The Newcastle upon Tyne Hospitals NHS Foundation Trust

Public Trust Board of Directors
Friday 27 November 2026, 10:15 – 12:45
Piano Room, Royal Victoria Infirmary (RVI)

Apologies: Joanne Race, Martin Wilson

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 25 September 2026 and matters arising	For discussion & approval	Paul Ennals
c.	10:17	Chair's Report	For assurance	Paul Ennals
d.	10:22	Chief Executive Report	For assurance	Rob Harrison
e.	10:30	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.	10:40	Trust Strategy update	For assurance	Patrick Garner
b.	10:48	Thirlwall Inquiry	For assurance	Ian Joy
c.	11:15	Board Visibility Programme	For assurance	Rachel Carter
d.	11:20	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.	11:30	Patient and Colleague Experiences	For assurance	Ian Joy
b.	11:35	Joint Medical Directors Report including: i) Guardian of Safe Working Report	For assurance	Michael Wright & Lucia Pareja-Cebrian
c.	11:45	Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs) report including: i) Bi-annual deep dive nurse staffing report	For assurance	Ian Joy

	Time	Item	Purpose	Lead
		ii) Bi-annual deep dive Allied Health Professionals Workforce Report		
d.	11:55	Maternity update including: i) Perinatal Quality Oversight Report including Maternity Incentive Scheme progress report	For assurance	Jenna Wall
4.	**Supporting great care – supporting everyone to do their job to the best of their ability with effective leadership, a just and learning culture and modern digital and physical environments**			
a.	12:05	Freedom to Speak Up (FTSU) bi-annual update	For assurance	Rachel Carter, Kathryn Smart & Paula Dimarco
b.	12:15	Engagement update including approval of principles	For assurance	Caroline Docking & Kelly Jupp
5.	**Items to approve**			
a.	12:25	Board Assurance Framework (BAF)	For assurance & approval	Patrick Garner
b.	12:33	Charity update including: i) Impact Report ii) Annual Report and Accounts	For assurance & approval	Wendy Balmain & Caroline Docking
6.	**Items to receive *[To cover by exception only]***			
a.	12:39	Chief Digital Information Officer Report	For assurance	Dave Elliott
b.	12:43	Meeting Action Log	For assurance	Paul Ennals
7.	**Any other business**			
a.	12:44	Any other business	For discussion	All

Date and Time of Next Meeting: Friday 29 January 2027, 10:15 – 11:45, Piano Room, Peacock Hall, RVI

Sir Paul Ennals, Chair
Mr Rob Harrison, Acting Chief Executive Officer
Ms Wendy Balmain, Vice Chair
Mr Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals
Dr Lucia Pareja-Cebrian, Joint Executive Medical Director
Dr Michael Wright, Joint Executive Medical Director
Mr Patrick Garner, Director of Performance and Governance
Mrs Rachel Carter, Director of Quality and Safety
Mr Dave Elliott, Chief Digital Information Officer
Mrs Caroline Docking, Director of Communications and Corporate Affairs
Mrs Jenna Wall, Director of Midwifery
Mrs Kelly Jupp, Trust Secretary
Ms Kathryn Smart, Freedom to Speak Up Guardian (FTSUG)
Ms Paula Dimarco, FTSUG

PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 25 SEPTEMBER 2026

Present:	Paul Ennals *[Chair]*	Chair
	Rob Harrison	Acting Chief Executive Officer (CEO)
	Jackie Bilcliff	Executive Director of Finance / Acting Deputy CEO
	Lucia Pareja-Cebrian	Joint Executive Medical Director (JEMD)
	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
	Wendy Balmain	Vice Chair/Non-Executive Director (NED)
	David Weatherburn	NED
	Hassan Kajee	NED
	Liz Bromley	NED
	Jeff Perring	NED
	Judith McKenna	NED
	Joanne Race	NED

In attendance:
Paul Hanson, Director of Estates, Facilities and Strategic Partnerships
Caroline Docking, Director of Communications and Corporate Affairs
Martin Wilson, Director - Great North Healthcare Alliance (GNHA) & Strategy
Patrick Garner, Director of Performance and Governance
Kelly Jupp, Trust Secretary
Jenna Wall, Director of Midwifery *(left the meeting at 11:43)*
Lydia Trendall, Chief Registrar *(left the meeting at 11:27)*
Marie Smith, Consultant Obstetrician *(for item 26/30 d. i) only)*
Richard Hearn, Consultant in Neonatal Paediatrics *(for item 26/30 d. i) only)*

Observers:
Tania Bell, Member of the Public
Kathryn Atkinson, People and Organisational Development (OD) Partner, Newcastle Hospitals
Ricky Mark Swan, Cyber Security Analyst, Newcastle Hospitals
Jo Pugh, Client Services Manager, North East and Yorkshire - NHS Professionals

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.

26/28 <u>INTRODUCTION:</u>

Paul Ennals welcomed all to the meeting and advised that the meeting was being recorded.

a. Apologies for Absence and Declarations of Interest

Apologies were received from Board members Anna Stabler, NED, and Michael Wright, JEMD, and attendees Rachel Carter, Director of Quality and Safety and Dave Elliott, Chief Digital Officer.

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

b. Minutes of the previous meeting held on 31 July 2026 and matters arising

The minutes of the meeting held on 31 July 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

Paul Ennals reflected on the significant progress made across the Trust, particularly regarding the improvements in some areas of organisational performance. He acknowledged the challenges presented by the ongoing national scrutiny of maternity services and regionally regarding breast services, pressures within cancer services, and workforce difficulties in some areas.

Following the recent publication of the Thirlwall Inquiry findings, further consideration would be given as part of the Chief Executive's update.

Recent changes within the Non-Executive Director team and Committee leadership arrangements were highlighted, which represented a period of transition for the Board.

Paul Ennals expressed his appreciation to all those involved in delivering the recent successful Staff Awards event which celebrated the achievements of Trust staff.

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

d. Chief Executive's Report including Thirlwall Inquiry update

Rob Harrison highlighted the following points:

- Progress against the Trust's five-year strategy.
- The launch of the new People Services structure, which had streamlined 34 service lines into five clearly defined teams.
- Ongoing operational pressures, which included elective waiting lists and sustained increases in Emergency Department (ED) attendances, in part due to the challenges

associated with the major building works to connect the Urgent Treatment Centre (UTC) and the ED.

- Cancer performance had improved in relation to the 28-day diagnostic standard, although further work was required to achieve sustained improvement against the 62-day treatment pathway standard.
- The Trust's overall position had improved from NHS Oversight Framework (NOF) segment 3 to segment 2 in Quarter 1. This reflected the positive progress made in performance.
- A continued Executive focus on quality and safety, supported by plans to strengthen leadership capability through strategic leadership development and a wider organisational excellence programme.
- Positive progress in pharmacy services, neighbourhood working and digital transformation, which included the development of an associated investment plan.
- The successful retention of the 0-19 services contract, with strong work undertaken by teams and partners to secure the positive tender outcome.
- Patient experience continued to improve, with the Trust having achieved a strong national ranking in the National Inpatient Survey and positive feedback from cancer patient experience surveys, with maternity survey results expected shortly.
- Recognition of the commitment of staff across the organisation and the importance of celebrating excellence through the recent Staff Awards event.

Paul Ennals queried whether the Children and Young People's Services tender presented an opportunity to consider more innovative and integrated models of delivery. He recognised that the service was well utilised but may benefit from a broader strategic approach. Rob Harrison advised that, whilst a new service specification was being developed, there was also a wider transformation programme underway which included partnership working with Family Hubs and consideration of how services could be delivered more effectively across the system.

Rob Harrison and Ian Joy highlighted the following points in relation to the Thirlwall Inquiry:

- A reflection on the recent national reports into maternity services and healthcare services more broadly. It was acknowledged that the findings were challenging and thought-provoking, and prompted reflection on culture, openness, transparency, the connectedness of Boards within their organisations and the ability to identify concerns at an early stage. Initial observations were shared in relation to the Thirlwall Inquiry, with agreement that a more detailed discussion on the recommendations, implications and required actions be brought back to the Trust Board meeting in November **[ACTION01]**.
- The Trust's response to the initial/emerging national recommendations. Further correspondence was expected once the Government had fully considered the report.
- Assurance was provided that the Trust had robust processes in place for reviewing child deaths; with emphasis placed on ensuring such processes were enacted consistently and comprehensively across the organisation.
- A formal response had been prepared to meet the required national deadline, with a commitment to ensure that any resulting changes were communicated clearly to staff.

- A gap analysis would be completed against the initial recommendations, with the recommendations including specific asks related to neonatal unit facilities and the use of cot cameras, with findings to be considered through the Quality Committee.
- Safeguarding arrangements, which included mandatory training, would be reviewed to ensure continued alignment with national best practice and any emerging recommendations.
- Several actions were already underway or formed part of existing improvement programmes. This provided a strong foundation for responding to any future requirements.

A discussion ensued which covered the following areas:

- Board members expressed support for the direction of travel and the actions being taken in response to the emerging recommendations. It was confirmed that a broad review would be undertaken, encompassing governance arrangements and embedded organisational processes.
- Clarity on the definition of 'relevant staff' in relation to child death review processes.
- The importance of transparency and openness, with actions aligned to the Trust's strategy, and a culture of encouraging staff to raise concerns and speak up when issues were identified.
- Assurance was provided that external expertise and challenge were incorporated into mortality review processes, with specialist support available through the Integrated Care Board (ICB).
- The immediate recommendations, which were being progressed.
- The considerable work undertaken in recent years to strengthen governance systems and speaking-up arrangements, with a continued focus on ensuring concerns were recognised, investigated appropriately and acted upon when identified.
- David Weatherburn, on behalf of the Quality Committee Chair and Liz Bromley, Maternity Champion both highlighted that well-established oversight arrangements were in place, and recognised the importance of transparency and public confidence.
- The forthcoming Board discussion, which Paul Ennals highlighted should extend beyond maternity and neonatal services to consider governance, culture, leadership and organisational learning more broadly.
- Board members sought and received assurance that there was clear executive leadership for this work, that appropriate processes were in place, and that no gaps in oversight had been identified at this stage.

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

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

Paul Ennals provided an overview of the Triple A reporting approach, with the following updates provided:

- Digital and Data Committee (D&DC): Hassan Kajee advised that an alert was raised regarding the Integrated Clinical Environment (ICE) system, which supported the flow of information between the Trust and primary care. Some issues had emerged following a technical upgrade, although assurance had been received that these were being appropriately managed and that no patient harm had occurred. D&DC members

had requested a review of lessons learned and consideration as to what could be done differently in the future. The issue had also prompted broader discussions regarding strategic digital resilience and information governance.

- Quality Committee: On behalf of Anna Stabler, Jeff Perring advised that three alerts were raised from the three meetings. Regarding Duty of Candour (DoC) compliance, Committee members felt that progress was insufficient and a detailed review was planned for the October 2026 Committee meeting. Six Never Events were reported during the year, with an increase in both the number and the variety of incident types (related to non-invasive procedures). In addition, a concern was raised regarding outstanding Clinical Audits that had not been completed as scheduled, with further scrutiny to be undertaken through the Audit, Risk and Assurance Committee (ARAC). David Weatherburn confirmed that the matter had been discussed at the ARAC meeting earlier this week.

  Board members noted the significant increase in Never Events and discussed the importance of understanding the context behind the figures. Clarification was provided that not all Never Events resulted in patient harm; however, all incidents were treated seriously and were subject to the same level of investigation and scrutiny. Never Events were reviewed, with strong clinical oversight from both nursing and medical teams, and DoC was applied.

  Lucia Pareja-Cebrian highlighted that one of the Quality Account priorities was in relation to reducing Never Events, particularly those related to invasive procedures. Because of this focus, there had been a positive increase in reporting.

  An update on the specific Never Events, any patient harm and associated learning would be presented to a future Trust Board meeting **[ACTION02]**.
- People Committee: Joanne Race outlined the alert relating to the Fairer Deal for Nursing programme, which reflected the scale of the issue and the associated uncertainty regarding funding. However assurance was provided on the Trust's collaborative approach to implementation. Positive progress was also reported from the People Services restructure, particularly in relation to cultural impact and improved triangulation of data.
- Finance and Performance Committee (F&PC): Judith McKenna highlighted the alerts relating to the implementation of the new financial reporting framework and elective waiting list performance, which was currently behind plan. Recovery plans were being developed and would be presented to the F&PC for further scrutiny and oversight.
- ARAC: David Weatherburn advised that no alerts were reported. He noted the significant progress made in developing the Board Assurance Framework (BAF) and risk reporting arrangements, both of which were now more focused and closely aligned to the Trust's strategy. An update on the Well-Led Review highlighted the substantial work underway to deliver and maintain progress against the action plan, with early indications having demonstrated a positive trajectory.
- Charity Committee: Wendy Balmain advised that there were no alerts to report. She highlighted the success of the Sir Bobby Robson Institute fundraising team, who received the Chair's Award at the Staff Awards, recognising their outstanding contribution. The significant achievement of securing £29 million of £30 million to

date towards the new build project was noted, along with the launch of the associated public fundraising campaign. Appreciation was also expressed to the Estates team for their work in managing the project's complexity and timescales to support successful delivery.

- Research, Innovation and Commercial Committee (RICC): Jeff Perring provided an update on the inaugural meeting of the Committee, with strong engagement and enthusiasm evident for the Trust's research agenda. At the time of the meeting, the Biomedical Research Centre (BRC) 5 submission was under development however had subsequently been submitted. RICC members discussed the challenges in achieving the 90-day study set-up target, which was identified as an alert. Committee members also considered changes to national reporting arrangements and the potential impact of the loss of associated funding if the target was not achieved, with further updates to be provided to the Committee as work progressed.
- Alliance Steering Group (ASG): Paul Ennals advised that it had been agreed to include the ASG Triple A reports within the Trust Board papers to show a more comprehensive overview of Alliance activity. Wendy Balmain confirmed that there were no alerts to report and emphasised the importance of increasing Board visibility and understanding of Alliance working. In particular, the Alliance's role in addressing shared challenges, supporting improvements in cancer performance, driving innovation, enhancing patient experience and facilitating shared learning across partner organisations was noted.

  David Weatherburn advised that he had attended the August 2026 ASG meeting and reflected positively on the opportunities the Alliance provided to resolve issues collaboratively, for leadership development and talent identification across the wider system.

Paul Ennals thanked the Committee Secretaries for ensuring that timely and up-to-date Triple A reports had been provided to support the Board's discussions. All agreed that additional time be added to future Board meeting agendas for consideration of the Triple A reports.

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

26/29 JOINING UP CARE – WORKING TOGETHER TO GIVE PEOPLE BETTER, QUICKER ACCESS TO EFFECTIVE CARE:

a. Board Visibility Programme

Ian Joy highlighted the following points:

- A summary of findings was included in Section 3, with no themes identified that required escalation or alert. Evidence from the visits highlighted that overall staff felt increasingly comfortable in raising any concerns they had, which supported a culture of openness and continuous improvement.
- An action log was being used to follow up actions raised.

- Two supporting reports were available for Board Members in the Reading Room on AdminControl for information.
- Feedback from a visit to the Children's Outpatients Department highlighted a cohesive and committed team, with a small number of operational concerns identified regarding room utilisation and set up, which were being actively addressed through appropriate follow-up actions.

David Weatherburn provided an update on his recent visit to ward 12, elderly medicine, and highlighted the following points:

- The Ward had a positive and well-managed environment characterised by strong teamwork, energy and pride among staff.
- The service was recognised as caring for a large and complex elderly patient cohort with acute medical needs, supported by a clear focus on delivering high-quality care.
- Recognition was given to the efforts of matrons and ward sisters in maintaining an appropriate skill mix to ensure safe and effective patient care.
- A positive and inclusive culture was observed, with staff at all levels encouraged to contribute and influence service improvement.
- Despite constraints associated with the existing facilities, the team continued to deliver high standards of care and maintain a positive working environment.
- Strong performance in managing staff absence was also noted, reflecting the commitment and resilience of the workforce.

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

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

Patrick Garner noted the following points:

- The report cover sheet highlighted three performance indicators as 'alerts', being Clostridioides Difficile Infection (Cdiff) cases, Cancer 31-day performance and sickness absence.
- The earlier CEO update on elective and ED performance.
- A particular focus on 31-day cancer performance, with challenges highlighted in radiotherapy performance due to national shortages amongst specialist therapy staff. Increased demand for specific treatment modalities had further contributed to performance pressures.

  To address workforce shortages, overtime was being offered where possible, and agency staff were being utilised when available. Work was also underway to develop sustainable solutions, including growing the internal workforce pipeline and increasing opportunities to attract and recruit newly qualified radiography staff.

  Surgical cancer and chemotherapy services were performing well and it was noted that if radiotherapy performance was excluded then 31-day cancer performance would be nearer to 90%.
- Productivity and service improvement opportunities had been considered through a range of forums, through Get It Right First Time (GIRFT) reviews and best practice benchmarking, with the primary issue identified as capacity rather than productivity.

- A detailed action plan covering performance against the 31-day cancer standard and wider cancer recovery priorities would be presented to the F&PC meeting in October for further scrutiny and oversight.

Ian Joy highlighted that Infection Prevention and Control (IPC) performance had been discussed at length in the Quality Committee. He noted that there had been increases in some key indicators such as Cdiff, associated with seasonal pressures. Performance varied across Clinical Boards, with tailored improvement plans in place through the IPC Improvement Group to address local challenges.

In relation to complaints performance, significant work had been undertaken to improve the timeliness of complaint responses however further improvement actions remained in progress to ensure continued enhancement of the complaints process and patient experience. Rob Harrison suggested that it would be beneficial to publish the range of negotiated complaints response timescales to improve transparency regarding both agreed extensions and overall performance. Ian Joy confirmed that this information was reviewed at the Complaints Panel meetings and could therefore be incorporated into future Quality Committee reports **[ACTION03]**.

Jeff Perring sought assurance that learning from complaints was leading to meaningful improvement, to which Ian Joy advised that complaint themes were reviewed at the Clinical Board Quality Oversight Groups and at the Complaints Panel. Whilst action plans had been developed to address identified issues, further work was needed to ensure the actions were SMART (specific, measurable, achievable, realistic and time-bound). Learning from complaints was informing service improvements and organisational change, although further work remained to embed this consistently across the Trust.

Vicky McFarlane-Reid highlighted the following points:

- There had been no sustained improvement in sickness absence performance to date, although unvalidated September 2026 data suggested a slight positive improvement to 5.5%.
- Both the number of employees absent, and the total number of days lost needed to be considered to fully understand the scale and impact of sickness absence across the Trust.
- The new People Business Partners were now in place to support services, with a focus on sharing good practice and strengthening local management of absence.
- Following the appointment of a dedicated Sickness Officer, a more proactive approach was being taken to sickness absence management across the organisation. A centrally coordinated weekly review of the 30 longest sickness absence cases had been established to provide greater oversight and facilitate earlier intervention, and an updated Sickness Absence Management Policy would be presented to the Trust Management Group (TMG) in October 2026 for review and consideration.

  Joanne Race advised that People Committee members had discussed sickness absence in detail and was assured that there was a clear organisational focus on addressing the issue. Continued monitoring of sickness absence would take place in Committee meetings.

Paul Ennals noted that assurance had been provided that the relevant Committees were maintaining detailed oversight of the alerts raised.

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

26/30 ADVANCING CARE – IMPROVING PATIENT CARE, EFFECTIVENESS AND QUALITY THROUGH INNOVATION, RESEARCH, IMPROVEMENT AND EDUCATION:

a. Patient and Colleague Experiences

Ian Joy advised that following the publication of the Ockenden and Amos reviews, it was felt important to share patient and colleague experiences from neonatal and maternity services. These services continued to be subject to significant national scrutiny, with a strong emphasis on delivering sustainable improvements. Learning extended beyond the technical aspects of clinical care to include compassion, culture and patient experience, particularly within high-pressure tertiary service environments. The importance of supporting staff wellbeing and recognising the link between staff experience, patient experience and the quality of care delivered was also highlighted.

Paul Ennals emphasised the importance of maintaining a balanced perspective, and receiving stories that recognised both positive and negative experiences. He noted that positive feedback from patients often correlated with positive staff experience and wellbeing, therefore supporting colleagues to deliver compassionate, high-quality care was extremely important.

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

b. Joint Medical Directors Report including:

Lucia Pareja-Cebrian highlighted the following points:

- The ongoing operational pressures within Urgent and Emergency Care (U&EC) and cancer services, with ED recovery actions focused on improving patient flow, frailty pathways and discharge processes.

  Cancer performance remained mixed, with strong performance in some pathways such as skin, offset by ongoing challenges in lung, urology and gastrointestinal services, impacted in part by radiography workforce shortages and endoscopy capacity constraints.
- Regarding Quality and Safety, Never Events were discussed earlier. Implementation of NATSSIPs2 plans continued, alongside ongoing work to support ambitions around the elimination of HIV transmission. The pilot programme in the ED for the identification of blood borne viruses had been extremely successful.
- Medical workforce changes, which included new Chief Registrars Lydia Trendall and Ramin Leylabi, who would be focussing on delivery of the 10 point plan for resident

doctors, particularly regarding improvement of rotas and digital processes. Ian Forrest was recently appointed at the new Director of Medical Education.

- Positive progress was reported in strengthening communications and relationships with e.g. the Local Negotiating Committee members.
- In relation to the Emergency Preparedness, Resilience and Response (EPRR) self-assessment, six standards remained partially compliant, principally relating to EPRR staffing capacity, pandemic preparedness, evacuation planning and business continuity development. Action plans were in place to address these gaps ahead of the forthcoming NHS England (NHSE) EPRR assurance review, due on 16 October 2026.
- The continued success of the Trust's transplant programme, which included current priorities to increase access to transplantation, optimise donor organ utilisation, support national programme developments and ensure the successful progression of the Assessment and Recovery Centre (ARC) from a pilot centre to a fully commissioned unit.

Hassan Kajee noted that assurance was provided that appropriate cancer recovery action plans were in place but queried whether Executive Team members were confident that the plans would be delivered. Lucia Pareja-Cebrian advised that work was underway to strengthen radiotherapy workforce capacity through training and pipeline development. Discussions through the Quality Performance Reviews (QPR) were being used to assess progress and consider whether additional actions were needed. A further update on the expected recovery position would be brought back through the correct governance route to provide greater visibility of performance trajectories and timescales.

Paul Ennals sought assurance regarding the reduction in Teaching Fellow posts to which Lucia Pareja-Cebrian advised that work was underway to identify the areas in which posts could be expanded, with a 30 September deadline for the final bid. She noted that a dedicated working group had been established to review contractual arrangements and consider changes to support the sustainability and development of the roles. This work also formed part of a broader review of medical education and training, which included the development of the Newcastle training offer in partnership with Alliance organisations.

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

[Lydia Trendall left the meeting and Marie Smith and Richard Hearn joined the meeting]

c. <u>Executive Director of Nursing, Midwifery and Allied Health Professionals (AHPs) report</u>

Ian Joy noted the following points:

- The earlier discussions on ongoing pressures within the ED, with the position subject to close monitoring and management.
- Preparations had been completed for the launch of the staff vaccination programme, with commencement dependent upon confirmation that vaccine supplies had arrived on site. A staff vaccination uptake target of 60-65% had been identified, with plans in place to support delivery of the target.

- Performance was benchmarking favourably for staff fit-testing compliance against comparable organisations but remained below the Trust's target level. Improvement actions related to fit-testing compliance were included within the Board Reading Room on AdminControl and were subject to discussion through the Quality Committee.

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

d. Maternity update including:

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

Jenna Wall highlighted the following points:

- A revised reporting format had been adopted, with routine metrics now reported through the IBR to enable greater focus on national benchmarking and areas of strategic significance.
- Benchmarking against the maternity 10 point-plan had identified two principles which remained at risk relating to patient experience data, specifically in relation to ethnicity and deprivation, and triage services. Patient experience data had been discussed in detail alongside the work of the patient experience team and triage services had been subject to a comprehensive review. Several amber-rated risks had been identified, which included issues relating to estate space, access standards and obstetric staffing.

  Funding had been secured for telephone triage services to introduce call recording functionality to support quality and assurance.
- Several of the issues highlighted in recent national reviews had already been identified locally, with improvement actions already underway prior to publication.
- Ongoing challenges remained relating to estates infrastructure and digital systems, which would require continued focus and investment.

As Maternity Safety Champion, Liz Bromley endorsed the update, and noted the significant estates challenges to be addressed to improve the environment for both patients and staff. She highlighted several smaller initiatives already being implemented within the Maternity Assessment Unit (MAU) to ensure staff felt listened to, supported and safe in their roles. Liz Bromley advised that staff were doing everything possible to maintain and improve patient safety, experience and outcomes, despite the challenges faced.

Marie Smith reflected on the ongoing challenges associated with the level of national scrutiny and noted that evolving requirements and expectations made it difficult to provide assurance due to the scale of the requirements. She emphasised the importance of making it easier for staff to generate the required reports for maternity services, and highlighted the challenges created by digital systems that were not fully integrated, which often required manual work to provide the required information. Sue Hillyard advised that additional management capacity has been secured to support reporting and to improve the collection and use of information and data to strengthen oversight, assurance and decision-making.

Richard Hearn agreed the same issue regarding reporting was present for neonates and highlighted the additional pressures created by duplication of the reporting requirements. Jenna Wall noted that concerns relating to digital infrastructure had been escalated through the Quality Committee to the ICB as part of discussions on the maternity care bundle. She acknowledged that, whilst some improvements could be addressed locally, several of the challenges were linked to national infrastructure issues that remained outside the direct control of the Trust.

Wendy Balmain highlighted that the Quality Committee continued to receive strong assurance through the quality of evidence and scrutiny provided by Jenna Wall and colleagues. She noted that understanding data related to ethnicity and deprivation remained an important Trust-wide issue and welcomed the work underway to strengthen assurance in this area. The importance of having access to robust data and using it effectively to identify inequalities, support decision-making and drive improvement was noted. Further consideration would be needed within the Health Inequalities Delivery Plan.

Rob Harrison emphasised the importance of considering the broader learning arising from the national maternity inquiries and reflecting on how key lessons could be applied across other services and areas of the Trust. He requested that Executive Team members consider whether the information and intelligence required from external reviews is collected and shared to identify issues early and provide assurance.

Patrick Garner noted that the Provider Capability Assessment had highlighted health inequalities as an area of focus, particularly in relation to the completeness and quality of data. He emphasised the importance of strengthening data collection to support a better understanding of inequalities and inform targeted improvement activity.

Paul Ennals acknowledged the significant pressures faced by staff, including the impact of external scrutiny and social media commentary, and reaffirmed the Trust Board's support, confidence and trust in colleagues across the organisation as they continued to deliver high-quality maternity and neonatal care in challenging circumstances.

It was **resolved**: to **receive** the report and **approve**:

i) The Maternal Care Bundle, 10 Point Plan and Triage self-assessments and actions plan in accordance with the national assurance process.
ii) The proposal for quarterly oversight of Maternal Care Bundle implementation by the Quality Committee.

[Jenna Wall, Marie Smith and Richard Hearn left the meeting].

ii) <u>Maternity Safety Champion Report</u>

Liz Bromley expressed confidence in the leadership of the service and reflected on discussions she had had with families regarding their experiences of care. She noted the significant progress that had been made in leadership engagement, visibility and cultural development, highlighting positive changes in how staff and leaders worked together. Liz

Bromley emphasised the importance of understanding the experiences of patients and families, noting that their feedback provided an important measure of the impact of service improvements and cultural change.

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

e. Winter Plan update

Sue Hillyard highlighted the following points:

- An updated version of the report was presented following amendments suggested at the F&PC meeting.
- The U&EC Recovery Plan had been reviewed by Quality Committee members and would be subject to a further deep-dive discussion at the October F&PC meeting.
- The importance of monitoring ED attendance and associated days as part of ongoing performance oversight was noted.
- A Board Assurance Statement (BAS) was required to be submitted, which was tested and discussed at a regional event held in the previous week.
- Two areas were rated red, which required continued focus, monitoring and assurance.

Judith McKenna thanked colleagues for the updates provided through the F&PC and noted the thorough and constructive discussion that had taken place in relation to the issues presented, particularly the two areas which required ongoing oversight and assurance.

Paul Ennals sought assurance regarding the assessment of corridor care risks and queried whether the current rating accurately reflected the level of concern. Sue Hillyard advised that she was confident the associated risks could be appropriately mitigated; however, it was noted that some organisations reporting lower levels of corridor care had assigned a red risk rating. It was therefore agreed that Sue Hillyard would review the assessment and provide further assurance on the appropriateness of the current risk rating in section 4.1 **[ACTION04]**.

Jeff Perring queried the delay to the Paediatric Intensive Care Unit (PICU) ventilation upgrade and the potential impact on winter capacity. Paul Hanson advised that the project formed part of a wider programme of capital works affecting intensive care capacity and confirmed that capacity plans had been developed in conjunction with Sue Hillyard and Lucia Pareja Cebrian. The implications had been considered in detail by the Executive Team. Lucia Pareja Cebrian added that the unit had been temporarily relocated to an alternative area and that no impact on operational capacity was anticipated, with the work expected to be completed before Christmas. Members also considered seasonal pressures, including Respiratory Syncytial Virus (RSV), and were assured that the overall bed base remained largely unchanged.

Sue Hillyard provided assurance that strong weekly governance arrangements were in place to oversee the estates programme, ensuring active management of risks and operational impacts. Paul Ennals recognised the significant contribution of the Estates team and commended their work in delivering a complex programme of capital projects while maintaining service continuity.

It was **resolved**: to **receive** the report and **approve:**

i) The core plan to mitigate this year's winter pressures and sustain safe services, with a level of ED performance >80% in line with submitted planning trajectories.

ii) The signing of the BAS by the Trust's Accountable Officer and Chair following review of the current risk rating in section 4.1.

26/31 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. Sustainability update including

i) Annual SHINE Update (Shine Report 25-26 & Carbon Reduction Plan (CRP))

Vicky McFarlaine-Reid presented the annual SHINE update and the CRP, which had both been considered in detail by F&PC members. Sustainability initiatives were increasingly being embedded as business as usual across the organisation and were reflected within the Trust's strategy. The CRP had been updated to meet required obligations and included revised carbon reduction targets to provide a more realistic trajectory over the next five years.

A proposal to seek additional funding for a geothermal energy initiative would be presented to the Board in the private session for approval.

It was **resolved**: to **receive** the report and **approve** the publication of the annual SHINE report and CRP.

26/32 ITEMS TO APPROVE:

a. Board Assurance Framework (BAF)

Patrick Garner explained that the report represented the first complete rewrite of the BAF, aligned to the Trust's strategy and subject to scrutiny through all relevant Committees. He noted that risks were now better understood, more visible and subject to active management. Given the relatively short period since implementation, further work remained in strengthening risk controls.

David Weatherburn advised that the risks had been reviewed and updated, resulting in a comprehensive and high quality BAF.

Work was ongoing to consider how the BAF would inform the work of Committees going forward. David Weatherburn noted that the BAF should help drive improvement by informing Committee priorities, scrutiny and actions.

Assurance was received from Committee Chairs that the revised BAF had been subject to thorough scrutiny and represented a significant improvement in the management and oversight of strategic risks. The importance of maintaining ongoing review of strategic risks that remained outside the Trust's risk appetite to ensure that appropriate mitigating actions continued to be identified, monitored and progressed was highlighted.

Martin Wilson explained that the partnership risk was directly owned by the Board rather than a Committee. ASG Triple A reports were now included within the Board agenda to provide an additional source of assurance. It was suggested that there may be scope to strengthen the management of the strategic risk on partnership working through further reporting considerations.

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

b. Finance and Performance Committee (F&PC) Terms of Reference (ToR)

Kelly Jupp advised that changes to the ToR for the F&PC had been approved by the Committee earlier in the week to formally incorporate oversight of transformation. The amendments reflected previous discussions at Board Development sessions and were intended to strengthen the Committee's governance and scrutiny of the Trust's transformation programme.

Judith McKenna noted that the inclusion of transformation within the Committee's remit was a temporary arrangement to test the approach and inform agreement on the most appropriate long-term governance arrangements.

A minor typographical error was highlighted in section 3.7.3 which Kelly Jupp agreed to correct.

It was **resolved**: to **receive** the report and **approve** the F&PC ToR.

26/33 ITEMS TO RECEIVE:

a. Learning from Deaths

Lucia Pareja Cebrian advised that oversight of Level 2 mortality reviews continued through the Mortality Surveillance Review Group. Whilst further work remained to be undertaken, appropriate processes and governance arrangements were in place.

It was **resolved**: to **receive** the Learning from Deaths report.

b. Meeting Action Log

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

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

26/34 ANY OTHER BUSINESS:

a. Any other business

There was no any other business discussed.

The meeting closed at 12.06.

Date of next meeting: Public Board of Directors – Friday 27 November.

Summary of actions:

1. Thirlwall Inquiry - Initial observations were shared in relation to the Thirlwall Inquiry, with agreement that a more detailed discussion on the recommendations, implications and required actions be brought back to the Trust Board meeting in November **[ACTION01]**.
2. Never Events - An update on the specific Never Events, any patient harm and associated learning would be presented to a future Trust Board meeting **[ACTION02]**.
3. Complaints responses - Rob Harrison suggested that it would be beneficial to publish the range of negotiated complaints response timescales to improve transparency regarding both agreed extensions and overall performance. Ian Joy confirmed that this information was reviewed at the Complaints Panel meetings and could therefore be incorporated into future Quality Committee reports **[ACTION03]**.
4. Corridor care risks - Paul Ennals sought assurance regarding the assessment of corridor care risks and queried whether the current rating accurately reflected the level of concern. Sue Hillyard advised that she was confident the associated risks could be appropriately mitigated; however, it was noted that some organisations reporting lower levels of corridor care had assigned a red risk rating. It was therefore agreed that Sue Hillyard would review the assessment and provide further assurance on the appropriateness of the current risk rating in section 4.1 **[ACTION04]**.

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Agenda Item A1(c)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 November 2026					
Title	Chair's Report					
Report of	Sir Paul Ennals, Chair					
Prepared by	Sir Paul Ennals, Chair Gillian Elsender, PA and Corporate Governance Officer					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☐		☒	
Summary	This report outlines a summary of the Chair's activity and key areas of recent focus since the previous Board meeting held in Public in September 2026: • Board Activity • Governor Activity • Informal Visits and Events • External Meetings					
Recommendation	The Trust Board is asked to note the contents of the report.					
Links to Strategic Priorities	Joining up Care		Advancing Care		Supporting great Care	
	☐		☐		☒	
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☐	☐	☐	☐
Link to the Board Assurance Framework [BAF]	No direct link however provides an update on key matters.					
Reports previously considered by	Previous reports presented at each Public meeting.					

CHAIR'S REPORT

As Board members will be aware the NHS Health Bill is currently progressing through the House of Lords Committee Stage, having completed all stages in the House of Commons and for Foundation Trusts, proposed changes could affect existing governance arrangements, including the future role of membership and Councils of Governors.

While the Government has indicated that Local Healthwatch organisations will be retained in recognition of the importance of an independent patient voice, no similar commitment has yet been made regarding the future of Foundation Trust membership arrangements or Councils of Governors, and these provisions remain subject to ongoing parliamentary scrutiny.

In anticipation of potential legislative change, the Trust remains committed to ensuring staff, patient and public voices continue to influence decision-making and service improvement, and work is underway in developing a refreshed engagement model to maintain strong and effective mechanisms for stakeholder involvement.

Board Activity

The Board development session in October focused on strengthening collective effectiveness through the use of the Lumina Spark framework, an assessment and personal development tool for leadership development. The session enabled Board members to explore how different perspectives and approaches contribute to effective decision-making, review how Board and Committee structures support strategic oversight, and identify opportunities to further strengthen governance arrangements.

Discussions highlighted the importance of maintaining a strategic focus, encouraging constructive challenge, making best use of diverse perspectives, and ensuring sufficient time is dedicated to the Trust's most significant priorities. The session concluded with agreement on a number of actions to support continued Board and Committee effectiveness and inform future governance development work.

ACTIVITY WITH GOVERNORS AND MEMBERS

At our Governor Workshop in October, in addition to our regular reports we received an update on Trust performance, highlighting continued challenges in cancer services and urgent care demand, alongside improvements in patient experience, oversight ratings and the Frailty Same Day Emergency Care service. Progress was also reported on major transformation, research and estate developments, with financial performance remaining on track despite ongoing efficiency pressures.

We heard about the work of Hassan Kajee, Non-Executive Director (NED) and Chair of the Digital & Data Committee, and David Weatherburn, (NED) and Chair of the Audit, Risk and Assurance Committee. Updates were provided covering digital transformation, cyber security, artificial intelligence governance, audit assurance and risk management. Governors

noted the important contribution of both committees to effective governance and organisational oversight.

Governors discussed the Trust's ongoing work to reduce health inequalities, implement the Anti-Racism Framework and strengthen organisational culture through leadership development, staff engagement and creating a more open, learning-focused environment. They emphasised the importance of listening to staff and ensuring feedback informs improvement.

In addition to our formal meetings, I continue to meet with Governors informally, the latest being on 6 October, providing a space for them to raise any issues arising between formal meetings and enabling me to update them on key regional and national developments.

ALLIANCE

The Alliance continues to develop collaborative programmes focused on improving patient outcomes, service quality and sustainability across partner organisations. Key areas of work include cancer improvement, workforce and leadership development, digital innovation, research, service improvement and collaborative procurement. The Alliance is also progressing plans for future engagement arrangements to ensure staff, patient and public voices continue to inform healthcare services and decision-making.

INFORMAL VISITS AND EVENTS

On 16th October 2026 it was a pleasure to welcome Professor Sir Chris Whitty, Chief Medical Officer for England, to the Trust where he visited the Great North Children's Hospital to learn more about the innovative services supporting children, young people and families across Newcastle and the wider region.

The visit included a tour of our children's respiratory ward, discussions with staff about our Family Hub and support for children and families with complex needs during hospital stays, and an opportunity to hear about Newcastle's integrated 0-19 service, delivered in partnership with public health.

Chris was keen to visit Newcastle as part of his preparation for his next Annual Report which will focus on children and young people, and he was grateful to colleagues for sharing their expertise. The visit showcased the strength of collaboration between hospital, community and local authority services in improving outcomes for our children and young people.

As part of the programme of engagement across the Trust, I attended the launch of the Trust's Anti-Racism Framework, which brought together colleagues, community representatives and partner organisations to reinforce the Trust's commitment to tackling racism and promoting inclusion. The event featured contributions from staff involved in developing the framework, panel discussions with representatives from Show Racism the Red Card, and opportunities for colleagues to make personal anti-racism pledges.

In addition to our own Anti-racism framework which the Board agreed in December, on 27 November, Rob Harrison, Chief Executive Officer, and I will sign the North East anti-racism coalition 'Becoming the Bridge' pledge on behalf of the organisation, signifying our commitment to move beyond statements of intent and take practical, measurable and collaborative action to tackle racism in the North East.

OTHER MEETINGS AND INFORMATION

On 8 October I joined regional colleagues where discussions centred on NHS performance, financial sustainability, workforce challenges and preparations for winter pressures. The event also highlighted opportunities for greater collaboration across organisations, including service improvement, cancer performance, leadership development and the sharing of best practice to improve patient outcomes and experience across the region.

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

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

RECOMMENDATION

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

Report of Sir Paul Ennals
Chair
12 November 2026

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Agenda item A1(e)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 November 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 & Wendy Balmain, Vice Chair of the People Committee Judith McKenna, Chair of the Finance and Performance Committee David Weatherburn, Chair of the Audit, Risk and Assurance Committee Jeff Perring, Chair of the Research, Commercial and 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 September 2026: • Digital & Data Committee – 12 November 2026 • Quality Committee – 22 October & 19 November 2026 • People Committee – 17 November 2026 • Finance & Performance Committee – 26 October & 23 November 2026 ***[To follow]*** • Audit, Risk & Assurance Committee – 24 November 2026 ***[To follow]*** • Research, Commercial & Innovation Committee – 16 November 2026 The individual Triple A reports list out any alerts, advise or assure matters arising from the Committee meetings. <u>Alerts are outlined for ease as below:</u> Quality Committee 22 October 2026 – • A deep dive report into **Duty of Candour compliance** was presented to the committee. It was noted due to recent audit and improvement in Duty of Candour compliance reporting; previous compliance was not fully accurate of actual position. The most recent compliance as noted in the Integrated Board Report is accurate and demonstrates further work is required to ensure compliance with statutory requirements. An improvement plan is in place and oversight by the Quality Committee will also remain. Finance & Performance Committee 26 October 2026 – • **Cancer Performance Deep Dive** – Cancer performance remains challenging against the 31-day and 62-day standards, particularly within breast, lung, urology and upper/lower gastrointestinal (GI) pathways, largely due to workforce and capacity constraints within radiotherapy. Recovery actions are in place, including recruitment, additional capacity and requests for regional support, with robust clinical oversight of patients experiencing delays. Clinical harm reviews continue to be completed for patients experiencing delays.		

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- **Emergency Department (ED) update** - Emergency care performance remains under pressure due to rising demand, estate constraints and ongoing corridor care challenges. The Urgent Treatment Centre (UTC) link project remains on track to complete in late December and is expected to improve patient flow and ambulance offloading. While mitigating actions including the opening of a Frailty Same Day Emergency Care (SDEC) expansion, ambulatory pathways, enhanced triage and targeted workforce investment are beginning to have an impact, risks remain until additional capacity, and longer-term service improvements are fully delivered.

Research, Innovation & Commercial (RIC) Committee 16 November 2026 -

- **Research Performance** - Committee members agreed that the principal escalation to the Trust Board remains the risk associated with research study set-up performance and achievement of the national 90-day target. Current improvement trajectories did not yet provide assurance that required performance levels would be achieved and a more detailed recovery plan was requested.

People Committee 17 November 2026 –

- **Integrated Board Report (IBR)** - The Committee noted that workforce performance remains challenged, with workforce numbers above plan, sickness absence remaining high, and appraisal compliance below target. Whilst improvement programmes are in place, there has been no sustained improvement in key indicators, particularly long-term absence associated with stress, anxiety and depression. Continued oversight and targeted action are therefore required.

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<tr><td>Recommendation</td><td colspan="6">The Trust Board is asked to note the contents of the Committee Triple A Reports/Chairs Logs.</td></tr>
<tr><td rowspan="2">Links 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>
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<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
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<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">Detailed in the individual Committee Triple A Reports/Chairs Logs.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Public Board meeting in September 2026.</td></tr>
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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:	12 November 2026
Chair of Committee / Group:	Hassan Kajee, Non-Executive Director

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

No alerts noted.

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)

Tier 2 Committee Governance – The Director of Digital proposed four Tier 2 groups and the terms of reference for each group were shared. The proposed groups are intended to move operational detail away from the Digital and Data Committee while preserving strategic assurance within the Committee. Committee members approved the structure, terms of reference and agreed to a six month review.

Integrated Clinical Environment (ICE) Upgrade – The Chief Digital Information Officer reported that the Trust had held a direct discussion with the supplier senior management about the issues which occurred during the upgrade. Updates will continue to be shared at future meetings along with clear documentation of the lessons learned.

Patient-Reported Outcome Measures (PROMs) Data – The Director of Digital informed the group that the PROMs application was paused due to assurance required over data security, with initial findings identifying no evidence of a cyber incident or inappropriate data exposure. The formal report will inform next steps, alongside wider work to strengthen governance for innovation, intellectual property and commercial arrangements.

Cybersecurity Resilience and Capacity – The ongoing cyber position, increasing threats and capacity pressures were noted. The Trust is shifting its focus towards resilience and recovery planning, supported by a cyber assessment and business case. Current cyber insurance arrangements will also be reviewed to ensure adequate recovery and forensic support.

Information Services Capacity - The Director of Performance and Governance reported that Information Services is managing increasing demand while prioritising statutory and strategic work. Copilot, automation and a governed data platform could improve efficiency and self-service, supporting the Trust's 2030 ambition for data-driven decision making.

Synovus – Committee members were briefed on the matter. The risk is currently considered low, pending further information, with the Data Protection Officer (DPO) to provide an update at the next meeting.

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

Apex Upgrade - The Apex upgrade for the Laboratory Information Management System (LIMS) has been completed and was reported to be successful with several minor issues but no significant issues reported/impact. The upgrade also moved the organisation onto a supported software version.

Information Commissioners Office (ICO) Audit Report - The ICO audit provided assurance, with a mandatory action to formalise consultation regarding high residual data-protection risks. The findings provide a useful baseline for existing improvement work, with the detailed a response to be progressed through the Digital and Data Governance Group.

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

No new risks noted

Cross-referrals to other Committees / Executive Director Leads

Research, Innovation and Commercial (RIC) Committee
Committee members discussed commercial income, and a potential risk regarding product development advice being given to external companies without a formal arrangement. The Associate Director Commercial Enterprise agreed to take this to the RIC and feedback to this committee.

Agreed actions	Responsibility / timescale
1. To provide a standing agenda verbal update on significant Tier 2 governance changes and ensure AAA reporting is used to shape future committee agendas.	Director of Digital / Chair of Digital and Data Committee, Ongoing
2. To produce a report describing generalise responses process for PHP (a programming language) vulnerabilities and share with the committee.	Chief Digital Information Officer Next committee meeting on 14 January 2027
3. The formal report on the assessment of the PROMs data will be shared with the Committee.	Director of Digital, Timescale to be confirmed
4. To review the Trust's commercial cyber insurance arrangements to confirm that they support practical incident response and recovery,	Director of Digital / Associate Director Commercial Enterprise, Timescale to be confirmed

including out-of-hours forensic capability.	
5. To share an update on the Synovus matter.	The Director of Performance and Governance, Next committee meeting on 14 January 2027

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Quality Committee
Date of Committee / Group:	22 October 2026
Chair of Committee / Group:	Anna Stabler, Non-Executive Director

Alert

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

- A deep dive report into Duty of Candour compliance was presented to the committee. It was noted due to recent audit and improvement in Duty of Candour compliance reporting; previous compliance was not fully accurate of actual position. The most recent compliance as noted in the Integrated Board Report (IBR) is accurate and demonstrates further work is required to ensure compliance with statutory requirements. An improvement plan is in place and oversight by the Quality Committee will also remain.

Advise

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

- Infection Prevention Control Improvement Group report demonstrated engagement is evident across Clinical Boards, with improvement plans in place and operational management of current infection control challenges. Concerns remain regarding inconsistent reporting, delays in data, and ongoing Methicillin-resistant Staphylococcus aureus (MRSA) performance issues. Further evidence of sustained improvement and delivery of actions is required before a higher level of assurance can be provided and the improvement group can be de-escalated.
- The Committee noted generally stable performance outlined in the IBR. There were positive improvements in key quality indicators, including reductions in both Clostridioides difficile (C. difficile) and Methicillin-sensitive Staphylococcus aureus (MSSA) rates, alongside sustained performance in harm-free care metrics. Assurance was strengthened by improved triangulation of formal complaints data and progress in complaint response times. No alerts were identified.
- The Perinatal Quality Surveillance Report demonstrated good assurance regarding oversight of operational, strategic challenges and mitigating actions. Work remains in progress to address key challenges relating to obstetric theatre capacity, obstetric ultrasound capacity due to recent sickness absence and foetal medicine services.
- In relation to Quality Priority 3 – Reduction in Lung Cancer Wait Times, the Committee noted significant improvement in performance against the 28-day Faster Diagnosis Standard. However, ongoing risks remain within the lung cancer pathway, particularly against the 31- and 62-day standards, due to radiotherapy capacity, surgical pathway challenges and reliance on continued funding. Further updates are being presented to the Finance and Performance Committee.

- The Committee noted improvements in the quality and depth of the Patient Experience reporting and recognised progress against national patient experience requirements. Concerns remain regarding the fragility and sustainability of the service due to workforce capacity pressures and the impact of reduced staffing levels on service delivery due to the temporary nature of funding. A substantive investment proposal is being drafted for consideration.
- The Committee received assurance that wards of concern are being effectively monitored, with no significant issues requiring escalation. Positive progress was also noted within the Accrediting Excellence (ACE) programme, with performance maintained or improved and rollout to outpatient and community services progressing. Ongoing oversight is required regarding workforce capacity and the programme's long-term sustainability.
- The Committee noted ongoing development of the Quality & Safety Peer Review process, including work to reduce duplication and improve consistency across services. Members were reassured that appropriate processes and oversight arrangements are in place, and that peer reviews are providing useful insight to support improvement. Areas of improvement were required and noted to ensure full compliance with expected standards and assurance gained regarding improvement plans. It was noted that further updates on care planning will be welcomed to provide additional assurance on the embedding and impact of the programme
- The Committee noted positive staff engagement and ongoing progress within the Facilities Management Change Programme, with some early improvements evident. However, catering remains a significant risk, particularly in relation to patient experience and food quality. While plans for equipment and service improvements are progressing, delivery is dependent on longer-term investment and implementation.
- The Committee received assurance that mortuary services continue to maintain appropriate standards of privacy, dignity and safeguarding, with no new access-related incidents reported. However, members were advised of a risk relating to delayed expansion works at the RVI mortuary, requiring temporary additional storage capacity over the winter period. Appropriate mitigations and oversight are in place, but ongoing monitoring is required until a permanent solution is delivered.

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

- The Committee was assured regarding the governance, oversight and delivery of maternity services, including progress against the 10-point improvement plan, delivery of the Maternity Incentive Scheme, and actions arising from the Thirlwall Report.

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

Cross-referrals to other Committees / Executive Director Leads

To note that the Commercial Trials audit is likely to transfer to Research, Innovation and Commercial Committee (RICC).

Agreed actions	Responsibility / timescale
1. Chair of the Committee to write on behalf of the Committee to congratulate the recipient of the national Infection Prevention and Control (IPC) Award.	1. Anna Stabler, Non-Executive Director – November 2026
2. IPC action plan for Family Health Clinical Board to be shared with the Committee.	2. Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals – November 2026
3. IPC report for January to include a trajectory of improvement by Clinical Board highlighting any outliers as well as Doctor ANTT (Aseptic Non-Touch Technique) and Fit Testing.	3. Lucia Pareja- Cebrian, joint medical Director – January 2027
4. VTE (Venous Thromboembolism) assessments undertaken within 24 hours of admission – learning from those Clinical Boards with highest compliance to be shared at Patient Safety Group.	4. Rachel Carter, Director of Quality & Safety.
5. Dates for Phase 3 of Medicines Reconciliation to be included in the relevant slide in the IBR.	5. Rachel Carter, Director of Quality & Safety. – November 2026.
6. Seek assurance that the current safeguarding training and education provide sufficient focus on the identification and escalation of safeguarding concerns in line with Thilrwall recommendations.	6. Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals – November 2026
7. To provide the roll out plan for the ACE programme over the next 12 months as an appendix to the next planned update.	7. Cheryl Teasdale, Associate Director of Nursing - November 2026
8. Following receipt of the final Clinical Research internal audit report, determine the most appropriate committee oversight arrangements and provide an update to the Committee.	8. Ian Joy, Executive Director of Nursing, Midwifery and Allied Health Professionals – November 2026

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Quality Committee
Date of Committee / Group:	17 November 2026
Chair of Committee / Group:	Anna Stabler, Non-Executive Director (NED)

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

- There were no 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)

- **Improvement Group update – Deteriorating Child –** Committee members were advised on the progress with the deteriorating-child action plan, including metrics for the three programme pillars, staged paediatric critical-care outreach implementation, interim Paediatric Early Warning System (PEWS) monitoring and continuing education requirements. Assurance was sought regarding progress against key milestones in the action plan and updates provided.
- **Integrated Board Report (IBR) –** A comprehensive update was received on the quality and safety elements of the IBR. Committee members noted the increase in incident reporting and complaints across the Trust. Work is underway to better understand emerging themes and trends, ensure timely responses to complaints and investigate incident reports to confirm correct incident grading. Ongoing monitoring will continue through the committee
- **Six-month review of all Quality Account Priorities –** Progress continues across all six quality priorities, including improved timeliness of responses to complaints. Performance against the 28-day Faster Diagnosis Standard (FDS) for lung cancer remained marginally below the national target, despite significant overachievement in two reporting months. Ongoing improvement actions are in place to support sustained compliance and further enhance diagnostic performance. Some areas of digital support were required and it was agreed to share key themes with digital and data colleagues.
- **Quality Performance Reviews (QPRs) –** Committee members agreed that visibility of quality alerts, actions and assurance arising from QPRs is valuable, including where issues have been resolved before formal reporting. A review will be undertaken to identify the most effective reporting approach, taking account of the accountability framework and the need to minimise duplication while maintaining appropriate oversight and assurance.
- **Clinical Audit / Guidelines Report –** Several national clinical audits are currently undergoing assessment to confirm eligibility and participation. Appropriate governance arrangements are in place to review participation decisions and

associated risks where participation is not undertaken. Ongoing oversight and assurance will be provided through established clinical audit governance processes, with regular reporting on progress, risks and mitigating actions.

- **Allied Health Professionals (AHP) update –** Emerging workforce challenges across the AHP workforce were highlighted, including increasing turnover in some professions and recruitment pressures within Podiatry and Therapeutic Radiography. Progress continues with implementation of AHP job planning, providing greater visibility of workforce capacity and deployment. Workforce development, education and planning activities remain in place to support service sustainability, while collaborative approaches across Clinical Boards are strengthening service integration and workforce resilience in key areas.
- **Quarter 2 reports:**
  - **Safeguarding –** An overview of safeguarding activity was noted, including challenges regarding the implementation of the Child Protection Information Sharing (CP-IS) programme, safeguarding training, and improvements relating to Children in Care and Mental Capacity Act compliance. Ongoing workforce and service pressures continue to be managed through established improvement plans and governance processes. Revised Safeguarding Committee Terms of Reference were approved.
  - **Learning Disability –** Committee members noted ongoing progress in improving services for people with learning disabilities and autism, including work to strengthen reasonable adjustments, improve care planning, enhance staff training, and review processes affecting access to care. Further improvements and assurance activity are ongoing to support patient experience, safety and equitable access to services. Additional audit detail was requested in future reports.
- **Six-month nurse staffing review deep dive –** Ongoing operational workforce pressures were noted across a number of clinical areas, driven by patient acuity, enhanced observation requirements and seasonal staffing challenges. Mitigating actions are in place, including targeted workforce initiatives and service reviews, and pressures continue to be closely managed to support safe patient care. The bi-annual staffing report was discussed in detail.
- **Board Assurance Framework (BAF) –** The BAF was ratified for Trust Board approval. It was noted that the failure to achieve compliance with national maternity standards assurance rating has moved from amber to green. Additional work was agreed relating to review of actions behind plan and the process for the confirmation of revised target dates.
- **Realignment of Tier 2 Committees -** A proposal to revise Quality Committee governance arrangements was considered to improve alignment with strategic priorities, the BAF, and to reduce duplication across reporting structures. Committee members supported the overall direction of travel but highlighted the need to maintain appropriate visibility of key priorities, within the revised arrangements. Further refinement of the proposals will be undertaken before being brought back for consideration.

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

- **Perinatal Quality Surveillance Report, including Maternity Incentive Scheme (MIS) update –** Assurance was provided that maternity and neonatal services continue to perform well, with progress against the MIS, strong neonatal audit outcomes, and compliance with safeguarding training requirements. While challenges remain relating to capacity, workforce, estates and implementation of national recommendations, appropriate mitigations, risk assessments and improvement plans are in place with risks being actively managed.
- **End of Life and Palliative Care –** Committee members noted continued progress in delivering the priorities of the Palliative Care Service, including greater integration of palliative and end of life care within wider system planning, development of service provision, workforce planning and digital improvements. Assurance was received of the high-quality care delivery through positive audit outcomes and patient feedback, while ongoing work continues to address future service needs and equitable access to care.
- **Six-month nurse staffing review deep dive -** The Committee received assurance regarding nurse staffing governance, staffing establishments and monitoring processes, supported by positive findings from a recent NHS England Assurance Review. Staffing risks and quality indicators continue to be subject to robust oversight, with areas of concern actively monitored through established governance arrangements.

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

No new risks.

Cross-referrals to other Committees / Executive Director Leads

- **Perinatal Quality Surveillance Report, including Maternity Incentive Scheme update** – Progress against the maternity equity and inclusion priority continues to be affected by limitations in QR-code functionality and the wider ability to provide communications in appropriate languages. The issue will be considered by the Digital and Data Committee as part of a broader organisational approach to accessible communications.
- **Safeguarding Quarter Report** – Domestic abuse affecting Trust staff was highlighted as an area requiring further consideration. The matter will be referred to the People Committee and relevant Tier 2 groups to better understand the scale and complexity of need, and to consider whether additional support arrangements are required.
- **Board Assurance Framework (BAF)** – For information to the Audit, Risk and Assurance Committee that all risks under the Quality Committee remit remain outside of the risk appetite tolerance.

Agreed actions	Responsibility / timescale
1. Improvement Group update – Deteriorating Child - Future updates to include monitoring and reporting of training uptake for both new and existing staff to provide assurance on	1. Raja Abouelella, Consultant Paediatric Intensivist / February 2027

implementation and compliance across the organisation.	
2. Safeguarding Quarter 2 Report - A verbal update on local improvement plans and trajectory against level 3 safeguarding training compliance will be provided at the next Committee meeting.	2. Ian Joy, Executive Director of Nursing, Midwifery & AHPs, & Helga Charters, Associate Director of Nursing / January 2027
3. Learning Disability Quarter 2 Report – Future reports to include relevant compliance and performance data, alongside a summary of the resource implications, identified gaps, expected benefits and anticipated outcomes associated with the Oliver McGowan Mandatory Training programme.	3. Ian Joy & Helga Charters / March 2027
4. End of Life and Palliative Care – To consider Children's Palliative Care reporting.	4. Ian Joy / January 2027
5. Realignment of Tier 2 Committees - Further refinement of the proposed governance arrangements, including the reporting format and review schedule, will be undertaken before the revised proposal is brought back to the Committee for consideration.	5. Rachel Carter, Director of Quality & Safety / February 2027
6. Patient Safety Group Triple A Report - Examples of cultural themes identified across the organisation will be considered through the People Programme Board to support ongoing discussion, learning and continuous improvement. Key themes and any resulting actions will be reported to the People Committee.	6. Ian Joy / January 2027

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	People Committee
Date of Committee / Group:	17 November 2026
Chair of Committee / Group:	Joanne Race, Non-Executive Director (NED)

Alert

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

- **Integrated Board Report (IBR)** - The Committee noted that workforce performance remains challenged, with workforce numbers above plan, sickness absence remaining high, and appraisal compliance below target. Whilst improvement programmes are in place, there has been no sustained improvement in key indicators, particularly long-term absence associated with stress, anxiety and depression. Continued oversight and targeted action are therefore required.

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)

- **Fairer Deal for Nursing** – The Committee received assurance that the national job evaluation programme is progressing in line with required timescales, with appropriate governance and staff engagement arrangements in place. Whilst compliance requirements are being met and early progress has been achieved, the Committee noted ongoing risks relating to organisational capacity, workforce engagement and the potential financial impact of review outcomes. These risks will continue to be monitored as the programme progresses.
- **Board Assurance Framework (BAF) –** The BAF was considered and ratified for Trust Board approval.
- **Updated People Committee Terms of Reference –** One minor amendment to the People Committee Terms of Reference was approved to add an Allied Health Professionals representative to the Committee membership.
- **Guardian of Safe Working (GoSW) Report –** The Committee received and noted the content of the report.

Assure

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

- **Welcome to the People Business Partners including NHS Staff Standards –** Committee members welcomed the new People Business Partners. Arrangements are in place to support the embedding of the new model, and the Committee was assured that appropriate governance, communication and oversight arrangements are in place to support successful implementation.

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• **Proud People, Great Care overview and action plan tracker –** An update was provided on the development of the People Strategy and its alignment with the Trust's ambition to deliver great care through its people. Committee members were assured that appropriate governance arrangements are in place through the People Programme Board and noted plans for further staff engagement, communication and regular progress reporting. • **Feeling well, Staff Psychology support services –** The Committee welcomed the positive impact of the Staff Psychology Service and noted that uptake has been in line with expectations, including amongst harder-to-reach staff groups. The service is working effectively in partnership with Clinical Boards and People Services, with a continued focus on prevention, staff wellbeing and support for those returning from long-term sickness absence. Further evaluation work is underway to measure impact and inform the long-term development of the service. • **Integrated Board Report (IBR) –** Committee members were assured that significant work is underway, including the implementation of new people initiatives, policies and support arrangements.	
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 Reduction Group update – Update to be received at the January 2027 Committee on next steps.	1. Vicky McFarlane-Reid, Executive Director of People and Commercial Innovation & Sue Hillyard, Interim Executive Director of Operations / January 2027
2. Welcome to the People Business Partners including NHS Staff Standards – An interim review will be presented to the Committee in March, with a full evaluation of the model and its benefits realisation scheduled for consideration by the Committee in July 2027.	2. Amy Callow, Director of People and Organisational Development (OD) / March 2027
3. People Programme Board updates to be added to the People Committee schedule of business on a quarterly basis.	3. Lauren Thompson, Corporate Governance Manager & Deputy Trust Secretary / November 2026
4. Guardian of Safe Working Report – The Executive Summary on the cover sheet to be updated prior to	4. Lucia Pareja-Cebrian, Joint Executive Medical Director / November 2026

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Public Trust Board with further information.	

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:	26 October 2026
Chair of Committee / Group:	Judith McKenna, Non-Executive Director (NED)

Alert

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

- **Cancer Performance Deep Dive –** Cancer performance remains challenging against the 31-day and 62-day standards, particularly within breast, lung, urology and upper/lower gastrointestinal (GI) pathways, largely due to workforce and capacity constraints within radiotherapy. Recovery actions are in place, including recruitment, additional capacity and requests for regional support, with robust clinical oversight of patients experiencing delays. Clinical harm reviews continue to be completed for patients experiencing delays.
- **Emergency Department (ED) update -** Emergency care performance remains under pressure due to rising demand, estate constraints and ongoing corridor care challenges. The Urgent Treatment Centre (UTC) link project remains on track to complete in late December and is expected to improve patient flow and ambulance offloading. While mitigating actions including the opening of a Frailty Same Day Emergency Care (SDEC) expansion, ambulatory pathways, enhanced triage and targeted workforce investment are beginning to have an impact, risks remain until additional capacity and longer-term service improvements are fully delivered.

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)

- **Peri-op and Critical Care Clinical Board –** At Month 6, the financial position is 0.1% overspent year-to-date (£90k adverse variance) including Cost Improvement Programme (CIP) delivery, with an underlying £850k underspend excluding CIP. Financial pressures remain, primarily linked to CIP delivery and workforce vacancies, however, activity is on plan and mitigating actions, including vacancy management, theatre utilisation improvements and productivity initiatives, continue to support delivery of the revised financial forecast.
- **Month 6 Financial reporting including –**
  - **Revenue / Cash / Provider Assurance Model (PAM) -** The Trust continues to forecast a breakeven year-end position; however, delivery remains dependent on achieving CIP targets and planned activity levels. Cost improvement delivery is behind plan and is being supported by non-recurrent mitigations. While the risk position has improved and cash performance

remains strong, the underlying deficit and reliance on one-off measures require continued close monitoring.
    - **Capital –** The Capital Programme remains broadly on track, with expenditure slightly behind plan but managed back to a breakeven position. Key risks relate to delivery of major schemes, which continue to be closely monitored.
    - **Mid-year review letter -** A draft response to the findings from the mid-year review has been prepared and will be considered by the Trust Board prior to submission. The issues raised are already being addressed through existing work programmes, and no new significant risks or concerns were identified for escalation.
- **Integrated Board Report (IBR) –** Diagnostic and elective recovery performance remains challenged, particularly within echocardiography and audiology. Recovery plans, including additional capacity, are being implemented. Elective recovery remains focused on reducing 18-week breaches, with progress made in reducing the number of patients waiting > 18 weeks for their first outpatients' appointment, although further improvement is required. ED and Cancer performance were discussed under their own agenda items.
- **Cash Group Terms of Reference (ToR) –** The ToR were subject to minor amendments to which the Committee approved.
- **Revenue Management Group ToR –** The ToR were subject to minor amendments to which the Committee approval.
- **Two procurement reports were approved.**
- **Service reviews -** An update on two service reviews was received and noted by the Committee. Both reviews will be presented to the Private Trust Board in the coming months.

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

- **Procurement update –** Procurement is supporting delivery of efficiency savings through commercial optimisation, supply chain improvements, collaborative working across the Alliance, and enhanced inventory management. Work is also underway to strengthen procurement capability and maximise value for money, with regular oversight of opportunities and contract activity.
- **Transformation Governance and approach to reporting -** Strengthened governance and oversight arrangements have been established for the Trust's major transformation programmes, with clear performance measures, milestone tracking and regular reporting through the Finance and Performance Committee to ensure alignment with strategic objectives. The Committee reviewed and approved the proposed approach.

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

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No cross-referrals discussed.	
Agreed actions	**Responsibility / timescale**
1. Transformation Governance and approach to reporting – to discuss future agenda items for the Schedule of Business for transformation.	1. Sue Hillyard, Interim Executive Director of Operations and Jackie Bilcliff, Acting Deputy Chief Executive & Executive Director of Finance / November 2026
2. Service Review – six monthly updates to be added to the Schedule of Business.	2. Lauren Thompson, Corporate Governance Manager/Deputy Trust Secretary / November 2026

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

Escalation and Assurance Report

Name of Committee / Group:	Research, Innovation & Commercial (RIC) Committee
Date of Committee / Group:	16 November 2026
Chair of Committee / Group:	Jeff Perring, 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)

- **Research Performance -** Committee members agreed that the principal escalation to the Trust Board remains the risk associated with research study set-up performance and achievement of the national 90-day target. Current improvement trajectories did not yet provide assurance that required performance levels would be achieved and a more detailed recovery plan was requested.

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)

- **Innovation** – Committee members received an update on progress relating to the NHS Clinical Entrepreneur Programme and the NHS InSites Programme. Examples of staff innovation projects being supported through the Trust's innovation pathway were shared, along with how participation in the programme provided access to mentorship, investment and commercialisation opportunities. Further work was required on available options and case studies illustrating different commercialisation routes.

- **Commercial** – An update was provided regarding Data Partnership Enterprise, Alliance work and the Newcastle Hospitals company shareholding. Additional information on current value and performance of shareholdings was requested. A future proposal on commercialisation models and shareholding strategy would be brought back to the Committee for consideration.

- **Research Integration** - Committee members received an update regarding discussions on closer integration of research activity within Clinical Boards. The importance of maximising benefits to patients was emphasised.

- **Medical Director Structure –** Committee members were advised on forthcoming recruitment to a senior leadership role that would formally combine research and innovation leadership arrangements.

- **Newcastle Hospitals Charity Research Funding** – An update was received from Newcastle Hospitals Charity on future research funding arrangements for the Research Pump-Prime and Research Impact Programmes.
  Committee members welcomed the development of a formal governance framework and noted the proposal to establish a Research Advisory Panel to assess applications and make recommendations to the Charity Committee.

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. Review options to enhance the Trust approach to intellectual property governance, contracts and staff obligations, including examples from other sectors.	1. Charlotte Fox, Innovation and Intellectual Property Lead / January 2027
2. Present case studies illustrating the lifecycle of spin-outs and commercialisation arrangements.	2. Charlotte Fox, Innovation and Intellectual Property Lead / January 2027
3. Develop proposals for future commercialisation and company shareholding strategy, including assessment of current value and returns.	3. Wayne Elliott, Associate Director Commercial Enterprise / January 2027
4. Continue development of Alliance federated data strategy and provide progress update.	4. Wayne Elliott, Associate Director Commercial Enterprise / January 2027

5.	Provide detailed recovery trajectory and assurance plan for achieving national 90-day study set-up targets that extends into 2027 and beyond.	5.	Jo Noble, Associate Director Clinical Research / January 2027

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 November 2026		
Title	Trust Strategy Update		
Report of	Patrick Garner, Director of Performance and Governance		
Prepared by	Lisa Jordan, Assistant Director of Strategy and Planning		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	This report provides the first consolidated assessment of delivery against the Trust Strategy, Caring, Improving and Learning Together 2026–2031. Overall, there is reasonable assurance that implementation is progressing, with evidence of delivery across Joining up care, Advancing care and Supporting great care. Of the 62 objectives/actions currently assessed, 42 are on track, 18 show minor deviation and two are assessed as significant risk. Two objectives require enhanced oversight. Delivery of the Trust's building decarbonisation ambition, including Public Sector Decarbonisation Scheme (PSDS) Phase 4, is affected by affordability and logistical pressures. The objective to establish a systematic approach to identifying and addressing unwarranted variation in clinical outcomes and practice is also at significant risk, primarily because the April 2027 timescale is no longer considered achievable, with December 2027 proposed. Clinical Board Quality and Performance Reviews (QPRs) provide increasing assurance that local strategies are translating into delivery, but have identified common dependencies around workforce and capacity, financial sustainability, system working and corporate enabling support. Several Strategic Delivery Plans also remain in draft or development, which will require continued oversight as the assurance framework matures. Delivery of the Strategy is increasingly being aligned with the 2027/28 planning process so that strategic priorities inform future financial, workforce, digital, estates and capital decisions. The principal immediate financial risk highlighted through strategy monitoring relates to the affordability of the PSDS Phase 4 decarbonisation programme. No overall change to the Trust's strategic direction is indicated. However, the significant-risk assessment relating to unwarranted clinical variation requires continued oversight. Work is progressing to strengthen clinical effectiveness, triangulate quality information and use Clinical Board QPRs to provide greater assurance on local delivery. Triple A assessment Advise: Two strategic objectives are at significant risk: building decarbonisation/PSDS Phase 4 and the timescale for systematically identifying and addressing unwarranted clinical variation.		

<table>
<tr><td></td><td colspan="6">Advise: The updated scorecard shows 18 objectives/actions with minor deviation. These remain recoverable within the agreed strategic direction, but the increased level of slippage reinforces the need for clear recovery actions, accountable leads and continued oversight alongside completion of Strategic Delivery Plans and management of cross-organisational dependencies.

Assure: The Board can take reasonable assurance that the Strategy is progressing and that the new monitoring arrangements are identifying exceptions and escalating material risks for management attention

The detailed Strategy Monitoring Balanced Scorecard Appendix has been included in the Trust Board Reading Room on AdminControl.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Trust Board should take assurance that appropriate arrangements are in place to monitor delivery of the Trust Strategy, identify areas of delivery risk and escalate issues requiring further action.</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>
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<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>
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<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">Links to all.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">This is the first consolidated report under the new strategy monitoring arrangements and will form part of the regular reporting cycle to ARAC and Trust Board.</td></tr>
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TRUST STRATEGY PROGRESS UPDATE

1. INTRODUCTION

The Trust Strategy establishes the organisation's longer-term strategic direction through three strategic priorities:

- **Joining up care**
- **Advancing care**
- **Supporting great care**

Delivery is underpinned by a series of strategic aims, objectives and detailed delivery plans, providing the connection between the Trust's strategic ambition and the programmes of work required to deliver it.

The Trust has agreed an assurance framework through which delivery of the strategy will be monitored. The Trust Board retains overall accountability for delivery, with Audit, Risk and Assurance Committee (ARAC) overseeing progress against the strategy and individual strategic delivery plans. Relevant Board Committees provide more detailed assurance aligned to the strategic domains and associated principal risks.

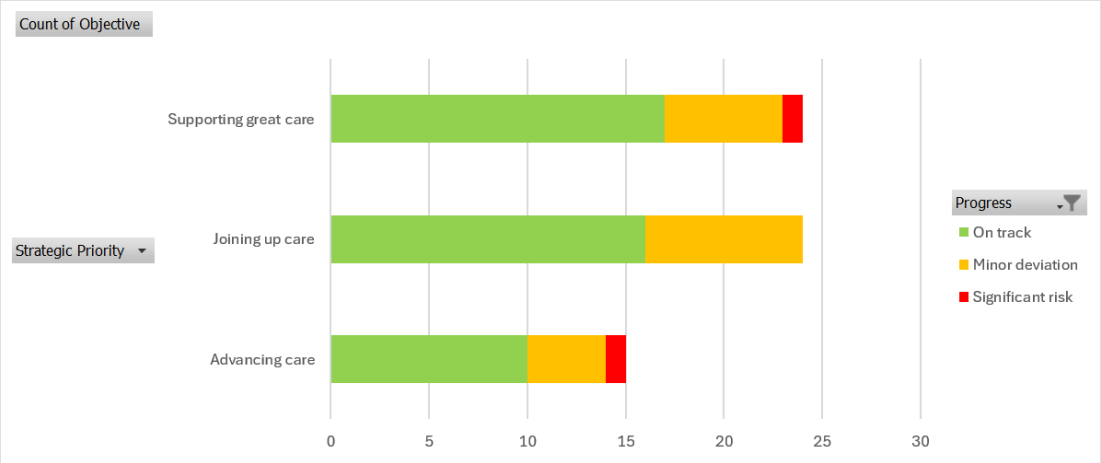
The agreed reporting cycle includes regular monitoring through operational and Board Committee arrangements, with an overall strategy report to ARAC every four months and subsequent summary and escalation to Trust Board.

This report represents the first consolidated assessment using the new monitoring arrangements.

2. OVERALL DELIVERY POSITION

The updated November assessment indicates that the majority of objectives/actions remain on track, although the level of minor deviation has increased and requires closer management attention.

The headline scorecard currently shows:



This means that 42 of the 62 objectives/actions currently assessed are reported as on track (68%), with 18 showing minor deviation and two assessed as significant risk. The full detail can be seen in Appendix 1: Strategy Monitoring Balanced Scorecard (Board Reading Room). At the time of writing this paper we did not have an update against the 'research' objectives, so these are excluded from the analysis. They will be included in the next update in March 2027.

Overall, the updated monitoring position continues to provide reasonable assurance that implementation of the Strategy is progressing, while showing a wider spread of recoverable slippage: 18 objectives/actions are now assessed as minor deviation and two remain at significant risk. These relate to delivery of the Trust's building decarbonisation ambitions, including the Public Sector Decarbonisation Scheme (PSDS) Phase 4 programme, and the timescale for developing a systematic approach to identifying and addressing unwarranted variation in clinical outcomes and practice.

The nature of these two risks is different. The decarbonisation risk reflects substantive affordability and delivery pressures which could affect achievement of the Trust's longer-term carbon reduction ambition. The clinical effectiveness risk is primarily associated with deliverability against the existing April 2027 timescale, with work already underway and a revised December 2027 target proposed. Neither currently indicates a requirement to alter the overall strategic direction, but both require enhanced oversight through the relevant governance arrangements.

Importantly, an action being reported as a minor deviation does not necessarily indicate that the strategic objective will not be delivered. The agreed definition is that delivery has slipped against timescale or quality, but recovery remains achievable without changing the underlying strategic goal. Significant risk indicates that critical milestones have been, or are highly likely to be, missed and that a change to scope or timeline, or formal escalation, may be required.

3. AREAS OF POSITIVE PROGRESS

Across the three strategic priorities there is evidence of delivery progressing across a broad range of programmes.

Examples include progress across neighbourhood and community care transformation, outpatient transformation, digital development, research and innovation, quality improvement and sustainability.

A range of digital actions are also currently reported as on track, including work relating to Clinical Board digital roadmaps, ambient voice technology, waiting-list monitoring, patient tracking and digital observations.

Within sustainability, progress reported includes continued transition of the Trust fleet, with 39% of the fleet electric at Quarter 2 (Q2) 2026/27, alongside further hybrid vehicles. There has also been progress in developing therapeutic green spaces and biodiversity initiatives.

These examples demonstrate that implementation of the Strategy has moved beyond the articulation of strategic ambition and is increasingly being translated into identifiable programmes, milestones and deliverables.

4. EXECUTIVE PRIORITIES FOR THE NEXT SIX MONTHS

Alongside implementation of the longer-term Trust Strategy, the Executive Team has identified a smaller number of organisational priorities requiring particular focus over the next six months. This is intended to provide near-term focus within the five-year strategic direction, rather than create a separate set of organisational priorities.

These priorities are:

1. Improve quality of care, reducing avoidable harm and never events.
2. Strengthen leadership capability and establish our developing excellence leadership programme.
3. Improve operational performance for emergency care and elective and cancer access standards.
4. Advance our transformation programmes of outpatients, surgery and neighbourhood care.
5. Accelerate digital transformation by building organisational capability and delivering digital changes that improve efficiency and effectiveness.
6. Deliver financial sustainability, breakeven and reduce the underlying deficit.

Progress against delivery of these will be included in the next Strategy update in March 2027.

5. CLINICAL BOARD STRATEGIC DELIVERY

As part of the Trust's approach to embedding delivery of the Strategy, each Clinical Board has developed its own strategic priorities aligned to the Trust Strategy. Progress against these priorities is being incorporated into the quarterly Quality and Performance Review (QPR) process, providing an important link between delivery at Clinical Board level and the Trust-wide strategy assurance framework.

The October QPR cycle provided the first opportunity to consider these strategic updates systematically alongside the established quality, performance, workforce and finance domains.

Overall, the discussions provided evidence that Clinical Boards are increasingly using their strategic plans to frame improvement and service development. This was evident in Family Health's use of its strategy to shape future emergency care models; Medicine & Emergency Care's focus on capacity, workforce innovation and system working; implementation of additional theatre capacity within Surgical & Specialist Services; measurable pathway redesign through single-point-of-access arrangements within Surgical & Associated Specialties; and Cancer & Haematology's focus on embedding research within future clinical delivery.

They also identified a number of cross-cutting constraints which could affect the pace of delivery, particularly workforce and capacity pressures, financial constraints and the need for enabling support from corporate or Trust-wide programmes.

Taken together, the October QPRs provide reasonable but not consistent assurance that Clinical Boards are beginning to embed their strategic plans into established operational governance and that the QPR process is providing an effective mechanism to connect local delivery with the Trust-wide Strategy.

Three themes emerge.

Firstly, strategic ownership is becoming more embedded. Clinical Boards are increasingly able to describe their strategic intent alongside tangible programmes of delivery, rather than treating the Clinical Board strategies as standalone documents.

Secondly, significant delivery is taking place despite operational pressures. Examples include additional theatre capacity, outpatient pathway redesign, capacity initiatives and development of new care models.

Thirdly, the discussions demonstrate that a number of strategic priorities depend upon Trust-wide enabling action. Capacity and workforce constraints, financial sustainability, system dependencies, appropriate governance arrangements and corporate support emerged repeatedly.

For future reporting cycles, the Performance and Governance team will continue to use QPRs as a source of assurance against Clinical Board strategic delivery. Greater consistency will be sought so that each Clinical Board provides a concise assessment of:

- progress against its agreed strategic priorities;
- overall confidence in delivery;
- evidence supporting that assessment;
- material risks or dependencies; and
- matters requiring Executive, Board Committee or Trust Board intervention.

6. STRATEGIC DELIVERY PLANS

The Trust strategy identifies 22 Strategic Delivery Plans (SDPs) for how we will deliver the Trust Strategy. Many of these plans are already underway and being monitored through the relevant Board tier 1 and tier 2 committees, Clinical Board meetings and lower-tier Committees/groups.

We now have SDPs for Clinical Boards, digital, commercial, transplantation, quality and safety, estates, climate emergency, neighbourhood and community services, outpatient transformation, research and innovation.

There is work continuing to finalise the draft strategic delivery plans for Genomics, Cancer, Robotic Surgery, Great North Children's Hospital and Health Inequalities SPDs which are all in draft and awaiting ratification at the relevant committee.

Further work is required to complete the SDPs for Communications, Education, People and the Financial plan. These are all under development with the relevant Executive involved.

There was a decision to incorporate the clinical strategy into the overall Trust strategy and therefore there won't be a standalone clinical strategic delivery plan. All of the above-mentioned plans will support delivery of the clinical strategic objectives of the Trust. The Great North Healthcare Alliance Plan is monitored through the Bilateral Boards and reported separately to the Trust Board and is therefore not included in this update.

7. RISK AND ASSURANCE

The monitoring framework has been deliberately designed to integrate strategy delivery with existing assurance arrangements rather than establish a parallel governance structure. Every action within the Strategy is intended to align with the relevant strategic risk and Board Committee, enabling detailed scrutiny through established governance arrangements. ARAC's role is to consider the overall picture of strategy delivery and determine whether the assurance provided is sufficient.

Where delivery moves materially off track, the agreed escalation framework provides for progression from local management and corrective action, through Executive oversight and the relevant Board Committee, with escalation to Trust Board where there is a critical risk to strategic delivery.

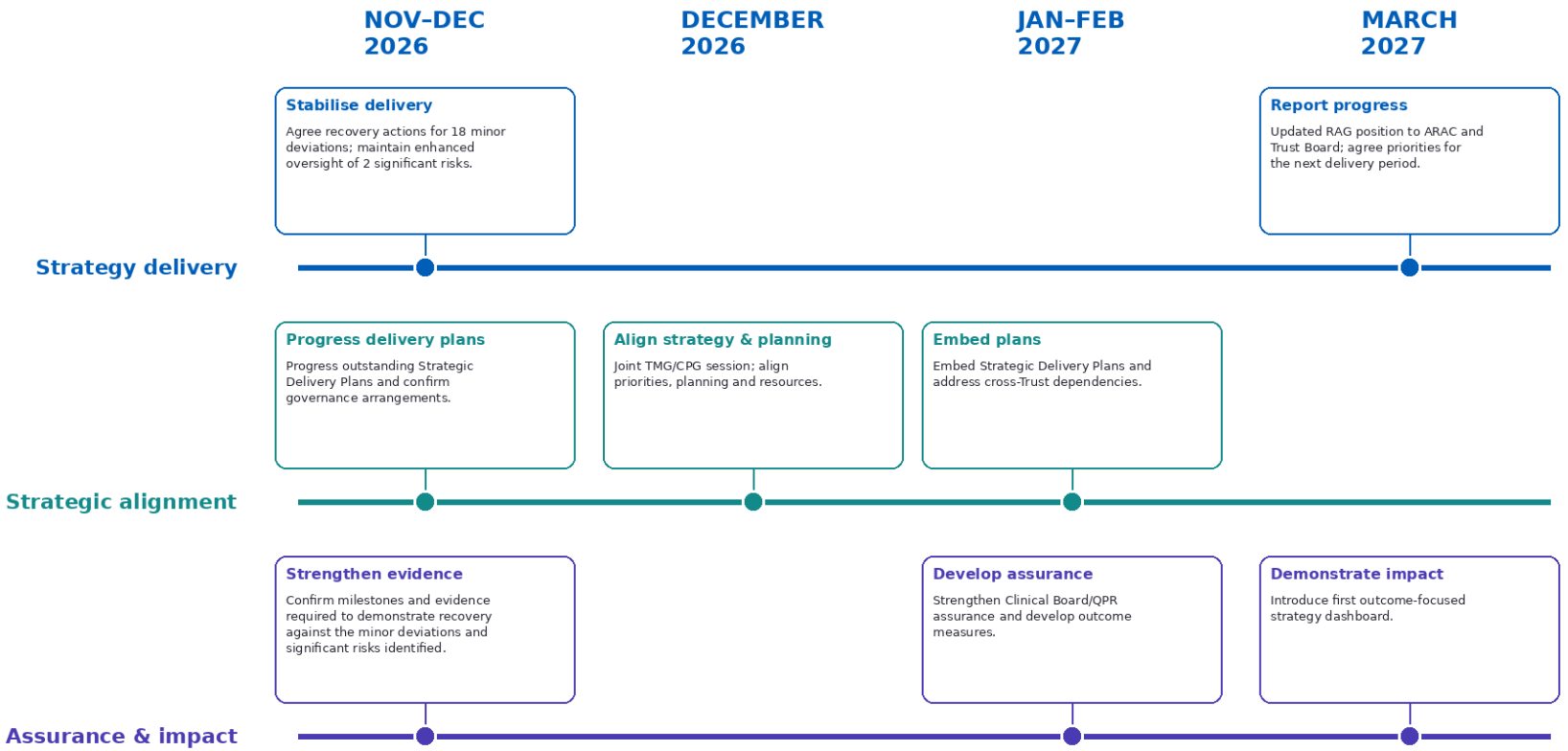
The Trust's current Board Assurance Framework similarly operates on the basis of defined principal strategic risks, risk ratings, sources of assurance and mitigating actions.
The current assessment does not indicate a need to reconsider the overall strategic direction. However, the two significant-risk objectives require continued close oversight, and the 18 minor deviations require clear recovery actions through the relevant governance routes. The decarbonisation programme remains under significant affordability and delivery pressure, while the clinical effectiveness risk continues to relate primarily to the achievability of the existing timescale.

8. NEXT STEPS

The first reporting cycle has established a baseline for oversight of strategy delivery and has demonstrated that the framework is identifying areas where delivery requires additional attention. The next phase will focus on strengthening the quality of assurance and embedding the approach within existing governance arrangements, as well as developing a dashboard to monitor overall effectiveness of the strategy to complement these updates. The timeline below describes how we will strengthen and embed delivery, monitoring and reporting of the strategy over the next 4 months.

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Next steps to March 2027



By March 2027, reporting will increasingly move from completion of actions towards demonstrating delivery, impact and outcomes.

Key:
CPG = Clinical Policy Group
TMG = Trust Management Group

9. SUMMARY AND CONCLUSION

Overall, the November 2026 assessment provides reasonable assurance that implementation of the Trust Strategy is progressing, although delivery confidence varies across the strategic objectives. The majority of objectives remain on track, with 18 areas of minor deviation and two objectives assessed as significant risk. The minor deviations are considered recoverable within the existing strategic direction but will require continued monitoring and clear evidence of recovery.

The two significant-risk objectives require continued Executive and governance oversight. For the Quality and Effectiveness objective relating to unwarranted variation in clinical outcomes and practice, work continues through peer review, audit, case discussion and pathway review; however, the current delivery date is no longer considered achievable and an extension to December 2027 is proposed.

A further Quality and Effectiveness objective, to create a clear Trust-wide understanding of clinical effectiveness work led by Clinical Boards, is currently assessed as a minor deviation. Progress is being made, but additional time is required to embed clinical ownership and ensure improvement priorities are locally owned, clinically credible and focused on what matters most to patients. An extension to March 2027 is therefore proposed.

The developing use of quarterly QPRs provides increasing visibility of Clinical Board strategic delivery and is strengthening the connection between strategic objectives and operational delivery. The maturity and consistency of this assurance will continue to develop through subsequent reporting cycles.

There is also increasing alignment between the Trust Strategy, Executive near-term priorities, major change programmes and the 2027/28 planning process. This should help concentrate organisational effort and resources on the areas of greatest strategic importance and ensure that strategic delivery is increasingly integrated into business-as-usual planning and governance.

Taken together, the position provides reasonable assurance over the Trust's arrangements for monitoring and managing delivery of the Strategy, while recognising the need for continued focus on recovery of areas of deviation, management of the two significant risks and further development of outcome-based assurance.

Report of Patrick Garner
Director of Performance and Governance
12 November 2026

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Agenda item A2(c)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	27 November 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 sixteen walkabouts by Executive Directors (n=8) and Non-Executive Directors (NEDs) (n=8) undertaken during September and October 2026. **Alert** • No Alerts identified. **Advise** • Workforce capacity and staff wellbeing remain recurring themes, including access to specialist cover, lone working and staff safety. • Opportunities for improvement were identified in communication, career development, environmental facilities, equipment and operational processes. • Two further walkabouts were completed in October 2026 and feedback is awaited. This will be included in future reports. **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 now 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.		

Links to Strategic Priorities (see appendix 1)	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]	Joining Up Care: 1.1 Failure to meet our care standards in a way which is designed around people, not organisations. 1.2 Failure to coordinate services which are effective 1.3 Failure to coordinate services which are available when our patients need them Advancing Care: 2.1 Inability to improve patient safety and patient harm through reliable, evidence-based care Supporting Great Care: 3.1 Failure to provide a healthy, safe, flexible and inclusive working environment that enables our people to thrive and deliver outstanding patient care.					
Reports previously considered by	The previous Board Visibility Programme Report was presented to the Trust Board in September 2026.					

BOARD VISIBILITY PROGRAMME

1. INTRODUCTION

This report provides an overview of the findings from sixteen walkabouts by Executive Directors (n=8) and Non-Executive Directors (NEDs) (n=8) undertaken during September and October 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. SUMMARY OF FINDINGS

The table below summarises 16 walkabouts undertaken throughout September and October 2026. Four walkabouts were carried out by Executive Directors in September and four in October. Four walkabouts were carried out by Non- Executive Directors in September and six in October. Feedback from two reports in this stream are yet to be received and will therefore be included in future reports. In total 18 Leadership Walkabouts were undertaken with a further six cancelled during this timeframe due to competing pressures in the walkabout team, estates work or scheduling issues.

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

Stream	Area visited	Date	Site	Membership of Walkabout Team	Staff who took part in the conversations
Stream One	Ward 3	02.09.2026	Freeman Hospital (FH)	Director of Quality & Safety, Complaints Manager, Trust Secretary.	Ward Sister, Ward Clerk, Staff Nurse, Housekeeper, Health Care Assistant, Pharmacist
	Urgent Treatment Centre	03.09.2026	Ponteland Road	Director of Great North Healthcare Alliance & Strategy, and Head of Quality Assurance & Clinical Effectiveness	Administrator, Admin Managers, Patient Care Navigator, Specialist Nurses
	Ward 36	11.09.2026	Royal Victoria Infirmary (RVI)	Executive Director of Nursing Midwifery and Allied Health Professionals, Patient Safety Lead	Charge Nurse, Dietitian, Housekeeper
	Ward 37 – Burns Unit	24.09.2026	RVI	Director of Estates, Facilities and Strategic Partnerships and	Sister, Staff Nurse, Clinical Educator

Stream	Area visited	Date	Site	Membership of Walkabout Team	Staff who took part in the conversations
				Patient Safety and Risk Manager	
	Haemophilia Centre	12.10.2026	RVI	Director of Improvement & Delivery and Quality Development Manager	Receptionist, Sister, Thrombosis Nurse, Clinical Nurse Specialist Paediatrics, Staff Nurse, Health Care Assistant
	Transport and Travel Team	15.10.2026	RVI	Director of Performance and Governance, Clinical Effectiveness Facilitator	Transport Lead, Deputy Manager, Administration Team Leader, Administrator
	Ward 10	16.10.2026	RVI: Great North Children's Hospital	Executive Director of People and Commercial Innovation and Head of Quality Assurance and Clinical Effectiveness	Ward Sister, Staff Nurse, Health Care Assistant and Occupational Therapist
	Ward 5	27.10.2026	RVI	Director or Quality & Safety, Partnership and Involvement Manager	Ward Sister/Charge Nurse, Ward Clerk, Staff Nurse, Health Care Assistant, Domestic, Housekeeper
	RVI - Ward 42	Cancelled by ward due to protected mealtimes			
	RVI - Antenatal Clinic	Cancelled due to competing pressures			
	Freeman Hospital - Sterile Services	Cancelled due to competing pressures			
	RVI - Ward 8 Great North Children's	Cancelled due to competing pressures			
	Regent Point - Community Stroke Services	Cancelled due to competing pressures			

Stream	Area visited	Date	Site	Membership of Walkabout Team	Staff who took part in the conversations
	RVI Ward 2B Great North Children's Hospital	Cancelled due to Estates works on the ward			
Stream Two	Fracture Clinic	01.09.2026	RVI	Non-Executive Director	Matron, Assistant Director of Operations (DOP), Senior Sister
	Ward 22 (Trauma and Orthopaedics)	01.09.2026	RVI	Non-Executive Director	Matron, Assistant DOP, Senior Sister
	Ward 23 (Trauma and Orthopaedics)	01.09.2026	RVI	Non-Executive Director	Matron, Assistant DOP, Senior Sister
	Integrated Laboratory Medicine	17.09.2026	FH	Non-Executive Director	Health Care Scientist Assistants, Biomedical scientists, Associate Physicians
	Assessment Unit	15.10.2026	RVI	Non-Executive Director	Housekeeper, Matron, Operational Service Manager (OSM), Sister, Consultant, Charge Nurse
	Ward 1A	15.10.2026	RVI: Great North Children's Hospital	Non-Executive Director	Not documented
	Ward 1A	22.10.2026		Non-Executive Director	Physios / Occupational Therapist / Physio Assistant, Assistant Director for Therapy Services
	Ward 2A	22.10.2026		Non-Executive Director	Physios / Occupational Therapist / Physio Assistant, Assistant Director for Therapy Services
	Ward 38	15.10.2026	RVI	Non-Executive Director	Awaiting Feedback

Stream	Area visited	Date	Site	Membership of Walkabout Team	Staff who took part in the conversations
	Pre-assessment clinic D	20.10.2026	RVI	Non-Executive Director	Awaiting Feedback

Key themes identified include:

- Across the areas visited, staff described supportive and inclusive teams, positive local leadership and strong multidisciplinary working. Staff generally felt valued and able to raise concerns, with many expressing pride in their teams, services and achievements.
- A strong commitment to compassionate, patient-centred care was evident despite operational pressures. Positive patient feedback, Accrediting Excellence Programme (ACE) achievements and strong relationships with long-term patients were highlighted, alongside good awareness of incident reporting and patient safety responsibilities.
- Workforce capacity and access to specialist clinical cover remained recurring themes. While staff generally reported feeling safe and supported and valued available wellbeing support, some concerns were raised regarding lone working, challenging behaviour and staff safety. Access to education, training, Continuing Professional Development (CPD) and research was viewed positively, with opportunities identified to further develop career progression and development pathways.
- Staff identified opportunities to improve the working environment and day-to-day operational experience, including space, storage, waiting areas, equipment, signage, privacy and security. Communication was also a recurring theme, particularly the accessibility and timeliness of information relating to service changes and organisational processes. Staff parking, including the application and appeals processes, was highlighted as a specific area where clearer communication and simpler processes would be welcomed.

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

- Ensure the identified environmental, staff safety, privacy and equipment matters on Wards 37 and 38 are addressed through the appropriate operational and estates processes, including the lone-working arrangements, burns cubicle works, privacy screening and replacement of bathing equipment.
- Display Freedom to Speak up and working well team information in ward areas.
- Support the continued development of the Haemophilia Centre through inclusion in the wider Great North Children's Hospital (GNCH) service review programme, consideration of future service arrangements including out-of-hours provision, engagement with Improvement Partners to review clinic and outpatient pathways, and increased staff engagement with Trust-wide quality and safety learning forums.
- Explore opportunities for the Transport team to provide education through Trust induction programmes or a Learning Lab package.

- Seek assurance regarding development and career progression opportunities for Healthcare Assistants on Ward 5, including access to the Nursing Associate programme, with an update on this and wider staff feedback provided to the Clinical Board triumvirate. Explore provision of facilities for parents to heat food on Ward 1a.

4. RECOMMENDATIONS

The Trust Board is asked to:

1. Note the findings and themes and actions 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 this improvement through subsequent reports.

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

Appendix 1: Board Visibility Programme: Executive Director

Walkabout Stream: Executive Director **Members of the Walkabout Team**: Paul Hanson, Director of Estates, Facilities and Strategic Partnerships and Paula Dimarco, Patient Safety and Risk Manager **Site/ Ward/ Department:** Ward 37, RVI (Burns Unit) **Job Title of staff spoken to (please do not include staff names):** Sister, staff nurse, clinical educator **Date:** 24/09/2026	
First Impressions	A positive ward environment was observed, which was welcoming, calm, clean and tidy. An opportunity was identified to review the waiting arrangements for outpatients attending for wound reviews and dressing changes, as patients were observed waiting in the area outside of the ward.
Observations i.e. Environmental / Staffing / Patients	People – everyone was very friendly. They enjoy working on the ward and are proud of the care and treatment they provide. We were told that it's difficult to get a job here because no one ever leaves. People feel safe and supported to raise concerns and report patient safety incidents. Everyone was proud of their Gold Accrediting Excellence (ACE) award and were hoping to repeat this success - assessment is being undertaken again over the next few weeks. Verbal abuse was reported to be 'normal' and this was excused as patients were in pain, although people recognised that being verbally abused was still unacceptable and they said they would report such incidents on InPhase. Staff generally reported feeling safe and supported; however, a low-level anxiety regarding personal safety and security was acknowledged. This reflected the unpredictable nature and timing of admissions, including out-of-hours transfers, and the potential for challenging or aggressive behaviour associated with some presentations. Environment – the environment was clean and tidy/uncluttered, including the clean utility room. Four main concerns were raised: 1. The location of the treatment room, away from the main ward and nurses' station, together with the absence of an alarm or staff assistance system, was identified as a potential safety risk. This is particularly relevant where information regarding potential risks may not be known until the patient has entered the treatment room. 2. Current waiting arrangements for outpatients are limited, with no dedicated private waiting area available. As a result, some patients wait in the area outside Wards 36 and 37, presenting an opportunity to review arrangements to better support patient comfort, privacy and dignity. 3. Work has been undertaken to enable the Burns Unit to care for Level 3 burns patients within a converted cubicle. While there were initial delays associated with communication and coordination of the works, local leadership demonstrated appropriate autonomy in managing the impact on the service. The works are now substantially complete; however, a known ventilation issue and some operational arrangements, including staffing and cover, require resolution before the cubicle becomes fully operational. 4. There is limited storage on the ward and a large number of dressings. Alternative options have been considered however are not viable for various reasons. Omnicell is due to be installed in November. Facilities – The importance of maintaining a consistently high standard of environmental cleanliness within the Burns Unit was recognised. While positive examples of close working between Hotel Services and the clinical team were highlighted, recent staffing changes have resulted in some variation in continuity. An action was agreed for Hotel Services management to work with the Ward Sister to review the current arrangements and identify an appropriate solution.

Summary	Staff were positive, engaged and proud of the care they provide, describing a supportive culture in which they feel able to speak up and raise patient safety concerns. The team also expressed pride in achieving Gold accreditation. While staff generally reported feeling safe, experiences of verbal abuse and challenging behaviour were highlighted, alongside some underlying concerns regarding personal safety. A number of environmental and operational issues were identified, including arrangements for staff assistance within the treatment room, outpatient waiting facilities, storage capacity and the safe operationalisation of the Level 3 burns cubicle. Equipment and environmental service pressures were also noted, including the availability of a reliable bath hoist and consistency of domestic support. These areas require appropriate follow-up to support a safe environment for both patients and staff.
Potential Actions Identified	Were there any issues you needed to address during your visit? ⓧ Yes ◯ No If yes, what was the issue(s)? 1. Loan working risk relating to isolated area of treatment room to be reviewed. 2. Outstanding tasks in relation to the newly converted level 3 cubicle. 3. Privacy screening needed on glass in the door between 38 and 37. 4. Review of domestic cover on the ward. 5. Repair of bathing equipment required. 6. No Freedom to speak up poster or working well team information available on the ward. Responsible person: Director of Estates, Facilities and Strategic Partnerships 1-5. Patient Safety and Risk Manager 6. When should this action be completed by: All actions have been completed Is a follow up visit required? ◯ Yes ⓧ No If yes, please state timeframe:

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: Judith McKenna, NED
Site/ Ward/ Department: Ward 22 (Trauma and Orthopaedics)
Job Title of staff spoken to (staff names are not required): Matron, Assistant Director of Operations, Senior Sister
Date: 01/09/2026

First Impressions	The ward entrance was clear and tidy. The people showing me round both cleaned their hands on entry and gently encouraged me to do so too. Information board was easy to see and clear.
Observations i.e. Environmental / Staffing / Patients	Flow is much improved on the ward now with support from patient services. There is limited storage for heavy moving equipment. However, the corridors are sensibly used with plenty of space to walk past. Changes to visiting hours have worked on this ward, meaning there is less pressure on particular times. There is a bottleneck around Occupational Therapy and Social Worker availability – the ward is open 24/7 but there is not a 7-day service for Occupational Therapy. Physiotherapy has a reduced service at the weekend. Repatriation to other hospitals is an issue, as across the rest of the hospital. IT – people have different ways of using the same systems. This generally isn't a problem but sometimes can cause issues if information is stored in different fields etc. Refresher training is ongoing to share best practice. Dictaphones – the use of Dictaphones still goes on because they are much more convenient than the alternative which needs to be plugged into a laptop. This is also becoming more expensive as tapes need replacing. Would be very helpful for IT to explain if an alternative is likely to come soon.
Summary	The ward was calm and people clearly knew their roles and priorities. Information sharing was good and improvement projects (i.e. IT refresher training) were already planned.
Potential Actions Identified	Were there any issues you needed to address during your visit? ◯ Yes ⓧ No If yes, what was the issue(s)? Responsible person: When should this action be completed by: Is a follow up visit required? ◯ Yes ◯ No If yes, please state timeframe:

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Agenda item A2(d)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 November 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** • Referral To Treatment (RTT) 18-week compliance remained static at 72.6% in September, whilst the total waiting list increased to 88,160 (+48). Trust under-performance against these metrics is being driven by under delivery against the 2026/27 activity plan in key specialties and points of delivery. Dermatology has capacity challenges due to changes in job planned activity over the past six months, with a drop of 14.5 clinical PAs (programmed activity). The service are exploring support from Plastic Surgery for the basal cell carcinoma (BCC) pathway, with a potential 10% 18-week performance improvement by March 2027 if agreed. • Long-term sickness is up to 4.04%. There are no signs of improving trajectory, and contributing factors remain around Anxiety/stress/depression (S10). Trust established 'Why absence matters' program focusing on supporting line managers to manage sickness absence. **Advise** • The National benchmark for term admissions is 5%. The Trust rate has remained consistently above the national 5% target in recent years, however, in September this was noted to be 5%. This will continue to be monitored closely. Further analysis is in progress of infants born within 37th week of pregnancy as this group represent 40% of admissions. • Emergency Department (ED) Performance (All Types) in September was 76.10%, a decrease of 0.91% compared to August (77.01%). Work has started on the Urgent Treatment Centre (UTC) ED link corridor. Focus has been given to safe temporary re-routing of patients, as two cubicles have been closed in ED, as well as space in Paediatric ED. • Mandatory training compliance is 92.09%; an increase from the last three months which had been showing a decreasing trend of compliance. The compliance is just above the 90% standard and therefore needs to be monitored to ensure continued compliance. **Assure** • There was a marked reduction in Methicillin-Sensitive Staphylococcus aureus (MSSA) cases during September, with 7 cases reported compared to 16 in August. There was 1 community-onset healthcare-associated (COHA) case and 6 hospital-onset healthcare-		

<table>
<tr><td></td><td colspan="6">associated (HOHA) cases. These cases are under review; findings will inform learning and improvement actions.
• In September, the 80% 28 Faster Diagnosis Standard (FDS) target was achieved, performance sat at 82.8%. FDS performance has improved through the skin pathway, supported by additional Dermatology clinics over the summer months and sustained performance gains.
• Trust Turnover rate is 8.71% and falls below the 10% target. Flexible working is supported and encouraged across the Trust, with consistently over 98% of applications approved.</td></tr>
<tr><td>Recommendation</td><td colspan="6">This paper is received to provide assurance to the Board of Directors 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>
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<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>
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<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">Links to all.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">This report is delivered on a monthly frequency.</td></tr>
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Agenda item A2(d)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

November 2026

Healthcare at its best
with people at our heart

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Variation / Assurance – Changes from previous month

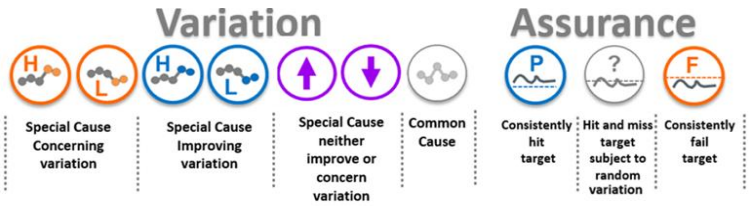
	Aug-26	Sep-26
Caesarian Section Deliveries		
Elective Caesarian Deliveries		
Cancer 31 Day Decision to Treatment		

Variation

- **Three** high level metrics have displayed changes in special cause variation from August 2026 to September 2026.
- Common cause variation to special cause variation (neither improve or concern):
  - Caesarean Section Deliveries
  - Elective Caesarean Deliveries
- Common cause variation to special cause variation of a concerning nature:
  - Cancer 31 Day Decision to Treatment

Assurance

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



Quality



Quality Overview

Metric	Period	Actual	Target	Variation	Assurance
HCAI - MSSA	Sep26	7	11		
HCAI – C. Diff	Sep-26	16	12		
Harm Free Care – inpatient (IP) Acquired Pressure Ulcers	Sep-26	37	Sustained reduction		
Harm Free Care – Adult Patient Falls	Sep-26	207			
Stillbirths	Sept-26	5			
Blood Loss ≥1500ml (per 1,000)	Sept-26	55 per 1000			
ATAIN	Sept-26	5%	5%		



Health Care Acquired Infections

- Methicillin-Sensitive Staphylococcus aureus (MSSA) cases decreased significantly (7 vs 16) but still remain within common cause variation. There were 1 Community-Onset Healthcare-Associated (COHA) and 6 Hospital-Onset Healthcare-Associated (HOHA) cases.
- *Clostridioides difficile* Infection (CDI) cases increased (16 v 11) but remains within common cause variation. There were 2 COHA and 14 HOHA cases.

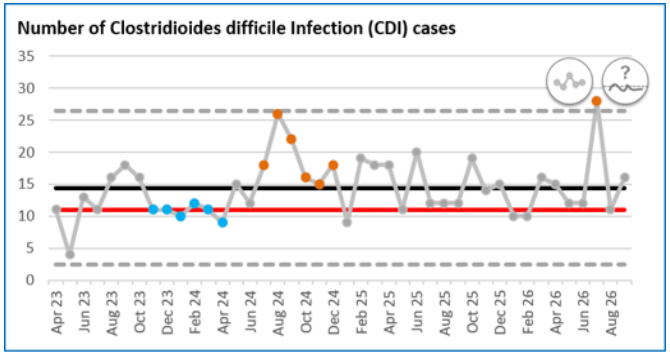
Harm Free Care

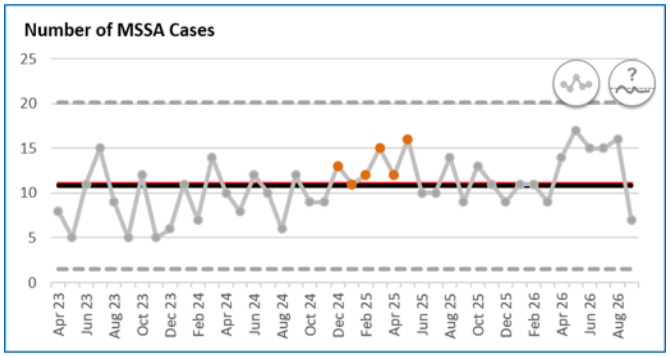
- Acute (Category 2 & above) pressure ulcers (PU) reported in September decreased (37 v 45).
- In September there continued to be a decrease in falls (207 v 216), remaining in common cause variation.

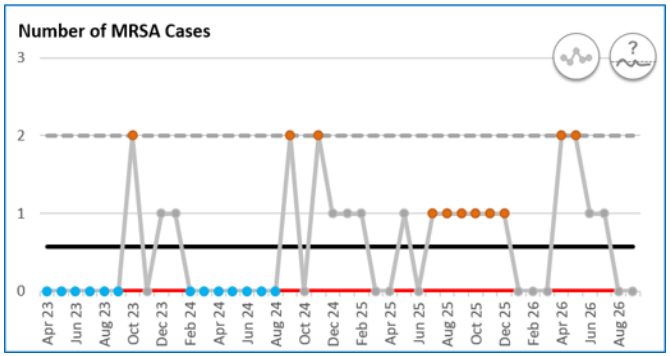
Perinatal Quality Surveillance

- There were 5 stillbirths in September 2026.
- Higher Post Partum Haemorrhage (PPH) rates are indicative of the complexities of the high-risk patient group and provision of the Placenta Accreta Spectrum service.
- The National benchmark for term admissions is 5%. The Trust rate has remained consistently above the national 5% target in recent years, however, in September this was noted to be 5%. This will continue to be monitored closely. Further analysis is in progress of infants born within 37th week of pregnancy as this group represent 40% of admissions.

Healthcare Associated Infections (HCAIs) (1/2)







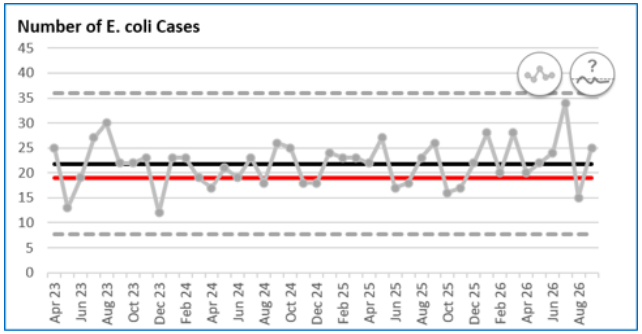
Standards

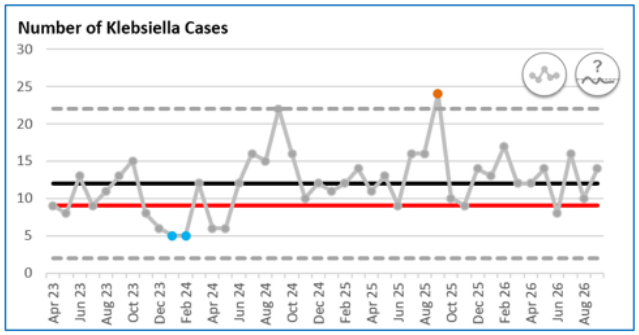
- **Zero methicillin-resistant Staphylococcus aureus (MRSA)** cases.
- **No more than 129 Methicillin-Sensitive Staphylococcus aureus (MSSA)** cases across the fiscal year (local target - 5% reduction from 2025/26) in line with the quality priority.
- **No more than 136 CDIs, 225 *E. coli*** cases, **108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

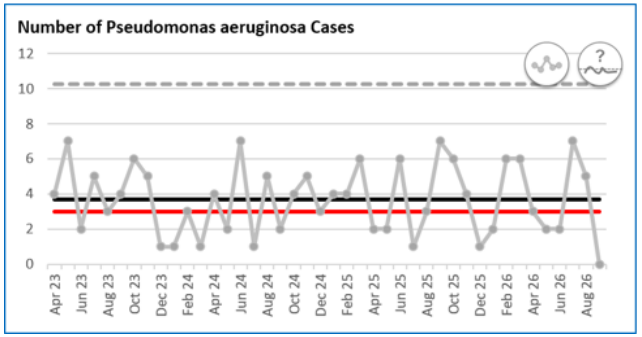
Current Position

- ***Clostridioides difficile* infection (CDI):** There was an increase in CDI cases during September, with 16 cases reported compared to 11 in August. There were 2 community-onset healthcare-associated (COHA) cases and 14 hospital-onset healthcare-associated (HOHA) cases. Of the 14 HOHA cases identified, four investigations have been completed with no contributory factors identified. Opportunities to strengthen aspects of care remain consistent with those reported previously, including timely patient isolation, stool chart documentation and prompt initiation of appropriate treatment. The remaining cases are under investigation.
- **MSSA bacteraemia:** MSSA bacteraemia cases decreased significant in September (7 cases compared with 16 in August) but remain in common cause variation. Of the 7 cases reported, 1 was COHA and 6 were HOHA. Of the 6 HOHA cases, 4 were associated with intravascular devices and met the investigation criteria. These cases are under review; findings will inform learning and improvement actions.
- **MRSA bacteraemia:** No MRSA bacteraemia cases were reported in September; therefore, the year-to-date total remains at 6 cases. Performance remains within common cause variation.
- ***Escherichia coli* (*E. coli*) bacteraemia:** *E. coli* bacteraemia cases increased in September (25 cases compared with 15 in August), with performance remaining within common cause variation. Of the 25 cases, 6 were COHA and 19 were HOHA. 4 HOHA cases have been identified for further investigation and are currently undergoing review.
- **Klebsiella bacteraemia:** Klebsiella bacteraemia cases increased in September (14 cases compared with 10 in August) but remained within common cause variation. Of the 14 cases reported, 5 were COHA and 9 were HOHA. Of the 9 HOHA cases, 2 required further investigation and are currently under review.
- **Pseudomonas aeruginosa bacteraemia:** No Pseudomonas aeruginosa bacteraemia cases were reported in September; therefore, the year-to-date total remains at 19 cases.

Healthcare Associated Infections (HCAIs) (2/2)







Themes and Actions

Environmental Decontamination

- Rollout of the enhanced Clinell Pod system is nearing completion across the Trust. The product has been positively received by staff and supports more efficient environmental decontamination through a reduced contact time.

Embedding Infection Prevention Control (IPC) Improvement

- IPC improvement workstreams continue across Harm Free Care, antimicrobial stewardship, Clinical Board improvement plans and strengthened assurance and surveillance processes. These initiatives support early identification of risk and targeted quality improvement activity.

Strategic Improvement

- Strategic work continues across vascular access and device management, intravenous (IV)-to-oral antimicrobial switch programmes, enhanced surveillance capability and skin integrity pathways. Collaborative work through the WaterLite programme in critical care was recently recognised with a National Quality Improvement Award, highlighting the impact of multidisciplinary working in improving patient safety.

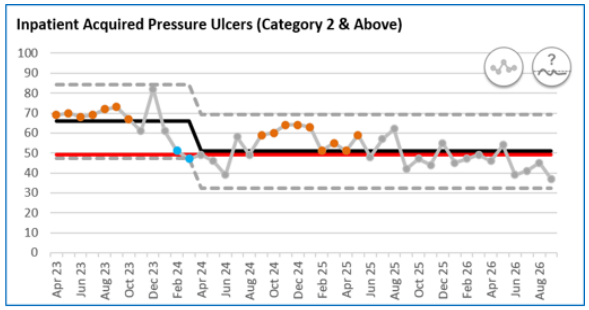
Impact and Board Assurance

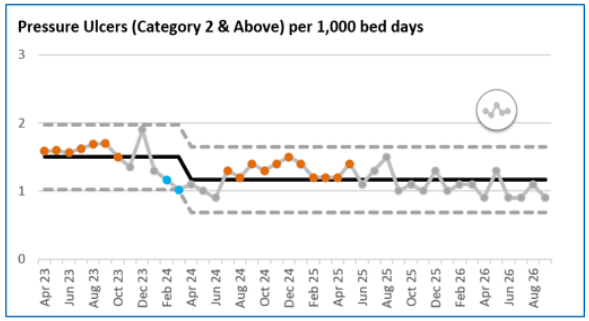
- Development of the IPC dashboard continues, with functionality and reporting capability significantly enhanced. Subject to final assurance testing, the dashboard is anticipated to go live in November 2026, strengthening visibility of IPC performance, trends and risks across the Trust.

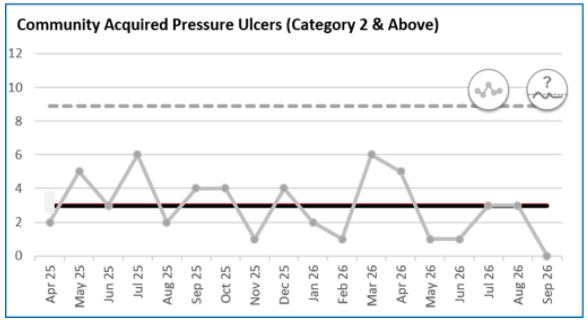
Key Message

- IPC improvement remains a key organisational priority. Progress continues across environmental decontamination, surveillance, antimicrobial stewardship and assurance processes, supporting improved oversight, informed decision-making and the delivery of safe patient care.

Harm Free Care: Pressure Damage (1/1)







Standard

Following the sustained reduction in pressure ulcers over the past two years, no specific numerical reduction target has been set for 2026/27. The focus will instead be on maintaining and evidencing the improvements achieved to date through Statistical Process Control (SPC), ensuring that performance remains stable and that reductions are sustained over time.

Current Position

September data demonstrates continued stability in pressure ulcer performance across inpatient services. Acute pressure ulcers (Category II and above) reduced from 45 cases in August to 37 cases in September. The rate per 1,000 bed days also decreased from 1.1 in August to 0.9 in September, indicating a continued positive trajectory.

Severity Breakdown

Of the inpatient pressure ulcers reported in September:

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

All Category III pressure ulcers are currently undergoing investigation to identify contributory factors, support organisational learning and inform targeted preventative actions aimed at reducing future harm.

Actions

Several quality improvement initiatives continue to support pressure ulcer prevention across the Trust, including:

- Ongoing review and update of the Pressure Ulcer Categorisation eLearning package.
- Development of a Pressure Ulcer Prevention leaflet for Day Unit and Outpatient areas.
- Commencement of work to develop a Trust-wide Pressure Ulcer Prevention Strategy.

Community Services

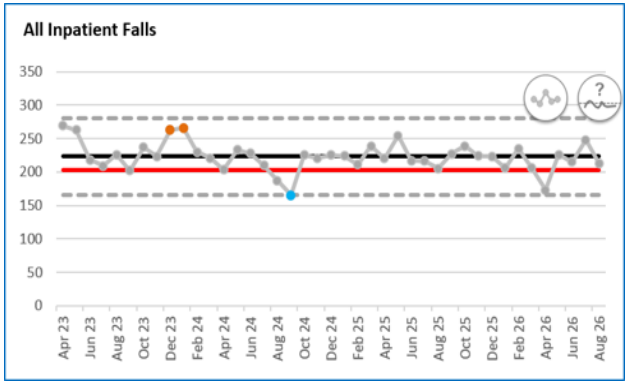
In September, Community Services reported:

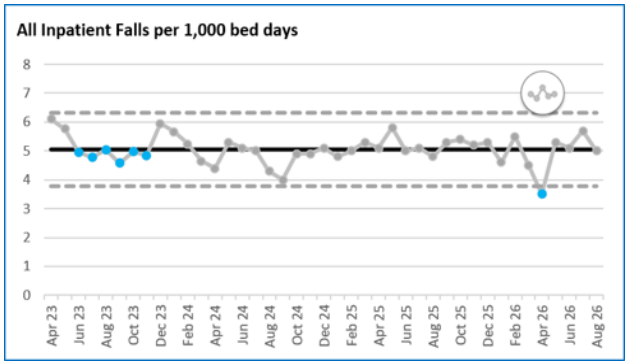
- Zero community-acquired pressure ulcers.
- Community teams continue to actively contribute to the implementation of actions from the Pressure Ulcer Task and Finish Group, supporting a consistent and collaborative approach to across care settings.

Summary

- Pressure ulcer performance remained stable throughout September, with reductions seen in both the number of acute pressure ulcers and the rate per 1,000 bed days. No Category IV pressure ulcers were reported across either inpatient or community services. Investigations into all Category III pressure ulcers are ongoing, while a range of improvement initiatives continue to strengthen prevention, enhance staff education, improve data quality, and support sustained performance improvement across the Trust.

Harm Free Care: Falls (1/1)





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 Statistical Process Control (SPC), with the expectation of demonstrating a sustained reduction over time.

Current Position

Falls decreased in September

- The number of inpatient falls continued to reduce, decreasing from 216 in August to 207 in September. The falls rate reduced from 5.1 to 4.8 per 1,000 bed days.
- Performance is unchanged when compared with September 2025, when 216 inpatient falls were reported, equating to a rate of 4.8 falls per 1,000 bed days.
- SPC charts continue to demonstrate common cause variation, indicating that performance remains stable and within expected limits.

Harm Summary

9 inpatient falls resulting in significant harm were reported in September, with 5 categorised as moderate harm and 4 categorised as severe harm.

- Moderate harm injuries included pubic ramus, distal fibula, vertebral and finger fractures, as well as an intracranial haemorrhage requiring specialist investigation and review. Severe harm resulted from four hip fractures requiring surgical intervention.
- In addition, a severe harm fall in the Emergency Department (ED) resulted in a neck of femur fracture.
- Learning from PSIRF Falls Reviews is collated and analysed for Trust-wide themes and trends, informing falls-related quality improvement, audit and research priorities.

Summary

- Pressure ulcer performance remained stable throughout September, with reductions seen in the number of acute pressure ulcers and the rate per 1,000 bed days. No Category IV pressure ulcers were reported in either inpatient or community services. Investigations into Category III pressure ulcers are ongoing, while a range of improvement initiatives continue to strengthen prevention, enhance staff education, improve data quality and support sustained performance improvement across the Trust.
- Falls performance improved in September, with both the total number of inpatient falls and the inpatient falls rate per 1,000 bed days decreasing compared with August. Performance was unchanged compared with September 2025, and SPC charts continue to demonstrate common cause variation, indicating that falls performance remains stable and within expected limits. 9 inpatient falls resulting in significant harm were reported during September, including five moderate harm incidents and four severe harm incidents. Learning from PSIRF Falls Reviews, complaints and litigation continues to be analysed for Trust-wide themes and trends, informing falls-related quality improvement, audit and research priorities. Key activity during the month included delivery of Falls Awareness Week 2026, establishment of an Escalator Review Group, hosting of the North East and Cumbria Falls Interest Group annual meeting, and agreement to implement a low-level bed rental model.

Harm Free Care: Venous Thromboembolism (VTE) Assessments

Standards

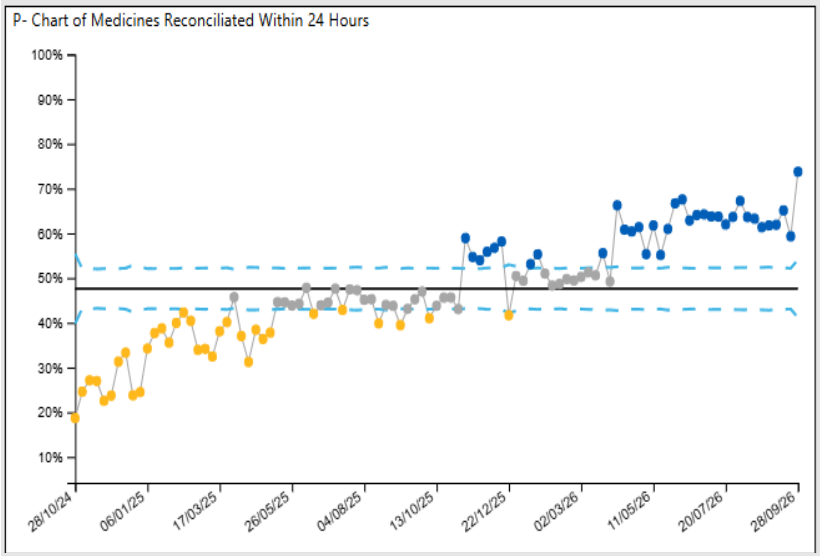
- **95%** of VTE (Venous Thromboembolism) assessments undertaken within 24 hours of admission (external target).

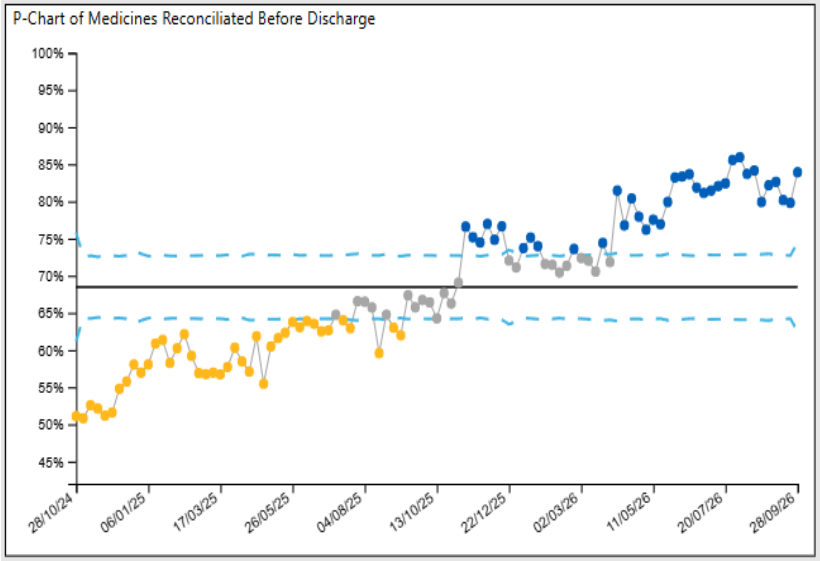
Current Position

- 97% VTE risk assessment completion during admission.
- 85% VTE risk assessment completion within 24 hours of an admission
- 75% 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.
- Awaiting the introduction of a pop up to remind prescribers to restart anticoagulation when it has been stopped
- New ways to provide patients with VTE information are being explored

Clinical Board	VTE risk assessment compliance at 24 hrs
Cancer and haematology	82%
Cardiothoracic services	76%
Family health	76%
Medicine and emergency care	93%
Perioperative and critical care	79%
Surgical and associated services	80%
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

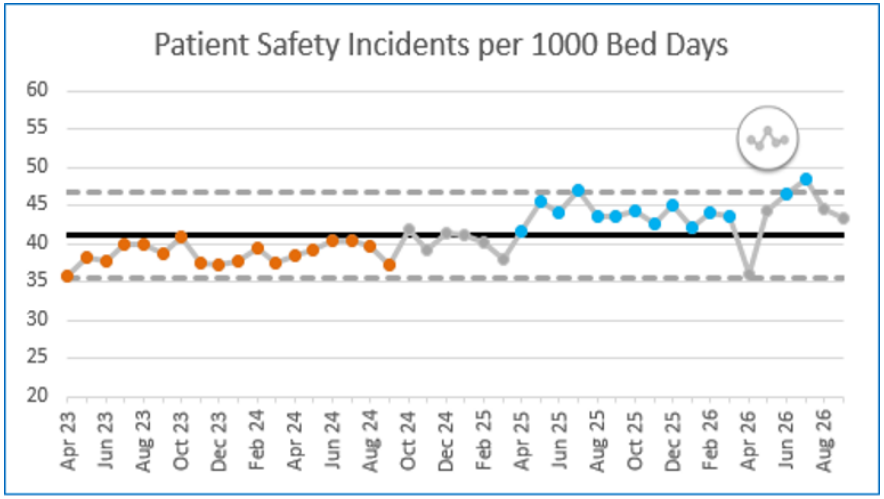
- All Phase 1 staff now in post; working on new target of 50-60%

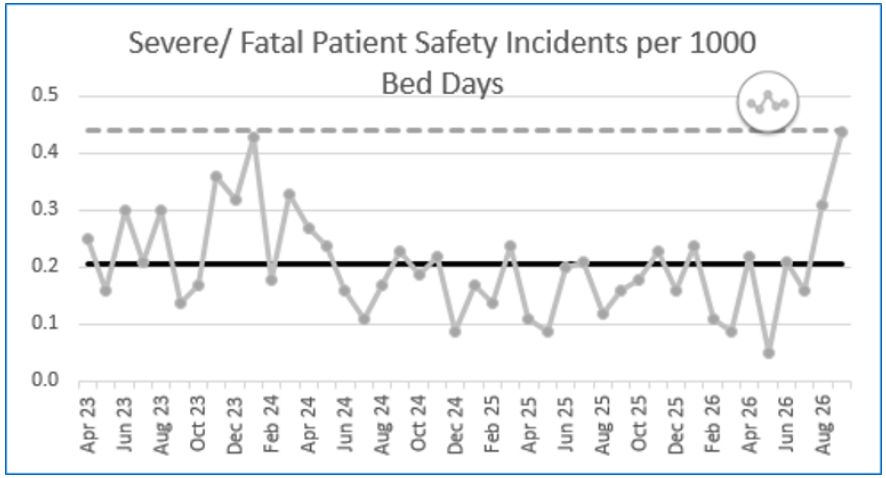
	Med rec within 24 hours Total Number & %		Total Med Rec before discharge Total Number & %	
July 2025	2099	**43%**	2488	52%
Aug 2025	1882	**40%**	2446	52%
Sept 2025	2006	**40%**	2567	53%
Oct 2025	2064	**41%**	2681	54%
Nov 2025	2105	**49%**	2564	59%
Dec 2025	2111	**51%**	2563	61%
Jan 2026	2362	**48%**	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%
Sept 2026	**2896**	**63%**	3712	81%

Narrative Sept 2026

- Phase 2 of business case has been approved, and work has begun to recruit staff into posts in 2 phases starting September 2026 and January 2027 with the full impact of this business case likely to be recognised Summer 2027. The pharmacy team will review in September 2027 what is needed for phase 3 which will be submitted in place for the new financial year.

Incident Reporting





Standards

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

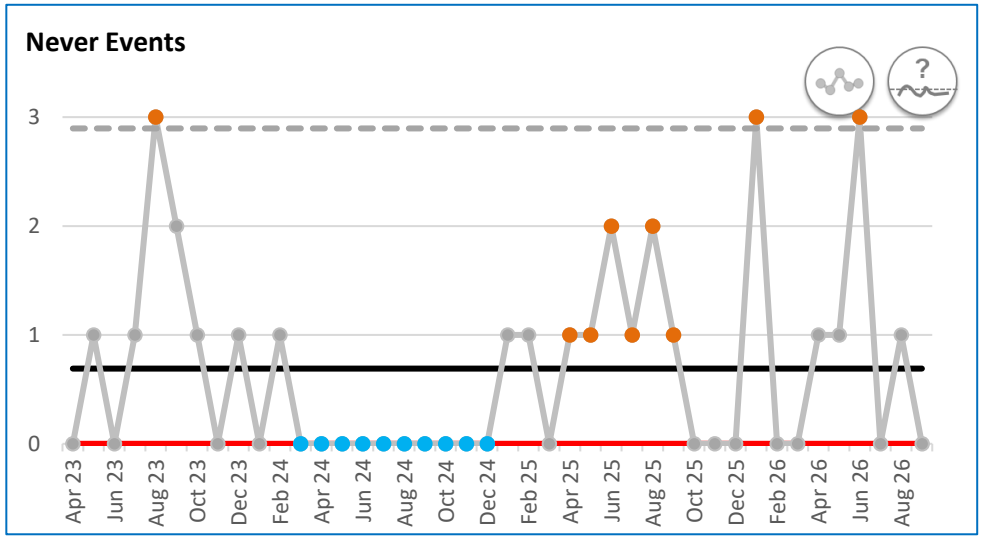
Current Position

- The total number of patient safety incidents per 1,000 bed days reported in September 2026 has decreased compared to August 2026.
- The number of severe/fatal safety incidents per 1,000 bed days increased in September 2026, compared with August 2026.
- Six After Action Reviews and five Patient Safety Incident Investigations were recorded in September 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
August 26	45130	Cardiothoracic Services	Cardiology	Misplaced nasogastric tube

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.

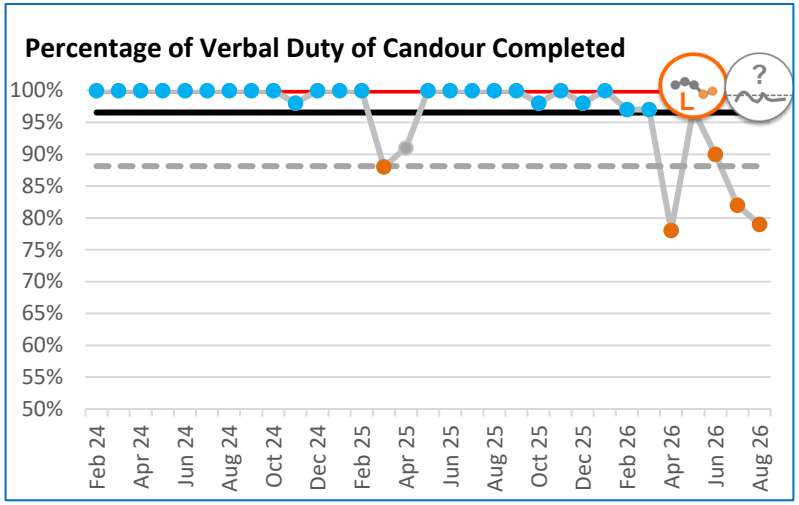
Current Position

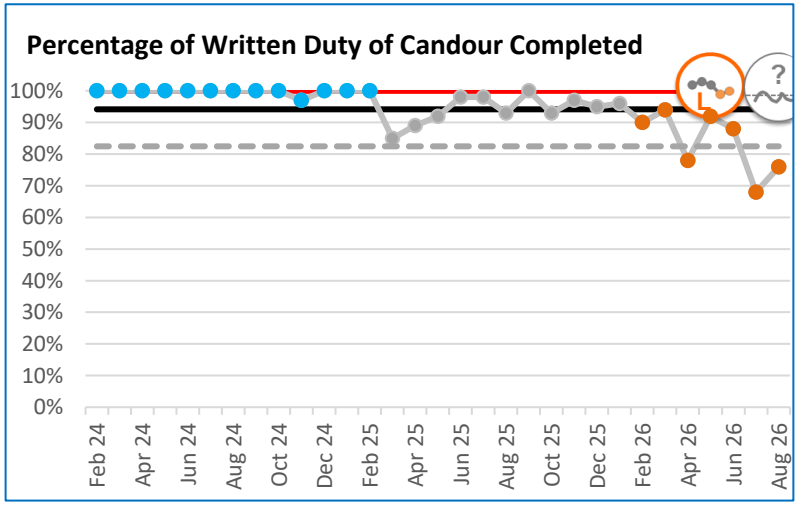
- No new Never Events were recorded in September 2026.
- Six Never Events have been recorded in 2026/27. In relation to harm: 1x no harm, 3x low harm, 1 x moderate harm and 1x severe harm (further detail can be found in the Reading Room).
- 11 Never Events were recorded in 2025/26.

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.
- 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.

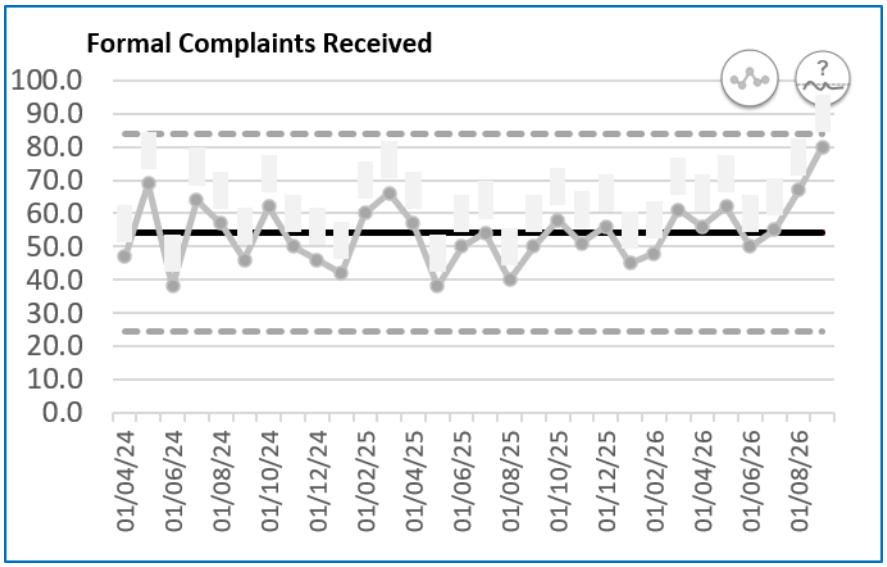
Current Position

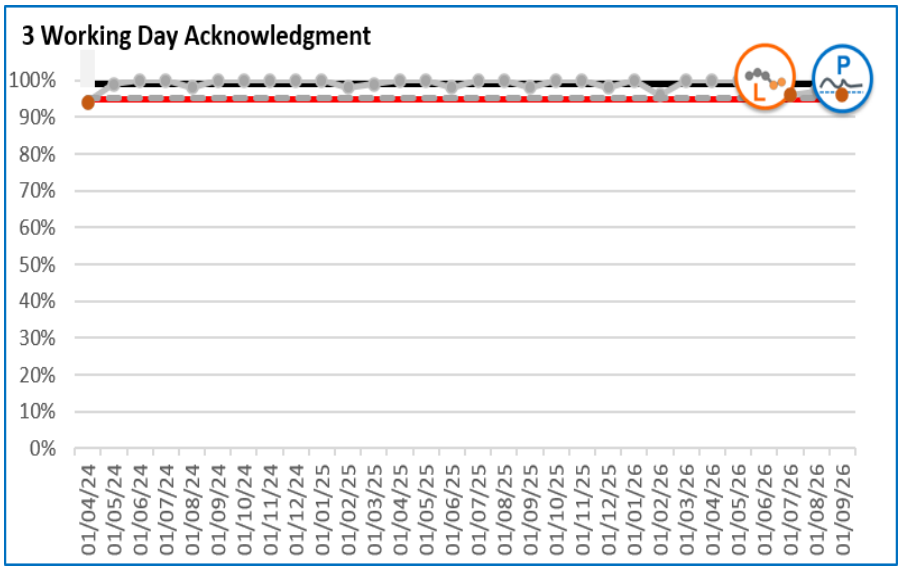
- Overall Trust compliance is measured using completion records from the InPhase incident module, with additional assurance of Regulation 20 compliance provided through audits reported to the Patient Safety Group and Quality Committee.
- Compliance with verbal and written DoC was below trust average in August 2026.
- Changes to the recording of DoC following the transition to InPhase have improved data accuracy, which may explain the observed reduction in reported compliance.

Action taken

- Clinical Board compliance is monitored through Quality Performance Reviews (QPRs).
- Trial of new Patient Safety Involvement Leads to support engagement in complex Patient Safety Incident Investigations.
- Development of Duty of Candour Improvement Plan to support improvements in compliance with statutory Duty of Candour requirements by strengthening documentation, staff capability, oversight and assurance.

Formal Complaints





Complaints Received

- The Trust had 80 formal complaints In September 2026. The average number of complaints opened for the previous financial year is 50 and the monthly data continues to show a fluctuation of variation above and below the average.

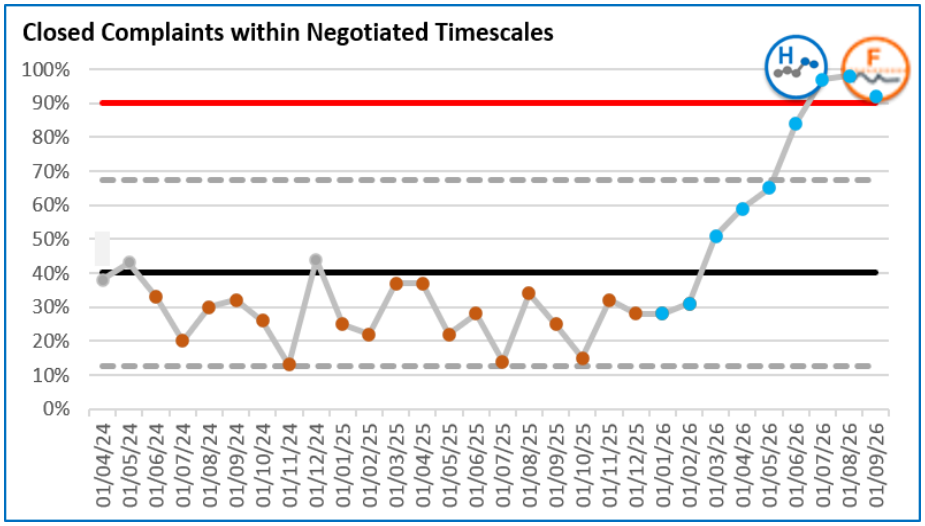
Complaints by Clinical Board

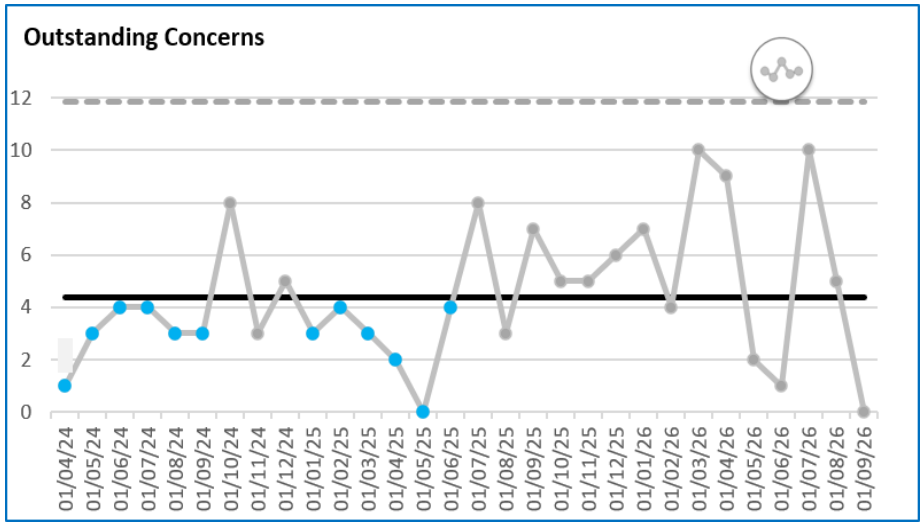
- The most complaints were opened for the following four Clinical Boards, collectively accounting for 62% of complaints this month:
    - Surgery & Specialist Services/Family Health 22 (28%)
    - Medicine & Emergency Care 21 (26%)
    - Surgery & Associated Specialties 11 (14%)

3-Day Acknowledgement of Complaints

- Minimal unavoidable fluctuation from maximum 100% achievement, last month saw a 96% 3-day acknowledgement compliance, despite a significant continuing increase in complaints from the data set average.

Formal Complaints





Negotiated Timescales

- In September there were 45 formal complaints closed and 38 (92%) were on time, within negotiated timescales This shows continuing substantial improvement above the internal Key Performance Indicator (KPI) of 90% with 9 positive moves (blue dots) in percentages, following the introduction of re-negotiated timescales and we will continue to monitoring this alongside further service improvements.

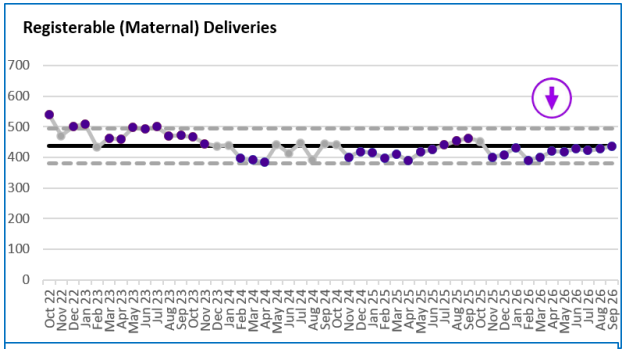
Complaints Subjects

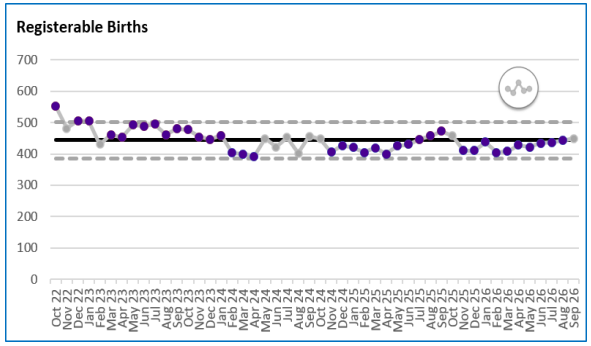
- Clinical treatment accounts for the most complaints collectively across the specialties with 40% of complaints opened this month (32). The top 3 relating to:
    - Accident & Emergency (A&E) 6 (8%)
    - Surgical 14 (20%)
    - Oncology/Obstetrics & Gynaecology/Paediatrics 3 (4%)

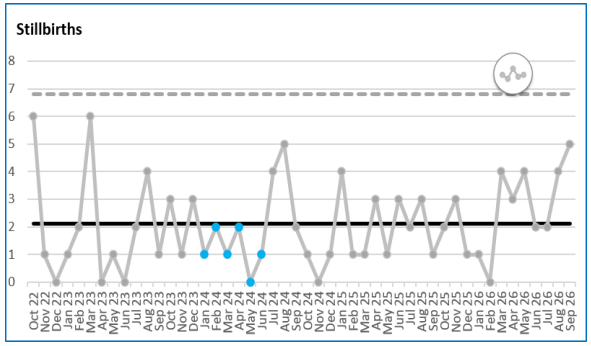
Outstanding Concerns

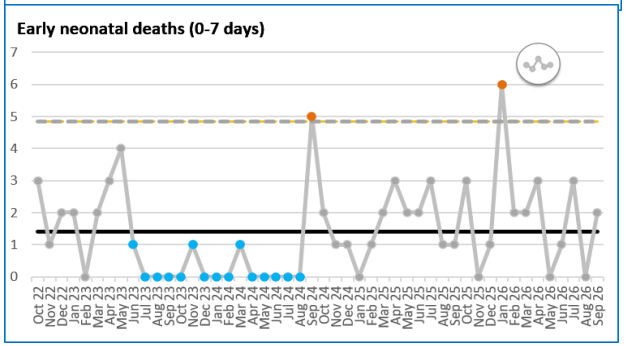
- Outstanding Concerns continue to fluctuate above and below the average, within the upper and lower limits. The upper limit was approached in March 26 and again more recently in July 26, however they are surrounded by lower monthly OSC numbers, with September 26 currently showing 0 OSCs; giving a monthly average of around 4 OSCs per month for the period.

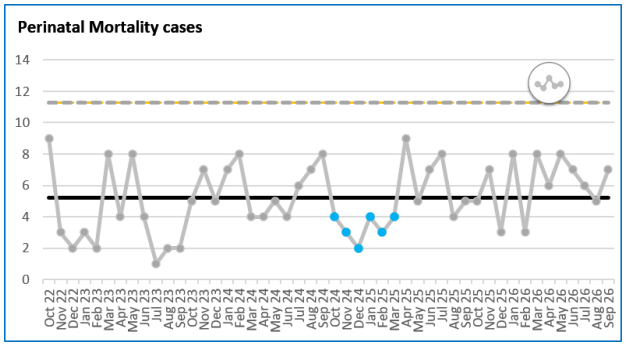
Perinatal Quality Oversight: Births











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.

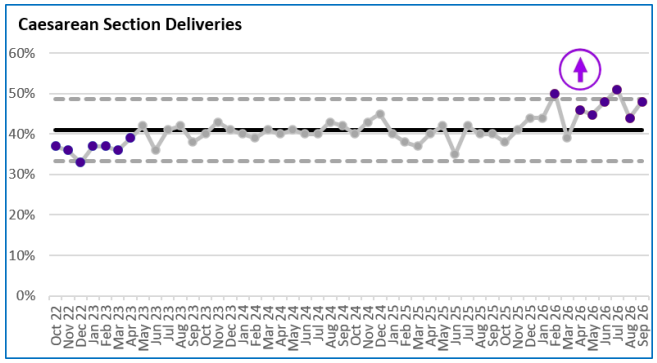
Stillbirths

- This data includes termination for fetal anomalies >24 weeks gestation. There were 5 stillbirths in September 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

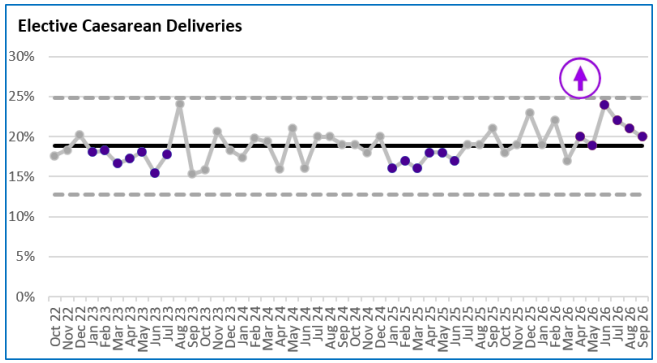
- The Trust has the highest level of neonatal intensive care provision supporting extremely premature babies. Early neonatal deaths are classified as death within 0-7 days of life (late neonatal deaths are those from 7-28 days). These deaths are reported to the Child Death Review panel who will have oversight of the investigation and review process. There were 2 early neonatal death in September 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



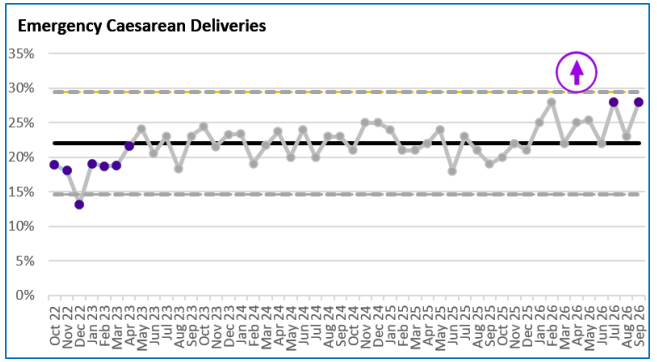
Caesarean section deliveries

- There is no defined national metric for caesarean section rates. The Trust had a caesarean section rate of 48% in September. 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

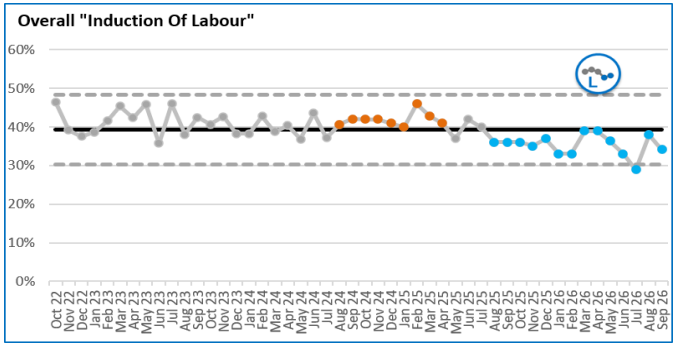
- The average England elective caesarean rate in Quarter 1 (Q1) 2026/27 was 21% and in NENC 21.2%.
- The Trust elective caesarean rate was 20% in September.
- The national rise in elective caesarean rates is partially due to an increasing proportion being undertaken due to maternal request in accordance 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

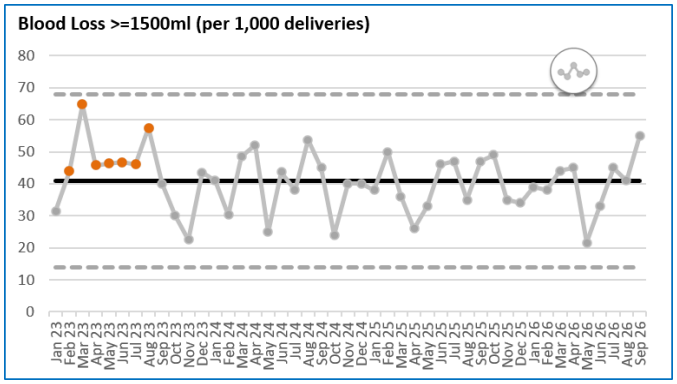
- The Trust emergency caesarean rate was 28% in September 2026. There is dedicated consultant presence on Labour Ward 8am-10pm daily, consultant led multi-disciplinary ward rounds occur twice daily. Most obstetric consultants remain onsite overnight, from 10pm-8am and are involved with all decisions 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



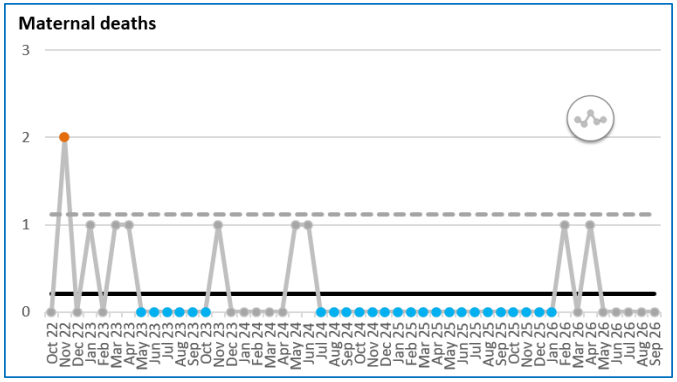
Induction of Labour

- 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 Royal College of Obstetricians and Gynaecologists (RCOG) guidance.
- England average for induction of labour (IOL) Q1 2026/27 was 28% and NENC 36.9%. The Trust induction of labour rate was 36.1% in Q1, with a rate of 34% in September 2026.
- There has been significant revision of the Trust IOL pathways following the national patient safety alert regarding the shortage of prostaglandins, cervical ripening balloons have been introduced with evaluation now underway.



Blood Loss ≥1500ml

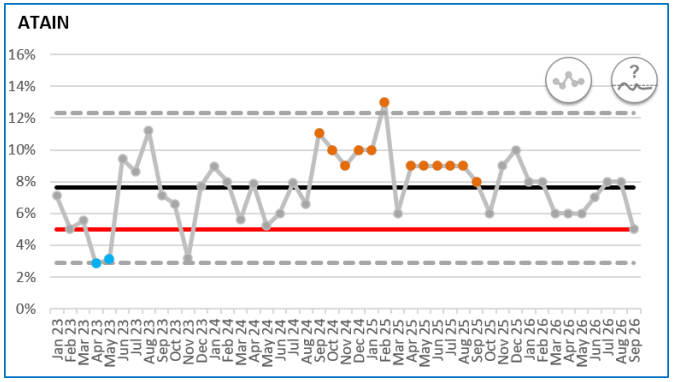
- The average Post Partum Haemorrhage (PPH) rate for Q1 2026/27 in England is 33 per 1000 and NENC average is 28 per 1000. The Trust PPH rate for September 2026 is 55 per 1000. Q1 average was 27 per 1000.
- Higher rates are indicative of the complexities of the high-risk patient group and provision of 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 have benchmarked 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.

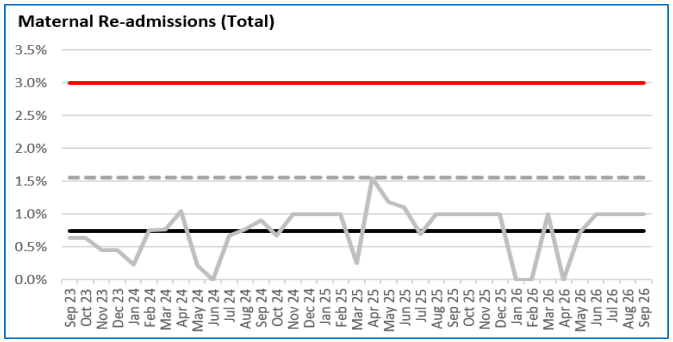


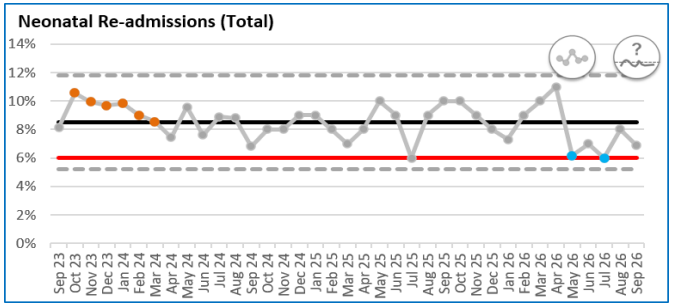
Maternal Deaths

- 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 September 2026.
- The regional maternity team have completed their thematic review of all maternal deaths across North East and Yorkshire between 2022-2024 and we await the outcome of the report.
- 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 has remained consistently above the national 5% target in recent years, however, was 5% in September 2026 and will continue to be monitored closely.

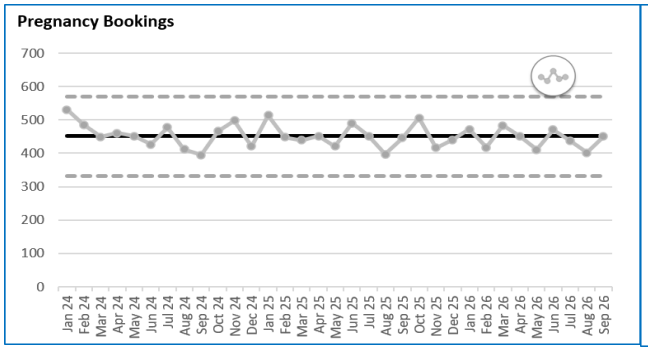
Maternal Readmissions

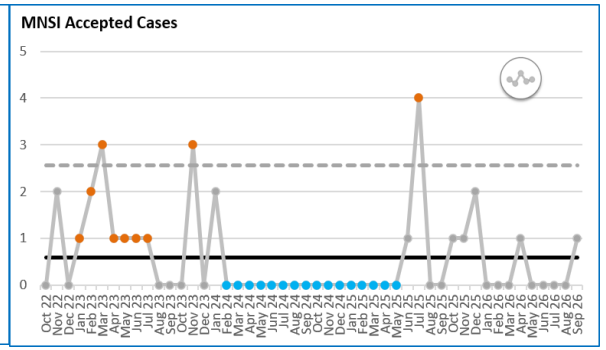
- National Maternity & Perinatal Audit (NMPA) Report (2025) the maternal postnatal readmission rate for England was 3.08% in 2023, rates varied by provider (Interquartile Range (IQR): 2.57–5.02% in Wales; 2.14–3.59% in England). The LMNS are benchmarking against the national mean readmission rate, hence 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, however the NMPA report flagged the Trust as an outlier and so work is underway to understand the considerable discrepancy between the internal data and the national report.

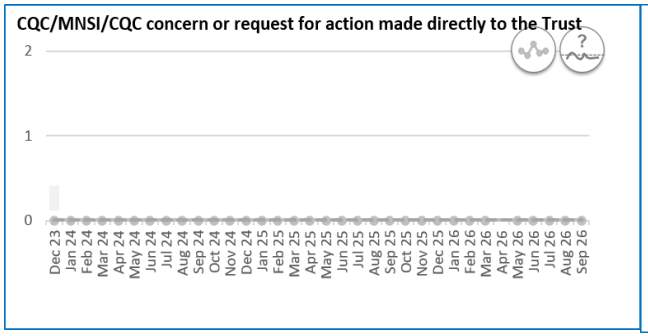
Neonatal Readmissions

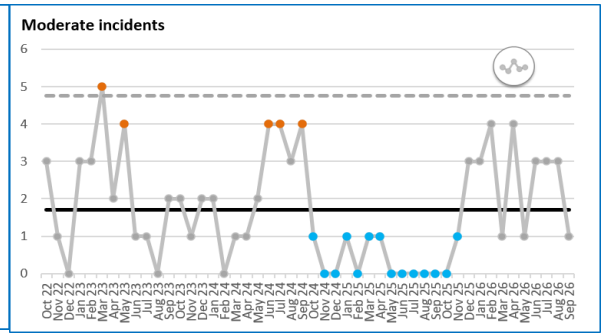
- The Clinical Quality Improvement Metrics (CQIM) for 'Babies readmitted to hospital who were under 30 days old' data is used as a comparison to Trust performance, hence the target of 6%.
- In September the readmission rate was 7%.
- A review of Q1 found 1299 babies were born within the Trust. 101 babies 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.

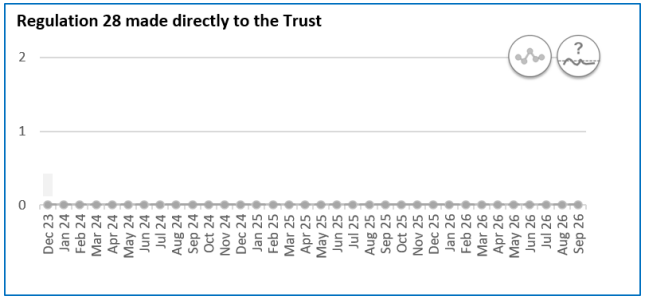
Perinatal Quality Oversight: Incidents & Bookings











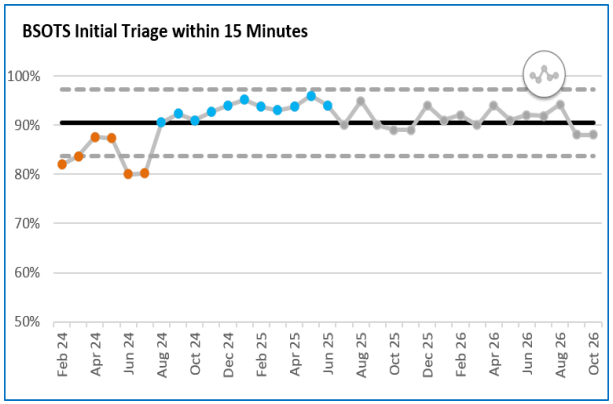
Pregnancy Bookings

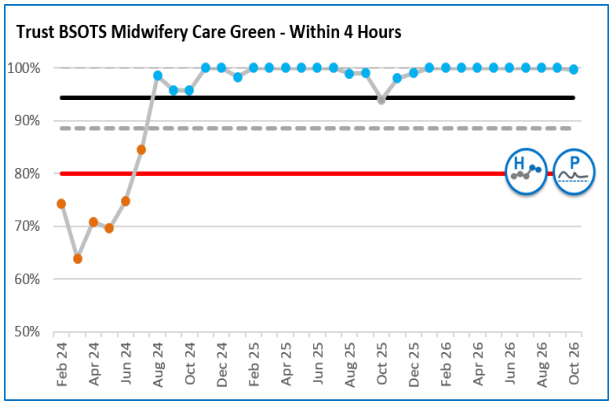
- The number of women choosing to book for care and delivery at the Trust had fallen since January 2024 and although is currently stable there has been no improvement in the number of bookings since the re-opening of the Birthing Centre. The number of bookings is a concern, and whilst reflects the reduced 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.

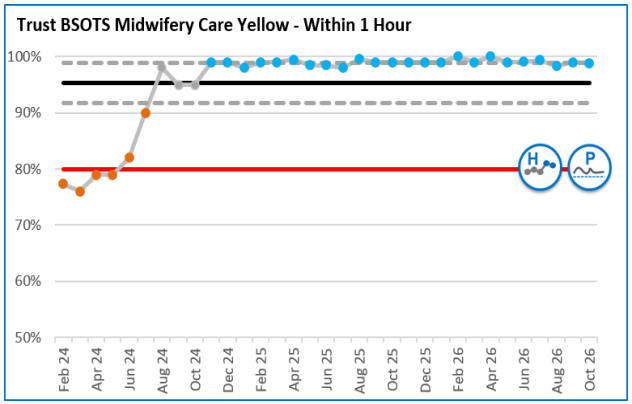
Incidents

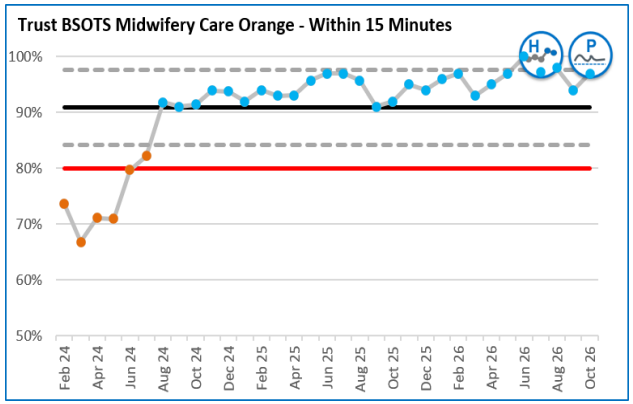
- Moderate incidents are now separated from externally reported MNSI cases which were previously grouped together. There was 1 moderate or above harm incident reported in September. Incidents are discussed at a multi disciplinary rapid review and presented to the Trust Response Action Review Meeting (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 September.
- There have been no regulation 28 notices in the last 12 months.

Perinatal Quality Oversight: Triage - Midwifery Care Timings





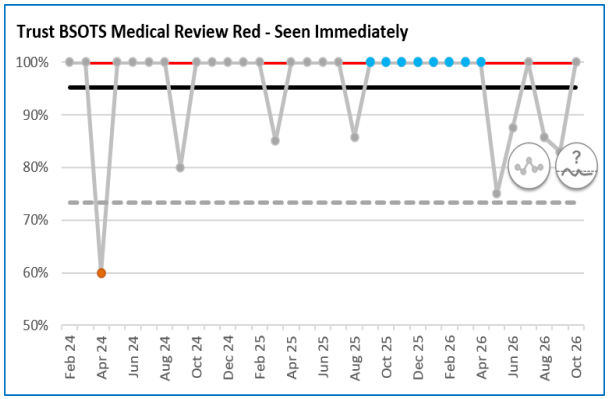


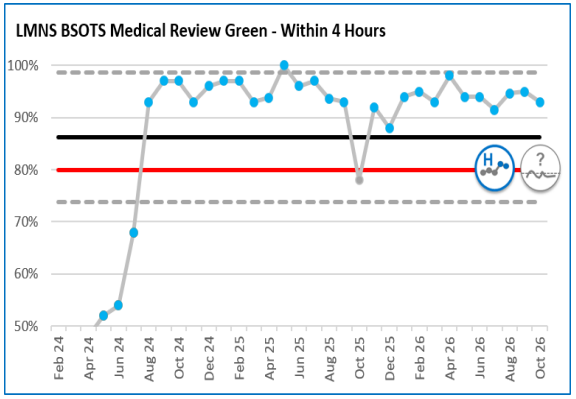


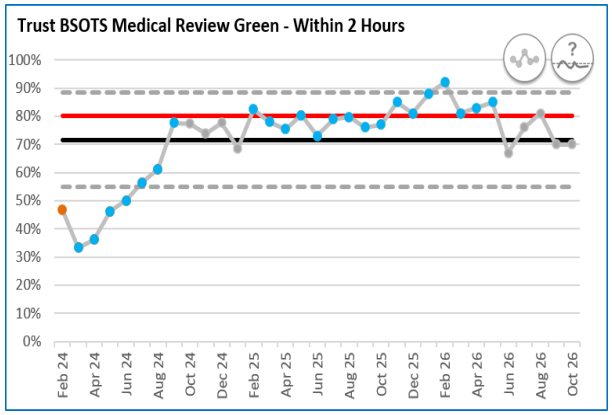
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

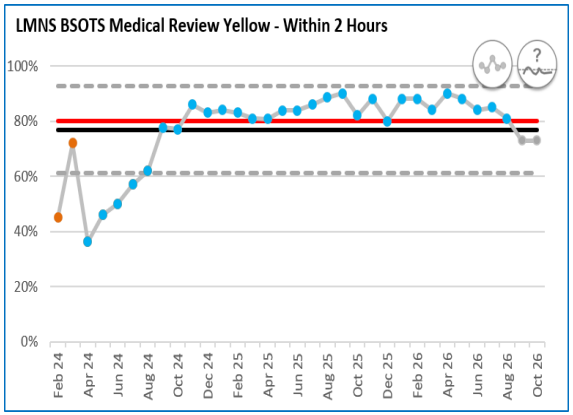
- The Trust implemented the BSOTS triage system in January 2024. Midwifery triage and subsequent review has improved considerably and has exceeded the Trust and LMNS target.
- Performance has deteriorated for initial triage, service leads are reviewing contributory factors and current actions to ensure improvement.
- 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





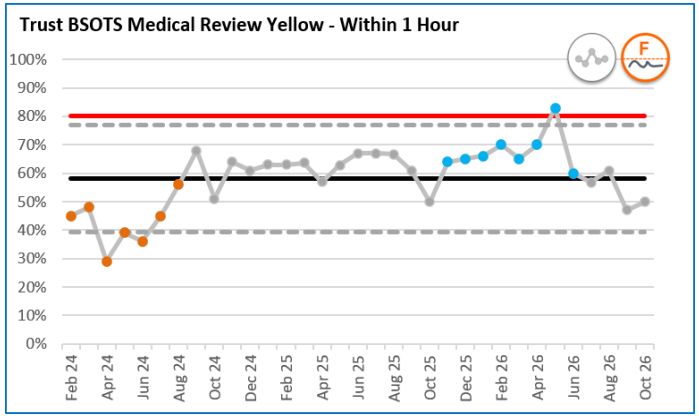


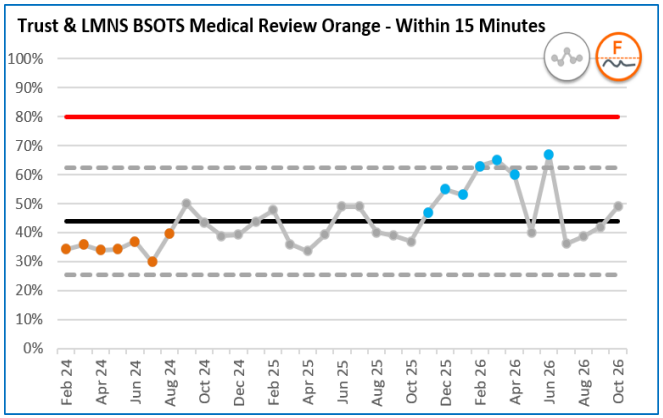


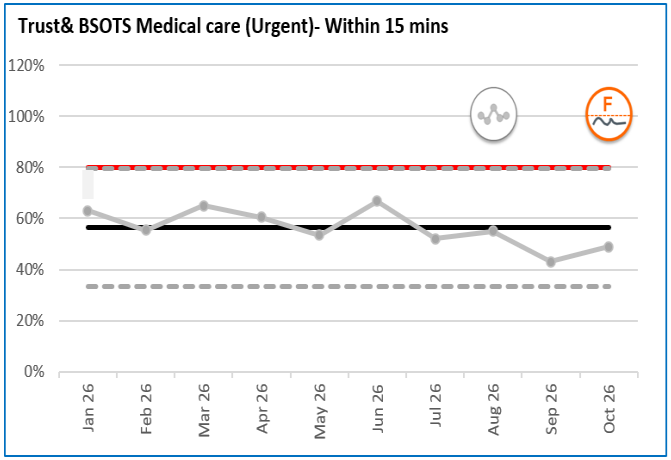
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

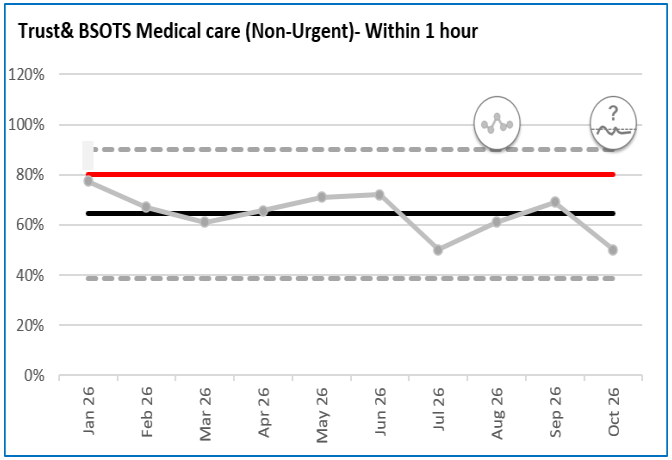
- The business case to commence call recording for the triage services has now been approved, timeframes for delivery by digital colleagues remains outstanding.
- The national BSOTS team recommend that women within the ‘orange’ category are further broken down into ‘urgent’ and ‘non-urgent’. The Trust can now access this data breakdown and reporting as per chart.
- 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: Triage - Medical Review Timings





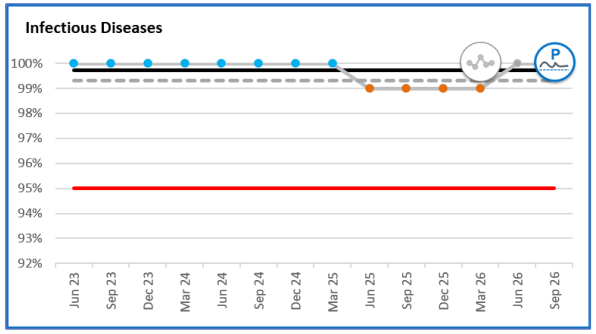


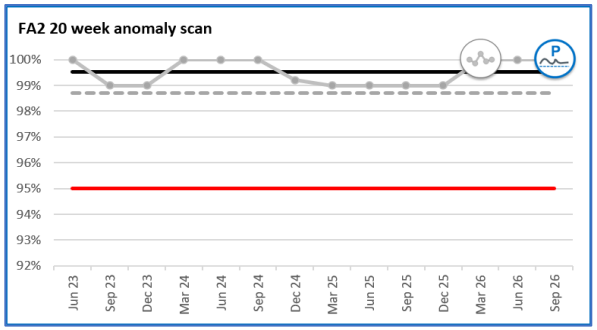


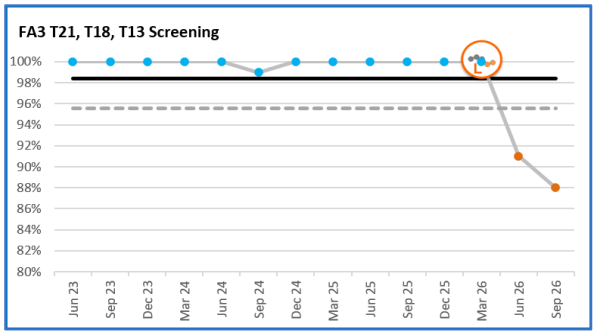
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

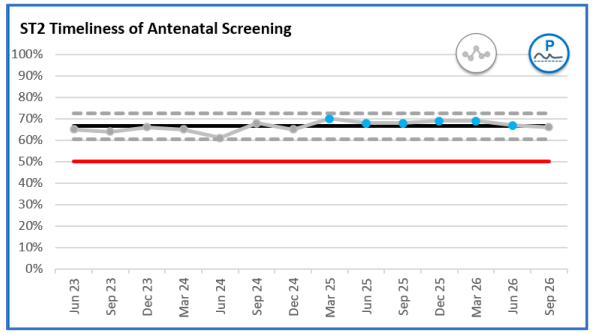
- There has been significant improvement in performance in the last 12 months.
- The national BSOTS team have recommended that women within the ‘orange’ category are further broken down into ‘urgent’ and ‘non-urgent’. Trust can now access this data breakdown and reporting as per chart. More data entries required to provide further analysis.
- The current estate, medical staffing and signage for the Triage services will need to be considered to achieve full compliance with the standards.

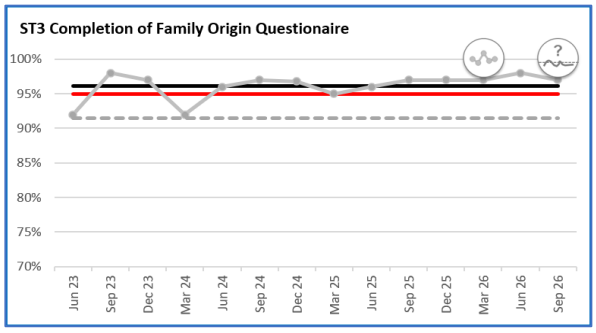
Perinatal Quality Oversight: Antenatal Screening

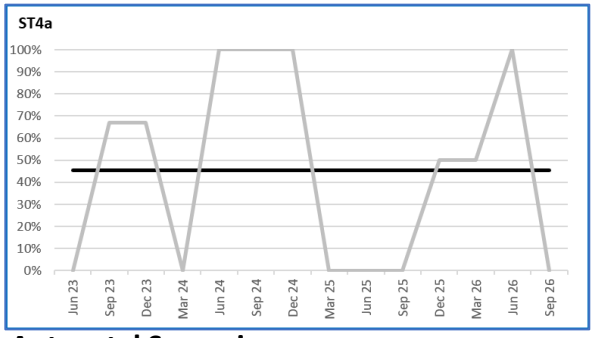


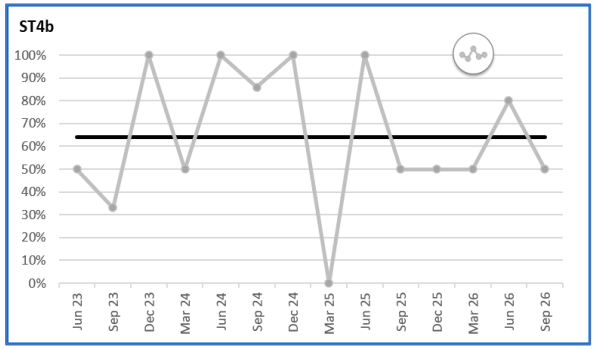


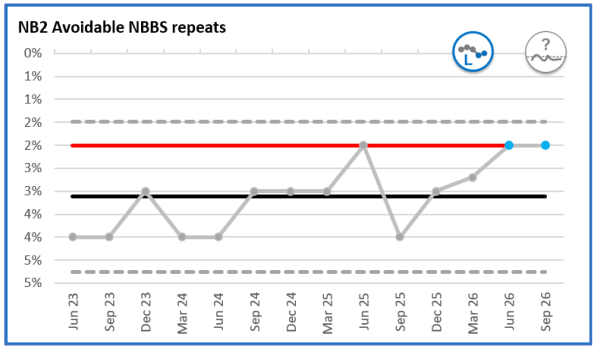








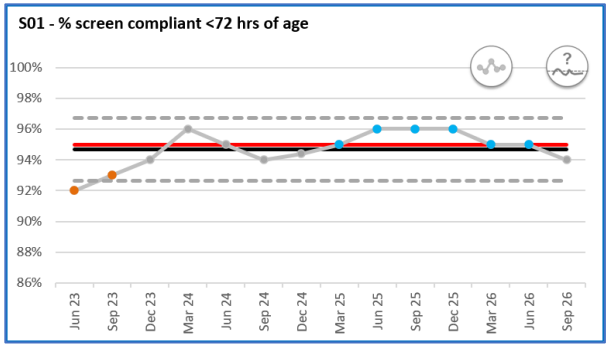


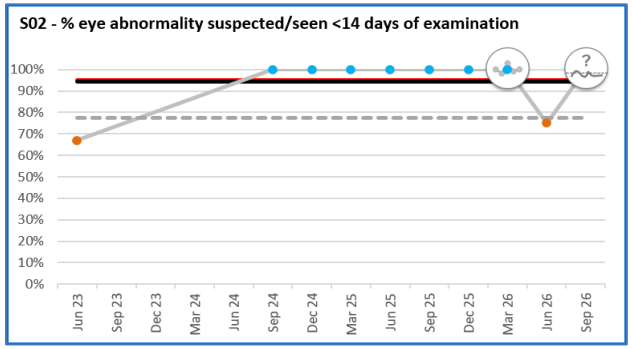


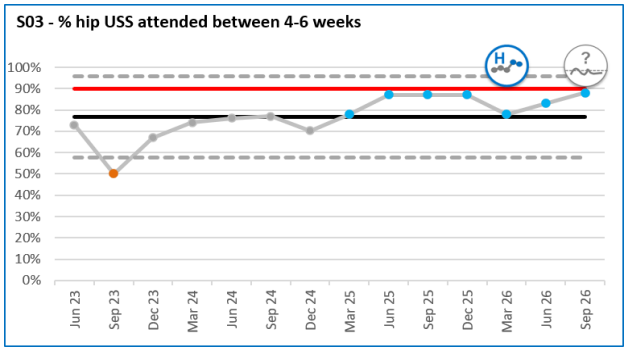
Antenatal Screening

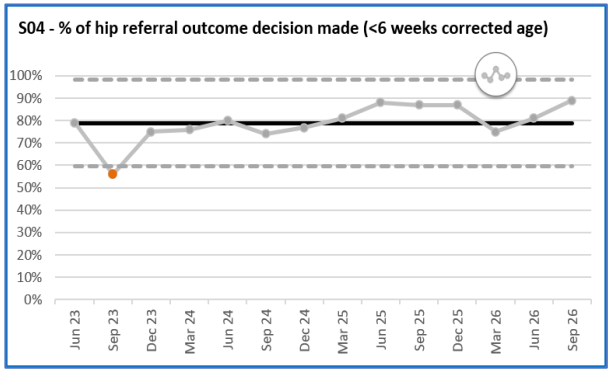
- A screening tracker has been developed by analysts and deployed to support failsafe processes and reporting.
- Focused action plan to reduce the number of avoidable repeats for the newborn blood spot sample to ensure improvements are sustained.
- The failsafe process for infectious diseases, sickle cell and thalassaemia, offered as part of booking bloods, is an area for improvement which should be addressed with digital solutions outstanding from a historical Patient Safety Incident Investigation (PSII).

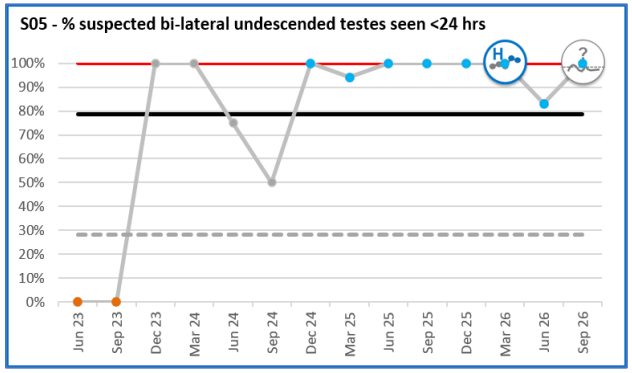
Perinatal Quality Oversight: Newborn and Infant Physical Screening Examination (NIPE) Screening







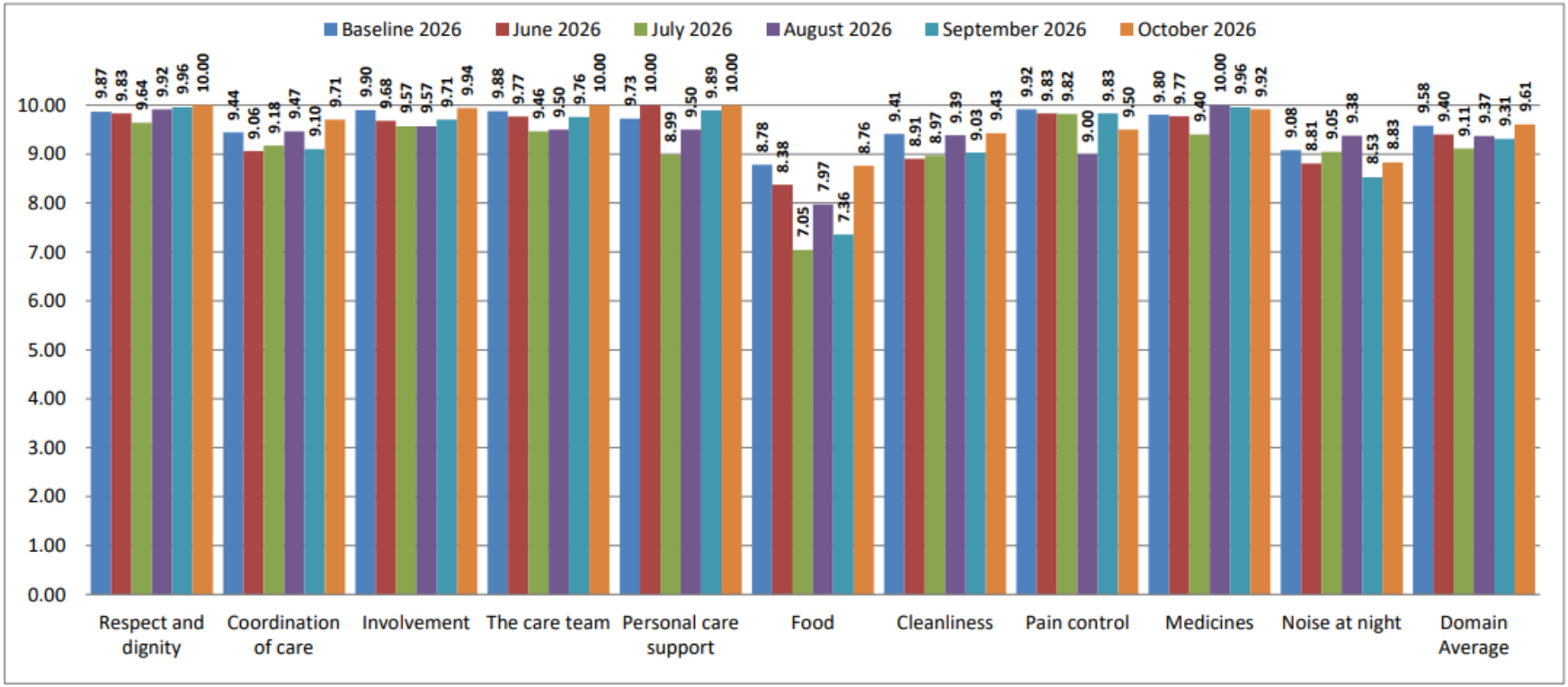




Newborn and Infant Physical Examination

- Whilst S01 is noted to be below the acceptable 95%, the 71 exceptions were all mitigated appropriately.
- 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 beginning to demonstrate an improvement to the Did Not Attend (DNA)/Was Not Brought (WNB) rate.

Perinatal Quality Oversight: Patient Experience



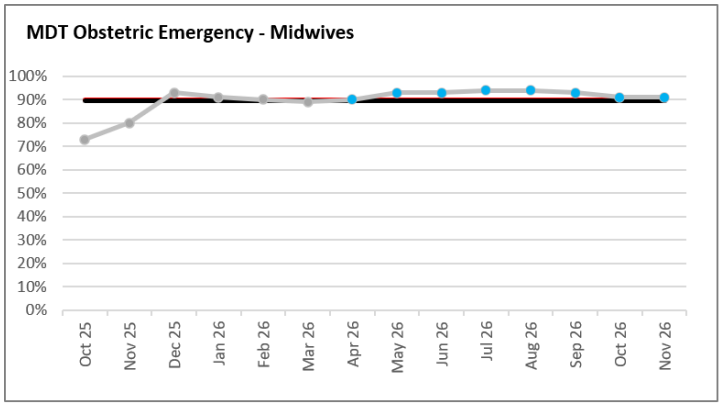
Patient perspective – Postnatal Ward 33

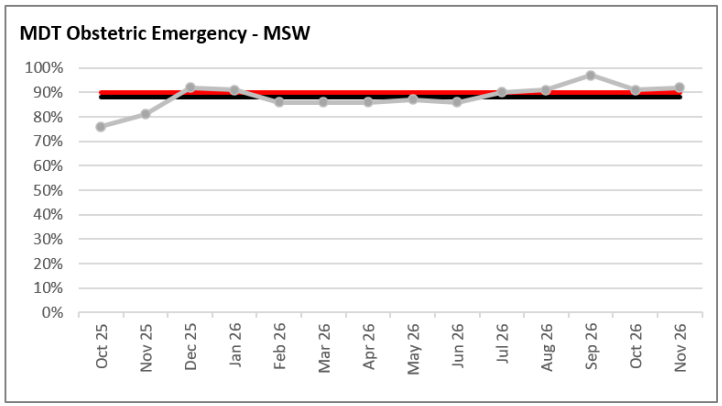
100 % of patients surveyed rated their overall experience on the ward as either good or very good. Feedback included:

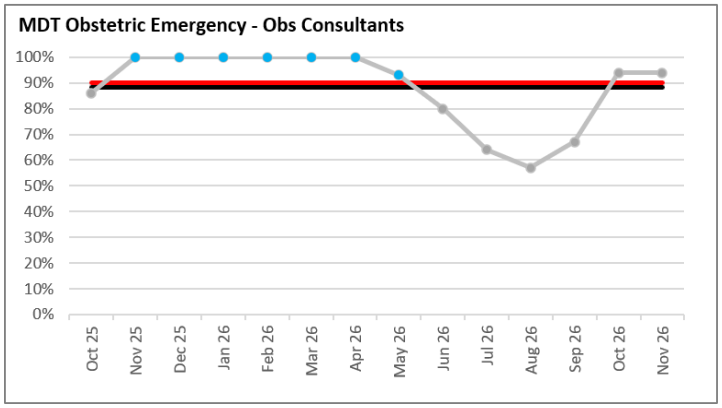
The staff work together very well. The handover yesterday was very thorough. I needed support for my baby latching on very frequently. The staff kept checking and asking, 'how are you managing?' They were really helpful. If you press the buzzer for support, they are very quick to respond. The food isn't our main type of food, it's ok, we eat Nigerian food. I had a cheese omelette yesterday which I really enjoyed. It was really nice. More seasoning would be nice though, the option to have salt as well. In terms of cleanliness, I need my sheets changing as they have blood on them but then I haven't asked. I've been asked several times about the level of pain I'm in and if I need medication. The light has bothered me in the corridor a little at night. Overall, I would say my experience on this ward has been 8.5/10.

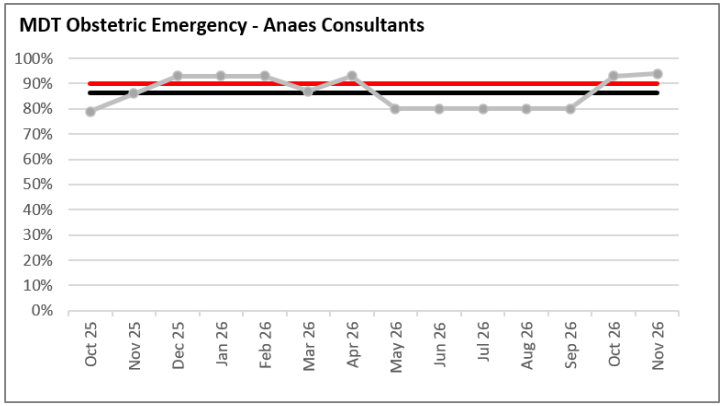
The perinatal service have engaged with the patient experience team and will trial a quarterly programme for the entire perinatal service in Q3.

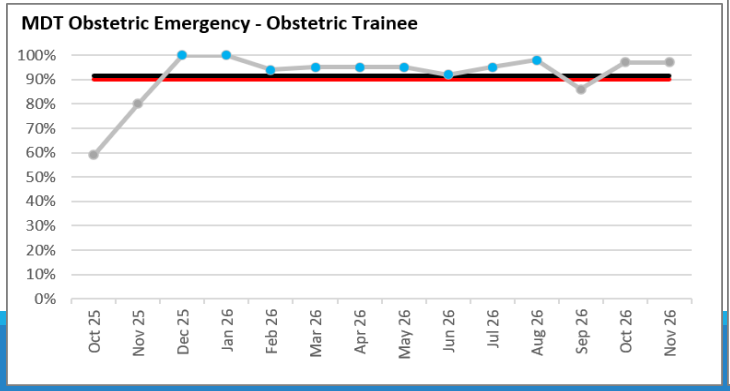
Perinatal Quality Oversight: Training (Maternity Incentive Scheme)

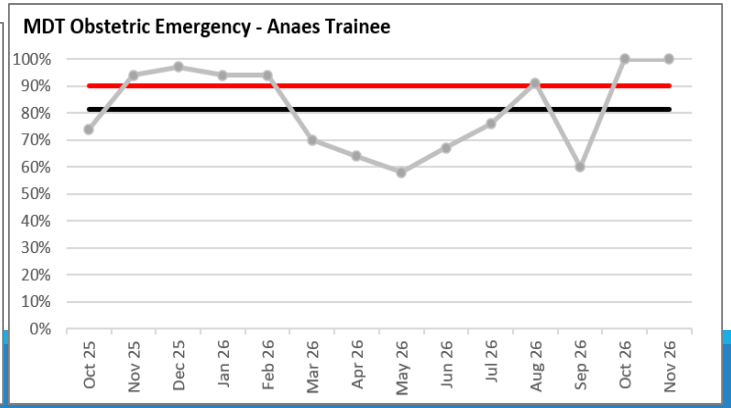












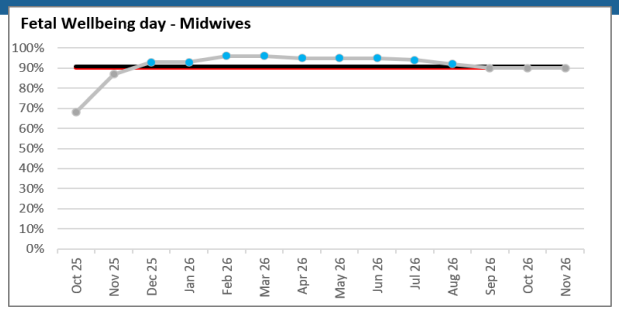
MIS Year 8 guidance has now been published, the Trust have scoped and planning has been completed against the updated requirements for safety action B (Training) which requires a minimum of 90% compliance (working toward expected trajectory of 100% compliance) for every required staff group at two points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

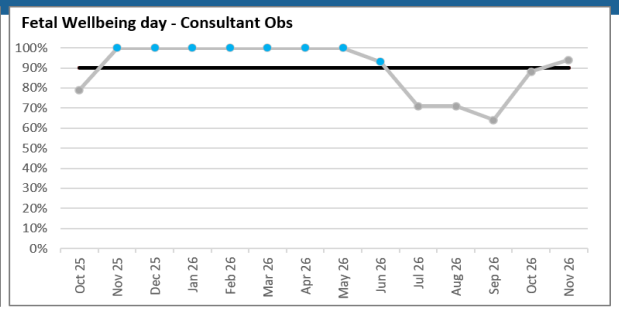
- Multi-professional maternity emergencies training
- Neonatal resuscitation training
- Fetal monitoring training

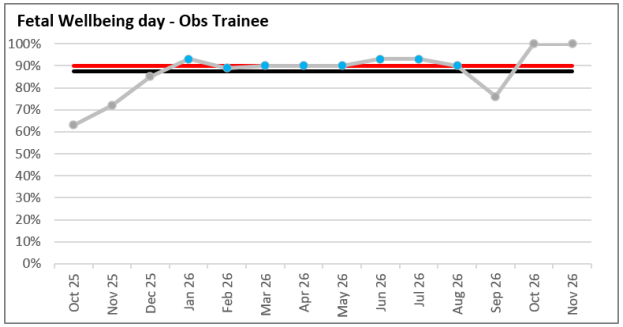
Due to the requirement to report above 90% compliance at 2 points in MIS year 8, charts have been changed to show a rolling monthly compliance to ensure detailed oversight of the % of compliance every month.

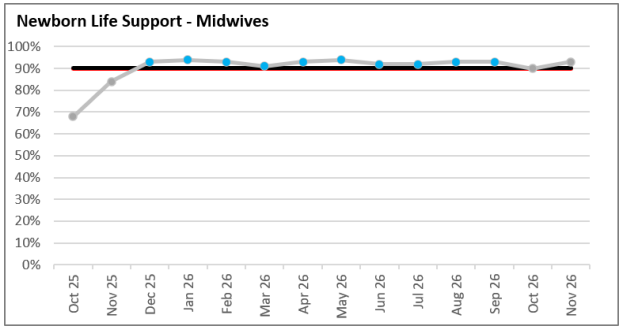
Obstetric Emergency Training by Staff Group:
Compliance above 90% for all staff groups.

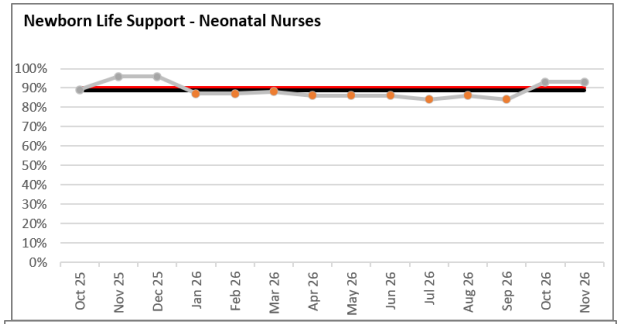
Perinatal Quality Oversight: Training (Maternity Incentive Scheme)

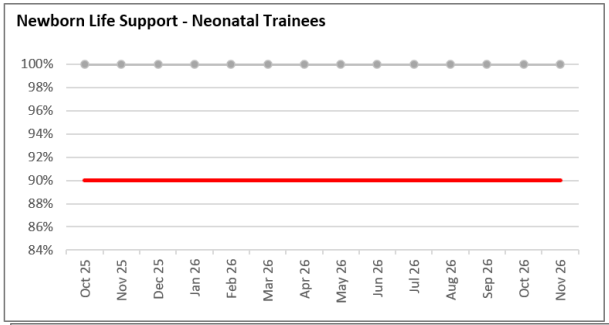


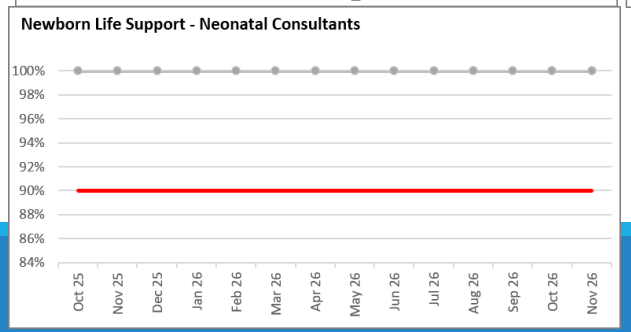


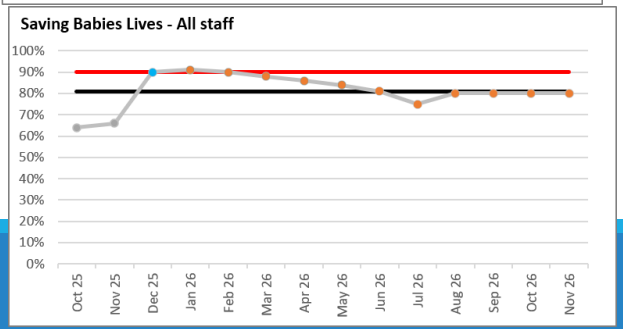










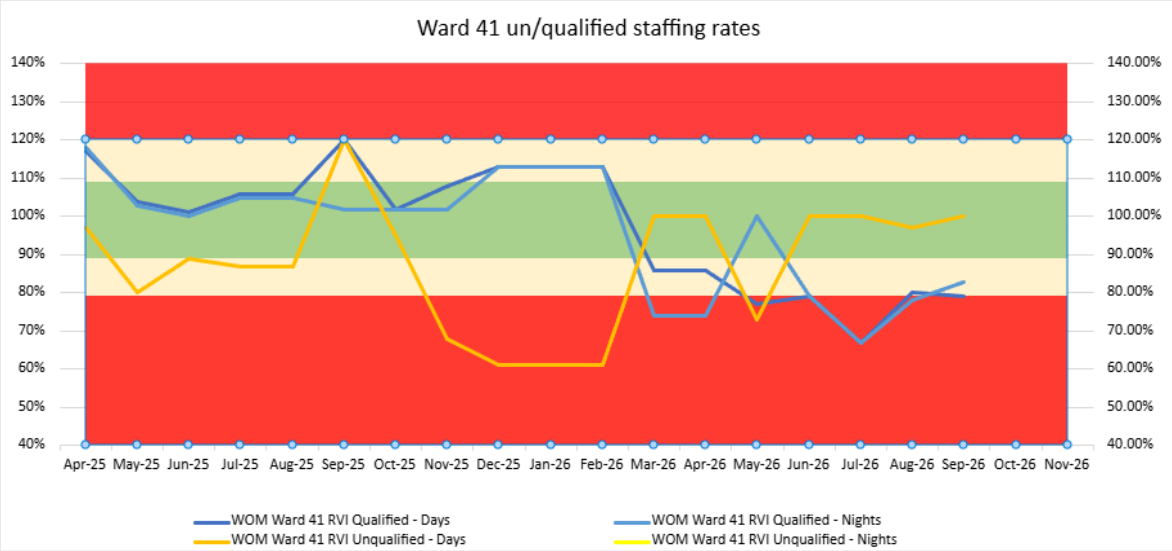


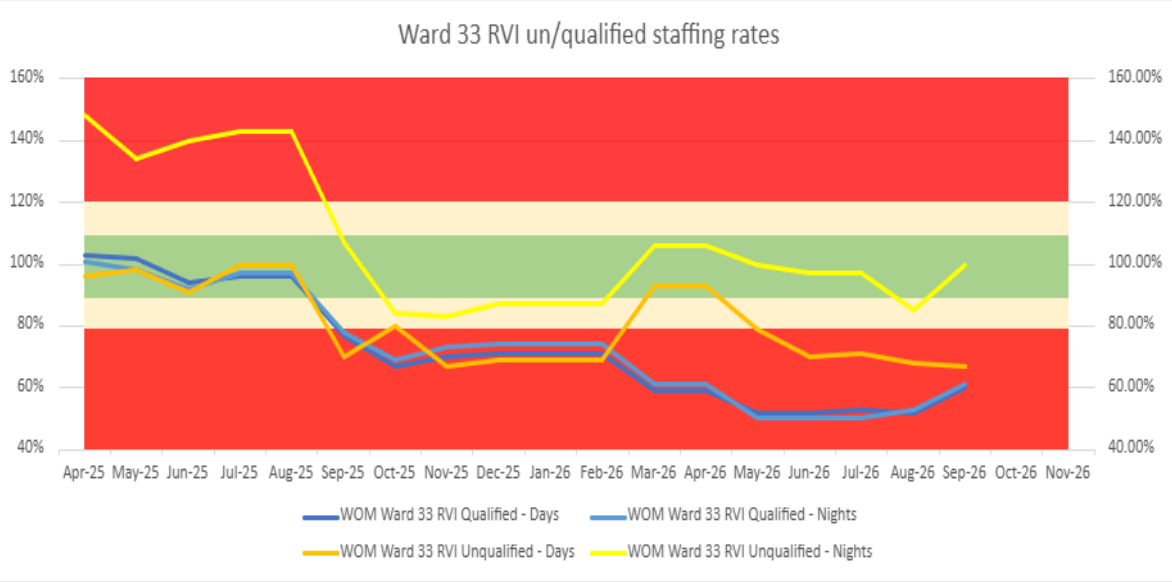
Fetal Wellbeing Training by Staff Group:
The Fetal Wellbeing training is essential training to ensure compliance with the implementation of the Saving Babies Lives Care Bundle version 3 (SBLCBv3) which aligns to the CNST/MIS.
Rolling monthly compliance for Midwives and Obstetric Trainees above 90%. Compliance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

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%. **90% compliance in all staff groups.**

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.
Audit requirement are that 90% of staff are trained between 1st Dec 2025 and 30th Nov 2026, plan to achieve this in place.

Perinatal Quality Oversight: Staffing fill rates





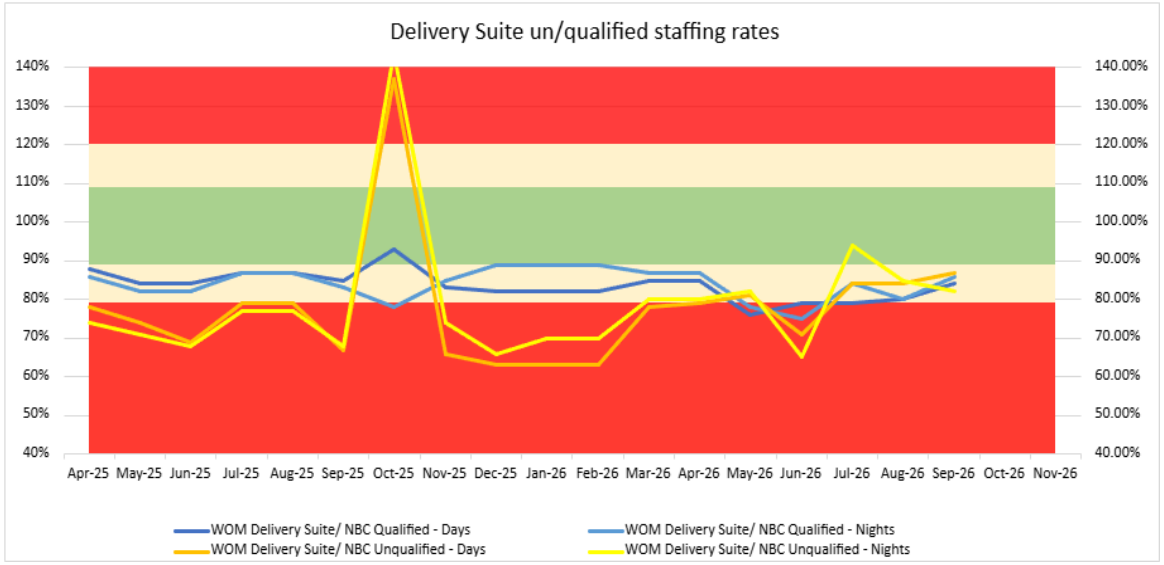
Antenatal Ward (41)

Birthrate Plus staffing templates for 3 qualified staff on nights are expected to go live in January 2027 following the recruitment undertaken in Summer 2026. The ward opened escalation beds in an additional bay on 13 occasions in September with midwifery fill rates exceeding the staffing establishment to maintain appropriate staff to patient ratios. The midwifery staffing escalation processes were enacted on each of these occasions to meet the needs of the service. There were 3 red flags in September 2026.

Postnatal Ward (33)

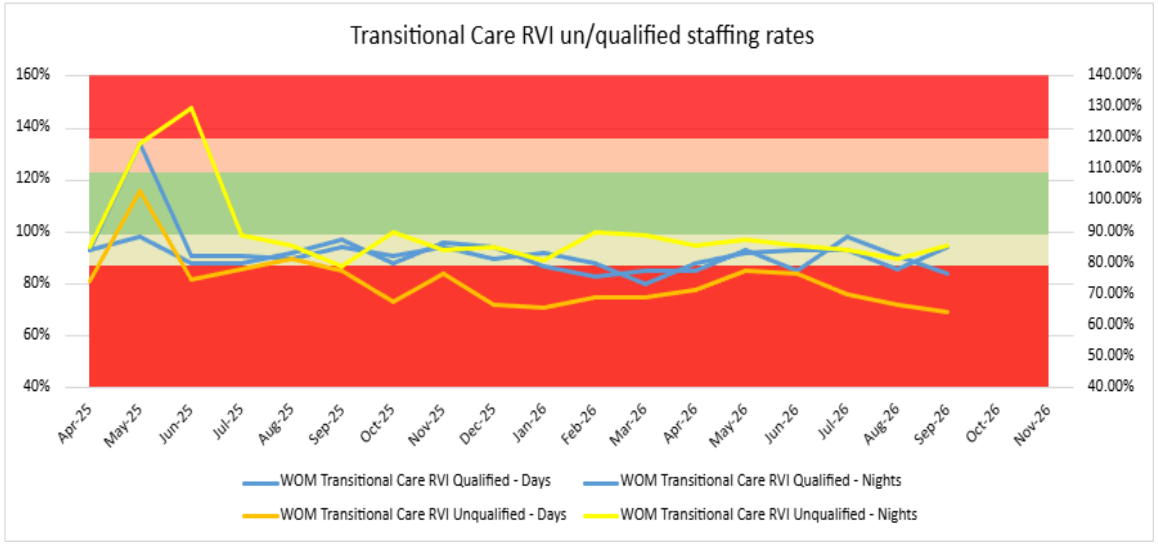
Since October 2025, the fill rate has been measured against Birthrate Plus with the postnatal establishment expected to achieve Birth Rate Plus in January 2027. In addition, due to the first phase of estates work within the perinatal department, postnatal patients have been decanted to the Newcastle 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. No red flags were reported in September 2026.

Perinatal Quality Oversight: Staffing fill rates



Intrapartum (Delivery Suite and Newcastle Birthing Centre)

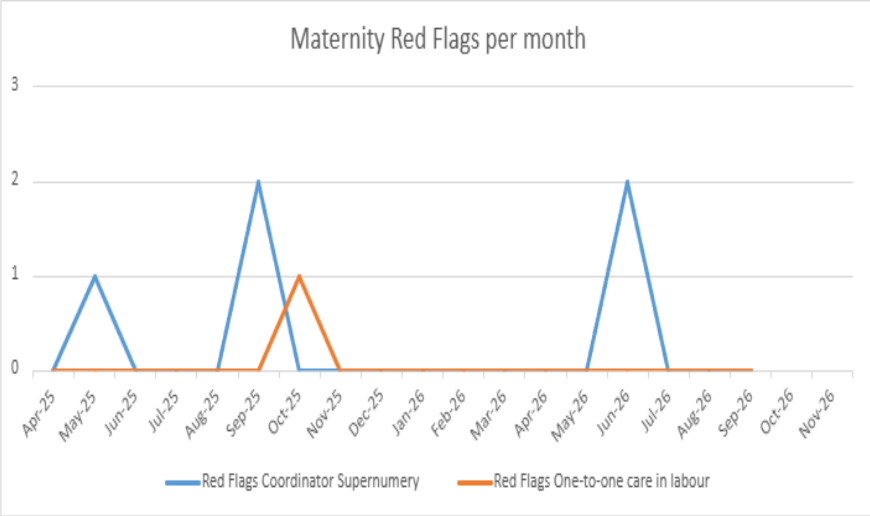
The midwifery fill rates for the intrapartum area remains stable despite the staffing position which is impacted by sickness and maternity leave. There were no red flags relating to the provision of one-to-one care in labour and no occasions when the co-ordinator was not supernumerary on Delivery Suite. The updated Allocate staffing template is now measuring fill rates against Birthrate Plus staffing recommendations for phase 3 templates.



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. No red flags reported for September.

Perinatal Quality Oversight: Operational Pressures Escalation Levels (OPEL)



NICE Red Flags

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

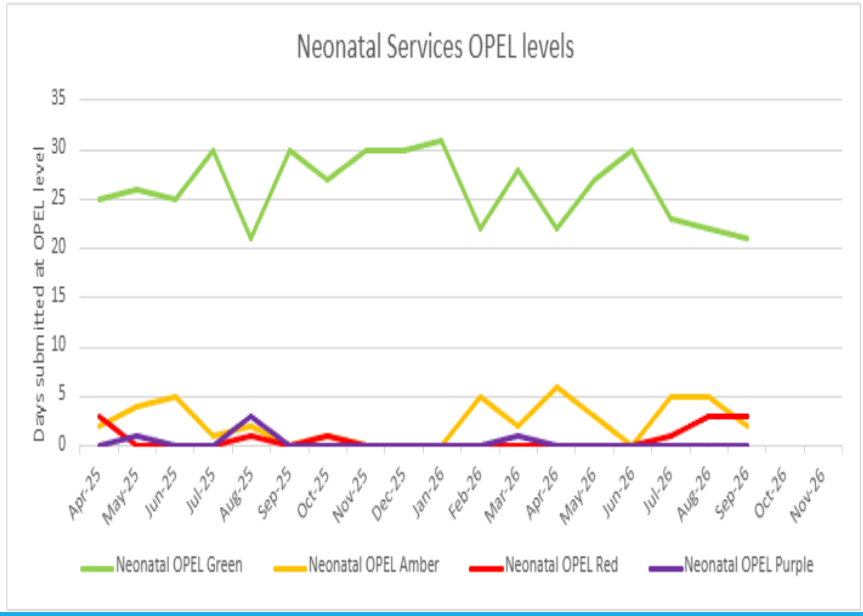
There were no occasions in September when one to one care in labour was not provided.

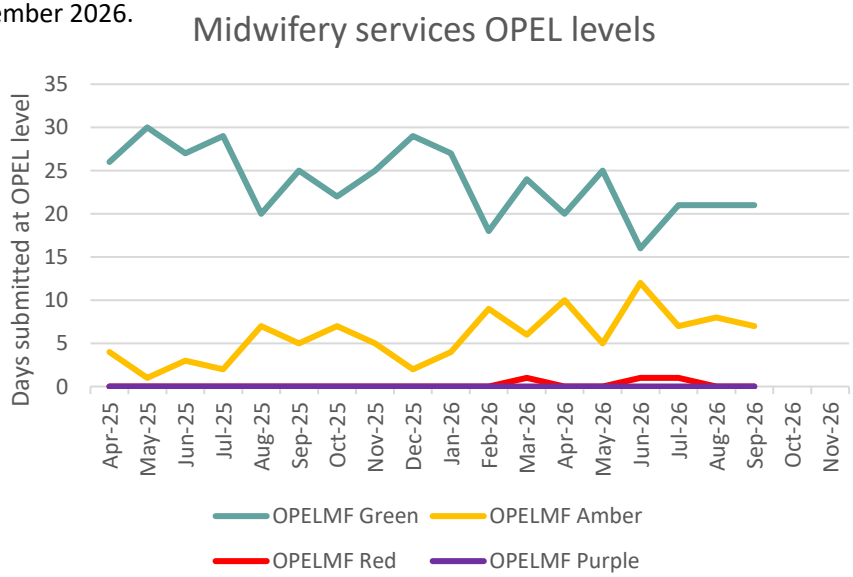
Operational Pressures Escalation Levels Maternity and Neonatal Framework

The neonatal service maintained Operational Pressures Escalation Level (OPEL) 1 for 21 days, OPEL 2 for 2 days and OPEL 3 for three days in September.

The maternity service maintained Operational Pressures Escalation Level (OPEL) 1 for 21 days in September and OPEL 2 for 7 days. There were no community escalations to support the acute service.

There was one occasion with obstetric absence for the Delivery Suite during September 2026.





Performance

Performance Overview

Metric	Period	Actual	Traj.	Target (by Mar-27)	Variation	Assurance
A&E Arrival to Admission / Discharge	Sep-26	76.1%	80.9%	82%		F
RTT 18 Weeks	Sep-26	72.6%	76.9%	81.1%	H	F
>52 Week Waiters	Sep-26	767	337	0	L	F
Cancer 28 Day FDS	Sep-26	82.8%	71.0%	80%	H	?
Cancer 31 Day	Sep-26	64.3%	90.6%	94%	L	F
Cancer 62 Day	Sep-26	61.5%	74.8%	80%		F
Diagnostic 6 Weeks	Sep-26	25.4%	12.9%	2.1%		F



Emergency Care

- Emergency Department (ED) Performance (All Types) in September was 76.10%, a decrease of 0.91% compared to August (77.01%). ED attendances increased in September to 24,728, 2,181 patients more than August.
- There were 557 ambulance handovers > 45 mins in September, this was an increase of 333 from August (224).

Elective Waits

- Referral To Treatment (RTT) 18-week compliance remained static at 72.6% in September.
- The waiting list increased to 88,160 (+48). 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.

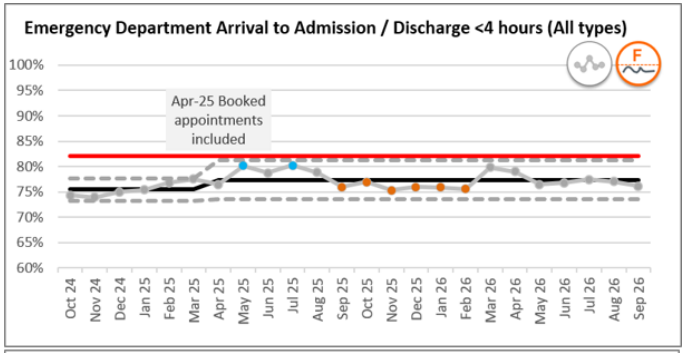
Cancer Care

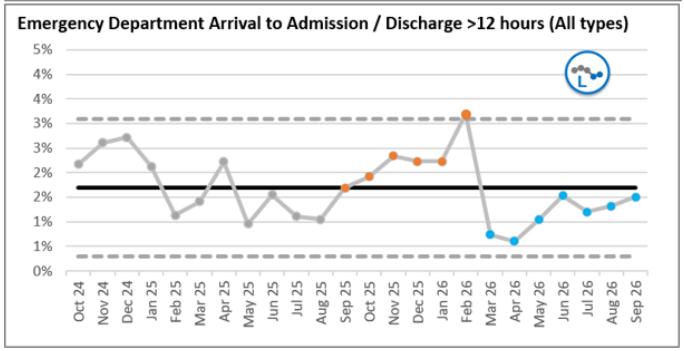
- In September, the 80% 28 Faster Diagnosis Standard (FDS) target was achieved, performance was 82.8%, a slight decrease from previous month of August (-1.2%). The 31-day performance has further declined to 64.3% (-8.1% compared to August), whilst the 62-day performance declined to 61.5% now demonstrating common cause variation.

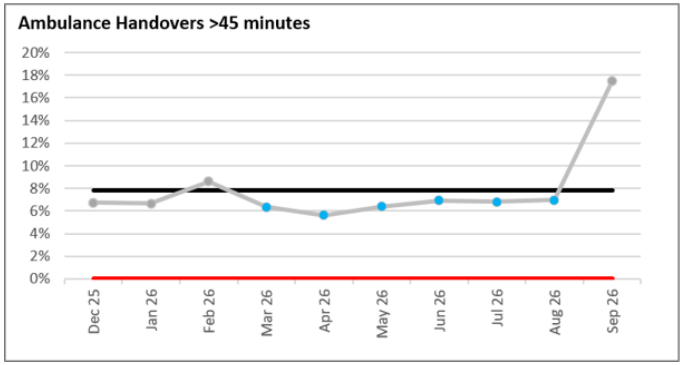
Diagnostics

- Performance against the 5% standard deteriorated in September, with **25.4% of patients waiting more than six weeks**. Three modalities were compliant in September, compared with two in August. Whilst the standard continues to be missed, overall 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.
- Higher % of patients admitted, discharged and transferred from ED within 12 hours across 2026/27 compared to 2025/26.

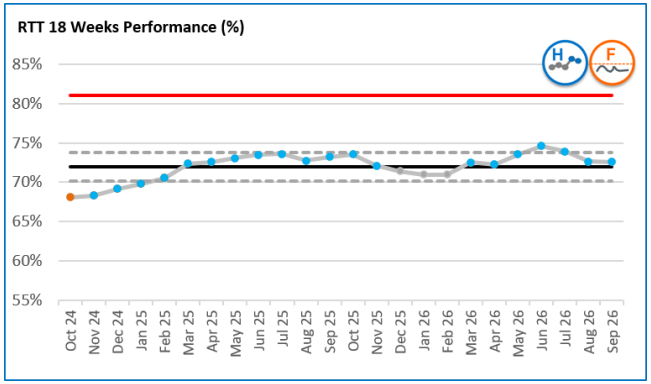
Current position

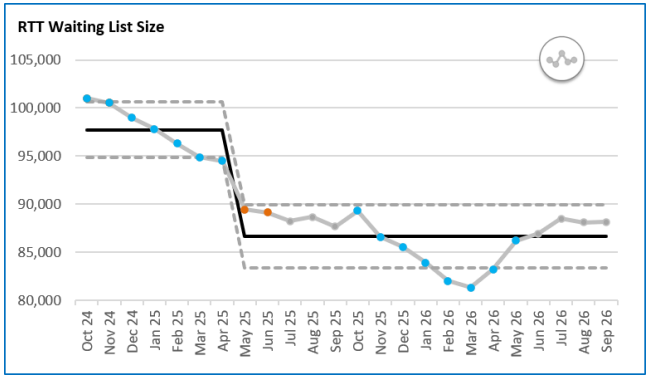
- ED Performance (All Types) in September was 76.10%, a decrease of 0.91% compared to August (77.01%). ED attendances increased in September to 24,728, 2,181 patients more than August. Type 1 adult attendances increased from 9,198 in August to 9,565 in September, 367 higher, but remained significantly higher than in previous years (September '25, 7,768). Paediatric Type 1 4hr performance for September was 81.72%, a decrease of 6.22% from August.
- ED Trolley waits >12 hours increased from 16 in August to 17 in September.
- ED Arrival to Admission / Discharge > 12 hours (All Types) in September was 1.54%, this was higher compared to 1.32% in August.
- There were 557 ambulance handovers > 45 mins in September, this was an increase of 333 from August (224). Of those handovers, September had 281 handovers >60mins, down from 76 handovers >60mins in August.

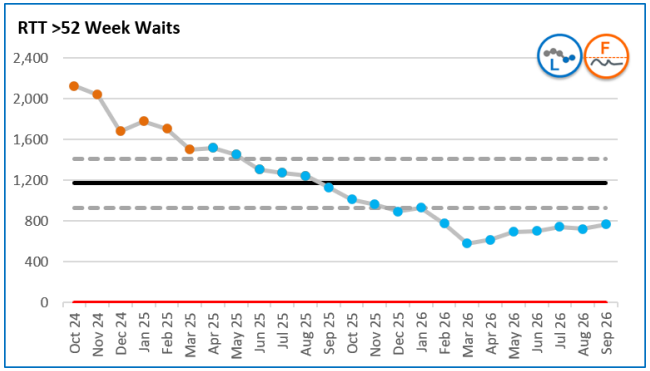
Action taken

- The Great North Children's Hospital Perfect week ran w/c 28th September. After the GNCH Perfect week, the 16:00 Bed Management meeting will stay in place and broaden attendance where possible. This has improved communication, planning and operational oversight at the end of the day for Sisters, Patient Safety Coordinators and Matrons.
- The service is increasing the number of Nurses in the department through recruitment and reducing the amount of front-loaded assessments. This will release ambulance crews quicker and reduce the average handover time.
- The Trust has been offered a review by Get It Right First Time to provide a facilitated and real-time review in line with Model Discharge Pathways. This provides focus on 1) in-hospital discharge planning and delivery 2) daily ward-based practices within the control of hospital teams and 3) standardising basic processes to reduce variation. This will commence initially in Older Peoples' Medicine Wards and be led by Community Services.
- A task and finish group has been started to review and drive forward the requirement to deliver a digital solution for the Trust, this is being led by Patient Flow.

Elective Waits







Standards

- 81.1% of patients on incomplete Referral to Treatment (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.

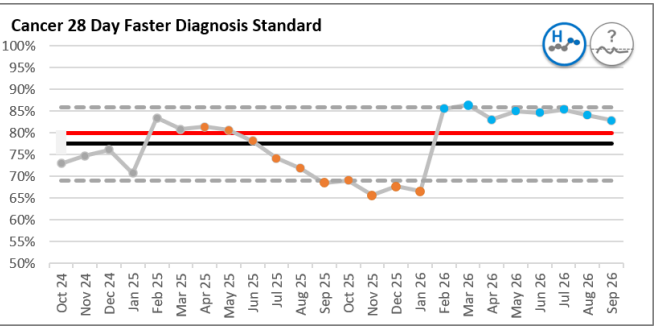
Current position

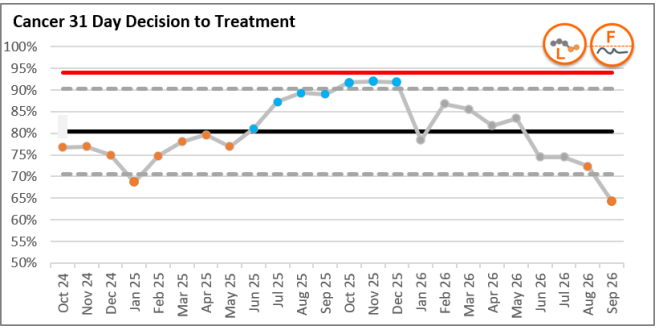
- RTT 18-week compliance remained static at 72.6% in September, whilst the total waiting list increased to 88,160 (+48).
- Trust under-performance against these metrics is being driven by under delivery against the 26/27 activity plan in key specialties and points of delivery. At the end of September, New Outpatient (NOP) delivery was at 91.9% of plan for the year to date, and 5.4% below outturn.
- In addition to under delivery of activity, specialty challenges are impacting 18-week performance.
- Dermatology has capacity challenges due to changes in job planned activity over the past six months, with a drop of 14.5 clinical PAs. Dermatology RTT performance in September was 66.3%.
- Restorative Dentistry performance was 44.7% in September. The service has insufficient capacity to meet demand due to vacant consultant posts.
- Pain Management performance was 38.6% in September. Challenges include capacity, a 10% Did Not Attend (DNA) rate and out of area referrals.
- 52 week waits increased to 767 (+45) due to capacity challenges in key specialties.
- Cardiology - Long waits for Left Atrial Appendage Occlusion (LAAO) – Compounded by a skills match issue where only one consultant can provide this procedure.
- Spinal Orthopaedics- The Adult Deformity service has significant capacity constraints.

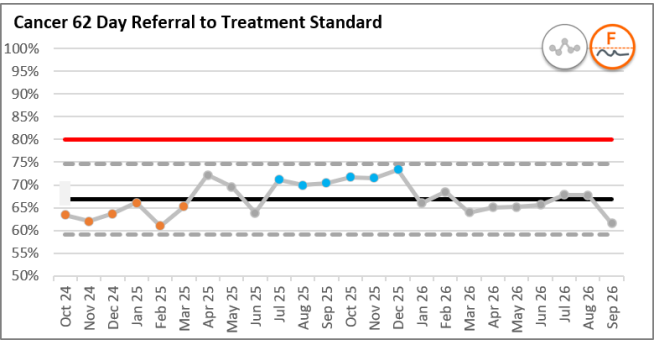
Action taken

- Dermatology are exploring support from Plastic Surgery for the Basal Cell Carcinoma (BCC) pathway, with a potential 10% 18-week performance improvement by March 2027 if agreed.
- Restorative Dentistry have successfully recruited new consultants; with the expectation this will improve 18-week performance by 5% in three months and 10% in six months.
- Pain Management have introduced partial booking to address high reschedule rates and DNAs. The service's 18-week trajectory aims to increase performance by 12% by March 2027.
- Progress is already being made with the LAAO patient cohort in Cardiology, with the service on track to clear 65-week LAAO waits by the end of November, and 52-week waits by March 2027.
- Additional lists have been put on for Spinal Adult Deformity patients, and the service is working on an engagement piece with their consultants to address their long wait challenges.

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).

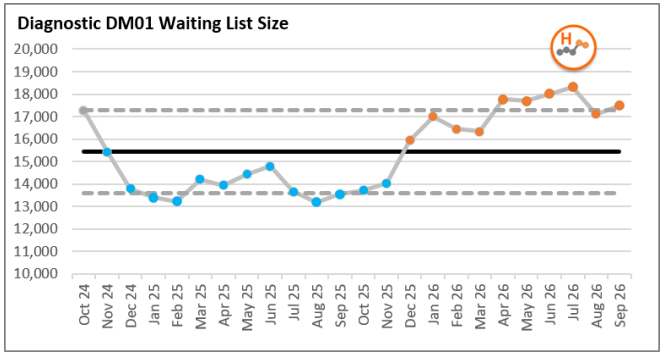
Current position

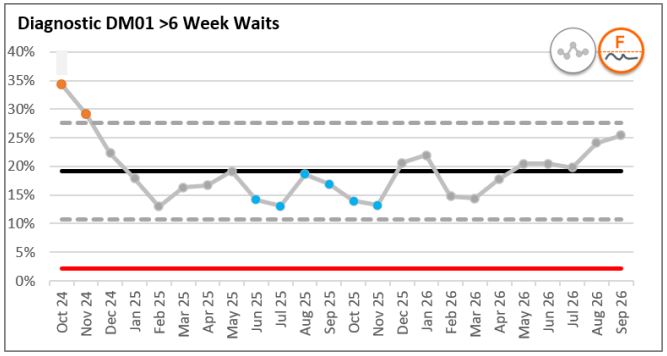
- In September, the 80% 28 FDS target was achieved, performance was 82.8%, a slight decrease from previous month of August (-1.2%). The 31-day performance has further declined to 64.3% (-8.1% compared to August), whilst the 62-day performance declined to 61.5% now demonstrating common cause variation.
- FDS performance remains above target and trajectory in September, mainly driven by the consistent improved performance in the Skin Cancer pathway.
- Cancer 31-day performance remains heavily impacted by Radiotherapy workforce pressures. Performance in September for Radiotherapy was at 33.7%.
- Lung, Upper GI, Lower GI and Urology Cancer pathways are all impacting on the decline in 62-day performance for September.

Action Taken

- Targeted work continues to reduce the >62-day treatment backlog, focusing on Lung, Upper GI, Urology and Lower GI pathways. Cancer Services is reviewing and strengthening tracking and escalation processes across tumour groups.
- Radiotherapy – aim to launch a dedicated national recruitment campaign for therapeutic radiographers, executive support for over recruitment of band 5 & 6 radiographers, continuous review of clinical prioritisation and pilot of new training programme to reduce time to completion of radiographer competencies.
- Lung – Partial referral pooling for Thoracic Surgery has now been agreed. Additional lung SABR lists taking place at the start of November.
- Breast - Ongoing collaboration with Northern Cancer Alliance (NCA) and Integrated Care Board (ICB) to improve regional services while supporting Durham. Increase in Cancer Waiting Time (CWT) performance observed in October, but referrals have risen again and are expected to impact November's performance.
- Urology - A task and finish group is being established to improve prostate cancer pathways following a decline in CWT performance.
- Endoscopy/HPB - Endoscopy surveillance capacity is being switched to cancer capacity to reduce times to diagnosis and treatment.

Diagnostics





6 Week Diagnostic Performance by Modality – September 2026			
MRI	17.5%	CT	4.5%
Non-obs US	0.2%	DEXA	2.3%
Audiology	36.8%	ECHO	61.5%
Electrophysiology	52.2%	Neurophysiology	24.4%
Sleep Studies	37.0%	Urodynamics	36.8%
Colonoscopy	40.4%	Flexi-Sig	40.2%
Cystoscopy	25.0%	Gastroscopy	35.9%
Newcastle Hospitals Total			**25.4%**

Standards

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

Current position

- Performance against the 5% standard deteriorated in September, with **25.4% of patients waiting more than six weeks**. Three modalities were compliant in September, compared with two in August. Whilst the standard continues to be missed, overall performance remains within common cause variation.
- **MRI** performance improved to **17.5%** in September (+6.7%). Key challenges remain around portering capacity and prolonged waits for general anaesthetic MRI examinations.
- **Echocardiogram (ECHO)** performance deteriorated further to **61.5%** in September (-5.2%). There has been a significant increase in patients waiting more than 13 weeks, rising to approximately 1,200 patients (+966 since June 2026). The service has raised concerns that this may be attributable to a data quality issue and is undertaking further validation.
- **Audiology** performance declined further to **36.8%**. The service has experienced several vacancies over the summer period, alongside high levels of staff sickness absence, which continue to adversely impact capacity and performance.

Action taken

- Within **MRI**, the extension of the mobile MRI unit until March 2027 has begun to reduce waiting list backlogs and improve performance. In addition, the new MRI scanner remains on track for completion by January 2027. Further work within the **MRI Improvement Plan** will focus on the general anaesthetic, pacemaker and cardiac MRI pathways, where long waits continue to affect the DM01 trajectory.
- Within **ECHO**, recruitment activity has been successful, with three Physiologists appointed following interviews held in October. Additional posts are planned for advertisement in November 2026. The service is also undertaking a comprehensive review of waiting list data, working closely with IT colleagues to improve data quality and assurance. Current indications suggest the reported waiting list may have been inflated following a digital process change, and this is being actively investigated.
- The **Audiology Improvement Programme** is focusing on the use of insourcing and bank staff to increase short-term DM01 capacity while the service progresses recruitment to its funded establishment.
- As part of the **Endoscopy Recovery Plan,** a request for mutual aid from Northumbria FT has been extended, with the ask to utilise some of their available Endoscopy capacity to reduce our waiting list backlogs. Implementation of the Nurse Endoscopist backfill protocol has commenced to improve list utilisation. The service is also exploring weekend waiting list initiatives, alongside recruitment, workforce development and the restoration of routine use of an additional procedure room to increase capacity and support backlog reduction.

Contractual & Planning Standards (1/2)

Theme	Standard	Trajectory	Jun-26	Jul-26	Aug-26	Sep-26	Num.	Den.	26/27 YTD
Activity									
Day Case	**100%** of 26/27 Plan	N/A	96.7%	97.1%	100.7%	**99.2%**	11,911	12,008	**99.6%**
Elective Overnight			91.6%	94.1%	100.7%	**83.6%**	1,637	1,959	**93.3%**
Outpatient New			92.8%	91.4%	89.4%	**86.3%**	24,723	28,639	**91.9%**
Outpatient Procedures			97.9%	96.3%	93.4%	**94.0%**	23,343	24,841	**96.2%**
Outpatient Review	N/A		96.8%	95.7%	98.3%	**95.1%**	68,464	71,994	**98.4%**
Non-Elective	N/A		98.9%	99.1%	99.7%	**92.8%**	891	960	**97.8%**
Emergency	N/A		108.9%	106.4%	97.8%	**109.7%**	6,850	6,242	**104.8%**
PIFU Take-up (%)	N/A	**3.9%**	3.2%	3.2%	3.4%	**3.5%**	4,345	123,354	**3.3%**
Urgent Ops. Cancelled Twice	**Zero**	N/A	0	0	0	**0**	0		**0**
Cancelled Ops. Rescheduled >28 Days	**Zero**	N/A	12	7	4	**0**	0		**37**
Elective Waits									
RTT Waiting List Size	**Reduction** from 25/26	**82,388**	86,941	88,477	88,112	**88,160**	88,160		
RTT <18 Week Wait	Constitutional: **92%** Interim: **81.1%** by Mar-27 (local target)	**76.3%**	74.6%	73.9%	72.6%	**72.6%**	64,015	88,160	**73.3%**
>52 Week Waiters	N/A	**386**	702	743	722	**767**	767		
Time to First Outpatient Appointment (18 Weeks)	N/A	**79.5%**	79.8%	79.0%	77.8%	**76.3%**	42,590	55,832	**78.3%**
Diagnostic Waiting List Size	N/A	**13,825**	18,006	18,319	17,096	**17,486**	17,486		**106,355**
Diagnostic >6 week wait	Constitutional: **1%** Interim: **2.1%** by Mar-27 (local target)	**13.1%**	20.4%	19.8%	24.1%	**25.4%**	4,436	17,486	**21.3%**
Community Services Waiting List	N/A	N/A	11,493	11,002	11,186	**11,453**	11,453		
Community Services >18 Week Wait	**78%** by Mar-27 (ICB target)		80.1%	81.2%	81.6%	**81.8%**	2,088	11,453	
Community Services >52 Week Waiters	N/A		612	612	641	**646**	646		

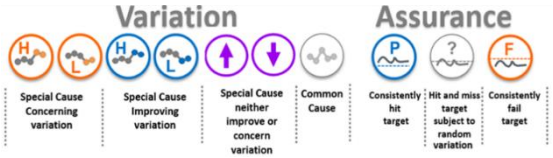
Contractual & Planning Standards (2/2)

Theme	Standard	Trajectory		Jun-26	Jul-26	Aug-26	Sep-26		Num.	Den.		26/27 YTD
Cancer Care												
28 Day Faster Diagnosis	**80%** Annual Average (by Mar-27)	**73.3%**		84.6%	85.3%	84.1%	**82.8%**		2,132	2,574		**84.2%**
31 Days (DTT to Treatment)	**94%**	**90.3%**		74.5%	74.7%	72.4%	**64.3%**		952	1,481		**74.9%**
62 Days (Referral to Treatment)	**80%** (by Mar-27)	**73.7%**		65.6%	66.8%	67.8%	**61.5%**		308	501		**65.3%**
>62 Day Cancer Waiters	**N/A**	**N/A**		260	291	287	**238**		238			
Urgent & Emergency Care												
A&E Arrival to Admission/Discharge (All types)	**82%** under 4 hours (by Mar-27)	**82.0%**		76.7%	77.4%	77.0%	**76.1%**		18,817	24,728		**77.1%**
A&E Arrival to Admission/Discharge <12 hours	**Increase** from 25/26 Average	**99.0%**		98.5%	98.8%	98.7%	**98.5%**		381	24,728		**98.8%**
Adult General & Acute Bed Occupancy	**N/A**	**87.5%**		88.5%	87.2%	85.7%	**89.6%**		1,277	1,426		**87.5%**
Ambulance Handovers >15 mins	**N/A**	**20.4%**		52.0%	55.5%	53.5%	**58.0%**		1,846	3,182		**54.0%**
Ambulance Handovers >45 mins	**Zero** (by Mar-27)	**3.7%**		6.9%	6.8%	7.0%	**17.5%**		557	3,182		**91.7%**
Urgent Community Response Standard	**>=70%** under 2 hours	**N/A**		84.4%	86.2%	88.7%	**82.2%**		287	349		**86.5%**
Safe, High Quality Care												
Mixed Sex Acommodation Breach	**Zero**	**N/A**		125	108	119	**131**		131			**704**
VTE Risk Assessment	**95%**			96.1%	95.8%	96.1%	**95.9%**					
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour			72.0%	77.0%	77.0%	**77.0%**					
Sepsis Screening Treat. (All)				68.0%	77.0%	77.0%	**77.0%**					

People

People overview

Metric	12-month rolling	Actual	Target	Variation	Assurance
Sickness	Sep-26	6.01%	4.9%		F
Short-term (Month only)	Sep-26	2.04%			
Long-term (Month Only)	Sep-26	4.04%			
Turnover	Sep-26	8.71%	10%		P
Mandatory training	Sep-26	92.09%	90%		P
Appraisal	Sep-26	85.07%	90%	H	F
Disabled staff	Sep-26	6.99%		H	
Ethnicity (BAME staff)	Sep-26	19.56%		H	



(Data is for period **1 October 2025 to 30 September 2026** unless otherwise stated)

Staff in post

- Total is 15,972.08 Full Time Equivalent (FTE) including Bank/agency
- Total substantive is 15,536.71 FTE, 17,742 headcount
- Above substantive pre-Covid by 2,098.16 FTE (+15.61%)
- Above total workforce plan of 15,534.50 FTE by 437.59 FTE (+2.82%)

Sickness – target 4.5%, performance 6.01% (+ 0.03%)

- Top reasons for sickness: anxiety/stress/depression 32.53% (-0.96%); gastrointestinal problems 10.49% (-0,29%); other musculoskeletal problems 8.34% (-0.99%)
- Short-term sickness change in 2.04% (+0.27%)
- Long term sickness change in September 4.04% (-0.05%)
- Average working days lost is **1,059** (headcount) per day for the reporting period. Short Term average days lost per day is **744**; long term average days lost per day is **393**.
- 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 8.71% (-0.16%)

- Reduction of 0.16%
- Top reason for leaving; voluntary resignation – work life balance 14.90%
- Top destinations: no employment 47.52%; other NHS organisation 28.14% (includes retire-return)

Mandatory training – target 90%, performance 92.09% (+0.28%)

- Increase of 0.28%
- Lowest is Medical and Dental 80.92% (+1.29%)
- Task & Finish Group has been commissioned to look at 'process and provision'.

Appraisal – target 90%, performance 85.07% (-0.78%)

- Overdue decreased to 2,144
- Senior doctors (consultant and Specialty and specialist (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 £20.3m, +£1.8m vs last year
- Total annual non-medical agency expenditure £1.8m, -£1.4m vs last year
- Total annual medical bank (locum) expenditure £13.4m, +£2.2m vs last year
- Total annual medical agency expenditure £2.2m, -£1.7m 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 September 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	15,156.64	16,421.78	15,536.71	2,098.16	380.07	-885.07
Total Bank & Agency Staff	501.60	377.86		435.37	-66.23	57.52	
Total	**13,940.15**	**15,534.50**	**16,421.78**	**15,972.08**	**2,031.93**	**437.59**	**-885.07**

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	10,678.99	11,405.52	10,746.03	1,423.33	67.04	-659.49
2. Total Non Medical - Non-Clinical Substantive Staff	2,226.73	2,391.82	2,870.10	2,628.99	402.27	237.17	-241.11
3. Total Medical and Dental Substantive Staff	1,732.92	2,072.23	2,136.66	2,150.17	417.25	77.94	13.51
4. Any other Staff (substantive staff)	156.19	13.60	9.50	11.51	-144.68	-2.09	2.01
5. Bank	441.22	356.91		417.35	-23.87	60.44	
6. Agency	60.38	20.95		18.02	-42.36	-2.93	
Total	**13,940.15**	**15,534.50**	**16,421.78**	**15,972.08**	**2,031.93**	**437.59**	**-885.07**

Current Position:

- Workforce is +2,031.93 FTE (+14.58%) above January 2020 (pre-Covid) position.
- Substantive workforce target at 30th September is 15,156.64 FTE.
- Substantive workforce actual position at 30th September 15,536.71 FTE.
- Substantive workforce is currently 380.07 FTE above plan for September.
  (see slide 3, top row, middle graph)
- NHS infrastructure support (substantive) is 237.17 FTE above plan.
- Bank is above plan.
- Agency is below plan.
- Agency usage reviewed and challenged weekly / monthly.
- Robust management of agency requests with active bank and redeployment

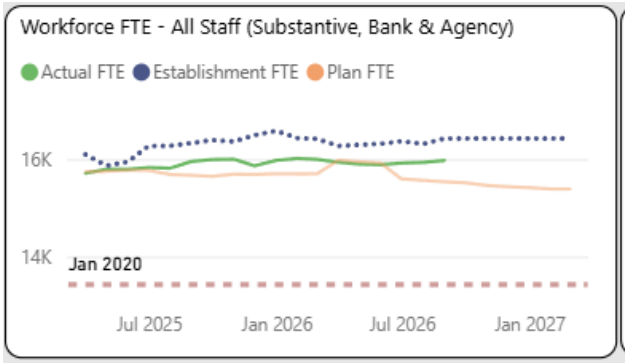
Underlying Issues

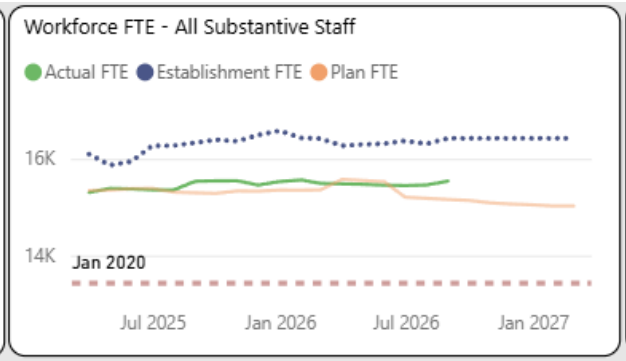
- Bank use due to switching requirements for additional hours from overtime to Bank which is more cost effective.
- Need to maintain safe services (e.g. healthcare assistants for enhanced care). Greater use being made of Bank options to reduce spend on agency.
- Practice of rostering staff may not be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

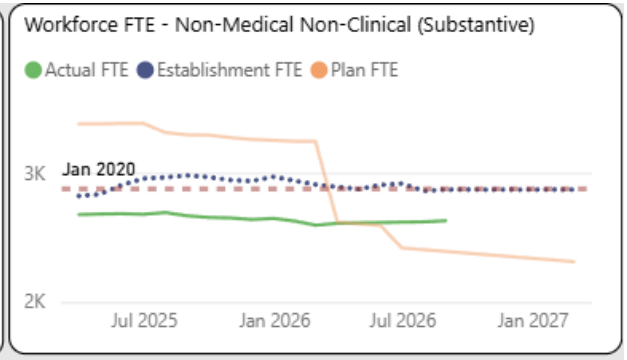
Actions Undertaken:

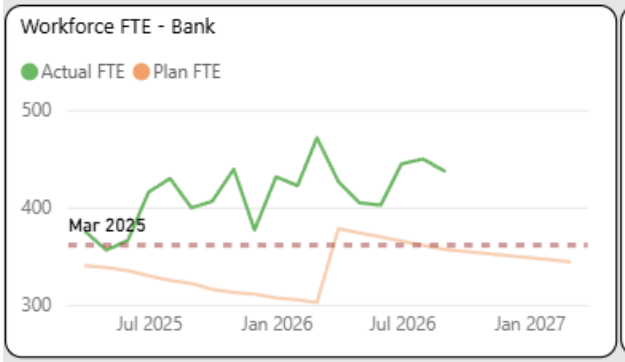
- Workforce Reduction Group (WROG) continues to meet bi-weekly, safeguarding the integrity of workforce controls to ultimately support a reduction in organisational headcount. The group functions as a 'gatekeeper' for specific workforce requests i.e. Mutually Agreed Resignation Scheme (MARS) skill mix and external advertising, ensuring all exceptions meet agreed upon criteria.
- A Task and Finish group has been established to review the Lead Employer Trust (LET) DR process and procedures to ensure that the data is timely and accurate. This review will take a number of weeks, with changes to existing processes to follow.

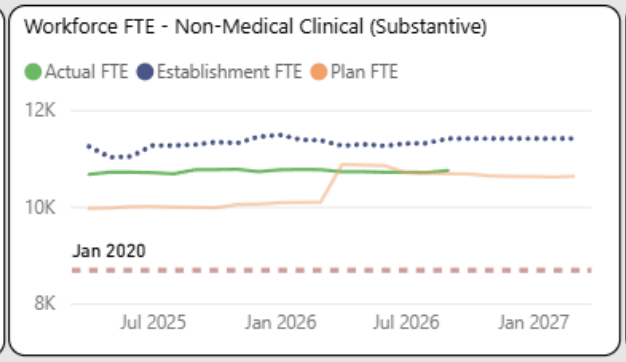
PWR – in-year overview position

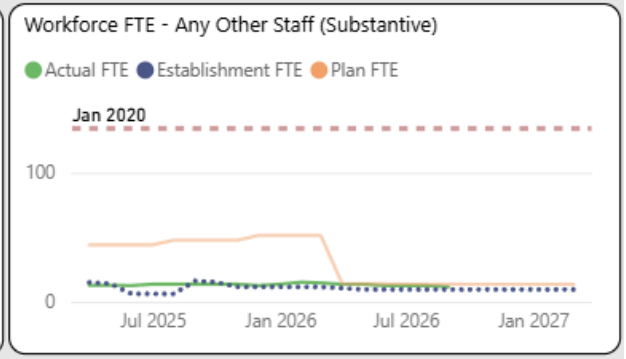


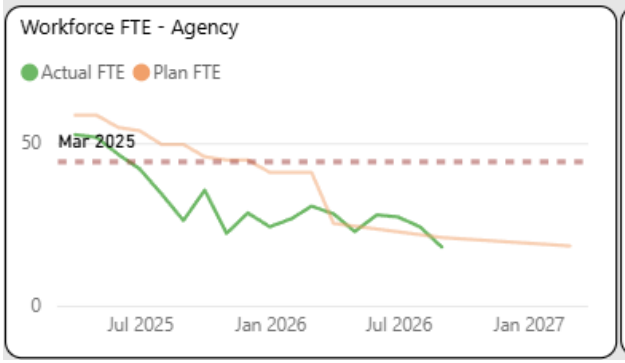


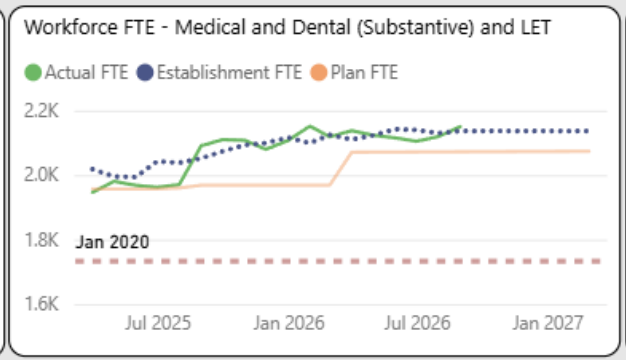


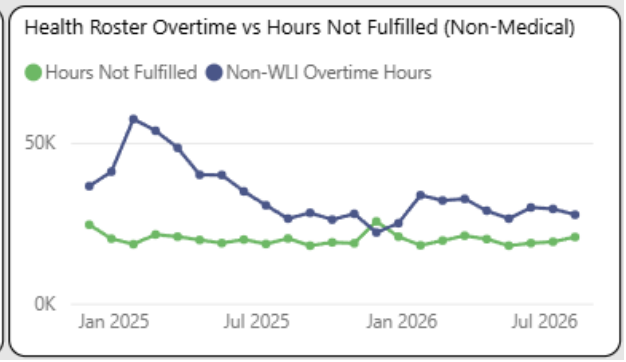






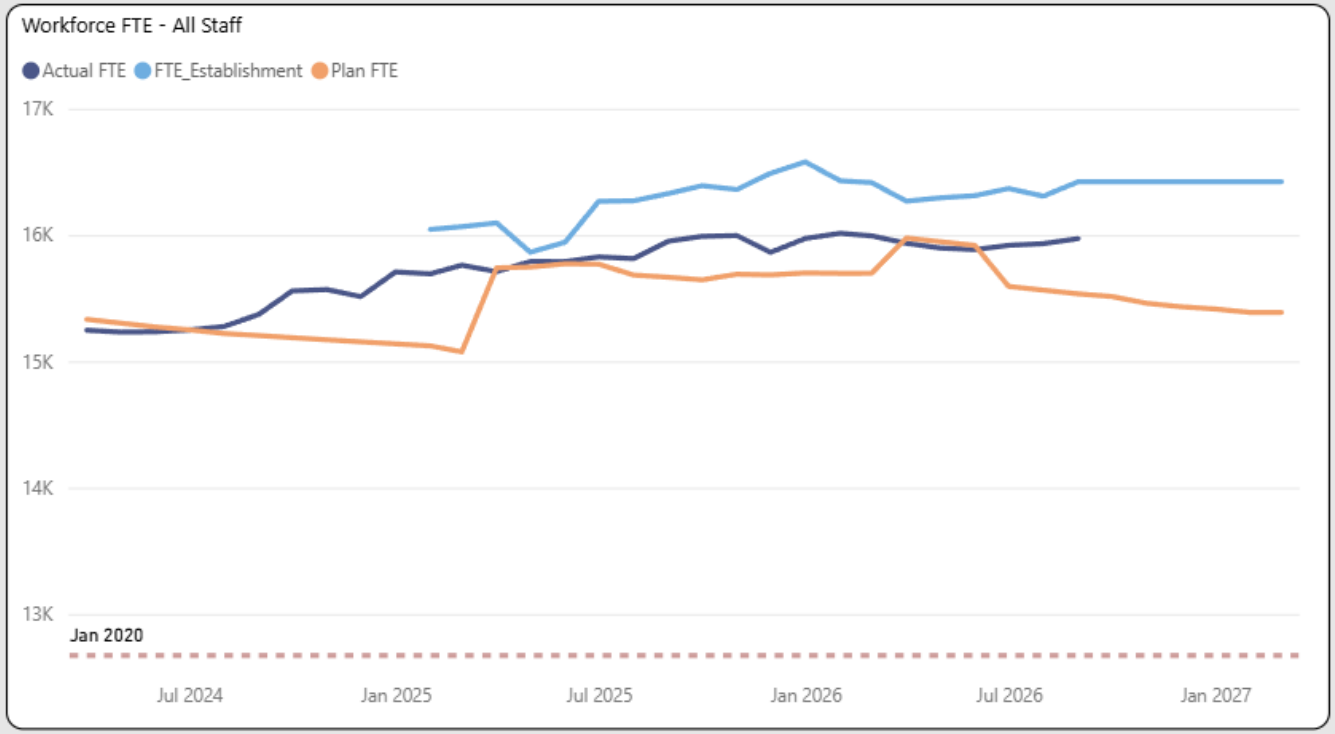






**Please note: The charts on this page include LET data

PWR – overview as-at September 2026



15,972.08
Current FTE

15,534.50
Plan FTE

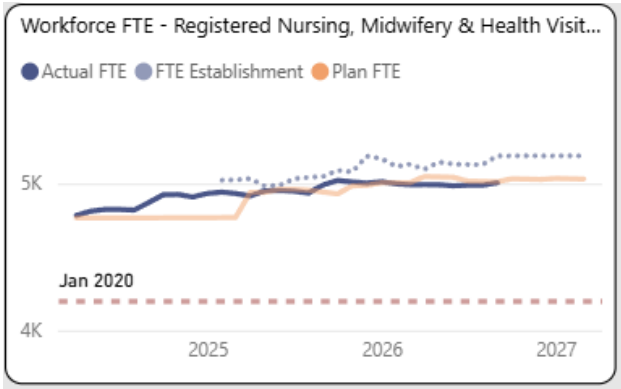
437.59
Current FTE v Plan

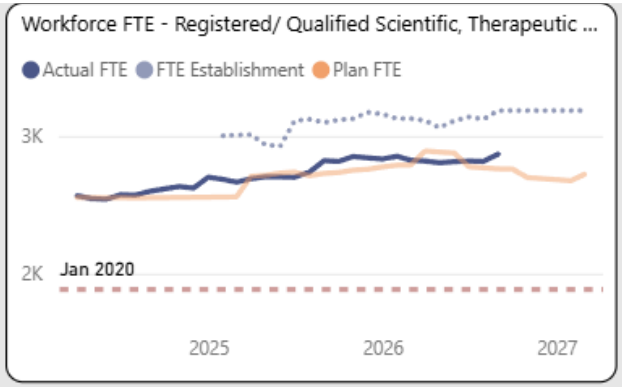
Headline Metric	Jan 2020 FTE	Plan FTE	Establishment	Current FTE	Current FTE v Jan 2020	Current FTE v Plan	Current FTE v Establishment
1. Total Non Medical - Clinical Substantive Staff	9,322.71	10,678.99	11,405.52	10,746.03	1,423.33	67.04	-659.49
2. Total Non Medical - Non-Clinical Substantive Staff	2,226.73	2,391.82	2,870.10	2,628.99	402.27	237.17	-241.11
3. Total Medical and Dental Substantive Staff	1,732.92	2,072.23	2,136.66	2,150.17	417.25	77.94	13.51
4. Any other Staff (substantive staff)	156.19	13.60	9.50	11.51	-144.68	-2.09	2.01
5. Bank	441.22	356.91		417.35	-23.87	60.44	
6. Agency	60.38	20.95		18.02	-42.36	-2.93	
Total	**13,940.15**	**15,534.50**	**16,421.78**	**15,972.08**	**2,031.93**	**437.59**	**-885.07**

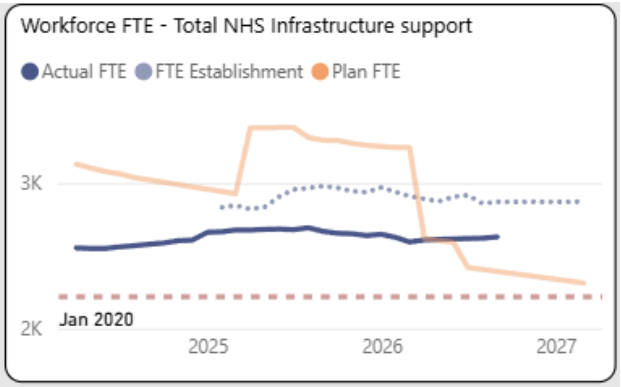
PWR – staff group overview as-at September 2026

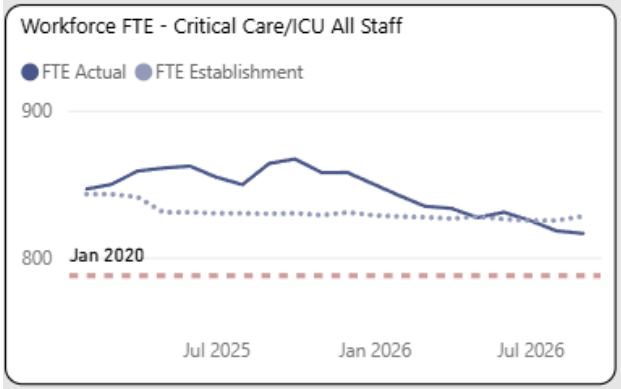
Sub Categories Metric	Jan 2020 FTE	Plan FTE	Establishment	Current FTE	Current FTE v Jan 2020	Current FTE v Plan	Current FTE v Establishment
1. Registered Nursing, Midwifery and Health visiting staff (substantive total)	4,200.28	5,011.91	5,189.06	5,005.26	804.98	-6.65	-183.80
2. Registered/ Qualified Scientific, Therapeutic and Technical Staff (substantive total)	1,994.12	2,380.95	2,592.69	2,434.22	440.10	53.27	-158.47
3. Support to Clinical staff (substantive total)	3,128.32	3,286.13	3,623.77	3,306.56	178.24	20.43	-317.21
4. Total NHS Infrastructure Support (includes A&C, estates, managers) (substantive total)	2,226.73	2,391.82	2,870.10	2,628.99	402.27	237.17	-241.11
5. Total Medical and Dental (substantive total)	1,732.92	2,072.23	2,136.66	2,150.17	417.25	77.94	13.51
6. Any other Staff (substantive total)	156.19	13.60	9.50	11.51	-144.68	-2.09	2.01
7. Bank Any other staff	0.00	0.00			0.00	0.00	
7. Bank Medical and dental	11.75	26.68		37.43	25.68	10.75	
7. Bank Registered nursing, midwifery and health visiting staff	111.27	102.83		126.85	15.58	24.02	
7. Bank Registered/ Qualified Scientific, Therapeutic and Technical staff	16.41	9.84		10.17	-6.24	0.33	
7. Bank Support to clinical staff	258.10	197.60		231.55	-26.55	33.95	
7. Bank Total NHS infrastructure support	43.69	19.96		11.35	-32.34	-8.61	
8. Agency Any other staff	0.00	0.00			0.00	0.00	
8. Agency Medical and dental	0.87	2.73		3.14	2.27	0.41	
8. Agency Registered nursing, midwifery and health visiting staff	2.86	3.62		3.30	0.44	-0.32	
8. Agency Registered scientific, therapeutic and technical staff	17.27	3.84		1.60	-15.67	-2.24	
8. Agency Support to clinical staff	23.68	10.76		9.99	-13.69	-0.77	
8. Agency Total NHS infrastructure support	15.70	0.00			-15.70	0.00	
Total	**13,940.15**	**15,534.50**	**16,421.78**	**15,972.08**	**2,031.93**	**437.59**	**-885.07**

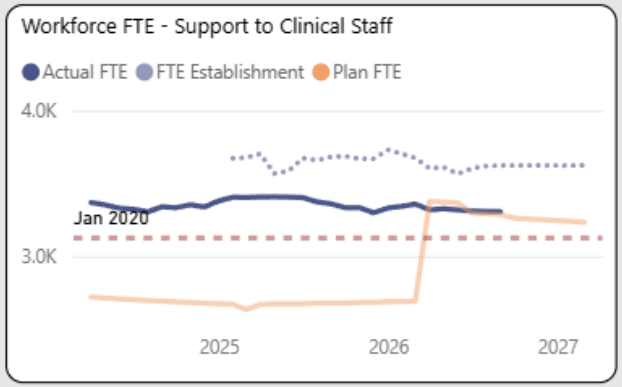
PWR – staff group overview in-year position

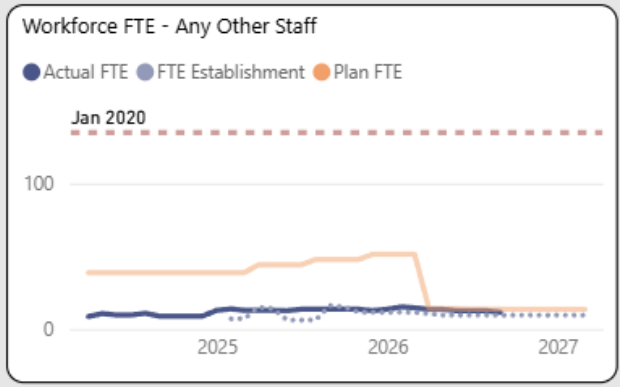


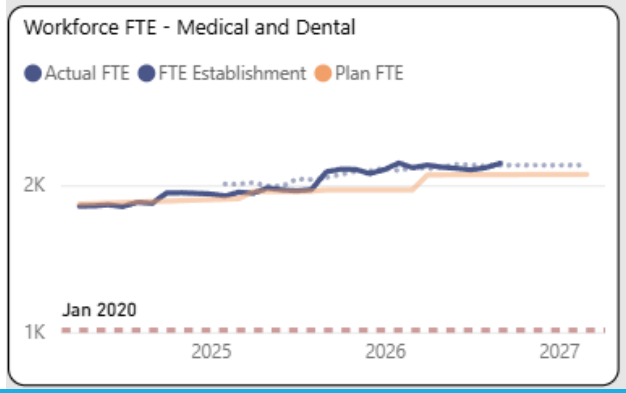










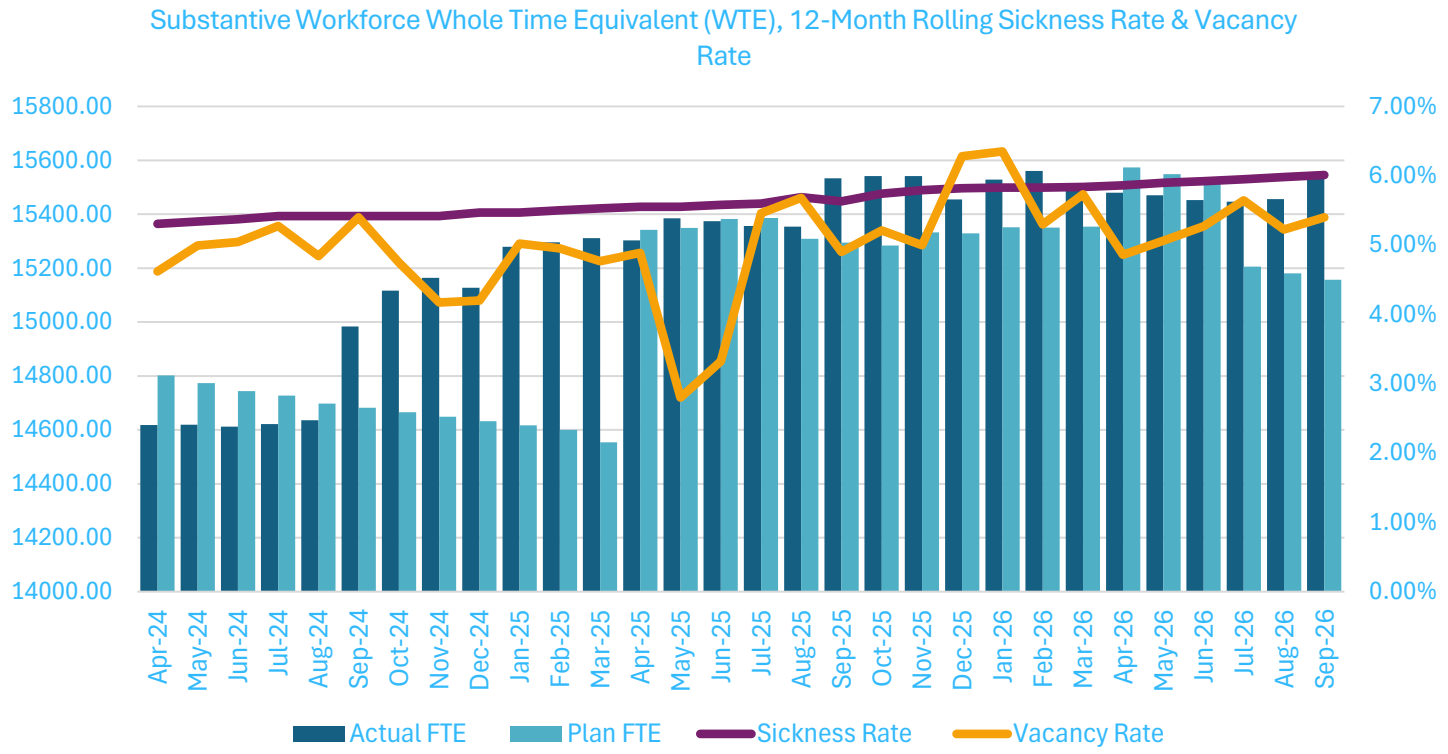


Vacancies

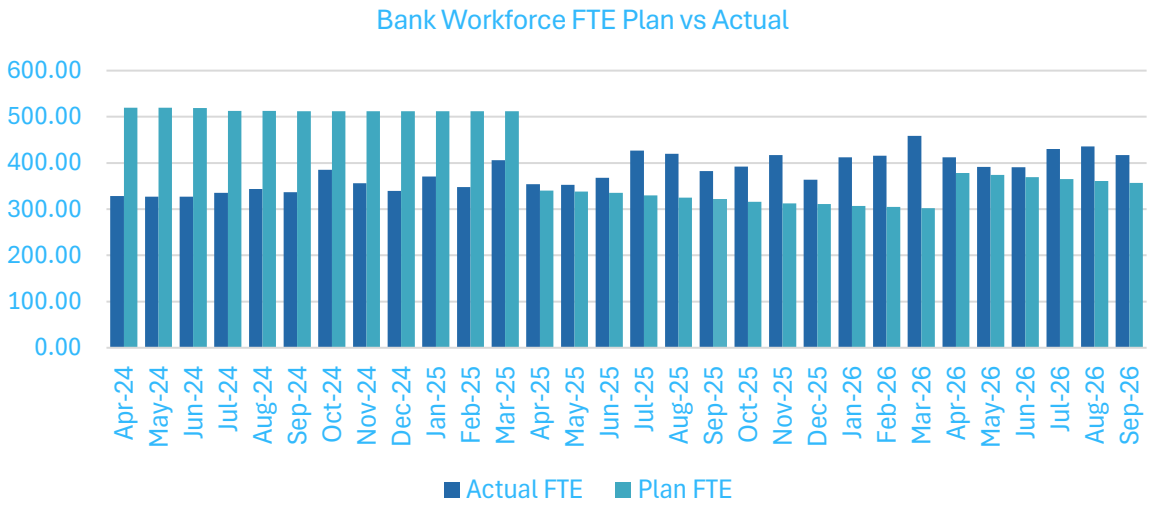
Summary Group	FTE Establishment	Actual FTE	Vacancy FTE	Vacancy FTE %
1. Total Non Medical - Clinical Substantive Staff	11405.52	10746.03	659.49	5.78%
2. Total Non Medical - Non-Clinical Substantive Staff	2870.10	2627.99	242.11	8.44%
3. Medical and Dental	2136.66	2150.18	-13.51	-0.63%
5. Other	9.50	11.51	-2.01	-21.12%
Total	**16421.78**	**15535.71**	**886.07**	**5.40%**

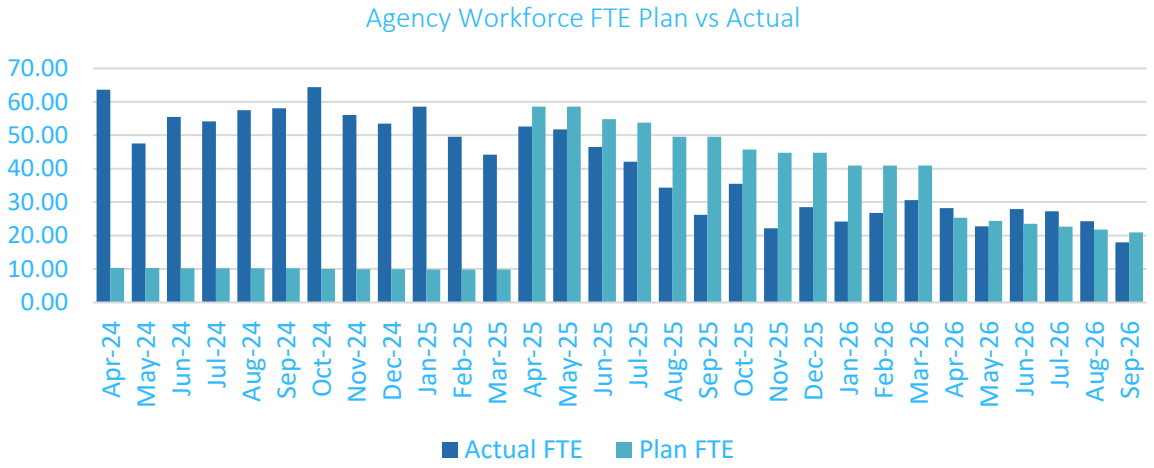
**Please note: The charts on this page include LET data

Substantive Workforce



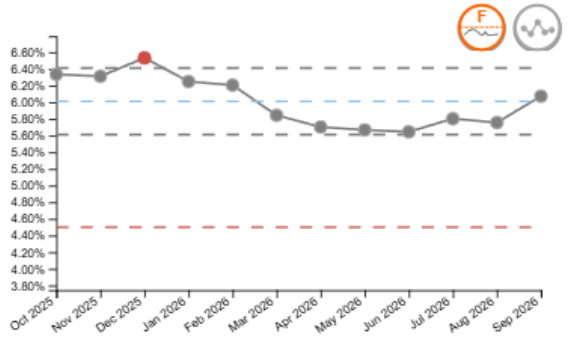
Bank and Agency Workforce



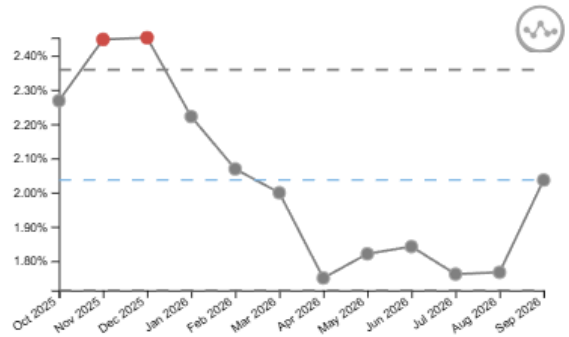


Sickness absence – 12-month average

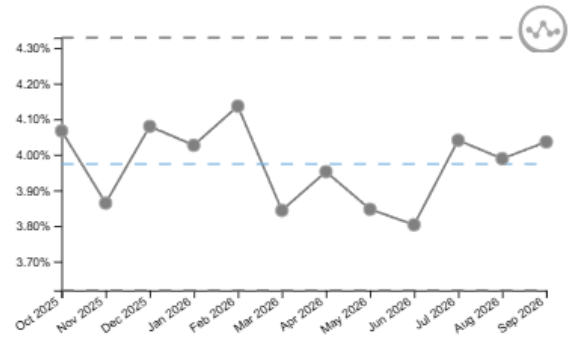
Trust Sickness %	12-Month Rolling	Value	Target
	Sep 26	6.01%	4.90%



Metric	Value
Short Term Sickness %	2.04%



Metric	Value
Long Term Sickness %	4.04%



Current Position:

- Top reasons for sickness:
  - Anxiety/stress/depression (S10) 32.53%
  - Gastrointestinal problems (S25) 10.49%
  - Other musculoskeletal problems (S12) 8.34%
- The 12-month rolling absence rate of 6.01% and the sick pay cost of £37.6m 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: 325,416.51 FTE.
- Average time lost per person: 22 days.
- Total cost of sick pay: £37.6m.
- Variation in sickness rates across Clinical Boards:
  - Lowest – Clinical and Diagnostic Services at 4.51% (short-term 1.80%, long term 3.01%)
  - Highest – Family Health at 6.79% (short-term 1.94%, long term 5.31%)

Actions Undertaken:

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

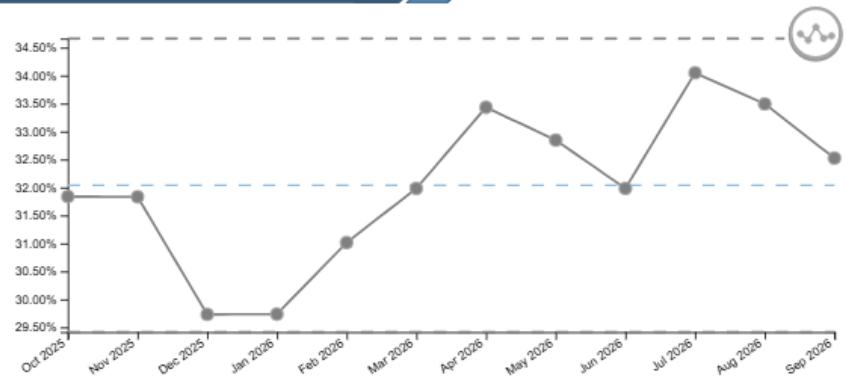
Sickness absence – top absence reasons

Trust Sickness %	12-Month Rolling	Value	Target
	Sep 26	6.01%	4.90%

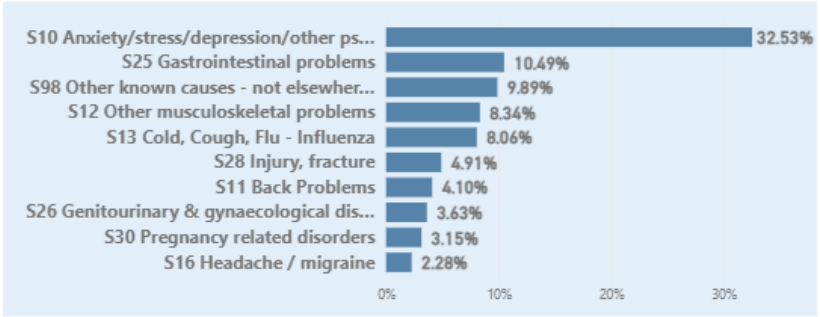
Sickness Reasons - SPC

S10 - Anxiety/stress/depression/ other psychiatric illness

32.53%

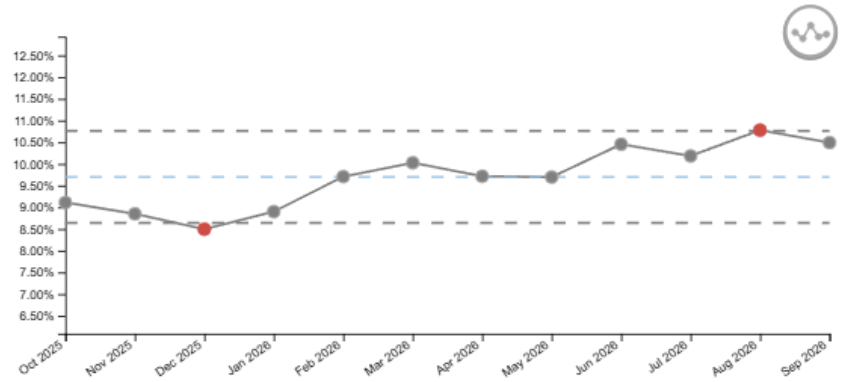


Top 10 Sickness Abscences



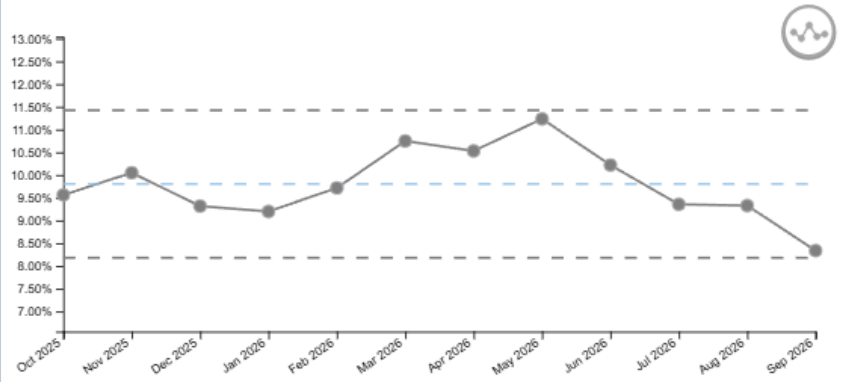
S25 - Gastrointestinal problems

10.49%

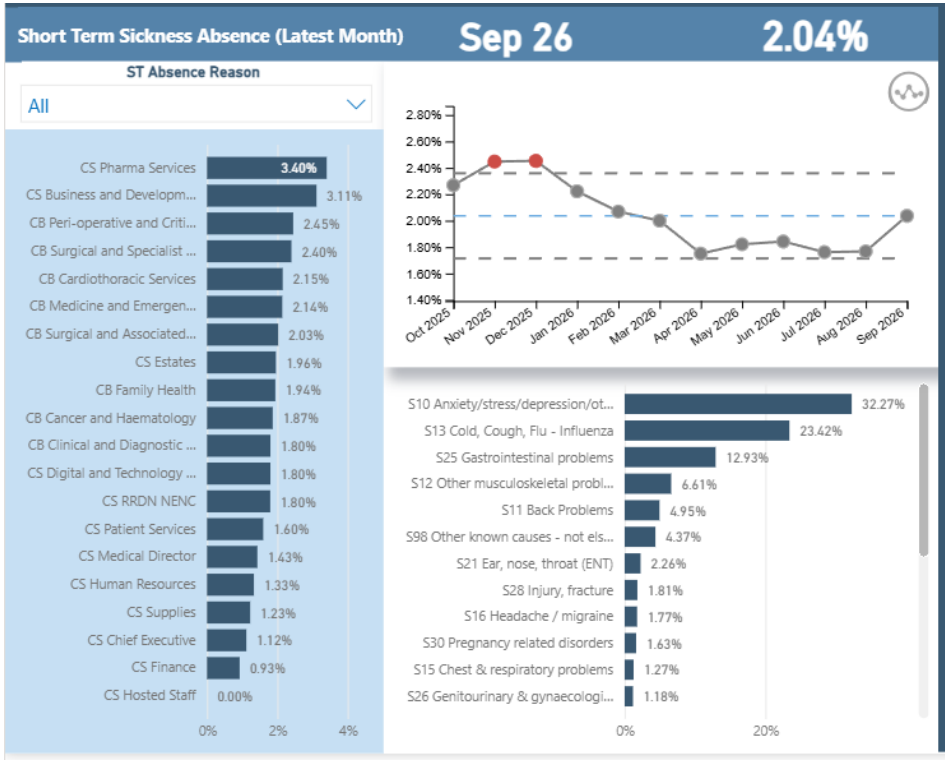


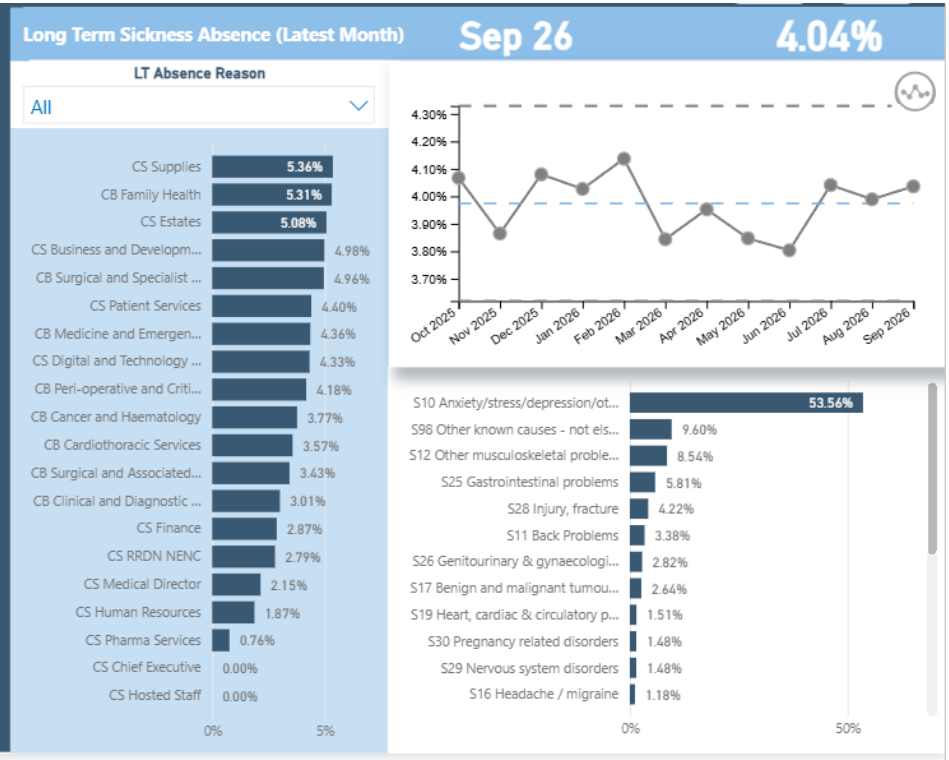
S12 - Other musculoskeletal problems

8.34%



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





Sickness – FTE working days lost & formal action activity

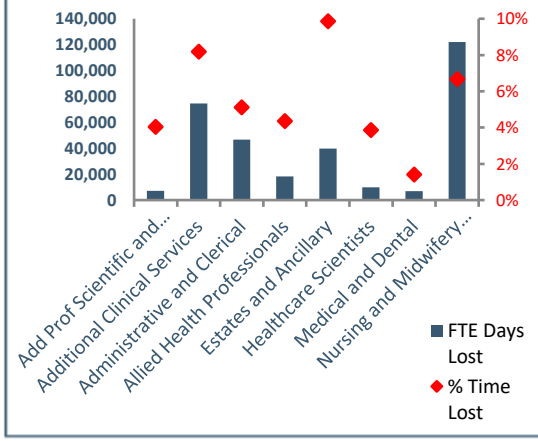
Sickness - FTE working days lost

FTE working days lost due to sickness

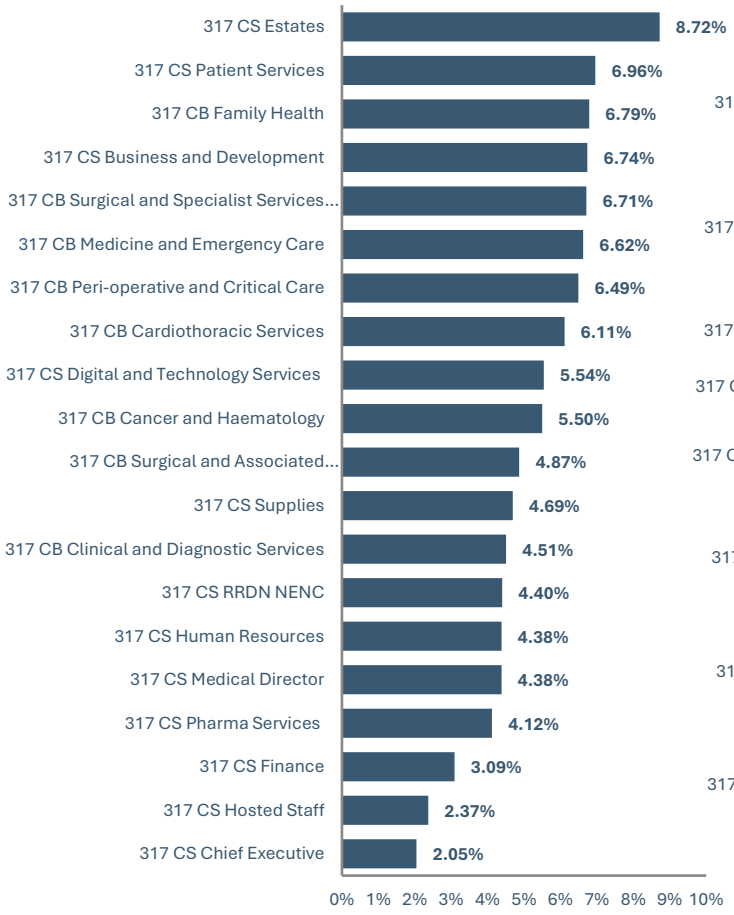
325,617

303,644 compared to the previous year.

Sickness Absence by Staff Group



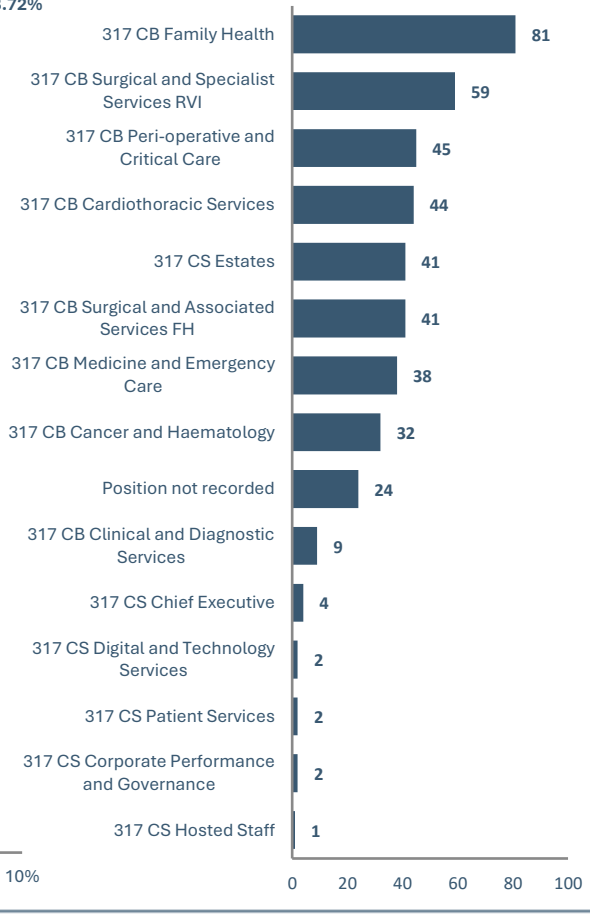
Sickness Absence (% Time Lost) by Clinical Board



Sickness - Formal Action

Latest Data - September 2026

Attendance Management – Formal Action by Clinical Board/ Corporate Service

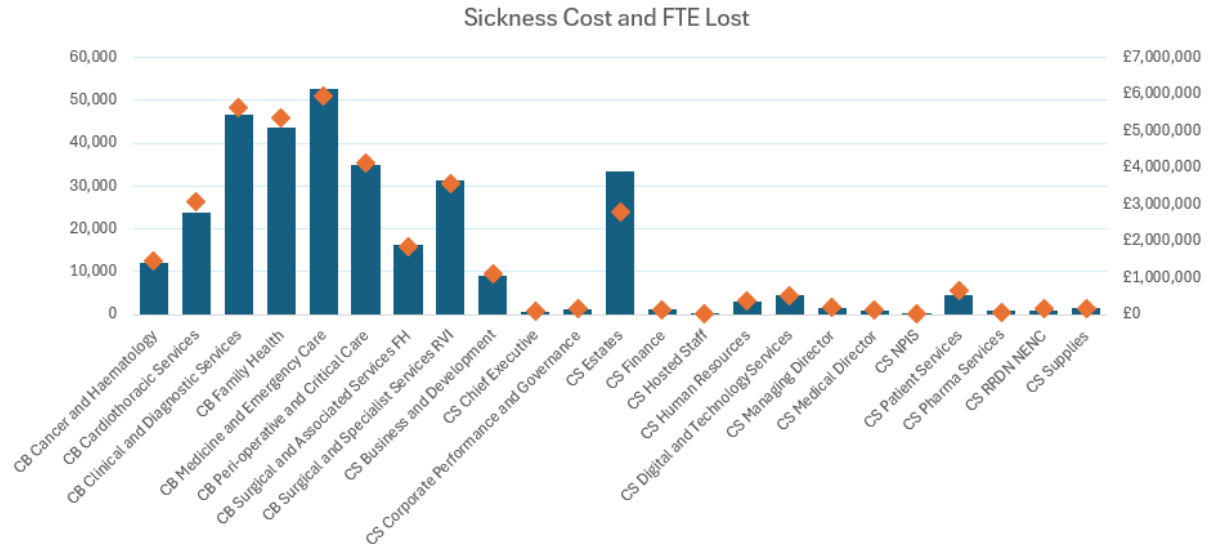


Sickness – FTE working days lost & cost of sick pay

Sickness Absence	12-Month period ending	Cost (£)	FTE Lost	Ave. No of Days Lost per FTE
	Sep 26	£37,600,929	325,416.51	21.99

Clinical Board	Cost (£)	FTE Lost	Ave. No of days
CB Cancer and Haematology	1,476,465	11,935.41	20.06
CB Cardiothoracic Services	3,070,497	23,756.57	22.58
CB Clinical and Diagnostic Services	5,625,450	46,730.82	16.56
CB Family Health	5,365,617	43,771.86	24.75
CB Medicine and Emergency Care	5,952,530	52,598.93	24.15
CB Peri-operative and Critical Care	4,131,179	34,903.14	23.88
CB Surgical and Associated Services FH	1,849,774	16,287.00	17.62
CB Surgical and Specialist Services RVI	3,572,321	31,474.62	24.62

Clinical Board	Cost (£)	FTE Lost	Ave. No of days lost per FTE
CS Business and Development	1,124,607	9,166.38	23.35
CS Chief Executive	95,058	565.10	7.50
CS Corporate Performance and Governance	148,214	1,110.56	13.06
CS Estates	2,784,625	33,560.92	31.62
CS Finance	137,253	1,271.01	11.26
CS Hosted Staff	22,210	289.60	8.36
CS Human Resources	355,288	3,043.17	16.02
CS Digital and Technology Services	513,290	4,601.36	20.25
CS Managing Director	183,598	1,416.90	19.13
CS Medical Director	130,672	843.73	16.24
CS NPIS	16,064	100.40	5.05
CS Patient Services	651,899	4,514.76	25.51
CS Pharma Services	60,533	871.55	15.06
CS RRDN NENC	167,125	1,003.23	15.96
CS Supplies	166,659	1,599.49	17.13

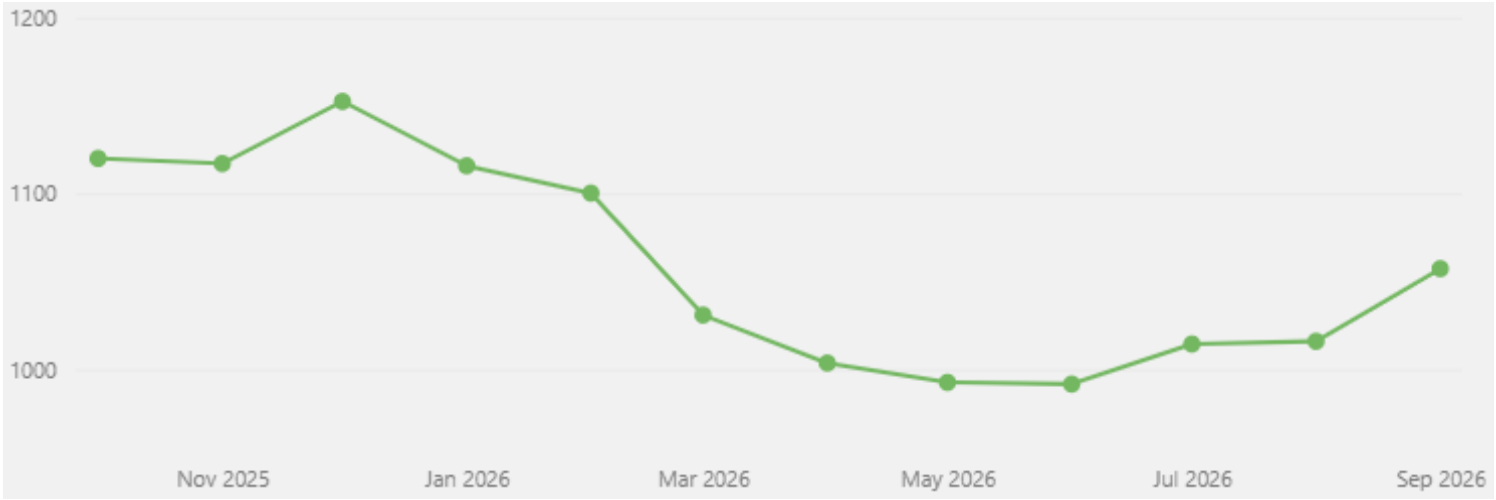


Sickness – Average working days lost per day

October 2025 to September 2026	Average Absence Headcount per Day
	1,059

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	1009	1057			

Rolling 12-month daily average



Sickness – Average working days lost per day

Rolling 12-month daily average

Long Term October 2025 to September 2026	Average Absence Headcount per Day
	744

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	664	640			

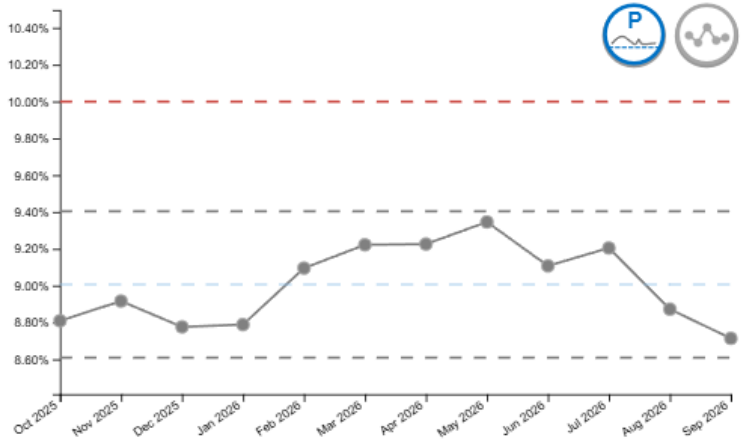
Short Term October 2025 to September 2026	Average Working Days Lost per Day*
	393

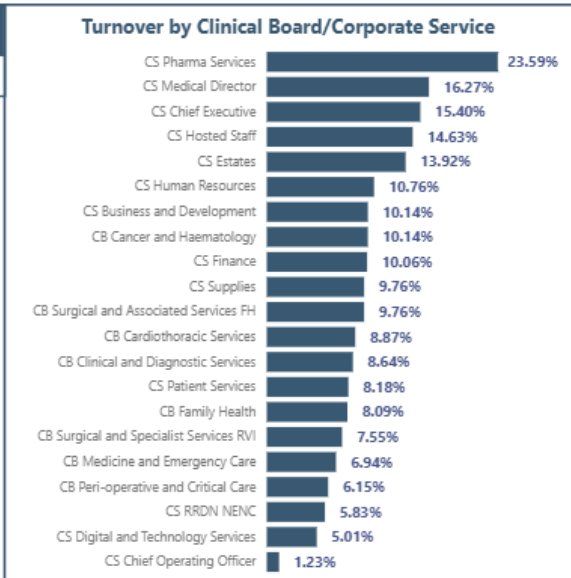
Month	Jan 26	Feb 26	Mar 26	Apr 26	May 26	Jun 26	Jul 26	Aug 26	Sept 26	Oct 26	Nov 26	Dec 26
Average Absence Headcount per Day by Month	451	445	384	344	375	359	378	345	417			

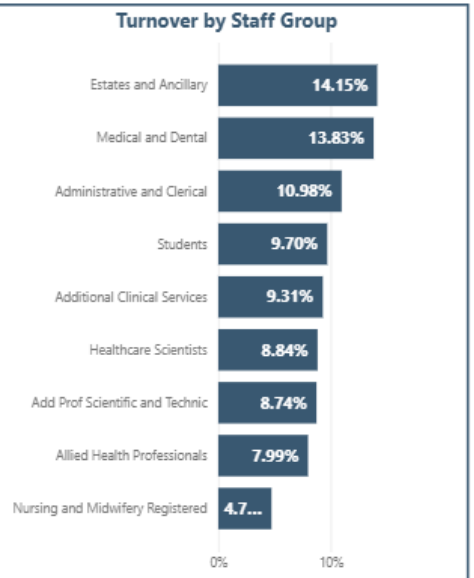
*Headcount

Turnover

Trust Turnover %	12-Month Rolling	Value	Target
	Sep 26	8.71%	10.00%







Current Position:	Underlying Issues	Actions Undertaken:
• All Clinical Boards are better than target. • Main reasons for staff leaving to a local Trust in last 12 months are promotion, work-life balance and relocation.	• 1481 leavers in 12-months to September 2026: 20% Administrative and Clerical (293); 18% Additional Clinical Services (273) • Top destinations – no employment (699, 47%); other NHS organisation (417, 28%). • Top reasons – work-life balance (217, 15%); retirement age (179, 12%); mutually agreed resignation (159, 11%)	• Flexible working. Supported and encouraged across the Trust. With consistently over 98% of applications are approved. • Monitoring – daily information available to managers via people dashboard; monthly performance reviews held with clinical boards; monthly meetings held between HR and clinical boards/corporate services.

Turnover

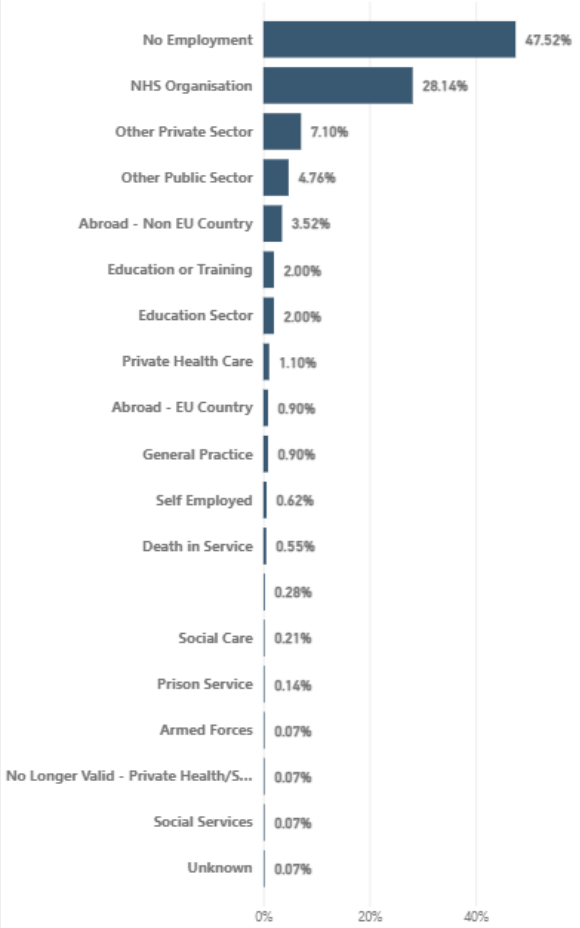
Trust Turnover %	12-Month Rolling	Value	Target
	Sep 26	8.71%	10.00%

Leaving Reasons

Leaving Reasons

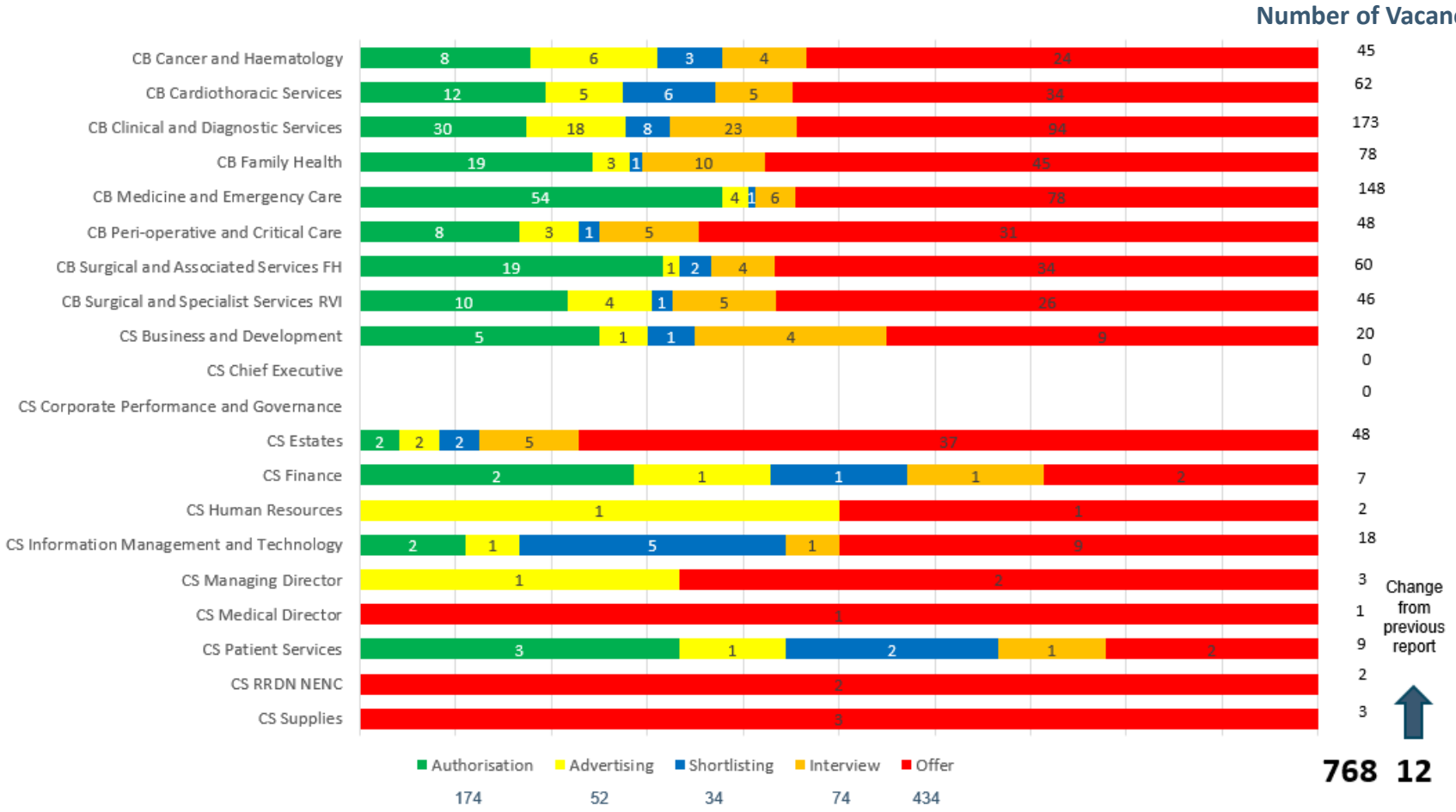
Leaving Reason	Leaving Reason %
Voluntary Resignation - Work Life Balance	14.90%
Retirement Age	12.21%
Mutually Agreed Resignation - Local Scheme with Repayment	10.83%
Voluntary Resignation - Relocation	10.76%
End of Fixed Term Contract	8.83%
Voluntary Resignation - Promotion	8.41%
Voluntary Resignation - Health	5.79%
Flexi Retirement	5.03%
Voluntary Resignation - To undertake further education or training	3.86%
Dismissal - Capability	2.97%
Voluntary Resignation - Incompatible Working Relationships	2.62%
Voluntary Resignation - Lack of Opportunities	2.55%
Voluntary resignation - Pay and Reward Related	2.14%
End of Fixed Term Contract - Other	1.38%
Voluntary Resignation - Child Dependants	1.38%
End of Fixed Term Contract - Completion of Training Scheme	1.17%
Voluntary Early Retirement - no Actuarial Reduction	1.03%
Dismissal - Conduct	0.76%
Retirement - Ill Health	0.69%
Voluntary Resignation - Adult Dependants	0.62%
Death in Service	0.55%
Voluntary Resignation - Other/Not Known	0.55%
Voluntary Early Retirement - with Actuarial Reduction	0.41%
Dismissal - Statutory Reason	0.34%
End of Fixed Term Contract - End of Work Requirement	0.14%
End of Fixed Term Contract - External Rotation	0.07%

Destination on Leaving



Destination On Leaving	Destination On Leaving %
No Employment	47.52%
NHS Organisation	28.14%
Other Private Sector	7.10%
Other Public Sector	4.76%
Abroad - Non EU Country	3.52%
Education or Training	2.00%
Education Sector	2.00%
Private Health Care	1.10%
Abroad - EU Country	0.90%
General Practice	0.90%
Self Employed	0.62%
Death in Service	0.55%
	0.28%
Social Care	0.21%
Prison Service	0.14%
Armed Forces	0.07%
No Longer Valid - Private Health/Social Care	0.07%
Social Services	0.07%
Unknown	0.07%

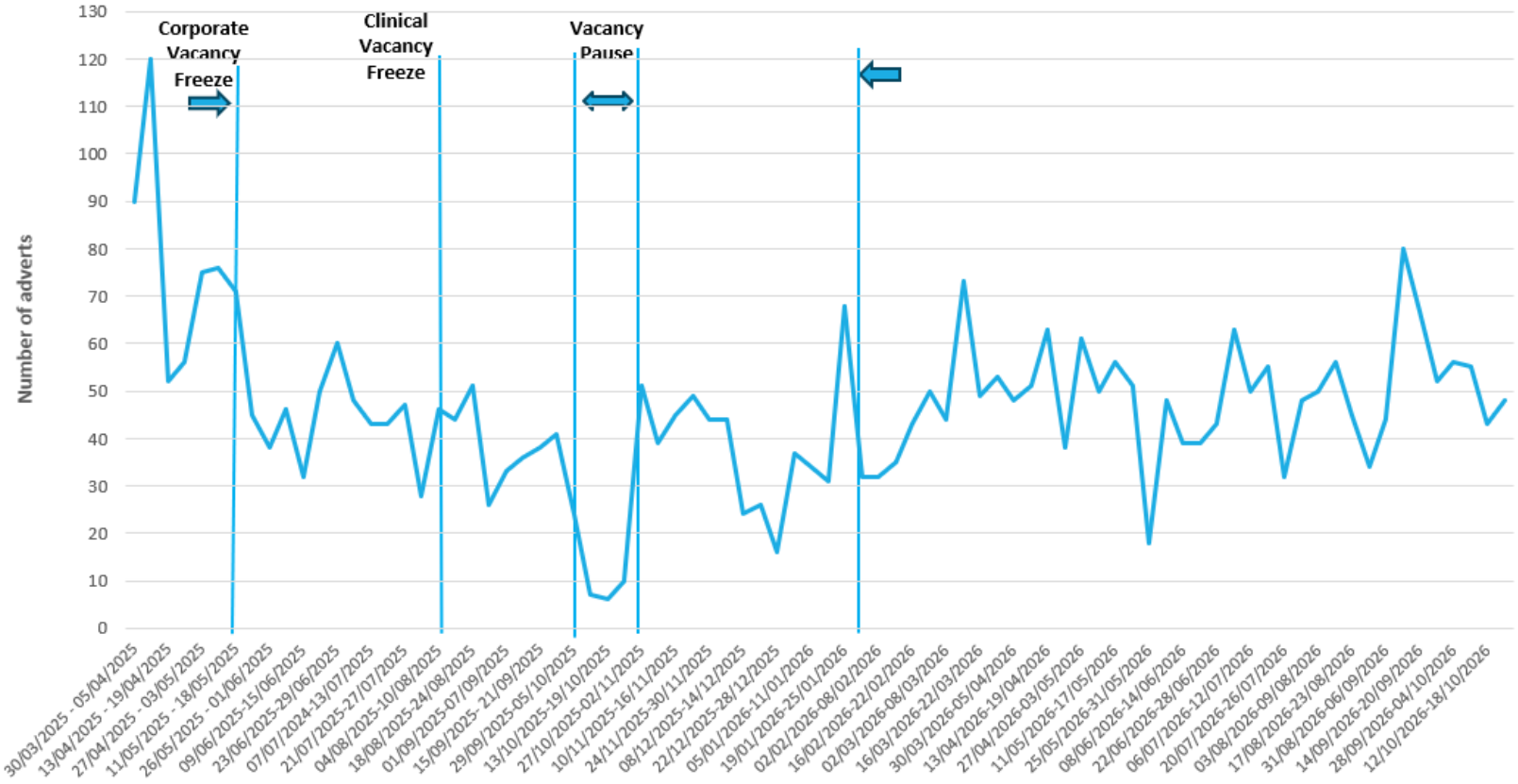
Recruitment - Vacancies in progress by stage – 26 October 2026



The chart illustrates that as of 26 October 2026, there were 768 vacancies progressing through the recruitment process—a increase of 12 compared to the previous period. The largest proportion of vacancies were at the conditional offer stage (57%), this is a increase from previous report due to the number of starters over recent weeks (was 55%). The numbers in the recruitment process are currently increasing with a current increase in Adverting and Interview similar from the previous report.

Recruitment - Vacancies in progress by stage

Total adverts w/e 25/10/2026	48
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	3199

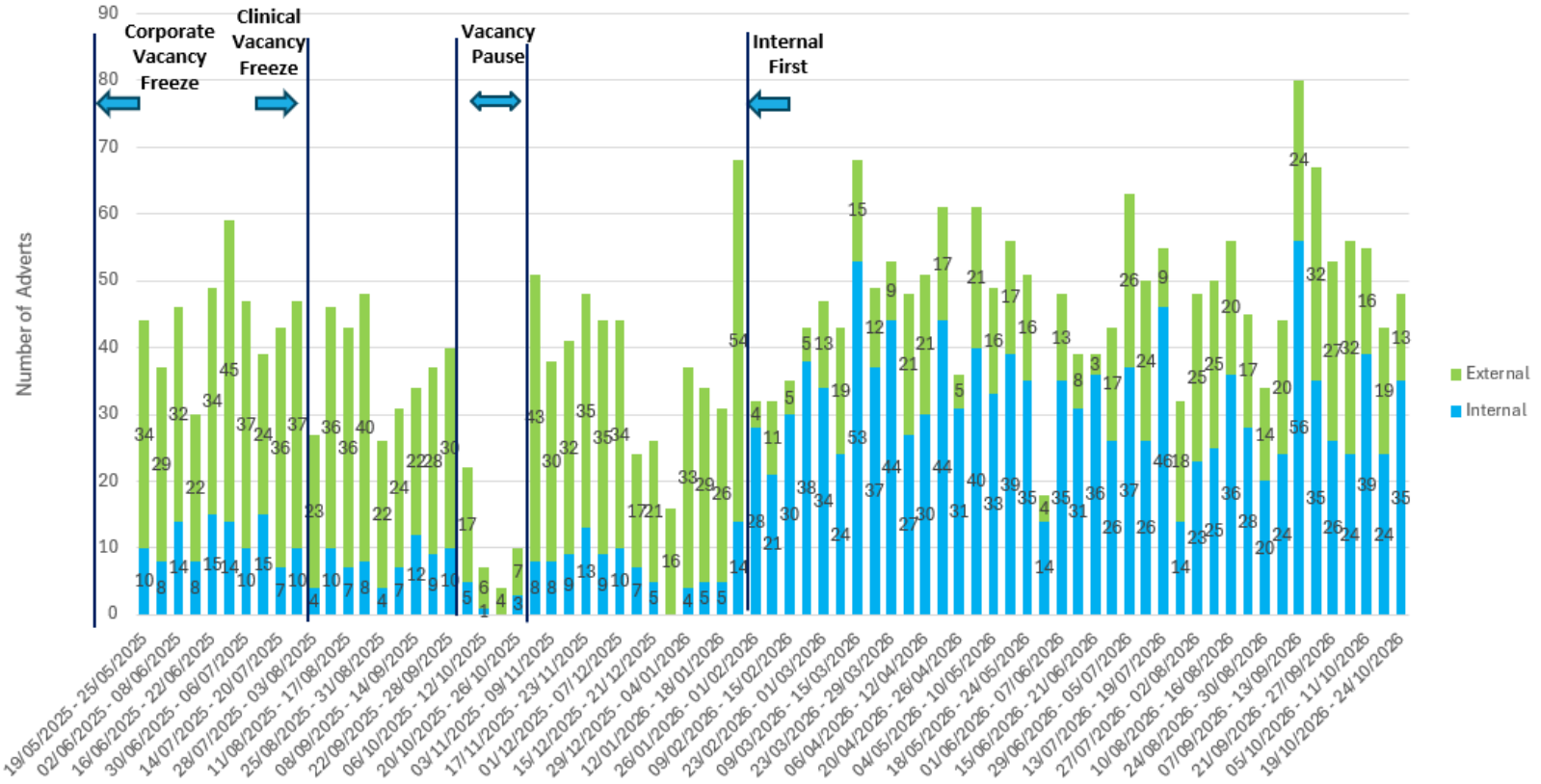


This graph shows a decline in the number of vacancies advertised during the recruitment pause and freezes. There has been increases in January, March 2026 and September over the generally consistent pattern of last 12 months. Overall, in 2026 their similar adverts compared to the same period in 2025 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 25/10/2026 **48**

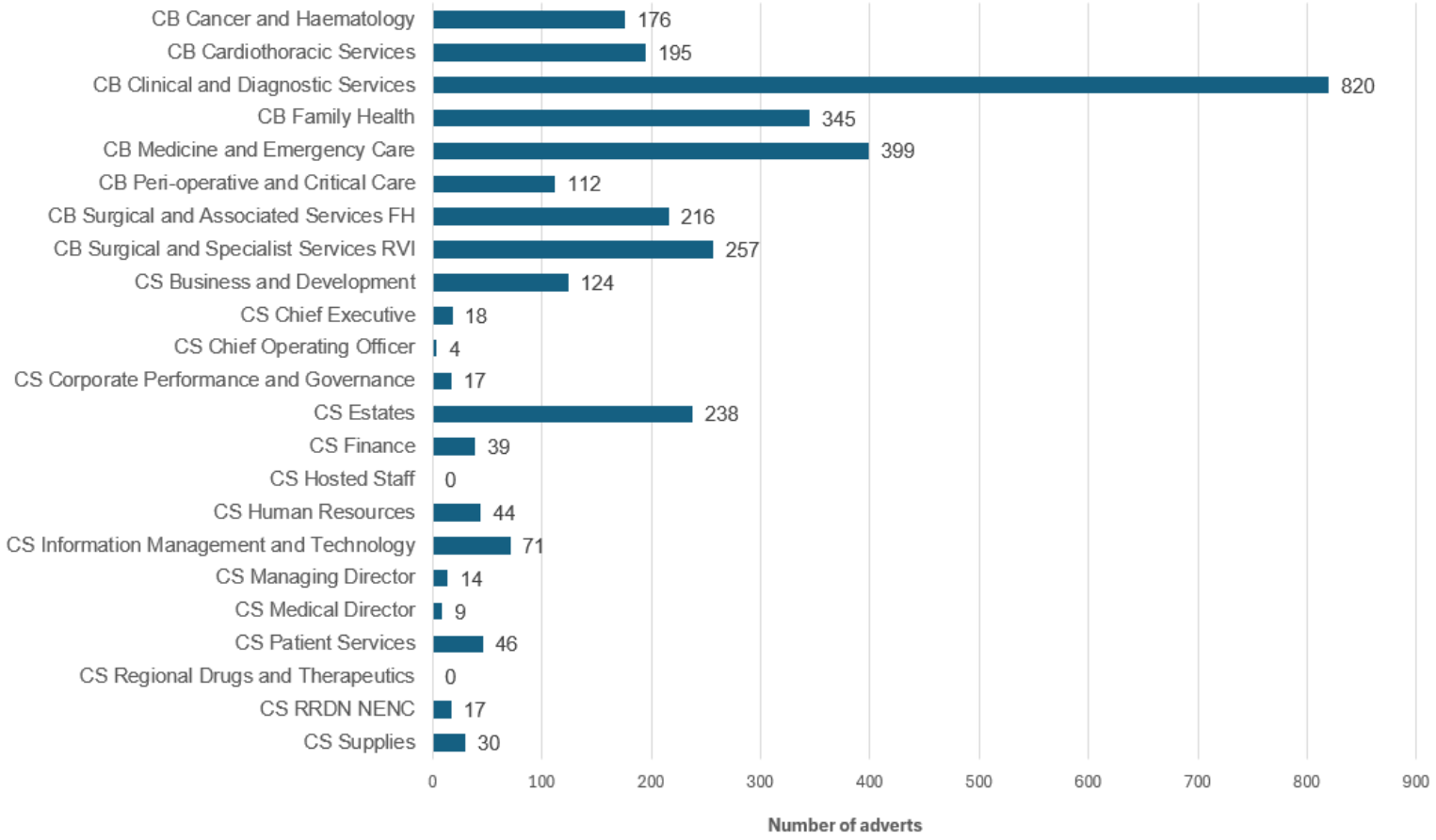
Number of adverts since corporate vacancy freeze on 14/05/2025, clinical vacancy freeze on 04/08/2025 and recruitment pause 01/10/2025-22/10/2025 and internal first on 26/01/2026 **3199**



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 02 October 2026 72.1% of candidates that were at conditional offer stage were external and 27.9% internal which is less than last month, a decrease of 3.1% on last month internal candidate share. This now the lowest internal offer share since 02/02/26 which was 23%. In recent weeks the trend has been back to external applicants and external offers.

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

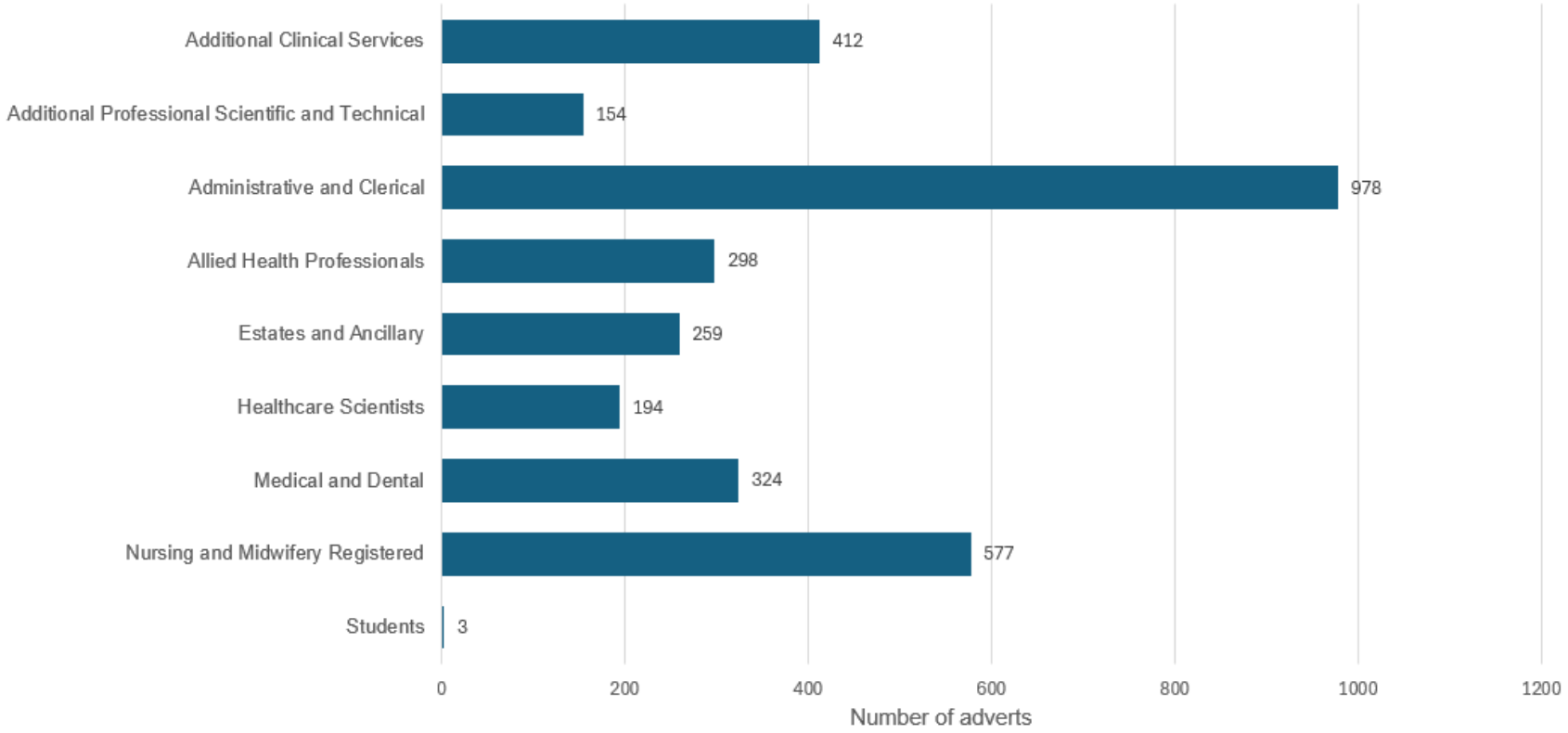


There has been 3,199 adverts since 14/05/2025. The highest number of adverts has been for Clinical and Diagnostic Services (820). However, this should be considered in proportion to the size of the Clinical Board. This is then followed by Medicine and Family Health.

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

3,199



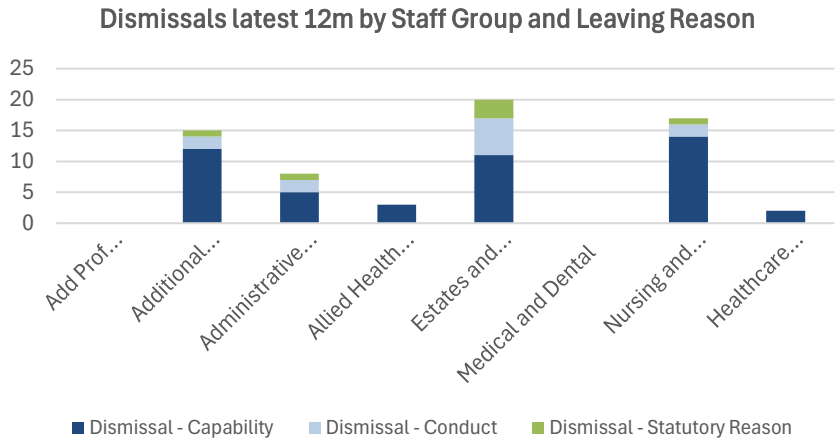
There has been 3,199 adverts since 14/05/2025. The largest volume of adverts since 14 May 2025 has been in Administrative and Clerical roles (978), followed by Nursing and Midwifery (577), with the lowest numbers in Additional Professional and Scientific positions with the exception of students.

Dismissals – 12 month rolling period ending September 2026

Dismissals	12-Month period ending	Dismissals Headcount	Dismissals FTE
	Sep 26	65	48.91

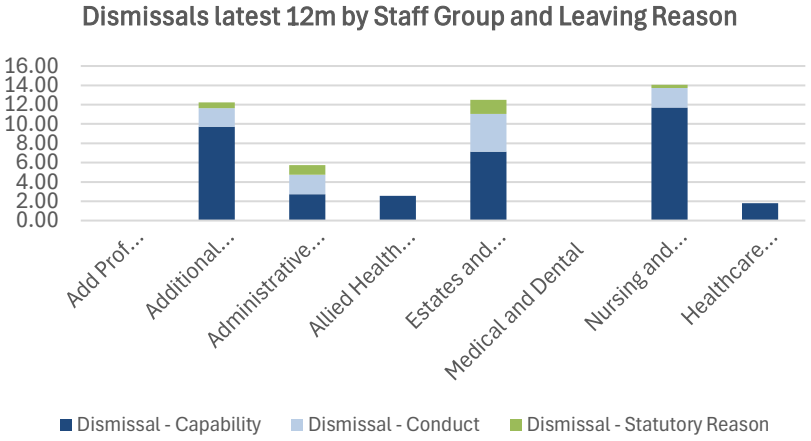
Headcount

Staff Group	Dismissal - Capability	Dismissal - Conduct	Dismissal - Statutory Reason	Total
Add Prof Scientific and Technic				
Additional Clinical Services	12	2	1	15
Administrative and Clerical	5	2	1	8
Allied Health Professionals	3			3
Estates and Ancillary	11	6	3	20
Medical and Dental				
Nursing and Midwifery Registered	14	2	1	17
Healthcare Scientists	2			2
Grand Total	47	12	6	65



FTE

Staff Group	Dismissal - Capability	Dismissal - Conduct	Dismissal - Statutory Reason	Total
Add Prof Scientific and Technic				
Additional Clinical Services	9.72	1.92	0.60	12.24
Administrative and Clerical	2.74	2.00	1.00	5.74
Allied Health Professionals	2.57			2.57
Estates and Ancillary	7.15	3.88	1.47	12.49
Medical and Dental				
Nursing and Midwifery Registered	11.71	2.00	0.35	14.06
Healthcare Scientists	1.80			1.80
Grand Total	35.69	9.80	3.41	48.91

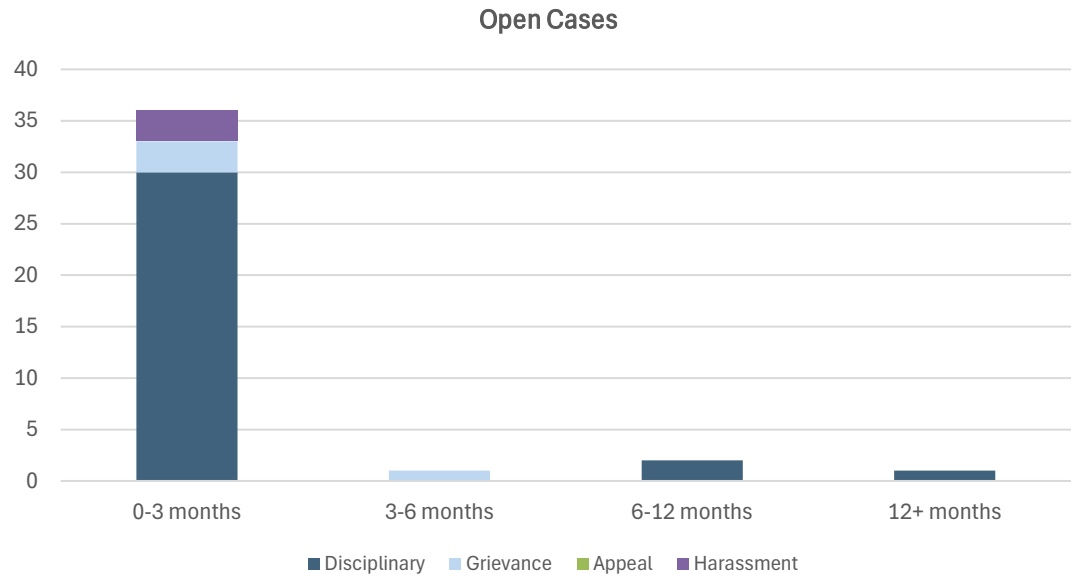


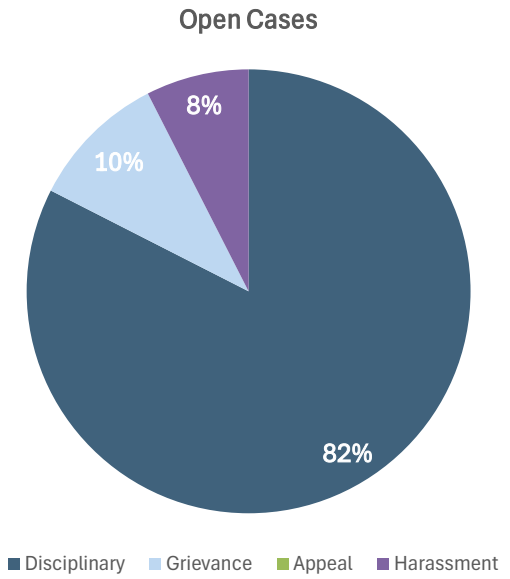
Employee Relations - Open Cases

Open Cases	Latest Month	Total Open Cases
	Sep 26	40

Case Type	0-3 months	3-6 months	6-12 months	12+ months	Total
Disciplinary	30	0	2	1	**33**
Grievance	3	1	0	0	**4**
Appeal	0	0	0	0	**0**
Harassment	3	0	0	0	**3**
Grand Total	**36**	**1**	**2**	**1**	**40**

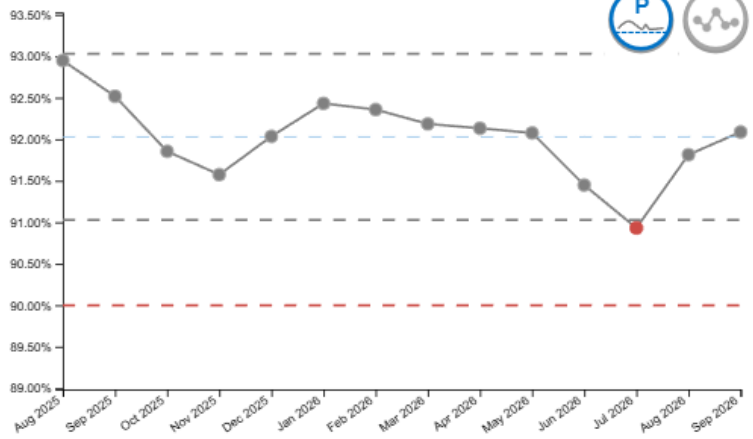
There are currently 40 open employee relations cases, 33 are disciplinary (of which 9 suspensions), 3 harassment and 4 grievance.

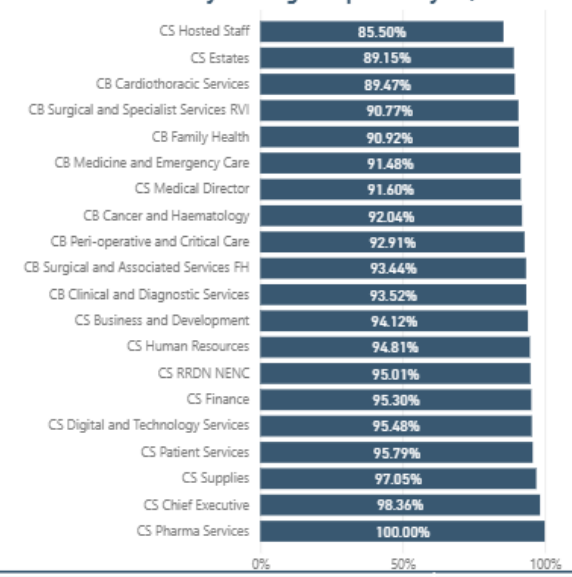


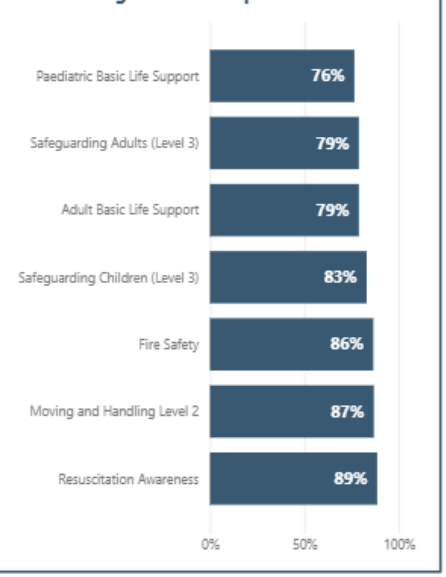


Mandatory training

Mandatory Training Compliance	Month	Value	Target
	Sep 26	92.09%	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 Care Quality Commission (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 (80.92%) with low compliance in Paediatric Basic Life Support (55.77%); Adult Basic Life Support (60.47%); Safeguarding Adults Level 3 (64.85%)*
- Face-to-face training can take more time away from work compared to online.
- Performance looked at as part of Well-led domain.
- Quality Improvement (QI) approach to improve resus compliance had limited impact.
- Oliver McGowan. Trust expected to show CQC how it has met legal requirements.

Actions Undertaken:

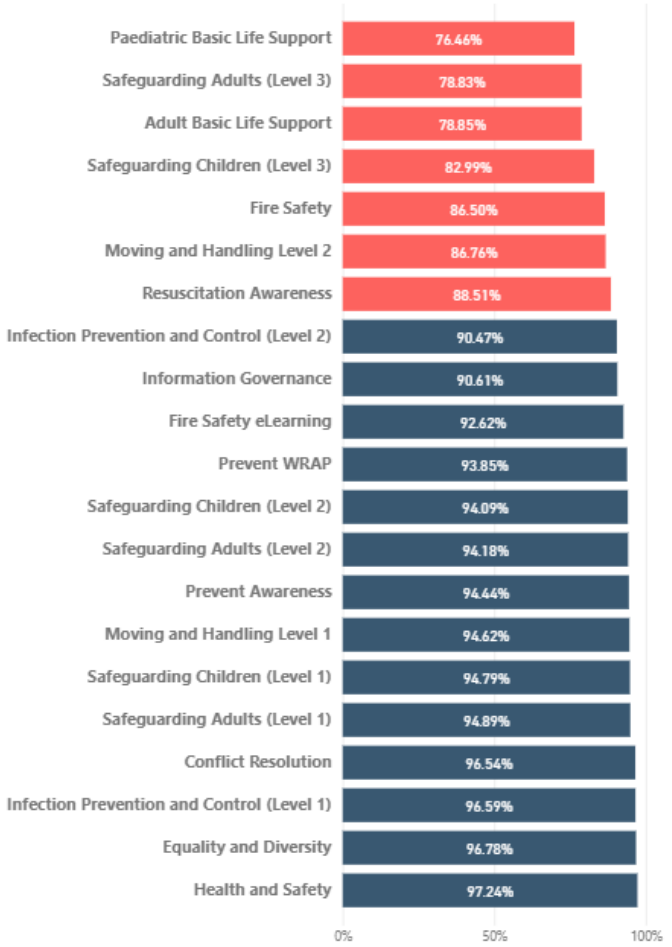
- Task & Finish Group has been established to look at 'process and provision'.
- CB Surgical and Specialist Services are establishing a 2-day bespoke drop-in session for learning lab.
- Infection prevention & control – in line with national guidelines, level 1 training to be allocated to all staff. In 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

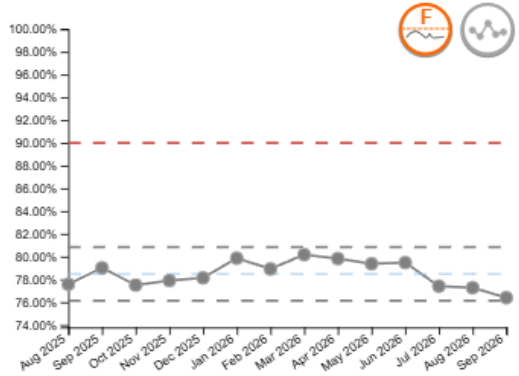
Mandatory Training Compliance	Month	Value	Target
	Sep 26	92.09%	90.00%

Training Course Compliance %

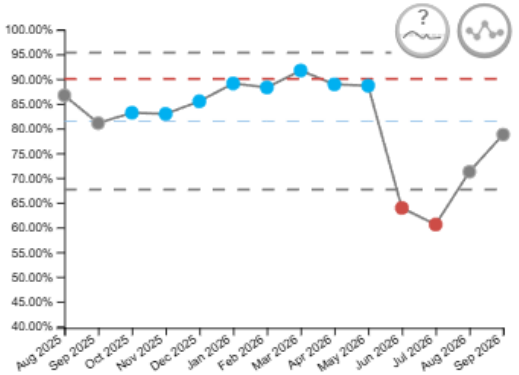


Lowest 4 Mandatory Training Compliance %

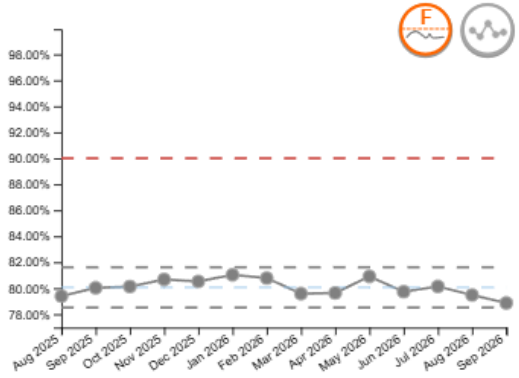
Paediatric Basic Life Support — 76%



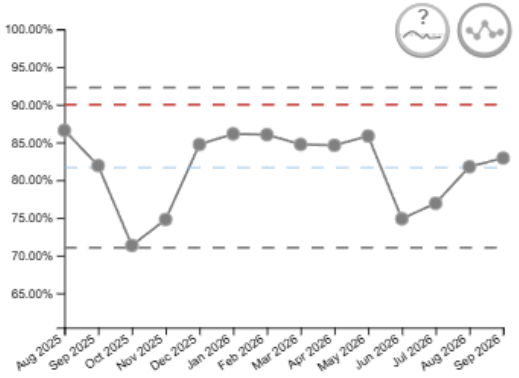
Safeguarding Adult (Level 3) — 79%



Adult Basic Life Support — 79%



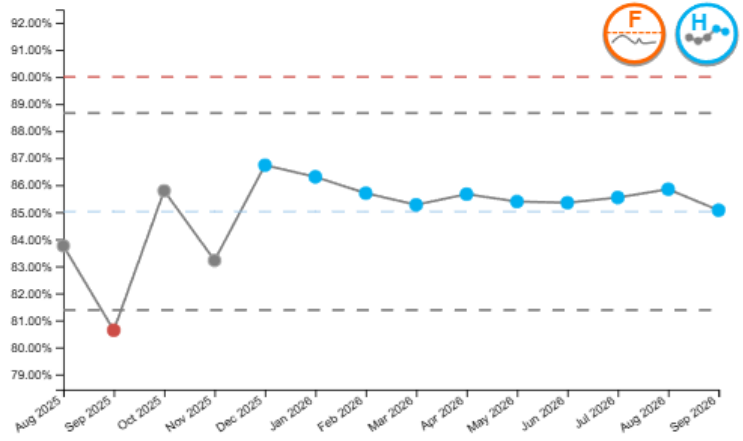
Safeguarding Children (Level 3) — 83%

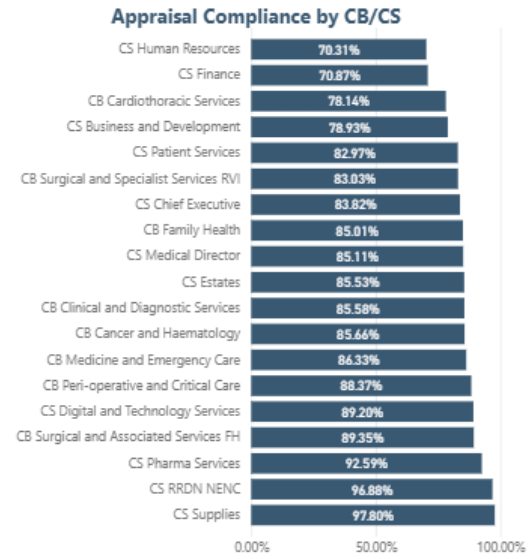


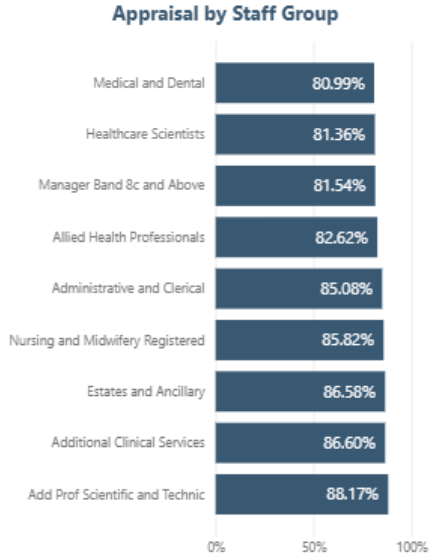
**Ongoing work to correct the assignment of Safeguarding Level 3 training has resulted in the courses being allocated to over 3,000 additional staff in phases. This has increased the number of staff required to complete the training and has temporarily affected compliance figures.*

Appraisal compliance

Appraisal Compliance	Month	Value	Target
	Sep 26	85.07%	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

- 2,144 appraisals are overdue with highest numbers in Nursing and Midwifery (676) and Admin and Clerical (354).
- Clinical board performance varies between 78.14% (Cardiothoracic Services) to 89.35% (Surgical and Associated Services).
- Corporate Service performance varies between 70.31% (Human Resources) to 97.80% (Supplies).
- Compliance impacted by time and capacity of managers and staff.

Actions Undertaken:

- Senior medical and dental staff (consultant and SAS) now typically have a weekly minimum of 1.5 (6 hours) and 1(4 hours) core 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 Programmed Activity (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 (£)
	Sep 26	£20,373,587	+£1,834,697

Bank Utilisation (£)

Staff Group	Oct 24 - Sep 25	Oct 25 - Sep 26	Difference
Admin & Clerical	£1,147,328	£424,769	-£722,559
Ancillary	£344,793	£286,803	-£57,990
Estates			£0
Nursing & Midwifery (Registered)	£6,410,587	£7,621,599	£1,211,012
Nursing & Midwifery (Unregistered)	£9,894,418	£11,098,845	£1,204,426
Professional & Technical	£741,764	£941,572	£199,807
Total	£18,538,890	£20,373,587	£1,834,697

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

Bank use (£) – medical (locum)

Bank Utilisation (£)	12-Month period ending	Total Bank Expenditure (£)	Total Bank Difference (£)
	Sep 26	£13,445,221	+£2,251,444

Bank Utilisation (£)

Staff Group	Oct 24 - Sep 25	Oct 25 - Sep 26	Difference
Medical - Consultant	£5,236,173	£7,334,859	£2,098,686
Medical - Specialty Doctors	-£293	£100,418	£100,711
Medical - Specialty Registrar	£3,526,316	£4,034,962	£508,646
Medical - Lower Specialty Trainee	£1,877,191	£1,386,884	-£490,307
Medical - SHO'S and HO'S	£95,894	£1	-£95,893
Dental - Consultant	£1,767	£104,775	£103,008
Dental - Career / Staff Grades	£121,136	£85,432	-£35,704
Dental - Registrar & Senior Registrar	£50,556	£379,929	£329,373
Dental - SHO'S and HO'S	£5,474	£17,961	£12,487
General Practitioner	£279,563	£0	-£279,563
Total	£11,193,777	£13,445,221	£2,251,444

Current Position:

- Total spend increased by £2.2m overall.
- Notable increases in cost of Medical Consultants and Registrars by +£2.1m and +£0.5m, respectively. Dental Registrar cost have also increased by £0.3m.
- Lower Specialty Trainee costs decreased significantly which reduced by -£0.5m. Similarly, General Practitioner costs decreased significantly which reduced by -£0.3m.

Underlying Issues

Effect of winter accrual:

- Clinical Board 5 advised of additional winter shifts which had not yet materialised. Finance accrued for the anticipated cost.
- During 2025/26, further analysis using MediRota showed that most of these shifts were already being captured. The accrual was therefore released in Month 6, resulting in locum expenditure of £135k for the month, compared with a typical monthly spend of £1.0m–£1.2m.
- The corresponding cost are partially reflected in the higher Agency Consultant expenditure, Month 7 2024/25 to Month 6 2025/26.
- Resident doctors have had **21** strike days between October 2025 and September 2026 compared with **5** in the prior 12 months.
- 2 sets of pay rises for medical staff which make up a potential 350k of the variance.

Actions Undertaken:

Agency use (£) – non-medical

Agency Utilisation (£)	12-Month period ending	Total Agency Expenditure (£)	Total Agency Difference (£)
	Sep 26	£1,834,687	-£1,369,688

Agency Utilisation (£)

Staff Group	Oct 24 - Sep 25	Oct 25 - Sep 26	Difference
Admin & Clerical	£183,138	£115,266	-£67,872
Ancillary	£2,330	£61,433	£59,103
Estates	£28,674	£50,064	£21,390
Nursing & Midwifery (Registered)	£716,971	£207,022	-£509,949
Nursing & Midwifery (Unregistered)	£1,265,215	£831,140	-£434,075
Professional & Technical	£1,008,048	£569,763	-£438,285
Total	£3,204,376	£1,834,687	-£1,369,688

Current Position:

- Costs reduced by c. £1.4m 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 (£)
	Sep 26	£2,235,972	-£1,713,072

Agency Utilisation (£)

Staff Group	Oct 24 - Sep 25	Oct 25 - Sep 26	Difference
Medical - Consultant	£3,877,707	£2,209,870	-£1,667,837
Agency - Career / Staff Grades	£4,145	£8,987	£4,842
Medical - Registrar & Senior Registrar	-£9,952	-£3,670	£6,282
Medical - SHO'S and HO'S	£72,184	£19,890	-£52,294
General Practitioner	£4,961	£896	-£4,065
Total	£3,949,044	£2,235,972	-£1,713,072

Current Position:

- Costs decreased by c. £1.7m, on previous year.
- Notable reductions in Consultant and Senior House Officers (SHOs)/House Officers (Hos)
- Consultants collectively working an average of 1,100 hours per month.

Underlying Issues

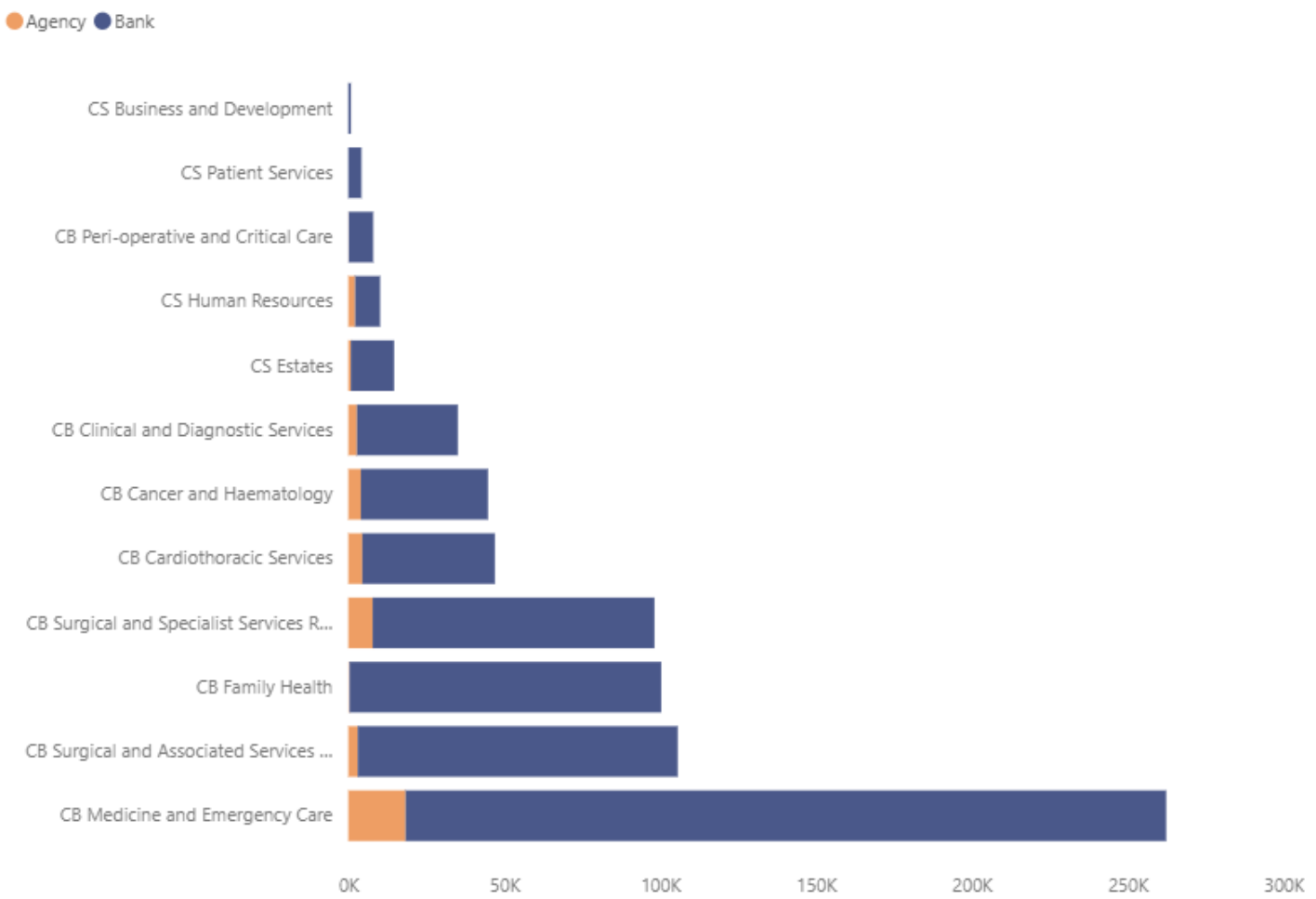
- Consultant spend. Staffing issues in Older People's Medicine and Stroke; off-framework arrangement in Paediatric Intensive Care Unit (PICU) due to sickness absence and recruitment; locum in General Medicine as part of Winter Plan 2024/25 ended in April 2025; agency Consultants unwilling to move to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

Actions Undertaken:

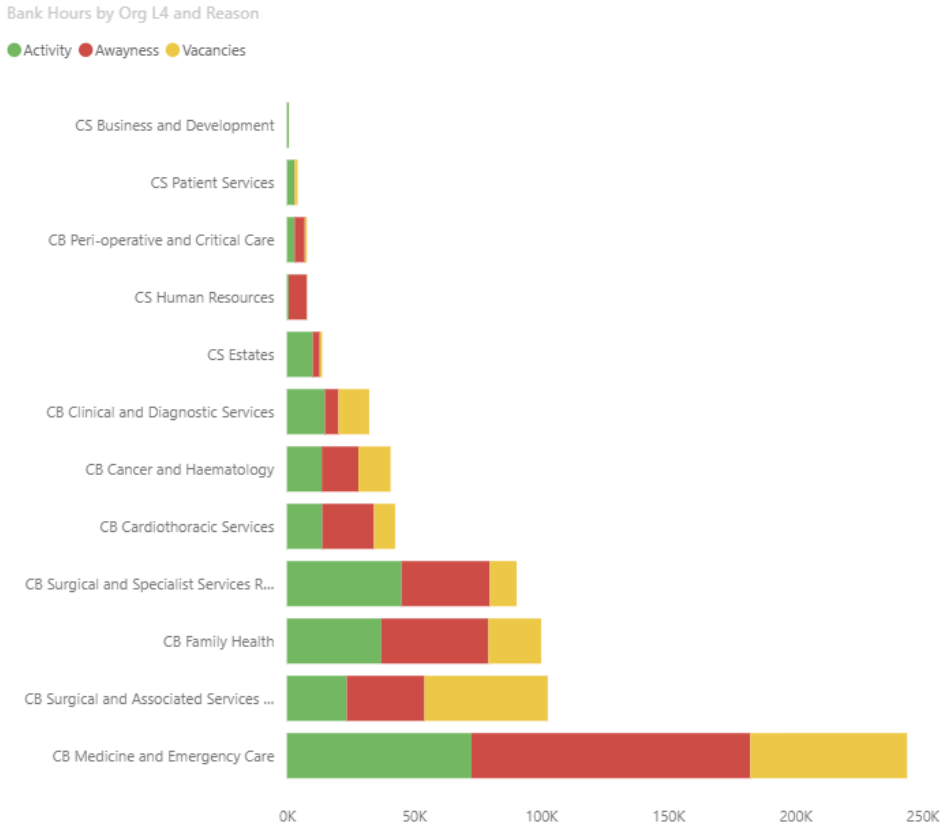
- Consultants. Trust contracts offered and declined; charges and hourly rates renegotiated wherever possible; recent recruitment in PICU has been successful reducing the need for agency.

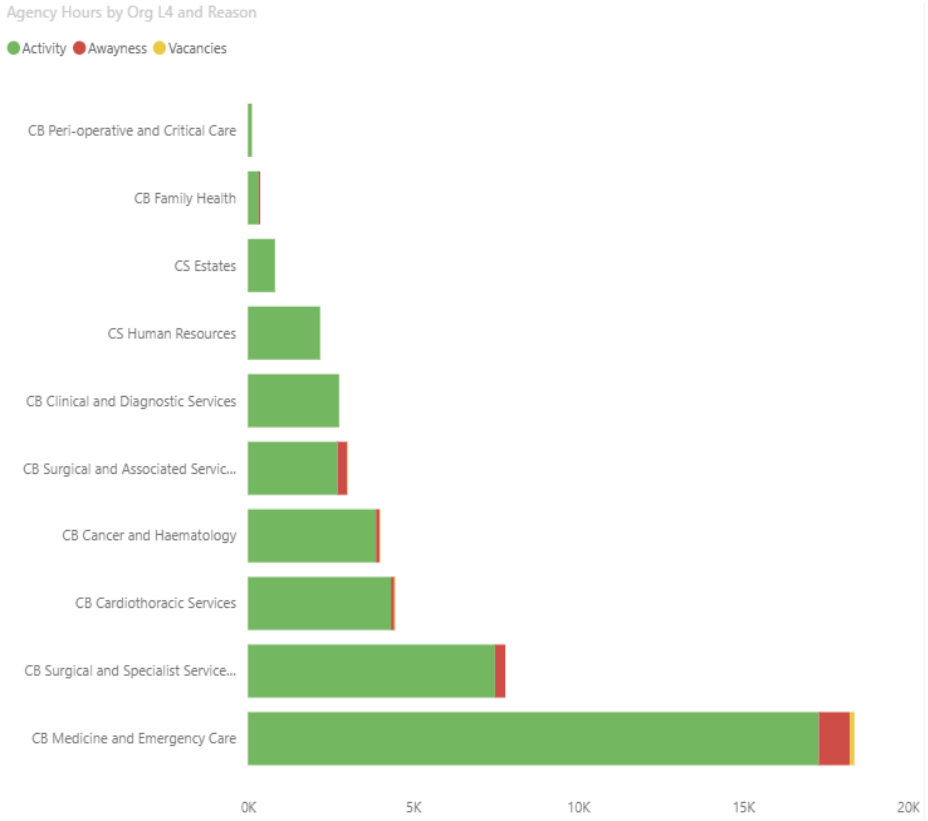
Bank & agency use - hours

Bank & Agency	12-Month period ending	Total Bank and Agency Hours
	Sep 26	731,393



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

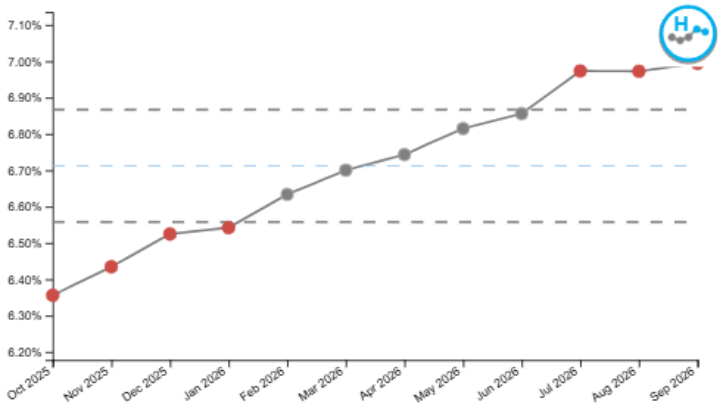


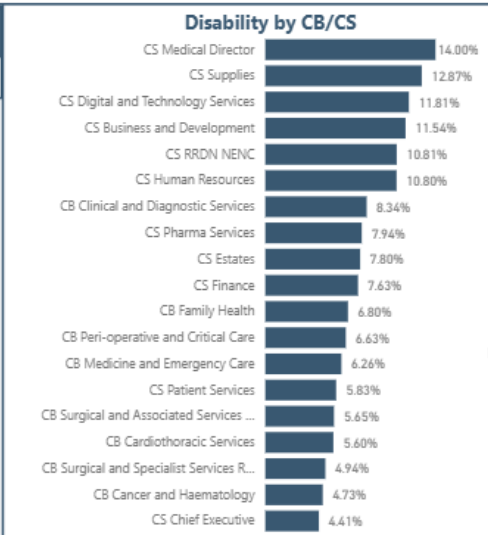


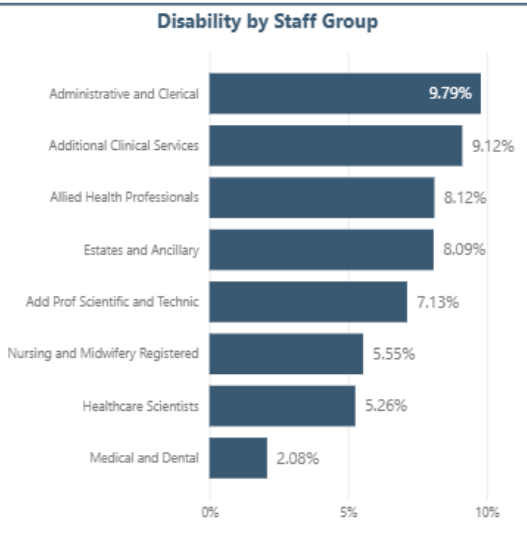
- **awayness**, including sickness, maternity, study leave, industrial action, etc.
- **activity**, including workload, acuity, waiting list initiative, etc.
- **vacancies**

Equality, diversity and inclusion (EDI) - disability

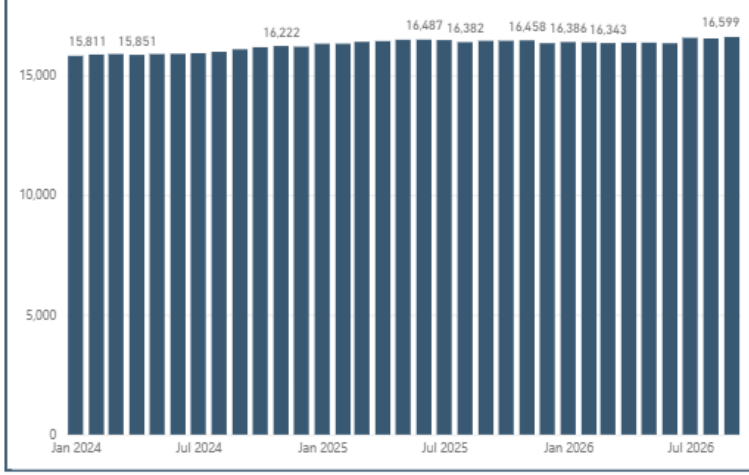
EDI - Disability	Month	Value	Trust Headcount
	Sep 26	6.99%	16,599







Trust Headcount Trend



Age Band

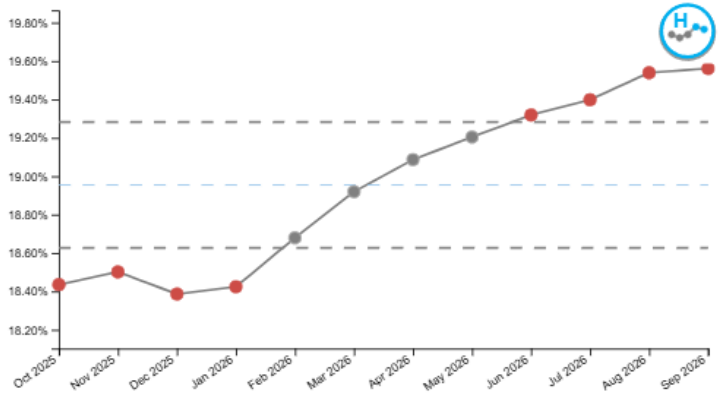
	Age Band	Disability %
1	<=20 Years	9.79%
2	21-25	14.21%
3	26-30	8.17%
4	31-35	6.95%
5	36-40	5.42%
6	41-45	5.34%
7	46-50	5.50%
8	51-55	6.95%
9	56-60	6.62%
10	61-65	7.60%
11	66-70	3.53%
12	>=71 Years	6.15%

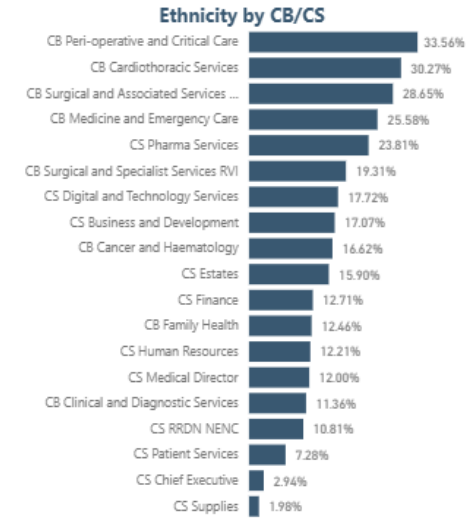
Current Position:

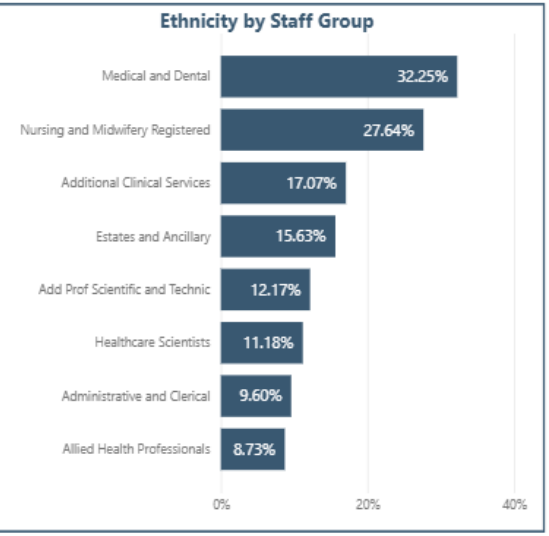
- Charts show percentage of staff in post each month by those disclosing a disability.
- Percentage of disabled staff continues to grow with the latest position reflecting 6.99% of the workforce.
- Workforce Disability Equality Standard (WDES) data from the National Staff Survey will be published at the end of April 2026, with key findings being linked/aligned to the 12-point EDI plan.
- The development of the leadership development program will have EDI integrated throughout.

Equality, diversity and inclusion (EDI) - ethnicity

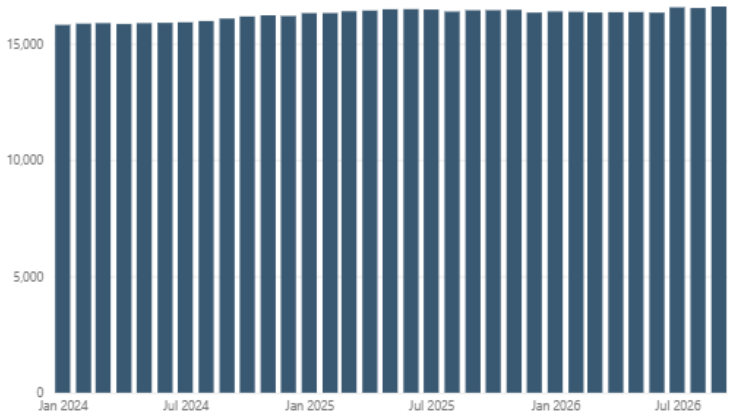
EDI - Ethnicity	Month	Value	Trust Headcount
	Sep 26	19.56%	16,599







Trust Headcount Trend



Age Band

	Age Band	BME %
1	<=20 Years	20.98%
2	21-25	14.94%
3	26-30	30.10%
4	31-35	25.35%
5	36-40	25.20%
6	41-45	17.41%
7	46-50	18.41%
8	51-55	17.40%
9	56-60	11.90%
10	61-65	6.11%
11	66-70	6.36%
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 19.56% 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

September 2026

Financial Health

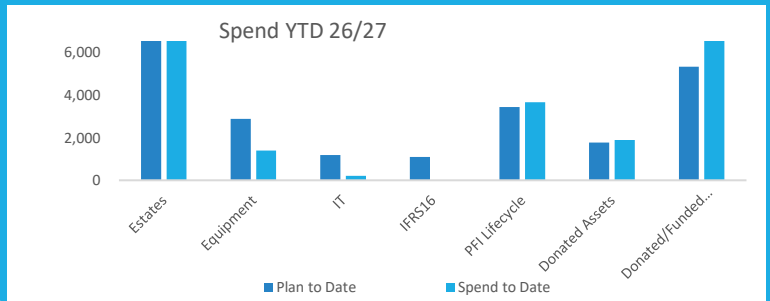


The Trust needs to take significant actions to deliver its financial objectives and is managing significant financial risk.

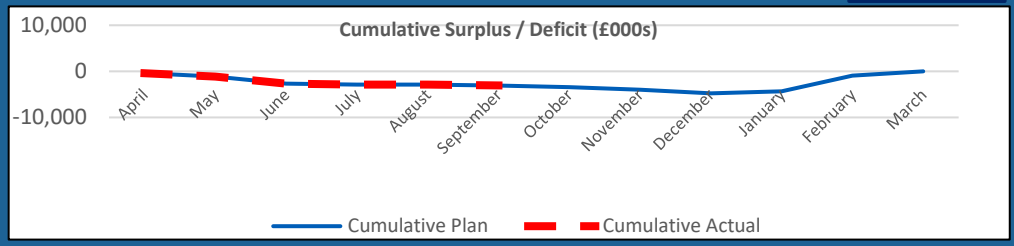
Financial Performance Month 6

- The trust delivered a deficit of £3 million in month 6, in line with the financial plan.
- Reported Cost Improvement Programme (CIP) for Clinical Boards and Corporate Services are behind plan.
- Industrial action costs in month 1 are £627k, no funding has been allocated by NHS England to cover as there has been in previous years.
- On the North East North Cumbria (NENC) ICB contract, there has been a reduction in income value compared to income expected in plan.
- Due to a higher than planned cash balance, interest receivable is higher than plan by £2,032k.
- There is an overspend on Matched, Block and tariff drugs, and pay, with an increase on expenditure on Clinical Supplies in September.

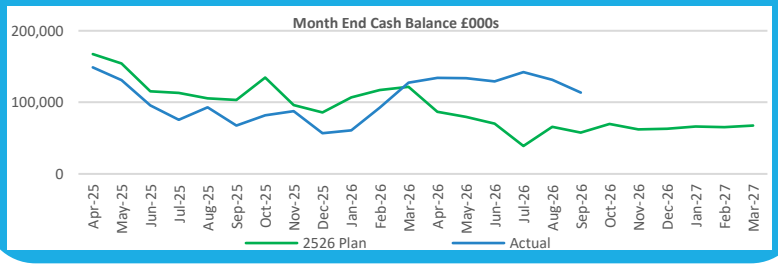
Capital Programme Delivery – Month 6



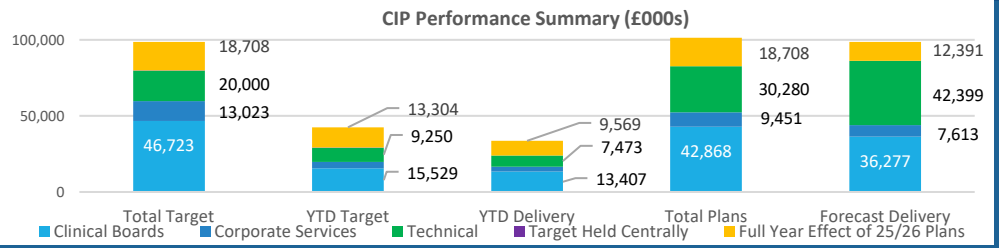
Cumulative Performance Against Plan



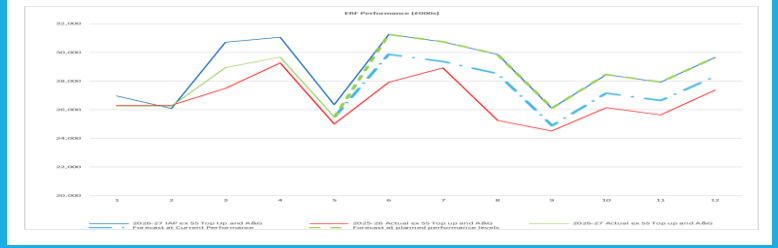
Cash Balance



Cost Improvement Programme Performance



Activity – Elective Recovery Income (M5 Flex)



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 – improving	**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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The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 November 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	The report contains two experiences. The first is from a patient who accessed care in the Trust and wanted to provide feedback on the care they experienced to support meaningful improvement and experienced challenges in doing so. The second is from a staff member who is leading an 'enhanced therapeutic observation of care' pilot in the Trust which focuses on improving the care to some of our most vulnerable patients. The reflections demonstrate the importance of this work as we focus on the delivery of high quality, individualised care. Both experiences are important to reflect on as we strive to deliver our strategic objectives, specifically Advancing Care and Supporting Great Care.					
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.					
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]	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:

During the Trust's Annual General Meeting, the Executive Director of Nursing, Midwifery and Allied Health Professionals met with a member of the public who had previously accessed our services and continued to be impacted by not just the care they received, but also how it felt to share feedback and the response they received. As we further develop our patient experience programme and deliver the aspiration of our Trust Strategy, specifically Supporting Great Care and Advancing Care, this reflection shows the critical need to ensure we capture meaningful feedback outside of the formal complaints and Patient Advice and Liaison Service (PALS) processes. We also need to ensure those sharing reflections feel heard and their feedback is acted on when appropriate.

Some of the clinically specific reflections below have been picked up with the relevant clinical areas, and we are using this experience alongside others to shape our future proposal and model for the patient experience programme.

Reflections:

'My occasional contact with PALS over the many years when my late partner was a patient, has taught me that in their words, "everything is treated as a complaint". Even when I don't want to complain but offer constructive feedback that provides the opportunity to make things better in the NHS for others in the future.

In May 2025, I had my second hip replacement. The outcome was excellent. But there is a significant memory about an issue in the overall experience that has stayed with me since.

I'm admittedly the biggest 'wimp' under the sun: Absolutely terrified of anything to do with surgery. I can't even watch surgery on television. About a month before the operation, I attended my pre-op appointment. There was a fantastic nurse there. We shared our personal experiences of bereavement and talked about our late partners. She was utterly empathetic, as my partner had died six months earlier. That conversation and her professionally supportive manner helped to put me at ease.

A couple of weeks before the operation, I received a request to attend a physiotherapy education session. I got the message only the day before, but fortunately I was able to rearrange things and attend the following week. There were about 30 people there. The session was very informative about what to expect and how to prepare for surgery. A physiotherapist handed round a model of a hip joint prosthesis and talked us through the operation. Being 'Mrs Squeamish', I hid behind my leaflet. They said that the surgeons were encouraging patients to have a spinal block rather than a general anaesthetic, explaining that this was based in research findings that "In general patients recover more quickly from the spinal block than from a general anaesthetic. I could feel my stomach leap into my mouth. They demonstrated how you had to lean over a trolley while the injection was given, and I felt

physically sick.

My state of mind for a host of reasons and experiences since the bereavement was already struggling and was exacerbated by that. I didn't say so in the room because my comments might have affected other patients there. With this topic on my mind, I hardly slept that night. The next morning, I rang the department you speak to about your appointment. To be fair, they did give me some reassurance. I said that I wanted a general anaesthetic, and they told me that I would always have a choice. I felt the tension lifting from my shoulders. I felt reassured because I believed the decision had been made and my wishes would be respected. Although I believe that person said that in good faith, I now know it not to be true as surgeons have autonomy in this respect.

On the day of surgery, I arrived at 7.00am. Because patients were separated only by curtains, I could hear the anaesthetist's conversation. I remember sitting there thinking, "Please don't talk to me about spinal blocks again."

The anaesthetist came to speak to me. I said, "Please don't talk about the spinal block." He said, "I can see from your record that you want a general anaesthetic, but I just need to explore with you what it is that you have against a spinal block." My immediate thought was, "No, you don't" and "for whose benefit?" So, I said firmly, " I don't want to see or hear anything during surgery."

Years ago, clinicians were seen as the professionals and patients generally listened and accepted. Things have mostly improved in this respect; I believe my surgeon had listened to my explanation of nervousness at first referral, so I was second on the list and didn't have the prospect of a longer anxious wait time. I too am a professional in my own field, and I mustered the courage to be able to assert my right to say "no" for my own reasons. That was not easy as I was already nervous and quite shaky, being only minutes from going to theatre.

They took me down to theatre. In the waiting bay, staff put a heated cover over me. I was very nervous and shaking. I also felt a bit labelled...as '"the one who didn't want the spinal block." At last, I had the injection in my hand and then I was unconscious. Everything went okay, and the outcome has been excellent. But once I reflected on it afterwards, I felt that one aspect of the whole experience wasn't acceptable and I wanted to feed back a suggestion to be considered to improve for other patients in the future.

My suggestion would be to have the conversation about anaesthetic, earlier, e.g. at the pre-op appointment rather than on the day of the operation and only a few minutes prior to going into theatre. Then, patients could have time to think about things, ask questions and come to a decision before the day of surgery when shortly going to theatre. For me, having that conversation again just five minutes before being taken into theatre was the wrong time and frankly exacerbated my anxiety.

I fully understand that there is sound research evidence showing that patients may recover more quickly from a spinal block than from a general anaesthetic. But we're all different. There are huge differences in how people feel about these things. Everyone is different. I would value more consideration of where the patient is emotionally and psychologically too. For me, having that conversation again only five minutes before theatre, was not seeing me as a person.

I fed back my suggestion via the hospital members' system. Unfortunately, the eventual response merely reiterated the rationale about the research which I already knew. I then felt my suggestion of a way to improve wasn't acknowledged recognising that this was not a complaint but an opportunity to share my experience and potentially positively impact future care.

Colleague Experience

Context:

Compassionate, individualised and therapeutic approaches are fundamental to the delivery of high-quality care. This is important for all our patients but especially those who are most vulnerable. Some of our patients require enhanced observation to ensure we reduce their risk of harm but often this has been focused on maintaining safety and reducing risk rather than the delivery of individualised care. To try and improve the experience of this vulnerable patient group we have launched an 'enhanced therapeutic observations and care' pilot. The lead nurse shares her early reflections of this pilot highlighting some early impact but also the continued work still required to improve the care experience for this vulnerable patient group.

Reflections:

I have spent my entire career caring for older people, including 11 years as a Senior Sister in Older People' Medicine before moving into this role. Throughout that time, understanding the person behind the diagnosis has always been at the heart of how I work. This role is particularly meaningful to me because of my own experience with my dad, who lived with dementia. Towards the end of his life, he became increasingly distressed and aggressive. I witnessed some truly excellent care in the care home where he lived, but I also saw occasions when the care he received fell short of what he deserved. When I considered applying for this post, some people questioned whether it might be too personal. For me, it was exactly the opposite. I firmly believe that if the staff caring for my dad had received the kind of training, support and engagement that we are now providing through enhanced therapeutic observations and care (ETOC), his experience could have been very different. That belief is what inspired me to take on the leadership of the ETOC pilot.

Historically, enhanced care has often focused on observing a patient and making sure they do not come to harm. It can become about sitting beside somebody, stopping them from falling. Safety is incredibly important, but we want to move beyond observation alone. We want to provide compassionate and personalised care.

The pilot supports patients living with dementia, delirium and other forms of cognitive impairment. A hospital admission can be frightening and disorientating. Someone may suddenly find themselves in an unfamiliar environment, surrounded by people they do not know and separated from the routines and relationships that normally help them feel safe. There is no one-size-fits-all approach. We need to understand the individual and explore how we can maintain their safety in a way that works for them. If that means walking up and down the ward with somebody, then we walk with them...

One gentleman we supported was Cantonese. He understood English, but communication became much more difficult when he was anxious, frustrated or agitated. We spoke to his wife and daughter and found out about his interests. He enjoyed mathematical puzzles and playing cards, and he used to love going to the casino. The team began using extra-large playing cards with him. He was able to remain quite calm while doing that, and he started engaging with the staff. He ended up showing them how to write numbers in Cantonese, which was quite a lovely moment. It was about finding a way to connect with him through his identity, his culture and the things he enjoyed.

Sometimes, the things that matter most can appear incredibly small.

I remember supporting another gentleman who had spent a long time in a cubicle. When the time came to move him into a bay, I said, 'Right, the bed is available here, so we'll move him into this one.' One of my team asked, 'Nicola, can we move the bed?' I asked her why... 'Because he loves looking out of the window, and that bed is miles away from it.' I had not thought of that. We moved the bed so that he could be beside the window, and it worked perfectly. Now, when we walk past the bay, we often see him standing safely at the window, looking at the view. To somebody else, the position of the bed might seem like a very small detail. But that member of staff had spent time with him and had gained an insight into what worked for him. She knew that being able to look out of the window mattered.

One of my most memorable experiences involved a woman who had previously enjoyed painting. We initially assumed that she would enjoy colouring in. She did not. She had absolutely no interest in doing it herself. However, when I walked into the bay, she was quite happily telling one of our therapeutic healthcare support workers which colours to use, commenting on how well she was doing and pointing out when she had gone over the lines. It reminded me how important it is to pick up on the person's cues. Our first assumption was that she would want to colour because she had enjoyed painting. What actually engaged her was directing somebody else and then talking about fashion and the things she remembered.

Families have felt the difference too. One woman told us that she had always felt apprehensive about leaving her husband on the ward. He had been living with dementia for several years, and she worried about what his care would be like when she was not there. She still spent a lot of time with him, but she told us she now felt much more reassured when she went home because she could see that staff were taking the time to engage with him.

Another family arrived while one of the team was using a reminiscence dice game with their relative. The numbered topics prompted conversations about areas of his life, including his childhood and career. The family were able to join in and engage with him in a way they had not managed for quite a long time. They told us they would normally sit and watch television because they did not know how else to prompt conversation. The activity gave them another way to be together and something they could continue using when he returned to his care home.

It sounds relatively simple: playing cards, a reminiscence activity, a conversation about someone's interests or moving a bed nearer to a window. But they are not insignificant. They come from taking the time to understand who somebody is, what is important to them and what might help them feel calmer, safer and more connected.

We cannot always achieve that level of engagement with every person. Families sometimes tell us, "We have tried this before. It isn't going to work." When we cannot engage in the way we hope, our focus must remain on maintaining the patient's safety and supporting their family. But when we do find that connection, the impact can be significant.

For two patients in particular, we have seen incidents and call-outs to security reduce substantially. For some patients, we have also seen a reduction in the level of care they need overnight after receiving therapeutic engagement during the day.

The team is learning all the time. We debrief every day and talk about what has worked, what has been difficult and whether there is anything else we could try. They are genuinely delighted when they discover something that makes a difference.

For me, this is about maintaining a person's identity, understanding. We are moving beyond simply observing patients. We are taking the time to understand them, their interests and culture, and keeping them connected. It is about truly seeing the person behind the risk or the diagnosis.

Report of Ian Joy
Executive Director of Nursing, Midwifery and
Allied Health Professionals
17 November 2026

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Agenda item A3(b)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	27 November 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	Significant operational pressures continue, particularly within urgent and emergency care and cancer services, although several improvement initiatives are underway. There is positive progress in digital transformation, deteriorating child workstreams, Infection Prevention and Control (IPC) governance and transplant service development. Assure • Frailty Same Day Emergency Care (SDEC) launched successfully and delivering high same-day discharge rates. • Digital transformation progressing strongly with 62 Electronic Patient Record (EPR) improvements and multiple innovation pilots. • Deteriorating Child programme largely on track with Paediatric Critical Care Outreach Team (PCCOT) approaching launch. • No new IPC safety concerns requiring escalation. • Assessment and Recovery Centre (ARC) transplantation programme moving into implementation phase. Advise • Emergency Department (ED) performance deterioration. • Cancer 62-day performance remains significantly challenged in major tumour groups. • Outpatient transformation progressing but slower than planned. • Teaching fellow workforce shortfall affecting educational delivery. Alert • Radiotherapy performance remains nationally concerning despite improvement. • Winter operational risk increased by delay to winter ward opening and sustained emergency demand. • Ongoing uncertainty around ARC commissioning and long-term funding.		
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 and challenges resulting from estates work in the ED. iii) Note the ongoing work to improve performance against cancer care targets and the challenges in specific tumour groups.		

Agenda item A3(b)

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

JOINT MEDICAL DIRECTORS REPORT

1. OPERATIONAL UPDATE

1.1) Urgent & Emergency Care (UEC)

Performance

- In October 2026 overall performance was 75.95% against the 4-hour target, down slightly from 76.9% for October 2025. Combined Urgent Treatment Centre (UTC) performance was 97.5%. Type 1 major performance against the 4-hour standard was 55.4% which has dropped significantly from October 2025 (60.8%).
- October 2026 saw the highest ever ambulance arrivals to the ED at 3,544.
- Corresponding to the start date of the estate's improvement works (new link corridor between the UTC and the ED) there has been a significant increase in ambulance handover delays. Active measures are being taken to mitigate against this as far as possible given the lengthened ambulance routes during the remainder of the works.
- The number of patients staying more than 12 hours remains relatively low (2.3% in September) as compared to regional (9.8%) and national (10.1%) figures.
- Patients needing admitted to hospital from the ED waited a mean of 310 minutes, well below the national figure of 661 minutes.

Frailty SDEC

- The opening of the Frailty SDEC service was expedited to 1st October 2026. Patients move from the Assessment Suite or the ED at opening (8am) for comprehensive geriatric assessment.
- In October the frailty service saw 227 patients within all UEC pathways, with 141 patients admitted to the new frailty unit. 64% of these patients were discharged on the same day.
- This is not yet at full functional capacity due to staffing issues. The next steps include introducing direct referral routes from the North East Ambulance Service NHS Foundation Trust (NEAS) and primary care.

ED/UTC

- The response to the decline in ED performance has accelerated. A significant number of additional medical staff shifts to support paediatrics and adults at peak day times and overnight over the next 6 months have been agreed.
- An Emergency Department Ambulatory Majors (EDAM) pilot model has launched using existing medical resource, providing dedicated consultant-led assessment of ambulatory Type 1 major category adult patients. Additional nursing support has been provided to ensure this can effectively improve key metrics.
- The workforce development of the UTC staff continues. Rotas within the UTC have been revised to ensure the most senior clinical decision makers are at the front desk at peak times and streaming criteria have been revised by the clinical teams.
- The works to construct and open the new link corridor between the UTC and ED remain on schedule. Clinical and operational teams are ensuring new processes will be ready for the opening of this critical new space which will include a new ambulance entrance and four assessment rooms.

- Additional Integrated Care Board (ICB) winter funding will also be used with Newcastle General Practice Services (NGPS) to boost GP capacity in the UTC.
- Clinical and operational teams are working with estates on the phase 2 development work to the ED. This has also involved work with Strategic Healthcare Planning who have provided models on the optimal clinical space required for the ED.

Patient Flow

- The use of the discharge lounge across both the Royal Victoria Infirmary (RVI) and the Freeman Hospital has grown which is critical to the early flow of patients out of the ED. Audit has shown that on average 41 patients per day are utilising the RVI discharge lounge (January to June 2026) before 10am each day as compared to 22 patients in 2025 thus expediting availability of medical bed capacity.
- The work to improve patient flow including reform of handover processes, use of criteria led discharge processes (e.g. in respiratory medicine) and enhanced nursing oversight is ongoing.

Winter

- Plans are in place to provide additional temporary capacity within medicine over winter. Opening of the winter ward is now expected during the first week of January 2027 rather than late December. Delays are linked to the Paediatric Intensive Care Unit (PICU) enabling works and associated ward reconfiguration requirements.
- Additional senior medical and resident medical personnel will be working both to care for medical boarder patients at the RVI and to bolster out of hours rotas within the Assessment Suite and SDEC.

1.2) Outpatients

The Outpatient Transformation Programme has been structured around three key workstreams:

- **Pillar 1: Improving Operational Efficiency** - Focusing on optimising outpatient processes, improving productivity, reducing unwarranted variation, and ensuring services are delivered as efficiently and effectively as possible.
- **Pillar 2: Embedding a Single Point of Access (SPoA)** - Implementing a SPoA across ten specialties over the coming months to streamline referral pathways, improve triage arrangements, and provide a more consistent experience for patients and referrers.
- **Pillar 3: Service Transformation and Innovation** - Supporting clinical services to redesign and transform their outpatient models through innovative approaches, embracing digital solutions, and developing more patient-centred ways of delivering care.

Progress across the three outpatient transformation pillars:

- **Pillar 1: Improving Operational Efficiency** - Progress against Pillar 1 continues, although at a slower pace than initially anticipated. This is largely due to the significant amount of work required to rebuild outpatient clinic templates while maintaining current levels of clinical activity. Despite these challenges, services remain engaged in the programme, and work is continuing to establish more efficient and sustainable outpatient pathways.

- **Pillar 2: Embedding a SPoA** - Progress in implementing a SPoA has been positive, with an increasing number of specialties adopting the model. Work continues to address a number of digital requirements, particularly ensuring seamless integration between the National Electronic Referral Service (e-RS) and the Trust's EPR system. These developments are essential to support efficient referral management, triage, and patient flow across services.
- **Pillar 3: Service Transformation and Innovation** - The focus of Pillar 3 is to support services in transforming outpatient care through innovation and the effective use of technology. This includes identifying opportunities where digital solutions can be introduced to redesign existing services, improve patient experience, increase clinical productivity, and deliver care in new and more effective ways. Services are being encouraged to adopt innovative models of care that maximise the benefits of digital technology while supporting long-term sustainability.

1.3) Digital and Data

Digital Services is currently undergoing a review of its structure with the establishment of four key functional groups:

- Digital Delivery Group
- Digital Adoption and Optimisation Group
- Data and Analytics Group
- Innovation Group

As part of this new operating model, the responsibilities previously undertaken by the Digital Optimisation Group will be incorporated into the Digital Adoption and Optimisation Group, creating a more streamlined approach to digital implementation, benefits realisation, and service improvement.

Over the past few weeks, 62 enhancements and upgrades to the EPR have been released through the sprint delivery programme, demonstrating continued progress in supporting frontline services and improving system functionality.

Joanne Todd, Director of Digital Services, is currently undertaking a review of digital team capacity and capability against the organisation's major transformation programmes. This includes alignment with the Outpatient Transformation Programme, Theatre Productivity Programme, Urgent Care Improvement Programme, and Neighbourhood Development initiatives. The review aims to ensure sufficient resource is available both to deliver the digital enablers required to support these transformational programmes and to maintain progress against the wider organisational digital roadmap.

Several innovative digital initiatives are also progressing and are expected to move into implementation or pilot phases shortly. These include:

- Trials of ambient voice technology across several clinical services to support clinical documentation and reduce administrative burden on clinicians.
- A trial of Microsoft Copilot Premium to evaluate opportunities for productivity gains, automation, and enhanced information management.

- Deployment of PowerChart applications on mobile devices, enabling clinicians to access and update patient records, including point-of-care documentation and dictation.
- Introduction of digital electrocardiogram (ECG) technology, allowing ECG results to be uploaded wirelessly and directly into the EPR, reducing manual handling and improving the availability of diagnostic information.

Collectively, these developments will strengthen the organisation's digital maturity, improve staff productivity, and support the delivery of safer, more efficient, and more patient-centred services across the Trust.

2. CANCER

Performance

28 Day Faster Diagnosis

28 Day	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Brain/CNS	100.0%	100.0%		100.0%	100.0%			100.0%	50.0%	100.0%	0.0%	100.0%	50.0%	100.0%
Breast	92.9%	92.8%	94.1%	94.2%	90.5%	89.0%	96.1%	91.9%	86.2%	88.7%	83.3%	83.6%	83.6%	88.8%
Breast Symptomatic	38.7%	33.3%	34.5%	42.8%	44.4%	26.0%	49.3%	47.3%	30.4%	22.7%	41.9%	62.6%	45.8%	50.0%
Childrens	50.0%	100.0%	14.3%	50.0%	50.0%		100.0%	100.0%	100.0%	85.7%		100.0%		66.7%
Colorectal	74.5%	71.1%	73.2%	69.6%	74.0%	64.8%	76.2%	69.9%	61.9%	66.8%	72.2%	65.5%	69.3%	68.2%
Gynae	76.3%	81.2%	85.5%	77.9%	81.7%	81.0%	84.1%	83.7%	86.2%	90.9%	78.8%	86.1%	81.2%	73.7%
Haematology	84.6%	100.0%	81.3%	90.9%	50.0%	66.7%	77.8%	68.8%	66.7%	84.6%	87.5%	88.9%	92.9%	66.7%
Head & Neck	90.6%	95.3%	95.4%	93.9%	91.0%	89.8%	92.6%	92.3%	88.2%	91.5%	87.4%	82.9%	85.0%	88.3%
Lung	76.3%	80.0%	81.3%	84.8%	89.3%	62.5%	85.3%	92.6%	75.0%	74.2%	72.2%	90.0%	80.8%	75.0%
NSS	92.9%	91.7%	100.0%	100.0%	76.5%	81.8%	91.7%	83.3%	88.9%	81.3%	84.6%	100.0%	86.7%	85.7%
Other			100.0%		100.0%		0.0%	100.0%						
Sarcoma	87.5%	77.8%	92.9%	78.6%	80.0%	81.8%	80.0%	88.9%	87.5%	92.9%	100.0%	90.0%	66.7%	72.7%
Skin	61.6%	53.3%	53.4%	47.0%	46.1%	54.1%	90.5%	96.9%	94.8%	96.9%	97.5%	97.0%	95.5%	95.2%
Testicular	100.0%	88.9%			100.0%		100.0%	87.5%	100.0%	90.0%	90.9%	100.0%	100.0%	100.0%
Upper GI	93.2%	89.5%	82.2%	80.6%	85.9%	77.9%	85.2%	88.4%	81.5%	84.6%	83.5%	81.7%	80.2%	71.2%
Urology	73.4%	76.3%	79.0%	75.5%	74.1%	62.0%	69.7%	71.9%	69.9%	72.1%	59.0%	65.8%	60.7%	52.4%
HPB	62.5%	70.0%	66.7%	62.5%	42.9%	60.0%	60.0%	88.9%	50.0%	57.1%	75.0%	66.7%	22.2%	42.9%
OGD	91.9%	91.2%	84.4%	82.1%	89.5%	78.9%	86.8%	84.4%	82.8%	87.1%	83.2%	79.6%	86.5%	73.5%
Trust Total	72.0%	68.6%	69.1%	65.5%	68.3%	66.5%	85.6%	86.4%	83.1%	85.0%	84.6%	85.3%	83.9%	82.8%
NHSE	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%	80.0%

Key:

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

62 Day Time to Treatment Target

62 Day	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26	Jun-26	Jul-26	Aug-26	Sep-26
Brain/CNS	83.3%	100.0%	100.0%	100.0%	92.9%	89.5%	81.8%	85.7%	85.7%	83.3%	92.9%	83.3%	81.0%	94.1%
Breast	83.5%	86.5%	82.8%	78.6%	86.3%	74.8%	78.8%	76.4%	77.5%	71.4%	77.5%	76.7%	72.4%	71.3%
Childrens	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	60.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Colorectal	40.0%	53.7%	48.6%	68.7%	44.4%	59.1%	42.9%	32.3%	58.3%	35.8%	41.3%	37.9%	39.1%	34.3%
Gynae	52.0%	50.0%	39.1%	71.4%	70.3%	83.3%	84.2%	78.6%	84.2%	56.3%	65.0%	70.4%	64.0%	75.0%
Haematology	76.1%	64.7%	96.2%	88.2%	86.4%	77.4%	90.9%	82.9%	72.3%	79.4%	86.9%	94.2%	93.5%	67.3%
Head & Neck	76.3%	72.2%	90.7%	82.5%	70.5%	65.8%	80.5%	86.5%	76.8%	64.3%	74.5%	58.8%	63.5%	53.9%
Lung	56.0%	56.9%	58.6%	49.6%	48.2%	44.1%	39.1%	38.6%	37.0%	41.1%	40.2%	36.2%	49.5%	33.9%
Other	50.0%	69.2%	71.4%	100.0%	87.5%	50.0%	100.0%	83.3%	44.4%	50.0%	62.5%	50.0%	60.0%	77.8%
Sarcoma	78.9%	70.0%	88.9%	84.2%	60.0%	57.1%	86.7%	66.7%	56.0%	100.0%	78.9%	56.3%	90.0%	76.9%
Skin	94.7%	90.7%	85.3%	86.5%	87.2%	87.8%	88.1%	93.2%	94.9%	96.5%	95.5%	97.6%	98.7%	96.6%
Upper GI	49.1%	47.4%	49.5%	44.4%	64.3%	38.1%	41.7%	43.6%	29.5%	35.0%	42.0%	49.5%	41.6%	47.7%
Urology	60.2%	52.3%	67.0%	61.1%	56.5%	57.8%	50.6%	50.0%	47.0%	56.0%	48.1%	65.5%	51.0%	52.9%
HPB	45.2%	54.7%	46.8%	45.3%	54.8%	38.1%	46.6%	42.2%	26.5%	35.1%	41.4%	54.2%	47.4%	48.3%
OGD	54.3%	30.4%	58.3%	42.9%	80.6%	38.1%	20.0%	47.1%	35.1%	34.8%	43.3%	33.3%	36.7%	51.2%
Trust Total	70.2%	70.4%	71.6%	71.1%	72.9%	66.1%	68.6%	63.9%	65.0%	65.1%	65.6%	66.8%	67.8%	62.0%
NHSE	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%	85.0%

28 Day Performance

28-day performance continues to be good overall, driven by strong performance in dermatology. 28-day performance in breast, impacted recently by changes in County Durham and Darlington NHS Foundation Trust (CDDFT) breast services, has improved in October.

62 Day (62D) Performance

62-day performance remains strong in skin. There are concerns in other areas, including all the major tumour groups; lung, urology, upper GI and colorectal though there is a marginal improvement in performance to date in October; 64% compliance vs 62% in September. Action plans are in place for these tumour groups alongside clinical leadership in patient tracking list (PTL) reviews to streamline pathways and ensure appropriate clinical prioritisation. For tumour groups with a high proportion of tertiary referrals, such as lung, the PTL also focuses on the 24-day window from tertiary referral to treatment in Newcastle Hospitals, in addition to total pathway days.

Radiotherapy

Newcastle Hospitals was the poorest performing Trust in England for 31 days radiotherapy targets in September 2026. There has been an improvement in 31-day radiotherapy performance in October from 33% to 48% with a corresponding increase in trust wide 31-day performance from 64% to 70.5%. There has been recruitment and phased commencement of new-starter therapy radiographers during September and October. Training will continue. The team are trying to safely target training to allow maximum throughput on the linear accelerators as early as possible in the training process. To maximise efficiency schedulers are working closely with patients to fill last minute vacant slots for planning and treatment. In addition, new workflows are being developed to try to reduce prostate radiotherapy appointments from 15 minutes to 10 minutes to increase

capacity. Referrals continue to be clinically prioritised. Specific clinical consideration is being given to reprioritising early-stage lung cancer to give this condition a higher rating.

Feedback on the business case recently submitted to the ICB, is awaited. A Getting It Right First Time (GIRFT) radiotherapy visit is anticipated on 7 December 2026.

Harm Review

The process of internal harm reviews continues for any patient who is not treated for cancer within 104 days of referral.

Inevitably as performance has deteriorated, the number of harm reviews required has increased but episodes of significant harm are proportionately lower suggesting clinical triage is effective in most cases. The majority of episodes of harm still affect patients awaiting treatment for lung cancer with occasional episodes involving hepatobiliary cancer patients.

3. QUALITY AND SAFETY

Work continues to reduce the number of never events in the Trust, particularly around invasive procedures. We are about to trial the implementation of surgical checklists in key areas across the Freeman Hospital and RVI sites.

4. PEOPLE – MEDICAL WORKFORCE UPDATE

The Clinical Director Development Programme is a new Trust leadership initiative designed to equip Clinical Directors with the skills, confidence and practical tools required to lead services effectively. It supports delivery of the Trust Strategy, strengthens medical leadership capability and provides a foundation for a longer-term leadership development pathway aligned to the Newcastle Excellence Programme. Key themes include leadership, people management, strategy, finance, quality and safety, job planning, and service transformation.

Job planning is one of the most important operational levers for Clinical Directors, with its implementation across the Trust still maturing and becoming more systematic. Next steps include strengthening Clinical Director capability to understand service demand, capacity and workforce utilisation, and to translate this into consultant job plans that support delivery, productivity and service objectives.

Current priorities include:

- Improving understanding of demand and capacity modelling and how this informs consultant activity and workforce planning.
- Increasing confidence in the use of data and business intelligence to support job planning decisions.
- Strengthening the link between job planning, service-level planning, capacity management and performance improvement.
- Ensuring close involvement of Operational Delivery Managers in job planning discussions and implementation.

- Delivering dedicated training for Clinical Directors through Session 5 of the Clinical Director Development Programme, covering job planning, service planning, capacity and demand management, leave management, Supporting Professional Activities (SPA) activity and dispute resolution.

5. PARTNERSHIPS

Primary care / community

We have continued to work with primary care/the ICB, and now monthly Interface meetings have started. Primary care has identified six high-priority issues to be addressed over a period of 6 months: Fit notes (complete), Consultant to Consultant referrals (policy updated and ratified through the Interface meeting/submitted to Clinical Policy Group (CPG) for approval), Investigation results, Advice and Guidance requests, Maternity prescribing and Outpatient prescribing.

A second Newcastle Local Medical Committee (LMC) & Newcastle Hospitals Roundtable Event has been scheduled for 24th November with a focus on "Left Shift" of services from Hospital to Community. The event will bring together primary care clinicians and representatives from Frailty/Falls/Syncope, Community Paediatric Immunology & Allergy, Ear, Nose and Throat (ENT), Diabetes and Community.

Great North Healthcare Alliance

North Cumbria Integrated Care (NCIC) NHS Trust has secured NHS England funding for a 1.0 Whole Time Equivalent (WTE) band 8B Operational Service Manager and 2PAs (programmed activity) of senior clinical leadership time. The resource will be used to strengthen the interface between NCIC and Newcastle Hospitals, and accelerate improvement in pathways where patients move between the two organisations for specialist advice, diagnosis, treatment or follow-up. Initial focus will be on high-priority specialties: Ophthalmology, Neurology, and Oral & Maxillofacial Surgery. An advert for the 8B post has been circulated internally and the Medical Directors of the Trusts have agreed Associate Medical Director (AMD) time will be allocated to support once the Operational Service Manager is in post.

6. MEDICAL EDUCATION

Postgraduate update

i) Dr Ian Forrest, consultant respiratory physician and current Deputy Director of Medical Education (DME) for postgraduate doctors, will start in post as the DME in January 2027.

ii) Current review of existing Medical Education tutor team is underway including renumeration for posts. Appropriate remuneration and equity between postgraduate and undergraduate tutors are crucial to the effectiveness of medical education. This will most likely require additional investment.

iii) National increase in training places:
   - Second round completed.

- Five successful bids from Newcastle Hospitals – 2 histopathology, 1 core surgery (paediatric surgery theme), 2 paediatric emergency medicine.
- The next round is for 750 posts nationally for August 2027.

iv) Locally Employed Doctors (LEDs):
- Guidance is emerging – there was a central instruction that these posts should be made permanent.
- Work being conducted in People Services regarding location and stage of training of LEDs.
- Recent guidance exempting post Certificate of Completion of Training fellow posts from permanent contracts.
- Discussions regarding similar position for teaching fellows – not currently agreed.

v) General Medical Council (GMC) survey results:
- Currently being analysed and discussed with clinical teams.
- Medical education department working together with Clinical Boards to formulate action plans.
- Face to face meetings with leads in areas in difficulty to offer support.

vi) Programme of educational quality panels is ongoing. This includes feedback from resident doctors.

vii) Annual Medical Education event will be held on the 29th of April 2027 at the Catalyst. Programme to be confirmed.

7. IMPROVEMENT GROUPS

i) Deteriorating Child

The Deteriorating Child Action Plan was refreshed in September, with actions progressing as planned. Outstanding key performance indicators for ongoing monitoring will be presented for ratification at the next group meeting on 26 November.

Nine of the ten actions within the revised plan are either complete or remain on track for delivery within the agreed timescales.

The PCCOT remains on track for a daytime service launch in late November/early December 2026, with full 24 hours a day/7 days a week (24/7) implementation planned by the end of the 2026/27 financial year.

ii IPC

The IPC Improvement Group continues to oversee delivery of Clinical Board IPC improvement plans, strengthening local ownership of Health Care Acquired Infection (HCAI) improvement, performance oversight and the implementation of learning from incidents.

No new quality or patient safety concerns requiring escalation were identified.

While variation remains across several IPC indicators, Clinical Boards have established governance, audit and improvement arrangements to drive greater consistency. Priority areas for improvement include medical Aseptic No Touch Technique competency, MRSA (methicillin-resistant Staphylococcus aureus) screening, fit-testing compliance, hand hygiene and device documentation.

Common themes identified across Clinical Boards continue to support shared learning and a coordinated approach to improvement. The IPC Team remains actively engaged through the Human Resources Business Partner model (HRBP), education programmes, policy development and targeted improvement support.

iii Transplantation Committee/ARC

The implementation of the ARC, with kidney and liver activity is scheduled to commence from 9 November, subject to final national discussions. Readiness documentation has been approved, and operational procedures will continue to be refined throughout the pilot phase.

Newcastle Hospitals is delivering a broader ARC model than other centres, providing 24/7 abdominal transplant capability alongside lung transplantation services. Full commissioning is awaited and expected in March 2028. Positive clinical outcome data has been received from the use of extended organ preservation technology, with strong transplant survival rates and reduced reliance on out-of-hours procedures.

Workforce planning remains a key priority, with recruitment proposals being developed to strengthen cardiothoracic and abdominal transplant capacity and support safe delivery of transplantation and ARC services.

Newcastle Hospitals and Great Ormond Street Hospital continue to collaborate on paediatric cardiac transplantation as part of the national strategy to increase organ utilisation and improve equity of access. The current focus is to develop a single referral pathway and a joint national multi-disciplinary team (MDT). Opportunities for other areas of joint collaboration for highly specialised services are being explored.

8. ALLIANCE CLINICAL FRAMEWORK GROUP

The Great North Healthcare Alliance Clinical Framework Group continues to provide clinical leadership for collaborative service development across partner organisations. Current priorities include cancer pathways (lung and urology), pathway transformation opportunities and reducing unwarranted variation in care. Work is underway to develop a prioritised programme of clinically led initiatives that support improved patient outcomes and sustainable service delivery across the region.

9. EMERGENCY PREPAREDNESS, RESILIENCE AND RESPONSE (EPRR)

An EPRR update report was shared at the Private Board meeting in October for information and therefore has not been included within the meeting papers this month (as per the

Schedule of Business). The annual EPRR report will be brought to the May 2027 Public Board meeting.

10. 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
18 November 2026

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Agenda item A3(b)(i)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 November 2026					
Title	Guardian of Safe Working Quarterly Report (Quarter 2 (Q2) 2026-27)					
Report of	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Prepared by	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☐		☒	
Summary	The terms and conditions of service (TCS) of the new junior doctor contract (2016) require the Guardian of Safe Working (GOSW) Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant. The content of this report outlines the number and main causes of exception reports for the period 1 July to 30 September 2026 for consideration by the Trust People Committee, prior to submission to the Trust Board. There are now 1,216 resident doctors within the Trust, including 1,204 employed under the 2016 Terms and Conditions of Service contract. During the quarter, 470 exception reports and 17 test reports were submitted, representing a substantial increase compared with the previous quarter (284 reports). This increase is consistent with the anticipated impact of changes to exception reporting arrangements introduced in February 2026, which have improved accessibility and reporting compliance Overall, the report provides **assurance** that robust exception-reporting processes are in place and that issues are being identified and acted upon locally. However, the continued rise in exception reporting and fines indicates ongoing workforce and operational pressures. The Trust should continue to monitor specialties with high exception reporting rates, review workforce-workload balance, and address recurrent support service issues, including phlebotomy provision, to reduce avoidable breaches and support safe working environments for resident doctors.					
Recommendation	The Trust Board is asked to note the contents of this report.					
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]	No direct link to the BAF. In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training.					

Agenda item A3(b)(i)

Reports previously considered by	Quarterly report of the Guardian of Safe Working Hours (GoSWH). Report discussed at the People Committee on 17 November 2026.

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

This quarterly report covers the period 1 July to 30 September 2026. The change in dates is to align with NHS England's national reporting window (NB the Q1 report covered the period from 27 March to 26 June 2026 and was reported to the People Committee and Trust Board in July 2026).

There are now 1,204 resident doctors on the TCS of the 2016 contract, and a total of 1,216 resident doctors in the Trust.

There were 470 exception reports in this period and 17 test exception reports, making a total of 487. Test exception reports are reports submitted on starting in post to evidence access to the reporting system. This compares to 284 exception reports in the previous quarter.

Changes to exception reporting were introduced on 4 February 2026. This has resulted in a continued increase in exception report numbers and fines. The pattern of exception reporting has also changed, with an increase in specialties exception reporting, an increase in fines, and an increase in exception reports from doctors in specialty training. The majority of exception reports are still from foundation level trainees. 310/470 exception reports were for breaches of working hours of 1 hour or less.

2. INTRODUCTION / BACKGROUND

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

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

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

3. QUARTERLY REPORTING DATA

This data is standardised to a national template and has been submitted to NHS England Data Collection Framework:

a) Number of exception reports submitted

Number of exception reports submitted over the last quarter:	**487**

b) Categories of exception reports submitted

Supporting information:

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Additional hours an unscheduled early start	£254.83	4.5	0		26
Additional hours an unscheduled late finish	£7,896	85	£4,393		384
Breaches of non-resident on-call patterns	£1,403	26.4	£5,851		16
The inability to take contractual breaks			0	37	37
Inadequacy of clinical support				4	4
Inadequacy of rostered skills mix				0	0
Raising concerns of a suspected non-compliant rota pattern				3	3
Detriment or threat of detriment related to exception reporting				0	0

Type of exception report	Outcome				Number of exception reports
	Pay	Time off in lieu	Penalty/ fine	For information	
Information breach			0		0
Access and completion resolved in time				0	0
Access and completion breaches			0		0
Access and completion test				17	17
Other: optional free text box	0	0	0	0	0
Total					**487**

c) Experiences of actual or threatened detriment

Quarterly survey response rate	0.057%
Doctors experiencing actual detriment as a result of exception reporting	5%
Doctors feeling that they are not discouraged from exception reporting	78%

There were 69 responses from a total of 1,193 individuals invited to participate. The low response rate is similar to that seen in other trusts. Comments regarding detriment have been reviewed, and where concerns relate to identifiable issues these have been raised within the appropriate department.

d) Withdrawals

Number of exception reports withdrawn over the last quarter	1

e) Access to individual doctors' exception reporting data

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

Number of exception reports disclosures over the last quarter	0

f) Work schedule reviews related to exception reporting pattern/instances

Number work schedules reviews related to exception reporting patterns or instances	1

g) Rota gaps on all shifts

Total number of rota gaps on all shifts over the last quarter	unknown

h) Additional information on an ad hoc basis

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

No escalations

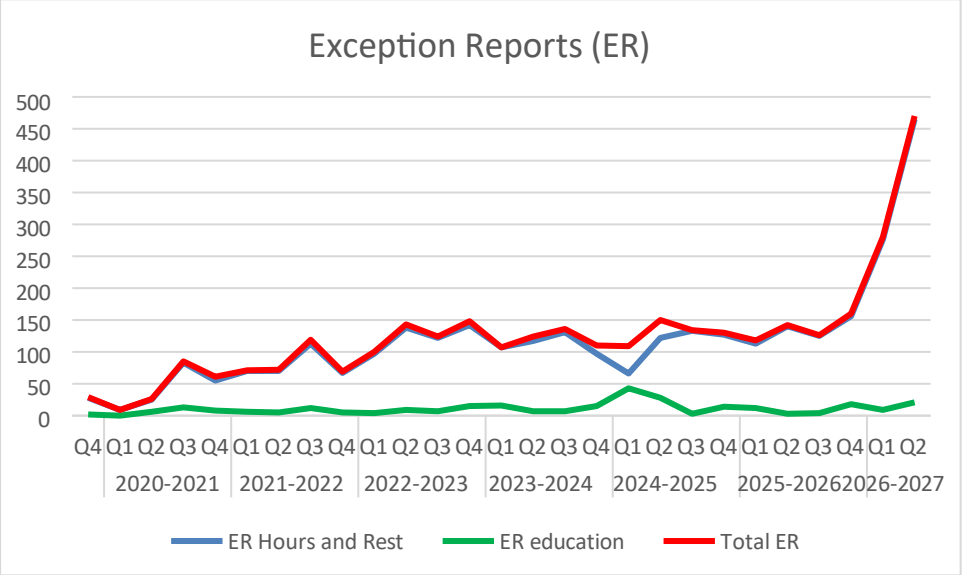
The GoSWH is required to report issues, with certain posts, that cannot be remedied locally and require a system-wide solution. The Board is required to raise the system-wide issue with partner organisations (for example, NHS England) to find a solution.

Not applicable

4. ADDITIONAL INFORMATION

		Previous quarter data for comparison)
Number of Resident Doctors on New Contract	1,204	(1,154)
Total Number of Resident Doctors	1,216	(1,166)
Number of Exception reports	470	(284)
Number of Exception reports for Hours Breaches	465	(280)
Number of Exception reports for Educational Breaches	21	(9)
Fines	73	(53)

5. EXCEPTION REPORTS



5.1 Exception Report by specialty – top 6

General Surgery	77
Geriatric Medicine	73
Acute Internal Medicine	64
Neurosurgery	61
Otolaryngology	59
Trauma and Orthopaedic Surgery	28

5.2 Example Themes from Exception Reports

Neurosurgery

The main drivers of excess hours were overrunning theatre lists, emergency operating, management of acutely unwell patients, and the completion of essential documentation and handovers. Reports also highlighted missed breaks, operational inefficiencies, and lost training opportunities. A work schedule review has been completed to better reflect the routine workload. High emergency workload burden remains an issue.

Acute Internal Medicine Royal Victoria Infirmary (RVI), Geriatric Medicine Freeman Hospital (FH)

The main themes for exception reports were when there was reduced staffing on the ward, backlog following leave or changeover, high patient volumes, management of acutely unwell patients and administrative burdens. Operational difficulties such as lack of phlebotomy support, equipment issues and delayed investigations further exacerbate workload pressures and contribute to late finishes.

Although exception reporting numbers are high, this comes from a large number of different resident doctors. There were more reports within geriatric medicine of resident doctors staying > 1 hour beyond their scheduled finish.

General Surgery

Exception reports were predominantly driven by workforce shortages, high clinical workload, and repeated breaches of rest and break requirements. Staffing gaps including sickness absence and rota vacancies frequently resulted in doctors working beyond rostered hours to manage acutely unwell patients, complete discharge processes and ensure safe handover. Documentation requirements, theatre overruns, lack of phlebotomy support and service pressures during on-call periods further contributed to overtime.

Otolaryngology

Exception reports were due to a combination of high workload, particularly due to emergency workload and management of acutely unwell patients, in addition to staffing shortages. Additional hours worked during non-resident on call shifts were also a cause of exception reports.

Trauma and Orthopaedic Surgery

Exception reports were predominantly driven by staffing shortages, high ward workload, and theatre overruns, resulting in recurrent late finishes and missed breaks. Documentation, family discussions and administrative tasks further contributed to overtime.

6 EXCEPTION REPORT OUTCOMES

6.1 Work Schedule Reviews

A work schedule was carried out for neurosurgery. This has now been approved.
A work schedule review is ongoing for Otolaryngology to ensure the hours more accurately reflect the work done.

6.2 Fines

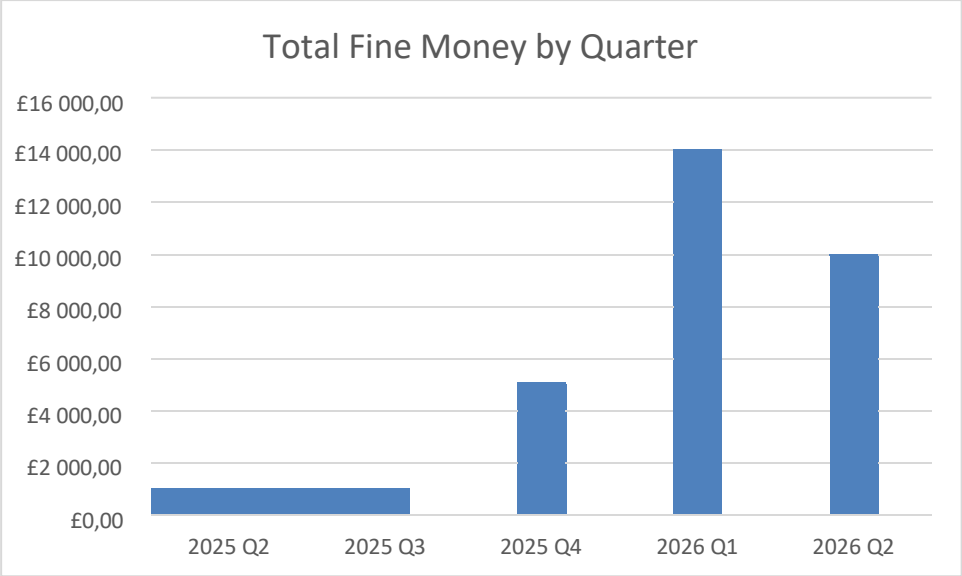
73 fines have been issued: Total fine money £10,245.71

- Surgical and Specialist Services: 31 fines. Total fine money £3,532.77
- Surgical and Associated Specialties: 25 fines. Total fine money £5,361.50
- Medicine and Emergency Care: 12 fines. Total fine money £693.45
- Cardiothoracic Services 3 fines. Total fine money £506.82
- Cancer and Haematology 2 fines. Total fine money £151.17

Extended shift length remains the most common contractual breach, with repeated reports across multiple specialties.

The largest financial impact comes from breaches of non-resident on call rest requirements, including several high-value fines exceeding £300-£900 per incident.

Neurosurgery continues to generate a high volume of work schedule breaches, predominantly through shifts exceeding 13 hours.



7. ISSUES ARISING

7.1 Workforce and workload

There has been an increase in exception reports from multiple different specialties. This may reflect the predicted increase following the changes in TCS in February. The majority of exception reports have come from foundation trainees, particularly F1s, although higher level trainees continue to exception report, particularly when they work significantly beyond their contracted hours.

The themes of exception reporting remain similar to previous reports, with workforce/workload imbalances being the major cause of residents staying late. High levels of administrative burdens and operational challenges regarding support services including lack of phlebotomy services also contribute.

7.2 Administrative Support

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

8 ROTA GAPS

Specialties and rotas with vacancies are outlined below.

Directorate	Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Sep-26	Aug-26	Jul-26
		Cancer and haematology					
Cancer Services	FH	Oncology	ST3+	22	1	1	1
		Cardiothoracic Services					
Cardiothoracic Services	FH	Cardiology	ST3+	15	3	3	2
Cardiothoracic Services	FH	Cardiothoracic Anaesthesia	ST3+	10	1	1	4
Cardiothoracic Services	FH	Cardiothoracic Surgery	F2/ST1-2	2	1	1	1
Cardiothoracic Services	FH	Cardiothoracic Surgery	ST3+	11	2	2	4
Cardiothoracic Services	FH	Paediatric Cardiology 2nd	ST3+	9	4	3	3
Cardiothoracic Services	FH	Respiratory Medicine	CMT/ST1-2	5	1.2	1.2	0.2
Cardiothoracic Services	FH	Respiratory Medicine	ST3+	8	1	1	0
		Family Health					
Children's Services	RVI	Paediatric Surgery 2nd	ST3+	9	1	1	1
Children's Services	RVI	Paediatrics 1st - ST1/ST2 (now including Paediatric Surgery)	F2/ST1/ST2	25	0.8	0.8	0.8
Children's Services	RVI	General Paediatrics	ST3+	23	0	0	1
Children's Services	RVI	Paediatric Oncology	ST3+	6	0.4	0.4	0.4
Children's Services	RVI	Paediatric ICU (PICU)	ST3+	10	2	1	1
Women's Services	RVI	Obstetrics & Gynaecology	F2/ST1/ST2	14	2	2	2
Women's Services	RVI	Obstetrics & Gynaecology	ST3+	22	4	4	2
Women's Services	RVI	Neonates	F2/ST1/ST2	7	0	0	1
		Surgical & Associated Specialities (FH)					
Surgical Services	FH	General Surgery	F2/ST1/ST2/ST3+	7	3	3	2
Surgical Services	FH	Vascular	ST3+	10	2	2	1
Surgical Services	RVI	General Surgery	ST3+	15	2.8	2.8	0.8
Urology	FH	Urology	ST3+	11	1	1	1
		Clinical and Diagnostic Services					
Integrated Lab Medicine	RVI	Histopathology	ST1/2	8	0.2	0.2	0.2
Radiology	RVI / FH	Radiology On Call	ST2 / ST3+	33	3	3	0
Integrated Lab Medicine	RVI	Medical Microbiology	ST1+	21	0.8	0.8	0.8
		Medicine					
Medicine	FH	General Internal Medicine	F2/GPVTS/CMT/TF	12	1.6	1.6	1.6

Directorate	Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Sep-26	Aug-26	Jul-26
Medicine	RVI	General Internal Medicine	ST3+	25	3	3	4
Medicine	RVI	Clinical Immunology	ST3+	3	1	1	0
Medicine	FH	Care of the Elderly	ST3+	5	1	1	1
Medicine	RVI	Accident & Emergency 1st	ACCS/ST1-2/CT1-2	20	3	3	1
Urology	FH	Renal Medicine	ST3+	6	0	0	1
Medicine	RVI	Accident & Emergency 2nd	ST3+	15	2	2	2
EPOD	RVI	Dermatology	ST3+	7	0.4	0.4	0.4
		Surgical & Specialist Services (RVI)					
Musculoskeletal	RVI	Orthopaedics	F2/ST1/ST2	4	1	1	1
Musculoskeletal	RVI/FRH	Orthopaedics	ST3+	19	2	2	2
Neurosciences	RVI	Neurosurgery	F2/ST1/ST2	5	0.2	0.2	0.20
Neurosciences	RVI	Neurosurgery	ST3+	13	1	1	1
Neurosciences	RVI	Neurology	F2/ST1/ST2	2	1	1	1
EPOD	RVI	Ophthalmology	ST3+	25	2	2	3
		Peri-operative FH					
Peri-operative & Critical Care	FH	Critical Care	F2 ST1-7	13	0.8	0.8	0.8
Peri-operative & Critical Care	FH	Anaesthetics General	ST1-7 CT1-2	27	3.6	3.6	3.6
		Peri-operative RVI					
Peri-operative & Critical Care	RVI	Critical Care	ST1+	16	2.8	2.8	2.8
Peri-operative & Critical Care	RVI	Anaesthetics	ST1-2 / ST3 +	40	1.4	1.4	1.4

Key:

ACCS – Acute Care Common Stem (CT equivalent)
CMT – Core Medical Trainee
CST – Core Surgical Trainee
CT – Core Trainee
FH – Freeman Hospital
GPVTS – GP Vocational Training Scheme
ICU – Intensive Care Unit
RVI – Royal Victoria Infirmary
ST – Specialist Trainee
TF – Teaching Fellow

9. LOCUM SPEND

Lead Employer Trust (LET) Locum Spend

April to June (Q1 2026-27)	£484,233
July to September (Q2 2026-27)	£549,303

Comment from the finance team**:**

'In terms of expenditure, we rely on the invoices from the LET and so there are differences between the actual incidence of spend and the Trust being invoiced for it.
There was an increase of £65k between Q1 & Q2 2026/27.
Of this increase, £71k related to Medicine and Emergency Care, £27k was Peri-operative and Critical Care, £10k was Clinical. This was partially offset by a decrease of £-12k related to Non-Clinical Board, £-11k related to Surgical and Associated Specialities.'

Trust Locum Spend

April to June (Q1 2026-27)	£797,144
July to September 2026 (Q2 2026-27)	£719,457

Spend on Trust locums between these periods decreased by £77,687.

10. RISKS AND MITIGATION

10.1 Changes to the TCS of the Contract

Changes to the TCS of the contract came in in February 2026. Exception reports are signed off by medical staffing with oversight by the GOSW. There is no involvement from supervisors. There has been a predictable increase in exception reports, with 310 of the 470 exception reports being for breaches of 1 hour or less.

The information breach risk with sharing data from exception reports remains a challenge as without specific consent, I am unable to share exception reports within a directorate if there is a risk of identification of the individual.

11. RESIDENT DOCTOR FORUM

Issues discussed included updates around bottlenecks in training and Locally Employed Doctors' contracts and NHS England's 10 point plan.

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

12. ACTIONS

The following actions are those mandated by NHS Employers:

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

Information to be shared	Recipient(s) of board reports	Frequency
Quarterly reports	• This report must be sent directly to: • the Joint Local Negotiating Committee (JLNC) • the Local Negotiating Committee (LNC) chair • at least one nominated LNC resident doctor, and relevant Resident Doctor Forum representatives upon completion. • This report must be made available to NHS England (Local office), the Care Quality Commission, the General Medical Council and the General Dental Council, the British Medical Association (BMA) or other recognised trade unions. • In addition, all quarterly reports must be publicly accessible online within one month after the report has been created.	Quarterly
Issues identified as a result of exception reporting that cannot be remedied locally and require a system-wide solution	LNC The board will raise the system-wide issue with partner organisations (e.g. NHS England) to find a solution.	Ad hoc

13. RECOMMENDATIONS

I recommend that we continue to review the workforce workload balance to ensure that safe staffing numbers are maintained, particularly focusing on areas with high numbers of exception reports per resident doctor.

Lack of support services, such as phlebotomy also contributes to doctors staying late. I recommend that we review the phlebotomy services to ensure consistent delivery of service.

I am stepping down from the role of Guardian of Safe Working Hours. This will likely be my last Board Report. Thank you for consideration of the issues highlighted.

Report of Henrietta Dawson
Consultant Anaesthetist

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Trust Guardian of Safe Working Hours
28 October 2026

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Agenda item A3(c)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	27 November 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**: Accrediting Excellence (ACE) • **Section 2**: Vaccination Update • **Section 3**: Integrated Quality Assurance Review (IQAR) Framework • **Section 4**: Safeguarding Quarter 1 (Q1) and Quarter 2 (Q2) Update • **Section 5:** Learning Disability Q1 and Q2 • **Section 6:** Nurse Staffing Deep Dive • **Section 7:** Allied Health Professionals (AHP) Professional Assurance and Workforce Update The following key points/risks are noted for the Trust Board's attention: **Alert:** • There are no new alerts to bring to the Trust Board's attention. **Advise:** • The long-term sustainability of the ACE Programme remains a risk, with current charitable funding anticipated to conclude within the next eight months. Identification of a sustainable funding model is being progressed to ensure the programme remains a fundamental part of the Trust's wider Excellence Programme (Section 1). • Development of the IQAR framework is underway to streamline assurance activity, reduce duplication and strengthen organisational oversight through improved triangulation of quality, safety, workforce and patient experience intelligence (Section 3). • Workforce capacity across all safeguarding functions continues to impact on delivery of all aspects of work and impacts on staff experience. Case work is prioritised and additional posts at risk have been supported across Adults, Children's and Maternity Safeguarding pending substantive investment. An investment proposal is being finalised. This risk is captured on the Trust's risk register (Section 4). • Delivery of Child Protection Information System (CP-IS) Phase 2 remains a significant organisational priority ahead of the national implementation deadline of December 2026. Whilst work is progressing with the Integrated Care Board (ICB) and service leads, the absence of an automated solution within eRecord and SystemOne is expected to create an		

<table>
<tr><td></td><td colspan="6">operational burden. A Trust-wide task and finish group with executive oversight has been established, and the associated implementation risk will be recorded on the Trust risk register (Section 4).
• Further work is required to identify and evaluate sustainable options for the future delivery of Oliver McGowan Mandatory Training across the Trust. Further details can be found within the report along with progress on other key improvement workstreams (Section 5).
• Workforce pressures persist in some services, particularly due to Enhanced Therapeutic Observation of Care (ETOC) demand, specialist workforce shortages and ongoing service transformation. Registered nurse and midwife fill rates reduced over the summer period, with night shifts more affected than day shifts, although recovery has been seen in September. Ongoing workforce redeployment maintains safe staffing levels but continues to impact staff experience. The 2026/27 Nurse Staffing Review programme remains underway, with a small number of complex services requiring further assessment. (Section 6).
• The AHP turnover rate has increased gradually, reaching 9% in May 2026 but remains below historical peaks. Therapeutic Radiography (TRAD) and Podiatry are highlighted as vulnerable professions. Over 600 Job Plans have now been completed, representing approximately 70% of the Trust's clinical AHP workforce. It is noted that over half (51%) of completed job plans are operating outside best practice guidance. (Section 7).

Assure:
• The ACE Programme continues to provide robust assurance of quality standards, with 47 clinical areas accredited, five areas reaccredited and 304 reviews completed since launching, supporting continuous improvement and recognition of excellence (Section 1).
• The staff vaccination programme is performing ahead of the same point in the previous year, with targeted interventions and enhanced reporting being implemented to improve uptake in lower-performing staff groups and clinical areas (Section 2).
• The Trust received the Newcastle Safeguarding Adult Board Annual report which is available for review.
• The Trust received Significant Assurance following the NHS England (NHSE) Safe Staffing Assurance Review with improvement actions agreed to strengthen reporting (Section 6).
• Completed Nurse Staffing Reviews indicate that funded establishments are broadly aligned with assessed staffing requirements (Section 6).
• AHP workforce planning, education and practice development activities continue to support teams and services ensuring quality, safety and experience for patients and staff (Section 7).</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 areas of risks and mitigating actions.
iii. Note the assurance relating to Nursing and Midwifery Safe Staffing Oversight as outlined by NHSE during their recent review.</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
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td><td>☒</td><td>☒</td></tr>
</table>

Link to Board Assurance Framework [BAF]	***Joining Up Care*** 1.1 Failure to meet our care standards in a way which is designed around people, not organisations. 1.2 Failure to coordinate services which are effective 1.3 Failure to coordinate services which are available when our patients need them ***Advancing Care*** 2.1 Inability to improve patient safety and patient harm through reliable, evidence-based care
Reports previously considered by	The Executive Director of Nursing, Midwifery and Allied Health Professionals Report is a regular comprehensive report bringing together a range of issues to the Trust Board.

EXECUTIVE DIRECTOR OF NURSING MIDWIFERY AND ALLIED HEALTH PROFESSIONALS REPORT

1. ACE UPDATE

The ACE Programme continues to develop as a key organisational framework for quality assurance, quality improvement and recognition of excellence across Newcastle Hospitals supporting improvements in quality, safety and patient experience.

The programme aligns with the Trust strategic priorities by providing a structured approach to assessing quality standards, identifying improvement opportunities, reducing unwarranted variation and celebrating excellence in patient care.

Feedback from accredited services continues to be positive, with teams reporting increased ownership of quality standards, improved staff engagement, stronger multidisciplinary working and enhanced visibility of leadership within clinical areas.

1.1 Programme Performance and Impact

ACE provides robust assurance through the assessment of patient experience, quality indicators, workforce measures, environmental standards, observation of practice and staff feedback. Since its launch in January 2025, 47 clinical areas have achieved accreditation, including inpatient wards, day units, and critical care services. A further 5 areas have successfully completed reaccreditation.

A total of 304 reviews, have so far been undertaken, including 152 environmental inspections, 65 baseline reviews, and 87 progress reviews. This activity continues to provide assurance against key quality standards while supporting teams to identify, implement and sustain improvements in patient care, as they progress towards accreditation.

The programme has expanded significantly through the development of 7 accreditation frameworks covering adult and children's inpatient services, day units, critical care and adult outpatient services. In addition, the ACE team has delivered 16 Trust-wide support and development sessions, helping to build capability, share best practice and strengthen staff engagement in quality improvement activities.

1.2 Future Developments

Work is underway to extend accreditation into additional service areas, including children's outpatient and district nursing community teams.

Development of the programme's digital infrastructure is underway, with a Business Intelligence dashboard currently being built. This will provide enhanced organisational oversight through accreditation outcome reporting and quarterly assurance tracking. The introduction of a digital scoring application is also in the build stage. The digital scoring application will enable real-time capture and analysis of accreditation data, helping to

identify trends in excellence, areas of concern, and opportunities for improvement. This will support targeted interventions, strengthen organisational oversight, improve reporting efficiency, and provide valuable intelligence to drive continuous quality improvement.

1.3 Risks

The principal risk remains the long-term sustainability of the programme. Current funding provided through Newcastle Hospitals Charity is anticipated to conclude within the next eight months. Identification of a sustainable funding model is being progressed to ensure the programme remains a fundamental part of the Trust's wider Excellence Programme

2. VACCINATION PROGRAMME UPDATE

The 2026/27 Staff Vaccination Programme is progressing well, with delivery established across all planned workstreams and uptake currently exceeding what was achieved at the equivalent stage of the 2025/26 campaign. As of 16 November 2026, 10,058 flu vaccinations have been recorded, including vaccinations delivered through the Trust programme and staff notifications of vaccinations received elsewhere. This represents approximately 1,500 additional vaccinations compared with the same point last year and is the 2nd highest regionally and in the top 10 nationally.

The established delivery model, incorporating fixed clinics, peer vaccinators, community-based provision and targeted walk-around activity, continues to perform effectively. Fixed clinics remain the principal route of delivery, accounting for approximately 78% of vaccinations, while peer vaccinators have delivered the remaining 22%. Vaccination activity continues across both acute sites and community services, supported by a record number of trained vaccinators and strong engagement from clinical teams. Feedback from services has been positive, with walk-around clinics valued for improving accessibility and enabling staff to receive vaccinations within their clinical working environment.

Community Services continue to report good progress, supported by enhanced volunteer capacity and ongoing clinic provision. Delivery within Maternity Services is similarly progressing well despite operational pressures, with central vaccination teams providing additional support where required. Although uptake remains variable across some clinical areas, Clinical Boards are actively promoting vaccination, and targeted interventions are being implemented to support areas where uptake is lower than anticipated.

A key focus for the next phase of the campaign will be the use of enhanced reporting to identify staff groups and clinical areas with lower vaccination rates. Access to more detailed "not vaccinated" reporting will support a more targeted approach, enabling resources to be directed where they are likely to have the greatest impact.

The patient vaccination programme continues with administration of flu vaccinations to patients, under an approved Patient Group Direction (PGD). This has provided valuable additional capacity and supported delivery within clinical services.

3. IQAR FRAMEWORK

As the Trust's quality governance arrangements have matured, a review of existing assurance activity identified opportunities to streamline multiple review, audit and compliance processes into a more integrated approach, reducing duplication and strengthening organisational oversight. While the current Quality and Safety Peer Review Programme provides valuable assurance and supports improvement, a number of quality standards are assessed repeatedly through different mechanisms, creating inefficiencies for clinical and facilities teams and generating multiple action plans covering similar themes.

To address this, work has commenced on the development of an IQAR framework. The proposed model will bring together intelligence from a range of existing assurance sources, including quality and safety reviews, workforce metrics, patient experience feedback, complaints, incidents, infection prevention and control assessments, environmental audits and other governance processes. This will create a more coordinated and intelligence-led approach to quality assurance.

The IQAR framework is intended to strengthen the triangulation of information, enabling a more comprehensive understanding of quality and safety risks at ward, service and organisational level. By consolidating existing assurance activity, the approach will reduce duplication, minimise the burden on clinical and facilities teams and support a single, prioritised improvement plan for services rather than multiple parallel action plans.

The transition to IQAR will also strengthen oversight and governance by providing clearer reporting of themes, risks and improvement actions, enhancing the Board's line of sight from frontline services. Importantly, the new framework will retain the key strengths of the current peer review process, including multidisciplinary review, independent challenge, staff engagement and a focus on continuous quality improvement.

Development of the framework will continue, with stakeholder engagement and testing of the proposed approach to ensure it delivers a streamlined, effective and sustainable quality assurance model that supports both organisational learning and improved patient outcomes. The aim is to ensure this is launched and embedded in the next financial year.

4. SAFEGUARDING UPDATES QUARTER 1 & 2

This summary of key points provides a bi-annual update of Safeguarding (Adult, Children's and Maternity) and Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) activity throughout the Trust.

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

4.1 Activity and Service Capacity

- Workforce capacity across all safeguarding functions continues to impact on delivery of all aspects of work and impacts on staff experience. Case work is prioritised and additional posts at risk have been supported across Adults, Children's and Maternity

Safeguarding pending substantive investment. An investment proposal is being finalised. This risk is captured on the Trust's risk register.

- Delivery of Child Protection Information System (CP-IS) Phase 2 remains a significant organisational priority ahead of the national implementation deadline of December 2026. Whilst work is progressing with the ICB and service leads, the absence of an automated solution within eRecord and SystemOne is expected to create an operational burden. A Trust-wide task and finish group with executive oversight has been established, and the associated implementation risk will be recorded on the Trust risk register.
- Safeguarding supervision compliance within the 0-19 Service reduced to 67% during Q2 and remains below the required standard. This is due to service demand and the prioritisation of case work. Improvement actions are in place.
- There remains a gap in the Designated Doctor role within the Trust. Progress is being managed by the Family Health Clinical Board with support from the Joint Medical Directors.
- Compliance with the completion of Initial and Review Health Assessments (RHA) for Children in Care continues to be monitored by the Family Health Clinical Board. Current compliance is below target and improvement actions are in place. Staffing capacity is impacting on the delivery of expected Key Performance Indicators (KPI's), and an investment proposal is being developed for consideration. A risk evaluation is being undertaken by the Clinical Board.
- Revised safeguarding governance arrangements have been approved, introducing enhanced operational, governance and committee oversight to strengthen assurance, risk escalation and organisational learning.
- The Newcastle Safeguarding Adult Annual Report has been finalised, and a copy is available in the Trust Board Reading Room.
- Since the Supreme Court of Northern Ireland (Attorney General of Northern Ireland: AGNI) handed down their judgement on 2nd June 2026, staff throughout inpatient wards have recognised and responded to the change. Communication has been provided Trust-wide and enhanced by practical guidance via the intranet. There has been a significant reduction in Urgent DoLS submissions, but this has been expected and is in line with AGNI changes. This has been acknowledged by October's regional Local Authority DoLS leads meeting, with the Trust being asked to share guidelines and experiences for wider learning across NHS trusts in the region.

4.2 Education and Training

- Safeguarding training compliance continues to be monitored through the Safeguarding Committee. The phased implementation of the revised safeguarding training programme, which commenced on 1 May 2026, has now been fully completed and the new training requirements are fully embedded across the organisation. Implementation has been supported through revised learning pathways, targeted communications and ongoing engagement with clinical and operational leaders to ensure staff are able to access the appropriate level of training in line with their role and responsibilities.
- Particular focus continues to be placed on improving compliance with Level 3 safeguarding training for both adults and children where there was greatest change in the revised training programme. Level 3 training is predominantly required for

clinical staff working in roles with greater safeguarding responsibilities. Targeted actions are underway with Clinical Boards and service leaders to identify areas of lower compliance, support staff completion, and strengthen local accountability. This is being monitored through Clinical Board Quality and Performance Reviews (QPRs).

- Current Compliance:
  Safeguarding adults level 1 = 95.95%, level 2 = 94.89% and level 3 = 84.52%,
  Safeguarding children level 1 = 95.95%, level 2 = 95.00% and level 3 = 84.20%
- Compliance with mandatory Level 1 Mental Capacity Act (MCA) training remains strong, with overall compliance at 93.89% across clinical and non-clinical patient-facing staff.
- Delivery of Level 2 MCA training remains paused pending the outcome of changes arising from the AGNI judgement and the finalisation of associated learning materials. This presents a workforce development risk, as newly appointed staff are currently unable to access Level 2 MCA training. Mitigating measures are in place whilst training content is reviewed and future-proofed, with staff continuing to access MCA and DoLS education through Level 1 and Level 3 Safeguarding training programmes. In addition to formal training, the MCA team continues to provide face-to-face supervision, ad hoc support and ward-based engagement.

5. LEARNING DISABILITY QUARTER 1 & 2

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

5.1 Activity and Service Capacity

- The Trust Autism Lead Practitioner role continues to become further embedded across the organisation. During Q2, a successful Autism Symposium was delivered, bringing together a wide range of professional groups from across the Trust and the wider region. This has helped strengthen collaborative relationships, raise awareness of autism-related priorities and support the ongoing development of the role.
- Risk 1712, relating to the risk of harm arising from the lack of dedicated safely furnished cubicles, remains under review. Work continues to identify and implement mitigating actions while longer-term solutions are explored to ensure appropriate environments are available to safely support patients requiring enhanced care and risk management.
- The Digital Team continues to support the development of processes to improve the identification and documentation of reasonable adjustments for patients on admission. Building on learning from the 2025 Reasonable Adjustments Pilot, an electronic Reasonable Adjustments Assessment is nearing completion and is expected to move into a trial phase shortly. This development will support more consistent questioning at admission, improve care planning and facilitate more personalised care delivery.
- An audit of inpatient documentation relating to the identification, planning and evaluation of reasonable adjustments was completed during Q2. The audit reviewed compliance with key standards across admission documentation, Reasonable Adjustment Care Plans and End of Shift Evaluations. Overall, findings demonstrate

continued improvement in compliance and the documentation of reasonable adjustments across both adult and paediatric services, with examples of good practice identified. However, application remains variable, and further work is required to achieve consistency across all areas.

5.2 Education and Training

- Compliance with Learning Disability and Autism e-learning at Diamond Standard remains above target, with overall staff compliance reported at 96.4%. Compliance with Oliver McGowan Mandatory Training (OMMT) on Learning Disability and Autism was 66% during the same period for those due to renew their training.
- The Integrated Care Board (ICB) funded Tier 2 training programme has now concluded. As a result, Risk 1357 remains under active review and reflects the Trust's concerns regarding the sustainability, future delivery model and resource implications associated with the ongoing implementation of mandatory training requirements.
- Further work is required to identify and evaluate sustainable options for the future delivery of OMMT across the Trust. An options appraisal will be developed and presented through the Learning Disability Governance Group, with recommendations subsequently brought forward for consideration to support future implementation and compliance.

6. NURSE STAFFING DEEP DIVE

The Nurse Staffing Deep Dive Report was presented to the Quality Committee on 19 November 2026 and provides the Trust's six-monthly Nurse Staffing Review alongside the quarterly Safe Staffing Assurance Report. The full report with detailed findings, supporting dashboards, workforce reviews and supplementary evidence are available within the Trust Board Reading Room.

The report provides overall assurance that the Trust remains compliant with national safer staffing requirements and continues to maintain effective governance processes to oversee nurse staffing, workforce risks and patient safety outcomes. The Trust has remained at Level 1 staffing escalation throughout the reporting period, indicating that normal service activity was maintained, safe staffing levels were sustained through collaborative workforce management from Matrons and Heads of Nursing.

Key points to note:

- There are no new staffing concerns. Trust-wide staffing indicators, including Care Hours Per Patient Day (CHPPD), staffing incidents, red flags and nurse staffing escalation metrics, remained within expected parameters throughout the reporting period. No wards required high-level intervention through the Nurse Staffing and Clinical Outcomes Group and triangulation of workforce, quality and patient safety metrics did not identify evidence of deterioration in care outcomes associated with staffing levels.
- Whilst overall assurance remains positive, a number of ongoing workforce challenges require continued oversight. Registered nurse fill rates reduced during

the summer period, particularly during night shifts, reflecting seasonal workforce pressures, vacancies and delays associated with newly qualified staff commencing employment. Although improvements were observed in September, workforce sustainability remains an area for ongoing monitoring.

- ETOC requirements continue to generate additional staffing demand in several clinical services and remain a significant factor influencing temporary staffing utilisation and workforce deployment decisions. Operational pressures also continue to necessitate cross-organisational staff redeployment to maintain safety.
- The 2026/27 Nurse Staffing Review programme remains ongoing. Whilst most completed reviews demonstrate broad alignment between funded establishments and assessed staffing requirements, a small number of complex services require further evaluation. This includes areas undergoing service transformation, services with significant ETOC requirements, specialist workforce challenges, emergency care settings and community services where evolving care models require further triangulation of staffing tools, professional judgement and quality indicators before recommendations can be finalised.
- A significant external assurance outcome was achieved during the reporting period through the NHSE Safe Staffing Assurance Review, where the Trust received a rating of Significant Assurance. The review recognised strengths in nurse staffing governance, establishment review processes, staffing escalation arrangements and the triangulation of workforce, quality and patient safety information. Whilst opportunities for further enhancement relating to residual workforce risk articulation, workforce sustainability and outcome reporting were identified, improvement actions have been agreed and will be incorporated into future reporting arrangements. The full NHSE review report is available within the Trust Board Reading Room.
- Recruitment and retention indicators continue to demonstrate positive progress, with registered nurse turnover improving from 6.39% to 4.26% and nurse vacancy rates remaining relatively low at 3.67%. Workforce development initiatives, including healthcare support worker recruitment campaigns, apprenticeship pathways and Registered Nursing Degree Apprenticeship programmes, are strengthening the Trust's long-term workforce pipeline.

Overall, the report concludes that, despite ongoing workforce pressures in some specialist and transforming services, the collective assessment of workforce metrics, patient safety indicators, quality measures and professional judgement provides assurance that nurse staffing arrangements remained sufficient to support the safe delivery of care across the Trust during the reporting period.

7. ALLIED HELATH PROFESSIONALS (AHP) PROFESSIONAL ASSURANCE AND WORKFORCE UPDATE

The Allied Health Professions (AHP) Professional Assurance and Workforce Report was presented to the Quality Committee on 19 November 2026. The full report and supporting documentation are available within the Reading Room.

Key points to note:

- AHP turnover has increased during 2026, reaching 9% in May. While overall turnover remains below historical and national averages, workforce movement continues to impact capacity, particularly within smaller services where vacancies have a disproportionate effect on resilience and service delivery.
- Significant progress has been made with AHP Job Planning, with more than 600 completed job plans covering approximately 70% of the clinical AHP workforce and full compliance achieved in four professions. However, analysis indicates that 51% of completed job plans operate outside recommended best-practice guidance, largely due to high levels of Direct Clinical Care activity and reduced Supporting Professional Activity time. This may limit opportunities for education, quality improvement, leadership development and service innovation.
- Podiatry remains a vulnerable profession due to workforce shortages, an ageing workforce, ongoing Band 5 vacancies and increasing demand associated with long-term conditions and diabetic foot disease. Recruitment and retention challenges continue to impact service sustainability despite workforce redesign and collaborative mitigation plans.
- TRAD continues to experience significant workforce pressures. Demand for radiotherapy services has increased substantially and workforce benchmarking identifies Newcastle Hospitals as having one of the highest patient attendances per Therapeutic Radiographer nationally. Current workforce capacity remains below recommended benchmarks, creating risks to future service expansion and sustainability. A comprehensive workforce plan is in place overseen by the Clinical Board.
- Workforce intelligence generated through Job Planning is providing greater visibility of workforce deployment and capacity and will support the next phase of work to develop demand modelling and strengthen workforce planning arrangements across AHP services.
- A range of mitigation plans are in place to address workforce risks within vulnerable professions, including apprenticeship pathways, workforce redesign, service reconfiguration, recruitment initiatives, capacity and demand reviews, and regional workforce development programmes.
- Significant collaborative work is progressing across Clinical Boards to strengthen integrated care pathways, therapy leadership, frailty services, community services and children's services. These developments support service sustainability, pathway integration and improved patient experience.
- There are a number of notable quality improvement achievements, including the successful implementation of a Trust-wide Therapy Supervision Framework, development of a structured Physiotherapy Work Experience Programme to strengthen the future workforce pipeline, and substantial reductions in waiting times within Community Speech and Language Therapy services through sustained improvement activity.

The report provides assurance that appropriate governance, workforce planning and service improvement arrangements are in place to support quality, safety and patient experience, whilst targeted actions continue to address known workforce vulnerabilities and future demand pressures.

8. RECOMMENDATIONS

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

i. Note and discuss the content of this report.
ii. Note the areas of risks and mitigating actions
iii. Note the assurance relating to Nursing and Midwifery Safe Staffing Oversight as outlined by NHSE during their recent review

Report of Ian Joy
Executive Director of Nursing, Midwifery and Allied Health Professionals
17 November 2026

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Agenda item A3(d)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 November 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. The report outlines the Trusts self-assessed position against the national priorities, including the Maternity Incentive Scheme (MIS), and alerts to any escalations and risks in relation to compliance. **Alert**: • There are no alerts. **Advise:** • One action from the 10 Point Plan remains at risk, implementing 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 Trust is continuing to complete the required audits, data analysis and actions outlined in the internal gap analysis, which is broadly on track, however the estates and medical staffing component remains a significant challenge. **Assure:** • The development of the bespoke Right Time surveys for Triage (Maternity Assessment Unit) and Neonatal Intensive Care Unit (NICU) is making good progress and is on track to be tested in November 2026. • The Quarter 2 (Q2) Right Time results were overall good, with the Trust in the top 20% with an average score of 86%. • As part of the national Perinatal Equity and Anti-Discrimination Programme (PEADP) the Trust has been assessed by Inspiring Hope against the staff engagement and workforce elements of the programme. The report received in October 2026 recommended no further external support is needed. • The Trust is compliant with the Perinatal Mortality Review Tool (PMRT) requirements of MIS year 8 guidance, and has ensured parents are engaged with reviews, and external experts attend to support these. • There are no escalations and the MIS is on track to achieve compliance. • The NHS England (NHSE) Regional Maternity Team have completed the 10 Point Plan baseline assessment regional review and provided feedback, the regional team concluded the submission was robust. • The Saving Babies Live Care Bundle Q2 position is improved, with all the required audits completed.		

<table>
<tr><td></td><td colspan="6">The National Neonatal Audit Programme 2025 data and report was published in October 2026. The National Neonatal Audit Programme (NNAP) assesses whether babies admitted to neonatal units receive consistent high-quality care and identifies areas for improvement. All measures within expected range with no alarms or alerts.
The Perinatal Service has completed the 5 immediate Thirlwall actions, but acknowledges the requirements are broader than this service, with the Trust Board required to provide assurance against the organisational position.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Trust Board is asked to:

i. Receive and discuss the report.
ii. Note compliance with the Perinatal Quality Surveillance Model and the positive trajectory towards achieving Maternity Incentive Scheme Year 8 compliance.
iii. Note the completion of an external review of the staff engagement and workforce elements of the Perinatal Equity and Anti-Discrimination Programme and the 10 Point Plan baseline assessment.
iv. Note the submission of the biannual perinatal workforce paper in the reading room to fulfil the Maternity Incentive Scheme requirements.</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>
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<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">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="6">Recurrent monthly report.</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. The report outlines the Trusts self-assessed position against the national priorities, including the MIS, and alerts to any escalations and risks in relation to compliance.

2. LISTENING TO WOMEN AND FAMILIES THROUGH SERVICE USER FEEDBACK

The development of the bespoke Right Time surveys for Triage (Maternity Assessment Unit) and Neonatal Intensive Care Unit (NICU) is making good progress and is on track to be tested in November 2026. The Intrapartum Real Time programme recommenced in October 2026 and elicited insightful results with 100% of the 15 patient surveyed rating their care as good or very good.

The Right Time survey methodology has now been updated and reflects the 2026 Care Quality Commission (CQC) National Maternity Survey. The Q2 results were overall good, with the Trust in the top 20% with an average score of 86%.

- Top 20% on 31 questions
- Middle 60% on 26 questions
- Bottom 20% on 4 questions

The results are reflective of the CQC Maternity Survey 2026 with the questions in the bottom 20% relating to mental health and a partner or someone else close to you involved in your care and able to stay on the maternity ward.

The Maternity and Neonatal Voice Partnership (MNVP) is currently evaluating the pilot of extended visiting on the postnatal, transitional care and antenatal ward to inform next steps. The Trust is unable to provide overnight accommodation in bays on the wards, and so the offer is limited to women receiving care on Newcastle Birthing Centre (NBC) and in a cubicle on the wards. The planned estates work will not remedy this, as the current footprint precludes the introduction of individual rooms.

3. CULTURE OF LEARNING, SAFETY AND SUPPORT

3.1. Perinatal Equity and Anti-Discrimination Programme

As part of the national PEADP the Trust has been assessed by Inspiring Hope against the staff engagement and workforce elements of the programme, with a report received in October 2026.

Recommended route: no further external support needed.

What makes the difference here:

- **Racism is named**. Staff and patient-facing posters say "no place for racism" and "recognise it, name it, report it", with a confidential, anonymous route to the leadership team.
- **The reporting route works in practice**. A racially minoritised colleague reported racist comments from service users through InPhase. Colleagues challenged it in real time, leaders spoke to the patients, and the loop was closed with the victim.
- **Facilitation is skilled and structured**. System-wide anti-racism and cultural curiosity training is delivered by Baby Lifeline-trained facilitators, always a global majority colleague with a white ally, backed by a racially minoritised member of the team.
- **Accountability is senior**. The Perinatal Anti-Racism Taskforce (PART) has run for just over a year and is chaired by the Associate Director of Operations.
- The Trust may be an exemplar for other Trusts, with its agreement. Leaders were clear they see themselves as "early days" in a generational culture shift.

3.2. PMRT

During Q2 20 PMRT multi-disciplinary team reviews were conducted. Themes were identified within these reviews and correlated with the learning from all cases from the previous year. There are 4 themes, some of which are also evident in Maternity and Neonatal Safety Investigation reports, reassuringly the Q1 themes associated with access to interpreting services and risk assessment for aspirin were not evident in the Q2 reviews. The themes were:

- Completion of Kleihauer
- Estate (individual rooms on Paediatric Intensive Care Unit (PICU) and capacity in maternity)
- Documentation (inconsistency across region)
- Communication (standardisation of documentation process in PICU and availability of information in various languages).

Actions have been agreed in response to these themes with progress monitored by the Perinatal Patient Safety Team.

National reports (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK), Ockenden & Amos) have highlighted that reviews must move from identifying what happened to understanding why, and action and monitor change where needed. Trusts are also required to monitor demographic data to recognise and review differences in outcomes. The Trust has integrated demographic data into the clinical outcomes dashboard to enable this. The Trust has developed the ‘Health Equity Score‘ (HES) Tool to consider protected characteristics and patient factors that could impact on health equity; higher scores may indicate multiple factors for consideration that could affect women and families’ ability to access care and/or receive equitable care.

The majority (18/20 cases) reviewed in Q2 did not have care issued which impacted on the outcome. There were 2 cases graded as C & D for a single element of the care, neither impacted on the sad loss of the baby as both were associated with significant fetal abnormalities.

The Trust is compliant with the PMRT requirements of MIS year 8 guidance, and has ensured parents are engaged with reviews, and external experts attend to support these.

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

4.1. Maternity Incentive Scheme

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. The October 2026 position is as follows - 119 actions (up by 26) are completed; 43 actions are on track (down by 11 as now complete) with a further action requiring completion this month.

Safety Action C requires confirmation that all eligible events must be notified through the NHSE submit a Perinatal Event (SPEN) portal to MBRRACE-UK, NHS Resolution (NHSR) Early Notification Scheme and Maternity and Newborn Safety Investigations (MNSI) as soon as possible after death or diagnosis. The Trust is compliant with this requirement.

4.2. 10 Point Plan for Maternity and Neonatal Care

Deliverable	Baseline compliance rating
1. Listening to women and families by rolling out Martha's Rule	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
5. Addressing health inequalities in maternity and neonatal outcomes	Partially compliant
6. Ensuring 24 hours a day/7 days a week (24/7) safety and responsiveness of services	Partially Compliant
7. Trust review of homebirth services	Compliant

Deliverable	Baseline compliance rating
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

The NHSE Regional Maternity Team have completed the baseline assessment submission regional review and provided feedback. The regional review found evidence of established assurance alongside several areas where they recommended strengthening the evidence in the December 2026 submission. These include:

- **1.1 Martha's Rule rollout.** Continue roll out. National Marthas Rule Team will collect data.
- **3.2 Clinical leadership participation.** Provide recent Board minutes demonstrating participation relevant maternity/neonatal Clinical Directors for perinatal agenda items.
- **6.4 Midwifery establishment and Birthrate Plus (BR+).** Provide evidence that Phase 3 funded establishment has been implemented and reconciled to the June 2024 BR+ requirement with professional judgement.
- **6.5 24/7 anaesthetic cover.** Provide current rota/assurance evidence for the trained anaesthetic-assistant requirement in addition to duty anaesthetist cover.
- **8.3 Open learning and compassionate debriefing.** Provide an implementation audit or case sample covering compassionate debriefing, key contact, family engagement and measurable improvement, and timely senior duty of candor, with actions for exceptions.

The review recognised established assurance in Martha's Rule rollout, outcomes, experience and Board reporting, Board accountability, equity and inequalities, workforce safety and responsiveness, homebirth services, incident, complaints and concerns governance, maternity triage and post-death care. The regional team concluded the submission was robust.

One action from the 10 Point Plan remains at risk - 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 Trust is continuing to complete the required audits, data analysis and actions outlined in the internal gap analysis, which is broadly on track, however the estates and medical staffing component remains a significant challenge.

4.3. Saving Babies Lives

Element	Progress
1. Reducing smoking in pregnancy	92% (11 of 12 indicators)
2. Fetal Growth: risk assessment, surveillance & management	75% (6 of 8 indicators)
3. Raising awareness of reduced fetal movement	100% (3 of 3 indicators)
4. Effective fetal monitoring during labour	100% (5 of 5 indicators)

Element	Progress
5. Reducing preterm births and optimising perinatal care	100% (8 of 8 indicators)
6. Management of pre-existing diabetes in pregnancy	100% (2 of 2 indicators)

The Q2 position is improved, with all the required audits completed. The Trust has clear improvement plans to achieve full compliance in the next quarter and monitoring this on a monthly basis.

4.4. NNAP

The National Neonatal Audit Programme 2025 data and report was published in October 2026. The NNAP assesses whether babies admitted to neonatal units receive consistent high-quality care and identifies areas for improvement. It is based on data relating to babies cared for in neonatal units in England, Scotland, Wales and Isle of Man between 1 January and 31 December 2025.

There are 18 measures and 10 performance metrics which reflect the quality of care and issues which impact survival or quality of life, allowing for comparison within networks and with similar services and the identification of issues and opportunities for improvement.

- 12 measures have improved in the 2025 report compared with the 2024:
  - Antenatal magnesium
  - Optimal cord clamping
  - Admission temperature
  - Breastmilk by 2 days of life
  - Breastmilk at 14 days of life
  - Blood stream infections
  - Necrotising enterocolitis
  - Non-invasive ventilation
  - Retinopathy of prematurity screening
  - Oxygen at 36 weeks corrected age or death
  - Parents seen within 24 hours
  - Bronchopulmonary Dysplasia (BPD - also called chronic lung disease of prematurity)
- 2 measures denote excellent performance (breast milk by day 2 and retinopathy of prematurity screening).
- All measures are within the expected range with no alarms or alerts.

5. THIRLWALL INQUIRY REPORT AND RECOMMENDATIONS

The Perinatal Service has completed the 5 immediate actions required, but acknowledges the requirements are broader than this service, with the Trust Board required to provide assurance against the organisational position.

- **Every Trust and Integrated Care Board (ICB) Board to review the Thirlwall report and to consider its findings at the next available public Board meeting.** *[The*

Thirlwall report was added to the Trust Board Reading Room for the September Board meeting]

- **Sudden and Unexpected Death In Children (SUDIC)**: A letter was sent from the Lead for Neonatal Mortality and Named Doctor for Paediatric Mortality on 25 September to all relevant staff and Board members regarding the SUDIC process. The Head of Neonatology has updated and ratified the 'Notification and Documentation of Neonatal Deaths Standard Operating Procedure'.
- **National Bereavement Care Pathway (NBCP) for stillbirth and neonatal death**: The Trust has a Women's Bereavement Group with oversight of the NBCP benchmarking and action plan, this work continues with no escalations regarding areas of specific concern.
- **Insulin**: An Omnicell (with biometrics data) will be available in the NICU following completion of the estates programme at the end of November 2026. The movement back into the completed unit will not completed until 18 December 2026, a risk assessment for the period 30 November and 18 December has been completed with mitigations in place. The gap analysis against the GIRFT recommendations has been completed with the Advanced Clinical Pharmacist (Medication Safety in Diabetes & Endocrinology).
- **Safeguarding**: Training compliance achieved across the service for Level 2 & 3.

6. CONCLUSION

The Perinatal Service continues to make good progress against national maternity and neonatal priorities, including the MIS, the 10 Point Plan for Maternity and Neonatal Services and Saving Babies' Lives Care Bundle. The Trust remains on track to achieve MIS Year 8 compliance, with no current escalations.

The delivery of improvements required to achieve full compliance with national maternity triage standards, particularly where estates and medical workforce constraints remain challenging.

The report provides assurance that effective governance arrangements remain in place, risks are being actively managed, and the service is responding proactively to national priorities and expectations and remains focused on delivering safe, personalised, equitable and high-quality care for women, babies and families.

7. RECOMMENDATIONS

The Trust Board is asked to:

i. Receive and discuss the report.
ii. Note compliance with the Perinatal Quality Surveillance Model and the positive trajectory towards achieving Maternity Incentive Scheme Year 8 compliance.
iii. Note the completion of an external review of the staff engagement and workforce elements of the Perinatal Equity and Anti-Discrimination Programme and the 10 Point Plan baseline assessment.

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

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Agenda item A4(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 November 2026		
Title	Freedom to Speak Up Guardian Bi-annual Report 2026-2027		
Report of	Rachel Carter, Director for Quality and Safety		
Prepared by	Paula Dimarco/Kathryn Smart, Freedom to Speak up Guardians		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	**Alert** For this reporting period there are no items to alert to the Trust Board. **Advise** • The data reported suggests that people are primarily speaking up because they: 1. Experience or witness inappropriate behaviours, incivility, bullying or intimidation. 2. Feel unsupported by managers or leaders. 3. Are concerned that workforce issues are creating patient safety risks. 4. Perceive unfairness, inconsistency or discrimination. 5. Feel psychologically unsafe to challenge decisions, ask questions or seek help. 6. Experience poor communication and organisational processes. 7. Feel vulnerable due to their status as new starters, temporary workers, internationally recruited staff or staff with health conditions/neurodiversity. • Concerns raised indicate there is a challenging picture of organisational culture in some areas with the need to improve psychological safety, civility and compassionate leadership behaviours to ensure workforce wellbeing and patient safety. • There is a need for strengthened accountability for leaders and managers to demonstrate effective communication, visible action and timely feedback when concerns are raised. • Introduction of a formal mechanism to share organisational learning and outcomes from Speaking Up is required to ensure staff can see how concerns have informed improvements. • The uptake of Speak Up, Listen Up and Follow Up training remains low across the organisation. **Assure:** • There is a high level of confidence in the Guardian service itself, a total of 91 concerns were raised, demonstrating continued staff willingness to speak up to the Guardians. • Anonymous reporting has reduced proportionately over reporting periods, suggesting increasing confidence in speaking up confidentially. • Engagement from global majority colleagues has increased, indicating broader accessibility and trust in the service. • Service user feedback remains positive, with 100% of respondents stating they would recommend the service and rating it highly.		

<table>
<tr><td></td><td colspan="6">The Guardian team continues extensive engagement activity across Trust sites, staff networks, champion meetings and leadership groups.
Emerging learning is being integrated into wider organisational initiatives, including the Just and Learning Culture programme, Resolution Hub development, leadership development activity and induction processes.
Arrangements are in place to strengthen governance through continued NHS England reporting, enhanced data collection and the in-progress development of a Power BI dashboard.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Board is asked to:
1. Receive the report and note the themes and trends emerging from Freedom to Speak Up activity between April and September 2026.
2. Recognise the link between staff experience, psychological safety and patient safety identified within the data.
3. Support the continued development of the Trust's Just and Learning Culture programme, with particular focus on civility, respect and compassionate leadership.
4. Endorse the establishment of a formal communication mechanism for sharing organisational learning arising from Freedom to Speak Up contacts and themes.
5. Support implementation of mandatory Speak Up, Listen Up and Follow Up training for relevant staff groups.
6. Seek assurance through regular reporting that identified cultural, leadership and wellbeing themes are being addressed within services and aligned to Board Assurance Framework risk 2.1.</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>
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<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>
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<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">Risk 2.1 - 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 Trust Board received the Annual report on 22 May 2026.</td></tr>
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FREEDOM TO SPEAK UP GUARDIAN BI-ANNUAL REPORT 2026-27

1. INTRODUCTION

This report provides detail of the activity undertaken by the Freedom to Speak Up Guardians (FTSUG) between 1st April 2026 and 30th September 2026, including themes and trends identified in the concerns that have been raised and any Trust-wide learning to be shared. It also includes data from the Work in Confidence anonymous reporting platform.

Two key events have occurred during this reporting period; following consultation on the proposed restructure of the Quality and Safety Department an increase in service provision from 1.0 whole-time-equivalent (wte) to 2.0 wte FTSUGs was agreed (planned start date for 2nd November), and the closure of the National Guardian Office (NGO) with NHS England assuming national-level FTSU activities, guidance preservation and guardian support functions from 1st July 2026. As a result of the NGO closure, the Trust has the following responsibilities:

- **Internal FTSU Ownership:** Trusts must fully integrate Freedom to Speak Up functions, governance, and oversight directly into their own organisational structures rather than relying on an external national body for day-to-day operations.
- **Maintaining the Guardian Role:** Trusts are required to keep the Freedom to Speak Up Guardian role embedded as part of the NHS Standard Contract to ensure workers continue to have independent, confidential internal routes to raise concerns.
- **Board Engagement and Culture:** Trust leadership and Boards must actively engage with FTSU matters, foster psychological safety, and ensure a culture of "speaking up, listening up, and following up".
- **Data and Reporting:** Trusts must maintain local data submission, proper record-keeping (retaining complaint records for 10+ years under strict information governance), and transparent management of concerns.

The FTSUGs continue to submit quarterly data, now to NHS England, to inform national trends and themes. Direct comparison of data with other organisations is discouraged due to the number of variables that can influence speaking up culture and how the data can be interpreted.

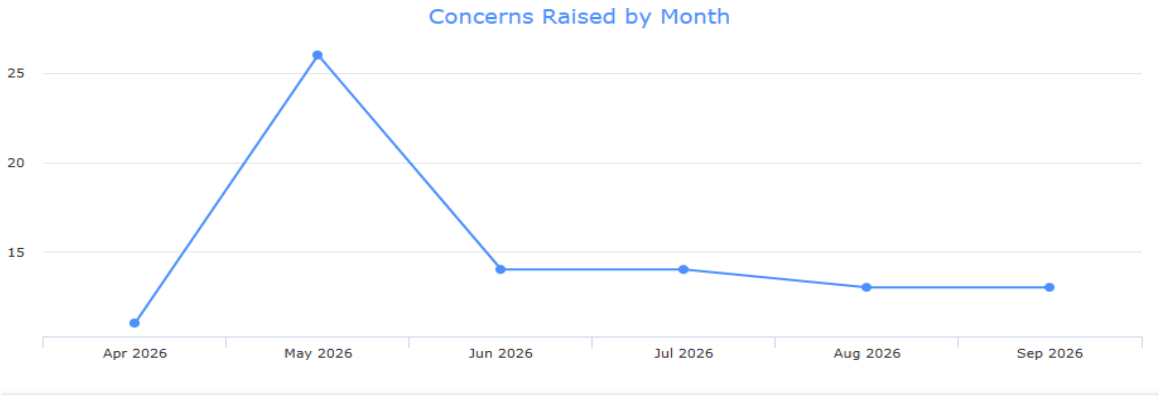
The Board-level FTSUG dashboard remains in progress, work on building a power BI dashboard has commenced with a planned completion date of December 2026.

2. SPEAK UP ACTIVITY

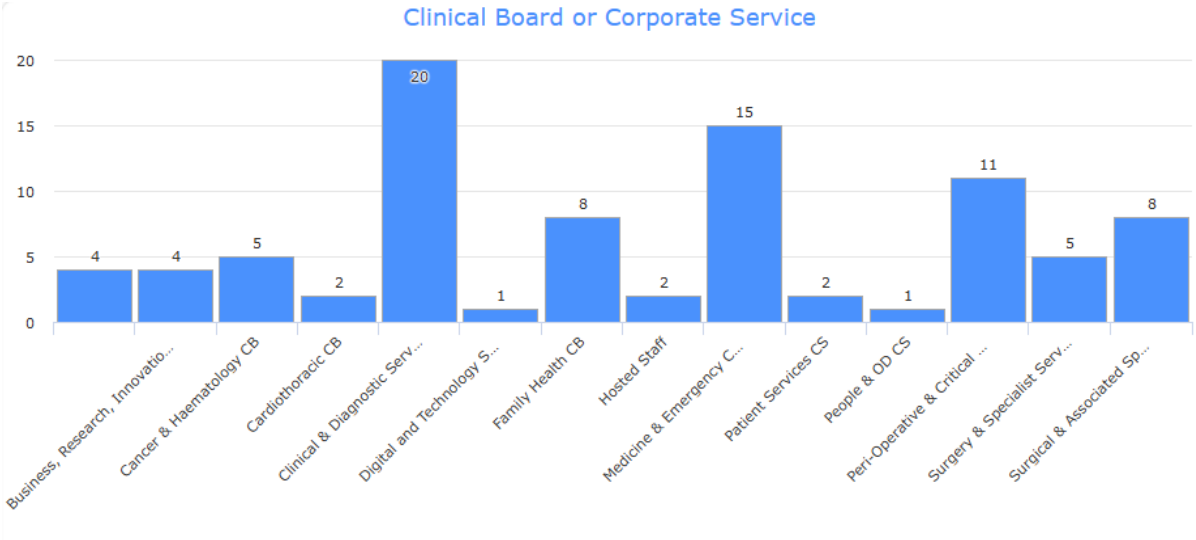
2.1 Concerns raised by month

A total of 91 concerns were raised via the FTSUGs during this time. Following a spike in May (possibly associated with information being shared within the Chief Executive Officer (CEO) roadshows) contact numbers have settled to a steady monthly rate. There has not been any targeted work in this timeframe.

There are currently 83 cases open with an additional 5 on hold. The reasons a case could be on hold include the person being absent from work or an associated people process being underway. 34 cases were closed in this timeframe.



2.2 Concerns raised by Clinical Board (CB) or Corporate Service (CS)

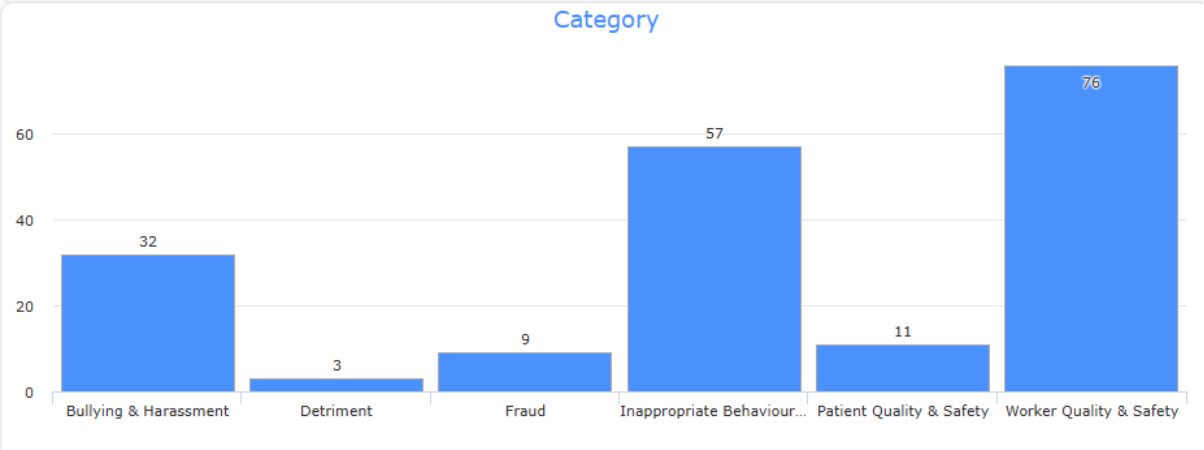


Data is unavailable in some cases where contact was made via the Work in Confidence system as the area of work is not always stated.

Clinical & Diagnostic Services (CDS) reported the highest volume of Freedom to Speak Up cases during the period. A significant proportion related to two discrete team-specific issues, indicating that the data are influenced by localised concerns rather than a widespread trend across the Clinical Board. Medicine & Emergency Care reported the second highest number of cases, with most concerns arising from emergency and acute care services. Review by the People and Equality, Diversity and Inclusion (EDI) teams has not identified evidence of discriminatory behaviour by senior staff towards junior colleagues or new starters within the areas concerned, providing assurance that the issues raised do not reflect broader concerns regarding discrimination.

2.3 Concerns raised by category

The most frequently reported category remains worker quality and safety, which strongly aligns with national FTSUG data where worker quality and safety accounts for 41% of concerns raised.



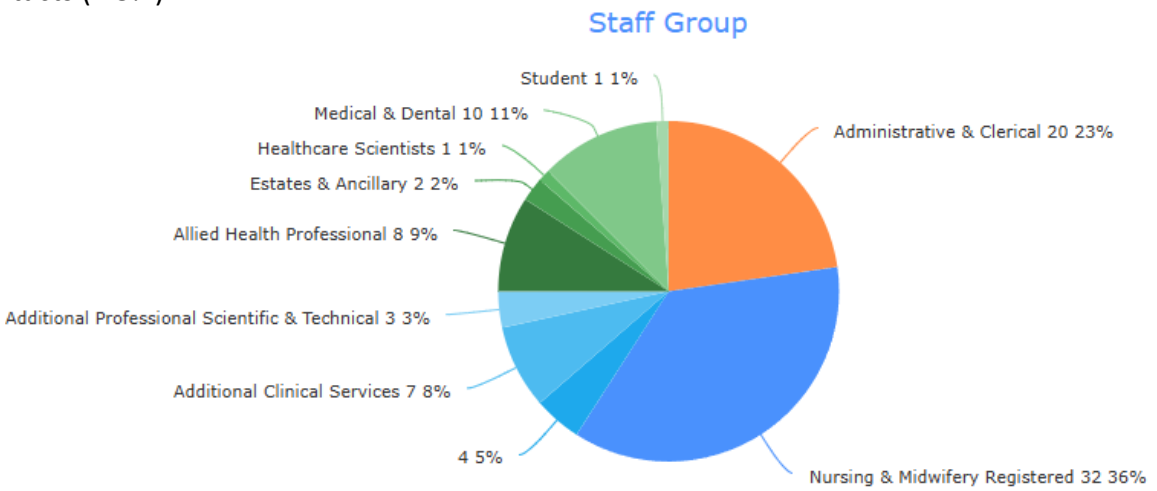
2.4 Concerns raised by subcategory

Recording of subcategories commenced during this period, with a full breakdown shown below. Work is ongoing to review and refine these subcategories, and a full report of all available data is planned for delivery to the December People Programme Board.

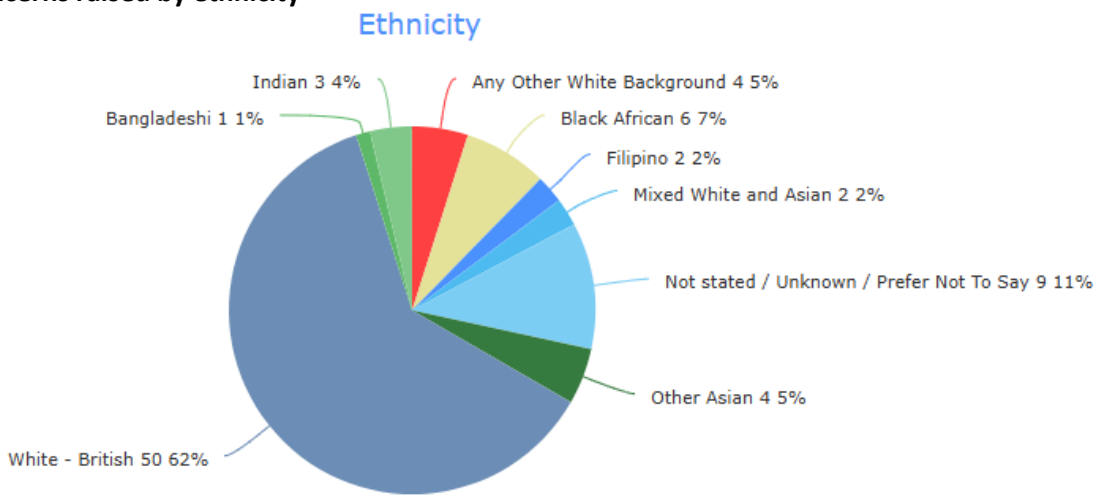
Actual harm to patient	2
Behaviour	19
Career progression	4
Civility	32
Culture of a group/team	13
Culture of Trust generally	1
Denying training/promotion opportunity	3
Environment of workplace	1
Financial	2
Individuals' behaviour	41
Insulting comments	7
Poor leadership culture	33
Poor leadership – not addressing problem	17
Poor management – not following performance management policy	2
Poor management – not following probation policy	1
Poor management – not following sickness absence policy	1
Poor management – not following process (other)	4
Poor management – not listening	9
Racial abuse	1
Racial discrimination	9
Reasonable adjustments (lack of access or application)	3
Regular undermining a competent colleague	10
Sexually inappropriate behaviours	1
Spreading malicious rumours	3
Staffing ability	6
Staffing levels	4
Unfair treatment	21
Verbal abuse	2
Wellbeing	33
Workload	3

2.5 Concerns raised by Staff Group

The data shows that a range of professions are using the FTSUG service. Staff group is not always provided as part of anonymous concerns, so this was unknown for as small group of contacts (4.5%).



2.6 Concerns raised by ethnicity



Most people speaking up are White British in line with previous reports. There has however been an increase in the number of global majority colleagues speaking up using the service from 11.5% to 20% which is encouraging to see. During this time there has been a change to data collection to capture information on all protected characteristics, a full data set of this will be included in the next report.

2.7 Concerns raised anonymously

During Quarter 1 (Q1) and Quarter 2 (Q2) 2026/27, 13 individuals raised concerns anonymously, representing 7% of all contacts received by the Freedom to Speak Up service during the period. Following initial engagement through the Work In Confidence platform, three individuals subsequently agreed to meet confidentially with a Freedom to Speak Up Guardian to discuss their concerns further.

The number of anonymous contacts has remained consistent with the preceding six-month period (13 compared with 12) but represents a lower proportion of overall contacts (7% compared with 12% and 14% in the two previous reporting periods). While caution should be applied in drawing conclusions from relatively small numbers, this trend may indicate increasing confidence in the

Freedom to Speak Up service and willingness among staff to engage directly with Guardians when raising concerns.

2.8 Reasons for contacting the Guardian

Collection of a new data set commenced during this reporting period capturing reasons for raising a concern via the FTSUGs rather than via other available route. This will be used to gain a greater understanding of any changes required to improve reporting culture. Initial responses were as follows:

24 - Already raised (via another route) and not aware of any action taken
23 - Fearful of detriment
3 - Unsure who manager is/who to report to
31 - Other

Common themes within the 'other' category includes: unable to talk to manager as they are part of issue, leadership behaviours have led to lack of psychological safety and not comfortable to raise concerns, not feeling listened to and wanting to feedback on experience of being part of a people process.

2.9 Data analysis – themes from closed cases

Analysis of closed concerns identified five recurring themes underpinning why people are speaking up:

1. Incivility, Bullying and Disrespectful Behaviour
Concerns frequently described rude, dismissive or intimidating behaviour, public criticism of colleagues, inappropriate communication, and a perceived failure of leaders to challenge poor conduct. Many reports reflected concerns about abuse of power, normalisation of unacceptable behaviours and a lack of effective resolution. Collectively, these issues point to cultural challenges rather than isolated individual behaviours. This mirrors national Freedom to Speak Up trends, where inappropriate behaviours and attitudes remain the most commonly reported concern.

2. Leadership and Management Practice
People raised concerns about poor communication, inconsistent decision-making, ineffective management of change, limited leadership visibility, lack of compassion in managing workforce issues, and insufficient feedback following escalation. The data suggests that dissatisfaction often related less to decisions themselves and more to how they were communicated and implemented.

3. Psychological Safety and Impact on Patient Care
Individuals reported feeling unable to ask questions, seek clarification, make suggestions, challenge decisions or raise concerns without fear of negative consequences. This suggests that psychological safety is not consistently experienced across all areas and may inhibit speaking up, learning and safe patient care.

4. Staff Wellbeing
Concerns highlighted inadequate support, emotional exhaustion, distress associated with formal processes, and a perceived lack of understanding around health conditions and mental wellbeing. In several cases, individuals described significant anxiety, loss of confidence and a negative impact on their wellbeing.

5. Fairness, Equality and Inclusion
Concerns included perceived discrimination, differential treatment of staff groups, challenges relating to neurodiversity, inconsistent application of policies, and inequitable access to

opportunities such as flexible working and application of reasonable adjustments. Whether or not concerns were substantiated, perceptions of unfairness appeared to undermine trust and confidence in organisational processes and contributed to individuals choosing to speak up.

Overall Observation
The themes identified through closed Freedom to Speak Up cases indicate that staff are most likely to raise concerns where workplace culture, leadership behaviours and psychological safety are perceived to be compromised. Across the five themes, concerns centred on respect, fairness, communication, inclusion and support rather than isolated operational issues. This suggests that continuing to strengthen leadership capability, promote positive workplace behaviours and improve psychological safety will be key to enhancing staff experience, supporting retention and wellbeing, and maintaining a culture in which concerns can be raised and addressed constructively.

2.10 Feedback from service users

Of the 34 cases closed with feedback requested, 17 people completed the survey. 100% of people said they would recommend the service and scored the service 4 or 5 out of 5. One person requested more clarity about the process, 16 either didn't comment or said they couldn't think of anyway the service could be improved.

Additional feedback included statements such as:

- Positive experience.
- Very efficient, easy to access. The team were very supportive.
- Such a valuable service for staff.
- Very much appreciated, the time and support offered and the follow ups to see how I was.
- Felt like a safe space and very helpful to speak out.

2.11 Engagement activity

As well as routinely attending all the Staff Network meetings, the quarterly regional FTSUG networking meeting and the quarterly Alliance FTSUG meeting, the FTSUGs have completed 13 targeted engagement activities across the 3 main sites ranging from clinical students to senior people in corporate services.

2.12 Sharing the learning

There isn't currently a way to formally share learning from FTSUG cases within the Trust. However a number of steps are being taken to address this including work with People Services teams to develop regular Trustwide communication on outcomes of speaking up. A standard slide deck with themes and anonymised actions is in development which will be shared monthly with champions and at staff networks. Proactive conversations between the FTSUGs and the Learning and Development (L&D) Team are currently used to inform delivery of current training and development courses. For example, where relevant L&D training references difficult conversations in the context of speak ups during their teaching. They also signpost all learners to speak up, listen up and follow up training as well as FTSUG services. In addition, as inappropriate use of mobile phones in clinical areas is frequently referenced in speak ups, use of mobile phones in the clinical environment will be explicitly referenced in Trust induction.

The FTSUGs are involved in shaping the Trust's Just and Learning Culture workstream and are sharing themes from concerns to inform the development of the Resolution Hub and associated processes, including specific experiences of colleagues who have been/are part of people processes.

2.13 E-learning training undertaken in this timeframe

Speak Up - 9
Listen Up - 12
Follow Up - 1

A request has been submitted to the Learning and Education Group for the consideration to make the above training mandatory for new starters. If approved the link to the speak up e-learning would be sent directly after induction, people with management responsibilities will also receive the link to listen up e-learning and senior managers will also receive the link for follow up e-learning.

3. CHAMPIONS

Two Champions have received training and 3 have left the network during this reporting period. The current number of trained champions is 31.

Following feedback, the expression of interest process has been amended to improve accessibility. Colleagues from other support services have attended 2 champions meetings to improve understanding of signposting routes (Chaplaincy and Working Well team). In addition to this an education session was delivered by the chair of the Race Equality Network (REN) titled 'Becoming anti-racist in practice' to support the champions in any cases where racism was witnessed/reported to. There has been one recorded speak up contact to a Champion. The outcome of this was signposting to the FTSUG.

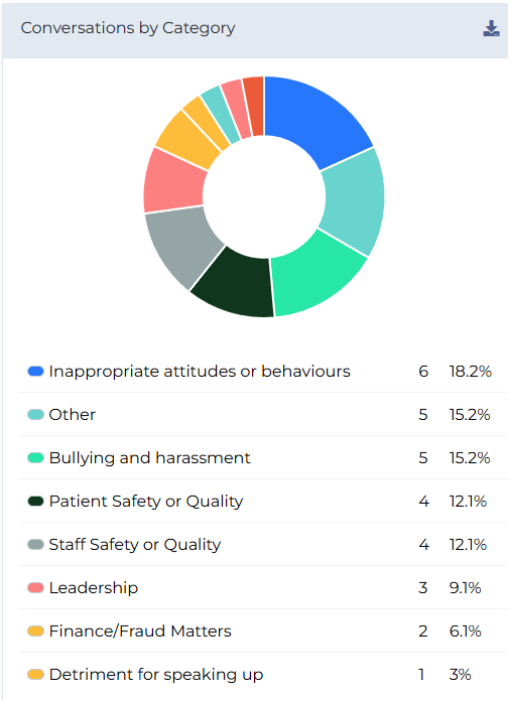
4. WORK IN CONFIDENCE

Between 01/04/2026 and 30/09/2026 37 new accounts were registered and 33 conversations were raised (although only 30 conversations are listed by category on the Work in Confidence platform)

9 conversations remain open

24 conversations were closed

Categories do not appear in the same order of most to least frequently selected as the FTSUG data, but the accuracy of conversation category has not been quality assured



5. CONCLUSION

The findings indicate a workforce that is generally confident and willing to speak up, reflecting a positive culture in which staff feel able to raise concerns, but is frequently doing so because of experiences of poor behaviours, lack of psychological safety and concerns about leadership practice.

The most significant finding is the close relationship between staff experience and patient safety risks. Staff repeatedly describe situations where incivility, fear, poor support or inadequate communication directly affect their ability to provide safe care.

The themes align very closely with national Freedom to Speak Up data, particularly the dominance of inappropriate behaviours, worker wellbeing concerns and psychological safety issues. This suggests the organisation is experiencing many of the same cultural challenges seen across the wider NHS, but with an opportunity to address them proactively through focused leadership, civility and culture improvement initiatives.

6. RECOMMENDATIONS

The Board is asked to:

7. Receive the report and note the themes and trends emerging from Freedom to Speak Up activity between April and September 2026.
8. Recognise the link between staff experience, psychological safety and patient safety identified within the data.
9. Support the continued development of the Trust's Just and Learning Culture programme, with particular focus on civility, respect and compassionate leadership.
10. Endorse the establishment of a formal communication mechanism for sharing organisational learning arising from Freedom to Speak Up contacts and themes.
11. Support implementation of mandatory Speak Up, Listen Up and Follow Up training for relevant staff groups.
12. Seek assurance through regular reporting that identified cultural, leadership and wellbeing themes are being addressed within services and aligned to Board Assurance Framework risk 2.1.

Report of Rachel Carter
Director for Quality and Safety
13 November 2026

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Agenda item A5(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 November 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. • All BAF current risk scores remain unchanged. • There are 6 BAF risks outside the risk appetite tolerance, these relate to: - **Failure to manage our resources sustainability and responsibly ensuring strong financial, productivity and commercial plans are delivered.** **- Failure to adequately maintain and continuously improve our facilities to ensure they support safe and efficient care.** **- Inability to improve patient safety and patient harm through reliable, evidence-based care.** **- Failure to coordinate services which are available when our patients need them.** **- Failure to coordinate services which are effective.** **- Failure to meet our care standards in a way which is designed around people, not organisations.** • There are 4 BAF risks within the risk appetite tolerance, these relate to: **- Failure to strengthen partnerships across neighbourhoods, the city, region and system.** **-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.** **- Failure to develop and implement modern, secure, reliable digital environments that support safe and efficient care.** • The BAF has been received by all Committees in November 2026. • Committee updates since the last meeting can be found within section 2 of this report. • Please note there is one risk that requires review by Audit, Risk and Assurance Committee (ARAC) as this is directly aligned to Trust Board. This relates to failure to strengthen partnerships across neighbourhood, the city, region and system.		
Recommendation	The Trust Board are asked to: • Receive the BAF. • Provide comments or feedback.		

<table>
<tr><td></td><td colspan="6">• Approve the BAF.</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">Not applicable.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Considered at the Audit, Risk and Assurance Committee and regular report to the Trust Board.</td></tr>
</table>

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 structured 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 provides 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 the 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

<u>Quality Committee</u>

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:

- All scores have remained unchanged.
- All risk appetite positions remain outside the risk appetite tolerance**.**

Risk 1.1. Failure to meet our care standards in a way which is designed around people, not organisations.

- Failure to promote and deliver equitable health access, experience and outcomes in our hospitals has had a full review to ensure controls and actions are fully aligned to the Trust strategic priorities and draft health inequality plans.
- Failure to achieve compliance with national maternity standards, assurances have been added in relation to completion of the 10-point plan gap analysis, triage implementation tool gap analysis and the establishment of a triage task and finish group.
- Failure to deliver improvements in our complaints process, phase 1 of the Integrated Board Report metrics is now complete, phase 2 metrics aligned to quality priorities are planned for completion by March 2027.
- Inability to identify and implement effective systems to support reasonable adjustments for learning disability and autistic patients; timescales have been extended for completion of the learning disabilities and autism plan.
- Failure to achieve compliance with national maternity standards assurance rating has moved from Amber to Green.

Risk 1.2. Failure to coordinate services which are effective.

- Four actions timescales have been extended in relation to:
  -Patient outcome data and reporting into Quality Performance Reviews.
  -Development of the Alliance Clinical Framework.
  -Support and develop optimisation of North East North Cumbria (NENC) pathways.
  -Develop and embed learning and sharing of best practice from Getting It Right First Time (GIRFT) and Peer Reviews.

Risk 2.1. Inability to improve patient safety and patient harm through reliable, evidence-based care.

- Failure to successfully develop and nurture a positive safety culture, control has been added relating to the recruitment of patient safety partners.
- The action relating to duty of candour has been updated to revise and develop a comprehensive duty of candour action plan.
- Failure to embed systems and processes to reduce hospital acquired infections and improve antimicrobial stewardship, action timescale has been extended in relation to Infection Prevention and Control (IPC) Policies and Standard Operating Procedures (SoPs).
- Failure to improve compliance with clinical effectiveness and outcomes standards, two action timescales have been extended relating to the development of a schedule of business for Quality & Safety (Q&S) focussed Quality Performance Reviews and review and update the clinical outcomes and effectiveness group terms of reference.

People Committee

There are two 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:

- All risk scores remain unchanged.
- All risk appetite positions remain in a tolerable risk position.

Risk 3.2. Failure to support and develop confident, compassionate and accountable leadership at every level.

- Controls have been added in relation to a proposal developed for a three tier leadership programme and appointment of programme support in place to deliver the leadership programme.

Risk 3.1. Failure to provide a healthy, safe, flexible and inclusive working environment that enables our people to thrive and deliver outstanding care.

- Controls added in relation to the completion of the Trust Anti-racism strategy and anti-racism training courses.

Digital and Data Committee

There is one strategic risk aligned to the Digital and Data Committee, this relates to:

- **3.5. Failure to develop and implement modern, reliable digital environments that support safe and efficient care.**

Updates since the last iteration of the BAF to the Digital and Data Committee include:

- Current risk score remains unchanged.
- All threat assurance levels remain red.
- The risk appetite position remains in a tolerable risk position.
- All actions have been identified however these require significant pieces of work and have longer timescales for completion.
- Five action timescales have been extended these relate to:
  -Review of digital assets
  -Review cyber security strategy and capability
  -Identify gaps in capability and defence
  -Unlawful access to patient records assessment and options appraisal for executive consideration
  -Develop change and implement change management process for all new technology
- Controls have been added in relation to development and implementation of the Digital and Data Committee Tier 2 Groups including new terms of reference and establishment of an Inappropriate Access Task and Finish Group.
- Two assurances have been added relating to:
  - Information Commissioner's Office (ICO) audit Data Protection – reasonable level of assurance received.

-AuditOne Internal Audit Data Sharing – reasonable level of assurance received.

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:

- Current risks scores for all strategic risks remain unchanged.
- All risk appetite positions remain outside risk appetite tolerance**.**
- Risk 3.3 Failure to adequately maintain and continuously improve our Estates and Facilities to ensure they support safe and efficient care has been reviewed and risk remains unchanged.

Risk 1.3. Failure to coordinate services which are available when our patients need them.

- Failure to meet key waiting time standards for cancer and elective care due to capacity constraints and pathway delays, 5 new actions have been added relating to:
  -lung cancer team to deploy patient pass to reduce time from referral to treatment.
  -endoscopy recovery group to oversee re-allocation of non-cancer capacity activity.
  -single point of access to be extended to accommodate neuro referrals.
  -full consultant review of trauma and orthopaedics referrals.
  -explore expansion of Campus for Ageing and Vitality (CAV) to increase ophthalmology service.
- Diagnostic bottlenecks due to workforce and utilisation issues impacting on decision making and timely treatment, two new actions have been added relating to:
  -building works to be completed to support additional MRI scanner capacity to increase activity.
  -recruitment into budgeted establishment in echo.
- Longer waits for community services compared to acute base services due to lack of visibility, 1 control has been added relating to:
  -Integrated Care Board (ICB) approval for GIRFT waiting list initiative proposals.

Risk 3.4. Failure to manage our resources sustainability and responsibility ensuring strong financial, productivity and commercial plans are delivered.

- Failure to receive national funding for continued resident doctors industrial action impacting the Trust financial plan to deliver planned financial breakeven position.
  -Current known threat has been mitigated within the financial position.
  -As the existing threat has been removed, assurance level has changed to green.
  -A watchful brief will continue for the remainder of the year due to potential for further industrial action.

- Failure to achieve activity targets funding in line with indicative activity plans resulting in a risk of funding withdrawal, one new action has been added in relation to:
  -implementation of targeted speciality specific action plans for all areas not achieving activity targets.
- Reliance on non-cash measures leading to a diminished cash balance and reliance on cash support, impacting our ability to invest in services and buildings and equipment, 1 new control added relating to pay terms initiative.
- Inability to deliver reductions in cost through Trust improvement plans and transformation programmes resulting in cost pressure impacting on delivery of planned position, all actions have had revised target dates added, new revised actions dates of December 2026.
- Failure to achieve required productivity gains across the Trust, 3 actions have revised target dates added, new revised action dates of December 2026.
- Under delivery of commercial income and growth to support financial recovery, 1 action has had a revised target date added, new revised target date of December 2026 and 1 assurance has been added relating to secured inward excess of £10m investment for infrastructure development.

Trust Board

There is one strategic risk aligned to the Trust Board, this relates to:

- **1.4. Failure to strengthen partnerships across neighbourhood, the city, region and system.**

Updates since the last report to Trust Board include:

- Current scores remain unchanged.
- The risk appetite position remains in a tolerable risk position.
- Completion of action relating to Great North Healthcare Alliance Joint Executive Event.
- 2 controls have been added relating to the Great North Healthcare Alliance Joint Executive Event and live overlap register.
- Three actions have been removed relating to shared alliance narrative, mapping values and leadership development and talent flow.

3.0. RECOMMENDATIONS

The Trust Board are asked to:

- Receive the BAF.
- Provide comments or feedback.
- Approve the BAF.

Report of:
Natalie Yeowart
Associate Director of Compliance, Governance and Risk
17 November 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	10.11.2026	**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 self-assessments and action plans in place. • Maternity Health Inequalities Quality Priority agreed for 2026/27 within quality account supported by 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 and established Tobacco Dependency Service in place, supporting targeted prevention. • Adoption of the Core20PLUS5 National NHS England (NHSE) Framework. • Health inequalities Power BI dashboards and quarterly integrated board report supporting monitoring of access, waiting lists, missed appointments and demographic data quality. • Integrated Care Board (ICB) funded alcohol care team recovery navigators and Tier 3 weight management service providing targeted support. • Learning disability liaison support, proactive admission planning, hospital passports,	• 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. • Integrated Board Report (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.	• Further development and embedding of health inequalities data into operational use – March 2027. • Finalise and secure approval of the refreshed Health Inequalities Strategic Delivery Plan, with named corporate and Clinical Board owners, cross-cutting responsibilities, resource dependencies and interim measures – January 2027. • Agree a coordinated patient-correspondence and literature approach covering appointment and discharge letters, clear language, easy-read and multilingual formats, template approval and patient testing – scope and governance by December 2026; first implementation phase by March 2027. • Obtain Clinical Board assurance that reasonable adjustments are identified, documented and delivered, with interim digital arrangements and a plan for the national connection – March 2027. • Complete a repeated missed-appointment review and agree action on communication barriers, reasonable adjustments, Was Not Brought considerations, safe follow-up and children's transition to adult services –	**2. Actions defined-most progressing, where delays are occurring interventions are being taken.**	

		reasonable-adjustment assessments and audit arrangements support individualised care; consistency of delivery and digital visibility remain improvement priorities. • Accessible Information Standard policy, training and preparatory arrangements are developed; technical testing and reliable operational workflows remain prerequisites to implementation. • Discharge-correspondence improvement work includes patient and primary-care representation and draft best-practice guidance. • Established neighbourhood, homelessness and community outreach pathways support underserved communities, including Joseph Cowan Centre wound clinics and equity-focused falls prevention activity.		March 2027. • Obtain progress and impact evidence from poverty-proofing work and confirm the operational process, capacity and communications for advance travel-cost assistance before wider publicity – March 2027. • Confirm public health intelligence post recruitment – December 2026. • Train 6 facilitators in Medicine and Emergency Care to ensure the education and training offer is embedded for health promotion to staff and patients – December 2026. Confirm progress and how training will translate into Making Every Contact Count activity and measurable benefit. • Monitor and deliver Clinical Board health inequality action plans – Year 1 plans by 31 March 2027. • Prepare evidence for the 25 November 2026 Schedule 2N commissioner assurance review, distinguishing completed work, impact evidence and remaining gaps; report agreed follow-up through PEHG in December 2026.		
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 implementation gap analysis completed and signed off by Trust Board. • Triage implementation tool gap analysis completed and signed off by Trust Board. • Triage task and finish group established, reporting to Quality and Safety Group. • 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 Group. • Family Health Quality Oversight Group (QOG). • Family Health Quality Performance Review (QPR) meetings. • Maternity Services Quality Dashboard and	• MIS compliance with oversight via MIS tracker reported to Quality Committee and Trust Board. • North East and Yorkshire regional team assurance return of 10-point plan submission. • Saving Babies Lives compliance via tracker. • Maternal Care Bundle compliance via tracker agreement to monitor progress via Quality Committee on quarterly basis. • Maternal Care Bundle Task and Finish Group Action plan, Reporting and Minutes. • Triage Task and Finish 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 survey results. • Obstetric Board notes and action log. • Quality & Safety and Women's Quality and	• Review of metrics in Integrated Board Report to align to 10 Point Plan - December 2026. • Develop Perinatal Strategy, linked to Trust strategy and national deliverables -initial submission September, final baseline by December 2026. • 10 Point Plan progress update to regional maternity team – December 2026. • Enact homebirth organisational change consultation recommendations for revised on call model – January 2027.	**1. Fully on plan across all actions.**	

		North East 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. • 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 of10 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 operating procedures. • National maternity and health inequalities dashboard.	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 Quality & Safety (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 Integrated Board Report. • 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.			
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. • Complaints improvement data for IBR, phase one complete.	• Improvement action plan with SMART (specific, measurable, achievable, realistic 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, phase 1 complete, phase two metrics to be developed to fully align to Quality priorities – March 2027.	**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 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	• 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.) January 2027. • Review and evaluate year one roll out	**2.Actions defined- most progressing, where delays are occurring interventions**	

		• LeDeR (Learning from Lives and Deaths: People with a Learning Disability and Autistic People) 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.	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.	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 desensitisation and have investigations undertaken – May 2027.	**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	11.11.2026	**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, 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. • Get It Right First Time (GIRFT) review and implementation. • GIRFT Oversight Group. • Alliance Strategic Intent. • External Reviews and Accreditations e.g. JACIE (Joint Accreditation Committee of ISCT-Europe and EBMT), United Kingdom Accreditation Service (UKAS), Human Tissue Authority (HTA) avoiding waste and ensuring best practice in support services that are intrinsic to pathway delivery. • Organ Utilisation Strategy.	• Individual clinical boards, directorates and departments governance structures. • Harm reviews of clinical pathways where issues are identified (e.g. 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 – January 2027 (October 2026). • Development of Alliance Clinical Framework – January 2027 (December 2026.) • Support and develop optimisation of NENC pathways – January 2027 (December 2026). • Develop and Embed learning and sharing of best practice from GIRFT and Peer Review mechanisms to support service improvements – March 2027 (December 2026).	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	

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	16.11.2026	**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, 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. • Frailty Same Day Emergency Care soft launch complete. • NHSE led missed opportunities audit.	• 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. • 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. • NHSE led missed opportunities audit complete.	• Completion of provider recovery actions submitted to NHS England (NHSE) by September 2026 relating to: • Flow and streaming optimisation: Redesign of triage and streaming processes, and enhanced Urgent Treatment Centre (UTC) involvement in queue management (including paediatric capability) - January 2027. • Clinical pathway development: Targeted pathway redesign, including refresh of specialty-specific plans (e.g. Eye Emergency Department (ED)) and strengthened ED–Assessment Suite integration – In progress – March 2027. • 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 – March 2027. • Community and system flow initiatives: Implementation and planned scale-up of NEAS care home conveyance avoidance pilot (85% success), introduction and rollout of Head Injury and Long Lie	**2. Actions defined-most progressing, where delays are occurring interventions are being taken.**	

				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 SPA. – March 2027. • Completion of business case for dedicated paediatric Same Day Emergency Care (SDEC) – November 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 Meeting reports, papers and recordings. • National benchmarking demonstrates track record of strong performance in waiting list and performance against RTT. • Weekly NUTH 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 Patient Tracking List (PTL) meetings. • Performance Improvement Plans monitored via Finance and Performance Committee, including deep dives. • Cancer Deep Dive Presentation to Finance and Performance (F&P) Committee. • Clinical board plans in place to deliver national productivity standards for outpatients.	• 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. • Lung cancer team to implement pooling for thoracic surgery and deploy roll out of Patient Pass to reduce time from referral to treatment -January 2027. • Endoscopy recovery group to oversee re-allocation of non cancer capacity to cancer activity -December 2026. • Single Point of Access: Tyneside Integrated Musculoskeletal Service to be extended to accommodate neuro referrals – November 2026. • Full consultant review of trauma and orthopaedic referrals in Care Coordination System to ensure appropriate patients are listed-November 2026. • Explore the expansion of Campus for Ageing and Vitality (CAV) to increase ophthalmology service – November 2026.	**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 restructure. • 24 new Echocardiology machines.	• Reduced Did Not Attend (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,	• Building works to be completed with additional scanner commissioned to increase activity – February 2027. • Recruitment into budgeted establishment in Echocardiogram (ECHO) - November 2026.	**2. Actions defined- most progressing, where delays are occurring interventions are being taken**	

		• Reinstated use of locum support during the week to support service capacity.	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 is enabling back-to-back appointments, reducing malfunctions and providing more accurate diagnoses and increased activity delivery.			
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. • ICB approved grants for Get It Right First Time Waiting List Initiative proposals for Podiatry and Children and Young People (CYP) Occupational Therapy.	• 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.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken**	

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	26.10.2026	**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 Chief Executive Officer (CEO), chair and vice chair of 4 Foundation Trusts (FTs)). • Bilaterals 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. • Great North Healthcare Alliance joint Executive Event.	• 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 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.	• 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. • Great North Healthcare Alliance joint	• 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. • Provider Collaborative Leadership Board.	• Mapping leadership development work across the Alliance – March 2027.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	

		Executive Event.	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 Group Strategic Approach to Clinical Services Board (SACS). • Various executive peer groups – eg Alliance Medical Directors meeting. • Live overlap register.	• 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. • Maintained live 'overlap register'.	• Scope cards for each overlapping workstream between Alliance, Provider Collaborative and Neighbourhood Health Board – November 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 Quality and Performance Reviews. • Minutes of Council of Governors. • Clinical Network and Operational Delivery Network reports. • Trust Annual Report. • 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 Foundation Trusts (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 Senior Responsible Officers (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	Exec Director of Nursing, Midwifery and 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	10.11.2026	**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. • Trustwide Patient Safety Incident Response Framework (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. • Patient Safety Partners recruited.	• Rapid Response Action Review Weekly Meeting /Patient Safety Incident Forum minutes and actions plans. • Central supportive governance. infrastructure to deliver the Patient Safety Incident Response Framework (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	• 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. • Duty of Candour Reported to Quality Committee in September, no demonstrated improvement in compliance, comprehensive Duty of Candour improvement action plan to be developed and completed – June 2027. • Delivery of 26/27 Quality Priorities – March 2027. • Development of Trust-Wide Quality and Safety plan – now drafted, to be presented to Quality Committee for approval – November 2026. • Deliver the Duty of Candour improvement plan by March 2027. • Complete programme of Clinical Board audits every 6 months and ensure implementation of improvement actions arising from audit findings.	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	

			statistical proven improvement in incident reporting. • Integrated Board Report 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.			
Failure to increase incident reporting and reduce proportion of incidents resulting in serious harm and never events.	RC	• Patient Safety Incident Response Framework (PSIRF). • InPhase incident reporting system. • Power Bi dashboards. • Integrated Board Report. • Weekly Rapid Response Action Review Meetings 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 Rapid Action Review Meetings (RARM) 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&SLF. • 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 NatSIPs 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.	• 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.	• Omnicell roll-out commencing - November 2026. • Dashboards for Omitted doses and CAT tools to be launched – December 2026. • Phase 2 of pharmacy business case – recruit in 2 phases: April 2027 to improve medicines reconciliation. • Medical gas training implementation and oxygen prescribing improvements – March 2027. • Continue 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.**	

		• Completed review of Medicines Reconciliation function across the Trust to identify urgent areas for improvement to attain to national best practice. • Revised medicines management action plan. • Established Medicines Management Oversight Group to ensure delivery of improvements. • Increased nursing infrastructure to support medicines safety.	• Quality Governance Structure via quality committee and Trust 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 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 SLA approved. • IPC Nursing Partner Model.	• 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 demonstrates93% 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 – March 2027 (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 January 2027 (September 2026). • Review and amend ToR for Clinical Outcomes and Effectiveness Group by April 2027 (December 2026). • Deliver an annual clinical audit programme aligned to strategic risks	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	

				and quality priorities by March 2027. • Increase compliance with local clinical audit completion by July 2027. • 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.	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	**People & Culture**
Date Added	15.07.2026	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Level**	**HIGH**
Last Reviewed	11.11.2026	**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. • 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 and Inclusion (EDI) Strategy. • Workforce Equality Standards. • Staff Networks. • Trust's Anti-Racism Strategy • Anti racism training courses.	• Workforce Race Equality Standard (WRES)/ Workforce Disability Equality Standard (WDES) Reports. • Recruitment and Retention Data. • Staff Survey Results. • Training delivered - Unconscious Bias and the Brain, Recognising and Responding to Racism, Embedding a Proactive Approach.	• Develop multi-year NHS Staff Standards implementation plan linked to People Strategy – December 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. • Implement the new Resolution Hub model to ensure all sexual safety concerns are reviewed and triaged within 48 hours of reporting - December 2026.	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	

				• 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.	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	**People & Culture**
Date Added	15.07.2026	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Level**	**HIGH**
Last Reviewed	11.11.2026	**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.
		• Proposal developed for three tier leadership programme.
		• Programme support in place to deliver the leadership programme.
			• 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 and Facilities	**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	16.11.2026	**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. • 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 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 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 • Integrated Care System (ICS) Infrastructure Board. • Computer-Aided Facility Management (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 and 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 Building Safety Act (BSA) delays. • Engagement with local MPs who plan to raise impact of BSA delays with the Parliamentary	• 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 Isolation Unit (HLIU) scheme. • Monthly meeting now in place with BSR team to discuss live applications and our pipeline allowing for early sight and management of future applications		**COMPLETE – Process agreed with BSA for early pre-application process to speed up BSA approvals.**	

		Under-Secretary of State in the Ministry of 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 (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 Electrical and Medical 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 Group • Incident reporting system. • Estates Strategic Delivery Plan 2026-31. • fire remedial works set out in PFI Contract Project Agreement and Settlement Agreement. • Private Finance Initiative (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 Private Finance Initiative (PFI) estate to a suitable condition with safe compliance and to manage	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 to	**2.Actions defined- most progressing, where delays**	

project delivery to 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. • 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.	complete the 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 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 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 Freeman Hospital (FH). Feasibility is complete to 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).	RJ	• 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 in place to support in-house teams.	• Monitoring of Capital Programme Delivery monthly – March 2027.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	

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 sustainability 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	16.11.2026	**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 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. • Director 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. • Indicative Activity Plan (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. • Implement targeted specialty specific action plans for all areas not achieving activity targets – December 2026.	**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.	• Current known threat has been mitigated within financial position however continue to keep a watchful brief for remainder of year due to potential further industrial action – March 2027.	**Current known threat for 2026/27 has been mitigated within financial position.**	

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 • Early identification of potential pressure through Director of Nursing National involvement. • Contract uplifts for medical pay award	• Agenda for change pay award costs matched to expenditure for month 4. • Final confirmation of contract uplifts for medical pay award received.	• Await outcome of Band 5 Nurse Reform Review – March 2027. • Continue to flag potential impact and seek funding through Regional NHSE – March 2027.	**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 (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. • Contract uplift for medical pay award. • Paying terms initiative.	• 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. • Final confirmation of contract uplift for medical pay away received. • Improved cash position seen due to paying terms initiative.	• Monitor and report cash position bi-monthly at Cash Group and Finance and Performance Committee Monthly – March 2027.	**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. • Medicines Value, Access and CIP Group (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 planned position.	SH	• Transformation & Improvement Group (formerly Access and Delivery Group) • Finance and Performance Committee. • Strategic Improvement Groups. • Trust Management Group. • Cost Improvement Group. • 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. • Equality and 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. • Rationalised transformation portfolio to focus organisational resource exclusively on one or two high-priority strategic programmes.	• 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 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 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.	• 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 – December 2026 (September 2026). • Evaluate the efficacy of strategic improvement programmes to identify underlying delivery challenges and operational barriers – December 2026 (October 2026). • Execute a portfolio-wide baseline review against the Programme Management Office (PMO) framework to ensure compliance with project management standards, optimise assurance, and actively facilitate successful delivery – December 2026 (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 – December 2026 (September 2026).	**2.Actions defined- most progressing, where delays are occurring interventions 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.	• 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 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	• Consider and implement formal mechanisms to monitor and deliver productivity targets and associated escalation plan -December 2026 (September 2026). • Establish precision service-line reporting to support clinical leadership in driving operational productivity – December 2026. • 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. December 2026 (September 2026). • Review of GIRFT governance -December 2026.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	

		• 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. • PMO formally assess, track, and risk-assure all productivity schemes. • GIRFT Oversight Group.	(PLICS) to help clinical boards manage resources and improve efficiency. Service Review Programme to monitor, evaluate, and improve healthcare delivery across the Trust.	• Implement process for Clinical boards (OSMs and CDs) to review and sign off specialty productivity dashboards data to ensure data accuracy and reliable – December 2026 (September 2026.)		
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 Property (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. • Secured inward excess of £10m investment for infrastructure development.	• Establish full costings for all commercial activity – Delayed, March 2027 (*September 26*). • Complete Pilot in CDS and present to Quality Performance Reviews in January 2027 (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	09.11.2026	**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	• Digital and Data Committee Tier 2 Groups providing oversight and input to prioritisation, sequencing and governance of digital initiatives. • Digital Leadership Team (SMT) meeting regularly to lead delivery, capacity and emerging risks and issues. • Digital and Data Committee (DDC).	• Digital and Data Committee Tier 2 Groups ToR, and triple A reports. • 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.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	
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. • Digital and Data Committee Tier 2 Groups providing oversight and input to prioritisation, sequencing and governance of digital initiatives. • Digital Leadership Team (SMT) meeting regularly to lead delivery, capacity and emerging risks and issues. • Digital and Data Committee (DDC).	• Digital Delivery plans roadmap. • Demand backlog. • Digital and Data Committee Tier 2 Groups ToR, and triple A reports. • 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 – initial draft 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”) –April 2027 (December 2026). • Ensure capability is aligned to demand and look to future proof including use of wider partner eco-system – December 2026.	**2.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 –April 2027 (December 2026). • Identify gaps in capability and defenses – April 2027 (December 2026). • Unlawful access to patient record baseline assessment and options appraisal for	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	

		• Digital and Data Committee.	• SIRO Assurance Report to Digital and Data Committee. • Information Commissioners Office (ICO) Data Protection Audit – reasonable level of assurance. • Audit One Internal Audit Data Sharing – reasonable level of assurance.	Executive Team consideration - December 2026 (September 2026).		
Lack of digital skills across the Trust to utilise enabling technology.	JT	• 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- March 2027 (December 2026).	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	

Risk ID	3.5
Comments:	

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Agenda item A5(b)(i)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 November 2026					
Title	Newcastle Hospitals Charity Impact Report 2025/26					
Report of	Teri Bayliss, Charity Director					
Prepared by	Michelle Davies, Communications and Engagement Manager					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☐		☒	
Summary	**Assure:** The purpose of this report is to share the Newcastle Hospitals Charity Impact Report for 2025-26. The Impact Report has been prepared to demonstrate the impact of projects, programmes and activities supported thanks to the generosity of the donors, fundraisers and supporters of the Charity. The Impact Report has been reviewed by Charity Committee prior to Trust Board.					
Recommendation	The Trust Board are asked to receive this report.					
Link to Strategic Priorities	Joining up care		Advancing care		Supporting great care	
	☐		☒		☒	
Impact	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☐	☐	☒	☐	☐	☐
Link to Board Assurance Framework [BAF]	Not applicable.					
Reports previously considered by	Annual report to Charity Committee.					

Newcastle Hospitals Charity



Impact report 2025/26

The home of

THE great north CHILDREN'S HOSPITAL

The Sir Bobby Robson Foundation

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Welcome

Welcome to our impact report for 2025-26. We are continually humbled by the generosity of all our supporters, donors and fundraisers. Your kindness means that this year we have been able to continue to support.

We're proud to be the official charity for Newcastle Hospitals and thanks to your support we have raised over £10.5 million to fund initiatives that allow us to go further for our hospitals.

Over the last year the efforts of our supporters have enabled us to commit funding totalling almost £4.8 million to support programmes, projects and activities across Newcastle Hospitals. This includes funding for over 600 diverse projects, our wide-ranging arts programme and our charity volunteer service - all with the aim of making a positive impact for patients, staff and the health of the community.

This year also saw the launch of our campaign to build a world-leading cancer trials and treatment centre at the Freeman Hospital. The £30 million Sir Bobby Robson Institute will be fully funded by The Sir Bobby Robson Foundation and will improve access to life-changing cancer research for patients in our region and beyond.



Throughout this report you will see the difference we can make together, whether this is through the unique impact of our arts and volunteer programmes, or through funding innovative projects. You can also find out more about how you can be part of our journey and help us achieve even more in the future.

On behalf of everyone at Newcastle Hospitals Charity – thank you for everything you continue to do – your support is making a real difference everyday.

Teri Bayliss,
Charity Director, Newcastle Hospitals Charity

Your support matters

Thanks to your incredible generosity we raised

£10.5 million

to fund initiatives that allow us to go further for our hospitals.

Over the last year we have been proud to commit funding totalling almost

£4.8m **to over** **600 diverse projects**

across Newcastle Hospitals, all with the aim of creating a positive impact.

None of this would be possible without the generosity of our supporters, partners and fundraisers – here are just some of the ways their support has made a difference to the patients, staff and wider communities of Newcastle Hospitals.

Sir Bobby Robson Foundation

Turning vision into reality

The Sir Bobby Robson Foundation is part of Newcastle Hospitals Charity.

Sir Bobby Robson launched his foundation in 2008 after his oncologist, Professor Ruth Plummer, asked if he knew anyone who might help her raise £500,000 to equip a cancer trials research centre at the Freeman Hospital.

Sir Bobby responded by launching his foundation, which is part of Newcastle Hospitals Charity, to get the money she needed. He described it as "like being at the helm of a team again" - his last and greatest team.

Now almost 20 years later the foundation has raised over £30 million and is embarking on its biggest challenge yet.



Working in partnership with Newcastle Hospitals and Newcastle University we are building the Sir Bobby Robson Institute – a world-leading cancer trials and research centre on the site of the Freeman Hospital.

The £30 million purpose-built centre will be fully funded by the foundation and will open to patients in 2028.

The institute will:

- Increase clinical trials capacity by 50%, giving more patients access to pioneering treatments.
- Accelerate the development of life changing and life saving drugs and therapies.
- Bring together clinicians, researchers and patients in one purpose built, state of the art centre.
- Create breakthroughs that will be felt across the North East, North Cumbria, North Yorkshire and around the world.



Total Raised
£29 MILLION

Total Needed
£30 MILLION

Thanks to the generosity of donors, supporters and fundraisers more than £29 million has been raised to support the project, including an incredible £2million donation from the Barbour Foundation.

This year we will begin the final push and turn vision into reality and create a beacon of hope for patients in our region and beyond.

Finding more effective ways to detect and treat cancer

Alongside our plans to build the Sir Bobby Robson Institute the foundation has continued to fund innovative projects to support patients with cancer in the North East.

Genetic test brings early detection and improved treatment for hereditary cancer.

A pioneering genetic test, enabled by funding from The Sir Bobby Robson Foundation and developed by doctors and scientists in Newcastle, is improving early diagnosis and treatment for people with hereditary cancer caused by a genetic condition.

The test identifies specific signs in a person's DNA that are characteristic of cancers linked with Lynch syndrome – and demonstrates the vital importance of clinical trials.

Hailed as a 'breakthrough' by scientists, the test can now be used on a urine sample from people with Lynch syndrome to identify difficult to detect cancers in the urinary tract – which includes kidney, bladder and ureter – before any symptoms are apparent.

Cancer of the urinary tract is one of the most common in people affected by the genetic condition, and without early detection treatment is less likely to be successful.

The test has been designed by a team from Newcastle Hospitals and Newcastle University, led by professor of clinical genetics, Sir John Burn.

“”

Sir John Burn said :

"This is a really exciting breakthrough and the pilot study results are unprecedented.

In our study, the test detected early-stage cancer in five people, four of those hadn't yet showed any symptoms.

This early diagnosis has meant less invasive treatment for these patients, and the test has also guided the medical team as to whether they have successfully removed all of the cancer and also how to carefully target treatment.

We're now looking to carry out larger studies to validate these results, with a view to establishing a life-saving Lynch syndrome urinary tract cancer surveillance programme.

We're extremely grateful to The Sir Bobby Robson Foundation, part of Newcastle Hospitals Charity, which has provided £74,000 of funding towards a larger trial."

Developing the next generation

We were pleased to once again provide funding for a resident doctor and a training research nurse post – both based within the Sir Bobby Robson Cancer Trials Research Centre.

Patients come from across the North East, north Cumbria and North Yorkshire for treatment at the centre, which offers hope for people with advanced cancer. In the last five years referrals have increased by over 40%.

The research and clinical trials undertaken there are part of long-term national and international efforts into the disease. Sir Bobby hoped they would become his legacy for others facing cancer.

Patients who attend the Sir Bobby Robson Centre often have complications arising from their cancer and its treatments. These posts add value and support exceptional patient care and, through training, develop competencies.

They receive a unique opportunity to develop their career in oncology, with the chance to gain experience in practice, research, support lab work and help deliver clinical trials.

Both posts not only support the patients who come to the centre but also allow the team to train and develop the next generation of clinical researchers in a highly specialised area.

Part of the team delivering vital clinical trials of new cancer drugs, the roles underline Sir Bobby's commitment and enthusiasm for investing in the 'next generation' of cancer specialists.



The Great North Children's Hospital fund; supporting children and families

We were proud to launch our Every Step campaign in September 2025. The campaign highlights the crucial support that The Great North Children's Hospital provides to children and their families throughout the hospital journey – from diagnosis, treatment and recovery to the ongoing care and emotional support after discharge.

We used footprints from patients, families and staff to demonstrate how The Great North Children's Hospital is there every step of the way – helping patients and families feel supported no matter where they are in their journey.

Each year – thanks to your generosity - we support projects that support young patients and their families who come to the hospital for treatment and care.

Here are just a few of the projects we have funded this year to support patients and families.



The little touches that make a big difference

Having a child in hospital is never easy. Families can often be away from home for long periods of time and there is little opportunity to take a break from the ward environment.

A survey conducted in 2022 found the average additional cost that parents had to pay while their child was in hospital, was £405 per week.

This cost included travel, additional childcare, loss of income, food, and drink. As part of a mapping exercise conducted by the NHS England food provision group, it highlighted only 15% of hospitals in the country feed the parent that stays.

Following a successful pilot supported by national funding we were able to support a grant to provide daily snack bags to resident parents at The Great North Children's Hospital.

Feedback from parents has been overwhelmingly positive, the food provision is helping to make a hospital stay just that little bit easier, making sure they can eat at a time of their choosing and in a location of choice.

Alongside the daily snack bags we also provide a weekly fruit box in each parent room in The Great North Children's Hospital – giving additional support to meet the nutritional needs of parents and offering an easy to access, healthy snack.

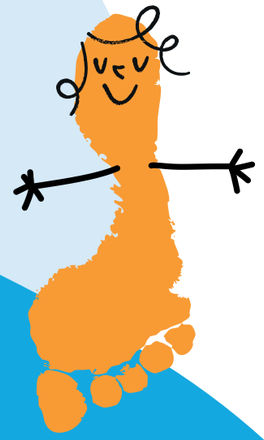
"Parent and staff feedback continues to highlight that this provision is extremely helpful, enabling parents to have some nutritional support for their health and wellbeing at a time when their priority is the needs of their child."

Paula Coulson
Senior nurse

THE great north CHILDREN'S HOSPITAL
with you at EVERY STEP

Sensational sensory room





Ward 1b is a children's neurology ward at the Great North Children's Hospital – the team care for children and young people with head injuries who need medical and surgical care.

We provided £14,194.25 to the ward to fund updating the sensory room equipment. The updates included floor mats that can be lifted and moved to accommodate patients in wheelchairs, new interactive panels, lighting and speakers. The new equipment means that more patients can access the room supporting rehab sessions and providing a calm and engaging space for families to use together during their hospital stay.

"We love going into the sensory room - it's so calm away from the bright lights of the ward."

Parent of young patient





"The sensory room is now a calm and versatile space where we can take children for individual sessions or groups to work on their goals."

Occupational therapist

Working in partnership

Each year we work in partnership with organisations across the North East to fund projects that support the health and wellbeing of children and young people both within the hospital environment and in the community.

Hoops4Health

Support beyond the hospital walls

Supporting the health and wellbeing of children and young people went beyond the hospital walls this year through our partnership with Newcastle Eagles and their Hoops4Health programme.

Hoops4Health is a major initiative run by Newcastle Eagles and the Eagles Community Foundation that uses basketball as an activity to share a range of positive health messages to young people in primary schools, including the importance of keeping physically active and leading a healthy lifestyle.

With the support of funding from Newcastle Hospitals Charity 20 Newcastle Schools – almost 900 children have benefitted from the programme.



Newcastle United Foundation

Our longstanding partnership with Newcastle United Foundation provides funding to support dedicated staff who work across the Great North Children's Hospital, providing respite and activity sessions for children living with chronic illnesses.

Delivering a wide range of sport and physical activity sessions across wards including football, golf, archery and curling the team also run a variety of sessions to support mental wellbeing such as unique LEGO builds, arts and crafts and STEM-based activities.

The impact of the sessions goes beyond the physical activities, they not only support patients but also provide valuable respite for parents and carers – meaning they can take a little time away from the ward. Often siblings often join in with activities bringing a sense of normality and creating shared experiences.

Our partnership with Newcastle United Foundation has also helped to provide children with a range of unforgettable experiences including NUFC match tickets, NUFC matchday experiences, as well as tickets for Sunderland, Middlesbrough, NUFC Women, Newcastle Eagles and stadium tours.



"We are totally humbled by Newcastle foundation and the difference it has made to our 8-year-old whilst receiving weekly chemotherapy in hospital. It has really supported transforming a challenging experience into positive memories and made a huge difference. We are very grateful."

Parent of young patient
Great North Children's Hospital.

Durham Cricket Foundation

Keeping children and young people active and engaged while they are in hospital can often be a challenge. Working in partnership with Durham Cricket Foundation we are supporting more young patients facing long-term hospital stays.

Joint funding has been awarded to support two members of staff to deliver three sessions each week to patients at the Great North Children's Hospital and on ward 23 at the Freeman Hospital. Alongside cricket, the staff provide activities such as archery, golf and seated activities. They also spend time playing board games and arts and crafts.

Coaching staff work closely with patients, adapting sessions to suit their physical ability, energy levels, and personal interests. Activities are designed not only to support physical wellbeing but also to contribute to emotional resilience and mental engagement.

Feedback from parents recognises the impact the sessions have on children and young people, they create a solid routine that grounds families during a time of high stress and upheaval. Through the partnership the men's and women's team also come and make a very special visit over the festive period to spread a little festive joy.

"This partnership brings real value to our patients, supporting their recovery and wellbeing throughout their hospital stay."

Andy McDonnel
Business manager, The Great North Children's Hospital





Supportive paws

This year we also continued our partnership with Wagg & Company helping to bring more therapy dogs to spend time with patients, families and colleagues across Newcastle Hospitals.

The amazing team of volunteers and their furry friends visit patients at the Freeman Hospital, RVI and Great North Children's Hospital. The time they spend with patients is invaluable, we know that spending time with animals – dogs in particular – can help release endorphins, reducing anxiety and lowering stress.

Visits not only lift spirits and brighten days but they can also help break up long stretches of time in hospital – bringing comfort and companionship to those who are away from their loved ones.

Supporting research



Nursing, midwifery & allied health professions

The Nursing, Midwifery and Allied Health Professions (NMAHPs) Researcher Development Institute was launched in 2022 – dedicated to the progression of research talent amongst NMAHPs and offering a new, innovative avenue to drive forward to professional research.

We supported this development with a multi-million-pound award that has greatly increased opportunities to allow nurses, midwives and AHPs (such as physiotherapists, paramedics, radiographers, dieticians, and speech therapists) to access much needed funding and support, enabling them to develop and lead research for the benefit of patients, staff, the community and beyond.

To date 46 individuals have been awarded fellowships and research internships, supporting experienced and early career professionals across a huge range of topics, supported by collaboration with Northumbria University.

The work of the Researcher Development Institute (RDI) continues to influence policy and practice regionally and nationally. This includes contributions to a range of national NHS England research focused work streams (Chief Nursing Officer (CNO) research plan, CNO professional strategy, workforce planning), leadership of or contribution to regional National Institute for Research Infrastructure awards, and membership of the range of NIHR panels from Health and Social Care Delivery Research Programme to personal awards from pre- to post-doctoral awards.

Ian Joy
Executive director of nursing, midwifery and allied health professionals said:

"We remain grateful to the Charity for their investment in this important agenda. Much has been achieved in the last four years. Whilst there remains much work to do, the future continues to look very bright, and the impact and influence of the RDI continues to grow due to the atmosphere both within the trust and feedback/interest externally."

Supporting and celebrating excellence

We know that the teams who work across Newcastle Hospitals to provide the very best care to patients and their families. Audit and assurance frameworks show that teams consistently deliver safe and high-quality care but how this is recognised, celebrated and accredited needed to be improved.

We provided funding to support a project to deliver high-quality care, enhance patient and staff experience, and celebrate excellence across over 200 clinical areas.

The Accrediting Excellence Programme (ACE) is designed to support staff to take pride in their work and to recognise and celebrate the care delivered every day. Alongside this it also supports the sharing of excellence and key themes.

The ACE framework provides a comprehensive view of the quality of care delivered across all wards and departments focussing on:

- **Harm free care**
- **Well led**
- **Patient experience**
- **Engagement and improvement**
- **Research**

“This process supports a real focus on clinical standards and expectations and gives a good insight into what is required for improvements.”

Ward sister



New & Innovative technology

A life changing first



We're always proud to support innovative, lifesaving and life-changing technology and were pleased to provide a grant to support the transformative Newcastle Organ Assessment Hub (NOAH) at the Freeman Hospital.

This year Mark Wrenn became the first patient to receive a life-saving lung transplant through the NOAH.

Mark had previously been fit and healthy, working in a physically demanding role as a telephone engineer, climbing and repairing telephone masts. In 2018, he began experiencing increasing breathlessness, initially thought to be asthma. Over the following years, his condition worsened significantly, leaving him dependent on permanent oxygen.

At the age of 40, Mark was diagnosed with a rare lung condition, known as obliterative bronchiolitis, alongside an unclassified systemic autoimmune disease. With his lung function reduced to just 22 per cent, he was told that a lung transplant was the only option to save his life. The new NOAH facility at the Freeman Hospital uses perfusion technology to preserve and assess donated organs, helping make more organs suitable for transplantation.

Mark was offered the opportunity to receive a transplant using this innovative organ preservation technology, becoming the first patient to benefit from Newcastle's newly launched ex-vivo lung perfusion (EVLP) programme.

Perfusion technology keeps donor organs supplied with oxygenated blood or nutrient-rich fluids, extending preservation time and allowing a more thorough assessment before transplant. Newcastle Hospitals has been at the forefront of organ perfusion innovation, having performed the UK's first EVLP transplant in 2009. NOAH is the only site in the country offering lung, liver and kidney perfusion under one roof.

"Without NOAH, I would still be waiting for a transplant – it's genuinely saved my life.

When I was told about this new technology and the opportunity it gave me, it felt like hope. I've gone from being on permanent oxygen and struggling to do everyday things, to starting to get my life back again.

Being able to spend time with my wife and children and think about the future once more means everything. I'll always be grateful to the donor family and to the teams here in Newcastle who made this possible."

Mark Wrenn

UK first thanks to purchase of MAZOR robot to improve single position spinal surgery

In 2024 we provided funding to purchase a MAZOR robot to support spinal surgery and improve patient outcomes.

The impact of this funding goes far beyond the purchase of equipment – it has the potential to support innovation and surgical advancements for months and years to come.

The MAZOR spinal robot has done just that by allowing surgeons to operate on a patient's spine while they lie on their side.

This allows access to the front of the spine through an abdominal incision and via the back to place screws in the spine.

Prior to having the robot, staff would have to change the position of the patient from their side to their front adding over an hour to the case, limiting surgical options.

The team collaborated with the robot manufacturer Medtronic, leading to them becoming a centre of reference to teach the technique to others reinforcing Newcastle's reputation as being at the forefront of robotic technologies.



Credit: Barry Pells

"We are the first hospital outside of the USA to complete a single position lateral surgery, anterior and posterior using the Mazor spinal robot; the third globally.

Since receiving the grant from the charity, we have successfully improved patient outcomes using this technology for the last two years. As it allows a reduction in theatre time, giving us more time for complex cases, we are pushing for all surgeries to be done this way."

Andrew Bowey, consultant orthopaedic surgeon, trauma and orthopaedics

Generous legacy helps Ophthalmology team see a bright future ahead

Thanks to a substantial legacy donation to Newcastle Hospitals Charity, specifically for ophthalmology, consultant ophthalmologist James Talks and his team have secured a significant bundle of technology that will boost ophthalmology research and improve aspects of the service offered to patients.

A new Canon OCT S1 camera will improve research capabilities for commercial and National Institute for Health and Care Research-funded clinical research trials. The new camera will produce a true colour, wide field image showing retinal circulation in high detail without the need to give patients an intravenous dye injection – a major improvement for the patient experience, reducing risk and improving clinic efficiency.

An EyeSi surgical simulator was purchased in 2011 and is no longer supported and needs to be replaced. The new model includes online access to teaching materials improving the benefits and experience for trainees. The EyeSi will improve the quality and availability of training for our medical trainees and will hopefully help in improving the feedback.

The new technology will improve the service for all patients seen annually within the busy ophthalmology service which sees around 120,000 patients each year, allowing the team to stay at the forefront of developments in this field.

> “This incredibly generous gift allows the hospital to provide state-of-the-art treatment, to the benefit of the people of the North East. Patients are diagnosed quickly and accurately, without the need for invasive treatment such as touching the eye. Gifts in Wills make a huge difference to our work.”
>
> **James Talks,** consultant ophthalmologist



Pump-priming research into knee replacement robotic technology

Over 100,000 primary knee replacements are performed each year in England and Wales for osteoarthrosis. The patella (kneecap) is the fulcrum for load when the knee is extended so correct movement is essential for movement such as stair climbing and descent or getting up from a seated position.

Whilst replacement of the tibial and femoral diseased surfaces at the knee joint is vital to a knee replacement, debate remains as to whether replacement of the back of the patella is beneficial to the patient. Unfortunately, dissatisfaction with knee replacement remains unacceptably high at 20% of cases and in many of these cases patients report symptoms relating to articulation between the back of the patella and front of the femur.

For consultant orthopaedic surgeon Professor David Deehan and his team, determining which patella to resurface or replace and how to place the patella in the optimal position at the time of joint replacement remains something of an inexact science.

In partnership with the Imperial College Biomechanics department, we joint-funded the team to carry out a year-long investigation to determine how and when to resurface the patella at the time of surgery using instrumented manual and then robotic principles.

A CAD CAM model of a robotic sensor was developed to map the movement of the kneecap in 3D.

Inspirational images

Ringing the bell to mark the end of cancer treatment is a significant moment for patients. This year we provided funding for an Instax camera and films so staff can capture the moment for patients and their families. With consent from patients they also display the images on a notice board so that other patients receiving treatment get to see how many get to ring the bell – it's a real morale booster and very emotive for staff and patients alike.



And the everyday differences

Sometimes, it is the small things that make a big difference. Over the last year we have supported staff from all areas of Newcastle Hospitals to implement ideas and projects that have a meaningful impact on patients and staff.



Supporting families during the darkest times

The trust's palliative care team take a holistic approach to caring for their families. We supported the team with a grant to help give families the opportunity to make memories with their children in the most difficult times of their lives. The team are able to provide equipment for hand casting, hand and footprints, jewellery charms and books to support bereavement.

We committed more than

£675k

in easy to access, smaller project funding, for projects seeking

£5,000 or less.

Any member of staff is encouraged to apply and the variety of the over

340 projects funded

shows the commitment and creativity of those who came forward for charity support.



Improving staff wellbeing

Supporting staff wellbeing is one of our key priorities and we were pleased to fund the development of a staff wellbeing room on ward 21 at the Freeman Hospital. Feedback from staff shows that the room has had a meaningful impact on their wellbeing, describing it as "a quiet place to reset and recharge for 10 or 15 minutes."

Supporting the World Transplant Games

We were proud to be able to support clinical scientist Wayne Hartley to represent Great Britain at the 2025 World Transplant Games. Competing with transplant recipients from around the world, Wayne not only helped Team GB top the medal table but demonstrate power of organ donation.



Arts programme

Over the past 12 months our arts teams have reached over

230,000

patients, visitors, staff and members of the wider community with over

330 creative engagement sessions

The team have also worked with 24 professional creative freelancers including dancers, musicians, visual artists and writers.



Credit: Colin Davison

Our arts programme is centred in growing evidence that arts and health (or creative health) programmes have the potential to hasten recovery times, address health inequalities and challenges facing healthcare, including ageing, long-term conditions, loneliness, isolation and mental health.

We are an active member of the National Art in Hospitals Network and have supported the development of new national guidelines for art in hospitals. This initiative seeks to advocate for the delivery of creative programmes, particularly within NHS healthcare settings.

The importance of music

This year we celebrated our first anniversary of hospital sessions - an ongoing programme of live music performances across the RVI and Freeman Hospital. Five professional musical acts each perform regularly in bays, cubicles and day rooms, playing a range of music responding to the environment and the mood of the audience.



Credit: Amelia Reed Photography

Meet our musicians

- Ceitidh Mac
- Jon Doran
- Rapasa Nyatrapasa Otieno
- Simon Wood
- Liz Corney
- Nicky Rushton



Listening to music has been proven to have positive effects on our health and wellbeing and research shows that it can elevate mood, improve memory and cognitive function, reduce stress, anxiety and blood pressure, have anti-inflammatory effects and enhances immune systems.

We have been piloting a singing for lung health programme that brings people together who have respiratory or lung conditions like COPD, lung cancer, asthma, to sing in groups in community settings, led by trained musician Liz Corney. Singing has been proven to reduce shortness of breath, strengthen muscles and help people to better manage their symptoms. As a group activity it is also evidenced to decrease social isolation and loneliness and improve quality of life. Following positive feedback and engagement, we are launching Newcastle Singing for Lung Health, a dedicated 12-week programme in 2026.

Another strand of the music programme is the development and support of Newcastle Hospital Singers. Open to staff, volunteers and patients they are a friendly group, who sing together for fun, including popular songs, folk, musicals, Geordie classics and feel-good tunes often performing both in, and out of, the hospitals. Singing together has many proven health and wellbeing benefits from lowering cortisol and relieving stress, strengthening our immune systems, as well as improving breathing and lung capacity.

Lighting up the community

We once again partnered with Northern Lights Newcastle - a light trail through Leazes Park.

Over 80,000 attendees experienced ‘Lantern Lane’ which featured the drawings of children and young people who were patients at Newcastle Hospitals in the run up to Christmas 2025.

The lanterns - each customised by children - were suspended above the pathway, forming a vibrant, glowing garden that celebrated creativity, imagination and community.



Sharing is caring



Shared reading is a partnership volunteer programme with writing development agency New Writing North, where specially trained shared reading volunteers read to - and talk with patients - discussing the stories they encounter together.

This can help negate social isolation, providing mental stimulation and alleviating boredom during hospital stays.

We currently deliver this in the haemodialysis unit at the Freeman Hospital, but this will expand to other areas in 2026. Books and reading allow us to connect to the world around us and shared reading is a way to encourage this connection for patients while they are in hospital and support their wellbeing beyond the hospital walls.

Supporting our colleagues

We launched a new staff art club and held taster sessions for Newcastle Hospitals colleagues to try different creative techniques, led by artist Louise Underwood.

Staff could also bring along their own creative projects to work on. The sessions are a great chance to learn new skills, connect with other colleagues and carve out some time each month to be creative, helping reduce stress and support wellbeing. We are looking forward to developing the club to provide a variety of creative opportunities in 2026. Our arts team also deliver creative activities in the trust destress and recharge sessions to further support staff wellbeing across trust sites.

“It’s really relaxed me. All day my heart has been going so fast, but this has calmed me for the rest of my shift.”

Staff member

Time to draw

This year we have also introduced free mindful creative activity booklets for staff and patients, produced biannually.

The first edition of Time to Draw has been created through staff engagement and was produced by artist duo Foundation Press. Creative practice, such as drawing can reduce biological stress markers and support flow state process, which can contribute to sustaining healthier lives.



“These are fantastic for our patients who require some distraction resources.”

Staff member

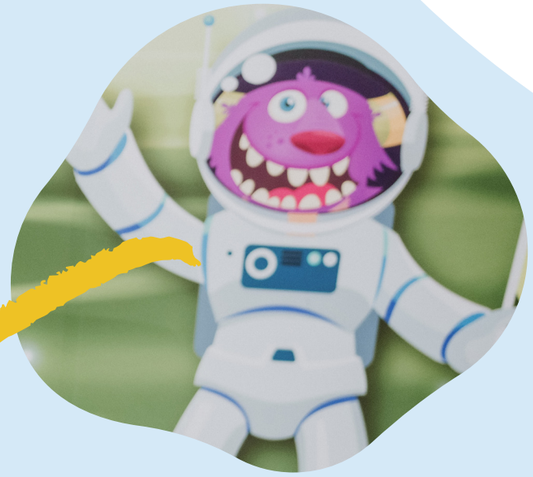
Bringing stories to life



Our continued partnership with Seven Stories, the National Centre for Children's Books, based in Newcastle has brought storytelling into the Great North Children's Hospital and Freeman Hospital, delivering both group sessions and 1:1 sessions at the bedside.

This brings stories to life, which helps patients to feel involved, builds confidence and introduces new creative and cultural experiences. that celebrated creativity, imagination and community.

seven stories
The National Centre for Children's Books





Movement as medicine

This year we were also excited to pilot a new project in partnership with Dance City.

Dance moves is a regular programme of participatory movement and dance activities, facilitated by professional dance artists Lynn Campbell and Sophie Douglas. Initially sessions engage patients in both stroke and orthopaedic rehabilitation wards using dance, movement and somatic techniques to promote greater awareness of - and connection to - our bodies.

The sessions aim to support patient wellbeing, aid recovery and create social moments to enjoy in the wards.

DANCECITY
DANCE FOR THE NORTH EAST



Enhancing our hospital spaces

Our arts programme also includes visual arts exhibitions, site-specific artworks across trust sites and connections with cultural and community settings.



Credit: Colin Davison

NHS Darkroom

Each year we partner with Sunderland University to deliver NHS Darkroom led by Johannah Churchill, a former Newcastle Hospitals nursing trainee, and now professional artist.

This photography programme offers NHS workers space to process lived experience through photography and the darkroom acts as a site of care and reflection to support healthcare staff. This year the resulting portraits and images were also displayed in a public exhibition at Northern Gallery of Contemporary Art. This meant NHS Darkroom met new audiences and made further visible the variety of professions working together, across Newcastle Hospitals.

Art in Motion

As the Newcastle Diabetes Centre moved into a more permanent home at the Freeman Hospital, we worked with staff and patient feedback to develop a suite of site-specific artworks specially commissioned for the new centre.

Working with artist Dan Savage, of Artstop Studios the artworks created take patients and staff on a journey over and along the bridges of the River Tyne. The symbolic use of bridges to reference the centre's move into the Freeman Hospital; a bridge, as a method to support us, to make supported crossings, moving from one place to another.

Embers of Care

A new national project by artist John Yayen, Embers of Care, involved the artist working with two staff members who have migrated from outside of the UK, to create a painting reflecting on their unique journeys and experiences.

Through this project and his art, Yayen seeks to bring visibility and recognition to the often-unseen hands and stories of migrant healthcare workers within the UK healthcare system. The completed final paintings are on public display in the RVI's New Victoria Wing, alongside portraits from several other NHS trusts.

Journeys

Journeys is a project and exhibition that explores the experiences of individuals impacted by organ donation and transplantation, visualised through maps and objects.

The project, developed by the NIHR Blood and Transplant Research Unit in Organ Donation and Transplantation at Cambridge and Newcastle universities and in collaboration with community publishers Foundation Press, invited participants to create maps to illustrate their unique journeys. In addition to the maps, participants selected objects that played significant roles in their experiences. The display is now installed in the Freeman Hospital – we also held a creative to support the launch.

Human elements

We also partnered with XP Gateshead School on their Year 8 cross-disciplinary project, 'What does it mean to be human?'

The project seeks to promote understanding of organ donation and transplantation with young people and their families. The arts installation is now installed on the RVI site.

Over the next year we'll continue to support the estates team to integrate site-specific artwork into refurbishment and capital projects, to enhance the patient experience within Newcastle Hospitals.

Considerate design of the hospital environment has been proven to improve patient recovery times, reduce violence and support staff wellbeing.

We can't wait to share some exciting new commissions already in development.

Volunteer programme

In the last year, our volunteers contributed over

44,000 hours

in a variety of roles

Our amazing team of charity volunteers continue to go above and beyond to help support patients, families, visitors and staff across Newcastle Hospitals.

They work in a variety of roles across the trust including meet and greet, mealtime support, charity events, retail and ward-based roles.

Their support is invaluable and makes a real difference to patient experience.

67 new volunteers recruited

33 active volunteer roles

More than **220** volunteers

Aged between **16-89** years old



Volunteering feedback

We know our volunteers are amazing but don't just take our word for it – we receive so much feedback from patients about how supportive our volunteers are during what can often be really challenging situations.

"I was in A&E due to severe pain. In the back part of the A&E there was an older gentleman who was bringing refreshments around for people. The contacts that we had with him throughout the hours I was there were so kind, reassuring and supportive. His small acts of kindness during a very painful time were exactly what my partner and I needed.

His reassuring words, coffee and biscuits for my partner and little drinks of juice for me helped us tremendously.

And of course, there will have been other volunteers there too all giving acts of kindness to others going through very difficult times."

A&E Patient

Inspiring the next generation of healthcare support



Our youth volunteer programme provided 30 local sixth form students with valuable ward-based experience, offering a meaningful introduction to healthcare volunteering and the realities of hospital life.

By supporting staff and patients during mealtimes, the volunteers played an active role in enhancing patient comfort and dignity, while gaining first hand insight into compassionate, non-clinical care.

The programme helped volunteers build confidence, communication skills and empathy, while developing their understanding of how teams work together on a ward to care for patients. In addition to enhancing the patient experience and supporting staff at busy times, the programme inspired young people to consider future careers in health and care, contributing to our long-term vision of supporting workforce development and creating healthier communities.



Supporting safe movement and independence through volunteering

In collaboration with Helpforce, this year we introduced a new activity and mobility volunteer role designed to promote meaningful movement, activity and engagement for older patients.

Developed alongside colleagues from Newcastle Hospitals including the harm free care team, senior physiotherapists, matrons and consultant physicians specialising in frailty and falls prevention, the programme addresses the high risk and impact of falls among older adults.

Our volunteers work across care of the elderly wards, supporting patients to carry out prescribed exercises designed by physiotherapists, encouraging safe movement, building confidence and helping patients remain active both during their hospital stay and as they prepare to return home. This collaborative approach supports falls prevention, patient wellbeing and independence, while easing pressure on clinical teams.

Festive programme



The festive period is such a special time of year, but not everyone gets to spend it at home celebrating with their loved ones. Whilst we can't change that, we can help to spread a little festive cheer and joy.

As always, our festive programme did just that. Thanks to the generosity of our supporters, we were able to support a full programme of events, provide those patients who couldn't be home with their loved ones with small gifts and brighten up wards and departments across Newcastle Hospitals with festive decorations.

We had an extensive live performance programme over the festive period, with pop-up live performances including Complete Ballet, a group of dancers who are over the age of 55; the Northern Counties Signing Choir, in collaboration with Percy Hedley school; and Back Chat Brass band. It is always a pleasure to welcome them all back to the hospitals and witness the joy they bring.

We were joined by visitors from the Theatre Royal's production of Aladdin, players from Newcastle United's men's and women's teams and Durham Cricket and the Tyne and Wear Fire and Rescue Service once again brought a very special visitor to greet the young patients at The Great North Children's Hospital.





This year we were once again inundated with generous gift in kind donations worth more than £150,000 from individuals and organisations. The gifts were distributed to young patients across Newcastle Hospitals, meaning that all children at The Great North Children's Hospital received a gift on Christmas Day.

Our events programme

Our successful panel discussion series Newcastle Hospitals Charity Presents continued with great success.

Open to members of the public, partners, staff and donors, NHC Presents gives us an opportunity to shine a light on some of the amazing projects we support, showing the invaluable difference they make across Newcastle Hospitals.

The first of our events this year focussed on ‘Celebrating Transplantation – A story of the NHS at its finest’. We were thrilled to be able to showcase Dr Rachel Clarke’s story about the incredible series of events leading up to – and including – Max Johnson’s heart transplant at the Freeman Hospital in 2017, performed by world leading surgeon Mr Asif Hasan. We were joined by Max’s mum Emma, Dr Rachel Clarke and Mr Asif Hasan who all spoke movingly about Max’s transplant.



For our second event, timed to coincide with International Women’s Day, the discussion highlighted the role of influential women across healthcare, business and philanthropy in shaping the future of research and regional impact.

The panel included, Chief Executive of Develop North PLC, Michelle Percy, and Anne Reece, Chair of the Reece Foundation. They were joined by Professor Ruth Plummer, Director of the Sir Bobby Robson Cancer Trials Research Centre, who shared insights into the simple question that led to the founding of The Sir Bobby Robson Foundation and how pioneering clinical trials are already transforming cancer treatment for patients across the region and beyond.

The conversation was chaired by Professor Jane Robinson, Pro-Vice-Chancellor Engagement and Place at Newcastle University, who leads the University’s work to strengthen partnerships that support the region’s development, and was opened by north east Mayor, Kim McGuinness.

The series will continue throughout the next year and we’re excited to be able to share more about some of the projects we’re supporting.



Magpies and Wor Flags unite



We teamed up with Newcastle United and Wor Flags to surprise young patients at the Great North Children’s Hospital – a real highlight of our event programme this year.

Magpies stars Kieran Trippier and Emily Murphy made a surprise visit to help young patients design a flag in celebration of the club’s Carabao Cup triumph.

They displayed their artistic flair for the afternoon to help a group of young patients add finishing touches to their artwork, as Wor Flags hosted a special guest takeover of our charity art programme.

Wor Flags’ design masterclass featured an overview of the inspiration behind their Wembley display, before patients were set the challenge of creating a flag of their own. Elements of each design were transformed into a flag commemorating the cup win, which was displayed in the Gallowgate End at St. James’ Park during the season-concluding fixture against Everton.



Your support makes a difference

Fundraising is at the heart of everything we do. It is powered by the generosity, commitment and belief of an incredible community of supporters who make our work possible year after year.

From individual fundraisers and major donors to trusts and foundations, corporate partners and those who choose to leave a legacy, every contribution has helped turn ambition into action.

We are incredibly grateful to every person that supports us in making a positive difference for the patients, staff and wider communities of Newcastle Hospitals.

Whether you are supporting Newcastle Hospitals Charity, The Sir Bobby Robson Foundation or The Great North Children's Hospital you are helping to make a meaningful difference to people's lives every day.

Thank you



Race night for ward 9



Megan Wallis and her family organised a charity race night and raffle.

They raised **£2,000** for ward 9 at The Great North Children's Hospital to say thank you after Megan's little boy Oaklee, spent a lot of time on the ward.



Fundraising in memory

Stacey Brown, from South Shields raised **£23,308** for Newcastle Hospitals Charity in memory of her husband, Chris.

Chris, 37, died three days after a motorbike accident earlier this year. The memory boxes created for their daughters meant so much to the family that Stacey began fundraising to support others facing bereavement.

Northern Gas & Power



Northern Gas & Power made a generous **£5,000** donation towards our Big Give campaign for The Great North Children's Hospital.

They also donated more than **£3,900** of gifts for our young patients spending time in hospital over the festive season.

Newcastle Hospitals Charity

THE great north CHILDREN'S HOSPITAL

The Sir Bobby Robson Foundation

Get involved

Your support can help us do more to improve the patient and visitor experience, improve the health and wellbeing of staff across Newcastle Hospitals and tackle health inequalities and key health issues.

We know much more can be achieved and as you to consider continuing your support so we can – together – transform even more lives.

Fundraise for us

We can only achieve all we do through the generosity of the many fundraisers who give their time to help raise vital funds, often undertaking their own personal challenges to show their appreciation for the work of staff at Newcastle Hospitals.

Organise an event

Host a charity run, bake sale, or a quiz night. These events are great for groups or work colleagues.

Participate in a challenge

Take on a sponsored challenge like the Great North Run, marathons, bike rides or swimming. Challenges are a great way to push yourself and get fit all while supporting Newcastle Hospitals Charity.

Corporate partnerships

If you own a business or work for a company, consider setting up a corporate partnership. This can include matching employee donations, sponsoring events, or organising team fundraising activities. Boosting your profile while giving back to your community.

Join our Business Club

For as little as £10 per month join our business club and receive a framed certificate, banner for your website, personalised email banner, member networking events and your logo on our website.

Thank you

Making a regular gift

Regular donations are a lifeline, enabling us to better plan for the future to make sure we reach those most in need of help. Scan the QR code below to start making a regular donation to Newcastle Hospitals Charity.

Leave a gift in your Will

Leaving a gift in your will is one of the greatest honours we can receive. Your gift will support innovative and transformative healthcare programmes that significantly improve the health and wellbeing of the patients, staff and wider communities of Newcastle Hospitals – creating an incredible legacy.

The process is straightforward, and our charitable status could reduce the overall tax amount of inheritance tax you would be liable to pay. To find out more, please call us on **0191 213 7235** or email **nuth.charity@nhs.net.**

Spread the word

We are always looking to reach more people and let them know about the amazing work of Newcastle Hospitals, and how we support them. Once you have finished reading this, why not pass it on to a friend or colleague who you think might be interested. To hear more about the work of Newcastle Hospitals Charity why not sign up to our newsletter.

Help us make a difference

£5 can support dementia patients with tea sets to help spark connections and conversations.

£10 per month can buy arts and craft supplies that our play specialists can use to help entertain and distract our youngest patients.

£25 can support distressed families with bereavement boxes to cherish important memories of a loved one.

£50 can provide equipment for a sensory room for children and young people who have autism and learning disabilities.

£150 can provide overnight accommodation for families dealing with end-of-life care, providing comfort and a safe haven to deal with the difficulties of losing a loved one.

£500 supports our research team to test and trial new approaches; without it, many projects which go on to provide new cures, drugs, treatments or diagnostics would not be possible.

Newcastle Hospitals Charity

Newcastle Hospitals Charity
The Fleming
Burdon Terrace
Jesmond
Newcastle upon Tyne
NE2 3AE

E: nuth.charity@nhs.net | **T:** 0191 213 7235

Charity Reg. 1057213

MAKE A DONATION

charity.newcastle-hospitals.nhs.uk

instagram.com/newcastle_nhs

@Newcastle Hospitals Charity

@newcastle_nhs

Registered with FUNDRAISING REGULATOR

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Agenda item A5(b)(ii)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 November 2026		
Title	Charity Annual Report and Accounts 2025/2026		
Report of	Caroline Docking, Director of Communications and Corporate Affairs		
Prepared by	Teri Bayliss, Charity Director; Michelle Davies, Communications and Engagement Manager and Gordon Burns, Charity Head of Finance		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☒	☐	☐
Summary	**Assure:** The purpose of this report is to provide assurance to the Trust Board that the Charity Committee has met its key responsibilities for 2025-2026, in line with its terms of reference and requirements of the Charity Commission. The Annual Report and financial statements for the year end 31 March 2026 have been prepared in accordance with the Charities Act 2022 and Charities SORP 2019 (FRS 102). The Annual Report and Accounts have been presented to both Charity Committee and Audit, Risk and Assurance Committee (ARAC) prior to Trust Board, as Corporate Trustee, for formal approval. The final Audit Findings Report was shared with both Charity Committee and ARAC members.		
Recommendation	The Trust Board are asked to approve the Annual Report and financial statements.		

Link to Strategic Priorities	Joining up care		Advancing care		Supporting great care	
	☐		☐		☒	
Impact	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☐	☒	☒	☐	☐	☐

Link to Board Assurance Framework [BAF]	Not applicable.
Reports previously considered by	Annual Report to Charity Committee, Audit, Risk and Assurance Committee and Trust Board.

The Newcastle Hospitals Charity Annual Report and Accounts 2025-2026

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Welcome from our Chair and our Charity Director

Welcome to our Annual Report and Financial Statements for the year ended 31 March 2026. We are continually humbled by the generosity of all our supporters, donors and fundraisers. Your kindness means that this year we have been able to continue to support projects across Newcastle Hospitals.

Along with the Committee of the Sir Bobby Robson Foundation we were delighted to receive planning consent to begin the development of the Trust's £30 million purpose-built cancer clinical trials centre at the Freeman Hospital – The Sir Bobby Robson Institute. We have committed £30 million to the project and have put together a team of experienced staff to develop a fundraising campaign to raise the remaining funds. Work began on preparing the site and we are delighted to say that construction began in June 2026. With generous support from trusts, foundations and individuals we are bringing this dream to life.

In 2025-26 we raised over £10.5 million to fund initiatives that allow us to go further for our hospitals, including funds for The Sir Bobby Robson Institute.

Over the last year the efforts of our supporters have enabled us to commit funding totalling almost £4.8 million to support programmes, projects and activities across Newcastle Hospitals. This includes funding for over 600 diverse projects, our wide-ranging arts programme and our charity volunteer service - all with the aim of making a positive impact for patients, staff and the health of the community.

Whilst the projects we support range in both size and scope; each one is a fantastic example of how your support can make a real difference. You can see more about our work and the effect that work can have by reading our latest Impact Report. You will see the difference we make, whether this is through the unique impact of our arts or volunteer programmes, or through funding innovative projects across Newcastle Hospitals.

Looking forward, Newcastle Hospitals Charity will continue to work in partnership with Newcastle Hospitals to complement their world-class healthcare services. Building on what has already been achieved, our ambition is to further strengthen our role as a key partner for the Trust and to increase the impact that we can make on improving the health of the region and beyond.

We remain incredibly grateful to every single supporter of Newcastle Hospitals Charity, and we are committed to delivering our future strategy to continue making a positive difference for the patients, staff and communities of Newcastle Hospitals.

With all the very best





Wendy Balmain
Charity Chair

Teri Bayliss
Charity Director

Our Charity details

Registered charity name	**Newcastle upon Tyne Hospitals NHS Charity**
Operating name	**Newcastle Hospitals Charity**
Registered charity number	**1057213**
Registered Address:	**Nelson House, The Fleming, Burdon Terrace, Newcastle upon Tyne, NE2 3AE**
Telephone:	**0191 223 7235**
Website:	**https://charity.newcastle-hospitals.nhs.uk/**
Corporate Trustee:	**Newcastle upon Tyne Hospitals NHS Foundation Trust**

Principal professional advisors

Investment Management	CCLA Investment Management Ltd, Senator House, 85 Queen Victoria Street, London, EC4V 4ET Newton Investment Management, Bank of New York Mellon Centre, 160 Queen Victoria Street, London, EC4V 4LA, UK
Bankers	HSBC PLC, 110 Grey Street, Newcastle upon Tyne, NE1 6JG Barclays Bank PLC 71 Grey Street, Newcastle upon Tyne NE99 1JA JP Morgan, 60 Victoria Embankment, London, EC4Y 0JP
External Auditors	Robson / Laidler Accountants, Fernwood House, Fernwood Road, Jesmond, Newcastle upon Tyne NE2 1TJ
Internal Audit	AuditOne, Northumbria House, Unit 7/8 Silver Fox Way, Cobalt Business Park, Newcastle upon Tyne, NE27 0QJ
Counter Fraud Services	Corporate Finance, Regent Point, Regent Farm Road, Gosforth, Newcastle upon Tyne NE3 3HD
Solicitors	Withers LLP, 16 Old Bailey, London EC4M 7EG Stone King LLP, Upper Borough Court, Bath, BA1 1RG

Strategic report

The Board of Directors of The Newcastle upon Tyne Hospitals NHS Foundation Trust as Corporate Trustee (the Trustee) present their annual report together with the audited financial statements of Newcastle Hospitals Charity (the Charity) for the year ended 31 March 2026. This report incorporates the requirements of the Strategic Report as required by Company Law.

The Trustee confirms that the annual report and financial statements of the Charity comply with the current statutory requirements; the requirements of the Charity's governing document; and the provisions of the Statement of Recommended Practice (SORP), applicable to charities preparing their accounts in accordance with the Financial Reporting Standard applicable in the UK and Republic of Ireland (FRS 102) (Second Edition, effective 1 January 2019). The new Charities Statement of Recommended Practice (SORP) 2026 came into effect on 1 January 2026 and applies to periods starting after 1 January 2026; which for our charity will be the year ending 31 March 2027. Where appropriate we have adopted the provisions of the Charities SORP (2026) in this report.

Who we are

Newcastle Hospitals Charity is the official charity of Newcastle Hospitals, which includes the Royal Victoria Infirmary, the Freeman Hospital, the Great North Children's Hospital, the Northern Centre for Cancer Care, Newcastle Dental Hospitals, Northern Genetics Service and many community services.

Our overall objective is outlined in our governing document and as such, funds are used "for any charitable purpose or purposes relating to the National Health Service or to general or specific purposes of The Newcastle upon Tyne Hospitals NHS Foundation Trust."

We have a set of aims, which benefit the public through our support for Newcastle Hospitals ('the Trust'). These aims ensure that the Trustee complies with the duty to have due regard to public benefit guidance published by the Charity Commission and set out in section 4 of the Charities Act 2006.

Our strategy

Newcastle Hospitals Charity is guided by the **three strategic goals**, established as part of our 2022-2026 Strategy, that shape how we move forward, as well as informing grant-making decisions.

These three strategic goals are:

- **Improve the patient and visitor experience, enhancing care for patients and the wider community.**
- **Improve staff health, wellbeing and development.**
- **Tackle health inequalities and key health issues for our region and nationally.**

These goals are at the heart of what we do and address our key stakeholders; patients and visitors; Newcastle Hospitals staff; and the wider communities surrounding Newcastle Hospitals.

Our main aim has been to provide funding for a range of initiatives that support the health of the Trust's community by continually enhancing patient care and experience across the hospitals and beyond. This includes providing additional equipment; supporting staff and their development; funding new and innovative research projects and working in partnership with other organisations to support community health initiatives.

To achieve this aim we continue to support:

- Capital projects for the provision of patient care, treatment or research.
- The purchase of equipment for use in patient care and treatment.
- Projects and initiatives aimed at making the patient stay in hospital as comfortable as possible.
- Staff training and development which ultimately translates into better care and treatment for patients.
- Medical research that aims to increase the knowledge and understanding of a range of illnesses/diseases and ultimately to provide cures or better treatment for patients.
- Partnership working to tackle health inequalities.

Review of the year

Partnership working continues to underpin our strategy and, while a large proportion of the funding we have provided has been awarded within the Trust, we are growing partnerships with external organisations who make a real difference to the lives of people while they are in hospital and when they are at home. Our Impact Report for the year sets out more detail and gives a deeper understanding about our activities and our outcomes.

Arts programme

Our arts programme is a core charity activity and during the past 12 months our arts teams have reached over **230,000 patients, visitors, staff and members of the wider community** and delivered **334 creative engagement sessions**. The team have worked with 24 professional creative freelancers including dancers, musicians, visual artists and writers.

This activity is centred in growing evidence that arts and health (or creative health) programmes have the potential to hasten recovery times, address health inequalities and challenges facing healthcare, including ageing, long-term conditions, loneliness, isolation and mental health. We are an active member of the National Art in Hospitals Network and have supported the development of new UK-wide national guidelines for art in hospitals.

The importance of music

This year we celebrated our first anniversary of 'Hospital Sessions' - an ongoing programme of live music performances, from five musical acts, across the RVI and Freeman Hospital.

We have piloted 'Newcastle Singing for Lung Health', a programme that brings people together who have respiratory or lung conditions to sing in groups, in community settings, led by trained musician Liz Corney.

Another strand of the music programme is ‘Newcastle Hospital Singers’. Open to staff, volunteers and patients they are a friendly group, who sing together for fun often performing both in, and out of, the hospitals.

Supporting our colleagues

We launched a new ‘Staff Art Club’ for Newcastle Hospitals colleagues to try different creative techniques, help reduce stress and improve wellbeing. Our arts team deliver creative activities in the Trust ‘destress and recharge’ sessions to further support staff wellbeing.

This year we have introduced free mindful creative activity booklets for staff and patients, produced biannually, with artist duo Foundation Press.

Improving our hospital spaces

Our arts programme also includes visual arts exhibitions, site-specific artworks across Trust sites and connections with cultural and community settings.

Each year we partner with Sunderland University to deliver ‘NHS Darkroom’ led by Johannah Churchill, a former Newcastle Hospitals nursing trainee, and now professional artist. This photography programme offers NHS workers space to process lived experience through photography and the darkroom acts as a site of care and reflection to support healthcare staff.

We also partnered with XP Gateshead School on their Year 8 cross-disciplinary project, ‘What does it mean to be human’ which seeks to promote understanding of organ donation and transplantation with young people and their families.

As the Newcastle Diabetes Centre moved into a more permanent home at the Freeman Hospital, we worked with artist Dan Savage, of Artstop Studios, engaging staff and patients to develop a suite of site-specific artworks.

A new national project by artist John Yayen, ‘Embers of Care’, involved the artist working with two staff members who have migrated from outside of the UK, to create a painting reflecting on their unique journeys and experiences. The project seeks to bring visibility and recognition to often unseen stories of migrant healthcare workers within the UK healthcare system.

‘Journeys’ is a project and display that explores the experiences of individuals impacted by organ donation and transplantation, visualised through maps and objects. The project was developed by the NIHR Blood and Transplant Research Unit in Organ Donation and Transplantation at Cambridge and Newcastle universities.

Festive programme

The festive period is such a special time of year, but not everyone gets to spend it at home celebrating with their loved ones. Whilst we can’t change that, we can help to spread a little festive cheer and joy.

As always, our festive programme did just that. Thanks to the generosity of our supporters, we were able to support a full programme of events, provide those patients who couldn’t be home with their loved ones with small gifts and brighten up wards and departments across Newcastle Hospitals with festive decorations.

Volunteer programme

Our amazing team of Newcastle Hospitals Charity volunteers continue to go above and beyond to help support patients, visitors and staff across Newcastle Hospitals. Our volunteers completed around **44,000 hours of volunteering** in a variety of roles including meet and greet, mealtime support, charity events, retail and ward-based support. The time, the generosity and the support from our volunteers is invaluable and makes a real difference to patient experience.

Funding programme

Over the last year we have been proud to commit funding totalling more than **£4.1 million** to diverse projects across Newcastle Hospitals, all with the aim of creating a positive impact. Each of the projects we support is directly linked to our three strategic aims, as set out in our 2022-2026 strategy.

As well as supporting patients and hospital staff directly, the larger projects we have supported play an enabling role in funding research and innovation, tackling health inequalities, and creating healthier communities across Newcastle and the wider region.

Working in partnership

Each year we work in partnership with organisations across the North East to fund projects that support the health and wellbeing of children and young people both within the hospital environment and in the community. This year we have worked with organisations such as:

Durham Cricket foundation	Newcastle United Foundation
Daft as a Brush	Skills for People
Newcastle Eagles and the Eagles Community Foundation - Hoops4Health	Wagg & Company

Making a difference

Sometimes, it is the small things that make a big difference. Over the last year we have supported staff from all areas of Newcastle Hospitals to implement ideas and projects that have a meaningful impact on patients and staff.

Over 600 projects were supported over the year and we allocated £0.7 million in easy to access, small project funding. Much of this was focused on staff health, wellbeing and development, and on initiatives that improved the everyday experience of patients.

The Great North Children's Hospital fund – supporting children and families

Every Step

We were proud to launch our Every Step campaign in September 2025. The campaign highlights the crucial support that the Great North Children's Hospital provides to children and their families throughout the hospital journey – from diagnosis, treatment and recovery to the ongoing care and emotional support after discharge. We used footprints from patients, families and staff to demonstrate how the Great North Children's Hospital is there every step of the way – helping patients and families feel supported no matter where they are in their journey.

Each year – thanks to your generosity we support projects that support young patients and their families who come to the hospital for treatment and care.

Sir Bobby Robson Foundation

Working in partnership with Newcastle Hospitals and Newcastle University we are building the Sir Bobby Robson Institute – a world-leading cancer trials and research centre on the site of the Freeman Hospital. The £30million purpose-built centre will be fully funded by the foundation and will open to patients in 2028.

Thanks to the generosity of donors, supporters and fundraisers more than £26.5 million has been raised to support the project, including an incredible £2million donation from the Barbour Foundation.

This year we will begin the final push and turn vision into reality and create a beacon of hope for patients in our region and beyond.

The institute will:

- Increase clinical trials capacity by 50%, giving more patients access to pioneering treatments.
- Accelerate the development of life-changing and life-saving drugs and therapies.
- Bring together clinicians, researchers and patients in one purpose-built, state-of-the-art centre.
- Create breakthroughs that will be felt across the North East, north Cumbria, North Yorkshire and around the world.

To read more about our activities, our achievements and our funded projects please see our **2025-2026 Impact Report**.

Raising funds

Fundraising is at the heart of everything we do. It is powered by the generosity, commitment and belief of an incredible community of supporters who make our work possible year after year. From individual fundraisers and major donors to trusts and foundations, corporate partners and those who choose to leave a legacy, every contribution has helped turn ambition into action.

We are incredibly grateful to every person that supports us in making a positive difference for the patients, staff and wider communities of Newcastle Hospitals. Whether you are supporting Newcastle Hospitals Charity, the Sir Bobby Robson Foundation or the Great North Children's Hospital you are helping to make a meaningful difference to people's lives every day.

Charity supporters

We are incredibly grateful to the continued and very generous support of our many supporters throughout 2025/26. Our activities are set out below highlighting the amazing commitment that our supporters have shown.

We achieve all that we do through the generosity of the many individuals willing to help raise vital funds, often undertaking their own personal challenges to show their appreciation for the work of staff at Newcastle Hospitals. The creativity, energy and dedication, from all parts of our community, has been incredible.

Individual supporters

Individual support is shown in many ways, including spending in our charity retail shops, regular monthly donations, or philanthropic donations. Some of our donors make significant gifts to the Charity each year but every gift contributes to how we can better support Newcastle Hospitals.

We also want to give special thanks to those donors that chose to remain anonymous; their philanthropic support continues to help shape the future of healthcare.

Corporate support

We work hard to develop our key relationships with those businesses across the region that share our vision, developing meaningful partnerships that help support business need and charity objectives. Our thanks go to all the businesses that helped us this year.

Trust and Foundations

We continue to develop relationships with key local, regional and national Trust and Foundation bodies, to work collaboratively on key initiatives that improve healthcare provision for staff, patients and their families.

Legacies

A gift to Newcastle Hospitals Charity in the form of a legacy is the greatest honour the Charity can receive. We rely on the hard work of Executors and their professional advisors to administer the estates of our benefactors and to bring them to a conclusion. We do not administer estates, as we recognise we do not have the expertise or the resources to offer this, and we recognise the efforts made by others on our behalf.

Thank you to all those who have helped us and are helping us to provide support to our hospitals.

Financial review of the year

This section provides a consolidated financial summary of Newcastle Hospitals Charity and the retail subsidiary for the year ended 31 March 2026. A full copy of the audited financial statements is included with this report, but the table below summarises our income and expenditure compared to the prior year.

Income and expenditure summary	**2026 £'000**	**2025 £'000**
Income:		
Voluntary income	4,650	7,588
Grants received	3,407	325
Other trading activities	999	576
Investment income	1,407	1,271
Total income	**10,463**	**9,760**
Expenditure on:		
Generating income	1,271	617
Trading activities	844	487
Charitable activities	33,971	6,992
Governance, support and other	859	973
Total expenditure	**36,945**	**9,069**
Net (deficit)/ surplus before investment gains and losses	**(26,482)**	**691**

Our results for the year are heavily affected by the recognition, within the costs of our charitable activities, of the £30 million commitment to the building costs of the Sir Bobby Robson Institute. This commitment has created a significant deficit for this financial year utilising the funds built up by the Sir Bobby Robson Foundation.

Our total income has increased from £9.8 million to £10.5 million, including £3.0 million of gifts in relation to the Sir Bobby Robson Institute. Legacy income has reduced in comparison with the prior year, as that year had recognised accrued legacy income for the first time.

Our trading income has increased as our retail subsidiary has operated the whole of the shop unit at the Freeman Hospital, and for the full year (2025: 50% of the unit was operated by the Trust's catering team). The cost of retail has increased significantly due mostly to the increase in the costs of goods for sale.

The costs of generating our income have increased as we have invested in the team to generate the remaining funds for the Sir Bobby Robson Institute capital costs.

Aside from the £30 million capital commitment, we have awarded £4.1 million of funding in the year; off-set by the cancellation of £1.1 million of older awards that had not been utilised or were no longer required. Our awards have been funded mostly from our designated reserves.

The net cost of the awards, along with the cost of our arts and volunteering programmes are included in the cost of our charitable activities.

We show the costs of governance, support and other expenditure as a separate heading to provide a clearer understanding of our activities each year.

Charity management costs

The Trust employs staff with relevant experience to generate income, manage our charitable activities, manage the strategy, finances and operations of the Charity. The total cost of those staff is recharged to the charity along with any specific associated costs incurred on the Charity's behalf.

The direct costs of managing the restricted fund of The Sir Bobby Robson Foundation are charged to the fund along with a management recharge, being 1% of the Foundation's income as agreed with the Committee members.

This year the Charity Committee, with support from the Trust Board, agreed we should recommence making a 3.5% charge to those of our 280 funds with a balance more than £10,000, to meet the costs of fund management, fundraising and the management of funding projects. All remaining operating costs are allocated to the general purposes fund.

Investment performance

Newcastle Hospitals Charity's investment objectives are to take a medium-term view and generate income and growth from low-risk investments. Our investments have been managed for several years by two experienced investment managers who have experience working with charitable clients and who operate within the requirements of Newcastle Hospitals Charity's investment policy and within an agreed risk appetite.

The two portfolios are managed on a discretionary basis with income distributed rather than accumulating. The Investment Managers report to the Charity Committee and performance of the portfolio is reviewed each quarter, providing information relating to performance, a market review and projection, and appropriate investment recommendations.

We saw an improvement in performance of the funds across the year but incurred reductions in value during March 2026, in line with all investments. In the period since the year end we have seen our investment values recover those reductions incurred in March. Markets remain volatile and we continue to monitor performance.

At the start of the financial year it was decided to move £7.6 million from the long term portfolio to a cash deposit fund. This money was part of the funds supporting our commitment to the new clinical trial centre and the change removed all market volatility risk as we move towards utilising the money. £2.0 million was withdrawn from the cash deposit in December 2025 to meet the first payments in relation to capital expenditure by the Trust.

To meet ongoing operating expenditure, and to meet the payments of our funding awards, £3.3 million was transferred from investments to operating cash. This highlighted the need to create a more liquid investment with reduced risk of market volatility, and it was agreed to move £10.0 million to an interest-bearing cash deposit account.

During 2025/26, Newcastle Hospitals Charity received £1,407k in dividends and interest from long and short-term investments (2025: £1,271k). Income attributable to funds held for The Sir Bobby Robson Foundation is allocated to that fund. The remaining income is allocated to the general purposes fund to help meet the running costs of the Charity.

Newton Investment Management Ltd

The objective of the Growth & Income Fund for Charities is to generate capital and income growth over a period of 5-7 years by investing at least 70% of the Sub-Fund's assets in a global portfolio of equities (company shares) and fixed income securities.

Newton's established charities team actively manages the fund. There are no investments in derivatives, no underwriting and distributions are made on a quarterly basis.

CCLA

The investment objective of the Ethical Investment Fund is to provide an average return over a business cycle of inflation plus 5%, whilst maintaining income in real terms. The Responsible Investment Policy of CCLA has three strands:

- Engagement on issues of corporate social responsibility with a view to optimising long- term economic returns.
- Engagement on corporate governance including proxy voting on issues to protect and enhance shareholder value.
- Setting appropriate constraints on investment and exposure to activities considered unacceptable by an independent board.

Having changed how we hold money for future funding and operations it was agreed to invite a number of investment managers to tender for investment management services. This tender took place over the Spring and Summer of 2026 with the help and support of the Trust.

Reserves

The Newcastle Hospitals Charity reserves policy intends to ensure an appropriate balance between enabling the Charity to fund strategic and transformational priorities in the medium term and to provide a financially sustainable approach to ensuring the meaningful role that the Charity can continue to provide in the long term.

Financial reserves are split into four areas:

- Operational reserve (our free reserves) – used to finance the day-to-day operating activities of Newcastle Hospitals Charity.
- Grant reserve (our designated funds) – held in anticipation of financing approved grants.

- Endowment reserve – if funds are available this would be used to provide returns to safeguard the long-term financial sustainability of the Newcastle Hospitals Charity.
- General reserve – financial resources in excess of those required by the operational, grant, and endowment reserves.

The total reserves as at 31 March 2026 are £11.8 million (2025: £37.0 million), the reduction being due to the recognition of the £30 million commitment to the Sir Bobby Robson Institute. The Sir Bobby Robson Foundation restricted reserve had a negative balance of £5.4 million at 31 March 2026, representing the fundraising target to meet the full cost of the commitment (2025: £19.8 million of net assets). The Charity Committee remain convinced the fundraising target can be achieved to bring the negative balance back into a positive position by 31 March 2027.

The unrestricted/designated funds stand at £17.2 million (2025: £17.1 million). The Charity aims to hold free reserves with a value sufficient to meet the coming year budget for operating costs. At 31 March 2026 the free reserves are calculated as £2.6 million, which compares with the 2025/26 budgeted operating costs of £2.9 million.

A look forward

Newcastle Hospitals Charity has been working to an ambitious strategy to 2026 which puts people at the heart of all our activities and is united with the aim of Newcastle Hospitals to make a real difference to the health and care of the people across the Trust and beyond. Our ambition is to strengthen our role as a key partner for the Trust and to increase the impact that we can make on improving the health of our region and beyond.

Working in close partnership with the Trust, our goals are to:

- Improve the patient and visitor experience, enhancing patient centred care.
- Improve staff health, wellbeing and development.
- Tackle health inequalities and key health issues for our region and nationally.

Structure and governance

Good governance is fundamental to Newcastle Hospitals Charity's continued success and enables us to continue to manage risks appropriately and deliver our charitable activities in compliance with all relevant legislation.

Charitable objects

Newcastle Hospitals Charity was formed by a Declaration of Trust on 16 July 1996 as The Freeman Group of Hospitals NHS Charity which was amended by a Supplemental Deed dated 17 March 1999 to the Newcastle upon Tyne Hospitals NHS Charity, Registration Number 1057213.

A Supplemental Deed dated 1 February 2016, which applies to the Charity today, refined the Charity's objects. Newcastle Hospitals Charity is constituted with a sole Corporate Trustee, which is the Board of Directors of The Newcastle upon Tyne Hospitals NHS Foundation Trust.

With effect from 1 April 2016, the Corporate Trustee was appointed as Trustee of the charitable funds formerly held on behalf of the NHS Trust by Newcastle Healthcare Charity (Reg.502473) under a Scheme formally approved by the Charity Commission for England & Wales on 21 March 2016. The funds were subsequently merged under the umbrella of the Trust's appointed charitable body, Newcastle upon Tyne Hospitals NHS Charity (Reg. 1057213) and have subsequently formed part of Newcastle Hospitals Charity's financial accounts from 2016/17 onwards.

The objects of Newcastle Hospitals Charity are to support any charitable purpose or purposes relating to the National Health Service or to general or specific purposes of The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Corporate Trustee

The Trustee(s) are the people and/or body who govern any charity. The trustee(s) have ultimate responsibility to ensure that legal or regulatory requirements and duties are complied with, and that good practice is followed and applied.

As defined by the Charities Act (2022) the sole Corporate Trustee of Newcastle Hospitals Charity has the responsibility for ensuring that the Trustee duties defined by the Charity Commission are upheld. There are no individual trustees of NHC, only the single voting body of The Newcastle upon Tyne Hospitals NHS Foundation Trust.

Statement of trustee responsibilities

The Trustee is responsible for ensuring that the Annual Report and Accounts are prepared in accordance with all applicable laws and regulations and company law requires financial statements are prepared annually.

Under that law, the Corporate Trustee has prepared the financial statements in accordance with United Kingdom Accounting Standards, comprising FRS 102 "The Financial Reporting Standard applicable in the UK and Republic of Ireland", and applicable law (United Kingdom Generally Accepted Accounting 26 Practice). Under company law, the Trustee must not approve the financial statements unless they are satisfied that they give a true and fair view of the state of the affairs of the charitable company.

Structure and governance (continued)

In preparing this Annual Report and Accounts, the Trustee is required to:

- Select suitable accounting policies and apply them consistently.
- Observe the methods and principles in the Charities Statement of Recommended Practice (SORP).
- Make judgments and estimates that are reasonable and prudent.
- State whether FRS 102 “The Financial Reporting Standard applicable in the UK and Republic of Ireland” has been followed.
- Prepare the financial statements on a ‘Going Concern’ basis unless it is inappropriate to presume that the Charity will continue in business.

The Trustee is responsible for ensuring that adequate accounting records are kept that are sufficient to show and explain Newcastle Hospitals Charity’s transactions. The Trustee is also responsible for disclosing, with reasonable accuracy at any time, the financial position of Newcastle Hospitals Charity to ensure compliance with the Companies Act 2006. It is also responsible for safeguarding the assets of Newcastle Hospitals Charity and for taking reasonable steps for the prevention and detection of fraud and other irregularities. Finally, the Trustee is responsible for the maintenance and integrity of Newcastle Hospitals Charity’s website.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Charity Committee

The Charity Committee has delegated authority from the Corporate Trustee as a statutory Committee established by the Board of Directors to manage, on behalf of the Board, “all charitable funds of the trust charity, considering the requirements and regulations of the Department of Health and Social Care and the Charity Commission for England and Wales”.

The Charity Committee membership for 2025 - 2026 comprised:

- Philip Kane, Non-Executive Director and Chair of the Charity Committee – stood down as Chair in February 2026
- Wendy Balmain, Non-Executive Director who became Chair of the Charity Committee from February 2026.
- Jackie Bilcliff, Chief Finance Officer
- Caroline Docking, Director of Communications and Corporate Affairs
- Ian Joy, Executive Director of Nursing, Midwifery and AHP (from July 2025)
- Bill MacLeod, Non-Executive Director
- Lucia Pareja-Cebrian, Joint Medical Director
- David Weatherburn, Non-Executive Director (from November 2024)
- Michael Wright, Joint medical Director

All members of the Committee receive training and development support both before joining, and on a continuing basis, to ensure their effectiveness as members. This is supported by the process of annual appraisal for all Non-Executive Directors.

The Charity Committee annually reviews their Terms of Reference and meets a minimum of four times per year. Agendas are set for each meeting utilising an agreed Schedule of Business. This provides assurance to the Board of Directors in its capacity as Corporate Trustee that robust processes are in place to enable statutory duties to be discharged, to enable the Trust's strategic objectives to be met, and to address and mitigate risk.

The quorum required for the transaction of business is three members, which includes at least one Executive and at least one Non-Executive Director.

Newcastle Hospitals Charity team

We have a dedicated team who develop and deliver the charity strategy, providing and managing our charitable activities, and includes administrative, financial, and fundraising resource. Newcastle Hospitals Charity does not directly employ staff; team members are employees of The Newcastle upon Tyne Hospitals NHS Foundation Trust and Newcastle Hospitals Charity is recharged for costs incurred in relation to both staffing and non-pay related expenditure incurred directly in relation to charity activities.

Charity funds

At the start of the year there were over 280 individual designated funds, which formally form part of our unrestricted funds, and which make up Newcastle Hospitals Charity. In line with guidance from the Charity Commission for NHS charities we treat funds as designated, as we are often told by donors they would like their donations to be used for a particular purpose. Work continues to rationalise our funds where possible, always ensuring donor wishes are respected, and making funds available for use both Trust wide and in specialty areas.

Newcastle Hospitals Charity manages a significant restricted fund, The Sir Bobby Robson Foundation. The Sir Bobby Robson Foundation works to help find more effective ways to detect and treat cancer for patients across the North East, Cumbria and beyond. The Foundation funds clinical trials and cancer research, pioneering cancer treatment and innovative cancer support services, such as acupuncture, complementary therapies and counselling. This funding has continued alongside the commitment to the new clinical trials centre

Policies and procedures

All Newcastle Hospitals Charity policies and associated procedures are designed to provide guidance that ensures consistent, ethical and professional standards are maintained in relation to charitable donations and fundraising, and that they are compliant with charity law and the regulations and standards set out by the Charity Commission, the Fundraising Regulator and the Healthcare Financial Management Association.

All working practices and procedures conform to the Charity Commission's guidelines and are subject to scrutiny by Internal and External Audits.

Newcastle Hospitals Charity follows The Newcastle upon Tyne Hospitals NHS Foundation Trust's stance and efforts to prevent modern slavery and human trafficking in its supply chain.

The Trust has reviewed and met its requirements in line with Section 54 of the Modern Slavery Act 2015.

Structure and governance (continued)

Funding and fund management

Newcastle Hospitals Charity comprises 289 individual funds, two of which are restricted in purpose and one of which is designated for general purposes. The remaining 286 unrestricted funds are linked to individual wards or clinical services, research into clinical areas, education, training and specific schemes/projects in accordance with the wishes of donors and charity objectives.

This includes the following 2 restricted funds:

- The Sir Bobby Robson Foundation which is held to 'provide assistance to any charitable or public body active in the North East of England which participates in the treatment of/ or research into cancer or which provides care in the community for cancer sufferers and/ or their dependants/carers'.
- The Fleming and Watson Children's Fund which is held for the 'care, treatment and relief by way of research or otherwise of sick children attending any of the hospitals or other facilities managed by or otherwise in any way connected with The Newcastle upon Tyne Hospitals NHS Foundation Trust, or any successor to that body'.

Use of the restricted funds by the Charity Committee is based on the recommendations of Clinical Boards within the Trust and connected to those funds. Use of the unrestricted funds is based on applications from members of Trust staff.

Our process for requesting funding now uses our Beacon customer relationship management system (CRM) which allows all requests to be assessed. Applicants must be able to demonstrate why it is appropriate to use charity funds in terms of additional benefit or enhancement to the service. This provides an assurance that expenditure is appropriate and can demonstrate benefit to the service.

The Committee considers all expenditure over £20,000 with a scheme of delegation to transfer authority to individual Committee Members or other members of staff as appropriate.

Newcastle Hospitals Charity has a policy of turning-over the balance of any fund in 5 years and colleagues are encouraged to use at least 20% of the available funds each year. Newcastle Hospitals Charity can apply to the Charity Commission to re-organise funds that are no longer relevant or cannot be usefully used and are encouraged to actively manage funds.

During 2025/26 we considered 798 (2024/25: 700) applications for funding from staff and external partners. That figure includes a very wide range of proposals some of which will span several years, and funding has been reserved.

Code of Fundraising Practice

Newcastle Hospitals Charity fully adheres to the Code of Fundraising Practice, which sets the standards that apply to fundraising carried out by all charitable institutions and third-party fundraisers in the UK.

Our donor promise

Without the generosity of our supporters, we would not be able to continue our work to enhance and improve the experience of patients and their families, as well as the amazing staff across all sites. Our ambition is to make the biggest difference, so we promise to make sure we look after supporters in the best way possible.

We are honest and open:

- We value donor generosity and will inform donors of where their fundraising will make the biggest difference.
- We will be clear about what we are fundraising for.
- We will be clear about how much of a certain donation goes straight to frontline services and how much is spent on the administration of the Charity.
- We will respect donor privacy and will never sell personal details to a third party.

We are committed to high standards:

- We will do all we can to ensure that fundraisers and volunteers abide by the Fundraising Regulator's Fundraising Promise.
- We will comply with the law, the Charity Commission and the Fundraising Regulator, including guidance around data protection and health and safety.
- Donor and fundraiser opinions matter to us. We are keen to help if they are unhappy with anything we have done. Complaints can be made via the contact details on the Charity website:

  https://charity.newcastle-hospitals.nhs.uk/contact-us/

We are respectful:

- We promise to communicate in a way that suits our donors/fundraisers and will be respectful of any changes they wish to make to this decision.
- We will treat every donation respectfully, and if a donor does not wish to continue their relationship with us, that will be respected.
- We are a member of the Fundraising Regulator and are proud to have committed to their Fundraising Promise, which delivers the highest standards possible across the Charity. We promise that our fundraising is always legal, open, honest and respectful.

Donor care

We will always aim to:

- Respond to all enquiries within two working days.
- Thank each donation within one working week of receipt.
- Ensure all supporters' details are recorded accurately and efficiently on the database.
- Make sure we record supporter contact preferences.

Privacy statement

We are committed to protecting and respecting personal information and always ensure transparency about how data will be used. Newcastle Hospitals Charity is fully compliant with the European General Data Protection Regulation and the UK Data Protection Act 2018.

Newcastle Hospitals Charity has a Privacy Statement, which sets out how we collect and use personal information and why it is important in enabling us to fulfil our charitable objectives. The statement is available in full on our website:

https://charity.newcastle-hospitals.nhs.uk/privacy/

Investment policy

Newcastle Hospitals Charity invests any funds not required immediately for expenditure through portfolios managed by two investment managers, CCLA and BNY Mellon Newton Investment Management, allowing performance comparisons and reducing the levels of risk. The CCLA element is held in their Ethical Investment Fund whilst Newton's is held in their Growth & Income Fund for Charities.

The portfolios are managed on a discretionary basis, with elements and investments chosen by the Investment Managers and comprise of equities, property, and cash. The equities comprise shareholdings in public companies with stock market quotations; however, both portfolios refrain from the direct investment in companies that derive a substantial amount of their profit from investment in tobacco.

Risk management and internal control

The Corporate Trustee considers that Newcastle Hospitals Charity has the necessary practices currently in place to assess all associated risks. A detailed Risk Register is continually maintained and monitored which identifies risk areas, the potential impact of those risks, and the steps taken to mitigate them. The Charity risk register has been maintained throughout 2025/2026, recording when a risk has been identified, who owns it, likelihood of occurrence, potential impact, and mitigating action.

Newcastle Hospitals Charity has adopted The Newcastle upon Tyne Hospitals NHS Foundation Trust (the Trust) Risk Management Policy and Procedures. The Risk Management Policy sets out the structures and processes for the identification, evaluation, and control of risk, as well as the system of internal control.

Principal risks

Newcastle Hospitals Charity continues to review risks on a quarterly basis with a risk report presented to the Charity Committee to provide assurance that charity risks continue to be managed effectively. The Charity Committee is chaired by a Non-Executive Director and has Trust Board of Directors membership.

The following areas of risk are considered the principal risks facing the charity. There are actions and controls in place for each to help mitigate the risk.

Investment risk

There is a finance risk to Charity investments and liquidity, which is caused by the potential impact of market downturn on generating target annual returns from investments, and maximising interest income from cash holdings. This could result in the inability to fulfil funding commitments / make new funding awards.

Sustainability risk

There is a risk to the financial and operational sustainability of the Charity caused by changes to NHS Terms and Conditions which impact on the operational cost of the Charity, and on reasonable ROI and value for money.

Governance and reputational risk

There is a risk to Charity Governance and reputation caused by clear lack of guidance and criteria that reflect charity law which could result in poor decision making and challenge from Charity Commission.

Strategic income risk

There is a risk that focusing fundraising on strategic priorities may result in a reduction in unrestricted income for other activities

Appointment of auditors

A resolution proposing the reappointment of Robson Laidler as auditors for the year ended 31 March 2027 will be put to the Trust Audit Committee.

Disclosure of information to auditors

Each of the persons who act for the Trustee at the time when this Trustee's report is approved has confirmed that:

- so far as that Trustee is aware, there is no relevant audit information of which the charity's auditors are unaware, and
- that the Trustee has taken all the steps that ought to have been taken as a Trustee in order to be aware of any relevant audit information and to establish that the charity's company's auditors are aware of that information.

In signing this report the Chair of the Charity Committee approves the strategic report in their capacity as representative of the Corporate Trustee.

Approved by the Trustee on **27 November 2026** and signed on their behalf by

_____

Wendy Balmain (Non-Executive Director)

Independent Auditor's report
To the Corporate Trustee of Newcastle upon Tyne Hospitals NHS Charity

Opinion

We have audited the financial statements of Newcastle upon Tyne Hospitals NHS Charity (the 'charity') for the year ended 31 March 2026 which comprise the Statement of Financial Activities, the Balance Sheet, the Statement of Cash Flow and notes to the financial statements, including a summary of significant accounting policies. The financial reporting framework that has been applied in their preparation is applicable law and United Kingdom Accounting Standards, including FRS 102 "The Financial Reporting Standard applicable in the UK and Republic of Ireland" (United Kingdom Generally Accepted Accounting Practice).

In our opinion, the financial statements:

- give a true and fair view of the state of the Charity's affairs as at 31 March 2026 and of its income and expenditure for the year then ended;
- have been properly prepared in accordance with United Kingdom Generally Accepted Accounting Practice; and
- have been prepared in accordance with the requirements of the Charities Act 2011.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the *Auditor's responsibilities for the audit of the financial statements* section of our report. We are independent of the charity in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

In auditing the financial statements, we have concluded that the trustee's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Charity's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the trustees with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the Charity Annual Report, other than the financial statements and our auditor's report thereon. The trustees are responsible for the other information. Our opinion on the financial statements does not cover the other information and we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements, or our knowledge obtained in the course of the audit, or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information.

If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Matters on which we are required to report by exception

In light of the knowledge and understanding of the Charity and its environment obtained in the course of the audit, we have not identified material misstatements in the Charity Annual Report.

We have nothing to report in respect of the following matters in relation to which the Charities (Accounts and Reports) Regulations 2008 requires us to report to you if, in our opinion:

- the information given in the financial statements is inconsistent in any material respect with the Charity Annual Report; or
- sufficient accounting records have not been kept; or
- the financial statements are not in agreement with the accounting records; or
- we have not received all the information and explanations we require for our audit.

Responsibilities of trustees

As explained more fully in the statement of trustee's responsibilities set out on page 13, the trustees are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view, and for such internal control as the trustees determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the trustees are responsible for assessing the Charity's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the trustees either intend to liquidate the Charity or to cease operations, or have no realistic alternative but to do so.

Auditor's responsibilities for the audit of the financial statements

We have been appointed as auditor under section 144 of the Charities Act 2011 and report in accordance with the Act and relevant regulations made or having effect thereunder.

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate,

they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud.

Based on our understanding of the Charity and its sector, we considered that non-compliance with the following laws and regulations might have a material effect on the financial statements: employment regulation, health and safety regulation, and anti-money laundering regulation.

To help us identify instances of non-compliance with these laws and regulations, and in identifying and assessing the risks of material misstatement in respect to non-compliance, our procedures included, but were not limited to:

- Inquiring of management and, where appropriate, those charged with governance, as to whether the Charity is in compliance with laws and regulations, and discussing their policies and procedures regarding compliance with laws and regulations;
- Inspecting correspondence, if any, with relevant licensing or regulatory authorities;
- Communicating identified laws and regulations to the engagement team and remaining alert to any indications of non-compliance throughout our audit; and
- Considering the risk of acts by the Charity which were contrary to applicable laws and regulations, including fraud.

We also considered those laws and regulations that have a direct effect on the preparation of the financial statements, such as tax legislation, pension legislation, the Companies Act 2006, the Charities Act 2011 and the Charities Statement of Recommended Practice.

In addition, we evaluated the trustees' and management's incentives and opportunities for fraudulent manipulation of the financial statements, including the risk of management override of controls, and determined that the principal risks related to posting manual journal entries to manipulate financial performance, management bias through judgements and assumptions in significant accounting estimates, income recognition (which we pinpointed to the cut-off assertion), and significant one-off or unusual transactions.

Our audit procedures in relation to fraud included but were not limited to:

- Making enquiries of the trustees and management on whether they had knowledge of any actual, suspected or alleged fraud.
- Gaining an understanding of the internal controls established to mitigate risks related to fraud.
- Discussing amongst the engagement team the risks of fraud.
- Addressing the risks of fraud through management override of controls by performing journal entry testing.

There are inherent limitations in the audit procedures described above and the primary responsibility for the prevention and detection of irregularities including fraud rests with management. As with any audit, there remained a risk of non-detection of irregularities, as these may involve collusion, forgery, intentional omissions, misrepresentations or the override of internal controls.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Use of the audit report

This report is made solely to the Charity's trustee, as a body, in accordance with Part 4 of the Charities (Accounts and Reports) Regulations 2008. Our audit work has been undertaken so that we might state to the Charity's trustees those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the charity and the Charity's trustee as a body, for our audit work, for this report, or for the opinions we have formed.

Signed_____

Nicholas Cunningham MSc BSc FCCA (Senior Statutory Auditor)
For and on behalf of Robson Laidler Accountants Limited, Statutory Auditor
Fernwood House, Fernwood Road, Jesmond, Newcastle upon Tyne NE2 1TJ

Date

Robson Laidler Accountants Limited is eligible for appointment as auditor of the charity by virtue of its eligibility for appointment as auditor of a company under section 1212 of the Companies Act 2006.

Financial statements for the year ending 31 March 2026

Newcastle Hospitals Charity

Consolidated statement of financial activities
Year ended 31 March 2026

	Note	Unrestricted funds	Designated funds	Restricted funds	**2026 total**	**2025 total**
		£'000	£'000	£'000	**£'000**	**£'000**
Incoming resources from:						
Voluntary income	3	696	3,349	4,012	**8,057**	**7,913**
Other trading activities:	4	-	999	-	**999**	**576**
Investment income		672	-	735	**1,407**	**1,271**
Total incoming resources		**1,368**	**4,348**	**4,747**	**10,463**	**9,760**
Expenditure on:						
Generating income	5	724	162	385	**1,271**	617
Retail activities	5	0	844	0	**844**	**487**
Charitable activities	5	877	3,290	29,803	**33,970**	**6,992**
Governance, support and other costs	5	721	139	-	**860**	**973**
Total expenditure		**2,322**	**4,435**	**30,188**	**36,945**	9,069
Net income/(expenditure) before investment gains and losses		**(954)**	**(87)**	**(25,441)**	**(26,482)**	**691**
Net (losses)/gains on investments	8	1,120	-	159	**1,279**	**(352)**
Net income/(expenditure)		**166**	**(87)**	**(25,282)**	**(25,203)**	339
Transfers between funds		-	-	-	**-**	**-**
Net movement in funds		**166**	**(87)**	**(25,282)**	**(25,203)**	**339**
Reconciliation of funds:						
Total funds brought forward	13	**2,451**	**14,728**	**19,845**	**37,024**	**36,685**
Total funds carried forward	13	**2,617**	**14,641**	**(5,437)**	**11,821**	**37,024**

The accounting policies and notes on pages 29 to 40 form part of these financial statements.

Newcastle Hospitals Charity

Balance sheet
Year ended 31 March 2026

	Note	Group 2026 £'000	Group 2025 £'000	Charity 2026 £'000	Charity 2025 £'000
Fixed assets					
Investments	8	15,200	34,852	**15,250**	**34,872**
Current assets					
Stocks and work in progress		43	16	-	-
Debtors	9	4,894	3,661	**4,792**	**3,596**
Short term investments		18,810	12,555	**18,810**	**12,555**
Cash at bank and in hand		12,432	2,169	**12,334**	**2,138**
Total current assets		36,179	18,401	**35,936**	**18,289**
Liabilities					
Creditors: Amounts falling due within 1 year	10	(28,448)	(13,888)	**(28,406)**	**(13,836)**
Net current (liabilities)/assets		7,731	4,513	**7,530**	**4,453**
Total assets less current liabilities		22,931	39,365	**22,780**	39,325
Creditors: Amounts falling due after more than 1 year	11	(11,110)	(2,341)	**(11,110)**	**(2,341)**
Total net assets		**11,821**	**37,024**	**11,670**	36,984
Funds					
Total funds	13	**11,821**	**37,024**	**11,670**	**36,984**

The accounting policies and notes on pages 29 to 40 form part of these financial statements.

The financial statements were approved and authorised for issue by the Corporate Trustee and were signed on its behalf by:

Wendy Balmain
Non-Executive Director

27 November 2026

Newcastle Hospitals Charity

Consolidated statement of cash flows
Year ended 31 March 2026

	Total funds 2026 £000	Total funds 2025 £000
Cash flows from operating activities		
Net cash provided by operating activities	**(5,820)**	**(3,920)**
Cash flows from investing activities		
Dividends and interest from investments	**1,407**	**1,271**
Transfer to short term investments	**7,600**	**3,346**
Investment in retail subsidiary	**-**	**-**
Withdrawals from investments	**13,331**	**5,625**
Net cash provided by investing activities	**22,338**	**10,242**
Change in cash and cash equivalents in the reporting period	**16,518**	**6,322**
Cash and cash equivalents at the beginning of the reporting period	**14,724**	**8,402**
Cash and cash equivalents at the end of the accounting period	**31,242**	**14,724**

Reconciliation of cash flows from operating activities

	Total funds 2026 £000	Total funds 2025 £000
Net (expenditure)/ income for the period as per SOFA	**(26,482)**	691
Adjustments for:		
Decrease/(increase) in stock	**(27)**	25
Dividends and interest from investments	**(1,407)**	(1,271)
(Increase) in debtors	**(1,233)**	(3,377)
Increase in creditors	**23,329**	12
Net cash provided by operating activities	**(5,820)**	(3,920)

Analysis of cash and cash equivalents

	Total funds 2026 £000	Total funds 2025 £000
Cash in hand	**12,432**	**2,169**
Short term investments	**18,810**	**12,555**
Total cash and cash equivalents	**31,242**	14,724

The accounting policies and notes on pages 29 to 40 form part of these financial statements.

1 Accounting policies

a) Basis of preparation

The financial statements are prepared under the historical cost convention as modified to include the revaluation of investments at market value, and in accordance with the Statement of Recommended Practice for Charities (SORP 2019) (Second Edition, effective 1 January 2019) and applicable accounting standards (FRS 102). Newcastle Hospitals Charity meets the definition of a public benefit entity under FRS102.

The accounts are prepared in pounds sterling rounded to the nearest thousand.

b) Going concern

The Trustee considers that there are no material uncertainties regarding the charity's ability to continue as a going concern. Using cash flow projections to March 2028, based on monthly cash flows in the budget and business plan, the Trustee considers current assets are sufficient to meet the cash flows required to meet current liabilities. In addition, the charity's investments are sufficiently liquid to meet future challenges and commitments.

c) Critical accounting judgements and estimates

In preparing these financial statements, management has made judgements, estimates and assumptions that affect the application of the charities accounting policies and the reported assets, liabilities, income and expenditure and the disclosures made in the financial statements. Estimates and judgements are continually evaluated and are based on historical experience and other factors, including expectations of future events that are believed to be reasonable under the circumstances.

Judgements have been made in respect of the valuation of legacy income accrued at the year end. The judgements and changes in policy are explained fully at (j) below.

d) Cash at bank and in hand

Cash at bank and cash in hand includes cash and short-term highly liquid investments with a short maturity of three months or less from the date of acquisition or opening of the deposit or similar account.

e) Financial instruments

The charity only has financial assets and financial liabilities of a kind that qualify as basic financial instruments. Basic financial instruments, including trade and other debtors and creditors are initially recognised at transaction value and subsequently measured at their settlement value.

f) Creditors and provisions

Creditors and provisions are recognised where the charity has a present obligation resulting from a past event that will probably result in the transfer of funds to a third party and the amount due to settle the obligation can be measured or estimated reliably.

g) Foreign currency translation

The charity's functional and presentation currency is pounds sterling. Monetary assets and liabilities denominated in foreign currencies are translated into sterling at the rates of exchange ruling at the balance sheet date. Transactions in foreign currencies are recorded at the rate ruling at the date of the transaction. All differences are recognised in the Statement of financial activities.

h) Income

Income is included in the Statement of financial activities as soon as all conditions for receipt have been met – including entitlement, probability of receipt and measurement of the amount.

1 Accounting policies (continued)

i) Gifts in kind

In line with our income policy, gifts in kind are only included in the financial statements where the value of the gift is material and can be measured and ascertained easily and accurately.

j) Legacies

In line with our income policy, legacy income is accrued at the balance sheet date if it can be shown there is an entitlement to the funds, if there is probability of receipt and the amount can be fairly measured. Only where all three of these factors can be satisfied is an amount included for the year. Legacy notifications and receipts are reviewed up to the date of the approval of the accounts and the results are adjusted if the likely receipt is considered material and there is evidence that we were entitled to the income at the year end.

k) Expenditure

Expenditure is recognised once there is a legal or constructive obligation to transfer economic benefit to a third party, it is probable that a transfer of economic benefit will be required in settlement and the amount of the obligation can be measured reliably.

l) Grants payable and reserves

Grants payable are funding awards approved for payment by the Charity Committee. Awards are made to third parties (including NHS bodies) in the furtherance of the charitable objectives wholly or mainly for the service provided by the Newcastle upon Tyne Hospitals NHS Foundation Trust (patient welfare, staff welfare, equipment and research). They are accounted for on an accruals basis where the conditions for their payment have been met or where a third party has a reasonable expectation that they will receive the grant.

The amount spent on grants in any year is related to the reserves policy of the Trustee, which seeks to maintain a maximum level of unrestricted funds. This allows the charity to maintain its working capital, which provides a regular flow of investment income for grants in future periods.

m) Governance and Support Costs

This includes all expenditure, including salaries, relating to activities that are not directly related to fundraising, charitable activities relating to the Arts or Volunteering Programmes, or the management of grant funding.

n) Investments

Investments are shown at market value. Changes in value during the year, whether realised or unrealised, are included in the statement of financial activities. Investment managers are appointed to manage the portfolios as common investment funds on a discretionary basis. The Trustees do not dictate changes to individual funds within the portfolios. The Trustees choose to disclose investments or withdrawals in relation to the portfolios but not individual acquisitions and disposals within the common investment funds. Investment management costs are met within the net returns notified to the charity by the investment managers and are not disclosed as separate items of expenditure.

1 Accounting policies (continued)

o) Tangible fixed assets and depreciation

Assets costing more than £5,000 are capitalised. Tangible fixed assets are carried at cost, net of depreciation and any provision for impairment.

Depreciation is provided at rates calculated to write off the cost of the assets, less any residual value, over their expected useful lives

p) Intangible fixed assets and amortisation

Intangible fixed assets are carried at cost, net of amortisation and any provision for impairment.

Amortisation is provided at rates calculated to write off the cost of the assets, less any residual value, over their expected useful lives.

Where tangible or intangible assets are in the course of construction or development at the year end, the costs incurred to the balance sheet date are shown as fixed assets.

q) Stocks

Stocks are valued at the lower of cost and net realisable value.

r) Fund structure and objects

All funds are used for the main Objects of the charity. The main categories of funds are:

Restricted – trusts created by donors with specific objects or linked charities;

Designated – unrestricted funds for which the Trustee has set a specific purpose or which are subject to restriction or use within the clinical boards of the NHS Trust; and

Unrestricted – resources that can be used by the Trustee at their discretion.

s) General information

The Newcastle upon Tyne Hospitals NHS Charity is registered as a Charity under the Charities Act 2011. The address of its registered office is:

Newcastle Hospitals Charity, Nelson House, The Fleming, Burdon Terrace, Jesmond, Newcastle upon Tyne, NE2 3AE.

2 Related Party Transactions

The Trust Board of The Newcastle upon Tyne Hospitals NHS Foundation Trust acts as Corporate Trustee for The Newcastle upon Tyne Hospitals Charity. The principal purpose of Newcastle upon Tyne Hospitals NHS Foundation Trust is the provision of NHS healthcare. The charitable trust has made revenue and capital payments to The Newcastle upon Tyne Hospitals NHS Foundation Trust. During the year none of the members of the Corporate Trustee Board, key management staff or parties related to them has undertaken any material transactions with the Newcastle upon Tyne Hospitals Charity.

During the financial year payments of £12,509k (2024/25: £8,193k) were made to the Newcastle upon Tyne Hospitals NHS Foundation Trust in respect of grants, goods and services procured on behalf of the charity and other charges made by the Trust. A further sum of £1,165k was due for payment at 31st March 2026 (This was £971k in 2024/25).

Charges made by Newcastle upon Tyne Hospitals NHS Foundation Trust (£2,054k) for administrative support and overheads, include the provision of staff, which enables the charity to fulfil its statutory duties and provide support for the day-to-day running of the charity. (This was £1,542k in 2024/25).

The Newcastle upon Tyne Hospitals NHS Foundation Trust is the ultimate parent entity as Corporate Trustee. The Corporate Trustee maintains control of the Charity via a Committee - the Charity Committee - which comprises executive and non-executive Directors of the Trust.

The consolidated accounts of Newcastle upon Tyne Hospitals NHS Foundation Trust are available from: Regent Point, Regent Farm Road, Newcastle upon Tyne, NE3 3HD.

There were no expenses or remuneration paid to the Trustees during the year (2024-25: Nil).

There were no transactions with Trustees or connected persons for the year to 31st March 2026 (2024-25: Nil).

No indemnity insurance was provided to the Trustees in the year to 31st March 2026 (2024-25: Nil).

There were no loans or guarantees secured against assets of the Charity in the year to 31st March 2026 (2024-25: Nil).

3 Voluntary income

	2026	2025
	£'000	£'000
Donations	3,224	1,448
Legacies	1,395	6,124
Income from donations and legacies	4,619	7,572
Grants receivable	3,407	325
Fundraising events	31	16
Total	**8,057**	**7,913**

Donations are gifts from businesses, members of the public, grateful patients, relatives of patients and staff.

Legacies are gifts included in Wills, which are for the benefit of services within our local hospitals.

The Charity recognises the contribution of volunteers who supplement the work in our retail subsidiary at the Freeman NHC Shop, the NCCC Shop, and the GNCH Pop up stand. It also notes the contribution at charitable events and, Volunteer services provided across the Trust. The lack of a reliable method of measuring, and the volume of volunteers used, has meant that this contribution is not financially recognised in the accounts of the Charity or the Trust.

Where gifts in kind have a material value these are recorded as income and an equal value recorded as relevant expenditure.

4 Other trading activities

	2026	2025
	£'000	£'000
Lottery	4	-
Retail activities (Note 10.2)	995	576
Total	**999**	**576**

5 Expenditure by activity

	Charitable activities £'000	Cost of Raising funds £'000	Retail Activities £'000	Governance and support costs £'000	2026 total £'000	2025 total £'000
Grant commitments:						
Capital expenditure	30,000	-	-	-	**30,000**	-
Patient education and welfare	1,256	-	-	-	**1,256**	**2,178**
Equipment	1,462	-	-	-	**1,462**	**4,235**
Staff education and welfare	1,434	-	-	-	**1,434**	**1,486**
Medical research	152	-	-	-	**152**	**1,683**
Funding commitments released	(1,116)	-	-	-	**(1,116)**	**(3,049)**
Grant commitments (Note 14)	**33,188**	**-**	**-**	**-**	**33,188**	**6,533**
Expenditure						
Audit fees	-	-	-	15	**15**	**12**
Other fees and services	147	411	-	147	**705**	**304**
Promotion/publicity/events	3	151	-	11	**165**	**199**
Retail activities	-	-	672	-	**672**	**407**
NHS services	-	-	-	54	**54**	**116**
Property related expenditure	43	59	-	44	**146**	**72**
Staff costs (Note 8)	589	650	172	589	**2,000**	**1,426**
Total expenditure	**33,970**	**1,271**	**844**	**860**	**36,945**	**9,069**

Grant commitments were previously shown net of those commitments unused and released in the year (grants written back). More details are shown in Note 14. All grants are made directly to The Newcastle upon Tyne Hospitals NHS Foundation Trust via a scheme of delegation operated by the Corporate Trustee. All grant funded activity is undertaken in accordance with standing orders and financial instructions.

Activities undertaken in relation to Grant Funding, providing the Arts Programme and the Volunteering Services are shown as costs supporting these charitable activities. The cost of time spent by governance and support staff on fundraising is allocated to the cost of raising funds based on an assessment of time spent on that activity. Fundraising, governance and support costs are allocated to relevant funds on an assessment of time spent on that activity.

6 Staff costs

There are no staff employed directly by the charity, the Charity purchases services from Newcastle-upon-Tyne NHS Foundation Trust. Salaries are based on the appropriate NHS Agenda for Change salary bands, terms and conditions.

As employees of Newcastle upon Tyne NHS Foundation Trust all staff are eligible to join the NHS Pension Scheme. All costs associated with the NHS Pension Scheme are recharged to the Charity.

Key management personnel

The key management personnel during the year were the members of the Charity Committee and the senior leadership team. The Charity Committee members received no remuneration in relation to their positions. The senior leadership team is made up of the Charity Director, the Head of Arts Programmes, Associate Director (Fundraising), Associate Director (Funding & Partnerships), Operations Manager and the Charity Head of Finance. All of the senior leadership team are employed by Newcastle upon Tyne Hospitals NHS Foundation Trust.

There were no redundancy or termination payments made in the year (2025: none).

7 Taxation

No tax charge has arisen in the year as the registered charity falls within Chapter 3 of the Corporation Taxes Act 2010 and section 256 of the Taxation of Chargeable Gains Act 1992, and is therefore potentially exempt from taxation of income and gains to the extent that they are applied to its charitable purposes. NHC Retail Limited has paid its taxable profits to the Charity under gift aid. The Charity is not registered for VAT. Expenditure is shown inclusive of VAT. NHC Retail Limited is registered for VAT.

8 Fixed asset investments (Charity)

	2026 total	2025 total
Common investment funds (Note 8.1)	**£'000**	**£'000**
Market value as at 1 April 2025	**34,852**	**44,175**
Withdrawals	**(20,931)**	**(8,971)**
Net movements in valuation	**1,279**	**(352)**
Market value as at 31 March 2026	**15,200**	**34,852**

	2026 total	2025 total
NHC Retail Limited (Note 8.2)	**£'000**	**£'000**
Cost as at 1 April 2025	**20**	**-**
Acquisitions in year	**30**	**20**
Cost value as at 31 March 2026	**50**	**20**

Total investments as at 31 March 2026	**15,250**	**34,872**

At 31 March 2026 the Group fixed asset investments amounted to £15,200,000 (2025: £34,852,000)

8.1 Common investment funds

The charity holds two investment portfolios; all held within the UK. The Trustee chooses not to show investments or withdrawals in relation to these common investment funds as the investment managers make all changes within the portfolios at their own discretion. Performance is measured on a total return and details of changes during the year are not disclosed.

Withdrawals

£3,330,000 was withdrawn during the year to meet operational need.

The Trustee approved the transfer of £7,600,000 held on behalf of The Sir Bobby Robson Foundation to the short-term liquid investment with CCLA to remove the investment risk associated with equity-based investments.

To reduce investment risk and to establish liquid funds to meet liabilities within one year, the Trustee approved the transfer of £10,000,000 to an interest-bearing bank account.

Historic cost of investment

The original value of the investments that were placed into the portfolios was £25,831,000.

8.2 NHC Retail Limited

At 1 October 2024 the Trustee approved the creation of a trading subsidiary to carry out the retail activities of the Charity. 20,000 £1 shares were acquired by the Charity, representing 100% of the ordinary share capital. To provide sufficient operating capital the Charity acquired a further 30,000 £1 ordinary shares in December 2025.

The financial results of the subsidiary for the year ended 31 March 2026 and the six months ended 31 March 2025 were as follows:

	2026 total	2025 total
	£'000	£'000
Income	**995**	**276**
Expenditure	**(844)**	**(236)**
Profit for the period	**151**	**40**
Closing net assets at 31 March 2026	**202**	**60**

9 Debtors

	Group		Charity	
	2026 total £'000	2025 total £'000	2026 total £'000	2025 total £'000
Accrued income	4,766	3,528	4,664	3,493
Prepayments	128	133	128	133
	4,894	3,661	4,792	3,596

10 Creditors: amounts falling due within one year

	Group		Charity	
	2026 total £'000	2025 total £'000	2026 total £'000	2025 total £'000
Trade creditors	1,188	1,009	1,165	971
Accrued expenditure	44	16	40	12
VAT payable	15	10	-	-
Funding awards payable (Note 12)	27,201	12,853	27,201	12,853
	28,448	13,888	28,406	13,836

Trade Creditors (Charity) represents the amount owed to a related party - The Newcastle upon Tyne Hospitals NHS Foundation Trust, for costs incurred on behalf of the charity in the furtherance of the Charity's objects. Trade Creditors (Group) includes suppliers of goods and services to NHC Retail Limited

11 Creditors: amounts falling due after one year

	Group and charity	
	2026 total £'000	2025 total £'000
Funding awards payable (Note 12)	11,110	2,341

12 Funding awards payable

	2026 Unrestricted £'000	2026 Designated £'000	2026 Restricted £'000	2026 Total £'000	2025 Total £'000
Funding commitments at start of year	7,021	6,538	1,635	**15,194**	**15,496**
Funding commitments made during the year	1,257	2,883	30,000	**34,140**	**9,582**
Funding commitments released in year	(365)	(643)	(108)	**(1,116)**	**(3,049)**
Funding commitments paid in year	(2,638)	(4,794)	(2,475)	**(9,907)**	**(6,835)**
Funding commitments at end of year	**5,275**	**3,984**	**29,052**	**38,311**	**15,194**

8

	2026 Unrestricted £'000	2026 Designated £'000	2026 Restricted £'000	2026 Total £'000	2025 Total £'000
Funding awards payable within one year (Note 10)	**4,025**	**3,714**	**19,462**	**27,201**	**12,853**
Funding award payable in more than one year (Note 11)	**1,250**	**270**	**9,590**	**11,110**	**2,341**
	5,275	**3,984**	**29,052**	**38,311**	**15,194**

The majority of our grant commitments are made to Newcastle upon Tyne Hospitals NHS Foundation Trust.

13 Funds

Total funds summary (current year):	Balance 1 April 2025	Income	Expenditure	Transfers between funds	Gains and losses	Balance 31 March 2026
	£'000	£'000	£'000	£'000	£'000	**£'000**
Unrestricted funds						
Designated funds	14,728	4,348	(4,435)	-	-	**14,641**
Unrestricted operational reserve	2,451	1,368	(2,322)	-	1,120	**2,617**
	17,179	5,716	(6,757)	-	1,120	**17,258**
Restricted funds	19,845	4,747	(30,188)	-	159	**(5,437)**
Total Funds	**37,024**	**10,463**	**(36,945)**	**-**	**1,279**	**11,821**

Designated funds

The unrestricted fund balance incorporates c.280 funds that the Trustee has historically agreed to treat as designated funds attached to a specific ward or service. A process of appropriately rationalising these funds is underway. The results and retained profit of NHC Retail is included within designated funds.

14 Commitments

A formal gift agreement was signed between the Charity, on behalf of The Sir Bobby Robson Foundation, and the Trust formally committing up to £30 million to meet the construction and fitting out costs of the development of the Sir Bobby Robson Institute, a cancer clinical trials research facility at the Freeman Hospital site. This support has been recognised in the financial statements as an expense and as a liability due within one year and beyond one year.

In the prior year, The Sir Bobby Robson Foundation Committee had agreed to commit up to £30 million towards the Institute utilising the restricted funds available at 31 March 2025 with a further £10 million to be raised through philanthropy and fundraising support.

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Agenda item A6(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	27 November 2026						
Title	Chief Digital Information Officer Board Report						
Report of	David Elliott, Alliance Chief Digital Information Officer (CDIO)						
Prepared by	Joanne Todd, Newcastle Hospitals Director of Digital						
Status of Report	Public		Private		Internal		
	☒		☐		☐		
Purpose of Report	For Decision		For Assurance		For Information		
	☐		☒		☒		
Summary	**Assure** This paper is to provide assurance to the Board on the Trust's digital enablement and service delivery over the last 12 months. The Report covers key areas of delivery, service and security to provide awareness of Digital and Technology Services activities. It will also highlight progress against the digital objectives in the Trust strategy.						
Recommendation	The Trust Board is requested to note the report.						
Link to Strategic Priorities	Joining up care		Advancing care		Supporting great care		
	☒		☐		☒		
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Reputation	Sustainability
	☒	☒	☒	☒	☒	☒	☒
Link to Board Assurance Framework [BAF]	Failure to develop and implement modern, secure, reliable digital environments that support safe and efficient care.						
Reports previously considered by	Annual update to the Public Trust Board.						

CHIEF DIGITAL OFFICER BOARD REPORT

OVERVIEW

The purpose of the Digital and Technology Service (DaTS) is to enable the digital ambition of the Trust whilst ensuring services are delivered in a safe and secure manner with minimal disruption.

Over the last 12 months DaTS have:

- Delivered over 60 programmes of work
- Taken over 145,000 calls through our service desk
- Managed 118 significant incidents
- 0 cyber incidents
- Made 12 reports to the Data Security Protection Toolkit of which 2 were cyber related
- Taken over 1,500,000 calls through our operator services
- Continued to develop the Great North Care Record

DaTS has worked across the Trust, especially aligned to the 8 clinical boards and enabling corporate functions, to highlight digital demand and prioritise delivery.

Over the next three years, our ambition is for patients to experience more joined-up care, with better integration of records across services and care settings, reducing the need to repeat information. For clinicians, this means easier access to the information they need and digital systems that better support clinical workflows, reduce duplication and release time for patient care. This will require continued integration of records, redesign and optimisation of Cerner, and a focused programme of digital transformation aligned to the Trust's priorities.

Aligned to the highlights above DaTS has been working to ensure future activity is also fully aligned to the Trust Strategy to 2031. Moving forward DaTS will provide:

- Enablement – delivery of major changes
- Foundations – ensure building on a strong base in a safe and secure manner
- Optimisation – build on the current services to ensure maximum return on existing systems
- Innovation – drive future services through innovation
- Skills – ensure skills throughout the Trust to maximise digital enablement

Moving forward it is key that there is a continued drive to:

- Manage and drive the use of data
- Utilise AI and automation
- Drive the adoption and use of centrally owned services like Co-pilot
- Develop services that are suitable for multiple uses across the Trust like digital messaging to patients
- Support the transformational activities within the Trust

Demand for DaTS services is increasing as the need for digital enablement continues to grow across the Trust and the wider NHS. It is essential that DaTS is developed and maintained as a high performing team who recognise the importance of the contribution made to colleagues, patients and their families and the wider community the Trust serves.

DaTS Services:

Delivery

Over the last 12 months the service has worked closely with the Trust's Clinical Boards to understand demand and prioritise the top 3 for each board. This work has then been the key focus of delivery.

Building on the work with Clinical Boards, DaTS will develop a three-year roadmap around a focused set of Trust-wide transformational priorities. These will be identified across clinical services, corporate functions and Trust transformation programmes, with selection driven by their potential to improve patient care, staff experience and organisational performance. The roadmap will bring together record integration, optimisation of existing systems and wider changes to how services operate, with the ambition of delivering a step change in how digital supports the organisation.

Delivery examples include:

- Care for the Dying
- Electronic Meal Ordering
- Continued eRecord Optimisation
- Dental Digitisation

Continued redesign and optimisation of Cerner will be a central part of this work. Working with clinical teams, the focus will be on improving usability, simplifying workflows and making better use of existing functionality. Alongside greater integration with other records and systems, this will support more joined-up care and reduce the administrative burden on clinicians.

Support

Our support teams ensure that the Trust's digital estate is managed and run in a safe and secure manner. This includes being the single point of contact for patients and colleagues.

Over the last 12 months:

- Service desk has received over 145,000 calls with an average speed to answer of 1min 10 secs.
- Operator service has received over 1,500,000 calls with an average speed to answer of 35 secs.
- 118 significant incidents have been managed across the Trust aiming to minimise service disruption

Moving forward a focus on the Trust's business and technology debt to replace, retire and remove will look to reduce service outages and the disruption this can cause. It is key that foundational services are strong to allow the development of digital enablement.

Cyber

It is essential that the Trust is safe and secure particularly from cyber threats. The NHS and therefore the Trust are always seen to be targets of significant potential threats as well as the wider threats as AI is delivered in all elements of health care.

Over the last 12 months the Trust has not had a Cyber incident that has impacted service operations where a supplier or Trust asset has been directly impacted from a Cyber event requiring full cyber incident response.

12 Items have been reported on DSPT portal, 2 of those relate to cyber events but did not cause significant impact to enact full incident response.

Moving forward focus will be on continuing to strengthen cyber defences and to hold regular exercises to test the Trust response should a significant incident occur.

Agenda item A6(a)

Great North Care Record (GNCR)

Work continues to develop and support GNCR. A recent benefits report showed GNCR saves health and care professionals an average of 77 minutes per day, generating approximately £1.5 million in time efficiency savings and demonstrating the potential to deliver up to £18 million in time efficiency savings annually across the system.

Key developments over the past 12 months include the launch of a new user dashboard, expansion in the voluntary and adult social care sector and further integration with other services.

Moving forward GNCR will continue to be developed in line with member needs.

Innovation

There is a need to support and develop digital innovation across the Trust as many of the most significant changes will come from those at the front line of care.

There have been many innovations over the last 12 months with examples being charting visualisation in ITU, development of List Logic to drive increased utilisation in out DTC and use of AI and automation to develop and manage data in our Labs.

Across the Trust over 1,000 Co-pilot licenses are being issued to measure with assistive AI will save our colleagues time to allow them to focus on other tasks.

Moving forward focus will be on facilitating further innovation by creating environments that are safe and secure designed to allow the curious to develop innovation ideas. Innovation comes in many forms, and it is key that an open mindset is in place to allow ideas to be nurtured and a safe environment where initial failures are celebrated as that is the basis to learning.

Summary

DaTS has delivered and supported the Trust to move forward in its digital journey. Moving forward the growing demand on digital enablement will require DaTS to be a high performing area that is fully integrated across the Trust. Investment and prioritisation of that investment will be essential to ensure the greatest impact of digital enablement is delivered to the Trust, colleagues, patients and their families moving forward.

Over the next three years, the emphasis will be on a focused set of Trust-wide transformational priorities that connect records, improve the use of Cerner and other core systems, and embed digital more fully in the redesign and delivery of services.

Report of Dave Elliott
Chief Digital Information Officer
20 November 2026

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PUBLIC BOARD MEETINGS - ACTIONS

Agenda item A6(b)

Log No.	BOARD DATE	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
170	25 Sept 2026	26/28 INTRODUCTION: d. Chief Executive's Report including Thirlwall Inquiry update	Initial observations were shared in relation to the Thirlwall Inquiry, with agreement that a more detailed discussion on the recommendations, implications and required actions be brought back to the Trust Board meeting in November [ACTION01].	IJ			21.10.26 - Included in the November Public Trust Board agenda. Propose to close action.
171	25 Sept 2026	26/28 INTRODUCTION: e. Committee Triple A reports	An update on the specific Never Events, any patient harm and associated learning would be presented to a future Trust Board meeting [ACTION02].	IJ/RC			21.10.26 - Included in the Integrated Board Report in November. Propose to close action.
172	25 Sept 2026	26/29 JOINING UP CARE – WORKING TOGETHER TO GIVE PEOPLE BETTER, QUICKER ACCESS TO EFFECTIVE CARE: b. Integrated Board Report (IBR)	Rob Harrison suggested that it would be beneficial to publish the range of negotiated complaints response timescales to improve transparency regarding both agreed extensions and overall performance. Ian Joy confirmed that this information was reviewed at the Complaints Panel meetings and could therefore be incorporated into future Quality Committee reports [ACTION03].	IJ			26.10.26 - Actioned via the Complaints Panel and followed up through the Experience of Care Group which met on 9th November 2026. Propose to close action.
173	25 Sept 2026	26/30 ADVANCING CARE – IMPROVING PATIENT CARE, EFFECTIVENESS AND QUALITY THROUGH INNOVATION, RESEARCH, IMPROVEMENT AND EDUCATION: e. Winter Plan update	Paul Ennals sought assurance regarding the assessment of corridor care risks and queried whether the current rating accurately reflected the level of concern. Sue Hillyard advised that she was confident the associated risks could be appropriately mitigated; however, it was noted that some organisations reporting lower levels of corridor care had assigned a red risk rating. It was therefore agreed that Sue Hillyard would review the assessment and provide further assurance on the appropriateness of the current risk rating in section 4.1 [ACTION04].	SH			21.10.26 - SH advised that the Corridor Care rating has been changed to red and was submitted on 30 September 2026. 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.