University Hospitals of North Midlands NHS Trust

AGENDA | Trust Board - Part 1 (in Public)

Meeting to be held on Wednesday 12th August 2026, 9.30 am to 12.15 pm

Room 1, Postgraduate Medical Centre, County Hospital, Stafford

Time	No.	Agenda Item	Purpose	Lead	Format	Page No.
9:30	**PROCEDURAL ITEMS**					
15 mins	01	Staff Story	Information	Mrs J Haire	Verbal	-
5 mins	02	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Ms J Small	Verbal	-
	03	Declarations of Interest	Information	Ms J Small	Verbal	-
	04	Minutes of the Meeting held 10th & 24th June 2026	Approval	Ms J Small	Enclosure	2
	05	Matters Arising via the Post Meeting Action Log	Assurance	Ms J Small	Enclosure	20
10 mins	06	Questions from Members of the Public in relation to matters on the agenda	Information	Ms J Small	Verbal	-
10:00	**CHAIR AND CHIEF EXECUTIVE UPDATES**					
10 mins	07	Chair's Update	Information	Ms J Small	Verbal	-
10 mins	08	Chief Executive's Report – August 2026	Information	Mr M Oldham	Enclosure	21
10 mins	09	Board Assurance Framework – Q1	Approval	Mrs C Cotton	Enclosure	28
10 mins	10	UEC Improvement Journey	Assurance	Mrs K Thorpe	Enclosure	68
10 mins	11	NHS England Board Assurance Statement: Mortuary Oversight and Post-Death Care	Information	Dr D Adamson	Enclosure	74
10:50 – 11:05 COMFORT BREAK						
11:05	**OUR PEOPLE**					
10 mins	12	UHNM Response to Mann Review	Information	Mrs J Haire	Enclosure	76
10 mins	13	UHNM Response to the National Resident Doctor Offer 2026	Information	Mrs J Haire	Enclosure	85
11:25	**PERFORMANCE**					
	14	Integrated Performance Report – Month 1 and Committee Assurance Reports:				
15 mins	14a	• Quality, Access & Outcomes Committee Assurance Report (02-07-26 & 05-08-26) • Quality & Access Dashboard	Assurance	Miss W Nicholson /Prof S Toor Mrs AM Riley/ Mrs K Thorpe	Enclosure	88 92
10 mins	14b	• People, Culture & Inclusion Committee Assurance Report (30-07-26) • People Dashboard	Assurance	Prof S Toor Mrs J Haire	Enclosure	148 150
15 mins	14c	• Finance & Business Performance Committee Assurance Report (06-07-26 & 03-08-26) • Finance Dashboard	Assurance	Ms T Bowen Mr M Oldham	Enclosure	164 169
12:05	**GOVERNANCE**					
5 mins	15	Audit Committee Assurance Report (06-08-26)	Assurance	Mrs M Monckton	Enclosure	179
12:10	**CLOSING MATTERS**					
5 mins	16	Review of Meeting Effectiveness Link to feedback form: https://forms.office.com/e/tydNkMB2Mj	Information	Ms J Small	Verbal	-
	17	Review of Business Cycle	Information	Ms J Small	Enclosure	181
12:15	**DATE AND TIME OF NEXT MEETING**					
	18	**Wednesday 7th October 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 10th August to nicola.hassall@uhnm.nhs.uk

Minutes of Meeting

Trust Board – Part 1 | 10th June 2026, 9.30 am to 12.25 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 (virtual)	Voting
Prof K Maddock	KM	Non-Executive Director	Voting
Mrs M Monckton	MM	Non-Executive Director	Voting
Miss W Nicholson MBE	WN	Non-Executive Director	Voting
Prof S Toor	ST	Non-Executive Director	Voting
Dr S Constable	SC	Chief Executive	Voting
Ms H Ashley	HA	Director of Strategy	Non-Voting
Mrs C Cotton	CC	Director of Governance & Communications	Non-Voting
Mrs A Freeman	AF	Chief Digital Information Officer	Non-Voting
Mrs J Haire	JH	Chief People Officer	Non-Voting
Mr M Oldham	MO	Chief Finance Officer	Voting
Mrs AM Riley OBE	AR	Chief Nurse	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**	
Dr D Adamson	DA	Chief Medical Officer	Voting

In Attendance:		
Name	**Initials**	**Title**
Mrs D Brayford		Acting Director of Midwifery (item 10)
Mrs J Dickson	JD	Deputy Director of Communications
Mrs J Hagan		Head of Nursing (item 1)
Mrs N Hassall	NH	Deputy Director of Governance (minutes)
Mrs M McNair		Lead Nurse for Mental Health and Learning Disability (item 1)
Dr AM Morris	AMM	Deputy Chief Medical Officer (representing Dr Adamson)

Members of Staff and Public: 0

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Patient Story**	
036/2026	A video was presented to the Board, https://vimeo.com/1198080314/62a6aaf17c?fl=ip&fe=ec, illustrating the care and experience of a patient, Mr Patrick Mongan, as described by his mother. The account highlighted Patrick's long-term care needs since birth and emphasised the importance of effective transition from paediatric to adult services. Miss Nicholson queried how the 'You're Welcome' quality criteria could be applied to transitional care, noting that support may extend up to the age of 25. Mrs Riley advised that this remained an area of active development, with a continued focus on strengthening transition pathways. She emphasised the importance of tailoring approaches to meet the individual needs of patients and their families.	

	Mrs Hagan highlighted the significance of ensuring a well-managed transition from paediatric to adult services and outlined the recent launch of a system-wide strategy to support this. She noted that the Trust benefitted from having community paediatricians on site who were familiar with families and supported early preparation. It was recognised that transition could be a source of anxiety for patients and families, and the new strategy aimed to address these concerns through earlier engagement. Mrs Haire reported on a recent visit to neurophysiology services, noting the positive impact of Oliver McGowan training. She highlighted how adjustments to the environment had improved support for children and adults with epilepsy, with wider benefits also observed. Ms Bowen welcomed the linkage to transitional care highlighted in the Chief Executive's report. She noted that the Board had not received an update on this area for some time and sought assurance that progress was being made at an appropriate pace, particularly in relation to improvements. Ms Ashley advised that, following several iterations, a Children's Hospital Board had been re-established and that transitional care was a key priority. Work was underway to determine the appropriate governance arrangements and to ensure alignment with the Brilliant Basics strategic programme. Mrs Hagan acknowledged that previous focus on a physical unit may have diverted attention from pathway development, and the current focus was on strengthening pathways and planning transition to adult care, from approximately 13 years of age. She further emphasised that successful delivery would require engagement beyond paediatric services, recognising this as a whole-system issue. Mrs Hagan confirmed that the Children's Hospital Board had recently met and had identified three key workstreams, including transitional care. Progress would be reported through this forum and escalated accordingly. While the concept of a dedicated physical space had been discussed, the primary focus remained on pathway development. Ms Small emphasised the importance of engaging with system partners to ensure a consistent and well-understood approach across organisations. Mrs Hagan noted that effective pathways existed elsewhere and that the Trust would seek to adopt and adapt established best practice rather than develop new models unnecessarily. **The Trust Board noted the patient story.** Mrs McNair and Mrs Hagan left the meeting.	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
037/2026	Ms Small welcomed members to the meeting. Apologies were received as noted above and the meeting was confirmed as quorate.	
3.	**Declarations of Interest**	
038/2026	Mr Oldham explained that he had taken on an interim role as Non-Executive Director at Countess of Chester but confirmed that there were no potential conflicts of interest with any items on the agenda.	

4.	**Minutes of the Meeting held 8th April 2026**	
039/2026	The minutes of the meeting held on 8th April were approved as a true and accurate record.	
5.	**Matters Arising via the Post Meeting Action Log**	
040/2026	PTB/625 – Mrs Riley highlighted that Maternity and Newborn Safety Investigation (MNSI) referral benchmarking information was to be included in future maternity reports.	
6.	**Questions from Members of the Public in relation to matters on the agenda**	
041/2026	No questions were received.	
CHAIR AND CHIEF EXECUTIVE UPDATES		
7.	**Chair's Update**	
042/2026	Ms Small reported that her term had been extended for a further 12 months. She continued to engage with workforce and clinical services across the Trust, including recent visits to the discharge lounge, where she was impressed by the use of electronic huddle boards and the availability of timely and up-to-date information. She had also visited urology and gynaecology services, including Wards 103, 104 and 105, and had requested a further visit to review colorectal wards. Ms Small noted her attendance at the opening of the Community Diagnostic Centre (CDC), describing it as an excellent facility located in the heart of Stoke-on-Trent. She highlighted the anticipated benefits in improving timely access to diagnostics and the potential impact on demand for services. At a system level, Ms Small reported that she had developed relationships with Mr Ian Green and Mr Simon Whitehouse. Mr Green had recently visited the Trust to observe a number of services, including the Emergency Department and robotics, and had responded positively and with enthusiasm. Ms Small welcomed the opportunity for continued engagement. She also advised that quarterly meetings had been established for system Chairs to share challenges and emerging issues. In addition, she continued to attend regional Chairs' and Chief Executive updates and had met with the newly appointed Regional Chair. Ms Small confirmed that two new Non-Executive Directors had been recruited, with pre-employment clearances underway. Arrangements were in place to support their onboarding and induction. **The Trust Board noted the update.**	
8.	**Chief Executive's Report - June 2026**	
043/2026	The report was taken as read and no comments / questions were raised. **The Trust Board received and noted the update.**	

9.	**Board Assurance Framework – Q4**	
044/2026	Mrs Cotton presented the Quarter 4 update of the Board Assurance Framework (BAF), noting that it had been subject to scrutiny by Committees. She advised that the Executive Summary highlighted key themes, including evidence of a maturing assurance framework as demonstrated through Committee discussions and risk movements. She further noted that work was underway to strengthen alignment between the BAF and the Trust's strategic programmes, recognising these as key mitigations proportionate to the scale of the risks. Development of the Quarter 1 BAF had commenced, alongside continued refinement of risk articulation. Mrs Cotton also highlighted that the BAF had again received a Substantial Assurance rating from Internal Audit, while emphasising the Trust's commitment to continuous improvement. Dr Constable welcomed the progress made and reinforced that the BAF was intended to operate as a live document. He noted the importance of presenting the BAF early within the Board agenda to help frame and drive strategic discussion. Ms Ashley reflected on whether further consideration was required to ensure the Board agenda sufficiently reflected the full range of strategic risks, noting that some risks, including those relating to population health, may otherwise appear understated. Mrs Cotton acknowledged this point and confirmed that this would be considered further, including potential refinements to headings, for example to more explicitly reference people, patients and population. Ms Small emphasised that the BAF should continue to inform and shape the Board and Committee agendas. Mrs Cotton confirmed that the sources of assurance underpinning the BAF were aligned across Committees. Ms Bowen welcomed the increasing maturity of the BAF, particularly the improved clarity regarding gaps in control and assurance. She noted that this enabled clearer line of sight between identified gaps and the actions in place to address them and commended this progress. Mrs Monckton queried the extent to which the BAF was used to shape Executive Team agendas. Dr Constable clarified that this was not its primary purpose, noting that the BAF was focused on assurance rather than Executive operational discussion. Mrs Cotton added that, while there was alignment through the Executive Team Charter, the primary function of the BAF remained the provision of assurance to the Board. **The Trust Board noted the update and approved the BAF for Quarter 4.**	
OUR PATIENTS: QUALITY, ACCESS & OUTCOMES		
10.	**Maternity & Neonatal PSIRF Investigation Report – Q4**	
045/2026	Mrs Brayford joined the meeting. Mrs Brayford reported that five new incidents had met the Patient Safety Incident Investigation (PSII) criteria. Of these, three had been reviewed through the Perinatal Mortality Review Tool (PMRT) and two had been reviewed externally by the Maternity and Newborn Safety Investigations (MNSI) programme. She emphasised the continued involvement of patients	

	and families to ensure they felt fully engaged in investigations relating to their care. A more detailed report had been presented to the Quality, Access and Outcomes Committee. Miss Nicholson highlighted that a key strength noted at Committee had been the way in which staff involved parents in the process, often going the extra mile to support their engagement. This was formally commended. Dr Constable sought assurance, given the national context for maternity and neonatal services, regarding the improvements in governance arrangements, independence and oversight. Mrs Brayford outlined the strengthened governance framework, confirming that clear lines of intelligence were in place from ward to Board and described a structured governance process spanning directorate, care group, executive and committee levels through to the Board. She further noted that over 85% of reviews undertaken via PMRT involved an external reviewer, supported by arrangements with the Local Operational Delivery Network (ODN) and a maternity unit outside the region, providing additional independent perspective. Mrs Brayford also highlighted the ongoing development of a transparent and open culture, supported by organisational changes which had more fully integrated maternity services within the wider Trust. This had enabled greater involvement in broader programmes of transformation and quality improvement. Mrs Riley noted the significant number of recommendations and actions received over recent years and emphasised the robust oversight in place across maternity and neonatal services. She acknowledged the considerable work undertaken by the team to provide assurance to the Board and confirmed that progress continued to be closely monitored. Dr Constable asked for insight into the current experience of staff working within maternity services. Mrs Brayford advised that engagement with midwives had commenced in preparation for the publication of the Ockenden and Amos reports, noting the national context, including a substantial number of recommendations, was placing considerable pressure on teams. She emphasised the importance of maintaining transparency and a learning culture, whilst acknowledging the impact on staff, including feelings of vulnerability. She also advised that additional support measures were being introduced, including counselling provision and access to trauma-informed practitioners. Professor Toor welcomed the proactive development of an action plan in anticipation of forthcoming national reports and emphasised the importance of building resilience within the team. She sought clarity on how the Board could further support staff. Mrs Brayford advised that recent leadership changes, including the appointment of a new Clinical Director, were supporting the rebuilding of capacity and trust. She welcomed Board visibility and engagement, including walkabouts, as a means of demonstrating support. Miss Nicholson emphasised the need to consider the impact on women and families, particularly in anticipation of national communications. Mrs Brayford confirmed that this was being actively considered in collaboration with the communications team, with a focus on balancing transparency with reassurance. She noted the importance of sharing positive outcomes and experiences to maintain confidence in services. It was also noted that NHS England was developing a national communications toolkit to support consistent messaging.	

	Mrs Riley stressed the importance of considering the local population impact and ensuring appropriate support mechanisms were in place for patients and families who may raise concerns. She highlighted the need to carefully balance communications, recognising the potential for increased scrutiny. In response to a query from Ms Small regarding support arrangements, Mrs Riley confirmed that concerns would be actively managed, including offering opportunities for patients and families to meet with the service where appropriate. Mrs Brayford added that bereavement midwives maintained ongoing relationships with families and continued to provide support. Ms Small thanked Mrs Brayford and acknowledged the challenging context for maternity services. She confirmed her intention to visit the team and reiterated the importance of visible Board support. Mrs Brayford also noted that consideration was also being given to how support could be extended to community-based midwives. **The Trust Board received and noted the update.** Mrs Brayford left the meeting.	
11.	**Quality Account 2025/26**	
046/2026	Mrs Riley presented the Quality Account for 2025/26, noting that it had been developed in line with statutory guidance and was currently out for consultation with external stakeholders. She confirmed that the document would be published on 30 June in line with the national deadline and that any comments or amendments from Board members could be incorporated outside the meeting ahead of circulation of the final version. Ms Bowen sought assurance on two areas within the report. Referring to page 16, she noted the reference to changes in governance structures and queried how improvement methodologies would be reflected within operations and business areas in 2026/27. Mrs Riley advised that work was underway to define how these would be positioned going forward, with a greater emphasis on alignment to strategic programmes. She noted that improvement activity would be reported through revised mechanisms, including the Brilliant Basics programme and annual delivery plans, and confirmed that this would be made clearer within the governance framework. Ms Bowen also queried content on page 36 relating to the Getting It Right First Time (GIRFT) programme, specifically in relation to action plans, key themes, and references to business cases and capital or estate support. She sought assurance on whether these themes were triangulated through the Finance and Performance Committee and whether they aligned with expected investment priorities. Ms Ashley clarified that GIRFT was a clinically led quality improvement programme focused on standards of care and ways of working, rather than being directly linked to capital investment requirements. She noted that references to business cases related specifically to particular service areas, such as interventional radiology and vascular services, and were not indicative of a broader correlation between GIRFT findings and investment needs. She also acknowledged that the reference within the report may require clarification. Ms Bowen further queried whether appropriate triangulation mechanisms were in place. Ms Ashley confirmed that improvement work was led by clinical teams, supported by the transformation team, and progressed through operational improvement boards. Performance considerations formed part of	

	these discussions where relevant, and any investment requirements would be reflected through the Finance and Performance Committee processes, although not directly driven by GIRFT. Mrs Thorpe noted that the information was considered through a different perspective within Committee discussions. Mrs Cotton advised that consideration would be given to producing a more accessible summary version of the report. **The Trust Board received and approved the Quality Account 2025/26.**	**CC**
12.	**Urgent and Emergency Care Improvement Journey**	
047/2026	Mrs Thorpe presented an update on urgent and emergency care performance, noting that up to the end of April there had been a slight improvement in both four-hour and twelve-hour performance metrics. Improvements had also been observed in ambulance handover times, with an average of one hour and five minutes. However, she reported that performance had deteriorated during May. While the average handover time remained similar overall, this masked two distinct periods of extended delays which had significantly increased the average. Mrs Thorpe advised that this position was not where the Trust would wish to be for patients or the wider population. She outlined a range of contributing factors, including a reduction in discharge rates, the closure of winter escalation capacity, and continued pressure within the urgent and emergency care (UEC) pathway. Work with the GIRFT team was ongoing to review admission rates and challenge pathways. She highlighted a number of actions underway, including improvements to access into the organisation, particularly for older patients. This included expanding access to enable older persons' consultants to provide advice prior to attendance, although it was noted that this facility was not yet fully utilised and would require further engagement with community partners. Work also continued to develop the frailty model, including separating Same Day Emergency Care (SDEC) from short-stay frailty beds, with further work planned to review the acute and general medical cohort. A continued focus on discharge remained a priority. Mrs Thorpe acknowledged the challenge in fully understanding the causes of the deterioration, noting that it appeared to be multifactorial. While some hypotheses had been identified, further analytical work was required to better understand the underlying drivers. Dr Constable noted that urgent and emergency care performance remained the Trust's most significant operational challenge and that the deterioration in May followed a period of improvement, highlighting ongoing fragility and lack of resilience within the system. Mrs Thorpe confirmed that performance over the preceding ten days had fluctuated. Dr Constable observed that the Trust appeared to be recovering more quickly from dips in performance than had previously been the case. Ms Bowen queried whether all GIRFT recommendations had been implemented and sought clarity on the duration of their involvement, as well as whether they could support further triangulation and deep-dive analysis. Mrs Thorpe advised that GIRFT had supported prioritisation of improvement work and facilitated a more holistic review of pathways and data. While progress was being made, variation in practice remained, and embedding	

	change would take time. GIRFT continued to support the Trust, although no defined end date had been set. She added that GIRFT tools were being applied to specific areas, particularly frailty pathways, while internal work to strengthen data triangulation was ongoing to ensure alignment with best practice. Professor Toor noted that while the quadrant report provided a useful focus on key issues, there was some overlap between areas of concern and areas of improvement, making it difficult to fully understand the trajectory and relationship between them. Mrs Thorpe explained that the quadrant report provided granular insight at ward and cohort level, highlighting variation across services. While some areas had demonstrated positive progress, such as the use of the discharge lounge, others remained areas of concern. She acknowledged that the summary presentation did not always fully convey this nuance and confirmed that future reports would aim to better articulate the context and interplay between performance indicators. Mrs Riley reflected that both improvement and challenge could coexist within a complex system of this scale, and that emerging positive indicators should be viewed alongside ongoing pressures. Mrs Thorpe emphasised the importance of strong leadership in ensuring that improvements were embedded and sustained. She highlighted the need for ownership at team level and active engagement within workstreams. She also noted the importance of detailed data analysis, including deeper exploration of what was working effectively and why, to inform ongoing improvement. Mrs Cotton emphasised the importance of communications and engagement, noting that each strategic programme would require dedicated resource and a clear communications plan. This would support a better understanding of performance data and help align activity to the overall strategic vision. **The Trust Board received and noted the update.**	
PERFORMANCE		
13.	**Integrated Performance Report – Month 1 and Committee Assurance Reports:**	
048/2026	<u>Quality, Access & Outcomes Committee Assurance Report (29-04-26 & 03-06-26)</u> Professor Maddock highlighted key issues arising from Committee discussions, noting that the Quarter 3 Medicines Optimisation report demonstrated good progress against a number of key projects. Work had also been undertaken to address areas of potential risk, including controlled drugs, with a full annual report to be presented in due course. She reported that action was being taken to address out-of-date Patient Group Directions (PGDs), with a dedicated lead now appointed to oversee this work. Ongoing challenges within the pharmacy workforce were also noted, particularly within ophthalmology and biologics services, which were identified as potential areas of risk. An update on cancer peer review had provided positive assurance overall; however, workforce pressures remained a recurring theme, particularly within non-clinical roles and key specialties, where gaps could impact service delivery if not addressed.	

	Professor Maddock further highlighted progress in the implementation of the chaperoning policy. While improvements had been made, some inconsistencies remained, particularly in relation to record keeping and process adherence. These were being addressed, with further audit work planned. She noted positively that elective care pathways continued to develop well. Ms Ashley raised concern regarding references within reports to business cases which had not been progressed through corporate processes. She noted the need to understand what alternative mitigations were in place where investment was not planned, and how gaps in provision had arisen. Professor Maddock highlighted issues relating to maternity and neonatal services, noting that workforce pressures, particularly within Allied Health Professionals (AHPs), continued to be a concern. She raised the specific risk associated with staffing gaps in services caring for highly premature babies, where the potential for long-term impact was significant but difficult to quantify. It was noted that further work was underway to review risk scoring in this area. Partial assurance was noted in relation to the Perinatal Mortality Review Tool (PMRT), although it was acknowledged that, in a small number of cases, families had declined to participate, in line with their wishes. Positively, full implementation and sustained compliance with the Saving Babies' Lives Care Bundle was reported. It was also noted that arrangements for compensatory rest for the obstetric consultant workforce were not yet fully formalised, with policy development ongoing. Mrs Haire added that Clinical Negligence Scheme for Trusts (CNST) requirements included the need for a Standard Operating Procedure (SOP) to address intensive on-call periods, which would require further review. In discussion, Ms Bowen sought assurance regarding the approach to business case development, including whether teams were proactively identifying service gaps and aligning proposals with Trust priorities. Ms Ashley advised that Care Groups were asked to identify their priorities; however, these did not always align with subject matter expertise, and there were challenges in the quality and consistency of business case development. She noted that processes were being strengthened to ensure proposals were considered through performance review mechanisms, reducing unnecessary work where proposals were not aligned to organisational priorities. It was acknowledged that teams could default to developing business cases where alternative approaches may be more appropriate. Mrs Haire highlighted the need to consider workforce risks across a broader range of staff groups, including through future discussions at the relevant Committee. Ms Ashley reiterated the importance of Care Group-led prioritisation and ensuring alignment across leadership structures. Mrs Cotton emphasised the opportunity to strengthen alignment between corporate and Care Group planning cycles, particularly in relation to strategic risks and business case prioritisation. She noted that this represented a gap which would require further work to ensure greater synchronisation. Mrs Riley confirmed that Care Groups were aware of and supportive of the business case process, although prioritisation remained a key challenge. Dr Constable emphasised the need to clearly distinguish between support for improvement initiatives and formal prioritisation, noting that decisions should be informed by risk-based approaches and the Trust's risk appetite.	

Mrs Monckton queried the level of autonomy available to budget holders in committing resources. Ms Ashley advised that proposals were typically presented as additional funding requests rather than disinvestment options. Mr Oldham confirmed that limited virement between budgets was permitted within defined thresholds; however, any commitments beyond agreed budgets required Executive approval. Dr Constable noted that, particularly in the current financial context, robust financial controls and oversight were essential.

Professor Maddock also reflected on the significant volume of maternity-related business, noting that items had been deferred from the Committee agenda to allow sufficient focus on this high-profile area. She advised that forthcoming national reports were likely to generate further actions and highlighted the need to work with maternity services to refine reporting arrangements and reduce duplication.

Mrs Cotton noted that there was an opportunity to continue to utilise agile governance arrangements and referenced the existing maternity assurance map. Ms Ashley suggested that a time-limited dedicated maternity committee could be considered if required. Mrs Riley acknowledged that the scale and profile of the agenda may necessitate additional oversight arrangements.

The Trust Board received and noted the update.

Quality & Access Dashboard

Mrs Riley reported that staff turnover continued to improve, reflecting positive progress, including within maternity services. She advised that three 'Call for Concern' cases had been identified, each associated with changes in management, and were subject to review to identify any learning.

Mrs Riley further highlighted strong engagement in the Patient Council, with over 77 applicants received. Work was underway to ensure the final Council was representative and appropriately constituted.

In relation to infection prevention and control (IPC), it was noted that final performance trajectories were awaited. It was anticipated that the target for Clostridium difficile (C. difficile) would remain unchanged, whilst an improved trajectory was expected for E. coli.

Mrs Riley also reported that compliance with timely observations remained below target by approximately 8%. She advised that revised approaches to improvement had been implemented and were beginning to demonstrate early positive impact.

Mrs Thorpe provided an update on access performance, noting that corridor care data had now been incorporated into the reporting pack. She advised that there had been a slight delay in the delivery of the Urgent Treatment Centre (UTC), and the aim was to become operational by the end of July.

Mrs Thorpe highlighted the ongoing challenge of patients waiting over 65 weeks for treatment. While acknowledging continued progress within the elective recovery programme, she noted that particular specialties remained areas of concern. Action plans were in place for these areas, supported by weekly Executive oversight.

The Trust Board received and noted the assurance report and dashboard.

	People, Culture and Inclusion Committee Assurance Report (28-05-26) Professor Maddock highlighted key areas from the Committee's discussions. She noted that the refreshed Chief People Officer report had been welcomed, demonstrating significant progress in relation to sexual safety and providing strong assurance against the assurance framework. She reported that the resident doctors' ten-point plan had been presented, showing good levels of engagement and providing assurance. It had been recognised that there had previously been a degree of disconnect between the resident doctors' agenda and the sexual safety agenda; however, this had now been addressed. Professor Maddock advised that the Freedom to Speak Up (FTSU) report indicated an increase in concerns raised, reflecting the national position. Key themes related to workforce pressures and behaviours. Partial assurance was noted, with data collection and the ability to triangulate data across metrics identified as areas requiring further development. She further reported that the Employee Relations report provided acceptable assurance, although it reflected a sustained high volume of cases and ongoing pressure within the People function. The average case duration remained above target, influenced by a small number of particularly complex and lengthy cases. The Staff Networks report was also welcomed by the Committee. An amendment was noted to correct the role title referenced in the highlight report to Sexual Safety Liaison Officer.	**NH**
049/2026	**The Trust Board received and noted the update.** People Dashboard Mrs Haire reported that the workforce position remained broadly stable, with continued improvements in turnover and sustained low usage of agency staff. However, she noted that this stability masked ongoing pressures in other areas, including sickness absence and Personal Development Review (PDR) compliance. She highlighted that workforce capacity constraints within the People function remained a challenge, with limited additional capacity available within line management structures. In relation to sickness absence, Mrs Haire advised that a programme of improvement work was planned over the next 12 months, with a particular focus on nursing and midwifery staff, as the largest workforce group and highest users of bank and agency staff. Deloitte had been commissioned to support root cause analysis, with further work to be progressed to prioritise and focus improvement actions. Ms Bowen queried whether the decline in PDR compliance and levels of sickness absence were linked to capacity constraints. Mrs Haire confirmed that this was partially attributable to resource gaps within People advisory roles, but more broadly reflected pressures on line managers, including time constraints and experience. She noted that discussions had also been held with the Local Negotiating Committee regarding the role of medical leaders in supporting sickness absence management. Ms Small sought assurance on actions to improve PDR compliance. Mrs Haire advised that PDR completion was a key performance metric, monitored through performance review processes, with Care Groups asked to prioritise	

	improvement. In some areas, trajectories for improvement had been requested. She emphasised the need to better link this work to the wider employee experience agenda. Mrs Monckton, reflecting on previous discussions at the Finance and Performance Committee, emphasised the need to understand the risks associated with workforce capacity constraints and whether these were clearly articulated. Mrs Haire confirmed that these issues had been discussed, including linkage to the business case process. Ms Ashley noted that while workforce gaps within People Services had been explicitly identified through Committee, there was not always equivalent visibility of capacity risks in other corporate areas. Mrs Riley queried reported increases in establishment, noting a rise of over 400 whole time equivalent (WTE), and sought clarification on whether this reflected funded or temporary capacity. Mrs Haire advised that this included approved business cases, such as the Community Diagnostic Centre (CDC), as well as capacity funded through reserves, including escalation capacity. She noted that establishment figures reflected cumulative decisions over time and undertook to provide further clarification on this point. Mr Oldham confirmed that a significant proportion related to CDC expansion. Ms Bowen referenced previous cross-Committee discussions highlighting organisational resource constraints and the need to clearly identify and reflect associated risks within the Board Assurance Framework (BAF). Mrs Cotton confirmed that this formed part of the ongoing refresh of the risk management process, noting that risks relating to capacity constraints should be embedded within relevant strategic risks rather than managed in isolation. Mrs Thorpe observed that some risks, such as those relating to productivity and utilisation, were cross-cutting and did not sit neatly within a single Executive portfolio. Mrs Cotton highlighted the opportunity to address this through programme governance structures. Ms Ashley emphasised the importance of clearly articulating how identified capacity gaps were being mitigated, particularly where decisions had been taken not to invest. Mrs Cotton confirmed that she would work with Executive Leads to ensure alignment between actions, strategic priorities and risk mitigation, with clearer articulation of how these were linked. Dr Constable noted that this required an agile approach and would continue to evolve. Mrs Monckton emphasised the importance of ensuring that there was a clear and understood process in place. **The Trust Board received and noted the assurance report and the People Dashboard.**	**JH**
050/2026	<u>Finance & Business Performance Committee Assurance Report (27-04-26 & 01-06-26)</u> Ms Bowen highlighted key areas from the Committee's discussions. She reported that the Strategic Programmes Executive Committee (SPEC) had been established, with governance arrangements in place to support reporting through to the Board. An update on transformation programmes had been received, noting that further work was required to clearly articulate the impact of strategic programme milestones. Ms Bowen also emphasised the importance of	

maintaining strong grip and control over business cases and investment decisions. She noted that Board Assurance Framework (BAF) risk 7 remained rated as extreme, reflecting underlying structural pressures.

The Committee commended the Month 12 financial position. However, recruitment challenges were identified as a key impediment to delivery across a number of areas.

Ms Bowen reported that delivery of Cost Improvement Programme (CIP) schemes remained a focus, with a gap in scheme identification. It had been agreed that 100% of CIP schemes should be identified by the end of Quarter 1, revised from the original target of the end of May. The Month 1 financial position had also been reviewed.

She further noted that the capital programme had reduced, linked to the Project STAR land sale, and that this had been appropriately reflected in reporting. The Committee had also received an IT standards report which provided assurance regarding controls in place, including in relation to shadow IT risks.

Ms Bowen also highlighted a corporate capacity paper which considered the resources required to enable delivery of strategic programmes. The introduction of a new integrated change framework had been positively received, with improved clarity welcomed by the Committee.

Ms Small sought assurance regarding the Month 1 CIP position and how grip and control would be maintained. This was noted as an ongoing focus for Executive oversight.

In response to a query from Professor Maddock regarding SPEC, Dr Constable confirmed that the Strategic Programmes Executive Committee was chaired by himself and provided oversight of the Trust's strategic programmes. He clarified that the Committee had a direct reporting line to the Board in respect of this work.

The Trust Board received and noted the update.

<u>Finance Dashboard</u>

Mr Oldham presented the Month 1 and Month 2 financial position. He reported that Month 1 had delivered a deficit of £6.5m, which was £3.0m adverse to plan. This variance was primarily driven by industrial action and under-delivery of the Cost Improvement Programme (CIP), with £2.8m planned but £1.1m below target. He noted that £1.2m of non-recurrent provisions from the previous year had been released into Month 1.

Mr Oldham further highlighted a £0.8m shortfall in income for Month 1, or approximately £1.2m when excluding pass-through elements. This reflected a combination of factors including delays in the Community Diagnostic Centre (CDC), the impact of industrial action, and ongoing non-elective pressures.

He reported that the Month 2 position had deteriorated to an £11.0m deficit, £5.0m adverse to plan. When adjusting for the impact of industrial action, performance remained broadly consistent with Month 1, indicating that progress in delivering CIP had not yet translated into financial improvement. Income performance also remained below plan, particularly within specialties previously highlighted as underperforming.

	Mrs Monckton queried the key drivers of the Month 2 variance, noting it was approximately £1.6m adverse to plan. She also sought assurance regarding the likelihood of achieving full CIP identification by the end of Quarter 1. Mr Oldham advised that while a gap in CIP identification remained, further detail on the drivers of the variance would be circulated and incorporated into future finance reports. He noted that assumptions had been made in relation to CIP delivery where detailed plans (Project Initiation Documents) were not yet in place. In addition, some schemes already in delivery were not yet achieving their expected financial benefit, and there were instances where activity was taking place without corresponding financial gains. He also highlighted that, in some cases, over-performance in income was masking underlying issues. He acknowledged that there remained an overall gap and that further work was required to identify and control mitigating actions. He further noted that there were schemes delivering benefits which were not yet formally captured within reporting mechanisms. Dr Constable noted that the financial position reflected a combination of CIP under-delivery and income shortfall and emphasised the need to clearly define and implement mitigating actions. Mr Oldham added that there was no additional funding available to cover the costs of industrial action, and that these costs would need to be mitigated internally. Mrs Thorpe highlighted that further industrial action was scheduled and reiterated the importance of robust triangulation of performance and financial data. She noted that delivery of individual schemes could mask underperformance in other areas and that a clear understanding of how schemes were delivering was essential to enable effective accountability. **The Trust Board received and noted the assurance report and dashboard.**	
GOVERNANCE		
14.	**Audit Committee Assurance Report (30-04-26)**	
051/2026	The Trust Board received and noted the assurance report.	
15.	**Fit and Proper Persons Annual Assurance Report**	
052/2026	Ms Small highlighted that all 18 board members subject to review had been subject to fit and proper persons checks and did not include the two new Non-Executive Directors, checks for which were underway. Mrs Hassall highlighted that internal audit were due to review the trusts Fit and Proper Persons processes in the 2026/27 Internal Audit Programme. **The Trust Board noted the outcome of the 2025/26 FPPT assurance process and took assurance that appropriate systems and processes were in place and operating effectively. The Trust Board confirmed that all in-scope Board members met the FPPT requirements and approved submission of the annual declaration to NHS England.**	
16.	**Annual Evaluation of the Board and Committees including Rules of Procedure**	
053/2026	Mrs Cotton presented the outcome of the Board and Committee effectiveness review, noting that a structured and embedded process had been followed. She highlighted that the use of AI had supported a more objective review of findings and overall provided a positive assessment.	

	Mrs Cotton confirmed that Committees had reviewed and approved their updated Terms of Reference, which had been incorporated into the Trust's Rules of Procedure. Actions identified through the effectiveness review would be progressed through Committee business cycles and would inform the Board development programme. Any additional actions arising would be incorporated into the Well-Led improvement plan. She further noted that the governance structure would be updated to include the Strategic Programmes Executive Committee (SPEC), with a minor amendment proposed. **The Trust Board received and noted the findings of both the Board Effectiveness Review and Committee Effectiveness Reviews. The Trust Board approved the revised Rules of Procedure and endorsed the proposed actions to further strengthen governance arrangements.**	
CLOSING MATTERS		
17.	**Review of Meeting Effectiveness**	
054/2026	Members were asked to provide feedback via Microsoft forms.	
18.	**Review of Business Cycle**	
055/2026	No further comments were provided.	
DATE AND TIME OF NEXT MEETING		
19.	**Wednesday 12th August 2026, 9.30 am, Room 1, Postgraduate Medical Centre, County Hospital**	

Minutes of Meeting

Extraordinary Trust Board – Part 1 | 24th June 2026, 9.00 am to 9.20 am

Via MS Teams

University Hospitals of North Midlands NHS Trust

Members Present:			
Name	**Initials**	**Title**	
Ms J Small	JS	Chair (Chair)	Voting
Prof K Maddock	KM	Non-Executive Director	Voting
Miss W Nicholson MBE	WN	Non-Executive Director	Voting
Prof S Toor	ST	Non-Executive Director	Voting
Dr S Constable	SC	Chief Executive	Voting
Ms H Ashley	HA	Director of Strategy	Non-Voting
Mrs C Cotton	CC	Director of Governance & Communications	Non-Voting
Dr D Adamson	DA	Chief Medical Officer	Voting
Mr M Oldham	MO	Chief Finance Officer	Voting

Apologies Received:			
Name	**Initials**	**Title**	
Ms T Bowen	TBo	Non-Executive Director (virtual)	Voting
Mrs M Monckton	MM	Non-Executive Director	Voting
Mrs A Freeman	AF	Chief Digital Information Officer	Non-Voting
Mrs J Haire	JH	Chief People Officer	Non-Voting
Mrs AM Riley OBE	AR	Chief Nurse	Voting
Mrs K Thorpe	KT	Interim Chief Operating Officer	Voting
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI	Non-Voting

In Attendance:		
Name	**Initials**	**Title**
Mrs N Hassall	NH	Deputy Director of Governance (minutes)
Mrs H Poole		Deputy Chief Digital Information Officer (representing Mrs Freeman)

Members of Staff and Public: 0

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
056/2026	Ms Small welcomed members to the meeting. Apologies were received as noted above and the meeting was confirmed as quorate.	
2.	**Declarations of Interest**	
057/2026	There were no declarations of interest.	
GOVERNANCE		
3.	**Audit Committee Assurance Report (19-06-26)**	
058/2026	The Trust Board received and noted the assurance report.	
4.	**2025/26 Annual Report and Annual Governance Statement**	
059/2026	Mrs Cotton highlighted the process undertaken to prepare the 2025/26 Annual Report and Annual Governance Statement, including the analytical review against the Group Accounting Manual, engagement with Executive Directors	

	and liaison with external audit. She recorded her thanks to Mrs Hassall for leading this work. Mrs Cotton highlighted that a public facing version of the document 'The Review of the Year' would be presented at the Annual General Meeting. **The Trust Board approved the 2025/26 Annual Report and Annual Governance Statement.**	
5.	**2025/26 Annual Accounts, Analytical Review & Certificates**	
060/2026	Mr Oldham advised that the 2025/26 Annual Accounts had been through the Audit Committee process and that the audit work was substantially complete. He confirmed that the outstanding matters were not expected to affect the audit opinion. The summary paper set out the Trust's three statutory duties in respect of the break-even duty, Capital Departmental Expenditure Limit and Better Payment Practice Code, and outlined how these had been achieved. A number of adjustments had been made and worked through in relation to the break-even duty, which had been met despite the Trust delivering a deficit. It was noted that the cumulative deficit position had reduced year on year since 2019/20; however, due to the historic cumulative deficit, a referral to the Secretary of State would still be required. Dr Adamson joined the meeting. The analytical review, which set out year-on-year movements, was provided for information. An additional paper had also been included which was discussed at the Audit Committee, in relation to the consideration of whether the charitable funds accounts should be consolidated within the Trust accounts, primarily due to a significant donation received at the end of the year. The paper outlined the assessment undertaken in respect of the level of control over the charity and materiality. It was agreed that the charitable funds accounts were not material for consolidation purposes, and external audit had agreed with this assessment. It was agreed that, going forwards, the charitable funds accounts would be reviewed as part of the Trust accounts at year end to support more timely consideration in future. The Trust Board noted that the accounts and certificates would be signed later that day prior to submission. Dr Constable thanked all teams involved for completing the process on time and to a high standard during a challenging period. He noted the good practice demonstrated in relation to version control, tracked changes and the transparent escalation of matters to the Audit Committee. He also acknowledged that these were Mr Oldham's final accounts for the Trust and thanked him for his contribution. Ms Small commended the report and recognised the challenges associated with the year under review. **The Trust Board approved the 2025/26 Annual Accounts, Analytical Review and Certificates.**	
6.	**Audit Findings Report and Letter of Representation**	
061/2026		

	Mr Oldham advised that the Audit Findings Report and Letter of Representation had been considered by the Audit Committee, where the external auditors had presented their findings. He reiterated that, as a result of the cumulative deficit position, a referral to the Secretary of State would be required. The audit opinion was positive and confirmed that the accounts presented a true and fair view. It was noted that the outstanding matters were not expected to impact the audit opinion. Mr Oldham discussed one unadjusted statement in relation to the annual leave accrual, which would be revisited and reviewed. The value for money report was noted to be largely positive. In response to a question from Ms Small regarding the implications and next steps associated with the referral to the Secretary of State, Mr Oldham explained that the referral had been required in previous years and confirmed that the position remained unchanged. He noted that, although the Trust had met the break-even duty since 2019/20 and historic debt had previously been written off, the legislative requirement for referral remained in place. **The Trust Board approved the Letter of Representation and noted the Audit Findings Report.**	
DATE AND TIME OF NEXT MEETING		
7.	**Wednesday 12th August 2026, 9.30 am, Room 1, Postgraduate Medical Centre, County Hospital**	

Post Meeting Action Log

Trust Board Part 1 - Open

As at **05 August 2026**

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/625	08/04/2026	Maternity & Neonatal PSIRF Investigation Report Q3	To explore whether regional or national benchmarking and comparative demographic analysis would be identified to support triangulation of quarterly data and strengthen understanding of trends over time.	Ann-Marie Riley	03/06/2026	05/08/2026	Update included within the Q4 report. This will be in future reports in line with CNST requirements	B
PTB/626	10/06/2026	Quality Account 2025/26	To consider the production of an easy read, more accessible summary version of the report.	Claire Cotton	31/08/2026		In progress via Communications Team.	GA
PTB/627	10/06/2026	People, Culture and Inclusion Committee Highlight Report (28-05-26)	An amendment was noted to correct the role title referenced in the highlight report to Sexual Safety Liaison Officer.	Nicola Hassall	11/06/2026	11/06/2026	Complete.	B
PTB/628	10/06/2026	People Dashboard	To clarify the reasons for the increase in Whole Time Equivalents in future reports.	Jane Haire	12/08/2026	13/07/2026	Complete - actioned within the 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 | 12th August 2026

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 10th June 2026, some of which are not covered elsewhere on the agenda for this meeting.

1. New Secretary of State for Health and Social Care

In July 2026, Yvette Cooper MP was appointed as Secretary of State for Health and Social Care. The appointment comes at a significant time for the NHS, with the implementation of the 10 Year Health Plan, the forthcoming Health Bill, and a range of national reform programmes focused on prevention, neighbourhood health services, digital transformation, workforce development and productivity.

Whilst national priorities remain centred on delivering the ambitions of the 10 Year Health Plan, the appointment provides an opportunity for renewed focus on improving access to care, reducing health inequalities, strengthening integration between health and social care and supporting long-term service transformation. The NHS continues to progress the three strategic shifts set out in the national plan: from hospital to community, from analogue to digital, and from sickness to prevention.

We will continue to work with system partners to deliver these national priorities through the Trust's strategic programmes, ensuring that local plans remain aligned with emerging policy direction and national expectations.

2. Ockenden, Amos and NHS England 100 Day Sprint Programme

We are continuing to progress work in response to the recommendations arising from the Ockenden and Amos reviews, alongside NHS England's recently launched 100 Day Sprint programme. Together, these initiatives provide an important opportunity to further strengthen maternity services, improve patient safety and ensure national best practice is embedded throughout care pathways.

A dedicated programme of work is being established to coordinate delivery of the various recommendations, support oversight of progress and ensure clear accountability for implementation. This includes benchmarking current arrangements against national requirements, developing action plans and establishing governance arrangements to monitor delivery and provide assurance to the Trust Board.

Alongside this work, we are progressing feasibility and estate planning to support future maternity service development, including consideration of longer-term solutions for maternity assessment and triage services. This will help ensure services remain safe, responsive and sustainable whilst meeting the needs of women and families across Staffordshire and surrounding areas.

Regular updates will be provided through our governance framework as implementation progresses, ensuring the Board receives assurance regarding delivery of actions, achievement of milestones and the impact of improvements on quality and safety.

3. Ethical Healthcare Review of the Trust's Electronic Patient Record (EPR)

An independent review of UHNM's Electronic Patient Record (EPR) environment has provided important assurance on the Trust's digital strategy and identified the priorities required to support future improvements. The review, commissioned by NHS England and undertaken by Ethical Healthcare Consulting, examined our current EPR position, future options and affordability.

The review recognised the significant progress made in strengthening our digital infrastructure but highlighted that ongoing system instability is now predominantly linked to the current Careflow system and iPortal rather than the underlying infrastructure. These issues continue to create operational challenges and impact staff confidence. The review also identified the integration as a significant technical risk and recognised that iPortal, whilst highly valued by clinical teams, is becoming increasingly difficult to sustain.

A key conclusion of the review was that an immediate, organisation-wide replacement of the EPR system is neither affordable nor deliverable within current timescales. Instead, the review recommends a phased approach focused on stabilising existing systems, reducing risk, improving reliability and strengthening supplier accountability, whilst developing a longer-term, evidence-based digital strategy.

Over the coming months, we will focus on reducing outages, improving system resilience, addressing the highest-risk components of the current architecture and progressing selected enhancements within the supplier roadmap where these can deliver demonstrable benefits for staff and patients. This work will help create the foundations for future digital transformation whilst ensuring services remain safe, sustainable and affordable.

4. IR(ME)R Radiotherapy Inspection at Royal Stoke

UHNM's Radiotherapy Service recently underwent an IR(ME)R inspection by the Care Quality Commission on 22 July 2026. Following the inspection, the Inspector confirmed that no actions are required as a result of the visit and highlighted numerous examples of excellent practice that will be recognised within the final inspection report.

The Inspector praised the Radiotherapy team for their achievements and the quality of the service provided, reflecting the team's ongoing commitment to patient safety, quality and regulatory compliance. The final report will be issued following completion of the formal reporting process.

5. New NHS Staff Standards to Improve Staff Experience

In July 2026, NHS England introduced six new NHS Staff Standards designed to improve and raise the profile of staff experience across the NHS. The standards build on the NHS People Promise and establish a minimum level of experience that all NHS employers are expected to provide, helping to reduce variation and promote a positive, inclusive workplace culture.

The standards focus on six key areas: line management, health and wellbeing, championing sexual safety, promoting flexible working, tackling racism, and violence prevention and reduction. Local partnership working and meaningful staff engagement are central to the successful implementation of the standards, ensuring that staff have a strong voice in shaping organisational culture and experience.

For the first time, performance against the standards will be measured through a dedicated staff standards score within the NHS Oversight Framework, providing greater accountability and transparency and supporting continuous improvement in staff experience across the NHS.

We are reviewing the requirements of the new standards and considering how existing initiatives, governance arrangements and improvement programmes can be aligned to support implementation and demonstrate compliance.

6. NHS Leadership and Management Framework (LAMF)

In July 2026, NHS England launched the NHS Leadership and Management Framework (LAMF), establishing a consistent set of professional standards, behaviours and competencies for leaders and managers across the NHS. Developed in response to the recommendations of the Messenger and Pollard reviews, the framework aims to strengthen leadership capability, support professional development and promote a shared approach to leadership and management at all levels of the organisation.

The framework introduces a code of practice and a structured set of leadership and management standards which NHS organisations are expected to begin implementing locally. As part of this process,

leaders and managers will be required to complete a self-assessment against the relevant standards by April 2027, with the outcomes informing appraisal, development planning and ongoing career conversations.

A 360-degree feedback tool is expected to be launched later this year to support implementation, alongside a new standard NHS appraisal framework. Together, these developments will provide a more consistent approach to leadership development, helping organisations identify strengths, target development opportunities and support the delivery of high-quality, compassionate and inclusive leadership across the NHS.

We are reviewing the implications of the framework and considering how existing leadership development, appraisal and talent management arrangements can be aligned to support implementation and maximise the benefit for colleagues and patients.

7. NMC Anti-Racism Principles

The Nursing and Midwifery Council (NMC) has published new principles to support anti-racism in nursing and midwifery education and practice, reinforcing the profession's commitment to equity, inclusion and culturally safe care. The principles are designed to help reduce health inequalities, improve patient experience and outcomes, and ensure that people from all backgrounds receive respectful and equitable care.

The principles provide a framework for educators, employers and registrants to recognise and address racism, challenge bias and discrimination, and embed anti-racist practice within learning and healthcare environments. They also promote greater accountability and support organisations to create inclusive cultures where diversity is valued and all staff feel safe, supported and able to thrive.

The publication forms part of the NMC's wider programme of work to strengthen equality, diversity and inclusion across the professions and will help prepare the sector for the introduction of the revised NMC Code in 2027. The principles are expected to influence education, professional development, workforce practices and patient care, supporting the delivery of more inclusive and equitable services.

8. Planned Consultant Industrial Action

A period of planned consultant industrial action is expected to take place later this month, and extensive preparations are underway across UHNM to minimise disruption to patient care and maintain safe services throughout the period.

As with previous industrial action, our priority will be to ensure that urgent, emergency, maternity and other time-critical services continue to operate safely, whilst seeking to maintain as much planned activity as possible. Careful planning is taking place across all Care Groups to assess risks, manage workforce availability and reduce the impact on patients.

Some appointments and procedures may need to be rescheduled where safe staffing cannot be maintained. Patients affected by any changes will be contacted directly, and teams will work hard to minimise inconvenience and maintain continuity of care wherever possible.

Robust command and control arrangements will be in place throughout the industrial action period, supported by strategic and tactical oversight and on-call leadership teams. These arrangements will enable the Trust to respond dynamically to emerging pressures, maintain patient flow and ensure that clinical risks are effectively managed.

9. National Award Recognises UHNM's Commitment to Continuous Improvement and Patient Safety

We have recently received national recognition for our work to improve patient safety through the effective use of data, team collaboration and continuous improvement. Our Continuous Improvement Academy and Quality, Safety & Compliance team were awarded the Learning and Improvement Through Reporting and Safety Insight Award at the RLDatix Connected Healthcare Summit Awards 2026.

The award recognises our work with frontline ward teams to identify challenges earlier, better understand performance and implement improvements that support safer care for patients. The programme was initially developed on Ward 223 Short Stay Unit at Royal Stoke Hospital, where it supported the team's successful progression from Silver to Gold accreditation within the Trust's Care Excellence Framework.

Building on this success, the programme is now being rolled out more widely across UHNM, helping teams use data more effectively, create shared ownership of improvement and embed continuous improvement as part of everyday practice. The national recognition reflects the Trust's commitment to learning, innovation and empowering staff to drive improvements that enhance quality, safety and patient experience.

10. Employee and Team Recognition

Chief Executive Award (June 2026) – Dr Antony George

The Chief Executive Award recognised Dr George, Specialist Doctor in Endocrinology, Diabetes and General Internal Medicine, for the exceptional contribution he makes to both patients and colleagues across our medical wards.

What stood out to me was the consistent emphasis on compassionate, person-centred care. Dr George is recognised not only for delivering safe and effective clinical care in often highly pressured environments, but also for the kindness, empathy and reassurance he provides to patients and their families. His approach ensures that patients are listened to, involved in decisions about their care and treated with dignity throughout their hospital journey.

The award also highlights the significant contribution Dr George makes to supporting patient flow across some of our busiest inpatient areas. By working collaboratively with multidisciplinary teams and maintaining a focus on safe and timely discharge, he helps improve the overall patient experience while supporting the effective operation of our services.

Importantly, this recognition reflects the positive impact he has on those around him. Dr George is highly regarded for the support, mentorship and guidance he provides to resident doctors and colleagues, creating an environment where staff feel valued, supported and able to develop. His professionalism, leadership and commitment to teamwork exemplify the values we aspire to demonstrate across UHNM every day.

Part 2: Policy & Publications Update

The following section provides an overview of significant national policies, publications and guidance issued since the last report which are relevant to UHNM.

Policy

- 10 Year Capital Plan for Health and Social Care (8 July 2026) – sets out how capital investment over the next decade will modernise health infrastructure and support delivery of the 10 Year Health Plan for England.
- Quality Strategy for NHS-funded Care in England (14 July 2026) – outlines the national priorities, case for change and delivery approach for quality improvement.
- Cardiovascular Disease (CVD) Modern Service Framework (7 July 2026) – provides a 10-year strategic vision to reduce premature mortality from cardiovascular disease in England.

- Health Bill: Providers Fact Sheet (19 May 2026) – outlines proposed legislative changes affecting NHS and independent providers to support delivery of the 10 Year Health Plan for England.
- National Cancer Plan for England (20 April 2026) – sets out the Government's ambitions to improve cancer care and outcomes by 2035.
- Women's Health Strategy for England (Renewed) (15 April 2026) – describes how women's health and healthcare will be improved over the next decade.
- Neighbourhood Health Framework (17 March 2026) – provides guidance to Integrated Care Boards, local authorities and partners on the development and delivery of neighbourhood health services.

Publications

- Independent Investigation into Maternity and Neonatal Services in England: Final Report and Recommendations (30 June 2026).
- Nottingham Maternity Review: Findings on Post-Death Care and Key Actions Following the Fuller Inquiry (26 June 2026).
- Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust (24 June 2026).

National Guidance and Letters

- Medical Device Regulation for Ambient Voice Technology Products (29 July 2026).
- Winter Planning 2026/27: Expectations and Assurance (17 July 2026).
- Launch of the NHS Leadership and Management Framework and New NHS Staff Standards (6 July 2026).
- Flu Vaccination Programme 2026/27 (2 July 2026).
- Expressions of Interest for New Postgraduate Training Posts (23 June 2026).
- Board and Executive Assurance: Cyber Security Risk (10 June 2026).
- Nursing Band 5 Job Evaluation (2 June 2026).

Each of the above developments will be reviewed by the relevant Executive Director and their teams to assess the implications for UHNM. Where required, actions, policy amendments, implementation plans and assurance arrangements will be developed and progressed through the Trust's governance and committee structure, with significant issues escalated to the Board as appropriate.

Part 4: Strategic Programmes Executive Committee Highlight Report

The first meeting of the Strategic Programmes Executive Committee was held on 26 June 2026.

Key Highlights

- The Committee has been established as a new Executive Committee to provide dedicated executive-level oversight, governance and leadership of the Trust's major strategic programmes, ensuring delivery of the Trust Strategy and Medium-Term Plan is translated into prioritised, deliverable programmes with clear accountability, milestones, risks and assurance routes.
- The Committee will provide direct assurance to the Trust Board on strategic delivery confidence, progress against outcomes and milestones, sufficiency of change capacity and capability, key risks, mitigations and any Board-level actions required.
- The first meeting considered the Trust's strategic delivery framework for 2026/27, including the need to adopt a consistent Integrated Change Framework across the organisation, refine the Strategic Programmes and strengthen governance to ensure sufficient oversight and accountability for delivery.
- The Committee noted that the Trust's refreshed strategy is supported by strategic programmes and plans aligned to the priorities of Our People, Our Patients and Our Population, with the strategic programme portfolio now comprising Brilliant Basics, Digitally Enabled Care Transformation, Future Hospital, Partnerships and Collaboration, and Financial Sustainability.
- Members recognised that the Strategic Programmes Executive Committee provides a single forum through which the Trust can maintain a shared understanding of its strategic programmes, programme scope, delivery status, risks and interdependencies. The Committee noted that this will strengthen the Trust's ability to provide coherent assurance to the Board, support ongoing Well-Led and Provider Capability assessments, and demonstrate progress against strategic priorities through a structured and consistent governance framework.

Assurance Provided
The Board is asked to note that the Strategic Programmes Executive Committee provides a strengthened mechanism for executive oversight of strategic delivery, including programme governance, prioritisation, sequencing, interdependencies, delivery confidence, change capacity and escalation of risks that may impact achievement of the Trust Strategy.

Key Risks / Issues to Escalate
- The scale, pace and complexity of strategic change will require careful prioritisation and sequencing to ensure delivery remains realistic, sustainable and aligned to available capacity and capability.
- The Committee will need to maintain close oversight of interdependencies between programmes and the interface between strategic programme delivery and business-as-usual operational performance.
- The Trust has recognised the need for a more consistent and coordinated approach to change management, as current arrangements do not always consistently deliver the intended improvements in patient care, adoption of technology, productivity or financial efficiency.

Actions / Work Underway
- Development and refinement of programme scopes to establish a clear, shared understanding of priorities, deliverables, milestones and risks across all strategic programmes.
- Introduction of a consistent approach to programme management, including stakeholder engagement, communication, patient involvement, benefits realisation and identification of early improvement opportunities.
- Regular review of programme interdependencies, delivery capacity and resource requirements to ensure programmes remain aligned and mutually supportive.
- Establishment of a reporting approach combining monthly portfolio oversight with periodic deep dives into individual strategic programmes.

Part 3: Consultant Appointments

The following table provides a summary of consultant medical staff interviews which have taken place during June and July 2026:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Cons Radiologist Uroradiology	Vacancy	Yes	6.7.26
Consultant Neonatologist	Newly created	Yes	22.6.26
Spinal Deformity Consultant	Vacancy	Yes	TBC
Consultant Ophthalmologist - Oculoplastics	Vacancy	Yes	TBC
Consultant Neuro-Diagnostic Radiologist	Vacancy	Yes	TBC (3 posts)
Consultant in Histopathology	Newly created	Yes	Yes
Consultant in Clinical Haematology	Newly created	Yes	TBC (3 posts)

The following table provides a summary of medical staff who have taken up positions in the Trust during June and July 2026:

Post Title	Reason for advertising	Start Date
Consultant Spinal Surgeon - Specialising in Spine Deformity	Vacancy	22.6.26
Consultant Neonatologist	Newly created	22.6.26
Consultant Interventional Cardiologist with interest in TAVI	Vacancy	29.6.26
Consultant Oncoplastic Breast Surgeon	Vacancy	20.7.26
Cons Radiologist interest in Uroradiology / Non-vascular Intervention	Vacancy	1.7.26

No medical vacancies closed without applications / candidates during June and July 2026:

Medical Management Appointments

The following table provides a summary of medical management interviews which have taken place during June and July 2026:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Robotic Research Lead	Newly created	Yes	TBC
Robotics Clinical Lead	Newly created	Yes	1.7.2026
End of Life Clinical Lead	Vacant post	Yes	TBC
Clinical Director for Acute Medicine	Vacant post	Yes	TBC
Clinical Director - Emergency Medicine	Vacant post	Yes	1.8.2026
Clinical Director Respiratory, Gastro and Infectious Diseases	Vacant post	Yes	TBC
Clinical Director General Medicine	Vacant post	Yes	1.8.2026

The following table provides a summary of medical management that have taken up positions in the Trust during June and July 2026:

Post Title	Reason for advertising	Start Date
Robotics Clinical Lead	Newly created	1.7.2026
Clinical Lead - Breast Radiology	Vacant post	29.6.2026
Clinical Lead - Paediatric Radiology	Vacant post	10.7.2026
Clinical Lead - Breast Screening	Vacant post	29.6.2026
Clinical Lead for Neurology	Vacant post	15.6.2026
Deputy Chief Medical Officer - System	Vacant post	6.7.2026
Clinical Business Units Medical Director x 5	Newly created	1.7.2026

There were no medical management vacancies that closed without applications / candidates during June and July 2026.

Executive Summary

Trust Board (Part 1) | 12th August 2026

Board Assurance Framework – Quarter 1

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**	✓	**Assurance**		**Agenda Item:**	9.
Author:	Nicola Hassall, Deputy Director of Governance							
Executive Lead:	Various							

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, which provides a structured approach to identifying and managing the key risks that could impact the delivery of the Trust's Strategic Priorities. It sets out the principal controls in place for each strategic risk 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 provides detailed oversight of specific strategic risks. Oversight of the overall BAF process rests with the Audit Committee.

This update reflects the position at Quarter 1 2026/27, as provided by Executive Leads.

Background

During Quarter 1, a comprehensive review of the BAF has been undertaken to strengthen its effectiveness as a strategic assurance tool. Key improvements include:

- Refreshing all risk descriptions using a consistent Cause → Event → Effect methodology.
- Strengthening the alignment between strategic risks and the Trust's primary issues relating to Financial Sustainability, Capacity & Capability, and System & Infrastructure.
- Improving the linkage between identified gaps in control and assurance, mitigating actions and planned risk score trajectories.
- Strengthening narrative regarding multi-year strategic risks, dependencies and target risk scores.
- Refining mitigating actions to ensure they are strategic, outcome-focused and directly aligned to identified assurance gaps.
- Increasing emphasis on benefits realisation, capacity and capability, and outcome measurement as key determinants of risk reduction.
- Improving consistency of terminology, assurance reporting and executive summaries across all strategic risks.

Following discussions with the Board during 2025/26, a new strategic risk (BAF 9) relating to the sustainability of urgent and emergency care performance has been incorporated into the Board Assurance Framework for 2026/27. This reflects the Board's recognition of the ongoing strategic challenges associated with demand, patient flow, discharge performance, workforce and bed capacity, and the need for continued oversight of the actions required to achieve sustainable improvement and eliminate corridor care.

Assessment

Quarter 1 2026/27 reflects a refreshed Board Assurance Framework (BAF) following the annual review and approval of the revised strategic risks by the Board. The updated framework provides a clearer articulation of the principal threats to delivery of the Trust's Strategic Priorities, with strengthened links between strategic risks, primary organisational issues, controls, assurances and mitigating actions.

Overall, the BAF continues to demonstrate that the Trust operates within a robust governance framework, with established controls and assurance mechanisms in place across all strategic risks. However, the majority of risks remain above their target risk tolerance levels, reflecting the ongoing challenges associated with operational performance, workforce sustainability, financial recovery, digital transformation and urgent and emergency care demand. Financial sustainability remains the most significant strategic threat, while workforce capacity and capability constraints continue to impact multiple strategic risks.

Key Thematic Issues Emerging in Quarter 1

- Financial sustainability and delivery of the in-year financial position remain the most significant strategic challenges, with continued reliance on delivery of recurring savings, productivity improvements and transformation programmes.
- Workforce capacity, capability and affordability pressures continue to influence delivery across a number of strategic risks, including service performance, organisational culture, digital transformation, research and innovation.
- Demand, capacity and patient flow pressures continue to impact urgent and emergency care performance, with ongoing focus on discharge, flow and reduction of corridor care.

- Digital transformation continues to progress, supported by strengthened governance, cyber assurance and compliance arrangements, although significant dependencies remain relating to infrastructure, funding and programme delivery.
- Population health, prevention and health inequalities programmes continue to mature, with greater emphasis on demonstrating measurable improvements in outcomes and reducing variation across the populations served by the Trust.
- Estate infrastructure and capital investment pressures remain significant long-term challenges, with continued reliance on external funding to address backlog maintenance and support future service transformation.

Risk Profile Overview

- Two of the nine strategic risks are currently assessed within the Trust's risk tolerance, with the remaining seven risks above their target risk scores.
- Two risks are assessed as providing acceptable assurance (Population Health and Estates), whilst seven risks are assessed as providing partial assurance. No risks are assessed as having no assurance.
- BAF 7 (Financial Sustainability) remains the highest-rated strategic risk at an extreme score of 25. BAF 6 (In-Year Financial Position) and BAF 9 (Urgent and Emergency Care Performance) also remain rated as extreme risks.
- BAF 8 (Research and Innovation) increased during Quarter 1 following delays associated with the NIHR Capital Investment programme and continuing workforce and infrastructure constraints.

Areas of Ongoing Concern

- The majority of strategic risks continue to remain above risk tolerance and will require sustained delivery of long-term improvement programmes before a reduction in residual risk can be realised.
- Financial recovery, delivery of recurrent savings and achievement of long-term financial sustainability remain significant areas of concern.
- Workforce capacity and capability constraints continue to affect organisational resilience and delivery of strategic priorities.
- Ongoing pressures within urgent and emergency care pathways continue to impact performance improvement and patient flow.
- Demonstrating the impact and sustainability of improvement initiatives remains a recurring assurance challenge across several strategic risks.

Looking ahead to Quarter 2, further work will focus on strengthening the maturity of the Board Assurance Framework by enhancing the alignment between controls, assurances, identified gaps and mitigating actions to provide a clearer line of sight between action delivery and demonstrable risk reduction. In addition, a review will be undertaken of how progress against strategic actions is reported to committees. Whilst actions are currently RAG rated against their original target completion dates, this approach does not always reflect the progress being made throughout the year or the long-term nature of many strategic actions. Consideration will therefore be given to introducing a more nuanced approach to reporting progress, enabling committees to better assess delivery against key milestones, the effectiveness of mitigating actions and the contribution these make towards strengthening assurance and reducing strategic risk over time.

Key Recommendations

The Trust Board is asked to receive and approve the BAF for Q1.

University Hospitals of North Midlands NHS Trust

Board Assurance Framework

Quarter 1 | 2026 - 2027

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

8	9	8

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 Strategic Programmes

Brilliant Basics: Standards & Performance | Addressing the immediate concerns facing our patients

Digitally Enabled Care Transformation | Standardising and redesigning pathways – enabled by a new EPR

Our Future Hospital Services | Designing services so they reflect the latest developments in medical knowledge and provider care closer to home

Collaborations & Networks | Working with others to ensure sustainable and joined-up care

Financial Sustainability | Delivering value, productivity and efficiency to ensure sustainable services for the future

Our Values

- Kind
- Excellent
- Together

Our Primary Issues

Culture, Capacity & Capability

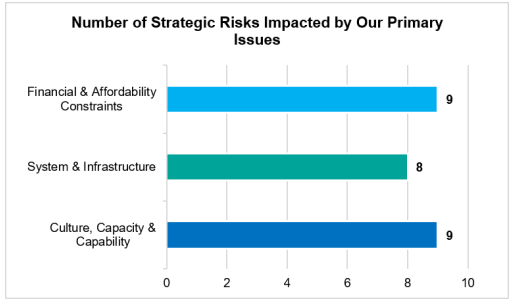
i.e. staff fatigue & burnout / workforce affordability & skills / digital and technological capacity

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 Low (1 - 3)	Moderate (4-6)	High (8-12)	Extreme (>15)	Committee Assurance Assessment Significant	Acceptable	Partial	None	NR	Gaps in Control	Gaps in Assurance	Action Plan Progress 2026/27 Complete	On Track	Delayed	Problematic
BAF 1	Inability to consistently deliver and improve safe timely and effective care	Ext 16 Partial				High 8	Minimal (1 - 4) Score has exceeded the tolerable score (5-9) since 2022/23	●	●	●	●	●	●	15	75	210	65	1	8	7	0	4	4	6	0	7	0	1
BAF 2	Inability to improve population health outcomes and reduce inequalities through effective service and system delivery	High 12 Acceptable				High 8 31/03/2028	Minimal (1 - 4) Score has exceeded the tolerable score (5-9) since 2023/24		●	●	●	●	●	0	0	0	0	0	3	3	0	1	4	6	0	7	0	0
BAF 9	Inability to sustain safe and timely urgent and emergency care performance	Ext 20 Partial				High 10 31/03/2029	Minimal (1 - 4) Score exceeds the tolerable score (5-9)	●	●	●	●	●	●	0	3	11	7	0	3	6	0	1	5	5	0	7	0	0
BAF 3	Inability to deliver a sustainable workforce and improve organisational culture	Ext 15 Partial				High 10 31/03/2028	Cautious (1 - 9) Score has exceeded the tolerable score (10-12) since 2024/25	●	●		●		●	5	22	97	32	0	2	4	0	0	3	7	0	5	0	5
BAF 4	Inability to deliver digitally enabled care	Ext 16 Partial				High 8 31/03/2028	Minimal (1 - 4) Score has exceeded the tolerable score (5-9) since 2022/23	●	●	●	●	●	●	7	39	53	13	0	1	0	0	1	4	3	0	6	0	0
BAF 5	Inability to maintain and modernise estate infrastructure to support safe and sustainable service delivery	High 12 Acceptable				High 8 31/03/2029	Cautious (1 - 9) Score has remained within the tolerable score (10-12) since 2022/23	●	●	●	●	●	●	8	26	66	9	0	2	0	0	1	9	3	0	0	0	7
BAF 6	Inability to Deliver In-Year Financial Position	Ext 20 Partial				High 12 31/03/2027	Cautious (1 - 9) Score has exceeded the tolerable score (10-12) since 2026/27	●	●	●	●	●	●	10	6	4	3	2	3	8	0	3	3	2	0	2	0	0
BAF 7	Inability to Deliver Financial Sustainability	Ext 25 Partial				High 12 31/03/2029	Cautious (1 - 9) Score has exceeded the tolerable score (10-12) since 2024/25	●	●	●	●	●	●	8	2	1	1	0	3	8	0	4	4	2	0	1	1	1
BAF 8	Inability to deliver the research and innovation strategy at the required scale, pace and impact	Ext 16 Partial				High 12 31/03/2027	Open 1 - 12 Score is within the tolerable score (15-16)	●	●	●	●	●	●	1	0	0	1	0	0	1	0	0	6	3	2	6	0	1
							Total	8	9	8	8	8	9										42	37	2	41	1	15

Financial sustainability remains the most significant strategic threat and workforce and capacity constraints continue to impact multiple BAF risks. Most risks remain dependent on multi-year transformation programmes and assurance gaps most commonly relate to benefits realisation and outcome measurement.

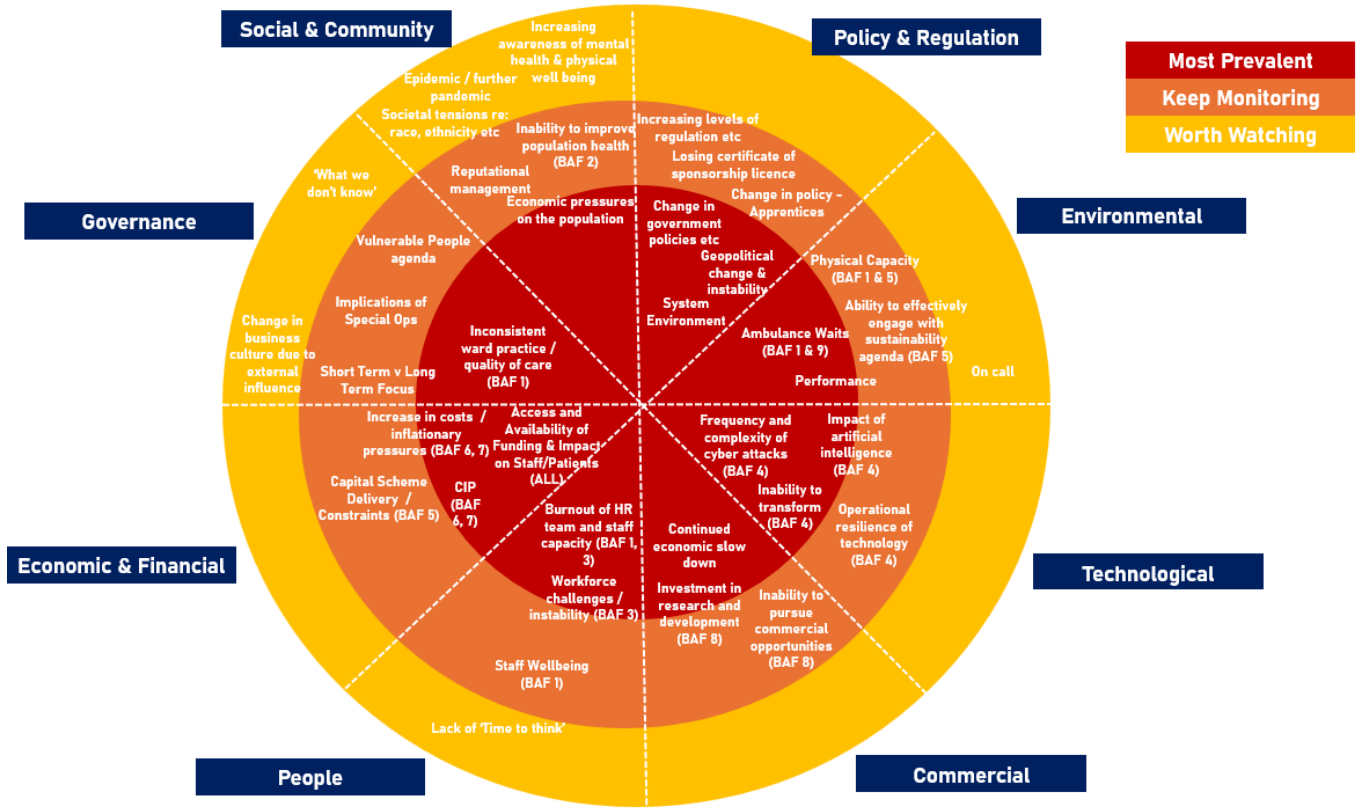
Positive Assurance

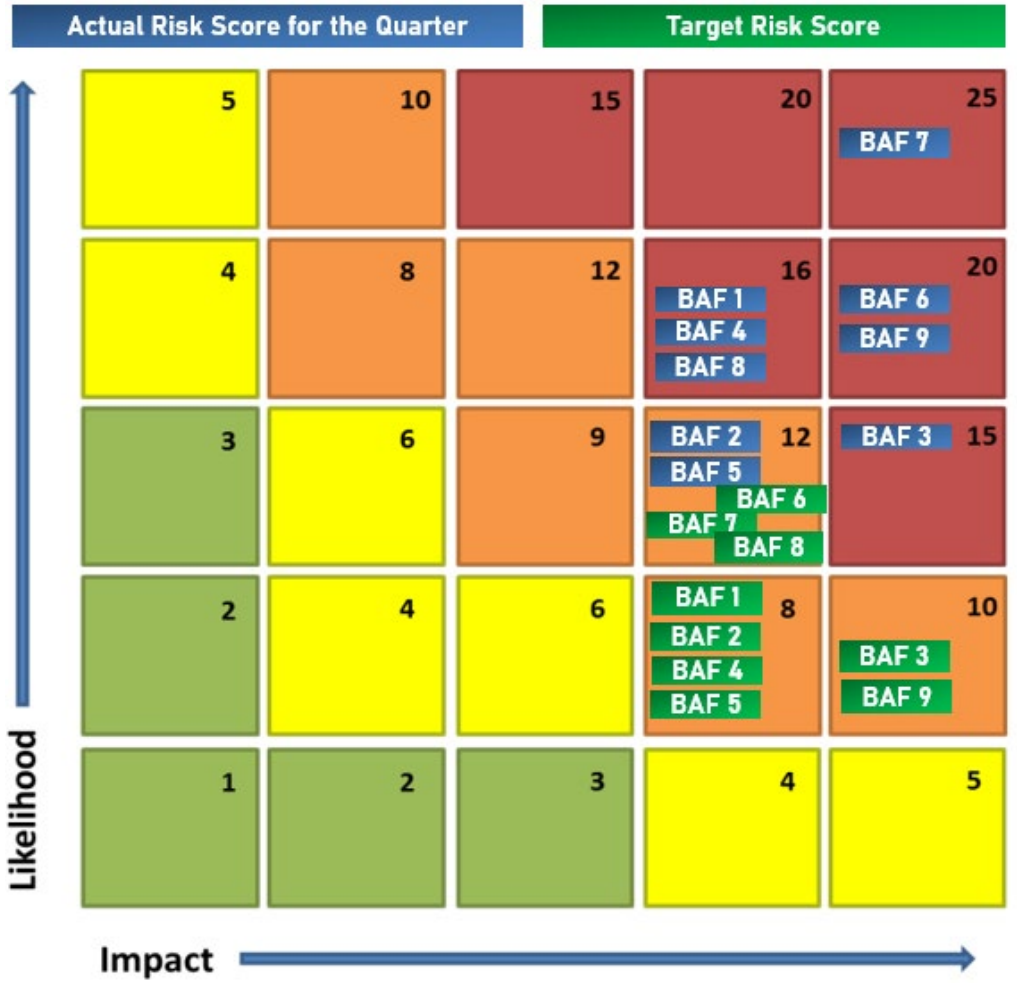
- 2 / 9 risks identified as providing acceptable assurance.
- 4% assurances received in quarter were rated as significant assurance and 31% as acceptable assurance.
- 3% of actions have been completed with 70% on track.
- 2 / 9 risk scores are within the risk tolerance.

Matters of Concern

- 7 / 9 risks identified as providing partial assurance.
- 46% assurances received in quarter were rated as partial assurance, 0% identified as having no assurance and 19% of assurances were not rated.
- 13% of assurance were not seen during Q1.
- 2% of actions are delayed and 25% problematic.
- 7 / 9 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.

Assurance Rating Key

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

BAF 1: Inability to Consistently Deliver and Improve Safe, Timely and Effective Care

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

Risk Description

Cause:	If we are unable to maintain sufficient workforce, service and organisational capacity, develop the clinical, leadership and improvement capability required to respond to current and future demand, effectively engage patients and communities in service design, and deliver the clinical service improvements required across our key services,
Event:	then we may be unable to consistently deliver safe, timely, effective and high-quality care, reduce avoidable harm, and achieve National Oversight Framework quality and performance requirements, including elective recovery objectives,
Effect:	resulting in variation in clinical outcomes and patient experience, increased patient safety risks, workforce pressures, failure to meet regulatory and performance standards, reduced public confidence, and associated reputational and financial impacts.

Potential to impact on our Strategic Priorities

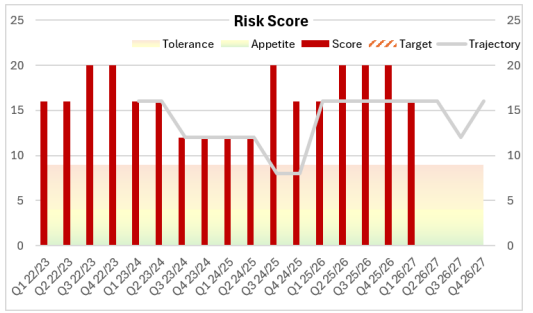
Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

	Q1	Q2	Q3	Q4	Target		Risk Appetite
Likelihood	4	4	3	4	2	31/03/2026 31/03/2028	Minimal 1 – 4
Consequence	4	4	4	4	4		Risk Tolerance
Risk Score	16	16	12	16	8		Mod/High 5 – 9

Linked Risks	Low (1-3)	Mod (4-6)	High (8-12)	Ext (15-25)
	15	75	210	65

The risk is expected to remain high throughout 2026/27, reflecting ongoing quality, performance and workforce challenges. A reduction in risk is anticipated during Q3 as improvements in avoidable harm, clinical outcomes and elective performance become embedded; however, winter pressures are expected to result in a temporary increase in Q4. Achievement of the target score by March 2028 is dependent on eliminating corridor care, achieving elective recovery standards, sustaining reductions in avoidable harm and hospital-acquired infection, and demonstrating triangulated improvement across patient outcomes, patient feedback and staff experience. Without delivery of the planned quality, safety and improvement programmes, the Trust is likely to experience continued variation in outcomes and experience, ongoing avoidable harm, and increasing difficulty in meeting quality, regulatory and performance requirements.



Overview – Summary of Key Q1 Changes

Q1 has seen positive progress in strengthening quality, safety, patient experience and clinical effectiveness. Public representatives have been recruited to the Patient Council, a new Patient Experience Lead has been appointed, and collaborative work across planned and unplanned care continues to support reductions in avoidable harm. Care Excellence Framework maturity has improved, with only one remaining bronze-rated area and 25% of areas now achieving silver status. Clinical effectiveness oversight has been strengthened, an independent review of continuous flow and corridor care arrangements provided positive assurance, and implementation of the national Maternity Early Warning Score in non-maternity areas continues to be considered. Performance improvements have also been demonstrated through reduced diagnostic turnaround times, improved diagnostic access, strengthening cancer performance and reductions in elective waiting times, supported by the Outpatient and Theatre Improvement Programmes.

The operational risk profile continues to highlight workforce shortages, access and waiting time pressures, diagnostic and cancer pathway constraints, urgent and emergency care flow challenges, digital vulnerabilities, and wider service capacity and infrastructure pressures. Controls and assurances remain focused on clinical governance, patient safety, clinical effectiveness, workforce, elective recovery and regulatory oversight, with Q1 assurances providing largely acceptable assurance regarding the effectiveness of governance, quality and safety arrangements. Key gaps relate to the consistent embedding of clinical effectiveness, development of co-production and patient experience arrangements, assessment of harm associated with delays in care, and the triangulation of outcome, safety and experience data to demonstrate sustained improvement. Further assurance is required regarding sustainable elimination of corridor care, the impact of health inequalities on outcomes and experience, and the translation of learning into measurable improvements in patient outcomes. Seven actions have been identified to address these gaps, with delivery expected to strengthen assurance regarding avoidable harm, clinical effectiveness, patient experience, co-production and elective recovery, supporting the planned reduction in risk through demonstrable improvements in outcomes, safety and quality performance.

BAF 1: Inability to Consistently Deliver and Improve Safe, Timely and Effective Care

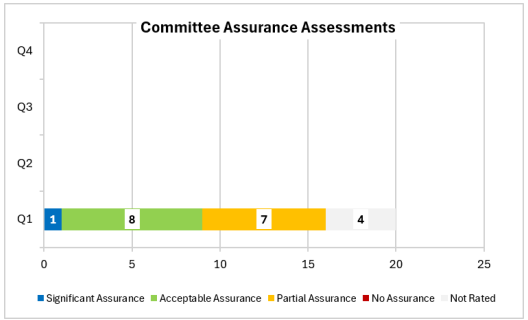
Key Controls Framework

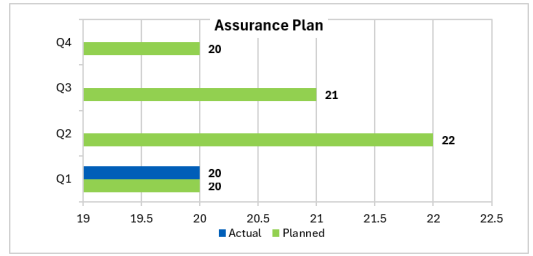
Care Group (n=7)	• Directorate Clinical Governance Framework, including mortality and morbidity review processes, Structured Judgement Reviews, Medical Examiner oversight and organisational learning. • Service Improvement and Quality Management Framework, supporting delivery of improvement programmes aligned to Trust priorities and quality objectives. • Clinical Audit and Quality Assurance Framework, including local audit programmes, action planning and monitoring of improvement actions. • Patient Pathway Management Framework, including patient tracking lists, pathway validation processes and specialty oversight arrangements. • Safe Staffing and Workforce Management Framework, supporting establishment reviews, workforce planning and oversight of staffing levels. • Workforce Compliance and Professional Standards Framework, including recruitment, induction, mandatory training, professional registration and revalidation requirements. • Elective and Operational Performance Improvement Framework, supporting delivery of elective recovery and clinical pathway improvement programmes.
Corporate (n=8)	• Quality Governance and Oversight Framework, including QAOC, Quality & Outcomes Group and Trust-wide escalation arrangements. • Performance and Risk Management Framework, including the Accountability & Performance Framework and Performance & Risk Reviews. • Clinical Quality Improvement Programme Framework, including national and local improvement programmes and associated governance arrangements. • Patient Safety, Mortality and Learning Framework, providing Trust-wide oversight of mortality, learning and improvement actions. • Clinical Audit and Effectiveness Framework, including Trust-wide audit programmes, re-audit cycles and action tracking. • Workforce Assurance and Clinical Leadership Framework, supporting workforce sustainability, safe staffing and clinical leadership arrangements. • Digital and Clinical Decision Support Framework, supporting safer, standardised clinical practice. • Quality, Access and Performance Strategic Planning Framework, including strategic improvement programmes, investment decisions and service transformation priorities.
System (n=4)	• External Regulatory and Quality Oversight Framework, including Care Quality Commission registration and regulatory scrutiny. • System Quality and Performance Assurance Framework, including Integrated Care Board quality, safety and compliance arrangements. • System Improvement and Collaborative Working Framework, supporting benchmarking, shared learning and pathway improvement through provider collaboratives and system boards. • External Clinical Quality Assurance Framework, including participation in national quality assurance and peer review processes.

Assurances Received and Rated – Quarter 1

Report Title	April	May	June
Cancer 104+ Day Breach Analysis			
Care Excellence Framework (CEF) Summary / Staffing Report		☒	Q3 & Q4
Clinical Effectiveness Update			
Infection Prevention Hospital Acquired Infection Report	Q4		
Maternity & Neonatal PSIRF Investigation Report		Q4	
Maternity Dashboard		Q4	
MBRRACE Report and Action Plan			
Mortality Assurance Report			
Patient Experience Report	☒	☒	Q3
Patient Safety Incident Investigation Report		☒	Q4
Perinatal Mortality Report			
Population Health / Waiting Inequalities List Report			
Quality Performance Report	M12	M1 - NR	M2
UHNM Internal Cancer Peer Review Report 2025			

Committee Assurance Assessment & Plan





BAF 1: Inability to Consistently Deliver and Improve Safe, Timely and Effective Care

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

Assurance is assessed as partial reflecting variability in improvement delivery and limited evidence of sustained impact across services.

Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=4)	• Clinical effectiveness arrangements are not yet consistently embedded across all Care Groups, resulting in variation in how learning, audit findings and outcome data are translated into improvements in practice (Action 2). • A formalised framework and reporting mechanism for co-production activity has not yet been fully implemented, limiting the ability to demonstrate patient and public involvement in service improvement (Action 3). • A consistent framework for assessing, reporting and understanding the impact of delays in care on patient safety, outcomes and experience is not yet fully established (Action 5). • Arrangements for systematically capturing, evaluating and responding to patient, family and staff feedback are not sufficiently mature to support quality improvement and assurance (Action 6).
Gaps in Assurance (n=6)	• Limited assurance regarding the sustainability of improvements in clinical outcomes, with insufficient triangulation of quality, operational and outcome metrics to demonstrate sustained impact (Actions 1 & 4) • Limited assurance that findings from audits, reviews, benchmarking and external assessments (including GIRFT and national clinical audits) consistently result in measurable improvements in practice and patient outcomes (Actions 1 & 2). • Insufficient triangulation of learning, improvement activity and outcome measures to demonstrate the impact of interventions and provide a clear 'so what' assessment (Actions 1 & 2) • Limited assurance regarding the scale, quality and impact of co-production activity across the Trust, and how this informs service development and improvement priorities (Action 3). • Limited assurance from patient, family and staff feedback to corroborate performance, safety and outcome metrics and demonstrate improvement from the patient perspective (Action 6). • Limited assurance that improvements in patient flow and capacity are sufficient to eliminate corridor care on a sustainable basis and maintain compliance during periods of operational pressure (Action 7). • Limited assurance regarding the impact of health inequalities on patient experience, access and outcomes, and whether improvement initiatives are reducing variation between different patient groups. (Action 8)

Risk Management Action Plan

No	Action	Due Date	Progress Report	2026/27 Q1	Q2	Q3	Q4
1	Deliver the Trust-wide Avoidable Harm Reduction Programme, with a focus on reducing hospital-acquired infections, pressure ulcers, falls and other key patient safety metrics, supported by regular monitoring and reporting of outcomes.	31/03/2027	Progress update to be provided following confirmation of implementation arrangements.				
2	Embed a standardised Clinical Effectiveness Framework across all Care Groups to ensure audit findings, reviews, learning and outcome data are consistently translated into measurable improvements in clinical practice and patient outcomes.	31/03/2027	Progress update to be provided following confirmation of implementation arrangements.				
3	Develop and implement a Trust-wide Co-production Framework, including mechanisms to systematically capture, monitor and evaluate co-production activity and its impact on service improvement and patient outcomes.	31/03/2027	Progress update to be provided following confirmation of implementation arrangements.				
4	Deliver the Elective Recovery and Improvement Programme to achieve elective access standards, improve diagnostic and cancer performance, and reduce waiting times in line with national requirements.	31/03/2027	Progress update to be provided following confirmation of implementation arrangements.				
5	Develop and implement a consistent Harm Assessment and Reporting Framework to strengthen understanding of the impact of delays on patient safety, clinical outcomes and patient experience, and inform improvement priorities.	~~31/12/2024~~ ~~31/03/2025~~ ~~01/10/2025~~ ~~01/04/2026~~ 31/08/2026	Action carried forward from 2025/26. Digital team has completed the iPortal note and flagging functionality. Business intelligence team is developing the reporting framework, after which the approach will be launched with clinical teams. Launch is anticipated within the next four months, subject to readiness confirmation.				
6	Implement mechanisms to capture, triangulate and respond to patient, family and staff experience data, ensuring feedback informs service improvement, quality priorities and assurance reporting.	31/03/2027	Progress update to be provided following confirmation of implementation arrangements.				
7	Deliver the GIRFT Corridor Care Improvement Action Plan, including the elimination of corridor care and continuous flow areas that do not meet required standards, supported by regular assurance of patient safety and experience.	31/03/2027	Progress update to be provided following confirmation of implementation arrangements.				
8	Develop and implement arrangements to capture and evaluate health inequalities outcome and experience data, ensuring improvement priorities are informed by disparities in access, experience and clinical outcomes.	31/03/2027	Progress update to be provided following confirmation of implementation arrangements.				

BAF 2: Inability to improve population health outcomes and reduce inequalities through effective service and system delivery

Quality, Access & Outcomes Committee | Director of Strategy

Risk Description

Cause:	If we are unable to work effectively with system partners, maintain the organisational capacity and analytical capability required to understand and address population health needs, and embed a population health approach consistently across our services, including reducing variation in access, outcomes and experience,
Event:	then our ability to improve population health outcomes and reduce health inequalities may be significantly limited, and we may be unable to consistently demonstrate and evidence the impact of our contribution to population outcomes,
Effect:	resulting in widening inequalities in access, experience and outcomes, increased demand for hospital-based services, failure to shift from reactive models of care to prevention, and poorer long-term health outcomes for our population.

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	31/03/2028	Minimal 1 – 4
Consequence	4	4	4	4	4		Risk Tolerance
Risk Score	12	12	12	12	8		Mod/High 5 – 9

Linked Risks	Low (1-3)	Mod (4-6)	High (8-12)	Ext (15-25)
	0	0	0	0

The risk is expected to reduce progressively as population health governance, intelligence capability and Care Group ownership continue to mature. However, measurable improvements in population outcomes and health inequalities will take time to materialise and remain dependent on sustained partnership working across the wider health and care system. Achievement of the target score is therefore expected during 2027/28 and is dependent upon demonstrating measurable improvements in population outcomes, reducing inequalities and embedding population health approaches consistently across services. Without sustained delivery of population health and inequality reduction initiatives, the Trust is unlikely to demonstrate measurable improvement in outcomes, resulting in widening inequalities, increasing demand for acute services and missed opportunities for prevention.

Overview – Summary of Key Q1 Changes

Progress continues to be made in embedding a population health approach across UHNM through the development of programmes focused on healthcare inequalities, prevention, Making Every Contact Count (MECC) and the Trust's Anchor Institution role. Governance has been strengthened through the establishment of the Executive-led Population Health Steering Group, supporting greater leadership, accountability and integration of population health priorities across Care Groups and corporate teams. Partnership working has continued to develop through the Health Inequalities Community of Practice and wider collaboration with ICS, Local Authority and VCSE partners. During Q1, UHNM successfully implemented its Smoke Free Strategy, increasing uptake of smoking cessation support amongst staff and patients, and was invited to lead a system-wide review of alcohol care pathways. Care Group population health plans have also been introduced, supporting the delivery of Core20PLUS5 priorities and targeted action to reduce inequalities and improve population outcomes.

Executive assurance remains Acceptable. Population health governance, intelligence and partnership arrangements continue to mature through delivery of the Population Health Strategy, Outcomes Framework, Care Group plans and system-wide collaboration. Whilst progress continues in embedding population health approaches, evidence of measurable impact on outcomes, inequalities and prevention remains at an early stage. Key gaps in control and assurance relate to variable embedding of population health approaches across Care Groups, reliance on system-wide delivery, limited capacity to scale prevention initiatives, and the developing maturity of the population health assurance framework. Assurance is also constrained by data quality, co-production and the ability to demonstrate and attribute measurable improvements in outcomes and inequalities. Three actions have been carried forward and four new actions identified for 2026/27. Delivery of these actions is expected to strengthen assurance regarding population health governance, outcome measurement, prevention and health inequalities, supporting risk reduction through improved evidence of impact, strengthened Care Group ownership and sustained system-wide delivery of population health initiatives.

BAF 2: Inability to improve population health outcomes and reduce inequalities through effective service and system delivery

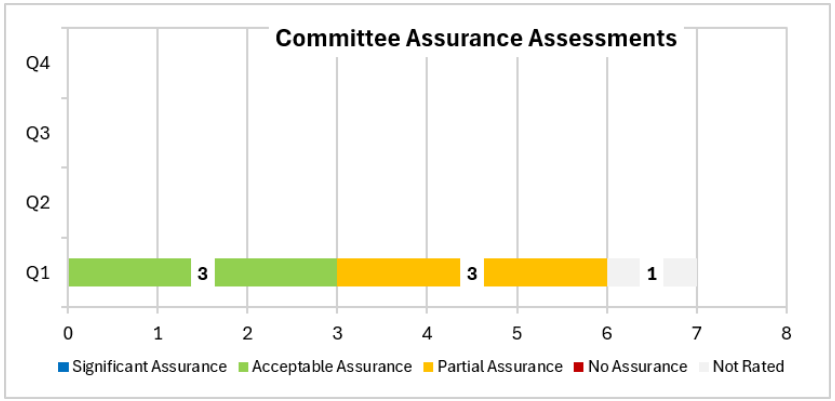
Key Controls Framework

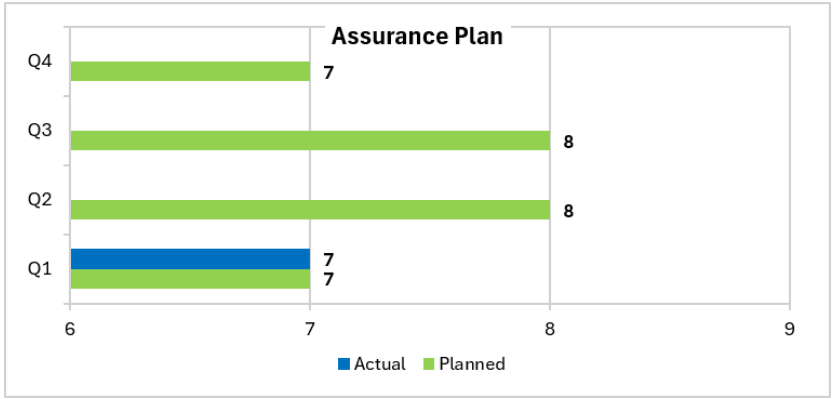
Care Group (n=6)	• A Population Health Outcomes Framework is in place, incorporating measures relating to health inequalities, prevention and population outcomes to inform service planning and monitor improvement across Care Groups. • Prevention and Making Every Contact Count (MECC) governance arrangements are in place to oversee delivery of prevention initiatives and embedding within clinical practice. • Structured engagement and co-production arrangements are in place, including partnership working with patients, communities and VCSE organisations, to inform service design and improve access for underserved groups. • Care Group programmes support sustainability, workforce wellbeing, community engagement and action to reduce health inequalities. • A population health approach is embedded within Care Group planning and delivery arrangements, supported by service-level plans addressing prevention and health inequalities. • Evidence-based population health tools and methodologies are used to identify inequalities, target interventions and support preventative approaches to care.
Corporate (n=8)	• A Population Health Strategic Plan is in place and delivered through programmes aligned to Trust and system priorities. • Population Health governance arrangements provide oversight, coordination and accountability for delivery across corporate teams and Care Groups. • Dedicated population health leadership, public health expertise and programme capacity are in place to support delivery of health inequalities and prevention priorities. • Health inequalities, prevention and MECC programmes are in place to develop, coordinate and scale targeted interventions across the Trust. • A Population Health Outcomes Framework is in place to monitor progress against population outcomes, prevention priorities and health inequalities. • Population health intelligence capability is in place to support identification of health inequalities, population segmentation and targeting of interventions. • Governance and improvement arrangements are in place to support the implementation, scaling and sustainability of prevention and health inequalities programmes. • Anchor Institution governance arrangements are in place to support and evaluate the Trust's contribution to employment, social value, sustainability and community wellbeing outcomes.
System (n=6)	• Active participation in system-wide population health partnerships supports coordinated delivery of prevention and health inequalities programmes across the ICS. • Population health intelligence capability is supported through collaborative working with ICB, Local Authority, OHID and other partners, enabling access to shared datasets, analytics and population health management tools. • Partnership arrangements are in place with Local Authorities, the ICB and public health organisations to support delivery of shared priorities and population outcomes. • System governance arrangements are in place to oversee delivery of population health strategies and action to reduce health inequalities. • Links with national, regional and local health protection networks support coordinated responses to wider public health challenges. • National population health and health inequalities priorities, including Core20PLUS5, are embedded within system-wide planning and delivery arrangements.

Assurances Received and Rated –Quarter 1

Report Title	April	May	June
Clinical Effectiveness Update			
Mortality Assurance Report			
Patient Experience Report	☒	☒	Q3
Population Health / Waiting Inequalities List Report			
Quality Performance Report	M12	M1 - NR	M2

Committee Assurance Assessment & Plan





BAF 2: Inability to improve population health outcomes and reduce inequalities through effective service and system 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

Assurance is assessed as acceptable reflecting strong strategic frameworks and partnership arrangements, but with recognised gaps in consistent embedding, impact measurement and long-term sustainability.

Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=4)	• Delivery of population health outcomes is not fully within the Trust's control, due to dependency on system partners and wider determinants of health, resulting in reduced ability to directly influence outcomes (Action 2) • A population health approach is not yet consistently embedded across Care Groups, including variability in the integration of prevention and health inequalities into clinical pathways, resulting in inconsistent delivery of population health interventions (Actions 3 & 7) • Population health interventions by ICS partners are not consistently aligned to a single strategic needs assessment, resulting in suboptimal prioritisation and targeting of resources (Actions 3 & 7) • Capacity and capability to scale and sustain population health and prevention programmes is not yet fully developed, resulting in reliance on specific teams or short-term initiatives (Action 6)
Gaps in Assurance (n=6)	• Limited assurance regarding the population health assurance framework, including lack of clarity on how success is measured and reported through governance structures (Action 1) • Limited assurance regarding the impact of population health interventions on outcomes, including difficulty attributing improvements to specific actions due to multi-partner delivery (Actions 1 & 2) • Limited assurance regarding the generation and translation of population health intelligence into service redesign and measurable improvements across Care Groups (Actions 3 & 5) • Assurance is still developing regarding consistent co-production with underserved communities and demonstrable impact on service design (Actions 4 & 5) • Incomplete and inconsistent data on protected characteristics and digital exclusion constrains full assurance that services meet the needs of all population groups (action 5) • Limited assurance regarding the scalability and sustainability of population health interventions, including dependence on short-term funding or pilot programmes (action 4 & 6)

Risk Management Action Plan

No	Action	Due Date	Progress Report	2026/27 Q1	Q2	Q3	Q4
1	Implement a Population Health Outcomes Framework to consistently measure, evidence and report the impact of population health interventions on outcomes, prevention and health inequalities.	31/03/2027	The Population Health Outcomes Framework continues to be developed and is regularly reported to Quality Committee. Initial application within infant mortality and cancer screening pathways is helping to refine outcome measures, monitoring arrangements and approaches to evidencing the impact of population health interventions on health inequalities and outcomes.				
2	Strengthen UHNM leadership and influence across ICS, regional and national population health programmes to improve alignment of system priorities, resources and interventions to local population needs and outcomes.	31/03/2027	Links with regional and national partners, including OHID and NHS England, continue to strengthen through dedicated public health leadership. Ongoing NHS England and ICB organisational changes provide opportunities to influence future population health priorities, partnership arrangements and delivery models, with greater clarity expected during Q3.				
3	Develop, implement and evaluate Care Group population health plans, using population health intelligence to inform service redesign, prevention activity and action to reduce health inequalities within priority pathways.	30/09/2026	Action carried forward from 2025/26. Care Groups continue to use pathway specific population health intelligence, including deprivation, ethnicity and geography, to inform service planning and prioritisation across priority pathways such as maternity, elective and cancer care. While progress has been made, implementation remains phased and variable, reflecting differences in pathway maturity, data quality and supporting infrastructure. Further work is required to embed a consistent population health approach across all Care Groups and to evidence measurable impact at scale.				
4	Implement a structured co-production framework with underserved communities to ensure service design, prevention initiatives and health inequalities programmes are informed by lived experience and community insight.	31/03/2027	Action carried forward from 2025/26. The co-production approach is being piloted through the outpatient transformation programme, supported by engagement with patient representatives, staff networks and VCSE partners. Established community partnerships continue to support engagement with underserved groups; however, further work is required to embed and scale the approach consistently across the Trust.				
5	Implement a population health data quality and intelligence improvement programme to strengthen the completeness and use of protected characteristic, digital exclusion and population health management data.	2026/27	Action carried forward from 2025/26. A Population Health+D14 Data Quality Improvement Plan is being developed, with priority areas identified. Engagement is underway with Digital, Graphnet and Business Intelligence teams to strengthen the quality, completeness and reporting of population health, health inequalities and digital exclusion data.				
6	Implement a structured framework for scaling and sustaining population health and prevention programmes, including prioritisation, resource alignment and governance oversight to support long-term impact.	31/03/2027	A structured approach to scaling and sustaining population health programmes is in development through collaboration between the Corporate Population Health Team and Care Groups. Population health intelligence capability is established, with ongoing work to strengthen reporting and evaluation arrangements to support delivery at scale.				
7	Develop and implement a Trust-wide Strategic Needs Assessment to inform prioritisation, service redesign and targeting of population health interventions, ensuring resources are aligned to population need.	31/12/2026	Initial scoping work has been completed, drawing on the ICS Strategic Needs Assessment and associated strategies to identify priority population health, prevention and inequalities opportunities. Draft Care Group population health plans have informed the emerging scope and priorities for the Trust-wide Strategic Needs Assessment.				

BAF 3: Inability to Deliver a Sustainable Workforce and Improve Organisational Culture

People, Culture and Inclusion Committee | Chief People Officer

Risk Description

Cause:	If we are unable to achieve workforce sustainability through the delivery of a credible and resourced long-term workforce plan—one that is underpinned by a positive, inclusive organisational culture and supported by sufficient organisational capacity, capability and system alignment—in the context of increasing financial pressures and affordability constraints,
Event:	Then we may encounter significant challenges in balancing the interdependent demands of workforce capacity, cost containment and the delivery of high-quality services. This includes challenges in attracting, developing and retaining a workforce of the right size and skill mix; deploying staff effectively; and delivering workforce transformation programmes, while simultaneously responding to financial recovery requirements and operational pressures,
Effect:	Resulting in negative impacts on colleague experience, engagement and wellbeing, and reduced ability to recruit, develop and retain staff. This may compromise the quality and safety of care for patients, limit delivery of operational and transformation objectives, and increase reliance on temporary staffing, unfunded capacity or cost-driven reductions, leading to adverse financial consequences and reduced organisational sustainability.

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	31/03/2028	Cautious 1 – 9
Consequence	5	5	5	5	5		Risk Tolerance
Risk Score	15	15	15	15	10		High 10 - 12

The risk is expected to remain high throughout 2026/27, reflecting the interdependency between workforce sustainability, financial performance and service delivery. Although workforce governance, planning and transformation arrangements continue to mature, benefits from longer-term workforce, organisational and digital transformation programmes are expected to be realised progressively. Ongoing workforce supply, affordability and capacity challenges mean the target score of 10 is not expected to be achieved until March 2028. Without delivery of workforce transformation, culture and sustainability programmes, workforce shortages, affordability pressures and organisational capacity constraints are likely to persist, impacting staff experience, service delivery and long-term organisational resilience.

Linked Risks	Low (1-3)	Mod (4-6)	High (8-12)	Ext (15-25)
	5	22	97	32

Overview – Summary of Key Q1

At Q1, the risk score remains unchanged at 15 (Extreme). Progress has been made in strengthening workforce governance, compliance and workforce development arrangements, including enhanced oversight of medical workforce expenditure, improvements to recruitment processes, implementation of workforce accountability frameworks, strengthened safeguarding and employment compliance arrangements, and continued investment in workforce supply and leadership development. However, workforce capacity and capability continue to be constrained by competing operational and transformation demands, with particular pressures within the People Directorate. Increasing demand and complexity associated with employee relations casework and Data Subject Access Requests, together with organisational redesign activity, financial pressures and forthcoming Employment Rights Act reforms, are expected to place further demands on workforce and leadership capacity. Whilst progress continues across workforce sustainability, culture, inclusion and wellbeing priorities, there is not yet sufficient evidence of sustained impact to support a reduction in the risk score.

The operational risk profile reinforces this position, highlighting workforce shortages, specialist staffing gaps, recruitment and retention pressures, increasing service demand and limited organisational capacity across clinical and corporate functions. These challenges continue to place pressure on staff wellbeing, leadership capacity, service resilience and organisational culture. Executive assurance remains Partial. The workforce control environment is supported by established workforce planning, governance, recruitment, retention and transformation arrangements, supported by structured oversight and reporting. However, assurance remains constrained by workforce supply, affordability, productivity and succession planning challenges, alongside the scale of transformation required to deliver long-term sustainability. Key gaps in control and assurance relate to Care Group capacity, workforce governance, organisational change, workforce capacity within People services, and the need to strengthen workforce engagement, experience and culture intelligence. Five actions have been carried forward from 2025/26 and five new actions identified. Delivery of these actions is expected to strengthen assurance regarding workforce sustainability, organisational culture, leadership capacity, workforce planning and colleague experience, supporting future risk reduction through improved workforce outcomes, organisational resilience and delivery of long-term workforce transformation objectives.

BAF 3: Inability to Deliver a Sustainable Workforce and Improve Organisational Culture

Key Controls Framework

Care Group (n=7)	• Care Group workforce plans are in place and aligned to Trust workforce, operational and financial plans, supporting sustainable workforce supply, service delivery requirements and affordability objectives. • Standardised workforce governance arrangements operate across Care Groups and Divisions, providing oversight of workforce performance, workforce risks, workforce transformation, establishment management and delivery of workforce plans. • Clinical workforce deployment, job planning, roster management and establishment management processes are in place to support safe staffing, effective workforce utilisation and operational resilience. • Recruitment, retention and workforce development programmes are in place within Care Groups to address workforce supply challenges, improve colleague experience and support delivery of the NHS People Promise. • Organisational culture, staff engagement and workforce development programmes are implemented within Care Groups to support colleague wellbeing, inclusion, retention, learning and continuous improvement. • Organisational change, workforce redesign and TUPE arrangements are managed through established governance processes to support workforce sustainability and service transformation. • Operational workforce resilience arrangements are in place, including redeployment, escalation and contingency arrangements to maintain service delivery during periods of heightened operational pressure.
Corporate (n=14)	• A People Strategy and long-term workforce planning framework are in place and aligned to the Trust Strategy, strategic programmes and annual planning cycle, providing a structured approach to workforce sustainability and workforce transformation. • An integrated workforce, operational and financial planning framework is in place to align workforce establishment, recruitment, transformation, productivity and affordability requirements. • Recruitment, retention and workforce supply programmes are in place, including apprenticeships, education pathways, international recruitment, career development opportunities and targeted retention initiatives. • An Accountability and Performance Framework is in place, defining organisational accountability, performance management, escalation and governance arrangements to support delivery of strategic and operational objectives. • Executive-led workforce governance arrangements are in place to provide oversight of workforce risks, workforce performance, affordability, workforce transformation and delivery of workforce priorities. • Comprehensive workforce information, performance reporting and analytical capability are in place to support evidence-based workforce planning, performance management and decision-making. • A Corporate Capacity framework is in place to ensure sufficient organisational capacity, programme management capability and leadership resource are available to deliver strategic priorities, workforce transformation and continuous improvement. • Workforce requirements arising from service transformation, productivity improvement and organisational change programmes are identified, prioritised and managed through established programme governance arrangements. • Leadership development, talent management and succession planning arrangements are in place to strengthen organisational capability, leadership continuity and future workforce resilience. • An Equality, Diversity and Inclusion Accountability Framework is in place, establishing leadership expectations, governance arrangements and accountability mechanisms to promote an inclusive culture, improve workforce experience and reduce inequalities. • A Freedom to Speak Up Accountability Framework is in place to promote psychological safety, openness, learning and staff confidence to raise concerns, supporting a positive organisational culture and continuous improvement. • Organisational culture, staff engagement, wellbeing and colleague support frameworks are in place to improve colleague experience, retention, attendance and workforce sustainability. • Education, training and professional development frameworks are in place to support workforce capability, professional standards, regulatory compliance and future workforce supply. • Temporary staffing governance, vacancy controls and establishment management arrangements are in place to support financial sustainability whilst maintaining safe and effective services.
System (n=5)	• Workforce planning arrangements are aligned with Integrated Care System, NHS England and education provider workforce strategies and priorities, supporting long-term workforce sustainability. • Partnership arrangements with system organisations, universities and education providers support workforce pipeline development, professional education and future workforce capacity. • National and regional workforce oversight arrangements are in place through NHS England, NHS Employers and other workforce governance forums, providing support, challenge and external benchmarking. • System and national workforce affordability controls are in place, including agency reduction requirements and oversight of temporary staffing expenditure. • Strategic partnership and lead-employer arrangements operate within agreed governance frameworks to support delivery of shared workforce services and workforce sustainability.

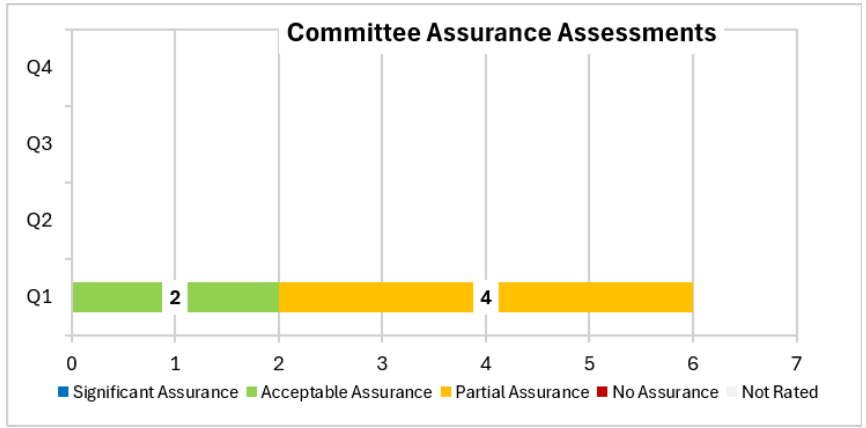
Assurances Received and Rated – Quarter 1

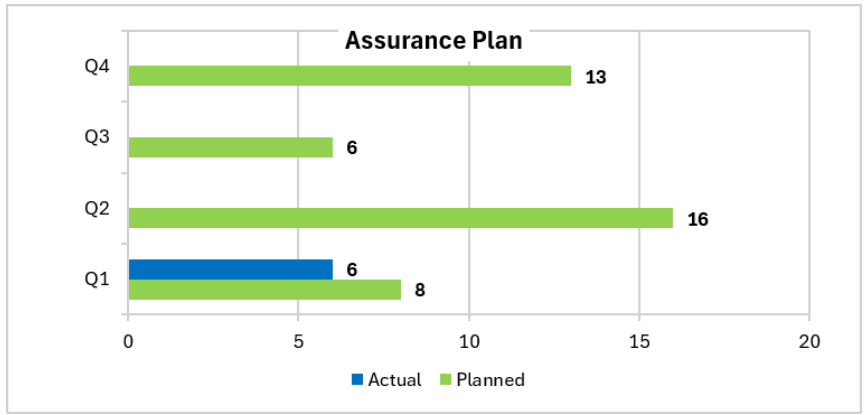
Report Title	May
Chief People Officer Report	P1
Nursing & Midwifery Staffing Report	
Sexual Safety Update	
Speaking Up Report	Q3/Q4
Staff Network Annual Report	
Workforce Plan Update 2026/27	

Assurance Rating Key

Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance

Committee Assurance Assessment & Plan





BAF 3: Inability to Deliver a Sustainable Workforce and Improve Organisational Culture

Executive Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
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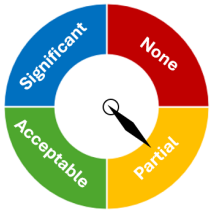


We have established governance arrangements, workforce planning processes and workforce initiatives to support workforce sustainability and organisational culture. Assurance remains partial due to capacity and capability challenges, financial pressures, and limited evidence of consistent delivery and impact across all areas. Actions are underway to strengthen governance, delivery oversight and workforce outcome measurement, with progress against these actions critical to achieving the planned reduction in risk.

Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=3)	• Care Group capacity and capability to effectively lead, prioritise and deliver People Plans is not consistently in place, resulting in variable delivery and oversight of workforce initiatives (Action 1) • Workforce governance arrangements are not yet fully embedded following transition to Care Group structures, resulting in inconsistencies in oversight and assurance (Action 2) • Limited organisational control over short notice additional medical shifts and payments above rate card, as approval processes are primarily clinically driven, reducing the ability to consistently apply financial and governance controls. (Action 3)
Gaps in Assurance (n=7)	• Limited assurance regarding the impact of financial pressures (Trust and system), including CIP delivery, on workforce sustainability, capacity and staff experience (Action 4) • Limited assurance regarding compliance with NHSE medical job planning requirements and the consistency and effectiveness of job planning processes across Care Groups. The Job Planning Policy review is very overdue. This is on the Trust's risk register and is regularly challenged through LNC. (Action 5) • Limited assurance regarding the organisation's ability to respond to workforce-related DSAR and FOI requests within statutory timescales due to increasing volume, complexity and resource constraints. (Action 6) • Limited assurance regarding staff experience and engagement, including reliance on NSS data with lower response rates potentially affecting representativeness and insight. (Action 7) • Require more consistent implementation of workforce (HR) policies, governance arrangements and initiatives across Care Groups and Divisions. (Action 8). • Sickness Absence rates continue to be higher than target (although not dissimilar to comparator provider Trusts). NB: Medium Term Workforce Plan in respect of reducing sickness to 4.1% over next 10 years. (Action 9) • The implementation of the Employment Rights Act 2025 and associated employment law reforms increases the risk that the Trust may not be fully prepared to implement new statutory employment rights, resulting in legal challenge, increased employment costs, operational disruption, inconsistent employment practice and reputational damage. (Action 10)

Risk Management Action Plan

No	Action	Due Date	Progress Report	2026/27 Q1	Q2	Q3	Q4
1	Implement targeted interventions to strengthen Care Group capacity and capability to deliver People Plans, supported by prioritisation, corporate support and resource allocation arrangements.	~~31/03/2026~~ ~~30/06/2026~~ 31/03/2027	Action carried forward from 2025/26. Leader capacity remains challenged by competing demands. Targeted OD support has continued throughout Q1. Development of an operational management competency framework, enhanced career pathways and the next Medical Leadership Development Programme will progress during Q2.				
2	Re-establish and embed Strategic Workforce Groups across Care Groups, with standardised terms of reference, governance arrangements and reporting.	~~31/12/2025~~ ~~31/03/2026~~ ~~30/06/2026~~ 30/09/2026	Action carried forward from 2025/26. Clinical & Scientific Services has agreed its Strategic Workforce Group arrangements, with implementation planned for Q2. Equivalent workforce assurance forums continue to operate within NMCPS and the EFP Division. Planned Care and Unplanned Care Groups have yet to re-establish their arrangements, whilst options for a comparable workforce assurance framework within Corporate Functions are being developed.				
3	Strengthen governance and approval arrangements for additional medical shifts and payments above rate card to improve financial oversight, compliance and affordability.	31/03/2027	Enhanced governance arrangements have been implemented through weekly medical pay panels to strengthen oversight of additional shifts and payments. A review of retrospective claims is underway, and a standard operating procedure for out-of-hours escalation and approval processes has been developed to improve consistency of financial and governance controls.				
4	Implement an approach to assess and mitigate the workforce impact of financial pressures, including CIP delivery, and monitor outcomes through established governance arrangements.	~~31/03/2026~~ ~~30/06/2026~~ 31/03/2027	Action carried forward from 2025/26. Governance arrangements have been established to monitor workforce and financial impacts, with Workforce Plan delivery reported through the People, Culture and Inclusion Committee and CIP delivery overseen through the Financial Improvement Oversight Group and reported to the Finance and Business Performance Committee.				
5	Review and strengthen consultant job planning arrangements to improve compliance with NHSE requirements and support consistent implementation across Care Groups.	~~31/12/2025~~ ~~31/03/2026~~ ~~30/06/2026~~ 31/03/2027	Action carried forward from 2025/26. External consultancy support did not provide a proposed way forward for the policy review. The matter has been escalated to the Chief Operating Officer and Chief Medical Officer, with the Deputy Chief Medical Officer now leading a review of the overdue Job Planning Policy to determine the appropriate approach and next steps. Consideration is now being progressed through the Medical Leadership Team.				
6	Implement a sustainable operating model for workforce-related Data Subject Access Requests to improve compliance with statutory timescales and service standards.	~~31/12/2025~~ ~~31/03/2026~~ ~~30/06/2026~~ 31/03/2027	Action carried forward from 2025/26. DSAR demand and complexity have continued to increase during Q1, resulting in ongoing delays and compliance challenges. Recognising this as a broader organisational issue affecting both workforce and patient requests, a collaborative review has been undertaken across People Services, Digital Services, Data Security & Protection and Legal Services, with a service development proposal submitted for EMT consideration in July 2026.				
7	Implement targeted interventions in response to NHS Staff Survey feedback to improve colleague engagement, experience and organisational culture.	31/03/2027	NHS Staff Survey results have been shared with Care Groups and Divisions, with local action plans being developed in response. Trust-level People Pulse reporting has been established, with Care Group and Divisional reporting being introduced from Q2 to support targeted interventions and monitoring. Work has commenced on NHS Staff Survey 2026 engagement activity, including 'You Said, We Did' communications, alongside plans to reinforce the Trust's refreshed values during Q2.				
8	Strengthen workforce policy and governance arrangements to support consistent implementation across Care Groups and Divisions.	31/03/2027	Work has progressed to standardise workforce policy documentation and strengthen governance arrangements across key employee relations processes. A full review of the MHPS and Disciplinary Policies will commence in Q2, alongside continued refinement of decision-making processes relating to sexual safety and police operations. Development of digital solutions to support consistent and efficient employee relations management is also underway.				
9	Implement a Sickness Absence Improvement Programme to reduce sickness absence and strengthen absence management processes, systems and governance.	31/03/2027	Monthly sickness absence assurance arrangements remained in place throughout Q1, supported by external review findings and benchmarking activity. Work is underway to develop a Trust-wide Sickness Absence Improvement Programme, with mobilisation planned for Q2 through a dedicated Programme Board and associated workstreams focused on reducing absence and improving underlying processes, systems and management arrangements.				
10	Prepare the organisation for implementation of the Employment Rights Act 2025, including policy, process, workforce and governance changes required to achieve compliance.	31/03/2027	Preparatory work for implementation of the Employment Rights Act 2025 will commence in Q2, including a compliance gap analysis, establishment of a task and finish group, review of workforce policies and documentation, and development of an organisational implementation programme. Governance arrangements will include regular oversight of implementation progress, employment relations activity, employment claims and compliance risks.				

BAF 4: Inability to Deliver Digitally Enabled Care

Finance and Business Performance Committee | Chief Digital Information Officer

Risk Description

Cause:	If we are unable to deliver digitally enabled care due to limitations in digital infrastructure, fragmented system ownership and governance, insufficient digital workforce and programme delivery capacity, system interoperability challenges, and ongoing financial constraints impacting prioritisation and investment in digital solutions,
Event:	then we will be unable to develop and deploy coherent, secure and scalable digital systems and capabilities,
Effect:	resulting in constrained service modernisation, reduced productivity, increased operational and cyber risk, inequitable access to services, reduced staff efficiency, and potential non-compliance with regulatory and digital standards.

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	2	31/03/2028	Minimal 1 – 4
Consequence	4	4	4	4	4		Risk Tolerance
Risk Score	16	16	16	12	8		Mod 5 – High 9

Linked Risks	Low (1-3)	Mod (4-6)	High (8-12)	Ext (15-25)
	7	39	53	13

The risk is expected to remain at an extreme level throughout most of 2026/27 whilst key digital programmes are delivered and compliance gaps addressed. Risk reduction is anticipated from Q4 2026/27 as improvements in governance, assurance, cyber security and system compliance become embedded, with further reductions during 2027/28 through digital estate rationalisation and strengthened controls. Achievement of the target score by March 2028 is dependent on delivery of key digital transformation programmes, improved compliance across the digital estate, strengthened supplier assurance, and realisation of benefits from strategic digital investments. Without delivery of the planned digital transformation and assurance activities, the Trust is likely to experience increasing digital risk, reduced operational efficiency, continued reliance on ageing systems and diminished ability to realise the benefits of digitally enabled care.

Overview – Summary of Key Q1 Changes

The risk score expected to remain at 16 during 2026/27 before reducing to 12 from Q4 2026/27 and to the target score of 8 by March 2028. During Q1, several actions strengthened the digital control environment, including approval of the device lifecycle business case, implementation of the Digital Accountability Framework, introduction of Digital Technology Assessment Criteria (DTAC) processes, development of system lifecycle arrangements, enhanced portfolio oversight, strengthened clinical safety governance and completion of a cyber assurance internal audit. These improvements have strengthened governance, oversight and accountability, although they have not yet reduced the residual risk score. Delivery remains dependent on continued management of key dependencies relating to capital funding, supplier delivery, Care Group engagement and national or regional funding decisions.

The operational risk profile continues to highlight cyber security vulnerabilities, ageing and unsupported infrastructure, system reliability issues, information governance risks and increasing dependency on complex digital systems. These risks are compounded by technical debt, digital capacity constraints and variable compliance with digital standards, reducing assurance that digital transformation can be delivered at pace whilst maintaining system resilience, data security and patient safety. Executive assurance remains Partial. Established governance, cyber security, information governance, clinical safety and programme management arrangements provide assurance that key risks are being actively managed. However, assurance remains constrained by the scale of digital transformation required, digital estate complexity, variable compliance and interoperability, and the need to demonstrate delivery of benefits and outcomes from digital investment. Key gaps in control and assurance relate to digital governance and compliance maturity, supplier assurance, interoperability and data sharing, digital estate lifecycle management, and benefits realisation. Six actions have been identified for 2026/27, incorporating two actions carried forward from 2025/26. Delivery of these actions is expected to strengthen assurance regarding digital governance, cyber security, system compliance, digital transformation and benefits realisation, supporting the planned reduction in risk through increased digital maturity, improved system resilience and delivery of strategic digital programmes.

BAF 4: Inability to Deliver Digitally Enabled Care

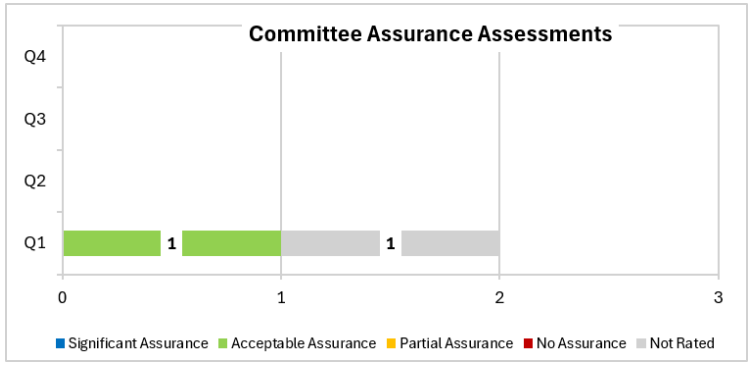
Key Controls Framework

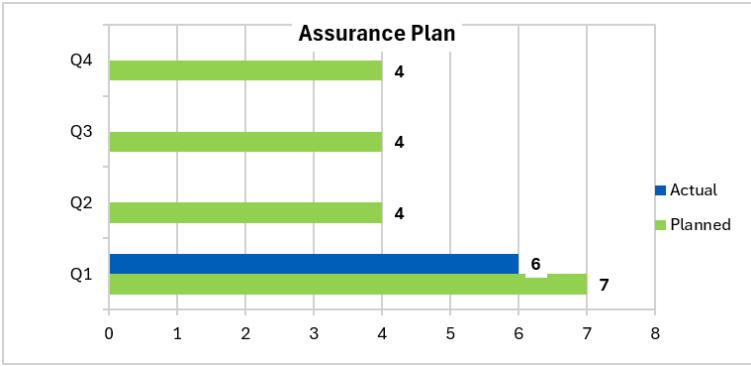
Care Group (n=12)	• Care Group digital governance arrangements provide oversight of digital risks, compliance, prioritisation and delivery of improvement actions. • Digital Business Partners embedded within Care Groups provide support, challenge and assurance on digital compliance, risk management and delivery. • Named Senior Responsible Owners (SROs) and Information Asset Owners are accountable for digital system compliance, risk management and improvement plans. • Information Asset Registers and Shadow IT Registers are maintained and regularly reviewed to identify and address compliance gaps. • Care Group action plans are in place to address Shadow IT, digital compliance and assurance requirements, with progress monitored through governance forums. • Clinical engagement is supported through Digital Nurses, Midwives, Pharmacists and Divisional CMIO arrangements. • Clinical Safety Officers are in place to identify, assess and mitigate digital clinical safety risks. • Digital service continuity arrangements are in place and tested to support resilience and recovery. • Routine review of information governance, clinical safety and DPIA compliance is undertaken through established governance processes. • Training and adoption programmes support the safe implementation and effective use of digital technologies. • Care Groups contribute to digital investment and capital planning processes to support infrastructure sustainability and service transformation. • Care Group digital assurance processes are in place to monitor system compliance with information governance, clinical safety and digital standards.
Corporate (n=19)	• Digital Strategic Plan and supporting governance framework provide strategic direction, prioritisation and oversight of digital transformation programmes. • Digital risk management framework in place, supported by regular review of digital risks, compliance and mitigations through established governance arrangements. • Data Security and Protection Toolkit (DSPT) / Cyber Assessment Framework (CAF) compliance arrangements are in place to provide assurance against national cyber and information governance standards. • Supplier assurance and due diligence arrangements are in place to assess and monitor digital, cyber security and information governance risks associated with third-party systems and services. • Executive Digital Data & Governance Group provides oversight of digital risk, standards compliance, cyber security, clinical safety and delivery. • Digital Accountability Framework defines ownership, accountability and assurance requirements for digital systems and services. • Digital policies, standards and assurance processes are in place to support compliance, security and governance requirements. • Formal business change, programme management and project governance arrangements support delivery of digital programmes and benefits realisation. • Clinical engagement is supported through the CMIO, CNIO and CAIO leadership model. • Digital and Data Security Protection Group provides oversight of information governance, cyber security and digital risk management. • Clinical safety governance arrangements, including safety assessments and safety case reviews, support the safe implementation of digital systems. • Cyber security monitoring, testing and assurance arrangements are in place to identify and mitigate cyber risks. • Regular reporting of digital risk, compliance and delivery performance is provided to Finance & Business Performance Committee and Audit Committee. • System lifecycle management arrangements support prioritisation, rationalisation and replacement of digital systems. • Digital maturity assessments, benchmarking and benefits realisation processes support continuous improvement and investment prioritisation. • Artificial Intelligence governance arrangements provide oversight of the safe, ethical and compliant deployment of AI solutions. • Change assurance processes ensure digital systems and upgrades are subject to appropriate review, risk assessment and approval prior to implementation. • Independent review, audit and assurance activity provides additional scrutiny of digital controls and compliance. • Regional Cyber Security Operations Centre provides continuous monitoring and security incident detection capability.
System (n=5)	• Participation in ICS-wide digital programmes supports interoperability, shared records and system-wide digital transformation. • System-wide cyber security services provide collaborative monitoring, threat detection and resilience arrangements. • Engagement in regional and national digital innovation networks supports adoption of best practice and emerging technologies. • Data Security and Protection Toolkit (DSPT) compliance arrangements support information governance and regulatory assurance. • Strategic system partnerships and regional investment programmes support delivery of major digital infrastructure and EPR developments.

Assurances Received and Rated – Q1

Report Title	April	May	June
Cyber Assessment Framework (CAF)-aligned Data Security & Protection Toolkit			
Cyber Security Assurance Report			
Digital Services - IT Standards Update			

Committee Assurance Assessment & Plan





BAF 4: Inability to Deliver Digitally Enabled Care

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

Assurance is rated as partial as, whilst a comprehensive control framework is in place, there are gaps in the consistent application and effectiveness of controls across the digital estate. In particular, incomplete compliance with governance and safety standards, variation across Care Groups, and limited consolidated visibility of risk continue to constrain assurance.

Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=4)	• Digital systems are not consistently subject to defined governance and compliance standards, including information asset ownership, DPIAs and clinical safety assurance, resulting in increased risk of non-compliance and unmanaged risk (Actions 1, 2 & 3) • Formalised due diligence and ongoing assurance processes for third-party suppliers are not consistently in place, resulting in increased risk relating to security, compliance and performance of external systems (Actions 3 & 6) • Digital systems are not consistently integrated or interoperable, resulting in limitations in delivering joined-up workflows and effective data sharing across services (Actions 4 & 5) • A comprehensive and prioritised programme for system review, rationalisation and lifecycle management is not yet fully in place, resulting in inefficiencies and increased complexity across the digital estate (Actions 4 & 5)
Gaps in Assurance (n=3)	• Limited assurance regarding the realisation of benefits from digital investment, including impact on service transformation, productivity and patient outcomes (Action 2) • Limited assurance regarding compliance with digital governance, clinical safety and data protection standards across all systems, including incomplete or inconsistent application of controls (Actions 1 & 3) • Limited assurance regarding delivery of digital programmes and improvement trajectories, including system compliance, rationalisation and interoperability (Actions 2, 4 & 5)

Risk Management Action Plan

No	Action	Due Date	Progress Report	2026/27 Q1	Q2	Q3	Q4
1	Implement a Trust-wide clinical safety compliance programme, establishing a baseline position, defined compliance trajectory and governance reporting, to ensure all applicable digital systems have an approved and current Clinical Safety Assurance Report.	31/03/2027	Clinical safety arrangements are established for new systems and upgrades, supported by trained Clinical Safety Officers and structured risk assessment workshops. A baseline assessment of existing systems is underway, with a compliance trajectory being developed and exceptions escalated through digital governance arrangements.				
2	Implement a single prioritised digital portfolio framework that links all approved digital programmes and projects to strategic priorities, BAF risk reduction, dependencies, resource requirements, benefits realisation measures and assurance milestones.	31/09/2026	A consolidated digital portfolio framework is being developed through Digital Governance and Project Accelerator, with programmes mapped to strategic objectives and BAF 4 risk reduction priorities. Work is ongoing to finalise dependencies, resource requirements, benefits realisation measures and assurance milestones.				
3	Implement a structured digital compliance improvement programme to achieve documented ownership, assurance and governance requirements for all priority systems and new deployments, including SROs, IAOs, DPIAs, DTAC assessments, clinical safety assurance, supplier assurance and go-live readiness reviews.	31/03/2027	The Digital Accountability Framework, Information Asset Register, DPIA process, DTAC assessments and Care Group governance arrangements are strengthening compliance and accountability. Assurance remains partial pending consistent evidence of compliance across all priority digital systems.				
4	Deliver the agreed infrastructure and system lifecycle improvement programme, including platform upgrades, cloud migration, hardware refresh and end-of-life system remediation, to improve resilience, security and system sustainability.	31/03/2027	Delivery of the infrastructure and system lifecycle programme is progressing, including platform upgrades, hardware refresh, cloud migration and end-of-life remediation activities. Delivery remains dependent on capital availability, internal capacity and supplier timelines.				
5	Confirm and implement the strategic roadmap for PAS optimisation, cloud stabilisation and future EPR transition, including governance arrangements, delivery model and alignment of interim optimisation activity with long-term digital objectives.	31/03/2027	PAS optimisation and cloud stabilisation continue to progress alongside development of the longer-term EPR roadmap to 2030. A Contract Change Notice is being developed with System C to support cloud hosting and MIDAS replacement, while funding bids have been submitted through the Frontline Productivity Programme to support PAS optimisation and clinical workspace redesign. The EPR business case has been approved and submitted regionally. Delivery remains dependent on funding decisions, supplier engagement, achievement of interim milestones and completion of the Ethical Healthcare review. A joint UHNM/System C partnership event has also been held to support future programme planning.				
6	Implement a consistent cyber assurance framework across all priority digital programmes, including risk assessment, supplier assurance, penetration testing (where appropriate), access controls, secure configuration standards and governance reporting.	31/03/2027	The internal audit review of the cyber assurance framework has been completed and received positively by Audit Committee, providing assurance regarding the maturity of cyber governance and control arrangements.				

BAF 5: Inability to Maintain and Modernise Estate Infrastructure to Support Safe and Sustainable Service Delivery

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

Risk Description

Cause:	If we are unable to secure sufficient and sustained investment, maintain the estate, infrastructure, workforce and organisational capability required to deliver a prioritised programme of estate development and modernisation, and respond to future service capacity requirements, due to increasing backlog maintenance, infrastructure constraints and reliance on external capital funding,
Event:	then we may be unable to provide high-quality, responsive services within safe, compliant and sustainable estate environments, and support the service capacity and infrastructure required to deliver our strategic objectives,
Effect:	resulting in continued growth in backlog maintenance, non-compliance with statutory and regulatory standards, increased risk to patient safety and service continuity, reduced efficiency and value for money, and constraints on service transformation, capacity expansion and future models of care.

Potential to impact on Our Strategic Priorities

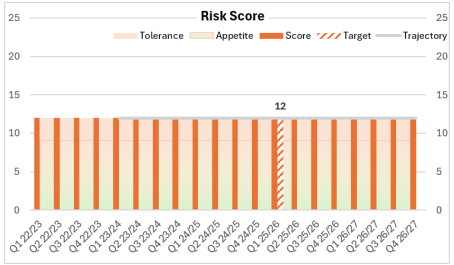
Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

	Q1	Q2	Q3	Q4	Target		Risk Appetite
Likelihood	3	3	3	3	2	31/03/2029	Cautious 1 – 9
Consequence	4	4	4	4	4		Risk Tolerance
Risk Score	12	12	12	12	8		High 10 - 12

Linked Risks	Low (1-3)	Mod (4-6)	High (8-12	Ext (15-25)
	8	26	66	9

The risk is expected to remain high throughout 2026/27 and beyond, reflecting the scale of backlog maintenance, constrained capital funding and the structural nature of the Trust's estate challenges. Whilst the planned actions will strengthen governance, prioritisation, compliance and infrastructure resilience, they are not expected to materially reduce the underlying risk in the short term, and the backlog maintenance liability is likely to continue to increase. Achievement of the target score is dependent upon securing significant future capital investment to address backlog maintenance, modernise infrastructure and support long-term estate transformation. Without sustained investment and delivery of estate modernisation programmes, backlog maintenance will continue to increase, placing greater pressure on infrastructure resilience, statutory compliance and the Trust's ability to support future service transformation and capacity requirements.



Overview – Summary of Key Q1 Changes

The risk remains high and on trajectory, reflecting ongoing challenges associated with backlog maintenance, ageing infrastructure, estate capacity constraints, workforce pressures and limited capital funding. During Q1, progress continued across a range of mitigation activities, including capital investment planning, delivery of sustainability initiatives, development of the Estates Strategy, workforce planning, Building Safety Act compliance and management of PFI-related risks. Whilst governance, compliance and assurance arrangements remain robust and provide confidence that estate risks are being appropriately managed, the scale of the estate challenge and reliance on external funding mean that the underlying risk is expected to remain elevated over the medium to long term.

The operational risk profile continues to highlight ageing infrastructure, estate compliance and fire safety requirements, accommodation and clinical space constraints, backlog maintenance pressures, and the resilience of critical plant and equipment. These challenges, together with limitations in estate capacity to support service expansion and new models of care, continue to constrain delivery of the Trust's longer-term estate strategy. Executive assurance remains Acceptable. Established maintenance, capital planning, compliance, safety and infrastructure governance arrangements provide assurance that estate risks are being actively managed. However, assurance remains constrained by the scale of backlog maintenance, limited capital funding, infrastructure capacity pressures and the complexity of delivering long-term estate modernisation and sustainability objectives. Key gaps in control and assurance relate to backlog maintenance and capital funding constraints, infrastructure resilience, delivery of strategic estate programmes, specialist workforce capacity, sustainability and Net Zero ambitions, and dependencies associated with suppliers, PFI arrangements and Building Safety Act requirements. All seven actions have been carried forward from 2025/26. Delivery of these actions is expected to strengthen assurance regarding estate compliance, infrastructure resilience, backlog maintenance management, capital investment planning and sustainability, supporting future risk reduction through improved estate condition, regulatory compliance and delivery of strategic estate programmes.

BAF 5: Inability to maintain and modernise estate infrastructure to support safe and sustainable service delivery

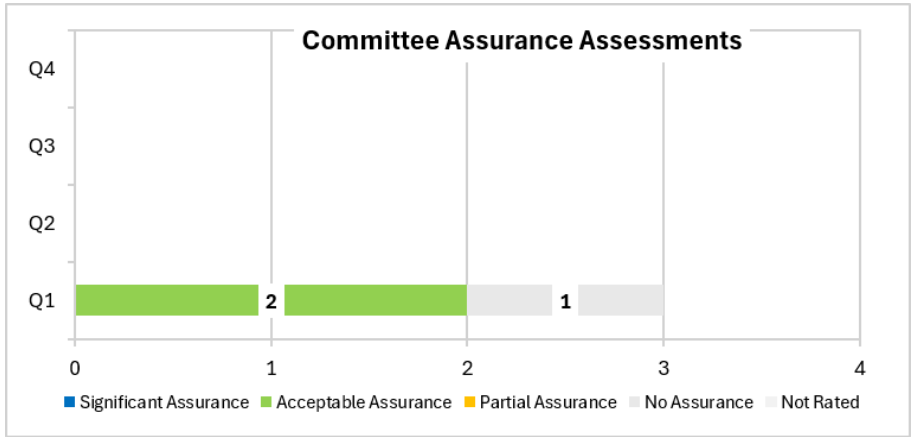
Key Controls Framework

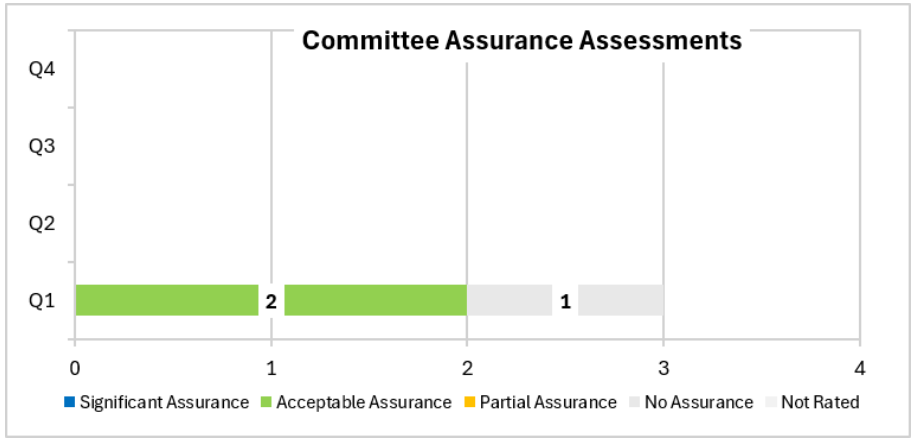
Care Group / Service (n=3)	• A planned preventative maintenance programme is in place to manage estate condition, supported by competent estates staff, performance monitoring and governance oversight. • Fire safety and security arrangements, including policies, risk assessments and compliance monitoring, are in place to support a safe and secure estate environment. • Sustainability governance arrangements are in place to oversee delivery of Net Zero Carbon objectives, compliance with national requirements and alignment of investment decisions to decarbonisation priorities.
Corporate (n=12)	• Backlog maintenance is risk-assessed, prioritised and managed through a structured capital planning process, with focus on risks to patient safety, statutory compliance and service continuity. • A capital investment programme is in place and monitored through established governance arrangements to prioritise investment against risk, strategic objectives and affordability. • Capital refurbishment programmes are in place to address high-risk backlog maintenance and estate infrastructure requirements. • An Estates and Facilities Strategic Plan is in place, aligned to the Clinical Strategy and informed by estate condition, service demand, sustainability requirements and affordability. • Programme governance arrangements are in place to oversee delivery of major capital and estate schemes, including management of risks, dependencies, benefits and contractor performance. • Building Safety Act compliance arrangements are in place for Higher Risk Buildings, supported by defined governance, accountability and assurance processes. • Fire safety and security assurance arrangements are in place to monitor compliance, risks and improvement actions across the estate. • Estate condition assessments and risk-based prioritisation processes are in place to inform investment decisions and management of backlog maintenance. • Sustainability and Net Zero Carbon delivery arrangements are in place, supported by the Trust Green Plan and associated improvement programmes. • Ongoing engagement with NHS England, system partners and external stakeholders supports access to capital funding and alignment of estate investment with strategic priorities. • Workforce and specialist estates expertise are in place to support safe operation, compliance and delivery of estate improvement programmes. • External audit and independent assurance arrangements provide oversight of capital planning, estate governance and compliance.
System (n=5)	• Collaborative working arrangements with system partners support estate planning, infrastructure development and sustainability objectives across the wider health system. • Ongoing engagement with NHS England, DHSC and PFI partners supports management of strategic estate risks, contractual obligations and funding opportunities. • System-wide sustainability partnerships support delivery of Net Zero Carbon objectives, access to external funding and adoption of best practice. • Participation in national and regional supplier and infrastructure programmes supports effective management of strategic estate and supply chain risks. • Joint governance arrangements with PFI partners support compliance with Building Safety Act requirements and management of estate-related risks.

Assurances Received and Rated – Q1

Report Title	April	May	June
Premises Assurance Model (PAM) and Estates Return Information Collection (ERIC) Annual Report			
Sustainability Bi-Annual Report			

Committee Assurance Assessment & Plan

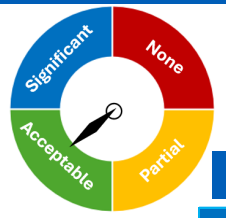




BAF 5: Inability to maintain and modernise estate infrastructure to support safe and sustainable service delivery

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



Assurance is rated as acceptable as robust governance, compliance and risk management arrangements are in place across Estates and Facilities, including effective prioritisation of backlog maintenance, capital planning and statutory compliance. However, assurance is constrained by the scale of the estate backlog and dependency on sustained capital investment, which limits the Trust's ability to fully mitigate the underlying risk.

Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=9)	• Available capital funding is not sufficient to address the scale and growth of backlog maintenance, resulting in continued increase in estate-related risk over the medium to long term (Action 1) • Estate Strategy and Development Control Plan are not yet fully mature, resulting in limited ability to progress strategic estate schemes and respond to funding opportunities (Action 2) • Physical estate constraints are not fully mitigated, including limited expansion capacity and reliance on modular solutions, resulting in restrictions on service transformation and reconfiguration (Actions 1 & 2) • Supplier capacity and availability are not consistently sufficient, resulting in increased delivery risk, cost pressures and extended programme timelines (Action 3) • Sustainability and Net Zero Carbon programmes are not yet fully developed or sufficiently funded, resulting in limited progress towards national targets and delivery of associated benefits (Action 4) • Estate infrastructure is not fully resilient to changing climate conditions, resulting in increased risk of service disruption and asset deterioration (Action 4) • Workforce capacity and capability within Estates and Facilities is not fully sufficient, resulting in risks to delivery of maintenance and capital programmes (Action 5) • PFI-related risks are not yet fully resolved, including latent defects and legacy infrastructure challenges, resulting in continued constraints on estate performance (Action 6) • Building Safety Act arrangements are not yet fully embedded across all Higher Risk Buildings, resulting in potential compliance, assurance and delivery risks. (Action 7)
Gaps in Assurance (n=3)	• Limited assurance regarding the Trust's ability to reduce backlog maintenance over time, given reliance on constrained capital funding and external investment (Action 1) • Limited assurance regarding the delivery and impact of capital investment programmes, including whether investment is sufficient to mitigate identified risks (Action 1) • Limited assurance regarding the deliverability and impact of the Estates Strategic Plan, including dependency on rightsizing, capital funding and feasibility development (Action 2) • Limited assurance regarding the sustainability of Estates and Facilities workforce capacity and capability required to deliver maintenance, compliance and capital programmes. (Action 5)

Risk Management Action Plan

No	Action	Due Date	Progress Report	2026/27 Q1	Q2	Q3	Q4
1	Secure and implement a risk-based capital investment programme to address the highest-risk backlog maintenance items, with investment prioritised against patient safety, statutory compliance, service continuity and strategic objectives.	~~28/06/2024~~ ~~31/12/2024~~ ~~31/03/2025~~ ~~30/06/2025~~ 30/06/2029	Action carried forward from 2025/26. Capital investment continues to be prioritised using a risk-based approach, focusing available funding on the highest-risk backlog maintenance items and replacement of critical infrastructure. Additional Backlog Safety Fund investment has been secured for a further two years through the ICB, alongside ongoing engagement with NHS England and system partners to maximise external funding opportunities. Whilst funding remains insufficient to eliminate the Trust's backlog maintenance liability, work continues to mitigate high and significant risks and maintain estate compliance, safety and resilience.				
2	Finalise and implement an Estates & Facilities Strategic Plan and Development Control Plan, informed by rightsizing, feasibility studies and clinical strategy, to establish a prioritised and deliverable programme of estate transformation.	~~30/06/2025~~ ~~30/12/2025~~ ~~02/02/2026~~ ~~01/06/2026~~ 01/09/2026	Action carried forward from 2025/26. The Board-approved Estates & Facilities Strategic Plan remains aligned to the Trust Strategy and wider organisational planning framework. Development of the supporting Estates Strategy and Development Control Plan continues, informed by rightsizing activity, service requirements and estate transformation priorities, with publication planned later in 2026/27.				
3	Implement a supplier assurance and performance management framework to strengthen oversight, monitor supplier performance and mitigate delivery risks associated with contractor and supply chain capacity.	~~31/03/2025~~ ~~30/06/2026~~ 30/06/2027	Action carried forward from 2025/26. Contractor performance and delivery risks continue to be monitored through established governance arrangements and NHS England framework processes. Whilst recent contractor performance and supply chain challenges have affected delivery in some areas, major capital schemes continue to progress, including the Urgent Treatment Centre development, alongside successful completion of the County Breast Care Unit and Community Diagnostic Centre.				
4	Develop and deliver a prioritised Sustainability, Net Zero Carbon and Climate Adaptation programme, including completion of feasibility studies and alignment of capital investment to national requirements and future estate resilience.	~~31/03/2025~~ ~~31/07/2025~~ ~~30/01/2026~~ ~~31/03/2026~~ 31/03/2027	Action carried forward from 2025/26. Capital funding has been secured to support improvements to the Royal Stoke heat network, with delivery scheduled to commence during 2026/27. Sustainability, decarbonisation and climate resilience initiatives continue through established governance arrangements, including the Executive-chaired Sustainability Development Steering Group. Further work is underway to finalise the climate adaptation strategy and complete feasibility studies to inform future estate design and investment priorities. Progress on some projects remains dependent on external partners, grid capacity constraints and completion of the District Energy Network business case.				
5	Develop and implement an Estates and Facilities workforce plan to improve recruitment, retention, skills development and succession planning, ensuring sufficient workforce capacity and capability to deliver maintenance, compliance and capital programmes.	~~27/12/2024~~ ~~31/01/2025~~ ~~30/07/2025~~ ~~30/03/2026~~ 30/03/2027	Action carried forward from 2025/26. Workforce actions continue to focus on recruitment, retention, succession planning and skills development across Estates and Facilities. Recruitment challenges remain, particularly for qualified craft staff, due to Agenda for Change pay constraints. Mitigating actions include investment in apprenticeship programmes, successful recruitment to engineering apprentice roles, implementation of a recruitment and retention premium, and additional workforce flexibility measures to support operational resilience.				
6	Implement and monitor a programme of work to address PFI-related risks, including latent defect remediation and engagement with PFI partners and lenders, to improve estate performance, compliance and resilience.	~~30/08/2024~~ ~~31/03/2025~~ ~~31/07/2025~~ ~~30/03/2026~~ ~~31/09/2026~~ 31/01/2027	Action carried forward from 2025/26. Remediation of PFI latent defects continues, with progress during Quarter 1 affected by Building Safety Act requirements and associated regulatory processes. The required Building Safety Act application has now been submitted by Project Co, supporting further progress during Quarter 2. Engagement with PFI partners and regulators remains ongoing to support delivery of remedial works and management of estate-related risks.				
7	Embed and maintain Building Safety Act compliance arrangements for Higher Risk Buildings, including defined governance, accountability, assurance and ongoing compliance monitoring.	~~31/10/2025~~ ~~31/03/2026~~ ~~31/06/2026~~ 31/10/2026	Action carried forward from 2025/26. Building Safety Act governance arrangements continue to be embedded across Higher Risk Buildings at Royal Stoke. Following the liquidation of a specialist compliance consultancy, an alternative provider has been appointed and compliance activities have continued. Golden Thread meetings have been established and responsibilities agreed with Project Co in relation to changes and capital works. Whilst Building Safety Regulator approval requirements continue to impact project timelines, these strengthened arrangements are expected to support further progress during Quarter 2.				

BAF 6: Inability to Deliver In-Year Financial Position

Finance and Business Performance Committee | Chief Finance Officer

Risk Description

Cause:	If we are unable to maintain the organisational capacity, leadership capability and programme delivery capability required to deliver recurrent savings, productivity improvements and financial recovery plans, in the context of increasing demand, workforce affordability pressures, inflationary costs and operational performance challenges,
Event:	then we may be unable to achieve our required in-year financial position,
Effect:	resulting in increased financial deficit, reduced organisational flexibility, constraints on service and transformation investment, heightened regulatory scrutiny, and reduced ability to deliver strategic priorities.

Potential to impact on Our Strategic Priorities

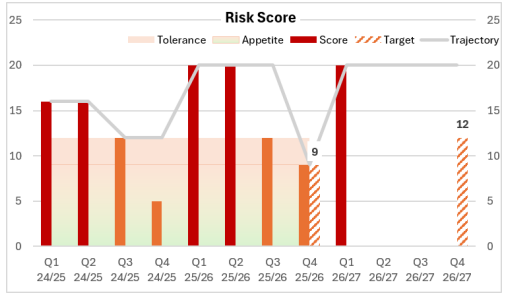
Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

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

Linked Risks	Low (1-3)	Mod (4-6)	High (8-12)	Ext (15-25)
	10	6	4	3

The risk is expected to remain at an extreme level throughout 2026/27, reflecting the scale of the financial challenge, uncertainty surrounding delivery of CIP schemes and the impact of demand, activity and cost pressures. Achievement of the target score is dependent upon successful delivery of CIP, productivity and financial recovery plans, together with sustained improvements in financial performance. Without delivery of these actions, the Trust is unlikely to achieve its in-year financial position, resulting in increasing financial pressures, reduced organisational flexibility and heightened regulatory scrutiny. Achievement of the target score of 12 by March 2027 is dependent upon delivery of recurrent savings, improvement in CIP performance and restoration of financial performance in line with plan.



Overview – Summary of Key Q1 Changes

At Q1, the risk remains extreme, with financial performance £6.1m behind plan. Delivery of the Cost Improvement Programme continues to represent a significant risk, with £53m currently assessed as high risk. Senior Responsible Officers are working with the PMO to refresh forecasts, strengthen mitigations and improve delivery confidence. Whilst established financial governance, planning, performance management and recovery arrangements remain in place, the scale of the financial challenge continues to require close oversight and active intervention.

The operational risk profile reinforces this position, highlighting risks associated with CIP delivery, workforce pay and establishment pressures, non-pay cost growth, demand volatility and delivery of planned income and productivity benefits. These factors continue to create financial uncertainty and reduce assurance that the Trust can achieve its planned financial position whilst maintaining service quality and performance. Executive assurance has reduced to Partial. Whilst existing governance, forecasting, recovery planning and CIP oversight arrangements provide assurance that key financial risks are being actively managed, assurance remains constrained by the scale of the financial challenge, reliance on CIP delivery and the continued requirement to deliver recurrent savings at pace. Key gaps in control and assurance relate to the maturity and delivery of recurrent CIP schemes, variation in delivery across Care Groups, the impact of demand and winter pressures on financial performance, and limited assurance regarding achievement of the in-year financial position and sustainable savings. Actions have been refreshed for 2026/27 to address these gaps. Delivery of the identified actions is expected to strengthen assurance regarding CIP delivery, financial recovery, productivity improvement and financial performance management, supporting risk reduction through improved delivery of planned savings, reduced financial variance and achievement of the agreed in-year financial position.

BAF 6: Inability to Deliver In-Year Financial Position

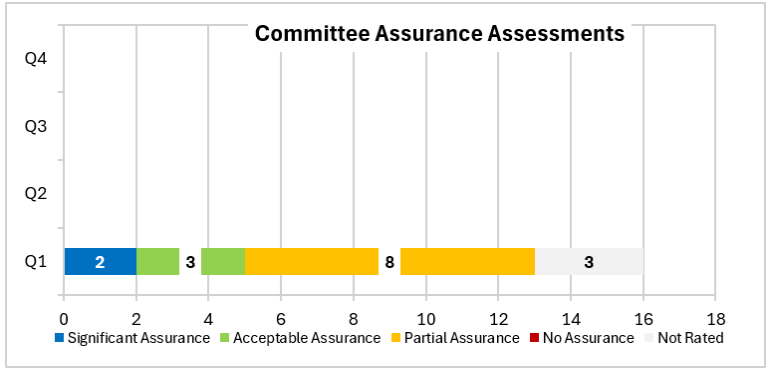
Key Controls Framework

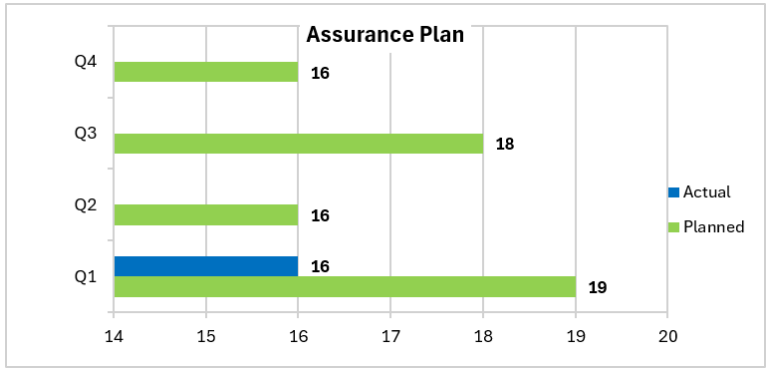
Care Group (n=5)	• Care Group financial governance arrangements are in place to oversee delivery of financial plans, Cost Improvement Programmes (CIP), activity performance and recovery actions. • Structured review processes are in place to monitor CIP delivery, identify variances and implement corrective actions where required. • Recovery plans are in place for underperforming services, with progress subject to review and challenge through established governance arrangements. • Executive approval and oversight arrangements are in place for RTT and activity-related investment decisions. • Standing Financial Instructions (SFIs), Scheme of Delegation and expenditure approval processes are in place to support financial control and accountability.
Corporate (n=12)	• Audit Committee provides oversight of the effectiveness of financial governance and internal control arrangements. • CIP delivery is centrally monitored through established governance arrangements, with delivery risks, mitigations and forecast achievement subject to regular review and escalation. • Finance Improvement Oversight Group provides oversight, challenge and escalation of financial recovery actions, CIP delivery and emerging financial risks. • Monthly financial forecasting processes are in place, including scenario modelling, variance analysis and development of mitigating actions. • Financial performance is monitored through established governance arrangements, including review of run-rate performance, activity delivery and income recovery. • Enhanced workforce controls are in place to support effective management of substantive, bank and agency staffing expenditure. • Investment controls are in place to ensure expenditure is prioritised in line with affordability, patient safety requirements and strategic priorities. • Business case approval and review arrangements are in place to ensure investment decisions are subject to affordability assessment, prioritisation and governance scrutiny prior to approval. • Medium Term Plan assumptions are aligned to annual financial planning arrangements and subject to regular review. • Non-recurrent mitigations are identified, monitored and reviewed to assess impact on delivery of the in-year financial plan and underlying financial position. • The pace of investment is actively managed in line with financial performance and affordability to support financial recovery and risk mitigation. • Processes are in place to identify, review and address breaches of Standing Financial Instructions, financial losses and special payments, supporting continuous improvement in financial control and governance.
System (n=2)	• Participation in system-wide financial recovery and improvement programmes supports delivery of shared financial objectives and system planning assumptions. • External and internal audit arrangements provide independent assurance regarding financial controls, governance and financial reporting.

Assurances Received and Rated – Quarter 1

Report Title	April	May	June
Audit Findings Report and Letter of Representation			
Business Case Review Schedule		Annual	☒
Cost Improvement Report			
Finance Report	M12	M1	M2
Losses and Special Payments and Stock Write Offs			
Procurement Report			
Productivity / Efficiency Performance Report			
SFI Breaches relating to Procurement processes and Single Tender Waivers			
SFI Breaches relating to Salary Overpayments			

Committee Assurance Assessment & Plan





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

Assurance is rated as partial as, while robust financial controls, governance and monitoring arrangements are in place, there remains uncertainty regarding the deliverability of the in-year financial position. Reliance on the successful delivery of CIP schemes, variability in demand and activity, and dependency on system-wide solutions limit confidence that the plan will be fully achieved.

Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=3)	• The CIP programme is not yet sufficiently developed with a high proportion of recurrent schemes, resulting in reliance on non-recurrent savings and reduced sustainability of delivery (Action 1) • Delivery of CIP schemes is not consistently achieved across Care Groups, resulting in variability in pace, ownership and implementation of savings (Action 1) • Winter and demand planning controls are not fully sufficient to mitigate demand volatility, resulting in risk to delivery of the in-year financial position (Action 2)
Gaps in Assurance (n=2)	• Limited assurance regarding the deliverability and timing of CIP schemes, including reliance on schemes at early stages of development and limited evidence of fully embedded and recurrent savings (Action 1) • Limited assurance regarding achievement of the in-year financial position, given reliance on future delivery of CIP and external system support in previous years (Action 1)

Risk Management Action Plan

No	Action	Due Date	Progress Report	2026/27 Q1	Q2	Q3	Q4
1	Develop, approve and deliver a credible and phased CIP programme, including detailed schemes, clear ownership, and monitoring of delivery, recurrence and risk, with regular escalation of slippage and mitigations through governance structures	31/03/2027	Ongoing.				
2	Develop and implement a winter plan aligned to financial assumptions, including identification and management of escalation areas, demand pressures and associated costs, with ongoing monitoring and mitigations to maintain delivery within the financial envelope	31/09/2026	Action not yet due.				

BAF 7: Inability to Deliver Financial Sustainability

Finance and Business Performance Committee | Chief Finance Officer

Risk Description

Cause:	If we are unable to maintain the organisational capacity, capability and system alignment required to deliver recurring productivity improvements, service transformation and sustainable financial recovery, due to ongoing cost pressures, the scale and recurring nature of CIP requirements, increasing demand, workforce affordability challenges, and reliance on non-recurrent funding and system support,
Event:	then we may be unable to achieve a sustainable financial position and deliver a break-even position within the required timescales,
Effect:	resulting in a continued structural deficit, increased external scrutiny and potential regulatory intervention, reduced organisational autonomy over financial and strategic decision-making, constraints on investment in workforce, digital and estate infrastructure, and a reduced ability to deliver sustainable, high-quality services over the long term.

Potential to impact on Our Strategic Priorities

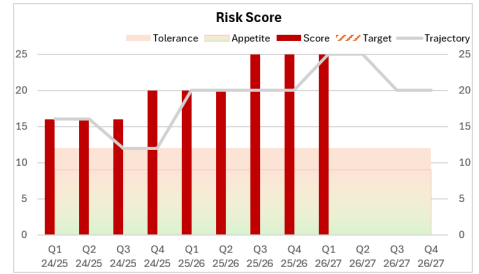
Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

	Q1	Q2	Q3	Q4	Target		Risk Appetite
Likelihood	5	5	4	4	3	31/03/2029	Cautious 1 – 9
Consequence	5	5	5	5	4		Risk Tolerance
Risk Score	25	25	20	20	12		High 10 - 12

Linked Risks	Low (1-3)	Mod (4-6)	High (8-12)	Ext (15-25)
	8	2	1	1

The risk is expected to remain at an extreme level during the early part of 2026/27, reflecting the scale of the financial sustainability challenge, ongoing reliance on recurrent CIP delivery and the need to finalise credible medium-term financial assumptions. Risk reduction is dependent on evidenced delivery of recurrent savings, productivity improvements, transformation benefits and improved financial performance. As these benefits are not yet realised, no reduction in the current risk score is assumed during the early quarters. Achievement of the target score remains a multi-year dependency and will require sustained delivery of financial recovery and transformation programmes. Without delivery of recurrent savings and transformation programmes, the Trust is likely to remain dependent on non-recurrent measures and unable to achieve a sustainable financial position. "Achievement of the target score of 12 by March 2029 is dependent on delivery of a credible Medium Term Financial Plan, recurrent savings replacing non-recurrent measures, and sustained improvements in productivity and efficiency.



Overview – Summary of Key Q1 Changes

At Q1, the risk remains extreme, with financial performance £6.1m behind plan. The 2026/27 CIP includes £21.9m of non-recurrent savings, creating additional pressure on the achievement of long-term financial sustainability. A Recovery Director is working with the Trust to develop a credible financial sustainability programme, focused on improving productivity, efficiency, cost avoidance and cost reduction. Whilst governance and recovery arrangements remain in place, delivery of sustainable financial improvement continues to depend upon the successful implementation of transformational change and recurrent savings programmes.

The operational risk profile reinforces this position, highlighting continued dependence on recurrent CIP delivery, achievement of productivity improvements and delivery of elective recovery benefits. The scale of the financial challenge and reliance on transformation programmes to realise anticipated benefits continue to reduce assurance that a sustainable financial position can be achieved over the medium term. Executive assurance remains Partial. Established financial governance, planning, recovery and transformation arrangements provide assurance that financial sustainability risks are being actively managed through structured oversight of recovery plans, medium-term financial planning and transformation programmes. However, assurance remains constrained by reliance on recurrent savings delivery, uncertainty regarding medium-term funding assumptions and system support arrangements, and the time required to realise sustainable productivity and transformation benefits. Key gaps in control and assurance relate to delivery of recurrent CIP schemes, maturity of medium-term financial planning assumptions, dependency on system funding and support, delivery of transformation and productivity improvements, and limited assurance regarding achievement of a sustainable long-term financial position. All three actions have been carried forward from 2025/26. Delivery of these actions is expected to strengthen assurance regarding recurrent savings delivery, medium-term financial planning, productivity improvement and financial transformation, supporting the planned reduction in risk through achievement of a more sustainable financial position and reduced reliance on non-recurrent measures.

BAF 7: Inability to Deliver Financial Sustainability

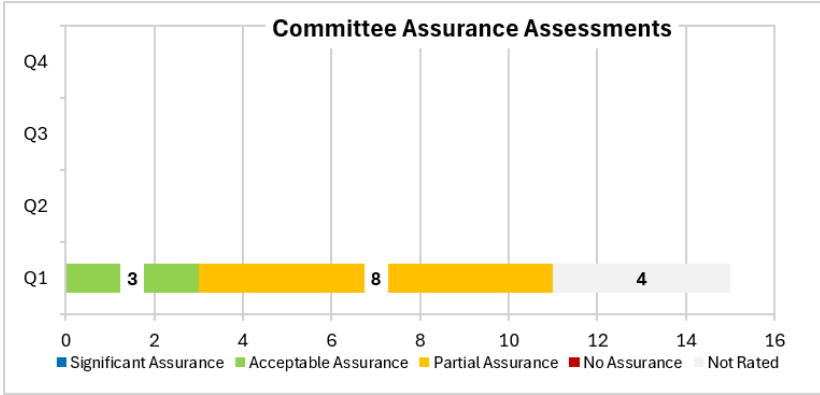
Key Controls Framework

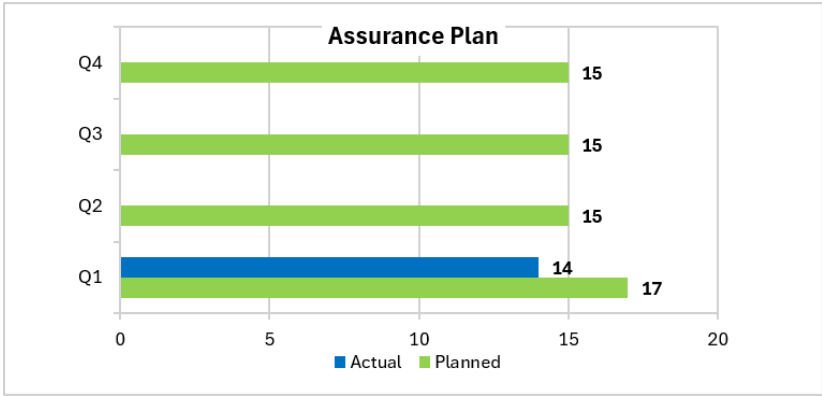
Care Group (n=4)	• Care Group Financial Improvement Framework, including delivery and monitoring of financial improvement plans, CIP and cost control measures. • Performance and Financial Review Meetings, providing oversight and challenge of financial performance, CIP delivery and variance against plan. • Investment Approval and Affordability Controls, ensuring discretionary expenditure is subject to affordability assessment and approved in line with delegated authority requirements. • Standing Financial Instructions and Scheme of Delegation, defining financial accountability, decision-making authority and financial control requirements.
Corporate (n=6)	• Executive Financial Improvement Oversight Framework, providing governance, challenge and oversight of financial recovery plans and delivery of the financial trajectory. • Recurrent Cost Improvement Programme (CIP), with structured identification, monitoring and delivery of sustainable efficiency opportunities. • Medium Term Financial Plan (MTFP), incorporating recurrent savings, activity and demand assumptions, system funding arrangements and financial recovery trajectories. • Financial Recovery and Transformation Programmes, designed to improve productivity, reduce the underlying cost base and deliver long-term financial sustainability. • Investment Control Framework, including approval thresholds, affordability assessments and 'double lock' arrangements for discretionary investment. • External Review and Improvement Support Arrangements, providing independent challenge and support to strengthen financial governance and recovery planning.
System (n=2)	• System Financial Planning and Partnership Arrangements, supporting alignment of financial plans, activity assumptions, funding and recovery trajectories with the ICB and system partners. • External Audit and Independent Assurance Framework, providing independent assurance on financial governance, control and reporting arrangements.

Assurances Received and Rated –Quarter 1

Report Title	April	May	June
Business Case Review Schedule		Annual	☒
Cost Improvement Report			
Finance Report	M12	M1	M2
Losses and Special Payments and Stock Write Offs			
Productivity / Efficiency Performance Report			
SFI Breaches relating to Procurement processes and Single Tender Waivers			
SFI Breaches relating to Salary Overpayments			

Committee Assurance Assessment & Plan





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

Assurance is rated as partial as, while financial governance, planning and oversight arrangements are in place, there remains limited confidence in the Trust's ability to deliver a sustainable financial position over the medium term. In particular, delivery of recurrent CIP schemes, achievement of productivity improvements and agreement of the underlying system and contractual position remain uncertain, with assurance largely dependent on future delivery and transformation rather than fully evidenced outcomes at this stage.

Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=4)	• Recurrent CIP schemes are not yet fully developed or identifiable at the scale required, resulting in continued reliance on non-recurrent savings (Action 1) • Medium-term financial planning assumptions are not yet fully defined or agreed, resulting in uncertainty in delivery of the financial trajectory (Action 2) • The underlying system and contractual financial position is not yet fully agreed, resulting in lack of clarity on funding assumptions and delivery expectations (Action 2) • Reliance on external system support is not sustainable over the medium term, resulting in ongoing risk to financial recovery (Actions 1, 2 & 3) • Transformation opportunities have not yet been fully realised, limiting the Trust's ability to reduce the underlying cost base and deliver sustainable productivity improvements (Action 3).
Gaps in Assurance (n=2)	• Limited assurance regarding the delivery of recurrent CIP and sustainable cost reduction required to achieve financial recovery over the medium term (Actions 1 & 3) • Limited assurance regarding the credibility of the medium-term financial trajectory, given reliance on future delivery of CIP, system support and evolving planning assumptions (Action 2)

Risk Management Action Plan

No	Action	Due Date	Progress Update	2026/27 Q1	Q2	Q3	Q4
1	Develop and deliver a recurrent Cost Improvement Programme (CIP) to identify sustainable efficiency opportunities, reduce reliance on non-recurrent measures and deliver recurring savings in support of medium-term financial sustainability.	~~31/03/2026~~ 2026/2027	Action carried forward from 2025/26. Ongoing reports provided to FBP detailing progress and delivery.				
2	Develop, agree and implement a credible Medium Term Financial Plan, aligning contractual, activity, CIP and funding assumptions to establish a realistic trajectory to financial sustainability.	~~01/04/2026~~ ~~30/06/2026~~ 31/08/2026	Action carried forward from 2025/26. Action ongoing.				
3	Develop and implement transformation programmes, including service redesign and 'left shift' of care, to improve productivity, reduce the underlying cost base and support long-term financial sustainability.	2026/27	Action carried forward from 2025/26.				

BAF 8: Inability to deliver the Research and Innovation Strategy at the required scale, pace and impact

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

Risk Description

Cause:	If we are unable to develop and deliver coordinated, prioritised and financially sustainable programmes of research and innovation, due to limitations in organisational capacity and capability, fragmented governance, and competing financial and operational pressures,
Event:	then we will be unable to consistently embed and scale research and innovation activity across clinical services,
Effect:	resulting in reduced ability to improve patient outcomes through evidence based and innovative care, diminished reputation and influence as a leading university hospital, reduced opportunities for patients to participate in research, challenges in attracting and retaining high calibre clinical and academic staff, and missed opportunities for external funding, partnerships and commercial development.

Potential to impact on Our Strategic Priorities

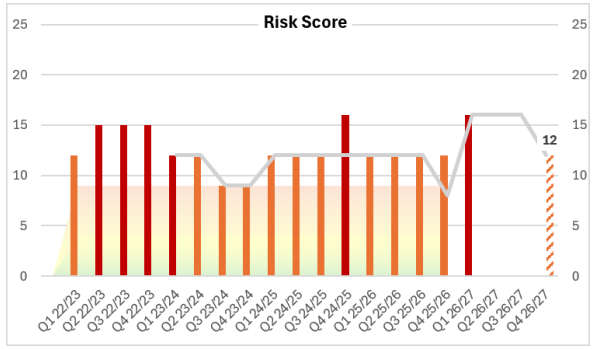
Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

	Q1	Q2	Q3	Q4	Target		Risk Appetite
Likelihood	4	4	4	3	3	31/03/2027	Open 1 - 12
Consequence	4	4	4	4	4		Risk Tolerance
Risk Score	16	16	16	12	12		Ext 15 - 16

Linked Risks	Low (1-3)	Mod (4-6)	High (8-12)	Ext (15-25)
	1	0	0	1

The risk is expected to remain at its current level during the early part of 2026/27, reflecting ongoing workforce and infrastructure capacity constraints and the time required to embed governance and prioritisation improvements. Achievement of the target score by March 2027 is dependent on strengthening research capacity and capability, establishing sustainable research infrastructure, increasing research participation and commercial activity, and delivering strategic research and innovation outcomes. Without sustained investment and improvement in these areas, the Trust is unlikely to realise the full benefits of research and innovation, limiting opportunities to improve patient outcomes, attract external funding and strengthen its position as a leading university hospital.



Overview – Summary of Key Q1 Changes

The risk score increased during Q1 following delays in progressing the NIHR Capital Investment award for refurbishment of the Clinical Education Centre, resulting in an estimated six-month delay and increased delivery and reputational risk. Workforce and resource constraints continue to impact delivery, including capacity pressures within DSP and Pathology affecting activation of commercial research studies, and insufficient protected time for Principal Investigators and Co-Principal Investigators to complete required training, contributing to the withdrawal of commercial research opportunities. Whilst capacity improvements are anticipated within the Research & Innovation Directorate, significant workforce and infrastructure pressures within CeNREE remain and are expected to continue to constrain delivery over the medium term.

The operational risk profile reinforces this position, highlighting the sustainability of key research and innovation infrastructure, supporting resources and specialist workforce capacity. Executive assurance remains Partial. Established governance, workforce, infrastructure, leadership and partnership arrangements provide assurance that research and innovation risks are being actively managed. However, assurance remains constrained by workforce capacity and capability challenges, limitations in research infrastructure, dependency on key specialist roles, and the need to strengthen organisational coordination, prioritisation and benefits realisation. Key gaps in control and assurance relate to research workforce capacity, development of Principal Investigator and clinical academic pipelines, research facilities and infrastructure, organisational prioritisation, and limited assurance regarding delivery of strategic outcomes and benefits realisation. Four actions have been carried forward from 2025/26 and four new actions identified. Delivery of these actions is expected to strengthen assurance regarding research capacity, infrastructure, workforce capability, organisational coordination and benefits realisation, supporting future risk reduction through increased research activity, improved delivery of strategic objectives and development of a more sustainable research and innovation operating model.

BAF 8: Inability to deliver the Research and Innovation Strategy at the required scale, pace and impact

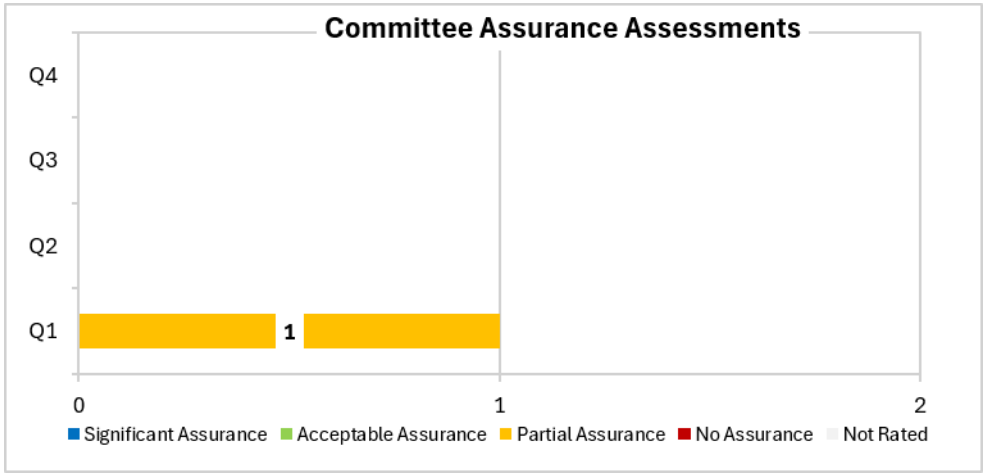
Key Controls Framework

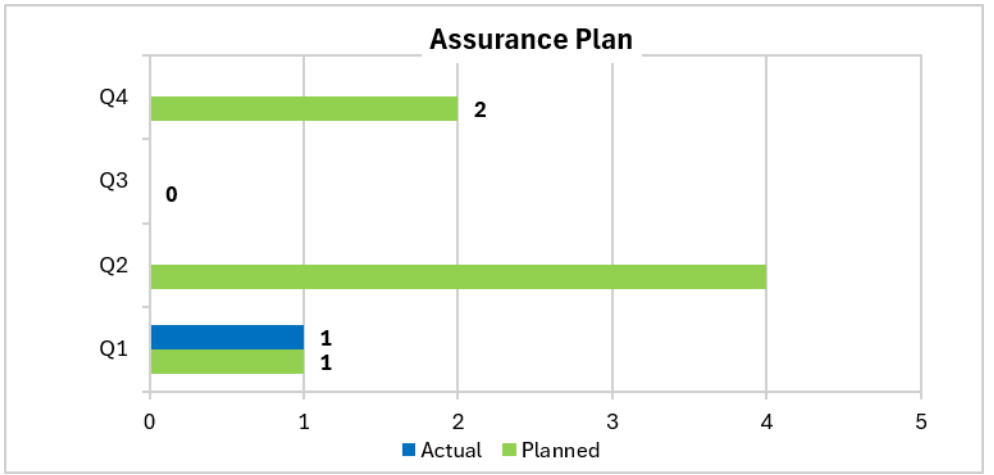
Care Group (n=6)	• Research and Innovation Workforce Framework, including workforce planning, recruitment and capacity management to support delivery of research and innovation priorities. • Research Delivery Leadership and Operational Oversight Arrangements, providing coordination of resources, delivery and operational performance across the Research & Innovation Directorate. • Research and Innovation Infrastructure, including dedicated research facilities and accommodation to support delivery of research and innovation activity. • Clinical Research Delivery Capability, including specialist research delivery roles to support research performance and study delivery. • CeNREE Workforce and Academic Development Framework, supporting research capability, leadership and academic development across professional groups. • Patient and Public Involvement and Engagement Framework, supporting inclusive participation and engagement in research activity.
Corporate (n=7)	• Research and Innovation Governance Framework, including oversight forums, defined accountability arrangements and escalation processes for performance and risk. • Research and Innovation Strategic Delivery Plan, aligned to Trust strategic priorities and supported by defined delivery objectives and responsible leads. • Executive Oversight and Accountability Arrangements, providing strategic leadership and organisational oversight of research and innovation delivery. • Research and Innovation Performance and Assurance Framework, including regular monitoring of delivery, performance, benefits realisation and key risks. • Research and Innovation Prioritisation Framework, aligning activity to organisational priorities, available capacity and financial constraints. • Research and Innovation Coordination Framework, supporting visibility, integration and collaboration across research and innovation activity within the Trust. • Research and Innovation Leadership Capacity, including key leadership roles to support delivery of the research and innovation strategy.
System (n=5)	• Academic Partnership Framework, including formal collaboration arrangements with Keele University and the University of Staffordshire. • Joint Academic and Clinical Appointment Arrangements, supporting integration between academic and clinical leadership. • Research Workforce Development Partnerships, including collaborative arrangements with partner organisations to support workforce development, recruitment and training. • Integrated Care System Research and Innovation Networks, supporting alignment to system-wide research and innovation priorities. • Regional and National Research Collaboration Frameworks, supporting participation in regional forums, national programmes and professional networks.

Assurances Received and Rated –Quarter 1

Report Title	April	May	June
Clinical Effectiveness Update			

Committee Assurance Assessment & Plan

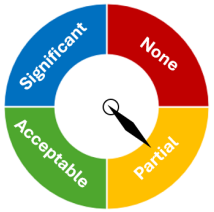




BAF 8: Inability to deliver the Research and Innovation Strategy at the required scale, pace and impact

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



Assurance remains rated as Partial. Whilst governance arrangements and strategic delivery plans for Research and Innovation are being strengthened, workforce capacity and capability constraints continue to limit confidence in the consistent delivery of research and innovation priorities across the organisation. This includes ongoing resource pressures within CeNREE and challenges in building research capacity across professional groups to support future growth in research activity. There remains limited assurance regarding delivery of strategic outcomes, benefits realisation and the development of a sustainable pipeline of research-active staff. Further work is required to strengthen organisational coordination, prioritisation, capacity building and performance reporting to improve assurance.

Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=6)	• Mandatory Good Clinical Practice (GCP) training is not consistently in place for all Principal and Chief Investigators, limiting readiness to deliver research studies (Action 2) • Research infrastructure and facilities are not yet fully developed or comparable to peer organisations, resulting in limited capacity to scale research activity (Action 3) • Insufficient CeNREE workforce capacity to support research capability development and growth in the number of research-active staff, including Principal Investigators and non-medical clinical academics (Actions 4 & 5). • Insufficient pool of Principal Investigators across professions and specialties to support growth in research activity, including expansion via CRDC (Action 6) • A formal prioritisation framework is not yet fully in place to align research and innovation activity with organisational capacity, local, regional and national strategic priorities and financial constraints, resulting in risk of misalignment and overcommitment (Action 7) • Research and innovation activity is not consistently coordinated across the organisation, resulting in duplication, inefficiency and lack of strategic alignment (Action 8)
Gaps in Assurance (n=3)	• Limited assurance regarding delivery of Research and Innovation Strategic Delivery Plans, including confidence in organisational capacity, prioritisation, coordination and implementation across the Trust (Actions 1, 7 & 8). • Limited assurance regarding workforce capacity and capability to support planned growth in research activity, including availability of Principal Investigators, delivery teams and research capacity-building resources across professional groups (Actions 4, 5 & 6). • Limited assurance regarding the consistent reporting of outcomes, impact and benefits realisation for research and innovation activity (Action 9)

Risk Management Action Plan

No	Action	Due Date	Progress Update	2026/27 Q1	Q2	Q3	Q4
1	Embed research and innovation within Care Group governance arrangements, including routine oversight of performance, delivery, workforce capacity and strategic risks.	~~30/09/2024~~ ~~31/03/2025~~ ~~30/09/2025~~ ~~31/12/2025~~ ~~30/06/2026~~ 31/08/2026	Action carried forward from 2025/26. Recruitment with care group research leads is progressing, with interviews scheduled for July 2026.				
2	Implement mandatory Good Clinical Practice (GCP) training in line with NIHR/HRA guidance to ensure Principal and Chief Investigators maintain research readiness and compliance.	~~31/12/2025~~ 28/04/2026	Action carried forward from 2025/26. Communications regarding the revised GCP requirements have been issued and implementation completed; ongoing compliance monitoring is in place.				
3	Develop and secure approval for a dedicated research facility to increase research infrastructure capacity and support growth in research activity.	31/03/2028	Action carried forward from 2025/26. Application remains in development and is progressing through the approval process.				
4	Increase research delivery workforce capacity to support study delivery, participant recruitment and future growth in research activity.	31/08/2026	Recruitment activity has been undertaken; following an unsuccessful appointment process, the post has been re-advertised.				
5	Increase and diversify the pool of Principal and Chief Investigators across professions and specialties through targeted development, mentorship and succession planning.	31/12/2026	Action carried forward from 2025/26. CeNREE continues to support research capacity and capability development through delivery of NIHR INSIGHTS, the West Midlands HCP Internship Programme, and NIHR pre-doctoral and doctoral fellowship opportunities.				
6	Develop and implement a Research and Innovation Prioritisation Framework to align activity with organisational priorities, available capacity and financial sustainability.	31/03/2027	Progress update to be provided following confirmation of implementation arrangements.				
7	Implement organisational coordination arrangements to improve visibility, alignment and integration of research and innovation activity across the Trust.	31/03/2027	Progress update to be provided following confirmation of implementation arrangements.				
8	Develop and implement a performance and benefits realisation framework for research and innovation activity, including defined KPIs and outcome measures.	31/03/2027	Progress update to be provided following confirmation of implementation arrangements.				

BAF 9: Inability to Sustain Safe and Timely Urgent and Emergency Care Performance

Quality, Access & Outcomes Committee | Chief Operating Officer

Risk Description

Cause:	If we are unable to maintain the workforce, bed, discharge and system capacity required to meet increasing demand, and develop the organisational and system capability required to deliver and sustain improvements in patient flow and urgent and emergency care pathways,
Event:	then we may be unable to sustainably improve urgent and emergency care performance, with continued ambulance handover delays, prolonged emergency department waits and ongoing reliance on escalation processes such as corridor care,
Effect:	resulting in increased patient safety risks and poorer patient experience, failure to achieve national performance standards, workforce pressures, reduced system resilience and deterioration in public, partner and regulatory confidence in the Trust's ability to deliver safe, timely and effective urgent and emergency 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	5	4	2	31/03/2029	Minimal 1 – 4
Consequence	5	5	5	5	5		Risk Tolerance
Risk Score	20	20	25	20	10		Mod/High 5 – 9

Linked Risks	Low (1-3)	Mod (4-6)	High (8-12)	Ext (15-25)
	0	3	11	7

The risk is expected to remain at an extreme level throughout 2026/27, reflecting sustained demand, patient flow and discharge challenges, workforce and bed capacity constraints, and reliance on system-wide improvements. A temporary increase in risk is anticipated during Q3 due to winter pressures. Whilst the UEC Improvement Plan is expected to deliver incremental improvements, these are likely to mitigate rather than materially reduce the overall risk profile in-year. Achievement of the target score is dependent on sustained improvements in patient flow, discharge performance, workforce and system capacity, elimination of corridor care, and recovery towards national performance standards. Without delivery of the UEC Improvement Plan and associated system-wide actions, patient flow and discharge challenges are likely to persist, increasing reliance on escalation measures, prolonging waits for patients and reducing the Trust's ability to achieve and sustain national performance standards.

Overview – Summary of Key Q1 Changes

Progress across the discharge and UEC improvement programme has remained positive during Q1, supported by continued development of the Integrated Discharge Hub (IDH), strengthened system collaboration and enhanced discharge pathways. Increasing demand for Pathway 1 support has been accommodated through expanded home-based care, VCSE, brokerage and Virtual Ward provision, contributing to improved discharge performance and reduced delays. Further improvements have been supported through integration of discharge facilitation functions, continued use of the HRD tool to identify discharge risks earlier, and development of enhanced VCSE provision. Across the urgent and emergency care pathway, work has continued to develop alternative pathways, strengthen senior clinical decision-making, improve referral quality and reduce avoidable conveyances. Winter planning has commenced, with agreed priorities and delivery of the UEC Improvement Plan continuing through a range of workstreams focused on patient flow, discharge processes, workforce resilience and urgent care capacity.

The operational risk profile continues to highlight pressures relating to emergency department capacity, ambulance handover delays, patient flow, corridor care, workforce shortages and the suitability of escalation areas. Collectively, these factors continue to impact the Trust's ability to consistently deliver safe, timely urgent and emergency care and achieve national performance standards. Executive assurance remains Partial. Established operational flow, discharge, capacity management, escalation and improvement arrangements provide assurance that key risks are being actively managed; however, assurance remains constrained by sustained demand, patient flow and discharge challenges, reliance on system-wide capacity improvements, and the scale of recovery required to achieve and sustain national standards. Key gaps in control and assurance relate to system step-up and discharge capacity, patient flow optimisation, bed capacity and escalation pressures, delivery of the UEC recovery trajectory, and limited assurance regarding the impact of prolonged waits on patient safety and outcomes. Seven actions have been identified for 2026/27 aligned to the UEC Improvement Plan. Delivery of these actions is expected to strengthen assurance regarding patient flow, discharge performance, system capacity, UEC recovery and patient safety, supporting future risk reduction through sustained improvements in performance, reduced reliance on escalation measures and recovery towards national standards.

BAF 9: Inability to Sustain Safe and Timely Urgent and Emergency Care Performance

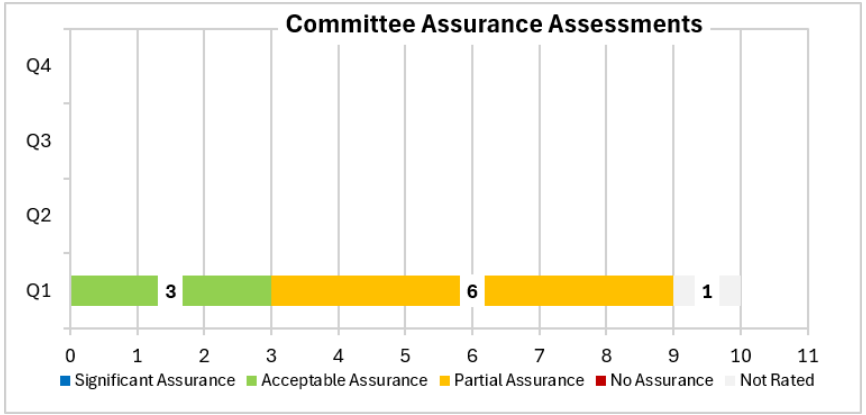
Key Controls Framework

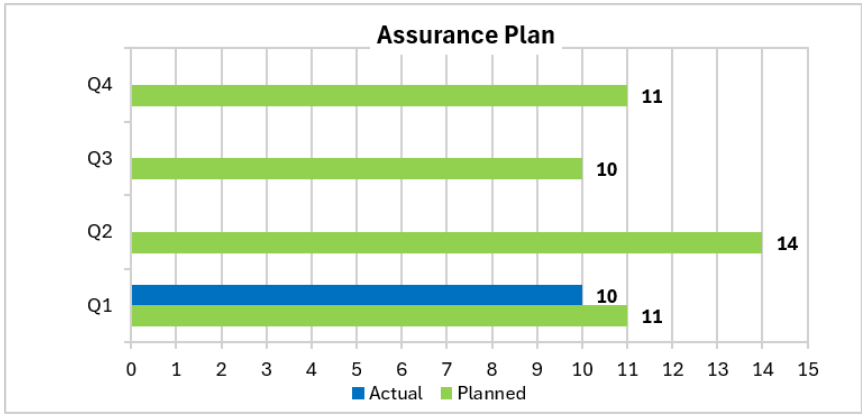
Care Group (n=6)	• Operational Capacity and Flow Management Framework, including daily capacity reviews, escalation processes and executive oversight of operational flow. • Discharge and Patient Flow Framework, including discharge escalation processes, early discharge arrangements and proactive discharge planning. • Emergency Department Flow Model, including rapid assessment and treatment arrangements, assessment within 15 minutes and use of alternative flow pathways such as 'fit to sit'. • Clinical Decision-Making and Specialty In-Reach Arrangements, supporting timely review, admission decisions and patient flow through the Emergency Department. • Admission Avoidance and Same Day Emergency Care Pathways, including Urgent Treatment Centre arrangements and initiatives to reduce avoidable admissions. • Demand, Conversion and Admission Management Processes, including monitoring of conversion rates and implementation of agreed admission criteria.
Corporate (n=8)	• Urgent and Emergency Care (UEC) Improvement Programme, with defined workstreams, delivery plans, accountabilities and oversight arrangements. • UEC Governance and Oversight Framework, including Improvement Board, Oversight Group and executive accountability arrangements. • Performance and Risk Management Framework, incorporating UEC performance review, escalation and corrective action processes. • Patient Flow and Capacity Management Framework, including bed occupancy, discharge performance and flow metrics. • Real-Time Patient Safety and Harm Monitoring Framework, including oversight of prolonged ED waits, corridor care, escalation space utilisation and associated patient safety indicators. • Corporate Escalation and Operational Response Framework, supporting organisational oversight and response to capacity pressures. • UEC Performance Intelligence Framework, including routine reporting of escalation space utilisation, corridor care indicators and flow metrics through the Trust's governance arrangements. • Quality, Access and Performance Strategic Plan, providing the longer-term improvement framework for recovery to national standards.
System (n=4)	• System Urgent and Emergency Care Governance Framework, including system boards, executive groups and escalation arrangements. • System Flow, Discharge and Intermediate Care Framework, supporting delivery of discharge pathways and out-of-hospital capacity. • System Improvement Partnership Arrangements, including agreed recovery trajectories, shared performance objectives and joint improvement actions. • External Improvement and Assurance Support, including GIRFT and NHS England oversight and challenge arrangements.

Assurances Received and Rated –Quarter 1

Report Title	April	May	June
Access Performance Report & UEC Oversight Group Highlight Report	M12	M1	M2
Clinical Effectiveness Update			
Mortality Assurance Report			
Patient Experience Report	☒	☒	Q3
Patient Safety Incident Investigation Report		☒	Q4
Quality Performance Report	M12	M1 - NR	M2

Committee Assurance Assessment & Plan





BAF 9: Inability to Sustain Safe and Timely Urgent and Emergency Care Performance

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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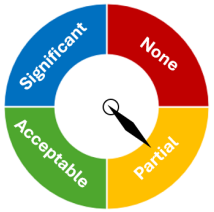
None	No confidence in delivery



Assurance is rated as partial as, whilst a comprehensive framework of controls and improvement programmes is in place, there remain gaps in the consistency of delivery of patient flow, discharge performance and system capacity. Sustained high demand, variability in Care Group implementation and reliance on system-wide solutions limit confidence in sustained improvement in the short term. There remains limited assurance regarding deliverability of the multi-year recovery trajectory, sustainability of improvements and the impact of prolonged waits on patient safety and outcomes.

Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=5)	• System step-up capacity pre-hospital is not consistently aligned with demand, resulting in patients attending the Trust who may be suitable for alternative pathways (Action 1). • Discharge processes are not consistently formalised as a core organisational control, including criteria-led discharge and early discharge standards, resulting in delays in patient flow and increased bed occupancy (Actions 3 and 5). • Internal patient flow processes are not consistently optimised across the pathway, including timely decision-making and movement between care settings, resulting in prolonged length of stay and ED congestion (Actions 2, 4 and 6). • Bed capacity and escalation management arrangements are not fully sufficient to meet sustained demand and acuity, resulting in continued reliance on escalation spaces and corridor care (Actions 4, 5 and 7). • System discharge capacity and pathway availability are not consistently aligned to demand, resulting in delays in patient discharge and reduced flow across the system (Actions 3 and 5).
Gaps in Assurance (n=5)	• Limited assurance regarding the deliverability of the multi-year UEC recovery trajectory, including confidence in achieving milestones and reducing risk exposure (Action 1 & 7) • Limited assurance regarding the sustainability of discharge performance and bed capacity, including the ability to maintain improvements over time (Action 2 & 3) • Limited assurance regarding optimisation and oversight of Emergency Department conversion rates and decision-making processes (Action 4) • Limited assurance regarding the impact of prolonged waits on patient safety and clinical outcomes, including corridor care and extended ED stays (Action 5 & 7) • Limited assurance regarding system capacity, including community and discharge pathways, to support timely patient flow and sustained performance improvement (Action 3 & 5)

Risk Management Action Plan

No	Action	Due Date	Progress Update	2026/27 Q1	Q2	Q3	Q4
1	Develop and implement pre-hospital admission avoidance and step-up pathways, including care home conveyance reduction, Call Before Convey, Silver Phone and direct access to SDEC where appropriate.	30/09/2026	Baseline analysis of care home conveyances, Call Before Convey activity and Silver Phone utilisation has been completed. Collaborative work with system partners is underway to reduce avoidable conveyances and develop alternative pathways, with opportunities for direct access to SDEC currently being evaluated				
2	Optimise Emergency Department front-door processes to improve early assessment, streaming, decision-making and admission avoidance.	30/09/2026	Improvement initiatives are underway, including implementation of RAT arrangements, development of enhanced triage processes, increased streaming to non-ED portals and strengthened senior decision-making processes. Workforce and pathway reviews are progressing to support sustainable reductions in conversion rates and improved patient flow.				
3	Standardise ward-based discharge and length of stay processes, including board rounds, early discharge standards, discharge lounge utilisation and stranded patient reviews.	30/09/2026	Work is underway to standardise board round processes and strengthen discharge management arrangements. Ward discharge trajectories have been agreed, with implementation of standard work and enhanced focus on pre-noon discharges planned from September 2026. Length of stay and delayed discharge reviews are being embedded into routine operational management processes.				
4	Strengthen bed movement, specialty escalation and internal flow arrangements to reduce delays, length of stay and reliance on escalation spaces.	31/10/2026	Work is progressing to improve specialty escalation processes, optimise patient movement and strengthen internal professional standards escalation arrangements. Development of escalation triggers and enhanced operational oversight arrangements is underway to support flow and reduce prolonged stays.				
5	Increase effective use of post-acute capacity, including discharge lounge utilisation and delivery of the purpose-built discharge lounge, to support timely patient discharge and flow.	31/10/2026	Improvements to current discharge lounge utilisation have been implemented. Final Business Case approval has been secured for the purpose-built discharge lounge, with the new facility planned to become operational in October 2026.				
6	Implement the County Hospital flow model, including bed movement, specialty input, timely escalation and non-verbal handover arrangements.	31/10/2026	Development of the County Hospital improvement model is underway, including strengthened escalation triggers, improvements to internal professional standards processes and implementation of non-verbal handover arrangements to support patient flow.				
7	Implement a UEC improvement assurance framework to monitor delivery against agreed milestones, early warning triggers, patient safety indicators and the multi-year recovery trajectory.	31/12/2026	Programme governance arrangements are in place, supported by defined workstreams, executive sponsorship and regular oversight. Work is underway to strengthen monitoring of key indicators, including ambulance handovers, decision-to-admit delays, discharge performance, prolonged waits and escalation triggers, to provide greater assurance regarding delivery of the recovery trajectory.				

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.

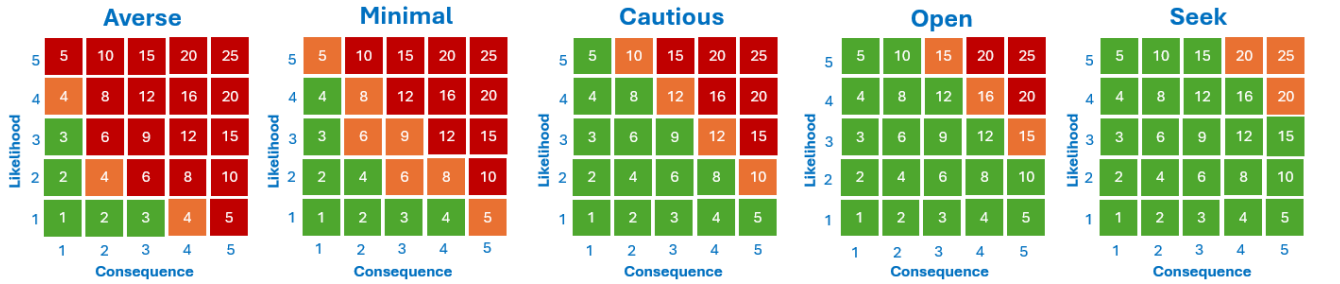
Financial Risk

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 (12 and Above) Quarter 1

ID	BAF Link	Opened	Title	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Risk Score (Target)	Division / Care Group
34791	1, 4	16/11/2024	Careflow Product Reliability and Availability	25				10	Central Functions Division
39469	1	02/03/2026	Timeliness of Endoscopy Incident Investigation and Duty of Candour Compliance	20				4	(CSS) Clinical Support Services CBU
34608	1, 3	01/12/2024	Trauma Floor 1:1 nursing assistant cost pressure	20				3	(PC) Specialised Surgery CBU
37400	1, 3	21/08/2025	Cardiac surgical service provision	20				3	(PC) Specialised Surgery CBU
21481	1, 3	28/06/2021	Reduced Breast service (Imaging), due to vacancy within Breast Radiologist workforce.	20				4	(CSS) Clinical Support Services CBU
39555	1, 3	08/03/2026	Radiology Reporting Backlogs	20				5	(CSS) Clinical Support Services CBU
40894	1, 3	01/07/2026	OG CNS Team Capacity and Workforce Demand	20				6	(PC) Surgery CBU
32545	1, 3	30/05/2024	Demand on our People Operations services is greater than our resource capacity.	20				9	Central Functions Division
39676	1, 3	13/03/2026	Clinical Perfusion - Lack of N+1 Out-of-Hours Provision	20				12	(PC) Specialised Surgery CBU
34619	1, 4	02/12/2024	Shadow IT and lack of system maintenance	20				5	Central Functions Division
9036	1, 4	25/10/2017	Vulnerability to Cyber Attack	20				12	Central Functions Division
25917	1, 5, 9	30/09/2022	Suitability of Cohort Area (Known as Ambulance Assessment 7 - 10)	20				2	(UPC) Urgent and Acute Care CBU
29374	5	15/08/2023	Uncontrolled and unsafe temperatures in minor operations room	20				4	(PC) Surgery CBU
21697	6, 7	07/07/2021	Shortfall against 25/26 CIP Plans - high risk £49.2 and medium risk £7.1m	20				8	Central Functions Division
36033	9	10/04/2025	Patient with Mental Health Conditions Absconding from ED (Both Sites)	20				5	(UPC) Urgent and Acute Care CBU
40453	1	20/05/2026	Urology typing demand & backlog	16				2	(PC) Surgery CBU
38160	1	29/10/2025	Loss of ACAH referral Hub	16				3	(CSS) Clinical Support Services CBU
17805	1	13/07/2020	Lung Nodule Management	16				4	(UPC) Medicine CBU
20448	1	17/03/2021	Patient LOS above 48 hrs on AMU - against Internal Standards	16				4	(UPC) Urgent and Acute Care CBU
25469	1	04/08/2022	Delivery of constitutional cancer quality standards	16				4	Surgical Division
25471	1	04/08/2022	Follow Up Delays	16				4	Surgical Division
26832	1	12/01/2023	Continuous Flow in Acute Medicine (Active Holding Areas)	16				4	(UPC) Urgent and Acute Care CBU
27156	1	07/02/2023	EMR/ESD Service - Lack of Operational Policy	16				4	(PC) Surgery CBU
30149	1	23/10/2023	AAA Time to Surgery	16				4	(PC) Surgery CBU
32807	1	19/06/2024	Head and Neck Cancer Delivery	16				4	(PC) Surgery CBU
33959	1	07/10/2024	Colorectal Cancer Position	16				4	(PC) Surgery CBU
36288	1	07/05/2025	Temporary NICU physiotherapy provision to end June 2025	16				4	(CSS) Clinical Support Services CBU
38404	1	19/11/2025	Pathology demand management and activity increase	16				4	North Midlands and Cheshire Pathology Service
38670	1	16/12/2025	Urology Cancer Position	16				4	(PC) Surgery CBU
8660	1	20/09/2017	Follow up back log (outpatient appointments)	16				6	(UPC) Medicine CBU
9738	1	05/02/2018	Nurse Training	16				6	(UPC) Urgent and Acute Care CBU
26887	1	18/01/2023	Ineffective Clinical Effectiveness Provision	16				6	Central Functions Division
32464	1	20/05/2024	Incorrect use of bedrails	16				6	Central Functions Division
34051	1	16/10/2024	Neurology Follow Up Backlogs	16				8	(UPC) Specialised Medicine CBU
37889	1	02/10/2025	Lack of flow out of Critical Care Unit	16				8	(PC) Surgical Support Services CBU
36860	1	24/06/2025	Inability to provide robust MRI service for scanning of patients with pacemakers	16				16	(CSS) Clinical Support Services CBU
37345	1, 3	12/08/2025	EAU Nurse Staffing	16				2	(UPC) Specialised Medicine CBU
29712	1, 3	14/09/2023	Neurophysiology Staff Shortages causing DMO1 breaches in Electromyography	16				4	(UPC) Specialised Medicine CBU
33720	1, 3	16/09/2024	AEC Nursing Workforce	16				4	(UPC) Urgent and Acute Care CBU

ID	BAF Link	Opened	Title	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Risk Score (Target)	Division / Care Group
34113	1, 3	23/10/2024	Quality, Safety and Compliance Resource - Imaging	16				4	(CSS) Clinical Support Services CBU
35274	1, 3	29/09/2025	Insufficient SLT workforce to meet clinical demand	16				4	(CSS) Clinical Support Services CBU
37497	1, 3	02/09/2025	SSDEC and SAU Staffing	16				4	(PC) Surgery CBU
37866	1, 3	30/09/2025	Insufficient workforce to deliver a safe dietetic service	16				4	(CSS) Clinical Support Services CBU
20626	1, 3	05/11/2020	Low staffing levels for Phlebotomy at Cheshire Sites	16				6	North Midlands and Cheshire Pathology Service
21591	1, 3	08/07/2021	Insufficient Clinical Staff to Support the NMCPS Microbiology Service	16				6	North Midlands and Cheshire Pathology Service
22969	1, 3	22/12/2021	Radiology Physics expert level staffing	16				6	(UPC) Specialised Medicine CBU
39804	1, 3	27/03/2026	Sarcoma Service Provision	16				6	(PC) Specialised Surgery CBU
34138	1, 3	24/10/2024	Workforce Information team's resource / capacity is significantly less than the current and growing demands on the service	16				8	Central Functions Division
10381	1, 3	27/04/2018	Medical Staffing - Haematology	16				9	(UPC) Specialised Medicine CBU
37230	1, 3	28/07/2025	Oncology Gynaecology Delays	16				9	(CSS) Women and Children's CBU
32806	1, 3	19/06/2024	Deficit in Neonatal AHP's provision for Speech & Language Therapy and Occupational Therapist support within NICU at UHNM	16				16	(CSS) Women and Children's CBU
36230	3	29/04/2025	Clinical Photography Workforce shortfall	16				4	(CSS) Clinical Support Services CBU
40370	3	14/05/2026	Insufficient number of in-date Clinical Holding Trainers within Planned Care CBU	16				6	(PC) Surgery CBU
40579	3	02/06/2026	Destabilisation of Staffing	16				8	(CSS) Clinical Support Services CBU
40248	4	05/05/2026	PACMAN Radiology Notifications Issues	16				1	(UPC) Urgent and Acute Care CBU
34158	4	18/10/2024	Admin Account Authorisation	16				4	Central Functions Division
37929	4	09/10/2025	Lack of ECG uploads to iportal	16				4	Central Functions Division
34277	4	06/11/2024	Need viable solution for redaction software for SARs and suitable available resource to act as data handlers	16				6	Central Functions Division
39235	4	11/02/2026	Risk of loss of function in Audiology due to PC issues	16				6	(PC) Surgery CBU
36963	5	04/07/2025	Weak Microsoft Authentication protocols many systems	16				4	Central Functions Division
37171	5	23/07/2025	China state-backed APT threats (HSA CareCert CC 4683)	16				4	Central Functions Division
37584	5	11/09/2025	Acute Care at Home Accommodation	16				4	(CSS) Clinical Support Services CBU
39775	5	24/03/2026	Lack of Media Facilities	16				4	Central Functions Division
32544	3, 6	30/05/2024	UHNM negotiations underway to upband & backpay all AfC B2 Healthcare Support Workers who have been delivering work at B3.	16				12	Central Functions Division
30986	8	11/01/2024	Centre for Research and Education Excellence (CeNREE) sustainability	16				6	Central Functions Division
17873	9	16/07/2020	Inability to Off-load Patients from Ambulances (both sites)	16				4	(UPC) Urgent and Acute Care CBU
24028	9	06/04/2022	Emergency Department Performance Standards not being achieved	16				6	(UPC) Urgent and Acute Care CBU
35094	3, 9	21/01/2025	Medical Staffing in ED Overnight & at Weekends	16				8	(UPC) Urgent and Acute Care CBU
36591	5, 9	21/05/2025	Fire Risk Royal Stoke Emergency Department due to Beds/Trolleys in corridors and circulation spaces	16				4	(UPC) Urgent and Acute Care CBU
32023	1	11/04/2024	Maternity Early Warning Scores not used for Maternity Patients outside of Maternity Dept	15				2	(CSS) Women and Children's CBU
38097	1	24/10/2025	Transition to NR Fit connectors for intrathecal procedures	15				3	(PC) Specialised Surgery CBU
31206	1	30/01/2024	Lack of therapy provision Ward 225 - Deconditioning of patients	15				4	(CSS) Clinical Support Services CBU
35516	1	26/02/2025	Endometriosis Backlog and Long Waits	15				4	(CSS) Women and Children's CBU
37896	1	02/10/2025	Triage of K2 maternity referrals	15				4	(CSS) Women and Children's CBU
27411	1	24/01/2023	ReSPECT	15				5	Central Functions Division
33109	1	16/07/2024	Audiology Waiting List Backlog	15				5	(PC) Surgery CBU
35342	1	10/02/2025	Process re: Non-Medical Prescribing	15				5	Central Functions Division

ID	BAF Link	Opened	Title	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Risk Score (Target)	Division / Care Group
18664	1	28/09/2020	Gynaecology 52 Week Long Waits	15				6	(CSS) Women and Children's CBU
35517	1	26/02/2025	Urogynae Backlog and Long Wait	15				6	(CSS) Women and Children's CBU
38937	1	14/01/2026	Complex nutritional patients lacking medical plan	15				6	(CSS) Clinical Support Services CBU
25177	1, 3	08/07/2022	TB Workforce & Screening Service	15				3	(UPC) Medicine CBU
40618	1, 3	04/06/2026	Acute Rehabilitation Workforce	15				4	(PC) Specialised Surgery CBU
19397	1, 3	21/12/2020	Impact of increased workload on service and Quality management system in Immunology	15				6	North Midlands and Cheshire Pathology Service
32486	1, 3	22/05/2024	Long Wait Patients in the Trauma Directorate	15				6	(PC) Specialised Surgery CBU
37397	3	20/08/2025	Management of Sexual Safety Cases	15				10	Central Functions Division
38893	1, 4	09/01/2026	Duplicate Clinical Narrative Discharge Summary Letters (DSL)	15				2	Central Functions Division
38948	4	15/01/2026	patient type being changed in CRIS automatically when the referral location is changed, unbeknownst to the user	15				4	(CSS) Clinical Support Services CBU
30476	4	20/11/2023	NHS Financial position and procurement of System Wide EPR	15				5	Central Functions Division
34869	4	24/12/2024	Technical Debt	15				5	Central Functions Division
37917	4	06/10/2025	Use of unsupported Windows 10 Operating System	15				5	Central Functions Division
20926	1, 5	30/04/2021	Emergency Department (Royal) Majors, Ambulatory & Children's Cubicle Doors	15				4	(UPC) Urgent and Acute Care CBU
38603	5	11/12/2025	Ambulatory Heart Failure Unit	15				4	(UPC) Specialised Medicine CBU
34188	6	29/10/2024	Non pay overspend - Histology send away activity	15				6	North Midlands and Cheshire Pathology Service
26808	9	09/01/2023	Holding Patients on the ED Corridor	15				4	(UPC) Urgent and Acute Care CBU
8901	1	05/12/2013	Ensure correct blood sample management	12				3	Central Functions Division
22518	1	29/10/2021	Cleanliness	12				3	Central Functions Division
24340	1	10/05/2022	Severe Asthma Service - impact once external funding ceases	12				3	(UPC) Medicine CBU
17470	1	12/06/2020	Compliance with NEWS and escalation (Royal)	12				4	(UPC) Urgent and Acute Care CBU
20181	1	26/02/2021	Overall medication management for Acute Med (Royal) - General Meds & CD's	12				4	(UPC) Urgent and Acute Care CBU
22934	1	15/12/2021	Lack of ECG Review/not following Chest Pain Process	12				4	(UPC) Urgent and Acute Care CBU
24025	1	06/04/2022	ILD Service - increased demand as a result of prescribing changes	12				4	(UPC) Medicine CBU
29052	1	10/07/2023	TB pharmacy dispensing out of Cobridge (service ceasing)	12				4	(UPC) Medicine CBU
29165	1	20/07/2023	Diabetic Pump Contracts	12				4	(CSS) Women and Children's CBU
32683	1	07/06/2024	Timely Reporting of Emergency MRI Results	12				4	(PC) Surgery CBU
34519	1	22/11/2024	Delivery of Gestational Diabetes GTT Clinics	12				4	Central Functions Division
35351	1	11/02/2025	Clinic over runs	12				4	Central Functions Division
35797	1	25/03/2025	ENT On Call Crosscover	12				4	(PC) Surgery CBU
36026	1	10/04/2025	Lack of Domestic Provision on AMRA & Short Stay for Timely Deep Cleaning	12				4	(UPC) Urgent and Acute Care CBU
36829	1	20/06/2025	Referral process for WET AMD patients	12				4	(PC) Surgery CBU
36859	1	24/06/2025	Inability to provide outpatient oral sedation service in MRI	12				4	(CSS) Clinical Support Services CBU
37225	1	31/07/2025	Inadequate governance processes in place for Homecare Medicines to manage supplier performance and patient safety/experience	12				4	(CSS) Clinical Support Services CBU
37521	1	04/09/2025	Stem Cell JACIE accreditation	12				4	(UPC) Specialised Medicine CBU
37892	1	02/10/2025	Lack of full 7 day cover from Occupational Therapy and Physiotherapy across all inpatient areas.	12				4	(CSS) Clinical Support Services CBU
38808	1	07/01/2026	Provision of GTT for pregnant women and birthing people	12				4	(CSS) Women and Children's CBU
38901	1	12/01/2026	Inadequate Dissemination of non clinical Time-Critical Information During Emergencies	12				4	Central Functions Division
39407	1	26/02/2026	Out of date EPAU guidelines, SOP's and PIL's	12				4	(CSS) Women and Children's CBU

ID	BAF Link	Opened	Title	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Risk Score (Target)	Division / Care Group
20435	1	16/03/2021	Paediatric Follow up Backlog	12				6	(CSS) Women and Children's CBU
27953	1	12/04/2023	Lack of provision for patients requiring DIEP surgery	12				6	(PC) Surgery CBU
31958	1	08/04/2024	MCHT Beckman Track & Stock yard (storage module)	12				6	North Midlands and Cheshire Pathology Service
32652	1	05/06/2024	Clinical Harm Review Process	12				6	Central Functions Division
33311	1	07/08/2024	Antenatal consultant clinic capacity	12				6	(CSS) Women and Children's CBU
34270	1	05/11/2024	Utilisation of Holistic Cancer Centre	12				6	(UPC) Specialised Medicine CBU
34325	1	11/11/2024	Incomplete Waiting list- 52 week position	12				6	(UPC) Specialised Medicine CBU
37816	1	26/09/2025	Patients outside of maternity services not being offered a Post Mortem for 12-16 week pregnancy loss	12				6	(CSS) Women and Children's CBU
8877	1	21/05/2012	Hospital Acquired Infections	12				8	Central Functions Division
17637	1	30/06/2020	Decline in cancer performance	12				8	(PC) Surgery CBU
30749	1	13/12/2023	Contact Lens/Low Visual Acuity (CL/LVA) Service Delivery	12				8	(PC) Surgery CBU
34789	1	02/12/2024	Corporate RTT (Referral to Treatment) Validation at UHNM	12				8	Central Functions Division
37887	1	02/10/2025	IPC concerns/issues	12				8	(PC) Surgical Support Services CBU
11415	1	20/08/2018	End of Life - Portable battery powered syringe pumps.	12				9	Central Functions Division
32740	1	12/06/2024	Expectation by NHSE of maintaining 80% utilisation of Staffordshire Virtual Wards	12				9	(CSS) Clinical Support Services CBU
29480	1, 3	30/08/2023	County and Ward 202 SACT Unit Staffing	12				2	(UPC) Specialised Medicine CBU
37660	1, 3	17/09/2025	Radiotherapy Staffing	12				2	(UPC) Specialised Medicine CBU
40609	1, 3	03/06/2026	Impact of radiology staffing shortfalls on breast cancer surgery performance	12				2	(PC) Surgery CBU
17967	1, 3	23/07/2020	Medical Cover Cardiothoracic ICU	12				3	(PC) Specialised Surgery CBU
37031	1, 3	10/07/2025	Stability of General Surgery Paediatric Service	12				3	(PC) Surgery CBU
38480	1, 3	28/11/2025	Deficit of 10.84WTE Band 5 Neonatal Nurses - BAPM TC Guidance	12				3	(CSS) Women and Children's CBU
8523	1, 3	01/09/2017	AMU Medical Workforce (both sites)	12				4	(UPC) Urgent and Acute Care CBU
20616	1, 3	01/08/2017	Insufficient Biomedical Scientific Staff Resource to Provide a Quality Haematology & Blood Transfusion Service at Macclesfield H	12				4	North Midlands and Cheshire Pathology Service
24837	1, 3	14/06/2022	Cystic Fibrosis workforce/service delivery	12				4	(UPC) Medicine CBU
25152	1, 3	06/07/2022	Insufficient trained staff in Pharmacy Technical Services to deliver aseptic products including chemotherapy to the Trust	12				4	(CSS) Clinical Support Services CBU
27071	1, 3	26/01/2023	NIV Service Workforce - Domiciliary service	12				4	(UPC) Medicine CBU
28944	1, 3	03/07/2023	Deficit in appropriate numbers in Skilled Neonatal Specialist Nurses.	12				4	(CSS) Women and Children's CBU
31429	1, 3	14/02/2024	Audiology Staffing	12				4	(PC) Surgery CBU
33539	1, 3	29/08/2024	Non Obstetric Ultrasound (NOUS) Performance - DM01 compliance	12				4	(CSS) Clinical Support Services CBU
33912	1, 3	01/10/2024	Anticoagulation Management Service staffing	12				4	North Midlands and Cheshire Pathology Service
34826	1, 3	13/12/2024	Child Health Rota remains a 1:7- The Tier 2 resident doctor cover does not meet service need.	12				4	(CSS) Women and Children's CBU
34960	1, 3	09/01/2025	AAA Screening Workforce - CST and Technicians	12				4	(PC) Surgery CBU
35328	1, 3	07/02/2025	Delivery of Lung Cancer Performance	12				4	(UPC) Medicine CBU
35330	1, 3	10/02/2025	County AMU nursing budget/establishment	12				4	(UPC) Urgent and Acute Care CBU
36825	1, 3	19/06/2025	Insufficient Homecare staffing to support continued patient growth and delivery of VAT cost-avoidance	12				4	(CSS) Clinical Support Services CBU
38447	1, 3	25/11/2025	Nursing workforce does not meet GPICS standards (Cardiothoracic ITU)	12				4	(PC) Surgical Support Services CBU
39470	1, 3	02/03/2026	Endoscopy Matron	12				4	(CSS) Clinical Support Services CBU
40085	1, 3	16/04/2026	Radiotherapy Vacancies	12				4	(UPC) Specialised Medicine CBU

ID	BAF Link	Opened	Title	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Risk Score (Target)	Division / Care Group
40226	1, 3	30/04/2026	Long term sickness in the paediatric orthopaedic CNS team	12				4	(PC) Specialised Surgery CBU
11294	1, 3	31/07/2018	NMCPS Pathology Histology Medical Capacity - dissection & reporting(achieving TAT)	12				6	North Midlands and Cheshire Pathology Service
24818	1, 3	13/06/2022	RSUH/CH Biochemistry Staffing and Shift Cover	12				6	North Midlands and Cheshire Pathology Service
29508	1, 3	01/09/2023	Inability to deliver hybrid closed loop pumps to type 1 diabetes patients	12				6	(UPC) Medicine CBU
32408	1, 3	14/05/2024	Clinical Perfusion- Inadequate Establishment & Staff Shortages	12				6	(PC) Specialised Surgery CBU
34265	1, 3	04/11/2024	Lipid clinic provision	12				6	North Midlands and Cheshire Pathology Service
34410	1, 3	18/11/2024	Early Pregnancy Assessment Unit (EPAU) sustainability of services	12				6	(CSS) Women and Children's CBU
35057	1, 3	17/01/2025	Inadequate Pharmacy Staffing to Emergency Departments	12				6	(CSS) Clinical Support Services CBU
36962	1, 3	04/07/2025	Therapies provision to SSCU patients	12				6	(PC) Surgical Support Services CBU
38908	1, 3	13/01/2026	Cardiac Assessment Nurse workforce issues	12				6	(UPC) Specialised Medicine CBU
25628	1, 3	01/09/2022	Ophthalmology Service Delivery	12				8	(PC) Surgery CBU
32891	1, 3	25/06/2024	Monitoring of None MS Toxic Drugs	12				9	(UPC) Specialised Medicine CBU
27153	1, 3	07/02/2023	QI Academy Staffing under-resourced to deliver sustainable change	12				12	Central Functions Division
8580	1, 3, 9	26/06/2019	(CQC) Medical staffing for the Emergency Department (both sites)	12				3	(UPC) Urgent and Acute Care CBU
25228	3, 9	12/07/2022	Nurse Staffing CED	12				4	(UPC) Urgent and Acute Care CBU
35847	3, 9	31/03/2025	Lack of Pharmacy for ED Department	12				4	(UPC) Urgent and Acute Care CBU
39222	3	10/02/2026	Reduced availability of Clinical Support Workers across Specialised Surgery CBU	12				3	(PC) Specialised Surgery CBU
33184	3	24/07/2024	Inability to provide timely management of Freedom to Speak Up Cases	12				4	Central Functions Division
37600	3	15/09/2025	Admin and Clerical Vacancies - Trauma Directorate	12				4	(PC) Specialised Surgery CBU
40225	3	01/04/2026	Admin & Clerical Team - Cardiac & Thoracic Surgery	12				4	(PC) Specialised Surgery CBU
32500	3	22/05/2024	TI Rates	12				6	Central Functions Division
39111	3	30/01/2026	Health and Safety Team Capacity	12				8	Central Functions Division
31987	3	09/04/2024	UK Visas and Immigration rules (legal migration rules)	12				12	Central Functions Division
26168	3, 4	26/10/2022	Pathology IT System Expertise and Capacity	12				6	North Midlands and Cheshire Pathology Service
34965	1, 4	10/01/2025	No MFA for Winpath Enterprise (LIMS)	12				2	North Midlands and Cheshire Pathology Service
38707	1, 4	19/12/2025	Safe storage of ITU Charts on CDs	12				2	(CSS) Women and Children's CBU
23759	1, 4	14/03/2022	Inappropriate clinical decisions due to large number of digital systems in place	12				4	Central Functions Division
25682	1, 4	05/09/2022	(CQC) Unstructured records Management	12				4	Central Functions Division
28354	1, 4	23/05/2023	Blood Analyser Lantronix UDS box	12				4	North Midlands and Cheshire Pathology Service
30477	1, 4	20/11/2023	Lack of records retention in line with Code of Practice	12				4	Central Functions Division
32033	1, 4	12/04/2024	AAA Screening operational charges and access	12				4	(PC) Surgery CBU
34580	1, 4	27/11/2024	CIM Hold and Error Queue Management	12				4	North Midlands and Cheshire Pathology Service
39112	1, 4	30/01/2026	K2 not in line with updated NICE guidance for intrapartum CTG classification	12				4	(CSS) Women and Children's CBU
34582	1, 4	27/11/2024	CIM Failovers	12				6	North Midlands and Cheshire Pathology Service
34594	1, 4	28/11/2024	Illegal Characters in SampleNet	12				6	North Midlands and Cheshire Pathology Service

ID	BAF Link	Opened	Title	Q1 Risk Score	Q2 Risk Score	Q3 Risk Score	Q4 Risk Score	Risk Score (Target)	Division / Care Group
34595	1, 4	28/11/2024	SampleNet Is Unable to Handle Time Changes	12				6	North Midlands and Cheshire Pathology Service
32551	1, 4	31/05/2024	Operational risk associated with the Pharmacy robot replacement	12				8	(CSS) Clinical Support Services CBU
37546	4	08/09/2025	Potential compromise of confidential information using Microsoft Copilot (free version)	12				1	Central Functions Division
40310	4	11/05/2026	Use of unauthorised AI Solution	12				3	Central Functions Division
8849	4	13/10/2017	Inappropriate use of mobile devices for work purposes	12				4	Central Functions Division
21784	4	06/08/2021	(CQC) Confidentiality, Integrity and Availability of Trust Information	12				4	Central Functions Division
33518	4	29/08/2024	Proactive audit & monitoring of patient record systems	12				4	Central Functions Division
35090	4	21/01/2025	Rapid AI Linux OS Out of support	12				4	(CSS) Clinical Support Services CBU
37662	4	17/09/2025	CVE - Cardiology PACS utilising ESXI 6.7 on VM's	12				4	(UPC) Specialised Medicine CBU
38343	4	14/11/2025	Aged assets that are end of life and out of support	12				4	Central Functions Division
38900	4	12/01/2026	Notification health record scanning solution will no longer be supported by the Supplier	12				4	Central Functions Division
39282	4	13/02/2026	Malware affecting backups impacting restoration	12				4	Central Functions Division
38981	4	16/01/2026	[CSC Clinical Narrative] Erroneous Clinical Information in Clinical Discharge Summaries	12				6	Central Functions Division
31185	4, 5	29/01/2024	DataCentre Air Conditioning EOL - Unfit for Purpose	12				4	Central Functions Division
32119	4, 5	21/04/2024	Insufficient storage capacity for IM&T goods in Digital Hub	12				4	Central Functions Division
35039	1, 5	17/01/2025	Pharmacy Cancer walk-in cold store Ward 202 performance and capacity	12				2	(CSS) Clinical Support Services CBU
28684	1, 5	14/06/2023	Lack of Clean Utility Room - Children's High Dependency	12				6	(CSS) Women and Children's CBU
37581	1, 5	11/09/2025	County MR1 Chiller Replacement	12				6	(CSS) Clinical Support Services CBU
38397	1, 5	18/11/2025	Reduction of MRI capacity as a result of scanner replacement programmes	12				6	(CSS) Clinical Support Services CBU
39050	5	23/01/2026	Cath Lab Pre Assessment Room	12				3	(UPC) Specialised Medicine CBU
28802	5	23/06/2023	Insufficient hub space and clinical room capacity for community midwifery teams	12				4	(CSS) Women and Children's CBU
29213	5	28/07/2023	ECT Cooper Building roof leaks	12				4	North Midlands and Cheshire Pathology Service
30237	5	04/09/2023	PFI latent defects	12				4	Estates, Facilities and PFI
30787	5	14/12/2023	Histology Consultant Office Accommodation	12				4	North Midlands and Cheshire Pathology Service
37358	5	14/08/2025	Fire and smoke spread in the Trent Building upper floor as a result of bin storage on the Hospital Street	12				4	Estates, Facilities and PFI
37840	5	30/09/2025	Lack of Audible Emergency Alarms in STS (Phase 2)	12				4	(PC) Surgical Support Services CBU
38804	5	06/01/2026	insufficient ultrasound scanning rooms	12				4	(CSS) Women and Children's CBU
39783	5	25/03/2026	Inadequate alarm system within therapies outpatient department at County	12				4	(CSS) Clinical Support Services CBU
25353	5	21/07/2022	Sale of RI and COPD Land later than NHSE funding requirement of 24/25	12				6	Central Functions Division
34099	5	21/10/2024	County Vertical Fire Compartmentation	12				6	Estates, Facilities and PFI
37357	5	14/08/2025	Fire and Smoke spread from the Holistic Care Centre to the Cancer Centre	12				6	Estates, Facilities and PFI
34299	1, 6	07/11/2024	Teenage & Young Adults Cancer Service	12				3	(UPC) Specialised Medicine CBU
32463	1, 6, 7	16/05/2024	Risk of not achieving £8.5 million contribution to County Elective Hub	12				3	(PC) Specialised Surgery CBU

Executive Summary

Trust Board (Part 1) | 12th August 2026

UEC Improvement Journey

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		
BAF 9	Inability to sustain safe and timely urgent and emergency care performance	**Ext 20**

Executive Summary

Situation

This paper updates Board members on the position regarding UEC pressures and ambulance handover and covers the Trust's improvement programme. This includes data up to the latest reported week at the time of writing, ending 19th July 2026. We remain in Tier 1 for national oversight of our UEC position. During the reporting period, we experienced critical incidents, firstly following the heatwave and secondly due to a digital outage.

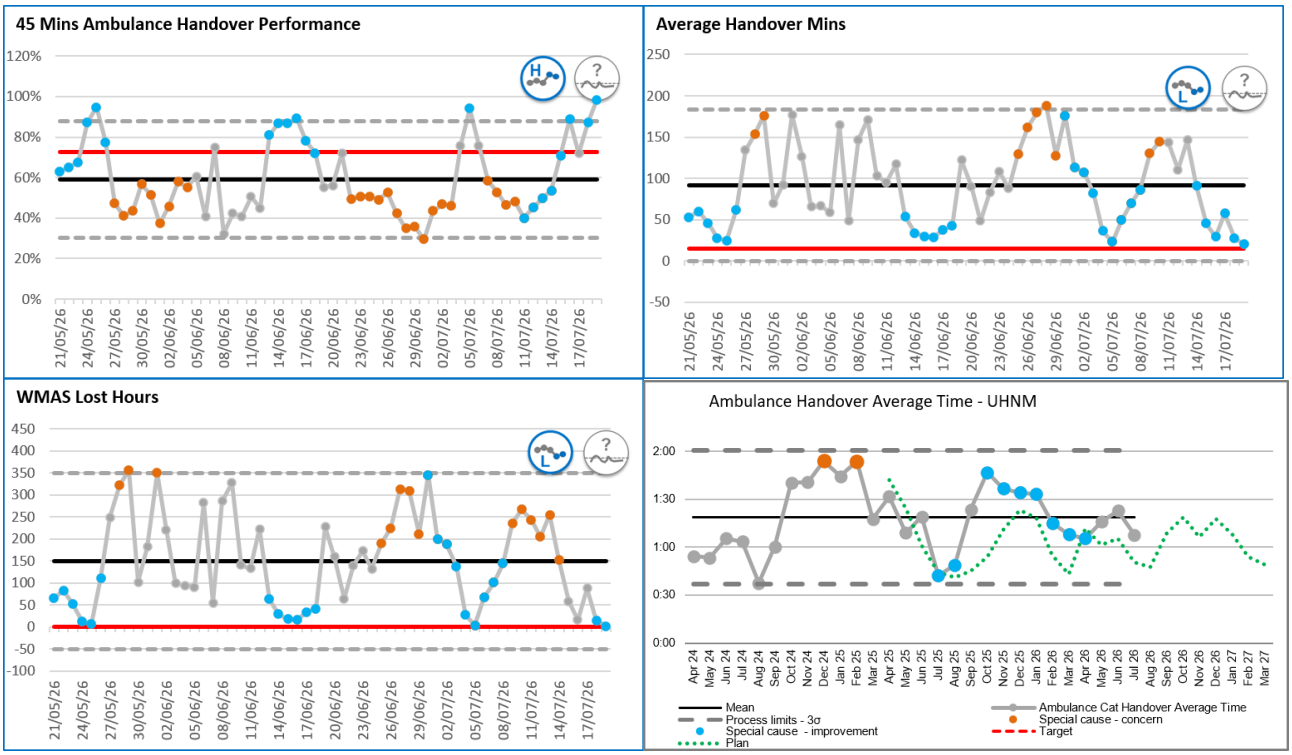
UHNM's UEC improvement data shows that ambulance handover delays continue to be driven by internal flow rather than attendances, as attendances remain broadly flat without significant variation. We see minimal correlation between overall ED attendances and handover performance; some of our busiest days have delivered strong handover compliance. The most consistent improvement occurs when we create early bed capacity. On days when we see a higher percentage of discharges before midday and 4pm, and occupancy falls below 93% by early afternoon, we achieve:

- faster CRTP (patients who are Clinically Ready to Proceed) movement
- ED time reduces from 8-9 hours to around 7-8 hours, and
- c.12 percentage-point improvement in <45-minute handovers.

The evidence remains clear: when we get flow right early in the day, performance improves across the whole UEC pathway, including ambulance handovers, ED 4-hour performance and patient experience. Our programme focuses on making these flow-enabling behaviours routine every day. We have also identified further work required on our criteria to admit patients, as benchmarked data shows that our admission rate is higher than that of similar organisations.

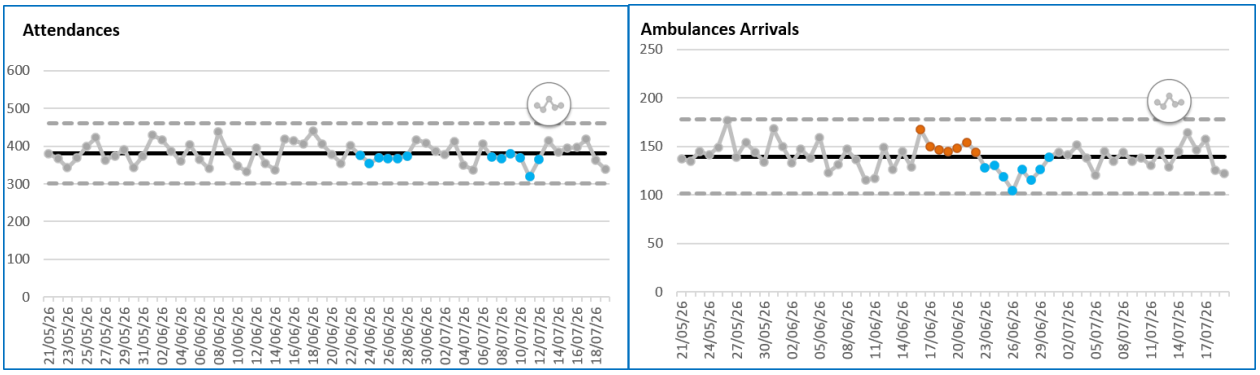
Although overall performance has not yet reached the desired standard for our patients, we have observed steady progress in the effectiveness of our UEC pathway, indicating that further improvement is achievable. There is no single solution; however, ongoing and sustained efforts through the UEC improvement programme are facilitating positive change. While we saw a deterioration in our improvement journey during May and June, this had returned to being broadly on track by mid-July, although slightly behind plan. The deterioration in June coincided with a significant period of heat, which increased decisions to admit, reduced discharges before 4pm and had a significant impact on the operational running of the hospital, leading to multiple business continuity plans being enacted.

Ambulance Handover



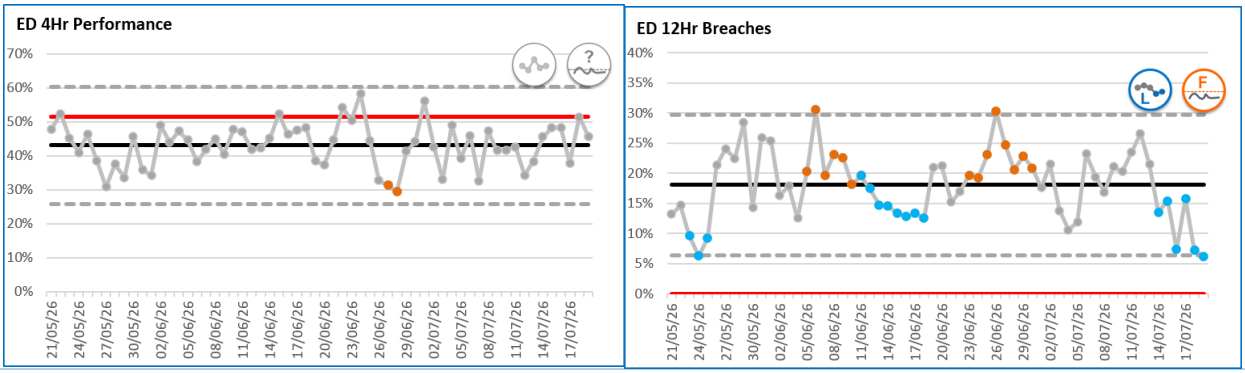
We continue to see variation in ambulance handover on a day-to-day basis; however, we are seeing statistically significant improvement following a period of normal variation.

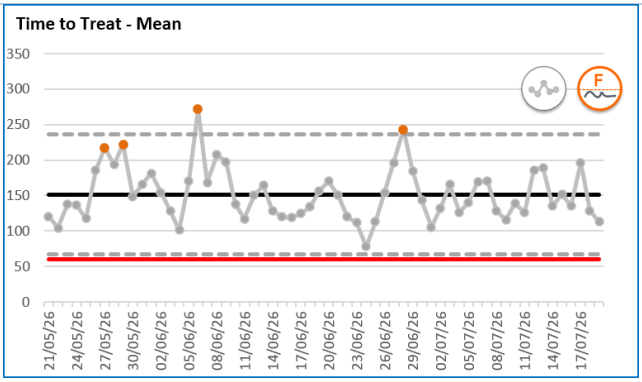
Attendances



Attendances overall remain without variation; however, ambulance attendances are down. This is not affecting the total number of patients to be treated.

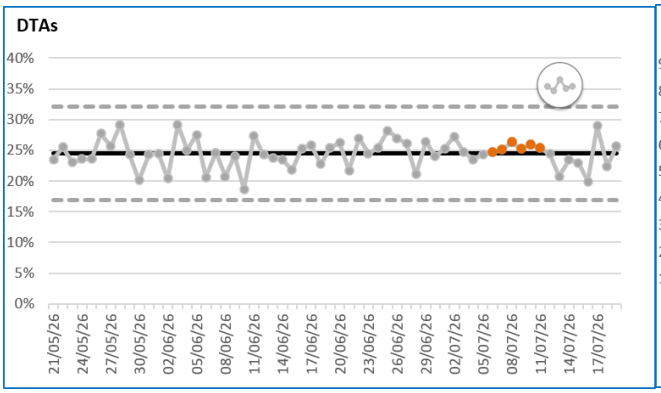
Time in the Emergency Department

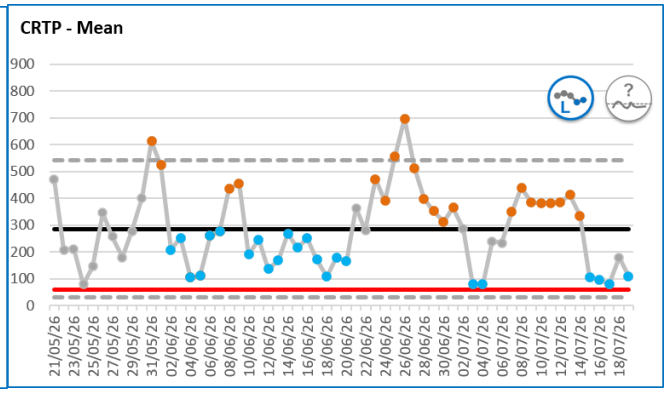




We continue to see variation in time to treatment on a day-to-day basis. However, we are seeing a slight improvement in 4-hour performance, and 12-hour performance is starting to show statistically significant improvement.

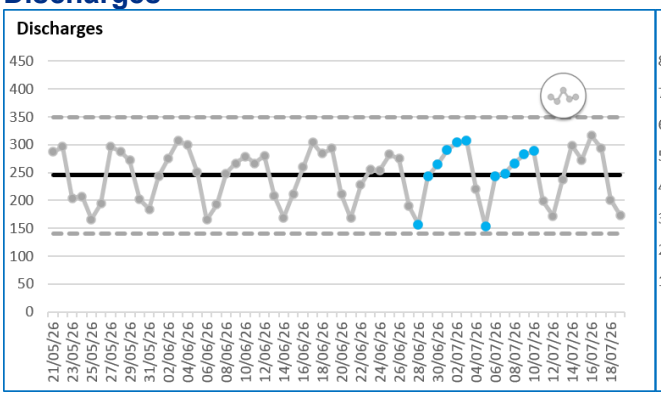
Decision to Admit and Clinically Ready to Proceed

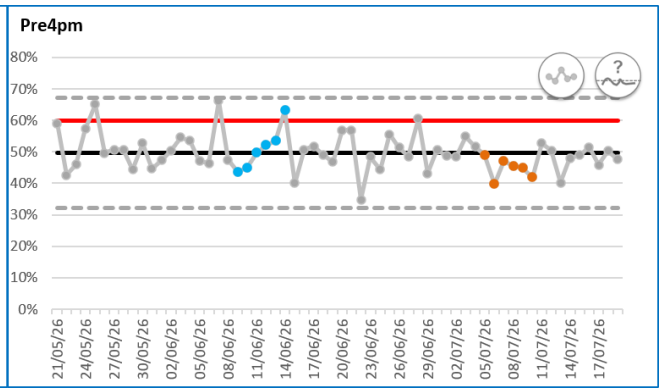




We have seen variation in both patients with a decision to admit and those who are clinically ready to proceed.

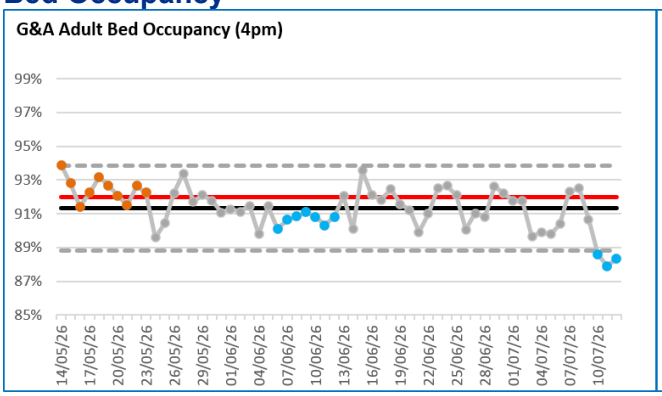
Discharges

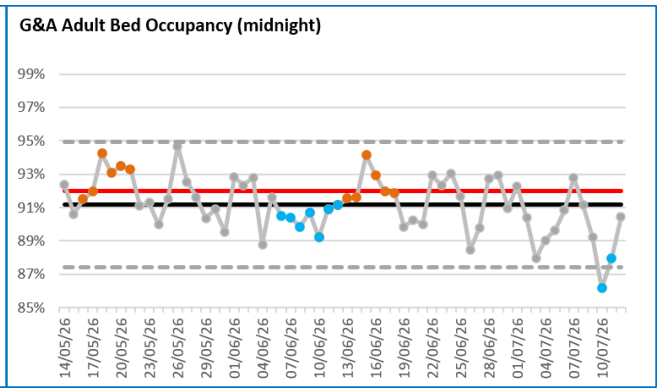




We continue to see variation in discharge on a day-to-day basis; however, when viewed alongside the monthly figures, we are seeing signs of improvement in bringing discharge earlier in the day.

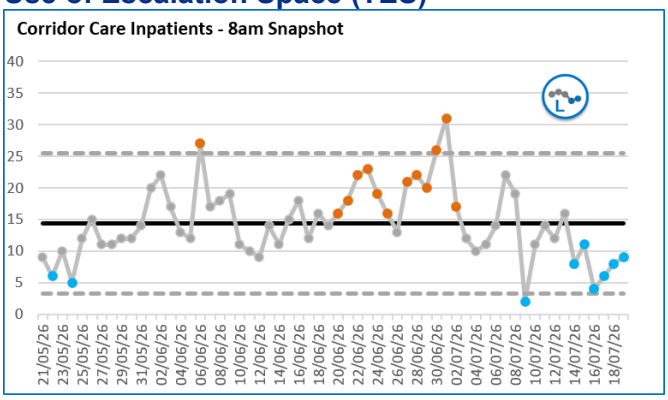
Bed Occupancy





Bed occupancy has seen a reduction

Use of Escalation Space (TES)

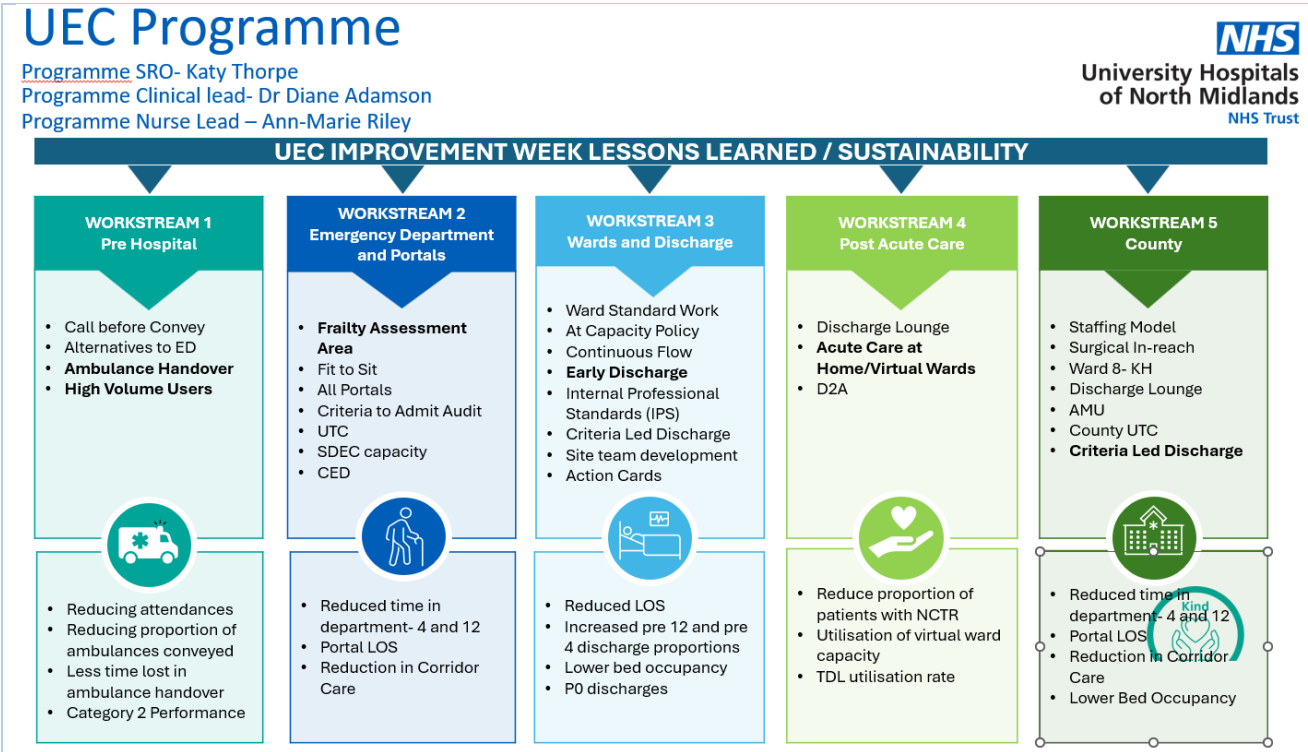


We continue to use escalation space in both ward and ED areas. This is audited on a daily basis, reported through Quality Committee and is showing some signs of reduction.

UEC Transformation Programme

Our UEC improvement plan is now in place following the visits in January 2025, when we invited the NHSE national team to support a review of our UEC pathways. Oversight is being monitored through our UEC Recovery and Oversight Meeting and is now supported by the UEC GIRFT team.

The final version of the programme is outlined below and has a weekly cadence to ensure it remains agile and focused on improvement work. The workstreams are outlined below, with the areas of intense work that are the highest priority for immediate change shown in bold.



We recently received a visit from the wider GIRFT team to check and challenge our programme and its leadership. The feedback was positive: “It felt like there has been a real shift and an increasing sense of positivity about what can be achieved.
It was very pleasing to see an absence of the corridor care or ambulances stacking outside the ED department that we have observed on previous visits.”

During the visit, they saw the exponential increase in patients using the discharge lounge, as well as the positivity and enthusiasm from staff on the unit. They also visited the Frailty Unit, “who couldn’t have been more passionate, committed and patient-focused. This gives us confidence about the positive impact that the estate changes, with an expanded Frailty footprint moved to the front door, will make with regard to flow and patient care.”

This forms part of a move to bring together the acute portals at the front door, which is scheduled for the end of August.

Conclusion

The report indicates that, although current performance remains below our expected standard for patient care, there are encouraging signs of continued improvement.

Tactical actions are taking place to mitigate patient risk while the full UEC programme is underway. Royal Stoke’s UEC data indicates that ambulance handover delays are mainly caused by internal flow issues, as attendances remain relatively stable. There is little correlation between ED attendances and handover performance; even on busy days, strong compliance can be achieved. Early bed capacity consistently improves results.

Key Recommendations

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

UEC Improvement Programme Quadrant Report – Summary of Programme
Month July 2026

University Hospitals of North Midlands NHS Trust

Exec Sponsor	Corporate Sponsor	Clinical Lead
Katy Thorpe	Mike Goodwin	Dr Di Adamson / Anne-Marie Riley

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

UTC Go-live: delayed to early September 2026 due to construction dependencies and workforce recruitment challenges
Workforce: Continued pressures across urgent and emergency care pathways affecting delivery pace
Data quality, reporting alignment and information-sharing arrangements remain under development across organisations
System-wide Senior Decision Maker (SDM): arrangement and operational ownership still require agreement
Discharge Lounge expansion, AC@H developments and pathway changes remain dependent on business cases, ICT and operational support
Ongoing pressures on **ambulance handovers, ED flow, frailty capacity and virtual ward utilisation**

KEY PERFORMANCE MEASURE(S)

National UEC standards: ED 4hr performance, 12hr waits, ambulance handover delays (>45mins)
Front door & flow: IPS, ED throughput, portal LoS, corridor care reduction
Admission Avoidance: ICC activity, Ac@H/UCR/Virtual ward utilisations, silver phone outcomes
Discharge & LoS: Pre-noon discharges (target 60/day), pathway 0 discharges, length of stay
Post-acute & system flow: D2A performance, discharge lounge utilisation, bed occupancy, post-acute capacity
HRD-enabled discharge outcomes: 67% or patients discharged home within 7 days

(Note: some workstreams still finalising KPI frameworks and data reporting)

KEY ACHIEVEMENTS and ESCALATIONS

Governance established across all five workstreams with programme delivery on track
GIRFT UEC recommendations embedded and improvement plans actively progressing
Head Injury SOP implemented with AC@H and admission avoidance pathways expanded
Model Ward approach implemented to improve discharge and reduce Length of Stay
Discharge Lounge Phase 2 design approved and discharge pending model progressing
County governance and strategic priorities established with UTC programme mobilised
Palliative Care funding secured and HRD MDT pilot launched

ACTIONS and MILESTONES FOR NEXT PERIOD

August
- Finalise and implement the ICC Senior Decision Maker model
- Continue ED/SDEC redesign and recruitment to key clinical posts
- Progress discharge improvement work, PDSA cycles and model ward implementation
- Complete data-sharing agreements and strengthen programme reporting and KPI frameworks

September
- Expand Silver Phone and Cre Home pathways across the system
- Complete UTC mobilisation and prepare for go live (7th September)
- Embed continuous flow, admission avoidance and post-acute care pathways across all sites

October
- Launch Discharge Loung Phase 2 and discharge pending model

Executive Summary

Trust Board | 12th August 2026

NHS England Board Assurance Statement: Mortuary Oversight and Post-Death Care

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**	✓	**Approval**		**Assurance**		**Agenda Item:**
Author:	Angus McGregor, Medical Director, NMCPS						
Executive Lead:	Di 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		

Executive Summary

Situation

On 26 June 2026, NHS England issued a letter to all NHS provider trusts requiring Boards to review and assure themselves of the effectiveness of local arrangements relating to mortuary oversight, post-death care, safeguarding, and implementation of the recommendations arising from the David Fuller Inquiry and findings of the Nottingham Maternity Review. Trusts were required to submit a signed Board Assurance Statement to NHS England by 31 July 2026. Due to the national submission deadline falling ahead of the next scheduled Board meeting, the Trust's Board Assurance Statement was approved via a virtual Trust Board process and submitted to NHS England by the required deadline.

Background

The NHS England request sought formal Board assurance that appropriate governance, safeguarding, oversight and assurance arrangements are in place for mortuary services and the care of deceased patients. Trusts were required to confirm compliance against a number of national assurance statements, including oversight of the 29 NHS-relevant recommendations from the Fuller Inquiry, executive accountability for safeguarding arrangements relating to deceased patients, robust governance arrangements for mortuary services, and plans to complete the NHS Premises Assurance Model assessment.

Assessment

The Trust submitted a completed Board Assurance Statement confirming compliance with all required assurance statements. The submission highlighted the role of the Human Tissue Authority (HTA) governance arrangements, including the established HTA Committee, ongoing oversight of the Fuller Inquiry action plan, executive safeguarding leadership, and continued monitoring through relevant Trust and joint governance structures. The submission also confirmed that arrangements are in place to complete and submit the NHS Premises Assurance Model assessment within the national timeframe.

Key Recommendations

The Trust Board is asked to note that the Board Assurance Statement relating to mortuary oversight and post-death care was approved through a virtual Board process and submitted to NHS England on 31 July 2026 in accordance with the national deadline, and to endorse the action taken on behalf of the Board.

TASK59437 Board Assurance Statement for NHS Provider Trusts

Trust Name	Trust CEO/AO name	Date	Trust Chair Name	Date
University Hospitals of North Midlands NHS Trust	Simon Constable	31st July 2026	Jacqueline Small	31st July 2026

Assurance statement	Confirmed (yes/no)	Additional comments or qualifications (optional)
The roles and responsibilities between the relevant teams responsible for mortuary care, including estates, safeguarding, pathology, bereavement, mortuary and corporate services, are clear, understood and are tested on a regular basis.	Yes	There is an established HTA committee that meets quarterly (membership which includes bereavement, pathology, mortuary and governance representatives). The HTA terms of reference will be adapted to explicitly cover the Fuller Inquiry and Nottingham Ockenden actions and its membership will be extended to include estates and safeguarding representatives. Assurance available: 1. HTA terms of reference 2. HTA Committee minutes and Quarterly Assurance Report 3. HTA slide pack presented to NMCPS Board July 2026
The Board has undertaken a review of progress against the 29 recommendations immediately relevant to the NHS as made by the Fuller Inquiry. Where the Trust is not fully meeting a specific recommendation, a time-limited action plan is in place to close any gaps.	Yes	A gap analysis was carried out following the Fuller Inquiry Reports and associated recommendations, with a paper and action log / plan discussed at Quality, Access and Outcomes Committee (QAOC) on 2nd April 2026. This identified the gaps across 4 mortuaries that sit under NMCPS. A further update is to be provided to the QAOC in October 2026 to provide an update on progress against the Fuller action plan and any work outstanding. Assurance available: 1. Fuller assurance paper presented to UHNM QAOC 2. Fuller action plan 3. Fuller Inquiry gap analysis presented at NMCPS Board in February and July 2026 showing significant progress in that period.
In line with updates to the NHS Safeguarding Accountability and Assurance Framework, executive leadership has been reviewed with clear oversight of arrangements for the safeguarding of people after they die.	Yes	The Chief Nurse and Safeguarding lead for the Trust are aware of their responsibility of their duty of safeguarding deceased patients stored within UHNM mortuaries/sites - mortuary quality checks are included in their audit, in line with the updated framework. Assurance provided by: 1. UHNM Safeguarding team link with HTA Committee
The Board can assure itself the organisation has a plan in place to ensure the effective oversight of matters relating to mortuaries, related storage areas (or wider facilities) where the deceased are cared for, including the correct information and governance arrangements. If it cannot, it has identified the actions necessary to address this and a plan is in place to implement them as a matter of urgency.	Yes	Assurance is provided via HTA committee minutes (quarterly) and Fuller Inquiry Assurance Paper considered by Quality, Access and Outcomes on 2nd April 2026. a further update paper is to be provided to QAOC in October 2026. Assurance provided by: 1. HTA Terms of reference 2. HTA Committee minutes 3. Fuller assurance report presented to QAOC 4. Fuller action plan managed through the UHNM HTA committee
For all issues related to estates, there is an agreed timeline in place to undertake a self-assessment against the latest version of the NHS Premises Assurance Model and submit data within the current window (closing 8 September 2026), ensuring that your plan includes PAM sign-off from your Board prior to submission.	Yes	An agreed programme is in place to complete and submit the 2026 NHS Premises Assurance Model return by the national deadline of 8 September 2026 for UHNM. The assessment is currently undergoing detailed review and validation in light of changes to the assessment criteria. Board oversight is provided through the Finance and Business Performance Committee, which will receive an update on the key findings and any significant issues arising from the assessment prior to submission at its meeting on 3rd September. Leighton and Macclesfield Hospitals will submit their PAM reports, with input from the mortuary manager (there are 3 separate HTA licences that cover the 4 NMCPS mortuaries). Assurance provided by: 1. UHNM Estates team link with HTA Committee

Executive Summary

Trust Board (Part 1) | 12th August 2026

UHNM Response to the Mann Review

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**	✓	**Approval**		**Assurance**		**Agenda Item:**	12.
Author:	Charlotte Lees, OD, Culture and Inclusion Business Partner							
Executive Lead:	Jane Haire, Chief People Officer / 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		
BAF3	Inability to Improve Workforce Sustainability & Organisational Culture	**Ext 15**

Executive Summary

Situation

The Mann Review was published in June 2026. The review examined how the NHS and its regulatory bodies recognise, report, investigate and respond to antisemitism and other forms of racism. In summary the review found that:

- Antisemitism and racism are widespread and, in some cases, normalised across NHS settings.
- Staff from black and minority ethnic backgrounds, and Jewish staff, are more likely to experience discrimination from colleagues, managers and the public.
- Some patients report lower levels of trust and confidence, with concerns about discrimination affecting access to care.
- Organisational responses are inconsistent, with variation in leadership, culture and practice across the NHS.
- Current arrangements for reporting and investigating racism are not always clear, consistent or effective.

The review calls for a "system-wide reset" with stronger leadership, greater accountability and culture change. The review makes a comprehensive set of 36 recommendations. The UK Government accepted all recommendations in full and has committed to acting on the findings and monitoring progress. Key actions include:

- Reporting progress to Parliament, with an initial update in October 2026.
- Introducing new NHS staff standards, including a focus on tackling racism.
- Strengthening accountability through the NHS Oversight Framework (NOF).
- Progressing regulatory reform, including changes to fitness-to-practise processes.

Background

The review was commissioned in response to:

- A rise in antisemitism and wider racism in society
- Reports of discrimination affecting NHS staff and patients including staff reporting they were considering leaving the NHS due to racism and patients sometimes avoiding treatment due to fear of discrimination
- Concerns that existing NHS systems were not effectively identifying or addressing racist incidents

Assessment - What the Mann Review means for UHNM:

The review reinforces that tackling antisemitism, and racism is a core leadership, workforce and patient safety responsibility. UHNM, and all other NHS organisations will need to:

- Take ownership of addressing racism locally, acting early and decisively, and embedding an understanding that antisemitism is a form of racism.
- Provide clear leadership and consistent organisational responses.
- Embed established anti-racism principles into organisational culture and practice, including consideration of nationally recognised definitions and frameworks relating to antisemitism, anti-Muslim hostility and wider anti-racist practice, whilst taking account of any further national guidance issued by NHS England, DHSC and relevant regulators
- Strengthen governance, including board oversight and assurance.
- Use data to identify inequalities and drive improvement.

- Ensure reporting and investigation processes are fair, timely and trusted. Investigations must be rooted in safeguarding principles and in line with the Macpherson principle that all complaints about incidents of racism should be recorded and investigated as such.
- Take a more proactive and preventative approach, rather than relying on escalation to regulators.

Any local policies, guidance, training or reporting arrangements developed in response to the Mann Review will continue to be applied fairly, proportionately and in accordance with employment law, equality legislation and national NHS guidance.

UHNM has an established Race Equality Task and Finish Group to lead and co-ordinate the Trust's response to persistent racial inequalities experienced by colleagues. The Group is focused on three priority areas identified through Workforce Race Equality Standard (WRES) data, where disparities remain most significant and sustained: recruitment outcomes, career progression, and the experience of harassment, bullying and racism at work.

The Trust Board can take assurance that a number of the areas highlighted within the Mann Review are already being addressed through existing workstreams. However, the review also highlights further opportunities to strengthen organisational arrangements, governance, accountability and culture, and to accelerate improvements in workforce and patient experience.

There is recognition of the continued presence and impact of racism within the organisation, although the intended outcomes for colleagues have not yet been fully realised. Whilst UHNM has participated in the Workforce Race Equality Standard (WRES) for over a decade, the majority of key workforce indicators show limited improvement, indicating that the intended impact of current interventions has not yet been fully realised. Progress will be monitored through Workforce Race Equality Standard indicators, NHS Staff Survey results, colleague experience measures and other relevant workforce and patient equality indicators to ensure improvements can be evidenced over time.

However, there is a clear opportunity to strengthen assurance and accelerate progress through the implementation of the Mann Review recommendations and the work of the UHNM Race Equality Task and Finish Group. Together, these programmes provide a robust framework for embedding anti-racism as an organisational priority, driving sustainable cultural change, improving the lived experience of colleagues, and ultimately delivering more equitable outcomes for both our workforce and patients.

Key Recommendations

The Trust Board is asked to note the following recommendations accepted by the Trust Executive Management Team.

1. Accept the Mann Review recommendations and note what these mean for UHNM and other NHS organisations.
2. Adopt a clear zero-tolerance position towards racism, supported by robust reporting, investigation and accountability arrangements.
3. Revise accountability and assurance reporting to provide active Board oversight and strengthen the senior leadership membership of the Task and Finish Group, enhancing this to a formal Steering Group.
4. Approve the Anti-Racism Statement, racism incident guidance and proposed Anti-Racism Policy, recognising that these will remain subject to review in light of future national guidance, legal developments and learning from implementation.
5. Update current statutory and mandatory Equality, Diversity and Inclusion training to reflect the antisemitism and anti-Muslim hostility definitions, while awaiting further guidance and requirements from NHS England.
6. Roll out local anti-racism training, co-ordinated by the corporate nursing team, and arrange an anti-racism session with the Trust Board.
7. Implement appropriate objectives for senior leadership on anti-racism.
8. Develop a communications strategy that explains to all colleagues and patients why this work is being undertaken.

Trust Board

UHNM Response to the Mann Review

12 August 2026

University Hospitals of North Midlands NHS Trust

Introduction

The Mann Review, led by Lord John Mann, was commissioned by the UK Government in October 2025. It was set up following:

- A rise in antisemitism and wider racism in society
- Reports of discrimination affecting NHS staff and patients including staff reporting they were considering leaving the NHS due to racism and patients sometimes avoiding treatment due to fear of discrimination
- Concerns that existing systems were not effectively identifying or addressing racist incidents

The review examined how the NHS and its regulatory bodies recognise, report, investigate and respond to antisemitism and other forms of racism.

Main findings

The review found that racism within the NHS is:

- Persistent and systemic - racism, including antisemitism, remains widespread and, at times, normalised, affecting both workforce experience and patient confidence and access to care.
- Inconsistently addressed - responses vary significantly between organisations and there is a lack of consistency in leadership, policies and practice.
- Poorly reported and managed - reporting systems are:
  - unclear
  - underused
  - not always trusted
- Undermining workforce and care quality - discrimination contributes to:
  - lower staff morale and retention
  - reduced patient trust
  - inequalities in care experience

Conclusions and recommendations

The review calls for a “system-wide reset” with stronger leadership, accountability and culture change. The review makes a comprehensive set of 36 recommendations, 14 of which require direct action by UHNM (Appendix 2). The UK Government accepted all recommendations in full in June 2026. The recommendations can be grouped into key themes:

Stronger leadership and accountability

- Make tackling racism a core organisational priority
- Ensure board-level responsibility for equality and anti-racism
- Link EDI outcomes to senior leaders’ performance

Better data, transparency and oversight

Improve collection and use of:

- Workforce data
- Patient experience data
- Strengthen use of tools like the Workforce Race Equality Standard (WRES)
- Increase public reporting and transparency

Clearer reporting and investigation processes

Introduce consistent national approaches to reporting racism

Improve:

- Investigation procedures
- Accountability for outcomes

Ensure staff understand:
- What constitutes racism
- How to report it

Culture change and anti-racist practice
- Embed an anti-racist organisational culture
- Define racism clearly to ensure shared understanding
- Ensure zero tolerance of racism from staff, patients and visitors

Training and capability building
Introduce mandatory anti-racism training, including:
- Antisemitism awareness
- Cultural competence
- Build capability to recognise, challenge and address racism effectively

Better support for staff
- Provide stronger support systems for staff experiencing racism
- Encourage safe reporting and speaking up
- Ensure organisations respond effectively to incidents

System-wide consistency (including regulators)
Ensure consistent standards across professional regulators and align expectations across:
- NHS organisations
- Arm's-length bodies
- Introduce national staff standards on tackling racism

What this means for UHNM

The review reinforces that tackling antisemitism and racism is a core leadership, workforce and patient safety responsibility. As an employer, UHNM needs to:

a) Take ownership of addressing racism locally, acting early and decisively, and embedding an understanding that antisemitism is a form of racism.
b) Provide clear leadership and consistent organisational responses.
c) Embed established anti-racism principles into organisational culture and practice, including:
    - the NHS Race and Health Observatory's seven anti-racism principles
    - the International Holocaust Remembrance Alliance (IHRA) working definition of antisemitism
    - the Government's non-statutory definition of anti-Muslim hostility
d) Strengthen governance, including board oversight and assurance.
e) Use data to identify inequalities and drive improvement.
f) Ensure reporting and investigation processes are fair, timely and trusted. Investigations must be rooted in safeguarding principles and in line with the Macpherson principle that all complaints about incidents of racism should be recorded and investigated as such.
g) Take a more proactive and preventative approach, rather than relying on escalation to regulators.

Next Steps

The national response to the Mann Review continues to evolve and further guidance is anticipated in a number of areas. UHNM will continue to review and update its approach in line with emerging national requirements and best practice guidance.

There is a significant programme of work underway. Employers including UHNM should expect further guidance and requirements, including:
- NHS staff standards (from 2026): Setting minimum expectations for modern employment, including a specific standard on tackling racism.
- New accountability metrics: A composite score in the NHS Operating Framework (NOF) linking workforce experience to organisational performance.
- National investigatory framework: A consistent approach to handling and investigating racism cases.

- Updated national guidance: Including uniform policies, branding and acceptable behaviours at work.
- Improved training frameworks: Updated mandatory training on equality, diversity and inclusion.
- Guidance on protecting staff: Including responding to discrimination from patients and the public.
- Enhancements to Workforce Race Equality Standards (WRES) and staff survey tools: To better capture and respond to staff experience.

UHNM Progress on Anti-Racism

The Race Equality Task and Finish Group continues to meet on a monthly basis. Key outputs from the group include:

- Multilingual Voices guidance (co-created with Ethnic Diversity Network) created as a result of concerns raised via the network, and via Freedom To Speak Up routes
- Anti-racism training (two NMAHP colleagues have undertaken specialist anti-racism training and developed a training package to be rolled out across the organisation)
- Cultural Ambassadors training commissioned from the NMC (currently underway) to focus on inclusive recruitment practice
- Refreshed the Trust's Anti-Racism Statement, created a new Anti-Racism Policy, and developed a quick guide on how to respond to incidents of racism towards UHNM colleagues; all require formal approval.
- People Directorate Decision Making Group process now includes EDI representation for cases involving allegations of racism
- Cultural Awareness and Inter-cultural communication e-learning to be launched in autumn 2026

Recommendations:

1. Acknowledge and accept the Mann recommendations and what these mean for UHNM and other NHS organisations.
2. Treat racism, including antisemitism, as a core organisational risk and priority, and take a zero-tolerance approach.
3. Review and revise accountability and assurance reporting to provide active Board oversight and strengthen the senior leadership membership of the Task and Finish Group.
4. Approve the Anti-Racism Statement, racism incident guidance and proposed Anti-Racism Policy, noting that these will be kept under review to reflect future national guidance and learning from implementation.
5. Update current statutory and mandatory EDI training to reflect the antisemitism and anti-Muslim hostility definitions, while awaiting further guidance and requirements from NHS England.
6. Roll out anti-racism training, co-ordinated by the corporate nursing team, and arrange an anti-racism session with the Trust Board.
7. Implement appropriate objectives for senior leadership on anti-racism.
8. Develop a communications strategy that explains why this work is being undertaken.

Progress against the Mann Review recommendations will be monitored through a detailed implementation plan overseen by the Race Equality Task and Finish Group, with periodic reporting to the People, Culture and Inclusion Committee and escalation of significant risks or barriers to the Trust Board.

Appendix 1: Definitions

Antisemitism
The International Holocaust Remembrance Association (IHRA) non-legally binding working definition of antisemitism is:

"Antisemitism is a certain perception of Jews, which may be expressed as hatred toward Jews. Rhetorical and physical manifestations of antisemitism are directed toward Jewish or non-Jewish individuals and/or their property, toward Jewish community institutions and religious facilities."

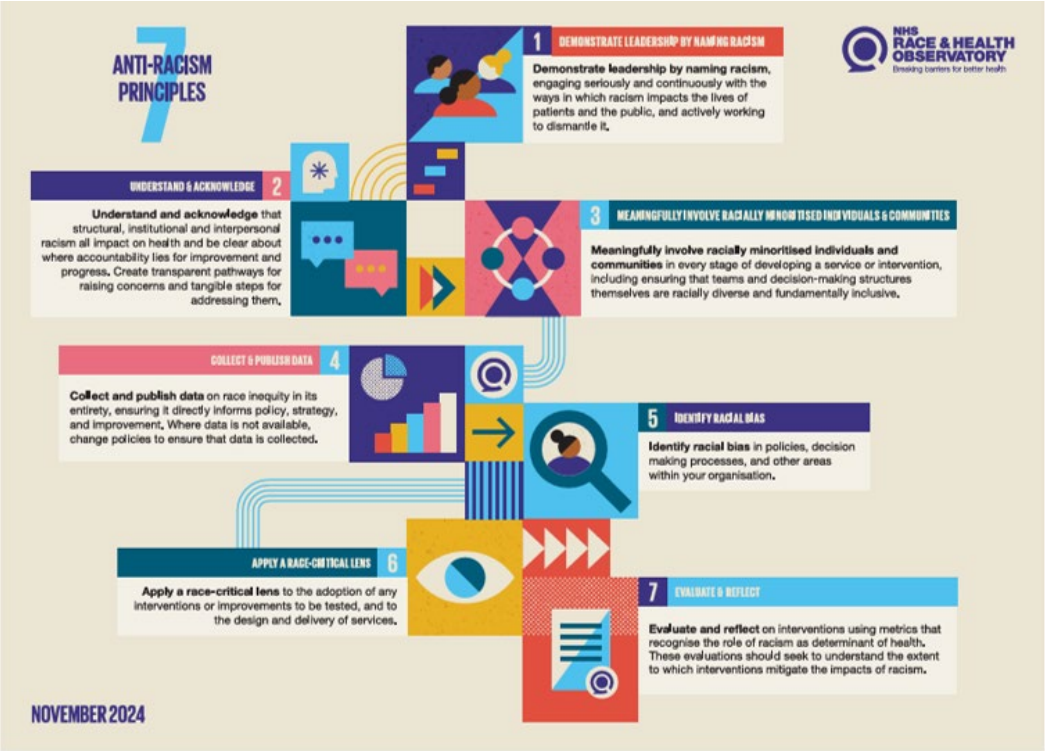
Anti-Muslim Hostility
The UK government's non-statutory definition of anti-Muslim hostility is:

Anti-Muslim hostility is intentionally engaging in, assisting or encouraging criminal acts – including acts of violence, vandalism, harassment, or intimidation, whether physical, verbal, written or electronically communicated – that are directed at Muslims because of their religion or at those who are perceived to be Muslim, including where that perception is based on assumptions about ethnicity, race or appearance.

It is also the prejudicial stereotyping of Muslims, or people perceived to be Muslim including because of their ethnic or racial backgrounds or their appearance and treating them as a collective group defined by fixed and negative characteristics, with the intention of encouraging hatred against them, irrespective of their actual opinions, beliefs or actions as individuals.

It is engaging in unlawful discrimination where the relevant conduct – including the creation or use of practices and biases within institutions – is intended to disadvantage Muslims in public and economic life.

NHS Race and Health Observatory 7 Principles of Anti-racism:



Appendix 2:

No.	Mann Review Recommendation – UHNM	Action Owner	Current UHNM Status	Action Required
1	The Department of Health and Social Care and the NHS should adopt the 7 NHS Race and Health Observatory workforce principles and encourage wider NHS organisations to do so.	UHNM	Recommend review of antisemitism, anti-Muslim hostility definitions and adoption of anti-racism principles.	Confirm adoption of the principles (noted within our Anti Racism Policy). Essential to this recommendation's impact, especially for the Jewish community, will include embedding an understanding that antisemitism is a form of racism.
3	In considering their work to develop robust, evidence-based workforce race equality standard (WRES) action plans, with specific, measurable targets, trusts should ensure they monitor progress against WRES action, applying the 'explain or reform' principles for any persistent inequalities. They should ensure any WRES plans are easily accessible to the public and should discuss their WRES planning at least annually at a public board meeting to help facilitate this. In the absence of Jewish ethnicity data trusts must also look at staff survey data in relation to Jewish staff alongside WRES indicators to understand how they are performing and addressing the experience of Jewish staff.	UHNM	WRES reviewed annually by board. SMART actions. WRES plans accessible on trust website.	Review NSS data by Jewish staff experience in addition to current analysis.
4	NHS boards and leaders should be held accountable for race equality and staff experience metrics, as part of the recently added score in the NHS Oversight Framework (NOF) that will support compliance with the new NHS Staff Standards. The metrics supporting this new NOF score, and trusts' performance on these, should be made publicly visible.	UHNM	Equality, Diversity and Inclusion Accountability Framework in place.	Provide evidence for NOF score.
5	There should be board-level oversight of all investigations related to racism through annual reporting on volume, themes, outcomes and timelines, deep-dives into hotspots or repeated patterns, and assurance that recommendations are implemented and monitored. Existing governance systems can also be strengthened.	UHNM	Only very high level oversight of employee relations cases provided. Culture Review Oversight Group in place.	Review content and level of assurance provided by Employee Relations Report and governance/oversight of this.
7	All NHS board members and senior leaders should have explicit, measurable equality, diversity and inclusion objectives embedded within their performance goals. Assessment against these objectives should reference the themes in the NHS Race and Health Observatory's 7 anti-racism principles as a framework for evidencing delivery.	UHNM	EDI objectives in place, but not specific to anti-racism.	Review and update objectives to ensure these are explicit and measurable.

No.	Mann Review Recommendation – UHNM	Action Owner	Current UHNM Status	Action Required
8	Some political identifiers can and do cause distress to patients, and employers should develop local policies to be clear about what is acceptable. In order to create an inclusive NHS, upholding the aim of everyone feeling safe to seek and receive care, NHS England should update national uniform guidance, in line with reviewing broader guidelines for those in the NHS using its name, logo or branding, including in relation to social media accounts.	NHSE / UHNM	UHNM has standards of dress policy.	update policy with updated guidance from NHSE when released.
9	All staff, including volunteers and sub-contracted staff, should be made fully aware of and have easy access to the documents, contracts and agreements that contain details of the expectations on them with respect to anti-racism, discrimination and fostering an inclusive NHS culture, including the NHS constitution, leadership and management standards (once published), and any volunteer agreements or codes of conduct.	UHNM	Need to establish current practice.	Update induction and onboarding for these groups to ensure compliance with recommendation.
12	Training for Patient Advice and Liaison Services and/or complaints handlers should be rolled out to better identify and handle complaints about racism and support their organisations in responding to racism. Complaints handlers in all settings should have clear process set out for sharing information and insights with other internal NHS functions and leadership, including taking advantage of tools like artificial intelligence to better understand their complaints data, supporting identifying trends.	UHNM	Establish current practice of analysis of complaints data to identify racism themes	Identify areas for improvement/use of AI. Provide training.
13	A single national set of policy frameworks should be developed and clearly signposted to support more effective handling and investigation of racial harassment and discrimination. Work should be undertaken to develop the skills and cultural capability to deal with these issues better in trusts, including how they are investigated and staff supported.	NHSE / UHNM	UHNM Race Equality Task and Finish Group has created an anti-racism policy, procedure and updated anti-racism statement	Ensure UHNM practice and policy meet, as a minimum these new frameworks
14	Trusts should take into account the relevant Advisory, Conciliation and Arbitration Service (ACAS) code in developing their processes and strongly consider routes for early intervention and resolution. The forthcoming review of the ACAS disciplinary and grievance code should support this.	UHNM	Work currently underway to review ER processes. Policy promotes early intervention and resolution.	include ACAS guidance once available. Increase training for investigating officers on racism.

No.	Mann Review Recommendation – UHNM	Action Owner	Current UHNM Status	Action Required
15	The Care Quality Commission (CQC), working with the Department of Health and Social Care (DHSC), should make greater use of powers to inspect NHS organisations on their equality, diversity and inclusion (EDI) performance, against patient inequalities and for staff workforce, under the 'well-led' domain. In doing so it should ensure that NHS boards and leaders are held accountable for delivering the staff standards as reflected in the NOF, including how organisations handle racist incidents and the effectiveness of reporting systems. More broadly, DHSC should consider how CQC might enhance its assessment of all NHS organisations for EDI performance and the role of the organisation's leadership in addressing racism. As referenced in the section of this report on reporting and investigation of racist incidents, this should include the handling of racist incidents.	CQC / UHNM	EDI Accountability Framework in place aligned to CQC quality statements.	Undertake self-assessment against NOF to assess level of assurance.
27	Establish national guidance, building on and updating the guidance issued following the 2024 riots, to support organisations when staff face violence or discrimination from patients or the public. This should include clear, context-specific guidance on how, in non-life threatening situations, trusts support staff to refuse access to services (to protect their safety and dignity). It is recommended that the NHS, the Department of Health and Social Care and others work closely with the UK healthcare professional regulators and patient and staff representatives to update this guidance, ensuring alignment with existing regulator guidance on this matter, and relevant legal duties. This should include real life examples of how NHS employers can protect staff. NHS employers should be held to account for implementing this guidance consistently and for taking firm action to protect staff.	Dept of Health and Social Care / UHNM	Draft UHNM guidance created by Race Equality Task & Finish Group, based on current best practice guidance.	Ensure any new updates to guidance are reflected in UHNM guidance and relevant training.
32	The NHS mandatory training module on equality, diversity and human rights - which is accessed by 1.5 million people - requires urgent updating and the specific inclusion of quality assured content on antisemitism and anti-Muslim hostility. Subject matter experts should be consulted as part of the content review and update. Staff should be required to undertake this training, once updated, without delay and not wait until the 3-year cycle renews. This training will be replaced in 2026 with another training framework which must include the aforementioned quality-assured materials.	NHSE / UHNM	UHNM currently does not use the E-LfH mandatory EDI training. Short non-mandated anti-racism training produced and being rolled out by corporate nursing team.	Update UHNM training immediately with content. Then transfer to new national training once available.
34	There must be mandatory training for the approximately 400 chairs and chief executives of NHS provider trusts on antisemitism, anti-racism and building on the Macpherson principles, within the next 6 months.	Trust Chair & CEO's	Board programmes have included EDI and Staff Networks lived experience sessions.	Suggest in the very short term the board undergo internal anti-racism training and/or arrange externally facilitated specialist session.

Executive Summary

Trust Board (Part 1) | 12th August 2026

UHNM Response to the National Resident Doctor Offer 2026

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**	✓	**Approval**		**Assurance**		**Agenda Item:**	13.
Author:	Diane Poulson, Assistant Director of Resourcing							
Executive Lead:	Jane Haire, Chief People 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

NHS England, alongside the Department of Health and Social Care and the BMA, has proposed a national Resident Doctor Offer for 2026. The offer is intended to respond to national concerns about pay progression, training costs, access to training opportunities and the working lives of resident doctors, with a strengthened expectation that employers demonstrate visible progress locally.

Background

The proposed offer focuses on four key areas: pay reform, reimbursement of mandatory training-related costs, expansion of training opportunities, and improvements to working lives. It also introduces enhanced engagement mechanisms between resident doctors, employers and national bodies, alongside national initiatives to increase specialty training numbers and create a pathway for eligible locally employed doctors (LED's) to transition onto substantive Specialty and Associate Specialist (SAS) doctor contracts.

Assessment

For UHNM, the most significant implications are the requirement to implement revised pay progression arrangements, establish processes for reimbursing eligible training-related expenses, support increased training and educational supervision capacity, improve the experience of resident doctors and Locally Employed Doctors, and strengthen Board oversight of delivery. These changes are likely to create workforce, financial, operational and governance implications, although some details remain subject to national implementation guidance and funding arrangements.

The proposals align closely with UHNM's People Strategy, Medical Workforce priorities and commitment to being an employer and educator of choice. Early preparation will position the Trust to maximise recruitment, retention and training benefits, ensure compliance with national expectations, and maintain clear oversight of the risks and opportunities associated with implementation.

Conclusion

UHNM commits to supporting implementation of the Resident Doctor Offer by ensuring fair access to training and career progression, improving the working lives of resident doctors and locally employed doctors, investing in educational capacity, and providing robust Board oversight of delivery and outcomes.

Key Recommendations

The Board is asked to note the Resident Doctor Offer, endorse continued preparatory work to align UHNM's workforce, education and wellbeing plans with the national commitments, and receive a further implementation update once contractual arrangements and funding mechanisms are confirmed.

Trust Board

UHNM Response to the National Resident Doctor Offer 2026

12 August 2026

1.0 Purpose

To inform the Trust Board of the NHS England offer to Resident Doctors and outline the associated organisational commitments required from UHNM to support implementation.

2.0 Background

NHS England, DHSC and the BMA have agreed a proposed package for Resident Doctors which aims to improve pay progression, reduce financial barriers to training, increase training opportunities and improve working lives. The offer builds upon NHS England's 10 Point Plan to improve resident doctors' working lives. The key elements of the offer include:

- Reform of pay progression linked to training competency achievement.
- Reimbursement of mandatory training-related costs, including eligible examination, portfolio and college membership fees.
- Creation of at least 4,000 additional training places nationally over three years.
- Strengthened focus on improving working conditions and wellbeing.
- Enhanced engagement structures between resident doctors, employers and NHS England.

3.0 Implications for UHNM

While many aspects of the offer will be nationally negotiated, local employers will be expected to support delivery and demonstrate progress. The areas of commitment for UHNM are:

3.1. Support Pay Reform Implementation

- Ensure timely implementation of new national pay arrangements.
- Work with educational and clinical leaders to facilitate earlier ARCP reviews where required to enable eligible doctors to progress through pay nodes.
- Support fair progression opportunities for Less Than Full Time (LTFT) doctors and Locally Employed Doctors (LEDs).

3.2. Reimbursement of Mandatory Training Costs

- Establish local processes to reimburse eligible examination fees, portfolio costs and Royal College membership fees in line with national guidance.
- Ensure transparent communication and administration processes for resident doctors and LEDs.

3.3. Expand and Support Training Capacity

- Respond to NHS England's expansion of specialty training places, including workforce redesign, educational supervision capacity and conversion of appropriate LED opportunities into training posts where feasible.
- Ensure sufficient educational supervision, clinical placement capacity and learning opportunities.

- Continue to develop career pathways for LEDs, including progression into training programmes and implementation of the national SAS Eligibility & Permanency Framework, providing eligible doctors with access to substantive SAS contracts.

3.4. Improve Working Lives

- Maintain active engagement with Resident Doctor Peer Leads.
- Continue delivery of the NHS England 10 Point Plan priorities locally.
- Strengthen support for resident doctor wellbeing, rest facilities, induction, access to education and rota quality.
- Enhance support arrangements for Locally Employed Doctors.

3.5. Strengthen Board Oversight

- Maintain executive and non-executive leadership oversight of resident doctor experience.
- Monitor delivery through workforce, education and people governance structures.
- Comply with any national requirement to report progress through annual accounts and workforce reporting arrangements.

4.0 Considerations

Key considerations for the Trust include:

- Financial pressures associated with reimbursement of training costs, expansion of training capacity and implementation of new employment frameworks for locally employed doctors and speciality and associate specialist doctors.
- Additional educational supervision and placement capacity requirements.
- Delivery risk if local processes are not established promptly.
- Reputational risk if resident doctor experience does not improve in line with national expectations.

5.0 Opportunities

The offer presents opportunities to:

- Improve attraction and retention of resident doctors.
- Enhance the experience of Locally Employed Doctors.
- Strengthen UHNM's position as a leading training organisation.
- Improve workforce sustainability through expanded training pathways, strengthened SAS career opportunities and improved retention of experienced locally employed doctors.

6.0 Recommendation

The Board is asked to note the Resident Doctor Offer, endorse continued preparatory work to align UHNM's workforce, education and wellbeing plans with the national commitments, and receive a further implementation update once contractual arrangements and funding mechanisms are confirmed.

Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE | 2nd July 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee noted a challenging **access** position in May, with deterioration in non-elective performance, sustained high emergency department attendances and acuity, and diagnostic performance impacted by MRI scanner outages during the heatwave. Whilst cancer faster diagnostic standard (FDS) remained above trajectory and early June performance showed improvement, the Committee highlighted the need for credible recovery plans for MRI and echocardiography, alongside continued focus on discharge, flow and capacity utilisation. Partial assurance was agreed. • In considering the **Executive Quality and Outcomes Group highlight report,** the Committee noted the key concerns in relation to hospital-acquired thrombosis, VTE risk assessment compliance following EPMA implementation, category 4 pressure ulcers, stroke thrombectomy pathway performance and workforce/service resilience across a number of specialties. • The Committee received partial assurance from the **Q3 Patient Experience and Complaints** report, noting ongoing work to improve maternity choice, strengthen complaints response performance and implement a triaged complaints process supported by scorecard monitoring. The Committee also discussed the current limitations on face-to-face PALS access due to staff safety concerns, while noting alternative routes for patient feedback, including ward-based patient experience volunteers, online access and a PALS presence at main reception. • The Committee discussed the need to strengthen **triangulation** of learning from patient experience, complaints, incidents and Freedom to Speak Up, noting that a new learning forum is being developed to reduce duplication and support shared learning across care groups. Existing incident review, complaints and risk management processes are increasingly being aligned, with future risk management system developments expected to further support thematic analysis and integrated learning. • The Committee received a detailed briefing on the **Ockenden** and **Amos** maternity reports, noting the significant volume of national and local actions, including immediate priorities around triage, care after death, culture, racism, governance, metrics and assurance. The Committee highlighted the need for clear prioritisation, robust Board oversight and improved real-time intelligence, while also recognising the psychological impact on maternity staff and the importance of sustained support, multidisciplinary input and system-wide improvement planning. • The Committee received partial assurance from the **Q4 Mortality Assurance** report, noting that overall mortality remained above expected levels but continued to show improvement, supported by strengthened clinical coding and data quality. Continued focus was required on pneumonia as a persistent outlier and specialty review backlogs.	• To provide quarterly reporting of themes and compliance **of 52 week breach harm reviews**, to the Committee going forward. • Further work to be undertaken to strengthen the **EQIA** process, including clearer consideration of positive and negative impacts and statutory equity responsibilities, with a further update to be provided in six months. • To consider reinstating a separate **Maternity** Quality Committee meeting to ensure full board oversight and assurance on maternity actions and progress, including consideration of a specific Board Assurance Framework risk for maternity.

Positive Assurances to Provide	Decisions Made
• The Committee received the **Q4 cancer 104-day breach analysis**, noting 116 patients had been treated beyond 104 days, a reduction from the previous quarter, with delays primarily linked to surgical capacity and urology remaining the highest-breach specialty. Assurance was provided that a risk-stratified harm review process was in place, with no harm identified in the completed reviews to date, and the Committee noted that psychological harm was included within the review process, as such acceptable assurance was agreed. • The Committee noted the implementation of a real-time harm review system for **52-week breaches**, including an iPortal note and flag to support immediate identification, review and tracking at care group and department level and consideration of psychological harm. • The Committee received acceptable assurance on the continued development of the **Population Health Programme**, noting progress in establishing care group plans aligned to population health priorities, national objectives and prevention opportunities. Further work was requested to strengthen visibility of children and young people, benefits realisation, implementation timelines and visual assurance reporting to demonstrate care group contributions to population health outcomes. • The Committee noted the update on the **Equality and Quality Impact Assessment** (EQIA) process, including revised ownership arrangements and ongoing operational challenges in ensuring effective review and discussion of EQIAs. • The Committee noted the **Executive Quality and Outcomes Group highlight report**, which provided positive assurance on patient safety alerts, mortality review learning, accreditation milestones and cancer harm review processes. • The Committee received the **Care Excellence Framework summary** and noted strong overall accreditation performance, with nearly two-thirds of areas rated gold and targeted support in place for the remaining bronze-rated area. Assurance was strengthened by patient leader involvement in visits and ongoing work to align	• No decisions were required to be made.

the framework to new CQC standards; however, the Committee agreed **acceptable assurance** for the process and **partial assurance** for outcomes where improvement was still required.

- The Committee received **acceptable assurance** from the **Quality Performance and Assurance** report, noting continued workforce stability within nursing and midwifery and positive progress in areas such as sepsis review and timely observations. Areas requiring continued focus included Friends and Family Test performance, VTE compliance, mixed sex accommodation breaches, avoidable harm, escalation space pressures and ongoing oversight of calls for concern/Martha's Rule.
- The Committee received **acceptable assurance** from the **Q4 Patient Safety Incident** report, noting the continued move towards proportionate investigation processes, strengthened patient and family involvement, and oversight through the Risk Management Panel. Key learning themes included early recognition, escalation and handover in time-critical situations, with ongoing work to embed sustainable improvements through continuous improvement support.
- The Committee received **acceptable assurance** from the **Q4 Mental Health, Learning Disability and Autism** report, noting clarification that Oliver McGowan training compliance was affected by the three-year training cycle and new e-learning intake, with increased face-to-face and virtual training activity. The Committee also noted additional recruitment to support service demand and ongoing partnership work with local authorities to improve communication and support for young people with mental health, learning disability and autism needs.

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
Comments on effectiveness were sought via MS teams.	

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Access Performance Report M2	1	Ext 20	Partial	Information	8.	Patient Experience Report Q3	1	Ext 20	Partial	Assurance
2.	104+ day breach analysis Q4	1	Ext 20	Acceptable	Assurance	9.	Quality Performance Report M2	1	Ext 20	Acceptable	Assurance
3.	Patient Waiting List Backlog Harm Review Update	1	Ext 20	Not applicable	Information	10.	Briefing Summary – Independent Review of Maternity Services at Nottingham University Hospitals NHS Trust	1	Ext 20	Not applicable	Information
4.	Population Health Programme Assurance Framework	2	High 12	Acceptable	Assurance	11.	PSII Report Q4	1	Ext 20	Acceptable	Assurance
5.	Quality Impact Assessment Update	1	Ext 20	Not applicable	Information	12.	Mortality Assurance Report Q4	1	Ext 20	Partial	Information
6.	Executive Quality & Outcomes Group Highlight Report	1	Ext 20	Not applicable	Information	13.	Mental Health Report Q4	1	Ext 20	Acceptable	Approval
7.	Care Excellence Framework Summary Q3 & Q4	1	Ext 20	Partial / Acceptable	Assurance						

Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE | 5th August 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The **Executive Quality and Outcomes** report highlighted a number of areas requiring continued oversight, including sepsis performance, ambulance handover delays, theatre workforce challenges, discharge summary quality and digital integration. The Committee received assurance that robust governance, mitigation and improvement arrangements remain in place, including external review where appropriate. • The Committee received the **domestic abuse management re-audit**, noting significant improvements in compliance with domestic abuse, stalking and harassment risk assessments. Partial assurance was provided, with further work required to strengthen documentation, staff confidence and consistency of response. The Committee welcomed the appointment of a dedicated Domestic Abuse Nurse and agreed to receive a progress update against the action plan in November 2026. • The Committee considered the **Quarter 1 Infection Prevention and Control** report and agreed a rating of partial assurance due to ongoing challenges in achieving national targets for E. coli bacteraemia and clostridium difficile infections, including the impact of revised NHS England thresholds. Assurance was provided that robust case reviews, targeted action plans and performance oversight remain in place, alongside continued work to improve aseptic non-touch technique compliance through training, audit and quality improvement initiatives. • Partial assurance was provided in relation to the **Infection Prevention Board Assurance Framework**. The Committee noted progress in reducing broad-spectrum antibiotic use in support of the national antimicrobial resistance strategy and received assurance that improvement actions remain in place to address blood culture processing delays. • The Committee received the **Quarter 4 Patient Experience Report**, which provided partial assurance. Members noted the continued increase in formal complaints alongside significant progress in reducing the complaints backlog and maintaining low escalation rates from PALS enquiries. Assurance was provided that strengthened arrangements for complaints handling, clinician engagement and organisational learning are supporting the timely resolution of concerns and service improvement. • The Committee received an update on **operational performance**, noting continued challenges in urgent and emergency care performance, including the delayed opening of the Urgent Treatment Centre at Royal Stoke. Members welcomed improvements in ambulance handover performance and received assurance that recovery actions remain a key organisational priority. The Committee also reviewed elective and diagnostic performance, including MRI capacity pressures and recovery plans, and discussed the longer-term risks associated with increasing demand, urgent care pressures and population health needs.	• Future **BAF** reports to continue to further develop action planning and progress reporting to strengthen Board assurance, including closer alignment with annual delivery plans, key performance indicators and demonstrable risk reduction.

Positive Assurances to Provide	Decisions Made
• The Committee received assurance that previously reported increases in HSMR and SHMI were attributable to a temporary **clinical coding** backlog arising from workforce constraints during 2025/26. Members noted that coding activity has recovered, mortality indicators are returning to expected levels, and existing mortality review processes continue to provide oversight. • The Committee reviewed the refreshed 2026/27 **Board Assurance Framework**, noting strengthened risk descriptions, enhanced articulation of controls and assurances, and the introduction of a new strategic risk relating to Urgent and Emergency Care. • The **Executive Quality and Outcomes** highlight report noted progress against a number of quality improvement initiatives, including the implementation and planned expansion of ambient voice technology to support clinical documentation and patient care. • The **Month 3 Quality Performance** report provided acceptable assurance. Members reviewed performance in healthcare-associated infections and noted areas requiring continued improvement, including pressure ulcer prevention, mixed sex accommodation breaches, complaints management and VTE risk assessment compliance. Assurance was provided that targeted improvement plans, strengthened oversight and digital solutions are in place to support sustained improvement. • The Committee received acceptable assurance regarding **never event** performance, noting a reduction in incidents and performance that compared favourably with national trends. Members were assured that robust governance, thematic reviews and targeted action plans remain in place to support learning and prevent recurrence.	• The Committee approved the **Board Assurance Framework**.

• The Committee received a verbal update on implementation of the **Chaperoning Policy**, noting significant progress in training compliance and structured clinical documentation. Members acknowledged ongoing challenges relating to record-keeping, operational delivery and cultural change, and received assurance that these are being addressed through audits, strengthened governance and digital solutions. • The Committee received the **annual Infection Prevention and Control** report, which provided **acceptable assurance**. Members noted strong performance in staff vaccination uptake, sepsis screening compliance and antimicrobial stewardship, alongside ongoing challenges in achieving national thresholds for clostridium difficile and MRSA bacteraemia. Assurance was provided that robust surveillance, review and improvement arrangements remain in place. • Members welcomed the establishment of the Patient and Carer Engagement Council and the enhanced approach to triangulating patient feedback, strengthening the use of patient experience information to inform service improvement.	

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
Comments on effectiveness were sought via MS teams.	• The Committee received assurance regarding **clinical coding** and it was agreed to refer this to the Finance and Business Performance Committee, in terms of the resulting limitations associated with historic benchmarking data associated with the affected period.

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 Q1	ALL	Various	N/A	Approval	7.	Infection Prevention, Vaccination & Sepsis Team Annual Report	1	Ext 16	Acceptable	Assurance
2.	Executive Quality & Outcomes Group Highlight Report (23-07-26)	1	Ext 16	N/A	Information	8.	Infection Prevention Report Q1	1	Ext 16	Partial	Assurance
3.	Quality Performance Report – M3	1, 2, 9	Various	Acceptable	Assurance	9.	Infection Prevention Board Assurance Framework			Partial	Assurance
4.	Never Event Comparison 2025/26	1	Ext 16	Acceptable	Assurance	10.	Patient Experience Report Q4	1, 2, 9	Various	Partial	Information
5.	Chaperoning Update			N/A	Information	11.	Access Performance Report	9	Ext 20	Partial	Assurance
6.	Re-audit of UHNM Policy C37 – Dealing with Domestic Abuse	1	Ext 16	Partial	Assurance						

NHS
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NHS Trust

Integrated Performance Report

Month 03 Performance

2026/27

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.

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			Q4 2025/26	3	NOF Score	Provider value	
Average metric score			Q4 2025/26	2.48	NOF Score	Provider value	
Unadjusted segment			Q4 2025/26	3	NOF Score	Provider value	
Financial override	Q4 2025/26	Yes	Yes		Yes	Provider median	

Domain Scores	Data period	Provider value		Chart
Access to services domain segment	Q4 2025/26	3	NOF Score	
Access to services domain score	Q4 2025/26	2.51	NOF Score	
Effectiveness and experience of care domain segment	Q4 2025/26	3	NOF Score	
Effectiveness and experience of care domain score	Q4 2025/26	2.22	NOF Score	
Patient safety domain segment	Q4 2025/26	3	NOF Score	
Patient safety domain score	Q4 2025/26	2.83	NOF Score	
People and workforce domain segment	Q4 2025/26	3	NOF Score	
People and workforce domain score	Q4 2025/26	2.72	NOF Score	
Finance and productivity domain segment	Q4 2025/26	3	NOF Score	
Finance and productivity domain score	Q4 2025/26	2.2	NOF Score	

Adjusted segment

Provider value Q4 2025/26

3 NOF Score

The best joined-up care for *all*

UHNM remains in segment 3 for quarter four, with the Financial Override applied. **Overall score was 2.47 in Q3, increasing slightly to 2.48 in Q4. This reflects a marginal deterioration, outlined as follows:**

- Access to services from 2.57 to 2.51 (remains in segment 3)
- Effectiveness and Experience from 2.16 to 2.22 (dropped to segment 3)
- Patient Safety from 2.67 to 2.83 (remains in segment 3)
- People and Workforce from 2.49 to 2.72 (dropped to segment 3)
- Finance and productivity from 2.35 to 2.22 (remains in segment 3)

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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 segment	Q4 2025/26	3	NOF Score	
Effectiveness and experience of care domain score	Q4 2025/26	2.22	NOF Score	

Patient experience	Data period	Provider value		Chart
CQC inpatient survey satisfaction rate score	Q4 2025/26	2	NOF Score	
Summary Hospital-level Mortality Indicator score	Q4 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			Q4 2025/26	2	NOF Score	Provider value	
Average number of days from discharge ready date to actual discharge date (including zero days)	Mar 2026	0.42	1.09		0.80	Provider median	

UHNM score in this domain has worsened in Q4, increase from 2.16 in Q3 to 2.22. As a result, UHNM has moved from segment 2 to segment 3.

This change is primarily driven by an increase in the average number of days from discharge ready to actual discharge date, rising from 0.31 to 0.42 days. Despite this deterioration compared with Q3, UHNM continues to perform better than both peers and the national average in Q4.

Patient Safety

University Hospitals of North Midlands NHS Trust

Patient Safety Domain Score	Data period	Provider value		Chart
Patient safety domain segment	Q4 2025/26	3	NOF Score	
Patient safety domain score	Q4 2025/26	2.83	NOF Score	

Patient safety Please note that the MRSA, C-Difficile and E-Coli scores each carry a one third weighting	Data period	Provider value	Peer average		National value	National value method	Chart
NHS Staff Survey - raising concerns sub-score score			Q4 2025/26	3	NOF Score	Provider value	
NHS Staff survey - raising concerns sub-score	2025	6.17	6.18		6.32	Provider median	
Number of MRSA bacteraemia cases score			Q4 2025/26	4	NOF Score	Provider value	
Number of MRSA bacteraemia cases (12 months)	To Mar 2026	9.00	5.00		3.50	Provider median	
Proportion of C. difficile infections score			Q4 2025/26	3	NOF Score	Provider value	
Proportion of C. difficile infections versus threshold (12 months)	To Mar 2026	1.17	1.11		1.09	Provider median	
Proportion of E. coli bacteraemia score			Q4 2025/26	1	NOF Score	Provider value	
Proportion of E. coli bacteraemia versus threshold (12 months)	To Mar 2026	1.00	1.18		1.17	Provider median	

UHNM remains in segment 3 for this domain, with the score increasing from 2.67 in Q3 to 2.83 in Q4, indicating a decline in performance.

This deterioration is primarily driven by reductions in the 'NHS staff survey – raising concerns sub-score' and an increase in EColi cases. While the staff survey result remains broadly in line with peers despite the decline, EColi cases are better than peers and the national average.
Although UHNM remain below peers in the proportion of CDiff cases, we did see an improvement in the rate.

Quality & Access | Overview

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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.

We did not meet the required target in June across a number of metrics ,DOC verbal, PU developed under UHNM, PU with lapses in care, FFT in ED and maternity, VTE, 3rd and 4th degree tears, C-Diff, e-Coli, sepsis screening maternity, and mixed sex accommodation breaches. The improvements in timely observations is being sustained - we are 7% off target performance. Complaints response times also continues to reduce.

There have been 9 Calls for Concern (Martha's Rule) during June 2026: Of the 9 cases referred in June: 1 qualified for a review, 8 had documented advice only and 1 had a change in management including transfer to HDU.

Trust have received a presumptive positive legionella result for an outlet on Ward 124 (renal) and on Ward 117 (Infectious Diseases) – both are high risk from water safety perspective. Estates have fitted point of use filters. Awaiting final confirmation. Urgent meeting to decide on our engineering strategy with estates colleagues and our external authorising engineer (water). Noted that the fitting of the Point of Use filters has significantly reduced any risk.

In addition, we have a second MRSAb on Ward 230. However, this patient was positive in County last month as a community sample, been negative and now positive again. This is likely a community case but it will be included in UHNM figures.

We are in the process of conducting the assessment of our maternity triage service (Amos 2026 action) and with consideration of the new National Maternity Triage Specification (published 7 July 2026); work is also underway to introduce Call for Concern to maternity and Neonatal services

As noted previously there are a number of emerging challenges which are affecting safe and effective management of cardiothoracic theatres. A risk summit is still to take place and further information provided to the Committee in due course.

What is driving this?

There is focused work across Planned and Unplanned to reduce avoidable harm. The support programme for Silver CEF areas, led by the Quality Team and the Continuous Improvement team, is proving to support teams to drive improvement across a range of metrics and to also increase CEF accreditation standards. This work won an award in the RLDatix Connected Health and Care Summit and Awards.

The Chief Nurse meets with the Care Group Nurse Directors to discuss progress reducing avoidable harm and monitor improvements.

As noted previously the benchmark performance for 3rd and 4th degree tears is potentially due to issues with data capture. The Team have been asked to review what we can do to ensure the correct data set is submitted.

There are robust processes to proactively review areas with any metrics of concerns to ensure timely assessment and mitigation where appropriate. Wards are encouraged to adopt safety stop huddles to ensure any patient risk is discussed and relevant plans of care are delivered.

The Chief Nurse suggests that the current performance remains at the level of acceptable assurance.

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

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

Intensive and specific corporate support to the only remaining Bronze CEF area continues and the adapted support to CEF Silver areas continues.

The Temporary Escalation space audits are highlighting some of the challenges and impact of the continuous flow model on the ward teams and subsequent care. We are encouraging the use of RED flags as this offers an opportunity for review from the senior team within the Care Groups.

Focused length of stay meetings to be introduced chaired by the CN; criteria led discharge now had a dedicated lead to support roll out across the Trust to support timely discharge from hospital – this is being supported by our Consultant colleagues; focused oversight on completion of TTOs and creation of early flow.

Planned and Unplanned Care are focused jointly on reducing avoidable harms. Planned care have noted that there is a lack of devices to support timely recording of observations and are actioning this.

HSMR continues to be higher than expected but is showing further improvements following the clinical coding improvement plan related to improving capacity within the team to allow full, prompt coding of all activity. Previously identified issues with clinical coding and capacity issues impacted ability to fully code all inpatient activity. Clinical Coding papers are being provided at Executive level and Quality, Access & Outcomes Committee on uncoded activity and the different submission deadlines (Flex, Freeze and Post Reconciliation).

The final report and recommendations of the National Maternity and Neonatal Investigation, led by Baroness Amos, was published on Tuesday 30 June –and a summary of this and the Ockenden Report was presented to Board on 8 July 2026. Action plans relating to these reports will be presented to Committee and Board once developed.

What can we expect in future reports?

We will update the committee quarterly on progress with the continuous improvement aspect of the quality/CQC/CEF improvement workstreams.

We will also update on progress with work being led by the CN and CMO to better understand moral injury and psychological safety across NMAHPs and medical staff.

The External review considering the MBRACE data has now commenced and is due to be completed in September but the Committee will be briefed if any escalations are received during the course of the review.

Quality & Access | Dashboard

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University Hospitals of North Midlands NHS Trust

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
HSMR (Rolling 12-months)	Mar 26	114.9	100.0			119.6	111.4	127.7
PSI per 1000 bed days	Jun 26	49	51			53	47	58
PSI with moderate harm or above per 1000 bed days	Jun 26	0.4	0.6			0.6	0.3	1.0
Patient Falls per 1000 bed days	Jun 26	4.7	-			4.7	3.8	5.6
Patient falls with harm per 1000 bed days	Jun 26	1.6	1.5			1.7	1.1	2.3
Medication incidents per 1000 bed days	Jun 26	6.6	6.0			5.9	4.6	7.1
Medication incidents with moderate harm or above (%	Jun 26	1%	5%			1%	-1%	4%
Never Events reported	Jun 26	0	0			0	-2	3
PSIIs instigated	Jun 26	1	0			2	-4	8
Duty of Candour verbal	Jun 26	87%	100%			91%	69%	113%
Duty of Candour written (letter sent within 10 working c	Jun 26	100%	100%			82%	49%	115%
Pressure Ulcers developed at uhnm per 1000 bed day	Jun 26	2.3	1.6			1.7	0.7	2.7
Pressure ulcers with lapses in care per 1000 bed days	Jun 26	0.8	-			0.5	0.1	0.9
Trust Apportioned Infections	Jun 26	66	-			50	27	73
Avoidable cases of MRSA Bacteraemia	Jun 26	0	0			0	0	1
HAI and COHA cases of C.Diff toxin	Jun 26	14	12			14	6	22
HAI E.Coli Bacteraemia Cases	Jun 26	25	17			20	6	33
Sepsis Screening - Inpatients	Jun 26	97%	90%			97%	90%	104%
Sepsis IVAB - Inpatients	Jun 26	100%	90%			99%	95%	103%
Sepsis Screening - ED	Jun 26	95%	90%			93%	86%	100%
Sepsis IVAB - ED	Jun 26	91%	90%			84%	66%	103%
Sepsis Screening - Maternity	Jun 26	86%	90%			96%	88%	104%
Sepsis IVAB - Maternity	Jun 26	100%	90%			98%	90%	106%
Sepsis Screening - Childrens	Jun 26	93%	90%			91%	80%	102%
Sepsis IVAB - Childrens	Jun 26	100%	90%			71%	12%	130%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
VTE Risk assessment Rate (timely) - data from ePMA	Jun 26	84%	95%			84%	#N/A	#N/A
Hospital Associated Thrombosis Rate	Jun 26	0.8	-			1.0	0.2	1.7
Care hours per patient day (safe staffing)	May 26	9.3	-			9.2	9.0	9.5
Timely Observations	Jun 26	83%	90%			80%	78%	82%
UHNM Inpatients - Friends & Family Test (% recomm	Jun 26	95%	95%			96%	94%	98%
UHNM A&E - Friends & Family Test (% recommendir	Jun 26	77%	85%			70%	61%	79%
UHNM Maternity - Friends & Family Test (% recomme	Jun 26	85%	95%			86%	70%	102%
Complaints - % closed within 25/40/60 working day tar	Apr 26	18%	-			26%	1%	50%
Written complaints rate per 10,000 spells	Jun 26	41	-			35	23	47
Mixed Sex Accommodation Breaches Reported	Jun 26	97	-			104	68	141
Maternity Induction of Labour - Breach performance	Jun 26	100%	95%			99%	96%	101%
Maternity Assessment Unit Triage within 15 minutes	Jun 26	87%	85%			90%	81%	99%
3rd/4th degree tears	Jun 26	9	-			8	1	15
Neonatal deaths	Jun 26	1	-			2	-1	5

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)

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	Ext 20	Partial	Ext 20	Partial

Quality & Access | [PSIs per 1000 bed days]

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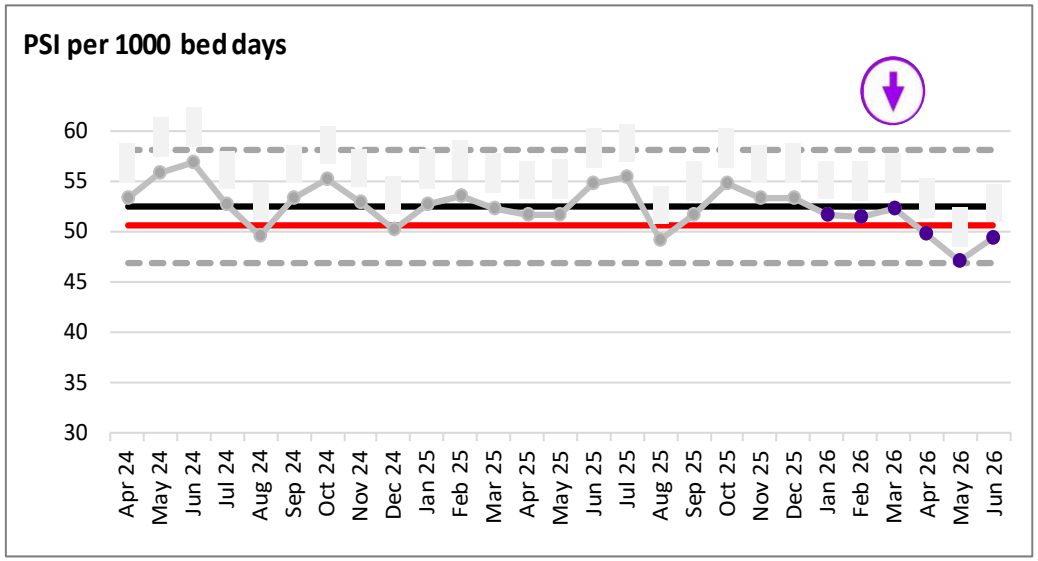
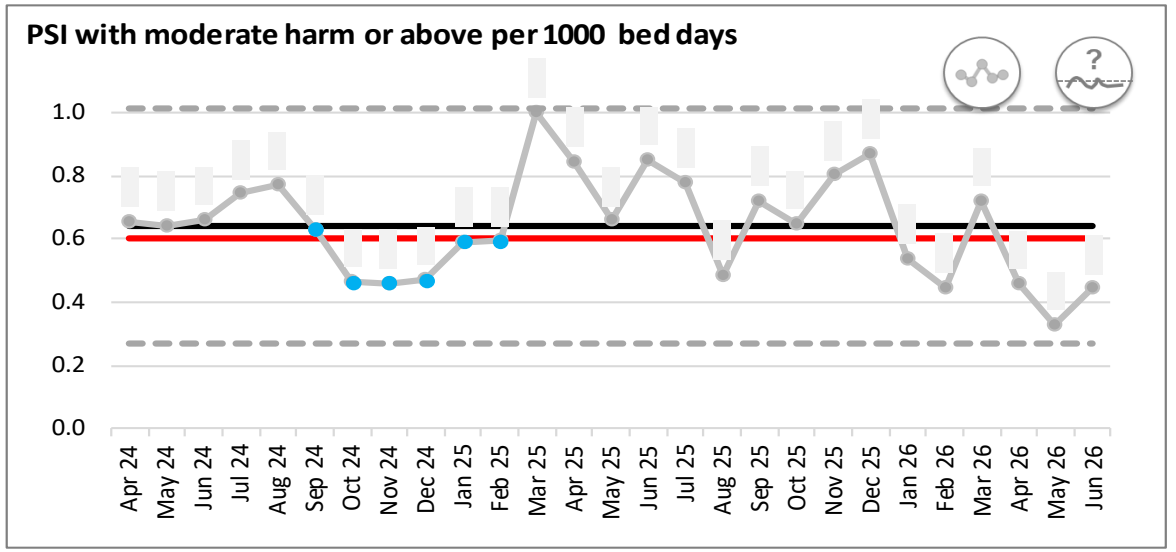
University Hospitals of North Midlands NHS Trust





What is driving this performance?

PSI rate for Jun-26 was within the usual range, but the chart shows 6 consecutive months below the average which may indicate significant change.

The most common Categories of incidents resulting moderate harm or greater in the past 6 months to Jun-26 were Treatment/procedure, Clinical assessment, Maternity triggers, Patient Falls, Clinical assessment, Accident, and Medication.

Continued encouragement and positive reinforcement of incident reporting across all harm levels.
Enhanced review of moderate harm and above incidents, including thematic reviews.

What are we doing about it?

Continued encouragement and positive reinforcement of incident reporting across all harm levels.

Enhanced review of moderate harm and above incidents, including thematic reviews.

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 a result of changes in the sedation guidelines

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]

Provide safe, effective and caring services

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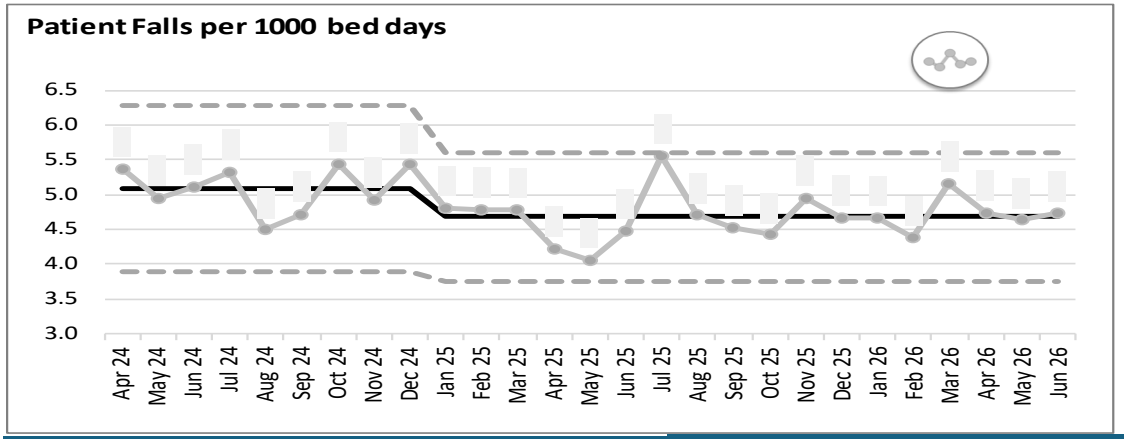
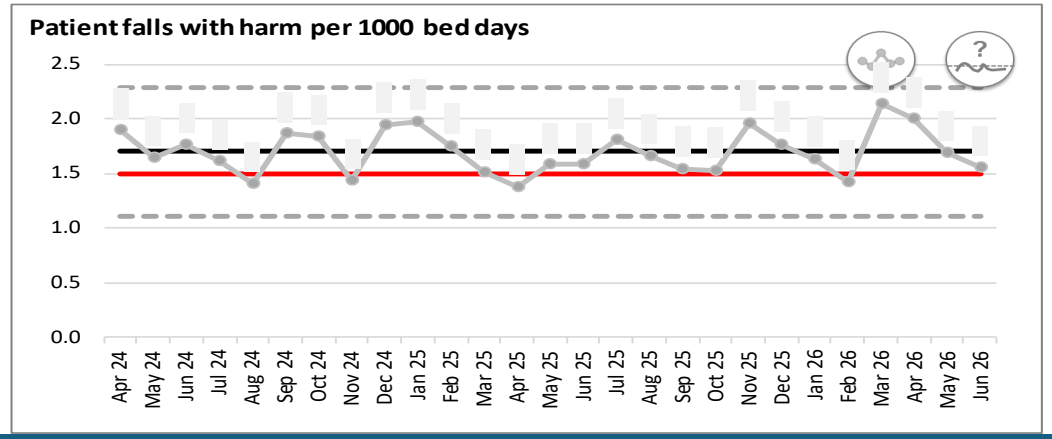




What is driving this performance?

Top reporters in June 2026: Ward 126– 13 falls, Stoke ED – 12 falls. Numbers for both areas are not unusual based on previous months.

2 falls resulting in a serious injury were reported in June, on the following wards: Stoke AMU, Ward 226.

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?

25 falls occurred on the two top reporting wards; no patient had suffered harm.

Ward 126 had a patient that appeared on the falls data for several weeks in June. This was due to the patient having seizures.

There has been a further patient fall in July for ECC which has caused harm. Awaiting availability of the ECC team to discuss improvements.

The two patients that were injured had not pressed the call bell to request assistance. Ward visits, communication and education has been delivered. Walkabouts show that not all patients have call bells and some call bell panels remain on night mode in the day.

Q&S Genome Falls Audits

- ECC 75%
- AMU 85%
- Ward 126 70%
- Ward 226 82%

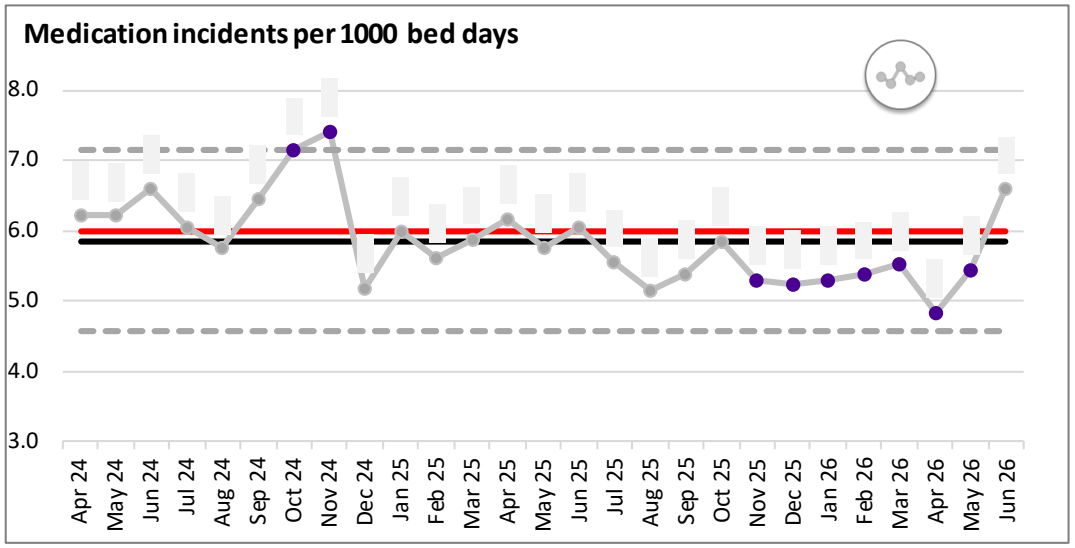
Falls champion education day in June. Falls CSW presentation in June.

Go Look Learn visits continue.

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



What is driving this performance?	What are we doing about it?
Reducing trend is noted as concern as it provides less opportunity to learn from low and no-harm incidents. Care Groups strengthened governance and learning via dedicated working groups/Pharmacy review, routine trend monitoring, and increased use of ePMA to improve prescribing and assurance	• Trust wide CQC preparation visits being undertaken by the pharmacy team where capacity allows. Wards also encouraged to self-assess & provided with paper tool (Tendable / Genome switch). • Engagement meetings held with planned and unplanned matrons re the current medicines and controlled drugs issues – await CSS meeting. • Clozapine guideline produced in response to adverse incidents / risk – await roll out. • Proposal to introduce trust wide single nurse administration of morphine sulphate 10mg / 5ml agreed. Governance plan under way to support implementation. • Action plan produced to support shortages of prostaglandin vaginal tablets and gel. • Medicine Safety support for switch to Genome.

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

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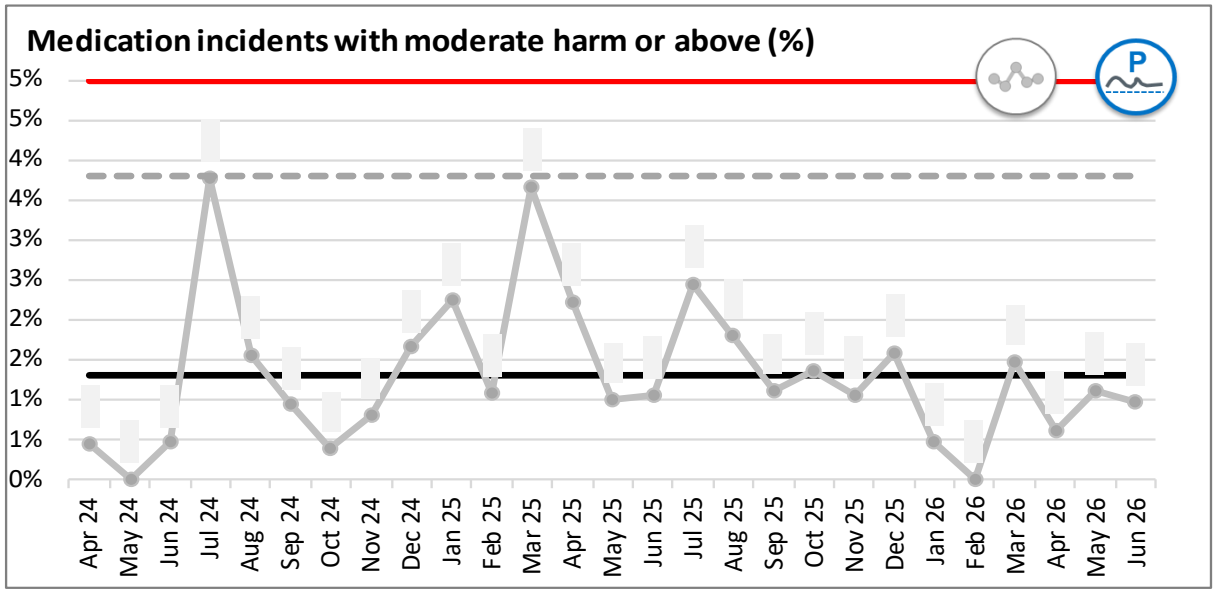

What is driving this performance?

In June 2026 there were zero incidents reported that were categorised as moderate harm or above.

Reporting is 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

ID	Incident Date	Location	Subcategory	Description	Actions

Quality & Access | [Never Events & PSIIs]

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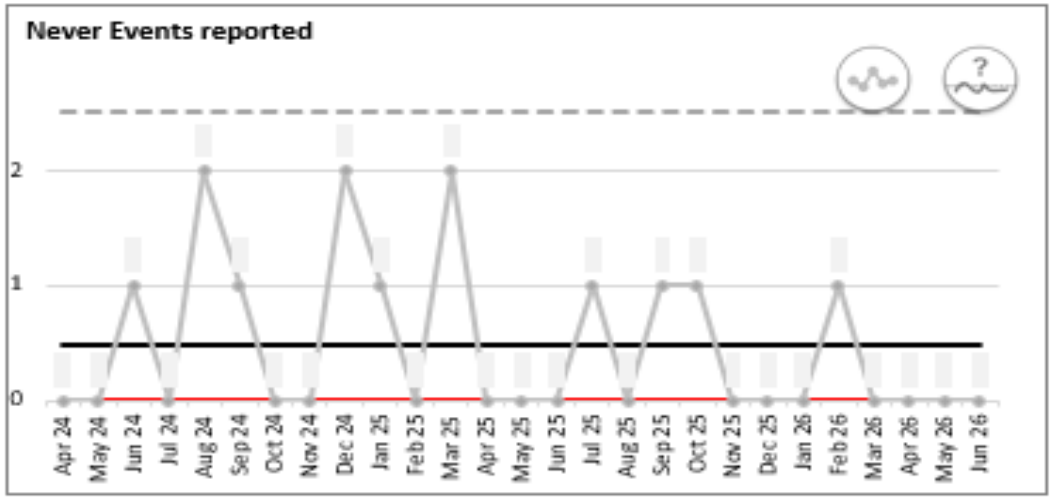

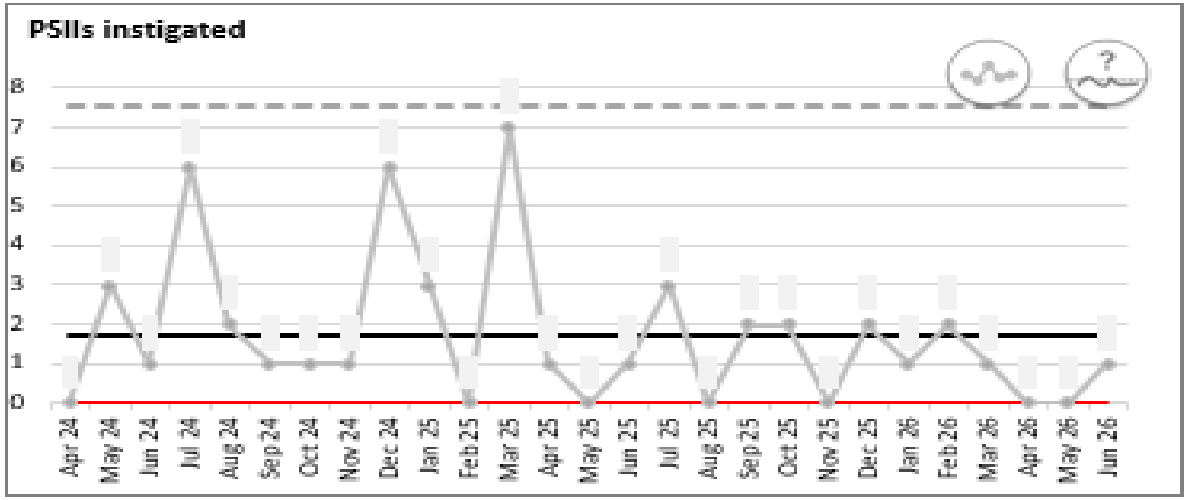

What is driving this performance?

No never events were identified during June 2026.

1 new PMRT was commissioned during June 2026, as per national reporting.

What are we doing about it?

Preterm baby born at 30+3 weeks gestation. Twin 1 of a set of twins: sudden collapse, resuscitation unsuccessful, Died 34+1 weeks gestation.

Quality & Access | [Duty of Candour]

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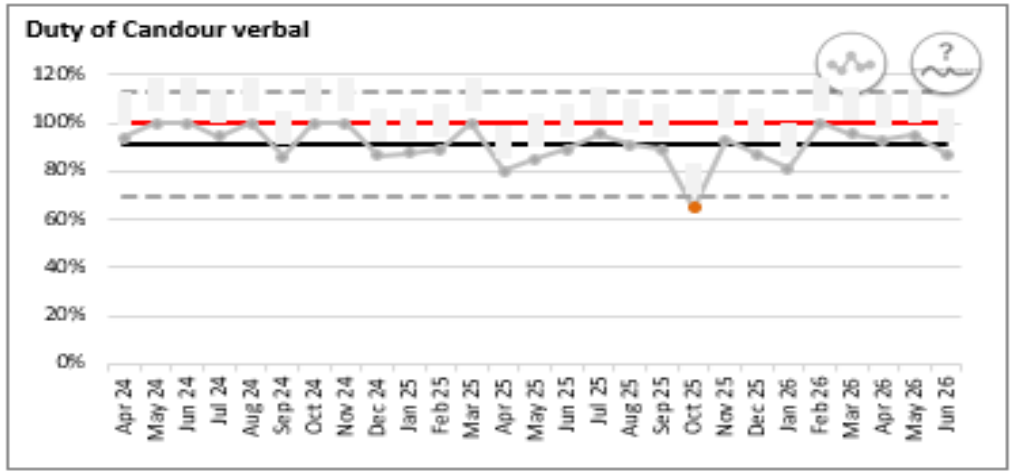
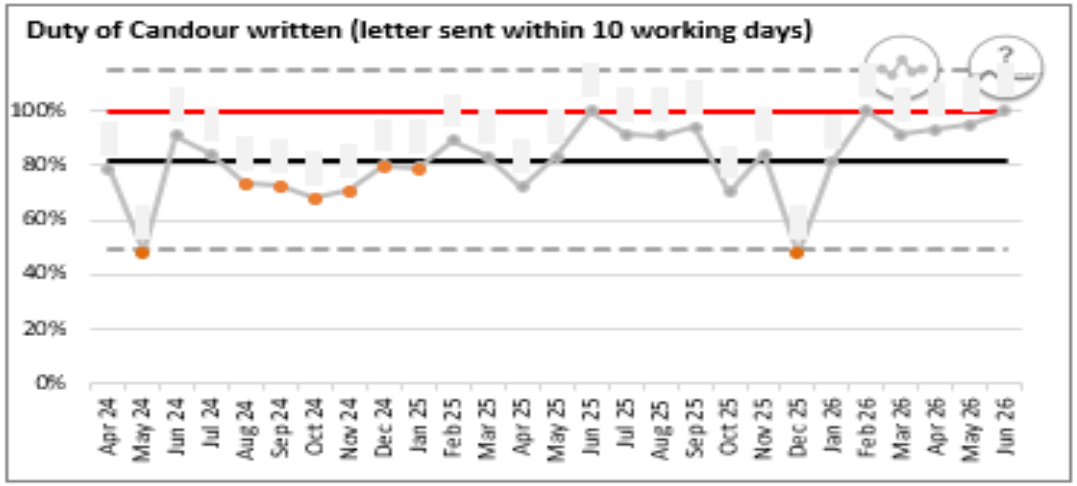




What is driving this performance?

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

There were 15 incidents that formally triggered duty of candour in June. 15 out of the 15 met compliance for written (100%) and 13 out of the 15 met the compliance for verbal (86%) and all breaches were in CSS.

What are we doing about it?

We continue to work closely with individual services and Care Group teams to reinforce the importance of undertaking and documenting both verbal and written Duty of Candour, and of being open with patients and their families when things go wrong. This strengthened approach ensures timely clinical review and verification of harm prior to initiating Duty of Candour, supporting greater consistency in compliance and providing enhanced assurance that disclosures are based on accurate, clinically validated information.

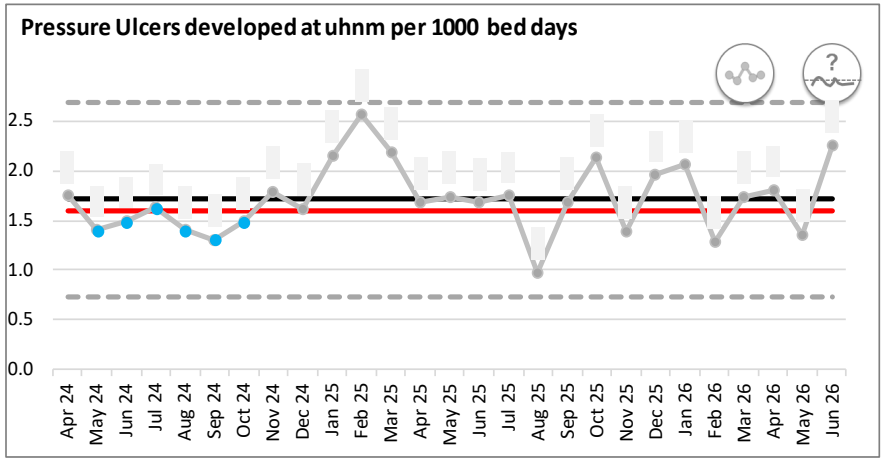
Teams are reminded that evidence of verbal Duty of Candour conversations must be clearly documented within Datix and the clinical record. A new Datix field has been implemented to capture the validation date, which has improved compliance where incidents meet the threshold for Duty of Candour. A supporting SOP has been developed to strengthen monitoring arrangements and escalation where compliance concerns are identified.

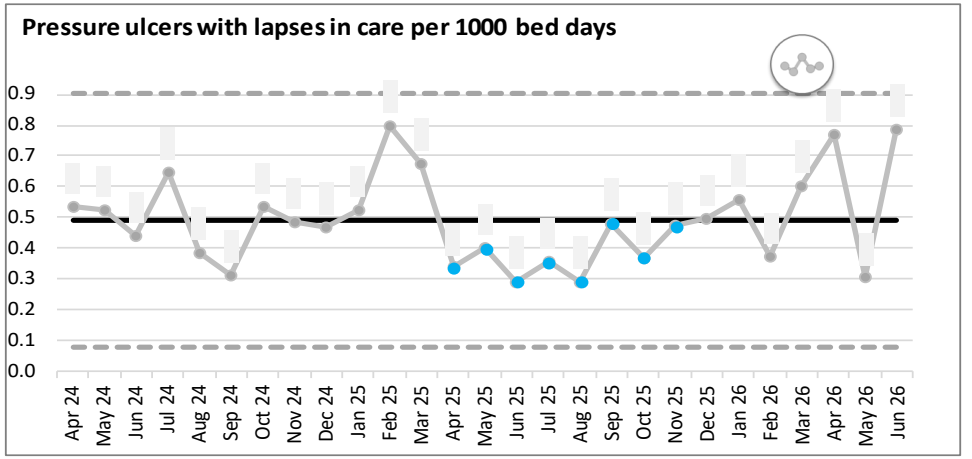
A structured Duty of Candour note within iPortal has also been agreed to further support this workstream. Quarterly audits are now in place to provide ongoing assurance and to identify opportunities for further improvement.

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





Type of Lapses Jun 2026	Total
Management of repositioning – position not changed	14
Management of repositioning - timeliness	10
Management of device	3
Management of heel offloading	2

What is driving this performance?

Both metrics are within usual range, based on cases reviewed as of the 3rd of the month.

On average, lapses in care have been identified for approximately 30% (circa 21) of the pressure ulcers reported as developing under UHNM care since April 2022.

There has been an increase in hospital acquired category 4 pressure ulcers.

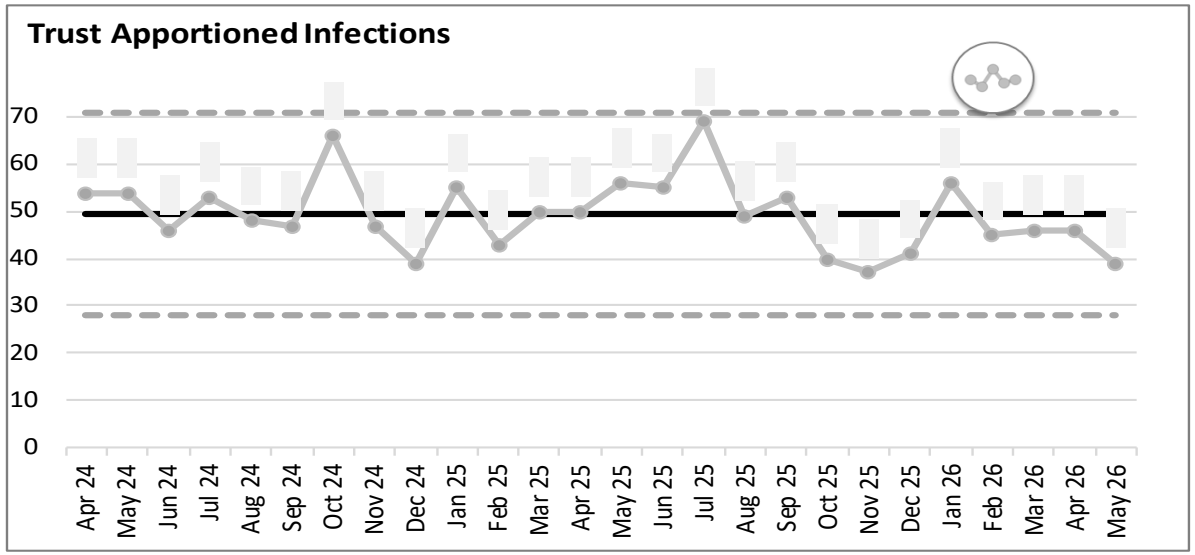
What are we doing about it?

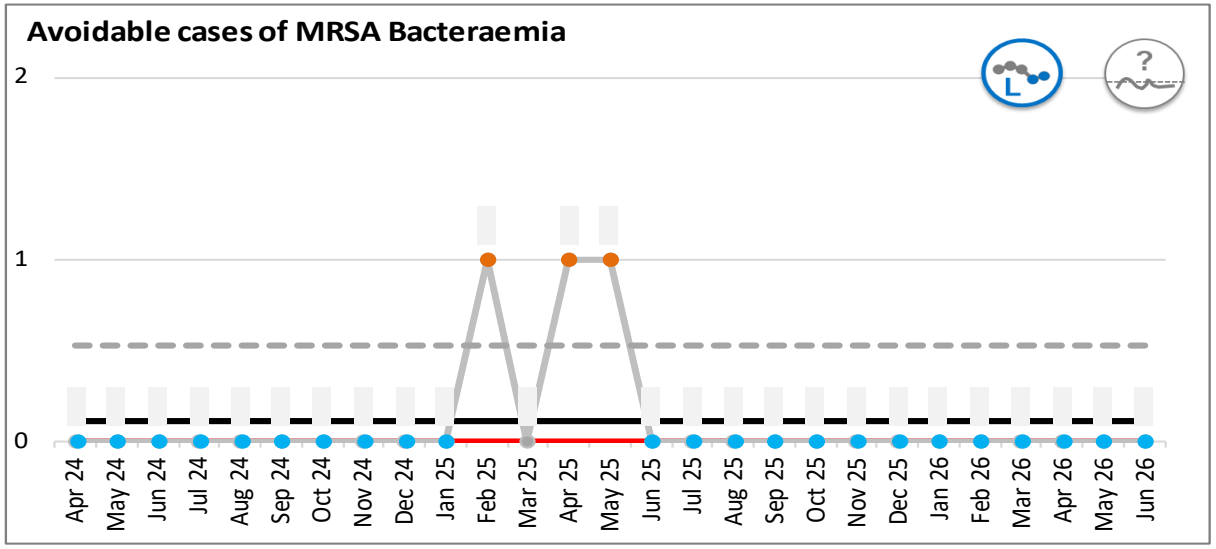
- Areas who have reported multiple HAPU within a month are invited to steering group to provide assurance of improvements
- Huddles taking place to discuss category 4 hospital acquired pressure ulcers, where care groups are invited. Collaborative work with the safeguarding team to create an algorithm for patients with complex needs, identifying and reporting safeguarding concerns sooner.
- Thematic review completed in relation to the Category 4 HAPU across the Care Groups and has been shared with EQOG and ICB.
- Campaign for the reduction of damage from oxygen devices to commence
- Audits being completed by the Quality and Safety team to support improvements. Annual audit for pressure prevention has commenced
- Ongoing implementation of Purpose T trust wide
- Collaborative work to commence with Tissue Viability, Quality and Safety Team, and Therapy teams looking into Contractors, effective repositioning, and standardised completion on documentation
- Champions programme re-commenced in March for the 2026 year, encouraged with cascading education
- To discuss with OD and training to review ESR package as mandatory training
- Safety alert shared for ongoing issues with mattresses and the cells
- Prompt cards being developed for staff, supporting with pressure prevention and categorisation
- Task and finish group set up and looking at unnecessary catheterisations

Quality & Access | [Trust Apportioned Infections & MRSA Bacteraemia

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is driving this performance?

Trust Apportioned Infections
Numbers remain within the usual range.

MRSA-b
No Avoidable MRSA Bacteraemia cases have been reported since May 2025.

What are we doing about it?

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

MRSA blind decolonisation is now Mandatory for all prescribers/clinicians to prescribe on patient admission onto EPMA and staff to sign only in EPMA.

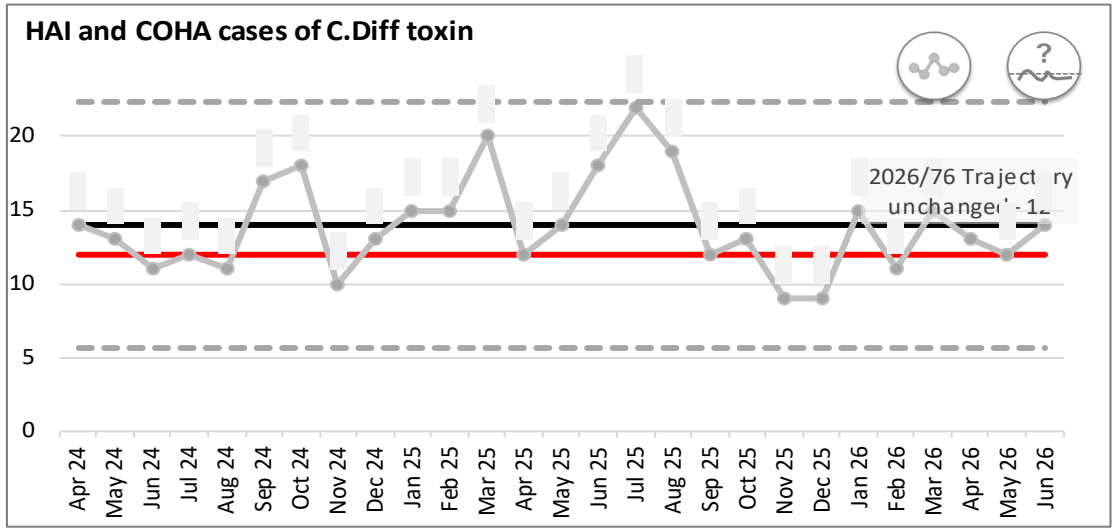
Continued surveillance for MRSA with immediate implementation of control measures to prevent transmission.

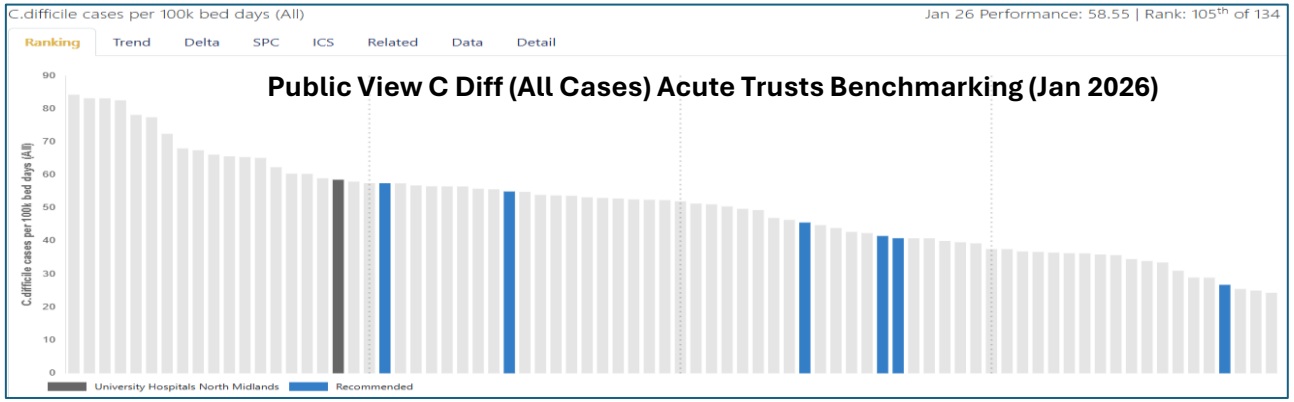
Close monitoring of MRSA audits compliance and robust actions remained in place.

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is driving this performance?

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 14 reported C diff cases in June 2026 – 8 x HAI and 6 x COHA
There have been two wards with a period of increased incidence reported in June - 1 with 2 HAI cases and 1 with 1 HAI + 1 COHA at Royal Stoke.

The 2026/27 objective for C-Diff has now been issued and UHNM threshold for 2026/27 is 144 (same as 2025/26).

What are we doing about it?

- Routine ribotyping of samples continues for samples from areas where we have periods of increased incidence only
- 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
- PSIRF process and monthly themes report
- Weekly AMS presence to support antimicrobial prescribing in both sites
- Bi-monthly C diff MDT meeting to discuss cases and share learning
- Ongoing Bed and Commode cleaning day bi-yearly
- C diff training and awareness provided to clinical staff including medics

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

Provide safe, effective and caring services

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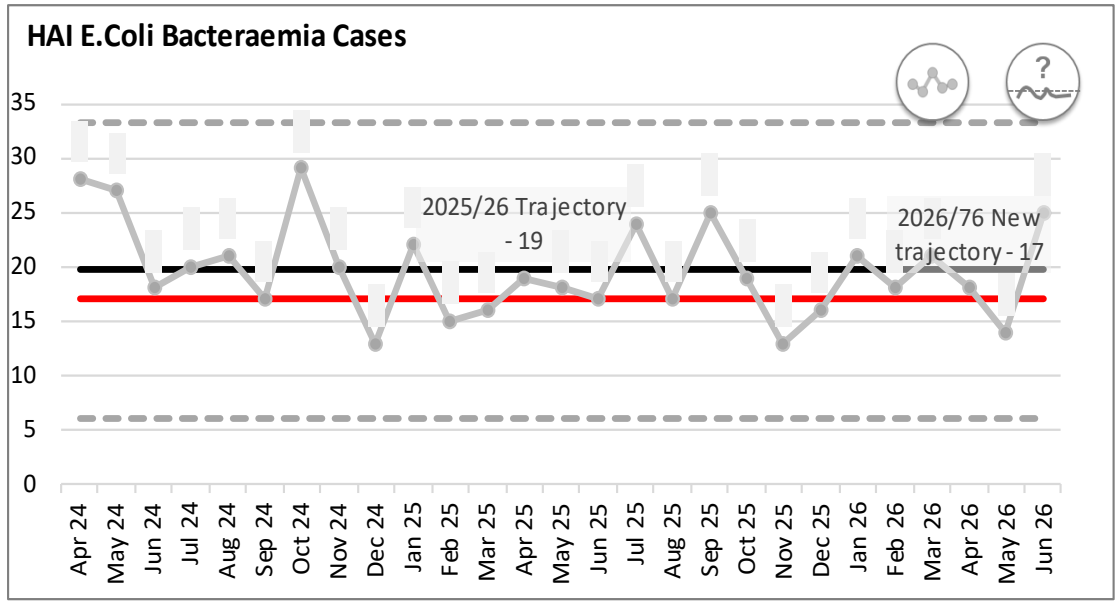
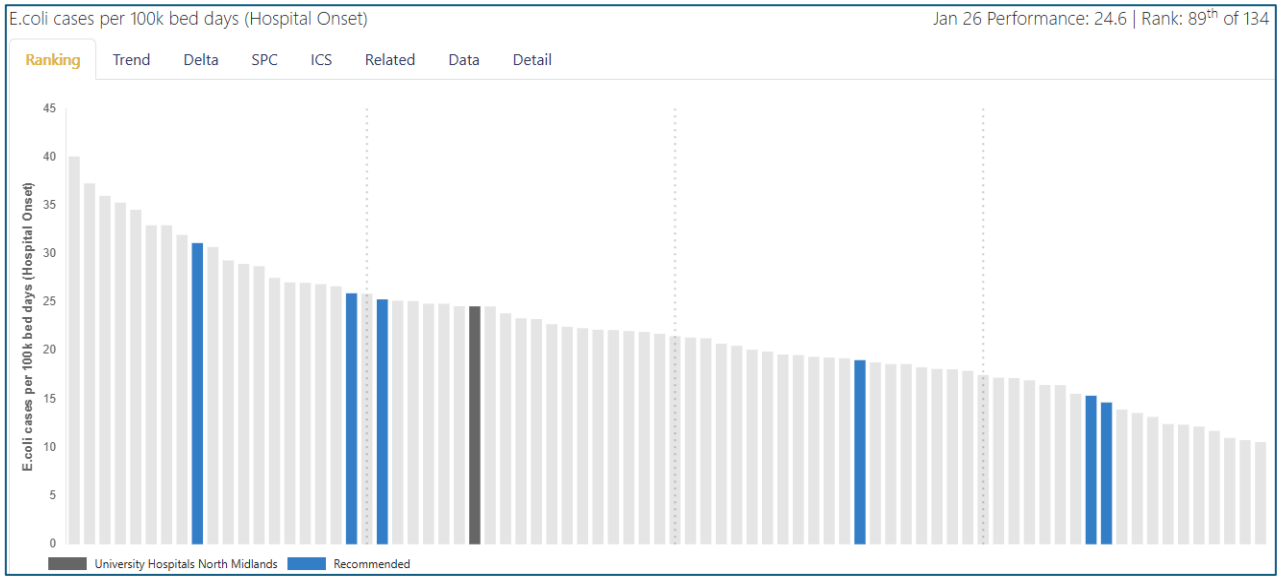


Public View Hospital Onset E.Coli Acute Trusts Benchmarking (Jan 2026)



What is driving this performance?

The target trajectory for 2026/27 has now been issued by NHSE and UHNMM trajectory has been reduced by 23 for 2026/27 to 206 compared to 2025/26 as we reported 229 against trajectory of 230.

As at June 2026 we have had 57 Trust apportioned cases (32 * HAI and 25 * COHA).

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.

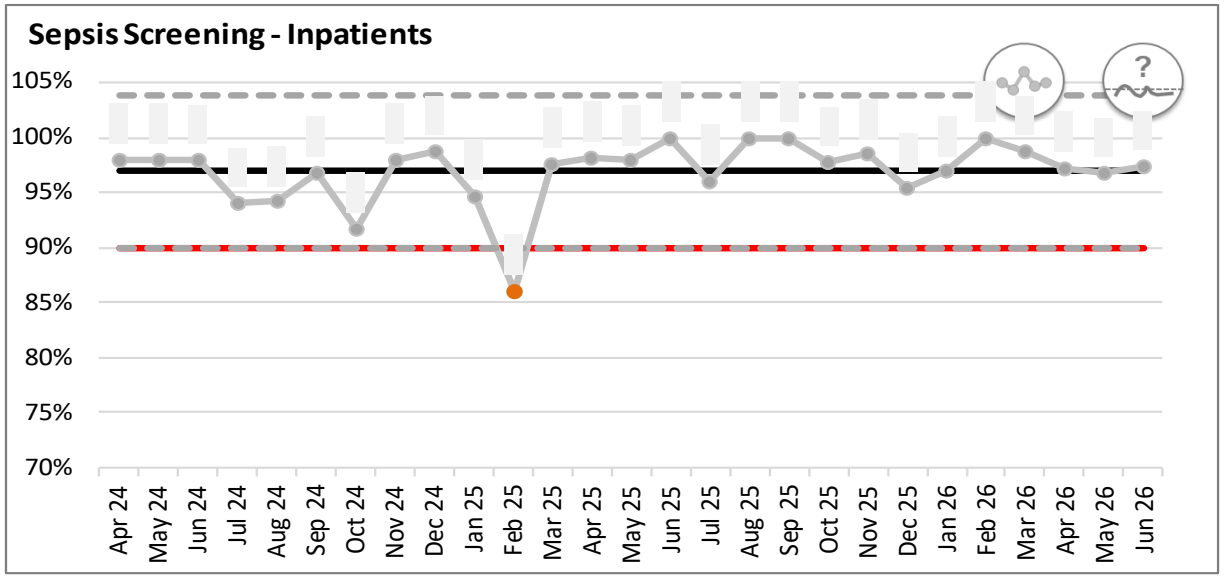
Early identification, appropriate management and treatment prioritised.

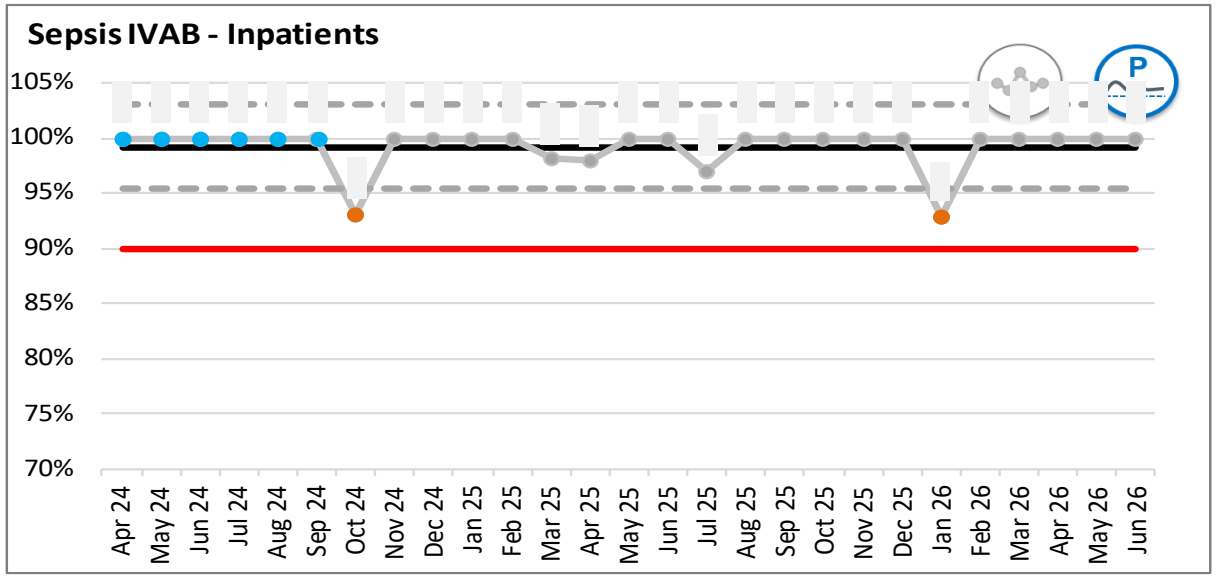
There is also an ongoing collaborative work around CAUTI with external colleagues. UHNM Task Finish group is also being established and works ongoing.

Quality & Access | [Sepsis – Adult Inpatient]

Provide safe, effective and caring services

NHS
University Hospitals of North Midlands
NHS Trust





What is driving this performance?

Inpatient screening compliance was within the usual range in June 2026 and has consistently exceeded the target since Mar-25.
Compliance for IVAB administration within one hour has also consistently exceeded the target.

A total of 124 cases were reviewed in May; there were 4 missed screens. 77 cases were identified as red flag sepsis, with 54 receiving an alternative diagnosis. Leaving 23 patients of which all 22 were already on antibiotics. There was 1 newly identified sepsis requiring IVAB within the hour which was administered within the hour.

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.

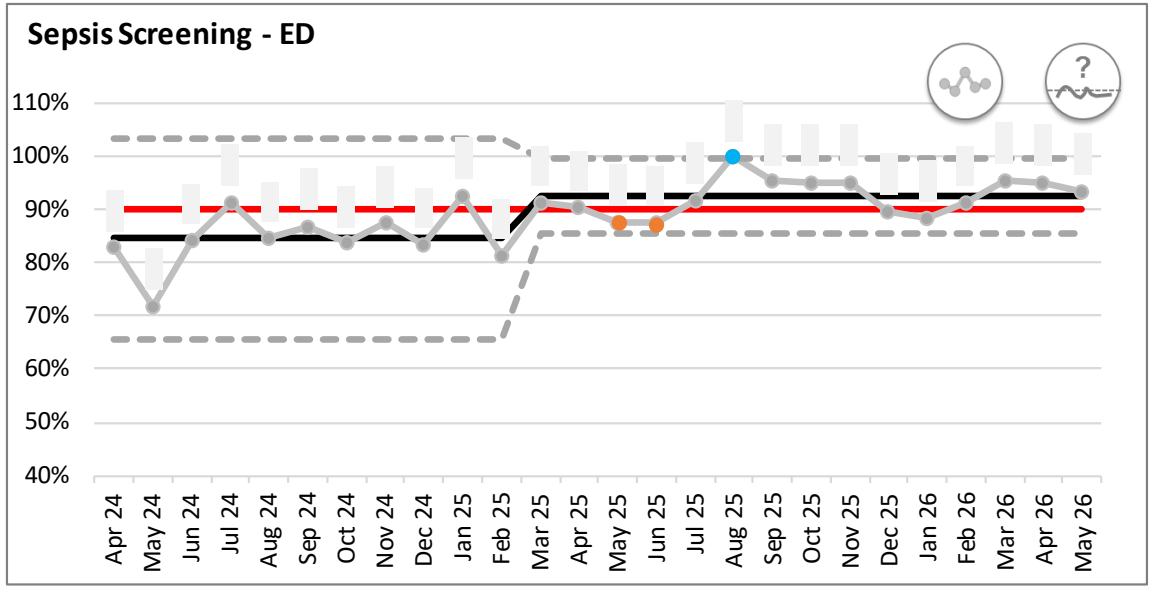
The sepsis will continue to provide sepsis kiosks/ drop- in sessions to targeted clinical areas.

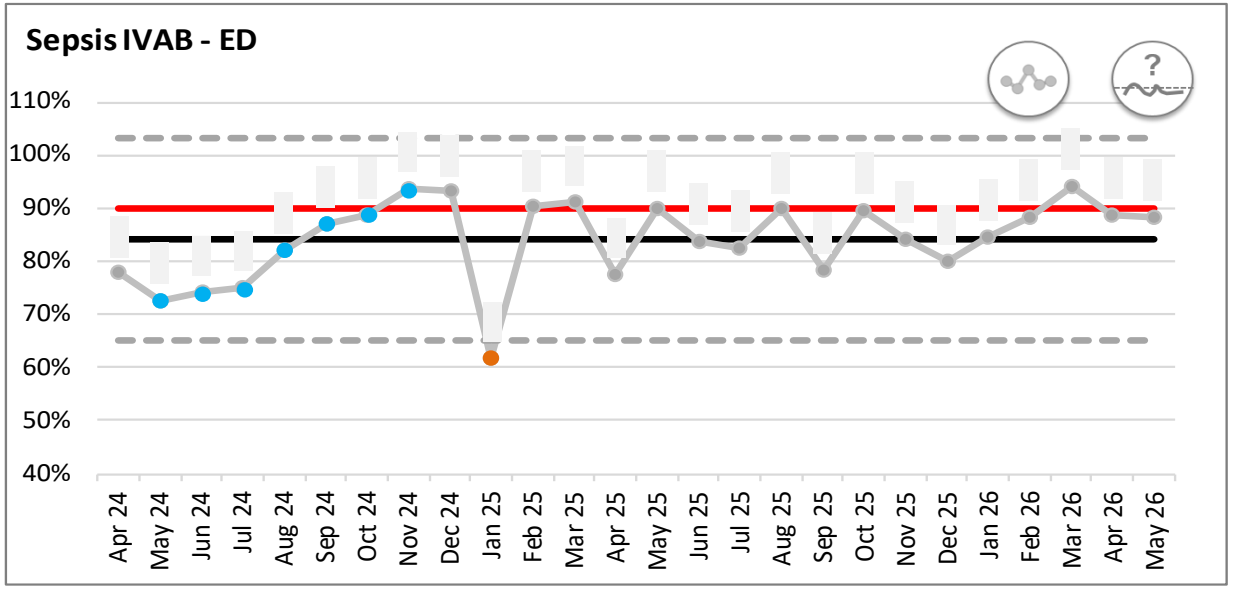
The sepsis team will continue to create drop-in training sessions for band 3s for all inpatient departments.

Quality & Access | [Sepsis – Emergency Portals]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is driving this performance?

Average compliance for adult emergency portals screening has been above the 90% target since Mar-25, but compliance is not yet strong enough to be confident of meeting the target every month.

Compliance with IVAB within 1 Hr has been above the average for 6 consecutive months which may indicate significant change.

In June, 171 cases were reviewed with 9 missed sepsis screens. 125 cases were identified as red flag sepsis – 79 had an alternative diagnosis, 26 were already on IV antibiotics. Leaving 20 newly identified sepsis patients. 4 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.
- ED Pit stop model under review; Improving Together huddles introduced; Tendable checklists introduced pending IT rollout

Quality & Access | [Sepsis – Maternity]

Provide safe, effective and caring services

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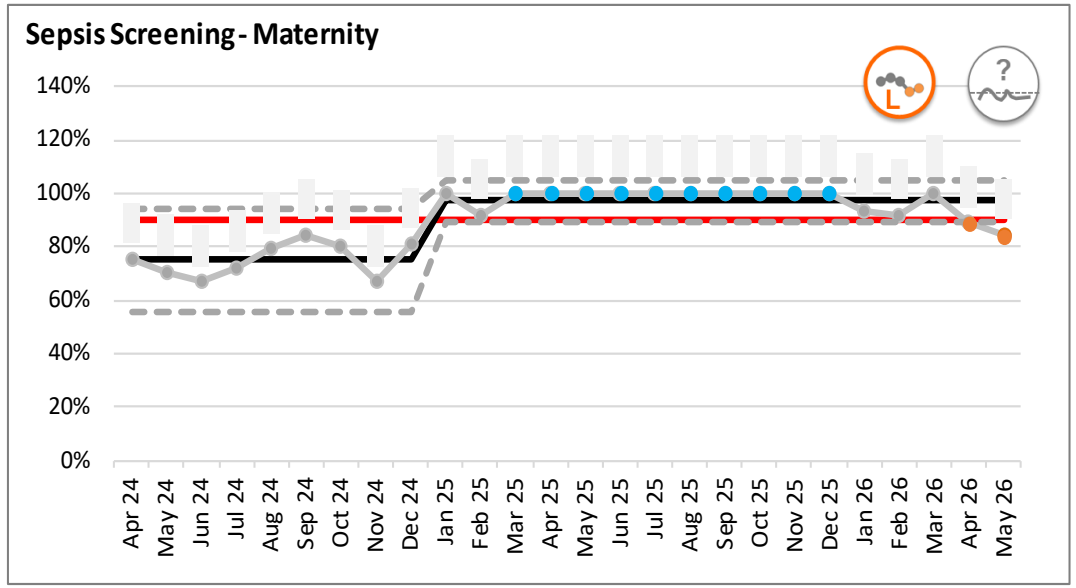

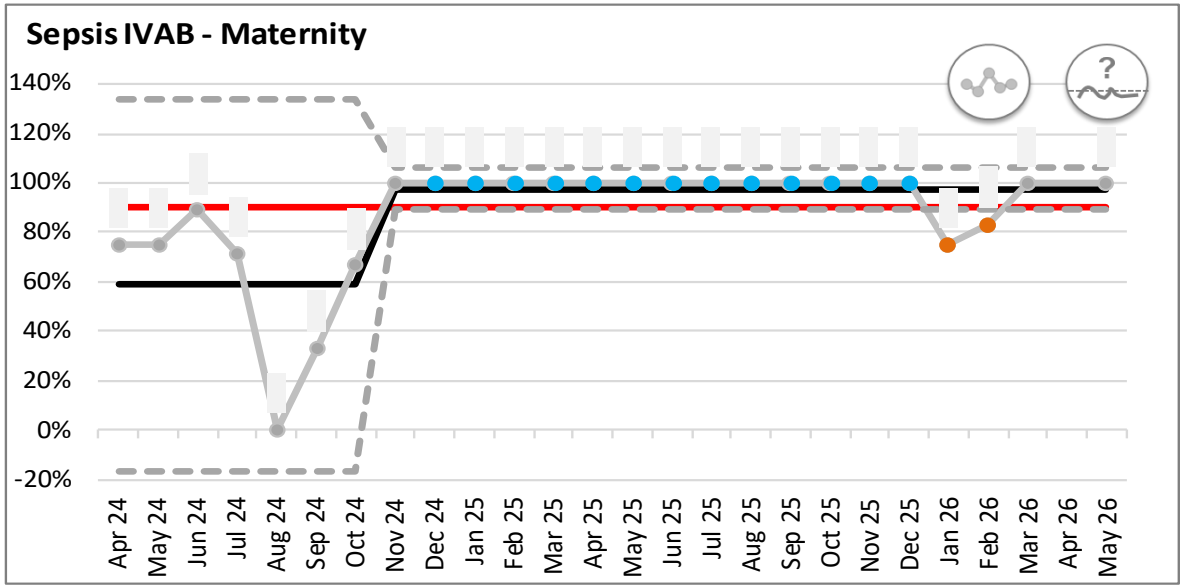

What is driving this performance?

A total of 15 cases were audited from the emergency portal MAU in June and there were 3 missed screens. 7 cases were reviewed for inpatients, and there were no missed sepsis screens.

For emergency portals, there was 1 red flag sepsis, and IV antibiotics were administered within 1 hour.

What are we doing about it?

Monthly audits undertaken and embedded with Lead Midwife for Sepsis.
The sepsis team continue to provide sepsis kiosks/ drop- in sessions to targeted clinical areas.
Visual prompts and flowcharts embedded in clinical areas

Quality & Access | [Sepsis – Children]

Provide safe, effective and caring services

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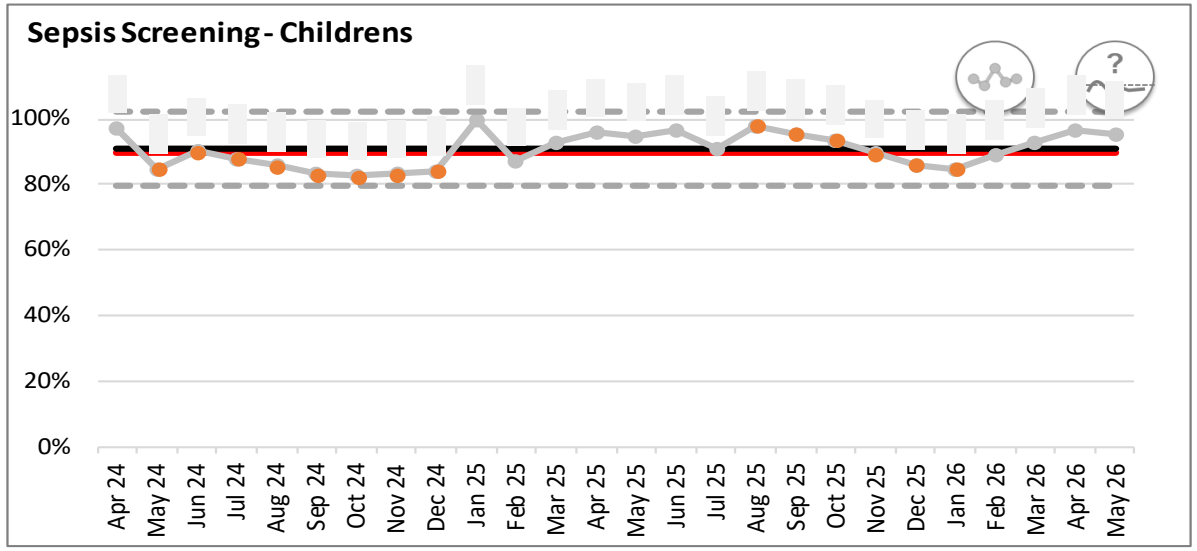
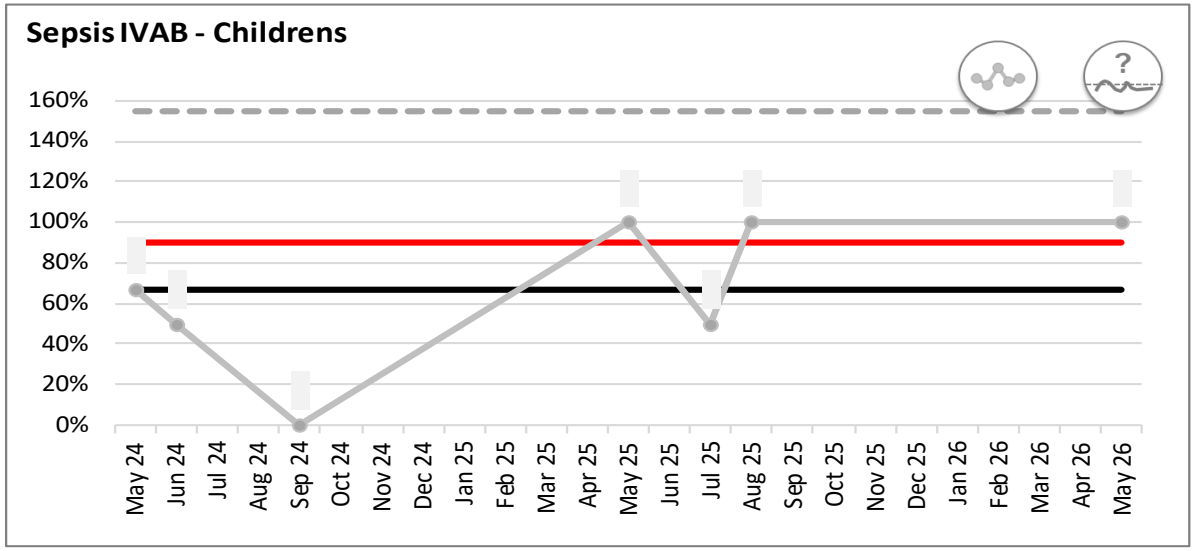




What is driving this performance?

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

There were 21 cases audited for emergency portals with 1 missed screens in June. 9 cases were audited for inpatients with 2 missed sepsis screens.

Only two true red flag sepsis cases has been identified from the randomised audits in the emergency portals or inpatients since August 2025.

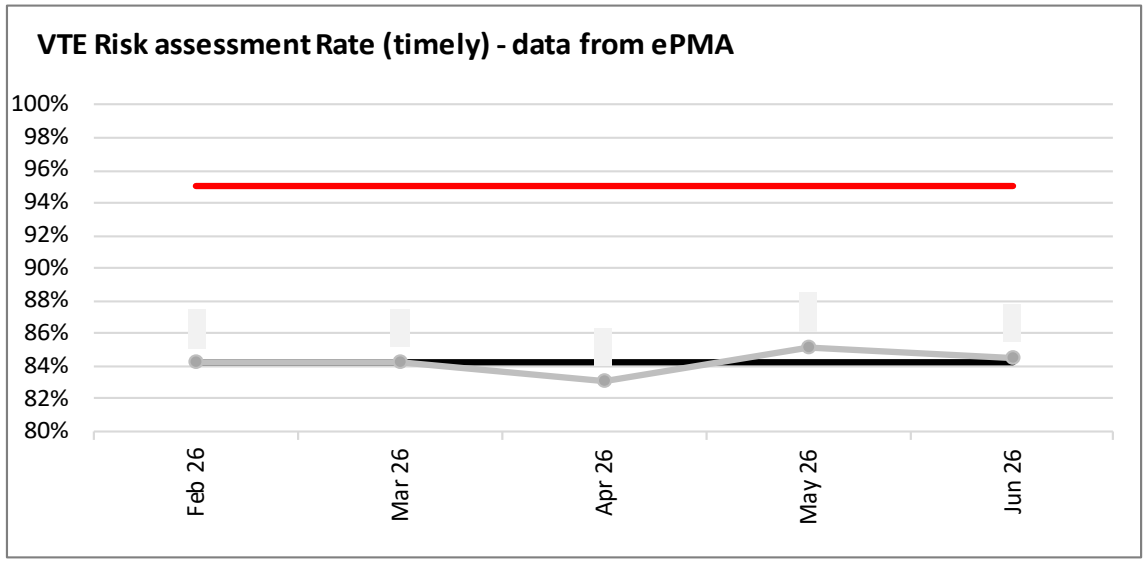
What are we doing about it?

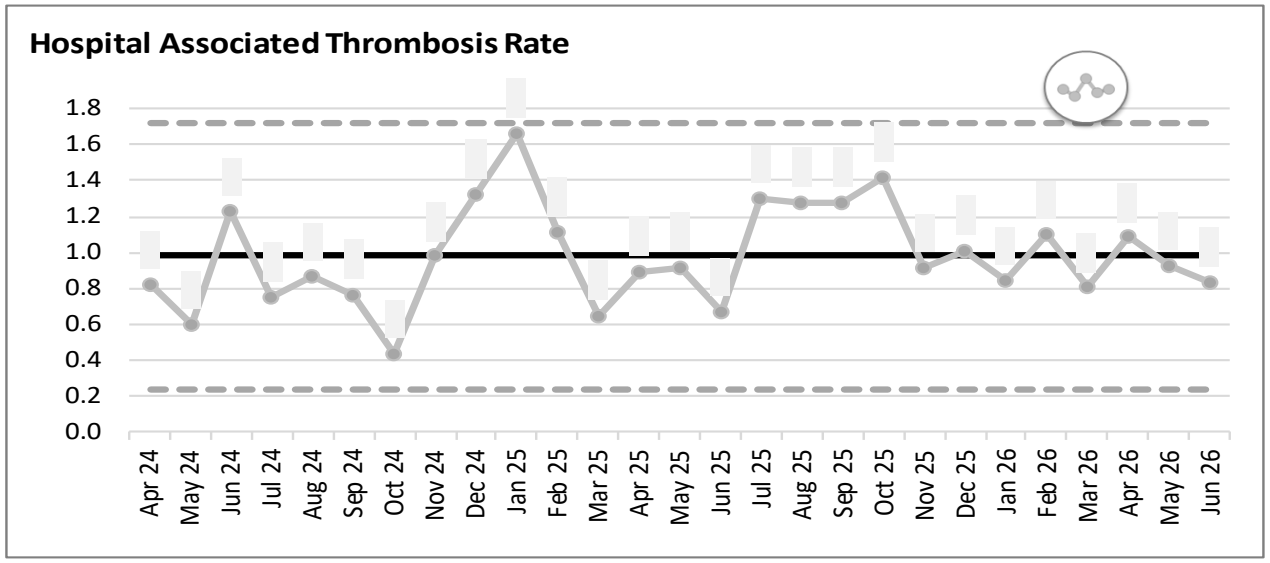
The sepsis team will continue to attend the mandatory training days and provide sepsis training to nursing staff and nursing assistants.

Quality & Access | [VTE & Hospital Associated Thrombosis]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is driving this performance?

Timely assessment means within 12h of admission to a ward, though guidance accompanying the national data collection states within 14h of the decision to admit.

Timely VTE risk assessment compliance averages 84% to date. Detailed analysis of early results found very few assessments are missed completely, but a significant proportion are not timely.

Where medications are prescribed in ED (where VTE is not mandatory, to allow for emergency prescribing), assessments are then often completed later than 12h after admission to a ward.

The Hospital Associated Thrombosis rate shows significant variability while still staying within control limits.

What are we doing about it?

Work has begun with Royal Stoke ED to incorporate VTE Risk assessment, which now appears on the A&E Dashboard, highlighting all patients requiring a VTE risk assessment. Possible digital prompt solutions are being considered to support early completion of VTE Risk assessment and the commencement of VTE prophylaxis

Work is underway with VTE Clinician Champions to incorporate the new VTE Assessment & Prophylaxis dashboard into Board/Ward rounds as standard work. A few trial areas have been identified to provide feedback. Early feedback is positive, but its use will require embedding into standard work

There has been an increase in Hospital Associated Thrombosis whereby patients have not been prescribed the appropriate prophylaxis following the full introduction of ePMA. A Safety Alert has been produced and shared with positive clinician feedback and engagement.

Quality & Access | [Safe staffing & Timely Observations]

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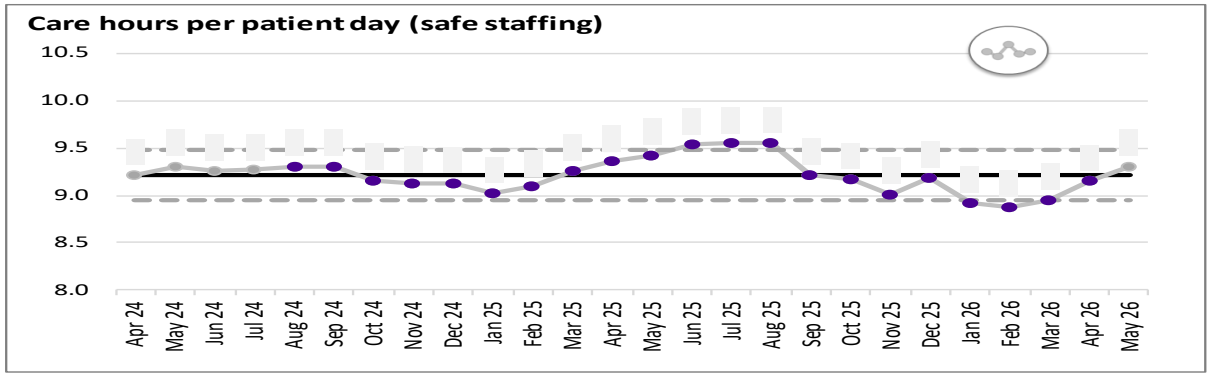
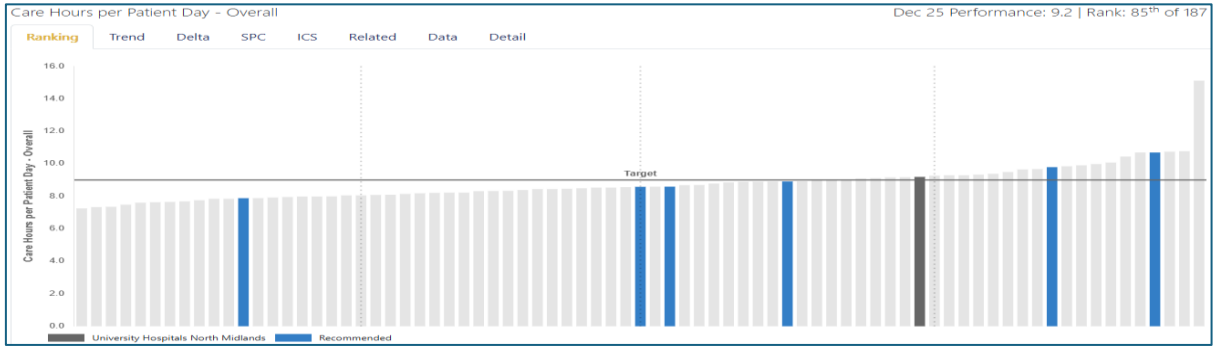
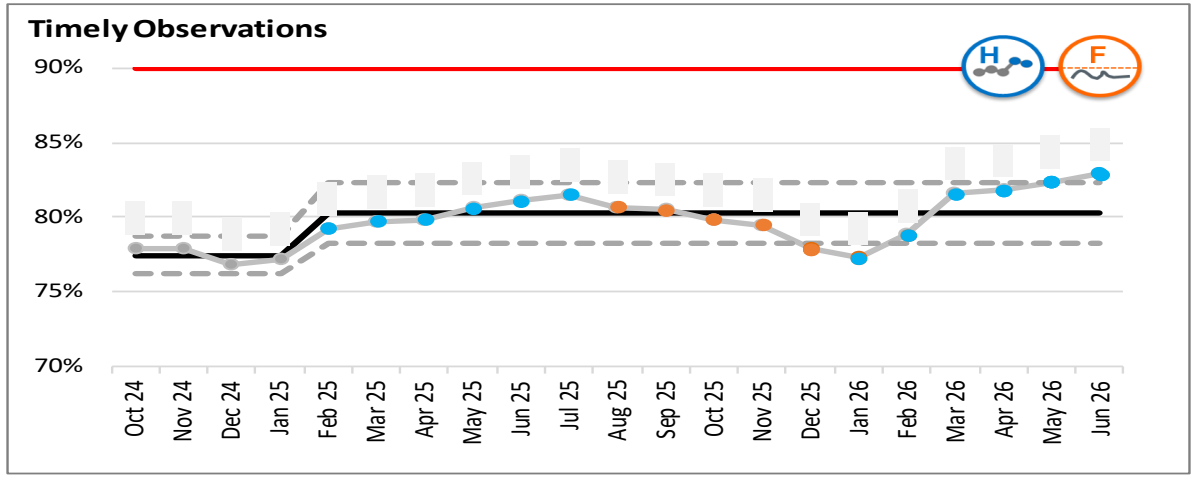






What is driving this performance?

Care hours per patient day (CHPPD)

- The decline in CHPPD due to CSW shortages now appears to been addressed.

Timely Observations

The proportion of observations recorded as timely in June 2026 was 83%, a record high by a small margin. However, only 13 wards/departments met the 90% target in June and 6 wards had compliance below 75%: Wards 78, 108, 76a, 107, FEAU, 109

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. 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.

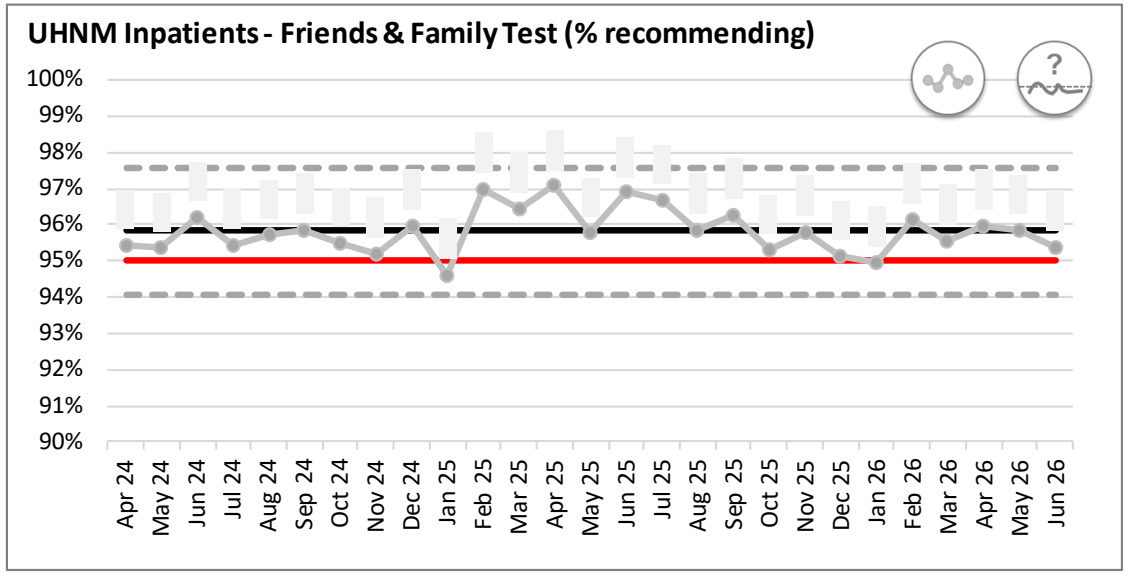
Individual area support and offer to attend the bronze ward review where appropriate.

We have also established a working group to look at reducing avoidable harms and timely observations are a key part in this work and how timely observations can be improved and the improvements embedded across the Trust

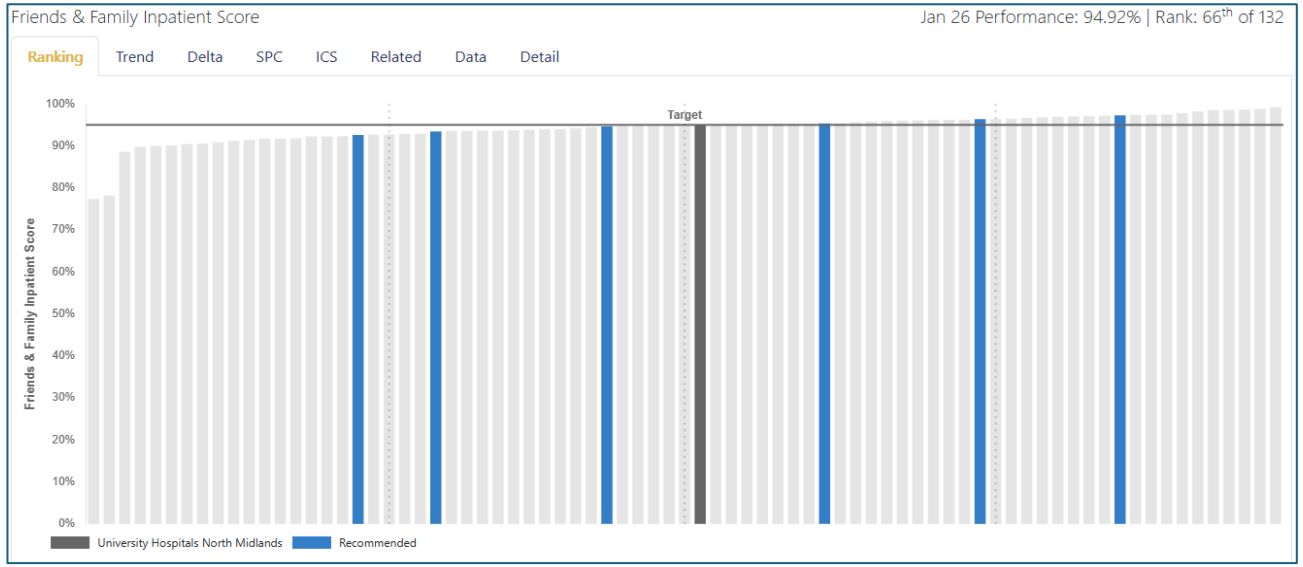
Quality & Access | [Friends & Family Test - Inpatients]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Public View FFT Inpatients Acute Trusts Benchmarking (Jan 2026)



What is driving this performance?

The monthly satisfaction rate for inpatient areas was within the usual range in June 2026. The average rate remains above the national average of 95% (April 2026 NHS England). UHNM were 9th out of 153 Trusts for total number of responses submitted, and 71st in the list for % positive responses, however 8 of the Trust's ahead of UHNM on the list also scored 96%.

In June 2026, a total of 2783 responses were collected from 65 inpatient and day case areas equating to a 25% return rate, which is within the usual range.

Average Care Group Scores are as follows:

- Unplanned - 19% response rate, 95% satisfaction score
- Planned - 37% response rate, 96% satisfaction (30% response target met since Apr-24)
- CSS (excluding Maternity, see separate slide) - 25 % response rate, 99.4% satisfaction score

What are we doing about it?

Recommendation Rates are visible on the 'Safe in our Hands' Dashboard.
Review each Clinical Care Group scoring and identify areas for improvement.
FFT areas of celebration and areas for improvement to be shared monthly at Patient Experience Group.
Monthly focus meeting with HoN's for each Care Group to identify areas they're proud of and areas for improvement based on FFT comments/feedback.

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

Provide safe, effective and caring services

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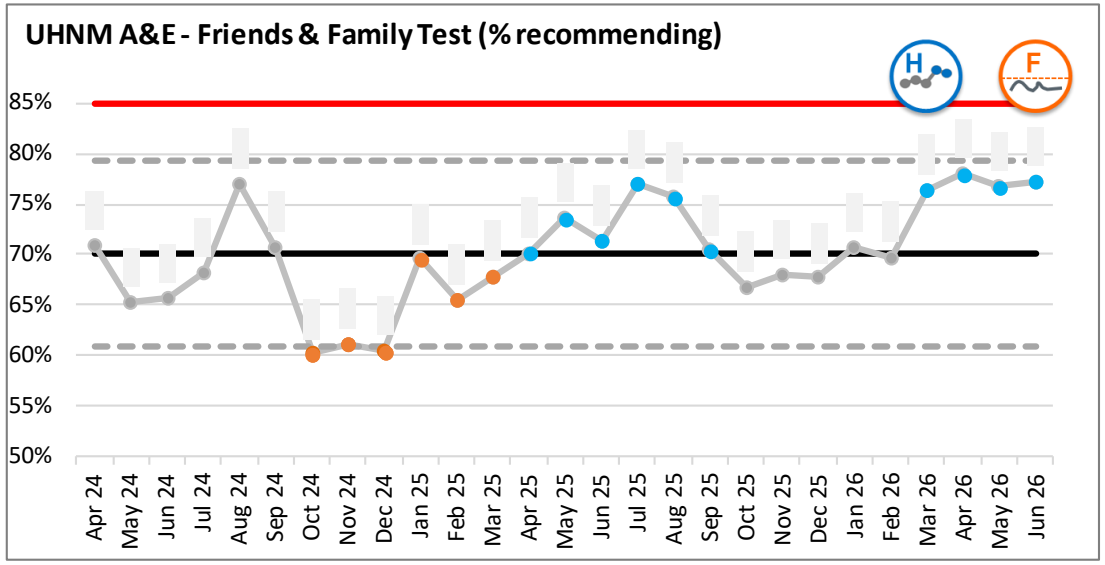
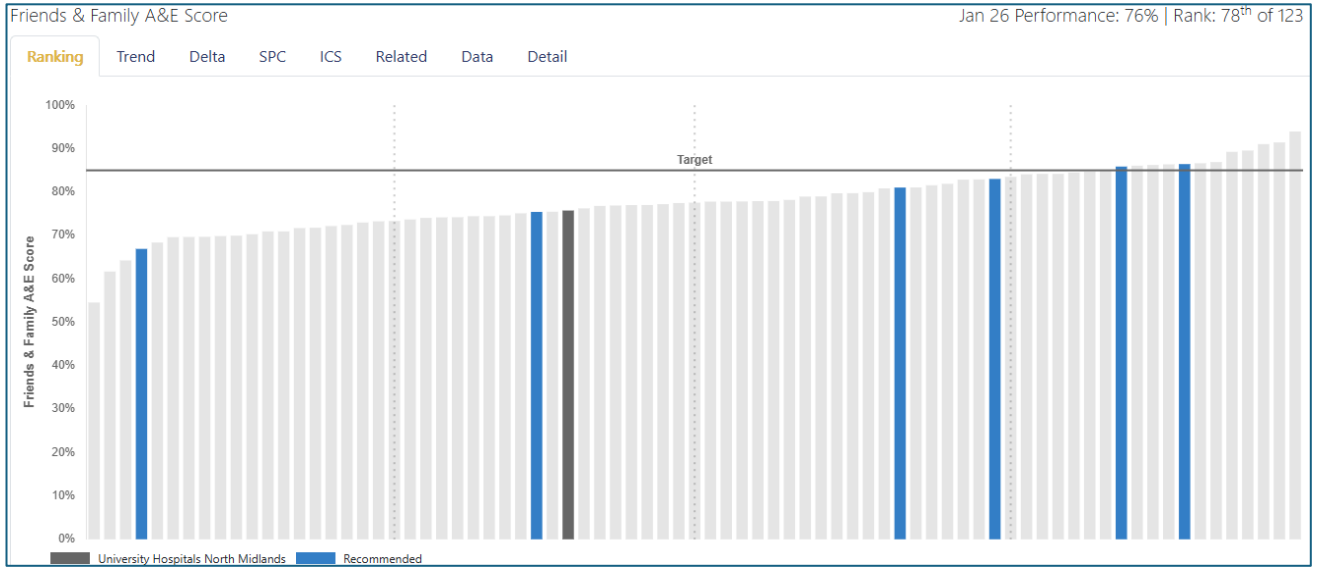


Public View FFT ED Score Acute Trusts Benchmarking (Jan 2026)



What is driving this performance?

The Trust received 1476 responses in June 2026 - a 15% response rate which is significantly above average. Satisfaction rates remains slightly below the national average of 80% (NHS England April 2026) although rates have been significantly higher than usual since Mar-26. ED County had a higher response and recommend rate at 20% and 87% respectively. ED Royal Stoke have 13% response rate and 70% recommend rate. ED County response and recommend rates were both significantly above average in June. ED Royal Stoke response rate was significantly above average in June.

UHNM is 13th out of 125 Trusts for the number of responses in ED and 54th out of 125 Trusts for the percentage positive results (NHS England April 26).

Themes for improvement from April 26 continue to be long waits for both sites. Access to pain relief and not feeling assured by the level of investigations undertaken are also key themes.

What are we doing about it?

- Simplified 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" in place.
- Dept Leads to consider how to make improvements with regards to communication in relation to staff attitude and patients feeling dismissed.
- Monthly focus meetings with HoN re continuing to increase response rate.

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

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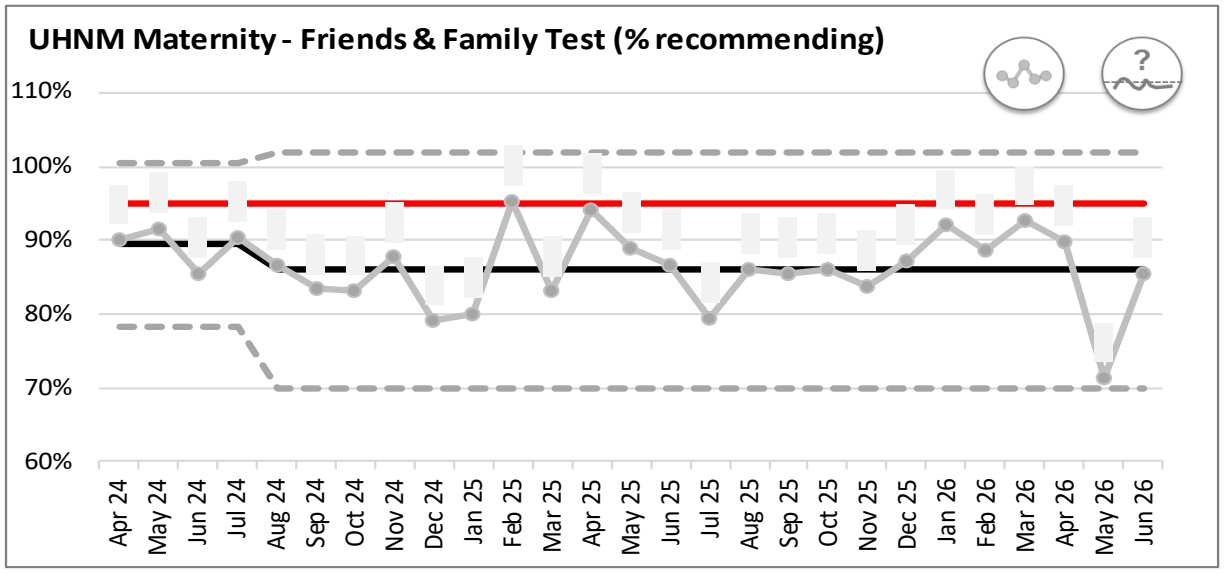

What is driving this performance?

The average % recommending has remained around 86% since 2024, somewhat below the 95% target. Nationally, the overall recommend rate is 92% (April 2026 NHS E). The figure for June is within the usual range.

There were a total of 62 surveys received in June 2026 across all 4 touch-points (ante-natal, birth, post-natal ward; post-natal community) with 25 of these being collected for the "Birth" touch-point, making the response rate 5% which is within the usual range. The average satisfaction scores are Ante-natal: 80%, Birth: 90%, Post-natal ward: 89%, Post-natal community: 90%. 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.

Monthly focus meeting with HoN's to discuss FFT response rate and results.

Quality & Access | [Formal Complaints]

Provide safe, effective and caring services

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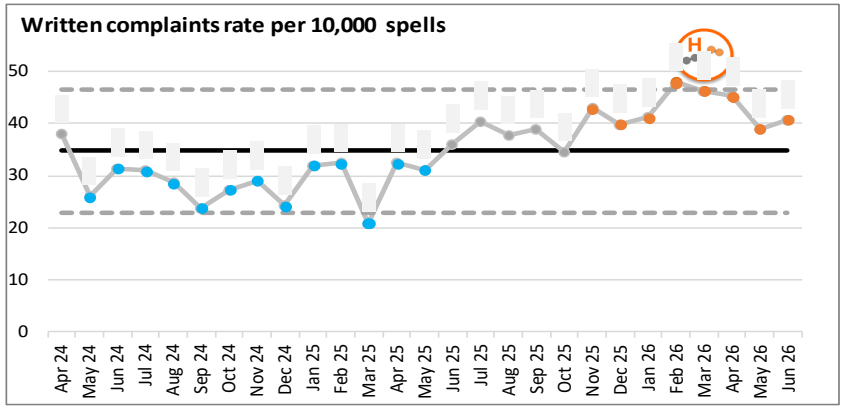
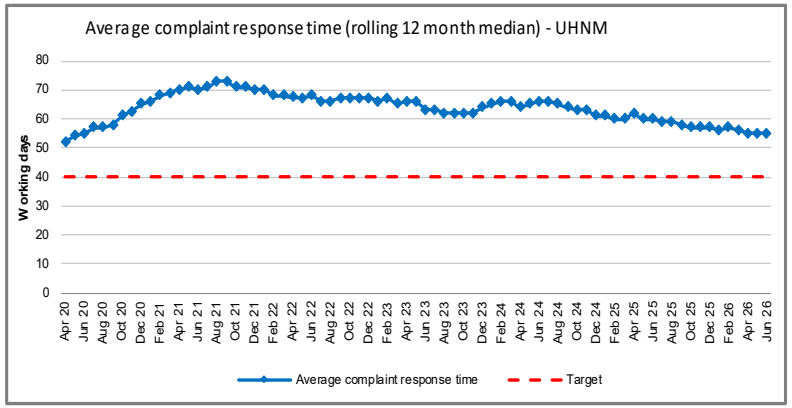
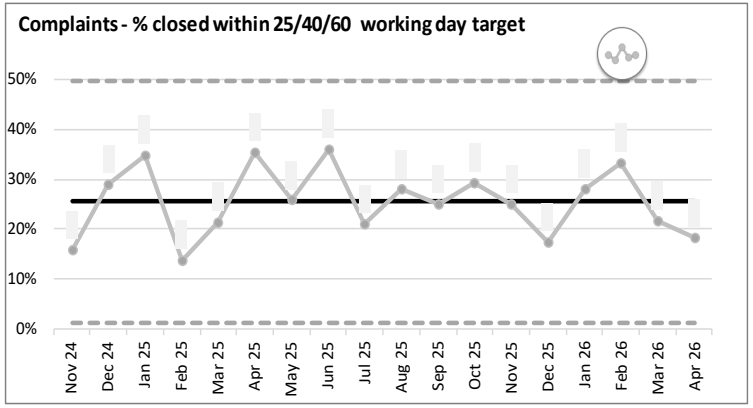






What is driving this performance?

The rate of complaints received remains significantly above average. Increases have been noted in relation to clinical treatment, patient care, appointments categories but not in relation to staff values or admissions, discharges & transfers.

A massive 122 complaints were closed in June 2026, with a median average response time of 59 working days (chart displays the rolling 12-month average). It is worth noting that although not yet meeting the response target we have reduced the average response time by 20 days since the post-pandemic peak in 2021.

Average response times have been on a downward trajectory since 2024, which is a significant achievement considering higher numbers of complaints received.

267 complaints were open at the end of June 2026, of which:

- 6 had been open longer than 12 months
- 32 had been open 6 – 12 months
- 38 had been open 3 – 6 months

The percentage of complaints closed within their allocated 25/40/60 working day target remains within the usual range around an average of just 26%.

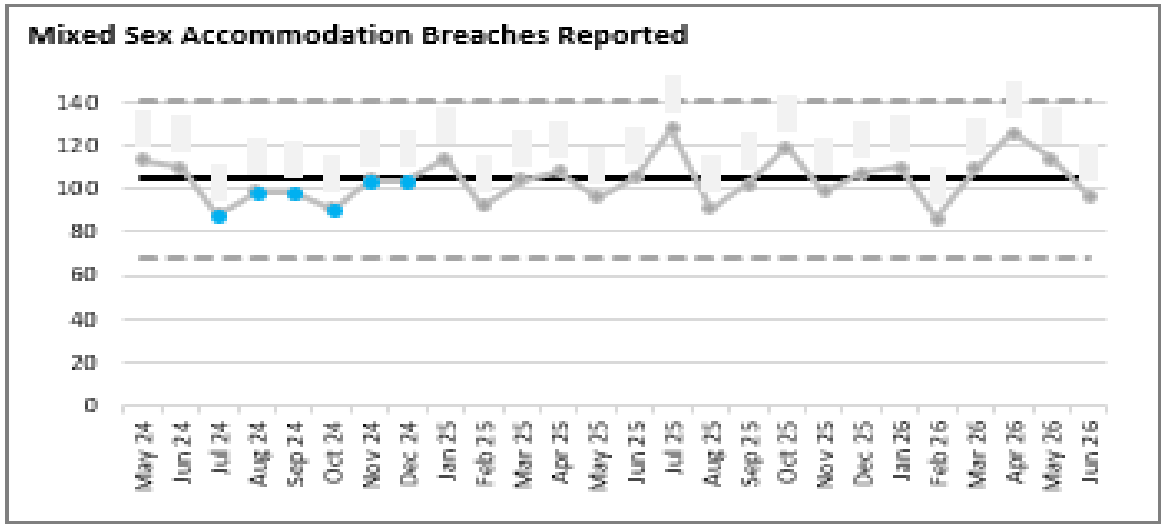
What are we doing about it?

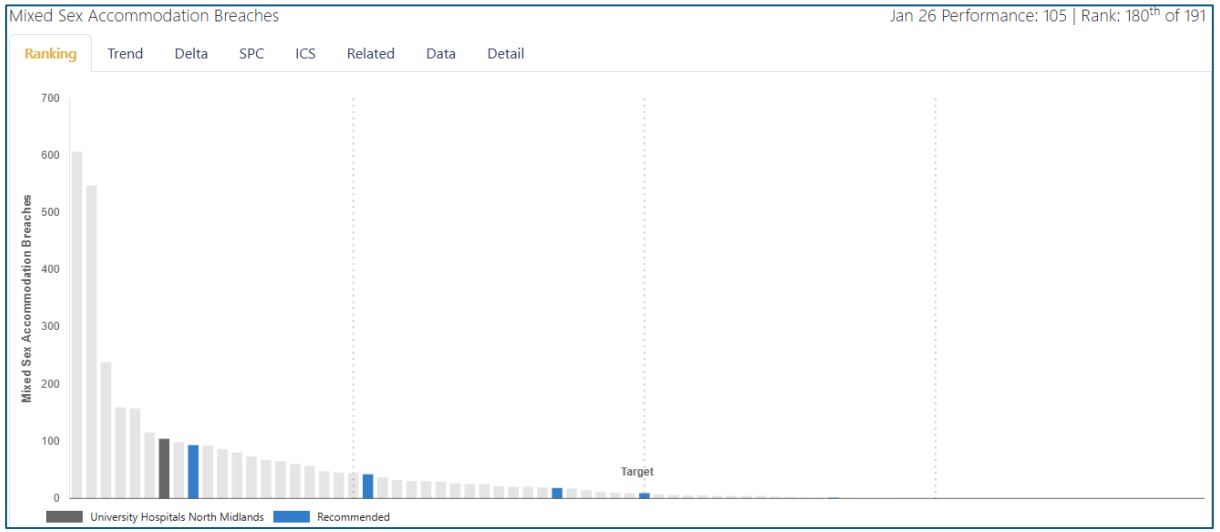
- Formal Escalation process in place to support with response times.
- Following receipt of Weightman's NHS Trust Benchmarking Report 2024/25 it was noted that In 2024/2025, UHNM received the fourth fewest written complaints in the benchmarking group, and approximately 51% more than in 2020-2021. UHNM exceeded the written complaints average in each year reported apart from 2022-2023.
- In 2024/2025, UHNM received the joint-third fewest written complaints per bed in the benchmarking group, and approximately 14% more than in 2020-2021. UHNM remained below the written complaints per bed average in every year reported.
- New process to be trialled May 2026 whereby IO's and admin are assigned to Care Groups - we have been reviewing how we can improve our complaints process; making it more efficient and streamlined and also work more closely with our Quality & Safety colleagues, especially on those cases which also involve aspects of the PSIRF process as we are seeing an increasing number of cases which cross-over. This will allow for better oversight of open complaints cases with earlier identification of any challenges in meeting timeframes, support with obtaining timely, high-quality responses and support with developing stronger, more robust learning actions from complaints.

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is driving this performance?

June 2026 reported 97 Mixed sex accommodation breaches with and overall reduction since the high point in July 2025. The number of mixed sex accommodation breaches was within the usual range, based on the previous numbers show, the in-month increase is above the long-term mean.

There are critical care and surgical special care.
There reasons are varied but include:

- pressure at the front door and the need decompress ED
- we are not following C51 to prioritise step downs and review elective capacity for cancellations
- bed allocation is late – often post midday due to delays in discharges/TTOs and discharge letters meaning patients listed as ready at 8am do not move till after 5pm
- sometimes patients allocated as ready are then not but its unclear if the ready time is then amended

What are we doing about it?

The UHNM Site Team have initiated a Test of Change (ToC) due to start in June.
We have allocated a Clinical site manager to be a Matron for site operations. Within this 12-week ToC they have a project to support and improve single sex breaches.
We have also progressed the digital support solution with a stepdown list due to become available in iPortal by the end of the month to record more timely referrals and allocation of beds.

We hope that these two improvements will support us in narrowing down where delays are occurring and support improvements to breach numbers as well as support BI improvements which with provide a more robust reporting solution.

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.

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

Provide safe, effective and caring services

NHS
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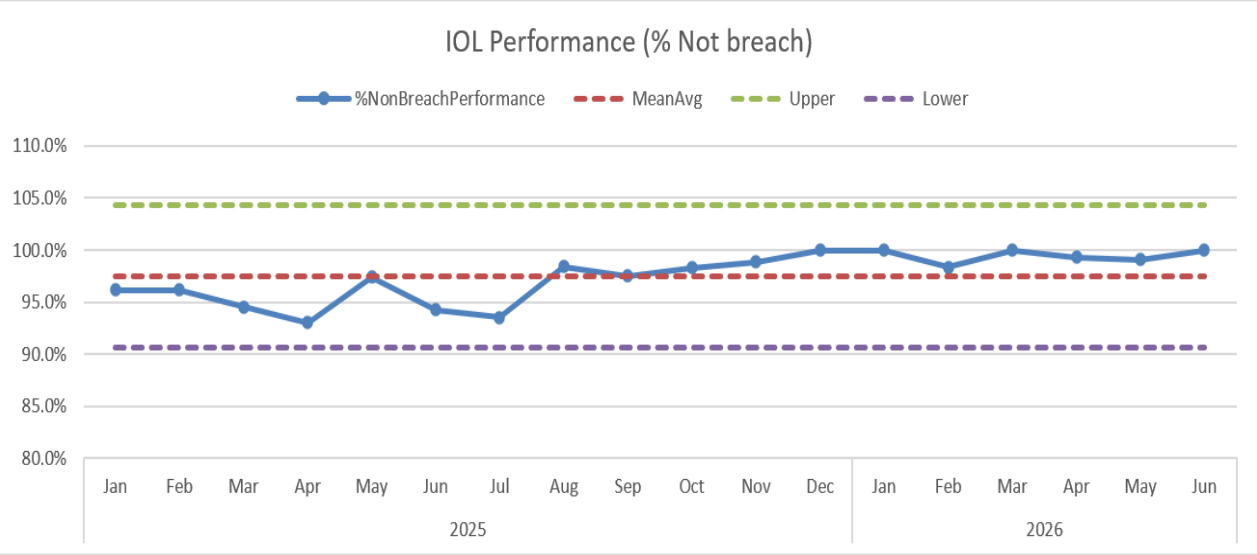
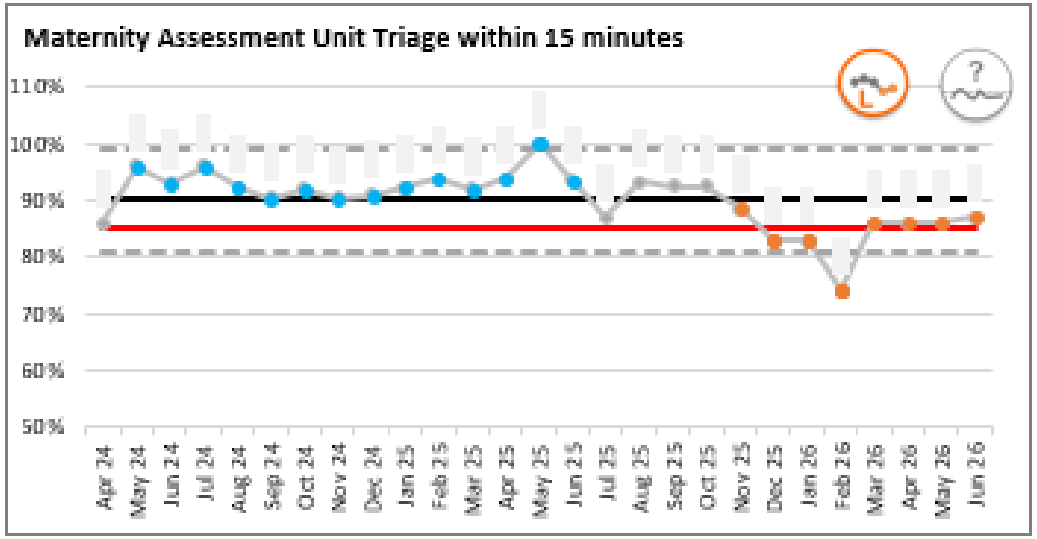




What is driving this performance?

Induction of Labour (IOL)

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..

Compliance with IOL for June is 100%

Daily oversight, safety netting and escalation of potential IOL breaches, including patient safety huddles.

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

Breach dates challenged when outside of guidance.

MAU

The target set of 85% of patients to be seen within 15 minutes on MAU was met with June's data at 86%

What are we doing about it?

Induction of Labour (IOL)

- Patients are admitted to the antenatal ward to await IOL and avoid breaching.
- Bi-monthly IOL Improvement Group to refine pathways and flow as required.
- DATIX submissions of any breaches for a full review for learning and to ensure no harm occurred.

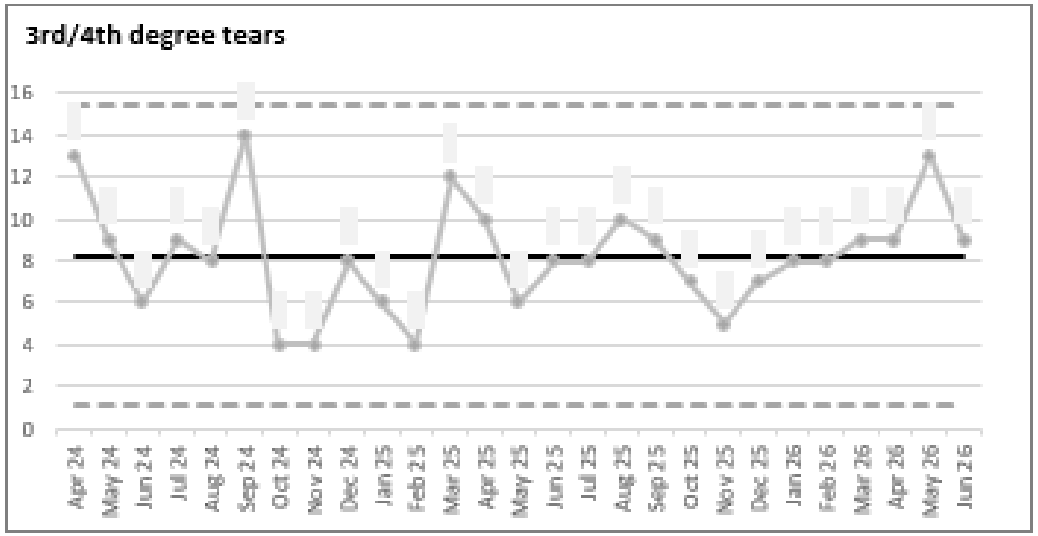
Maternity Triage

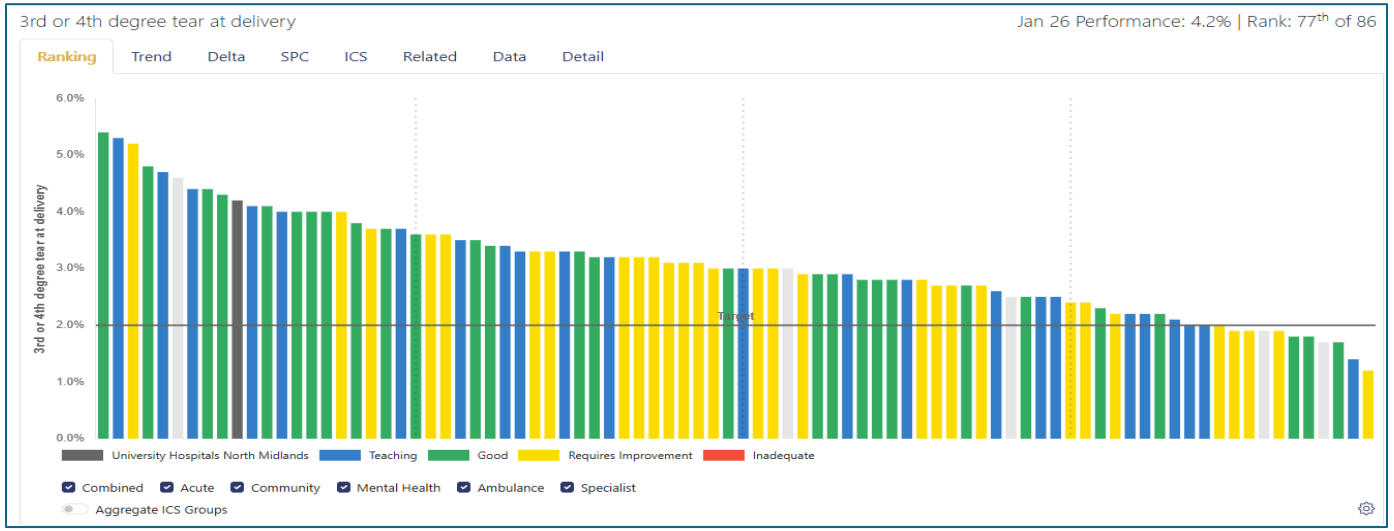
- Continued monitoring through MAU Improvement Group with daily review of breaches.
- Use of Datix and safety huddles to support learning and escalation.
- Refresh of A3 improvement plan to support sustainability.
- Workforce stabilisation (MSW and clerical roles) to support flow and performance.

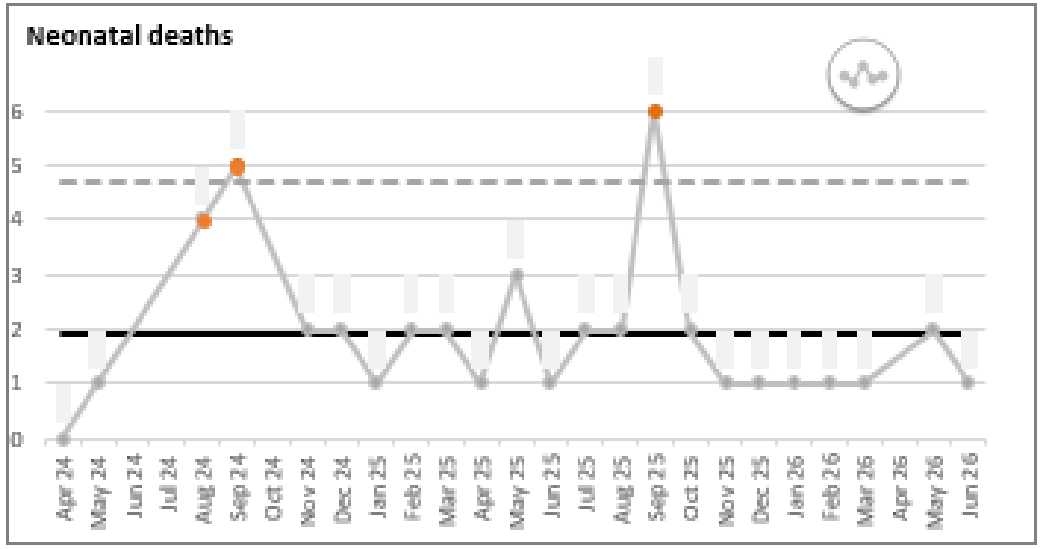
Quality & Access | [3rd/4th degree tears & Neonatal deaths]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust







What is driving this performance?

3rd/4th degree tears
There were 9 recorded 3rd/4th degree tears in June 2026, which brings the data back to within acceptable limits this month.

Neonatal deaths
1 neonatal death was recorded during June 2026.

What are we doing about it?

3rd & 4th Degree Tears (OASI)
- Timely Datix submission and review to support rapid learning.
- Ongoing audit and review by the Perineal Health Team.
- Targeted training and feedback informed by emerging themes.

Neonatal Deaths
- Rapid obstetric and neonatal reviews for all cases.
- Full investigation via PMRT, with reporting through Directorate, Care Group and Trust Board.
- Continued external assurance through WMPN and MIS Year 7 standards.

Quality & Access | [HSMR / SHMI]

Provide safe, effective and caring services

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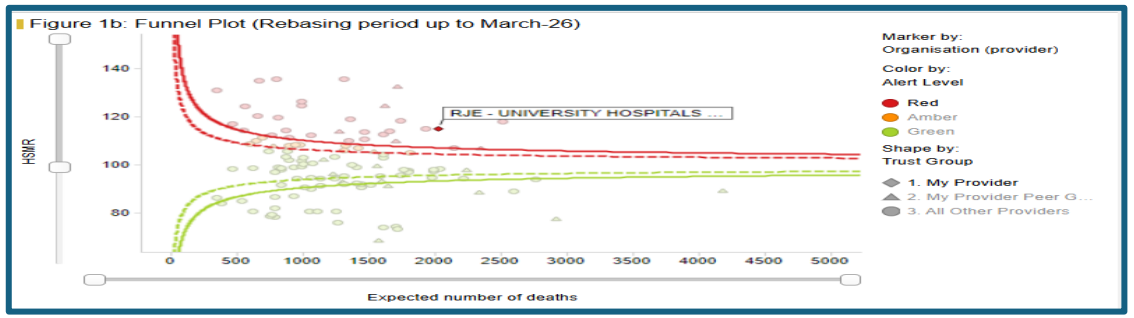
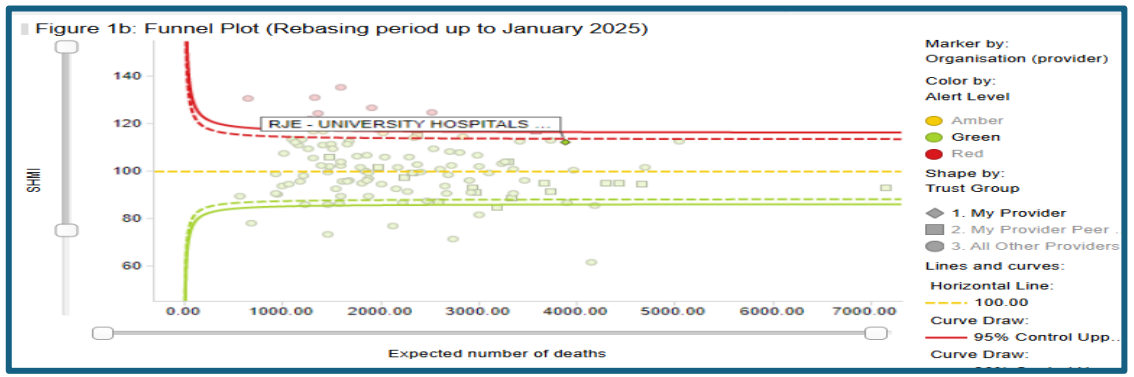
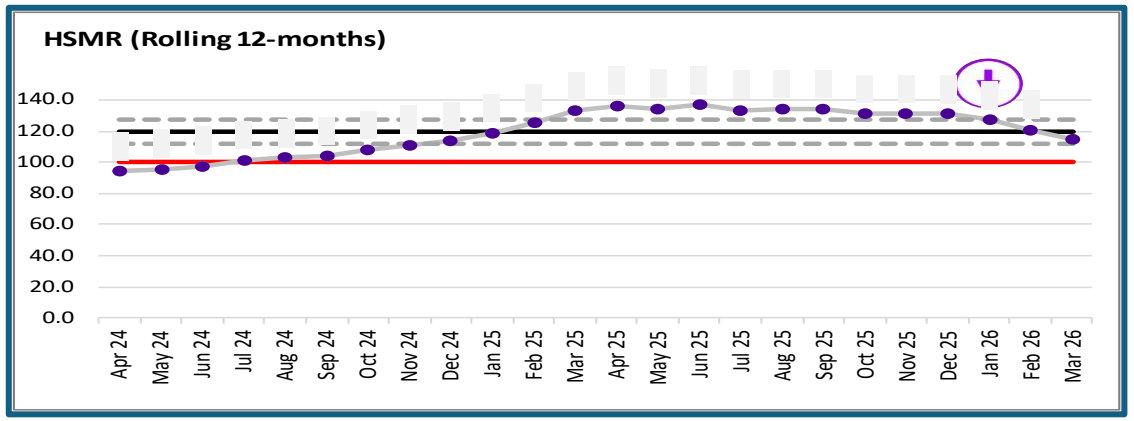






What is driving this performance?

UHNM HSMR remains higher than expected based on case mix and standardisation for current 12-month period (April 2025 – March 2026). The current 12-month HSMR is 114.9.

There have been continued in-month reductions in monthly HSMR since August 2025 following further data refresh and submissions completed by Clinical Coding Team.

UHNM SHMI also remains higher than expected at 112.39 for current 12-month period (March 2025 – February 2026).

The HSMR/SHMI issue re coding backlog continues in the rolling 12-month figures.

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 have seen improvements for HSMR and SHMI during the second half of 2025/2026.
- The HED data refresh represents the 'Month 13' HES publication that is produced at the end of each financial year. This data is based on the March Post-Reconciliation submissions; therefore, the data does not move along a month as Month 13 covers the full financial year's data submission, (April to March) with updated coding for completeness.
- Further reviews within HED system and available data analysis re coding depth underway.
- Remains under review and have shared update with QAOC and ICB.

Quality & Access | [NPSA Alerts received and overdue]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

Open / Overdue Alerts:

	Year	Alert Type	CAS Status	Alert Reference Number	Alert Title/Device	Date Issued	Deadline Date	Comments	Actions
	2025	Nat/PSA	Open	Nat/PSA/2025/006/NHPS	Harm from Allergic reaction due to misinterpretation of prescription.	20/11/25	20/11/26	There are reports of healthcare staff recording a patients penicillin allergy as penicillamine allergy in the EPMA. This look-a-like sound-a-like error risks a patient with a known penicillin allergy being administered a penicillin base antibiotic and having a potentially fatal reaction.	Work with digital systems to develop/deploy additional built in mitigations to reduce inadvertent recording of the wrong allergy.

What is driving this performance?

In June 2026 UHNM received no new Patient Safety Alerts that were applicable to the Trust.

There is only one NHS Patient Safety Alert open, and this is within the completion deadline of 20/11/26.

What are we doing about it?

Actions are ongoing to ensure that the necessary requirements of the alerts are being effectively implemented.

Quality & Access | [Clinical Effectiveness]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

- 3 external inspections were undertaken during Q1:
  - Human Tissue Authority - Post Mortem Licence 12224
    - 1 Critical Shortfall
    - 10 Major Shortfalls
    - 4 Minor Shortfalls
    - Action plan has been developed
  - British Standards Institution (BSI) Accreditation (Oncology) Accredited to ISO9001
    - No minor nonconformities were identified during the assessment
  - Radiopharmacy Audit
    - A total of 17 recommendations were made
    - Action plan has been developed
- There are 13 pieces of NICE Guidance awaiting implementation into practice, reduction of 7 from the Q4 update .
  - 5 are with the Clinical Team to complete the gap analysis
  - 8 are currently being implemented. Teams addressing gaps in the current service.
- Getting It Right First Time (GIRFT) - Following an unprecedented number of GIRFT visits throughout 2025 / 2026, UHNM is currently committed to developing and implementing action plans across 5 clinical areas
  - Breast Surgery – 6 recommendations
    - 2 actions completed
    - 5 actions are on track
    - 1 action problematic - The problematic actions relate breast conservations rates
  - General Surgery – 12 recommendations
    - 3 actions completed
    - 7 actions are on track
    - 1 action problematic - relates to the provision of a business case to expand enhanced care capacity
    - 1 action delayed - relates to the provision of a 24/ 7 surgical service at County Hospital.
  - Interventional Radiology – 19 recommendations
    - 4 actions completed
    - 14 actions on track
    - 1 action problematic - The problematic action relates to the provision of an education programme for ward nursing staff to ensure that patients are correctly prepped for IR procedures
  - Urology - 14 recommendations
    - 3 actions completed
    - 1 actions on track
    - 10 problematic actions - The problematic actions are currently with the Urology clinical and management teams to review. Issues currently being addressed include:

    •Increased access to robotic time – needs to be supported by additional theatre lists
    •Job planning and Consultant availability
    •Review of coding processes
    •Review of the pathway between UHNM and SATH
  - Vascular – 22 actions
    - 3 actions completed
    - 10 actions on track
    - 5 delayed actions - The problematic actions are currently with the Vascular clinical and management teams to review. Issues currently being addressed include:

    •Possible business case to support the provision of a Perioperative Care for Older People undergoing Surgery Service
    •Job planning
    •Tracking patients requiring elective aortic aneurysm repair and carotid endarterectomy to determine reasons for delays
    •Provision of service model for Diabetic patients.
- 10 Clinical Audits were published in Q4:
  - 3 Significant Assurance
  - 3 Significant Assurance with Minor Improvements
  - 4 Partial Assurance

NB. A Clinical Effectiveness Report is going to be tabled at meetings during August 2026. The report will expand on the information presented on this update and will detail actions and risk mitigations for all reports / audits published requiring improvements in practice

- Action plans for each inspection, audit, report being developed in conjunction with the Clinical Teams
- NICE guidance escalation – via the Care Group Assurance Meeting
- Provision of Directorate and Care Group Quality Outcome Meetings to support oversight and ownership of Clinical Effectiveness priorities by the Care Group
- Provision of overarching Care Group Clinical Effectiveness action plan to ensure triangulation and avoid duplication of work
- Care Group Governance and Clinical Effectiveness Leads in post.
- Consideration being given to Speciality, Care Group and Trustwide Clinical Effectiveness KPIs

Access to Services

University Hospitals of North Midlands NHS Trust

Access to Services	Data period	Provider value		Chart
Access to services domain segment	Q4 2025/26	3	NOF Score	
Access to services domain score	Q4 2025/26	2.51	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	Q4 2025/26	3	NOF Score		Provider value	
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Mar 2026	64.74%	63.48%	64.83%	Provider median	
Difference between planned and actual 18 week performance score	Q4 2025/26	1	NOF Score		Provider value	
Difference between planned and actual 18 week performance	Mar 2026	1.95%	-0.36%	0.99%	Provider median	
Percentage of patients waiting over 52 weeks for elective treatment score	Q4 2025/26	3	NOF Score		Provider value	
Percentage of patients waiting over 52 weeks for elective treatment	Mar 2026	1.82%	1.25%	0.96%	Provider median	
Percentage of patients waiting over 52 weeks for community services score	Q4 2025/26	1	NOF Score		Provider value	

Cancer Care	Data period	Provider value	Peer average	National value	National value method	Chart
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral score	Q4 2025/26	2	NOF Score		Provider value	
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral (quarter)	To Mar 2026	78.60%	77.50%	79.34%	Provider median	
Percentage of patients treated for cancer within 62 days of referral score	Q4 2025/26	3	NOF Score		Provider value	
Percentage of patients treated for cancer within 62 days of referral (quarter)	To Mar 2026	67.02%	67.18%	70.24%	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	Q4 2025/26	4	NOF Score		Provider value	
Percentage of emergency department attendances admitted, transferred or discharged within four hours (quarter)	To Mar 2026	64.97%	72.37%	74.01%	Provider median	
Percentage of emergency department attendances spending over 12 hours in the department score	Q4 2025/26	3	NOF Score		Provider value	
Percentage of emergency department attendances spending over 12 hours in the department (quarter)	To Mar 2026	10.69%	9.44%	8.71%	Provider median	

UHNM remains in segment 3 for this domain and has seen an improvement in the NOF score, reducing from 2.57 in Q3 to 2.51 in Q4. This 0.06 improvement is largely driven by better performance within Cancer and Elective care.

Elective Care – performance has improved across all metrics and better than peers for RTT 18wk performance and the Difference between planned and actual 18wk performance.

Cancer Care – both indicators have improved since Q3, resulting in a stronger NOF score and suggesting that UHNM's rate of improvement has exceeded that of peers.

Urgent and Emergency Care – 4hr performance has declined since Q3, with the NOF score increasing from 3.78 to 4.
12hr performance has also deteriorated, however relative performance has improved compared to peers, reflected in an improvement in the NOF score from 3.21 to 3.

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

Validated 4-hour performance was 67.5% for June, down 0.4%pts from 67.9% in May, which is 4.9%pts behind trajectory. County continues to perform better than the RSUH site.

2444 patients waited longer than 12 hours in ED (619 more than plan, and 147 more patients than May). 9.4% of patients in ED breached 12 hours, vs a target of 7.3%, and 8.9% in May.

June saw 5181 ambulances arrive at UHNM, with an average handover time of 1 hour 24 minutes, a 7-minute increase when compared with May. 62.45% of ambulances were handed over within 45 minutes (a 3.7% reduction in performance since May and 4% short of plan in Month

UHNM saw an almost identical attendance profile in June vs May (just under 26,000) and the second highest attendance profile since October showing sustained pressure in terms of demand. County experienced the highest attendance numbers for over 12 months. Continued high acuity with over 60% of ED attendances requiring Majors or Resus

The Trust remains in tier 1 for our UEC performance with the support on site of the GIRFT team.

Cancer:

Combined faster diagnosis standard performance final May position was reported at 77% against a trajectory of 80.22%. The provisional June position is currently at 78.64% against a trajectory of 80.88% which is still in validation.

31-day final May position was reported at 91.55% against a trajectory of 91.61% .The provisional June position is currently at 90.77% against a trajectory of 90.84%.

Combined 62-day performance final May position was reported at 69.42% against a trajectory of 67.25%. The provisional June position is currently at 59.08% against a trajectory of 68.05%. This position is expected to improve through validation.

Diagnostics:

Junes DM01 validated performance was 78.6% against trajectory of 96.6%. Current performance is 79.3% (23/07) 95% being the national standard.

CDC delay to go live for endoscopy will have an impact on DM01 performance.

RTT:

18-week performance has deteriorated in June to 62.15% (unvalidated) from 63.61% (validated) in May.

Our 52-week performance is monitored as a % of patients on our total waiting list who are over 52 weeks. For the month of June, 52-week actuals decreased from 1.88% to 1.8%. This standard is to achieve by the end of the year is to get to 1%.

RTT % Waiting 1st Contact for June was 74.1%; 0.2% off plan.

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 and Cancer. UHNM are no longer in Tier 2 for our Diagnostic performance.

Elective

Quality & Access | Overview

NHS
University Hospitals of North Midlands
NHS Trust

Overview from the Chief Operating Officer

What is driving this?

Non-Elective

- Following six months of sustained improvement, May and June saw a deterioration in Ambulance Handover performance, linked to high attendance and conveyance numbers. With additional challenges of sever hot weather and digital outages.
- Whilst January 26 to April 26 saw a year-on-year reduction in the ambulance handover lost hours of around 7,500 hours, May 26 saw 567 more hours lost to ambulance handovers than the same month last year, and June saw an almost identical handover delay average compared to the same month last year.
- The end of the winter additional capacity (particularly the return of W102 to elective care) and the maintenance programme have had an undoubted impact on our capacity, particularly at RSUH. The creation of the decant ward (122) following the closure of W80, has facilitated the continuation of the maintenance programme.
- Attendance volumes continued to be elevated, with almost 26,000 attendances again in June. We would normally expect to see a drop in attendances in July and August.
- ED conversion rate remains higher than target – with weekly Type 1 performance in June ranging from 40.1% to 45.9%, all significantly above target of 30%
- Acuity remains challenged in ED presentations with 60% for Resus or Majors
- Corridor Care remains in use, in both ED and continuous flow risk assessed spaces.

Elective

Continued reduction in the overall cancer backlog, with significant improvements seen within the Head and Neck pathway. Reduction in the backlog of patients exceeding the 28-Day FDS within Colorectal and Upper GI pathways. Introduction of the Digital Pathway solution is already demonstrating improvements in turnaround times, with reductions in average reporting delays. Cancer Services team attendance at speciality-specific away days has helped strengthen awareness of cancer performance standards, targets and improvement initiatives. Strong engagement with the Peer Review Programme across specialties, with comprehensive action plans now being developed and monitored. Challenges remain within thoracic surgical booking processes, resulting in delays in the allocation of TCI dates and increasing the risk of treatment pathway breaches. Recovery actions are being progressed in collaboration with the surgical team. Radiology reporting delays continue to impact performance against the 28-Day FDS across all sites, with the greatest impact observed within Colorectal and Gynaecology pathways. Delays in CT booking have been experienced due to vacancies within the scheduling team. Assurance has been provided that diagnostic capacity remains sufficient, and performance is expected to improve as staffing levels stabilise.

Diagnostics: MRI is now showing as the majority contributor for UHNMs overall DM01 performance. MRI performance is 69.2% with 1.3% 13-week breaches (0.3% decrease in 13-week breaches since last month). Echocardiography is also a specialty of concern, with performance at 36.3%; an improvement of 4.1% since last month. Diagnostic Cell will track the recovery action plan. CDC endoscopy delay for go live due to air change and water testing.

RTT: Performance has deteriorated again in June to 62.15% (unvalidated) from 63.61% (validated) in May and is now further behind plan.
Total PTL has increased significantly again from 70,772 in May to 72,873 (unvalidated) in June. There are several factors contributing to this – lower than average removal rate sustained throughout April and into May, exacerbated by Easter and school holidays; higher than average addition rate throughout April and May / reduction in activity / validation & tracking / cancellations in theatres / MRI capacity due to the heat.
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, Oral Max-Facs and Gynaecology.

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 is developing at pace, with each workstream established and working on high impact deliverables
- Each workstream now has a clear Executive SRO, Corporate sponsor, Care Group SROs, Clinical lead and Improvement support, complemented by the work of the GIRFT UEC team
- Governance of the workstreams has been simplified and strengthened, with a focus on continuous improvement
- We continue to meet weekly with the national GIRFT leads, focusing on rapid improvement actions to improve ambulance handover performance, reduce 12 hour in dept volumes and reduce corridor care
- We are working through a 6 week change programme in order to drive embedded improvement at pace, including a redesign of the Acute Medicine pathway over the summer months.
- UTC building works has been delayed due to a challenge between principal and subcontractors. The building is now due to open 7th September (was 31st July), but estates colleagues are pushing for an earlier date if possible.

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. Collaborative working group in process between Histopathology, Directorates and Cancer Services to identify specimens for reporting on appropriate triage pathway – Cancer Team have implemented an automated solution with pathology.

Echocardiography drafting recovery plan for diagnostic recovery. CDC mitigation of TI / WLI to offset endoscopy activity loss. Urgent review of approval of use of CDC estate for endoscopy to be rearranged.

17 Elective Recovery bids have been approved and are being urgently mobilised. Expected activity for New / FUP / Elective / Daycase that supports on PTL size / RTT 18-week performance to be tracked weekly, with executive oversight given against the phasing of schemes going live. MBI ROVA license extended a further 12 months, with all approved recovery bids requiring all admin / operational teams to be trained and using MBI ROVA going forward. This will embed better focus on validation of next steps / to shut pathways of patients. Manual validation also commissioned through Patient Not Present funded allocation; 5000 pathways currently being validated to support with PTL reduction. ICB requested for comparison of IS send for 25/26 v. allocation for 26/27 to understand growth of PTL; opportunity to send full pathways to IS pending confirmation of ICB allocation.

65-week action plan in place for long wait speciality recovery. This includes allocation of vacant theatres, locum by sub-specialty and stand up of targeted extra lists for services with long waiters.

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

Whilst we remain below trajectory, and performance deteriorated in both May and June, we attribute this to the specific challenges of losing the winter bed base, the 5-yearly maintenance programme capacity reduction, some spikes in demand and some particular challenges with discharge volumes.

- Our performance remains below the standard we aspire to deliver, but noticeable improvement in 4-hour, 12-hour and ambulance handover times so far in 2026 are encouraging, despite our performance in the last 2 months.
- The utilisation of corridor care has marginally reduced and will be tracked and monitored in both real-time and in retrospect within our governance framework.
- Improved admission avoidance for Frailty patient cohort as a result of protecting Frailty SDEC bays to maximum capacity.
- The complexity of the 5 yearly Statutory Maintenance Programme for the PFI is an added complexity for the summer months. The operational and estates teams are working hard to mitigate the risk and minimise impact on patients and performance.
- The current 26/27 improvement trajectory does not return us to the national standard until year 3 but does represent a significant and ambitious improvement compared to our current and historic performance.

Elective

For cancer, an established collaborative working group between Histopathology, Directorates and Cancer Services to identify specimens for reporting on appropriate triage pathway. iPortal shared pathology escalation currently live for lung and gynae, next sites LGI and HPB. A refocus on daily and weekly oversight of 28 Day PTL with escalations to specialties to ensure data completeness and avoid tip-overs. WMCA funding has been received to support performance improvements.

For RTT position, UHNM expect to improve in line with our planning trajectories as recovery funding and schemes go live, with an ongoing reduction in our longest waiting patients. Activity and performance to be tracked weekly through EOMG and also to execs for assurance / escalation.

MRI recovery plan to follow in line with the NOUS recovery plan and oversight to be taken through the Diagnostic Cell. With CDC now open, Diagnostic Cell will also track the activity delivery against plan for CDC phase 1 specialities / modalities.

Activity v. Plan to be tracked against elective metrics as part of new year plan, which will also include the recovery funding additional activity.

Quality & Access | Dashboard

University Hospitals of North Midlands NHS Trust

KPI	Latest month	Measure	Target	Variation	Assurance
UEC 4 Hour Performance	Jun 26	67.5%	77.1%		F
UEC 4 Hour Performance (Aged <18)	Jun 26	88.1%	77.1%		P
Over 12 hours in ED	Jun 26	2444	-		
Over 12 hours in ED (Aged <18)	Jun 26	33	-		
Ambulance Handover Average Time	Jun 26	01:22:45	00:49:12		?
Corridor Care ED	Jun 26	2129	-		
Corridor Care Inpatient (8am)	Jun 26	573	-	H	
Cancer 28 Day FDS	Jun 26	78.6%	82.7%		?
Cancer 31 Day Combined	Jun 26	90.8%	94.8%		?
Cancer 62 Day Combined	Jun 26	59.1%	80.5%		F
Diagnostics DM01 Performance	Jun 26	78.6%	99.0%	H	F
RTT Performance - <18 Weeks	Jun 26	61.6%	70.3%	H	F
RTT Performance - % 52+ Weeks	Jun 26	2.0%	1.0%	L	F
RTT Performance - % Waiting 1st Contact	Jun 26	74.1%	78.1%	H	F
RTT Performance - <18 Weeks (Aged <18)	Jun 26	70.3%	70.3%		?
RTT Performance - % 52+ Weeks (Aged <18)	Jun 26	1.7%	1.0%	L	F
RTT Performance - % Waiting 1st Contact (Aged <18)	Jun 26	84.5%	78.1%		P

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	Ext 20	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

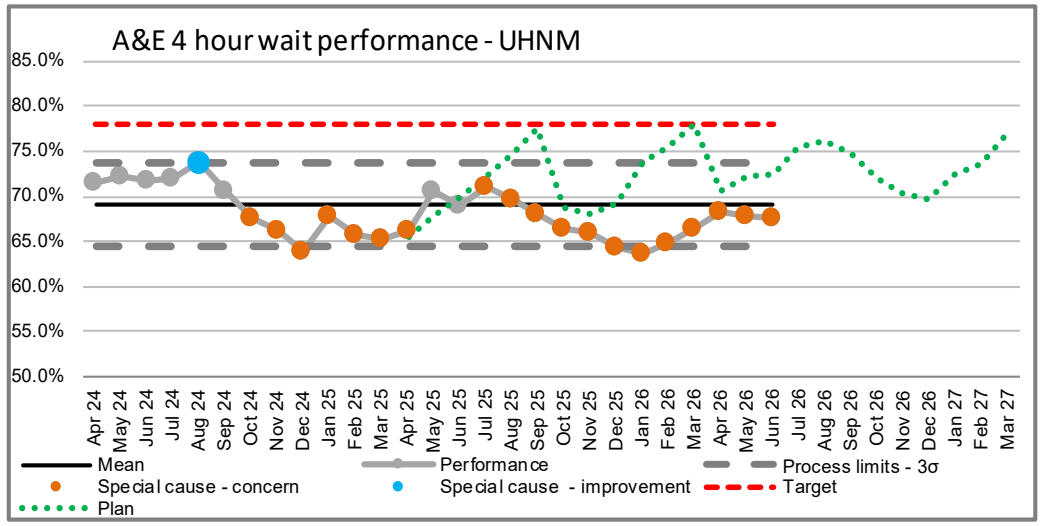
Variation

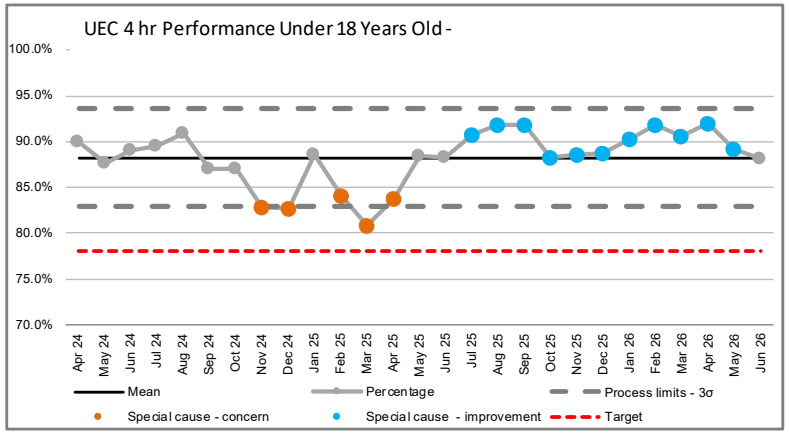
	H / L	H / L
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

VARIATION	P	?	F	No Target
H / L			Diagnostics DM01 Performance RTT Performance - <18 Weeks RTT Performance - % 52+ Weeks RTT Performance - % Waiting 1st Contact RTT Performance - % 52+ Weeks (Aged <18)	
Common cause	UEC 4 Hour Performance (Aged <18) RTT Performance - % Waiting 1st Contact (Aged <18)	Ambulance Handover Average Time Cancer 28 Day FDS Cancer 31 Day Combined RTT Performance - <18 Weeks (Aged <18)	UEC 4 Hour Performance Cancer 62 Day Combined	Over 12 hours in ED Over 12 hours in ED (Aged <18) Corridor Care ED
H / L				Corridor Care Inpatient (8am)

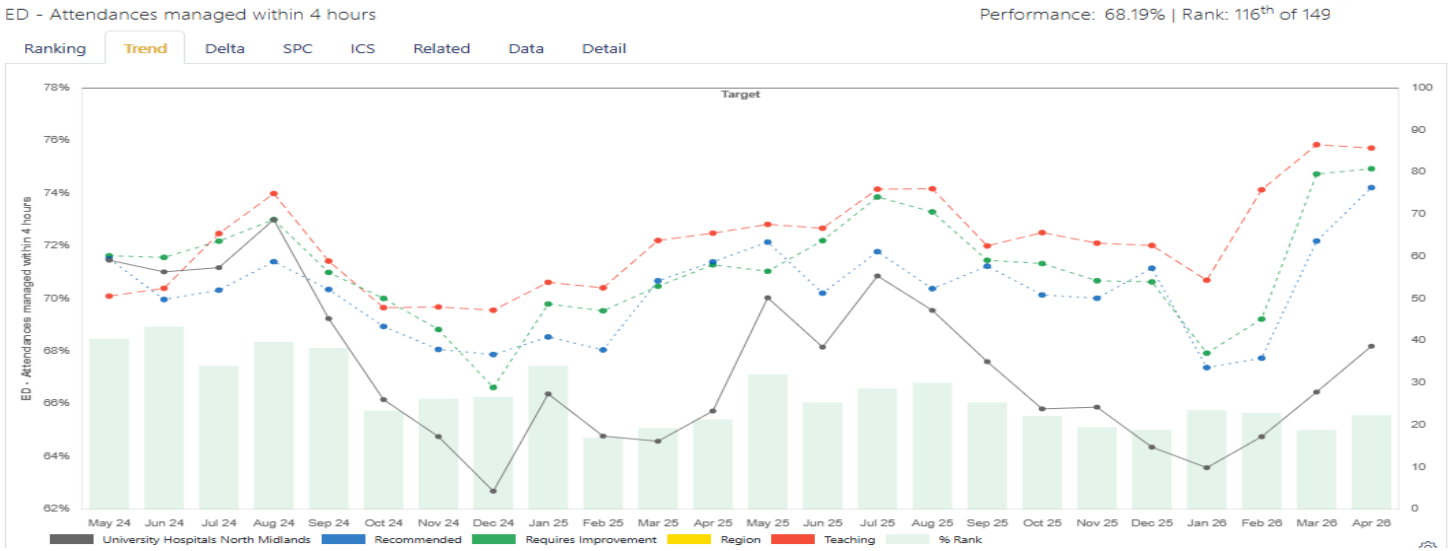
Quality & Access | UEC 4-hour Target

University Hospitals of North Midlands NHS Trust





Variation	Assurance	Monitoring against plan				
			Mar 26	Apr 26	May 26	Jun 26
	Target 78%	Actual	66.5%	68.2%	67.9%	67.5%
Background		Plan	78.0%	70.6%	72.3%	72.4%
The percentage of patients admitted, transferred or discharged within 4 hours of arrival at A&E		Variance	-11.5%	-2.4%	-4.4%	-4.8%



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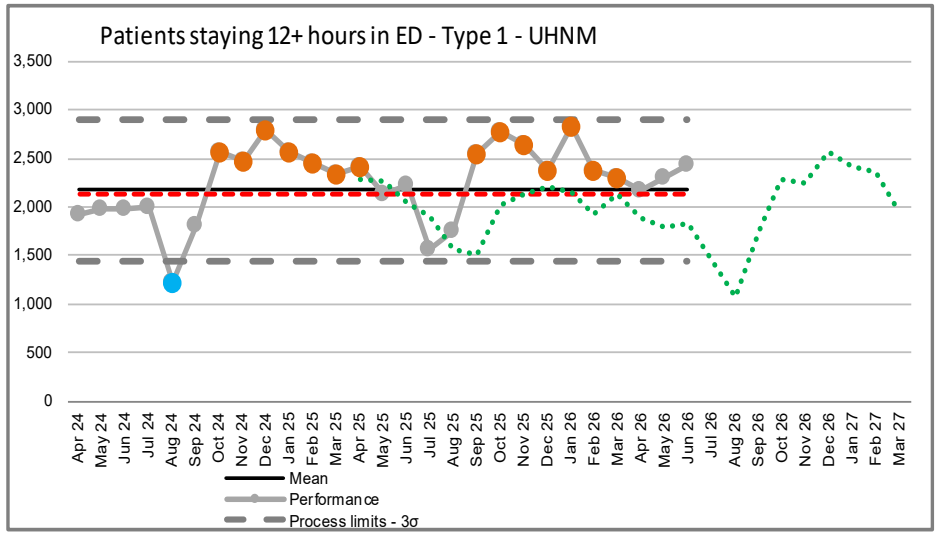
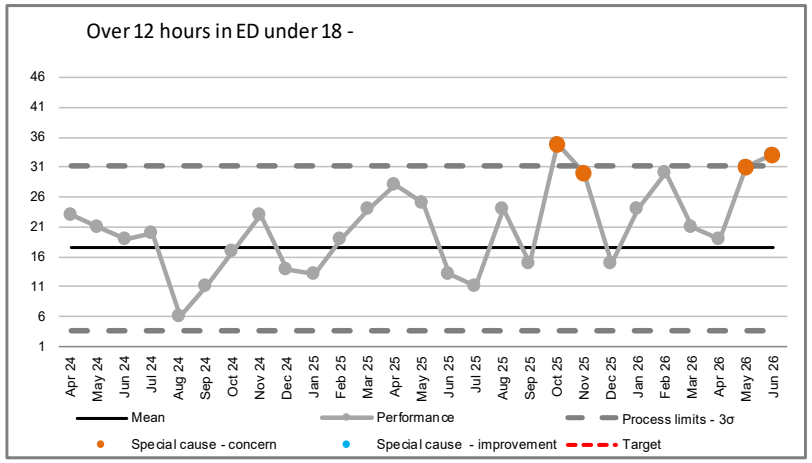
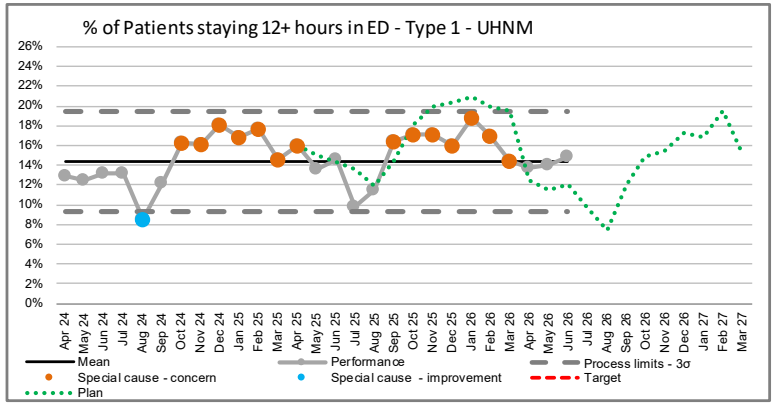
Quality & Access | Over 12-hours in ED From Arrival

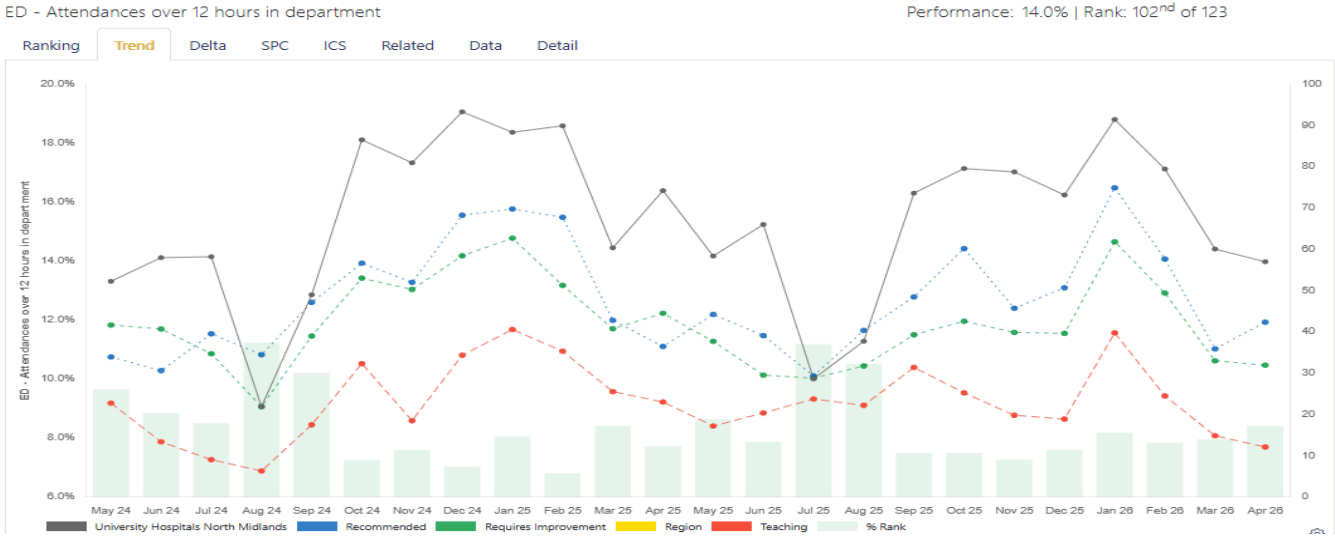
University Hospitals of North Midlands NHS Trust





Variation	Assurance		Monitoring against plan				
				Mar 26	Apr 26	May 26	Jun 26
	Target	2128	Actual	2,311	2,174	2,297	2,444
Background			Plan	2,128	1,890	1,800	1,825
The number of patients admitted,transferred or discharged over 12 hours after arrival at A&E			Variance	183	284	497	619





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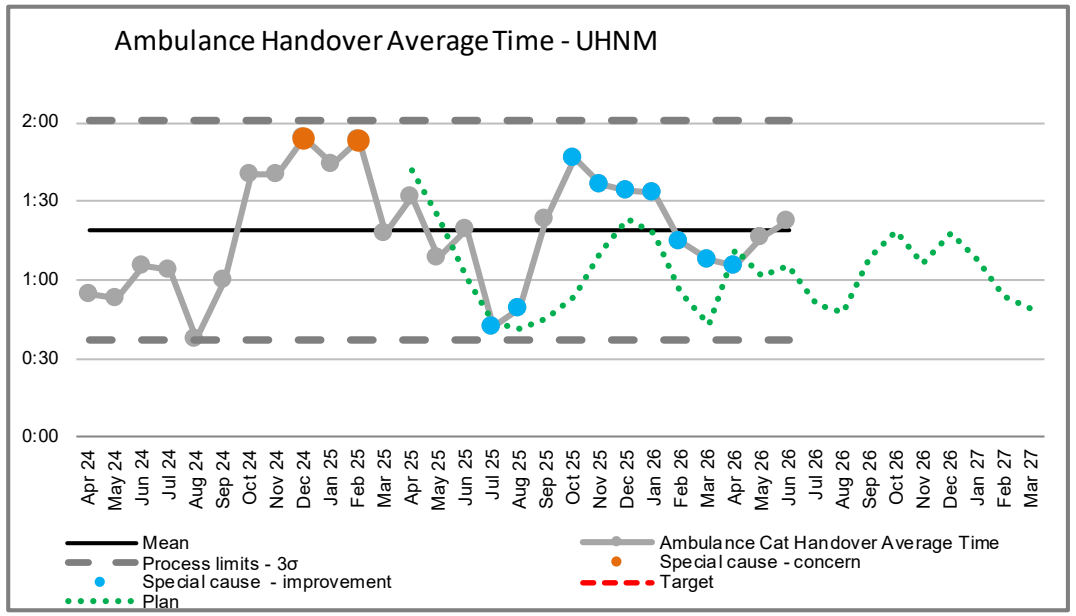
Quality & Access | Ambulance Handover Average Time

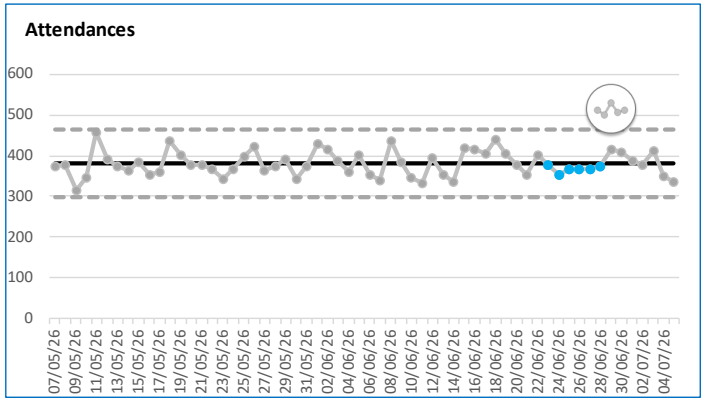
University Hospitals of North Midlands NHS Trust

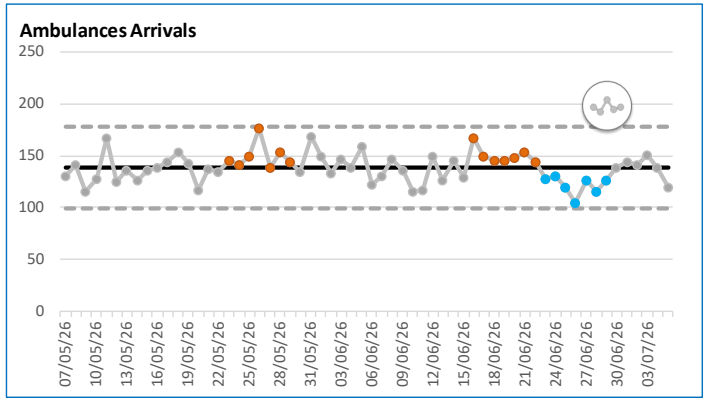


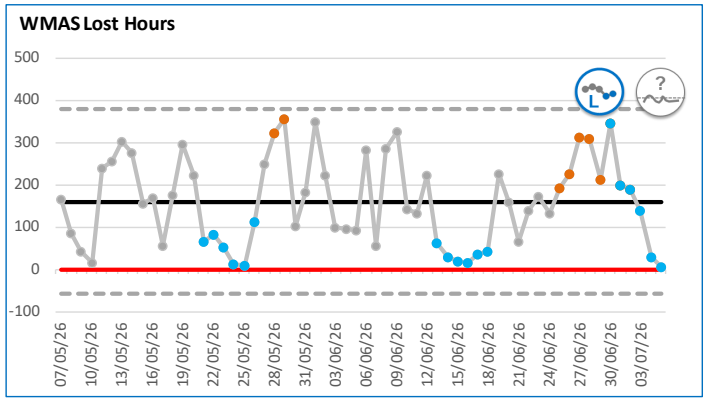
Variation	Assurance		Monitoring against plan				
				Mar 26	Apr 26	May 26	Jun 26
	Target	0:00:00	Actual	1:07:57	1:05:34	1:15:53	1:22:45
Background			Plan	0:43:00	1:11:49	1:01:28	1:05:21
The average time taken for patients to be handed over from Ambulances arriving at UHNM.			Variance	0:24:57	-0:06:15	0:14:25	0:17:24

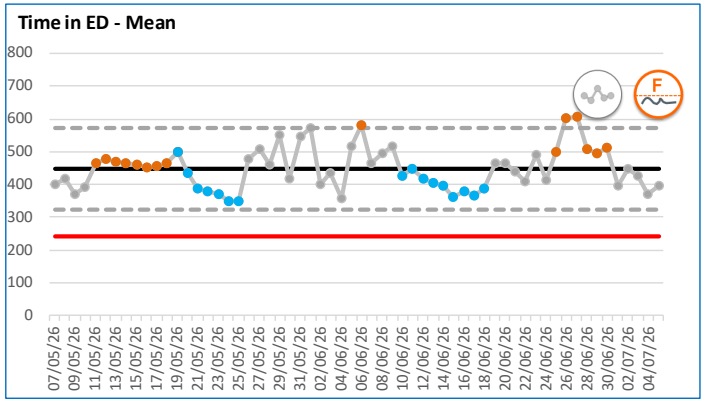
Quality & Access | Non Elective – Royal Stoke

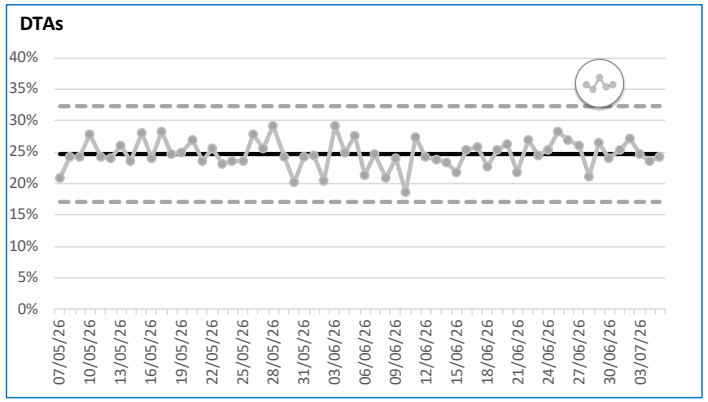
University Hospitals of North Midlands NHS Trust

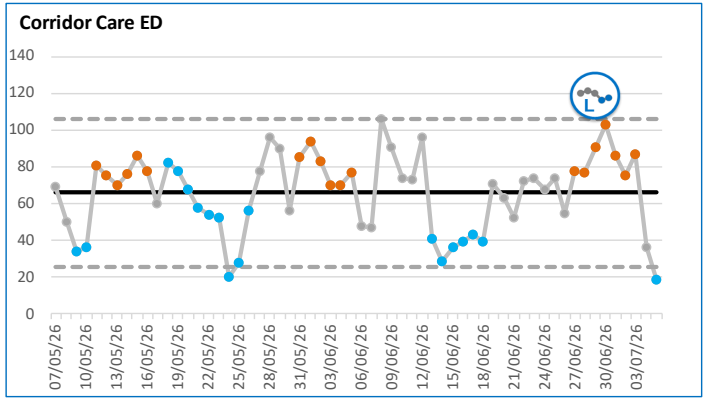


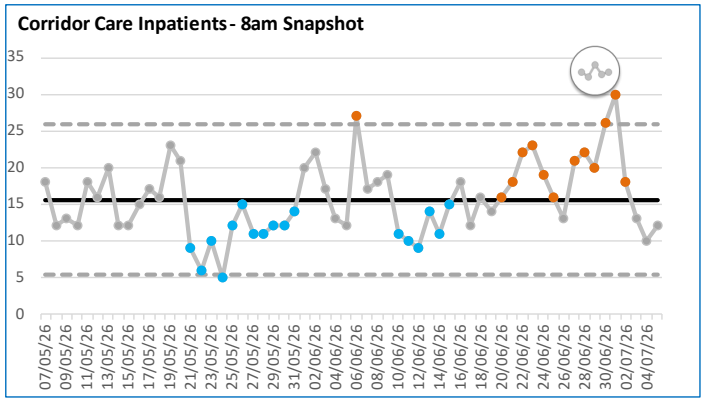


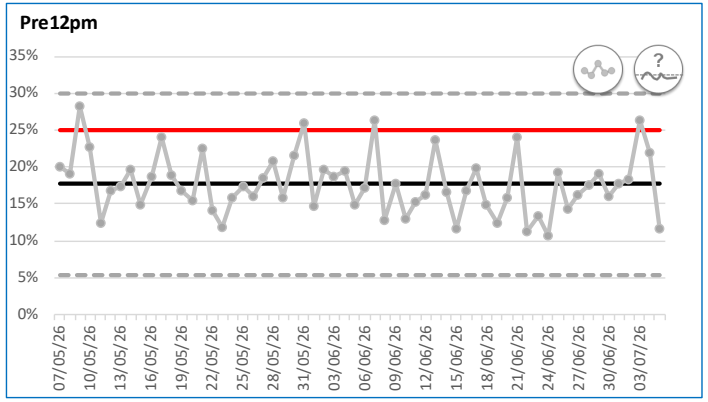


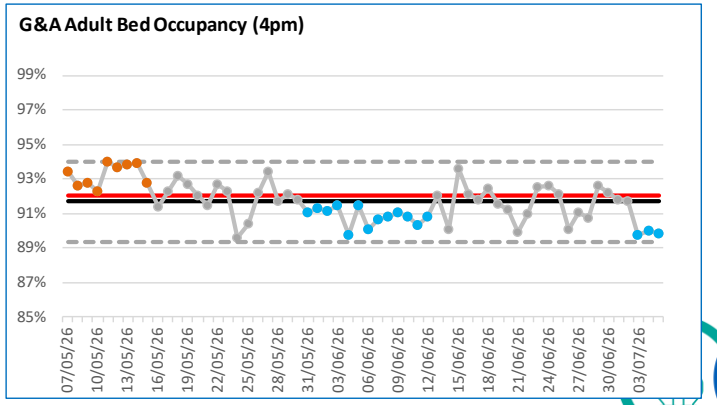












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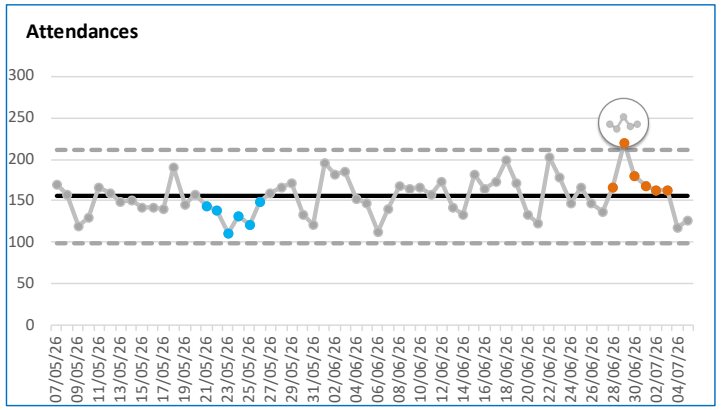
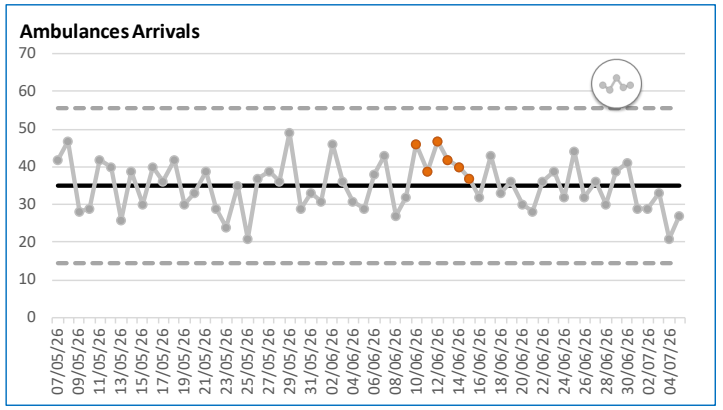
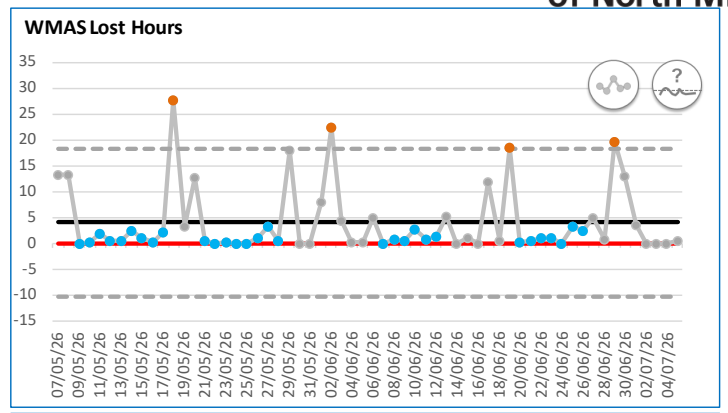
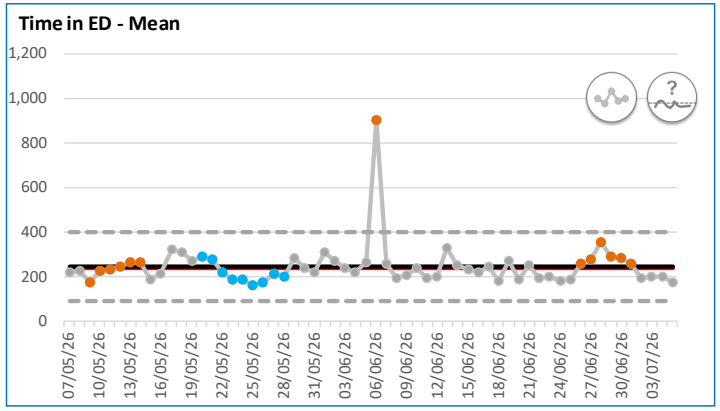
Quality & Access | Non Elective – County

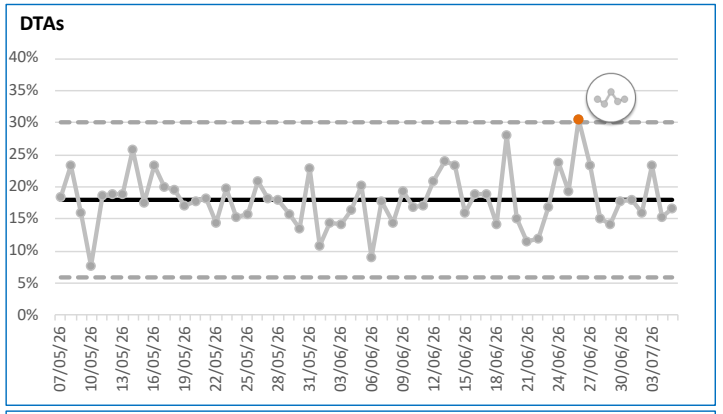
University Hospitals of North Midlands NHS Trust

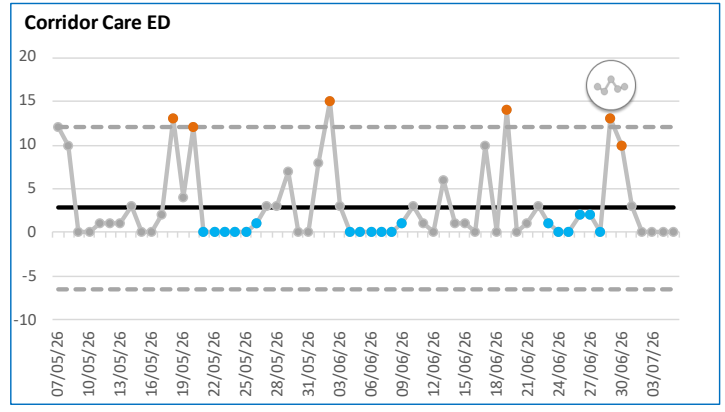


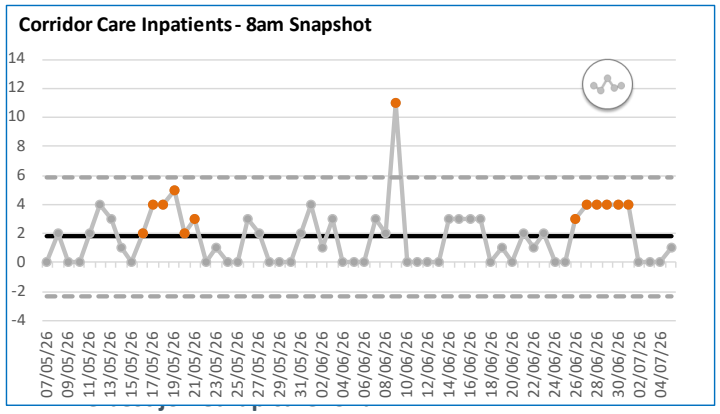


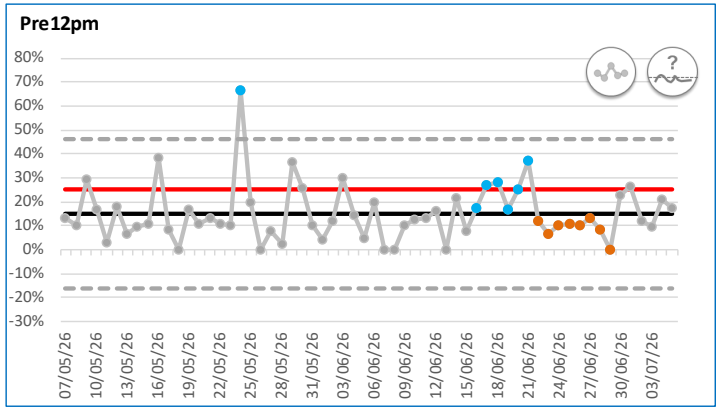


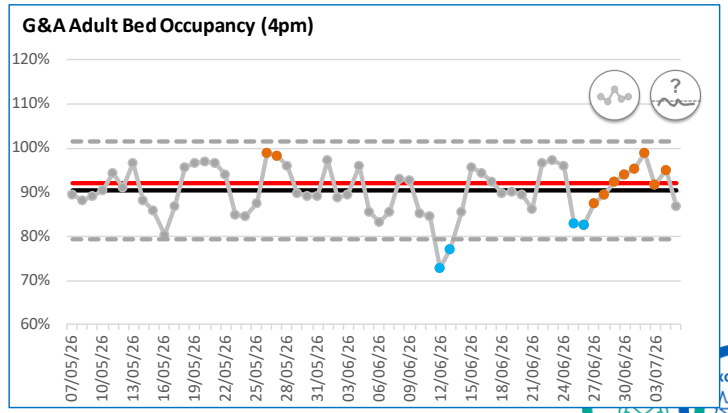












Quality & Access | Non-Elective

University Hospitals of North Midlands NHS Trust

What is the data telling us?

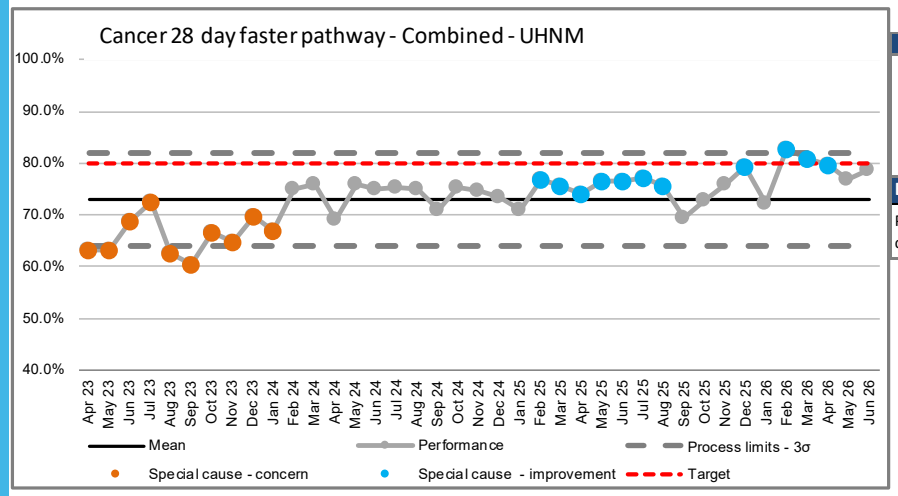
- The data for June is showing a reduction of 0.4% in relation to 4-hour performance vs May (4.9% short of trajectory, a further drift of 0.5% from plan in month)
- There has also been a minor decline in 12-hour performance in month. 9.4% of patients in ED breached 12 hours, vs a target of 7.3%, and 8.9% in May
- In month, 2444 patients waited longer than 12 hours in ED (619 more than plan, and 147 more patients than May
- June saw 5181 ambulances arrive at UHNM, with an average handover time of 1 hour 24 minutes
- This handover time is a 7-minute increase when compared with May
- 62.45% of ambulances were handed over within 45 minutes (a 3.7% reduction in performance since May and 4% short of plan in Month
- An almost identical attendance profile in June vs May (just under 26,000) and the second highest attendance profile since October showing sustained pressure in terms of demand
- County experienced the highest attendance numbers for over 12 months
- Continued high acuity with over 60% of ED attendances requiring Majors or Resus
- Reliance on corridor care as a result of increased demand and reduced bed base

What are we doing about it?

- Working with ICB around improving engagement regards call before convey, and utilisation of Silver Phone – reduced conveyances will help decompress department and improve performance
- Working with WMAS to improve number of patients arriving with clinical frailty score to support improved FSDEC streaming
- Decant ward created to support with maintenance programme – lessen net bed impact when wards shut due to maintenance works
- Await opening of UTC to improve streaming of minor injury and minor illness patients to support with 4-hour performance – current go love date 31/07
- Focus via UEC workstreams on ward processes, pre-noon discharges to provide flow and egress out of ED earlier in the day – support with all performance metrics (4/12, ambulance handovers)
- Work ongoing around Acute Med co-location following GIRFT visit. Derive efficiencies around timeliness of patient moves out of ED
- Simpler pathways for movement out of ED – Frailty SDEC, Medical SDEC, Surgical SDEC or inpatient bed

Quality & Access | Cancer 28 Day FDS

University Hospitals of North Midlands NHS Trust

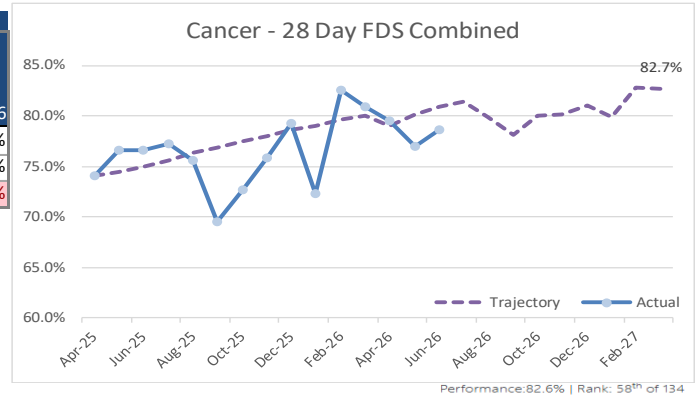


Variation	Assurance
	Target: 80%

Background

Performance of confirmation or exclusion of cancer communicated with patients within the 28 day timeframe.

Monitoring against plan	Mar 26	Apr 26	May 26	Jun 26
Actual	81.0%	79.6%	77.0%	78.6%
Plan	80.1%	79.0%	80.2%	80.9%
Variance	0.9%	0.6%	-3.2%	-2.2%



What is the data telling us?

- The final March position was reported at 80.97% against a trajectory of 80.09%
- The final April position was reported at 79.56% against a trajectory of 79.01%
- The final May position was reported at 77% against a trajectory of 80.22%

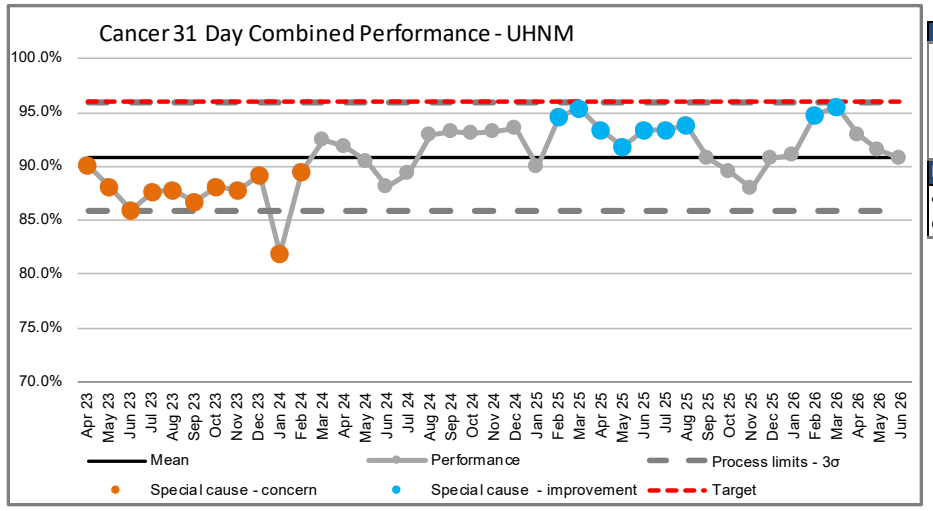
- There is good performance among most specialties.
- Specialties performing particularly well include Skin, Breast & Paeds.
- Specialties falling below standard include H&N, Lung, Colorectal & Urology.
- Specialties falling way below standard but with low volumes include Brain and Sarcoma.

What are we doing about it?

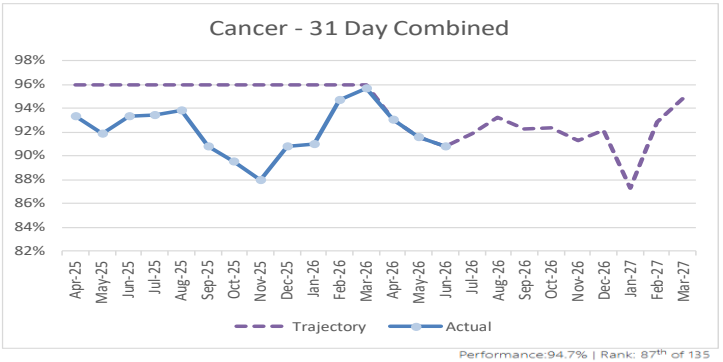
- The standard has been achieved in Feb and March – and just missed in April.
- May and provisional June show a further deterioration.
- Imaging reporting is impacting timely diagnosis and rule out of cancer.
- Maintaining oversight through the Cancer Delivery Group meetings to bring focus on operational delivery for improvement plans and adherence to agreed trajectories for 26/27.
- A breakdown of cancer diagnosed versus excluded performance is provided to all specialities with improvement plans focused on diagnosing quicker.
- Patient level escalations sent weekly as part of all cancer PTL escalations for senior oversight and daily oversight by the Cancer Team, to support achievement of the standard.
- Oversight and tracking of WMCA investment cases to ensure funds are spent effectively and on time by directorates.

Quality & Access | Cancer 31 Day Combined

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				Mar 26	Apr 26	May 26	Jun 26
	Target	96%	Actual	95.6%	93.0%	91.5%	90.8%
Background			Plan	96.0%	93.0%	91.6%	90.8%
% patients beginning their treatment for cancer within 31 days following an urgent GP referral for suspected cancer			Variance	-0.4%	0.0%	-0.1%	-0.1%



What is the data telling us?

- The final February position was reported at 94.70%
- The final April position was reported at 92.99% against a trajectory of 93.03%
- The final May position was reported at 91.55% against a trajectory of 91.61%
- The provisional June position is currently at 90.77% against a trajectory of 90.84%

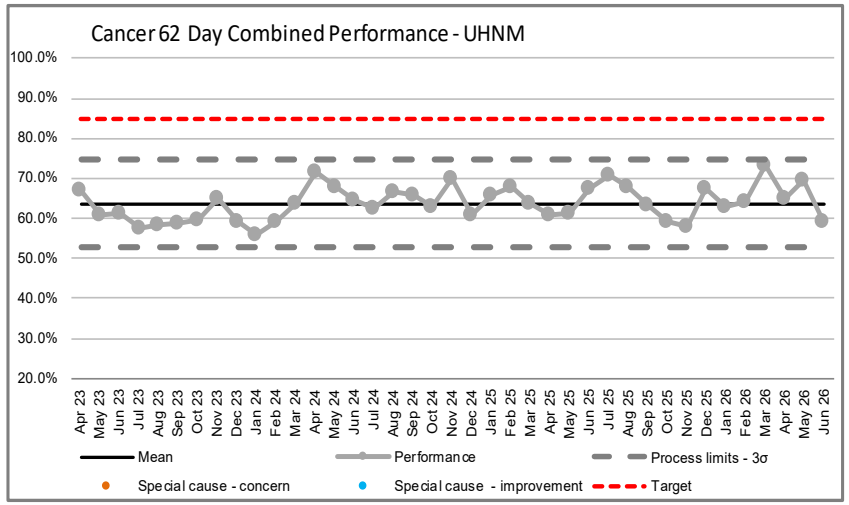
- Strong performance reported in February and March – April and May close to trajectory.
- Specialties performing well include Breast and Haematology.
- Challenges in access to surgical capacity remain within Lung, Gynae, Colorectal, and Urology.
- Within the 31-day cohort of patients breaching surgery, the main delay reason is attributable to lack of capacity in colorectal, gynae and urology tumour sites.

What are we doing about it?

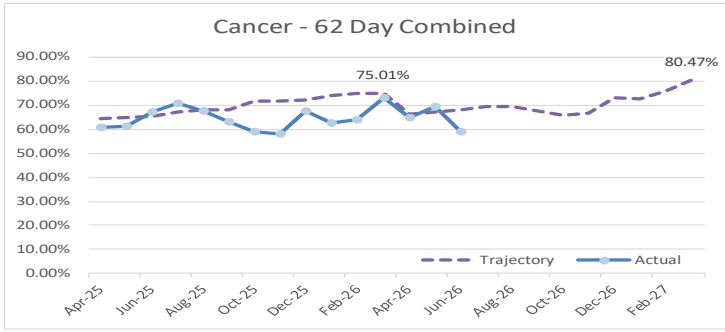
- The Trust and specialties are actively reviewing theatre capacity to ensure utilisation of all capacity available.
- Escalation of surgical capacity constraints at all appropriate forums such as Cancer Delivery Group, Specialty Improvement Groups, Cancer Services Strategy Group & Elective Oversight Group.
- Cancer services team are focussed on expediting 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.

Quality & Access | Cancer 62 Day Combined

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan	Mar 26	Apr 26	May 26	Jun 26
			Actual	73.2%	64.9%	69.4%	59.1%
	Target	85%	Plan	75.0%	66.1%	67.2%	68.0%
Background			Variance	-1.8%	-1.2%	2.2%	-9.0%
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer							



What is the data telling us?

- The final February position was reported at 64.21% against a trajectory of 74.87%
- The final April position was reported at 64.89% against a trajectory of 66.12%
- The final May position was reported at 69.42% against a trajectory of 67.25%
- The provisional June position is currently at 59.08% against a trajectory of 68.05%

- 73% performance in March 26 was close to the 75% trajectory and the highest performing month of the past 3 years. Since then performance has been declining, impacted by access to timely imaging reporting and surgical capacity.

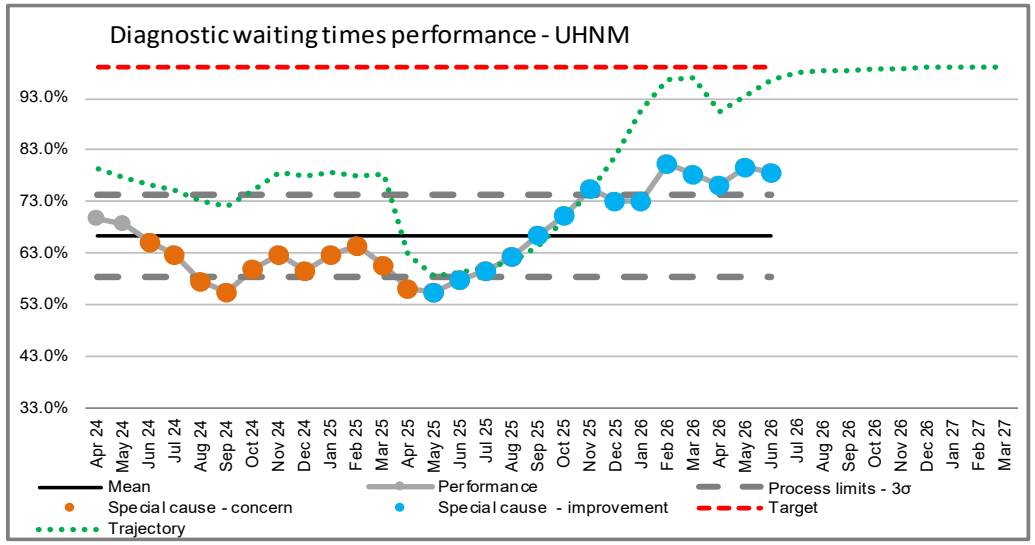
- Surgical capacity constraints (including robotics) affecting Gynae, Colorectal and Skin.
- Complex pathways (i.e. multiple investigations, second look biopsies, molecular and genetics testing) impact referral to treatment timelines, particularly in Lung.

What are we doing about it?

- Increased oversight of cancer improvement plans for diagnostic and specialty services, managed through the 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 pathology, Skin and Thoracic in particular.
- Collaborative working group in process between Histopathology, Directorates and Cancer Services to identify specimens for reporting on appropriate triage pathway - Cancer Team have implemented an automated solution with pathology.

Quality & Access | Diagnostics DM01 Performance

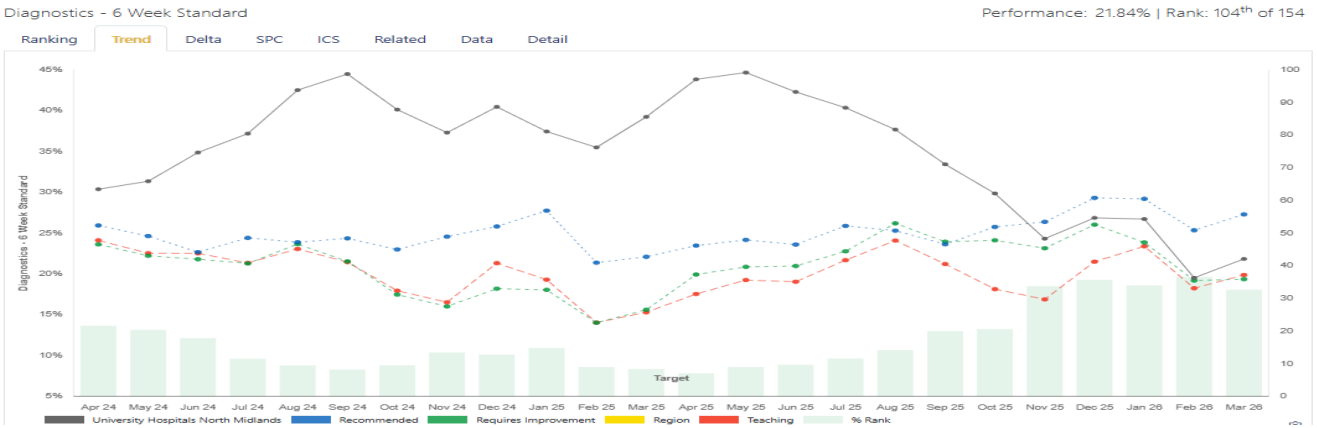
University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F
	Target 99.0%

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

Monitoring against plan	Mar 26	Apr 26	May 26	Jun 26
Actual	78.2%	76.1%	79.6%	78.6%
Plan	97.0%	90.3%	93.6%	96.6%
Variance	-18.9%	-14.2%	-14.0%	-18.0%



What is the data telling us?

DM01 validated performance was 78.6%; 18% off plan. Plan set for June for 96.6%. 95% being the national standard.

MRI DM01 performance
MRI is now showing as the majority contributor for UHNMs overall DM01 performance. MRI performance is 69.2% with 1.3% 13-week breaches (0.3% decrease in 13-week breaches since last month).

Echocardiography DM01 performance
is also a specialty of concern, with performance at 36.3%; an improvement of 4.1% since last month. Diagnostic Cell will track the recovery action plan

NOUS
Unvalidated performance is 91.8% - 2.2% increase since last month

Neurophysiology
Unvalidated performance is 84.7% - 3.4% increase since last month

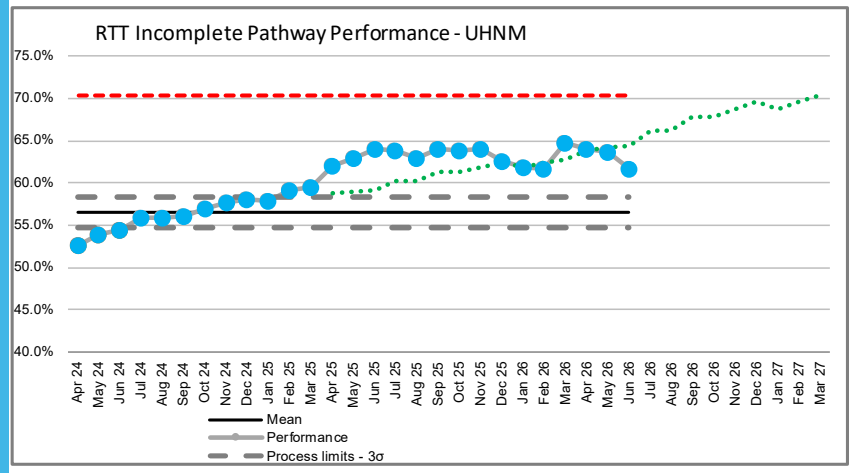
What are we doing about it?

MRI
Updated recovery plan for MRI requested through Care Group and to be monitored through Diagnostic Cell

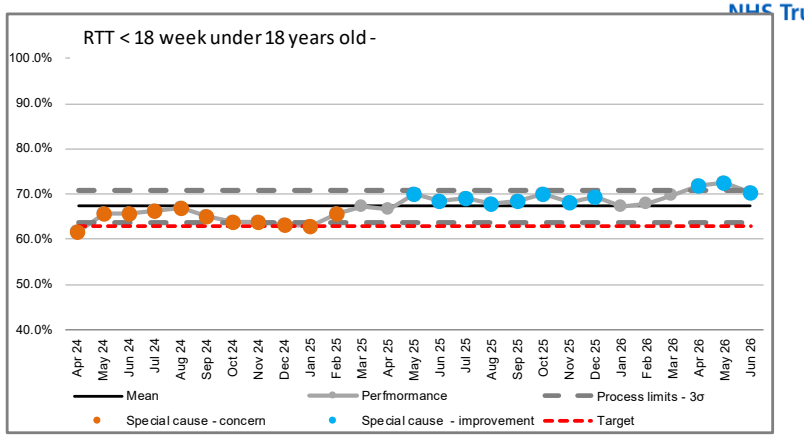
Echocardiography
Recovery plan for Echo requested through care group to be monitored through Diagnostic Cell

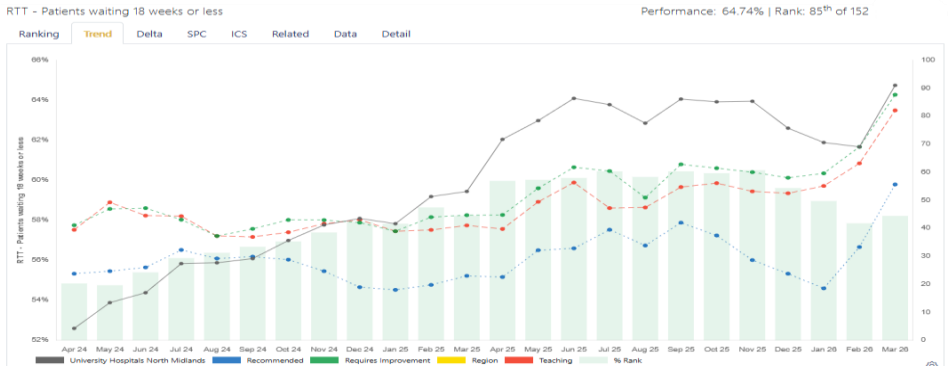
Cystoscopy
DQ still showing poor performance; directorate working with informatics to ensure correct patient data is tracked through

Quality & Access | RTT Performance



Variation	Assurance		Monitoring against plan				
				Mar 26	Apr 26	May 26	Jun 26
	Target	70%	Actual	64.7%	64.1%	63.7%	61.6%
Background			Plan	62.8%	63.9%	64.2%	64.5%
The percentage of patients waiting less than 18 weeks for treatment.			Variance	1.9%	0.1%	-0.5%	-2.8%





What is the data telling us?

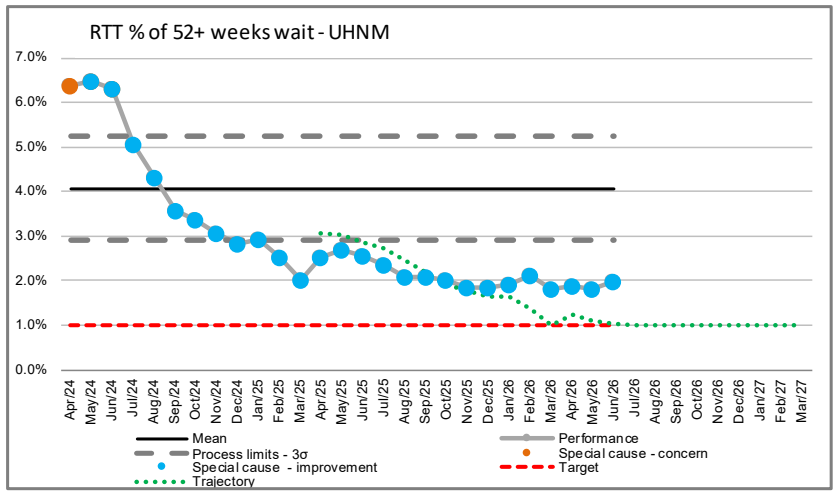
- Performance has deteriorated again in June to 62.15% (unvalidated) from 63.61% (validated) in May, and is now further behind plan.
- Total PTL has increased very significantly again from 70,772 in May to 72,873 (unvalidated) in May. There are several factors contributing to this – lower than average removal rate sustained throughout April and into May, exacerbated by Easter and school holidays; higher than average addition rate throughout April and May barring second week of school holidays), reduction in activity, validation, and tracking following Sprints ending, cancellations in theatres and MRI capacity due to the heat.
- From April onwards, sustained reduction in removals from the waiting list.

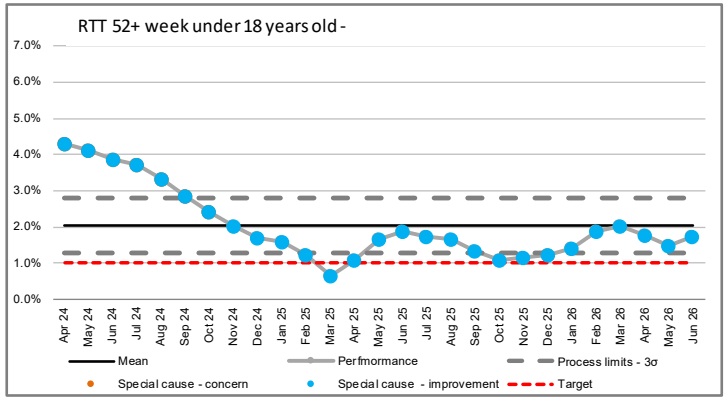
What are we doing about it?

- Rollout of Rova continues – extension of licence for a further 12 months.
- Detailed action plan now in place to allocate vacant theatres and stand up targeted extra lists for services with long waiters
- ICB working with UHNM to review referrals from primary care. ANP / Pharmacist referral increases noted through ops to clinical conversations

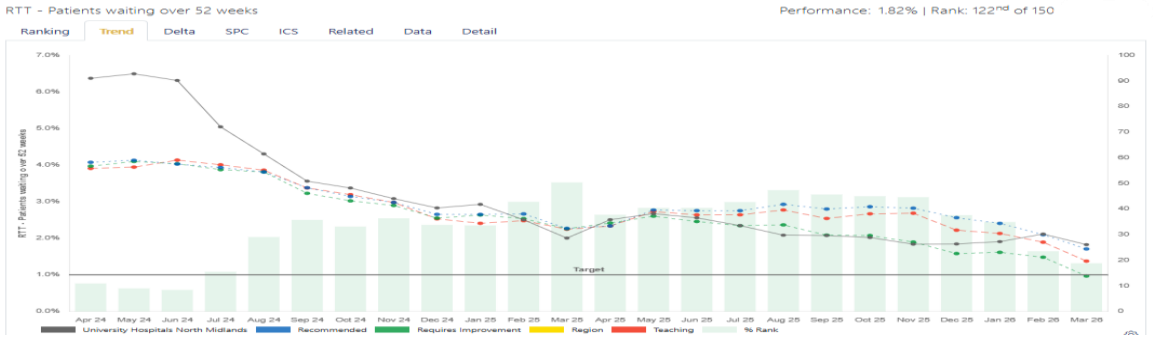
Quality & Access | RTT Performance – % 52+ Weeks

University Hospitals of North Midlands NHS Trust





Variation	Assurance	Monitoring against plan				
			Mar 26	Apr 26	May 26	Jun 26
	Target 1.00%	Actual	1.83%	1.88%	1.81%	1.99%
Background		Plan	1.00%	1.22%	1.12%	1.03%
The percentage of patients on a RTT pathway who have waited longer than 52 weeks for treatment compared to the total number of open RTT pathways.		Variance	0.8%	0.7%	0.7%	1.0%



What is the data telling us?

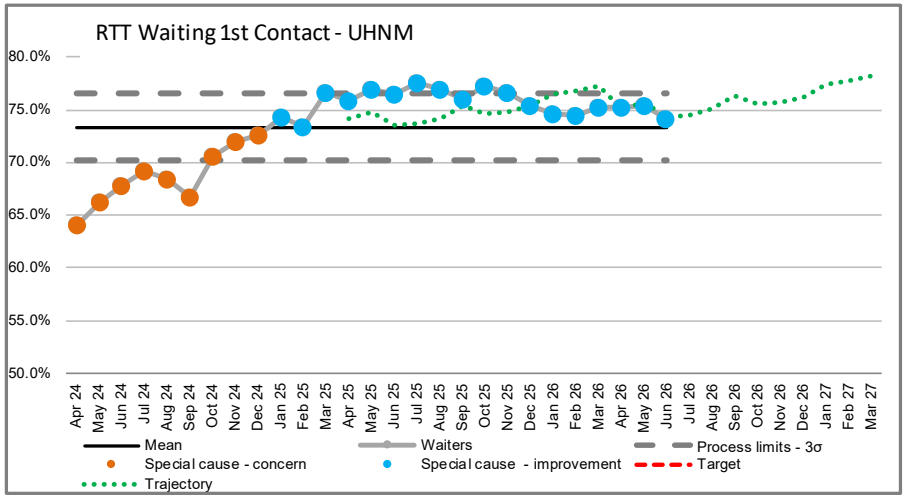
- Percentage of total PTL above 52 weeks has seen an increase in June.
- 52 week actuals has increased, from 1,284 to 1,397 (unvalidated)
- This cohort is extensively validated, so there's not much scope for improvement through validation alone

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

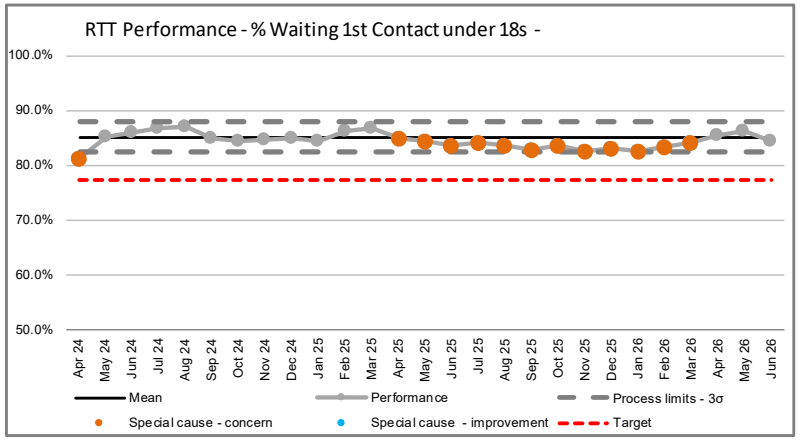


Variation	Assurance
H	P
	Target 0.0%

Background

Of all patients waiting for first event after referral - the percentage that are waiting under 18 weeks

Monitoring against plan	Mar 26	Apr 26	May 26	Jun 26
Actual	75.2%	75.3%	75.4%	74.1%
Plan	77.3%	75.1%	75.7%	74.4%
Variance	-2.0%	0.2%	-0.3%	-0.2%



What is the data telling us?

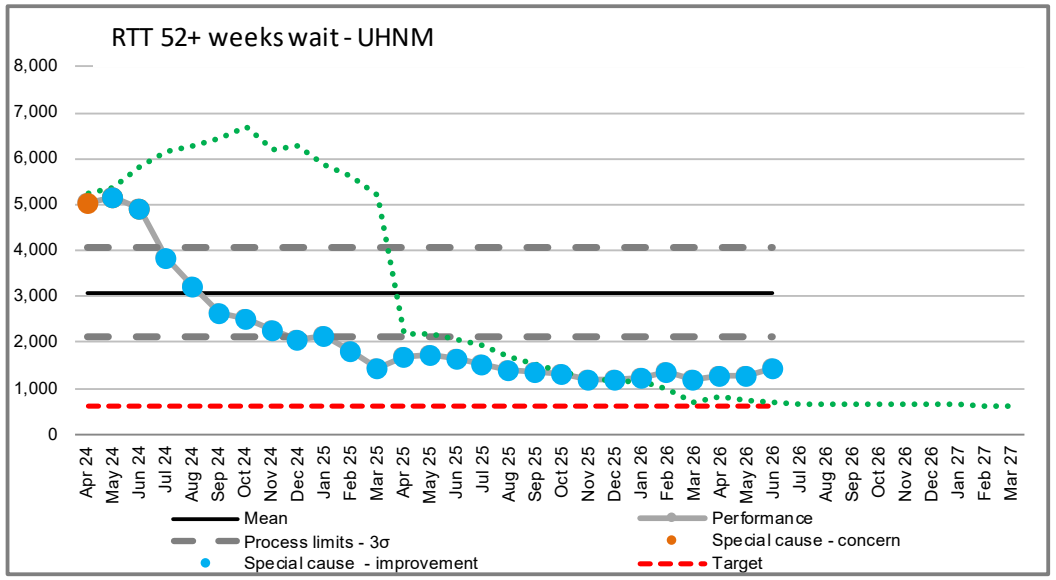
- Time to first contact has reduced and is now slightly off plan, at 74.1%
- The Elective sprint increasing the volume of Outpatient 1st New Activity in Q4 had brought the trust further back on plan, and while performance dupped in May, it has held steady for June and is closer to plan.
- Of the September 52 week cohort, 385 patients have yet to have their 1st appointment booked (down from 741 last month). 44% of these are in Ophthalmology, 33% Cardiology, 7% Nephrology and 4% Gastroenterology.

What are we doing about it?

- £107k earned from Patient not Present clock stops in May.
- Reviewing clinic templates to release more capacity
- Developing use of ambient voice technology to decrease clinic admin and increase clinical capacity during OP attendances.

Quality & Access | RTT No. of Long Waiting Patients

University Hospitals of North Midlands NHS Trust



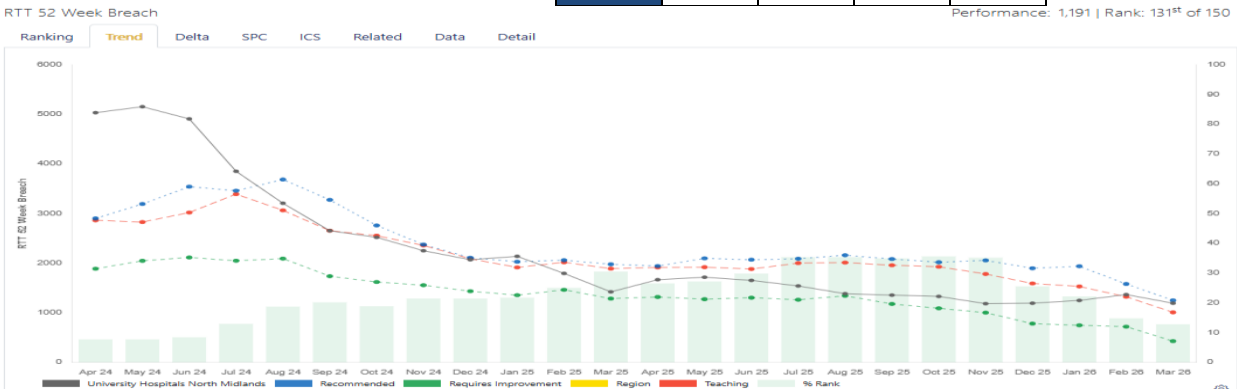
Variation	Assurance

Target	612

Background

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

Monitoring against plan	Mar 26	Apr 26	May 26	Jun 26
Actual	1,197	1,285	1,277	1,447
Plan	700	812	734	678
Variance	497	473	543	769
65+	83	103	87	64
78+	6	1	3	6
104+	2	0	0	1



What is the data telling us?

- 4 patients breaches 78 weeks in May – an ENT patient awaiting a complex procedure requiring custom made equipment, and 3 orthopaedic patients also requiring equipment, Stoke only or a joint procedure with 2 surgeons.
- 65 week waits have improved further in June, down from 89 in May to 61 in May.
- 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, Oral MaxFacs and Gynaecology.

What are we doing about it?

- Micromanaging long waiting patients at daily / weekly PTL meetings – meetings stepped up to 3 times weekly in some directorates
- Cohorts of patients identified and non-admitted prioritised for urgent next steps
- Orthopaedics & Spinal now running through weekends through County Hub
- ERF funding approved to increase evening and weekend operating capacity
- Although numbers have increased this month, the proportion of long waiters which are non-admitted is decreasing, demonstrating improvements earlier on in the pathway bringing down waiting times in the mid-longer term.

Highlight Report

PEOPLE, CULTURE AND INCLUSION COMMITTEE | 30th July 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The **Violence Prevention and Reduction** report highlighted that violence and aggression towards staff remained a significant concern, with a higher proportion of violent incidents, variation between staff survey and Datix data, and limited criminal justice outcomes. The Committee emphasised the need for a stronger zero-tolerance approach, improved data triangulation, clearer Trust-led reporting processes and enhanced support for affected staff. Partial assurance was recorded pending further evidence of impact. • The **Chief People Officer** report highlighted progress against workforce priorities, including legislative preparedness, sexual safety, anti-racism and workforce growth. The Committee sought clearer evidence that cultural transformation is being experienced by frontline staff and noted continuing risks relating to sickness absence, appraisal compliance, bank expenditure, affordability and capacity. Partial assurance was agreed. • The Committee welcomed the significant achievements delivered through the **Centre for Nursing and Midwifery Research Excellence** (CeNREE) Annual Report, including support for over 500 staff and securing £1.5m of external funding. Partial assurance reflected ongoing risks relating to long-term sustainability, research funding and clinical academic capacity. The Committee highlighted the importance of ensuring that Advanced and Consultant Practitioners are able to fulfil the research pillar of practice through appropriate protected time, recognising this as a key enabler of research capacity, workforce development and the Trust's ambitions as a university teaching hospital. • The **Learning and Education Annual Report** showed continued growth in learners and educators, alongside sustainability pressures from supervision requirements and workforce capacity constraints. Partial assurance was recorded, with actions focused on strengthening education capacity, governance and alignment with workforce planning.	• Future **fire safety** reports to be enhanced to include total number of areas requiring fire drills and the target of drills per year. • Review and strengthen the organisational process for reporting and responding to **violence and abuse** against staff, ensuring the Trust—not individuals—takes responsibility for police reporting. • Future **Staff Screening, Pre-employment Checks and Workforce Compliance Assurance** reports to include outcomes of DBS disclosure decisions.

Positive Assurances to Provide	Decisions Made
• The Q1 **Board Assurance Framework** review demonstrated improved strategic focus, clearer risk descriptions and stronger alignment between actions and risks. BAF 3 remained at 15 with partial assurance, reflecting continued workforce capacity, operational and financial pressures, with governance strengthened through the re-establishment of Strategic Workforce Groups. • The annual **Fire Safety Report** provided acceptable assurance, noting strengthened fire safety governance, completed fire risk assessments, increased fire drills and satisfactory Fire Service audits. Incident learning and monitoring arrangements had been re-established to identify trends and support continual improvement. • The annual **Security Management Report** provided acceptable assurance on service developments and incident investigation arrangements. Violence and aggression remained the most frequently reported incident type, with further work required to triangulate data, address patient absconding and manage continuing risks at the Old Infirmary site. • The **Health and Safety Quarterly Report** provided acceptable assurance on progress across key health and safety priorities, including development of a strengthened immunisation policy, targeted actions to improve manual handling training compliance, and learning from sharps incident investigations. The Committee noted further work underway to introduce dedicated health and safety advisors for each Care Group from September and to review the slips, trips and falls policy, supporting more targeted compliance oversight, risk assessment and incident prevention. • The **Executive Health and Safety Group** highlighted fire safety, violence and aggression, and occupational health as key areas of focus. Further work was requested to strengthen occupational health reporting, policy review and the flow of assurance between Occupational Health, Infection Prevention and Control and the Group. Acceptable assurance was provided. • The Committee received acceptable assurance on **staff screening, pre-employment checks and workforce compliance**, supported by positive audit findings and continued compliance with NHS Employment Check Standards. Further monitoring was requested on DBS disclosure outcomes, legislative changes and associated internal control risks. • The **Mandatory Learning Oversight Group** report provided acceptable assurance on statutory and mandatory training governance, including rationalised requirements, national learning packages and revised refresher frequencies. Further work will strengthen outcome measures and evidence of training effectiveness.	• The Committee approved the **Terms of Reference** for the Executive Health and Safety Group.

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
Comments on effectiveness were sought via MS teams.	The Committee considered cross-committee feedback on corporate capacity and capability and received assurance that workforce risks are managed through established governance routes, including Care Group performance reviews, risk registers, executive oversight and business case processes. Members noted the need for continued triangulation of workforce, quality and financial considerations, alignment with the Medium Term Plan, and concise reporting to support strategic oversight.

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 Q1 2026/27	ALL	Various	N/A	Approval	7.	Chief People Officer Report	3	Ext 15	Partial	Assurance
2.	Fire Safety Annual Report 2025/26	5	High 12	Acceptable	Assurance	8.	Staff Screening, Pre-employment Checks and Workforce Compliance Assurance			Acceptable	Assurance
3.	Security Management Annual Report 2025/26	5	High 12	Acceptable	Assurance	9.	CeNREE Annual Report 2025/ 26	8	Ext 16	Partial	Assurance
4.	Violence Prevention & Reduction Report	5	High 12	Partial	Assurance	10.	Learning & Education Annual Report 2025/26	3, 8	Ext 15 / Ext 16	Partial	Assurance
5.	Health & Safety Report Q4	5	High 12	Acceptable	Assurance	11.	Mandatory Learning Oversight Group Assurance Report			Acceptable	Assurance
6.	Health & Safety Group Highlight Reports (19-05-26 & 23-06-26)	5	High 12	N/A	Information	12.	Executive Health and Safety Group Terms of Reference	5	High 12	N/A	Approval

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Integrated Performance Report

Month 03 Performance

2026/27

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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.

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			Q4 2025/26	3	NOF Score	Provider value	
Average metric score			Q4 2025/26	2.48	NOF Score	Provider value	
Unadjusted segment			Q4 2025/26	3	NOF Score	Provider value	
Financial override	Q4 2025/26	Yes	Yes		Yes	Provider median	

Domain Scores	Data period	Provider value		Chart
Access to services domain segment	Q4 2025/26	3	NOF Score	
Access to services domain score	Q4 2025/26	2.51	NOF Score	
Effectiveness and experience of care domain segment	Q4 2025/26	3	NOF Score	
Effectiveness and experience of care domain score	Q4 2025/26	2.22	NOF Score	
Patient safety domain segment	Q4 2025/26	3	NOF Score	
Patient safety domain score	Q4 2025/26	2.83	NOF Score	
People and workforce domain segment	Q4 2025/26	3	NOF Score	
People and workforce domain score	Q4 2025/26	2.72	NOF Score	
Finance and productivity domain segment	Q4 2025/26	3	NOF Score	
Finance and productivity domain score	Q4 2025/26	2.2	NOF Score	

Adjusted segment

Provider value Q4 2025/26

3 NOF Score

The best joined-up care for *all*

UHNM remains in segment 3 for quarter four, with the Financial Override applied. **Overall score was 2.47 in Q3, increasing slightly to 2.48 in Q4. This reflects a marginal deterioration, outlined as follows:**

- Access to services from 2.57 to 2.51 (remains in segment 3)
- Effectiveness and Experience from 2.16 to 2.22 (dropped to segment 3)
- Patient Safety from 2.67 to 2.83 (remains in segment 3)
- People and Workforce from 2.49 to 2.72 (dropped to segment 3)
- Finance and productivity from 2.35 to 2.22 (remains in segment 3)

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People and Workforce

University Hospitals of North Midlands NHS Trust

People and workforce	Data period	Provider value		Chart
People and workforce domain segment	Q4 2025/26	3	NOF Score	
People and workforce domain score	Q4 2025/26	2.72	NOF Score	

Retention and Culture	Data period	Provider value	Peer average	National value	National value method	Chart
Sickness absence rate score	Q4 2025/26	3	NOF Score		Provider value	
Sickness absence rate (quarter)	To Dec 2025	5.88%	5.44%	5.88%	Provider median	
NHS staff survey engagement theme sub-score score	Q4 2025/26	3	NOF Score		Provider value	
NHS staff survey engagement theme sub-score	2025	6.67	6.54	6.80	Provider median	

UHNM has moved from segment 2 in Q3 to segment 3 in Q4, with the overall score increasing from 2.49 in Q3 to 2.72 in Q4.

Sickness absence has risen from 5.13% to 5.88%, representing a greater decline than other trusts, reflected in the NOF score increasing from 2.35 in Q3 to 3.00 in Q4.

The staff survey engagement score has also seen a deterioration in Q4 (6.67 compared to 6.84 in Q3), with the NOF score increasing from 2.62 to 3.00.

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 6.4 for April 2026, (6.6 for January 2026), against a target of 7.2. The Staff Engagement Score is now captured using the NHS People Pulse Survey, which is collected quarterly, with the next data collection scheduled for July 2026. Moving to this new platform will allow for more consistent and standardised reporting against our peers.

Sickness absence remains above our expected standard of 4.1%. In-month sickness increased to 5.38% while the rolling 12-month cumulative sickness rates increased slightly to 5.45%. Overall, sickness absences continue to be driven by stress and anxiety, followed by other musculoskeletal problems and then other gastrointestinal problems, as the second and third most common reasons. In June, 287 episodes of Cold, Cough, Flu, and Chest & Respiratory conditions were reported, compared to 297 episodes in May — representing a 3.4% month-on-month decrease.

Turnover and ***vacancy*** metrics continue to perform well against our expected standards. The turnover rate in June 2026 remains low, at 7.5%, which is consistently below our 11% target, for the last 3 years. Vacancies also remain low, at 6.8%, which is reflective of the reintegration of 567 WTE, offset by the planned cumulative CIP of 165 WTE by [current] year-end, delivered progressively from Month 1. Any remaining variance in the vacancy rate is reflective of the combined bank and agency utilisation, and any approved business case funding, which ultimately affects the overall vacancy rate.

Agency costs remained static at 1.4%, in June 2026, mirroring the 1.4% seen in May 2026. In real-terms, overall agency usage increased slightly to 97.85 WTE in June from 96.98 WTE in May 2026, which is 20.53 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. June saw a further decrease in the in-month sickness absence percentage, influenced by seasonal fluctuations associated with a reduction in the episodes of cold, cough & flu, and Covid-19.

Agency expenditure was 20.53 WTE above plan, with all staff groups performing below plan, except for Medical & Dental who are 14 WTE above plan due to vacancies across general & acute medicine, neuro and pathology services, with specialist knowledge and experience needed to also support in clinical coding accounting for 6.38 WTE. Agency use is 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 moved to quarterly (with the survey open for 14 days) from 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.

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 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 through the Summer months, we should continue to see a continued stabilisation in sickness absence reasons associated with gastrointestinal, cold & flu, and Covid-19 related symptoms.

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%	7.6%	7.5%	H	P	
Staff Vacancy Rate	8.0%	7.6%	6.8%		?	
Sickness Absence (In Month)	3.4%	5.1%	5.4%		F	
Appraisal (PDR)	95.0%	80.7%	81.9%	L	F	
Agency Utilisation	3.2%	1.4%	1.4%	L	P	
Employee Engagement	7.2	6.4	6.4		F	

Related Strategy and Board Assurance Framework (BAF)

People Strategy

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 3: Sustainable Workforce	Ext 15	Partial	Ext 15	Partial	Ext 15	Partial	Ext 15	Partial

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People | Employee Engagement

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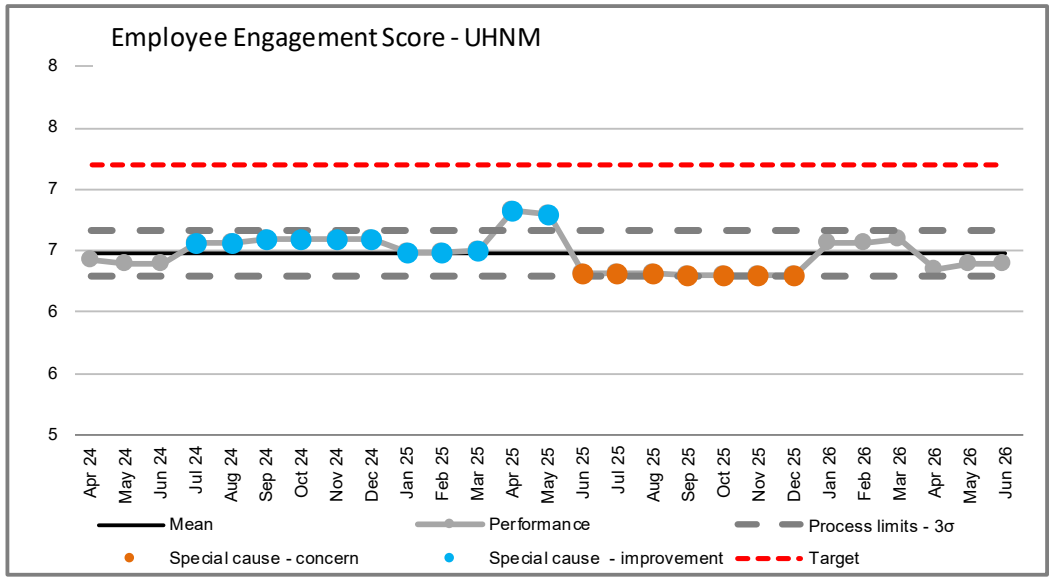

Variation	Assurance
	F

Target	Apr 26	May 26	Jun 26
7.2	6.4	6.4	6.4

Background

What is the data telling us?

The Staff Engagement score decreased to 6.4 in April 2026, (6.6 in January) against a target of 7.2. This slight decrease could be attributed to our transition from the local Staff Pulse to the national NHS People Pulse Survey which our colleagues may be less familiar with.

The Staff Engagement Score is now captured using the NHS People Pulse Survey, which is collected quarterly, with the next data collection scheduled for July 2026. Moving to this new platform will allow for more consistent and standardised reporting against our peers.

The 2025 National Staff Survey achieved an overall 41% response rate, which is close to the 2024 National Staff Survey's 45% response rate.

What are we doing about it?

The survey 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 July 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, now that the 2025/26 data is available.

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People | Sickness Absence in Month

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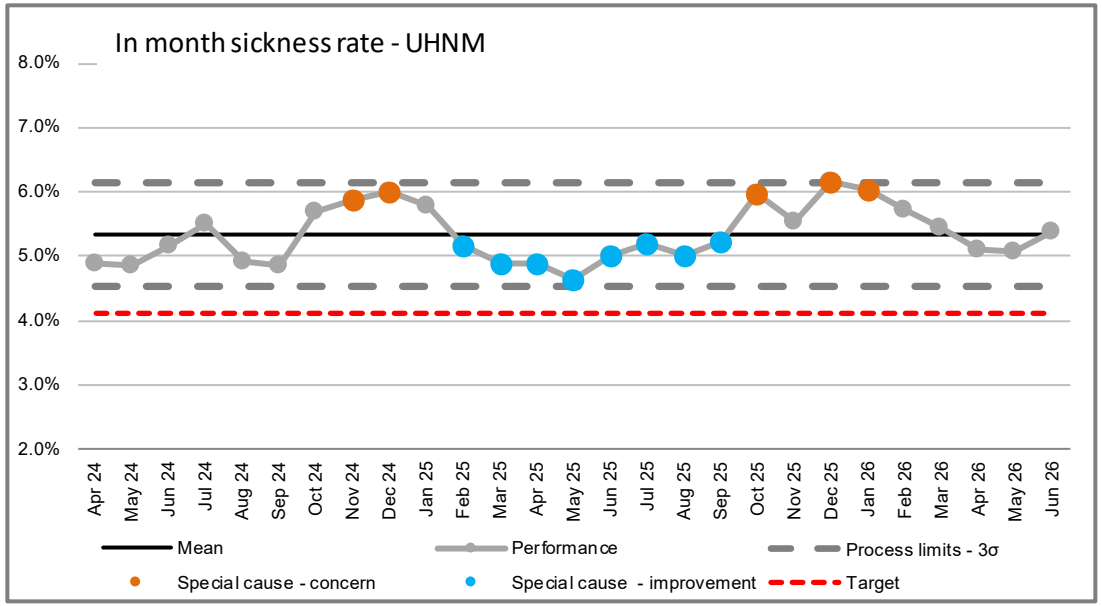


Variation	Assurance

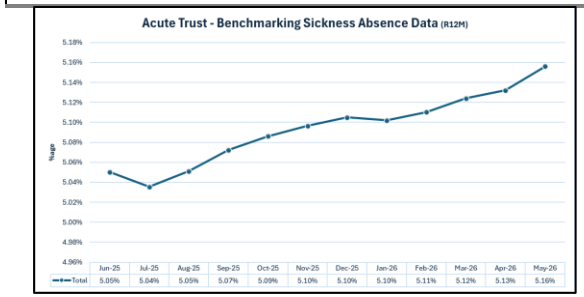
Target	Apr 26	May 26	Jun 26
4.1%	5.1%	5.1%	5.4%

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 May-26 - 5.2%)



What is the data telling us?

The rolling 12-month average sickness absence rate increased to 5.45% (5.43% in May 2026) against the target of 4.1%, resulting from the higher sickness absence rates seen over this specific 12-month period.

The in-month sickness absence rate increased to 5.38% in June (5.06% in May 2026) with other musculoskeletal problems seeing the largest increase of 0.8%, while stress and anxiety and gastrointestinal problems seeing a 0.7% and 0.2% reduction, respectively.

In rank order (highest first), the top 3 reasons for absences during June were: (1) Anxiety/stress/depression/other psychiatric illnesses, (2) Other musculoskeletal problems, (3) Gastrointestinal problems.

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.

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People | Vacancy Rate

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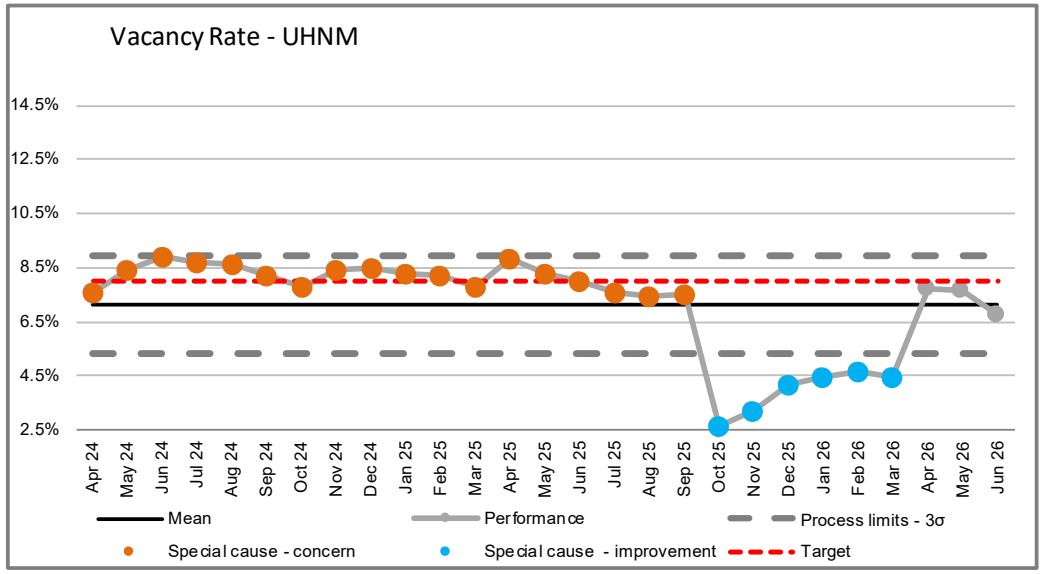


Variation	Assurance

Target	Apr 26	May 26	Jun 26
8%	7.8%	7.6%	6.8%

Background

Based on Full Establishment (Substantive, Bank & Agency)

Vacancies at 30-06-26	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,875.43	1,668.26	207.17	11.05%	11.13%
Registered Nursing	3947.54	3854.95	92.59	2.35%	3.84%
All other Staff Groups	7123.06	6548.47	574.59	8.07%	8.84%
Total	12,946.03	12,071.68	874.35	6.75%	7.62%

What is the data telling us?

Our successful recruitment and retention processes, alongside low vacancies and turnover rates, are other factors behind the reduction in our overall vacancy rate.

June's vacancy rate decreased to 6.8%, from 7.6% in May-26. (The 2026/27 establishment reflects the reintegration of 567 WTE, offset by a planned cumulative CIP of 165 WTE by year-end, delivered progressively from Month 1. Any remaining variance is reflective of the combined bank and agency utilisation and any approved business case funding, which will ultimately affect the overall vacancy rate.)

Colleagues in post increased in June 2026 by 83.28 fte, budgeted establishment decreased by 31.83 fte, which decreased the vacancy fte by 115.11 fte.

[*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 30/06/26]

What are we doing about it?

We continue with our successful recruitment events, targeting specific roles across multiple professions and divisions/care groups.

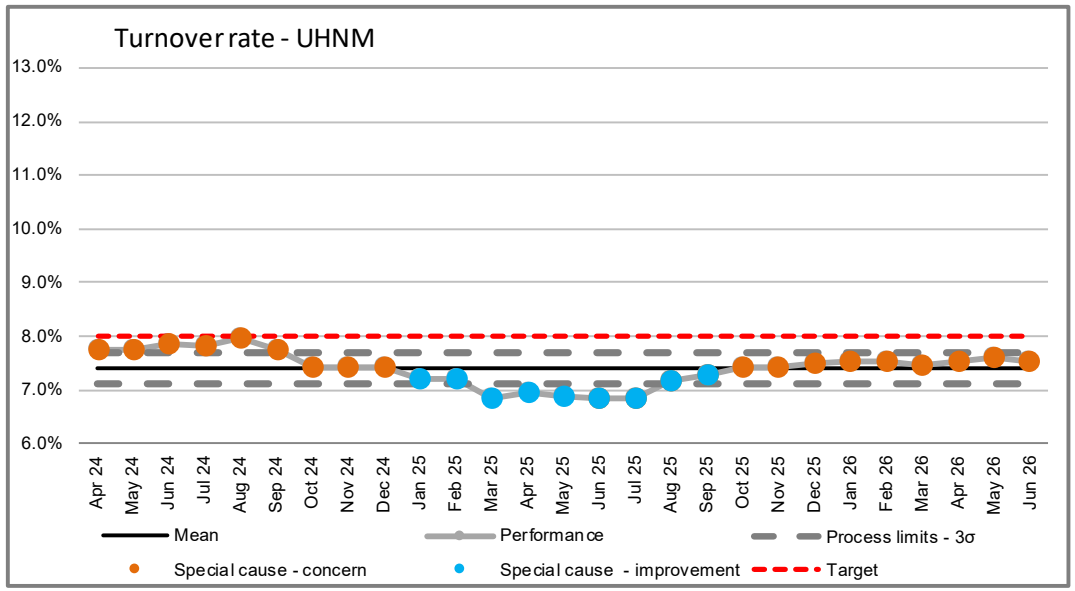
Targeted social media campaigns continue, advertising that our organisation is a great place to work.

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

Creating a great place to work for everyone



University Hospitals of North Midlands NHS Trust

Variation	Assurance
H	P

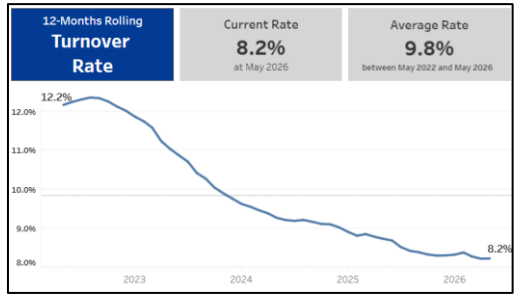
Target	Apr 26	May 26	Jun 26
8.0%	7.5%	7.6%	7.5%

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 May 2026)



What is the data telling us?

June 2026's turnover rate decreased slightly to 7.5% (7.6% in May 2026), which is consistently below the Trust's 11% target, for the last three years.

Our overall turnover rates are also well below the national averages when compared to other Acute Trusts rate of 8.2%

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 :

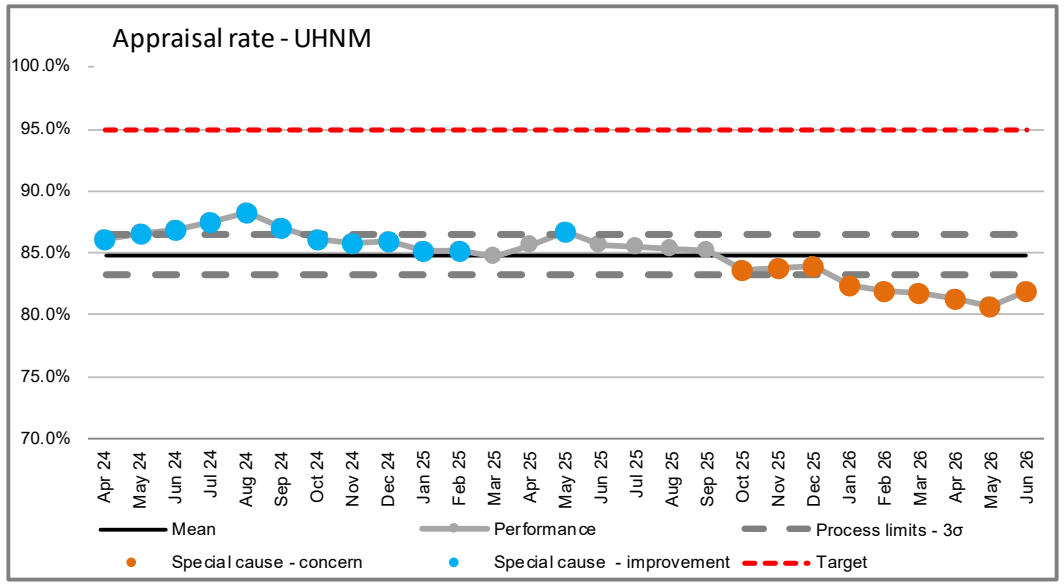
- Medical Staffing finishing school.
- Employment of a People Promise (Retention) Manager who currently continues in a fixed term post.
- Monthly targeted campaigns aligned to our Trust Values. For example, June included Pride Month, celebrating our LGBTQ+ people, raising awareness and challenging prejudice, where our LGBTQ+ communities and allies came together to honour their positive impact, ongoing challenges and to celebrate progress toward equality.

Kind Excellent Together

People | Appraisal Rate

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

Target	Apr 26	May 26	Jun 26
95%	81.3%	80.7%	81.9%

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.

June's appraisal rates increased appreciably to 81.9% from 80.7% in May 2026, despite an on-going ESR issue, in legacy code, which has been causing some issues for some Managers when attempting to enter their appraisal data. Infosys (who support ESR) are currently working on a solution. Workarounds such as using the Chrome web browser and alternate PC's are the only solutions which appear to work, for some Managers.

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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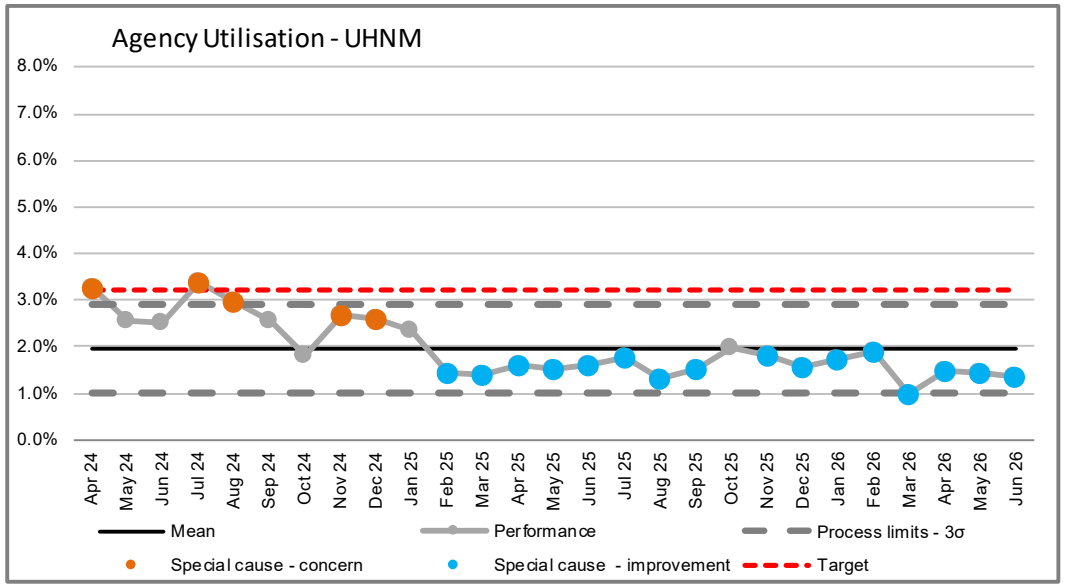
People | Agency Utilisation

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Apr 26	May 26	Jun 26
3.2%	1.5%	1.4%	1.4%

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 remained at 1.4% in June 2026, (1.4% in May 2026).

In real-terms, overall agency usage increased slightly to 97.85 WTE in June 2026, from 96.98 WTE in May, which is 20.53 WTE above plan, driven by vacancies across general & acute medicine, neuro and pathology services, in Medical & Dental.

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 over 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

Finance & Business Performance Committee | 6th July 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee received an update on the reset of the **2026/27 Cost Improvement Plan** (CIP) and its submission to NHS England, noting the development of a more fully supported programme with enhanced weekly Executive oversight and planned internal audit review. **Partial assurance** was provided, with residual risks remaining around delivery and the need to secure stakeholder sign-off for individual schemes. • The Committee noted **partial assurance** in relation to **Month 2 financial performance**, with a reported deficit of £11.1m driven by industrial action costs, CIP shortfall, income underperformance and continued agency and bank spend pressures. The Committee discussed recovery programmes, enhanced controls, capital prioritisation and the need to strengthen service line reporting and benchmarking to translate national efficiency opportunities into actionable local delivery plans. • The Committee noted **partial assurance** in relation to **digital compliance**, with a reduction in reported compliant systems attributed to changes in reporting methodology, alongside an increase in active system reviews. Further clarity was requested on month-on-month trajectory reporting to support improved oversight of progress, which would be incorporated into future reports.	• The Committee considered the governance and reporting arrangements for **strategic plans**, agreeing that future updates should be staggered across the committee business cycle, with clearer ownership and reporting responsibilities. • Updated **business case review** paper to be considered at the next meeting.
Positive Assurances to Provide	**Decisions Made**
• The Committee received an update on **corporate capacity investment**, noting the contribution to strategic delivery, productivity and CIP ambitions. **Acceptable assurance** was provided, with further clarity requested on KPIs, implementation timelines, governance and live dates to support ongoing monitoring of delivery and benefits realisation. • The Committee received an update on **outpatient transformation**, noting **acceptable assurance** on the benefits delivered through the Four Eyes review, including process improvements, centralised booking, reduced postage costs and increased productivity. The Committee noted the phased approach and associated dependencies, including recruitment to the centralised outpatient team, and was assured that capacity gaps would be addressed as booking activity transfers.	• The Committee approved to proceed with the initial **capital** works in relation to the helipad in advance of the business case being considered by the Committee at the next meeting. • The Committee approved the following **e-REAFs** 18146, 18303, 18409, 18428, 18399, 18439. • The Committee approved the **Implementation of Heidi Ambient Voice Technology AI Solution**.
Comments on the Effectiveness of the Meeting	**Cross Committee Considerations**
• Comments on effectiveness were sought via Microsoft Forms	• 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.	Corporate Capacity: Enabling Strategic Delivery	3, 6	Ext 16	Ext 20	Acceptable	Assurance	5.	Business Case Review Update	6, 7	Ext 20	Ext 25	N/A	Not discussed
2.	Optimising Capacity and Productivity in Outpatients	-	-		Acceptable	Assurance	6.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	6, 7	Ext 20	Ext 25	N/A	Approval
3.	CIP 2026/27 Update	6, 7	Ext 20	Ext 25	Partial	Assurance	7.	BC-0641 Implementation of Heidi Ambient Voice Technology AI Solution	4	Ext 16		N/A	Approval
4.	Finance Report – Month 2	6, 7	Ext 20	Ext 25	Partial	Assurance	8.	Digital Services - IT Standards Update	4	Ext 16		Partial	Assurance

Highlight Report

Finance & Business Performance Committee | 3rd August 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee considered the quarterly **Productivity Report** and that the Trust achieved its 2% productivity improvement target. Members discussed national benchmarking opportunities, particularly within A&E, elective care and premium pay rates, received an update on theatre utilisation improvement work being supported through a dedicated CIP workstream, and highlighted the need for greater transparency regarding bank and agency staffing costs. The Committee also emphasised the importance of enhancing Board understanding of productivity measures and requested that future reports provide greater context and assurance to support Board scrutiny. **Partial assurance** was agreed. • The Committee received the **Cost Improvement Programme (CIP)** update, noting progress in reconciling the original £73m plan with the recovery trajectory while acknowledging the ongoing delivery challenge, including a £7m gap in identified schemes and a steeper savings profile in the coming months. Members discussed the risks associated with non-delivery, including increased NHS England scrutiny and continued reliance on non-recurrent measures, and received assurance that strengthened governance, reporting arrangements and opportunity identification were being supported through the appointment of an Interim Programme Director for Financial Sustainability. **Partial assurance** was provided. • **Month 3 Finance** report provided **partial assurance**. The Committee noted a year-to-date deficit of £14.4m and a £6.1m adverse variance to plan, driven primarily by industrial action, pay pressures and un-transacted CIP. Members discussed the significant recovery required to achieve the planned financial position, received assurance regarding mitigation actions including elective recovery and accelerated CIP delivery, and noted improving trends in bank and agency expenditure, whilst recognising the ongoing risks associated with workforce costs, industrial action and winter pressures. • The Committee received **partial assurance** regarding the **Digital Services Assurance** report and agreed a move to quarterly reporting to provide a more meaningful view of progress. Members also supported the introduction of a new audit measure to monitor compliance with requirements aimed at preventing unlawful access to patient records, including assurance that all systems have appropriate user controls and audit trails in place, with future reports incorporating this enhanced oversight. • The Committee received **partial assurance** on progress against the **business case reviews**, in particular the Obstetrics and Gynaecology workforce investment business case, noting continued demand growth, recruitment challenges and emerging workforce pressures. Members emphasised the importance of strengthening demand forecasting through greater use of national benchmarking data and ensuring future business cases clearly articulate the risks, benefits and limitations of proposed investments where financial constraints prevent full demand being met. The Committee also noted ongoing work to improve workforce sustainability and recruitment within the specialty.	• Update report from the **Interim Programme Director for Financial Sustainability** to be provided to September's meeting. • Future **productivity reports** to provide greater visibility of theatre utilisation improvement initiatives and benefits with separate reporting of bank and agency staffing costs to improve transparency and oversight. • To provide an update on **CDC** activity and performance to October's meeting.
Positive Assurances to Provide	**Decisions Made**
• The Committee noted the improvements to risk descriptions, controls, assurances and executive summaries within the **Quarter 1 Board Assurance Framework (BAF)** and received assurance that strategic risks and risk ratings had been subject to robust Executive review. Members discussed risk interdependencies, particularly the impact of financial sustainability across the wider risk profile and highlighted the need for continued refinement of strategic alignment, estates-related actions and financial governance arrangements, which will be reflected in future quarterly updates. • The Committee received assurance regarding the operational feasibility of delivering the helipad safety works with minimal disruption to helicopter operations, noting the regulatory and patient safety rationale for the investment, and discussed the anticipated staffing cost savings associated with the proposed automated solution.	• The Committee approved the **Q1 BAF.** • The Committee approved **Business Case 0646 Royal Stoke Helipad Safety Improvement Scheme**, which included a contribution from charitable funds.

• The Committee received an update on the **National Cost Collection Submission** noting the robust validation and review processes undertaken to ensure data quality and compliance. Members were advised that a costing assurance framework was being developed to strengthen engagement between operational, clinical and finance teams, support productivity improvement and inform business decision-making, with further updates to be provided following publication of national benchmarking indices. • **Community Diagnostic Centre (CDC) Q1 Performance report** provided an update on CDC activity and performance, noting that ongoing validation work was required before a fully accurate position could be confirmed. Members discussed areas of underperformance across several diagnostic services, acknowledged the actions being taken to improve data quality, coding and service utilisation, and noted that a fully validated position covering the first six months of operation would be presented in October. The Committee also highlighted the need to better understand the emerging risk profile, operational learning and financial implications as the service matures.	• The Committee approved the increase in the **Capital Programme**.

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Comments on effectiveness were sought via Microsoft Forms	•

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 Q1	All	Various	N/A	Approval	6.	Costing Collection Post Submission Report 2025/26	-	-	N/A	Information
2.	BC-0646 Royal Stoke Helipad Safety Improvement Scheme	-	-	N/A	Approval	7.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order Expenditure	-	-	N/A	Approval
3.	Productivity Report	6, 7	Ext 20 / Ext 25	Partial	Assurance	8.	Community Diagnostic Centre Performance Q1	-	-	N/A	Information
4.	Cost Improvement Programme 2026/27	6, 7	Ext 20 / Ext 25	Partial	Assurance	9.	Digital Services – IT Standards Update	4	Ext 16	Partial	Assurance
5.	Finance Report – Month 3	6, 7	Ext 20 / Ext 25	Partial		10.	Business Case Review update	6, 7	Ext 20 / Ext 25	Partial	Assurance

Since 14th May to 14th July 2026, 9 contract awards over £1.5 m were made, as follows:

- **NOM6816 – Provision of O365 Licenses,** supplied by CDW, for the period 01/08/2026 – 31/07/2027, at a total cost of £1,887,807.88, approved on 10th June 2026.
- **MED2073 – Extension of Supply of Energy, Stapling and Trocars,** supplied by J&J via NHSSC, for the period 01/04/2027 – 31/03/2028, at a total cost of £1,626,436.80, providing savings of £33,016.66 – Negated Inflation, approved on 10th June 2026.
- **MED2083 – Supply of Sutures,** supplied by Metronic / J&J, for the period 01/07/2026 – 30/06/2030, at a total cost of £2,645,373.16, providing savings of £40,275.78 Negated Inflation (for years 2, 3 and 4) and £43,197 Cost Avoidance, approved on 10th June 2026.
- **MED3147 – Cytotoxic Dose Banded – Chemo, Immunotherapy and Monoclonal Medicines,** supplied by Quantum Pharmaceutical, Sciensus Pharma, Qualasept, Bath ASU (HTE Ref: 02548), Baxter (HTE Ref: 02549), for the period 01/07/2026 – 30/06/2027, at a total cost of £14,000,000, approved on 10th June 2026.
- **MED1127 – Supply of Pacemakers,** supplied by Abbott Medical / Medtronic / Biotronik, for the period 01/06/2026 – 31/05/2030, at a total cost of £15,347,374.97, providing savings of £233,663.76 – NI (for Year 2, 3 and 4), approved on 10th June 2026.
- **NOM5375 – Provision of Care Park Management at Royal Stoke University Hospital,** supplied by APCOA Parking (UK) Ltd, for the period 01/08/2026 – 31/07/2028 (Extension), at a total cost of £1,863,157.20, approved on 9th July 2026.
- **NAT9132 – Medical Locums Temporary Staffing Contract,** supplied by various, for the period 01/11/2026 – 31/10/2028 (Extension), at a total cost of £14,483,136, providing savings of NI savings of £73,501 in year and £147,003 NI savings full year effect, approved on 9th July 2026.
- **NOM4898 – Non-Emergency and High Dependency Patient Transport Service UHNM (9 Month Extension),** supplied by EMED Limited, for the period 01/09/2026 – 31/05/2027 (9 month Extension), at a total cost of £2,080,264.40, approved on 8th July 2026.
- **MED0976 – Supply of X-Ray Contrast Media,** supplied by Bayer, Bracco, GE Healthcare, Guerbet, for the period 01/09/2026 – 31/08/2027, at a total cost of £1,850,000, providing NI savings of £38,480, approved on 8th July 2026.

University Hospitals of North Midlands NHS Trust

Integrated Performance Report

Month 03 Performance

2026/27

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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.

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			Q4 2025/26	3	NOF Score	Provider value	
Average metric score			Q4 2025/26	2.48	NOF Score	Provider value	
Unadjusted segment			Q4 2025/26	3	NOF Score	Provider value	
Financial override	Q4 2025/26	Yes	Yes		Yes	Provider median	

Domain Scores	Data period	Provider value		Chart
Access to services domain segment	Q4 2025/26	3	NOF Score	
Access to services domain score	Q4 2025/26	2.51	NOF Score	
Effectiveness and experience of care domain segment	Q4 2025/26	3	NOF Score	
Effectiveness and experience of care domain score	Q4 2025/26	2.22	NOF Score	
Patient safety domain segment	Q4 2025/26	3	NOF Score	
Patient safety domain score	Q4 2025/26	2.83	NOF Score	
People and workforce domain segment	Q4 2025/26	3	NOF Score	
People and workforce domain score	Q4 2025/26	2.72	NOF Score	
Finance and productivity domain segment	Q4 2025/26	3	NOF Score	
Finance and productivity domain score	Q4 2025/26	2.2	NOF Score	

Adjusted segment

Provider value Q4 2025/26

3 NOF Score

The best joined-up care for *all*

UHNM remains in segment 3 for quarter four, with the Financial Override applied. **Overall score was 2.47 in Q3, increasing slightly to 2.48 in Q4. This reflects a marginal deterioration, outlined as follows:**

- Access to services from 2.57 to 2.51 (remains in segment 3)
- Effectiveness and Experience from 2.16 to 2.22 (dropped to segment 3)
- Patient Safety from 2.67 to 2.83 (remains in segment 3)
- People and Workforce from 2.49 to 2.72 (dropped to segment 3)
- Finance and productivity from 2.35 to 2.22 (remains in segment 3)

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Finance and Productivity

University Hospitals of North Midlands NHS Trust

Finance and productivity								Data period	Provider value		Chart
Finance and productivity domain segment								Q4 2025/26	3	NOF Score	
Finance and productivity domain score								Q4 2025/26	2.2	NOF Score	
Finance Please note that only the combined finance score contributes to the domain score	Data period	Provider value		Peer average		National value	National value method	Chart			
Combined finance score				Q4 2025/26	1	NOF Score	Provider value				
Planned surplus/deficit score				Q4 2025/26	1	NOF Score	Provider value				
Planned surplus/deficit	Q4 2025/26	0.00%		-0.48%		0.00%	Provider median				
Variance year-to-date to financial plan score				Q4 2025/26	2	NOF Score	Provider value				
Variance year-to-date to financial plan	Mar 2026	-0.34		-1.78		0.35	Provider median				
Productivity Please note: In Q1 2025/26, the implied productivity metric for ICBs applied only to acute trusts. This was later expanded to all trust types, so Q1 figures are not directly comparable with later quarters.	Data period	Provider value		Peer average		National value	National value method	Chart			
Implied productivity level score				Q4 2025/26	3	NOF Score	Provider value				
Implied productivity level	Dec 2025	0.58%		0.44%		2.57%	Provider median				

UHNM remains in segment 3 for this domain, despite the overall score increasing from 2.35 in Q3 to 2.20 in Q4, indicating an improvement in performance.
This change is primarily driven by the Implied Productivity level which has improved, moving from -1.80% in Q3 to 0.58% in Q4, with the corresponding NOF score improving from 3.71 to 3.00.
However, the year to date variance against financial plan, has fallen from 0.00 to -0.34, resulting in the NOF score increasing from 1 to 2.

Finance | Financial Summary

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

This report presents the financial performance of the Trust for June 2026 (Month 3).

The Trust reported a deficit of £14.4m at Month 3, which is a £6.1m overspend against plan.

Income: The income at month 3 is below plan by £1.8m, which relates to patient income £2.9m (£1.0m pass through drugs and devices) below plan and operating income £1.0m above plan.

Expenditure: Total operating expenditure is overspent by £4.9m. Pay expenditure was £213.7m to Month 3, generating an overspend of £6.1m year to date. The year-to-date position includes £1.6m of cost relating to industrial action. Non pay expenditure to Month 3 is £123.7m against a plan of £125.0m, resulting in a £1.3m underspend year to date.

CIP: The Trust had a £73.1m CIP target for 2026/27. At Month 3, it has delivered £4.9m of in year savings, an under performance of £4.1m against the £9.0m target.

Capital: At month 3 capital expenditure of £12.048m is £0.134m lower than plan which is mainly due to expenditure on the completion of the CDC enabling works and IM&T sub-group being lower than plan and partly offset by replacement medical equipment being delivered earlier than planned. A breakdown of the movement is shown in Appendix 1.

Statement of Financial Position: The Month 3 Statement of Financial Position shows total assets employed of £275.2m. The cash balance is £63.9m against a plan of £55.9m, details of the differences are provided within the report.

Financial Outlook and Risk: Following a detailed bottom-up review at Month 3, the Trust is forecasting an unmitigated year-end deficit of £58.6m, driven primarily by clinical income underperformance and the non-delivery of planned efficiencies, although significant opportunities remain through elective recovery, CIP delivery and other financial recovery actions which could improve the year-end 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	High 12	Acceptable	High 9	Acceptable
BAF 7: Inability to Deliver Financial Sustainability	Ext 20	Partial	Ext 20	Partial	Ext 25	Partial	Ext 25	Partial

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Finance | Income and Expenditure

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

The Trust has reported a £14.4m deficit at Month 3, which is a £6.1m overspend to the planned £8.3m deficit. The below summarises the Income and Expenditure position at Month 3.

Income & Expenditure Summary Month 03 2026/27	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	1,231.6	102.8	103.8	0.9	307.4	304.5	(2.9)
Other Operating Income	100.5	8.5	8.8	0.3	25.2	26.2	1.0
Total Income	**1,332.1**	**111.3**	**112.6**	**1.3**	**332.6**	**330.7**	**(1.8)**
Pay Expenditure	(825.6)	(69.3)	(71.3)	(2.0)	(207.6)	(213.7)	(6.1)
Non Pay Expenditure	(473.2)	(41.6)	(42.0)	(0.4)	(125.0)	(123.7)	1.3
Total Operational Costs	**(1,298.8)**	**(110.9)**	**(113.3)**	**(2.4)**	**(332.5)**	**(337.4)**	**(4.9)**
EBITDA	**33.3**	**0.4**	**(0.7)**	**(1.1)**	**0.0**	**(6.7)**	**(6.7)**
Interest Receivable	2.9	0.2	0.4	0.1	0.7	1.2	0.5
PDC	(4.8)	(0.4)	(0.4)	(0.0)	(1.2)	(1.2)	(0.0)
Finance Cost	(31.4)	(2.6)	(2.6)	(0.0)	(7.8)	(7.9)	(0.0)
Other Gains or Losses	0.0	0.0	0.1	0.1	0.0	0.1	0.1
Surplus / (Deficit)	**0.0**	**(2.4)**	**(3.3)**	**(0.9)**	**(8.3)**	**(14.4)**	**(6.1)**

The Trust overspend of £6.1m is mainly driven by the under delivery of CIP £4.1m (includes partial non delivery of elective income), £1.6m net costs incurred for industrial action that took place during April and £2.2m elective activity being below plan.

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Finance | CIP

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

The Trust has a £73.1m CIP target for 2026/27. At Month 3, it has delivered £4.9m of in-year savings, which is £4.1m below the month 3 plan of £9.0m. The month 3 position includes £1.6m of non-recurrent saving which were not planned to deliver until later in the financial year. The earlier delivery of these non-recurrent CIP has mitigation part of the under delivery of recurrent schemes. The table below provides an overview of the CIP plan and delivery at month 3.

CIP Summary Month 3 2026/27 £m	Annual	In Month			Year to date		
	Plan	Plan	Actual	Variance	Plan	Actual	Variance
Recurrent							
Income	13.4	0.9	0.5	(0.5)	2.8	0.7	(2.1)
Pay	21.7	1.4	1.3	(0.1)	3.4	1.6	(1.8)
Non Pay	12.1	0.9	0.4	(0.6)	2.7	1.0	(1.7)
Total Recurrent	**47.2**	**3.3**	**2.1**	**(1.2)**	**9.0**	**3.3**	**(5.7)**
Non Recurrent							
Income	-	-	-	-	-	-	-
Pay	-	-	0.1	0.1	-	0.1	0.1
Non Pay	25.9	-	0.1	0.1	-	1.5	1.5
Total Non Recurrent	**25.9**	**-**	**0.2**	**0.2**	**-**	**1.6**	**1.6**
Total CIP	**73.1**	**3.3**	**2.2**	**(1.0)**	**9.0**	**4.9**	**(4.1)**

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Finance | Capital

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

The below table sets out the capital plan agreed at the May Committee. Capital funding and expenditure have increased by £3.582m in June and a revised plan and the movements from the approved May capital plan are shown in **Table 10**. The Committee is asked to approve the movements detailed and the revised June capital plan.

The main changes include a revised plan of £3.0m for charitable funded capital expenditure, of which £0.8m is in relation to the safety works for the Helipad. IFRS16 lease remeasurement expenditure has reduced by £1.0m due to new lease arrangements being signed for the use of rooms at Community Health centres, which have a shorter lease term than initially expected. There have also been the following changes:

- several variances to the cost of previously prioritised schemes,
- slippage in the phasing of a number of multi-year schemes; and
- an increase in internal capital funding.

The change in forecast expenditure reported last month for the estimated cost of £2.9m for the replacement of endoscopy equipment at County Hospital (prior to the completion of a business case) is now incorporated into the revised June plan. Overall, a shortfall of £0.3m in funding remains which will be monitored and updated in future months.

For PDC Constitutional Standards schemes a rephasing in funding of £0.8m between the Stoke discharge lounge and the diagnostics schemes was agreed with NHSE. This enables the completion of the Stoke discharge lounge scheme in 2026/27 and increases diagnostic funding in 2027/28.

UHNM Capital Expenditure Plan	May Capital Plan 2026/27 £m	June revised Capital Plan 2026/27 £m	Variance	Month 3 Plan £m	Month 3 Actual £m	Variance £m
Pre-committed items - PFI and Loans						
PFI re-payment of liability	23.738	23.738	0.000	5.935	5.935	0.000
PFI lifecycle commitments	3.237	3.237	0.000	0.810	0.810	0.000
PFI Managed Equipment Scheme	1.518	1.518	0.000	1.050	1.050	0.000
Repayment of IFRS16 leases	4.608	4.608	0.000	1.152	1.152	0.000
Total PFI and IFRS16 lease repayments commitments	**33.101**	**33.101**	**0.000**	**8.947**	**8.947**	**0.000**
Pre-committed schemes						
Finance salaries	0.074	0.074	0.000	0.019	0.020	0.001
Estates salaries	0.754	0.754	0.000	0.188	0.181	(0.007)
IM&T salaries	0.401	0.401	0.000	0.000	0.000	0.000
AI salaries - BC	0.346	0.346	0.000	0.000	0.000	0.000
PFI enabling costs	0.200	0.200	0.000	0.000	0.010	0.010
Network & Comms BC525	1.072	1.072	0.000	0.050	0.059	0.009
LED lighting BC546	0.462	0.462	0.000	0.000	0.000	0.000
IM&T computer hardware refresh BC569	3.127	3.127	0.000	0.066	0.061	(0.005)
ED ambulance off - enabling ward moves	0.305	0.305	0.000	0.000	0.000	0.000
Endoscopy works 7th room - PDC allocation prior yrs	0.731	0.097	(0.634)	0.000	0.000	0.000
Completion of estates safety funding LTHW and chiller	0.745	0.975	0.230	0.150	0.144	(0.006)
Completion of CDC enabling	1.300	1.300	0.000	0.400	0.290	(0.110)
Completion of County Breast Unit	0.218	0.218	0.000	0.090	0.159	0.069
Completion of CDC IM&T	0.040	0.040	0.000	0.040	0.036	(0.004)
CDC pathways - 25/26 brokerage	0.393	0.393	0.000	0.030	0.030	0.000
CDC Endoscopy 4th room - 25/26 brokerage	1.000	1.000	0.000	0.000	0.000	0.000
Frontline digitalisation EPR 2025/26	0.322	0.322	0.000	0.113	0.120	0.007
Negative pressure - compliance	0.200	0.215	0.015	0.000	0.000	0.000
EPMA - outpatients	0.210	0.210	0.000	0.104	0.133	0.029
PDC physiological science brought forward	0.235	0.235	0.000	0.000	0.000	0.000
Maternity - improvement to bereavement services/estate	0.129	0.129	0.000	0.000	0.000	0.000
Project Star - RI remedial work	0.010	0.010	0.000	0.000	0.000	0.000
Managing H&S risk register - BC562	0.043	0.043	0.000	0.000	0.000	0.000
Elective Hub - TBC	0.195	0.195	0.000	0.042	0.042	0.000
Pathology LIMS slippage	0.305	0.305	0.000	0.000	0.000	0.000
Royal Stoke ED healthcare planning feasibility	0.047	0.047	0.000	0.008	0.008	0.000
Central Contingency & risk	0.500	0.500	0.000	0.000	0.000	0.000
Total pre-committed schemes	**13.364**	**12.975**	**(0.389)**	**1.300**	**1.293**	**(0.007)**

UHNM Capital Expenditure Plan	May Capital Plan 2026/27 £m	June revised Capital Plan 2026/27 £m	Variance	Month 3 Plan £m	Month 3 Actual £m	Variance £m
Capital Planning Prioritised Schemes						
Care Group allocation - £2m additional funding	0.000	0.000	0.000	0.000	0.000	0.000
Stryker Power tools RemB	0.220	0.220	0.000	0.220	0.220	0.000
Operating tables x 4 for County Theatres	0.135	0.183	0.048	0.000	0.000	0.000
Respiratory Clearance Devices	0.014	0.000	(0.014)	0.000	0.000	0.000
Windows 11 Upgrades for Diagnostic Equipment in Neurophysiology	0.093	0.117	0.024	0.000	0.000	0.000
Screening Room - CH room 4	0.500	0.552	0.052	0.000	0.000	0.000
Micro Plastic sets	0.057	0.057	0.000	0.000	0.000	0.000
UPS Replacements	0.080	0.080	0.000	0.009	0.009	0.000
MAU Wall removal	0.014	0.014	0.000	0.000	0.000	0.000
Replacement of Echo Blood Grouping analyser	0.026	0.031	0.005	0.000	0.000	0.000
Medical Gas Equipment	0.150	0.150	0.000	0.000	0.000	0.000
Replacement of RO plant	0.200	0.200	0.000	0.000	0.000	0.000
Cardiac Cath Lan - Cardiology PACS replacement	0.020	0.040	0.020	0.000	0.000	0.000
Audiology -County soundproofing	0.630	0.630	0.000	0.000	0.000	0.000
Refurbishment of RSUH Cancer Centre Pharmacy including Cold Store	0.728	0.728	0.000	0.000	0.000	0.000
PET-CT Autoinjector	0.058	0.069	0.011	0.000	0.000	0.000
Royal Stoke road enhancements	0.300	0.300	0.000	0.054	0.054	0.000
Sedation Equipment - Capnography	0.156	0.156	0.000	0.000	0.000	0.000
Heidi ambient voice technology AI solution BC	0.377	0.377	0.000	0.000	0.000	0.000
Endoscopy Medilogic	0.000	0.071	0.071	0.000	0.000	0.000
County High-Definition Procedural Screens - X4 Rooms	0.087	0.087	0.000	0.086	0.086	0.000
Safety Works to Royal Stoke Helipad - BC required	0.776	0.776	0.000	0.000	0.000	0.000
Total Capital Planning Prioritised Schemes	**4.621**	**4.838**	**0.217**	**0.369**	**0.369**	**0.000**
Other corporate schemes						
IFRS16 Lease liability re-measurement	0.200	(0.800)	(1.000)	0.000	0.000	0.000
Vehicles lease renewals	0.415	0.415	0.000	0.149	0.149	0.000
Heart Lung by-pass equipment replacement	1.500	1.306	(0.194)	0.000	0.000	0.000
Urology robot (lease)	0.305	0.305	0.000	0.000	0.000	0.000
Roache Sakura equipment (IFRS16)	0.225	0.225	0.000	0.000	0.000	0.000
Endoscopy scopes County Hospital & requirement to extend RS lease	0.000	2.900	2.900	0.000	0.000	0.000
Heat Network Efficiency Scheme	0.729	0.729	0.000	0.000	0.000	0.000
Total Other corporate schemes	**3.374**	**5.080**	**1.706**	**0.149**	**0.149**	**0.000**
Capital sub-group (ICB allocation)						
IMT Sub Group Total Funding	1.750	1.750	0.000	0.343	0.084	(0.259)
2025/26 slippage	0.552	0.552	0.000	0.000	0.000	0.000
Medical Devices Sub Group	2.500	2.500	0.000	0.155	0.313	0.158
Estates Sub Group Total Funding	2.000	2.000	0.000	0.060	0.062	0.002
Estates safety - additional allocation	1.694	1.694	0.000	0.000	0.000	0.000
Health & Safety compliance	0.150	0.150	0.000	0.000	0.000	0.000
Total Capital Sub-Groups	**8.646**	**8.646**	**0.000**	**0.558**	**0.459**	**(0.099)**
Total Internal Capital Expenditure	**30.005**	**31.539**	**1.534**	**2.376**	**2.270**	**(0.106)**
Funding to allocate/(shortfall)	0.662	(0.308)	(0.970)	0.000	0.000	0.000
Total Operational Capital/internally funded expenditure	**63.768**	**64.332**	**0.564**	**11.323**	**11.217**	**(0.106)**

UHNM Capital Expenditure Plan	May Capital Plan 2026/27 £m	June revised Capital Plan 2026/27 £m	Variance	Month 3 Plan £m	Month 3 Actual £m	Variance £m
Additional CRL / Externally Funded PDC (multi-year schemes)						
Charitable funded expenditure	0.000	2.204	2.204	0.076	0.076	0.000
Charitable funded contribution - helipad safety works	0.000	0.814	0.814	0.000	0.000	0.000
Externally Funded PDC						
PDC Constitutional standards Royal Stoke UTC Estates	2.694	2.694	0.000	0.429	0.429	0.000
PDC Constitutional standards Royal Stoke UTC Digital	0.616	0.616	0.000	0.000	0.000	0.000
PDC Constitutional Standards Stoke Discharge Lounge	0.300	1.100	0.800	0.000	0.000	0.000
PDC Constitutional Standards UTC County	2.100	2.100	0.000	0.000	0.000	0.000
PDC Constitutional standards Urgent Emergency Care	0.800	0.800	0.000	0.000	0.000	0.000
PDC Constitutional Standards Diagnostics CDC Expansion	1.800	1.000	(0.800)	0.000	0.000	0.000
PDC Pathology LIMS	1.270	1.270	0.000	0.354	0.326	(0.028)
Total Additional CRL / PDC Funded expenditure	**9.580**	**12.598**	**3.018**	**0.859**	**0.831**	**(0.028)**
Total Capital Expenditure	**73.348**	**76.930**	**3.582**	**12.182**	**12.048**	**(0.134)**

UHNM Capital Funding Plan -2026/27 to 2029/30	May Capital Plan 2026/27 £m	June revised Capital Plan 2026/27 £m	Variance	Month 3 Plan £m	Month 3 Actual £m	Variance £m
Total PFI and IFRS 16 lease repayments commitments	33.101	33.101	0.000	8.947	8.947	0.000
Total ICB capital allocation	26.051	26.051	0.000	3.159	3.025	(0.134)
Elective Care Capital Incentive Scheme - RTTS	2.000	2.000	0.000	0.000	0.000	0.000
PDC Estates Safety	1.694	1.694	0.000	0.000	0.000	0.000
PDC Constitutional standards Urgent Treatment Centre	3.310	3.310	0.000	0.000	0.000	0.000
PDC Constitutional Standards Stoke Discharge Lounge	0.300	1.100	0.800	0.000	0.000	0.000
PDC Constitutional Standards UTC County & discharge	2.100	2.100	0.000	0.000	0.000	0.000
PDC Constitutional standards Urgent Emergency Care	0.800	0.800	0.000	0.000	0.000	0.000
PDC Constitutional Standards Diagnostics	1.800	1.000	(0.800)	0.000	0.000	0.000
PDC Pathology LIMS	1.270	1.270	0.000	0.000	0.000	0.000
Land disposal - RI/COPD	0.000	0.000	0.000	0.000	0.000	0.000
Other disposals	0.425	0.789	0.364	0.000	0.000	0.000
Charitable funds	0.000	3.018	3.018	0.076	0.076	0.000
Internal resources capital to revenue	0.000	0.200	0.200	0.000	0.000	0.000
Internal resources - VAT and accruals release	0.497	0.497	0.000	0.000	0.000	0.000
Total capital funding	**73.348**	**76.930**	**3.582**	**12.182**	**12.048**	**(0.134)**
Funding to be allocated/(shortfall)	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**	**0.000**

Kind Excellent Together

Finance | Balance Sheet

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

Statement of Financial Position	31/03/2026	30/06/2026		
	Actual £m	Plan £m	Actual £m	Variance £m
Property, Plant & Equipment	732.3	734.0	730.5	(3.4)
Right of Use Assets	21.8	20.9	21.0	0.0
Intangible Assets	12.1	13.5	13.4	(0.1)
Trade and other Receivables	1.0	1.1	1.0	(0.1)
Total Non-Current Assets	**767.3**	**769.5**	**765.9**	**(3.6)**
Inventories	21.4	21.0	21.3	0.3
Trade and other Receivables	51.2	53.0	56.9	3.9
Asset held for sale	7.7	7.7	7.7	-
Cash and Cash Equivalents	88.1	55.9	63.9	8.0
Total Current Assets	**168.4**	**137.5**	**149.7**	**12.2**
Trade and other payables	(136.9)	(112.0)	(128.3)	(16.3)
Borrowings	(28.8)	(28.8)	(28.6)	0.2
Provisions	(1.1)	(1.1)	(0.7)	0.3
Total Current Liabilities	**(166.7)**	**(141.9)**	**(157.7)**	**(15.8)**
Borrowings	(482.2)	(479.7)	(479.4)	0.3
Provisions	(3.4)	(3.4)	(3.4)	0.0
Total Non-Current Liabilities	**(485.7)**	**(483.1)**	**(482.7)**	**0.3**
Total Assets Employed	**283.3**	**282.1**	**275.2**	**(6.8)**
Financed By:				-
Public Dividend Capital	775.6	775.6	775.6	-
Retained Earnings	(692.0)	(697.8)	(704.7)	(6.8)
Revaluation Reserve	199.7	204.3	204.3	-
Total Taxpayers Equity	**283.3**	**282.1**	**275.2**	**(6.8)**

Highlight Report

AUDIT COMMITTEE | 6th August 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee reviewed progress against **internal audit recommendations**, noting that 75 actions remained under review, with delays largely attributable to the scale and complexity of longer-term improvement programmes rather than a lack of progress. Partial assurance was provided that evidence was routinely obtained to support the closure of completed actions, and further reporting on the causes of delays will be included in future updates. • The Committee received partial assurance regarding the **corporate governance** report, noting high compliance with declarations of interest and actions underway to strengthen policy oversight and reduce overdue policy reviews. Assurance was provided on progress to address delays in HR policy reviews through prioritisation and governance controls, with the Committee requesting a further assessment of workforce resilience risks and mitigating actions. • The Committee received partial assurance regarding the Trust's **cyber security** arrangements, noting continued improvement in the Trust's external security posture and progress towards forthcoming national cyber security requirements. Members discussed emerging risks associated with AI-enabled cyber threats, phishing and digital impersonation, and were assured that further gap analysis, assurance mapping and policy reviews are underway to strengthen organisational resilience and support compliance with NHS cyber security standards.	• To take forward conversation with **internal audit** regarding the possibility of obtaining assurance on rostering. • To conduct a **risk assessment** to understand the impact of lack of resilience in the HR team, including the effect on policy updates and other areas, and report back to the committee with findings and proposed actions. • Ensure the **central tenant migration** risk is clearly articulated, including risk assessment and mitigation plans. • Review the current **password policy** (IT17), specifically the three-year rotation period, and report back with recommendations for alignment to best practice. • Provide clearer reporting in the next audit committee paper distinguishing between staff who open **phishing** emails and those who click through and enter data, to better assess risk. • Collaborate to design and implement a Microsoft Teams **phishing** simulation exercise to test staff awareness of emerging Teams-based fraud risks.

Positive Assurances to Provide	Decisions Made
• The Committee received an update on the delivery of the **Internal Audit** plan, noting that revisions to the timetable for some reviews would not adversely impact the annual audit opinion. • The Committee received acceptable assurance on the refreshed **Board Assurance Framework**, which included strengthened risk descriptions, controls, assurance measures and action plans. Members reviewed the alignment of assurances to principal risks, discussed opportunities to further strengthen action tracking and assurance mapping, and noted that further refinements will be incorporated as part of the Quarter 2 review. • Acceptable assurance was provided by the update on the **failure to prevent fraud gap analysis**, noting the completion of outstanding actions. • The Committee received acceptable assurance regarding the Trust's management of **losses, special payments and inventory controls**, noting that reported losses were predominantly attributable to bad debt write-offs, with stock losses remaining low. Assurance was also provided on progress towards implementation of the National Inventory Management System, which was expected to strengthen stock control, reduce waste and write-offs, and enhance patient safety through improved inventory management arrangements. • The Committee received significant assurance regarding compliance with the **Standing Financial Instructions**, noting that reported breaches were predominantly administrative in nature and related to retrospective purchase orders. Members reviewed **single tender waivers** and were assured that appropriate justification and governance arrangements were in place, with ongoing work to further strengthen procurement compliance and reporting processes.	• The Committee approved FA01 Asset Accounting, FA02 Inventory Control and F15 Salary Overpayments **policies**

• The Committee reviewed the management of **salary overpayments**, noting ongoing recovery arrangements and assurance that enhanced training, monitoring and process improvements were being implemented to reduce recurrence. Members recognised the impact of wider system limitations and national payroll system changes and agreed that future reports should provide greater detail on corrective actions and progress, resulting in assurance being moderated from Significant to **acceptable**. • The Committee received an update on **counter fraud** arrangements, noting proactive investigation activity, fraud awareness initiatives and benchmarking which demonstrated a positive reporting culture. Members reviewed emerging cyber fraud risks, including phishing through Microsoft Teams, and supported targeted awareness and testing activities to strengthen organisational resilience. The Committee also noted progress in assessing compliance with the Economic Crime and Corporate Transparency Act and the ongoing review of fraud prevention controls.	

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Comments on effectiveness were sought via MS Forms.	• 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.	Internal Audit Progress Report	Various		Not applicable	Information	7.	Policies for Approval: - FA01 Asset Accounting - FA02 Inventory Control - F15 Salary Overpayments			Not applicable	Approval
2.	Corporate Governance Report	Various		Partial	Assurance	8.	LCFS 2026/27 Progress Report: - 2025/26 Reactive Benchmarking Report - 2025/26 Failure to Prevent Fraud Review			Not applicable	Information
3.	Audit Action Tracker	Various		Partial	Assurance	9.	Losses and Special Payments Update Q1	6, 7	Ext 20 / Ext 25	Acceptable	Assurance
4.	Cyber Security Assurance Report	4	Ext 16	Partial	Assurance	10.	SFI Breaches and Single Tender Waivers Q1	6,7	Ext 20 / Ext 25	Significant	Assurance
5.	Board Assurance Framework Q1	All		Acceptable	Assurance	11.	SFI Breaches related to Late Termination and Change Forms Q1	6, 7	Ext 20 / Ext 25	Acceptable	Assurance
6.	Failure to Prevent Fraud – Progress Update			Acceptable	Assurance						

Trust Board

2026/27 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	Apr	Jun	Aug	Oct	Dec	Feb
		8	10	12	7	9	10
PROCEDURAL ITEMS							
Patient / Staff Story	Chief Nurse / Chief People Officer	Staff	Pt	Staff	Pt	Staff	Pt
Chairs Update	Chair						
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						
Mortality Assurance Annual Report	Chief Medical Officer						
Maternity Serious Incident Report	Chief Nurse	**Q3**	**Q4**	Q1			
MAU and Maternity Patient Experience Update	Chief Nurse						
Annual Saving Babies Lives & Maternity Care Bundle Report	Chief Nurse						
Annual MOSS Alert Safety Check	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, Ethnicity and Disability Pay Gap Report	Chief People Officer						
Speaking Up 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						
OUR POPULATION							
Population Health Strategic Plan Update	Director of Strategy						
FINANCE AND BUSINESS PERFORMANCE							
Finance & Business Performance Committee Assurance Report	Director of Governance						
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 Strategy & 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						
Well-Led / Provider Capability Integrated Action Plan	Director of Governance						
Risk Management Policy	Director of Governance						
Complaints Policy	Chief Nurse						
Annual Organ Donation Report	Chief Medical Officer						