform the Chair and the Corporate Performance team, as well as assigning a Deputy to attend on their behalf.

- 4.3 Meeting Chairs will ensure there is a consistent approach to QPRs by following the issues specified in the agenda, as approved by the Executive Team.

5 RELATIONSHIPS AND REPORTING ARRANGEMENTS

- 5.1 Reviews will be scheduled at least 6 weeks prior to the proposed date.
- 5.2 Reports for the meeting should be submitted by the agreed deadlines.
- 5.3 Information providers must secure sign-off from the Directors of Operations before providing the document to the Performance Team - once a document is received it will be assumed that it has been signed-off.
- 5.4 The Performance Team will then collate, check, clarify and format documents with the aim of distributing a complete ahead of the review date to all attendees. Post-review, it will be the responsibility of the performance team to circulate draft minutes and action logs in a timely manner.
- 5.5 The Clinical Board will provide a presentation pack 3 working days in advance to lead the review meeting attendees through the exception reports.
- 5.6 To co-ordinate QPRs, flexibility will be required on behalf of all members and administration teams should make every effort to ensure these are a priority.

6 REPORTING OUTCOMES AND BOARD FEEDBACK

- 6.1 It is expected that each Clinical Board will have in place arrangements for similar review meetings with their Clinical Directorates ahead of the Clinical Board performance review meeting.
- 6.2 Following each round of QPR meetings, the key performance issues arising from the meetings will be drawn together by the Deputy Chief Executive/Nominated Executive Lead and discussed by the Executive Team. This provides an opportunity for key issues to be escalated, particularly where they might involve or impact on more than one Clinical Board or Corporate Department. This in turn informs the discussion of performance by the Board of Directors' Committees, and the Board itself. The Triple A report from the QPR meetings will be included with the papers for the Quality and Finance & Performance Committees, and Trust Board.

7. QUORUM

- 7.1 Quorum will be six members. Of which, at least two should be Executive Team members and at least two should be Clinical Board members (for Clinical Board QPRs) or Corporate Department members (for Corporate Department QPRs).
- 7.2 The frequency of meetings will depend on which autonomy level the Clinical Board or Corporate Department is assigned to.

8. REVIEW

- 8.1 The Terms of Reference will normally be reviewed at least every three years, with recommendations on changes submitted to the Executive Team for approval.

Date Approved and issued	[TBA – July 2026]
Version Number:	Version 4
Next Review:	[TBA – July 2028]
To be reviewed by:	Trust Management Group
To be approved by:	Executive Team
Executive Responsibility: Lead	Deputy Chief Executive/Nominated Executive

Appendix 5 – Trust Management Group Terms of Reference

TRUST MANAGEMENT GROUP (TMG)

TERMS OF REFERENCE

Purpose

The Trust Management Group is the senior leadership of Newcastle Hospitals meeting together to support good decision making and leadership by:

- Building, developing and maintaining a cohesive senior team, modelling the right behaviours and values for the rest of the organisation;
- Developing and maintaining effective strategic situational awareness of the organisation, the wider NHS, the region and national health and social care matters;
- Testing approaches and strategic plans before formal governance decisions; and
- Working together to develop solutions to shared challenges to support the strategic direction of the organisation to deliver safe and high-quality care.

Membership

Trust Management Group comprises the leadership of the Clinical Boards, the Executive Team, senior clinical, operational and corporate leadership of the organisation. Specifically, this is

- a) Chief Executive Officer (CEO) (Chair);
- b) All Executive Team members and Corporate Heads (as agreed with the Chair);
- c) All Clinical Board Chairs;
- d) All Associate Medical Directors;
- e) All Associate Directors of Nursing, Midwifery and Allied Health Professionals;
- f) All Directors of Operations; and
- g) All Heads of Nursing.

Occasional deputy attendance will be agreed with the Chair but deputies are not expected as a matter of routine; for example where the Clinical Board Triumvirate are represented. Colleagues may attend for specific items.

Frequency

Trust Management Group meets fortnightly on Wednesday at 08.15. It may meet more or less frequently and at other times as required.

Work Programme

The Work Programme for Trust Management Group is, ultimately the responsibility of the Chief Executive but is held on their behalf by a small working group of TMG members who ensure the programme is timely and relevant.

Process

The Work Programme will be clear and transparent ensuring colleagues can prepare in advance. Each item will be framed carefully to be clear what is asked of TMG. Each item will be properly resolved into action and TMG will hold itself accountable for delivering those agreed actions.

Expectations

Trust Management Group expects the following key meeting principles to be adhered to:

- Proactive participation and active listening;
- Focus and purpose to avoid repetition;
- Inclusion and effort made to listen carefully;
- Proper dissent where there is disagreement; and
- Members to take responsibility to brief colleagues who miss a meeting or item.

The Chatham House Rule will apply, except where it is explicitly agreed not to. And TMG members take Cabinet responsibility for agreed action and decisions.

Matching the mechanism to the matter

Approaches to individual matters will be adjusted to suite the matter. That will mean attendance, framing, timing, time taken and a range of tools will be required.

That framing will make it clear whether the item is:

- **Telling;** sharing information with TMG;
- **Developing;** testing thinking ahead of formal decision;
- **Solving;** mobilising the expertise and experience of TMG to solve a problem; or
- **Energising;** unsticking an issue and gaining support and momentum.

Regular Review

The Chair will review each meeting as it closes, confirming action, communication and testing how well each meeting has gone.

The membership and terms of reference will be reviewed annually at the start of each business year and no later than the end of April.

Date Approved and issued:	January 2026
Version Number:	Version 6
Next Review:	March 2027
To be reviewed by:	Trust Management Group
To be approved by:	Executive Team
Executive Responsibility:	CEO

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 July 2026					
Title	Annual Statement on behalf of The Newcastle upon Tyne Hospitals NHS Foundation Trust - Modern Slavery and Human Trafficking Act 2015					
Report of	Kelly Jupp, Trust Secretary Dan Shelley, Procurement and Supply Chain Director					
Prepared by	Kelly Jupp, Trust Secretary Dan Shelley, Procurement and Supply Chain Director					
Status of Report	Public	Private		Internal		
	☒	☐		☐		
Purpose of Report	For Decision	For Assurance		For Information		
	☒	☒		☐		
Summary	Since 2025 the Trust has adopted the National Department of Health and Social Care (DHSC) and NHS England (NHSE) Modern Slavery Statement, this is refreshed in May each year with the title referencing the previous financial year.					
Recommendation	The Trust Board is asked to agree that the wording in section 3(i) be added to the Trust website to replace the existing Annual Statement and note the Trusts ongoing CIPS (Chartered Institute of Procurement & Supply) Ethical Procurement Accreditation.					
Links to Strategic Objectives	Joining up care	Advancing care		Supporting great care		
	☐	☒		☐		
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☐	☒	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link.					
Reports previously considered by	This is an annual submission. The previous report was approved by the Committee on 22 July 2025 and subsequently the Trust Board on 25 July 2025. Report considered at the Audit, Risk and Assurance Committee meeting on 28 July 2026.					

ANNUAL STATEMENT ON BEHALF OF THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST

MODERN SLAVERY AND HUMAN TRAFFICKING ACT 2015

1. INTRODUCTION

In May 2025 the Trust adopted the NHSE modern slavery statement.

The national Statement refers to the previous financial year in its title, therefore the current statement is named **NHS England modern slavery and human trafficking statement for 2025/26**.

2. 2026 UPDATE

Following NHS Board approval, the NHS modern slavery statement for 2025/26 was published on behalf of **ALL** NHS bodies in May 2026 [see [NHS England » NHS England modern slavery and human trafficking statement for 2025/26](#)].

The government announced on 13 March 2025 the merger of NHSE with the DHSC. This statement covers the steps taken by NHSE to support the wider NHS to address the risk of modern slavery in the health service and the steps the NHS system is expected to take locally.

DHSC and NHSE teams continue to work in collaboration to mitigate modern slavery and the approach to future NHS statements will be considered as the organisations integrate.

NHS organisations are encouraged to defer to this group statement and link to it directly from their websites rather than produce individual statements.

In addition to aligning with the national policies and guidance the Trust is still the only NHS Trust to hold the Corporate Ethics Accreditation from the CIPS. This accreditation demonstrates the Trust commitment to ethical procurement and recognises that all staff making procurement decisions are training and pass the annual assessment.

3. RECOMMENDATION

The Trust Board are asked to:

- i) Agree that the following wording be added to the Trust website to replace the existing Annual Statement:

The Trust recognises that it has a responsibility to take a robust approach to preventing and addressing any concerns regarding modern slavery and human trafficking and is absolutely committed to eradicating modern slavery and human trafficking.

Agenda item A5(b)

The Trust is also fully committed to working towards supply chains, and business activities, that are free from ethical and labour standards abuses.

The NHS modern slavery and human trafficking statement can be found here at [NHS England » NHS England modern slavery and human trafficking statement for 2025/26](#).

- ii) Note the Trusts ongoing CIPS Ethical Procurement accreditation.

**Report of Kelly Jupp, Trust Secretary, and Dan Shelley Procurement and Supply Chain Director
July 2026**

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	Approved by Charity Committee via email					
Title	Annual Review of the Newcastle Hospitals Charity Committee 2025/26					
Report of	Phil Kane, Committee Chair (until 31 May 2026) Wendy Balmain, Committee Chair (from 1 June 2026)					
Prepared by	Amanda Waterfall, Operations Manager					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☒		☒		☐	
Summary	The purpose of this report is to provide assurance to the Trust Board that the Charity Committee has met its key responsibilities for 2025/26, in line with their terms of reference.					
Recommendation	The Board is asked to approve this report outlining 2025/26 work undertaken and note the key areas to revisit during 2026/27.					
Link to Strategic Priorities	Joining up care		Advancing care		Supporting great care	
	☐		☒		☐	
Impact	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☐	☒	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	Not applicable.					
Reports previously considered by	Annual Review of the Committee.					

ANNUAL REVIEW OF THE NEWCASTLE HOSPITALS CHARITY COMMITTEE 2025/26

EXECUTIVE SUMMARY

The report includes:

- A summary of the committee's purpose and responsibilities;
- The committee membership and meeting attendance during 2025/26;
- The key achievements in 2025/26;
- The funding applications approved in 2025/26, with those exceeding £100,000 outlined;
- Financial management and controls reporting arrangements;
- Governance, internal controls and risk management;
- Progress areas for 2026/27; and
- The priority actions for the coming year.

The Committee is asked to approve this report outlining 2025/26 work undertaken and note the key areas and priority actions to revisit during 2026/27.

ANNUAL REVIEW OF THE NEWCASTLE HOSPITALS CHARITY COMMITTEE 2025/26

1. PURPOSE

The purpose of this report is to provide assurance to the Trust's Board of Directors (BoD) that the Charity Committee has met its key responsibilities for 2025/26, in line with its terms of reference.

The following sections outline overall achievements throughout the year. The report also outlines action points for continuing development during the coming year.

2. COMMITTEE RESPONSIBILITIES

The Charity Committee is a statutory committee established by the BoD to manage, on behalf of the BoD, all charitable funds of which the Trust is Corporate Trustee, and to ensure that the management of the charity is compliant with the regulations set out by the Charity Commission (CC) for England and Wales and the Fundraising Regulator.

The key purpose of the Charity Committee is to:

- Ensure that there is a robust process in place to consider the application of the Trust's charitable funds in accordance with their respective governing documents and ensure that funds are used in accordance with the charity's objectives – all with the budget, priorities and spending criteria determined by the Trust Board as trustees and consistent with the Charities Act 2022 and the Charities (Protection and Social Investment) Act 2016 (the 'PSI Act 2016');
- Provide oversight to ensure that the Trust's charitable funds are managed in accordance with statutory requirements of the Charity Commission (CC), the Fundraising Regulator, the Department of Health & Social Care guidance and that the Trust's Standing Orders, Reservation of Powers to the Board and Delegation of Powers, the Scheme of Delegation and Standing Financial Instructions are appropriate in this context; and
- Make decisions, on behalf of the Corporate Trustee, involving the sound investment of charity funds in a way that both preserves their capital value and produces a proper return consistent with prudent investment and ensures compliance with the Trustees Act 2000, the Charities Act 2022, the PSI Act 2016 and CC regulations.

The committee fulfils this responsibility through the receipt of assurances from management, investment managers, and other sources.

3. COMMITTEE MEMBERSHIP AND MEETINGS

The Committee is appointed by the Board and consists of six members of the BoD with a quorum being three members, with at least one Executive Director (ED) and one Non-Executive Director (NED) in attendance.

Four ordinary meetings were held between 1 April 2025 and 31 March 2026. Attendance was as follows:

	Attendance at ordinary meetings
Phil Kane, NED and Committee Chair	3 of 4
Bill MacLeod, NED	4 of 4
David Weatherburn, NED	2 of 4
Wendy Balmain, NED and Vice Chair	4 of 4
Lucia Pareja Cebrian, Joint Medical Director	3 of 4
Jackie Bilcliff, Chief Finance Officer	2 of 4
Caroline Docking, Director of Communications and Corporate Affairs	2 of 4
*Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals (AHP)	1 of 3

* Ian Joy joined the Committee in July 2025, meeting dates for 2025/26 were finalised and in diaries, apologies for the meetings were received due to prior commitments and scheduled annual leave.

It was agreed in year 2022/23 that additional meetings were required to consider funding applications and therefore, a further six funding-only meetings were held between 1 April 2025 and 31 March 2026. Attendance was as follows:

	Attendance at Funding only meetings
Phil Kane, NED and Committee Chair	6 of 6
Bill Macleod, NED	5 of 6
David Weatherburn, NED	5 of 6
Wendy Balmain, NED and Vice Chair**	2 of 6
Lucia Pareja Cebrian, Joint Medical Director	4 of 6
Jackie Bilcliff, Chief Finance Officer	4 of 6
Caroline Docking, Director of Communications and Corporate Affairs	6 of 6
Ian Joy, Executive Director of Nursing, Midwifery and AHPs	3 of 4

**Wendy Balmain joined the Committee in February 2025, meeting dates for 2025/26 were finalised and in diaries, apologies for the funding only meetings were received due to prior diary commitments and scheduled annual leave.

The main committee met the minimum number of four meetings per year and other attendees at the meetings included:

- The Newcastle Hospitals Charity (NHC) Director;
- The Head of Charity Finance;
- Associate Director of Funding and Partnerships – NHC;
- The Engagement and Impact Officer - NHC
- The Head of Arts Programmes - NHC;
- The Operations Manager – NHC;
- The Sir Bobby Robson Institute (SBRI) Campaign Director;
- The Database and Information Officer – NHC;
- The Associate Medical Director for Children and Young People’s Services;
- The Volunteer Services Manager;
- A Governor Observer;
- Partner, Stoneking LLP.

The Charity Operations Manager acted as the Committee Secretary.

4. KEY ACHIEVEMENTS

During 2025/26, the following matters were considered by the committee:

- The Charity Director provided a comprehensive update at each of the meetings in relation to progress against the Charity Strategy; namely fundraising and retail, communications and engagement, charity operations, Key Performance Indicators (KPI’s) and the arts programme. Further to this:
 - At the May 2025 meeting, a presentation on Charity Governance was received.
 - At the September 2025 meeting, a discussion on the Charity Strategy beyond 2026 took place.
 - At the November 2025 and February 2026 meetings a paper and update on the Options Appraisal of Governance Models for Newcastle Hospitals Charity was received.
 - At the November 2025 and February 2026 meetings a discussion took place regarding the commencement of a review of fundraising.
- The Committee received the Charity Risk Statement in May 2025, September 2025, November 2025 and February 2026.
- The Committee received and approved the 2025/26 KPIs.
- The 2024/25 Impact Report was received.
- The draft Charity Annual Report and Accounts were received in September 2025 and approved at Trust Board in November 2025.
- The Committee continued to receive finance management reports at each meeting and throughout the year considered its approach to unrealised gains and received an overview of cashflow, a quarterly report on funds committed and not drawn down, an

update on rationalisation of funds and a summary of bank accounts, signatories, and delegated authorities.

- The Committee received quarterly summary investment reports from Newton's and CCLA.
- A report on Charity Retail was received in May 2025.
- The North East & North Cumbria NHC Charities Collaborative Working paper was received in November 2025.
- Funding proposals were presented for the consideration of the Committee at the additional Funding only meetings held in May 2025, June 2025, July 2025, December 2025, January 2026, March 2026 and at the main meetings held in September and November 2025. These are outlined in section 6. In addition, a report of recent funding activity was presented at each funding only meeting, an overview of the funding approach within NHC, as well as a summary of funding under £20,000 agreed between meetings.
- The Committee received an Arts Programme update at the September 2025 meeting.
- The Volunteer Services Manager attended the February 2026 Meeting and gave a presentation.

5. FUNDING PROGRAMMES

During 2025/26, the Committee considered funding applications for approval.

The total value of all £20k+ proposals supported in 2025-26 to date was £3,379,761.43 and the total funding committed to all proposals supported in 2025-26 was £4,186,630.52.

The following funding of over £100,000 were approved:

- Trust Staff Health and Wellbeing Programme (a new psychology service), £863,243
- Transforming Lung Transplant Outcomes through Ex-Vivo Lung Perfusion (EVLP), £341,820
- Paediatric Hearts Retrieval Programme, £150,000
- Staff Christmas Lunch 2025, £169,570
- Newcastle United Foundation youth workers, £100,000
- Great North Children's Hospital youth workers, £148,946

Applications that exceeded £1m were required to be considered and agreed by the Board of Directors.

Essential Funding Criteria 2025/26 was received by the Committee.

A 2024/2025 Funding Programme Summary and 2025/26 Funding Programmes update was received.

A bi-annual update on monitoring and evaluation of funded proposals was received.

The management of all funding applications moved over to the Beacon relationship management system in February 2026.

6. FINANCIAL MANAGEMENT, CONTROL & REPORTING

The committee continued to ensure that financial reporting was reviewed throughout the year with the following quarterly reports being received:

- Cashflow including income targets and expenditure.
- Funds committed and not yet drawn down quarterly report.
- Charity banking/investment signatories.
- Further work undertaken on the rationalisation of Charity funds.
- Following a legal recommendation that a shared resources agreement (SRA) be established for all other operational services, as per the connected charity guidance and charity law. A draft SRA was further discussed at the meetings in September 2025 and February 2026.

Steps are being taken to gain further assurance that costs on external service providers are under active review with a view to further maximising value.

The committee continued to receive regular reports from the Trust's Investment Fund Managers, CCLA and Newton's, as well as the charity's own financial report.

Charity income of £10,463.00 for 2025/26. Please see below for the breakdown of income received.

Charity Income Received in 2025/26

2026					2025				2024
Return on Investment (ROI)	Group	Charity	Fundraising	Retail					
Income	10463	9468	8057	995					
Costs	2974	2130	1271	844					
ROI	£2.52	£3.45	£5.34	£0.18					
Costs per £1 raised	Group	Charity	Fundraising	Retail					
	£0.28	£0.22	£0.16	£0.85					
Voluntary Income	Unrestricted	Designated	Restricted	Total	Unrestricted	Designated	Restricted	Total	Total
Donations	249	2,390	585	3,224	196	899	353	1,448	1,842
Legacies	296	938	161	1,395	969	3,987	1,168	6,124	2,418
Total Income from Donations and Legacies	545	3,328	746	4,619	1,165	4,886	1,521	7,521	4,260
Grants receivable	128	13	3,266	3,407	16	0	0	16	22
Fundraising Events	23	8	0	31	16				
Total Voluntary Income	696	3,349	4,012	8,057	1,383	5,009	1,521	7,913	4,282
Other Trading Activities									
Lottery	0	4	0	4	0	0	0	0	0
Retail	0	995	0	995	0	576	0	576	574
Gift Aid from Subsidiary	0	0	0	0					
Total	0	999	0	999	0	576	0	576	574
Investment Income	672	0	735	1,407	926	0	345	1,271	1,265
Total Incoming Resources	1,368	4,348	4747	10,463	2,309	5,585	1,866	9,760	6,121

7. GOVERNANCE, INTERNAL CONTROL AND RISK MANAGEMENT

Areas of strategic risk were outlined in the charity risk statement presented through the year. These were:

- Charity Governance and Reputation;
- Financial and Operational Sustainability;
- Fundraising Income; and
- Charity Investments and Liquidity.

The risk appetite for each risk area was considered and agreed and would continue to be reviewed in light of developments. Additional controls in place were also outlined.

The Charity ended the year with one managed and two tolerated risks.

The committee had a schedule of business for 2025/26 and utilised a rolling programme and action log to track committee actions.

The Charity Committee Terms of Reference were agreed at the May Committee Meeting and then at Trust Board on 26 June 2025.

The Connected Charities Checklist was received by Charity Committee in September 2025.

A Draft Conflicts of Interest Policy/Process was received and approved by Committee in February 2026.

Minutes from The Sir Bobby Robson Foundation Committee and the Great North Children's Hospital Advisory Committee were received throughout the year.

There were no matters arising during the course of the year that required reporting to the Charity Commission.

8. PROGRESS FOR 2025/26 & REVIEW OF EFFECTIVENESS

Key areas to be revisited during 2026/27 are:

- Performance against the key areas of focus in the charity strategy continue to roll forward. This includes the need to ensure that the committee are kept abreast of any areas of potential risk to this and where strategic aims are unlikely to be achieved and will help inform the new Charity Strategy.
- A clear framework/funding programme to be completed, agreed and approved by the Committee.
- Quarterly updates to Committee on the Sir Bobby Robson Institute Funding Campaign.

The Committee will be required to receive assurances regarding the activities outlined above.

An annual effectiveness survey was circulated to Committee members. Feedback was received from 3 Charity Committee members, which highlighted the following:

- Responses were largely positive. Most respondents agreed or strongly agreed that:
 - The Committee has a clearly defined role, purpose and objectives (as set out in its Terms of Reference).
 - The meeting is well managed in terms of scheduling, agenda setting and time management.
 - The skill mix and number of people who attend is appropriate.
 - The purpose of papers being presented is made clear by the author, with actions, issues and assurances clearly defined.
 - Committee members actively participate and make relevant contributions to discussions.
 - The cross-representation of members at Committee meetings enhances the quality and reliability of decisions.
 - There is no unnecessary duplication between Committees.
 - The frequency of the meetings enables business to be conducted effectively.
 - The Chair clearly captures decisions and actions arising throughout the committee meetings.
 - The Chair clearly captures the decision-making process and ensures it is understood by Committee members.
 - It is clear when the Committee needs to escalate matters for the attention of the Board or to another Committee.
 - The Committee Chair effectively addresses conflicts, concerns or issues that arise within the Committee.
 - The Committee Chair effectively manages time allocated to allow discussion on key items and encourages participation from newer / less experienced members.
 - Committee members and meeting attendees are actively engaged and focussed on the reports under discussion.
 - The Committee effectively considers and weighs the potential risks and benefits associated with the decisions made.
 - The Committee members are given the opportunity to provide input and contribute to the decision-making process.
 - The style and quality of meeting papers is appropriate for the meeting.
 - Meeting papers are succinct and set out the key issues, assurances and any gaps in assurances.
 - The Committee values and considers diverse perspectives and opinions when making decisions.
 - The Committee's decision-making process is clear, transparent and inclusive.
 - The Committee ensures that processes are in place to create robust action plans with clear ownership, timeframes, and dependencies all of which are monitored and followed up.
 - The Committee receives assurance that identified actions are completed in line with agreed timescales.
 - Decisions are based on and related to the evidence presented to the Committee.
 - Record keeping is prompt and accurate.

- The Committee's goals, objectives and activities are clearly aligned with the Trust's vision and strategy.
 - Committee's meetings and agendas are focussed on addressing priorities aligned with the Trust's vision and strategy.
 - The Committee's decision-making process reflects the Trust's vision and strategy.
 - The Committee effectively fosters a culture and environment that supports the pursuit of the Committee's vision and strategy.
 - The Committee is actively engaged in discussions and decision-making processes that contribute to the realisation of the Trust's vision and strategy.
 - The Committee is effective in communicating and reporting on risks, issues and performance, and escalating these where necessary.
 - Where information or risks need to be discussed in more than one committee, there is effective escalation between committees.
 - The Chair provides adequate support and guidance in managing risks, issues and performance.
 - Committee members actively discuss the strategic risks in the Board Assurance Framework (BAF) that are within the remit of the Committee.
- There was one statement where one respondent included 'Neither Agree or Disagree'
 - The Committee is actively engaged in discussions and decision-making processes that contribute to the realisation of the Trust's vision and strategy.
 - Additional feedback comments were included which covered:
 - One respondent noted that both the Trust Strategy and Charity Strategy are currently being developed and alignment between both strategies will be strengthened in the coming months.
 - Another respondent noted that some of the questions about Trust strategy are not so relevant to this committee - while seeking alignment to the Trust, the Charity is independent and this balance is an important feature of committee discussions.
 - One respondent noted that although the Trust strategy is in production, the group has a clear charity strategy.

9. **RECOMMENDATION**

The Committee is asked to approve this report outlining 2025/26 work undertaken and note the key areas and priority actions to revisit during 2026/27.

Report of Phil Kane
Charity Committee Chair until 31 May 2026

Wendy Balmain
Charity Committee Chair from 1 June 2026
11 July 2026

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	31 July 2026					
Title	NHS England (NHSE) Post Death Care Board Assurance Statement					
Report of	Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals (AHP). Patrick Garner, Director of Performance and Governance. Michael Wright, Joint Medical Director.					
Prepared by	Natalie Yeowart, Associate Director of Compliance, Assurance and Risk.					
Status of Report	Public ☒		Private ☐		Internal ☐	
Purpose of Report	For Decision ☒		For Assurance ☒		For Information ☐	
Summary	On 28th November 2023, Sir Jonathan Michael, Chair of the Inquiry into the inappropriate and unlawful actions of David Fuller at Maidstone and Tunbridge Wells NHS Trust published the Fuller Inquiry Report which identified significant failing in relating to the care of the deceased. On the 24th June 2026 the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust was published which also identified significant issues with post-death care practices. In response, NHS England has set out clear expectations for all post death services and have requested that each Trust Board provide assurance that they have robustly assessed the effectiveness of governance in place to ensure the Human Tissue Authority (HTA) standards are achieved, Fuller recommendations are actioned and oversight and governance processes are robust. Over the last 18 months a significant amount of work has been undertaken to review and improve the Trust mortuary services and associated governance arrangements. A summary of the key assurances are documented in section 2 of this report. The Trust are required to provide a formal Post Death Care Board Assurance Statement to NHS England by the 31st July 2026. This has been drafted and can be found in Appendix 1.					
Recommendation	The Trust Board are asked to: • Receive the summary report • Review and approve the Post Death Care Board Assurance Statement in Appendix 1.					
Link to Strategic Priorities	Joining up care ☒		Advancing care ☐		Supporting great care ☒	
Impact	Quality ☒	Legal ☒	Finance ☐	Human Resources ☐	Equality & Diversity ☐	Sustainability ☐

Agenda item A5(d)

Link to Board Assurance Framework [BAF]	1.1 Failure to meet our care standards in a way which is designed around people, not organisations.
Reports previously considered by	Standalone report. Presented to the Audit, Risk and Assurance Committee on 28 July 2026.

NHSE POST DEATH CARE BOARD ASSURANCE FRAMEWORK STATEMENT

1. INTRODUCTION.

On 28th November 2023, Sir Jonathan Michael, Chair of the Inquiry into the inappropriate and unlawful actions of David Fuller at Maidstone and Tunbridge Wells NHS Trust published the Fuller Inquiry Report which identified significant failing in relating to the care of the deceased.

On the 24th June 2026 the Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust was published which also identified significant issues with post-death care practices.

The findings relating to post-death care within the Nottingham Review report as well as the key findings from the Fuller Inquiry has highlighted the critical importance of delivering safe, compassionate and dignified care for deceased patients and families of the deceased.

Both reports identified significant shortcomings in post-death care, including failures in bereavement support, communication, mortuary practices and governance, demonstrating that the quality of care provided after death has a lasting impact on bereaved families and their experiences.

In response, NHSE has set out clear expectations for all post death services and have requested that each Trust Board provide assurance that they have robustly assessed the effectiveness of governance in place to ensure the HTA standards are achieved, Fuller recommendations are actioned and oversight and governance processes are robust.

2. TRUST REVIEW

Over the last 18 months a significant amount of work has been undertaken to review and improve the Trust Mortuary services and associated governance arrangements. The Trust were selected by the Fuller Inquiry to participate in the phase 2 review of NHS Trust's into the care of the deceased, preparation for this included a review of all Fuller findings and a comprehensive action plan was completed to self-assess against all 29 actions. 28/29 actions are now complete, with the remaining action (swipe access on exit doors) to be completed by the end of August 2026.

Robust governance and assurance processes are in place to ensure ongoing monitoring and reporting of post death care and ward to board oversight can be demonstrated. A HTA Designated Individual has been appointed who has responsibility for ensuring all HTA Regulated Activity Standards are achieved, providing bi-annual reports to the Compliance and Assurance Group in relation to compliance with regulated standards.

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Further positive assurance has been received following recent independent inspections from the HTA and the United Kingdom Accreditation Service (UKAS) demonstrating high compliance with standards.

The Executive Director of Nursing, Midwifery and AHP has professional responsibility for privacy and dignity of the deceased and undertakes quarterly assurance visits to ensure safeguarding, security, privacy and dignity standards are maintained.

The Executive Director of Nursing, Midwifery and AHP provides a bi-annual report to the Quality Committee which documents any areas of good practice, any concerns raised by staff and any actions that require escalation or action, ensuring plans are put in place to address any areas of improvement required.

In relation to Mortuary Estate, the Trust undertook a self-assessment of the Trust mortuaries and body stores against the latest version of the NHS Premises Assurance Model in June 2026, one recommendation was identified within the self-assessment regarding swipe access on exit doors, as documented above this was previously identified by the Trust and will be completed by the end of August 2026.

Based upon the information reviewed and the work that has been completed over the last 18 months a high level of assurance is demonstrated. A formal Post Death Care Board Assurance Statement must be returned to NHSE by the 31st July 2026. This has been drafted and can be found in Appendix 1.

3. RECOMMENDATIONS

The Trust Board are asked to:

- Receive the summary report;
- Review and approve the Post Death Care Board Assurance Statement in Appendix 1.

Report of:

Natalie Yeowart

Associate Director of Compliance Assurance and Risk.

22 July 2026

Post Death Care Trust Board Assurance Statement

Assurance Statement	Confirmed (Yes/No)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.	Yes	Robust controls are in place to ensure that the roles and responsibilities for staff who have responsibility for the care of the deceased are understood. A Quality Management System is in place with policies and procedures which are audited and reviewed on a regular basis. Regular multi-disciplinary governance meetings are in place with representatives in attendance from pathology (including the Designated Individual), bereavement, mortuary, estates and facilities and corporate staff ensuring that regular communication and dissemination of information. Safeguarding staff are invited to attend as and when a safeguarding issue requires further discussion and consideration.
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	Yes	The Trust were selected by the Fuller Inquiry to participate in the phase 2 review of NHS Trusts. As part of this review a comprehensive review was undertaken of the Trust's care of the deceased. Preparation for this included a review of findings of the Fuller Inquiry and a comprehensive action plan to self-assess ourselves against the 29 recommendations. 28/29 recommendations are now complete with robust governance and assurance processes in place to ensure ongoing monitoring. There is one remaining action awaiting completion, this relates to the installation of 'swipe to exit' door controls, this is in progress and is on target for completion by August 2026.

Assurance Statement	Confirmed (Yes/No)	Additional comments or qualifications (optional)
		In addition, further positive assurance has been received following recent independent inspections from the Human Tissue Authority (HTA) and the United Kingdom Accreditation Service (UKAS).
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.	Yes	The Executive Director of Nursing, Midwifery and AHP has professional responsibility for privacy and dignity of the deceased and undertakes quarterly assurance visits to ensure safeguarding, security, privacy and dignity standards are maintained. The Executive Director of Nursing, Midwifery and AHP provides a bi-annual report to the Quality Committee (a committee of the Trust Board), which documents any areas of good practice, any concerns raised by staff and any actions that require escalation or action, ensuring plans are put in place to address any areas of improvement required. The Trust's Safeguarding Operational Group has reviewed the recently updated Safeguarding Accountability and Assurance Framework and have undertaken a gap analysis. Work is in progress to review existing policies to ensure they align with the updated framework.
The Board can assure itself that the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.	Yes	The Board is assured that there is effective oversight of matters relating to the mortuary and related storage areas. A ward to board governance and reporting framework is in place which includes a robust and effective escalation processes. The Trust Compliance and Assurance Group has oversight of compliance and assurance across the Trust and receives a bi-annual assurance report from the Trust appointed HTA Designated Individual which provides assurance that regulatory

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Assurance Statement	Confirmed (Yes/No)	Additional comments or qualifications (optional)
		standards are monitored and achieved. Human Tissue Authority governance and standards are included within the Trust's Internal Audit Programme for 2026/27. In addition, as documented above further positive assurance has been received following recent independent inspections from the HTA and the UKAS.
For all issues relating to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model (PAM) and submit data within the current window (closing date 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.	Yes	The Trust undertook a self-assessment of the Trust mortuaries and body stores against the latest version of the NHS Premises Assurance Model in June 2026. The Trust Estates and Facilities Team are currently reviewing and finalising the data collection, plans are in place for this to be considered at a Finance and Performance Committee, a Committee of the Trust Board in August 2026 prior to submission on 8th September 2026.

Trust Name	Trust CEO/AO Name	Date	Trust Chair Name	Date
The Newcastle upon Tyne Hospitals NHS Foundation Trust.	Robert Harrison Interim Chief Executive/Accountable Officer.		Sir Paul Ennals Chair	

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PUBLIC BOARD MEETINGS - ACTIONS

Agenda item A6(a)

Log No.	BOARD DATE	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
166	27 March 2026	26/08 FOCUS ON FUNDAMENTALS – QUALITY, PERFORMANCE AND FINANCE: e. Joint Medical Directors (JMD) Report including Mental Health update	The Trust’s Mental Health Group met yesterday, and an update would be provided to the Trust Board on progress since the last CQC report [ACTION01]. Paul Ennals noted that it would be useful to discuss this topic through the Quality Committee.	LPC/MWr			14.05.26 - Joint Medical Director (LPC) will discuss with Rachael Gregory, Associate Director of Nursing, and an update paper on Mental Health will be brought to the Quality Committee and Trust Board in June. 23.07.26 - Paper presented at the Quality Committee in June and an update included in the July Public Trust Board Joint Medical Directors paper. Propose to close action.
167	22 May 2026	26/17 SUPPORTING GREAT CARE – SUPPORTING EVERYONE TO DO THEIR JOB TO THE BEST OF THEIR ABILITY WITH EFFECTIVE LEADERSHIP, A JUST AND LEARNING CULTURE AND MODERN DIGITAL AND PHYSICAL ENVIRONMENTS: c. Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) Report/Survey Results	Progress on the People restructure was estimated at 30–40%, with a deliberate and careful approach being taken to appointments despite challenges. A need was identified for greater assurance that current plans and resources would be sufficient to deliver a meaningful cultural reset [ACTION01].	VMR			23.07.26 - VMR advised that the HR team will officially transition into People Services with a go live date of 1st September 2026. The senior team have all now been appointed, including the People and Organisational Development Partners. The latter are critical as will start to co design work with clinical boards and corporate services that will support cultural change. Cultural change will not be immediate, but several priorities for the People Service team in 2026/27 are designed with this aim in mind – establishment of the resolution hub, introduction of a just and learning culture, leadership development programs, evaluation and expansion of working well. Propose to close action.

KEY

NEW ACTION	To be included to indicate when an action has been added to the log.
ON HOLD	Action on hold.
OVERDUE	When an action has reached or exceeded its agreed completion date. Owners will be asked to address the action at the next meeting.
IN PROGRESS	Action is progressing inline with its anticipated completion date. Information included to track progress.
COMPLETE	Action has been completed to the satisfaction of the Committee and will be kept on the 'in progress' log until the next meeting to demonstrate completion before being moved to the 'complete' log.