The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Public Trust Board of Directors' Meeting

Friday 28 November 2025, 09.45 – 12.15

Venue: Culture Centre Boardroom, Royal Victoria Infirmary (RVI)

Agenda

Item		Lead	Paper	Timing
1.	Apologies for absence and declarations of interest	Paul Ennals	Verbal	09:45 – 09:46
2.	Minutes of the Meeting held on 26 September 2025 and Matters Arising	Paul Ennals	Attached	09:46 – 09:47
3.	Chair's Report	Paul Ennals	Attached	09:47 – 10:05
4.	Chief Executive's Report, including Care Quality Commission (CQC) and Finance updates	Rob Harrison	Presentation	10:05 – 10:25
Strategic items:				
5.	Patient and Staff Stories	Annie Laverty	Attached	10:25 – 10:32
6.	Board Visibility Programme	Ian Joy	Attached & Reading Room	10:32 – 10:42
7.	Cardiac Surgery update	Michael Wright	Verbal	10:42 – 10:52
8.	Integrated Board Report (IBR)	Patrick Garner	Attached	10:52 – 11:05
9.	The big picture – national and local perspectives on the 10 year plan	Morag Burton & John Isaacs	Attached	11:05 – 11:25
	Comfort break			***11:25 – 11:30***
Items to receive *[NB for information – matters to be raised by exception only]*:				11:30 – 12:05
10.	Director reports:			
	a. Joint Medical Directors Report including:	Michael Wright & Lucia Pareja-Cebrian	Attached	
	i) Guardian of Safe Working Report		Attached	
	b. Executive Director of Nursing Report including:	Ian Joy	Attached	
	i) Nurse staffing review - deep dive		Attached & Reading Room	
	c. Maternity:	Ian Joy & Jenna Wall		
	i) Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress report		Attached & Reading Room	
	ii) Maternity Safety Champion Report	Liz Bromley	Attached	
	d. People update: Sexual Safety Audit	Vicky McFarlane-Reid	Attached	

11.	Provider Capability Assessment	Patrick Garner	Attached	
12.	Committee Updates: a. Chair Meeting Logs b. Alliance Committees Update on progress	 Committee Chairs Martin Wilson	 Attached Attached	
13.	Health and Safety Annual Report	Ian Joy	Attached	
Items to approve:				12:05 – 12:08
14.	Board Assurance Framework (BAF)	Patrick Garner	Attached	
Any other business:				12:08 – 12:15
15.	Meeting Action Log	Paul Ennals	Attached	
16.	Any other business	All	Verbal	

Date of next meeting:
Public Board of Directors – Friday 30 January 2026

Sir Paul Ennals, Chair

Mrs Liz Bromley, Non-Executive Director and Maternity Safety Champion

Mr Rob Harrison, Acting Chief Executive Officer

Mr Ian Joy, Executive Director of Nursing

Dr Michael Wright, Joint Medical Director

Mrs Lucia Pareja-Cebrian, Joint Medical Director

Dr Vicky McFarlane-Reid, Director for Commercial Development & Innovation

Mr Patrick Garner, Director of Performance and Governance

Mrs Annie Laverty, Chief Experience Officer

Mrs Jenna Wall, Director of Midwifery

Professor John Isaacs, Associate Medical Director for Research

Morag Burton, Network Director NIHR Research Delivery Network: North East and North Cumbria

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PUBLIC TRUST BOARD OF DIRECTORS MEETING

DRAFT MINUTES OF THE MEETING HELD 26 SEPTEMBER 2025

Present:	Paul Ennals *[Chair]*	Chair
	Rob Harrison	Acting Chief Executive Officer
	Lucia Pareja-Cebrian	Joint Medical Director *(from 10:18)*
	Jackie Bilcliff	Chief Finance Officer
	Ian Joy	Executive Director of Nursing
	Vicky McFarlane Reid	Director for Commercial Development & Innovation
	Sue Hillyard	Interim Director of Operations
	Bill MacLeod	Non-Executive Director (NED)
	Liz Bromley	NED
	David Weatherburn	NED
	Anna Stabler	NED
	Bernie McCardle	NED
	Hassan Kajee	NED
	Phil Kane	NED
	Wendy Balmain	NED

In attendance:
Nini Adetuberu, Associate NED
Paul Hanson, Director of Estates, Facilities and Strategic Partnerships
Caroline Docking, Director of Communications and Corporate Affairs
Rachel Carter, Director of Quality and Safety
Patrick Garner, Director of Performance and Governance
Annie Laverty, Chief Experience Officer
Kelly Jupp, Trust Secretary
Russell Jones, Deputy Director of Estates
Jenna Wall, Director of Midwifery *(for item 25/23 i) c))*

Observers:
David Black, Appointed Governor
James Boyle, Enterprise Accounts Manager, Medtronic UK and Ireland
Andrew Goldsborough, Trainee Healthcare Scientist, Newcastle Hospitals
Andy Roughan, Videographer, Northumbria Healthcare NHS Foundation Trust

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.

25/21 <u>STANDING ITEMS:</u>

i) Apologies for Absence and Declarations of Interest

Paul Ennals welcomed all to the meeting.

Apologies were received from Michael Wright, Joint Medical Director, Amy Callow, Associate Director for People and Organisation Development, and Martin Wilson, Director - Great North Healthcare Alliance (GNHA) & Strategy.

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

ii) Minutes of the previous meeting held on 25 July 2025 and matters arising

The minutes of the meeting held on 25 July 2025 were accepted as a true record of the business transacted.

Paul Ennals noted with sadness that Lexi, the patient who shared a remarkable letter as part of the Patient and Staff Stories item at the previous Public Board meeting, had since passed away. The Board of Directors expressed their condolences and gratitude for Lexi's contribution in helping to improve care through the sharing of her experiences.

It was recognised that the winter plan had been discussed at length through several forums such as the Finance and Performance Committee.

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

iii) Chair's Report

The Chair's Report was received for information.

Paul Ennals acknowledged the sense of renewal that the month of September brought, similar to the start of a new academic year. He shared reflections on both positive developments and areas of challenge since the last Public Board meeting in July.

In relation to the Great North Run (GNR), over 500 runners had participated this year on behalf of Newcastle Hospitals, Feedback from our charity participants was overwhelmingly positive, with the event considered a great success. Places were now available for the GNR 2026.

The ongoing financial challenges affecting all areas of the NHS was noted, along with the impact these pressures were having locally and nationally. Reference was made to a recent Health Service Journal (HSJ) article which highlighted the financial strain across the sector. Paul Ennals emphasised the importance of maintaining morale and momentum across teams, remaining consistent and continuous in efforts to improve the financial position despite external pressures.

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

[Lucia Pareja-Cebrian joined the meeting]

iv) Chief Executive's Report, including CQC update:

Rob Harrison highlighted the following points:

- The eight big signals identified across the organisation, which had been translated into 3 focused priority areas for improvement.
- The Trust moved to Segment 2 in the NHS Oversight Framework, with an increase of 50 places, reflecting organisational growth and opportunity.
- Gratitude was expressed to all colleagues across the organisation for their hard work and ongoing commitment to patient care.
- The importance of access to care.
- Emphasis on the need to tighten financial planning, particularly in preparation for winter pressures.
- Recognition of the importance of staff wellbeing, cultural engagement, and support initiatives.
- Opportunities for improvement such as Health Care Associated Infections (HCAI), sickness absence, productivity and cancer waiting times were also key improvement areas in the next 5-year strategic plan.

A discussion ensued regarding the Well-Led Improvement programme and delivering meaningful change.

Jackie Bilcliff noted the following points:

- At month 5 position, the Trust had an on-plan deficit of £8.4m, with a trajectory to breakeven by the year-end.
- £33m in savings had been achieved, largely non-recurrently which meant that focus was required on delivery of recurrent savings.
- The capital plan was slightly ahead of schedule, forecasted to meet the year-end targets despite delivery pressures.
- Risks identified regarding financial plan delivery related to the subsidiary company establishment, elective activity, and the pay award.

Paul Ennals thanked Jackie Bilcliff and the finance team for their significant efforts.

Ian Joy highlighted the following points:

- The Integrated Quality Improvement Group (IQIG) met this week with no escalations reported.
- The next formal meeting with the Care Quality Commission (CQC) was scheduled for next week.
- The CQC action plan remained under Quality Committee oversight; two actions were behind schedule, but recovery plans were in place.

Paul Ennals noted the gradual embedding of CQC actions into business as usual and welcomed the shift away from having CQC as a separate standing agenda item.

Liz Bromley queried if there was a clinical services team included in the winter plan focussed on keeping patients at home and reducing Accident & Emergency (A&E) attendance. Sue Hillyard advised that the new Director of Community Services would focus on enhancing winter readiness. Work was underway on the Neighbourhood Health Strategy and hospital flow model, including integration with the Discharge Team.

Paul Ennals encouraged all Board members to receive their flu vaccinations before the next Public Trust Board meeting. Ian Joy advised that the vaccination programme would go-live next week, with planned appointments and peer vaccinators available. Paul Ennals stressed the importance of collective action and leadership on this and Ian Joy agreed to coordinate a flu vaccination drop in session on the day of the next Board meeting for those who wished to be vaccinated **[ACTION01]**.

Anna Stabler highlighted that the dashboard showed improvement in 65 week wait performance and queried if the national target to eradicate by mid-December was ambitious or achievable. Patrick Garner explained that the trajectory was to reach zero by the financial year-end, with risks in corneal grafts (material shortage) and spinal deformity (staffing and profiling of elective activity).

Phil Kane noted the changes in national policy in terms of Covid vaccinations and sought clarification regarding if potential Covid cases amongst staff would be monitored. Lucia Pareja-Cebrian advised that sickness absence would be monitored/reported. Ian Joy explained that close monitoring of patient numbers and impact would also take place.

Paul Ennals emphasised the importance of a forward-looking strategy, financial mitigation, and leadership beyond 2026. Efforts on winter planning and vaccination were acknowledged.

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

iii) Chair's Report

Paul Ennals referred to the Chair's Report discussed earlier and explained that it included the Board Development Programme for approval. Sustainability was agreed to be added as a key discussion topic in the next 12 months, and flexibility retained to adapt to evolving needs.

It was **resolved:** to **receive** the report and **approve** the Board Development Programme.

25/22 STRATEGIC ITEMS:

i) Patient and Staff Stories

Annie Laverty emphasised the importance of human connection in care delivery. The patient story from Ward 35 highlighted staff behaviours that brought warmth and

compassion, linked to the spirit of Christmas and family. The Pyjama campaign across the hospital was mentioned which reinforced dignity and comfort for patients. The family involved planned to continue their work in 2025.

In relation to the staff story, in maternity, patient experience was tracked monthly with live data shared openly with staff to drive improvement. Rachael, Midwife & Deputy Matron, reflected on the belief that every woman deserved choice and control in their care. A story was shared showing how culturally sensitive care supports staff wellbeing, patient dignity and compassionate care.

Ian Joy highlighted the value of staff spending meaningful time with patients and that while care was safe, in some cases it lacked the emotional depth seen in ward 35's example. He reinforced that staff were committed to delivering the highest standards but there was a need to identify space to reflect on patient experiences.

Liz Bromley advocated the use of learning and Continuing Professional Development (CPD) and suggested using the ward 35 story as a best practice example in leadership programmes.

Paul Ennals shared his views on learning and reflection, acknowledging the need for deeper/more challenging discussions as appropriate.

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

ii) <u>NHS Staff Survey update</u>

Vicky McFarlane-Reid highlighted the following points:

- Strong collaboration between the People Directorate, staff experience team, and the communications team.
- The robust campaign to promote the staff survey which included:
    - Ensuring that staff had sufficient time and space to complete the survey within the nine-week window for completion.
    - Weekly sitreps – fostering healthy competition across teams.
    - A small thank you in the form of a breakfast voucher from Greggs for everyone completing a survey.
- The aim was to achieve a 75% response rate. This would demonstrate meaningful engagement, with the ambition of having a workforce that felt cared for and valued. Communications messages were noted to be vital in driving participation and engagement.

Paul Ennals noted the importance of reinforcing that feedback was heard and acted on from the last survey to build trust and credibility.

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

iii) <u>Board Visibility Programme</u>

Rachel Carter noted the following points:

- 20 visits were conducted between June 2025 and August 2025 with full details available in the AdminControl Reading Room.
- The themes identified were reassuring, confirming known issues already being addressed.
- The programme ensured engagement and feedback with staff who may not hear updates through other channels.
- Stream 2 was functioning well, supporting meaningful reflection and learning.
- Stream 1 was maturing. This stream focused on Clinical Board senior leaders, Director and Executive Director involvement. There were four visits per month which were open to all colleagues.
- The programme ensured visibility and connection between leadership and frontline teams.

Rob Harrison emphasised the importance of balancing the formal visits structure with informal visibility and encouraged leaders to continue walkabouts as part of their roles, ensuring presence and connection without being constrained by the visits process itself. A discussion ensued which covered:

- The potential risk of reducing impact if the programme became overly formalised.
- The need for a clear mechanism to escalate items identified during any informal interactions to ensure they were acted upon appropriately. A structured process was noted to be in place to document and escalate concerns or themes requiring attention from the formal visits.
- The follow up of any issues raised at NED visits. David Weatherburn advised that following his most recent visit to Hepatology, Ian Joy had already responded to an issue raised.
- Building informal working relationships was important and contributing positively to service improvement. David Weatherburn noted that not every contact/meeting required formal reporting and advised that he had regular contact with the palliative care team every two weeks.
- Staff appreciation that visits were being conducted, staff were being listened to and that visible changes and improvements were becoming evident during follow-up visits.
- Expectations regarding issues raised and actions taken.

Paul Ennals noted the value of the visits and that they were taken seriously by the Executive Team. The Board of Directors supported the recommendation to streamline reporting to remove the inclusion of the regular Clinical Board leadership team visits.

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

iv) <u>Sustainability update</u>

Paul Ennals advised that he and Vicky McFarlane-Reid were the Trust Board Champions for sustainability.

James Dixon highlighted the following points:

- The Annual Sustainability Report and Carbon Reduction Plan were presented, fulfilling requirements under procurement regulations and demonstrating the Trust's commitment to reducing carbon emissions.
- The SHINE Report included performance metrics and strategic updates, with contributions to the report from across the organisation.
- Controllable emissions had dropped by 13%, reflecting post-COVID estate adjustments, including the closure of expanded testing labs.
- Achieved an 18% reduction in carbon emissions, despite the high carbon intensity associated with patient care.
- The Tyne Bridge initiative was highlighted as a success, though integration into the broader sustainability strategy remained a challenge.
- The Carbon Reduction Plan was scheduled for Board approval in March 2026, with an action plan to be finalised by the end of the financial year.
- Proposal to align sustainability planning with the Trust's wider strategy, with a request for sustainability to be included in the Quarter 4 Board Development Programme.

  As discussed earlier, Kelly Jupp agreed to amend the Board Development Programme to incorporate sustainability into Quarter 4 of the programme **[ACTION02]**.
- Ongoing challenges included:
  - Climate emergency impacts (e.g. heatwaves) affecting service delivery.
  - Capacity and financial constraints, despite notable successes.
  - Gaps in sustainability leadership roles within Clinical and Corporate Boards, with training and development needed.
- The Estates Net Zero Team had secured £42 million in external grant funding, with 25% allocated to the Freeman Hospital. Solutions were still needed for the remaining 75%.
- There was potential for increased collaboration with local authorities and regional alliances. Liz Bromley suggested linking in with Liam Carr, Sustainability and Curriculum Officer, from the Newcastle College Group to share insights and challenges.

Paul Ennals sought clarification regarding Alliance working to which Paul Hanson summarised the decarbonisation plans, which included collaboration with Northumbria Healthcare, Gateshead Health, and North Cumbria Integrated Care. The Net Zero workstream was active under the climate emergency programme.

Bill MacLeod raised the importance of factoring sustainability into neighbourhood health and the Urgent Treatment Centre (UTC) developments. Paul Hanson advised that this is being addressed through a 10-year asset management plan, embedding low-carbon design and energy standards at every stage.

Paul Ennals noted the interest from Trust Governors in sustainability efforts and emphasised the need for a mechanism to integrate sustainability into the wider Trust strategy and Board Development Programme. He acknowledged the financial challenges but commended the progress in securing external funding and building commitment to Net Zero and encouraged collaborative working across Newcastle and the Alliance.

It was **resolved:** to **receive** the report and **approve** the Annual Sustainability Report and Carbon Reduction Plan for publication.

v) Integrated Board Report (IBR)

Patrick Garner highlighted the following points:

- The IBR now included further detail on the NHS Oversight Framework.
- Five metrics showed special cause variation, indicating significant changes in performance.
- Never Events remained a key patient safety priority.
- Mortality indicators had shifted from common cause variation to special cause, with data now below the monthly average.
- Maternity triage was moved from special cause variation to common cause, indicating stabilisation.
- Five of the seven Key Performance Indicators (KPIs) showed an improving trend.
- A&E performance (arrival to admission/discharge) had improved, though challenges remained post-July with performance at 79.3%.
- Radiotherapy waiting times showed a positive shift, attributed to successful staff recruitment, including overseas recruitment.

Anna Stabler highlighted the ongoing work to address performance under the Patient Safety Incident Response Framework (PSIRF).

Rachel Carter advised that in relation to the National Safety Standards for Invasive Procedures (NatSIPs), regular meetings with Clinical Boards and surgical specialties had taken place to increase visibility and process understanding.

Nini Adetuberu referred to the Trust's target of zero Never Events, stressing the importance of learning to prevent recurrence. Rachel Carter agreed, noting that while the recent Never Events occurred in Orthopaedics, they involved different teams and contexts. Immediate learning was shared with teams, with full investigations taking up to six months and requiring engagement with both medical and nursing teams.

Lucia Pareja-Cebrian highlighted the extensive work under the NatSIPs programme, particularly through the Interventional Procedures Group. While Never Events occurred, they were not associated with patient harm but still required learning.

Rob Harrison explained that the culture of learning and engagement was crucial, and noted the importance of recognition and buy-in across teams, beyond just having formal mechanisms for learning in place.

Ian Joy advised that concerns had been addressed regarding variation in maternity services performance metrics, particularly in the assessment unit. Response times had improved and were now in line with expectations, with updates discussed at the Quality Committee.

Paul Ennals questioned the 52-week waits in community services. Patrick Garner advised that this related to Podiatry, which had been integrated into the diabetes service, resulting

in reduced community resource, and Children & Young People's Speech and Language Therapy (SALT) which was part of the autism diagnostic pathway, where capacity was insufficient to meet demand. Discussions with commissioners were ongoing, and the Newcastle PLACE Board was exploring options to increase capacity, though this would take time. Community wait performance had been flagged through the Finance and Performance Committee and would be discussed further at a deep dive in the November meeting. Paul Ennals acknowledged the strong focus on this issue and the need for continued strategic oversight.

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

25/23 ITEMS TO RECEIVE

i) Director reports:

a. Joint Medical Directors (JMD) Report

Lucia Pareja-Cebrian highlighted the following points:

- There remained a significant focus on reviewing cancer performance and patient pathways. Opportunities for improvement had been identified in the 62 week wait in upper and lower GI, lung and urology. In relation to the lung cancer pathway, ongoing discussions were taking place regarding treatment locations and pathway changes.
- The National Cancer Patient Experience Survey had been published. Some feedback received reflected experiences across the full pathway, not just within Newcastle Hospitals. Work was taking place regarding response rates, and specifically to improve the response rates in relation ethnic diversity.
- With regards to the High-Level Isolation Unit, funding had been secured and refurbishment plans developed.
- Martha's rule had been fully implemented and there was an ongoing data review to assess the impact.
- The Trust introduced an Opt-Out initiative for Blood Borne Virus (BBV) testing in the Emergency Department (ED) in March 2025. The programme had been successful in identifying patients with active HIV, Hepatitis C, or Hepatitis B infections who may not have otherwise received a diagnosis.
- Newcastle Hospitals received a response rate of 66.4% for the General Medical Council (GMC) Trainee survey. Small improvements were noted however further progress was needed. Issues that were raised related to Wi-Fi and IT access and availability of hot food. The junior doctor mess refurbishment had been completed since the survey. Bullying and harassment was acknowledged as an area of concern, with actions planned to encourage speaking up, and to reduce any incidences.
- Newcastle Hospitals was ranked lowest out of the 10 hospitals in the Shelford Group for the Trainer survey results, as it had for three consecutive years. Changes to the recently reviewed job planning policy would improve the time available for training and it was hoped that this would lead to improvements in next year's survey.

Paul Ennals advised that the GMC survey results were discussed in detail at the most recent People Committee meeting. Bernie McCardle, Committee Chair noted the expected

improvement in job planning and that potential cultural issues such as bullying and harassment were taken seriously with appropriate actions taking place.

NHS England (NHSE) had published a 10-point plan to improve the working lives of resident doctors which covered some of the aspects referred to in the GMC survey. There was a requirement to undertake work in areas identified for improvement, taking into consideration that trainees moved locations on 8 week rotations. An update was planned for the People Committee in early spring 2026.

Anna Stabler advised over recent years, assurance had been gained on the 104-day harm review process and the implementation of the Call for Concern initiative. Oversight of these processes had now been devolved to Tier 2 Committees, which would manage operational oversight and escalate any issues as appropriate to the Quality Committee to ensure strategic oversight and accountability.

Paul Ennals referred to the two regulation 28 reports received and that significant discussion had taken place at the most recent Council of Governors meeting. Lucia Pareja-Cebrian explained that two reports were received in early September 2025 relating to Surgical-Associated Infection and Mechanical Thrombectomy. In both cases, it was determined that the recommendations would not have altered the outcomes for the individual patients involved. For the surgical-associated infection case, the pathway was being reviewed, and implementation of recommendations progressing. Responses to the Coroner would include detailed actions being taken, where appropriate.

Rob Harrison noted the importance of learning to prevent future harm. Mechanical thrombectomy was a commissioned service, and the case had been reviewed in that context.

David Weatherburn shared his feedback as a former clinical litigation lawyer. It was acknowledged that changes in Coroners may result in variability in reporting and engagement, but the Trust remained committed to taking the matters seriously and responding appropriately.

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

b. <u>Executive Director of Nursing Report</u>

Ian Joy highlighted the following points:

- September was a busy month, with increased pressure regarding demand and acuity levels.
- Trust nurse staffing escalation had been stepped down to level 1.
- In relation to nurse staffing and clinical outcomes, Medicine and Elderly Care wards were specifically highlighted as follows:
    - The Matron and Sister in Charge had worked well to balance the impact of staff absence with maintaining the highest standards of patient care.
    - Oversight and mitigation measures were in place and functioning effectively.

- In terms of reporting to the Quality Committee, safeguarding teams continued to deliver excellent internal services and acted as a valued system partner. Safeguarding activity levels had increased in both numbers and complexity across all providers. The Trust internal audit report in 2024 in relation to Safeguarding governance and risk management had ten recommended actions. A separate review of the governance system was underway to ensure processes were streamlined and effective.
- Regarding the learning disabilities activity, ongoing improvement work continued under Integrated Quality Improvement Group (IQIG) and continued work with the CQC. Local teams were delivering exceptional work, focussed on learning disability care and ensuring reasonable adjustments to improve equity and access.
- Recruitment and retention work continued with the Trust being shortlisted for a Nursing Times Workforce Award.

Paul Ennals acknowledged the significant effort made by staff across multiple areas and noted that the updates had been discussed through various Committees. He expressed thanks and appreciation to all staff for their continued commitment and resilience.

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

c. Maternity

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

Jenna Wall highlighted the following points:

- September was a busy month for maternity services, with increased activity and preparation for the national transformation programme expected to launch during the month.
- The Trust triggered a further quarterly safety alert for the number of stillbirths on the North East North Cumbria Clinical Indicators Dashboard in Quarter 1. Further analytics were performed which indicated duplicate counting and rounded numbers, when these cases were removed the Trust returned to within a 95% confidence limit.
- The Operational Pressure Escalation Level (OPEL) status remained in a good position.
- The six-monthly deep dive report staffing report was available in the AdminControl Reading Room.
- Collaboration with perioperative services was ongoing on the future staffing model in response to recent patient safety incidents in obstetric theatres, linked to Safety Action 5.
- Fetal medicine services were being supported by locum staff, with compensatory rest arrangements in place, compliant with Safety Action 4.
- Staffing levels were relatively strong, though compliance with Safety Action 5 continued to present risks.
- Compliance with the Perinatal Quality Surveillance Model (PQSM) and the receipt of the minimum data measures in accordance with Safety Action 9.

Anna Stabler noted the importance of speaking to the national team to rectify the safety alert dashboard issue to which Ian Joy advised that Jenna Wall had escalated to the North

East and North Cumbria Integrated Care Board (ICB) and that he would escalate further if deemed necessary.

Paul Ennals highlighted the progress regarding the perinatal culture and wellbeing action plan (linked to safety action 4) however noted that there was a continuing risk around compliance with safety action 5 and the neonatal critical care review.

The scope of the nationally led maternity review was queried, and whether any exceptions were anticipated. Jenna Wall advised that the Terms of Reference (ToR) for the review were consistent with previous national reviews, e.g. Ockenden. Organisations subject to the review would be contacted within a three-month period, beginning in December 2025. An initial assessment indicated that the Trust was in a strong position, and no unexpected issues were anticipated.

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

ii) Maternity Safety Champion Report

Liz Bromley highlighted the following points:

- The maternity leadership team continued to facilitate high-level discussions on clinical concerns, safety, and Equality, Diversity & Inclusion (EDI) awareness.
- The value of having access to detailed insights was noted and the openness of conversations was praised.
- Staff were increasingly willing to speak up, supported by the visible presence of Trust Board members, which fostered familiarity and trust.
- Confidence in Jenna Wall's leadership, particularly in understanding what was going well, areas for improvement, and what actions were being taken.

Board members discussed:

- The expected national reviews of maternity services and the importance of comparing the Trust's performance/position against any issues identified in any published national reports.
- The need to learn from recent media stories and any incidents that had occurred in other Trusts. Jenna Wall advised that benchmarking was being conducted using CQC reports and other learning sources e.g. the recent HSJ article from Leeds Trust.
- The relationship between the Intensive Treatment Unit (ITU) and low dependency care, and the maternity demand against the specialised commissioning position.
- The national survey results for Maternity were expected within the next six weeks.

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

d. People Plan Update

Vicky McFarlane-Reid provided a verbal update. Year 2 of the People Plan was noted to mark a shift from listening and planning in Year 1 to implementation and delivery. The plan was closely aligned with key strategic priorities, with a strong focus on improving the experience for colleagues across the Trust. The plan included building a dedicated team for

psychological support (with over 300 Mental Health First Aiders now active across the organisation), the launch of a self-referral service within Occupational Health and the appointment of two Freedom to Speak Up Guardians (FTSUG).

Embedding HR resources directly within Clinical Boards to support local delivery and responsiveness was an important area.

Bernie McCardle advised that an update was provided at the most recent People Committee and that Year 2 progress would be monitored and assurance sought in future meetings. Year 1 actions had successfully established the infrastructure, and Year 2 was focused on building outcomes and delivering impact.

Caroline Docking explained that ongoing EDI work, which included the ambition to become an anti-racist organisation, was being incorporated into the People Plan. Actions were being aligned to ensure consistency and visibility across programmes.

All acknowledged that embedding the plan would take time, but that progress was evident. Paul Ennals thanked staff on behalf of the Board for their continued commitment and effort in delivering the People Plan and supporting colleagues.

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

ii) Committee Chair Meeting Logs

The Trust Board received the Committee Chair Meeting Logs for information.

In relation to the Quality Committee, Anna Stabler advised that assurance had been sought from the Cardiac Oversight Group regarding completion of the original Cardio action plan which included actions related to external reports and CQC findings. The final action was signed off as complete at the end of August 2025, being the return of resident training doctors with immediate effect from August next year. The Group was chaired by a Non Executive Director (NED), in line with the Accountability Framework. The recommendation to be made at the Private Board meeting later today would be to consider transitioning the Oversight group to an Executive chaired improvement group meeting rather than NED chaired. It was noted that the phase 2 action plan included further cultural development work and TheValueCircle programme outcomes. Ian Joy explained that the new Improvement Group will continue to report into the Quality Committee.

With regards to the People Committee, Bernie McCardle referred to the court case regarding sex and gender and advised that work was ongoing in this area, with an update to be provided to the People Committee in due course. The resident doctor dispute was not yet fully resolved and during the Guardian of Safe Working update, it was noted that potential changes in exception reporting were being considered. Monitoring of resource impact was underway.

Bill MacLeod reported that at the July Finance and Performance Committee, the Peri-operative and Critical Care Clinical Board presented a challenging financial position, which would require continued oversight and strategic planning.

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

25/24 ITEMS TO APPROVE:

i) Board Assurance Framework (BAF)

Patrick Garner highlighted the following points:

- With regards to the Quality Committee, eight new threats had been added, and six actions were currently behind plan with new timescales added.
- In relation to the People Committee, threat assurance levels had been updated from red to amber.
- 3 new actions were added to the Finance and Performance Committee relating to consideration of cash management guidance from NHSE, development of forecasting models and NHS Oversight Framework (NOF) metrics.
- The Audit, Risk & Assurance Committee (ARAC) risk scores remained unchanged, with all previous actions completed and the interim strategy approved.
- One new action was added for the Trust Board in relation to the commencement of a Shared Chair to extend the remit to include Gateshead Health NHS Foundation Trust from 1 October 2025.

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

25/25 ANY OTHER BUSINESS:

i) Meeting Action Log

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

ii) Any other business

There was no any other business discussed and the meeting closed at 11.57am.

Date of next meeting:
Public Board of Directors – Friday 28 November 2025

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Agenda Item A3

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 November 2025					
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 2025: • Board Activity • Governor Activity • Informal Visits • Alliance • External Meetings					
Recommendation	The Board is asked to note the contents of the report.					
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. Pioneers – Ensuring that we are at the forefront of health innovation and research.					
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.					

CHAIRS REPORT

As we head towards the end of the year, November is often a time for reflection and gratitude especially to those who gave their today for our tomorrow. I have attended two memorial events and laid wreathes on behalf of the NHS.

From 1 October 2025 my role as Shared Chair was formally expanded to include Gateshead Health NHS Foundation Trust and I have continued with my comprehensive induction programme at Gateshead.

BOARD ACTIVITY

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

- Discussions in relation to the key findings from our external well-led review. We received some initial headline feedback and discussed next steps in terms of areas for action.
- Reviewing our Provider Capability Assessment submission and identifying further areas of improvement.
- Continuing our preparation for the Care Quality Commission (CQC) well-led re-inspection through recapping on roles and responsibilities, governance structures and processes, and culture and behaviours.
- Revisiting psychological safety both within the Board of Directors and in strengthening our Trust wide culture.

ACTIVITY WITH GOVERNORS AND MEMBERS

At our Governor Workshop in October, in addition to our standard reports, we continued our focus on Equality, Diversity and Inclusion (EDI) facilitated by our Executive Leads Caroline Docking and Martin Wilson, with Lee-Anne Naidoo, Improvement Programme Manager. We revisited progress during 2025/26, focussing specifically on the progress made since the previous Governor update in July and plans for October. Lee-Anne shared an update on the development of our Anti Racist Framework and we discussed the implications for the Trust of the Supreme Court Judgement regarding the term ‘sex’.

The workshop included an update from Rob Harrison, Chief Executive Officer (CEO), on local matters, recent news and achievements, regular reports on patient and staff experience, performance and finance, as well as a more detailed Estates update. We also heard about the work of two of our assurance Committees from Anna Stabler, Non-Executive Director (NED) Chair of the Quality Committee and Hassan Kajee, NED Chair of the Digital and Data Committee.

Plans are well underway for our next members’ event on 4 December focussed on diabetes and technology. At the event we will share information on the latest technology being used to improve health outcomes and quality of life for people living with type 1 diabetes, particularly for pregnant women. We look forward to seeing you there.

INFORMAL VISITS

I have continued with my informal visits across all parts of the organisation to meet with staff. To pick out some examples:

- I visited the Emergency Department at the Royal Victoria Infirmary (RVI) during the recent round of industrial action for resident doctors. I observed the true commitment and dedication shown by staff to patients and to each other during these challenging times.

- Located at the Freeman Hospital is our Northern Centre for Cancer care (NCCC). My visit to NCCC highlighted the innovative work being undertaken within our Trust to treat patients with cancer. I witnessed first-hand the excellent quality of care and compassion shown to our patients.

- Since Alliance collaboration has enabled us to reduce waiting lists for cardiothoracic events, I was given the opportunity to follow the revised patient pathway and understand how collaboration has been producing improvements in patient outcomes.

- Along with Anna Stabler, I attended an evening visit to multiple wards at our Freeman Hospital; key issues are contained within the Board Visibility Report that goes to our Public Board meetings.

ALLIANCE

The momentum for joint working continues at pace, and each month we can see more evidence of positive outcomes from the collaborative work that we have initiated. There continues to be good progress with Alliance developments.

Monthly meetings of the Joint Committee (of the 3 East Coast trusts) and the Committee in Common (all 4 partners) continue, where we receive regular reports on progress in the three areas of delegated authority (IT, finance and research), and consider progress on the range of bilateral collaborations.

OTHER MEETINGS AND INFORMATION

Monthly I meet with the Chair, CEO and senior officers of the Integrated Care Board (ICB), along with other Foundation Trust Chairs, to discuss issues of common interest. There is also a strong informal network between Chairs now, in recognition that some colleagues elsewhere in the region are facing some real organisational challenges – I am doing my best to ensure that we can support colleague trusts wherever possible, and am grateful for the support that has been offered by several Board colleagues to neighbouring trusts.

As mentioned in my previous report, focus has continued on the challenging financial position together with medium-term planning for 2026/27, and has involved me in direct meetings with NHS England and the ICB.

Along with Anna Stabler and Caroline Docking, our Director of Communications and Corporate Affairs, I attended the Trust Celebrating Transplantation event, which included a conversation on 'The Story of a Heart', a book written by Dr Rachel Clarke. The book told the extraordinary tale of the heart transplant between two children, Max Johnson and Keira Ball, that changed UK legal history. Max's mum was present for the truly uplifting evening.

I also had the privilege of attending our recent Celebrating Excellence Awards ceremony for staff where I shared presenting duties with Rob Harrison. Great event.

Both events highlighted the fantastic care and treatment being provided across the Trust.

Since the previous Board meeting there has been a significant number of national publications, consultations and guidance documents released which we are in the process of reviewing and understanding from a governance perspective. This includes the draft Advanced Foundation Trust programme guide for applicants which is out to consultation until 11 January 2026.

We are in an active period of change within the NHS, nationally and regionally. I spent a fruitful two days with NHS Providers, providing me with the opportunity to discuss a range of issues with our substantive CEO Jim Mackey.

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

RECOMMENDATION

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

Report of Sir Paul Ennals
Chair
20 November 2025

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Agenda item A5

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 November 2025					
Title	Patient and Staff Stories					
Report of	Annie Laverty – Chief Experience Officer					
Prepared by	Marilyn Hodges – Associate Director Patient and Staff Experience					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	**Patient Experience Story:** Grahame, a retired nurse, shares a powerful and deeply personal account of his seven-week stay at the Freeman Hospital following renal failure and complex health challenges. Despite enduring severe pain and feeling depersonalised as "bed A6," Grahame's story highlights missed opportunities for compassionate, person-centred care. His experience underscores the emotional impact of assumptions, fragmented care, and poor discharge planning — but also the transformative power of kindness, as shown by a Dietitian who simply saw him as a person. Grahame's reflections call for renewed focus on listening, empathy, and the core values of nursing. **Staff Experience Story:** Hazel and Delfim, Domestic Assistants on Ward 3 (Children's Haematopoietic Stem Cell Transplant Unit) at the Great North Children's Hospital, play a vital role in supporting families through long and challenging hospital stays. Known for their warmth, humour and dedication, they bring a sense of normality to patients and their parents alike and are regularly mentioned in Real Time Patient Experience feedback as "making the world a better place". Their commitment to infection control, emotional resilience, and ability to connect across cultures exemplifies the compassionate care that underpins Ward 3.					
Recommendation	The Board is asked to receive both stories for information and to note our commitment to learning from all experiences of receiving and providing care.					
Links to Strategic Objectives	Putting patients at the heart of everything we do and providing care of the highest standard, focusing on safety and quality.					
	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☒	☐
Link to Board Assurance Framework [BAF]	Linked to key areas in the BAF relating to the quality and safety of care and workforce.					
Reports previously considered by	Patient and People stories are a recurrent feature of all Public Board meetings.					

Patient story

Background context: Thirteen years ago, a blood clot led to three failed bypasses and a below-knee amputation for Grahame. Years of unmanaged pain followed until an MRI revealed neuromas, which were removed — but the pain persisted, evolving into complex pain syndrome. In 2024, after an aortic aneurysm repair, he developed severe kidney pain due to renal artery occlusion, requiring a stent. His kidney shrank, leading to renal failure. After seven weeks in the Freeman Hospital battling renal failure and two infections, Grahame — a retired nurse — often felt isolated and overlooked. These experiences left him questioning not only what went wrong, but also the values of the nursing profession he once proudly served.

Patient story: *I thought long about sharing my story. I was a nurse – good at noticing things – but what I experienced on the ward and how it made me feel was not good. I don't think I've finished giving yet, and that's what drives me to tell my story… the story of the power of simply being kind.*

It's hard to describe the level of pain I experienced in those first weeks. The pain team were supportive, but there were problems with adequate relief, which I've raised with the medical team. I was reduced to a number… just "bed A6".

I can't describe the depersonalisation of being identified by my bed number, alongside assumptions and missed opportunities for personalised care. I was acutely ill, in pain – and not once in 7 weeks was I offered an assisted wash. The assumption was I could do it myself. Intravenous support was haphazard. My veins were difficult, cannulas didn't last. One nurse took 9 attempts and broke nearly every sterile procedure rule. I felt too ill to argue. Eventually, a PICC line was inserted. I was told to drink 3 jugs of water daily, but I wasn't eating due to nausea, and water made me feel worse. I pleaded for IV fluids overnight. It made a difference – I felt refreshed and had less kidney pain.

I lost confidence in their commitment to care. Once the vascular issue was addressed, everything else was dismissed. The renal team said it wasn't their responsibility because vascular caused the problem. I was stuck in the middle — bed A6, a renal issue on a vascular ward.

One person saved me – the Dietitian. She found supplements I could tolerate after failed nasogastric feeding. She saw me at my lowest, in tears, and gave me what I needed most… a hug. In that moment, she saw me as Grahame – not a problem, not a bed number – but a person.

I praised the nursing staff during my worst stages, but not one asked how I was feeling. This is a fundamental part of nursing. I never felt part of the team caring for me. Medical and nursing staff failed in this crucial aspect of care. Though it left me ashamed of being a nurse, I don't blame individuals. I blame the system that allows this. If we keep giving nurses more roles, we take them away from direct patient care. Sometimes I blame myself – should I have challenged more? But when you're ill, it's hard. If I was stronger, I'd have asked to see my care plan… I don't know if one existed, or if I had a named nurse.

The final blow came with discharge planning – or the lack of it. I said I could manage, partly because I'd been promised a visit from the Pain Team Consultant and had finally received a tolerable supplement. I assumed I'd be sent home with a small supply, knowing I couldn't cook. But early the next morning, I was abruptly told I was going to the discharge lounge. I was stunned. A nurse said the ambulance was delayed due to medication issues. "I can only tolerate 15 minutes in my chair, and you expect me to sit all day?" I said. She told me it was policy. I replied that patient needs should be central to any policy. She later said the lounge had a bed.

Feeling more sick than angry, I gathered my few belongings, and wheeled myself into the corridor. The bay doors closed behind me. I was told someone from the lounge would come for me – so I waited… A junior doctor passed me, clearly seeing I was in pain, but didn't intervene. I asked a nurse for pain relief—she went on her break. I waited 45 minutes in the corridor before being taken to the lounge. I never saw the pain consultant, never received the supplements, and despite clear reasons why I shouldn't have been discharged — I was.

For me, it is not about blame. It is about sharing my story to help clinical staff realise the power and impact you have on your patients. The cumulative harm from assumptions and missed opportunities to care. It starts with listening to a patient – really sitting and listening to what they felt. It is about opening your eyes… that is where you start. By seeing the person in bed A6 – and believing in the power of simply being kind.

Staff story

Picture 1: Delfim Oliveira and Hazel Falcus pictured outside of Ward 3 at the Great North Children's Hospital

Context: Hazel and Delfim work as Domestic Assistants on Ward 3, the Children's Haematopoietic Stem Cell Transplant Unit, where strict isolation protocols and infection

control measures are of utmost importance. Through the Real time patient experience programme, numerous parents mentioned the difference Delfim and Hazel make – "making the world a better place", "breaking up the day" and having the "normal conversations". Delfim, who joined Newcastle Hospitals five years ago from Portugal, has also won the "Unsung Hero" award last year at the Celebrating Excellence Awards.

Staff story: *We don't talk about medical stuff. We talk about holidays, pets, silly things. Just normal life. That's what they need — a bit of normality. Ward 3 is very different - here, they can be with us for months, so you get to know them, build relationships. That's special — but it's also hard...*

Cleanliness is so important on Ward 3. It's not like other wards — we spend around 30 minutes in each room to make sure everything is spotless. There's pressure, but it's worth it. You want the best for the kids. We wash our hands 50 times a day, easily. But for someone new to the ward, it can be overwhelming.

I've [Delfim] learned bits of Polish, Arabic, and even Saudi dialect so I can speak to families in their own language. It's a small thing, but it means a lot. And now some of the parents are even speaking Geordie!

We had a little lad on the ward recently — he was amazing. We danced, played games. When you see a consultant doing the chicken dance, you know it's okay for us to join in too.

You do get sad - you see hard things. But we've learned not to take the sadness home. When one of us is down, the other picks us up. Having that relationship, that friendship with each other is key. We've had some tough times recently — we lost a few patients in a short space of time. That's never easy. The nurses deserve so much credit. They're the ones treating the kids and have amazing rapport as well, and we see how much it affects the nurses emotionally.

The best days on Ward 3? When a child rings the bell after treatment. Everyone claps and has tears in their eyes as it's so overwhelming. Your heart sings. You're so happy — the kids can go home and get on with their lives. It can be a mix of emotions too – you're happy, but also sad, because you won't see them again.

What keeps us going is the kids. We go in and talk utter rubbish — and that's the break they need. We're there for the children, the parents, the families. We want them to trust us. We're just normal — and sometimes, that's exactly what they need...

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Agenda item A6

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 November 2025					
Title	Board Visibility Programme					
Report of	Rachel Carter, Director of Quality & Safety					
Prepared by	Fiona Gladstone, Clinical Effectiveness Advisor					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☒			
Summary	The objective of the Board Visibility Programme is to provide a structure that enables identification of areas where care delivery may require improvement, support and expertise to address the more difficult issues that may be impacting on the quality and safety of patients and staff. The walkabouts raise awareness of front-line issues and support the visibility and accessibility of senior leaders within the organisation. This report provides an overview of the findings from the eleven informal visits by Non-Executive Directors undertaken throughout September and October 2025. There were no formal leadership walkabouts undertaken by Executive Team members and senior members from the Quality and Safety Team during this time as the programme transitioned to the new model described in the paper presented to Trust Board in September 2025.					
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 Objectives	Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.					
Reports previously considered by	The previous Leadership Walkabouts and NED Informal Visits Report was presented to the Trust Board in September 2025.					

BOARD VISIBILITY PROGRAMME

1. INTRODUCTION

This report provides an overview of the findings from the eleven informal visits by Non-Executive Directors (NEDs) and visits undertaken during September and October 2025. There were no formal leadership walkabouts undertaken by Executive Team members and senior members from the Quality and Safety Team during this time as the programme transitioned to the new model described in the paper presented to Trust Board in September 2025.

Since 2023, Non-Executive Directors have commenced an informal visits programme to supplement the pre-existing Leadership Walkabout programme. The informal visits are unaccompanied visits to areas/services across the Trust, with the areas selected generally identified by the individual NED. In addition, Executive Team members also undertake informal visits.

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).

The leadership walkabouts are announced, with the ward or area being notified of the walkabout, the team visiting and the time of their visit. The aim is to provide this information approximately one week prior to the visit.

A short guide is provided to the walkabout team/NED visits which offers a summary of the purpose of the visit and includes prompts to facilitate informal productive conversations.

For example:

- What does a great day here look like?
- What stops you having great days?
- What could be done to make things even better?

Following the visit, the walkabout team are asked to provide a free-text summary report which highlights what they felt were the most important themes from the staff they spoke to. The template allows the inclusion of brief details of any issues addressed during visits and if any further action is required. The data is then collated by the Quality & Effectiveness team (combined with the NED visits information) and presented in this report.

3. SUMMARY OF FINDINGS

The table below summarises the eleven walkabouts undertaken at the Royal Victoria Infirmary (RVI) and Freeman Hospital (FH), by the NEDs as part of stream two. Stream One walkabouts will re-commence in November 2025, following the transition to a new model, including members of the Executive Team and Quality and Safety Team only. Further detail is provided in the Summary of Findings Report in the Board of Directors Reading Room.

Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
Stream Two	Mortuary	FH	Non-Executive Director	Not Specified
	North-East Assisted Ventilation Service		Non-Executive Director	Consultants, Nurse Consultants, Nurse Specialists, Trainee Doctors, Administration Lead, Operational Service Manager
	Peri-Ops Central and Ear, Nose & Throat (ENT) Theatres Recovery Suite	FH	Non-Executive Director	Matron, Band 2
	Ward 16	FH	Non-Executive Director	Assistant Operational Service Manager, Matron, Sister, Consultant,
	Palliative Care	RVI	Non-Executive Director	Consultant, Senior Nurse, Nurse Specialist
	Dental Hospital	RVI	Non-Executive Director	Not Specified
	Night Visit to: Wards 2a, 2b, 3, 4, 5 Ward 22, Emergency Department	Great North Children's Hospital (GNCH) RVI	Three Non-Executive Directors	Staff Nurse, Healthcare Assistant, Nurse in Charge, Security

Stream	Area visited	Site	Membership of Walkabout Team	Staff who took part in the conversations
	Pharmacy	RVI	Non-Executive Director Director of Pharmacy	
	Ward 5, 6, 7	FH	Non-Executive Director	Matron, General Manager, Associate Director of Operations, Head of Nursing
	Wards 36, 45, 46	RVI	Non-Executive Director, Director of Operations, Associate Director of Operations, Head of Nursing, Matron	Not Specified
	Ward 38/Institute of Transplantation (IOT)	FH	Non-Executive Director	Clinical Board Chair, Director of Operations, Matron

Key themes identified include:

- Patients were always observed to be treated with dignity and respect, and patient care was a priority.
- Staff were proud of the work they do.
- Staff were comfortable to raise concerns.
- Evidence of quality improvement initiatives.
- The move to InPhase from Datix received positive feedback.
- Estates issues were identified throughout the walkabouts and highlighted as a concern by staff. Specifically, space and storage issues were identified, relating to a lack of bathroom space and areas for private discussions with patients.
- Faulty IT equipment and sub optimal Wi-Fi connections were a frustration for staff, however the new PC carts were well received.

Issues for escalation include:

- Estates to further review entrance doors to mortuary and resolve difficulty with the door lock.
- Ward 16, FH staff experience, related to ward portfolio, workload and communication.
- Raise query from Palliative Care with Charity in relation to fund management.
- Environmental issues identified in the Dental Hospital and theatre recovery areas.
- Fix or replace faulty IT equipment on Ward 22, RVI.
- Provide four additional drip stands and IV pumps for Ward 22, RVI.
- Investigate and resolve remuneration for bank staff after planned shift time has ended and where there are still tasks remaining.
- Review staff redeployment processes to ensure safe cover is maintained when staff are moved between wards.

- Improve Wi-Fi connectivity/speed in GNCH (Wards 3/4) to support remote working for parents of long-term patients.
- Follow up charity funding which has been approved but not received for intra-oral scanners.
- Address recurring IT issues in airlocked bays on GNCH Wards 3/4.
- Reinforce staff wellbeing support, particularly in emotionally demanding areas like GNCH.
- Investigate frequency of Emergency Department waiting room checks to ensure compliance with 30-minute safety check protocols.
- Reinforce switching off lights in unused areas (e.g., piano room) to support energy efficiency.

5. RECOMMENDATION

The Trust Board is asked to note the contents of this report in relation to positive feedback from Trust staff and concerns escalated/suggestions raised for improvements.

Report of Rachel Carter, Director of Quality & Safety
Prepared by Fiona Gladstone, Clinical Effectiveness Advisor
12 November 2025

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Agenda item A8

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 November 2025		
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	This paper is to provide assurance to the Trust Board on the Trust's performance against key indicators relating to Quality & Safety, Access, People and Finance. **Quality** • Methicillin-susceptible staphylococcus aureus (MSSA) reduced in September (9 v 14) compared to the previous month. The rate is now within the parameters of common cause variation but remains a concern. An Infection Prevention and Control (IPC) Improvement Group has been established to provide oversight of IPC improvement programmes. • There was 1 stillbirth in September 2025. The Trust has triggered a safety alert for the number of stillbirths on the Clinical Indicators Dashboard. In accordance with the Local Maternity and Neonatal System (LMNS) safety signal process this instigated a review of the data - further analytics have been performed by the NHS England (NHSE) analytics team which indicate duplicate counting - when these cases were removed the Trust returned to within a 95% confidence limit. **Performance** • Emergency Department (ED) Performance (All Types) in September was 75.9%, a drop of 1.8% compared to September (77.7%). ED attendances continued to rise in September from August, the proportion of Type 1 (Major) attendances however decreased. • The total waiting list size reduced again in September to 87,666. The Trust's participation in an NHS England coordinated validation sprint has been key to waiting list reductions in 2025/26. • In September, the 80% 28 Faster Diagnosis Standard (FDS) target was not achieved (68.5%) and is now showing special cause variation of a concerning nature. **People** • The substantive workforce is 2,001 Full Time Equivalents (FTE) (14%) above the pre-Covid substantive position and 275 FTE (1.76%) above the 2025/26 workforce plan for substantive staff.		

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The 12-month rolling absence rate of 5.7% and the sick pay cost of £33.7m are significantly above the target of 5% and £25m respectively.
2,698 appraisals are overdue with highest numbers in Nursing and Midwifery (847) and Admin and Clerical (504).

Finance

At month 6 the Trust is reporting a £4.3m deficit which is in line with the plan, however in delivering this position, the Trust has had to bring forward technical savings to offset new pressures and under delivery of Cost Improvement Programme (CIP).
The CIP of £106 million is phased over the year with a plan of £42.2 million to month 6. Year to date Clinical Boards and Corporate Services have delivered £15.5m (of which £11.1m is recurrent). To mitigate the CIP on Clinical Boards and Corporate Services delivery, £26.7m of non-recurrent technical measures have been actioned which is £13.8m more than planned for.

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<tr><td>Recommendation</td><td colspan="6">For assurance.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focussing on safety and quality.

Performance – Being outstanding now and in the future.</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>
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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 a regular paper provided to Trust Board.</td></tr>
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Agenda item A8

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Integrated Board Report

November 2025

Healthcare at its best
with people at our heart

Contents

SPC Variation / Assurance – Changes from previous month

	Aug-25	Sep-25
HCAI - MSSA	H	
HCAI - Klebsiella cases		H
Never Events		H
Level 2 Mortality reviews undertaken		L
ATAIN		H
Cancer 28 Day FDS		L
Cancer 31 Day		H
Short-term sickness	L	
Turnover	L	
Appraisals		L

SPC Variation

- **10** high level metrics have displayed changes in special cause variation from August to September 2025.
- **Health Care Associated Infections (HCAI) - Methicillin-Sensitive Staphylococcus aureus (MSSA) –** has moved from showing special cause variation of a concerning nature (high) to common cause variation.
- **HCAI - Klebsiella –** has moved from showing common cause variation to special cause variation of a concerning nature (high).
- **Never events –** has moved from showing common cause variation to special cause variation of a concerning nature (high). A new Trust Patient Safety Incident Response Framework (PSIRF) priority is being introduced to successfully implement NatSSIPS2 into the organisation, led by a Project Board with dedicated resources to drive improvement. NatSSIPS 2, or the National Safety Standards for Invasive Procedures 2, is a set of guidelines designed to improve patient safety during invasive procedures and to reduce the occurrence of Never Events.
- **Level 2 mortality reviews –** has moved from showing common cause variation to special cause variation of a concerning nature (low).
- **Avoiding Term Admission into Neonatal Units (ATAIN) –** has moved from showing common cause variation to special cause variation of a concerning nature (high).
- **Cancer 28 Day Faster Diagnosis Standard (FDS) –** has moved from showing common cause variation to special cause variation of a concerning nature (low). This is driven by skin cancer performance – regional conversations to appropriately redirect referrals and manage organisational demand continue, including recent changes made to the signposting of clinics made available to refer into GPs.
- **Cancer 31 Day –** has moved from showing common cause variation to special cause variation of an improving nature (high).
- **Short-term sickness and Turnover –** have moved from showing special cause variation of an improving nature (low) to common cause variation.
- **Appraisals –** has moved from showing common cause variation to special cause variation of a concerning nature (low).

SPC Assurance

- No changes have been noted in SPC assurance levels this month.

Quality

Quality Overview

Metric	Period	Actual	Target	Variation	Assurance
HCAI - MSSA	Sep-25	9	9		
HCAI – C. Diff	Sep-25	12	12		
Harm Free Care – Inpatient (IP) Acquired Pressure Ulcers	Sep-25	42	Sustained reduction		
Harm Free Care – Adult Patient Falls	Sep-25	227			
Stillbirths	Sep-25	1			
Blood Loss ≥1500ml (per 1,000)	Sep-25	47 per 1000			
ATAIN	Sep-25	8%	5%		

Health Care Acquired Infections

- Methicillin-susceptible staphylococcus aureus (MSSA) reduced in September (9 v 14) compared to the previous month. The rate is now within the parameters of common cause variation but remains a concern. An Infection Prevention and Control (IPC) improvement group has been established to provide oversight of IPC improvement programmes.
- *Clostridioides difficile (C.Diff)* Infection (CDI) cases remained the same in September (12 v 12). This static position has remained for 3 months. This rate is within the parameters of common cause variation.

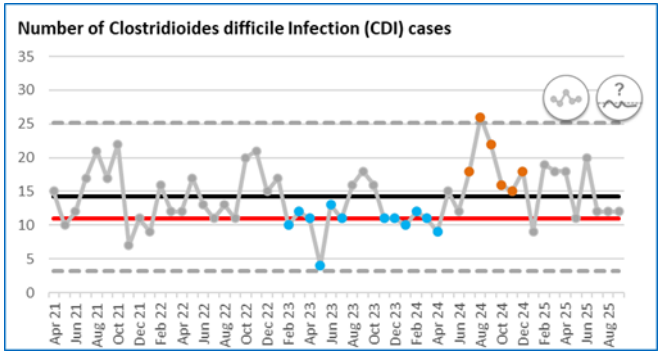
Harm Free Care

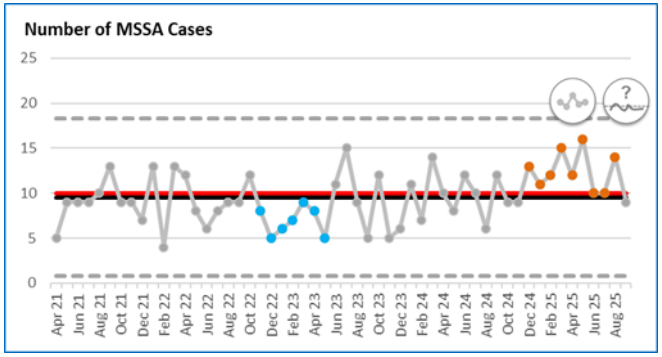
- Acute Pressure Ulcers (PU) reported in September reduced (42 v 62) – the lowest count in this financial year. Whilst this maybe a seasonal variation, all cases are reviewed to ensure learning points are identified and actioned.
- In September there was an increase in falls (227 v 202).

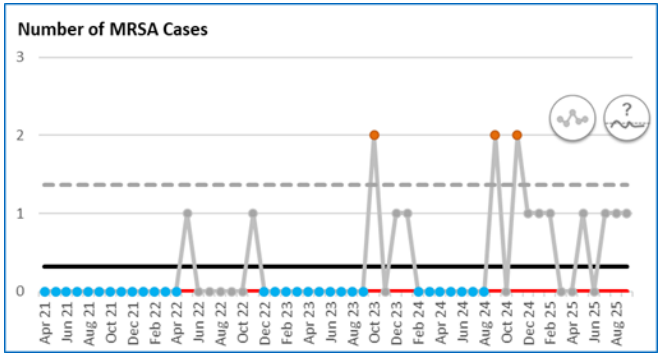
Perinatal Quality Surveillance

- There was 1 stillbirth in September 2025. The Trust has triggered a safety alert for the number of stillbirths on the Clinical Indicators Dashboard. In accordance with the Local Maternity and Neonatal System (LMNS) safety signal process this instigated a review of the data - further analytics have been performed by the NHS England (NHSE) analytics team which indicate duplicate counting - when these cases were removed the Trust returned to within a 95% confidence limit.
- The National benchmark for term admissions is 5%. The Trust rate remains consistently above the national 5% target; July and August this was 9% with a small reduction to 8% in September. Three quality improvement workstreams have been identified - care of infants of diabetic mothers, thermoregulation and respiratory issues following delivery by elective caesarean section. Progress is monitored by the Quality and Safety Group and is linked to compliance with Safety Action 3 of Maternity Incentive Scheme.

Healthcare Associated Infections (HCAIs) (1/2)







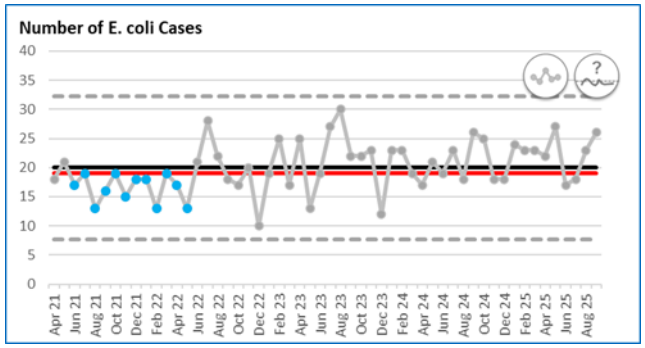
Standards

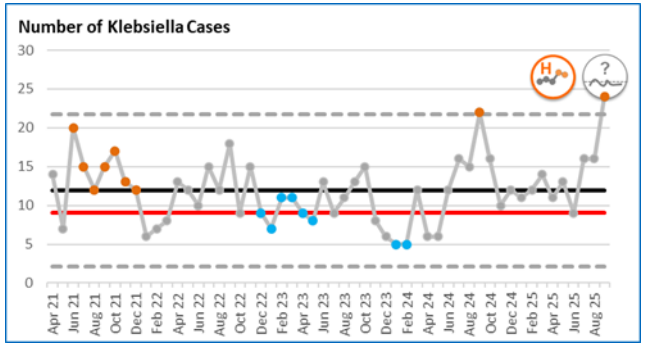
- **Zero MRSA** cases.
- **No more than 115 MSSA** cases across the financial year (local target - 10% reduction from 2024/25).
- **No more than 136 CDIs, 225 *E. coli*** cases, **108 Klebsiella** cases or **34 Pseudomonas aeruginosa** cases across the financial year.

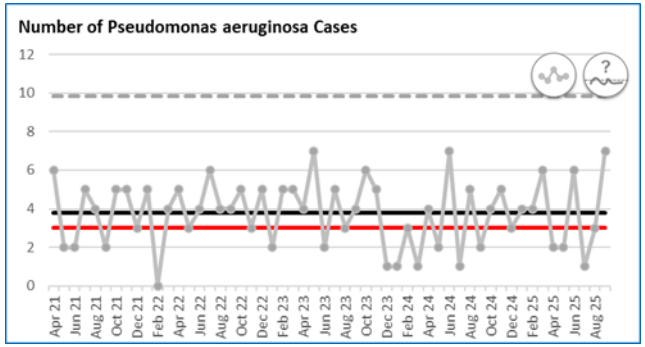
Current Position

- There was no change in the number of CDI cases for the 3rd consecutive month (12 v 12, this remains within the parameters of common cause variation. There were 2 Community Onset Healthcare Associated (COHA) cases and 10 Hospital Onset Healthcare Associated (HOHA) cases, of which 1 was found to have identified contributory factors relating to the infection. Themes identified for learning were: delays in sending a specimen and treatment administration, stool documentation and antibiotic stewardship.
- The number of MSSA cases reduced in September (9 v 14) and now takes the rate to within the parameters of common cause variation .
- There was 1 Methicillin-Resistant Staphylococcus aureus (MRSA) cases in September, the total cases for this financial year is 4. An identified theme is device management. A review of the area's risk register was undertaken and inconsistent availability of appropriate skin cleansing preparation agents for this patient group was identified. Additionally, an amendment to the MRSA policy has been agreed, introducing an additional screening parameter specifically for Maternity Services.
- There was an increase in the number of *Escherichia coli* (*E. coli*) bacteraemia cases compared to the previous month (26 v 23). A review of the cases is underway.
- The was a significant increase in the number of Klebsiella bacteraemia cases this month compared to the previous month (24 v 16), and this takes the rate within the parameters of special cause variation. A review of the cases is underway.
- There was a significant increase seen in Pseudomonas aeruginosa cases compared to previous month (7 v 3), however this remains in line with common cause variation. A review of the cases is underway.
- A theme identified from bloodstream infection reviews include suboptimal documentation and management of urinary catheters, as well as issues related to antibiotic stewardship.

Healthcare Associated Infections (HCAIs) (2/2)



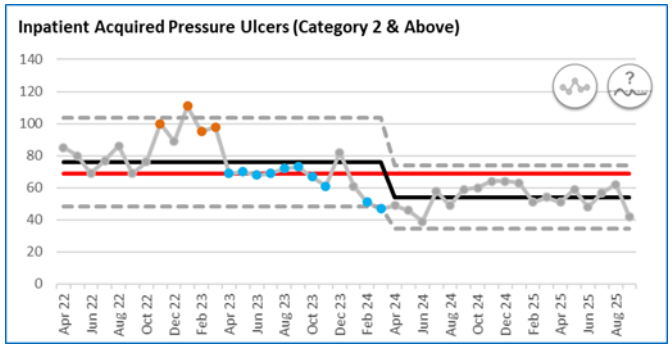


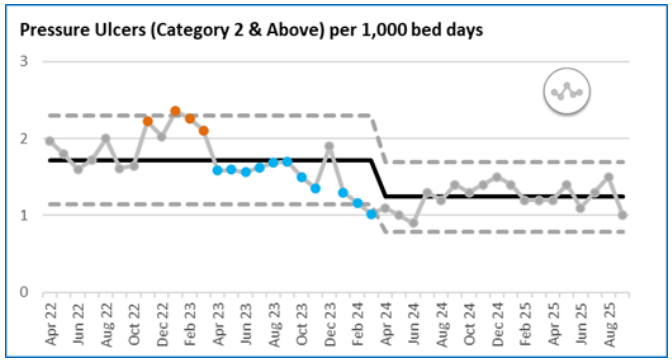


Action taken

- The themes identified from investigations, demonstrate areas for improvement at ward and department level and include hand hygiene compliance, decontamination of equipment, invasive device management, stool monitoring, antimicrobial washes, MRSA screening & eradication.
- Several initiatives are currently underway:
    - A programme aimed at improving hand hygiene compliance and reducing unnecessary glove use across the Trust continues to align with broader HCAI reduction strategies.
    - Hand hygiene masterclasses are being delivered throughout the organisation.
    - IPC validation audits — including the 'Take 5' reviews for cannulation and urinary catheter use, along with toilet aid audits — continue to be carried out. These audits assess device management, decontamination practices, and clinical staff knowledge across all inpatient areas. They also support education and improvement efforts in collaboration with Clinical Educators.The IPC team is scheduled to present the audit findings at the November IPC team meeting, with the Associate Director of Nursing and the Director of Infection Prevention Control (DIPC).
- An Executive led IPC Improvement Group has been established to comprehensively review all strategies aimed at reducing HCAIs and agree targeted interventions to make improvements across HCAI metrics. Oversight is provided by the Quality Committee.
- Surgery and Associated Specialties (SAS) Clinical Board are reviewing hepatobiliary infections associated with Gram Negative Bloodstream Infections (GNBSI) to identify contributory factors and improvement actions.
- Trust IV Device Related Infection Prevention Care Bundle will be presented at the Clinical Risk Group (CRG), Matrons forums and Harm Free Care forums for agreement prior to implementation.
- The Trust MRSA policy review has been completed, with messages simplified and screening procedures clarified.

Harm Free Care: Pressure Damage





Standard

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

Current Position

Reduction in Cases:

- Acute pressure ulcers (Category II and above) decreased from **62 in August to 42 in September**.
- Rate per 1,000 Bed Days, reduced from **1.5 in August to 1.0 in September**.
- Chart indicates a **sustained reduction** with **no special cause variation**.

Severity Breakdown:

- **No Category IV** pressure ulcers reported.
- **Four Category III** pressure ulcers reported.
- All cases are under investigation to identify contributory factors and learning opportunities.

Key areas for improvement:

- Timely capture of images for pressure ulcer documentation.
- Completion of skin/pressure ulcer risk assessments.
- Completion of pressure ulcer prevention and categorisation training.
- Implementation of mattress champions and regular mattress audits.

Action taken

Purpose T Implementation:

- Tissue Viability team supported clinical staff with rollout at the end of September 2025.

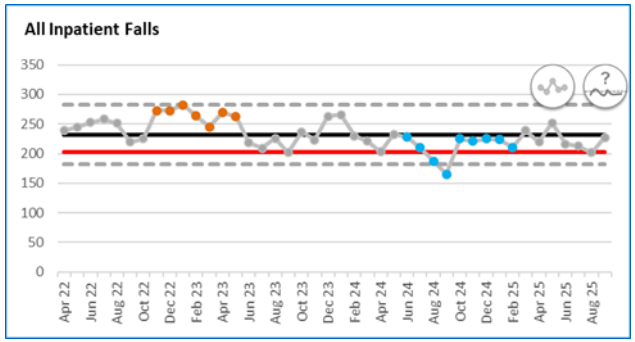
Compliance Audits:

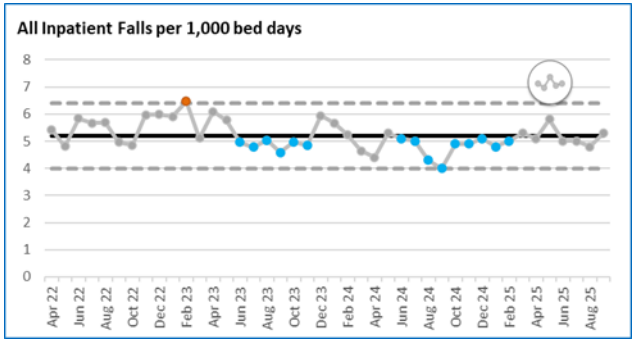
- Scheduled for end of October; decision on switching off Braden tool to follow.

Documentation Updates:

- Tissue Viability and Digital teams collaborating to update wound and skin assessment documentation.
- Relaunch of updated Tissue Viability referral criteria, wound assessment, and care plan planned.

Harm Free Care: Falls





Standard

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

Current position – Falls (September 2025)

Falls Incidents:

- Increased to **227** from **202** in August.
- Falls per 1,000 bed days rose from **4.8 to 5.3**.

Harm Levels:

- **10 falls (5%)** resulted in moderate or above harm:
- 5 moderate harm.
- 3 severe harm.
- 1 moderate harm in Emergency Department (ED).

Investigations:

- All moderate and above harm falls investigated on InPhase.
- Falls Prevention Coordinator supports teams to identify learning and actions.

Positive Trend:

- Hip fracture rate from inpatient falls reduced from **6% (2 years ago)** to **just over 3%**.
- Falls Prevention Coordinator commended for Trust-wide awareness and prevention work.

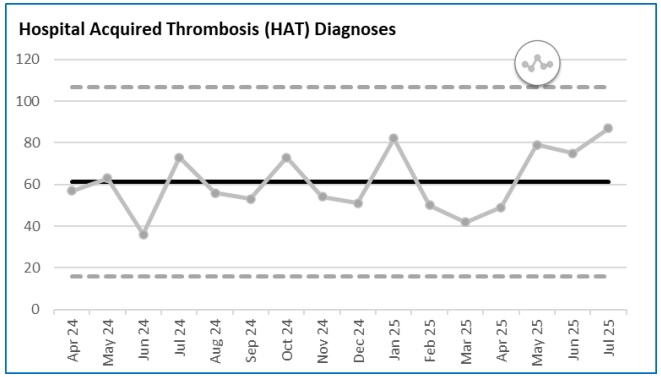
Key Areas for Improvement

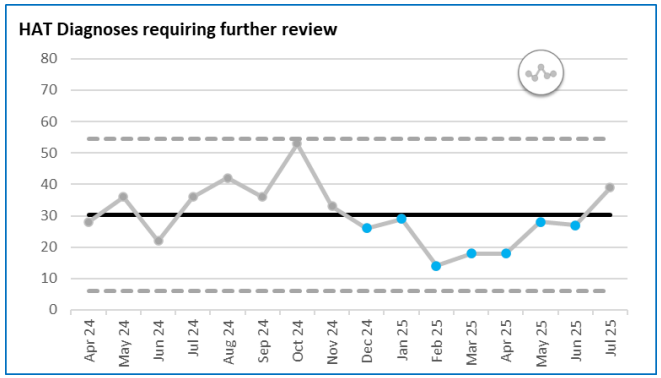
- Completion of multifactorial assessment to optimise safe activity.
- Completion of 4AT (delirium screening).
- Vision assessment for patients at risk.
- Medication review in relation to falls.

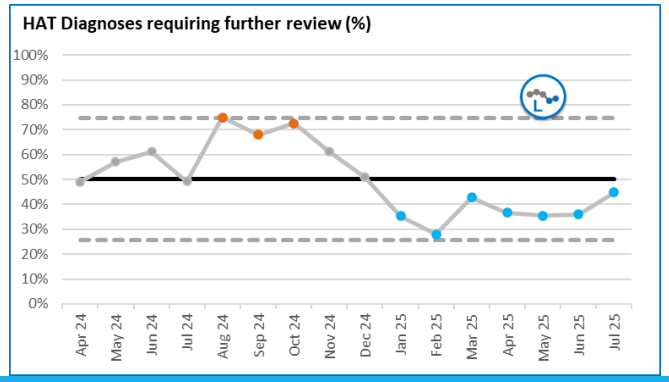
Actions Taken

- Education by the Falls Prevention Coordinator promoting the requirement to complete screening, assessments and medication reviews.
- Trust wide Enhanced Care Observation Audit completed on 1st October 2025 (results pending).
- Review of post-fall CT head protocol underway.

Harm Free Care: VTE Assessments & HAT







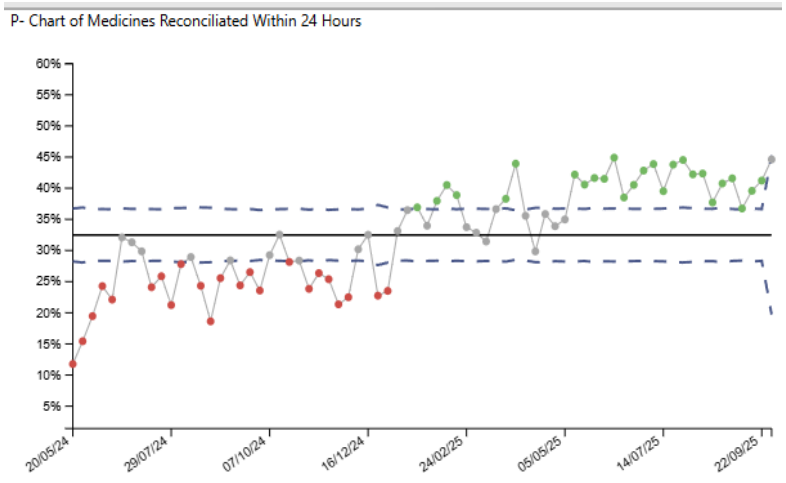
Standards

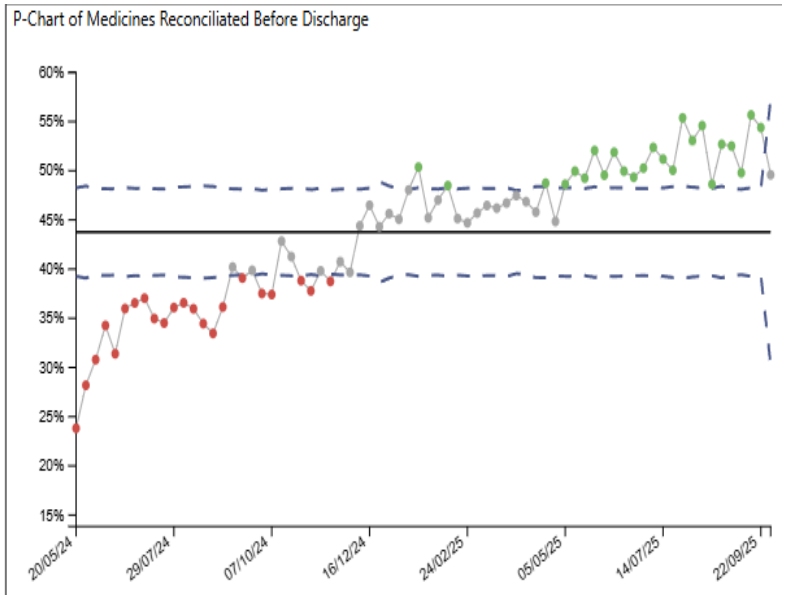
- **95%** of Venous Thromboembolism (VTE) assessments undertaken within 24 hours of admission (external target).
- **To reduce** the number of Hospital Acquired Thrombosis (HATs) for review (these are HATs that have been associated with sub-optimal VTE prevention).

Current Position

- We are compliant with the NHS standard of >95% completed within 24 hours.
- A VTE risk assessment dashboard that shows compliance over time should be completed by the end of 2025.
- 35% of HATs were identified as needing further review in September 2025.

Medicines Reconciliation (Med Rec)





Standards

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

Current Position

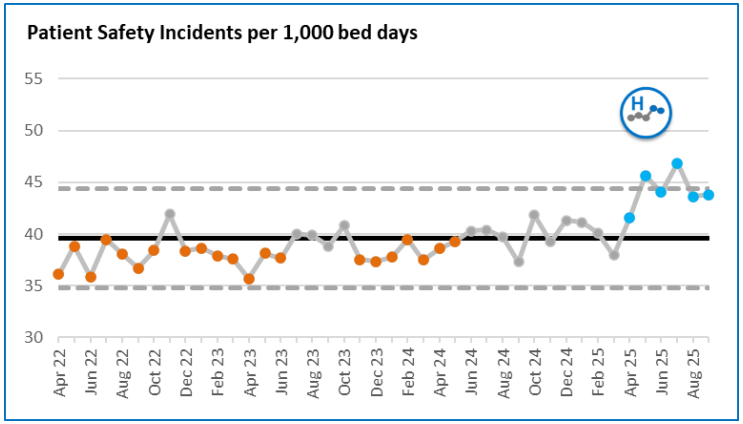
- 40% target within 24 hours achieved for the first time in June 2025.

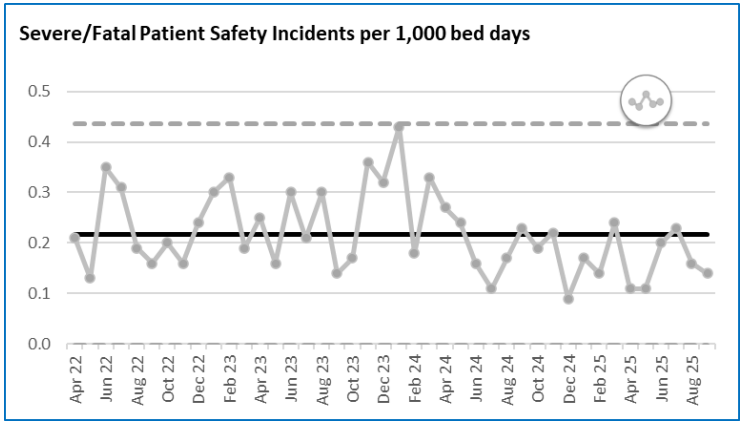
	Med rec within 24 hours Total Number / %		Total Med Rec before discharge Total Number / %	
December 2024	1280	**27%**	2065	46%
January 2025	1696	**34%**	2353	51%
February 2025	1718	**39%**	2103	52%
March 2025	1692	**34%**	2261	48%
April 2025	1811	**37%**	2305	50%
May 2025	1809	**38%**	2335	52%
June 2025	1974	**42%**	2393	54%
July 2025	2099	**43%**	2488	52%
August 2025	1882	**40%**	2446	52%
September 2025	2006	**40%**	2567	**53%**

Action taken

- Quality Improvement (QI) project on-going to test different ways of working to improve medicines reconciliation rates without adversely impacting other core services (e.g. patient flow, medicine supply, operational duties).
- Phase 1 of the staffing business case approved with staggered start dates starting from September 2025.
- On-call service undertaken in September. Once completed in October it is anticipated this will release staff to provide additional pharmacy support for medicines reconciliation at weekends.

Incident Reporting





Standards

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

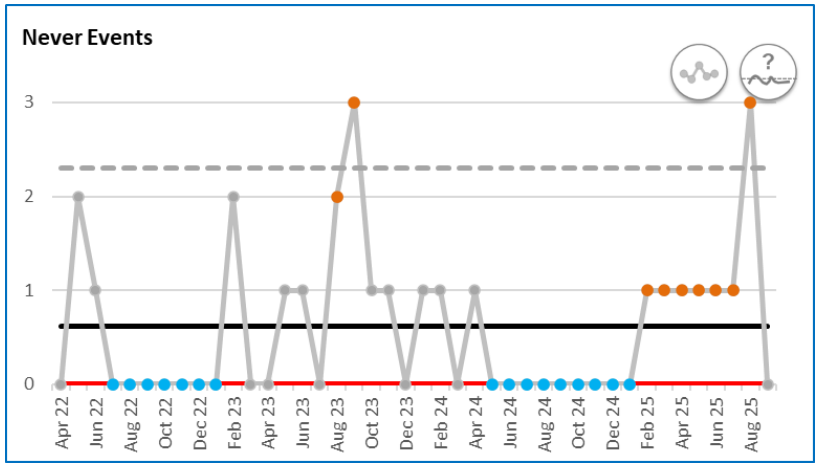
Current Position

- The total number of patient safety incidents per 1,000 bed days reported in September 2025 remained the same compared to August 2025.
- The number of severe/fatal safety incidents per 1,000 bed days has decreased in September 2025, compared with August 2025.
- One Patient Safety Incident Investigation and eight After Action Reviews were completed in September 2025.

Action taken

- Clinical Boards have access to incident reporting rates and have identified areas of low reporting, implementing targeted plans to address this.
- Raising awareness of incidents and dissemination of learning continues to through the Patient Safety Bulletin and Clinical Risk Group.
- Questions relating to patient safety are included in the Trustwide peer reviews and the Accrediting Excellence Programme.
- Psychological support services being developed to support staff involved with patient safety events.

Never Events



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

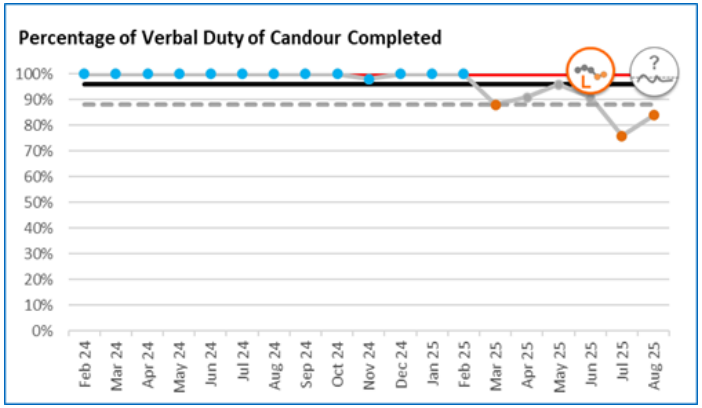
- No Never Events were recorded in September.
- A total of seven Never Events have been recorded for the 2025/26 period.

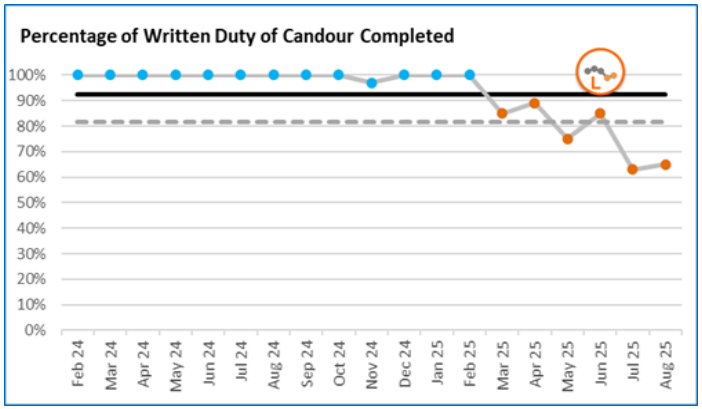
Action taken

- New Trust PSRIF priority is being introduced to successfully implement NatSSIPS2 into the organisation, led by a Project Board with dedicated resources to drive improvement.
- NatSSIPs 2, is a set of guidelines designed to improve patient safety during invasive procedures and to reduce the occurrence of Never Events.
- A newly established Invasive Procedures Group has been introduced to strengthen the governance of invasive procedures and support the PSIRF priority.

Never Events 25/26	Ref	Clinical Board	Speciality	Never Event
April 25	9031	Surgery & Specialist Services	Orthopaedics	Wrong site surgery
May 25	983	Surgery & Specialist Services	Orthopaedics	Wrong implant /prothesis
June 25	3168	Cardiothoracic	Cardiology	Wrong site surgery
July 25	6311	Surgery & Specialist Services	Orthopaedics	Wrong site surgery
August 25	8426	Surgery & Specialist Services	Orthopaedics	Wrong implant / prothesis
August 25	9458	Perio-Operative & Critical Care	Theatres	Wrong implant / prothesis
August 25	10030	Cardiothoracic	Cardiothoracic Surgery	Wrong implant / prothesis

Duty of Candour





Standards

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

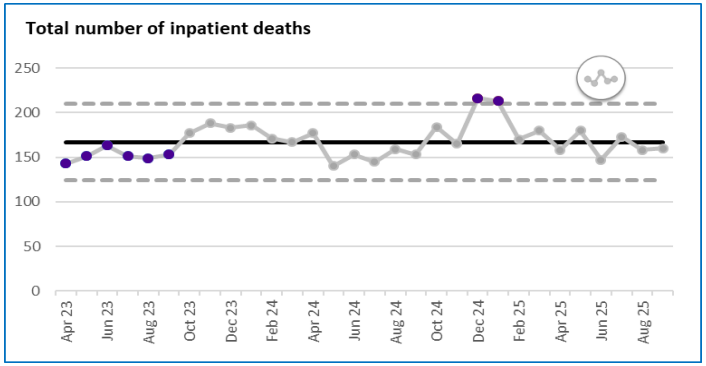
Current Position

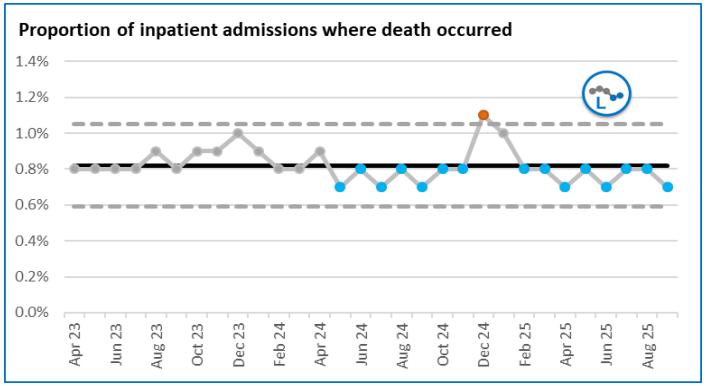
- Data for overall Trust compliance is taken from records of completion in the incident module of InPhase / Datix. Additional assurances for compliance with the statutory requirements of Regulation 20 are undertaken through regular audits reported to Quality Committee.
- A review of the audit schedule is in progress to increase activity to enable improvements in the standards of DoC responses and more timely feedback to the Clinical Boards.
- Trust compliance for verbal duty of candour, for the period February 2024 to August 2025 has decreased to 95%, compared with 96% the previous month.
- Trust compliance for written duty of candour, for the period February 2024 to August 2025 has decreased to 90%, compared with 92% the previous month.
- Incident reporting moved to InPhase in May 2025 and Datix was changed to read only from 14th July 2025 to allow data migration to take place. Any updates to DoC compliance for the period prior to May 2025 will not be represented in the graphs until migration to InPhase has been completed.

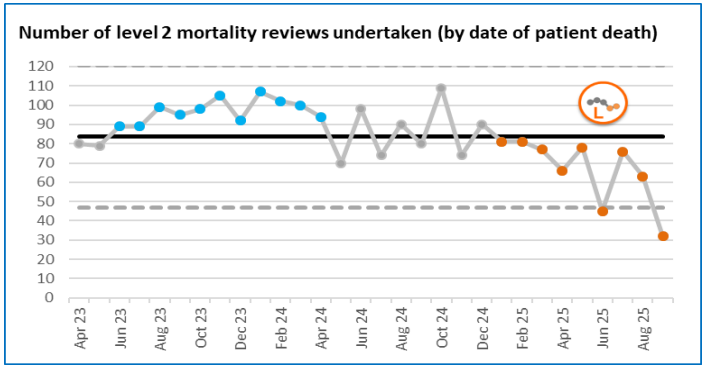
Action taken

- Ongoing work to update and reintroduce DoC compliance dashboards across the Trust.
- Changes implemented to InPhase to support more accurate compliance recording.

Mortality Indicators (1/2)







Standards

- Due to the recent changes nationally to the Medical Examiner (ME) process, from September 2024 it is now a statutory requirement **all deaths are reviewed** by either the Coroner or ME (level 1 mortality review criteria).

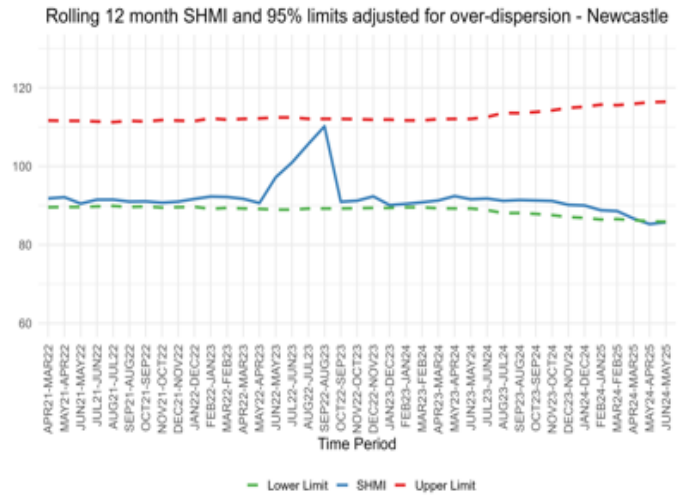
Current Position

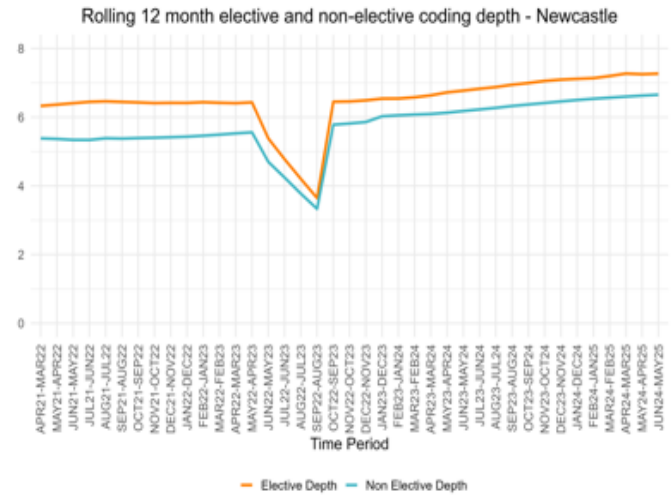
- There were 160 inpatient deaths in total reported in September 2025. This is an increase of 2 on the previous month.
- The crude mortality rate in September 2025 is 0.7%. This is a decrease of 0.1% on the previous month and remains well within the average for the Trust.
- Out of the 160 inpatient deaths reported, there are 32 completed level 2 mortality reviews entered into the Trust mortality review database to date.
- Additionally, a further 78 Level 2 reviews were completed in September 2025 for patients who died prior to this date.
- None of the completed reviews undertaken in September have been scored with a high HOGAN or National Confidential Enquiry into Patient Outcome and Death (NCEPOD) grading.
- One patient with a confirmed learning disability died in September 2025.

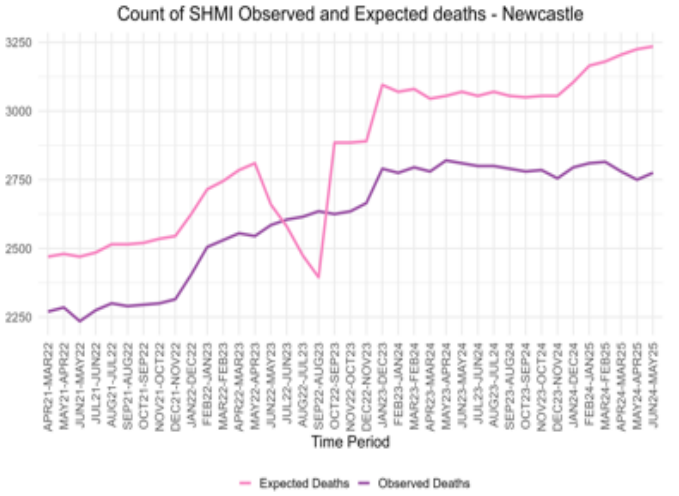
Action taken

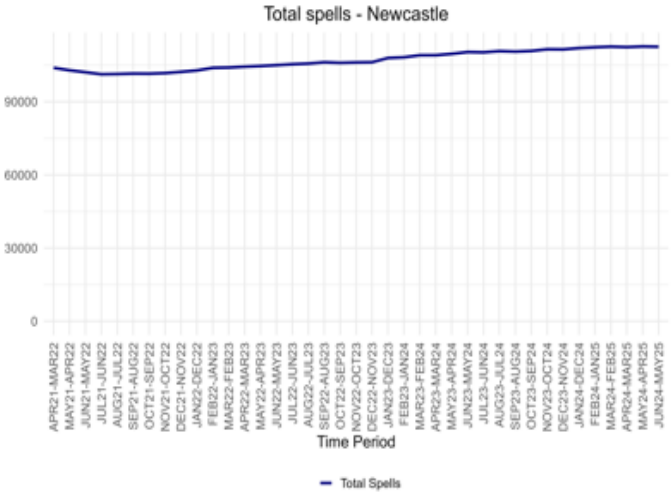
- All inpatient deaths are continually monitored.
- The number of level 2 mortality reviews will rise significantly over the coming months as Morbidity and Mortality (M&M) meetings continue to take place.
- Outstanding Level 2 mortality reviews requested by the Trust's Medical Examiners, other specialities or deemed as required in line with the Trust's Mortality Monitoring policy have been escalated to the Mortality Surveillance Group and the Clinical Board Quality Oversight Groups for action.
- November's Quality and Performance Reviews (QPRs) will include an update from the Clinical Boards on the position of their outstanding mortality reviews.

Mortality Indicators (2/2)









SHMI (Summary Hospital-level Mortality Indicator)
Within the latest published SHMI data (June 2024 – May 2025) the Trust SHMI is at 0.86. This is within the 'lower than expected' category.

Observed & Expected deaths Between June 2024 – May 2025, the Trust has 2,775 observed deaths and 3,235 expected deaths.

Coding Depth
Coding depth has a substantial impact on mortality indicators. Within the latest published SHMI data the Trust has an elective coding depth of 7.3 and a non-elective coding depth of 6.7*.

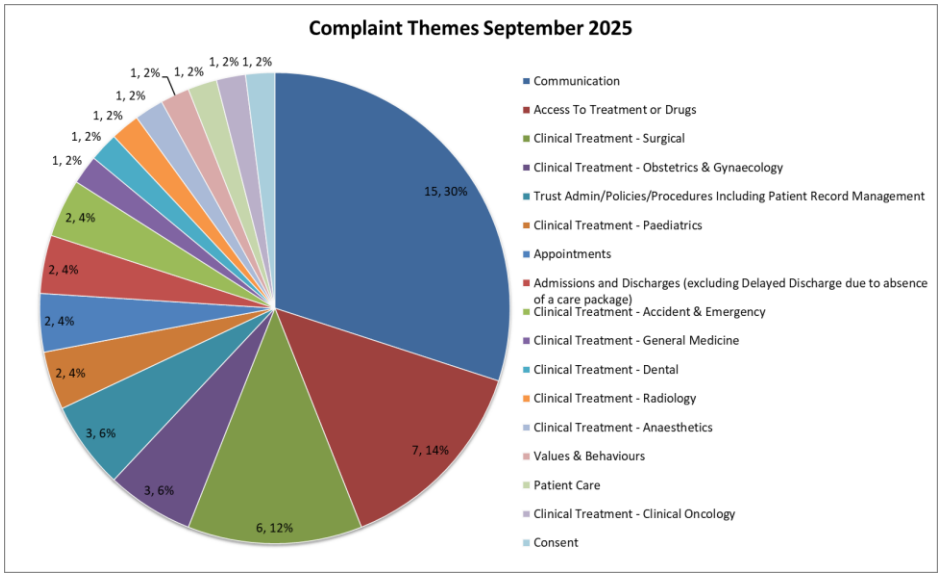
Spells with palliative code
Between June 2024 – May 2025, the Trust has a 1.8% palliative care coding rate.

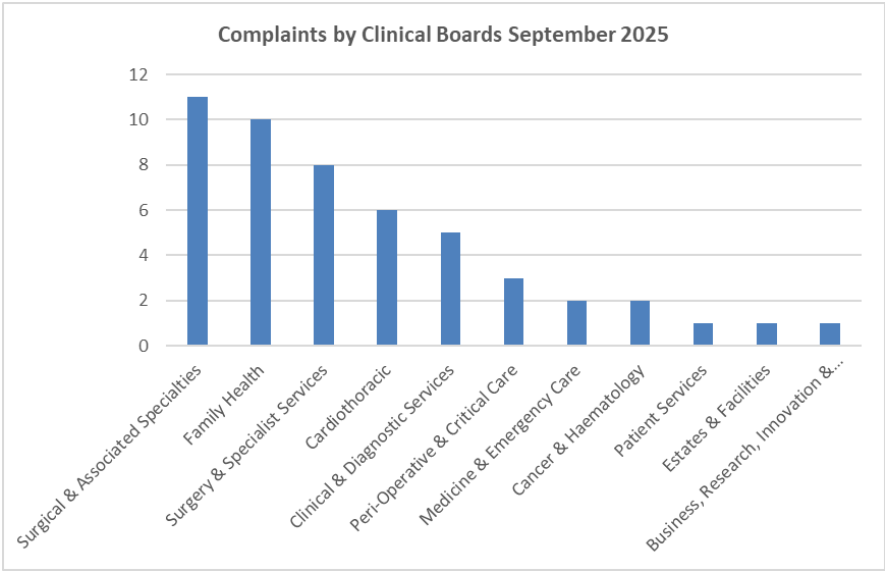
Total Spells
NEQOS have introduced a new graph describing the pattern of total provider spells for the reported period (bottom right). This replaces the previous graph depicting the pattern of palliative care coding spells.

All data rolling 12-month periods. Data as reported by NHS England/ NEQOS.

** An issue with the Trust's SUS data flow affected clinical coding completeness (now resolved).*

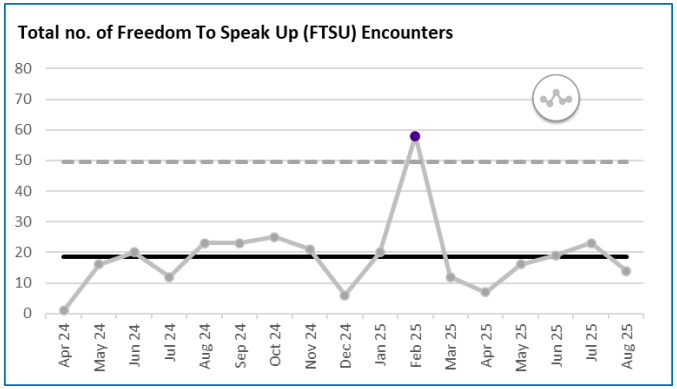
Formal Complaints





- The Trust has had 50 formal complaints In September 2025. The average number of complaints opened for the previous financial year is 54.
- The main theme for complaints this month was Communication, accounting for 30% of the complaints (15).
- Clinical treatment accounts for the most complaints collectively across the specialties with 36% of complaints opened this month (18).
- The most complaints were opened for the following Clinical Boards:
    - Surgical & Associated Specialties 11 (22%).
    - Family Health 10 (20%).
    - Surgery & Specialist Services 8 (16%).

Freedom to Speak Up



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Total
CB Surgery and Specialist Services RVI						16	16
CB Peri-operative and Critical Care	1	3	5	5			14
CB Clinical and Research Services	4	6					10
CB Clinical and Diagnostic Services			2	1	3	3	9
CB Family Health	1	2	1	1	1	1	7
(blank)			2	3	2		7
CS Business Development				1	1	4	6
CS Estates		1	2	1	1	1	6
CB Cardiothoracic Services		1	3	1			5
CB Medicine and Emergency Care						5	5
CB Surgical and Associated Services FH				2	3		5
CB Surgical and Specialist Services RVI		1		3	1		5
CS Unknown			3				3
CB Cancer and Haematology	1					1	2
CS Chief Executive			1				1
CS Human Resources						1	1
CS Information Management and Technology		1					1
CS Patient Services					1		1
CS Unkown		1					1
	7	16	19	18	13	32	105

Standards

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

Current Position

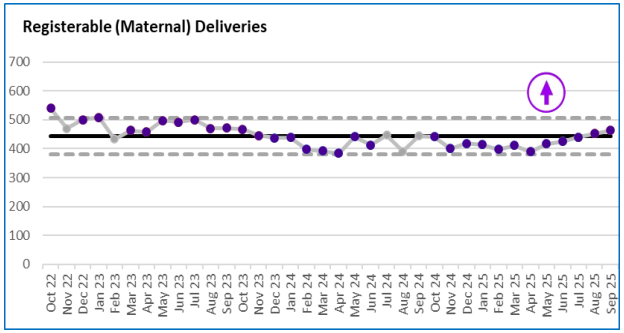
- There were a total of 32 speak up encounters made to the Freedom To Speak Up (FTSU) Guardian (FTSUG) in September. 16 of these were in Surgical and Specialist Services (SSS), 11 of which were as a result of the targeted staff experience work being carried out in ophthalmology.
- 3 speak ups were raised anonymously through the Work In Confidence platform.
- The most frequently reported category of concern reported in September 2025 was inappropriate attitudes and behaviours (16), followed by worker quality and safety (15), bullying and harassment (6) and patient safety and quality (5). Poor management was a frequently identified sub-category (25).
- Two cases specifically included concerns of racism and these have been escalated appropriately.
- No cases of detriment were reported.
- There are currently 19 trained FTSU Champions.

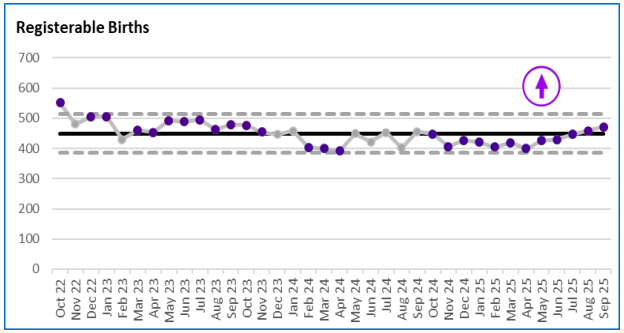
Action Taken

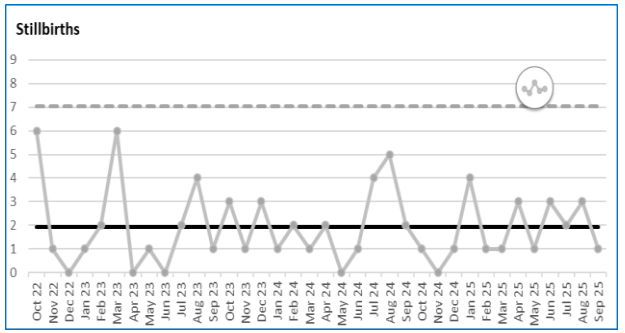
- Drop-in sessions within all ophthalmology service-delivery areas as part of staff experience work.
- Attendance at Proud to Be Admin day.
- Involvement in World Patient Safety Day to highlight speaking up in relation to patient safety.
- Met with new Head of Chaplaincy to strengthen partnership working.
- Networking with FTSUGs in the region through the Keeping in Touch event.

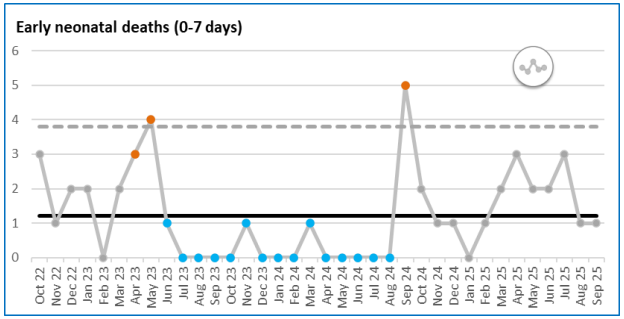
Primary topic	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Total
Inappropriate behaviour and attitudes		2	5	10	4	13	34
Worker safety and quality		4	2	5	7	11	29
Bullying and harassment	2	3	3	1	1	6	16
Poor management	3	5	5				13
Patient safety and quality	2	1	1			2	6
(blank)			2	2	1		5
Civility		1					1
Disadvantageous demeaning treatment as a result of speaking up			1				1
Grand Total	**7**	**16**	**19**	**18**	**13**	**32**	**105**

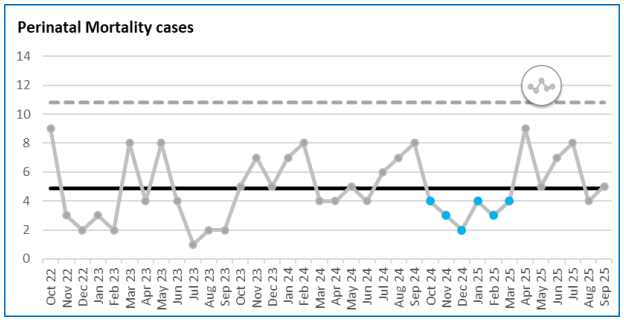
Perinatal Quality Oversight: Births











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 Northeast, saw a decline in live births, the overall increase in births appears to be primarily caused by the number of births in the West Midlands and London. There is concern that there has been a reduction in the market share of the Trust following the long-term suspension of the Birthing Centre, the current birth rate is stable, but a communication plan is in development to increase booking numbers.

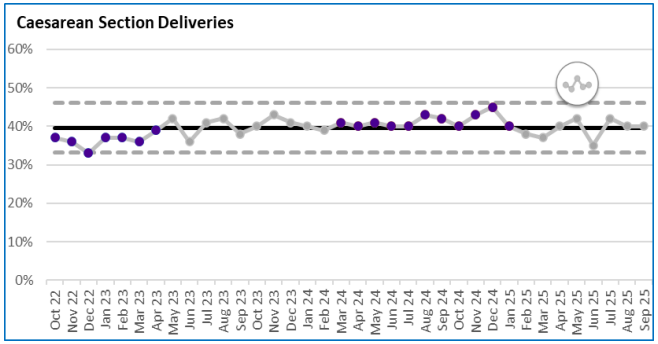
Stillbirths

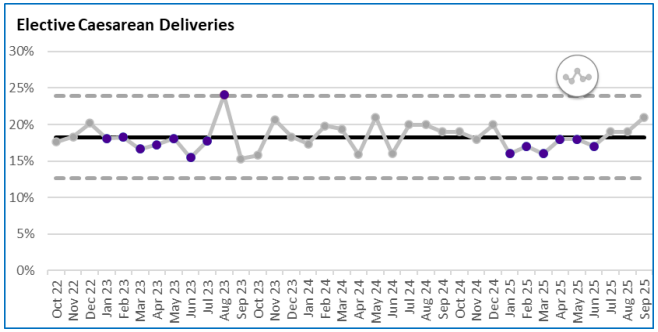
- This data includes termination for fetal anomalies >24 weeks gestation. There was one stillbirth in September 2025. This case meets the criteria for review using the Perinatal Mortality Review Tool (PMRT) process. (Average per 1000 births: England 3.2, North East and North Cumbria (NENC) 3.6). The Trust has triggered a safety alert for the number of stillbirths on the Clinical Indicators Dashboard. In accordance with the Local Maternity and Neonatal System (LMNS) safety signal process this instigated a review of the data. Further analytics have been performed by the NHSE analytics team which indicate duplicate counting, when these cases were removed the Trust returned to within a 95% confidence limit.

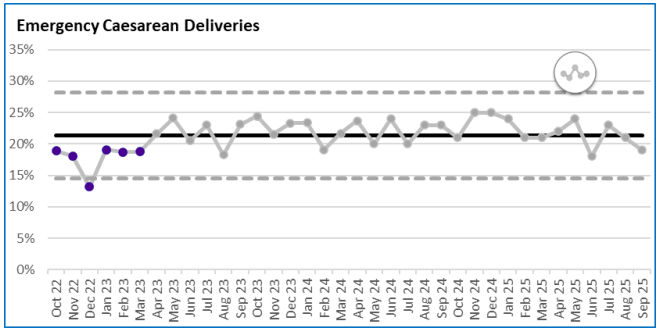
Early Neonatal Deaths

- The Trust has the highest level of neonatal intensive care provision supporting extremely premature babies. These deaths are reported to the Child Death Review panel who will have oversight of the investigation and review process. There was one early neonatal death in September 2025.

Perinatal Quality Oversight: Deliveries







Caesarean section deliveries

- In England 42.9% of births are caesarean section, in the North East North Cumbria (NENC) for Q1 this was 43.4%. There is no defined national metric for caesarean section rates.
- The Trust Q4 average was 36.6%. The Quarter 1 (Q1) average was 38.1%.
- The Trust had a comparable caesarean section rate of 40.0% in September 2025, however, 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.
- National reports, including Ockenden and Reading the Signals (East Kent) have highlighted lower caesarean section rates do not reflect improved patient safety or the importance of offering individualised and personalised care where women's voices are heard.

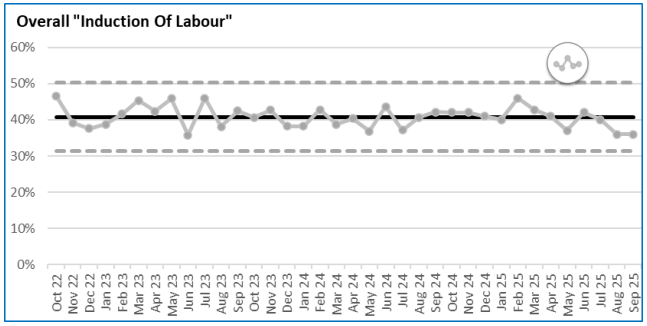
Elective Caesarean section

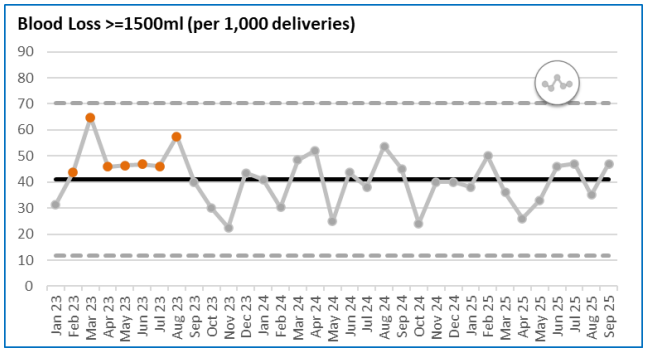
- The average England elective caesarean rate in Q1 was 19.8% and in NENC 20.2%.
- The Trust elective caesarean rate is stable at 21% in September (was 20% in July and 19% in August).
- The national rise in elective caesarean rates is partially due to an increasing proportion being undertaken due to maternal request in accordance with the National Institute for Health and Care Excellence (NICE) guidance.
- The Trust has a shared decision-making philosophy and offers informed, non-directive counselling for women over mode of delivery. There is an obstetrician/midwifery specialised clinic to facilitate this counselling and patient choice.

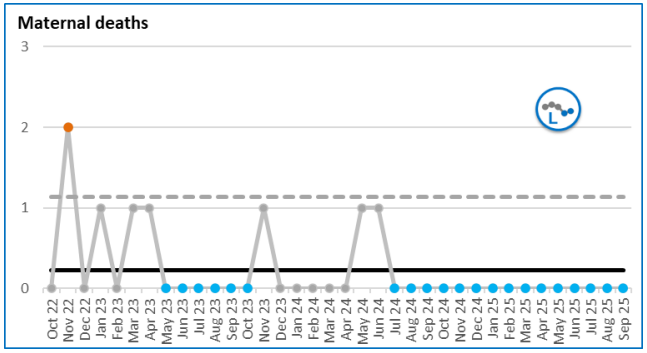
Emergency Caesarean section

- The England average for Q1 2024/25 was 23.6%, and NENC mean 20.5%.
- The Trust emergency caesarean rate was 19% in September. There is dedicated consultant presence on Labour Ward 8am-10pm daily, consultant led multi-disciplinary ward rounds occur twice daily. The majority of obstetric consultants remain onsite overnight, from 10pm-8am and are involved with all decisions for emergency caesarean section births.

Perinatal Quality Oversight: Labour







Induction of Labour

- The number of women being induced during pregnancy has increased due to changes in national guidelines as part of the Saving Babies Lives Care Bundle and other NICE and Royal College of Obstetricians and Gynaecologists (RCOG) guidance.
- England average for induction of labour Q1 2025/26 was 29.3% and NENC 35.3%. The Trust induction of labour rate for September is 36% (static from August). The Induction of Labour Quality Improvement Plan (QIP) reviewing pathways and patient experience is making good progress as the Trust is aware that the current facilities offered to women undergoing induction of labour require improvement.

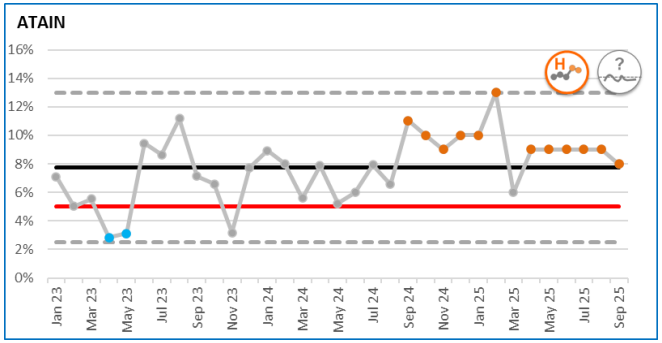
Blood Loss ≥1500ml

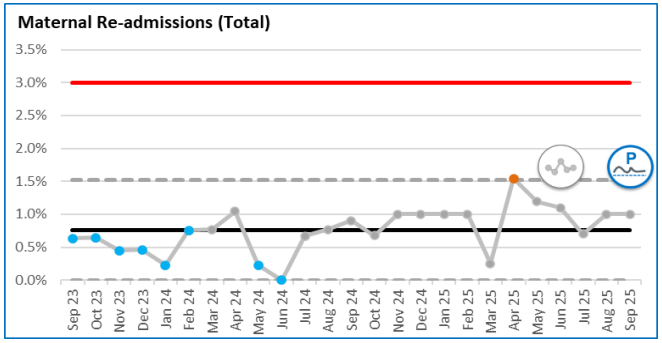
- The average Post Partum Haemorrhage (PPH) rate for Q1 2025/26 in England is 32 per 1000 and NENC average is 26 per 1000. The Trust PPH rate for September is 47 per 1000 (August rate 35 and July 47 per 1000). The Trust Q4 average was 29 per 1000, Q1 average was 35 per 1000 and Q2 average 43 per 1000.
- 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.

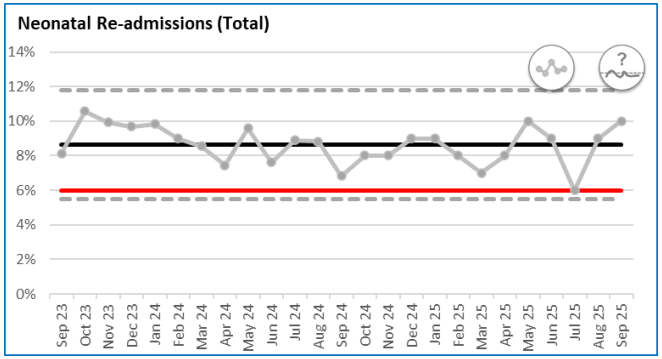
Maternal Deaths

- 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. Early maternal deaths are the death of a woman while pregnant or within 42 days of pregnancy (including termination of pregnancy). Late maternal deaths are reported from 42 days to 365 days of pregnancy. Direct deaths result from obstetric complications of the pregnant state. Indirect deaths are those from pre-existing disease or disease that developed but has no direct link to obstetric cause and was aggravated by pregnancy. Early maternal deaths are also reported to Maternity & Newborn Safety Investigations (MNSI), investigation is dependent on certain criteria. There have been no maternal deaths reported between July 2024 and September 2025.

Perinatal Quality Oversight: Admissions







Avoiding Term Admission into Neonatal Units ()

- The National benchmark for term admissions is 5%. The Trust rate remains consistently above the national 5% target; from June to August this was 9% and September 8%. Three quality improvement workstreams have been identified. The workstreams are care of infants of diabetic mothers, thermoregulation and respiratory issues following delivery by elective caesarean section, progress is monitored by the Quality and Safety Group and is linked to compliance with Safety Action 3 of Maternity Incentive Scheme. The neonatal nurse outreach pilot for theatre recovery commenced in August 2025.

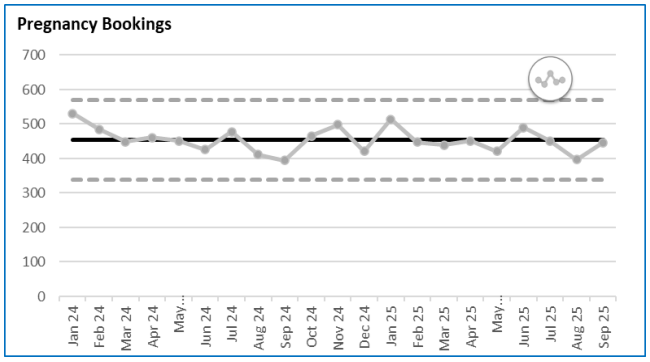
Maternal Readmissions

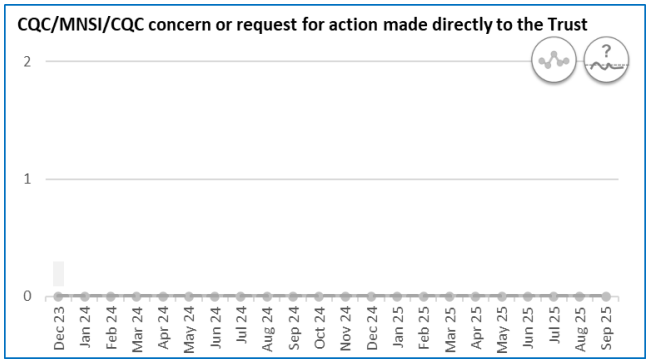
- National Maternity & Perinatal Audit (NMPA) Report (2022) the maternal postnatal readmission rate for England was 3.3%, with rates being higher following caesarean section compared with vaginal birth (4.3% vs 2.9%). The LMNS are working to agree a NENC Key Performance Indicator (KPI) for this metric, in the interim a target against the national average of 3% has been set. Maternal readmission rate for the Trust is consistently below the national average and has been 1% or less from June to September 2025.

Neonatal Readmissions

- The Clinical Quality Improvement Metrics (CQIM) for ‘Babies readmitted to hospital who were under 30 days old’ data is used as a comparison to Trust performance, hence the target of 6%.
- In September 2025 the readmission rate was 10%.
- The neonatal team are currently reviewing the management of jaundice guidance which is impacting the readmission rate and exploring the coding for the cases.

Perinatal Quality Oversight: Incidents & Bookings



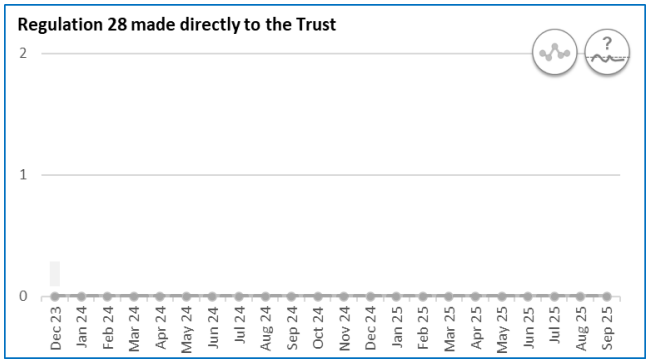


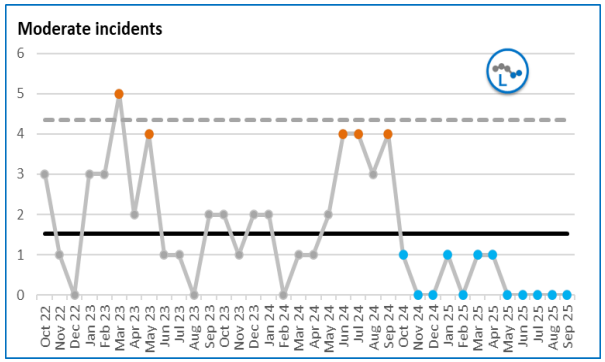
Pregnancy Bookings

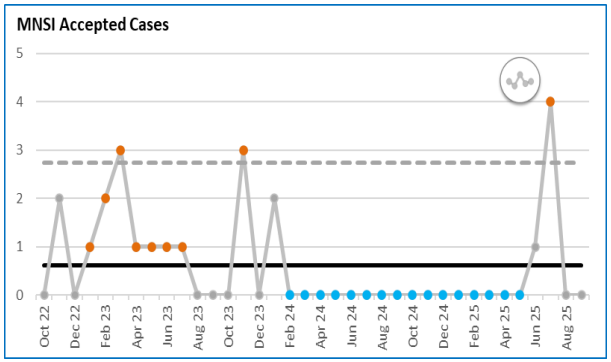
- The number of women choosing to book for care and delivery at the Trust had fallen since January 2024 and although is currently stable there has been no improvement in the number of bookings since the re-opening of the Birthing Centre. The number of bookings is a concern, and whilst reflects the reduced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

Incidents

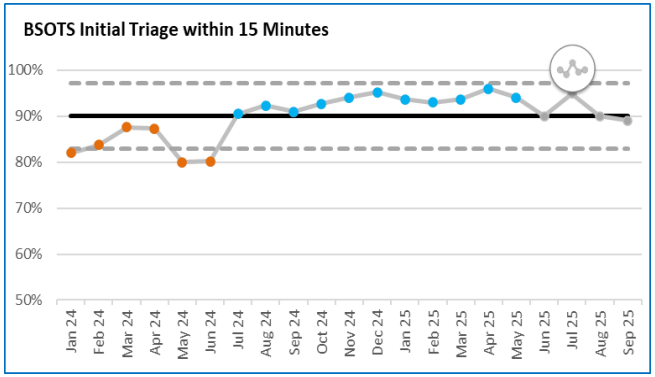
- This month we have separated moderate incidents from externally reported MNSI cases which were previously grouped together. There were no moderate or above harm incidents reported in September, these incidents are discussed at a multi disciplinary rapid review and presented to the Trust Response Action Review Meeting (RARM) to agree a proportionate learning response.
- Perinatal incidents referred to MNSI for external review are now detailed separately. These include cases involving neonatal brain injury - Hypoxic Ischaemic Encephalopathy (HIE), Term Intrapartum Stillbirths, Early Neonatal deaths and Maternal deaths. There were no new cases in September. MNSI continue to progress 5 cases for external review. MNSI reviews are usually completed within 6 months from referral.
- There have been no CQC/MNSI concerns or requests for action in the last 12 months.
- There have been no regulation 28 notices in the last 12 months.

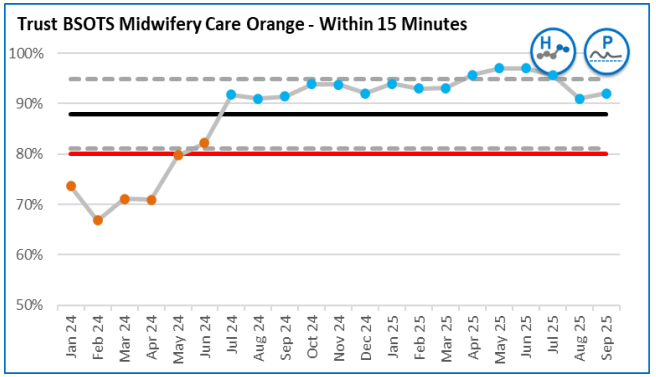


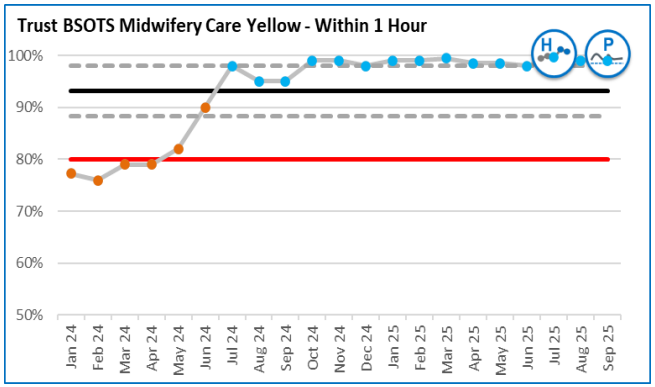


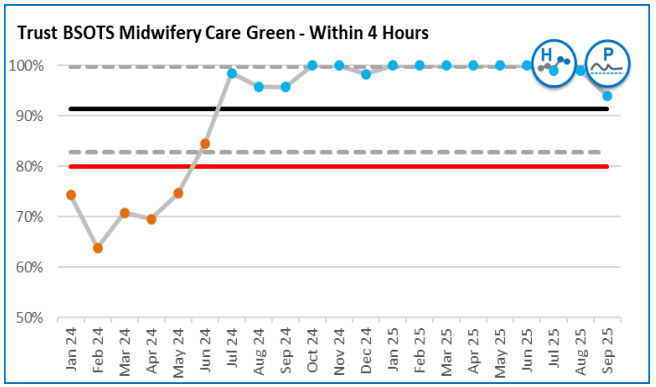


Perinatal Quality Oversight: Triage - Midwifery Care Timings





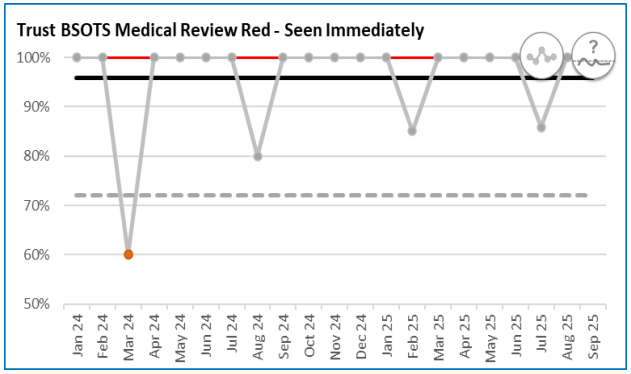


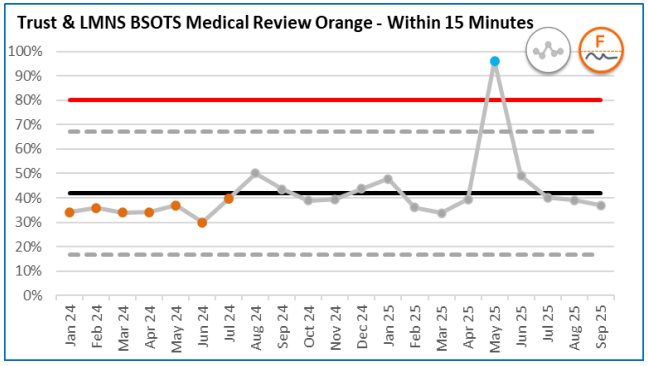


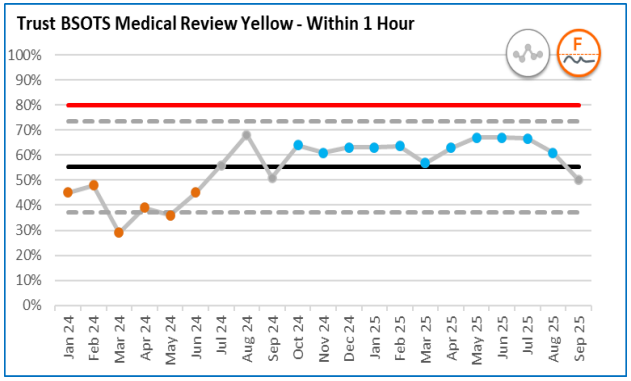
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

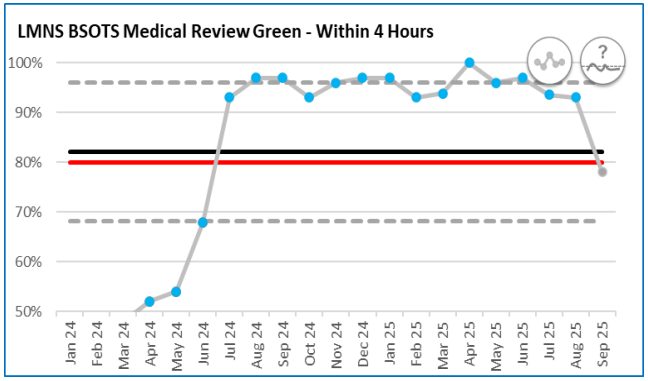
- The Trust implemented the BSOTS triage system in January 2024. Midwifery triage and subsequent review has improved considerably and has exceeded the Trust and LMNS target.
- Good performance continues to be sustained across every category for midwifery review.
- The triage within 15 minutes metric is subject to close scrutiny to monitor the impact of early pregnancy referrals from Emergency Department being supported by Maternity Assessment Unit following the cessation of the gynae overnight pathway from ED.

Perinatal Quality Oversight: Triage - Medical Review Timings





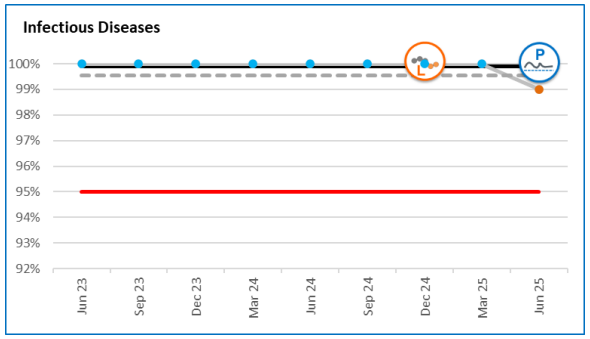


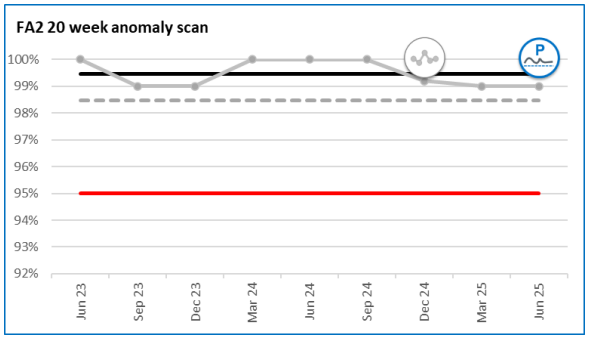


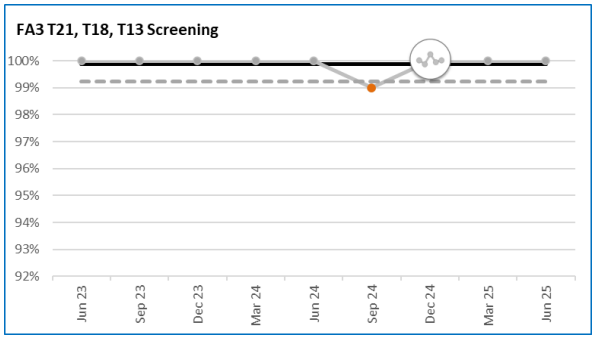
Birmingham Symptom Specific Obstetric Triage System (BSOTS)

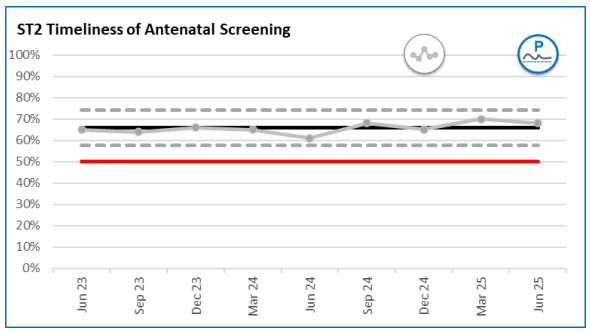
- There has been significant improvement in performance in the last 12 months.
- Unfortunately, the business case for a project to commence call recording and capturing patient experience for the triage services has been paused. This has been a safety recommendation from MNSI and PMRT investigations.
- Medical review for women in the orange category remains challenging, performance has remained at baseline level throughout Q2 2025. Further assurance regarding time interval for review, and the reason for attendance, is reviewed monthly at Quality & Safety (Q&S).

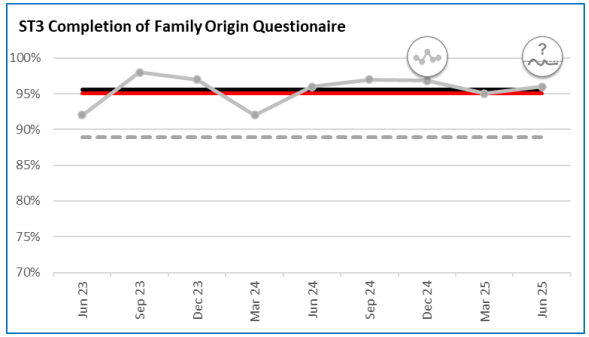
Perinatal Quality Oversight: Antenatal Screening

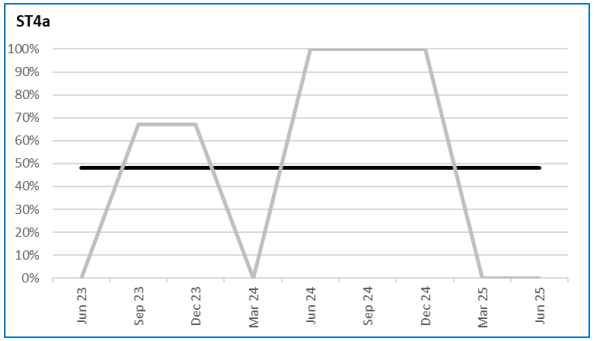


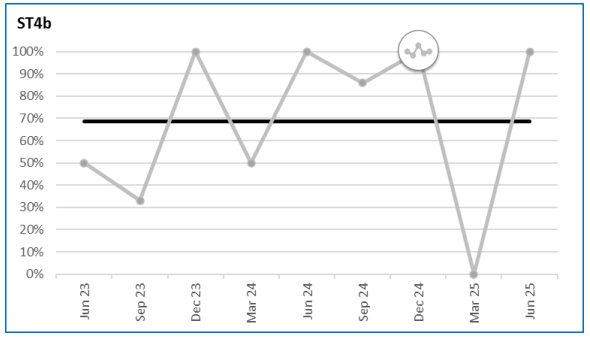


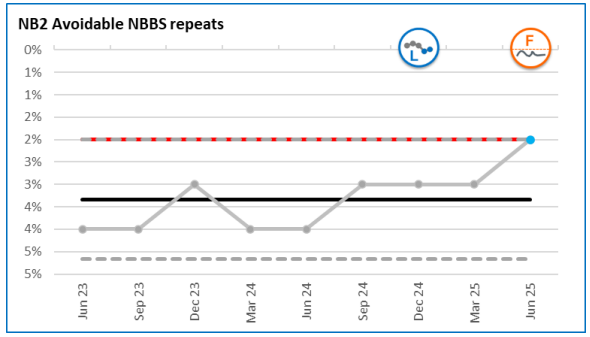








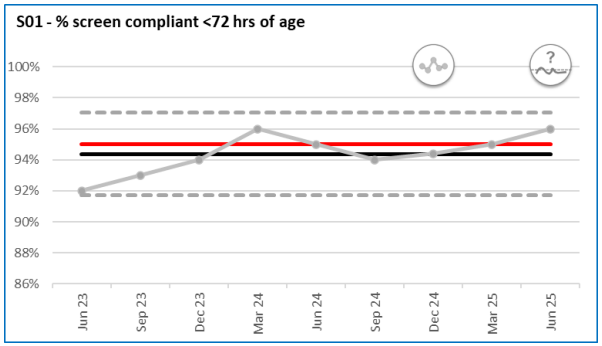


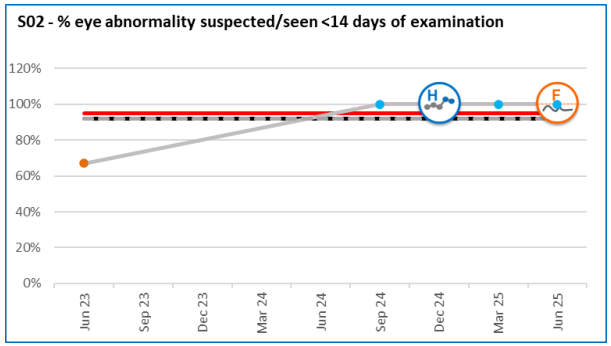


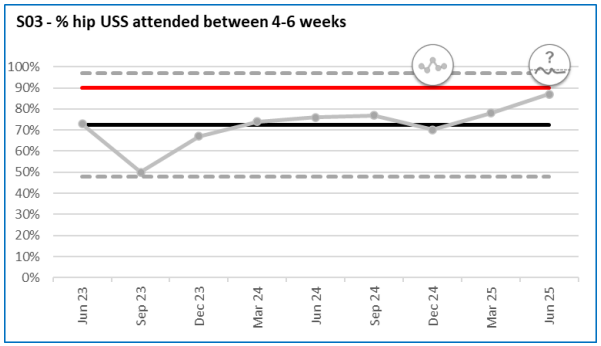
Antenatal Screening

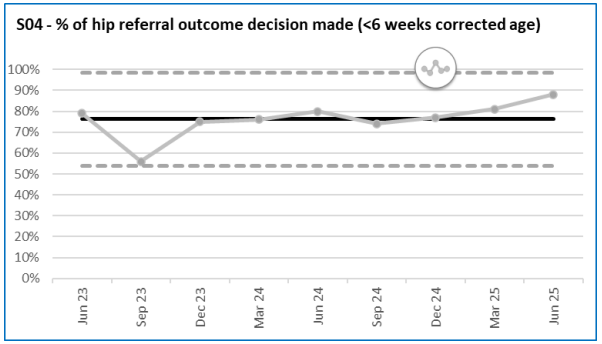
- QIP to review antenatal clinic patient flow, failsafe and administration processes is making good progress but is impacted by consultant capacity to provide cross cover.
- Improved performance in newborn blood spot repeats.
- Screening tracker has been developed by analysts and deployed to support failsafe processes and reporting as per the recommendation in the patient safety incident investigation (PSII).

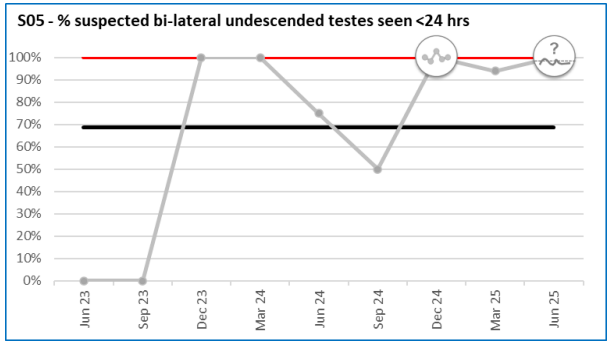
Perinatal Quality Oversight: NIPE Screening







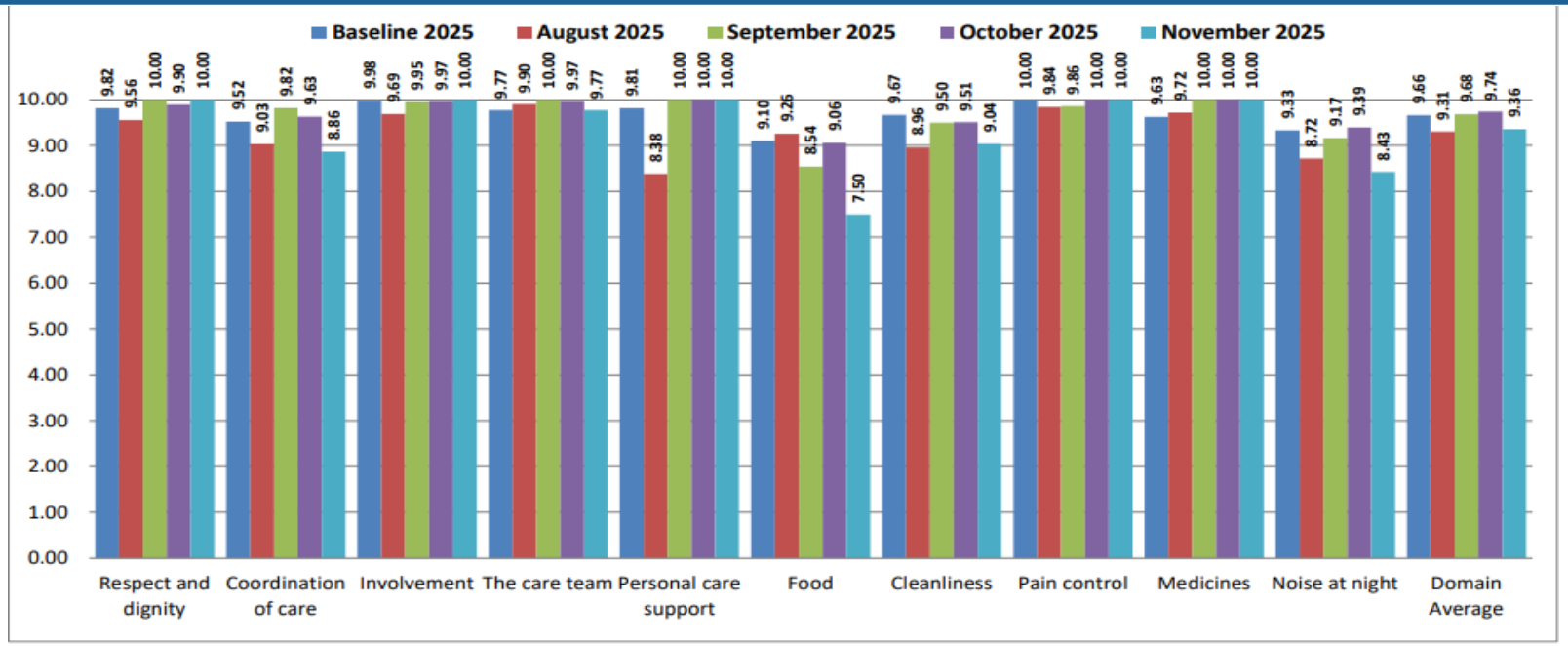




Newborn and Infant Physical Examination (NIPE)

- Improved performance across all elements.
- Screening tracker has been developed by analysts and deployed to support failsafe processes and reporting as per the recommendation in the Patient Safety Incident Investigation (PSII).

Perinatal Quality Oversight: Patient Experience

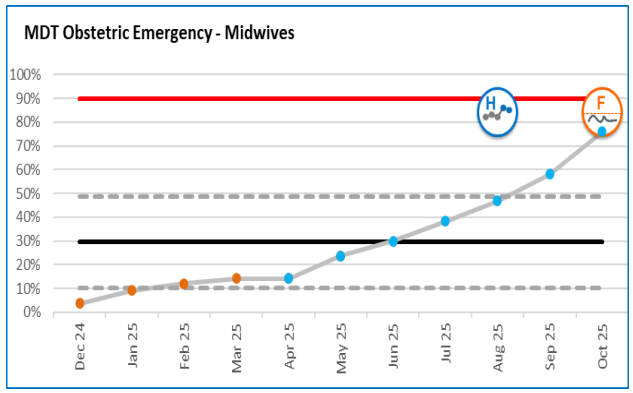


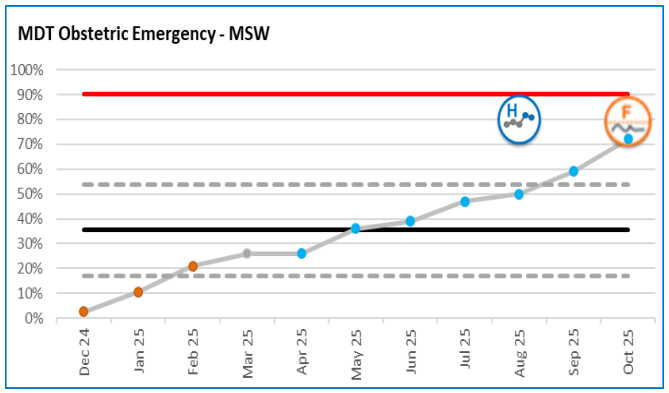
Patient perspective – Ward 33, Postnatal

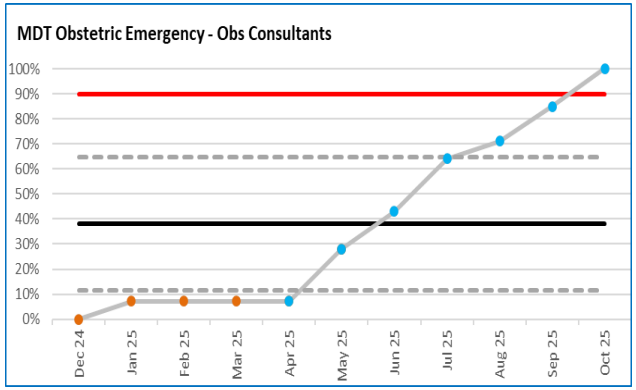
82% of patients surveyed rated their overall experience on the ward as either good or very good.
Number of patients on new medication: 4
Number of respondents: 11

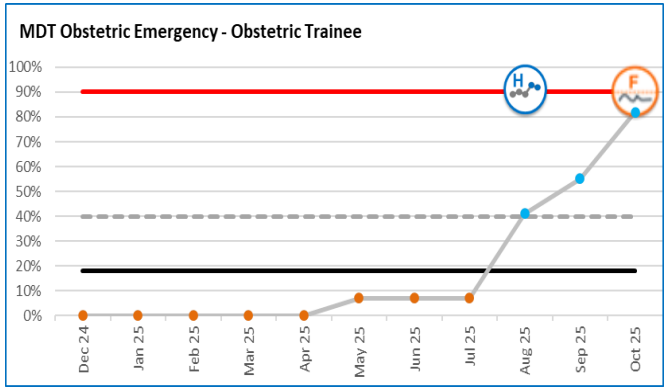
- Everything has all been the same and consistent. The staff work very well together; I've been really looked after. With the cleanliness, there's a lot of stains around. Last night got a little noisier, but not too bad.
- Things have been inconsistent once or twice. The day shift work well together, and the night shift work well together. I find there's a slight lack of communication between the two shifts with handover and things. I've heard people say, "that's a day shift/night shift problem". It's things like I asked a member of staff one night for some support socks and they couldn't find them, but when I asked the day shift, they were able to find them in 10 minutes. I've been able to speak to staff, and they've all been lovely about it. The staff have been really good with me and the baby, so I do have confidence in them. The food has no flavour. I had the honey and mustard chicken and it looked disgusting. There are a lot of babies crying, and it's quite hard when I think it's my baby crying. Everything has been absolutely fine.
- Definitely [respect and dignity]. There have been no inconsistencies yet. The staff work very well together from what I can see. Yes, I've been able to talk about my concerns, they've been very good about that. Yes definitely [attention when needed].

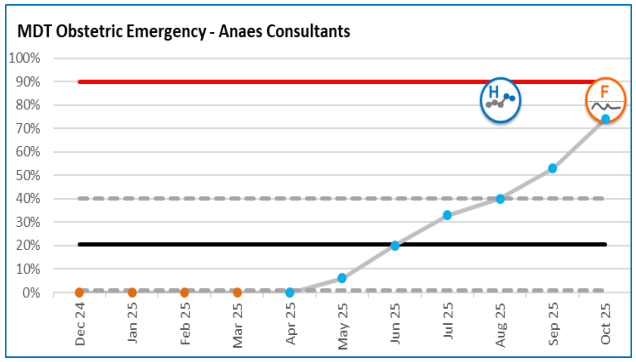
Perinatal Quality Oversight: Training (Maternity Incentive Scheme)

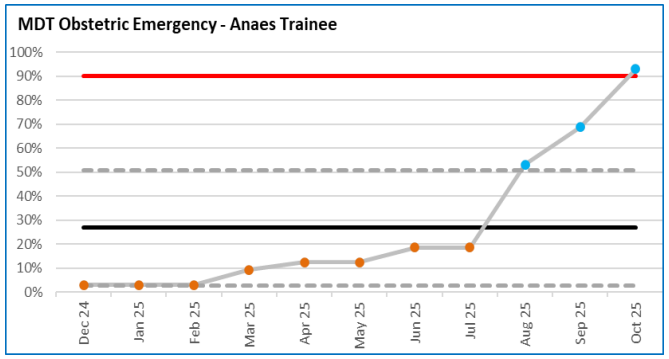












Obstetric Emergency Training by Staff Group:

In accordance with the Clinical Negligence Scheme for Trusts Maternity Incentive Scheme (CNST MIS) Year 7 guidance, safety action 8 requires 90% attendance in each relevant staff group at:

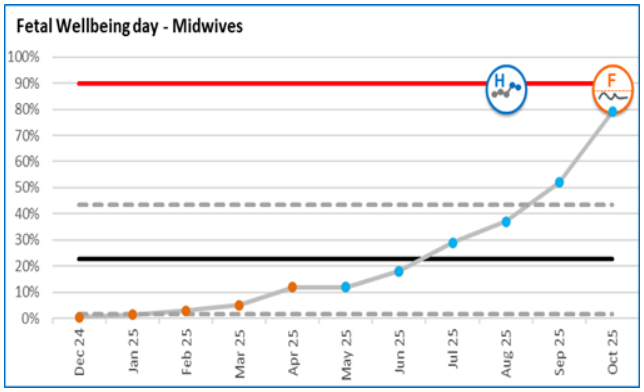
- Multi-professional maternity emergencies training.
- Neonatal resuscitation training.
- Fetal monitoring training.

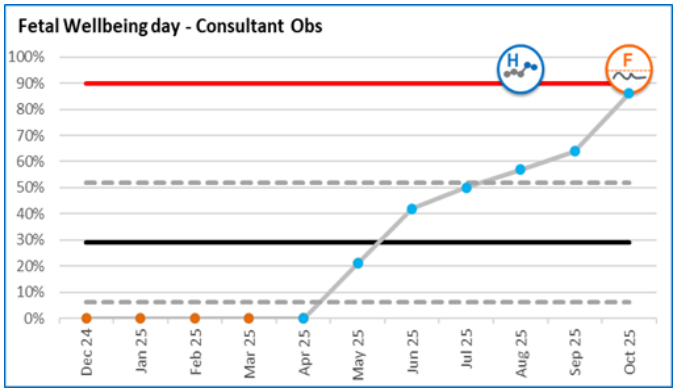
The fetal monitoring and obstetric emergencies training account for one whole day respectively.

An additional requirement is to ensure at least one emergency simulation is performed within a clinical area (not simulation suite) during the MIS reporting period to capture attendance from the wider professional team, the Trust are compliant with this requirement.

The Trust is on track to achieve compliance with the obstetric emergency training across all staff groups.

Perinatal Quality Oversight: Training (Maternity Incentive Scheme (MIS))

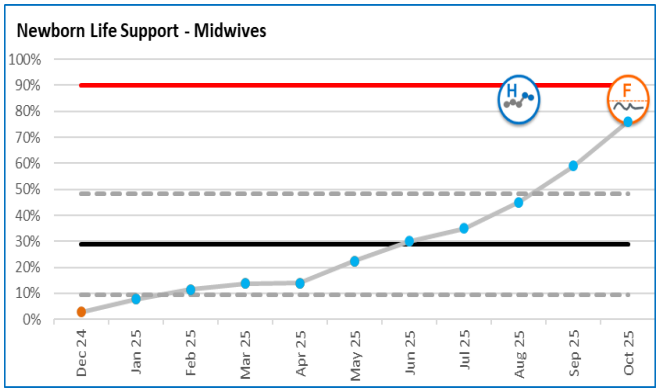


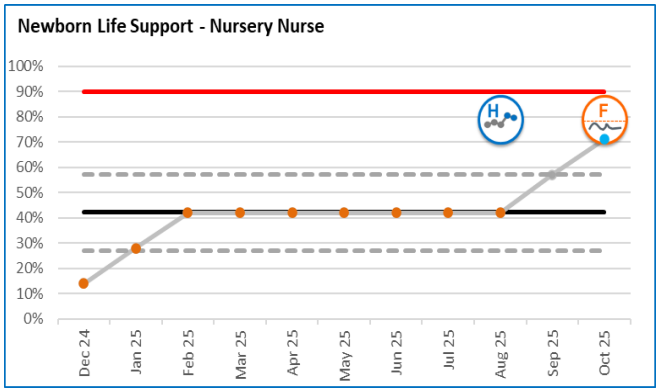


Fetal Wellbeing Training by Staff Group:

The Fetal Wellbeing training is essential training to ensure compliance with the implementation of the Saving Babies Lives Care Bundle version 3 (SBLCBv3) which aligns to the CNST MIS Year 7 Safety Action 6 and 8.

The Trust is on track to achieve compliance across all the required staff groups; however, this remains challenging and has senior oversight.





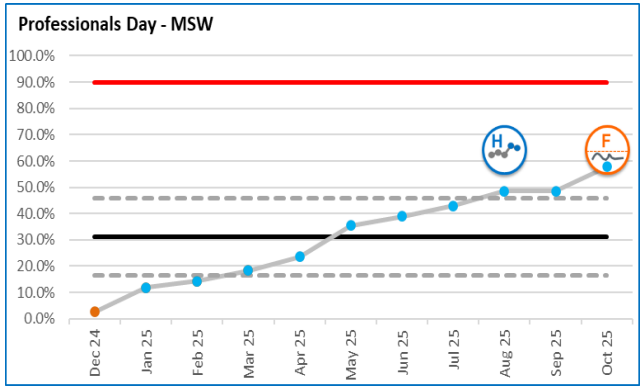
Newborn Life Support by Staff Group:

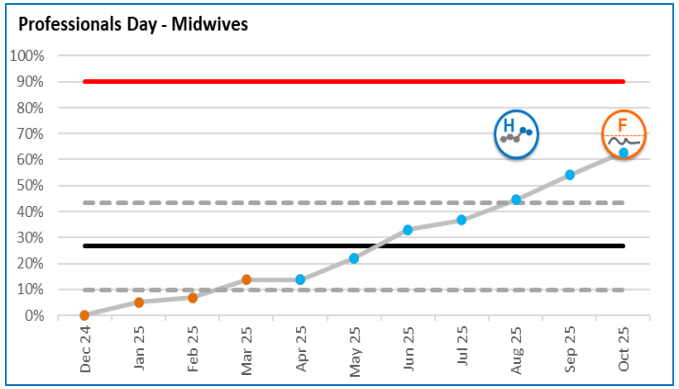
The newborn life support training is essential training to ensure compliance with MIS Year 7 Safety Action 8

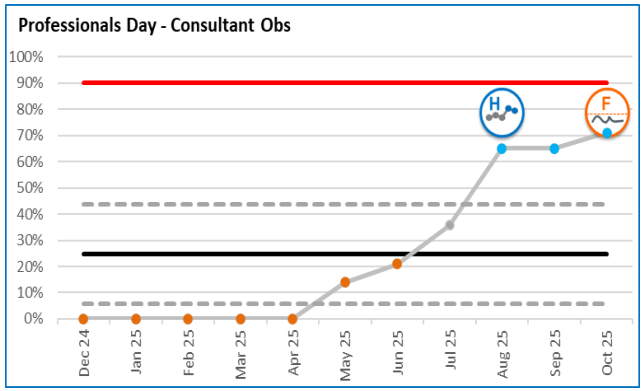
The Trust is on track to achieve compliance across all the required staff groups; however, this remains challenging and has senior oversight.

The neonatal data will be available from next month.

Perinatal Quality Oversight: Training (Maternity Incentive Scheme)





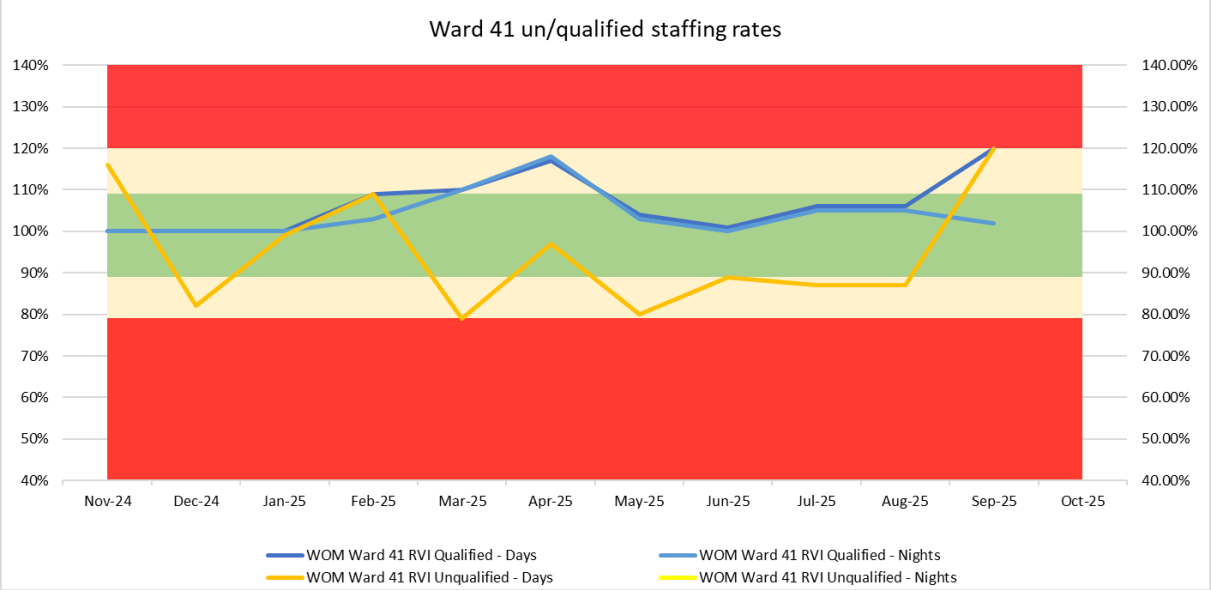


Saving Babies Lives Training by Staff Group:

The 'Professional' 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) which aligns to the CNST MIS Year 7 Safety Action 6.

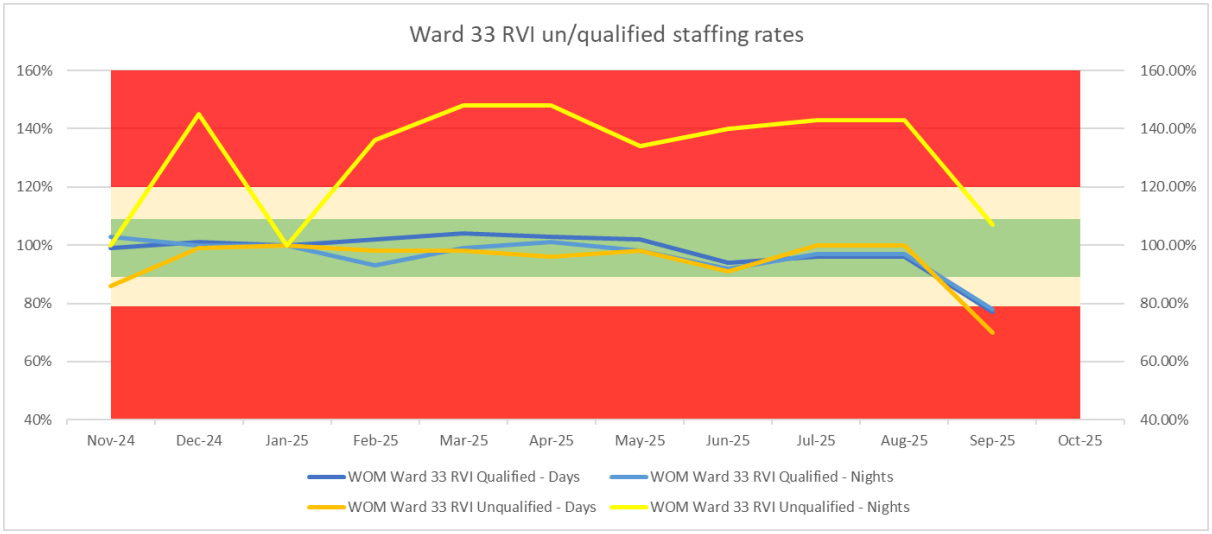
The training sessions scheduled in November will ensure the Trust is compliant.

Perinatal Quality Oversight: Staffing fill rates



Antenatal Ward (41)

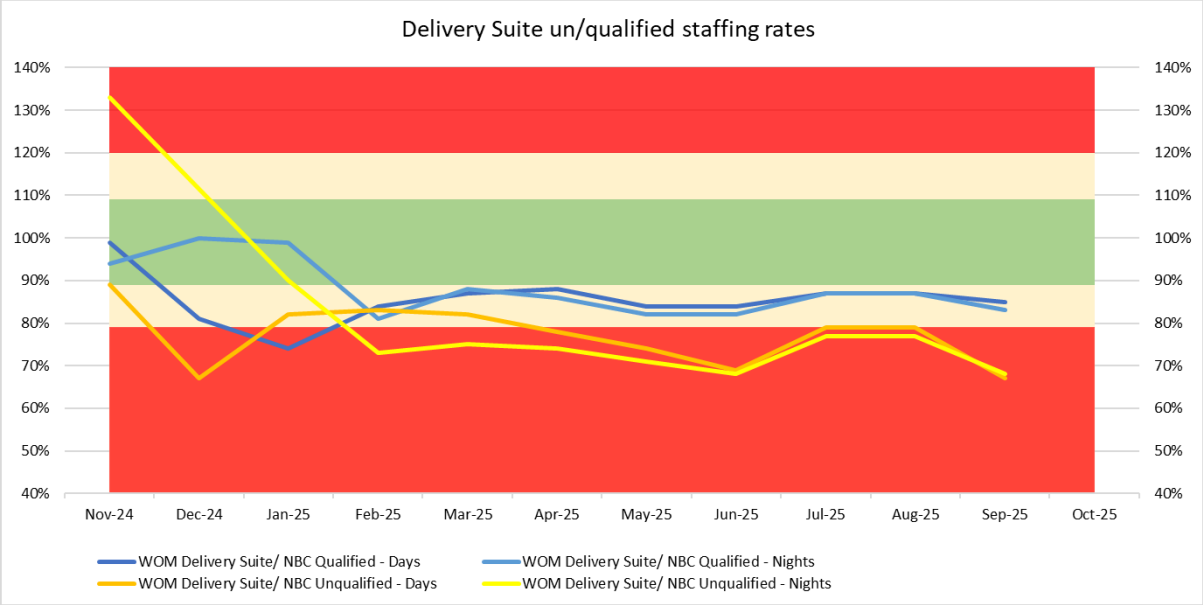
During September Ward 41 admitted an increased number of high-risk antenatal patients, some of whom required enhanced observations, hence an increase in the number of unqualified staff on night shift to support safety. The ward opened escalation beds in the additional bay; hence the midwifery fill rates exceeded the staffing establishment to maintain appropriate ratios.

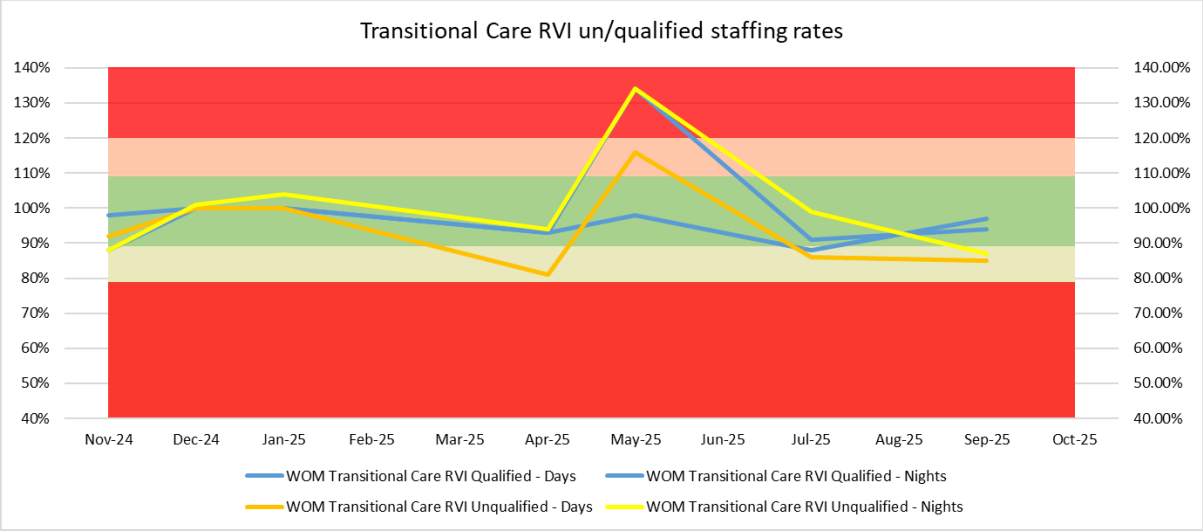


Postnatal Ward (33)

The fill rates for the postnatal ward have been impacted by sickness and escalation to support antenatal inpatient and intrapartum care during September. The midwifery staffing establishment has been depleted by maternity leave and vacant posts whilst awaiting the new entrant midwives coming into post. 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.

Perinatal Quality Oversight: Staffing fill rates





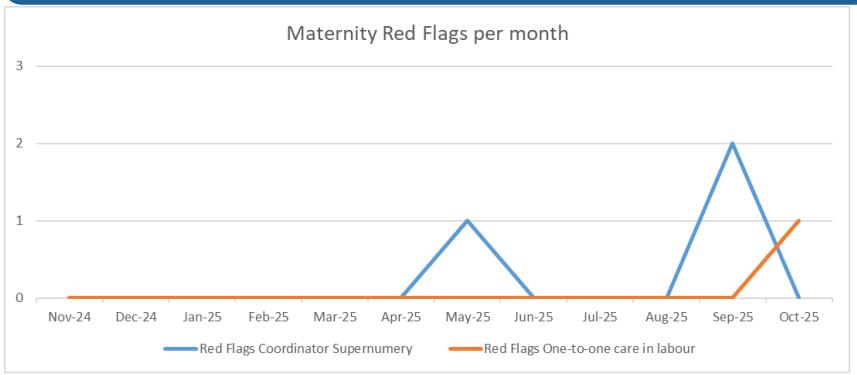
Intrapartum (Delivery Suite and Newcastle Birthing Centre)

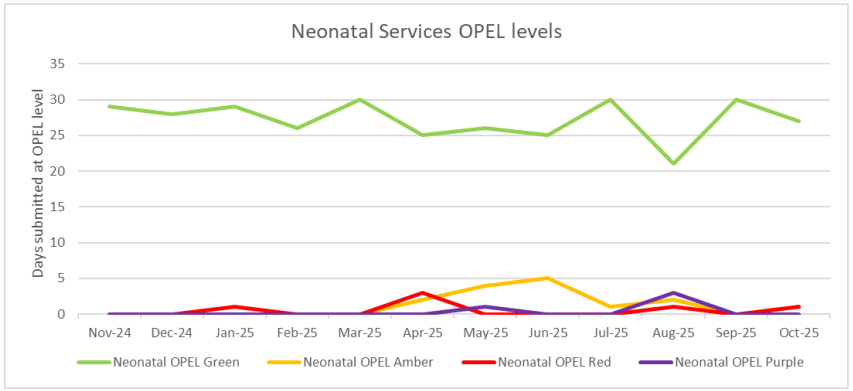
The midwifery fill rates for the intrapartum team remain stable despite the staffing position which is impacted by sickness and maternity leave. There were no red flags relating to the provision of one-to-one care in labour, but increased activity resulted in the co-ordinator not being supernumerary for part of the shift. On 19th September 22 babies were born. September was a busy month, with 431 babies born on the Delivery Suite, 38 in the Birthing Centre and 2 babies born at home.

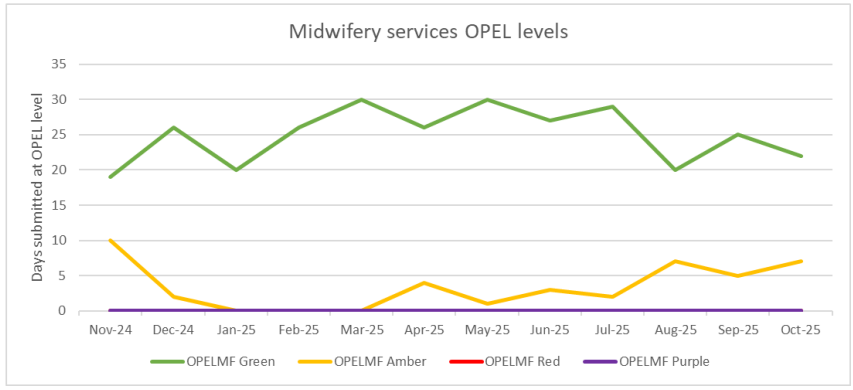
Transitional Care Ward (34)

The fill rates for Transitional Care ward for qualified and unqualified staff are stable. The escalation standard operating procedure to support appropriate nursing ratios has been agreed with the Neonatal Intensive Care Unit.

Perinatal Quality Oversight: Operational Pressures Escalation Levels (OPEL)







National Institute for Health and Care Excellence (NICE) Red Flags

There were 2 occasions in September when the co-ordinator was not supernumerary, secondary to operational pressures, for part of a shift, the Trust remains compliant with the MIS safety action 5 guidance as the co-ordinator was supernumerary for the beginning of the shift.

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

Operational Pressures Escalation Levels Maternity and Neonatal Framework

The maternity service maintained Operational Pressures Escalation Level (OPEL) 1 for 25 days in September, and OPEL 2 for 5 days. There were no staffing InPhase reports and no community escalations to support the acute service.

The neonatal service maintained OPEL 1 for 30 days in September. There were no staffing InPhase reports or delays to admissions or transfers out of region.

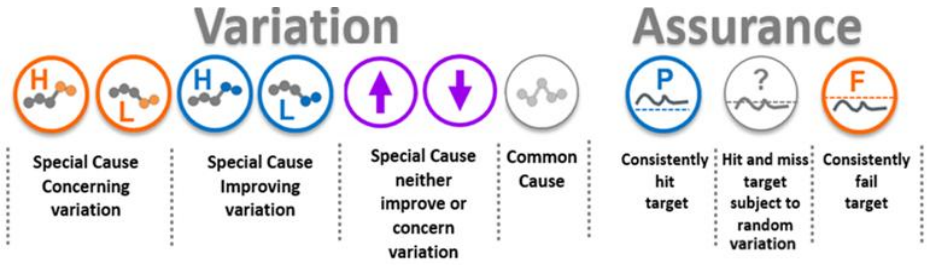
The Trust provided mutual aid to other providers on 3 occasions, accepting women for induction of labour to support system safety.

There were no gaps in obstetric or anaesthetic cover for the Delivery Suite during September 2025.

Performance

Performance Overview

Metric	Period	Actual	Traj.	Target	Variation	Assurance
Accident & Emergency (A&E) Arrival to Admission / Discharge	Sep-25	75.9%	83.4%	78%		?
Referral to Treatment (RTT) 18 Weeks	Sep-25	73.2%	72.2%	92%	H	F
>52 Week Waiters (% of total Patient Tracking List (PTL))	Sep-25	1.3%	1.1%	1%	L	F
Cancer 28 Day FDS	Sep-25	68.5%	80.9%	80%	L	?
Cancer 31 Day	Sep-25	89.0%	76.0%	96%	H	F
Cancer 62 Day	Sep-25	70.4%	66.5%	75%	H	F
Diagnostic 6 Weeks	Sep-25	16.9%	7.4%	5%	L	F



Emergency Care

- Emergency Department (ED) Performance (All Types) in September was 75.9%, a drop of 1.8% compared to September (77.7%). ED attendances continued to rise in September from August, the proportion of Type 1 Major however decreased.
- ED Arrival to Admission / Discharge > 12 hours (Type 1) in September was 2.8%, a 1.0% decrease from the previous month.

Elective Waits

- September 2025 witnessed a further decrease in >52-week waiters at Newcastle Hospitals, falling to 1,131 (-114). The number of >65 week waits also decreased to 64 (-25).
- The total waiting list size reduced again in September to 87,666. The Trust's participation in an NHS England coordinated validation sprint has been key to waiting list reductions in 2025/26.

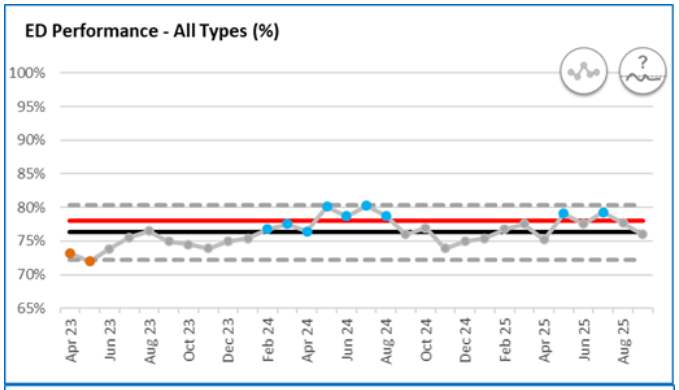
Cancer Care

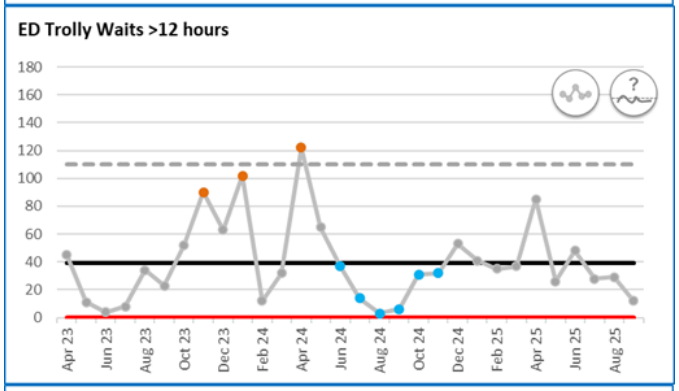
- In September, the 80% 28 Faster Diagnosis Standard (FDS) target was not achieved (68.5%) is now showing special cause variation of a concerning nature.
- 31-day performance was below standard and declined slightly to 89%.
- 62-day performance improved marginally to 70.4%.

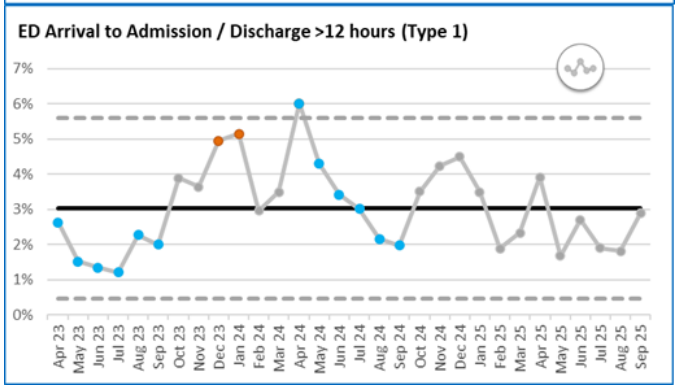
Diagnostics

- Performance against the 5% standard improved in September – 16.9% of patients were waiting over six weeks. The target continues to be consistently failed but there is special cause variation of an improving nature after considerable improvement in 2024/25.

Emergency Care







Standards

- 78% of patients to be admitted/transferred/discharged from A&E in <4 hours (by March 2026).
- No ambulance handovers to Accident & Emergency (A&E) exceeding 60 minutes.
- Reduction from 2024/25 in waits over 12 hours from A&E arrival to admission/discharge (Type 1).

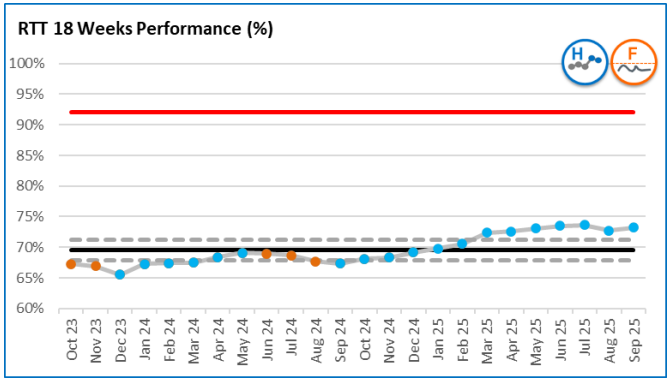
Current position

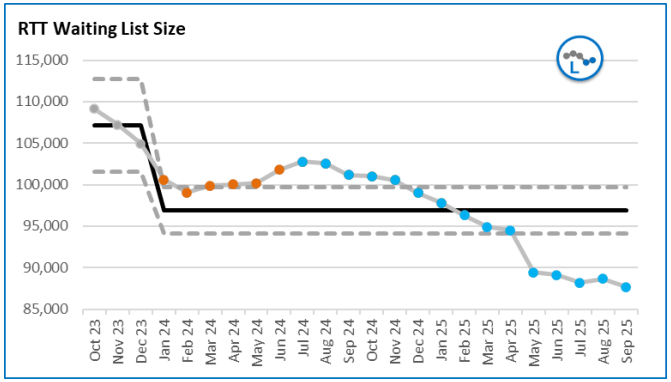
- ED Performance (All Types) in September was 75.9%, a drop of 1.8% compared to September (77.7%). ED attendances continued to rise in September from August, the proportion of Type 1 Major however decreased.
- ED Trolley waits >12 hours reduced, dropping to 12 in September from 29 in August.
- ED Arrival to Admission / Discharge > 12 hours (Type 1) in September was 2.8%, a 1.0% decrease from the previous month.
- The number of Ambulance Handovers > 60 mins has continued to reduce, down to 17 in September from 92 in August. This was a major reduction thanks to a new extra shift for a Nursing member of staff to lead ambulance handover times. This post was not recurring. The extra member of staff also impacted the number of Ambulance handovers over 30 minutes, which also reduced to 386 in September from 579 the previous month.

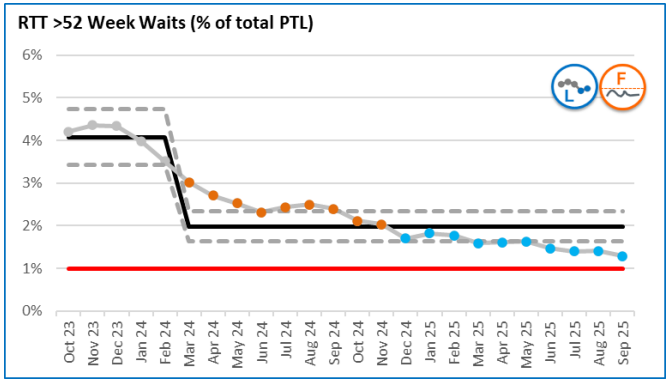
Action taken

- Work has started on assessing the impact of the Urgent Treatment Centre (UTC) on Type 1 and Type 3 performance across Adult and Paediatric ED.
- ED and Assessment Suite have started using CapMan to allocate beds and reduce the number of phone calls between departments and support timely transfer of patients.
- Work ongoing to support cascade and adherence to ED interprofessional standards.
- Review of direct streaming pathways to Same Day Emergency Care (SDEC) to support earlier arrival from ED.
- Trialling bookable appointments for GPs earlier in the day to maximise capacity when SDEC is quieter from an ED admissions point of view.
- Continuous Flow Standard Operating Procedure (SOP) – Trying to focus on facilitating flow earlier in the day prior to completion of Assessment Suite ward round. This has only been trialled in Medicine, this SOP identifies safe spaces in all bed holding Clinical Boards.

Elective Waits







Standards

- 92% of patients on incomplete Referral To Treatment (RTT) pathways to be waiting less than 18 weeks.
- Zero tolerance on incomplete RTT waits over 65 weeks.
- <1% of incomplete RTT waits over 52 weeks (by March 2026).
- 72% of patients time to first outpatient appointment <18 weeks (local target of 82.6%).

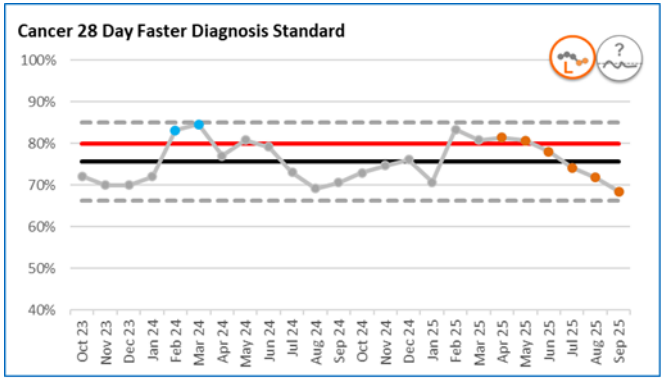
Current position

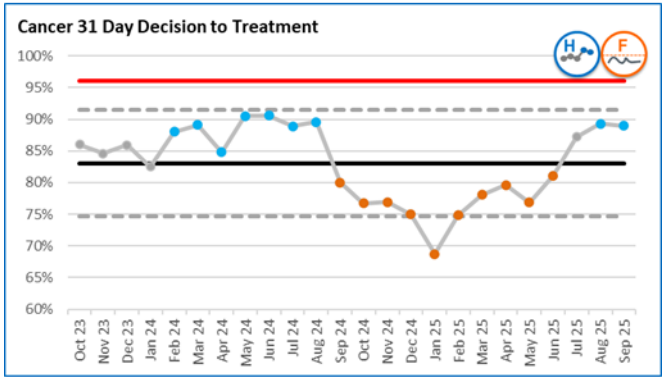
- September 2025 witnessed a further decrease in >52-week waiters at Newcastle Hospitals, falling to 1,131 (-114). The number of >65 week waits also decreased to 64 (-25).
- >78-week waiters reduced from 9 in August to 1 in September, with the single Vascular Surgery patient that breached being a prisoner which caused logistical challenges.
- Whilst the Trust is now pivoting focus to clearing 52-week waiters and making improvements to the front-end of the RTT pathway, it continues to manage issues at sub-specialty level impacting remaining 65-week waiters ahead of the national clearance deadline of 21st December, including:
    - Ophthalmology continue to manage corneal graft tissue availability alongside capacity pressures for ocular plastics, squint surgery, cataracts and glaucoma.
    - Ear, Nose & Throat (ENT) are currently unable to offer a vestibular service due to sickness & maternity leave.
    - Pressures in Urology particularly related to increased referrals and outpatients waits for functional urology.
- The total waiting list size reduced again in September to 87,666. The Trust's participation in an NHS England coordinated validation sprint has been key to waiting list reductions in 2025/26. A further validation sprint is scheduled to commence in quarter three.

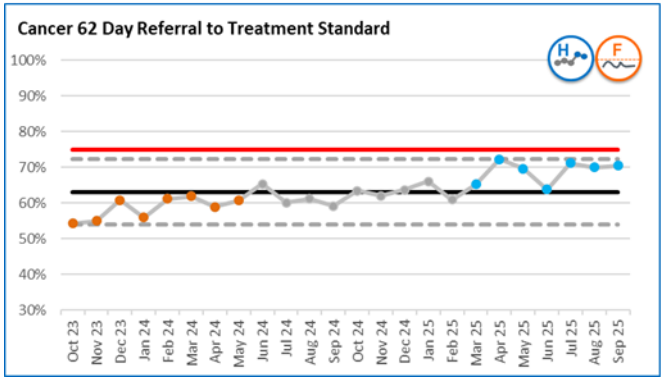
Action taken

- ENT have been offered mutual aid for vestibular testing from County Durham & Darlington NHS Foundation Trust (CDDFT), with the anticipation this will alleviate long-waits pressures until the Newcastle Hospitals service can re-commence.
- Ophthalmology are working with Peri-Op colleagues to identify additional lists for squint surgery-supported by the Executive Team. Opportunities have also been identified to run ocular plastics lists from the Campus for Aging and Vitality (CAV) with no additional nursing resource required.
- Urology are providing increased availability for diagnostics and follow-up appointments to give patients more flexibility and improve waiting times.

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 (by March 2026).
- 96% to wait no more than 31 days from diagnosis to first cancer treatment.
- 75% of patients to wait no more than 62 days from urgent/screening referral to first cancer treatment (by March 2026).

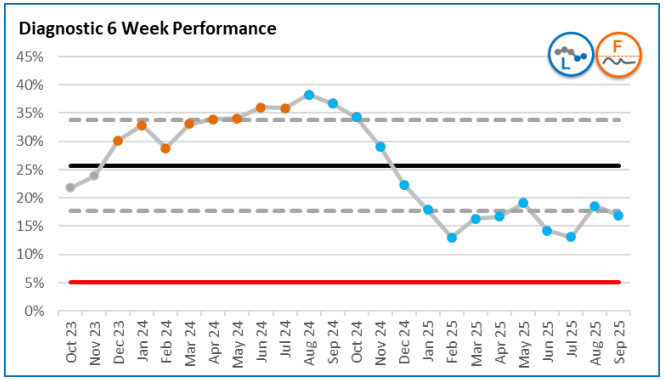
Current position

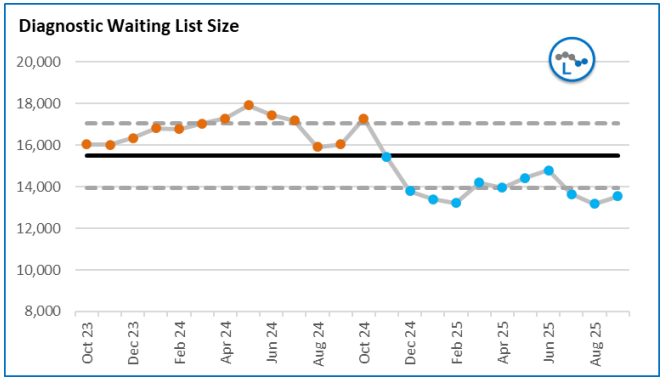
- In September, the 80% 28 FDS target was not achieved (68.5%) and shows a sustained decline.
- 31-day performance remains stable at 89.0% in September.
- 62-day performance continues to show special cause variation of an improving nature (70.4% for September), and efforts from the clinical teams to reduce numbers continue, as well as ensuring adequate plans are in place for the upcoming junior doctor strike to maintain full capacity.
- Automation software is being explored to maximise efficiency of the tracking and expediating patients through the pathways.
- Late referrals from other hospitals for treatment continue to impact our 62-day performance.
- There are currently capacity constraints within MRI as one machine continues to be out of action and turnaround times for cancer patients have increased.
- A review of treatments that do not happen on a cancer pathway is being undertaken to ensure data quality and to evaluate the impact that these patients may have on 62-day performance.
- Lower GI - current endoscopy challenges due to staffing shortages – turnover and sickness.

Action taken

- Skin - increased referrals impacting on Trust 28-day compliance, general dermatology capacity is being switched to skin cancer clinics carefully to not affect elective long waiters.
- Gynae – new consultant posts are now in place and active at the front of the pathway. No significant improvement in 62-day expected until January 2026, due to phased integration.
- Lung - capacity created through Northern Cancer Alliance (NCA) funding for navigational bronchoscopy. New respiratory consultant has started and is expected to support improvements at front of pathway.
- Lower GI – exploratory work underway to look at rehousing Endobronchial Ultrasound (EBUS) work in the Institute of Transplantation theatres to create additional endoscopy staffing capacity. Current vacant capacity does not align with lung consultant job plans therefore causing difficulty in operational implementation. This would however also require £150K in equipment investment.

Diagnostics





6 Week Diagnostic Performance by Modality – September 2025			
MRI	17.1%	CT	3.4%
Non-obs Ultrasound	11.8%	DEXA (Bone density)	9.1%
Audiology	22.8%	ECHO	67.3%
Electrophysiology	0%	Neurophysiology	5.3%
Sleep Studies	46.2%	Urodynamics	42.2%
Colonoscopy	17.7%	Flexi-Sig	19.6%
Cystoscopy	30.4%	Gastroscopy	27.6%
Newcastle Hospitals Total			**16.9%**

Standards

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

Current position:

- Performance against the 5% standard improved in September – 16.9% of patients were waiting over six weeks. The target continues to be consistently failed but there is special cause variation of an improving nature after considerable improvement in 2024/25.
- Sleep Studies (46.2%) and Echo (67.3%) remain the areas with the most challenged performance. Echo's IT issues at the Metrocentre Community Diagnostic Centre (CDC) temporarily diverted team capacity away from routine validation of the waiting list, resulting in a worsening position.
- Magnetic Resonance Imaging (MRI) have recently been impacted by a malfunctioning scanner at the Freeman Hospital (FRH), and the service are working with Siemens who have taken responsibility for replacing the faulty parts over the coming weeks. The Trust has secured another relocatable MRI at FRH which will become operational in early November. MRI have the most >13-week waiters (206).
- The waiting list grew by 354 patients in August, with increases across Radiology. There were 447 patients waiting >13 weeks at the end of August.

Action taken

- MRI continue with targeted work to significantly reduce the longest periods of downtime between scans – a recent assessment showed the average time between scans was 17 minutes, but that this is significantly exacerbated by the longest waits.
- Neuro MRI have managed to increase productivity through an improvement project that has implemented staggered lists and a dedicated porter. They are also using acceleration software to increase capacity by reducing scan times per patient.
- Regular weekend Neuroradiology General Anaesthetic (GA) MRI lists are being run to address the >13-week waiters, with a play specialist being deployed to great effect in reducing the number of paediatric patients requiring general anaesthetic.
- An ECHO recovery plan is being refreshed based on the improvement initiatives that were trialled over the summer. Trajectories will take into account the impact of waiting list validation (focussed tranches due to capacity and ongoing issue related to Future Orders implementation), increased staffing and more efficient use of appointments (e.g. back-to-back clinics).
- Endoscopy have successfully recruited staff to enable all rooms to be staffed more consistently.

Contractual & Planning Standards (1/2)

Theme	Standard	Trajectory (Aug-25)	Jun-25	Jul-25	Aug-25	Sep-25	Num.	Den.	25/26 YTD
Activity									
Day Case	**100%** of 25/26 Plan (equivalent to 118% of 19/20 value-weighted activity)	N/A	99.7%	98.5%	97.9%	**94.5%**	11,403	12,070	**99.4%**
Elective Overnight			93.5%	92.5%	98.8%	**89.3%**	1,789	2,003	**96.0%**
Outpatient New			101.2%	98.6%	94.1%	**95.8%**	27,215	28,420	**98.5%**
Outpatient Procedures			96.3%	97.6%	92.9%	**84.1%**	20,235	24,060	**94.4%**
Outpatient Review	N/A		108.2%	106.5%	105.5%	**108.9%**	71,110	65,305	**108.9%**
Non-Elective			91.2%	93.5%	96.8%	**95.8%**	1,002	1,046	**91.7%**
Emergency			102.9%	105.7%	97.7%	**109.6%**	6,499	5,931	**104.4%**
Diagnostic Activity	**100%** of 25/26 Plan	N/A	103.4%	101.7%	112.3%	**107.3%**	24,478	22,808	**105.0%**
PIFU Take-up (%)	>=**5%** of all OP atts. (by Mar-29)	**3.2%**	2.7%	2.7%	2.7%	**2.5%**	3,127	124,943	**2.6%**
Day case rates (BADS procedures)	**85%**	N/A	**84.0%**	TBC	TBC	TBC			
Capped Theatre Utilisation	**85%**	N/A	81.9%	81.0%	82.0%	**83.4%**			
Urgent Ops. Cancelled Twice	**Zero**	N/A	0	0	0	**0**	0		**0**
Cancelled Ops. Rescheduled >28 Days	**Zero**	N/A	2	5	9	**2**	2		**26**
Elective Waits									
RTT Waiting List Size	**Reduction** from 24/25	**94,083**	89,130	88,211	88,675	**87,666**	87,666		
RTT 18 Week Wait	**92%**	**72.2%**	73.5%	73.6%	72.7%	**73.2%**	64,182	88,675	**73.1%**
>78 Week Waiters	**Zero**	**0**	12	9	9	**1**	1		
>65 Week Waiters	**Zero**	**0**	71	68	89	**64**	64		
>52 Week Waiters	**N/A**	**855**	1,307	1,275	1,245	**1,131**	1,131		
>52 Week Waiters (% of Total WL)	**<1% of total WL** (by Mar-26)	**0.9%**	1.5%	1.4%	1.4%	**1.3%**	1,131	88,675	**1.5%**
>12 Week Waiters Validated	**90%**	N/A	94.7%	95.9%	99.3%	**98.7%**	21,419	22,363	**96.8%**
Time to First Outpatient Appointment (18 Weeks)	**72%** (local target of **82.6%**)	**79.0%**	78.8%	79.6%	78.2%	**78.3%**	40,242	52,606	**78.7%**
RTT Waiting List (Children & Young Persons <=18 yrs)	N/A	**12,419**	12,538	12,330	12,233	**11,783**	11,783		
>52 Week Waits (Children & Young Persons <=18 yrs)		**74**	201	162	144	**149**	149		
Community Services Waiting List	N/A	N/A	11,349	11,135	**10,444**	TBC	TBC		
Community Services >52 Week Waiters			514	626	**694**	TBC	TBC		
Diagnostic 6 week wait	<=**5%** (local target of **<=11.4%**)	**7.4%**	14.2%	13.1%	9.5%	**8.6%**	2,290	13,183	**16.4%**

Contractual & Planning Standards (2/2)

Theme	Standard	Trajectory (Aug-25)	Jun-25	Jul-25	Aug-25	Sep-25	Num.	Den.	25/26 YTD
Cancer Care									
28 Day Faster Diagnosis	**80%** (by Mar-26)	**82.3%**	78.1%	74.2%	71.9%	**68.5%**	2,419	3,258	**75.8%**
31 Days (DTT to Treatment)	**96%**	**78.0%**	81.1%	87.3%	89.3%	**89.0%**	1,339	1,534	**83.9%**
62 Days (Referral to Treatment)	**75%** (by Mar-26)	**68.3%**	63.8%	71.2%	69.9%	**70.4%**	359	504	**69.5%**
>62 Day Cancer Waiters	**N/A**	**N/A**	135	137	120	**127**	127		**69.4%**
Urgent & Emergency Care									
A&E Arrival to Admission/Discharge (All types)	**>=78%** under 4 hours (by Mar-26)	**83.4%**	78.7%	80.2%	78.8%	**76.0%**	16,578	20,033	**78.4%**
A&E Arrival to Admission/Discharge (Type 1)	**Reduction** from 24/25	**2.0%**	2.7%	1.9%	1.8%	**2.9%**	369	11,603	**2.5%**
A&E Decision to Admit to Admission >12 Hours	**Zero** over 12 hours	**N/A**	48	28	29	**12**	12		**228**
Adult General & Acute Bed Occupancy	**<=92%**	**88.8%**	90.1%	87.3%	86.4%	**88.8%**	1,267	1,415	**88.5%**
Ambulance Handovers <15 mins	**65%**	**N/A**	47.6%	44.4%	42.5%	**51.0%**	1,708	3,237	**45.7%**
Ambulance Handovers <30 mins	**95%**		77.9%	78.9%	79.3%	**88.0%**	2,949	3,237	**79.7%**
Ambulance Handovers >60 mins	**Zero**		136	108	92	**17**	17		**663**
Urgent Community Response Standard	**>=70%** under 2 hours	**N/A**	78.3%	80.8%	84.5%	**87.8%**	294	296	**82.5%**
Safe, High Quality Care									
MiYed SeY Acommodation Breach	**Zero**	**N/A**	74	79	61	**66**	66		**415**
VTE Risk Assessment	**95%**		97.6%	**97.1%**	TBC	TBC			
Sepsis Screening Treat. (Emergency)	**>=90%** (of sample) under 1 hour		**70.0%**	TBC	TBC	TBC			
Sepsis Screening Treat. (All)			**89.0%**	TBC	TBC	TBC			

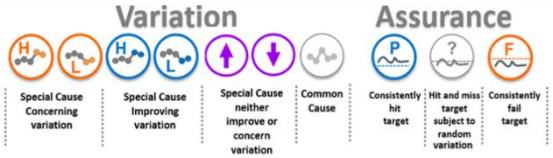
NHS Oversight Framework Q1 2025/26

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST (RTD) - Quarter 1 2025/26						
		Raw measure	**Ranking**	**Raw score derived**	**Final Score**	**Group Score**
DOMAIN SCORE - Access to Services						
Proportion of incomplete patient pathways waiting over 52 weeks		1.46%	38/131	2.16	2.16	
Proportion of incomplete patient pathways waiting less than 18 weeks (Gap to plan)		2.14%	Meet / exceed plan	1.00	1.00	
Proportion of incomplete patient pathways waiting less than 18 weeks (scored absolute performance)		73.53%	6/131	1.12	1.12	
Percentage of community services waiting list waiting over 52 weeks		6.12%	90/121	3.23	3.23	
Proportion of urgent referrals to receive a definitive diagnosis within 4 weeks		80.04%	Meet / exceed target	1.00	1.00	
Proportion of patients treated for cancer within 62 days of referral		68.48%	76/118	3.01	3.01	
% of patients managed in under 4 hours in ED		77.30%	49/123	2.22	2.22	
% of patients spending over 12 hours in ED		2.32%	16/123	1.37	1.37	
DOMAIN SCORE - Access to Services						1.89
National CQC inpatient survey overall experience rating		As expected	As expected	2.00	2.00	
Summary Hospital Mortality Indicator		As expected	As expected	2.00	2.00	
Urgent Community Response % achieving 2hr standard		70.61%	59/63	3.00	3.00	
Average number of days between discharge ready date and actual date of discharge		0.60	39/126	1.91	1.91	
DOMAIN SCORE - Effectiveness and Experience						2.23
NHS Staff Survey raising concerns sub-score (PRV)		6.37	79/134	2.76	2.76	
HCAI measure 1: 12 month rolling count of MRSA cases		8.00	118/134	3.72	1.23	
HCAI measure 2: 12 month rolling count of C.Difficile cases as a proportion of trust threshold		154.41%	116/134	3.71	1.22	
HCAI measure 3: 12 month rolling count of e.coli cases as a proportion of trust threshold		117.33%	76/134	2.97	0.98	
CQC safe domain inspection rating		Requires improvement	Requires improvement	3.00	3.00	
DOMAIN SCORE - Patient Safety						3.07
Sickness absence rate		6.01%	156/205	3.28	3.28	
NHS Staff Survey engagement sub-score (PRV)		6.83	76/134	2.69	2.69	
DOMAIN SCORE - People and Workforce						2.99
Planned surplus / deficit as a proportion of turnover		0.0%	Planned surplus/deficit	1.00		
YTD surplus / deficit		0.0%	Meet / exceed plan	1.00		
Aggregated finance score					1.00	
Implied rate of productivity compared with baseline		0.26%	102/134	3.28	3.28	
DOMAIN SCORE - Productivity & value for money						2.14
Finance Override						NO
OVERALL AVERAGE SCORE				51.42	43.451	2.29
		FINAL SEGMENTATION				**2**

People

People overview

Metric	12-month rolling	Actual	Target	Variation	Assurance
Sickness	Sep-25	5.69%	4.5%		F
Short-term (Month only)	Sep-25	1.97%			
Long-term (Month Only)	Sep-25	3.73%			
Turnover	Sep-25	8.72%	10%		P
Mandatory training	Sep-25	92.52%	90%		P
Appraisal	Sep-25	80.63%	90%	L	F
Disabled staff	Sep-25	6.31%		H	
Ethnicity (BAME staff)	Sep-25	18.39%		H	



Staff in post

- Total is 15,941 Full Time Equivalent (FTE) including Bank/agency.
- Total substantive is 15,533.38 FTE, 17,797 headcount.
- Above substantive pre-Covid by 2,001 FTE (+14%).
- Above workforce plan of 15,666 FTE by 275 FTE (+1.76%).

Sickness

- Top reasons for sickness: anxiety/stress/depression 34% (-1%); other musculoskeletal problems 10% (-1%); cough, cold, flu – influenza (+3.9%).
- Short-term sickness change in September -0.31% 1.97%.
- Long term sickness change in September -0.01% to 3.73%.

Retention & Turnover

- Reduction of 0.09%.Top reason for leaving: retirement age at 15.26%.
- Top destinations: no employment 42.34%; other NHS organisation 30.72% (includes retire-return).

Mandatory training & Appraisal

- Reduction of 0.43% (MT), overdue appraisals increased to 2,698.
- Lowest is Medical and Dental (decreased by 1.66%) 81.88%.
- Seven courses are below target.

Bank & Agency

- Total annual non-medical bank expenditure £18.5m, +£1.7m vs last year.
- Total annual non-medical agency expenditure £3.2m, -£0.82m vs last year.
- Total annual medical agency expenditure £3.9m, +1.0m vs last year.

Equality & Diversity

- Disabled staff change in September +0.09% to 6.31%.
- Black, Asian and Minority Ethnic (BAME) staff change in September +0.16% to 18.39%.

Provider workforce return (PWR) – overview as-at September 2025

Headline Metric	Jan 2020 FTE	Plan FTE	Establishment	Current FTE	Current FTE v Jan 2020	Current FTE v Plan	Current FTE v Establishment
1. Total Non Medical - Clinical Substantive Staff	8,684.15	9,984.66	10,492.88	10,051.21	1,367.06	66.55	-441.67
2. Total Non Medical - Non-Clinical Substantive Staff	2,874.99	3,293.45	3,767.64	3,377.27	502.28	83.82	-390.37
3. Total Medical and Dental Substantive Staff	1,732.92	1,968.52	2,051.89	2,090.68	357.76	122.17	38.79
4. Any other Staff (substantive staff)	146.48	47.75	16.16	13.60	-132.88	-34.15	-2.56
5. Bank	441.22	321.92		382.38	-58.84	60.46	
6. Agency	60.38	49.58		26.18	-34.20	-23.40	
Total	**13,940.15**	**15,665.88**	**16,328.57**	**15,941.33**	**2,001.18**	**275.45**	**-795.81**

Current Position:

- Substantive workforce is +2,094 FTE (13.5%) above January 2020 (pre-Covid) position.
- Substantive workforce target at year-end is 15,352 FTE.
- Substantive workforce target as at 30 September is 15,294 FTE.
- Substantive workforce actual position as at 30 September is 15,533 FTE
- Substantive workforce is currently +239 FTE above plan for September.

(see next slide, top row, middle graph)

- NHS infrastructure support (substantive) is 83.82 FTE above plan.
- Bank is off plan.
- Agency is better than plan.
- Additional hours are being worked as overtime whereas Bank would be a cheaper option.
- Overtime appears to be used despite contract hours being unfilled, however the gap is reducing.

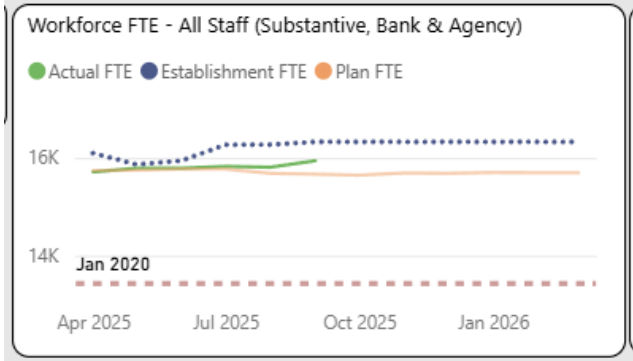
Underlying Issues

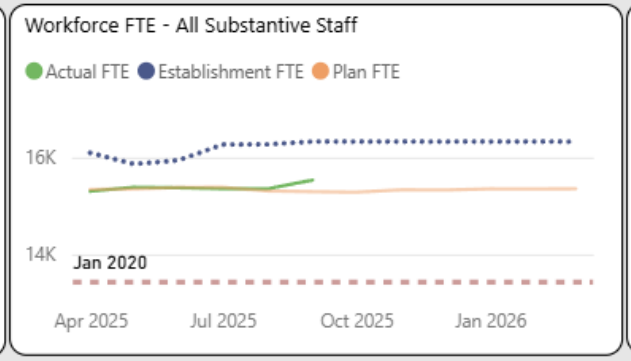
- Bank use due to switching requirements for additional hours from overtime to Bank which is more cost effective.
- Need to maintain safe services (e.g. healthcare assistants for enhanced care). Greater use being made of Bank options to reduce spend on agency.
- Practice of rostering staff may not be optimal in some areas. Potential need for some refresher training.
- Mid-term financial review in October led to adjustment of our workforce plan predictions for the second half of the year to reflect the impact of the following: approved business cases in-year; outcome of voluntary severance scheme; outcome of wholly-owned subsidiary.

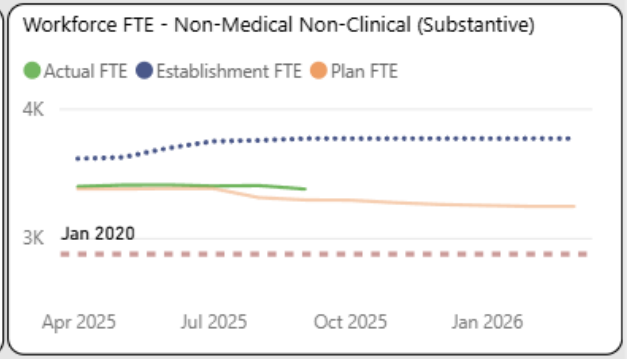
Actions Undertaken:

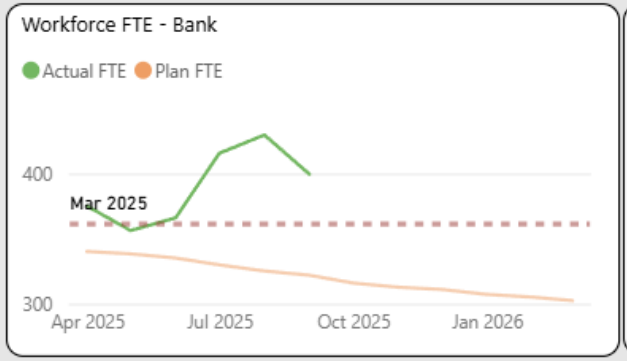
- The aim is to reduce the workforce by 400 FTE by 31 March 2026 through various measures:
  - A mutually agreed resignation scheme was offered to all staff between 13 October and 2 November. Applications will be decided by the Chief Executive and outcomes notified to staff in December. Notice periods will run from December until March.
  - Recruitment activity was temporarily paused in October and all services were asked to review their recruitment/vacancy position to prioritise and/or re-plan their needs going forward.
- To support the shift from overtime to Bank, around 800 substantive staff have been fast-tracked as additions to the Bank.

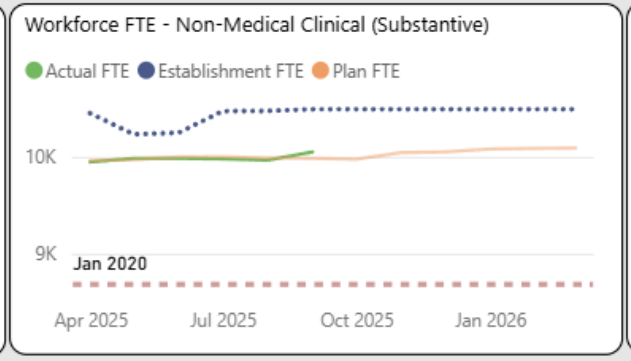
Provider Workforce Return (PWR) – in-year overview position

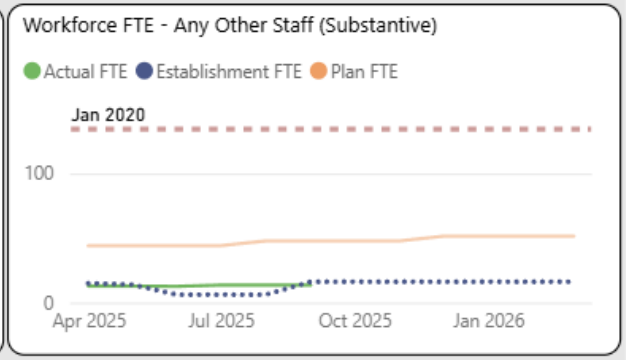


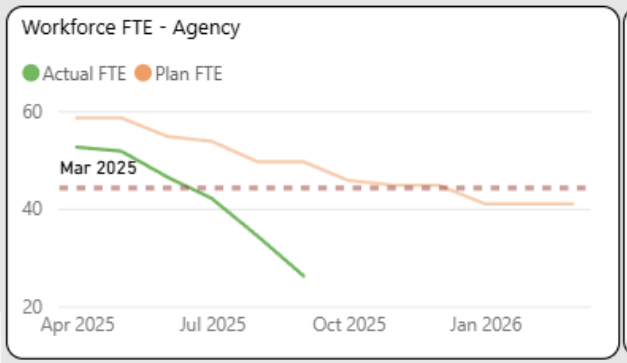


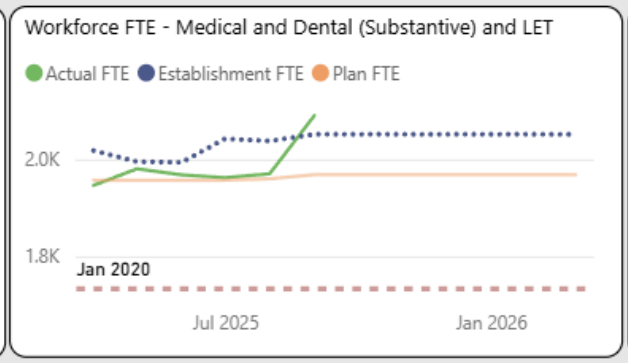


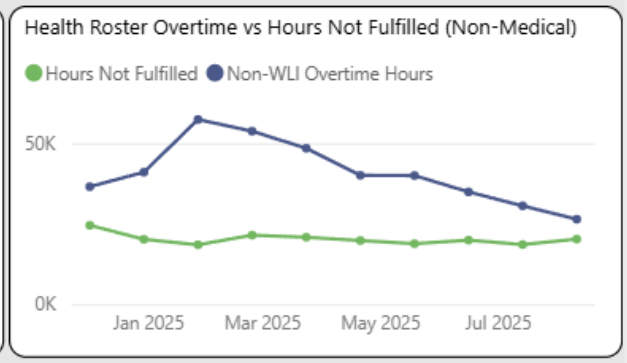










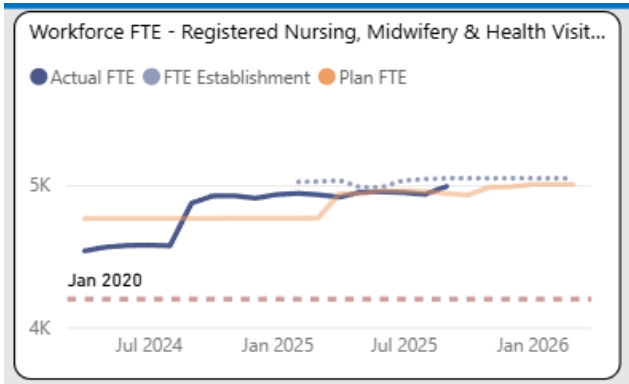


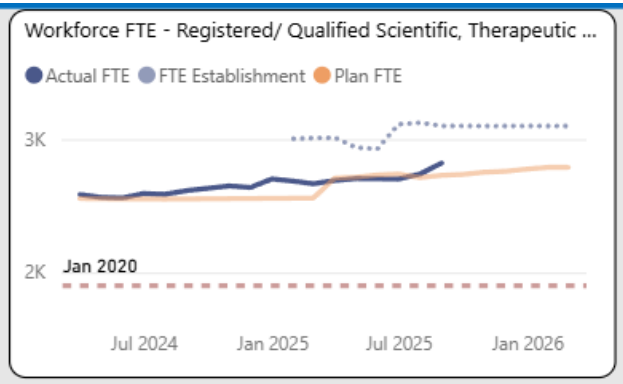
**Please note: The charts on this page include LET data

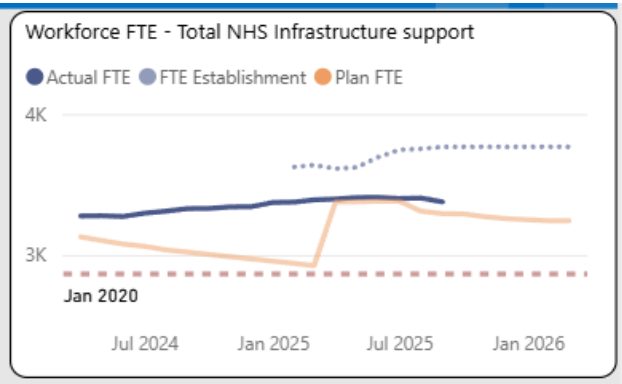
PWR – staff group overview as-at September 2025

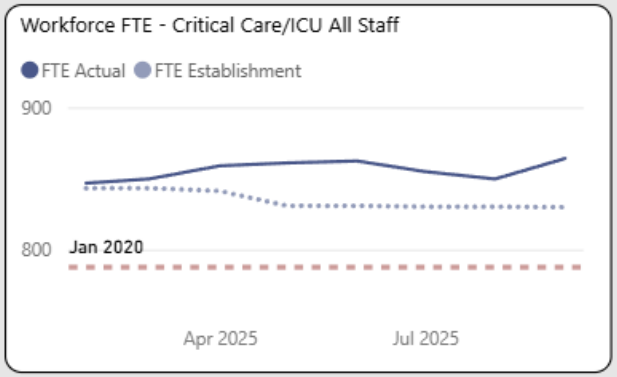
Sub Categories Metric	Jan 2020 FTE	Plan FTE	Establishment	Current FTE	Current FTE v Jan 2020	Current FTE v Plan	Current FTE v Establishment
1. Registered Nursing, Midwifery and Health visiting staff (substantive total)	4,202.08	4,941.92	5,048.38	4,991.18	789.11	49.26	-57.20
2. Registered/ Qualified Scientific, Therapeutic and Technical Staff (substantive total)	1,993.02	2,364.37	2,549.34	2,410.53	417.51	46.16	-138.81
3. Support to Clinical staff (substantive total)	2,489.06	2,678.36	2,895.16	2,649.50	160.44	-28.87	-245.66
4. Total NHS Infrastructure Support (includes A&C, estates, managers) (substantive total)	2,874.99	3,293.45	3,767.64	3,377.27	502.28	83.82	-390.37
5. Total Medical and Dental (substantive total)	1,732.92	1,968.52	2,051.89	2,090.68	357.76	122.17	38.79
6. Any other Staff (substantive total)	146.48	47.75	16.16	13.60	-132.88	-34.15	-2.56
7. Bank Any other staff	0.00	0.00			0.00	0.00	
7. Bank Medical and dental	11.75	15.48		28.59	16.84	13.10	
7. Bank Registered nursing, midwifery and health visiting staff	111.27	81.00		110.16	-1.11	29.16	
7. Bank Registered/ Qualified Scientific, Therapeutic and Technical staff	16.41	11.48		10.54	-5.87	-0.94	
7. Bank Support to clinical staff	258.10	184.36		211.71	-46.39	27.35	
7. Bank Total NHS infrastructure support	43.69	29.60		21.39	-22.30	-8.21	
8. Agency Any other staff	0.00	0.00			0.00	0.00	
8. Agency Medical and dental	0.87	6.79		3.41	2.54	-3.38	
8. Agency Registered nursing, midwifery and health visiting staff	2.86	4.53		4.52	1.66	-0.01	
8. Agency Registered scientific, therapeutic and technical staff	17.27	4.16		4.80	-12.47	0.64	
8. Agency Support to clinical staff	23.68	33.10		13.45	-10.23	-19.65	
8. Agency Total NHS infrastructure support	15.70	1.00			-15.70	-1.00	
Total	**13,940.15**	**15,665.88**	**16,328.57**	**15,941.33**	**2,001.18**	**275.45**	**-795.81**

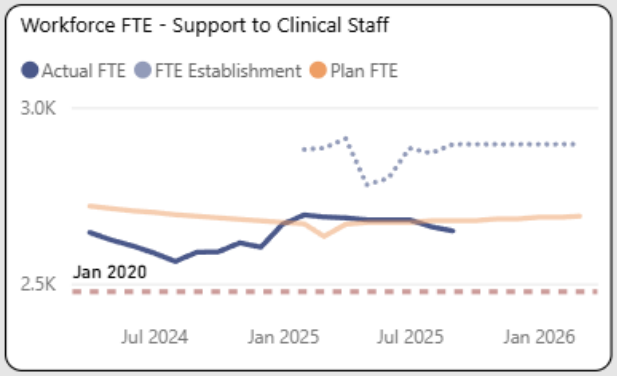
PWR – staff group overview in-year position

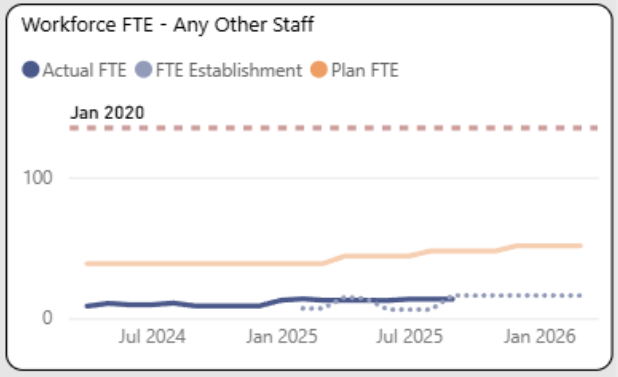


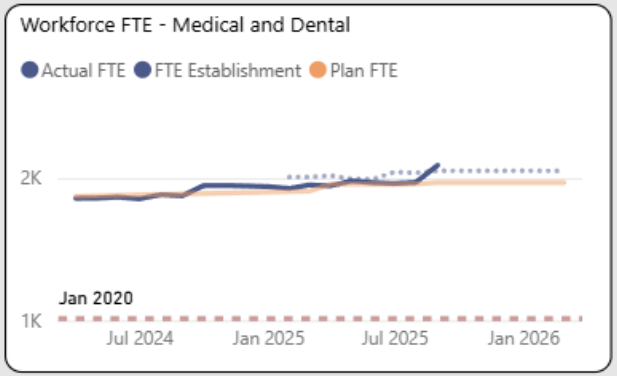










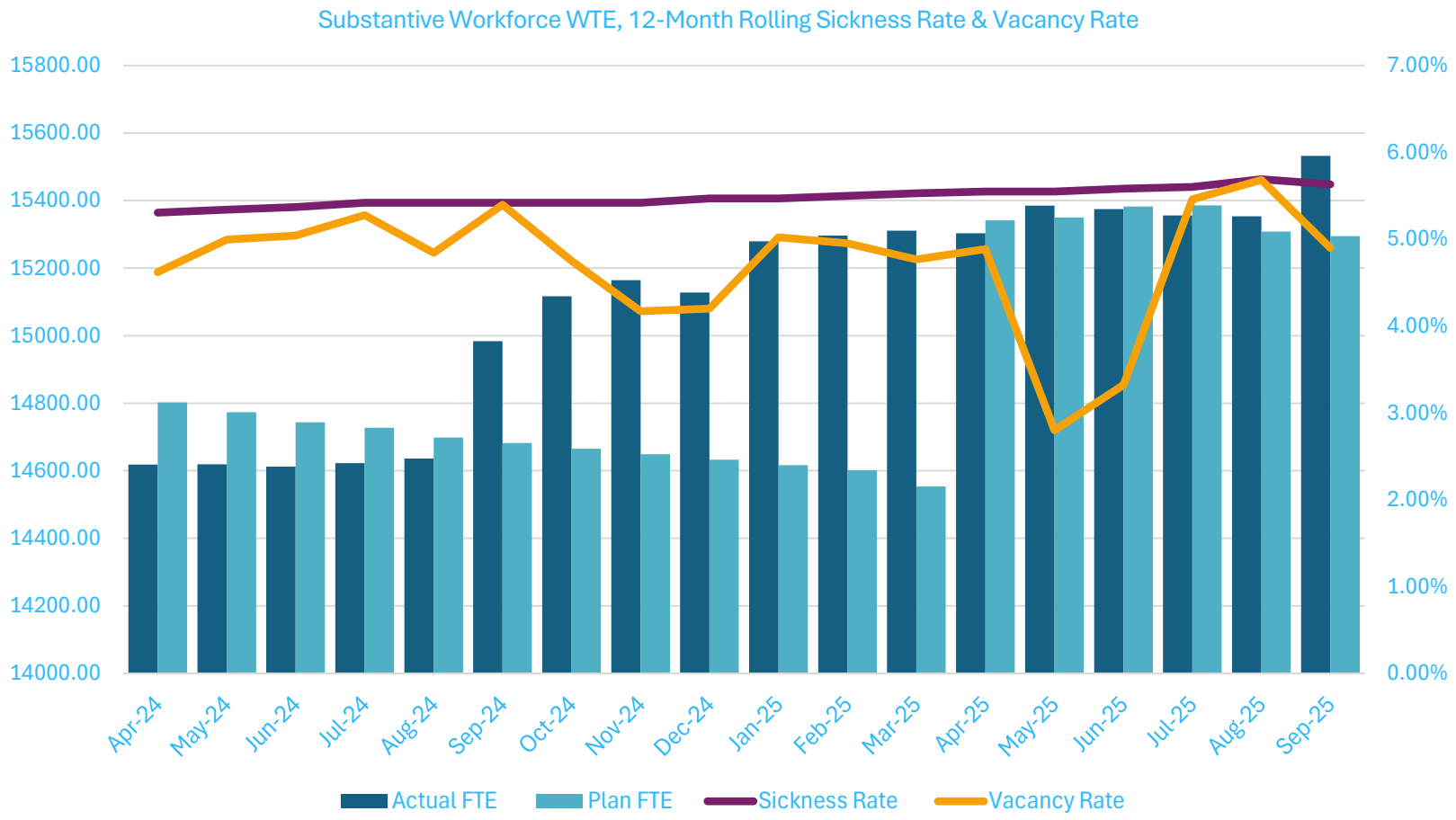


**Please note: The charts on this page include LET data

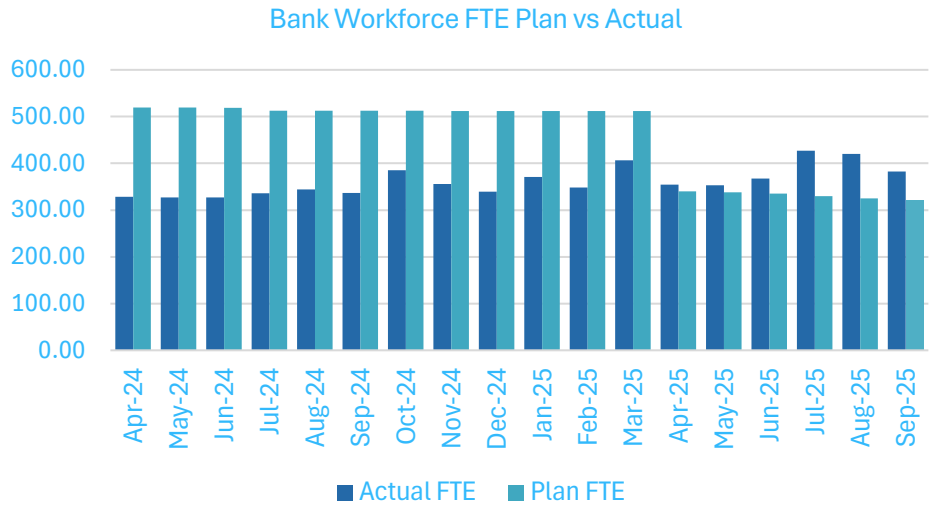
Vacancies

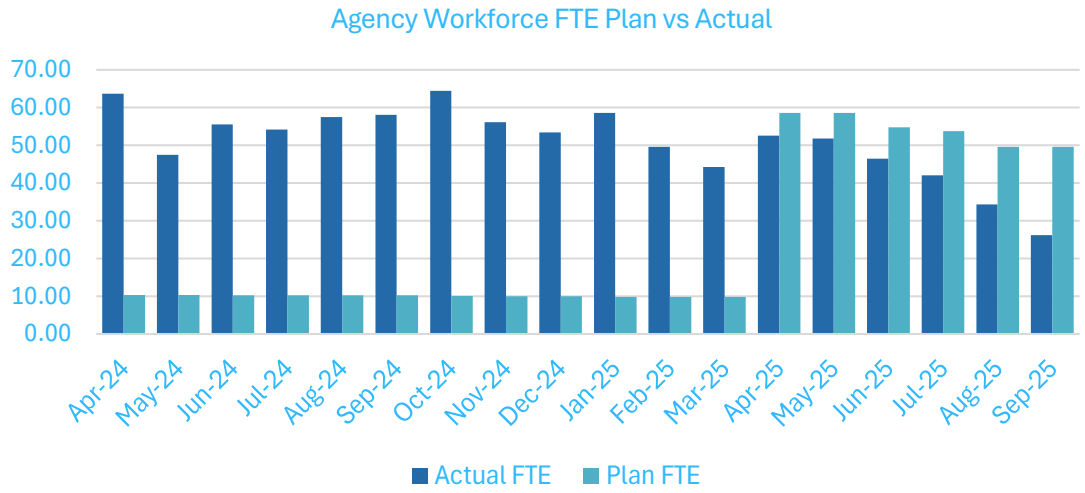
Summary Group	FTE Establishment	Actual FTE	Vacancy FTE	Vacancy FTE %
1. Total Non Medical - Clinical Substantive Staff	10492.88	10049.82	443.06	4.22%
2. Total Non Medical - Non-Clinical Substantive Staff	3767.64	3376.27	391.37	10.39%
3. Medical and Dental	2051.89	2088.69	-36.79	-1.79%
5. Other	16.16	13.60	2.56	15.84%
Total	**16328.57**	**15528.38**	**800.19**	**4.90%**

Substantive Workforce



Bank and Agency Workforce



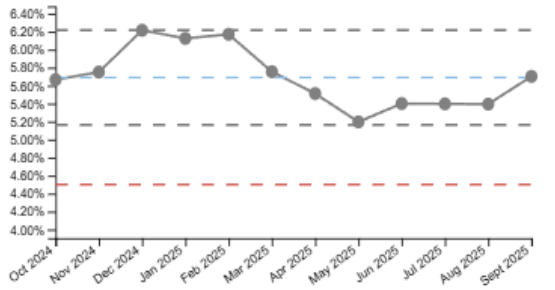


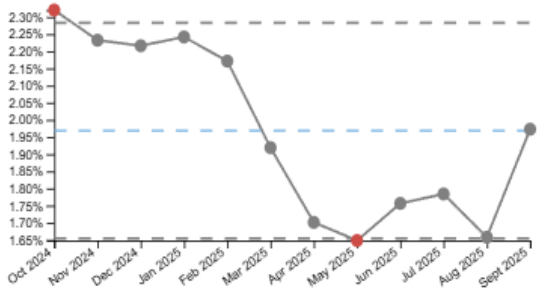
Sickness absence – 12-month average

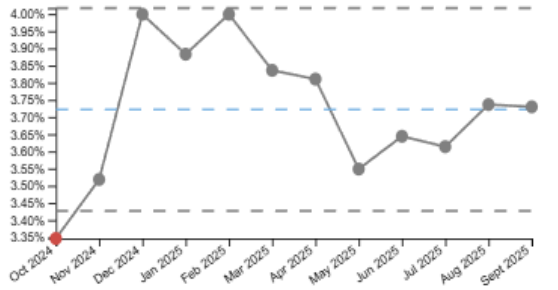
Trust Sickness %	12-Month Rolling	Value	Target
	Sep 25	5.69%	4.50%

Metric	Value
Short Term Sickness %	1.97%

Metric	Value
Long Term Sickness %	3.73%







Current Position:

- Top reasons for sickness:
  - Anxiety/stress/depression (S10) 33.78%
  - Other musculoskeletal problems (S12) 10.10%
  - Cold, Cough, Flu – Influenza (S13) 9.22%
- The 12-month rolling absence rate of 5.7% and the sick pay cost of £33.7m are significantly above the target of 5% and £25m respectively.
- Marked increase in short-term sickness.

Underlying Issues

- Anxiety/stress/depression (S10) is main reason for sickness absence. Some is work-related and some is due to issues outside of work.
- Uptick in short-term sickness due to cold/flu.
- Total days lost: 303,638 FTEs.
- Average time lost per person: 21 days.
- Total cost of sick pay: £33.7m.
- Variation in sickness rates across Clinical Boards:
  - Lowest – Clinical and Diagnostic Services at 4.48% (short-term 1.77%, long term 2.80%)
  - Highest – Peri-operative and Critical Care at 6.64% (short-term 2.17%, long term 3.38%)

Actions Undertaken:

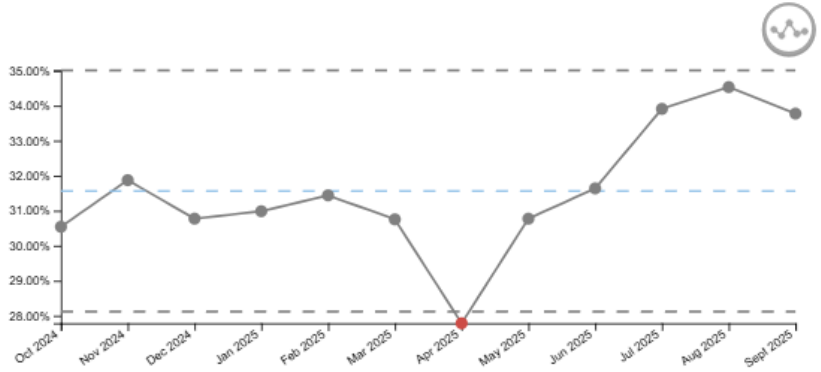
- Health & Wellbeing Offer (HAWB) offer – work continuing to set up a staff support service and reintroduce Mental Health First Aiders (MHFA). Two positions appointed to and training for MHFA has commenced.
- Occupational Health. Flu vaccination program in place.
- Sickness. Deep dive into long-term sickness absence showed over 600 cases. Follow up and training on attendance management is rolling out for managers from the HR Advisory team.
- Accountability – monthly performance reviews held with Clinical Boards; monthly meetings held between HR and Clinical Boards/Corporate Services. Associate Director of People & Organisational Development and Head of Workforce Advisory Services meeting with Directors of Operations to discuss and support attendance management.

Sickness absence – top absence reasons

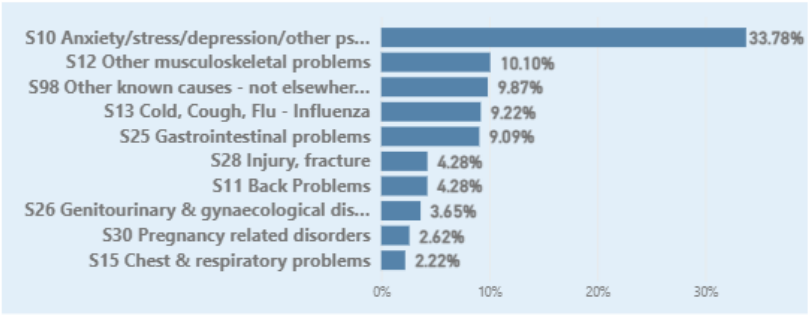
Trust Sickness %	12-Month Rolling	Value	Target
	Sep 25	5.69%	4.50%

Sickness Reasons - SPC

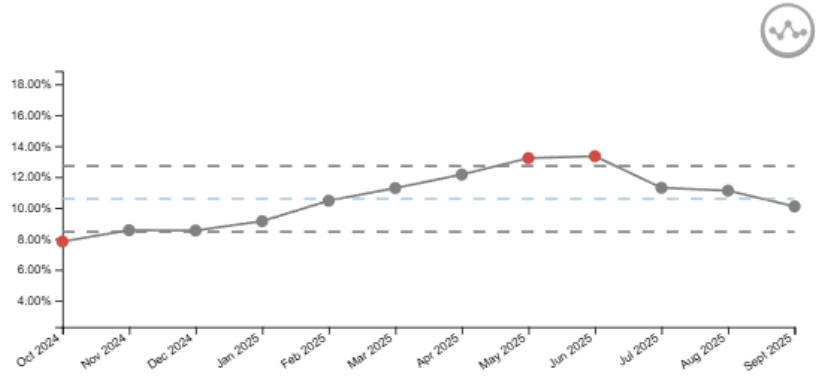
S10 - Anxiety/stress/depression/ other psychiatric illness 33.78%



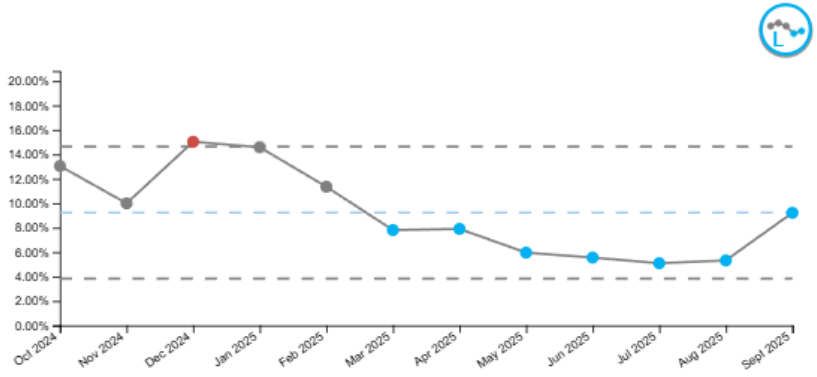
Top 10 Sickness Abscences



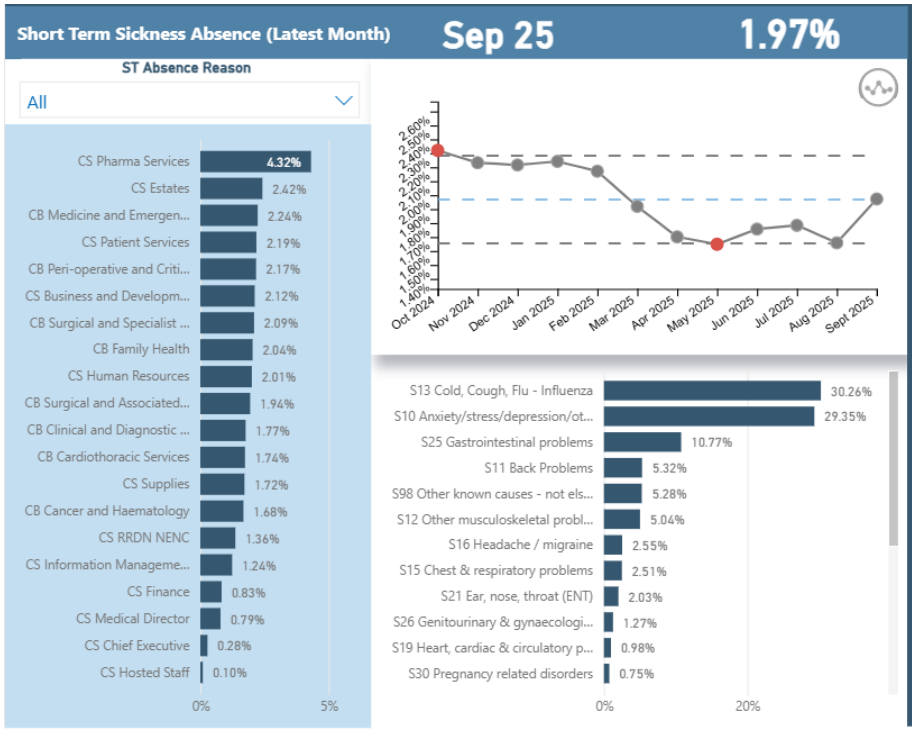
S12 Other musculoskeletal problems 10.10%

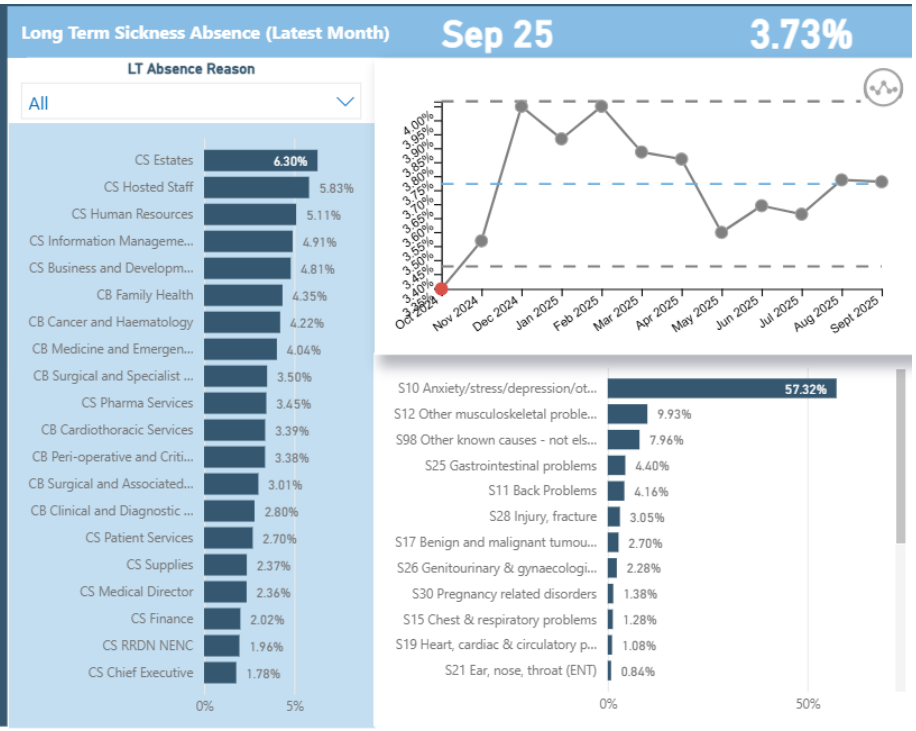


S13 Cold, Cough, Flu - Influenza 9.22%



Sickness absence – short & long term analysis by Clinical Board/Corporate Service & reason





Sickness – FTE working days lost & formal action activity

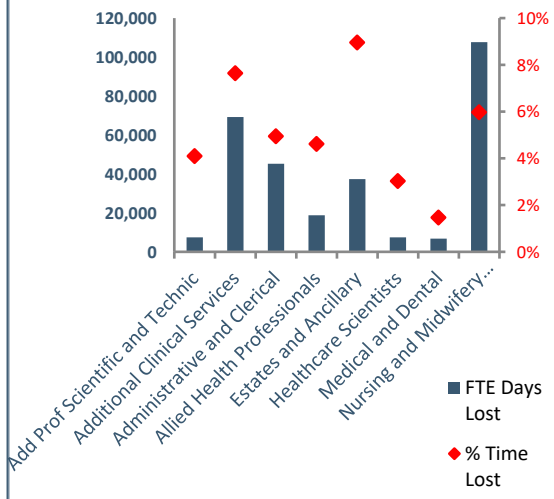
Sickness - FTE working days lost

FTE working days lost due to sickness

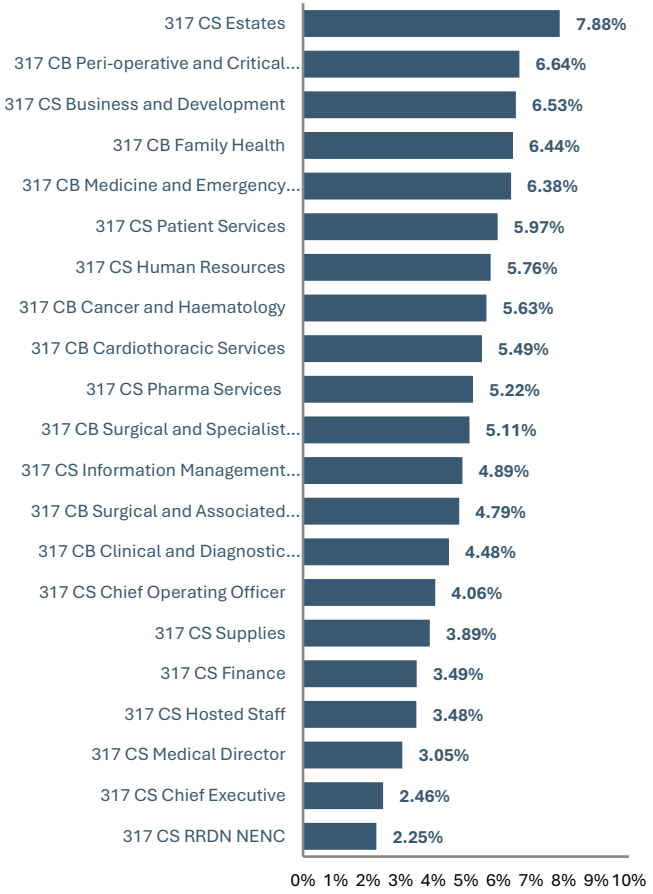
303,638

280,067 compared to the previous year.

Sickness Absence by Staff Group



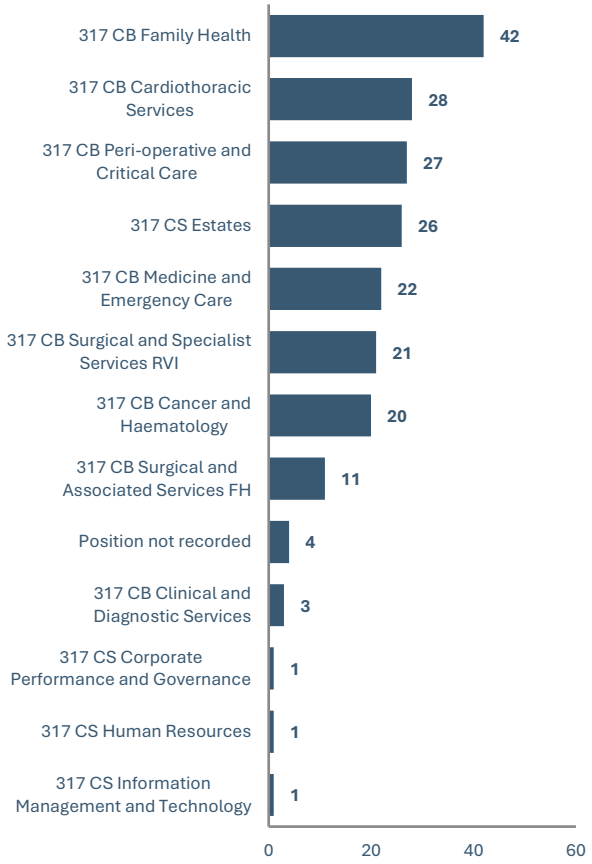
Sickness Absence (% Time Lost) by Clinical Board



Sickness - Formal Action

Latest Data - September 2025

Attendance Management – Formal Action by Clinical Board/ Corporate Service

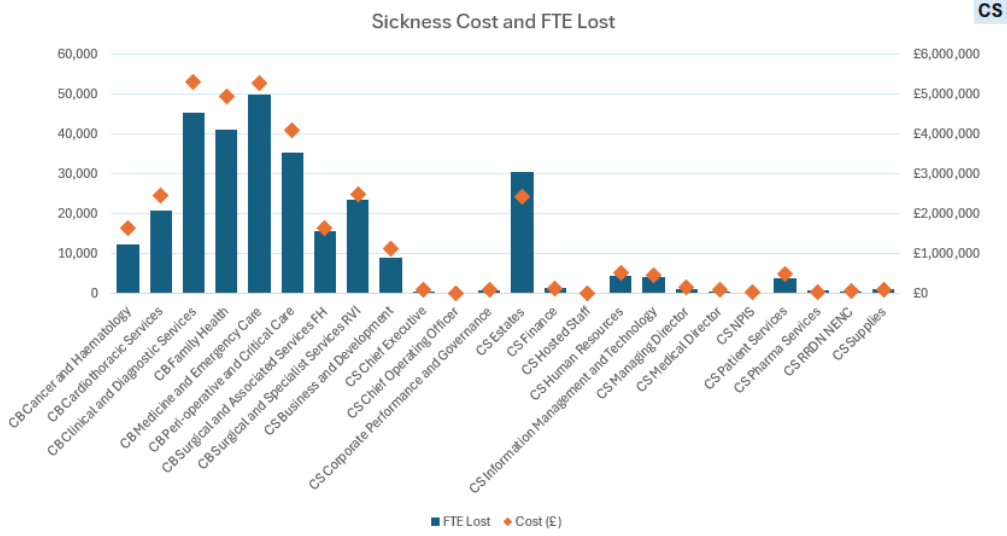


Sickness – FTE working days lost & cost of sick pay

Sickness Absence	12-Month period ending	Cost (£)	FTE Lost	Ave. No of Days Lost per FTE
	Sep 25	£33,748,816	303,638.37	20.69

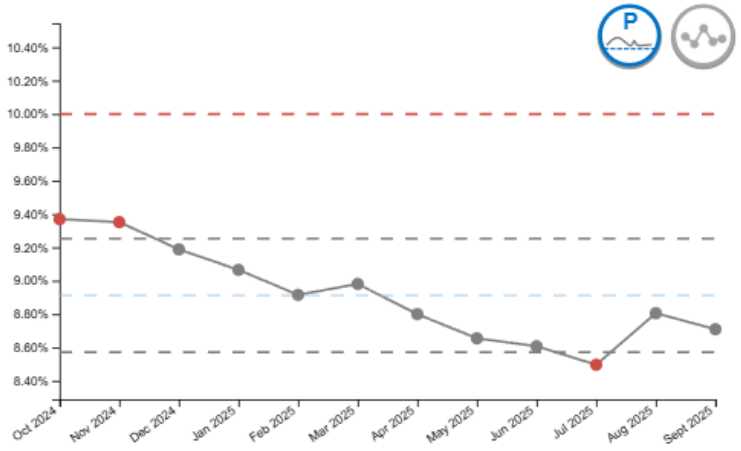
Clinical Board	Cost (£)	FTE Lost	Ave. No of days lost per FTE
CB Cancer and Haematology	1,631,356	12,231.68	20.54
CB Cardiothoracic Services	2,446,597	20,895.15	19.92
CB Clinical and Diagnostic Services	5,311,679	45,295.71	16.28
CB Family Health	4,938,418	41,107.64	23.47
CB Medicine and Emergency Care	5,278,712	49,926.94	22.99
CB Peri-operative and Critical Care	4,109,026	35,337.90	24.40
CB Surgical and Associated Services FH	1,655,001	15,722.30	17.53
CB Surgical and Specialist Services RVI	2,475,544	23,616.79	18.74

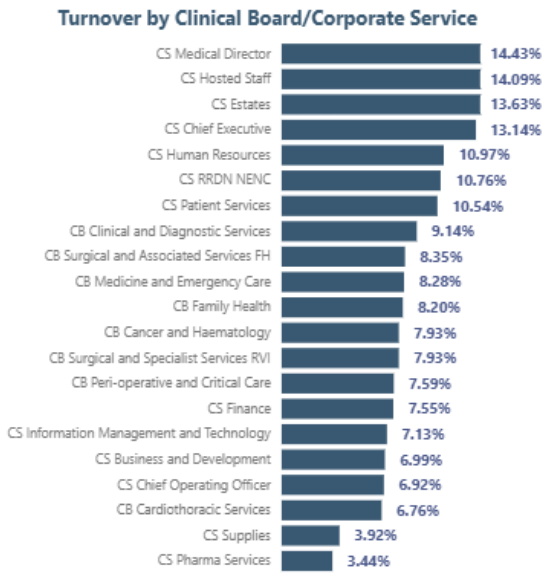
Clinical Board	Cost (£)	FTE Lost	Ave. No of days lost per FTE
CS Business and Development	1,125,308	9,056.80	22.95
CS Chief Executive	90,746	583.93	8.64
CS Chief Operating Officer	0	0.00	0.00
CS Corporate Performance and Governance	85,435	768.61	9.33
CS Estates	2,434,371	30,484.24	28.65
CS Finance	138,725	1,420.69	12.78
CS Hosted Staff	18,313	334.00	11.06
CS Human Resources	533,477	4,415.05	21.06
CS Information Management and Technology	453,010	4,194.41	18.06
CS Managing Director	159,546	1,147.33	14.51
CS Medical Director	93,058	609.40	11.00
CS NPIS	34,797	188.70	9.81
CS Patient Services	504,262	3,779.75	20.83
CS Pharma Services	50,746	784.49	15.30
CS RRDN NENC	71,829	490.91	8.23
CS Supplies	108,858	1,245.95	13.55

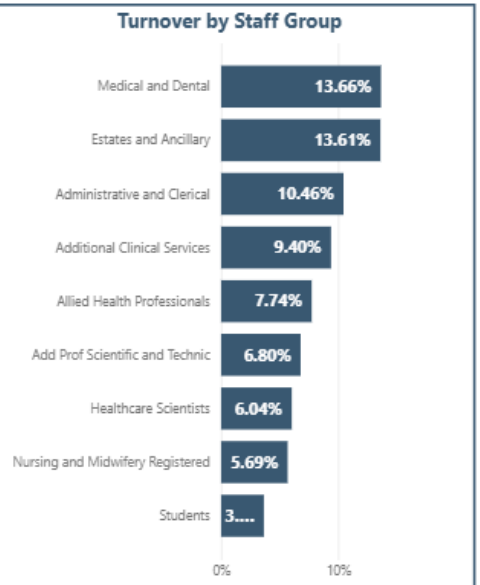


Turnover

Trust Turnover %	12-Month Rolling	Value	Target
	Sep 25	8.72%	10.00%







Current Position:

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

Underlying Issues

- 1,468 leavers in 12-months to September 2025: 21% Nursing & Midwifery (315), 19% Administrative and Clerical (286).
- Top destinations – no employment (622, 42%); other NHS organisation (452, 31%).
- Top reasons – retirement age (222, 15%); relocation (196, 13%); work-life balance (194, 13%).

Actions Undertaken:

- Flexible working. Supported and encouraged across the Trust. 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

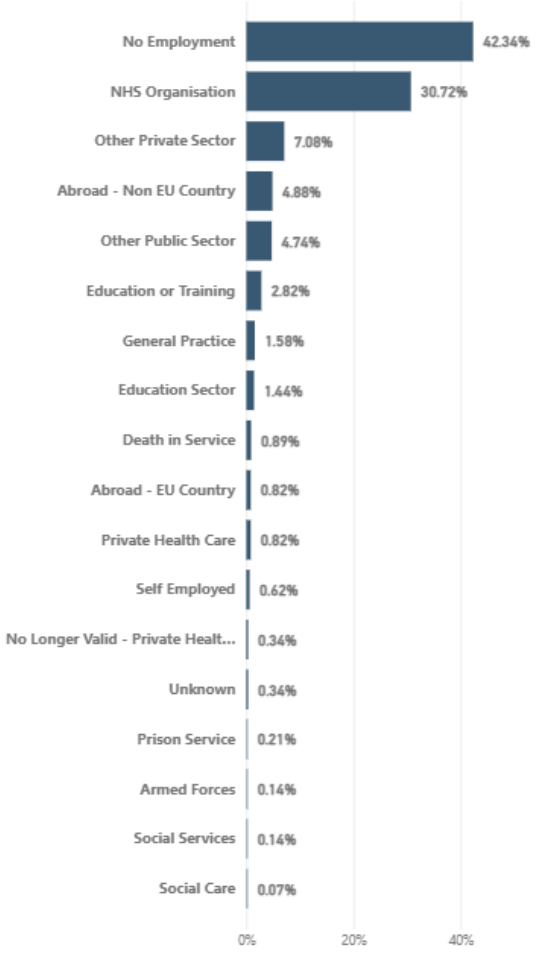
Trust Turnover %	12-Month Rolling	Value	Target
	Sep 25	8.72%	10.00%

Leaving Reasons

Leaving Reasons

Leaving Reason	Leaving Reason %
Retirement Age	15.26%
Voluntary Resignation - Relocation	13.47%
Voluntary Resignation - Work Life Balance	13.33%
Voluntary Resignation - Promotion	9.14%
Flexi Retirement	8.73%
End of Fixed Term Contract	7.84%
Voluntary Resignation - Health	6.74%
Voluntary Resignation - To undertake further education or training	3.99%
Voluntary Resignation - Incompatible Working Relationships	3.64%
Voluntary Resignation - Lack of Opportunities	2.20%
Dismissal - Capability	2.06%
End of Fixed Term Contract - Completion of Training Scheme	1.79%
End of Fixed Term Contract - Other	1.65%
Mutually Agreed Resignation - Local Scheme with Repayment	1.58%
Voluntary Resignation - Child Dependants	1.44%
Voluntary resignation - Pay and Reward Related	1.31%
Voluntary Resignation - Other/Not Known	0.96%
Death in Service	0.89%
Voluntary Early Retirement - with Actuarial Reduction	0.76%
Retirement - Ill Health	0.62%
Voluntary Early Retirement - no Actuarial Reduction	0.62%
Redundancy - Compulsory	0.48%
Voluntary Resignation - Adult Dependants	0.41%
End of Fixed Term Contract - External Rotation	0.34%
Dismissal - Conduct	0.21%
Dismissal - Statutory Reason	0.21%
End of Fixed Term Contract - End of Work Requirement	0.21%
Bank Staff not fulfilled minimum work requirement	0.07%
Redundancy - Voluntary	0.07%

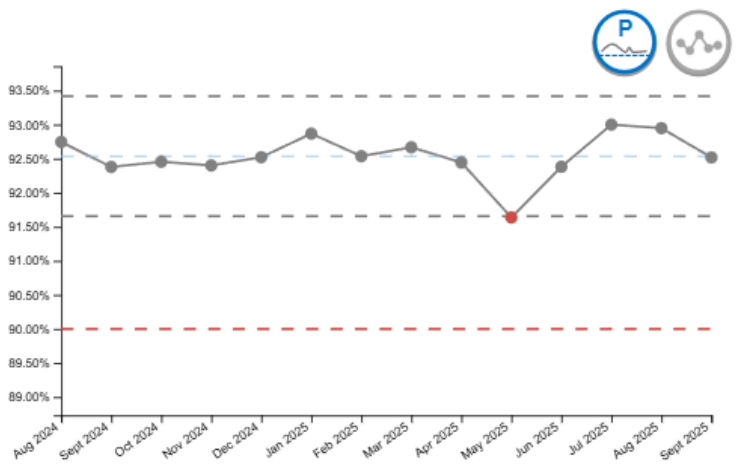
Destination on Leaving

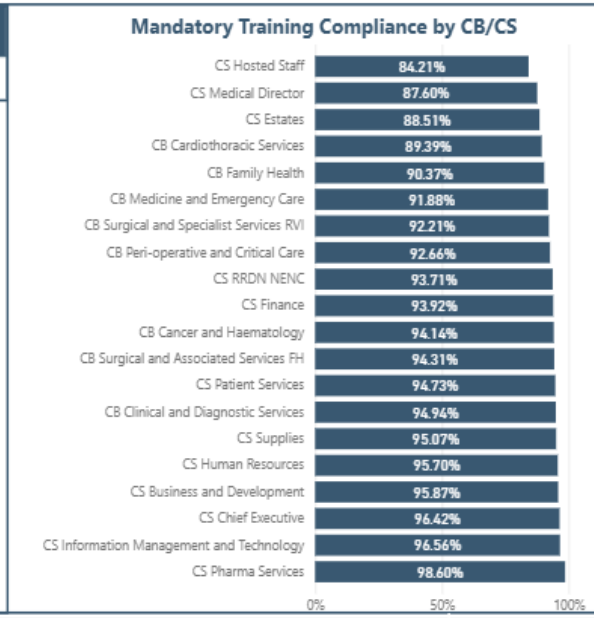


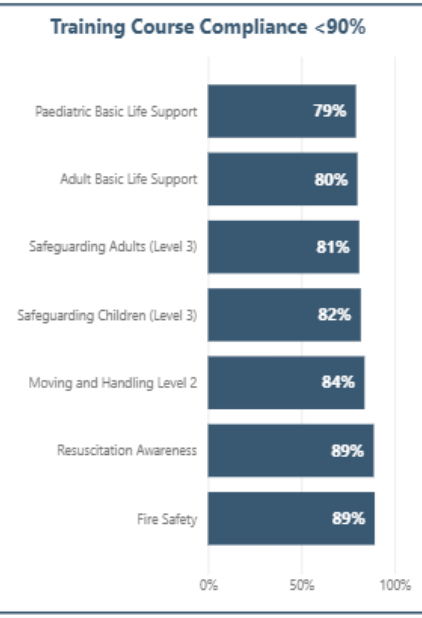
Destination On Leaving	Destination On Leaving %
No Employment	42.34%
NHS Organisation	30.72%
Other Private Sector	7.08%
Abroad - Non EU Country	4.88%
Other Public Sector	4.74%
Education or Training	2.82%
General Practice	1.58%
Education Sector	1.44%
Death in Service	0.89%
Abroad - EU Country	0.82%
Private Health Care	0.82%
Self Employed	0.62%
No Longer Valid - Private Health/Social Care	0.34%
Unknown	0.34%
Prison Service	0.21%
Armed Forces	0.14%
Social Services	0.14%
Social Care	0.07%

Mandatory training

Mandatory Training Compliance	Month	Value	Target
	Sep 25	92.52%	90.00%







Current Position:

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

Underlying Issues

- Medical and Dental – have lowest overall compliance (81.88%) with low compliance in Adult Basic Life Support (60.96%); Paediatric Basic Life support (62.08%); Safeguarding Children - Level 3 (64.38%).
- 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.

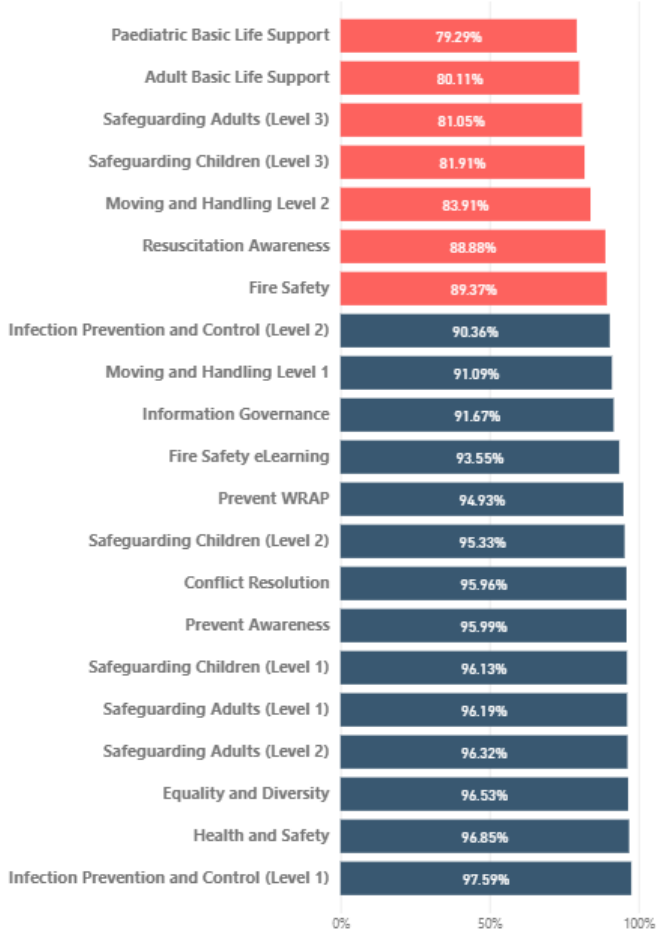
Actions Undertaken:

- 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.
- HR actively seeking assurance from outliers that they have plans in place to address compliance. Accountability will be addressed on a monthly basis.

Mandatory training

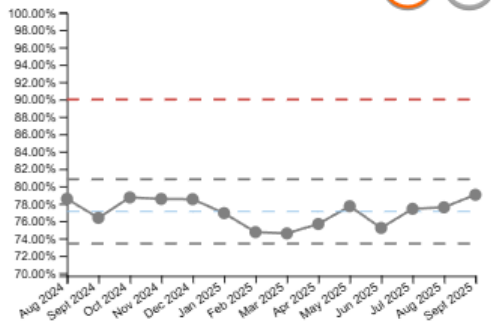
Mandatory Training Compliance	Month	Value	Target
	Sep 25	92.52%	90.00%

Training Course Compliance %

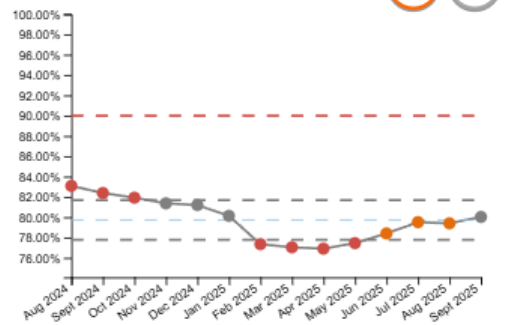


Lowest 4 Mandatory Training Compliance %

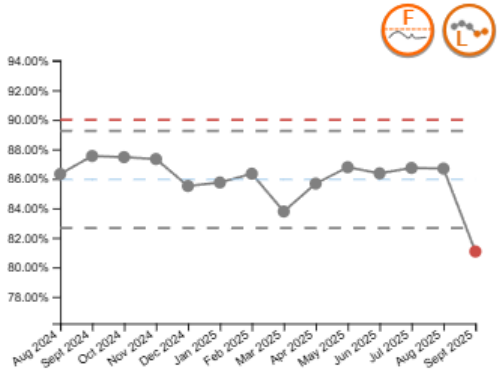
Paediatric Life Support 79%



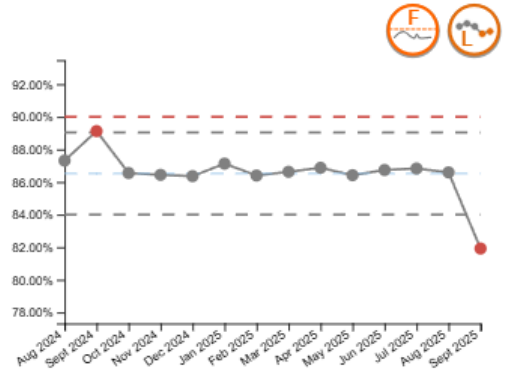
Adult Life Support 80%



Safeguarding Adults (Level 3) 81%

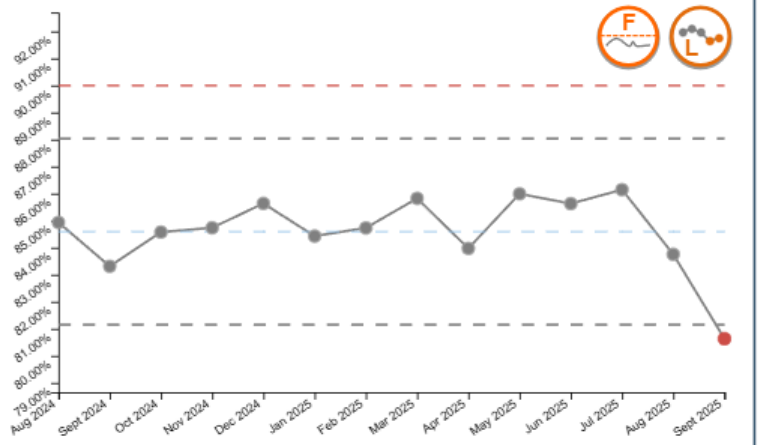


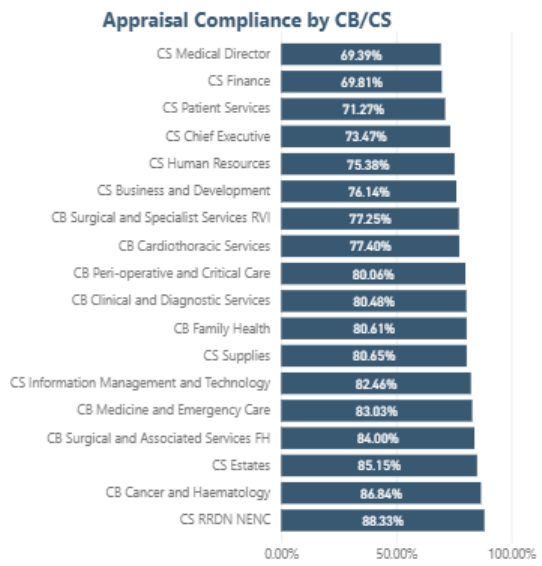
Safeguarding Children (Level 3) 82%

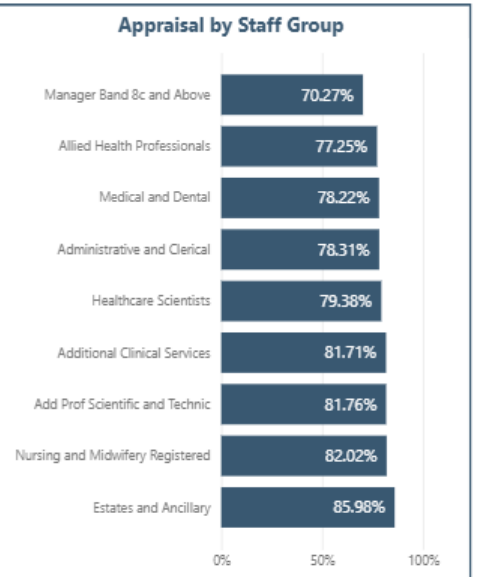


Appraisal compliance

Appraisal Compliance	Month	Value	Target
	Sep 25	80.63%	90.00%







Current Position:

- Overall performance is consistently below target and declining over the last two months.
- No area has met the target.

Underlying Issues

- 2,698 appraisals are overdue with highest numbers in Nursing and Midwifery (847) and Admin and Clerical (504).
- Clinical Board performance varies between 77.25% (surgical and specialist services) to 86.84% (cancer and haematology).
- Corporate Service performance varies between 69.39% (medical director) to 88.33% (Regional Research Delivery Network (RRDN)).
- Compliance impacted by time and capacity of managers and staff.

Actions Undertaken:

- HR actively seeking assurance from outliers that they have plans in place to address compliance. Accountability will be addressed on a monthly basis.
- Mental & Dental (M&D) staff. Quarterly updates are sent to clinical board chairs.

Bank use (£) – non-medical

Bank Utilisation (£)	12-Month period ending	Total Bank Expenditure (£)	Total Bank Difference (£)
	Sep 25	£18,538,890	+£1,771,371

Bank Utilisation (£)

Staff Group	Oct 23 - Sep 24	Oct 24 - Sep 25	Difference
Admin & Clerical	£1,162,487	£1,147,328	-£15,159
Ancillary	£268,150	£344,793	£76,643
Estates			£0
Nursing & Midwifery (Registered)	£5,465,942	£6,410,587	£944,644
Nursing & Midwifery (Unregistered)	£9,044,542	£9,894,418	£849,877
Professional & Technical	£826,398	£741,764	-£84,634
Total	£16,767,519	£18,538,890	£1,771,371

Current Position:

- Cost of Bank has increased for Nursing & Midwifery (N&M) unregistered due to service need for enhanced care.
- Ancillary increase is due to challenges from turnover, vacancies and sickness absence.

Underlying Issues

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

Actions Undertaken:

- Target reduction in bank staff of 10% set for 2025/26.
- Work continues to reduce bank usage with effective rostering and direction.
- Aiming to reduce agency use of Healthcare Assistant (HCAs) for enhanced care.
- To support the shift from overtime to Bank, around 800 substantive staff have been fast-tracked as additions to the Bank.

Agency use (£) – non-medical

Agency Utilisation (£)	12-Month period ending	Total Agency Expenditure (£)	Total Agency Difference (£)
	Sep 25	£3,204,376	-£821,809

Agency Utilisation (£)

Staff Group	Oct 23 - Sep 24	Oct 24 - Sep 25	Difference
Admin & Clerical	£349,561	£176,538	-£173,022
Ancillary	£23,029	£2,330	-£20,699
Estates	£26,475	£28,674	£2,199
Nursing & Midwifery (Registered)	£220,225	£716,971	£496,746
Nursing & Midwifery (Unregistered)	£2,348,265	£1,271,815	-£1,076,451
Professional & Technical	£1,058,629	£1,008,048	-£50,581
Total	£4,026,185	£3,204,376	-£821,809

Current Position:

- Costs reduced by c. £0.8m on previous year.
- Notable reductions in Nursing & Midwifery (unregistered) and Admin & Clerical.

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:

- Agency cost – target reduction of £2m set for 2025/26.
- Increasing bank availability to reduce agency use.
- Agency usage reviewed and challenged monthly.
- Reduced agency use of HCAs for enhanced care shifts by switching to Bank.

Agency use (£) – medical

Agency Utilisation (£)	12-Month period ending	Total Agency Expenditure (£)	Total Agency Difference (£)
	Sep 25	£3,948,924	+£1,051,564

Agency Utilisation (£)

Staff Group	Oct 23 - Sep 24	Oct 24 - Sep 25	Difference
Medical - Consultant	£2,455,095	£3,877,707	£1,422,612
Agency - Career / Staff Grades	£86,540	-£9,626	-£96,166
Medical - Registrar & Senior Registrar	£264,986	£3,699	-£261,287
Medical - SHO'S and HO'S	£90,274	£72,184	-£18,091
General Practitioner	£466	£4,961	£4,495
Total	£2,897,361	£3,948,924	£1,051,564

Current Position:

- Costs increased by c. £1.0m on previous year.
- Notable reductions in Registrar/Senior Registrar and Career/Staff Grades.
- Significant increase in Consultant spend.
- Consultants collectively working an average of 1,100 hours per month.

Underlying Issues

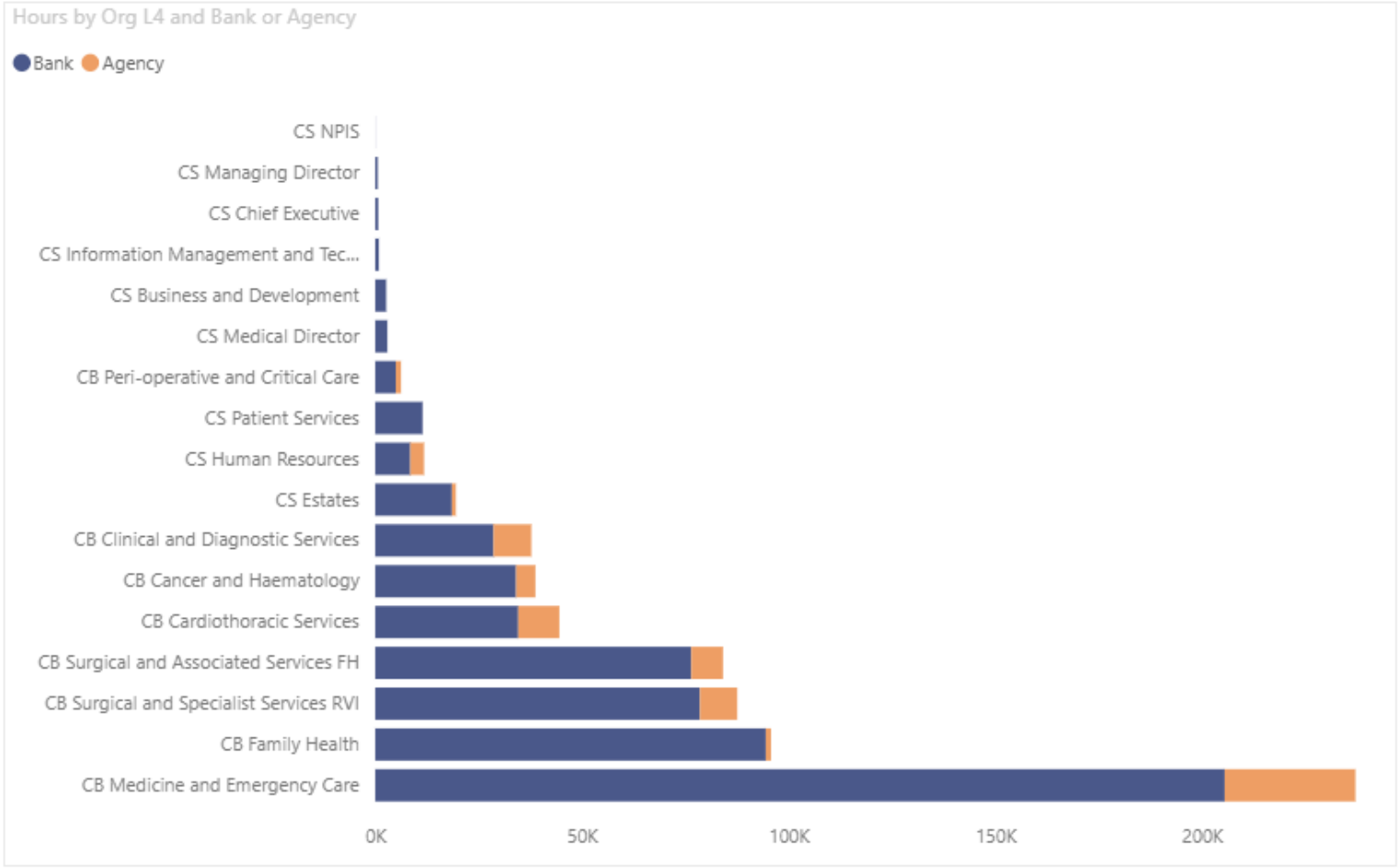
- Consultant spend. Staffing issues in Older People's Medicine and Stroke; off-framework arrangement in Paediatric Intensive Care Unit (PICU) due to sickness absence and recruitment; locum in General Medicine as part of Winter Plan 2024/25 ended in April 2025; agency Consultants unwilling to move to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

Actions Undertaken:

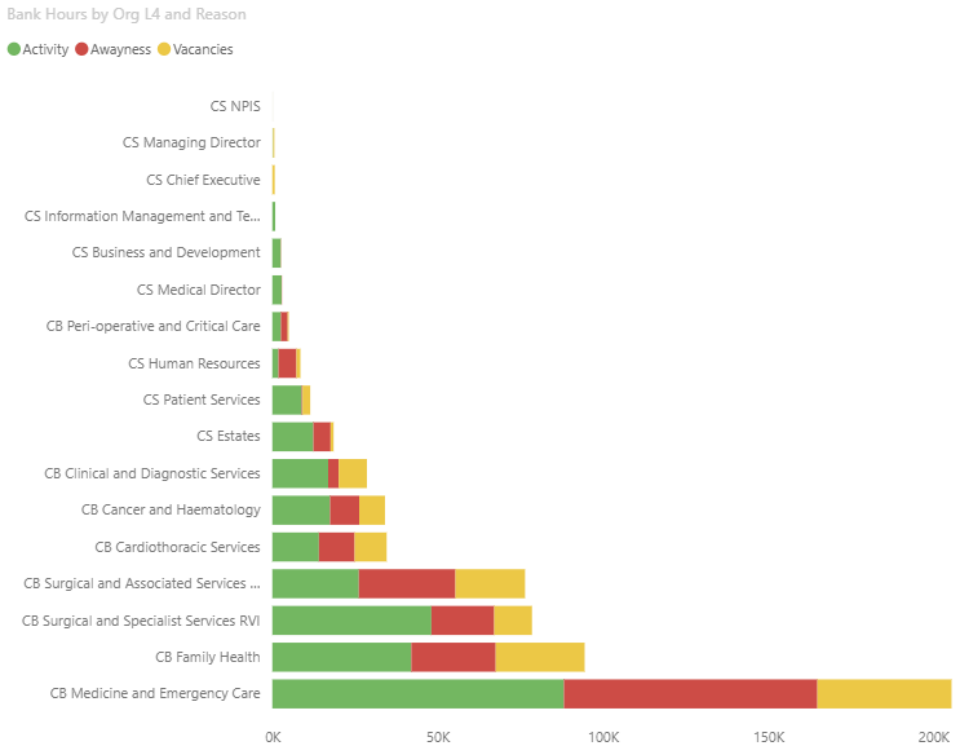
- Consultants. Trust contracts offered and declined; charges and hourly rates renegotiated wherever possible; recent recruitment in PICU has been successful reducing the need for agency.

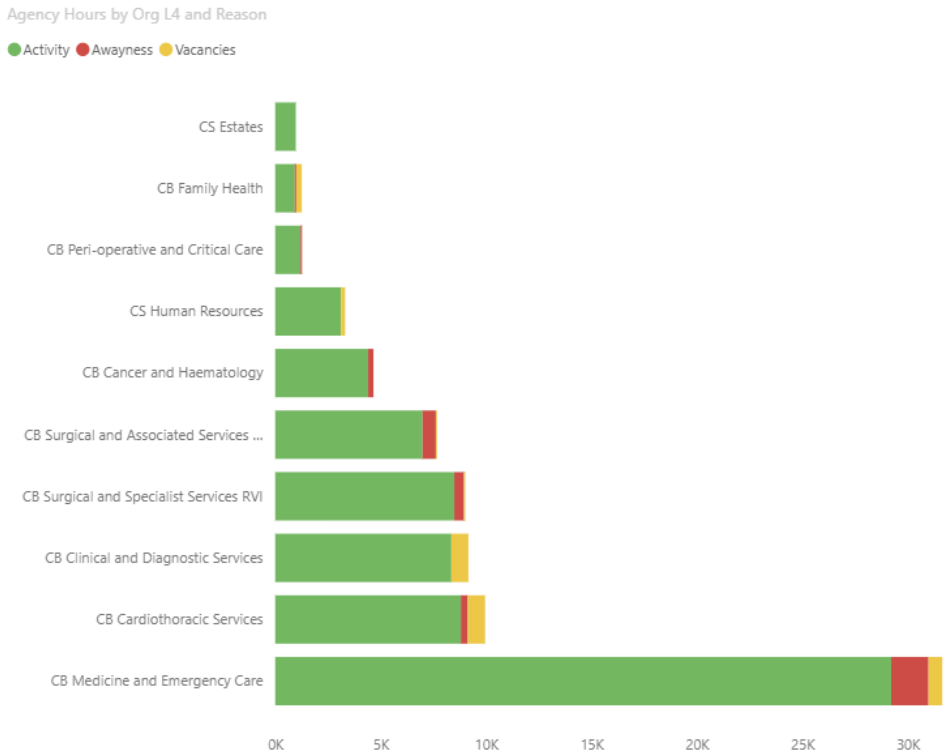
Bank & agency use - hours

Bank & Agency	12-Month period ending	Total Bank and Agency Hours
	Sep 25	682,602



Bank & agency hours (latest 12-month period ending August 2025)

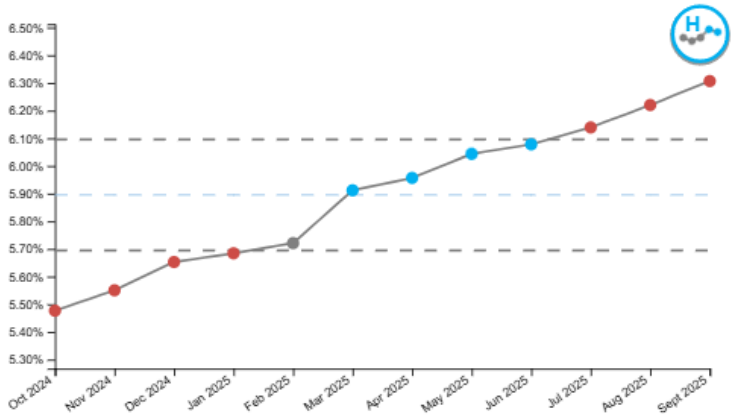


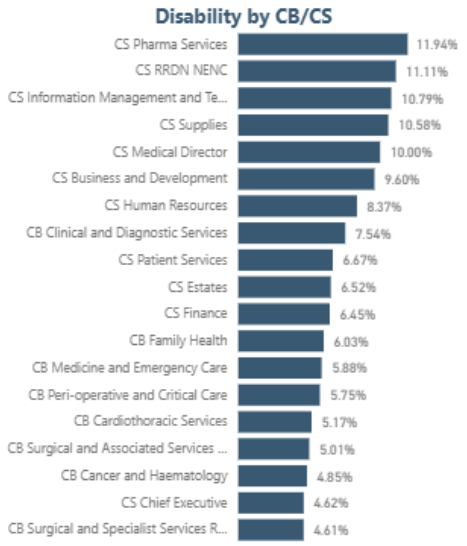


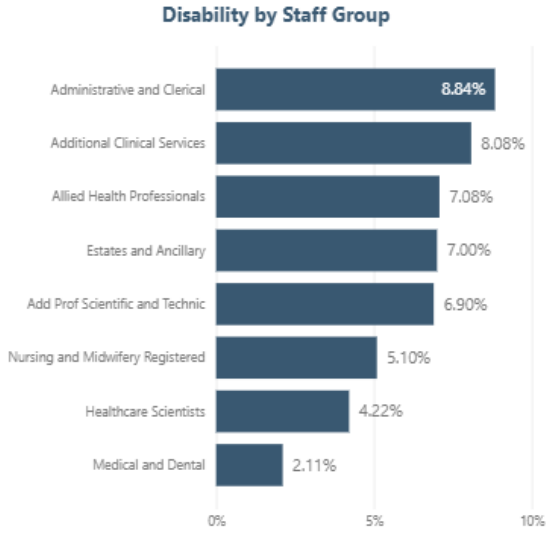
- **awayness**, including sickness, maternity, study leave, industrial action, etc.
- **activity**, including workload, acuity, waiting list initiative, etc.
- **vacancies**

Equality, Diversity and Inclusion (EDI) - disability

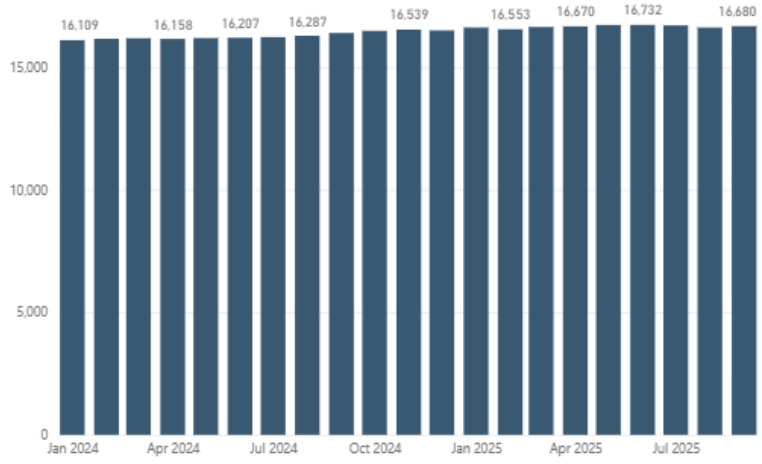
EDI - Disability	Month	Value	Trust Headcount
	Sep 25	6.31%	16,680







Trust Headcount Trend



Age Band

	Age Band	Disability %
1	<=20 Years	8.16%
2	21-25	12.54%
3	26-30	7.49%
4	31-35	6.44%
5	36-40	5.10%
6	41-45	4.91%
7	46-50	4.96%
8	51-55	5.85%
9	56-60	5.96%
10	61-65	6.02%
11	66-70	3.95%
12	>=71 Years	3.39%

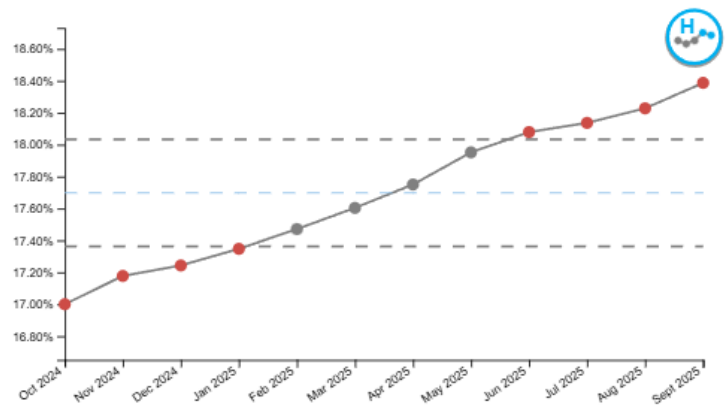
Current Position:

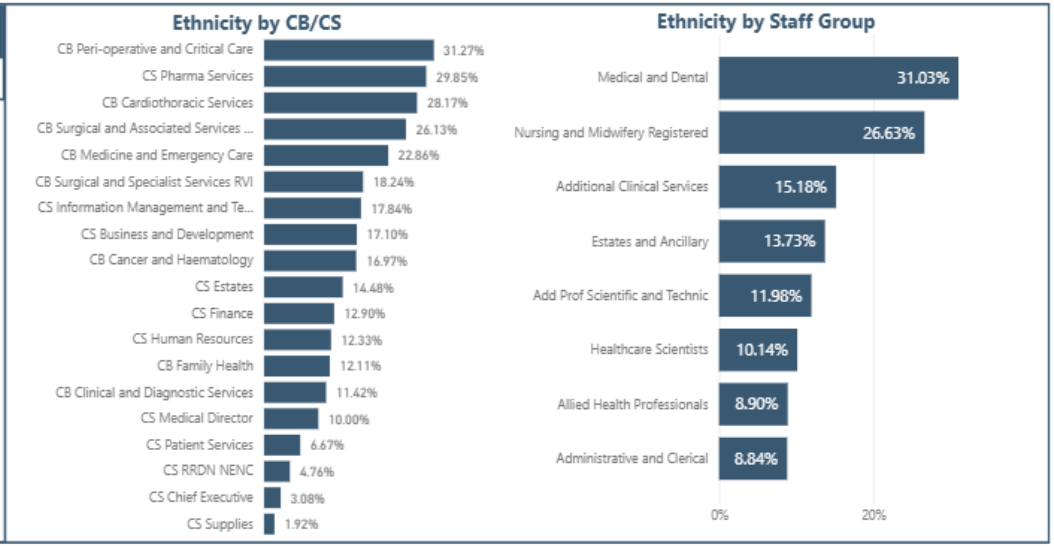
Charts show percentage of staff in post each month by those disclosing a disability.

Percentage of disabled staff continues to grow with the latest position reflecting 6.31% of the workforce.

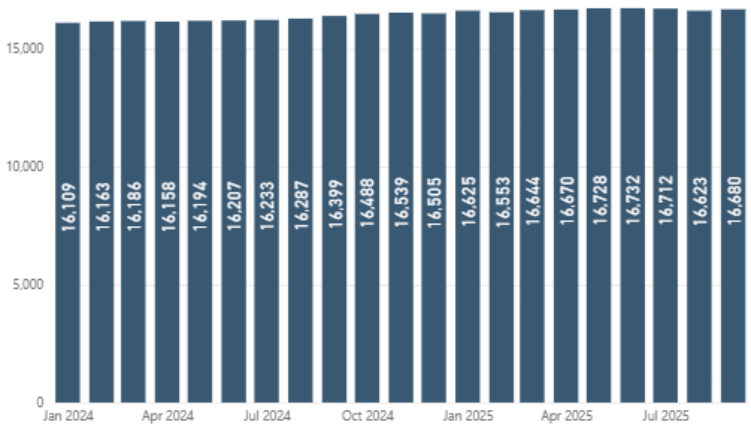
Equality, Diversity and Inclusion (EDI) - ethnicity

EDI - Ethnicity	Month	Value	Trust Headcount
	Sep 25	18.39%	16,680





Trust Headcount Trend



Age Band

	Age Band	BME %
1	<=20 Years	19.05%
2	21-25	16.67%
3	26-30	27.33%
4	31-35	24.23%
5	36-40	22.95%
6	41-45	15.50%
7	46-50	19.43%
8	51-55	16.60%
9	56-60	9.56%
10	61-65	5.60%
11	66-70	5.53%
12	>=71 Years	3.39%

Current Position:

Charts show percentage of staff in post each month by ethnicity (BAME).

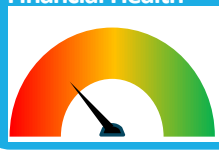
Percentage of BAME staff continues to grow with the latest position reflecting 18.39% of the workforce.

Finance

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

September 2025

Financial Health



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

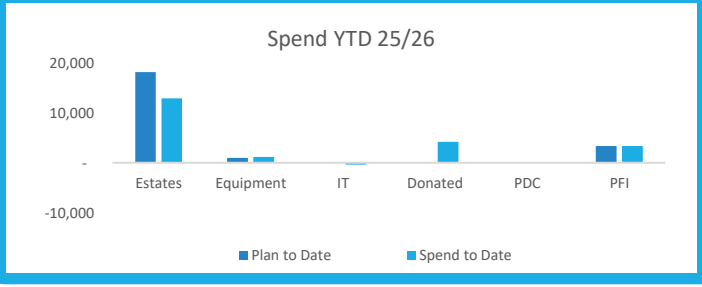
Financial Performance Month 6

The Trust has a plan to break even for the 2025/26 financial plan. To do this, it needs to deliver £106m of savings, manage expenditure within budgets and to deliver Elective Recovery Fund Income of £351m.

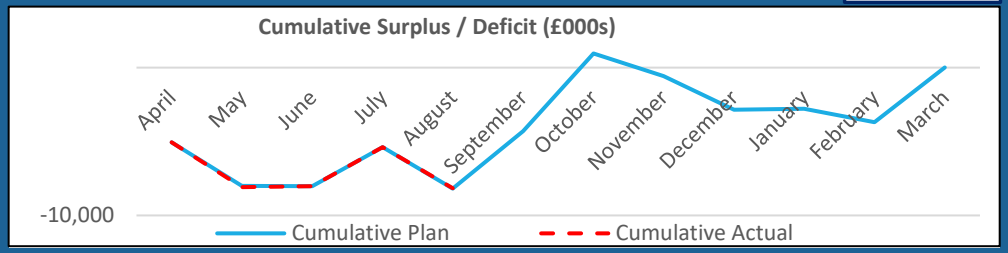
At month 6 the Trust is reporting a £4.3m deficit which is in line with the plan, however in delivering this position, the Trust has had to bring forward technical savings to offset new pressures and under delivery of Cost Improvement Programme (CIP).

- There are new pay pressures at month 6 due to unfunded pay award £1.8 million and cost associated with junior doctor industrial action of £794k which are negating some reductions in temporary pay.
- Pressures in relation to non-matched drugs, with a further £1m (Medicine and Family Health Clinical Boards), and block drugs have seen a reduction of £0.4 million as drugs in Cancer have been identified as matched.
- The CIP of £106 million is phased over the year with a plan of £42.2 million to Month 6. Year to date Clinical Boards and Corporate Services have delivered £15.5m (of which £11.1m is recurrent). To mitigate the CIP on Clinical Boards and Corporate Services delivery, £26.7m of non recurrent technical measures have been actioned which is £13.8m more than planned for.
- Activity which comes under the ERF scheme translates to £3.5m of additional income above the cap and is recognised within the position, albeit adverse (£5m) to plan at month 6.

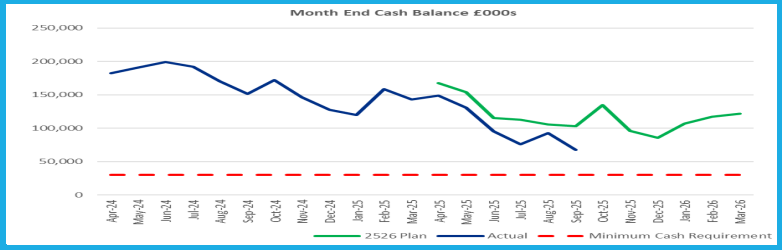
Capital Programme Delivery – Month 6



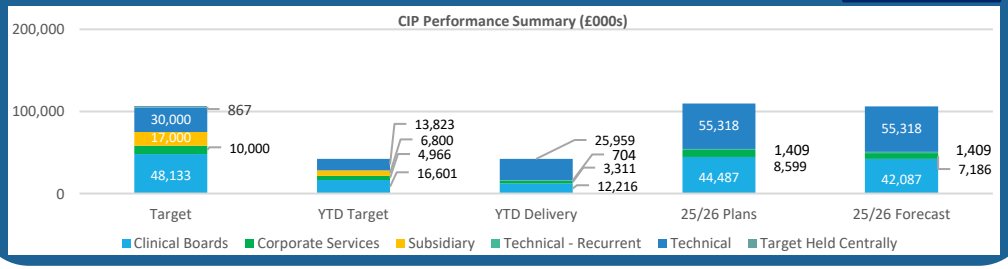
Cumulative Performance Against Plan



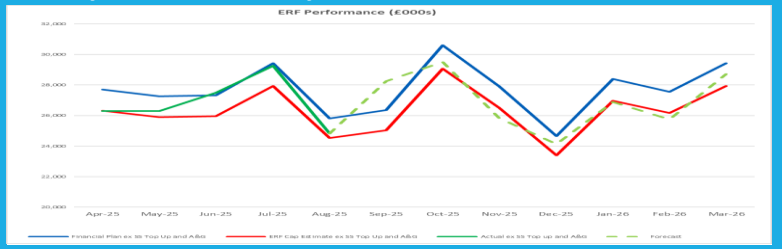
Cash Balance



Cost Improvement Programme Performance



Activity – Elective Recovery Income



Sustainability

High level Dashboard Q1 2025/26

Sustainability High-level Dashboard - Q1 2025/26 (April - June 2025)

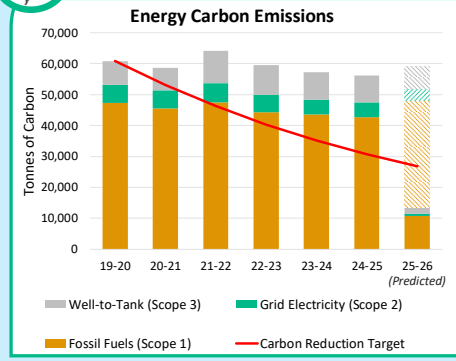
Shine – Sustainable Healthcare in Newcastle

NHS – The Newcastle upon Tyne Hospitals NHS Foundation Trust

STRATEGIC UPDATE

Capacity: ⊖ one vacancy in Estates Net Zero Team (corporate freeze) ⊕ recruited Clinical Sustainability Fellow and shortlisting EOIs for Clinical Sustainability Lead (funded via charity), Nature Recovery Ranger (external charity) and Biodiversity PhD student (part-funded by Northumbria Uni)
Funding: Net Zero Team have now secured almost £50m in grants (for energy efficiency/carbon saving projects inc. LED, Solar PV & heat pumps)
Culture: slow progress with Clinical Boards embedding sustainability into their governance via the TMG-approved Shine 10-steps (CDS making most progress)
Governance: Integrated Board Report now includes quarterly Shine dashboard
Procurement: 5th annual Net Zero Supplier event held in May, first joint event with NCC, 100% increase in suppliers engaged = improved data
Born Green Generation: team working on projects in Maternity to reduce plastics by 3,500kg/yr and save over £22,000/yr (three-year European funding)
PSDS4 £40.5m Project: significant delivery risk emerging due to Cabinet Office spend controls. Procurement Team leading on liaison whilst project team work on

ENERGY — RAG



- Q1 energy use increased by 28% (13.4 GWh) compared to 24-25. 97% (13 GWh) of which is gas use at Freeman Hospital. This is due to 24-25 Energy Centre gas CHP down time (burning less gas and importing greener grid electricity) compared to running the gas CHPs at 100% in 25-26 due to emergency generator faults.
- There is also a 2% increase in electricity due to a warmer summer this year.
- PSDS4 and GB Energy funded projects progressing with

PEOPLE

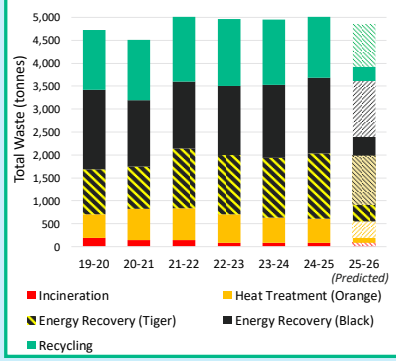
Green Champion Engagement
1030 Green Champions
(10% increase Q1)

SHINE Rewards Staff Benefit Programme and App
368,140 tCO_2e
avoided end of Q1 through staff actions since the launch of the programme (1407 users)

Social Media Communications
492 followers
(10% increase Q1)

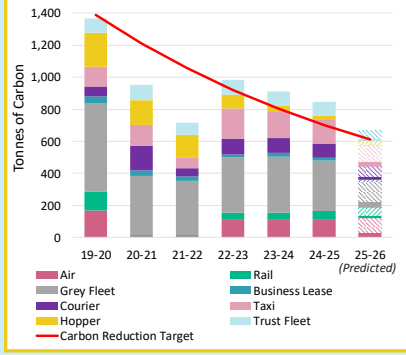
SHINE Awards for SUSQI Projects
3 projects
awarded a Shine Award Q1

WASTE — RAG



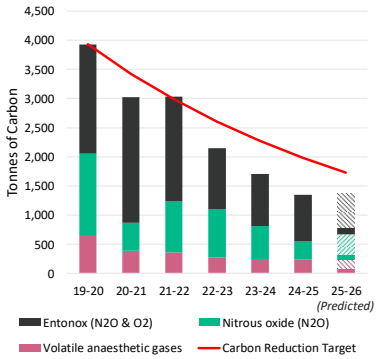
- Q1 tonnage c.5% down compared to 24-25. Welcome but unexpected. Reasons are being investigated.
- Hazardous waste = 11.4% (under 2025 Target of 12%). Benefits of introducing tiger waste into the Emergency Department.
- Recycling rate at 26% (target of 35% remains a challenge). Charity investment in public-facing bins in Q3 is hoped to have a positive impact.
- Team will be supporting training of Environment Agency hazardous waste inspectors.

JOURNEYS AND CLEAN AIR — RAG



- **Award winning Travel Team**: Gold Cycle friendly employer & Mobilityways award for park and ride promotion.
- Marketplace at Induction promoting active and sustainable travel.
- National Clean Air Day webinar and stalls (June).
- Working to reduce CO_2 impact of our salary sacrifice cars.
- Planning for World Car Free Day with the council (Q2).
- Team working with NECA to support development of our Travel Strategy.

CARE — RAG



- Q1 emissions similar to last year.
- Clinical Sustainability Fellow appointed.
- Clinical Diagnostic Services Board leading the way with the Shine 10 Step Framework for embedding sustainability from ward to board.
- Embedding sustainabilty into the **Ward Accreditation Framework**.
- Trust have become the first northern signatory to the **Circular Economy**

A Guide to SPC

SPC Icons & How to Interpret (1/4)

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

SPC Icons & How to Interpret (2/4)

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

SPC Icons & How to Interpret (3/4)

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

SPC Icons & How to Interpret (4/4)

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

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NIHR | National Institute for Health and Care Research

The Big Picture : The commercial & DHSC perspective

Morag Burton
Network Director
NIHR Regional Research Delivery Network (RRDN)
North East and North Cumbria

Changing research landscape

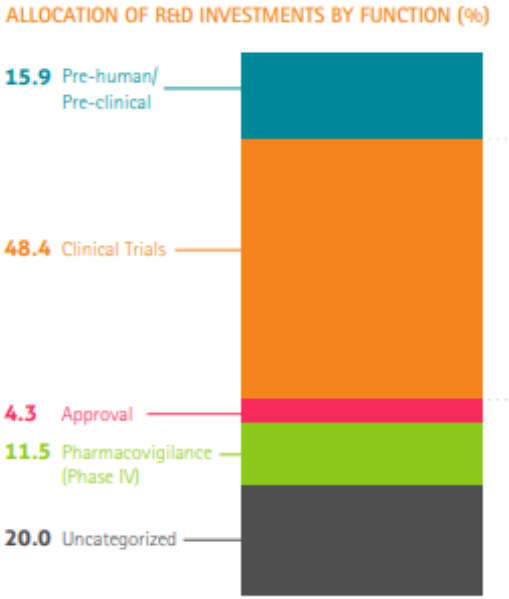
HOSPITAL *to* **HOME**	**ANALOGUE** *to* **DIGITAL** *and building the workforce of the future*	**SICKNESS** *to* **PREVENTION**

Fit for the future: 10 Year Health Plan for England

Driving growth, innovation and better health outcomes

Life Sciences Sector Plan

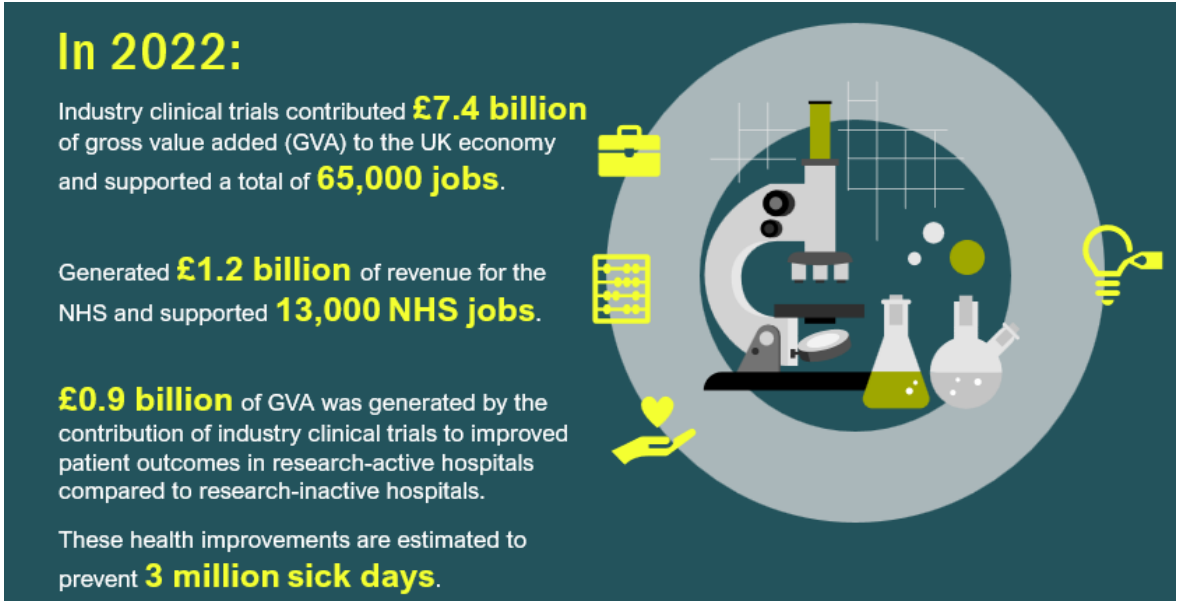
Why are clinical trials important to industry and the UK?



Source: Efpia The Pharmaceutical Industry in Figures, 2024. PhRMA annual membership survey 2023

50% of a company's Research & Development (R&D) investment is spent on clinical trials

Industry clinical trials deliver significant value to the UK economy, the NHS, patients and the UK's R&D base



The value of industry clinical trials to the UK - extended report

Status of clinical Trials in the UK


Life Sciences R&D

Rescuing patient access to industry clinical trials in the UK

abpi

About the ABPI

The ABPI exists to make the UK the best place in the world to research, develop and use new medicines and vaccines. We represent companies of all sizes who invest in discovering the medicines of the future. Our members supply cutting edge treatments that improve and save the lives of millions of people. We work in partnership with Government and the NHS so patients can get new treatments faster and the NHS can plan how much it spends on medicines. Every day, we partner with organisations in the life sciences community and beyond to transform lives across the UK.

Executive summary

- Patient access to industry research has fallen dramatically from 50,112 participants recruited to industry clinical trials on the National Institute for Health and Care Research Clinical Research Network (NIHR CRN) in 2017/18 to 28,193 in 2021/22 – a 44% decline.
- Reduced access to interventional industry clinical trials has significant consequences for patients, whose access to innovative treatments is diminishing. This has particularly serious implications for the health outcomes of patients with limited treatment options in routine care, such as people living with rare diseases.
- Consistently slow and variable study set-up timelines are driving this decline. Between 2018 and 2020, the median time between a clinical trial in the UK applying for regulatory approval and that trial delivering its first dose to a participant rose by 25 days to 247 days – placing the UK 7th amongst a basket of comparator countries.
- As a result, the number of industry clinical trials initiated in the UK per year has fallen by 41% between 2017 and 2021. Pharmaceutical companies are increasingly placing their trials in other countries (e.g. Spain and Australia) and reviewing UK research affiliate headcounts. The ABPI's data shows this is already impacting the UK's global rankings, with the UK dropping from 4th in 2017 to 10th in 2021 for Phase III industry clinical trials.
- The decline in patient access to research and industry clinical trial activity points to a clear and serious threat to the long-term future of industry clinical research in the UK – and the benefits it brings to patients, the NHS, and the economy. The Government must act


Commercial clinical trials in the UK: the Lord O'Shaughnessy review – final report

Department of Health & Social Care

Policy paper

Full government response to the Lord O'Shaughnessy review into commercial clinical trials

Updated 8 December 2023

Contents

Ministerial foreword

Executive summary

Governance

1. Progress since the initial response in May 2023

2. Our next steps

Annex A: summary of recommendations and response status

Ministerial foreword

We welcome the areas highlighted by Lord O'Shaughnessy in his review of commercial trials, which has brought a fresh perspective and helped us to prioritise key areas of the ongoing work to implement the vision set out in Saving and Improving Lives: The Future of UK Clinical Research Delivery.

The actions we are taking now to address the recommendations of the review will provide benefits for patients and the NHS across the UK, improve the environment for all types of clinical research and drive forward improvements urgently to maintain our

Table 1: Global rankings – number of pharmaceutical industry interventional clinical trials initiated in 2023, by country, by phase (compared with global rankings in 2022)

Rank	Country	Phase I	Country	Phase II	Country	Phase III
1	USA	384	USA	702	USA	415
2	China	349	China	361	China (↑1)	315
3	Australia	82	Spain	185	Spain (↓1)	241
4	Japan (↑1)	72	UK (↑2)	156	Japan (↑2)	226
5	UK (↓1)	58	Germany	149	Canada (↑4)	225
6	Canada (↑2)	45	France (↓2)	144	Germany (↑2)	221
7	Spain (↓1)	43	Japan (↑2)	141	Italy	217
8	Germany (↓1)	37	Canada	139	UK (↑2)	212
9	France	31	Australia (↓2)	131	France (↓4)	200
10	Belgium (↑1)	21	Italy (↓1)	122	Poland (↓2)	195

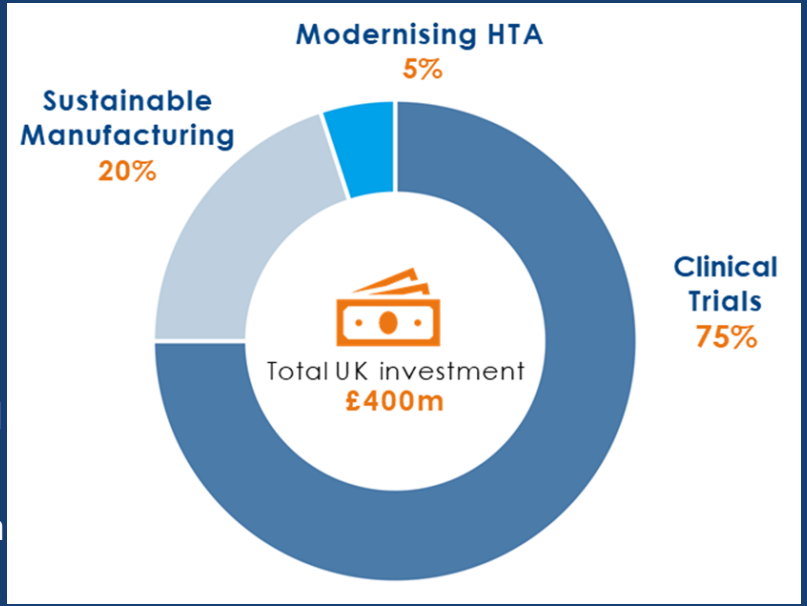
2022 2023 2024

Voluntary Scheme for Branded Medicines Pricing and Access (VPAG) Investment Programme

- World first Life Sciences Investment Programme funded by industry as part of the VPAG deal

- Up to £400m to strengthen UK competitiveness in health and life sciences and drive innovation-led growth through investments in all 4 UK nations over 5 years

  - ~75% to expedite delivery of **commercial pharmaceutical clinical trials** in the UK
  - ~20% to support UK **manufacturing** innovation ecosystem
  - ~5% for innovative **health technology assessment (HTA)** approaches



Desired outcomes from the Clinical Trials Investment Programme

Increased opportunity for participants across UK to access industry clinical trials via CRDCs, especially in areas of high disease burden and unmet need

Improved delivery of trials will incentivise industry to place more trials in the UK, meaning more patients potentially benefit from innovative therapies

Greater capacity within the UK to deliver industry and non-commercial trials

Increased revenue for the NHS from more industry trials placed in the UK

NIHR | National Institute for Health and Care Research

The Big Picture : the NIHR RDN perspective

Right research, right settings

New NIHR Research Delivery Network (RDN) to deliver key government priority projects | NIHR

- A key strategic ambition of the new organisation is to grow the amount of clinical research
- The RDN is key to delivering research inclusion
- More research in primary care, community care and residential settings, making research delivery as inclusive as possible

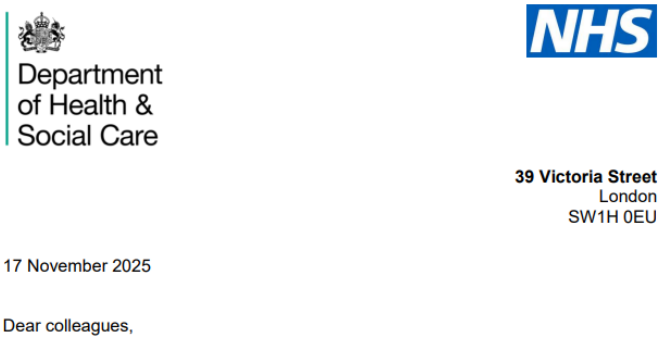
NIHR | Research Delivery Network

RDN mission and remit

NIHR RDN is funded by the Department of Health and Social Care (DHSC) to **enable** the health and care system to **attract, optimise and deliver** research across England.

- Supporting **delivery** of research which has been funded by NIHR, research charities, other public funders and the life sciences industry
- Increasing **capacity and capability** to deliver research for the future
- Covering three different **types of research** - clinical, public health and social care
- Across four **different settings** - hospital, primary care, community, and residential (and any of these in combination)

DHSC asks of NHS Trusts regarding: 150 days



Department of Health & Social Care

NHS

39 Victoria Street
London
SW1H 0EU

17 November 2025

Dear colleagues,

Supporting National Ambitions for Life Sciences Research and the 150-day target on set-up of clinical trials

The UK government is determined to make the UK a global leader in clinical research. This is essential to ensure patients receive and have access to new novel treatments and healthcare, as well as supporting growth as part of our economy. We are expecting everyone in receipt of National Institute for Health and Care Research (NIHR) funds to show leadership in delivering the key 150-day (or less) target for setting up clinical trials and ensuring all commercial income is recovered.

As announced by the Prime Minister in April 2025, our goal is clear: **all clinical trials must be set up within 150 days by March 2026**. This is a headline action in the 10 Year Health Plan for England, reinforced in the Life Sciences Sector Plan. It is now a requirement in the new 'Medium Term Planning Framework – delivering change together 2026/27 to 2028/29' (page 24).

We are expecting that every NHS Trust, particularly those receiving significant NIHR infrastructure funding or research capability funding (RCF), to deliver this target, as well as ensuring all commercial income is recovered, or face reductions to NIHR funding in the future. This aligns with expectations for performance-related funding under the NIHR Research Delivery Network (RDN) funding model for 26/27, where 20% of an organisation's funding model allocation will be based on achievements against key performance indicators, including set-up within 150 days. Final NHS Trust

Trust support from RDN where needed and funding flows in support of this work, including allocation, and reactive funding (awards made now)

How can the RDN help?

- Agile Research Delivery Team (to support delivery and collaboration across settings)
- Study Support Service (to support set up)
- Responsive Funding (to unblock blocks to speedy set up and delivery)
- Data and reports to demonstrate progress
- Working with Chief Investigators to bridge relationships with commercial sponsors and Contract Research Organisations (CROs)
- Data completeness

What's in it for the Trust?

- Protects NIHR infrastructure and funding awards
- Income (including overhead and capacity building - 190% of direct costs)
- Additional Workforce
- Full study costs - medication and investigations (which otherwise would be Business as Usual (BAU) commissioned)
- Broader relationships with commercial sponsors, repeat business and collaborative research opportunities
- Commercial partnerships
- Access to cutting edge treatments and care for our patients
- Cross sector relationships and collaborations (care closer to home for our patients) - support better clinical relationships

NIHR | National Institute for Health and Care Research

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NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Research at Newcastle Hospitals
Cementing the Partnerships

28 November 2025

John Isaacs
Director of Research

Healthcare at its best
with people at our heart

Research and the ten-year plan

- “In chapter 8, we outline our ambition to transform the NHS into a global research and innovation powerhouse. Our success will depend on making research, development and innovation a core part of everyday clinical work…”
- Time for research…funding for research…more clinical academic roles…

- Most current focus is on commercial clinical trials – performance, start-up times etc. –which we are addressing highly successfully
- By itself, however, commercial research will not help “the UK lead the world in developing the treatments and technologies of the future”

Major research infrastructure in Newcastle

- NIHR Biomedical Research Centre (BRC) (innovation; analogue to digital)
- NIHR Applied Research Collaboration (Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW) hosted) – public health (hospital to community, prevention)
- NIHR Clinical Research Facility (phase 1, 2 innovation)
- NIHR Commercial Research Delivery Centre (phase 3, 4 delivery)
- Diagnostics NE (diagnostics, precision medicine)
- Newcastle Health Research Partnership Academy – supporting academic careers across all healthcare professions
- Formal industry partnerships around trials and data
- Regional partnerships
- There is so much more that we can achieve in partnership

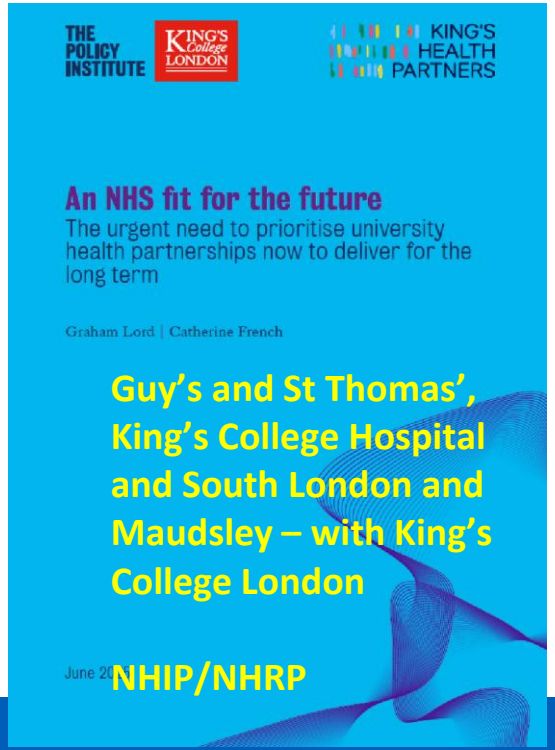
Five Big Bets

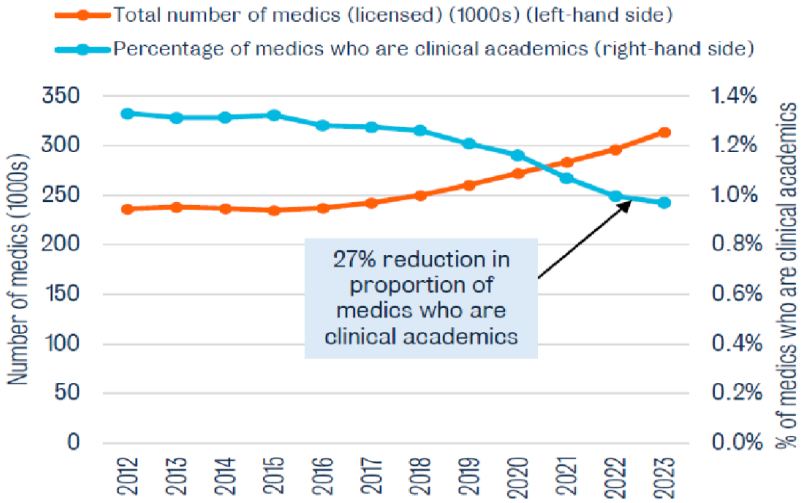
- Data
- Artificial intelligence (AI)
- Genomics
- Wearables
- Robotics

- National Innovation Centre for Data (NICD), industry partnerships
- AI-MULTIPLY
- NHS England Genomics hub
- Multi £m European Union (EU) funding (Lynn Rochester, Fai Ng)

- Also: Cancer, rare disease, multi-morbidity, inflammation medicine
- But we can do even better

The partnership challenge





Source: The General Medical Council List of Registered Medical Practitioners (data only available from 2012), and Medical School Council Clinical Academic Survey.

Clinical academics AND clinician researchers

The pandemic – vaccines, RECOVERY trial – strong partnerships work!

Tensions/risks/solutions

Tension	Risk	Solution
Insufficient funding for staff to engage in meaningful research	Status quo maintained or lost – limited innovative research	Revisit funding flows – invest to grow research
Research infrastructure such as BRC perceived as too 'university'	Disengagement, reduced relevance, ignorance/agnosticism	Train and embed NHS leaders within research infrastructure
Value of partnership not recognised, especially at 'middle management' level	Cynicism/hostility/obstruction/ stagnation	Strong messaging from the top. Reward partnership working. Emphasise contributions/ opportunities/values*
Frictions (largely) consequent on financial pressure	Obstructs and prevents innovative research, creates conflict and adversity	Mindset change: some income better than no income; added value of research; ?Special Purpose Vehicle to share success and risk

**Clinical researcher benefits: honorary Newcastle University (NU) status with privileges; Newcastle Health Research Partnership (NHRP) academy; promotion/leadership opportunities*
Newcastle Hospitals benefits: clinical contributions; quality NIHR research infrastructure and associated overhead; innovative research/Intellectual Property
Clinical academic/NU benefits: a valued/strong NHS partner providing translational and clinical research opportunities

Summary

- We are doing ok but we could do a lot better
- Do we want to be a District General Hospital (DGH) doing research – or an academic health partnership at the cutting edge of innovation?
- This will take some ‘shifts’ in mindset, approach and reward
- Particularly in today’s world of equality, diversity and inclusion we must recognise and value our partners, working together to boost our reputation as an international centre of research and innovation
- We have the essential elements, we need to maximise their value for our patients and ourselves!

Agenda item A10(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 November 2025					
Title	Joint Medical Directors Report					
Report of	Dr Lucia Pareja-Cebrian / Dr Michael Wright					
Prepared by	Associate Medical Directors					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☒		☒	
Summary	This report highlights issues the Joint Medical Directors wish the Board to be made aware of. The following items are described in more detail within this report: • Urgent and Emergency Care Update • Cancer Update • Quality & Safety • Medical Education Update • Industrial Action					
Recommendation	The Trust Board is asked to: i. Note the contents of the report. ii. Note the ongoing challenges with demand on urgent and emergency care services. iii. Note the ongoing work to improve performance against cancer care targets and the particular challenges in specific tumour groups. iv. Recognise the work done to maintain patient safety and elective activity during recent resident medical staff industrial action.					
Links to Strategic Objectives	All					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link.					
Reports previously considered by	This is a regular report to Board. Previous similar reports have been submitted.					

JOINT MEDICAL DIRECTORS REPORT

1. URGENT & EMERGENCY CARE UPDATE

Demand on both the Royal Victoria Infirmary (RVI) Emergency Department (ED) and emergency admission pathways are under significant pressure.

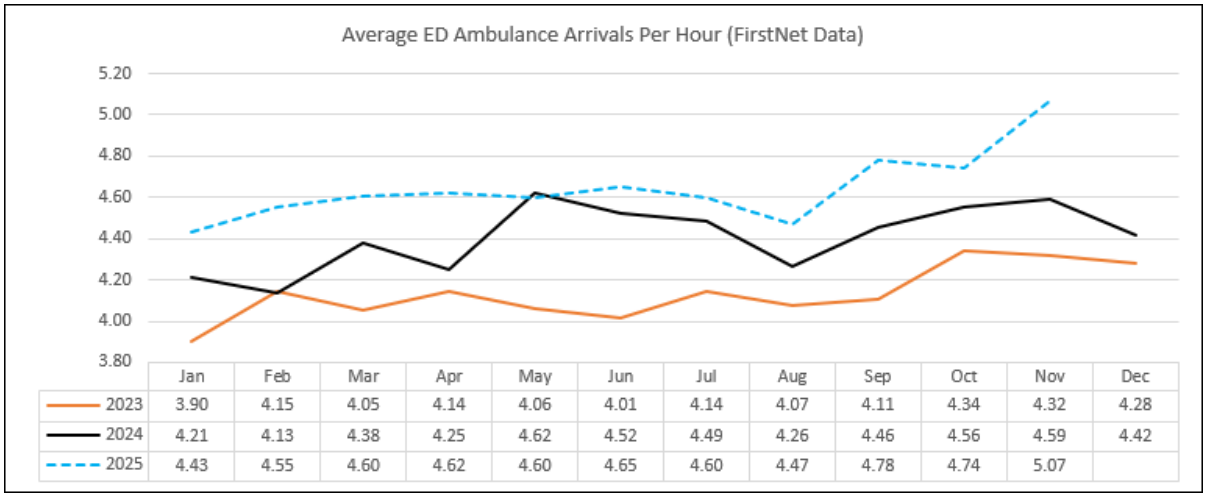
Emergency ambulance arrivals are at the highest levels we have experienced, and this is causing congestion in the main ED and conversion to admission is leading to long waits for beds.

Overall performance for October was 76.95% and Type 1 performance was 60.83%. Rising influenza and Covid cases are adding additional flow challenges with the need for isolation and estates cleaning.

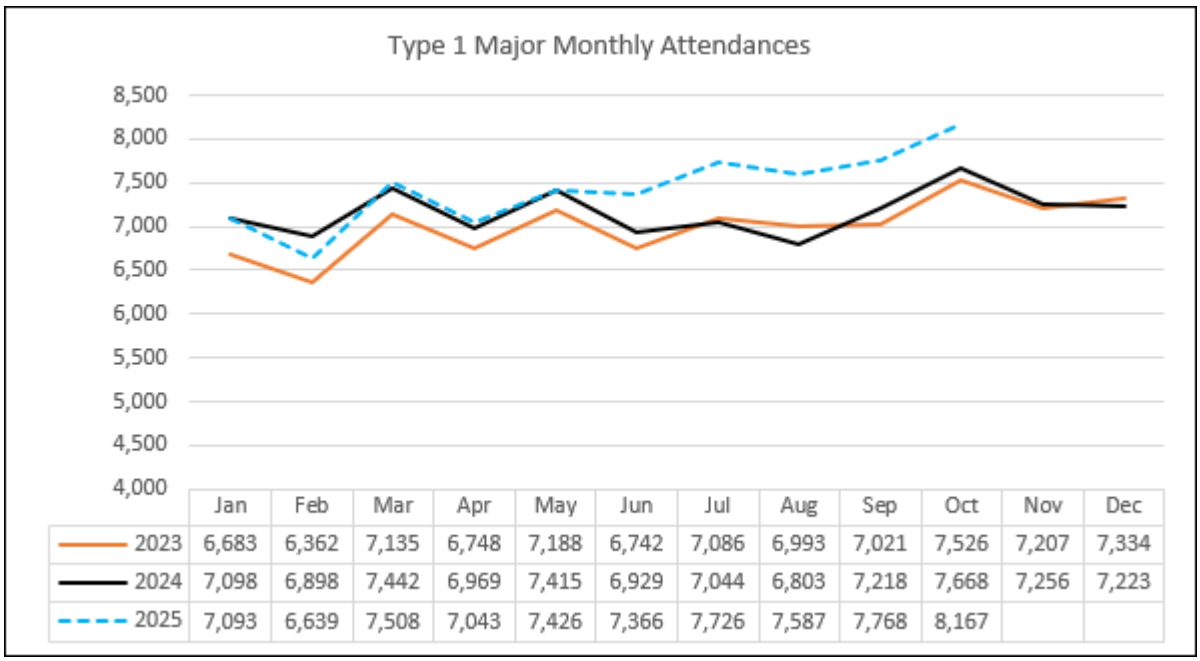
Discharge from hospital have been impacted by challenges with same day discharge, but this has been partially offset by the Trust contracting its own discharge ambulance for 6 months.

The RVI Urgent Treatment Centre (UTC) is on schedule to open in January 2026 although there remains a small amount of building work to complete.

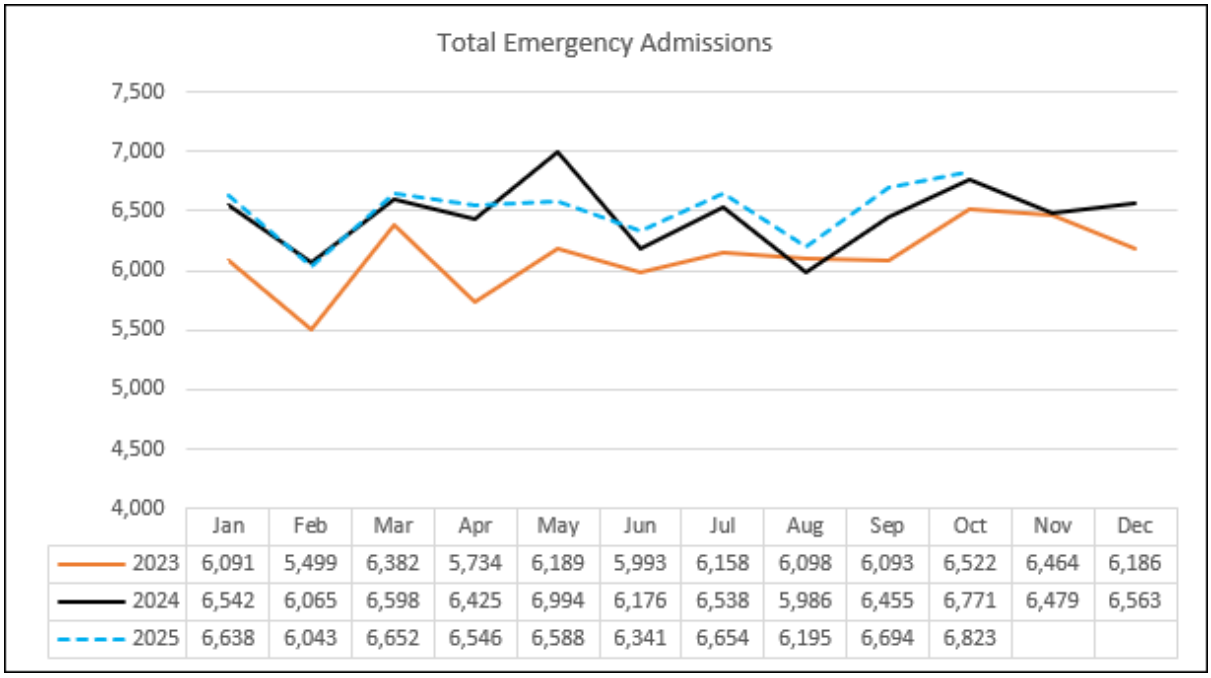
The winter ward at the Freeman Hospital and other winter schemes to relieve pressure will be implemented from 29th December although some additional staffing has been brought forward to mitigate against current pressures.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	3.90	4.15	4.05	4.14	4.06	4.01	4.14	4.07	4.11	4.34	4.32	4.28
2024	4.21	4.13	4.38	4.25	4.62	4.52	4.49	4.26	4.46	4.56	4.59	4.42
2025	4.43	4.55	4.60	4.62	4.60	4.65	4.60	4.47	4.78	4.74	5.07	



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	6,683	6,362	7,135	6,748	7,188	6,742	7,086	6,993	7,021	7,526	7,207	7,334
2024	7,098	6,898	7,442	6,969	7,415	6,929	7,044	6,803	7,218	7,668	7,256	7,223
2025	7,093	6,639	7,508	7,043	7,426	7,366	7,726	7,587	7,768	8,167		



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	6,091	5,499	6,382	5,734	6,189	5,993	6,158	6,098	6,093	6,522	6,464	6,186
2024	6,542	6,065	6,598	6,425	6,994	6,176	6,538	5,986	6,455	6,771	6,479	6,563
2025	6,638	6,043	6,652	6,546	6,588	6,341	6,654	6,195	6,694	6,823		

ED Blood Borne Virus Opt-out testing at Newcastle Hospitals

Routine opt-out blood borne virus testing is now live in 79 type 1 emergency departments across England. This means there is routine blood borne virus testing in over half of all the major emergency departments across the country. This builds on testing already routinely available through GPs and sexual health services across England and is an example of the NHS making every contact with patients count, helping people to stay well, avoid illness and saving lives. The service was first established at Newcastle Hospitals in March 2025.

Nationally the project has now delivered over 12 million blood-borne virus tests to people attending the emergency department. Over 11,000 people have been found with a new diagnosis of a blood-borne virus through this programme. At Newcastle Hospitals 31,916

blood borne virus tests have been conducted since March 2025, leading to 89 new positive diagnoses, including 29 Hepatitis C, 53 Hepatitis B and 7 HIV.

The vast majority of people newly diagnosed with a blood-borne virus in the emergency department had never tested before and may be unlikely to access testing in any other setting.

People diagnosed with a blood-borne virus on the emergency department are now being linked to specialist care, treatment and peer support.

2. CANCER UPDATE

i) Performance

28 Day Faster Diagnosis

		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Trust Total	Actual	77.0%	80.8%	79.2%	73.0%	69.2%	70.6%	73.1%	74.7%	76.1%	70.7%	83.4%	80.9%	81.4%	80.3%	78.1%	74.2%	71.9%	68.5%

		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Brain/CNS	Actual			50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%		50.0%	100.0%	100.0%	100.0%	100.0%
Breast	Actual	95.5%	96.4%	95.8%	94.7%	93.9%	96.3%	96.8%	97.8%	96.0%	94.4%	97.0%	97.1%	95.6%	92.5%	84.8%	95.5%	92.9%	92.8%
Breast Symptomatic	Actual	65.3%	55.8%	60.9%	60.4%	54.7%	80.2%	85.4%	82.7%	61.9%	63.6%	70.9%	56.1%	65.5%	53.3%	55.5%	47.0%	38.7%	33.3%
Childrens	Actual	100.0%	100.0%	60.0%	66.7%	60.0%	100.0%	100.0%	60.0%	0.0%	66.7%	100.0%	66.7%	83.3%	100.0%	46.2%	100.0%	50.0%	100.0%
Colorectal	Actual	60.6%	70.0%	65.9%	61.7%	63.5%	59.2%	65.8%	69.5%	71.1%	64.0%	80.2%	74.4%	61.8%	61.1%	72.0%	75.0%	74.5%	71.1%
Gynae	Actual	60.6%	70.0%	65.9%	61.7%	63.5%	59.2%	65.8%	69.5%	71.1%	64.0%	80.2%	74.4%	61.8%	61.1%	75.0%	85.1%	77.0%	81.1%
Haematology	Actual	72.7%	93.8%	75.0%	81.8%	73.3%	72.7%	100.0%	91.7%	89.5%	100.0%	94.4%	70.0%	100.0%	81.8%	73.1%	86.7%	84.6%	100.0%
Head & Neck	Actual	87.2%	91.5%	92.1%	91.4%	91.2%	89.9%	89.7%	87.1%	91.8%	90.9%	93.3%	86.2%	85.9%	89.0%	88.9%	87.0%	90.6%	95.3%
Lung	Actual	85.7%	81.6%	71.0%	60.8%	82.5%	63.0%	78.6%	75.5%	76.3%	86.0%	82.5%	85.4%	72.7%	74.5%	84.8%	74.4%	76.3%	83.3%
NSS	Actual	80.0%	100.0%	92.3%	92.9%	87.5%	87.5%	86.7%	90.9%	85.7%	63.6%				77.8%	90.5%	100.0%	92.9%	84.6%
Other	Actual	100.0%		100.0%		0.0%		100.0%	50.0%	0.0%		100.0%	0.0%	100.0%		0.0%	100.0%		
Sarcoma	Actual	42.9%	66.7%	66.7%	88.9%	80.0%	87.5%	88.9%	85.7%	92.9%	100.0%	72.7%	80.0%	90.0%	72.7%	100.0%	84.6%	87.5%	77.8%
Skin	Actual	75.7%	78.8%	78.2%	66.4%	62.6%	58.6%	63.0%	65.2%	68.9%	60.9%	81.5%	79.1%	82.5%	82.0%	74.8%	63.9%	61.5%	52.8%
Testicular	Actual	100.0%	100.0%	91.7%	100.0%	100.0%	90.0%	92.3%	87.5%	93.8%	90.9%	90.0%	100.0%	100.0%	100.0%	90.0%	100.0%	100.0%	88.9%
Upper GI	Actual	73.2%	76.0%	62.6%	65.9%	59.3%	60.8%	74.3%	76.7%	85.9%	86.5%	88.2%	83.5%	79.5%	77.5%	85.0%	80.8%	92.1%	89.5%
Urology	Actual	69.9%	75.7%	77.7%	82.4%	80.9%	80.6%	64.5%	60.2%	50.9%	31.7%	56.3%	68.0%	78.8%	65.2%	67.5%	71.1%	72.1%	76.8%
HPB	Actual	12.5%	66.7%	0.0%	33.3%	0.0%	20.0%	33.3%	16.7%	66.7%	0.0%	66.7%	58.3%	62.5%	27.3%	60.0%	42.9%	62.5%	70.0%
OGD	Actual	79.2%	74.1%	61.9%	65.5%	60.3%	59.7%	75.9%	82.8%	92.4%	88.5%	90.6%	86.0%	79.2%	88.1%	86.3%	86.0%	91.9%	91.2%

62 Day Time to Treatment Target

		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Trust Total	Actual	59.0%	60.2%	65.2%	59.9%	60.8%	59.4%	63.4%	62.0%	63.7%	66.1%	61.0%	65.2%	72.2%	69.6%	63.8%	71.2%	69.9%	70.4%

		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25
Brain/CNS	Actual	100.0%	100.0%	100.0%	87.5%	100.0%	100.0%	100.0%	92.6%	100.0%	100.0%	90.0%	100.0%	88.2%	91.3%	100.0%	82.6%	83.3%	100.0%
Breast	Actual	89.9%	93.8%	97.8%	89.7%	89.9%	91.8%	87.5%	90.5%	90.8%	87.7%	88.1%	77.7%	95.1%	88.9%	89.8%	92.1%	83.5%	86.5%
Childrens	Actual			100.0%			100.0%		100.0%	100.0%	100.0%		100.0%		100.0%		100.0%	100.0%	100.0%
Colorectal	Actual	25.3%	46.4%	28.8%	49.3%	47.5%	48.1%	34.8%	44.1%	31.3%	50.6%	34.5%	72.9%	55.3%	48.2%	38.7%	41.4%	37.7%	53.7%
Gynae	Actual	45.0%	63.2%	73.7%	60.0%	56.3%	77.8%	76.9%	57.7%	35.5%	64.0%	48.0%	39.3%	77.8%	48.3%	77.3%	41.4%	53.8%	50.0%
Haematology	Actual	82.1%	66.7%	93.2%	90.0%	90.0%	81.8%	83.0%	92.1%	83.3%	100.0%	85.3%	82.4%	86.7%	88.4%	81.6%	83.9%	75.6%	64.7%
Head & Neck	Actual	80.0%	66.7%	79.4%	80.0%	77.2%	66.7%	72.9%	75.0%	59.0%	85.4%	80.7%	60.0%	75.8%	92.1%	75.8%	79.7%	75.0%	72.2%
Lung	Actual	29.3%	46.0%	48.3%	34.8%	29.3%	33.5%	39.2%	43.1%	55.1%	45.1%	36.3%	46.2%	49.6%	42.5%	40.7%	63.7%	55.0%	56.9%
Other	Actual	77.8%	78.0%	33.3%	28.6%	83.3%	33.3%	62.5%	63.6%	100.0%	50.0%	41.7%	100.0%	83.3%	63.6%	100.0%	83.3%	50.0%	69.2%
Sarcoma	Actual	71.4%	77.8%	85.7%	53.8%	64.7%	76.9%	81.3%	58.3%	57.1%	68.2%	94.7%	81.3%	100.0%	80.0%	100.0%	63.6%	78.9%	70.0%
Skin	Actual	80.5%	87.9%	87.9%	83.5%	92.6%	87.0%	89.2%	75.4%	77.9%	82.3%	79.2%	82.9%	90.2%	95.7%	89.7%	90.5%	94.7%	90.7%
Upper GI	Actual	45.3%	41.4%	40.4%	36.7%	51.1%	39.8%	46.5%	39.2%	37.6%	40.4%	53.2%	41.3%	40.9%	44.0%	41.8%	49.6%	48.6%	47.4%
Urology	Actual	47.0%	38.4%	52.4%	46.9%	37.8%	44.6%	50.4%	50.0%	58.4%	66.7%	40.5%	61.3%	56.5%	54.7%	40.8%	55.5%	60.4%	51.9%
HPB	Actual	44.2%	23.1%	41.7%	58.1%	44.7%	52.4%	37.9%	41.4%	46.2%	41.0%	58.5%	53.4%	45.8%	51.4%	39.1%	54.1%	50.6%	51.6%
OGD	Actual	47.6%	56.3%	54.5%	38.2%	44.4%	48.4%	59.1%	55.9%	54.2%	61.3%	66.7%	48.1%	35.6%	36.8%	48.1%	38.9%	43.3%	28.6%

Cancer performance is still below the standard required and that which we would want to see. Validated performance data submitted for September 2025 show that the 28-day compliance has fallen to 68.5% (75.7% for those diagnosed with cancer and 67.9% in those subsequently found not to have cancer). The main reason for the deterioration in performance on the 28-day faster diagnosis pathway is a deterioration in the performance within the skin pathway. Skin contributed 1,219 patients to the data in September which is roughly 50% of the patient cohort overall. If patients on the skin pathway were excluded from 28-day analysis the performance would be 81.2%. Reasons for dropping performance in skin are well understood high referral rates especially over the summer months; lack of physical space to run additional clinics and biopsy sessions in normal working hours and low take up of Waiting List Initiative and overtime offers by clinical staff; reduced use of teledermatology in primary care. A series of workstreams is ongoing to tackle these issues including discussion with Northumbria Healthcare to ensure patients are referred to the nearest provider where this is clinically appropriate, assessment of Manor Walks as a venue for more clinical work, engaging with the Northern Cancer Alliance who are scoping further teledermatology opportunities and directing some patients direct to plastic surgery at Newcastle Hospitals if surgical treatment is the likely outcome. There is likely to be some improvement in skin pathway compliance over the winter if the usual pattern of reduction in referrals holds true this year.

In terms of patient impact and outcomes, the skin pathway has high compliance at 62 days (over 90%); the risk to patient safety associated with a delay to diagnosis at 28 days is very low on this pathway (though this doesn't account for anxiety caused in the waiting period). This is because for many skin lesions an excision biopsy both allows a diagnosis to be reached, and a lesion treated at one visit, and this happens within 62-days but less frequently within 28-days. Considerable work has been undertaken and continues to ensure accuracy in tracking these patients as the flow is different from that of other tumours.
The overall performance on 62-day pathways is slowly improving and reached 70% in September. There is clearly work to do to reach the NHS England target of 85% by March 2027. The number of patients waiting beyond 62-days on urgent suspected cancer pathways week ending 2 November 2025 is 136 which, whilst demonstrating an overall downward trend since December 2023 is static in recent months.

Radiotherapy performance, which in terms of targets principally impacts the 31-day treatment target, continues to improve month on month as assessed by mean time from referral to commencement of treatment. The team have achieved 92.5% of patients treated within 31 days of referral for radiotherapy in September and unvalidated data suggest this may reach 98% in October. There has clearly been a huge amount of work done by the team to improve performance and to do so with careful and clear clinical prioritisation to prevent patient harm. Staffing is still fragile with multiple at-risk professions delivering patient care; careful ongoing monitoring is essential to minimise wait times.

The most consistently challenged tumour groups in terms of 62 day performance remain lower gastrointestinal (GI), upper GI, lung and urology. Regular fortnightly review meetings are in place with the teams to review action plans and to overcome barriers to improvement wherever possible.

ii) Tumour Group Issues

There remain regular tumour group clinical and operational meetings to highlight risks and try to remove barriers when there are challenging situations. Significant current issues are:

- Navigational Bronchoscopy: Kit lease now requested, staff are trained. Aiming to commence service January 2026, though physical space still needs to be negotiated list by list with endoscopy. Medicine developing a plan for sustainable funding beyond 12 months (NCA support given for 12 months)
- Increasing endoscopy capacity to facilitate endobronchial ultrasound (EBUS), navigational bronchoscopy and hepatobiliary endoscopy procedures.
- Creating a theatre with a scanner at the Freeman Hospital to allow expansion of ablation work in interventional radiology with routine general anaesthetic lists and preservation of access to static CT facilities at the Freeman Hospital.
- Dermatology issues as highlighted above.
- Robotic access is currently being reviewed by the Surgical and Associated Services (SAS) Clinical Board as access is challenged due to capacity issues.

iii) Cancer Governance

National Cancer Patient Experience Survey (NCPES)
NCPES results have been discussed with tumour leads and at the Cancer Clinical Board. Each tumour group has been asked to highlight any specific area that they wish to focus on in their workplan for 2026. One area we have elected to focus on more globally is patient access to financial guidance after a cancer diagnosis. This will involve engagement with charities and consideration of provision of basic guidance and signposting in a pack developed for prehabilitation post-diagnosis.

iv) Flatiron

The first wave of data, pertaining to just over 22,000 patients has been transferred over to the Flatiron platform. The first curated data is anticipated as being available March / April 2026.

3. QUALITY AND SAFETY

i) Patient Safety Incident Response Framework (PSIRF) Priority Project – Invasive Procedure

The project board met for the first time on 5 November, and the Terms of Reference were approved. The greater part of the project is the refresh and overhaul of the major components of the National Safety Standards for Invasive Procedures – 2nd edition (NatSSIPs 2).

https://cpoc.org.uk/guidelines-and-resources/guidelines/national-safety-standards-invasive-procedures-natssips

Comprising organisational standards alongside the specific element of procedural safety during an individual case these guide the shape of the project specifically in theatre. The Project Board will oversee the design and structure of the project, will support the individual work streams, assure and oversee work and ensure Trust communications and wider engagement.

The Project Board comprises representatives for all Clinical Boards and wider input specifically from the Peri-op Clinical Board. Theatre Nursing involvement is absolutely key to the delivery of this project – ideally this would involve specific seconded roles although funding for such a position is difficult.

The project will work alongside the RVI Theatre Efficiency Initiatives and ensure that new and key safety processes are embedded alongside work process improvements.

The three identified work streams at this point are:

- In-theatre work-stream – led by Dr Suzy Jackson (Consultant Obstetrician and Clinical Director (CD) for Quality and Safety) and Mr Damian Holliman (Consultant Neurosurgeon).
- Implant Safety Process – led by Consultant Orthopaedic Surgeons Mr Paul Fearon and Miss Sarah Eastwood.
- Out of theatre procedures – led by Dr Ruairidh Martin, Consultant Cardiologist.

We hope this project will engage very large numbers of staff involved in procedures both within and outside theatres in a significant and exciting safety project.

Specific areas we hope to deliver improvement include:

- Consent and procedure verification – we know our current process has vulnerability and that legal claims with respect to consenting errors have occurred within the organisation.
- Start of day team brief – focussing this discussion very specifically on safety vulnerabilities that day, recording and using this discussion through the day, ensuring attendance of the most senior clinicians.
- Checklist and sign in overhaul and opportunity to consider bespoke process per activity.
- Implant safety.
- Minor and non-theatre process.

This is a very large and ambitious project. ***The ultimate measurement and aim is to reduce avoidable harm in any patient undergoing an invasive procedure***.

ii) <u>Quality and Safety Community of Practice</u>

This new bi-monthly meeting commenced on 10 October 2025. This new structure aims to form a regular face to face whole afternoon meeting between clinical board and corporate quality and safety teams. This strengthens the existing formal and informal meeting channels and is an opportunity for problem and information sharing and to give time for rich discussion and strategic and operational planning. This successful first meeting involved discussion of:

- Fluid prescribing and fluid balance monitoring on the wards.
- Infection control initiatives – SAS Board.
- Martha's Rule – operational update and data analysis.

Future meeting agenda includes:

- Consent.
- Radiology Error investigation.
- New Intervention Procedure – Clinical Board Assurance.

iii) Business Cases

Whilst a process is ongoing for ranking of business cases to address quality issues, of particular importance is the ongoing support for the very successful Venous thromboembolism (VTE) PSIRF priority project. The specific artificial intelligence (AI) module which underpins this work (automatically identifying all patients in whom we have diagnosed a new thrombus) requires long term support.

4. MEDICAL EDUCATION

i) Currently working through the Self-Assessment Report and the Quality Improvement Plan for the 2025 cycle. Work is underway in some of the areas where there have been particular concerns about training such as Haematology, Microbiology and Ophthalmology. Action plans for each area in the process of being created and will be described in a future report.

ii) Development of facilities survey underway to send out to all Resident Doctors to understand where the areas of focus need to be. Results will be shared with the Medical Directors and Guardian of Safe Working Hours (GoSW).

iii) The Chief Medical Registrar and the Medical Education team are creating a pilot programme for 'Feedback Fridays' in response to some of the concerns raised in the General Medical Council (GMC) survey data around giving feedback.

iv) There have been requests for some bespoke 'Insights discovery' sessions and these will be delivered in due course.

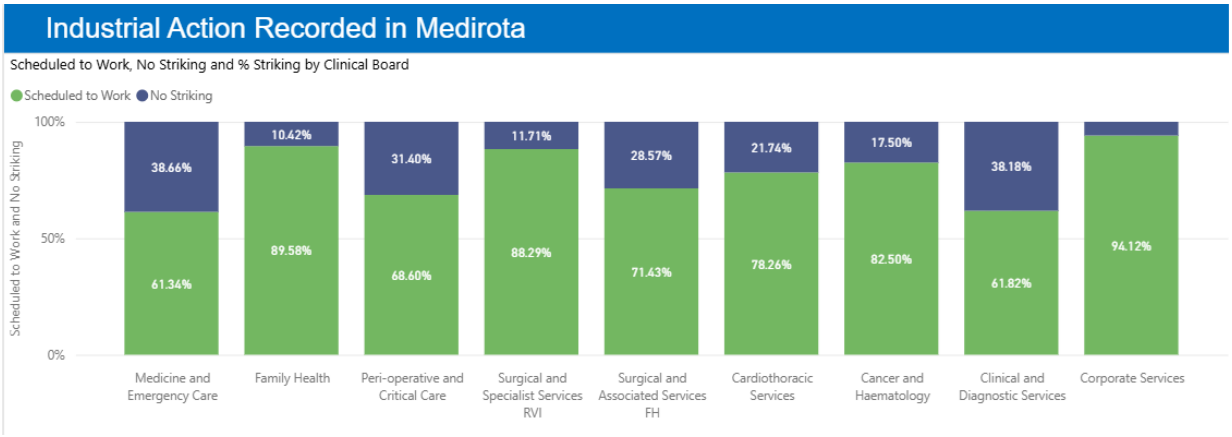
v) Teaching continues for all grades however, we continue to struggle to recruit trained faculty for various programmes including simulation teaching.

vi) Recent national Resident doctor negotiations indicate a move towards additional training posts and the creation of a further core training programme. We await further information on this.

vii) Resource constraints remain a concern with the inability to support some workstreams due to ongoing operational demands.

6. INDUSTRIAL ACTION

A proportion of resident medical staff took part in Industrial Action during the period 14 November to 19 November. The number of staff taking industrial action in each of the Clinical Boards is shown below.



Contingency planning involving all of the clinical boards, Medical Directors' team, senior nursing team and operational teams ensured that appropriate resources were identified to ensure that the hospital remained safe and that care was provided to as many patients as possible throughout. We are extremely grateful to all staff who offered to work additional hours to cover service gaps arising out of the industrial action. We are particularly grateful to those who made personal sacrifices to provide this cover. We would like to thank all staff, including but not limited to all medical staff who supported our patients in this way.

As a result of the commitment of staff we were able to provide Urgent and Emergency care at a similar standard and to the same access levels as normal.

Elective care was maintained with 95% of planned activity being delivered across the period of the industrial action.

It is important to recognise the additional resource required across the organisation to plan for and deliver safe care during the industrial action.

7. 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 particular challenges in specific tumour groups.
iv) Recognise the work done to maintain patient safety and elective activity during recent resident medical staff industrial action.

Report of
Dr Lucia Pareja-Cebrian/ Dr Michael Wright
Joint Medical Directors
14 November 2025

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Agenda item A10(a)(i)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 November 2025					
Title	Guardian of Safe Working (GOSW) Quarterly Report (Quarter 2 (Q2) 2025-26)					
Report of	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Prepared by	Dr Henrietta Dawson, Trust Guardian of Safe Working Hours					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☐		☒	
Summary	The terms and conditions of service (TCS) of the new junior doctor contract (2016) require the Guardian of Safe Working Hours to provide a quarterly report to the Trust Board to give assurance to the Board that the junior doctors' hours are safe and compliant. The content of this report outlines the number and main causes of exception reports for the period 27 June to 26 September 2025 for consideration by the Trust Board.					
Recommendation	The Trust Board is asked to note the contents of this report.					
Links to Strategic Objectives	Patients – Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐
Link to Board Assurance Framework [BAF]	No direct link to the BAF. In order to maintain quality and safety, we must have a junior doctor workforce who can work within safe hours and receive excellent training.					
Reports previously considered by	Quarterly report of the Guardian of Safe Working Hours. The report was considered at the 18 November 2025 People Committee.					

GUARDIAN OF SAFE WORKING QUARTERLY REPORT

1. EXECUTIVE SUMMARY

This quarterly report covers the period 27 June to 26 September 2025.

There are now 1,182 resident doctors on the TCS of the 2016 contract, and a total of 1,200 resident doctors in the Trust.

There were 142 exception reports in this period. This compares to 118 exception reports in the previous quarter.

The main areas of exception reports are general medicine and general surgery.

The main cause of exception reports is when there is a workforce/workload imbalance.

2. INTRODUCTION / BACKGROUND

The Resident Doctor Contract came into effect on 3 August 2016, reviewed in August 2019, with further changes due to be implemented by February 2026. 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 Guardian of Safe Working Hours must provide a quarterly report to the Trust Board to give assurance to the Board that the doctors' hours are safe and compliant. The revised TCS of the contract and exception reporting changes have now been published and are expected to be effective from February 2026.

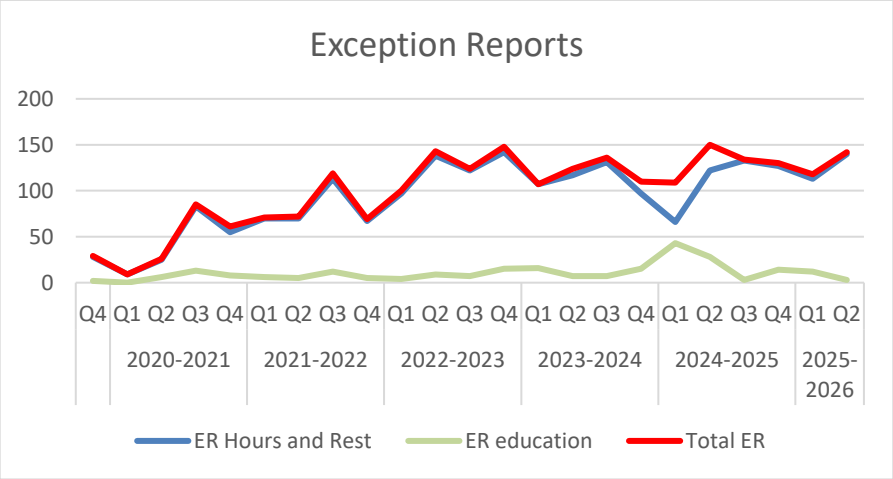
The principles of the framework agreement are to improve access, confidentiality and ease of exception reporting. Resident doctors will be able to decide compensation and supervisors will be removed from the exception reporting process. We are still awaiting further information, but other changes which have been suggested include standardisation of Board reporting to enable national benchmarking.

3. HIGH LEVEL DATA

		(Previous quarter data for comparison)
Number of Resident Doctors on New Contract	1,182	(1,116)
Total Number of Resident Doctors	1,200	(1,139)
Number of Exception reports	142	(118)
Number of Exception reports for Hours Breaches	140	(113)
Number of Exception reports for Educational Breaches	3	(12)

Fines	7	(14)
Admin Support for Role	Good	
Job Planned time for supervisors	Good	

4. EXCEPTION REPORTS



4.1 Exception Report by Speciality (Top 4)

		(Previous quarter for comparison)
General Medicine	43	(76)
General Surgery	45	(10)
Ophthalmology	15	(9)
Orthopaedics	11	(0)

4.2 Exception Report by Rota/Grade

General medicine

Royal Victoria Infirmary (RVI) (F1)	3
RVI (SHO)	4
Freeman Hospital (FH) (F1)	21
FH (SHO)	15

General Surgery

FH (F1) including Hepato-Pancreato-Biliary (HPB), colorectal, vascular	27
FH (F2/SHO/StR)	3
RVI (F1)	15

Ophthalmology

StR	11
SHO	4

Orthopaedics

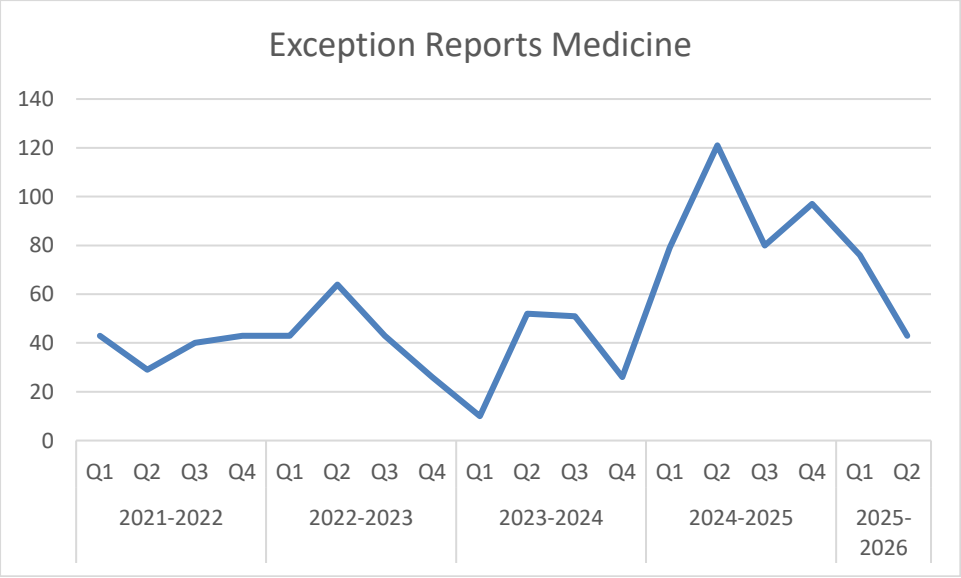
RVI	7
FH	4

4.3 Example Themes from Exception Reports

General Medicine RVI/FH

'Called on to ward 20 for 2 days due to low staffing. High clinical load during shift; unable to achieve breaks. '

An additional 5 F1s were assigned across FH and RVI in August 2023 (Q2 2023-2024), with a further 5 F1s added to the workforce in August 2024. 2 additional F2s were also added (commenced August 2025). As mentioned in previous Board reports, there was an increase in exception reporting numbers in 2024-2025 despite the increase in workforce. The finance team have, however, noted a reduction in locum spend for medicine which may have been influenced by the increased foundation doctor workforce.

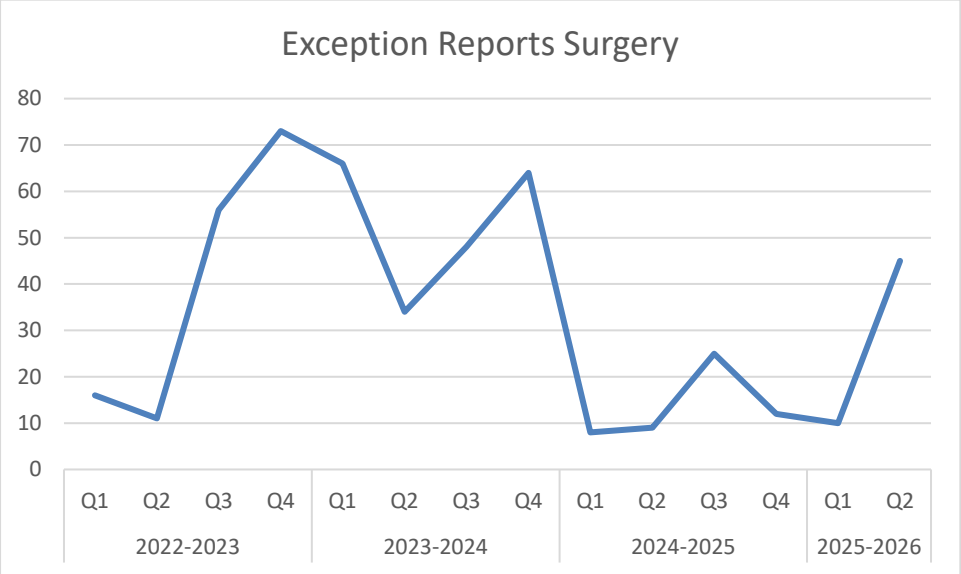


General Surgery FH

'Another extremely busy day covering HPB/colorectal across 3 wards... In fact ward round was still not finished with about a third of the list to go when I left around 9.30pm. Missed break as would have been unsafe to take it. Then stayed late again to ensure safe handover and review critical findings on today's investigations.'

An additional F1 was assigned in August 2023 with a further post added in August 2024. 1 additional F2 (commenced August 2025) has been assigned to this area, and a total of 5

additional F1s assigned to surgery across both sites. There was an improvement in exception reporting numbers. However exception report numbers have now increased again. This area has previously been an area of concern. I will continue to monitor exception reports and their content.



Ophthalmology

The majority of exceptions related to non-resident on call hours worked.

Orthopaedics

'It was my first ever weekend shift. Multiple patients were unwell around the same time; had to take some time to discuss with family members about certain situations. I did not eat until I got home around 9:30. '

5. EXCEPTION REPORT OUTCOMES

5.1 Work Schedule Reviews

No work schedule reviews were completed on the back of exception reports.

5.2 Fines

7 fines have been issued:

- Ophthalmology (4 fines): Rule breached "Unable to achieve minimum overnight continuous rest of five hours between 22:00 and 07:00 during a non-resident on-call (NROC); Unable to achieve the minimum 8 hours total rest per 24-hour NROC shift." Total fine money £439.50.
- Cardiology (2 fines): Rule breached "Late finish; Exceeded the maximum 13-hour shift length." Total fine money £119.26.

- Orthopaedics (FH) (1 fine): Rule breached "Late finish; Exceeded the maximum 13-hour shift length." Total fine money £21.77

6. ISSUES ARISING

6.1 Workforce and workload

The recurring theme as to when exception reports are raised is when there is a reduction of doctor numbers on the ward or high workloads. Q2 includes large changeovers in resident doctors, and newly qualified F1s commencing in post. There is a predicted 'learning curve' during this time.

There has been an increase in Foundation Doctors in post. In August 2023 an extra 9 foundation posts were created, with an additional 10 posts created in August 2024. F1 posts have focused mainly on medicine and surgery, and F2 posts have included rotations in haematology/oncology, ophthalmology, paediatrics, emergency medicine as well as medicine and surgery. Haematology/oncology has previously been an area of concern due to high numbers of exception reports but is not currently. This may be due to the increased workforce.

The increase in foundation posts has not shown a direct correlation with a reduction in exception reporting numbers. The reasons for exception reporting is multifactorial. Where previously exception reports commented on below minimum staffing, this has not been mentioned in recent exception reports. It should also be noted, as previously mentioned in Board reports, that the working patterns of doctors has changed over the last few years.

There is an increase in requirement for doctors to spend time away from clinical commitments on educational activities. The increase in doctor numbers has likely allowed this to happen while still maintaining safe staffing.

Locum spend has decreased. This is also likely to be multifactorial but may reflect an increased resilience in the workforce numbers.

6.2 Supervisor Engagement

Supervisor engagement is generally good.

6.3 Administrative Support

Administrative support is currently good.

7. ROTA GAPS

Specialties and rotas with vacancies are outlined below.

Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Sep-25	Aug-25	Jul-25
	Cancer Services					
FH	Oncology	ST3+	22	1	1	4.5
	Cardiothoracic Services					
FH	Cardiology	ST3+	15	1	1	2
FH	Cardiothoracic Anaesthesia	ST3+	10	0	0	1
FH	Cardiothoracic Surgery	F2/ST1-2	2	2	2	2
FH	Cardiothoracic Surgery	ST3+	11	2	2	2
FH	Cardiothoracic Transplant	ST3+	3	1	1	1
FH	Paediatric Intensive Care Unit (PICU)	ST3+	8	0	0	1
FH	Paediatric Cardiology 1st	F2/ST1/ST2	7	0.2	0.2	0.2
FH	Paediatric Cardiology 2nd	ST3+	9	1	1	3
FH	Respiratory Medicine	CMT/ST1-2	5	0.2	0.2	0.2
	Family Health					
RVI	Paediatrics 1st - ST1/ST2 (now inc Paeds Surgery)	F2/ST1/ST2	25	1.4	1.4	1.4
RVI	Obstetrics & Gynaecology	F2/ST1/ST2	14	0	0	1.4
RVI	Obstetrics & Gynaecology	ST3+	22	1	1	3
RVI	Neonates	F2/ST1/ST2	7	0	0	1
	Surgical & Associated Specialities (FH)					
FH	Vascular	ST3+	10	0	0	1.5
RVI	General Surgery	F2/ST1/ST2	7	1	1	0
RVI	General Surgery	ST3+	15	0.8	0.8	0.8
FH	Urology	F2/ST1/ST2	7	0	0	1
FH	Ear, Nose & Throat (ENT)	F2 / CST / ST1-2	5	1	1	0
	Clinical and Diagnostic Services					
RVI	Histopathology	ST1/2	8	0.2	0.2	0.2
RVI	MM rota integrated with ID and MV and GIM	ST1+	21	1.6	1.6	1.6
RVI / FH	Radiology On Call	ST2 / ST3+	33	0	0	2
	Medicine					
RVI	CMT BOH and FOH Combined (August 2019)	CMT	11	1	1	0
RVI	CMT Acute - ACU (August 2019)	CMT	2	1	1	1
RVI	ACCS on Assessment Suite Only	ACCS	2	0	0	0.2
RVI	General Internal Medicine	ST3+	25	3	3	1
FH	Care of the Elderly	ST3+	5	2	2	1
RVI	Accident & Emergency 1st	F2	7	0	0	0

Site	Specialty/Sub Specialty	Grade	No required on rota (at full complement)	Sep-25	Aug-25	Jul-25
RVI	Accident & Emergency 1st	ACCS/ST1-2/CT1-2	20	1	1	1
RVI	Accident & Emergency 2nd	ST3+	15	3	3	2
RVI	Dermatology	ST3+	7	0.4	0.4	0.4
	Surgical & Specialist Services (RVI)					
RVI	Ophthalmology	F2/ST1/ST2	6	1	1	2
RVI	Ophthalmology	ST3+	25	3	3	1
RVI/FRH	Orthopaedics	ST3+	19	2	2	1
FH	Orthopaedics	F2/ST1/ST2	4	2	2	0
RVI	Neurosurgery	F2/ST1/ST2	5	0.2	0.2	1.2
RVI	Neurosurgery	ST3+	13	1	1	1
RVI	Neurology	IMT/CMT	3	0.2	0.2	0.2
	Peri-operative					
FH	Critical Care	F2 ST1-7	13	0.8	0.8	1
FH	Anaesthetics General	ST1-7 CT1-2	27	2.8	1.8	2.8
RVI	Critical Care	ST1+	16	2.6	2.6	4.6
RVI	Anaesthetics	ST1-2 / ST3 +	40	2.2	2.2	3.6

Key:
CMT – Core Medical Trainee
IMT – Internal Medicine Trainee
CT – Core Trainee
CST – Core Surgical Trainee
ACCS – Acute Care Common Stem (CT equivalent)
ST – Specialist Trainee
LED - Locally Employed Doctor
LET - Lead Employer Trust
LTFT - Less Than Full Time
BOH – Back of House
FOH – Front of House
ACU - Ambulatory Care Unit
MM – Medical Microbiology
ID – Infection Disease
MV – Medical Virology
GIM – General Internal Medicine

8. LOCUM SPEND

The purpose of reporting locum spend is as a source of information indicating where there is a workload/workforce imbalance.

Lead Employer Trust (LET) Locum Spend

July to September (Q2 2025-2026)	£433,718
April to June (Q1 2025-2026)	£550,340
January to March (Q4 2024-2025)	£687,977

Comment from 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 a decrease of £117k between Q1 25/26 & Q2 25/26. Of this decrease, £155k was Medicine & Emergency Care & -£45k Family Health, offset by an increase of £76k in Surgical & Specialist Services.'

Trust Locum Spend

July to September (Q2 2025-2026)	£704,937
April to June (Q1 2025-2026)	£710,027
January to March (Q4 2024-2025)	£774,552

Comment from finance team:

'Spend on Trust locums between these periods decreased by £5k. Within this there was an increase of £54k for establishment vacancies, offset by a reduction of £46k for winter pressures.'

9. RISKS AND MITIGATION

9.1 Board assurance of safe staffing

The purpose of this report is to provide assurance to the Board that the doctors' hours are safe and compliant. The evidence from exception reports does not refute that doctors' hours are safe and compliant.

However, the absence of reports of non-compliance does not necessarily indicate compliance. To provide full assurance of safe staffing, we would require full and accurate data on multiple aspects as outlined below:

A. Compliant work schedules – Work schedules issued to resident doctors are compliant.
B. Duty rosters – there is no central monitoring of compliance of individual duty rosters, which may vary greatly from the issued work schedule. Where concerns are raised these are addressed.
C. Exception Reporting – exception reporting data is useful to highlight issues but relies on accurate reporting in all areas, therefore data quality is variable.
D. Rota Gaps – there is no central reporting system for gaps on actual working rotas. Rota gaps reported are due to established vacancies.
E. Locum Spend – this gives an indication of where additional workforce is required, but there is incomplete linkage to cause.

9.2 Changes to the TCS of the Contract

As previously indicated, changes to the TCS of the contract are due to come in in February 2026. Exception reports will be signed off by medical staffing with oversight by the GOSW. There will be no involvement from supervisors. It is anticipated this will increase exception reporting and result in a significant cost in additional hours remuneration.

The changes will also result in considerable increases in work for both medical staffing and the GOSW. Additional fines will be applicable for delays in access to the exception reporting framework and breaches in confidentiality. Medical staffing will be required to action all exception reports within 10 days. Work is currently underway to look at ways of implementing the changes. This may require some local agreements which are acceptable to both the Trust and the resident doctors.

10. RESIDENT DOCTOR FORUM

Issues discussed included concerns around bottlenecks in training and potential lack of employment for doctors.

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

11. RECOMMENDATIONS

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

I also recommend that we consider the implications of the changes to the TCS of the Resident Doctor Contract both in terms of the financial implications and the increase in administrative workload. I recommend that the Board considers appointment of a safe working hours administrator similar to other Trusts nationally and regionally.

Report of Henrietta Dawson
Consultant Anaesthetist
Trust Guardian of Safe Working Hours
22 October 2025

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Agenda item A10(b)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 November 2025		
Title	Executive Director of Nursing (EDoN) Report		
Report of	Ian Joy Executive Director of Nursing		
Prepared by	Lisa Guthrie Deputy 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 areas of responsibility. The content of this report outlines: • Section 1: Safeguarding and Mental Capacity Act/Deprivation of Liberty Safeguards (DoLS) Quarter 2 Highlight Report • Section 2: Learning Disability Quarter 2 Highlight Report • Section 3: Flu Vaccination Programme The following key points/risks are noted for the Trust Board's attention: • The increased activity across the safeguarding teams is recognised in Risk 1475. Work is prioritised to enable representation at multi-agency safeguarding meetings. Improvement of safeguarding information visibility is being progressed and is recognised in Risk 1463. Policy monitoring audits have been delayed for adults due to clinical capacity. These will be completed for review at the next Safeguarding Committee. All safeguarding maternity and children's audits are up to date. • A staff safety risk related to home visits in locations where gang activity occurs was escalated to the safeguarding team. This has been reviewed and support provided to the affected Clinical Boards. • A comprehensive review has taken place on safeguarding training compliance, which highlighted a number of staff did not have the required safeguarding training attached to their roles on the learning lab system. Immediate action was taken to assign appropriate levels to affected staff but this has impacted current compliance. Despite this, Level 1 and 2 adult and children compliance is above Trust target. Level 3 adult and children compliance is below the 90% threshold at 82.44% and 83.09% respectively. It is likely that compliance will fluctuate over the coming months and this will be closely monitored. Training allocation for affected staff has been prioritised for high-risk areas. • Level 1 Mental Capacity Act (MCA) training which is mandatory for all staff is 96.94%. Level 2 MCA and DoLS e-learning, launched in December 2024 is 83.42% which is an increase from Q1. • Referrals to the Learning Disability Liaison Team remain high with many patients requiring multiprofessional and multiagency input. Staffing challenges remain but progress has been made with the Autism Lead Practitioner role appointed and the Learning Disability Lead post in the recruitment process.		

<table>
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In Q2 mandatory training for Learning Disability compliance has increased to 91.5% and is above the Trust target. The Trust continues to review training plans in line with national expectations of the Oliver McGowan Training. A proposed implementation plan detailing an incremental roll out over a three-year period has been developed.
The Learning Disability Care Quality Commission (CQC) Action Plan is overseen by the Learning Disability Steering Group. The phase 2 action plan which has been developed is being transitioned into business as usual.
The vaccination programme was launched on 3 October 2025 with monitoring via the Vaccination Steering Group.
Inpatient vaccination will be delivered between November 2025 and March 2026.
The Department of Health and Social Care (DHSC) target is to increase staff flu vaccination uptake by 5% compared to 2018–19 with an aim to achieve 72% overall.
Current compliance 45.6% compared with 40.69% at the same point last year.
To meet the 72% target, 4,478 additional vaccinations are required by March 2026.
Reporting is supported by real-time digital recording with fortnightly updates provided to the Executive Team.

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<tr><td>Recommendation</td><td colspan="6">The Board of Directors is asked
i) Receive and discuss the report.
ii) Note the risks and mitigations in relation to the Safeguarding, MCA and Learning Disability Liaison Teams.
iii) Note the vaccination programme plan in line with best practice guidance.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Putting patients at the heart of everything we do. Providing care of the highest standards focusing on safety and quality.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">BAF risk ID 1.1 - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">The EDoN update is a regular comprehensive report bringing together a range of issues to the Trust Board.</td></tr>
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EXECUTIVE DIRECTOR OF NURSING REPORT

1. SAFEGUARDING AND MENTAL CAPACITY ACT (MCA) QUARTER 2 (Q2)

This summary of key points provides a Q2 update of Safeguarding (Adult, Children's and Maternity) and Mental Capacity Act and Deprivation of Liberty Safeguards (DoLS) activity throughout the Trust. This detail was presented to the Safeguarding Committee (7 October 2025) and to the Quality Committee (18 November 2025).

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

1.1 Activity and Service Capacity

- The increased activity across the safeguarding teams is recognised in Risk 1475. This risk records the inability to respond to and deliver timely advice due to service demands. Oversight of mitigating actions is provided by the Safeguarding Committee.
- Work is prioritised to enable representation at multi-agency safeguarding meetings and when attendance is not possible written information is submitted to Newcastle Safeguarding Adults Board (NSAB).
- Improvement of safeguarding information visibility is being progressed with support from the Medical Director and digital health team and is recognised in Risk 1463.
- A staff safety risk related to home visits in locations where gang activity occurs has been escalated to the safeguarding team. The safeguarding team will contribute to the risk review process with the relevant clinical boards for these vulnerable workers.
- There has been a 93% increase in in Multi-Agency Safeguarding Hub (MASH) activity compared to the previous year, with no additional resources allocated. This increase has been noted at NSAB and further review is required with local authority partners.
- The Trust 2024 internal audit report regarding Safeguarding governance recommended ten actions. The action relating to Newcastle Safeguarding Adults Board (NSAB) meetings was reopened to confirm changes were embedded. To further ensure robust governance is in place, a review has been commissioned to evaluate the effectiveness of all existing Safeguarding/MCA and DoLS governance processes**.** A follow up audit is planned for January and the audit memorandum has been reviewed and agreed.
- Policies and the audit schedule are reviewed at the Safeguarding Committee. The completion of policy monitoring audits has been delayed for adults due to capacity challenges as previously mentioned. These will be completed for review at the next Safeguarding Committee. All safeguarding maternity and children's audits are up to date.
- Q2 MCA audit data is under review as some of the sample comes from September 2025. This detail will be available in the Q3 report.

1.2 Education and Training

- Safeguarding training compliance is closely monitored at Safeguarding Committee.
- A comprehensive review has taken place on safeguarding training compliance, which has highlighted that a number of staff did not have safeguarding training attached to their roles. Immediate action to assign appropriate safeguarding levels to affected staff took place but this finding has impacted current compliance.

- Despite this, safeguarding training figures for end Q2 for Level 1 and 2 remain above Trust target, with Level 1 training at 90.54%, % and Level 2 at 91.82%. Safeguarding adult Level 3 compliance is 82.44% and is below the Trust 90% standard.
- The training allocation for affected staff has been prioritised for high-risk areas; in particular Level 3 safeguarding has been expedited. The launch of new Level 3 e-learning will allow transition over a period 12 months for staff to move to their new required training levels.
- Safeguarding children Level 1 compliance rates are 90.38% and Level 2 91.21%. Level 3 Children's safeguarding sits at 83.09% which is below the required target.
- Q2 Level 1 MCA training is 96.94%. Level 2 MCA and DoLS e-learning was launched in December 2024, current compliance is 83.42% which is an increase from Q1.

2. LEARNING DISABILITY QUARTER 2 (Q2)

This summary of key points provides a Q2 update of Learning Disabilities activity throughout the Trust. This detail was presented to the Experience of Care Group and Quality Committee Quality Committee (November 2025).

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

2.1 Activity and Service Pressures

- Referral activity remains high with many patients requiring multiprofessional and multiagency input. In Q2 there were 617 inpatient and day case attendances which represents an increase compared to 549 in Q1.
- Quality improvement work continues but sustainable improvement remains challenging. The audit approach has been revised and Matrons now undertake weekly data collection with findings reported to the associate director of nursing and local improvement actions agreed.
- Staffing challenges remain with support provided from an appropriately skilled nurse. Progress has been made with the Autism Lead Practitioner role appointed and the Learning Disability Lead post in the recruitment process.

2.2 Mandatory training for Learning Disability and Autism

- In Q2 compliance has increased to 91.5% and is above the Trust target of 90%. Compliance is monitored the Learning Disability Steering Group.
- The Trust continues to review training plans in line with national expectations of the Oliver McGowan Training. A proposed implementation plan detailing an incremental roll out over a three-year period has been developed. As previously noted, the delivery of training will be challenging both operationally and financially in acute settings, and the Learning Disability Network continue to lead regional discussions. In the meantime, support and education is provided to staff on managing distressed behaviours, providing reasonable adjustments and the use of hospital passports.

2.3 CQC Action Plan

The Learning Disability CQC Action Plan is overseen by the Learning Disability Steering Group at bi-monthly meetings. The phase 2 action plan includes four remaining open actions from the original plan which are being transitioned into business as usual.

Key points to note:

- The Trust is actively engaging with patients with lived experience to ensure services meet their needs and improvements are co-produced. This project remains live and on plan through collaboration with Skills for People.
- The Trust should have a Learning Disability strategy in place. This action was delayed due to the need to ensure collaboration with those with lived experience. The strategy has been developed with Skills for People and is now in draft format for review. It is expected that this will be completed to be launched and aligned to the Trust revised strategy.

3. FLU VACCINATION PROGRAMME

The Trust flu vaccination programme aims to maximise vaccine uptake and ensure staff are well-informed, to support their choice to receive the flu vaccination and is in line with national guidance. Covid-19 vaccination has been removed from the staff programme following a government decision in June 2025; it will now only be offered to the most vulnerable patient populations. Inpatient vaccination will be delivered by a Registered Nurse between November 2025 and March 2026. The programme launched on 3 October 2025 and is supported by robust governance and assurance processes through the Vaccination Steering Group.

The DHSC target is to increase staff flu vaccination uptake by 5% compared to 2018–19 with an aim to achieve 72% overall. Current compliance reporting is supported by real-time digital recording with fortnightly updates provided to the Executive Team.

The Trust performance, as of 20 November 2025, is 45.6% of staff have received their flu vaccination. This is 7,757 doses of vaccine given from 16,994 staff, these figures are broadly comparable to 2018 performance when adjusted for staff numbers growth. The compliance at this point in the 2024/25 programme was 40.69%.

To meet the 72% target, 4,478 additional vaccinations are required by March 2026. It is anticipated that there will be some adjustment of figures for staff who have received their vaccination outside of the Trust, which means that the figure requiring vaccination may be lower. Processes are in place to capture this information regarding externally delivered vaccinations.

4. RECOMMENDATION

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

Report of Ian Joy
Executive Director of Nursing
28 November 2025

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Agenda item A10(b)(i)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 November 2025		
Title	Nurse Staffing Review Paper – Deep Dive		
Report of	Ian Joy, Executive Director of Nursing		
Prepared by	Lisa Guthrie, Director of Nursing Peter Towns, Associate Director of Nursing Lindsey Cooper, Senior Nurse: Nurse & Midwifery Staffing		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☒
Summary	This report comprises both the Nurse Staffing six-month review (2025/26 Quarters 1 and 2) and the quarterly safe staffing assurance report. The report fulfils the recommendations of the NHS Improvement 'Developing Workforce Safeguards' guidance (October 2018) and adheres to the recommendations set out by the National Quality Board (NQB 2016): How to ensure the right people, with the right skills, are in the right place at the right time. It updates the Trust Board in relation to the following: **Key points/risks to bring to the Board's attention.** • A nursing safe staffing guidance document is provided along with the Safe Staffing Dashboard in the reading room to complement the details contained within this report. • Level one staffing escalation is in place and will remain unless escalation criteria has been met. • Robust staffing oversight remains in place through the Nurse Staffing and Clinical Outcomes Group. One ward (GNCH 3) has required high-level support due to staffing concerns. This was mitigated by closed beds and a supportive action plan. Following a peer review, the ward has now been de-escalated. • There is an upward trend in staffing-related incidents and red flag events, primarily in small teams experiencing sickness absence. Local mitigations are in place to manage risk but there remains challenges in meeting all enhanced care observation requirements. • A consistent number of wards have reported fill rates <85% over the past 18 months. All critical care areas reported <85% Registered Nurse (RN) fill rates in the last quarter. These figures assume full occupancy and there are risk mitigations in place. • In line with national guidance, the Nurse Staffing Review Process has been completed, and the details are contained within the report. Where potential staffing shortfalls exist, mitigating actions are in place. • Work is ongoing to finalise costings and demand templates for some areas, which is to be completed in quarters 3 and 4. • Based on the information contained within this report, recognising mitigating actions are in place and continued work is required in some areas to understand any investment requirements, the staffing establishments are broadly fit for purpose.		

Agenda item A10(b)(i)

<table>
<tr><td>Recommendation</td><td colspan="6">Trust Board is asked to:
i) Receive and review the quarterly staffing and outcomes review.
ii) Receive and review the deep dive staffing review report.
iii) Comment on the content of this approach, which has been prepared in line with national guidance.
iv) Acknowledge and comment on actions outlined within the document.</td></tr>
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(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☒</td><td>☒</td><td>☒</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">BAF risk ID 1.1 - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">The Quality Committee and Board have previously received the annual nurse staffing review report, the six-month review report and quarterly safer staffing assurance reports.</td></tr>
</table>

NURSE STAFFING REVIEW PAPER

1. INTRODUCTION/BACKGROUND

This paper combines the nurse staffing six-month review report along with the quarterly safe staffing assurance report. The purpose of the paper is to provide assurance that the Trust remains compliant with national guidance in relation to safer staffing. The Developing Workforce Safeguards (2018) guidance is clear in the requirement to undertake an in-depth nurse staffing review every six months and update be provided to the Trust Board on actions and progress.

2. NURSE STAFFING UPDATE

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

2.1 Nurse Staffing Escalation

The Trust Nursing Safe Staffing Guidelines provide a robust framework to ensure safe nurse staffing governance and identifies a clear process for safe staffing escalation. The guideline has been updated and ratified by the Professional Practice Assurance Group (PPAG). The Trust staffing escalation is currently at level one due to the following thresholds being met:

- Normal service activity is maintained.
- Safe staffing levels are maintained with collaboration between Clinical Boards.
- Minimal surge bed capacity is in use with little reciprocal impact on safe staffing levels.
- Trust-wide registered nurse staffing fill rates have been maintained above 85%.

The following actions remain and are overseen by the Executive Director of Nursing:

- Senior nursing daily staffing review, reported to the operational and tactical control teams.
- SafeCare (daily deployment tool) is utilised to deploy staff within and across Clinical Boards.
- Daily review of staffing red flags and staffing incident reports.
- Each Clinical Board ensures rostering of a sister/charge nurse on shift until 8pm, 7 days a week.

Weekend Senior Nurse/Matron cover continues, which enhances staffing and professional oversight out of hours. Level one will remain in place unless escalation criteria is met.

2.2 Nurse Staffing and Clinical Outcomes

The monitoring of safer staffing metrics against clinical outcomes/nurse sensitive indicators as mandated in national guidance continues via the Nurse Staffing and Clinical Outcomes Operational Group (NSCO Group). Below is an overview for the last quarter:

Month	Total	Clinical Board	High level support	Medium level support	Low level support
Jul-25	5	Family Health Services	GNCH03	GNCH01a, GNCH01b, GNCH02a	GNCH12
	2	Surgical and Specialist Services RVI		RV22, RV16	
	0	Perioperative Services			
	4	Cardiothoracic Services			FHPICU, FH21, FH24, FH25
	2	Medicine and Emergency Care Services		RVAS	FH17
	0	Surgical and Associated Services FH			
	2	Cancer and Clinical Haematology Services		NCCC34	NCCC33
Total	**15**		**1**	**7**	**7**
Aug-25	3	Family Health Services		GNCH01a, GNCH01b, GNCH3	
	2	Surgical and Specialist Services RVI		RV22, RV16	
	1	Perioperative Services			RV38
	5	Cardiothoracic Services		FH30	FH21, FH24, FH25, FH29
	2	Medicine and Emergency Care Services		RVAS	FH17
	0	Surgical and Associated Services FH			
	2	Cancer and Clinical Haematology Services		NCCC34	NCCC33
Total	**15**		**0**	**8**	**7**
Sep-25	4	Family Health Services		GNCH01a, GNCH01b, GNCH3	GNCH12
	2	Surgical and Specialist Services RVI		RV22, RV16	
	1	Perioperative Services			RV38
	4	Cardiothoracic Services		FH30	FH21, FH25, FH29
	2	Medicine and Emergency Care Services		RVAS	FH18
	0	Surgical and Associated Services FH			
	2	Cancer and Clinical Haematology Services		NCCC34	NCCC33
Total	**15**		**0**	**8**	**7**

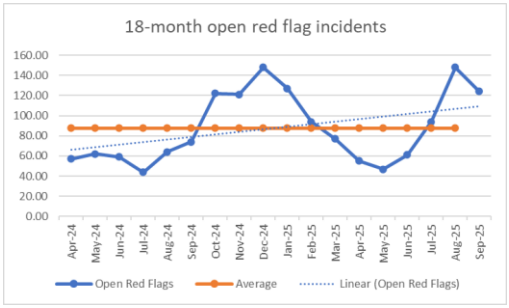
*FH (Freeman Hospital) *RV (Royal Victoria Infirmary) *GNCH (Great North Children's Hospital) *NCCC (Northern Centre for Cancer Care)

The key points to note:

- One ward (GNCH 3) has required high-level support due to staffing concerns. This was mitigated by closed beds and a supportive action plan. Progress through the action plan and successful recruitment led to a positive peer review. Following which the NSCO group agreed to de-escalate to medium level support, with a condensed action plan.
- No wards are currently receiving high level support.

2.3 Datix and Red Flag data

Red flag and staffing incident data is reviewed daily (Monday-Friday) by the senior nursing team and is presented, along with themes and trends to the NSCO Group and PPAG monthly.



The key points to note:

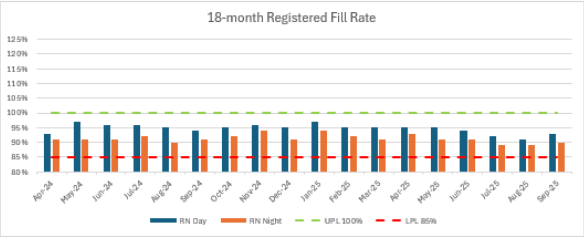
- There is an upward trend in staffing-related incidents and red flag events. These are primarily driven by small teams experiencing elevated levels of sickness absence.
- The highest number of staffing incidents this quarter were reported in Perioperative Services, particularly due to sickness absence in the Royal Victoria Infirmary (RVI) outreach service. Local mitigations remain in place to manage risk, while the Clinical Board works through longer term options to build staffing resilience in this team.
- Over two-thirds of red flags were reported during weekday day shifts, with the most frequent types being “shortfall in RN time” and “missed intentional rounding.” This contrasts with fill rate data, which shows lower RN staffing levels on night shifts—suggesting that more shortfalls might be expected overnight. This discrepancy warrants further monitoring and investigation, including a review of red flag definitions to ensure accurate reporting and alignment with staffing trends.
- Medicine and Emergency Care reported the highest number of red flags, reflecting its size, inclusion of front-of-house services, and high levels of enhanced care observation. Ward 42 RVI (Acute Stroke) reported the highest number of red flags, primarily due to short-term sickness and redeployment challenges on night shift.
- Red flag terminology is being reviewed in collaboration with ward staff to ensure they accurately reflect staffing challenges. This includes capturing instances where enhanced care observations were not provided. The aim is to improve the quality of intelligence used to mitigate risk and enhance patient safety.
- Red Flag, incident and harm data is triangulated and reviewed at NSOG, where themes are identified support is provided and action plans implemented.

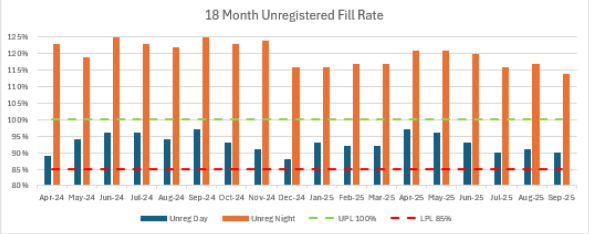
2.4 Care Hours Per Patient Day (CHPPD) data

The NSCO group continues monthly monitoring of ward-level CHPPD via the safer staffing dashboard. CHPPD is used for benchmarking in nurse staffing reviews, though its value is limited due to broad ward categorisation. Trust-level CHPPD remains consistent with the 18-month average (8.7-9.1) despite a dip in fill rates over the last quarter. The Trust’s CHPPD is slightly below the Shelford peer median of 9.6. However, it is noted that the high number of critical care and specialist areas in the Trust inflates the overall CHPPD figure. Some non-specialist inpatient wards benchmark lower than Model Hospital comparators, direct comparisons remain challenging due to variations in patient acuity, skill mix, and care delivery models; therefore, CHPPD is not used as a standalone measure but rather as one component within the broader nurse staffing review process. There are no new areas for escalation.

2.5 Planned versus actual hours (fill rates)

The planned and actual staffing hours are converted into percentage “fill rates” which are recorded on the safer staffing dashboard, rag rated and reviewed monthly by the NSCO group. RN fill rates <85% are reported to the Executive Director of Nursing each month.





Key points to note:

- A consistent number of wards have reported fill rates <85% over the past 18 months.
- Over the last 3 months, an average of eight wards reported RN fill rates <85% on dayshift and fourteen during nightshift based on planned versus actual data.
- All critical care areas reported <85% RN fill rate last quarter. These figures assume full occupancy in these areas. In practice staffing is deployed flexibly to meet service demand, with mitigations in place to manage risk and ensure safe patient care. In non-critical care areas, staffing mitigations continued to be applied at both local and Trust levels, in line with the established staffing escalation guidelines.
- Rostering support remains active through training and the 'Check, Challenge, and Coach' process, aimed at optimising rosters and maximising staffing levels within available resources.

2.6 Temporary Staffing

Newcastle Hospitals Staff Bank supply temporary staffing to wards and departments to fill short-term vacancies or absence. Additional oversight is provided by temporary staffing and agency usage reports which are distributed to the senior corporate nursing team and Heads of Nursing weekly.

Key points to note:

- Over the past 12 months temporary staffing patterns have shifted notably.
- Requested shifts for unregistered staff have followed a downward trend, while filled bank shifts for this group have slightly increased. Despite this rise in fill rates, unregistered bank spend has remained stable, likely due to the reduced number of requests.
- Unregistered agency usage has seen a sharp decline, with filled shifts falling by more than half.
- Registered staff have shown an upward trend in both requested shifts and fill rates. Registered bank spend has increased modestly, reflecting this growth. Meanwhile, filled registered agency shifts have demonstrated a slight downward trajectory.
- The trends indicate a gradual shift away from agency reliance, particularly for unregistered roles, and a more efficient use of internal bank resources.

2.7 2024/2025 Nurse Staffing Review (NSR) Update

2.7.1 Progress of review

The corporate nursing team coordinates nurse staffing reviews (NSR) using a combination of evidence-based tools, such as the Safer Nursing Care Tool (SNCT) and the Community Nursing Safer Staffing Tool (CNSST)—alongside nurse-sensitive indicators and professional judgement. These reviews inform staffing establishment recommendations in line with national guidance.

SNCT data is collected twice yearly across most inpatient wards, excluding critical care and wards with fewer than 12 beds. In Emergency Departments, tailored SNCT tools are used for both paediatric and adult majors. For clinical areas without validated tools, such as outpatient departments, day units, and small wards, staffing assessments rely on professional judgement supported by national standards.

The results from evidence-based tools are shared with Matrons and participating clinical leaders to support informed decision-making and continuous improvement in safe staffing models.

Nursing establishments are calculated with a budgeted uplift to account for annual leave, sickness, and parental leave. The Safe Nursing Care Tool (SNCT) for adult in-patient and Children and Young People (CYP) services assumes a 22% uplift. The Trust currently funds a 20% uplift, comprising 14% for annual leave, 3% for sickness absence, and 3% for study leave, maternity leave is excluded from the Trust's uplift calculation. To mitigate this gap, maternity leave cover is offered substantively for Band 3 Healthcare Support Worker (HCSW) and Band 5 Registered Nurse (RN) posts. This results in a consistent 2% differential between SNCT assumptions and Trust-funded uplift. It is important to highlight that the 3% sickness absence allowance is regularly exceeded. Additionally, other types of leave such as bereavement leave are not included in the uplift calculation. These factors contribute to a discrepancy between planned and actual staffing levels, which may necessitate the use of temporary staffing, overtime, or operating with reduced staffing levels. This risk is recognised and mitigated where possible.

2.7.2 Adult In-Patient Wards and Assessment Suite

In line with national guidance, SNCT data was collected in August 2025 across eligible adult and assessment suite inpatient areas. Comprehensive nurse staffing reviews are scheduled for completion by the end of Q4 2025/26. These reviews, undertaken collaboratively with Heads of Nursing, Directors of Operations, and Finance Managers and are informed by professional judgements, gathered during "light touch" meetings with Matrons and clinical leaders following SNCT data capture periods.

Summary of findings to date:

- **Family Health Services:** The Clinical Board continues to explore gynaecology service pathways as part of the ongoing review. Notable developments within the emergency gynaecology pathway have resulted in improved nightshift staffing efficiencies on Ward 40, leading to a reduction in reliance on temporary staffing. Further work is required to fully evaluate service demand and inform a sustainable and future-proof staffing model.

• **Surgical and Specialist Services:** The NSR for the trauma and orthopaedic wards at the RVI has been completed. The Clinical Board is currently evaluating the recommendations, which highlight a staffing shortfall driven by patient acuity and dependency levels. Temporary staffing measures are in place to mitigate immediate risks. A service transformation within burns and plastics, encompassing Ward 37 RVI and associated outpatient and specialist

areas, has been implemented to optimise patient pathways. This transformation has been supported by a Quality Impact Assessment (QIA). Other specialty establishments are considered broadly fit for purpose, with formal reviews planned by the end of Q4.

• **Perioperative and Critical Care Services:** The NSR process indicates that current nursing establishments are sufficient to meet core bedside care requirements. Some skill mix adjustments and redistribution of resources is recommended to ensure consistency and equity in staffing levels between critical care units. Final sign-off of the review has been extended to allow further exploration of critical care support staff roles and to enhance alignment with the Guidelines for the Provision of Intensive Care Services (GPICS) standards. The areas out with GPICS standards are Clinical Nurse Educator resource, number of supernumerary staff per 21+ beds and 24/7 critical care outreach cover at RVI.

Regarding the Clinical Nurse Educator resource this should be a minimum of 1.0 Whole-Time-Equivalent (WTE) per 75 nursing staff. At present the educator resource is approximately 1.0 WTE per 120 staff. An additional 3.0 WTE has been requested in the critical care business case. In the meantime, educators work as team across all units to respond to educational needs. Should the bed requirement on Wards 37 and 18 be 21 increase they would require a second supernumerary nurse. However, in practice this only occurs with increased level 2 patients or delayed discharges therefore acuity is lower resulting in less staff being required. The inability to provide 24/7 outreach at the RVI has also been included in the critical care business case and at present is mitigated by the calls being triaged by a senior critical care nurse based in critical care.

• **Cardiothoracic Services:** The NSR has been concluded, resulting in establishment and budgetary adjustments across several wards to ensure staffing levels are optimally aligned with the delivery of safe, high-quality care. These revised staffing models are currently being monitored through both the NSR and NSCO processes. The impact of Extra Corporeal Membrane Oxygenation (ECMO) provision on the nursing workforce remains under review.

• **Medicine and Emergency Care Services:** The NSR process has been extended to explore a revised model for Enhanced Therapeutic Observation Care (ETOC) support. Rather than incorporating ETOC roles within existing ward establishments, a dedicated team is being considered, with a specialist lead and trained ETOC Healthcare Assistants (HCA), to focus on therapeutic care. This approach aims to enhance patient safety, improve staff and patient experience, and reduce length of stay. Current risks are mitigated by temporary staffing. A full inpatient review is planned for this quarter, alongside ongoing work to adjust shift patterns in line with European Working Time Directive (EWTD) requirements, supporting staff wellbeing and addressing high sickness levels.

• **Surgical and Associated Services:** Ward 8 FH has completed its NSR, supported by a QIA, which endorsed a skill mix adjustment and an increase in WTE to better meet service needs and align the establishment more closely with SNCT outcomes. The nursing establishments across the remaining wards are broadly fit for purpose; however, a full review is scheduled to take place during this quarter.

• **Cancer and Clinical Haematology Services:** The NSR has indicated that current nursing establishments are broadly fit for purpose. However, the staffing and electronic rostering teams are working closely with the Clinical Board to understand the causes of inpatient staffing overspend. A full nurse staffing review is scheduled for this quarter to ensure alignment with service needs and financial sustainability.

2.7.3 Children and Young People (CYP) In-Patient Wards

The Trust utilises the Safe Nursing Care Tool (SNCT-CYP) as the evidence-based methodology for determining nursing establishments across CYP inpatient services. SNCT data was captured in August 2025 across all eligible CYP inpatient areas. In-depth and light-touch reviews were held during Q1 of 2025/26, with clinical leaders, Matrons and Heads of Nursing, Director of Operations and Finance Managers.

Family Health Services: The Clinical Board is currently reviewing the recommendations from the previous nurse staffing review, alongside bed occupancy data. Completion of the NSR process is anticipated by the end of Q4.
Cardiothoracic Services: The NSR for this quarter has been signed off, with Freeman Hospital (FH) Ward 23 receiving an increase in nightshift establishment at weekends to match weekday levels. This adjustment reflects the presence of High Dependency Unit (HDU) patients and the overspill of high-acuity cases. Further benchmarking and discussion are required for the Paediatric Intensive Care Unit (PICU) and Ward 23 due to the complexity and specialised nature of these services. These changes will be further evaluated as part of the 2026/27 NSR cycle.

2.7.4 Adult and Paediatric Emergency Departments

The Trust utilises Emergency Department SNCT as the evidence-based methodology for determining nursing establishments within Emergency Departments.

Adult Emergency Department (Majors): SNCT findings suggest that the current establishment is broadly fit for purpose. However, the department remains heavily reliant on temporary staffing due to several factors, including the complex geography of the unit, enhanced care observation requirements, and the presence of long-stay patients. Further analysis is underway to better understand these additional staffing demands, supported by a gap analysis aligned with Nursing Workforce Standards for Type 1 Emergency Departments (RCN) guidance. Work is also ongoing to review and potentially revise shift patterns to ensure compliance with EWTD rest requirements. These changes aim to better match staffing to service activity peaks and troughs, while supporting staff wellbeing considering high sickness absence rates. A full NSR is planned for this quarter.
Paediatric Emergency Department and Assessment Unit: A staged demand template has been developed to improve staffing responsiveness to departmental attendance, in alignment with national guidance. Following review, the decision was made to separate the cost centre into nursing and non-nursing components to enable clearer understanding of staffing demand and the impact of any changes. This work is currently in progress.

The impact of the planned co-located Urgent Treatment Centre on adult majors and Paediatric Emergency Assessment Unit (PEAU) activity and the associated workforce requirements remains under evaluation.

2.7.5 Community (CNSST)

Version 2 of the Community Nursing and Specialist Staffing Tool (CNSST) was launched in January 2025, with 14-day data captures completed in March and August 2025 following staff training and validation. Initial findings suggest a potential gap between current staffing establishments and patient demand, acuity, and dependency. A formal review is scheduled for completion by the end of Q4, which will triangulate CNSST data with professional judgement and nurse-sensitive indicators to inform evidence-based recommendations.

2.7.6 Non-bed holding areas

Nurse staffing reviews of non-bed holding areas are complex as there is a lack of evidence-based staffing tools, and the process relies on triangulation of professional judgement, service activity levels, and nurse sensitive indicators, which can often be challenging to measure. This is further complicated by a lack of available benchmarking.

Family Health Services: The NSR was concluded for CYP non-bed holding areas, with the Clinical Board working through the recommendations. The NSR for gynaecology out-patient areas is planned for Q3.
Surgical and Specialist Services: The emergency eye outpatient demand template has been separated onto its own budget and template, with an adjusted skill mix and shift pattern to meet the needs of the service, a QIA to support this has been completed. The other areas within surgery and specialist services are being planned in by the end of Q3.
Perioperative Services: Due to the number and complexity of theatre services, Perioperative Services are developing a bespoke staffing model. Once finalised, a full NSR will be undertaken to assess its impact.
Cardiothoracic Services: The NSR for non-inpatient cardiothoracic services has been completed for 2025/26. Budget adjustments have enabled a small increase in staffing for the paediatric outpatient department to support resilience and accommodate increased service demand. Catheter laboratories have received an uplift to support full operational capacity. Establishment recommendations have also been made for cardiothoracic theatres, anaesthetics, and recovery areas. The Clinical Board is currently reviewing these to reduce reliance on agency staffing in this highly specialised area.
Medicine and Emergency Care: Skill mix changes have been implemented to improve efficiency in the diabetes service and the discharge lounge at the RVI. Remaining non-bed holding area reviews will be conducted alongside inpatient reviews planned for this quarter.
Surgical and Associated Services: Some Skill mix changes supported by a QIA have been implemented to meet service demand, enhance clinical standards, and reduce temporary staffing for Ear, Nose & Throat (ENT) outpatients, concluding their NSR. The NSR for endourology theatres was completed in Q2, and the Clinical Board is currently considering the recommendations. Reviews of remaining non-bed holding areas are scheduled for Q3.
Cancer and Haematology Services: Staffing reviews have supported skill mix changes in the Cumbria chemotherapy service and Ward 36 Northern Centre for Cancer Care (NCCC) to meet training and supervision requirements for specialised clinical skills and leadership. A

full review of non-bed holding areas will be conducted alongside inpatient reviews this quarter.

Clinical and Diagnostic Services: The NSR for Cramlington outpatients has been completed, and the Clinical Board is currently reviewing the recommendations.

2.8 Conclusions and Actions from the Nurse Staffing Review

From this deep dive staffing review, the following conclusions have been drawn:

- Robust staffing oversight remains in place through the NSOG. The one ward requiring high level support has been de-escalated with an action plan remaining in place.
- Fill rates, red flags and CHPPD metrics are monitored, a consistent number of wards have reported fill rates <85% over the past 18 months. All critical care areas reported <85% RN fill rate last quarter. These figures assume full occupancy and there are risk mitigations.
- Check, challenge and coach support continues to optimise rosters and maximising staffing levels within available resources.
- The SNCT data capture has been completed in line with national guidance and the results triangulated with professional judgment. Most staffing establishments remain broadly fit for purpose.
- There are several areas identified in this report which may necessitate additional resource. Temporary mitigations are in place whilst options are explored within Clinical Boards.

The following actions are proposed:

- Finalise revised demand templates and costings for all areas requiring potential additional resource. All changes will be reviewed and signed off by the Executive Director of Nursing.
- Conclude the staffing reviews in identified clinical areas.
- Continue to provide roster optimisation support to realise efficiencies.

3. RECRUITMENT AND RETENTION

Key points to note:

- The current RN turnover is 5.12%. This demonstrates a continued reduction from the previously reported 6.22% in the same period last year.
- The current RN vacancy rate is 2.5%. This demonstrates an increase but is below the figure of 3.36% reported in the same period last year. This relates to current staff in post and does not include those staff currently in the recruitment process.
- The current HCSW turnover rate currently 8.64% and demonstrates a reduction from 9.49% in the same period last year.
- The HCSW vacancy rate has reduced and is currently 9.4%. This is similar to the figure of 9.5% reported in the same period last year.
- Recruitment and retention work continues with the introduction of an internal transfer process and a streamlined process for bank staff to apply for substantive posts. These offers complement responsive generic and bespoke recruitment.

- There are 12 final year adult nursing students who were successful at interview but found their preferred post was not available. These new registrants are held on a reserve list with vacancies being offered regularly. A planned approach which will support winter preparation will see further posts made available. All paediatric nursing students have been appointed into substantive posts.

4. RECOMMENDATIONS

The Trust Board is asked to:

i) Receive and review the quarterly staffing and outcomes review.
ii) Receive and review the deep dive staffing review report.
iii) Review and note the progress with the actions from the previous review.
iv) Comment on the content of this approach which has been prepared in line with national guidance.
v) Acknowledge and comment on actions outlined within the document.

Report of Ian Joy
Executive Director of Nursing
19 November 2025

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The Newcastle upon Tyne Hospitals
NHS Foundation Trust

TRUST BOARD

Date of meeting	28 November 2025		
Title	Perinatal Quality Oversight Report, including Maternity Incentive Scheme update		
Report of	Ian Joy, Executive Director of Nursing		
Prepared by	Jenna Wall, Director of Midwifery		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight. Key points/risks to note: • A Qualified in Speciality (QIS) options paper was discussed at the Northern Neonatal Network (NNN) Board meeting in October 2025, unfortunately due to a lack of clarity regarding funding a decision was not made. In the interim the NNN will commence a QIS element of the pathway via an e-learning platform from January 2026. • The Perinatal Culture and Staff Wellbeing action plan is making good progress. The results from October demonstrate improvement, but there is still much to do to improve the staff experience within the perinatal services. • Safety Action 8 remains a challenge; this is being reviewed weekly by the Director of Midwifery to ensure the Trust remains on track to achieve by the end of November. There has been substantial progress in the last two months. • Safety action 5 remains at risk until the workforce investment plan is agreed, the business case is for discussion at Obstetric Board in November. • The Trust have sought clarification on the Maternity and Neonatal Safety Investigations (MNSI) triage process as an increased number of cases have been accepted for investigation by MNSI, including babies who have been referred as part of Cooling in Mild Encephalopathy Trial (COMET). MNSI have not been able to provide clarity on the triage selection process and have escalated this internally for further discussion, there is a risk that there are disproportionately more cases being investigated in the Trust because of COMET and the triage process which is potentially a reputational risk and impacts the staffing capacity of the Patient Safety team. • The Trust has been impacted by three separate System C (BadgerNet) issues during August, September, and October 2025. The Trust was notified in August 2025 that it was affected by data synchronisation issues associated with a Vista B database which has resulted in missing data from clinical records. The 14 impacted records have been identified and clinical harm reviews completed; no harm was identified. There is a risk that the missing data may impact the Maternity Service Data Set (MSDS) which subsequently is used for performance dashboards and Maternity Incentive Scheme. • The NNN proposal to enact the recommendations of the Neonatal Critical Care Review (NCCR) was agreed at the NNN Board in October 2025. Sunderland Royal Hospital will be		

<table>
<tr><td></td><td colspan="6">redesignated as a Local Neonatal Unit (LNU) and no longer provide therapeutic cooling or long-term ventilation. Modelling indicates that 26 babies per year will need to be transferred to Newcastle Royal Victoria Infirmary (RVI) and the James Cook University Hospital, this increased activity can be accommodated within the existing commissioned cot capacity.
• A national update was provided to the Trust on 16 October 2025 outlining the next steps to improve care for women, babies, and families. The Trust does not need to take any action in response to the national update at this time.</td></tr>
<tr><td>Recommendation</td><td colspan="6">Trust Board is asked to:

i. Receive and discuss the report.
ii. Note compliance with the Perinatal Quality Oversight Model (PQOM)
iii. Note the risk regarding Safety Action 5 and 8 and progress with the Maternity Incentive Scheme.
iv. Note the Q1 Midwifery Staffing report is available in the reading room.
v. Note the risk associated with the MNSI triage process.
vi. Note the digital issues, and the potential impact on MSDS data.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Putting patients at the heart of everything we do. Providing care of the highest standards focussing on safety and quality.</td></tr>
<tr><td rowspan="2">Impact

(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☐</td><td>☐</td><td>☒</td><td>☐</td><td>☐</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">Principal Risk - Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.

Threat - Failure to improve the safety and quality of patient and staff experience in Maternity Services.</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Previous reports have been presented to the Quality Committee, Maternity Update, Midwifery staffing paper, Maternity Incentive Scheme (Clinical Negligence Scheme for Trusts (CNST)).</td></tr>
</table>

PERINATAL QUALITY OVERSIGHT REPORT

1. INTRODUCTION

This report provides the Trust Board with an overview of the Maternity Service compliance with the Perinatal Quality Oversight Model (PQOM), based on the locally and nationally agreed measures to monitor maternity and neonatal safety. In August 2025, the model was updated and the minimum key data items included in the PQOM have been expanded compared with those required in the previous model.

The purpose of the report is to inform the Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. The report outlines the Trusts current self-assessed position against the Year 7 Maternity Incentive Scheme 10 Safety Actions and any escalations.

2. LISTENING TO WOMEN AND FAMILIES THROUGH SERVICE USER FEEDBACK

The Real and Right Time Patient Experience Programme continues to yield valuable insights into the experience of women and families accessing the maternity service. The Real Time results are included within the monthly Integrated Board Report.

The September 2025 Right Time survey was delivered to 399 women, with 88 responding (22%). The Trust is in the middle 60% of Trusts overall for September, having been previously in the top 20%. It is in the top 20% for 37 questions, middle 60% for 14 questions and bottom 20% for 6 questions.

The results are good in the following areas:

- Communication with staff at all stages of pregnancy.
- Cleanliness.
- Help with feeding.
- Not been left alone at a worrying time.

These areas score consistently high and reflect the progress made with staffing, UNICEF education and training compliance and the provision of one to one care in labour.

The results could be improved for the following areas:

- Care while pregnant: Midwives providing relevant information around feeding baby.
- Care while pregnant: Providing information about warning signs to look out for during pregnancy.
- Care after birth: Asking women and providing information about mental health.

The elements associated with care whilst pregnant are not themes in previous reports and will be monitored. The provision of information about mental health, both before and after birth, remains a consistent theme which is being addressed via an action plan following the

funding award from the Integrated Care Board (ICB) to establish a Maternal Mental Health Service. The task and finish group report into the Perinatal Public Health and Prevention Group (PPHPG) and is making timely progress.

The results of the patient experience programme are considered by the Perinatal Engagement and Inclusion Group (PEIG), co-chaired by the Maternity and Neonatal Voice Partnership (MNVP) Lead, and integrated into the Care Quality Commission (CQC) Maternity Survey Action Plan, a requirement of Safety Action 7, which is monitored by PEIG.

3. WORKFORCE

3.1 Qualified in Speciality (QIS) training

To comply with British Association of Perinatal Medicine (BAPM) standards, 70% or more of the qualified nursing workforce within a neonatal service must hold a qualified in speciality (QIS) qualification. This figure increases with activity and acuity, based on the services the Trust provides the expectation is 80% of nurses working in intensive and high dependency should be qualified in speciality.

In June 2021, a Health Education England (HEE) commissioned review of QIS education and training across England, highlighted a lack of accessibility, standardisation, and professional regulation. The report concluded that the quality, consistency, and transferability of QIS training could not be guaranteed. In November 2024, following extensive stakeholder consultation, NHS England (NHSE) published National Standards for Neonatal QIS training, with a compliance deadline of September 2025. To gain neonatal QIS qualification, both foundation (QIS F) and specialist (QIS S) education and training must now be completed, inclusive of at least 150 supernumerary practice hours in a Neonatal Intensive Care Unit.

An options paper was discussed at the Northern Neonatal Network (NNN) Board meeting in October 2025.

1. Collaborate with a local Higher Education Institution (HEI) to develop a regional QIS S for delivery starting September 2026.
2. Permanently refer learners out of the region for the QIS S component.
3. Develop and deliver an Operational Delivery Networks (ODN)-supported QIS S course with accreditation, available from September 2026.

Unfortunately, due to a lack of clarity regarding funding a decision was not made. In the interim the NNN will commence the QIS F element of the pathway via an e-learning platform from January 2026, this will be a supportive measure for new entrant nurses and those new to neonatal nursing and provide the foundation elements.

Currently 64% of Band 5-7 nursing establishment is QIS trained. When training places do become available nursing staff will need to be released in a phased approach to maintain service provision and therefore it is likely the recovery to achieve compliance will take several years. The Trust is exploring with HEI the timelines to reinstate training locally, and what support the Trust could provide to expediate this.

3.2 Midwifery workforce

The Trust Board is provided with an overview of midwifery staffing and assurance that the Trust is compliant with national guidance in relation to safe staffing and the ongoing monitoring processes which support ensuring safe staffing levels are maintained, including Safety Action 5 of the Maternity Incentive Scheme (MIS).

The Quarter 1&2 Midwifery Staffing report, informed by the Birthrate Plus daily acuity tool data and the Birthrate Plus report received in July 2024, is available in the reading room. The report also provides an update on progress with the staffing review recommendations.

Subsequent papers will assess the multidisciplinary staffing position in a maternity staffing paper to address all the requirements of the Perinatal Quality Oversight Model and the Maternity Incentive Scheme rather than separately in the Perinatal Quality Oversight Report to Quality Committee and Trust Board.

A staffing action plan is required to ensure compliance with Safety Action 5 as the Trust is currently not compliant with the requirement for a funded establishment based on Birthrate Plus. Trust Board minutes must show the agreed plan, including timescale for achieving the appropriate uplift in funded establishment, the plan must include mitigation to cover any shortfalls and will be submitted to Trust Board in January 2026.

4. CULTURE OF LEARNING, SAFETY AND SUPPORT

4.1 Perinatal staff experience

The Perinatal Culture and Staff Wellbeing action plan and progress is a standing item on each staff forum. The results from September discussed at the general staff meeting in October, generating positive discussion. The results from October demonstrate progress, but there is still much to do to improve the staff experience within the perinatal services. The action plan and staff experience results are monitored by the Perinatal People and Culture Group, chaired by the Head of Midwifery and Associate Director of Operations. There were no Freedom to Speak up contacts during September 2025.

Statement	Sep-25 % Agree/Strongly Agree [n=93]	Oct-25 % Agree/Strongly Agree [n=93]	Diff (+/-)
At work, I always know what's expected of me and what my responsibilities are.	87%	95%	8%
I have the tools, equipment and materials that I need to do my job properly.	32%	59%	27%
Every day, at work, I am able to do what I do best.	37%	63%	27%
I receive praise and recognition for doing good work on a weekly basis.	13%	25%	12%
My immediate line manager seems to care about me as a person.	55%	66%	11%
My immediate manager encourages me and my development at work.	43%	53%	10%
At work, I am valued, my opinions seem to count.	33%	42%	9%
I feel that my role makes a difference to patients / service users.	86%	98%	12%
The team I work with are committed to doing quality work.	80%	89%	10%
I feel a strong personal attachment to my team.	60%	68%	8%
At work, someone has talked to me about my progress and opportunities to improve my knowledge and skills in the last 6 months.	42%	56%	14%
I have felt supported to develop my potential this last year.	34%	51%	16%
Care of patients / service users is my organisation's top priority.	67%	77%	11%
I would recommend the organisation as a place to work.	41%	61%	20%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	67%	83%	16%
Overall Engagement Score	**52%**	**66%**	**14%**

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

5.1 Clinical Indicator Dashboard

The Trust has triggered safety alerts on North East North Cumbria (NENC) Clinical Indicators Quarter 1 Dashboard for the number of preterm births and the number of babies born with an Appearance, Pulse, Grimace, Activity and Respiration (APGAR) score <7 at 5 minutes of age. The Trust is concerned that the data quality issues of duplicated records, highlighted by the stillbirth rate analytics, are being replicated with other metrics where care is provided across multiple Trusts.

As the only Trust in the ICB providing a Level 3 Neonatal Intensive Care Unit (NICU) with surgical services the Trust receives in-utero transfers from across the NENC to ensure babies are 'born in the right place'. The NENC ICB is the highest performing nationally regarding babies being born in units with the correct level of neonatal care based on their gestation and surgical requirements. It is not clear whether the number of preterm births reported has been impacted by duplicated records after patients have received antenatal care in the Trust during their pregnancy, or whether this is a result of appropriate in-utero transfers.

The Trust has previously completed a review following a safety signal for APGAR score <7 at 5 minutes of age in February 2025. Only one theme emerged from the review which was the incorrect calculation of APGAR score when babies are receiving facial Personal Emergency Evacuation Plan (PEEP) and have regular respiratory effort and a score of 1 was often assigned when this should be 2. A review of the quarter 1 data has confirmed this issue has now been resolved; however, 43 babies were recorded with an APGAR <7 at 5 minutes, but only 26 were singleton pregnancies with a gestational length at birth between 259 and 315 days, hence the rate reported on the dashboard is inaccurate.

These issues have been escalated to the NHSE analytics team, a response is awaited.

5.2 Maternity Incentive Scheme

Safety Action	Trust self-assessed position
Safety action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard?	On track
Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?	On track
Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?	On track
Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?	On track
Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard?	At Risk
Safety action 6: Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version 3.2?	On track
Safety action 7: Listen to women, parents & families using maternity and neonatal services & co-produce services with users.	On Track
Safety action 8: Can you evidence the following three elements of local training plans and 'in-house', 1 day multi professional training?	At Risk
Safety action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	On track
Safety action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 1 December 2024 to 30 November 2025	On track

The required standard for Safety Action 8 remains a challenge, whilst there are scheduled training days any absence within the team is a risk to compliance. This is being reviewed weekly by the Director of Midwifery to ensure the Trust remains on track to achieve by the end of November.

Safety action 5 remains at risk until the workforce investment plan is agreed, the business case is for discussion at Obstetric Board in November.

The Maternity Incentive Scheme Tracker is included within the reading room to provide further detail of progress against the 10 safety actions. The final submission date to NHS Resolution is 3 March 2026.

5.3 Maternity and Neonatal Safety Investigation (MNSI) triage process

The Maternity and Neonatal Safety Investigations (MNSI) programme continues to investigate certain cases of early neonatal deaths, intrapartum stillbirths and severe brain injury in babies born at term following labour and maternal deaths in England.

MNSI no longer routinely investigate events involving therapeutically cooled babies where there is no apparent ongoing neurological injury following cooling therapy; however, this remains one of the criteria for referral. MNSI triage cases and decide which investigations proceed based on the baby's clinical outcome after discussion with the family and the Trust.

The Trust have sought clarification on the triage process as an increased number of cases have been accepted for investigation by MNSI, including babies who have been referred as they are being cooled as part of Cooling in Mild Encephalopathy Trial (COMET). MNSI have not been able to provide clarity on the triage selection process and have escalated this internally for further discussion, there is a risk that there are disproportionately more cases being investigated in the Trust because of COMET and triage process which is potentially a reputational risk and impacts the staffing capacity of the Patient Safety team.

5.4 Digital challenges

The Trust has been impacted by three separate System C (BadgerNet) issues during August, September, and October 2025.

- Cardiotocograph (CTG) outage resulting in CTG not being available for digital archiving resulting in incomplete digital records as the CTG is only available on paper. This issue was resolved 31 October 2025.

- Data corruption following server migration which is impacting the development of the internal clinical dashboard. It is hoped this issue will be resolved by mid-November 2025.

- Data synching and missing data. The Trust was notified in August 2025 that it was among five other Trusts within the ICB affected by data synchronisation issues associated with a Vista B database which has resulted in missing data from clinical records. The 14 impacted records have been identified and clinical harm reviews completed; no harm was identified. There is a risk that the missing data may impact the Maternity Service Data Set (MSDS) which subsequently is used for performance dashboards and Maternity Incentive Scheme. The Trust accepted advance release of R71 system update in September 2025 and there have been no further issues. The issue was escalated to NHSE/ICB/LMNS and clinical safety officer and the Executive Director.

6. NEONATAL CRITICAL CARE REVIEW

The Northern Neonatal Network (NNN) proposal to enact the recommendations of the Neonatal Critical Care Review (NCCR) was agreed at the NNN Board in October 2025. Sunderland Royal Hospital will be redesignated as a Local Neonatal Unit (LNU) and no longer provide therapeutic cooling or long-term ventilation. Modelling indicates that 26 babies per

year will need to be transferred to Newcastle RVI and the James Cook University Hospital, this increased activity can be accommodated within the existing commissioned cot capacity. There will be a minimal impact on maternity service provision as most transfers with be neonatal rather than in-utero, however parental accommodation remains a concern for parents who live outside of Newcastle.

7. NHSE UPDATES

A national update was provided to the Trust on 16 October 2025 outlining the next steps to improve care for women, babies, and families.

- Perinatal Equity and Anti-Discrimination Programme: this will give perinatal teams the skills and tools they need to improve the experiences and outcomes of ethnic minority groups and those from deprived communities, and to improve the working lives of staff from these groups.

The Perinatal Anti-Racism Taskforce continues to make substantial progress in advance of the launch of this national programme.

- Submit a Perinatal Event Notification service: this portal streamlines the administrative time required by frontline staff to notify perinatal safety events to MBRRACE-UK (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries Across the UK); Maternity and Newborn Safety Investigations; and NHS Resolution Early Notification Scheme.

The Trust has ensured that the relevant personnel has access, this is complicated by the provision of perinatal and children's services across multiple teams at the RVI and the Freeman Hospital site, a standard operating procedure has been developed to support timely notification.

- Maternity and Neonatal Performance Dashboard: This set of metrics will be used to monitor performance in maternity and neonatal services in all parts of the system, supporting trusts and integrated care boards to monitor and have insight into their own progress. The dashboard represents a balanced scorecard of operational, outcome and patient experience measures.

    - Obstetric unit suspensions.
    - Internal and external neonatal unit suspensions.
    - Delays to induction of labour greater than 24 hours.
    - MBRRACE stillbirth rate.
    - MBRRACE neonatal mortality rate.
    - Postpartum haemorrhage 1500ml rate.
    - Optimal perinatal care composite measure.
    - Patient experience measure: CQC maternity survey.

The proposed metrics are reported within the Trust governance and reporting structures with appropriate scrutiny.

- Maternity and Neonatal Improvement Support Team: will replace the current Maternity Safety Support Programme and will have the additional focus of neonatal, as well as maternity, expertise. The team will support trusts to develop diagnostic, and improvement plans for their maternity services, including a focus on tackling inequalities.

The Trust is not impacted as the service has not entered the Maternity Safety Support Programme (MSSP).

The Trust does not need to take any immediate action in response to the national update.

8. CONCLUSION

The Trust Board are provided with an update on the Maternity Service compliance with the Perinatal Quality Oversight Model and the main quality and safety considerations of the perinatal service.

There are improvement plans in place, and evidence included within this report and within the supporting evidence, to ensure compliance with the Maternity Incentive Scheme, Three Year Plan for Maternity and Neonatal Care and improve staff and patient experience; performance is being tracked and progress monitored to ensure the mitigations in place are supporting patient safety.

9. RECOMMENDATIONS

Trust Board is asked to:

i. Receive and discuss the report.
ii. Note compliance with the Perinatal Quality Oversight Model (PQOM)
iii. Note the risk regarding Safety Action 5 and 8 and progress with the Maternity Incentive Scheme.
iv. Note the Q&1 Midwifery Staffing report is available in the reading room.
v. Note the risk associated with the MNSI triage process.
vi. Note the digital issues, and the potential impact on MSDS data.

Report of Ian Joy
Executive Director of Nursing
19 November 2025

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Agenda Item A10(c)(ii)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 November 2025					
Title	Maternity Safety Champion Report					
Report of	Liz Bromley, Non-Executive Director (NED) and Trust Maternity Safety Champion					
Prepared by	Liz Bromley, NED and Trust Maternity Safety Champion					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☒		☒	
Summary	This report summarises feedback from the Maternity Safety Champion since the last report shared at the September 2025 Trust Board meeting.					
Recommendation	The Trust Board is asked to receive the report and consider/discuss the content.					
Links to Strategic Objectives	Performance: Being outstanding now and in the future.					
Impact (Please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☐	☒	☐	☐
Link to Board Assurance Framework (BAF)	No direct link. Risks are detailed within the main body of the report.					
Reports previously considered by	Last report presented at the Public Board meeting on 26 September 2025.					

MATERNITY SAFETY CHAMPION REPORT - AUTUMN 2025

My October walkaround was the first time in many months that I have experienced some negative vibes. The staff in the Maternity Assessment Unit (MAU) who are usually so upbeat are beginning to lose faith that they will ever have improved accommodation or a dedicated consultant. They had no knowledge of the Estates Masterplan although they accepted that maybe they weren't listening to the communications about it. Whilst unsure what was planned, they were sure that no work had begun.

What was more worrying, and if as stated, a potential safety issue, was the concern expressed about the MAU taking on emergency gynae work overnight 'due to funding cuts'. There have been no additional staff in the unit since March and bank healthcare staff are working overnight. Accident & Emergency (A&E) are triaging women and sending them straight up to the MAU where, due to the space constraints, women who are miscarrying are sitting next to heavily pregnant women; this is creating a very challenging atmosphere for everyone. Seven women have recently been sent up from A&E, bypassing the A&E triaging system, via the gynae pathway. More concerning has been the number of non-pregnant patients being sent to the MAU with UTIs. The incident reporting system seems not to be working as expected. If this is happening as described, there would seem to be a training issue for staff in A&E, and possibly in MAU as well if the intention is for the unit to take referred work, and clearly there needs to be a shared understanding of responsibilities and signposting.

Staff spoke about removing foetuses in the MAU rooms, which are not fit for purpose, and do not offer the patient the kind of experience they should expect, especially when considering the distressing circumstances they are in.

Staff also expressed concern about the shift patterns, saying that often the busiest times are afternoons (12 – 6pm) when there are often only 4 staff on duty. They manage by using the 'emergency huddle' to bring staff in from other areas to help ease the pressure as required.

Positive news was that lots of new staff were joining the teams, 2 more midwives, some Band 5 staff, 7 maternity care assistants, and new housekeepers have also been welcomed.

In neonates there was anticipation of the move of Intensive Treatment Unit (ITU) to Ward 32 – lots to be done in a short time. I was told that there has been email communication about the plans but 'people forget' because they are busy with the day job.

There was an upbeat tone to my question about workload – colleagues had definitely seen an improvement and were happy, although they also acknowledged that the presence of a 'floater' made a big difference. The ward was busy but not full when I visited with 27 babies in the 38 available cots. There was a baby in whose father was not allowed to visit, having just been released from prison, with a restraining order. The staff were amazingly sanguine, they were all aware of the issue and were clear on what to do if he tried to gain entry (again), which was reassuring.

I also took the opportunity to visit the Neonates Transport team who are located in the same area. Five very cheerful people were squashed into a very small space, one using a laptop literally on her lap. The room was very warm and they had fans to keep it bearable. I wonder whether with the proposed estates moves there might be an opportunity to give them some more appropriate space.

I was disappointed when I called into the Birthing Centre to receive a very cool reception. The staff member was quite suspicious, didn't seem to know what a Maternity Safety Champion role was about, and had nothing to share, other than that one baby had been born in the Centre that day. She was reluctant to speak about the challenges of the interpretation services and I felt quite unwelcome, which is a first.

On a final and very important note, I chatted with the sister of a patient who had given birth to a 4lb baby boy. Mum and baby were both doing well; her sister said that they were being very well looked after, and she and the (little) 'big sister' were being made very welcome. Despite some of the less positive moments during my walkaround, this conversation was enriching and was in fact what the department is really all about – well cared for babies and happy mothers and families.

Management response from Jenna Wall, Director of Midwifery

The gynaecology service did not have a funded overnight early pregnancy pathway, prior to August 2025 this service was provided by bank nurses on Ward 40. An Equality Impact Assessment (EQIA) was completed and it was agreed that the use of bank staff to provide this service would cease and the pathway would revert to Emergency Department (ED). Following some concern from the gynaecology clinical leadership team it was agreed that the Maternity Assessment Unit would support the pathway for an interim period until the completion of a broader gynaecology pathway service review. This proposal is planned for discussion at the EQIA panel on 7th November, it is hoped that this will provide a resolution and return the service to gynaecology. In the interim, we acknowledge the potential impact on patient experience and have worked with the patient experience team to collate right time data. The current provision is safe but is not in keeping with the national bereavement care pathway and has impacted staff experience. We have met with the team to explore their concerns and update them with a timescale for the service to return to gynaecology but understand their frustration and concern.

Activity in the Maternity Assessment Unit is unpredictable. The triage performance remains good despite the fluctuations in activity; however, the staffing shift patterns will be modified in phase 2 of the staffing review to reflect the variance of activity. I'm pleased to hear the safety huddle to support safe staffing has been embedded and is being utilised to ensure safety across the service.

The atmosphere in the department when I visited in November was significantly more positive than my last visit. The MAU was pleased to have a meeting in the diary to review the unpalatable responsibilities for A&E gynae admissions. Colleagues commented positively on the fact that more big departmental meetings were happening and that it was great to see Jenna at these meetings. The meetings were well advertised and were flexible in terms

of being face to face and/or on Microsoft Teams. Some colleagues would appreciate training to use Teams and particularly the Teams channels more confidently and more effectively. The Masterplan is always on the agenda and colleagues now feel better informed about what is happening and when. That said, I am not sure that people really believe that estates changes are coming that will benefit the MAU.

People have told me, and I believe that I have reported on this before, that a door to the MAU office and a screen at the reception desk would make staff, particularly those working overnight, feel safer. There was an instance recently of a dad coming into the office uninvited and when challenged said he was 'just using your phone'. This unacceptable behaviour could be easily prevented by the installation of a door and or a screen, neither of which would seem to me to be particularly expensive.

I had the opportunity to spend quite some time with a young couple who were new parents.

Their child was born by emergency c-section on 28/10; the team was 'fantastic', the parents said that they could barely believe that it was an emergency birth; the experience was 'amazing' and the recovery support, including by a student midwife, was excellent throughout. Unfortunately, whilst mum was on Ward 33 she developed post-natal sepsis (undiagnosed in the first instance) rendering her unable to get out of bed, and feeling very unsafe in terms of handling her baby.

Mum was given morphine, she felt very unwell with fever and sweats. The baby was screaming making the mum feel very distressed despite her own illness. The midwife ('A') who was working overnight refused to help with the baby, wouldn't change her nappy, told mum that she was 'too busy to help her all night'; refused to let dad in to look after the baby until in the end he rang the MAU and one of the senior midwives intervened in the situation. The senior midwife and all the other midwives who were involved were described as 'fantastic'. The sepsis was diagnosed, the extent of the illness confirmed and by the third day after the birth mum was able to get out of bed and use the toilet. She was also given her own room for the rest of her time on the ward.

The new parents complained about the treatment that had been given out by Midwife A and a student midwife also expressed concerns. The senior midwife investigated what had happened. She told the parents that Midwife A had not realised how ill or upset the new mum had been. She offered to deliver team training to help ensure that this would not happen again; the parents were not satisfied with this as they had absolutely no issue with the team – it was about one particular individual.

Following a phone call a couple of days before my conversation suggesting that the matter had come to a conclusion, the family have raised a PALS complaint. The couple were articulate, thoughtful and reflective of their experience and I would suggest that, on the face of their narrative, a deeper investigation into the behaviour of one individual might be appropriate.

The Neonates Unit was being challenged by staff sickness. Most of the cots were busy and the father who was subject to a restraining order (mentioned in previous reports) continues

to be a risk as the baby and mother are still on the unit. The ICU was down to 7 staff out of the 9 or 10 who are needed to ensure safety. Staff had been pulled from other areas to ensure that appropriate levels of staffing were present, but clearly the need is for experienced staff in the department. However, people were optimistic about the de-cant which is planned for mid-December and are prepping for it with enthusiasm. The plan to increase from 3 bays to 4 will be a significant improvement for infection control.

Report of
Liz Bromley, Non-Executive Director
20 November 2025

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Agenda item A10(d)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Trust Board

Date of meeting	28 November 2025					
Title	Sexual Safety Audit					
Report of	Vicky McFarlane Reid, Executive Director for Commercial Development and Innovation, and Executive Lead for People					
Prepared by						
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☒		☐	
Summary	On the 20th August the Trust received a request from NHS England (NHSE) to complete a sexual safety audit. The audit results were shared at the People Committee in September 2025. This report was first shared at People Committee in September 2025 and it outlines the Trust's current position and proposed actions across all ten Charter principles. The following additional steps are proposed to provide greater oversight and visibility: 1) The design and development of a People Review Panel which will allow matters of sexual safety misconduct to be addressed in an effective and time efficient manner. 2) Development of a data set to understand where matters are being reported and how the data can be used to make proactive interventions. 3) Complete the e module in Learning lab – request that the Board lead by example. 4) Develop a visual flow chart to describe how and where to raise issues.					
Recommendation	Support the next steps and request Board members to complete e-module in Learning lab.					
Links to Strategic Objectives	BAF People and Culture					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☐	☐	☐	☒	☒	☐
Link to Board Assurance Framework [BAF]	BAF People risks.					
Reports previously considered by	This report was first shared at People Committee in September 2025.					

NHS
The Newcastle upon Tyne Hospitals
NHS Foundation Trust

SEXUAL SAFETY CHARTER ASSURANCE FRAMEWORK AUDIT

PRINCIPLE		
1. We will actively work to eradicate sexual harassment and abuse in the workplace. **2. We will promote a culture that fosters openness and transparency and does not tolerate unwanted, harmful and/or inappropriate sexual behaviours.**		
Actions	**Current Position**	**Proposed actions**
Have clear plans to focus the organisation on prevention and culture change.	The Trust has signed up to NHSE's Sexual safety charter. We have also co-developed in partnership with staff a Behaviour and Civility Charter and training has been delivered to c16,000 staff. The training is also available on line. Bespoke microaggression and incivility workshop developed and rolled out in areas of need. Data around sexual harassment was included in the People Plan Equality Impact Assessment (EIA) both year 1 and year 2, i.e. it was recognised as a key area of concern.	

Actions	Current Position	Proposed actions
Set clear standards of behaviour in policies and enforce them.	Standards of behaviour clearly set out in Sexual Misconduct and Sexual Violence Policy, Dignity & Respect at Work Policy, Disciplinary Policy, and Behaviour and Civility Charter.	
Core training for all staff and specialist training for those who need it.	National e-learning on sexual misconduct available to all staff on the Trust's Learning Lab platform. Behaviour and Civility Charter. Bespoke microaggression and incivility.	Undertake organisational Training Needs Analysis (TNA) which will inform who might benefit further training.
Communications campaign shared with all staff.	Policy launched jointly to all staff by the CEO and Chair of Staff Side.	Launch of a three-tiered promotional campaign aimed at both staff and patients focusing on Racism, Sexual Misconduct and Behaviour / Civility, is in year 2 of our People Plan.
Establish a structure risk management and escalation process for sexual misconduct, including defined risk thresholds for escalation to executive and board levels.	The Trust has oversight/advisory groups for all employee relations cases with either Executive representation or a route for escalation where required. The Trust is currently developing a People Review Panel to meet to discuss within 48 hours any cases of potential gross misconduct around allegations of sexual misconduct or racist behaviour.	
Board-level ownership and accountability for cultural issues, prevention strategies, and oversight.	Equality, Diversity and Inclusion (EDI) and Health and Wellbeing both key priorities for the Trust Board and the People Plan.	Set up the established assurance and governance structures, People Committee, and Programme Delivery Board to link with this specific work around sexual harassment.

Actions	Current Position	Proposed actions
Embed tackling sexual misconduct and protecting the sexual safety of our workforce into all relevant business as usual areas – for example, training, contracts, induction and EDI improvement plans.	The Trust has established a People and Culture Multi-Disciplinary Team (MDT).	Review how we develop policies to explicitly require consideration of incorporating key elements such as sexual misconduct, racism.
Clear signposting to policies and support services, which are easily accessible to all staff.	The policies are all on the intranet and detail reporting options, process, and support available both internally and externally.	
Visible, senior leadership.	The Trust signed up to the Charter at a senior level and the Executive and Board are committed to offering their full support. Regular CEO roadshows and briefings.	
Appoint domestic abuse and sexual violence lead (DASV).	We have an identified DASV Lead.	

PRINCIPLE		
3. We will take an intersectional approach to the sexual safety of our workforce, recognising certain groups will experience sexual harassment and abuse at a disproportionate rate.		
Actions	**Current Position**	**Proposed actions**
Complete equality impact assessment of sexual safety and misconduct work (including policies).	Comprehensive EIA completed for Sexual Misconduct and Sexual Violence policy.	
Engage through staff networks, EDI officials and experts by experience to ensure that all cohorts of our staff are represented appropriately and robustly as part of this work.	Full engagement through these groups.	

Actions	Current Position	Proposed actions
Use data from NHS staff surveys, cut be EDI metrics, to understand staff experience and inform iterative development of key products.	Work on this ongoing.	Develop a data set around sexual harassment which will also further inform the EIA.
Tailor responses to ensure they are appropriate for groups that experience sexual misconduct at a disproportionate rate.		This will follow on once we have data set.

PRINCIPLE		
4. We will provide appropriate support for those in our workforce who experience unwanted, inappropriate and/or harmful sexual behaviours.		
Actions	**Current Position**	**Proposed actions**
Confidential information and resources are available on the intranet and staff are signposted to them regularly.	The Sexual Misconduct and Sexual Violence Policy is available on the Trust intranet and offers a range of support and resources.	
Staff support structures, like the Employee Assistance Programme, have guidance on sexual misconduct pathways to specialist support.	This will feed into the continued development of a Trust wide health, wellbeing, and psychological support service, and mental health first aiders.	
The support offer is monitored to inform continuous improvement and ensure appropriateness. Offsite support can be offered.	The support offer will be reviewed regularly.	
Relevant policies are evidence based and informed by data and subject matter expertise.		Develop a data set around sexual harassment which will also further inform the EIA.

PRINCIPLE		
5. We will clearly communicate standards of behaviour. This includes expected action for those who witness inappropriate, unwanted and/or harmful behaviour. **6. We will ensure appropriate, specific, clear policies are in place. They will include appropriate and timely action against alleged perpetrators.**		
Actions	**Current Position**	**Proposed actions**
Sexual misconduct policy is clear on standards of behaviour, the role of those who witness inappropriate behaviour, and any interactions with other relevant policies.	The policy sets out standards of behaviour, with examples of sexual misconduct and sexual violence. An appendix covers what a member of staff is expected to do if they witness sexual misconduct or sexual violence. The policy sets out the link to the Disciplinary Policy.	
Roll out communications campaign to all staff.	Policy launched jointly to all staff by the CEO and Chair of Staff Side.	One of the actions of our People Plan is to develop and deliver a co-produced plan to focus on tackling racism, sexual misconduct and incivility; this will include both staff facing and patient facing elements. Within the People Plan actions we continue work to overcome issues with reporting so we can proactively contact and support staff who have experienced discrimination, assault or harm at work.
Sexual safety and misconduct are comprehensively addressed in induction and all staff training.	The Medical Director delivers a PowerPoint presentation at Resident Doctor induction.	Consider where this can best sit within the wider Corporate Induction, perhaps aligned with the Freedom To Speak Up (FTSU) element.
Publish a policy on sexual misconduct in line with the NHS national policy framework.	Published policy is in line with the NHS national policy framework.	

Actions	Current Position	Proposed actions
Sexual misconduct policy is supported by flowchart and easy-read version and is easily accessible to all staff.	Policy was created in an easy-read format.	A flowchart to be added.
Conduct/competence policies should take account of complexities in cases where it may initially be unclear whether behaviours and actions should be considered as conduct or capability.	Clear distinction in policies between conduct and competence.	
Policies set out roles and responsibilities of people in the organisation, for example, HR and people professionals, safeguarding teams, freedom to speak up guardians, mental health first aiders, leadership, line managers.	This isn't set out explicitly in the Policy.	Development of a generic visual for reporting mechanisms to identify, share and promote reporting routes so that we have one established version which is simple to follow.
Provide tools and support for line managers to understand their responsibilities and how to follow escalation processes consistently.	The policy provides guidance on how to respond to a sexual misconduct or sexual violence disclosure. Advice can be sought from Human Resources (HR) without naming the reporting party if they wish to maintain confidentiality.	As above. Will also integrate into the New Manager Handbook.
Policies are clear about action that needs to be taken against perpetrators, by whom, when and how.	Within the context of a Just and Learning Culture, the Trust's position is that of zero tolerance by which we mean we will take all reports seriously and appropriate and timely action will be taken which will be *proportionate to the behaviour.* This will apply to everyone in the Trust equally regardless of seniority or role.	The Trust has oversight/advisory groups for all employee relations cases with either Executive representation or a route for escalation where required. The Trust is currently developing a People Review Panel to meet to discuss within 48 hours any cases of potential gross misconduct around allegations of sexual misconduct or racist behaviour.

Actions	Current Position	Proposed actions
Polices are clear about investigation processes and standards.	The Sexual Misconduct and Sexual Violence Policy has a link to the Disciplinary Policy which sets out the investigation process.	
Policies are clear about the circumstances in which complaints and investigations about staff should be shared with future employers and police.	The Sexual Misconduct and Sexual Violence Policy states that due to the sensitive nature of the matter, confidentiality will be maintained where possible throughout the process. As such, information will usually only be shared with other individuals or parties (either internal or external) with the reporting party's agreement.	
Chaperoning policies are clear about the role of chaperones in relation to sensitive examinations.	The Trust's Chaperone Policy sets out that the role of the chaperone is to: (a) be sensitive, and respectful of the patient's dignity and confidentiality. (b) be prepared to reassure the patient if they show signs of distress of discomfort. (c) be familiar with the procedures involved in a routine intimate examination. (d) stay for the whole examination and be able to observe what the doctor/clinician is doing. (e) be prepared to raise concerns if required.	

PRINCIPLE		
7. We will ensure appropriate, specific, clear training is in place.		
Actions	**Current Position**	**Proposed actions**
Training is available for all staff to recognise and report sexual misconduct and to understand how to support colleagues (victims and witnesses).	National e-learning on sexual misconduct available to all staff on the Trust's Learning Lab platform.	Promote availability of the training and encourage completion.
Specialist training is available for those who need it to ensure effective support, reporting and investigations (for case managers, investigators and responsible officers).		Undertake organisational TNA which will inform who might benefit further training. The Trust is currently looking at policy development as part of a wider piece of work reviewing format and creating toolkits to support managers.
Training is developed for managers to support culture change.		Undertake organisational TNA which will inform who might benefit further training.
All staff have undertaken national e-learning on sexual misconduct.	National e-learning on sexual misconduct available to all staff on the Trust's Learning Lab platform.	The training will be promoted in the roll out of communications via the Board and Executives leading by example.

PRINCIPLE		
8. We will ensure appropriate reporting mechanisms are in place.		
Actions	**Current Position**	**Proposed actions**
Policy outlines sexual misconduct reporting mechanisms, including anonymous reporting.	Policy outlines reporting via a number of routes including line manager, HR, Freedom to Speak Guardian, trade union representative, or anonymously though the latter limits how much support can be given.	Development of a generic visual for reporting mechanisms to identify, share and promote reporting routes so that we have one established version which is simple to follow.

Actions	Current Position	Proposed actions
Reporting mechanisms are widely communicated to ensure awareness.	The reporting mechanisms are in the policy which was launched last year and communicated to staff by the CEO and Chair of Staff Side.	As above.
Freedom to Speak Up infrastructure and training for guardians updated to include sexual misconduct.		This will be part of the organisational TNA.
There is a clear safeguarding process for identifying unusual patterns of patient record access (where an electronic patient record is in place).	Audits can be run on request or where there are specific concerns about access. Access can be restricted where appropriate. Before accessing the system, there is a pop up message advising the individual to continue only if they are directly involved in the care or treatment of the patient.	

PRINCIPLE		
9. We will take all reports of sexual misconduct seriously, and appropriate and timely action will be taken in all cases.		
Actions	**Current Position**	**Proposed actions**
Clear actions and action-owners set out in the sexual misconduct policy.	This isn't set out explicitly in the Policy.	To be added as an Appendix to the policy.
Timeframes for action set out in sexual misconduct policy.	The Policy does not currently set out timeframes for action.	We are currently trialling timeframes in disciplinary investigations to establish what is reasonable and achievable with a view to including these in the policies. We are also introducing a 'review' at the end of each case which will cover timescales.

Actions	Current Position	Proposed actions
Ensure access to external investigators.	There is access to external investigators via external organisations we have used on occasion, and we have retired consultant staff on the bank to assist with investigations where appropriate mainly due to capacity issues.	There are no current plans to expand this but it may be considered at a later date.
Ensure access to external subject matter experts.	We have access to safeguarding experts, and the option to seek legal advice where appropriate. We have access to Trust wide health, wellbeing, and psychological support service. We also have local police contacts.	
Executive/board reporting, including on relevant data and learning from surveys, reports and investigations of sexual misconduct, FTSU, complaints.		We are currently reviewing our reporting to the People Committee and Board including detail of data, sources, frequency, and any learning.
Establish a governance and risk oversight process for serious and complex misconduct cases, with defined escalation thresholds for executive and Board review.	The Trust has oversight/advisory groups for all employee relations cases with either Executive representation or a route for escalation where required. The Trust is currently developing a People Review Panel to meet to discuss within 48 hours any cases of potential gross misconduct around allegations of sexual misconduct or racist behaviour.	
There are timely routes to share with HR concerns raised through professional and clinical avenues that could have a sexual component plus data from FTSU and sexual misconduct reporting is triangulated to support.	The Trust has established a People and Culture MDT to pull together all the sources of data and concerns.	

Actions	Current Position	Proposed actions
There is a process for investigations to move from competence to conduct.	Clear distinction in policies between conduct and competence.	

PRINCIPLE		
10. We will transparently capture and share data on the prevalence of sexual misconduct and staff experience of sexual misconduct.		
Actions	**Current Position**	**Proposed actions**
Staff survey results are published and shared, with actions taken/to be taken to address issues and risks raised in the results.		Develop a data set around sexual harassment which will also further inform the EIA.
Executive/Board reporting on cases, including relevant data and learning.	We are currently reviewing our reporting to the People Committee and Board to include detail of data, sources, frequency, and any learning.	

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Agenda item A11

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 November 2025.		
Title	NHS Oversight Framework (NOF) Provider Capability Self-Assessment.		
Report of	Patrick Garner, Director of Performance and Governance.		
Prepared by	Natalie Yeowart, Head of Corporate Risk and Assurance.		
Status of Report	Public	Private	Internal
	☒	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	To build upon the foundations for the upcoming ten-year health plan, NHS England (NHSE) have published a revised approach to the oversight of NHS Providers, The NHS Oversight Framework (NOF). Alongside the NHS Oversight Framework trusts are required to complete a self-assessment of their organisation's capability. A provider capability self-assessment tracker has been created to support the Trust to complete an initial assessment and in year monitoring of capability against each domain with supporting key lines of enquiry to consider Trust compliance with each domain. The Trust have drawn upon information, reports, board papers and assurance documents as well as third party information available to consider and provide a statement for each key line of enquiry as well as provide the evidence and assurance items that support each statement. A formal Provider Capability Assessment declaration has been submitted confirming compliance with each of the six domains.		
Recommendation	The Trust Board are asked to: • Receive the content of this report. • Note the formal declaration has been submitted confirming compliance.		
Links to Strategic Objectives	Links to all strategic objectives.		

Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☒	☒

Link to Board Assurance Framework	Links to the full Board Assurance Framework document.
Reports previously considered by	This a new report for Board.

NHS OVERSIGHT FRAMEWORK (NOF) PROVIDER CAPABILITY SELF-ASSESSMENT.

1. INTRODUCTION

To build upon the foundations for the upcoming ten-year health plan, NHS England (NHSE) have published a revised approach to the oversight of NHS Providers, The NHS Oversight Framework (NOF).

Alongside the NHS Oversight Framework trusts are required to complete a self-assessment of their organisation's capability.

2. PROVIDER TRUST CAPABILITY

The capability self-assessment is focused around six domains as set out in the Insightful Board Framework:

- Strategy, leadership and planning
- Quality of care
- People and culture
- Access and delivery of services
- Productivity and value for money
- Financial performance and oversight

Each domain is supported by multiple key lines of enquiry to support providers to understand and assess their organisations capabilities, strengths, weaknesses and the challenges faced. A compliance statement is then made on each domain with supporting evidence and assurance documents for each domain.

Regional oversight teams will then review each providers submission and consider the statement and evidence provided using a rang of considerations including historical track record, regulatory history and any relevant third-party information. The oversight team will the decide upon a providers capability rating for each provider which will then be published by NHS England.

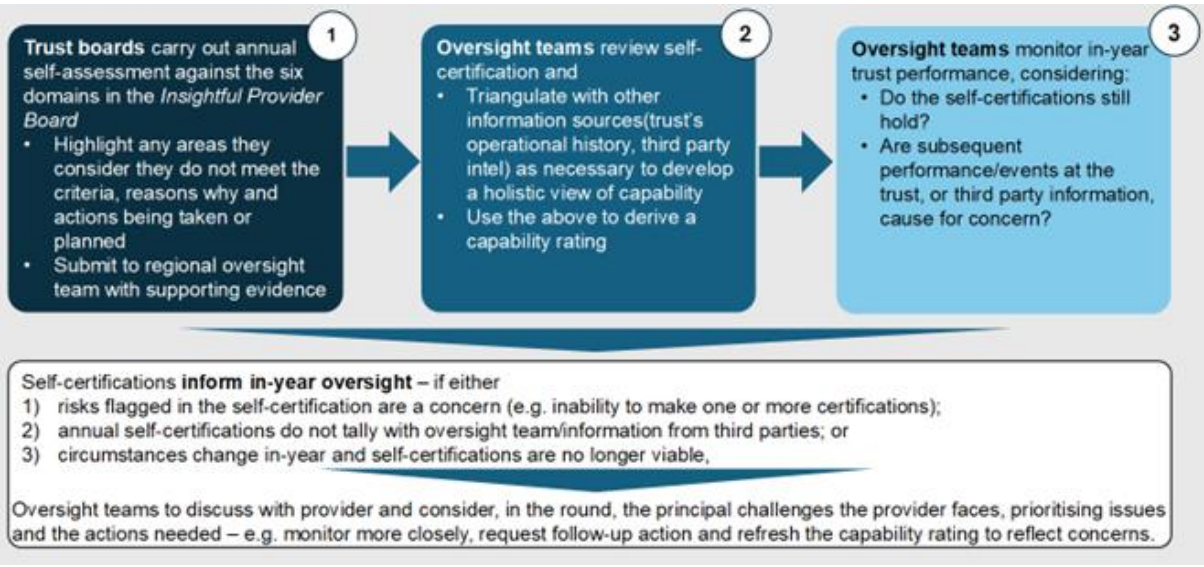
The capability ratings are as follows:

Rating	Indicative criteria
Green High confidence in management.	• No concerns evident from the self-assessment or subsequent performance. • No concerns arising from third-party information. • High confidence in the trust's ability to deliver on its priorities based on track record over past 12–24 months.

Amber – green Some concerns or areas that need addressing.	• After discussion with the trust, some concerns emerging across more than 1 domain, but these as yet are not affecting quality of care, delivery of core services, finance or the wider reputation of the NHS. • Trust has prepared plan(s) to address any problems with associated timeframe for delivery. • Historical issues/track record mean NHS England does not (yet) have full confidence in the board.
Amber – red Material issue needs addressing or failure to address major issues over time.	• Issues with self-assessment or subsequent issues across multiple domains. • Failure to deliver on agreed plans to address a material issue. • Potentially in breach of licence.
Red Significant concerns arising from poor delivery, governance and other issues.	• Material or long-running concerns at the organisation that management has been unable to grip. • NHS trust in breach of licence or likely to be

The capability self-assessment process will then move to in-year monitoring by providers and NHS England with an annual self-assessment return in line with the annual governance statement as part of end of year submissions.

Figure 1. below shows the capability assessment cycle and process.



3. THE TRUST SELF ASSESSMENT

A provider capability self-assessment tracker has been created to support the Trust to complete an initial assessment and in year monitoring of capability against each domain with supporting key lines of enquiry to consider Trust compliance with each domain.

A member of the Executive Team was appointed as Senior Responsible Officer for each of the 6 domains and completed an assessment of current compliance. In doing this they have drawn upon information, reports, board papers and assurance documents, as well as third party information available to consider and provide a statement for each key line of enquiry. This detailed provider capability self-assessment tracker can be found in appendix 1.0.

4. THE TRUST BOARD CAPABILITY ASSESSMENT DECLARATION

Following the completing of the provider capability self-assessment review then Trust are then required to submit a formal provider capability assessment declaration confirming compliance with each of the six domains.

The Executive Team have considered the completed self-assessment tracker and have not identified any material finding and therefore recommend that the Trust Board supports a positive submission with a 'confirmed' statement of compliance for each domain. The Trust provider capability assessment board assurance declaration is provided in appendix 2.0 for consideration by Trust Board.

Any areas of improvement that have been identified through this review will be included in an action plan and will be monitored and updated as part of the in-year monitoring process with a 6 monthly update report to Audit, Risk and Assurance Committee and Trust Board.

5. RECOMMEDATIONS

The Trust Board are asked to:

- Receive the content of this report;
- Note the formal declaration has been submitted confirming compliance.

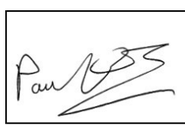
Report of:
Patrick Garner
Director of Performance and Governance
21.11.2025

The Newcastle upon Tyne Hospitals NHS Foundation Trust Provider Capability Self-Assessment October 2025

	The Board is satisfied that…		*(Mitigating/contextual factors where boards cannot confirm or where further information is helpful)*
Strategy, leadership and planning	• The trust's strategy reflects clear priorities for itself as well as shared objectives with system partners • The trust is meeting and will continue to meet any requirements placed on it by ongoing enforcement action from NHSE • The board has the skills, capacity and experience to lead the organisation • The trust is working effectively and collaboratively with its system partners and provider collaborative for the overall good of the system(s) and population served	**Confirmed**	Newcastle Hospitals has a published Strategy aligned with ICS and wider NHS policy, though it is an interim one year document published before the 10 Year Health Plan. A longer term 5 year strategy from 2026/27 is under development. Financial planning is linked with the ICB, including capital programme oversight. Transformation priorities are co-produced with system partners through the Great North Healthcare Alliance and ICS. There are no specific requirements placed on the Trust by regulatory instruments or the national Performance Improvement Programme at this time as it is in NOF segment 2. The Trust actively engages in a wide range of national programmes and local initiatives to support performance improvement, such as various GIRFT programmes and the Provider Collaborative Planned Care Board, amongst others. The Trust is currently fully compliant with the conditions of the its provider licence. The Board has the skills, capacity and experience to lead the organisation, clear accountabilities for all areas including quality, access, operationals, finance and workforce are in place. The Trust is fully compliant with the NHS Fit and Proper Persons Framework, annual review processes are in place to assess the capabiility and appraisal of Trust Board Members. The Trust recognises the benefits of working collaboratively with provider trust partners and plays an active role in the Great North Healthcare Alliance and the North East and North Cumbria Provider Collaborative. The importance of this work is recognised in being a principal risk on the Board Assurance Framework that "Inability to sufficiently influence priorities of key partnerships (including the Great North Healthcare Alliance, the ICB, Provider Collaborative and Newcastle place arrangements) or to deliver on agreed commitments due to capacity or culture, impacting on our ability to effectively deliver sustainable local and regional healthcare commitments."
Quality of care	• Having had regard to relevant NHS England guidance (supported by Care Quality Commission information, its own information on patient safety incidents, patterns of complaints and any further metrics it chooses to adopt), the trust has, and will keep in place, effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients • Systems are in place to monitor patient experience and there are clear paths to relay safety concerns to the board	**Confirmed**	The Trust has undertaken a substantial improvement programme in response to the CQC report and findings in 2023. A key focus was to implement and embed and effective governance structure which provided assurance internally and externally that key risks to quality and safety were understood, reported and overseen. Progress has been checked through objective measures and internal audit. The Trust met the threshold for removal of license restrictions in 2024. There is robust Trust Board engagement in quality of care across the Trust which can be evidenced through a number of objective measures including but not limited to: Non-Executive Director and Senior Leader Visibility Programme and subsequent reports, Quality Committee attendance,minutes and action logs, Non-Executive Director and Executive Director objectives and personal performance measurement, Maternity Safety Champion reports and processes and Non-Executive Director attendance at Tier 2 committee meetings to provide oversight, check and challenge. The Trust has a Patient and Staff Experience Team in place who lead a Real Time and Right Time Experience of Care Programme across the Trust using real time data. The Trust also considers national data to seek views of our staff and patients including the National Staff Survey, National Patient Survey and National Cancer Survey. The Team actively work with clinical boards and corporate deparments to support the improvement of patient and safety experience using qualitive and quantive data available. In addtion there is a Trust Board visibility programme in place which includes ad-hoc visits to ward and department with a focuss on staff and patient experience ensuring the Trust has a robust monitoring and can contiually improve the quality of healthcare provided by the Trust.
People and Culture	• Staff feedback is used to improve the quality of care provided by the trust • Staff have the relevant skills and capacity to undertake their roles, with training and development programmes in place at all levels • Staff can express concerns in an open and constructive environment	**Confirmed**	The Trust Board uses staff feedback to improve the quality of care provided to the Trust. In response to staff feedback the Trust recruited a Chief Experience Officer and the establishment of a Staff Experience team. The Trust consider and report several feedback and surveys to Trust Committee and Trust Board including the staff survey, general medical Council Trainee Survey and WRES and WDES, this data informs and drives actions which are consolidated into the People Plan and the delivery of one of the Trusts Strategic priorities for this year "making it better for our collegues." The Trust regularly reviews training needs at all levels across the Trust. The Trust has a well established Statutory and Mandatory Training Group who regularly consider the Trust statutory and mandatory training needs. The Trust have recently reviewed and made improvements to the Trust appraisal process to ensure that staff have the ability to identify areas of development and additional training needs. The Trust have an extensive training and education offer across the Trust that can be accessed by all staff. Advice and guidance is available on training and education from the Trust's clinical educators and the Education and training deparment leads. The Trust introduced Fundamentals of Care Clinical Training Programme and the Healthcare Academy to ensure new clinical staff to the organisation have baseline skills in place. Regular reporting is in place to monitor the Trust's statutory and mandatory training compliance,The Trust's overall training compliance is reported monthly via the Integrated Board Report (IBR) which ensures regular visibility and oversight at the highest level of governance. The Trust fosters a safe reporting culture, where staff are encouraged and supported to raise concerns without fear of detriment. This is part of a wider piece of work to improve the safety culture across the organisation, which has started to show some signs of improvement, particularly in incident reporting. There remains work to do to improve the oevrall safety culture of the organisation.The Trust has a clear and accessible FTSU process, supported by mulitple reporting routes and internal communication. All concerns are addressed in line with policy, with outcomes shared appropriately.
Access and delivery of services	• Plans are in place to improve performance against the relevant access and waiting times standards • The trust can identify and address inequalities in access/waiting times to NHS services across its patients • Appropriate population health targets have been agreed with the ICB	**Confirmed**	The Trust has improvement plans in place for all key access targets. These include secific cancer tumour site action plans to address where improvements are required to improve access for our patients. Sucessful implementation of the processes associated with this has demonstrated a level of grip and control recognised both through internal governance structures and also externally, as evidenced by the de-escalation from Tier 2 oversight for cancer diagnostics in Q2 of 2025/26. Action plans are also in place to achieve the 1% target of < 1% 52 weeks by the end of March 2026, with RTT performance . Work continues on improving ED performance with a Trust wide improvement group in place to oversee this improvement work including the work up of the winter plan for 2025/26. The Trust is also working with GIRFT looking at specific areas for improvement in ED e.g. Ambulance handover times. Linking of specific population health measures has been completed with operational reports and systems within the Trust, these inlcude the outpatients and inpatients patient tracking lists and links to the Federated Data Platform Care Coordination System application. In addition The Trust has estalbished a Promoting Equity in Health Group (PHEG) who oversee the completion of a self assessment tool for each of Clinical Boards. This exercise is aimed at captuting the work already underway in this area as well as identifying priorities to improving health and wellbeing for patients for each Clinical Board. Population health targets have been agreed with the ICB as a contributing partner of of the North East and Noarth Cumbria Joint Forward Plan 2023-2028. The Trust also has a newly developed Health Inequalities strategy which has oversight by the Board through Quality Commitee. The Trust has also agreed to work with partners in the Great North Healthcare Alliance on a 'Community Promise' focusing on joint work in relation to education, employment, ecomonic development, enviroment and improving inequalities.

Productivity and value for money	• Plans are in place to deliver productivity improvements as referenced in the NHS Model Health System guidance, the Insightful board and other guidance as relevant	**Confirmed**	The Trust have plans in place to deliver productivity improvements, utilising multiple data sources for benchmarking such as Model Health, PLICS, NOF Segmentation metrics and GIRFT data. The Trust has internally adopted theatre utilisation tools through the NHS Federated Data Platform which has supported in the redution in long waits, a Service Review Programme is in place using PLICS data to identify outliers from a cost versus income perspective and key productivity metrics have been produced alighned to each quality improvement group and monitored via the Access, Improvement and Delivery Group. The Trust have plans in place to actively identify productivity improvements, however further work is require to deliver each programme of work to realise planned productivity rate. Current productivity improvement plans include: - Establishment of Quality Improvement Groups with aligned key productivity metrics. - Quality Performance Reviews across the Trust aligned to key productivity themes. - Job Planning Programme. - Urgent and Emergency Care Operational Productivity Programme focusing on length of stay, patient flow, bed base and discharge. - Outpatient transformation Programme (Outpatients Re-imagined) - Theatre Utilisation Programme (including use of CCS) - Adoption of NHS App to improve access to healthcare services and appointment information. - Establishment of People Programme Board to develop and monitor workforce transformation and planning. - CIP Programme - including a focus on reduction in variable workforce spend. - Productivity analysis and modelling in 27 specialities. - GIRFT Further faster programmes aimed at elective and UEC perfromance improvement
Financial performance and oversight	• The trust has a robust financial governance framework and appropriate contract management arrangements • Financial risk is managed effectively and financial considerations (for example, efficiency programmes) do not adversely affect patient care and outcomes • The trust engages with its system partners on the optimal use of NHS resources and supports the overall system in delivering its planned financial outturn	**Confirmed**	The Trust has a robust financial governance and contract management framework is in place supported by clear governance structures and reporting and a internal audit programme with suffient breadth and depth. The Trust has revenue plans which are agreed through a system approach to setting the overall financial plan for the ICS including the ICB. Assumptions used to formulate the plan are agreed with system partners, such as inflation assumptions, treatment of service development funding and convergence factors to ensure a collective understanding and approach. In previous years the financial plan has been submitted to the ICS with built in period of triangulation and consolidation. The ICS receive a capital allocation as a whole in 2025/26 and then work collaboratively with partner to assess the allocation of CDEL with each partner. The Infrastructure Board (Directors of Estates and DOFs) and Capital Collaborative Group (DOFs) have been set up to facilitate this collaborative approach. Through the infrastructure board a assessment of the needs profile of each organisation has been made including critical infrastructure, back log maintenance and business needs. The Trust Board agrees a financial plan at the beginning of the financial year and budgets through the Budget Setting Framework. Budgets are delegated to Clinical Boards and Corporate Service departments and signed off by the appropriate Executive / Director. The performance against these plans/budget are monitored monthly through budget meetings with budget holders, QPRs with Clinical Boards and through a monthly detailed report to the F&PC and Trust Board. All areas are subject to a performance framework which rates performance and any lag against the plan reported. Clinical Boards attend Finance and Performance Committee meetings on a rotational basis to discuss and present financial performance and any remedial action required. Underlying drivers are reported across the Trust and also by Clinical Board and / or Corporate Service. The Trust has a robust process in place to ensure cost improvement schemes have appropriate governance, with auditiable documentation which complies with quality and safety priorities. The process in 25/26 requires completion of a Equality, Quality Impact Assessment (EQIA) screening form for all cost improvement schemes. A EQIA Panel is in place consisting of the Executive Director of Nursing and Joint Medical Directors to review and consider the impact on quality with regular reporting into clinical boards Cost Improvement Plan support meetings, financial recovery steering group , finance and performance committee and Quality Committee.
	In addition, the board confirms that it has not received any relevant third-party information contradicting or undermining the information underpinning the disclosures above.	**Confirmed**	At the time of submitting this self declaration, the Trust Board has not received any third-party information contradicting or undermining the information underpinning the disclosure above.

Signed on behalf of the board of directors



Name	Paul Ennals, Chair
Date	23 October 2025

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Agenda item A12(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 November 2025					
Title	Committee Chair Meeting Logs					
Report of	Phil Kane, Chair of the Charity Committee Hassan Kajee, Chair of the Digital and Data Committee Anna Stabler, Chair of the Quality Committee Bernie McCardle, Chair of the People Committee Bill MacLeod, Chair of the Finance and Performance Committee David Weatherburn, Chair of the Audit, Risk and Assurance Committee					
Prepared by	Gillian Elsender, PA and Corporate Governance Officer Lauren Thomspon, Corporate Governance Manager/Deputy Trust Secretary					
Status of Report	Public		Private		Internal	
	☒		☐		☐	
Purpose of Report	For Decision		For Assurance		For Information	
	☐		☒		☐	
Summary	The following Committee Chairs Logs are included since the last Public Trust Board meeting in September 2025: • Charity Committee – 10 November 2025 • Digital & Data Committee – 11 September 2025 • Quality Committee – 16 September and 14 October 2025 • People Committee – 23 September 2025 • Finance & Performance Committee – 22 September and 20 October 2025 • Audit, Risk & Assurance Committee – 23 September 2025					
Recommendation	The Trust Board is asked to note the contents of the Committee Chair Logs.					
Links to Strategic Objectives	Links to all strategic objectives.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☐	☒	☒	☐	☐
Link to Board Assurance Framework [BAF]	Detailed in the individual Committee Chairs Logs.					
Reports previously considered by	Public Board meeting in September 2025.					

Agenda item A12(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Charity Committee - Chair's Log

Meeting: Charity Committee	**Date of Meeting**: 10 November 2025
Connecting to: ARAC Trust Board	**Date of Meeting**: 25 November 28 November

Key topics discussed in the meeting

- The minutes of the previous meeting held on 9 September 2025 was confirmed received as an accurate record.
- The action log was reviewed with updates noted.
- An update was given on the Sir Bobby Robson Institute fundraising campaign.
- An Options Appraisal of Charity governance models was received and discussed.
- An update on a review of fundraising was given.
- Funding Proposals were discussed in relation to:
  - 1958 – Surgical and Associated Services Clinical Board - Improving the quality of care of patients undergoing thyroid surgery £26,213 – **Supported.**
  - 1919 – Family Health - Evaluation of Nanopore sequencing in Paediatric Central Nervous System tumour diagnostics - £35,091 – **Supported.**
  - 1999 – Cardiothoracic Services- Improving staff facilities - £20,457 – **Supported.**
  - 2005 – Cancer & Haematology - Multi-headed Microscope –£25,125 – **Supported**.
  - 2036 - Cancer & Haematology – Bladder Scanners for Radiotherapy - £24,876 – **Supported**.
- A summary of funding agreed since the last Committee was received.
- The bi-annual update on monitoring and evaluation of funded proposals was received.
- Management accounts to 31 September 2025 were received and discussed.
- An update on rationalisation of funds was received, and it was noted that work is ongoing.
- The "Funds committed and not yet drawn" down quarterly report was received.
- A review of investments and banking was received and discussed.
- The Charity Risk Statement was received.
- The Charity Arts Programme Plan was received.
- The North East & Cumbria NHS Charities Collaborative Working Paper was received.
- The minutes of the Sir Bobby Robson Foundation Committee were received.

Actions agreed in the meeting	Responsibility / timescale
1. Wendy Balmain advised the committee needed to understand the scale of the "lost opportunities" (e.g. approaches made and not supported) for SBRI. KB to bring report to February Committee.	1. Kate Bradley, Campaign Director 2. Amanda Waterfall, Charity Operations Manager

2. A Charity Committee development session to be arranged to discuss an options appraisal of charity governance models. To include key stakeholders to be confirmed.	
3. Preparatory work to be undertaken before development session to include one to ones with key stakeholders e.g. committee members and other Trust Board members to ensure different perspectives can shape content for the event. AW to arrange meetings ahead of February Charity Committee Meeting.	3. Teri Bayliss, Charity Director/Amanda Waterfall
4. Detail of comparative benchmarking from peer group charities to be added to the options appraisal paper. ahead of February Charity Committee.	4. Teri Bayliss
5. Bill MacLeod, NED noted that the Charity has come a long way since 2020 and noted a financial appraisal of costs and expected additional income relative to governance model would be helpful within the options appraisal.	5. Gordon Burns, Charity Head of Finance
6. Jackie Bilcliff asked if representatives of Charities who have changed their governance could attend the Trust Board Session. Teri Bayliss advised that several had already offered to do so.	6. Teri Bayliss
7. Wendy Balmain, NED noted that there was a total spend of £146,792.70 for funding of projects up to £20k in this period and asked if a comparative report could be produced as standard to show the variance in the last 12 months.	7. Richard Haigh, Head of Grant Programmes - Charity
8. Previous conversations had taken place regarding investment management and reorganisation of banking arrangements. Concerns re Interest lost due to delay in actions being progressed. Amanda Waterfall to add to Action Log.	8. Amanda Waterfall
9. More visibility of Investment Managers at Committee required. Investment Managers to be invited to Charity Committee.	9. Amanda Waterfall
10. Teri Bayliss to update Phil Kane, Chair of the Committee and NED re discussion on the North East & Cumbria NHS Charities Collaborative Working Paper	10. Teri Bayliss
Escalation of issues for action by connecting group	**Responsibility / timescale**

Not applicable.	Not applicable.
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
The Charity Risk Statement was shared – two tolerated risks and one managed risk.	

Agenda item A12(a)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Digital & Data (D&D) Committee Chair's Log

Meeting: Digital & Data Committee	**Date of Meeting**: 11 September 2025
Connecting to: Audit, Risk & Assurance Committee and Trust Board	**Date of Meeting**: 25 November 2025 28 November 2025
Key topics discussed in the meeting	

- **Team Awards:** The Chief Digital Officer highlighted that the Digital team have been nominated for three awards at the Celebrating Excellence Awards. These are for the Remote Hosting Organisation (RHO) Upgrade, Connect North East and North Cumbria (NENC) and Follow Up Finder.

- **Alliance Update:** A procurement exercise will be taking place, looking at what the key priorities are across the Alliance and what would fit from an organisation point of view. This will take place in the next two to three months and an update of the items which can be procured as an Alliance will be shared with the committee. A new shared Governance role, which has been approved by the Alliance, will go out to advert soon.

- **Project Update:** There is currently over 500 requests for projects. A 'front door' process is being developed to ensure projects are only started when funding is confirmed. The Care Optimisation Group is tasked with prioritising projects. Communication strategies such as newsletters are being considered to increase transparency. Plans are progressing to publish the Digital team's project priorities and progress, providing clarity to stakeholders about which projects are being worked on and the rationale for prioritisation.

- **Update on Care Quality Commission (CQC) progress**
  The Chief Nursing Information Officer provided an overview of the CQC update report which covered the four key CQC themes: Training, Care Planning, System Navigation, and Escalation and Clinical Risk recording. Initiatives include new Electronic Patient Record (EPR) features, optimised care plans, and the introduction of Smart Zone for improved alert management.

- **Digital Transformation Projects Updates:** The Head of IT Programmes provided an update on digital transformation projects, including Electronic Meal Ordering, ICNets infection control and the Community Diagnostic Centre (CDC), highlighting progress, challenges, and lessons learnt.

- **IT Service Management Update including critical incident review:** The Head of IT Service Management and Head of IT Service Delivery reported on the progress with Windows 11 and Office 2016 upgrades, endpoint compliance, and service desk performance, addressing challenges with legacy systems, resource constraints, and the impact on support metrics.

- **Information Services, Coding, and Data Science Strategy:** The Head of Information Services presented an overview of the Information Services team, covering clinical coding, statutory reporting, data quality, analysis, and data science, and discussed challenges, automation opportunities, and the need for strategic alignment with digital and Artificial Intelligence (AI) initiatives.

- **Reliance Data Enterprise and Commercial Data Partnerships:** The Associate Director for Commercial Enterprise provided an update on the Reliance data enterprise project, including onboarding commercial partners, data migration, patient opt-out processes, and alignment with regional secure data environments, with a focus on transparency and regulatory compliance.

- **Strategic Risk Management and Committee Assurance:** The Head of Corporate Risk & Assurance Manager / Chief Digital Information Officer discussed the development of a principal risk framework aligned with the trust's 10-year plan, the need for improved visibility of operational and strategic risks and plans to present a draft risk overview at the next committee meeting.

Actions agreed in the meeting	Responsibility / timescale
1. Community Diagnostic Centre (CDC) To bring details of the CDC lessons learned to the next committee meeting.	1. Head of IT Programme Management Timescale: Committee meeting 13th November 2025
2. Information Services To share from an assurance point of view what this committee needs to know and understand.	2. Head of Information Services Timescale: Next Committee meeting on 13th November 2025
3. Date Partnership / Commercial To share from an assurance point of view what this committee needs to know and understand.	3. Associate Director for Commercial Enterprise Timescale: Next Committee meeting 13th November 2025
4. Board Assurance Framework (BAF)/Risk Report and emerging risks To bring the first version of the risk framework to the next meeting.	4. Head of Corporate Risk & Assurance Manager / Chief Digital Officer Timescale: Next Committee meeting 13th November 2025
Escalation of issues for action by connecting group	**Responsibility / timescale**
None identified.	
Risks (Include ID if currently on risk register)	**Responsibility / timescale**

There are no emerging risks. The new risk framework for Digital and Technology Services will be shared at the next meeting.	

Agenda item A12(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Quality Committee
Chair's Log

Meeting: Quality Committee	**Date of Meeting**: 16 September 2025
Connecting to: Audit Risk & Assurance Committee and Trust Board	**Date of Meeting**: 25 and 28 November 2025
Key topics discussed in the meeting	

- **Care Quality Commission (CQC)** – A general update on progress within the following areas were received details of which were included within the reports:
    - Emergency Department
    - Cardiac Oversight Group
    - Well Led progress
    - Infection Prevention Control (IPC) Improvement Group
- **Health Inequalities -** A final version of the Health Inequalities Strategy was presented which provided the Quality Committee with an update on the SMART Strategic Goals in the strategy, the proposed implementation plan and summarised progress made to date by the Clinical Boards in undertaking self-assessments and putting forward action plans and agreeing priorities for action.
- **Quarter 1 Reports**
    - **Safeguarding -** The paper presented an Executive Summary of the Quarter 1 (Q1) 2025/26 Safeguarding and Mental Capacity Act reports presented to the Trust Safeguarding Committee on 29 July 2025. Key points to note were the increased activity across the safeguarding teams. Adult safeguarding case complexity is evident, and is reflected in the region as well as an increase in domestic abuse related deaths.
    - **Learning Disability -** The Learning Disability Q1 report showed that activity remains high, with complex patients being referred to the Learning Disability Liaison Team. A dedicated resource has recently been appointed to lead on work for appropriate care for autistic patients. The Trust is currently reviewing the training plans in line with national expectations of the Oliver McGowan Training. Collaborative work with Skills for People continues to have a positive impact in shaping our services for the future.
    - **Learning From Deaths -** The report provided assurance that processes for Learning from Deaths across the organisation are in line with best practice as defined in the National Quality Boards (NQB) National Guidance on Learning from Deaths (LFD) March 2017. It also summarised the processes that are in

place to provide assurance that all deaths are reviewed including those with potentially modifiable factors.

- **Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress -** The report provided the Quality Committee of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. A number of items were brought to the Committee's attention as outlined in the report summary section with escalations noted, discussed and further escalation agreed within the meeting.
- **Quality Impact Assessment (QIA) -** The report detailed the robust process in place to ensure that cost improvement schemes have appropriate governance, with auditable documentation which complies with quality and safety priorities.
- **Quality & Safety Peer Reviews -** The report provided oversight on the level of compliance to quality and safety standards. This quarterly paper highlights areas that are achieving high standards and those that are required to implement improvement strategies to reach them. It also identifies common themes around compliance to core standards.
- **Clinical Audit/Guidelines Report -** The report provided current compliance and assurance processes in monitoring the Clinical Audit Programme across the Trust including Local Clinical Audits, the Corporate Audit Programme and National Clinical Audits.
- **Cancer Patient Outcomes / HARM reviews -** the report provided an update on work surrounding review of potential harm for any patient who has breached 104 days on a cancer pathway. Papers were previously presented to the Committee in March 2024, April 2024 and March 2025. The patient tracking list (PTL) process is utilised to actively manage patients on pathways and the harm review process takes place after treatment is commenced.
- An update on the roll out of **'Call for Concern' (Martha's Rule)** in paediatrics was provided.
- **World Health Organisation (WHO) Surgical Safety Checklist to NATSSIPS2 (National Safety Standards for Invasive Procedures) -** This report highlighted the ongoing risk of patient harm due to adverse surgical patient safety incidents, including Never Events, reported within the Trust. Progress was made during 2024/25 with a significant reduction in the number of Never Events reported. It also provided information and assurance to the Quality Committee regarding the strengthening of governance around this workstream.
- **Board Assurance Framework (BAF) -** The report provided the Quality Committee with the Trust Board approved BAF risks relating to the Quality Committee's area of focus. The committee endorsed the changes recommended in the paper.
- **The Integrated Quality & Performance Report** was presented which provided assurance to the committee on the Trust's performance against key Indicators relating to Quality & Safety, Access, People, Finance and Health Inequalities.
- **Management Group Chairs Logs were received for the following:**
    - i) Clinical Outcomes & Effectiveness Group
    - ii) Patient Safety Group
    - iii) Transplantation Committee
    - iv) Medicines Management Oversight Group
    - v) Promoting Equity in Health Group
    - vi) Experience of Care Group

○ vii) Care for All Group	
Actions agreed in the meeting	**Responsibility / timescale**
1. Next CQC Emergency Department update to include review of the oversight and governance of the improvement group.	• Catherine Carr, Head of Nursing and Executive Director of Nursing – October Committee
2. Infection Prevention Control Improvement Group – next update to include Terms of Reference, progress update and oversight of work plan. This will be via the CQC/Improvement Group update.	• Joint Medical Directors – October Committee
3. To agree dates for when updates are received by the Committee in relation to the Health Inequalities Strategy.	• Joint Medical Directors and Executive Director of Nursing - Progress with strategy actions will be provided through the Chairs Logs from Health Inequalities Group and through the update reports as part of the Quality Committee schedule of business.
4. Learning from deaths – 17 outstanding level 2 reviews. To determine timescales for completion and how long they have been outstanding.	• Director of Quality & Safety – October meeting
5. Learning from Deaths – to include themes and trends of preventability of deaths to the next report as well as further analysis of deaths of Patients with Learning Disability (LeDeR)	• Director of Quality & Safety – December meeting
6. The reputational risk associated with the incorrect stillbirth data on the NENC and national dashboard. To be raised with Integrated Care Board (ICB).	• Lynn Craig - Deputy Director of Nursing, NENC – October meeting
7. Learning from the Matron Governance Reports via the Task & Finish Group to be shared with the Committee	• Executive Director of Nursing – This will be included in the Rapid Quality and Safety Peer Review update in Quarter 4
8. During the Pilot for Call for Concern (Martha's Rule) – how many calls were from staff rather than from patients	• Gus Vincent, Associate Director of Quality & Safety – October meeting

9. Deep Dive in to waiting list for MRI scans for Epilepsies in children, young people and adults, - update to be provided to the Committee	• Executive Director of Operations / Associate Director of Quality & Safety – October 2025
10. Congenital heart disease service - the transition from children's services to adult services, if not supported, can lead to young people being lost to follow up, 42% of patients in the region – detailed look into this and provide response.	• Executive Director of Operations – October Committee meeting
Escalation of issues for action by connecting group/Trust Board	**Responsibility / timescale**
• A recommendation would be made to the Trust Board to transition the Cardiac Oversight Group from being Non-Executive Director (NED) chaired to Executive chaired following positive correspondence regarding approval to resume Cardiac Surgery trainee provision.	• Anna Stabler – September Board
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Detailed within the BAF	

Agenda Item A12(a)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Quality Committee
Chair's Log

Meeting: Quality Committee	**Date of Meeting**: 14 October 2025
Connecting to: Audit Risk & Assurance Committee and Trust Board	**Date of Meeting**: 25 and 28 November 2025
Key topics discussed in the meeting	

- **Care Quality Commission (CQC)** – A general update on progress within the following areas were received details of which were included within the reports:
  - Emergency Department
  - Hepato-Pancreato-Biliary (HPB) Improvement Group
  - Well Led progress
  - Infection Prevention Control (IPC) Improvement Group
  - Deteriorating Child Improvement
- **Perinatal Quality Surveillance Report including Maternity Incentive Scheme progress -** The report provided the Quality Committee of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team. A number of items were brought to the Committee's attention as outlined in the report summary section with escalations noted, discussed and further escalation agreed within the meeting.
- **Patient & Staff Experience** - The report provided a comprehensive update on the quality of care experienced by patients, service users, carers, and families over the last 3 months. The Trust continues to make strong progress in rolling out its Real-Time Patient Experience Programme, a key priority in this year's Quality Account. The Trust continues to gather large-scale patient feedback, enabling detailed insights into care quality across all levels of the organisation. A detailed review of patient comments from August 2025 has provided valuable insights into areas of strength and improvement.
- **Duty of Candour Deep Dive -** Duty of candour (DoC) encompasses open and honest communication between healthcare organisations, patients and their families, when moderate or above harm has been caused to a patient during the provision of their care. The Trust continues to demonstrate strong performance in Duty of Candour (DoC) compliance, reflecting its commitment to transparency and patient-centred care. Efforts are underway to enhance the quality and clarity of DoC responses, ensuring they are more patient-focused and provide high-quality information.
- **Patient Safety Incident Response Framework (PSIRF) Bi-annual Report -** PSIRF replaced the Serious Incident Framework (SIF) in the Trust from January 31, 2024. The report provided an overview of the introduction of the PSRIF during year one. It highlighted

activities carried out 31st January 2025 to 31 August 2025 and the ongoing plans for 2025/2026. PSIRF continues to embed across the Trust, with encouraging progress in incident reporting and governance structures.

- **Wards of concern & Accrediting Excellence (ACE) Progress Report including progress on Quality Priority 4 [Expanding the Accrediting Excellence programme for wards and departments] -** This report highlighted wards of concern raised via the professional Nurse Staffing and Clinical Outcomes group (NS&O) along with an update on the Accrediting Excellence Programme (ACE) demonstrating progress against the Quality Account priority – Expanding the ACE programme for Wards and Departments. The Trust continues to monitor ward performance and staffing resilience, with targeted actions in place to address emerging concerns. The Accreditation for Care Excellence (ACE) programme continues to expand and drive improvements in ward safety and care standards.
- **Mortuary Privacy and Dignity update -** Significant progress has been made to enhance privacy and dignity within mortuary services across Trust sites, alongside strengthened governance and oversight.
- **AHP Workforce Update -** The report provided an update on the Allied Health Professions (AHP) Workforce, and related professional priorities, up to September 2025. The Trust has seen modest growth in its AHP workforce, with ongoing efforts to address retention and recruitment challenges. Workforce supply is generally healthy across most professions. The apprenticeship model is being used to support supply in high-risk areas.
- **The Integrated Quality & Performance Report** was presented which provided assurance to the committee on the Trust's performance against key Indicators relating to Quality & Safety, Access, People, Finance and Health Inequalities.
- **Legal Update & Learning from Claims -** The report outlined the number of claims and Inquests the Trust received in Q1-2 of 2025/26 broken down by speciality and claim type and highlighted learning from litigation and inquests. It also highlighted any legal matters arising in the reporting period which the Committee should be aware of.
- **Management Group Chairs Logs were received for the following:**
  - i) Patient Safety Group
  - ii) Medicines Management Oversight Group
  - iii) Experience of Care Group
  - iv) Promoting Equity in Health Group
  - v) Transplantation Committee
- **Summary of Internal Audit Reports relating to the Quality Committee** The report supports the Quality Committee in tracking progress and gaining assurance on internal audits aligned to its area of focus. All internal audits are now aligned to a relevant Trust Board Committee to support oversight.

Actions agreed in the meeting	Responsibility / timescale
1. Safeguarding Training compliance data not being logged correctly in ESR. A cross-reference will be made with the People Committee, to ensure oversight and assurance.	• Gillian Elesender, PA to Corporate Governance Officer - November Committee

2. Emergency Department (ED) update. Revised action plan be included in the Reading Room for the next Committee meeting in November	• Catherine Carr, Head of Nursing Medicine and Emergency Care Clinical Board – November Committee
3. HPB (Hepato-Pancreato-Biliary) Improvement Group. Engage North East Quality Observatory Service (NEQOS) to help define what data should be presented and map available data sources to clinical effectiveness.	• Rachel Carter, Director of Quality & Safety - November Committee
4. Infection Prevention Control - Further discussion would be held with the Executive Team the following day to review and potentially restructure the whole approach to IPC across the Trust which in turn would be escalated to Trust Board for oversight.	• Rob Harrison, Acting CEO and Ian Joy, Executive Director of Nursing – November Committee
5. Perinatal Quality Surveillance Report including Maternity Incentive Scheme Progress - next update includes an update in relation to the Qualified In Specialty (QIS) training and the implications for the Trust in terms of delivery of care and/or reputation	• Jenna Wall, Director of Midwifery – November Committee
6. QIS - escalate the issue of QIS training to the ICB for them to provide some dedicated focus.	• Richard Scott, Director of Nursing – ICB – November meeting
7. QIS - to raise this on behalf of the Trust at the North East & Yorkshire Nursing, Midwifery, and Allied Health Professionals Workforce committee	• Lynn Craig, Deputy Director of Nursing – ICB – November meeting
8. Patient and Staff Experience - a single assurance paper with an attached improvement action plan to be provided aligned with the “Waiting Well” initiative. This would provide a consistent and holistic view of waiting list management and its impact on patient experience.	• Lead to be determined for January Committee
9. Duty of Candour compliance – caveat added to the Integrated Board Report	• Rachel Carter – November Committee
10. Duty of Candour - A progress update will be brought back to the committee in three months as part of the Improvement Group updates, with a more detailed review in six months	• Rachel Carter – January 2025 and April 2026

Escalation of issues for action by connecting group/Trust Board	Responsibility / timescale
• Further discussion would be held with the Executive Team the following day to review and potentially restructure the whole approach to Infection Prevention Control across the Trust which in turn would be escalated to Trust Board for oversight.	• Rob Harrison and Ian Joy
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• Detailed within the BAF	

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

People Committee - Chair's Log

Meeting: People	**Date of Meeting**: 23 September 2025
Connecting to: Audit, Risk & Assurance Committee and Trust Board	**Date of Meeting**: 25 November 2025 28 November 2025
Key topics discussed in the meeting	

- The Committee received a HIV confident update which included the four objectives (prevent, test, treat and retain) and information regarding the importance of addressing stigma. Newcastle Hospitals is the first non-London Trust to become a HIV confident pioneer. It was agreed that the Executive Team would consider mandating the HIV confident package for all healthcare staff during the wider review of Statutory and Mandatory training.
- A Year 2 people plan update was provided in relation to the work that is taking place to communicate what the people plan aims to achieve in year 2 and actions that have taken place from year 1.
- An update on Behaviours and Civilities was received which included staff feedback from the Behaviour and Civility training delivered between October 2024 to June 2025 and a proposal for the next phase to build on the awareness raising and to enable the Trust to address persistent inappropriate behaviour.
- The Committee received an update on the Sexual Safety Charter Assurance Framework Audit which included the Trust's current position and proposed actions across all the ten charter principles. No immediate escalations were identified, but continued development of governance, training, and data reporting is recommended.
- The Freedom to Speak Up Guardians (FTSUG) provided an update on the FTSU service including the newly developed dashboard. A discussion took place regarding the format of future reporting to the People Committee.
- An update on the NHS national and local staff survey was received noting that the 2025 NHS staff survey will launch on 29 September 2025. All staff are encouraged to take part and as a thank you and to show that staff opinions are valued, staff who respond will receive a voucher for Greggs. The aim is to hit a target of 75% and Clinical Boards / Corporate Services will receive updates on their completion rates.
- The Committee received an update on the latest GMC trainee and trainer survey results. Whilst learning is being drawn and shared from positive areas, departments and directorates within the Clinical Boards are working on action plans to improve training and sufficient time for training where gaps and opportunities to improve have been highlighted.
- The 10-point plan to improve resident doctors' lives was discussed which sets out actions for NHS England (NHSE) and individual Trust's to act on within 12 weeks. Certain areas are already in place however this needs to be consistent for all resident doctors.

- A Communication update was provided which included the agreement of the interim strategy, reactive responses to media enquiries and the upcoming work in autumn such as the staff survey, flu vaccination launch, staff awards and winter operational communications.
- The Integrated Board Report was discussed in detail including the work that is taking place to better understand people establishment data with a view to producing dashboards to provide more intelligence. It was noted that sickness absence is an ongoing challenge and in relation to mandatory training, basic life support still needs to improve.
- An apprenticeship update was received in relation to the Trust's current position and urgent actions required regarding the apprenticeship levy, particularly relating to the Level 7 qualifications ahead of the December 2025 deadline.
- The Board Assurance Framework (BAF) was presented and since the last People Committee meeting, the risks have been reviewed by the Director of Commercial Development and Innovation. Two new actions have been added to the threats, these relate to the delivery of 2025/26 Equality, Diversity and Inclusion (EDI) priorities and consideration of additional workforce reduction schemes. A number of threat assurance levels have been updated to amber from red.
- A report was presented with regards to Deaths in Service and having looked at best practice nationally, and in the NHS sector, actions were proposed to strengthen the Trust's response and provide appropriate support to colleagues whenever there is a death in service.
- There were no new and emerging risks.

Actions agreed in the meeting	Responsibility / timescale
1. Year 2 people plan – it was agreed that the next update would include evidence regarding actions taken from the year 1 and year 2 and how the people plan has been embedded within Clinical Boards / Corporate Services.	1. Amy Callow, Associate Director of People and Organisational Development (OD) / November 2025
2. Behaviour and civilities – it was agreed that a discussion would take place regarding establishing a working group to develop the proposal for a proactive in reach service.	2. Amy Callow and Ashley Tiplady, Deputy Head of Education, Training and Workforce / November 2025
3. Sexual Safety Charter Assurance Framework Audit – an update to be provided at the November People Committee meeting on the specific actions required.	3. Amy Callow / November 2025
4. GMC trainee and trainer survey – the People Committee to receive an update at a future meeting early in the new year once progress has been made.	4. Lucia Pareja-Cebrian, Joint Medical Director / January 2026 or March 2026 [TBC]
5. Integrated Board Report – further information to be included in the next report regarding current vacancies versus the target.	5. Paul Turner, Head of HR Services / November 2025

Escalation of issues for action by connecting group	Responsibility / timescale
No new escalations.	Not applicable.
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
Risk ID 2.1 - Failure to improve and maintain an organisational culture, in line with our Trust values and our People Plan. Risk ID 2.2 - Failure to effectively manage organisational change and related leadership and governance required to ensure effective supporting structures with the new Trust operating model. Risk ID 2.3 - Failure to deliver effective workforce planning to allow the Trust to forecast and adapt to changing NHS healthcare landscape, financial constraints and address staff shortages and retention.	Not applicable.

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Finance and Performance (F&P) Committee - Chair's Log

Meeting: Finance and Performance Committee	**Date of Meeting**: 22 September 2025
Connecting to: Audit, Risk and Assurance Committee and Trust Board	**Date of Meeting**: 25 November 2025 28 November 2025
Key topics discussed in the meeting	

- The Surgical and Associated Specialties Clinical Board provided an update on their financial and Cost Improvement Programme (CIP) position. At month 5 the Clinical Board was underspent by £269k, with a year-end forecast of a £400k underspend. CIP delivery was ahead of the phasing plan at month 5, with £1.5m of £3.9m transacted and Elective Recovery Funding (ERF) was currently over-performing. Use of waiting list initiatives (WLI) had been paused and further significant savings were expected in relation to drugs savings through positive work undertaken with Pharmacy staff.
- In relation to the month 5 finance report, the Trust remains on plan with a deficit of circa £8m. Pressures have arisen linked to Industrial Action, the Pay Award underfunding and rising drugs costs which have necessitated the early application of non-recurrent measures to meet the planned position. The current forecast outturn position was to breakeven and Committee members discussed associated risks which included under performance of recurrent CIP and the cash position.
- An overview of the month 5 capital expenditure underspend and in-year capital pressures was provided, with the majority of the significant schemes noted to be on track. Committee members approved the additional capital request to upgrade the High-Level Infection Unit.
- Regarding submission of the proposal to establish a new subsidiary, business case approval was still awaited from NHS England (NHSE).
- The Integrated Board Report (IBR) was presented and the key areas highlighted were in relation to:
    - Publication of the NHS Oversight Framework, with the Trust being categorised in segment 2 for Quarter 1 performance, ranked 26 out of 134 trusts.
    - The five high level metrics which displayed changes in special cause variation since the last month were outlined, being never events, proportion of inpatient admissions where death occurred, Birmingham Symptom Specific Obstetric Triage System (BSOTS) initial triage within 15 minutes, Accident & Emergency (A&E) arrival to admission/discharge and cancer 31 day standard.
    - A deep dive into cancer and diagnostics took place highlighting the following areas:
        - The work underway to increase capacity to manage the seasonal increase in potential skin cancer referrals.

- The pathway mapping actions being taken to improve the Trust lung cancer performance e.g. through reducing pathway length via earlier scanning.
- Community Diagnostic Centre (CDC) capacity and utilisation.

- Committee members approved the sign off of the Winter Plan Assurance Template, as delegated by the Trust Board into the F&P Committee.
- An update was provided on the previous investment made into the Emergency Department (ED). Committee members discussed the key challenges which included improving ambulance handover performance, reducing corridor care and mental health support for patients in ED, with improvement work ongoing in these areas.
- The Board Assurance Framework (BAF) including the strategic risks aligned to the Committee was presented with the risk scores remaining unchanged. An overview was provided of the actions completed, new actions added, and a new threat and associated controls, assurances and actions added. Committee members agreed that the BAF report is received bi-monthly in line with the other Board Committees.
- The annual sustainability update was discussed with several recommendations agreed, including submission of the Annual Shine Report 2024/25 and the Carbon Reduction Plan 2025 to the Trust Board for approval to publish.
- An options appraisal was outlined regarding Stage 2 of the CDC.
- A procurement report regarding off-site printing was approved, as were minor amendments to the Capital Management Group Terms of Reference.
- Committee members endorsed the National Cost Collection submission.
- The Minutes and Chairs Log for tier 2 groups were received.
- Confirmation was received that the Trust was de-escalated from the tiering process for cancer.
- The Committee received the Chairs Logs and minutes of the Capital Management Group (July and August), Financial Recovery Steering Group (August) and Supplies and Service Procurement (July and August).

Actions agreed in the meeting	Responsibility / timescale
1. Annual sustainability report – Kelly Jupp, Trust Secretary to incorporate a session on sustainability into the Board Development Programme.	1. Kelly Jupp – 26 September 2025
2. National Cost Collection – Jackie Bilcliff, Chief Finance Officer to provide a future update on productivity considerations arising from the national cost collection data.	2. Jackie Bilcliff – 24 November 2025
3. Kelly Jupp to ensure 30 minutes of time is ring-fenced at the end of each meeting agenda for Committee members to discuss any private Committee business items.	3. Kelly Jupp – 20 October 2025
Escalation of issues for action by connecting group	**Responsibility / timescale**
1. Bill MacLeod, Committee Chair to escalate the ongoing financial challenges to the Trust Board. 2. Board decision needed regarding the options appraisal for the CDC.	1. Bill MacLeod – 26 September 2025 2. Sue Hillyard, Director of Operations – 26 September 2025
Risks (Include ID if currently on risk register)	**Responsibility / timescale**

• 6.1 - Failure to manage our finances effectively to improve our underlying deficit and deliver long term financial sustainability • 6.2 - Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care • 5.1 Failure to maintain the standard of the Trust Estate, Environment, and Infrastructure could result in a disruption to clinical activities and impact on the quality of care delivered.	F&P Committee

Agenda item A12(a)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

Finance and Performance (F&P) Committee - Chair's Log

Meeting: Finance and Performance Committee	**Date of Meeting**: 20 October 2025
Connecting to: Trust Board	**Date of Meeting**: 28 November 2025
Key topics discussed in the meeting	

- In relation to the month 6 finance report, there was no reported variance against the plan of £4.3m, despite pressures linked to Industrial Action, the Pay Award and Drugs (block and tariff). In terms of the Cost Improvement Programme (CIP), £42m of savings were delivered - Clinical Boards had delivered £12m against their £17m target and Corporate Services had delivered £3m against their £5m target.
- An overview of the month 6 capital expenditure was provided with capital expenditure to date being £19.8m against a plan of £25.3m.
- The Integrated Board Report (IBR) was presented and the key areas highlighted were in relation to:
    - Continued strong performance in electives, currently ranked 4th nationally for Referral to Treatment (RTT).
    - Progress made towards eradicating 78-week waiters, later than hoped, but still a significant achievement.
    - In terms of cancer, compliance with the Faster Diagnosis Standard (FDS) remained a challenge, primarily due to high volume of skin referrals.
- A deep dive into emergency care took place with the following points noted:
    - Accident & Emergency (A&E) admissions increased in August compared to July, and again in September.
    - Ambulance handover delays had dramatically improved, down to 17 in September 2025, a strong result reflecting recent efforts.
    - Improvements were seen in Paediatric performance and in Emergency Eye Casualty services.
    - The continuous flow model piloted last week with patients resulted in patients being sent to wards more efficiently.
    - Emphasis on adapting to patient volumes with a new operational approach.
- An update on planning for 2026/27 and beyond was provided. It was noted that the Trust were awaiting formal planning guidance, but preparatory work was underway. Clinical Board engagement has been initiated to ensure activity was reflected in job plans. The Equality and Quality Impact Assessment (EQIA) process had been embedded into the CIP programme, with plans to expand for quality cases from Clinical Boards.
- The Committee received an update on the Intellectual Property (IP) policy. Since the approval of the updated policy in April 2025, awareness of the content across commercial and research facing staff groups had been a key component of work. As such, 50 colleagues had been engaged, new content had been created on the Trust intranet and the team was in the process of creating an online training module.

- A commercial schemes progress update was received with a clear focus on maximising income from scheme growth, processes and adhering to strategic principles, which was having a positive impact on commercial growth and the pipeline of work. There continued to be an increasing commitment to supporting commercial growth from teams across the organisation, with discussions embedded into standard reporting and Trust structures.
- A summary of Internal Audit Reports relating to the F&P Committee was discussed. There were eleven internal audits within the Trust's 2025/26 Internal Audit Plan relating to the Committee areas of focus.
- A procurement update was provided which included progress to date regarding the CIP, Alliance work and scan 4 safety scheme.
- The Access and Improvement Delivery group Terms of Reference (ToR) were approved and it was noted that this group would report into the F&P Committee.
- A procurement report was ratified in principle and a future business case discussed.
- The Committee received the Chairs Logs and minutes of the Capital Management Group (September), Financial Recovery Steering Group (September), Supplies and Service Procurement (September) and Access and Improvement Delivery Group (September).
- A list of Business Cases taken to the Planning and Strategy Group and Financial Recovery Steering Group was received.

Actions agreed in the meeting	Responsibility / timescale
1. A cash update to be included on the November F&P Committee agenda.	1. Jackie Bilcliff, Chief Finance Officer / November 2025
2. Review of commercial schemes – a future update to include profit made, contributions to the Trust's financial position and potential future schemes in the pipeline for 2026 and beyond.	2. Wayne Elliott, Associate Director, Commercial Enterprise / December 2025 & January 2026
3. Summary of Internal Audit reports relating to the F&P Committee – the Committee to receive an update on the status of the internal audit plan.	3. Patrick Garner, Director of Performance and Governance / November 2025
4. Procurement report – further details to be clarified prior to the Private Trust Board meeting on 23 October 2025.	4. Dan Shelley, Procurement & Supply Chain Director / October 2025
Escalation of issues for action by connecting group	**Responsibility / timescale**
No new escalations.	Not applicable.
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
• 6.1 - Failure to manage our finances effectively to improve our underlying deficit and deliver long term financial sustainability • 6.2 - Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care	F&P Committee

• 5.1 Failure to maintain the standard of the Trust Estate, Environment, and Infrastructure could result in a disruption to clinical activities and impact on the quality of care delivered.	

Agenda item A12(a)

The Newcastle upon Tyne Hospitals
NHS Foundation Trust

Audit, Risk and Assurance Committee (ARAC) - Chair's Log

Meeting: ARAC	**Date of Meeting**: 23 September 2025
Connecting to: Trust Board	**Date of Meeting**: 28 November 2025
Key topics discussed in the meeting	

- The meeting action log was received and there were no matters requiring attention. The actions proposed for closure were agreed as complete.
- Key updates from the Digital & Data (D&D), Quality, Finance & Performance (F&P) and People Committee Chairs were shared:
  - Quality - World Health Organization (WHO) Surgical Safety Checklist – the Committee were supportive of the two outstanding internal audit actions being incorporated into the National Safety Standards for Invasive Procedures (NatSSIPs2) standards framework within the Trust. Work had been undertaken to ensure Chairs Logs from tier 2 feeder groups were routinely received by the Committee and it was agreed that tier 2 group meeting minutes would also now be added into the Committee Reading Room from October. Assurances had been received regarding Marthas Rule and the 104week wait harm review processes, with reporting re-routed back into the Patient Safety Group. A recommendation would be made to the Trust Board to transition the Cardiac Oversight Group from being Non-Executive Director (NED) chaired to Executive chaired following positive correspondence regarding approval to resume Cardiac Surgery trainee provision.
  - F&P - The challenging financial position and mitigation plans. Committee members discussed the deep dive into lung cancer performance and quality considerations in the pathway, linking through to the Quality Committee.
  - People – no updated shared as the Committee were scheduled to meet later the same day.
  - D&D - Committee members had further discussed the challenges associated with prioritisation of the vast number of digital projects. Challenges were highlighted regarding service desk performance pressures, effectiveness of care plans, Community Diagnostic Centre (CDC) bookings/utilisation and the data being shared as part of the two new commercial data partnerships. Committee members discussed the need to move to a more strategic focus, with digital risks to be explored further at the next meeting.
- Board Assurance Framework (BAF) – Updates to the BAF included the completion of actions, addition of new actions, controls, and threats; and updates to the assurance sections for some threats. Committee members approved the assurance rating recommendations proposed. The specific risk aligned to the Committee was discussed, with many actions completed. Committee members agreed that the Board Assurance Framework (BAF) report would be received bi-monthly.

- Risk Report – Following Committee feedback, rationales/updates on current risk positions were now included in the 15 or above risk report. As at 15 September 2025, the Trust held 375 risks (310 Open and 65 tolerated). A reduction in compliance with risk reviews had been observed within Clinical Boards, in part due to leadership changes in some Boards. Actions had been identified within the Risk Validation Group to improve compliance.
- Designated Individual Mortuary update – Report provided an update on regulated activity. It was proposed to strengthen governance arrangements through the creation of a new NED chaired Tissue Retention Oversight Group. A gap analysis on the Fuller review recommendations would be presented to future Executive Team and ARAC meetings. A Human Tissue Authority re-inspection would take place in October.
- New corporate offence update – an overview was provided of the new offence, with the focus on ensuring reasonable fraud prevention procedures are put in place. Key considerations include prevention procedures in community/smaller sites and taking a proportionate approach.
- Charity Annual Report and Accounts – The audited accounts were presented, accompanied by a clean audit opinion. Committee members discussed the change in the accounting treatment of legacies, use of restricted and designated funds and auditor reappointment.
- Health and Safety Annual Report 2024/25 – key report headlines were shared with Committee members. Discussion covered support for lone workers, incidents and Health and Safety Executive visits, equipment testing compliance and reducing violence and aggression incidents.
- The Schedule of approval of single tender action and breaches and waivers exception report was received.
- Committees Chairs Logs were received for the following Committee meetings:
  - F&PC – 21 July 2025
  - Quality Committee – 15 July 2025
  - People Committee – 21 July 2025
  - D&D Committee – 10 July 2025
  - Compliance and Assurance Group – 2 September 2025
  - Charity Committee – 8 July 2025 (Funding only)
- WHO Surgical Safety Checklist to NATSIPS2 (National Safety Standards for Invasive Procedures) – Committee members agreed that the 2 internal audit actions be incorporated into NatSSIPs2 as referenced earlier.

Actions agreed in the meeting	Responsibility / timescale
1. Risk Report – Lucia Pareja-Cebrian, Joint Medical Director and Patrick Garner, Director of Performance and Governance to discuss the feedback from Committee members on the frequency of risk reviews with Risk Validation Group meetings to determine whether the risk management policy requires any changes. Update to be shared at the ARAC in November 2025.	1. Lucia Pareja-Cebrian / Patrick Garner – 25 November 2025
2. Health and Safety Annual Report – Rachel Carter, Director of Quality & Safety to: a. Ensure that the next report includes an update on equipment testing compliance.	2. Rachel Carter – 25 November 2025

b. Update section 4 in the report to ensure the dates listed for policies and procedures are accurate, along with the quarterly report dates. c. Consider whether the stress in the workplace review group is required or duplicates work conducted in the Health and Wellbeing Group.	
Escalation of issues for action by connecting group	**Responsibility / timescale**
No specific escalations were identified for the ARAC.	N/a
Risks (Include ID if currently on risk register)	**Responsibility / timescale**
All BAF risks were detailed in the BAF report.	N/a

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Agenda item A12(b)

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 November 2025					
Title	Great North Healthcare Alliance					
Report of	Martin Wilson, Director Great North Healthcare Alliance and Strategy					
Prepared by	Martin Wilson and other members of the Alliance Formation Team					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☐	☒			
Summary	The paper provides an update on: 1. Great North Healthcare Alliance progress, specifically against the Strategic Objectives for 2025/26. 2. Governance – following from a discussion at the Alliance Steering Group there is an update on the proposed updates to the Alliance governance arrangements, specifically the Committees in Common and Joint Committee.					
Recommendation	The Trust Board is asked to note the progress made.					
Links to Strategic Objectives	Patients, People, Performance, Partnerships, Pioneering					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☒	☒	☐	☒
Link to Board Assurance Framework [BAF]	Risk 7.1 - Inability to sufficiently influence priorities of key partnerships (including the Great North Healthcare Alliance, the ICB, Provider Collaborative and Newcastle place arrangements) or to deliver on agreed commitments due to capacity or culture, impacting on our ability to effectively deliver local and regional healthcare commitments.					
Reports previously considered by	New report.					

GREAT NORTH HEALTHCARE ALLIANCE

1. PROGRESS UPDATE

The Great North Healthcare Alliance is a partnership between the NHS Trusts in Gateshead, Newcastle, Northumbria and North Cumbria.

As a reminder, the Alliance is overseen by an Alliance Steering Group that meets monthly in two formats, a Committees in Common with Board level members from all four trusts in the Alliance, and a Joint Committee with Board level members from Gateshead, Newcastle and Northumbria trusts. This arrangement reflects the greater delegated powers for some functions agreed between those three trusts as part of the development of the Alliance.

Trust Boards are asked to note appendix 1, a progress summary against the Alliance's strategic objectives for 2025/26 previously signed off by the Alliance Steering Group.

Boards should note that the Alliance trust Chief Executives are midway through a series of discussions to review the strategic intent and direction of the Alliance. It is expected that the substantive outputs of these discussions will be presented to and discussed with the Steering Group and Trust Boards in late 2025 and early 2026.

2. COMMITTEES IN COMMON

Since May 2025, Non-Executive Director representatives have attended the Committees in Common meetings as attendees, but not as members. This was initially to provide additional oversight and assurance over certain agenda items, but also helped correct against a perceived imbalance between the Committees in Common and the Joint Committee.

The Steering Group agreed that Non-Executive Director attendance at the Committees in Common should continue, with the same individual Non-Executive Directors attending as proposed in section 3 below. No changes are required to the Committees in Common terms of reference as there is space within these for the Committees in Common to "invite such persons as considered relevant". Non-Executive Directors attending would not have a vote or count to quoracy.

No other changes are proposed to the Committees in Common arrangements.

3. JOINT COMMITTEE MEMBERSHIP AND ATTENDEES

When the Joint Committee was established in January 2025 individual Non-Executive Director attendance was due to be reviewed after 12 months (see appendix 2, section 4). Whilst no substantive changes to the membership formulation of the Committee are proposed, a proposal was supported by the Steering Group that the attending Non-Executive Director members be updated to be Vice Chairs of the three 'East Coast' trusts

and we move away from specific Non-Executive Director portfolios being represented. This would reflect the movement to a Shared Chair for the three East Coast trusts.

The Steering Group also supported a proposal to add the Chair of North Cumbria and a Non-Executive Director as attendees at the Joint Committee (see appendix 2, section 5). This would remove the need for the Chair of North Cumbria Integrated Care NHS Foundation Trust and a Non-Executive Director to 'leave' an Alliance Steering Group mid-meeting where the Committees in Common and Joint Committee run concurrently, and ensure an equal visibility on issues being discussed across the four trusts.

The delegations to the Joint Committee will need to be updated prior to the next financial year, in particular the finance delegation which was narrowly defined to the contract negotiations for 2025/26 which have concluded. It is proposed that these be more substantively reviewed in early 2026 following the conclusion of the Alliance strategic intent discussions that are flagged in section 1 above.

Suggested topics that the Steering Group has mentioned at this stage include: medium term financial planning delivery, possible special-purpose vehicles, neighbourhood health, and use of digital solutions. Subject to these updated delegations, we might wish to have additional Non-Executive Director attendance at the Joint Committee to support the development of and provide assurance on specific pieces of work.

The above proposals would require amendments to the Terms of Reference. Subject to Trust Board views it is proposed that these amendments be made as one in early 2026.

Other considerations

Possible future arrangements – as we review the Alliance governance there is an opportunity to consider whether the Committees in Common and the Joint Committee should be streamlined into one Committee. The long-held ambition is for all four trusts to be members of the Joint Committee, and with the new membership and attendance arrangements at the Joint Committee mirroring the Committees in Common, Committees in Common business could be heard in the Joint Committee. Changes to this would require the Alliance Collaboration Agreement to be updated.

The Steering Group also considered the monthly frequency, timing and location of the meetings and agreed to not make changes at present.

4. RECOMMENDATION

The Trust Board is asked to note the update and Governance proposals for future approval.

Report of Martin Wilson
Director - Great North Healthcare Alliance & Strategy
20 November 2025

Note prepared by Great North Healthcare Alliance Formation Team: Andrew Edmunds, Northumbria, Martin Wilson, Newcastle; Nicola Bruce, Gateshead; Steve Park, North Cumbria

Agenda item A12(b)

Fair progress is being made on the 2025/26 priorities For the Alliance agreed in March 2025

Appendix 1

NHS
Great North Healthcare Alliance

25/26 Priorities	Progress to date	
• To have **addressed known weaknesses in services** across neighbouring trusts by working together as good bilateral partners	Positive executive level working together on bilateral basis. 3 bilaterals now in place and meeting monthly with a focus on problem solving particularly operational and performance issues in clinical services. Further to go, for example, through the planned North Cumbria: Newcastle Hospitals clinical summit, to ensure existing examples of working together at clinical lead and middle manager levels become the norm.	
• To have **improved productivity and efficiency** and reduced unwarranted variation in clinical and back-office services to become financially sustainable	This continues to be hard to do but is a recognised purpose of most Alliance work including bilaterals. Alliance benchmarking information on relative cost and efficiency of clinical and back-office services shared at Executive level and sometimes used at service level. Little push back on data quality. Progress mainly made in clinical pathways around operational and performance issues because that information is readily available, whereas a lack of information and comparable information on outcomes and experience. Improvements are needed regarding clinical or back- office leaders stepping forward to drive opportunities on Alliance wide basis, but some ideas surfacing on bilateral basis.	
• To have **shifted towards community and out of hospital care** and have secured support for our plan to transform care AND have fit for purpose buildings that enable us to deliver efficient high-quality care	Significant area of focus within Foundation Trusts (FTs) and with place-based partners to co-design neighbourhood work. Given additional emphasis by 10 Year Health Plan. Each trust at different starting point. Alliance level work focussing on levelling up FT offers to primary care and agreeing direction of travel regarding supporting Northumbria Integrated Health Organisation (IHO) ambition ahead of wider move to IHO model by other FTs. Alliance Construction Programme has continued market engagement with event in July and bilaterals due to complete September. Discussions focussed on current funded 4-year programme and indicative settlement ahead of the longer, as yet, unfunded ambitions. 4 trust estates and facilities senior teams discussing previously agreed priorities and greater collaboration.	
• To have **improved our digital services** so that staff find it easier to do their work and we have released back-office costs to reinvest in improving our services	Joint Chief Digital Officer (CDO) appointed across Northumbria, Gateshead and Newcastle. Current focus on stabilising safe digital foundations ahead of longer-term transformation ambitions. Work underway on structures inside the digital teams and operating model. Opportunities for efficiencies between services being identified. Scale of opportunities outlined in 10 Year Health Plan exceed current resource levels in some areas.	
• To have **deepened our collaboration** and strengthened our shared leadership as the NHS moves to a more decentralised model based on local leadership	Deepened collaboration and move to decentralised through; 3 bilaterals between FTs; strengthened neighbourhood planning work at place level with partners. Shared leadership evidenced by close working of CEOs; appointment of Shared Chair and Shared CDO across Gateshead, Newcastle and Northumbria; appointment of Trudie Davies within the Alliance to interim CEO at North Cumbria Integrated Care (NCIC); bringing Non-Executive Directors (NEDs) into Committees in Common; Alliance director and Alliance Formation Team (AFT).	

Milestones for 25/26 delivery (set summer 2024)	Progress	
Care Quality Commission (CQC) Good (or better) x 3	Improvements in performance in many areas. Newcastle Hospitals deescalated from previous CQC concerns. CQC rating change in 2025/26 not likely due to CQC internal rebuilding and reinspection programme. NHS Oversight Framework (NOF) ratings range from 1-4.	
Begin comprehensive review of NCIC sub/tertiary specialties with Newcastle Hospitals. Begin phased transfers of any agreed upon specialties	Closer Executive level working between NCIC and Newcastle Hospitals, including monthly bilaterals and planned Executive to Executive and joint Clinical Summit. Services prioritised for joint exploration. Collation of Service Level Agreements (SLAs) undertaken.	
Shared culture model and leadership programme in place	Culture is becoming far much more collaborative but work on a specific culture model not progressed. Sharing some leadership roles across Alliance. Some cross trust participation in leadership programmes.	
Joint recruitment campaigns in place to attract talent in high need areas – particularly in NCIC	Some collaboration around specific posts to aid recruitment. Discussions underway between Newcastle Hospitals and NCIC around models of joint appointments and other measures to aid recruitment.	
Clinical framework agreed – with information on estates & digital	Medical directors leading work to develop shared clinical principles ahead of likely developing a broader clinical framework in conjunction with directors of nursing and operations.	
Medium Term Financial Plan in place	Plan in development. Shared 3-year forecasts completed.	
Analysis of NCICs structural deficit and potential measures	Work undertaken by NCIC. Discussions with Directors of Finance as part of development of medium-term finance plan.	
Deliver significant improvements in quality and access towards recovery of constitutional standards	Alliance performance on each of the main access standards is improving (Accident & Emergency, Referral to Treatment, cancer 28 & 62 day, and diagnostics) but remains well below the best levels achieved historically.	
Compact written between primary and secondary care	Primary care workstream looking to level up offer from secondary care. Supports neighbourhood discussions.	
Early adopter Integrated Neighbourhood Health Service teams	Significant area of focus within FTs and with place-based partners to co-design neighbourhood work.	
Specialty Improvement Plans developed	Current focus is on doing these on bilateral basis. May become more of a feature of Alliance wide clinical pathway reviews on back of clinical framework currently being drafted by Medical Directors.	
Joint research and life science strategy agreed	Work underway with research and innovation focus. Big innovation event scheduled October 2025.	
Big Build: reviewed top 20 strategic sites for neighbourhood health centres; first Full Business Cases (FBCs) written; joint shared venture developed	Discussion regarding neighbourhood health centres part of place discussions. Alliance Construction Programme continued market engagement. Longer term ambitions unfunded. 4 FT estate teams discussing greater collaboration.	
Co-brand all initiatives Trust and Alliance	Examples include cobranding Community Diagnostic Centre, Big Innovation Conversation, Carol Service, website	
Review Joint Committee and lead director areas	6-month review of joint committee arrangements done by AFT with recommendations to next Steering Group.	
Aligned Staff Survey questions	Deprioritised as a current area of focus within overall workforce programme.	

Appendix 2 – Joint Committee Terms of Reference

GREAT NORTH HEALTHCARE ALLIANCE JOINT COMMITTEE

Terms of Reference

1. **Status of Joint Committee**

1.1 The Newcastle upon Tyne Hospitals NHS Foundation Trust, Northumbria Healthcare NHS Foundation Trust and Gateshead Health NHS Foundation Trust (the "**Trusts**") together with North Cumbria Integrated Care NHS Foundation Trust are parties to a strategic collaboration known as the Great North Healthcare Alliance.

1.2 To facilitate joint working across the Trusts, the Trusts have agreed to establish and constitute a joint committee pursuant to sections 65Z5 and 65Z6 of the National Health Service Act 2006 with these terms of reference ("**Terms of Reference**"), to be known as the "Great North Healthcare Alliance Joint Committee" (the "**Joint Committee**").

1.3 The Joint Committee is a committee of the boards of each of the Trusts and therefore its decisions are binding on each Trust. The Joint Committee is authorised by each of the Trusts' boards to carry out the functions set out in these Terms of Reference to ensure the Joint Committee can fulfil its purpose.

1.4 The Joint Committee does not replace the Alliance Committees, which are the committees in common established in accordance with the Collaboration Agreement by the Trusts and North Cumbria Integrated Care NHS Foundation Trust.

2. **Purpose of the Joint Committee**

2.1 The purpose of the Joint Committee is to ensure appropriate governance arrangements are in place to enable joint decision making in relation to the functions described in these Terms of Refence and the Annex which the Trusts have agreed to exercise jointly.

2.2 The Joint Committee will be responsible for setting the strategic direction and associated oversight of the functions described in these Terms of Reference and the Annex (“the Joint Committee Work Plan”).

3. **Responsibilities of the Joint Committee**

3.1 The general responsibilities of the Joint Committee are to:

3.2 formulate, agree and implement strategies for delivery of the Joint Committee Work Plan specifically finance, digital and research and life sciences matters and provide overall strategic oversight in respect of the Joint Committee Work Plan;

3.3 review and scrutinise strategic key deliverables and ensure adherence to the required timescales;

3.4 obtain assurance that all applicable law is being complied with in relation to the Joint Committee Work Plan;

3.5 review the risks associated with the Joint Committee Work Plan and the performance of any of the Trusts in terms of the impact of the Joint Committee Work Plan and recommend remedial and mitigating actions across the Trusts;

3.6 obtain assurance that risks associated with the Joint Committee Work Plan are being identified, managed and mitigated;

3.7 agree the overall budget, financial contribution and use of resources in respect of the Joint Committee Work Plan.

3.8 The Joint Committee has the specific responsibilities set out in the Annex to these Terms of Reference.

3.9 Functions not delegated to the Joint Committee in accordance with these Terms of Reference are retained by the Trusts' boards or other Trusts' committees.

3.10 Unless authorised by the Trust Boards or set out within the Scheme of Delegation, the Joint Committee may not:

3.10.1 form sub-committees;

3.10.2 pool budgets or establish any risk-gain share arrangements;

3.10.3 commit a Trust to any spend, loan or investment (including capital investment) or acquire or dispose of Trust property;

3.11.4 commit a Trust to enter into a contract, other than as permitted by these Terms of Reference; or

3.11.5 carry out any function which is governed by a statutory process or reserved in law to a statutory committee of a Trust, including constitutional amendments and Trust board appointments, or which may not be exercised jointly according to law or NHS England guidance.

3.11 The Joint Committee is authorised by the Trust boards to obtain independent legal or other professional advice and to secure the attendance of such persons with relevant experience or expertise at any meeting of the Committee.

3.12 In carrying out its functions, the Joint Committee will abide by the Nolan Principles and shall have regard to NHS England's statutory guidance on arrangements for delegation and joint exercise of statutory functions (as may be updated from time to time).

4. Membership

4.1 The members of the Joint Committee shall be:

4.1.1 the Chief Executive Officer of each of the Trusts; and

4.1.2 the Chair of each of the Trusts.

4.1.3 A Non-Executive Director from each of the Trusts, one whose Trust portfolio is Finance, one whose Trust portfolio is People and the other whose Trust

portfolio is Quality. The Non-Executive Director members will rotate with new members appointed every twelve (12) months.

4.2 Each of the members shall nominate a deputy to attend Joint Committee meetings on their behalf when necessary ("**Nominated Deputy**"), provided that:

4.2.1 the Nominated Deputy for a Non-Executive Director shall be a Non-Executive Director;

4.2.2 the Nominated Deputy for an Executive Director shall be an Executive Director; and

4.2.3 the Nominated Deputy must be a voting board member of the respective Trust.

4.3 Where Nominated Deputies are attending Joint Committee meetings on behalf of a member they shall be entitled to:

4.3.1 be counted towards the quorum of a meeting; and

4.3.2 exercise voting rights.

4.4 The Trusts will ensure that, except for urgent or unavoidable reasons, their respective member (or their Nominated Deputy) attends and fully participates in the meetings of the Joint Committee.

4.5 The first chair of the Joint Committee shall be the chairperson of Gateshead Health NHS Foundation Trust ("**Joint Committee Chair**"). The Joint Committee Chair will rotate between the Chairs of the Trusts every twelve (12) months.

4.6 In the absence of the Joint Committee Chair at any meeting, the members present shall nominate one of the other Non-Executive Director members to chair the meeting.

5. **Attendance by non-members**

5.1 The Joint Committee may invite such persons as considered relevant to any agenda item to attend meetings of the Joint Committee but such persons shall not count towards the quorum or have the right to vote at such meetings.

5.2 Attendance by non-members shall be recorded in the shared minutes of the Joint Committees.

5.3 Meetings of the Joint Committee will be regularly attended by:

5.3.1 the Chief Executive Officer of North Cumbria Integrated Care NHS Foundation Trust;

5.3.2 the Finance Director of Northumbria Healthcare NHS Foundation Trust;

5.3.3 the IT Director of Northumbria Healthcare NHS Foundation Trust,

5.3.4 the Director for Commercial Development and Innovation of the Newcastle upon Tyne Hospitals NHS Foundation Trust; and

5.3.5 at least one Member of the Alliance Formation Team.

("**Regular Attendees**")

5.4 Regular Attendees:

5.4.1 will receive advance copies of the notice, agenda and papers for meetings, unless the Joint Committee directs otherwise;

5.4.2 may be invited, at the discretion of the Joint Committee Chair, to ask questions and address the meeting;

5.4.3 will not have a vote and will not count for the purposes of quorum; and

5.4.4 will be reviewed on or before 30 June 2025.

5.5 Any non-member may be asked to leave a meeting, or part of a meeting, at the discretion of the Joint Committee Chair.

6. Meetings and decision making

6.1 Subject to the provisions of this paragraph, the Joint Committee may regulate its proceedings as it sees fit.

6.2 The Joint Committee will meet at least monthly, at a time and date consistent with the Alliance Committees in Common.

6.3 The members will be given no less than five (5) clear business days' notice of its meetings. This will be accompanied by an agenda and supporting papers which shall be sent to each member no later than five (5) clear business days' before the date of the meeting.

6.4 A member may give notice to the Joint Committee Chair that an urgent meeting of the Joint Committee is required. Where such notice is provided the Joint Committee Chair shall liaise with the members to arrange an urgent meeting.

6.5 Meetings of the Joint Committee shall take place in private to facilitate discussion and decision making on matters which are commercially sensitive or confidential.

6.6 For a meeting to be quorate each of the Trusts must be represented by one of their Executive Directors (or Nominated Deputy for their Executive Director) and one of their Non-Executive Directors. No decision may be taken at any meeting unless a quorum is present.

6.7 If any member is disqualified from voting due to a conflict of interest pursuant to section 8 of these Terms of Reference, they shall not count towards the quorum.

6.8 The Joint Committee will seek to make decisions on a consensus basis. Where consensus is reached the Joint Committee Chair shall ensure that the consensus agreement is understood by all members and it shall be recorded in the minutes.

6.9 Where the Joint Committee is unable to reach a consensus and the decision is put to a vote, the decision shall require unanimity to pass.

6.10 Each member shall have one vote.

6.11 Any member of the Joint Committee may participate in its meetings by secure telephone or video conference, provided that all members are able to hear each other such that they can contribute to discussions and decisions.

7. Administrative

7.1 Administrative support shall be provided by a Trust Secretary from one of the three Trusts. This responsibility shall rotate between the Trusts every twelve (12) months..

7.2 A schedule of meetings of the Joint Committee shall be drawn up for each financial year and circulated to the Trusts .

7.3 The agenda for the Joint Committee shall be determined collectively by the members.

7.4 The Joint Committee will prepare an annual report for the Trusts' boards on its performance.

8. Conflicts of Interest

8.1 Each member must declare any actual or potential conflicts of interests in relation to an item of scheduled or likely business at the start of each meeting. For the avoidance of doubt, where a potential conflict of interest arises during the course of a meeting, the relevant member must declare such conflict of interest without delay.

8.2 Declared conflicts of interests will be recorded in the minutes.

9. Reporting requirements

9.1 The Joint Committee shall provide such reports and updates as may be required each of the Trusts' boards from time to time which may include updates to board meetings in private or committee meetings.

9.2 The minutes of the Joint Committee shall be provided to the Trust Secretary for each of the Trusts for inclusion on the private agenda for each Trusts' board meetings.

10. Review and amendment

10.1 Subject to section 10.2, these Terms of Reference will be reviewed annually.

10.2 These Terms of Reference may be reviewed at any time to reflect strategic developments and the evolving nature of the work between the Trusts. Any amendments must be approved by the boards of the Trusts prior to amendments taking effect.

Annex 1 – Specific Responsibilities for the Joint Committee Work Plan.

Finance	• Agreement of activity and financial contracts with the Integrated Care Board for financial year 2025/26 for the three Trusts. • The Lead Director to be the lead negotiator, but will work closely with the respective Trust Finance Directors to do this as part of their respective statutory responsibilities.
Digital and Information Technology (I.T.)	• Specific activities in support of the Alliance Digital Ambition – as agreed at the Alliance Committees in Common. • Activities that cover: o Scoping project that identifies what action is required in each Trust to ensure strong and equitable foundations for future development. o Identification of any costs that are required to provide strong and equitable foundations across the three Trusts.
Research and Life Sciences	• Scoping project to identify and understand what activity is undertaken in each organisation, alongside specific opportunities for joint or collaborative projects in the future.

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Agenda item A13

The Newcastle upon Tyne Hospitals NHS Foundation Trust

TRUST BOARD

Date of meeting	28 November 2025					
Title	Health and Safety Annual Report 2024-25					
Report of	Rachel Carter, Director of Quality and Safety					
Prepared by	Craig Newby, Health, Safety and Risk Lead/Tim White, Head of Risk Compliance and Assurance					
Status of Report	Public	Private	Internal			
	☒	☐	☐			
Purpose of Report	For Decision	For Assurance	For Information			
	☐	☒	☐			
Summary	The purpose of this report is to provide the Trust Board with an update on health and safety activity across the organisation during 2024-25, in summary: • The report highlights effective assurance around the compliance with health and safety legislation. Moving and Handling compliance has improved over the period. The work around the self-harm risk assessment programme has meant the Health and Safety Inspection Programme has had to be halted temporarily. • Health and safety incidents remain relatively stable and within the upper and lower control levels; however, there have been slight increases in violence and aggression compared to previous years. The violence and aggression incident profile shows increases in both non-physical aggression and physical assaults on staff. • Slight increase in RIDDOR reportable incidents in 2024-25. The number of Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) reportable incidents for the period, has increased slightly, but statistically remains between the upper and lower control levels.					
Recommendation	The Trust Board are asked to note the content of the report and its findings.					
Links to Strategic Objectives	• Putting patients at the heart of everything we do. Providing care of the highest standard focusing on safety and quality. • Maintain compliance with all regulatory requirements.					
Impact (please mark as appropriate)	Quality	Legal	Finance	Human Resources	Equality & Diversity	Sustainability
	☒	☒	☐	☐	☐	☐
Link to Board Assurance Framework [BAF]	• Potential for harm to patients, staff and/or the public • Enforcement action from regulatory bodies.					
Reports previously considered by	This report is an annual health and safety update presented to the Health and Safety Committee, Compliance and Assurance Group, Audit, Risk and Assurance Committee (ARAC). This report was reviewed by ARAC in September 2025.					

HEALTH AND SAFETY ANNUAL REPORT 2024/2025

1. INTRODUCTION

The Health & Safety annual report covers the period 1 April 2024 to 31 March 2025. The annual report outlines key developments and the work that has been undertaken during this reporting period as well as a review of all health and safety related incidents. It reflects the Trust's compliance with the Board of Directors approved 'Statement of Intent' and Health & Safety Policy Statement, which requires those responsible for health and safety within the organisation and during Trust activities to:

- Comply with health and safety legislation.
- Implement health and safety arrangements.
- Comply with monitoring and reporting mechanisms appropriate to internal and external key stakeholders and statutory bodies.
- Develop partnership working and to ensure health and safety arrangements are maintained for all.

In progressing the management strategy of health and safety throughout the Trust, the Compliance and Assurance Team continues to observe the HSG65 model "Managing for Health and Safety". The key components of the Plan, Do, Check, Act (PDCA) framework can be summarised, as follows:

Plan Determine policy, plan for implementation.

Do Profile health and safety risks, organise for health and safety management, and implement the plan.

Check Measure performance, investigate accidents and incidents.

Act Review performance, apply learning. This framework directly maps with the PDSA methodology, Plan, Do, Study, Act

2. MEETINGS & ATTENDANCE

The Health and Safety Committee has met four times during the period 1 April 2024 to 31 March 2025 and achieved an attendance rate of 74%.

Members	20/06/24	19/09/24	11/12/24	13/03/25
Chair: Head of Risk, Compliance and Assurance				
Vice Chair: Deputy Director of Quality & Safety				
Director of Quality and Effectiveness				
Health Safety and Risk Lead				
Associate Director of Nursing				
Health and Safety Advisors				
Health and Safety Administrator				
Integrated Governance Manager				
Occupational Health Clinical Lead				
Estates Compliance and Risk Manager				
Portering and Security Manager				
Senior Human Resources Manager				
Workforce Development Manager				

Members	20/06/24	19/09/24	11/12/24	13/03/25
Directorate Manager				
Lead Moving and Handling Coordinator				
Integrated Laboratory representative				
Newcastle University Safety Advisor				
Staff Side Representatives				

3. TERMS OF REFERENCE

The Terms of Reference for the Health and Safety Committee were reviewed and approved by the Committee on 20th June 2024.

4. POLICIES & PROCEDURES

The policies below were approved by the Health and Safety Committee during the period 1st April 2024 to 31st March 2025.

Policy/Procedure	Date Approved
Pregnant Workers Policy	11/12/2024
Safe Use of Liquid Nitrogen and Solid Carbon Dioxide	11/12/2024
Latex Policy (not approved at Clinical Policy Group (CPG)- further review required)	20/06/2024
Lone Worker Policy	13/03/2025
Hand Arm Vibration Policy	23/07/2024
Workplace Temperatures – Advice and Guidance	19/09/2024
Personal Protective Equipment Policy	19/09/2024
Health and Safety Operational Policy	28/01/2025

Quarterly and annual reports received at the Health and Safety Committee during 1st April 2024 to 31st March 2025.

Quarterly Reports	Annual Reports / Strategies
Training	Radiation Protection
Estates Health and Safety	Security
Health and Safety Compliance	Health and Safety Annual Report
Inspection Programme	Moving and Handling
Health and Safety Incidents	Safer Sharps
Sharps Incidents	Violence Prevention and Reduction Strategy
Security	Young Workers Audit
Moving and Handling	Pregnant Workers
Health and Safety Risks	
Occupational Health	
Self-Harm Risk Assessment Programme	

Minutes for the following committees and groups were reviewed quarterly in 1st April 2024 to 31st March 2025.

Related Committee Minutes
Trust Security Group
Stress in the Workplace Review Group
Radiation Protection Committee
Dental Health & Safety Committee
Laboratory Health and Safety Committee
Violence Reduction Group
Safer Sharps Review Group
Datix / Inphase User Group
Latex Safety Group

5. TRAINING

The Health and Safety Team has successfully delivered 47 training courses during 1st April 2024 to 31st March 2025.

Courses	Number of Sessions
Risk Assessor	8
COSHH Assessor	9
Stress Training for Managers	8
Mental Health First Aid Courses	0
Ladder Safety Training	4
Breakaway Training	18

In addition to these courses, 273 staff also completed the Datix e-learning training and over 100 staff received ad-hoc lone worker device training comprising of both e-learning and face to face sessions.

6. LEGAL COMPLIANCE

The table below outlines the main Health & Safety (H&S) legislation and identifies the proactive work that the Trust has carried out in order to comply:

Legislation	RAG Rating	Description of actions/compliance
Health & Safety at Work Act 1974		Compliant, specific areas of assurance include: • Competent persons in place to help discharge legal duties. • Health and Safety Committee held 4 times a year – which are well attended. During 2024-25 the Committee met four times, in line with expectations.
Management of Health & Safety at Work Regulations 1999		Compliant, specific areas of assurance include: • H&S Inspection programme, all clinical areas audited on a 2-year cycle, requires audit actions to be addressed at service level within given timescales to ensure full compliance. Where possible these actions are completed during the inspection process. The Health and Safety Inspection Programme was

Legislation	RAG Rating	Description of actions/compliance
		halted in June 2024 to concentrate on self-harm risk assessments, which has weakened assurance. Plans to reintroduce the Inspection programme mid 2025-26. • Risk assessment training is provided to all areas and risk assessment paperwork has recently been reviewed. Requirement for role specific risk assessments, production, and quality of these is monitored via the audit / inspection programme. • The most recent Health and Safety Compliance audit showed the number of departments that have a trained risk assessor was 95%.
Control of Substances Hazardous to Health (COSHH) 2005		Compliant, specific areas of assurance include: • COSHH policy has been revised with enhanced guidance on the risk assessment process e.g. Dangerous Substances and Explosive Atmospheres Regulations (DSEAR). • COSHH Risk assessment form simplified in order to improve compliance with Regulation 6. • COSHH awareness included in all H&S Awareness training, Induction Training. • Specific half-day COSHH training provided monthly. • COSHH compliance reviewed in Ward areas as part of health and safety audit / inspection programme. • Post Care Quality Commission (CQC) work undertaken to ensure COSHH products, in clinical areas, are stored in line with policy. • The most recent Health and Safety Compliance audit showed the number of departments that have a trained COSHH risk assessor at 94%.
Display Screen Equipment Regulations 1992 Moving and Handling (M&H) Operations Regulations 1992		Compliance and specific areas of assurance include: • This policy aims to ensure that effective arrangements are in place for working with display screen equipment and to meet the requirements of the Display Screen Equipment (DSE) Regulations 1992 (amended 2003). To safeguard staff safety and comfort whilst working with DSE. • Moving and Handling Level 1 Training Figures - The required standard is 95% compliance with the overall compliance for the year being 93.46%. • Moving and Handling Level 2 Training Figures - The required standard is 95% compliance with the overall compliance for the year being 80%. • Current Compliance Audit M&H compliance score is 95%. • Office Chair Assessment Service - There have been a total of 330 referrals in 2024/25 compared with 235 referrals in 2023/24. • Overall, 39.24% of all departmental assessments were received by the Moving and Handling Team who experienced reduced staffing in 2024/2025 to support. The Moving and Handling Team have submitted an improvement plan to address this.

Legislation	RAG Rating	Description of actions/compliance
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR)		Minor non-compliance with reporting timeframes. • Process in place to highlight, review and report incidents meeting RIDDOR reporting requirements. • 75% of the reported incidents meet the over 7-day absence criteria. • Learning from RIDDOR incidents is shared at the Trust Health & Safety Committee and other respective assurance meetings. • Ongoing work undertaken to remind managers of reporting timeframes.
Health and Safety (Sharp Instruments in Healthcare) Regulations 2013		Compliance and specific areas of assurance include: • The Trust continues to monitor ordering practices to ensure compliance with the Regulations and use of safe sharps devices wherever reasonably practicable. Work continues to "mask" non-safe sharps devices from the NHS Supply Chain Catalogue to reduce ordering practices where not supported by underlying risk assessment. • Where safe sharps are not reasonably practicable, we continue to ensure and have taken steps to enhance robust risk assessment and mitigation measures are in place. The modified Medical Sharps risk assessment tool has been embedded across the organisation as risks are migrated over from the previous template. All new risk assessments are completed using this template and will transition across to the Inphase Document App during 2025-26. • Sharps disposal remains a priority, and the Safer Sharps Review Group continues to advocate the use of point of care disposal and use of SharpSmart sharps boxes. SharpSmart on wheels is now embedded in the Trust and our entire fleet of SharpSmarts continues to be updated systematically across all areas of the Trust. • Safer Sharps Review Group meet Bi-monthly with representation from a variety of Trust departments including Clinical Education, Procurement, Supplies, Sustainability & Waste and Patient Safety. • The Trust is currently on the 8th edition of the Safer Sharps Inventory. • The Datix system is integrated with a live dashboard to allow in-depth analysis of sharps related incidents to identify incident reduction initiatives across the organisation. This facility will be transferred across to the new Inphase system during 2025-26. • A new Safer Sharps e-learning package has been developed and has been incorporated into levels 1 and 2 of the Trust Infection Prevention and Control (IPC) training package, available on Learning Lab.

Legislation	RAG Rating	Description of actions/compliance
Health & Safety Information for Employees Regulations (Amendment) 2009		Compliance and specific areas of assurance include: • The H&S intranet page has been revised and transitioned across to the new Trust Intranet site during 2024-25. • Trade Union H&S Reps are in place. • Health and Safety Committee held four times a year is well attended by Managers, Trust Competent Persons, TU Representatives and H&S Coordinators: • Reports on Audits, Action Plan progress, Key Performance Indicators (KPIs) and Risk Register. • Health and Safety Committee acts as consultative committee for H&S policies, audit reports, action plan progress, and health and safety related risk register entries. • Staffside representatives also attend key subgroups to the Health and Safety Committee such as the Stress at Work Review Group.
Health & Safety Consultation with Employees Regulations 1996		
Safety Representatives and Safety Committees Regulations 1977		
Lifting Operations and Lifting Equipment Regulations (LOLER) 1998		Compliance and specific areas of assurance include: • Trust Lifting Operation and Lifting Equipment (LOLER) Policy introduced in November 2021. This policy has been extensively reviewed, and an updated version is due to be approved in June 2025. • Moving and Handling Team have a system related to gantry hoists that are assembled in a cubicle of a bariatric patient. • Electronics and Medical Engineering (EME) currently ensure all LOLER equipment meets the requirements of the regulations and are currently looking to introduce a new system, which would make them the first point of contact as opposed to the service company. • Estates have a comprehensive maintenance programme for all lifts ensuring this meets all LOLER requirements. • Passenger lifts falling under LOLER legislation are managed via the Estates Directorate including maintenance and records. Quarterly and annual Lift Safety Reports are presented to the Trust Electrical Safety Group. • A revised LOLER Policy will be introduced in 2025-26 to help clarify role specific responsibilities.
Provision and Use of Work Equipment Regulations (PUWER) 1998		Compliance and specific areas of assurance include: • Trust Provision and Use of Work Equipment (PUWER) Policy introduced in November 2021. This policy has been extensively reviewed, and an updated version is due to be approved in June / July 2025 to help clarify role specific responsibilities. • The Health and Safety Compliance audit includes a section for Estates around PUWER. In the Quarter 3 2024-25 Health and Safety Compliance Audit the Estates directorate scored 91%

Legislation	RAG Rating	Description of actions/compliance
		against the standards. Actions are in place to increase this to 100%. • Workshops have a general workshop risk assessment in place, and a template task/equipment risk assessment has been issued for comment and feedback with a view to implementation for all fixed work equipment, this will address specific PUWER requirements for each individual item. Workshop equipment issues continue to be discussed at both site and Estates wide H&S groups with training delivered to all joinery staff on their woodworking equipment. Estates are looking to source a suitable maintenance/training provider for mechanical workshop equipment due to the retirement of the previous service provider. Housekeeping issues continue with discipline specific initiatives ongoing to try and resolve.

7. HEALTH & SAFETY COMPLIANCE

Health & Safety Compliance audit results are reported quarterly to the Trust Health and Safety Committee for each Directorate. This compliance tool is an indicator of risk assessment completion across 16 common areas of health and safety which also include radiation and fire safety. The most recent report for Quarter 3 2024-2025 indicates that compliance across the Trust for the 16 general areas of health and safety is at 94% overall. There is ongoing work to further improve the quality of risk controls and close gaps in associated arrangements at service level.

All Departments are subject to a health and safety Inspection as part of a 24-month cycle to support local risk assessors and validate information collected under the compliance audit tool. Departments are provided with an action plan following each inspection. There have been 32 Health and Safety inspections undertaken during this period. The inspections have been undertaken across three Clinical Boards as part of the inspection programme. Along with other measures, the compliance and inspection arrangements support an overall reduction in harm. The inspection programme plays an important role in validating compliance, the development of safe systems of work, leading to improved risk controls whilst supporting services. Due to an increased demand to undertake self-harm risk assessments, the inspection programme was halted in June 2024, which is reflected in the reduced number of inspections undertaken during the period. To ensure continual improvement, the Health and Safety Inspection Programme will be reviewed and updated in 2025-26 prior to the programme being re-started.

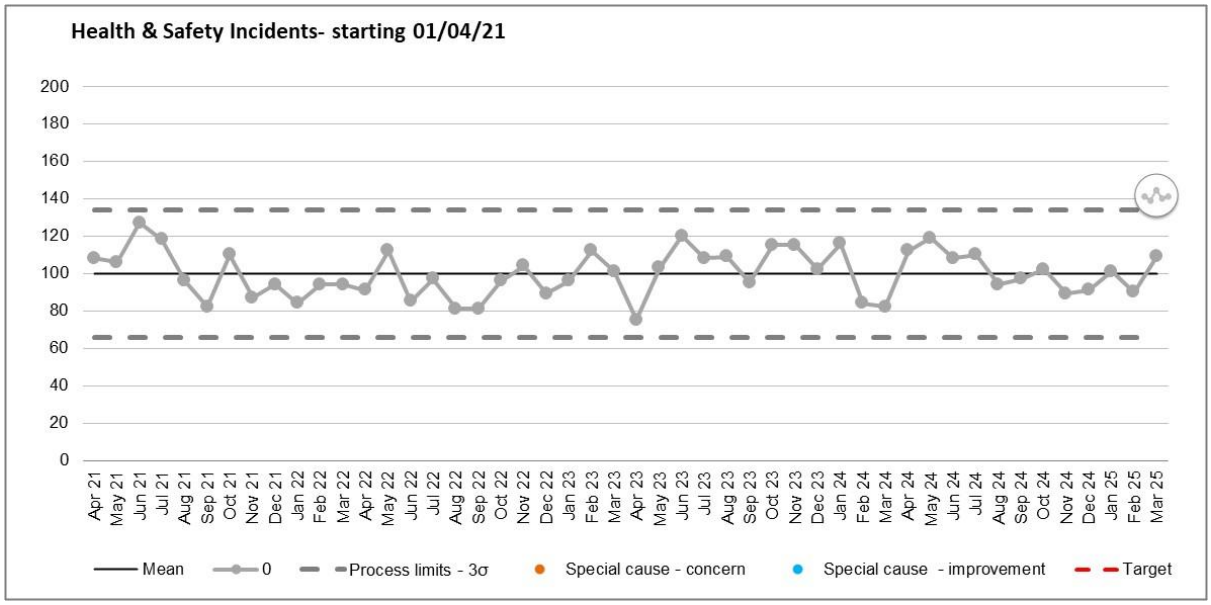
Following CQC inspection the self-harm risk assessment programme was reviewed and implemented. This involved the assessment of approximately 280 departments across the organisation. Findings were documented using CQC templates, uploaded to the new Inphase system and remedial work was undertaken in high-risk areas to further reduce the risk of self-harm. During 2025-26 further work will be undertaken to consider required

remedial work in medium and low risk areas and the self-harm risk assessment process will become part of the ongoing Health and Safety Inspection Programme.

The Compliance and Assurance department continue to work closely with the Estates department supporting the review of governance, monitoring and assurance measures around the Estates related functions of the Trust. Health and safety representation on key committees and groups continues to be provided.

8. HEALTH AND SAFETY INCIDENTS

The number and type of staff related incidents for each Directorate during the period of 1st April 2024 to 31st March 2025 is shown in table below. There is a very small increase (2 incidents) in health and safety incidents for 2024 – 2025 compared to the previous year, showing no statistical cause for concern.



The above Statistical Process Chart (SPC) shows health and safety incidents to continue to track close to the mean and there are no 'special cause' concern data trends over the previous 12 months.

Health and Safety Incidents by Category 2024-25

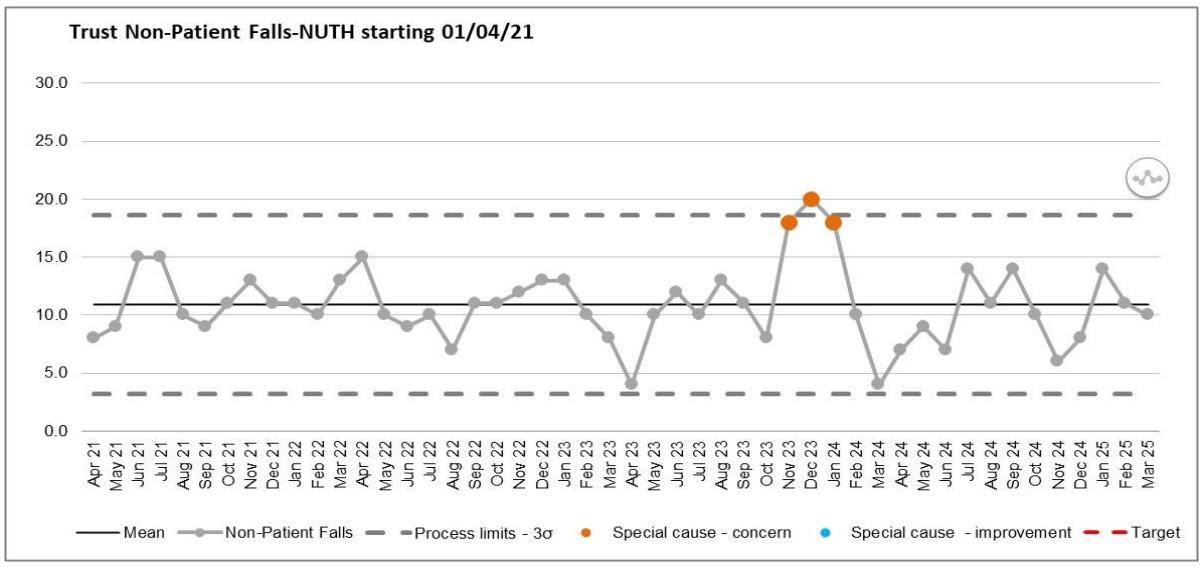
	Accident (involving staff, visitors etc.)	Buildings, Infrastructure or Environment	Exposure to Hazardous Substance	Facilities	Moving & Handling	Non-Patient Slip, Trip or Fall	Total

Business, Research, Innovation	6	0	2	1	0	2	11
Estates & Facilities	101	130	11	0	19	28	289
Finance	5	3	0	0	1	0	9
Human Resources	4	1	1	0	0	2	8
Digital and Technology Services	2	1	0	0	0	0	3
Patient Services	1	0	1	0	0	4	6
Family Health	98	22	11	0	6	16	153
Surgery and Specialist Services	80	9	6	0	1	9	105
Peri-Operative & Critical Care	106	11	22	0	12	8	159
Cardiothoracic	35	4	11	0	7	2	59
Medicine and Emergency Care	90	17	18	0	8	16	149
Surgical & Associated Specialties	43	3	12	0	5	9	72
Cancer and Haematology	21	2	5	0	3	5	36
Clinical and Diagnostic Services	69	16	40	0	17	18	160
External Trust / Organisation	0	1	0	0	0	0	1
Deputy Chief Executive	0	0	0	0	0	2	2
Total	661	220	140	1	79	121	1222

Incidents logged against Estates include incidents that occurred in general areas and do not reflect the number of incidents related to Estates staff. The number of incidents categorised under 'Accident (involving staff, visitors etc.)' includes needlestick injuries, which make up a majority of incidents within this category. These incidents are picked up in more detail in section 11 below.

9. SLIPS, TRIPS AND FALLS

A comparison of key slip, trip and fall types for staff and visitors for the period 2021 – 2025 is shown in the SPC chart below.



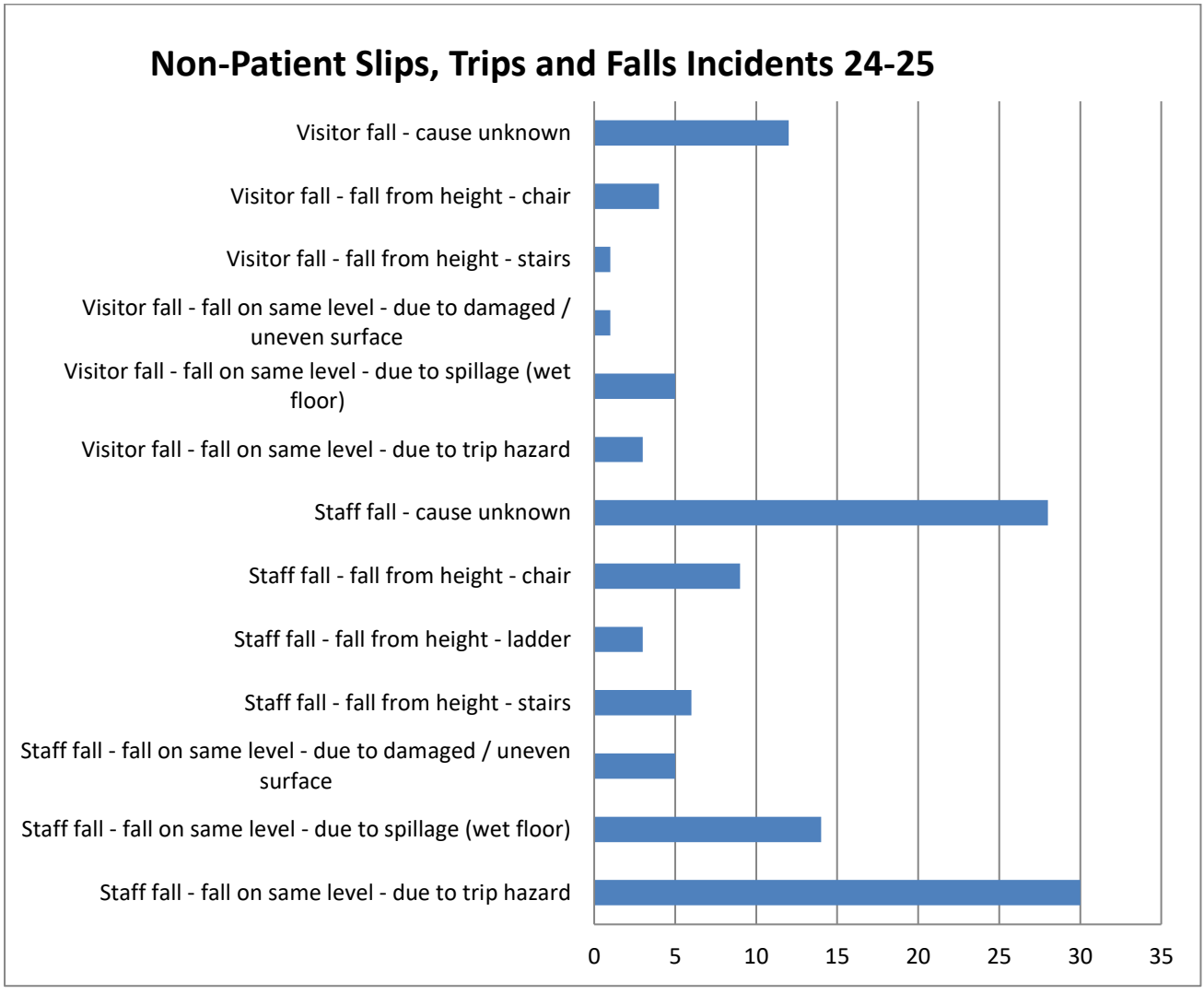
Non-patient slips, trips and falls have reduced this year from 138 in 2023-24 to 121 in 2024-25. This shows a moderately decreasing trend now mapping close to the mean and within the upper and lower control limits, shown above. The increase during winter identified

several incidents in relation to inclement weather; however, there were no significant themes and incidents were investigated and dealt with appropriately. During winter 2024-25 the number incidents fell significantly to well below average levels.

During the period 2024-25 there were no significant trends or themes that advocated the reinstatement of the Non-Patient Slips, Trips and Falls Group. As an assurance mechanism, this would be the expected future action should activity increase significantly, or specific themes are identified.

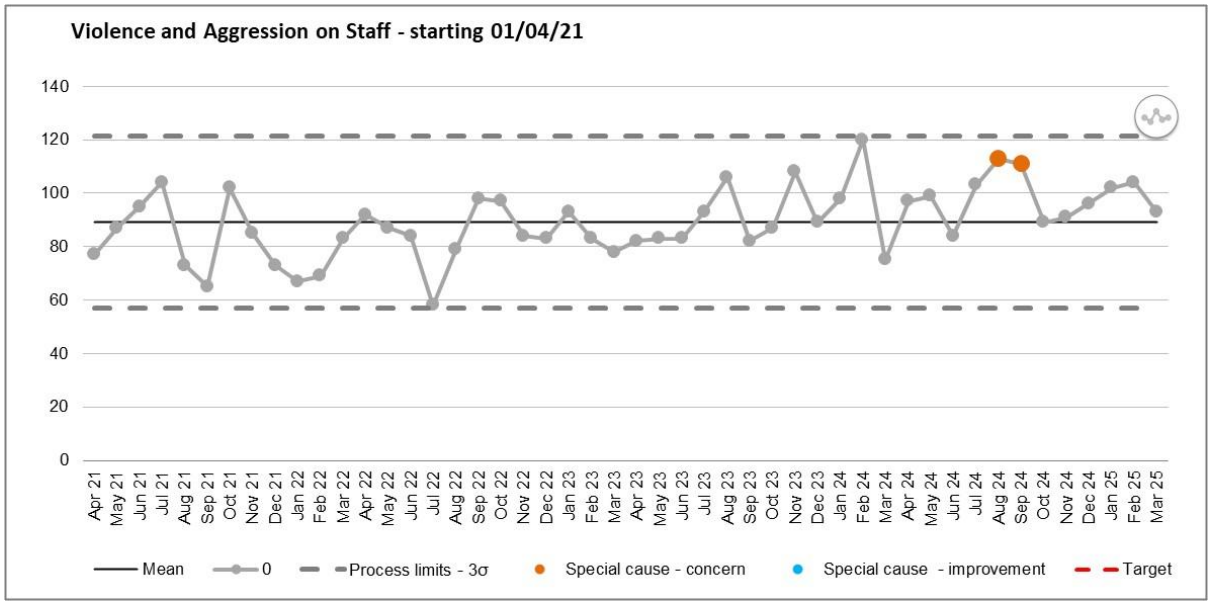
External zonal inspections continue to take place across main hospital sites, helping to identify and rectify any contributory factors and the non-patient slips trips and falls dashboard continues to provide valuable information for incident trends and analysis. All RIDDOR reportable falls have been investigated fully and where necessary remedial action has been undertaken, and lessons have been shared.

The chart below shows all non-patient slips, trips and falls by sub-category during period 2024-25:



10. VIOLENCE AND AGGRESSION

Violence and aggression rates have continued to fluctuate over the period; however, incidents have increased overall by 15% this year in comparison to 2023-24. The data shows a 6% increase in physical assaults on staff but a further 20% increase in non-physical aggression towards staff (almost 50% increase since 2018-19).



	18-19	19-20	20-21	21-22	22-23	23-24	24-25
Non-Physical	584	588	602	637	579	725	865
Racial	11	11	15	17	22	30	36
Sexual	9	13	11	17	23	28	28
Physical	259	273	257	305	387	331	350
Total	863	885	885	976	1011	1113	1279

Further analysis of data shows the Emergency Department (ED) and Security team reported almost 1 in 4 of all violence and aggression related incidents during period 1st April 2024 – 31st March 2025. There is a strong correlation around the increased number of Psychiatric Liaison referrals and violence and aggression within ED. This factored alongside challenging wait times generally, including delays for psychiatric assessment, a challenging environment, and delays in finding beds (both acute and mental health), creates a unique dynamic reflected in the incident data. Some of these issues fall outside the organisations control and regular dialogue with other agencies such as Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust (CNTW), Northumbria Police and social services are essential. Security plays a pivotal role in supporting the management of violence and aggression in clinical areas; particularly ED, which is supported in the figures below.

The Violent Marker Panel has approved the marking of 166 patient records during 2024/2025; this represents a very slight decrease from the previous year. The conflict resolution training programme is a requirement for all staff with a regular patient facing role. This programme equips staff to recognise the ways that violence escalates, helps identify the behavioural and physical signs in people and provides a range of de-

escalation techniques. At end of the period the training compliance for Conflict Resolution was 96% across the organisation. In addition to this, staff working in higher risk areas, such as community, Emergency Department, Intensive Care Units (ICU's), etc have been offered Breakaway training. During the period 159 staff have received training and further sessions are being funded into 2025-26.

A review of physical intervention (restraint) training provision for security staff was undertaken in 2018 and a more sustainable training model implemented (General Services Association accredited programme). Training compliance has fallen slightly to 69% during the period. There are plans in place to raise this to 100%.

One of the key objectives of the Compliance and Assurance team is the reduction of violence / aggression and restrictive interventions. Several workstreams are currently ongoing, for example:

- The Trust Violence Reduction Group continues to meet every quarter.
- Compliance with the amended version of the NHS England national standards for Violence Reduction.
- **Risk Assessments** – All wards and departments have violence and aggression risk assessments. In addition to this the wards / departments with the highest levels of violence and aggression have been assessed using an enhanced risk assessment tool. Risk assessment compliance is monitored via the quarterly health and safety compliance audit and the health and safety inspection programme.
- **Violence Reduction Initiatives** – Several clinical areas have highlighted preventative workstreams. For example, nationally recognised work within the Great North Children's Hospital (GNCH) focussing on conflict resolution with families and carers. Additionally, Surgery and Specialist Services have been utilising Ward Clerks to help identify any violence related flags for pre-admission patients.
- Clinical Environment is a known causal factor of violence and aggression and a number of workstreams have been established to identify a set of standards for room design, especially for patients that are neuro diverse, mental health concerns or have a learning disability.
- The ward-based violence reduction programme seeks the views of staff around the management of challenging behaviour and how that impacts on their wellbeing. The results of the initial survey are shared before deciding with the teams what initiatives can be adopted to help prevent and manage violence and aggression. For example, gaps in awareness around mental health, learning disability, personality disorders and addictions. Psychiatric Liaison have subsequently provided bitesize training sessions over a short period, which are generally well attended and evaluated.
- **Lone Working** – Over 1100 lone worker devices are in operation across the organisation, primarily with staff who work alone in a community setting. The devices provide staff with an easy and discrete method of raising the alarm and getting a rapid response from emergency services if required. Work continues to raise awareness with staff and ensure the devices are used to their maximum capacity.
- **Poster Campaign** – The Communication Team have recently designed new posters for consideration, which will be used across a number of formats during 2025/26.

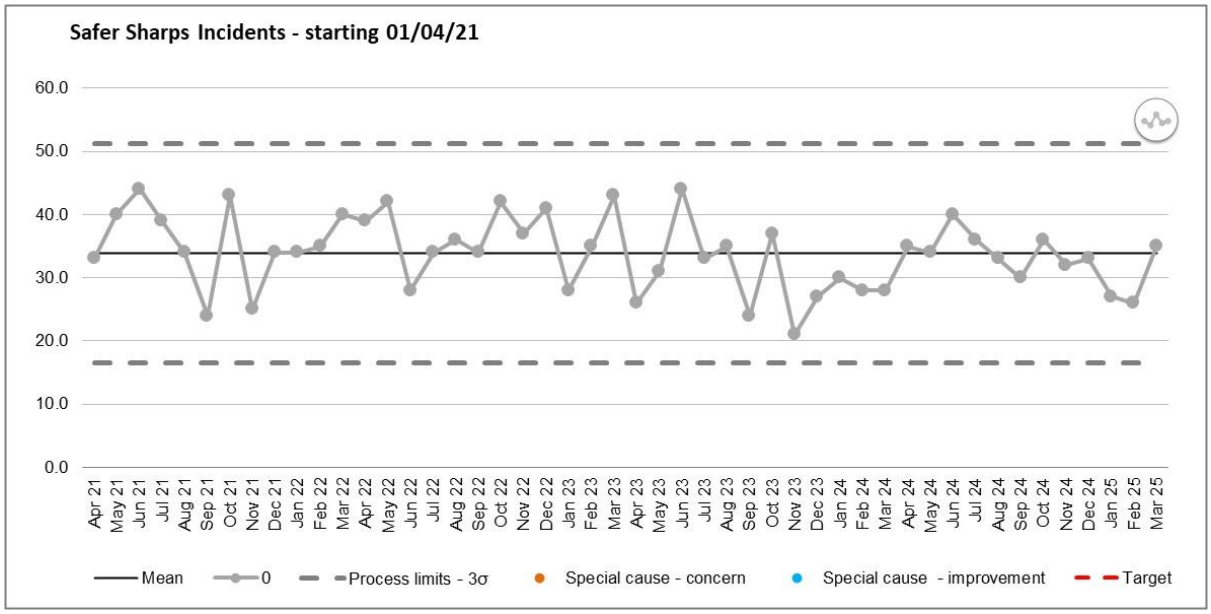
- **Patient Record Flagging System** – Information sharing remains a common theme and recent meetings have highlighted the need for this to be added to the Trust Risk Register, to identify a resource for sharing information across all internal platforms and the possibility of using a centralised part of Erecord to record all cards and alert flags.
- **ED Navigators** – ED Navigators have recently been introduced to ED in relation to social prescribing; however, this pilot did not work as well as expected. There are plans in place to re-introduce ED Navigators, during 2025-26, with a remit to reduce violence and aggression, which is funded by the Northumbria Police Violence Reduction Unit. These Navigator roles are based around reducing violent crime and engaging with patients who may be the perpetrators or victims of violent crime. Their aim, using tools such as social prescribing, is to support patients to lead lives away from violent crime.
- **Cosmic Officer** – The role of the Northumbria Police Cosmic Officer in ED has recently been extended. The Trust funds this role to act as both a deterrent and to help manage challenging behaviour in ED during busy times of the week.

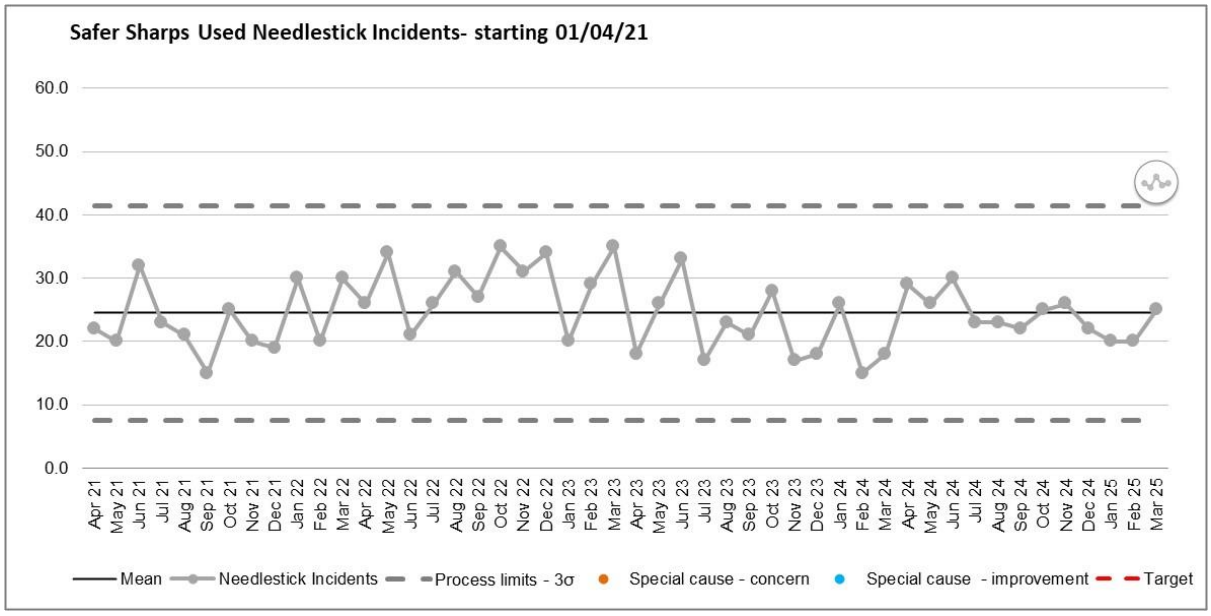
11. SHARPS INCIDENTS

The Safer Sharps Review Group met three times during 2024-25. During this time period the group has refreshed its membership and Terms of Reference (January 2024) and has a work plan for 2025-26. Work to date has focused on reviewing current assurance regarding the use of safer sharps devices in all appropriate clinical areas and ensuring risk assessments for use of non-safety devices (where reasonably practicable) are up to date and reflect robust safety practice. There continues to be a significant amount of work to improve the collection, analysis and evaluation of sharps data, including the development of a sharp's dashboard, with the aim of providing clinical boards and the Safer Sharps Review Group with thematic data, in order to be able to target interventions to reduce sharps injuries in the Trust. A further focus for the group is standardising and improving sharps education across the Trust, initially via an eLearning package and corporate induction.

A programme of work is planned to commence in May 2025, led by the Trust Medical Devices Co-ordinator and Senior Procurement Specialist, to review and update version eight of the Trust Safer Sharps inventory. The Waste Management team continue to contribute to the SSRG as a core member, recently trialling and implementing several different initiatives to reduce sharps related clinical waste in addition to reducing injuries related to disposal of sharps.

There were 397 sharps incidents during the period, of these 291 (12% increase on previous year) relate to dirty sharps with the remainder being clean or non-medical sharps incidents. None of these incidents were reported to the Health and Safety Executive (HSE) under RIDDOR requirements.





Further analysis of this data will be provided separately to the Health and Safety Committee and the Sharps Annual Report will be presented at the August 2025 meeting.

12. STRESS MANAGEMENT

The Stress in the Workplace Review Group (SWRG) met twice during 2024-25. Membership includes H&S, Occupational Health Service (OHS), Human Resources (HR), Staff Development, Health Improvement, Chaplaincy and Staff Side. The terms of reference were reviewed in June 2024-25 to reflect the current membership and challenges around quoracy. The Group reports to the Trust Health and Safety Committee. Its role is to ensure that the requirements of the stress policy are met and progress the development of arrangements to prevent and manage stress. The stress risk assessment process remains the main mechanism to manage work related stress including areas of stress related sickness

absence. The HR Department promote the process of supporting Clinical Boards in the completion of both service level and individual risk assessments. The Trust Stress risk assessment process is included in the manager induction programme. There has also been an ongoing series of monthly training sessions held across the Trust to instruct mangers in the risk assessment process, run by the H&S team. Occupational Health have also provided a number of one hour 'Managing Stress' seminars, which are online sessions open to all members of staff. The future of the group is currently being discussed and considered to prevent unnecessary duplication. It is possible the wellbeing elements of the terms of reference will be picked up by the Health and Wellbeing Steering Group, whilst compliance with HSE Stress Management Standards could be considered as a specific agenda item at the quarterly Health and Safety Committee.

Mental Health First Aid (MHFA) training was introduced across the organisation in 2016. The MHFA course teaches attendees to recognise the early signs of a mental health problem and the knowledge to provide help and support to staff across the organisation. A review of support for staff is currently underway (June 2025), which includes the ongoing provision and sustainable funding of the MHFA programme.

13. LONE WORKING

The Trust acknowledges the number of staff working in higher risk environments such as community-based nursing teams. During 2024-25 further devices have been added to the system with around 1100 devices now active across the Trust. During the year, further work has been undertaken to increase usage rates and ensure staff use the devices correctly.

Staff usage rates are based on staff leaving yellow alerts at each location they visit, leaving vital location information. During the period staff have activated 31,153 yellow alerts, slightly lower than the previous year. Further work is due to take place this year to enhance this further and continually work with staff teams to raise awareness around the importance of the lone worker system and the safety benefits it provides staff.
There have been no genuine red alerts during the period.

The results of this year's Lone Worker Survey highlighted a significant majority (76%) of staff find the device easy to use and 88% of staff carry their devices when working out in the community. The Compliance and Assurance Team have provided continued support during the period and ensure the submission of new devices and user information was both accurate and timely.

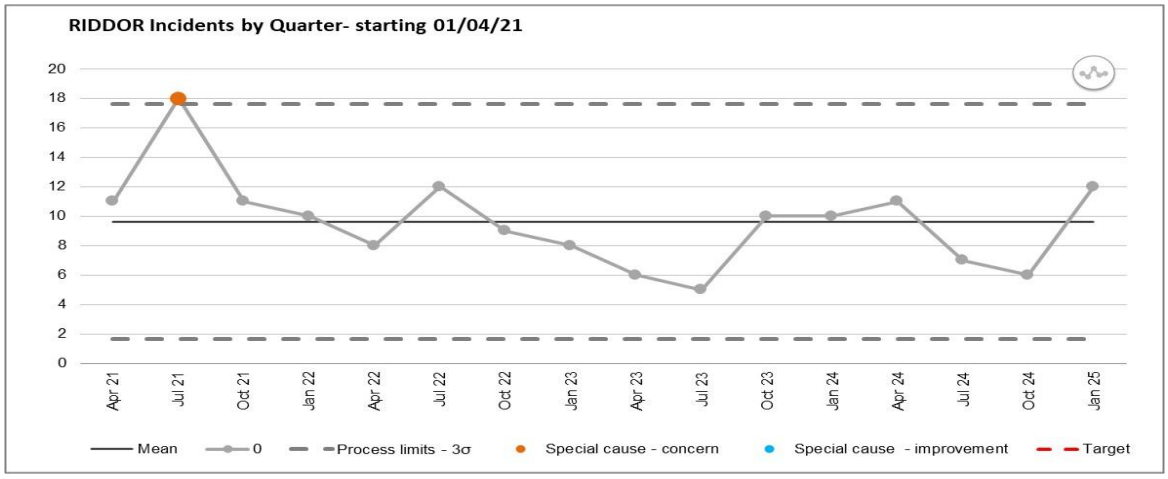
14. REPORTING OF INJURIES DISEASES & DANGEROUS OCCURRENCES REGULATIONS

There has been a slight increase in the number of RIDDOR incidents compared to 2023 - 2024 from 31 to 36 incidents in 2024 - 2025. There were 7 specified (major) injuries reported to the Health and Safety Executive. One of the incidents was reported as a Dangerous Occurrence and was in relation to the potential exposure of staff to Class 3 pathogens in the Micro-biology laboratory. This related to changes in the local exhaust

ventilation system, which impacted on the functionality of one of the safety cabinets. The remaining incidents reported were categorised as resulting in an over 7-day absence from work as a result of an injury. Eleven of these absences have resulted from moving and handling incidents (all of which have been investigated by the Trust Moving and Handling Team). Five incidents were related to violence and aggression. All RIDDOR incidents are investigated by the reporting directorate and the followed up by the supporting Health and Safety Advisor under the continuous monitoring and support arrangements undertaken by the Health and Safety Team.

	Aggression & Violence	Accident (involving staff, visitors etc.)	Equipment (Non Clinical)	Exposure to Hazardous Substance	Moving & Handling	Non-Patient Slip, Trip or Fall	Total
Apr 2024	1	2	0	0	2	0	5
May 2024	0	1	0	0	1	1	3
Jun 2024	2	0	0	0	0	1	3
Jul 2024	0	2	0	0	0	0	2
Aug 2024	0	2	0	0	0	0	2
Sep 2024	0	1	0	0	0	2	3
Oct 2024	1	1	0	0	0	1	3
Nov 2024	1	0	0	0	0	1	2
Dec 2024	0	1	0	0	0	0	1
Jan 2025	0	3	0	0	0	1	4
Feb 2025	0	0	1	0	0	4	5
Mar 2025	0	2	0	1	0	0	3
Total	5	14	1	1	3	11	36

The SPC chart below shows the trend around RIDDOR reporting since quarter one of 2021. Further analysis of the latest financial year found a range of different types of incidents across several Directorates. There were no significant themes or trends to indicate why numbers remain relatively high.



15. EXTERNAL INVESTIGATIONS

During this period there were no health and safety-based investigations undertaken by external agencies.

16. RISK REGISTER

A Risk Management update report is provided at each meeting of the Health and Safety Committee. This is for Committee oversight, as the management and review of risks is the responsibility of each Clinical Board/Speciality through their Governance Meeting structures.

The report details Trust-wide high rated risks (12+) that are aligned to the Health and Safety Committee's areas of focus. The report also reflects the Trust's Risk Appetite for those risks linked to Quality Outcomes – **Safety**, Effectiveness, Experience where the Risk Appetite is *" Low*" (*) and the Risk Tolerance Score is between 6 to 10, namely *"We have a LOW appetite for risk taking in relation to Quality Outcomes. We will take measured and considered risks to improve and deliver quality outcomes where there is potential for long term benefit, however we will not compromise the quality of care we provide or the safety of the patients in our care."*

The Committee will also receive details and the rationale for any closed risks.

17. DATIX / INPHASE DEVELOPMENTS

During 2024-25 the compliance and assurance team started to develop plans to move the Trust quality and safety management system from Datix to Inphase. This included a detailed tendering process and business case to support the progression over to the new Inphase system. This extensive work has developed into a comprehensive implementation project to support the roll out of a number of applications including Incident, Policies and Guidelines, NICE, Central Alerting System, Risk, Customer Feedback and Legal. The scope and demand of this work, on the Compliance and Assurance department should not be underestimated and it's expected this work will extend well into 2025-26 to also include the eventual closure of the Datix system and migration of all relevant information to the new Inphase platform. During this changeover period, work has focussed around improving the incident reporting culture of the organisation. Early indications suggest incident reporting is improving, and this is expected to continue as the new system becomes embedded in day-to-day practice.

18. RECOMMENDATIONS

The Trust Board is requested to receive the report and endorse the developments.

Report of Rachel Carter
Director of Quality and Safety

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The Newcastle upon Tyne Hospitals NHS Foundation Trust

PUBLIC TRUST BOARD

Date of meeting	28 November 2025		
Title	Board Assurance Framework Report.		
Report of	Patrick Garner, Director of Performance and Governance.		
Prepared by	Natalie Yeowart, Head of Corporate Risk and Assurance.		
Status of Report	Public	Private	Internal
	☐	☐	☐
Purpose of Report	For Decision	For Assurance	For Information
	☐	☒	☐
Summary	This report aims to support the Trust Board to gain assurance that strategic risks aligned to the committee are being managed effectively; that risks have an appropriate action plan in place to mitigate them; and that risk scores are realistic and achievable. **Quality Committee** **Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.** Key points to note: • The risk has been reviewed by the Executive Director of Nursing. • The current risk score remains at a score of 15(5x3). • Three new actions have been added on threats: develop a comprehensive mental health audit programme, develop freedom to speak up guardian plan and improve duty of candour documentation. • 2 actions are currently behind plan and new timescales have been added: develop new approach management of guidelines/standards and care optimisation group 12-month priorities. • Further controls have been added to Medicine management threat: medicines management internal audit – reasonable level of assurance and Failure to successfully develop and nurture a positive safety culture threat – freedom to speak up guardian in place. • Minor wording changes have been made to the Maternity threat specifically changing references to perinatal quality surveillance to perinatal quality oversight. **People Committee** **2.1 Failure to improve and maintain an organisational culture, in line with our Trust values and our People Plan.** **2.2 Failure to effectively manage organisational change and related leadership and governance required to ensure effective supporting structures with the new Trust operating model.** **2.3 Failure to deliver effective workforce planning to allow the Trust to forecast and adapt to changing NHS healthcare landscape, financial constraints and address staff shortages and retention.** Key points to note: • The risk has been reviewed by the Director of Commercial Development and Innovation.		

- All current risk scores remain unchanged.
- Additional controls added in relation to: MARS scheme, workforce reduction oversight group establishment, workforce reduction targets allocated to each Clinical Board and each Corporate service and vacancy freeze from 1st – 22nd Oct.
- Following Board Development Session with Grant Thornton it was indicated that further work is required in the People domain and therefore a full comprehensive review of the BAF risks will be completed following receipt of the Grant Thornton Well Led Report.

Finance Committee

6.1 Failure to manage our finances effectively to improve our underlying deficit and deliver long-term financial sustainability.

6.2 Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care.

5.1 Failure to maintain the standard of the Trust estate, environment, and infrastructure could result in a disruption to clinical activities and impact on the quality of care.

Key points to note:

- Strategic risks have been reviewed by The Chief Finance Officer, Director of Performance and Governance and Deputy Director of Estates and Facilities.
- All risk scores remain unchanged.
- Actions have been completed relating to ICB planned cash payment, review and update of performance reporting, submission of NOF provider capability assessment and implementation of frailty care model.
- New actions have been added relating to consideration of NHSE cash management guidance, review of cash management and control, capacity and demand template completion, development of NHS Oversight Framework metrics, outcome of NHS Oversight Framework capability assessment and governance rating, pathway changes to improve ED performance, review of cancer pathway, review of priority estates and equipment replacements and free Freeman Ward 12 as decant facility to allow for ward refurbishments.

Digital and Data Committee

Failure to deliver and improve the digital capability required to support the delivery of safe, effective and efficient patient care.

Key points to note:

- A new strategic principal risk was proposed to the Committee 'Failure to deliver and improve the digital capability required to support the delivery of safe, effective and efficient patient care.
- Three associated threats to achieving the principal risks were proposed:
  1. Increased risks relating to foundational digital tasks superseding priorities over strategic goals.
  2. Lack of staff skill set and resources to deliver digital plans.
  3. Lack of available financial envelope to deliver digital priorities.
- Initial actions have been added in relation to digital roadmap, review of operational needs relating to digital plan, baseline resource review, recruitment of a Deputy CIO, baseline review of skillset across digital workforce and the implementation of a new digital organisational structure.
- All threats have an assurance level of red.
- Current risk score is 20.

Audit Committee

<table>
<tr><td></td><td colspan="6">Failure to implement effective governance systems and processes across the Trust to assess, monitor and drive improvements in quality and safety.
Key points to note:
Risk scores remain unchanged.
2 Actions have been completed relating NHS Oversight Framework Capability Assessment and Risk Management Intranet page and guidance.
3 new actions have been added in relation to the development of in year capability assessment process and monitoring, NHS Oversight Framework metrics alignment to Accountability and autonomy framework and confirmation of NHSE review of capability assessment submission and confirmation of Trust governance rating.
Trust Board
Inability to sufficiently influence priorities of key partnerships (including the Great North Healthcare Alliance, the ICB, Provider Collaborative and Newcastle place arrangements) or to deliver on agreed commitments due to capacity or culture, impacting on our ability to effectively deliver sustainable local and regional healthcare commitments.

Key points of note:
Risk scores remain unchanged.
2 actions have been completed relating to Alliance formation team establishment and join Alliance governor event held.
1 action timescale has been revised relating to Alliance strategic intent considerations.
Assurance rating remains green.</td></tr>
<tr><td>Recommendation</td><td colspan="6">The Public Trust Board are asked to:
Approve the Board Assurance Framework.
Provide any feedback or comments.</td></tr>
<tr><td>Links to Strategic Objectives</td><td colspan="6">Links to all strategic objectives.</td></tr>
<tr><td rowspan="2">Impact
(please mark as appropriate)</td><td>Quality</td><td>Legal</td><td>Finance</td><td>Human Resources</td><td>Equality & Diversity</td><td>Sustainability</td></tr>
<tr><td>☒</td><td>☒</td><td>☒</td><td>☒</td><td>☐</td><td>☒</td></tr>
<tr><td>Link to Board Assurance Framework [BAF]</td><td colspan="6">N/A</td></tr>
<tr><td>Reports previously considered by</td><td colspan="6">Executive Leads and Committees of the Trust Board, Audit, Risk and Assurance Committee.</td></tr>
</table>

BOARD ASSURANCE FRAMEWORK 2025/2026 – NOVEMBER 2025

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. These will be individually rated by the lead committee noting the level of assurance they can take that the actions will be effective in treating the risk (see below for key)

Committee assurance ratings:

Green (significant) = 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
- no gaps in assurance or control AND current exposure risk rating = target
OR - gaps in control and assurance are being addressed.
Amber (moderate) = 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 (limited) = 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.**

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Inability to maintain and improve patient safety and quality of care that delivers the highest standards of care and outcomes for our patients.	**Strategic objective**	1. Quality of Care will be our main priority.

Lead Committee	Quality Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Nursing	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Quality and Safety
Date Added	01.05.2025	**Likelihood**	**4**	**3**	**1**	**Risk Appetite Tolerance**	Low
Last Reviewed	10.11.2025	**Risk Score**	**20**	**15**	**5**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (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 with an enhanced focus on shared learning and a systems-based approach to improvement, creating a psychologically safe environment and listening to staff and patients.	• Patient Safety Incident Response Framework (PSIRF) went live in January 2024. • Central supportive governance infrastructure to deliver the PSIRF • The Quality Governance Framework is underpinned by Quality Oversight Groups (QOG's) in each Clinical Board. • Response Action Review Meetings. • Policies and Procedures. • Patient Safety Incident Forum. • Incident reporting system. • Clinical Risk Group. • Rapid Quality and Safety Peer Reviews. • Freedom To Speak Up Guardian.	• Response Action Review Meeting /Patient Safety Incident Forum minutes and actions plans. • Strengthened quality of learning responses by ensuring a standardised approval methodology is used. • Monitoring of compliance with PSIRF timeframes for learning responses. Power BI dashboards shared at Clinical Board QOG's and Quality and Performance Reviews. • Regular PSIRF update reports to Patient Safety Group. • Integrated Quality Report to Quality Committee. • Oversight through Clinical Board Quality. Oversight Group, reported into Quality and Performance Reviews and the Executive Team. • CQC Delivery Group and CQC Assurance Group oversight. • Staff Survey – demonstrates increased response rate of 65%. • Clinical Risk Group reports and sharing of learning, national patient safety alerts etc. • Rapid Quality and Safety Peer Review Paper to Quality Committee December – demonstrates 93% trust compliance with assessment framework. • Freedom To Speak Up biannual report to Trust Board.	• Develop and embed a positive reporting and safety Culture evidenced by pulse survey and staff survey and monitoring of reporting – January 2026. • Delivery of CQC action plan – Actions on track to be completed by deadline, please see CQC phase 2 action plan document for exact timescales. • Reporting of Duty of Candour improvement to Quality Committee – actions required to support staff to improve documentation of verbal DoC and improve quality of DoC letters. Update to Quality Committee Jan 2026, formal report April 2026. • Deliver 25/26 Quality Priorities. Aim for 3% increase in incident reporting and 90% of all staff will have received training in Patient Safety by 31st March 2026 • Development of Trust-Wide Quality and Safety plan – in draft, working group in place to ensure engagement, launch April 2026. • Recruit Patient Safety Partners from the Trust Participation & Involvement Panel – December 2025. 1 in post. • Implement NAtSIPPS framework Trust-wide by – Oct 2026. • Development of a Freedom to Speak Up Guardian Plan – December 2025.	**2- Actions defined – most progressing, where delays are occurring interventions are being taken.**	

Failure to safeguard and deliver care in line with the Mental Health Act and Mental Capacity Act.	• Mental Capacity Steering Group. Mental Health Committee. • PLT meetings with core services. • Restraint Review Group. • MCA Quarterly audit framework. • Health and Safety Committee. • Patient Experience and Engagement Group. • MCA training programmes/compliance. • Learning Disability Steering Group. • LeDeR review group. • Environment review completed on two areas of concern highlighted in Trust CQC report, along with areas of high risk. • and MCA oversight by Safeguarding Committee/Quality Committee/Trust Board. Learning Disabilities oversight by Experience of Care Group/Quality Committee/Trust Board • Mental Health Awareness Training (specific packages for high-risk staff groups e.g. Security staff) • Core quarterly mental health assessment metrics agreed. • Self-Harm Risk Assessment Programme	• The number of Mental Capacity Act (MCA) forms being completed before DoLS form submissions has been steadily increasing, now up to 92% from 84% (Q1). • Evidenced switch between sub-standard and minimal requirements of MCA quality, which has increased from 27% (Q1) to 41% (Aug-Sept), with good quality increasing from 14-15%. Sub-standard assessments have therefore reduced from 59% (Q1) to 44% (Aug-Sept). • Audit of 60 patients who have a Learning Disability flag. 16 assessments of capacity were completed in total. All of which were appropriately documented in the ADhoc MCA form. • Of the 16 MCA 1 forms completed, 6 (38%) were of minimum standard, 10 (62) were of a good standard • MHA provider review recommendations, action plan and evidence of completion. • Learning Disabilities and MCA reporting and minutes to Safeguarding Committee/Experience of Care Group/Quality Committee and Trust Board. • Compliance with Mental Health Awareness Training (98.1% June 25). • Quarterly mental health assessment audit framework. • Self-Harm Risk Assessment Programme complete; remediation commenced in January 25 for high risk areas. • Training Video to support reasonable adjustments launched and documentation of reasonable adjustment pilot commenced June 2025. • The Self Harm Risk Assessments are on InPhase	• Level 2 MCA training programme launched and mandated for all relevant staff - compliance to 90% by June was not achieved. Current compliance 81% with aim to achieve 90% target in Q3 • Agree long term training framework for Learning Disabilities and Autism, ICB. National expectation of the Oliver McGowan Training confirmed. • Development and approval of phase 2 Self Harm Programme of Estates works (Medium/Low risk areas – January 2026.) • Draft of Learning Disability and Autism Strategy completed. To consult and finalise by end of Q3. • Develop comprehensive MH audit programme in development – November 2025.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Failure to achieve best practice clinical standards and associated recommendations/actions.	• Clinical Audit and Guidelines Group. • Clinical Outcomes and Effectiveness Group. • Get It Right First Time (GIRFT) oversight group. • Clinical Effectiveness metrics. • New Interventional Procedures Group. Review • Stocktake of progress with Clinical Board Quality Oversight Groups completed. • Stocktake of progress with clinical board QoGs. • Review of QoG activity presented to Quality Committee in October 2024.	• Clinical Audit and Guidelines Group minutes and Action plans. • Clinical Outcomes and Effectiveness Group (COEG)minutes and action plans. • Bi-annual Reports to Quality Committee. • Bi-annual Clinical Audit Report to ARAC. • GIRFT Oversight Group reports and minutes. • Minutes and reports of New Interventional Procedures including Robotic Surgical Group- reports to COEG. • Quality Oversight Group dashboards. • Initial stocktake of QOG activity completed in May 2024-shared with CB's. • Clinical Board Governance Internal Audit – audit report – reasonable assurance.	• Design and implement a standardised quarterly quality reporting mechanism/dashboard including communications and guidance for clinical boards to report into Quality Performance Reviews (QPR). This will include compliance with all metrics e.g. GIRFT/NICE via Inphase risk management system – April 2026. • Review and develop new processes for management of Trust non-compliance with standards/guidelines - propose organisational approach to Quality Committee – report to Quality Committee April 2026.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Gaps in assurance regarding compliance with policy and best practice relating to medication safety, storage, security and learning from medication incidents. This could directly impact care quality and safety	• 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. • Care Quality Commission (CQC) Delivery Group. • 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.	• Monthly audit data of ward and department compliance with core standards with dissemination of learning and action. • Policy audits undertaken and reported through medicines management committee. • Datix data and trends relating to medicines management reported and reviewed. • Peer review and external review reports and audit data. • CQC Delivery Group monitoring, reporting and minutes. • Compliance and Assurance Group reporting and minutes. • Quality Governance Structure via quality committee and Trust Board. • September Rapid Quality and Safety Review Audit Data. • Medicines Management (NUTH 2024/25-17) internal audit – Reasonable level of assurance.	• Actions as outlined in MMOG Action Plan.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Failure to improve the safety and quality of patient and staff experience in Maternity Services.	• Maternity Incentive Scheme and Three-Year action plan in place. These are reported into Quality Committee and Trust Board. • Robust Perinatal Patient Safety Team in place • Maternity Operational Oversight Group (MOOG) • Board Maternity Safety Champions • Incident Review Group • Women's Quality and Safety Group • Family Health QOG • Monthly Maternity Staff meetings • Maternity Voices Partnership - Lead quorate member of Quality and Safety Group and	• Improvement action plan in place covering all core CQC must and should do moved to business as usual with reporting via MOOG. • SOF Enhanced Surveillance Exit meeting and review of evidence with ICB and LMNS completed in May 2025, exit agreed with return to routine oversight via LMNS from June 2025. • 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. • Project PROMISE spend plan aligned to staff	• Maternity Services phase 3 investment plan – December 2025.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**	

	Obstetric Board member. • LMNS (Local Maternity and Neonatal System) oversight of Quality Oversight Model (PQOM) metrics and Maternity Incentive Scheme. • Real time patient/staff experience programme. • Workforce review including outputs of 2024 birthrate plus. • Refreshed perinatal governance structure aligned to themes of Three-Year Plan for Maternity and Neonatal care, reporting into Obstetric Board. • NENC Clinical Outcomes Dashboard and safety signal review process. • Review and refresh of Perinatal Quality Oversight Metrics. • Perinatal Anti-Racism Taskforce (PART) and associated action plan. • Staff wellbeing and cultural improvement plan. • Perinatal senior nurse/midwife on call introduced August 2025.	wellbeing and cultural improvement plan. • Obstetrics Board. • Reporting and oversight into Quality Committee and Trust Board • Maternity Services Quality Dashboard and NENC Clinical Outcomes Dashboard. • Annual CQC Maternity Survey results – improvement in some domains, no reduction in results, improved position in NENC ranking. • CNST/MIS compliance. • Incident data • Incident review group reporting and actions. • Family Health meeting minutes and QOG minutes. • Perinatal staff experience programme. • Workforce review outputs and report. • Peri-natal quality oversight metrics monitored and reported to Quality Committee. • Midwifery staffing and red flags monitored and • reported to MOOG and Quality Committee in Integrated Board Report.			
Failure to embed the learning from external service reviews.	• Cardiac Oversight Group • Cardiothoracic Improvement plan, including improvement actions from CQC and other external reviews. • NUTH Quality Improvement Group • Quality and Performance Reviews • Review infrastructure of quality oversight and local governance groups.	• Cardiac Oversight group reporting and minutes. • Reports to Trust Board and Quality Committee • Maintenance of central external review log • Central oversight of implementation of recommendations and monitoring of action plan completion via Quality and Performance Reviews • Compliance and Assurance Group Reports and Minutes.	• Development of dashboard framework for Clinical Board oversight of actions/areas for improvement by April 2026. • Design and implement a standardised quarterly quality and safety reporting mechanism for clinical boards to report into QPRs to be developed as part of the Inphase – April 2026.	**2-Actions defined-most progressing, where delays are Occurring interventions are being taken.**	

Failure to deliver and adopt digital optimisation initiatives that drive measurable improvements in patient safety and quality of care.	• IT Town Hall, engagement sessions and Staff Roadshows. • Trust-wide adoption coaches appointed. • Digital Health Team Care optimisation project. • Digital leaders' group. • Care optimisation group. • Care Planning Task and Finish Group. • Minimum Nursing Documentation Standard • Care planning training. • Nursing documentation audit framework • Patient correspondence/letters audit to validate Clinical Board processes to maintain oversight of timeliness of completion of correspondence • Secondary review of all systems' functionality in relation to patient correspondence/letters. • Digital care planning Reporting to Quality Committee. • Digital Clinical Educators appointed • Refreshed induction training for all staff when onboarding into the organisation • Digital and Data Committee providing oversight to Trust Board • Digital improvements prioritisation and oversight.	• Presentations slides, staff roadshow sides and feedback from staff. • Supplier assessment based on site visit. Regular main Electronic Patient Record (EPR) supplier engagement. • Power BI report of all discharge summaries in all areas in real time. • E-record reminders to clinicians of encounters that require discharge summary. • Care Planning Task and Finish Group Action Plan. • Review of core care plans – 6 core care plans released in to live system – increased usage of care plans since launch 40,265 used as at December 2024. • Standardisation of nursing documentation – end of shift inpatient, critical care and paediatrics introduced into live system. • Care planning training now available within the EPR • Nursing documentation audit framework – document standards now in place, aligned to trust guidelines. • Power BI report available to all clinical boards for routine validation of various aspects of care including safety assessments, dementia and delirium, IPC, VTE, Lines and Devices. • Secondary review of all system functionality in relation to patient correspondence and letters provided positive assurance relating to processes in place. • Digital care planning report received by QC in April 2025. • Digital improvements identified through quality and safety forums into the Care Optimisation Group for prioritisation, oversight and tracking.	• Completion of Care Planning Project – April 2026. • Standardisation of use of SystmOne commencing with template audit – January 2026 • Care optimisation group to share priorities for the next 12 months – This has been delayed, now expected December 2025. • Define the organisation digital capacity to inform structured delivery plan. Refining capability for optimisation, enabling timely implementation of change. – Dec 2025 • Development of regular communication cycles to the organisation to inform staff of the planned work – October 2025. • Review and optimisation of current systems used to create and send clinical correspondence, including discharge summaries, operation notes, clinical letters – March 26 • Clinical hardware refresh to be undertaken. – Starting Sept 25, completed by March 26	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Failure to embed effective systems and processes to recognise and prevent avoidable Hospital Acquired Infections	• 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	• IPC Board Assurance Framework document. • IPC Operational Group and Committee minutes and action logs • Integrated Quality Performance Report with an overview of IPC and HCAI metrics reporting to Committees of the Trust Board. • IPC Committee minutes and reports. • Local, regional and national benchmarking data • Clinical Board QOG and Governance meeting minutes and action logs. • Clinical Assurance Tool results • Rapid Quality and Safety Peer review results and action plans demonstrates 93% trust compliance with assessment framework.	• Implementation of IPC Improvement Group to provide oversight of HCAI reduction strategies and assess level of assurance of compliance with policy and procedural standards – group to be implemented by September 2025 and action plan and reporting framework to be in place by November 2025.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

	support Clinical Board 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.	• Quality and Performance review minutes and action log • Clinical Board improvement plans in place in areas of high occurrence of HCAI.			

Risk ID	1.1
Comments:	

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Failure to implement effective governance systems and processes across the Trust to assess, monitor and drive improvements in quality and safety.	**Strategic objective**	1. Quality of care will be our main priority.

Lead Committee	Audit, Risk and Assurance Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Performance and Governance	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	Compliance and Regulatory
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	16.11.2025	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Failure to implement effective integrated governance focused on clinical quality, risk, finance, and performance Ward to Board.	• Revised corporate governance structure and reporting arrangements in place. Clinical Board Governance arrangements established including QOGs/QPRs/directorates. • Audit, Risk and Assurance Committee established. • CQC delivery group established. • Clinical Board Risk Registers. • Risk Validation Group • Recovery Oversight Group • Cardiac Oversight Group • Clinical Assurance Group • Review of QoG activity presented to Quality Committee in October 2024. • CQC phase one action plan. • CQC phase two action plan. • Clinical Board Governance Audit. • Access and Improvement Delivery Group Established to provide greater oversight and governance in relation to performance and productivity metrics. • Trust Interim Strategy. • NOF Trust Capability Self-Assessment	• Terms of Reference – committees of Board. • Minutes of committee meetings. • Committee schedule of business. • Corporate Organograms. • Minutes of QOG/QPR and directorate governance meetings. • Effective governance system report to Trust Board. • CQC delivery group minutes and action plans. • Quality Performance Reviews and summary to Board and relevant committees. • External Tabletop Governance Report. • External leadership and governance review. • Feedback at IQIG • Internal audit of CQC phase one action plan – substantial assurance received. • Internal audit of CQC phase two action plan – reasonable assurance received. • Clinical Board Governance Audit – reasonable assurance received. • Access and Improvement Group ToR and minutes. • Trust Interim Strategy in place, plan on a page accessible to staff on Intranet. • NOF Trust Capability Self-Assessment completed, and Trust Board Development Session delivered to review assurances and agree final self-assessment rating – Compliant agreed.	• Deliver Board Development programme 25/26 – March 2026. • Operationalise Accountability Framework including monitoring/governance and review mechanisms – January 2026 • Develop Trust Governance Handbook – February 2026. • Develop 5-year strategy – March 2026. • Commission and complete External Well-Led review- Underway, complete, awaiting final report – December 2025. • Complete Ward to Board Review of Governance – March 2026. • Develop in year NOF capability assessment process – January 2025. • NOF metrics to form accountability and autonomy framework and measured across the Trust – January 2026. • Await NOF Capability Assessment outcome and governance rating – December 2025.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Failure to embed escalation processes and ensure executive oversight.	• Performance and accountability framework. • Standardised reporting and governance. • Clinical Board development plan in place. • Quality performance review process. • Executive Leads for clinical boards. • Reporting hub dashboards. • Quality Oversight Group Evaluation. Risk Management Dashboard. • Clinical Board Governance Audit.	• Performance and accountability framework document. • Clinical board reporting and minutes. • Performance review reports and minutes. • Clinical Board Chairs update to Executive Team. • Quality Committee Quality Oversight Evaluation Report, June 2024. • Clinical Board update report presented to Trust Board. • The value circle report on QPR process. • The value circle report on effective governance Audit One Risk Management and Board Assurance Framework Core Audit – Good level of assurance received. • Clinical Board Governance Audit – reasonable assurance received.	• Operationalise Accountability Framework and Autonomy framework including monitoring/governance and review mechanisms – January 2026. • Complete Ward to Board review of Governance – March 2026.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Failure to implement effective risk management including clear escalation and accountability.	• New risk management policy. • Refresh of risk management governance and reporting. • Quality and Safety leads appointed. • Risk Validation Group established. • Audit, Risk and Assurance Group established. • Risk management dashboard. • Executive Team lead assigned to CBs. • Refresh of risk management training for risk system users. • Engagement with clinical boards. • Implementation of risk decision tool -risk vs issue. • Risk Management SOP. • Refreshed Board Assurance Framework. Implementation/engagement risk refresher sessions provided to risk system users. • Risk Management and Board Assurance Framework Risk and compliance based internal audit. • Risk management induction video for all staff. • Inphase Risk Application Training. • Risk Appetite Statement. • Risk Management Intranet page.	• Risk Management Policy document and associated guidance. • Reporting, accountability, and escalation structure. • Terms of reference and minutes for the risk validation group • Historical risk trajectory. • Risk management dashboard. • Reporting to CQC Delivery Group weekly. • Risk management training TNA. • Clinical board risk presentation. • Embedded into clinical board governance arrangements – qog minutes and reporting. • Audit, Risk and Assurance ToR, minutes, and Reports. • Clinical Risk reporting to Quality Committee. • Quality Performance Reviews and summary report to Board • Risk management and Board Assurance Framework risk and compliance based internal audit – good level of assurance. • Risk Induction Video available on learning lab. • Inphase Risk Application Training now rolled out to all existing users. • Risk Appetite Statement Approved at Trust Board. • Risk Management intranet created with key guides, advise, contacts and supporting information for all staff.	• Implement further strategies to support ward/departmental level risk identification and documentation – work now underway to roll out Inphase system, delayed due to resource April 2026. • Develop Risk Management Strategy – March 2026. • Develop Risk Management Intranet page with– October 2025 • Develop Risk Appetite methodology – April 2026. • Further development and improvement of Inphase Risk System – March 2026.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Risk ID	1.2

Comments:

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Failure to manage our finances effectively to improve our underlying deficit and deliver long-term financial sustainability.	**Strategic objective**	6. We will take our responsibilities as a public service seriously, carefully managing our money and performance.

Lead Committee	Finance	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Chief Finance Officer	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Finance/VfM
Date Added	08.05.2025	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	11.11.2025	**Risk Score**	**25**	**20**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
ERF activity plans do not sufficiently deliver activity targets and therefore increase financial risk to the Trust.	• 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. • DOPs and Clinical Board Chairs accountability for delivery of activity targets. • Monthly reporting reinstated • IAP introduced as a part of the contracting process/requirement with NHSE and ICB (Indicative Activity Plan). Will be mandated. • IAP agreed. • Performance Gap early reporting.	• 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 • Internal and external audit of income levels • Finance Dashboard. • IAP in place, however at a lower activity level than required to meet standards required. Early reporting mechanisms and now specifically discussed at each Finance and Performance Committee.	• Conversations ongoing with commissioners re-fund available to pay for ERF activity above cap. National policy awaited (no timescale) but monthly updates provided.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Insufficient capability and capacity to deliver significant change programs to deliver the Financial Recovery Programme including CIP delivery.	• Financial governance framework in place, moving to accountability framework and delegated financial controls • Budget setting principles and budgets in place, including CIP targets by corporate area and clinical board • Enhanced CIP reporting / CIP organisational lead in place • CIP dashboard in BI • Day to day budget management processes in place including budget holder and DFM attendance/CBFM model and part of senior team • Monthly performance reviews, one in 3 finance focused. • Capital Management Group. • Clinical Board sign off of budgets and CIP targets. • Supplies and Services Procurement Cttee • Financial Recovery Plan and Financial Recovery Steering Group • Purchasing via procurement frameworks where appropriate • DOPs reinforcing financial grip and control. through engagement with teams. • Financial Recovery regular discussion/action planning on TMG. • Annual Internal and External Audit complete • ICB Grip and Control investigation and intervention complete. • Financial communications strategy. • Corporate services CIP targets set. Assessment capability for financial delegation completed - financial indicators developed. • Performance Gap early reporting.	• Budgetary oversight at DOP level • Monthly revenue report at CB and corporate service level. • Deviations from SFIs reported to SSPG committee including action taken. • Regular reporting of compliance through Internal Audit and monitoring of recommendations – Report to ARAC quarterly on Internal audit progress. • HFMA audit of control reported through to ARAC • Reporting framework to ICB / cost control framework implemented. • NHSE/I monthly finance monitoring • Going concern and financial controls audit • Early indication of required targets prior to start of financial year (5% January 2025) • Mazars external audit – satisfactory assurance, no issues re going concern. • First financial specific coms issued in January 2025. • CIP Dashboard on reporting hub, allowing CBs and CDs ability to monitor and view plans. • Revenue reporting and FRP reporting to Finance and Performance Cttee • Integrated Performance Report (IPR, refreshed) to Governors and Public Board of Directors • Monitoring and challenge of delivery of plans by FRSG, fortnightly. • Monthly QIG specifically re financial performance with ICB and NHSE colleagues to give assurance of progress. • Financial indicators contained within the financial revenue report from July. • Early reporting mechanisms and now specifically discussed at each Finance and Performance Committee.	• Delivery of TVC development programme – March 2026. • Delivery and mitigation plan meetings with clinical Boards and Corporate Services – March 2026.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Unplanned emerging cost pressures not included within the agreed balanced plan	• Horizon scanning • Executive team discussions • Planning and strategy group and financial recovery steering group re business cases and approval • Proactive engagement with suppliers • Supply and procurement committee. • Financial governance framework • ICB DOFs meeting. • Shelford networking / understanding the environment. • Use of frameworks. • Opportunities through Alliance working. • Engagement with MTPF workstreams (ICS). Annual Internal and External Audit complete. • In year emerging cost pressures identified, discussed and reported through Finance IQUIG (monthly)	• CB and CD finance reporting • Budget sign off and hold to account through accountability framework • ICS updates through Finance report and CEO report to Committees and Board • Finance report to Board, Finance and Performance Committee identifies any unplanned pressures and actions. • Procurement report to Finance and Performance Committee identifies any cost pressures emerging through procurement activity. • Regional finance returns monthly. • Mazars external audit – satisfactory assurance, no issues re going concern. • In year emerging cost pressures identified, discussed and reported through Finance IQUIG (monthly)	• Strengthen grip and control measures through financial recovery steering group – March 2026. • Adoption and embedding of financial accountability framework - bimonthly review of position by clinical board – Monthly reviews of position – March 2026. • Strengthen horizon scanning through Alliance DOF and national meetings/updates monthly – ongoing through 25/26 financial year -March 2026.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	

Reliance on non-cash measures leading to a diminished cash balance and reliance on cash support, impacting our ability to invest in buildings and equipment.	• Financial Recovery Plan • Non cash element of financial recovery defined and identified • Finance committee reporting and discussion • Financial Recovery Plan including cash releasing (CIP) • Other controls as above re management and reporting of CIP achievement • Capital management group • Strengthened discussion of cash position and reporting to finance Committee. • Enhanced cash reporting. • Integrated Care Board (ICB) cash payment request.	• 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.	• Consider and develop actions necessary to mitigate cash position should CIP not deliver - July 2025. Enhanced cash reporting to Finance and Performance Committee completed • To consider cash management guidance from NHSE at Finance and Performance Committee – on November agenda. • Review of cash management and control processes, for example payment to terms implementation – January 2025.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Subsidiary company is not formed, and benefits don't accrue due to approvals and/or industrial relations issues.	• Meetings with NHSE • NHSE panel assessment • OBC and FBC • Bi-weekly meetings with staffside • Joint meeting with staffside and NHSE • Staff Side regular engagement meetings.	• NHSE provided with all information relevant to make an informed decision • Continued thinking on benefits of forming a subsidiary company (risk, seeking) • All engagement material shared with staffside • All comms shared with staffside prior to sending out • Guarantees provided re terms and conditions, pensions issues and recognition agreement for staffside • Staff side engagement meetings 2 weekly.	• Further actions currently unavailable due to pause in progress / NHSE approval. Financial planning and forecasting for the year end now assuming no savings from new subsidiary undertakings.	**1.Fully on plan across all actions.**	
Under delivery of commercial income and growth to support financial recovery.	• Commercial Strategy • Commercial Delivery and Innovation Group • Commercial delivery Operational Group • Dedicated Commercial team established. • Commercial Update report. • Data Partnership model. • Data Partnership Group. • Sales force implementation. • Commercial schemes identified by Clinical Boards and Corporate Directorates. • Commercial Dashboards. • IP Policy developed. • Strengthened commercial governance at Clinical Board Level.	• Strategy document and updates reported to Finance and Performance Committee. • Commercial update report to F&P. • Data Partnership Proposal accepted by F&P. under engagement with other committees and groups currently. • Data partnership group reporting to commercial delivery and innovation group. • Tracking commercial pipeline. • Commercial schemes reporting alongside financial recovery plans. • Commercial dashboard data suggests marginal growth, further actions required as per action plan. • Commercial updates presented to Finance and Performance Committee. • First 2 data partnership agreed, and contract signed – Flatiron and Promptly. • Commercial representative at clinical board cost improvement meetings.	• Develop commercial principles for external contracts for full scale adoption in order to maximise potential returns. Commercial contracting course to be delivered – October 2025. • Strengthen governance and awareness relating to IP protection and data access - IP policy updated. Online course currently being built with Newcastle hospitals academy. Data partnership group continues drive awareness of value of data. – November 2025. • Strengthen our job descriptions for senior staff to include data access alongside IP - March 2026.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Risk ID	6.1

Comments:

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Failure to achieve NHS performance standards impacting on our ability to maintain high standards of care.	**Strategic objective**	6. We will take our responsibilities as a public service seriously, carefully managing our money and performance.

Lead Committee	Finance and Performance Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Performance and Governance	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	Compliance and Regulatory
Date Added	01.05.2024	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	17.11.2025	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Failure to manage capacity and demand.	• PMO supported programme of demand and capacity planning across all surgical specialties completed. • Weekly Stand-up highlighting areas of performance focus. • Daily Site meetings and Site Handover. • Weekly specialty /tumour group PTL meetings for long waits and cancer. • Fortnightly performance meetings with operational leads for long waits and cancer. • Local A&E Delivery Board, supporting the management of non-elective patients across the system. • Weekly attendance at Provider Collaborative Mutual Support Co-ordination group facilitating patient transfers and collaboration amongst local providers to level demand, make use of system capacity. • Validation of the RTT/non-RTT of long waits. • Implementation of new ED rota. • Targeted cancer improvement plans based on National Cancer Pathway Analyser Tool • Waiting list booking process Training. • Cancer Tiering System Exit. • Outpatient capacity templates. • Service review programme. • Performance Reporting.	• Revised Accountability Framework. • Activity and Income reports. • Integrated Quality and Performance Board Report. • Monthly Integrated Quality Performance Reviews. • Theatre Utilisation Data • CEO performance summary TMG including national performance comparisons • Performance Improvement Plans monitored via Finance and Performance Committee, including deep dives incorporated into the cycle of business • Further development of the Integrated Quality and Performance Board Report – reported to Committees and Trust Board. • Implementation of new ED rota, report to Finance and Performance Committee - improved safety. • Targeted cancer improvement plans with quarterly updates to F&P Committee • Tier 2 escalation process for cancer performance – positive feedback on progress by NHSE/ICB • Trust has successfully exited Cancer Tiering System. • Full review of outpatient capacity templates undertaken. • Service review process and methodology confirmed and service review programme in place. • Review and update of performance reporting information complete and updated in reporting	• Operationalisation of the Accountability Framework in progress – to be delivered by January 2026 2025/16 • Capacity and demand templates being completed for pressurised services as part of the medium-term planning framework, to be completed by the end of January 2026.	**2 – Action defined-most progressing, where delays are occurring interventions are being taken.**	

Utilising available resource effectively – workforce, estate, and equipment.	• Activity plans developed with Clinical Boards as part of the annual planning process. • Productivity targets set as part of the • Capital planning process through Capital Management Group. • Allocation of growth funding from commissioners to under pressure services, where available. • Revised annual planning process to incorporate approval of business cases for the coming financial year and utilisation. • Operational reports establishing weekly activity and value performance reports. • Diagnostic, Surgical and Outpatient Improvement Groups in place, with organisation wide scope to deliver improvements in effectiveness. Histopathology Turnaround times reporting. Productivity metrics established.	• Integrated Quality and Performance Board Report. • Monthly Integrated Quality Performance Reviews. • Trust Management Group (TMG) Updates. • Clinical Board meeting minutes. • Weekly Activity and Elective Recovery Fund (ERF) (income) reports. • Histopathology turnaround times reported and discussed at QPR. • Productivity metrics reported through Financial Recovery Steering Group.	• Improve theatre utilisation to greater than 85% by the end of March 2026. • Longer term capacity modelling for radiology modalities to be completed by December 2025 – delayed due to organisational change.	**2 – Action defined- most progressing, where delays are occurring interventions are being taken.**	
Failure to achieve NHS Oversight Framework (NOF) standards/ratings to ensure Trust receives strengthened local autonomy.	• NOF Segmentation review • Access and Improvement Group Established. • NOF methodology. • Trust currently in NOF segmentation 2. • Initial NOF provider capability assessment completed.	• Analysis completed looking at drivers of the NOF segmentation for Q1. • NOF Segmentation discussed and reported through Access and Improvement Group. • NOF methodology reported and discussed at Trust Board. • Trust Board development session regarding NOF Self-assessment submission and review of evidence/assurances – Trust self-assessment rating amber/green.	• Develop forecasting model to get early sight of potential future segmentation at the end of each quarter – November 2025. • NOF metrics to form accountability and autonomy framework and measured across the Trust – January 2026. • Await NOF Capability Assessment outcome and governance rating – December 2025.	**2 – Action defined- most progressing, where delays are occurring interventions are being taken.**	

Failure to transform and change service models at pace.	• Clinical Board Improvement Plans. • Winter Plan. • Bespoke programmes of support to critical / fragile services. • Clinical Board Structure in place from April 2023 • Alliance working groups. • GIRFT engagement and sharing of alternatives models, tools, and support. • Outpatient Improvement Group. • Surgical Improvement Group. • Diagnostic Improvement Groups. • Urgent and Emergency Care Improvement Group. • Monthly meetings in place with primary care. • Trust Winter Plan 2025/26. • Medicine and Emergency Care Frailty Model	• TMG Oversight. • Executive Team Oversight. • Quality Performance Reviews. • Monthly IPR to committees and Board. • Clinical Board meeting minutes. • Outpatient Improvement Group actions. • Surgical Improvement Group actions. • Diagnostic Improvement Group actions. • UEC Improvement Group actions. • Cancer Board actions. • Improvement and project management resource reprioritised to support priority actions/service changes. • Trust Winter Plan agreed and in place. • Effective frailty model implemented.	• Develop and implement co-located UTC – Opening January 2026 • Pathway changes aimed at improving ED performance including ambulance handovers as part of the GIRFT Further Faster UEC programme – March 2026 • Further round of reviewing cancer pathways to identify 'bottlenecks' and areas of improvement being carried out as part of the planning submission for 2026/27 – January 2026.	**2 – Action defined- most progressing, where delays are occurring interventions are being taken.**	
Clinical service failure at neighbouring Trusts impacting on NUTH performance – also linked to strategic risk	• Trust based Clinical Strategy work across the Alliance including a focus on vulnerable services. • Attendance at the Provider Collaborative Mutual Support Coordination Group and Alliance groups. • Alliance plans for identified services addressed through Bilateral Board meetings and workstreams.	• Regular updates to TMG. • CEO attendance at Great North Health Care Alliance Steering Group and Minutes. • Monitoring via the Bilateral Boards –First iteration of Alliance performance report complete.		**1.Fully on plan across all actions.**	

Risk ID	6.2
Comments:	

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Failure to maintain the standard of the Trust estate, environment, and infrastructure could result in a disruption to clinical activities and impact on the quality of care.	**Strategic objective**	5.Our building will be fit for purpose.

Lead Committee	Finance and Performance	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Estates, Facilities & Strategic Partnerships	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Compliance and Regulatory
Date Added	01.05.2024	**Likelihood**	**4**	**4**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	10.11.2025	**Risk Score**	**20**	**20**	**5**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Uncertainty and programme risk due to delays in Building Safety Act (BSA) approval will delay delivery and increase costs of construction/ refurbishments projects in “high-risk buildings”.	• Clearly identify every aspect requiring compliance. • Ongoing engagement with Contractors/HSE. • Engage professional/legal advice. • Discussions with NHS England (NHSE)/DHSC regarding impact on NHS. • Repository of Trust Estate where HRB applies. • DHSC Engagement regarding BSA delays. • Engagement with local MPs who plan to raise impact of BSA delays with the Parliamentary Under-Secretary of State in the Ministry of Housing, Communities and Local Government	• BSA applications. • Ongoing correspondence with Contractors/HSE. • HRB repository now in place.	• Correspondence with Contractors/HSE – project specific timeline - March 2026. • Reporting capital plan and cashflows through CMG and F&PC – March 2026. •	**4-Actions defined - but largely behind plan.**	
Insufficient national capital funding allocation to effectively manage the lifecycle replacement or upgrade of the Trust Estate, Environment and Critical Infrastructure assets (Backlog Maintenance).	• Condition monitoring of assets undertaken annually to enable ongoing re-prioritisation of backlog maintenance programme. • Annual capital investment plan including estates and medical devices. • Estates Strategy. • ICS Infrastructure plan. • Annual condition survey (20%) to determine condition of infrastructure in accordance with NHS Backlog Methodology. • Alignment of condition surveys. • Risk based asset plan and report	• Estates Risk Management & Governance Group minutes and action logs. • ERIC/Model Health System. • Estates Investment, Planning, Strategy and Capital Investment Group. • CIR plan 2025/26 Capital programme. • Capital Management Group oversight. • CMG report - Finance and Performance Committee. • ICS Infrastructure Board. • Condition surveys now aligned on CAFM system. • Risk based asset report providing clinical board prioritisation of Backlog Maintenance.	• Carry out a condition survey of built environment, critical plant and equipment as part of subsidiary service agreement – - Paused pending discussion with NHS England regarding central funding – December 2025. • Regular review of priority replacement plant and equipment requests by CMG - March 2026.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Compliance with fire safety regulations & standards - Failure to deliver fire safety systems remediation programmes	• Risk based fire remediation programme. Condition monitoring of fire safety assets undertaken annually to enable ongoing re-prioritisation of fire safety remediation programme. • Monthly fire safety remediation programme monitoring reports. • Fire Safety Reports. • Incident reporting system. • Estates Strategy.	• Trust Fire Safety Group minutes and action logs. • Oversight by Estates Fire Directors Group. • Estates Risk Management & Governance Group minutes and action logs. • Quarterly report to Compliance & Assurance Group. • Reports to Capital Management Group. • Fire Safety report to Trust Board.	• Fire Remediation works continue in line with the agreed 2025/26 Plan as a workstream as part of the wider Capital Plan – March 2026 • Re-procurement of the Fire Remediation Contractor still planned with tender award in place by April 2026 • A small number of High Risk areas still remain across both RVI and FH due to access constraints. These are included within 2026/27 plan to be completed (pending access) by March 2027.	**3-Action defined- work started but behind plan.**	
Failure of ageing critical estates M&E engineering infrastructure (Ventilation, Water, Electrical (HV & LV systems), Decontamination and Medical Gas Pipeline Systems).	• 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 undertaken annually to enable ongoing re-prioritisation of backlog maintenance programme. • Monthly HTM Compliance Monitoring Reports. • Health & Safety Reports. • Incident reporting system. • Capital Programme. • Estates Strategy. • Trust Policies and Procedures. • Annual condition survey (20%) to determine condition of infrastructure in accordance with NHS Backlog Methodology. • Risk based asset plan and report	• Estates Operational Management Structures. • Estates Investment, Planning, Strategy and Capital Investment Group. • CIR plan 2024/5 Capital programme. • Oversight via Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety). • Estates Risk Management & Governance Group minutes and action logs. • Quarterly report to Compliance & Assurance Group. • Capital Management Group oversight. • IPCC oversight. • Independent Authorising Engineer annual HTM compliance Audit. • Trust Internal Audit Programme (AuditOne). • Risk based asset report providing clinical board prioritisation of Backlog Maintenance.	• Carry out condition survey of built environment, critical plant and equipment as part of subsidiary service agreement – - Paused pending discussion with NHS England regarding central funding – December 2025. • Regular review of priority replacement plant and equipment requests by CMG - March 2026.	**2-Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Insufficient national capital funding allocation to effectively manage the lifecycle replacement or upgrade of critical medical devices (Imaging assets, Theatre Equipment etc.).	• Condition monitoring of assets undertaken annually to enable ongoing re-prioritisation of capital replacement programme. • Annual capital plan includes medical devices. • 3-year medical device asset replacement. • 3-year lifecycle replacement plan. • Medical Device replacement plan agreed for 2025/26 Capital programme.	• Medical Director medical device replacement oversight/prioritisation group. • Estates Investment, Planning, Strategy and Capital Investment Group. • Medical Device replacement plan 2025/26 Capital programme. • Capital Management Group oversight. • CMG report - Finance and Performance Committee. • Medical Device Steering Group. • medical device asset replacement monitored via Capital/Financial planning meetings. • Lifecycle replacement plan and programme in place.	• Regular review of priority requests by Medical Director and medical device • replacement oversight/prioritisation group March 2026.	**1.Fully on plan across all actions.**	

Failure of ageing critical medical devices assets (Imaging assets, Theatre Equipment etc.).	• Regular planned preventive maintenance programme (PPM) in place in line with the requirements of MHRA guidance. • Monthly Compliance Monitoring Reports. • Incident reporting system. • Capital Programme. • Trust Policies and Procedures. • Analysis of CAFM medical device data to identify failure trends.	• EME Operational Management Structures. • Annual report to Medical Device Steering Group. • Estates Risk Management & Governance Group minutes and action logs.	• Regular review of priority requests by Medical Director and medical device replacement oversight/prioritisation group March 2026.	**1.Fully on plan across all actions.**	
Failure to maintain the Quality and Safety of the care environment to meet CQC regulatory standards and deliver Trust priorities and ambitions including environments that are Dementia Friendly and free from Self Harm risks.	• Regular planned preventive maintenance programme (PPM) in place in line with the requirements of SFG20 and Health Technical Memoranda (HTM) guidance. • Health & Safety Audit Reports. • Incident reporting system. • Capital Programme. • Estates Strategy. • Trust Policies and Procedures	• Estates and Facilities Operational Management Structures. • Estates Risk Management & Governance Group minutes and action logs. • Quarterly report to Compliance & Assurance Group. • PLACE Assessments. • NHS Premises Assurance Model (PAM). • IPCC oversight. • CQC Delivery Group. • CQC Standards Assurance Group. • Trust Internal Audit Programme (AuditOne).	• Dementia Friendly Estates options appraisal to be finalised and escalated for approval including any agreed plan of work – Q4 2025. • Finalise Trust standard specifications (including dementia standards) to follow on any refurbishment programme within capital plans - Q4 2025 • Phase 2 - Compliance with Self Harm Risk Assessment recommendations 18–24-month programme subject to CMG approval, currently outside of capital plan for 2025/26. Q3 2025. • Review and implement agreed improvements relating to Real Time Patient Satisfaction Surveys - ongoing Q4 2025/2026.	**2-Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Lack of decant facility compromises the delivery of planned Estates objectives including ward refurbishment programme, fire remediation works and critical infrastructure replacement.	• Estates Strategy. • Liaison meetings with Patient Services to minimise impact on clinical activity. • Project Management meetings. • Review by Estates Programme Sub Group.	• Senior Operational meetings. • Capital Management Group oversight. • Estates Strategy & Capital Investment Group. • Estates Programme Sub Group.	• Free FH Ward 12 as decant facility for one ward refurbishment per year – March 2026. • Co-ordinate with Patient Services to negotiate access and minimise impact on patient activity - timing project specific throughout the year to March 2026. • Alliance Construction Programme aims to delivery decant facilities – Long term.	**5-Action not yet fully defined.**	
Failure to maintain and invest in the PFI estate to keep it in a suitable and quality condition and at a safe level of compliance.	• Monitoring of Private Finance Initiative (PFI) annual and 5-year lifecycle plan (Lifecycle investment is included within the Project Agreement and Unitary Charge for the PFI Estate). • Monitoring of PFI annual condition surveys. • Regular zonal and ad hoc inspections of PFI areas.	• PFI Monthly Review Meetings. • PFI Liaison Committee. • Trust Safety Groups (e.g. Strategic Water Safety Group, Fire Safety). • Compliance & Assurance Group. • Trust Internal Audit Programme (AuditOne) • Independent Authorising Engineer annual HTM compliance Audit. • PLACE audits. • Monitor helpdesk reporting.	• Continue zonal inspection processes to identify and remedy any slippage in condition. Checks to take place monthly until end of concession in 2043. • Performance of the PFI Centre of Best Practice condition survey process – delayed by settlements and commercial negotiation, now due in Q1 2026-27.	**3-Action defined-work started but behind plan.**	

Failure to manage project delivery within PFI estate will impact the ability to transform services and improve efficiency.	• Follow variation procedure outlined with PFI Project Agreement. • Track works requests and escalate slippage. • Review progress within meeting structures. • Implement alternative routes if required. • Management of works requests.	• Review at monthly Variation meetings. • PFI Liaison Committee. • Track and manage works requests through variation procedure and meeting structure -takes place monthly.	• Deed of variation being prepared for HSN direct delivery – Letter of Intent issued May 2025 Deed yet to be in place, now due Q4 2025. • Implemented June 2025 as targeted with first scheme completed during Q3 2025.	**4-Actions defined - but largely behind plan.**	
Reduced fire compliance during PFI Programme of fire remedial works.	• Obligations to perform and conclude fire remedial works set out in PFI Project Agreement and Settlement Agreement. • Maintain meetings structures to manage progress with the works.	• Independent certification for each zone when completed. • Ongoing compliance requirements contained within PFI Project Agreement. • PFI Fire Steering Group.	• Regular reviews of requirements and progress with the remedial works – still targeted for April 2026.	**4-Actions defined - but largely behind plan.**	
Non-compliance of elements of PFI Ventilation and Air Conditioning Systems	• Obligations to perform remedial works set out in PFI Project Agreement. • Legal support if required to resolve any disagreements.	• Compliance requirements contained within PFI Project Agreement. • Performance reports. • Performance report review meetings. • PFI Liaison Committee.	• Seek remedial scope and programme from PFI partners - Q1 2026. On plan. • Manage terms of the PFI Project Agreement to conclude remedial works through to Dec 2026. On plan.	**3-Action defined-work started but behind plan.**	
Non-compliance of elements of PFI Electrical Systems.	• Obligations to perform remedial works set out in PFI Project Agreement. • Legal support if required to resolve any disagreements.	• Compliance requirements contained within PFI Project Agreement. • Performance reports. • Performance report review meetings. • PFI Liaison Committee.	• Seek remedial scope and programme from PFI partners – slightly delayed due to design of remedials required, now due Q4 2025. Manage terms of the PFI Project Agreement to conclude remedial works through to Dec 2026 – on plan. • Commence condition survey of electrical installations to fully define issues and required remedial action plan for Q4 2025	**5- Actions not yet fully defined.**	

Risk ID	5.1

Comments:

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Failure to improve and maintain an organisational culture, in line with our Trust values and our People Plan.	**Strategic objective**	2. We will be a great place to work where everyone feels supported.

Lead Committee	People Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Commercial Development & Innovation.	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	People & Culture
Date Added	01.05.2025	**Likelihood**	**5**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	29.10.2025	**Risk Score**	**20**	**16**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Failure to review and improve team working across the Trust following declining staff survey results in relation to 'we work as a team' question.	• Health and Wellbeing Steering Group. • People Programme Board. • Occupational Health Self-Referral Service. • Evaluation and appraisal of Trust Compassionate Leadership Programme.	• Health and Wellbeing Steering Group minutes. • People Programme Board Minutes. • Live in August 2025. • Evaluation of Trust Compassionate Leadership Programme completed August 2025. • Occupational Health Self-Referral Service live.	• Staff psychology support service, 2025/26 – December 2025. • Staff Survey results – March/April 2026.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Failure to foster a supportive and inclusive culture across the Trust to ensure all staff groups feel safe, valued and respected.	• Staff Networks established including Enabled, Race Equality Network, Pride and Women's. • EDI Steering Group. • Health and Wellbeing Steering Group • Developed and launched Trust Behaviours and Civility Charter • NHS England's Sexual Safety in Healthcare Charter • New Sexual Misconduct and Sexual Violence Policy • EDI Development Session delivered at TMG and Trust Board. • Cultural Ambassadors in place. • People dashboard. • Let's Talk Race session with the Trust Board in March 2025. • Sexual safety and misconduct audit. • Year 2 EDI 2025/26 priorities developed. • People and Culture MDT Group Established. • Occupational Health Self-Referral Service.	• Health and Wellbeing Steering Group minutes. • People Strategy. • People Strategy Year 1 deliverables. • Safe Staffing Internal audit – Reasonable assurance • Freedom to speak up Internal audit – Reasonable assurance • F2SUG assurance report to People Committee. • People Committee minutes. • Clinical Board People Oversight Groups. • People Programme Board. • Micro aggression and incivilities training – 88.7% Trust staff compliance with training. • EDI and Let's Talk Race Presentation and slides. • People Dashboard reporting. • Completed and priority actions/finding to PC November. • Year 2 EDI 2025/26 priorities paper to People Committee July 2025. • Occupational Health Self-Referral Service live.	• People Plan Year 2 programme launch – November 2025 – to be reviewed in light of Grant Thornton feedback • Staff psychology support service, 2025/26 – December 2025. • Further development of People Oversight Groups in CBs as part of PP Year 2 action plans – due to organisational change in dept this framework is currently in development – review in January 2026. • Delivery of Year 2 2025/26 EDI Priorities – March 2026.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Risk ID	2.1

Comments:

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Failure to effectively manage organisational change and related leadership and governance required to ensure effective supporting structures with the new Trust operating model.	**Strategic objective**	6.We will take our responsibilities as a public service seriously, carefully managing our money and performance.

Lead Committee	People Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Commercial Development & Innovation.	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	People and Culture
Date Added	01.05.2025	**Likelihood**	**4**	**3**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	29.10.2025	**Risk Score**	**20**	**12**	**4**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Failure to support staff with their health and wellbeing leading to increased sickness absence.	• Health and Wellbeing Steering Group in place. • Better Health at Work Award • Health and Wellbeing policy in place. • People Strategy. • completed including Wellbeing Gap Analysis. • People Programme Board. • Sexual Safety Charter. • Behaviours and civilities charter in place. • Staff Health and Wellbeing offers including Trust travel scheme, financial wellbeing, meal cards, access to helping hands, Staff social club and fitness centres. • Equality Diversity and Inclusion (EDI) – Staff Networks, High Impact Actions, EDI Steering Group, WRES, WDES, EDS • Cultural Ambassadors. • Health and Wellbeing Policy in place. • People and Culture MDT Group Established.	• Health and Wellbeing Steering Group minutes. • IBR - People report. Board (mthly); People Committee (bi-mthly); Employment Partnership Forum (mthly). • People Strategy, Year 1 delivery programme • Performance review report for Clinical Boards (mthly). • Sexual safety charter awareness and training in place. • People Strategy Year 1 programmes. • Internal Audit reports (absence management; HAWB initiatives; F2SUG). • People dashboard and reports. • F2SUG reports. • People Committee minutes. • Clinical Board People Oversight Groups. • People Programme Board. • Health and Wellbeing ad EDI Steering Groups in place • Behaviours and civilities charter awareness and training in place – Trust compliance 88.7% • Health and Wellbeing Policy ratified August 2025.	• People Plan Year 2 programme launch – November 2025 – to be reviewed in light of Grant Thornton feedback • Staff psychology support service, 2025/26 – December2025. • Target reduction in sickness absence of 0.5% - March 2026. • Anti Racism Framework 2025/26 – November 2025. • Evaluate learning and sharing from CB People Oversight Groups – due to organisational change in dept this framework is currently in development – review in December/January 2026.	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	

Failure to deliver improvements to leadership and governance across the Trust.	• Organisational Change policy in place. • People Strategy. • SubCo Operational Group in place. • SubCo People Group in place. • People Programme Board. • People Transformation Group. Employment Partnership Forum.	• Project management records. • Internal Audit report. • People Programme Board minutes and actions. • People Transformation Group minutes and actions. • People Committee minutes and actions. • Employment Partnership Forum minutes and actions. • SubCo Operational Group minutes and actions. • SubCo People Group minutes and actions.	• Business Partner Model – January 2025. • Develop BP working Group – July 2025. – complete, additional support added. • Explore Just learning culture – January 2026	**2.Actions defined- most progressing, where delays are occurring interventions are being taken.**	

Risk ID	2.2
Comments:	

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Failure to deliver effective workforce planning to allow the Trust to forecast and adapt to changing NHS healthcare landscape, financial constraints and address staff shortages and retention.	**Strategic objective**	2. We will be a great place to work where everyone feels supported.

Lead Committee	People Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Director of Commercial Development & Innovation.	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	People & Culture
Date Added	01.05.2025	**Likelihood**	**4**	**3**	**1**	**Risk Appetite Tolerance**	
Last Reviewed	29.10.2025	**Risk Score**	**20**	**15**	**5**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Trust plans to reduce corporate headcount by 50% of 2019/20 growth potentially de-stabilising corporate functions.	• Financial Recovery Steering Group. • Integrated Board Report (IBR) - People report. Board (mthly); People Committee (bi-mthly); Employment Partnership Forum (mthly). • PWR data mapping with PFR data. • Redeployment policy in place. • Redeployment group meets weekly. • Local Vacancy Freeze. • Voluntary Severance Scheme complete • MARS opened to all staff 13th October to 2nd November. • Workforce reduction oversight group established October 2025. SH as SRO. • Workforce reduction targets allocated to each Clinical Board and each Corporate service. Target is to reduce WTE by 400. • Vacancy freeze from 1st Oct – 22nd Oct.	• Voluntary severance scheme drawn up. • Redeployment group minutes and actions. • Workforce reduction data reported to FRSG. • SIT REP to Execs on vacancy hold.	• Consider additional workforce reduction schemes.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	
Underdeveloped workforce planning mechanisms impacting on our ability to effectively forecast workforce needs.	• PWR data (mthly). • Clinical Board People Oversight Groups in place. • People dashboards and BI reports. • People Programme Board.	• PWR data. • People dashboard and BI reports. • Clinical Board/Corporate Service workforce plans. • People Programme Board minutes. • People Transformation Group minutes.	• Business partner model 2025/26 – January 2026. • Workforce planning benchmarking exercise – January 2026.	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Capacity and capability to effectively support workforce planning in the Trust.	• Operational Planning Group in place. • ESR in place, including Establishment. • PWR data. • People dashboards and BI reports. • People Programme Board.	• Operational Planning Group minutes. • ESR reports. • PWR data/reports. • People dashboards and BI reports. • People Programme Board minutes.	Business partner model 2025/26 – January 2026	**2.Actions defined-most progressing, where delays are occurring interventions are being taken.**	

Risk ID	2.3
Comments:	

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Failure to deliver and improve the digital capability required to support the delivery of safe, effective and efficient patient care.	**Strategic objective**	4. Our technology will support our work and patients' care.

Lead Committee	Digital and Data Committee	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	David Elliott Alliance Chief Digital Information Officer	**Impact**	**5**	**5**	**5**	**Risk Appetite Category**	Digital Technology
Date Added	03.11.2025	**Likelihood**	**4**	**4**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	03.11.2025	**Risk Score**	**20**	**20**	**10**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Increased risks relating to foundational digital tasks superseding priorities over strategic goals.	• Care Optimisation group controls priority and governance of projects • Digital Senior Management Team Meetings. • Digital and Data Committee.	• Care Optimisation group controls priority and governance of projects – Terms of Reference, Minutes, agenda and Chairs Log to Digital and Data Committee. • Digital Senior Management Team Meetings established and meeting Weekly. • Digital and Data Committee ToR, Minutes, agenda, papers and escalations to Trust Board.	• Clinical Boards to consider top three priorities in each clinical board to add to the digital priorities roadmap - December 2025 • Review the operational needs of the digital plan that may not be covered via Care Optimisation Group are covered in the priorities -December 2025 • Complete baseline resource review to understand digital resource requirements to ensure systems up to date and running – March 2026	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	

Lack of staff skill set and resources to deliver digital plans.			• Recruit a Deputy CIO – January 2025 • Baseline review of skills across Digital workforce to understanding of the skillset and workforce needs to deliver the Digital plan and priorities – March 2026 • Implement new digital organisational structure developed in line with the above skillset requirements – May 2026	**2. Actions defined- most progressing, where delays are occurring interventions are being taken.**	
Lack of available financial envelope to deliver digital priorities.			Await capital plan 2026 outline to see if we can switch revenue\capital regime to enable transformation. – April 2026	**5. Actions not yet fully defined.**	

Risk ID	4.1

Comments:

Board Assurance Framework 2025/2026

Principal Risk (what could stop us from achieving our strategic objective)	Inability to sufficiently influence priorities of key partnerships (including the Great North Healthcare Alliance, the ICB, Provider Collaborative and Newcastle place arrangements) or to deliver on agreed commitments due to capacity or culture, impacting on our ability to effectively deliver sustainable local and regional healthcare commitments.	**Strategic objective**	7. We will make sure we deliver our commitments to the communities who depend on us.

Lead Committee	Trust Board	**Risk Rating**	**Initial**	**Current**	**Target**	**Risk Appetite**	
Executive Lead	Martin Wilson,	**Impact**	**4**	**4**	**4**	**Risk Appetite Category**	System and Partnerships
Date Added	Director Great North Healthcare Alliance	**Likelihood**	**4**	**3**	**2**	**Risk Appetite Tolerance**	
Last Reviewed	3.11.2025	**Risk Score**	**16**	**12**	**8**	**Risk Appetite Rating**	

Threat (what might cause this to happen)	**Controls (what controls do we already have in place to manage the risk and reduce the likelihood of the threat)**	**Sources of Assurance (Evidence that controls which are in place are effective, 3 lines of defence)**	**Actions and Timescales (Further actions required to manage risk)**	**Action Progress Indicator**	**Threat Assurance Level**
Lack of appropriate Board, Executive and senior clinician capacity to influence the key partnerships and/or culture of the organisation resistant to working in effective partnerships.	• Great North Healthcare Alliance Steering Group Committees in Common • Great North Healthcare Alliance Joint Committee. 3 lead directors in place for delegated functions of financial planning, digital and research and innovation. • Bilateral group between Northumbria and Newcastle meeting monthly. • Bilateral sub-committee between North Cumbria and Newcastle meeting monthly. • Bilateral sub-committee between Gateshead and Newcastle meeting monthly. • Great North Healthcare Alliance Director and Alliance Formation Team in place. • ICS Board. • Great North Healthcare Alliance Collaboration Agreement based around improving collaboration working whilst retaining organisational independence. • Provider collaborative leadership board. • Newcastle place based ICB sub-committee. • Alliance Vision, Workplan and Milestones. • Alliance Performance Dashboard. • Shared Chair in post across Newcastle, Northumbria, and Gateshead.	• Chair and CEO member of Great North Healthcare Alliance Steering Group Committees in Common and Joint Committee. • CEO member of Provider Collaborative Leadership Board. • Executive Directors leading appropriate Alliance work streams with peers. • Acting CEO chairs Newcastle Place ICB Sub-Committee. • Alliance vision and 3-year work plan approved by Trust Board and supported by Council of Governors and NENC ICB. • Great North Healthcare Alliance Steering Group Committees in Common and Joint Committee Minutes • Great North Healthcare Alliance written updates to Trust Board and Council of Governors. • Joint Alliance Governor event was held in October 2025. ICB/Provider Collaborative and PLACE Minutes • Legal support to ensure legislative compliance • ICB approval of Alliance Case for Change. • ICB led stakeholder engagement assurance of Alliance plan very positive. • NHSE assured Alliance shared leadership arrangements	• Work underway to develop refreshed Alliance Strategic Intent for consideration by CEOs, Chairs and Alliance Steering Group – November 2025. • Alliance Construction Programme (“Big Build”) – full market engagement to be undertaken following the successful event with policy makers and potential funders and construction partners held in December 2025.	**1-Fully on plan across all actions.**	

	• Director for the Great North Healthcare Alliance and (Trust) Strategy leads Alliance Formation Team.	• Alliance updated Collaboration Agreement. • Alliance and wider partnership working embedded within the Trust interim and draft clinical strategy			

Risk ID	7.1
Comments:	

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PUBLIC BOARD MEETINGS - ACTIONS

Agenda item A15

Log No.	BOARD DATE	AGENDA ITEM	ACTION	ACTION BY	Previous meeting status	Current meeting status	Notes
147	23-May-25	25/13 ITEMS TO RECEIVE i). Guardian of Safe Working (GoSW) Report	Mr Kajee sought clarification with regards to the recommendation in the report on continuing to review the workforce and queried whether the Trust was considered to be safe in terms of working hours. The JMD-W explained the role of the Guardian in ensuring that working conditions were safe and to highlight exception reporting. The JMD-W agreed to ask the GOSW to highlight further information in terms of assurance as to safety in future reports [ACTION04].	MWr			14.07.25 - KJ emailed the GoSW on 14 July. 25.07.25- Paul Ennals referred to actions 147 and 148 on the action log which related to the GoSW report and advised that the required information would be included in the next report. 18.09.25 - Information to be included at the November Public Board of Directors meeting. 20.11.25 - New section added into the November report (section 9.1). Propose to close action.
148	23-May-25	25/13 ITEMS TO RECEIVE i). Guardian of Safe Working (GoSW) Report	The ACEO referred to the increases in resident doctor posts and that it would be useful to include content with regards to the changes that had been made, how this aligned to outcomes within the report and to whether this had a positive or negative impact in those areas from an exception reporting perspective. The JMD-W agreed to follow up [ACTION05].	MWr			14.07.25 - KJ emailed the GoSW 14 July. 25.07.25- Paul Ennals referred to actions 147 and 148 on the action log which related to the GoSW report and advised that the required information would be included in the next report. 18.09.25 - Information to be included at the November Public Board of Directors meeting. 20.11.25 - Included in the November GoSW report. Propose to close action.
153	26 September 2025	25/21 STANDING ITEMS: iv) Chief Executive's Report, including CQC update	Ian Joy agreed to coordinate a flu vaccination drop in on the day of the next Board meeting for those who wish to be vaccinated [ACTION01].	IJ			13.10.25 - LT arranged for Board members to receive their vaccination prior to Private Trust Board on 23 October. Propose to close action.
154	26 September 2025	25/22 STRATEGIC ITEMS: iv) Sustainability update	Kelly Jupp agreed to amend the Board Development Programme to incorporate sustainability into Quarter 4 of the programme [ACTION02].	KJ			13.10.25 - The Board Development Programme has been updated. 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.