University Hospitals of North Midlands NHS Trust

AGENDA | Trust Board - Part 1 (in Public)

Meeting held on Wednesday 10th December 2025 at 9.30 am to 12.30 pm

Trust Boardroom, Third Floor, Springfield, RSUH

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
9:30	**PROCEDURAL ITEMS**					
20 mins	01	Staff Story	Information	Mrs J Haire	Verbal	
5 mins	02	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Prof S Toor	Verbal	
	03	Declarations of Interest	Information	Prof S Toor	Verbal	
	04	Minutes of the Meeting held 8th October 2025	Approval	Prof S Toor	Enclosure	
	05	Matters Arising via the Post Meeting Action Log	Assurance	Prof S Toor	Enclosure	
10 mins	06	Questions from Members of the Public in relation to matters on the agenda	Information	Prof S Toor	Verbal	
10:05	**CHAIR AND CHIEF EXECUTIVE UPDATES**					
10 mins	07	Chief Executive's Report – December 2025	Information	Dr S Constable	Enclosure	
10 mins	08	Board Assurance Framework – Q2	Assurance	Mrs N Hassall	Enclosure	All
10:25	**OUR PATIENTS: QUALITY, ACCESS & OUTCOMES**					
10 mins	09	Maternity & Neonatal PSIRF Investigation Report Q2	Assurance	Mrs D Brayford	Enclosure	1
15 mins	10	UEC Pressure and Ambulance Handover Update	Assurance	Mrs K Thorpe	Enclosure	1
10 mins	11	Nurse Staffing Establishment Review	Assurance	Mrs AM Riley	Enclosure	1
11:00 – 11:15 COMFORT BREAK						
11:15	**OUR PEOPLE**					
10 mins	12	Speaking Up Report Q1/Q2 2025/26	Assurance	Mrs N Hassall	Enclosure	3
11:25	**PERFORMANCE**					
	13	Integrated Performance Report – Month 5 and Committee Assurance Reports:				
20 mins	13a	• Quality, Access & Outcomes Committee Assurance Report (07-11-25, 26-11-25 & 04-12-25) • Quality & Access Dashboard	Assurance	Prof A Hassell Mrs AM Riley/ Mrs K Thorpe	Enclosure	1
15 mins	13b	• Finance & Business Performance Committee Assurance Report (03-11-25 & 01-12-25) • Finance Dashboard	Assurance	Ms T Bowen Mr M Oldham	Enclosure	6, 7
10 mins	13c	• People, Culture and Inclusion Committee Assurance Report (03-12-25) • People Dashboard	Assurance	Mrs L Bainbridge Mrs J Haire	Enclosure	3
12:10	**GOVERNANCE**					
5 mins	14	Audit Committee Assurance Report (06-11-25)	Assurance	Mrs M Monckton	Enclosure	
10 mins	15	EPRR Core Standards Assurance	Assurance	Mrs K Thorpe	Enclosure	
12:25	**CLOSING MATTERS**					
5 mins	16	Review of Meeting Effectiveness Link to feedback form: https://forms.office.com/e/tydNkMB2Mj	Information	Prof S Toor	Verbal	
	17	Review of Business Cycle	Information	Prof S Toor	Enclosure	
12:30	**DATE AND TIME OF NEXT MEETING**					
	18	**Wednesday 11th February 2026, 9.30 am, Trust Boardroom, Third Floor, Springfield, Royal Stoke**				

Questions from the Public - Please submit questions in relation to the agenda, by 9.00 am 8th December to nicola.hassall@uhnm.nhs.uk

Minutes of Meeting

Trust Board – Part 1 | 8th October 2025 9.30 am to 1.15 pm

Trust Boardroom, Third Floor, Springfield

University Hospitals of North Midlands NHS Trust

Members Present:			
Name	**Initials**	**Title**	
Ms J Small	JS	Chair (Chair)	Voting
Ms T Bowen	TBo	Non-Executive Director	Voting
Prof A Hassell	AH	Associate Non-Executive Director	Non-Voting
Prof K Maddock	KM	Non-Executive Director	Voting
Mrs M Monckton	MM	Non-Executive Director (virtual)	Voting
Miss W Nicholson MBE	WN	Non-Executive Director (virtual)	Non-Voting
Prof S Toor	ST	Non-Executive Director (virtual)	Voting
Dr S Constable	SC	Chief Executive	Voting
Dr D Adamson	DA	Chief Medical Officer	Voting
Ms H Ashley	HA	Director of Strategy	Non-Voting
Mrs C Cotton	CC	Director of Governance & Communications	Non-Voting
Mr M Oldham	MO	Chief Finance Officer (virtual)	Voting
Mrs A Freeman	AF	Chief Digital Information Officer	Non-Voting
Mrs J Haire	JH	Chief People Officer	Non-Voting
Mrs K Thorpe	KT	Interim Chief Operating Officer	Voting
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI	Non-Voting

Apologies Received:			
Name	**Initials**	**Title**	
Mrs L Bainbridge	LB	Non-Executive Director	Voting
Mrs AM Riley	AR	Chief Nurse	Voting

In Attendance:		
Name	**Initials**	**Title**
Mrs J Dickson	JD	Deputy Director of Communications
Mrs N Hassall	NH	Deputy Director of Governance (minutes)
Mrs J Holmes	JH	Deputy Chief Nurse (representing Mrs Riley)
Dr M Poulson	MP	Deputy Chief Medical Officer (item 15)
Mrs S Jamieson	SJ	Head of Midwifery (item 11)

Members of Staff and Public: 5

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Patient Story**	
095/2025	A patient story was shared with members of the Trust Board via the following link: https://vimeo.com/1123912934/aa2e540ec7?share=copy which highlighted the experience of a family following the discharge of a relative. Mrs Cotton opened the discussion by referring to recent conversations around patient communication, noting the importance of listening and learning from such stories. Professor Hassell welcomed the improvements made following the complaint but expressed concern over the initial response, which lacked empathy and compassion. Dr Adamson agreed, stating that basic elements of patient communication and end-of-life care must be consistently delivered, and praised the co-creation of improvements with the family.	

	Mrs Monckton thanked the family for sharing their experience and queried whether the Trust had implemented the suggested improvements and how the complaint had been investigated. Mrs Huntley confirmed that the complaint had been fully investigated and that the elderly care team was taking forward the recommendations. Mrs Haire commended the family's generosity in sharing their story and emphasised the power of listening, referencing the impact of Mrs Pope's experience. Ms Bowen extended condolences and raised concerns about whether this was an isolated incident or indicative of a broader pattern. She questioned the clarity of communication and whether families were leaving conversations with differing understandings. Mrs Huntley responded that complaints were triaged, and trends considered, acknowledging challenges around health literacy. She noted that training was underway to improve communication and ensure explanations were provided rather than making assumptions. Dr Constable highlighted the difficulty of such communications and the value of face-to-face meetings to capture nuances. He confirmed that all complaints and responses were reviewed by him and triangulated with other governance concerns. Mrs Freeman noted that the patient had received a discharge summary which suggested it was not user-friendly and suggested that the format and language be reviewed. She proposed exploring AI solutions to rewrite discharge summaries in a more accessible way. Ms Small thanked the family for sharing such an emotive story and welcomed the co-production of the discharge pack. She emphasised the importance of clear documentation to support families during difficult times. Ms Bowen queried whether staff felt empowered to prevent inappropriate discharges, raising concerns about missed opportunities for intervention. **The Trust Board noted the patient story.**	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
096/2025	Ms Small welcomed members to the meeting. Apologies were received as noted above and the meeting was confirmed as quorate.	
3.	**Declarations of Interest**	
097/2025	There were no declarations of interest raised.	
4.	**Minutes of the Meeting held 9th July 2025**	
098/2025	The minutes of the meeting held on 9th July were approved as a true and accurate record.	
5.	**Matters Arising via the Post Meeting Action Log**	
099/2025	PTB/617 – Mr Oldham provided an update on coding progress, confirming that coding was complete and monthly HSMR data was being reviewed to provide assurance. A report was being prepared to explore wider issues impacted by incomplete coding, which would be presented at the next Quality Access and Outcomes (QAOC) Committee.	

	PTB/618 - Mrs Haire reported that the People Dashboard action was on track and that the team had been asked to include standard bullet points for clarity in future reports.	
6.	**Questions from Members of the Public in relation to matters on the agenda**	
100/2025	Mr Syme referred to diagnostics performance, in particular non-obstetric ultrasound waits and access. He referred to recent UHNM data in terms of patients waiting over 6 weeks and 13 weeks, stating that when compared to other data from NHS England that the wait exceeding 6 weeks was the highest in England. He made reference to initiatives which were described at the Integrated Care Board (ICB) meeting in September and queried what other initiatives were being devised by the Trust for implementation to address the access to non-obstetric ultrasound. Mrs Thorpe responded that Community Diagnostic Centre (CDC) capacity was already funded and not an additional cost. She explained that not all patients could be moved out of the 13-week wait category and that registrars were assisting with training. Two posts had been recruited and were due to start within three months, with locums providing backfill. Mr Syme referred to the national Urgent and Emergency Care (UEC) plan 2025 which required all NHS Acute Trusts to devise a strategy / plan to return ambulance handovers to the national requirement i.e. 15 minutes. He queried the present state of play regarding UHNM devising such as strategy/plan and when the action plan would get the Trust back on track to turning ambulances around within 15 minutes at ED portals. Mrs Thorpe explained that the Trust was currently working towards a 45-minute handover target and an assurance visit from the national advisor was scheduled to review the use of corridor care and escalation spaces.	
CHAIR AND CHIEF EXECUTIVE UPDATES		
7.	**Chair's Update**	
101/2025	Ms Small reflected on her first four months as joint Chair with Midlands Partnership NHS Foundation Trust (MPFT). She highlighted her engagement with executive and non-executive directors to understand key challenges and areas of focus. She had attended all Board committees and met monthly with the Freedom to Speak Up Guardian to gain insight into organisational culture. She reported on service visits, including to wards 221, 226, and 228, a tour of the Emergency Department to understand patient flow and reconfiguration and considered the challenges associated with caring for frail and elderly patients. She had also observed robotic surgery and met with research and innovation leads. Her focus for November would include further ED visits and engagement with Black History Month activities.	
8.	**Chief Executive's Report – October 2025**	
102/2025	Dr Constable provided an overview of operational performance. He noted improvements in elective care, placing UHNM in the top half nationally, but acknowledged challenges in non-elective care, where performance was in the bottom third. He attributed recent challenges to a sharp increase in respiratory viruses and Covid admissions and added that increased cases of flu and	

	respiratory syncytial virus (RSV) were also being experienced within the community. He also observed that ED attendances were 50% higher than expected, suggesting difficulties in accessing alternative care. Professor Hassell asked about system-wide collaboration, and Dr Constable confirmed strong engagement from partners and the need for agility in modifying plans. **The Trust Board received and noted the update.**	
9.	**Provider Collaborative Update**	
103/2025	Ms Ashley provided an update on the progress of the respiratory project, noting that revised patient pathways were due to be trialled in the coming weeks. These pathways aimed to improve identification and turnaround of patients at the front door, supported by initiatives such as hot clinics and handovers to community teams. She acknowledged the broader challenge of extending these improvements and emphasised the importance of collaboration across the ICB cluster. Ms Ashley also referenced ongoing work with Shropshire, Telford and Wrekin on back-office and corporate services, highlighting the potential for increased resilience. Ms Bowen queried the governance arrangements for the UEC forum. Ms Ashley explained that governance was intentionally light touch to avoid burdening transformation efforts, given that these services were already delivered by the Trust. She added that metrics were being developed to measure both activity and impact. Mrs Thorpe clarified that while transformation governance was minimal, UEC specifics were embedded within winter schemes and monitored through the winter assurance programme. Ms Small welcomed the respiratory pathway work and asked about the communication strategy for patients. Ms Ashley responded that the initial focus had been on developing the offer, with patient information and communications to follow. She emphasised the importance of supporting patients in understanding how to keep themselves well. **The Trust Board received and noted the update.**	
10.	**Board Assurance Framework – Quarter 1**	
104/2025	Mrs Cotton introduced the Quarter 1 update on the Board Assurance Framework (BAF), referencing earlier strategic risk discussions held by the Board. She explained that the strategic priorities had been refreshed earlier in the year alongside the performance and accountability framework, with the BAF forming a key component. Work was ongoing to ensure alignment between the BAF and care group-level strategic risks, including planning workshops with care group leadership boards to identify strategic risks related to people, patients and population. Dr Constable added that the BAF should be viewed within the broader context of organisational change, including the new strategy, performance framework, behavioural framework and restructure. He emphasised the importance of cultural change and structural alignment in driving performance improvement. Mrs Cotton noted that engagement with care group leadership teams had been helpful in setting governance expectations and adapting meeting structures to better fit their needs.	

	Ms Bowen referred to the feedback on the BAF at committee level and the need to identify key actions that could significantly address the strategic risks. Mrs Cotton confirmed that three major issues had been identified which impact most risks and as such should be the focus. Ms Small welcomed the approach and noted that committee oversight and care group engagement should lead to progress on foundational improvements and cultural change. Mrs Cotton concluded by highlighting system-wide collaboration on the BAF, including regular discussions and the development of a strategic risk map to identify similarities and differences across the system. **The Trust Board received and approved the Board Assurance Framework for Quarter 1.**	
OUR PATIENTS: QUALITY, ACCESS & OUTCOMES		
11.	**Maternity and Neonatal PSIRF Investigation Report – Quarter 1**	
105/2025	Mrs Jamieson presented the Quarter 1 report, noting that four new incidents had been reported that met the criteria for Patient Safety Incident Investigations (PSII). She confirmed that duty of candour had been applied to all eligible incidents within the required timeframes and that actions were being monitored through directorate governance. Themes had been clearly reported and triangulated with complaints and other incidents. The Trust had achieved 100% compliance in reporting to the Maternity and Neonatal Safety Improvement Programme (MNSI) and NHS Resolution (NHSR). Mrs Jamieson also reported that the Perinatal Mortality Review Tool (PMRT) required external review of cases, with UHNM exceeding the 50% target by achieving over 90% and the Trust continued to engage families and provide accessible information. Professor Hassell welcomed the increase in external reviews and noted that the expanded version of the report had been considered at committee level. Dr Constable asked for an update on collaborative work with local authority colleagues on perinatal mortality. Mrs Jamieson confirmed that initial meetings had taken place with public health representatives and that efforts were underway to reduce smoking and improve vaccination uptake, including the deployment of a vaccination bus to reach communities. Ms Ashley commented on the evolving role of the acute Trust in supporting public health initiatives and challenging misconceptions about its capabilities. Professor Toor welcomed the community engagement and asked about communication strategies for vaccination, including multilingual messaging. Mrs Jamieson confirmed that funding had been identified and that communications were being developed. Ms Small praised the partnership work and requested that vaccination data be included in the winter plan. **The Trust Board received and noted the update.**	
12.	**Mortality Assurance Annual Report 2024/25**	
106/2025	Dr Adamson presented the annual report, highlighting significant progress in learning from deaths, increased attendance at mortality reviews and closure of actions. She noted that mortality indices had increased, but crude mortality	

	remained in line with expectations. The medical examiner service was reviewing deaths in addition to Structured Judgement Reviews (SJRs), and improvements in coding were underway following the recruitment of four coders. Dr Adamson acknowledged concerns about increased deaths among patients with long stays in ED, although no direct causal links had been identified. She also referenced positive PMRT performance and outlined actions for the coming year. Dr Constable emphasised the importance of taking into account qualitative assessments and external scrutiny in providing assurance. Mr Oldham discussed the implications of coding gaps, noting that while income had not been directly affected, comparisons with peers could be flawed. He confirmed that 100% coding had resumed from April 2025 and that retrospective coding of 39,000 episodes was not planned due to cost and time constraints. He stated that this would be considered in the paper being prepared for the QAOC and the issue regarding coding had been raised with NHSE and the ICB. Ms Bowen asked about progress with the Electronic Patient Record (EPR) business case, and Mrs Freeman explained that regional funding had not yet been allocated, delaying progress. She added that contract negotiations with System C were ongoing. Mrs Freeman also mentioned the potential use of AI-based coding solutions, pending approval. Dr Constable reiterated dissatisfaction with the current situation and the need for assurance through alternative mechanisms. Ms Small asked about the dissemination of learning from SJRs and it was noted that all departments held mortality and morbidity meetings although a standardise approach in spreading learning was required. Mrs Cotton confirmed that this linked to a broader communications strategy in terms of sharing learning in a consistent and easily digestible way. **The Trust Board received and approved the report.**	
13.	**Urgent and Emergency Care Pressures, Ambulance Handovers & Winter Plan**	
107/2025	Mrs Thorpe presented the winter planning update, noting that data modelling indicated the Trust was three to four weeks ahead of schedule, which reflected early flu trends observed in Australia. Tactical actions had already been implemented, including the deployment of 24/7 Hospital Ambulance Liaison Officers (HALO) at the front door to receive ambulances, with all staff fully trained. Escalation spaces had been expanded, including corridor care, and ward areas had been reconfigured to support continuous patient flow. She reported positive developments in care group leadership and the formation of the unplanned care group, which had reviewed the current front door model. The next iteration would focus on integrating acute medical and ED services. The vaccination programme had commenced, and the waterfall diagram would be updated to reflect progress. Ms Bowen asked whether a Red, Amber, Green (RAG) rating was being applied to the winter plan. Mrs Thorpe confirmed that the system held weekly winter assurance meetings, and additional data would be incorporated.	

	Professor Maddock raised concerns about staffing, particularly in light of increased absences. Mrs Thorpe responded that recruitment was underway, targeting newly qualified staff and ensuring experienced staff were appropriately distributed. Mrs Haire reported a rise in staff absences, with 100 more than the previous month, with a large number due to Covid. A winter wellbeing plan was in place, including flu vaccinations and targeted support for high-pressure areas. Miss Nicholson referred to the spike in covid cases and queried the national policy on Covid vaccinations for staff. Ms Ashley confirmed that current policy did not support Covid vaccination for staff. Ms Small requested assurance regarding patient safety in corridor care. Mrs Holmes explained that additional quality comfort rounds were being conducted to maintain dignity, and procedures were carried out in private rooms. Mrs Thorpe added that strict nursing ratios and criteria were in place for corridor care. **The Trust Board received and noted the update.**	
14.	**Undertakings – Urgent & Emergency Care / Elective Care Recovery Programmes**	
108/2025	Dr Constable reminded the Board that enforcement undertakings had been issued by NHSE in October 2023. Most had now been removed, with two residual undertakings remaining for UEC and elective care. The Trust's response would be submitted to NHSE and reflected existing plans. Mrs Thorpe provided further detail, noting that the undertakings required a return to performance standards, including the 45-minute ambulance handover target. She acknowledged that some workstreams were off trajectory and that the elective improvement plan needed to address high-difficulty specialties. Ms Bowen referred to the request for elective care services to consider milestones over the next decade. Mrs Thorpe explained that transformation in some areas required broader system change, and the ICB strategy included long-term planning. Ms Ashley noted that the neighbourhood model was underdeveloped in Staffordshire compared to other regions. Ms Small asked whether the provider collaborative could influence this and Ms Ashley confirmed that joint governance structures were in place, but more work was needed. Mrs Monckton queried whether winter pressures had been factored into the trajectory. Mrs Thorpe confirmed that they had, although not as early, and the trajectory would be resubmitted. Professor Hassell observed that most workstreams were off track, suggesting either flawed planning or ineffective implementation. Mrs Thorpe acknowledged both possibilities and emphasised the need for agility in identifying actions. Dr Constable stated that if the plan was not delivering, it must be revised. Mrs Thorpe confirmed that the plan was iterative and had been based on national advisor recommendations. Ms Ashley added that constant requests for improvement plans made it difficult to remain agile. Professor Hassell stressed the importance of understanding why workstreams were failing. Mrs Thorpe confirmed that tiering conversations were in place for weekly reviews. Ms Monckton raised concerns about assurance if the trajectory could not be trusted. Ms Small agreed and called for clarity on assurance mechanisms. Dr	

	Constable reiterated that the plan was sound but not delivering, and external consultation would be sought to improve it. **The Trust Board endorsed the submission to NHSE but noted that the programme plan required further review to ensure assurance on direction of travel.**	
OUR PEOPLE		
15.	**Appraisal and Revalidation Annual Report**	
109/2025	Dr Poulson presented the annual report, confirming that all appraisals were conducted in line with national standards. He noted challenges with the current system, which prevented appraisals from being completed after April, and proposed moving the appraisal window to February/March. Recruitment of additional appraisers was underway, and the Trust was also expanding the pool of case investigators and managers for MHPS cases. A Responsible Officer Advisory Group (ROAG) had also been established to support case review and lead appraisers. Professor Hassell queried the 25% rate of unapproved missed appraisals, which Dr Poulson attributed to timing issues. He also confirmed that a regular Quality Assurance process was in place, including consideration of external reviews and Mrs Cotton suggested exploring internal audit options. Ms Small asked how more appraisers could be recruited, and Dr Poulson explained that expressions of interest were invited, and training sessions held regularly. He added that consideration to align appraisal duties within job plans were being considered and for those colleagues who had missed an appraisal, further analysis was undertaken to establish whether this was a recurring trend. Dr Adamson thanked Dr Poulson for stepping into the role as Responsible Officer and emphasised the importance of consultant engagement. Dr Constable noted the regulatory significance of appraisals and their contribution to patient outcomes. Ms Small commented that the process was integral to good outcomes for patients and thanked Dr Poulson for the report. **The Trust Board received and noted the report and approved the findings.**	
16.	**Speaking Up Report Quarter 3 & Quarter 4 2024/25**	
110/2025	Mrs Cotton reported that Speaking Up Week would take place week commencing 13th October, which had been condensed from a month-long campaign. Activities included “Wear Green Wednesday” and the promotion of newly recruited champions, with 30 added in the second wave. She emphasised the need for holistic cultural change and integration of speaking up mechanisms, including the Guardian of Safe Working and the sexual safety agenda. A Freedom to Speak Up (FTSU) accountability framework had also been developed to clarify expectations. Mrs Thorpe welcomed the accountability framework which was helpful in triangulating performance data. Mrs Whitehead noted that policy and procedure concerns were the most common category and suggested reviewing policy volume and communication. Mrs Haire added that AI	

	solutions were being explored to improve policy navigation particularly within the People Directorate. Ms Bowen asked whether the Trust was committed to addressing emerging themes. Mrs Cotton confirmed that a development plan was being prepared for corporate and care group priorities. Ms Bowen welcomed the champion recruitment and suggested more inclusive posters. Ms Small proposed video soundbites to promote speaking up. Mrs Cotton confirmed that this was being considered. **The Trust Board received and noted the report.**	
17.	**Workforce Race and Workforce Disability Equality Standard Reports 2025**	
111/2025	Mrs Haire presented the annual reports, noting that Black and Minority Ethnic (BAME) representation had increased to 29.2% over five years. However, gaps remained at senior leadership levels, including the Board. Career progression had improved, but white applicants were still more likely to be appointed. Bullying, harassment and discrimination rates were higher among ethnic minority staff, and this remained a focus area. The ethnicity pay gap favoured ethnic minorities due to their representation in higher-paid roles and disability representation stood at 5.7%, with 28% of staff reporting long-term conditions. Campaigns were underway to promote reasonable adjustments and review management training. Professor Toor asked about the integration of FTSU, Equality Diversity and Inclusion (EDI) and behavioural frameworks. Mrs Cotton confirmed that a suite of interconnected frameworks had been developed. Mrs Freeman queried the impact of higher salaries among consultants, and Mrs Haire acknowledged the need to address diversity drop-off at Band 7 and 8a levels. Ms Small asked how the Trust was addressing recruitment bias. Mrs Haire outlined debiasing strategies and positive action campaigns. Ms Small stressed the importance of consistency and accountability among hiring managers to which Mrs Haire agreed was challenging in terms of the reach to hiring managers and ensuring they were being held accountable for the decisions they made. **The Trust Board received and approved the report.**	
18.	**Equality, Diversity and Inclusion Annual Report 2024-25**	
112/2025	Mrs Haire sought approval for the publication of the EDI Annual Report. She summarised the Trust's achievements, including enhanced patient feedback, accessible communications, national recognition, and the launch of an anti-racist statement. Staff networks had grown, and priorities for 2025/26 were outlined. **The Trust Board received and approved the report.**	
PERFORMANCE		
19.	**Integrated Performance Report – Month 5 and Committee Assurance Reports:**	

113/2025	<u>Quality, Access & Outcomes Committee Assurance Report (31-07-25, 28-08-25 & 01-10-25)</u> Professor Hassell reported on infection prevention, waiting list equity, and sepsis management in children's service and he welcomed the update in relation to the Care Excellence Framework whereby the number of bronze rated areas had reduced from 6 to 1. Maternity services received positive assurance in a number of areas and the Committee noted that Board Safety Champions were supporting the perinatal leadership team to better understand and craft local cultures, including identifying and escalating safety and quality concerns and offering support where required. It was noted that this included meetings with the Perinatal Leadership Team and the Maternity and Neonatal Voices Partnership (MNVP) bi-monthly as a minimum and that any support required of the Trust Board had been identified and is being implemented. It was noted that the Trust Board (or QAOC) monitored improvement in maternity and neonatal culture, and any identified support considered and implemented. It was noted that this had particularly been achieved with the presentation and review of the Cultural Improvement Plan for Maternity and Neonatal Services. Professor Hassell continued to highlight the patient experience report for Quarter 1 which demonstrated a 28% increase in the number of formal complaints. This trend was being reviewed in the context of responses provided by the Patient Advice and Liaison Service (PALS) and subsequent follow-up actions. Despite the rise in complaints, there was notable progress in patient and public involvement, with several examples of good practice highlighted. The Trust reported an 8% increase in safeguarding referrals in the year, and the service successfully managed the increased demand, maintaining appropriate safeguarding standards and response times. The neonatal team presented findings from the 2024 National Audit, which identified the Trust as an outlier for bronchopulmonary dysplasia, a condition primarily affecting premature infants. Assurance was provided to the Board, as Quarter 1 and Quarter 2 figures demonstrated improvement, with rates lower than the network average, indicating significant progress and assurance in this area. <u>Quality & Access Dashboard</u> Mrs Holmes highlighted the following: • Infection Prevention Week was to take place on 20th October, during which the Trust would undertake a comprehensive bed and commode cleaning initiative. It was noted that indications from the exercise in the previous year suggested a positive impact on C. diff rates. • A presentation on the 'Stay in the Bay' initiative was delivered to QAOC, demonstrating a reduction in patient falls within designated areas. This was recognised as a positive development in patient safety. • Friends and Family Test (FFT) response rates had increased, attributed to a streamlining of the questionnaire, which reduced the number of questions and improved accessibility. • There was a notable rise in complaints during Q1, with 306 complaints remaining open at the time of reporting. Significant work was underway to analyse the underlying causes and identify areas for improvement.	

	• The Electronic Prescribing and Medicines Administration (EPMA) system had been successfully implemented at County Hospital, marking a key milestone in digital transformation. • Martha's Rule – Call for Concern had been rolled out across four adult wards, reflecting the Trust's commitment to learning and continuous improvement in patient escalation pathways. • Sepsis screening performance remained below the desired threshold, but the team expressed confidence that target levels could be achieved with ongoing efforts. Mrs Thorpe highlighted the following: • Attendances across services continued to rise during the reporting period. Further detailed analysis was required to understand the underlying drivers of this increase. • In relation to cancer performance, there was ongoing improvement in the Faster Diagnosis Standard (FDS). However, challenges were noted over the summer regarding the 62-day pathway, particularly within dermatology. An action plan was implemented to restore performance, with improvements expected from October onwards. • Referral to Treatment (RTT) performance remained on trajectory for incomplete pathways, with notable progress in orthopaedics. Some challenges persisted in ophthalmology and Ear, Nose and Throat (ENT), for which external support was being sought to address capacity and service delivery. • The Diagnostic Waiting Times (DM01) continued to present a consistent challenge, particularly in Non-Obstetric Ultrasound (NOUS). As of the latest report: o 10,563 patients were on the NOUS waiting list, a reduction from 15,500 in June. o 3,466 patients had been waiting over 13 weeks, down from 7,000. o 4,371 patients were waiting under 6 weeks. o The Trust remained on trajectory to achieve 95% compliance by March, with ongoing monitoring and targeted actions. o Recruitment challenges persisted in sonography and mitigation strategies were being implemented. o System partners had undertaken a review of referral appropriateness, with support from General Practitioners (GPs) to ensure patients were being directed to the correct pathways. Ms Small raised concerns regarding the Trust's ability to maintain current scanning rates, given ongoing recruitment challenges within sonography services. Mrs Thorpe confirmed that the recruitment campaign included the introduction of additional training posts. She noted that the opening of the CDC would help address some of the current pressures, with further detail available within the elective programme. Dr Constable emphasised that clinical capacity was only effective when aligned with appropriate demand management. Work was ongoing with system colleagues to ensure the right tests are requested at the right time, improving efficiency and patient outcomes. Ms Bowen queried the status of the Electronic Prescribing and Medicines Administration (EPMA) rollout and whether the revised plan was on track. Mrs Freeman confirmed that the programme was progressing as planned, with care groups prepared for a fast rollout. Ms Bowen asked about user feedback, to which Mrs Holmes responded that there was a positive response from staff,	

	describing a “real buzz” around the system, with only positive feedback received to date. **The Trust Board received and noted the assurance report and dashboard.**	
114/2025	<u>Finance & Business Performance Committee Assurance Report (28-07-25, 01-09-25 & 29-09-25)</u> Ms Bowen presented the Committee’s assurance report, highlighting the following key points: • In Quarter 1, three out of five strategic risks overseen by the Committee were categorised as extreme, requiring heightened oversight. • The UTC experienced a delay, with a partial handover now expected in January. • The Cost Improvement Programme (CIP) showed improvement by September; however, only partial assurance could be provided due to concerns around delivery. The Committee awaited the outcome of a recalibration exercise to determine whether current targets remained appropriate. • The productivity report received partial assurance, with further deep dives planned, including a review of theatre utilisation. • A new demand and activity report was introduced to strengthen assurance and provide greater visibility of operational pressures. • The business case review also received partial assurance. Since April, 13 business cases had been completed, though several required further review. An updated report was being developed to assess key themes and determine whether anticipated benefits were being realised. • Substantial assurance was provided in relation to sustainability and procurement, and the Committee welcomed the introduction of the new Green Plan. Mrs Whitehead confirmed that efforts were underway to expedite the UTC opening, with a partial handover planned for January. Ms Small queried the level of assurance regarding the CIP’s deliverability. In response, Ms Bowen noted that while improvements had been made, delivery remained challenging. A recent NHS England visit had reviewed governance and leadership in this area, confirming that grip and control mechanisms were in place. The Trust was awaiting the recalibration output to assess whether targets needed adjustment. Ms Ashley added that the recalibration exercise was nearly complete, with findings to be presented to the Executive Recovery Oversight Group (EROG). She noted that of the £50 million CIP target, half was non-recurrent, and that limited progress had been made towards closing the £30 million recurrent gap. Ms Small expressed concern about the confidence in delivering the £30 million recurrent element, to which Ms Ashley agreed, stating that given the time remaining in the financial year, a realistic approach was required to address the gap. Dr Constable confirmed that plans for the next financial year were already in development and aligned with strategic programmes. He acknowledged that the unmitigated risk associated with the CIP was anticipated and consistent with previous forecasts.	

	Mr Oldham reported that the NHS England visit had reviewed governance and control arrangements and found no concerns in those areas. However, the unmitigated financial risk of £25 million by year-end remained a key issue. <u>Finance Dashboard</u> Mr Oldham reported that the Trust remained on track at Month 5, with the capital programme progressing as forecasted. The organisation maintained a strong cash position, and performance in Month 6 continued in line with expectations. He noted that the efficiency programme would see a stepped increase from Month 7 onwards, and this had been factored into planning assumptions. The system-wide financial position was also reported to be on track, although the system continued to carry an unmitigated financial risk of £25 million, which was specific to UHNM. Mr Oldham further confirmed that the Urgent Treatment Centre (UTC) had been approved by the System Finance Committee. **The Trust Board received and noted the assurance report and dashboard.**	
115/2025	<u>People, Culture and Inclusion Committee Assurance Report (30-07-25 & 30-09-25)</u> Professor Toor provided an overview of the Committee's recent discussions and highlighted the following key points: • The Committee received significant assurance from the Undergraduate Medical School Report, which included positive feedback from the General Medical Council (GMC) visit. Additionally, the Trust noted an improvement in national league table rankings, reflecting the quality of its medical education provision. • In relation to the Chief Scientist role, Professor Toor acknowledged the national challenges in recruitment. However, the Committee welcomed the strong level of commitment demonstrated across the Trust and provided acceptable assurance regarding the progress made to date. <u>People Dashboard</u> Mrs Haire provided an update on the latest People Dashboard, highlighting the following key points: • Staff turnover remained low, indicating stability within the workforce. • Vacancy rates were also low, although a slight increase was noted in medical and scientific roles. • Sickness absence improved in August, but early indicators suggested a rising trend, with expectations of further deterioration in the coming months. • A focused approach to sickness absence was being embedded within performance reviews, with an integrated emphasis on wellbeing and support. • Personal Development Reviews (PDRs) continued to be a priority area. • Agency utilisation had decreased, while bank staff usage remained high, contributing to ongoing financial recovery challenges. • The Trust was actively promoting staff engagement campaigns and encouraging completion of the staff survey. Ms Bowen queried whether care groups were now fully embedded. Mrs Haire confirmed that they were, with Tier 4 structures being finalised. A pause in	

	further redesign was planned to follow this phase. Mrs Cotton reported that Leadership Boards commenced in September, as scheduled. Dr Constable shared that the first full performance and risk review meetings had taken place, describing them as a step change in the quality of discussions and triangulation, with other members also noting the positive impact of the new format. Ms Small raised concerns about the anticipated rise in sickness absence and asked how wellbeing support was being brought forward to maintain workforce stability. In response, Mrs Haire confirmed that efforts were being made to create opportunities for wellbeing conversations, with a focus on supporting line managers and colleagues. She emphasised the importance of line manager capability and the quality of support provided, which remained a key area of focus. **The Trust Board received and noted the assurance report and dashboard.**	
GOVERNANCE		
20.	**Audit Committee Assurance Report (31-07-25)**	
116/2025	Mrs Monckton reported on outstanding actions, policy tracking, and internal audit progress. She praised the cyber security report and stated that the Committee continued to be concerned about shadow IT. Mrs Cotton suggested refreshing accountability expectations in relation to shadow IT Mrs Freeman agreed, stating that this linked to the recruitment of a business relationship manager. **The Trust Board received and noted the assurance report.**	
21.	**Provider Capability Assessment**	
117/2025	Mrs Cotton confirmed that the assessment was now part of the NHS Oversight Framework (NOF) and would be submitted to NHSE by 22nd October. A desktop review had been completed, and initial comments had been provided by NHSE which were to be taken into account prior to submission. It was noted that the time at the Board Development Day on 15th October would consider the submission further. Mrs Cotton drew attention to NOF framework indicator summary within the Integrated Performance Report which was the lens by which the Trust was monitored by regulators.	
CLOSING MATTERS		
22.	**Review of Meeting Effectiveness**	
118/2025	Members were asked to provide feedback via MS forms.	
23.	**Review of Business Cycle**	
119/2025	No further comments were provided.	
DATE AND TIME OF NEXT MEETING		
24.	**Wednesday 10th December 2025, 9.30 am, Trust Boardroom, Third Floor, Springfield, Royal Stoke**	

Post Meeting Action Log

Trust Board Part 1 - Open

As at **03 December 2025**

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/617	09/07/2025	Quality Access and Outcomes Committee Highlight Report	To provide further assurance to QAOC on the actions being taken to address the HSMR and provision of alternative assurance, including consideration of using monthly HED data.	Mark Oldham	07/11/2025	07/11/2025	Complete. Specific update provided at November's meeting.	B
PTB/618	09/07/2025	People Dashboard	To include additional narrative within the dashboard to explain the reason for the differences in reporting nursing vacancies.	Jane Haire	07/11/2025	20/10/2025	Included as a standard explanation in the next Integrated Performance Report.	B

CURRENT PROGRESS RATING					
B	Complete / Business as Usual	Action completed	A	Problematic	Due date has been moved once. Revised due date provided.
GA / GB	On Track	GA. Action on track – not yet completed GB. Action on track – not yet started	R	Delayed	Due date has been moved twice or more. Revised due date provided.

Chief Executive's Report
Trust Board | 10th December 2025

University Hospitals of North Midlands NHS Trust

Part 1: Highlight Report

This report provides the Trust Board with an overview of a range of strategic and operational issues since the last public meeting on 8th October 2025, some of which are not covered elsewhere on the agenda for this meeting.

1. National NHS Staff Survey 2024/25

The National Staff Survey campaign closed on 28th November 2025 with a response rate of 40.9%, reflecting significant effort from leaders across the Trust to encourage participation. The final response rate will be confirmed on 4th December 2025 once all paper surveys have been processed. Whilst this is lower than the 2024 figure, despite the extensive work involved in the campaign, the results will provide valuable insights and will be published in the public domain in March 2026.

2. Flu Vaccination Programme 2024/25

As a Trust, and at the time of writing, 5,769 of us have already been vaccinated compared to 3,753 last year, which is over a 50% increase, and nearly achieving our ambition for this year.

Early analysis of the effectiveness of the flu vaccine shows it is providing strong protection for all, typically as we have seen in other years, despite emergence of a new "drifted" flu strain, subclade k, driving an unusually early flu season.

The UK Health Security Agency (UKHSA) assesses vaccine effectiveness by studying whether people who have been vaccinated are less likely to attend or be admitted to hospital with flu. Flu strains can fluctuate throughout the season causing different waves and those more prevalent earlier may change as winter progresses. The flu vaccine has several components protecting against the 3 main flu virus types.

The UK flu programme uses technologically advanced vaccines optimised for each patient group. Whatever strains do circulate here this winter, we can be confident that the vaccine will still help give protection to those most vulnerable from developing serious illness and being hospitalised and it remains our best defence.

3. Senior Clinical Leadership

In October, I was delighted to formally announce the appointment of Dr Diane Adamson as our Chief Medical Officer (CMO).

Her appointment follows a six-month period as our Interim CMO and then a highly competitive recruitment process, which attracted a strong field of candidates. The rigorous selection process included multiple stages of assessment and interviews, with input from a diverse stakeholder panel including representatives from across UHNM, NHS England, Keele University and Staffordshire and Stoke-on-Trent Integrated Care Board. This inclusive approach ensured that the successful candidate reflected the values, priorities, and ambitions of our wider health and care system.

Dr Adamson brings unique and diverse clinical and leadership experience to the role. She began her NHS career in nursing before joining Royal Stoke as part of the first cohort of clinical training at Keele University, through the Manchester–Keele Collaboration. She completed her postgraduate medical training across the West Midlands and in Wales, specialising in general and vascular surgery. Following an accident that led to a long-term disability, Di transitioned to emergency medicine and major trauma.

Here at UHNM, Di has served as a consultant in emergency medicine and major trauma, Clinical Lead for emergency medicine, and Divisional Medical Director for Women's, Children's and Clinical Support Services.

In October, I was also able to recognise a huge achievement for our Chief Nurse, Ann Marie Riley, who scooped the very first DAISY PEN Lifetime Achievement Award at this year's Picker Experience Network Awards. This new award was all about recognising people who've made a real, lasting difference to patient experience, and Ann Marie's nomination is a perfect example of that.

Over more than 30 years, Ann Marie has gone from critical care nurse to national movement leader, transforming patient experience through culture change, measurable harm reduction, and global influence. She's led the way on things such as #EndPJparalysis movement, and has made a real difference in reducing falls, pressure ulcers and complaints. Her work has changed how we think about mobility and dignity in care, not just here but internationally, and she continues to drive that change at UHNM every day.

4. Welcome to the Getting It Right First Time (UEC) Team

Both of our hospitals are, often, under significant operational pressure, particularly in our Emergency Department at Royal Stoke. This has been intensified in recent weeks by a sharp rise in flu and other respiratory illnesses, which has led to higher demand across our wards and services.

At the same time, we continue to perform poorly relative to others around ambulance handover delays and waiting times in the ED. These delays are not only distressing for patients and their families, but also deeply frustrating for our staff. Whilst other trusts face similar issues, our urgent and emergency care performance puts us in the bottom quartile nationally. Although it's a complex picture, there are things we can do to improve.

Patient flow - how patients move through and out of our hospitals - is everyone's responsibility. It affects every part of the organisation, from the front door to discharge and everything in between. There is much our local system partners can do to help us, but as chief executive of UHNM I want to make sure we are following national best (evidence-based) practice ourselves, implementing it rigorously and consistently, and making sure we are as productive as possible.

To help us build on the improvements we have already made (and that saw some definite but short-lived improvements especially over July and August), we are starting a focused piece of work, supported by our colleagues from the Getting It Right First Time (GIRFT- UEC) Team, formerly known as ECIST (the national Emergency Care Improvement Support Team). This partnership will give us the benefit of external, expert support to help us make real, practical improvements for our patients. Together, we'll be working to:

- Reduce unnecessary delays and waits
- Decongest our Emergency Department
- Get patients to the right place, first time
- Improve safety and outcomes for our patients
- Create headspace for teams to test and embed change
- Support site and system recovery oversight

5. BMA Resident Doctors' Industrial Action

The British Medical Association (BMA) undertook strike action in November, which started at 7am Friday 14 November 2025 until 7am on Wednesday 19 November 2025.

We know that this comes at a time when our hospitals are already under significant pressure and I want to acknowledge how challenging this is, not just professionally, but personally. During the last round of industrial action in July, we showed what we can achieve when we pull together. Thanks to extraordinary efforts, we were able to maintain more planned care than during previous strikes, meaning more patients received the care they needed. The challenge now is to build on that performance and maintain safe, high-quality care not only during the strike but also in the weeks that follow, particularly as we further enter the winter period and anticipate a rise in flu cases.

We had been told to expect a further spike in 'flu cases immediately after this industrial action and this is exactly what we have seen.

Our top priorities during industrial action were:

- Maintaining safe emergency and urgent care, including maternity services.
- Supporting patient flow, ensuring efficient discharge and managing length of stay.
- Preserving elective care as much as possible.
- Maintaining priority treatments, including urgent elective surgery and cancer care.

We worked hard to minimise disruption, rescheduling appointments where necessary, and communicating clearly and compassionately with patients.

A further round of BMA industrial action is scheduled before Christmas.

6. A Night Full of Stars 2025

I was delighted to join over 200 colleagues, volunteers, sponsors and supporters who came together to celebrate our annual A Night Full of Stars on 7 November 2025. It was an uplifting evening of inspiration, admiration and positivity, with 11 awards handed out during the ceremony.

It really was wonderful to see so many colleagues come together under one roof and I was truly heartened to see once again the camaraderie and support shown by all guests towards our finalists and winners.

I am particularly pleased that we managed to keep the presentation of this year's very special Outstanding Achievement Award top secret until the big reveal. It was a pleasure to personally hand over the trophy to a very deserving recipient, Lorraine Whitehead, Director of Estates, Facilities and PFI. Lorraine joined the Trust as a YTS (Youth Training Scheme) trainee 40 years ago.

Congratulations must go to all this year's winners and finalists, and indeed everyone who was nominated.

Our full list of our A Night Full of Stars winners is as follows:

- Rising Star Award - Sarah Tinsley, Pharmacy Team Leader.
- Inclusion Award - UHNM Disability, Long Term Condition and Neurodiversity Staff Network
- Excellence Award - Dr Alice Holt, Emergency Medicine Consultant
- Team of the Year Award - Ward 221
- UHNM Charity Award - The HRD Collaborate Team
- Unsung Hero Award - Mick Mallin, Operational Support Manager
- Colleague of the Year Award - Dr Rebecca Dack, Paediatric Consultant
- People's Choice Award - Sarah Lake, Bereavement Midwife
- Kindness and Compassion Award - Jude Davies, Lead Professional Midwifery Advocate
- Collaboration Award - The Estates and Recruitment Teams
- Outstanding Achievement Award Winner - Lorraine Whitehead, Director of Estates, Facilities and PFI.

7. Prevention of Future Deaths/Regulation 28 Notices

There has been no regulation 28 notices in October and November 2025.

8. BadgerNet

Digital transformation features very heavily in our UHNM strategy, and indeed the NHS 10 Year Plan. In November, we were very pleased to see the Neonatal Intensive Care Unit (NICU) launch our upgraded electronic patient records (EPR) system, BadgerNet, known to all our staff as 'Badger'.

This neonatal and maternity system is already used by more than 200 NHS Trusts and supports over 40,000 women and families every day in the UK. It is also used by every neonatal unit in New Zealand, with family-facing elements translated into common languages including Polish, Punjabi, Romanian and Māori.

All our medical and nursing documentation will be recorded in Badger, including observations, fluid balances, medical ward rounds, procedures and communication with family and social services. Having a digital, paper-lite system means more accurate and complete records, which supports safer, higher-quality

care for our babies and families. It also brings many practical benefits, including remote access to notes and historical information, fewer lost or misplaced records, reduced printing costs, easier transfer of records to other hospitals and the ability for multiple members of our large multi-disciplinary team to document at the same time.

We are particularly excited about new features such as parent reports. These electronic updates give parents and carers a simple clinical overview of their baby's care, along with explanations of common neonatal terms to avoid any confusion with medical jargon. This supports our ongoing commitment to family-centred care. Badger also collects key data for the National Neonatal Audit Programme (NNAP), a national benchmarking tool that helps ensure babies across the UK receive consistent high-quality care.

The launch marks the end of a year-long project involving the Badger team, UHNM's Digital Services and our dedicated Badger user managers who have helped design the live system and train all staff working on NICU.

9. Mouth Cancer

Mouth Cancer Action Month in November was an important opportunity to raise awareness of one of the fastest-growing cancers in the UK. Across the country, teams like our oral surgery team are working hard to increase understanding of early symptoms and encourage people to seek help sooner.

Recent figures from NHS England show that mouth cancer cases have reached their highest levels, with 9,293 new cases recorded last year. This represents a 37 per-cent increase over the past decade, and annual deaths have risen by 42 per-cent to 2,970.

Despite this rise, public awareness remains low. Almost a quarter of people do not realise mouth cancer can occur, and only one in five are able to recognise the common symptoms. These figures highlight how important early detection, education and community engagement really are.

Within UHNM, the oral surgery department provides essential care for patients with suspected or confirmed mouth cancer. The team are involved from the very first stages of identifying suspicious lesions through to diagnosis using biopsy, clinical assessment, and imaging. They work closely with our multi-disciplinary team to plan treatment, including reconstruction where required, and provide rehabilitation and long-term follow-up care. This whole pathway approach ensures patients and their families receive consistent support during what can be an incredibly difficult and emotional time.

10. Eye and Tissue Donation Service

November marked the first anniversary of UHNM's Eye and Tissue Donation Service. UHNM is one of only ten NHS Trusts across the UK to be commissioned by NHS Blood and Transplant (NHSBT) to operate its own in-house eye and tissue donation service. In just twelve months the team has enabled the retrieval of 105 corneas, 12 heart valves, 11 bone donations, four tendons and four skin donations.

Each of these donations represents both the incredible generosity of families who have chosen to help others at a time of great loss and sadness, and the work of our UHNM staff who ensure every retrieval is carried out with the utmost care and compassion.

The service has also enabled UHNM to appoint its first dedicated eye and tissue donation nurses, who work closely with the bereavement and mortuary teams to identify potential donors, support families and coordinate the retrieval process on-site at the Royal Stoke.

As corneas must be retrieved within 24 hours of death, being able to carry out cornea retrievals in-house has been vital in meeting this time-sensitive need. Almost anyone can be a cornea donor as age, poor eyesight or other medical conditions rarely prevent donation. Thanks to this service UHNM is helping to address a national shortage and give more patients the gift of sight.

The team has a long-term goal of supporting at least one donation every day. Their work not only changes lives but brings comfort to families who know their loved one has helped others.

11. North Midlands Commercial Research Delivery Centre

November also saw the official opening of our brand-new North Midlands Commercial Research Delivery Centre (CRDC) at the Royal Stoke University Hospital. This was an exciting milestone not just for our Research and Innovation teams, but for every patient, colleague and partner connected to UHNM.

Thanks to £3.1 million of UK Government investment through the National Institute for Health and Care Research (NIHR), the North Midlands CRDC brings together our clinicians, academics and industry partners under one roof. It will enable us to deliver more studies, more quickly and to offer our patients across Staffordshire and the wider region easier access to the very latest treatments and clinical trials right on their doorstep.

The North Midlands CRDC is part of a national network of new centres designed to strengthen the NHS's capacity to deliver world-class commercial research. For UHNM it cements our position as a leading research-active trust and builds on the strong partnerships we already have.

Every study we deliver ultimately helps our staff to provide the best evidence-based care and our patients to live healthier, longer lives. By growing our research capacity, particularly for under-represented professions such as nursing, midwifery, allied health, healthcare science and pharmacy, we can turn cutting-edge science into better care faster and give more of our people and local population the opportunity to take part in research that could change both their lives and the lives of others.

12. World AIDS Day

If you want a good example of how rapid progress in science and medicine have changed healthcare and outcomes, then you need look no further than how we manage HIV disease now compared to what happened even 30 years ago. Monday 1st December 2025 was World AIDS Day, and UHNM marked it with renewed efforts to help diagnose HIV infections.

HIV (Human Immunodeficiency Virus) is a virus that weakens the immune system and increases the risk of serious illness. There is currently no cure, but with treatment most people with HIV can live a long and healthy life. Treatment and prevention have developed significantly over recent decades, but the prognosis remains poor if undiagnosed.

The government is committed to achieving zero new HIV infections, AIDS and HIV-related deaths in England by 2030. The Global AIDS Strategy 2021–2026 is a bold new approach to use an inequalities lens to close the gaps that are preventing progress towards ending AIDS. The Global AIDS Strategy aims to reduce these inequalities that drive the AIDS epidemic and prioritize people who are not yet accessing life-saving HIV services.

Medical advances mean people with HIV can expect a long and healthy life and that we have the tools to stop HIV transmissions for good. HIV continues to be highly stigmatised and misunderstood, and even the stigma relating to testing alone remains a barrier to reducing the number of new cases and transmissions.

The Blood Borne Virus Opt-out Scheme was adopted and implemented here at UHNM in March 2025. This aims to remove this stigma of testing by allowing routine testing for those attending our ED departments to take place. This has resulted in over 30,000 additional HIV tests being performed over the last 7 months for those patients attending ED at County and Royal Stoke.

The number of tests completed now sits at 31,731; The number of HIV positive tests: 51. Due to the collaborative efforts of our Emergency Departments, Infectious Diseases, Virology, and our colleagues at our Sexual Health Services, we are diagnosing these new HIV cases as part of the BBV Opt-out scheme. These patients are now being treated, helping reduce transmission and support the government 2030 target.

13. Welcome to our newly qualified nurses and nursing associates

It was good to spend some time with our newly qualified nurses and nursing associates in November during their preceptorship week. Sixty nurses and nursing associates attended this preceptorship event from areas across the Trust and another 90 will be attending a similar event in December. In 2025, a total of 316 nurses and nursing associates have started their 12-month preceptorship with us.

Preceptorship at UHNM is a 12-month period of increased supervision and support for newly qualified nurses and nursing associates and also international nurses and individuals that have transferred to the Trust.

The corporate preceptorship week features sessions on Freedom-To-Speak Up, leadership, Professional Nurse Advocates, a safe medications workshop, quality and safety and continuing professional development opportunities amongst other things.

NHSE have standards for preceptorship which the Trust has to follow and a lot of work is ongoing to ensure that our newly qualified nurses and nursing associates have a robust preceptorship. Preceptorship is shown to improve retention, and a quality preceptorship package helps us to attract staff. Last year we were finalists for the Nursing Times Preceptorship of The Year award.

14. UHNM at the Gurdwara

In November several colleagues spent some time at the Guru Nanak Gurdwara and Sikh Cultural Centre in Stoke-on-Trent, alongside local Sikh leaders for a community health event aimed at tackling health inequalities. It was a powerful reminder of why forging strong relationships across our communities is essential to improving the health of our local population.

The idea for this visit grew from an earlier meeting at the Gurdwara, where it became clear that members of the congregation would value direct access to NHS information, advice, and support. That insight prompted our OD team to pilot a dedicated event that brought a range of NHS services directly into a trusted community setting. It provided somewhere for the local communities to feel comfortable, welcome and able to ask questions without hesitation.

Several services came together to offer support on cancer screening programmes, including bowel, breast, lung, and cervical, as well as advice on early detection, symptoms to look out for, and the importance of taking up screening invitations. Visitors were also able to speak with clinicians about diet, exercise, mental wellbeing and general health concerns and eligible attendees also had access to flu vaccinations.

Issues that came up from the Sikh community were challenges when navigating the NHS such as limited health literacy, language, cultural considerations and a lack of confidence in using digital tools all make accessing care more complicated than it should be.

Hearing these experiences first-hand reinforced how important it is for us to communicate clearly and to meet people where they are. By bringing services into community spaces like the gurdwara, we are able to break down those barriers and make healthcare more accessible in a meaningful way.

15. Employee and Team Recognition

Appreciation of UHNM staff from patients, family, visitors, and colleagues

I have personally recognised the contribution of the following colleagues:

- Suzanne Bailey, Executive Assistant
- Emma Mellor and Team, Medical Workforce
- Eden Tagg, Clinical Network Programme Manager
- Sue Perks, Head of Elective Access
- Dr Davidson Adelakun, GPVTS - ED RSUH
- Diane Poulson, Assistant Director of HR
- Louise Stockdale, Head of Sustainability & Transformation

- Laura Norcup, Executive Assistant
- Janet Hagan, Head of Nursing - Women's and Children's Health
- Lynn Dudley, Senior Project Support
- Julie Rowney, Patient Experience Advisor
- Gill Herbert, Patient Experience Administrator
- Brooke Shaw, Staff Nurse - ED RSUH
- James Wood, Communications Officer
- Cathy Cotterill, Emergency Nurse Practitioner - ED County Hospital
- Dr Adina Pavel, Specialty Doctor - Emergency Medicine
- Lauren Birks, Communications Officer
- Amanda Jellyman, Communications Assistant
- Dr Fiona Hibberts, Deputy Chief Nurse
- Andrew Fraser, Business Intelligence Manager - Digital Services

Part 2: Consultant Appointments

The following table provides a summary of consultant medical staff interviews which have taken place during October and November 2025:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Plastics	Vacancy	Yes	TBC
Consultant in Palliative Medicine	Newly created	Yes	TBC
Spinal Deformity	Vacancy	Yes	TBC
Acute Medicine	Vacancy	No	n/a
Consultant Neonatologist	Vacancy	No	n/a
Consultant Cardiothoracic Radiologist	Vacancy	Yes	TBC

The following table provides a summary of medical staff who have taken up positions in the Trust during October and November 2025:

Post Title	Reason for advertising	Start Date
Consultant Orthopaedic Surgeon	Newly created	20.10.25
Consultant Orthopaedic Surgeon	Newly created	17.11.25
Consultant in Respiratory with Specialist interest	Vacancy	3.11.25

No medical vacancies closed without applications / candidates during October and November 2025.

Medical Management Appointments

The following table provides a summary of medical management interviews which have taken place during October and November 2025:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Clinical Business Units Medical Director	Vacancy	Yes	2 TBC 1 started on 10.11.25
Clinical Director of Imaging	Vacancy	Yes	4.11.25

The following table provides a summary of medical management who have taken up positions in the Trust during October and November 2025:

Post Title	Reason for advertising	Start Date
Clinical Director – Acute and Urgent Care	Vacancy	1.10.25
Clinical Business Units Medical Director	Vacancy	10.11.25
Clinical Director of Imaging	Vacancy	4.11.25

No medical management vacancies closed without applications/candidates during October and November 2025.

Executive Summary

Trust Board | 10th December 2025

Board Assurance Framework – Quarter 2

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**	✓	**Assurance**		**Agenda Item:**	8
Author:	Nicola Hassall, Deputy Director of Governance							
Executive Lead:	Claire Cotton, Director of Governance							

Alignment with our Strategic Priorities	
Our People We will create an inclusive environment where everyone learns, thrives and makes a positive difference	✓
Our Patients We will provide timely, innovative and effective services to our patients	✓
Our Population We will tackle inequality and improve the health of our population	✓

Executive Summary

Situation

The Board Assurance Framework (BAF) is a dynamic document, reviewed and updated quarterly, that provides a structured approach to identifying and managing the key risks that could impact the delivery of our Strategic Priorities. It outlines the principal controls in place and the assurance mechanisms used to assess their effectiveness.

Prior to submission to the Trust Board, the BAF is reviewed by the Finance and Business Performance, People, Culture and Inclusion, and Quality, Access and Outcomes Committees—each of which oversees specific strategic risks. Oversight of the overall BAF process rests with the Audit Committee.

This latest update reflects the position at Quarter 1 of 2025/26, as provided by Executive Leads. It was presented to the relevant Board Committees for assurance and approval in July, ahead of final submission to the Trust Board.

Background

The strategic risks within the 2024/25 Board Assurance Framework (BAF) were reviewed and refreshed by the Executive Team and subsequently approved by the Board in April 2025, in line with the annual review process. For 2025/26, the BAF format has been streamlined to focus on the key elements of the summary BAF, eliminating the need for two separate documents.

The revised risk appetite statement—also approved by the Board in April 2025—has informed the setting of tolerable risk scores. All risks have been aligned with the updated Strategic Priorities: Our People, Our Patients, and Our Population and, as discussed during the April Board session, the primary issues identified by the Executive Team have been mapped to each strategic risk to enhance clarity and accountability.

Assessment

A summary of the main changes in the BAF are provided below.

- The 'most threatened' of our Strategic Priorities is 'Our Patients, with all 8 Strategic Risks posing a threat to its achievement. Our People and Our Population priorities are threatened by 7 of our Strategic Risks. All 8 Strategic Risks are impacted by our primary issues of financial and affordability constraints and culture, capacity and capability, with 7 risks impacted by system and infrastructure.
- The most significant strategic risks continue to relate to our inability to deliver the required in-year financial position and financial sustainability (BAF 6 & BAF 7), with a score of Extreme 20, significantly above the risk tolerance. In addition, our inability to sustain safe and effective care delivery has increased to a score of Extreme 20 for Q2 as a result of the impact of waits in ED on patient outcomes. There remain 2 other strategic risks which have extreme scores (BAF 3 and BAF 4).
- BAF 5 – inability to deliver investment in estate infrastructure and workforce is the only risk within the risk tolerance, with a score of High 12. In addition, BAF 8 is within the revised risk appetite for research, innovation and development, at a score of High 12.
- The number of linked risks for the quarter have been refreshed and the most linked risks continue to be in relation to BAF 1. Summaries of key themes relating to the linked risks are included within the document, and actual linked risks are listed in Appendix 2.
- Further work has been undertaken for Q2 to ensure actions are specifically identified to address each gap in control and assurance. As such there has been an increase in the number of actions identified. As at Q2 16 actions have been completed, 42 are on track, 3 are delayed and 9 problematic.
- There are a number of sources of assurance which have not been seen in line with business cycles and where possible, these are or have been rescheduled.

Key Recommendations

The Trust Board is asked to approve or amend the BAF, considering whether risk scores, assurance assessments and actions are an accurate reflection of the current position.

University Hospitals of North Midlands NHS Trust

Board Assurance Framework

Quarter 2 | 2025 - 2026

Kind Excellent Together

Strategic Framework and Threat to Strategic Priorities

Our Priorities

Our People

We will create an **inclusive** workforce where **everyone** learns, thrives, and makes a positive difference

Key Metric:
Staff Engagement Score

Our Patients

We will provide **timely, innovative** and effective services to our **patients**

Key Metric:
Combined Hospital Score

Our Population

We will **tackle inequality,** and improve the health of our population

Key Metric:
Number Years in Good Health

Number of Strategic Risks Threatening Our Priorities

7	8	7

Our Values

- Kind
- Excellent
- Together

Our Programmes

Brilliant Basics: Standards & Performance	Digitally Enabled Care Transformation	Our Future Hospital Services	Collaborations & Networks
Addressing the immediate concerns facing our patients	Standardising and redesigning pathways – enabled by a new EPR	Designing services so they reflect the latest developments in medical knowledge and provide care closer to home	Working with others to ensure sustainable and joined-up care

Our Strategic Plans

Quality, Access & Performance | People | Population Health | Digital | Research | Innovation | Estates & Facilities

Our Primary Issues

Culture, Capacity & Capability

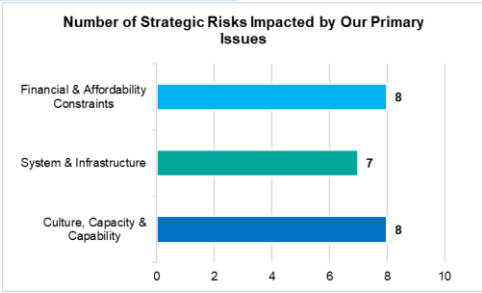
i.e. staff fatigue & burnout / workforce affordability & skills / digital and technological capacity

System & Infrastructure

i.e. inability to effectively work together to change & transform services / silo working / infrastructure and capital limitations / research & innovation constraints

Financial & Affordability Constraints

i.e. financial issues / affordability of services / sustainability & demand management



Summary

BAF No.	Risk Title	Risk Score & Assurance Assessment Q1	Q2	Q3	Q4	Target	Risk Appetite	Strategic Priorities			Primary Issues			No. of Linked Risks	Committee Assurance Assessment: Significant	Acceptable	Partial	None	NR	Gaps in Control	Gaps in Assurance	Action Plan Progress: Complete	On Track	Delayed	Problematic
BAF 1	Inability to Sustain Safe and Effective Care Delivery	Ext 16 Partial	Ext 20 Partial			High 8 ~~31/03/2026~~ 31/03/2027	Minimal (1 - 4) Score has exceeded the tolerable score (5-9) since 2022/23	●	●	●	●	●	●	359 ↓	1 ↓	4 ↓	9 ↓	0 ↓	19 ↑	4 ↓	5 ↑	4 ↑	6 ↑	1 →	2 ↓
BAF 2	Inability to Design and Deliver Services that Address Local Population Needs	High 10 Acceptable	High 10 Acceptable			High 8 31/03/2026	Minimal (1 - 4) Score has exceeded the tolerable score (5-9) since 2023/24		●	●	●	●	●	1 →	0 →	2 ↑	0 →	0 →	2 ↑	1 →	1 →	1 ↑	5 ↑	0 →	0 →
BAF 3	Inability to Improve Workforce Sustainability & Organisational Culture	Ext 15 Partial	Ext 15 Partial			High 10 31/03/2027	Cautious (1 - 9) Score has exceeded the tolerable score (10-12) since 2024/25	●	●		●		●	140 ↑	2 ↑	6 ↑	6 ↑	0 →	7 ↑	4 →	3 ↑	0 →	8 ↑	0 →	0 →
BAF 4	Inability to Deliver Digitally Enabled Care Transformation	Ext 16 Partial	Ext 16 Partial			High 8 31/03/2026	Minimal (1 - 4) Score has exceeded the tolerable score (5-9) since 2022/23	●	●	●	●	●	●	107 ↑	0 →	2 ↑	0 ↓	0 →	0 →	7 →	4 ↓	2 ↑	10 ↑	0 →	0 ↓
BAF 5	Inability to Deliver Investment in Estate Infrastructure & Workforce	High 12 Acceptable	High 12 Acceptable			High 12 Achieved Q1 2025	Cautious (1 - 9) Score has remained within the tolerable score (10-12) since 2022/23	●	●	●	●	●	●	86 ↑	1 ↓	1 →	0 →	0 →	0 →	15 ↑	1 ↑	0 →	3 ↑	2 →	4 →
BAF 6	Inability to Deliver In-Year Financial Position	Ext 20 Partial	Ext 20 Partial			High 12 ~~31/03/2026~~ 31/03/2027	Cautious (1 - 9) Score has returned to exceeding the tolerable score (10-12) in Q1 2025/26	●	●	●	●	●	●	14 ↓	1 ↓	3 ↓	8 →	0 ↓	1 ↓	3 →	2 ↓	3 ↑	3 ↑	0 →	0 →
BAF 7	Inability to Deliver Financial Sustainability	Ext 20 Partial	Ext 20 Partial			High 12 31/03/2027	Cautious (1 - 9) Score has exceeded the tolerable score (10-12) since 2024/25	●	●	●	●	●	●	3 →	1 ↓	0 ↓	8 →	0 ↓	1 ↓	4 ↑	1 →	4 ↑	2 ↑	0 →	1 ↓
BAF 8	Inability to Sustain Research and Innovation Excellence	High 12 Partial	High 12 Partial			High 8 31/03/2026	Open 1 - 12 Score is in line with risk appetite (1-12)	●	●	●	●	●	●	2 →	0 →	0 →	0 →	0 →	0 →	4 →	3 ↓	2 ↑	5 ↑	0 ↓	2 ↓
							TOTAL	7	8	7	8	7	8							42 ↑	20 →	16 ↑	42 ↑	3 ↓	9 ↓

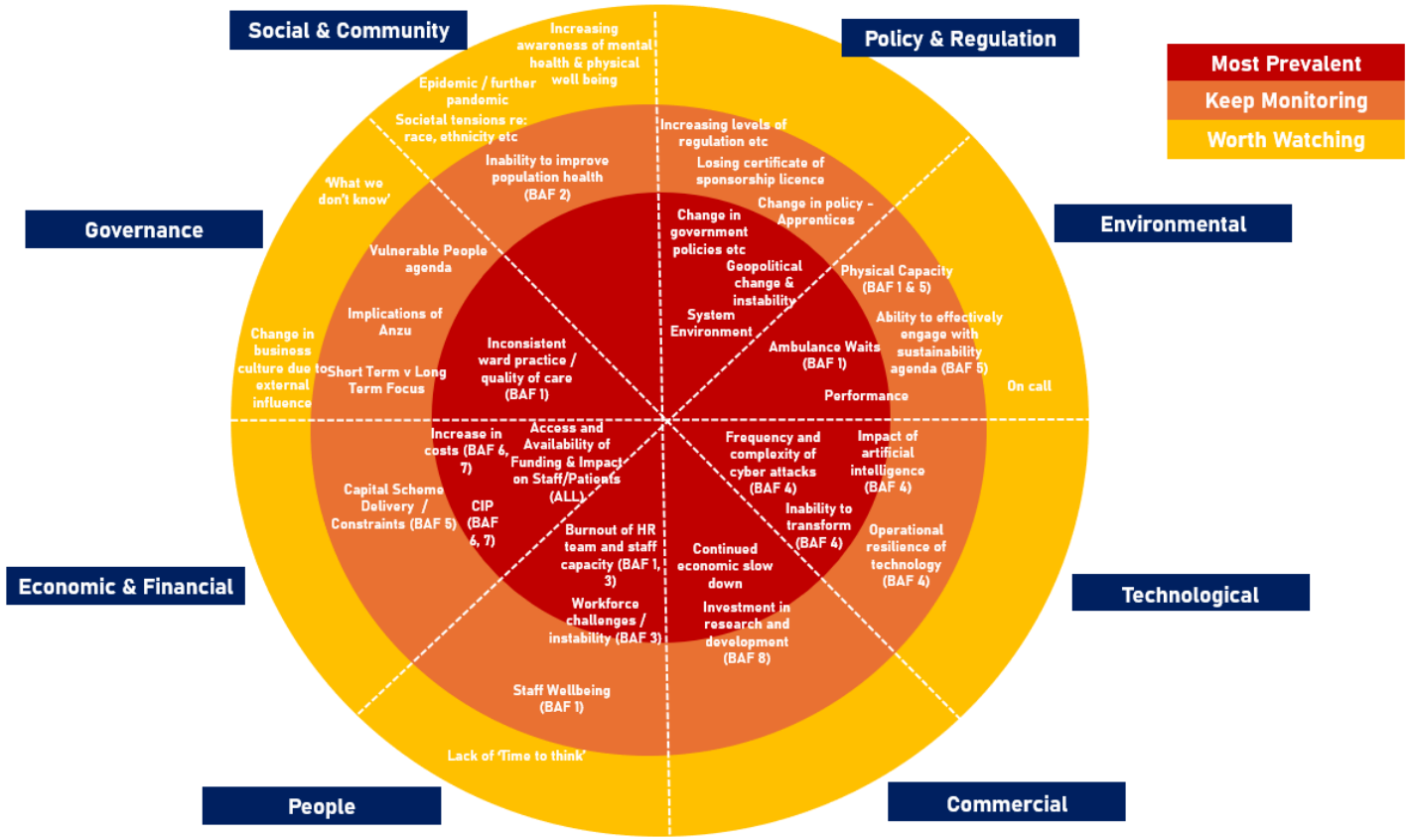
Positive Assurance

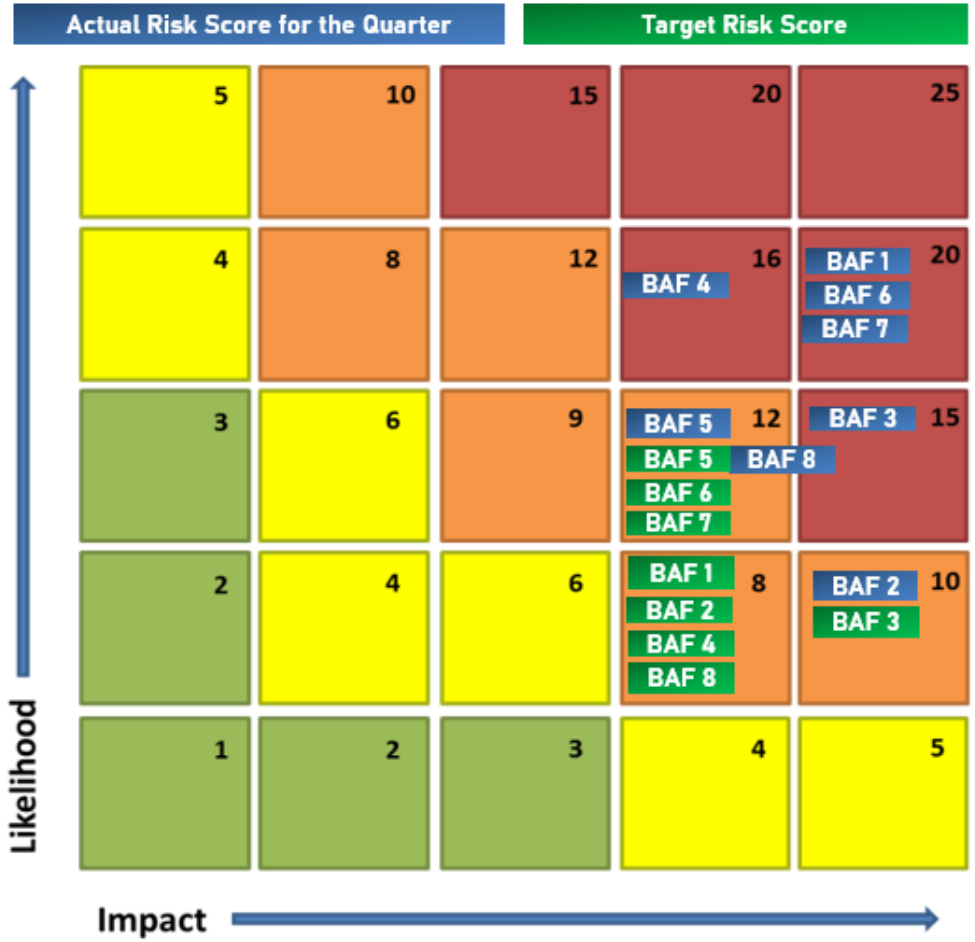
- 2 / 8 risks identified as providing acceptable assurance
- 7% (↓) assurances were rated as significant assurance and 21% (↓) as acceptable assurance
- 23% (↑) of actions have been completed with 60% (↑) on track
- 1 / 8 risks in line with risk tolerance and target risk score and 1 / 8 risk in line with the risk appetite

Matters of Concern

- 6 / 8 risks identified as providing partial assurance
- 36% (↓) assurances were rated as partial assurance and 0% (↓) identified as having no assurance
- 17% of assurance were not seen during Q2 (↑)
- 4% (↓) of actions are delayed and 13% (↓) problematic
- 6 / 8 risk scores are above the tolerance (↓)

Risk Radar & Heat Map





The risk radar continues to be reviewed each quarter, taking into account the most recent information on emerging risks, from our Internal Auditors, RSM. Whilst a number of risks already form part of the Board Assurance Framework, and have been mapped accordingly, other risks form part of the operational risk register.

BAF 1: Inability to Sustain Safe and Effective Care Delivery

Quality, Access & Outcomes Committee | Chief Nurse, Chief Medical Officer & Chief Operating Officer

Risk Description

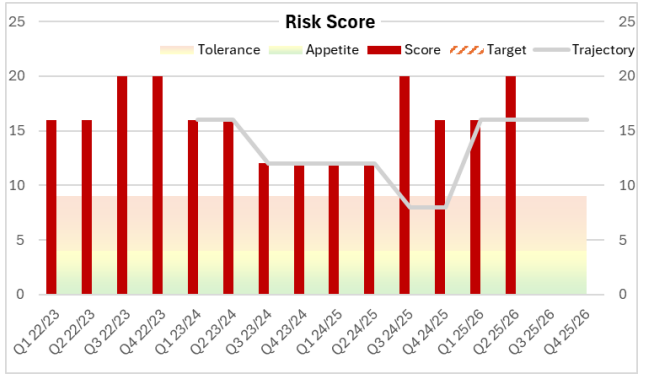
Cause:	If we experience limitations in workforce availability, equipment, service capacity, financial constraints, or, lack a culture of continuous improvement,
Event:	Then we may be unable to consistently deliver safe, timely and effective care across maternity services, urgent and emergency care (UEC), elective care and diagnostics,
Effect:	Resulting in poorer patient outcomes and experience, reduced staff wellbeing, widening health inequalities, non-compliance with quality and regulatory standards, increased complaints / litigation and reputational damage.

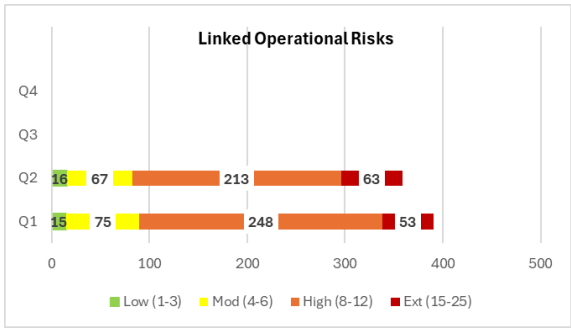
Potential to impact on our Strategic Priorities

Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

	Q1	Q2	Q3	Q4	Target		Risk Appetite
Likelihood	4	4	4	4	2	~~31/03/2026~~ 31/03/2027	Minimal 1 – 4
Consequence	4	5	4	4	4		Risk Tolerance
Risk Score	16	20	16	16	8		Mod/High 5 – 9





Executive Overview – Rationale for Risk Score and Progress made in Quarter 2

Following discussion at QAOC in Quarter 1, the date to achieve the target risk score has been amended to March 2027, given winter pressures which were expected to remain prevalent in March 2026 and that the associated improvement programmes will not be completed and having an impact until the following year.

In addition, the risk score for Q2 has increased to Extreme 20. This is due to continuing significant ambulance delays and the associated impact on patient outcomes for those waiting in the Emergency Department (ED). September also saw an increase in staff sickness and a decrease in fill rate for bank shifts, with ED particularly impacted by staff absence. To respond to the increasing pressure on the UEC pathway, our continuous flow model is needing to be enacted regularly.

Positively, the Trust has submitted its UEC and elective recovery programmes as part of our undertakings, and we are not seeing a particular deterioration in our quality metrics.

What is this telling us?

Whilst the target (tolerable) risk score remains the same at High 8, aligned with the revised risk appetite statement, the target date of March 2026 has changed to March 2027 to reflect the anticipated date of completion for our improvement programmes. Consequently, the trajectory for Q4 has also been reset.

The number of linked risks have decreased from Q1, although there continues to be the highest number of operational risks linked to this strategic risk. The key themes in relation to these linked risks relate to workforce shortages and staffing challenges, resource, capacity and infrastructure constraints and process, compliance and quality management. This risk has the potential to impact on all three strategic priorities in addition to being impacted by our three primary issues.

BAF 1: Inability to Sustain Safe and Effective Care Delivery

Key Controls Framework

Care Group (n=13)

- Capacity calls in place x4 daily, including Executive Director and Care Group attendance
- Care Group referral to treatment (RTT) meetings held twice weekly
- Clinical staff recruitment, induction, mandatory training, registration and revalidation
- County Elective Hub Group meetings held twice monthly
- Diagnostic cell in place
- Directorate Mortality and Morbidity meetings held monthly, to review deaths and discuss cases including input from Medical Examiner and use of Structured Judgement Reviews
- Elective Improvement Programme
- Safe medical, nursing, midwifery and Allied Health Professional (AHP) staffing levels defined for all areas
- Tumour site cancer patient tracking list (PTL) meetings held weekly
- Urgent and Emergency Care Improvement Programme
- Validation plan to ensure all patients >52 weeks are validated
- Weekend planning meetings held weekly
- Weekly elective oversight management group

Corporate (n=33)

- Birth Rate Plus staffing assessment for midwifery services
- Birthrate plus business case approved
- Cardiology business case approved
- Capacity, demand, organisational and system bed model completed
- Care Excellence Framework with enhanced patient-led monitoring for bronze review panel meetings
- Child Health Tier 2 Resident Doctor business case approved
- Clinical policies, procedures, guidelines, pathways, supporting documentation and IT systems in place
- Clinical Audit Programme in place
- Corporate escalation process in place regarding current operational status and action required
- Community Diagnostic Centre business case approved
- County Hospital Daycase Unit in place
- County Frailty business case approved
- CT and MRI Scanner business case approved
- Elective Hub business case approved
- Electronic Prescribing and Medicines Administration (EPMA) System piloted and being rolled out
- Executive Recovery Oversight Group
- Internal rapid handover process within Emergency Department
- Maternity and Neonatal Single Delivery Plan Framework
- Medical Workforce Group
- Mortality Review Group
- Nephrology Service - sustainability and recurrent investment in the medical, nursing and administration workforce (Phase 1)
- Nurse staffing establishment reviews undertaken every 6 months
- Performance and Accountability Framework
- Performance and Risk Reviews
- People Plan in place
- Quality and Outcomes Group, with bi-monthly focus on Quality and Safety / Outcomes
- Respiratory business case approved
- Robotic Assisted Surgery Expansion business case approved
- Strategic Delivery Unit with responsibility for delivery of strategic plans
- Surgical Site Infections and theatre cleanliness deep dives undertaken and reported through the appropriate governance structure
- Urgent Treatment Centre business case approved
- Winter planning staffing approved
- Winter escalation capacity opened ahead of schedule

System (n=11)

- Care Quality Commission (CQC) registration
- Healthwatch and Maternity and Neonatal Voices Partnership (MNVP) Meetings
- Integrated Care Board (ICB) quality, safety and compliance meetings
- Provider Collaborative in place
- Screening Quality Assurance Services (SQAS) Assessments
- System Executive ambulance improvement Task and Finish Group meetings held on a weekly basis
- System partners meetings held, including with West Midlands Ambulance Service, on a weekly basis
- System Planned Care Board in place
- System Urgent Emergency Care Board in place
- Tiering calls chaired by Regional NHSE with regards to urgent and planned care performance
- Winter calls with System Partners regarding urgent and emergency care, held daily

Key Assurances Received in Quarter 1 & 2

Assurance Source	April	May	June	July	Aug	Sept
Access Performance Report & Executive Recovery Oversight Group Highlight Report	M12	M1	M2	M3	M4	M5 | NR
Allied Health Professional Workforce Establishment Review				☒		☒
Cancer 104+ Day Breach Analysis	☒			☒	Q4	NR
Care Excellence Framework (CEF) Summary / Staffing Report					Q1	
Care Quality Commission Inspection Update	☒					
Chief Healthcare Scientist Update		☒				
Chief People Officer Report						☒
Chief Pharmacist Workforce Report						☒
Clinical Effectiveness Update	NR				☒	☒
Community Diagnostic Centre Business Case Update						
County Elective Hub Review						
End of Life Annual Report						
Hospital Associated Thrombosis Increase November 2024 - February 2025						
ICB Quality Assurance Visit Reports		NR				
Legal Services Annual Litigation & Inquest Report						
Major Trauma Peer Review		☒				
Maternity & Neonatal PSIRF Investigation Report					Q1	
Maternity & Neonatal Single Delivery Plan (SDP) Framework Internal Audit						
Maternity & Neonatal Voices Partnership Feedback Report		☒			☒	
Maternity Dashboard					Q1	
Maternity Quality & Safety Oversight Group Assurance Report		NR			NR	
Medical Examiner Service Update						
Medical Workforce Group Assurance Report						
Medicines Optimisation & Safety Report		Q4				
Mortality Assurance Report				Annual		NR
National Neonatal Audit Programme (NNAP) Outlier for Bronchopulmonary Dysplasia (BPD) for 2024 Assurance						NR
Nurse Staffing Establishment Review		☒		NR		
Patient Council Update						
Patient Experience Report				Q4		Q1 | NR
Patient Safety Incident Investigation Report	Q4			Q1		
Patient Waiting List Backlog						NR
Perinatal Mortality Report					Q1	
PLACE Inspection Findings and Action Plan						
Quality & Outcomes Group Assurance Report	NR	NR	☒	NR	NR	NR
Quality Account		NR				
Quality Impact Assessment Report					☒	NR
Quality Performance Report	M12	M1 | NR	M2	M3 | NR	M4	M5 | NR
Readmissions Analysis						☒
Regulation 28 Update						
Saving Babies Lives Care Bundle						
Stay in the Bay						NR
Strategic Development Unit Project Management Internal Audit						
Urgent Treatment Centre Update				NR	NR	
Waiting Inequalities List Report				NR		
Wellbeing Report						
Winter Close Down Report			☒	NR		

Assurance Rating Key

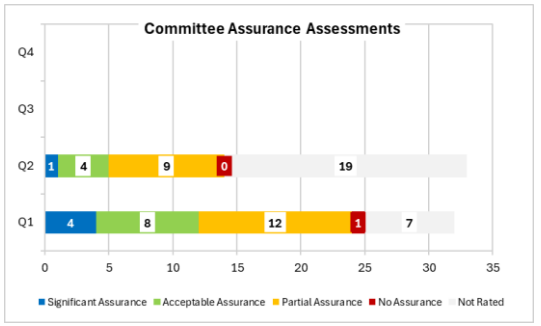
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

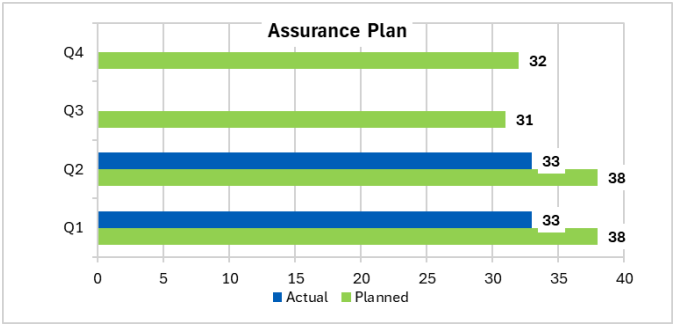
BAF 1: Inability to Sustain Safe and Effective Care Delivery

Executive Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

Committee Assurance Assessment & Plan





Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=4)	• Clinical effectiveness provision within Care Groups to be embedded (action 2) • Schemes to be identified to create additional capacity for challenged specialties (action 7) • Challenged specialties for elective delivery where additional capacity cannot be found in a timely manner (action 7) • Inability to maintain future workforce requirements and pipelines (action 9)
Gaps in Assurance (n=5)	• Robust system is required for evaluating harm in patients waiting for elective procedures (action 1) • Coding issues identified in relation to SHMI and HSMR (action 8) • Assessment of quality of care in relation to use of temporary escalation spaces (action 10) • Tendable contract due to expire 2026/2027 (action 11) • To further enhance Provider Collaborative support for UEC pathways and deflect attendances from ED in addition to discharge pathways to community services, over and above current plans (action 12)

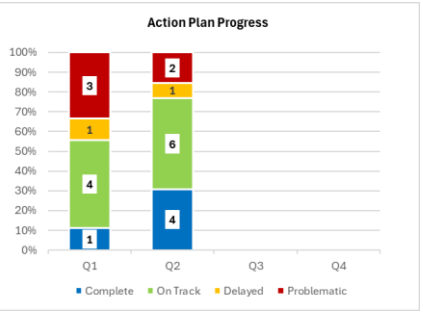
What is this data telling us?

The executive assurance rating assessment continues to be rated as partial. There has been a decrease in the number of positive assurances received by Committees in Q2 and an increase in the number of assurances not rated (although QAOC in September was not quorate and therefore unable to confirm levels of assurance). The number of assurance reports not seen as planned in the quarter remained the same as Q1, and these have been rescheduled.

Three actions have been completed in Q2 with four new actions having been identified, with specific actions identified to address any gaps in control and assurance. Seven of the twelve actions are due to be completed in Q3.

Risk Management Action Plan

No	Action	Due Date	Progress Report	2025/2026 Q1	Q2	Q3	Q4
1	Harm review process for long wait patients to be integrated and enhanced	~~31/12/2024~~ ~~31/03/2025~~ ~~01/10/2025~~ 01/04/2026	Carry forward from Q1 2024/25. Update provided to QAOC, where it was highlighted that due to capacity constraints within the digital team, progress had been paused, as such the due date has been moved to reflect this.				
2	Embed clinical effectiveness processes within Care Groups, to provide oversight of patient outcome data	~~31/12/2024~~ ~~31/03/2025~~ 01/02/2026	Carry forward from Q1 2024/25. Update on clinical effectiveness to be discussed at QAOC during Quarter 3.				
3	Deliver ePMA programme	31/12/2025	Carry forward from Q1 2024/25. Pilot completed and rollout underway and to be completed by December 2025.				
4	Review of national patient safety review and to consider how patient experience can be incorporated into standalone groups	31/12/2025	Recruitment to patient partnership chair to take place by the end of October 2025. Terms of reference for the Patient Engagement and Partnership Council have been drafted, which links with other patient councils and outreach to the community. Associated governance structure being set up with the next phase to be completed in the New Year to align work with the Care Groups and ensure reporting to the Committee/Board				
5	Winter bed modelling to be reviewed and assessed	~~31/03/2025~~ ~~30/05/2025~~ 31/08/2025	Carry forward from Q3 2024/25 Complete in Quarter 2 and included as part of the winter plan.				
6	Large language data validation of waiting lists to be delivered via MBI	~~31/03/2025~~ 31/07/2025	Carry forward from Q3 2024/25. This action remains ongoing and has become business as usual, with Artificial Intelligence being utilised to continually revalidate lists, therefore the action has been closed.				
7	Build additional capacity via different pathways i.e. acute care at home / virtual wards	31/03/2026	This has been addressed as part of the winter plan.				
8	Identify actions to resolve the coding backlog and identify interim assurance for HSMR/SHMI	~~31/08/2025~~ 31/10/2025	Coding is now fully complete from April 2025. A further paper regarding this is to be considered by QAOC in October 2025.				
9	To consider the action required to maintain future workforce requirements and pipelines	31/12/2025	Paper to be taken to the Executive Team for consideration, in terms of addressing the gap in capability to undertake this piece of work	N/A			
10	To obtain further assurance in relation to the risk assessment and use of temporary escalation spaces	31/12/2025	Action not yet due	N/A			
11	To consider the action required to continue with the nursing assurance system, given the impending end date for Tendable	31/12/2025	Action not yet due	N/A			
12	To further embed the Provider Collaborative Operational Group	31/12/2025	Action not yet due	N/A			



BAF 2: Inability to Design/Deliver Services that Address Local Population Needs

Quality, Access & Outcomes Committee | Director of Strategy

Risk Description

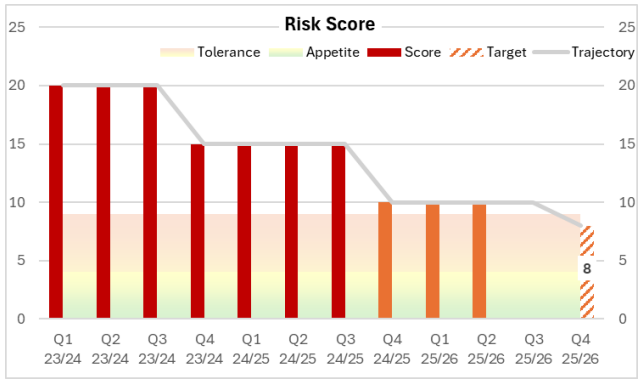
Cause:	If we are unable to effectively design and deliver services that are responsive to the specific needs of our local population,
Event:	Then our ability to improve population health and reduce health inequalities may be significantly limited,
Effect:	Resulting in increased and unsustainable demand on local health and care services, organisational capacity being exceeded, impacting service delivery and deterioration in patient outcomes and widening health disparities.

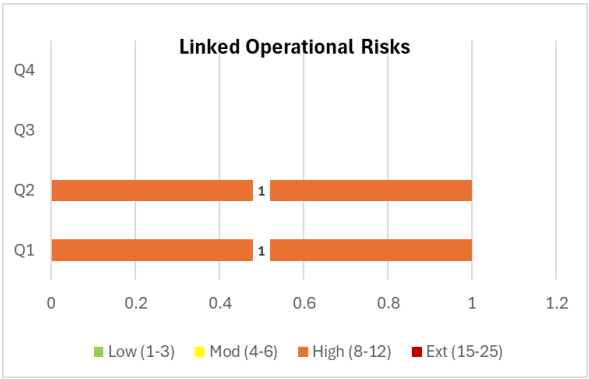
Potential to impact on our Strategic Priorities

Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

	Q1	Q2	Q3	Q4	Target	31/03/2026	Risk Appetite
Likelihood	2	2	2	2	2		Minimal 1 – 4
Consequence	5	5	5	4	4		Risk Tolerance
Risk Score	10	10	10	8	8		Mod/High 5 – 9





Executive Overview – Rationale for Risk Score and Progress made in Quarter 2

The risk score remains on trajectory for Q2. There continues to be significant programmes of work in place across prevention, health inequalities and anchor organisation, which are receiving national and regional attention. As a consequence, we have been successful in being awarded further Office for Health Improvement and Disparities (OHID) funding to create a second public health practitioner post – with this role working across the interface between UHNM and community dental teams initially (then broadening out to the children's CORE20PLUS5). The Trust flu vaccination programme has been expanded in 2025 to include outpatients, patients (long stay and care home discharges) and staff which is a test of a preventative approach to winter. There has also been focused work with the maternity team to develop a practical response to infant mortality within our population, and this is being developed into a clear plan that shows the areas we can influence and those which will need response from our partners. We have developed a system-wide weight management service (SWITCH) as part of a "Tier 3" response (more complex cohort) and we are currently developing a research proposal to enable this service to be expanded, to be submitted in November 2025.

What is the data telling us?

The risk score has remained the same as at Q1 and remains on trajectory to achieve the target (tolerable) risk score by March 2026.

There remains one linked operational risk to this strategic risk, and the number remains the lowest across all strategic risks.

This risk has the potential to impact on two strategic priorities in addition to being impacted by our three primary issues.

BAF 2: Inability to Design/Deliver Services that Address Local Population Needs

Key Controls Framework

Care Group (n=4)	• Corporate outcomes framework (e.g. infant mortality) focussing speciality work and aligned in response to operational challenges (e.g. expanded flu vaccination campaign) • Health inequality, making every contact count identified across trust services with active programmes of work developed • Health equity assessment tool (HEAT) and continuous improvement techniques in use • Sustainability programme, workforce wellbeing, community engagement, elective recovery active within care groups
Corporate (n=5)	• Deputy Director of Strategy and Transformation given specific responsibilities for Health and Wellbeing / Reducing Health Inequalities with dedicated public health consultant capacity in place • Health inequalities prevention groups in place to focus on actions and targeted interventions • Office for Health Improvement and Disparities (OHID) funded intelligence and public health practitioner posts • Population Health strategic plan approved as part of 2035 Trust Strategy (key focus on population throughout), supported by programmes of work • Population Health Steering Group re-established following trust-wide governance changes
System (n=8)	• Health protection links in place to support national/regional/system public health needs, i.e. measles • ICP Strategy approved with a focus on '5P's' across the life course which all centre on reducing health inequalities across Staffordshire and Stoke-on-Trent • Improving Population Health Board established at ICB level with representation from UHNM. UHNM is now lead on system work (e.g. Alcohol, weight management) • Local Authority led workstreams (e.g. Infant mortality programme) • National CORE20PLUS5 priorities • Public Health alliance in place between ICB, UHNM and Staffordshire County Council to improve cross working of consultant resource. • Population Health Management linked datasets • Regional Health Inequalities Network

Key Assurances Received in Quarter 1 & 2

Assurance Source	April	May	June	July	Aug	Sept
Partnerships and Collaboration						
Quality Impact Assessment Report					☒	NR
Sustainability Bi-Annual Report						
Waiting Inequalities List Report				NR		

Assurance Rating Key

Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

BAF 2: Inability to Design/Deliver Services that Address Local Population Needs

Executive Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
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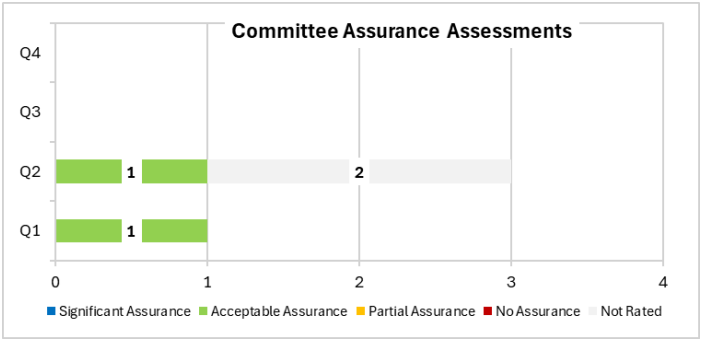
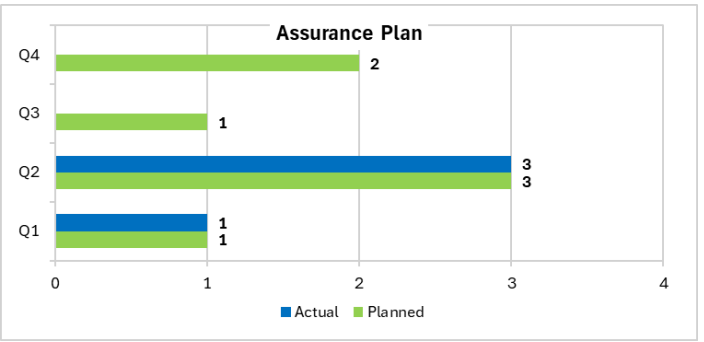
Committee Assurance Assessment & Plan





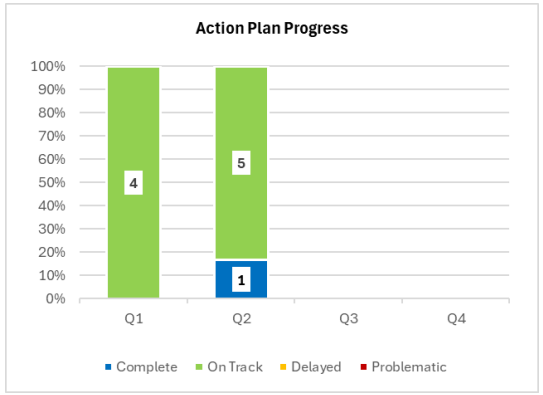
Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=1)	• With the change in executive portfolios, the lead for anchor work needs to be clarified (action 5)
Gaps in Assurance (n=1)	• The committee reporting requirements are being reconfigured to align with the revised Trust Governance (action 7)

What is this data telling us?

The executive assurance rating assessment continues to be rated as acceptable, although work is continuing to increase reporting on health inequalities to QAOC. The source of assurance considered in Q2 was rated as acceptable assurance and all 3 assurance reports were considered in the quarter as planned.

One action has been completed in Q1 with two new actions having been identified, with specific actions in place to address the gaps in control and assurance. Three actions are due to be completed in Q3.



Risk Management Action Plan

No	Action	Due Date	Progress Report	2025/26 Q1	Q2	Q3	Q4
1	Evidence base to confirm impact of interventions, to reduce health inequalities and prevent ill-health	31/03/2026	On track to deliver, with particular focus on infant mortality, vaccination, cancer, elective care, weight management, tobacco dependency and alcohol.				
2	Interventions to target workforce access and health	31/12/2025	Our workforce has been analysed to identified whether there may be areas for intervention.				
3	Improve use of population health management tools	30/09/2025	Complete - this has been delivered, with use of the ICB pathfinder tool and graphnet.				
4	Raise regional and national profile of the programme	31/03/2026	On track to deliver by 31/03/26				
5	To confirm the lead for Anchor Instituion following change in Executive portfolios	30/11/2025	Action not yet due.	N/A			
6	To improve the level of assurance provided to QAOC	31/12/2025	Changes made to the business cycle to incorporate updates on Health and Wellbeing Strategy progress. In addition, Pouplation Health Strategic Plan is to be considered by the Board in November	N/A			

BAF 3: Inability to Improve Workforce Sustainability & Organisational Culture

People, Culture and Inclusion Committee | Chief People Officer

Risk Description

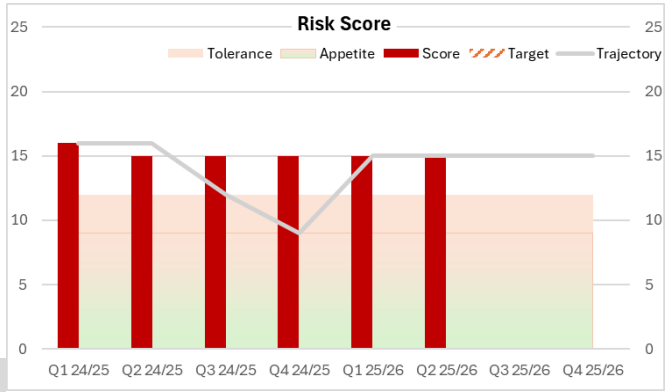
Cause:	If we are unable to achieve workforce sustainability through the implementation of an effective long term workforce plan – one that is underpinned by a positive, inclusive organisational culture,
Event:	Then, we may encounter significant challenges in attracting and retaining top talent, in addition to maintaining a workforce of the right size, with the appropriate values and behaviours to meet organisational demands,
Effect:	Resulting in negative impacts on colleague experience, wellbeing, recruitment, development and retention. This has the potential to compromise the quality of care for our patients, affect our inability to meet operational targets and deliver service transformation, and lead to increased reliance on premium staffing, negatively affecting our financial position.

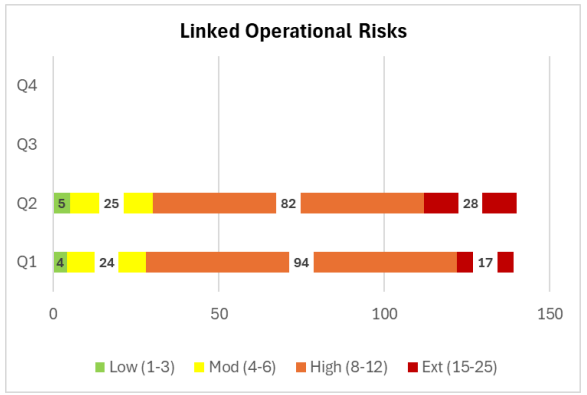
Potential to impact on Our Strategic Priorities

Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

	Q1	Q2	Q3	Q4	Target		Risk Appetite
Likelihood	3	3	3	3	2	31/03/2027	Cautious 1 – 9
Consequence	5	5	5	5	5		Risk Tolerance
Risk Score	15	15	15	15	10		High 10 - 12





Executive Overview – Rational for Risk Score and Progress made in Quarter 2

The risk score for Q2 has remained the same as Q1. Vacancies have continued to perform well at 7.5% for August against the stretch target of 8.0%. Sickness absence rates were 5.2% compared to 5.3% for Q1 with anxiety/stress/depression being the leading reason. Staff turnover has continued to be better than the target of 10% over the last three months; 7.2 % in August. Agency pay costs have been well controlled, and better that target of 3.2%, averaging at 1.6%. Statutory and mandatory training performance reduced slightly to 94.3%, essential to role stood at 85% in September. PDR rates remained static at 85.3%.

The organisational structure redesign has continued, including processes to realign leadership roles at tiers, 2, 3 and 4. Good progress has been made, but this has required significant focus and engagement from leaders and has unsettled teams at various levels of the organisation during the transition. There has been a continued increase in number and complexity of Employee Relations cases (with 62 new cases in Q2), and workforce related Subject Access Requests, and workforce related FOIs.

What is this telling us?

The risk score has remained the same as Q1 and on trajectory.

The number of linked risks has increased from Q1, with the risk continuing to have the second highest number of operational linked risks when compared to other strategic risks. The top 3 themes in relation to the linked risks relate to staffing shortages and recruitment difficulties, resource and capacity constraints and skills, training and experience gaps. This risk has the potential to impact two strategic priorities in addition to being impacted by two of our primary issues.

BAF 3: Inability to Improve Workforce Sustainability & Organisational Culture

Key Controls Framework

Care Group (n=14)	• Care Group Workforce Assurance Groups in place held monthly • Clinical Business Unit Performance Review Meetings held bi-monthly • Partnership Agreements for UHNM as lead provider/employer in place with appropriate governance • Apprenticeship targets in place and uptake against plan monitored • Care Group monitoring of staffing levels subject to vacancy controls. Internal deployment and redeployment of staff to support safer staffing levels • Care Group workforce organisational change / re-design / TUPE processes delivered in accordance with agreed governance and employment legislation • Insourcing contracts in place in key areas to support the operational recovery plan • Medical rota coordinators aligned to Care Groups to support operational planning • Workforce plans in place and budgets transacted accordingly, including Cost Improvement Plans (CIP) delivery • Culture improvement programme and plans in place • National Education Training Survey action plan in place with the aim of delivering a better learner and trainer experience • Operational escalation plans in place, including for periods of Industrial Action • Retention initiatives in place; including key focus on the NHS People Promise areas • Staff engagement / NHS National Staff Survey metrics and associated action plans are reviewed at Performance and Risk Review Meetings
Corporate (n=32)	• Care Group Performance and Risk Review meetings in place held bi-monthly • Local negotiation consultative committee meetings regularly held with our Trade Union colleagues • Mandatory Learning Oversight Group (MLOG) Terms of Reference refreshed • Medical Workforce Assurance Group • People (HR) policies and procedures in place and reviewed in accordance with policy review governance. • People Operations resource increase business case approved and recruitment progressing • Strategy and delivery plan for 'Our People' priorities, including key highlights key strategic areas of focus and programmes of activity for our workforce for 2025/26 • Strategic Workforce Executive Group meetings held quarterly • Chief Allied Health Professional (AHP) and Chief Healthcare Scientist roles in place with annual reporting • Education leads and teams working with providers across the System to enhance opportunities for learning and the education experience for our trainees • Establishment Workforce Plan in place for 2025/26 • Established Banks (workforce) in place – including Nursing, Medics, Admin & Clerical, and other groups • Medical Staffing weekly meetings to review rotas, gaps and progress against recruitment • Nurse Establishment Reviews reported twice yearly • Operational Escalation / Winter Planning Group stood up at the appropriate time in the year. • Pipeline of approved business cases in key areas profiled into the workforce establishment to enable tracking of vacancies and workforce supply • Work-flow recruitment management system to track and optimise on-boarding processes with ongoing general recruitment drives • Unplanned absences tracked daily (via Empactis) to support local planning • UK Visas and Immigration (UKVI) data gap understood and mitigated with visa compliance system introduced and supplemented by auditing right to work checks • Vacancy controls in place, as part of system and local financial recovery, including bank and agency usage • Workforce requirements for corporately led transformation programmes identified • Development Programmes in place including Platinum, Gold and Silver Connects, High Potential Scheme, Leadership Workshops, Senior Leadership Programme, Fundamentals of Medical Leadership & Management • Equality, Diversity and Inclusion Accountability Framework launched • Flexible working action plan reviewed with priority actions identified • Organisational culture and staff engagement improvement plans in place • Pastoral model of support for colleagues going through HR/Employee relations processes • Staff Networks established with task and finish groups as appropriate for specific in year priorities. • Sexual safety action plan in place, and system wide sexual safety conference held • Talent and succession planning in place • Values refreshed and launched in August alongside refreshed Behavioural Framework • Violence and aggression reduction campaign • Wellbeing activities in place such as Wellbeing Festival, Wellbeing Thursdays, Men's health podcasts
System (n=4)	• ICS People, Culture and Inclusion workstream member • NHSE regional and national oversight; including review meetings. NHS Employers support to workforce leaders. • National target for agency reduction with associated national and system controls for non-clinical agency expenditure • National NHS Staff Council member, to help shape and influence national policy

Key Assurances Received in Quarter 1 & 2

Assurance Source	April	May	June	July	Aug	Sept
Allied Health Professional Workforce Establishment Review				☒		☒
Appraisal and Revalidation Annual Report						NR
Armed Forces Report 2024/25						NR
Chief Healthcare Scientist Update		☒				
Chief People Officer Report						☒
Chief Pharmacist Workforce Report						☒
Employee Relations Casework Trends (formerly Formal Case Activity Report)						☒
Equality, Diversity & Inclusion Annual Report						
Equity and Inclusion Assurance Tool						
Guardian of Safe Working Report		Q3		Q4		Q1
Job Planning Spotlight				NR		
Learning and Education Annual Report						☒
Maternity & Neonatal Cultural Improvement Plan 2025-2027						
Maternity & Neonatal Workforce Report						
Nurse Staffing Establishment Review		☒		NR		
Postgraduate Medical Education Report						
Resident Doctors 10 Point Plan						NR
Sexual Safety Charter Assurance Framework						NR
Sexual Safety Update						
Speaking Up Report				Q3 / Q4		
Statutory & Mandatory Training Review						
Strategic Workforce Group Assurance Report				NR		
Talent and Succession Planning Update		☒				
Undergraduate Medical School Report		☒				
Violence Prevention and Reduction Update						
Wellbeing Report						
Workforce Plan Update						
Workforce Race and Workforce Disability Equality Standard						

Assurance Rating Key

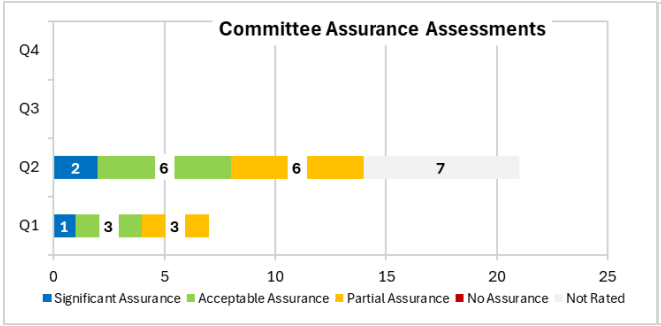
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

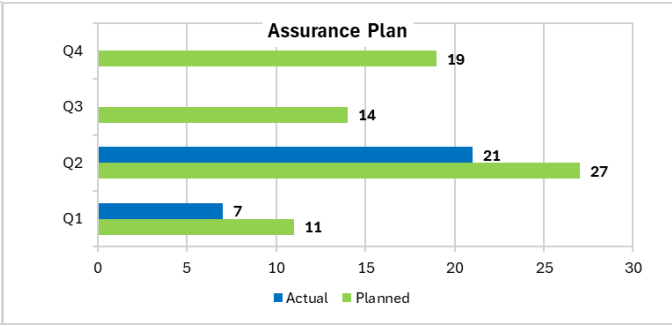
BAF 3: Inability to Improve Workforce Sustainability & Organisational Culture

Executive Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

Committee Assurance Assessment & Plan





Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=4)	• Care Group capacity to effectively manage and drive their People Plans (action 1) • Transition of the Clinical Divisions to three Care Groups during Q2 saw the Care Groups standing down their 'old' divisional Workforce Assurance Groups (action 2) • Risk in respect of the programme for up banding of Healthcare Support Workers from Agenda for Change Band 2 to 3; particularly in respect to the cost of (a) forward pay and (b) back pay (action 3)
Gaps in Assurance (n=3)	• Impact of financial pressures (Trust and System), including CIP targets on the workforce (action 4) • Job Planning (Medical Consultant) performance (action 5) • Workforce related Freedom of Information [FOI] requests and workforce Subject Access Requests [SAR] continue to be a challenge with an increasing number and complexity of requests received and inadequate resources to handle them (action 6) • Mutually Agreed Resignations Scheme (MARS) outcomes to be determined (action 7)

What is this data telling us?

The Executive Assurance Assessment continues to be rated as partial, although the majority of assurances presented in quarter were positive, with 6 items were not seen as planned which have been rescheduled.

The action plan has been refreshed for Q2, to ensure that actions have been identified to address each gap in control and assurance, resulting in eight different actions being listed, six of which are due to be completed in Q3.

Risk Management Action Plan

No	Action	Due Date	Progress Report	2025/26 Q1	Q2	Q3	Q4
1	To release the pressure on Care Groups capacity in order to manage and drive their People plans	31/03/2026	The last phase of the organisation redesign programme has been paused from Mid-Nov to Mid-Feb 2026 in order for teams to focus on winter pressures	N/A			
2	To reinstate Care Group Workforce Assurance Groups	31/12/2025	Action not yet due.	N/A			
3	Payments to be made in October regarding the Band 2 to 3 Healthcare Assistants back pay lump sum	31/10/2025	Data validation and data file produced by Workforce Information Team during Q2 and being processed by payroll for Oct pay. Total cost pressure to the organisation of circa £4.3m (excluding on-costs).	N/A			
4	Finalisation of the identification of recurrent CIP and the associated impact on workforce	31/03/2026	Action not yet due.	N/A			
5	To review the approach to job planning to identify efficiencies, and a report is due to be produced in Q3.	31/12/2025	Action not yet due. Report to be provide	N/A			
6	Business case to be identified, in order to address the inadequacy of resources to respond to workforce related FOIs and SAR's	31/12/2025	Action not yet due.	N/A			
7	Outcome of the MARS scheme to be confirmed and approved	31/10/2025	Formal approval processes will be completed in October. Indicative annual recurrent saving / benefit to the Trust (CIP) of c£500k.	N/A			
8	Education, Training and Development Accountability Framework to be launched	30/11/2025	Action not yet due.	N/A			

BAF 4: Inability to Deliver Digitally Enabled Care Transformation

Finance and Business Performance Committee | Chief Digital Information Officer

Risk Description

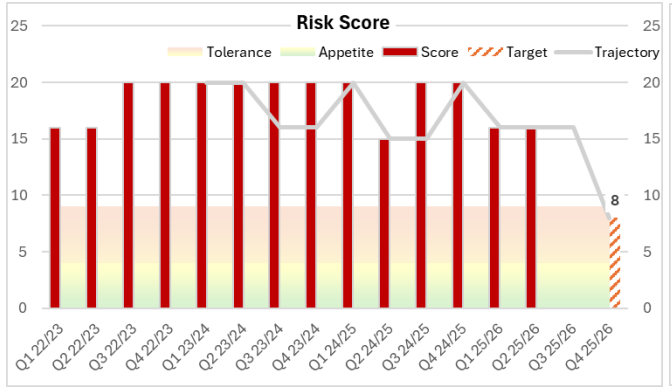
Cause:	If we are unable to deliver digitally enabled care transformation due to ongoing limitations in digital infrastructure, workforce capability, system interoperability, and financial constraints,
Event:	Then our capacity to innovate, modernise services and improve patient safety, care quality, and operational efficiency will be significantly constrained,
Effect:	Resulting in compromised patient outcomes, reduced staff productivity, inequitable access to service across geographies, and non-compliance with regulatory requirements.

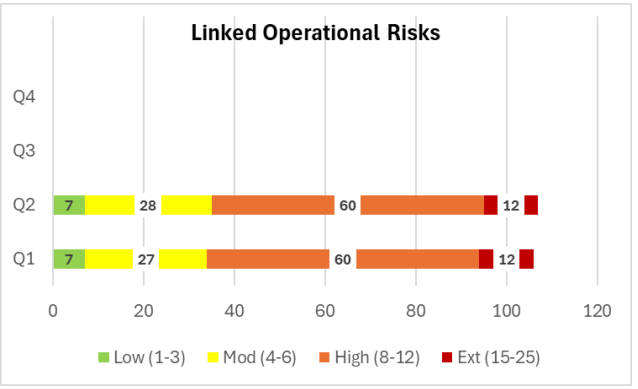
Potential to impact on Our Strategic Priorities

Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

	Q1	Q2	Q3	Q4	Target		Risk Appetite
Likelihood	4	4	4	2	2	31/03/2026	Minimal 1 – 4
Consequence	4	4	4	4	4		Risk Tolerance
Risk Score	16	16	16	8	8		Mod 5 – High 9





Executive Overview – Rationale for Risk Score and Progress made in Quarter 2

This quarter has seen significant advancements in our digital transformation initiatives. The Electronic Prescribing and Medicines Administration (EPMA) system is now operational at Ward 15 at County Hospital, marking a major milestone in our efforts to enhance medication safety and efficiency. Additionally, pilot projects for Artificial Intelligence (AI) are now underway in the Emergency Department (ED) and Respiratory (Sleep) units, with the aim of leveraging AI technology to improve patient care and outcomes. Furthermore, the Picture Archiving and Communication System (PACS) reporting project has been successfully completed, ensuring streamlined and efficient radiology reporting across our facilities.

What is this telling us?

The target (tolerable) risk score of High 8, aligned the revised risk appetite statement is expected to be achieved by March 2026, and the risk score has remained at Extreme 16 for Q2 in line with the trajectory. This risk has the potential to impact on all three strategic priorities in addition to being impacted by our three primary issues.

The number of linked risks has increased from Q1; continuing with the third highest number of linked operational risks when compared to other strategic risks. The top 3 themes in relation to the linked risks relate to cyber security and data protection weaknesses, obsolete, unsupported or poorly maintained systems/infrastructure and fragmented, inefficient or poorly integrated information management.

BAF 4: Inability to Deliver Digitally Enabled Care Transformation

Key Controls Framework

Care Group (n=14)	• Capital programme engagement to secure funds of replacement of out of support hardware and software and for additional investment to support clinical transformation • Clinical engagement through Chief Medical Information Officer (CMIO) and Chief Nurse Information Officer (CNIO) along with digital nurses, midwives, pharmacists and divisional CMIOs • Clinical safety officers in place and trained • Device lifecycle management business case approved allowing equipment >5 years old to be replaced • Digital Business Partners now started to attend Care Group Boards • Digital Pathology Scanning Capacity expanded • Digital operational groups (bi-monthly); ensuring digital initiatives align with national mandates and strategic goals • Digital service continuity plans annually tested • Information Asset Register with assigned information asset owners • National guidelines regularly reviewed to identify any gaps in compliance • LIMS and Order Communications Results and reporting system implemented • Risk registers regularly reviewed and updated • Shadow IT register shared with Care Groups • Training programmes remain ongoing, tied to the rollout of new technologies and systems
Corporate (n=9)	• Artificial Intelligence team and governance structure in place • Digital and Data Security Protection Group monitors active management of IM&T risks via monthly Risk Register Reports • Digital maturity assessments to enable the prioritisation of core capabilities • Digital services management print lease contract approved • Digital Services support standards documented and sent to system owners • Digital policies in place • Freedom of Information improvement plan developed • Frontline digitalisation investment approved • Regional Cyber Security Operations Centre live with over 450 servers reporting to the Security Information and Event Management System (SIEM)
System (n=5)	• Data protection toolkit completed, and improvement plan agreed with NHS England • Digital Health Clinical Information Officer (CIO) Network member • NHS England EPR Business Case approved and submitted to region • Regional and national innovation networks contributions • West Midlands Imaging Network outline business case approved

Key Assurances Received in Quarter 1 & 2

Assurance Source	April	May	June	July	Aug	Sept
Cyber Security Assurance Report						
Cyber Assessment Framework Follow Up Internal Audit						

Assurance Rating Key

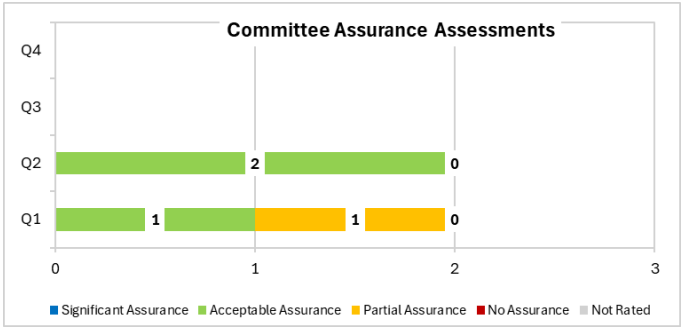
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

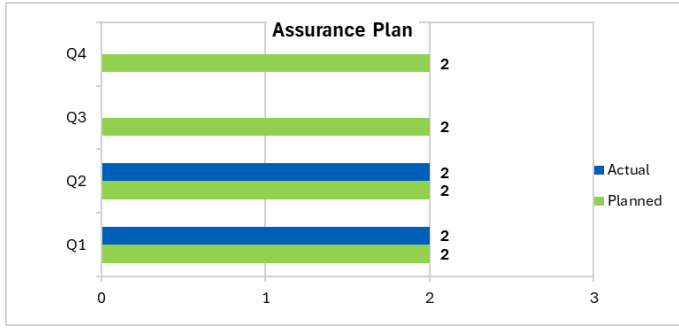
BAF 4: Inability to Deliver Digitally Enabled Care Transformation

Executive Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

Committee Assurance Assessment & Plan





Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=7)	• Digital solutions are not consistently integrated (action 4) • Digital skills training insufficient for the wider workforce (action 6) • Funding is limited and significantly less than the suggested 5% (action 11) • Nationally mandated standards not yet met (action 2) • Obsolete technology in use (action 3) • Review and upgrading of all 405 solutions not in place (action 5) • Shadow IT not operated in line with NHS standards (action 4)
Gaps in Assurance (n=4)	• Clinical Safety Assurance Reports not in place for all systems (action 7) • Governance arrangements for artificial intelligence (action 10) • Data Protection Impact Assessment (DPIAs) not in place for all systems (action 9) • Digital Technology Assessment Criteria (DTAC) not in place for all systems (action 8)

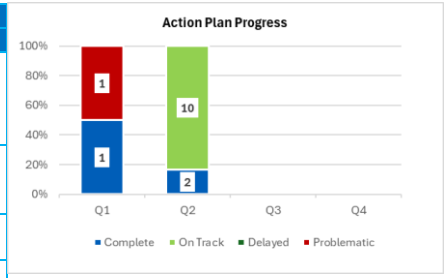
What is the data telling us?

The executive assurance rating assessment continues to be rated as partial although both items presented in quarter were seen as planned and received an acceptable assurance rating.

Ten new actions have been identified in the quarter and mapped to each gap in control / assurance and the one outstanding action from 2024/25 has now been completed. Seven of the ten actions are due to be completed by the end of Quarter 3.

Risk Management Action Plan

No	Action	Due Date	Progress Report	2025/26 Q1	Q2	Q3	Q4
1	Pilot of ePMA	~~31/10/2024~~ ~~30/11/2024~~ ~~30/03/2025~~ 30/10/2025	Carry forward from Q1 2024/25. Pilot completed and rollout underway				
2	Map current systems against NHS Digital and NHS England standards	01/12/2025	Mapping exercise to commence against DSPT, DTAC, DCB0129/0160	N/A			
3	Identify and risk assess obsolete hardware/software	01/01/2026	Action not yet due	N/A			
4	Communications regarding the digital need process to reduce Shadow IT to be improved	30/10/2025	Action not yet due	N/A			
5	Systems supplier map for systems managed by IT and Care Groups to be undertaken, including contract end dates and timescales to migrate, to aid lifecycle management	01/01/2026	Action not yet due	N/A			
6	Review modern training tools to enable enhanced training for the wider workforce	01/02/2026	Action not yet due	N/A			
7	Work with Care Groups on getting their solutions clinically safety assessed	31/03/2026	Action not yet due	N/A			
8	Mandate DTAC completion as part of system onboarding and annual review. Escalate non-compliant systems through digital governance committees for remediation or retirement	01/01/2026	Action not yet due	N/A			
9	Introduce new governance structure holding Care Groups to account for Shadow IT, which does not meet NHS digital standards	31/03/2026	Action not yet due	N/A			
10	AI oversight committee to be established to monitor deployments of all ID and obtain assurance on safety	01/12/2025	Action not yet due	N/A			
11	Report on corporate services benchmarking to be considered by Executives, to consider the investment level in digital services	01/11/2025	Action not yet due	N/A			



BAF 5: Inability to Deliver Investment in Estate Infrastructure & Workforce

Finance and Business Performance Committee | Director of Estates, Facilities & PFI

Risk Description

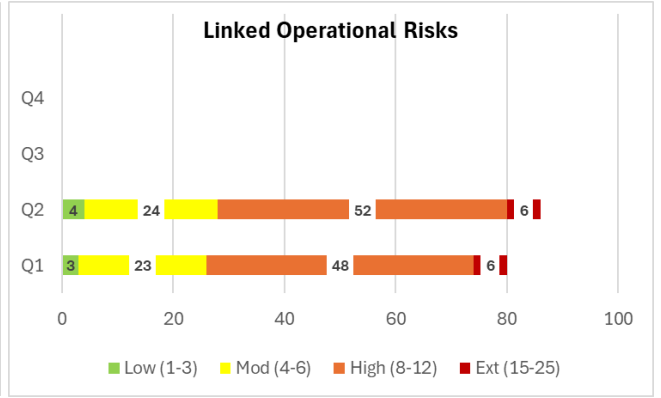
Cause:	If we are unable to secure sufficient investment to develop and modernise our estate infrastructure and workforce,
Event:	Then we may be unable to deliver high quality, responsive services in a safe, compliant, and sustainable environment,
Effect:	Resulting in non-compliance with national standards, increased infrastructure risks, reduced value for money, underperformance against key objectives, and negative impacts on patient safety and service access.

Potential to impact on Our Strategic Priorities

Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

	Q1	Q2	Q3	Q4	Target		Risk Appetite
Likelihood	3	3	3	3	3	Achieved Q1 2025	Cautious 1 – 9
Consequence	4	4	4	4	4		Risk Tolerance
Risk Score	12	12	12	12	12		High 10 - 12



Executive Overview – Rationale for Risk Score and Progress made in Quarter 2

Whilst the current risk score continues to be in line with the risk target, this is largely due to the additional limited capital funding to address increasing backlog risks and decarbonisation targets.

There has been a reduction in the number of supply chain partners and risks in terms of energy security, supply and costs in quarter and there remain challenges in terms of the ability to agree and deliver formal variations within the PFI, to address the requirements from the Building Safety Act 2022. However, work is progressing at pace with a view to supporting resolution.

We continue to manage the Trusts current backlog maintenance position, currently with a CIR £15 m and overall backlog of £75 m which is predicted to rise to over £100 m in 28/29 with current predicted investment. Confirmation has been received that the Sustainability and Net Zero Carbon capital investment subgroup has increased from £100 k to £500 k from 2026/27.

What is this telling us?

The target (tolerable) risk score of High 12, aligned the revised risk appetite statement continues to have been achieved. This risk has the potential to impact on all three strategic priorities in addition to being impacted by our three primary issues.

The number of linked risks has increase from Q1, with the fourth highest number of linked operational risks compared to other strategic risks. The top 3 themes in relation to the linked risks relate to building, infrastructure and environmental deficiencies, fire safety and emergency preparedness and space, capacity and compliance constraints. .

BAF 5: Inability to Deliver Investment in Estate Infrastructure & Workforce

Key Controls Framework

Care Group / Service (n=3)	• Estate condition: Planned Preventative Maintenance programme; competent Estates staff / Authorised persons; KPIs monitored through CEF / Environmental Audits, Maintenance Operational Board; Operational Policies, Service Specifications PFI, 6 Facet Survey • Fire Safety / Security Policies; Protocols, Guidelines; patrolling, CCTV, Risk Assessments in place • Sustainability / Net Zero Carbon (NZC): Sustainable Development Steering Group (biannual), Sustainability Working Groups (monthly), Nitrous Oxide Waste Reduction Group (to meet NHSE funding T&Cs), Public Sector Decarbonisation Scheme (PSDS) Group (to meet DESNZ funding T&Cs) Sustainability and NZC capital investment subgroup, NZC Trust Board Lead (Director EFP), Clinical NZC lead
Corporate (n=9)	• Capital team / programme in place and audited by External Audit annually • Capital refurbishment targeted as appropriate to address significant risk backlog, with risk assessments undertaken to inform management, maintenance, testing & inspection regime • Estate Condition - Capital bids against prioritised list of Estate 6 Facet Findings with subsequent approval via Capital Investment Group • Estate Strategy – Clinical & System Strategy and independent review used to inform content • Fire/Security: 'On the spot' fire improvement notices, Fire Safety KPIs & ad-hoc audits/inspections • Fire Safety and Security close working with local Police and visibility on site • Green Plan 2025/26-28/29 approved • Low Carbon Care Framework approved and launched • Sustainability / NZC: Biannual Sustainability performance report to Finance and Business Performance
System (n=6)	• Collaborative working with system partners on estate infrastructure and sustainability agenda, members of key working groups to drive transformation and efficiency in these areas • Jointly agreed interpretation of Building Safety Act between Trust and PFI partners • Liaison with NHS England and Department of Health PFU on PFI material issues • Participation in National Programme Strategic Supplier Relationship Management (SSRM) hosted by Cabinet Office & HM Treasury • Statutory maintenance programme – Maintenance Operational Board. • Sustainability / NZC: Work with external partners regarding zero-capital solutions and grant funding applications, attendance at ICS and Midlands Greener Delivery Groups and system-wide projects

Key Assurances Received in Quarter 1 & 2

Assurance Source	April	May	June	July	Aug	Sept
Fire Safety Annual Report						
PLACE Inspection Findings and Action Plan						
Security Management Annual Report						
Sustainability Bi-Annual Report						

Assurance Rating Key

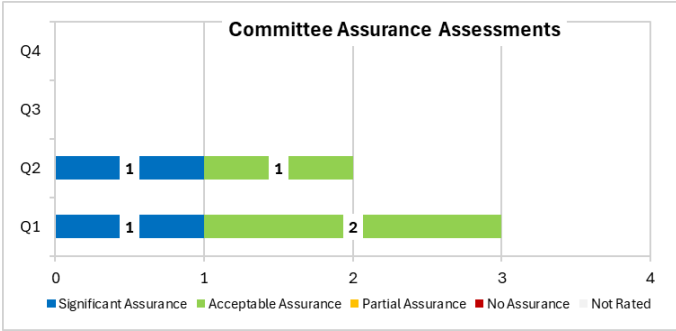
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

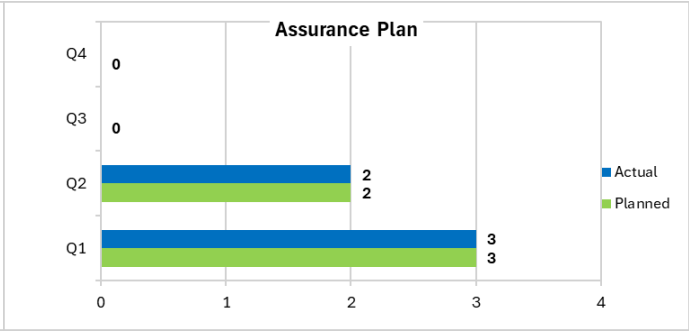
BAF 5: Inability to Deliver Investment in Estate Infrastructure & Workforce

Executive Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

Committee Assurance Assessment & Plan





Gaps to be Addressed and Links to Action Plan

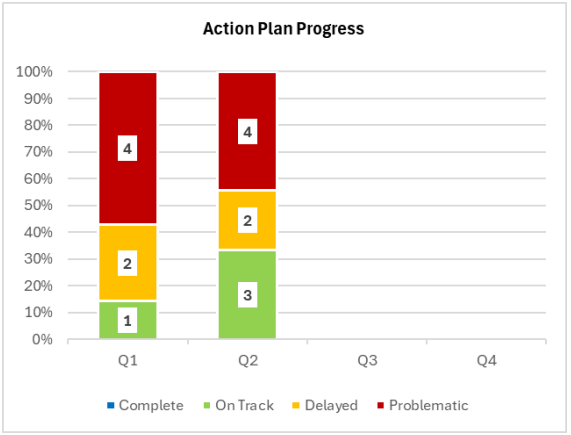
Gaps in Control (n=15)

- Maintenance backlog programme underfunded; this will see a continued rise in backlog figures over next 5-year plan (Retained Estates) (Action 1)
- Sustainability / NZC programme, additional capital funding identified to support, but remains underfunded overall, which will result in missed opportunities in delivering revenue and carbon savings (Action 5)
- Clinical strategies gap, and lack of completed feasibilities to deliver agreed clinical plans and Royal Institute of British Architects (RIBA) stage 2 designs and budget costs to match emergency funding as this becomes available to bid for (Action 2)
- Expansion space for modulars at Royal Stoke not able to be expanded, rightsizing to drive development and refurbishment in the right place to ensure sustainable development control plan (DCP), with a phase delivery approach, 5–10-year DCP. (Action 2)
- National NHS framework suppliers limited, bidding for large amounts of NHS funded work, national procurement means one supplier can win multiple schemes and therefore drive resource issues, which can impact programme and cost. (Action 3)
- Sustainability feasibilities limited in number resulting in being unable to quickly utilise available capital when it becomes available (Action 5)
- Existing NHS estate is designed to current NHS and Chartered Institute of Building Services Engineers (CIBSE) guidance which currently does not account for the constantly increasing summer hotter prolonged periods, and colder winter snaps. Real risk to estate infrastructure resilience (Action 9)
- Capital & revenue funding limited, to deliver identified carbon reduction schemes, required to meet nationally mandated targets (Action 1)
- Challenges with pay and the ability to recruit and retain our skilled workforce with private sector pay comparison to agenda for change (AFC) (Action 6)
- Ageing workforce with a risk of losing site knowledge onto future apprentices which can only be funded via current establishment budget (Action 6)
- Lack of ability to over recruit in areas of high turnover, resulting in bank and overtime whilst we recruit replacement substantive posts (Action 6)
- Lack of training budget within current funding to upskill workforce for evolving and more digital and technical infrastructure. Becoming more reliant of external contractors at premium costs (Action 6)
- Remedial works for PFI Latent Defects to be concluded (Action 7)
- Rightsizing work to inform Estate Strategy and Development Control Plan to be concluded (Action 2)
- Supply Chain Partners – small number of suppliers operating across many hospital Trusts impacting on supplier resilience, flexibility and confidence in programme and cost model delivery. Significant schemes underway in year include CDC, Elective Hub, UTCs and Breast Care (Action 3)

Gaps in Assurance (n=1)

- Lack of updates on progress against the Estates Strategic Plan provided to Finance and Business Performance due to refresh of Our Strategy (Action 9)

Risk Management Action Plan



No	Action	Due Date	Progress Report	2025/26 Q1	Q2	Q3	Q4
1	Capital funding	~~28/06/2024~~ ~~31/12/2024~~ ~~31/03/2025~~ ~~30/06/2025~~ 30/06/2029	Carry forward from Q1 2024/25. Ongoing work with finance team to understand funding opportunities, building on previous successful capital funding bids from NHSE. Work also remains ongoing on the bids for future years backlog safety fund being made available for the next 3 years, of £750m per year				
2	Estates strategic plan	~~30/06/2025~~ 30/12/2025	The Estate and Facilities strategic plan is in the final stages of production and will align to the outcome of the Trust's rightsizing work programme which continues as a separate workstream.				
3	Supply chain partners	~~31/03/2025~~ 30/06/2026	Capital team liaising with NHSE regarding letting of P23 contracts in line with framework agreements. Monthly monitoring of appointed P23 PSCP carried out by capital team to inform NHSE on quality and performance. Facilities teams continue to monitor limited suppliers' performance and associated service and price risks. Focus in year on CDC; Breast; UTC; and Discharge Lounge.				
4	Sustainability/net zero carbon	~~31/03/2025~~ ~~31/07/2025~~ 30/01/2026	Due diligence on the connectivity of RSUH to the proposed District Energy Network underway and business case completion is forecast for April 2026. Keep Warm, Keep Well expansion case is expected to be completed by December 2025.				
5	Workforce	~~27/12/2024~~ ~~31/01/2025~~ ~~30/07/2025~~ 30/03/2026	Continue to review building and engineering agenda for change pay rates vs that of the private sector and Estates recruitment and retention business case. Ongoing work with recruitment to ensure shortest timeline for recruitment and developing further training opportunities within current establishment, via learning and education plan, to provide succession planning within technical areas. Two new engineering apprentice positions successfully recruited to and are now in post.				
6	PFI partners / lender issues	~~30/08/2024~~ ~~31/03/2025~~ ~~31/07/2025~~ 30/03/2026	To conclude supplemental agreement for N&C Variation and to conclude remedial works for PFI Latent Defect Issues. Delays partially linked to Building Safety Act challenges.				
7	Building safety act	31/10/2025	Conclude interpretation of Building Safety Act requirements with specialist advisors and Partners and produce responsibility matrix.				
8	Review impact of global warming	31/03/2026	Undertake a review of the impact of global warming on the estate infrastructure and associated guidance to inform appropriate actions to mitigate risk, with existing infrastructure and future infrastructure decision making	N/A			
9	To include quarterly updates on the Estates Strategy to the FBP	31/03/2026	Due to be presented to the Trust Board in November 2025, following which quarterly progress updates will be scheduled on the FBP business cycle	N/A			

What is the data telling us?

The Executive Assurance Assessment continues to be rated as acceptable assurance and all two sources of assurance were presented in quarter as planned and received positive ratings.

Two new actions have been identified in Q2 and mapped to each gap in control and assurance. Two actions are due to be completed in Q3.

BAF 6: Inability to Deliver In-Year Financial Position

Finance and Business Performance Committee | Chief Finance Officer

Risk Description

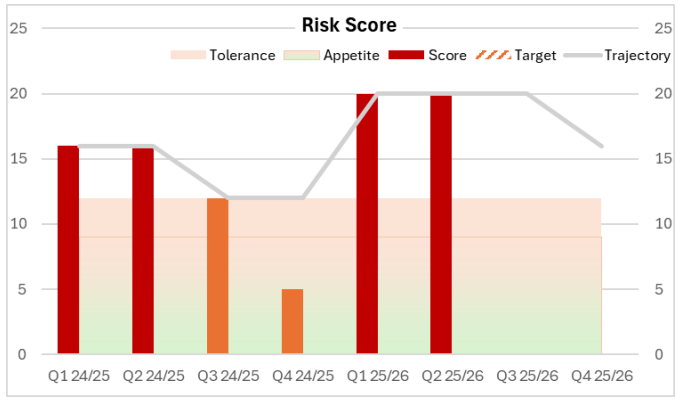
Cause:	If we, or system partners, are unable to manage within the financial assumptions underpinning the 2025/26 revenue plan,
Event:	Then we may be unable to deliver our agreed financial position for 2025/26,
Effect:	resulting in an increased level of external scrutiny and potential regulatory intervention, reduced autonomy in financial and strategic decision-making, inability to invest in critical areas such as workforce, digital infrastructure and estate development, challenges in maintaining service affordability and managing rising demand and adverse impacts on the quality, accessibility and sustainability of patient care

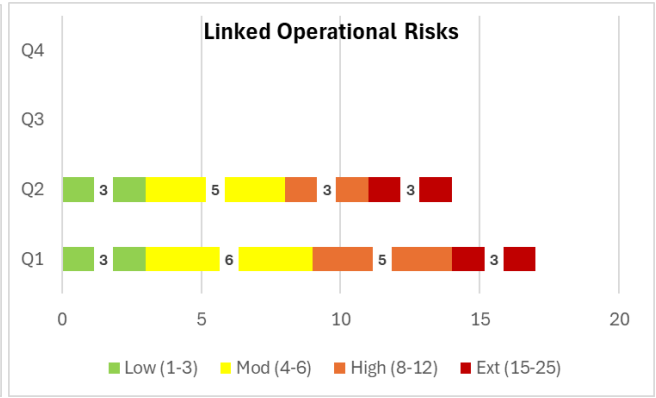
Potential to impact on Our Strategic Priorities

Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

	Q1	Q2	Q3	Q4	Target		Risk Appetite
Likelihood	4	4	4	4	3	~~31/03/2026~~ 31/03/2027	Cautious 1 – 9
Consequence	5	5	5	4	4		Risk Tolerance
Risk Score	20	20	20	16	12		High 10 - 12





What is the data telling us?

The target (tolerable) risk score of 12 remains unchanged, although the target date has been moved out to March 2027 given the continued gaps in identification of cost improvements to the level required. As such the trajectory for Q4 has been revisited.

The number of linked risks has decreased compared to Q1. The main themes in relation to these operational links risks relate to weaknesses in financial planning, controls and funding, process and system controls and workforce planning challenges. This risk has the potential to impact on all three strategic priorities in addition to being impacted by our three primary issues.

Executive Overview – Rationale for Risk Score and Progress made in Quarter 2

Whilst the risk score of Extreme 20 for Q2 is as planned, the trajectory for Q4 has increased from 12 to 16, due to there still being notable gaps in the forecast, and although some progress has been made on cost improvements (i.e. MARS/ potential delivery additional support), it is unlikely that the entire gap will be closed. Whilst the likelihood is therefore expected to increase, the value of the deficit is expected to be lower.

Whilst NHSE have requested a recovery plan this is insufficiently developed to take any further assurance at this stage, and the position will be reviewed post submission on the 20th October.

BAF 6: Inability to Deliver In-Year Financial Position

Key Controls Framework

Care Group (n=5)	• CIP meetings held, chaired by Chief Operating Officer • Executive Team approving and monitoring spend against Elective Recovery Fund • Performance Management meetings in place with the Care Groups with financial performance included as a driver metric. Additional executive focus through Executive Recovery Oversight Group • Recovery plans being prepared by the services for underperforming areas on elective activity and financial forecast • Standing Financial Instructions (SFIs), scheme of delegation and approval structure for any additional expenditure in place
Corporate (n=9)	• Audit Committee oversight of system of internal control such as SFI breaches, write offs etc • Executive Recovery Oversight Group in place • Finance report to Finance and Business Performance Committee (FBP) with associated scrutiny; enhanced to include run rate performance and impact of activity levels of income recovery • Forecast undertaken monthly to identify best, likely and worst-case ranges reported through FBP • Future investments guidance issued to the Care Groups in that only investment requests where significant patient safety risks are involved will be considered and any additional investments will now need to go through the double lock • Non-recurrent mitigations well understood but constantly assessed and quantified • Reset of the bed model and final allocation of system capacity funding undertaken • Strategy Delivery Unit in place • Vacancy and workforce controls enhanced
System (n=5)	• External auditor review of reported financial position • Internal audit programme to be utilised depending on changing risks in financial plan • PWC assessment of Grip and Control measures • System Recovery Programme • Varying the pace of investment to provide additional mitigation

Key Assurances Received in Quarter 1 & 2

Assurance Source	April	May	June	July	Aug	Sept
Annual Accounts						
Audit Findings Report and Letter of Representation						
Audited Accounts and Financial Statements and Analytical Review			NR			
Business Case Review Schedule						
Cost Improvement Report						
Demand and Activity Performance Report		NR	☒	☒	☒	NR
Finance Report	M12	M1	M2	M3	M4	M5
Grip and Control: Medical Staff and Nursing Bank and Agency Controls Internal Audit						
Losses and Special Payments and Stock Write Offs						
Medicines Finance, Procurement and Supplies Report						
Overseas Patients Activity				☒		
Procurement Report						
Productivity Performance Report						
SFI Breaches relating to Procurement processes and Single Tender Waivers						
SFI Breaches relating to Salary Overpayments						

Assurance Rating Key

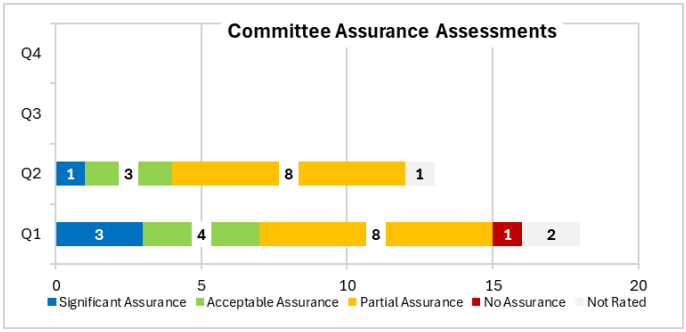
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

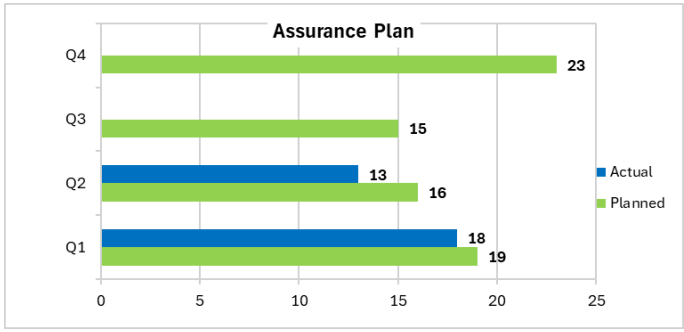
BAF 6: Inability to Deliver In-Year Financial Position

Executive Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

Committee Assurance Assessment & Plan





Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=3)	• Recurrent CIP versus non-recurrent (Action 1) • Under delivery of elective work (Action 2) • Understanding of increased bank staffing spend (Action 3)
Gaps in Assurance (n=2)	• Elective recovery plan to be developed detailing implications (action 2) • Some CIP schemes to be worked up in detail (Action 1)

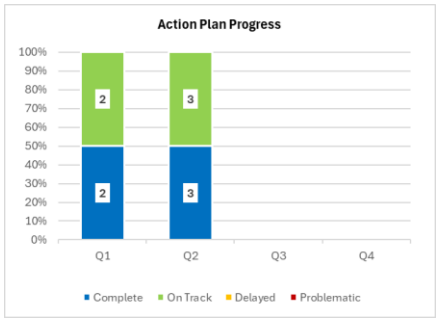
What is the data telling us?

The Executive Assurance Assessment continues to be rated as partial assurance. All but 1 source of assurance was presented in quarter as planned, with 4 having received positive ratings, and the majority being rated as partial assurance.

Two new actions have been identified for Q2, with each gap in control and assurance having associated actions identified. One action is due to be completed in Q3.

Risk Management Action Plan

No	Action	Due Date	Progress Report	2025/26 Q1	Q2	Q3	Q4
1	Identification and delivery of recurrent CIP	31/03/2026	Ongoing reports provided to FBP detailing progress and delivery. Outcome of recalibration exercise to be reported in October 2025.				
2	Ensure delivery of elective targets	31/03/2026	Elective Recovery Programme submitted to NHSE as part of undertakings.				
3	Deep dives to take place to understand increase in bank spend	31/12/2025		N/A			
4	Contract to be confirmed	30/09/2025	Complete.	N/A			



BAF 7: Inability to Deliver Financial Sustainability

Finance and Business Performance Committee | Chief Finance Officer

Risk Description

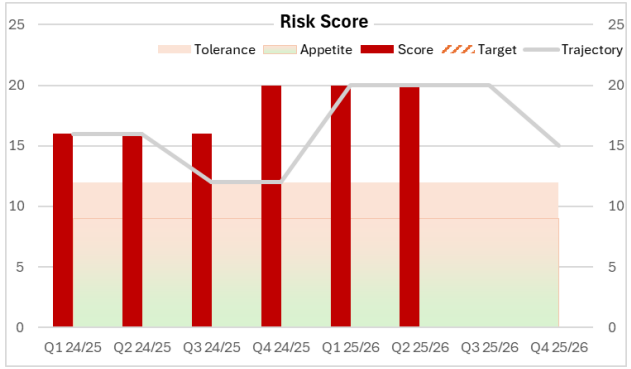
Cause:	If we, or system partners, are unable to manage within the assumptions made within the financial plan for 2025/26,
Event:	Then our underlying financial position will deteriorate further,
Effect:	resulting in reduced availability of funding for essential investments, an increased level of external scrutiny (level 5) and potential regulatory intervention, loss of autonomy over financial and strategic investment decision making within the Trust, breach of statutory financial duties, adverse impact on the Trust's ability to deliver sustainable and high-quality care.

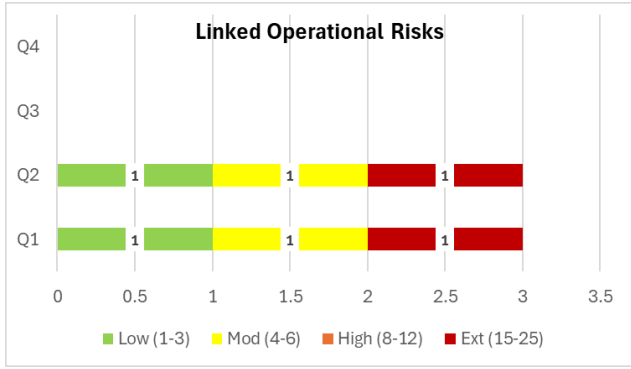
Potential to impact on Our Strategic Priorities

Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

	Q1	Q2	Q3	Q4	Target		Risk Appetite
Likelihood	4	4	4	3	3	31/03/2027	Cautious 1 – 9
Consequence	5	5	5	5	4		Risk Tolerance
Risk Score	20	20	20	15	12		High 10 - 12





What is the data telling us?

The risk score for Q2 remains on trajectory at Extreme 20. The number of linked risks has remained the same as Q1, with the third lowest across all strategic risks. The main themes in relation to the linked operational risks relate to ineffective workforce planning, failure to develop and deliver cost improvement programmes and operational/strategic planning gaps.

This risk has the potential to impact on all three strategic priorities in addition to being impacted by our three primary issues.

Executive Overview – Rationale for Risk Score and Progress made in Quarter 2

Although the Trust has remained on plan, the system the position is not meeting the plan. The forecast for the year is being prepared 4, and it is expected that the Trust will be forecasting a deficit from the plan. There are several risks within the CIP plan and further mitigations will need to be worked up. The target score has been set at 2026/27 due to the deficit support failing out at the end of 2025/26 resulting in an inability to meet the target in year.

BAF 7: Inability to Deliver Financial Sustainability

Key Controls Framework

Care Group (n=4)	• Care Group attendance monthly Financial Recovery Group • Executive Team approval of additional investment up to £250,000 • Performance Management meetings in place with the Care Groups with financial performance included as a driver metric. • Standing Financial Instructions and scheme of delegation
Corporate (n=4)	• Executive Financial Recovery Group established to give oversight of CIP delivery both corporate schemes and Care Group targets. • Finance report in place to Finance and Business Performance Committee with associated scrutiny; enhanced to include run rate performance and impact of activity levels of income recovery. • Future investments guidance issued to the Care Groups in that only investment requests where significant patient safety risks are involved will be considered and any additional investments will now need to go through the double lock • Reset of the bed model and final allocation of system capacity funding undertaken
System (n=3)	• External audit programme in place • Internal audit programme adjusted to reflect changing risks in financial plan • System Recovery Programme

Key Assurances Received in Quarter 1 & 2

Assurance Source	April	May	June	July	Aug	Sept	Oct
Accounting Policies Update							
Annual Accounts							
Annual Accounts Timetable							
Audit Findings Report and Letter of Representation							
Audited Accounts and Financial Statements and Analytical Review			NR				
Business Case Review Schedule							
Cost Improvement Report							
Demand and Activity Performance Report		NR	☒	☒	☒	NR	
Draft Financial Outlook							
Finance Report	M12	M1	M2	M3	M4	M5	M6
Going Concern							
Grip and Control: Medical Staff and Nursing Bank and Agency Controls Internal Audit							
Key Financial Controls Internal Audit							
Medicines Finance, Procurement and Supplies Report							
Overseas Patients Activity				☒			
Overseas Visitors / Private Patient Policy Audit							
Private Patients Policy Audit							
Procurement Report							
Productivity Performance Report							

Assurance Rating Key

Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

BAF 7: Inability to Deliver Financial Sustainability

Executive Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

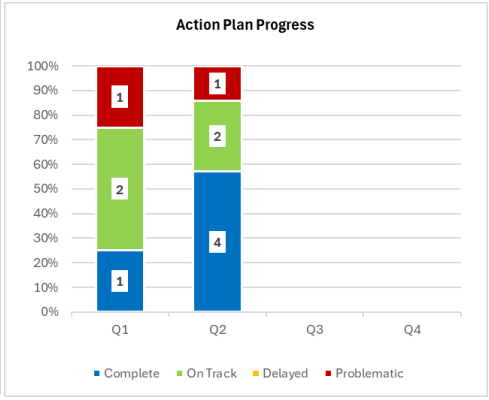
Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=4)	• Fully signed off CIP Plan (action 1) • Recurrent CIP versus non-recurrent (action 1) • Underlying contractual position requires finalising, and agreement not yet reached. (action 4) • Unclear on Trusts ability to access support for costs of potential redundancy may undermine CIP delivery in year (action 5)
Gaps in Assurance (n=1)	• Triangulation of Care Group activity plan versus income assumptions (action 6)

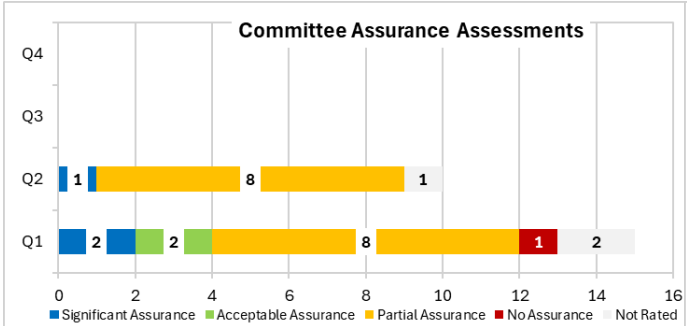
What is this data telling us?

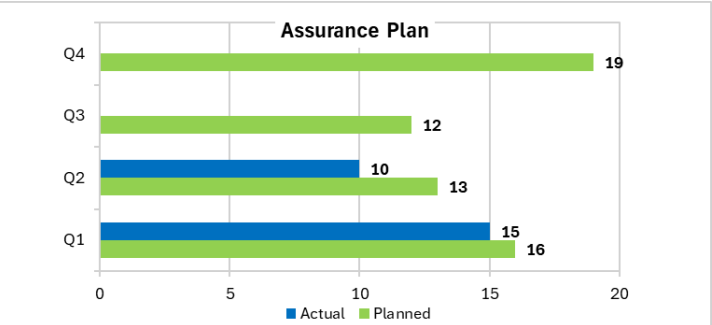
The Executive Assurance Assessment continues to be rated as partial assurance, and all but two sources of assurance were presented in quarter as planned, with a decrease in the number of positive ratings.

Three additional actions have been identified in quarter, which have been completed with one action due to be completed in Q3.



Committee Assurance Assessment & Plan





Risk Management Action Plan

No	Action	Due Date	Progress Update	2025/26 Q1	Q2	Q3	Q4
1	Identification and delivery of recurrent CIP	31/03/2026	Although similar action for 2024/25 - reset for 2025/26.Ongoing reports provided to FBP detailing progress and delivery. Outcome of recalibration exercise to be reported in October 2025.				
2	Ensure delivery of elective targets	31/03/2026	Although similar action for 2024/25 - reset for 2025/26. Elective Recovery Programme submitted to NHSE as part of undertakings.				
3	Tough decisions	~~31/01/2025~~ ~~31/05/2025~~ 31/12/2025	Carry forward from 2024/25.				
4	To confirm the contract	30/09/2025	Complete.	N/A			
5	To confirm the ability to support costs of potential redundancy.	30/09/2025	Complete, although confirmed that nc	N/A			
6	Performance and Risk Reviews to take place, including the new balanced scorecard	30/09/2025	Complete.	N/A			

BAF 8: Inability to Sustain Research and Innovation Excellence

Finance and Business Performance Committee | Director of Strategy & Chief Medical Officer

Risk Description

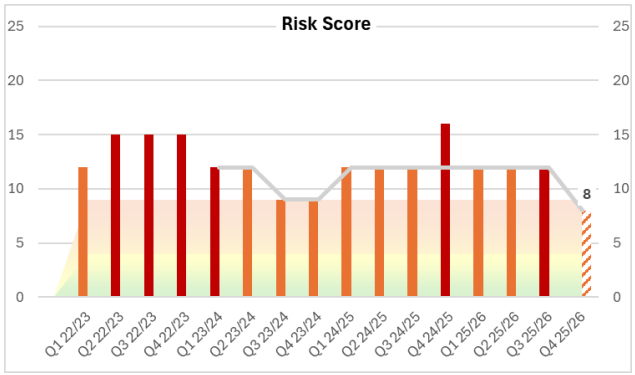
Cause:	If we are unable to deliver a comprehensive, ambitious and financially sustainable programme of research and innovation, and a culture that supports both,
Event:	Then our ability to provide high-quality, cutting-edge care will be compromised,
Effect:	resulting in a diminished reputation as a leading university hospital in research and innovation, fewer opportunities for patients to participate in research studies, limitations in delivering innovative, evidence-based care, challenges in attracting and retaining highly skilled clinical and academic colleagues and missed opportunities to seek external funding, partnerships and commercialisation.

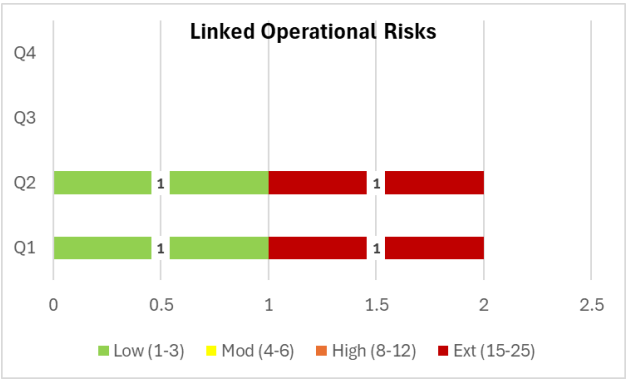
Potential to impact on Our Strategic Priorities

Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

	Q1	Q2	Q3	Q4	Target		Risk Appetite
Likelihood	3	3	3	2	2	31/03/2026	Open 1 - 12
Consequence	4	4	4	4	4		Risk Tolerance
Risk Score	12	12	12	8	8		Ext 15 - 16





What is the data telling us?

The risk score for Q2 remains on trajectory at High 12 which is in line with the revised risk appetite. The number of linked risks has remained the same as Q1, with the second lowest number of operational linked risks across all strategic risks.

This risk has the potential to impact on all three strategic priorities in addition to being impacted by our three primary issues.

Executive Overview – Rationale for Risk Score and Progress made in Quarter 2

During Quarter 2, there have been a number of positive developments which offer evidence, and therefore assurance, on the delivery of our research and innovation strategic ambitions.

In particular, the hosting of the first ever UHNM Innovation Summit, the appointment of an interim chair for the Research & Innovation Strategy Delivery Oversight Forum, progress on Commercial Research Delivery Centre (CRDC) and additional capacity to support delivery are all tangible examples of the progress made during recent months.

Whilst the risk score has remained at High 12 further work is required to ensure these developments are embedded, to address other risks, and to strengthen governance arrangements to reflect the breadth of activity covered through UHNM Research and Innovation.

BAF 8: Inability to Sustain Research and Innovation Excellence

Key Controls Framework

Care Group (n=4)	• Clinical Research Matron in post • CRDC rooms released to R&I so that they can now be furnished and opened as the CRDC • Research Operations and Leadership Meeting within the R&I department to coordinate and support operational activities. • Recruitment monitoring and forecasting are being utilised within the R&I department to align with growth-oriented strategic objectives, with forecasts contributing to feasibility assessments.
Corporate (n=6)	• Clinical Education Centre to provide a dedicated base for a range of research, education, learning and development teams to come together supported by the Executive Team • Interim Chair appointed to the Research Strategy and Innovation Strategy Delivery Oversight Group • Patient, Public Involvement and Engagement Lead appointed • Research Strategy Delivery Oversight Forum terms of reference being updated to reflect Strategic Delivery Plans and ensure appropriate arrangements in place to provide oversight of delivery • Strategic Delivery Plans for Research and Innovation codesigned through Research Strategy Delivery Oversight Forum • Widening out the R&I Directorate staff recruitment for delivery beyond nursing to include midwives, AHP's and other research active professions (e.g. recent appointment of Physician Associate as Band 7 lead research practitioner)
System (n=7)	• Active programme to improve relationships with both Keele University and University of Staffordshire at organisational level – this will include research agenda – Strategic Partnership Agreements now in place with both Universities • Active participation in the Communities of Practice for the National Contract Value Review • Closer working with MPFT – Work force training & recruitment • Keele and UHNM have agreed revised process for medical joint appointments between the two organisations • National strategies from the Chief Nurse Office for England, the Chief Midwifery Office for England and the Chief Allied Health Professional Office for England, which will support implementation of CeNREE priorities. • UHNM is a part of SSHERPa, contributing to the ICS research agenda – SSHERPa expanding remit to include Innovation • UHNM is a member of the West Midlands R&D Research Forum.

Key Assurances Received in Quarter 1 & 2

Assurance Source	April	May	June	July	Aug	Sept
CeNREE Update						

Assurance Rating Key

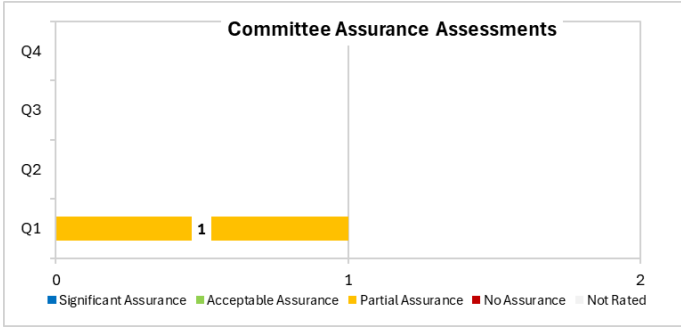
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

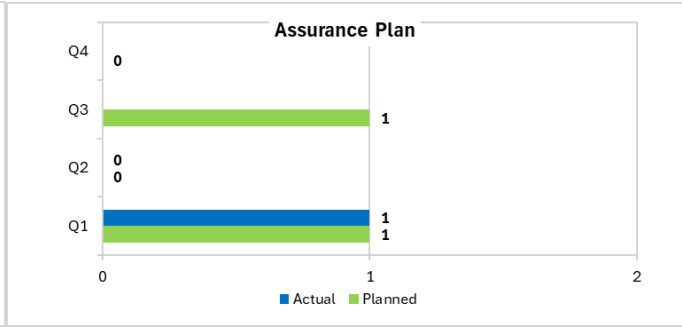
BAF 8: Inability to Sustain Research and Innovation Excellence

Executive Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

Committee Assurance Assessment & Plan





Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=4)	• No key performance indicators for reporting research engagement/risk at Executive level e.g. number of joint appointments and number of research active staff (Action 5) • No plan to make FTCs substantive or invest in CeNREE so research capacity building WTE will reduce to 1.4 WTE and UHNM will be unable to fulfil the requirements of the UHNM Strategic plan or the national 10-year plan (Action 6) • Mandatory GCP training for Principal/Chief Investigators (Action 7) • No dedicated Research Facility as seen within comparator regional Trusts (Action 8)
Gaps in Assurance (n=3)	• Lack of reporting from research and innovation KPIs into Exec level Committees (Action 5) • The current governance arrangements require strengthening to ensure there is sufficient visibility on the breadth of research and innovation activity and associated risks and responsibilities (Action 9) • CeNREE research development support will cease to function in April 2026 due to expiry of fixed term contracts (Action 6)

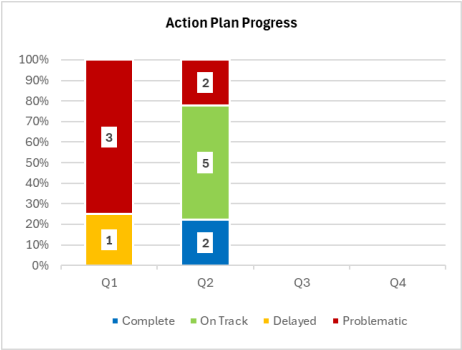
What is this data telling us?

The Executive Assurance Assessment continues to be rated as partial assurance and work remains ongoing to increase the number of assurances received by Committees in relation to this risk.

Five new actions have been identified in Q2 and each gap in control and assurance has an associated action identified. Five actions are due to be completed in Q3.

Risk Management Action Plan

No	Action	Due Date	Progress Update	2025/26 Q1	Q2	Q3	Q4
1	Research to form part of Care Group Board Agendas	~~30/09/2024~~ ~~31/03/2025~~ ~~30/09/2025~~ 31/12/2025	Care Group structure finalised. Medical research lead and non-medical research lead to be identified within each care group				
2	Commissioning an external specialist to review QMS prior to MHRA inspection	~~30/09/2024~~ ~~31/12/2024~~ ~~30/06/2025~~ 31/12/2025	Governance manager liaising with the RRDN to visit and undertake a dummy MHRA audit inspection				
3	Increasing PPIE investment and developing a strategy, involving all R&I, CeNREE, support services, and Care Group representation ensuring patient voice is at the heart of Research development	~~31/03/2025~~ 30/09/2025	PPIE Lead Dr Wanda Russell start date 15.09.25, PPIE officer Louise Barlow started 01.07.25				
4	Action plan for international commercial opportunities to be developed	~~31/03/2025~~ ~~30/06/2025~~ 31/12/2025	Executive Team have confirmed that this is not a priority area for progress at the current time - therefore action closed				
5	Agree KPIs for research reporting that best inform the Exec team on status/risks and responsibilities	31/12/2025		N/A			
6	Paper to be presented to the Executive Team regarding future investment in CeNREE resourcing	31/03/2026		N/A			
7	To act on the guidance from NIHR and HRA regarding the Mandatory GCP training	31/12/2025	Not due to come into effect in the UK until April 2026 - awaiting further joint guidance from NIHR and HRA to roll out the updated training before April 2026. All details of current GCP are on the Edge system for reporting.	N/A			
8	NIHR application to be submitted regarding dedicated Research Facility	31/03/2028	CRF status, Estate space required to be released to R&I, NIHR application to be submitted 2027/28	N/A			
9	To enhance reporting regarding research and innovation into Committees	31/12/2025	Mapping exercise undertaken to identify any gaps in reporting due to the changes in governance structure. Business cycles being updated. In addition, discussions are taking place with the Director of Strategy to reintroduce an Executive lead forum	N/A			



Risk Appetite Framework

Appendix 1

Risk Types

Clinical Risk

The risk of poor patient experience and outcomes resulting from inadequate systems and processes associated with our capacity planning, infection prevention & control, patient experience, patient safety & outcomes and research & development.

Operational Risk

The risk of direct or indirect loss resulting from inadequate or failed internal processes and systems or from external events.

Workforce Risk

The risk of unsafe or ineffective patient care resulting from inadequate systems and processes associated with our workforce supply, skills & capacity, performance and retention, within an appropriate culture.

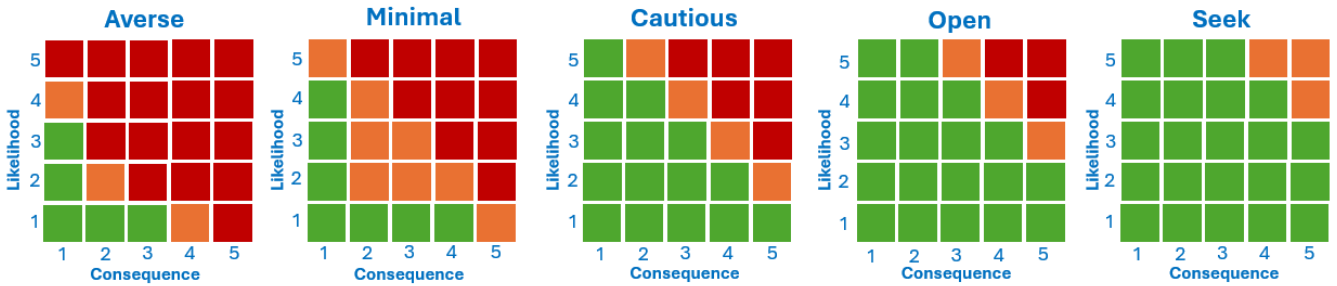
Financial Risk

The risk of direct or indirect loss resulting from inadequate systems and processes relating to our management of finances, financial reporting, funding and cash management.

External Risk

The risk of direct or indirect loss as a result of a failure to comply with regulation, operate within the Law and deliver on our partnership obligations.

Risk Appetite and Tolerance Levels



Within Risk Appetite | **Within Risk Tolerance** | **Outside of Risk Appetite & Tolerance**

Categories of Risk		Risk Appetite	Risk Score Tolerance
Clinical Risk	Patient Safety & Outcomes	Minimal 1 - 4	Mod / High 5 - 9
	Patient Experience	Minimal 1 – 4	Mod / High 5 - 9
	Infection Prevention & Control	Minimal 1 – 4	Mod / High 5 - 9
	Capacity Planning	Cautious 1 – 9	High 10 – 12
	Research, Innovation & Development	Open 1 - 12	Extreme 15 – 16
Operational Risk	Health & Safety	Minimal 1 – 4	Mod / High 5 - 9
	Information Security	Minimal 1 – 4	Mod / High 5 - 9
	Business Continuity	Cautious 1 – 9	High 10 - 12
	Information Governance	Cautious 1 – 9	High 10 – 12
	Physical Assets	Cautious 1 – 9	High 10 – 12
Workforce Risk	Workforce Supply	Cautious 1 – 9	High 10 – 12
	Workforce Deployment	Cautious 1 – 9	High 10 – 12
	Workforce Retention	Cautious 1 – 9	High 10 – 12
	Workforce Performance	Cautious 1 – 9	High 10 – 12
Financial Risk	Counter Fraud	Averse 1 – 3	Mod 4
	Financial Reporting	Minimal 1 – 4	Mod / High 5 - 9
	Estates Infrastructure	Cautious 1 – 9	High 10 – 12
	Management & Value for Money	Cautious 1 – 9	High 10 – 12
	Revenue Funding & Cash	Cautious 1 – 9	High 10 – 12
	Supply Chain	Cautious 1 – 9	High 10 - 12
External Risk	Legal & Governance	Averse 1 – 3	Mod 4
	Regulatory Risk	Averse 1 – 3	Mod 4
	Strategic Planning	Cautious 1 – 9	High 10 – 12
	Partnership Working	Open 1 – 12	Extreme 15 - 16

Appendix 2 - Linked Risks

ID	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group	BAF Link
34791	16/11/2024	Careflow Product Reliability and Availability	25	25			10	Central Functions Division	1, 4
33427	19/08/2024	Non Medical Referring - Protocols	20	20			6	Clinical and Scientific Services	1
34270	05/11/2024	Utilisation of Holistic Cancer Centre	12	20			6	Unplanned Care	1
34083	18/10/2024	County ED boarding patients overnight	12	20			1	Unplanned Care	1
32545	30/05/2024	Demand on our People Operations services is greater than our resource capacity.	20	20			9	Central Functions Division	1, 3
34113	23/10/2024	Quality, Safety and Compliance Resource - Imaging	12	20			4	Clinical and Scientific Services	1, 3
21481	28/06/2021	Reduced Breast service (Imaging), due to vacancy within Breast Radiologist workforce.	16	20			4	Clinical and Scientific Services	1, 3
35614	06/03/2025	patient pathways affected by lack of non medical referrer oversight and governance	20	20			4	Clinical and Scientific Services	1, 3
34608	01/12/2024	Trauma Floor 1:1 nursing assistant cost pressure	20	20			3	Planned Care	1, 3
37397	20/08/2025	Management of Sexual Safety Cases	N/A	20			10	Central Functions Division	3
34619	02/12/2024	Shadow IT and lack of system maintenance	20	20			5	Central Functions Division	1, 4
22641	15/11/2021	Blood Sciences Managed Service Contract tender	16	20			4	NMCPS	6
21697	07/07/2021	Shortfall against 25/26 CIP Plans - high risk £49.2 and medium risk £7.1m	20	20			8	Central Functions Division	6, 7
26887	18/01/2023	Ineffective Clinical Effectiveness Provision	16	16			6	Central Functions Division	1
32464	20/05/2024	Incorrect use of bedrails	16	16			6	Central Functions Division	1
34789	02/12/2024	Corporate RTT (Referral to Treatment) Validation at UHNM	16	16			8	Central Functions Division	1
36050	14/04/2025	Challenges with Trust PGD sign off procedures	20	16			2	Clinical and Scientific Services	1
29812	27/09/2023	Replacement Medical Devices - Capital and Revenue Funding Risk	16	16			4	Estates, Facilities and PFI	1
31958	08/04/2024	MCHT Beckman Track & Stock yard (storage module)	16	16			6	NMCPS	1
32034	12/04/2024	AAA Mobile Ultrasound Machines Renewal	12	16			6	Planned Care	1
33959	07/10/2024	Colorectal Cancer Position	16	16			2	Planned Care	1
30149	23/10/2023	AAA Time to Surgery	16	16			4	Planned Care	1
32807	19/06/2024	Head and Neck Cancer Delivery	16	16			4	Planned Care	1
27156	07/02/2023	EMR/ESD Service - Lack of Operational Policy	16	16			6	Planned Care	1
25469	04/08/2022	Delivery of constitutional cancer quality standards	16	16			4	Planned Care	1
25471	04/08/2022	Follow Up Delays	16	16			4	Planned Care	1
17873	16/07/2020	Inability to Off-load Patients from Ambulances (both sites)	16	16			4	Unplanned Care	1
20448	17/03/2021	Patient LOS above 48 hrs on AMU - against Internal Standards	16	16			4	Unplanned Care	1
26832	12/01/2023	Your Next Patient (Holding Areas Queues) Acute Medicine	16	16			4	Unplanned Care	1
24028	06/04/2022	Emergency Department Performance Standards not being achieved	16	16			6	Unplanned Care	1
34138	24/10/2024	Workforce Information team's resource / capacity is significantly less than the current and growing demands on the service	16	16			8	Central Functions Division	1, 3

ID	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group	BAF Link
26995	20/01/2023	Radiology Reporting Backlog - Body Radiology	12	16			4	Clinical and Scientific Services	1, 3
26997	20/01/2023	Radiology Reporting Backlog - Neuro Radiology	12	16			4	Clinical and Scientific Services	1, 3
33426	19/08/2024	Non Medical Referring - Management Resource	16	16			6	Clinical and Scientific Services	1, 3
26921	20/01/2023	Radiology Reporting Backlog - MSK	8	16			4	Clinical and Scientific Services	1, 3
35274	29/09/2025	Insufficient SLT workforce to meet clinical demand	N/A	16			4	Clinical and Scientific Services	1, 3
37866	30/09/2025	Insufficient workforce to deliver a safe dietetic service	N/A	16			4	Clinical and Scientific Services	1, 3
34826	13/12/2024	Child Health Rota remains a 1:7- The Tier 2 resident doctor cover does not meet service need.	16	16			4	Clinical and Scientific Services	1, 3
18842	05/10/2020	Gaps within the Junior Medical Rota	16	16			6	Clinical and Scientific Services	1, 3
32149	24/04/2024	MNG Consultant workforce recruitment	16	16			8	Clinical and Scientific Services	1, 3
32806	19/06/2024	Deficit in Neonatal AHP's provision for Speech & Language Therapy and Occupational Therapist support within NICU at UHNM	6	16			16	Clinical and Scientific Services	1, 3
24818	13/06/2022	RSUH/CH Biochemistry Staffing and Shift Cover	12	16			6	NMCPS	1, 3
34265	04/11/2024	Lipid clinic provision	16	16			6	NMCPS	1, 3
34960	09/01/2025	AAA Screening Workforce - CST and Technicians	16	16			4	Planned Care	1, 3
37497	02/09/2025	SSDEC Staffing	N/A	16			4	Planned Care	1, 3
35962	26/03/2025	Fragility of ILD service - nursing	16	16			4	Unplanned Care	1, 3
10381	27/04/2018	Medical Staffing - Haematology	16	16			9	Unplanned Care	1, 3
33720	16/09/2024	AEC Nursing Workforce	16	16			4	Unplanned Care	1, 3
35094	21/01/2025	Medical Staffing in ED Overnight & at Weekends	16	16			8	Unplanned Care	1, 3
25454	02/08/2022	EPMA and/or Clinical Narrative System not fit for purpose	16	16			4	Central Functions Division	1, 4
25893	29/09/2022	Delay in EPMA roll out	16	16			4	Central Functions Division	1, 4
32551	31/05/2024	Operational risk associated with the Pharmacy robot replacement	12	16			8	Clinical and Scientific Services	1, 4
32544	30/05/2024	UHNM negotiations underway to upband & backpay all AfC B2 Healthcare Support Workers who have been delivering work at B3.	16	16			12	Central Functions Division	3, 6
34158	18/10/2024	Admin Account Authorisation	16	16			4	Central Functions Division	4
34277	06/11/2024	Need viable solution for redaction software for SARs and suitable available resource to act as data handlers	16	16			6	Central Functions Division	4
36963	04/07/2025	Weak Microsoft Authentication protocols many systems	N/A	16			4	Central Functions Division	5
37171	23/07/2025	China state-backed APT threats (HSA CareCert CC 4683)	N/A	16			4	Central Functions Division	5
35798	25/03/2025	Doors at STS	16	16			4	Planned Care	5

ID	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group	BAF Link
30986	11/01/2024	Centre for Research and Education Excellence (CeNREE) sustainability	16	16			6	Central Functions Division	8
32023	11/04/2024	Maternity Early Warning Scores not used for Maternity Patients outside of Maternity Dept	15	15			2	Clinical and Scientific Services	1
35516	26/02/2025	Endometriosis Backlog and Long Waits	15	15			4	Clinical and Scientific Services	1
35517	26/02/2025	Urogynae Backlog and Long Wait	15	15			4	Clinical and Scientific Services	1
18664	28/09/2020	Gynaecology 52 Week Long Waits	15	15			6	Clinical and Scientific Services	1
37324	08/08/2025	IOL on Blossom Suite not receiving daily medical review as part of ward round	N/A	15			4	Clinical and Scientific Services	1
33109	16/07/2024	Audiology Waiting List Backlog	15	15			5	Planned Care	1
26808	09/01/2023	Holding Patients on the ED Corridor	12	15			4	Unplanned Care	1
19397	21/12/2020	Impact of increased workload on service and Quality management system in Immunology	12	15			6	NMCPS	1, 3
32486	22/05/2024	Long Wait Patients in the Trauma Directorate	15	15			6	Planned Care	1, 3
31724	11/03/2024	Non clinical users able to order on behalf of clinician for IRMER requests	15	15			5	Central Functions Division	1, 4
9036	25/10/2017	Vulnerability to Cyber Attack	15	15			12	Central Functions Division	1, 4
25917	30/09/2022	Suitability of Cohort Area (Known as Ambulance Assessment 7 - 10)	15	15			2	Unplanned Care	1, 5
20926	30/04/2021	Emergency Department (Royal) Majors, Ambulatory & Children's Cubicle Doors	15	15			4	Unplanned Care	1, 5
34369	13/11/2024	ECC Patient toilet facilities safety and prevention	15	15			8	Unplanned Care	1, 5
30476	20/11/2023	NHS Financial position and procurement of System Wide EPR	15	15			5	Central Functions Division	4
34869	24/12/2024	Technical Debt	15	15			5	Central Functions Division	4
36083	16/04/2025	Display of antibiotic sensitivity results in iPortal	10	15			5	NMCPS	4
34519	22/11/2024	Delivery of Gestational Diabetes GTT Clinics	12	12			4	Central Functions Division	1
35351	11/02/2025	Clinic over runs	12	12			4	Central Functions Division	1
8901	05/12/2013	Ensure correct blood sample management	12	12			6	Central Functions Division	1
32652	05/06/2024	Clinical Harm Review Process	12	12			6	Central Functions Division	1
11415	20/08/2018	End of Life - Portable battery powered syringe pumps.	12	12			9	Central Functions Division	1
28881	30/06/2023	Breast Screening community locations	12	12			2	Clinical and Scientific Services	1
32954	29/06/2024	Siemens software error	12	12			2	Clinical and Scientific Services	1
30573	30/11/2023	Inability to support patient pathway turnaround times in MRI due to not being able to secure sufficient GA slots to meet demand	12	12			4	Clinical and Scientific Services	1
33928	02/10/2024	Noncompliance with requirements of the Fetal anomaly screening programme (FASP) & saving babies lives pathways	12	12			4	Clinical and Scientific Services	1

ID	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group	BAF Link
32124	22/04/2024	Service Level Agreement between SaTH & Leighton for IR Referrals	12	**12**			6	Clinical and Scientific Services	1
15788	13/01/2020	(CQC) Delivery of RTT Performance - Diagnostic Capacity	12	**12**			8	Clinical and Scientific Services	1
32082	17/04/2024	Potential loss of AVS	6	**12**			2	Clinical and Scientific Services	1
29165	20/07/2023	Diabetic Pump Contracts	12	**12**			4	Clinical and Scientific Services	1
33223	19/07/2024	Ante-natal prescriptions in the community	12	**12**			4	Clinical and Scientific Services	1
20435	16/03/2021	Paediatric Follow up Backlog	12	**12**			6	Clinical and Scientific Services	1
32013	10/04/2024	Insufficient number of maternity theatre slots for Category 4 caesarean section	12	**12**			6	Clinical and Scientific Services	1
33311	07/08/2024	Antenatal consultant clinic capacity	12	**12**			6	Clinical and Scientific Services	1
35466	21/02/2025	RSUH/CH Haematology Advia 2120 reliability	12	**12**			4	NMCPS	1
32683	07/06/2024	Timely Reporting of Emergency MRI Results	12	**12**			4	Planned Care	1
35797	25/03/2025	ENT On Call Crosscover	12	**12**			4	Planned Care	1
36829	20/06/2025	Referral process for WET AMD patients	12	**12**			4	Planned Care	1
36830	20/06/2025	Ward 111 Band 3 staff members are unable to provide basic tracheostomy care	12	**12**			4	Planned Care	1
27953	12/04/2023	Lack of provision for patients requiring DIEP surgery	12	**12**			6	Planned Care	1
17637	30/06/2020	Decline in cancer performance	12	**12**			8	Planned Care	1
30749	13/12/2023	Contact Lens/Low Visual Acuity (CL/LVA) Service Delivery	12	**12**			8	Planned Care	1
35615	07/03/2025	Adherence to Trust Policy MM06: Prescribing, Storage, Supply and Administration of Controlled Drugs	12	**12**			2	Planned Care	1
35527	27/02/2025	County Elective Hub Theatres Equipment	16	**12**			4	Planned Care	1
25470	04/08/2022	Increasing waiting list size and patients waiting greater than 18 weeks for treatment	12	**12**			4	Planned Care	1
31806	18/03/2024	No Psychological provision for renal patients	12	**12**			2	Unplanned Care	1
24340	10/05/2022	Severe Asthma Service - impact once external funding ceases	12	**12**			3	Unplanned Care	1
24025	06/04/2022	ILD Service - increased demand as a result of prescribing changes	12	**12**			4	Unplanned Care	1
32423	15/05/2024	Interruption to Plasma Service due to Machine Failure	12	**12**			4	Unplanned Care	1
35166	27/01/2025	Central access for Specialised Medicine	12	**12**			4	Unplanned Care	1
8660	20/09/2017	Follow up back log (outpatient appointments)	12	**12**			6	Unplanned Care	1
35708	03/03/2025	RTT Delivery - outpatient capacity/wait times to achieve 52wks	12	**12**			6	Unplanned Care	1
34302	17/07/2024	Diabetes patient Clinical follow up	9	**12**			4	Unplanned Care	1
26529	28/11/2022	Leighton Hospital Hyper-Acute Stroke Pathway	12	**12**			4	Unplanned Care	1
34050	14/10/2024	Neurology Toxic Non MS Drug Monitoring	12	**12**			6	Unplanned Care	1
34051	16/10/2024	Neurology Follow Up Backlogs	9	**12**			8	Unplanned Care	1
24213	29/04/2022	Enhanced Primary Care (EhPC) Service Staffing and Demand	12	**12**			3	Unplanned Care	1

ID	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group	BAF Link
12699	15/02/2019	High Acuity Emergency Patients	12	**12**			4	Unplanned Care	1
17470	12/06/2020	Compliance with NEWS and escalation (Royal)	12	**12**			4	Unplanned Care	1
9738	05/02/2018	Nurse Training	12	**12**			6	Unplanned Care	1
14958	29/10/2024	Triage Times (Royal) In Adults and Children's ED	16	**12**			6	Unplanned Care	1
27153	07/02/2023	QI Academy Staffing under-resourced to deliver sustainable change	12	**12**			12	Central Functions Division	1, 3
21719	29/07/2021	Medicine Safety Officer Vacancy	12	**12**			4	Clinical and Scientific Services	1, 3
25152	06/07/2022	Insufficient trained staff in Pharmacy Technical Services to deliver aseptic products including chemotherapy to the Trust	12	**12**			4	Clinical and Scientific Services	1, 3
33514	29/08/2024	Ultrasound Imaging Workforce	12	**12**			4	Clinical and Scientific Services	1, 3
35057	17/01/2025	Inadequate Pharmacy Staffing to Emergency Departments	12	**12**			6	Clinical and Scientific Services	1, 3
33539	29/08/2024	Non Obstetric Ultrasound (NOUS) Performance - DM01 compliance	16	**12**			4	Clinical and Scientific Services	1, 3
37337	11/08/2025	Consultant pa assurance	N/A	**12**			8	Clinical and Scientific Services	1, 3
28944	03/07/2023	Deficit in appropriate numbers in Skilled Neonatal Specialist Nurses.	12	**12**			4	Clinical and Scientific Services	1, 3
32490	22/05/2024	Insufficient Epilepsy CNS cover.	12	**12**			4	Clinical and Scientific Services	1, 3
37305	06/08/2025	Achievement of Maternity Incentive Scheme Year 7	N/A	**12**			4	Clinical and Scientific Services	1, 3
33912	01/10/2024	Anticoagulation Management Service staffing	12	**12**			4	NMCPS	1, 3
34408	18/11/2024	Haematology Advanced Practitioner Biomedical Scientist - fragility of service	12	**12**			4	NMCPS	1, 3
11294	31/07/2018	NMCPS Pathology Histology Medical Capacity - dissection & reporting(achieving TAT)	12	**12**			6	NMCPS	1, 3
20626	05/11/2020	Low staffing levels for Phlebotomy at Cheshire Sites	12	**12**			6	NMCPS	1, 3
21591	08/07/2021	Insufficient Clinical Staff to Support the NMCPS Microbiology Service	12	**12**			6	NMCPS	1, 3
17967	23/07/2020	Medical Cover Cardiothoracic ICU	12	**12**			3	Planned Care	1, 3
32408	14/05/2024	Clinical Perfusion- Inadequate Establishment & Staff Shortages	12	**12**			6	Planned Care	1, 3
36794	16/06/2025	Clinical nursing staffing of the spinal deformity service	12	**12**			2	Planned Care	1, 3
31429	14/02/2024	Audiology Staffing	12	**12**			4	Planned Care	1, 3
25628	01/09/2022	Ophthalmology Service Delivery	12	**12**			8	Planned Care	1, 3
37031	10/07/2025	Stability of General Surgery Paediatric Service	N/A	**12**			3	Planned Care	1, 3
33270	20/08/2024	Breast Care Service	9	**12**			4	Planned Care	1, 3
37669	17/09/2025	Head and Neck Workforce	N/A	**12**			4	Planned Care	1, 3
36962	04/07/2025	Therapies provision to SSCU patients	N/A	**12**			6	Planned Care	1, 3
31807	18/03/2024	No nursing Clinical Educator in post in Renal	12	**12**			2	Unplanned Care	1, 3

ID	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group	BAF Link
15664	13/01/2020	Liver Mortality - CQC actions	12	**12**			4	Unplanned Care	1, 3
24837	14/06/2022	Cystic Fibrosis workforce/service delivery	12	**12**			4	Unplanned Care	1, 3
27071	26/01/2023	NIV Service Workforce - Domiciliary service	12	**12**			4	Unplanned Care	1, 3
29508	01/09/2023	Inability to deliver hybrid closed loop pumps to type 1 diabetes patients	12	**12**			6	Unplanned Care	1, 3
25467	04/08/2022	Funding for HD capacity and workforce	12	**12**			8	Unplanned Care	1, 3
29712	14/09/2023	Consultant and Scientist Shortages in Neurophysiology	12	**12**			4	Unplanned Care	1, 3
32977	02/07/2024	Palliative Care staffing	12	**12**			6	Unplanned Care	1, 3
32891	25/06/2024	Epilepsy Specialist Nursing Resource Availability	12	**12**			12	Unplanned Care	1, 3
8523	01/09/2017	AMU Workforce (both sites)	12	**12**			4	Unplanned Care	1, 3
35330	10/02/2025	County AMU nursing budget/establishment	12	**12**			4	Unplanned Care	1, 3
35847	31/03/2025	Lack of Pharmacy for ED Departments	12	**12**			4	Unplanned Care	1, 3
23759	14/03/2022	Inappropriate clinical decisions due to large number of digital systems in place	12	**12**			4	Central Functions Division	1, 4
25682	05/09/2022	(CQC) Unstructured records Management	12	**12**			4	Central Functions Division	1, 4
30477	20/11/2023	Lack of records retention in line with Code of Practice	12	**12**			4	Central Functions Division	1, 4
30129	24/10/2023	Inpatient E-notification initial report not enabled	12	**12**			2	Clinical and Scientific Services	1, 4
33674	23/07/2024	Sectra PACS Imaging - No Security Endpoint protection	12	**12**			12	Clinical and Scientific Services	1, 4
33424	19/08/2024	Non Medical Referring - Ownership and Maintenance of the Database	20	**12**			6	Clinical and Scientific Services	1, 4
29217	28/07/2023	Egrow digital plotting for height and weight	12	**12**			2	Clinical and Scientific Services	1, 4
29744	18/09/2023	Cardiac Imaging Storage	12	**12**			2	Clinical and Scientific Services	1, 4
34965	10/01/2025	No MFA for Winpath Enterprise (LIMS)	12	**12**			2	NMCPS	1, 4
21332	16/06/2021	NMCPS Management of Incidents across all network sites	12	**12**			4	NMCPS	1, 4
28354	23/05/2023	Blood Analyser Lantronix UDS box	12	**12**			4	NMCPS	1, 4
34580	27/11/2024	CIM Hold and Error Queue Management	12	**12**			4	NMCPS	1, 4
34582	27/11/2024	CIM Failovers	12	**12**			6	NMCPS	1, 4
34594	28/11/2024	Illegal Characters in SampleNet	12	**12**			6	NMCPS	1, 4
34595	28/11/2024	SampleNet Is Unable to Handle Time Changes	12	**12**			6	NMCPS	1, 4
26427	16/11/2022	Use of Q-pulse as electronic quality management system	16	**12**			6	NMCPS	1, 4
32033	12/04/2024	AAA Screening operational charges and access	12	**12**			4	Planned Care	1, 4
31527	26/02/2024	Auto-Contouring	12	**12**			6	Unplanned Care	1, 4
25309	19/07/2022	Medicines Storage Area Temperatures Exceeding 25 degrees C	12	**12**			1	Clinical and Scientific Services	1, 5
35039	17/01/2025	Pharmacy Cancer walk-in cold store Ward 202 performance and capacity	12	**12**			2	Clinical and Scientific Services	1, 5
28684	14/06/2023	Lack of Clean Utility Room - Children's High Dependency	12	**12**			6	Clinical and Scientific Services	1, 5

ID	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group	BAF Link
35126	14/01/2025	Electrical High Voltage infrastructure capacity on Royal Stoke site	12	**12**			4	Estates, Facilities and PFI	1, 5
33184	24/07/2024	Inability to provide timely management of Freedom to Speak Up Cases	12	**12**			4	Central Functions Division	3
32500	22/05/2024	TI Rates	12	**12**			6	Central Functions Division	3
34115	23/10/2024	Inability to comply with compensatory rest due to on call requirements	12	**12**			6	Clinical and Scientific Services	3
36656	03/06/2025	Secretarial staff shortages within Gynaecology	12	**12**			12	Clinical and Scientific Services	3
26168	26/10/2022	Pathology IT System Expertise	12	**12**			6	NMCPS	3, 4
21784	06/08/2021	(CQC) Confidentiality, Integrity and Availability of Trust Information	12	**12**			4	Central Functions Division	4
28595	01/06/2023	COIN Network	12	**12**			4	Central Functions Division	4
33518	29/08/2024	Proactive audit & monitoring of patient record systems	12	**12**			4	Central Functions Division	4
34157	17/10/2024	DC1-SQLDB19 _ DC2-SQLDB20	12	**12**			6	Central Functions Division	4
8849	13/10/2017	Inappropriate use of mobile devices for work purposes	12	**12**			4	Central Functions Division	4
33097	01/03/2024	Reduced Security Support - (Sophos exemptions) for the Omnicell Automated Dispensing Cabinets	12	**12**			4	Clinical and Scientific Services	4
35090	21/01/2025	Rapid AI Linux OS Out of support	12	**12**			4	Clinical and Scientific Services	4
35318	06/02/2025	Biochemistry RSUH Track system	12	**12**			4	NMCPS	4
12595	01/02/2019	(1) Image Vault Storage (2) security update patches	12	**12**			4	Unplanned Care	4
31185	29/01/2024	DataCentre Air Conditioning EOL - Unfit for Purpose	12	**12**			4	Central Functions Division	4, 5
25353	21/07/2022	Sale of RI and COPD Land later than NHSE funding requirement of 24/25	12	**12**			6	Central Functions Division	5
36966	04/07/2025	Outdated and vulnerable 7-Zip installs	N/A	**12**			4	Central Functions Division	5
36884	27/06/2025	Inability to accommodate the Endoscopy Booking & Manager Team in current location	16	**12**			4	Clinical and Scientific Services	5
28802	23/06/2023	Insufficient hub space and clinical room capacity for community midwifery teams	12	**12**			4	Clinical and Scientific Services	5
30237	04/09/2023	PFI latent defects	12	**12**			4	Estates, Facilities and PFI	5
29213	28/07/2023	ECT Cooper Building roof leaks	12	**12**			4	NMCPS	5
30787	14/12/2023	Histology Consultant Office Accommodation	8	**12**			4	NMCPS	5
37840	30/09/2025	Lack of Audible Emergency Alarms in STS (Phase 2)	N/A	**12**			4	Planned Care	5
34188	29/10/2024	Non pay overspend - Histology send away activity	12	**12**			6	NMCPS	6

Executive Summary

Trust Board | 10th December 2025

Maternity & Neonatal PSIRF Investigation Report – Quarter 2

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**	✓	**Approval**	✓	**Assurance**	✓	**Agenda Item:**	9.
Author:	Catherine Hegarty, Quality & Risk Manager							
Executive Lead:	Anne-Marie Riley, Chief Nurse							

Alignment with our Strategic Priorities		
	Our People We will create an inclusive environment where everyone learns, thrives and makes a positive difference	✓
	Our Patients We will provide timely, innovative and effective services to our patients	✓
	Our Population We will tackle inequality and improve the health of our population	✓

Risk Register Mapping		

Executive Summary

Situation

At the start of December 2023, UHNM ceased to report incidents under the national Serious Incident Framework as the new national Patient Safety Incident Response Framework (PSIRF) for learning from incidents was formally adopted following development of new incident response templates. The Trust's approach and local Patient Safety Incident Response Plan (PSIRP) was approved at Trust Board in October and then approved by the ICB in November 2023. The ICS agreed for 3 main providers to all formally adopt the PSIRF approaches and not report incidents as serious incidents under the Serious Incident Framework.

Maternity & Neonatal incidents are a national priority within the PSIRF framework. National systems capture certain Maternity and neonatal incidents that require a standardised approach, these systems are:

PMRT:

Standardised perinatal mortality review tool which supports high quality standardised perinatal reviews on the principle of 'review once, review well'. The tool is used to review the maternity care, neonatal care and bereavement care for all families who have:

- A Late fetal loss (between from 22-23+6 gestation)
- Stillbirth (24 weeks and beyond)
- A Neonatal Death (deaths up to 28 days of age)

The care is graded (A-D) according to quality of care in relation to influence on outcome.

MNSI (formerly HSIB):

Maternity & Newborn Safety Investigations (MNSI) is a national programme to improve maternity safety across the NHS in England. An independent investigation is conducted for maternity incidents that meet the current MNSI criteria and safety recommendations are fed back to trusts to improve services. The incidents investigated under the MNSI criteria are:

- Intrapartum stillbirth
- Early neonatal death (0-6 days of life)
- Potential severe brain injury
- Maternal death (within 42 days of the end of pregnancy)

All incidents that meet MNSI criteria or are considered to grade as C or D on the PMRT will be reported through UHNM governance processes as PSII's.

All incidents that meet the criteria for referral to MNSI due to a potential severe brain injury are also referred to the Early notification scheme and information is given to families in an accessible format. If this is not possible an action plan will be devised to ensure improvements for the future.

The report also provides assurance that incidents are being investigated timely and appropriately. Lessons are learned from these investigations and actions taken to address any patient safety concerns.

The report provides a summary of the patient safety incidents that are being reviewed under the new PSIRF framework to provide oversight and assurance that issues are identified, learning is disseminated, and actions are formulated to improve patient safety and experience.

MBRRACE-uk confidential enquiry reports (2025) continue to recognise inequalities as a theme in maternal and perinatal mortality particularly relating to ethnicity and social deprivation. These inequalities have been considered within the cases detailed within this report.

No of open maternity and neonatal PSIRF reviews:	
PMRT (Not reportable as PSII) PMRT (Reportable as PSII)	34 7 (inc MNSI cases)
MNSI: In progress Final report received Actions plans developed and for approval through governance process	7 5 1 1
PSII (Local Priority)	2
AAR	11
Thematic Review	2
Case Record Review	4

Assessment

In Quarter 2 there was 4 new incidents reported that met the criteria for PSII's:

- July 2025 2
- August 2025 2
- September 2025 0

Category of Incidents:

- 1 PMRT (Potentially score C or above)
- 2 MNSI
- 1 PSII (local priority)

Duty of candour was performed with families for all eligible incidents and information given in an accessible format. One final report from MNSI has been received in Quarter 2 and an action plan has been developed to meet safety recommendations. One of the MNSI referral incidents in quarter 2 also met the criteria for early notification scheme and has been referred to NHS Resolution and information given to the family in an accessible format.

Assurance Assessment		
Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	*X*
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	
No Assurance	No confidence in delivery	
Rationale		
All incidents are reviewed weekly at the Obstetric and Neonatal risk meeting to identify any immediate learning or themes. A rapid review of care is completed for incidents that meet the national reporting criteria or are considered of moderate harm or above. Incidents that meet the criteria for PMRT or MNSI will follow a robust review process, and any immediate actions or local reviews will be implemented as a result of a rapid review or a PSIRF response review.		

Key Recommendations

The Trust Board is asked to receive and note the report and to note the following:

- All actions from PMRT and PSIRF investigations are monitored through the directorate outcomes meeting
- Clear process to ensure themes are highlighted and triangulated with all incidents, claims, complaints and inquests
- Continue to achieve 100% compliance in reporting all qualifying cases to MNSI and NHSR Early Notification scheme (ENS)
- Continue to ensure that all families who qualify for MNSI and ENS referral, receive information in a format that is accessible to them.

Executive Summary

Trust Board | 10th December 2025

UEC Pressure and Ambulance Handover Update

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**		**Assurance**	✓	**Agenda Item:**	10.
Author:	Katy Thorpe, Chief Operating Officer							
Executive Lead:	Katy Thorpe, Chief Operating Officer / Ann Marie Riley, Chief Nurse / Diane Adamson, Chief Medical Officer							

Alignment with our Strategic Priorities		
	Our People We will create an inclusive environment where everyone learns, thrives and makes a positive difference	
	Our Patients We will provide timely, innovative and effective services to our patients	✓
	Our Population We will tackle inequality and improve the health of our population	

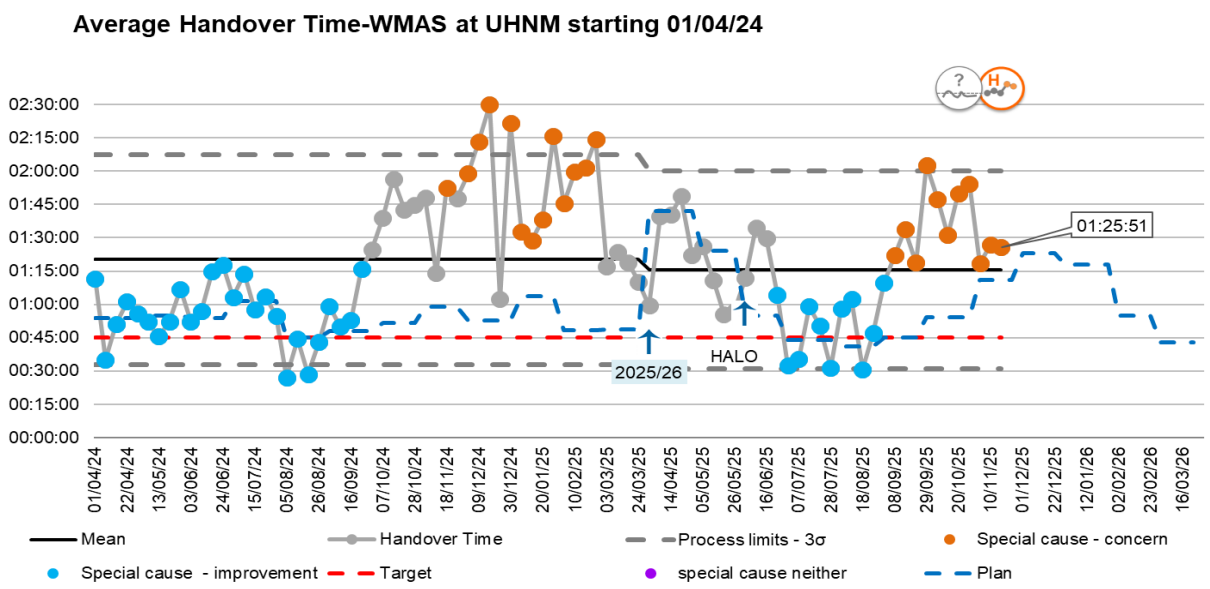
Risk Register Mapping		
BAF4	Delivering responsive patient care	15 (extreme)

Executive Summary

Situation

- This paper is to update board members on the situation with regard to UEC pressure and ambulance handover delays.
- This covers data up to the latest reported week which was 10/11/2025
- We remain in tier 1 for national oversight for our UEC position.

Ambulance Handover



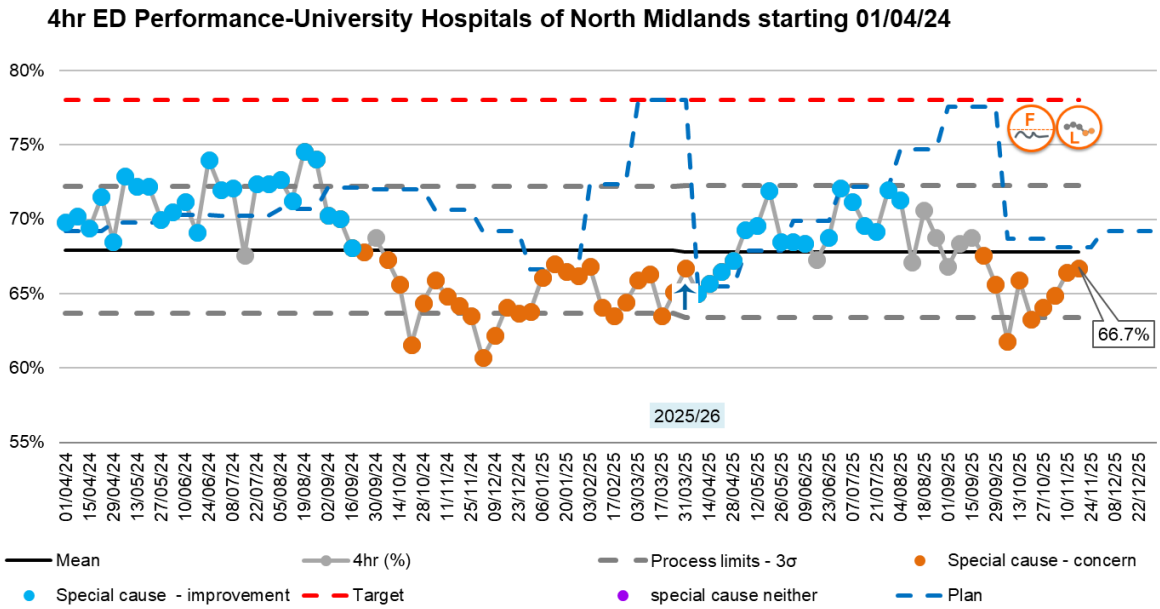
Average Handover Time

- Average Handover Time last week improved by 1 minute to 1hr 25mins 51secs with November currently reporting as worse than plan at 1hr 29mins 09secs.
- Handover Trajectory for latest week was 54.3%, down 1% on the previous week. November is reporting as 55.1%, up from 53.6% in October.
- Time Lost (> 15mins) due to handover rose marginally to 1,547 hours from 1,533 hours.

Category 2 Response Time

- Category 2 Response Times for the latest available week (w/e 16th November) dropped below 30 minutes for the 1st time in 10 week ending at 27m 28secs. This placed the system 18th out of 42 nationally and 6th out of 11 regionally.
- The 4-week average was 38m 34secs.

Four Hour Performance

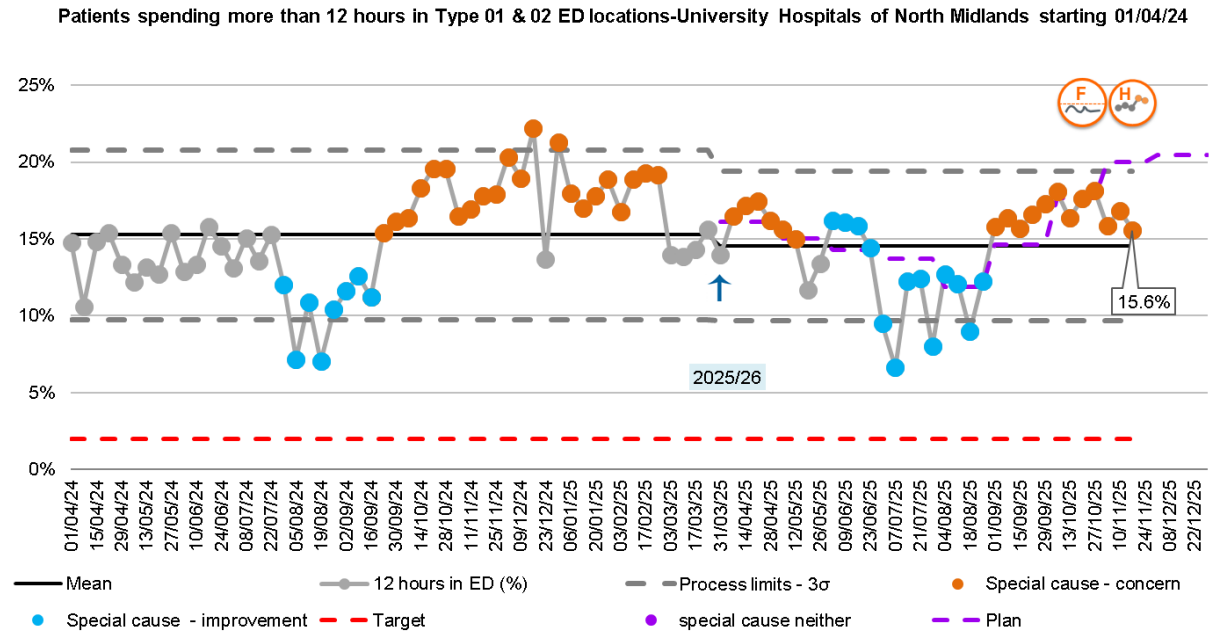


- Last week reported a marginal improvement in performance of 0.3% against the previous week, rising to 66.7%.
- November's current position of 65.6% is 2.5% worse than plan.

Paediatric 4hr Performance

- Last week Type 1 Paediatrics reported a 2.7% deterioration in performance against the previous week, dropping to 63.7%.

12 Hour Performance



- Provisional 12hr performance for last week improved by 1.3% to 15.6%.
- November is currently reporting as 16.58%, 3.45% better than plan.

Tactical Mitigating Actions

There are a number of mitigating actions in place which are a continuation of last month's report including:

Reducing Ambulance Handover

- Continuation of system workstream and monitoring in place with a daily tracker monitored via SCC, escalations via System calls as required,
- Consultant assigned to RAT ambulances on arrival at RSUH,
- Focus remains on sustaining performance in line with system plan however, operational challenges continue to remain prevalent including walk-in demand, acuity challenges and IPC.

System Multi-Disciplinary Review

- Weekly system meetings continue to review potentially inappropriate cases led by clinical leads with structured feedback to partners being completed. This is of both UHNM bed base and also system partners to support discharge.
- Focus meeting on Falls pathway for patients who are receiving anti-coagulant medication

Ward Process & Discharge

- UHNM discharge targets now agreed in principle,
- Discharge Facilitator change complete – all wards will now receive cover daily,
- Therapist in the Integrated Discharge Hub mobilised 3rd November for 4 weeks. Positive feedback at mid point review,
- UHNM LOS continues to be supported by ESIST,
- UHNM - have recruited RNs for escalation spaces,
- IDH successfully recruited to FEAU Pull post.

Front Door

- UTC – Capital/building works commenced and on track for January.
- UHNM operating GOLD Command in operation with associated GIRFT UEC coaching. GOLD Command competency framework in development with GIRFT UEC colleagues.
- Standard work developed for oversight of Trust Escalation Space (Care Group Leadership Teams), and also Executive led wellbeing visits with digital capture of assessments ongoing.
- Frailty SDEC– continuing to see increasing number of patients assessed and discharged same day.
- At Capacity and OPEL Framework strengthened and progressing through approval process.
- Improvement in EhPC slot utilisation, despite the ongoing UTC building works.
- Continuation of Rapid Assessment and Treat consultant model supported as part of Winter plan

Bed & Site Management

- Strengthened Site Management with Heads of Nursing now recruited
- CSMs recruited and shadowing/training period has commenced.
- GOLD Command support for site ongoing whilst in escalated OPEL.

Infection Prevention

- Winter vaccination programme commenced 1 October for staff & patients
- Outpatients: vaccination team targeting under 65 with chronic conditions & those patients less likely to take up community vaccination offers.
- Staff vaccination campaign live; uptake is good – execs taking lead with CEO daily message sharing photos of exec team receiving their vaccines.
- Twice daily IP review of inpatient areas, & restrictions with 7-day service cover.

ICC

- 111 redirection rate for w/c 10.11.25 was 89.4%. Total number of 111 referrals was 47 (previous week was 35),
- Interim leadership arrangements put in place following departure of Clinical Operational lead. Team being supported by collective leadership within Community Hospitals & Intermediate Care Portfolio,
- Continued support of development of X-ray at Home pilot to address unmet demand for x-ray without conveyance to ED,

- Team supported with senior clinical decision making via Nurse in Charge at Walk in Centre now ICC is co-located at Haywood Hospital. This senior support will support positive risk taking and improved decision-making leading to increased redirection rate,
- UHNM colleagues visited the ICC to better understand the service and support with developing new pathways,
- Weekly visits booked to the WMAS hubs to build relationships with paramedics, and further discussions on CBC.

System Surge Planning/Winter Review

- Winter plan continues to be within mobilisation phase, schemes being monitored via UEC Governance and daily system calls,
- Plan for reduced occupancy to be achieved for Christmas drafted, and shared with partners for comment through a system approach
- Agreement for Community teams to engage with the Top 10 Residential and Nursing home attendances to RSUH. This pilot with ensure patients receive the most appropriate care for their needs and aim to reduce reliance on Ambulance service and conveyance to ED.
- Public Health and Primary care leading "staying healthy this winter" care home webinar to support this sector over the winter months.
- WMAS CAD system update being onboarded to support Call before you Convey. Aim for go live in December.

Mobilisation of surge/winter schemes progressing and is detailed below as to the November opening profile:

Acute:

- 73 of the 80 planned beds for November are open. There has been a delay in two schemes; one to expand the transitional discharge lounge, the other for additional OPAT spaces. These will be carried forward to December. Other December capacity has been brought forward to mitigate this risk.
- 32 of 32 planned additional virtual ward spaces

Community:

- 7 of 4 planned D2A bed capacity – delivered ahead of plan.

UEC Transformation Programme

Our UEC improvement plan is now in place following the visits in January where we invited in the NHSE national team to support with a review of our UEC pathways. The oversight of this is being monitored through our CEO led 'Executive Recovery and Oversight Meeting'. The highlight report for this is reported through Quality, Access and Outcomes Committee. A copy of this highlight report is attached to this paper. This is being supported now by the GIRFT team (previously ECIST)

Early Impact of Improvement

Working collaboratively across UHNM and GIRFT UEC teams; Following an intensive month of diagnostics, identification of key themes blocking patient flow, on-site improvement support and extended access to clinical and operational expertise, there have been some early successes. Although the Trust remains challenged, there has been a key focus on patient safety, decompression of ED and improving patient flow.

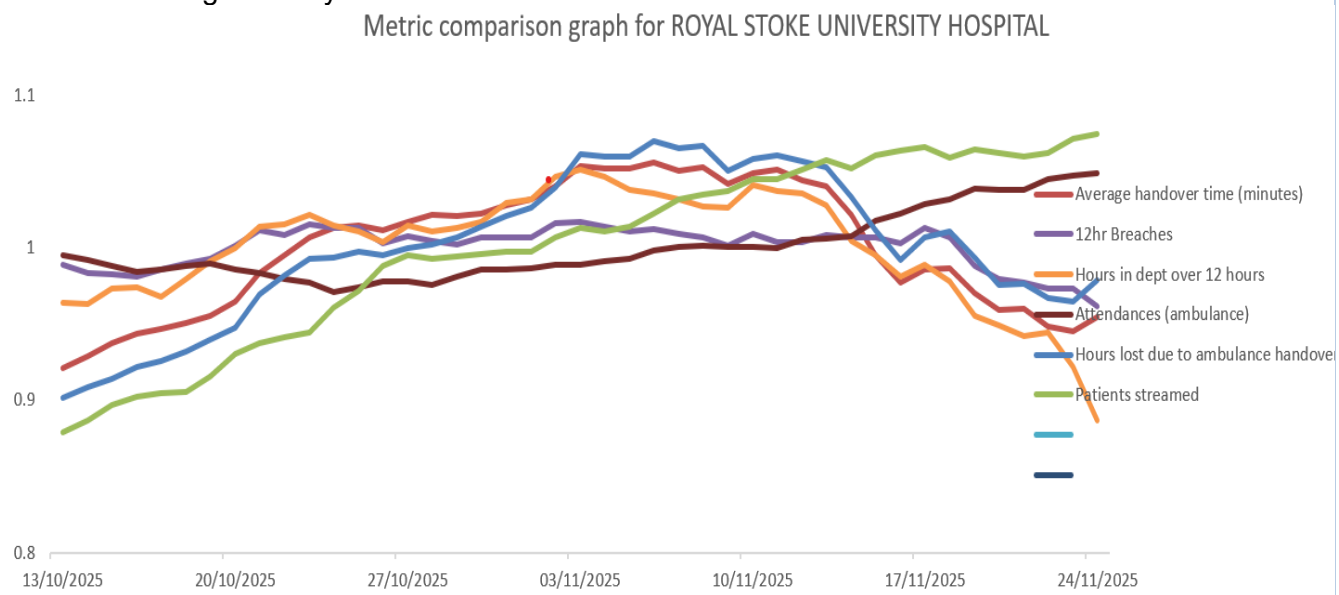
What we have done:

- Established executive oversight by providing specific coaching support to site operations team and executives running OPEL meetings.
- Supported escalation actions during an extended OPEL4 period
- Focus in unplanned care on early discharge identification and earlier flow from ED
- Promotion of use of assessment areas (medical and frailty) to reduce ED demand, reduce admissions and improve outcomes
- Length of Stay review process introduced with Unplanned Care Group leads to reduce stays and diagnostics in hospital
- Supported front door mobile RAT to maximise safety for waiting ambulance patients and increase non-ED streaming

- Supported new frailty assessment to reduce occupancy and improve outcomes for frail elderly

Early Impact (this data is from Tuesday 25th November and compares the 30 days leading up to then with the previous 30 days):

- Reduction in ambulance hours lost due to handover delays of 8.8% (despite an increase of 11.5% ambulance attendance)
- Reduction of 6.9% 12hr breaches
- 23% reduction in time in dept >12hrs
- 7% increase in patients streamed to appropriate services
- Reduced length of stay



Of note 29.3% increase in temporary escalation spaces occupied non ED and 11.4% increase in temporary escalation spaces occupied ED do not refer to the number of spaces in existence but the number of patients that spend any time in one, the number of spaces are the same but more patients experience a short time in one rather than fewer patients spend longer time in one. This is not where we would want care for our patients, but we are seeing patients move out of these spaces in a timelier way and are spreading the risk of ambulance holds through the organisation in order to decompress ED.

Conclusion

This report notes the current performance for our UEC pathways which had been improving in line with the monthly trajectory, this has gone off track from the beginning of September and has continued. This is not the performance we want for our patients or population.

Tactical actions are taking place to mitigate patient risk while the full UEC programme is underway.

Key Recommendations

The Board is asked to receive the update re UEC and to note the actions being taken.

Executive Summary

Trust Board | 10th December 2025

Nurse Staffing Establishment Review

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**		**Assurance**	✓	**Agenda Item:**	11.
Author:	Jane Holmes - Deputy Chief Nurse							
Executive Lead:	Ann-Marie Riley- Chief Nurse							

Alignment with our Strategic Priorities	
Our People We will create an inclusive environment where everyone learns, thrives and makes a positive difference	✓
Our Patients We will provide timely, innovative and effective services to our patients	✓
Our Population We will tackle inequality and improve the health of our population	✓

Risk Register Mapping		
BAF 1	Inability to Sustain Safe and Effective Care Delivery	**Ext 20**
BAF 3	Inability to Improve Workforce Sustainability and Organisational Culture	**Ext 15**

Executive Summary

Situation

There is clear evidence nationally and locally that registered nurse staffing levels directly impact patient safety, quality of care, and staff experience. UHNM is required to assure the Board that nurse staffing is reviewed in line with national guidance and that current arrangements maintain patient safety while addressing workforce pressures.

Background

- The National Quality Board (NQB) framework, introduced in 2013 following the Francis Report, sets out ten expectations for safe staffing. Trust Boards must receive a nursing and midwifery workforce review twice yearly.
- This report covers adult inpatient areas (excluding midwifery, which had an external Birth-Rate Plus review) and excludes outpatients and theatres, which will be included in the next review.
- The review was undertaken in October/November 2025 during a period of heightened financial scrutiny and efficiency requirements. Internal audit has provided significant assurance on the establishment review process.
- Current uplift for ward-based nursing is 21.5%, but absence rates remain high (27–32%), requiring temporary staff backfill and impacting morale, particularly ahead of winter pressures.
- Recruitment and retention have improved, with no reported vacancies; however, this is offset by the impact of the 567 WTE CIP programme, meaning some budgets appear over-established.
- Temporary staffing costs remain significant, with six-month indicative spend exceeding £12.8m across Care Groups.

Assessment

- Patient need is currently met, and there is no immediate risk to safety while bed modelling work concludes. However, gaps remain between agreed rosters and budgets, and uplift levels do not reflect actual absence rates.
- The Royal College of Nursing recommends a 27% uplift to cover leave and training, which exceeds UHNM's current provision of 21.5%, and given the level of absence caused by sickness this is to be reconsidered by the Executive Team
- Enhanced observation requirements continue to drive additional shifts, and a corporate review is planned to manage this demand.
- Early results from the 'Stay in the Bay' initiative show a 70% reduction in moderate-harm falls, suggesting potential for wider rollout to improve safety and reduced temporary staffing costs.

- Business cases for additional WTE (292.54 posts, £11.7m estimated cost) may be required following completion of bed modelling and executive discussion on uplift adjustments. These will be led by Care Group Leadership teams.
- Indicative temporary staffing spend (six months to Oct 2025) - registered 389.42 WTE (£7.36m) and unregistered 413.94 WTE (£5.50m), a total of £12.86m across Care Groups. This is based on day-rate only (no enhanced hours or on-costs), top Band 5/3 rates and 100% fill; expenditure is driven primarily by establishment vacancies, sickness, additional work, and therapeutic/enhanced observations, and is consistent with WTE booked above vacancy gap on the temporary staffing dashboard.

Key Recommendations:

The Trust Board is asked to:

1. Note the progress made to ensure compliance with national guidance in relation to maintaining safe nursing and midwifery staffing levels.

2. Endorse the recommendations and proposed actions highlighted within the report.

3. Note that the Care Group leadership teams will be responsible for developing business cases in line with the recommendations from the establishment review and that no changes to establishments will be made before a business case is approved.

Nurse Staffing
Establishment Review Paper
November 2025

University Hospitals of North Midlands NHS Trust

1. Introduction

There is a body of empirical evidence demonstrating the impact of inadequate nurse staffing levels and skill mix to poor patient outcomes and poor staff experience. Safe staffing continues to be nationally recognised in a number of high profile publications.

In 2013, following findings of the Francis Report (2013) the National Quality Board (NQB) set out ten expectations and a framework within which organisations and staff should make decisions about safe staffing. From 2016 to 2018 the NQB published updated safe staffing guidance and a set of expectations regarding nursing and midwifery staffing. The guidance emphasises that the NHS provider boards are accountable for ensuring that their organisations have the right skills in place for safe, sustainable and productive staffing. The NQB guidance makes explicit the requirements of NHS providers.

Expectation One Right Staff	Expectation Two Right Skills	Expectation Three Right Place and Time
• Evidence based workforce planning. • Professional judgement. • Compare staffing with peers.	• Mandatory training, development and education. • Working with the multi-disciplinary teams. • Recruitment and retention.	• Productive workforce and eliminating waste. • Efficient deployment and flexibilities. • Efficient employment and minimise agency.

Developing Workforce Safeguards was issued by NHSI in October 2018. This publication supports organisations to use best practice in effective staff deployment and workforce planning, utilising evidence based tools and professional judgement to ensure the right staff, with the right skills, are in the right place at the right time. The Trust Board is expected to confirm their staffing governance processes are safe and sustainable through the Trust annual governance statement.

In 2021, the Royal College of Nursing (RCN) released a publication titled "Nursing Workforce Standards: supporting a safe and effective nursing workforce." This document aims to provide guidance and support for maintaining a safe and effective nursing workforce. This document has been refreshed in 2025.

Within this paper, you will find the methodology used during the establishment review process, which took place throughout October 2025 across all three of our Newly formed Care Groups, previously known as divisions. It also assures that the methodology employed to assess safe nurse staffing, aligns with the aforementioned standards. The publication outlines the priority areas of investment for each division, along with key findings and associated recommendations. Additionally, it includes important quality metrics and harm data for each division, which can be used to validate and support the recommendations provided.

2. Nursing and Midwifery Staffing Review October/November 2025

According to the NQB guidance, it is expected that a review of the nursing and midwifery workforce is presented to the Trust Board twice a year. Previously the most recent staffing review took place in the late Spring of 2025 and was stalled to ensure it captured the requirement to address the Band 2 and Band 3 workforce plan.

Research indicates that maintaining appropriate nurse staffing levels has a positive impact on various aspects of patient care, both clinically and economically. These benefits include: improved patient satisfaction, decreased medication errors, fewer incidents of falls, reduced pressure damage, lower rates of healthcare-associated infections, decreased mortality rates, reduced hospital readmissions and length of stay, decreased patient care costs, and mitigated nurse fatigue and burnout, which in turn directly correlates and affects recruitment and retention. Furthermore, studies suggest that when the registered nurse (RN) to patient staffing ratio on adult inpatient wards exceeds 1:8, there is a higher likelihood of

compromised patient care, such as missed or delayed aspects of care, increased risk of harm, and an elevated risk of excess mortality.

Additional staffing that is incorporated into contracts to enable and allow for efficient and responsible management of planned and unplanned leave is known as Headroom or Uplift. There is no nationally agreed headroom and locally this varies. UHNM currently supports an uplift of 21.5% for the majority of areas (there are some areas with a higher uplift which reflects the specific training time required for that area).

This does not however adequately cover the consistent level of absence caused by sickness, other absence or maternity/paternity leave. The Royal College of Nursing now recommend an uplift of 27% to ensure establishments have an adequate allowance built into the budget to allow for annual leave, sickness absence, other types of leave, and training and development. We have not proposed change previously given the instability of the workforce, however despite consistent minimal vacancies, and improved retention, the overall total absence has remained over 25% and therefore a change to the uplift should be considered to support reduced reliance on temporary staffing.

Royal College of Nursing guidance suggests on an acute ward there should be an RN: Nursing Assistant skill mix ratio of no less than 65:35 for base wards, where applicable, 70:30 for specialty wards and 80:20 for specialty units e.g. ICU.

This overview monitors wards against these standards.

Bed Provision	Description	Expected Staffing Level	Skill Mix Suggested
Intensive Care	Beds identified – critical care areas	1 Registered Nurse: 1 patient.	80:20
High Dependency	Designated beds in a defined unit/area.	1 Registered Nurse: 2 patients.	80:20
Level 1	Designated beds on general Wards.	1 Registered Nurse: 4 patients.	70:30
General Care	Majority of inpatient Wards	1 RN: 7 patients or less (dependant on acuity/activity) during the day.	65:35

3. Approach

In the Summer of 2025, UHNM moved from 4 Divisions to 3 Care Groups. The Deputy Chief Nurse led initial discussions with each Care Group Nurse Director, and our Data Manager developed the Harm Free Care Quality data template to reflect 3 Care Groups. The data analyst provided the Harm data for the last 6 months to ensure this review was Quality led and a copy of the previous establishment review was given for reference. Each Divisional nurse was asked to lead discussions with the ward/dept. leaders in their division to review the data, collate professional judgements and determine the safe staffing levels required within their areas and then return to discuss current position and data.

The information collected within Divisions included, funded establishment (as agreed by Finance), quality and HR metrics, shift patterns, key performance indicators for staff rostering and a discussion about ward layout and other professional judgement factors that might affect the number of registrants and non-registrants required.

The Divisional Nurses each had several further meetings with the Deputy Chief Nurse to then respectfully check and challenge proposed staffing levels against their harm data and any new business cases.

Quality metrics for the previous 6-12 months were also considered, including harm free care metrics, Clinical Excellence Framework (CEF) scores, relevant HR data and rostering key performance indicators. Key performance indicators for rostering were also included. The compliance with recording acuity for the

safer care tool was recorded where possible and individual ward compliance was discussed at the review meetings.

All collated data and relevant guidance were triangulated to determine whether the current funded staffing levels were satisfactory, or whether additional staffing was recommended.

Successful ongoing recruitment, and an improvement in retention, had reduced that number to currently zero vacancies. This is misleading though as because of the 567 WTE CIP programme which was modelled into the pay budgets, the data is currently showing no vacancies at the moment. This is because some of the nursing budgets are actually showing as over established.

Based on Full Establishment

Vacancies at 31-10-25	**Budgeted Establishment**	**Staff In Post fte**	**Vacancies**	**Vacancy %**	**Previous Month**
Medical and Dental	1,781.06	1,637.95	143.11	8.04%	9.80%
Registered Nursing	3647.61	3772.45	-124.84	-3.42%	3.52%
All other Staff Groups	6751.94	6447.09	304.85	4.51%	9.06%
Total	**12,180.61**	**11,857.49**	**323.12**	**2.65%**	**7.50%**

Total proposed additional WTE		**Estimated Cost**
Registered Nurses:	157.76WTE	£7,625,960
Health Care Assistants:	121.7 WTE	£4,112,851
Totals	**292.54 WTE**	**£11,738,811**

Cost estimates are based on top of 2025 pay scales, with on costs (and inclusive off 21.5% uplift to the service) but without enhancements for nights, weekends etc. The above predominantly reflects the same requests as previous reviews which did not progressed to business cases given the vacancies across the Trust at the time. It also includes unfunded capacity that has remained open without substantive funding.

Temporary staffing indicative spend in the 6 months leading up to October 2025
The following costs are based on the following assumptions and therefore are only indicative costs:

- All costs are day rate – no enhanced hours/night rate
- No oncosts
- Unregistered based on Top band 3 rate
- Registered based on Top band 5 rate
- Based on 100% fill (so total demand to bank)
- Indicative costs not been sent to finance

Care Group	**Registered WTE**	**Un registered WTE**	**Indicative cost band 5**	**Indicative cost Band 2**
Unplanned	202.03	263.14	£3,818,133.12	£3,498,865.65
Planned	124.47	119.96	£2,352,341.15	£1,595,097.53
Clinical & Scientific	62.92	30.84	£1,189,205.44	£410,102.33
Grand Total	389.42	413.94	£7,359,679.72	£5,504,065.52

These requested WTE equivalent are consistent with the current WTE booked above Vacancy gap on the temporary staffing dashboard based on the past 6 months.

Of the requested hours and costs detailed, the most used request reasons are referenced below by Care Group. These factors contribute to the significant expenditure on temporary staff.

Indicative costs below are based on the same assumptions as above (6 months data to the end of Oct):

	Unplanned Hours		Unplanned Indicative Cost	
	Registered	Unregistered	Unregistered	Registered
Estab Vacancies	60051.87	85981.10	£816,705.39	£1,160,802.58
Sickness	50342.55	46247.47	£684,658.68	£973,121.49
Additional Work	52998.95	38127.32	£720,785.72	£1,024,469.70
	1247.75	53049.28	£16,969.40	£24,119.01

	Planned Hours		Planned Indicative Cost	
	Registered	Unregistered	Unregistered	Registered
Estab Vacancies	39184.42	27028.32	£532,908.07	£757,434.77
Sickness	35923.32	28590.33	£488,557.11	£694,397.71
Therapeutic Observations	3014.75	34768.00	£41,000.60	£58,275.12
Additional Work	19526.83	11219.75	£265,564.93	£377,453.69

	Clinical and Scientific Hours		Clinical and Scientific Indicative Cost	
	Registered	Unregistered	Unregistered	Registered
Additional Work	32976.18	11695.08	£448,476.09	£637,429.62
Estab Vacancies	11613.00	15171.42	£157,936.80	£224,479.29
Sickness	6146.30	2116.50	£83,589.68	£118,807.98
Maternity Leave	6657.50		£90,542.00	£128,689.48

This demonstrates the ongoing spend on Temporary Staffing and the controls around temporary staffing are under regular review.

Any requests for additional staff must be presented via a business case. This review highlights the safe staffing requirements only and is not aimed to seek agreement regarding funding.

Executive Summary

Trust Board | 10th December 2025

Speaking Up, Biannual Report, Quarters 1 and 2

NHS
University Hospitals of North Midlands
NHS Trust

Purpose:	**Information**		**Approval**		**Assurance**	✓	**Agenda Item:**	12
Author:	Rob Irving, Freedom to Speak Up Guardian							
Executive Lead:	Claire Cotton, Director of Governance & Communications							

Alignment with our Strategic Priorities	
Our People We will create an inclusive environment where everyone learns, thrives and makes a positive difference	✓
Our Patients We will provide timely, innovative and effective services to our patients	✓
Our Population We will tackle inequality and improve the health of our population	

Risk Register Mapping		
	Speaking Up Culture	**Mod 6**

Executive Summary

Situation

The Speaking Up Report is a biannual report designed to provide assurance to the People, Culture and Inclusion Committee on the work of the Freedom to Speak Up Guardian. The report covers quarters 1 and quarter 2 of 2025 /2026.

Background

The National Guardians Office, Care Quality Commission and NHS England all have a role in setting the national expectations for the NHS in relation to speaking up.

The National Guardian's Office (NGO) plays a crucial role in fostering a positive speaking up culture. It leads, trains and supports a network of Freedom to Speak Up Guardian's, conducts speaking up reviews and provides guidance and challenge to the healthcare system.

The Care Quality Commission Well Led Framework has specific quality statements in relation to speaking up, and expects leaders to:

- Ensure that all colleagues and leaders act with openness, honesty and transparency.
- Ensure that all colleagues and leaders actively promote staff empowerment to drive improvement.
- Encourage colleagues to raise concerns and promote the value of doing so, in order that all colleagues are confident that their voices will be heard.
- Ensure that there is a culture of speaking up where colleagues actively raise concerns and those who do (including external whistleblowers) are supported, without fear of detriment.
- Ensure that when concerns are raised, leaders investigate sensitively and confidentially, and lessons are shared and acted on.
- Ensure that when something goes wrong, people receive a sincere and timely apology and are told about any actions being taken to prevent the same happening again.

Finally, NHS England aim to ensure that everyone working in the NHS feels safe and confident to speak up. They seek to improve the quality of speaking up arrangements in a number of ways including evaluation of concerns, organisational culture and the quality of care provided, provision of a support scheme for those who have spoken up and the development of policy, guidance and resources.

Assessment

Overview & Activity:

- 185 concerns were raised in Q1 and Q2 (79 in Q1, 106 in Q2), representing a 54% increase from the previous period and the highest ever recorded for a single quarter. This rise is attributed to increased Guardian resources and greater workforce confidence in raising issues. The main category of concern related to inappropriate attitudes and behaviours, (35% of concerns), with behaviour-related issues accounting for 50% of all concerns, consistent with long-standing trends.

National & Regional Developments:

- The National Guardian's Office (NGO) will be abolished as an independent NHS agency in March 2026, with its functions absorbed by the Department of Health and Social Care. The Freedom to Speak Up Guardian role will remain in the NHS standard contract until at least 2027.
- Overseas-trained NHS workers face barriers to speaking up, including visa dependency and fear of professional referrals, highlighting the need for culturally competent support.

Guardian Network & Local Developments:

- Expansion of Champion Network: Over 20 new Freedom to Speak Up Champions appointed, representing diverse backgrounds, to increase staff confidence and service visibility. Recruitment is ongoing.
- FTSU Teaching: 363 staff received training sessions in Q1/Q2, with ongoing efforts to expand reach.

Data & Trends:

- Themes identified a number of hotspot areas with issues around civility, respect, and adherence to policy. Race-related concerns have increased, reflecting wider societal tensions.
- Ethnicity Data: White British staff accounted for 50% of concerns (down from 66%), BAME representation increased slightly to 21% (down from 29% last year), and 27% did not state ethnicity, indicating possible barriers or preference for anonymity.

Detriment & Case Management:

- 2 cases (1%) reported detriment as a result of speaking up, a reduction from previous periods. Majority of cases (59%) were closed, but timely closure remains a challenge.

Benchmarking

- National Position: UHNM ranked 31st out of 44 for concerns raised in Q4 2024/25, and 10th out of 47 in Q1 2025/26. Bullying and harassment concerns remain above average compared to similar Trusts.

Priorities & Looking Ahead

- Review and establish new procedures for cases of alleged detriment.
- Overhaul data collection systems for improved confidentiality and integrity.
- Increase service visibility through staff engagement and communications.
- Adapt to national changes, including the closure of the NGO.

Assurance Assessment		
Significant	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable	General confidence in delivery of existing mechanisms / objectives	
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	✓
No Assurance	No confidence in delivery	

Rationale

Whilst there is assurance around the arrangements to support staff to speak up, as evidenced through the increased number of concerns and the improved Staff Survey Scores, there remains work to be done around the way in which concerns are responded to. In addition, further work is being progressed to embed the Freedom to Speak Up Accountability Framework as part of ongoing leadership development.

Key Recommendations

The Trust Board is asked to consider the assurance provided through this report, and the priorities planned to continue to strengthen our speaking up culture / arrangements.

Speaking Up

Biannual Report, Quarters 1 and 2
2025 - 2026

Contents

Introduction

Overview from the Freedom to Speak Up Guardian

This biannual report provides an overview of activities and developments, along with an analysis of Speaking Up during quarters 1 and 2, 2025/2026.

During this period, our Freedom to Speak Up (FTSU) Guardians have continued to build relationships and networks with senior leaders and colleagues from across the organisation, Integrated Care System (ICS) and the region, as well as progressing the ongoing development of the service and working through some of the challenges that have been highlighted in previous reports.

Quarters 1 (Q1) and 2 (Q2) 2025/2026 saw a number of developments and opportunities both locally, regionally and nationally. Following the appointment of John Beckett as Deputy Freedom to Speak Up Guardian in March 2025, the reporting period saw a further increase in the number of concerns being raised.

185 concerns were raised, with 79 during Q1 and 106 during Q2, an increase from 120 concerns (54%) raised in the previous reporting period. This is a further increase on previously unprecedented levels of concern raised in Q1/Q2 2024/2025 (150 concerns). As such this reporting period saw our highest numbers of concerns ever received during a single quarter. It is considered that this increase may be associated with the additional Guardian resources, resulting in greater visibility and engagement with the workforce. The increased volume of concerns may also indicate greater workforce confidence in raising workplace issues as part of routine practice.

Despite ongoing efforts to improve our data collection system, challenges remain regarding data integrity and the potential for data loss, with a number of issues which have taken the Lead Guardian some time to rectify. Accurate and effective data is key in improving the service we can deliver, as well as making it as easy as possible for our staff to raise concerns. We will continue our focus on this, as well as our ability to triangulate with other sources of information, and the Lead Guardian and Deputy will be meeting with IT colleagues to explore available options.

We continue to work on the self-reflection tool, which is an ongoing process and will allow us to review leadership and governance arrangements and identify further areas to develop and improve.

Our highest category of concern for the period reverted to “inappropriate attitudes and behaviours” having been “policy and procedure” in Q3/Q4 of the previous year. These concerns accounted for 35% of concerns raised. Q3/Q4 was the first time that a non-behaviour related category had been the highest reporting category, and as such previous trends are once again coming to the for. Issues relating to behaviour once again accounted for exactly 50% of all concerns raised which is in line with long standing trends.

Concerns in the two behavioural categories continue to account for around 50% of all concerns raised (51% in quarters 3 and 4), which highlights the need to continue to utilise our newly refreshed values to focus on the impact of poor behaviours not only for our staff but for our patients. It is anticipated that the ongoing initiatives will influence staff interactions.

The increase in concerns related to policy and procedure continues a trend observed in the previous six months. This may suggest that some staff perceive policies and processes are not consistently followed, and we will continue to monitor this trend.

National and Regional Developments

Developments During the Quarters

Dash Review confirms abolishment of National Guardian's Office

The Dash Review was published in July and confirmed that The National Guardian's Office (NGO) will be closed as an independent NHS agency in March 2026, with its functions being absorbed in The Department of Health and Social Care as part of the government's 10-year health strategy to be aligned with other staff voice functions. Further details are currently limited, although it has been confirmed that the role of the Freedom to Speak Up Guardian will remain as part of the NHS standard contract until at least 2027. Details of support and guidance for Guardians currently provided by the NGO remains unclear at this time.

Dr Jayne Chidgey-Clarke retires from her role as National Guardian

In August it was announced that Dr Jayne Chidgey-Clark was stepping down from her role as National Guardian for the NHS, following four years of service. Jayne was appointed in December 2021 and had led the NGO since then.

Reflecting on her time in the role, Dr Chidgey-Clark said:

"It has been an incredible privilege to work with a network of over 1,200 local Guardians across the NHS, independent sector and national bodies. I would like to thank those workers who have had the courage to speak up to their Guardians, and all the Guardians who work so hard to be part of the improving culture in their organisations.

"I also want to thank those leaders who listen well, follow up, and actively demonstrate a listening and learning culture. It has been a privilege to work alongside my team at the National Guardian's Office, and with patient safety and quality leaders across the NHS, in supporting improvements to the speaking up culture.

"It was with great sadness that I received the news of the abolishment of the National Guardian's Office and my role, as there is still so much more to do. My hope is that all leaders, managers and regulators will continue to prioritise improving workplace culture and embed the principles and practices of Freedom to Speak Up – so that speaking up, listening up and following up truly become business as usual."

While the National Guardian role will not be replaced, Beth Carter, National Lead for Guardian Support, will oversee the running of the National Guardian's Office as interim Director, ensuring continuity during this transitional period.

Overseas Trained Workers in the NHS Fear Speaking Up

Following publication of the NGO's Speak Up Review, 'Listening and Learning: Amplifying the voices of overseas trained workers, a review of the speaking up experiences of overseas trained workers in England', this called for action to:

- Make recruitment and retention guidance support speaking up
- Design speaking up arrangements that work for everyone
- Use better data to understand and improve experiences
- Build cultural competence and awareness to remove barriers to speaking up

Dr Isabella Teteh explored how being on a work visa affects speaking up, describing a vicious cycle that prevents overseas nurses from doing so. For many overseas-trained workers in the NHS, their right to live and work in the UK is tied directly to their employment as they hold work visas sponsored by their employers. This creates a dependence that affects far more than just job security. It changes their relationship with workplace safety and their willingness to raise concerns. The review heard that some overseas-trained workers found themselves facing professional referrals soon after arrival. One system representative described a troubling pattern: "Some managers raise referrals within two weeks of an overseas-trained worker arriving, simply because they haven't 'hit the ground running'. There's little consideration for the fact that they've left their home country, arrived in a foreign place with a different language and are still adjusting." Instead of recognising the natural adaptation period these workers need, some organisations jump straight to formal concerns processes rather than providing support. The response, instead, is punitive and lacks cultural intelligence. This creates a vicious cycle. The fear of referrals, combined with visa insecurity, generates enormous stress and makes workers even less likely to speak up about legitimate concerns.

National and Regional Developments

NGO Annual Report 2024/25

In August, The NGO published its annual report for 2024/25 entitled Culture is a Patient Safety Issue

Key Findings

- 2024/25 saw the highest number of cases reported to guardians since the programme
- began.
- Workers continue to express positive views about the Freedom to Speak Up Guardian role
- Inappropriate attitudes and behaviours remain the most common theme of concern.
- Concerns related to worker safety and wellbeing are increasing.
- Confidence in organisations to address concerns is in decline.
- NHS trusts are showing a positive shift, with more full-time guardians being appointed.

Challenges

- Fear of detriment or a belief that speaking up will not make a difference remains a key
- barrier of speaking up.
- Prolonged investigations and rigid human resource processes contribute to anxiety and
- negatively impact the wellbeing of those raising concerns.
- A lack of outcomes, delayed feedback, and breakdowns in communication weaken trust
- between workers and organisations.
- A perceived lack of compassionate responses from line managers and senior leaders when concerns are raised reinforces the belief that “nothing will change”.

Call to Action

Creating a culture where speaking up is a routine part of organisational life requires deliberate and timely action. While the data highlights meaningful progress, it also reveals ongoing challenges that call for unified leadership and a strong, system-wide commitment.

For senior leaders:

- Champion psychological safety by modelling openness, transparency, and responsiveness.
- Invest in full-time guardian roles, in line with recruitment framework recommendation.
- Act on feedback by closing the loop with workers and demonstrating visible change.

For line managers:

- Prioritise compassionate leadership by developing the skills to listen, support, and act.
- Create safe spaces for informal resolution and early intervention.
- Engage in training to understand your role in fostering a culture of trust.

For organisations:

- Embed speaking up into strategy priorities, aligning it with patient safety, workforce
- wellbeing, and quality improvement.
- Strengthen data use to inform proactive interventions.
- Ensure accountability by monitoring resolution rates and follow through on concerns.

National and Regional Developments

NGO National Guardian's Survey 2025

In September, the NGO published its annual thematic review, exploring how the role is delivered in practice, examining guardians' experiences and perceptions across several key areas.

Key Findings

- Time allocation: Inconsistent access to ring-fenced time limits effectiveness. Many reported lack sufficient time to engage proactively, manage caseloads, and maintain visibility.
- Resources and infrastructure: Lack of funding, space, and communications support needed to carry out the Guardian role effectively. Confidentiality and trust are compromised without dedicated budgets or private meeting areas.
- Recognition and remuneration: Concerns persist regarding the minimum pay band recommendation, Band 7 or equivalent does not reflect the leadership and strategic influence required. Respondents seek better alignment between responsibilities and pay.
- Support from the National Guardian's Office: While valued, respondents call for more timely, practical, and tailored resources. With the Dash review's changes, future support and functions are currently being discussed with Department of Health and Social Care, NHS England and Care Quality Commission and remains to be defined at the time of report writing.
- Influence and engagement: Respondents are seeking a stronger, more visible national presence with the authority to challenge poor practice, support complex cases and hold organisations accountable. With the transition following the Dash review, NHS England and Department of Health and Social Care will need to consider how best to meet these expectations.
- Role satisfaction: Nine out of ten guardians would recommend the role. Despite its emotional demands, especially in NHS trusts, many find it deeply rewarding, reinforcing the need for robust support to sustain their wellbeing and impact.

Recommendations for Organisations

- Enhance Local Implementation and Role Capacity – ensure local implementation of roles align to national policy. Apply locally appropriate guardian to staff ratio to support manageable caseloads and enable proactive engagement.
- Improve Organisational Support – including ringfenced time, ensure guardians have access to confidential meeting spaces, a dedicated budget for training, travel, and promotional activities. Ensure speak up processes are inclusive and accessible to all staff, including those from underrepresented groups.
- Strengthen Communications - Promote consistent, strategic communications support at the organisational level, beyond campaign-based activity to raise awareness and visibility of the Freedom to Speak Up Guardians.
- Engage Leadership -Provide targeted training for managers and senior leaders on key people related policies, especially where these intersect with speak up concerns, such as grievance procedures, disciplinary processes, and recruitment practices. Mandate Freedom to Speak Up training for all managers and senior managers to reduce barriers to speak up and understand the importance of the guardian function. Promote visible leadership support for Freedom to Speak Up guardians. Active endorsement from senior leaders helps build trust and signals a genuine commitment to openness and psychological safety across the organisation.
- Support Guardian Wellbeing -Individual organisations should recognise and proactively address the emotional demands of the role. Employing organisations should encourage guardians to access wellbeing resources, peer support, and reflective practice opportunities. NHS trusts need to pay particular attention to burnout risks, where emotional strain is often more pronounced.

Local Developments

Developments During the Quarters

Rob Irving, Lead Freedom to Speak Up Guardian, and his Deputy Guardian John Beckett have continued to identify and work on key areas for development of our service. Below provides a brief outline of some of the work they have undertaken during the quarters.

Freedom to Speak Up Champions

Following on from the work undertaken in the previous quarters to expand our network of Freedom to Speak Up Champions, a role descriptor, advert and expressions of interest were invited. The lead and deputy guardian undertook a recruitment process whereby over fifty expressions of interest have led to the appointment of an additional twenty Champions. Appointed champions participated in an informal interview process and completed three modules of training, designed to align their understanding of the role and values with those of the NGO.

The additional champions were launched on 13th October in conjunction with Speaking Up Week 2025, and their details shared on the FTSU Intranet page, with accompanying biographies and photographs. The newly appointed champions represent a range of professional, ethnic, gender, and cultural backgrounds, providing staff with options to speak to a champion they feel comfortable approaching.

Recruitment is ongoing and continuous. The ongoing expansion of the champion network is intended to increase workforce confidence in the organisation's commitment to listening to staff. The service also seeks to address the gap between staff confidence in speaking up and their belief that the organisation will respond appropriately.

FTSU Teaching

Deputy Guardian John Beckett has taken on teaching responsibilities for the service and since his appointment has delivered a number of teaching sessions to FY1/2 doctors in training, student nurses and new starters in both nursing and nursing assistant roles. John continues to liaise with the People OD Team, Staffordshire University and CeNREE programmes in order to enhance the provision of FTSU teaching across these staff groups. Since Q1 teaching sessions have been delivered to 363 members of staff across the organisation and the service continues to explore avenues to expand its reach and deliver its teaching session to an even wider audience.

Local Developments

Developments During the Quarters

FTSU Accountability Framework

In conjunction with the Director of Governance and Communications, The Lead Guardian produced an FTSU accountability framework in order to ensure accountability of the care groups around speaking up. The framework documented expectations as set out by the National Guardian's Office and Care Quality Commission before stipulating what we expect of our leaders in terms of leadership, governance, behaviour, training, learning and continuous improvement.

Leadership Commitment

- ✓ **Champion a speaking up culture** by role-modelling openness, transparency and psychological safety
- ✓ **Regularly communicate** the importance of speaking up and the protections in place for those who do
- ✓ **Visibly support** the Freedom to Speak Up (FTSU) Guardians and Champions

Governance & Oversight

- ✓ Embed FTSU into **governance structures**, including regular reporting to the Care Group Leadership Board
- ✓ Ensure that themes from concerns are reviewed at senior leadership meetings and that learning is captured and acted upon
- ✓ Completing relevant aspects of the **FTSU self-reflection** tool

Culture & Behaviour

- ✓ Foster a **just and learning culture**, where staff are not blamed for raising concerns
- ✓ Ensure **no detriment** comes to individuals who speak up
- ✓ Promote **inclusive leadership**, ensuring all voices are heard, especially from underrepresented groups

Training & Development

- ✓ Complete the three **FTSU training modules on ESR (Speak Up, Listen Up Follow Up)** and ensure their teams do the same
- ✓ Participate in **reflective learning** from FTSU cases and share insights across the organisation
- ✓ Support the development of **local FTSU Champions** within their Care Group

Responsiveness & Learning

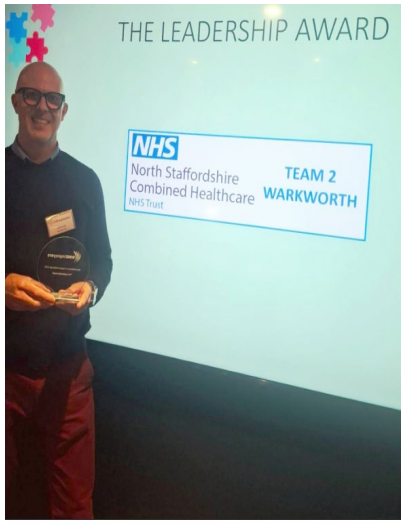
- ✓ Ensure concerns are **responded to promptly**, in line with the **Speaking Up Policy**, with clear communication of investigation methods, outcomes and learning actions back to the individual who raised them
- ✓ Monitor and act on FTSU **themes and trends** to drive improvement
- ✓ Share **learning from FTSU cases** to prevent recurrence and improve care quality

Continuous Improvement

- ✓ Regularly review and **improve FTSU processes** in collaboration with the FTSU Guardian
- ✓ **Learn** from national best practice and colleague feedback
- ✓ Lead on **action plans** arising from FTSU reviews and ensure delivery is monitored and evaluated

West Midlands Employers Tri Sector Challenge

The Lead Guardian was one of three staff which represented UHNM in a team with Combined Healthcare at the West Midlands Employers Tri Sector Challenge held in Wolverhampton in September. The team performed very well and were nominated for the overall team award, won the leadership award and were commended for their communication skills.



Local Developments

Developments During the Quarters

UHNM NMAHP Inclusion Conference

Deputy Guardian John Beckett represented FTSU at the recent UHNM Nursing, Midwifery and Allied Health Professionals Inclusion Conference at Port Vale FC. The event was organised by Sophie Barber, Lead Educator for NMAHP Inclusion and this was held during inclusion week. The event had a number of keynote speakers including Michelle Cox, Darren Moore and Carol Shanahan OBE, focused on lived experience of discrimination, inclusive recruitment, an action plan for change and featured discussion panels, workshops and networking opportunities. John was able to engage with delegates, promoting Freedom to Speak Up and the work we do as part of the cultural change agenda.

Mock Employment Tribunal

Both the lead and deputy guardians alongside colleagues from the People Directorate attended a mock employment tribunal in Birmingham organised by Browne Jacobson. As both Guardians have been involved in recent speak up cases that have been subject to tribunal claims this was an extremely useful experience that provided a safe, realistic simulation of a real tribunal. The session covered the following:

- Education and training: Educating attendees on the tribunal process, from the roles of the participants to the procedures involved.
- Risk identification: Learning about common mistakes and "pitfalls" in the workplace that could lead to a claim, helping organizations prevent them.
- Experience and practice: Providing the opportunity to experience the pressure of giving evidence, cross-examination, and presenting a case in a low-stakes environment.
- Understanding outcomes: Exploring how cases unfold in practice, how decisions are made, and the potential financial implications of a claim.
- Preparation insight: Providing insight into the preparations required in advance, including evidence, witness statements, and other documents.

Speak-Net

Collaborative work between Charlotte Phillips from the University of Staffordshire and the FTSU team at UHNM is in the early stages of development. Charlotte has already conducted a study at UHNM that has looked at improvement of speaking up within maternity services and we are looking forward to working more closely with her to look at our wider speaking up processes and procedures to make further improvements across the organisation. The FTSU team are involved with Speak-NET, a project that aims to initiate a community of practice networks through bringing health systems staff, service users, quality and safety professionals and health researchers together to share learning and insights to support ongoing improvement of speak up conditions and capabilities. Charlotte supported UHNM at this year's AGM where she displayed some of the collaborative work she has conducted.

Other Activity

Other activities undertaken by the Lead Guardian and Deputy Guardian include:

- Bronze **Care Excellent Framework (CEF)** panellist, monitoring wards identified as in need of improvement, with many having a culture element that goes hand in hand with their performance. Support is offered to improve relationships and communication.
- Members of **Sexual Safety Working Group,** providing input from a FTSU perspective.
- **Wednesday Walkabouts** to wards and departments, to meet and engage with managers and their teams.
- Regular **engagement with other key stakeholders** such as Professional Nurse Advocates, Organisational Development Team, Staff Networks and Trade Unions.

Thematic Review

Developing Themes

There have continued to be a number of challenges to overcome as reported previously. These have been discussed and presented in detail at the People, Culture and Inclusion Committee. Themes related to:

- Hotspot areas - concerns regarding attitudes and behaviours, issues regarding policy compliance and breakdown in working relationships

- Race - recent national tensions around migration and race have been reflected within UHNM, with Freedom to Speak Up receiving more concerns from international staff about racism and inclusion. Issues include discomfort in workplace discussions, language use in clinical and communal settings, and fears about raising concerns due to visa dependency. Some staff feel excluded when colleagues use their first language, while international staff value this for comfort and family communication. Concerns also relate to potential patient safety risks when non-English languages are used clinically. These themes highlight the need for clear organisational guidance to promote inclusion, effective communication, and teamwork.

- Fragility of data collection and triangulation – whilst some enhancements have been made further conversations are to be held to ensure data integrity and confidentiality

Feedback

FTSU feedback forms are provided to every person whose concern is closed in the given time period. The feedback system is voluntary and whilst the service has aimed to make the process straightforward and anonymous, response rates remain lower than anticipated.

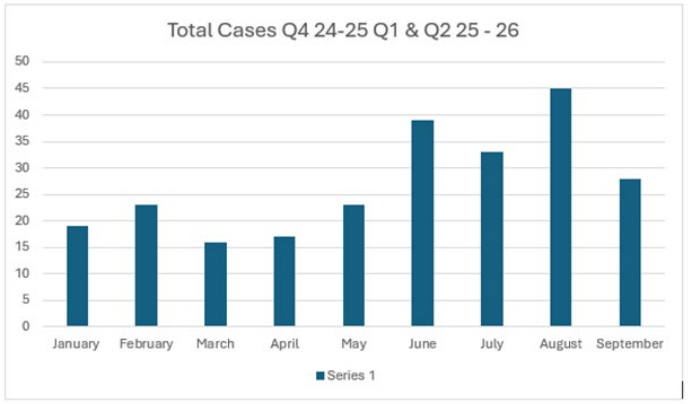
Of those who responded:

- 81% identified as female
- 79% identified as White British
- 96% reported satisfaction with the way the FTSU Service handled their concern
- 79% were satisfied with the Trust's investigation once escalated
- 70% felt their issue had been resolved
- 48% reported improvement in their situation as a result of speaking up
- 78% indicated they would speak up again.

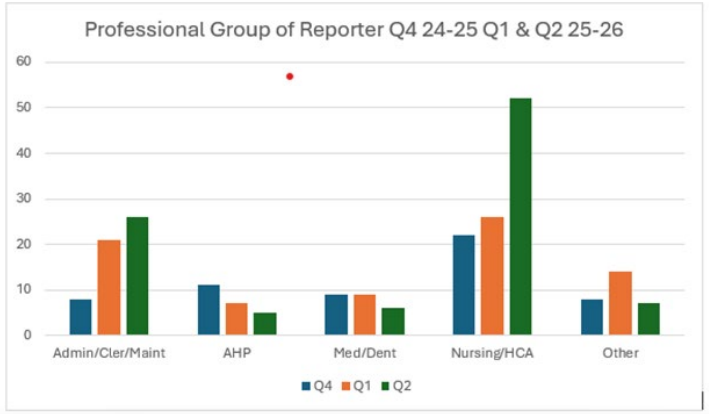
Concerns Raised During the Quarters

Number and Types

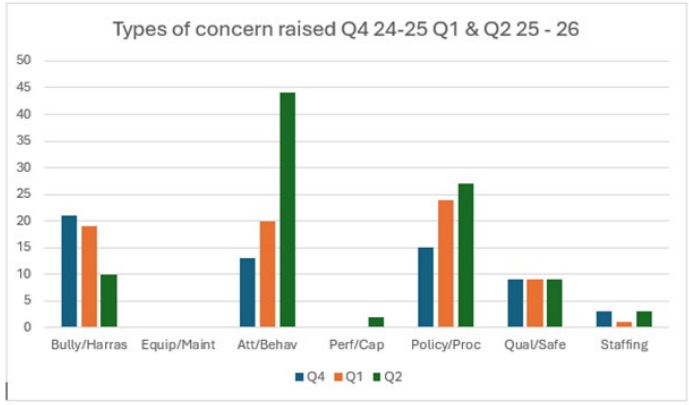
Total Concerns Raised



Professional Group



Types Of Concern Raised



What is the data telling us?

There were 79 concerns raised during Q1 and 106 in Q2. This is an increase of 23% on the same periods the previous year. The increase may be attributed to:

- The increased capacity into the service with the introduction of the Deputy FTSU Guardian allowing greater engagement and visibility of the team.
- A concerted effort to spend more time and have greater engagement with staff at County Hospital.
- Improved and consistent social media presence.

Types of concern:

- The top category of concerns raised reverted to inappropriate attitudes and behaviours for this reporting period (35%), having been policy and procedure for the first time ever in the previous reporting period. Policy and procedure accounted for 28% of concerns raised, while bullying and harassment accounted for 16% and quality and safety concerns 10%
- 50% of all concerns were behaviour related, a now firmly established consistent trend across recent quarters.
- There is no particular trend emerging around the types of staff raising concerns.

What are we doing about it?

- Continue proactive promotion of the Speaking Up service across the organisation, aligned with the People Plan.
- Build and maintain strong networks with leaders to foster a positive speaking up culture.
- Monitor trends in concern categories, particularly behaviour-related concerns
- Support cultural change by reinforcing the Trust's Being Kind agenda, Trust Values, and NHS People Promise.
- Promote recognition initiatives such as Enable, Platinum, Gold, and Silver Connects awards to encourage positive behaviours.
- Continue to engage with leaders investigating concerns into behaviour related concerns to look at targeted interventions.
- Track reporting patterns by staff group, specifically monitoring the increase in reports from Medical and Dental staff, which appears to be disproportionate from the general increase in the number of concerns raised.

Concerns Raised During the Quarters

Ethnicity and Divisional

Concerns by Division / Quarter

	Surgical Division				WCS Division				Network Division				Medicine Division				Estates, Facilities & PFI				Central Functions				Pathology Network			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2022/2023	1	2	2	4	31	19	12	3	4	3	8	2	6	10	10	9	1	2	4	0	3	7	15	3	2	0	2	1
2023/2024	6	9	16	16	4	12	13	11	8	5	12	11	10	10	19	16	0	2	1	0	3	3	15	7	1	1	1	0
2024/2025	20	12	23	15	8	14	5	9	6	14	9	10	14	16	8	10	4	0	3	2	9	16	10	10	0	1	1	1
2025/2026	31	27			10	8			12	9			6	35			2	4			10	14			3	2		

Ethnicity of Staff Raising Concerns

Ethnicity	Quarter 3+ 4 (2024/25)	Quarter 1 + 2 (2025/26)	Change
White British	80 (66%)	93 (50%)	↓
Other White Background	6 (5%)	4 (2%)	↓
BAME	21 (18%)	38 (21%)	↑
Did Not State	13 (11%)	50 (27%)	↑

What is the data telling us?

The ethnicity data compares the ethnicity of individuals raising concerns over the first half Q1 and Q2 of the year and the second half of 2024/25

- White British has accounted for the majority of concerns in both periods but decreased from 66% to 50%.
- Other white background representation returned to 2% from 5%, returning to normal levels having spiked in the last reporting period.
- BAME increased slightly from 18% to 21% but this is still significantly down from the 29% seen in the equivalent reporting period last year. This decrease may warrant further exploration to determine whether it reflects a reduction in concerns or indicates potential barriers to speaking up.
- The proportion of staff who did not state their ethnicity increased from 11% to 27%. This may indicate a preference for anonymity, discomfort in disclosing demographic information, or situations where reporters do not meet directly with Guardians and are unable to confirm ethnicity.

What are we doing about it?

The shift in reporting patterns may reflect changes in awareness, confidence or accessibility of the speaking up service among different ethnic groups. Further analysis and engagement may help ensure equitable access and trust in the process across all demographics.

Speaking Up efforts should maintain strong engagement in high-reporting areas such as Surgery and Medicine and explore reasons for consistently low reporting in areas such as Pathology, Network, and EFPFI. While low numbers may reflect fewer issues or higher staff satisfaction, it remains important to ensure all staff feel safe, informed, and empowered to raise concerns. Continued attention is also needed in WCCSS, where a recent decline in reporting warrants further understanding.

The FTSU Guardians continue to participate in the Data, Culture, Learning and Understanding Group, which gathers data from relevant sources to improve understanding and support organisational learning. Recent improvements in data collection have enabled better availability of information for identifying developing themes and hotspots.

Concerns Raised During the Quarters

Detriment and Case Management

Detriment as a Result of Raising Concerns

Q1 / Q2	2

Status of Concerns Raised

	Q3 24/25			Q4 24/25			Q1 25/26			Q2 25/26		
	Raised	Closed	Open	Raised	Closed	Open	Raised	Closed	Open	Raised	Closed	Open
Quarterly Totals	62	54	8	58	40	18	79	64	15	106	47	59

What is the data telling us?

Of the 185 cases reported, 2 individuals reported detriment as a result of raising their concern. This represents 1% of cases and whilst this remains regrettable, is positive to see a further reduction following the spike in Q1/2 2024/25. Reporters sometimes find it challenging to distinguish between a general perception of detrimental treatment and actual detriment experienced as a direct result of raising a concern. Careful consideration is given to these distinctions during case review. This continues to be the case and careful consideration is given to whether there is a general feeling of detrimental treatment or actual detriment is being suffered as a direct result of raising a concern.

In Q1 and Q2, the majority of cases had been closed (59%), compared to 78% in the previous reporting period and 60% in Q4 of 2023/2024. This reflects ongoing challenges in achieving timely case closure, including operational pressures faced by managers during investigations.

What are we doing about it?

The work being undertaken in relation to detriment is described earlier in this report. It includes actions being taken such as convening an executive panel, revising policies and processes, and ensuring alignment with recently published NGO guidance.

Some cases remain open due to investigations not being completed within the desired timeframe, despite regular follow-up. These challenges have been escalated by the People Directorate through employee relations reporting.

Benchmarking

NGO Data

We use benchmarking from the National Guardian's Office to compare our speaking up data with similar organisations, helping us to better understand volumes and effectiveness of our speaking up arrangements. The data used here is Q4 2024/25 and Q1 2025 / 2026 which is the latest available.

Total Number of Speaking Up Reports by NHS / NHS Foundation Trust

We ranked 31st out of 44 organisations for total number of concerns raised during Q4 2024/2025 and 10th out of 47 in Q1 2025/2026. We reported 58 concerns in Q4 and 79 in Q1, which was above average of 58 and 79 concerns for each reporting period respectively. Further analysis is shown here:

UHNM's number of concerns that include an element of bullying and harassment continues to be significantly above the average for other Trusts of a similar size and this has been a consistent feature in recent reports

UHNM Ranking within this Benchmarking Group Q4 2024/25				
Category of Concern	UHNM Ranking* (high to low)	No. Cases**	Average	Above ↑ / Below ↓ Average
Anonymous cases	9/19	10	8.13	↑
Element of patient safety / quality	10/21	16	12.16	↑
Element of worker safety	17/32	17	24.29	↓
Element of bullying / harassment	5/25	36	13.63	↑
Element of inappropriate attitudes / behaviour	19/28	13	24.79	↓
Detriment as a result of speaking up	5/8	3	1.47	↑

UHNM Ranking within this Benchmarking Group Q1 2025/26				
Category of Concern	UHNM Ranking* (high to low)	No. Cases**	Average	Above ↑ / Below ↓ Average
Anonymous cases	8 /15	7	7.3	↓
Element of patient safety / quality	5/18	15	7.6	↑
Element of worker safety	16/27	16	20.6	↓
Element of bullying / harassment	3/20	33	11.6	↑
Element of inappropriate attitudes / behaviour	Joint 19/31	20	23.4	↓
Detriment as a result of speaking up	Joint 6/7	1	1.1	↓

Benchmarking

NGO Full Dataset

Organisation Name	Type of Organisation	Quarter	Size of Organisation	Region	Number of cases brought to Freedom Speak Up Guardians	Number of cases raised anonymously	Number of cases with an element of patient safety or quality	Number of cases with an element of worker safety or wellbeing	Number of cases with an element of bullying or harassment	Number of cases with an element of other inappropriate attitudes or behaviours	Number of cases where people indicate that they are suffering disadvantageous and/or demeaning treatment
University Hospitals Plymouth NHS Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	South West	190	37	59	135	52	142	0
Nottingham University Hospitals NHS Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	Midlands	159	6	3	4	14	16	0
Nottinghamshire Healthcare NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	Midlands	143	6	23	28	16	72	0
Somerset NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	South West	126	16	55	97	11	35	1
University Hospitals of Derby and Burton NHS Founda	NHS Trust/Foun	Q4 2024/2	Large (more th	Midlands	119	11	38	70	42	45	0
United Lincolnshire Hospitals NHS Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	Midlands	115	9	8	16	11	52	2
University Hospitals of Leicester NHS Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	Midlands	110	9	19	33	18	83	1
Hampshire and Isle of Wight Healthcare	NHS Trust/Foun	Q4 2024/2	Large (more th	South East	108	7	11	47	7	35	2
Guy's and St Thomas' NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	London	106	9	16	7	12	43	0
Leeds Teaching Hospitals NHS Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	North East & '	103	3	47	25	6	25	0
East Lancashire Hospitals NHS Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	North West	97	0	2	32	12	32	0
Manchester University NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	North West	93	11	20	64	41	21	24
Mersey Care NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	North West	89	38	6	54	4	25	0
Oxford University Hospitals NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	South East	89	46	15	47	22	26	3
The Newcastle upon Tyne Hospitals NHS Foundation	NHS Trust/Foun	Q4 2024/2	Large (more th	North East & '	88	16	5	9	10	62	2
Cambridge University Hospitals NHS Foundation Trus	NHS Trust/Foun	Q4 2024/2	Large (more th	East of Englai	78	2	5	30	18	32	4
Hull University Teaching Hospitals NHS Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	North East & '	76	3	16	18	10	16	0
University Hospitals Birmingham NHS Foundation Tru	NHS Trust/Foun	Q4 2024/2	Large (more th	Midlands	76	1	10	13	40	22	0
East Suffolk and North Essex NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	East of Englai	74	11	25	37	20	0	5
The Royal Wolverhampton NHS Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	Midlands	68	17	8	23	8	1	0
Liverpool University Hospitals NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	North West	64	2	21	46	9	44	0
University Hospitals Sussex NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	South East	63	7	10	14	11	38	0
Mid and South Essex NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	East of Englai	59	8	19	6	13	18	0
University Hospitals of North Midlands NHS Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	Midlands	58	10	16	17	36	13	3
Bedfordshire Hospitals NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	East of Englai	55	0	5	35	18	35	0
King's College Hospital NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	London	55	3	4	0	5	18	2
Mid Yorkshire Teaching NHS Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	North East & '	53	1	5	2	11	0	0
Frimley Health NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	South East	51	4	11	28	2	7	2
Barts Health NHS Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	London	49	8	1	2	12	18	0
South Tees Hospitals NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	North East & '	44	21	5	12	12	13	1
University College London Hospitals NHS Foundation	NHS Trust/Foun	Q4 2024/2	Large (more th	London	39	12	1	1	17	25	0
Midlands Partnership University NHS Foundation Trus	NHS Trust/Foun	Q4 2024/2	Large (more th	Midlands	36	1	15	33	4	11	3
Sheffield Teaching Hospitals NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	North East & '	33	8	6	15	11	5	6
University Hospitals Bristol and Weston NHS Foundat	NHS Trust/Foun	Q4 2024/2	Large (more th	South West	32	1	5	9	0	6	0
Royal Devon University Healthcare NHS Foundation T	NHS Trust/Foun	Q4 2024/2	Large (more th	South West	30	0	4	17	13	13	0
University Hospitals Coventry and Warwickshire NHS	NHS Trust/Foun	Q4 2024/2	Large (more th	Midlands	28	6	2	10	6	6	0
Cumbria, Northumberland, Tyne and Wear NHS Foun	NHS Trust/Foun	Q4 2024/2	Large (more th	North East & '	26	2	2	3	10	8	2
St George's University Hospitals NHS Foundation Tru	NHS Trust/Foun	Q4 2024/2	Large (more th	London	25	5	1	1	8	5	0
Imperial College Healthcare NHS Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	London	23	0	4	3	8	8	0
Northumbria Healthcare NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	North East & '	20	0	3	9	3	2	0
University Hospital Southampton NHS Foundation Tru	NHS Trust/Foun	Q4 2024/2	Large (more th	South East	17	0	0	3	1	12	0
Royal Free London NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	London	14	0	1	1	11	1	0
Coventry and Warwickshire Partnership NHS Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	Midlands	13	1	3	13	5	0	2
East Kent Hospitals University NHS Foundation Trust	NHS Trust/Foun	Q4 2024/2	Large (more th	South East	0	0	0	0	0	0	0

Organisation Name	Type of Organisation	Quarter	Size of Organisation	Region	Number of cases brought to Freedom Speak Up Guardians	Number of cases raised anonymously	Number of cases with an element of patient safety or quality	Number of cases with an element of worker safety or wellbeing	Number of cases with an element of bullying or harassment	Number of cases with an element of other inappropriate attitudes or behaviours	Number of cases where people indicate that they are suffering disadvantageous and/or demeaning treatment
University Hospitals Plymouth NHS Trust	NHS Trust	Q1 25-26	Large (more th	National/Multi-	152	18	48	124	66	105	2
Nottingham University Hospitals NHS Trust	NHS Trust	Q1 25-26	Large (more th	Midlands	145	6	5	5	19	25	0
Mersey Care NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	North West	114	34	11	57	7	37	0
Hampshire and Isle of Wight Healthcare NHS Trust	NHS Trust	Q1 25-26	Large (more th	South East	110	6	11	60	10	22	1
Somerset NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	South West	95	15	19	62	15	32	0
Nottinghamshire Healthcare NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	Midlands	94	0	8	11	16	31	0
University Hospitals of Leicester NHS Trust	NHS Trust	Q1 25-26	Large (more th	North West	93	5	7	39	9	56	3
Guy's and St Thomas' NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	London	86	2	3	13	15	17	0
University Hospitals Birmingham NHS Foundation Tru	NHS Trust	Q1 25-26	Large (more th	Midlands	86	2	2	8	36	33	3
King's College Hospital NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	London	84	0	21	0	4	17	1
University Hospitals of North Midlands NHS Trust	NHS Trust	Q1 25-26	Large (more th	Midlands	79	7	15	16	33	20	1
East Lancashire Hospitals NHS Trust	NHS Trust	Q1 25-26	Large (more th	North West	76	3	6	34	8	25	0
Oxford University Hospitals NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	South East	73	45	2	24	20	38	5
Manchester University NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	North West	70	11	18	51	19	38	12
Hull University Teaching Hospitals NHS Trust	NHS Trust	Q1 25-26	Large (more th	North East an	68	0	3	11	3	14	2
Bedfordshire Hospitals NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	East of Englai	62	0	3	48	24	25	0
Barts Health NHS Trust	NHS Trust	Q1 25-26	Large (more th	London	60	6	2	1	4	50	0
Cambridge University Hospitals NHS Foundation Trus	NHS Trust	Q1 25-26	Large (more th	East of Englai	58	2	9	25	13	25	0
Mid and South Essex NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	East of Englai	57	6	3	1	15	28	0
The Royal Wolverhampton NHS Trust	NHS Trust	Q1 25-26	Large (more th	Midlands	56	27	0	3	9	29	0
University Hospitals Sussex NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	South East	56	1	4	8	9	43	1
East Kent Hospitals University NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	South East	54	18	9	4	4	27	0
Leeds Teaching Hospitals NHS Trust	NHS Trust	Q1 25-26	Large (more th	North East an	53	15	6	16	9	22	0
Mid Yorkshire Teaching NHS Trust	NHS Trust	Q1 25-26	Large (more th	North East an	45	1	3	3	10	0	0
South Tees Hospitals NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	North East an	43	17	6	21	4	24	1
Frimley Health NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	South East	42	5	13	29	2	23	2
University College London Hospitals NHS Foundation	NHS Trust	Q1 25-26	Large (more th	London	36	5	3	3	6	26	1
Royal Devon University Healthcare NHS Foundation T	NHS Trust	Q1 25-26	Large (more th	South West	35	1	3	23	16	20	1
Lincolnshire Partnership NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	Midlands	34	1	4	19	8	3	0
East Suffolk and North Essex NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	East of Englai	32	1	11	6	8	10	2
Midlands Partnership University NHS Foundation Trus	NHS Trust	Q1 25-26	Large (more th	Midlands	32	5	14	26	12	21	4
Northumbria Healthcare NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	North East an	31	1	0	19	3	7	0
Cumbria Northumberland Tyne and Wear NHS Found	NHS Trust	Q1 25-26	Large (more th	North East an	28	0	4	6	4	2	0
University Hospitals Bristol and Weston NHS Foundat	NHS Trust	Q1 25-26	Large (more th	South West	25	1	1	8	6	5	0
University Hospitals Coventry and Warwickshire NHS	NHS Trust	Q1 25-26	Large (more th	Midlands	24	3	3	15	1	2	0
London Ambulance Service NHS Trust	NHS Trust	Q1 25-26	Large (more th	London	22	0	0	2	1	11	0
Sheffield Teaching Hospitals NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	North East an	20	4	13	3	3	4	0
Northern Care Alliance NHS Foundation Trust	NHS Trust	Q1 25-26	Large (more th	North West	19	17	4	16	5	14	0
St George's University Hospitals NHS Foundation Tru	NHS Trust	Q1 25-26	Large (more th	London	19	0	4	0	7	0	0
Imperial College Healthcare NHS Trust	NHS Trust	Q1 25-26	Large (more th	London	13	2	3	4	1	6	0

Looking Ahead

Priorities for the Next Quarter

As we continue to develop our services, we have identified a number of key priorities that will be our focus for the coming quarter. These are described below.

- Review policy and establish a new procedure to effectively deal with cases of alleged detriment as a direct result of raising a concern
- Establish a system whereby the FTSU Guardians can ensure that reporters concerns have been fairly and objectively investigated, and outcomes are commensurate with evidence produced
- Data collection system to be overhauled to reflect changes from divisions to care groups prior to new financial year.
- Review the current data collection, reporting, and triangulation system to address risks related to confidentiality, data integrity, and triangulation capabilities. Guardians will continue to explore more efficient methods for data collection and reporting, including options such as internal development of a web-based secure reporting system or the purchase of a third-party application.
- Continue to increase service visibility through ward and department visits, social media, communications, and presentations.
- Continue to explore networking opportunities with system partners and regional colleagues to incorporate best practice into work at UHNM.
- Adapt the service to reflect national changes, including the abolishment of the National Guardian's Office.

Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE | 7th November 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The **Board Assurance Framework** for Q2 was presented and the Committee queried whether the risk score for Q3 was realistic, given winter pressures. In addition, the Committee noted the additional work undertaken to ensure safety checks were in place for the use of temporary escalation spaces, with audits and wellbeing checks being undertaken. • **Quality and Outcomes Group (outcomes focussed)** highlighted issues with attendance, with canvassing of attendance being undertaken. It was noted that Governance leads had been appointed, and further capacity was to be identified. • Deterioration in **non-elective** performance highlighted, partly impacted by the delay in introducing the Urgent Treatment Centre, with the associated trajectories being reviewed. Attendances remained high and higher than last winter in addition to an increase of 7.5% to 8% on ambulance conveyances, compared to 2024. As a result, some winter plan mitigations were to be brought forward. • In terms of **elective** performance and the number of 65 week patients, it was anticipated that 31 patients would remain by December and as such the Trust was not expecting to achieve the trajectory of reducing this to zero by the end of December. • Partial assurance was agreed for the **cancer 104+ day breach** report, whereby 103 had been reported in Q1, 76 of which had been referred from the GP and 27 from screening. It was noted that the majority of breaches had been attributed to capacity constraints, but also an element of patient choice at 9%. 60% patients treated over 104 days went on to receive surgery and harm reviews were continuing to be undertaken, with further work to be undertaken to establish the categorisation of harm. • **Quality performance** report highlighted initial improvements in Venous Thromboembolism (VTE) compliance following the introduction of ePMA and further assurance was to be provided to the Integrated Care Board in relation to timely observations. Partial assurance was agreed. • **Infection Prevention Board Assurance Framework** highlighted the completion of the action in relation to the cleaning manual. Partial assurance was agreed, due to the number of outstanding actions such as addressing blood culture delays at County Hospital. It was noted that in terms of the ED cohort area it was anticipated that this would be delayed further due to winter pressures. • **Infection Prevention Report** highlighted 1 MRSA bacteraemia, but all necessary procedures had been put into place and as such it was deemed unavoidable. The Trust remained above trajectory for c-difficile and e-coli with actions ongoing to consider the themes. • Assurance was provided in terms of the mitigation put in place within the **Emergency Department corridor**, which continued to be at levels which the Trust did not wish to deliver. This included ensuring fire evacuation routes were useable, the provision of staff psychological support, including pastoral support, the use of Professional Nurse Advocates, and enhanced support for newly qualified nurses. It was also noted that food provisions were provided to patients and relatives and enhancements to comfort had been made.	• Executives to consider how best to share the **'hear my voice, feel my story'** initiative across all Care Groups was to be considered by Executives. It was also agreed to consider including this at a future Board meeting. • Relevant metrics which could be impacted by the **uncoded activity** for 2024/25, to be flagged on relevant dashboards and within relevant benchmarking reports. • Get It Right First Time (GIRFT) team assisting and reviewing **non-elective** processes within the Emergency Department, the outcome of which would be reviewed in terms of benefits realisation. • Executive Team to consider the action required to address the overdue **safety alert** from March 2024. • Update on **safeguarding** - domestic abuse to be provided to the Committee in addition to the outcome of the re-audit, in April 2026. • Results from the audit of the use of **escalation spaces** to be brought to the Committee. • Interim Standard Operating Procedure in place for **endoscopy sedation**, in addition to prospective auditing, the results from which would be reported to Quality and Outcomes Group.

Positive Assurances to Provide	Decisions Made
• The Committee welcomed the presentation regarding the **'hear my voice, feel my story'** initiative which involved, staff, patients and their families in sharing learning following adverse incidents • Acceptable assurance was provided by the **coding** update, noting that from April 2025 100% of activity had been coded. It was noted that there remained 39,000 uncoded episodes from 2024/25 affecting any case mix adjusted during that time on non-elective activity. In addition, it was highlighted that the dip in HSMR and SHMI correlated with the time the Trust stopped using agency staff within the coding team. The Committee welcomed the use of Artificial Intelligence in helping to code activity. • It was noted that **DM01 performance** was in line with trajectory and the work to address non-obstetric ultrasound delays was going well. • The Committee welcomed the staff uptake for **flu** vaccinations, with over 4,500 staff vaccinated, the second highest in 5 years. • The Committee considered whether partial assurance should be provided for the **Safeguarding Adults Annual Report** due to gaps in assurance for domestic abuse, although it was agreed that given the assurance provided for other areas of the safeguarding agenda that acceptable assurance was provided. The increase in referrals and impact on resource and whether this was sufficient for the 2025/26 priorities was queried and the way in which the Trust was working with partners to share capacity was noted. It was noted that whilst some increase in resources had already been agreed, a further business case was expecting to be developed. • Acceptable assurance was provided by the **Patient Safety Incident Investigation** report, and the Committee welcomed quality of the report and noted the improvement in assessing and collating feedback from patients and staff.	• No decisions were required to be made

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
Comments on effectiveness were sought via MS Teams.	There were no cross-committee considerations identified.

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	"Hear My Voice, Feel My Story"	1	Ext 20	Not Applicable	Assurance	8.	Quality Performance Report – Month 6 2025/26	1	Ext 20	Partial	Assurance
2.	Clinical Coding Update	1	36869 Ext 20	Acceptable	Assurance	9.	Infection Prevention Board Assurance Framework Q2 2025/26	1	Ext 20	Partial	Assurance
3.	Executive Quality & Outcomes Group Highlight Report (09-10-25)	1	-	Not Applicable	Assurance	10.	Infection Prevention Hospital Acquired Infection Report Q2 2025/26	1	Ext 20	Partial	Assurance
4.	Q2 Board Assurance Framework	ALL	Various	Not Applicable	Approval	11.	Safeguarding Adults Annual Report 2024/25	1	Ext 20	Acceptable	Assurance
5.	Access Performance Report Month 6 25/26 • Executive Recovery Oversight Group Highlight Report	1	Ext 20	Partial	Assurance	12.	Patient Safety Incident Investigation Report Q2 2025/26	1	Ext 20	Acceptable	Assurance
6.	104+ Day Breach Analysis Q1 2025/26	1	Ext 20	Partial	Assurance	13.	Endoscopy Sedation Update	1	-	-	Information
7.	ED Corridor Support	1	ID26808 High 12 ID36591 High 12	Not Assessed	Assurance						

Highlight Report

EXTRAORDINARY MATERNITY QUALITY, ACCESS & OUTCOMES COMMITTEE | 26th November 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• An update was provided on two **coroners** cases which involved maternity, 1 neonatal death concluded with a natural cause of death but gross failures in care identified, and no sanctions taken. The second case was noted to be a neonatal death with no cause for concern identified by the coroner, who was assured by the actions taken and decisions made.	• The associated action plan following the **coroner's** case was to be shared with the Committee for assurance of the actions taken. In addition, wraparound support was being provided to the staff. • Due to the increase in resource required to complete **PMRTs**, a request to proceed was being prepared.

Positive Assurances to Provide	Decisions Made
• Update on **Maternity Outcomes Signal System (MOSS) critical safety checklist** provided which focusses on intrapartum issues. Three level one signals were identified in the pilot phase, the details of which were provided to the Committee. It was noted that safety checks were required to be undertaken for each signal within 3 days, and no additional areas of learning had been identified which provided **significant assurance**. Discussions remained ongoing in terms of embedding the reviews into existing governance mechanisms to avoid duplication of effort and providing feedback to national teams. • **Maternity dashboard** demonstrated that training was on trajectory to achieve compliance, and work continued towards the Maternity Incentivisation Scheme targets for Year 7. It was noted that the Maternity Safety Champions meet bi-monthly with the Perinatal Leadership team. The dashboard is in line with the Perinatal Quality Surveillance Model. • **Re-audit of Consultant Attendance at required situations for Q1 and Q2** demonstrated improvements in attendance which reflected recent recruitment efforts. It was noted that compliance was in line with the minimum CNST Standard safety action 4. • **Perinatal mortality review tool** (PMRT) highlighted 10 cases which were presented in Q2. The Trust was 100% compliant for completion of PMRT reviews and reports within the timeframe in line with CNST safety Action 1. • **Maternity and neonatal workforce report** for Q1/Q2 highlighted that following completion of Birthrate plus, an associated business case had been approved, and the funded establishment was compliant with BirthRate Plus. The report demonstrated that the midwifery coordinator remained supernumerary, and actions remained ongoing regarding increasing the number of Qualified in Speciality trained nurses. It was noted that the neonatal medical workforce met the relevant BAPM recommendations although the Neonatal nursing workforce was not in line with BAPM nurse staffing standards and the action plan was agreed by the Committee. • Q2 **Patient Safety Investigation and Response Framework** (PSIRF) report highlighted compliance with all elements of safety action 10, with all cases reported as required within the required timeline. It was recognised that the Committee had previously had sight of qualifying MNSI/EN incidents and numbers and evidence that families had received information on the role of MNSI and NHS Resolution EN scheme, including duty of candour. In Quarter 2, 4 new incidents were reported. • An action plan had been identified and agreed by the Committee in relation to **neonatal transitional care**, to progress towards a transitional care pathway based on the British Association of Perinatal Medicine (BAPM) framework for babies. • Criteria for employing **long-term and short-term locum doctors in obstetrics & gynaecology** highlighted compliance for the past 2 years with appropriate failsafes in place	• No decisions were required to be made

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
Comments on effectiveness were sought via MS Teams.	There were no cross-committee considerations identified.

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Maternity Outcomes Signal System (MOSS) Critical Safety Checklist	1	Ext 20	Significant	Assurance	6.	Maternity and Neonatal PSIRF Investigation Report Q2	1	Ext 20	Not assessed	Assurance
2.	Maternity Dashboard Q2 2025/26	1	Ext 20	Not assessed	Assurance	9.	Quality Improvement Project Update: Bedside Screening and Treatment for Early Onset Neonatal Sepsis	1	Ext 20	Not assessed	Assurance
3.	Re-audit of Consultant Attendance at Required Situations Q1/Q2	1	Ext 20	Not assessed	Assurance	10.	Transitional Care Compliance (BAPM) Action Plan	1	Ext 20	Acceptable	Assurance
4.	Perinatal Mortality Report Q2	1	Ext 20	Not assessed	Approval	11.	Long-term / Short-term Locum Doctors in Obstetrics & Gynaecology Audit	1	Ext 20	Not assessed	Assurance
5.	Maternity and Neonatal Workforce Report Q1/Q2	1	ID32806	Not assessed	Assurance						Assurance

Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE | 4th December 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Partial assurance was provided following the **spinal and cranial surgical site infection (SSI)** review which was undertaken due to the Trust being identified as a national outlier for cranial surgery and regionally for spinal surgery surgical site infections. Whilst an action plan was in place and there had been an improvement in environmental cleaning, with no SSIs being recently noted, this improvement needed to be sustained. • **Access performance** provided partial assurance. There were continuing difficulties with non-elective performance, and the programme of work with the Urgent and Emergency Care Get it Right First Time team was highlighted. The increase in ED attendances was noted, affecting patient waits which was similar across the Midlands and impacted in part due to a second wave of flu cases. • The Committee received partial assurance from the **medicines optimisation and safety** report for Q1 and Q2, which highlighted increasing medicines expenditure. The paper highlighted an ongoing issue and risk in relation to patient group directions with actions to be taken and it was noted that a chair of the Medicines Optimisation and Safety Group had been confirmed. The gaps in medical leadership affecting various committees was highlighted and although interim actions had been taken regarding increasing resource, a further business case was expected to be submitted in 2026/27. • Partial assurance was provided by the **end of life care** mock Care Quality Commission (CQC) visit which was undertaken to provide assurance given the last CQC visit was undertaken in 2015. Overall, key themes identified a compassionate culture, although there had been some delay in recognising patients nearing the end of life resulting in reactive actions as opposed to proactive planning. In addition, challenges with documentation, responsiveness and training were noted. An associated delivery plan had been produced based on the results which was to be monitored by the End of Life Steering Group and the Committee agreed to receive an update on progress on recommendations in six months.	• Update on the recent **Joint Advisory Group** (JAG) accreditation process to be provided to the Committee • Update to be provided on the stroke pathway following escalation from the **Quality and Outcomes Group** • Follow up audits and updates in relation to **spinal and cranial SSIs** to be provided to the Committee, via quarterly infection prevention updates • Data in terms of use of escalation spaces to be included in the **access performance** report going forwards • **EPMA** roll out continued to take place, with further enhancements to be made to discharge letters • Given the gaps in key medical **leadership** roles, identified by a number of reports, it was agreed to consider providing a register of key roles to the Committee for assurance that these were in place

Positive Assurances to Provide	Decisions Made
• A presentation was provided on the successful pilot of a **lower limb wound pathway,** which reduced clinic appointments by 50% for early-referred patients, improved pain and mobility and enabled earlier discharge. It was agreed to share the resources with education leaders. • The update on **looked after children** highlighted that demand had doubled and there were workforce gaps whereby there was no named doctor and nurse for looked after children. Plans to address this were queried and it was noted that a business case was to be prepared, it was also confirmed that a recovery plan was in place following previous challenges in meeting statutory deadlines. The Committee queried the wellbeing support in place for the team and the actions taken to support staff on an ongoing basis were noted. Whilst significant assurance was provided in terms of the service provided by the team, due to the sustainability challenges and gaps with the lack of a named nurse and doctor, it was agreed that the assurance rating be reduced to acceptable assurance. • An update on **sepsis in children's services** was provided for Quarter 2 which demonstrated significant assurance. Whilst screening had been missed for 5 patients during the period, no patients had red flags for antibiotic requirements, nor subsequently developed sepsis. In addition, an audit of 25 patient records demonstrated that all patients had a Paediatric Early Warning System (PEWS) assessment, and for 3 who did not have a sepsis screening tool completed, these had been reviewed in real time by a senior clinician. It was agreed to continue to provide updates on this a quarterly basis in the interim. • Acceptable assurance was provided by the **vulnerable patient** team for 2024/25 which highlighted the successful rollout of the Oliver McGowan mandatory training, updated delivery plans aligning with national standards and active engagement with the regional mental health and learning disability networks. The Committee noted the increase in referrals for mental health and the number of patients detained under the Mental Health Act. As such the resources for safeguarding were queried given the size of the workload and complexity of cases and this remained under review. • **Legal services annual litigation and inquest** report provided acceptable assurance. It was highlighted that a review of over 500 claims had been undertaken, with a particular focus on those which had not previously been raised as a complaint or incident given the missed opportunity to identify learning. This data had been shared with clinical teams, the governance of which would be monitored via the Quality and Outcomes Group. The increase in both claims and inquests in the year were noted, with inquests increasing in terms of complexity. • The Committee welcomed the improvement in **RTT performance** • Acceptable assurance was provided by the **maternity single delivery plan** for Q2, with positive assurances in relation to infant mortality, launch of the continuity of carer team, birth choices clinic, full implementation of perinatal pelvic health, 100% retention for newly registered midwives and implementation of equity and equality plan to reduce workforce inequalities.	• No decisions were required to be made

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
Comments on effectiveness were sought via MS Teams.	There were no cross committee considerations.

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Lower Limb Wound Pathway Update	1	Ext 20	Not applicable	Information	8.	Access Performance Report Month 7 / H2 Operational Priorities Performance	1	Ext 20	Partial	Assurance
2.	Executive Quality & Outcomes Group Highlight Report (26-11-25)	1	Ext 20	Not assessed	Assurance	9.	Medicines Optimisation & Safety Report Q1/Q2	1	Ext 20	Partial	Assurance
3.	Vulnerable Patients Annual Report 2024/25	1	Ext 20	Acceptable	Assurance	10.	End of Life Care Mock Care Quality Commission Visit	1	Ext 20	Partial	Assurance
4.	Looked after Children Annual Report 2024/25	1	Ext 20	Acceptable	Assurance	11.	Maternity Quality & Safety Oversight Group Assurance Report	1	Ext 20	Not assessed	Assurance
5.	Spinal and Cranial Surgical Site Infection Review	1	Ext 20	Partial	Assurance	12.	UHNM Benchmark against Maternity Single Delivery Plan Q2	1	Ext 20	Acceptable	Assurance
6.	Sepsis in Children's Services Q2	1	Ext 20	Significant	Assurance	13.	Quality Performance Report – Month 7	1	Ext 20	Not assessed	Assurance
7.	Legal Services Annual Litigation & Inquest Report			Acceptable	Assurance						

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 07 Performance

2025/26

Kind Excellent Together

University Hospitals of North Midlands NHS Trust

Contents

Statistical Process Control

University Hospitals of North Midlands NHS Trust

This report uses Statistical Process Control (SPC) methods to draw two main observations of performance data and the below key, and icons are used to describe what the data is telling us.

Variation	Are we seeing significant improvement, significant decline or no significant change?
Assurance	How assured of consistently meeting the target can we be?

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: **orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

NHS Oversight Framework Summary

University Hospitals of North Midlands NHS Trust

Headlines	Data period	Provider value	Peer average	National value	National value method	Chart
Adjusted segment			Q1 2025/26 3	NOF Score	Provider value	
Average metric score			Q1 2025/26 2.47	NOF Score	Provider value	
Unadjusted segment			Q1 2025/26 3	NOF Score	Provider value	
Financial override	Q1 2025/26	No	Yes	Yes	Provider median	
Is the organisation in the Recovery Support Programme?	Q1 2025/26	No	No	No	Provider median	

Domain Scores	Data period	Provider value		Chart
Access to services domain segment	Q1 2025/26	3	NOF Score	
Access to services domain score	Q1 2025/26	2.55	NOF Score	
Effectiveness and experience of care domain segment	Q1 2025/26	2	NOF Score	
Effectiveness and experience of care domain score	Q1 2025/26	2.17	NOF Score	
Patient safety domain segment	Q1 2025/26	3	NOF Score	
Patient safety domain score	Q1 2025/26	2.63	NOF Score	
People and workforce domain segment	Q1 2025/26	2	NOF Score	
People and workforce domain score	Q1 2025/26	2.53	NOF Score	
Finance and productivity domain segment	Q1 2025/26	3	NOF Score	
Finance and productivity domain score	Q1 2025/26	2.36	NOF Score	

UHNM is placed in segment 3 and is positioned in the middle of this segment.
UHNM demonstrates a balanced performance across the NOF domains, with all domain scores within the mid range point nationally.

Kind Excellent Together

NOF - Effectiveness and Experience

University Hospitals of North Midlands NHS Trust

Effectiveness and experience of care	Data period	Provider value		Chart
Effectiveness and experience of care domain score	Q1 2025/26	2.17	NOF Score	

Patient experience	Data period	Provider value		Chart
CQC inpatient survey satisfaction rate score	Q1 2025/26	2	NOF Score	
Summary Hospital-level Mortality Indicator score	Q1 2025/26	3	NOF Score	

Effective flow and discharge	Data period	Provider value	Peer average	National value	National value method	Chart
Average number of days from discharge ready date to actual discharge date (including zero days) score			Q1 2025/26 1.5	NOF Score	Provider value	
Average number of days from discharge ready date to actual discharge date (including zero days)	Jun 2025	0.4	0.7	0.7	Provider median	

UHNM performs well, with scores that reflect strong clinical outcomes and positive patient experience, resulting in a mid range position nationally. SHMI performance has deteriorated to the 9th worst performing nationally. The deterioration is not due to any increase in the number of recorded deaths or crude mortality but is owing to a drop in clinical coding of non elective spells causing the calculated risk of death to be artificially low for these patients.

NOF - Patient Safety

University Hospitals of North Midlands NHS Trust

Pateint Safety Domain Score	Data period	Provider value		Chart
Patient safety domain score	Q1 2025/26	2.63	NOF Score	

Patient safety	Data period	Provider value	Peer average	National value	National value method	Chart
NHS Staff Survey - raising concerns sub-score score			Q1 2025/26 2.71	NOF Score	Provider value	
NHS Staff survey - raising concerns sub-score	2024	6.37	6.32	6.42	Provider median	
Number of MRSA infections score			Q1 2025/26 3.81	NOF Score	Provider value	
Number of MRSA infections (12 months)	To Jun 2025	9.00	4.00	3.00	Provider median	
Rate of C-Difficile infections score			Q1 2025/26 2.85	NOF Score	Provider value	
Rate of C-Difficile infections (12 months)	To Jun 2025	1.22	1.19	1.22	Provider median	
Rate of E-Coli infections score			Q1 2025/26 1	NOF Score	Provider value	
Rate of E-Coli infections (12 months)	To Jun 2025	0.99	1.12	1.16	Provider median	

UHNM demonstrates a good and consistent performance across the Patient Safety domain, positioning itself favourably compared to other Acute Trusts nationally. While UHNM performs well overall, there remains opportunities for further improvement in the infection rates. Both MRSA and CDiff have seen a deterioration since April 2025, with MRSA being significantly below peer and national level.

Quality & Access | Overview

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

Overview from the Chief Nurse and Chief Medical Officer

How are we doing against our trajectories and expected standards?

We met the required performance across a range of metrics and the NMAHP workforce remains stable. We have a range of processes to assess and triangulate safe staffing requirements, fill rates, staff experience and quality metrics and outcomes; and subsequent supportive interventions when and if required.

Where possible national benchmarking using Public View has been included for the available indicators. The Recommended Trusts for comparison (blue columns) are Nottingham University Hospitals, UHCW, UHDB, University Hospitals of Leicester and East Lancashire Hospitals.

We are reviewing an emerging increase in CPE cases in the West Building and will update the committee next time on these cases and any learning.

There have been 3 Calls for Concern (Martha's Rule) during October 2025 and 1 of these triggered review with updated clinical treatment.

What is driving this?

We failed to meet the required target for DOC verbal and written, VTE assessments, HAT, C-Diff (31% above YTD target upper limit),pressure ulcers developed under UHNM per 1000 bed days, e-coli (3.1% above YTD upper target limit), complaint response time (however this is the best performance since July 2020), timely observations, single sex accommodation breaches, ED Sepsis IVAB, FFT in ED and maternity, and HSMR/SHMI. There has also been one never event which is under investigation.

Single sex breaches were all in critical care and caused by an inability to transfer patients to wards due to capacity constraints. There are no reported concerns re privacy and dignity for any of these breaches.

There are two deep dives in progress relating to RSUH theatres and the SLT service are now complete and will be reported to the committee

The current performance is at the level of limited assurance.

There has been continued poor performance in relation to VTE assessments due to poor recording of date and time of the assessment.

Quality& Access | Overview

Provide safe, effective and caring services

University Hospitals of North Midlands

Overview from the Chief Nurse and Chief Medical Officer

What are we doing to correct this and mitigate against any deterioration?

Our work continues with all services across the Trust in our education and implementation of the National PSIRF methodologies and principles for incident responses and learning. A single harm free care action plan that will incorporate learning for fall, pressure damage and hospital acquired infection is now developed and will be presented to QAOG for sign off and will then be applicable for all relevant wards/depts.
Intensive and specific corporate support to Bronze CEF wards continues and is proving impactful and continues to support areas CEF Silver wards.
Engagement sessions will continue with NMAHPs colleagues into the New Year to co-design a new Excellence Framework that will replace the current CEF – this will be presented to Committee once completed.
EPMA roll out continues as planned.
Focused project work continues for our Non-Medical Prescribers database and maturity matrix.
Pilot at County to trail decaffeinated drinks as standard – we will monitor impact and patient feedback and report this to the committee once the pilot is completed
Nutrition and Hydration Summit to take place before the end of Q3, with improvement actions being fed back to QAOG and the committee
We have introduced new digital audits for our temporary escalation spaces which we will report to committee once embedded.
We have also reviewed the requirement to complete additional assessments (behaviour, sleep, continence) before some complex discharge patients can have their plan of care determined - these assessments add to the LOS per patient. Through collaborative working with the care nurse nursing leads and the IDH we will cease the need to complete the additional assessments before Christmas which will support a reduced LOS for these patient groups.

What can we expect in future reports?

We continue to with Wigan Hospital Trust to enhance our awareness and approach to addressing Poor Behaviours within our EDI work and share an approach to our anti-racism work.
The thematic review regarding patients who abscond from ED will be presented to Committee at the next available meeting. We will also update the committee on our position regarding the national action plan for antimicrobial resistance via the Infection Prevention BAF.

HSMR and SHMI are anticipated to start to decrease as a result of recent changes and improvements in clinical coding. In April and May 2025, both metrics demonstrated improvement following the completion of full activity coding. Ongoing monitoring will continue, with assurances sought via the Mortality Review Group, and further details will be provided through Mortality Assurance Reports.
It has also been observed that there has been a decline in both the numbers and rate of Palliative Care codes during the period affected by coding issues. Further analysis is underway to assess the potential impact of this reduction, with findings to be reported to the Mortality Review Group, as decreased palliative care coding can influence the number of expected deaths per month.
This matter remains under ongoing review, and updates have been shared with both QAOC and the ICB.

Quality & Access | Dashboard

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
PSI per 1000 bed days	Oct 25	52.6	50.7			53.2	45.2	61.1
PSI with moderate harm or above per 1000 bed days	Oct 25	0.6	0.6			0.7	0.3	1.1
Patient Falls per 1000 bed days	Oct 25	4.3	-			5.0	3.8	6.2
Patient falls with harm per 1000 bed days	Oct 25	1.5	1.5			1.7	1.2	2.2
Medication incidents per 1000 bed days	Oct 25	5.3	6.0			6.3	4.5	8.1
Medication incidents with moderate harm or above (%	Oct 25	2%	5%			2%	-1%	4%
Pressure Ulcers developed at uhnm per 1000 bed day	Oct 25	2.2	1.6			1.7	0.8	2.6
Pressure ulcers with lapses in care per 1000 bed days	Oct 25	0.4	-			0.5	0.1	0.9
Never Events reported	Oct 25	1	0			1	-2	3
PSIIs instigated	Oct 25	2	0			2	-4	8
Duty of Candour verbal	Oct 25	65%	100%			93%	77%	109%
Duty of Candour written (letter sent within 10 working c	Oct 25	70%	100%			80%	49%	111%
Maternity Induction of Labour - Breach performance	Sep 25	98%	95%			98%	95%	101%
Maternity Assessment Unit Triage within 15 minutes	Sep 25	92%	85%			93%	86%	100%
Timely Observations	Oct 25	80%	90%			80%	79%	82%
VTE Risk assessment Rate (timely) - data from Tenda	Oct 25	84%	95%			86%	82%	91%
Hospital Associated Thrombosis Rate	Oct 25	1.4	-			1.0	0.3	1.7
Sepsis Screening - Inpatients	Oct 25	98%	90%			96%	87%	105%
Sepsis IVAB - Inpatients	Oct 25	100%	90%			99%	97%	102%
Sepsis Screening - ED	Oct 25	95%	90%			86%	70%	101%
Sepsis IVAB - ED	Oct 25	90%	90%			84%	61%	107%
Sepsis Screening - Maternity	Oct 25	100%	90%			81%	55%	107%
Sepsis IVAB - Maternity	Oct 25	100%	90%			85%	47%	123%
Sepsis Screening - Childrens	Oct 25	94%	90%			90%	72%	108%
Sepsis IVAB - Childrens	Aug 25	100%	90%			79%	34%	123%

The Assurance icons refers to when we are consistently passing or falling short of our target and our data has been within or outside our agreed target range.

The icon will remain grey as long as we remain within the target range set (e.g. between the upper and lower limits) even if we have consistently exceed the target and the variability icon is

The icon will change to blue only when we are consistently passing the target and the target is outside the process limits.

The icon will change to orange when we consistently fall to achieve the target and the target is outside the process limits.

The Assurance icon is not an assurance statement on quality & safety of the service/care but on statistical confidence.

Related Strategy and Board Assurance Framework (BAF)

Quality Strategy

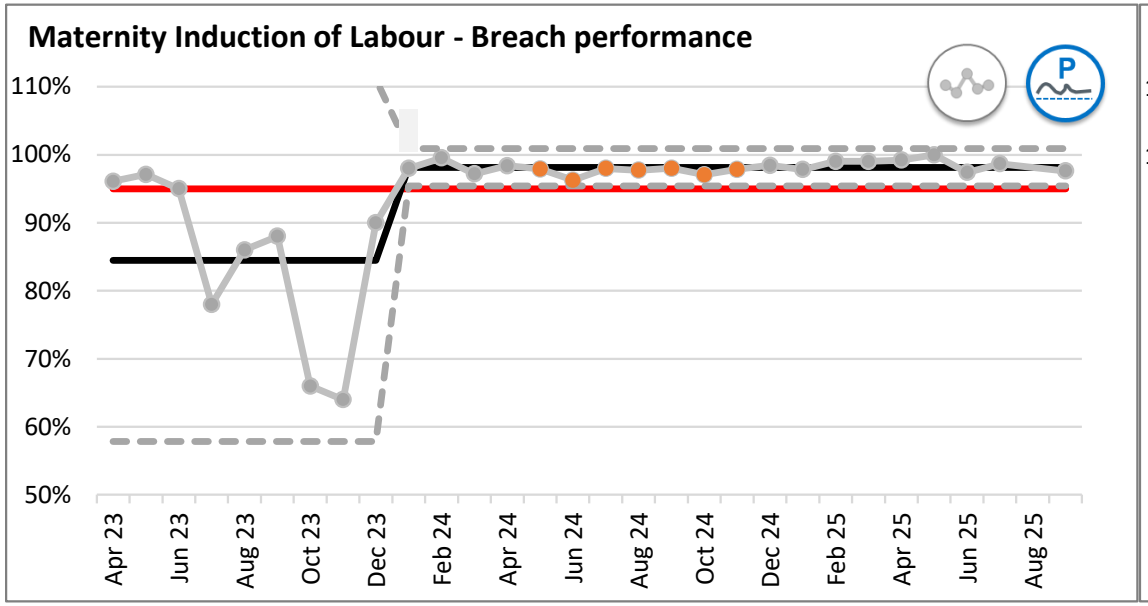
The best joined-up care for *all*

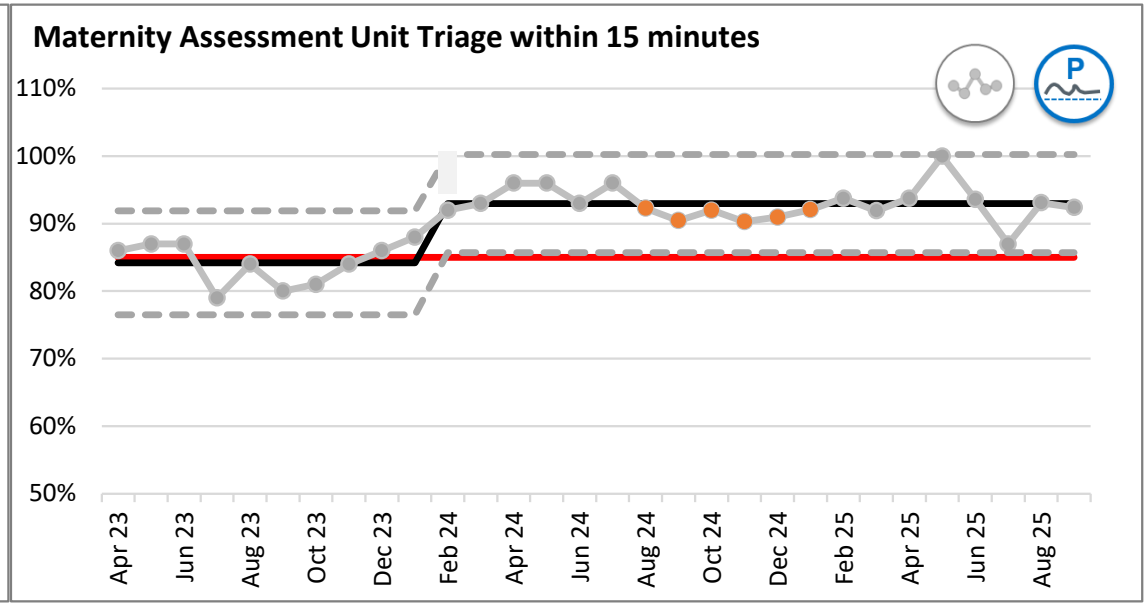
BAF Risk	Q1 (2025/26)		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 1: Delivering Positive Patient Outcomes	High 12	Acceptable	High 12	Acceptable				

Quality & Access | [Induction of Labour & MAU Triage]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is driving this performance?

The target of 95% for timely admission of women for induction of labour has been consistently achieved since January 2024, with October being 98.46%

Core IOL midwifery workforce provides consistency within the department to ensure on going timely admissions. Collaborative input with the Consultant Obstetricians to ensure the workload is organised and prioritised appropriately.

Ongoing IOL improvement group highlights any process changes that are required to ensure timely admissions. Consultant lead for IOL supports multi-disciplinary working.

The target set of 85% of patients to be seen within 15 minutes on MAU has been consistently met since December 2023.

The development of the MAU improvement group in December 2023 and implementation of actions have contributed to the improvement and sustained reduction in MAU breaches.

What are we doing about it?

Any IOL breaches are safety netted and incident reported for full review through the internal governance process. IOL Datix are grouped into an IOL Improvement group tab, allowing a refined audit & review with focus on IOL themes.
Any IOL breaches are discussed daily at the patient safety huddle and escalated. Admission will be offered prior to breaching when this is forecast. Prioritisation occurs daily by the on call Consultant Obstetrician for all IOL's booked for that day- this will include any deferred IOL.
All midwifery induction core vacancies now recruited. Additional recruited trained midwives will commence post in the unit from October sustaining progress made.

The MAU improvement group meet monthly to continue to discuss and sustain the driver metrics.
All MAU timing breaches are reviewed daily via audit and individual cases are investigated if evidence of potential harm.
MAU triage breaches are included in daily patient safety huddle and reported via the daily sitrep
The A3 will be refreshed to focus on sustainability of current performance. MSW and ward clerk staff are now fully recruited which aids flow through the department sustaining our improvement.

Quality & Access | [PSIs per 1000 bed days]

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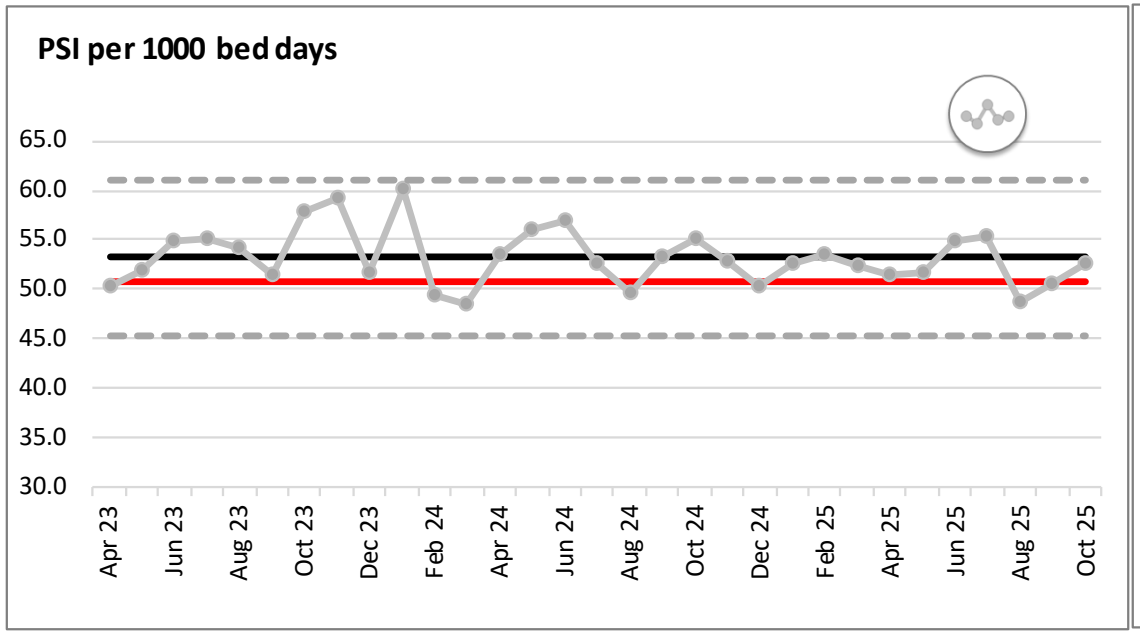

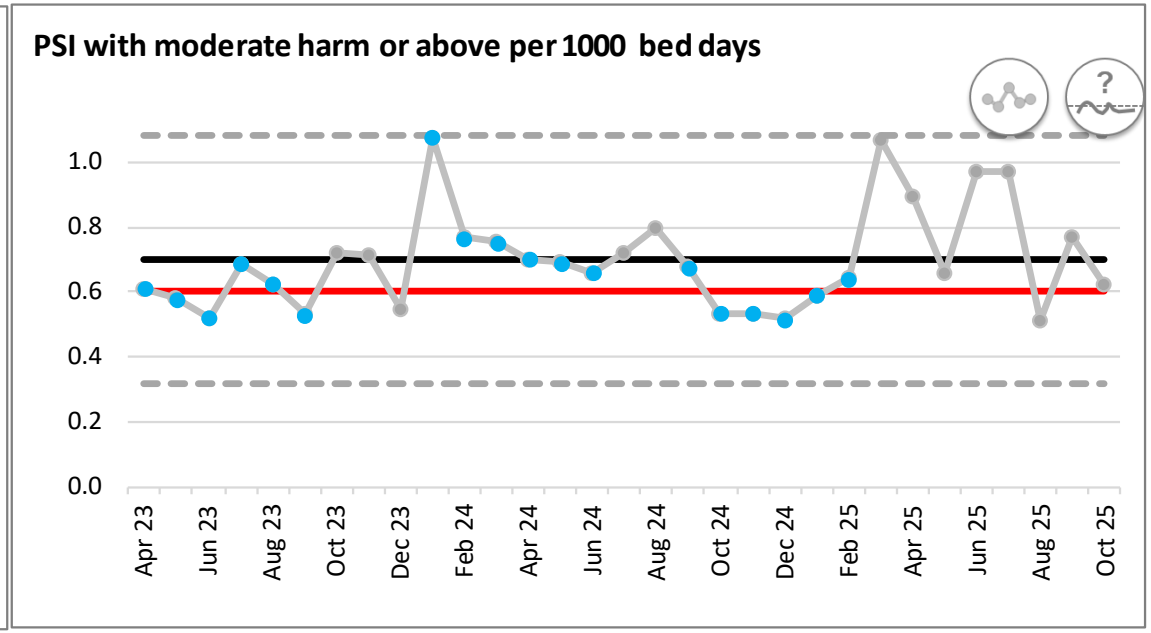

What is driving this performance?

The rate of PSIs reported as resulting in moderate harm or greater has varied considerably but the average remains consistent since 2024.

The most common Categories in the past 6 months were Treatment/procedure, Clinical assessment, Patient Falls and Medication.

The total PSI reporting rate within the Trust has stayed impressively consistent, preserving the enhancements and higher average rates established since October 2022. The introduction of LFPSE reporting and the extra questions required by NHSE in February 2024 did not affect the stability of reporting rates when compared to the same months of 2023.

What are we doing about it?

Reviewing harm profile and locations / categories for moderate harm and above incidents in relation to Endoscopy related incidents with the Directorate Team to determine impact on patients as result of changes in the sedation guidelines

We are continuing to complete thematic reviews to ensure wider learning is captured and actions to improve the quality and safety of care delivered are in place. These are Trust's Patient Safety Group and Quality, Access & Outcomes Group.

To utilise LFPSE data published to assess/benchmark our reporting and outcomes as soon as this is available. Noted that 99% of all NHS providers are now utilising LFPSE.

Quality & Access | [Patient Falls]

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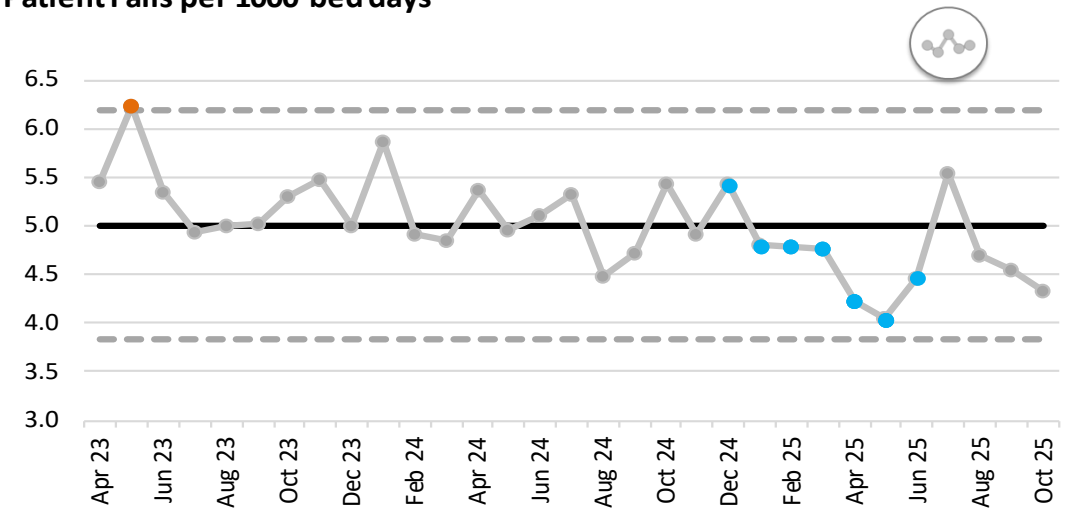
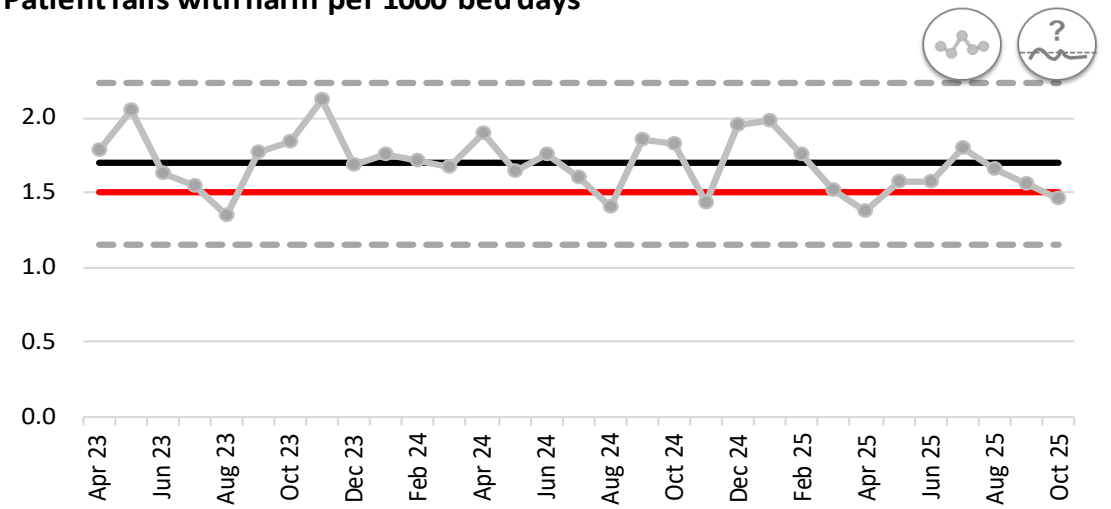
Patient Falls per 1000 bed days



Patient falls with harm per 1000 bed days



What is driving this performance?

The average rate of reported patient falls per 1000 bed days was within the usual range in October 2025. The rate of patient falls resulting in harm has remained consistent since June 2023.

Top reporters in October 2025: Stoke AMU – 15 falls, Stoke ED – 11 falls, Ward 12 – 9 falls, Short Stay Unit – 8 falls.
None of these numbers for October were significantly higher than in previous months.

2 falls resulting in a serious injury were reported in October, on the following wards: Ward 122 (n=1), Ward 201 (n=1).
It is important to note that a fall resulting in serious injury does not automatically raise red flags for any ward. Each incident is investigated to determine whether adequate precautions were implemented, and the findings are summarised on the right.

What are we doing about it?

Tendable audits have been completed on the 4 top reporting areas by the Q&S team and the results were discussed with ward/dept staff at the time of the visit. Observational Tendable audits continue.

Both serious injuries involved patients that were independent with ADL's and no concerns with cognition. Both patients had falls whilst leaving the toilet.

One patient became lightheaded and fell (no postural drop).

One patient stumbled and fell.

Toolkits were completed; one ward had no actions to complete and the other had 1 action regarding neuro-observations.

All facets of falls prevention were discussed at the time.

Quality & Access | [Medication Incidents per 1000 bed days]

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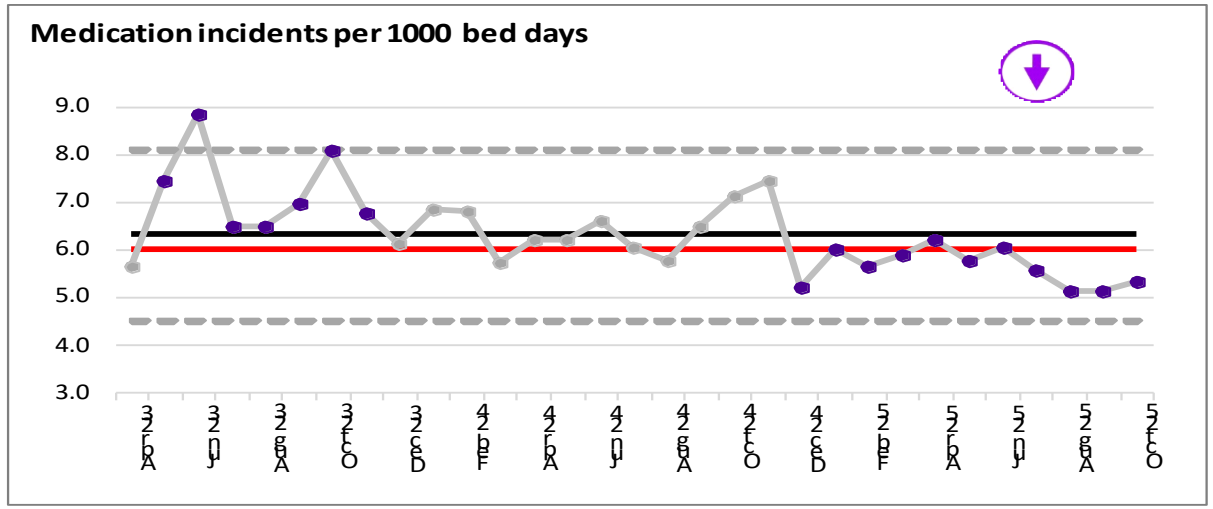

What is driving this performance?

The rate of reported medication-related incidents appears to have been on a downward trajectory since 2023.
NB: The rate was significantly lower before 2023 – average 5.0 incidents per 1000 bed days, so the latest rates are just returning to the previous normal range.

What are we doing about it?

A. Extensive pharmacist and pharmacy technician support for the ePMA roll-out is on-going.
B. Low molecular weight heparin switch from Dalteparin to Enoxaparin. While this provides a timely financial opportunity, this also reduces the risk of future drug shortages which would create a significant patient risk.

3. New skills sessions provided at the end of the summer for F1s and F2 feeding in learning from prescribing themes (e.g. warfarin and DOACs, which medicines to stop / continue when a patient is receiving VRII / FRII, opioids & opioid toxicity, penicillin allergies, safe use of paracetamol, interactions and adverse drug reactions.
4. Session for 63 Ward Managers, Matrons & Quality Nurses re improving medicines CEF compliance, shared good practice, expert advice provided.
5. Controlled Drug audit and Theatres Controlled Drug audit reports completed – await report.
6. Leadership and specialist advice provided regarding:

A. Codeine losses – an area with a previous issue has issues again. Risk assessed & further restrictions implemented urgently. No intelligence on a person of interest.
B. Two prescriber concerns: one has now been referred for formal investigation re potential misappropriation of FP10s, the other is under formal HR investigation around prescribing medicines not permitted for a supplementary prescriber.

Quality & Access | [Medication Incidents % with moderate harm or above]

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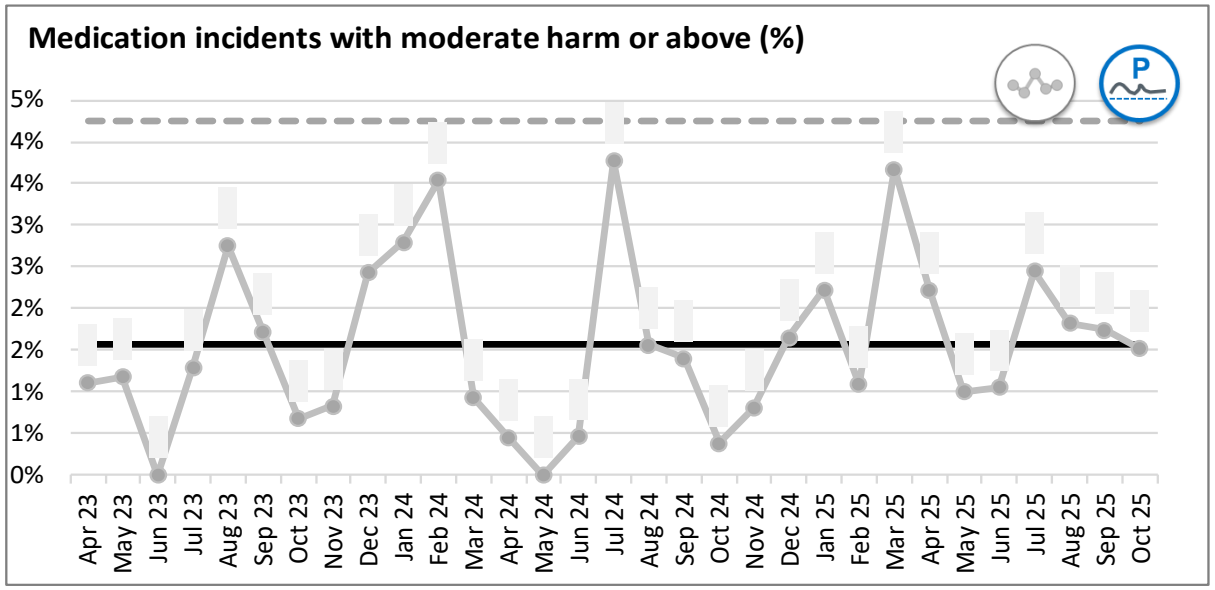


What is driving this performance?

In October 2025 there were three incidents were reported that resulted in moderate harm, which falls within usual monthly variation and remains consistently below the benchmark rate, offering positive reassurance that this standard is being met.

What are we doing about it?

The reported incidents are reviewed and assessed, along with input from the relevant clinical areas to share learning and actions.

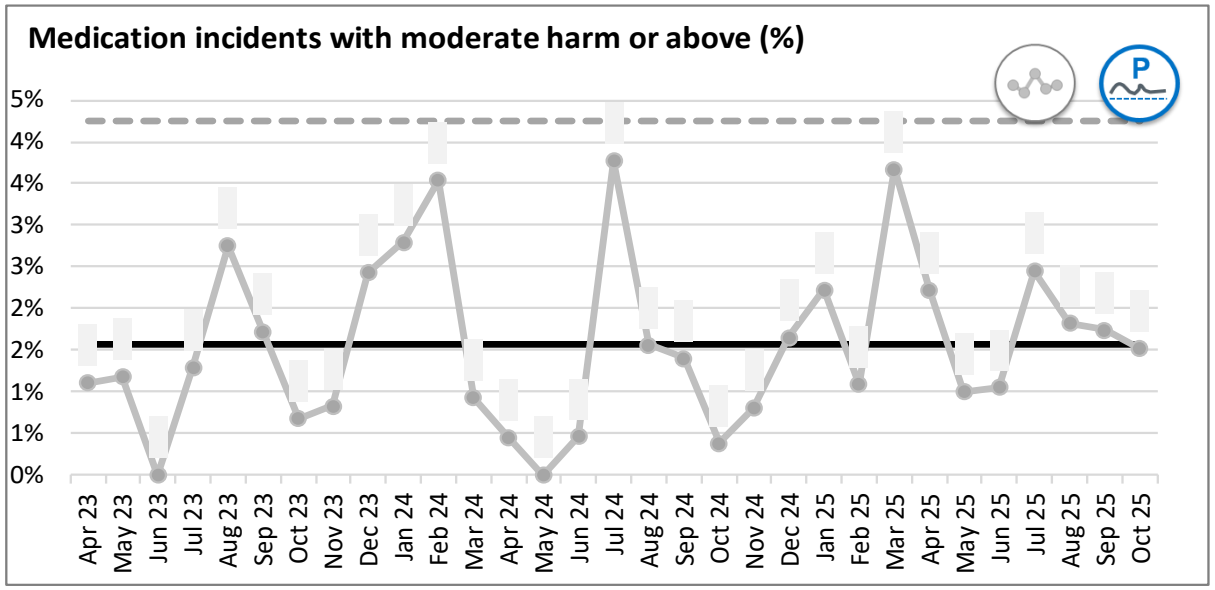
Learning is shared and where applicable learning alerts issued to raise staff awareness of issues related to medications / medicines

Kind Excellent Together

Quality & Access | [Medication Incidents % with moderate harm or above]

Provide safe, effective and caring services

University Hospitals of North Midlands



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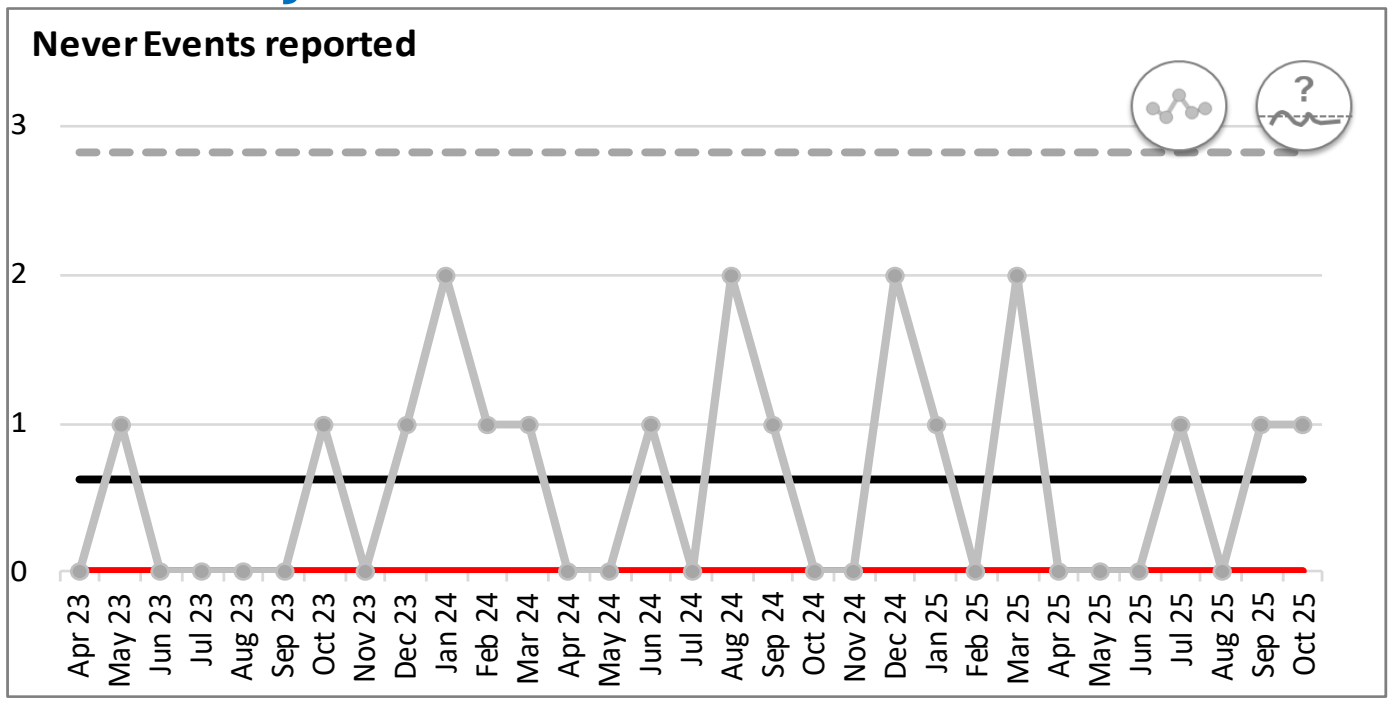
ID	Incident date	Location	Sub Category	Description	Action Taken
381840	11/10/2025	Neonatal Unit (NICU)	Incorrect strength of infusion	Incorrect dose of Tazocin administered via infusion. Was to be given sterile due to going through a long line. Equipment prepared, purple folder for instructions on how to make up read. Realised within an hour of making up that we had not diluted the second time so the amount given had been from the first reconstitution value.	Recorded within medicines management thematic review. Staff nurses able to demonstrate sound reflection and learning from this incident. Shared with wider NICU Team as "Learning from Datix"
384965	12/11/2025	Ward 113 - Respiratory Medicine	Contraindication due to interactions with other medications	Patient prescribed clarithromycin, patient also on Tacrolimus. Clarithromycin can increase tacrolimus levels. Clarithromycin may have caused the increase in levels and may have caused this patients clinical condition to worsen.	Renal team recognised on 26/10 that clarithromycin should not be given with tacrolimus and stopped it then. They also reduced the tacrolimus dose and continued to monitor and advise regarding this patient.
384049	03/11/2025	(County) Pharmacy Dispensary	Incorrect dose	Incorrect dose of Bumetanide dispensed in a venalink. Patient was prescribed 2mg BD but only 1mg BD was dispensed.	Dispenser (labelled) - changed process and will now ignore the drug strength that comes before the actual dose to eliminate the confusion. This will prevent this type of error from happening again. Dispenser (Filled VL) - Self check before popping VL ACT Raised issue and the TTO template has now been changed to make the drug and strength distinguishable from the dose. This should reduce the confusion caused by the TTO layout. This has been shared during team brief and in the monthly learning from errors newsletter to allow for wider team learning.

Kind Excellent Together

Quality & Access | [Never Events per month]

University Hospitals of North Midlands NHS Trust



What is driving this performance?

There was 1 reported Never Events during October 2025 which related to incorrect prosthesis used during total hip replacement in August 2025. No harm recorded and notified of error following call from patient after left clinic.

What are we doing about it?

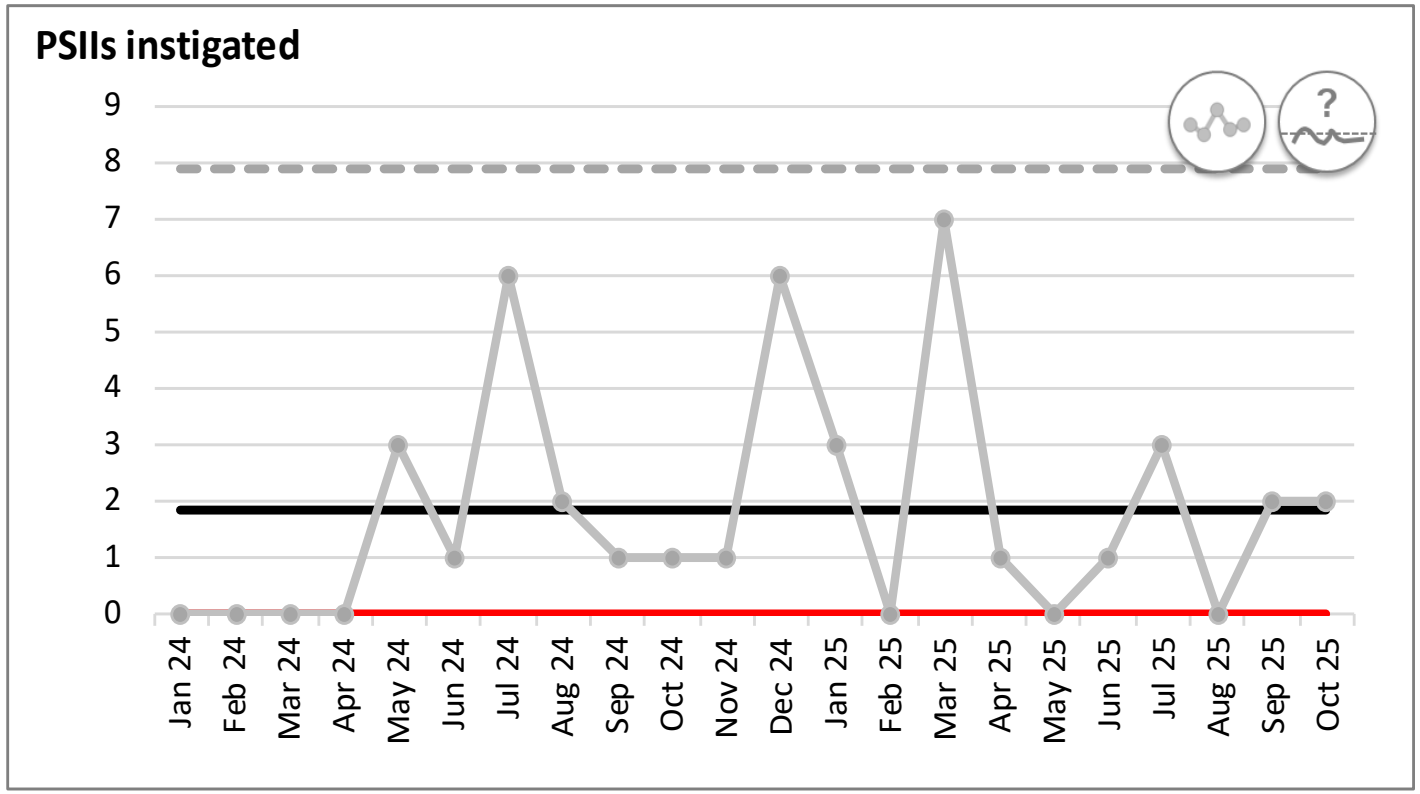
The latest incident identified following review of data for submission to the National Joint Registry. Identified that the implants used were not the intended size. The acetabular (cup) liner was 36mm and the corresponding articulating femoral head was 32mm and smaller than planned. Patient has been met with in clinic and noted that the hip is performing well but also explained about the error and patient agreed to correct the error and revision procedure to be undertaken to remove the 32mm head and insert correct 36mm head.

Under new Never Event guidance an After-Action Review is being undertaken. Learning will be shared with patient and across the Directorate , Care Group and Trust via relevant quality and safety forums.

Previously reported Never Events are under review and will be reported to Risk Management Panel.

Quality & Access | [PSIIs per month]

University Hospitals of North Midlands NHS Trust



What is driving this performance?

We have reported 2 new PSIIs during October 2025 including the Never Event noted. The second PSII reported related to patient with spinal cord injury suffered cardiac arrest with potential impact of delay in catheter change and drainage of bladder.

What are we doing about it?

Incidents have initial reviews completed and PSII's agreed as per national reporting guidance for MNSI and PMRT cases, Never Events and concerns raised via complaint for treatment delays.

PSII agreed following initial review of the incident and competed mortality review. Independent response leads have been appointed to review systems and process learning.

Quality & Access | [Duty of Candour]

University Hospitals of North Midlands NHS Trust

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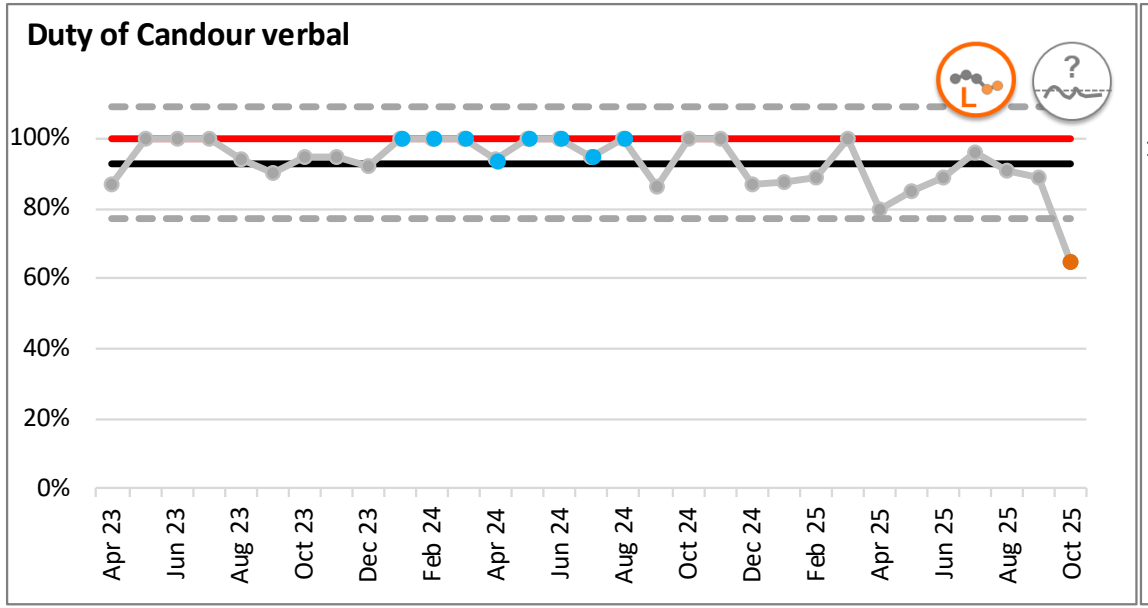

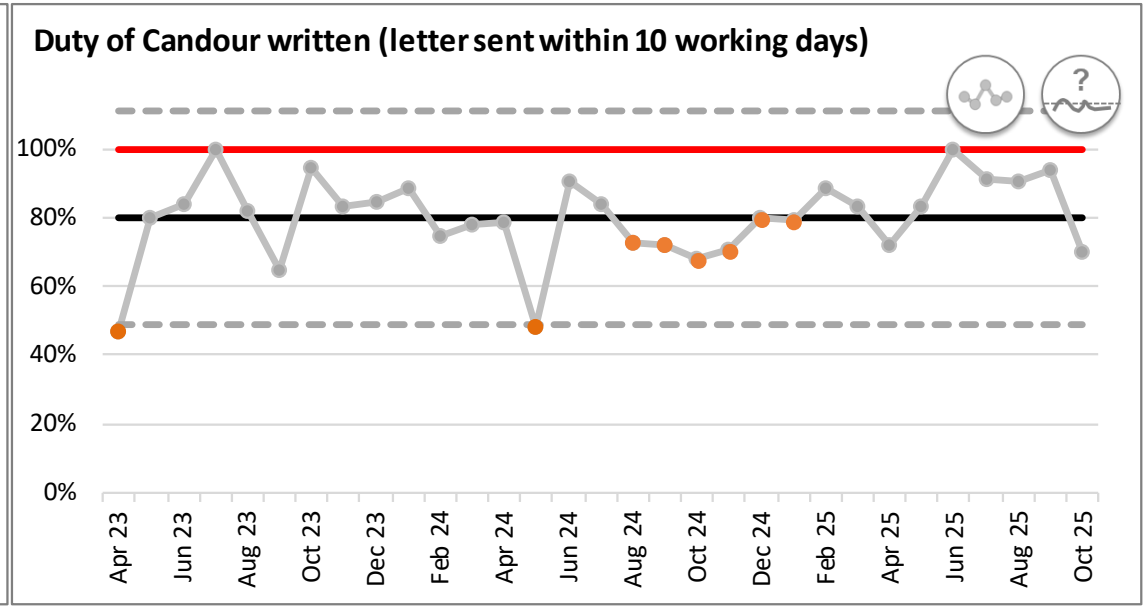

What is driving this performance?

Verbal Duty of Candour is not always consistently documented in Datix.

11 out of 17 incidents that formally triggered duty of candour in October. (64.7%) have had verbal discussions recorded within Datix. CSS care had 6 late verbal notifications. Out of the 17 cases, 12 of them met the 10-working day internal target (70%). There were 5 cases breaching: 3 in CSS and 2 in Planned Care, conflicting demands not enabling them to use management time to undertake these tasks as the main reason, the letters were all sent outside of the time frame.

Compliance with documented provision of Duty of Candour letters to patients and/or their relatives within 10 working days of identifying an incident has averaged 80% since May 2023.

What are we doing about it?

We are continuing to work with individual areas and with Divisional Teams to continue to raise the importance of undertaking verbal and written Duty of Candour, documenting in Datix and being open with patients and their relatives when things go wrong.

Teams are reminded that evidence of verbal Duty of Candour must be recorded in Datix and notes to demonstrate that conversations have been completed. When reviewing and discussing with staff the discussions are being held but these are not always being appropriately recorded in Datix.

Work is underway to develop a structured note on iPortal. Audits are now being undertaken quarterly.

Quality & Access | [Pressure ulcers developed under UHNM care]

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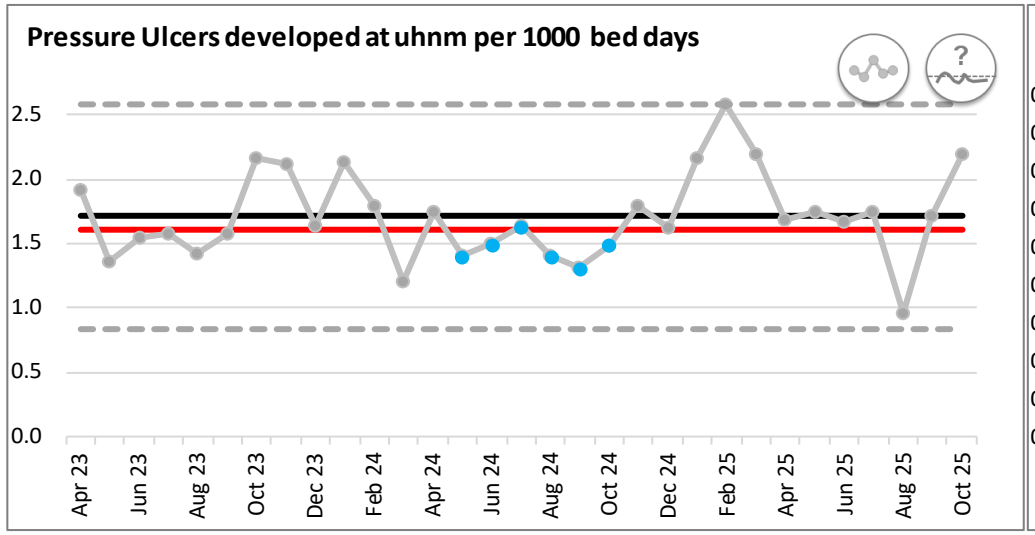

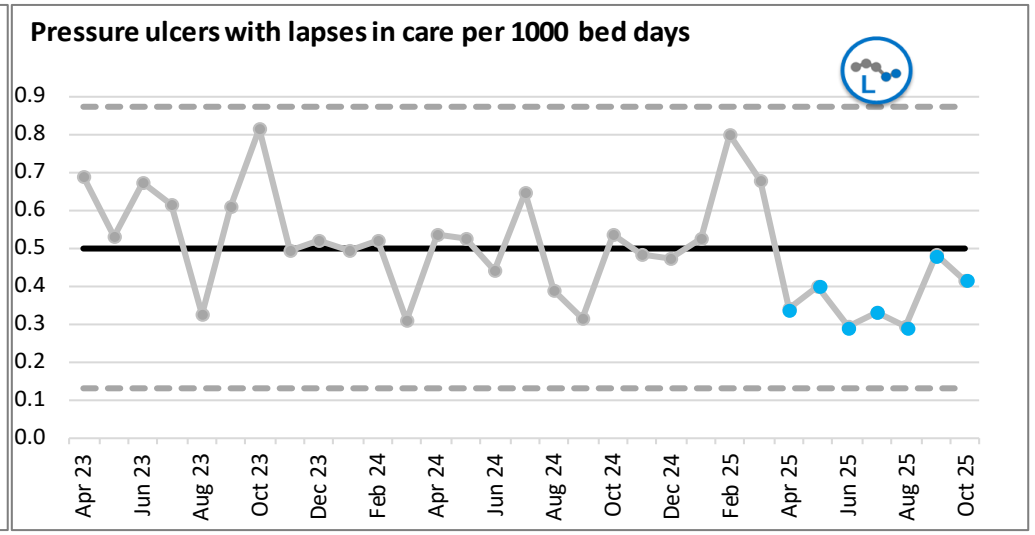

Type of Lapses Oct 2025	Total
Management of repositioning	7
Management of heel offloading	4
Management of device	3

What is driving this performance?

The rate of pressure ulcers reported as developing under UHNM care was within the usual range in October 2025. Each specific category of pressure damage were also within normal limits.

The rate of pressure ulcers with lapses in care identified has been below the average for 7 consecutive months, based on cases reviewed as of the 3rd of the month, which may indicate significant change.

On average, lapses in care have been identified for approximately 30% of the pressure ulcers reported as developing under UHNM care since April 2022.

7 urethral splits were reported in October 2025, 3 of which were noted to have lapses in care (2 TBC). This is consistent with numbers seen since Jul-24.

What are we doing about it?

The ESR education package has been utilised on AMU padlet (information platform). If successful, will be shared further.
Skin Health booklet now available to order. Educational video completed and shared with teams on how to complete the booklet. The electronic wound assessment is also now live.
Rep for Frontier (Repose products) has been attending wards to deliver education on the product
Independent Tendable audits for pressure prevention will complete re-auditing in October
The trust mattress audit will be completed in October with support from the company
Prompt cards being printed for staff to include categorisation, pressure prevention and pathways
Preparations being made for Stop the Pressure in November
Champions programme continues with the next session being wound assessment
Toolkits being completed for pressure ulcers with lapses in care where areas will create an action plan.
Category 2's with lapses in care will now be part of a thematic review. This will be shared with each care group.
HFCE has commenced education within ED Stoke
ED are completing a thematic review and to have one action plan to manage the increase of incidents. The action plan will be presented at steering group
Multiple reporting areas attend steering group to discuss improvements being made and share learning. Areas will have visits from the Quality and Safety team prior to attending.
Observational audits have been completed on areas where concerns have been voiced.

Quality & Access | [HAI E.Coli Bacteraemia cases per month]

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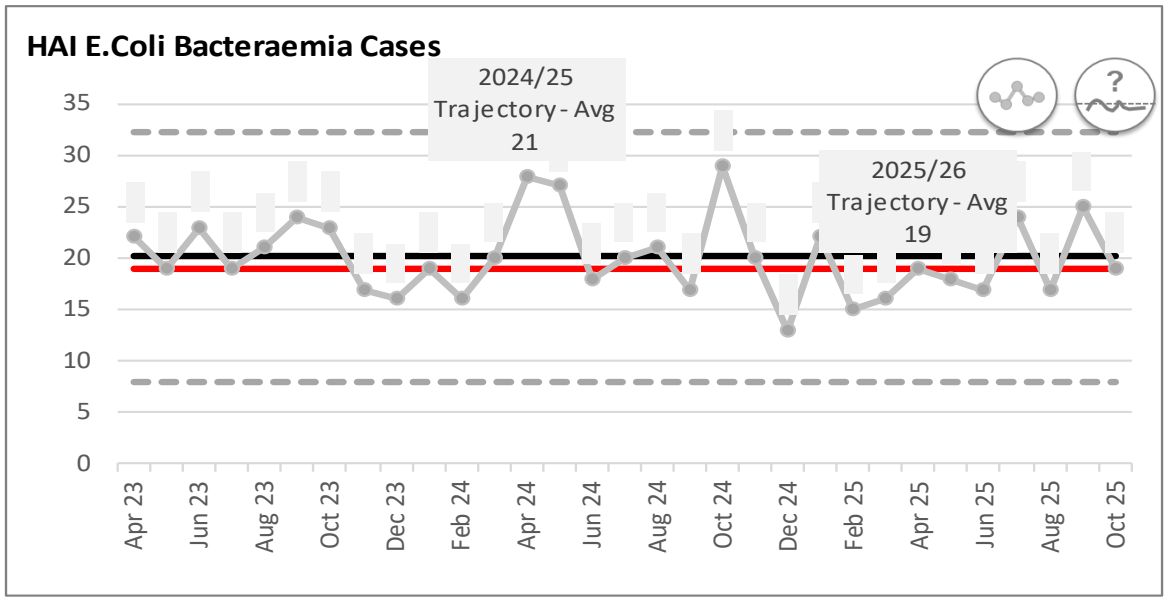

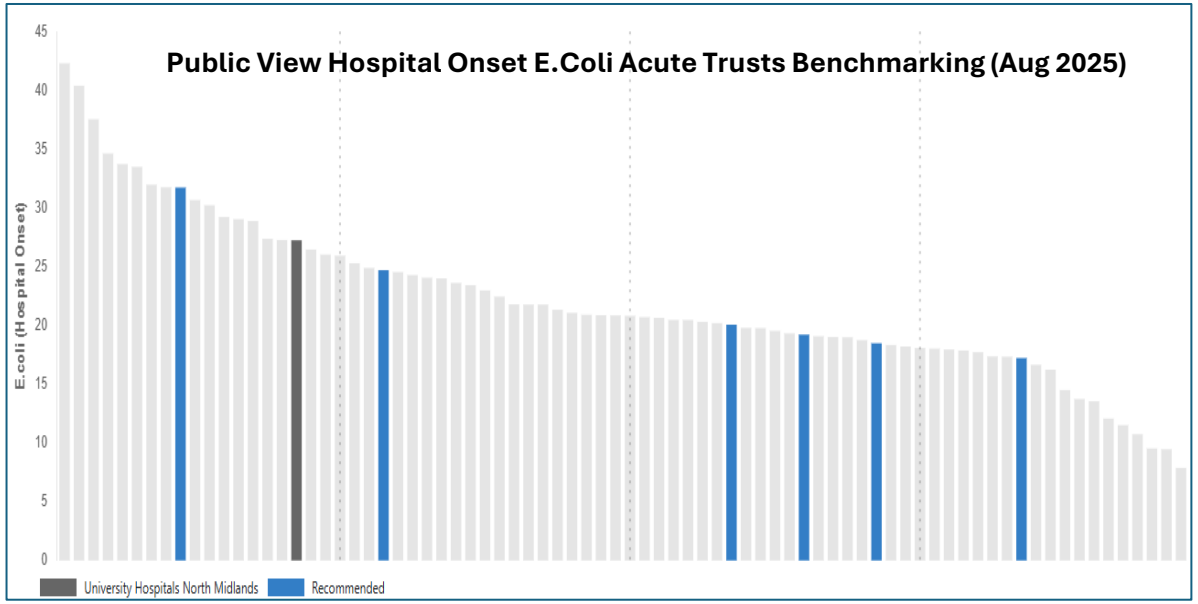

What is driving this performance?

The average monthly number of E.coli cases has stood at 20 since 2022, just above the 2025-6 upper limit, and the number of cases identified in October 2025 was within the usual range.

The target trajectory for 2025/26 has been provided by NHSE, setting a maximum monthly average of 19 cases. As in previous years, this figure encompasses both Hospital-Acquired Infections (HAI) and Community-Onset Healthcare-Associated Infections (COHA).

As at October 2025 we have had 140 Trust apportioned cases (79 * HAI and 61 * COHA) versus a year to date upper limit of 135 (3.7% over the upper limit).

What are we doing about it?

ICB-wide (and nationally) E.coli rates are also high and have been awarded a grant to look into potential reasons for these higher than expected rates. There is now a Health Economy stream for e coli work to identify what our root causes are and if they match national themes.

Additionally, the ICB have established a T&F group to look at urinary tract infections. Updated national guidelines for UTIs have been issued to both primary and secondary care.

We are also reviewing patient blood results to check for indications of dehydration. There is also an ongoing collaborative work around CAUTI with external colleagues.

Quality & Access | [Avoidable MRSA Bacteraemia cases per month]

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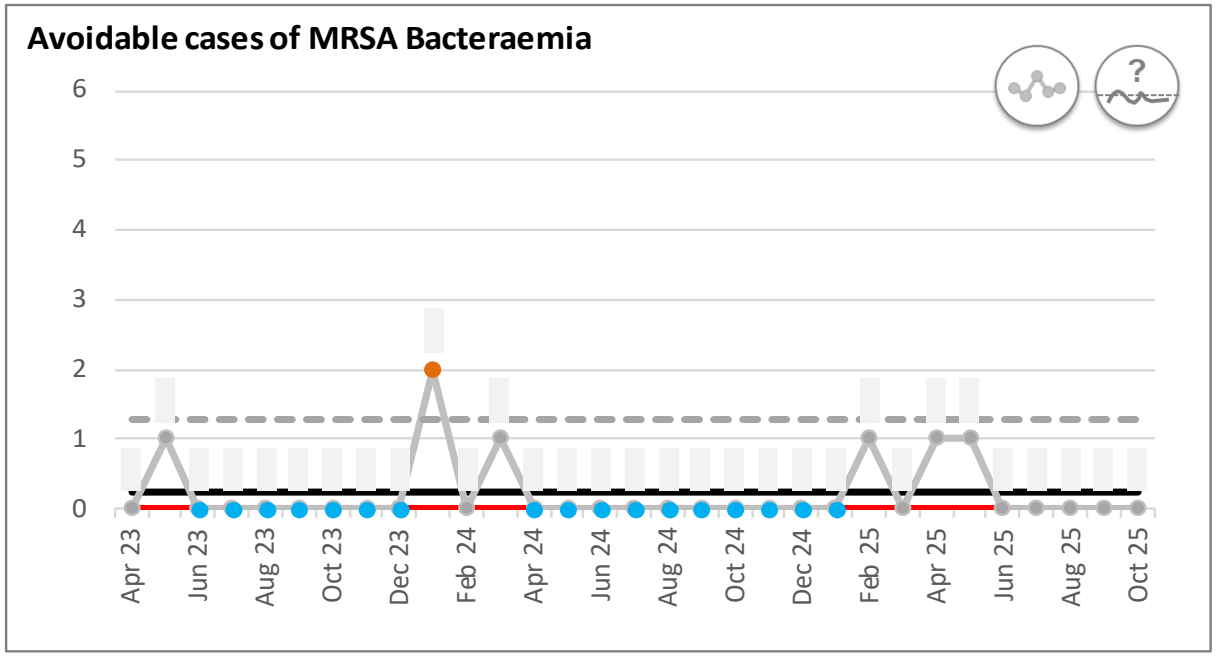

What is driving this performance?

No MRSA Bacteraemia cases reported since May2025.

What are we doing about it?

MRSA screening education continues. Focus IP audits for MRSA screening, decolonisation and PVC care are still on-going.

Continued surveillance for MRSA with immediate implementation of control measures to prevent transmission.

Following a post infection review for the case in May a MRSA screening alert has been issued trustwide, and the Maternity MRSA guidelines have been reviewed and updated.

Quality & Access | [Reported C Diff cases per month]

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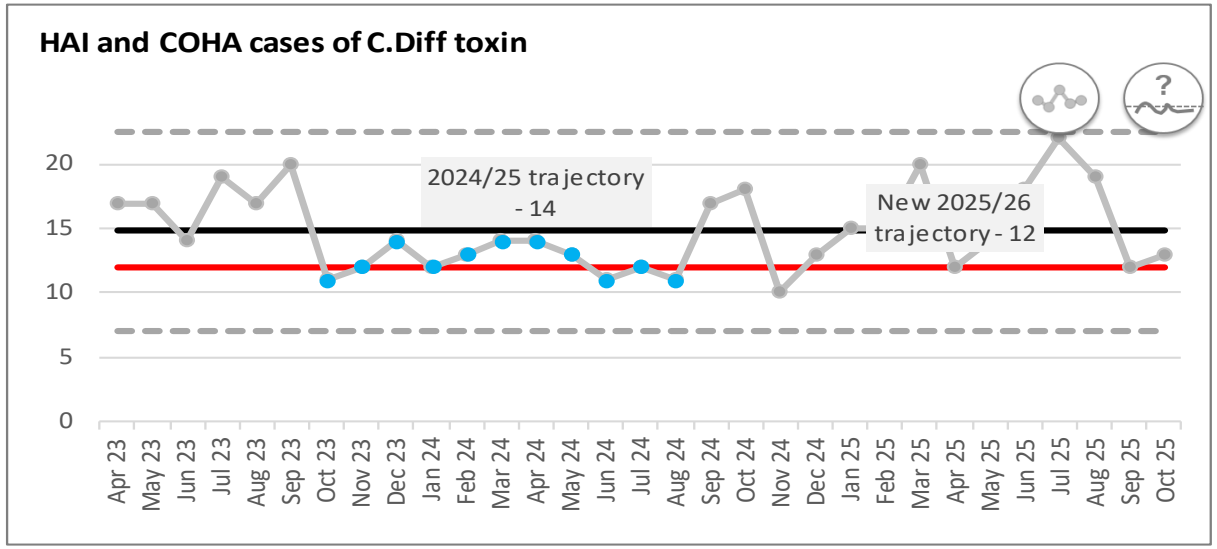

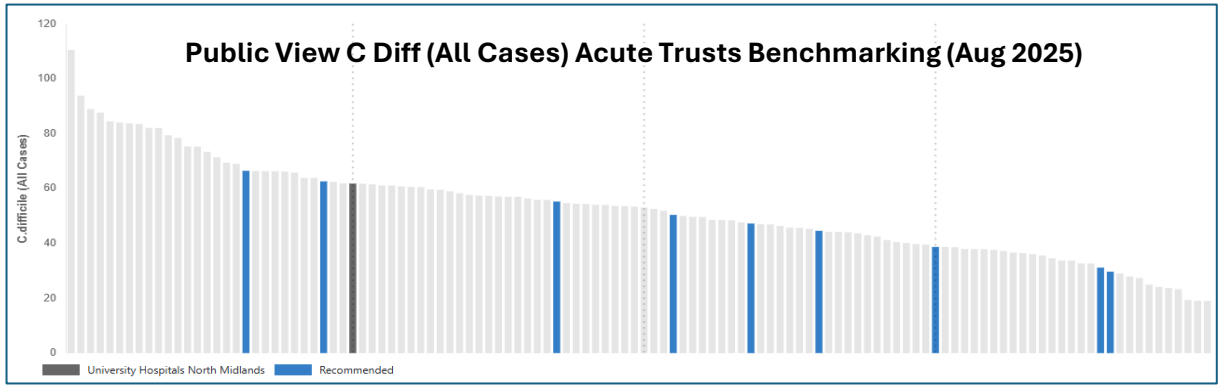

What is driving this performance?

The monthly number of C-Diff cases was within the usual range in October 2025. C diff has been declared a National Incident by the UKHSA due to the increased number of cases throughout England; work is ongoing to try to understand the reasons behind this.

There have been 13 reported C diff cases in October 2025 - 7 x HAI and 6 x COHA
There has been one period of increased incidence reported in October with 2 HAI cases.

The 24/25 objective for C-Diff is 179 cases or less.
The 25/26 objective for C-Diff is 144 cases or less. This was released in June 2025.
As at October 2025 we have had 110 Trust apportioned cases (69 * HAI and 41 * COHA) versus a year to date upper limit of 84 (31% over the upper limit).

What are we doing about it?

- Routine ribotyping of samples continues for samples from areas where we have periods of increased incidence only
- CURB -95 score added to CAP antimicrobial Microguide (Eolas)
- Antimicrobial working group to remind clinical areas to send urine samples when UTI is suspected and ensure appropriate choice of antibiotic for treatment of UTI
- Additional oversight of C-Diff cases is being implemented where there is potential learning in terms of antibiotic use
- Big bed clean commenced from 9th July 2025 & repeated in Oct 2025 IP week
- PSIRF process and monthly themes report
- Weekly AMS presence at County to support antimicrobial prescribing

Commode cleaning day completed January 2025 and October 2025. Aim for twice yearly.

- The existing Pneumonia guidelines were reviewed, revised and ratified through ASG and launched to prescribers in early January. Key changes involve the reduction in the use of Co-Amoxiclav in CAP, with a focus on using the narrower spectrum oral antimicrobials where possible or a prompt IV to oral switch
- There has been a deterioration in the number of late sampling for patients admitted with diarrhoea resulting in classification as hospital onset.
- There has been several repeat sampling of known C diff cases outside the 28-day period resulting in a patient being included multiple times

Quality & Access | [NPSA Alerts received and overdue]

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University Hospitals of North Midlands NHS Trust

New Alerts received:

Year	Alert Type	CAS Status	Alert Reference Number	Alert Title/Device	Date Issued	Deadline Date	Comments	Actions

Open / Overdue Alerts:

Year	Alert Type	CAS Status	Alert Reference Number	Alert Title/Device	Date Issued	Deadline Date	Comments	Actions
2023	Nat/PSA	Overdue	Nat/PSA/2023/010 MHRA	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls.	31/08/23	01/03/24	Awaiting final confirmation of updated ESR Stat & Mand training from the Mandatory Learning Oversight Group. When confirmed the alert will be closed. Extraordinary meeting planned to review training.	ESR Training to be updated
2025	Nat/PSA	Open	Nat/PSA/2025/005/NHSPS	Harm from delayed administration of rasburicase for tumour lysis syndrome	09/09/25	09/03/26	Pharmacy liaising with various areas within the trust. i.e. emergency care, Haematology/Oncology, Critical Care.	

Closed Alerts:

What is driving this performance?

In October 2025, UHNM received 0 new Patient Safety alert.
At present, there are 2 NHS Patient Safety Alerts that remain open and 1 of these remains overdue
The overdue alert has been addressed, and actions are ongoing to ensure that the necessary requirements of the alerts are being effectively implemented.

What are we doing about it?

Nat/PSA 2023/010 MHRA is awaiting final approval for the Bed Rails Training to be back on ESR and part of Stat & Mand training. Approval awaited from Mandatory Learning Oversight Group

The overdue alert has agreed action plans in place and assurances have been received that actions are being taken. CAS / MHRA website are updated with progress

Quality & Access | [Friends & Family Test - Inpatients]

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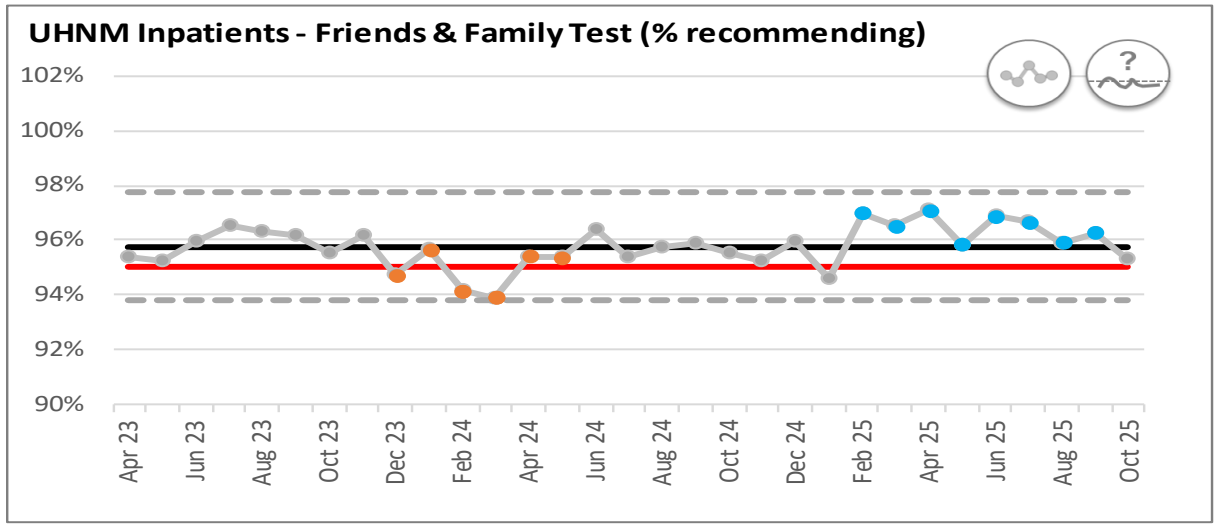
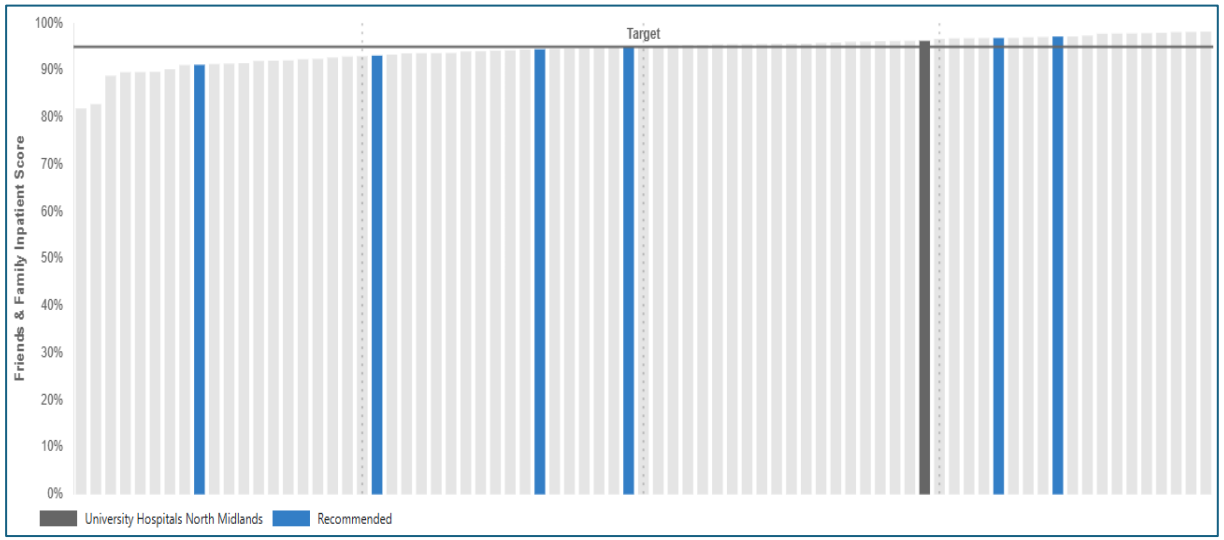


Public View FFT Inpatients Acute Trusts Benchmarking (Sept 2025)



What is driving this performance?

The monthly satisfaction rate for inpatient areas was within the usual range in October 2025. The average rate remains above the national average of 94% (Sept 2025 NHS England).

In October 2025, a total of 2848 responses were collected from 65 inpatient and day case areas equating to a 24% return rate, which is close to the average for the past 12 months.
Average Care Group Scores are as follows:

- Unplanned - 19% response rate, 96% satisfaction score
- Planned - 39% response rate, 96% satisfaction (30% response target met since Nov-23)
- CSS (excluding Maternity, see separate slide) - 25 % response rate since Apr-25, 99% satisfaction score

CSS's response rate (Children & young people's Directorate) has been significantly higher on average since Apr-25.

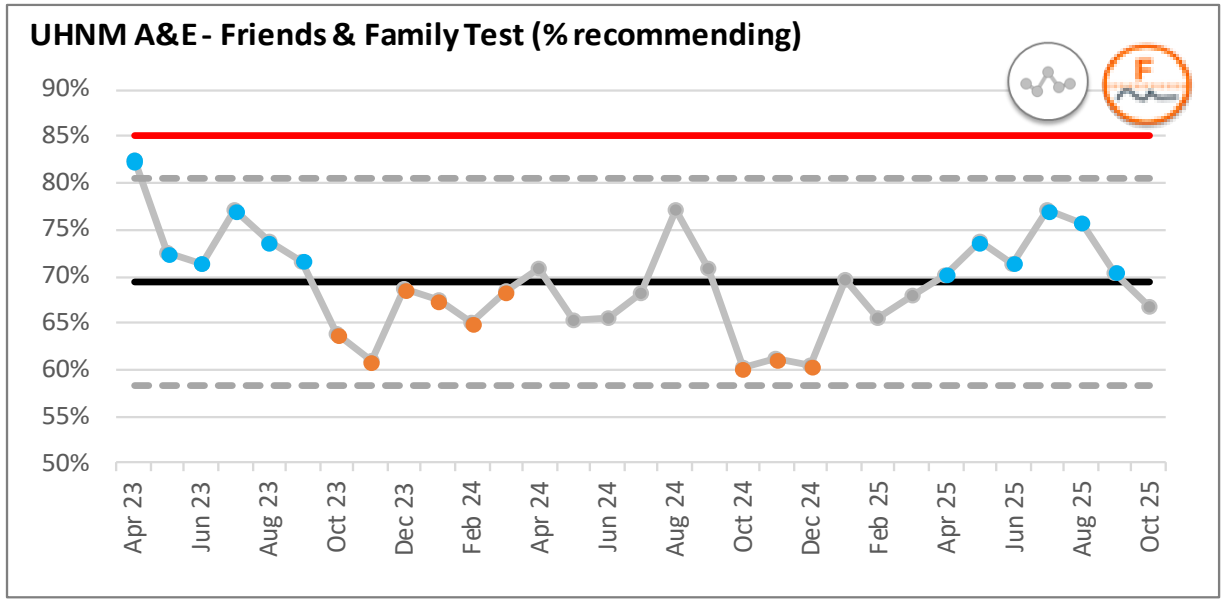
What are we doing about it?

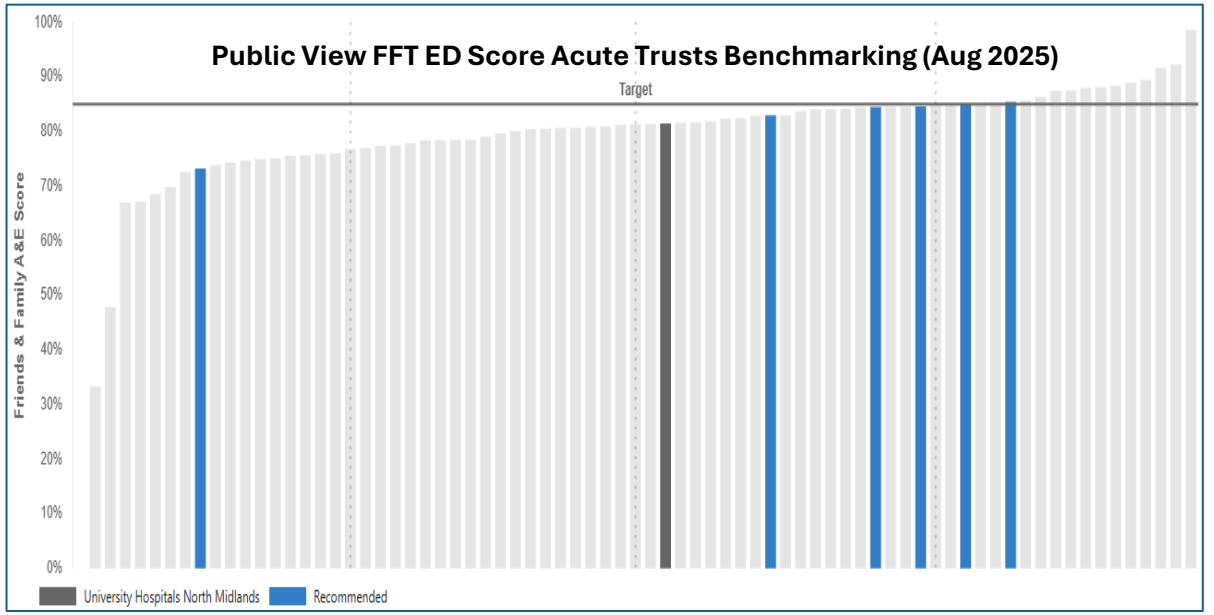
Following the trial period, a simplified survey will now be used in all inpatient, Emergency Portal and Daycase areas containing the mandatory "Overall, how was your experience of our service?" with the 6 response options ("very good" through to "very poor" or "don't know".)
We have included Recommendation Rates on our Quality Dial of The Day Dashboard.
RAG rating is simplified to show just response rate and recommendation rate.
Review each Clinical Care Group scoring and identify areas for improvement.
Work continues around a suite of patient priorities based on patient feedback:
Timely medications- a new task & finish group has been started to include Patient Rep and PSP
Pain management
Involvement in care and decision making
Improving the experience of our oncology patients

Quality & Access | [Friends & Family Test - ED]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is driving this performance?

The Trust received 975 responses in October 2025 - a 10% response rate which is within the usual range. Satisfaction rates remains somewhat below the national average of 79% (NHS England Sept 2025) and have varied considerably over the past couple of years.

UHNM is 29th out of 120 Trusts for the number of responses in ED and 47th out of 124 Trusts for the percentage positive results (NHS England Sept 2025).

Themes for improvement from Oct 2025 continue to be long waits for both sites. With communication being a focal point for improvement specifically relating to expectations and wait times. ED Matron has actions she is working on with the team specifically relating to communication.

What are we doing about it?

- The digital system is not able to support more than one submission point each survey as each submission would then become a new survey. Therefore, to simplify, a trial period commenced from Feb 25 with the "ED Survey" now only containing the mandatory "Overall, how was your experience of our service?" with the 6 response options ("very good" through to "very poor" or "don't know". This commenced end of January 2025.
- QR code made visible throughout the department.
- Consideration to alternative methods of sharing QR code such as “business cards” available on reception and throughout the department.
- Dept Leads to consider how to make improvements with regards to communication in relation to staff attitude and patients feeling dismissed.

Quality & Access | [Friends & Family Test - Maternity]

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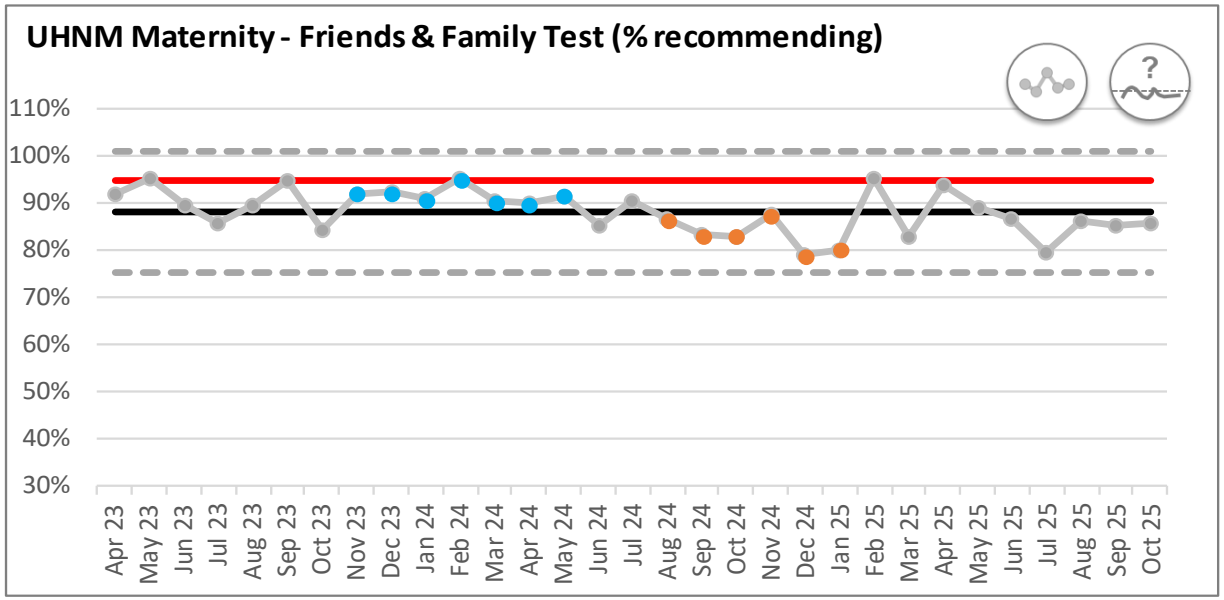

What is driving this performance?

The average % recommending has remained around 89% since 2023, a little below the 95% target. Nationally, the overall recommend rate is 92% (Dec 2024 NHS E).

There were a total of 122 surveys received in October 2025 across all 4 touch-points (ante-natal, birth, post-natal ward; post-natal community) with 38 of these being collected for the "Birth" touch-point, making the response rate 7% which was close to the usual average. The average satisfaction scores are Ante-natal: 81%, Birth: 90%, Post-natal ward: 90%, Post-natal community: 92%. No significant shifts or trends are currently evident in any of these satisfaction scores.

What are we doing about it?

Continue to monitor the efficacy of collecting feedback via text message
Proposal put forward for "business cards" with QR code. Waiting confirmation from Management team.

Look at incorporating the questions from the National Maternity Survey which requires the most improvement into the FFT survey.

Discuss with management team with regards to increasing survey completion for post-natal community

Quality & Access | [Complaints Response Time]

Provide safe, effective and caring services

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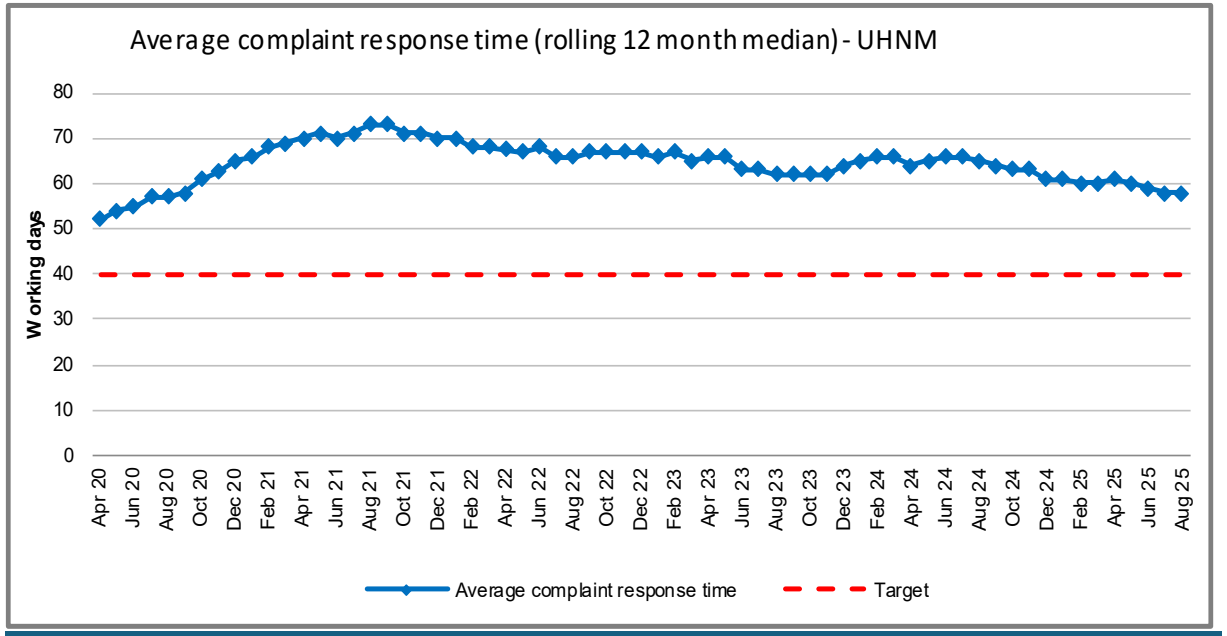

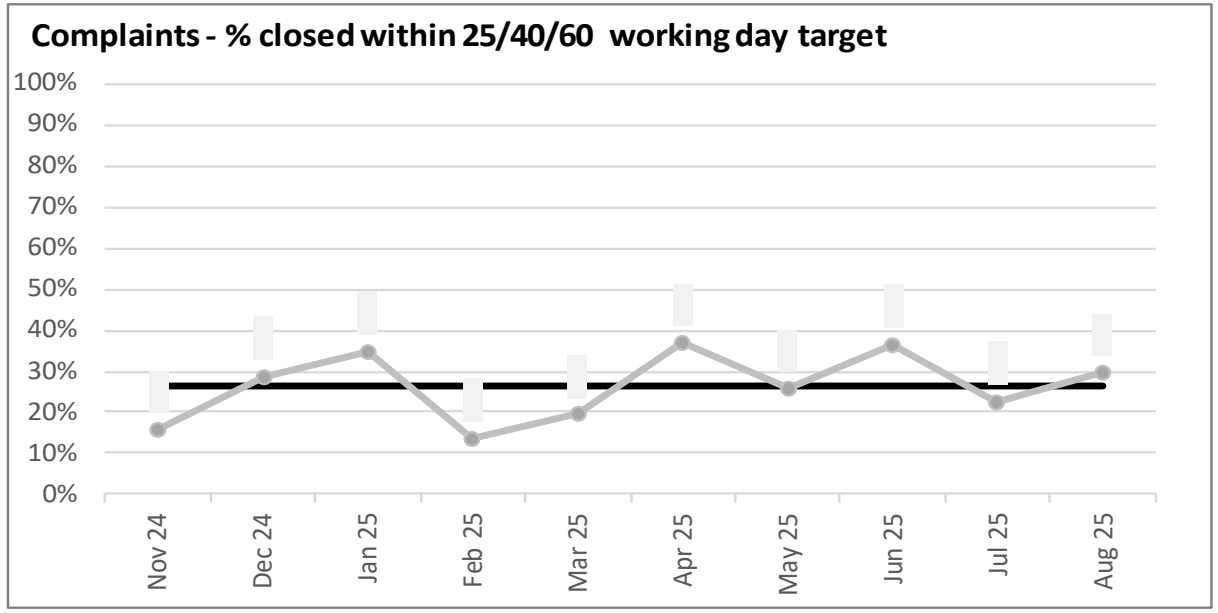

What is driving this performance?

91 complaints were closed in October 2025, with a median average response time of 56 working days.
The chart shows the average complaint response time peaked in 2021 but has been on a downward trajectory since mid 2024, though it remains some way above the 40 working day target.

255 complaints were open at the end of October 2025, of which:

- 10 had been open longer than 12 months
- 12 had been open 6 – 12 months
- 63 had been open 3 – 6 months

- Since November 2024 complaints received have been assigned a target resolution time of 25/40/60 working days, and as of the first week of November, 27% of complaints opened between November 2024 and August 2025 were closed within target.

What are we doing about it?

An updated reporting structure has been implemented to more accurately capture at what stage open complaints are within the formal process.
New Complaints Policy includes complaint response times triage.
Formal Escalation process enacted to support with response times.

Quality & Access | [Timely Observations]

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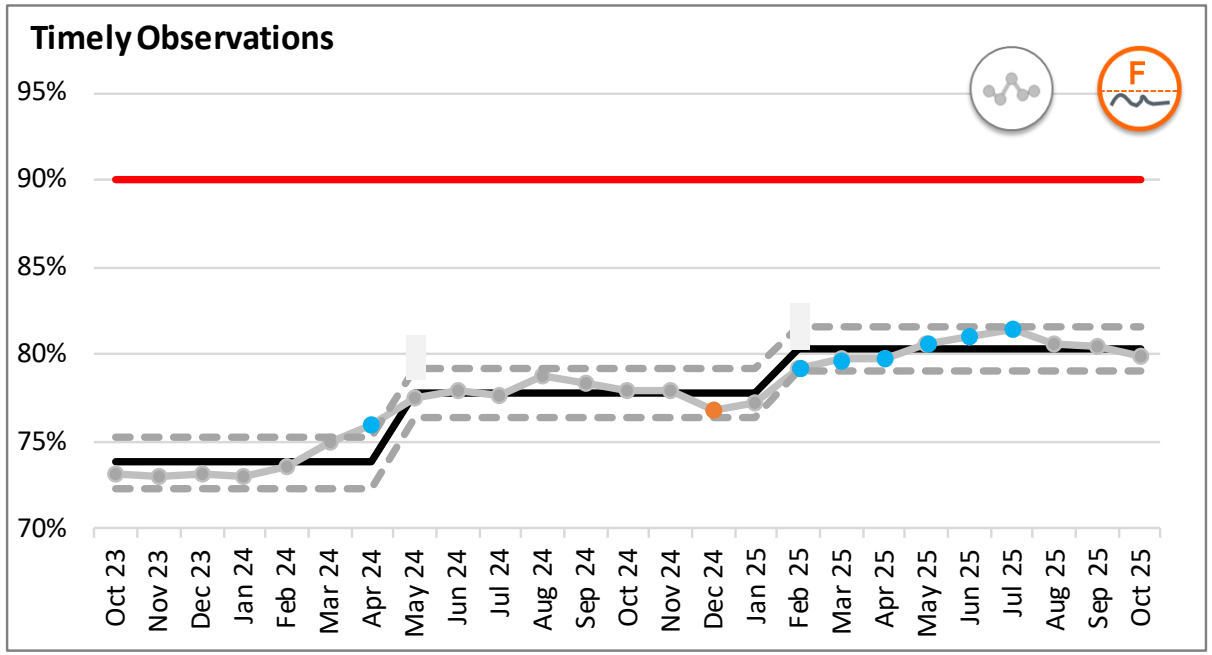

What is driving this performance?

The proportion of observations recorded as timely in October 2025 was 80%. Compliance appears to have plateaued some way below the target.

- Only 9 wards/departments met the 90% target in October.
- 5 wards had compliance below 70%, all from Medicine CBU:
  - Ward 15
  - Ward 76b
  - Ward 78
  - Ward 113
  - Ward 12

What are we doing about it?

Individual Wards and Departments continue to be reviewed and monitored as part of the monthly Performance Review process and actions are identified to improve compliance. In August we experienced a huge problem with our Careflow and iPortal EPRs, which impacted the data collection.

Planned and Unplanned Care Groups have timely observations as a driver metric and there is a corporate A3 Improvement Project underway considering additional actions required to improve overall compliance/performance.

Compliance with timely completion of observations is an essential element within the SAFE domain of the Care Excellence Framework (CEF) award criteria. Digital Nurses are working with the bronze wards to support this action.

Individual area support and offer to attend the bronze ward review where appropriate

Expecting delivery of new iPad mini in the next month and a refresh of devices will be rolled out soon as practicable resource dependant, date to be confirmed Joint drop-in refresher session re NEWS 2 and timely observation.

Vitals has now been rolled out in ED and therefore team focus can return to education and supporting timely observations work.

The new Safer dashboard ('Dials of the Day') shows observations, timeliness and is colour coded for CEF awards, and roll out is planned throughout 2025.

Quality & Access | [Mixed Sex Accommodation / Single Sex Breaches]

Provide safe, effective and caring services

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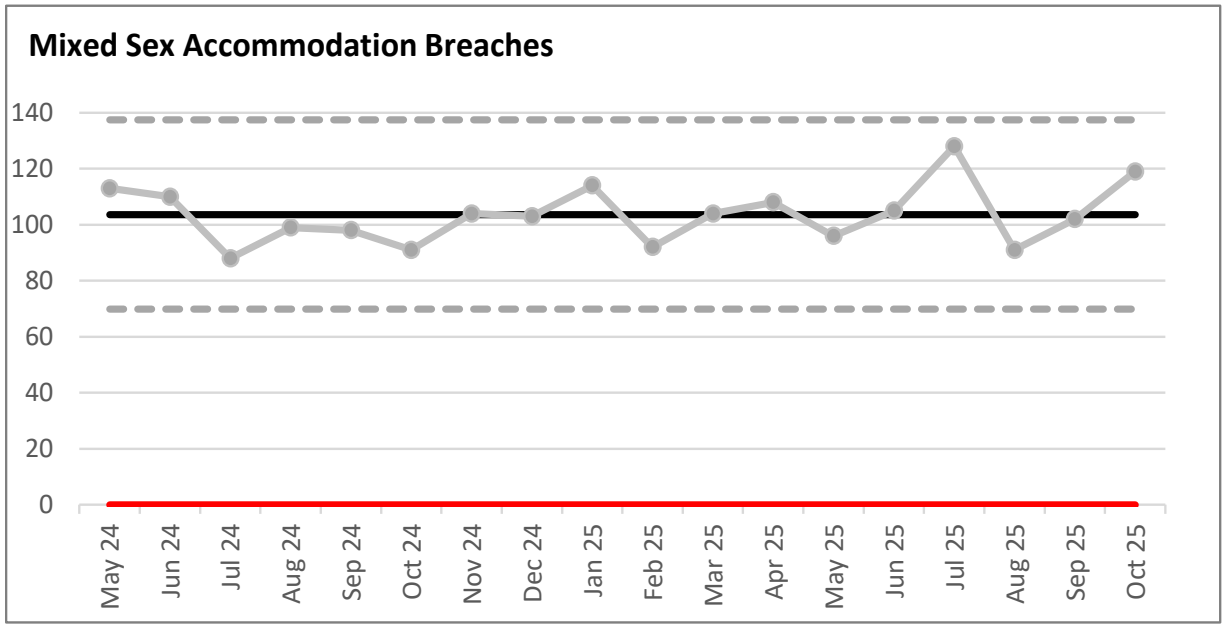

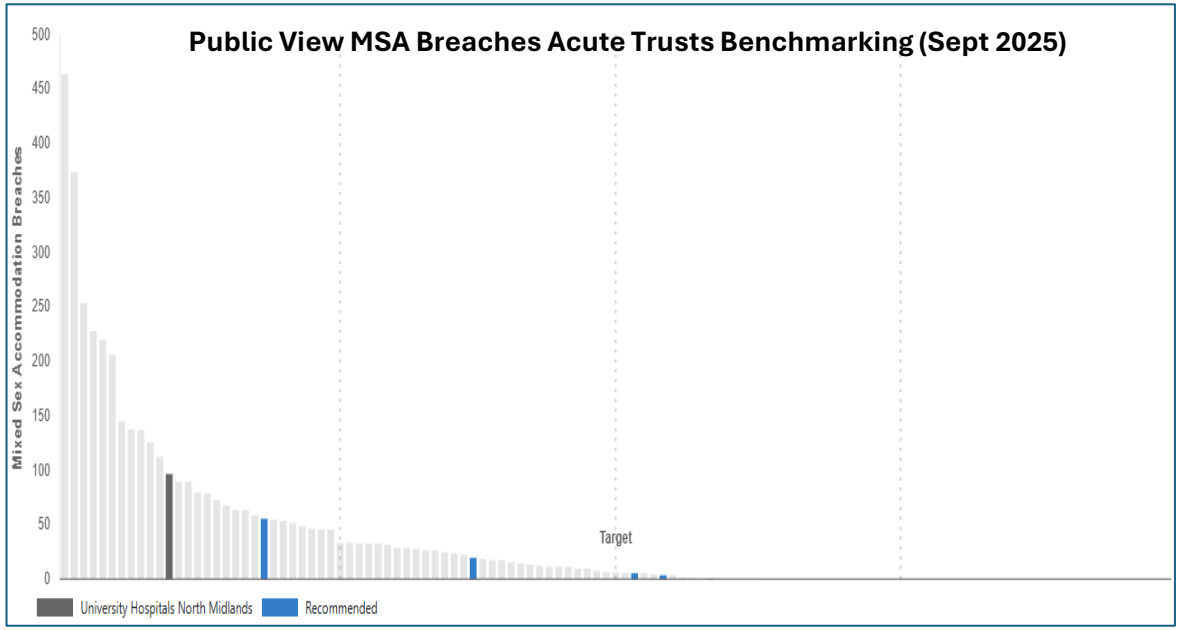

What is driving this performance?

The number of mixed sex accommodation breaches was within the usual range, based on the previous numbers show, the in month reduction was below the long term mean.

All identified breaches occurred within the SSCU or Critical Care settings.

What are we doing about it?

An improvement plan is being created to ensure a plan approach to the reduction of breaches. This will include a review of policy and SOPs relating to Single Sex Accommodation, tracking of breach incidents, including reasons and review of patient feedback/complaints, inclusion of step-down needs into site/bed and escalation SOPs. This will form part of the UED workstreams commenced in Spring 2025.

Continued incident reporting via Datix will be completed for each week of breaches in critical care/SSCU with individual incident reports for any ward-based breaches.

Regular summaries of breaches to be shared with senior divisional and operational teams to highlight risk and potential harm.

Quality & Access | [VTE & Hospital Associated Thrombosis]

Provide safe, effective and caring services

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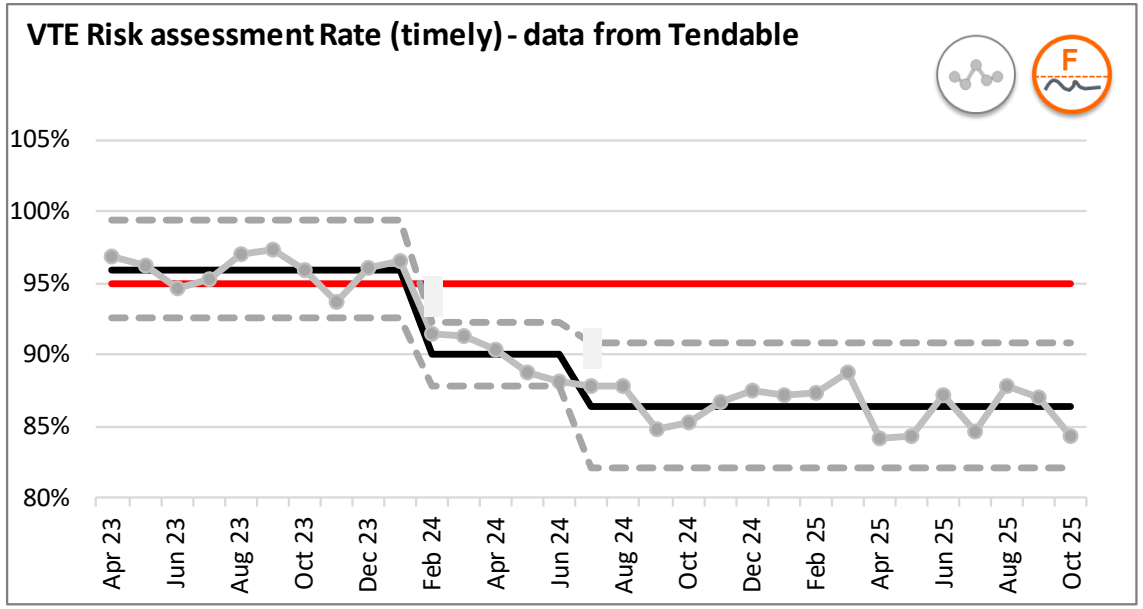

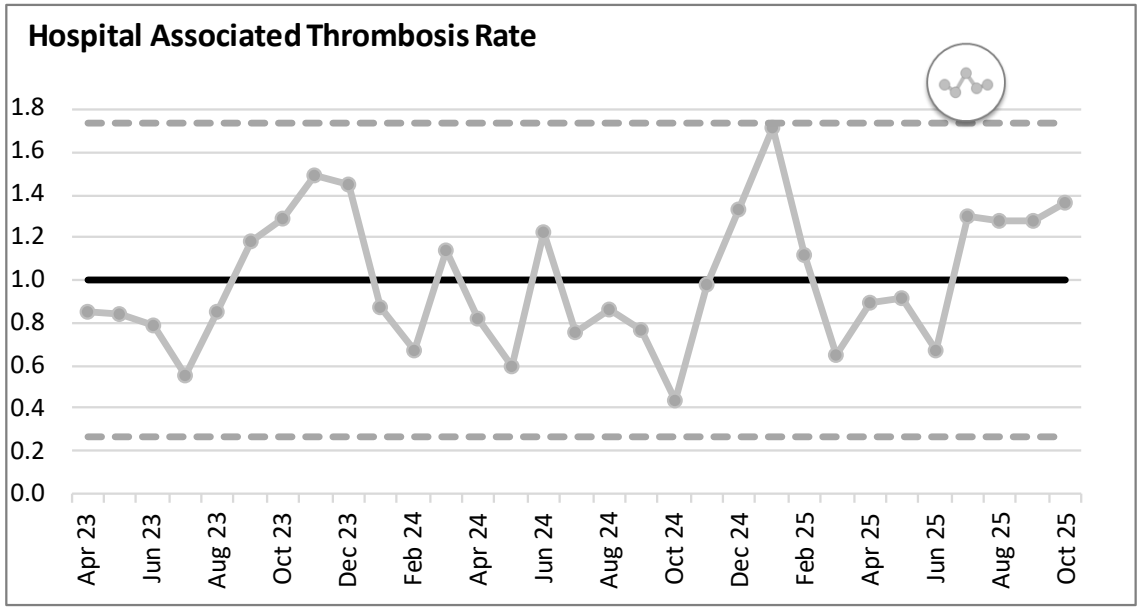

What is driving this performance?

VTE assessment data comes from audits conducted by ward staff, answering the question: "Has the VTE risk assessment been completed within 12 hours of admission?"

Low performance is largely due to the failure to document the date and time of the assessments: 10% of charts audited were missing date or time, and only 2% of assessments have not been completed at all. 98% of prophylaxis doses are given, or reasons documented if withheld.

The Hospital Associated Thrombosis rate shows significant variability while still staying within control limits. There appears to be something of a seasonal pattern, with peaks in the past three winters.

The apparent decrease in compliance with timely VTE Risk assessments in the past year does not seem to correlate with any notable rise in the HAT rate.

What are we doing about it?

EPMA once fully introduced will provide an accurate picture of VTE risk assessment completion. A sample review of County Inpatient data is encouraging for patients having an initial assessment completed. Work is underway in sharing with clinicians the importance of reassessment.

Changes to VTE risk assessment requirements
NICE guidance (NG89) amendment September 2025 all medical, surgical and trauma patients should be assessed for VTE risk as soon as possible after admission and in accident and emergency, if they have not been admitted within 12 hours. The VTE Steering Group are starting initial conversations with ED regarding how to achieve this.

Key Themes identified from HAT Investigations; Missed doses; particularly first dose. Once ePMA is fully implemented and data on missed doses can be collected the VTE Steering Group aim to launch improvement project on missed doses.

Quality & Access | [HSMR / SHMI]

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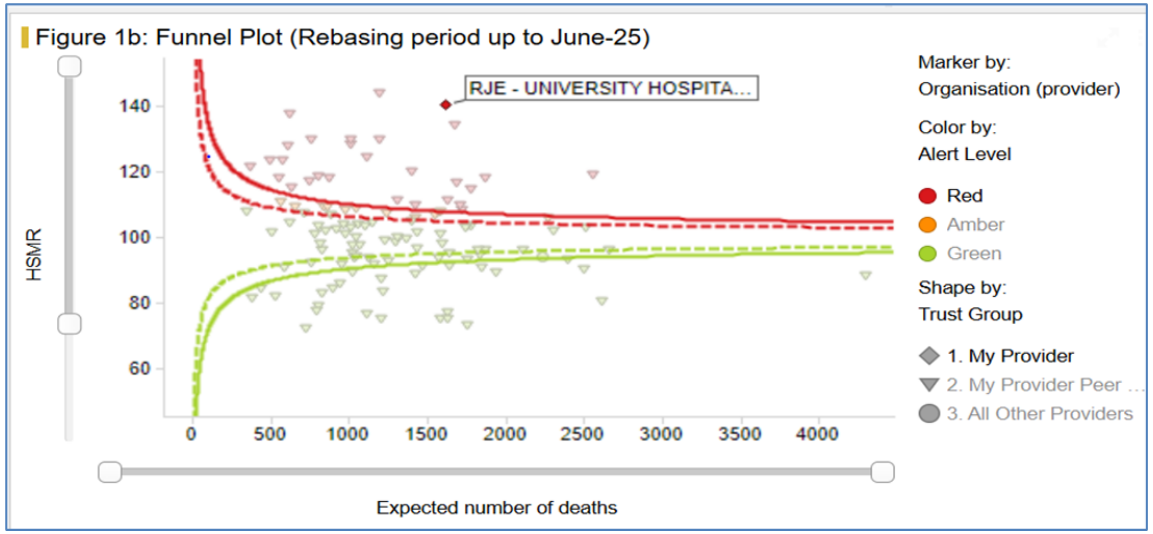

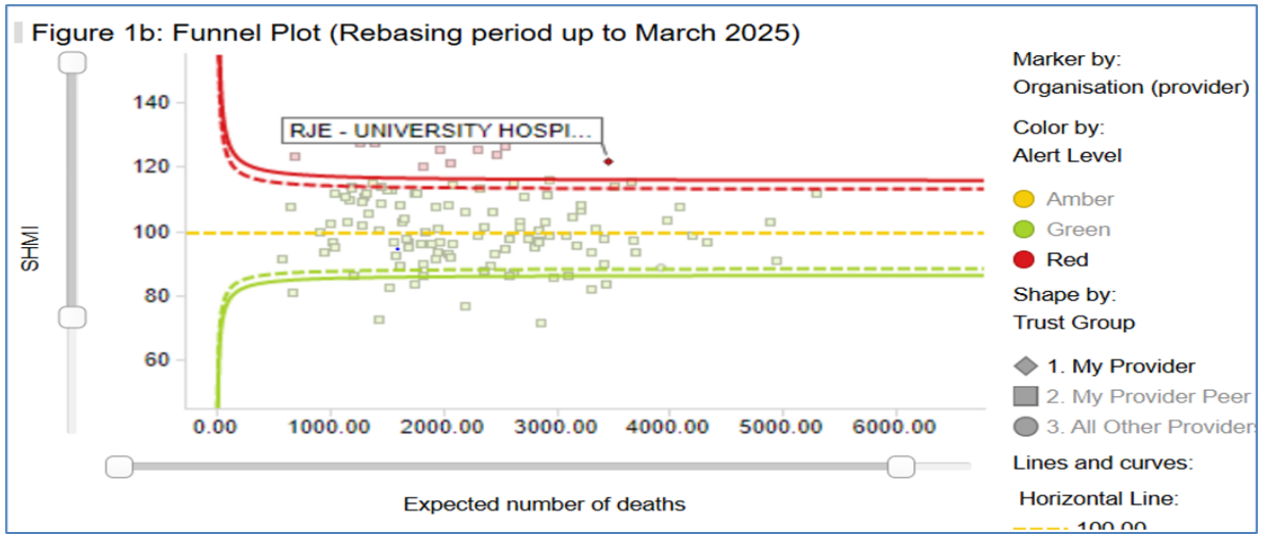

What is driving this performance?

UHNM HSMR remains significantly higher than expected based on case mix and standardisation for current 12-month period (July 2024 – June 2025). The current 12-month HSMR is 140.74. Previous month reported 138.44 but following further data upload this improved to 133.6.

UHNM SHMI also remains higher than expected at 121.58 for current 12-month period (June 2024 – May 2025) but has decreased from previous 12-month period 127.17.

The HSMR/SHMI issue re coding backlog continues in the rolling 12-month figures. We have not noted a similar increase in the Trust's crude mortality rate at same time as the HSMR increases and therefore the increase appears to be linked with the potential coding issues in relation to not all activity being fully coded. The rolling 12-month crude rate has reduced slightly from 2.44% to 2.37%.

What are we doing about it?

- Have not seen changes in outcomes of the completed mortality reviews / SJRs highlighting and concerns in practice linked to the period of increased HSMR
- Clinical Coding have provided full coding from April 2025 activity and the last 2 months of HSMR have seen improvements for April and May 2025.
- Have noted that there has been a reduction in the numbers and rate of Palliative Care codes during the coding issues. This is being further reviewed to assess the potential impact and reported to Mortality review Group as the reduced coding of palliative care will have impact on the number of expected deaths per month
- Remains under review and have shared update with QAOC and ICB.

Quality & Access | [Sepsis – Adult Inpatient]

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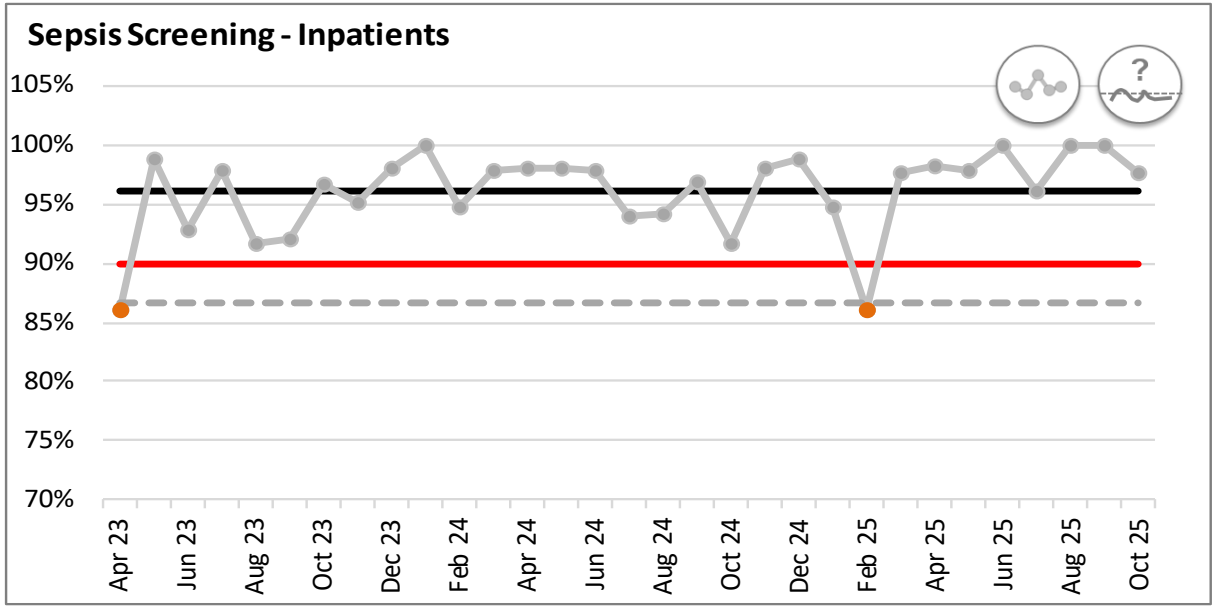
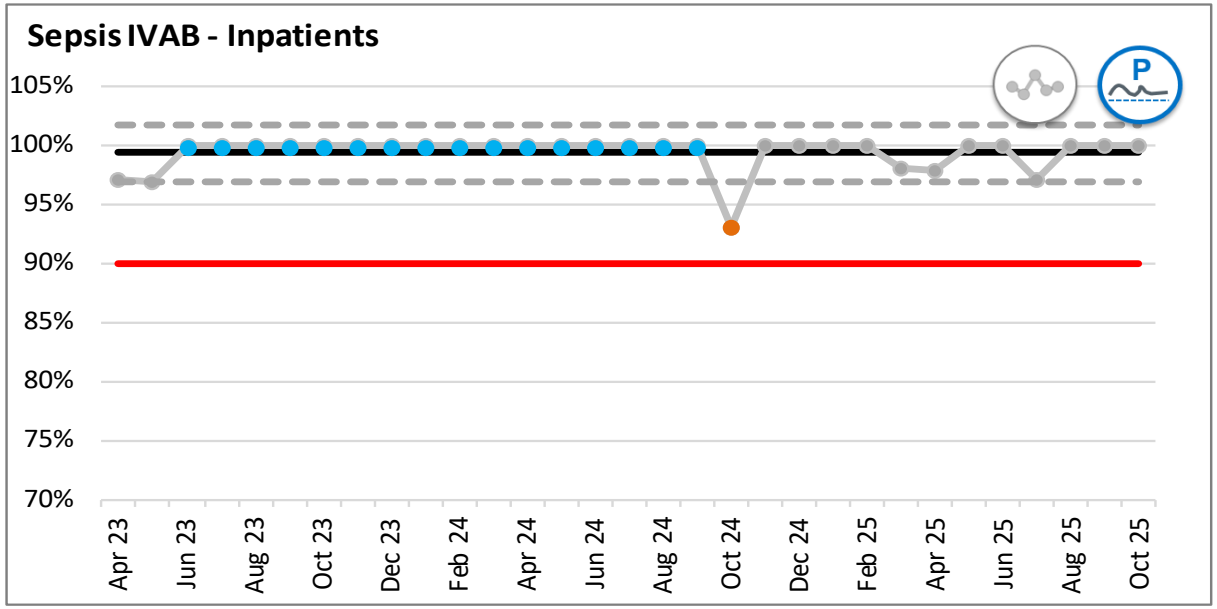




What is driving this performance?

Inpatient screening compliance was within the usual range in October 2025.
Average compliance for IVAB administration within one hour far exceeds the target.

A total of 132 cases were reviewed in October; there were three missed screenings. Among these, 86 cases were identified as red flag sepsis, with 56 receiving alternative diagnoses and the remaining 30 patients were already on IVAB treatment., leaving no newly identified sepsis.

What are we doing about it?

The sepsis team continue to raise awareness of the importance of sepsis screening and IVAB compliance by being involved in HCA induction and qualified nurse's preceptorship programmes.

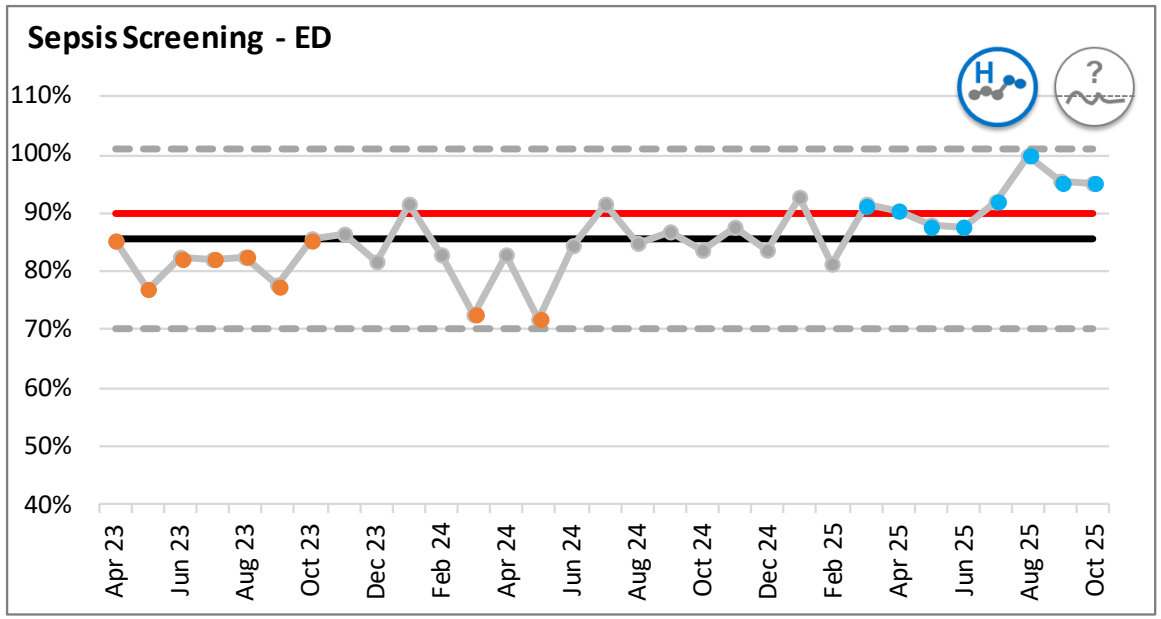
The sepsis will continue to provide sepsis kiosks/ drop- in sessions to targeted clinical areas.

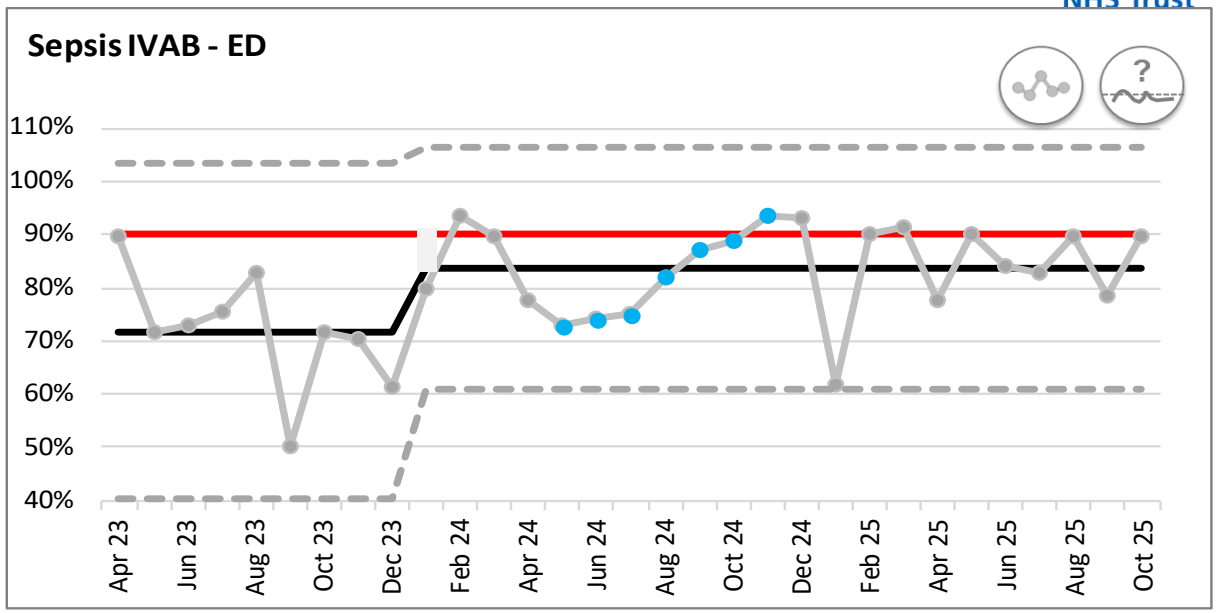
The sepsis team will continue to create drop-in training sessions for band 3s for all inpatient departments.

Quality & Access | [Sepsis – Emergency Portals]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is driving this performance?

Adult Emergency portals screening compliance has been above the average for 9 consecutive months which may indicate significant change.

Average compliance with IVAB within 1 Hr remains a little below the target.

In October, 166 cases were reviewed with 8 missed sepsis screens. Among these, 121 cases were identified as red flag sepsis. 73 of these had an alternative diagnosis, 23 were already on IV antibiotics. Leaving 25 newly identified sepsis patients. 5 of these patients received IV antibiotics outside the target 1 hour window.

What are we doing about it?

- The sepsis team continue by closely monitor compliance by visiting and auditing ED regularly.
- Regular meetings with ED senior team with robust actions in place.
- Face to face sepsis induction / training for new nursing staff, nursing assistant and medical staff continue.
- Introduced Deteriorating Patient Vocera devices and assigned clinician role (Tier 3) in resus to review patients and make timely decisions re: sepsis or other significant condition. Reviewing usage following introduction and outcomes are awaited.

Quality & Access | [Sepsis – Children]

Provide safe, effective and caring services

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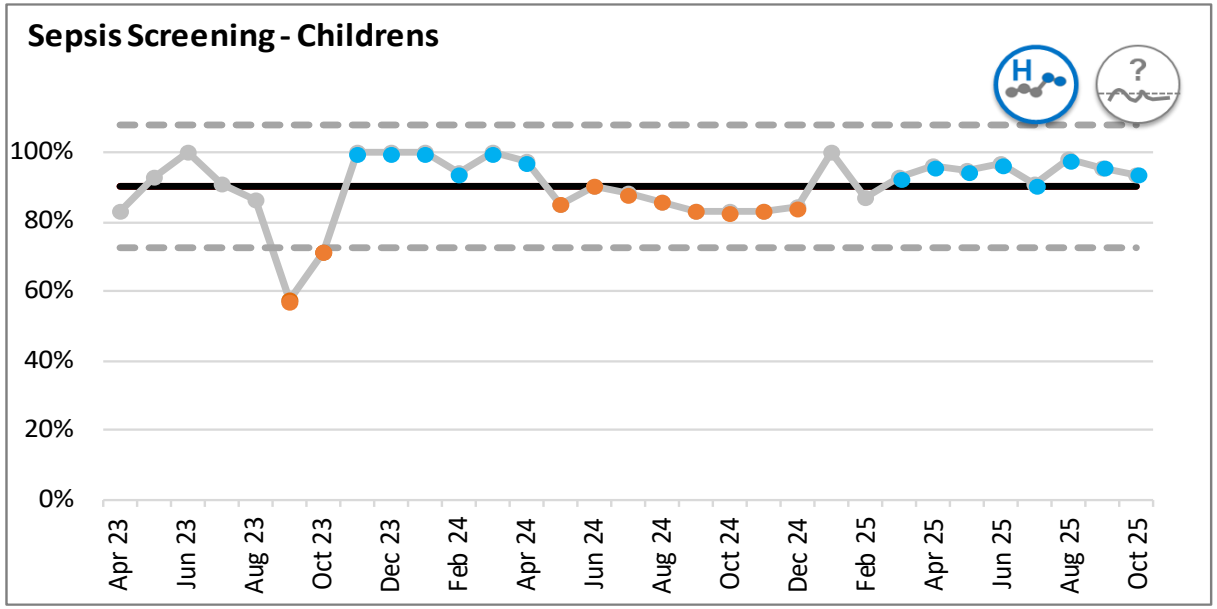

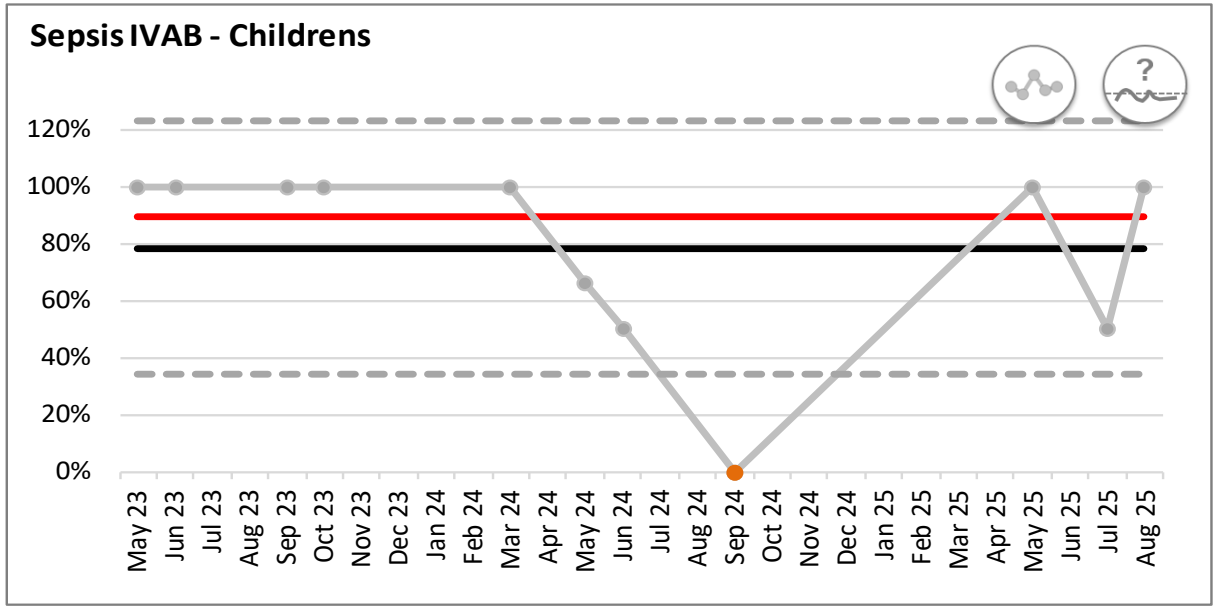

What is driving this performance?

We continue to see only a small number of children trigger with PEWS >5 and above in inpatient areas.

There were 31 cases audited for emergency portals with no missed screens in October. 7 cases were audited for inpatients with 3 missed sepsis screens. No true red flag sepsis were identified from the randomised audits in the emergency portals or inpatients.

What are we doing about it?

The sepsis team has continued to adjust the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective.

The sepsis team will continue to attend the mandatory training days and provide sepsis training to nursing staff and nursing assistants.

Quality & Access | [Sepsis – Maternity]

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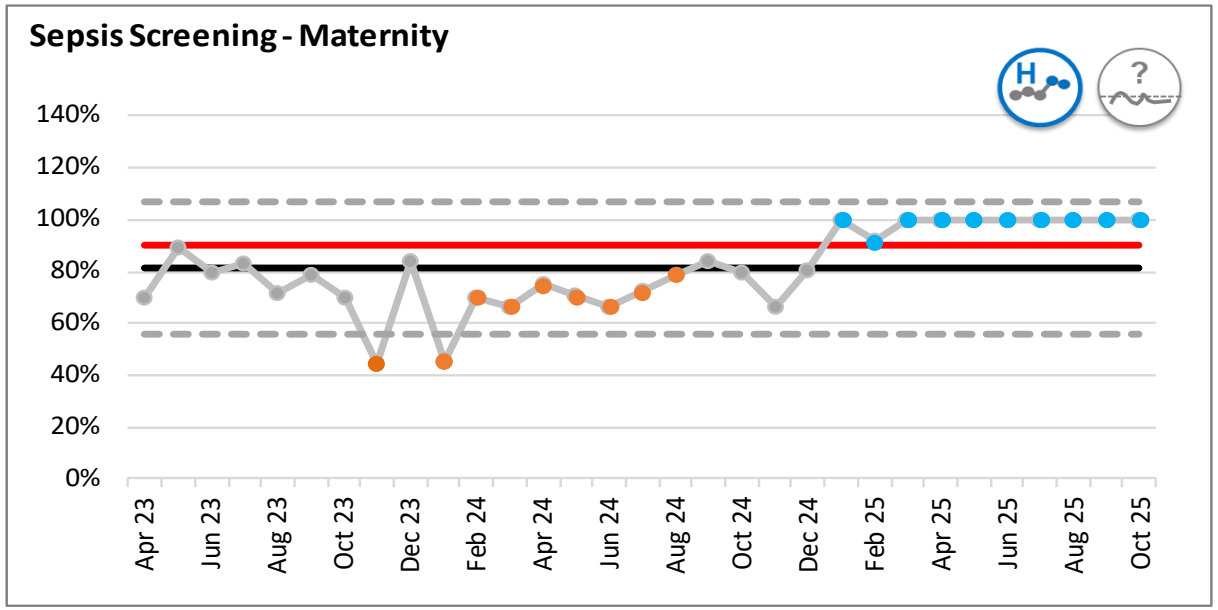
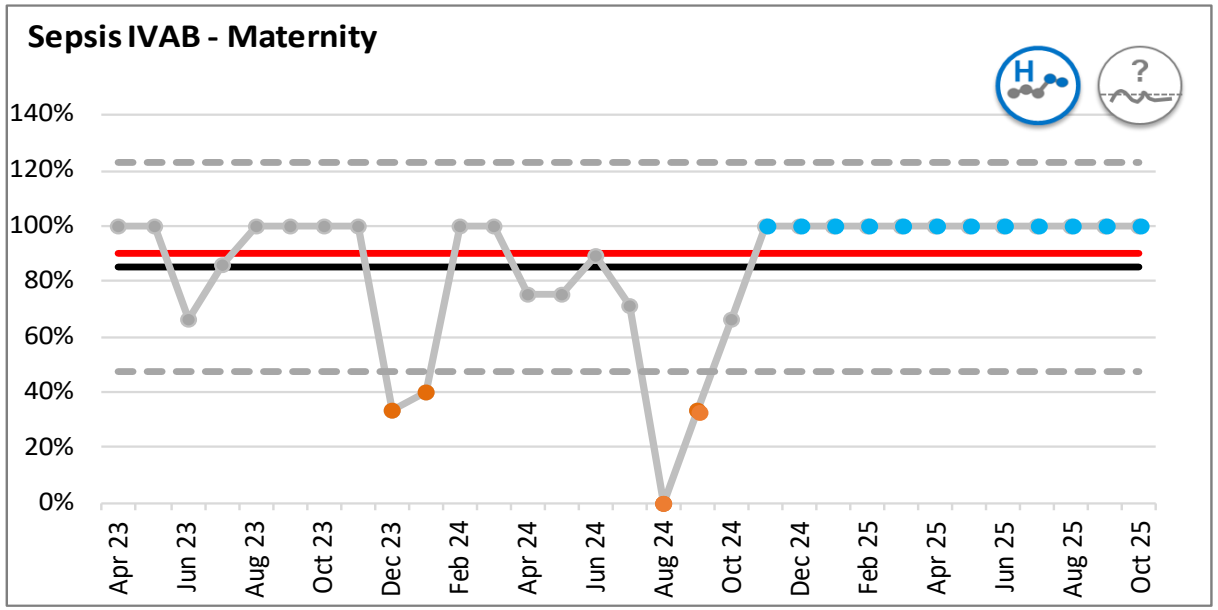




What is driving this performance?

Maternity audits regarding screening compliance have met the target since Jan-25 and the target for administering IVAB within one hour for both inpatient and emergency portals has been met consistently since November 2024. However, IVAB compliance is assessed using a limited number of cases.

A total of 6 cases were audited from the emergency portal MAU in October and 8 cases reviewed for inpatients, and there were no missed sepsis screens.

What are we doing about it?

Monthly maternity skills drill is now replaced with ad hoc sepsis sessions in each clinical area.

Sepsis sessions will focus and highlight the importance of screening documentation.

The sepsis team will create further awareness and plan collaborative work with maternity educators and senior team.

Quality & Access | [Clinical Effectiveness]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

- 3 External Accreditations undertaken during Q2 / Q3
  - BSI: Clinical Technology – no nonconformities
  - BSI: HSDU – 1 minor nonconformity
  - JAG Accreditation – did not meet accreditation standards. 8 recommendations.
- 23 Pieces of NICE guidance outstanding for more than 12 months
- 15 National Audit published during Q2 / Q3
- 3 NCEPOD reports published during Q2 / Q3
- 9 Cancer outcome reports published during Q2 / Q3
- 5 GIRFT visits were undertaken during Q2 / Q3
  - Breast Surgery
  - General Surgery
  - Vascular
  - Urology
  - Interventional Radiology
- 24 LocSSIP audits were published during Q1:
  - 13 Significant Assurance
  - 11 Significant Assurance with Minor Improvements
- 20 Clinical audits were published in Q2 / Q3:
  - 10 Significant Assurance
  - 5 Significant Assurance with Minor Improvements
  - 4 Partial Assurance
  - 1 No Assurance

What are we doing about it?

- Action plans for each inspection, audit, report being developed in conjunction with the Clinical Teams
- NICE guidance escalation – via the Care Group Management Team
- Provision of Directorate and Care Group Quality Outcome Meetings to support oversight and ownership of Clinical Effectiveness priorities by the Care Group
- Consideration being given to an overarching Care Group Clinical Effectiveness action plan to ensure triangulation and avoid duplication of work.
- Care Group Clinical Effectiveness Managers recruited to support the Care Groups. Post holders will begin on 1st December 2025
- Care Group Governance and Clinical Effectiveness Leads in post.

What are we doing about it?

Proposed new Clinical Effectiveness KPIs to promote Care Group ownership and Executive oversight & assurance:

Quality Statement	Indicator
We plan and deliver people's care and treatment with them, including what is important and matters to them. We do this in line with legislation and current evidence-based good practice and standards	NICE guidance implemented into practice with assurance mechanism identified
	Participation in national audits / programmes with associated action plan
	Provision of action plan following GIRFT visit
	Number of patients who feel that they were involved in decisions made about their care
	Number of patients receiving a Senior Review with 14 hours of admission
	Number of patients who had a individualised plan of care
We routinely monitor people's care and treatment to continuously improve it. We ensure outcomes are positive and consistent, and that they meet both clinical expectations and the expectations of people themselves	Number of GIRFT pathways audited as part of the Divisional Clinical Audit Programmes
	Number of Clinical Audits demonstrating Significant Assurance
	Compliance with the mandatory completion of questions relating to the never event criteria on the LocSSIP Safety Checklist
	Number of patients who have reported a positive outcome following their hospital admission / procedure

The Care Plan Delivery plans will be updated and will include KPI compliance as part of the summary page. KPI's will be monitored at the Care Plan meetings and will be used to provide assurance to QOG and QAOC

NOF - Access to Services

University Hospitals of North Midlands NHS Trust

Access to Services	Data period	Provider value				Chart
Access to services domain score			Q1 2025/26	2.55	NOF Score	

Elective Care	Data period	Provider value	Peer average		National value	National value method	Chart
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment score			Q1 2025/26	2.04	NOF Score	Provider value	
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Jun 2025	64.08%	56.59%		60.72%	Provider median	
Difference between planned and actual 18 week performance score			Q1 2025/26	1	NOF Score	Provider value	
Difference between planned and actual 18 week performance	Jun 2025	4.91%	1.42%		0.99%	Provider median	
Percentage of patients waiting over 52 weeks for elective treatment score			Q1 2025/26	2.83	NOF Score	Provider value	
Percentage of patients waiting over 52 weeks for elective treatment	Jun 2025	2.56%	2.75%		2.40%	Provider median	
Percentage of patients waiting over 52 weeks for community services score			Q1 2025/26	1	NOF Score	Provider value	
Percentage of patients waiting over 52 weeks for community services	Jun 2025	0.00%	0.15%		1.04%	Provider median	

Cancer Care	Data period	Provider value	Peer average		National value	National value method	Chart
Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks score			Q1 2025/26	2.97	NOF Score	Provider value	
Percentage of urgent referrals to receive a definitive diagnosis within 4 weeks	Jun 2025	75.78%	75.42%		76.88%	Provider median	
Percentage of patients treated for cancer within 62 days of referral score			Q1 2025/26	3.36	NOF Score	Provider value	
Percentage of patients treated for cancer within 62 days of referral	Jun 2025	63.17%	61.66%		71.12%	Provider median	

Urgent and Emergency Care	Data period	Provider value	Peer average		National value	National value method	Chart
Percentage of emergency department attendances admitted, transferred or discharged within four hours score			Q1 2025/26	3.59	NOF Score	Provider value	
Percentage of emergency department attendances admitted, transferred or discharged within four hours	Jun 2025	68.00%	74.70%		76.00%	Provider median	
Percentage of emergency department attendances spending over 12 hours in the department score			Q1 2025/26	3.58	NOF Score	Provider value	
Percentage of emergency department attendances spending over 12 hours in the department	Jun 2025	15.15%	12.11%		8.36%	Provider median	

UHNM's access metrics show mixed performance. While elective recovery is progressing, urgent care pathways remain under pressure. Compared nationally, UHNM is positioned in the middle.

Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

How are we doing against our trajectories and expected standards?

Non-Elective

For the 4-hour standard in UEC our validated performance deteriorated to 65.8% in October compared to 67.6% for September. This is 2.9%pts behind our trajectory of 68.7%, which has now adjusted to account for the late delivery of the UTC programme. The national target for this standard is 78%.

In October, 2769 patients waited longer than 12 hours in our Emergency Department against a plan of 2,021. This is 222 more patients waiting longer than 12 hours compared to September, and 748 more patients than in the trajectory for October.

5151 ambulances arrived at UHNM in October with 53% of these handed over within 45 minutes. Average handover time in October was 1 hour and 46 minutes, an average increase of 23 minutes from September.

This has meant that during October 2483 patients waited in an ambulance for longer than 45 minutes, this compares to 2197 patients in September.

The Trust remains in tier 1 for our UEC performance.

Elective

Cancer:
The combined faster diagnosis standard performance validated September position ended 7.3% off trajectory. October is currently unvalidated but is at 74.45% which is below the trajectory of 77.54%, however recovery to align back to plan has taken grip quickly.
31-day August validated performance was 90.79%; 5.2% off trajectory against plan.
Combined 62-day performance final September 2025 position was 63.14% against a trajectory of 68.05%; 4.9% off plan. Provisional October position is currently at 59.64% against a trajectory of 71.53%

Diagnostics:
September DM01 validated position was 66.6% against trajectory of 64.5%.
October DM01 unvalidated performance was 68.1% against trajectory of 69.6%. Validated position is expected to be 70.2% against plan of 69.6%

RTT:
Octobers overall RTT performance is 63.3%; comfortably above trajectory which is 61.3% (1.9% ahead of plan), the standard for this is 63%
Our 52-week performance is monitored as a % of patients on our total waiting list who are over 52 weeks. For the month of October, 52-week plan reduced from 2.1% to 1.9%. 52-week actuals tracking at 2.04%
This standard to achieve by the end of the year is to get to 1%.
We are ahead of our planned trajectory for wait for first appointment at 77.2%, the plan for this is 74.6%; 2.7% positive variance.

We continue to have patients waiting over 65 weeks. Whilst some patients have experienced a delay to undergoing their surgery our clinical and operational teams have worked to ensure that patients with the greatest clinical need were not impacted. This backlog does have a reducing trend, but this is not as quickly as we would like.

The Trust continues to be in Tier 2 for Planned Care, Cancer and Diagnostics.

Quality & Access | Overview

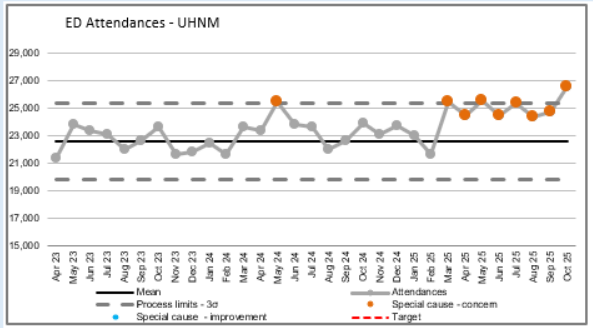
University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

What is driving this?

Non-Elective

4-hour performance is 2.9% behind our revised improvement trajectory. Seasonal activity increases have been seen earlier than anticipated, with 26,522 attendances in October, more than three standard deviations from the mean. October attendances were 7.4% higher than in September, with 1,800 additional patients attending our Emergency Departments this month compared to last.



Variation	Assurance
H	

Target	Aug 25	Sep 25	Oct 25
N/A	24368	24706	26522

Background

Total number of patients attending the Emergency Department including all Types (exc Type 5) for all Sites.

In response to the increased Demand, our Winter Plan has been enacted earlier than planned, with ward 102 (RSUH) transitioning from Planned Care to Unplanned and Ward 8 (County) opening in the month. Continuous Flow remains in place, and is being enacted to the agreed protocol. We continue to work alongside colleagues from the GIRFT UEC team, focusing on Ward processes and Length of Stay, Site Command and Control and Internal Professional Standards.

Elective

The deterioration in FDS cancer performance when compared to last month, was due unbooked skin referrals and the cessation of text messaging service Accurx, used by multiple cancer sites to communicate an exclusion of cancer to patients. Colorectal, haematology, head & neck and skin are the most challenged specialties and are underperforming against their trajectories. However, we are continuing to see a year-on-year improvement for this standard.

Non-Obstetric Ultrasound is the majority contributor for overall DM01 performance variance. Non obstetric ultrasound is currently in line with the trajectory developed to meet 95% DM01 performance by March 2026. DM01 position has improved by 5.2% over the last 3 months due to NOUS recovery now taking grip. Unvalidated NOUS performance is now 45.4%; a 5% increase since last month.

RTT Performance has improved significantly through extensive validation work completed by MBI, the Corporate Validation Team and the Care Groups. Performance is 63.92%; above trajectory by 1.9%. UHNM rank against acute trusts has improved from 98th to 63rd. Validated month end position in Total WL size has seen a further decrease in October, from 65,925 to 65,910.

The number of 78-week breaches has decreased again from 3 in September to 1 in October. The reduction in patients waiting >65weeks to be treated has been possible due to an increase in capacity funded through ERF and close management of the waiting lists and booking processes. 65-week waits have also reduced to 75 in October from 100 in September. There is some risk with the extensive validation work underway of pop-up long waiters – these will be managed through the trust's "uncorrected breaches" process. Specialties which impact are Orthopaedics, ENT, Ophthalmology and Gynaecology. The rate of reduction of patients waiting over 65 week shows that most of these patients are on admitted pathways who require an RSUH bed for a complex procedure requiring some combination of specific surgeons, surgical robots and extended theatre time.

Quality & Access | Overview

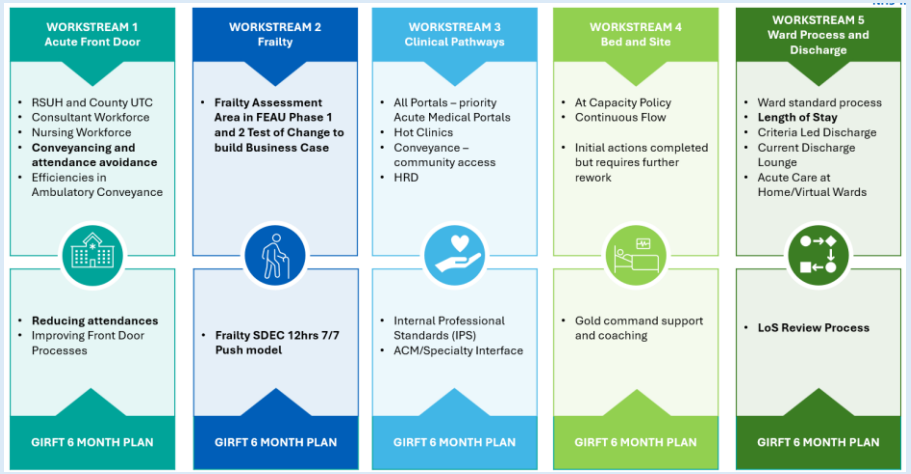
University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

What are we doing to correct this and mitigate against any deterioration?

Non-Elective

Our UEC improvement plan has now been in place since April 2025. The focus of the workstreams has been mapped to the work of the GIRFT UEC team, focusing on the pareto actions to derive maximal performance improvement. Clear governance of the workstream remains in place, with strengthened operational grip and control of performance in recent weeks.



Elective

Improvement plans in cancer with associated trajectories by tumour site to reduce the diagnosed and undiagnosed backlog of patient 62 days will continue to be monitored and developed. Delays due to histopathology (in line with other centres regionally) will need to be offset by further improvements in patients' pathways. Cancer Services Team have increased their validation of pathways continues.

As our UEC improvement programme develops, elective bed capacity is available to support our elective programme of work.

The digital and operational teams have worked with external partners to develop a process to validate the majority of our c700,000 patients on our waiting lists. Validation work will continue at pace to deliver the asks of the national validation sprint. Work so far has targeted known areas of challenge with data quality and clock stop capture, which is disproportionally patients waiting 18+ weeks. 60% of the patients waiting <18 weeks have yet to be seen, as opposed to 30% of those waiting above 18 weeks; less risk of error. The ROVA validation tool has now commenced automated validation, which will extend to the entire waiting list. This has shown nearly 2000 pathways which can be closed, leading to an indicative improvement in performance of 1.3%.

Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

What can we expect in future reports?

Non-Elective

Given the early arrival of winter and a significant spike in demand, October performance was not where we wanted it to be. The increased attendances, combining with an earlier than anticipated rise in seasonal viruses and associated infection prevention controls have impacted on performance. Winter is expected to be challenging both locally and nationally (considering both international trends and academic modelling), but the early enactment of the winter plan, our work with GIRFT UEC and our delivery of our UEC Improvement plan have demonstrated some encouraging signs of recovery.

Going forward, improvements in 4-hour performance, 12 hour and ambulance handover delays will be tracked and monitored in both real-time and in retrospect within our governance framework. We have seen the correlation between improvements in flow and these indicators.

Our At Capacity and OPEL Framework is being strengthened, with System wide Action Cards to de-escalate the sites and minimise the risk of harm to both patients and staff being developed. Whilst this winter will be challenging for all of us in the NHS, the early indications of improvement are promising.

Elective

We expect to improve in line with our planning trajectories and an ongoing reduction in our longest waiting patients

For cancer, collaborative working group in process between Histopathology, Directorates and Cancer Services to identify specimens for reporting on appropriate triage pathway - Cancer Team are currently reviewing an automated solution with pathology. The PTL size and the 62+ backlog is growing, mainly attributable to Skin, as several patients have been booked outside of their 28-day and 62-day targets for diagnostic biopsies and planned treatments. This will impact performance reported for November and December, but this has been predicted and performance will improve as 28-day Skin delivery is recovered. An outsourced provider has given urgent capacity for first new and procedures to support in the backlog of skin cancer patients. All standards will be impacted by this specialty. Clinical and operational recovery meetings are taking place to urgently recover Skin position.

County Elective Hub went live on the 7th April. Extended Weekend and evening sessions started in September. Notably procedure numbers will significantly increase across County Theatres; activity increase to be tracked against delivery, specifically for Orthopaedics / General Surgery / Gynaecology

Quality & Access | Dashboard

University Hospitals of North Midlands NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance	R12M Trend
UEC 4 Hour Performance	78%	68.0%	65.8%			
UEC 4 Hour Performance (Aged <18)	78%	91.9%	88.1%			
Over 12 hours in ED	2,128	2,546	2,769			
Over 12 hours in ED (Aged <18)	0	15	35			
Ambulance Handover Average Time	00:43:00	01:23:36	01:46:43			
Cancer 28 Day FDS	80%	69.5%	74.5%			
Cancer 31 Day Combined	96%	90.8%	89.0%			
Cancer 62 Day Combined	75%	63.1%	58.6%			
Diagnostics DM01 Performance	97%	66.6%	68.1%			
RTT Performance - <18 Weeks	63%	64.1%	63.3%			
RTT Performance - % 52+ Weeks	1%	2.1%	2.0%			
RTT Performance - % Waiting 1st Contact	77%	76.0%	77.2%			
RTT Performance - <18 Weeks (Aged <18)	63%	67.7%	69.1%			
RTT Performance - % 52+ Weeks (Aged <18)	1%	1.3%	1.1%			
RTT Performance - % Waiting 1st Contact (Aged <18)	77%	82.2%	82.9%			

Related Strategy and Board Assurance Framework (BAF)

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 1: Inability to Sustain Safe and Effective Care Delivery	Ext 16	Partial	Ext 20	Partial				

Assurance Grid

University Hospitals of North Midlands NHS Trust

Assurance / Variation Key

Assurance

?	P	F
Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

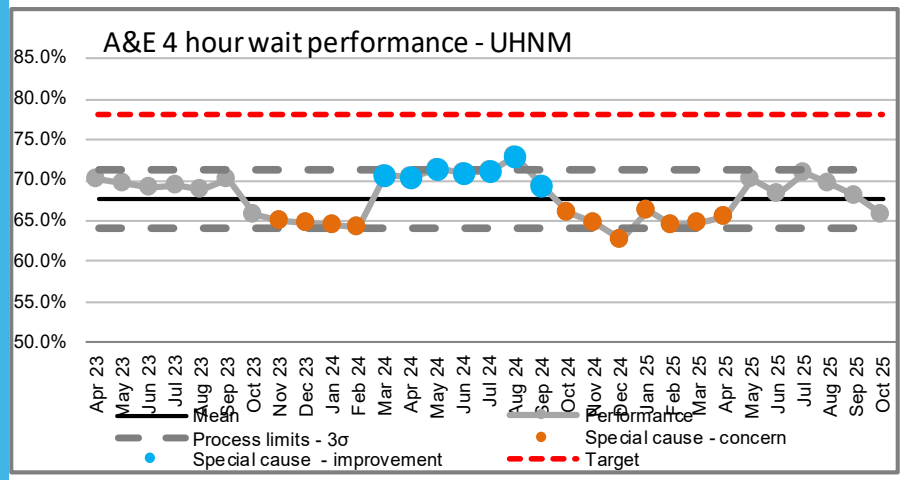
Variation

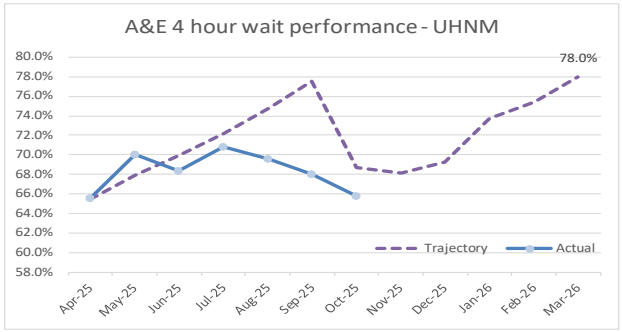
	H / L	H / L
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

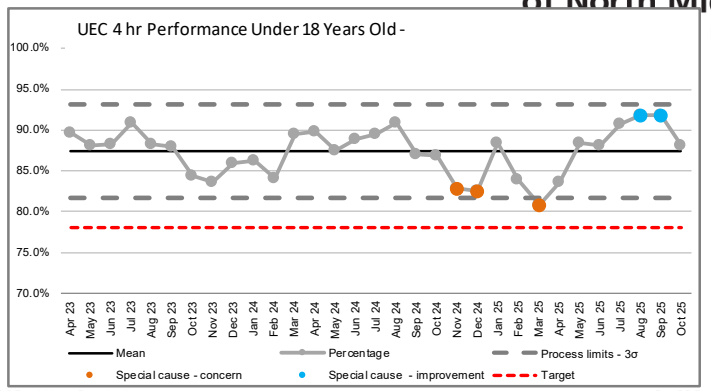
VARIATION \ ASSURANCE	P	?	F	No Target
H / L		RTT Performance - <18 Weeks (Aged <18) RTT Performance - % Waiting 1st Contact (Aged <18)	RTT Performance - <18 Weeks RTT Performance - % 52+ Weeks RTT Performance - % Waiting 1st Contact RTT Performance - % 52+ Weeks (Aged <18)	
	UEC 4 Hour Performance (Aged <18)	Ambulance Handover Average Time Cancer 28 Day FDS	UEC 4 Hour Performance Cancer 31 Day Combined Cancer 62 Day Combined Diagnostics DM01 Performance	
H / L		Over 12 hours in ED	Over 12 hours in ED (Aged <18)	

Quality & Access | UEC 4-hour Target

University Hospitals of North Midlands NHS Trust







Variation	Assurance		Monitoring against plan				
				Jul 25	Aug 25	Sep 25	Oct 25
	Target	78%	Actual	70.9%	69.6%	68.0%	65.8%
Background			Plan	72.2%	74.7%	77.6%	68.7%
The percentage of patients admitted, transferred or discharged within 4 hours of arrival at A&E			Variance	-1.3%	-5.1%	-9.6%	-2.9%

A&E - 4 Hour Standard — Oct 25 Performance: 65.81% | Rank: 117th of 150

What is the data telling us?

Validated performance is 65.8% for October, a marginal drop from 68% in September. Performance remains relatively stable with less than 5% variation in the last 6 months (May – October).

We came off original trajectory in September and as such, plan was adjusted. In October, plan was 68.7%, which we fell short of 2.9%. Revised trajectory for November is 68.1% and December 69.2%. By site, RSUH performance was 41.6% vs a target of 41.9%, and County 60.5% vs a target of 63%.

Overall admitted performance was 36.3% vs a target of 30.1%. By site, RSUH 34.8%, above target of 26.5%, County 42.1% vs a target of 43.8%.

Overall Non-admitted performance was 54.6% vs a target of 61.1%. By site, RSUH 47.5% vs a target of 55.1%, County 69.4% vs a target of 73.6%.

What are we doing about it?

The UTC project for Royal Stoke is back online with clinical model currently being worked up. Anticipate the benefits of the UTC to come online in January 2026, with full benefits / capacity opening in June 2026.

In the meantime, November will see a new streaming tool for EHPC implemented, looking to increase the number of patients going to EHPC, positively impacting 4-hour performance.

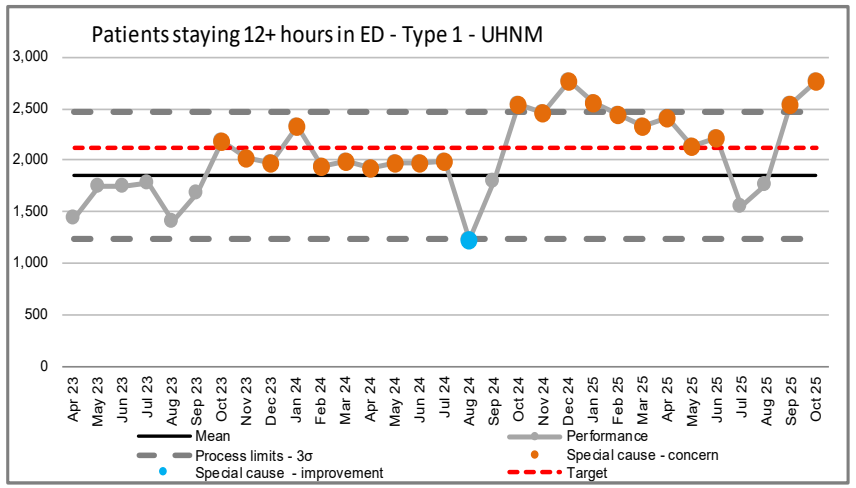
Our previous model of YNP (your next patient) has been transitioned to a continuous flow model.

Review of current standard work and development of medical and nursing standard work for navigation and triage and for the ambulance offloads

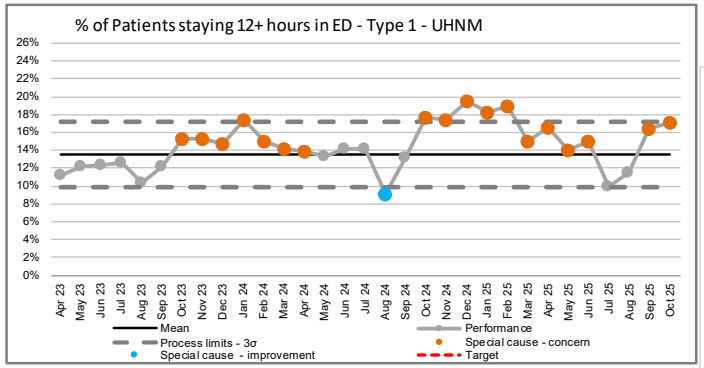
AMRA is now open 24/7 which will see a number of patients pulled from ED overnight (c.12) which will have a small positive impact on 4-hour performance.

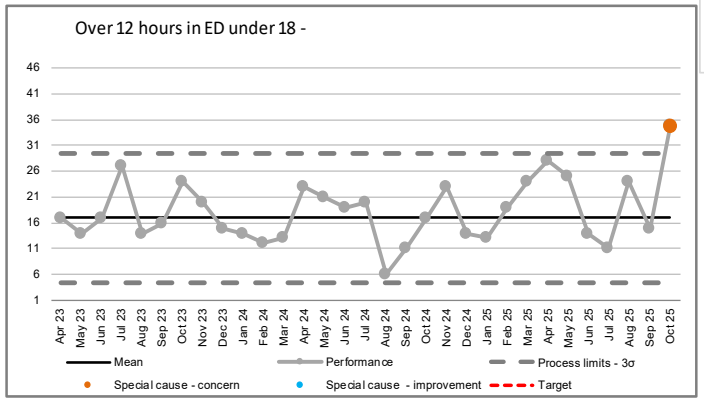
Quality & Access | Over 12-hours in ED From Arrival

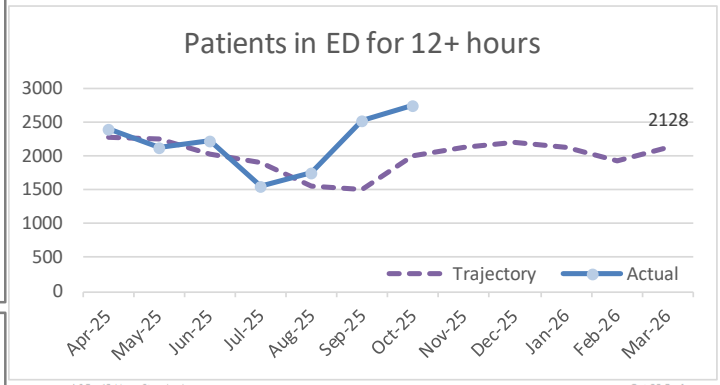
University Hospitals of North Midlands NHS Trust

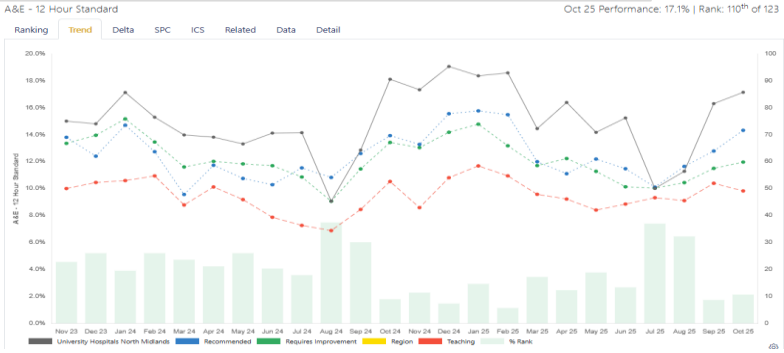


Variation	Assurance		Monitoring against plan				
				Jul 25	Aug 25	Sep 25	Oct 25
	Target	2128	Actual	1,559	1,759	2,546	2,769
Background			Plan	1,907	1,565	1,502	2,021
The number of patients admitted,transferred or discharged over 12 hours after arrival at A&E			Variance	-348	194	1044	748









What is the data telling us?

In October, 2769 patients waited longer than 12 hours in ED against a plan of 2,021 (variance of -748). By site, 2408 at RSUH and 361 at County. Overall performance was 10.5% against a target of 12.1%.

Performance had been tracking along trajectory, however with the earlier than planned arrival of winter and increased acuity has meant length of stay in our deeper bed base has also increased. The impact of this has been felt by those patients waiting for admission in ED.

We have also seen a reduction in pre-noon and pre-4pm discharges which has contributed to this.

What are we doing about it?

The Frailty ToC will continue to support in the same way, for this cohort of patients. Early data suggests around 40 patients pulled per week direct to FEAU (160 per month).

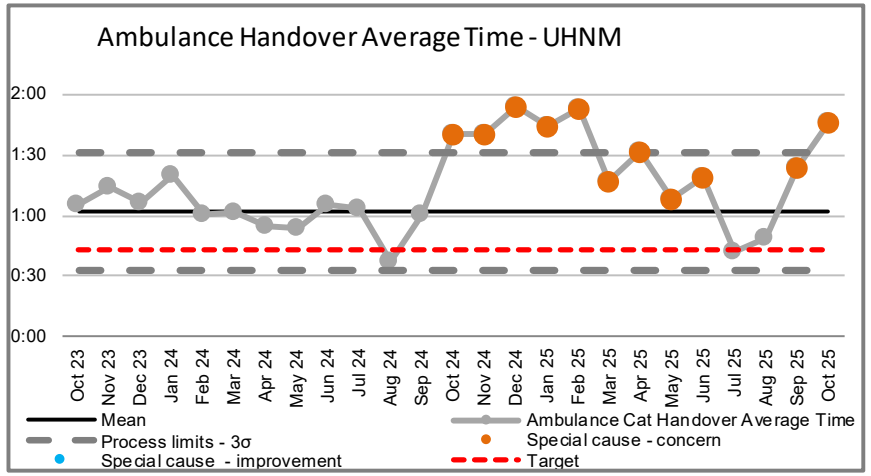
Similarly, as per the AMRA ToC, AMRA is now open 24/7 which will see a number of patients pulled from ED overnight (c.12) which will have a small positive impact on 12-hour performance. This could equate to around 84 patients per week (360 per month).

Through both ToC's, in excess of 500 patients per month could be diverted to portals supporting improved 4 and 12-hour performance.

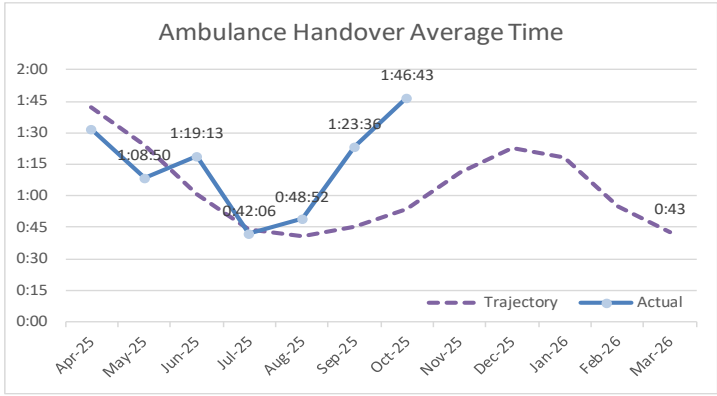
ECIST now with the organisation to focus on ward processes to hopefully support with flow efficiency. We are also working to OPEL level 4 actions for a period of 4 weeks which will help maximise flow.

Quality & Access | Ambulance Handover Average Time

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				Jul 25	Aug 25	Sep 25	Oct 25
	Target	0:43:00	Actual	0:42:06	0:48:52	1:23:36	1:46:43
Background			Plan	0:44:00	0:41:00	0:45:00	0:54:00
The average time taken for patients to be handed over from Ambulances arriving at UHNM.			Variance	-0:01:54	0:07:52	0:38:36	0:52:43



What is the data telling us?

5151 ambulances arrived at UHNM in October – 52.79 % of these handed over within 45 minutes. This is a decline in performance from September, where this figure was 56.85%.

This has meant that during October 2483 patients waited in an ambulance for longer than 45 minutes, this compares to 2197 patients in September.

By site: RSUH was 46.44%, and County 79.03%.

Average handover time in October was 1 hour and 46 minutes, an average increase of 23 minutes from September. Underperformance against plan of 52:43 minutes.

What are we doing about it?

An ambulance handover test of change which focussed on a RAT model was started on 13/10, but quickly stopped due to lack of sufficient space to deliver the RAT model appropriately.

Positive progress is being made to improve streaming pathways to FEAU, alongside AMRA now operating 24/7. These changes will enhance patient flow from the ED, supporting quicker ambulance offloads in some cases.

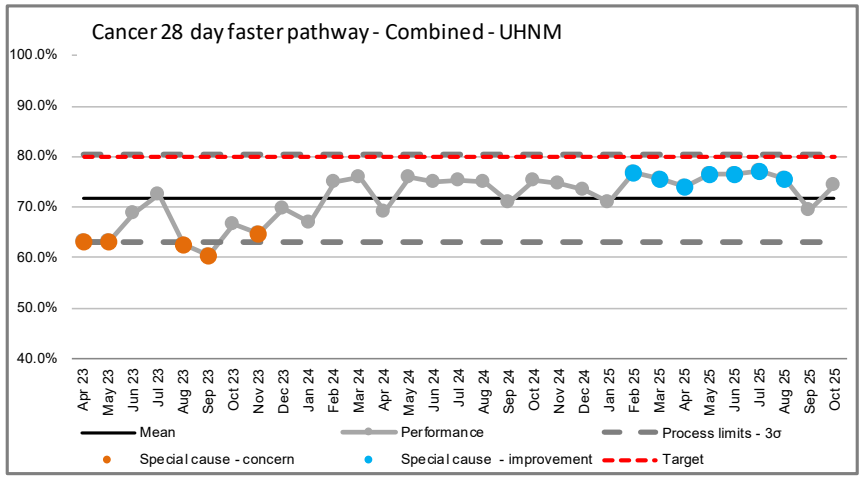
Nineteen new RNs joined the ED at the end of September. All have now completed their supernumerary period as of early November. This will allow the corridor to be staffed to a level of 15 more consistently, helping to reduce the number of ambulances waiting outside.

We are implementing OPEL Level 4 actions over the next four weeks to improve organisational flow and consequently decrease the number of ambulances waiting.

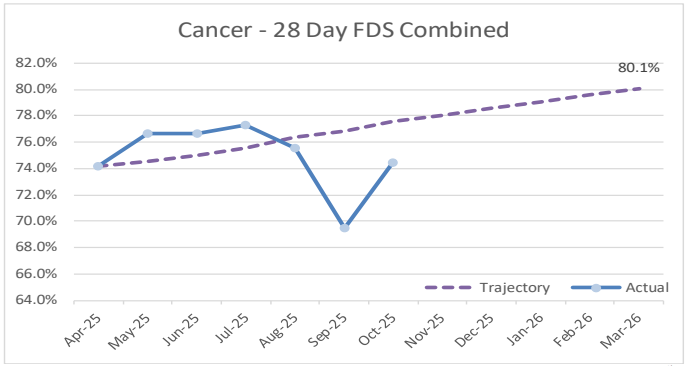
ECIST are with UHNM for the next 6 months with a focus on ward and discharge processes which will also support improved flow.

Quality & Access | Cancer 28 Day FDS

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan	Jul 25	Aug 25	Sep 25	Oct 25
		Target	80%	Actual	77.3%	75.6%	69.5%	74.5%
				Plan	75.6%	76.4%	76.9%	77.5%
Background				Variance	1.7%	-0.8%	-7.4%	-3.1%
Performance of confirmation or exclusion of cancer communicated with patients within the 28 day timeframe.								



What is the data telling us?

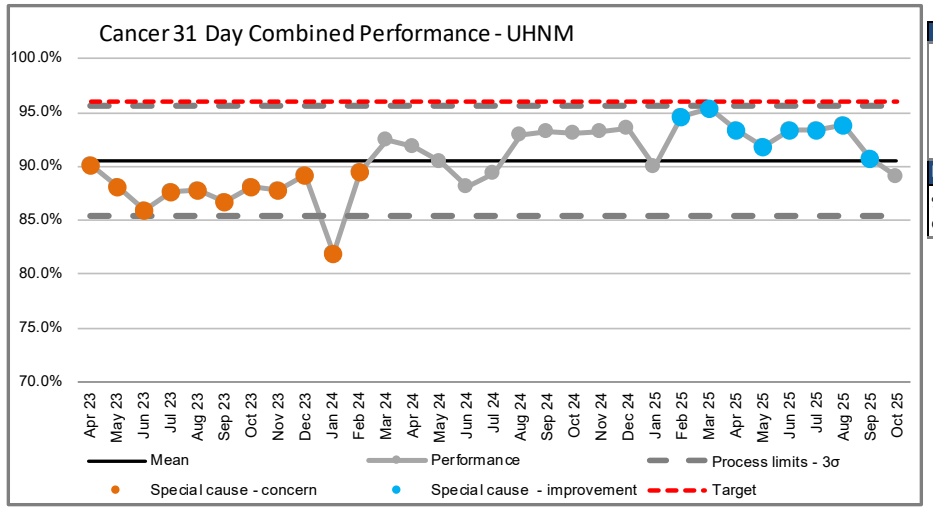
- The final September position was reported at 69.5% against a trajectory of 76.89%. This was impacted by the cessation of text messaging service Accurx, used by multiple cancer sites to communicate an exclusion of cancer to patients.
- The October position is being validated and currently sits at 74.45% which is below the trajectory of 77.54%.
- Colorectal, haematology, head & neck and skin are the most challenged specialties and are underperforming against their trajectories.
- The PTL size and the 62+ backlog is growing, mainly attributable to Skin, as a number of patients have been booked outside of their 28 day and 62 day targets for diagnostic biopsies and planned treatments. This will impact performance reported for November and December.

What are we doing about it?

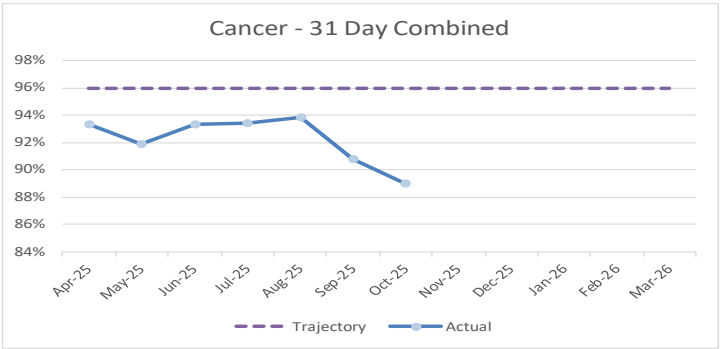
- Alternative patient communication methods are being enacted by directorate teams e.g. use of standardised letter templates and PKB messaging.
- Maintaining the Cancer Delivery Group meetings to bring focus on operational delivery for improvement plans and adherence to agreed trajectories for 25/26.
- High level escalations sent weekly as part of all cancer PTL escalations for senior oversight and daily oversight by the Cancer Team, escalating pathways to support achievement of the standard.
- Oversight and tracking of WMCA investment cases to ensure funds are spent effectively and on time by directorates.
- Skin - subcontracting for additional activity to reduce the volume of patients waiting on the PTL.

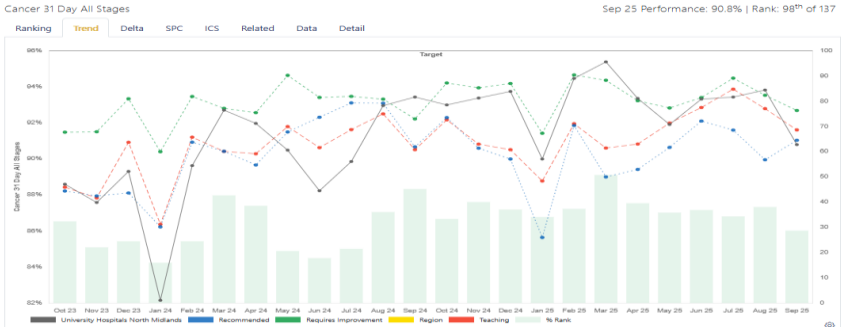
Quality & Access | Cancer 31 Day Combined

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				Jul 25	Aug 25	Sep 25	Oct 25
	Target	96%	Actual	93.4%	93.8%	90.8%	89.0%
Background			Plan	96.0%	96.0%	96.0%	96.0%
% patients beginning their treatment for cancer within 31 days following an urgent GP referral for suspected cancer			Variance	-2.6%	-2.2%	-5.2%	-7.0%





What is the data telling us?

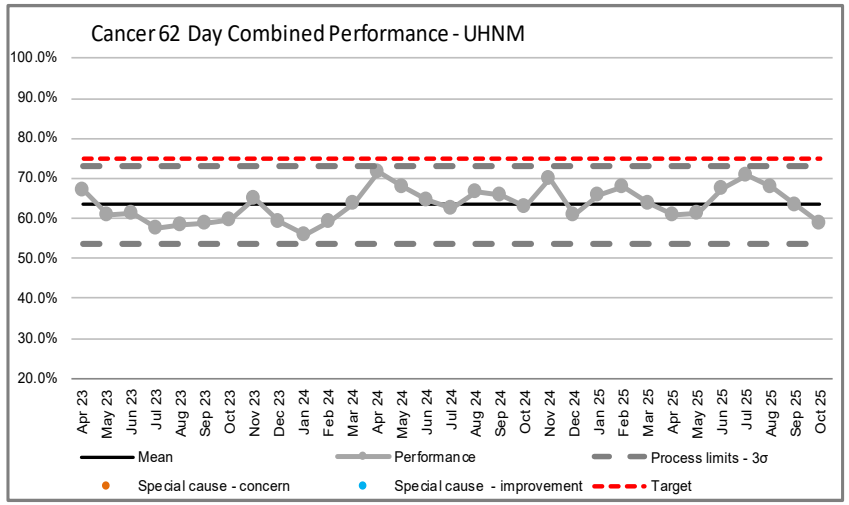
- The final September position was reported at 90.79%
- The provisional October position is currently at 89.56%
- The majority of 31-day breaches are attributable to patients receiving surgery as either a first or a subsequent cancer treatment above the 31-day breach range.
- Within the 31-day cohort of patients breaching surgery, the main delay reason is attributable to lack of capacity in colorectal, gynae, urology and skin tumour sites.
- Radiotherapy and Systemic Anti Cancer Treatments have also seen a slight deterioration of performance. Current waits for Skin Oncology first appointments are at 4 weeks.

What are we doing about it?

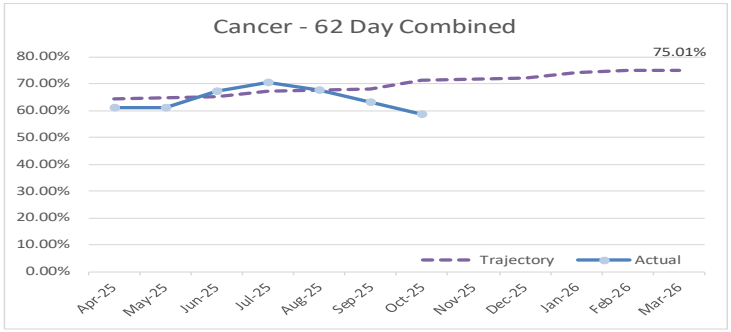
- The Trust and specialties are actively reviewing theatre capacity to ensure utilisation of all capacity available.
- Escalate surgical capacity constraints at all appropriate forums such as Cancer Delivery Group, Specialty Improvement Groups, Cancer Services Strategy Group & Elective Oversight Group.
- Cancer services team are focussed on future dated subsequent treatments to ensure compliance with the cancer standards.
- Education and training is being delivered within the booking / secretarial teams to ensure compliance with Cancer Waiting Times standards
- Colorectal have been successful in gaining investment from WMCA to increase theatres at weekends.

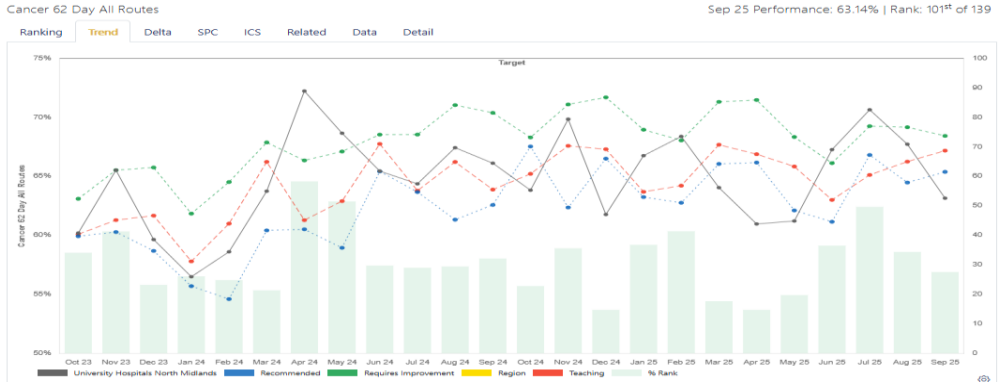
Quality & Access | Cancer 62 Day Combined

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				Jul 25	Aug 25	Sep 25	Oct 25
	Target	75%	Actual	70.6%	67.7%	63.1%	58.6%
Background			Plan	67.2%	67.9%	68.1%	71.5%
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer			Variance	3.4%	-0.2%	-4.9%	-12.9%





What is the data telling us?

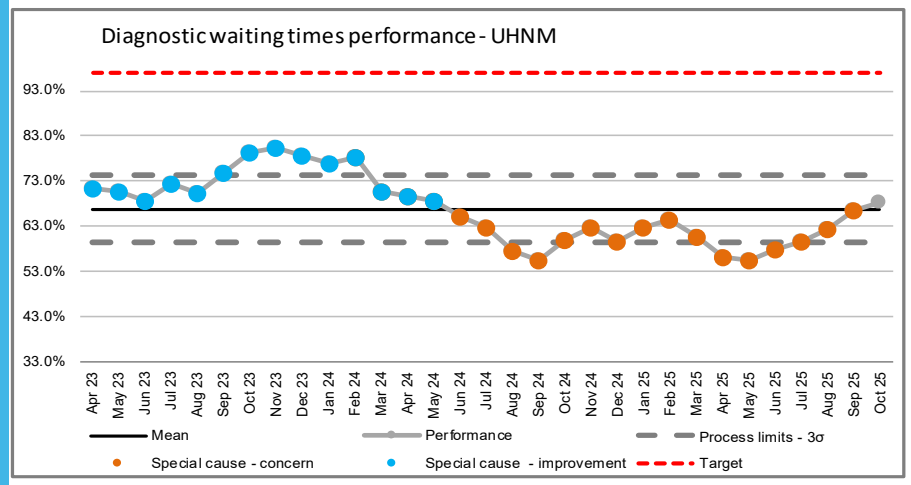
- The final September position was reported at 63.14% against a trajectory of 68.05%
- The provisional October position is currently at 59.64% against a trajectory of 71.53%
- Breast, Colorectal, Gynae, Head & Neck, Skin & Upper GI are below their trajectories.
- Skin performance is particularly challenged owing to capacity for diagnostics and treatment which is significantly impacting on performance from September onwards.
- Surgical capacity constraints (including robotics) affecting Gynae, Colorectal and Skin.
- Complex pathways (i.e. multiple investigations, second look biopsies, molecular and genetics testing).

What are we doing about it?

- Increased oversight and adherence to improvement plans for support services such as pathology and radiology to bring down TAT in the diagnostic phase of challenged pathways, managed through Cancer Delivery Group.
- Validation work to ensure Cancer Waiting Times guidance is being applied appropriately is planned 4 weeks ahead of upload to ensure an accurate position is reported. A 1 year funded Validation post holder has commenced in September with a remit to prospectively review activity and pathways.
- Theatre utilisation and access to the robot being discussed regularly at EOG. Third robot has recently been commissioned and is in use.
- Recent additional funding received to support colorectal theatres, pathology, and lung in particular.
- Collaborative working group in process between Histopathology, Directorates and Cancer Services to identify specimens for reporting on appropriate triage pathway - Cancer Team are currently reviewing an automated solution with pathology.

Quality & Access | Diagnostics DM01 Performance

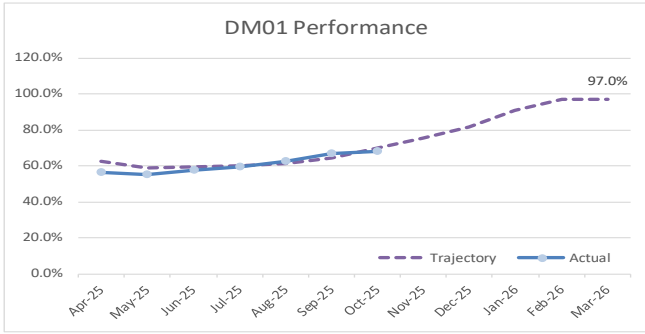
University Hospitals of North Midlands NHS Trust

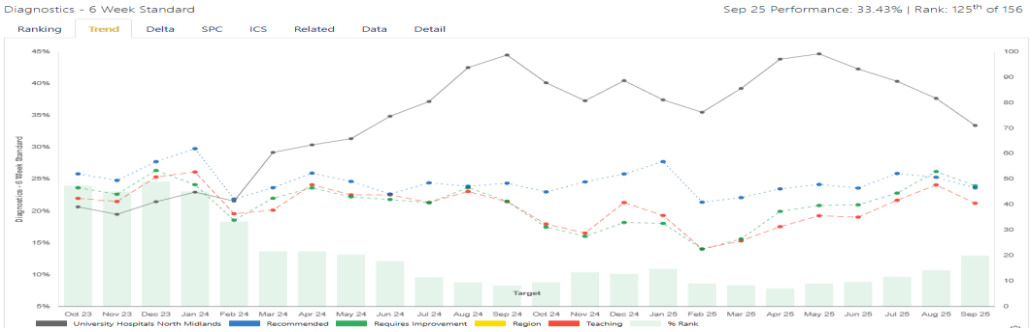


Variation	Assurance		Monitoring against plan				
				Jul 25	Aug 25	Sep 25	Oct 25
	Target	97.0%	Actual	59.7%	62.3%	66.6%	68.1%
			Plan	60.1%	61.3%	64.5%	69.6%
			Variance	-0.5%	1.0%	2.1%	-1.5%

Background

The percentage of patients waiting less than 6 weeks for the diagnostic test.





What is the data telling us?

October DM01 unvalidated performance was 68.1% against trajectory of 69.6%.
Validated position is expected to be 70.2% against plan of 69.6%.
95% being the national standard.

Non-Obstetric Ultrasound is the majority contributor for UHNMs overall DM01 performance variance against the national standard

- NOUS performance is on track against their monthly trajectory. DM01 position has improved by 5.2% over the last 3 months due to NOUS recovery now taking grip
- Unvalidated performance is now 45.4%; a 5% increase since last month

Endoscopy is also a major contributor to overall DM01 performance

- Endoscopy performance reached 99% in June and July, however the position deteriorated in August to 78.3% as predicted due to loss of CDC capacity. 18-weeks did deliver capacity as described in the ERF paper and October month end delivered 95% performance

What are we doing about it?

Non obstetric Ultrasound

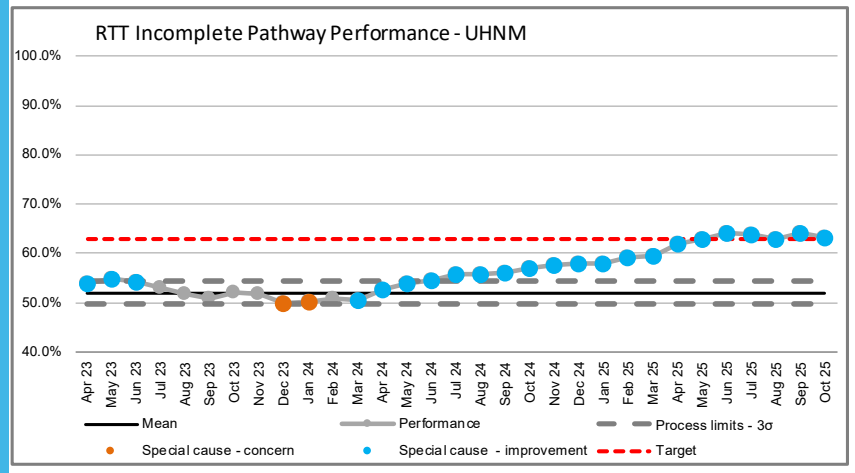
- DM01 position has improved by 2.5% due to NOUS recovery. Backlog position is starting to recover which will support an improvement in DM01 position in the coming months; now under 11,000 patients waiting for appointment and 3,131 waiting over 13 weeks
- 1000 patients have been discharged from NOUS backlog following clinical revalidation. LLC authorisation agreed
- New MSK pathway being finalised with MPFT; new Non-medical referral SOP approaching sign-off which will allow diversion of appropriate activity to NIMS service

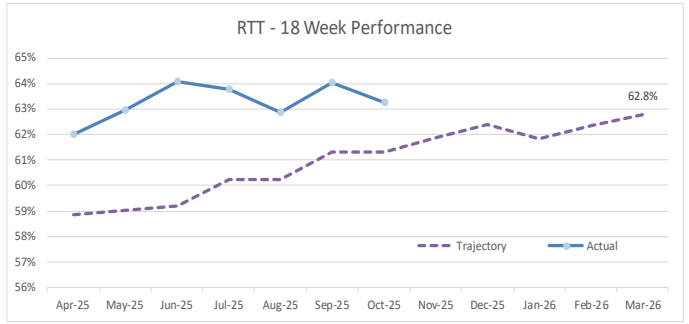
Endoscopy

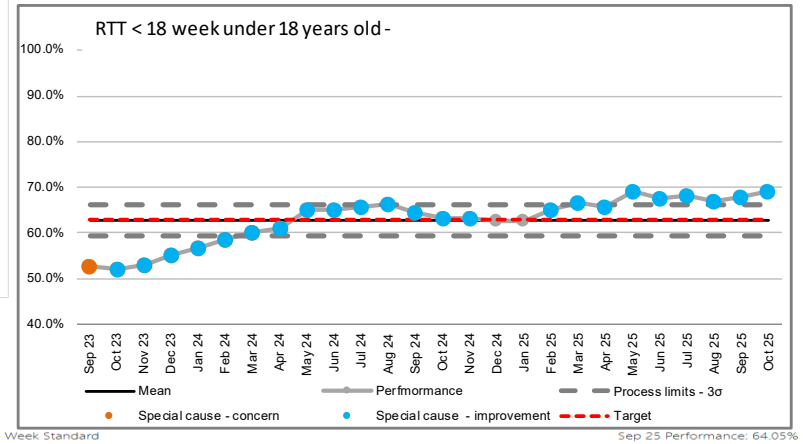
- Capacity paper for October has approved to stabilise DM01. Full business case being worked on to take to execs for Nov to March to bridge CDC gap until April 26. Consultant only slots will need WLI support from Gastro Consultants; Gastro aware and looking to support

Quality & Access | RTT Performance

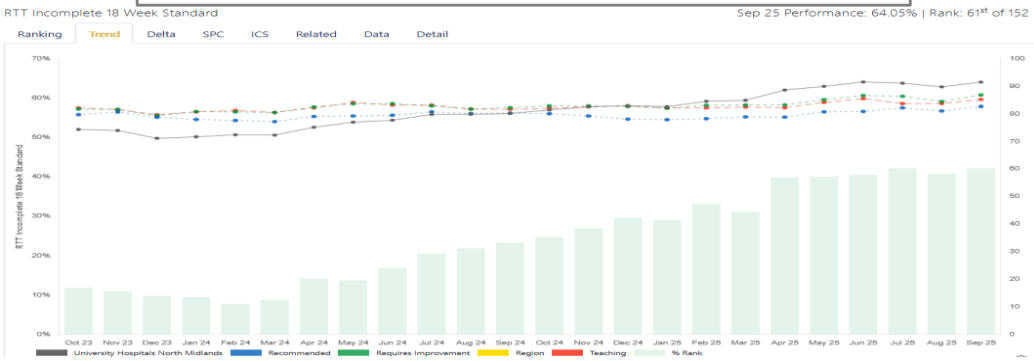
University Hospitals of North Midlands NHS Trust







Variation	Assurance		Monitoring against plan				
				Jul 25	Aug 25	Sep 25	Oct 25
	Target	63%	Actual	63.8%	62.9%	64.1%	63.3%
Background			Plan	60.2%	60.2%	61.3%	61.3%
			Variance	3.5%	2.6%	2.7%	1.9%
The percentage of patients waiting less than 18 weeks for treatment.							



What is the data telling us?

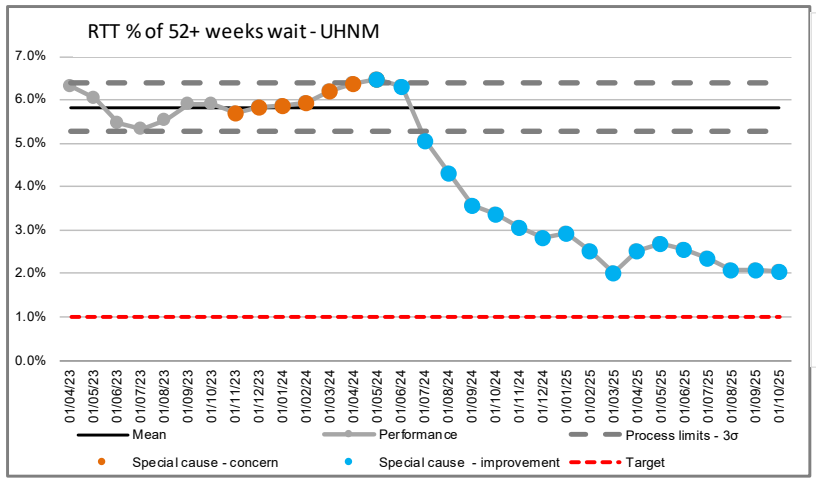
- Performance has improved significantly through extensive validation work completed by MBI, the Corporate Validation Team and the Care Groups. Performance is 63.92%; comfortably above trajectory
- Rank against acute trusts has improved from 98th to 63rd,
- Validated month end position in Total WL size has seen a further decrease in October, to 65,910 from 65,925

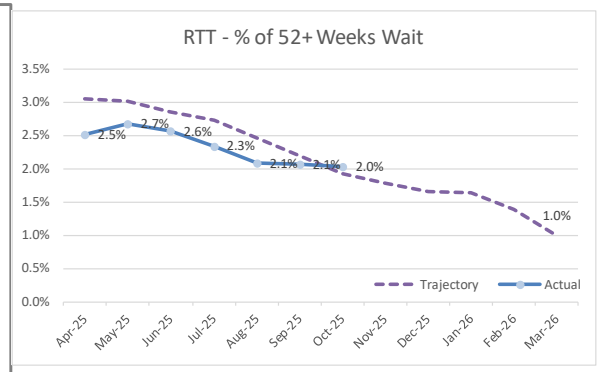
What are we doing about it?

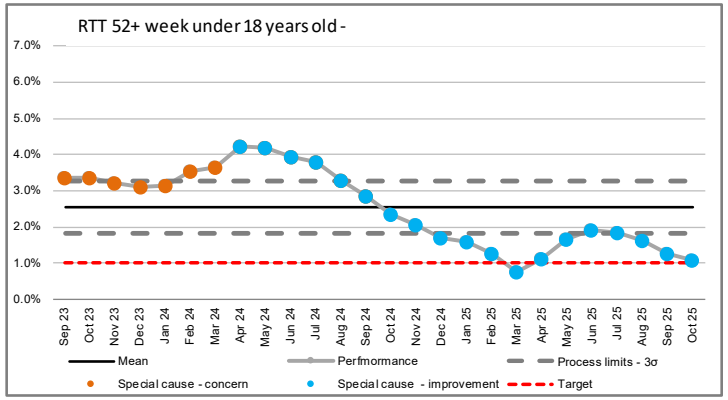
- Validation work will continue at pace to deliver the asks of the national validation sprint
- Work so far has targeted known areas of challenge with data quality and clock stop capture, which is disproportionally patients waiting 18+ weeks. 60% of the patients waiting <18 weeks have yet to be seen, as opposed to 30% of those waiting above 18 weeks; less risk of error
- The ROVA validation tool has now commenced automated validation, which will extend to the entire waiting list. This has shown nearly 2000 pathways which can be closed, leading to an indicative improvement in performance of 1.3%.

Quality & Access | RTT Performance – % 52+ Weeks

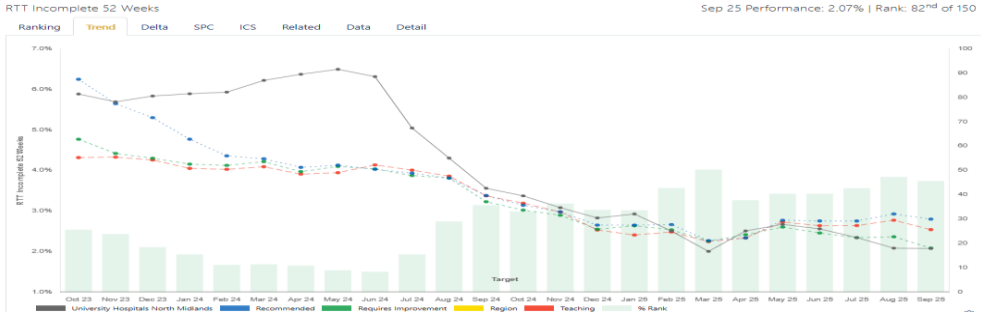
University Hospitals of North Midlands NHS Trust







Variation	Assurance		Monitoring against plan				
				Jul 25	Aug 25	Sep 25	Oct 25
	Target	1.00%	Actual	2.35%	2.08%	2.07%	2.04%
Background			Plan	2.74%	2.46%	2.19%	1.93%
The percentage of patients on a RTT pathway who have			Variance	-0.4%	-0.4%	-0.1%	0.1%



What is the data telling us?

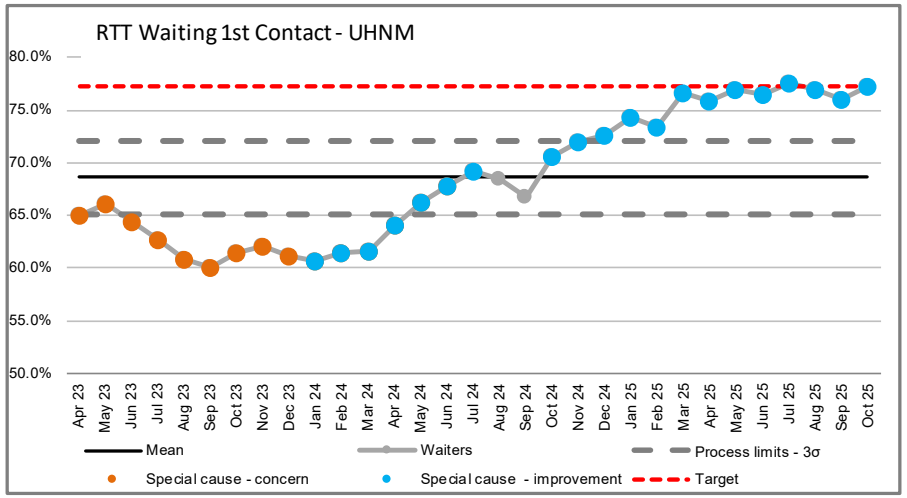
- For the month of October 52 week plan reduced from 2.1% to 1.8%. 52-week actuals still tracking at 2.1%
- Gynae have an overall contribution of 350 patients of the 1374 patients breaching 52 weeks. This equates to 25% of 52-week breaches for UHNM
- Although the proportion of our waiting list waiting above 52 weeks has continually reduced, the cumulative effect of extended UEC pressures has slowed down progress
- This cohort is extensively validated, so there's not much scope for improvement through validation alone
- Another factor influencing this is the reduction in total waiting list size, so the unavoidable side effect of the validation programme is an increase in the percentage of the waiting list over 52 weeks

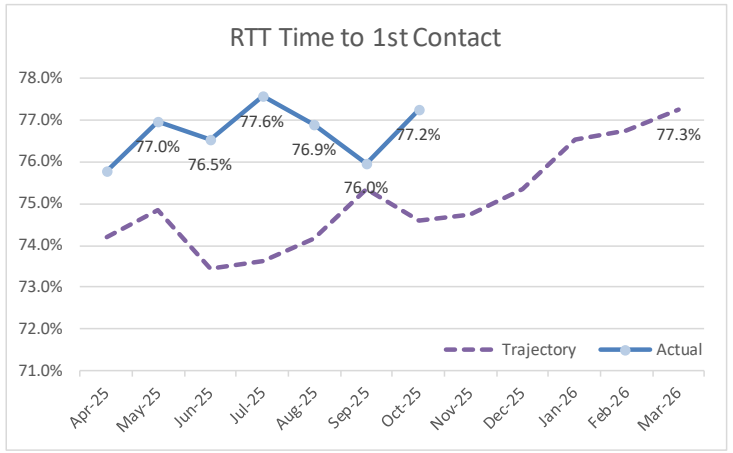
What are we doing about it?

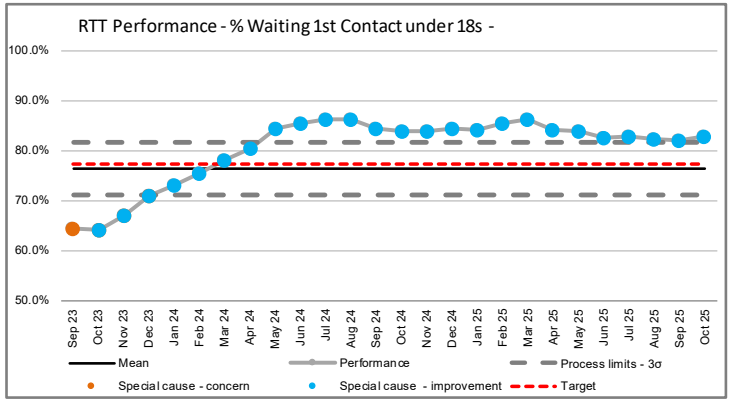
- Gynae Recovery funding approved at execs to deliver substantial additional activity through weekend and STS working; activity against recovery to be tracked separately on a week-by-week basis
- The ROVA validation tool also highlights pathways where actions have not been taken, and groups pathways awaiting the same action for easier tracking of patients at all stages of the pathway
- Validation data is captured systematically in terms of what errors are being made and in which services, allowing for more targeted training and support for more challenged areas
- This metric will improve as the above takes hold, and far fewer patients reach 52 weeks in the mid-longer term.

Quality & Access | RTT % Waiting 1st Contact

University Hospitals of North Midlands NHS Trust







Variation	Assurance		Monitoring against plan				
				Jul 25	Aug 25	Sep 25	Oct 25
	Target	77.3%	Actual	77.6%	76.9%	76.0%	77.2%
Background			Plan	73.6%	74.2%	75.4%	74.6%
Of all patients waiting for first event after referral - the percentage that are waiting under 18 weeks			Variance	3.9%	2.7%	0.6%	2.7%

What is the data telling us?

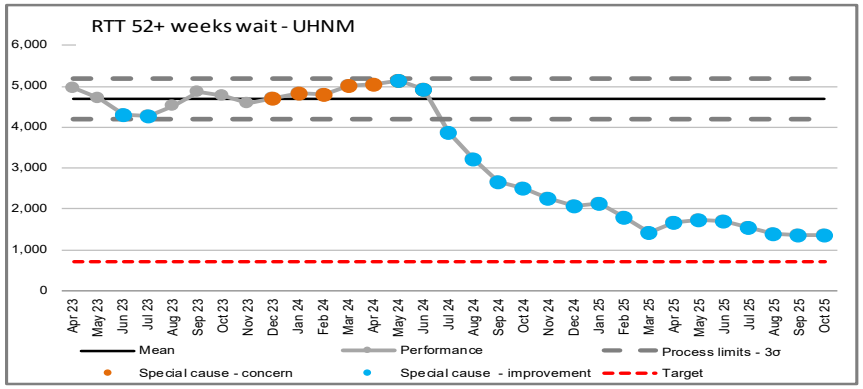
- UHNM is a regional leader on this metric and ahead of plan
- Time to first contact performance remains strong at 77.24% against a plan of 74.6%

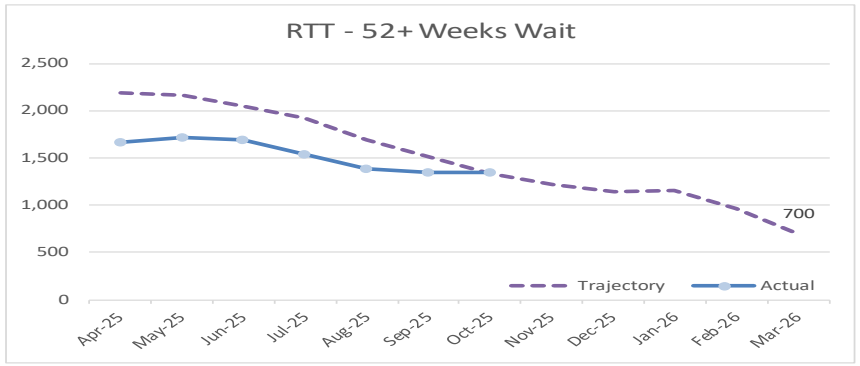
What are we doing about it?

- 52-week 1st contact for patients by March '26 are required to be seen by January '26. Performance being tracked weekly through EOMG
- ERF papers approved, and mobilisation has been quicker than expected for outpatient clinics
- Increased validation of Cardiology pathways for patients awaiting 1st contact, as not all should be on an RTT pathway
- Work to understand the Ophthalmology increase is underway; a reduction in independent sector cataract capacity within the ICS in 2024/25 has likely had an impact

Quality & Access | RTT No. of Long Waiting Patients

University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	700

Background

The number of patients on a RTT pathway who have waited longer than 52 weeks for treatment.

Monitoring against plan	Jul 25	Aug 25	Sep 25	Oct 25
Actual	1,543	1,385	1,355	1,347
Plan	1,930	1,699	1,520	1,341
Variance	-387	-314	-165	6
65+	110	105	100	79
78+	15	7	3	1
104+	1	0	0	0

What is the data telling us?

- The number of 78 week breaches has decreased again from 3 in September to 1 in October.
- 65 week waits have also reduced to 75 in October from 100 in September
- There is some risk with the extensive validation work underway of pop-up long waiters – these will be managed through the trust's "uncorrected breaches" process
- Particular specialties which impact are Orthopaedics, ENT, Ophthalmology and Gynaecology.

What are we doing about it?

- Micromanaging long waiting patients at daily/weekly PTL meetings
- ERF funding approved to increase evening and weekend operating capacity

Highlight Report

Finance & Business Performance Committee | 3rd November 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate

- The Committee welcomed the strengthening of action planning to address specific gaps in control and assurance within the **Board Assurance Framework** (BAF) for Quarter 2. Members challenged the number of actions whereby the target dates had changed a number of times, and it was agreed to include further rationale for changes in timelines within the next update.
- The Committee challenged the relationship between risk scores and the likelihood of meeting **financial plans**, and it was noted that the impact of future planning guidance would be considered as part of the Q3 update.
- Clarity was also requested on the management of **shadow IT** in terms of whether the Trust aimed for zero shadow IT or for effective governance of existing systems.
- **Month 6 financial performance** had slightly improved, due to a reduction in bank spend, resulting in delivery of £13.0 m deficit which was in line with the planned deficit of £13.1 m. The Committee noted the progress towards the workforce reduction target and the controls in place. The ongoing work with care groups to assess any potential impact of stepping down activity was also noted.
- The Committee received an update on the **financial outlook** and the underlying deficit of £39.6 m (assuming £13.5 m deficit in the current year). The Committee discussed the need for a detailed analysis of deficit drivers and the importance of transformation to address structural issues.
- An update on the **Cost Improvement Programme** (CIPs) highlighted that 71% of fully developed CIPs remained to be delivered, with particular challenges in terms of the level of non-recurrent savings being utilised. Following the recalibration exercise, a further £5 m opportunity was identified, and this was being worked through.
- Concerns were raised about assurance, prioritisation, commercial maturity, and lessons learned in the **transformation** programme. The need for strengthened governance and evidence of benefit realisation was also highlighted. It was agreed that the assurance rating for the **transformation** update was partial, due to the further assurance required around timelines and benefits.

Major Actions Commissioned / Work Underway

- To amend the **BAF** for Q3 to include an action regarding the timeline for identification and delivery of the 2026/27 Cost Improvement Programme (CIP), review of the language used within some of the actions for BAF 4, provide more clarity and assurance on shadow IT management and review the risk appetite for financial risks.
- Get it Right First Time review to be undertaken for **haematology,** with any associated investment to be subject to separate investment cases
- Update on **medium term planning** to be provided to the Committee by December 2025, including 2026/27 CIP plan.
- Further narrative of **CIP** schemes which were due to come online and be delivered, to be included within the next update.
- Further visibility of how **backlog maintenance and estate optimisation** could be impacted by transformation capital schemes and agreed to include in future reports

Positive Assurances to Provide

- The Committee welcomed the **Transformation** update on the progress of the 4 strategic programmes. It was agreed to enhance future reports by including RAG ratings and assurance in terms of who was leading the specific programmes i.e. PMO.
- Acceptable assurance was provided by the **Premises Assurance Model** (PAM) and **Estates Return Information Collection** (ERIC). It was noted that for the PAM a self-assessment of good had been identified. For ERIC it was noted that the Trust was considering comparisons with peers, and that future reports would include these comparisons.

Decisions Made

- The Committee approved the **haematology** disinvestment and associated cost pressure
- The Committee approved the business case for **replacement of glucose and ketone meters**
- The Committee approved the **endoscopy elective recovery bid** for the period November 2025 to March 2026
- The Committee agreed to approve the **budget setting policy** at the next meeting
- The Committee approved **e-REAFs** 17146, 17128, 17082, 17055, 17224, 17213 and 13856

Comments on the Effectiveness of the Meeting

Cross Committee Considerations

• Comments on effectiveness were sought via MS teams	• Cross-committee assurance required on the alignment of initiatives with the Trust's strategy. • Further update in relation to transformation to be provided to wider Board members

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Board Assurance Framework	ALL		N/A	Approval	7.	CIP Report	6, 7	Ext 20	Partial	Assurance
2.	BC-0619 Haematology Disinvestment	-		N/A	Approval	8.	M6 Demand and Activity Report	6, 7	Ext 20	Not assessed	Assurance
3.	BC-0624 Replacement of Meters for Glucose and Ketone Testing	-		N/A	Approval	9.	Transformation Programme	2, 4	10 16	Partial	Assurance
4.	Endoscopy Elective Recovery Bid	1	Ext 20	N/A	Approval	10.	Premises Assurance Model (PAM) and Estates Return Information Collection (ERIC) Annual Report	5	High 12	Acceptable	Assurance
5.	Finance Report – Month 6 • Recovery Plan Letter / Response	6, 7	Ext 20	Partial	Assurance	11.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-		N/A	Approval
6.	Financial Outlook 2026/27	6, 7	Ext 20	Partial	Assurance						

Highlight Report

Finance & Business Performance Committee | 1st December 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Month 7 **financial performance** demonstrated £10.4 m deficit which was in line with plan. Deficit support funding had been confirmed for Q3 and key risks related to underperformance in elective recovery and reliance on non-recurrent measures. Work remained ongoing with regards to reducing the potential year-end deficit of £13 m (reduced by £0.5 m at month 6) and the route to break even, working alongside system partners • **Capital plan** reduced in year for the Urgent Treatment Centre (UTC) at County Hospital and discharge lounge, with expenditure at £36.3 m against the plan of £42.9 m • **Cost Improvement Programme (CIP)** highlighted that the focus had moved to identifying schemes for 2026/27. To date £53.2 m schemes had been fully developed (71%) of the plan. High risk schemes were noted and the Trust continued to work with Deloitte to understand the drivers of the deficit for 26/27, and any to be addressed in 25/26 • **Activity and demand** performance report highlighted an increase in Emergency Department attendances, alongside patients having a higher acuity, although further assurance regarding this was requested. Issues in relation to the counting of activity were noted which were being investigated and corrective actions taken to ensure accurate reporting going forwards. It was agreed that future reports should focus on performance and effectiveness as opposed to non-elective demand given that many of the actions to reduce this remained outside of the organisation's control • **Emergency Preparedness, Resilience and Response** (EPRR) core standards demonstrated partial compliance with 49 / 62 (79%) core standards achieved, an improvement from the previous year. Discussions remained ongoing with regards to ensuring appropriate resource was in place within the EPRR team given the actions to be taken in order to achieve full compliance. It was noted that the Committee would continue to maintain oversight of EPRR, with updates being provided to the Trust Board as required	• Further assurance to be provided to the Committee in January regarding the remit of the **Strategy Delivery Unit** and its effectiveness given the focus on CIP, capacity and capability for transformation and sustaining changed behaviours and learning • **Job planning** compliance and process to be reported through to People, Culture and Inclusion Committee with the outputs of any associated transformation schemes to be reported to the Committee • Further update to be provided to the Committee in relation to the **land sale** for the Royal Infirmary and COPD sites and any additional mitigations required • Meeting to be held with Non-Executives regarding the **medium-term plan** • Deep dive to be undertaken to identify the root causes of the coding issue in relation to **ED activity**

Positive Assurances to Provide	Decisions Made
• The Committee received an in-depth presentation on NHS **productivity**, benchmarking and cost collection, including national expectations, current performance and the Trust's approach to identifying and realising efficiency opportunities.	• The Committee approved the **Budget Setting Standard Operating Procedure,** noting that this would be updated accordingly as future guidance was received • The Committee approved the **Cardiothoracic Workforce – Middle Grade Cardiothoracic Anaesthetists** Business Case, option 2, with further assurance to be provided regarding the timeline for recruitment and the associated strategic workforce plan • The Committee approved **e-REAFs** 16516, 17233 and 17212

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Comments on effectiveness were sought via MS teams	• Further assurance to be provided to Quality, Access and Outcomes Committee regarding **non-elective activity** and the outputs from the test of change within frailty and AMRA

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Budget Setting Standard Operating Procedure	6, 7	Ext 20	Not applicable	Approval	7.	CIP Report	6, 7	Ext 20	Partial	Assurance
2.	BC-0608 Cardiothoracic Workforce – Middle Grade Cardiothoracic Anaesthetists	1, 3	ID17967	Not applicable	Approval	8.	Demand and Activity Performance Report Month 7 2025/26 • Reporting of Emergency Department Attendances	1, 6, 7	Ext 20	Not assessed	Assurance
3.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-	-	Not applicable	Approval	9.	Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assurance	-	-	Partial	Assurance
4.	Finance Report – Month 7 2025/26	6, 7	Ext 20	Partial	Assurance	10.	Productivity Deep Dive	6, 7	Ext 20	Not applicable	Information

Since 14th September to 14th November 2025, 3 contract awards over £1.5 m were made, as follows:

- **Provision of Blood Glucose & Ketone Monitoring Consumables, Support and Equipment,** supplied by Roche Diagnostics Ltd, for the period 01/04/26 – 31/03/31, at a total cost of £2,362,008, providing negated inflation savings of £16,581.29, approved on 3rd October 2025
- **NMCPS Pathology Managed Service Contract,** supplied by Siemens Healthcare Diagnostics, for the period 01/10/26 – 30/09/28, at a total cost of £19,061,156, providing cost reduction savings of £270,944, approved on 10th October 2025
- **NMCPS Blood Sciences Managed Service Contract,** supplied by Beckman Coulter UK, for the period 01/10/25 – 30/09/28, at a total cost of £8,490,024.47, providing cost reduction savings of £5,097.14, approved on 10th October 2025

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 07 Performance

2025/26

Kind Excellent Together

University Hospitals of North Midlands NHS Trust

Contents

Statistical Process Control

University Hospitals of North Midlands NHS Trust

This report uses Statistical Process Control (SPC) methods to draw two main observations of performance data and the below key, and icons are used to describe what the data is telling us.

Variation	Are we seeing significant improvement, significant decline or no significant change?
Assurance	How assured of consistently meeting the target can we be?

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: **orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

NHS Oversight Framework Summary

University Hospitals of North Midlands NHS Trust

Headlines	Data period	Provider value	Peer average	National value	National value method	Chart
Adjusted segment			Q1 2025/26 3	NOF Score	Provider value	
Average metric score			Q1 2025/26 2.47	NOF Score	Provider value	
Unadjusted segment			Q1 2025/26 3	NOF Score	Provider value	
Financial override	Q1 2025/26	No	Yes	Yes	Provider median	
Is the organisation in the Recovery Support Programme?	Q1 2025/26	No	No	No	Provider median	

Domain Scores	Data period	Provider value		Chart
Access to services domain segment	Q1 2025/26	3	NOF Score	
Access to services domain score	Q1 2025/26	2.55	NOF Score	
Effectiveness and experience of care domain segment	Q1 2025/26	2	NOF Score	
Effectiveness and experience of care domain score	Q1 2025/26	2.17	NOF Score	
Patient safety domain segment	Q1 2025/26	3	NOF Score	
Patient safety domain score	Q1 2025/26	2.63	NOF Score	
People and workforce domain segment	Q1 2025/26	2	NOF Score	
People and workforce domain score	Q1 2025/26	2.53	NOF Score	
Finance and productivity domain segment	Q1 2025/26	3	NOF Score	
Finance and productivity domain score	Q1 2025/26	2.36	NOF Score	

UHNM is placed in segment 3 and is positioned in the middle of this segment.
UHNM demonstrates a balanced performance across the NOF domains, with all domain scores within the mid range point nationally.

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NOF - Finance and Productivity

Finance and productivity	Data period	Provider value		Chart
Finance and productivity domain score	Q1 2025/26	2.36	NOF Score	

Finance	Data period	Provider value	Peer average	National value	National value method	Chart
Combined finance score			Q1 2025/26 1	NOF Score	Provider value	
Planned surplus/deficit score			Q1 2025/26 1	NOF Score	Provider value	
Planned surplus/deficit	Apr 2025	0.00%	-2.03%	0.00%	Provider median	
Variance year-to-date to financial plan score			Q1 2025/26 1	NOF Score	Provider value	
Variance year-to-date to financial plan	Jun 2025	0.03	-0.62	0.00	Provider median	

Productivity	Data period	Provider value	Peer average	National value	National value method	Chart
Implied productivity level score			Q1 2025/26 3.73	NOF Score	Provider value	
Implied productivity level	Mar 2025	-2.47%	1.74%	2.91%	Provider median	

UHNM is demonstrating a good position when compared nationally, although latest months data is suggesting some deterioration across each metric. Productivity metrics require continued focus as these are positioned in the lowest quartile.

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Finance | Financial Summary

Getting the most from our resources including staff, assets and money

This report presents the financial performance of the Trust for October 2025 (Month 7).

The Trust has delivered a £10.4m deficit at month seven, which is in line with the planned deficit of £10.4m.

Income: The income is underperforming by £8.6m, mainly due to lower-than-expected income from pass-through devices and drugs (which are offset by reduction in non-pay spend), and a delay in Community Diagnostic Centre income.

Activity: The month seven Elective Inpatients and Outpatient activity is £6.8m below the plan. For 2025/26, it has been with the ICB that any under performance against the ERF target will be re-invested as non-recurrent deficit support funding. Therefore, for Staffordshire and Stoke ICB the income level for the ERF funding reflects the agreed plan.

Expenditure: There is a year to date pay underspend of £2.0m, most notably against NHS Infrastructure Support. Non-pay is underspent by £5.0m, mainly due to lower expenditure for pass through devices and drugs (offset by an under recovery of income).

Financial Outlook 2025/26: The Trust's updated forecast shows a year-end deficit of £13.0m, an improvement since month six of £0.5m.

CIP: The Trust has a £74.8m CIP target for 2025/26. To month seven, the Trust is reporting £24.3m savings in year, against a target of £30.6m, however £3.0m is being delivered non-recurrently above the original non recurrent plan of £9.9m.

Capital: The capital expenditure plan for 2025/26 is £111.1m with a reprofiled forecast of £103.9m. The reduction is due to the discharge lounge scheme and part of the UTC scheme being deferred to 2026/27. The year-to-date position shows a spend of £36.3 m against plan of £42.9m, with the underspend mainly relating to CDC Phase 1 and Breast Care Unit. Expenditure is expected to recover but will need close monitoring.

Statement of Financial Position: The month seven Statement of Financial Position shows total assets employed of £257.7m. The cash balance is £88.5m against a plan of £64.7m. The variance is mainly due to cash received relating to ERF overperformance and Education Contract Training.

System Position: The system month seven position has a favourable variance of £0.7m from the planned deficit of £19.3m.

Financial Risks: Several risks have been identified that could deteriorate the Trust's financial position, including additional unfunded escalation capacity, shortfall against CIP plans, winter planning, and lower activity levels than required to meet ERF income targets. In addition, recent developments in respect of Resident Doctors industrial action represents a further risk as there are no indications impact will be funded. Mitigations will need to be put in place if there is a deterioration in the financial position.

Related Strategy and Board Assurance Framework (BAF)

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 6: Inability to Deliver In-Year Financial Position	Ext 20	Partial	Ext 20	Partial				
BAF 7: Inability to Deliver Financial Sustainability	Ext 20	Partial	Ext 20	Partial				

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Finance | Income and Expenditure

Getting the most from our resources including staff, assets and money

The Trust has delivered a £10.4m deficit at month seven, which is in line with the planned deficit of £10.4m. The table below summarises the Income and Expenditure position at month seven.

Income & Expenditure Summary Month 07 2025/26	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	1,216.9	103.3	103.1	(0.2)	711.9	702.2	(9.7)
Other Operating Income	101.1	8.0	9.2	1.2	57.2	58.3	1.1
Total Income	**1,317.9**	**111.3**	**112.3**	**1.0**	**769.0**	**760.5**	**(8.6)**
Pay Expenditure	(784.0)	(64.4)	(62.7)	1.7	(465.3)	(463.2)	2.0
Non Pay Expenditure	(501.7)	(41.6)	(44.5)	(3.0)	(295.4)	(290.4)	5.0
Total Operational Costs	**(1,285.7)**	**(106.0)**	**(107.2)**	**(1.2)**	**(760.7)**	**(753.7)**	**7.0**
EBITDA	**32.2**	**5.3**	**5.1**	**(0.2)**	**8.4**	**6.8**	**(1.6)**
Interest Receivable	2.6	0.2	0.4	0.2	1.5	3.3	1.8
PDC	(4.8)	(0.4)	(0.4)	(0.0)	(2.8)	(3.0)	(0.2)
Finance Cost	(30.0)	(2.5)	(2.5)	(0.0)	(17.5)	(17.5)	(0.1)
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit)	**(0.0)**	**2.7**	**2.6**	**(0.1)**	**(10.4)**	**(10.4)**	**0.0**

Finance | CIP

Getting the most from our resources including staff, assets and money

The Trust has a £74.8m CIP target for 2025/26. To month seven, the Trust is reporting £24.3m savings in year, against a target of £30.6m, however £3.0m is being delivered non-recurrently above the original non recurrent plan of £9.9m.

The table below summarises the month seven position:

	Plan Plan 31/10/2025 YTD £'000	Actual Actual 31/10/2025 YTD £'000	Variance Variance 31/10/2025 YTD £'000
Recurrent			
Pay - Recurrent	13,212	5,396	(7,816)
Non-pay - Recurrent	5,466	3,643	(1,823)
Income - Recurrent	2,044	2,350	306
Total recurrent efficiencies	**20,722**	**11,389**	**(9,333)**
Non recurrent			
Pay - Non-recurrent	3,377	8,065	4,688
Non-pay - Non-recurrent	4,708	4,463	(245)
Income - Non-recurrent	1,777	357	(1,420)
Total non-recurrent efficiencies	**9,862**	**12,885**	**3,023**
Total Efficiencies	**30,584**	**24,274**	**(6,310)**

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Finance | Capital

Getting the most from our resources including staff, assets and money

The table below sets out the capital expenditure plan for 2025/26 of £111.1m and the reprofiled forecast of £103.9m.
At month seven capital expenditure is £36.3m against a plan of £42.9m, an underspend of £6.6m. Of this, £13.4m relates to PFI/IFRS16 lease commitments. Key underspends include CDC enabling works (£2.8m), County Breast Unit (£1.6m), and capital sub-groups (£1.9m), mainly IM&T (£0.9m). No major risks identified to year-end.
The month seven forecast shows a £1.7m funding shortfall but includes endoscopy equipment replacement at Royal Stoke and County sites. However, this is based on high level assumptions whilst an options appraisal is being drawn up. Confirmation on endoscopy costs will be brought to the committees next meeting.

UHNM Capital Expenditure Plan 2025/26	Revised Capital Plan £m	Forecast outturn £m	Variance £m	YTD plan M7 £m	YTD actual M7 £m	Variance £m
Pre-committed items - PFI and Loans						
PFI re-payment of liability	14.900	14.900	0.000	8.692	8.692	0.000
PFI lifecycle commitments	2.268	2.268	0.000	1.442	1.442	0.000
PFI PACS refresh - increase to PFI liability	0.200	0.200	0.000	0.000	0.000	0.000
PFI MES - increase to PFI liability TBC	7.131	7.131	0.000	0.737	0.737	0.000
Repayment of IFRS16 leases	4.272	4.272	0.000	2.492	2.492	0.000
Total PFI and IFRS 16 lease repayments commitments	**28.771**	**28.771**	**0.000**	**13.363**	**13.363**	**0.000**
Investment items						
PFI enabling costs	0.181	0.181	0.000	0.016	0.016	0.000
Network & Comms BCS25	0.748	0.389	0.359	0.060	0.060	0.000
LED lighting BCS46	0.427	0.427	0.000	0.022	0.022	0.000
IM&T computer hardware refresh BCS69	2.142	2.142	0.000	0.577	0.503	0.074
Investment funding for new business cases 25/26	0.250	0.306	(0.056)	0.000	0.000	0.000
Project Star - RI remedial work	0.010	0.010	0.000	0.000	0.001	(0.001)
ED ambulance off - enabling ward moves	0.006	0.006	0.000	0.006	0.006	0.000
Endoscopy works 7th room - PDC ICB allocation TBC	0.009	0.009	0.000	0.009	0.009	0.000
Completion of County Holding Bay	0.074	0.074	0.000	0.074	0.020	0.054
Managing H&S risk register - BCS62 (from £500k)	0.043	0.043	0.000	0.000	0.000	0.000
Endoscopy BC GI PHYS BCS83	0.130	0.130	0.000	0.130	0.130	0.000
Royal Stoke high voltage upgrade BC required	0.752	0.752	0.000	0.204	0.027	0.177
Printer lease refresh BCS91	0.593	0.593	0.000	0.593	0.593	0.000
Elective hub 24/25 BC brought forward spend	0.632	0.932	(0.300)	0.433	0.433	0.000
County CT replacement	1.200	0.000	1.200	0.000	0.000	0.000
SoN CIG	0.100	0.100	0.000	0.097	0.097	0.000
Day Case completion costs	0.000	0.097	(0.097)	0.113	0.113	0.000
SoN Fortinet licences	0.000	0.399	(0.399)	0.000	0.000	0.000
PSDS - completion of business case	0.000	0.286	(0.286)	0.090	0.090	0.000
Sustainability Heat Network - Business Case design fees	0.000	0.110	(0.110)	0.000	0.000	0.000
SoN - Shine ambulatory unit	0.000	0.061	(0.061)	0.000	0.000	0.000
Removal of Covid staff wellbeing cabins	0.000	0.075	(0.075)	0.028	0.028	0.000
Replacement meters glucose keytone testing BC	0.000	0.433	(0.433)	0.000	0.000	0.000
SoN Stryker trollies	0.000	0.111	(0.111)	0.000	0.000	0.000
Endoscopy equipment replacement	0.000	5.452	(5.452)	0.000	0.000	0.000
Central Contingency & risk	0.000	0.000	0.000	0.000	0.000	0.000
Funding to allocate/(shortfall)	(0.373)	(1.683)	1.310	0.000	0.000	0.000
Total Pre committed Investment items	**6.924**	**11.435**	**(4.511)**	**2.452**	**2.148**	**0.304**
Capital sub-group (ICB allocation)						
IMT Sub Group Total Funding	2.535	2.535	0.000	1.278	0.389	0.889
Medical Devices Sub Group	3.600	3.600	0.000	1.613	1.110	0.503
Estates Sub Group Total Funding	5.462	5.486	(0.024)	1.805	1.307	0.498
Health & Safety compliance	0.156	0.156	0.000	0.008	0.010	(0.002)
Net zero carbon (sustainability) initiatives	0.100	0.024	0.076	0.000	0.000	0.000
Total Capital Sub-Groups	**11.853**	**11.801**	**0.052**	**4.704**	**2.816**	**1.888**

UHNM Capital Expenditure Plan 2025/26	Revised Capital Plan £m	Forecast outturn £m	Variance £m	YTD plan M7 £m	YTD actual M7 £m	Variance £m
IFRS16 leases						
Lease liability re-measurement	0.200	0.200	0.000	0.083	0.083	0.000
IFRS16 Guy Hilton	0.010	0.010	0.000	0.010	0.009	0.001
IFRS 16 New Vehicles lease	0.188	0.188	0.000	0.000	0.000	0.000
IFRS16 Leighton and Macclesfield Path Beckman	1.036	1.036	0.000	0.000	0.000	0.000
IFRS16 Endoscopic Equipment renewal/expansion	1.511	0.113	1.398	0.000	0.000	0.000
IFRS16 Stoke and County Pathology (Siemens lease ext Sep 25)	0.301	0.301	0.000	0.000	0.000	0.000
IFRS16 Bridge Centre	0.143	0.143	0.000	0.000	0.000	0.000
IFRS16 Medtronic Nitron	0.000	0.073	(0.073)	0.000	0.000	0.000
IFRS16 Payroll offices lease renewal (2 yrs)	0.066	0.066	0.000	0.066	0.066	0.000
Total IFRS 16 leases	**3.455**	**2.130**	**1.325**	**0.159**	**0.158**	**0.001**
Total Internal Capital Expenditure programme	**51.003**	**54.137**	**(3.134)**	**20.678**	**18.485**	**2.193**
Additional CRL / Externally Funded PDC (multi-year schemes)						
CDC phase 1 medical equipment	1.879	1.879	0.000	0.097	0.097	0.000
CDC IM&T	0.223	0.123	0.100	0.000	0.000	0.000
CDC phase 1 estates enabling	22.555	21.855	0.700	11.499	8.706	2.793
CDC phase 1 cost pressure	0.595	0.595	0.000	0.000	0.000	0.000
CDC endoscopy expansion	3.100	0.100	3.000	0.000	0.000	0.000
CDC endoscopy expansion - programme costs	0.000	0.500	(0.500)	0.000	0.000	0.000
CDC endoscopy expansion - 4th endoscopy room equipment	0.000	1.000	(1.000)	0.000	0.000	0.000
CDC endoscopy expansion - feasibility study	0.000	0.300	(0.300)	0.000	0.000	0.000
TIF 2 PDC (Breast Unit)	9.086	8.936	0.150	6.555	4.931	1.624
TIF 2 PDC (Breast Unit) cost pressure	0.430	0.430	0.000	0.000	0.000	0.000
Frontline Digitalisation - PDC funded 2024/25	1.120	1.120	0.000	0.611	0.611	0.000
Frontline Digitalisation EPR - PDC funded 2024/25	0.680	0.680	0.000	0.000	0.000	0.000
Charitable funded expenditure	3.834	3.834	0.000	3.167	3.167	0.000
Externally Funded PDC (2025/26 schemes)						
PDC Constitutional Standards Urgent Treatment Centre - enabling work	7.775	2.140	5.635	0.151	0.151	0.000
PDC Urgent Treatment Centres - programme costs	0.000	0.200	(0.200)	0.000	0.000	0.000
PDC Constitutional Standards Imaging and MRI	2.583	2.583	0.000	0.008	0.008	0.000
PDC Constitutional Standards Equipment for Physiological Science	0.590	0.460	0.130	0.059	0.059	0.000
PDC County Discharge Lounge	2.375	0.000	2.375	0.000	0.000	0.000
PDC Elective equipment	0.839	0.539	0.300	0.000	0.000	0.000
PDC Digital Pathology Scanners	0.827	0.827	0.000	0.061	0.061	0.000
PDC Pathology LIMS	1.628	1.628	0.000	0.000	0.000	0.000
Total Additional CRL / PDC Funded expenditure	**60.119**	**49.729**	**10.390**	**22.208**	**17.791**	**4.417**
Total Capital Expenditure	**111.122**	**103.866**	**7.256**	**42.886**	**36.276**	**6.610**

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Finance | Balance Sheet

Getting the most from our resources including staff, assets and money

Balance sheet as at Month 7	31/03/2025	31/10/2025		
	Actual £m	Plan £m	Actual £m	Variance £m
Property, Plant & Equipment*	715.7	725.0	721.9	(3.1)
Right of Use Assets*	23.1	21.1	20.7	(0.4)
Intangible Assets*	16.0	13.5	13.1	(0.4)
Trade and other Receivables	1.1	1.1	1.1	0.0
Total Non Current Assets	**755.9**	**760.6**	**756.7**	**(3.9)**
Inventories	19.2	18.7	21.1	2.4
Trade and other Receivables	43.5	54.4	56.8	2.5
Asset held for sale*	10.9	10.9	10.9	-
Cash and Cash Equivalents	84.2	64.7	88.5	23.8
Total Current Assets	**157.8**	**148.7**	**177.3**	**28.7**
Trade and other payables	(129.4)	(131.3)	(160.6)	(29.3)
Borrowings	(20.3)	(25.7)	(19.5)	6.2
Provisions	(8.5)	(9.3)	(4.3)	5.0
Total Current Liabilities	**(158.2)**	**(166.3)**	**(184.4)**	**(18.1)**
Borrowings	(490.3)	(484.6)	(489.6)	(5.0)
Provisions	(2.8)	(2.3)	(2.3)	(0.0)
Total Non Current Liabilities	**(493.0)**	**(486.9)**	**(491.9)**	**(5.1)**
Total Assets Employed	**262.5**	**256.1**	**257.7**	**1.6**
Financed By:				-
Public Dividend Capital	734.9	734.9	734.9	0.0
Retained Earnings	(680.7)	(687.1)	(685.5)	1.6
Revaluation Reserve *	208.3	208.3	208.3	(0.0)
Total Taxpayers Equity	**262.5**	**256.1**	**257.7**	**1.6**

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Finance | Conclusion

Getting the most from our resources including staff, assets and money

The Trust has delivered a £10.4m deficit, which is on plan for month seven. The income and expenditure analysis reveals key variances, including lower-than-expected income from pass-through devices and drugs, and a delay in Community Diagnostic Centre income.

The Trust has carried out a full year forecast based for the year; this bottom-up forecast indicates a deficit of £25.0 for the year end. Following further review and challenge the forecast outturn deficit has improved to £13.0m. There are risks within this forecast that may require mitigation and work continues to close the gap to breakeven.

The Trust has a £74.8m CIP target for 2025/26. To month seven, the Trust is reporting £24.3m savings in year, against a target of £30.6m, however £3.0m is being delivered non-recurrently above the original non recurrent plan of £9.9m.

The capital expenditure plan for 2025/26 is £111.1m with a reprofiled forecast of £103.9m. This is due to the discharge lounge scheme and part of the UTC scheme being deferred to 2026/27. The year-to-date position shows a spend of £36.3 m against plan of £42.9m, mainly relating to CDC Phase 1 and Breast Care Unit. Expenditure is expected to recover but will need close monitoring.

The month seven Statement of Financial Position shows total assets employed at £257.7m. The cash balance is £88.5m against a plan of £64.7m. The variance is mainly due to cash received relating to ERF overperformance and Education Contract Training.

The system month position has a favourable variance of £0.7m from the planned deficit of £19.3m.

Several risks have been identified that could deteriorate the Trust's financial position, including additional unfunded capacity and shortfall against CIP plans, Mitigations will need to be put in place if there is a deterioration in the financial position.

Highlight Report

PEOPLE CULTURE & INCLUSION COMMITTEE | 3rd DECEMBER 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• **Guardian of Safe Working** report highlighted the revision of terms of reference for the Resident Doctor Forum, implications from the exception reporting reform which was expected to increase reporting. The report also highlighted a reduction in trainee vacancies. • Partial assurance was provided by the **Allied Health Professional Workforce Establishment Review** which demonstrated significant reduction in vacancies, whilst acknowledging that there remained ongoing challenges in specific specialties. Further work was planned in relation to improving demand and capacity data for more accurate workforce planning. • **Chief People Officer** report highlighted that vacancy rates and staff turnover remained below target, in addition to agency expenditure being significantly below the national target. The ongoing challenges in relation to capacity within the People Directorate, particularly for managing employment relations, sexual safety, workforce planning and organisational development were noted for escalation, whilst accepting that some additional resource had already been approved, further cases were being considered. • **Nurse staffing establishment** review highlighted no significant changes from previous reviews and a consistent level of staffing. Further conversations were required at the Executive Team regarding the recommended 27% uplift compared to the organisations budget of 21% which was exceeded by absences • Partial assurance was provided by the **Freedom to Speak Up** report which highlighted the proposed abolishment of the National Guardian's Office. Recruitment and expansion of the champions network was highlighted in addition to the launch of the freedom to speak up accountability framework. There had been a 23% increase in concerns raised, with themes related to inappropriate attitudes and behaviours, bullying and policy issues • The Committee welcomed sight of the updated **policies** in relation to sexual misconduct, disclosure and barring service and managing allegations against people in positions of trust. However, some concerns regarding implementation of the policies were raised by the Committee in addition to the need to clarify expectations for managers and ensuring wellbeing wraparound support was in place. • **Employee relations** report for Q1 and 2 highlighted 150 cases within the period covering disciplinary, Maintaining High Professional Standards (MHPS) and resolution of employee relation cases. The main themes were consistent with those reported in the previous period, sexual misconduct and data security and protection breaches. The Committee noted the additional capacity put in place, the closure of a number of long-term cases and improvements in investigations being concluded within the 28 day target. In addition, decision making groups were being implemented. • Partial assurance was provided by the **health and safety** report due to the further improvements which were required, with a focus on timely incident reporting, revision of training modules and challenges with manual handling training compliance.	• Further engagement sessions to be held with **students** to gather qualitative data to inform targeted actions, following release of the National Education and Training (NETS) survey • Review of the efficacy of the **stay in the bay** initiative to be explored in terms of long-term savings and system-wide benefits • Further work to be undertaken by the **Freedom to Speak Up** team with Digital Services colleagues regarding improving upon data / case management • Executive conversation to be held with regards to enabling the **Freedom to Speak Up Guardian** to provide assurance of the objectivity and fairness of investigations, whilst balancing confidentiality and transparency. • Further assurance to be provided in relation to the progress of additional business cases to increase People Directorate **capacity** • Further assurance to be provided in relation to the confirmation of the actions taken following the conclusion of **employee relations cases** • Further consideration to be given as to how to close the feedback loop with colleagues to demonstrate the actions taken following raising **concerns**

Positive Assurances to Provide	Decisions Made
• **Learning and education** annual report 2024/25 provided acceptable assurance with various achievements shared such as CPD funding distribution, work experience opportunities and clinical observation placements. The challenges associated with apprenticeship funding and backfill / resource constraints were noted, which were creating barriers to release staff for off the job training. • Acceptable assurance was provided by the **Health and Wellbeing** report which highlighted actions in relation to mental, physical and financial well-being. Further work was being taken forward to provide support within high pressure areas in addition to supporting line managers in fostering a positive organisational culture.	• No decisions were required to be made

• **Acceptable assurance** provided by the update in relation to the capacity in place to deliver on key **equality, diversity and inclusion** action plans. The associated governance arrangements were outlined, including the ongoing conversations regarding staff networks and the introduction of an associated accountability framework.	

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Survey available to complete / provide feedback on effectiveness	• **Finance and Business Performance**; in terms of the resource required within the People Directorate to deliver transformational change and workforce planning • **Quality, Access & Outcomes Committee**; the ongoing level of pressure in the organisation in relation to activity, access, ambulance holds and impact on colleague health and wellbeing • **Quality, Access & Outcomes Committee**; to build upon existing reporting to ensure this included a focus on children's metrics

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Allied Health Professional Workforce Establishment Review	1, 3	20 15	Partial	Assurance	8.	Speaking Up Report Q1/Q2	3	Ext 15	Partial	Assurance
2.	Guardian of Safe Working Report Q2	3	Ext 15	Not assessed	Assurance	9.	Sexual Misconduct / DBS / Persons in a Position of Trust Policies	1, 3	Ext 15	Acceptable	Assurance
3.	Chief People Officer Report & Strategic Workforce Group Highlight Report (23-10-25)	3	Ext 15	Partial	Assurance	10.	Employee Relations Casework Trends Q1/Q2	3	Ext 15	Partial	Assurance
4.	Briefing Report: NHS Pay Review Body Evidence Submission 2026/27	-		Not applicable	Information	11.	Health & Safety Report Q2	-		Partial	Approval
5.	Learning & Education Annual Report 2024/25	3	Ext 15	Acceptable	Assurance	12.	Executive Health & Safety Group Highlight Report (18-11-25)	-		Not assessed	Assurance
6.	Health & Wellbeing Report	3	Ext 15	Acceptable	Assurance	13.	Priority & Capacity – EDI Action Plas	3	Ext 15	Acceptable	Information
7.	Nurse Staffing Establishment Review	1, 3	20 15	Not assessed	Assurance						

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 07 Performance

2025/26

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University Hospitals of North Midlands NHS Trust

Contents

Statistical Process Control

University Hospitals of North Midlands NHS Trust

This report uses Statistical Process Control (SPC) methods to draw two main observations of performance data and the below key, and icons are used to describe what the data is telling us.

Variation	Are we seeing significant improvement, significant decline or no significant change?
Assurance	How assured of consistently meeting the target can we be?

Variation			Assurance		
					
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values	Variation indicates inconsistently hitting passing and falling short of the target	Variation indicates consistently (P)assing the target	Variation indicates consistently (F)alling short of the target

Variation icons: **orange** indicates concerning **special cause variation** requiring action; **blue** indicates where improvement appears to lie, and **grey** indicates no significant change (**common cause variation**).

Assurance icons: **Blue** indicates that you would consistently expect to achieve a target. **Orange** indicates that you would consistently expect to miss the target. A **grey** icon tells you that sometimes the target will be met and sometimes missed due to random variation – in a RAG report this indicator would flip between red and green.

Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

NHS Oversight Framework Summary

University Hospitals of North Midlands NHS Trust

Headlines	Data period	Provider value	Peer average	National value	National value method	Chart
Adjusted segment			Q1 2025/26 3	NOF Score	Provider value	
Average metric score			Q1 2025/26 2.47	NOF Score	Provider value	
Unadjusted segment			Q1 2025/26 3	NOF Score	Provider value	
Financial override	Q1 2025/26	No	Yes	Yes	Provider median	
Is the organisation in the Recovery Support Programme?	Q1 2025/26	No	No	No	Provider median	

Domain Scores	Data period	Provider value		Chart
Access to services domain segment	Q1 2025/26	3	NOF Score	
Access to services domain score	Q1 2025/26	2.55	NOF Score	
Effectiveness and experience of care domain segment	Q1 2025/26	2	NOF Score	
Effectiveness and experience of care domain score	Q1 2025/26	2.17	NOF Score	
Patient safety domain segment	Q1 2025/26	3	NOF Score	
Patient safety domain score	Q1 2025/26	2.63	NOF Score	
People and workforce domain segment	Q1 2025/26	2	NOF Score	
People and workforce domain score	Q1 2025/26	2.53	NOF Score	
Finance and productivity domain segment	Q1 2025/26	3	NOF Score	
Finance and productivity domain score	Q1 2025/26	2.36	NOF Score	

UHNM is placed in segment 3 and is positioned in the middle of this segment.
UHNM demonstrates a balanced performance across the NOF domains, with all domain scores within the mid range point nationally.

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NOF - People and Workforce

University Hospitals of North Midlands NHS Trust

People and workforce	Data period	Provider value		Chart
People and workforce domain score	Q1 2025/26	2.53	NOF Score	

Retention and Culture	Data period	Provider value	Peer average	National value	National value method	Chart
Sickness absence rate score			Q1 2025/26 2.43	NOF Score	Provider value	
Sickness absence rate	Mar 2025	5.29%	5.42%	5.35%	Provider median	
NHS staff survey engagement theme sub-score score			Q1 2025/26 2.62	NOF Score	Provider value	
NHS staff survey engagement theme sub-score	Dec 2024	6.84	6.78	6.88	Provider median	

This domain has seen an improvement owing to a reduced sickness absence rate to 5.29%. This being below the peer and national average.

People | Overview

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NHS Trust

Overview from the Chief People Officer

How are we doing against our trajectories and expected standards?

Our most recent *Staff Engagement* score was 6.3 for July 2025, slightly down from the score of 6.8 for April 2025, against a target of 7.2. The Staff Voice Survey is now collected quarterly, but has been paused for the 2025 National Staff Survey.

Sickness absence remains above our expected standard of 3.39%. In month sickness increased to 5.96%, while the 12-month cumulative rate increased slightly to 5.28%, from 5.27% in September 2025. The main driver of this continues to be stress and anxiety, followed by other musculoskeletal problems and then cold, cough, flu, as the second and third most common reasons. 977 separate episodes of Cold, Cough, Flu, and Chest & Respiratory were reported in October, compared to 668 such episodes in September, which is a 46.2% increase between months.

Turnover and *vacancy* metrics continue to perform well against our expected standards. The turnover rate in October 2025 remained extremely low, at 7.4%, which remains consistently below our 11% target, for almost 3 years. Vacancies decreased sharply to 2.7%, in line with Month 7's modelling of the 567 WTE CIP workforce reduction. Colleagues in post increased in Registered Nursing (+89.92), Infrastructure (+13.62), Medical and Dental (+4.06) and ST&T (+9.96) with Support to Clinical Staff reducing by (21.74) fte, while the overall vacancy rate was affected by a -558.16 fte decrease in the total budgeted establishment.

Agency costs increased to 1.97%, in October 2025, from 1.51% in September 2025, which is below the threshold set by NHS England. In real-terms, overall agency usage increased to 113 WTE in October from 90.18 WTE in September, which is 17.91 WTE above plan.

What is driving this?

Sickness absence is driven by many factors, including stress and anxiety and seasonal changes such as colds, cough and chest & respiratory problems. October saw a marked increase in in-month sickness absence, influenced by increases in recorded episodes of cold, cough & flu, and Covid-19.

Agency expenditure was 19.91 WTE above plan, driven by Medical & Dental being above plan due to vacancies, maternity leave and sickness absence, in addition to cardiac perfusionist vacancies, with all other staff groups below plan. Agency use is also influenced by the additional scrutiny at executive and care group level which is having the desired effect in reducing overall agency spend, with some agency activity being converted to bank expenditure, as well.

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People | Overview

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Overview from the Chief People Officer

What are we doing to correct this and mitigate against any deterioration?

The staff voice has moved to quarterly (with the survey open for 14 days) for FY24/25 to prevent survey fatigue and to allow more time for the divisions & care groups to review and respond to feedback 'you said, we will'.

Sickness absence continues to be monitored at directorate performance reviews. Areas with over 8% or of concern are supported by the People Advisors, focusing on long term sickness cases. Our people are also provided with many online and in-person resources, to improve their personal resiliency when coping with work-related stress. A review of policy compliance of the top 10 cases for short and long term absence continues across all divisions/care groups. A Christmas and New Year predictive staffing tool has been developed.

Agency Expenditure remains subject to continued scrutiny through the Care Group Performance Reviews and the Medical Workforce Assurance Group. There is also regular focus at ICB level on workforce numbers, agency spend and controls. Additional data sources are being provided to allow for more granular discussions, via the new temporary staffing dashboard, which is updated on a weekly basis. Deloitte are also currently working with us to identify other opportunities to reduce temporary staffing expenditure.

The system-level controls implemented in our Electronic Rostering solution for all nursing and midwifery rosters continue to serve as the primary layer of control, complemented by the scrutiny provided through Divisional/Care Group Performance Reviews.

What can we expect in future reports?

As we move further into Autumn, we may see an increase in sickness absence reasons associated with gastrointestinal, cold & flu, and Covid-19 related symptoms amongst the patient facing teams. When combined with underlying increases in stress and anxiety, we may see an increasing sickness absence rate, over the coming months.

Until October, agency use has been under plan, but as we move further into the Winter months, and as a result of the Industrial Action, we may see agency usage increasing to track just above plan in November 2025. Despite this, and the additional scrutiny, of agency expenditure, the on-going elective recovery programme activity, and the continued need for escalation capacity and the additional demand in theatres and endoscopy services, and in the emergency portals, there are still many influences demanding the need for agency.

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People | Dashboard

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Metric	Target	Previous	Latest	Variation	Assurance	R12M Trend
Staff Turnover (R12M)	11.0%	7.3%	7.4%			
Staff Vacancy Rate	8.0%	7.5%	2.7%			
Sickness Absence (In Month)	3.4%	5.2%	6.0%			
Appraisal (PDR)	95.0%	85.1%	83.6%			
Agency Utilisation	3.2%	1.5%	2.0%			
Employee Engagement	7.2	6.3	6.3			

Related Strategy and Board Assurance Framework (BAF)

People Strategy

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 2: Inability to Improve Workforce Sustainability & Organisational Culture	Ext 15	Partial	Ext 15	Partial				

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People | Employee Engagement

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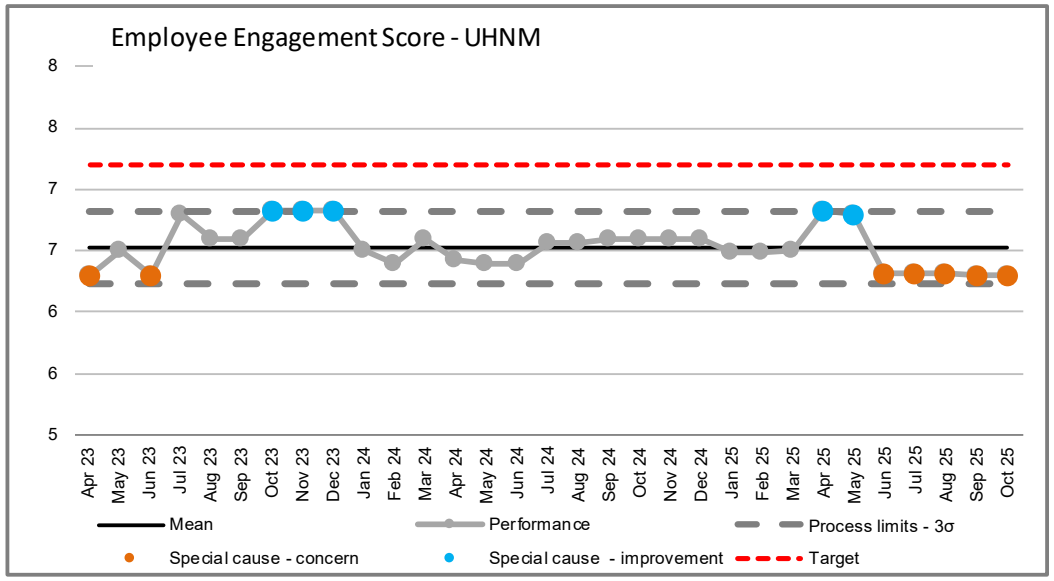

Variation	Assurance
L	F

Target	Aug 25	Sep 25	Oct 25
7.2	6.3	6.3	6.3

Background

What is the data telling us?

Our most recent Staff Engagement score was 6.3, for July 2025, down from the score of 6.8 for April 2025, against a target of 7.2.

The Staff Voice Survey is now collected quarterly and has been paused during the 2025 National Staff Survey period.

The 2024 National Staff Survey achieved an overall 45% response rate, which is comparable to the 44.9% response rate we achieved in 2023/24.

What are we doing about it?

The survey has moved to quarterly (with the survey open for 14 days) for FY24/25 to prevent survey fatigue and to allow more time for the divisions & care groups to review and respond to feedback 'you said, we will'. The next reportable period is January 2026.

Sustained operational pressures continue to impact on overall employee engagement.

All Divisions and Care Groups will develop their staff survey response plans and have a driver metric for staff engagement, once the 2025/26's data is available.

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People | Sickness Absence in Month

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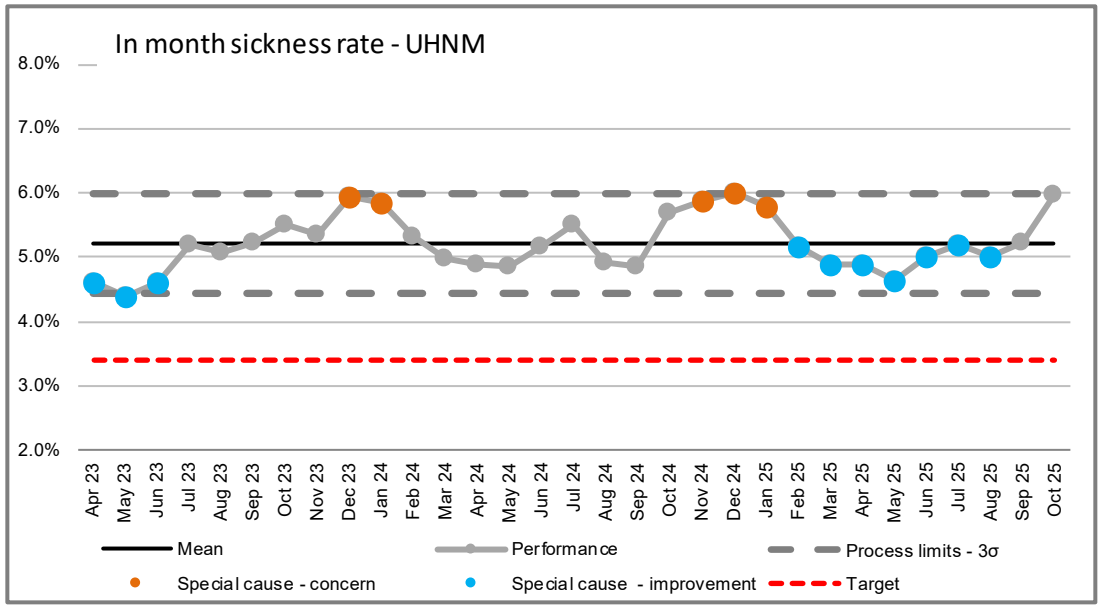


Variation	Assurance
	

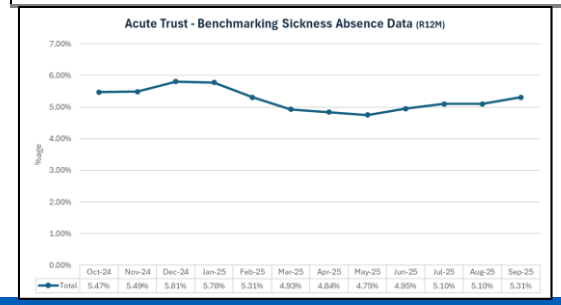
Target	Aug 25	Sep 25	Oct 25
3.4%	5.0%	5.2%	6.0%

Background

Percentage of days lost to staff sickness

Our sickness absence rates are very similar to other Acute Trust's when examining the available benchmarking data.

(Benchmarking data effective Sept 2025- 5.31%)



What is the data telling us?

The rolling 12-month average sickness absence rate increased slightly to 5.28% (5.27% in September 2025) against the target of 3.4%.

The in-month sickness absence increased to 5.96% in October (5.23% in September 2025) with Cold, Cough, Flu – influenza seeing the largest increase of 3.4% while stress & anxiety and other musculoskeletal problems decreased by 1% and 0.6%, respectively.

In rank order (highest first), the top 3 reasons for absences during October were: (1) Anxiety/stress/depression/other psychiatric illnesses, (2) Other musculoskeletal problems, (3) Cold, Cough, Flu – influenza.

What are we doing about it?

Unplanned Care - sickness absence continues to be monitored at CBU performance reviews. Areas with over 8% or of concern are supported by the People Advisor focusing on long term sickness cases.

Unplanned Care – assessment of hotspot areas for long and short term absences to provide targeted support including re-training.

Clinical & Scientific Services Care Group - Deep dives into hot spot/high absence areas to target interventions as well as continuing absence surgeries.

People | Vacancy Rate

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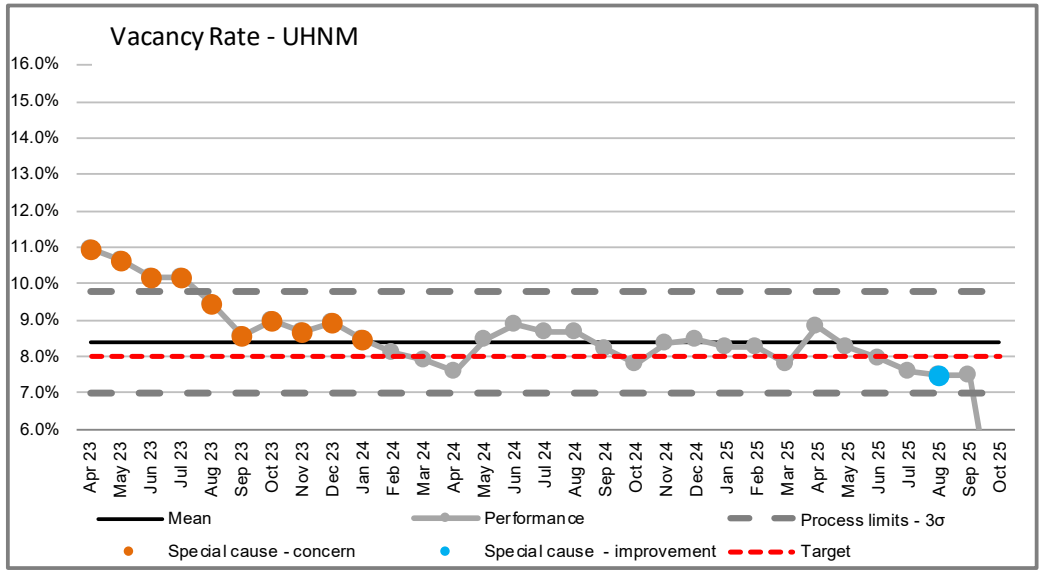

Variation	Assurance
	

Target	Aug 25	Sep 25	Oct 25
8%	7.5%	7.5%	2.7%

Background

Based on Full Establishment (Substantive, Bank & Agency)

Vacancies at 31-10-25	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,781.06	1,637.95	143.11	8.04%	9.80%
Registered Nursing	3647.61	3772.45	-124.84	-3.42%	3.52%
All other Staff Groups	6751.94	6447.09	304.85	4.51%	9.06%
Total	12,180.61	11,857.49	323.12	2.65%	7.50%

What is the data telling us?

Vacancies decreased sharply in line with Month 7's modelling of the 567 WTE CIP workforce reduction.

Our successful recruitment and retention processes, alongside low vacancies and turnover rates, are other factors behind the reduction in our overall vacancy rate.

Colleagues in post increased in October 2025 by 75.45 fte, budgeted establishment decreased by 558.16 fte, as part of the workforce CIP programme, which decreased the vacancy fte by 633.61.

[*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 31/10/25]

What are we doing about it?

We continue with our successful recruitment events, targeting specific roles across multiple professions and divisions/care groups.

Targeted social media campaigns continue, advertising that our organisation is a great place to work.

We continue our targeted spotlights on our colleagues, which supplement our recruitment campaigns.

(The national provider workforce return report defines the overall staff vacancies as the variance between the current total staff in post and the planned (budgeted) establishment. Total staff in post includes substantive, bank and agency WTE and as such not all "reported vacancies" are being recruited to, to allow for temporary staffing use.)

People | Turnover Rate

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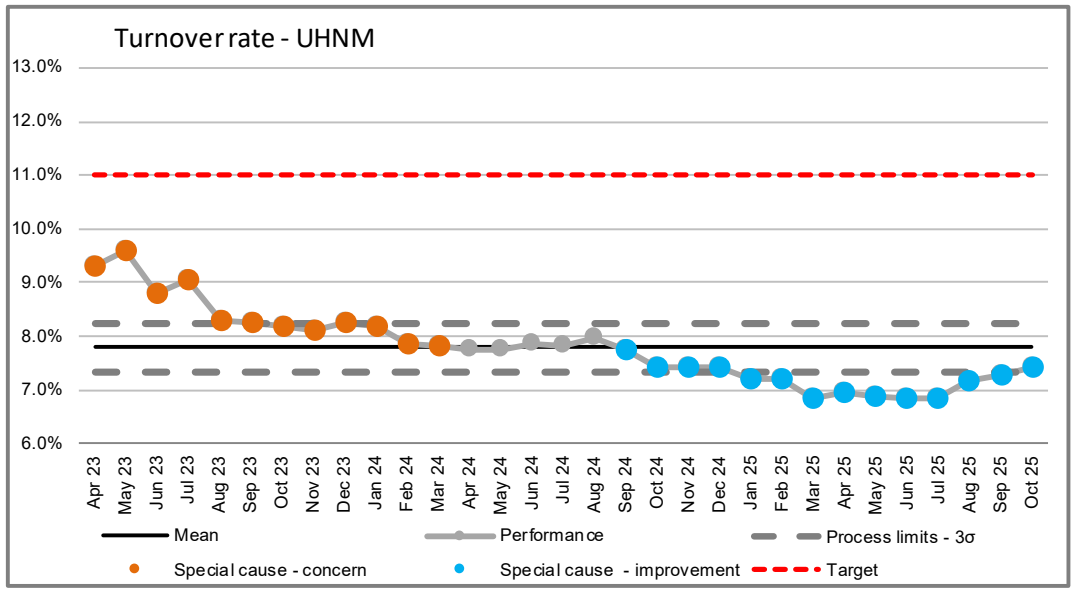

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Variation	Assurance
	

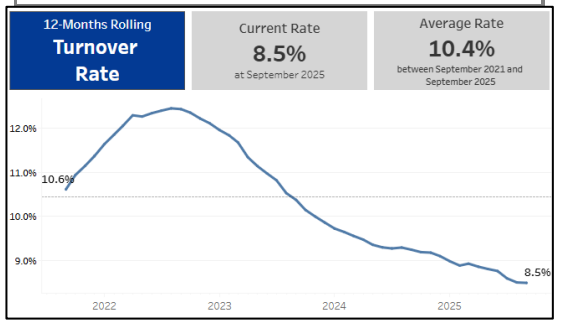
Target	Aug 25	Sep 25	Oct 25
11.0%	7.2%	7.3%	7.4%

Background

Turnover rate.

Based on the most recent benchmarking data, comparing ourselves against other Acute Trusts, our overall turnover is much lower.

(Benchmarking data effective September 2025)



What is the data telling us?

The turnover rate in October 2025 remains extremely low, at 7.4%, (7.3% in September 2025), which is consistently below the Trust's 11% target, for almost three years.

Or overall turnover rates are also well below the national averages when compared to other Acute Trusts.

What are we doing about it?

Turnover continues to perform well against our expected standards, reflecting our programmes of work which make this a great place to work. Some recent examples include :

- Medical Staffing finishing school.
- Employment of a People Promise (Retention) Manager who currently continues in a fixed term post.
- Monthly targeted campaigns aligned to our Trust Values. For example, October included the *Black History Month*, celebrating national and local inclusion, as a time to honour heritage, celebrate achievement and reflect on the strength of unity.

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People | Appraisal Rate

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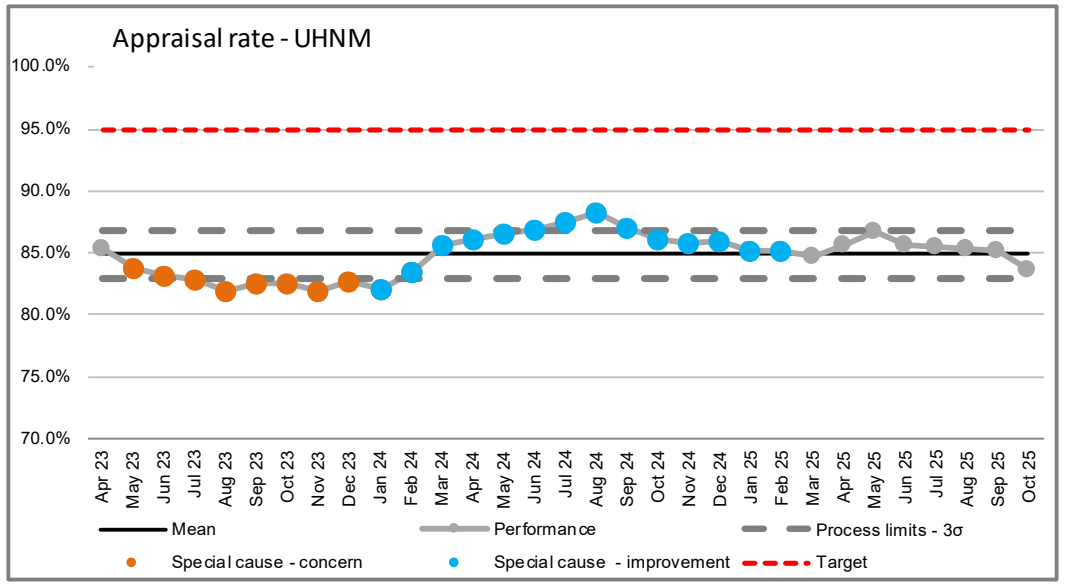

Variation	Assurance
	F

Target	Aug 25	Sep 25	Oct 25
95%	85.3%	85.1%	83.6%

Background

Percentage of people who have had a documented appraisal within the last 12 months.

What is the data telling us?

Performance Development Reviews (PDR's) continue to perform below our 95% target.

October's appraisal rates decreased to 83.6% from 85.1% in September 2025, with Estates, Facilities and PFI Division achieving a compliance rating of 96.86%.

The Divisions & Care Groups continue to monitor and review their PDR performance.

What are we doing about it?

NMCPS - All out of date PDR's are scheduled with line managers.

Planned Care– Monthly compliance report, with a focus on hotspots.

Unplanned Care – Weekly updates reports on compliance. With focused assistance on those areas with the lowest compliance.

Clinical & Scientific Services Care Group – Weekly performance reports and assurance meetings.

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People | Agency Utilisation

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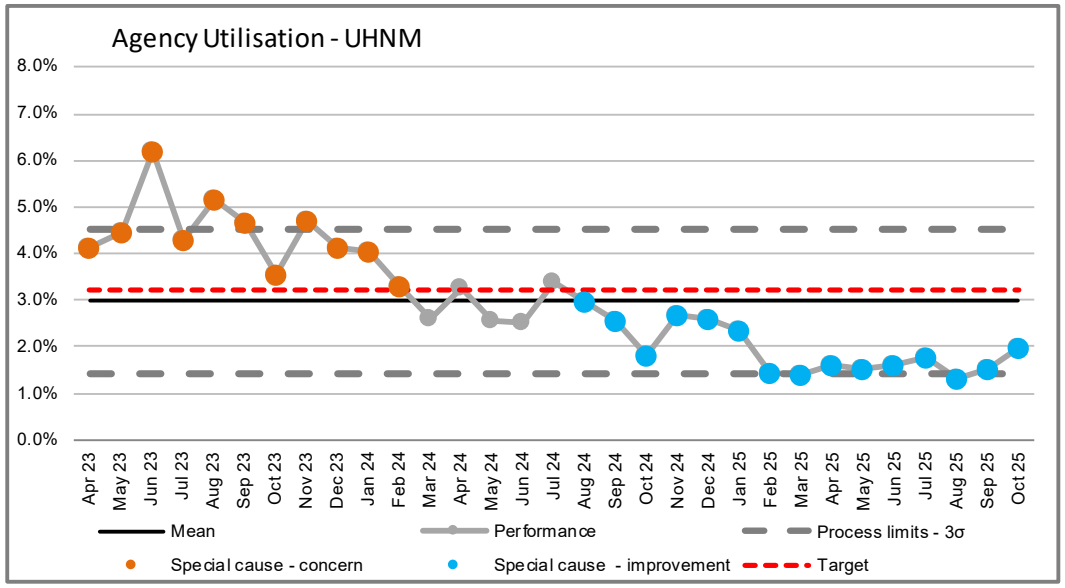

Variation	Assurance

Target	Aug 25	Sep 25	Oct 25
3.2%	1.3%	1.5%	2.0%

Background

Agency cost as a percentage of total pay cost

What is the data telling us?

Agency cost is calculated as a percentage of the total Pay Costs, which increased to 1.97% in October 2025, (1.51% in September 2025).

In real-terms, overall agency usage increased to 113 WTE in October from 90.18 WTE in September 2025, which is 17.91 WTE above plan, driven by Medical & Dental's vacancies, maternity leave and sickness absence, and cardiac perfusionist vacancies, with all other staff groups below plan.

Executive and divisional/care group level scrutiny, in addition to the software level controls would appear to be having the desired effect of keeping the overall agency usage within plan. We have had no off-framework agency use for 12 months.

What are we doing about it?

- Agency use is monitored and discussed at monthly divisional/care group meetings. This includes reviewing long-term agency use.
- All current in-sourcing contracts are reviewed monthly, to ensure that they do not breach rules regarding off-framework agency use.
- All off-framework agency arrangements have been reviewed and all off-framework use ceased at the end of July 2024.
- System level controls have been implemented in our Electronic Rostering solution, for all nursing & midwifery rosters, which now require Matron level authorisation prior to being filled by either bank and/or agency. These additional controls appear to be having the desired effect in controlling the use of bank and agency, through higher levels of scrutiny by the senior clinical nursing teams.

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Highlight Report

AUDIT COMMITTEE | 6th November 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee were made aware of a cross-committee consideration from People, Culture and Inclusion Committee, in terms of the previously approved increase in health and safety resource, required as part of a **Health and Safety Executive (HSE)** letter of contravention. It was noted that there had been challenges in recruiting into the team and therefore alternative staffing models were being considered. • The Committee raised concern regarding the delay in commencing the internal audit into the **Strategy Development Unit** and further discussion was to be undertaken with the Director of Strategy • Partial assurance was agreed for the **corporate governance** report, reflecting the further work required to reduce the number of out-of-date policies, and assessing their current level of risk. However, the Committee welcomed the improvements made to the report and transparency	• A standard operating procedure was being developed in order to improve the timeliness of responding to, and agreeing, **internal audit reports**. • Further assurance to be provided in the actions to be taken to reduce the number of **out of date policies**, particularly within the remit of the Chief Medical Officer • Further assurance to be provided to the next meeting from respective Executive Directors for any **policies** rated as delayed. • Further assurance required in terms of the existing risk in relation to use of **Shadow IT** • To consider the way in which communications in relation to **phishing** exercises and outcomes could be enhanced • To provide the action plan for the **failure to prevent fraud analysis** to a future meeting

Positive Assurances to Provide	Decisions Made
• The committee received further assurance on the actions being taken to complete the 9 delayed **internal audit recommendations**, with specific updates provided by respective Executive Directors. The assurance rating was agreed at acceptable given the reduction in delayed actions since the previous meeting, although this would be kept under review • The committee received the completed **internal audit** into Operation Anzu Actions review which provided **Substantial Assurance** • The **cyber security assurance report** provided **acceptable assurance.** Further assurance was provided in terms of embedding the actions taken in relation to Shadow IT, the safety controls put in place to assess new pieces of technology and the controls used when implementing Artificial Intelligence. • The Committee welcomed the enhancements made to the **Board Assurance Framework** (BAF). Further work to enhance the levels of assurance for research and innovation were also noted. • The **Gap Analysis into Failure to Prevent Fraud** provided assurance following the introduction of the new Economic Crime and Corporate Transparency act. Further actions were to be taken particularly to strengthen communications and a refresh of the fraud risk assessment, in conjunction with the Local Counter Fraud Specialist. • The **Counter Fraud** progress report highlighted progress on local counter fraud activities, including proactive exercises, International Fraud Awareness Week, case referrals and benchmarking, with discussion on overdue actions and digital solutions for declarations of interest. • **Acceptable assurance** was provided by the **losses and special payments** report, noting that total losses for the year totalled £1,381,646. • Four **single tender waivers** during Q2 were noted in addition to 92 breaches due to late purchase orders of which, 11 were over £100,000. It was noted that these were for procedural reasons • **SFI breaches** provided **significant assurance** with 173 salary overpayments in the year noted, at a value of £396,246 year to date, with £129,753 repayment plans to be agreed • **Significant assurance** was provided following the review of **internal audit and local counter fraud** and **external audit.**	• The Committee agreed to de-prioritise and close 6 previous **internal audit recommendations** • The Committee approved the revised **Anti-Bribery and Anti-Fraud Policy** (G18) • The committee approved the proposed **bad debt write offs** totalling £941,524, related to overseas patients, the majority of which would be related to emergency treatment, although it was noted that provisions for these had been made

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
Comments on effectiveness were sought via MS Forms	• Review and transformation of **job planning** to be considered at Finance and Business Performance in due course • Committees requested to focus on assessing the risk score and tolerance within the **BAF** for Q3 • Timing of the **internal audit** into Strategy Development Unit to be considered at Finance and Business Performance

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Audit Action Tracker	Various		Acceptable	Assurance	8.	Local Counter Fraud Specialists Progress Report	-	10836 3 (low)	Not Assessed	Assurance
2.	Internal Audit Progress report • Operation Anzu Actions Review	-		Substantial	Assurance	9.	Losses and Special Payments Update Q2 2025/26	6	Ext 20	Acceptable	Assurance
3.	Corporate Governance Report	Various	10836 3 (Low)	Partial	Assurance	10.	SFI Breaches and Single Tender Waivers Q2 2025/26	6	Ext 20	Acceptable	Information
4.	Cyber Security Assurance Report	4	Ext 16	Acceptable	Assurance	11.	SFI Breaches related to Late Termination and Change Forms Q1 2025/26	6	Ext 20	Significant	Assurance
5.	Board Assurance Framework Q1 2025/26	All	Various	Not Applicable	Approval	12.	Review of the Internal Audit and Local Counter Fraud Function	-	-	Significant	Assurance
6.	Failure to Prevent Fraud – Gap Analysis	-	-	Not Assessed	Assurance	13.	Annual External Audit Effectiveness Review	-	-	Significant	Assurance
7.	G18 Anti-Bribery and Anti-Fraud Policy – Minor Amends	-	-	Not Applicable	Approval						

Executive Summary

Trust Board | 10th December 2025

EPRR Core Standards Assurance

University Hospitals of North Midlands NHS Trust

Purpose:	Information		Approval		Assurance	✓	Agenda Item:	11
Author:	J Dodds, Head of EPRR							
Executive Lead:	Katy Thorpe, Chief Operating Officer / Mike Goodwin, Deputy Chief Operating Officer							

Alignment with our Strategic Priorities		
	Our People We will create an inclusive environment where everyone learns, thrives and makes a positive difference	✓
	Our Patients We will provide timely, innovative and effective services to our patients	✓
	Our Population We will tackle inequality and improve the health of our population	✓

Executive Summary

Situation

- As part of ensuring how compliant a Trust is in delivering their Emergency Preparedness, Resilience and Response (EPRR), a set of core standards has been developed, and each Trust is asked to self-assess against the annual NHS Core Standards for EPRR.
- UHNM is required to submit Annual Assurance to the Integrated Care Board and NHS England against the NHS England Core Standards for EPRR.
- Core standards Assessments were required to be submitted by 30th August 2025, and UHNM met this deadline.
- A further request for additional evidence was received from NHSE & the ICB on 20th October
- A confirm and challenge meeting was undertaken with ICB, NHSE, and UHNM COO, DCOO, and Head of EPRR on 6th November (rescheduled from 4th November), and a final assessment position was submitted on 12th November
- The agreed position was reported to SSoT LHRP on 26th November 2025.

Background

- The assessment document for EPRR is a total of 62 individual core standards, split over 10 Domains:
  - Governance
  - Duty to Assess Risk
  - Duty to maintain plans
  - Command and Control
  - Training and Exercising
  - Response
  - Warning and Informing
  - Cooperation
  - Business Continuity
  - Hazmat / CBRN

- The compliance level for each standard is defined as:

Compliance Level	Definition
Fully Compliant	Fully compliant with the Core Standard
Partially Compliant	Not compliant with the Core Standard. The organisation's EPRR work programme demonstrates evidence of progress and an action plan is in place to achieve full compliance within the next 12 months.
Non-Compliant	Not compliant with the core standard. In line with the organisation's EPRR work programme, compliance will not be reached within the next 12 months.

- Following the 2024 Confirm and Challenge process, UHNM reported position was 48/62 (77%) (Partially Compliant)

2024 Partially Compliant	77% - 88% -	48/62 Core Standards (77%)
2023 Non-compliant	Below 76% -	21/ 62 Core Standards (34%)

- Following the **2024** Confirm and Challenge process, UHNM self-assessed against 48/62 (77%) of Core Standards (Partially Compliant), initially with 27 challenges from the ICB / NHSE, but after subsequent evidence submission, reduced to 7 challenges.

Partial compliance	77% -88%	48 / 62 Core Standards (77%)

2025 process

- Once the Core Standards assessment is submitted, ICB and NHS England review the submission, together with supporting evidence.
- ICB & NHS England requested additional supporting evidence during October (note only documents produced prior to 30th August (the deadline for submission) can be used as further evidence).
- A check and challenge process wite Trust, ICB and NHS England took place towards at the beginning of November (6th November rescheduled from 4th November).
- A final, agreed, report was submitted from the Trust to the ICB and NHS during November, for ratification at the Local Health Resilience Partnership (LHRP) on 26th November 2025.

Assessment

- NHS England and the ICB undertake a rigorous assessment against each core standard and require detailed evidence to support each position that the trust submits.
- The overall EPRR assurance rating is based on the percentage of core standards the organisations assess itself as being 'fully compliant' with:

Organisational rating	Criteria
Fully	The organisation is fully compliant against 100% of the relevant NHS EPRR Core Standards (62/62 Core Standards)
Substantial	The organisation is fully compliant against 89-99% of the relevant NHS Core Standards (55 – 61 of 62 Core Standards)
Partial	The organisation is fully compliant against 77-88% of the relevant NHS Core Standards (47 – 54 of 65 Core Standards)
Non-compliant	The organisation is fully compliant up to 76% of the relevant NHS Core Standards (less than 47 of 65 Core Standards)

What are the key conclusions (positive or negative)?

- UHNM EPRR have been undertaking a comprehensive review of the core standards submission for 2025, which has been subject to an in depth Confirm and Challenge process with ICB and NHSE.
- The EPRR team have been managing a recruitment freeze against the Band 7 that left last year, and also long term sick leave / redeployment of Band 8A (>12 months), meaning the whole EPRR programme has been managed by Head of EPRR and EPRR Support Officer, who has been acting up to a Band 6 role for the duration.
- UHNM EPRR are reporting Partial Compliance rating, with 49/62 (79%) core standards being assessed as fully compliant, with 13/62 (21%) requiring some further work to ensure full compliance.
- Although this is only slightly improved from the 2024 assessment (+ 1 standard), it must be borne in mind that there were initially 27 challenges from ICB / NHSE against standards last year, as opposed to 6 this year (5 of which the trust accepted, and 1 was successfully challenged

2025 Reporting

Partial Compliance	>76%	49/62 Core Standards (79%)

What are the solutions?

- Based on the above, EPRR are on track to Self-Declare Partial compliance (>76%), with some further work required to confirm compliance in the following areas:
- A change in the governance process covering some policies is required.
- There are several areas within the Business Continuity Cycle that need addressing, and this will be a key focus
- On Call arrangements need agreement and sign off.
- We need to undertake training to ensure the trust has a suitable cadre of loggists.
- Mass Casualty Plans (although ongoing work is taking place), and requires some additional work with Regional and ICB partners
- Pandemic Flu – needs updating to New and Emerging Pandemics, and requires lessons learnt from COVID adding
- Evacuation and Shelter planning requires an update, but work is ongoing, and requires some additional work with Regional and ICB partners
- Mass Countermeasures requires further work on how countermeasures are received and distributed by the trust

Based on the above, EPRR can report they will be aiming to report Partial Compliance with Core Standards for 2025/26

Assurance Assessment		
Significant Assurance	High level of confidence in delivery of existing mechanisms / objectives	
Acceptable Assurance	General confidence in delivery of existing mechanisms / objectives	
Partial Assurance	Some confidence in delivery of existing mechanisms / objectives, some areas of concern	✓
No Assurance	No confidence in delivery	

Key Recommendations

The Trust Board is asked to receive and note the position for the EPRR Core Standards for 2025/26, noting that further discussions will take place regarding the resource required to deliver the actions associated with the identified solutions.

Trust Board

2025/26 BUSINESS CYCLE

KEY TO RAG STATUS	
Paper rescheduled for future meeting	
Paper rescheduled for next meeting	
Paper taken to meeting as scheduled	

Title of Paper	Executive Lead	May	July	Oct	Dec	Feb
		7	9	8	10	11
PROCEDURAL ITEMS						
Patient / Staff Story	Chief Nurse / Chief People Officer	Pt	Staff	Pt	Staff	Pt
Chief Executives Report	Chief Executive					
Board Assurance Framework	Director of Governance	Q4		Q1	Q2	Q3
OUR PATIENTS: QUALITY, ACCESS & OUTCOMES						
Quality, Access & Outcomes Committee Assurance Report	Director of Governance					
Care Quality Commission Action Plan	Chief Nurse					
Mortality Assurance Annual Report	Chief Medical Officer					
Maternity Serious Incident Report	Chief Nurse					
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI					
Bi Annual Nurse Staffing Assurance Report	Chief Nurse					
Quality Account	Chief Nurse					
Winter Plan	Chief Operating Officer					
NHS Resolution Maternity Incentive Scheme	Chief Nurse					
Quality, Access & Performance Strategic Plan Update	Chief Nurse / Chief Medical Officer / Chief Operating Officer					
Integrated Performance Report	Various					
OUR PEOPLE						
People, Culture & Inclusion Committee Assurance Report	Director of Governance					
Staff Survey Report	Chief People Officer					
Gender Pay Gap Report	Chief People Officer					
Raising Concerns Report	Director of Governance					
Revalidation	Chief Medical Officer					
Workforce Disability Equality and Workforce Race Equality Reports	Chief People Officer					
Equality, Diversity and Inclusion Annual Report	Chief People Officer					
People Strategic Plan Update	Chief People Officer					
Bi-Annual Establishment Review (Other Professions)	Chief People Officer					

Title of Paper	Executive Lead	May	July	Oct	Dec	Feb
		7	9	8	10	11
OUR POPULATION						
Population Health Strategic Plan Update	Director of Strategy					
FINANCE AND BUSINESS PERFORMANCE						
Finance & Business Performance Committee Assurance Report	Director of Governance					
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,500,001 and above	Director of Strategy		N/A		N/A	
Annual Report and Accounts including Going Concern	Chief Finance Officer					
Annual Plan	Director of Strategy					
Financial Plan including Capital Programme	Chief Finance Officer					
Standing Financial Instructions	Chief Finance Officer					
Scheme of Reservation and Delegation of Powers	Chief Finance Officer					
OUR STRATEGIC PLANS						
Digital Strategic Plan Update	Chief Digital Information Officer					
Research Strategic Plan Update	Chief Medical Officer					
Innovation Strategic Plan Update	Director of Strategy					
Estates & Facilities Strategic Plan Update	Director of Estates, Facilities & PFI					
GOVERNANCE						
Audit Committee Assurance Report	Director of Governance					
Fit and Proper Persons Annual Assurance Report	Director of Governance					
Anchor Institution Update	Director of Communications					
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer					
Annual Evaluation of the Board Committees	Director of Governance					
Annual Review of the Rules of Procedure	Director of Governance					
Board Development Programme	Director of Governance					
Well-Led Self Assessment	Director of Governance					
Risk Management Policy	Director of Governance					
Complaints Policy	Chief Nurse					