Summary

1 This paper seeks Board approval of a refreshed strategic intent for the Great North Healthcare Alliance. The proposed intent clarifies that the Alliance will focus on:

- Delivering excellent tertiary and secondary hospital services
- Strengthening neighbourhood care closer to patients
- Supporting patient choice and reducing inequalities
- Improving sustainability and financial resilience through collective action

Subject to approval, a second phase of work will identify a small number of priority pathways for progression in 2026/27, supported by detailed clinical, financial and engagement work.

Background

2 Our Great North Healthcare Alliance was formed as a concept that was supported by all four Trust Boards in December 2023.

3 The governance journey of the Alliance can be marked by:

- Decision by each Trust Board to form the Alliance (December 2023)
- Alliance Steering Group established (January 2024)
- Joint Board event established (May 2024)
- Collaboration Agreement, Committees in Common and Joint Committee established (June 2024)
- Three Bilaterals established (Newcastle with: Northumbria (September 2024); North Cumbria (February 2025); and Gateshead (May 2025))
- NHS England and ICB assurance of Alliance arrangements (late 2024 – early 2025)
- Shared Chair role across Gateshead, Newcastle and Northumbria FTs (phased implementation completed October 2025)

4 The strategic direction journey of the Alliance can be seen in the evolution of the following Trust Board approved documents:

- Alliance formation paper (December 2023)

- Alliance objectives and principles as set out in the Collaboration Agreement (June 2024)

- Alliance vision, 1,3- and 5-year milestones, and goals – linked in part to the ICB ask for a case for change (November 2024)

- Alliance 2025/26 strategic priorities (March 2025)

5 During 2025, the Alliance Steering Group and Trust Boards have all agreed that the Alliance is making fair, but not great, progress. This is not a criticism of anyone involved and is likely driven by factors such as:

- What “we” are trying to achieve through “our Alliance” is not easy. It requires trust between partners at many levels of the organisations, and this takes time to develop. The Alliance is learning about how best to make cross organisational changes happen.

- NHS accountability mechanisms reinforce the primacy of individual organisational delivery, such as through NHS Oversight Framework (NOF) ratings. It is noted that as management and leadership capacity is tight, the focus is drawn to the urgent in-organisation activities rather than the equally important inter-Alliance activities which are key to longer term sustainability and delivery.

- There has been change in leadership within the Trusts in the Alliance, including 4 chief executives who have all been in post for 2 years or less, and of these 3 are in acting roles. Similarly two of the three chairs who were involved in establishing the Alliance are no longer in post.

- The current governance model of the Alliance does not ensure sufficient active involvement of the breadth of Board members particularly executive directors, as the formal structures only include chair, chief executive and one non-executive director from each Trust.

- Bilateral and peer networks across the Alliance are not as robust as may be required to deliver high impact. The light touch / informality of some of these arrangements was deliberately designed to avoid placing a burden on busy executives, but a consequence may be that people have not prioritised sufficient time to engage with partners in the other Alliance trusts that is required to develop the trusting relationships which are required (see first bullet above).

- When it comes to corporate service efficiency opportunities there are the complications of 1) understandable desire to keep services locally run and 2) potential duplication with ICS / regional discussions particularly in HR.

6 Alliance Trust chairs and chief executives are very keen for the Alliance to be refocussed and reenergised around a refreshed strategic intent that recognises changes in context and advances each of the Trusts. This paper, developed by and with the chief executives, and iterated following consideration at the Alliance Steering Group and with relevant partners at place, sets out a new proposed strategic intent for the Alliance.

A proposed strategic intent of the Alliance is "Working together to deliver excellent tertiary and secondary hospital services, while strengthening neighbourhood care closer to patients' homes."

7 The Alliance has the overall vision of "working together to deliver excellence in healthcare".

8 The Alliance recognises that excellent hospital services cannot be delivered in isolation from primary care, community services, mental health and local authority partners. Strengthening neighbourhood care and where possible enabling more integrated pathways closer to where patients live, will be fundamental to delivering sustainable secondary and tertiary services.

9 The Alliance will therefore work proactively with Integrated Care Boards, local authorities, primary care networks, community providers and voluntary sector partners to ensure that pathway redesign improves patient outcomes and experience, reduces health inequalities and supports prevention.

10 The Alliance Steering Group proposes that a purpose of the Alliance should be focussed on those things which bind the trusts together for the benefit of patients, namely the interdependencies of prevention, primary, community / neighbourhood, secondary care hospital and tertiary specialist services, within the Alliance. All Trusts share important missions in providing excellent secondary care hospital services in their area for local people and communities, and recognise that this also supports the provision of the best possible tertiary services across the Alliance as a whole. The Alliance also recognises the importance of patient choice, and that this is driven by a range of issues including where services can be practically delivered, where patients and their families live and work, and transport routes.

11 By working together with a focus 'to deliver excellent tertiary and secondary hospital services, while strengthening neighbourhood care closer to patients' homes' it is expected that the Alliance will:

- Enable more people / patients to receive their care local to where they live, including by Trusts working differently with each other. Wherever possible this will be done to increase rather than reduce, choice and the range of services provided in each place.

- Provide the right accessible services to the right people in the right environment with patient choice at the heart of this and mindful of health inequalities.

- Work in a way that supports each trust to be successful and for patients to benefit from improved service provision.

- Make progress on the 3 shifts, particularly around moving more hospital care to be provided in hospitals and communities / neighbourhoods closer to where patients live. The shifts from analogue to digital, and from treatment to prevention will also enable the wider success of the Alliance and its proposed strategic intent. Without this transformation in models of care, the NHS locally will need to provide and staff many hundreds of additional

hospital beds over the next decade to deal with changes in population and patient demographics.

- Strengthen tertiary services as an asset to all patients in the Alliance, and address services where long-term sustainability and resilience require strengthening, particularly in North Cumbria, by having these services increasingly provided by Newcastle Hospitals. In doing so the Alliance will ensure services are accessible and adopt the principle that 'we will localise where possible and centralise where necessary to ensure safe, quality, sustainable care'.

- Engage proactively, and where appropriate collectively, in commissioning discussions about how best to organise and provide services.

12 To achieve this strategic intent requires many things, including clarification on what is considered as a tertiary service, which parts of centralised services can be best provided more locally than at present, and which sub-tertiary services other Trusts should be released from providing to focus on secondary care services or maintain / support delivery closer to home. This includes reviewing secondary care service pathways and patient flows so that more patients from Gateshead, North Tyneside, Northumbria and North Cumbria that currently receive secondary care hospital care in Newcastle, can choose to be cared for in Gateshead, Northumbria and North Cumbria trusts, releasing capacity for Newcastle to take more of the tertiary care.

13 Any changes to patient flows will be clinically led, evidence based and shaped through meaningful engagement with patients, carers and partners and with commissioning colleagues to ensure resources flows with the activity. Improving convenience, reducing travel burden and supporting continuity of care will be central considerations.

14 The focus on hospital services in the above is not to the exclusion other services. The move to greater integrated neighbourhood care and increased primary, community and prevention is a key intention of the Alliance's vision of "working together to deliver excellence in healthcare". There is recognition that some of these discussions need to happen at place rather than with hospital services.

15 Appropriate patient involvement and commissioner and wider engagement will be a necessary part of any clinically led service discussions.

16 Delivering this strategic intent will require cultural and digital change alongside clinical redesign. Success depends on collective leadership behaviours, stronger cross-organisational trust and a willingness to prioritise Alliance objectives alongside local accountabilities. Greater digital maturity — including interoperable systems, shared data and improved digital access for patients — will be essential enablers. This represents a leadership challenge for Boards and executives, whose visible sponsorship of collaboration and digital transformation will be critical to delivery.

Ambition and performance – what are excellent services?

17 The intended benefits of this strategic intent are improved outcomes and experience for patients across the Alliance footprint; patients should have choice and experience more timely access to care, improved continuity across pathways and reduced unnecessary travel. Strengthening tertiary services will support higher quality, safer and more sustainable specialist care, while better alignment of secondary and neighbourhood services will help ensure care is delivered closer to home wherever clinically appropriate. Collectively, this approach aims to reduce unwarranted variation, narrow health inequalities and deliver consistently high standards of care for all communities served by the Alliance.

18 There are already many excellent secondary care and tertiary acute hospital services within Alliance trusts. Where these don't exist the aim would be to get to a performance position that is deliverable and acceptable with the most financially efficient patient pathways on a service-by-service basis.

19 At times there has been expectations that the Alliance would solve the big issues 'for' trusts. With an increasing appreciation that the Alliance is the trusts working together rather than a separate entity with its own distinct resources, an intended focus of this refreshed strategic intent is to be on maintaining everyone's performance and for everyone's performance to improve. This is based on a recognition that some Trusts need to improve more quickly than others and there is a need to help each other in a proactive way to do this.

20 Tackling this will require a light touch process for surfacing where a Trust is not going to be able to maintain performance and needs the help of other Alliance Trusts AND a process for the respective Trusts to discuss and develop solutions. This has tended to be part of the function of the Bilaterals, but with less of an intended focus on maintaining everyone's performance than will be the case in future.

21 It is recognised that the most financially efficient pathway for the same service in different trusts will not cost the same, reflecting variations in scale, estate, workforce, digital enablers etc. Ultimately it would be helpful to have patient-level costing and income information available on a consistent basis for all services in all trusts and to use this to address unwarranted variation and reduce cost. A detailed analytical data pack has been developed to support this work and is available to inform future pathway discussions and Alliance-level decision-making. The data pack will be used iteratively by the Clinical Framework Group and executive teams as specific services are prioritised.

What are secondary care services and what are tertiary services?

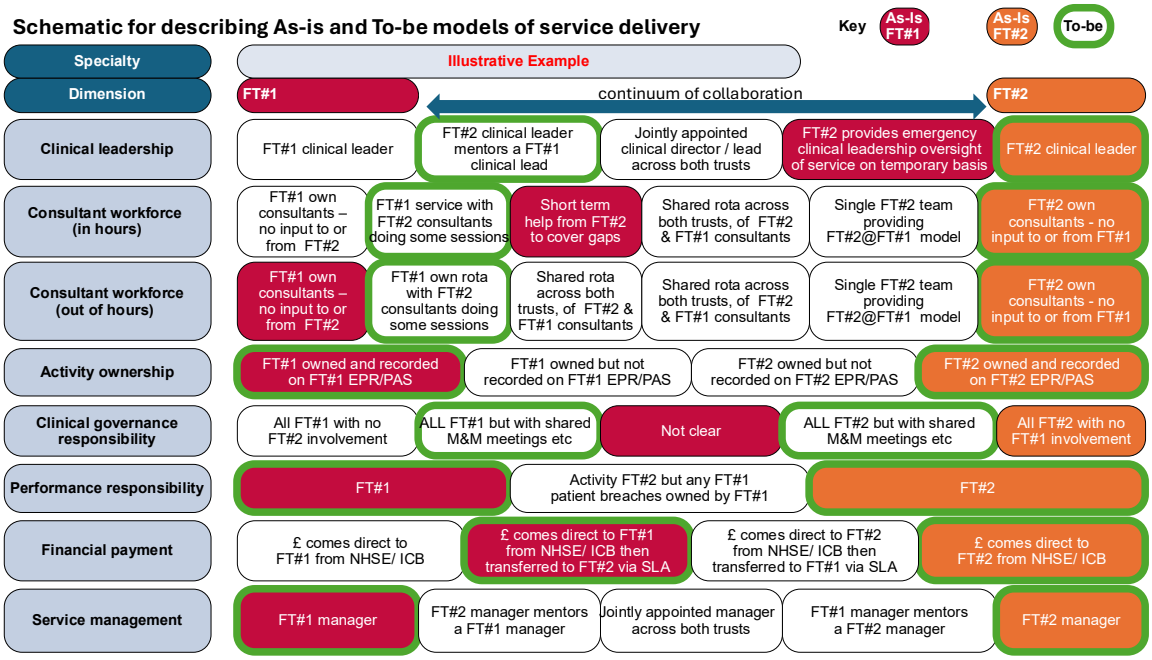
22 There are around 100 different clinical specialties provided by Trusts within the Great North Healthcare Alliance. Of these, there are 16 inpatient treatment functions provided by all 4 trusts (Breast Surgery, Cardiology, Clinical Haematology, Colorectal Surgery, Elderly Medicine, Gastroenterology, General Internal Medicine, General Surgery, Gynaecology, Neonatal Critical Care, Obstetrics, Paediatric, Respiratory Medicine, Stroke Medicine, Trauma and Orthopaedic, and Urology).

23 The variation in other treatment functions provided across all four trusts reflects a combination of differences in services provided and / or organisational strengths, and clinically led approaches to mapping activity to treatment functions.

24 The above information is based on which Trust has responsibility for providing each treatment function, noting this is not always the same as where a service is provided. Indeed there are many variations in models of how care is organised and delivered across the Alliance, with differences in accountability, leadership, workforce, clinical governance, activity reporting, payment, and other arrangements between services. It is recognised that this variation in models can make it difficult to understand current arrangements and to align partners in co-designing improved models of service delivery.

25 To address this a simple draft schematic has been developed that can be populated to show the As-is and To-be models for each service. It is intended a version of this schematic, once updated with any improvements to structure, be used each time executive and senior clinical and operational leads from Alliance Trusts are working together on how to deliver excellent secondary care and excellent tertiary hospital services.

Figure 2 – Illustrative example of populated Schematic for describing the As-is and To-be models for a clinical service between two trusts in the Alliance



Opportunity to strengthen secondary care and tertiary services through cross area patient flows

26 Recent analysis undertaken within the Alliance shows the significant inter area patient flows that exist within the Alliance. 19% of patients treated within the Alliance come from a different local authority area within the wider Alliance area. These flows are broadly in three groupings:

- ‘Boundary patients’ – who live in one local authority area but access secondary care hospital care in another local authority area.

- ‘Shared patient acute specialties’ – where some patients receive part of their care in their local trust and require some element of specialist or tertiary care – most likely in Newcastle.

- ‘Tertiary services’ –services that are only provided locally within Newcastle Hospitals and for which all patients must receive their care from there. The use of ‘tertiary’ for this grouping of services is an oversimplistic misnomer as whilst it includes true tertiary specialised services like cardiac transplant, it also includes services such as dermatology, ENT and ophthalmology which are not tertiary services. This is explored further in para 34 below.

27 It will always be appropriate for some patients who live in one area to have their secondary care in a neighbouring trust, for example where a trust is specifically commissioned to do so, where there is patient choice and/or ongoing medical care, and where a patient takes sick or has an accident away from home and is taken to the nearest available hospital. Where this isn’t the case there are opportunities to revisit patient flows to enable more patients to receive excellent care local to where they live and for capacity to be released to support patients requiring excellent tertiary care to the benefit of all patients in the Alliance.

Tertiary services and the opportunities to strengthen these services

28 It is very difficult to define tertiary services as a number of differing approaches can be taken, each with their own weaknesses and each generating a different list of what constitutes tertiary services. The approaches can be:

- Based on where services are and are not currently provided – e.g. Treatment functions with services that are locally only provided by Newcastle

- Based on how patients are referred – e.g. Treatment functions with services provided following consultant to consultant referral rather than GP referral.

- Based on whether services are commissioned as specialised or highly specialised – e.g. Treatment functions with services commissioned by NHS England Specialised Commissioning teams. OR,

- Based on whether services need to be provided in a tertiary centre hospital – e.g. Treatment functions with services that need to be collocated alongside other specific collocated tertiary centre services such as PICU.

29 Of the treatment functions provided by only one Alliance Trust, most of these treatment functions are provided by Newcastle Hospitals, reflecting its role as the region’s main tertiary provider. The remainder of treatment functions provided by a different single provider are linked to a combination of specialised commissioning and specialty coding issues as set out in para 23.

Sub tertiary services in North Cumbria

30 The range of treatment functions provided by each Trust has been collated and compared as part of this work. This has helped identify those specialties that are only provided within the Alliance by both Newcastle and North Cumbria. These services are worthy of consideration for a) whether they are tertiary / sub-tertiary services and b) whether they may be better provided within the Alliance by a single provider Trust, even if they are to remain being provided in two or more locations.

31 It is recognised that the higher current cost of providing services in North Cumbria is driven mostly by workforce costs, including an existing but reducing reliance on high-cost agency staffing. Through this strategic intent work there is the ambition and opportunity to reduce these excess costs through appropriately innovative workforce models. Analytical work undertaken within the Alliance indicates variation in scale, productivity and cost across a number of sub-tertiary specialties.

32 One of the complexities of specialised services is that they are a disproportionate driver of service deficits in Newcastle over secondary care services. Specialised commissioned services occupy about one-fifth of that Trust's beds, generate about one-third of its income, but drives one-half of its current deficit. This links to the Trust providing the widest range of these services anywhere in the NHS, and the relatively low population it serves for a very wide geography. Other specialist trusts are generally bigger and concentrate on a smaller range of services, such that they have economies of scale in those services. Further work is required to understand variation in specialist care activity per weighted population in each area across the Alliance and to consider opportunities to level up access.

33 There are opportunities to strengthen the Alliance's tertiary services, for example, by ensuring that economies of scale are maximised and that in any negotiations with commissioners the Alliance presents a strong collective position around levelling inequity in national funding allocations and service provision access.

Services that may be mistaken for tertiary services

34 The following treatment functions are sometimes referred to as being specialist or tertiary, not because of the nature of the specialty but because they are provided on a once only basis for the three east coast Alliance trusts. These treatment functions have low levels of specialised commissioning and elsewhere in the country they tend to be provided by the vast majority of acute trusts.

- Dermatology – provided by 91/119 acute trusts nationally and 5/8 trusts across the North East and North Cumbria area.

- ENT – provided by 112/119 acute trusts nationally and 5/8 trusts across the North East and North Cumbria area.

- Ophthalmology –provided by 107/119 acute trusts nationally and 5/8 trusts across the North East and North Cumbria area.

To note: 1) Whilst these are not specialist or tertiary treatment functions overall within them there are some treatments that are specialist; 2) these services are also provided by North Cumbria trust as shown at para 31; 3) services may be provided by Newcastle Hospitals but delivered from hospitals owned and run by other Alliance trusts.

35 These arrangements have been in place for 15+ years and reflect previous agreements between trusts about service configurations and sustainability. There may be opportunities to move some parts of pathways related to these services closer to where patients live, recognising that any change would have workforce implications that need to be considered as part of reviewing pathways. Where there are downsides with current centralised model in terms of patient travel and accessibility, there are some upsides for example in service productivity. In each of these treatment functions Newcastle provides the service at median, better than median, or top-decile levels of productivity. North Cumbria provides the service at below median levels of productivity.

How the Alliance strategic intent relates to wider system and regional activities on clinical strategy

36 In developing this strategic intent there has been recognition of some existing lack of clarity, confusion and/or duplication of effort between a number of existing structures for collaboration (Alliance, Provider Collaborative, managed clinical networks and each of the ones in each place).

37 Some of this layering of structures is beneficial because it enables work to be done at the right level, but it does create confusion for people as it is not simple to navigate what is being done by each and why. It can create duplication for busy clinical and executive leaders and is resource intensive.

38 On this clinical side this predominantly relates to the work of the Provider Collaborative Strategic Approach to Clinical Services (SACS) which is coordinated by a SACS Board. On the corporate service side this related to discussions around potential target operating models for some people functions which are being explored at Provider Collaborative, regional and national levels.

39 It is proposed that:

- The following nested approach framework be adopted, recognising that most of the clinical planning and strategy work will be done within each FT (including with neighbourhood partners), followed in scale of effort and impact, by the work done at Alliance level, and then to a lesser extent by the SACS work.

Figure 3 – Intended nested approach to how clinical planning and strategy work will be taken forward between Trusts, the Alliance and wider system and regional activities

- Work be undertaken between Alliance Medical Directors and the Alliance Formation Team to identify the small number of services that are most appropriate for SACS level engagement.

- Where there are discussions on the corporate side relating to potential collaborations, the Alliance have a named chief executive and/or executive lead who will work with the relevant executives in each trust in any wider discussions. This arrangement is already in place for people functions with Trudie Davies leading as Senior Responsible Owner for the Alliance and the Provider Collaborative.

Integrated Health Organisations (IHOs)

40 The national policy direction toward the development of Integrated Health Organisations (IHOs) provides an important context for this work. IHOs are intended to support closer integration of hospital, community and neighbourhood services within defined geographies.

41 The Alliance's strategic intent is compatible with, and may provide a foundation for, future IHO development within parts of the Alliance footprint. Strengthening collaboration between hospital services and neighbourhood partners will support improved population health outcomes while ensuring specialist services remain sustainable.

42 The Alliance does not predetermine any future organisational form but recognises that clearer clinical pathway alignment and mutual accountability are prerequisites for any deeper integration.

Implementation

43 We propose to take forward the strategic intent set out in this paper through the following steps:

44 **Recommendation 1:** We commit to working to a collective leadership approach for the Alliance based on the following principles:

- We are all part of the NHS, and patients and staff benefit when we work together.
- To be successful as an Alliance we need each of our organisations to be successful.
- We have a collective leadership responsibility for ‘our’ Alliance – it is not ‘The’ Alliance, or something owned and led by others.
- We prioritise collective action where scale provides a clear benefit.
- We value unified governance and shared decision-making on matters related to the Alliance.
- We value expertise-led action: power is distributed to clinical and corporate workstreams and teams rather than remaining solely with executive boards, ensuring those closest to the patient drive innovation.
- We have mutual accountability, including that trusts are held accountable to each other for "living within their means," to achieve a balanced system financial position.

45 **Recommendation 2:** We will co-create an overarching clinical framework and plan for the Alliance, which prioritises and defines the clinical pathways to optimise services we want to make progress on together as the Alliance for the benefit of patients based on their choices. Funding discussions will be required to support this recommendation. This work will be led by an Alliance Clinical Framework Group (CFG) comprising representatives from the executive teams and reporting to chief executives, who may or may not choose to join this group themselves. The resulting framework will be developed with appropriate wider engagement within Trusts, and the final document will be subject to Board approvals. This work will enable the Alliance to have a clearer clinical plan and streamline engagement with the wider system SACS work as set out in para 39.

46 **Recommendation 3:** We will ask Alliance medical directors to reach a clinical consensus view of which treatment functions, and/or subspecialties within them, are tertiary and the pros and cons for moving these closer to hospitals and communities where patients live. We will use this to help us ‘localise where possible and centralise where necessary’ recognising the importance of patient choice and that in most pathways some elements of care can be delivered in patients’ homes and local hospital settings.

47 **Recommendation 4:** We will commission a programme of work with appropriate clinical and operational leadership and relevant analytical input to

look at cross-area patient flows for secondary care, mapping what is provided now and what the impacts would be of changing flows. The work will look at options that releases capacity to deliver tertiary care AND that improves patient choice, quality and overall service sustainability across the Alliance. Appropriate commissioner discussions and wider engagement will be part of any clinically led service discussions that progress, recognising that the release of any capacity in Newcastle may require increased capacity in other trusts. Recommendations will come from the Clinical Framework Group and be subject to Alliance Committee and relevant Board approvals.

48 **Recommendation 5:** We recognise that the strategic intent set out in this paper is more specific than we have previously been about 'our Alliance'. To reflect our mutual accountability and our commitments to the Alliance, once our strategic intent is agreed, we will update our broader Trust strategies to reflect the wording and sentiment of it where appropriate. If and where there are any actions in local trust strategies that are not consistent with the Alliance strategic intent, we will bring these to the attention of our Trust Boards and address this, and update Alliance partners accordingly.

49 **Recommendation 6:** Recognising that the **function** of the Alliance will be focussed on delivering excellent tertiary and excellent secondary care services, we are minded to adjust the governance **form** of the Alliance to help us deliver these functions. Specifically we are proposing to:

- Create the Alliance Clinical Framework Group (CFG) referenced above, with the responsibility to produce the draft overarching clinical framework and plan. This group will be time limited in the first instance and be accountable through the chief executives, who will provide updates to the Alliance Committees.

- Simplify the Alliance committee governance, potentially by merging the Committees in Common and Joint Committee meetings into a single meeting with the same attendees. One section of the agenda will be to deal with 'delegated' matters from the 3 east coast trusts with voting limited to members from GHFT, NHCT and NUTH. This simplified "Alliance Committee" will be a Tier 1 committee of each Trust Board and appear as such in all Trust governance structures and reporting arrangements.

- Learn from how each of the three Bilaterals have been working and improve consistency by moving to a more standardised model with greater clinical representation (through strengthening associate medical director / clinical board chair membership), strengthened business management (through alliance formation team coordination), and greater accountability (through minutes going to the Alliance Committee for approval).

50 In taking forward the above 6 recommendations we do not believe that the range of delegations to the Joint Committee of Gateshead, Newcastle and Northumbria Trusts needs to change because of this work at this time.

51 We will ask the Director of the Great North Healthcare Alliance and the Alliance Formation Team to make sure that the above actions are implemented through a road map to delivery with appropriate chief executive oversight and regular updates to the Alliance Committee and Trust Boards.

Next steps

52 This paper represents **Stage 1** of the refreshed Alliance direction: agreement of a clarified strategic intent and governance alignment.

53 Subject to approval by each Trust Board, **Stage 2** will commence and will include:

- Identification of a small number of priority clinical pathways to progress
- Agreement of clear selection criteria (quality impact, patient benefit, sustainability, workforce resilience, financial opportunity)
- Structured engagement with patients, staff, commissioners and partners
- Identification of early “proof of concept” changes to demonstrate impact

54 The Alliance Clinical Framework Group will bring forward recommendations on these initial priorities within twelve months of establishment.

Recommendation

55 The Board of Directors are asked to:

- approve this paper as the strategic intent of the Great North Healthcare Alliance.

Martin Wilson on behalf of Great North Healthcare Alliance Chief Executives

March 2026

NHS
Great North Healthcare Alliance
Gateshead | Newcastle | North Cumbria | Northumbria

2025/26 Progress report

April 2026

This report sets out delivery against 25/26 objectives

NHS
Great North Healthcare Alliance
Gateshead | Newcastle | North Cumbria | Northumbria

This report sets out:

- Overall context of progress made
- Delivery against each of the 5 strategic priorities for 25/26
- Progress against the wider set of 25/26 milestones
- Progress updates from each of the 3 bilateral relationships – including lessons learned
- Examples of progress made during 25/26, written in a way that may be helpful with patient, staff, governor and board facing communications about the impact of the Alliance

In 2025/26 we have made good progress in some areas, with further work to do in others

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The Alliance Steering Group and Trust Boards have all agreed that the Alliance is making fair, but not great, progress. This is not a criticism of anyone involved and is likely driven by factors such as:

- What “we” are trying to achieve through “our Alliance” is not easy. It requires trust between partners at many levels of the organisations, and this takes time to develop. The Alliance is learning about how best to make cross organisational changes happen.
- NHS accountability mechanisms reinforce the primacy of individual organisational delivery, such as through NHS Oversight Framework (NOF) ratings. It is noted that as management and leadership capacity is tight, the focus is drawn to the urgent in-organisation activities rather than the equally important inter-Alliance activities which are key to longer term sustainability and delivery.
- There has been change in leadership within the Trusts in the Alliance, including 4 chief executives who have all been in post for 3.5 years or less, and of these 3 are in acting roles. Similarly two of the three chairs who were involved in establishing the Alliance are no longer in post.
- The Bilateral model continues to support progress in many areas. That said, some discussions and networks across the Alliance are not as robust as may be required to deliver high impact. The light touch / informality of some of these arrangements was deliberately designed to avoid placing a burden on busy colleagues, but a consequence may be that people have not prioritised sufficient time to engage with partners in the other Alliance trusts that is required to develop the trusting relationships which are required (see first bullet above).
- Alongside this, our discussions around the strategic intent of the Alliance considered how to improve the interface between the Alliance Steering Group, wider Board members, and executives and senior leaders, in particular clinical leaders.
- When it comes to corporate service efficiency opportunities there are the complications of 1) understandable desire to keep services locally run and 2) potential duplication with ICS / regional discussions particularly in HR.

The Alliance Steering Group agreed 5 strategic priorities for 2025/26, with progress shown below (p 1 of 2)

NHS
Great North Healthcare Alliance

25/26 Priorities	Progress by year end March 2026 (RAG rating based on progress against expectations for 25/26)	
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 with a focus on problem solving particularly operational and performance issues in clinical services. Improvements delivered include patient acute cardiology, audiology, NCIC skin and head and neck waits. Focus shifting from addressing issues where one trust is fairing more poorly, to jointly working on areas where overall improvements can be made. Doing collaborative work like the Alliance requires time commitment from already busy executive, clinical and managerial leads and this continues to be a challenge. Focussed support from the Alliance Formation Team in planning and facilitating meetings and discussions found to be very helpful with this. • GHFT board strategic options work clear on renewed priorities for bilateral collaboration, but the bilateral itself stalled for a number of months. QEF transport / logistics support to Newcastle. • Further to go to ensure the existing positive examples of working together at clinical lead and middle manager levels become norm. East coast medical leaders' workshops helpful in building wider clinical engagement and collaboration on priorities. • Alliance strategic intent approved by Boards to 'Work together to deliver excellent tertiary and secondary hospital services, while strengthening neighbourhood care closer to patients' homes'	
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 exec level and sometimes used at service level. 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. Some back office opportunities and ideas are surfacing on bilateral basis, as well as at a regional level beyond the Alliance.	
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 focus in FTs with place-based partners to co-design neighbourhood work with opportunity for shared learning. Each trust at different starting point. • Alliance focus on levelling up FT offers to primary care (including radiology access) and agreeing direction of travel. • ASG supporting Northumbria IHO ambition ahead of wider move to IHO model by other Alliance FTs. • Research commissioned showing no international evidence of impact on inequalities of moving care into community but many other benefits. Results helping local community shift. Follow up research with 2 Community Diagnostic Centres. • Alliance Construction Programme has involved significant market engagement and work with regional and national colleagues to shape the approach. Focus on funded 4 year programme ahead of the longer, as yet, unfunded ambitions. • 4 trust estates teams collaborating on electronics, medical engineering, plans to reduce carbon and capital planning.	

Continued (p 2 of 2)

NHS
Great North
Healthcare Alliance

25/26 Priorities	Progress by year end March 2026 (RAG rating based on progress against expectations for 25/26)	
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 Information Officer appointed across Northumbria, Gateshead and Newcastle. Current focus on stabilising safe digital foundations ahead of longer-term transformation ambitions. • Collaboration between trusts where significant operational digital incidents arise, eg Gateshead PACS. • Work underway on digital governance and risk 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. • Challenge re ensuring all trusts on same page re scale / share of investment needed to deliver ambition asked for. • Opportunity for LIMS collaboration across NHCT, NCIC and NUTH being progressed.	
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; bilaterals between FTs; strengthened neighbourhood planning work at place level with partners; east coast medical leaders' workshops. • Shared leadership evidenced by: close working of CEOs; appointment of Shared Chair and Shared CIO across Gateshead, Newcastle and Northumbria; appointment of Trudie Davies within the Alliance as interim CEO at NCIC; lead directors for finance and research and life sciences, role of Alliance director and Alliance Formation Team, collaboration between estates and facilities teams. • It is recognised that each of the 4 FTs are at different starting points and need to respond to different contexts. For example the inclusion of NCIC in the national Improvement Regime with 'Intensive Government Support' and Northumbria's exploration of Integrated Healthcare Organisation / Advanced Foundation Trust potential developments means collaboration will not be a one size fits all model. • Strengthened 'wrap around' Alliance governance with changes to Alliance Steering Group to move to a single joint meeting and appointment of vice chairs onto the group.	

In addition to the 5 strategic priorities a number of milestones for the year were set. Progress on those is shown below.

NHS Great North

Milestones for 25/26 delivery	Progress by year end March 2026	
CQC Good (or better) x 3	Improvements in performance in many areas. NUTH deescalated from CQC concerns. FT NOF ratings range from 1-4 with NCIC in the intensive recovery programme	
Begin comprehensive review of NCIC sub/tertiary specialties with NUTH. Begin phased transfers of any agreed upon specialties	Closer exec level working between NCIC and NUTH, including monthly bilaterals and planned Clinical Summit. Number of service collaborations underway (OMFS, ophthalmology, paeds T&O) with others being identified. Time consuming.	
Shared culture principles and leadership programme in place	Culture is becoming much more collaborative but work on specific culture principles for how we will and should work not progressed. Sharing some leadership roles across Alliance. Some cross trust participation in leadership programmes.	
Joint recruitment campaigns in place to attract high need areas	Some collaboration specific posts to aid recruitment, mostly between NUTH and NCIC, but also some in other bilaterals.	
Clinical framework agreed	Strategic Intent agreed to “Work together to deliver excellent tertiary and secondary hospital services, while strengthening neighbourhood care closer to patients’ homes”. Clinical Framework Group being established	
Medium Term Financial Plan in place	4 Trust medium term financial plans developed in partnership supported by the Alliance and submitted to NHS England. Alliance level planning is mostly an aggregation of 4 FT plans rather than demonstrating impact of Alliance working. Further work to be done on CIP delivery, coding , counting and where services can share to mutual benefit	
Analysis of NCICs structural deficit and potential measures	Work undertaken by NCIC. Discussions with DoFs as part of development of medium term finance plan	
Deliver significant improvements in quality and access towards recovery of constitutional standards	Significant improvements in areas such as acute coronary syndrome, audiology, head and neck and NCIC skin waits. Overall Alliance performance on each of the main access standards is improving (A&E, RTT, 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 clarifying 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	Work taking place at appropriate differing levels, eg bilaterally on skin and vascular / diabetes between NUTH and NHCT; on a 3 way east coast basis via medical directors on stroke, spines, deteriorating child, audiology and urology. Will be major focus of Clinical Framework Group and development of Alliance clinical plan.	
Joint research and life science strategy agreed	Work underway with research and innovation focus. Big research conversation and big innovation events held.	
Big Build: reviewed top 20 strategic sites for neighbourhood health centres; first FBCs written; joint shared venture developed	Discussion re 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 relevant initiatives Trust and Alliance	Examples include cobranding Community Diagnostic Centre, Big Innovation Conversation, Carol Service, website	
Review Joint Committee and lead director areas	Review of joint committee arrangements done. Changes approved as set out in ‘wrap around governance’ paper.	
Aligned Staff Survey questions	Deprioritised as a current area of focus within overall workforce programme.	

Important work is progressed through bilaterals, such as the one between Northumbria and Newcastle as summarised here

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Complete | On track | At risk | Off track | New suggestion

#	Work area		Description of progress and next steps
1	Audiology		• Encouraging delivery from Bright Charity to support RNIB activity. Risks exist around ongoing affordability and delivery of DM01 position. Last discussed at Bilateral in September. • Concerns and comments from Northumbria Governors and stakeholders still present.
2	Urology		• Continued challenges despite progress to deliver an improvement plan that has resulted in NHCT looking at out and insourcing. Also reviewing SLA, and a shared approach to workforce issues, including job planning, cost-sharing sickness and leave, and recruitment. Last discussed at Bilateral in September. • Work and discussions have shifted out of bilateral meetings into direct / business as usual forums. Ongoing issues being looked at via NCA re MDT and radiology limitations on MDT impacting on cancer performance
3	Skin and plastics		• Ongoing discussions to agree approach to tackling high referral volumes across both trusts and changes to DoS; changes have seen drop in referral numbers to NUTH and increase in NHCT. Agreed to have discussions with respective partners, looking at having discussions with primary care, using technology / AI solutions, looking to other national best practice, and then working with ICB and Cancer Alliance across this to support onward commissioning.
4	West patient flows		• Joint project sub-group set up to look at data from both trusts, separating this from anecdotes. Output coming back to next bilateral board to understand whether there are any options to be developed based on the data.
5	Vascular and diabetes		• Good early discussion in March bilateral to outline opportunities to improve pathways, patient outcomes and operational pressures from varied demographic issues. Exploring data and forming sub-group to take forward work, reporting to next Bilateral.
6	LIMS		• In principle discussions ongoing around extending NHCT LIMS provision to Newcastle. Procurement risks being assessed and worked through. Taken forward through digital / Joint CIO discussions.
7	Pain management		• Reviewing historic issues and service transfer, exploring where improvements are possible.
8	Other issues		• Some areas have moved off the Bilateral agenda, either through them not requiring specific focus that warrants discussion, or because they have moved to ‘business as usual’ type forums – ILD, upper GI, Manor Walks, OMFS, Sterile Services, staff passporting.

Key learning points from the past year

- Bilateral meeting frequency reduced – now c.6-weekly – but duration increased. Single item agendas have been useful to flush out opinions to then focus on solutions.
- Sense from attendees that most recent meetings have been most and increasingly productive. Nature of collaborative options has expanded but still some views raised that are seen as uncollaborative, or seeking to part blame and risk deliverables that are beneficial to patients.
- Discussions increasingly seeking to outline an affordable model of provision that can then be discussed with the ICB to commission but needs to be done prior to any change in pathway to avoid unintended consequences

Important work is progressed through bilaterals, such as the one between North Cumbria and Newcastle as summarised here

Complete | On track | At risk | Off track | New suggestion

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#	Work area		Description of progress and next steps
1	Exec to Exec		• Monthly bilaterals continue. Regular and frequent discussions between CEOs, medical directors and COOs, supported by bilateral discussions between estate, finance, nursing and others. Joint executive to executive held.
2	OMFS		• Services in NCIC currently stabilised with increased input from Newcastle colleagues. Progress slow and relationships could be better. Medical directors and external facilitators working with colleagues in both trust to build relationships around implementing constructive plan.
3	Paeds T&O		• Issues around medical capacity at NCIC supported by in-reach support from GNCH. Intention to ensure that recruitment of consultant at NCIC is supported by continued and paid sessional input from GNCH consultants.
4	Ophthalmology		• Services in both trusts challenged with risks around follow up care (e.g. glaucoma) and capacity. Significant medical and wider clinical leadership support provided by Newcastle into NCIC. Discussions currently underway around how best to support and sustain NCIC service in longer term. Given the significance of the risks to NCIC patients it may be necessary to urgently explore options outside the GNHCA footprint if local mitigations can't be identified.
5	Collaboration model		• Draft collaboration model paper developed and discussed. Principles contained within it currently being checked between bilateral peers with the aim of making good progress and potentially adopting as a blueprint for other bilateral relationships within the Alliance.
6	Gastro		• NCIC have recently asked for help with this specialty due to significant shortfall in consultant capacity. Medical directors bringing together leaders from both trusts to scope the options for collaboration. GNHCA CEOs are aware and supporting clinical leaders to see if any solutions can be reached
7	Research and education		• Medical director dialogue about opportunities linked to new Cumbria Imperial Pears Medical School
8	Clinical summit		• Intention to hold a joint clinical summit of c30 senior clinical leaders to build senior clinical relationships between the 2 trusts, so that as individuals and collectively they (1) share better understanding of each others challenges in providing high quality care, (2) identify ways to work together to improve services for patients and staff, and (3) can more easily work directly in delivering these improvements. Intention to hold in June. Proposal with MDs and DoNs.

Key learning points from the past year

- New NCIC interim CEO and chair have brought Alliance working into greater focus within the Board who are supportive of the Alliance strategic intent direction of travel.
- Need for active day to day executive involvement where fragility of some clinical level relationships can show up in some unexpected developments that can knock back collaborative clinical and managerial working.
- Greater service level managerial and leadership churn than seen in other bilaterals reinforces need for good program governance and reporting in and to bilateral discussions.

Important work is progressed through bilaterals, such as the one between Gateshead and Newcastle as summarised here

Complete | On track | At risk | Off track | New suggestion

NHS
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#	Work area		Description of progress and next steps
1	Gateshead Board support for closer Alliance working		• Gateshead Board have considered various strategic sustainability options and concluded that strong collaboration via the Alliance is key. • 6 clinical pathways identified for prioritised progress via Alliance with Newcastle in acute oncology, cancer, cardiology, paeds, stroke and urology.
2	Alliance strategic intent		• Both Boards and executive teams have approved Alliance Strategic Intent to 'Work together to deliver excellent tertiary and secondary hospital services, while strengthening neighbourhood care closer to patients' homes'.
3	East Coast Medical Directors' collaboration		• Close medical director collaboration between the two trusts and with Northumbria. Very helpful monthly meetings with progress being made in identifying and taking forward opportunities for collaboration. Gateshead MD to Chair Clinical Framework Group for the Alliance as a whole. • Active engagement from senior clinical leaders from both trusts in 2 east coast medical leaders' workshops that have identified specific areas of focus for collaboration in stroke, spines and paeds. Joint working groups being established.
4	Bilateral meetings		• Bilateral meetings have lost momentum. Renewed focus required aligned to the clinical pathways identified above with face to face meetings in working time.
5	Paediatric collaboration		• Positive discussions between senior medical and managerial leaders about opportunities for closer collaboration around acute and community paediatric models of care between Gateshead and Newcastle GNCH. Further two meetings to be arranged with the aim to draft up a proposal for a future model for paediatric care between the two trusts as part of the wider network arrangements.
6	Urology		• Continued challenges despite numerous discussions at operational management level to improve access for patients. SLA for 26-27 has confirmed a capacity / demand imbalance in relation to Gateshead referrals. • Opportunities considered about changing service model but challenges with stranded costs. Joint update paper being prepared for consideration by executive leaders to look at next steps.
7	CDC		• Collaborative Community Diagnostic Centre opened at Metro Centre providing increased capacity and reducing patient waits. Challenges with different booking and digital systems. Good governance arrangements in place to address operational and strategic issues. • Phase 2 of the CDC successfully supported by NHSE. Facility to be regionally available rather than via a bilateral model. Focus on embedding neighbourhood health within phase 2. • Intention to build on Alliance prevention workstream research into impact of moving care from hospital to community by undertaking follow up study between Metro Centre and Workington CDCs looking at opportunities to reduce inequalities in access etc.

Key learning points from the past year

- Bilateral working requires both Board / executive commitment to the Alliance model and relevant executive director capacity to engage in and drive the work.
- SLA issues need to be brought into bi-lateral discussions.

Examples of progress made during 2025/26 through the Great North Healthcare Alliance

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- **Stronger working relationships across hospitals:** Staff across the Alliance are working together better than ever before. In places where relationships were once difficult, teams now feel more positive, supportive and aligned. This stronger way of working is helping us make faster decisions and deliver improvements more quickly, supported by regular joint working and strong leadership from our Boards.
- **Faster treatment for heart attack patients:** Patients with acute coronary syndromes are now being transferred to the Freeman Hospital for specialist treatment much more quickly. Average waiting times have been cut from four days to two. This means better outcomes for patients, quicker recovery, and shorter hospital stays.
- **More care available closer to home:** New services and improved care pathways mean more patients can now be diagnosed and treated locally, without unnecessary trips to hospital. Two new Community Diagnostic Centres have opened in Workington and at the Metrocentre. These have helped reduce waits for head and neck services in Cumbria, and for lung disease services in Northumberland and North Tyneside.
- **Quicker access to hearing aid support:** By working with voluntary sector partners, patients can now get hearing aid supplies and repairs more quickly and closer to home. This frees up NHS staff to focus on patients with more complex hearing needs, improving care for everyone.
- **Better recruitment to hard-to-fill roles:** Trusts have worked together to recruit consultants in specialties where staffing has been a challenge. By advertising and recruiting jointly, services are becoming more stable and resilient for patients.
- **Making services more consistent for GP practices and patients:** The Alliance recognised that access to tests and services offered to GPs and patients varied between trusts without clear reasons. Trusts are now working together to align and improve these offers, making it easier for GPs to refer patients and for patients to receive the care they need.
- **Sharing clinical expertise to improve care:** Clinical leaders from different trusts now meet regularly to share learning and solve problems together. For example, in children's services this joint working helped open up more capacity over the winter, supporting safer care for families.
- **Successfully used real-time patient feedback in 4 emergency departments** to build leadership capability, empower teams, and improve patient experience
- **Stepping in to support when problems arise:** When one trust experiences difficulties, others step in to help. For example, when digital radiology systems failed in Gateshead, other Alliance trusts shared staff and expertise so patient care could continue with minimal disruption.
- **Improving care pathways along the east coast:** Senior medical leaders from the three east coast trusts are meeting regularly to improve how services work across organisations. This is helping to smooth patient journeys and make it easier for staff to work together across trust boundaries.
- **A shared vision for the future:** All Alliance organisations have agreed a clear shared ambition: to work together to deliver excellent hospital services while strengthening care closer to people's homes. This shared direction is guiding decisions and future improvements.
- **Using research to reduce inequalities and improve value:** A local university has helped research the impact of moving services from hospitals into the community, particularly on health inequalities. This evidence is shaping how services change, ensuring improvements benefit patients and make best use of public money. Further research is now underway to make the most effective use of Community Diagnostic Centres.