The Newcastle upon Tyne Hospitals NHS Foundation Trust

Public Trust Board of Directors
Friday 25 September 2026, 10:15 – 12:15
Piano Room, Royal Victoria Infirmary (RVI)

Apologies: Anna Stabler, Michael Wright, Rachel Carter

Agenda

	Time	Item	Purpose	Lead
1.	**Introduction**			
a.	10:15	Apologies for absence and declarations of interest	For discussion	Paul Ennals
b.	10:16	Minutes of the Public Board of Directors meeting held on 31 July 2026 and matters arising	For discussion & approval	Paul Ennals
c.	10:17	Chair's Report ***[Verbal]***	For assurance	Paul Ennals
d.	10:25	Chief Executive Report	For assurance	Rob Harrison
e.	10:35	Committee Triple A reports	For discussion & assurance	Committee Chairs
2.	**Joining up care – working together to give people better, quicker access to effective care**			
a.	10:45	Board Visibility Programme	For assurance	Ian Joy
b.	10:52	Integrated Board Report (IBR)	For assurance	Patrick Garner & Executive Leads
3.	**Advancing Care – improving patient care, effectiveness and quality through innovation, research, improvement and education**			
a.	11:05	Patient and Colleague Experiences	For assurance	Ian Joy
b.	11:15	Joint Medical Directors Report	For assurance	Lucia Pareja-Cebrian
c.	11:25	Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs) report	For assurance	Ian Joy
d.	11:35	Maternity update including: i) Perinatal Quality Oversight Report including Maternity Incentive Scheme progress report ii) Maternity Safety Champion Report	For assurance & approval	Jenna Wall Liz Bromley

	Time	Item	Purpose	Lead
e.	11:45	Winter Plan update	For assurance & approval	Sue Hillyard & Nichola Kenny
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.	11:55	Sustainability update including: i) Annual Shine Update (Shine Report 25-26 & CRP)	For assurance & approval	Vicky McFarlane-Reid
5.	**Items to approve**			
a.	12:00	Board Assurance Framework (BAF)	For assurance & approval	Patrick Garner
b.	12:05	Finance and Performance Committee Terms of Reference	For assurance & approval	Kelly Jupp
6.	**Items to receive *[To cover by exception only]***			
a.	12:10	Learning from Deaths	For assurance	Lucia Pareja-Cebrian
b.	12:13	Meeting Action Log	For assurance	Paul Ennals
7.	**Any other business**			
a.	12:14	Any other business	For discussion	All

Date and Time of Next Meeting: Friday 27 November 2026, 10:15 – 12:15, Piano Room, Peacock Hall, RVI

Sir Paul Ennals, Chair
Mr Rob Harrison, Acting Chief Executive Officer
Mrs Liz Bromley, Non-Executive Director & Senior Independent Director (SID)
Mr Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals
Dr Lucia Pareja-Cebrian, Joint Medical Director
Mr Patrick Garner, Director of Performance and Governance
Dr Vicky McFarlane-Reid, Executive Director of People and Commercial Innovation
Mrs Jenna Wall, Director of Midwifery
Mrs Nichola Kenny, Director of Improvement and Delivery
Mrs Kelly Jupp, Trust Secretary

PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 31 JULY 2026

Present:	Paul Ennals *[Chair]*	Chair
	Jackie Bilcliff	Acting Deputy Chief Executive/Chief Finance Officer
	Lucia Pareja-Cebrian	Joint Medical Director (JMD)
	Michael Wright	JMD
	Ian Joy	Executive Director of Nursing, Midwifery & Allied Health Professionals (AHPs)
	Vicky McFarlane-Reid	Executive Director of People & Commercial Innovation
	Sue Hillyard	Interim Executive Director of Operations
	Anna Stabler	Non-Executive Director (NED)
	David Weatherburn	NED
	Hassan Kajee	NED
	Liz Bromley	NED
	Bernie McCardle	NED
	Jeff Perring	NED
	Wendy Balmain	NED
	Judith McKenna	NED

In attendance:
Caroline Docking, Director of Communications and Corporate Affairs
Martin Wilson, Director - Great North Healthcare Alliance (GNHA) & Strategy
Patrick Garner, Director of Performance and Governance
Dave Elliott, Chief Digital Officer
Kelly Jupp, Trust Secretary
Keith Hodgson, Assistant Director of Estates
James Dixon, Associate Director of Sustainability
Lee-Ann Naidoo, Improvement Programme Manager

Observers:
Tania Bell, Member of the Public
Michael Taylor, Head of Partnerships, Cinapsis
Tom Vellender, Director of Growth and Partnerships, The Guardian Service Limited

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.

26/21 <u>INTRODUCTION:</u>

Paul Ennals reflected on the recent Council of Governors and Annual Members' Meeting (AMM), noting that both had been positive and constructive, with the overall mood feeling encouraging. He acknowledged that pressures across the NHS remained significant, with a new Government, emerging action plans and evolving national strategies meaning that the pace of change was increasing rather than reducing. Despite these challenges, he expressed his hope that colleagues across the Trust would continue to recognise the many positive developments and achievements taking place and feel encouraged by the progress being made.

Paul Ennals noted several changes in NEDs since the last meeting, including saying farewell to Bill MacLeod, NED, earlier in the week. He warmly welcomed Jeff Perring to his first Trust Board meeting as a NED and congratulated Judith McKenna on her move from Associate NED to NED.

a. Apologies for Absence and Declarations of Interest

Apologies were received from Board member Rob Harrison, Acting Chief Executive Officer, and attendees Joanne Race, Associate NED, Rachel Carter, Director of Quality and Safety, Paul Hanson, Director of Estates, Facilities and Strategic Partnerships and Jenna Wall, Director of Midwifery.

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 22 May 2026 and matters arising

The minutes of the meeting held on 22 May 2026 were accepted as a true record of the business transacted.

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

c. Chair's Report

The Chair's Report was received for information.

Paul Ennals noted that since the last meeting a new Secretary of State for Health and Social Care had been appointed, and whilst communications were currently in the early stages, further updates were expected in due course. He also highlighted the ongoing activity of the Trust Board and Council of Governors, including several visits across the organisation to engage with colleagues and see services firsthand.

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

d. Chief Executive's Report

Jackie Bilcliff highlighted the following points:

- Thanks were expressed to colleagues for their support whilst the Acting Chief Executive Officer was on annual leave.
- The launch of the Trust's new strategy and the senior leadership event held on 1 July 2026 to focus on implementation and embedding the strategy across the organisation.
- The continued priority on improving Accident & Emergency (A&E) and cancer performance, whilst ensuring patients and staff remained well supported and cared for.
- Brief updates in relation to the Lord Mann Review, the AMM, Council of Governors and Committee activity.
- Appreciation was extended to all involved in delivering a successful AMM, which included the formal adoption of the Annual Report and Accounts. The market stall events were recognised as a positive initiative, with thanks given to colleagues for their time and contributions.
- Improvement in the National Cancer Patient Experience Survey results, with Newcastle Hospitals ranked 36th out of 129 trusts, compared with 49th place in the previous year. Whilst the improvement was encouraging, it was acknowledged that further progress was still required.

Anna Stabler referred to the positive improvement of the Trust's positioning in the National Cancer Patient Experience Survey results and recognised the efforts of staff who continued to work under challenging circumstances to deliver high-quality care for patients. It was agreed that the National Cancer Patient Experience Survey results link would be circulated to Trust Board members for information **[ACTION01]**.

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

e. <u>Committee Triple A reports</u>

The following updates were provided:

- Hassan Kajee reported that there were no alerts arising from the May and July Digital and Data Committee meetings. Discussions had focused on patient and clinical safety in relation to digital systems, and the laboratory information management system risk had been de-escalated. A new agreement with Northumbria Healthcare had been signed for the laboratory system, which represented a positive development, with implementation now underway. The appointment of Joanne Todd as Director of Digital was welcomed, and it was noted that she would lead the development of a new Digital and Data Strategy.
- Anna Stabler reported that Quality Committee members had raised an alert in May relating to Freedom to Speak Up (FTSU), reflecting a decline in speaking up rates that mirrored the national trend. The matter had also been discussed by People Committee members. In relation to the improvement groups, work continued across several areas, including ophthalmology, with de-escalation being considered where appropriate.

  Bernie McCardle noted that overall increased use of FTSU channels was encouraging and highlighted the importance of ongoing scrutiny through the People Committee,

with six-monthly reporting to the Trust Board. Good progress was being made in strengthening the FTSU infrastructure and increasing capacity.

- Bernie McCardle reported that People Committee members had considered FTSU arrangements, and noted that the slight deterioration in reporting rates was consistent with the national trend. The Trust Board received a detailed FTSU report in May, and the matter remained a key area of focus for improvement.

  Paul Ennals requested that the most up-to-date Committee Triple A reports were presented to future Trust Board meetings.
- In relation to the Finance and Performance Committee (F&PC), Judith McKenna advised that financial outputs and cash continued to be areas of focus. One alert was raised in the July Committee meeting relating to the introduction of the new financial oversight framework.
- With regards to the Audit, Risk and Assurance Committee, David Weatherburn thanked colleagues for their work in delivering a smooth year-end process and noted the contribution of the External Auditors at the AMM.

  Paul Ennals advised that a query was raised at the AMM regarding whether the significant weakness referenced in the external audit report on value for money arrangements could be removed following the improvements made. This related to the Care Quality Commission (CQC) inspection finding of 'inadequate' for the well-led domain and it was the view of the external auditors that the significant weakness should remain in the report until a CQC re-inspection occurred and the well-led rating improved. David Weatherburn explained that the external auditors had taken a cautious approach in their report however they had agreed that this matter would be discussed further with the national technical team at Forvis Mazars. An update was also provided on the development of the new Board Assurance Framework at the July Committee meeting, with the final version scheduled for approval in September.
- Wendy Balmain advised that the Charity Committee had not met since the last Public Trust Board meeting, however the funding only meeting chair's action log was included in the papers. The Trust Board had agreed in principle to explore the creation of a Charitable Incorporated Organisation, with further discussion scheduled later in the day. It was noted that the charity continued to work effectively to ensure donor funding was used appropriately and delivered meaningful improvements to patient care and outcomes.

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

26/22 JOINING UP CARE – WORKING TOGETHER TO GIVE PEOPLE BETTER, QUICKER ACCESS TO EFFECTIVE CARE:

a. Board Visibility Programme

Ian Joy highlighted the gap in the staff survey results between overall staff experience and colleagues' willingness to recommend the Trust as both a place to work and a place to receive care. He noted the strong commitment across the organisation to improving staff

engagement, whilst recognising the increasing complexity of patients' needs and the growing pressures associated with rising workloads.

Paul Ennals welcomed the new style of reporting, noting that it provided greater clarity and supported the Trust Board in identifying emerging issues and gaining assurance in key areas.

Anna Stabler reflected on her fourth or fifth visit to the theatres department, and noted a significant positive change in culture amongst the theatre staff over the past two years. She highlighted improvements made, which included increased storage capacity, and observed that staffing and Intensive Treatment Unit (ITU) capacity challenges, which had previously impacted activity, now felt better managed within a more supportive team environment. In response, Sue Hillyard noted that demand for critical care and theatre capacity continued to be high, with several competing priorities to balance. Work was underway to respond to the national direction of travel in conducting more transplant activity during day-time working hours and to make more effective use of available space, whilst also addressing capacity pressures arising from increased demand across the wider healthcare system.

Ian Joy reflected on his visit to Ward 7 at the Great North Children's Hospital (GNCH), which provided day-case paediatric and renal dialysis services. He highlighted the team's commitment and expertise, describing it as a "small but mighty" service supporting highly specialised patients, including those transitioning into adulthood. All acknowledged the importance of ensuring that smaller specialist teams felt valued and understood within the wider organisation and the need to continue building resilience within the workforce to support the increasing complexity of care.

A discussion ensued which covered the following areas:

- The Trust provided two specialist dialysis services across different sites, which was uncommon. Greater integration could be achieved through future co-location of services. The strategic build programme was recognised as an important long-term opportunity to support service integration and improve patient experience.
- The importance of supporting young people transitioning from paediatric to adult services, with transition planning identified as a key priority. Work was underway to explore how the transition experience could be strengthened, including discussions with Mark Anderson, Family Health Clinical Board Chair.

  Board members reflected on feedback from families who had experienced challenges during the transition process and highlighted the need for care to be tailored to individual patient needs. A focused programme of work was being discussed to improve transition arrangements and ensure patients and families received consistent support throughout the process.

  An update on the transition from child to adult services would be provided to a future meeting of the Quality Committee. It was agreed that Jeff Perring would review the paper prior to its submission to the Quality Committee **[ACTION02]**.

Assurance was provided that progress was being made and confidence was expressed in the breadth of Trust Board and Governor visits undertaken, with the clear learning and insights arising from them.

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

b. Integrated Board Report (IBR)

Patrick Garner noted the following points:

- Five indicators had changed since the previous report, with two key areas of focus highlighted:
    - Performance against the 18-week referral to treatment (RTT) standard continued to improve, with the latest available data showing performance had increased by 1.1% to 74.6%, which demonstrated a positive trajectory. A detailed review of elective care performance would be presented to the F&PC in September.
    - Performance against the 12-hour Emergency Department (ED) standard remained strong, although not achieving the targets set out in the plan, with the Trust continuing to rank among the top performing organisations nationally. However significant pressures remained within the ED, including high patient volumes attending the Urgent Treatment Centre (UTC) and an increase in patient acuity, which contributed to challenges in achieving the four-hour standard.

      The F&PC members discussed a range of actions to support ED improvement at the July meeting and agreed to receive a further update in September.

      NHS England (NHSE) planned to undertake a missed opportunities audit in August.
- Through the monthly Quality Performance Review (QPR) process, longer-term plans relating to radiotherapy and tertiary referral challenges had been discussed.
- Discussions would continue with Alliance partners to review referral pathways and support service improvement.

Anna Stabler reported that the Quality Committee had held robust discussions regarding the two never events reported in April and May, and received assurance that neither patient had been harmed. The incidents were being managed through the Patient Safety Incident Response Framework (PSIRF), with further work underway to strengthen resilience and reduce the risk of recurrence. Committee members also considered Duty of Candour, with a further update scheduled for September, and Anna Stabler commended the work of the Pharmacy team who had demonstrated improved performance in medicines reconciliation.

In relation to the financial position, Jackie Bilcliff advised that the Trust remained on plan at Month 3, delivering a positive financial position year to date. She acknowledged the significant challenge of achieving the full-year financial target, including delivery of the Cost Improvement Programme (CIP), but noted that work continued to maintain financial

stability and support delivery of the planned position. It was also reported that enhanced financial oversight arrangements had been introduced across the region.

Vicky McFarlane-Reid explained that the Trust was expecting a workforce deep dive from NHSE on 14 August as part of a review being undertaken across all trusts in the region. Progress continued to be made towards workforce reduction targets, although some challenges remained. Sickness absence was discussed, with collective efforts underway to support staff and improve performance in this area, which continued to be a concern. People Committee members held a constructive discussion on Statutory and Mandatory training compliance, in particular to consider any potential safety implications, and received assurance that there were no current safety concerns arising from performance levels.

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

26/23 ADVANCING CARE – IMPROVING PATIENT CARE, EFFECTIVENESS AND QUALITY THROUGH INNOVATION, RESEARCH, IMPROVEMENT AND EDUCATION:

a. Patient and Colleague Experiences

Ian Joy highlighted the importance of learning from lived experience feedback, and particularly the strong link between colleagues feeling cared for and valued, and improved organisational performance and patient outcomes. Patient experience feedback gathered from the Real Time Patient Experience Programme was largely very positive; however, one example was shared how a patient had not been involved in a key conversation affecting their future care. The real-time feedback programme had successfully identified the issue and enabled it to addressed promptly.

In relation to colleague experience, Ian Joy emphasised the need for ensuring staff felt a sense of ownership alongside accountability in delivering high-quality care and services.

David Weatherburn observed that there had been a noticeable shift in culture over the past nine months, with a stronger emphasis on learning and continuous improvement. He noted the positive and healthy challenge provided through discussions and scrutiny processes, and welcomed the openness amongst teams in learning from experiences, with less evidence of defensive behaviours and a greater focus on improvement.

Paul Ennals queried the longer-term sustainability of the charitable funding supporting the Real Time Right Time programme. In response, Ian Joy advised that the intention was to embed the programme within business-as-usual arrangements across the organisation to ensure its long-term sustainability. Funding was secured until 2027, allowing time to determine the most appropriate future funding model.

It was **resolved**: to **receive** the Patient and Colleague Experiences update.

b. Joint Medical Directors Report including:

Lucia Pareja-Cebrian highlighted the following points:

- An update was provided on changes to the Associate Medical Director (AMD) structure, with work undertaken to map responsibilities across the governance structure.
- Significant numbers of attendances continued to be seen each month, alongside increasing patient acuity and higher levels of admissions in ED. Work was ongoing to improve and eliminate corridor care, supported by the commencement of Phase 2 building works for the UTC corridor link.
- Chris Gibbons was the new AMD for digital developments, with a significant programme of work underway to improve outpatient processes.
- Cancer performance continued to improve in specific areas, particularly against the 28-day standard, however breast and lung cancer pathways remained areas of focus due to performance challenges.
- Concerns regarding radiotherapy performance were acknowledged, with work ongoing to address the difficulties.
- Reviews of cancer pathways were being undertaken, including visits to other centres to identify opportunities for improvement and best practice. In additional improvements had been made to ablation services.
- The NHSE Quality Strategy was released on 14 July and included ten enablers, one of which aligned closely with work already underway within the Trust.
- Updates were provided on the response to the Amos and Ockenden reports, including the 100-day maternity and neonatal improvement sprint, with emphasis placed on the joint responsibility of medical and nursing leadership.
- Progress on mental health initiatives was reported through the Quality Committee.
- Gus Vincent, AMD, was leading on departmental leadership development and training for Heads of Department. Vicky McFarlane-Reid reported a positive discussion with TheValueCircle and expressed her appreciation for the progress made to date, particularly the nuanced approach being taken to leadership development.
- An update was provided on the AMD partnership work being led by Phil Yates.
- The recently published General Medical Council (GMC) survey results would be included in a future report and would be discussed at the People Committee.
- Progress had been made by several improvement groups, such as the infection prevention and control (IPC) and the deteriorating child groups.
- Significant work had been undertaken to support transplant services, including development of the Assessment and Recovery Centres (ARC) programme.
- An update was provided on the Alliance Framework work, and thanks were expressed to Martin Wilson for his leadership and contribution in this area.

A discussion ensued which covered the following areas:

- Status of the cancer business case. Sue Hillyard noted that feedback was still awaited, with proposals currently being developed as part of the financial planning process for next year.

  Anna Stabler queried whether funding would be reallocated to the Trust considering the increased activity being received from other areas. No funding reallocations were expected during the current financial year. Close working continued with colleagues in

North Cumbria, as well as exploration of opportunities for support from the independent sector.

The latest cancer data showed a correlation between referrals being received later in the pathway and the ability to achieve the 62-day cancer standard. The findings identified areas for further discussion with system partners to improve referral pathways and patient flow.

- Potential consultant industrial action. A formal mandate from the British Medical Association (BMA) had not yet been issued, and therefore no further action had been confirmed at this stage.
- Progress against the Resident Doctors 10-point plan. Consideration was being given to the appointment of two Chief Registrars to increase clinical engagement. Good progress was being made against the plan, supported by effective communication with stakeholders and the use of alternative communication channels to strengthen engagement and awareness.

  The 10-point plan had been presented to the People Committee, where members received updates demonstrating good progress against the actions and welcomed the positive developments achieved to date.

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

i) Guardian of Safe Working (GoSW) report

Michael Wright advised that changes to the basis of exception reporting had resulted in a significant increase in reports and associated financial penalties, with this trend expected to continue. Attention was drawn to surgical specialties.

Paul Ennals advised that the reported 70% increase was being reflected across other Alliance partners.

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

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

Ian Joy highlighted the following points:

- Within the ED, corridor care remained an 'alert' within both the Integrated Board Report, the Joint Medical Director's report and this report. It was acknowledged that the provision of corridor care was not the experience the Trust wished to provide for patients or staff.

  The challenges contributing to corridor care were recognised as complex, with a recovery plan in place and a quality-focused update scheduled for the Quality Committee in September.
- Progress regarding the NHSE Fairer Deal for Nurses programme following correspondence received in June requesting an updated delivery plan. A review of

band 5 job descriptions had been completed, discussed by the People Committee and approved for submission. People Committee members also discussed staff-side liaison arrangements.

The delivery plan had now been submitted and was made available in the Trust Board Reading Room on AdminControl, with associated risks clearly identified.

- A staff vaccination campaign plan was submitted by the required deadline of 31 July, with a vaccination uptake target of 60-65%.
- The Trust Board would continue to receive updates on progress against the areas referred to earlier.

A discussion ensued which covered the following areas:

- Adoption of the Triple A reporting format more consistently across Trust Board papers to strengthen the tracking of alerts and provide a clearer framework for assurance, while noting that some refinement of the template may be beneficial. It was advised that this had already been discussed by the Executive Team and that efforts would be made to increase the use of the Triple A format within report cover sheets and future Trust Board reporting.
- Pressures within ED and the continued use of corridor care, with recognition of the importance of strengthening community-based services to support patient flow and provide assurance regarding the Trust's overall position. Challenges remained complex as referenced earlier. Ongoing work to improve patient flow was noted, which included the development of a frailty service aimed at ensuring patients were assessed and treated as efficiently as possible.
- In relation to the fairer deal for nurses, the significant scale of the job evaluation programme and the work required to deliver it successfully. Assurance was provided that a comprehensive work plan was in place, with confidence that delivery would be achieved by October 2028. Learning from previous job evaluation work, including that undertaken for Band 3 roles, had informed the approach, albeit the technical complexity involved was recognised. Additional capacity was being put in place to support delivery, with quarterly progress updates to be submitted to the People Committee. The proposed approach had been considered by the People Committee and was fully supported by Staff Side representatives, who had reaffirmed their commitment to the programme.
- Work was progressing on the UTC corridor link and the phase 2 development, with activity and capacity modelling underway. Plans were likely to involve the use of decant space to create additional cubicle capacity. The programme remained complex, involving multiple phases and detailed clinical modelling, with work this year focused on design and preparation for future development phases.

Paul Ennals noted the ambition to achieve a 100% Board vaccination rate, recognising the importance of vaccination in protecting both patients and colleagues.

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

d. <u>Maternity update including:</u>

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

Ian Joy noted the following points:

- The distressing failings and avoidable harm highlighted in the Amos and Ockenden reports. The Trust's commitment to learning from the reports and driving improvement was reaffirmed, along with the need to support colleagues in the areas impacted by the reports.
- Six listening events had been held by the Clinical Board Leadership Team to support engagement, reflection and learning, with several Senior Leaders in attendance.
- Improvement actions were being progressed through a 10-point action plan.

[Paul Ennals left the meeting at 11:17, Wendy Balmain took over chairing responsibilities]

- The Clinical Board Leadership Team and Executive Directors had met and discussed reflections and actions from the Amos and Ockenden reports.
- An escalation regarding funding for maternity mental health services had been resolved, with the service expected to commence in Quarter 3.
- Progress against the Maternity Incentive Scheme (MIS) remained on track.
- Changes to reporting requirements for perinatal reviews meant that the reports would no longer be presented as a separate paper but would be incorporated into existing reporting arrangements.

A discussion ensued which covered the following areas:

- Assurance was provided regarding outpatient prescribing arrangements for women, and the recent launch of the single point of access was welcomed as a significant development.
- The contribution of midwifery colleagues was recognised, with excellent participation noted through the stall at the AMM.
- The importance of continuing to support staff following the publication of national maternity reports and ensuring that any unintended consequences, including impacts on staff morale, were fully understood and addressed. Many of the recommended actions were already being implemented proactively within the Trust and midwifery teams in Newcastle continued to deliver a high-quality service, with improvements evident through positive patient feedback. Proactive leadership was being demonstrated within maternity services, and recognition was given to the robust improvement work underway prior to the publication of the reports.

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

[Paul Ennals re-joined the meeting at 11.20 and resumed chairing responsibilities]

ii) Maternity Safety Champion Report

Liz Bromley highlighted both the challenges and opportunities associated with implementing technology across maternity services, particularly in relation to the Electronic Patient Record (EPR) programme. She also noted the national issues affecting access to translators and

interpreters, and the impact this could have on patient experience. In addition, she emphasised the importance of supporting staff ideas for service improvement and providing opportunities for continued professional development.

Ian Joy highlighted the value of the Maternity Safety Champion role and noted that further reflection on the report actions would be undertaken to help inform ongoing improvement work.

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

26/24 **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. Lord Mann Review – Trust response

Caroline Docking highlighted the following points:

- Lee-Ann Naidoo was welcomed and had recently been appointed to a new role as Head of People, Inclusion and Belonging.
- Recent national guidance on tackling racism in the NHS had been considered.
- Reflections on the progress made in developing the Anti-racism framework, with anti-racism embedded within the Trust's strategy. However further work was required to drive meaningful change across the organisation.
- The guidance had been considered in the context of both adopting national definitions and addressing all forms of racism and discrimination through a broader organisational approach.
- People Committee members had highlighted the importance of ensuring that policies, procedures and working practices did not discriminate against any individual.
- A request to adopt the report recommendations, recognising that the Trust remains on a developmental journey and must continue to focus on delivering tangible impact.
- Data relating to racism had been reviewed, including reports of racist behaviour directed towards staff by both patients and colleagues.
- The need for a consistent and robust organisational response to incidents of racism was emphasised, with a clear commitment to maintaining a zero-tolerance approach.
- Ongoing work to address racism and promote inclusion across the organisation was crucial.

Lee-Ann Naidoo noted that progressing the work would take time and require a continued commitment to learning and improvement. She emphasised the importance of holding the organisation to account for delivering meaningful change and acknowledged the progress made to date, including learning from the Lord Mann Review and the strengthened focus on accountability.

Bernie McCardle welcomed the report, noting that it was clearly presented and well explained. He highlighted the importance of embedding a sustained cultural shift across the organisation and maintaining a clear commitment to not tolerating racism in any form.

Hassan Kajee reflected on the challenges experienced by many individuals, through their lived experiences, and acknowledged the broader societal context in which this work was being undertaken. He emphasised the importance of continued efforts to support both staff and patients, noting the need to commit to developing a genuine understanding of the issues involved and the meaningful difference that these actions could make.

Vicky McFarlane-Reid advised that, over the last 12 months, the highest number of reported incidents of racism had involved patients towards staff. Reports of racism between staff members totalled four incidents, while eight incidents involved visitors towards staff. A bold and proactive approach was needed, both internally and externally, to challenge racism and support an inclusive and respectful culture for all.

It was **resolved**: to **receive** the report and **approve** the formal adoption of the NHS Race and Health Observatory Seven Anti-Racism Principles.

b. Climate Emergency Plan

James Dixon reflected on the discussion held by Board members in June regarding the impact of the heatwave, and highlighted the operational challenges already being experienced across the Trust. He emphasised that climate change was not solely a future challenge but one that was affecting services currently. The plan sets out the Trust's response, centred on caring for people and caring for the planet, and was fully aligned with the Trust Strategy. It focused on delivering high-quality, affordable and sustainable care, with progress already evident across several areas. Recognising the current financial climate, the plan had been developed to be realistic and achievable, embedding sustainability into clinical care, leadership and stewardship. There was an opportunity and a responsibility to lead by example, supporting the health and wellbeing of current and future generations. Appreciation was also expressed for the feedback received during the development of the plan.

Judith McKenna highlighted that the plan had been considered at the most recent F&PC meeting, where it received strong support. She noted that the decision to reset the targets had been viewed positively, helping to ensure that the plan was realistic, achievable and aligned with the current financial and operational context.

It was **resolved**: to **receive** the report and **approve** the publication of the Climate Emergency Plan 2026-2031.

26/25 ITEMS TO APPROVE:

a. Accountability Framework

Patrick Garner advised that the key changes were outlined within the report cover sheet. He highlighted the inclusion of further narrative to clarify oversight and improvement group arrangements, together with enhancements on the performance management framework.

The revised approach performance management approach brought together quality, people and financial performance through the QPR process, with a further update on segmentation to be provided to a future private Trust Board meeting.

David Weatherburn welcomed the strengthened approach to risk management, noting that the framework provided greater clarity on how risks were escalated through Tier 1 Committees and supported their effective resolution. The practical framework supported real-time oversight, assurance and improvement activity.

Kelly Jupp noted the comprehensive discussion that took place at the most recent Audit, Risk and Assurance Committee on the document.

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

b. Modern Slavery Declaration

Kelly Jupp advised that the Trust had been encouraged to align its approach with the updated NHSE Modern Slavery Statement published in May. The report had been considered by the Audit, Risk and Assurance Committee earlier in the week, where it was discussed and supported.

It was **resolved**: to **receive** the report and **approve** the Modern Slavery Declaration.

c. Charity Committee Annual Report

Caroline Docking explained that the Charity Committee Annual Report had been reviewed at the Charity Committee meeting, with key updates highlighted in the cover sheet.

Wendy Balmain noted that the Trust's charity had invested £4.2 million in initiatives that supported both patients and staff. She highlighted the health and wellbeing service funded through charitable donations as a positive example, and noted that the charity continued to ensure funds were invested in areas that delivered meaningful benefits and improvements for those who use and work within Trust services.

It was **resolved**: to **receive** the report and **approve** the Charity Committee Annual Report 2025/26.

d. NHS England (NHSE) Post Death Care Board Assurance Statement

Michael Wright advised that the statement had been developed in response to recommendations arising from the Fuller and Ockenden reports. NHSE had requested assurance from trusts that post-death processes and governance arrangements met the required standards. He reported that assurance had been provided across all domains, which reflected the significant work undertaken by teams across the organisation. He thanked colleagues for their efforts.

Anna Stabler advised that regular six-monthly updates were provided to the Quality Committee via Ian Joy. She recognised the substantial amount of work undertaken and expressed her thanks to all staff who had worked at pace to strengthen mortuary governance arrangements.

It was **resolved**: to **receive** the report and **approve** the submission of the NHSE Post Death Care Board Assurance Statement.

26/26 ITEMS TO RECEIVE:

a. 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.

26/27 ANY OTHER BUSINESS:

a. Any other business

There was no any other business discussed.

As this was Bernie McCardle's final Board of Directors' meeting, Paul Ennals, on behalf of the Trust Board, recognised and thanked Bernie for his immense contribution and the support he had provided to many colleagues across the organisation. Board members expressed sincere appreciation for his dedication, commitment, and leadership, and wished him every success and happiness for the future when he leaves his role in September 2026.

The meeting closed at 11.46.

Date of next meeting: Public Board of Directors – Friday 25 September.

Summary of actions:

1. It was agreed that the National Cancer Patient Experience Survey results link would be circulated to Trust Board members for information **[ACTION01].**
2. An update on the transition from child to adult services would be provided to a future meeting of the Quality Committee. It was agreed that Jeff Perring would review the paper prior to its submission to the Quality Committee **[ACTION02].**

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 September 2026					
Title	Committee Triple A Reports					
Report of	Hassan Kajee, Chair of the Digital and Data Committee Anna Stabler, Chair of the Quality Committee Joanne Race, Chair of the People Committee Judith McKenna, Chair of the Finance and Performance Committee David Weatherburn, Chair of the Audit, Risk and Assurance Committee Wendy Balmain, Chair of the Charity Committee Jeff Perring, Chair of the Research, Commercial & Innovation Committee					
Prepared by	Lauren Thompson, Corporate Governance Manager/Deputy Trust Secretary					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☒		☐	
Summary	**Assure** The following Committee Triple A Reports/Chairs Logs are included since the last Public Trust Board meeting in July 2026: • Digital & Data Committee – 9 July & 10 September 2026 • Quality Committee – 23 July, 27 August & 17 September 2026 • People Committee – 21 July & 15 September 2026 • Finance & Performance Committee – 27 July & 21 September 2026 ***[To follow]*** • Audit, Risk & Assurance Committee – 28 July & 22 September 2026 ***[To follow]*** • Charity Committee – 24 September 2026 ***[To follow]*** • Research, Commercial & Innovation Committee – 1 September 2026 The individual Triple A reports list out any alerts, advise or assure matters arising from the Committee meetings.					
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.					

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Reports previously considered by	Public Board meeting in July 2026.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Agenda item A1(e)

Escalation and Assurance Report

Name of Committee / Group:	Digital and Data Committee
Date of Committee / Group:	9th July 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.

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)

Artificial Intelligence (AI) Update
The Committee received an update on the Trust's AI Foundations Plan. An AI Steering Group has been established, and work is underway to develop the supporting policy and governance framework. Significant progress has been made since December, with a focus on establishing the necessary foundations, including training, governance arrangements, and processes for evaluating AI products. It was confirmed that both clinical and operational AI are within scope, and a clear delivery plan for the next 12 months is being developed.

Strategy Impact Day
The Strategy Impact Day highlighted the growing importance of digital and data capabilities with digital themes featured strongly throughout the event reinforcing the need for a clear and coordinated approach to setting organisational priorities and a more structured approach to support their development. Further discussions will take place over the coming months to consider process improvement, funding requirements, and prioritisation.

Laboratory Information Management System (LIMS) Project
An update on the LIMS project was received, confirming that procurement has been completed and the contract signed. Recruitment is progressing and discussions with the current supplier regarding the database upgrade are ongoing. Capital funding has been secured from NHS England (NHSE), while the associated revenue implications continue to be reviewed. The Committee discussed governance and oversight arrangements and noted that a dedicated Senior Responsible Officer (SRO) has been appointed (Chris Shaw, Associate Director of Operations) for LIMS will support the programme. The committee were advised that the primary challenge relates to integration rather than technology. The Committee agreed to continue receiving regular progress updates.

Digital Clinical Safety Approach
The Clinical Safety Officer presented a proposal to expand the Trust's clinical safety capability to address gaps in the oversight of existing and legacy systems. The Committee supported the proposed approach, noting that a risk assessment and

business case will now be developed and progressed through the appropriate governance process. A further update will be provided at a future meeting.

Clinical Coding
The Committee noted ongoing workforce challenges within the Clinical Coding team due to the lengthy training period required for new staff. Opportunities to support the service through automation and AI are being explored, with initial plans to implement Robotic Process Automation (RPA) for high volume tasks. A further update will be provided at a future meeting.

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

Care of the Dying Patient
An update was shared on the project which will replace paper-based processes with a digital single point of access for documentation. Following initial delays, significant progress has been made, with testing currently underway. Go-live is scheduled for 18 August, with project closure expected in September.

Electronic Meal Ordering (EMO)
The committee were informed that the project has progressed following increased supplier engagement. Configuration activities have been completed, and a phased Trust-wide rollout is planned. The core system has been fully funded by the Trust charity. The system is expected to deliver food cost savings and enhance patient experience by enabling digital meal ordering, including via patients' own devices. Implementation will be supported by the IT Training Team in collaboration with ward, catering, and facilities teams.

0365
An update was provided on the migration of Trust data and user content to SharePoint Online and OneDrive. Significant progress has been made, with clinical areas completed and corporate areas currently being migrated. The project has enabled the Trust to reclaim over 1,000 Microsoft licences through increased use of browser-based applications, although some documents containing embedded macros will continue to require licensed desktop applications.

National Chief Digital, Data and Technology Office Visit
Ther committee were informed that Rob Thompson, Chief Digital, Data and Technology Officer for the Department of Health and Social Care and NHS England, would be visiting the Trust tomorrow.

Senior Information Risk Owner (SIRO)
Patrick Garner presented the annual SIRO report, noting that it provides a more comprehensive overview than previous reports and complements the operational assurance reports. The Committee reviewed the report and accepted the overall SIRO assurance position.

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

None noted

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Cross-referrals to other Committees / Executive Director Leads	
Audit and Risk Assurance Committee (ARAC) • Update on LIMS [cross referred for information rather than action] • Clinical Safety Approach for existing and legacy systems and associated resourcing considerations [cross referred for information rather than action]	
Agreed actions	**Responsibility / timescale**
Artificial Intelligence (AI) To share the Terms of Reference for the AI Steering Group with the committee.	Director of Innovation / September 2026
Artificial Intelligence (AI) Meeting to be arranged to discuss the next phase of AI.	Director of Digital and Director of Innovation / September 2026
Artificial Intelligence (AI) Meeting to be arranged to discuss the governance model of AI work.	Chief Digital Information Officer and Director of Performance and Governance (SIRO) / September 2026
Patient Pathway To provide an update at the next committee meeting of a standardised process across the Trust for patient pathway.	Director of Improvement and Delivery / September 2026
Digital/Data incident review To share the report with the committee of the recent power failure at the Royal Victoria Infirmary (RVI) server room.	Chief Digital Information Officer / September 2026

The Newcastle upon Tyne Hospitals NHS Foundation Trust

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Escalation and Assurance Report

Name of Committee / Group:	Digital and Data Committee
Date of Committee / Group:	10th September 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)

ICE Upgrade - The Committee discussed technical and governance matters of the ICE upgrade. It was suggested to carry out a further root cause and clinical safety review.

Advise

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

Digital Delivery Transformation - Chief Digital Officer advised the Committee that further work is required to define what transformation means and how it should be delivered across digital and operational teams.

Data Centre Outage - The Committee reviewed the June data-centre outage report, noting completed mitigations. Improvements areas included monitoring and on-call arrangements, and planned reporting through executive and board governance.

Electronic Meal Ordering (EMO) - A discussion took place in relation to the project timescale. Assurance was provided that the team remains actively engaged and will escalate any issues as soon as the implications are known. The Committee welcomed the transparency of the update and stressed the importance of maintaining delivery due to the benefits for patients.

Governance Review - A review of the digital governance structure is underway to clarify the purpose, membership and reporting arrangements of key groups, ensuring they provide effective assurance and align with the Trust's wider governance framework. The Committee welcomed the review and the opportunity to strengthen governance arrangements.

Data Partnership Expansion - The Associate Director Commercial Enterprise outlined progress from the data partnership programme, including embedded technology partners, research-grade data assets, commercial revenue, and plans to expand clinical use, automation, approval governance, and regional collaboration.

Assure

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

Digital Delivery – The Chief Digital Officer reported that more than 60 digital deliverables had been completed in the previous 12 months, including significant foundational work.

Care of the Dying Patient - The Care of the Dying pathway went live on Tuesday 8 September and has been successfully implemented. Patients have already been placed on the pathway, with no issues reported to date. The team noted the positive progress and recognised the significant work undertaken to achieve the go-live.

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	
ICE Upgrade – to escalate to Audit, Risk and Assurance Committee as above.	
Agreed actions	**Responsibility / timescale**
1. ICE Upgrade Provide the Digital and Data Committee with an update on the ICE upgrade, with a more detailed report if required. An update will be provided at the next committee meeting.	1. Chief Digital Officer / Joint Medical Director Timescale – 12 November 2026
2. Care Optimisation Group A revised governance model is to be developed and brought back to a future committee for sign-off.	2. Associate Medical Director (Digital) Timescale – Future committee meeting

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Agenda item A1(e)

Escalation and Assurance Report

Name of Committee / Group:	Quality Committee
Date of Committee / Group:	23 July 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)

- The Board will be asked to note the ongoing concerns regarding the limited pace of improvement in relation to Duty of Candour documentation compliance. Despite agreed actions and monitoring arrangements, progress has not gained sufficient traction to provide the level of assurance required that sustainable improvements are being delivered across the organisation. A deep dive paper will be scheduled for the October 2026 Quality Committee which will provide an overview of the improvement plan.

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 Deteriorating Child** – The Committee noted progress, including completion of escalation processes and the establishment of the Paediatric Critical Care Outreach Team. Ongoing work to improve the recognition and management of deteriorating children, Paediatric Intensive Care Unit (PICU) capacity and patient flow was welcomed. However, further assurance was required due to the absence of clear milestones, delivery dates and outcome measures, and members noted plans to strengthen reporting through the introduction of Key Performance Indicators (KPIs) and clearer performance metrics.
- **Integrated Board Report (IBR) –** The Committee received assurance that overall quality and safety performance remains positive, with strong harm-free care delivery, effective oversight of Infection Prevention and Control, and a positive reporting culture. Concerns remained regarding Duty of Candour documentation compliance, and it was agreed that further review and escalation were required.
- **Patient Experience Report** - The Committee noted positive patient experience results and evidence that feedback is being used to drive service improvements across the Trust. While assurance was provided regarding ongoing patient experience activity, concerns were raised about reduced team capacity and the long-term sustainability of the programme.
- **Perinatal Quality Surveillance Report Including Maternity Incentive Scheme** The Committee received assurance that progress continues across maternity services, including improvements in fetal medicine referral times, induction of

labour performance, and maternal mental health provision. Ongoing work to improve communication, patient engagement and equity of access was noted, alongside continued challenges relating to interpreting services and GP prescribing arrangements.

- **Patient Safety Incident Response Framework (PSIRF)** The Committee noted continued progress in embedding PSIRF, with increased incident reporting, strong investigation processes, and high levels of patient safety training compliance. While assurance was provided regarding the quality of investigations and organisational learning, further work is required to address capacity challenges, strengthen the sharing of learning, and develop the health equity agenda.
- **Wards of Concern and Accrediting Excellence (ACE) -** The Committee received assurance that appropriate processes are in place to identify and monitor wards of concern, with no significant issues requiring escalation. Members noted ongoing workforce challenges, continued progress within the ACE Programme, and the need to review arrangements for wards requiring prolonged enhanced support.
- **Quality & Safety Peer Reviews -** The Committee noted improvements across the Quality and Safety Peer Review Programme, with only one area remaining subject to a formal action plan. Members discussed reduced review activity due to capacity constraints and received assurance that work is underway to review the future model and maintain effective assurance arrangements. Ongoing work to improve personalised care planning was also noted.

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

- **Quality Performance Reviews (QPR) -** The Committee received assurance that no new significant quality or safety concerns had been identified through the QPR process. Members noted strengthened quality governance across Clinical Boards, supported by improved oversight arrangements and the introduction of a formal action tracking process. Ongoing risks relating to critical care flow, psychological support services, digital systems, diagnostic result endorsement and violence and aggression are being actively managed through established governance processes
- **Quality Priority 2 and Medicines Management Oversight Group Report** The Committee received assurance that medicines management performance continues to improve, with progress in medicines reconciliation, ward compliance, medicines safety, and antimicrobial stewardship. Positive assurance was also provided through recent Medicines & Healthcare products Regulatory Agency (MHRA) and General Pharmaceutical Council inspections, with effective governance and improvement arrangements in place.

(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

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Agreed actions	Responsibility / timescale
1. Never Event Report covering the details, actions and learning be presented to the Committee.	1. Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals / September 2026
2. Thanks from the Committee to be extended to Ward 3, Freeman Hospital, for their work in relation to improving Patient Experience	2. Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals / August 2026
3. Update on Violence & Aggression programme to be provided to a future Committee.	3. Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals / October 2026
4. Discussion on the capture and dissemination of learning across the organisation in relation to health equity.	4. Rachel Carter, Director of Quality & Safety, Patrick Garner, Director of Performance & Governance / September 2026.
5. Medicines Management – future reports to include quality metrics from the subsidiary, alongside benchmarking where appropriate.	5. Julie Swaddle, Director of Pharmacy – will be included in next update in January 2027.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Quality Committee
Date of Committee / Group:	27th August 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 noted ongoing oversight of the IPC improvement plan and received assurance that progress is being made in key areas, including antimicrobial stewardship. Continued focus is required on hand hygiene compliance, with improvement actions being monitored through existing governance arrangements. The importance of understanding barriers to compliance, strengthening staff engagement and maintaining a strong culture of patient safety was discussed, with further progress updates to be reported through the Quality Committee.
- **Integrated Board Report (IBR) –** The Committee received assurance that there were no new Never Events reported and noted ongoing improvements in complaints management, including strengthened patient engagement, revised processes and a focus on response quality and timeliness. Progress has been made in addressing community-acquired pressure damage, including improvements to data quality, dashboard development, workforce oversight and targeted action plans. Further updates on these areas will be provided through future reports.
- **Quarter 1 Learning from Deaths report –** The stable mortality performance was noted and ongoing work to strengthen learning from mortality reviews. Challenges remain in the timeliness of some Level 2 reviews and in extracting organisational learning from current reporting systems. There are plans to improve review completion rates, enhance thematic analysis, and develop a more sophisticated digital solution to support learning, oversight and quality improvement.

Assure

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

- **Perinatal Quality Surveillance Report Including Maternity Incentive Scheme –** The Committee received assurance that maternity and neonatal services remain

safe and continue to demonstrate progress against key improvement priorities despite ongoing workforce and capacity challenges. Recruitment, staffing oversight, performance against national maternity standards, and delivery of the Maternity 10-Point Improvement Plan are being actively managed, with evidence of improving indicators and robust governance arrangements in place. Members acknowledged the significant commitment of staff and were assured that key risks continue to be closely monitored and mitigated. • **Review of Trust Organ Utilisation Strategy – Feedback and Required Actions** - The Committee received assurance that transplant services continue to make positive progress, with supportive external feedback, ongoing improvements in performance metrics, and the Trust remaining well positioned to achieve Assessment and Recovery Centre (ARC) status.
(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 new cross-referrals identified.

Agreed actions	Responsibility / timescale
• ICB (Integrated Care Board) Representative update – Query to be followed up as to if the ICB will share Learn from Patient Safety Events (LFPSE) system learning across the system and embed it within primary care improvement plans.	1. Emma Place, Senior Quality and Safety Manager, North East and North Cumbria (NENC) ICB / September 2026
1. Improvement Group update IPC – IPC action plan to be included in the Admin Control Reading Room for Committee members information at the September Committee meeting with the next update planned for the October Committee meeting.	2. Lucia Pareja-Cebrian, Executive Joint Medical Director / September 2026
2. Board Assurance Framework (BAF) – A review of the Quality Committee agenda (including headings) to ensure alignment with the BAF, Schedule of Business (SoB), and the outcomes of the Quality Governance Review.	3. Ian Joy, Executive Director of Nursing, Midwifery and AHPs / November 2026 & as part of the annual Committee Terms of Reference (ToR) and SoB review.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Quality Committee
Date of Committee / Group:	17 September 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)

- Six never events had been reported during the year. Unlike the previous year, when most incidents involved invasive procedures, the current events were diverse. All cases were being managed through robust review processes, including Patient Safety Incident Investigations or After-Action Reviews
- Audit Risk & Assurance Committee to be advised that not all National Clinical Audits will be completed. An update paper will be received to Quality Committee in November advising what audits will be completed and the rationale for those that will not be completed.

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)

- **Never Event Update -** The Committee received a detailed analysis of never events which were being managed through robust review processes, with learning focused on system factors, human factors, communication, and equipment design rather than individual blame. Members noted progress on trust-wide invasive procedure safety workstreams, immediate risk-reduction measures, and plans for leadership development and human factors training.
- **Deteriorating Child Improvement Group -** The Committee noted progress across the programme and welcomed the development of performance indicators but highlighted the need for clearer milestones, delivery dates and outcome measures to demonstrate impact.
- **Emergency Department Improvement Group -** The Committee noted significant improvements in governance, processes and patient flow. Members discussed the impact of ongoing estate works and winter pressures, alongside mitigating actions. While progress was recognised, the Committee advised continued oversight due to the operational risks associated with construction works, patient flow pressures and winter demand, agreeing to retain oversight and receive a close-out report in January before considering de-escalation.
- **Integrated Board Report (IBR) –** The Committee noted generally stable performance. Improvements were reported in complaint closure rates, while targeted actions remain in place for community-acquired pressure damage and Duty of Candour. No alerts were identified.
- **Perinatal Quality Surveillance Report Including Maternity Incentive Scheme**

The Committee was assured that maternity and neonatal services remain safe, with strong governance, oversight and progress against the national 10 Point Plan. The Committee recommended Board endorsement of the Maternity Care Bundle submission but that risks to delivery remain across a number of areas. Trust is on track to deliver the Maternity Incentive Scheme. Trust Board are recommended to delegate ongoing oversight of the Maternity Care Bundle to the Quality Committee, with any emerging risks or issues escalated to the Board as required.

- **Safeguarding and Mental Capacity Act Quarter 1 Report -** The Committee noted increasing safeguarding demand and complexity, with temporary investment supporting service resilience and a workforce review underway to inform future capacity. Progress was reported on digital safeguarding, information sharing, supervision and training arrangements. Members also noted the impact of recent Mental Capacity Act (MCA) legal changes and advised continued focus on workforce sustainability, documentation quality, compliance with statutory requirements, and implementation of audit learning.

1. **Learning Disability Quarter 1 Report -** The Committee received assurance on progress in improving care for patients with learning disabilities and autism, including updates relating to a dedicated space for patient procedures, appointment of an autism lead practitioner, development of digital reasonable-adjustment records, and dedicated spaces for patients experiencing distressed behaviours. Members advised continued focus on sustaining delivery of Oliver McGowan Mandatory Training.

   Equality Quality Impact Assessment (EQIA) - The Committee welcomed strengthened oversight through the EQIA Panel, including review of all workforce reduction proposals and monthly monitoring arrangements, and advised continued focus on completing outstanding assessments and maintaining effective management of quality, equality and workforce risks.

- **Clinical Audit/Guidelines Report -** The Committee noted improved clinical audit governance through the new InPhase system and enhanced oversight of audit activity. Members discussed challenges arising from overdue local audits, limited capacity to support national audit requirements, and the likelihood that some national audits will not be completed. The Committee advised continued focus on prioritising audits that deliver meaningful quality improvement, clarifying national audit delivery plans, and strengthening guideline management and oversight.
- **Board Assurance Framework -** The Committee noted progress in strengthening risk governance and assurance. While assurance was considered to be moving in the right direction, members advised that further work is required to strengthen the link between strategic risks, actions, Tier 2 committee oversight and Quality Committee reporting. The Committee noted that three strategic risks remain outside the Board's risk appetite and will receive further review in November alongside a revised quality governance framework and updated assurance arrangements from January 2027.

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

Ophthalmology Improvement Group – the Committee acknowledged the substantial work undertaken by the Clinical Board with assurance related to the effectiveness of governance, escalation, and improvement processes. Based on

the evidence presented and the discussion held, the Committee supported de-escalation from the Improvement Group, with ongoing oversight to continue through the Quality Performance Review process.	
(any new risks / proposed changes to risk scores – include risk ID where known)	
Cross-referrals to other Committees / Executive Director Leads	
• During the Deteriorating Child Improvement Group update a concern regarding delays with digital developments of paediatric e-observations was noted. The Chair has subsequently asked for this to be referred to Digital and Data Committee for consideration/comment.	
Agreed actions	**Responsibility / timescale**
1. Discussion with Director of People and Operational Development about content of planned Leadership Development Programme to ensure includes learning relating to human factors	1. Rachel Carter, Director of Quality & Safety – October Meeting
2. Data metrics and targets to be included in the next update of Deteriorating Child Improvement Group update.	2. Mark Anderson, Clinical Board Chair – November meeting
3. Members agreed to escalate system-wide dependencies to the Integrated Care Board (ICB), including arrangements for primary care prescribing of low molecular weight heparin and the digital solution required to support mental health self-assessment compliance in Maternity Services	3. Emma Place, Senior Quality and Safety Manager, North East and North Cumbria (NENC) ICB
4. To confirm date of when Trust Clinical Records Policy will be updated.	4. Rachel Carter, Director of Quality & Safety – October Meeting
5. Update paper to be provided in relation to status of non/completion of National Clinical Audits.	5. Rachel Carter, Director of Quality & Safety – November Meeting
6. To provide an update on the reasons why there is a delay to Trustwide Record Keeping Policy.	6. Jason Ramsingh, Associate Medical Director – October Committee

The Newcastle upon Tyne Hospitals NHS Foundation Trust

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Escalation and Assurance Report

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

- **New financial framework -** The Committee noted the introduction of a new regional financial oversight framework, with the Trust currently assessed as Amber, indicating targeted support and increased scrutiny. While no immediate concerns were raised regarding performance, there is a risk of additional reporting requirements, governance pressures and potential escalation if financial plans are not delivered. Ongoing monitoring and strengthened assurance arrangements will be required to respond effectively to the enhanced oversight regime.

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)

- **Month 3 revenue report including Cash –** The Committee reviewed financial performance and noted that results remain broadly in line with plan, supported by improved delivery of Cost Improvement Programme (CIP) schemes and a stronger cash position. However, concerns remain regarding the sustainability of savings, workforce reductions, and reliance on non-recurrent measures. Continued focus on workforce planning, CIP maturity, and delivery of recurrent efficiencies will be required to mitigate financial risks and support long-term sustainability.
- **Capital –** The Committee received assurance that the capital programme is being actively managed, with some schemes rephased to align with operational and financial requirements. While delivery risks remain around major projects, dependencies and infrastructure works, robust governance arrangements are in place, and forecasts indicate the programme will remain within approved limits.
- **Integrated Board Report including Emergency Department (ED) Deep Dive –** Improvements were noted in elective care and sustained 28 days Faster Diagnosis Standard, performance however several indicators remain below target, particularly Emergency Care 4-hour standard, diagnostics and other aspects of cancer performance. Recovery actions are in place, but continued focus on capacity, workforce challenges and pathway improvements will be required to achieve planned trajectories and deliver sustained performance improvement.

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In terms of the ED, there are continued pressures within urgent and emergency care, driven by a significant increase in Type 1 ED attendances and rising demand from neighbouring health systems. A range of mitigating actions are underway, including workforce recruitment, pathway redesign, capacity reviews, Same Day Emergency Care (SDEC) development, and system-wide engagement. While there is assurance that the key drivers are understood and improvement plans are in place, sustained demand, patient flow challenges, corridor care, and winter pressures mean ongoing monitoring and further evaluation of the effectiveness of interventions will be required.

- **Review of Commercial Schemes -** The Committee noted positive progress in commercial income generation and governance, with performance exceeding plan. Further work is required to evaluate the return on investment of key initiatives and identify opportunities to expand commercial activity in support of the Trust's long-term financial sustainability.
- **A number of business cases and procurement reports were approved.**
- **Climate Emergency Plan –** Committee members noted the strong alignment with the Trust Strategy and its focus on addressing the increasing operational impacts of climate change. Assurance was received that the revised targets are ambitious yet achievable, supported by external funding, strong staff engagement, and ongoing sustainability initiatives. The Clinical Emergency Plan was endorsed for Trust Board approval.

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

- **Well Led Finance Assessment -** Strong assurance was received from the positive internal audit report, which confirmed effective financial controls, governance arrangements and oversight of Clinical Board and Corporate Services CIP processes. Recommendations were limited and will be incorporated into a consolidated action plan, demonstrating a robust control environment and a commitment to continuous improvement.

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 discussed.

Agreed actions	Responsibility / timescale
1. New financial framework – The Finance and Workforce teams to review and update reporting templates to enable consistent weekly monitoring and reporting of workforce reduction,	1. Jackie Bilcliff, Chief Finance Officer/Acting Deputy Chief Executive & Jo Mason, Deputy Chief Finance Officer / September 2026

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workforce metrics, and delivery against agreed targets.	
2. Well Led Finance Assessment – A summary report outlining progress against the recommendations arising from the assessment will be presented to the Finance and Performance Committee and Trust Board for oversight and assurance.	2. Jackie Bilcliff / September 2026
3. Emergency Department Deep Dive – A further update on Emergency Department performance, including progress against recovery actions and the impact of interventions implemented, will be presented to the September Finance and Performance Committee for review and assurance.	3. Patrick Garner, Director of Performance and Governance & Marcus Weatherly, Director of Operations for Medicine and Emergency Care Clinical Board / September 2026
4. Review of Commercial Schemes – It was agreed to undertake further analysis of the return on investment and financial benefits associated with key commercial initiatives and identify opportunities to expand commercial activity to support the Trust's long-term financial sustainability and strategic objectives.	4. Wayne Elliott, Associate Director – Commercial Enterprise / October 2026
5. Business Case – Procurement to circulate a briefing note to Committee members prior to the Trust Board meeting, outlining the rationale for the current procurement and maintenance arrangements, including justification for retaining the existing supplier and the associated governance and assurance processes.	5. Dan Shelley, Procurement and Supply Chain Director / July 2026
6. Finance and Performance Committee Terms of Reference – As part of the next annual review, the Terms of Reference will be reviewed to ensure that performance oversight responsibilities are appropriately articulated alongside the Committee's financial duties.	6. Jackie Bilcliff, Patrick Garner & Lauren Thomspon, Corporate Governance Manager/Deputy Trust Secretary / March 2027

The Newcastle upon Tyne Hospitals NHS Foundation Trust

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Escalation and Assurance Report

Name of Committee / Group:	People Committee
Date of Committee / Group:	21st July 2026
Chair of Committee / Group:	Bernie McCardle, Non-Executive Director (NED)

Alert

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

- **Fairer deal for nursing –** While good progress has been made so far, Committee members noted the substantial amount of work still required to review job descriptions and emphasised that this should not be underestimated. The review process may also have financial implications.

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)

- **People Plan overview and action plan tracker -** The People Plan is being refreshed to align more closely with the Trust Strategy, focusing on Leading Well, Feeling Well, Working Well, and Treating Each Other Well. Alongside this, the HR function is transforming into People Services, supported by a new operating model from September 2026. The transformation will focus on leadership development, equality and inclusion, culture, trauma-informed practice, and service improvement to ensure the workforce is fully supported to deliver outstanding patient care.
- **Behaviour and Civility update, Plans to tackle racism, sexual misconduct and incivility and restorative and just learning culture -** The introduction of the new NHS Staff Standards brings stronger expectations around Board accountability, workforce culture, policy compliance and assurance. A Trust-wide review and gap analysis is being undertaken to assess current performance, identify priorities and determine implementation requirements. Existing work on behaviours, civility, inclusion, speaking up, staff wellbeing and organisational culture provides a strong foundation to support the successful adoption of the new standards.
- **Health and Wellbeing update, Supporting staff attendance to reduce short term and long term sickness –** Good progress is being made through strengthened oversight, staff engagement, manager training and revised policies. However, further work is needed to improve consistency across managers, increase awareness of available support, and ensure accountability for delivering sustained reductions in sickness absence. Continued focus on leadership, communication and sharing best practice will be key to success.
- **Valued and Heard, Staff engagement including staff survey –** There is a strong long-term commitment across the Trust to improving organisational culture and staff experience. As this work progresses, careful consideration will be needed

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around communications and engagement to ensure that messaging is clear, consistent and meaningful for staff.

- **Integrated Board Report (IBR) –** Positive progress was noted in recruitment, retention and sickness absence. However, further work is needed to address challenges around workforce reduction plans and statutory and mandatory training compliance, particularly within Medical and Dental staff groups, to ensure consistent implementation and assurance of any patient safety implications.
- **Lord Mann Review –** The Committee received assurance that the Trust is responding appropriately to the Lord Mann Review and related NHS England requirements. Further consideration of the implications for the Trust's Equality, Diversity and Inclusion (EDI) and anti-racism programmes will be brought back through the EDI Action Plan, with recommendations approved for Trust Board consideration.
- **Board Assurance Framework (BAF) –** It was noted that the BAF is under development in line with the new Trust Strategy.
- **Guardian of Safe Working (GoSW) Quarter 1 Report -** The Committee welcomed the revised report and increased transparency through exception reporting. While the Trust is not an outlier, ongoing concerns remain around working patterns, rota pressures and training opportunities in some specialties. Further work is required to address these issues, improve reporting awareness and ensure consistent local resolution of concerns.

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

- **Fairer deal for nursing –** The Committee welcomed the strong collaborative approach to job evaluation and received assurance that constructive partnership working is supporting progress. Staff, particularly within nursing teams, are engaging positively with training and embracing the opportunities the process presents, providing confidence in implementation and future sustainability.

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.	Equality, Diversity and Inclusion (EDI) action plan to be discussed at the September Committee meeting.	1.	Caroline Docking, Director of Communications and Corporate Affairs / September 2026
2.	A detailed discussion to take place regarding workforce reduction at the September Committee meeting.	2.	Sue Hillyard, Interim Executive Director of Operations & Vicky McFarlane-Reid, Executive Director of People and Commercial Innovation / September 2026

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Escalation and Assurance Report

Name of Committee / Group:	People Committee
Date of Committee / Group:	15th September 2026
Chair of Committee / Group:	Bernie McCardle, Non-Executive Director (NED)

Alert

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

No alerts requiring escalation.

Advise

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

- **Workforce deep dive –** The Committee received a confidential update on the Trust's workforce plan. Assurance was received however there is further work to complete.
- **Equality, Diversity and Inclusion (EDI) high impact action plan -** The Committee received an update on the Trust's EDI programme, focusing on the development of the next phase of work and its alignment with the Trust strategy and values. Discussions highlighted the importance of embedding EDI across existing organisational plans and governance structures, making best use of staff feedback and existing intelligence, and ensuring actions deliver meaningful and measurable improvements for staff and patients.
- **People Plan overview and action plan tracker –** An update was provided on the development of the refreshed People Plan, which will align with the Trust Strategy and build on progress made through the current plan. Discussion focused on ensuring the plan has clear priorities, measurable outcomes and a strong emphasis on staff wellbeing, culture, leadership and workforce support. Members highlighted the importance of demonstrating impact through effective use of workforce data and learning from staff experience, with the plan intended to support continuous improvement and be embedded within the Trust's day-to-day business.
- **Freedom to Speak Up (FTSU) –** An update was received on the development of the FTSU service, including work to improve reporting, data and case management processes. Members discussed themes relating to confidence in speaking up, concerns about detriment and the importance of creating a culture where colleagues feel safe and supported to raise concerns. Progress was noted, with further improvements planned to strengthen oversight and reporting.
- **Culture update -** The Committee received an update on progress in addressing workforce and cultural concerns in some specific service areas. Members noted positive improvements through strengthened leadership, workforce planning and

staff engagement, while recognising that some challenges remain. Ongoing actions will continue to support staff and strengthen team culture, with a further update to be provided in six months.

- **Resident doctors 10 point plan –** An update was provided on work to improve medical workforce systems and processes, including rostering arrangements and a review of digital tools. Members noted that plans are in place to address ongoing challenges, with regular oversight and monitoring of progress.
- **Developing Excellence –** Committee members received an update on the development of a refreshed leadership offer to strengthen leadership capability across the organisation. Plans to introduce a tiered programme with external support, focused on leadership behaviours, management skills and creating positive team cultures was discussed.
- **Integrated Board Report (IBR) -** Assurance was received on performance, including sickness absence and staff turnover. Members noted that dedicated resource is in place to support sickness management and that turnover remains at 9.2%, performing better than the 10% target. It was noted that some areas remain below target and continue to be monitored.

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

- **Behaviours and Civility update - Violence & Aggression to staff -** The Committee received assurance on action being taken to reduce violence and aggression towards staff, including improved reporting, stronger partnership working with police and local agencies, and the introduction of enhanced security measures. Members noted the focus on understanding incident trends, supporting staff and using data to target improvements, with further work progressing through existing governance arrangements.
- **Job Planning update –** Assurance was received that planning for 2027/28 is progressing well with service-level planning underway. Further detail and oversight will continue to be provided through the People Committee and the Finance and Performance Committee.
- **Board Assurance Framework (BAF) -** Assurance was received on the management of strategic risks within the BAF. Members noted that actions had been further developed and strengthened, with clear plans in place to support delivery and risk mitigation. The BAF was ratified for Trust Board approval.

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.	**Workforce deep dive** – The Committee to receive a progress update from the Workforce Reduction Group at the next Committee meeting.	1.	Sue Hillyard, Interim Executive Director of Operations / November 2026
2.	**FTSU update** – To circulate a tool kit for managers - understanding detriment, to Committee members.	2.	Kathryn Smart, FTSU Guardian / September 2026
3.	**Culture update** – A further update to be presented to the Committee in six months' time regarding the specific service areas actioned.	3.	Claire Pinder, Director of Operations / March 2027

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Escalation and Assurance Report

Name of Committee / Group:	Audit, Risk and Assurance Committee
Date of Committee / Group:	28 July 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 discussed the development of the new BAF and initial thinking around the creation of an Executive Oversight Group for transformation-related threats to strategic risks. Members highlighted the importance of maintaining visibility, accountability and effective assurance arrangements for strategic risks and agreed an assurance rating of "Advise".
- **Grant Thornton Well-Led Review –** Committee members agreed that the Well-Led Plan should remain categorised as "Advise" for the Triple A report. Whilst positive progress had been made, and assurance received on delivery arrangements, further evidence of impact, and completion of outstanding actions was required before a higher level of assurance could be achieved.
- **Internal Audit Progress Report** - Committee members received assurance on progress against the audit programme, and noted that audit plan delivery and implementation would remain an ongoing area of oversight and therefore continued to be rated as 'Advise'. A proposed change to the 2026/27 audit plan, to defer the Clinical Audit review was approved.
- **Counter Fraud Report** - Assurance was provided that counter fraud arrangements remained effective and compliant with national standards. Work was ongoing to address new legislative requirements, strengthen controls and training, and monitor emerging fraud risks.
- **Accountability Framework -** Committee members reviewed and supported the revised Performance and Accountability Framework, with amendments made to the wording on accountability arrangements and the introduction of Clinical Board segmentation.

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- **Modern Slavery Act Statement** - Committee members approved the updated Annual Statement, with ongoing work to strengthen Modern Slavery Act assurance within procurement controls.
- **Request to Write off Debt** - Committee members approved the write-off relating to a research study sponsor in liquidation and were briefed on actions being taken regarding learnings/continuous improvement.

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

- **Risk Report** - Committee members received assurance that Trust-wide risk management arrangements remained effective and agreed a Triple A rating of 'Assure'.
- **External Audit Annual Report** - An unqualified audit opinion was issued on the financial statements (being the best possible outcome), therefore agreed an 'Assure' rating.
- **Counter Fraud Annual Report** - Committee members received the Counter Fraud Annual Report, which consolidated updates previously presented throughout the year, and noted that the Trust had achieved full compliance with the Counter Fraud Functional Standard. Members approved the annual return and welcomed the achievement.
- **NHS England (NHSE) Post Death Care Board Assurance Statement** - Committee members received assurance regarding compliance with Human Tissue Authority requirements, with improvements in governance and oversight highlighted, along with positive regulatory inspection outcomes, and robust evidence supporting the Trust's self-assessment for submission to NHSE.
- **Fit & Proper Persons Test Annual Report –** Committee members received strong assurance that all 2025/26 Fit and Proper Persons Test requirements had been met, supported by positive internal audit findings and robust governance arrangements.

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. Mortality review training - Ian Joy advised that a mortality review update was scheduled for the August Quality Committee meeting, and he would ask Rachel Carter to include a specific update on Level 2 reviews, governance involvement and any associated risks	1. Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professional (AHPs) – September Meeting.

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2. Payment diversion investigation case - A paper had been prepared to highlight the learnings from the case which would be shared with the Executive Team and Committee for the next meeting	2. Ivan Bradshaw, Fraud Specialist Manager – September Meeting.
3. Modern Slavery Statement - Bernie McArdle asked whether identified or prevented modern slavery incidents are routinely reported. Kelly Jupp advised that a recent regional case had previously been shared with the Committee and agreed to explore including such information in future reporting.	3. Kelly Jupp, Trust Secretary – November Meeting
4. FPPT - It was suggested that a review be undertaken of the statutory and mandatory training requirements applicable to in-scope individuals to ensure they remained appropriate and proportionate, particularly where clinical responsibilities may require additional training	4. Rachel Cockburn, People Resourcing Manager – November Meeting
5. To seek clarification regarding the reported delay to the Care of the Dying Patient Programme implementation and provide an update to the Committee.	5. Hassan Kajee, Non-Executive Director – September Meeting

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Escalation and Assurance Report

Name of Committee / Group:	Research, Innovation & Commercial (RIC) Committee
Date of Committee / Group:	1 September 2026
Chair of Committee / Group:	Jeff Perring

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 is a risk to future Biomedical Research Centre (BRC) and infrastructure funding if 90-day study set-up performance targets are not achieved.

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)

- **Research Performance Report -** The Committee received a report outlining proposed research performance measures in line with the NHS England Board Reporting Framework [monitory research activity] which was recently published (August 2026) and noted the:
  - Risk of loss of National Institute for Health and Care Research (NIHR) Research Delivery Network income due to revised national funding methodology.

- **National Centre for Neurotechnology and Restoration -** The Committee received an update regarding development of the Centre and highlighted the:
  - Significant strategic opportunity arising from the National Centre.
  - Need to finalise governance arrangements for the Centre, including Trust and University oversight structures.

- **BRC5 Submission -** The Committee received a progress report on the forthcoming BRC5 funding submission and regional collaboration model.

- **Commercial -** The Committee received an update on progress relating to data partnerships programmes, and discussed in particular the:
  - Growth and benefits arising from data partnership programmes.

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

• No items for assure were notified.
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
1. RIC Committee Terms of Reference (ToR) - The Committee agreed that the ToR should be updated and reviewed after an initial period of operation i.e. 6-months.	1. Vicky McFarlane-Reid, Executive Director of People and Commercial Innovation / March 2027
2. Research Performance Report – The Committee requested a detailed recovery/action plan to improve 90-day set up performance and mitigate funding risks at the next meeting.	3. Jo Noble / November 2026
3. Research Performance Report - It was agreed to carry out a review of portfolio prioritisation arrangements and strengthen controls around non-funded non-portfolio studies and process to be put in place.	4. Jo Noble / November 2026
4. National Centre for Neurotechnology and Restoration – It was agreed that the Centre would have suggested opportunities in place by the next Committee meeting.	6. Akbar Hussain, Consultant Neurosurgeon and Mhairi Spurr, Senior Commercial Business Manager – Health & Life Sciences / November 2026
5. National Centre for Neurotechnology and Restoration – The Committee noted the report and agreed that the next update would be provided at the January 2027 Committee meeting.	7. Akbar Hussain, Consultant Neurosurgeon and Mhairi Spurr, Senior Commercial Business Manager – Health & Life Sciences / January 2027
6. BRC5 Submission - The Committee noted the report and supported submission of the application by the 17 September 2026. Final application to be shared with Committee Chair.	8. Andy Blamire, Dean, Transitional & Clinical Research Institute, NIHR Biomedical Research Centre, Newcastle and Martin Dixon, Chief Operating Officer (COO), NIHR Biomedical Research Centre & Newcastle Health Research
7. Innovation - The Committee requested future reporting include	9. Charlotte Fox, Innovation & Intellectual Property Lead

	Key Performance Indicators (KPI) dashboards, reporting framework for innovation activity/outcome measures and present practical case studies demonstrating progression through gateway process and measurable impact at future meetings focusing on different ones.		Rebecca Haynes, Chief Executive Officer (CEO) Newcastle GP Services / November 2026
8.	Commercial - It was agreed that there is a need to establish a Data Partnership Approval Group and associated governance arrangements.	10.	Wayne Elliott, Associate Director – Commercial Enterprise / November 2026
9.	A report to be provided on the benefits realised from data partnerships, including examples of research and service improvement impacts.	11.	Wayne Elliott, Associate Director – Commercial Enterprise / November 2026

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The Newcastle upon Tyne Hospitals
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TRUST BOARD

Date of meeting	25 September 2026		
Title	Board Visibility Programme		
Report of	Rachel Carter, Director of Quality & Safety		
Prepared by	Fiona Gladstone, Clinical Effectiveness Facilitator		
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-one walkabouts by Executive Directors (n=9) and Non-Executive Directors (NEDs) (n=12) undertaken during July and August 2026. **Alert** • No Alerts identified. **Advise** • Across the areas visited safety and operational concerns have been raised locally and are being progressed through appropriate management and governance processes, including blood collection arrangements, security measures, emergency call systems and access to interpretation services. • Board visibility activity continues to identify recurring themes relating to workforce sustainability, estates and infrastructure, digital systems, communication and operational flow. **Assure** • Feedback consistently highlighted high levels of staff commitment, compassionate care, strong multidisciplinary working, supportive leadership and a positive culture of continuous improvement. • Action plans are in place to address issues identified, with further assurance to be strengthened through the development of a formal action-tracking and feedback process.		

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					
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 previous Board Visibility Programme Report was presented to the Trust Board in July 2026.					

BOARD VISIBILITY PROGRAMME

1. INTRODUCTION

This report provides an overview of the findings from the twenty-one walkabouts by Executive Directors (n=9) and Non-Executive Directors (NEDs) (n=12) undertaken during July and August 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 includes:

- 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 to Trust Board (Appendix 1 & 2).

All other walkabout reports are collated by month and can be found in the Reading Room for consideration.

2. BOARD VISIBILITY PROGRAMME IMPROVEMENT WORKSTREAM

A joint improvement programme is currently being undertaken by the Clinical Effectiveness and Corporate Governance teams to strengthen and enhance the Board Visibility Programme. The aim is to make the process as accessible and effective as possible for walkabout participants, while ensuring a robust approach to the identification, escalation, ownership and resolution of issues.

Key elements of the improvement work include revision of the current reporting template, strengthening reporting requirements to ensure consistent completion of documentation, particularly where actions are identified, and the development of supporting guidance for colleagues participating in walkabouts.

In addition, an action-tracking log is being developed to provide improved oversight of issues identified during walkabouts, enabling actions to be monitored and assurance to be obtained that appropriate responses have been implemented. A new feedback mechanism is also being introduced for areas visited. This will ensure teams are informed of the key themes and issues escalated through the governance process and are able to see how concerns raised during walkabouts have been addressed.
Progress updates on this improvement programme will be provided to the Trust Board through future reports.

3. SUMMARY OF FINDINGS

The table below summarises the walkabouts undertaken throughout July and August 2026. Three walkabouts were carried out by Executive Directors in July and six in August. Four walkabouts were carried out by Non-Executive Directors in July and eight in August. In total 21 Leadership Walkabouts were undertaken with a further two cancelled during this timeframe due to competing pressures in the walkabout team.

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
	Corporate Cancer Services	13.07.2026	Regent Point	Director of Communications and Corporate Affairs,	Cancer Information Manager, Cancer Modernisation Lead, Senior Information

Stream	Area visited	Date	Site	Membership of Walkabout Team	Staff who took part in the conversations
Stream One				Freedom to Speak up Guardian	Manager, Data Quality Officer, Cancer Pathway Manager, Multidisciplinary Team (MDT) Administrator/Patient Navigator
	Children's Outpatient Department	20.07.2026	Royal Victoria Infirmary (RVI) – Great North Children's Hospital (GNCH)	Director of Quality and Safety, Quality Development Manager	Senior Sister, Matron, Staff Nurse, Health Care Assistants (HCA) x2, administrative staff (Reception), Burns Outreach Team
	Manor Walks – various specialties	21.07.2026	Manor Walks	Director of Improvement and Delivery, Head of Quality and Safety	Senior Sister, Junior Sister Audiologist, Cancer Nurse Specialist, Reception Staff, Volunteers
	Ward 33	02.08.2026	RVI	Executive Joint Medical Director, Quality Development Manager	Sister
	Mortuary	05.08.2026	Freeman Hospital (FH)	Director of Performance and Governance, Patient Safety and Risk Manager	Operations Manager, Anatomical Pathological Technician (APT), Senior APT, Mortuary Technical Assistant
	Ward 2 – Urology	10.08.2026	FH	Executive Joint Medical Director, Freedom to Speak up Guardian	Ward clerk, Senior sister, Staff nurse, F2 Doctors
	Mortuary	11.08.2026	RVI	Director of Performance and Governance, Patient Safety and Risk Manager	Operations Manager, Anatomical Pathological Technician (APT),

Stream	Area visited	Date	Site	Membership of Walkabout Team	Staff who took part in the conversations
					Senior APT, Mortuary Technical Assistant
	Operator Services	13.08.2026	Regent Point	Director of Communications and Corporate Affairs, Patient Safety Manager	Operational Services Manager (OSM) (IT) responsible for management of the Operator Team
	Ward 18 – Intensive Care Unit (ICU)/High Dependency Unit (HDU)	21.08.2026	RVI	Director of Estates, Facilities and Strategic Partnerships, Clinical Effectiveness Advisor	Matron, Sister
	Connie Lewcock Resource Centre	Unable to go ahead due to competing pressures in the Walkabout Team			
	Equality, Diversity and Inclusion Team	Unable to go ahead due to competing pressures in the Walkabout Team			
Stream Two	Urgent Treatment Centre and Accident & Emergency (A&E)	08.07.2026	RVI	Non-Executive Director	Consultant, Sisters, Band 7, 6, 5 nurses, volunteers and HCA
	Wards 17, 18 and 20 Elderly People's Medicine	09.07.2026	FH	Non-Executive Director	OSM, Consultant, Sisters, Matron, Staff Nurses in charge, housekeepers and ward clerks
	Cresta Clinic	15.07.2026	CAV	Non-Executive Director	Senior Sister
	Outpatients	15.07.2026	RVI	Non-Executive Director	Senior Sister, Office Manager
	Ward 12 Elderly Medicine	11.08.2026	FH	Non-Executive Director	Matron, Junior Sister, Staff Nurse, HCA
	Ward 43 (part of Neuroscience visit)	14.08.2026	RVI	Non-Executive Director	OSM, Sister/Charge Nurse
	Ward 16 (part of Neuroscience visit)	14.08.2026	RVI	Non-Executive Director	OSM, Senior Sister

Stream	Area visited	Date	Site	Membership of Walkabout Team	Staff who took part in the conversations
	Neurophysiology (part of Neuroscience visit)	14.08.2026	RVI	Non-Executive Director	OSM, Clinical Physiology Team Manager
	Dental Hospital	14.08.2026	RVI	Non-Executive Director	Dental Nurse Manager/Senior Dental Nurse and Assistant OSM, Dental Directorate
	Radiology Department	24.08.2026	RVI	Non-Executive Director	Band 5 Radiographers, CT/ MRI/ Reporting Radiographers, Reception staff, Appointments team, radiographer assistants
	Northern Medical Physics and Clinical Engineering Team (NMPCE) - Regional Healthcare Engineering Aids for living, Gait Assessment Lab	25.08.2026	FH	Non-Executive Director	Head of Departments, Physio, Clinical Scientists, Healthcare Technicians, Engineer
	Ophthalmology A&E and Outpatient Department (OPD)	27.08.2026	RVI	Non-Executive Director	Nursing staff

Key themes identified include:

- A consistent theme across services were high levels of staff dedication, compassion and pride in delivering patient care, despite operational pressures.
- Teams frequently described supportive colleagues, strong multidisciplinary working and a willingness to go the extra mile for patients.
- Many areas reported positive cultural developments associated with visible and supportive leadership. Staff described improvements in communication, increased openness and a continued move towards a more just and learning-focused culture.

- Workforce sustainability remains a challenge in some services, with teams identifying recruitment and retention pressures, levels of sickness absence, limited opportunities for training and development, and the impact of sustained demand on staff wellbeing.
- Estates and infrastructure were recurring themes across services visited. Staff highlighted opportunities to improve clinical environments, including storage capacity, layout, temperature control, equipment, staff facilities and overall utilisation of available space.
- Digital and IT systems were identified as areas for further development, particularly in relation to system interoperability, access to applications and the timeliness of digital approval processes.
- Some services highlighted operational challenges impacting patient flow and productivity, including delays associated with transport and portering services, discharge processes, repatriation arrangements, appointment scheduling and clinical and bed capacity.
- Communication was identified as an area for improvement, with staff seeking greater feedback following incident reporting, more consistent dissemination of information and increased clarity around organisational processes.
- While there was a strong focus on delivering safe and effective patient care, staff also identified several areas for continued improvement, including blood collection processes, emergency call systems, security arrangements, access to interpretation services and the availability of equipment to support patient accessibility.
- Services demonstrated a strong commitment to continuous improvement and innovation, identifying opportunities such as enhanced utilisation of Manor Walks and Cresta facilities. Staff noted that progress is sometimes constrained by financial and workforce capacity considerations.

The following actions and areas for further review have been identified to support ongoing service improvement, operational effectiveness and assurance:

- The General Manager for Cancer Flow and Performance to meet with the Walkabout team to further explore key themes, challenges and opportunities for service development.
- Further review is planned in relation to patient safety and environmental considerations within Children's Outpatients, including self-harm risk assessment processes and associated safety assurance arrangements.
- Opportunities have been identified to further enhance patient experience and review medicines management processes relating to Manor Walks.
- A review of translation and interpretation provision within maternity services to be undertaken to ensure accessibility.
- Planned changes to mortuary processes relating to the transfer of deceased children will be considered through the Mortuary and Bereavement Group.
- Operational matters identified on Ward 2 will be reviewed, including SharePoint access, medical workforce arrangements and radiology request cancellation processes.

- Estates and facilities improvements have been identified on Ward 18, including enhancements to patient privacy, equipment testing and maintenance, environmental repairs, equipment room modifications and restoration of patient television services.
- Operator Services will review escalation and alert management arrangements, including Observational Skill-based Clinical Assessment tool for Resuscitation (OSCAR) alerts, microbiology on-call processes and red-card patient pathways, to support operational effectiveness and patient safety.
- Further consideration will be given to dedicated portering support within Radiology, alongside a review of workforce matters relating to roles and responsibilities across reporting services.
- Opportunities to optimise the implementation and utilisation of new digital equipment within NMPCE at the Freeman Hospital will be explored, with specific consideration of information governance and cyber security requirements.

4. RECOMMENDATION

The Trust Board is asked to:

1. Note the findings and themes arising from the Board Visibility Programme during the reporting period.
2. Support the ongoing improvement work being undertaken to strengthen the Board Visibility Programme, including enhancements to reporting, action tracking and feedback mechanisms.
3. Receive future updates on the implementation and effectiveness of these improvements through subsequent reports.

Report of Rachel Carter, Director of Quality & Safety
Prepared by Fiona Gladstone, Clinical Effectiveness Facilitator
9 September 2026

Appendix 1: Board Visibility Programme: Executive Director

Walkabout Stream: Executive Director
Members of the Walkabout Team: Director of Quality and Safety, & Quality Development Manager

Site/ Ward/ Department: Children's Outpatient's Department – GNCH- RVI

Job Title of staff spoken to (staff names are not required): Senior Sister, Matron, Staff Nurse, Health Care Assistants x2, administrative staff (Reception), Burns Outreach Team.
Date: 20.07.2026

First Impressions	Area was welcoming, appeared well organised, child orientated with toys in foyer area as outside play area remains closed until a Health & Safety assessment has been done on the resurfacing of the flooring.
Observations i.e. Environment/ Staffing/ Patients	• Staff across roles felt well supported and valued teamwork, describing managers as approachable. A learning culture was evidenced by turnover of HCA roles, who left to further advance careers in NHS. Staff repeatedly talked of working hours in a positive way as it allowed work/home life balance. • Utilisation of rooms is under review and is part of an ongoing QI project (clinical utilisation). New and Bank HCA staff felt supported, found huddles useful and felt able to ask any questions if needed. Admin staff understand the need but are frustrated at reallocation for work to cover different areas. • Concerns have been raised regarding the reliability and timeliness of the blood sample transport process. Ward staff report that urgent blood samples are no longer consistently being collected within the expected 20-minute timeframe, resulting in some samples clotting and others being unaccounted for. An incident report has been completed via InPhase for each occurrence, and the Portering Supervisor has been made aware of the issues. In addition, the evening blood collection service is reported to be inconsistent, and the pneumatic tube system has not been operating reliably. As an interim mitigation, clinical staff have amended their working practices to ensure that all blood samples are taken by 17:10 and are subsequently delivered to the laboratory by ward staff. The Senior Sister continues to escalate these concerns through the appropriate management channels due to the potential impact on patient care and service delivery. • Staff felt that floor cleanliness has declined following change of previous staff. Senior Sister is addressing the issue. • Staff expressed concerns regarding the redevelopment of the external play area. Feedback indicates a perception that the decision to convert the space to a green area was made without adequate consultation with frontline teams, highlighting the importance of staff engagement in future environmental change projects. • Burns Outreach team felt mats would be beneficial in rooms as floors hard – Senior Sister rectified this on visit. Also felt that check in can sometimes be lengthy but understood this is due to busy nature of department.
Summary	It is a busy department with 20 specialities. There is a good MDT and staff are proud to work here. Staff highlighted that work life balance is good, describing the team as 'beautiful' and expressing how rewarding it is to see children playing.

Potential Actions Identified

Were there any issues you needed to address during your visit? x Yes ○ No

If yes, what was the issue(s)?

Key challenges/Questions asked of the Walkabout Team during visit:

1. White forms – Staff have heard that they are being discarded due to volume. Action: communication of processes to be more explicit as currently confusing.

2. Play area – New floor has been completed but can't use as needs health and safety inspection. Who is responsible for this?

3. Health & Safety – Have plug sockets, sharp desk ends and low hanging coat hooks been included as part of previous environmental and self-harm risk assessments?

4. Play area – Decision in relation to future purpose and OPD staff involvement in that process.

Responsible person: R Carter to provide relevant contacts for the Senior Sister

When should this action be completed by: 31st July 2026

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Appendix 2: Board Visibility Programme: Non-Executive Director

Walkabout Stream: Non-Executive Director

Members of the Walkabout Team: Non Executive Director

Site/ Ward/ Department: Freeman Ward 12 Elderly Medicine-decant ward

Job Title of staff spoken to (staff names are not required): Matron, Junior Sister, Staff Nurse, HCA

Date: 11/8/26 at 9.30 am

First Impressions	This was a follow-up from previous visits to Elderly Medicine as the ward wasn't able to offer dates then. The ward is a temporary one having moved from Ward 31 at the RVI but it's clear the staff are settled well now.
Observations i.e. Environment/ Staffing/ Patients	• As with previous visits this was an energetic team that presented a strong sense of morale and commitment. This is evidenced by lower-than-average sickness absence. They believe the Trust wellness programme, particularly early intervention works. Figures are skewed by a small number of long-term absentees. • Positives include impressive use of Power BI at shift start and virtual meetings to manage resource against patient need on a daily basis (this allows cover to be given where needed across this cluster of wards). • A strong and experienced senior team with a good track record of career development, but not always in Elderly Medicine. • Thoughtful and innovative approach to care, e.g. pilots on canula management and good vision of improvements that would help quality and budgets over time (see later). • Clearly good and open relationships with Executives and awareness of how to work within the Clinical Board set up. • They are looking forward to being involved in ACE and feel they could secure silver. There are no major issues of concern, just a basket of desirable outcomes to support enhanced care and budget control. This is not an exhaustive list as Matron is a continuous improvement supporter, and keen to propagate innovation in her teams. • The lack of dedicated phlebotomy support they can access (one of a number of small drags on their ability to discharge quickly and well). A contrast between Freeman and RVI on this, the latter having a more responsive model they say. They have the same generic issues as colleagues in Elderly Medicine re delays in discharge. They also would love greater resource on therapies. • They would like to have more ward clerk resource on admin. Their's remain Band 2, even that would mean HCA could help with patient walking/ exercise etc. • Although their space is a more up to date version than some of the other Elderly Medicine wards it's not bespoke. There are some issues e.g. a Treatment Room that is used only for equipment storage. The work space for portable work station caddies isn't big enough. There are some open coded doors (not drugs) for ease of rapid access e.g. sickness bowls.
Summary	The team demonstrates strong morale, leadership, and innovation, with effective resource management and a focus on continuous improvement. Key challenges include discharge delays, limited support resources, and some ward environment constraints.
Potential Actions Identified	Were there any issues you needed to address during your visit? ◯ Yes ⊗ No If yes, what was the issue(s)?

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Agenda item A2(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 September 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	**Alert** • Clostridioides difficile Infection (CDI) cases increased significantly (28 v 12) and is now showing special cause variation of a concerning nature. There were 11 community-onset healthcare-associated (COHA) and 17 Hospital-Onset Healthcare-Associated (HOHA) cases. Seasonal increases are typically observed during the summer months, and this pattern is consistent with the Trust's longitudinal data. All HOHA cases are subject to investigation through the Patient Safety Incident Response Framework (PSIRF) process. • Cancer 31-day performance remains heavily impacted by radiotherapy workforce pressures and is now showing special cause variation of a concerning nature. Referrals are being screened by a senior radiographer to clarify priority against a set of criteria agreed by Clinical Oncologists and ratified by colleagues within the Operational Delivery Networks (ODN) Radiology service. Agency and overtime is being offered to support waiting times. • The Trust is unfortunately above the projected sickness absence position – there are no signs of a consistent improving trajectory. The Trust has established a 'Why absence matters' program focusing on supporting line managers to manage sickness absence. **Advise** • The number of inpatient falls rose from 215 in June to 248 in July, with the falls rate increasing from 5.1 to 5.7 per 1,000 bed days. Statistical process control (SPC) charts continue to demonstrate common cause variation, indicating that performance remains stable and within expected limits. Falls activity has shown a recurring seasonal summer increase over recent years, both locally and across Shelford Group Trusts, with no clear explanation identified. • Emergency care performance against the 4-hour standard (all types) in July was 77.39%, an increase of 0.64% compared to June (76.75%) but continues to fall short of the national standard. Work has started on the Urgent Treatment Centre Emergency Department (ED) link corridor - two cubicles have been closed in ED, as well as the triage room and play room in Paediatric ED. This has limited the amount of space available to treat patients. Focus has been given to safe temporary re-routing of patients. • Mandatory training compliance is 90.93% but is showing a decreasing trend of compliance - currently just above the 90% standard and therefore needs to be monitored to ensure continued compliance. Five Clinical Boards and Corporate Services fell below the 90% target.		

<table>
<tr><td></td><td colspan="6">Assure
There is a continued trend of increased incident reporting across the Trust, ensuring learning from safety events is being shared and maximised across the organisation. The total number of patient safety incidents per 1,000 bed days reported in July 2026 increased compared to June 2026. Raising awareness of incidents and dissemination of learning continues to through the Patient Safety Bulletin, Safety Spotlights and The Quality & Safety Learning Forum.
In July, the 80% 28 Faster Diagnosis Standard (FDS) target was achieved, performance sat at 85.3% and demonstrates special cause variation of an improving nature. Strong performance against the FDS has been driven by improvements on the skin pathway. The Dermatology service have set out a clear plan for additional lists across the breadth of the summer.
Trust Turnover rate is 9.22% which is below the 10% target. Flexible working is being supported and encouraged across the Trust - 98% of applications are approved. Daily information is available to managers via the people dashboard; monthly performance reviews are held with clinical boards and between HR and clinical boards/corporate services.</td></tr>
<tr><td>Recommendation</td><td colspan="6">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.</td></tr>
<tr><td rowspan="2">Link to Strategic Priorities</td><td colspan="2">Joining up care</td><td colspan="2">Advancing care</td><td colspan="2">Supporting great care</td></tr>
<tr><td colspan="2">☒</td><td colspan="2">☒</td><td colspan="2">☒</td></tr>
<tr><td rowspan="2">Impact</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☒</td><td>☐</td><td>☐</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">Failure to meet our care standards in a way which is designed around people, not organisations.
Failure to coordinate services which are effective.
Failure to coordinate services which are available when our patients need them.
Inability to improve patient safety and patient harm through reliable, evidence-based care.
Failure to provide a healthy, safe, flexible and inclusive working environment that enables our people to thrive and deliver outstanding patient care.
Failure to manage our resources sustainably and responsibly ensuring strong financial, productivity and commercial plans are delivered.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">This report is delivered on a monthly frequency.</td></tr>
</table>

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

September 2026

Healthcare at its best
with people at our heart

Contents

Variation / Assurance – Changes from previous month

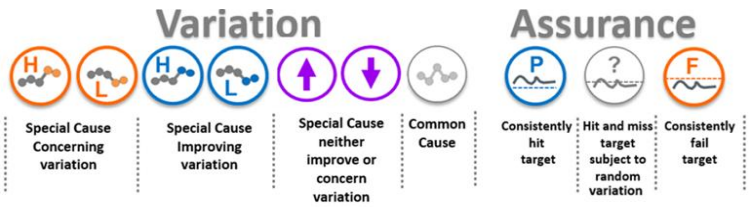
	Jun-26	Jul-26
Neonatal Readmissions		L
Never Events	H	
HCAI - C. Diff		H
Cancer 31 Day Decision to Treatment		L
Mandatory Training		L

Variation

- **Five** high level metrics have displayed changes in special cause variation from June 2026 to July 2026.
- Common cause variation to special cause variation of an improving nature (low):
  - Neonatal Readmissions
- Special cause variation of a deteriorating nature (high) to common cause variation:
  - Never Events
- Common cause variation to special cause variation of a deteriorating nature (high):
  - Healthcare-Associated Infection (HCAI) – C. Diff
- Common cause variation to special cause variation of a deteriorating nature (low) :
  - Cancer 31 Day Decision to Treatment
  - Mandatory Training

Assurance

- **No** high-level metrics displayed changes in special cause assurance from June 2026 to July 2026.



Quality

Quality Overview

Metric	Period	Actual	Target	Variation	Assurance
HCAI - MSSA	Jul-26	15	10		
HCAI – C. Diff	Jul-26	28	11	H	
Harm Free Care – IP Acquired Pressure Ulcers	Jul-26	41	Sustained reduction		
Harm Free Care – Adult Patient Falls	Jul-26	248			
Stillbirths	Jun-26	2			
Blood Loss ≥1500ml (per 1,000)	Jun-26	33 per 1000			
ATAIN	Jun-26	7%	5%		

Health Care Acquired Infections

- Methicillin-Sensitive Staphylococcus aureus (MSSA) cases remained static (15 vs 15) and remained within common cause variation. There were 8 Community-Onset Healthcare-Associated (COHA) and 7 Hospital-Onset Healthcare-Associated (HOHA) cases.
- *Clostridioides difficile* Infection (CDI) cases increased significantly (28 v 12) and is now in special cause for concern variation. There were 11 COHA and 17 HOHA cases.

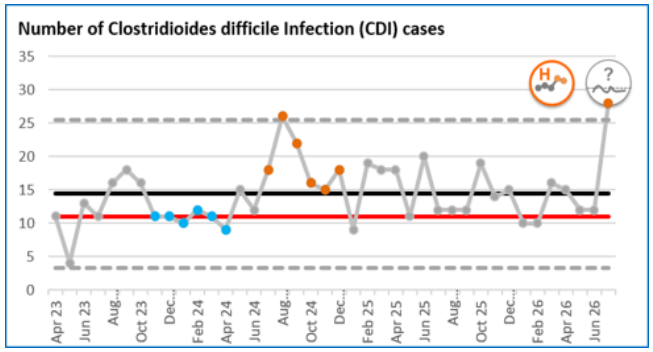
Harm Free Care

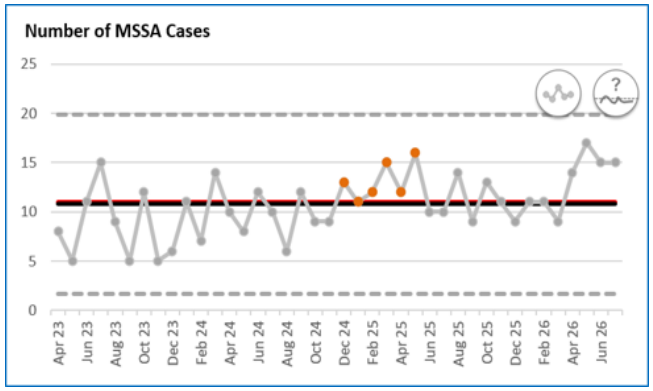
- Acute (Category 2 & above) pressure ulcers (PU) reported in July slightly increased (41 v 40).
- In July there was a marked increase in falls (248 v 215) but this remains in common cause variation.

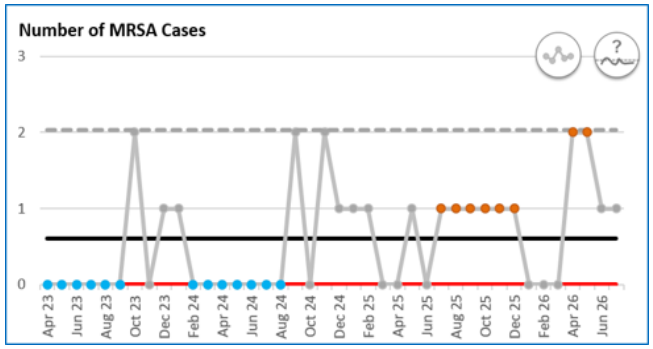
Perinatal Quality Surveillance

- There were two stillbirths in June 2026.
- The National benchmark for term admissions is 5%. The Trust rate remains consistently above the national 5% target with 7% term admission rate in June. Further analysis is in progress of infants born within 37th week of pregnancy as this group represent 40% of admissions.

Healthcare Associated Infections (HCAIs) (1/3)







Standards

- **Zero meticillin-resistant Staphylococcus aureus (MRSA)** cases
- **No more than 129 MSSA** cases across the fiscal year (local target - 5% reduction from 2025/26) in line with the quality priority.
- **No more than 136 CDIs, 225 *E. coli*** cases, **108 Klebsiella** cases or **34 Pseudomonas aeruginosa** cases across the financial year.

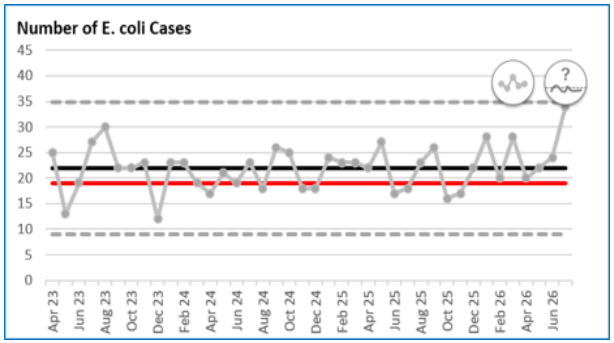
National Picture (UKHSA)

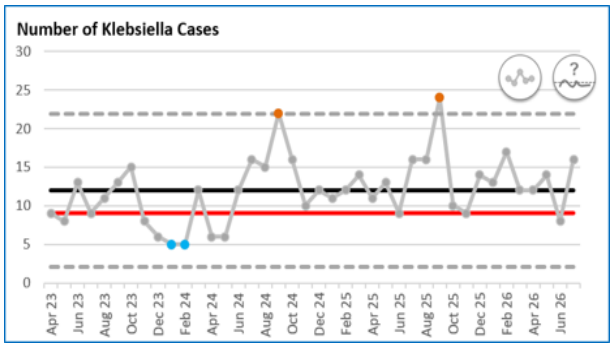
- National bloodstream infections (BSIs) continue to rise, particularly **Klebsiella (+4.3%)**, **Pseudomonas aeruginosa (+9.9%)** and **MRSA (+17.2%)** year-on-year.
- **MSSA** incidence has increased by **42.6% since surveillance commenced** and remains **9.6% above pre-pandemic levels**.
- National **CDI** rates have fallen by **4.0% year-on-year.** The Trust has achieved a 17% reduction in CDI cases in 2025/26 compared with 2024/25.
- ***E. coli*** remains the most frequently reported BSI nationally. National *E. coli* rates are **24.2% higher than at the start of surveillance**, driven largely by community-onset infections.

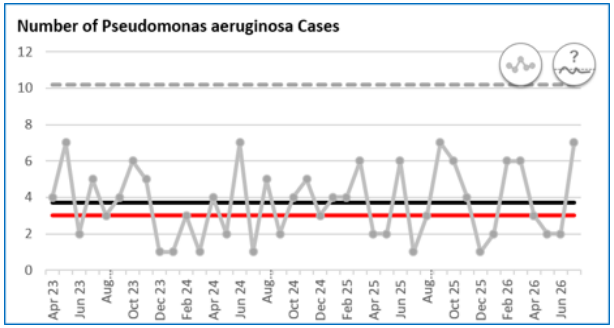
Current Position

- ***Clostridioides difficile* infection (CDI):** There was a marked increase in CDI cases during July (28 cases compared with 12 in June). With 11 Community-Onset Healthcare-Associated (COHA), and 17 Hospital-Onset Healthcare-Associated (HOHA). Seasonal increases are typically observed during the summer months, and this pattern is consistent with the Trust's longitudinal data. All HOHA cases are subject to investigation through the Patient Safety Incident Response Framework (PSIRF) process. Of the 17 cases requiring review, 10 investigations have been completed. No concerns were identified regarding antimicrobial stewardship (AMS) or infection prevention and control (IPC) practices in these cases, and they were therefore classified as low harm. Emerging themes included delayed diagnosis in certain patient groups, particularly older people, delays in specimen transport to the laboratory, delays in treatment initiation, and the use of inappropriate antibiotics. There is also an association with frailty and the acquisition of multidrug-resistant Urinary Tract Infections (UTIs) requiring broad-spectrum antibiotic therapy. The remaining 7 investigations are outstanding, and with clinical areas to investigate, resulting in delays to completion of the review process. These issues will be addressed through joint working between IPC, AMS and Clinical Boards.

Healthcare Associated Infections (HCAIs) (2/3)







Current Position continued

- **Methicillin-Sensitive *Staphylococcus aureus* (MSSA) bacteraemia:** MSSA bacteraemia cases remained stable in July (15 cases compared with 15 in June) and were within expected variation. Of the 15 cases reported, 6 met the criteria for investigation, comprising 3 COHA cases, 2 HOHA cases associated with intravascular devices, and 1 recurrent case in paediatric oncology. Key themes identified in the intravascular device-associated cases relate to inadequate documentation of device insertion, ongoing management, and removal. Further work is being undertaken to strengthen compliance with documentation and device management standards.
- **Methicillin-Resistant *Staphylococcus aureus* (MRSA) bacteraemia:** One MRSA bacteraemia case was reported in July, classified as HOHA, bringing the year-to-date total to six cases. Performance remains within common cause variation. Investigation of the case identified issues relating to screening compliance, incomplete skin decolonisation, and inappropriate antimicrobial therapy.
- ***Escherichia coli* (*E. coli*) bacteraemia:** *E. coli* bacteraemia cases increased significantly in July (34 cases compared with 24 in June), representing the highest monthly total reported by the Trust since surveillance commenced in 2015/16. Despite this increase, performance remained within common cause variation. Of the 34 cases, 7 were COHA and 27 were HOHA. Six of the HOHA cases required investigation due to identified contributory factors; five were associated with catheter-associated urinary tract infections (CAUTIs) and one was related to a cardiac device. The remaining 21 HOHA cases did not meet investigation criteria and were associated with the following primary sources of infection: urinary tract infection (n=6), hepatobiliary infection (n=6), gastrointestinal infection (n=3), chest infection (n=3), and unknown source (n=3).
- **Klebsiella bacteraemia:** Klebsiella bacteraemia cases doubled in July (16 cases compared with 8 in June) but remained within common cause variation. Of the 16 cases, 5 were COHA and 11 were HOHA. Two HOHA cases (18%) required investigation: one low-harm case associated with an intravascular device and one Carbapenemase-Producing Enterobacterales (CPE)-related case, classified as moderate harm, where the investigation remains outstanding. The remaining nine HOHA cases were attributed to intravascular devices (n=1), chest infections (n=2), gastrointestinal infections (n=3), hepatobiliary infections (n=2), and an unknown source (n=1).
- **Pseudomonas aeruginosa bacteraemia:** Cases increased in July (7 cases compared with 2 in June). Two cases (28.6%) required investigation, one associated with device management and one with suspected neutropenic sepsis. The remaining cases were found to have no preventable contributory factors and were not associated with identifiable lapses in care.

Healthcare Associated Infections (HCAIs) (3/3)

Overall Summary

Several bloodstream infection indicators increased during July, reflecting national trends and increasing patient complexity. The most notable increases were observed in CDI and *E. coli* bacteraemia; however, all indicators remained within expected variation. Investigation findings continue to identify opportunities for improvement in areas including device management, antimicrobial stewardship, diagnostic timeliness and urinary catheter care. The actions remain focused on reducing avoidable infection, minimising patient harm and improving patient outcomes.

Themes and Actions

Infection Prevention and Control Programme Update

- Senior nurse-led Harm Free Care intervention audits commenced in June 2026, with early findings demonstrating improved oversight of invasive devices and more timely removal of devices that are no longer clinically required.
- The first cycle of pharmacy-led AMS audits has been completed, achieving 90% compliance.
- Clinical Board IPC improvement plans have been submitted and formally reviewed, strengthening local ownership and accountability.
- Enhancement of SharePoint resources to improve accessibility of IPC guidance and assurance information.

Ongoing Improvement Priorities

The following workstreams remain on track:

- Development of the IPC assurance dashboard to improve visibility of infection prevention metrics and compliance monitoring.
- Thematic review of AMS audit findings to identify opportunities for targeted quality improvement (QI).

Strategic Workstreams

Key programmes supporting reductions in avoidable infection include:

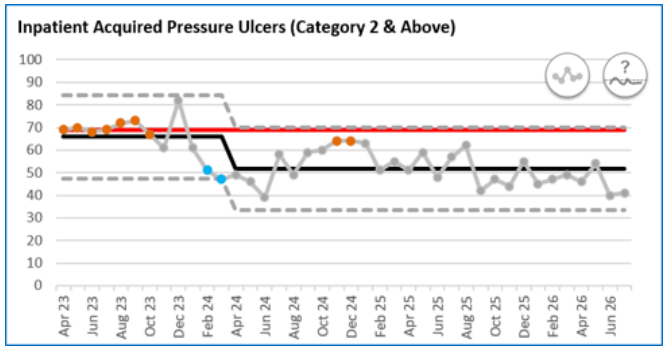
- Vascular Access Improvement Programme.
- Hospital at Night Quality Improvement Programme progressing the training and competency assessment of ward-based nursing staff in peripheral cannula insertion, strengthening workforce capability and supporting safer, more consistent vascular access practice across the Trust.
- IV to Oral Antimicrobial Switch Programme.
- Development of enhanced surveillance and analytical capability using R data beyond MRSA reporting.
- Improvement of skin integrity pathways in collaboration with the Tissue Viability Team.

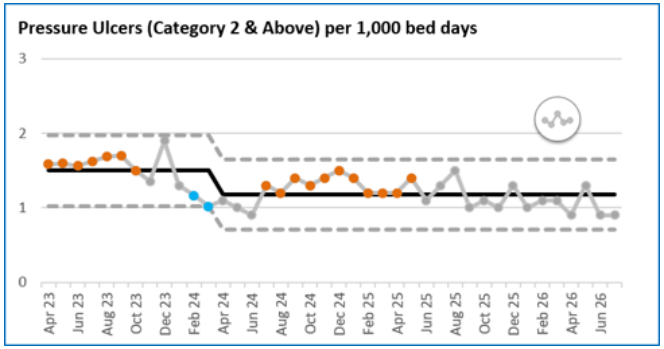
Impact and Board Assurance

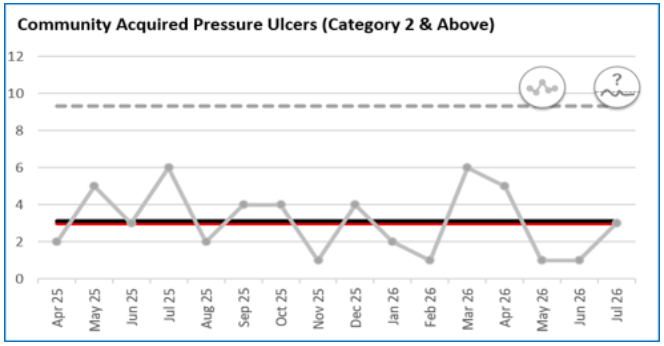
- Early evidence demonstrates improved clinical oversight of line and device management, strengthened AMS arrangements, and enhanced accountability for IPC performance across Clinical Boards.
- The IPC programme continues to focus on reducing avoidable infection through early identification of risks, proactive management of invasive devices, strengthened antimicrobial stewardship, and improved assurance processes. This provides assurance that improvement activity is targeted towards the areas most likely to reduce preventable harm and improve patient outcomes.

KEY MESSAGE: Robust governance arrangements are now in place to support earlier identification of improvement opportunities, strengthen clinical ownership of infection prevention, and maintain focus on reducing avoidable HCAIs.

Harm Free Care: Pressure Damage (1/1)







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

July data demonstrates stability in pressure ulcer performance across inpatient services. The number of acute pressure ulcers (Category II and above) increased slightly from 40 cases in June to 41 cases in July, representing a 2.5% increase. The rate per 1,000 bed days remained static at 0.9.

Severity Breakdown

For inpatient pressure ulcers reported during July:

- No Category IV pressure ulcers were reported.
- Four Category III pressure ulcers were reported.

All Category III pressure ulcers are currently under investigation to identify contributory factors, share learning, and inform preventative measures.

Actions

- Wards with high incidence of pressure ulcers are supported with learning and quality improvement initiatives.
- Pressure Ulcer Categorisation eLearning updated.

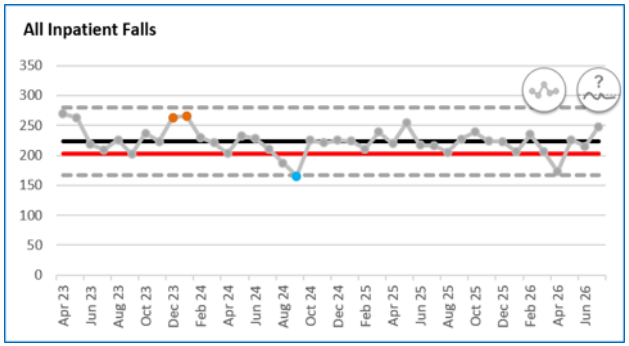
In the Community

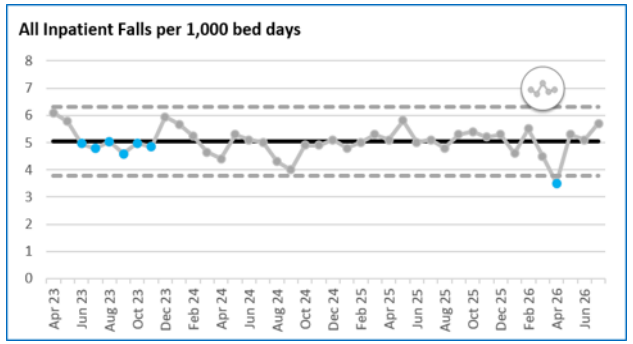
There were 2 Category II, 1 Category III but no Category IV community-acquired pressure ulcers reported in July.

Following an increase in Category II community acquired pressure ulcers in the preceding year a working group has been established and initial actions agreed:

- Progress with Purpose-T, develop guidance for all the community teams with clear standards of care expected from each service.
- Develop an ASSKING template for community nurses.
- Community Tissue Viability Nurse (TVN) team to audit the 50 category II pressure ulcers from April 2025-March 2026.
- Work started to develop a dashboard for community acquired pressure ulcers.

Harm Free Care: Falls (1/2)





Standard

With the sustained reduction in inpatient falls in the past two years, specific numerical reduction targets have not been set. Instead, continued improvement will be monitored through , with the expectation of demonstrating a sustained reduction over time.

Current Position

Falls increased in July:

- The number of inpatient falls rose from 215 in June to 248 in July, with the falls rate increasing from 5.1 to 5.7 per 1,000 bed days.
- Despite this month-on-month increase, performance remains slightly improved compared with July 2025, when 251 inpatient falls were reported, equating to 5.8 falls per 1,000 bed days.
- charts continue to demonstrate common cause variation, indicating that performance remains stable and within expected limits.
- Falls activity has shown a recurring seasonal summer increase over recent years, both locally and across Shelford Group Trusts, with no clear explanation identified.

Harm Summary

- 5 inpatient falls resulting in significant harm were reported, 4 categorised as moderate harm and 1 categorised as severe harm.
- Injuries resulting in moderate harm included a rib fracture with pneumothorax, a metatarsal fracture, a scalp haematoma requiring blood transfusion, and an L1 vertebral fracture with neuropathic pain. Severe harm was associated with a neck of femur fracture

Actions Taken

- Met with the Integrated Care Board (ICB) to support development of a falls strategy, aligning frailty and falls pathways across Newcastle and the North East and Cumbria.
- Shelford Group Falls Collaborative, presenting annual falls data and reports to support benchmarking, meaningful comparison and shared learning.
- Commenced recruitment for an National Institute for Health and Care Research (NIHR)-funded service improvement study exploring staff perceived barriers and facilitators to the PSIRF falls review process.
- Delivered falls education at FY1 induction and, with Haematology and Neuroradiology colleagues, launched post-fall intranet resources for resident doctors rotating into the Trust.
- Presented Eat Drink Dress Move (EDDM) programme for consideration by the Professional Practice Assurance Group (PPAG).

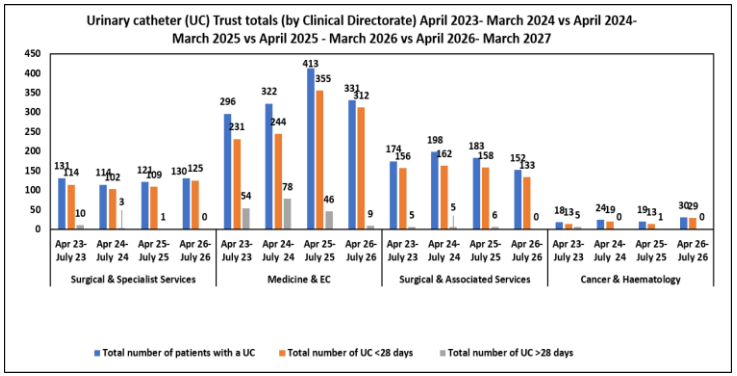
Harm Free Care: Falls (2/2)

Summary

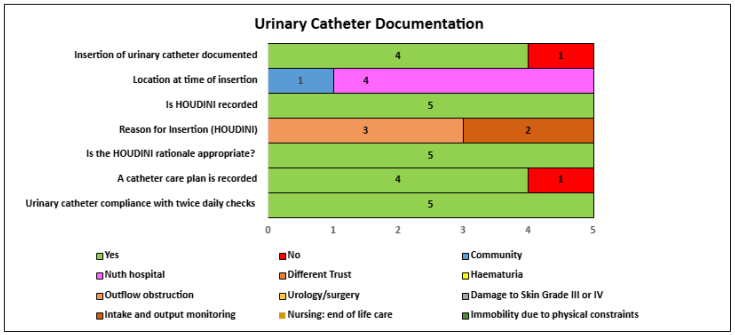
- Falls performance deteriorated in July, with both the total number of inpatient falls and the inpatient falls rate per 1,000 bed days increasing compared with June.
- Despite this month-on-month increase, performance remains marginally improved compared with July 2025. charts continue to demonstrate common cause variation, indicating performance remains stable and within expected limits.
- A seasonal increase in falls activity has again been observed during the summer months, consistent with trends seen locally and across Shelford Group Trusts.
- Five significant harm falls were reported during July, including four moderate harm incidents and one severe harm incident.
- Ongoing work includes strengthening regional and national collaboration through engagement with the Integrated Care Board (ICB) and Shelford Group, progressing falls-related research, enhancing junior doctor education and resources, and developing proposals to reduce deconditioning and associated risks across the Trust.

Harm Free Care: Urinary Catheter Reduction

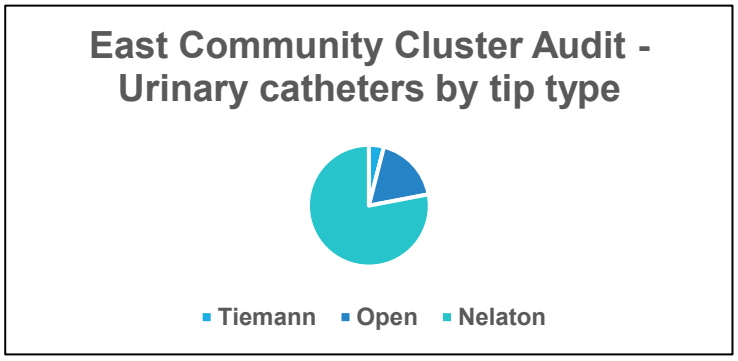
Graph 1



Graph 2



Graph 3



Background

Adhering to harm free care and catheter care standards supports efforts to reduce urinary gram-negative bloodstream infections, specifically catheter associated urinary tract infections (CAUTI). The aim of striving for improvement in patient outcomes, engagement with staff & the wider community assists with identifying potential challenges and maps out quality improvement initiatives.

Standard

- Currently there are no national benchmarking/surveillance tools to compare our work.

Current position

- The percentage of patients with urinary catheters (UC) in situ for greater than 28 days across hospital and community continues to be monitored, this is important as the daily risk of bacteriuria varies from **3% to 7%** when a catheter remains in situ and **3.6%** of those with CAUTI develop secondary infections such as bacteraemia or septicaemia which can be fatal.
- *Graph 1* illustrates the continued low running trend of urinary catheters in situ for greater than 28 days. Within Medicine & EC data includes those patients admitted with a urinary catheter from the community.
- *Graph 2* shows a recent Take 5 UC re-audit on Ward 22 Royal Victoria Infirmary (RVI). The results demonstrate improvement in catheter practice, with 100% compliance in HOUDINI documentation, catheter rationale, twice-daily reviews, drainage bag management and catheter hygiene standards, and catheter care plans completed in 80% of patients.
- *Graph 3* shows the number of catheters by tip types across the east community cluster. By utilising more open-tip catheters it is hoped that unplanned interventions and re-catheterisations will reduce.

Action taken

- Optimising the management of urinary tract infection (UTI) and CAUTI through quality improvement clinical interventions, recommendations, and patient reviews.
- Ad hoc training is provided informally to the clinical areas in acute and community settings
- Clinical walk rounds continue across primary and secondary care to discuss best practice around catheter care and management.
- A collaborative approach to Gram-negative bloodstream infections (GNBSI) reviews: Urinary E. coli information is shared by IPC and discussed with the continence service to assist with focusing on attributing themes and implementing prevention strategies
- No Catheter No CAUTI relaunch planning for November 2026, creating a catheter safety pause initiative (CATH PAUSE)
- Catheter Avoidance: a collaborative approach to improving catheter care practice, utilising education, clinical walk rounds, and audit. Quarterly IPC Take 3 urinary catheter audit demonstrated poor compliance with the use of catheter fixation devices therefore ongoing work to target this is underway. RVI Ward 22 and 16 & Freeman Hospital (FH) Ward 18 are taking part in a trial of alternative catheter fixation devices following staff feedback.
- Open-tip catheter QI: auditing is underway and prescription changes for open-tip catheters have started. Data will be gathered for the previous 6 months, then analysed for improvements to unplanned interventions following 6 months of use.
- ICARE Project: Staff education and clinical walk rounds have been successfully completed. Post-project staff questionnaires are currently in progress to evaluate the impact of the intervention.

Harm Free Care: VTE Assessments

Standards

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

Current Position

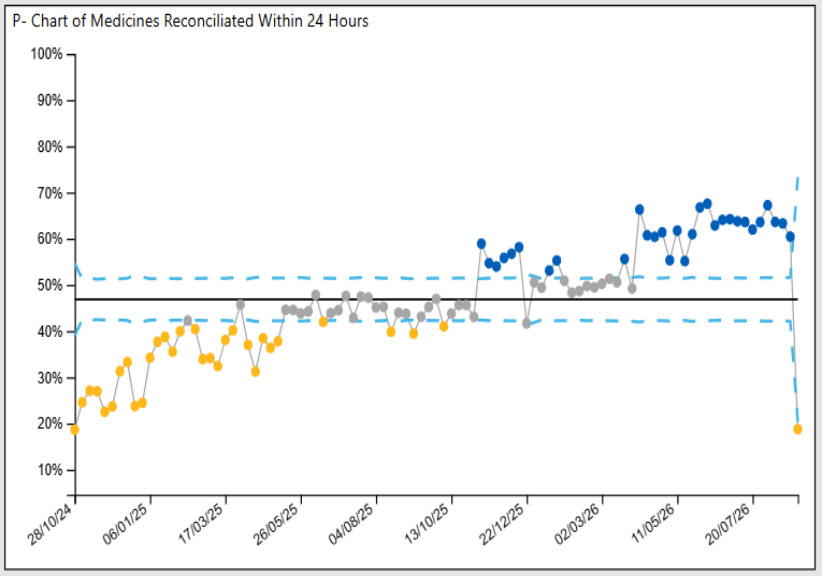
- 97% VTE risk assessment completion during admission.
- 87% VTE risk assessment completion within 24 hours of an admission
- 77% VTE risk assessment completion within 14 hours of an admission.

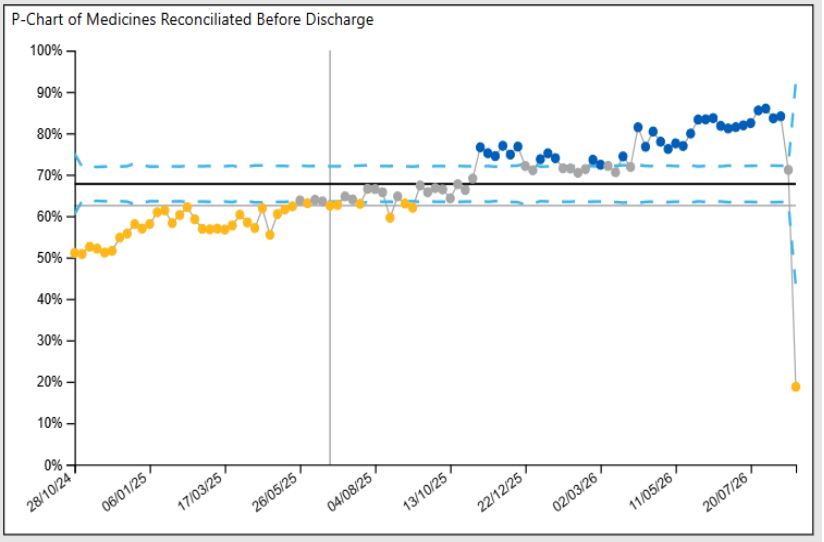
- The accuracy of the VTE risk assessment compliance data is limited as:
  - It provides only a snapshot view and does not allow analysis over time.
  - Inclusion of inappropriate patient groups that should be excluded (e.g. dental hospital patients).

- 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	81%
Cardiothoracic services	79%
Family health	76%
Medicine and emergency care	94%
Perioperative and critical care	92%
Surgical and associated services	86%
Surgical and specialist services	81%

Medicines Reconciliation (Med Rec)





Standards

- Target 40% with existing staffing;
- 50-60% after implementation of phase 1 of staffing business case
- 60-80% after implementation of phase 2
- 80% after implementation of phase 3

Current Position

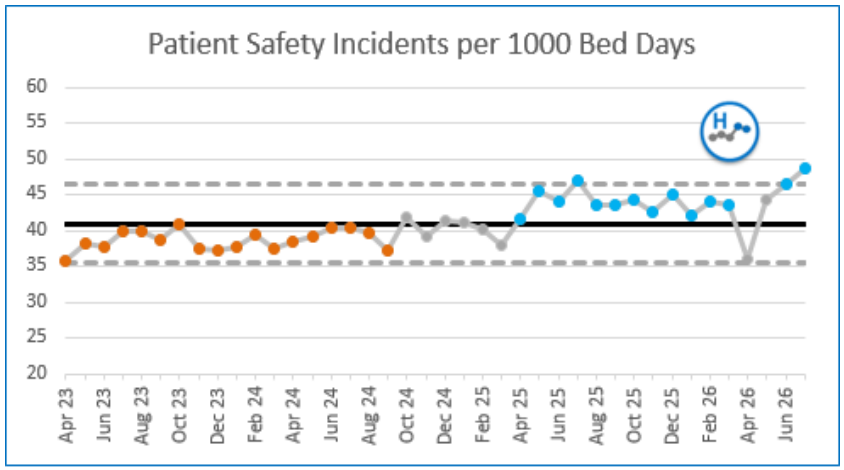
- All Phase 1 staff now in post; working on new target of 50-60%

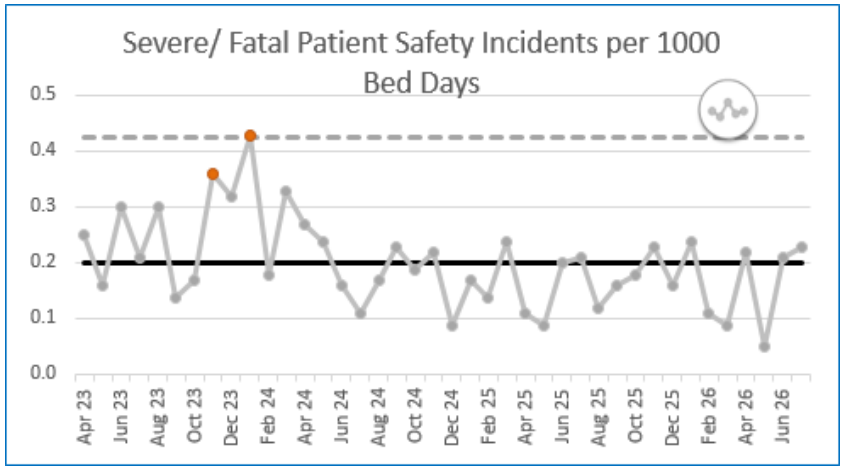
	Med Rec within 24 hours Total Number & %		Total Med Rec before discharge Total Number & %	
July 2025	2099	**43%**	2488	52%
Aug 2025	1882	**40%**	2446	52%
Sept 2025	2006	**40%**	2567	53%
Oct 2025	2064	**41%**	2681	54%
Nov 2025	2105	**49%**	2564	59%
Dec 2025	2111	**51%**	2563	61%
Jan 2026	2362	**48%**	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%
July 2026	**2955**	**64%**	3814	82%
Aug 2026	**2655**	**62%**	3438	81%

Narrative Aug 2026

- Phase 2 of business has been approved and work has begun to recruit staff into posts.

Incident Reporting





Standards

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

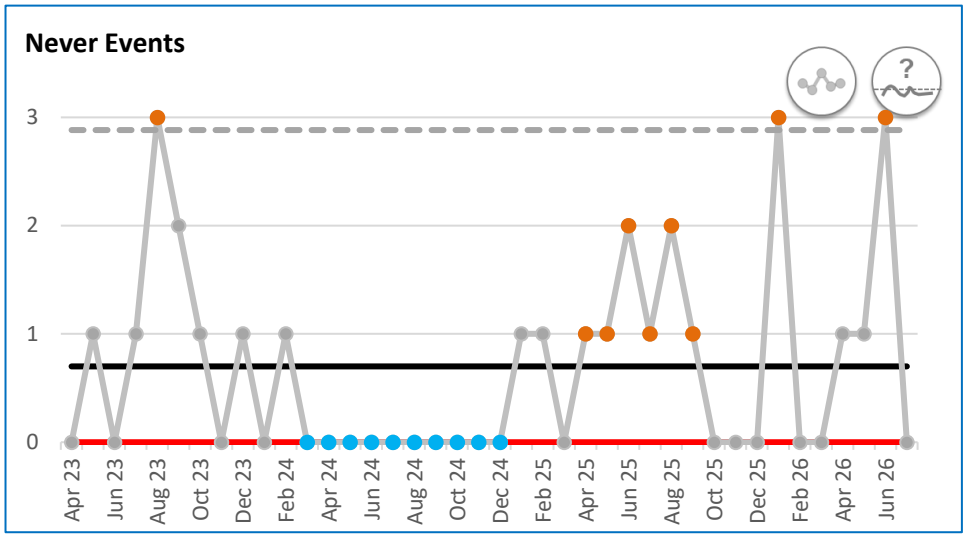
Current Position

- The total number of patient safety incidents per 1,000 bed days reported in July 2026 increased compared to June 2026.
- The number of severe/fatal safety incidents per 1,000 bed days increased in July 2026, compared with June 2026.
- Five After Action Reviews and two Patient Safety Incident Investigations were recorded in July 2026.

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 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



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
June 26	37531	Clinical & Diagnostic Services	Radiology	Wrong site surgery
June 26	38391	Clinical & Diagnostic Services	Radiology	Wrong implant / prothesis
June 26	39375	Medicine & Emergency Care	Respiratory	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.

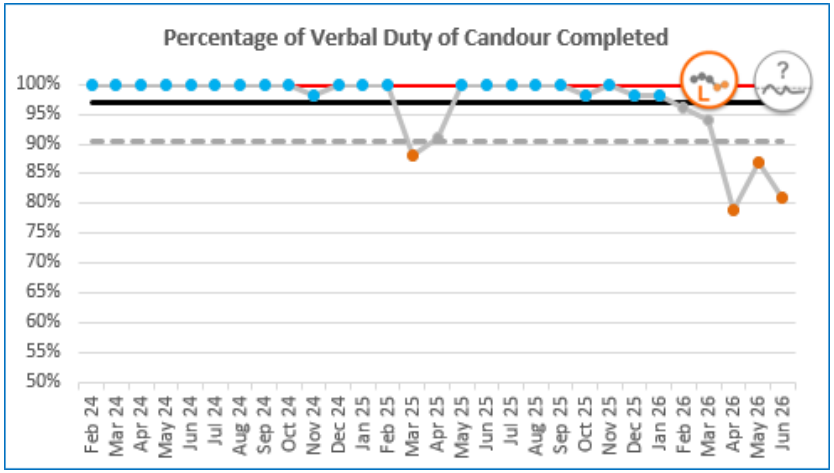
Current Position

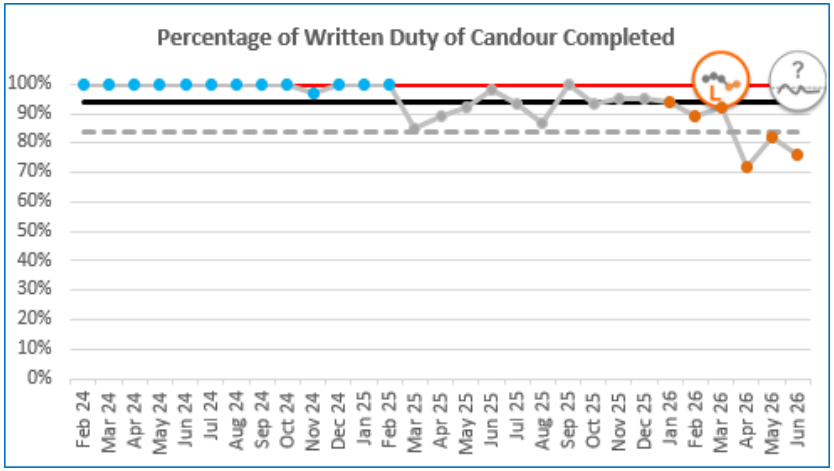
- No new Never Events were recorded in July 2026.
- Five Never Events have been recorded in 26/27.
- 11 Never Events were recorded in 25/26.

Action taken

- Never Event oversight has been strengthened through review of all incidents to identify common contributory factors, emerging risks and opportunities for system-wide learning.
- Patient Safety Incident Response Framework (PSIRF) led implementation of NatSSIPs2 is supporting improvements in invasive procedure safety through the development of a consistent trust wide approach, overseen by a Project Board with regular reporting to Quality Committee.
- Medical gas safety controls have been strengthened, including equipment rationalisation, environmental controls and compliance assurance audits.
- Learning from Never Events is being shared across Clinical Boards to support the reduction of variation in practice and strengthen preventative controls in high-risk clinical processes.

Duty of Candour





Standards

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

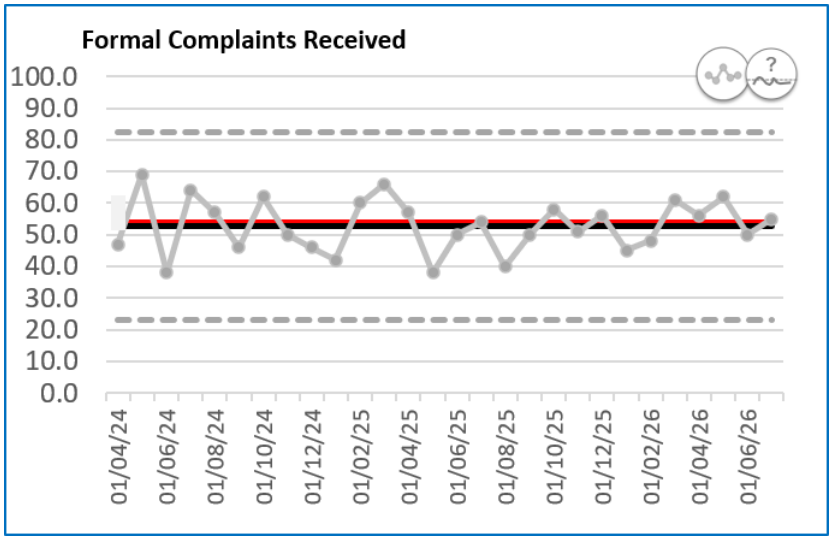
Current Position

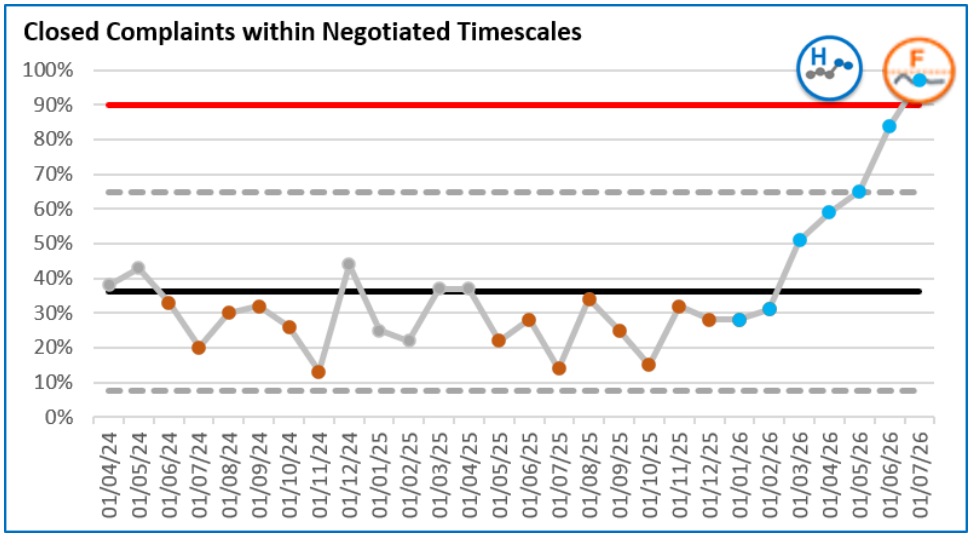
- Data for overall Trust compliance is taken from records of completion in the incident module of InPhase. Additional assurances for compliance with the statutory requirements of Regulation 20 are undertaken through audits reported to Patient Safety Group and Quality Committee.
- Compliance with verbal and written DoC was below the trust average in June 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 ongoing with the IPC team to ensure accuracy of harm grading and more timely review of incidents to support improvements in the Trust's duty of candour position.
- Trial of new Patient Safety Involvement Leads to support engagement in complex Patient Safety Incident Investigations.

Formal Complaints





- The Trust had 55 formal complaints In July 2026. The average number of complaints opened for the previous financial year is 50 and continues to show a fluctuation of variation above and below the average.

- Clinical treatment accounts for the most complaints collectively across the specialties with 36% of complaints opened this month (20). The top 3 relating to: Surgical 8 (14%); Accident & Emergency (A&E) 4 (7%); and Medicine/Obstetrics & Gynaecology 3/3 (5%/5%);

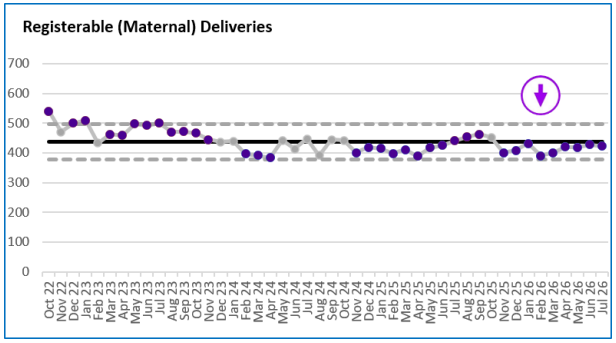
- The most complaints were opened for the following three Clinical Boards, collectively accounting for 63% of complaints this month:

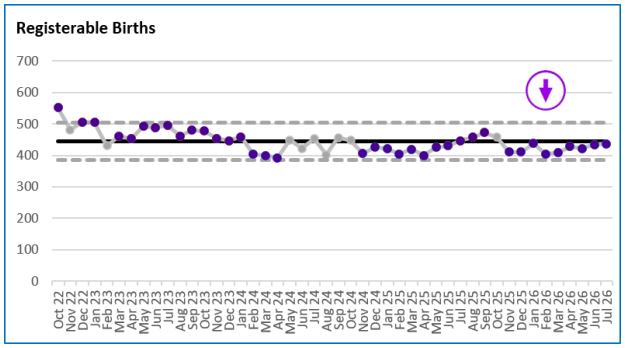
    - Medicine & Emergency Care 16 (29%)
    - Surgery & Specialist Services 10 (18%)
    - Surgery & Associated Specialties 9 (16%)

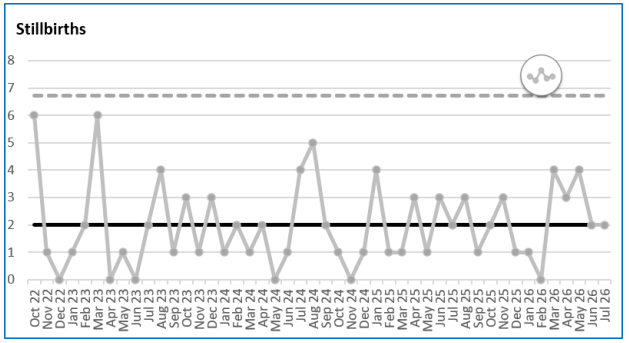
- In July there were 73 formal complaints closed and 71 (97%) were on time, within negotiated timescales This shows continuing substantial improvement towards the internal Key Performance Indicator (KPI) of 90% with 7 positive moves in percentages, following the introduction of re-negotiated timescales and we will continue to monitoring this alongside further service improvements.

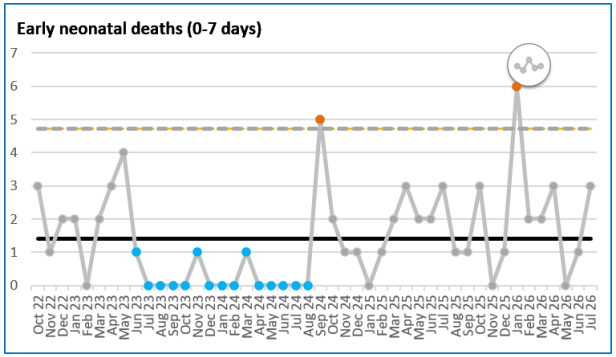
- A draft Complaints Summary Dashboard will be presented at the September Experience of Care Group.

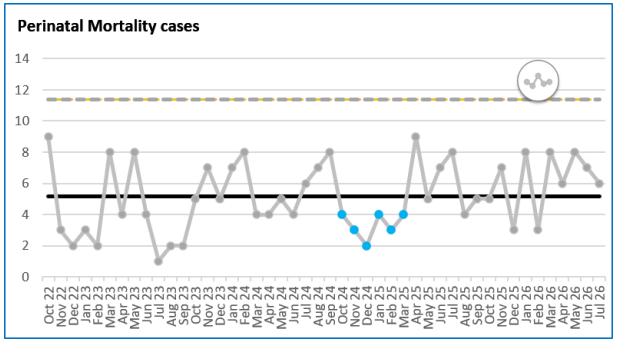
Perinatal Quality Oversight: Births











Deliveries/Births

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

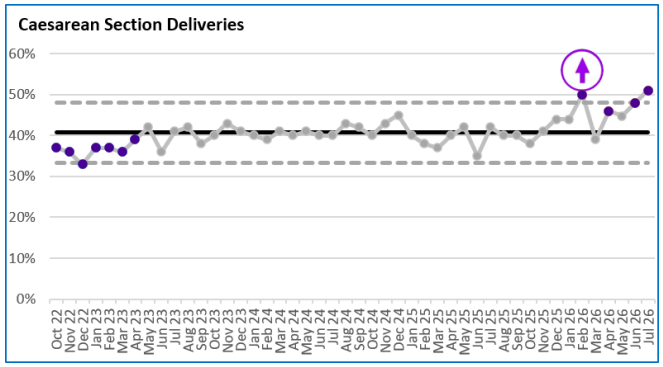
Stillbirths

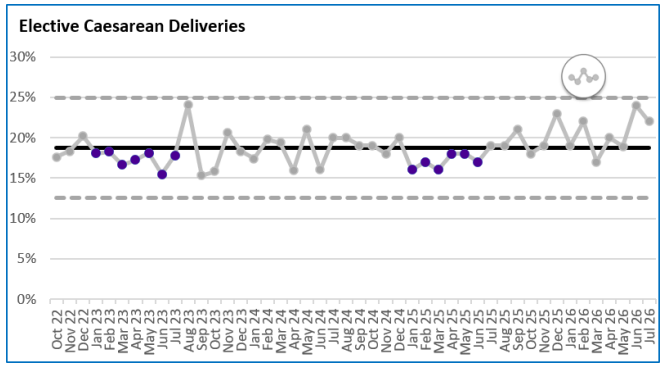
- This data includes termination for fetal anomalies >24 weeks gestation. There were two stillbirths in July 2026; all cases meet criteria for review through the Perinatal Mortality Review Tool (PMRT). The PMRT quarterly report is submitted to Trust Board in accordance with the Maternity Incentive Scheme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

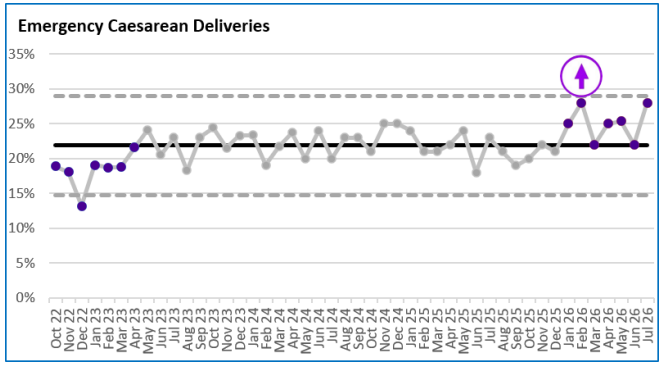
Early Neonatal Deaths

- The Trust has the highest level of neonatal intensive care provision supporting extremely premature babies. Early neonatal deaths are classified as death within 0-7 days of life (late neonatal deaths are those from 7-28 days). These deaths are reported to the Child Death Review panel who will have oversight of the investigation and review process. There were 3 early neonatal death in July 2026. Early neonatal deaths often include extremely premature infants born before 24 weeks gestation and may also include babies with complex congenital anomalies.

Perinatal Quality Oversight: Deliveries







Caesarean section deliveries

- In England 42.9% of births are caesarean section, in the North East North Cumbria (NENC) for Quarter 1 (Q1) this was 43.4%. There is no defined national metric for caesarean section rates.
- The Trust had a caesarean section rate of 50% in July. It should be noted that the caesarean section rate for the Trust, and nationally, is challenging operationally and there has been an associated impact on the perioperative staffing requirements to maintain a safe service which is being reviewed by the leadership teams. A quality case has been submitted, with a comprehensive action plan jointly owned by Peri-operatives and Maternity leadership team.

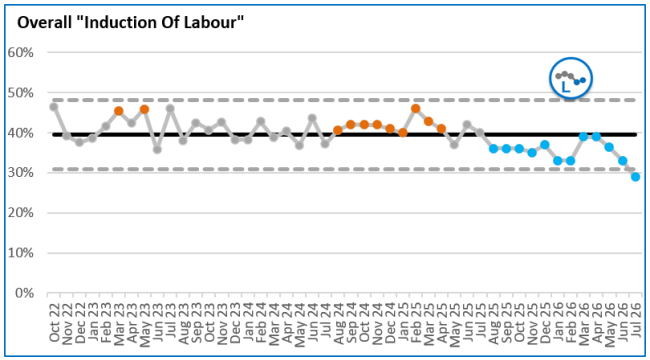
Elective Caesarean section

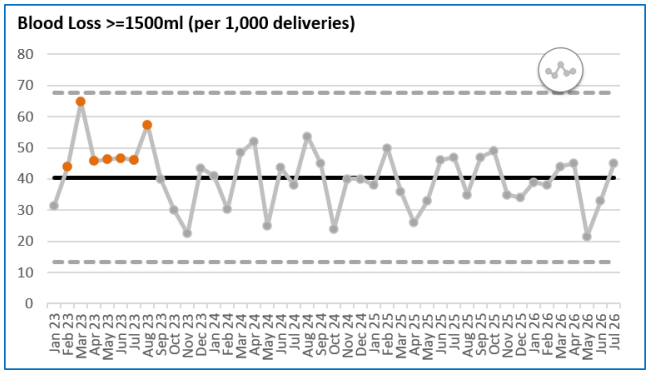
- The average England elective caesarean rate in Q4 2025/26 was 20.9% and in NENC 21.3%.
- The Trust elective caesarean rate was 22% in July.
- The national rise in elective caesarean rates is partially due to an increasing proportion being undertaken due to maternal request in accordance with the National Institute for Health and Care Excellence (NICE) guidance.
- The Trust has a shared decision-making philosophy and offers informed, non-directive counselling for women over mode of delivery. There is an obstetrician/midwifery specialised clinic to facilitate this counselling and patient choice.

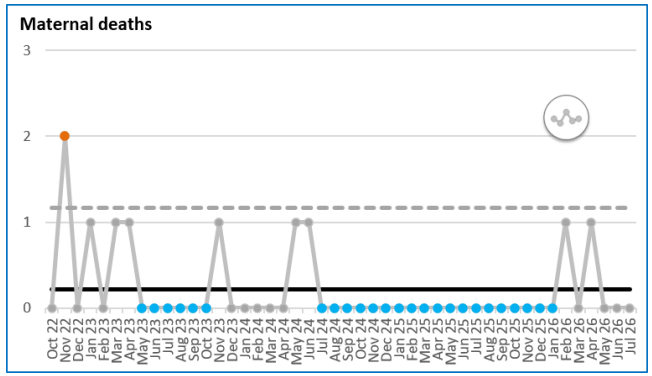
Emergency Caesarean section

- The England average for Q1 2025/26 was 23.6%, and NENC mean 20.5%.
- The Trust emergency caesarean rate was 28% in July 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.
- Capacity and demand modelling for obstetric theatres is currently underway as a requirement of the Maternity Incentive Scheme Year 8 Safety Action A.

Perinatal Quality Oversight: Labour







Induction of Labour

- The number of women being induced during pregnancy has increased due to changes in national guidelines as part of the Saving Babies Lives Care Bundle and other NICE and RCOG guidance.
- England average for induction of labour (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 29% in July 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.

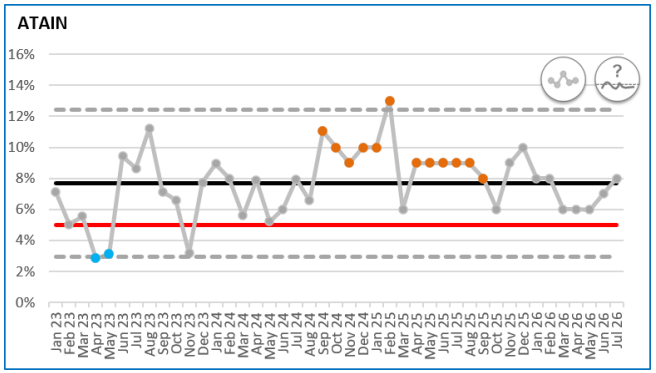
Blood Loss ≥1500ml

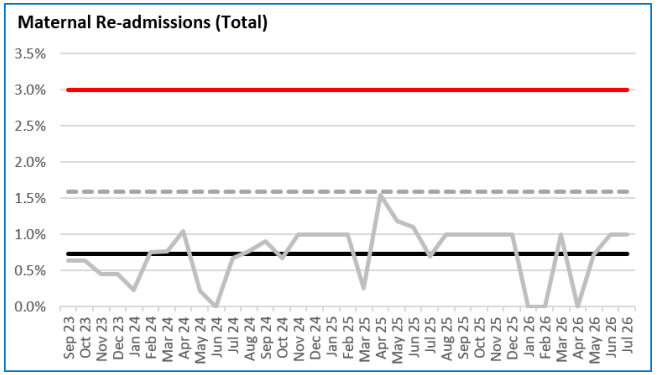
- The average Post Partum Haemorrhage (PPH) rate for Q4 2025/26 in England is 30 per 1000 and NENC average is 27 per 1000. The Trust PPH rate for July 2026 is 45 per 1000. Q1 average was 33 per 1000.
- Higher rates are indicative of the complexities of the high-risk patient group and provision of the Placenta Accreta Spectrum service as confirmed by the previous review.
- Element 5 of the newly published 'The Maternal Care Bundle' (MCB) (NHS England, 2026) requires Trusts to implement safety actions for obstetric blood loss/PPH and ensure multidisciplinary review of cases ≥2000ml . The Trust are currently benchmarking against all elements within the MCB but do not anticipate any significant increase in reporting PPH as many of the required standards are already implemented within the maternity services.

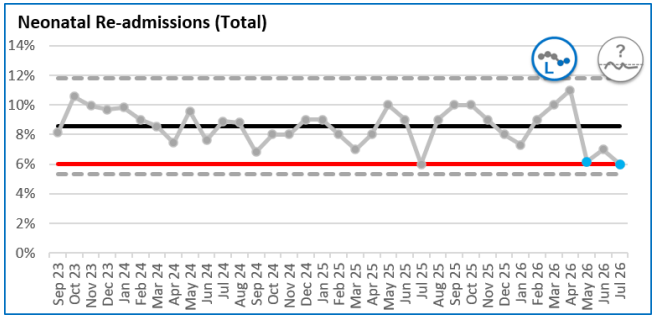
Maternal Deaths

- Maternal deaths are reported to Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) and an annual national report is provided. There 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 July 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 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 July this was 8%. Three quality improvement workstreams are ongoing. 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, the staffing model to support this group of babies is currently being considered.

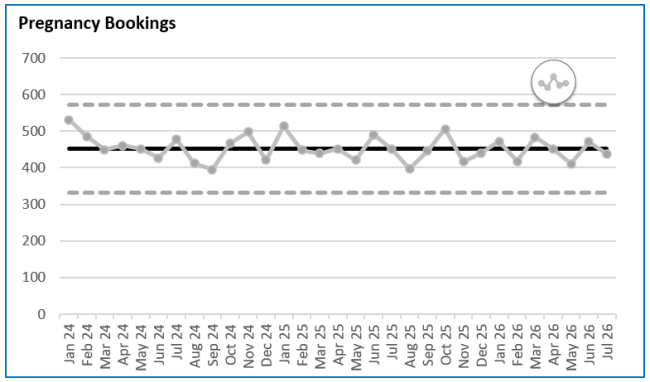
Maternal Readmissions

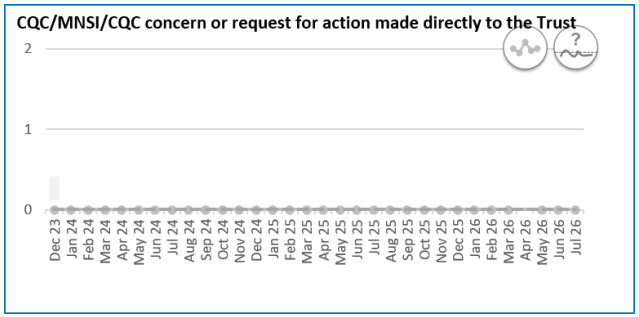
- National Maternity & Perinatal Audit (NMPA) Report (2025) the maternal postnatal readmission rate for England was 3.08% in 2023, rates varied by provider (Interquartile Range (IQR): 2.57–5.02% in Wales; 2.14–3.59% in England). The LMNS are benchmarking against the national mean readmission rate, hence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

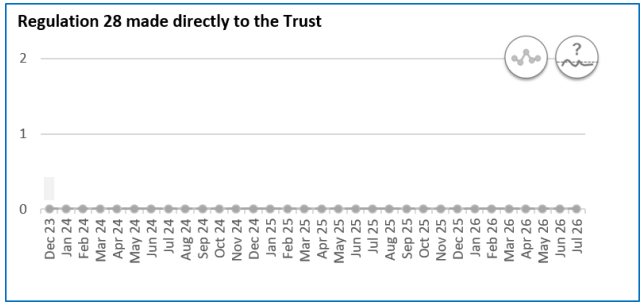
Neonatal Readmissions

- The Clinical Quality Improvement Metrics (CQIM) for 'Babies readmitted to hospital who were under 30 days old' data is used as a comparison to Trust performance, hence the target of 6%.
- In June the readmission rate was 6%.
- A review of Q1 1299 babies were born within the Trust. 101 babies were re-admitted within the first 30 days of life, representing a re-admission rate of 7.78%.
- Review of the re-admission cohort identified that 50 babies (3.85% of all births) were admitted under the care of the Great North Children's Hospital (GNCH) for conditions not directly related to maternity or intrapartum care. A further 7 babies (0.54% of all births) were re-admitted alongside their mothers during a maternal hospital admission. These cases were not associated with neonatal illness requiring separate specialist neonatal management. Overall, 51 babies were admitted to maternity service during Q1, equating to 3.93% of all live births. This figure includes babies requiring postnatal assessment, monitoring, or treatment within maternity services rather than admission to a neonatal unit for feeding issues, jaundice and hypothermia.
- Quarterly monitoring and analysis will continue.
- Work is ongoing to support improved data quality.

Perinatal Quality Oversight: Incidents & Bookings





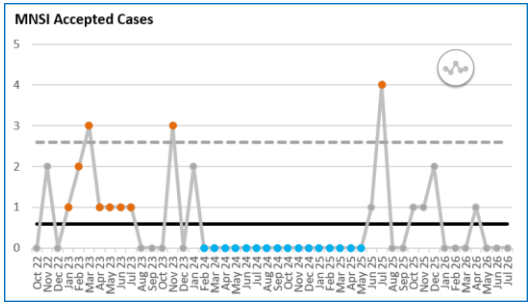


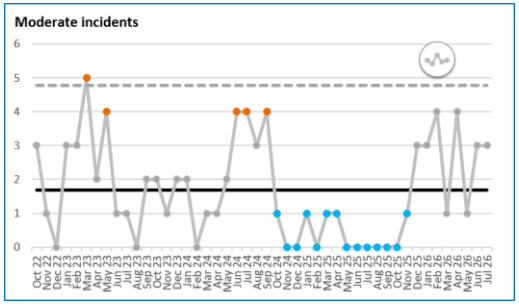
Pregnancy Bookings

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

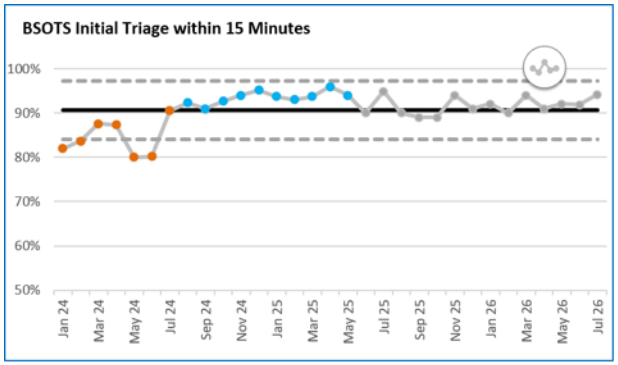
Incidents

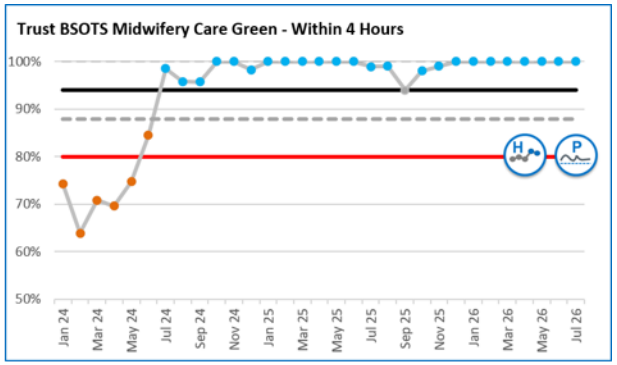
- Moderate incidents are now separated from externally reported MNSI cases which were previously grouped together. There were 3 moderate or above harm incident reported in July. Incidents are discussed at a multi disciplinary rapid review and presented to the Trust Response Action Review Meeting (RARM) to agree a proportionate learning response.
- Perinatal incidents referred to Maternity and Newborn Safety Investigations (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 July.
- There have been no regulation 28 notices in the last 12 months.

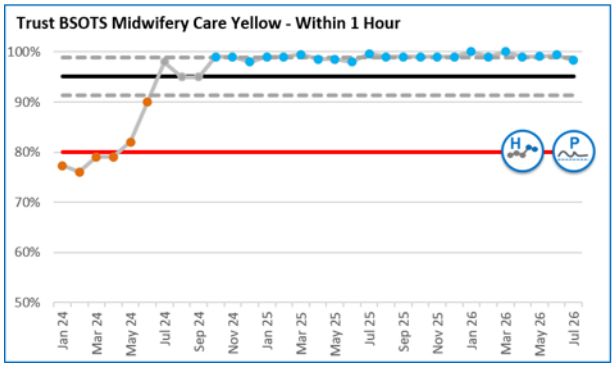


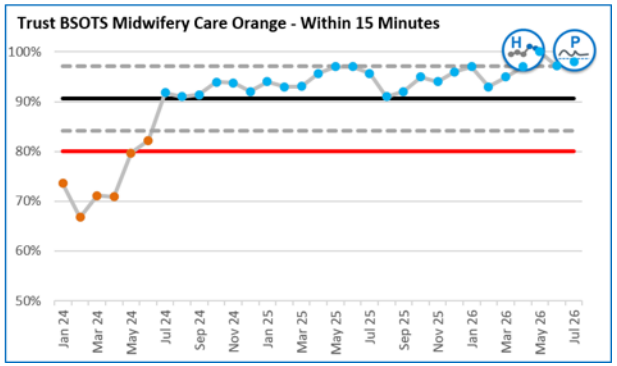


Perinatal Quality Oversight: Triage - Midwifery Care Timings





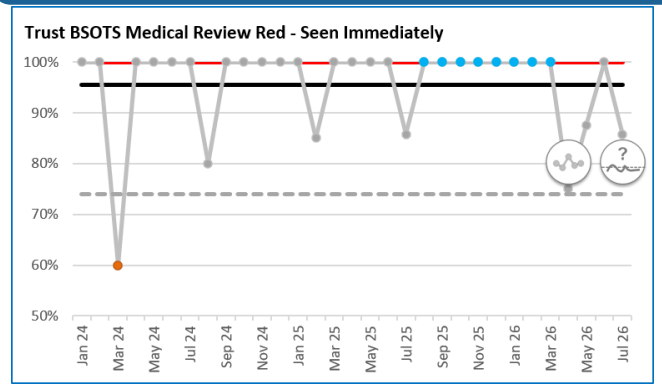


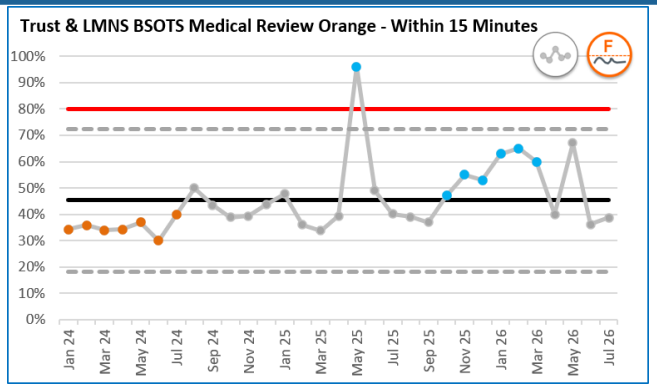


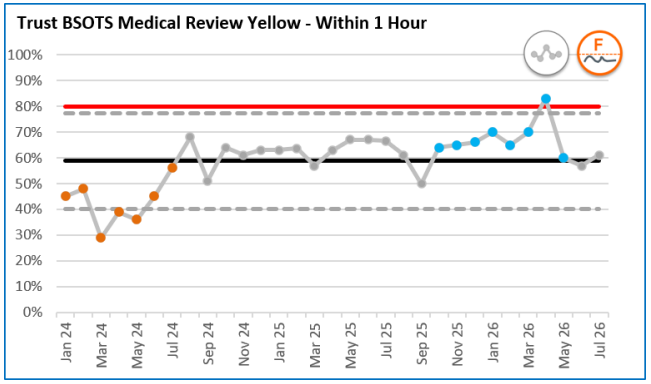
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

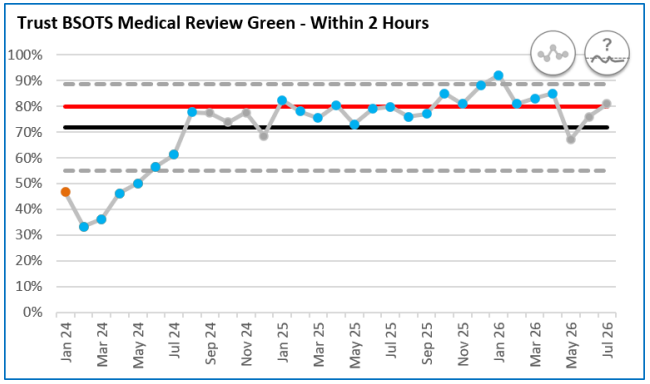
- The Trust implemented the BSOTS triage system in January 2024. Midwifery triage and subsequent review has improved considerably and has exceeded the Trust and LMNS target.
- Good performance continues to be sustained across every category for midwifery review.
- The Trust has completed a gap analysis against the NHS England (NHSE) Triage specification published in July 2026 and has an action plan to ensure the metrics required as part of this specification are developed. The metrics include the midwifery and medical review times, but also additional measures from a health inequalities perspective.

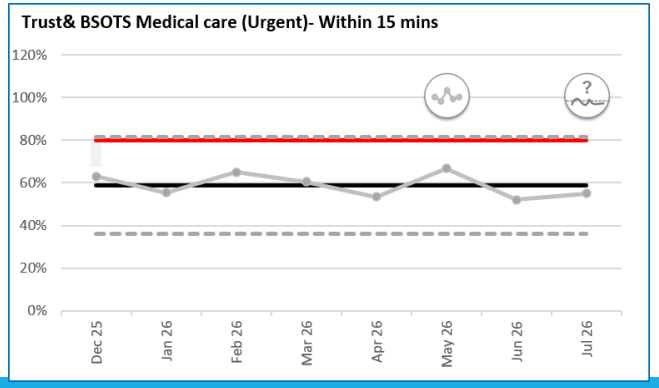
Perinatal Quality Oversight: Triage - Medical Review Timings

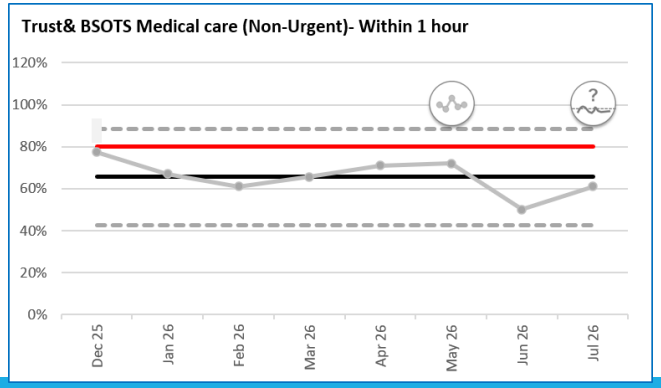








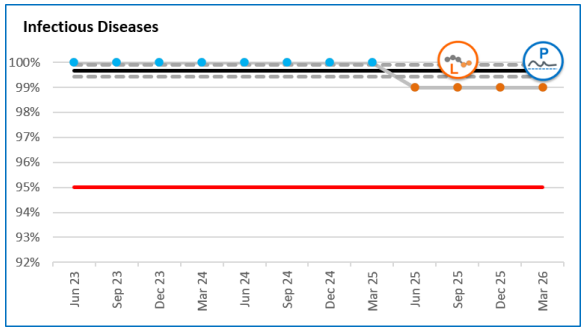


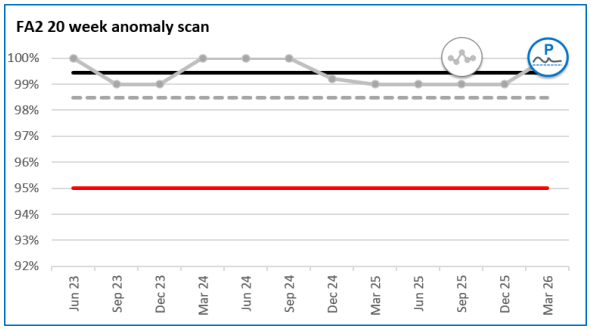


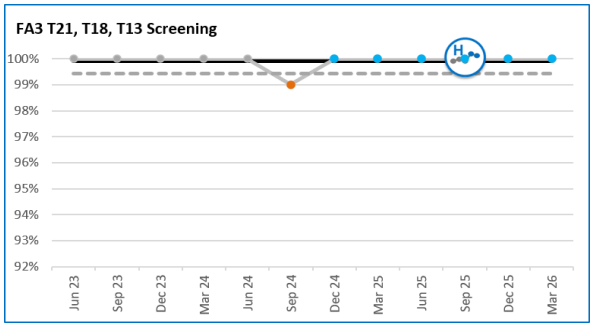
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

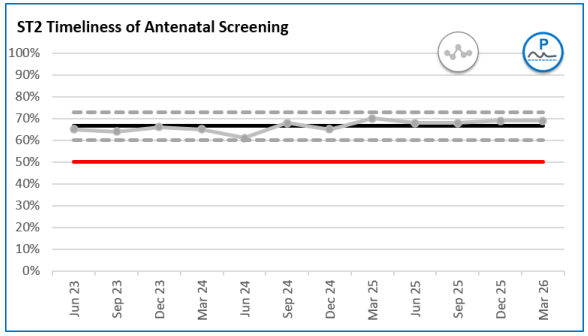
- There has been significant improvement in performance in the last 12 months.
- As previously highlighted, the business case to commence call recording for the triage services has been paused. This remains a risk within the service and is subject to ongoing discussions.
- The national BSOTS team have recommended that women within the 'orange' category are further broken down into 'urgent' and 'non-urgent'. Trust can now access this data breakdown and reporting as per chart. More data entries required to provide further analysis.
- A national toolkit and specification was published in July 2026, benchmarking against the standards has been completed.
- The current estate, medical staffing and signage for the Triage services will need to be considered to achieve full compliance with the standards.

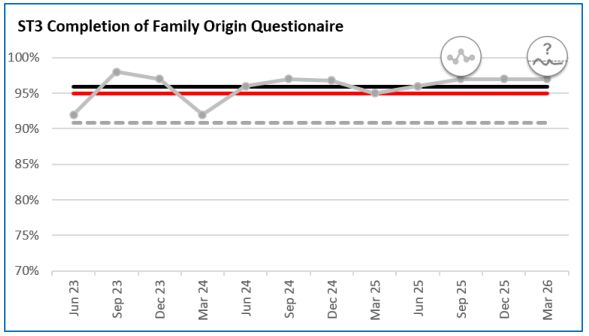
Perinatal Quality Oversight: Antenatal Screening

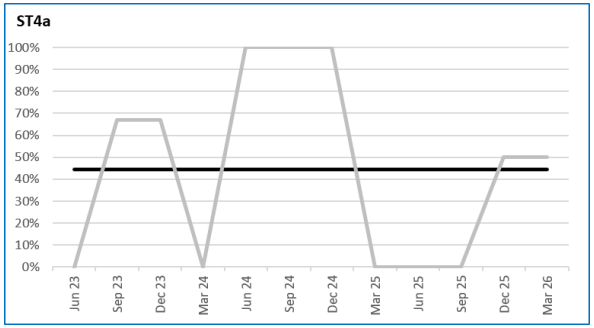


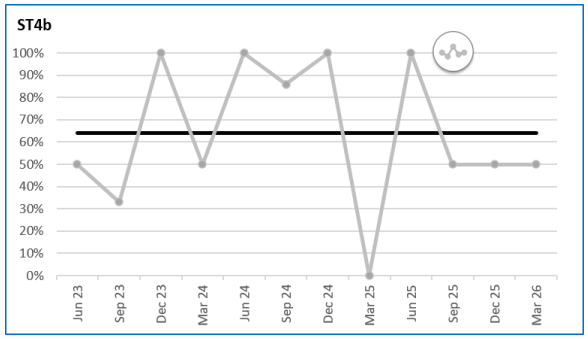


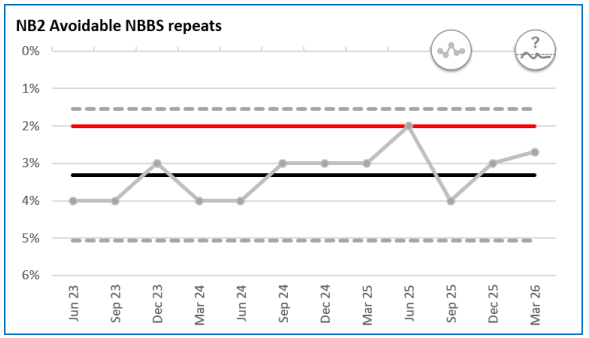








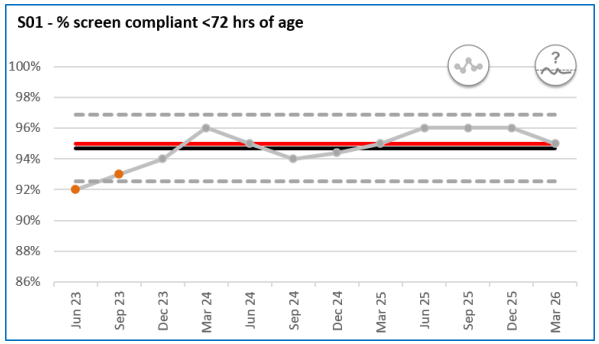


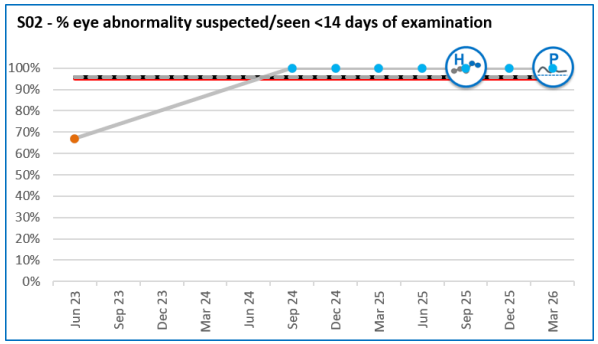


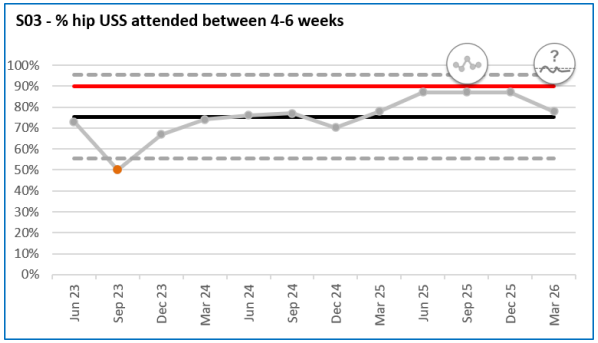
Antenatal Screening

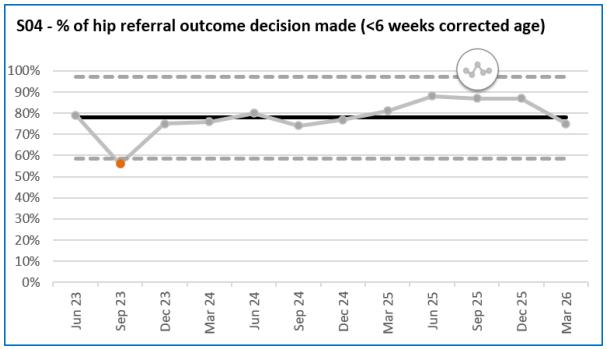
- A screening tracker has been developed by analysts and deployed to support failsafe processes and reporting.
- There is a focused action plan to reduce the number of avoidable repeats for the newborn blood spot sample.
- The failsafe process for infectious diseases is currently being considered as needs to be developed.

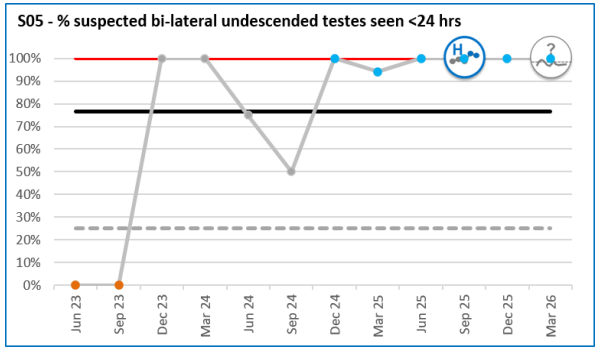
Perinatal Quality Oversight: NIPE Screening







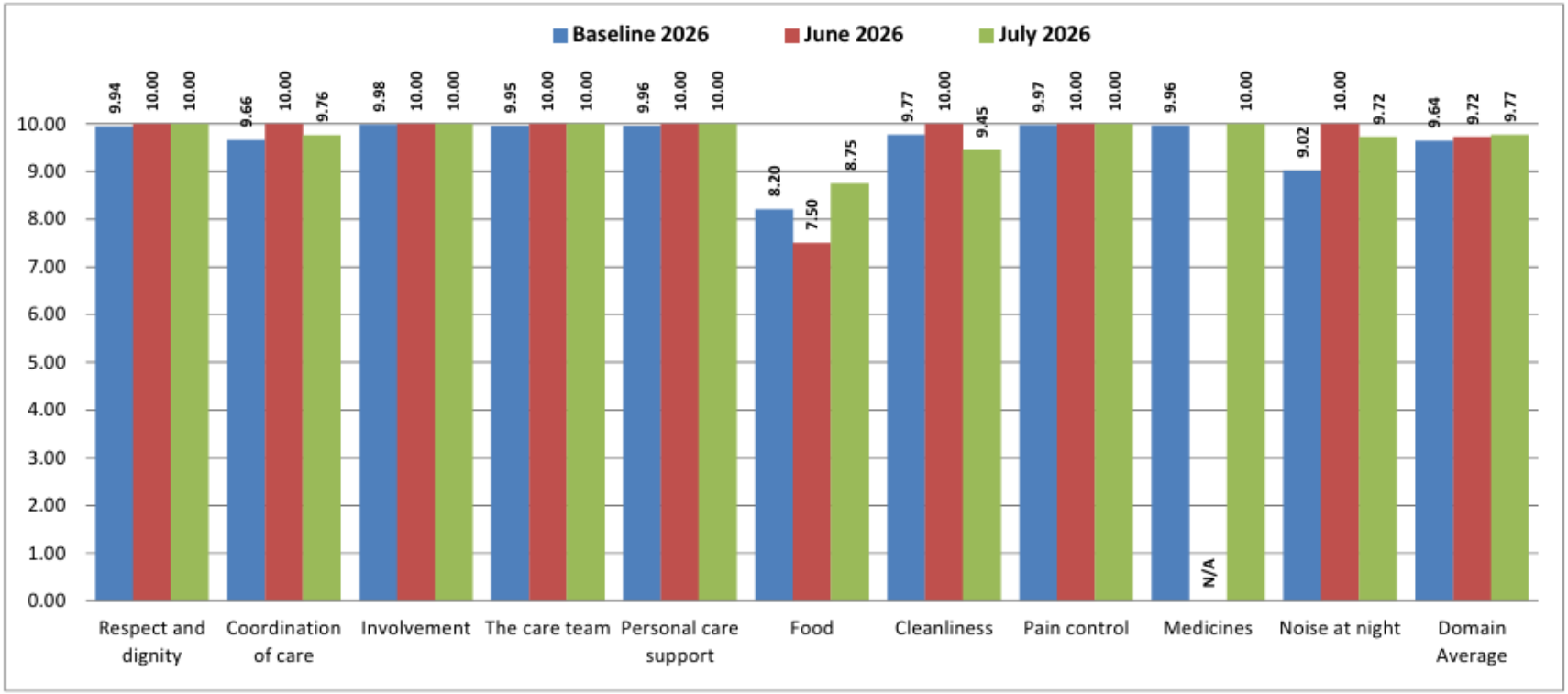




Newborn and Infant Physical Examination

- A screening tracker has been developed by analysts and deployed to support failsafe processes and reporting.
- 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

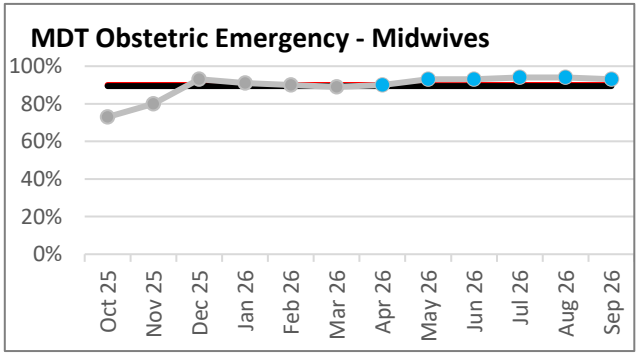
100 % of patients surveyed rated their overall experience on the ward as either good or very good. Feedback included:

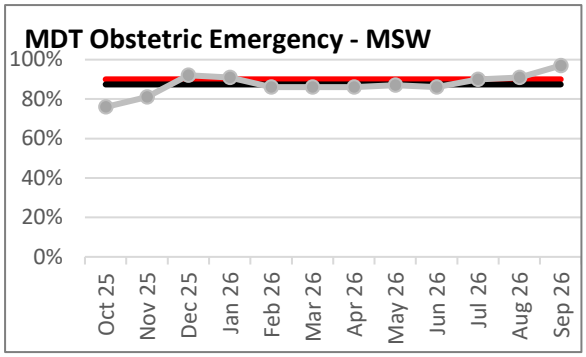
We haven't been here long. The staff welcomed us and showed us where everything is. We have pulled the curtains around to give us a bit more privacy. We haven't had anything planned yet or seen any Doctors, but I am sure everything will be fine. The ward seems clean and tidy. There isn't much space so I think it could get cluttered easy.

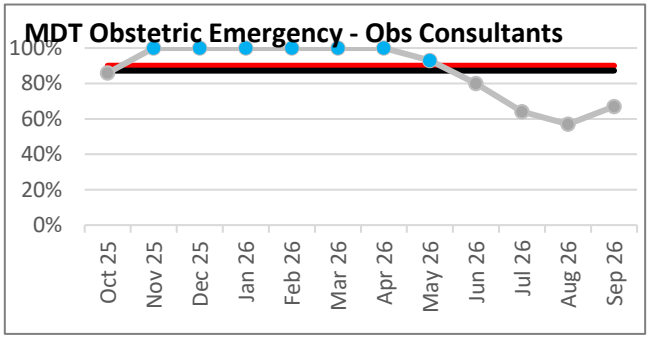
I have been here for one night. The staff have been very nice, and I have been treated well. I have had no complaints.

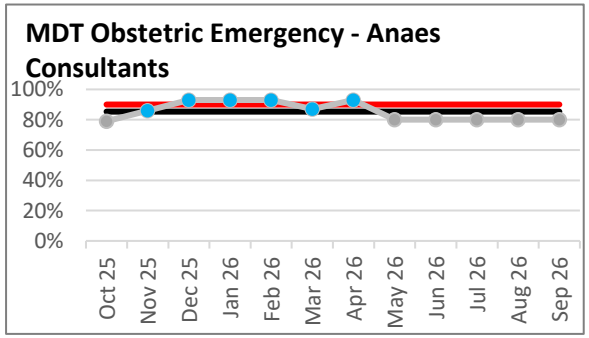
Unfortunately Delivery Suite has been suspended from the real time patient experience programme from July 2026 following a prioritisation exercise by the patient experience team.

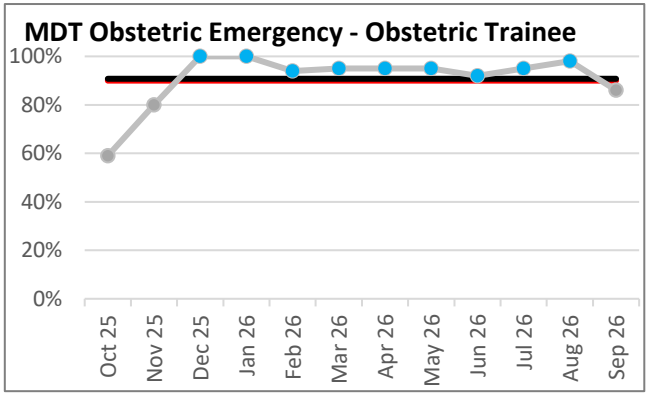
Perinatal Quality Oversight: Training (Maternity Incentive Scheme)

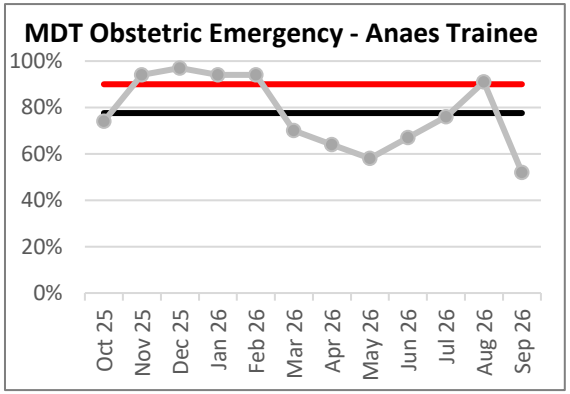












MIS Year 8 guidance has now been published, the Trust have scoped and planning has been completed against the updated requirements for safety action B (Training) which requires a minimum of 90% compliance (working toward expected trajectory of 100% compliance) for every required staff group at two points during the MIS year (**12th October 2026 (locally agreed and 30th November 2026**) for:

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

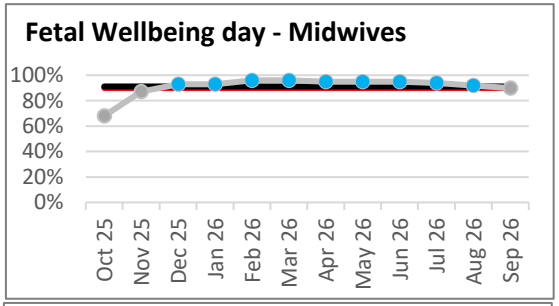
Due to the requirement to report above 90% compliance at 2 points in MIS year 8, charts have been changed to show a rolling monthly compliance to ensure detailed oversight of the % of compliance every month. The first checkpoint was agreed locally by the Training Group in July 2026 to be 12th October 2026.

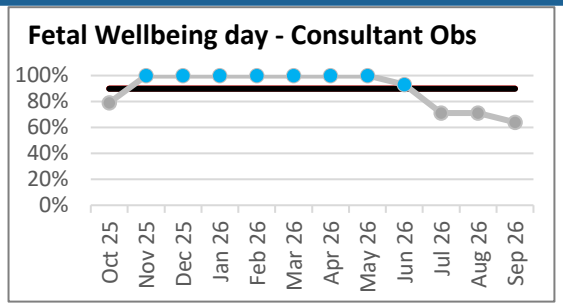
Obstetric Emergency Training by Staff Group:
Compliance above 90% and continuous on track for Midwives and Maternity Support Worker (MSW).

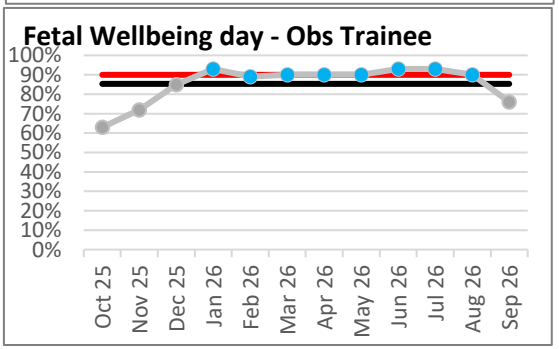
Action plan in place to ensure recovery to 90% compliance for Consultant Obstetricians and Anaesthetics and Anaesthetic Trainees in line with MIS requirements.

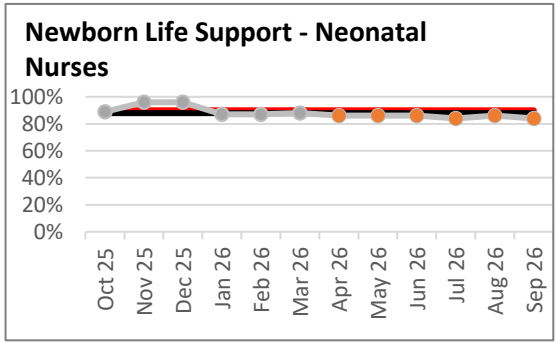
Drop in August 2026 representative of new rotation medical staff who have not attended Obs emergency training previously. Will require training within 3 months of posting.

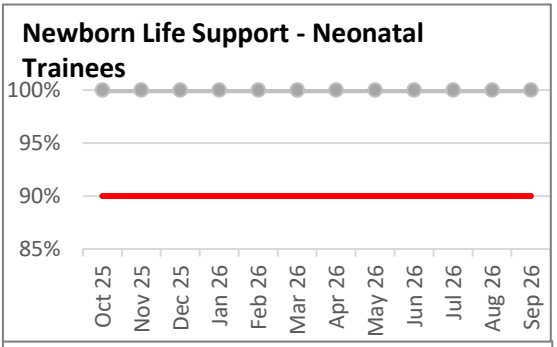
Perinatal Quality Oversight: Training (Maternity Incentive Scheme)

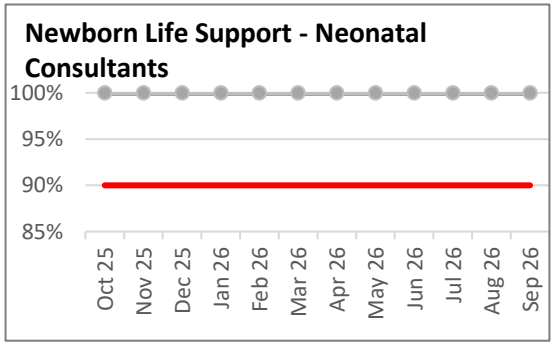


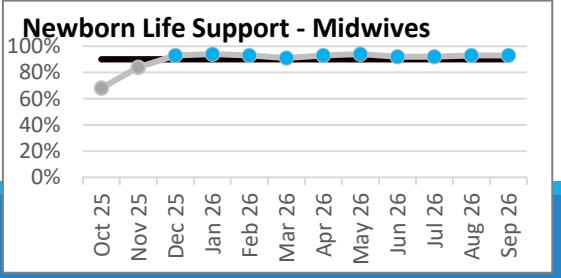


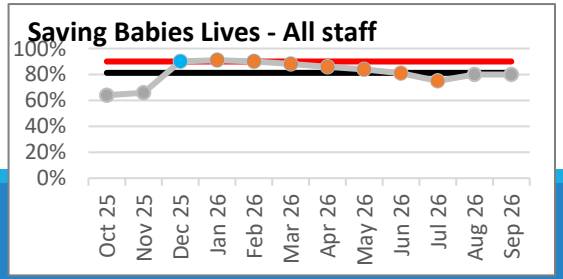










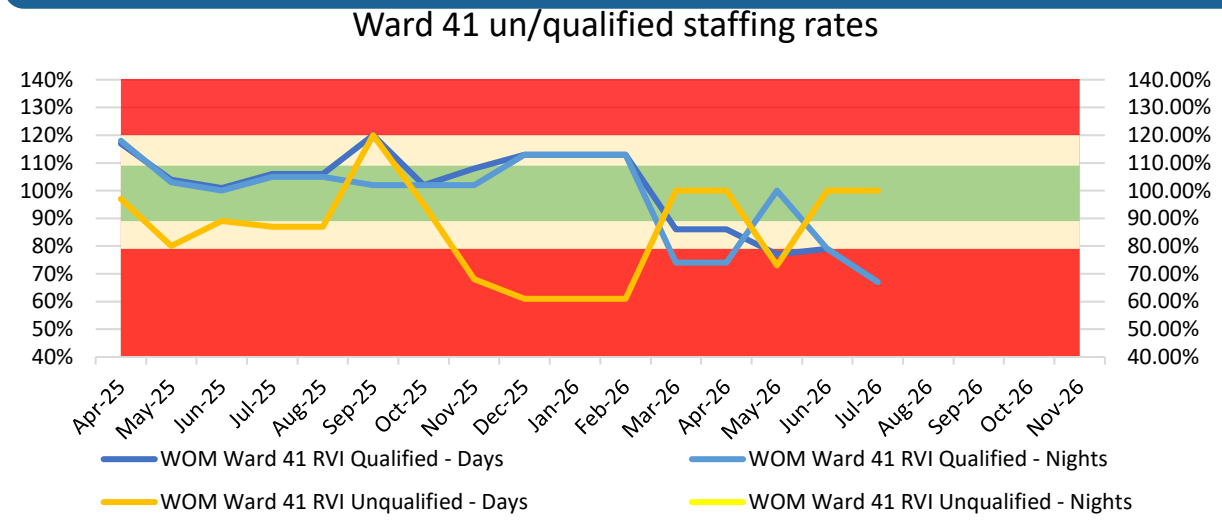


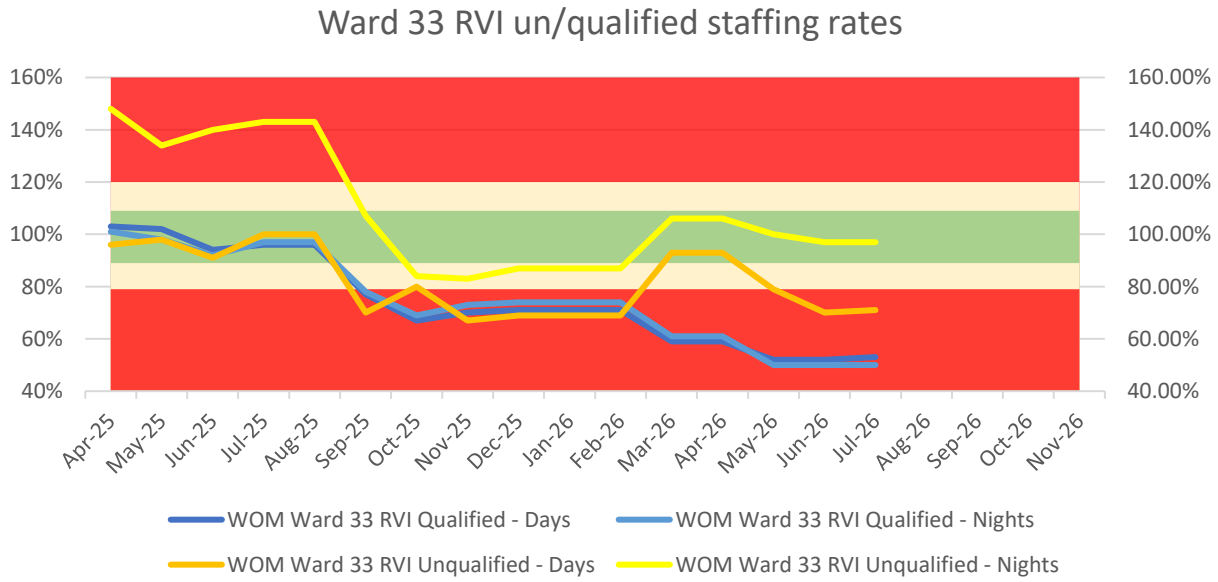
Fetal Wellbeing Training by Staff Group:
The Fetal Wellbeing training is essential training to ensure compliance with the implementation of the Saving Babies Lives Care Bundle version 3 (SBLCBv3) which aligns to the CNST/MIS.
Rolling monthly compliance for Midwives and Obstetric Trainees above 90%.
Action 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





Antenatal Ward (41)

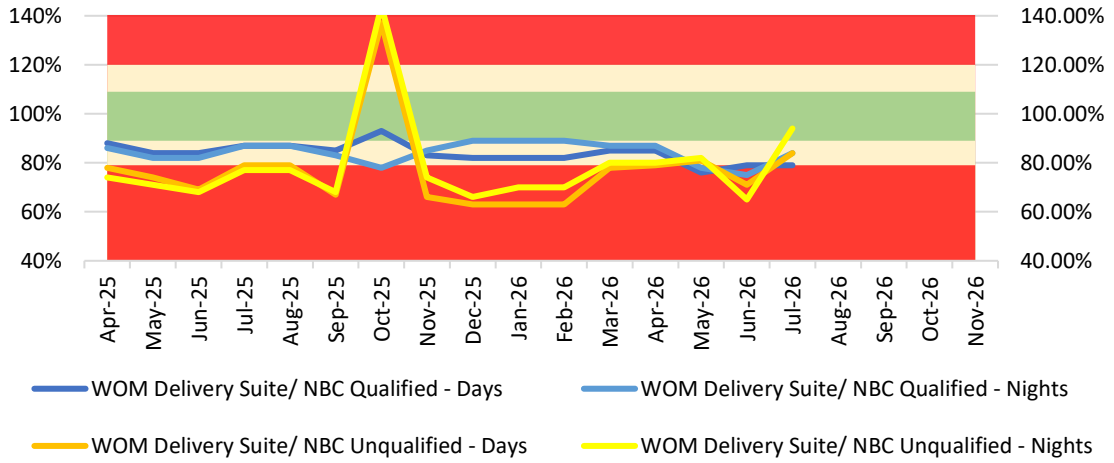
The qualified night and day fill rates have been stable, up to December. Birthrate Plus staffing templates for 3 qualified staff on nights are expected to go live late 2026. The ward opened escalation beds in an additional bay on 3 occasions in July with midwifery fill rates exceeding the staffing establishment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

Postnatal Ward (33)

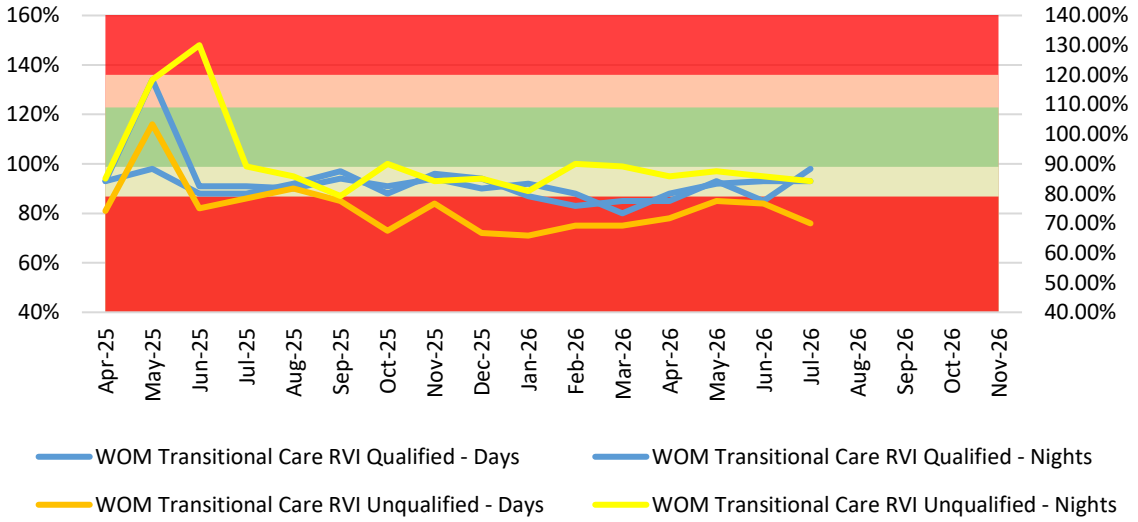
In October 2025 the updated Allocate template has been introduced and the fill rate is measured against Birthrate Plus. The service will not achieve Birthrate Plus staffing compliance until October 2026. In addition, due to the first phase of estates work within the perinatal department, postnatal patients have been decanted to the Newcastle Birthing Centre with care provided by a postnatal midwife, this midwife has been redeployed from the postnatal ward staffing establishment appropriately. 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



Transitional Care RVI un/qualified staffing rates



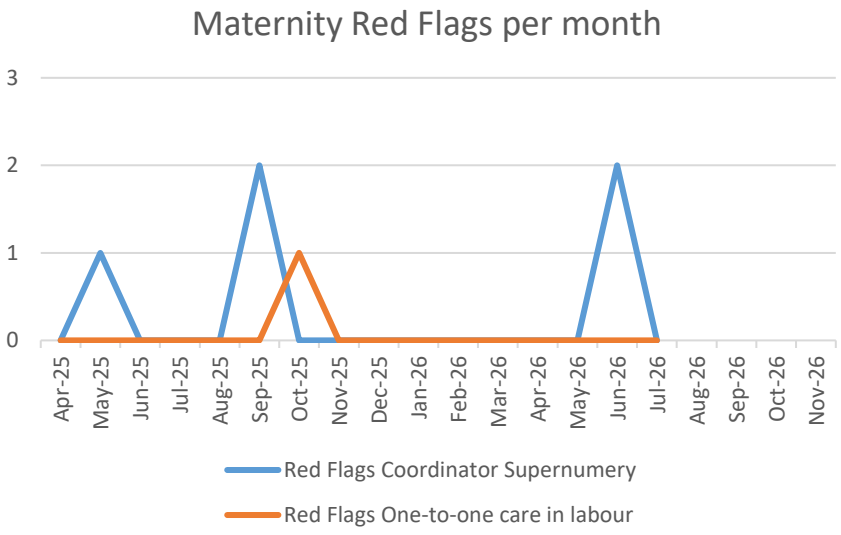
Intrapartum (Delivery Suite and Newcastle Birthing Centre)

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 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: Operational Pressures Escalation Levels (OPEL)



NICE Red Flags

There were no occasions in July when the co-ordinator was not supernumerary, secondary to operational pressures.

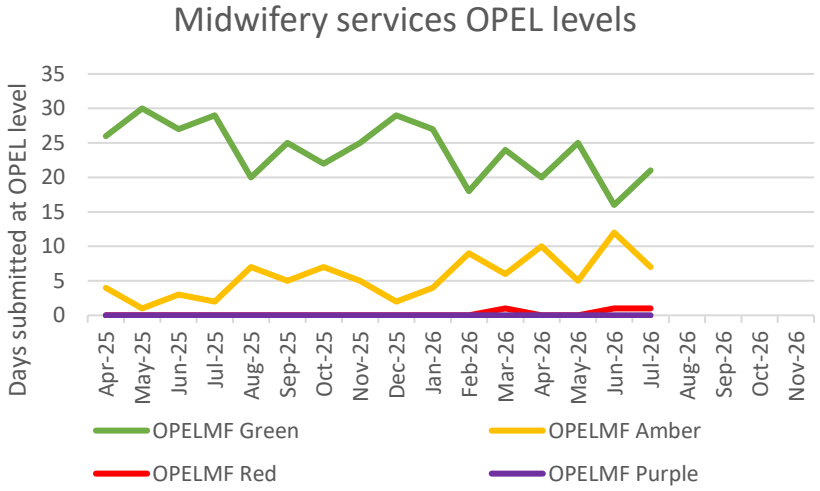
There were no occasions in July when one to one care in labour was not provided.

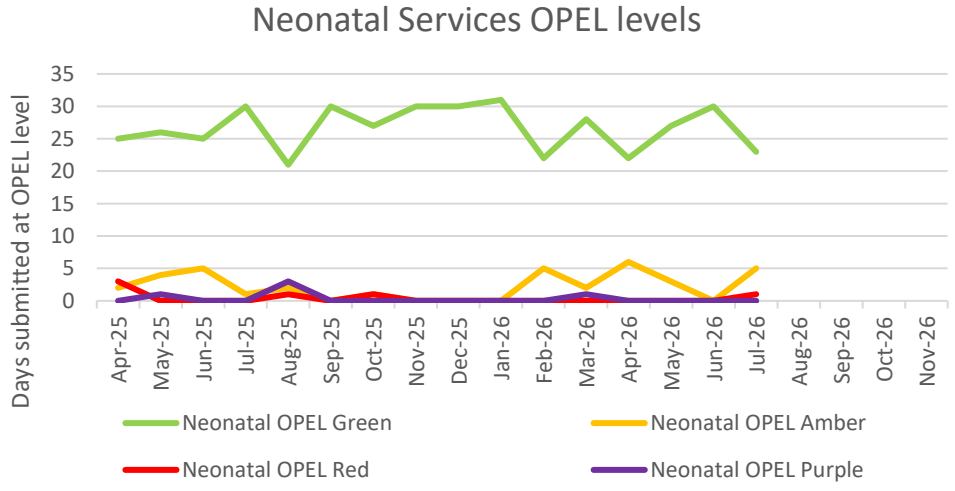
Operational Pressures Escalation Levels Maternity and Neonatal Framework

The neonatal service maintained Operational Pressures Escalation Level (OPEL) 1 for 23 days in July. There was 1 staffing InPhase report.

The maternity service maintained Operational Pressures Escalation Level (OPEL) 1 for 21 days in July and OPEL 2 for 7 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 July 2026.





Performance

Performance Overview

Metric	Period	Actual	Traj.	Target (by Mar-27)	Variation	Assurance
A&E Arrival to Admission / Discharge	Jul-26	77.4%	82.8%	82%		F
RTT 18 Weeks	Jul-26	73.9%	76.6%	81.1%	H	F
>52 Week Waiters	Jul-26	743	411	0	L	F
Cancer 28 Day FDS	Jul-26	85.3%	75.9%	80%	H	?
Cancer 31 Day	Jul-26	74.7%	89.4%	94%	L	F
Cancer 62 Day	Jul-26	66.8%	72.2%	80%		F
Diagnostic 6 Weeks	Jul-26	19.8%	13.8%	2.1%		F

Emergency Care

- Emergency Department (ED) Performance (All Types) in July was 77.39%, an increase of 0.64% compared to June (76.75%). ED attendances decreased in July to 23,640, 134 patients less than June.
- ED Arrival to Admission / Discharge > 12 hours (Type 1) in July was 1.20%, this was down compared to 1.53% in June.

Elective Waits

- Referral To Treatment (RTT) 18-week compliance decreased to 73.9% in July (-0.7% from June). An extended submission deadline was again provided by NHS England to support additional validation.
- The waiting list increased to 88,447 in July (+1,536). Training to stop data quality errors at source has been provided across specialties to mitigate against further waiting list increases, but challenges remain following the conclusion of the validation sprint at the end of March 2026.

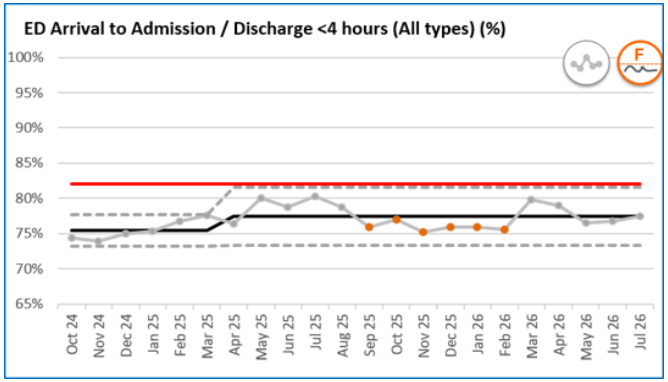
Cancer Care

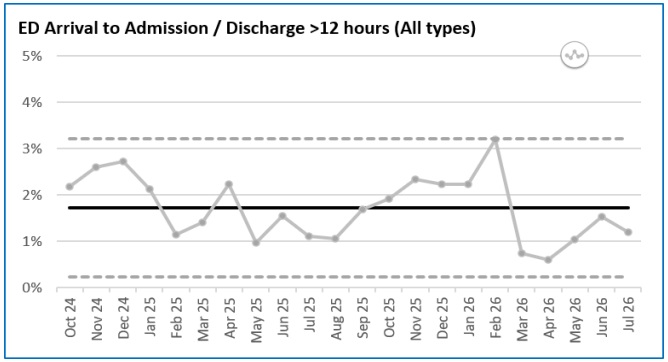
- In July, the 80% 28 Faster Diagnosis Standard (FDS) target was achieved, performance sat at 84.6% and demonstrates special cause variation of an improving nature. 31-day performance decreased to 74.6% in June, whilst 62-day performance rose slightly to 65.6%. It is too soon to tell whether the slight rise against the 62-day performance standard is due to a trend or natural variation.
- 31-day performance remains heavily impacted by radiotherapy workforce pressures. Radiology capacity continues to impact waiting times in the Breast service.

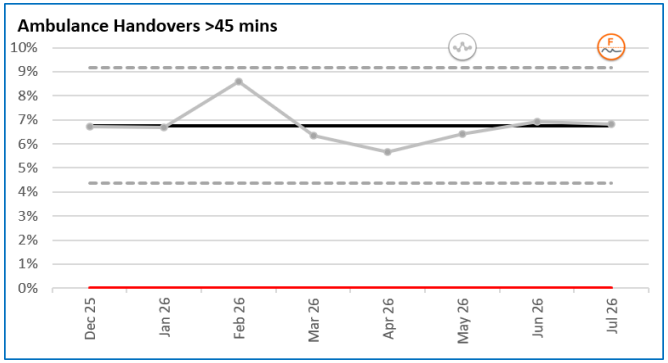
Diagnostics

- Performance against the 5% standard improved slightly in July– 19.8% of patients were waiting over six weeks. Four modalities were compliant in July, compared to one in June. The target continues to be consistently failed but performance remains within common cause variation.

Emergency Care







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.

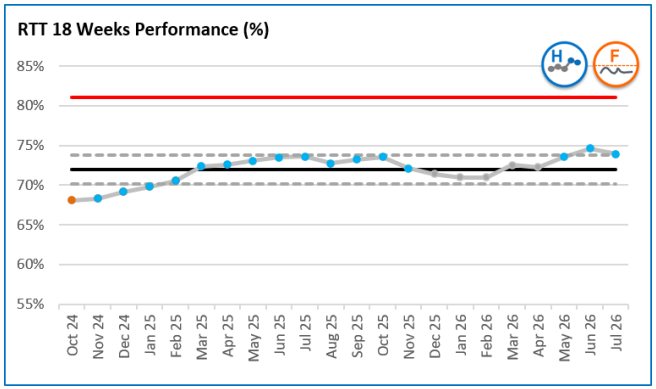
Current position

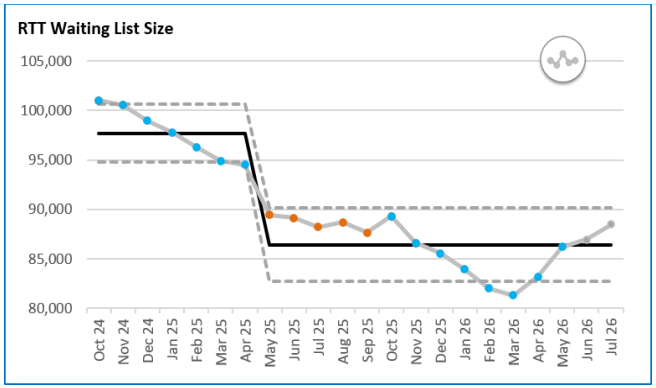
- ED Performance (All Types) in July was 77.39%, an increase of 0.64% compared to June (76.75%). ED attendances decreased in July to 23,640, 134 patients less than June. Type 1 Major attendances increased from 8,991 in June to 9,246 in July, 255 higher, but remained significantly higher than in previous years. Paediatric Type 1 4hr performance for July was 88.8%.
- ED Trolley waits >12 hours decreased from 20 in June to 3 in July.
- ED Arrival to Admission / Discharge > 12 hours (Type 1) in July was 1.20%, this was down compared to 1.53% in June.
- There were 217 handovers > 45 mins in July, this was a decrease of 4 from June (221). Of those handovers, July had 51 handovers >60mins, down from 61 handovers >60mins in June.

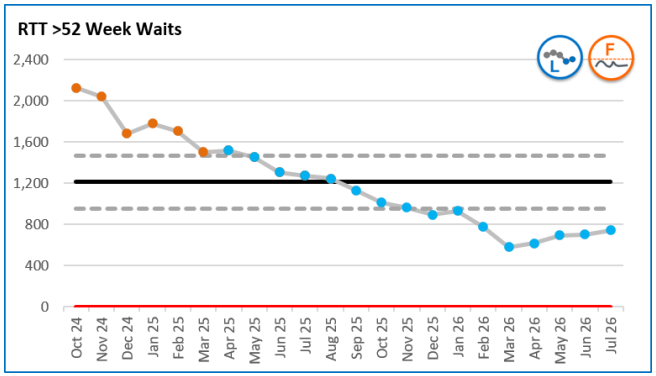
Action taken

- Staffing towards the end of July and August was challenging within the middle-grade medical rota due to gaps in senior doctor cover. The situation is expected to improve from September following planned rota changes.
- The team trialled shifts with a Senior Streamer on the front door, turning patients away where appropriate or streaming them into the Urgent Treatment Centre (UTC). This had positive results reducing the number of Type 1 attendances and having them treated in the UTC. This role will be reinstated in January as overtime shifts due to sickness and further training requirements for staff.
- A missed opportunities audit has been undertaken in collaboration with GIRFT to identify areas for improvement in front door streaming. The final report is expected later this month and will help inform future improvement initiatives.
- Work has started on the UTC – ED Link corridor. Two cubicles have been closed in ED, as well as the triage room and play room in Paediatrics ED. This has limited the amount of space available to treat patients. In addition to this, there is a new rotation of Medics in ED, as well as existing absences in the team which the team are managing at present. Focus has been given to safe temporary re-routing of patients.

Elective 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.

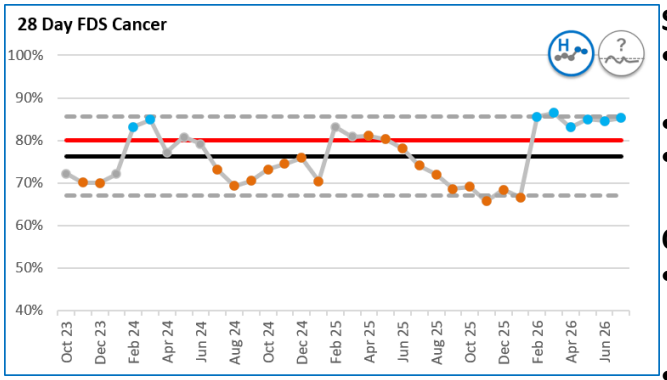
Current position

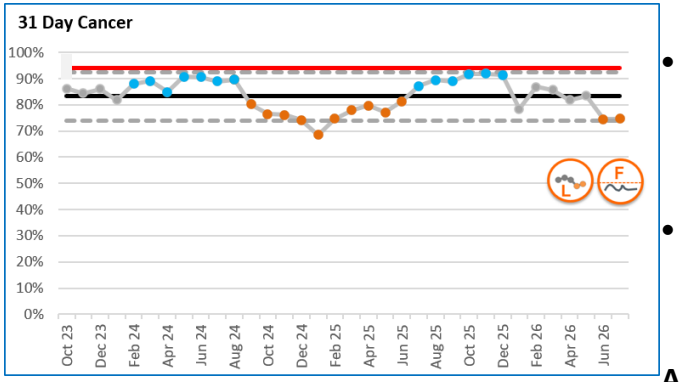
- RTT 18-week compliance decreased to 73.9% in July (-0.7% from June). An extended submission deadline was again provided by NHS England (NHSE) to support additional validation.
- The waiting list increased to 88,447 in July (+1,536). Training to stop errors at source has been provided across specialties to mitigate against further waiting list increases, but challenges remain following the conclusion of the validation sprint at the end of March 2026.
- Outpatient capacity challenges remain with the average wait to first appointment above or close to 18 weeks in key specialties. There has been an increase in Patient Initiated Follow-Up (PIFU) but performance remains below local ambitions and the national 5% ambition.
- July 2026 witnessed an increase in >52-week waiters at Newcastle Hospitals, rising to 743 (+41). Current challenges affecting specialties with long waiters include:
    - Spinal Orthopaedics have ongoing issues with theatre staffing and training, resulting in the service losing an entire theatre per week. Patients on the waiting list who are not fit to proceed have increased waiting times and worsened patient experience.
    - Cardiology have long waiters for Left Atrial Appendage Occlusion (LAAO) – Compounded by a skills match issue where only one consultant can provide this procedure. The Trust is reaching out to other providers to discuss the possibility of mutual aid.
    - Spinal Neurosciences waiting times that vary considerably by consultant, particularly for the most complex cases that can only be performed by one or two consultants.

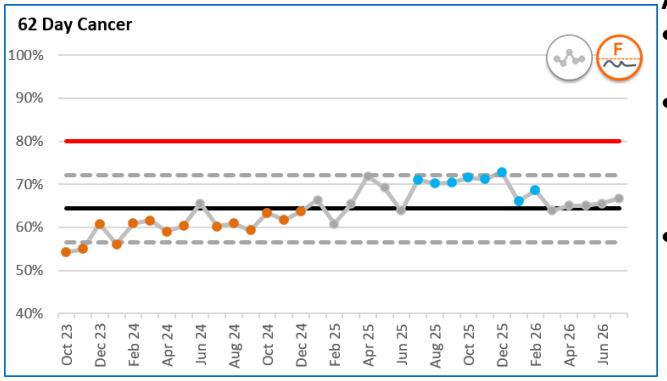
Action taken

- The Trust is driving action planning to improve RTT performance, with a regular specialty updates schedule established through the Trust's Fortnightly RTT meeting.
- Spinal Orthopaedics have implemented pathway changes by moving cutting cases to the Day Treatment Centre. There is an anticipation that in the long-term this will reduce long waits in the service as patients are more likely to be on a day case pathway.
- 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







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).

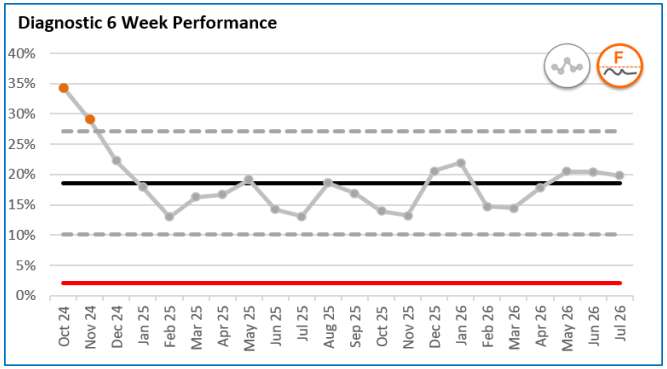
Current position

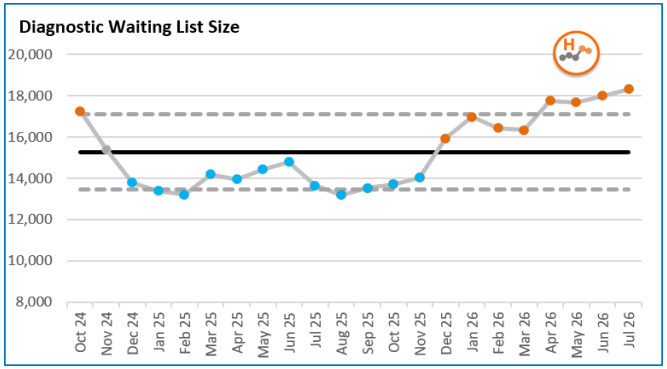
- In July, the 80% 28 FDS target was achieved, performance sat at 85.3% and demonstrates special cause variation of an improving nature. 31-day performance remains below both target and trajectory at 74.7% in July, whilst 62-day performance improved slightly to 66.8%.
- Strong performance against the 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.
- Cancer 31-day performance remains heavily impacted by radiotherapy workforce pressures and is now showing special cause variation of a concerning nature. Referrals are being screened by a senior radiographer to clarify priority against a set of criteria agreed by Clinical Oncologists and ratified by colleagues within the Operational Delivery Networks (ODN) Radiology service. Agency and overtime is being offered to support waiting times.
- The Trust 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

- Targeted approach to reduce the backlog of patients waiting >62 days for treatment continues, focusing on key actions within key contributing groups – Lung, Upper GI, Urology and Lower GI.
- Breast – Short-term plan developed to increase one-stop clinic capacity at the front of the pathway within breast radiology. Thoracic surgeons are pooling referrals from Multi-disciplinary Teams (MDT) and there are ongoing discussions between surgeons and managers about how pooling could be done differently, with interest from a number of the surgeons.
- 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





6 Week Diagnostic Performance by Modality – July 2026			
MRI	23.2%	CT	4.9%
Non-obs US	2.3%	DEXA	4.1%
Audiology	8.7%	ECHO	54.2%
Electrophysiology	7.1%	Neurophysiology	4%
Sleep Studies	31.7%	Urodynamics	24%
Colonoscopy	34.5%	Flexi-Sig	40.8%
Cystoscopy	23.3%	Gastroscopy	32.6%
Newcastle Hospitals Total			**19.8%**

Standards

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

Current position:

- Performance against the 5% standard improved slightly in July– 19.8% of patients were waiting over six weeks. Four modalities were compliant in July, compared to one in June. The target continues to be consistently failed but performance remains within common cause variation.
- Strong performance improvements in Audiology continued in July, with compliance down to 8.7%. 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 fit appointments of particular concern.
- MRI performance increased to 23.2% in July (+3%). Portering remains one of the biggest challenges in the modality, as well as long waits for general anaesthetic MRI tests.
- Performance in Echo deteriorated to 54.2% over 6 weeks in July. Inconsistent and unpredictable slot usage, combined with staffing challenges (vacancy, absence) is reducing throughput.

Action taken

- An MRI Improvement Plan has been set up to tackle performance challenges in the modality. The plan focuses on scanner productivity gains, Deep Resolve Software, trailing dual table tests to increase throughput and making booking and scheduling improvements. It is estimated that these changes could provide an 8% productivity gain to support performance recovery.
- Bioplane (E-Imaging) equipment has been implemented to tackle nerve root injection backlogs. Additional sessions are also being added on a weekly basis to increase throughput.
- 24 new Echo machines were delivered in March following a successful funding bid with 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.
- 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	Apr-26	May-26	Jun-26	Jul-26	Num.	Den.	26/27 YTD
Activity									
Day Case	**100%** of 26/27 Plan	N/A	101.7%	102.8%	96.6%	**97.1%**	11,976	12,335	**99.3%**
Elective Overnight			93.2%	98.7%	92.0%	**94.3%**	1,847	1,959	**94.4%**
Outpatient New			96.1%	94.0%	92.2%	**91.1%**	25,983	28,508	**93.2%**
Outpatient Procedures			99.0%	97.5%	92.2%	**96.1%**	24,425	25,406	**96.1%**
Outpatient Review	N/A		104.1%	100.2%	96.6%	**95.0%**	68,083	71,667	**98.8%**
Non-Elective			99.2%	97.1%	99.3%	**99.4%**	986	992	**98.7%**
Emergency			103.2%	103.0%	108.9%	**106.6%**	6,875	6,450	**105.4%**
PIFU Take-up (%)	N/A	**3.7%**	3.4%	3.2%	3.2%	**3.3%**	4,081	125,457	**3.3%**
Urgent Ops. Cancelled Twice	**Zero**	N/A	0	0	0	**0**	0		**0**
Cancelled Ops. Rescheduled >28 Days	**Zero**	N/A	7	7	12	**7**	7		**33**
Elective Waits									
RTT Waiting List Size	**Reduction** from 25/26	**83,487**	83,207	86,198	86,941	**88,477**	88,477		
RTT <18 Week Wait	Constitutional: **92%** Interim: **81.1%** by Mar-27 (local target)	**75.5%**	72.3%	73.5%	74.6%	**73.9%**	65,419	88,477	**73.6%**
>52 Week Waiters	N/A	**436**	616	693	702	**743**	743		
Time to First Outpatient Appointment (18 Weeks)	N/A	**80.0%**	77.1%	79.6%	79.8%	**79.0%**	43,183	54,657	**78.9%**
Diagnostic Waiting List Size	N/A	**13,985**	17,766	17,682	18,006	**18,319**	18,319		**71,773**
Diagnostic >6 week wait	Constitutional: **1%** Interim: **2.1%** by Mar-27 (local target)	**14.2%**	17.8%	20.5%	20.4%	**19.8%**	3,630	18,319	**19.6%**
Community Services Waiting List	N/A	N/A	11,369	11,412	11,493	**11,494**	11,494		
Community Services >18 Week Wait	**78%** by Mar-27 (ICB target)		78.0%	79.6%	80.1%	**77.7%**	2,066	11,494	
Community Services >52 Week Waiters	N/A		729	657	612	**612**	612		

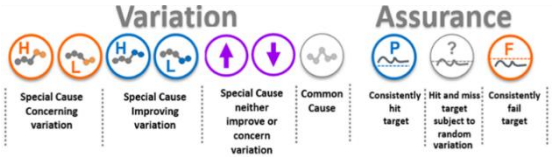
Contractual & Planning Standards (2/2)

Theme	Standard	Trajectory	Apr-26	May-26	Jun-26	Jul-26	Num.	Den.	26/27 YTD
Cancer Care									
28 Day Faster Diagnosis	**80%** Annual Average (by Mar-27)	**79.3%**	83.1%	85.0%	84.6%	**85.3%**	2,418	2,835	**84.5%**
31 Days (DTT to Treatment)	**94%**	**89.7%**	81.8%	83.4%	74.5%	**74.7%**	1,087	1,456	**78.4%**
62 Days (Referral to Treatment)	**80%** (by Mar-27)	**70.0%**	65.0%	65.1%	65.6%	**66.8%**	331	495	**65.6%**
>62 Day Cancer Waiters	**N/A**	**N/A**	260	280	260	**287**	287		
Urgent & Emergency Care									
A&E Arrival to Admission/Discharge (All types)	**82%** under 4 hours (by Mar-27)	**82.2%**	79.0%	76.5%	76.7%	**77.4%**	18,296	23,640	**77.4%**
A&E Arrival to Admission/Discharge <12 hours	**Increase** from 25/26 Average	**98.6%**	99.4%	99.0%	98.5%	**98.8%**	283	23,640	**98.9%**
Adult General & Acute Bed Occupancy	**N/A**	**91.4%**	86.2%	87.9%	88.5%	**0.0%**	0	1,440	**65.7%**
Ambulance Handovers >15 mins	**N/A**	**32.2%**	52.0%	53.3%	52.0%	**55.5%**	1,770	3,187	**53.2%**
Ambulance Handovers >45 mins	**Zero** (by Mar-27)	**6.5%**	5.6%	6.4%	6.9%	**6.8%**	217	3,187	**93.6%**
Urgent Community Response Standard	**>=70%** under 2 hours	**N/A**	89.1%	89.4%	84.4%	**86.2%**	268	311	**87.3%**
Safe, High Quality Care									
Mixed Sex Acommodation Breach	**Zero**	**N/A**	95	126	125	**108**	108		**454**
VTE Risk Assessment	**95%**		96.1%	96.1%	96.1%	**TBC**			
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour		**72.0%**			TBC			
Sepsis Screening Treat. (All)			**68.0%**			TBC			

People

People overview

Metric	12-month rolling	Actual	Target	Variation	Assurance
Sickness	Jul-26	5.95%	4.9%		F
Short-term (Month only)	Jul-26	1.76%			
Long-term (Month Only)	Jul-26	4.04%			
Turnover	Jul-26	9.22%	10%		P
Mandatory training	Jul-26	90.93%	90%	L	P
Appraisal	Jul-26	85.54%	90%	H	F
Disabled staff	Jul-26	6.97%		H	
Ethnicity (BAME staff)	Jul-26	19.40%		H	



(Data is for period **1 August 2025 to 31 July 2026** unless otherwise stated)

Staff in post

- Total is 15,903.05 Full Time Equivalent (FTE) including Bank/agency
- Total substantive is 15,445.14 FTE, 17,657 headcount
- Above substantive pre-Covid by 2,006.59 FTE (+14.93%)
- Above total workforce plan of 15,593.38 FTE by 309.68 FTE (+1.99%)

Sickness – target 4.5%, performance 5.95% (+ 0.03%)

- Top reasons for sickness: anxiety/stress/depression 34.05% (+2.07%); gastrointestinal problems 10.18% (-0.27%); other musculoskeletal problems 9.36% (-0.86%)
- Short-term sickness change in June 1.76% (-0.08%)
- Long term sickness change in June 4.04% (+0.24%)
- Average working days lost is **1,048** (headcount) per day for the reporting period. Short Term average days lost per day is **734**; long term average days lost per day is **375**.
- Trust wide initiative to look at 'why does absence matter' which is tasked with reducing sickness by 0.5% - lead by Director of Operations for Medicine

Retention & Turnover – target 10%, performance 9.22% (+0.11%)

- Increase of 0.11%
- Top reason for leaving; voluntary resignation – work life balance 14.72%
- Top destinations: no employment 48.18%; other NHS organisation 26.78% (includes retire-return)

Mandatory training – target 90%, performance 90.93% (-0.52%)

- Reduction of 0.52%
- Lowest is Medical and Dental 78.67% (-0.20%)
- Task & Finish Group has been commissioned to look at 'process and provision'.

Appraisal – target 90%, performance 85.54% (+0.19%)

- Overdue decreased to 2,054
- Senior doctors (consultant and SAS) have had set 1.5 SPA (6 hours a week) in their job plans since job planning began which was designed to cover things including Mandatory Training, and appraisal preparation.

Bank & Agency

- Total annual non-medical bank expenditure £19.8m, +£1.8m vs last year
- Total annual non-medical agency expenditure £2.0m, -£1.5m vs last year
- Total annual medical bank (locum) expenditure £12.9m, +£1.8m vs last year
- Total annual medical agency expenditure £2.1m, -£2.3m vs last year

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

Provider workforce return (PWR) – overview as-at July 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	15,205.27	16,368.34	15,445.14	2,006.59	239.87	-923.20
Total Bank & Agency Staff	501.60	388.11		457.91	-43.69	69.81	
Total	**13,940.15**	**15,593.38**	**16,368.34**	**15,903.05**	**1,962.90**	**309.68**	**-923.20**

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	10,701.48	11,302.64	10,709.59	1,386.88	8.11	-593.05
2. Total Non Medical - Non-Clinical Substantive Staff	2,226.73	2,418.44	2,916.27	2,618.14	391.41	199.70	-298.13
3. Total Medical and Dental Substantive Staff	1,732.92	2,071.70	2,139.93	2,104.90	371.98	33.20	-35.03
4. Any other Staff (substantive staff)	156.19	13.65	9.50	12.51	-143.68	-1.14	3.01
5. Bank	441.22	365.41		430.63	-10.59	65.22	
6. Agency	60.38	22.70		27.29	-33.09	4.59	
Total	**13,940.15**	**15,593.38**	**16,368.34**	**15,903.05**	**1,962.90**	**309.68**	**-923.20**

Current Position:

- Workforce is +1,962.90 FTE (+14.08%) above January 2020 (pre-Covid) position.
- Substantive workforce target at 31st July is 15,205.27 FTE.
- Substantive workforce actual position at 31st July is 15,445.14 FTE.
- Substantive workforce is currently 239.87 FTE above for July.
  (see slide 3, top row, middle graph)
- NHS infrastructure support (substantive) is 199.70 FTE above plan.
- Bank is above plan.
- Agency is above plan.
- Agency usage reviewed and challenged weekly / monthly.
- Robust management of agency requests with active bank and redeployment

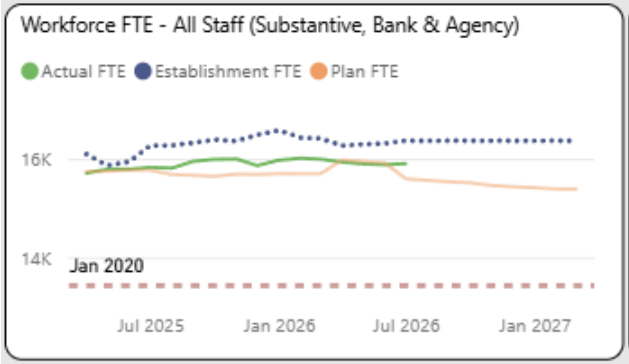
Underlying Issues

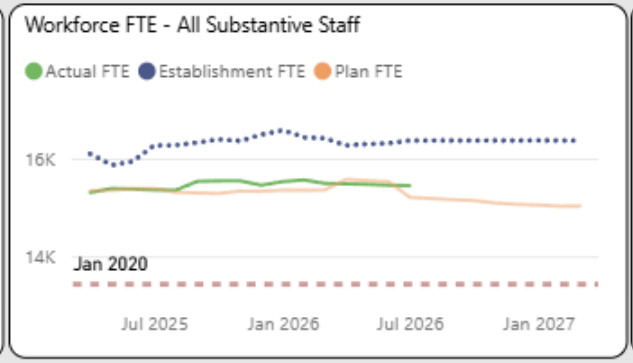
- Bank use due to switching requirements for additional hours from overtime to Bank which is more cost effective.
- Need to maintain safe services (e.g. healthcare assistants for enhanced care). Greater use being made of Bank options to reduce spend on agency.
- Practice of rostering staff may not be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

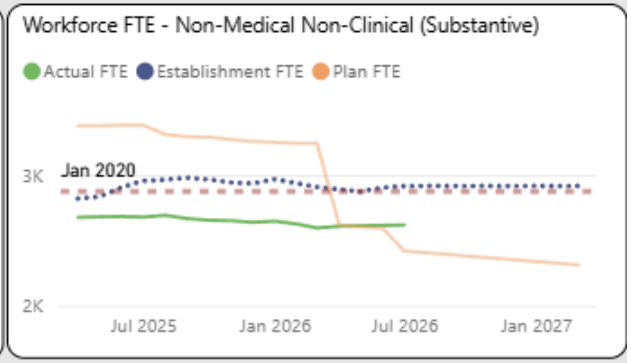
Actions Undertaken:

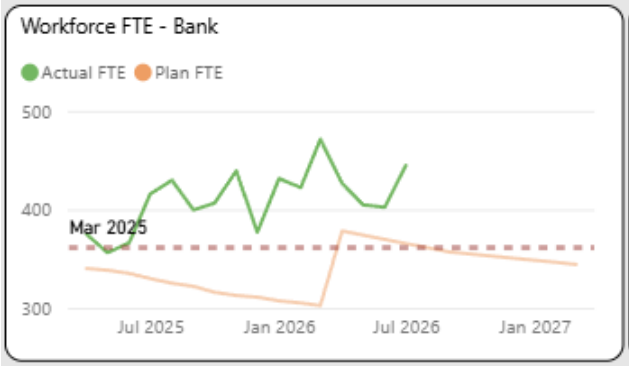
- Workforce Reduction Group (WRG) continues to meet bi-weekly, safeguarding the integrity of workforce controls to ultimately support a reduction in organisational headcount. The group functions as a 'gatekeeper' for specific workforce requests i.e. Mutually Agreed Resignation Scheme (MARS) skill mix 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.

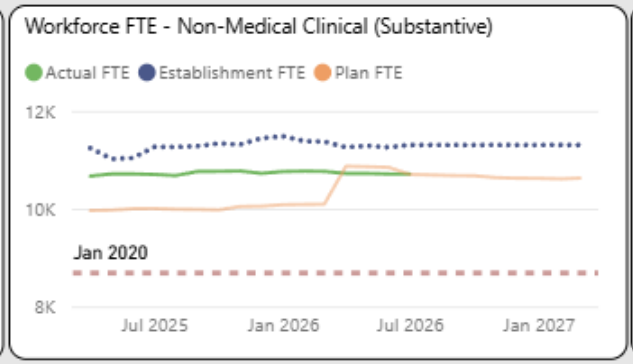
PWR – in-year overview position

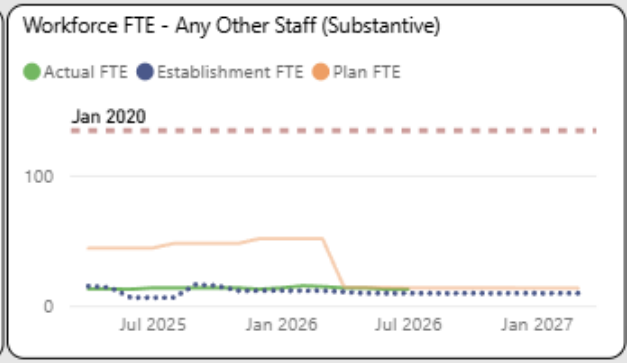


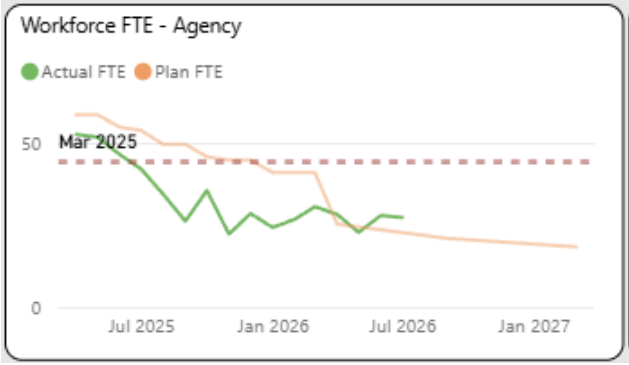


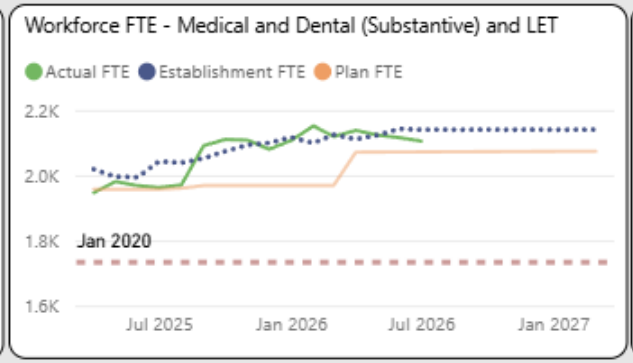


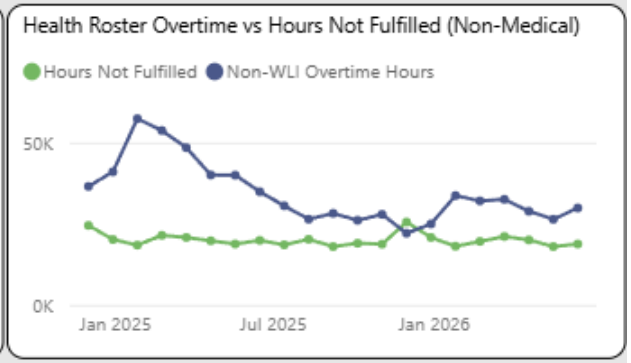










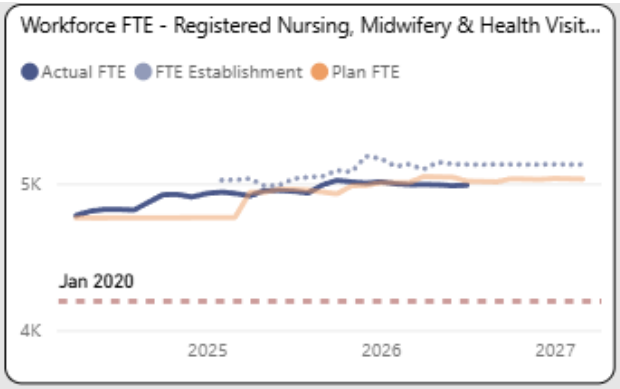


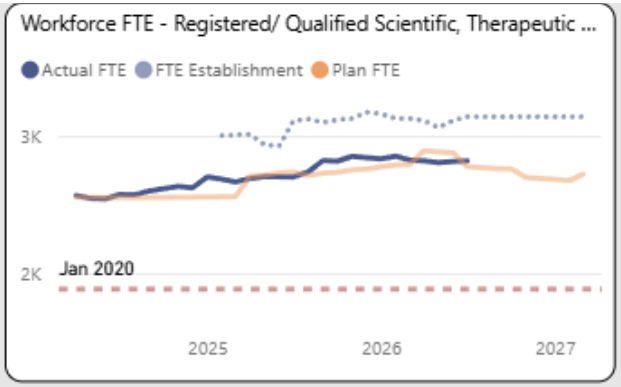
**Please note: The charts on this page include LET data

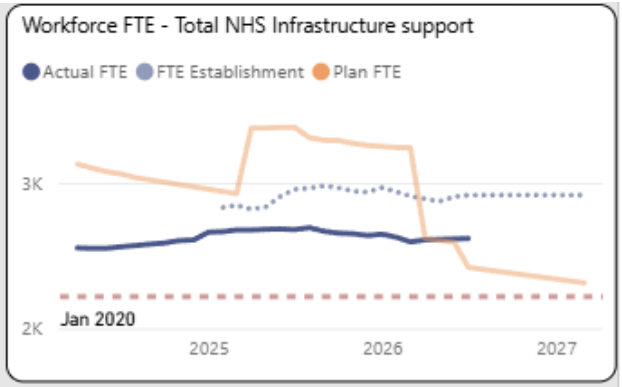
PWR – staff group overview as-at July 2026

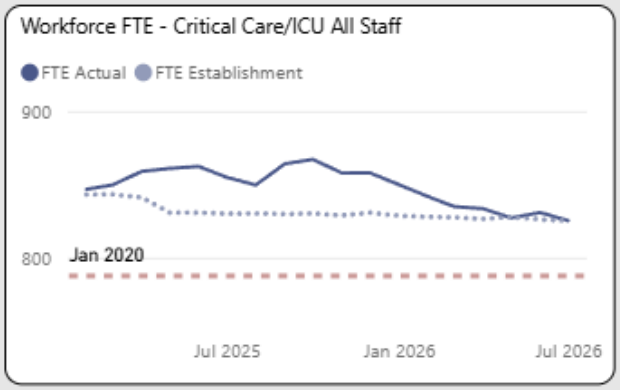
Sub Categories Metric	Jan 2020 FTE	Plan FTE	Establishment	Current FTE	Current FTE v Jan 2020	Current FTE v Plan	Current FTE v Establishment
1. Registered Nursing, Midwifery and Health visiting staff (substantive total)	4,200.28	5,016.08	5,129.93	4,988.95	788.67	-27.13	-140.98
2. Registered/ Qualified Scientific, Therapeutic and Technical Staff (substantive total)	1,994.12	2,388.58	2,569.73	2,409.28	415.17	20.70	-160.45
3. Support to Clinical staff (substantive total)	3,128.32	3,296.82	3,602.98	3,311.36	183.04	14.54	-291.62
4. Total NHS Infrastructure Support (includes A&C, estates, managers) (substantive total)	2,226.73	2,418.44	2,916.27	2,618.14	391.41	199.70	-298.13
5. Total Medical and Dental (substantive total)	1,732.92	2,071.70	2,139.93	2,104.90	371.98	33.20	-35.03
6. Any other Staff (substantive total)	156.19	13.65	9.50	12.51	-143.68	-1.14	3.01
7. Bank Any other staff	0.00	0.00			0.00	0.00	
7. Bank Medical and dental	11.75	27.32		45.57	33.82	18.25	
7. Bank Registered nursing, midwifery and health visiting staff	111.27	105.27		126.53	15.26	21.26	
7. Bank Registered/ Qualified Scientific, Therapeutic and Technical staff	16.41	10.07		10.50	-5.91	0.43	
7. Bank Support to clinical staff	258.10	202.31		233.20	-24.90	30.89	
7. Bank Total NHS infrastructure support	43.69	20.44		14.83	-28.86	-5.61	
8. Agency Any other staff	0.00	0.00			0.00	0.00	
8. Agency Medical and dental	0.87	2.96		4.20	3.33	1.25	
8. Agency Registered nursing, midwifery and health visiting staff	2.86	3.92		3.31	0.45	-0.61	
8. Agency Registered scientific, therapeutic and technical staff	17.27	4.16		2.37	-14.90	-1.79	
8. Agency Support to clinical staff	23.68	11.66		17.40	-6.28	5.74	
8. Agency Total NHS infrastructure support	15.70	0.00			-15.70	0.00	
Total	**13,940.15**	**15,593.38**	**16,368.34**	**15,903.05**	**1,962.90**	**309.68**	**-923.20**

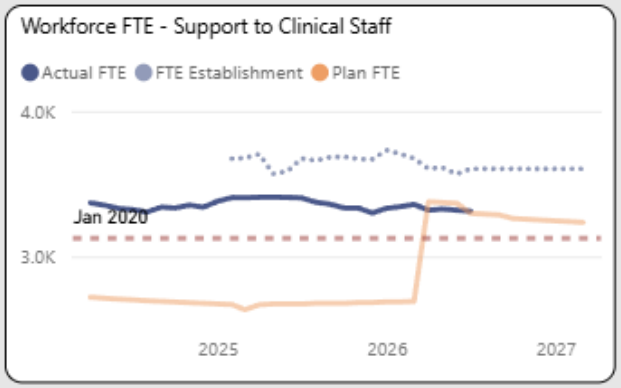
PWR – staff group overview in-year position

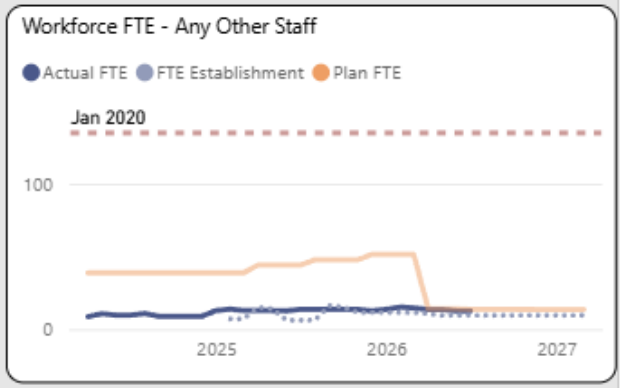


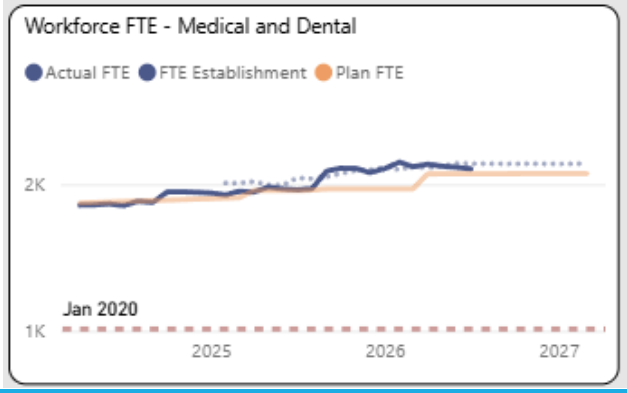










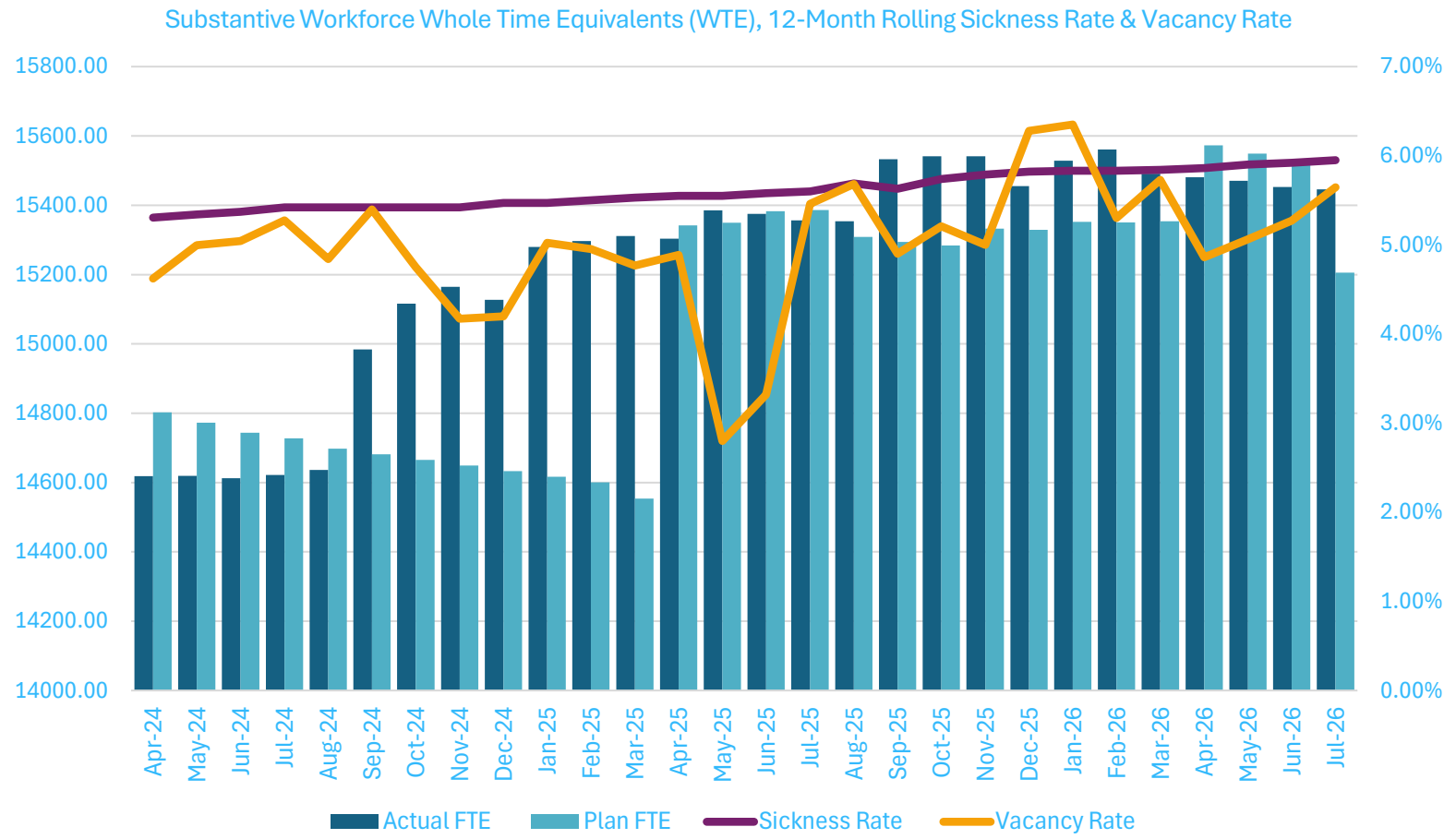


Vacancies

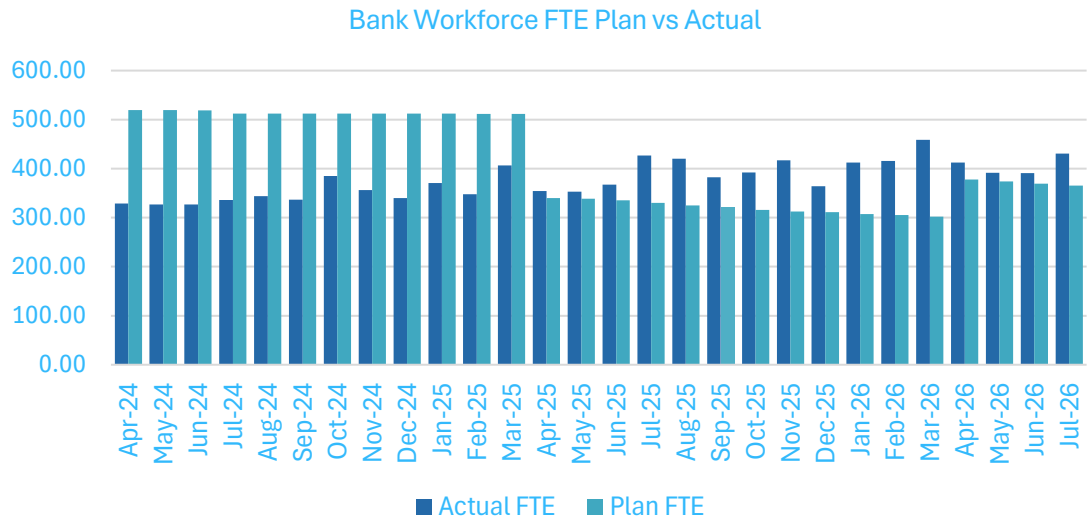
Summary Group	FTE Establishment	Actual FTE	Vacancy FTE	Vacancy FTE %
1. Total Non Medical - Clinical Substantive Staff	11302.64	10710.59	592.05	5.24%
2. Total Non Medical - Non-Clinical Substantive Staff	2916.27	2617.14	299.13	10.26%
3. Medical and Dental	2139.93	2103.90	36.03	1.68%
5. Other	9.50	12.51	-3.01	-31.65%
Total	**16368.34**	**15444.14**	**924.20**	**5.65%**

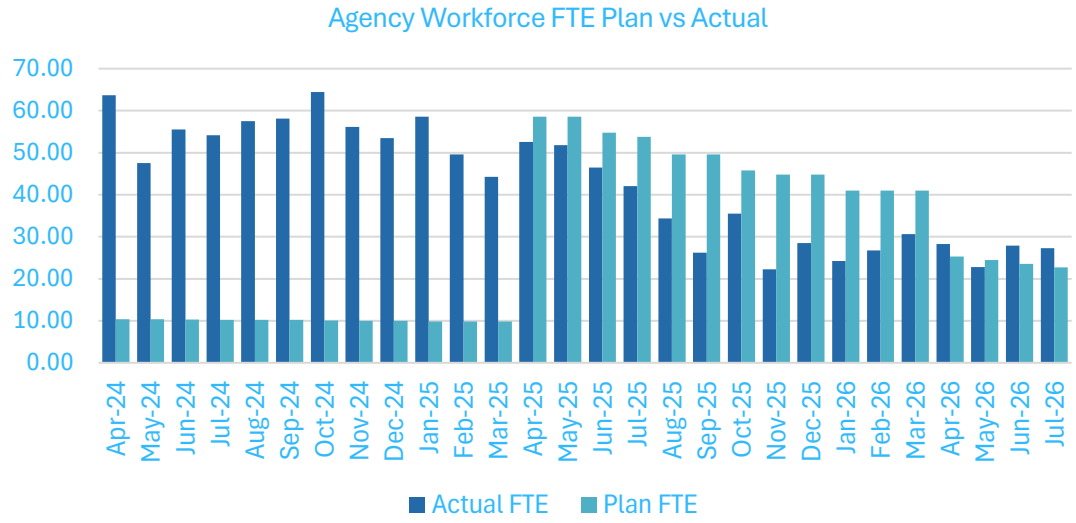
**Please note: The charts on this page include LET data

Substantive Workforce



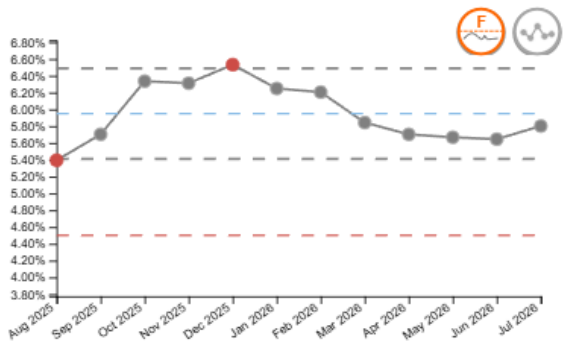
Bank and Agency Workforce



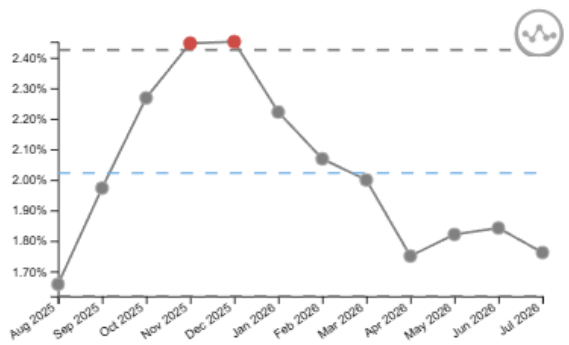


Sickness absence – 12-month average

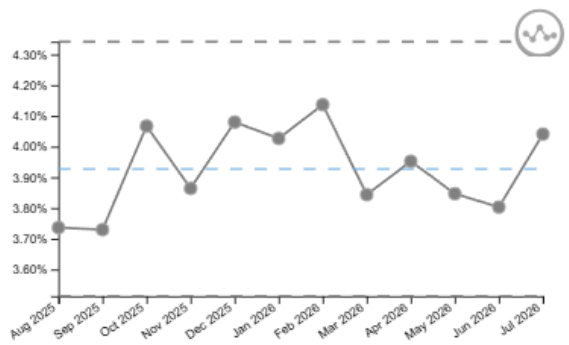
Trust Sickness %	12-Month Rolling	Value	Target
	Jul 26	5.95%	4.90%



Metric	Value
Short Term Sickness %	1.76%



Metric	Value
Long Term Sickness %	4.04%



Current Position:

- Top reasons for sickness:
  - Anxiety/stress/depression (S10) 34.05%
  - Gastrointestinal problems (S25) 10.18%
  - Other musculoskeletal problems (S12) 9.36%
- The 12-month rolling absence rate of 5.95% and the sick pay cost of £36.9m 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: 321,972.78 FTE.
- Average time lost per person: 22 days.
- Total cost of sick pay: £36.9m.
- Variation in sickness rates across Clinical Boards:
  - Lowest – Clinical and Diagnostic Services at 4.44% (short-term 1.62%, long term 2.73%)
  - Highest – Family Health at 6.62% (short-term 1.71%, long term 4.84%)

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.
- 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. 152 colleagues trained as of 31 March 2026. 2 Scaffolding sessions taken place and support resources under development.

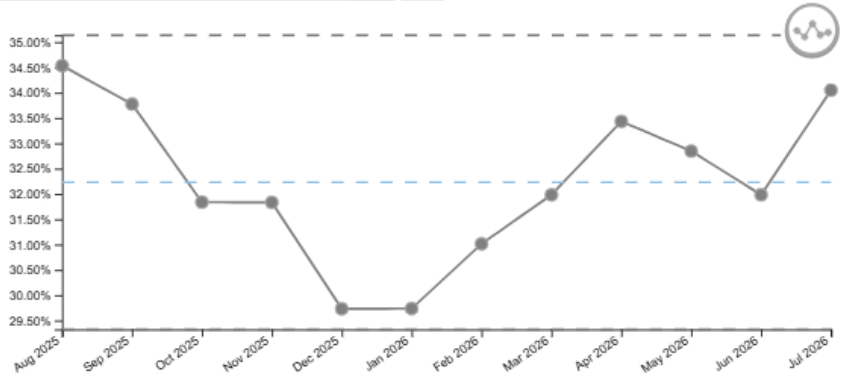
Sickness absence – top absence reasons

Trust Sickness %	12-Month Rolling	Value	Target
	Jul 26	5.95%	4.90%

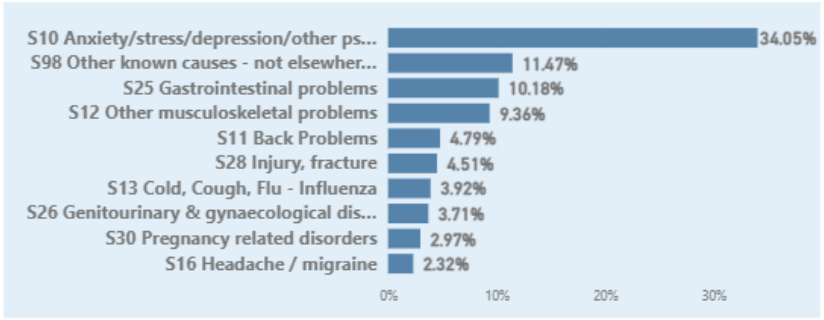
Sickness Reasons - SPC

S10 - Anxiety/stress/depression/ other psychiatric illness

34.05%

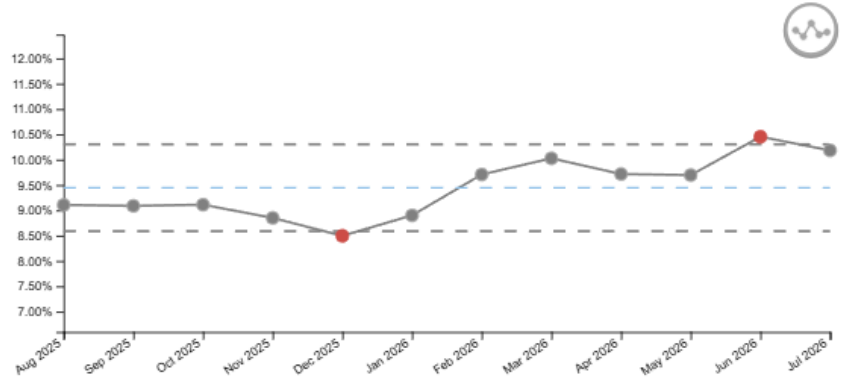


Top 10 Sickness Abscences



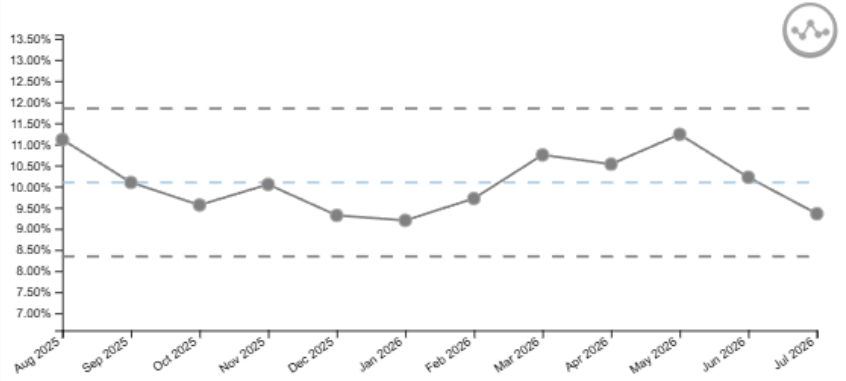
S25 - Gastrointestinal problems

10.18%

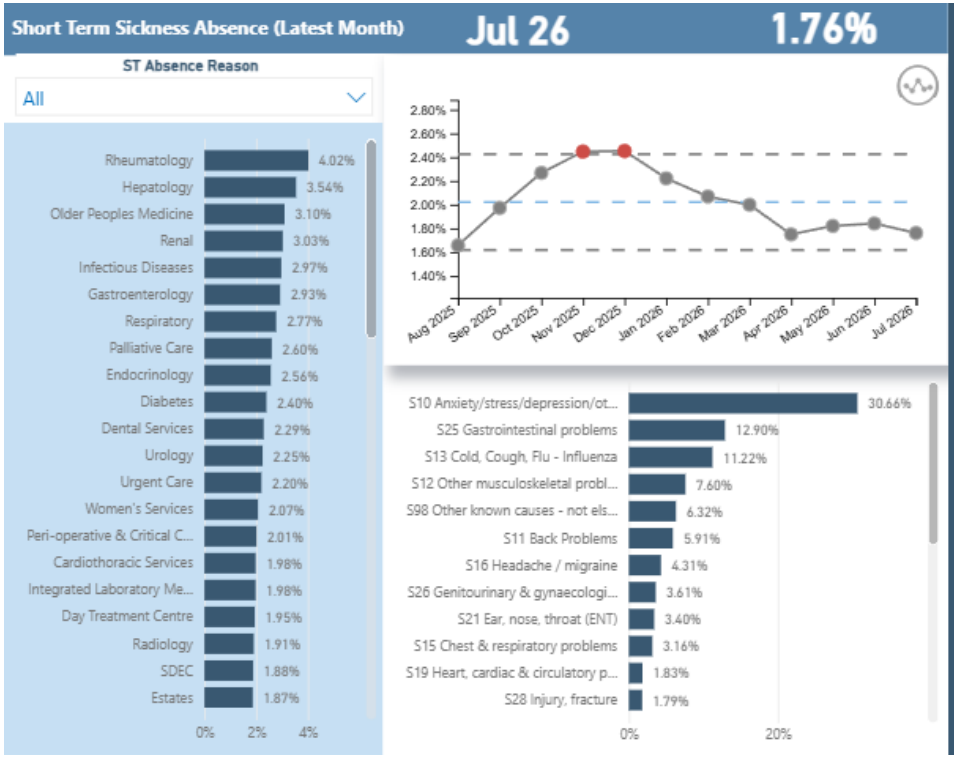


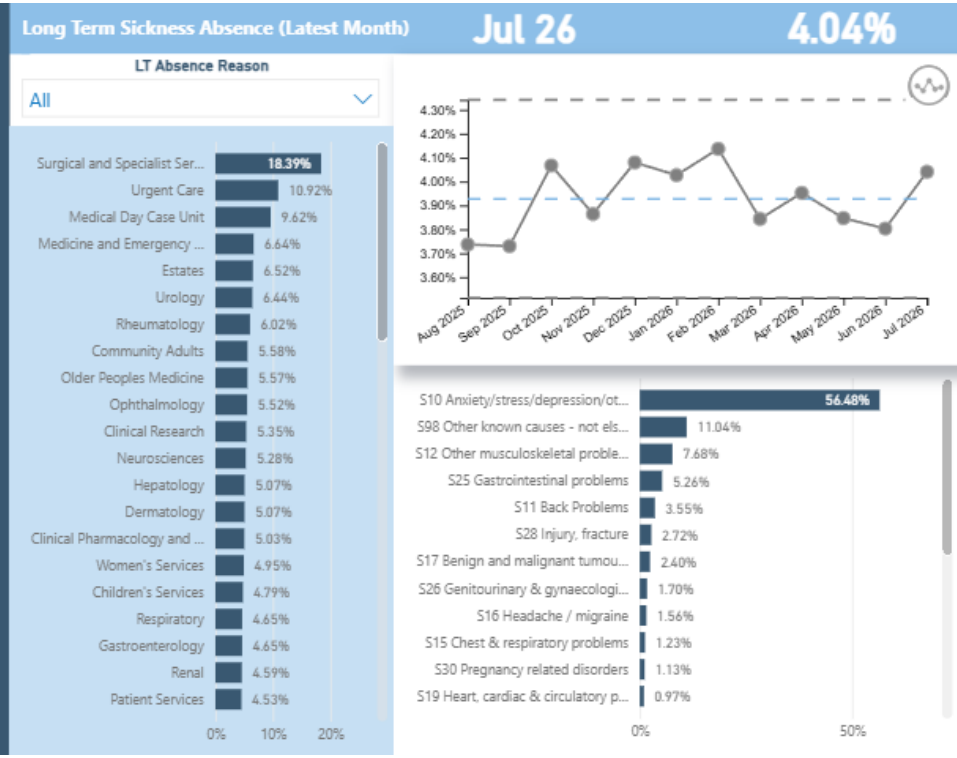
S12 Other musculoskeletal problems

9.36%



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





Sickness – FTE working days lost & formal action activity

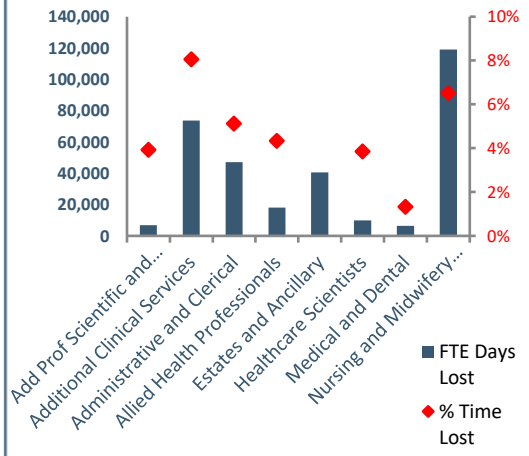
Sickness - FTE working days lost

FTE working days lost due to sickness

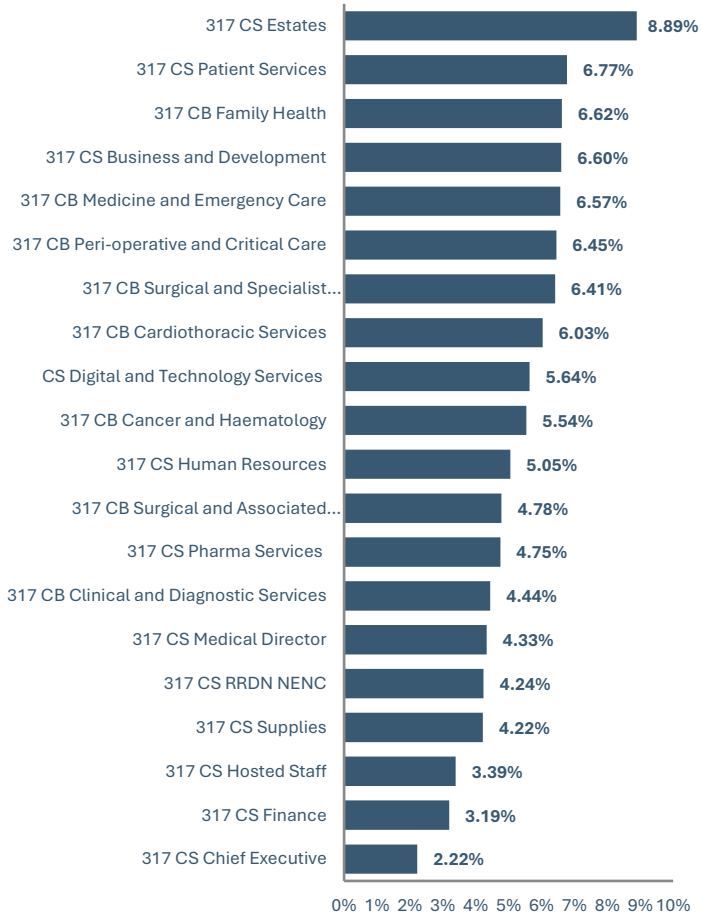
321,713

297,046 compared to the previous year.

Sickness Absence by Staff Group



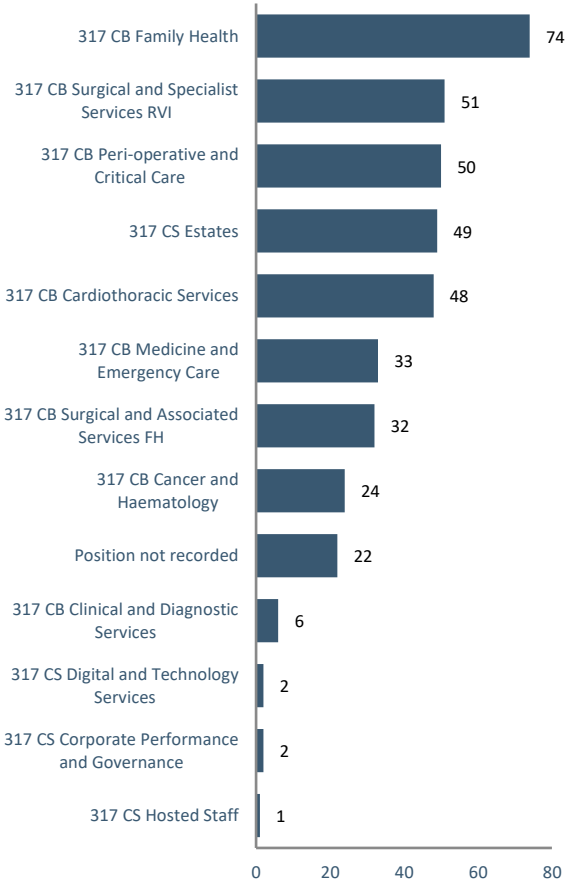
Sickness Absence (% Time Lost) by Clinical Board



Sickness - Formal Action

Latest Data - June 2026

Attendance Management – Formal Action by Clinical Board/ Corporate Service

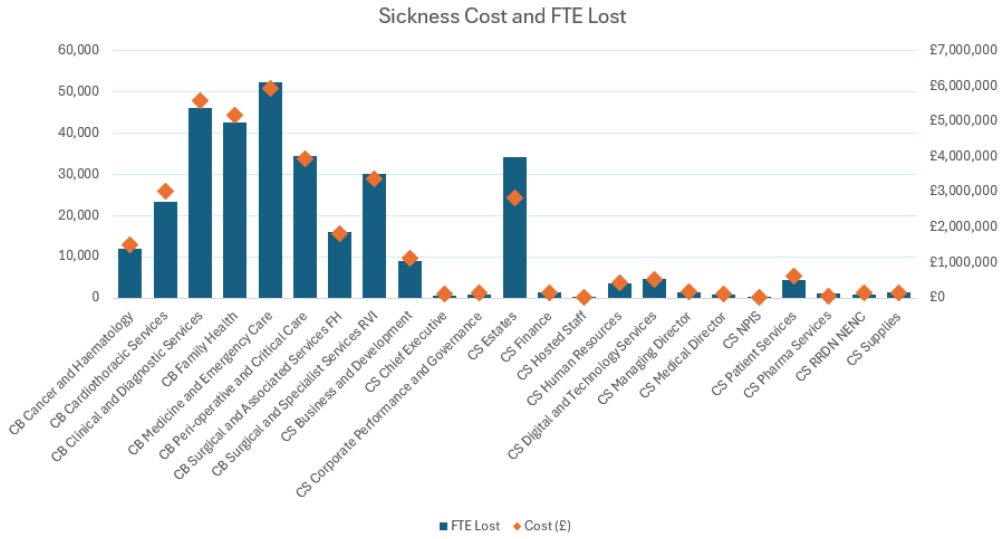


Sickness – FTE working days lost & cost of sick pay

Sickness Absence	12-Month period ending	Cost (£)	FTE Lost	Ave. No of Days Lost per FTE
	Jul 26	£36,934,115	321,972.78	21.76

Clinical Board	Cost (£)	FTE Lost	Ave. No of days
CB Cancer and Haematology	1,517,358	12,066.06	20.25
CB Cardiothoracic Services	3,012,281	23,423.56	22.25
CB Clinical and Diagnostic Services	5,583,794	46,105.89	16.34
CB Family Health	5,167,453	42,567.72	24.01
CB Medicine and Emergency Care	5,921,610	52,298.58	24.00
CB Peri-operative and Critical Care	3,935,016	34,384.71	23.56
CB Surgical and Associated Services FH	1,822,628	15,954.64	17.34
CB Surgical and Specialist Services RVI	3,362,799	30,168.67	23.62

Clinical Board	Cost (£)	FTE Lost	Ave. No of days lost per FTE
CS Business and Development	1,111,964	9,053.37	23.03
CS Chief Executive	103,459	608.00	8.12
CS Corporate Performance and Governance	131,411	970.08	11.43
CS Estates	2,844,643	34,257.21	32.28
CS Finance	145,419	1,318.27	11.63
CS Hosted Staff	27,035	409.60	12.05
CS Human Resources	422,647	3,554.19	18.48
CS Digital and Technology Services	527,184	4,691.44	20.61
CS Managing Director	166,808	1,363.20	18.14
CS Medical Director	118,995	856.49	16.05
CS NPIS	22,786	132.00	6.63
CS Patient Services	630,932	4,396.57	24.67
CS Pharma Services	64,750	1,007.71	17.45
CS RRDN NENC	140,573	943.54	15.35
CS Supplies	152,572	1,441.29	15.42

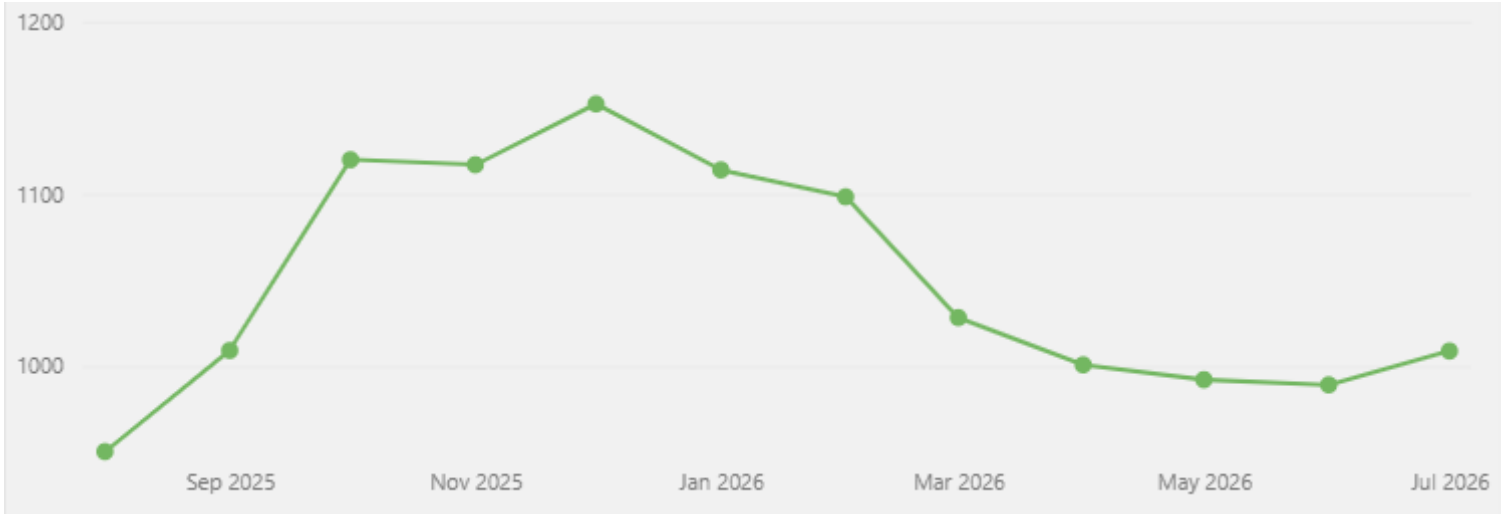


Sickness – Average working days lost per day

August 2025 to July 2026	Average Absence Headcount per Day
	1,048

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 Absence Headcount per Day by Month	1,101	1,092	1,023	993	988	986	1009					

Rolling 12-month daily average



Sickness – Average working days lost per day

Rolling 12-month daily average

Long Term August 2025 to July 2026	Average Absence Headcount per Day
	734

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 Absence Headcount per Day by Month	649	647	639	649	613	628	631					

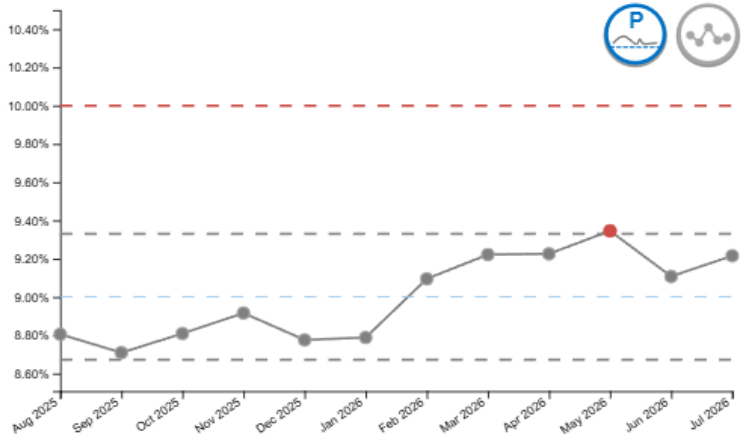
Short Term August 2025 to July 2026	Average Working Days Lost per Day*
	375

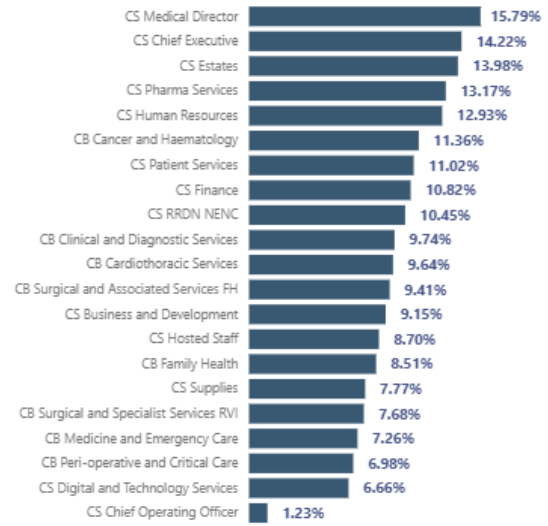
Month	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26	Oct 26	Nov 26	Dec 26
Average Absence Headcount per Day by Month	451	445	384	344	375	359	378					

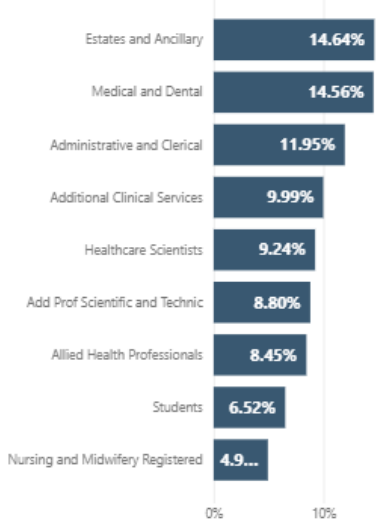
*Headcount

Turnover

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







Current Position:

- All Clinical Boards are better than target.
- Main reasons for staff leaving to a local Trust in last 12 months are promotion, work-life balance and relocation.

Underlying Issues

- 1567 leavers in 12-months to July 2026: 20% Administrative and Clerical (318); 19% Additional Clinical Services (294)
- Top destinations – no employment (752, 48%); other NHS organisation (419, 27%).
- Top reasons – work-life balance (227, 15%); retirement age (202, 13%); mutually agreed resignation (177, 12%)

Actions Undertaken:

- Flexible working. Supported and encouraged across the Trust. With consistently over 98% of applications are approved.
- Monitoring – daily information available to managers via people dashboard; monthly performance reviews held with clinical boards; monthly meetings held between HR and clinical boards/corporate services.

Turnover

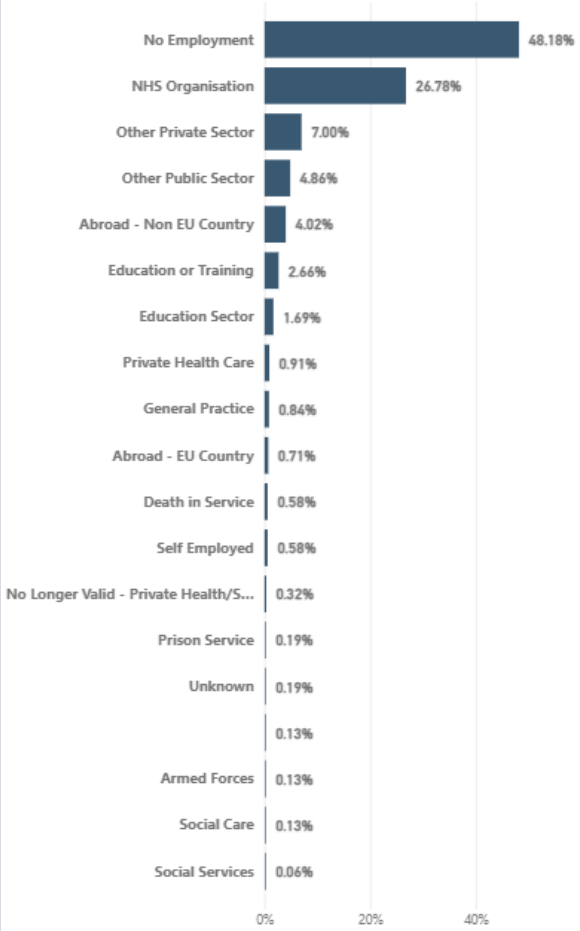
Trust Turnover %	12-Month Rolling	Value	Target
	Jul 26	9.22%	10.00%

Leaving Reasons

Leaving Reasons

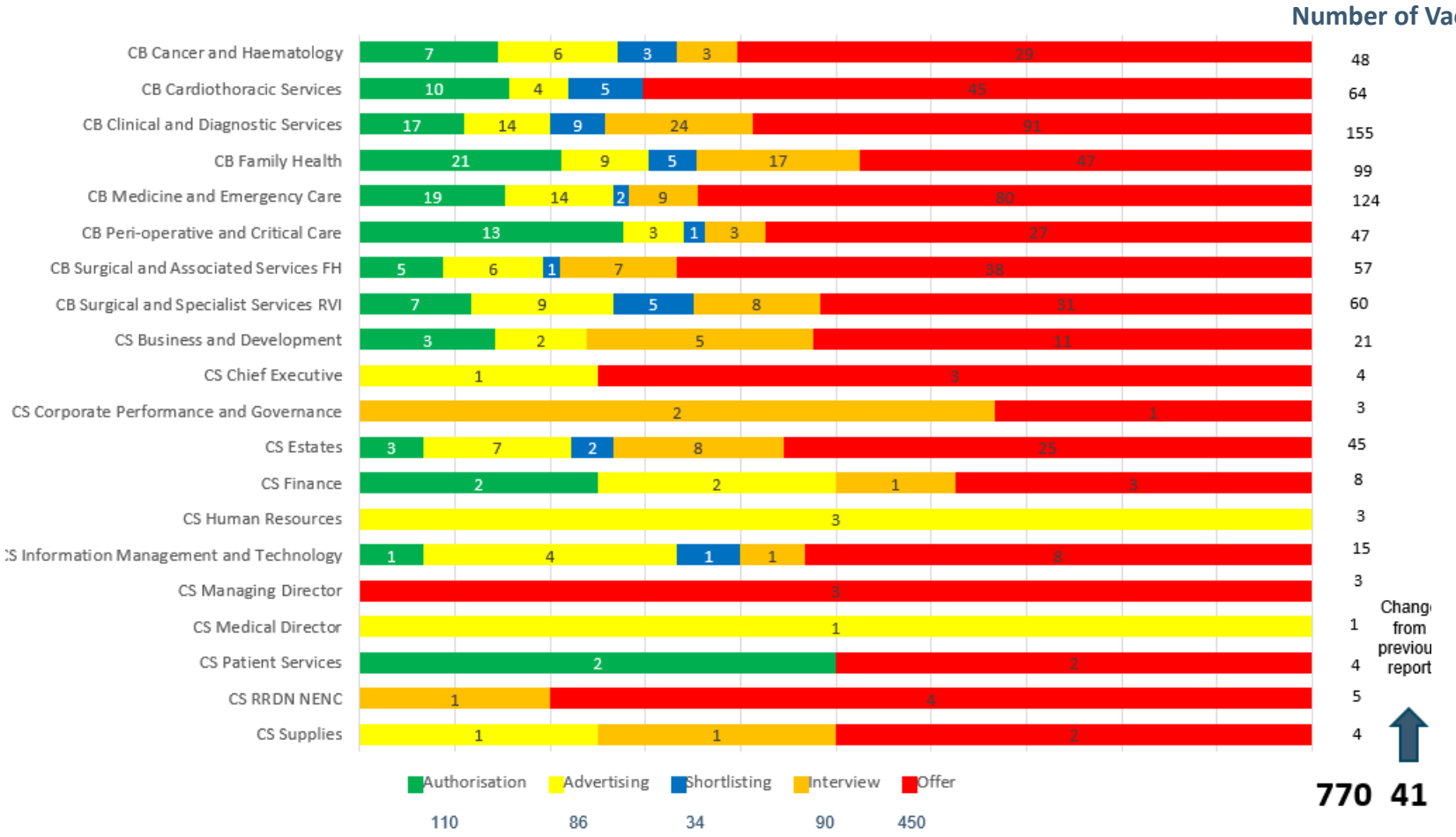
Leaving Reason	Leaving Reason %
Voluntary Resignation - Work Life Balance	14.72%
Retirement Age	13.10%
Mutually Agreed Resignation - Local Scheme with Repayment	11.48%
Voluntary Resignation - Relocation	10.44%
End of Fixed Term Contract	8.56%
Voluntary Resignation - Promotion	7.65%
Voluntary Resignation - Health	5.58%
Flexi Retirement	5.25%
Voluntary Resignation - To undertake further education or training	3.96%
Dismissal - Capability	2.66%
Voluntary Resignation - Incompatible Working Relationships	2.66%
Voluntary Resignation - Lack of Opportunities	2.59%
End of Fixed Term Contract - Completion of Training Scheme	1.75%
Voluntary resignation - Pay and Reward Related	1.69%
Voluntary Resignation - Child Dependants	1.36%
End of Fixed Term Contract - Other	1.30%
Voluntary Early Retirement - no Actuarial Reduction	0.97%
Voluntary Resignation - Other/Not Known	0.65%
Death in Service	0.58%
Dismissal - Conduct	0.58%
Voluntary Early Retirement - with Actuarial Reduction	0.58%
Retirement - Ill Health	0.52%
Voluntary Resignation - Adult Dependants	0.45%
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%

Destination on Leaving



Destination On Leaving	Destination On Leaving %
No Employment	48.18%
NHS Organisation	26.78%
Other Private Sector	7.00%
Other Public Sector	4.86%
Abroad - Non EU Country	4.02%
Education or Training	2.66%
Education Sector	1.69%
Private Health Care	0.91%
General Practice	0.84%
Abroad - EU Country	0.71%
Death in Service	0.58%
Self Employed	0.58%
No Longer Valid - Private Health/Social Care	0.32%
Prison Service	0.19%
Unknown	0.19%
	0.13%
Armed Forces	0.13%
Social Care	0.13%
Social Services	0.06%

Recruitment - Vacancies in progress by stage – 11 August 2026

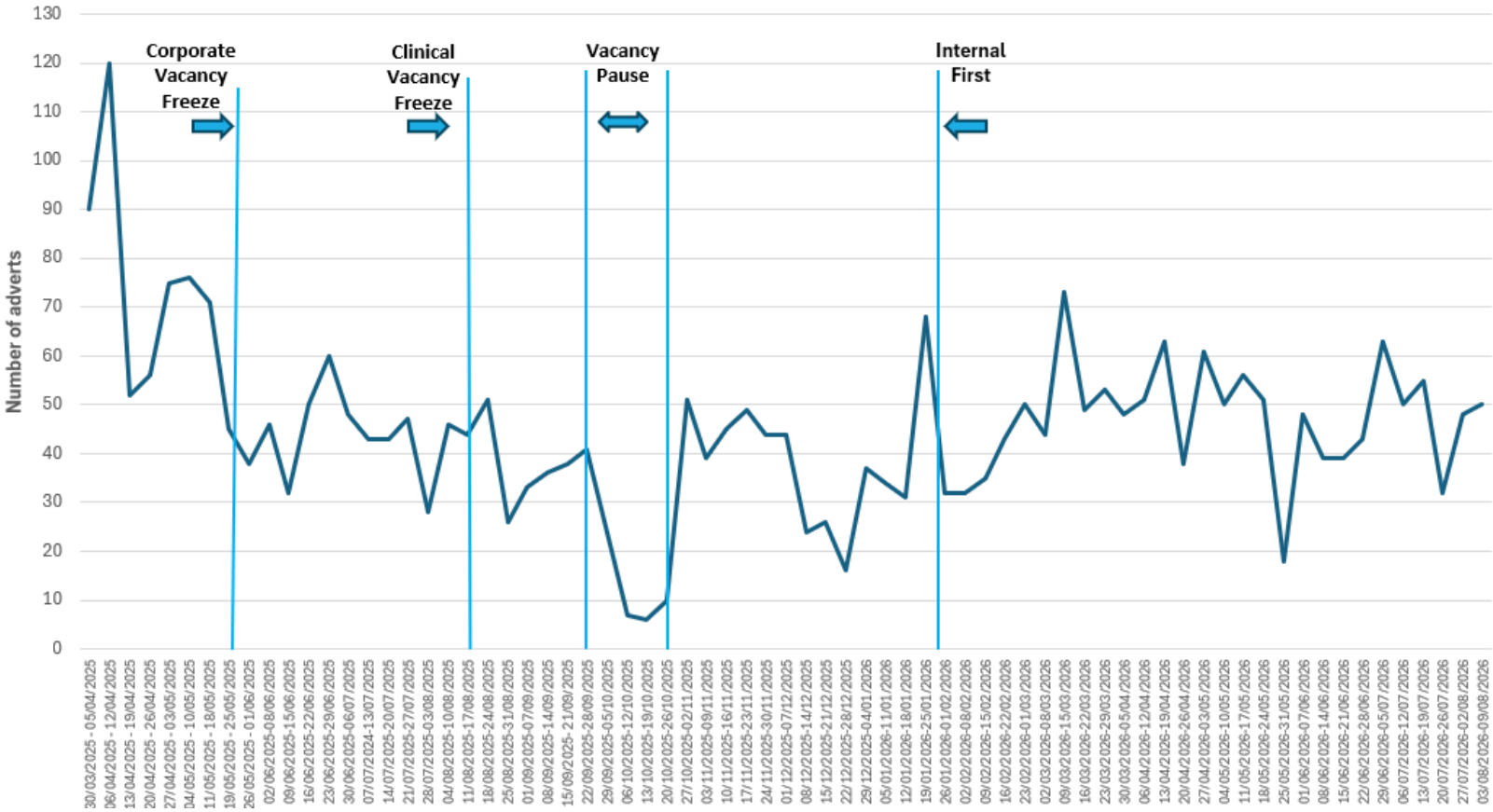


The chart illustrates that as of 11 August 2026, there were 770 vacancies progressing through the recruitment process—a increase of 41 compared to the previous period. The largest proportion of vacancies were at the conditional offer stage (58%), this is a decrease from previous report due to the number of starters over recent weeks. The numbers in the recruitment process are currently increasing with a current increase in Adverting and Interview from the previous report.

Recruitment - Vacancies in progress by stage

Total adverts w/e 09/08/2026 **50**

Number of adverts since corporate vacancy freeze on 14/05/2025, clinical vacancy freeze on 04/08/2025 and recruitment pause 01/10/2025-22/10/2025 **2618**

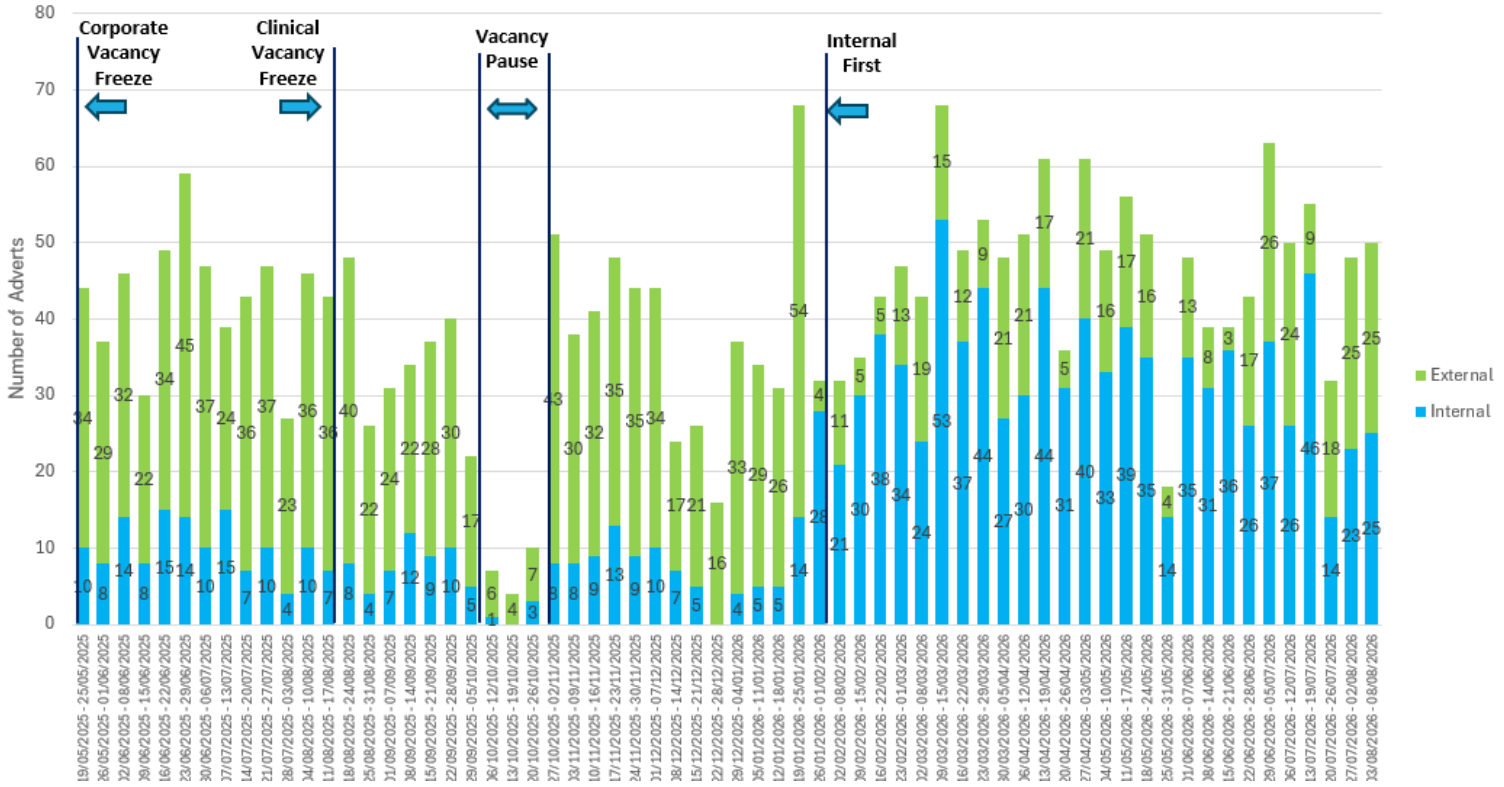


This graph shows a decline in the number of vacancies advertised during the recruitment pause and freezes. There has been increases in January and March 2026. Overall, in 2026 their similar adverts compared to the same period in 2025 with recent weeks the same or higher in 2026 than they were in 2025 (This could be attributed to annual recruitments that take place in this period of time). However, this demonstrates that the additional approval methods have not reduced the number of posts being advertised.

Recruitment – Adverts Overview – Internal v External Advertising

Total adverts w/e 09/08/2026 **50**

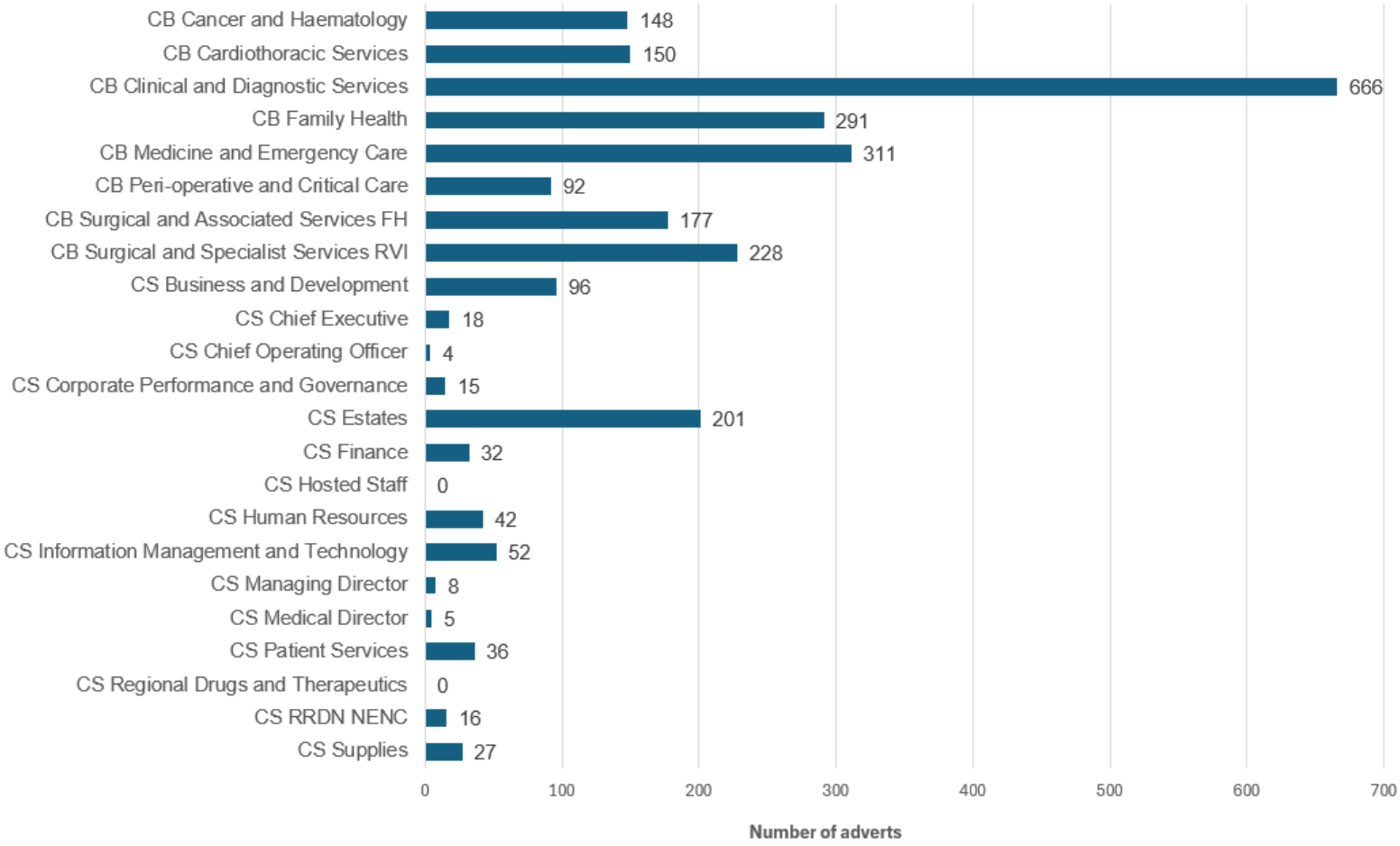
Number of adverts since corporate vacancy freeze on 14/05/2025, clinical vacancy freeze on 04/08/2025 and recruitment pause 01/10/2025-22/10/2025 and internal first on 26/01/2026 **2618**



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 11 August 2026 65% of candidates that were at conditional offer stage were external and 35% internal which is the same as 31 March 2026, a decrease of 4.5% on last month. However as our pipeline for Staff Nurses, Healthcare Assistants and Medical and Dental is currently external excluding those groups; 47.6% of candidates are external and 52.4% are internal which is getting closer to the 60% internal that we were looking to be working towards. This is showing that there is a decrease in the number of external candidates being offered posts compared with the previous month. As part of the Workforce Reduction Group this is being reviewed and reported on a fortnightly basis.

Recruitment - Adverts

Adverts by Clinical Board/Corporate Service since corporate vacancy freeze on 14/05/2025, clinical vacancy freeze on 04/08/2025 and recruitment pause 01/10/2025-22/10/2025

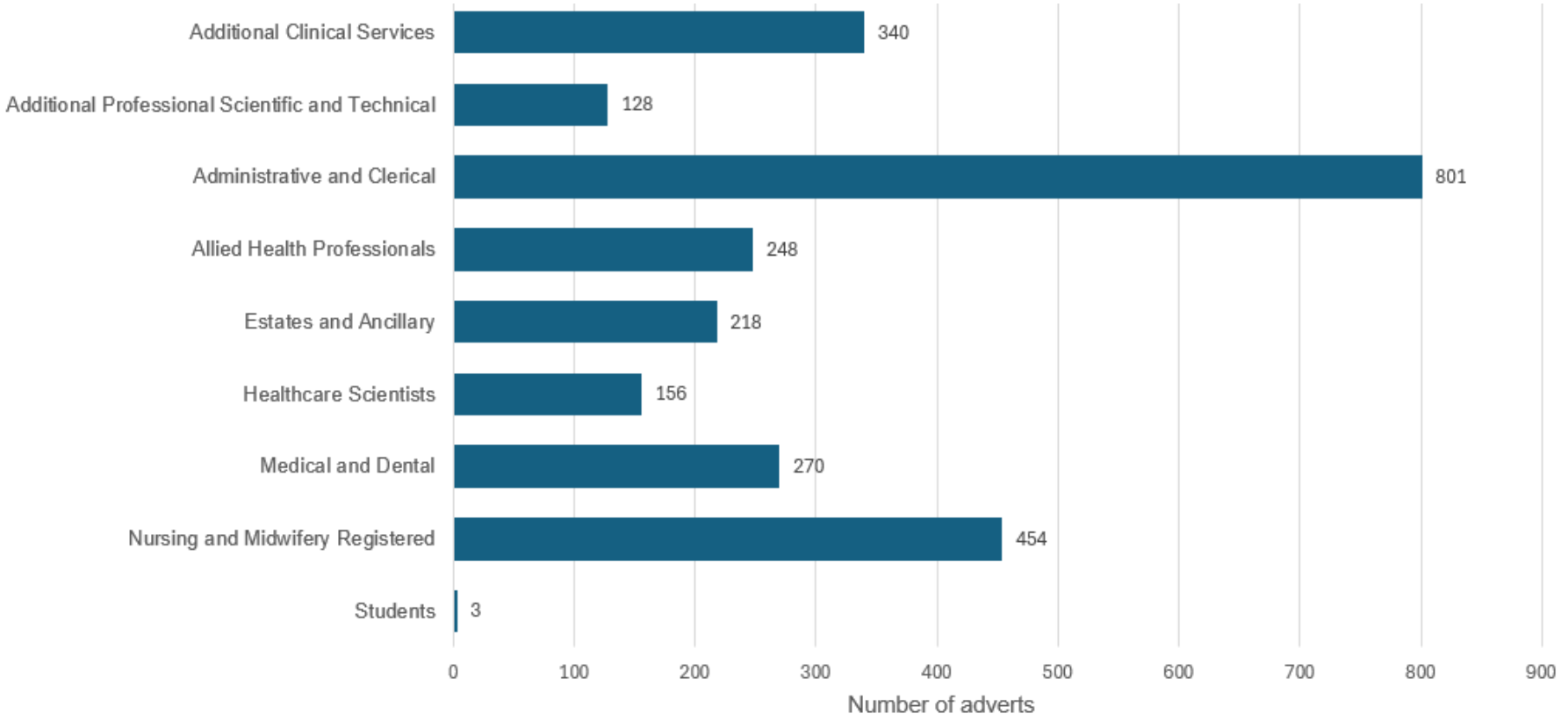


There has been 2618 adverts since 14/05/2025. The highest number of adverts has been for Clinical and Diagnostic Services. However, this should be considered in proportion to the size of the Clinical Board.

Recruitment - Adverts

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

2,618



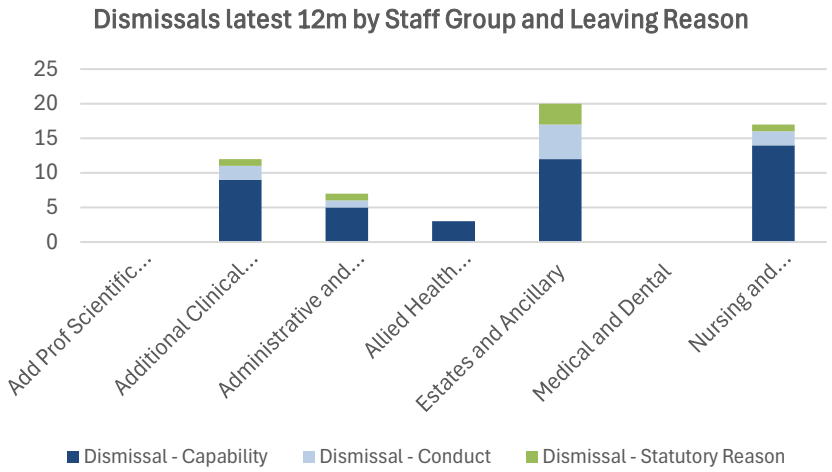
There has been 2618 adverts since 14/05/2025. The largest volume of adverts since 14 May 2025 has been in Administrative and Clerical roles, followed by Nursing and Midwifery, with the lowest numbers in Additional Professional and Scientific positions with the exception of students.

Dismissals – 12 month rolling period ending July 2026

Dismissals	12-Month period ending	Dismissals Headcount	Dismissals FTE
	Jul 26	61	44.56

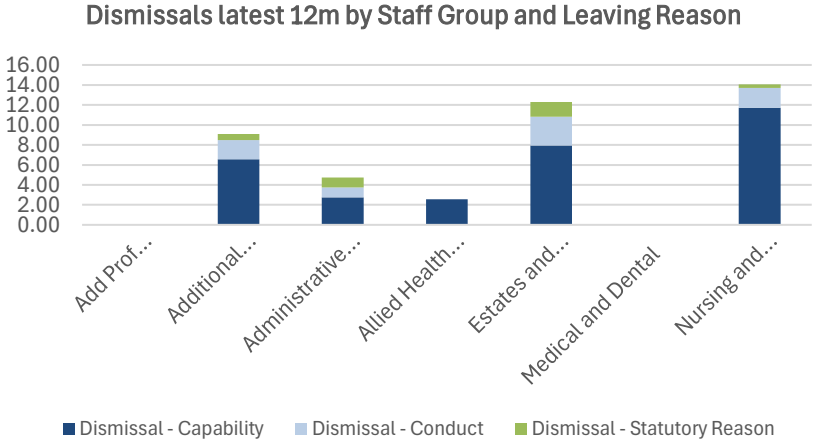
Headcount

Staff Group	Dismissal - Capability	Dismissal - Conduct	Dismissal - Statutory Reason	Total
Add Prof Scientific and Technic				
Additional Clinical Services	9	2	1	12
Administrative and Clerical	5	1	1	7
Allied Health Professionals	3			3
Estates and Ancillary	12	5	3	20
Medical and Dental				
Nursing and Midwifery Registered	14	2	1	17
Healthcare Scientists	2			2
Grand Total	45	10	6	61



FTE

Staff Group	Dismissal - Capability	Dismissal - Conduct	Dismissal - Statutory Reason	Total
Add Prof Scientific and Technic				
Additional Clinical Services	6.57	1.92	0.60	9.09
Administrative and Clerical	2.74	1.00	1.00	4.74
Allied Health Professionals	2.57			2.57
Estates and Ancillary	7.95	2.88	1.47	12.29
Medical and Dental				
Nursing and Midwifery Registered	11.71	2.00	0.35	14.06
Healthcare Scientists	1.80			1.80
Grand Total	33.35	7.80	3.41	44.56



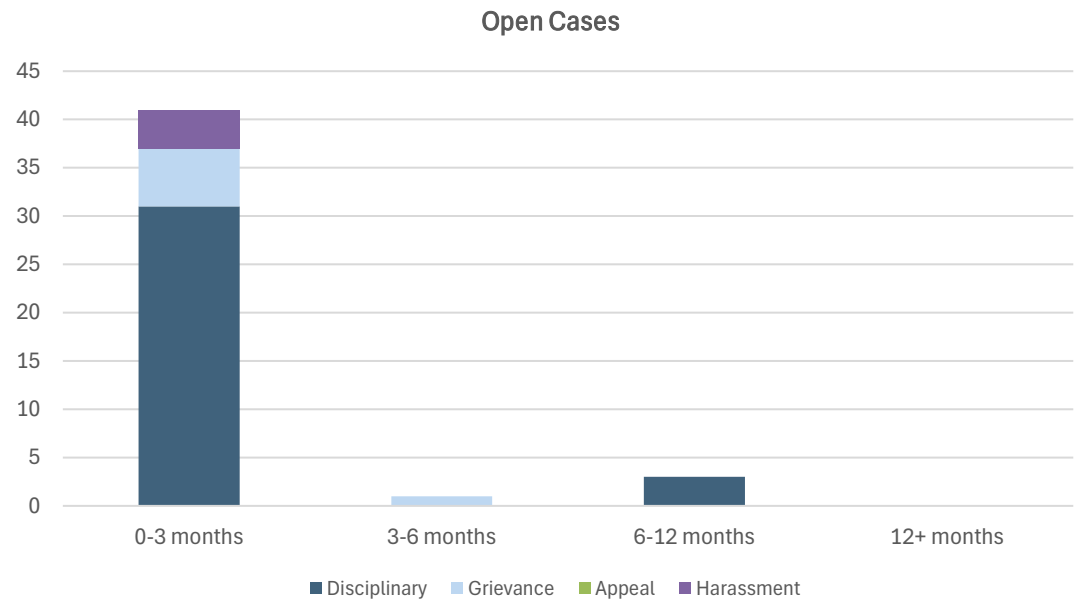
Employee Relations - Open Cases

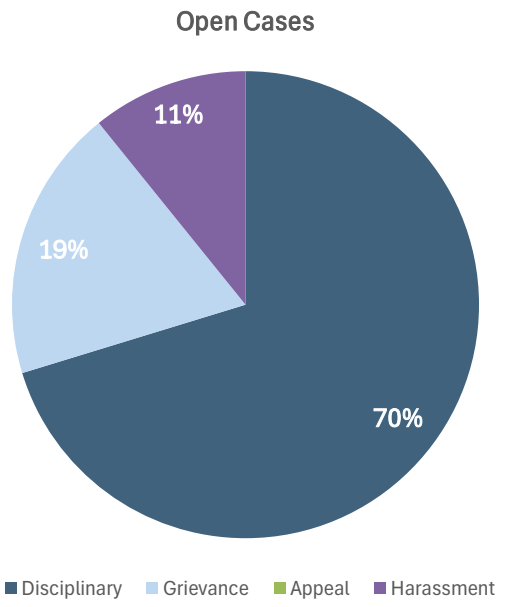
Open Cases	Latest Month	Total Open Cases
	Jul 26	45

Case Type	0-3 months	3-6 months	6-12 months	12+ months	Total
Disciplinary	31		3		**34**
Grievance	6	1	0	0	**7**
Appeal	0	0	0	0	**0**
Harassment	4	0	0	0	**4**
Grand Total	**43**	**1**	**3**	**0**	**45**

There are currently 45 open employee relations cases, of 34 are disciplinary (of which 8 suspensions), 4 harassment and 7 grievance.

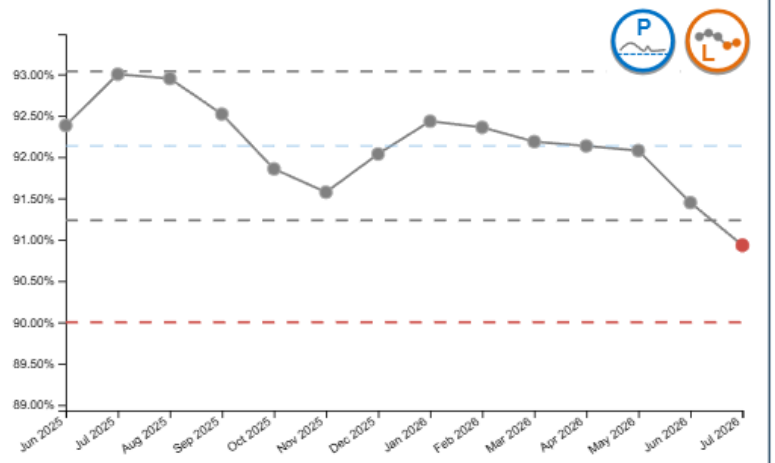
6 of the 45 (13.33%) have been raised since April 2026.

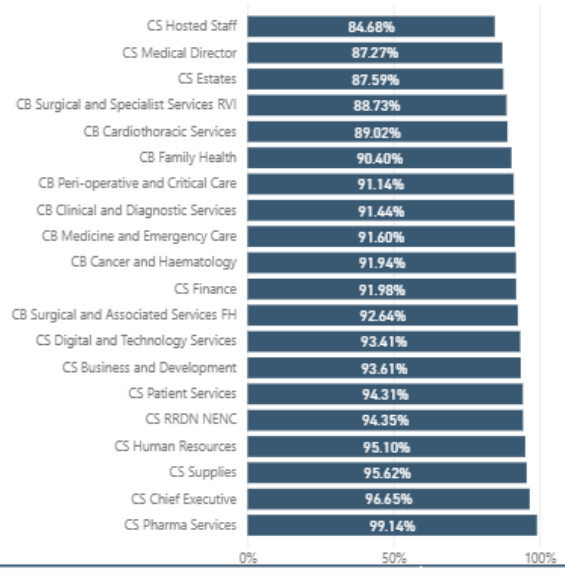


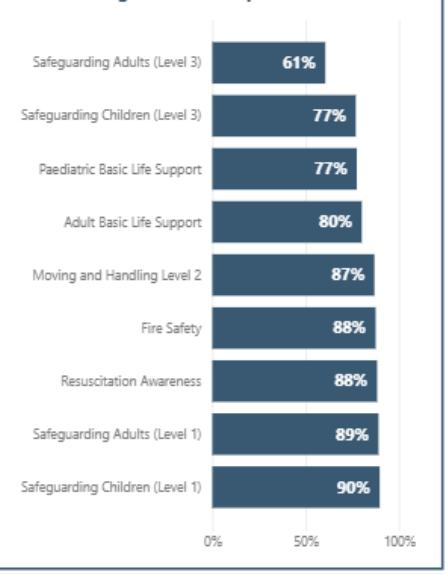


Mandatory training

Mandatory Training Compliance	Month	Value	Target
	Jul 26	90.93%	90.00%







Current Position:

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

Underlying Issues

- Medical and Dental – have lowest overall compliance (78.67%) with low compliance in Prevent Awareness (23.08%); Safeguarding Adults Level 3 (40.84%)*; Paediatric Basic Life Support (53.46%)
- Face-to-face training can take more time away from work compared to online.
- Performance looked at as part of Well-led domain.
- Quality Improvement (QI) approach to improve resus compliance had limited impact.
- Oliver McGowan. Trust expected to show Care Quality Commission (CQC) how it has met legal requirements.

Actions Undertaken:

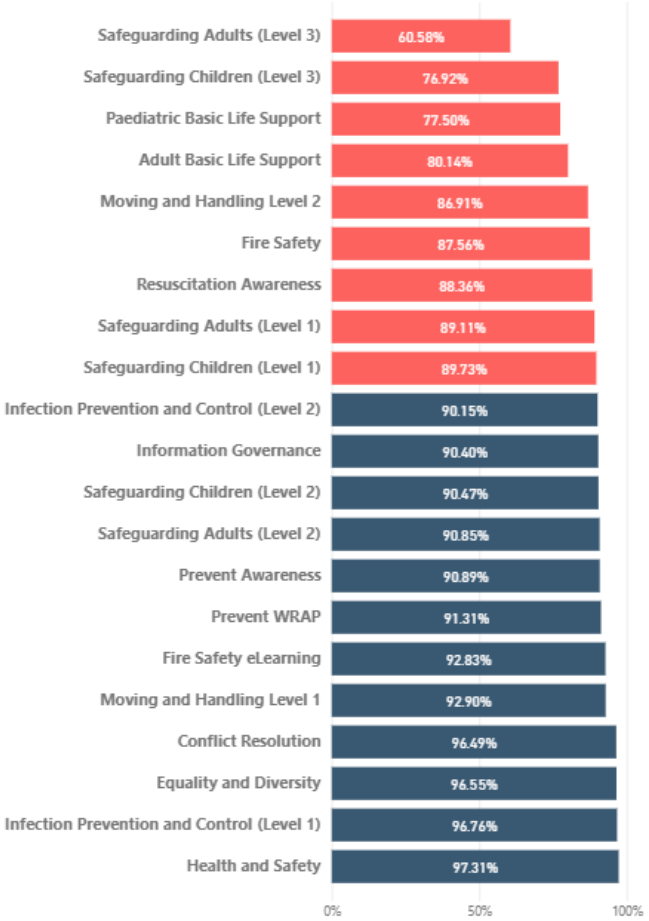
- Task & Finish Group has been established to look at 'process and provision'.
- Clinical Board (CB) Surgical and Specialist Services are establishing a 2-day bespoke drop-in session for learning lab.
- Infection prevention & control – in line with national guidelines, level 1 training to be allocated to all staff. In agreement with IPC team, staff will be awarded compliance where they have completed level 2 in the last 3 years, therefore no immediate negative impact expected.
- Adult and children's safeguarding – audience changes have started to address those with no safeguarding attached.

**Ongoing work to correct the assignment of Safeguarding Adults Level 3 training has resulted in the course being allocated to over 3,000 additional staff in phases. This has increased the number of staff required to complete the training and has temporarily affected compliance figures.*

Mandatory training

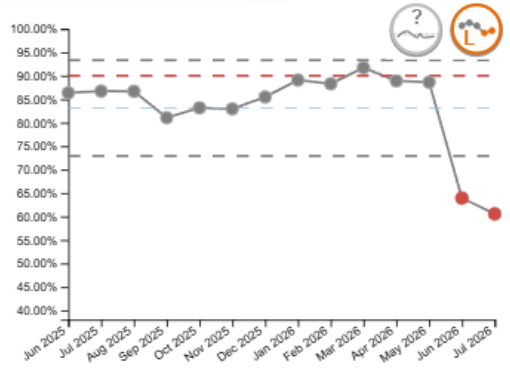
Mandatory Training Compliance	Month	Value	Target
	Jul 26	90.93%	90.00%

Training Course Compliance %

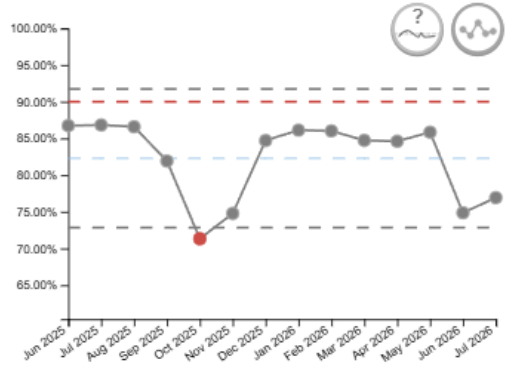


Lowest 4 Mandatory Training Compliance %

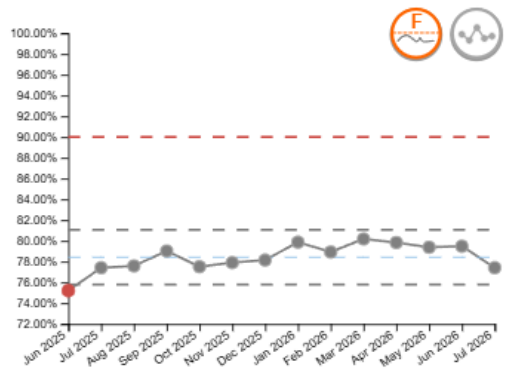
Safeguarding Adults (Level 3) — 61%



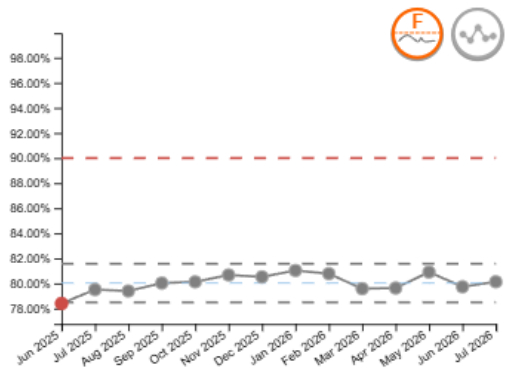
Safeguarding Children (Level 3) — 77%



Paediatric Basic Life Support — 77%



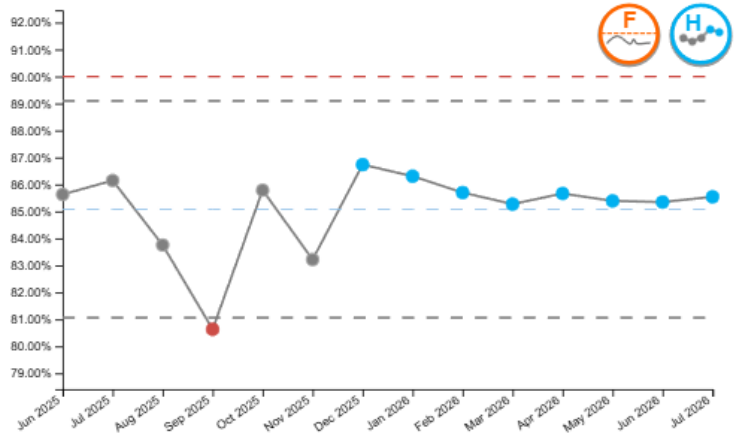
Adult Basic Life Support — 80%

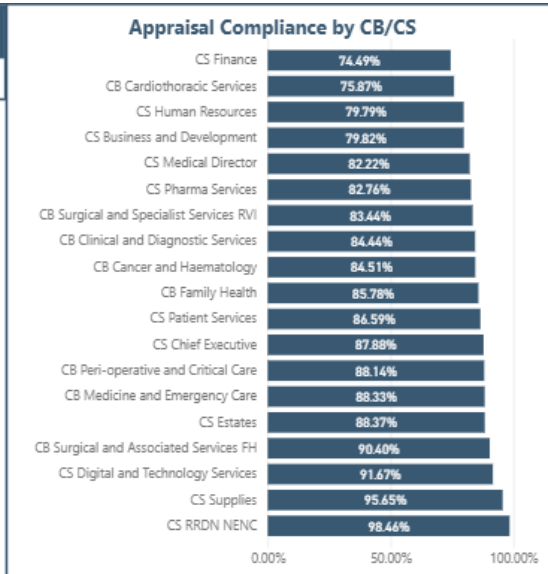


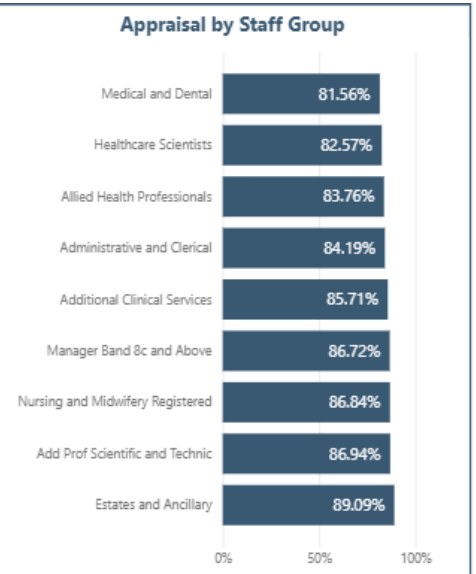
**Ongoing work to correct the assignment of Safeguarding Level 3 training has resulted in the courses being allocated to over 3,000 additional staff in phases. This has increased the number of staff required to complete the training and has temporarily affected compliance figures.*

Appraisal compliance

Appraisal Compliance	Month	Value	Target
	Jul 26	85.54%	90.00%







Current Position:

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

Underlying Issues

- 2,054 appraisals are overdue with highest numbers in Nursing and Midwifery (623) and Admin and Clerical (374).
- Clinical board performance varies between 75.87% (Cardiothoracic Services) to 90.40% (Surgical and Associated Services).
- Corporate Service performance varies between 74.49% (Finance) to 98.46% (RRDN).
- Compliance impacted by time and capacity of managers and staff.

Actions Undertaken:

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

Bank use (£) – non-medical

Bank Utilisation (£)	12-Month period ending	Total Bank Expenditure (£)	Total Bank Difference (£)
	Jul 26	£19,833,578	+£1,757,153

Bank Utilisation (£)

Staff Group	Aug 24 - Jul 25	Aug 25 - Jul 26	Difference
Admin & Clerical	£1,136,895	£543,532	-£593,363
Ancillary	£330,947	£289,743	-£41,204
Estates			£0
Nursing & Midwifery (Registered)	£6,069,316	£7,344,488	£1,275,172
Nursing & Midwifery (Unregistered)	£9,791,755	£10,739,334	£947,580
Professional & Technical	£747,512	£916,481	£168,968
Total	£18,076,424	£19,833,578	£1,757,153

Current Position:

- Cost of Bank has increased for Nursing & Midwifery (N&M) unregistered due to service need for enhanced care.

Underlying Issues

- N&M unregistered increase due to service need for enhanced care.
- Ancillary increase due to challenges from Additional hours are being worked as overtime rather than Bank which is a more costly option.

Actions Undertaken:

- Work continues to reduce bank usage with effective rostering and direction.
- Aiming to reduce agency use of HCAs for enhanced care.
- To support the shift from overtime to Bank, around 1200 substantive staff have been fast-tracked as additions to the Bank.

Bank use (£) – medical (locum)

Bank Utilisation (£)	12-Month period ending	Total Bank Expenditure (£)	Total Bank Difference (£)
	Jul 26	£12,910,729	+£1,822,143

Bank Utilisation (£)

Staff Group	Aug 24 - Jul 25	Aug 25 - Jul 26	Difference
Medical - Consultant	£5,158,176	£7,001,638	£1,843,462
Medical - Career / Staff Grades	£34,491	£101,183	£66,692
Medical - Registrar & Senior Registrar	£3,224,784	£4,193,033	£968,249
Medical - Lower Specialty Trainee	£1,792,225	£1,336,797	-£455,428
Medical - SHO'S and HO'S	£419,747	-£288,664	-£708,411
Dental - Consultant	£1,767	£85,309	£83,542
Dental - Career / Staff Grades	£116,633	£90,225	-£26,408
Dental - Registrar & Senior Registrar	£10,763	£368,280	£357,517
Dental - SHO'S and HO'S	£622	£22,928	£22,306
General Practitioner	£329,378	£0	-£329,378
Total	£11,088,586	£12,910,729	£1,822,143

Current Position:	Underlying Issues	Actions Undertaken:

- Total spend increased by £1.8m overall.
- Notable increases in cost of Medical Consultants and Registrars by +£1.8m and +£968k, respectively. Dental Registrar costs also increased by £357k.
- Medical SHO/HO costs decreased significantly by -£708k as did Lower Specialty Trainee costs which reduced by -£455k.

Agency use (£) – non-medical

Agency Utilisation (£)	12-Month period ending	Total Agency Expenditure (£)	Total Agency Difference (£)
	Jul 26	£1,989,893	-£1,520,100

Agency Utilisation (£)

Staff Group	Aug 24 - Jul 25	Aug 25 - Jul 26	Difference
Admin & Clerical	£157,239	£138,267	-£18,972
Ancillary	£6,499	£51,231	£44,732
Estates	£30,869	£51,353	£20,483
Nursing & Midwifery (Registered)	£722,647	£261,599	-£461,048
Nursing & Midwifery (Unregistered)	£1,388,671	£827,849	-£560,822
Professional & Technical	£1,204,068	£659,595	-£544,473
Total	£3,509,993	£1,989,893	-£1,520,100

Current Position:

- Costs reduced by c. £1.5m on previous year.
- Notable reductions in Nursing & Midwifery (registered and unregistered) and Professional & Technical.

Underlying Issues

- Registered nurse agency use – hotspots in Theatres and Cardiothoracic Services for scrub and anaesthetic nurses. Pressures also continue for Nurse Practitioners.

Actions Undertaken:

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

Agency use (£) – medical

Agency Utilisation (£)	12-Month period ending	Total Agency Expenditure (£)	Total Agency Difference (£)
	Jul 26	£2,077,746	-£2,300,103

Agency Utilisation (£)

Staff Group	Aug 24 - Jul 25	Aug 25 - Jul 26	Difference
Medical - Consultant	£4,306,153	£2,022,938	-£2,283,215
Agency - Career / Staff Grades	£5,896	£8,162	£2,266
Medical - Registrar & Senior Registrar	-£10,195	£3,374	£13,568
Medical - SHO'S and HO'S	£71,033	£42,376	-£28,657
General Practitioner	£4,961	£896	-£4,065
Total	£4,377,848	£2,077,746	-£2,300,103

Current Position:

- Costs decreased by c. £2.3m, on previous year.
- Notable reductions in Consultant and SHOs/HOs
- Consultants collectively working an average of 1,100 hours per month.

Underlying Issues

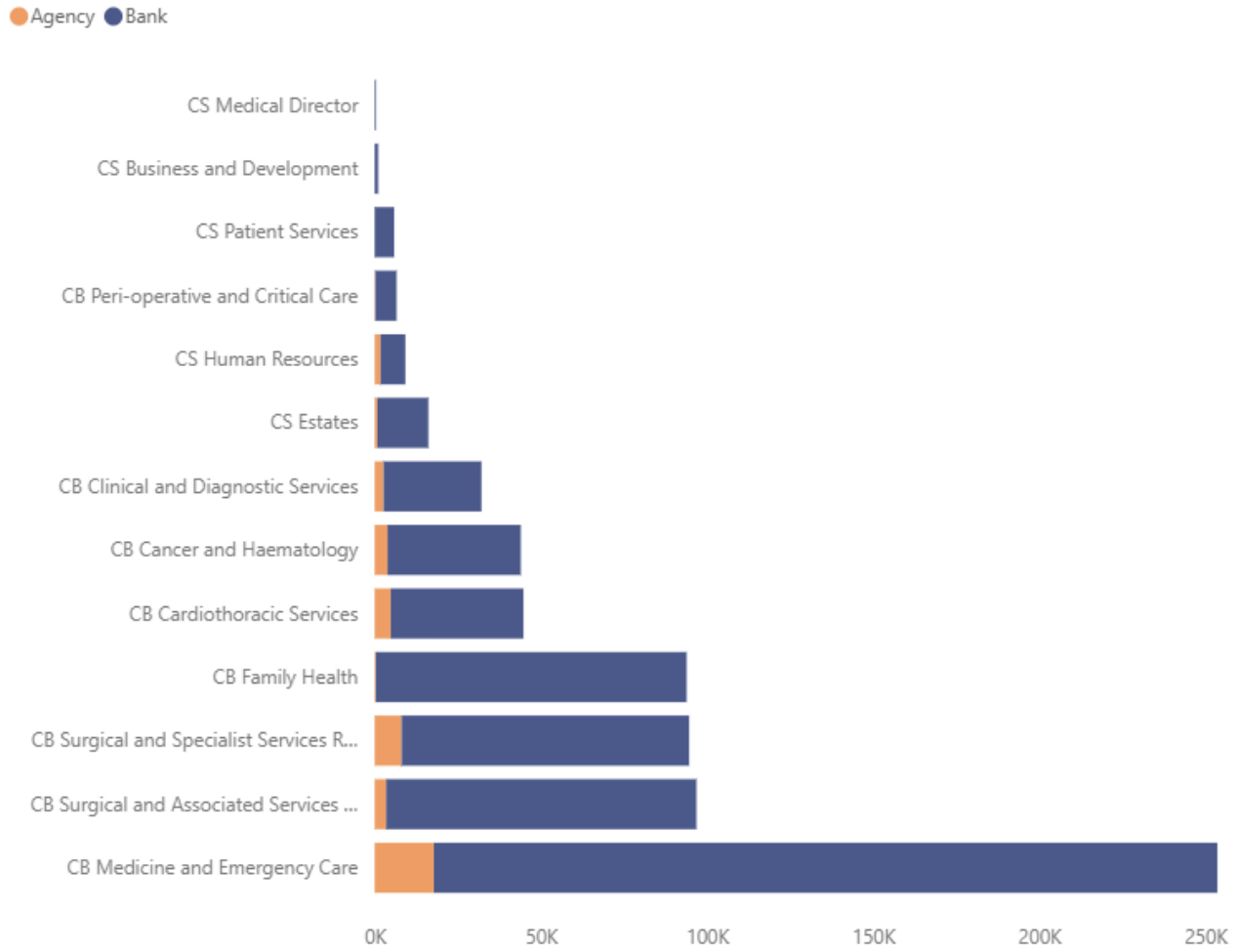
- Consultant spend. Staffing issues in Older People's Medicine and Stroke; off-framework arrangement in PICU due to sickness absence and recruitment; locum in General Medicine as part of Winter Plan 2024/25 ended in April 2025; agency Consultants unwilling to move to a Trust contract.

Actions Undertaken:

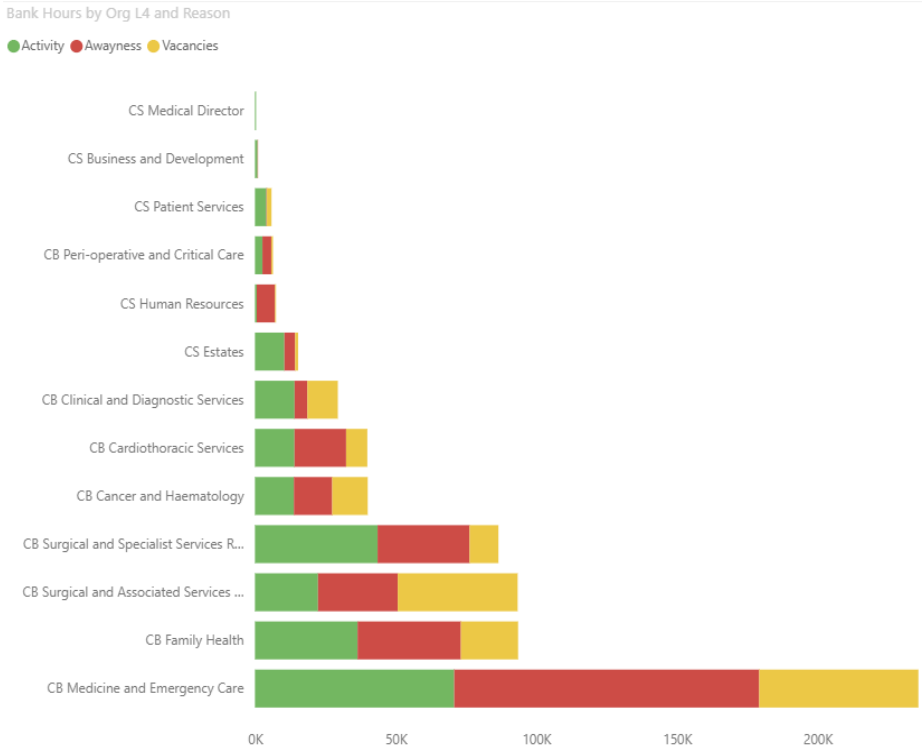
- Consultants. Trust contracts offered and declined; charges and hourly rates renegotiated wherever possible; recent recruitment in PICU has been successful reducing the need for agency.

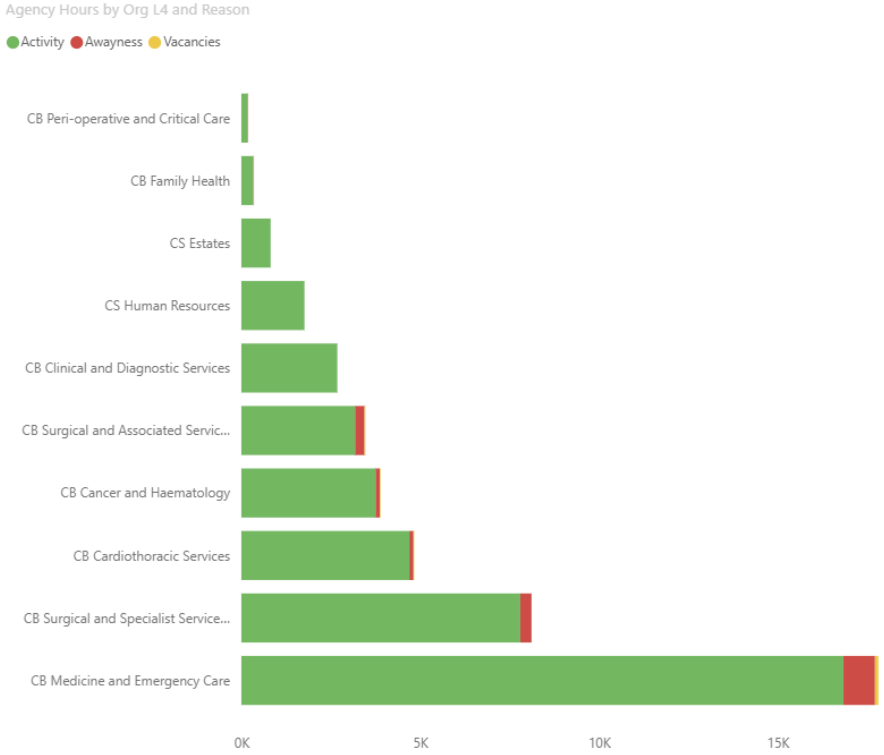
Bank & agency use - hours

Bank & Agency	12-Month period ending	Total Bank and Agency Hours
	Jul 26	699,473



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

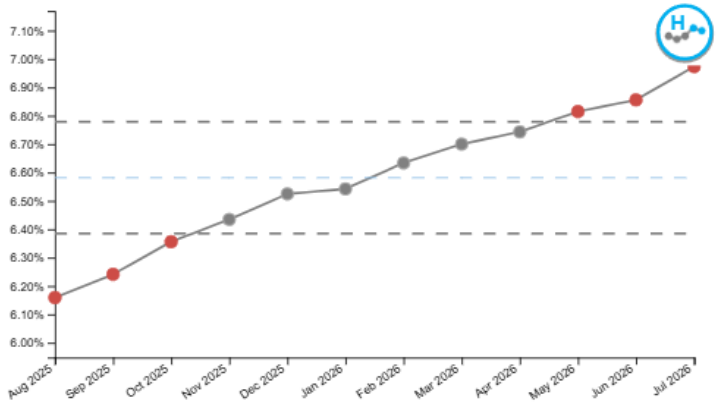


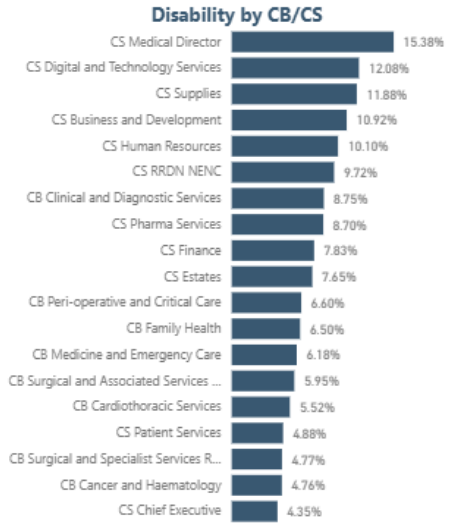


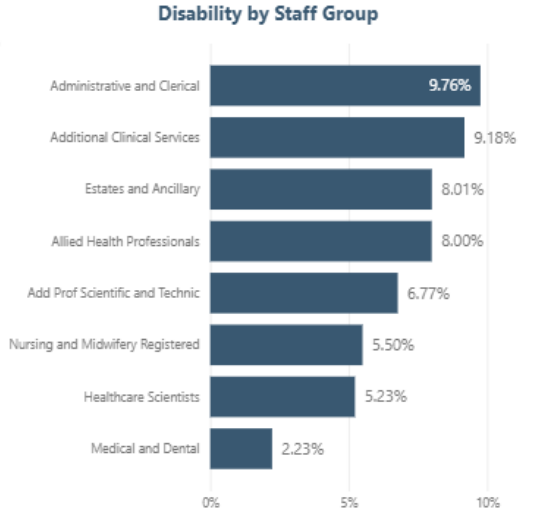
- **awayness**, including sickness, maternity, study leave, industrial action, etc.
- **activity**, including workload, acuity, waiting list initiative, etc.
- **vacancies**

Equality, diversity and inclusion (EDI) - disability

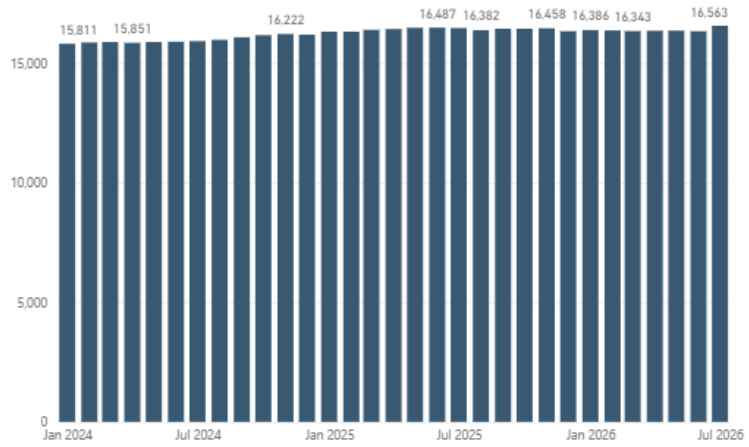
EDI - Disability	Month	Value	Trust Headcount
	Jul 26	6.97%	16,563







Trust Headcount Trend



Age Band

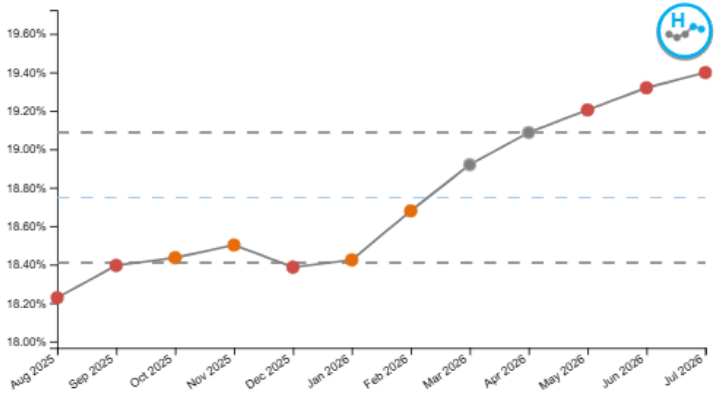
	Age Band	Disability %
1	<=20 Years	9.87%
2	21-25	14.24%
3	26-30	8.53%
4	31-35	6.90%
5	36-40	5.51%
6	41-45	5.31%
7	46-50	5.29%
8	51-55	6.76%
9	56-60	6.32%
10	61-65	7.43%
11	66-70	5.13%
12	>=71 Years	4.62%

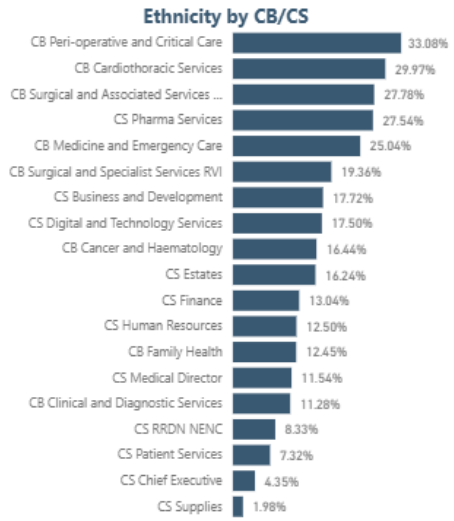
Current Position:

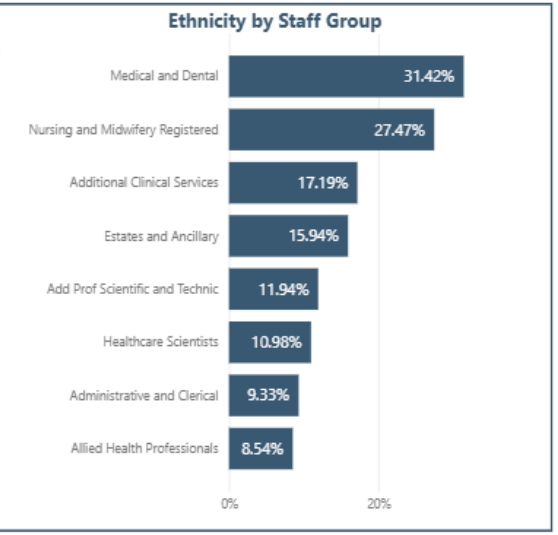
- Charts show percentage of staff in post each month by those disclosing a disability.
- Percentage of disabled staff continues to grow with the latest position reflecting 6.97% of the workforce.
- Workforce Disability Equality Standard (WDES) data from the National Staff Survey will be published at the end of April 2026, with key findings being linked/aligned to the 12-point Equality Diversity Inclusion (EDI) plan.
- The development of the leadership development program will have EDI integrated throughout.

Equality, diversity and inclusion (EDI) - ethnicity

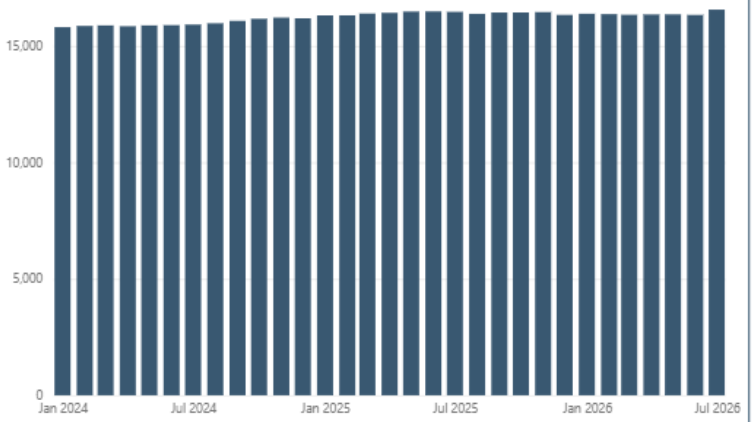
EDI - Ethnicity	Month	Value	Trust Headcount
	Jul 26	19.40%	16,563







Trust Headcount Trend



Age Band

	Age Band	BME %
1	<=20 Years	23.03%
2	21-25	14.91%
3	26-30	29.64%
4	31-35	25.23%
5	36-40	24.65%
6	41-45	17.13%
7	46-50	18.74%
8	51-55	17.04%
9	56-60	11.54%
10	61-65	6.27%
11	66-70	6.23%
12	>=71 Years	4.62%

Current Position:

- Charts show percentage of staff in post each month by ethnicity (BAME).
- Percentage of BAME staff has increased slightly with the latest position reflecting 19.40% of the workforce.
- WRES data from the National Staff Survey will be published at the end of April 2026, with key findings being linked/aligned to the 12-point EDI plan.
- The development of the leadership development program will have EDI integrated throughout.

Finance

The Newcastle Upon Tyne Hospitals NHS Foundation Trust
Finance Dashboard 2026/27

July 2026

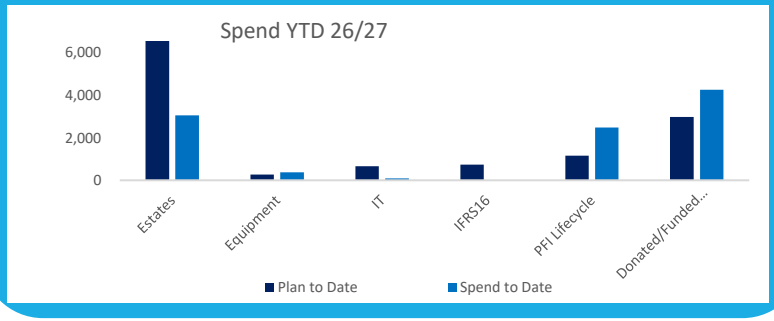
Financial Health

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

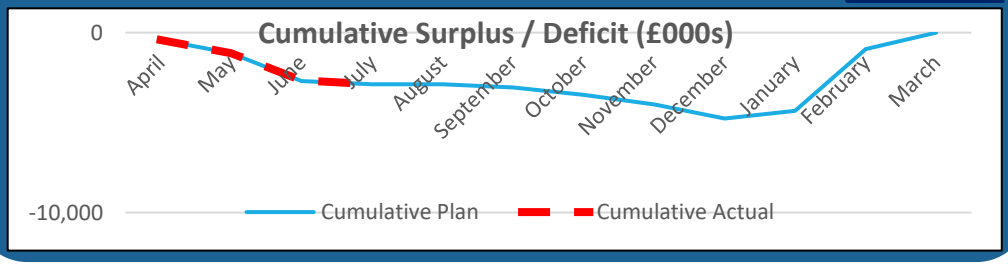
Financial Performance Month 4

- The trust delivered a deficit of £2.9 million in month 4, 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 ICB contract, there has been a reduction in income value compared to income expected in plan.
- Reported CIP for Clinical Boards and Corporate Services are behind plan.
- Due to a higher than planned cash balance, interest receivable is higher than plan by £1,390k.
- There is an overspend on Block and tariff drugs, off-set by an underspend on matched drugs and overspends on pay, with expenditure on Clinical Supplies increasing.

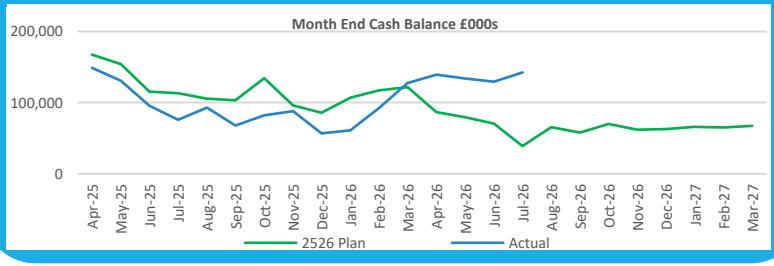
Capital Programme Delivery – Month 4



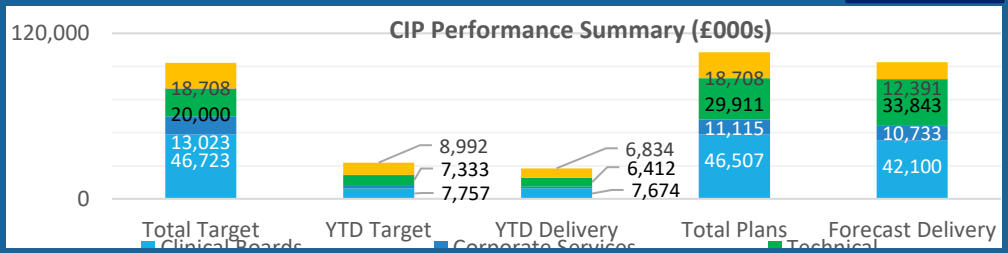
Cumulative Performance Against Plan



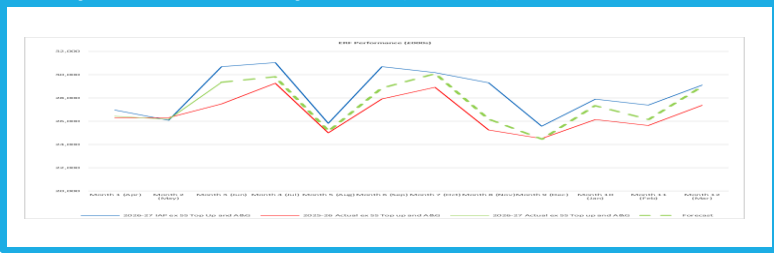
Cash Balance



Cost Improvement Programme Performance



Activity – Elective Recovery Income (M3 Flex)



Sustainability

High level Dashboard

Sustainability High-level Dashboard - Q1 2026/27 (April - June 2026)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

STRATEGIC UPDATE

Strategy: Environmental sustainability included as a priority in the final version of the Trust Strategy and a key part of 'Supporting Great Care'. Climate Emergency Plan highlighted as a strategic delivery plan in Trust Strategy. New Climate Emergency Plan 2026-2031 approved by Board in July.

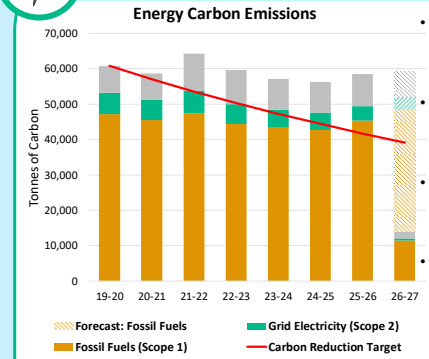
Culture: Embedding sustainability into our DNA: sustainability assessment included as a core requirement of the **accreditation ACE framework** and inspections scheduled for Q2, charity-funded Clinical Sustainability Lead (Dr Kanagasundaram) engaging with clinical boards to show benefits of embedding sustainability into clinical improvement projects

Born Green Generation: Entering our final year of the three-year European-funded programme to reduce plastics and harmful chemicals in Maternity at RVI. Successful projects include a switch to reusable tourniquets and theatre hats, sustainable c-section skin prep (swab on a stick) and BioBins for placenta disposal. Reducing costs and fossil fuel plastic.

PSDS4 £40.5m Grant for Estates Decarbonisation: Robertson Coonstruction appointed as delivery partner, currently working on stage two design and implementation with challenging financial and operational programmes.

Green Spaces: Our externally-funded **Nature Recovery Ranger** has helped coordinate a number of staff health and wellbeing events as well as finalising development of our first Green Spaces & Health Plan with our Trust Green Spaces Group.

ENERGY — RAG



- Emissions from energy have **risen slightly in Q1** resulting in a projected increase by the end of the year.
- Primary driver is the increased electrical demand for cooling (earllier heatwave this year) and UTC fully operational.
- Energy Team working with Veolia to reduce over production of energy which could see an improvement in Q2 position.
- **Forecast energy emissions will remain steady (*above target*)** until PSDS4 completion (2028) and RVI city heat network potential (2030+).

PEOPLE — RAG

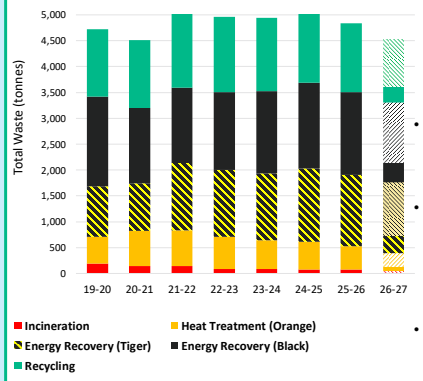
Staff Engagement
1,327 Green Champions
(4%↑)

Training and Education
21 engagement and training events

Social Media Communications
663 followers
(4% ↑)

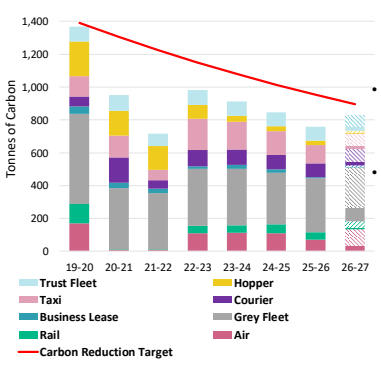
SHINE Awards for SusQI Projects
6 projects
awarded a Shine Award Q1 26/27

WASTE — RAG



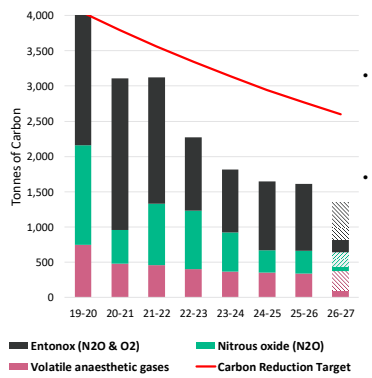
- **Total waste disposal is estimated to reduce again this year** though Q1 figures need to be further analysed for potential under-reporting of clinical waste tonnages by our contractor.
- Primary driver is believed to be a **reduction in consumable spend** as part of CIP push.
- **Hazardous waste disposal is at lowest level** - less than 10% of total waste (with clinical waste for incineration, red on graph, at only 1%).
- **Recycling rate is 45%** of non-clinical waste (27% of total).

JOURNEYS AND CLEAN AIR — RAG



- There has been a **rise in short-haul international flights in Q1 that has resulted in a rise in carbon emissions**.
- All other categories of transpot emissions are similar to last year.
- Charity funded bike maintenance sessions have taken place across 3 sites, helping staff to commute actively to work (**94% of staff said the service encouraged them to cycle to work**).

CARE — RAG



- Q1 data indicates that we may see a **slight reduction on anaesthetic gas emissions this year**.
- Improved methodology for calculating Entonox (N_2O & O_2 mix) emissions will be reported on next quarter.
- Our **Nitrous Oxide Waste Mitigation MDT** continues to meet monthly to progress clinical opportunities to reduce waste and switch to a lean supply wherever possible.

A Guide to 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.	

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 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 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 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.

Icons & How to Interpret (3/4)

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

Icons & How to Interpret (4/4)

Variation/Performance	Assurance: P	Assurance: ?	Assurance: F	Assurance: (blank)
Special cause – concerning	**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.
Special cause – improving				**Unsure** **Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event above the upper process limits; a continued upward trend or shift above the mean. • There is no target set for this metric.
Special cause – deteriorating				**Unsure** **Investigate and Understand** • This metric is showing a statistically significant variation. • There has been a one off event below the lower process limits; a continued downward trend or shift below the mean. • There is no target set for this metric.
Common cause				**Unknown** **Watch and Learn** • There is insufficient data to create a chart. • At the moment we cannot determine either special or common cause. • There is currently no target set for this metric

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Agenda item A3(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 September 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 Marilyn Hodges – Associate Director – Staff and Patient Experience		
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. 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, highlighted the fundamental importance of understanding the lived experience of patients and families accessing care as well as understanding the experience of staff working in our services. There are various mechanisms by which the service listens to, learns from and responds to positive and negative feedback and lived experience, the details of which are contained within the regular Perinatal Quality Surveillance Report. The experiences contained within this report are recent reflections of a parent's experience of the care their children received in our neonatal services and a reflection from a senior midwife from our Maternity and Neonatal Services.		
Recommendation	The Board is asked to receive both experiences, for information and to note our commitment to learning from all experiences of receiving and providing care.		
Links to Strategic Objectives	**Advancing Care** - improving patient care, effectiveness and quality through innovation, research, improvement and education **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 experience was shared with the Neonatal Team and some of the Executive Team by a family who wanted to share their reflections of the care they experienced whilst their twin boys were cared for in the neonatal unit.

Reflections:

Those were the longest 3 months of our lives, but the whole experience was made just about bearable due to the exemplary level of care that our boys received on the neonatal unit. I therefore felt the need to feed it back.

The medical care was fantastic, and the consultant team were diligent, invested, knowledgeable, and did a great job of involving us as parents, both explaining the reasons and options for treatment and care, as well seeking our opinion on a whole host of matters. Importantly, it felt to us like they genuinely cared for the boys and their care.

The important high nursing:patient ratios, combined with our long "shifts" in the unit meant that we spent more time with the neonatal nursing staff than we have our family and friends. The level of care was outstanding. The attention to detail was as fantastic as their nursing skills. Most importantly for us as parents, the nursing staff made it their mission to ensure the boys were looked after almost as their own, whilst incorporating our individual concerns/idiosyncrasies/preferences. Many of the nurses picked us up off the floor (metaphorically and sometimes almost literally) and do a stellar job in listening to, and borderline counselling, parents in a way I'm not sure they are trained to.

I obviously can't comment on the culture from within the department, but to a relative looking from the outside, it seemed like a really positive and healthy culture of prioritising patient care and supporting parents. Staff were professional and respectful of colleagues.

I was nervous being a "long-term patient" as I know from the other side how things will always go wrong at some point and that hospital care is never perfect, but I was really pleasantly surprised with the level of care, the minimal numbers of inevitable errors/mishaps and candour which came immediately following them, and the attitude of staff towards their patients and their relatives.

I could go on for a lot longer, listing all the positives but an email can't do justice to just how much the team helped us (and all the other families we met) in our darkest time, not to mention the small detail of keeping our sons alive! It is a really odd and horrifying feeling, going home from hospital and not taking your tiny newborn babies with you, instead leaving them "alone" with strangers. Only, thanks to the neonatal team, we didn't feel like they were alone, and we sometimes even managed some sleep because we knew they were in safe, capable, and caring hands. We will forever be grateful.

Overall, we found the whole neonatal team (nurses, housekeepers, dieticians, feeding team, physios, Ots [Occupational Therapists], doctors etc.) to be a wonderful group of staff who embody the values of the trust and are simply a credit to Newcastle Hospitals.

Colleague Experience

Context:

This experience was shared by one of the Delivery Suite Co-Ordinator's who was recently interviewed to understand their experience of working within the peri-natal service. It includes reflections on their career development, the challenges of their current role and on the recent national maternity publications.

Reflections:

There was a time when I used to come home from a shift on Delivery Suite in tears. When I first qualified and was rotating around different areas, Delivery Suite terrified me. It was high risk, busy, stressful and emotional. It could feel completely overwhelming.

Then, as my confidence grew, something changed. A core midwife position came up, and I remember telling my family that I was going to apply. They said, "What? Are you joking? You used to come home in tears." And I said, "Yes, but I love it now."

My journey into midwifery was never something I took for granted. I grew up in a family where nobody had been to university before. We did not have a lot of money, so even getting to university felt like quite a big deal. At the beginning of my training, I was going through a difficult time personally. I failed my first OSCE [Objective Structured Clinical Examination] and remember thinking, "Oh no, I've done the wrong thing." But people around me encouraged me to keep going.

I graduated with a First and received a student midwife award from Newcastle. I was a single mum with two young children and the award came with some prize money. It allowed me to buy my children's passports, which I could never have afforded at the time. That little bit of recognition meant so much to me. I knew I did not want to work anywhere else.

After being a core midwife for a while, I trained as a coordinator. I was so frightened at first because coordinating Delivery Suite at the RVI [Royal Victoria Infirmary] is something else. You are spinning so many plates all at once. You are managing a large team, sometimes caring for 24 women, overseeing the caesarean section theatre and keeping an overview of everything that is happening. Having done this now for almost 3 years, I absolutely know that this is me and I do not want to do anything else. I think it is that feeling you get when you find your calling.

No two shifts are ever the same. Sometimes women arrive and there are no empty rooms. A midwife might deliver one baby and immediately need to care for another woman. It can be relentless. I sometimes explain it is a bit like A&E [Accident and Emergency] - unpredictable.

There is so much attention on maternity services nationally at the moment. Reading the Ockenden and Amos reports was difficult. I remember thinking that I felt really sorry for the staff working in those units. It also made me reflect on what we have in Newcastle and how

important it is that staff feel able to speak up, escalate concerns and know they will be supported. For me, that support makes a massive difference.

If there is sickness, the unit is full or I feel something is unsafe, I know I can say so. We have daily safety huddles, with people from every area talking honestly about the pressures they are facing and whether one team can support another. Those huddles have helped to break down barriers and build better relationships.

If something major happens at three o'clock in the morning, I also know there is someone at the end of the phone. Sometimes they might come in. Sometimes they listen to my plan and say, "Yes, I agree. Carry on and ring me back if you need me." That reassurance can be exactly what you need.

My team is what keeps me coming back too. If we have a bad outcome or feel challenged by something, we get each other through it.

Recently, we cared for a woman who arrived by helicopter. I had never experienced anything like it before. It happened at handover, when I was due to finish, but I stayed to help. It was incredibly challenging. On my drive home, my adrenaline was still through the roof, so I rang a senior colleague and debriefed. She listened and was really complimentary about what the team had done. That was all I needed. I did not go home thinking we had done something wrong. I went home feeling really proud of the team.

What people do not always see is how much midwives care. During a particularly complex caesarean section and hysterectomy, I encouraged the midwife to come away for at least half an hour. She said, "I'm not. They're about to deliver the baby and I don't want to leave her."

Patient safety is also about being open when things do not go as planned. I feel we have moved away from a blame culture. If there is an error, we look at what happened, whether the system let them down and what we can change. The important thing is being honest, supporting the staff involved and learning – not blaming.

If every member of the Board could spend a day on Delivery Suite, I would want them to see the kindness and really good teamwork, from our domestics all the way through to our consultant anaesthetists. I would want them to see women in our care feeling safe.

I feel very lucky to work at Newcastle. Years ago, people might have looked at the coordinator role and said, "Absolutely not. I am not doing that." Now we have core midwives who want to become coordinators. They can see that it is difficult, but also that it is respected and well supported.

I think that says a lot about where we are as a service. Despite the pressure and the difficult days, I still love coming to work. I do not want to do anything else.

Report of Ian Joy
Executive Director of Nursing, Midwifery and Allied Health Professionals
25 September 2026

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Agenda item A3(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 September 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 (UEC) • Cancer • Quality & Safety • People – Medical Workforce Update • Partnerships update • Medical Education • 10 Point Plan Update • Improvement Groups update • Alliance Clinical Framework Group • Emergency Preparedness, Resilience and Response (EPRR) update		
Recommendation	The Trust Board is asked to: i) Note the contents of the report. ii) Note the ongoing challenges with demand on urgent and emergency care services. iii) Note the 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
	☒	☐	☒	☒	☐	☐

Link to Board Assurance Framework [BAF]	Failure to meet our care standards in a way which is designed around people, not organisations. Failure to coordinate services which are effective. Inability to improve patient safety and patient harm through reliable, evidence-based care.
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

Performance

August Type 1 performance was 57.79% with an overall performance once Eye Casualty and Urgent Treatment Centre (UTC) patients are included of 77.01%. This is significant reduction in Type 1 performance compared to the same period last year. Type 1 adult majors attendances remain higher than the same period and probably reflect the additional activity generated as a result of the onsite UTC. We have moved to 11th in the country at reducing 12 hour Emergency Department (ED) breaches and continue to have a focus on eliminating corridor care.

Admission Avoidance

Schemes to reduce hospital attendances are increasing in activity with 112 admissions into the Frailty Virtual ward in August 2026 compared to 23 in August 2024, 529 Urgent Community Response (UCR) contacts in August 2026 compared to 450 in August 2024 and a small number of "call before convey" call from the North East Ambulance Service (NEAS) to community teams.

Discharge

In July/ August 2026, 1-1.36% of beds were occupied by patients awaiting either a care package or care home placement. A further 392 bed days were lost due to patients awaiting repatriation to surrounding trusts and we are working with partners in the region to address opportunities for pathway improvement. There is a growing challenge with increasing admissions in the homeless population and work is underway with the local authority towards a collaborative approach to best support this group of patients. Longstanding plans to digitalise bed management across Newcastle Hospitals should be in place in time for this winter.

Emergency Department/ Urgent Treatment Centre/ Acute Medicine

In response to deteriorating Emergency Department performance and increasing levels of corridor care, a coordinated improvement programme has been implemented through the Medicine and Emergency Care Coordination (MECC) Board. Key actions include:

- Introduction of a weekly multidisciplinary performance review meeting, chaired by the Clinical Board Chair, to provide focused oversight of Emergency Department performance, patient flow and corridor care.
- Acceleration of the Frailty Same Day Emergency Care service, with phased opening brought forward to September 2026 to support admission avoidance and reduce Emergency Department demand.

- Launch of an Emergency Department Ambulatory Majors (EDAM) pilot model, providing dedicated consultant-led assessment of ambulatory Type 1 patients and creating additional clinical streaming capacity.
- Implementation of three-times-daily Emergency Department operational briefings to strengthen early senior escalation, improve patient safety oversight and support delivery of the four-hour standard.
- Intensified patient flow interventions, including enhanced nursing and leadership oversight, strengthened discharge processes, daily bed capacity reviews, criteria-led discharge initiatives and twice-weekly executive-led escalation meetings to address speciality response delays.
- Ongoing development of Urgent Treatment Centre capacity, including discussions with Newcastle GP Services regarding increased winter GP cover and expansion of the successful senior decision-maker model, which has demonstrated diversion of approximately 20 patients per day away from the Emergency Department to a more appropriate setting.

Collectively, these measures are intended to improve patient flow, reduce delays in care, minimise corridor care, strengthen clinical oversight and support recovery of urgent and emergency care performance ahead of winter pressures.

Blood Borne Virus (BBV) Opt-Out Testing

The Emergency Department Blood Borne Virus Opt-Out Testing Programme continues to deliver significant benefits for both individual patients and population health. Since implementation in March 2025, over 31,900 tests have been undertaken, identifying 89 previously undiagnosed cases of Hepatitis B, Hepatitis C and HIV. Patients diagnosed through the programme are being successfully linked to specialist treatment and support services, helping to reduce health inequalities, improve outcomes and prevent onward transmission of infection. This work is integral to deliver the national ambition to end all new HIV transmissions in England by 2030.

ii) Digital & Data Update

During late August and early September 2026, Newcastle Hospitals experienced some issues following an upgrade to the ICE system, which is used for pathology and radiology results reporting. The incident resulted in disruption to interfaces between the Trust and primary care, affecting the transmission of results and letters to GP practices. Most technical issues were resolved within a few days; the Trust has focused on strengthening communication mechanisms with primary care, and ensure appropriate governance, risk review, and learning from the event.

2. CANCER

28 Day Faster Diagnosis

Agenda item A3(b)

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	Jul-26
Brain/CNS	Actual			100.0%	100.0%		100.0%	100.0%			100.0%	50.0%	100.0%	0.0%	100.0%
Breast	Actual	95.4%	95.5%	92.9%	92.8%	94.1%	94.2%	90.5%	89.0%	96.1%	91.9%	86.2%	88.7%	83.3%	83.6%
Breast Symptomatic	Actual	55.5%	47.0%	38.7%	33.3%	34.5%	42.8%	44.4%	26.0%	49.3%	47.3%	30.4%	22.7%	41.9%	62.6%
Childrens	Actual	50.0%	100.0%	50.0%	100.0%	14.3%	50.0%	50.0%		100.0%	100.0%	100.0%	85.7%		100.0%
Colorectal	Actual	71.0%	75.1%	74.5%	71.1%	73.2%	69.6%	74.0%	64.8%	76.2%	69.9%	61.9%	66.8%	72.2%	65.5%
Gynae	Actual	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%	86.1%
Haematology	Actual	80.0%	86.7%	84.6%	100.0%	81.3%	90.9%	50.0%	66.7%	77.8%	68.8%	66.7%	84.6%	87.5%	88.9%
Head & Neck	Actual	89.0%	87.0%	90.6%	95.3%	95.4%	93.9%	91.0%	89.8%	92.6%	92.3%	88.2%	91.5%	87.4%	82.9%
Lung	Actual	84.8%	74.4%	76.3%	80.0%	81.3%	84.8%	89.3%	62.5%	85.3%	92.6%	75.0%	74.2%	72.2%	90.0%
NSS	Actual	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%	100.0%
Other	Actual	0.0%	100.0%			100.0%		100.0%		0.0%	100.0%				
Sarcoma	Actual	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%	90.0%
Skin	Actual	74.9%	63.9%	61.6%	53.3%	53.4%	47.0%	46.1%	54.1%	90.5%	96.9%	94.8%	96.9%	97.5%	97.0%
Testicular	Actual	90.0%	100.0%	100.0%	88.9%			100.0%		100.0%	87.5%	100.0%	90.0%	90.9%	100.0%
Upper GI	Actual	84.3%	80.0%	93.2%	89.5%	82.2%	80.6%	85.9%	77.9%	85.2%	88.4%	81.5%	84.6%	83.5%	81.7%
Urology	Actual	65.4%	69.9%	73.4%	76.3%	79.0%	75.5%	74.1%	62.0%	69.7%	71.9%	69.9%	72.1%	59.0%	65.8%
HPB	Actual	60.0%	42.9%	62.5%	70.0%	66.7%	62.5%	42.9%	60.0%	60.0%	88.9%	50.0%	57.1%	75.0%	66.7%
OGD	Actual	86.3%	86.0%	91.9%	91.2%	84.4%	82.1%	89.5%	78.9%	86.8%	84.4%	82.8%	87.1%	83.2%	79.6%
Trust Total	Actual	78.1%	74.1%	72.0%	68.6%	69.1%	65.5%	68.3%	66.5%	85.6%	86.4%	83.1%	85.0%	84.6%	85.3%

62 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	Jul-26
Brain/CNS	Actual	100.0%	82.6%	83.3%	100.0%	100.0%	100.0%	92.9%	89.5%	81.8%	85.7%	85.7%	83.3%	92.9%	83.3%
Breast	Actual	89.8%	92.1%	83.5%	86.5%	82.8%	78.6%	86.3%	74.8%	78.8%	76.4%	77.5%	71.4%	77.5%	76.7%
Childrens	Actual	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	Actual	38.2%	40.8%	40.0%	53.7%	48.6%	68.7%	44.4%	59.1%	42.9%	32.3%	58.3%	35.8%	41.3%	37.9%
Gynae	Actual	79.2%	42.9%	52.0%	50.0%	39.1%	71.4%	70.3%	83.3%	84.2%	78.6%	84.2%	56.3%	65.0%	70.4%
Haematology	Actual	81.6%	83.9%	76.1%	64.7%	96.2%	88.2%	86.4%	77.4%	90.9%	82.9%	72.3%	79.4%	86.9%	94.2%
Head & Neck	Actual	75.8%	79.7%	76.3%	72.2%	90.7%	82.5%	70.5%	65.8%	80.5%	86.5%	76.8%	64.3%	74.5%	58.8%
Lung	Actual	40.7%	63.5%	56.0%	56.9%	58.6%	49.6%	48.2%	44.1%	39.1%	38.6%	37.0%	41.1%	40.2%	36.2%
Other	Actual	100.0%	83.3%	50.0%	69.2%	71.4%	100.0%	87.5%	50.0%	100.0%	83.3%	44.4%	50.0%	62.5%	50.0%
Sarcoma	Actual	100.0%	63.6%	78.9%	70.0%	88.9%	84.2%	60.0%	57.1%	86.7%	66.7%	56.0%	100.0%	78.9%	56.3%
Skin	Actual	89.7%	90.5%	94.7%	90.7%	85.3%	86.5%	87.2%	87.8%	88.1%	93.2%	94.9%	96.5%	95.5%	97.6%
Upper GI	Actual	41.8%	49.6%	49.1%	47.4%	49.5%	44.4%	64.3%	38.1%	41.7%	43.6%	29.5%	35.0%	42.0%	49.5%
Urology	Actual	41.3%	55.1%	60.2%	52.3%	67.0%	61.1%	56.5%	57.8%	50.6%	50.0%	47.0%	56.0%	48.1%	65.5%
HPB	Actual	34.7%	50.7%	45.2%	54.7%	46.8%	45.3%	54.8%	38.1%	46.6%	42.2%	26.5%	35.1%	41.4%	54.2%
OGD	Actual	50.0%	47.9%	54.3%	30.4%	58.3%	42.9%	80.6%	38.1%	20.0%	47.1%	35.1%	34.8%	43.3%	33.3%
Trust Total	Actual	63.9%	71.1%	70.2%	70.4%	71.6%	71.1%	72.9%	66.1%	68.6%	63.9%	65.0%	65.1%	65.6%	66.8%
NHSE	Target	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%	85.0%

= 100%

Key:

- *CNS – Central Nervous System*
- *NHSE - NHS England*
- *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, driven by strong performance in dermatology, despite the usual summer pressures, partly as a result of pathway changes,

adjustments to tracking procedures and additional outpatient activity provided over the summer months.

ii) Breast

Challenges remain in the symptomatic breast service (28 day performance in particular) though there is currently month on month improvement. There has been an impact of the County Durham and Darlington NHS Foundation Trust (CDDFT) patient pathway change across the region. The Newcastle Hospitals team have maximised capacity for Waiting List Initiative (WLI) work. Close monitoring continues both in terms of performance and referral patterns. The business case for right sizing of the service has been submitted to the Integrated Care Board (ICB). It is our position that recurrent funding is necessary to allow recruitment particularly to consultant radiographer and radiologists posts.

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. When broken down by treatment modality, 62 day performance is approximately; surgery 80%, palliative care 80%, chemotherapy 60%, radiotherapy 20%.

For patients transferred for treatment a breach is not incurred by the Trust if patients are treated within 24 days of inter-provider transfer (IPT). Currently we hit this target in 20% of cases. This is a focus in Patient Tracking List (PTL) meetings and we are working to increase visibility of this secondary target. Work is ongoing to ensure IPT dates are correctly recorded. An updated policy is expected from the Northern Cancer Alliance.

Specific issues are highlighted below:

Radiotherapy

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. 11 colleagues have been recruited to start during September 2026 but will require training in the role as they are recent graduates. Currently Linear Accelerators (LINACs) are underutilised in both Newcastle and Cumbria because of staff shortages. Referrals continue to be clinically prioritised, and an action plan is in development to provide assurance that all possible mitigations are in place.

A radiotherapy action plan is in place which includes: changing the training pathway to ensure newly recruited staff can maximise their contribution as early as possible; trialling new ways of working to try to reduce time per appointment for more straightforward plans; over-recruit radiographers when possible; explore options for radiographer training in the North East in conjunction with James Cook Hospital.

Alongside these measures a business case has been submitted to ICB for rightsizing the team based on benchmarking against other radiotherapy centres alongside recent Getting It Right First Time (GIRFT) feedback. The proposal is a phased model over 3 years to facilitate treatment delivery and development of new techniques recommended by GIRFT. Discussions have commenced with commissioners. The total case comprises 94 new whole-time-equivalent (WTE) posts.

Ablation

As per previous reports there is ongoing development of a revenue case to support the capital funding agreed earlier this year. The aim is to have plans submitted to the building regulatory team by December 2026 alongside a funded staffing model.

Endoscopy

Capacity in endoscopy continues to negatively impact 28-day outcomes in upper GI and colorectal pathways. An endoscopy working group has been established and an options appraisal is awaited. In the short term a banding uplift has been agreed for nurse endoscopists which should allow a greater number of lists to be backfilled by nursing colleagues thus increasing capacity.

Tertiary Referrals and Region-wide Pathways

The inherent pathway delay that occurs when a patient needs to be seen at a tertiary unit for treatment is acknowledged. It is important that referrals reach the tertiary centre as early in the pathway as possible and the treatment ensues (24-day rule) as rapidly as possible. A regional performance group has been established by the Northern Cancer Alliance to link regional Chief Operating Officers (COOs), with the first meeting in September 2026.

3. QUALITY AND SAFETY

Six Never Events have been reported during 2026/27, with comprehensive Patient Safety Incident Response Framework (PSIRF) reviews underway and Trust-wide improvement actions focused on procedural safety, implementation of NatSSIPs2, strengthened medical gas safety controls and enhanced organisational learning. Clinical audit and guideline oversight will strengthen through the introduction of a new Clinical Effectiveness Register, improved monitoring of national audit performance and a review of local clinical guideline governance. Learning from incidents, audits and national benchmarking is being translated into targeted quality improvement actions, although further work is required to improve compliance with clinical audit programmes and address risks relating to guideline management and accessibility. Oversight will be maintained through the Quality Committee.

4. PEOPLE – MEDICAL WORKFORCE UPDATE

A bespoke Clinical Director and Head of Department Development Programme has been designed to support current and aspiring medical leaders across the Trust. The programme

comprises six structured workshops covering leadership, people management, finance and business planning, quality and safety, and strategic job planning. Developed in partnership with TheValueCircle and aligned to the Newcastle Excellence Programme, it seeks to strengthen the capability, confidence and consistency of medical leaders in delivering high-quality services, leading teams and supporting the Trust's strategic objectives.

5. PARTNERSHIPS

Primary Care Interface and Engagement

Engagement with primary care has focused on strengthening relationships with Newcastle GP Services, Primary Care Network (PCN) Clinical Directors and Local Medical Committee (LMC) Chairs. A structured programme has been agreed to address longstanding interface issues on a prioritised, monthly basis, with consideration being given to replacing the GP Concerns Inbox with a more responsive GP Feedback and Alert System.

Three services have now implemented the Single Point of Access model following a dedicated GP engagement event, with further service roll-out and engagement planned, including a further event in November.

The recent ICE upgrade incident highlighted the need for more robust communication arrangements with primary care. Work is underway with the ICB and primary care colleagues to establish an agreed mechanism for urgent operational communications and service updates.

6. MEDICAL EDUCATION

Undergraduate Medical Education

The 2026/27 academic year has commenced with a total of 236 medical students across Years 3 to 5 (Year 3: 69 students plus 11 Newcastle University Community-Based Medicine Programme students; Year 4: 83 students; Year 5: 84 students). While student numbers remain high, educational capacity continues to be challenged by a reduction in Teaching Fellow (TF) posts from 29 in 2025/26 to 26 in 2026/27, with the Obstetrics & Gynaecology Teaching Fellow start date still to be confirmed.

Student wellbeing requirements continue to rise significantly, with the number of students requiring pastoral support increasing from 90 in 2025/26 to 125 in 2026/27. To strengthen this area, a Pastoral Tutor and a Medical Assistantship Lead have been appointed by the undergraduate team.

Other developments include:

- An Undergraduate Medical Education (UGME) Tariff Meeting is scheduled for 12 October.
- Discussions continue with St George's University (Northumbria) regarding delivery of Early Clinical and Community Experience (ECCE) placements.

- Ongoing monitoring of educational capacity and resource requirements remains a priority.

Postgraduate Medical Education

Dr Ian Forrest, Consultant Respiratory Physician and current Deputy Director of Medical Education (DME), has been appointed as the new Director of Medical Education, with a start date to be confirmed.

The first phase of the national expansion of postgraduate medical training places has concluded successfully across the North East. Newcastle Hospitals secured additional training capacity through successful bids for:

- A Paediatric Surgery Core Training (CT) post.
- An Internal Medicine Training (IMT) post in Clinical Pharmacology and Therapeutics.

A further national expansion of 750 posts is planned for August 2027. These posts will be funded through placement fees only, with associated study leave and educational funding. To date, only one local bid (Histopathology) has been submitted, with financial sustainability identified as the principal barrier to wider participation. Engagement with Clinical Boards is continuing.

National policy direction indicates that Locally Employed Doctor (LED) posts should move towards permanent employment arrangements. This has significant workforce, contractual and educational implications, particularly regarding supervision, training opportunities and portfolio requirements. A dedicated working group is being established to oversee implementation and workforce planning.

Additional updates include:

- The Annual Deanery Quality Management (ADQM) review took place on 11 June 2026; the formal report is awaited.
- The General Medical Council (GMC) National Training Survey findings have been shared with Medical Directors, Board Chairs, Clinical Directors and educational leads and discussed at Medical Directors Group meetings.
- Notable improvement has been reported in the trainer survey metric relating to ‘time for training’, with the Trust no longer an outlier.
- Trust-wide action planning is underway following survey results, with targeted support being offered to areas identified as outliers.
- Resident doctors returned to Cardiothoracic Surgery training placements from August 2026, with continued monitoring by both the Trust and NHS England.
- A review of the Medical Education Tutor team, including remuneration arrangements, is underway.
- The Annual Medical Education Conference will be held at the Catalyst on 29 April 2027, with the programme currently being developed.

7. 10 POINT PLAN

Delivery of the NHS England Resident Doctor 10 Point Plan remains on track, with progress reported across workforce wellbeing, facilities, education, supervision and engagement. A

Trust-wide action plan is being implemented through the Resident Doctor Steering Group, with ongoing oversight to ensure delivery of national standards and improvements in resident doctor experience, recruitment and retention. A final implementation gap analysis will be presented for Board approval prior to submission to NHS England in December 2026. Running in parallel, there is ongoing work at board and directorate level around the themes arising from the GMC survey, with appropriate action plans to improve where needed. Two new chief registrars have been appointed to the Trust meanwhile.

8. IMPROVEMENT GROUPS

i Deteriorating Child

The Trust continues to progress its Deteriorating Child Improvement Programme, focused on strengthening the recognition and management of clinical deterioration in children. Work remains centred on improving escalation processes, standardising practice, enhancing staff capability and providing assurance through governance and learning systems. Work to establish an outreach service by the end of the year continues and is overseen by this work.

ii Infection Prevention and Control (IPC)

IPC performance remains a key organisational priority. Improvement work continues across healthcare-associated infections, antimicrobial stewardship, surveillance and assurance processes, with a focus on reducing avoidable infections, strengthening compliance with best practice, and supporting patient safety and quality of care. Progress is reported to the Quality Committee.

iii Transplantation Committee / ARC

The Transplantation Committee continues to oversee delivery of the Trust's transplant strategy, including organ utilisation, service development, governance and performance. The Trust's transplant utilisation strategy has received commendation from NHS Blood and Transplant. Current priorities include increasing access to transplantation, optimising donor organ utilisation, supporting national programme developments and ensuring the successful progression of Assessment and Recovery Centre (ARC) related infrastructure and operational developments from a pilot centre to a fully commissioned unit.

9. ALLIANCE CLINICAL FRAMEWORK GROUP

The Alliance Clinical Framework Group continues to provide clinical collaboration to enable pathway improvement across Alliance partners. Current priorities focus on cancer services, particularly lung and urology pathways, through pathway redesign, reduction of unwarranted variation and strengthened clinical collaboration. The expected benefits include improved patient outcomes and experience, more consistent standards of care, enhanced pathway performance and better utilisation of clinical expertise across the Alliance. Future areas of work are also being identified, for example, improving patient experience and care through the last stages of life.

10. EPRR

The Trust remains substantially assured in relation to its EPRR responsibilities. The 2026 self-assessment demonstrates compliance with the vast majority of NHS England Core Standards, with no areas assessed as non-compliant. Six standards remain partially compliant, principally relating to EPRR staffing capacity, pandemic preparedness, evacuation planning and business continuity development. Action plans are in place to address these gaps ahead of the forthcoming NHS England EPRR assurance review, due on 16th October. The board will receive a full report following that review. The latest version of the self-assessment is included in the Board Reading Room for information.

11. 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
16 September 2026

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Agenda item A3(c)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 September 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 Report • **Section 2**: Fairer Pay for Nursing • **Section 3**: Registered Nurse Degree Apprenticeship • **Section 4**: Vaccination Update • **Section 5:** Face Fit Testing The following key points/risks are noted for the Trust Board's attention: **Alert:** • Staffing pressures within the Emergency Department due to high attendances along with service reconfiguration and estates work have impacted on key clinical metrics. Oversight is managed through established escalation processes with an update provided for the Quality Committee in September. (**Section 1)** **Advise:** • Increased nursing staffing incidents were reported, particularly within Adult Critical Care Outreach and the Cardiothoracic Intensive Care Unit driven by sickness absence, unfilled shifts and workforce pressures. These reflect known workforce pressures in a small number of specialist services rather than a Trust-wide deterioration in staffing. Local oversight remains in place with root cause analysis reviews underway to identify sustainable solutions. **(Section 1)** • The Trust continues to progress delivery of the Fairer Pay for Nursing programme, including implementation of the national Band 5 Job Evaluation review. An update is provided in the report and there are no new escalations to note. **(Section 2)** • Preparations for the 2026/27 staff vaccination campaign are progressing to plan and will support future workforce sustainability and resilience. There are no new risks to note and detail of progress is contained within the report. **(Section 4)** • Staff fit testing compliance is being closely monitored in line with a national focus on compliance improvement in NHS England (NHSE) preparedness expectations. Compliance benchmarks well when compared nationally but at circa 50%, is well below the national target. Improvement actions are outlined within the report. **(Section 5)** **Assure:**		

<table>
<tr><td></td><td colspan="6">Trust-wide nurse staffing escalation remains at Level 1, with established governance arrangements maintaining safe staffing levels. No wards required high-level support during the reporting period, fill rates remain above escalation thresholds, turnover continues to improve, and fit testing compliance is significantly above the reported national position. Robust oversight arrangements remain in place through the Nurse Staffing and Clinical Outcomes Group and Executive Director governance processes. (Section 1)
Recruitment and retention remain positive, with reduced turnover rates. (Section 1)</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Board of Directors is asked
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 ‘Fairer Dear for Nursing’ programme delivery.
iv. Note the vaccination programme delivery.
v. Note the face fit testing compliance and benchmarking</td></tr>
<tr><td rowspan="2">Link to Strategic Priorities</td><td colspan="2">Joining up care</td><td colspan="2">Advancing care</td><td colspan="2">Supporting great care</td></tr>
<tr><td colspan="2">☐</td><td colspan="2">☒</td><td colspan="2">☒</td></tr>
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(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
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<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">Failure to meet our care standards in a way which is designed around people, not organisations.
Inability to improve patient safety and patient harm through reliable, evidence-based care.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">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.</td></tr>
</table>

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. Nurse Staffing Metrics are reported live in the Nurse Staffing Metrics Dashboard in the Newcastle Hospitals reporting hub.

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. Staffing pressures within the Emergency Department due to sustained high attendances along with service reconfiguration and estates work continue to be managed through established escalation processes. Urgent Treatment Centre triage risks are being mitigated through Emergency Department support while a sustainable staffing model is developed.

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

- 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

Monitoring of nursing safer staffing metrics incidents continues through the Nurse Staffing and Clinical Outcomes (NSCO) Group. These measures are reviewed alongside clinical outcomes, nurse-sensitive indicators, patient experience data and professional judgement concerns to identify emerging risks, target support and provide assurance regarding safe staffing arrangements. Perinatal services are not included within this section, as the monitoring and reporting of the workforce, quality and safety indicators is through the Perinatal Operational Assurance Group. Further information regarding the NSCO process is provided within the reading room. An overview for the last quarter is provided below:

Month	Total	Clinical Board	High level support	Medium level support	Low level support
Jun 26	5	Family Health			GNCH 1a, 1b, 2, 9, 12
	6	Surgical & Specialist			RV15, RV16, RV43, RV20, RV22, RV23,
	1	Perioperative			FH37
	1	Cardiothoracic			FH21
	4	Medicine & Emergency Care			RVAS, RV44, RV48, FH13,
	2	Surgical & Associated			FH03, FH08
	1	Cancer & Haematology		NCCC34	
	20		**0**	**1**	**19**
Jul 26	5	Family Health			GNCH1a, 1b, 2, 9, 12
	3	Surgical & Specialist			RV22, RV15, RV16
	0	Perioperative			
	1	Cardiothoracic			FH21
	4	Medicine & Emergency Care			RVAS, RV44, FH13, FH16
	1	Surgical & Associated		FH08	
	1	Cancer & Haematology		NCCC34	
	15		**0**	**2**	**13**
Aug 26	5	Family Health			GNCH 1a, 1b, 2, 4, 9
	3	Surgical & Specialist			RV22, RV15, RV16
	0	Perioperative			
	1	Cardiothoracic			FH30
	5	Medicine & Emergency Care			RVAS, RV44, FH13, FH16, FH20
	2	Surgical & Associated		FH08	FH02
	1	Cancer & Haematology		NCCC34	
	17		**0**	**2**	**15**

Key:
AS – Assessment Suite
FH – Freeman Hospital [followed by Ward number]
GNCH – Great North Children's Hospital [followed by Ward number]
NCCC – Northern Centre for Cancer Care [followed by Ward number]
RV/RVI – Royal Victoria Infirmary [followed by Ward number]

The key points to note:

- No wards required high-level support during the reporting period, indicating sustained stability.
- Wards requiring medium-level support increased to two in the last quarter. Formal action plans are in place, with progress monitored through the NSCO Group.
- In line with NSCO processes, Ward 34 NCCC has completed a nurse staffing review and will now undergo peer review, having remained at medium-level support for more than six months. Findings will be reviewed by the EDoNMAHPs to determine any further actions required before moving to de-escalation.
- Key improvement themes identified during the quarter include:
  - Infection prevention and control (IPC), medication safety and leadership continue to be recurring themes.

- Staffing has emerged as a new theme this quarter, with challenges relating to vacancies, skill mix, sickness absence, turnover and e-rostering practices. This applies to a small number of services rather than across the organisation with local actions and mitigations in place or being explored.

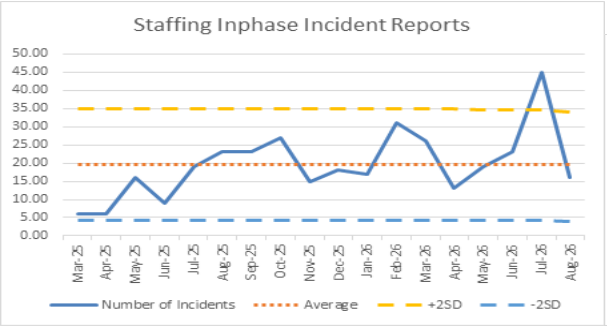
- eObservations and the management of the deteriorating patient are no longer predominant themes, reflecting the impact of improvement work led by the deteriorating patient team in partnership with Clinical Boards and ward leadership teams, with oversight through the NSCO Group.

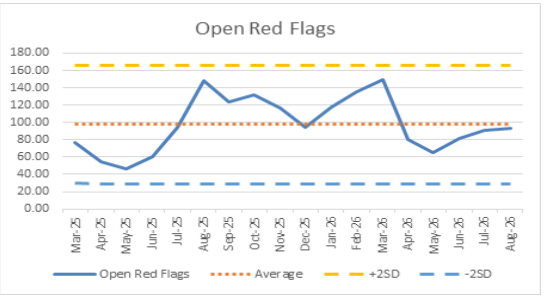
1.3 Inphase staffing incident reports and Red Flag data

Nursing and midwifery staffing incidents and SafeCare red flags continue to be monitored and reviewed through established nurse staffing governance processes. These measures provide an early indication of staffing pressures and are reviewed alongside workforce, quality and patient safety indicators to identify emerging themes and inform workforce planning decisions. Perinatal services do not report SafeCare red flags. Further information on governance arrangements is provided in the reading room.

The key points to note:

- Staffing incidents increased during the quarter, rising from 19 incidents in May 2026 to 23 in June, and 45 in July. The July position exceeded the upper control limit and was primarily associated with sickness absence, unfilled shifts and workforce pressures within Adult Critical Care Outreach and ECMO (extracorporeal membrane oxygenation) services.
- The increase in staffing incidents reflects known workforce pressures in a small number of specialist services rather than a Trust-wide deterioration in staffing performance. Mitigations were implemented and continue to be monitored through existing governance processes.
- Open red flags remained within expected limits throughout the quarter, although variation was observed between clinical areas. The most frequently reported red flag continued to be shortfall in registered nurse time.
- Emergency Department red flags and staffing concerns were associated with sustained high attendance levels, departmental reconfiguration and support for Urgent Treatment Centre triage arrangements. These pressures continue to be managed through Clinical Board governance and established escalation processes.
- Review of incidents and red flags has not identified any new recurring organisational themes. Workforce pressures continue to be consistent with known challenges relating to vacancies, sickness absence, recruitment and skill mix within a small number of services.
- Staffing incident trends and red flag data continue to inform workforce reviews, establishment discussions and targeted improvement activity where required.





1.4 Care Hours Per Patient Day (CHPPD) data

CHPPD is reviewed alongside workforce, quality and patient safety indicators through the Nursing Staffing Clinical Outcomes (NSCO) process and during the nurse staffing review process and should not be interpreted in isolation. Further information regarding the use, limitations and governance of CHPPD, including ward-level monitoring and benchmarking considerations, is provided within the reading room documentation.

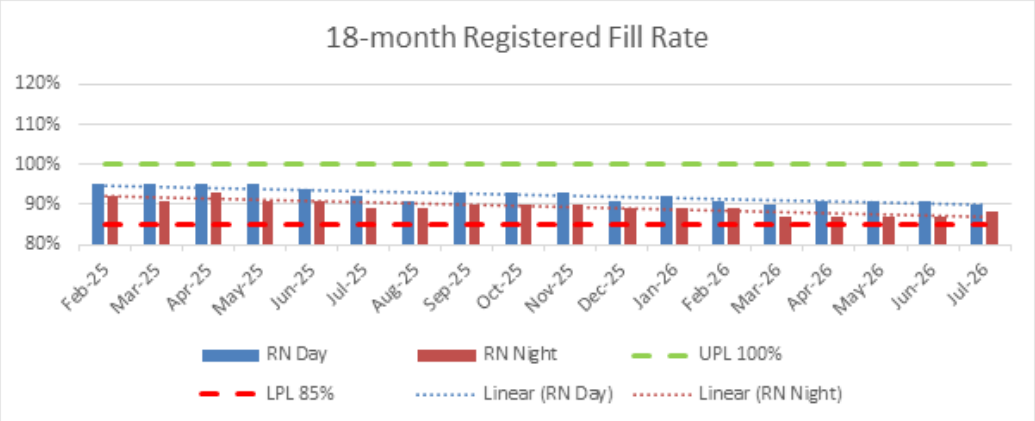
The Trust-wide CHPPD for nursing and midwifery inpatient services remained stable during the quarter, with reported CHPPD of 8.9 in May 2026, 8.9 in June 2026 and 9.0 in July 2026. This is consistent with the 18-month average of 8.9 CHPPD and indicates a stable overall staffing position across inpatient services, with variation remaining within expected limits.

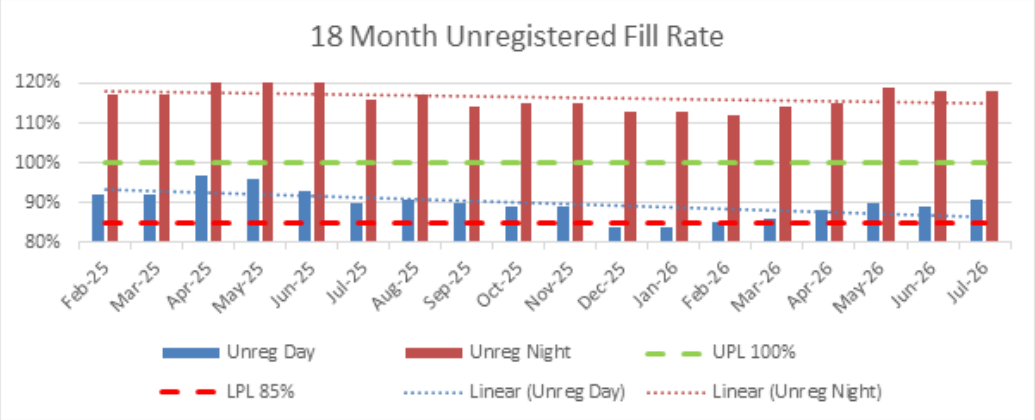
1.5 Planned versus actual hours (fill rates)

Registered Nurse and Midwife (RN/RM) and unregistered staff fill rates continue to be monitored through the safer staffing dashboard and reviewed monthly by the NSCO Group. Whilst planned staffing gaps remain in some areas, overall fill rate performance has remained stable during the quarter, supported by temporary staffing, deployment processes and local workforce mitigations. Detailed information regarding fill rate methodology, limitations and escalation arrangements is provided within the Reading Room.

Key points to note:

- Registered fill rates have remained relatively stable during the quarter. Day shift fill rates remained around 90% and night shift fill rates around 87%.
- Both day and night registered fill rates remain above the Trust escalation threshold of 85%.
- The number of wards reporting RN fill rates below 85% continues to fluctuate and is monitored through NSCO Group, Professional Practice Oversight Group and Quality Committee, with appropriate escalation and support provided where required.
- Unregistered staffing continues to provide resilience, with night shift fill rates consistently above planned levels and day shift fill rates remaining stable at around 90% throughout the quarter.
- Temporary staffing and workforce deployment continue to support delivery of planned staffing levels while recruitment, service transformation and establishment reviews progress across several services.





1.6 Temporary Staffing

Newcastle Hospitals Staff Bank provides temporary staffing to wards and departments to support short-term vacancies, unplanned absence and fluctuations in demand. Temporary staffing and agency utilisation reports are distributed weekly to the Senior Corporate Nursing Team and Heads of Nursing, providing ongoing oversight of workforce pressures and staffing mitigations. Enhanced Therapeutic Observation and Care (ETOC) hours are monitored monthly through the NHSE Provider Workforce Return to support oversight of demand, workforce utilisation and quality of care. Agency staffing is sourced through approved framework providers and used in accordance with established workforce governance and break glass processes. Temporary staffing remains an important mitigation to support safe staffing, and utilisation has remained within expected limits overall during the reporting period.

Key points to note:

- Registered temporary staffing demand reduced by 15% during the quarter. However, bank-filled duties also reduced, resulting in a small reduction in fill rates to below the long-term average, although remaining within expected limits. Continued monitoring is required to determine whether this reflects reduced bank availability or normal variation in demand.
- Unregistered temporary staffing demand remained within expected limits during the quarter. Increased bank-filled duties resulted in fill rates remaining above the long-term average, demonstrating continued resilience in the unregistered workforce.
- Bank staffing remains the primary temporary staffing solution for both registered and unregistered workforce groups. Agency utilisation remains low overall, with unregistered agency use continuing to reduce.
- Registered ETOC activity remains minimal. Unregistered ETOC hours have continued

to reduce during the quarter and are largely delivered by substantive staff, with bank utilisation remaining stable and agency utilisation continuing to decline. Despite this positive trend, a proportion of ETOC hours remain unfilled, indicating ongoing workforce risk. The ETOC pilot within Medicine remains underway and will inform future workforce planning and sustainable staffing arrangements.

1.7 Recruitment and Retention

- The current RN turnover is 4.59%. This demonstrates a continued reduction from the previously reported 6.62% in the same period last year.
- The current Healthcare Support Worker (HCSW) turnover rate is currently 6.57% and demonstrates a small increase in comparison to the same period last year.
- RN vacancy rate is approximately 2.77%, with HCSW vacancy rate higher at 9.69%
- Both HCSW and RN recruitment has been taking place six weekly from January 2026, alternating between internal and external adverts for RN.
- To address the higher HCSW vacancy rate, recruitment will be focused on apprenticeships in the next month, which supports workforce sustainability by strengthening the talent pipeline and widening access to healthcare career.
- RN recruitment focused on a bespoke event for the Emergency Department, in which 19 appointments were made. A further bespoke recruitment day is planned to support Critical Care areas across the Trust.
- Final-year nursing students due to qualify in September 2026 were invited to interview from May 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. 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. Of the 89 students successfully recruited through this process, 74 have been allocated to posts, with a further 15 candidates currently awaiting suitable vacancies. Ongoing vacancy reviews will continue to facilitate the placement of remaining candidates into substantive roles.
- Staff bank recruitment will continue for both RN and HCSWs in line with generic recruitment principles, which has proved successful in the last few months.

2. FAIRER PAY FOR NURSING

The Board is asked to note continued progress in relation to the national Nursing and Midwifery Job Evaluation Programme. Following submission of the delivery plan on 31 July 2026 the Trust has developed a core Band 5 nursing job description and is progressing a phased programme of engagement across a range of clinical services, including cancer services, critical care and community services. Workforce capacity requirements to support implementation are also being reviewed alongside emerging national and regional guidance.

The Trust's approach is aligned with the wider regional programme across the North East and North Cumbria, where all organisations have submitted delivery plans and are working in partnership with staff side colleagues and trade unions. Regional assurance highlights a shared commitment to transparent engagement and ensuring staff have opportunities to

contribute to the review process. Job evaluation capacity remains a recognised delivery risk across the region, with organisations actively strengthening capability through training, succession planning and collaboration.

In support of this work, all nursing colleagues received written correspondence jointly written by the EDoNMAHP and Chair of Staff Side on 30 July 2026. The letter provided an update on the Government's national commitment to strengthen nursing careers, improve pay fairness and ensure nursing roles are appropriately recognised through the NHS Job Evaluation Framework. It outlined the national requirement for an employer-led review of all Band 5 nursing roles, confirmed that review outcomes are not predetermined and emphasised the requirement for partnership working with staff side representatives and active involvement of frontline nurses throughout the process. The communication also summarised the significant preparatory work already undertaken within the Trust, including the establishment of a joint project group with staff side representation, the training of 24 additional job evaluation panel members, development of revised Band 5 nursing job descriptions, creation of a Trust-wide engagement plan and submission of the Trust delivery plan to NHS England. The Trust has committed to completing reviews within the next 12 to 18 months, ahead of the national October 2028 deadline, with engagement sessions, guidance and FAQs (frequently asked questions) being developed to ensure colleagues are fully informed and supported throughout the programme.

3. REGISTERED NURSE DEGREE APPRENTICESHIP

Newcastle Hospitals, through a successful application for an NHSE funding award, has identified an opportunity to expand its nursing workforce through the apprenticeship route as part of the national 2,000 More Nurse Apprenticeships Programme, demonstrating a commitment to developing the nursing workforce through alternative education pathways.

The strategic benefits of apprenticeship expansion in supporting workforce sustainability, widening participation and reducing health inequalities have been established in the Trust "grow our own" approach, enabling local people to access nursing careers while remaining within their communities. This supports the NHS 10-Year Plan ambitions by increasing access to nursing education for individuals who may otherwise face barriers to traditional university routes, while also strengthening workforce diversity, inclusion and representation.

The proposed apprenticeship model is a key mechanism for addressing recruitment and retention challenges by creating a sustainable pipeline of registered nurses by providing progression opportunities for existing staff, such as nurse associates and embedding learners within clinical teams throughout their training. The apprenticeship model is also recognised as supporting long-term workforce transformation by developing a flexible, skilled and resilient workforce capable of meeting future healthcare demands.

The Trust was awarded funding for six top-up shortened degree nursing apprenticeship places, compared with the 25 places requested. The approved places will be delivered in partnership with the University of Sunderland, with the first cohort expected to commence in January 2027 and complete in January 2029. The funding, will support employer costs associated with onboarding, supervision, placement capacity and workforce backfill,

enabling the Trust to continue developing its future nursing workforce through apprenticeship pathways.

4. VACCINATION UPDATE

Preparation for the 2026/27 Staff Vaccination Campaign is progressing in line with plan under the oversight of the Staff Vaccination Steering Group. Following submission of the Trust's vaccination delivery plan to NHSE, key workstreams including workforce mobilisation, training, communications and reporting are all underway. The proposed delivery model remains aligned to the approach used successfully in previous campaigns, with programme launch anticipated at the beginning of October, subject to confirmation of vaccine supply arrangements.

Workforce readiness is developing well. To date, 110 peer vaccinators have been recruited, with strong engagement from clinical teams. Fixed clinic preparations are advanced, with equipment, cleaning arrangements, staffing rotas and reserve capacity in place. A key area of focus remains ensuring staff can be released from clinical duties to complete required training and support delivery of the campaign.

Regional expectations for vaccine uptake remain at 60-65%, and the Trust continues to develop communications and engagement activity to support staff participation and address vaccine hesitancy. Community service preparations are progressing well, with increased volunteer support compared to last year and plans for community-based vaccination clinics on track. Digital reporting solutions and dashboard development are currently being tested, alongside automation processes to improve programme administration. Confirmation of the anticipated vaccine delivery schedule is awaited; however, planning assumptions remain based on receipt of approximately 12,500 vaccines, with regular Executive and Board updates to be provided throughout the campaign.

4. FACE FIT TESTING

Following publication of the UK Covid-19 Inquiry Module 3 Report, NHSE has reinforced expectations of Trusts to strengthen pandemic preparedness through improved FFP3 (filtering face piece class 3) fit testing, enhanced respiratory protection arrangements and accurate workforce data recording. Trusts are required to ensure fit testing status and fit testing capacity are recorded within the Electronic Staff Record (ESR)/Learning Lab for nursing, allied health professional and medical/dental staff groups by November 2026. This programme aims to strengthen workforce safety and resilience, support future emergency preparedness and provide accurate intelligence to inform national Personal Protective Equipment (PPE) supply planning. NHSE has highlighted significant under-recording nationally, with most Trusts reporting fit testing records for fewer than 25% of staff and many reporting no fit testing capacity data.

The Fit Testing Compliance Benchmark Report is provided in the reading room and demonstrates that Newcastle Hospitals is well placed to respond to these requirements and is performing above the current national benchmark. The Trust is fully compliant with ESR/Learning Lab recording and reporting requirements, supported by an automated recall

system, weekly performance dashboards and established governance arrangements. Current fit testing compliance stands at 49% across the workforce, significantly above the reported national position.

Recent service improvements have increased productivity and reduced appointment duration, while proactive management of non-attendance rates and renewed outreach activity are helping to maximise utilisation of available capacity. Actions are underway to target low-compliance groups, strengthen leadership accountability and increase uptake, with the Trust aiming to achieve greater than 80% workforce compliance by November 2026 in line with NHSE expectations.

5. RECOMMENDATIONS

The Board of Directors is asked to note and discuss the content of this report.

Report of Ian Joy
Executive Director of Nursing, Midwifery and Allied Health Professionals
10 September 2026

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 September 2026		
Title	Perinatal Quality Oversight Report, including Maternity Incentive Scheme update and 10 Point Plan for Maternity and Neonatal Services.		
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. This month the report will focus on the Trusts self-assessed position against the national priorities following the publication of the 10 Point Plan for Maternity and Neonatal Services, national triage specification and maternal care bundle, and alert to any escalations and risks in relation to compliance. **Alert**: • The Trust Perinatal Leadership Team have escalated the maternal care bundle (MCB) digital requirements to the NHS England (NHSE) regional and national maternity team and System C. There is currently no timescale for these to be resolved. Further details are contained within the report. • The Trust Perinatal Leadership team have escalated to the Local Maternity and Neonatal System (LMNS) and Integrated Care Board (ICB) the lack of a commissioned pathway for Low Molecular Weight Heparin (LMWH) to be prescribed prior to booking by Primary Care, this issue will be escalated via the Family Health Quality Performance Review as no progress has been made since the publication of the MCB in January 2026. **Advise:** • The Perinatal Leadership Team have completed a benchmarking of the Trust position against the objectives of the MCB, details of which can be found in the report. Collation of Quarter 1 & 2 audit data is underway. • As outlined in the report, there are 2 actions from the 10 Point Plan for Maternity and Neonatal Services at risk of non-compliance by 31 December 2026, relating to patient experience data and triage provision. • There are 3 principles from the national triage specification at risk of non-compliance within the next 12 months. Even with significant investment it is unlikely the Trust could achieve the requirements for obstetric consultant medical staffing, estate provision, and call recording. • The number of audits and data points which are required to be reported, with the majority requiring manual audit, will have a significant impact on staffing capacity which will need to be balanced with clinical care provision. This will be monitored by the		

<table>
<tr><td></td><td colspan="7">Quality and Safety Group with appropriate escalation via the Family Health Board governance processes.

Assure:
• Whilst the Trust MCB position may look challenged, two of the elements require national self-assessment tools to be agreed and incorporated into maternity electronic patient records, and ICB commissioning.
• The perinatal leadership team are assured by the collation of triangulated patient experience data monitored by the Perinatal Engagement and Inclusion Group, and whilst improvements in the Real and Right Time programme would allow for the identification of variance in experience by deprivation and ethnicity, other data sources are currently utilised to give a high level overview of any disparity in experience.
• The perinatal leadership are confident the current triage services are safe, supported by the triage performance data, with appropriate staffing escalation processes to ensure senior oversight, and whilst the estate provision is poor, mitigations are in place to ensure visibility of the waiting room and management of patient flow.
• The Maternity Incentive Scheme is on track to achieve compliance.

Recommended Triple A outcome – Advise</td></tr>
<tr><td>Recommendation</td><td colspan="7">The Trust Board is asked to:
i. Receive and discuss the report.
ii. Endorse the Maternal Care Bundle, 10 Point Plan and Triage self-assessments and actions plan in accordance with the national assurance process.
iii. Note the required national and ICB escalations associated with the Maternal Care Bundle implementation.
iv. Agree the proposal for quarterly oversight of Maternal Care Bundle implementation by the Quality Committee.
v. Note compliance with the Perinatal Quality Surveillance Model (PQOM).</td></tr>
<tr><td rowspan="2">Link to Strategic Priorities</td><td colspan="2">Joining up care</td><td colspan="3">Advancing care</td><td colspan="2">Supporting great care</td></tr>
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(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Reputation</td><td>Sustainability</td></tr>
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<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="7">Principal Risk - Failure to meet our care standards in a way which is designed around people, not organisations.
Threat – Failure to achieve compliance with the national Maternity and Neonatal deliverables.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="7">Previous reports have been presented to the Quality Committee, Maternity Update, Midwifery staffing paper, Maternity Incentive Scheme (Clinical Negligence Scheme for Trusts (CNST)).</td></tr>
</table>

PERINATAL QUALITY OVERSIGHT REPORT

1. INTRODUCTION

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

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. This month the report focuses on the Trusts self-assessed position against the national priorities following the publication of the 10 Point Plan for Maternity and Neonatal Services, national triage specification and maternal care bundle, and alert to any escalations and risks in relation to compliance.

2. TEN POINT PLAN FOR MATERNITY AND NEONATAL SERVICES

Following the publication of Baroness Amos' Independent Investigation into maternity and neonatal services in England, and the most recent Ockenden report, NHS England (NHSE) created a 10 Point Plan for maternity and neonatal services with a national ask to prioritise these urgent actions. These urgent actions will support, and report into, the National Maternity and Neonatal Taskforce as it develops the National Action Plan, which will be published in December.

On 12 August 2026 NHSE provided an update on the assurance process intended to support and evidence progress. Trusts have been asked to submit the standardised national reporting template to their NHSE region, following approval by the Trust Board, at two points:

- Baseline assessment: 25 September 2026
- Progress update: 31 December 2026

Regional teams will review returns, provide constructive challenge where needed, identify where additional support is required, and escalate significant concerns nationally to enable timely action.

Deliverable	Baseline compliance rating
1. Listening to women and families by rolling out Martha's Rule	Partially compliant
2. Listen to women and their families using real time outcome and experience acted upon at Trust Board	Partially compliant
3. Dual board-level accountability between medical director and chief nursing officers for perinatal care	Compliant
4. Amos into action – staff listening exercise	Not required

Deliverable	Baseline compliance rating
5. Addressing health inequalities in maternity and neonatal outcomes	Partially compliant
6. Ensuring 24/7 safety and responsiveness of services	Compliant
7. Trust review of homebirth services	Compliant
8. Responding to incidents, complaints and concerns with humanity and candour	Compliant
9. Deliver safe and effective triage in maternity services	Partially compliant
10. Post death care	Compliant

There is a comprehensive internal action plan in place to seek compliance by 31 December 2026. The action plan and NHSE reporting template are in the reading room.

There are two actions at risk.

1. Patient experience data to identify variance by ethnicity and deprivation.
2. Implement improvements in line with national triage guidance to ensure women have consistent access to high quality, responsive triage across the NHS within 12 months.

The perinatal leadership team are assured by the collation of triangulated patient experience data monitored by the Perinatal Engagement and Inclusion Group, and whilst improvements in the Real and Right Time programme would allow for the identification of variance in experience by deprivation and ethnicity, other data sources are currently utilised to give a high level overview of any disparity in experience.

The NHSE benching tool and internal action plan are included in the reading room.

3. NATIONAL TRIAGE SPECIFICATION

As outlined above, the Trust must commit to delivering safe and effective maternity triage in accordance with the national specification, published in July 2026. There is an expectation that organisations will have fully implemented the specification within 12 months of publication.

The Trust must, within 3 months of publication, have audited current maternity triage services, completed a gap analysis against this specification, and developed an implementation plan, with progress reported through a public Trust Board meeting, and shared with this with the regional NHSE team. The Trust has established reporting on triage performance within the Integrated Board Report.

The maternity triage specification has 10 principles.

10 Triage principles	Fully in place %	Part in place %	Not in place %	Not relevant%
1. Access and integration	45	45	9	0
2. Recognition as urgent care	50	40	10	0
3. Assessment and care of women	60	20	0	20
4. Clear information for women	0	100	0	0
5. Telephone maternity triage	0	100	0	0
6. Service user voice and experience	20	60	0	20
7. Facilities and estate	50	20	30	0
8. Staffing	42	42	17	0
9. Equity and equality	60	40	0	0
10. Data and measurement	43	43	14	0

Following completion of the gap analysis the principles at risk of non-compliance within 12 months are.

- Estate – visible waiting area, adequate clinical space, accessible toilets.
- Staffing – obstetric consultant capacity.
- Telephone maternity triage - call recording.

Even with significant investment it is unlikely the Trust could achieve the requirements within 12 months. The perinatal leadership are confident the current triage services are safe, supported by the triage performance data, with appropriate staffing escalation processes to ensure senior oversight, and whilst the estate provision is poor, mitigations are in place to ensure visibility of the waiting room and management of patient flow.

The sheer number of audits and data points which are required to be reported, with the majority requiring manual audit, will have a significant impact on staffing capacity which will need to be balanced with clinical care provision.

The NHSE benching tool and internal action plan are included in the reading room.

4. 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

There are no escalations and the scheme is on track to achieve compliance, Safety Action E requires the Trust Board to have plan agreed for delivery of the Maternal Care Bundle, and to have fully embedded the Saving Babies Lives Care Bundle.

4.1. Maternal Care Bundle

The MCB was published by NHSE in January 2026 and sets out best practice guidance across five areas of clinical care. The aim is to reduce maternal morbidity and mortality and reduce inequalities in these adverse outcomes.

The MCB requires co-ordinated action across NHS services. The factors underlying maternal mortality and morbidity often extend beyond the scope of maternity and neonatal care alone, involving a range of other services including medical specialties, emergency and ambulance services, mental health services, and primary care. A whole-system approach is therefore essential.

The Maternity Incentive Scheme Year 8, published in March 2026, introduced the requirement for Trusts to, in accordance with Safety Action E, have a plan ratified by Trust Boards by March 2027 to implement the MCB. Progress with implementation should then be reviewed quarterly through established governance routes. Unfortunately, the national implementation tool outlining the audit requirements and technical specification was not published until July 2026.

Following the publication of the 10 Point Plan for Maternity and Neonatal Services the Trust must have a Trust Board endorsed action plan as a requirement of Point 5. The Trust has now completed a benchmarking with the requirements; this document is included in the reading room.

4.1.1. Element 1 – Venous thromboembolism

Element 1 prioritises a national early pregnancy self-assessment questionnaire at first NHS contact to identify women who require Low Molecular Weight Heparin (LMWH) and ensure they receive this within 72 hours. This creates an equitable, evidence based approach that closes the unsafe gap between antenatal booking and standardises early prevention across all points of entry to maternity care.

Unfortunately progress with this element is predicated by the availability of the digital national self-assessment questionnaire to women, Primary Care and in the BadgerNet single point of access referral, as well as the Integrated Care Board (ICB) agreeing arrangements for LMWH to be prescribed in early pregnancy (that is, before antenatal booking).

The Trust has established an internal task and finish group with the relevant stakeholders and is currently undertaking baseline audits.

The Trust Perinatal Leadership Team have escalated the digital requirements to the NHSE regional and national maternity team and System C. There is currently no timescale for this to be resolved.

The Trust Perinatal Leadership team have escalated to the Local Maternity and Neonatal System (LMNS) and ICB the lack of a commissioned pathway for LMWH to be prescribed prior to booking by Primary Care, this issue will be escalated via the Family Health Quality Performance Review as no progress has been made since the publication of the MCB in January 2026.

4.1.2. Element 2 – Pre-hospital and acute care

Element 2 focus on two key areas, implementing the national Maternity Early Warning Score (MEWS) across all acute, urgent, and pre-hospital settings to ensure consistency and timely escalation, and standard ambulance pre-alert processes with clear access to labour wards and strengthened referral pathways to Maternal Medicine Centres.

The Trust has already introduced the ICB Pre-alert process and established an internal task and finish group with the relevant stakeholders and is currently undertaking baseline audits. Investment is required to strengthen signage; this is currently being scoped.

The updates required to the Trust existing MEWS system are planned for September 2026, this timescale was determined by the digital team capacity to undertake this work.

4.1.3. Element 3 – Epilepsy in pregnancy

Element 3 emphasises establishing local epilepsy in pregnancy teams with timely access to Maternal Medicine Network (MMN) expertise for more complex cases.

The Trust hosts the North East North Cumbria MMN, and has the appropriate multidisciplinary staffing, however there are capacity concerns to ensure the timescales for review are consistently achieved. Further work is underway to understand the impact on the Trust of an increase in referrals from other Trusts within the ICB who are unable to achieve the required standards.

4.1.4. Element 4 – Maternal mental health

Element 4 addresses the variation and inconsistency in how emotional wellbeing is assessed across maternity services with the introduction of a self-administered tool using the Whooley questions ahead of key antenatal and postnatal appointments.

Unfortunately progress with this element is predicated by the availability of the digital self-assessment questionnaire to women. The Trust Perinatal Leadership Team have escalated the lack of digital specification to the NHSE regional and national maternity team, and to System C for an update regarding the timing of implementation. There is currently no timescale for this to be resolved.

4.1.5. Element 5 – Obstetric haemorrhage

Element 5 focuses on early, accurate detection and timely senior escalation through standardised cumulative blood loss measurement, clear escalation thresholds, and consistent multidisciplinary review.

The Trust has established an internal task and finish group with the relevant stakeholders and is currently undertaking baseline audits and reviewing the existing guidance.

4.1.6. Trust position and next steps

The Perinatal Leadership Team have completed a benchmarking of the Trust position against the objectives of the MCB, and collation of Quarter 1&2 audit data is underway.

Whilst the Trust position may look challenged, two of the elements require national self-assessment tools to be agreed and incorporated into maternity electronic patients records and another ICB commissioning.

The Trust is working through the internal elements which are achievable and will provide a quarterly update on the audit findings and progress via the Quality and Safety Group. There are a substantial number of audits to be completed on a quarterly basis which will impact staffing capacity.

In accordance with the Maternity Incentive Scheme guidance the plan needs to be ratified by the Trust Board and monitoring arrangements agreed.

4.2. Saving Babies Lives Care Bundle V3 (SBLCB)

MIS Year 8 Safety Action E requires the Trust to fully embed the Saving Babies Lives Care Bundle in practice, this includes the appropriate obstetric and midwifery roles and capacity.

The Trust is compliant with the staffing requirements for fetal wellbeing and preterm birth prevention which includes:

- Lead fetal wellbeing midwife (minimum of 0.4 WTE).
- Lead fetal wellbeing consultant obstetrician (minimum 0.1 WTE).
- Obstetric consultant lead for preterm birth, delivering care through a specific preterm birth clinic.
- Lead preterm birth midwife.
- Neonatal consultant lead for preterm perinatal optimisation.
- Identified neonatal nursing lead for preterm perinatal optimisation.

5. NATIONAL MATERNITY AND PERINATAL AUDIT (NMPA)

The National Maternity and Perinatal Audit (NMPA) has published its report on outcomes for births that took place in the NHS during 2024 in England, Scotland, and Wales.
Three measures have been selected as indicators which are subject to ‘outlier reporting.’

The three indicators are:

- Proportion of women giving birth vaginally to a singleton baby between 37+0 and 42+6 weeks of gestation, who experience a third or fourth degree tear.
- Proportion of women and birthing people giving birth to a singleton baby between 34+0 and 42+6 weeks of gestation, who have a postpartum haemorrhage (PPH) of 1500 ml or more.
- Proportion of liveborn, singleton babies born between 34+0 and 42+6 weeks of gestation, with a 5-minute Apgar score less than 7.

The Trust was previously alerted to safety signal from the North East and North Cumbria (NENC) Clinical Indicator Dashboard in relation to the Apgar score and has completed comprehensive deep dives and audits to understand if there were any safety implications and learning. This learning from the Apgar audit was shared with the LMNS and the ICB at the time of the reviews to inform practice, and the clinical teams and analysts who support the LMNS and Trusts. The review team completing the Apgar <7 at 5 minutes review found

missing data in records and the incorrect classification of Apgar score when babies are receiving PEEP (Positive End-Expiratory Pressure) with regular respiratory activity.

The LMNS identified discrepancies in the Maternity Services Data Set (MSDS) data and have been working as a system to resolve. As a system we have identified how to remove duplicates using the site code in MSDS. The Trust is assured the PPH rates reported within the NENC Clinical Indicators Dashboard are accurate and demonstrate the Trust is not an outlier following the previous review, however, the MSDS data reported nationally continues to include duplications.

On this basis the Trust identified data entry errors and clinical factors which influenced the potential alarm and responded to the NMPA to request that the Trust was not reported as an outlier, unfortunately this was not accepted and the Trust has been reported as an alarm level outlier for Apgar score <7 and PPH.

The Trust will continue to monitor the data for these metrics and contribute to the national Health Inequalities Dashboard development group to improve national data quality. The Trust will inform the Care Quality Commission (CQC) of the outlier status at the next CQC engagement meeting.

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 Leadership Team is assured that maternity and neonatal services remain safe, with established governance arrangements providing effective oversight through the Perinatal Quality Oversight Model. Compliance with the Maternity Incentive Scheme Year 8 remains on track, and significant progress has been made in assessing the Trust's position against the requirements of the 10 Point Plan for Maternity and Neonatal Services, the National Triage Specification, and the Maternal Care Bundle.

Whilst a number of areas are currently assessed as partially compliant, the majority have comprehensive action plans in place with clear trajectories for improvement. The risks to compliance relate to requirements that are dependent on national digital solutions, commissioning arrangements, or significant workforce and estate investment.

The Trust continues to work towards implementation of all the national workstreams; however, the volume of new audit and reporting requirements will require careful management to ensure that assurance activities are balanced against the need to maintain safe clinical care and workforce capacity.

8. RECOMMENDATIONS

The Trust Board is asked to:

i. Receive and discuss the report.
ii. Endorse the Maternal Care Bundle, 10 Point Plan and Triage self-assessments and actions plan in accordance with the national assurance process.
iii. Note the required national and ICB escalations associated with the Maternal Care Bundle implementation.
iv. Agree the proposal for quarterly oversight of Maternal Care Bundle implementation by the Quality Committee.
v. Note compliance with the Perinatal Quality Surveillance Model (PQOM).

Report of Ian Joy
Executive Director of Nursing
10 September 2026

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Agenda item A3(d)(ii)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	25 September 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 July 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 Failure to meet our care standards in a way which is designed around people, not organisations.					
Reports previously considered by	Last report presented at the Public Board meeting on 31 July 2026.					

MATERNITY SAFETY CHAMPION REPORT – AUGUST 2026

My report from the summer months is short but very positive.

Staff working hard in the Maternity Assessment Unit (MAU) now have a screen behind their reception desk that allows them to see the waiting area. This is such a simple and effective solution to a problem that comes from a less than ideal configuration of the building.

They have been visited by Estates and measured up for a door.

They have a direct link to their own consultant which is a major step forward for service efficiency and patient experience.

The very welcome changes to Ward 43, Gynaecological Services, have stemmed the influx of overnight patients to the MAU, which has eased pressure on the overnight service, but more importantly, given a much better patient experience during what may be a distressing time.

Although they were busy as ever, colleagues in the MAU were very welcoming and seemed positive about everything that is happening at the moment. The area was clean and tidy with easy to read notice boards monitoring patient activity and the surrounding area and ward generally were calm and tidy.

The MAU needs a fridge, to compensate for there being no space for a staff room, and a water fountain for patients. It is understood that a plumbed in water source is not appropriate (infection control), but bottled water would be an option to be considered.

Colleagues working in neo-nates reported that the service was busy but well managed and that they were confident in staffing numbers.

I was able to talk to two patient families both of whom were very satisfied with the care and service that they and their babies were receiving.

One family had a baby born at 24 weeks, now 40 weeks old, likely to stay in the Royal Victoria Infirmary (RVI) for some more time. Mum was optimistic and very happy with care received.

Another family's baby arrived at 29 weeks, and they were looking forward to taking the baby home very soon, after a couple of weeks on the ward, but they were also feeling nervous. They were very positive about care received and the information shared with them. Both families would recommend the RVI's maternity services.

A representative of Tiny Lives was also present which gave me the chance to have a chat about the impact of their work. They said that it would be very helpful if more information were available for parking permits for families.

That morning I had attended the fire safety course and was very mindful to look for potential fire hazards and danger points throughout my walkabout. There were none.

Report of
Liz Bromley, Maternity Safety Champion and Senior Independent Director (SID)
August 2026

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Agenda item A4(a)(i)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 September 2026		
Title	SHINE (Sustainable Healthcare in Newcastle) Annual Update		
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 SHINE programme continues to provide strategic leadership for the Trust's environmental sustainability agenda, supporting great care and the delivery of NHS net zero commitments whilst improving population health, organisational resilience and resource stewardship. During 2025/26, sustainability has become increasingly embedded within routine business processes, governance arrangements and service improvement activity. This includes incorporation of sustainability into the Trust Strategy 2026-2031, further development of clinically led sustainable quality improvement (SusQI) activity, expansion of the Trust's network of over 1,200 Green Champions, and continued integration of sustainability into procurement, estates and operational decision making. The Board approved the Trust's Climate Emergency Plan 2026-2031 in July 2026. The Plan establishes a clear strategic framework for the next phase of delivery, positioning sustainability as an integral component of delivering high-quality, efficient and resilient healthcare through the principle of "Caring for People and Planet" and weaving a green thread of sustainability through our organisational DNA. This paper provides an annual update on delivery of the SHINE programme, updates on implementation of the Climate Emergency Plan 2026-2031 (approved in July) and seeks approval of the Shine Annual Report 2025-26 and refreshed Carbon Reduction Plan for publication. Triple A rating: Advise		
Recommendation	Trust Board of Directors is recommended to: i) Note the progress made through the SHINE programme during 2025-26, ii) Review and approve the final draft of the Trust's Annual Shine Report 2025-26 for publication, and iii) Review and approve the final draft of the Trust's Carbon Reduction Plan 2026 for publication.		
Link to Strategic Priorities	Joining up care	Advancing care	Supporting great care
	☐	☐	☒

Agenda item A4(a)(i)

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	Interim six-monthly progress update presented to Board in March 2026. Draft five-year Climate Emergency Plan presented to Board in July 2026. This report is the scheduled annual update to Trust Board in September 2026.					

SUSTAINABLE HEALTHCARE IN NEWCASTLE (SHINE) ANNUAL UPDATE

1. STRATEGIC IMPLICATIONS

1.1 Quality and Patient Safety

The SHINE programme supports delivery of high-quality, sustainable healthcare through clinically led service improvement, more efficient care pathways and improved climate resilience. Examples include reductions in anaesthetic gas emissions, sustainable quality improvement projects and the development of adaptation planning to ensure care remains safe and effective in a changing climate.

1.2 Finance and Resources

Many sustainability initiatives deliver both environmental and financial benefits. Recent examples include staff-led SHINE projects that have generated measurable savings, optimisation of estates infrastructure and implementation of projects funded through external investment streams such as the Public Sector Decarbonisation Scheme and Born Green Generation project.

1.3 Workforce

The programme continues to support staff engagement and organisational culture, evidenced by the Trust's network of more than 1,200 Green Champions and annual staff surveys showing that 98% of respondents believe it is important that the Trust works in a more environmentally sustainable way.

1.4 Risk and Resilience

The Climate Emergency Plan strengthens the Trust's response to emerging climate-related risks including heat, severe weather events, energy resilience and supply chain disruption, whilst supporting compliance with national NHS sustainability requirements.

1.5 Health Inequalities and Population Health

Climate action can deliver significant health co-benefits through cleaner air, active travel, access to green space and more sustainable models of care. The programme therefore contributes to wider ambitions to improve population health and reduce health inequalities across the communities served by the Trust.

2. PROGRESS AND ACHIEVEMENTS DURING 2025-26

The SHINE programme has continued to mature and deliver measurable benefits across the organisation. Examples of progress during the year include:

- Commencement of the £46 million Public Sector Decarbonisation Scheme programme, incorporating £40.5 million of government grant funding, which is expected to deliver significant reductions in estate-related carbon emissions whilst improving the resilience and condition of key hospital infrastructure.
- Delivery of the new Urgent Treatment Centre, our most sustainable building to date, with no fossil fuel heating and incorporating renewable energy in the form of heat pumps and solar generation.
- Continued reduction in emissions associated with anaesthetic gases, including sustained reductions following the phase out of desflurane and further work to reduce nitrous oxide waste. Anaesthetic gas emissions have reduced by around 60% from the baseline year.
- Expansion of clinically led sustainability initiatives, including projects such as KIDZscan, which reduced the need for general anaesthesia in paediatric MRI pathways, delivering benefits for patients, reducing costs and avoiding carbon emissions.
- Strengthened supplier engagement through the Trust's 5-Step Net Zero Supplier Framework, with more than 75% of supplier spend now supported by supplier-reported carbon data and over 600 organisations engaged through the latest regional supplier event.
- Further progress on clean air and sustainable travel, including expansion of electric vehicle use, continued operation of the electric staff hopper bus service and improvement in the Trust's Clean Air Hospital Framework score from 17% in 2019/20 to 51% in 2025/26.
- Continued reduction in waste per patient contact and maintenance of the Trust's long-standing position of sending zero waste to landfill.

Further detail is provided within our full Shine Annual Report 2025-26 (Appendix 1) which has been approved by the Sustainable Healthcare Committee, and will be presented to the Finance & Performance Committee on Monday 21 September, prior to presentation to the Board for review and final approval prior to publication.

3. CLIMATE EMERGENCY PLAN 2026-2031

Following extensive engagement with staff, patients, partners and stakeholders during 2025/26, the Trust's Climate Emergency Plan 2026-2031 was approved by the Board in July 2026. The Plan aligns directly with the Trust Strategy and establishes environmental sustainability as a key enabler of delivering high-quality care into the future.

The Plan adopts a vision of delivering "Sustainable Healthcare in Newcastle for People and Planet" and is structured around three strategic goals:

- Zero Carbon Care
- Clean Air
- Zero Waste

Delivery will be coordinated through the established SHINE programme, covering eight priority action areas: People, Care, Energy & Water, Journeys, Procurement, Waste & Resources, Buildings and Biodiversity.

Implementation has now commenced, with progress to be monitored through the Sustainable Healthcare Committee and reported routinely through existing Board governance arrangements (quarterly Integrated Board Report dashboards and six-monthly Board progress reports).

4. CARBON REDUCTION PLAN

The refreshed Carbon Reduction Plan (Appendix 2) updates the Trust's greenhouse gas emissions position and sets out the delivery trajectory required to support the ambitions contained within the Climate Emergency Plan 2026-2031. The Plan has been developed in accordance with Government and NHS carbon reporting requirements and will support the Trust's ongoing participation in public sector procurement frameworks and tendering opportunities.

Key messages within the updated Plan include:

- Confirmation of the Trust's revised target to reduce its controllable carbon footprint by 50% by 2031, reflecting both the scale of the climate challenge and the practical lessons learned since the adoption of the original 2030 net zero ambition.
- Recognition that carbon emissions from energy use have reduced by approximately 9% from the 2019/20 baseline despite increasing healthcare activity, demonstrating continued progress whilst also highlighting the need for significant further investment in estate decarbonisation to achieve our ambitious targets.
- Identification of the Trust's £46 million Public Sector Decarbonisation Scheme programme as the single most significant carbon reduction opportunity over the next five years, with anticipated reductions of approximately 10,000 tonnes CO_2e per annum once fully delivered.
- Continued focus on reducing emissions beyond the Trust's direct control through supplier engagement, with over 75% of supplier spend now associated with supplier-reported carbon data, strengthening the accuracy of reporting and supporting future decarbonisation efforts across the supply chain.

This Carbon Reduction Plan provides a realistic and evidence-based pathway for reducing the Trust's environmental impact whilst maintaining safe, effective and financially sustainable healthcare services. This will be presented to the Finance & Performance Committee on 21 September and is presented to Board for review and final approval prior to publication.

5 RISKS & CHALLENGES

Whilst strong foundations have been established, and positive progress continues, several strategic risks remain relevant to delivery:

- Significant decarbonisation of the Trust's estate (the highest proportion of our controllable carbon emissions) remains dependent on external capital investment and successful delivery of major infrastructure projects, particularly at the Royal

Victoria Infirmary where reliance on fossil fuel heating systems remains a significant challenge.

- Financial pressures and competing operational priorities may affect the pace of implementation of some sustainability initiatives.
- Supply chain emissions remain the largest component of the Trust's overall carbon footprint and are heavily dependent on the pace of decarbonisation by suppliers and wider NHS supply chains.
- The increasing impacts of climate change, including extreme weather, energy resilience challenges, operational disruption and broader population health impacts, present growing risks to service delivery.

These risks continue to be managed through programme governance arrangements and are reflected in the Climate Emergency Plan and associated work programmes.

The overall risk to the organisation is recorded and managed within the InPhase system – risk register entry #950 (Climate Emergency) and is reviewed quarterly by the Sustainable Healthcare Committee, a sub-committee of Finance & Performance Committee.

6 GOVERNANCE AND ASSURANCE

The SHINE programme is overseen through the Trust's established governance arrangements, with the Sustainable Healthcare Committee providing programme oversight and reporting through the Finance and Performance Committee to the Board.

Regular reporting is provided through Integrated Board Reports, six-monthly progress reports and the annual SHINE Report. Sustainability measures have also been embedded within several organisational processes, including the Accrediting Excellence framework, business case development and strategic planning arrangements.

7 RECOMMENDATIONS

Trust Board of Directors is recommended to:

i) Note the progress made through the SHINE programme during 2025-26,
ii) Review and approve the final draft of the Trust’s Annual Shine Report 2025-26 for publication, and
iii) Review and approve the final draft of the Trust’s Carbon Reduction Plan 2026 for publication.

Report of Vicky Mc Farlane Reid
Executive Lead for Sustainability

By James Dixon
Associate Director – Environmental Sustainability
14 September 2026


NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust
Shine
Sustainable Healthcare in Newcastle
Embedding sustainability into our DNA
Annual Report 2025-26

Celebrating Excellence Shine Award winners: Green Prescribing intervention to lower liquid amoxicillin use (GPILL)

Contents

1. Foreword

I am pleased to introduce this year's Shine Report, marking the conclusion of our six-year Climate Emergency Strategy and setting our direction for the future.

Whilst there is much to celebrate, I must start by acknowledging that we haven't stayed within the original ambition of a science aligned carbon budget for 1.5 degrees and that our 2030 target is no longer achievable. We are not alone in this as many organisations are finding these targets difficult to realise. Our ambitious goals were set with a genuine intent to limit our carbon emissions. There are many reasons why this challenge has proved unachievable, but we remain committed to continued action to reduce our contribution to the escalating climate crisis and public health emergency.

This report demonstrates the progress we have made in embedding environmental sustainability into the way we work every day. Sustainability is no longer a standalone ambition—it is integral to how we deliver care, how we support our colleagues, and how we plan for the future.

Over the past year, we have worked closely with our colleagues, patients and partners to shape our new Trust Strategy, Caring, Learning and Improving Together. Through this, we have made a clear commitment to place sustainability at the heart of our priorities for 2026–2031. A strong and visible 'green thread' runs throughout the strategy, reflecting our ambition to be a modern, compassionate and well-led organisation that delivers high-quality care in a way that is environmentally and socially responsible.

Responding to the climate emergency is fundamental to this ambition. The climate crisis is already affecting the health of our communities, widening inequalities and increasing pressure on services. As a large NHS organisation, we have both an opportunity and a responsibility to reduce our environmental impact while ensuring our services remain resilient and able to meet future demand.

Our next phase will be delivered through our Climate Emergency Plan for 2026–2031, focused on three clear goals: delivering zero carbon care, improving air quality, and achieving zero waste. These goals provide a practical and measurable framework to support our wider strategic objectives and to help our colleagues deliver excellent, sustainable care.

I am particularly encouraged by the strength of support from our colleagues. Sustainability continues to be a priority for our staff, with 98% of colleagues telling us it is important that the Trust works in a more environmentally sustainable way. Our network of over 1,200 Green Champions is a powerful example of how our people are leading change, helping us to embed sustainability into clinical practice, operational delivery and decision-making at every level.

We have also strengthened how sustainability is reflected in our governance and improvement work—embedding it within our Accrediting Excellence programme and ensuring regular Board oversight through our Integrated Board Reports. This reflects our commitment to making sustainability part of how we measure success as an organisation.

The support of Newcastle Hospitals Charity has enabled us to accelerate progress, investing in projects that are helping to embed sustainable practice across the Trust and enhancing greenspace for health and wellbeing benefits for patients and colleagues. This includes the appointment of clinical sustainability leads, who are driving the adoption of sustainable quality improvement approaches and working with clinical teams to better understand and reduce the environmental impact of care.

We are also planning significant interventions to reduce our carbon footprint. The first year of our £46 million Public Sector Decarbonisation Scheme programme has been successfully delivered, with significant work underway at the Freeman Hospital and community sites to improve energy efficiency and introduce low-carbon technologies. While challenges remain—particularly in decarbonising our largest site, the Royal Victoria Infirmary—we remain committed to working with partners to secure the investment and policy support needed to meet our long-term ambitions.

Across our clinical services, teams are leading innovation and improvement—from reducing plastic use in maternity services, to developing more sustainable approaches in theatres, emergency care and specialist pathways. Equally, our corporate and support teams are playing a vital role, demonstrating that sustainability is everyone's business.

Improving air quality and reducing waste are also critical areas of focus. Through our Travel and Transport Plan and our ongoing commitment to cleaner air initiatives, we are taking practical steps to reduce emissions and create healthier environments for patients, colleagues and our communities. At the same time, our work to reduce waste—including improvements to recycling and more sustainable use of resources—is delivering both environmental and financial benefits. Our commitment to sustainable procurement means a focus on buying less and buying better, spending our money with suppliers that support our sustainability and social value goals.

This report highlights both the progress we have made and the challenges that remain. What is clear is that sustainability is now firmly part of our culture at Newcastle Hospitals. By continuing to work together—with our colleagues, patients, partners and communities—we will build on this strong foundation and deliver care that is not only outstanding, but sustainable for the future.

I hope you find this report both informative and inspiring.

Rob Harrison
Acting Chief Executive,
Newcastle Hospitals

▲ *Speech and Language Therapists taking part in the Green Champion plant competition*

2. Introduction

As Executive Lead for Climate Emergency, and Chair of the Sustainable Healthcare Committee, I am pleased to introduce the Sustainable Healthcare in Newcastle (Shine) Annual Report.

In 2019 Newcastle Hospitals declared a climate emergency, acknowledging that this was also a health emergency. Following this a Climate Emergency Strategy was developed for 2020-2025, which set out goals to reduce our carbon emissions, improve our air quality and improve waste management. At Newcastle Hospitals alongside our Trust strategy, we are working to develop our **new Climate Emergency Plan for 2026-2031**.

As Baroness Brown of Cambridge, Chair of the Adaptation Committee has said in a recent Climate Change Committee report, A Well-Adapted UK, "*We must not let either the complexity of the issue or the unknowns of the future stop us from setting some sensible targets. We must get on with the things we know can deliver significant improvement to people's lives.*" Since we declared a climate emergency in 2019 we have achieved a lot, despite the challenges, but our fundamental reliance on fossil gas to heat and power our buildings has not changed. Significant capital is required to switch to renewable solutions. Our staff worked hard to bring in **Public Sector Decarbonisation Scheme funding which will drop our emissions by 25% in 2028**. Our new Climate Emergency Plan has been informed with our experience over the last 5 years and shows a trajectory, if we achieve our ambitious goals such as bringing geothermal to the RVI, that we could **halve our emissions by 2030 and reach net zero by 2040**.

We work in a context where **putting patient care and safety is at the heart of everything we do**. To ensure we can deliver excellent patient care there are some key areas that we need to ensure we are performing well in, such as waiting lists for elective care, waiting times in our emergency department and waiting times for cancer diagnosis and treatment.

Whilst our clinicians want to provide the best possible care at the point of access, **if we do not deal with the climate emergency then there will be problems with that delivery of care**, from extreme weather events increasing demand, to future pandemics requiring prioritisation of resource, to unavailable stock and supplies needed to deliver care. The recent National Security Assessment on Global Biodiversity and Ecosystem Collapse highlighted how critical the issues are.

We recognise that the way to reach our goals is to **embed environmental sustainability into our existing processes**, so that it is a factor in our decision making and in how we prioritise.

I am pleased to see the successes we have already had in embedding sustainability into our processes and procedures, supported by the grassroots work of our staff. At our annual **Celebrating Excellence** awards we were able to see the huge amount of amazing work happening to embed sustainability into our delivery of care. The **Shine category**, last year, was won by Paediatrician **Dr Emma Lim** and her team, who have pioneered work on "KidzMed" enabling children to swallow pills, reducing the impact of our medicines by switching from liquid to pills, which has significant patient benefit as well as a reduced carbon footprint. The work has expanded to adult services and the winning project, **Green prescribing intervention to lower liquid amoxicillin use (GPILL)** sought to reduce prescriptions of liquid amoxicillin, which has a carbon footprint 3 times that of the tablet form.

▲ *Green Champion meeting launching plant competition*

We also celebrated the work of those shortlisted for the award, which included a project initiated by **Clinical Sustainability Fellow Dr Emma Vittery**, embedding nature connection into the children's day unit at the RVI, work by **Pharmacists Sophia Martins** and **Suzi Butler** seeking to reduce plastic waste in pharmacy, a multi-disciplinary programme of work to **reduce onsite smoking** and **Julie Miller**, **reproductive science practitioner** and a sustainability advocate who has reduced reliance on single use items at the Centre for Life.

The green thread of sustainability was spread out beyond the Shine award category, from **David Coxon** our Energy Manager winning the **Rising Star** award to Paediatric-oncology Nurse **Jade Ryles** winning the **Quality Improvement and Patient Safety** award for her work "KidzScan" seeking to introduce play therapy instead of a general anaesthetic for paediatric patients requiring an MRI, reducing the carbon footprint of the care pathway. The **TAPER2 team** won the **Partnership Working** award for their work on opioid deprescribing, and the **Emergency department** were nominated for a project seeking to diagnose blood born viruses and ensure early treatment avoiding serious health problems. **Holly Downes** was nominated in the **Rising Star** category; Holly has supported the physiotherapy rehabilitation team to embed sustainability into their service. A part of sustainability often unseen is keeping our areas neat and tidy, this avoids wasting equipment and stock. **Denise Morrow** was nominated in the **Unsung Hero** category for her work ensuring Ward 15 is immaculate, including keeping the linen cupboard tidy and knowing exactly what is needed when. In the **Clinician of the Year** category **Gail Fisher** was championed for ensuring children are vaccinated, an important public health measure that will help avoid future carbon-intensive treatment, and **Chris Browell** was celebrated for his work in making surgery at the Day Treatment Centre more efficient, improving their use of resources. In the **Team of the Year** category, we celebrated the **portering department** for their work which includes ensuring efficient waste management.

We work in a context where putting patient care and safety is at the heart of everything we do.

It is encouraging and gives me hope to share this glimpse of the work going on by our dedicated staff across the organisation, seeking to **embed sustainability into our DNA** and I look forward to supporting our clinical sustainability leads to embed a susQI approach within our clinical boards. Our overarching goals of **clean air**, **zero carbon care and zero waste** will remain our focus as we commence the next phase of our response to the climate emergency.

Victoria McFarlane Reid
Executive Director Lead
for Sustainability

Shine
Sustainable Healthcare in Newcastle

Embedding Sustainability into our DNA

5 step low carbon supplier framework
supporting our suppliers to reduce carbon

Waste and Resources Plan
exceeding our target for reducing hazardous clinical waste

Energy Efficiency and Decarbonisation Investment
embedded into Estates Strategic Delivery Plan

Green digital
recycling assets avoiding 333 tonnes of carbon

Trust Strategy
sustainability is a key priority

Health Inequalities Strategic Plan
prioritising public health and equity for sustainability co-benefits

Clean Air Hospital Framework
improved our score from 17% to 51%

1,200 Green champions
a growing network, sharing learning

Food and drink strategy
sustainability is a key pillar

Medicines management
CQC compliance improving patient safety and reducing waste

Born Green Generation

Born Green Generation
plastic and carbon reduction in maternity

Still to do list

- [ ] **Travel and Transport plan**
sustainable and active travel
- [ ] **Greenspaces and Health Plan**
strategising the link between health and greenspaces
- [ ] **ACE accreditation framework**
sustainability in our clinical areas
- [ ] **Clinical Sustainability Leads**
embedding sustainability in clinical boards
- [ ] **£46 million Public Sector Decarbonisation Scheme**
complete the project and realise environmental and cost savings

3. Performance

Please see our Climate Emergency Strategy for a detailed breakdown of our three long-term goals and our vision to reach Net Zero.

We are mirroring the Greener NHS definitions of 'carbon footprint' and 'carbon footprint plus' which were published in 'Delivering a Net Zero NHS'. In addition, we have also continued to calculate and present our carbon performance in line with the global best practice framework of the Greenhouse Gas Protocol.

Category	Sub-category	Total tCO_2e			% change from previous year	% change from baseline year
		2019-20 (baseline)	2024-25	2025-26		
Newcastle Hospitals carbon footprint	**Scope 1**					
	Building energy – fossil fuels	54,858	50,145	53,034	6	-3
	Refrigerant gases	477	203	289	43	-39
	Anaesthetic gases	4,036	1,645	1,614	-2	-60
	Trust fleet	112	101	106	5	-5
	Scope 2					
	Building energy - purchased electricity[4]	4,933	5,146	4,576	-11	-7
	Scope 3					
	Water	441	185	200	8	-55
	Waste	558	419	361	-14	-35
	Inhalers	1,399	1,322	1159	-12	-17
	Business Travel	1,335	949	860	-9	-36
Newcastle Hospitals Carbon Footprint Total		**68,149**	**60,115**	**62,198**	**3**	**-9**
Patient Numbers (total patient contacts)		**1,788,469**	**1,906,701**	**1,960,098**	**3**	**10**
Footprint Carbon Intensity (tCO_2e per patient contact)		**0.038**	**0.032**	**0.032**	**6**	**-17**
Medicines, medical equipment and other supply chain	Medicines and chemicals	67,952	54,140	63,481	17	-7
	Other supply chain	39,094	200,402	151,273	-25	287
	Medical equipment	42,415	175,195	303,784	73	616
	Patient Transport Service	1,870	1,849	1,868	1	0
	Procurement total	**151,332**	**431,586**	**520,406**		
Personal travel	Staff commute	14,863	11,498	12,016	5	-19
	Patient and visitor travel	22,257	20,790	21,209	2	4
Newcastle Hospitals Carbon Footprint Plus Total		**254,975**	**523,988**	**615,830**	**11**	**129**
Footprint Plus Carbon Intensity (tCO_2e per patient contact)		**0.142**	**0.275**	**0.297**	**8**	**109**

Table 1: Breakdown of Total Newcastle Hospitals Carbon Footprint[1]

[i] Full carbon footprint report available on request

3.1 Carbon Footprint

This year, for the first time since 2021-22, we have seen an increase in fossil fuel consumption for building energy. This is due to a back-up generator fault at the start of the year at Freeman Hospital, so to ensure a reliable supply of power we had to burn more fossil gas to generate more electricity with our combined heat and power plant than we normally would. Whilst we progress with our decarbonisation projects, to reduce our reliance on fossil fuels in the future, this does highlight our short-term reliance on fossil fuels for our life-critical hospital energy supplies.

We continue to make good progress with our work on reducing the emissions associated with anaesthetic gases, and we have seen a drop in emissions from the prescription of inhalers for the first time since the Covid-19 pandemic. There are also reductions in our business travel emissions as we seek to decarbonise and make efficiencies to the way our staff travel.

We are continually trying to improve our calculation process so in some areas, the calculation methods have altered, or the data source is improved. For example, there was a change nationally to the way electricity emissions are calculated, due to the continued decarbonisation of the grid, which has led to a more significant reduction in our carbon footprint for purchased electricity. See our full carbon footprint report for more detail.[i]

NEWCASTLE HOSPITALS CARBON FOOTPRINT

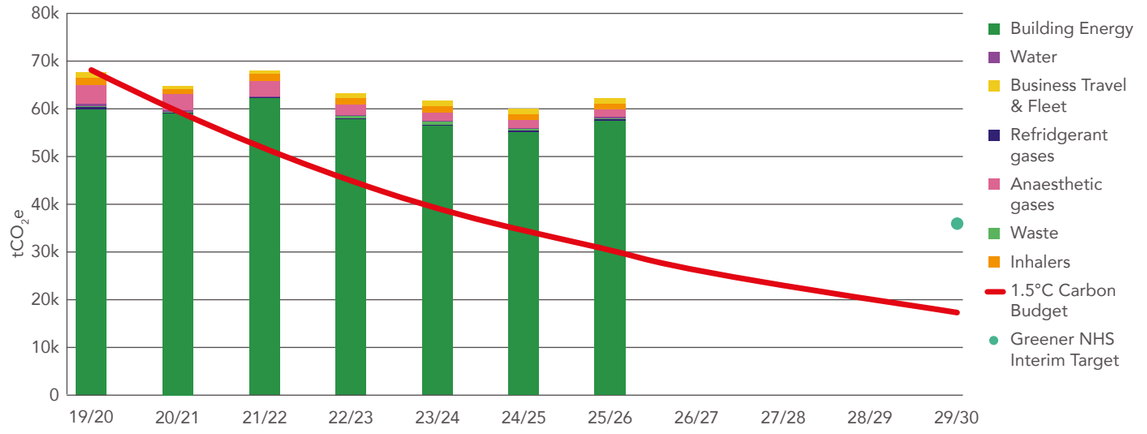


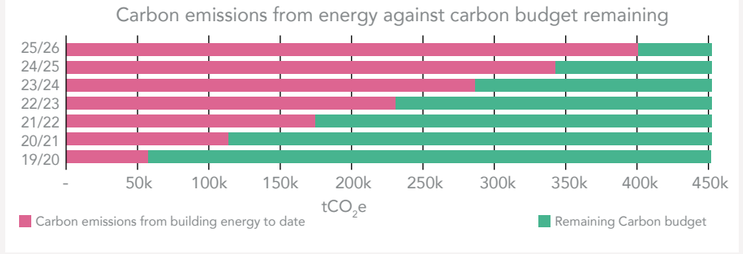
Figure 1: Newcastle Hospitals Carbon Footprint

HOW MUCH OF OUR CARBON BUDGET HAVE WE USED?

We have almost exceeded the carbon budget which we set ourselves as an organisation when we launched our Climate Emergency Strategy. This was in conjunction with the Tyndall Centre for Climate Change Research and corresponded to limiting our contribution to global warming, at an organisational level, ensuring that global temperatures remained well below 2°C.

The Climate Change Committee in their statutory report "The Seventh Carbon Budget" continue to monitor our contributions nationally. In this report they said: "*Net Zero CO2 emissions as well as deep reductions in other GHG emissions globally are required to halt further global warming. While it is now almost inevitable that warming levels will exceed 1.5°C in the next ten years, it may still be possible to limit warming to 1.5°C in the longer term, provided deep global emissions cuts begin immediately.*"

In our revised Climate Emergency Plan we will continue to monitor and reduce our emissions, looking at innovative ways to power our buildings such as via deep geothermal. We will set out how the £40.5million of Public Sector Decarbonisation Scheme funding will support decarbonisation at the Freeman hospital. We will engage with leadership locally and nationally to promote the embedding of sustainability into everything we and the wider NHS do.



The methodology for reporting our carbon footprint plus has continued to evolve, as we work with our partners across the Great North Healthcare Alliance, following our 5-step low carbon supplier framework. We have made progress in collaborating with the Greener NHS team on the consistency of data collection platforms. We have used Evergreen Sustainable Supplier Assessment data for the first time to supplement our supplier reported data set.

Previously we used a spend-based method to calculate our Scope 3 category 1 emissions, which provided an estimated amount of greenhouse gases dependent on how much we had spent. This would not consider our suppliers' efforts to de-carbonise their goods and services. We are working to improve the accuracy of our supply chain emissions by adopting the greenhouse gas protocol hybrid method. We now collect data directly from our suppliers, via our framework and the Evergreen assessment so we can see the benefit of efforts suppliers take to produce their goods and services more sustainably.

We have seen an increase in supplier engagement, with 600 suppliers attending our 6th annual event either in person or online, and an increase in the proportion of supplier reported data (75% of spend).

With improved confidence in our supply chain carbon data, we are in a position this year to establish a base line against which to track progress towards our Net Zero 2040 target. This includes a recalculation of last years Scope 3 category 1 and category 2 emissions which is shown in the graph below.

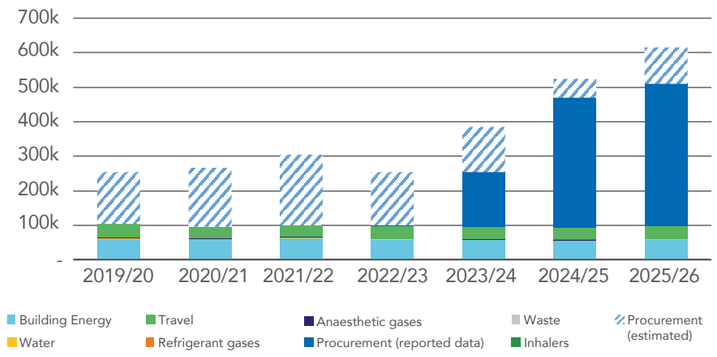


Figure 2: NHS Carbon Footprint Plus

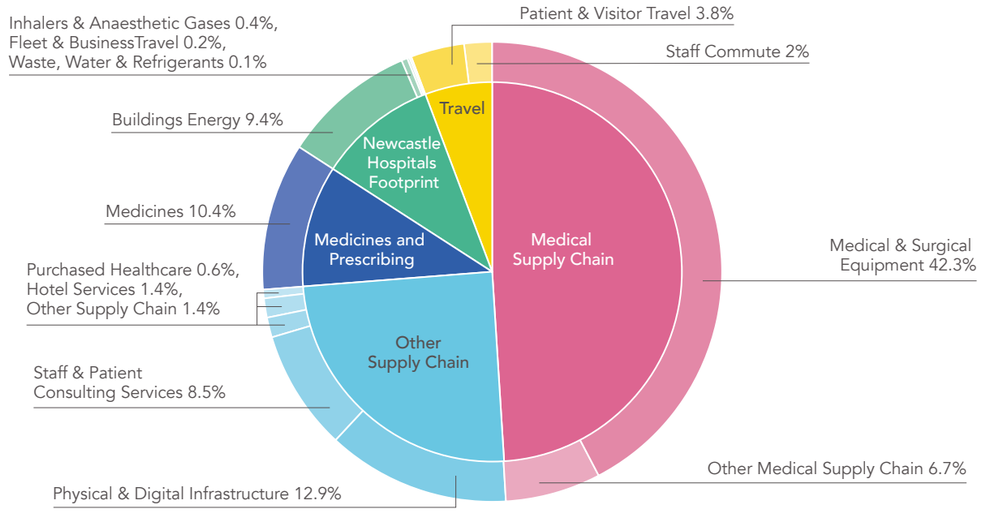
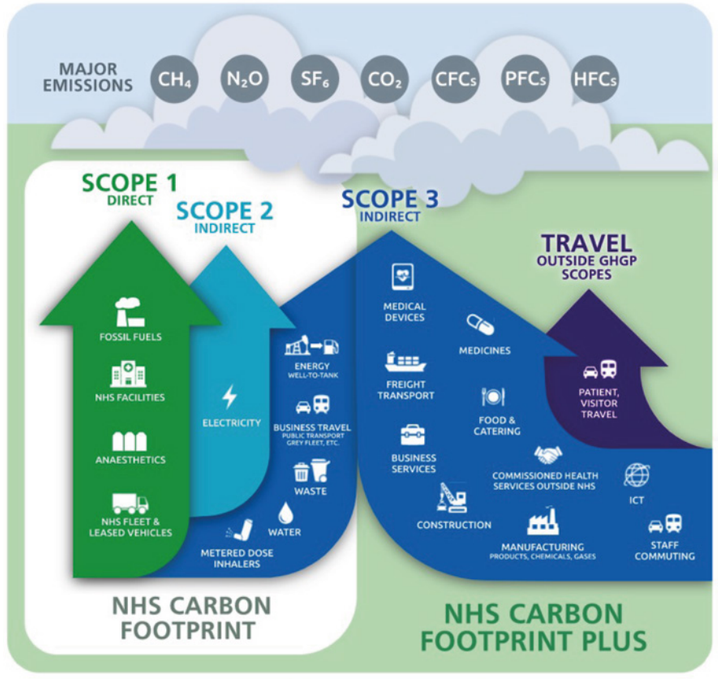


Figure 3: NHS Carbon Footprint Plus emissions breakdown



3.2 Staff Engagement

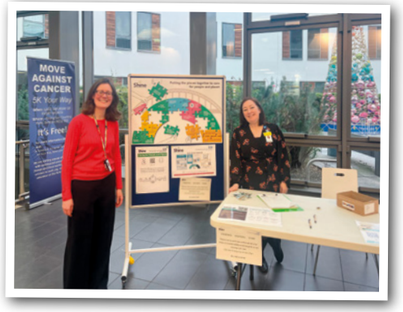
STAFF SUSTAINABILITY SURVEY

Every year, since 2016, we have asked our staff for their views on sustainability in our annual staff sustainability survey. Of the 648 members of staff that completed the survey this year 98% said that it is important for the Trust to work in a more sustainable way.

81% of staff that undertook the survey were aware of the sustainability work undertaken by the Trust, a minor drop of 1% since last year.

With no change overall from last year 64% of staff report that the Trust makes it easy for them to act in a more sustainable way when doing their jobs, and we will continue to monitor this important trend.

Engaging with staff at a stall to seek their views on the Climate Emergency Strategy refresh.



How important do you think it is for the Trust to work in a more sustainable way?

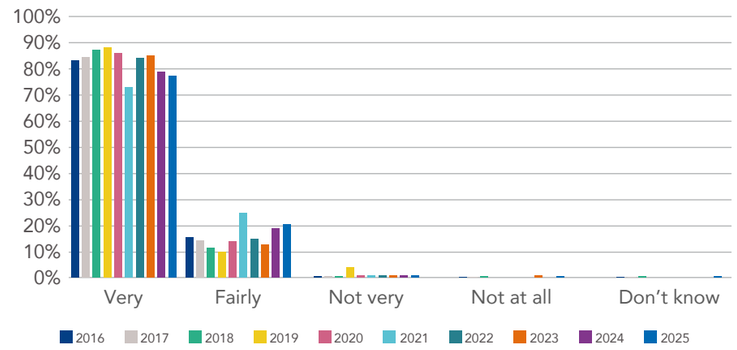


Figure 4: Staff survey – how important do you think it is for the Trust to work in a more sustainable way?

Are you aware of the sustainability work of the Trust?

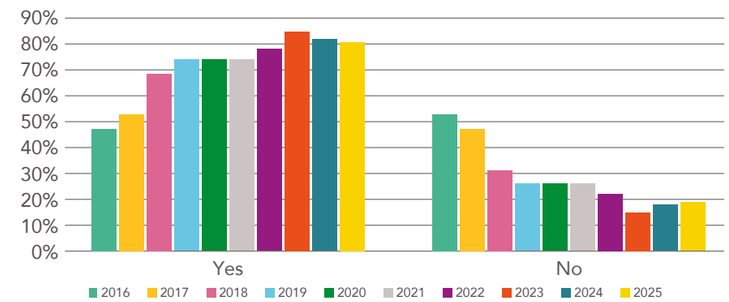


Figure 5: Staff survey – are you aware of the sustainability work of the Trust?

How easy does the Trust make it for you to act in a more sustainable way when doing your job?

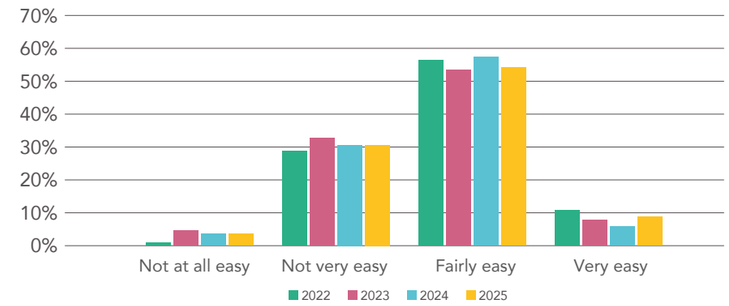


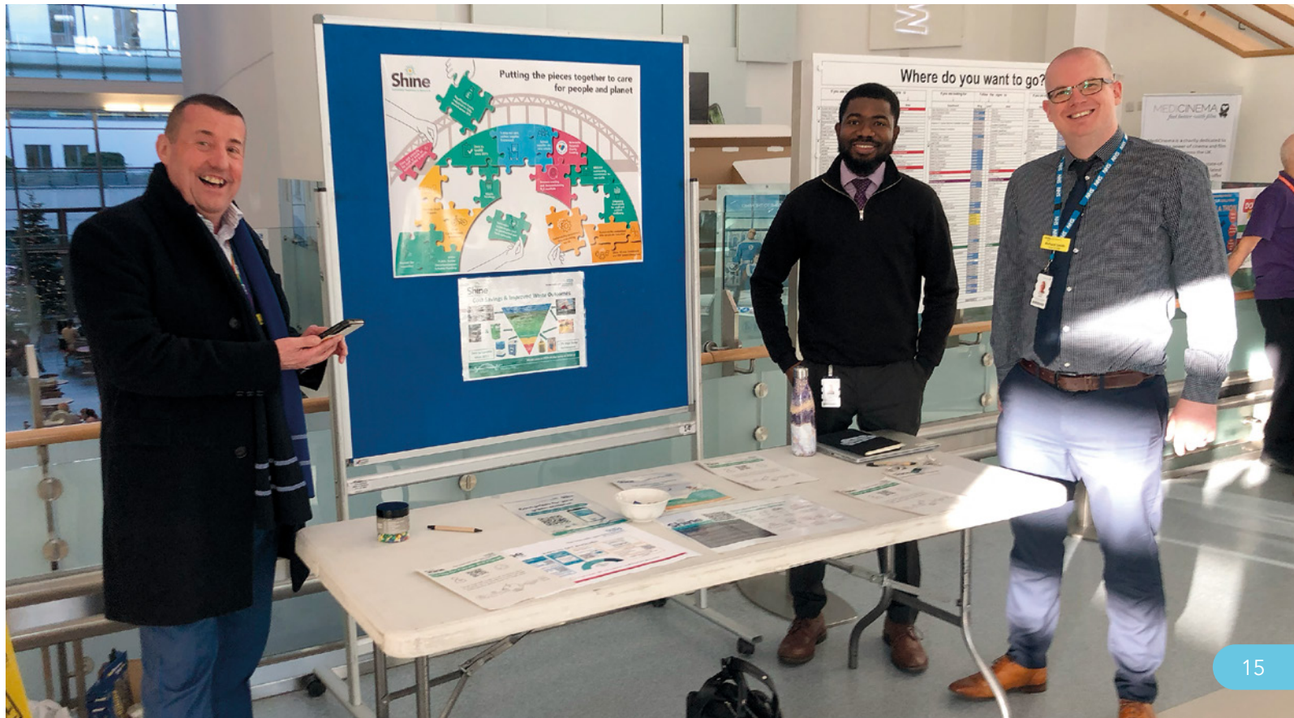
Figure 6: Staff survey – how easy does the Trust make it for you to act in a more sustainable way

This year we also asked:

How should we engage with staff on our climate emergency strategy refresh?

The answers allowed us to ensure we were balancing online engagement with face-to-face engagement, and we achieved this with stalls, attending various meetings, a survey promoted across the Trust and sharing via our staff newsletter and social media. We produced a poster which we encouraged our over 1,000 Green Champions to share with their colleagues, and we attended senior staff meetings to cascade the opportunity to contribute to our over 20,000 members of staff.

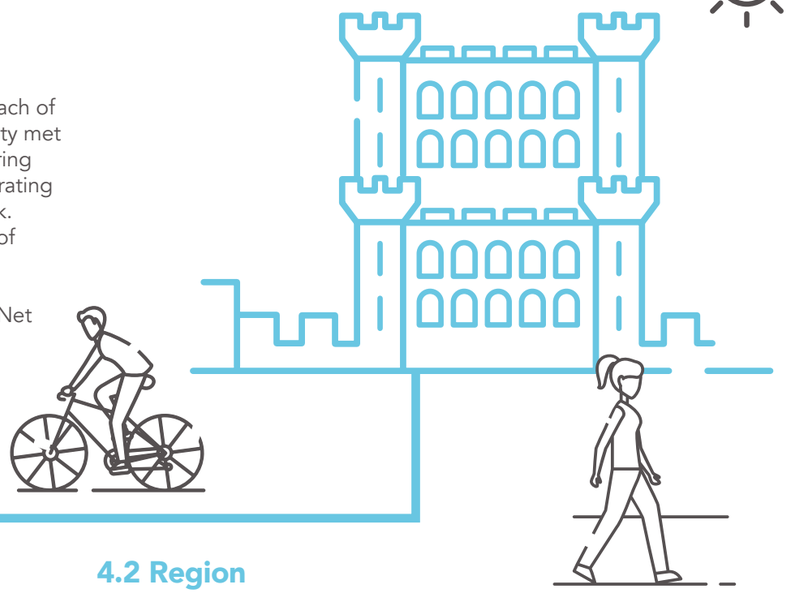
Figure 7: Word Cloud – the biggest words were most frequently mentioned in answer to the question.



4. Leadership, partnerships and collaboration

4.1 City

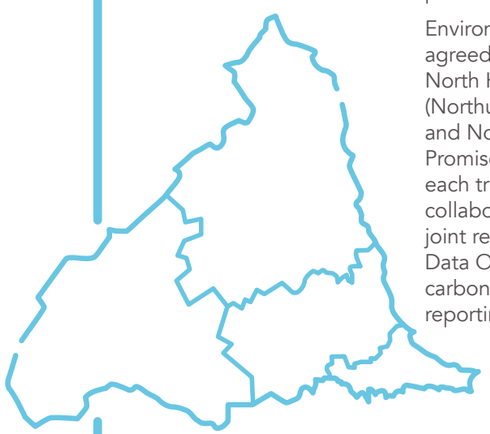
The sustainability leads from each of the anchor institutions in the city met in January, with the aim of sharing strategic priorities and collaborating on shared programmes of work. The group agreed a schedule of future meetings and to collate progress updates that will be presented at the city council's Net Zero Board meetings.



4.2 Region

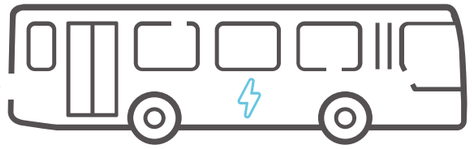
We continue to co-chair the **North East and North Cumbria (NENC) Provider Collaborative Sustainability Leads** meetings, to share best practice across our group of 11 provider Trusts.

Environmental sustainability was agreed as a key priority in our Great North Healthcare Alliance (Northumbria, Newcastle, Gateshead and North Cumbria) Community Promise. The sustainability leads from each trust agreed a number of collaboration priorities including the joint recruitment of a shared Net Zero Data Officer to improve consistent carbon accounting and progress reporting across the Alliance.



Our 6th annual sustainable supplier event saw increased collaboration across the region with public sector procurement colleagues. The event was opened by our Chair, Sir Paul Ennals, who is also Chair at Gateshead Health NHS Foundation Trust and Northumbria Healthcare NHS Foundation Trust. We are aligning our approaches across the region in how we engage with suppliers and measure and report on our Scope 3 emissions.

Our energy, waste and sustainability leads continue to work with peers across the region to benchmark, share best practice and align approaches to our improvement work. All with the collective aim of improving patient care, reducing operating costs and improving environmental performance.

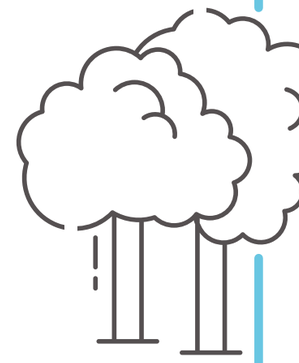


4.3 National

We joined colleagues at Northumbria Healthcare at the UK Health Security Agency (UKHSA) Air Pollution Event in November 2025 showcasing work to implement Global Action Plan's 'Clean Air Hospitals Framework'. This has included installing small, low-cost tubes called diffusion tubes at outdoor locations at the Royal Victoria Infirmary, Freeman Hospital and Northumbria Specialist Emergency Care Hospital.

Our energy team have supported collaboration of energy managers across the country, presenting to different energy manager groups and **publishing in the Energy Manager Association magazine**. David Coxon is on steering groups for national energy projects and he co-chairs the Energy National Performance Advisory Group meetings.

Our Born Green Generation team have shared their work in multiple forums, including the Greener AHP week in April, the Faculty of Sustainable Healthcare in September, and in a round table on sustainability with the NHS England Chief Nurse's Office and Greener NHS.



4.4 International

As an executive member of **Health Care Without Harm Europe** we worked with colleagues from healthcare organisations across Europe to refresh their strategy, to help accelerate the transition of the European healthcare sector into a force for planetary health: low-carbon, climate-resilient, circular, non-toxic and centred on sustainable practices.

Our sustainability manager, Anna-Lisa Mills, presented at **Clean Med Europe 2025**, Europe's leading conference on sustainable healthcare. Sharing our sector-leading approach to greenhouse gas reporting she helped other hospital sustainability leads to measure, report and create plans for reducing these emissions.

As a pioneer partner of the Born Green Generation movement, aiming to reduce newborn exposure to plastics and harmful chemicals in maternity settings, we continue to collaborate with partners in Great Ormond Street Hospital, Center for Sustainable Hospitals in Region Midtjylland, Denmark and Centre Hospitalier Angouleme in France. Our work has not only reduced newborn exposure to plastic and saved money in Newcastle but has been spread across fellow pioneer partners and we are now working with a fast followers cohort of maternity hospitals to take these benefits further.

5. Key Action Areas

This section explores the progress made in each of our Shine action areas which feed into our three Climate Emergency Strategy goals, and the plans for next year and beyond.

We have mapped action across these areas within our existing eight Shine themes.

People
Inspire, inform and empower our people to deliver sustainable healthcare

Care
Develop low carbon care pathways adapted to our changing climate

Energy
Minimise energy use and replace fossil fuels with zero carbon energy sources

Water
Minimise water use

Journeys
Embed active, clean, low carbon travel

Waste
Dispose of less, reuse and recycle more

Procurement
Work with our supply chain to decarbonise

Buildings & Land
Provide healthy, sustainable and biodiverse spaces

5.1 People

AIM

Inspire, inform and empower our people to deliver sustainable healthcare:

- Embed Shine and climate emergency action into the culture of our organisation, demonstrated in staff behaviours
- Upskill our workforce and ensure capacity to address the climate emergency
- Empower our people to make the most sustainable choice
- Extend our reach to influence action amongst our wider stakeholders, including patients

Staff signposted to sustainability training and bespoke training offered to teams across the Trust

PERFORMANCE

GREEN CHAMPION ENGAGEMENT

↑ **38%**

Over 1,200 Green Champions

SHINE REWARDS STAFF BENEFIT PROGRAMME AND APP

421 tCO_2e

avoided through staff actions since the launch of the program

SOCIAL MEDIA COMMUNICATIONS

↑ **61%**

636 followers

SHINE AWARDS FOR SUSQI PROJECTS

20 projects

awarded a Shine Award this year

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

- Lead Green Champion appointed to co-ordinate the Green Champion network and increase engagement
- Hosted our first Climate Cafe, allowing staff to share the emotional impact of the climate emergency
- The "GPILL" project won the Shine category of the annual Celebrating Excellence Awards, for their work developing a behaviour change intervention using information about greenhouse gas emissions to reduce liquid antibiotic prescribing
- Ongoing uptake in Clinical and Diagnostic Services of the Shine 10 step framework with sustainability embedded into the Therapy Services plan
- Staff signposted to sustainability training and bespoke training offered to teams across the Trust
- 20 Shine Awards given to staff led projects avoiding over 350 tonnes of CO_2e and saving the Trust over £170,000
- Climate Emergency Action Fund launched, funded by Newcastle Hospital Charities, to support staff-led sustainability projects
- Regular clothes and toy swaps held by our health and wellbeing team

PLANS FOR THE NEXT YEAR

- Embed sustainability into the new Trust Strategy
- Develop and publish our new Climate Emergency Plan
- Formalise the green champion network and provide clear and relevant resources to green champions in clinical areas
- Embed sustainability into the ward accreditation framework
- Extend the reach of Climate Cafes to front line staff
- Provide sustainability training to staff in corporate services
- Set up a Human Resources working group to identify opportunities and ensure sustainability is embedded into our People Plan and Trust policies

CASE STUDY: GREEN CHAMPIONS LOVE PLANTS!

Lead Green Champion, Cam Abbott and Nature Recovery Ranger Duika Burges Watson have worked together over the past year to support our Green Champions to engage with the network and strengthen their connection with nature.

At a meeting in January a Green Champion plant competition was launched - to encourage colleagues to bring greenery into office spaces and non-clinical staff areas, recognising the benefit to staff wellbeing in being close to nature.

The competition was very popular, with 73 members of staff collecting a plant and sharing their progress through the Green Champions Team Channel.

5.2 Models of Care

AIM

Develop low carbon care pathways adapted to our changing climate:

- Engage in research and innovation in order to lower carbon across our care pathways
- Lead on the systematic reduction of anaesthetic gas environmental impact across all care pathways
- Collaborate to reduce the carbon footprint of respiratory care through a detailed review of inhaler prescription and use
- Empower our clinicians to improve the sustainability of their models of care

PERFORMANCE

INHALERS - Carbon Footprint (controllable emissions)

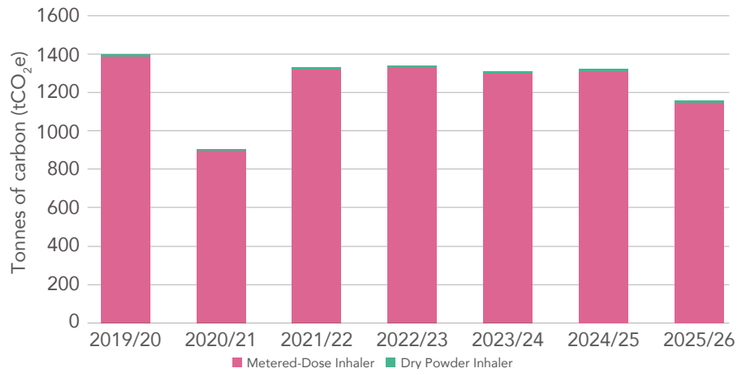


Figure 8: Carbon Footprint from inhaler prescribing at Newcastle Hospitals

ANAESTHETIC GAS - Carbon Footprint (controllable emissions)

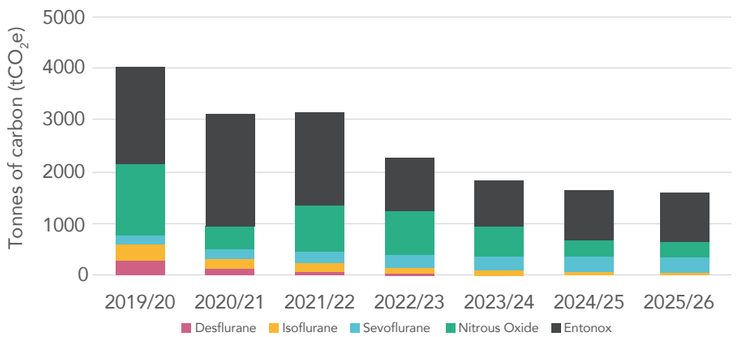


Figure 9: Carbon emissions from anaesthetic gas use at Newcastle Hospitals

▼ *Dr Suren Kanagasundaram, Clinical Sustainability Lead*

▲ *Dr Louise Sanderson, Deputy Clinical Sustainability Lead*

◀ *Frances Slowie, presenting work on board level training*

20 Shine awards given to staff-led projects seeking to reduce the environmental impact of their service areas, avoiding over 350 tonnes of CO_2e and £170,000

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

- Our nitrous oxide waste mitigation team received £15,000 grant funding to trial portable supply manifolds to reduce nitrous oxide waste in children's theatres
- Newcastle Hospitals Charity supported the appointment of clinical sustainability leads and a clinical sustainability fellow
- 20 Shine awards given to staff-led projects seeking to reduce the environmental impact of their service areas, avoiding over 350 tonnes of CO_2e and £170,000
- Born Green Generation project embedded into maternity avoiding 2 tonnes of plastic waste annually
- SusQI resources, signposting and tools improved for staff to embed sustainability into improvement work
- Sustainable Healthcare Satellite meetings, with Newcastle Health Research Partnership, to promote sustainable healthcare collaboration in research

◀ *Eco-influencers Ward 2b GNCH*

▶ *Dr Sarah Peters clinical sustainability fellow*

PLANS FOR THE NEXT YEAR

- Switch from piped nitrous oxide to canisters where clinically feasible, to further reduce nitrous oxide waste
- Sustainability leads to work with clinical boards to identify sustainability opportunities and celebrate successes
- Embed a susQI lens to our quality improvement work
- Train more staff on susQI tools, via Newcastle Hospitals susQI forum, sharing impact stories across the Trust
- Improve the clinical governance of sustainable healthcare via the Models of Care working group and clinical board reporting
- Implement a Climate Adaptation Plan to ensure our patients receive excellent care in a changing climate

CASE STUDY:
SHINE AWARD WINNER: *KIDZscan*

Jade Ryles, a paediatric neuro-oncology specialist nurse, led the KIDZscan project in oncology to reduce the number of general anaesthetics a child needs for scans to aid treatment and diagnosis. Jade's approach was to provide children with procedural preparation sessions, supported by play therapists, to support them to undergo an MRI scan without the need for a general anaesthetic.

Jade obtained charitable funding to expand the project to all young people's procedures. The project supported 140 scans (avoiding general anaesthetic) with an estimated carbon avoided of 17.36 tonnes of CO_2e.

From a cost perspective Jade saved the Trust £135,000 in the pilot phase alone, avoiding spend on sedative drugs, staff time and allowing for more use of the MRI scanners.

The project supported children to avoid the risks of a general anaesthetic with less time in hospital and less time away from their daily routines.

▲ *Paediatric patients' drawings of their MRI experiences*

5.3 Energy & Water

AIM: ENERGY

Reduce carbon emissions from energy use, in line with science informed budgets, to be on track for net zero by 2030:

- Minimise energy use
- Improve energy efficiency
- Replace fossil fuels with low and zero carbon energy sources
- Maximise generation of renewable energy on site

AIM: WATER

Reduce carbon emissions from water use in our buildings:

- Eliminate wasted water
- Increase water efficiency

David Coxon winning Rising Star at the Celebrating Excellence Awards

PERFORMANCE

For the first year since covid recovery we have reported an increase in our carbon emissions associated with powering our buildings. This was due to a failure in the back-up generator at the Freeman hospital, requiring the combined heat and power plant to run at full capacity, resulting in increased fossil gas usage. Our estates teams are working hard to implement the public sector decarbonisation scheme projects which will allow us to reduce our reliance on gas in the future.

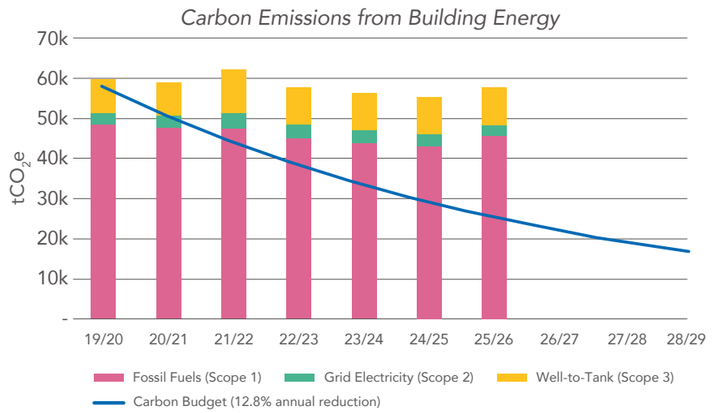


Figure 10: Carbon Emissions from Building Energy

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

Solar PV array on the RVI MSCP

- Completion of the Urgent Treatment Centre; our first building compliant with the Net Zero Building Standard, including heat pumps and solar panels
- Increased generation of renewable electricity on site: we now have 1,293 solar panels
- Gas supplies removed at Crawford House and Regent Point, continuing our transition away from fossil fuels
- Significant improvements made to our building level metering provision for Freeman electricity, enabling targeted efficiencies
- Commenced the £46 million Public Sector Decarbonisation Scheme Phase 4 project to decarbonise the Freeman Hospital and two community sites
- LED Lighting upgrade programme at the Freeman Hospital multi-storey carpark, via PFI partners Mitie
- Optimisation of RVI estates boilers saving more than £40,000 annually
- David Coxon, Energy Manager, awarded the Trust's Rising Star award at the Celebrating Excellence awards and Energy Manager of the Year Award from the Energy Managers Association

PLANS FOR THE NEXT YEAR

- Continue to implement the Public Sector Decarbonisation Scheme Phase 4 heat decarbonisation programme: progressing with de-steaming at Freeman and enabling works at the two community sites (Benfield Park and Ponteland Road)
- Expand sub metering of heat (steam) at the RVI to enable identification of efficiencies
- Expansion of theatre ventilation out-of-hours setback controls to realise significant cost and carbon savings
- Install 104 solar panels for the Urgent Treatment Centre at RVI
- Work with city partners to design a geothermal city heat network for the RVI

CASE STUDY: URGENT TREATMENT CENTRE, ROYAL VICTORIA INFIRMARY

To alleviate the strain on our Accident and Emergency Department at the Royal Victoria Infirmary an Urgent Treatment Centre has been constructed, our first building to comply with the NHS Net Zero Building Standard. The centre has dedicated waiting areas for each service pathway, along with modern clinical spaces and a thoughtfully designed layout to enhance patient flow, streamline services and reduce waiting times. The building will be powered by 104 solar panels and thermally controlled by 4 heat pumps. A back up generator was also upgraded and is fuelled by hydrogenated vegetable oil a cleaner, lower carbon fuel source.

5.4 Journeys & Clean Air

AIM

Embed active, clean and low carbon travel to improve air quality and reduce carbon emissions from journeys:

- Reduce air pollution and carbon emissions from our owned and commissioned transport operations
- Use our influence to help fast-track the decarbonisation of transport in our supply chain
- Increase the proportion of people accessing our sites by active and sustainable travel methods
- Provide more care closer to, or at, home

PERFORMANCE

Overall, our emissions reduced, in part due to the government reducing their estimate of greenhouse gas emissions emanating from air travel, and due to our cost improvement work reducing taxi usage. There were no diesel miles from our "business lease" cars from September 2025 due to the ban on diesel vehicles through our business lease car scheme. There was an increase in our "grey fleet" emissions, staff using their own vehicle for travel, but an overall downward trend from our baseline.

Travel within Newcastle Hospitals Carbon Footprint

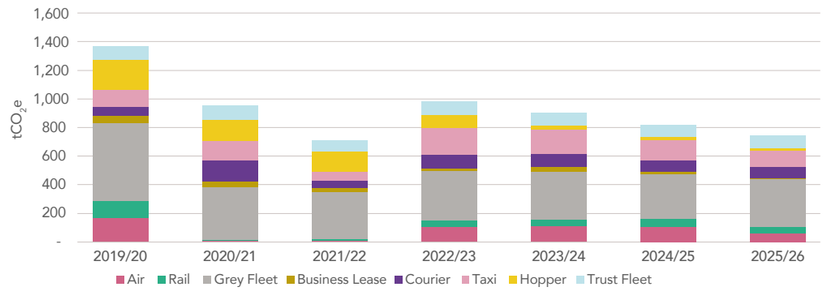


Figure 11: Carbon footprint from travel within the Newcastle Hospitals Carbon Footprint

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR, JOURNEYS

- Work started to develop a Travel and Transport Plan, to embed a sustainable approach to travel planning across the Trust, increasing rates of active and sustainable travel
- Newcastle Hospitals Charity funding provided bike maintenance sessions for staff held across our three main sites
- Maintained gold award for cycle friendly employer and engagement with staff via the active travel user group
- Expanded the Flock mobility scheme (shared transportation for renal dialysis patients) to use the electric vehicles for other areas when not needed by renal
- Construction of one of our on-site cycle hubs started at the Royal Victoria Infirmary
- Digital team swapped their vans from diesel to EV, saving £32,500 and 5.5 tCO_2e a year

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR, CLEAN AIR

- Improved our score on the Clean Air Hospital Framework to 51% "good" thanks to actions such as the integration of air quality measures in our building works
- Hosted a Clean Air Day webinar, opened by our Acting CEO Rob Harrison, with expert medical speakers on the impact of air pollution for our patients
- Confirmed our commitment to the no-idling policy as this extended across other healthcare trusts in the north east
- Started to engage with staff and key stakeholders around the integration of air quality information into patient conversations
- Engagement with our Nature Recovery Ranger to ensure Freeman Nature Trail included low pollution zones

PLANS FOR THE NEXT YEAR

- Integrate air quality information into patient conversations via Making Every Contact Count
- Host our fourth Clean Air Day, emphasising the health impacts of air pollution and strengthening the call for practical measures to reduce exposure
- Continue to increase our score on the Clean Air Hospital Framework and develop a Clean Air Improvement Plan
- Gain Board approval and commence implementation of the Travel and Transport Plan
- Identify a social enterprise / community interest group to run our on-site cycle hubs
- Install dedicated cycle parking for electric bicycles and electric scooters
- Install two rapid EV chargers for electric ambulances and install an additional 17 chargers across the Trust
- Engage with local city partners on infrastructure improvements and active travel initiatives

CASE STUDY: SHINE AWARD WINNER: *David Bull and the Digital Team reducing transport related emissions*

The IT Desktop Support Team currently support over 40 community sites with over 1,000 digital devices across the north east. To reduce the impact of our digital services David Bull, Desktop support manager, worked with the travel and transport team to switch from diesel to electric vans.

The goal was to transition to electric vehicles without any impact on the service provided. The team first trialled an electric vehicle at the Royal Victoria Infirmary for 4 months, ensuring that the weekly average mileage could support this option, that the vehicle was suitable and that they could conveniently charge it.

Working with the transport team, they were able to charge the vehicle from an app on a slow charge overnight. This meant that on return to the office the following morning the van had enough power for the day ahead.

The digital team have now completed the order of 2 electric vans for the Desktop Support team, saving the Trust £3,000 on lease costs, £29,500 on fuel costs and 5.5 tonnes of CO_2e annually.

Travel and transport team promoting active and sustainable travel at induction

5.5 Waste

AIM

Generate less waste; reuse and recycle more, and ensure unavoidable waste is disposed of in the most sustainable way:

- Reduce the amount of waste we create by working and purchasing in more resource-efficient ways
- Increase the number of items we reuse with a focus on reducing single-use plastics
- Repair or reuse more items that can be repaired or reused
- Increase the amount of waste that we reuse or recycle to 35% of consigned waste by volume

Reusable cups promotion at our charity shop

PERFORMANCE

- Total volume of waste has decreased by 4%
- The average volume of waste per patient has decreased to the lowest level of 2.4kg per patient contact
- Recycling increased by 1% however we did not meet our 2025 target of 35%
- Hazardous waste is at its lowest level ever at 11% of total waste volumes
- Prevention and reuse data estimated from sterile services department, sterile linen, loan equipment service repairs and collection of wooden pallets to show how we can report on progress embedding waste hierarchy principles and recognise teams avoiding waste

Annual Waste Performance

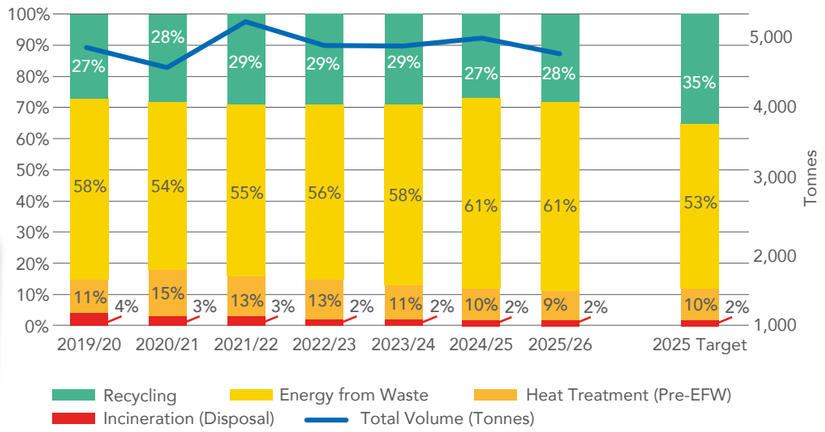


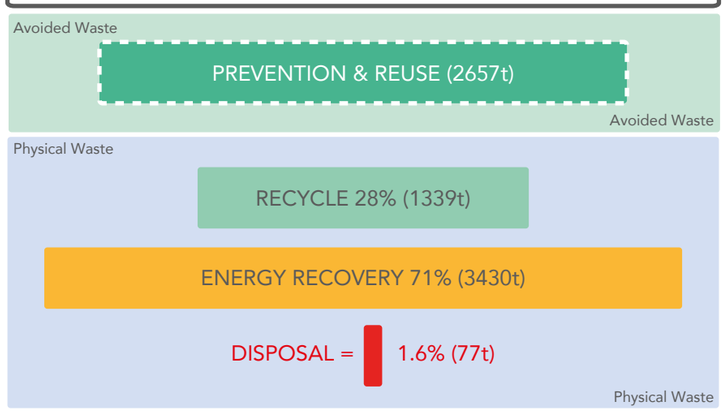
Figure 12: Total annual waste disposed of by waste outcome

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

- Thanks to Newcastle Hospitals Charity, during Waste Awareness Week public facing bins were upgraded so the public know where to put waste, implementing Simpler Recycling legislation
- Coffee cup waste segregation promoted to ensure recycling is not contaminated
- Bin the Wipe campaign, in collaboration with Northumbrian Water, to reduce the number of toilet blockages at the Royal Victoria Infirmary, which costs £100,000 a year
- 82 waste audits completed in wards and departments
- Reuse metrics calculated and reported
- The non-infectious (tiger bag) waste stream was introduced to our community sites moving an additional 3 tonnes of waste every month away from treatment
- Working with Converge we recycled 3,000 units of IT, over 90% of the devices recycled have had a second life, either through refurbishment or by components being deployed elsewhere avoiding 34 tonnes of waste


▲ *Improved waste facilities at Ponteland Road Urgent Treatment Centre*

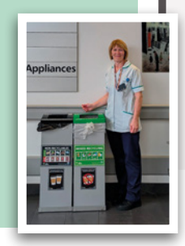
NEWCASTLE HOSPITALS - WASTE HIERARCHY OUTCOMES 25/26



ZERO WASTE VISION

PLANS FOR THE NEXT YEAR

- Extend food waste recycling into staff eating areas and rest rooms
- Refresh and implement the Waste and Resources Plan to ensure an enhanced focus on prevention and reuse across the Trust
- Continue to complete regular waste audits in line with the Accrediting Excellence programme
- Upgrade infrastructure for waste segregation on site
- Enhance recycling at community sites such as Geoffrey Rhodes and the Campus for Aging and Vitality
- Explore opportunities for diverting clinical waste from high temperature incineration in collaboration with 3 other acute healthcare trusts in the region



CASE STUDY: SHINE AWARD WINNER: BORN GREEN GENERATION

Aly Kimber-Herridge, a research midwife with over 30 years of experience, is currently working on the Born Green Generation project, seeking to reduce the reliance on plastic in maternity services due to its harmful effects. She says "*The first principle of healthcare is to do no harm, yet our dependence on single-use plastics sits in direct contradiction to this. Plastic is everywhere in our environment, and once produced, it never truly disappears. There are thousands of varieties, mostly derived from petrochemicals, and over time, they break down into microplastic particles. These particles have been found in places as remote as the Mariana Trench and the peak of Everest – and, more concerningly, throughout the human body. They have been detected in brain tissue, ovaries, umbilical cords, and even in meconium, a baby's first stool.*"

To combat this the team have made simple switches such as from plastic gallipots to cardboard, introduced sustainable sharps and placenta disposal and led a trial on sustainable skin preparation for caeserean sections. Their work has avoided the use of almost 2 tonnes of plastic or 51,000 individual items.

5.6 Procurement

AIM

Embed sustainability and support for climate emergency action into all purchasing decisions, working towards a net zero carbon supply chain:

- Consume less
- Embed carbon reduction into our procurement processes
- Establish positive relationships with key suppliers
- Engage in research and innovation in order to reduce impact across whole value chain
- Improve confidence in our supply chain carbon data
- Invest more in our local supply chain
- Increase the amount of sustainable, local, healthy food available to staff, patients and visitors

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

- In collaboration with Newcastle City Council and with support from the North East Combined Authority and Newcastle Hospitals Charity held our 5th and 6th annual supplier events, increasing collaboration across the North East public sector and working with the supplier community. Chair of Newcastle Hospitals, Northumbria Healthcare and Gateshead Health Sir Paul Ennals opened both events. Over 600 attended on 24 March 2026 in person and online

PERFORMANCE

As the graph on page 12 shows, carbon emissions associated with purchased goods and services are estimated to account for 89% of our total carbon impact. We have revised our calculation from last year and provided a baseline for emissions against which progress will be tracked:

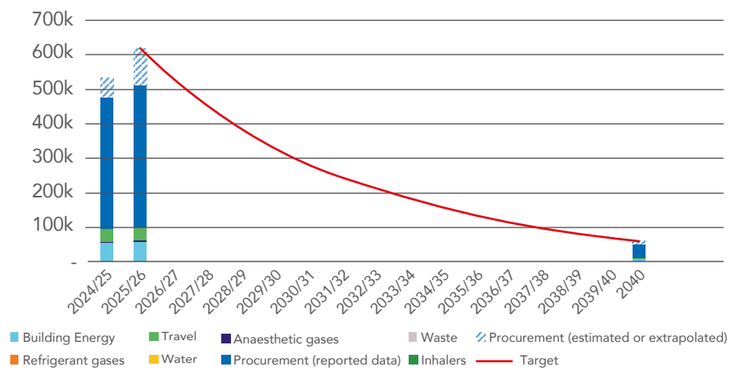


Figure 13: NHS Carbon Footprint Plus: baseline and target

This year we held our 5th and 6th supplier events, seeking to support our suppliers via our 5 Step low carbon supplier framework on their decarbonisation journeys. We moved the 6th one forward at the request of Newcastle City Council, to allow for an open discussion ahead of the pre-election period and to ensure a wider public sector involvement.

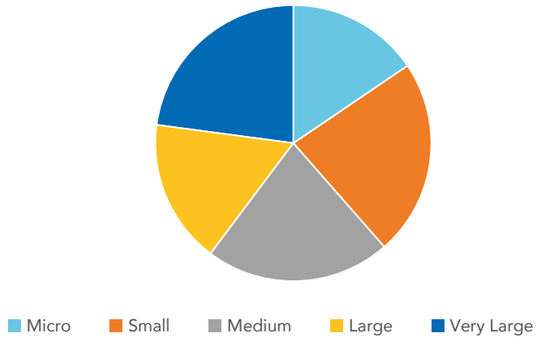


Fig 14: Mix of supply chain companies that attended our 6th annual supplier event by size

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR (CONTINNUED)

- Collaborated across the Great North Healthcare Alliance, recruiting a net zero data officer to ensure a consistent approach to carbon reporting
- Improved the governance of sustainability in procurement by establishing a steering group to oversee the progress of the existing working group
- Continued to promote and engage suppliers with our 5 step low carbon supplier framework, improving our sustainable procurement webpage so that suppliers can access support
- Extended the reach of our Linkedin supplier network, which now includes all of the North East public sector
- Commenced implementation of changing from paper based menus to an electronic meal ordering system. When concluded we expect to make savings of £250,000 on food waste and offer more sustainable, low carbon menus.

PLANS FOR THE NEXT YEAR

- Revise and update the sustainable procurement policy
- Carry on sustainability as a priority in the new Procurement Plan
- Ensure collaborative working across Newcastle Hospitals so that sustainability and a "buy less buy better" approach is embedded into cost improvement and materials management. Work to improve efficiencies via dedicated projects (e.g. electronic meal ordering, Scan4Safety and review of procedure packs)
- Improve confidence in the carbon data we are reporting and track progress against established baseline
- Continue to increase engagement with the 5-step low carbon supplier framework
- Establish a standardised approach to reporting across the Great North Healthcare Alliance

IMPACT STORY: INCREASING COLLABORATION ACROSS THE NORTH EAST

▲ *Sir Paul Ennals, Chair opening the supplier event*

With support from Newcastle Hospitals Charity we worked with colleagues across the North East public sector to host the North East Public Sector Sustainable and Social Value Supplier Event 2026, on 24 March 2026, our 6th annual supplier event.

This event started six years ago, initially run solely by Newcastle Hospitals for our suppliers. We have sought to collaborate to ensure a consistent approach across the region, and so this year the event was hosted by Newcastle City Council with support from the North East Combined Authority and Newcastle Hospitals Charity and collaboration from Northumbria University, Health Innovation North East and North Cumbria, the Great North Healthcare Alliance and Net Zero North East England. 600 attended the event either in person or remotely.

Our chair Sir Paul Ennals opened the event with a call to arms for climate action. He said it is easier if the public sector work together to combat the climate crisis, and that we are not going to stop working towards Net Zero, "if we don't take climate action, the world for our children and grandchildren is going to be an awful lot harder than the world we live in today".

There were speakers from the private and public sector, with panel discussions answering questions from the audience about how we can influence our suppliers, and how our suppliers can help us reach net zero.

5.7 Buildings and Land

AIM

Provide healthy, sustainable and biodiverse spaces for patients, staff and visitors:

- Include opportunities for sustainability innovations in all new builds and refurbishments based on recognised standards
- Build climate adaptation and resilience into our management of existing estate as well as all new builds and refurbishments
- Expand our green space and enhance the biodiversity of our land

PERFORMANCE

Table 2: Statutory Biodiversity Metric Scores across the RVI and FH Sites

LOCATION AND ASSESSMENT TYPE	BASE LINE - *MARCH (YEAR)	2025 RESULT – *SEPTEMBER	2052 TARGET
FH habitat units	24.28 (2022)	26.85	28.89
FH hedgerow units	4.22 (2022)	4.8	4.93
RVI habitat units	23.87 (2023)	16.3	25.19
RVI hedgerow units	0.5 (2023)	0.58	0.77

*Notes about method: We have appointed an independent ecology specialist to complete these audits annually, since March 2021. It has been difficult to set a reliable baseline and track our progress to date, due to changes in methodology over this time period (through multiple versions) and the time of year the assessments were completed (we have moved from completing this task close to the end of the annual reporting cycle (March) to the summer (August) when biodiversity is at its best).

ACTIONS AND ACHIEVEMENTS FROM THIS YEAR

- Sir Bobby Robson Institute for cancer research has a design aim of BREEAM outstanding and aims to achieve the NHS Net Zero Building Standard
- Urgent Treatment Centre complete, our first non-fossil fuel building
- Improvement of governance via our Greenspaces Working Group including developing a project tracker and collaboration with our grounds maintenance contractor
- Onboarded our Nature Recovery Ranger who has engaged with staff and patients on multiple projects including:
  - Freeman Hospital nature trail development
  - Wellbeing labyrinth
  - Bioblitz and big pond dip
  - Sensory engagement, bringing nature into our wards
- Onboarded PhD student to evaluate the health and wellbeing benefits of green space to patients, staff, visitors and community
- Submitted grant applications for green the grey projects for internal courtyards

Planting bulbs at the Freeman Labyrinth

PLANS FOR THE NEXT YEAR

- Embed sustainability into the construction of Sir Bobby Robson Institute
- Work with capital team on decarbonisation at the Freeman, Ponteland Road Health Centre and Benfield Park Healthcare and Diagnostic Centre
- Finalise the Greenspaces and Health Plan
- Implement green the grey projects such as the old outpatient department courtyard with the help of Newcastle Hospitals Charity funding (Climate Emergency Action Fund)
- Establish a Freeman Hospital nature trail
- Establish a nature recovery volunteer programme with Volunteer Services
- Support our corporate volunteers to engage in greenspace activities
- Increase engagement with local providers like the Natural History Society of Northumbria and Ouseburn Way
- Progress the PhD study on the biodiversity benefits to health

It is my first day and I've already used this lovely space three times. Please keep it forever

CASE STUDY: STAFF AND PATIENT WELLBEING AT THE FREEMAN HOSPITAL LABYRINTH

At Newcastle Hospitals we were lucky to be chosen to host a Nature Recovery Ranger from the Centre for Sustainable Healthcare. Dr Duika Burges-Watson recently joined the sustainability team and has had a huge impact across the Trust.

One of her projects was to develop a labyrinth at the Freeman Hospital. With the help of estates colleagues and our grounds maintenance contractor Duika laid out the plans, and then invited colleagues and children from the Free Spirits Nursery to plant bulbs in the Autumn. The labyrinth consists of 20 metres of a walking meditation path wide enough for wheelchairs, and in the spring we saw the flowers erupt: purple crocuses, muscari and alliums.

Our clinical psychology teams have used the labyrinth as a therapeutic space for patients, and our staff have taken much needed breaks slowly walking and talking about their day.

One visitor said: "Being here makes me feel relaxed and it's an area to reflect. I came to give the dog a walk while my wife was at her appointment." A member of staff said: "It is my first day and I've already used this lovely space three times. Please keep it forever."

6. Overall Performance

In our Climate Emergency Strategy, we set out three long term goals, and the actions we planned to take by 2025 for the eight Shine themes. This is our final summary of how we have progressed towards those goals, and the published actions. More detailed reports are included for each area in Section 5 of this report, and the final Climate Emergency Action Plan is available on our website.

We will continue to seek to mitigate our impact in line with our science aligned targets and adapt to a changing climate

KEY

Red
Not achieved

Amber
Partially achieved

Green
Achieved

SHINE THEME	RAG RATING	What have we achieved since the launch of our Climate Emergency Strategy
Energy & Water		We have reduced our carbon emissions, against a backdrop of increasing clinical activity, but we are not on track to achieve our target of Net Zero by 2030. We have established the foundations to enable significant carbon reductions in the future: • Recruited an Energy Manager, Assistant Energy Manager, Estates Net Zero Delivery Manager and Estates Net Zero Project Lead • Improved building level metering to ensure targeted efficiencies • Decarbonised Regent Point avoiding 40 tonnes of CO_2e annually • Installed 1,293 solar panels • Successfully bid for Public Sector Decarbonisation Scheme funding (£40.5 million) to reduce emissions at the Freeman Hospital and two community sites.
Journeys & Clean Air		We have reduced carbon emissions from our journeys and increased our score on the Clean Air Hospital Framework: • Ban of diesel lease vehicles • Recruitment of a PhD student to monitor air quality and report on our progress with the Clean Air Hospital Framework • Gold cycle friendly employer • Electric staff "Hopper" bus between our two main hospital sites avoiding 144 tonnes of CO_2e annually
Waste		We have improved waste outcomes and reduced tonnage of waste per patient contact: • Reduced the annual volume of waste at the 'disposal' level of the waste hierarchy by 117 tonnes from our baseline • Implemented tiger waste (non-infectious clinical) stream segregation across the Trust • Programme of waste audits at ward level • Waste talk on induction for all new staff • Joined the Circular Economy Healthcare Alliance to prioritise reuse over single use
Procurement		We have increased engagement with suppliers and embedded sustainability into our procurement function: • Mandatory 5 step low carbon procurement framework • Annual supplier event with increasing collaboration across the public and private sector • Sustainable procurement policy overseen by a sustainable procurement steering group • Cool Food pledge to reduce our carbon emissions by 25% by 2030 and embedding sustainability into our Food and Drink strategy
Models of Care		We have increased capacity for clinical colleagues to deliver sustainability work and are starting to embed sustainability into clinical boards: • Thanks to Newcastle Hospitals Charity we have been supported by clinical sustainability fellows and appointed clinical sustainability leads • Newcastle Health Research Partnership Sustainable Satellite set up to enable collaboration on research opportunities • Improved resources and signposting for clinicians working on susQI • Set up a nitrous oxide MDT to bring in efficiencies and move away from a piped supply where not clinically required • Installed units which capture Entonox in maternity and "crack" it to harmless oxygen and nitrogen
Buildings & Land		We have worked with estates colleagues to ensure net zero building principles are standard in our capital programme: • Our Urgent Treatment Centre at the RVI is our first building to be built without reliance on fossil fuels • Thanks to Centre for Sustainable Healthcare we have hosted a Nature Recovery Ranger • Built a pond at the Freeman to improve biodiversity • Adaptation plans created and awaiting implementation
People		Increased our Green Champion network and continued to promote climate action: • Environmental sustainability embedded into our trust-wide strategy • 1,300 green champions across the Trust • Launched a staff behaviour change programme • Regular communications included in staff newsletters and on social media • Sustainability and climate emergency action included in job adverts and job descriptions

7. Contact Details

This Annual Report 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.

Let us know your thoughts on this report, and how it could be improved

If you wish to contact the Sustainability Team please email **nuth.environment@nhs.net**

Or write to us at: Sustainability Team (Estates Department)
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Queen Victoria Road
Newcastle upon Tyne
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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)**

8. Glossary

BREEAM – Building Research Establishment Environmental Assessment Method used to assess, rate and certify the sustainability of buildings.

Carbon dioxide equivalent (CO_2e) – A carbon dioxide equivalent or CO_2e, 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.

CHP – Combined Heat and Power, the production of electricity or power, with usable heat as a by-product, from a single source of energy, in this case gas.

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.

Greenhouse gas protocol – global standardised framework to measure and manage greenhouse gas emissions.

Hybrid method – used to calculate emissions from purchased goods and services. Method uses a combination of supplier-specific activity data (where available) and secondary data to fill the gaps. This method involves collecting allocated scope 1 and scope 2 emission data directly from suppliers; and using secondary data to calculate upstream emissions wherever supplier-specific data is not available.

ICS – 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.

NHS England Net Zero Supplier Roadmap & Evergreen Framework – In September 2021 a supplier roadmap was approved to help suppliers align with the NHS net zero ambition. The Evergreen sustainable supplier assessment is the mechanism for suppliers to engage with the NHS on the requirements of the roadmap. https://www.england.nhs.uk/greenernhs/get-involved/suppliers/

PPN 06/20 – Procurement Policy Note 06/20 (PPN06/20) applies to procurements covered by the Public Contracts Regulations 2015 and requires a minimum of a 10% weighting for social value questions.

PPN 06/21 – Public Procurement Notice 06/21 (PPN06/21) requires all companies and organisations who apply for central government contracts (above £5m framework value) to publish a Carbon Reduction Plan and demonstrate their alignment with the government's 2050 Net Zero goals.

PSDS – The Public Sector Decarbonisation Scheme (PSDS) provides grants for public sector bodies to fund heat decarbonisation and energy efficiency measures.

Shelford Group – is a collaboration between ten of the largest teaching and research NHS hospital trusts in England.

Spend-based method – used to estimate emissions from purchased goods and services by collecting data on the economic value of goods and services purchased and multiplying it by relevant secondary (e.g. industry average) emission factors.

Waste hierarchy – The waste hierarchy ranks waste management options according to what is best for the environment.

[i] **Notes about methodology:**

- Newcastle Hospitals NHS Foundation Trust has adopted an operational control approach to establishing the boundary. The methodology adopted in line with the Greenhouse Gas Protocol1 and the BEIS Environmental Reporting Guidelines. The calculations were completed on the SmartCarbonTM Calculator using the latest UK Government emissions factors.
- CO_2e is the universal unit of measurement to indicate the global warming potential (GWP) of Greenhouse Gases (GHGs), expressed in terms of the GWP of one unit of carbon dioxide. There are seven main GHGs that contribute to climate change, as covered by the Kyoto Protocol: carbon dioxide (CO_2), methane (CH_4), nitrous oxide (N_2O), hydrofluorocarbons (HFCs), perfluorocarbons (PFCs), sulphur hexafluoride (SF_6) and nitrogen trifluoride (NF_3). Different activities emit different gases. Using CO_2e allows all greenhouse gases to be measured on a like-for-like basis.
- For National grid electricity consumption, Newcastle Hospitals NHS Foundation Trust has included factors for the transmission and distribution of electricity (T&D) losses, which occur between the power station and site(s). The emissions from T&D has been accounted for in Scope 3. As with other Scope 3 impacts, reporting T&D is voluntary but is recommended standard practice by UK Government.
- Well-to-tank (WTT) fuels conversion factors have been included to account for the upstream Scope 3 emissions associated with extraction, refining and transportation of the raw fuel sources to an organisation's site (or asset), prior to combustion. As with other Scope 3 impacts, reporting WTT is voluntary but is recommended standard practice by UK Government.
- Procurement carbon emissions are calculated using a hybrid method – deducting known scope 1 & 2 reported carbon data from suppliers from the carbon footprint calculated using a spend based method - £ spent in eclass spend categories multiplied by average carbon factors for those categories.
- A full SECR compliant report is available on request. https://sciencebasedtargets.org/resources/files/Net-Zero-Standard.pdf

"We often talk of saving the planet, but the truth is that we must do these things to save ourselves."

Sir David Attenborough

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Carbon Reduction Plan

Supplier name: **The Newcastle upon Tyne Hospitals NHS Foundation Trust**

Publication date: **[To be added]**

Commitment to achieving Net Zero

Newcastle Hospitals was the first healthcare organisation in the world to declare a climate emergency and acknowledge the associated risk to patient health. In 2021, we were the first healthcare organisation to become a signatory to the United Nations Framework Convention on Climate Change (UNFCC) Race to Zero[i].

In 2020, we published a 5-year Climate Emergency Strategy[ii] with a Net Zero target of 2030 for the emissions we control. This year we reviewed this target with our Board, in developing our next five year plan, and acknowledged that we will be unable to meet this target within current operational, financial and system constraints. Our new target is to reduce our controllable carbon footprint by 50%, from our baseline, over the next five years.

This year we have embedded care for the environment in the Newcastle Hospitals strategy: Caring, improving and learning together (2026-2031)[iii]. We consider care for the environment as one of our values.

Our revised vision and goals in respect of the climate emergency are within our Climate Emergency Plan for 2026-2031. 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

Baseline Emissions Footprint

Baseline emissions are a record of the greenhouse gases that have been produced in the past. Baseline emissions are the reference point against which emissions reduction can be measured. Under the Greenhouse Gas (GHG) Protocol, a base year is a fixed historical point in time for which a company has verifiable greenhouse gas emissions data, against which its current and future emissions are compared to track progress toward reduction targets. Entities must select their base year from the earliest point with reliable data.

Baseline Year: April 2019 – March 2020	
Additional Details relating to the Baseline Emissions calculations.	
We have adopted an operational control approach to setting the Carbon Footprint boundary and use the SmartCarbon Calculator[iv] to measure and report our carbon performance annually. The platform uses the UK Government Carbon Emission factors[v] and supplementary healthcare specific factors, as well as a comprehensive supply chain hybrid approach. This methodology is in line with the NHS Net Zero Plan[vi], The GHG Protocol Corporate Accounting and Reporting Standard[vii], The Greenhouse Gas Protocol Corporate Value Chain (Scope 3) Accounting and Reporting Standard[viii] and technical guidance[ix], as well as complying with the Streamlined Energy and Reporting Regulations (SECR)[x]. Please see our Annual Reports[xi] and Full Carbon Footprint reports for more details.	
Baseline year emissions: April 2019 – March 2020	
EMISSIONS	**TOTAL (tCO_2e)**
Scope 1	53,122.78
Scope 2	2,959.25
Scope 3 **(Included Sources)**	198,649.39 (1. Purchased Goods and Services 4. Upstream transportation and distribution 5. Waste generated in operations 6. Business travel 7. Employee commuting 9. Downstream transportation and distribution)

NHS Carbon Footprint (see Fig. 1 below)	68,149
Total Emissions NHS Carbon Footprint Plus (see Fig. 1)	254,731

Current Emissions Reporting

Reporting Year: April 2025 – March 2026	
EMISSIONS	**TOTAL (tCO_2e)**
Scope 1	47,490.9
Scope 2	2,742.48
Scope 3 (Included Sources)	565,597.02 (1. Purchased goods and services; 2. Capital Goods; 3. Fuel and Energy-related activities; 4. Upstream transportation and distribution; 5. Waste generated in operations; 6. Business travel; 7. Employee commuting; 9. Downstream transportation and distribution)
NHS Carbon Footprint (see Figure 1)	62,198
Total Emissions NHS Carbon Footprint Plus (see Figure 1)	615,830

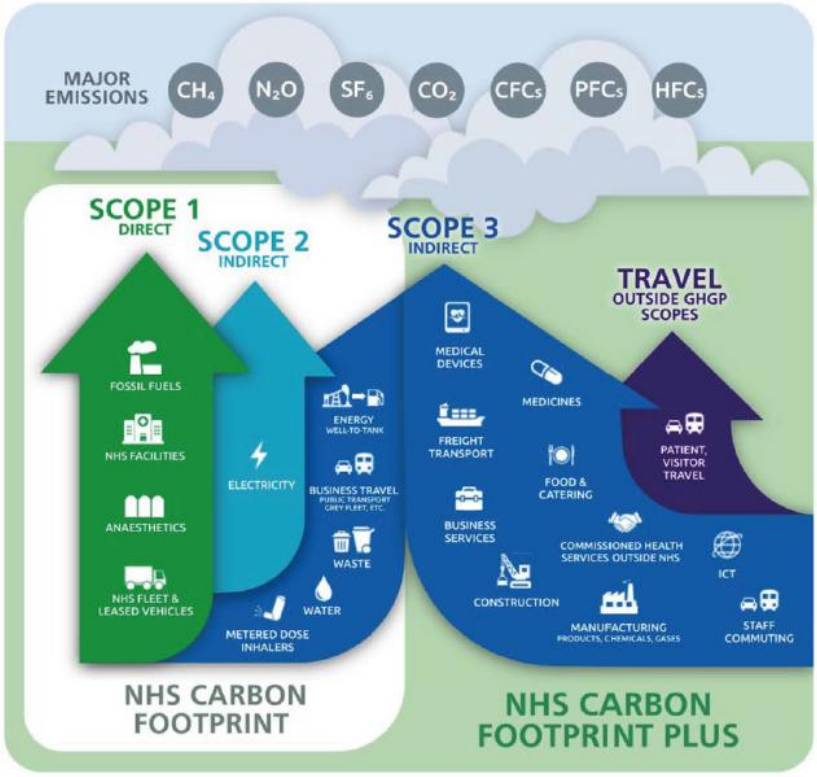
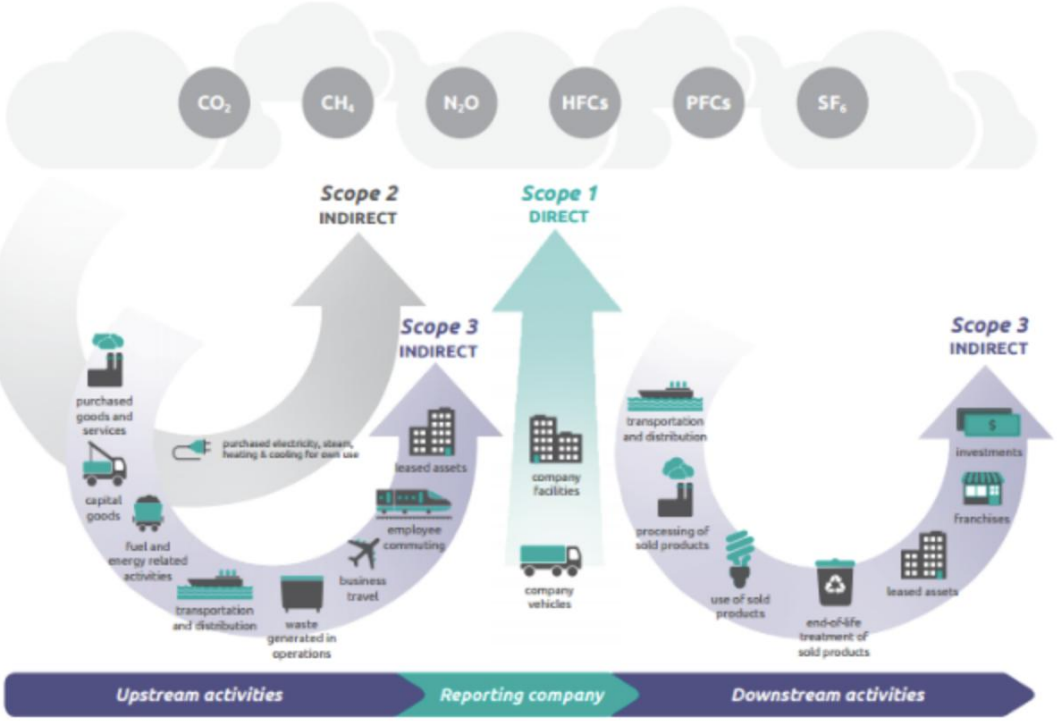


Figure 1. Greenhouse Gas Protocol scopes in the context of the NHS[xii]



GHG Inventory Diagram. Source: Greenhouse Gas Protocol

Figure 2. GHG Inventory Diagram[xiii]

Emissions Reduction Targets

We set a target to achieve Net Zero for our NHS Carbon Footprint by 2030 in 2019. Due to a lack of funding to replace fossil gas power systems we will be unable to meet this target.

The revised target set out in our Climate Emergency Plan for 2026-2031 is that we will reduce our emissions by 50% by 2031, to [28,041.02 tCO2e if scope 1 and 2 or 34,075.72 tCO2e if NHS Footprint]. This remains an ambitious target, reliant on the Public Sector Decarbonisation Scheme funding to decarbonise the Freeman Hospital and two community sites, and the grid reaching net zero. We are working with city partners to establish a Newcastle City North deep geothermal district heat network to support decarbonisation at the Royal Victoria Infirmary. Below is our progress and trajectory.

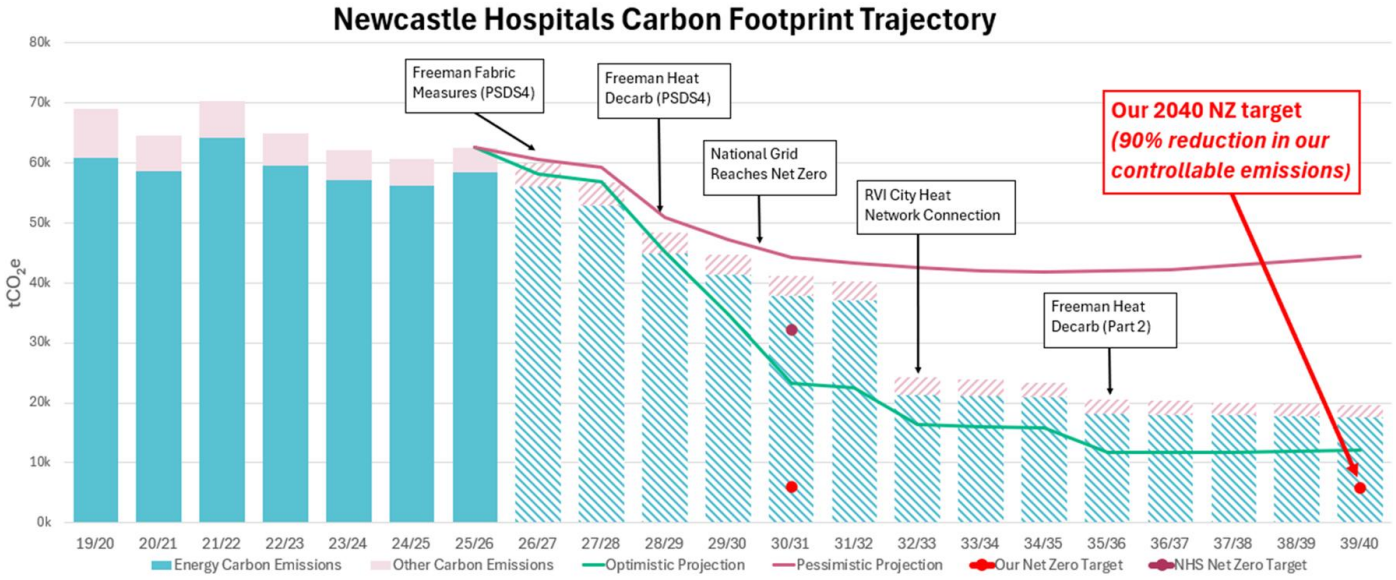


Figure 3: Newcastle Hospitals Carbon Footprint Trajectory

We have set a reduction target for our NHS Carbon Footprint Plus of 90% by 2040, or 61,583.04 tCO2e.

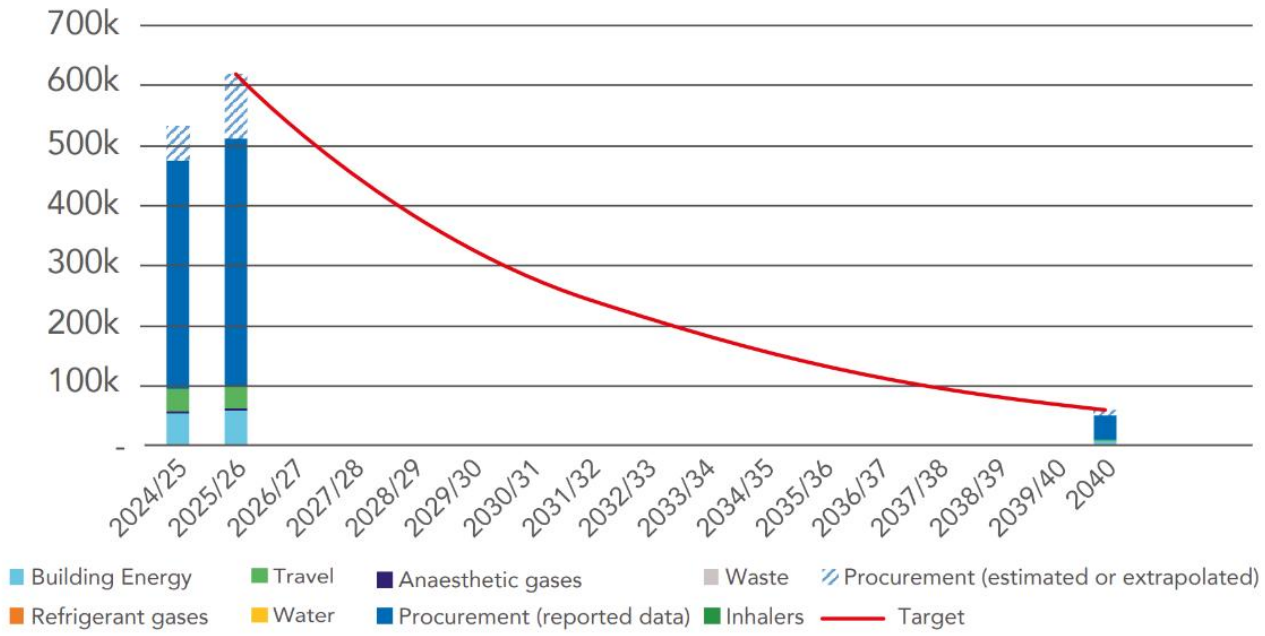


Figure 4: Newcastle Hospitals Carbon Footprint Plus Trajectory

Please see our annual Shine Reports for further detail[xiv].

Carbon Reduction Projects

Completed Carbon Reduction Initiatives

The following environmental management measures and projects have been completed or implemented since the 2019 baseline for our NHS Carbon Footprint. The carbon emission reduction achieved by these schemes overall equates to 6,094.68 tCO_2e, a 9% reduction against the 2019 baseline and the measures will be in effect when performing the contract. Some of this reduction will be due to improved carbon factors and grid decarbonisation.

ORGANISATIONAL CULTURE

- We were the first healthcare organisation in the world to declare a climate emergency as a health emergency and commit to fast-tracking the decarbonisation of our services.
- We hold green accreditation with Investors in the Environment for our approach to organisational environmental management.

- Our Sustainable Healthcare in Newcastle (Shine) programme covers eight priority action areas and our Sustainability Team works closely with our network of over 1200 staff Green Champions to reduce our environmental impact in these areas.
- We have received funding from Newcastle Hospitals Charity to assist with projects including: funding for staff led susQI (sustainable quality improvement) projects, clinical leads to drive change in our clinical boards, clinical sustainability fellow who undertook a susQI project, bike maintenance sessions for staff to encourage active and sustainable travel, green the grey projects to make green space more available to staff, improved waste facilities to increase appropriate segregation.

BUILDING ENERGY

- We install energy efficient Light Emitting Diode (LED) lighting as standard on refurbishments and continue to transition our estate from fluorescent to LED.
- We have installed solar panels on the roof of the multi-storey car park at Leazes Wing Royal Victoria Infirmary (RVI), the Day Treatment Centre (DTC) at the Freeman Hospital, and Regent Point. There are now 1,293 solar panels across our sites generating almost 350 MWh annually.
- Funding via PSDS Phase 3b to decarbonise Regent Point project completed August 2024. LED lights, heat pumps for the entire energy demand of the building, solar panels and Building Management System (BMS) upgrades. Carbon emission reduction of 40 tCO_2e annually.
- Funding from National Energy Efficiency Fund #3 (NEEF3) of £750,000 for LED lighting at the RVI and solar panels at Freeman Hospital.
- Funding of £92,000 under the Centralised Energy Purchasing Agreement (CEPA) scheme for electrical sub metering at the Freeman Hospital.
- Funding from GB energy of £58,763 for solar panels at the RVI Hospital, completed in early 2026/27
- Funding of £179,664 for Electric Vehicle (EV) chargers across the RVI and Freeman Hospital.
- Public Sector Decarbonisation Scheme Phase 4 funding (£40.5 million) to upgrade core mechanical, electrical and building-fabric assets across the estates over a 3-year funding period from April 2025 – March 2028, delivering renewal of ageing heating systems, installation of modern, low-carbon heating technologies and improved conditions for staff and patients, estimating a 25% reduction in emissions, estimated at almost 10,000 tCO_2e annually from 2028.

LOWER CARBON CARE

- We limited and then ceased use of desflurane, an environmentally damaging volatile anaesthetic gas, and decommissioned the nitrous oxide manifold at our Freeman Hospital. We continue with clinically led projects to further reduce nitrous oxide waste at RVI, where the gas is still required for paediatric and dental anaesthesia.
- We were the first healthcare organisation in the UK to implement nitrous ‘cracking’ technology, which is used as standard in our Maternity Services at RVI. This equates to a carbon emission reduction of 2,422.39 tCO_2e (3%) against our 2019 baseline. The calculation for the volume of

nitrous oxygen cracked by the devices was improved this year using more accurate data, in part from the devices themselves and in part using estimates based on the levels of nitrous oxide in the room atmosphere.

TRANSPORT & CLEAN AIR

- We have developed a Travel and Transport Plan to promote and incentivise the travel hierarchy to staff, including personalised travel plans, discounted public transport, cycle to work scheme and cycle storage infrastructure.
- We are recognised as a Gold Cycle Friendly Employer.
- We have commissioned zero-tailpipe-emission all-electric buses from local operator Go North East to run our staff hopper service. This equates to an annual carbon emission reduction of 144 tCO_2e (0.2%) against our 2019 baseline.
- We utilise the Clean Air Hospital Framework (CAHF) as a tool to reduce local and global air pollution. Our current self-assessed score against this framework is 51% “good”. We jointly fund a Clean Air PhD student, with Northumbria University, to progress our CAHF score.

WASTE

- We send zero waste to landfill (and have done since 2011)
- We use reusable sharps containers (and have done since 2004)
- Our waste training and auditing efforts have resulted in sector leading segregation rates, with less than 2% of our waste sent for disposal – the rest sent for energy recovery or recycling.

BIODIVERSITY

- We are hosting a Nature Recovery Ranger from the Centre for Sustainable Healthcare who is working with staff and patients to improve access to green space and therapeutic interventions.
- We are implementing our 30-year Biodiversity Management Plan to improve our biodiversity metric across our estate, knowing that access to nature and green space can improve patient recovery rates and staff health & wellbeing.
- We are developing a Green Spaces and Health Plan for 2026-2031.
- We jointly fund a PhD student from Northumbria University who is studying the links between patient health and availability of green space.

SUPPLY CHAIN

- We have established a dedicated Sustainable Supplier webpage, LinkedIn Group and email inbox to promote collaboration and knowledge share in the supplier community. We have over 850 supply chain companies actively engaged in our 5-step Net Zero Supplier Framework, collectively working towards our shared Net Zero target of 2040 for our scope 3 emissions (see note[1]). Over 75% of our suppliers (by spend) are providing carbon performance data to support our Scope 3 hybrid calculations.

- We have a sustainable procurement policy with sustainability integrated into our procurement policy. Our steering group and working group meet monthly to implement the sustainable procurement action plan and adopt a 'buy less, buy better' approach.
- We work collaboratively with the public sector across the North East to promote sustainable procurement, including via annual supplier events, this year with over 600 attendees.
- We have a 10% weighting on social value on Invitations To Tender for all new procurement.

In the future we hope to implement further measures such as:

BUILDING ENERGY

- Improvements to energy and water metering, to provide enhanced monitoring & targeting.
- Delivery of GB energy funded solar panels at the RVI Hospital.
- Delivery of EV chargers across the RVI and Freeman, to support decarbonisation of our fleet and those of our key partners.
- Further roll out of LED lighting, to ultimately achieve 100% coverage, and consideration for installation of solar panels on all viable roof space or surface car parks.
- Evolving our Heat Decarbonisation Plans to include our community properties.
- Continue to apply for government grant funding to deliver our estates net zero strategy.
- Exploration of options to source renewable heat from geothermal energy and/or city heat networks.
- Implementation of plans to shut down air handing units when not in use, in line with national policy.

LOWER CARBON CARE

- Decommissioning nitrous oxide manifold at our RVI site (switching to a lean nitrous oxide supply where there is still a clinical need).
- Further lowering the carbon in our maternity services care pathway by collaborating with European hospitals in our three-year 'Born Green Generation' project.

TRANSPORT & CLEAN AIR

- Launch the Travel and Transport plan promoting active and sustainable travel.
- Full electrification of our Trust owned and leased fleet.
- Improve infrastructure for active travel access to our sites, including staff e-bike provision.
- Work towards a sector-leading score of 70% on the Clean Air Hospital Framework (excellent status).
- Increased EV charging facilities for Trust fleet.

WASTE

- Explore innovative opportunities to reduce waste volumes and increase reuse i.e. reusable theatre hats, trialling reusable equipment to replace single use and expanding our food waste recycling.
- Improve reporting of waste in line with the waste hierarchy to show the value of reuse.

BIODIVERSITY

- Progress our 30-year Biodiversity Management Plan to improve our biodiversity metric across our estate.
- Implement the Green Spaces and Health Plan for 2026 – 2031.

SUPPLY CHAIN

- Increase confidence and accuracy in emissions associated with Scope 3 category 1, Purchased Goods and Services, by increasing the proportion of suppliers engaged in our 5-step framework and from 'extrapolated' to 'reported' data in our hybrid calculation.
- Implement Sustainable Procurement 5 year plan.

Declaration and Sign Off

This Carbon Reduction Plan has been completed in accordance with PPN 006 and associated guidance and reporting standard for Carbon Reduction Plans.

Emissions have been reported and recorded in accordance with the published reporting standard for Carbon Reduction Plans and the GHG Reporting Protocol corporate standard[xv] and uses the appropriate Government emission conversion factors for greenhouse gas company reporting[xvi].

Scope 1 and Scope 2 emissions have been reported in accordance with SECR requirements, and the required subset of Scope 3 emissions. The full carbon footprint has been reported in accordance with the published reporting standard for Carbon Reduction Plans and the Corporate Value Chain (Scope 3) Standard[xvii].

This Carbon Reduction Plan has been reviewed and signed off by the board of directors.

Signed on behalf of the Supplier:

Rob Harrison, Acting Chief Executive

Date:

Sir Paul Ennals, Chair

Date:

Footnotes

[i] https://racetozero.unfccc.int/system/race-to-zero/
[ii] https://www.newcastle-hospitals.nhs.uk/wp-content/uploads/2024/06/Climate-strategy-2020-2025.pdf
[iii] Our strategy: Caring, improving and learning together (2026 - 2031) - Newcastle Hospitals NHS Foundation Trust
[iv] https://www.smartcarboncalculator.com/
[v] https://www.gov.uk/government/collections/government-conversion-factors-for-company-reporting
[vi] https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/
[vii] https://ghgprotocol.org/corporate-standard
[viii] https://ghgprotocol.org/standards/scope-3-standard
[ix] https://ghgprotocol.org/scope-3-calculation-guidance-2
[x] https://www.gov.uk/government/publications/environmental-reporting-guidelines-including-mandatory-greenhouse-gas-emissions-reporting-guidance
[xi] https://www.newcastle-hospitals.nhs.uk/about/sustainable-healthcare/shine-annual-reports/
[xii] https://www.england.nhs.uk/greenernhs/a-net-zero-nhs/
[xiii] Homepage | GHG Protocol
[xiv] https://www.newcastle-hospitals.nhs.uk/about/sustainable-healthcare/shine-annual-reports/
[xv] https://ghgprotocol.org/corporate-standard
[xvi] https://www.gov.uk/government/collections/government-conversion-factors-for-company-reporting
[xvii] https://ghgprotocol.org/standards/scope-3-standard

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Agenda item A5(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

PUBLIC TRUST BOARD

Date of meeting	25 September 2026		
Title	Board Assurance Framework		
Report of	Patrick Garner, Director of Performance and Governance.		
Prepared by	Natalie Yeowart, Associate Director of Compliance, Governance and Risk.		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☐
Summary	An efficient and effective Board Assurance Framework (BAF) is a fundamental component of good governance; it provides the Trust Board with a structure tool that enables the organisation to focus on those risks that might compromise the achievement of its Strategic Objectives. **Quality Committee** There are three new strategic risks aligned to the Quality Committee, these relate to: • **Failure to meet our care standards in a way which is designed around people, not organisations.** • **Failure to coordinate services which are effective.** • **Inability to improve patient safety and patient harm through reliable, evidence-based care.** Updates since the last iteration of the BAF to Quality Committee include: • The threat in relation to learning disability and autistic patients has been reviewed and updated to include further controls, assurances and actions. • The threat in relation to Duty of Candour has been reviewed and updated to refine the threat description, update the controls, assurances and actions. • Two Audit One internal audit reports providing levels of assurance have been aligned to the Quality Committee BAF relating to Safeguarding Follow up (good) and Duty of Candour (reasonable) • The Risk Appetite Framework has been applied to the BAF, as of September 2026, all three strategic risks are outside of the risk appetite tolerance. **People Committee** There are two new strategic risks proposed for alignment to the People Committee, these relate to: • **Failure to provide a healthy, safe, flexible and inclusive working environment that enables our people to thrive and deliver outstanding patient care.** • **Failure to support and develop confident, compassionate and accountable leadership at every level.** Updates since the last iteration of the BAF to People Committee include: • Comprehensive actions have been added to each threat.		

	• Further work is required to strengthen the controls and assurances for each risk and associated threat. **Digital and Data Committee** This was the first iteration of the new BAF for 2026-2027 for review and consideration by the Digital and Data Committee. There is one new strategic risk aligned to the Digital and Data Committee, this relate to: • **Failure to develop and implement modern, reliable digital environments that support safe and efficient care.** The risk appetite framework has been applied to the BAF, as at September 2026, the digital and data committee strategic risk is currently in a tolerable risk appetite position. **Finance and Performance Committee** There are three strategic risks aligned to the Finance and Performance Committee, these relate to: • **Failure to coordinate services which are available when our patients need them. current score 16.** • **Failure to adequately maintain and continuously improve our estates and facilities to ensure they support safe and efficient care. Current score 20.** • **Failure to manage our resources sustainab**ly **and responsibly ensuring strong financial, productivity and commercial plans are delivered. Current Score 20.** Updates since the last iteration of the BAF to Finance and Performance Committee include: • Transformation and productivity has been realigned to the Finance and Performance Committee, threats relating to transformation and productivity are now included within 'failure to manage our resources sustainably and responsibly ensuring strong financial, productivity and commercial plans are delivered.' • 10 controls have been added relating to winter plan, cancer deep dive, agreed national productivity standards outpatients, echocardiology recovery plan, 40-week reporting, additional staffing, e-imaging, fire remediation contract, commercial delivery plan, research and innovation committee. • 9 new actions have been added relating to monitoring of diagnostic performance, delivery of MRI improvement plan, Northern Centre for Cancer Care (NCCC) MR utilisation proposal, NHS Estates national facet funding allocation, review of decant Freeman Hospital (FRH) for inclusion in 5-year capital programme, Referral to Treatment (RTT) recovery plans, activity plans, monitoring of activity and confirmation of uplift to medical pay award. • 7 actions are delayed with new deadlines added relating to Shelford Group Finance responses, rationalisation of transformation portfolio and full costings for commercial activity, Private Finance Initiative (PFI) final settlement, remedial scope and programme for PFI, completion of deed variation for Healthcare Support (Newcastle) and completion of business case for paediatric same day emergency care. • 1 threat is now complete and has moved from an amber assurance level to a green assurance level, this relates to failure to deliver refurbishments and construction capital schemes due to delays in building safety act approval, a business safety act early pre application process has been agreed and implemented and has improved business safety act approval processes for the Trust. • All three risks continue to be outside of the Trust risk appetite.
Recommendation	Public Trust Board are asked to: • Review the BAF September 2026-2027 • Provide comments or feedback.

	• Approve the BAF.					
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]	N/A					
Reports previously considered by	Regular report to Committees and Trust Board.					

BOARD ASSURANCE FRAMEWORK 2026-2027

1.0 INTRODUCTION

An efficient and effective Board Assurance Framework (BAF) is a fundamental component of good governance; it provides the Trust Board with a structure tool that enables the organisation to focus on those risks that might compromise the achievement of its Strategic Objectives.

The Audit Committee Handbook identifies the Board Assurance Framework as the key source of evidence that links strategic objectives to risks and assurances, and the main planning tool that the board should use for discharging its overall responsibilities for internal control.

The Board Assurance Framework provide an organisation with:

- A simple but comprehensive method for the effective and focussed management of the principal risks that arise in meeting the Trust's strategic objectives.
- A structure for evidence to support the statement of internal control and annual governance statement.
- A strategic focus to drive the Trust Board and Committee agenda and reporting rather than operational issues.
- A planning tool for the Trust boards to determine where to make the most efficient use of their resources and focussed improvement.
- A means to the identification of which strategic objectives are at risk of achievement, where controls are inadequate or where the organisation has insufficient assurance.
- Structured assurance where risks are being management effectively and objectives are being delivered.

2.0 BOARD ASSURANCE FRAMEWORK REVIEW

Quality Committee

There are three new strategic risks aligned to the Quality Committee, these relate to:

- **Failure to meet our care standards in a way which is designed around people, not organisations.**
- **Failure to coordinate services which are effective.**
- **Inability to improve patient safety and patient harm through reliable, evidence-based care.**

Updates since the last iteration of the BAF to Quality Committee include:

- The threat in relation to learning disability and autistic patients has been reviewed and updated to include further controls, assurances and actions.

- The threat in relation to Duty of Candour has been reviewed and updated to refine the threat description, update the controls, assurances and actions.
- Two Audit One internal audit reports providing levels of assurance have been aligned to the Quality Committee BAF relating to Safeguarding Follow up (good) and Duty of Candour (reasonable)
- The Risk Appetite Framework has been applied to the BAF, as of September 2026, all three strategic risks are outside of the risk appetite tolerance.

People Committee

There are two new strategic risks proposed for alignment to the People Committee, these relate to:

- **Failure to provide a healthy, safe, flexible and inclusive working environment that enables our people to thrive and deliver outstanding patient care.**
- **Failure to support and develop confident, compassionate and accountable leadership at every level.**

Updates since the last iteration of the BAF to People Committee include:

- Comprehensive actions have been added to each threat.
- Further work is required to strengthen the controls and assurances for each risk and associated threat.

Digital and Data Committee

This was the first iteration of the new Board Assurance Framework for 2026-2027 for review and consideration by the Digital and Data Committee.

There is one new strategic risk aligned to the Digital and Data Committee, this relate to:

- **Failure to develop and implement modern, reliable digital environments that support safe and efficient care.**

The risk appetite framework has been applied to the BAF, as at September 2026, the digital and data committee strategic risk is currently in a tolerable risk appetite position.

Finance and Performance Committee

There are three strategic risks aligned to the Finance and Performance Committee, these relate to:

- **Failure to coordinate services which are available when our patients need them. current score 16.**
- **Failure to adequately maintain and continuously improve our estates and facilities to ensure they support safe and efficient care. Current score 20.**
- **Failure to manage our resources sustainability and responsibly ensuring strong financial, productivity and commercial plans are delivered. Current Score 20.**

Updates since the last iteration of the BAF to Finance and Performance Committee include:

- Transformation and productivity has been realigned to the Finance and Performance Committee, threats relating to transformation and productivity are now included

within 'failure to manage our resources sustainably and responsibly ensuring strong financial, productivity and commercial plans are delivered.'

- 10 controls have been added relating to winter plan, cancer deep dive, agreed national productivity standards outpatients, echocardiology recovery plan, 40-week reporting, additional staffing, e-imaging, fire remediation contract, commercial delivery plan, research and innovation committee.
- 9 new actions have been added relating to monitoring of diagnostic performance, delivery of MRI improvement plan, Northern Centre for Cancer Care (NCCC) MR utilisation proposal, NHS Estates national facet funding allocation, review of decant Freeman Hospital (FRH) for inclusion in 5-year capital programme, Referral to Treatment (RTT) recovery plans, activity plans, monitoring of activity and confirmation of uplift to medical pay award.
- 7 actions are delayed with new deadlines added relating to Shelford Group Finance responses, rationalisation of transformation portfolio and full costings for commercial activity, Private Finance Initiative (PFI) final settlement, remedial scope and programme for PFI, completion of deed variation for Healthcare Support (Newcastle) and completion of business case for paediatric same day emergency care.
- 1 threat is now complete and has moved from an amber assurance level to a green assurance level, this relates to failure to deliver refurbishments and construction capital schemes due to delays in building safety act approval, a business safety act early pre application process has been agreed and implemented and has improved business safety act approval processes for the Trust.
- All three risks continue to be outside of the Trust risk appetite.

3.0. RECOMMENDATIONS

The Public Trust Board are asked to:

- Review the BAF September 2026-2027
- Provide comments or feedback.
- Approve the BAF.

Report of:
Natalie Yeowart
Associate Director of Compliance, Governance and Risk
17 September 2026

BOARD ASSURANCE FRAMEWORK 2026-2027

The Newcastle upon Tyne Hospitals NHS Foundation Trust

The key elements of the BAF are:

- A description of each Principal (strategic) Risk, that forms the basis of the Trust's risk framework (with corresponding corporate and operational risks defined at a Trust-wide and service level if available).
- Risk ratings – initial, current and target levels.
- Clear identification of primary strategic threats and opportunities that are considered likely to increase or reduce the Principal Risk, within which they are expected to materialise.
- A statement of risk appetite for each risk.
- Sources of assurance incorporate the three lines of defence: (1) **Management** (those responsible for the area reported on); (2) **Risk and compliance functions** (internal but independent of the area reported on); and (3) **Independent assurance** (Internal audit and other external assurance providers) to demonstrate the assurance and confidence of the control in place.
- Key actions identified for each threat; each assigned a timescale for completion.

Committee assurance ratings:
Green = Positive assurance: the Committee is satisfied that there is reliable evidence of the appropriateness of the current risk treatment strategy in addressing the threat or opportunity OR no gaps in assurance or control and current exposure risk rating = target.
Amber = Inconclusive assurance: the Committee is not satisfied that there is sufficient evidence to be able to make a judgement as to the appropriateness of the current risk treatment strategy.
Red = Negative assurance: the Committee is not satisfied that there is sufficient reliable evidence that the current risk treatment strategy is appropriate to the nature and/or scale of the threat or opportunity.

Action progress Indicators:
One progress indicator should be added in the action progress indicator box for each threat to demonstrate action progress.

1. **Fully on plan across all actions.**
2. **Actions defined- most progressing, where delays are occurring interventions are being taken.**
3. **Actions defined – work started but behind plan.**
4. **Actions defined -but largely behind plan.**
5. **Actions not yet fully defined.**

Risk Appetite Framework
A risk appetite position (Optimal/Tolerable/Outside) should be selected for each principal risk based upon the current risk score.

Risk Appetite Level	Optimal Risk Position	Tolerable Risk Position	Outside of Risk Appetite
Low	1 - 5	6 -10	>10
Moderate	1 - 8	9 - 15	>15
High	1 - 10	12 - 20	>20

Board Assurance Framework 2026/2027

Strategic Objective	**1. Joining up Care – working together to give people better, quicker access to effective care.**
Principal Risk (what could stop us from achieving our strategic objective)	**Failure to meet our care standards in a way which is designed around people, not organisations.**

Lead Committee	Quality Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Executive Director of Nursing, Midwifery and Allied Health Professionals (AHP)	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	**Quality and Safety**
Date Added	10.06.2026	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Level**	**LOW**
Last Reviewed	09.09.2026	**Risk Score**	**25**	**20**	**10**	**Risk Appetite Position**	**OUTSIDE OF APPETITE**

Threat (what might cause this to happen)	**Lead**	**Controls** (What controls do we already have in place)	**Sources of Assurance** (Evidence that the controls in place are effective)	**Actions** (Further actions required to manage risk)	**Action Progress Indicator**	**Threat Assurance Level**
Failure to promote and deliver equitable health access, experience and outcomes in our hospitals.	PG	• Promoting Equity in Health Group (PEHG) established reporting to Quality Committee. • Clinical Board health inequality action plans in place. • Maternity Health Inequalities Quality Priority agreed for 2026/27 within quality account. • Integrated Board Report (IBR). • Perinatal Public Health and Prevention Group. • Newcastle Health Inequalities strategic delivery plan developed and approved. • Clinical Board Health Inequality Self Assessments completed. • Trust Smoke Free Policy in place. • Adoption of the Core20PLUS5 National NHS England (NHSE) Framework. • Equity population profiling. • Health inequalities PowerBi Dashboards. • Tobacco dependency service established. • Integrated Care Board (ICB) funded alcohol care team recovery navigators appointed. • North ICB Waiting Well Programme established. • Population Health Management Fellows appointed. • Tier 3 weight management services established.	• Promoting Equity in Health Group Terms of Reference (ToR) and minutes. • Health inequalities report to Quality Committee 6 monthly. • Escalation and Assurance Report to Quality Committee monthly. • Quality committee ToR and minutes. • Clinical Board health inequality action plans. • Quality Account. • IBR monitors and reports health inequality information quarterly, reported through committees of the Board and Trust Board. • ToR and Minutes of perinatal public health and prevention group. • Clinical Board health inequality self-assessment documents. • Trust smoke free policy document. • PowerBI dashboards detailing Index Multiple Deprivation (IMD), ethnicity, Learning Disability flags and Did Not Attends (DNAs). • Equity population profiling data reported into trust prevention services ensuring a data driven approach to health inequalities. • Tier 3 weight management service targeting 20% most deprived.	• Reduce Did Not Attends/Will Not Attends by 3% among patients with Index Multiple Deprivation 1 and 2 and ethnically minoritised persons – December 2027. • Identify and implement reasonable adjustments for patients with additional needs – December 2028. • Measure clinical outcomes of 100% of ethnically minoritised persons, people with learning disabilities and autistic people – December 2028. • Train 6 facilitators in Medicine and Emergency Care to ensure education and training offer is embedded for health promotion to staff and patients – December 2026. • Monitor and deliver Clinical Board health inequality action plans - Year 1 plans by 31st March 2027.	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	

Failure to achieve compliance with national Maternity and Neonatal Services Standards.	JW	• Maternity Incentive Scheme (MIS) Year 8 monitoring group in place, with comprehensive tracker. • Maternal Care Bundle element task and finish groups in place. • 10 Point Plan gap analysis completed. • Birmingham Symptom-specific Obstetric Triage System (BSOTS) action plan completed. • Homebirth action plan completed. • Robust Perinatal Patient Safety Team in place. • Staff wellbeing and cultural improvement plan. • Perinatal Operational Assurance Group (POAG). • Board Maternity Safety Champions Group. • Incident Review Group. • Women's Quality and Safety (Q&S) Group. • Family Health Quality Oversight Group (QOG). • Family Health Quality Performance Review (QPR) meetings. • Maternity Services Quality Dashboard and North East and North Cumbria (NENC) Clinical Outcomes Dashboard. • Monthly Maternity General Staff meetings. • Maternity Voices Partnership - Lead quorate member of Quality and Safety Group and Obstetric Board member. • NHS England (NHSE) Regional Maternity Team oversight of Quality Oversight Model (PQOM) metrics and Maternity Incentive Scheme. • Real-time patient/staff experience programme. • Biannual perinatal workforce review. Perinatal governance structure aligned to themes of 10 Point Plan, reporting into Obstetric Board. • Perinatal staff experience programme. • NENC Clinical Outcomes Dashboard and safety signal review process. • Perinatal Anti-Racism Taskforce (PART). • Perinatal senior nurse/midwife on call introduced August 2025. • Completion of daily national maternity SitRep. • Maternity Outcomes Signal System (MOSS) data and associated standard	• MIS compliance with oversight via MIS tracker reported to Quality Committee and Trust Board. • Saving Babies Lives compliance via tracker. • Maternal Care Bundle compliance via tracker. • Maternal Care Bundle Task and Finish (T&F) Group Action plan, Reporting and Minutes. • Perinatal Quality Oversight metrics in Integrated Board Report, reported to Quality Committee and Trust Board. • 10 Point Plan gap analysis completed and reported to Quality Committee. • POAG minutes, reports and agenda. • Staff wellbeing and cultural improvement plan in place and monitored via People and Culture Group drawing insights from the staff experience programmes and SCORE (Safety, Communication, Operational Reliability, and Engagement) survey results. • Obstetric Board notes and action log. • Quality & Safety and Women's Quality and Safety Action log and notes. • Annual Care Quality Commission (CQC) Maternity Survey results – improvement in some domains, no reduction in results, improved position in NENC ranking. • Biannual perinatal workforce paper. • Incident data and scorecard reported to Q&S group. • Incident review group reporting and actions. • Family Health meeting minutes and QPR & QOG minutes. • Perinatal quality oversight metrics monitored and reported to Quality Committee. • Midwifery staffing and red flags monitored and reported to POAG and Quality Committee in IBR. • Maternity Outcome Signal System reported to Quality and Safety group monthly. • National dashboard reported to Quality and Safety group and regional/ICB oversight. • PART Action plan in place. • Staff wellbeing and cultural improvement plan.	• Maternal Care Bundle action plan to be signed off by Trust Board -September 2026. • Review of metrics in Integrated Board Report to align to 10 Point Plan - December 2026. • Establish Triage T&F group -September 2026. • Complete NHSE triage implementation tool gap analysis - October 2026. • Complete NHSE 10 Point Plan implementation tool gap analysis to be signed off by Trust Board and submitted to NHSE December 2026. • Review Perinatal Leadership structures to ensure adequate capacity to achieve actions - October 2026. • Develop Perinatal Strategy, linked to Trust strategy and national deliverables - initial submission September, final baseline by December 2026. • Review format of Perinatal Quality Oversight report to Quality Committee and Trust Board to ensure it fulfils requirements of 10 Point Plan – first submission September 2026, final submission December 2026. • Complete ongoing homebirth on call organisational change consultation - October 2026.	1. **Fully on plan across all actions.**	

		operating procedures. • National maternity and health inequalities dashboard.				
Failure to deliver improvement in our complaints process.	RC	• Complaints Improvement Task and Finish Group established with representation from all Clinical Boards to ensure Trustwide improvements. • Complaints Panel providing oversight and governance of complaints data and processes. • Experience of Care Group established providing escalation into Quality Committee. • Benchmarking self-assessment against the Parliamentary and Health Service Ombudsman (PHSO) standards completed.	• Improvement action plan with SMART (specific, measurable, achievable, relevant and time-bound) objectives. • Performance and quality metrics reported monthly in the Integrated Board Report to Quality Committee and Trust Board. • Executive level review of all complaint responses as a quality assurance process prior to Chief Executive Officer (CEO) signing off. • Patient Experience feedback via survey. • External assurance received from the Parliamentary and Health Service Ombudsman.	• Completion of Complaints Task and Finish Group action plan to achieve high quality and timely responses by March 2027. • Improvement data to be further developed for IBR and distribution to Clinical Boards by September 2026.	**1. Fully on plan across all actions.**	
Inability to identify and implement effective systems to support reasonable adjustments for learning disability and autistic patients.	IJ	• Mental Capacity Act (MCA) Quarterly audit framework including focused audit on patients with a learning disability. • MCA training programmes/compliance. • Learning Disability Governance Group in place. • LeDeR (Learning from Lives and Deaths) Review Panel with oversight by Experience of Care Group, Quality Committee. • Level 2 MCA training compliance. • Deprivation of Liberty Safeguards. • Oliver McGowan Mandatory Training for Learning Disabilities and Autism and Diamond Standards Training. Under review. • Live Dashboard to provide overview of patients with a Learning Disability or those who are Autistic to ensure visibility and supportive intervention. • Environmental Quality Checks undertaken by those with lived experience. • Reasonable Adjustments and Use of Hospital Passport Audit. • Internal Audit Reports.	• LeDeR reviews demonstrating improvement in use of hospital passport and reasonable adjustments. Areas of good practice noted and shared. • 96% compliance with Diamond Standards Training. 14930 completions. • Oliver McGowan Mandatory Training for Learning Disability and Autism launched in Quarter 1 (Q1) 2026/27. • Weekly case review by Matrons to ensure real time action to address any gaps in reasonable adjustments and use of hospital passports. Increase in Liaison Team capacity to support real time patient review and proactive admission planning. • Quarterly audit of 'Use of Hospital Passports' and Documentation of Reasonable Adjustments' in place. • NUTH 2025-2026 Follow up of Safeguarding – Good level of Assurance from internal audit report.	• Draft of Learning Disability and Autism Plan completed. Currently working on presentation of the plan and launch to align to newly published Trust Strategy - September 2026. • Review and evaluate year one roll out of Oliver McGowan Mandatory Training for Learning Disability and Autism and agree sustainable training plan in line with Oliver McGowan Code – April 2027. • Identify suitable estates resolution or mitigating actions to existing risk relating to suitable cubicle environment for patients in distress – February 2027. • Pilot and evaluate dedicated clinical space for complex learning disability and autistic patients to undergo desensitization and have investigations undertaken – May 2027.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken**	

Risk ID	1.1
Comments:	

Board Assurance Framework 2026/2027

Strategic Objective	**1. Joining up Care – working together to give people better, quicker access to effective care.**
Principal Risk (what could stop us from achieving our strategic objective)	**Failure to coordinate services which are effective.**

Lead Committee	Quality Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Joint Medical Directors	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	**Quality and Safety**
Date Added	11.06.2026	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Level**	**LOW**
Last Reviewed	09.09.2026	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Position**	**OUTSIDE OF APPETITE**

Threat (what might cause this to happen)	**Lead**	**Controls** (What controls do we already have in place)	**Sources of Assurance** (Evidence that the controls in place are effective)	**Actions** (Further actions required to manage risk)	**Action Progress Indicator**	**Threat Assurance Level**
Failure to deliver continuous and effective clinical pathways	LPC/MWr	• Cancer pathway reviews, seeking alignment with “best in class” (lung, gastrointestinal (GI), urology). • Clinical Board Governance. • Quality Oversight Groups. • Harm Review Process. • Alliance Medical Leaders Group, identifying areas for improvement for pathway delivery within the system. • Alliance Bilateral Boards, identifying and working towards solutions for secondary and tertiary care pathway delivery. • Getting It Right First Time (GIRFT) review and implementation where appropriate. • GIRFT Oversight Group. • Alliance Strategic Intent. • External Reviews and Accreditations e.g. Joint Accreditation Committee of ISCT and EBMT [stem cell transplantation and cellular therapies] (JACIE), United Kingdom Accreditation Service (UKAS), Human Tissue Authority (HTA)) avoiding waste and ensuring best practice in support services that are intrinsic to pathway delivery.	• Individual Clinical Boards, directorates and departments governance structures. • Harm reviews of clinical pathways where issues are identified (eg long waits, cancer delays). • Quality Oversight Groups ToR, Reports and Minutes. • Alliance Medical Leaders Group, identifying areas for improvement for pathway delivery within the system. • Alliance Bilateral Board ToR, Reports and Minutes. • GIRFT Assessments and Action plans. • Performance metrics reported to identify unwarranted variation • GIRFT Oversight Group ToR, Minutes and Papers, reports to Compliance and Assurance Group, Quality Committee and Audit, Risk and Assurance Committee. • External Review and accreditations – minutes ToR and reports of Compliance and Assurance Group, and escalation and assurance reports to Audit, Risk and Assurance Committee. • Organ Utilisation Strategy implemented.	• Delivery 2026/27 Service review programme – 31st March 2027. Development and implementation Patient Outcome Data and reporting into Quality Performance Reviews – October 2026. • Development of Alliance Clinical Framework – December 2026. • Support and develop optimisation of NENC pathways – December 2026. • Develop and Embed External Review learning and sharing of best practice mechanisms to support service improvements – December 2026.	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	

		• Organ Utilisation Strategy.				

Risk ID	1.2

Comments:

Board Assurance Framework 2026/2027

Strategic Objective	**1. Joining up Care – working together to give people better, quicker access to effective care.**
Principal Risk (what could stop us from achieving our strategic objective)	**Failure to coordinate services which are available when our patients need them.**

Lead Committee	Finance and Performance Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Performance & Governance	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	**Performance**
Date Added	11.06.2026	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Level**	**MODERATE**
Last Reviewed	16.09.2026	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Position**	**OUTSIDE OF APPETITE**

Threat (what might cause this to happen)	**Lead**	**Controls (What controls do we already have in place)**	**Sources of Assurance (Evidence that the controls in place are effective)**	**Actions (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Increased urgent and emergency care demand impacting flow	SH	• Daily Site Meetings and Site Handover. • Operational Management on Call Rota. • Implementation of Rapid Access service including Urgent Treatment Centre (UTC), Frailty Same Day Emergency Care, 2-hour Urgent Community Response and 24-hour District Nursing Service. • Additional fortnightly performance oversight introduced from June 2026. • Winter Plan.	• Improvements in 12-hour waits demonstrated through Integrated Board Report reported to Finance and Performance Committee (IBR). • Improvements in ambulance handover delays demonstrated through Integrated Board Report reported to Finance and Performance Committee (IBR). • Completion of the GIRFT Further Faster programme for Emergency Department (ED). • Performance deep dive presentations to Finance and Performance Committee. • Positive response and evaluation of the winter plan for 2025/26. • Initial assessment of winter plan completed.	• Completion of provider recovery actions submitted to NHSE by September 2026 relating to: • Flow and streaming optimisation: Redesign of triage and streaming processes, and enhanced UTC involvement in queue management (including paediatric capability). • Front-door and ambulatory care improvements: Introduction of bookable UTC appointments, strengthened front-of-house coordination, and expanded use of ambulatory pathways and low-risk early ward routing. • Clinical pathway development: Targeted pathway redesign, including refresh of specialty-specific plans (e.g. Eye ED) and strengthened ED–Assessment Suite integration. • Demand and capacity management: Review of ED overnight demand, improved escalation processes via Trust-wide Standard Operating Procedure (SOP) adherence, and development of digital bed management solutions. • System working and discharge flow: Improved partnership working across	**2. Actions defined-most progressing, where delays are occurring interventions are being taken.**	

				services and action to address discharge delays, including transport constraints. • Community and system flow initiatives: Implementation and planned scale-up of North East Ambulance Service (NEAS) care home conveyance avoidance pilot (85% success), introduction and rollout of Head Injury and Long Lie pathways via Urgent Community Response Team (UCRT); workforce upskilling to deliver IV/subcutaneous treatments to support admission avoidance and timely discharge; and development of a bed bureau/UCR interface to intercept appropriate cases via the community Single Point of Access (SPA). • Completion of business case for dedicated paediatric Same Day Emergency Care (SDEC) – Currently in process delayed - October 2026 (*August 2026).*		

Failure to meet key waiting time standards for cancer and elective care due to capacity constraints and pathway delays.	PG	• Finance and Performance Committee.
		• Weekly specialty /tumour group Patient Tracking List meetings for long waits and cancer.
		• Operational Performance Meetings with operational leads for long waits and cancer.
		• Provider Collaborative Mutual Support Co-ordination group.
		• Waiting List Management Processes in place.
		• Clinical Board Performance Improvement Plans.
		• Referral to Treatment (RTT) training delivered to clerical teams.
		• Targeted cancer improvement plans based on National Cancer Pathway Analyser Tool.
		• Allocation of growth funding from commissioners to under pressure services where available.
		• Service review process and methodology confirmed and service review programme in place.
		• Cancer deep dive on 62 days performance.
		• Agreed national productivity standards for outpatients.
			• Finance and Performance ToR, Minutes and schedule of business.
			• Patient Tracking List (PTL) Meeting reports, papers and recordings.
			• National benchmarking demonstrates track record of strong performance in waiting list and performance against RTT.
			• Weekly Newcastle Hospitals representation at Provider Collaborative Mutual Support Coordination Group facilitating patient transfers and collaboration amongst local providers to level demand.
			• Validation of the RTT/non-RTT of long waits via PTL meetings.
			• Performance Improvement Plans monitored via Finance and Performance (F&P) Committee, including deep dives.
			• Cancer Deep Dive Presentation to F&P.
			• Clinical board plans in place to deliver national productivity standards for outpatients.
				• Provide advice and guidance to GPs in all specialties, ensuring all specialties meet the national average diversion rate of at least 45%. – October 2026.
				• Completion of outpatient transformation actions by March 2027 as outlined in Year 1 of the Trust Strategy:
				  • Implement a fully operational single point of access, initially in 10 specialties.
				  • Review and change outpatient clinic templates to align with GIRFT standards.
				• Completion of capacity and demand modelling for theatres matched to job plans – March 2027.
					2. Actions defined- most progressing, where delays are occurring interventions are being taken	

Diagnostic bottlenecks due to workforce and utilisation issues impacting on decision making and timely treatment.	SH	• Specific Patient Engagement Platform introduced to improve the booking and scheduling processes in radiology modalities. • Capital planning process through Capital Management Group to replace diagnostic equipment. • Weekly list oversight meetings. • Echocardiology recovery plan. • Audiology Insourcing. • 24 new Echocardiology machines. • Bioplane E-Imaging. • RTT Team 40 week report. • Two additional sonographers appointed.	• Reduced DNA rates in radiology modalities. • Deep dive updates to F&P Committee. • Regular update on Radiology and Cell Pathology turnround times (TAT) via Clinical and Diagnostics Services QPR. • Positive TAT benchmarking. • Insourcing is in place in Audiology to support clearance of the> 6 week backlog. Additionally, following a comprehensive service review and re-structure, appointments have been made, including the appointment of clinical leads and a service manager to improve leadership within the Audiology team. • Weekly list oversight by Clinical Director/Service Manager/Sisters/Admin Manager have been established within main Endoscopy to identify if any list can be reopened (even if reduced capacity e.g. 6-point list instead of standard 12 points). • 24 new Echocardiology machines now in full operation. This enabling back-to-back appointments, reducing malfunctions and providing more accurate diagnoses and increased activity delivery. • Biplane E-imaging implemented to improve nerve root injection backlog and additional session provided. • RTT 40 week reporting to radiology supporting management of long waiters and preventing long wait breaches.	• Continue to monitor diagnostic performance/workforce and utilisation issues impacting on decision making and timely treatment – March 2027. • Delivery of MRI Improvement Plan – March 2027. • Northern Centre for Cancer Care (NCCC) MRI utilisation proposal and agreement – October 2026.	**2. Actions defined- most progressing, where delays are occurring interventions are being taken**	
Longer waits for community services compared to acute bases services due to lack of visibility.		• Regular reporting on Community Waits. • Task & finish Group in place targeting longest waits.	• Deep dive updates to F&P Committee. • Gradual reduction in specific long waiter groups demonstrated.	• Regular meetings with commissioners to discuss ceasing low risk podiatry referrals – March 2027. • ICB Senior Leadership Team (SLT) to consider sustaining non-recurrent work for the long occupational therapy (OT) wait times and the adaptation service. Awaiting response from ICB colleagues attending the Newcastle Hospitals Community Contract meeting – September 2026.	**5. Actions not yet fully defined.**	

Risk ID	1.3
Comments:	

Board Assurance Framework 2026/2027

Strategic Objective	**1. Joining up Care – working together to give people better, quicker access to effective care.**
Principal Risk (what could stop us from achieving our strategic objective)	**Failure to strengthen partnerships across neighbourhood, the city, region and system.**

Lead Committee	Trust Board	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director – Great North Healthcare Alliance & Strategy	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	**System and Partnership**
Date Added	20.07.2026	**Likelihood**	**4**	**3**	**1**	**Risk Appetite Level**	**HIGH**
Last Reviewed	17.09.2026	**Risk Score**	**20**	**15**	**5**	**Risk Appetite Position**	**TOLERABLE RISK POSITION**

Threat (what might cause this to happen)	**Lead**	**Controls** (What controls do we already have in place)	**Sources of Assurance** (Evidence that the controls in place are effective)	**Actions** (Further actions required to manage risk)	**Action Progress Indicator**	**Threat Assurance Level**
Leaders are not sufficiently aligned in their partnership thinking and risk appetite, such that plans are developed that do not have wider support or opportunities are missed.	RH	• Great North Healthcare Alliance. Collaboration Agreement and Steering Group (includes CEO, chair and vice chair of 4 Foundation Trusts (FTs)). • Bilateral meetings with each of Gateshead, North Cumbria and Northumbria FTs. • Great North Healthcare Alliance Clinical Framework Group. • Shared chair across Newcastle, Gateshead and Northumbria FTs. • Newcastle Neighbourhood Health Board. • Northeast and North Cumbria Provider. Collaborative Leadership Board. • Trust Management Group. • Clinical Board Quality and Performance Reviews.	• Trust Strategy. • Minutes of Alliance Steering Group (Committees in Common and Joint Committee). • Minutes of Gateshead, North Cumbria and Northumbria Bilaterals. • Minutes of Great North Healthcare Alliance Clinical Framework Group. • Alliance Risk Register. • Alliance Strategic Intent and Senior Responsible Officer (SROs) implementation plan. • Minutes of Newcastle Neighbourhood Health Board. • Minutes of Northeast and North Cumbria Provider Collaborative Leadership Board. • Minutes of Trust Management Group. • Minutes of Clinical Board Quality and Performance Reviews. • Northeast and North Cumbria joint Strategic Plan.	• Great North Healthcare Alliance joint Executive Event – 19 October 2026. • Refresh of Alliance ambitions following return of substantive CEO – April 2027. • Newcastle Neighbourhood Health Plan- March 2027. • Newcastle Board development session on partnership thinking and risk appetite – April 2027.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Culture behaviours within and between Trusts could result in inhibited collaborative working	RH	• Trust People Committee. • Alliance Steering Group. • Bilaterals with each of Gateshead, North Cumbria and Northumbria FTs. • Northeast and North Cumbria Provider. Collaborative Leadership Board. • Trust Management Group. • Clinical Board Quality and Performance Reviews.	• Trust Strategy. • Trust Values co-produced with staff. • Trust People Plan. • Minutes of Trust People Committee. • Minutes of Alliance Steering Group. • Minutes of Gateshead, North Cumbria and Northumbria Bilaterals. • Alliance Culture and Leadership Model.	• Shared Alliance Narrative – September 2026. • Mapping Values of the 4 Alliance Trusts – September 2026. • Leadership development and talent flow – September 2027. • Mapping leadership development work across the Alliance – March 2027.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	

			• Provider Collaborative Leadership Board minutes. • Minutes of Northeast and North Cumbria Provider Collaborative Leadership Board. • Minutes of Trust Management Group. • Minutes of Clinical Board Quality and Performance Reviews.			
Lack of capacity to meaningfully engage in partnership working and/or to support the implementation of agreed plans	MW	• Alliance Steering Group. • Alliance Formation Team. • Bilaterals with each of Gateshead, North Cumbria and Northumbria FTs. • Newcastle Neighbourhood Health Board and Neighbourhood Delivery Group (aka the 'Bunker Team'). • Northeast and North Cumbria Provider Collaborative Leadership Board. • Trust Management Group. • Clinical Board Quality and Performance Reviews.	• Minutes of Alliance Steering Group. • Alliance Risk Register specific risk on capacity. • Executive personal objectives. • Minutes of Gateshead, North Cumbria and Northumbria Bilaterals. • Minutes of Newcastle Neighbourhood Health Board. • Minutes of Northeast and North Cumbria Provider Collaborative Leadership Board. • Minutes of Trust Management Group. • Minutes of Clinical Board Quality and Performance Reviews.	• Alliance chairs, CEOs and Alliance director to discuss how best to address capacity risk – November 2026. • Refresh of Alliance ambitions following return of substantive CEO – April 2027.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Overlap and confusion between different layers of partnership working	MW	• Alliance Steering Group. • Newcastle Neighbourhood Health Board. • Northeast and North Cumbria Provider. Collaborative Leadership Board. • Great North Healthcare Alliance Clinical Framework GroupStrategic Approach to Clinical Services Board (SACS). • Various executive peer groups – e.g. Alliance Medical Directors meeting.	• Trust Strategy. • Alliance Strategic Intent paper. • Joint Alliance and Provider Collaborative paper of 'Collaborative Activity'. • Alliance work plan and summary grid of workstreams and partnerships involved. • Minutes of Alliance Steering Group. • Provider Collaborative Leadership Board minutes. • Minutes of Great North Healthcare Alliance Clinical Framework Group. • SACS Board minutes.	• Scope cards for each overlapping workstream between Alliance, Provider Collaborative and Neighbourhood Health Board – October 2026. • Develop and maintain live 'overlap register' – October 2026.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Staff and patients are not appropriately engaged in improving clinical pathways	LPC/ MWr/ IJ	• Alliance Clinical Framework Group. • Trust Clinical Policy Group. • Trust Management Group. • Bilaterals with each of Gateshead, North Cumbria and Northumbria FTs. • Trust Partnership Forum. • Clinical Board Quality and Performance Reviews. • Council of Governors.	• Trust Strategy. • Minutes of Alliance Clinical Framework Group. • Minutes of Trust Clinical Policy Group. • Minutes of Trust Management Group. • Minutes of Trust Partnership Forum. • Minutes of Gateshead, North Cumbria and Northumbria Bilaterals. • Minutes of Trust Partnership Forum. • Clinical Board 5-year plans. • Minutes of Clinical Board QPRs. • Minutes of Council of Governors. • Clinical Network and Operational Delivery Network reports. • Trust Annual Report. • Council of Governors Minutes. • Right Time patient feedback. • Staff surveys.	• Development of Alliance Clinical Framework Group Plan – March 2027. • Alliance Paediatric Service Review – April 2027.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	

Local implementation of national policies impedes rather than improves partnership working	RH	• Great North Healthcare Alliance Collaboration Agreement and Steering Group includes CEO, chair and vice chair of 4 FTs. • Bilaterals with each of Gateshead, North Cumbria and Northumbria FTs. • Shared chair across Newcastle, Gateshead and Northumbria FTs. • Newcastle Neighbourhood Health Board. • Northeast and North Cumbria Provider Collaborative Leadership Board. • Trust Management Group. • Clinical Board Quality and Performance Reviews.	• Trust Strategy. • Minutes of Alliance Steering Group (Committees in Common and Joint Committee). • Minutes of Gateshead, North Cumbria and Northumbria Bilaterals. • Alliance Risk Register. • Alliance Strategic Intent. • Minutes of Newcastle Neighbourhood Health Board. • Northeast and North Cumbria joint Strategic Plan. • Minutes of Northeast and North Cumbria Provider Collaborative Leadership Board. • Minutes of Trust Management Group. • Minutes of Clinical Board Quality and Performance Reviews.	• Executive Team developing register of national policies with named leads, key actions and implementation dates to ensure successful local implementation – March 2027. • Complete implementation of Alliance Strategic Intent and SROs implementation plan.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	

Risk ID	1.4
Comments:	

Board Assurance Framework 2026/2027

Strategic Objective	**2. Advancing Care – improving patient care, effectiveness and quality though innovation, research, improvement and education.**
Principal Risk (what could stop us from achieving our strategic objective)	**Inability to improve patient safety and patient harm through reliable, evidence-based care.**

Lead Committee	Quality Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Executive Director of Nursing, Midwifery and AHPs.	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	**Quality and Safety**
Date Added	10.06.2026	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Level**	**LOW**
Last Reviewed	09.09.2026	**Risk Score**	**25**	**20**	**10**	**Risk Appetite Position**	**OUTSIDE OF APPETITE**

Threat (what might cause this to happen)	**Lead**	**Controls** (What controls do we already have in place)	**Sources of Assurance** (Evidence that the controls in place are effective)	**Actions** (Further actions required to manage risk)	**Action Progress Indicator**	**Threat Assurance Level**
Failure to successfully develop and nurture a positive safety culture, including supporting staff to report incidents, speak up about concerns, and fulfil their responsibilities under the Duty of Candour, with an enhanced focus on shared learning, psychological safety, openness, transparency, and a systems-based approach to improvement.	RC	• Patient Safety Incident Response Framework (PSIRF). • Rapid Quality and Safety Peer Reviews. • Trust wide PSIRF working group. • Incident reporting system (InPhase). • Freedom to Speak Up Guardian. • Response Action Review Meetings. • Quality & Safety Communications and learning plans in place. • Staff survey and Speak Up data. • Duty of Candour Policy, training programmes and monitoring arrangements. • Clinical Board audits of Duty of Candour compliance. • Integrated Board Report. • Internal audit reports.	• Rapid Response Action Review Weekly Meeting /Patient Safety Incident Forum minutes and actions plans. • Central supportive governance. infrastructure to deliver the PSIRF. • Strengthened quality of learning responses by ensuring a standardised approval methodology is used. • Monitoring compliance with PSIRF timeframes for learning responses. Power BI dashboards. • Incident reporting system (InPhase) mechanisms for staff to report incidents, near misses and concerns. • Freedom to Speak Up arrangements to support psychological safety. • Response Action Review learning response processes. • Quality & Safety Communications and learning Forums, safety bulletins and mechanisms to share organisational learning. • Staff survey and Speak Up data reviewed to monitor culture and psychological safety. • Regular PSIRF update reports to Patient Safety Group and Quality Committee. • Incident reporting data demonstrates a statistical proven improvement in	• Embed and improve Trust safety culture evidenced by improved scores in relation to safety culture and staff confidence to report using pulse surveys and annual staff survey – March 2027. • Reporting of Duty of Candour (DoC) improvement to Quality Committee – actions required to support staff to improve documentation of verbal DoC and improve quality of DoC letters. Update to Quality Committee April 2026, next formal report September 2026. • Delivery of 26/27 Quality Priorities. • Development of Trust-Wide Quality and Safety plan – in draft, working group in place to ensure engagement, launch September 2026. • Recruit Patient Safety Partners from the Trust Participation & Involvement Panel – 1 in post. Refresh of model in progress, aim to recruit minimum of 2 Patient Safety Partners – recruitment delayed until September 2026. • Deliver the Duty of Candour improvement plan by March 2027. • Complete programme of Clinical Board audits every 6 months and ensure	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	

			incident reporting. • IBR to Quality Committee and Trust Board. • Duty of Candour documentation prompts and workflows within InPhase. • Clinical Board audits of Duty of Candour compliance reports to Quality Performance Reviews and Quality Committee. • Clinical Board Quality Oversight Group, reported into Quality and Performance Reviews and the Executive Team. • Rapid Quality and Safety Peer Review Paper. • Freedom To Speak Up biannual report to Trust Board. • Duty of Candour audit programme and compliance reviews reported to Patient Safety Group and Quality Committee. • NUTH 2025-2026 22 Duty of Candour – reasonable assurance (internal audit).	implementation of improvement actions arising from audit findings.		
Failure to increase incident reporting and reduce proportion of incidents resulting in serious harm and never events.	RC	• PSIRF. • InPhase incident reporting system. • Power Bi dashboards. • Integrated Board Report. • Weekly Rapid Response Action Review Meetings (RARM) in place. • Patient Safety Incident Forum established. • PSIRF Priority Invasive Procedures Project Board.	• Incident reporting numbers and harm grading reported monthly via the IBR to Quality Committee and Trust Board. • Weekly RARMs discuss appropriate learning response types to ensure learning from incidents. • All Patient Safety Incident Investigation (PSII) and After Action Review (AAR) learning responses reported to Patient Safety Incident Forum. Cases of Trustwide learning then shared at Q&S Learning Forum (LF). • PSIRF Priority Invasive Procedures Project Board action plan. • PSIRF Priority Invasive Procedures Project Board report to Quality Committee.	• Increase incident reporting, reducing the proportion of incidents resulting in serious harm and an in-year reduction in Never Events related to invasive procedures by 31st March 2027. • Implement NatSSIPs 2 (National Safety Standards for Invasive Procedures 2) framework Trust-wide by March 2027. • Embed and improve Trust safety culture evidenced by improved scores in relation to safety culture and staff confidence to report using pulse surveys and annual staff survey – March 2027.	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Failure to ensure safer, more effective medicine use across the Trust.	JSw	• Medication Safety Task and Finish Group providing oversight of key improvement actions. • Monthly audit framework measuring. compliance with policy to inform areas for improvement. • Internal peer review process. • Existing medication governance and oversight structures. • Medicine Management Policies and procedures. • Commissioned and completed expert external review to inform improvement work streams. • CQC Delivery Group. • Completed review of Medicines Reconciliation function across the Trust to	• Bi-Monthly audit data of ward and department compliance with core standards with dissemination of learning and action. • Policy audits undertaken and reported through medicines management committee. • Datix data and trends relating to medicines management reported and reviewed. • Peer review and external review reports and audit data. • CQC Delivery Group monitoring, reporting and minutes. • Compliance and Assurance Group reporting and minutes. • Quality Governance Structure via quality committee and Trust	• Omnicell roll-out commencing - November 2026. • Dashboards for Omitted doses and Clinical Assurance Toolkit (CAT) tools to be launched – December 2026. • Phase 2 of pharmacy business case – recruit in 2 phases: September 2026 and for April 2027 to improve medicines reconciliation further Medical gas training implementation and oxygen prescribing improvements. • Continue Quality Improvement (QI) work from Medication safety incidents – March 2027. • Continue to monitor capital plan for opportunities to fund Trustwide	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	

		identify urgent areas for improvement to attain to national best practice. • Revised medicines management action plan. • Established Medicines Management Oversight Group to ensure delivery of improvements. • Increased nursing infrastructure to support medicines safety.	Board. • September Rapid Quality and Safety Review Audit Data.	temperature monitoring- March 2027.		
Failure to embed systems and processes to reduce avoidable Hospital Acquired Infections and improve antimicrobial stewardship	LPC	• Infection Prevention and Control (IPC) Board Assurance Framework. • Integrated Quality and Performance Report. • IPC Committee and subgroups. • Clinical Board Governance Meetings and Quality Oversight Group. • Local and National Benchmarking. • IPC policies. • Clinical Board Improvement plans. • Clinical Assurance Toolkit Audits. • Accrediting Excellence (ACE) Programme. • Antimicrobial Stewardship Policy and Framework. • IPC Corporate Team in place with clear roles and responsibilities to support Clinical Board Healthcare Associated Infection (HCAI) reduction strategies. • IPC investigation process in place for every hospital associated with HCAI. Moderate and above HCAI incidents, serious incidents and outbreaks with identifiable contributory factors reviewed through the PSIRF framework. • IPC Corporate Team in place with clear roles and responsibilities to support Clinical Board HCAI reduction strategies. • IPC Improvement Group. • IPC Improvement priorities agreed. • IPC Action Plan. • IPC Nursing handbook. • Business Continuity Plan. • Clinical Board Service Level Agreement (SLA) approved.	• IPC Board Assurance Framework document. • IPC Operational Group and Committee minutes and action logs • Integrated Quality Performance Report with an overview of IPC and HCAI metrics reporting to Committees of the Trust Board. • IPC Committee minutes and reports. • Local, regional and national benchmarking data. • Clinical Board QOG and Governance meeting minutes and action logs. • Clinical Assurance Tool results. • Rapid Quality and Safety Peer review results and action plans demonstrates 93% trust compliance with assessment framework. • Quality and Performance review minutes and action log. • Clinical Board improvement plans in place in areas of high occurrence of HCAI. • IPC Improvement Group minutes and action plan – updates provided to Quality Committee. • IPC Nursing business partner model approach adopted.	• Review and update of all IPC related Policies and consider development of IPC SOPs – October 2026. • Complete IPC cultural ambitions – April 2027.	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Failure to improve compliance with clinical effectiveness and outcome standards	RC	• GIRFT Oversight Group. • Clinical Outcomes and Effectiveness Group (COEG). • Clinical Audit & Guidelines Group (CAGG). • Quality Account Working Group. • Quality Account 2026/27 Priorities agreed.	• GIRFT Oversight Group minutes and action plans. • COEG minutes. • CAGG Minutes.	• Develop schedule of business for Q&S focused QPRs by September 2026. • Review and amend ToR for Clinical Outcomes and Effectiveness Group by December 2026. • Deliver an annual clinical audit programme aligned to strategic risks and quality priorities by March 2027. • Increase compliance with local clinical audit completion by July 2027.	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	

				• Increase compliance with National Clinical Audit completion by July 2027. • Implement dashboards incorporating outcome indicators by September 2027. • Review Specialist Services Quality Dashboards (SSQD) processes in conjunction with Information Services and Clinical Boards to improve data quality and meaningful analysis – December 2026.		

Risk ID	2.1
Comments:	

Board Assurance Framework 2026/2027

Strategic Objective	**3. 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.**
Principal Risk (what could stop us from achieving our strategic objective)	**Failure to provide a healthy, safe, flexible and inclusive working environment that enables our people to thrive and deliver outstanding patient care.**

Lead Committee	People Committee.	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Executive Director of People and Commercial Innovation.	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	**People & Culture**
Date Added	15.07.2026	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Level**	**HIGH**
Last Reviewed	07.09.2026	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Position**	**TOLERABLE RISK POSITION**

Threat (what might cause this to happen)	**Lead**	**Controls** (What controls do we already have in place)	**Sources of Assurance** (Evidence that the controls in place are effective)	**Actions** (Further actions required to manage risk)	**Action Progress Indicator**	**Threat Assurance Level**
Poor staff wellbeing leading to sickness absence, turnover and reduced engagement.	AfC	• Occupational Health Service. • Employee Assistance Programme. • Wellbeing Offer. • People Committee Meeting. • Human Resources (HR) to People Services transition and establishment of People Partners who will be directly aligned with clinical boards to understand local issues. • Board approved Sickness Reduction plan. • Organisation wide focus on Sickness via - why absence matters. • Data to be presented as numbers of staff off and days lost rather than percentages.	• Staff Survey Results. • Sickness Absence Data. • Retention Metrics. • People Committee Minutes, Reports and ToR.	• Implement NHS Staff Standard for Health and Wellbeing including rest facilities and wellbeing support – December 2026. • Develop a Trust-wide workforce wellbeing dashboard to monitor trends in sickness absence, stress, burnout and employee relations activity -December 2026. • Development of long-term sick data for managers and allocation of project manager from people services to focus on sickness absence – December 2026. • Strengthen occupational health, counselling and wellbeing support pathways, ensuring clear visibility and access for all staff - December 2026. • Embed wellbeing discussions into regular one-to-ones and appraisal processes -March 2027. • Include health, wellbeing and psychosocial risks within departmental health and safety reviews March 2027. • Provide targeted support for teams showing early signs of workforce pressure, poor survey results or increased absence - March 2027.	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Failure to provide flexible working opportunities.	AfC	• Flexible Working Policy. • Team Rostering Systems. • Workforce Planning Processes.	• Flexible Working Requests Data. • Staff Survey Results. • Workforce Metrics.	• Full implementation of NHS Staff Standard for Promoting Flexible Working – December 2026. • Launch a Trust-wide flexible working programme to identify and remove barriers to access - March 2027. • Implement new approach to flexible working including improvements in organisational culture whereby flexible working is an option considered for all roles wherever service delivery allows - March	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	

				2027. • Review all people policies and managerial guidance to ensure fair and consistent decision-making - March 2027. • Develop agile working models that support, hybrid working, cross-site working and flexible start and finish times – March 2027. • Work with services to redesign working arrangements around the needs of our 24/7 workforce and patient demand patterns – March 2027. • Develop and implement practical guidance and training on managing hybrid and flexible teams – March 2027.		
Staff experience inequity or barriers affecting inclusion, retention and recruitment.	AfC	• Equality, Diversity & Inclusion (EDI) Strategy. • Workforce Equality Standards. • Staff Networks.	• Workforce Race Equality Standard (WRES)/Workforce Disability Equality Standard (WDES) Reports. • Recruitment and Retention Data. • Staff Survey Results.	• Develop multi-year NHS Staff Standards implementation plan linked to People Strategy – December 2026. • Fully implement the Trust's Anti-Racism Strategy with clear executive oversight and accountability. Launch on 31st October 2026. • Embed the new Head of Belonging, Culture and Inclusion role to co-ordinate delivery of the strategy. Including the development of a detailed 90-day implementation plan setting out priorities, milestones and success measures - December 2026. • Review of existing networks and listening mechanisms to better understand experiences of racial discrimination and inequity - December 2026. • Develop new support and guidance to staff experiencing racism - December 2026. • Deliver and implement an anti-racism learning and accountability sessions for leaders, managers and senior decision-makers -March 2027. • Root and branch review of informal resolution routes - March 2027. • Establish a weekly Violence Prevention Review Meeting involving operational, workforce, security and health and safety leads - March 2027. • Review of Red Card and Yellow Card processes to ensure consistent application - March 2027. • Incorporate violence reduction measures within departmental risk registers and health and safety governance arrangements. (March 2027). • Develop targeted interventions for high-risk services and locations based on incident data - March 2027. • Director of People and Organisational Development (OD) to undertake a full review of the Trust's Sexual Safety Action Plan and update priorities against national guidance – March 2027. • Develop and launch a refreshed communication campaign outlining expectations, reporting routes and support available for colleagues - March 2027.	**2. Actions defined- most progressing, where delays are occurring interventions are being taken..**	

				• Implement the new Resolution Hub model to ensure all sexual safety concerns are reviewed and triaged within 48 hours of reporting - December 2026. • Establish a formal People Review Panel to oversee serious sexual safety concerns and monitor organisational learning - December 2026. • Deliver targeted training for managers and investigators on handling sexual safety concerns sensitively and effectively - December 2026.		

Risk ID	3.1
Comments:	

Board Assurance Framework 2026/2027

Strategic Objective	**3. 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.**
Principal Risk (what could stop us from achieving our strategic objective)	**Failure to support and develop confident, compassionate and accountable leadership at every level.**

Lead Committee	People Committee.	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Executive Director of People and Commercial Innovation.	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	**People & Culture**
Date Added	15.07.2026	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Level**	**HIGH**
Last Reviewed	07.09.2026	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Position**	**TOLERABLE RISK POSITION**

Threat (what might cause this to happen)	**Lead**	**Controls** (What controls do we already have in place)	**Sources of Assurance** (Evidence that the controls in place are effective)	**Actions** (Further actions required to manage risk)	**Action Progress Indicator**	**Threat Assurance Level**

Inconsistent leadership capability, management practice and support for line managers across the organisation.	VMR	• Leadership Framework.
		• Leadership Development Programmes – although offer is fragmented and there is no professional agnostic approach in place.
		• HR to People Services transition and establishment of People Partners who will be directly aligned with clinical boards to understand local issues.
		• Appraisal Process; Corporate and Local Induction.
			• NHS Staff Survey results.
			• Staff Pulse Surveys.
			• Appraisal Compliance Reports.
			• Leadership Programme Participation Data.
			• Workforce Metrics.
			• People Committee Reports.
				• Develop and implement NHS Staff Standard for Line Management; establish minimum expectations for all line managers; develop a Trust-wide leadership curriculum; strengthen support for managers leading change – December 2026.
				• Develop and implement a Delivering Excellence Leadership Programme for all new and existing line managers, establishing a consistent Trust-wide management standard - March 2027.
				• Introduce a mandatory line management framework covering key people processes such as:
				  ○ wellbeing conversations
				  ○ performance management
				  ○ absence management
				  ○ equality and inclusion responsibilities
				  ○ handling difficult conversations.
				  By March 2027.
				• Develop a management toolkit and resource hub to support managers in applying policy and best practice consistently - March 2027.
				• Incorporate staff feedback on management quality into leadership development and performance reviews - March 2027.
					2. Actions defined- most progressing, where delays are occurring interventions are being taken.	

Insufficient leadership capability to deliver workforce transformation and cultural improvement.	VMR	• Workforce Planning Framework; Organisational Development Programmes; Executive and Senior Leadership Development.	• Workforce Turnover Data; Vacancy Rates; Staff Experience Metrics; Organisational Development Evaluation Reports.	• Develop targeted leadership interventions for high-risk services; establish leadership succession and talent management arrangements – October 2026. • Establish quarterly leadership forums to share learning, best practice and emerging workforce challenges - March 2027.	**2. Actions defined- most progressing, where delays are occurring interventions are being taken**	

				• Appoint an external source of support to develop and implement the new leadership programme - March 2027.		

Risk ID	3.2
Comments:	

Board Assurance Framework 2026/2027

Strategic Objective	**3. 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.**
Principal Risk (what could stop us from achieving our strategic objective)	**Failure to adequately maintain and continuously improve our Estates and facilities to ensure they support safe and efficient care.**

Lead Committee	Finance and Performance Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Estates, Facilities & Strategic Partnerships	**Impact**	5	5	5	**Risk Appetite Category**	Compliance and Regulatory
Date Added	12.06.2026	**Likelihood**	4	4	1	**Risk Appetite Level**	**LOW**
Last Reviewed	15.09.2026	**Risk Score**	20	20	5	**Risk Appetite Position**	**OUTSIDE OF APPETITE**

Threat (what might cause this to happen)	**Lead**	**Controls** (What controls do we already have in place)	**Sources of Assurance** (Evidence that the controls in place are effective)	**Actions** (Further actions required to manage risk)	**Action Progress Indicator**	**Threat Assurance Level**
Failure to effectively manage the lifecycle replacement or upgrade of the Trust Estate, Environment, building & engineering infrastructure and medical equipment assets within available capital and revenue budgets.	RJ	• Condition monitoring of assets undertaken annually to enable ongoing re-prioritisation of backlog maintenance programme and medical; equipment replacement programme. • 5-year Capital Investment Plan (including estates and medical devices) in place. • 5- year Estates Strategic delivery Plan in place. • Capital Strategy (CS) Infrastructure plan. • Alignment of condition surveys. • Risk based asset plan and report. • Annual condition survey. • Capital Management Group. • Estates Risk Management and Governance. • Medical Equipment Steering Group. • Condition surveys aligned with Computer-Aided Facilities Management (CAFM) system. • Risk based asset reporting.	• Minutes and actions logs from: Estates Risk Management & Governance Group (ERMGG); Medical Equipment Steering Group (MDSG); and Estates Investment, Planning, Strategy and Capital Investment Group. • Capital Management Group (CMG) oversight (CMG report - Finance and Performance Committee). • Costs reported via Estates Returns Information Collection (ERIC)/Model Health System with oversight from NHSE. • 5- year capital programme. • Medical Device Lifecycle Replacement Plan. • ICS Infrastructure Board. • CAFM System.	• Undertake a 6- facet survey of the build environment, critical plant and equipment with Alliance Partners – March 2027. • Await funding allocation details for NHS Estates national facet survey – March 2027.	**5. Actions not yet fully defined.**	
Failure to deliver refurbishment and construction capital schemes on target due to delays in Building Safety Act (BSA) approval which could increase costs of construction/refurbishments projects in “high-risk buildings”.	KH	• Ongoing engagement with Contractors/Health & Safety Executive (HSE). • Engaged professional/legal advice. • Regular communication with NHSE/Department of Health and Social Care (DHSC) regarding impact on NHS and support change. • Repository of Trust Estate where Higher-Risk Building (HRB) applies. • DHSC Engagement regarding BSA delays. • Engagement with local MPs who plan to raise impact of BSA delays with the Parliamentary Under-Secretary of State in the Ministry of	• BSA applications (enhanced understanding of BSA linked projects and application requirements) • Ongoing correspondence with Contractors/HSE. • HRB repository in place. • BSA early pre-application to speed up process. Early benefit seen through prompt approval for High-Level Infectious Diseases Unit (HLIU) scheme.		**COMPLETE – Process agreed with BSA for early pre-application process to speed up BSA approvals.**	

		Housing, Communities and Local Government. • Reporting capital plan and cashflows. • Correspondence with contractors/HSE to confirm project specific timeline. • Improved BSA early pre-application process.				
Failure to maintain services due to ageing building and engineering infrastructure (Ventilation, Water, Electrical (High & Low voltage (HV & LV) systems), Decontamination, Medical Gas Pipeline Systems, building fabric and structure)	RJ	• Regular planned preventive maintenance programme (PPM) in place in line with the requirements of SFG20 and Health Technical Memoranda (HTM) guidance. • Condition monitoring of assets is undertaken annually. • Monthly HTM compliance monitoring reporting. • 5- year Estates Strategic delivery Plan in place. • 5-year Capital Investment Plan (including estates and medical devices) in place. • Trust Policies and Procedures. • Annual condition surveys. • Risk based asset plan and report. • Planned preventive maintenance programme. • Compliance and Assurance Group. • Capital Management Group.	• Estates Operational and electronic and mechanical engineering (EME) Management structures. • Annual report to Medical Device Steering Group and Compliance and Assurance Group. • 5- year capital programme (include Critical infrastructure requirements and medical equipment). • Oversight via Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety, Medical Devices Steering Group). • Minutes and actions log from: Estates Risk Management & Governance Group (ERMGG); Infection Prevention Control Committee (IPCC), Medical Equipment Steering Group (MDSG); and Estates Investment, Planning, Strategy and Capital Investment Group. • Bi-monthly Triple A report to Compliance & Assurance Group (ERMGG and CAG). • Independent Authorising Engineer annual HTM compliance Audit. • Risk based asset report providing clinical board prioritisation.	• Undertake a 6- facet survey of the build environment, critical plant and equipment with Alliance Partners – March 2027. • Await funding allocation details for NHS Estates national facet survey – March 2027.	**5. Actions not yet fully defined.**	
Failure to meet fire safety regulations and standards due to delays in fire remediation work programme (PFI and Retained Estate) due to available capital funding and access to clinical areas.	RJ	• Risk-based fire remediation programme. • Condition monitoring of fire safety assets. • Fire Directors Gorup. • Incident reporting system. • Estates Strategic Delivery Plan 2026-31. • Fire remedial works set out in Private Finance Initiative (PFI) Contract Project Agreement and Settlement Agreement. • PFI meetings in place. • Fire Remediation Contract in place.	• Fire Directors Group-Monthly updates on fire safety remediation programme. • Condition monitoring documentation. • Oversight by Estates Fire Directors Group. • Estates Risk Management & Governance Group minutes and action logs. • Regular reviews of requirements and progress with the remedial works – reviewed monthly for 2025/26. • Quarterly report to Compliance & Assurance Group. • Reports to Capital Management Group. • Fire Safety report to Trust Board. • Fire Remediation works in 2026/27 plan as part of the wider Capital Plan. • PFI meetings structures to manage progress with the PFI fire remediation works. • 3 Year contract in place to complete fire remediation.	• Completion of fully integrated programme of Fire remediation works has been agreed as part of the 5-year capital programme 2026-31 and will be reviewed on an annual basis as part of capital programme- March 2027.	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Failure to maintain the PFI estate to a suitable condition with safe compliance and to manage project delivery to	RJ	• PFI meetings in place. • PFI annual and 5-year lifecycle plan (Lifecycle investment is included within the Project Agreement and Unitary Charge for the PFI	• PFI Monthly Review Meetings. • PFI Liaison Committee. • Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety).	• Completion of deed of variation for Healthcare Support Newcastle delivery – delayed, though agreement has been reached	**2.Actions defined- most progressing, where delays**	

transform services due to constraints within PFI Contract Restraints.		Estate). • PFI annual condition surveys. • Zonal and ad hoc inspections of PFI areas. • Variation procedure outlined with PFI Project Agreement followed. • PFI Project Agreement. • Independent Authorising Engineer annual HTM compliance Audit. • Patient-Led Assessments of the Care Environment (PLACE) Audit programme in place. Remedial scope and programme from PFI partners (Ventilation).	• Zonal inspection processes to identify and remedy any slippage in condition. • Monitor helpdesk reporting. • PFI best practice conditions survey - heads of terms for settlements agreed that include commitments to remedial works, performance improvements and a condition survey. • Compliance requirements contained within PFI Project Agreement. • Monthly Variation Meetings minutes. • PFI Liaison Committee. • Remedial scope and programme from PFI partners (Ventilation) complete.	to complete the Sexual Assault Referral Centre (SARC) and Mortuary expansion project whilst this is being prepared December 2026 (*July 2026*). • Delivery of Medical equipment replacement projects – March 2027. • – scope agreed and works commenced, particularly in Paediatric Intensive Care Unit (PICU). • Remedial scope and programme from PFI partners (Electrical) – delayed– December 2026 (*June 2026*). • Manage terms of the PFI Project Agreement to conclude fire remedial works- December 2026. • PFI final settlement (Ventilation & Electrical) to be agreed, delayed– December 2026 *(July 2026*) 2026.	**are occurring interventions are being taken.**	
Failure to deliver ward and theatre refurbishment programmes, fire remediation works and critical infrastructure replacements due to lack of decant facilities (currently 1 decant ward at FH, nothing at RVI).	RJ	• Estates Strategic Plan 2026-31. • Liaison meetings with Patient Services to minimise impact on clinical activity. • Project Management meetings. • Review by Estates Strategy & Capital Investment Group. • Estates Programme Sub-Group Freeman Hospital (FH) Ward 12 used as decant facility for one ward refurbishment per year subject to available Capital funding. • Ward and theatre condition environments league table across Royal Victoria Infirmary (RVI) and Freeman Hospital in place. • Co-ordinating with Patient Services to negotiate access and minimise impact on patient activity - timing project specific throughout the year. • Alliance Construction Programme aims to delivery decant facilities – Long term (5-10 years). • Feasibility study considering the options for 1-2 decant wards at the FH.	• Minutes and actions log from: Senior Operational Meetings, Estates Investment, Planning, Strategy and Capital Investment Group. • Capital Management Group oversight (CMG report - Finance and Performance Committee). • 5- year capital programme (include ward and refurbishments) Feasibility study considering the options for 1-2 decant wards at the FH. Feasibility is complete to Royal Institute of British Architects (RIBA) stage 2.	• Review and prioritisation of Decant Freeman Hospital (FRH) at Estates Strategy Capital Investment Group for inclusion in 5-year capital programme due to significant investment required – December 2026.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Failure to deliver a demanding capital programme and additional pressures (i.e. SBRi, Advanced Therapies, HLIU) due to level of substantive Preventative Maintenance and other stakeholder reliance. (estates operations, IPC and Clinical teams).		• Project Management Approach in place. • Prioritised adjustment to capital plan as required. • Capital programme and sharing at Estates. Clinical Board meetings to enable advance planning of resources. • Estates Strategy & Capital Investment Group. • Preventative Maintenance consultancy.	• Adjusting allocated resources to projects. Capital part of all safety group agendas. • Minutes and actions log from: Senior Operational Meetings, Estates Investment, Planning, Strategy and Capital Investment Group and Estates Clinical Boards. • Capital Management Group oversight (CMG report - Finance and Performance Committee). • 5- year capital programme (includes ward and refurbishments) • Preventative Maintenance consultancy resource	• Monitoring of Capital Programme Delivery monthly – March 2027.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	

			in place to support in-house teams.			

Risk ID	3.3

Comments:

Board Assurance Framework 2026/2027

Strategic Objective	**3. 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.**
Principal Risk (what could stop us from achieving our strategic objective)	**Failure to manage our resources sustainably and responsibly ensuring strong financial, productivity and commercial plans are delivered.**

Lead Committee	Finance and Performance Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Deputy Chief Executive/Chief Finance Officer.	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Finance/VfM
Date Added	02.06.2026	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Level**	Moderate
Last Reviewed	11.09.2026	**Risk Score**	**25**	**20**	**10**	**Risk Appetite Position**	**OUTSIDE OF APPETITE**

Threat (what might cause this to happen)	**Lead**	**Controls** (What controls do we already have in place)	**Sources of Assurance** (Evidence that the controls in place are effective)	**Actions** (Further actions required to manage risk)	**Action Progress Indicator**	**Threat Assurance Level**
Failure to achieve activity targets funded in line with Indicative Activity Plan (IAP) resulting risk of funding withdrawal.	JB	• Activity targets produced for each specialty. • Funding has been delegated at the start of the year for specific areas where identified this is necessary for impact. • Directors of Operations (DOPs) and Clinical Board Chairs accountability for delivery of activity targets. • Monthly reporting in place. • IAP introduced as a part of the contracting process/requirement with NHSE and ICB. • IAP agreed (draft). • Early identification and reporting of Performance Gaps. • Grant Thornton Well Led Assessment completed. • Internal Contract Management Group.	• Activity reporting via monthly performance reviews and corrective action agreed where possible, against IAP. • Monthly reporting of targets, activity and financial impact to Finance and Performance Committee and Trust Board including obstacles and corrective action highlighted through trend analysis. • National reporting back to Trust of validated activity levels (quarterly) – assurance provided around validity of internal reporting. • Finance Dashboard. • IAP in place (draft). • Early reporting mechanisms and now specifically discussed at each Finance and Performance Committee. • Grant Thornton Well Led Assessment returned a good/outstanding rating on the key financial domains. • Internal Contract Management Group ToR, Minutes and papers.	• Deliver RTT recovery Plans – March 2027. • Finalise IAP with NHSE (ICB agreed) – November 2026. • Monitor IAP cost activity monthly to assess risk – March 2027.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Failure to receive national funding for continued resident doctors industrial action impacting the Trust financial plan to deliver planned financial breakeven position.	JB	• Not possible to implement controls relating to national policy.	• Positive national discussions negated the Industrial action planned for June 2026.	• Continue to Report financial pressures locally through monthly NHSE Regional Finance Meeting – March 2027.	**5.Actions not yet fully defined.**	

Lack of sufficient national funding for pay costs (specifically the annual pay award and the regrading of band 5 to 6) impacting delivery of the planned financial position.	JB	• Agenda for Change pay away costs.	• Agenda for change pay award costs matched to expenditure for month 4.	• Early identification of potential pressure through Director of Nursing National involvement – March 2027. • Director of Finance to coordinate and analyse Shelford Group Trusts responses – delayed, deadline extended to November 2026 (*September 2026).* • Await outcome of Band 5 Nurse Reform Review – Expected Sept-October 2026. • Await final confirmation of contract uplifts for agreed medical pay award – September 2026.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Reliance on non-cash measures leading to a diminished cash balance and reliance on cash support, impacting on our ability to invest in services and buildings and equipment.	JB	• Financial Recovery Plan. • Finance Report. • Non cash element of financial recovery defined and identified. • Finance and Performance Committee. • Financial Recovery Plan including cash releasing (Cost Improvement programme (CIP)). • CIP Clinical Board Governance including escalation. • Capital management group. • Strengthened discussion of cash position and reporting to Finance and Performance Committee. • Enhanced cash reporting to Finance and Performance Committee. • Review of cash management and control processes. • Cost Improvement Programme Group. • Cash Group. • Capital Management Group.	• Finance Committee ToR, Minutes and Reports. • Cash forecast within regular finance and board reporting. • Daily / weekly cash management. • Reporting of progress on cash releasing savings through financial recovery steering group and finance committee. • Reporting of progress against capital plan to finance committee and Trust board. • Reporting of progress against capital plan to Capital Management Group. • Increased reporting of cash position via Monthly Finance Report to Finance and Performance Committee. • Enhanced cash reporting to Finance and Performance Committee. • ICB agreed to earlier than planned cash payment of specific items before end of December. • Cost Improvement Group ToR, minutes and reports. • Capital Management Group ToR, minutes and report. • Cash Group ToR, minutes and Reports.	• Monitor and report cash position bi-monthly at Cash Group and Finance and Performance Committee Monthly – March 2027. • Await final confirmation of contract uplifts for agreed medical pay award – September 2026.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Unplanned for cost pressures emerge in-year, specifically relating to non-pay budgets such as drugs, devices and supplies, impacting on delivery of the planned position.	JB	• Revenue reporting through to Finance and Performance Committee. • Revenue Management Group (tier 2). • Internal Contracting Board. • MVAC meeting, monthly - horizon scanning. identification of new drugs coming online etc. • Revenue Reporting.	• Finance and Performance Committee ToR, Minutes and Reports. • Revenue Management Group ToR, Minutes and Reports. • Director of Pharmacy presence on Internal Contracting Board. • MVAC ToR, Minutes and reports. • Monthly revenue reporting highlights emerging pressures, monthly forecasting of year end position enabling rapid action where necessary.	• Forecast monitoring of year end position and reporting monthly to Finance and Performance Committee – March 2027. • Escalate unplanned drug costs with ICB and Commissioners at Regional Drug Committee – March 2027.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Inability to deliver reductions in cost through trust improvement plans and transformation programmes resulting in cost pressure impacting on delivery of	SH	• Transformation & Improvement Group (formerly Access and Delivery Group). • Finance and Performance Committee. • Strategic Improvement Groups. • Trust Management Group. • Cost Improvement Group.	• Transformation & Improvement Group ToR, minutes and reports. • Finance and Performance Committee ToR, Minutes and Update Reports. • Strategic Improvement Groups- Formal prioritisation of workstreams by four dedicated	• Conduct a formal governance review of all transformation programmes to ensure appropriate forum alignment, eliminate reporting duplication, and optimise committee structures to better support project delivery – September 2026.	**2.Actions defined- most progressing, where delays are occurring interventions**	

planned position.		• Quality Performance reviews Regular progress updates on improvement workstreams embedded within Monthly Performance Reviews (MPRs) for Clinical Boards and corporate functions. • Project Management Governance in place - formal programme management structures and documentation, utilising standardised methodologies such as PRINCE2 or Agile. • Integrated Board Report. • PowerBi Transformation dashboards. • Quality Impact Assessments (EQIAs). • EQIA Panel. • Project Management Office and Quality Improvement Team Restructure Complete. • Service Improvement Team Established. • Named clinical leads embedded into every service transformation project to drive frontline ownership.	against established value, risk, key deliverables and resource criteria. • Trust Management Group strategic oversight and escalation mechanism to resolve high-level programme roadblocks and conflicts. • Cost Improvement Group tracks Key Performance Indicators (KPIs) across a subset of transformation workstreams, measuring the impact on financial performance reporting to Executive Team. • Project documentation, risk logs and action trackers. • Monthly Quality Performance review with regular progress updates on improvement workstreams embedded within Monthly Performance Reviews (MPRs) for Clinical Boards and corporate functions. • Integrated Board Report includes transformation metrics reports to committees of the Board and Trust Board. • Quality Impact Assessments (EQIAs) signed off by Medical and Nursing Directors before transformational schemes begin and formal report provided to Quality Committee for assurance. • EQIA Panel documentation and assessments.	• Rationalise the transformation portfolio to focus organisational resource exclusively on one or two high-priority strategic programmes delayed – December 2026 (*July 2026)*. • Evaluate the efficacy of strategic improvement programmes to identify underlying delivery challenges and operational barriers – October 2026. • Execute a portfolio-wide baseline review against the PMO framework to ensure compliance with project management standards, optimise assurance, and actively facilitate successful delivery -October 2026. • Develop and embed a direct escalation and feedback pathway for clinical leads to report frontline cultural resistance or operational barriers straight to the Transformation & Improvement Group – September 2026.	**are being taken.**	
Failure to achieve required productivity gains across the Trust.	SH	• A structured Cost Improvement Programme (CIP) process requiring a formal Quality Impact Assessment (QIA) signed off by the Medical Director and Chief Nurse before any productivity scheme initiated. • Mandatory annual consultant job planning rounds to ensure staffing matches peak demand periods and on call requirements. • Evidence-based clinical pathways across all specialties to reduce risk of unwarranted variation. • E-Rostering systems to align staffing with patient acuity, reducing reliance on temporary bank or agency spend. • Power BI dashboards to track KPIs such as activity vs plan, length of stay and outpatient optimisation. • Harmonised cost-saving goals with productivity metrics to meet performance ambitions. • Monthly performance reviews chaired by Executive to hold clinical boards to account for baseline variations. • Frontline staff trained in QI methodologies to support elimination of waste and streamline daily processes.	• Deployment of Care Co-ordination system to increase theatre optimisation • Finance and Performance Committee Reports: Monthly metrics showing CIP delivery performance against target profiles and recovery plan trajectories. • Quality Committee Safety Reports: Regular reports ensuring that implemented productivity gains have not caused negative trends in patient harm, readmission rates, or staff burnout. • NHSE independent review of the Programme Management Office (PMO) structure, CIP development and validation processes, and data accuracy within the Trust's performance dashboards. • External Benchmarking Data: Peer group data validations from NHSE confirming the Trust's relative efficiency rankings. • Patient Level Information & Costing System (PLICS) to help clinical boards manage resources and improve efficiency. • Service Review Programme to monitor, evaluate, and improve healthcare delivery across the Trust.	• Consider and implement formal mechanisms to monitor and deliver productivity targets and associated escalation plan -September 2026. • Establish precision service-line reporting to support clinical leadership in driving operational productivity. • Explore potential inclusion and alignment of activity targets with annual consultant job planning – December 2026. • Improve visibility of available data sources and explore automated reporting to provide regular updates on Model Health System benchmarks and GIRFT (Getting It Right First Time) indicators. September 2026. • Review of GIRFT governance -December 2026. • Implement process for Clinical boards (Operational Service Managers (OSMs) and Clinical Directors (CDs)) to review and sign off specialty productivity dashboards data to ensure data accuracy and reliable – September 2026.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	

		• PMO formally assess, track, and risk-assure all productivity schemes. • GIRFT Oversight Group.				
Under delivery of commercial income and growth to support financial recovery.	WE	• Commercial Strategy. • Dedicated Commercial team established. • Data Partnership model. • Data Partnership Steering Group. • Sales force implementation. • Commercial schemes identified by Clinical Boards and Corporate Directorates. • Commercial Dashboards. • Intellectual Policy (IP) Policy developed. • Strengthened commercial governance at Clinical Board Level. • Optimised commercial team structure. • Research, Innovation and Commercial Committee. • Trust Commercial Strategic delivery plan.	• Strategy document and updates reported to Finance and Performance Committee. • Commercial update report to F&P. • Data Partnership Proposal accepted by F&P. • Data partnership group reporting to commercial delivery and innovation group. • Tracking commercial pipeline. • Commercial schemes reporting alongside financial recovery plans. • Commercial dashboard data suggests strong growth. • Commercial representative at clinical board cost improvement meetings. • Strengthened governance and awareness relating to IP protection and data access - IP policy updated and SoP socialised. • Consolidation of Commercial & Innovation teams Developed commercial contracts and suite of Non-disclosure agreements (NDA's). • Research, Innovation and Commercial Committee ToR, Agenda, Minutes and Reports. • Trust Commercial strategic delivery plan developed.	• Establish full costings for all commercial activity – Delayed, March 2027 (*September 2026*). • Complete Pilot in CDS September 2026 • Start Private & International patients March 2027. • Develop IP dashboard to manage and utilise IP - December 2026.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	

Risk ID	3.4
Comments:	

Board Assurance Framework 2026/2027

Strategic Objective	**3. 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.**
Principal Risk (what could stop us from achieving our strategic objective)	**Failure to develop and implement modern, secure, reliable digital environments that support safe and efficient care.**

Lead Committee	Digital and Data Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Chief Digital Officer	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	**Digital**
Date Added	24.06.2026	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Level**	**HIGH**
Last Reviewed	01.09.2026	**Risk Score**	**25**	**20**	**10**	**Risk Appetite Position**	**TOLERABLE RISK POSITION**

Threat (what might cause this to happen)	**Lead**	**Controls** (What controls do we already have in place)	**Sources of Assurance** (Evidence that the controls in place are effective)	**Actions** (Further actions required to manage risk)	**Action Progress Indicator**	**Threat Assurance Level**
Technical and business system debt could impact availability, service efficiency, security and cost to support which may also result in loss of service	JT	• Care Optimisation Group providing prioritisation, sequencing and governance of digital initiatives. • Digital Senior Management Team (SMT) meeting weekly to oversee delivery, capacity and emerging risks and issues. • Digital and Data Committee (DDC).	• Care Optimisation Group ToR, Reports and Minutes. • Digital Senior Management Team ToR, Reports and Minutes. • Digital and Data Committee ToR, Reports and Minutes.	• Creation of register and treatment plan to replace, upgrade or retire technical and business system debt – April 2027. • Review and develop capacity and investment plan to tackle technical debt – April 2027.	**5. Actions not yet fully defined.**	
Digital ambition of the Trust is greater than capability for change associated with the ambition Capacity and capability of the digital workforce aligned to the current and future estate.	JT	• Regularly review capacity against demand. • Trust Wide Digital Plan in place with delivery timescales confirmed. • Clinical Board digital priorities confirmed. • Care Optimisation Group providing prioritisation, sequencing and governance of digital initiatives. • Digital Senior Management Team (SMT) meeting weekly to oversee delivery, capacity and emerging risks and issues. • Digital and Data Committee (DDC).	• Digital Delivery plans roadmap. • Demand backlog. • Care Optimisation Group ToR, Reports and Minutes. • Digital Senior Management Team ToR, Reports and Minutes. • Digital and Data Committee ToR, Reports and Minutes.	• Review and refine demand prioritisation and agree with Executive prioritisation list for a 3-year timeframe reviewed in 6-month windows – December 2026. • Create capability map – December 2026. • Undergo digital organisational review – December 2026 • Review/audit asset use to ensure assets are utilised fully (“sweat the assets”) – December 2026. • Ensure capability is aligned to demand and look to future proof including use of wider partner eco-system – December 2026.	**1. Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Failure to maintain and protect against constant evolving external cyber threats, data breaches and supplier vulnerabilities.	JT	• Data Security and Protection Toolkit (DSPT) assessment. • Security and access controls Management in place. • External Audit Penetration Testing. • Digital and Data Governance Group.	• DSPT assessment – High level of Assurance received. • Sapphire Penetration testing is completed. • Digital and Data Governance Group ToR, Reports, Minutes and Action log.	• Review Cyber strategy and capabilities across the Trust – December 2026. • Identify gaps in capability and defenses – December 2026. • Create rolling programme to defend and assure Trust – December 2026.	**5. Actions not yet fully defined.**	

		• Digital and Data Committee.	• Senior Information Risk Owner (SIRO) Assurance Report to Digital and Data Committee.	• Unlawful access to patient record baseline assessment and options appraisal for Executive Team consideration – September 2026.		
Lack of digital skills across the Trust to utilise enabling technology.	JT	• Information Technology (IT) Training Team in place. • IT/Digital Training resources on Trust Intranet. • Digital Training courses programme.	• Mandatory training records. • Skills audit. • Training resources and materials.	• Review training and compliance – December 2026. • Ensure new training and change management embedded – March 2027. • Develop and implement change management process for all new technology- December 2026.	**5. Actions not yet fully defined.**	

Risk ID	3.5
Comments:	

Agenda item A5(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	25 September 2026					
Title	Updated Finance and Performance Committee Terms of Reference					
Report of	Jackie Bilcliff, Chief Finance Officer / Acting Deputy Chief Executive					
Prepared by	Lauren Thompson, Corporate Governance Manager / Deputy Trust Secretary					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☒		☐		☐	
Summary	**Advise** Following a Board Development session discussion on the alignment of the strategic risks and associated threats to tier 1 Committees, the Finance and Performance Committee's Terms of Reference (ToR) have been subject to minor amendments to incorporate 'Transformation' into a new section 3.7. The changes strengthen the Committee's oversight of transformation by clarifying responsibilities for strategic alignment, programme assurance, impact assessment, benefits realisation, constructive challenge and business case approval.					
Recommendation	The Trust Board is asked to approve the updated Terms of Reference.					
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	Last approved at the July 2026 Committee, via email to Trust Board in August 2026 and presented for approval at the September 2026 Committee.					

Terms of Reference – Finance & Performance Committee

1. Constitution and Authority

1.1 The Finance & Performance (F&P) Committee is a non-statutory Committee established by the Trust Board of Directors to provide assurance to the Board on the delivery of the financial aspects of the Trust's annual Operational Plan, including financial strategy and planning, transformation and sustainability, the financial performance of the Trust, and on commercial and procurement activity, including strategic investments.

1.2 The Committee has no executive powers other than those specifically delegated in these Terms of Reference. It may establish and agree Terms of Reference for sub-committees or task and finish groups to undertake specific tasks, but may not delegate any powers detailed in these Terms of Reference.

1.3 The Committee is authorised by the Board to investigate any activity within its Terms of Reference and to seek any information it requires from any officer of the Trust to support its work, as and when required.

1.4 The Committee is authorised by the Board to obtain external legal or other independent professional advice and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary.

1.5 Committee members will seek assurance that the strategic objectives from the Trust Strategy which are aligned to the Committee are being effectively delivered. This will include that all principal risks and associated threats within the Board Assurance Framework are being mitigated, through in-depth scrutiny and escalation of any issues.

2. Purpose

The purpose of the Committee is to seek assurance, on behalf of the Board of Directors:

2.1 that the strategic financial priorities, risk and performance considerations are aligned and support the Trust's strategic objectives and its long-term sustainability;

2.2 that there is effective management of financial risk, and any potential to compromise the achievement of the strategic objectives is mitigated against;

2.3 that reporting on the financial and activity performance of the Trust is being triangulated against agreed plans, progress and performance measures, with progress reported to the Trust Board;

2.4 that the Trust's resources and assets are being used and maintained effectively and efficiently;

2.5 on the robustness, credibility and quality of financial management and planning information, which is reviewed and triangulated by the Committee;

2.6 on the Trust's compliance with current statutory and external reporting standards and requirements, including NHS and Treasury policies and procedures;

2.7 on the development, effective management, and delivery of the Trust's capital investment programme, and that this is fit for purpose;

2.8 to review, assess and gain assurance on the effectiveness of mitigations and action plans as set out in the Board Assurance Framework specific to the committee purpose and function; and

2.9 on the robustness of procurement strategies, decision-making and documentation.

2.10 The Committee will provide the Trust Board of Directors with advice and support to review the procedure for managing investments is fit for purpose (regarding investments in services and business cases), Commercial Strategy, Procurement Strategy and Sustainability (Shine Report).

3. Duties

3.1 Cycle of Business

The Committee will:

3.1.1 set an annual set of objectives and an annual plan for its work to form part of the Board's Annual Cycle of Business, informed by the Board Assurance Framework, and report to the Board on its progress.

3.2 Strategies and policies

The Committee will:

3.2.1 review the Trust's financial plans and transformation programmes, and advise the Board on how strong, complete and aligned they are with the Trust's vision and objectives;

3.2.2 review guidance on the financial components of annual planning, including revenue, budgets, capital, targets, and resource use;

3.2.3 review, and recommend to the Board, the Annual Financial Plan, including key financial performance indicators;

3.2.4 advise on key financial and commercial policies including costing, revenue, capital, working capital, treasury, investments, and benefits realisation before Board approval;

3.2.5 seek assurance that financial policies and plans are aligned to the Trust's agreed approach to the development of place-based, systems and regional working, and align with the Trust's strategic approach to commissioners and stakeholders;

3.2.6 identify learning and development needs arising from the work of the Committee for consideration by the People Committee.

3.3 Annual Financial Plan

The Committee will:

3.3.1 review the Trust's Annual Financial Plan for recommendation and approval by the Board;

3.3.2 review progress and performance against the approved plan and any significant supporting plans and targets, and analyse the robustness of any corrective action required to address emerging cost pressures and risks;

3.3.3 review the Trust's Statement of Financial Position, with a particular focus on debtors, creditors, and asset valuations; and

3.3.4 receive and review an overview of financial and service delivery agreements and key contractual arrangements entered into by the Trust.

3.4 Risk

The Committee will:

3.4.1 Receive the risks held on the Board Assurance Framework pertaining to the Committees area of focus to review the suitability and robustness of risk mitigations and action plans with regard to their potential impact on the Trust Strategic Objectives. To provide the Audit, Risk and Assurance Committee with assurance on the effectiveness of the management of principal risks relating to the Committees purpose and function.

3.5 Performance and progress reporting

The Committee will:

3.5.1 monitor the Trust's performance reporting systems, ensuring that the Board is assured of continued compliance through its annual reporting processes, reporting by exception where required to the Board;

3.5.2 agree a succinct set of key performance and progress measures relating to the full assurance purpose of the Committee, including:

- the Trust's strategic financial priorities;
- national performance and statutory targets;
- consolidated financial performance summaries and related budgets;
- statement of financial position;
- working capital performance;
- cash flow status;
- progress on capital investment programme;
- regulatory oversight ratings;
- risk mitigation; and
- information from sub committees / task and finish groups.

3.5.3 triangulate progress against these measures and seek assurance around any performance issues identified, including proposed corrective actions;

3.5.4 provide regular reports to the Board, including as part of the bi-monthly Integrated Board Report, on assurance around key areas of Trust performance, risk, and corrective actions, both retrospectively and prospectively;

3.5.5 agree a programme of benchmarking activities and reference points to inform the understanding and effectiveness of the Committee and its work;

3.5.6 be assured of the credibility of sources of evidence and data used for planning and progress reporting to the Committee, and to the Board, in relation to the Committee's purpose and function;

3.5.7 ensure the alignment and consistency of Board assurances, use of data and intelligence, by working closely with the Audit, Risk and Assurance Committee, Quality Committee, People Committee and Digital and Data Committee;

3.5.8 review the following formal reports to the Board as part of the Annual Cycle of Business:

- Annual Financial Plan;
- Finance Reports; and
- Capital Investment Policy

3.6 Capital, investments, acquisitions and disposals

3.6.1 review the Trust's capital and investment policies against appropriate benchmarks prior to recommendation for Board approval;

3.6.2 agree a consistent and robust methodology for the assessment of proposed capital expenditure, acquisitions, joint ventures, equity stakes, major property transactions, mergers, and formal or informal alliances with other Institutions;

3.6.3 review business cases and proposals over the threshold specified within the Trust Scheme of Delegation, and provide advice to the Board accordingly;

3.6.4 assure the Trust Board, on a regular basis, of the effectiveness of, and compliance with, the capital and investment strategies and related policies, including the effective prioritisation of investment decisions, the robustness of processes and rigour of investment decision-making, and report on this as part of the Committee's Annual Report to the Board;

3.6.5 seek assurance that a process is in place to monitor the performance of investments, which incorporates a review of the benefits realised as part of infrastructure and service improvement investments made; and

3.6.6 exercise delegated responsibility on behalf of the Board in line with the Standing Financial Instructions for proposals for acquisition and disposal of assets in accordance with Trust policy.

3.7 Transformation

3.7.1 seek assurance:
a. that the organisation's approach to transformation is in accordance with the Trust strategy and takes account of system transformation requirements.
b. on the delivery of significant transformation programmes and monitoring outcomes, lessons learned and benefits realisation post completion.
c. that transformation programmes have been subject to an equality and quality impact assessment.

3.7.2 provide strategic steer and constructive challenge regarding the development of transformation programmes.

3.7.3 review and approval of transformation business cases (over the threshold specified within the Scheme of Delegation).

3.8 Commercial strategy

3.8.1 provide support and advice on the development and implementation of the commercial strategy for the Trust.

3.8.2 assure the Trust Board, on a regular basis, of the effectiveness of, and compliance with, the commercial strategy and related policies, including the effective prioritisation of commercial decisions, the robustness of processes and rigour of commercial decision-making, and report on this as part of the Committee's Annual Report to the Board.

3.9 Subsidiary company reporting

3.9.1 monitor the effectiveness of subsidiary company/companies financial and operational performance reporting systems, ensuring that the Board is assured of continued compliance through its annual reporting processes, reporting by exception where required to the Board.

3.10 Statutory compliance

3.10.1 ensure, on behalf of the Board, that current statutory and regulatory compliance and reporting requirements are met, including compliance with treasury policies and procedures and the appropriate safeguards for security of the Trust's funds as an NHS Foundation Trust;

3.10.2 ensure the proper reporting of actions deemed "high-risk" by regulators, or actions with an equity component, which entail a potentially significant risk to reputation or to the stability of the business of the Trust, or which create material contingent liabilities;

3.10.3 ensure future legislative and regulatory and reporting requirements are identified and appropriate action taken; and

3.10.4 consider, and recommend for approval by the Audit, Risk & Assurance Committee, any proposed changes to Trust Standing Financial Instructions, Standing Orders and Scheme of Delegation.

4. Membership and quorum

4.1 Membership

4.1 Members of the Committee shall be appointed by the Trust Board of Directors and shall be made up of at least six members drawn from Non-Executive Directors (three members minimum) and members of the Executive Team (three members minimum).

4.2 One of the Non-Executive members will be appointed by the Trust Board of Directors as the Chair of the Committee and another as Vice Chair (who will chair the meeting in the absence of the Committee Chair if required).

4.3 The membership of the Committee shall include:

- a Non-Executive member;
- the Chief Finance Officer;
- the Deputy Chief Executive Officer or nominated Executive Lead;
- the Director of Estates, Facilities and Strategic Partnerships;
- the Director of Performance and Governance;
- Associate Medical Director representative; and
- Director of Operations representative.

4.4 The Chief Executive, as the Trust's Accountable Officer, shall have the right to attend the Committee at any time. Otherwise, only members of the Committee have the right to attend Committee meetings. Other non-committee members may be invited to attend and assist the Committee from time to time, according to particular items being considered and discussed.

4.5 In the absence of the Committee Chair, the Vice-Chair shall chair the meeting. Members are expected to attend all meetings and will be required to provide an explanation to the Chair of the Committee if they fail to attend more than two meetings in a financial year.

4.6 The Chief Finance Officer shall act as Executive Lead for the Committee.

4.7 Members are able to attend Committee meetings in person, by telephone, or by other electronic means (all participation formats will count towards the quorum).

4.8 The Council of Governors may nominate one Governor to attend Committee meetings on a quarterly cycle by rotation to observe proceedings. The observation of Board assurance Committees by Governors shall be subject to conditions agreed by the Board. The Chair of the Committee may, in exceptional circumstances, exclude governors from being present for specific items.

4.9 The Trust Secretary, or their designated deputy, shall act as the Committee Secretary. The Trust Secretary, or a suitable alternative agreed in advance with the Chair of the Committee, shall attend all meetings of the Committee.

4.10 The Chair of the Board of Directors will not be a member of the Committee but may be in attendance.

Quorum

4.11 The quorum necessary for the transaction of business shall be four members, as defined in 4.2 and 4.3 above, including the Chair or Vice Chair and at least one Non-Executive Director.

4.12 A duly convened meeting of the Committee at which a quorum is present shall be competent to exercise all or any of the authorities, powers, and discretions delegated to the Committee.

5. Committee Administration, Reporting and Accountability

5.1 The Committee Chair will report formally to the Trust Board of Directors on its proceedings after each meeting on all matters within its duties and responsibilities, summarising areas where action or improvement is needed and matters requiring escalation after each F&P Committee meeting.

5.2 The terms of reference shall be reviewed by the Committee and approved by the Board of Directors on an annual basis.

5.3 The Committee will meet a minimum of ten times a year and at such other times as the Chair of the Committee, in consultation with the Committee Secretary, shall require, allowing the Committee to discharge all of its responsibilities.

5.4 The Chair may at any time convene additional meetings, or Extraordinary meetings of the Committee to consider business that requires urgent attention.

5.5 The agenda will be set in advance by the Chair, with the Trust Secretary and Executive Lead, reflecting an integrated cycle of meetings and business, which is agreed each year for the Board and its Committees, to ensure it fulfils its duties and responsibilities in an open and transparent manner.

5.6 Notice of each meeting confirming the venue, time and date, together with an agenda of items to be discussed, shall be made available to each member of the Committee, no less than five working days before the date of the meeting in electronic form. Supporting papers shall be made available no later than three working days before the date of the meeting.

5.7 Committee papers shall include an outline of their purpose and key points in line with the Trust's Committee protocol, and make clear what actions are expected of the Committee.

5.8 The Chair shall establish, at the beginning of each meeting, the existence of any conflicts of interest and ensure that these are recorded in the minutes accordingly.

5.9 The Committee Secretary shall minute the proceedings of all Committee meetings, including recording the names of those present, in attendance and absent. Draft minutes of Committee meetings shall be made available promptly to all members of the Committee, normally within ten working days of the meeting. A Triple A Report will be produced which will be included in the Public Board of Directors papers.

5.10 The Committee shall, at least once a year, review its own performance, using a process agreed for all Board committees by the Board, and produce an Annual Committee Report outlining how the Committee has discharged its responsibilities and met its Terms of Reference.

Procedural control statement: 11 September 2026
Date approved: [TBC]
Approved by: Finance & Performance Committee and Trust Board
Trust Board Review date: [TBA]

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Agenda item A6(a)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	25 September 2026		
Title	Learning from Deaths, Quarter 1 2026/27 (April - June 2026)		
Report of	Rachel Carter, Director of Quality and Safety		
Prepared by	Danielle Smith, Patient Safety Improvement Manager		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	**Alert** The Trust continues to demonstrate a stable mortality profile, with 488 inpatient deaths recorded in Quarter 1 (Q1) 2026/27 compared with 485 in the same quarter last year. Mortality review completion rates remain affected by timing delays, with 167 Level 2 (L2) reviews completed for Q1 deaths (34.2% of deaths) at the reporting cut-off. Four deaths reviewed during the quarter were assessed as potentially preventable and have progressed through patient safety processes. Recurring learning themes include delays in diagnosis, investigations, treatment and escalation, together with communication issues and failures to act on abnormal results (with identified actions/outcomes outlined later in this report). **Advise** Trust Board should maintain oversight of outstanding Level 2 reviews and continue to seek assurance on the monitoring of Clinical Board performance in completing reviews in a timely manner via the Quality Committee. Focus should be given to learning arising from delays in care, communication failures and management of abnormal results. The Committee is asked to support the Mortality and Learning from Deaths Improvement Project to deliver digital enhancements, streamline review processes and address recommendations from the Audit One Coronial Process Audit. Continued work to improve demographic data quality will strengthen equity-based mortality surveillance. **Assure** The report provides assurance that Learning from Deaths arrangements remain aligned with National Quality Board guidance. Mortality indicators remain favourable, with fewer observed deaths than expected and a Summary Hospital Mortality Indicator (SHMI) of 87.6 categorised as “as expected”. Robust arrangements remain in place for Medical Examiner referrals, learning from lives and deaths reviews (LeDeR), escalation through Response Action Review Meeting (RARM) and Patient Safety Incident Response Framework (PSIRF) investigations, and dissemination of learning to Clinical Boards.		
Recommendation	The Trust Board is asked to: (i) Receive the report. (ii) Note the actions taken to improve oversight and reporting in relation to continued monitoring as required by national Learning from Death criteria. (iii) Note the updates on planned improvement processes and outstanding actions.		

Agenda item A6(a)

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]	Failure to meet our care standards in a way which is designed around people, not organisations.
Reports previously considered by	This report forms part of the regular quarterly reporting cycle for Learning from Deaths.

LEARNING FROM DEATHS

1. INTRODUCTION

Following Care Quality Commission (CQC) recommendations on investigating patient deaths, the National Quality Board introduced the National Guidance on Learning from Deaths in April 2017 to provide a consistent approach for NHS trusts to identify, investigate and learn from deaths in their care. In line with this guidance, The Newcastle upon Tyne Hospitals NHS Foundation Trust produces a quarterly report on mortality quality metrics, providing assurance to the Quality Committee and Trust Board that effective monitoring, review and learning processes are in place, and that any identified care issues lead to improvements in patient care.

2. SUMMARY OF INPATIENT DEATHS

In Q1 2026/27, the Trust recorded 488 deaths, a slight increase compared with 485 deaths in Q1 2025/26. Figure 1 provides a monthly breakdown of deaths recorded during the reporting period.

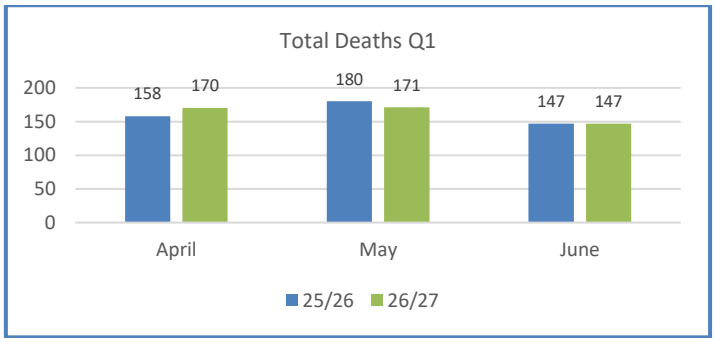

Figure 1: Total Deaths Q1 25/26 vs. 26/27

From January 2026, the Mortality Surveillance Group began monitoring mortality data by protected characteristics. Q1 2026/27 data showed that most deaths occurred in male patients, those aged 80 and over, and patients identifying as White British. Ethnicity and civil status were frequently recorded as unknown or not stated. These findings were generally consistent with expected population trends, but, following presentation of mortality data at the Promoting Equity in Health Group, improvements in recording ethnicity and civil status were identified as required and are planned to be addressed through staff education and awareness initiatives.

Between January 2025 and June 2026, the Trust reported an average of 171 deaths per month, with a mean crude mortality rate of 0.8%. Aside from a temporary increase in January 2025, attributed to predicted higher numbers of respiratory admissions during the flu season (UK Health Security Agency (UKHSA), 2024), mortality reporting remained stable with no significant variation over the period.

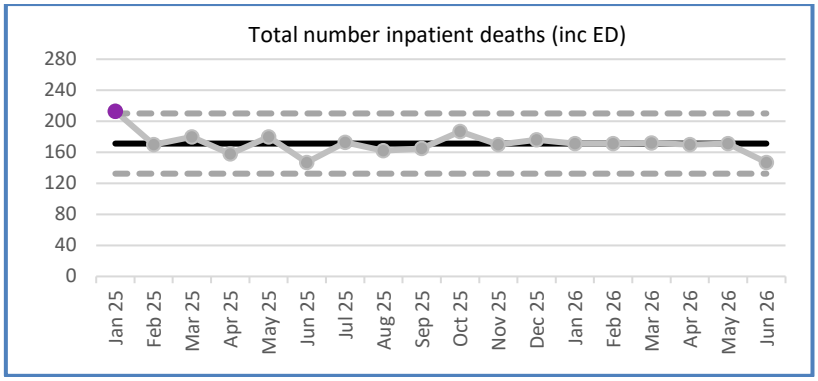

Figure 2: Monthly Deaths Jan 25 - Jun 26 including Emergency Department (ED)

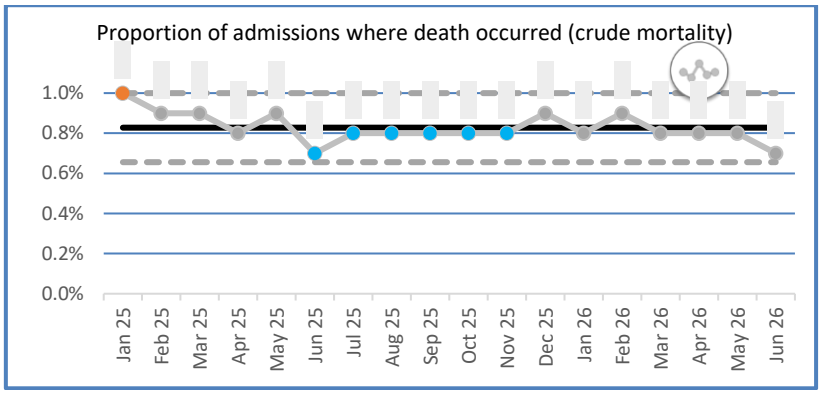

Figure 3: Crude Mortality Rates Jan 25 - Jun 26

Data provided by the North East Quality Observatory (NEQOS) on behalf of NHS England, for the period January 2025 to December 2025 (including deaths within 30 days of discharge) shows:

- The Trust recorded less observed deaths (*n = 2775*) than expected (*n = 3165*).
- Newcastle Hospitals has a Summary Hospital Mortality Indicator (SHMI) of 87.6 ('as expected').
- The total number of provider spells recorded in the period is 113,530.
- The elective coding depth is 7.5 and the non-elective coding depth is 6.7 (England average 6.8 and 6.3 respectively).
- The percentage of provider spells with palliative care coding is 1.9% (England average 2.1%).
- The percentage of provider spells with an invalid primary diagnosis coded is 0% (England average 3.5%).

3. SUMMARY OF LEVEL 2 REVIEWS

3.1 Completed Level 2 Reviews

In Q1 2026/27, 167 Level 2 reviews were completed for the 488 reported deaths, representing 34.2% of deaths, although some patients had more than one review recorded. A further 73 Level 2 reviews were completed during the quarter for deaths that occurred before the reporting period. While Level 2 reviews are primarily undertaken for adult inpatient deaths, some deaths of young people cared for in the ED or adult Intensive Care Units may also receive a voluntary Level 2 review alongside the statutory Child Death Review process. Figure 4 shows the monthly breakdown of completed reviews.

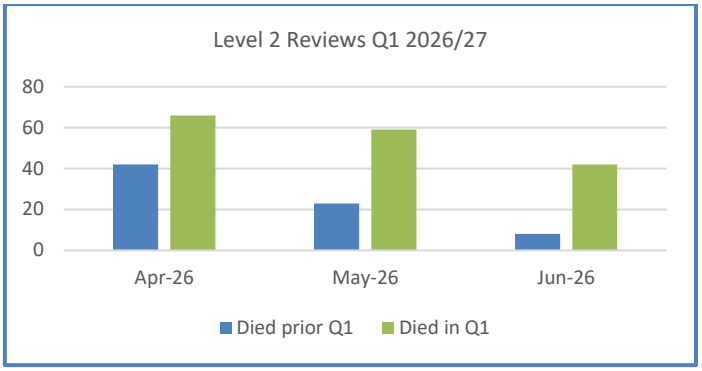

Figure 4: Level 2 reviews Q1 2026/27 (data correct as of 30/07/26)

Observation of completed Level 2 reviews (by date patient died) from January 2025 to the end of June 2026 shows that the clinical teams complete a mean of 73 reviews per month:

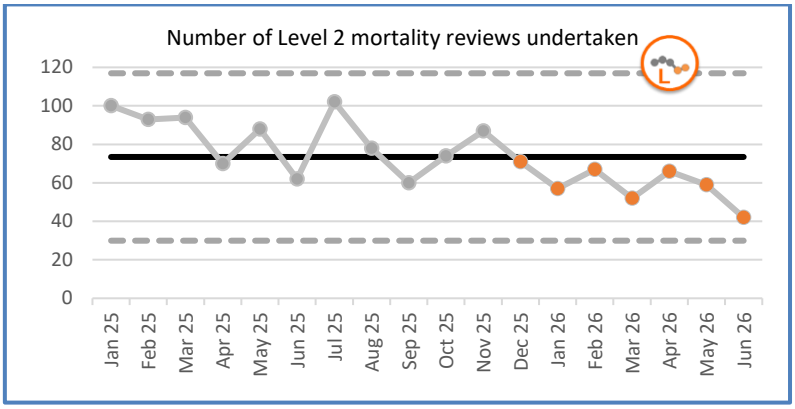

Figure 5: Level 2 Reviews Jan 25 - Jun 26 (data correct as of 30/07/26)

Whilst the number of completed Level 2 reviews decreases towards the end of the reporting period, this is likely to reflect timing rather than performance, as additional reviews for Q1 deaths are expected once Morbidity & Mortality (M&M) meetings are held. Delays in completing reviews can result in some cases from awaiting pathology or post-mortem findings, outcomes of coronial inquests, or information from external organisations. Outstanding Level 2 reviews continue to be monitored and reported monthly to Clinical Boards. This issue was highlighted during the July 2026 Quality and Performance Reviews with Clinical Board leadership teams.

3.2 Medical Examiner (ME) Initiated Level 2 Reviews

Between July 2025 and June 2026, Medical Examiners referred 80 cases for Level 2 review. At the time of reporting, 62 reviews had been completed, one was in draft, 13 had not yet started, and four referrals were discounted after being submitted in error. There were no outstanding referrals from deaths occurring before this period. All Medical Examiner referrals are monitored by the Quality and Safety team and reported monthly to Clinical Boards. Figure 6 shows the monthly number of referrals and completed reviews.

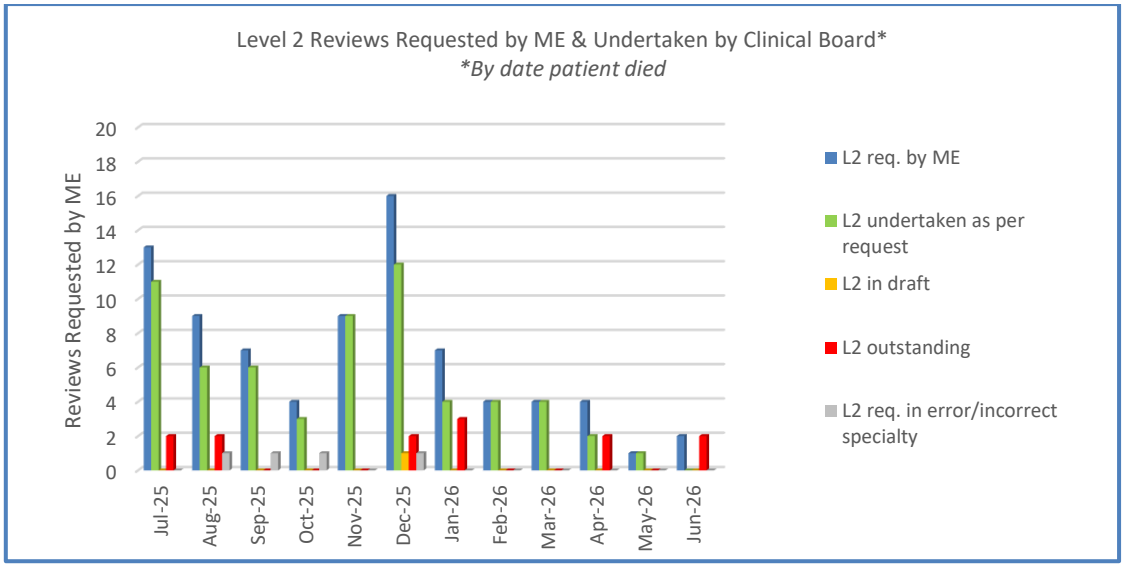

Figure 6: L2 Reviews Requested by ME Jul 25 – Jun 26 (data correct as of 30/07/26)

3.3 Patients with Learning Disability

Since April 2025, 28 deaths of adult patients with a recognised learning disability have been recorded, with 24 receiving a completed Level 2 review through the LeDeR Panel. During the same period, 2,579 patients with a confirmed learning disability were admitted to the Trust, including day case, elective and non-elective admissions, although some individuals may be counted more than once due to multiple admissions. Figure 7 provides a monthly breakdown of admissions, deaths and completed reviews over the 12 months to the end of Q1 2026/27.

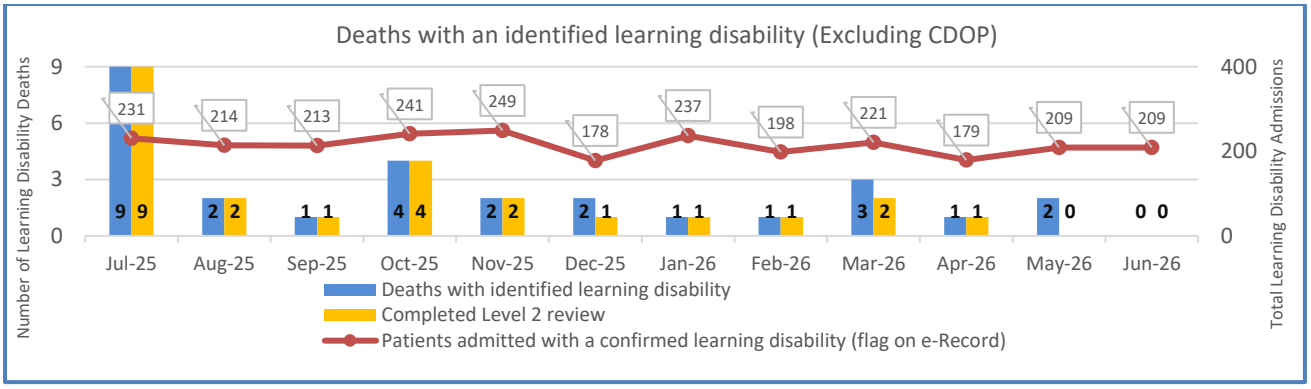

Figure 7: LeDeR Level 2 Reviews Jul 25 – Jun 26 (data correct as of 30/07/26)

LeDeR reviews identified both good practice and opportunities for improvement. Strengths included clear and compassionate communication with patients and families, effective multidisciplinary working, and good documentation of reasonable adjustments. Areas for learning included variability in the quality of Mental Capacity Act assessments, improvements to consent form completion, and better support for patients who decline a particular treatment option to explore alternative approaches. Learning and good practice from each review are shared with the relevant Clinical Boards to promote awareness and improvement.

4. DEATHS WITHIN 12 MONTHS OF PREGNANCY

A maternal death is defined as the death of a woman who has been pregnant within the previous 12 months, regardless of the pregnancy outcome. The Trust recorded one maternal death in Q1 2026/27, which met national reporting criteria. The case is being investigated as a Patient Safety Incident Investigation (PSII) due to a safety event that may have contributed to the patient's death.

5. LEARNING FROM DEATHS Q1 2026/27

All deaths undergoing a Level 2 review are assigned both HOGAN and National Confidential Enquiry into Patient Outcome and Death (NCEPOD) scores. In accordance with Trust policy, cases receiving a HOGAN score of 4 or above or an NCEPOD score of 3 are flagged for further review and consideration of a patient safety learning response under the Patient Safety Incident Response Framework (PSIRF).

5.1 HOGAN Scores

HOGAN scores are a guide as to the preventability of the patient's death and are defined as:

HOGAN 1	Definitely not preventable
HOGAN 2	Slight evidence for preventability
HOGAN 3	Possibly preventable but not very likely, less than 50-50 but close call
HOGAN 4	Probably preventable, more than 50-50 but close call
HOGAN 5	Strong evidence for preventability
HOGAN 6	Definitely preventable

Figure 8 provides a breakdown of reviews for patients who died in Q1 by HOGAN scores for the quarter:

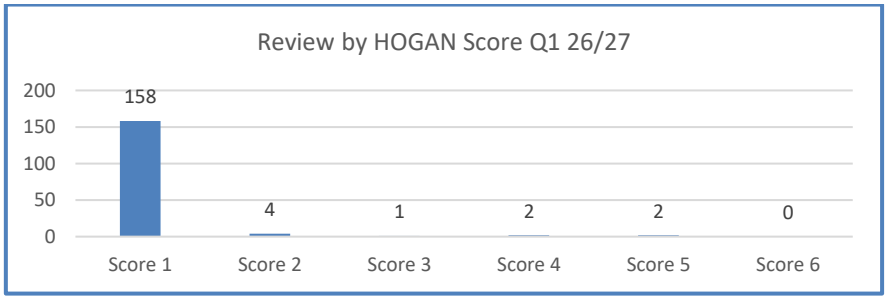

Figure 8: Q1 26/27 Completed L2 Reviews by HOGAN Scores (data correct as of 30/07/26)

Two cases received a HOGAN 4 score and were reported as incidents, with both currently under Clinical Board review and one potentially subject to downgrading following further assessment. Two cases received a HOGAN 5 score; both of which have since been declared as a PSII following rapid review by the clinical board and presentation at the Trust's Rapid Action Response Meeting (RARM).

5.2 NCEPOD Scores

NCEPOD scores are a guide as to the quality of care provided to the patient during their final admission, and are defined as per the following scale:

NCEPOD 1	Good practice: A standard you would accept from yourself, your trainees and your institution
NCEPOD 2A	Room for improvement: Aspects of clinical care that could have been better
NCEPOD 2B	Room for improvement: Aspects of organisational care that could have been better
NCEPOD 2C	Room for improvement: Aspects of clinical and organisational care that could have been better
NCEPOD 3	Less than satisfactory: Several aspects of clinical and/ or organisational care that were well below what you would accept from yourself, your trainees and your organisation

Figure 9 details the breakdown of reviews for patients who died in Q1 by NCEPOD scores for the quarter:

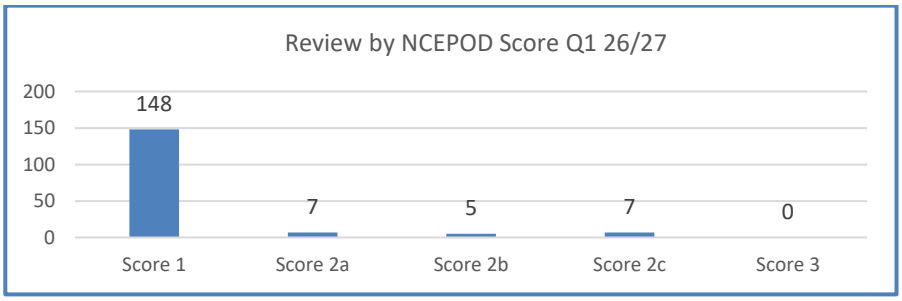

Figure 9: Q1 26/27 Completed L2 Reviews by NCEPOD Scores (data correct as of 30/07/26)

5.3 Reviews Completed for Deaths Prior to Q1 2026/27

73 reviews were completed in Q1 for deaths that occurred prior to 1 April 2026. Of these:

- 62 were given a score of HOGAN 1
- 8 were scored HOGAN 2
- 1 was scored HOGAN 3
- 2 were given a score of HOGAN 4
- 52 were scored NCEPOD 1
- 16 were scored NCEPOD 2A
- 2 were scored NCEPOD 2B
- 3 were scored NCEPOD 2C

The two cases scored HOGAN 4 were presented at RARM prior to completion of the Level 2 following submission of an incident report and declared as PSIIs which are now under investigation.

5.4 Thematic Analysis of Learning Points from NCEPOD Scores

The below table presents the thematic analysis of the learning points from all 40 reviews completed in Q1 (39 patients due to 1 patient having two reviews) that were allocated an NCEPOD score of 2 (*note: cases may have identified more than one theme*):

Theme	Overview of cases	Actions/ Outcomes
Delayed investigations/ reviews/ treatment/ diagnosis	11 cases identified delays in diagnosis, follow-up, imaging, investigations, surgery or escalation for senior review. In four cases, delays were considered to have contributed to the patient's outcome (2 HOGAN 4; 2 HOGAN 5).	High-scoring cases have been escalated through patient safety processes, with three PSIIs underway and one case undergoing further review before RARM. Three cases have been referred for secondary review, one case is being managed via the complaints process, and the remainder have generated local learning and educational actions.
Communication	Five cases identified communication issues between clinical teams or with families.	The HOGAN 4 case is under further Clinical Board review before RARM presentation. One case is being managed through the complaints process.

Theme	Overview of cases	Actions/ Outcomes
	One case (HOGAN 4) was considered to have potentially affected the patient's outcome.	Remaining cases have resulted in local learning around treatment plans, escalation processes and consultant cover arrangements.
Documentation	Seven cases highlighted variable documentation quality, including incomplete records of clinical decisions, reviews, assessments and procedure risks. None affected patient outcomes.	Cases were reviewed through local M&M meetings, with feedback provided to reinforce the importance of accurate and timely documentation.
Abnormal results	Four cases involved failure to act on abnormal results. In two cases, this did not affect outcomes. One case is awaiting specialty review. The fourth case was the aforementioned maternal death (HOGAN 5).	A radiology case (that did not affect the patient's outcome) has been referred to the Radiology Education and Learning Meeting as a case study. One specialty review is awaited. The maternal death has been declared a PSII.
Clinical decision making	Nine cases identified learning relating to clinical decision making, including around diagnosis, treatment and discharge, escalation and patient boarding. None were considered to have affected outcomes.	Local learning included reinforcing senior involvement in changed discharge plans, escalation of high-risk surgical patients, consideration of infection control impacts, education on emergency airway management and best-interest decisions, adherence to pre-hydration policies, and improved documentation of clinical decisions.
Other	Three cases highlighted learning relating to referral platform functionality, management of patients who repeatedly self-discharge, and recognition of atypical physiological deterioration.	Improvement work is underway with the referral platform provider to enhance multidisciplinary processes. Governance and M&M discussions have reinforced the importance of multidisciplinary collaboration and understanding system pressures when managing complex cases.
Unknown	In four cases it was not possible to ascertain from the review what the learning points were.	Not applicable.

5.5 Other Cases Reviewed Under the Learning from Death Criteria

The Trust's RARM panel reviews any patient deaths recorded as a patient safety event via InPhase to be considered under the Learning from Deaths criteria, in addition to cases escalated via the mortality review process. In Q1 2026/27, 6 cases met this criteria for review by the panel.

5.6 Completed Investigations and Learning

Completed PSIRF investigations are presented to the Trust's monthly Patient Safety Incident Forum (PSIF) for scrutiny and final approval. In Q1 2026/27, no completed investigations relating to events where a patient had died were submitted to PSIF for approval.

6. MORTALITY/ LEARNING FROM DEATHS IMPROVEMENT PROJECT

Further to the update provided in the previous report, this project is now underway and in the early stages of defining scope, practicality and implementation. Developments to date include:

- Appointment of a clinical lead.
- Initial discussions between clinical lead and Patient Safety Improvement Manager (formerly Integrated Governance Manager – Patient Safety) to understand project ask and viability.
- Planned meeting with IT representative in August 2026 and submission of digital development request for planned e-Record improvements.
- Planned protected time with InPhase team in October 2026 for design consultation and application build.
- Planned pilot and consultations with small number of clinical teams (to be agreed).
- A completion date of March 2027 has been proposed.

7. AUDIT ONE CORONIAL PROCESS AUDIT ACTION

The Trust's Audit, Risk and Assurance Committee (ARAC) noted that one action in relation to mortality monitoring procedures remained outstanding as of July 2026 following the Coronial Process audit undertaken by AuditOne in late 2025, as follows:

The provision of targeted training to clinical governance leads should be considered to reinforce:

- *The importance of completing Level 2 reviews.*
- *The need for clear documentation of decisions and rationale.*

Management should continue to contact governance leads to ensure that any deaths meeting the criteria for Level 2 (L2) reviews are:

- *Appropriately reviewed.*
- *Recorded on the mortality database.*
- *Reported to the Patient Safety team if a review is not required, along with the supporting rationale.*

Additionally, consideration should be given to implementing periodic spot checks to ensure compliance with the review and documentation process.

A response has been provided to the Trust's Corporate Risk and Assurance Team to advise that this action has been superseded by the improvement project now underway however in respect of the recommendation to contact governance leads to ensure appropriate review, etc., this is already in place and takes place monthly via regular reporting and communication with the relevant teams.

8. RECOMMENDATIONS

To:

(i) Receive the report.
(ii) Note the actions taken to improve oversight and reporting in relation to continued monitoring as required by national Learning from Death criteria.
(iii) Note the updates on planned improvement processes and outstanding actions.

Report of Rachel Carter
Director of Quality and Safety
30 July 2026

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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
168	31 July 2026	26/21 INTRODUCTION: d. Chief Executive's Report	It was agreed that the National Cancer Patient Experience Survey results link would be circulated to Trust Board members [ACTION01].	LT			31.07.26 - Circulated to Board members via email. Propose to close action.
169	31 July 2026	26/22 JOINING UP CARE – WORKING TOGETHER TO GIVE PEOPLE BETTER, QUICKER ACCESS TO EFFECTIVE CARE: a. Board Visibility Programme	An update on the transition from child to adult services will be provided to a future meeting of the Quality Committee. It was agreed that Jeff Perring would review the paper prior to its submission to the Quality Committee [ACTION02].	LPC/MWr			14.09.26 - Timescale requested from action owners. 17.09.26 - The Medical Directors are addressing this action and have shared with Clinical Board colleagues. A bespoke piece of work will be commissioned to review all current transition and outline any areas for improvement. It is expected that this will take around 6 months and will be added to the schedule of business for Quality Committee in the 2027/28 schedule of business. 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.