University Hospitals of North Midlands NHS Trust

AGENDA | Trust Board - Part 1 (in Public)

Meeting held on Wednesday 9th July 2025 at 9.30 am to 12.15 pm

Trust Boardroom, Third Floor, Springfield, RSUH

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
9:30	**PROCEDURAL ITEMS**					
20 mins	01	Colleague 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 7th May 2025 & of the Extraordinary Meeting held 25th June 2025	Approval	Ms J Small	Enclosure	
	05	Matters Arising via the Post Meeting Action Log	Assurance	Ms J Small	Enclosure	
10 mins	06	Chief Executive's Report – July 2025	Information	Ms H Ashley	Enclosure	
10 mins	07	Annual Plan 2025/26	Approval	Ms H Ashley	Enclosure	
10:15	**OUR PATIENTS: QUALITY, ACCESS & OUTCOMES**					
15 mins	08	Urgent and Emergency Care Pressures, Ambulance Handover and Winter Update	Assurance	Mrs K Thorpe	Enclosure	1, 4
10 mins	09	Maternity Serious Incident Report	Assurance	Mrs AM Riley	Enclosure	
10:40 – 10:55 COMFORT BREAK						
10:55	**PERFORMANCE**					
	10	Integrated Performance Report – Month 2 and Committee Assurance Reports:				
25 mins	10a	• Quality, Access & Outcomes Committee Assurance Report (05-06-25 & 04-07-25) • Quality & Access Dashboard	Assurance	Prof A Hassell Mrs AM Riley / Mrs K Thorpe	Enclosure	1
20 mins	10b	• Finance & Efficiency Committee Assurance Report (02-06-25 & 30-06-25) • Finance Dashboard	Assurance	Ms T Bowen Mr M Oldham	Enclosure	7, 8
10 mins	10c	• People, Culture and Inclusion Committee Assurance Report (05-06-25) • People Dashboard	Assurance	Prof G Crowe Mrs J Haire	Enclosure	2
11:50	**GOVERNANCE**					
10 mins	11	Rules of Procedure & Output of Committee Effectiveness 2024/25	Approval	Mrs C Cotton	Enclosure	
10 mins	12	Board Seminar Plan 2025/26	Approval	Mrs C Cotton	Enclosure	
12:10	**CLOSING MATTERS**					
5 mins	13	Review of Meeting Effectiveness • Did the Board, via the agenda, papers and discussion, fulfil its objectives of supporting our communities, staff and stakeholders? • Was the balance of the agenda correct between strategy and performance?	Information	Ms J Small	Verbal	
	14	Review of Business Cycle	Information	Ms J Small	Enclosure	
	15	Questions from Members of the Public	Information	Ms J Small	Verbal	
12:15	**DATE AND TIME OF NEXT MEETING**					
	16	**Wednesday 8th October 2025, 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 7th July to nicola.hassall@uhnm.nhs.uk

Minutes of Meeting

Trust Board – Part 1 | 7th May 2025 9.30 am to 12.25 pm

Trust Boardroom, Third Floor, Springfield

University Hospitals of North Midlands NHS Trust

Members Present:			
Name	**Initials**	**Title**	
Mr D Wakefield	DW	Chairman (Chair)	Voting
Mrs L Bainbridge	LB	Non-Executive Director	Voting
Ms T Bowen	TBo	Non-Executive Director (virtual)	Voting
Prof A Hassell	AH	Associate Non-Executive Director	Non-Voting
Prof K Maddock	KM	Non-Executive Director	Voting
Mrs M Monckton	MM	Non-Executive Director (virtual)	Voting
Miss W Nicholson MBE	WN	Associate Non-Executive Director	Non-Voting
Prof S Toor	ST	Non-Executive Director	Voting
Dr S Constable	SC	Chief Executive	Voting
Dr D Adamson	DA	Interim Chief Medical Officer	Voting
Ms H Ashley	HA	Director of Strategy	Non-Voting
Mrs C Cotton	CC	Director of Governance	Non-Voting
Mr M Oldham	MO	Chief Finance Officer	Voting
Mrs AM Riley	AR	Chief Nurse	Voting
Mrs L Thomson	LT	Director of Communications	Non-Voting
Mrs K Thorpe	KT	Interim Chief Operating Officer	Voting
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI	Non-Voting

Apologies Received:		
Name	**Initials**	**Title**
Prof G Crowe	GC	Non-Executive Director
Mrs A Freeman	AF	Chief Digital Information Officer
Mrs J Haire	JH	Chief People Officer

In Attendance:		
Name	**Initials**	**Title**
Mrs J Davies	JD	Professional Midwifery Advocate (item 1)
Mrs N Hassall	NH	Deputy Director of Governance (minutes)
Mrs S Jamieson	SJ	Director of Midwifery (item 1)
Miss K Myatt	KM	Deputy Chief People Officer (representing Mrs Haire)
Mrs S Seadon	SS	Community Midwife (item 1)
Ms J Small	JS	Chair – MPFT (observing)

Members of Staff and Public: 5

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Patient Story**	
	The following video was played https://vimeo.com/1080828139/12f1d6d3ca which highlighted the story from Sophie Jebb Bowman, a maternity patient who shared her experience of the support provided to her during her pregnancy.	
045/2025	Professor Toor welcomed the story and queried, as part of the work of the equality, diversity and inclusion (EDI) midwife, how the team were aiming to include patients with neurodiversity within the EDI strategy. Mrs Jamieson stated that the recently appointed EDI midwife was taking forward work such as training, working on continuity of carer and focussing on care within the most deprived areas. She added that the midwife also had links to the safeguarding team. Mrs Seadon added that because of Sophie's autism she	

	assisted in ensuring appointments were held at regular times of the day, and for a longer time as this meant her partner could join her. Professor Hassell queried whether providing the additional support was resource intensive and a challenge when having to manage resources. Mrs Seadon agreed but added that healthcare support workers were utilised and that this relied on good teamwork. Mr Wakefield queried whether it was normal for Mrs Davies to support patients during the birth and Mrs Davies explained that she was trained in birth trauma and as such had techniques to help women relax, so provided that support to Sophie. She stated that the support resulted in better outcomes for the patient as it made it easier for the team to care for them. Mr Wakefield referred to the comments made in terms of the Early Pregnancy Assessment Unit (EPAU) and queried what the unit was used for. Mrs Seadon explained that EPAU saw women who were under 16 weeks pregnant, and patients were referred to the unit by their GP. She added that after this time, patients would be seen in the Midwifery Assessment Unit (MAU). Mr Wakefield congratulated both Mrs Seadon and Mrs Davies for the praise provided by Sophie. He summarised that despite Sophie being frightened and worried, given her previous miscarriages and neurodiversity, the midwives obviously had a huge impression whereby Sophie felt they saved her baby's life. He welcomed the comments made about the flexibility of the service and added that the issue highlighted with regards to MAU would be taken on board and reflected upon. **The Trust Board noted the patient story.** Mrs Jamieson, Mrs Seadon and Mrs Davies left the meeting.	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
046/2025	Mr Wakefield welcomed members to the meeting. Apologies were received as noted above and it was confirmed that the meeting was quorate. Mr Wakefield welcomed Mrs Small, the new Chair who was to take over from him on 1st June 2015 and he also welcomed Dr Adamson as Interim Chief Medical Officer and Miss Myatt who was representing Mrs Haire in her absence.	
3.	**Declarations of Interest**	
047/2025	There were no declarations of interest raised.	
4.	**Minutes of the Meeting held 12th March 2025**	
048/2025	The minutes of the meeting held 12th March 2025 were approved as a true and accurate record.	
5.	**Matters Arising via the Post Meeting Action Log**	
049/2025	PTB/606 – It was agreed to take an update on outstanding appraisals / revalidation to the People, Culture and Inclusion (PCI) Committee.	

	PTB/610 – Mr Wakefield requested clarity of the number of patients diverted from the Emergency Department and Mrs Thorpe clarified that the reference to 100 diverts per day related to those accessing call before convey, although it was not known how many of these would have been actual attendances.	
6.	**Chief Executive's Report – March 2025**	
	Dr Constable drew attention to the reference regarding the Care Quality Commission (CQC) maternity report which had been released and improved the rating to good. He also referred to the new strategy which had been included in light of the previous engagement and consideration. Dr Constable highlighted that the meeting was Mr Wakefield's last board meeting and formally put on record his thanks from the Board for the last 7 years. Miss Nicholson referred to the Trust's commitment to preventive care for children, which she felt should be referenced in the strategy. Ms Bowen referred to the strategy and the aim of developing hospitals as smoke free and queried whether there was a plan in place. Ms Ashley stated that conversations were being clinically led by the respiratory team whereby the Trust was trying to address this from a preventative perspective. In addition, actions were being considered from an estate perspective.	
050/2025	Mr Wakefield referred to the reference to the Operational Pressures Escalation Level (OPEL) within the report and queried what the present level was. Mrs Thorpe highlighted that this stood at level 3. Mr Wakefield queried whether the Non-Executive Directors needed to be made more aware of the OPEL levels and Mrs Thorpe stated that this changed every 12 hours. Mr Wakefield referred to the heat network and plans over the next 5 years and queried, given the cost of energy, whether the increased cost was being factored into the business case. Mrs Whitehead confirmed that the business case would include the increase in costs. Professor Hassell welcomed the improved CQC rating for maternity and Mr Wakefield queried how this impacted on the Trust's overall rating. Mrs Riley stated that the overall score remained as Requires Improvement due to the ratings for the UEC pathway, medicine and outpatients. She stated for the overall rating to improve, the rating for one of those areas also needed to improve. **The Trust Board received and noted the report.**	
7.	**Board Assurance Framework (BAF) – Quarter 4**	
051/2025	Mrs Cotton presented the summary for quarter 4 and referred to the discussions held in considering the BAF for coming year, with the emphasis on risks across the system. She stated that from an Annual Governance Statement (AGS) perspective the top three risks reported at the end of the year related to financial sustainability, responsive patient care and digital capability. Mr Wakefield referred the references within the document to the Electronic Patient Record (EPR) which referred to the reliance on funding from the	

	centre and given the spending review and current situation with restricted spending, he queried whether a particular risk should be referenced on the BAF. Ms Ashley stated that the challenge related to revenue and that the same restraints on capital funding had not been recognised, particularly given that the funding had already been confirmed. Mr Wakefield referred to the previous business case which identified the revenue running at a loss and Mr Oldham stated that was a risk although savings were made in future years and the revenue profile needed to be considered as such. Mrs Cotton referenced the specific risks on the risk register in relation to the EPR and the consequences of continuing to use the current system as opposed to the risks associated with delivering a new system. In addition, she highlighted that as EPR was a major programme within the new strategy, any risks to the new strategy would feature within the BAF for Quarter 1. Mr Oldham referred to the original risk in relation to capital and that national discussions highlighted that the spend profiles would need to be different in the future. Mr Wakefield referred to the number of actions which had turned red in Quarter 4 with no future date identified and it was noted that these were to be reconsidered as part of the planning for the Quarter 1 BAF. **The Trust Board approved the summary BAF for Quarter 4.**	
8.	**Our Strategy**	
052/2025	Ms Ashley referred to the previous discussions regarding the refresh of the strategy which was being presented to the Board in public as part of its launch. She explained that the previous strategy was written at a point when the organisation came together with part of Mid Staffordshire NHS Foundation Trust to form a new organisation and given how far the organisation had come since that time, the change in strategy was significant, in particular the revised focus on the health of the population. Ms Ashley stated that a separate strategy on a page had been developed which described the programmes which supported the delivery of the strategy and added that the programmes were being scoped in addition to outlining the strategic delivery plans. Ms Ashley referred to initial comments from the organisation on the strategy whereby the format was welcomed in addition to its simplicity and focus on the population. Mrs Cotton added that as part of the launch, the Trust had refreshed its branding. Mrs Monckton queried whether finance should be referenced as a specific strategic plan and Ms Ashley stated that whilst it was not specifically named, it was included within the strategic programmes i.e. brilliant basics. Mr Oldham added that brilliant basics would focus on productivity, benchmarking and ensuring resources aligned with demand. Mr Wakefield queried whether the change in financial landscape and the emphasis on productivity needed to be considered and suggested that the items covered as part of each strategic programme be shared with the Board in due course.	

	Mrs Cotton stated that in terms of the corporate governance structure, the updates on strategy would include focusing on delivery of the major programmes. Mr Wakefield referred to the large underlying deficit and that the strategy for the next 5 years needed to reduce the deficit, as such the Board needed to reflect on how that would be undertaken. Mr Oldham stated that once the long-term plan had been published that would need to be taken into account. **The Trust Board approved the strategy noting the additional information which was to be provided in relation to the content of each strategic programme.**	
OUR PATIENTS: QUALITY, ACCESS & OUTCOMES		
9.	**Urgent and Emergency Care (UEC) Pressures, Ambulance Handover and Winter Update**	
053/2025	Mrs Thorpe highlighted the following: • An update provided on winter and the impact of the Easter break • Recent performance which had returned to normal variation • Tactical actions in addition to the high-level actions which were being taken in respect of the UEC programme in addition to detailed plans • The impact of the community service transformation programme which had been worked up with partners, and had been modelled into the overarching improvement programme Professor Hassell queried what key metrics Non-Executive Directors should focus on to monitor any improvements and Mrs Thorpe highlighted that monitoring of ambulance handovers and 4 / 12 hour performance was key. Dr Constable added that the 3 outcomes were those which the Trust was held to account for, within the tier 2 meetings with NHS England (NHSE). Ms Bowen questioned whether additional context / benchmarking of the number of people attending the Emergency Department (ED), including walk-ins, their acuity and number of ambulances, could be included so that the non-executives could determine whether there had been any changes in key challenges. Mrs Thorpe stated that the national context depended on the population served and provision of community services, as such, there were some Trusts which were better comparators than others, however she agreed to consider including national / comparator context within future reports. Mr Wakefield referred to the action plans in place for each of the workstreams and queried how non-executives would receive assurance that these were delivering as planned. Mrs Thorpe stated that the main source of assurance would be monitoring of the 3 key metrics. Dr Constable stated that the assurance needed to be based on outcomes. He stated that if, despite doing things which were recommendations from others, they were not having the desired improvement, the Trust needed to be agile about changing what it was doing. Dr Adamson referred to the level of focus on the UEC pathway, which had been planned differently and separated, to provide greater accountability. Ms Bowen stated that the actual expectation needed to be clear within the Trust's key performance indicators and timescales and Mr Wakefield agreed,	**KT**

	adding that if the actions being taken were not improving performance, reports needed to be clear of the reasons for this. Mrs Thorpe stated that the trajectories for improvement had already been built into the delivery plan for 2025/26. Professor Hassell queried how areas of exception would be reported to the Board and Mrs Thorpe referred to the highlight reports from the Recovery Oversight Group which would escalate any risks and issues to the Finance and Efficiency (FEC) and Quality, Access and Outcomes (QAC) Committees. **The Trust Board received and noted the update.**	
10.	**Annual PLACE Inspection Findings**	
054/2025	Mrs Whitehead presented the results following the inspection in 2024 whereby the Trust achieved above the national average across all criteria for the second consecutive year, demonstrating the Trust's commitment in providing positive patient and staff experience. She explained that the associated action plan for further improvements had been considered at QAC. Mr Wakefield congratulated the team on another set of fantastic results. Ms Bowen reflected that the scores were well above average and this should be recognised. Mrs Whitehead put on record her thanks to the Charity for helping to increase particularly for dementia patients. **The Trust Board received and noted the findings.**	
OUR PEOPLE		
11.	**Staff Survey Results 2024**	
055/2025	Miss Myatt highlighted the following: • The Trust had maintained 45% completion rate which was a real time improvement in the number completed • Overall, the Trust maintained its position from 2023, with positive gains across the board • There were some specific areas of improvement i.e. flexible working which reflected the actions which had been undertaken in the past 2 years • The staff engagement score was below target, but there had been some positive improvement, and the Trust had received a certificate of recognition from NHSE congratulating the Trust on improving experience and engagement • Four areas of focus had been identified for future actions Ms Bowen congratulated the improvement in flexible working and referred to the scores in relation to violence and aggression and sexual safety and queried whether that reflected a national trend or whether the Trust was an outlier. Miss Myatt referenced the increase in local and national reporting following the introduction of the sexual safety charter. She also highlighted that the Trust had been congratulated in national forums for improving reporting lines on sexual safety in particular, actions for which would continue during 2025/26. Professor Maddock referred to the response rate which remained below target and queried what good practice could be taken on board to increase	

	responses. Miss Myatt referred to a visit which had been arranged to Leicester in order to take on board learning. She added that learning from divisions who had higher response rates was also being taken forward. Dr Adamson added that the right mix of nursing, medics and operational leads was required to be visibly pushing the agenda forward. Miss Myatt highlighted that a review of the staff groups completing the survey had identified under representation for medics and as such actions were to be taken with the Medical Workforce Group to identify how the response rates could improve. Dr Constable stated that the key was more general engagement which needed take place with all staff groups every day and not just before the survey. He added that Executives also needed to role model such behaviours. Mr Wakefield agreed, given that engagement would also increase productivity and deliver improved outcomes. **The Trust Board received and noted the report.**	
12.	**Gender Pay Gap Report 2024-25**	
056/2025	Miss Myatt highlighted the following: • The Trust was required to publish the report annually and had seen a year-on-year improvement across key metrics whereby the mean gap was 27% however, it was recognised that extreme earners would skew the data and as such the median gap was more realistic. • There had been some changes in workforce profile with more women in more senior agenda for change roles and more men within middle and lower banded agenda for change roles. • Across all medical roles, women equated to approximately 40.5% of workforce and 29% in consultant roles. • Changes regarding clinical excellence awards meant that these were contractual • The women's network was considering what further actions could be taken Mrs Bainbridge welcomed the explanation of the actions taken to address the disparity between male and female staffing. She queried the actions being taken to consider equal opportunities as part of recruitment into medical / consultant roles and Miss Myatt stated that additional actions could be reflected in future action plans. Mr Wakefield welcomed the action regarding extending pay gap reporting and ethnicity to which Miss Myatt responded that it would provide an insight into protected characteristics as well as marginalised groups. **The Trust Board received and noted the gender pay metrics and actions identified for 2025/26 to further reduce the gender pay gap at the Trust.**	
FINANCE AND EFFICIENCY		
13.	**Financial Plan 2025/26**	
057/2025	Mr Oldham referred to the final plan which had been submitted and highlighted the following: • The Trust had challenged the level of growth and deficit support and agreed a joint piece of work regarding growth, the impact on cost base	

	and how that was reflected in contracts. • Discussions had taken place regarding deficit support funding and there had been an agreement to include £37.2 m into the plan which would be paid for by the Integrated Care Board (ICB), enabling the Trust to achieve a break-even plan, although this needed to be agreed within the contract. The break-even plan had also been reflected in the position resulting in a stronger cash position. • £75 m Cost Improvement Programme (CIP) was required • One of the main risks related to the inability to deliver operational standards in an affordable manner and a review of Elective Recovery Funds (ERF) was required given the number of bids and solutions available for investment, although this may require a move in activity from one specialty to another • Capital allocation had increased to £103 m • Additional risks related to the delivery of the CIP given the significant number of red rated schemes and the need to identify mitigation for any slippage. • In addition, there were some minimal risks regarding the disposal of the Royal Infirmary site. Mrs Monckton referred to the discussion at FEC on CIP progress and associated governance. Ms Ashley highlighted that a further discussion regarding the governance surrounding the recovery programme was to be discussed in part 2. Mr Wakefield referred to the £75 CIP programme, of which nearly £50 m was high risk. As such, he queried the contingency plans to cover the risk which required working across the system to reduce costs by realigning services. Dr Constable stated that community transformation through the provider collaborative was also required in addition to considering back-office support. Mr Wakefield stated that given the scale of the challenge, the non-executive directors needed to be assured of the potential mitigation. Ms Ashley referred to the extraordinary FEC meeting whereby over £30 m capital bids had been approved which had since been supported by NHSE and were required as part of improving operational performance. Mr Wakefield referred to activity which did not demonstrate a year-on-year increase, and he queried how that linked to the discussion with regards to ERF. Mr Oldham referred to the need to be clear of what the Trust was signing up to in terms of activity and that the work with the ICB on growth and activity was important as raw data suggested no growth in non-elective cases although the Trust was aware that some things were being counted differently and could not be directly compared. Ms Ashley added that the ERF trajectory was previously volume based which had since changed to a percentage as such the same correlation could not be determined. Dr Constable thanked Mr Oldham and the team for the work undertaken in submitting the financial plan. **The Trust Board received and approved the 2025/26 financial plan.**	
PERFORMANCE		
14a	**Quality Governance Committee Assurance Report (03-04-25 & 29-04-25)**	
058/2025	Professor Hassell highlighted the following areas of partial assurance from the meeting on 3rd April:	

	• Patient experience report although the Committee welcomed the encouraging national and emergency care survey results • Medicines optimisation mainly due to the delays in implementing the Electronic Prescribing and Medicines Administration (EPMA) system • Care Excellence Framework due to eight areas having been rated as bronze although the Committee was assured of the process in place • Quarter 3 mortality due to the ongoing coding issues which was making it difficult to interpret the HSMR as the Trust was not confident of the overall denominator, although crude mortality had not changed. In addition, Structured Judgement Reviews and mortality reviews had not flagged any particular issues. Professor Hassell also highlighted the positive assurance notably the improvement in the maternity CQC rating and the work of the equality, diversity and inclusion midwife. Professor Hassell highlighted the following areas of partial assurance from the meeting on 29th April: • Venous Thromboembolism (VTE) risk assessment figures remained under review • Infection prevention highlighted one avoidable MRSA cases, although the Committee noted the good work undertaken in relation to achieving c-difficile and e-coli targets • Cases of flu and norovirus over the winter, had been the worst in 5 years although the Committee was positively assured of the mitigations put in place to take prompt proactive action to isolate patients in acute portals as well as discharging patients home with diarrhoea and vomiting • The proposed items to be considered as part of the revised governance structure were to be articulated to the Committee • The Hospital User Group were to be asked for suggestions on how the patient voice could be heard at future meetings **The Trust Board received and noted the assurance reports.**	
15.	**High Quality Dashboard**	
059/2025	Mrs Riley highlighted the following: • The CQC had confirmed an improved rating for maternity of good. It was noted that only a third of units had been rated as good nationally, with no formal must or should do actions identified • Incident of harms from falls should read medication incidents and this had been slightly skewed due to external incidents • Two never events were reported in month which would be reported to QAC • The Trust had met the targets for both c-difficile and e-coli and the Trust was working with the Health Surveillance Agency to review the way in which national targets were set • Complaints response times required further improvement • There had been gradual improvement in timely observations, with work being undertaken to address variations in individual practice • In terms of VTE assessments, the reason for not achieving performance was due to the date and time of assessment not being recorded, and the Trusts who achieve the target use an EPMA. Monitoring of thrombosis was taking place in the interim with one peak in cases identified, the review of which was provided to QAC	
16.	**Performance & Finance Committee Assurance Report (31-03-25 & 28-**	

	04-25	
060/2025	Ms Bowen highlighted the following from the meeting on 31st March: • The cash flow profile continued to be monitored • Assurance was requested on waiting lists, specifically data around ethnicity and children's service • An update was provided on the governance for financial and operational recovery • Positive assurance was provided on productivity and benchmarking data which highlighted potential savings • Good progress had been made on procurement savings • The Committee agreed to receive highlight reports from elective and non-elective programmes Ms Bowen highlighted the following from the meeting on 28th April: • Further assurance was requested on the governance associated with CIP • The final 2024/25 BAF was considered and the refinements made for the 2025/26 BAF were noted • An action had been requested in terms of non-obstetric ultrasound performance and the associated trajectory for improvement **The Trust Board received and noted the assurance report.**	
17.	**Responsive Dashboard**	
061/2025	Mrs Thorpe highlighted the following: • Continuing trend of improvement for all long wait patients despite lower numbers being treated over winter • County Hub was open and resulting in an increase in productivity • Continuing improvement in faster diagnostic standard for cancer and the highest performance for 31 day cancer was noted. 62 day cancer performance remained a challenge and would be focussed on during 2025/26 • Non-obstetric ultrasound had improved in endoscopy for DM01 and the route to compliance was to be articulated, linked to the work being done on capacity and GP access to the service Mr Wakefield referred to the improvement in cancer due to the increase in capacity and queried whether that was expected to continue in 2025/26. Mrs Thorpe stated that bids to West Midlands Cancer Alliance had been made, and Ms Ashley stated that these had yet to be confirmed due to funding cuts. Mrs Thorpe stated that the funding in the previous year focussed on endoscopy recovery and since that time a business case for endoscopy had been agreed, therefore she was confident that a sustainable endoscopy plan was in place.	
18.	**Resources Dashboard**	
062/2025	Mr Oldham highlighted the following: • Growth in activity was to be tracked through FEC • The Trust delivered £18.1 m deficit which was the agreed position with NHSE, despite the initial plan being break-even. However, the Trust took a £20 m CIP in addition to receiving no funding for growth. • In year the Trust had absorbed the cost pressure relating to the band 2 to band 3 work of £8 m, growth in activity resulting in £6 m loss of ERF during winter and recruited to vacant posts and key developments	

	leading to a reduction in agency spend. In addition, growth in activity led to an increase in UEC costs and despite this, there remained a good grip on pay costs. • In terms of capital the Trust achieved its Capital Resource Limit Mr Wakefield queried why borrowing had increased on the balance sheet and Mr Oldham stated that this related to the revaluation under IFRS16 and liability for the PFI. He confirmed that this would not be cash consuming.	
19.	**Audit Committee Assurance Report (01-05-25)**	
063/2025	Mrs Monckton highlighted the following: • Cyber assurance report provided partial assurance, but the Committee was assured of the work being undertaken • A deep dive on shadow IT was being undertaken • In terms of outstanding internal audit actions a review of low rated actions was being undertaken to determine if these had been superseded • Continued focus on out of date policies • Substantial assurance provided on the BAF from the internal audit review • Reasonable assurance was provided by the Head of Internal Audit Opinion • The annual accounts had been submitted as per timetable **The Trust Board received and noted the assurance report.** Mrs Monckton left the meeting.	
20.	**People, Culture and Inclusion Committee Assurance Report (04-04-25)**	
064/2025	Professor Toor highlighted the following: • The Committee considered the data associated with disability and ethnicity which required further triangulation • A number of areas received partial assurance, one being the apprenticeship levy with challenges associated with uptake • Employee relations casework highlighted high case volumes with 11% meeting the 28 day target. Work on an artificial intelligence solution was being considered due to this area of concern • In terms of health and safety the Committee noted the Health and Safety Executive Letter of Contravention and some delays although a plan was in place to rectify these • Positive assurance was provided in terms of NHSE commending the Trust on its Equality, Diversity and Inclusion plan. In addition to positive assurance being provided by the pharmacy workforce update **The Trust Board received and noted the assurance report.**	
21.	**People Dashboard**	
065/2025	Miss Myatt highlighted the following: • Quarterly staff voice results for April demonstrated 6.82 staff engagement score which was in line with the staff survey score of 6.84. Actions were being taken to consider how to further increase responses • There had been a decrease in sickness absence to 4.9 which had slightly impacted on the overall 12 month run rate. Top reasons related to stress, anxiety and depression but for matters outside of work	

	• Vacancy and turnover continued to reduce, and turnover remained well below the national average • Appraisal completion remained static with metrics included in performance reviews • Agency spend was below threshold Mr Wakefield queried why the 95 WTE agency usage in February had increased to 220 in March to which Miss Myatt agreed to confirm. Mr Oldham highlighted that some additional spend would relate to it being the year end and people taking leave. He stated that part of the work in relation to CIP was looking at rostering practices and how much leave people can take and the timing of this. It was agreed to take this point back to PCI. Ms Bowen welcomed the turnover rate and queried why the engagement scores were not higher given the low turnover rate. Mr Oldham stated that the turnover rate was not dissimilar to others trusts and given the financial controls being put in place, there was less of an opportunity to move to other trusts.	**KM**
22.	**Improving & Innovating Dashboard**	
066/2025	Ms Ashley stated that the metrics for 2025/26 would be reviewed and that the Clinical Research Delivery Centre was due to open which was positive, in addition to ongoing conversations being held with Keele University.	
23.	**System & Partners Dashboard**	
067/2025	Ms Ashley referred to the work being done on 3 priority areas and added that the ICB had asked the Trust to take the system lead for alcohol and alcohol prevention, based on the work already undertaken. **The Trust Board received and noted the integrated performance report.**	
GOVERNANCE		
24.	**Fit and Proper Persons (FPPT) Annual Assurance Report**	
068/2025	Mrs Cotton highlighted the process undertaken for the year in relation to FFPT checks. She highlighted that a proposal was taken to the Nomination and Remuneration Committee regarding DBS checks whereby it was recommended that the Trust moved to requesting enhanced checks for all board members. Mrs Cotton highlighted that the annual submission to NHSE would be provided by June 2025. **The Trust Board received and noted the update and agreed that enhanced DBS checks be undertaken for all Board members within the next 12 months.**	
CLOSING MATTERS		
25.	**Review of Meeting Effectiveness**	
069/2025	There were no comments made.	
26.	**Review of Business Cycle**	
070/2025	There were no further comments on the business cycle.	

27.	**Questions from Members of the Public**	
071/2025	Mr Syme referred to the improvement in Maternity Services as per the CQC rating of "Good" compared to the previous rating and stated that the team were deserving of praise, thanks and congratulation. Mr Syme referred to the workforce plan and total substantive workforce establishment, in particular for registered nurses, midwifery and health visiting staff. He referred to the overall workforce reduction of 4% in 2025/26 in comparison to a 7% reduction for registered nurses and queried the reason for this, particularly given the reductions already made in bank and agency. Ms Ashley highlighted that the reduction related to operational improvement and associated recovery plans. She stated that the plan aimed to reduce inpatient capacity, and through turnover the Trust was aiming to reduce the amount of inpatient capacity as this would not require the same level of workforce. She stated that if the improvement did not take place, then headcount could not reduce. Mrs Riley stated that if the bed base reduced the bulk of associated workforce was nurses, although she confirmed that the Trust had committed that any capacity which was open would be staffed correctly. Mr Oldham added that the as the schemes developed, reductions in other staff groups may be identified. Mr Syme referred to UEC performance which required improvement and referred to ambulance handovers delays, in particular the lost hours which exceeded 60000 hours. He queried, that until the work streams come online, what mitigations were in place to reduce ambulance handovers delays. Mr Wakefield referred to the earlier discussion and stated that the three metrics would continue to be reported on and monitored at each meeting. Mr Syme thanked Mr Wakefield for what he had done for the local population particularly leading the Trust during Financial Special Measures and covid.	
DATE AND TIME OF NEXT MEETING		
28.	**Wednesday 9th July 2025, 9.30 am, Trust Boardroom, Third Floor, Springfield, Royal Stoke**	

Minutes of Meeting

Trust Board – Part 1 | 25th June 2025 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
Mrs L Bainbridge	LB	Non-Executive Director	Voting
Ms T Bowen	TBo	Non-Executive Director	Voting
Prof G Crowe	GC	Non-Executive Director	Voting
Prof A Hassell	AH	Associate Non-Executive Director	Non-Voting
Miss W Nicholson MBE	WN	Associate Non-Executive Director	Non-Voting
Dr S Constable	SC	Chief Executive	Voting
Dr D Adamson	DA	Interim Chief Medical Officer	Voting
Mrs C Cotton	CC	Director of Governance	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	AR	Chief Nurse	Voting
Mrs L Thomson	LT	Director of Communications	Non-Voting
Prof S Toor	ST	Non-Executive Director	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**	
Ms H Ashley	HA	Director of Strategy	Non-Voting
Prof K Maddock	KM	Non-Executive Director	Voting
Mrs M Monckton	MM	Non-Executive Director	Voting

In Attendance:		
Name	**Initials**	**Title**
Mrs N Hassall	NH	Deputy Director of Governance (minutes)
Mr N Sone	NS	Deputy Director of Finance – Financial Controller
Mrs S Proffitt	SP	Deputy Chief Finance Officer

Members of Staff and Public: 0

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
072/2025	Ms Small welcomed members to the meeting. Apologies were received as noted above and the meeting was confirmed as quorate.	
2.	**Declarations of Interest**	
073/2025	There were no declarations of interest raised.	
GOVERNANCE		
3.	**Audit Committee Assurance Report (20/06/25)**	
074/2025	Ms Bowen provided an overview of the key matters discussed at the Audit Committee: • The external audit report identified financial sustainability as a key area of weakness.	

	• An unqualified audit opinion was issued, consistent with previous years and in line with standard procedure for trusts operating in deficit. • The internal audit review of grip and control measures for medical staffing and nurse bank agency controls concluded with a rating of substantial assurance. • Further assurance was deemed necessary in relation to transformation and major project management. These matters were referred to the Finance and Business Performance Committee for further oversight. Ms Small queried whether the actions relating to transformation and major project management would be presented to the Board. Ms Bowen confirmed that the Audit Committee would monitor the recommendations, with specific actions concerning transformation being directed to the Finance and Efficiency Committee. **The Trust Board received and noted the Audit Committee Assurance Report.**	
4.	**2024/25 Annual Report and Annual Governance Statement**	
075/2025	Mrs Cotton presented the Annual Report and Annual Governance Statement, highlighting the following: • The report had received formal approval from the Audit Committee and had been prepared in accordance with the Group Accounting Manual (GAM) and NHS England guidance. • Several amendments had been made since the initial circulation, notably changes to asset valuations and numerical updates on pages 85 and 86. • The Trust had subsequently received confirmation of the audit conclusion regarding the Cyber Assurance Framework, which had been incorporated into pages 60 and 63 of the report. • Following agreement, electronic signatures would be applied, and the document would be submitted to NHS England prior to publication on the Trust's website. • The annual accounts would be appended to the report to form a single consolidated document. • Planning was underway for the Annual General Meeting (AGM) in September, where the Annual Report and Accounts would be formally presented. Ms Small welcomed the comprehensive information provided in the report. Mrs Haire requested a correction to the employee engagement score to reflect the staff survey result, which should read 6.83 / 6.84. Ms Small expressed appreciation to all those involved in the production of the Annual Report. **Subject to the aforementioned amendment, the Trust Board formally approved the 2024/25 Annual Report.**	**CC**
5.	**2024/25 Annual Accounts, Analytical Review and Certificates**	
076/2025	Mr Oldham presented the Annual Accounts and associated documentation, noting the following: • The reported financial position aligned with the initial submission, with a deficit of £18.1 million, consistent with the management accounts. • Two valuation-related adjustments had been made. These included movements identified during audit discussions with the District Valuer, which revealed an error, and minor classification adjustments. • A Section 30 referral to the Secretary of State was to be submitted once again.	

	• Compliance with the capital resource limit was achieved, in line with expectations. This included agreed slippage within the scheme and minor technical under delivery, although overall delivery was as planned. • Payment terms were met in accordance with the established targets. **The Trust Board approved the Annual Accounts, which were to be shared with the External Auditors and appended to the Annual Report.**	
6.	**Audit Findings Report and Letter of Representation**	
077/2025	Mr Oldham reported that a revised Audit Findings Report was anticipated following the completion of additional testing. He noted: • An unadjusted accounts payable item had been identified, relating to a missed accrual in week 52 of the supply chain. This was deemed immaterial, and lessons had been noted for future improvement. • An additional adjustment was identified due to an error in the pathology system report, which formed the basis of an accrual. Transitioning to the new Laboratory Information Management System (LIMS) had presented challenges, and the position had been overstated. The two findings effectively offset each other. • Aside from these issues, the audit report was clean, and an unqualified opinion was expected. The final report would be circulated once provided. Ms Small raised a query regarding the pathology reporting error and the measures implemented to prevent recurrence. Mr Oldham confirmed that a new LIMS had been implemented. While the Trust had initially relied on legacy reports, the supplier had since updated the reporting tools to ensure accuracy. A full review of audit findings and lessons learned would be undertaken, with all auditor recommendations accepted and tracked via the Audit Committee. **The Trust Board approved the Audit Findings Report and the Letter of Representation.** Ms Small concluded the discussion by acknowledging all contributors involved in the collation and production of the year-end documentation.	
DATE AND TIME OF NEXT MEETING		
6.	**Wednesday 9th July 2025, 9.30 am, Trust Boardroom, Third Floor, Springfield, Royal Stoke**	

Post Meeting Action Log

Trust Board Part 1 - Open

As at **03 July 2025**

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/606	09/10/2024	Appraisal and Revalidation Annual Report	It was agreed to provide further information to the People, Culture and Inclusion (PCI) Committee, in terms of when the outstanding appraisals were due to be undertaken.	Di Adamson	18/12/2024	03/07/2025	While 82% of doctors completed their annual appraisal by 31 March 2025, it should be noted that the remaining 18% cannot be retrospectively appraised due to the closure of the appraisal year. However, it is important to note that a missed appraisal does not automatically result in a negative impact on revalidation, as the GMC considers a broader portfolio of evidence. To improve compliance for 2025/26, the Trust's new Lead Appraiser has implemented a structured improvement plan, including: - Recruitment and training of additional appraisers - Monthly monitoring of appraisal completion rates with escalation for non-engagement - Redistribution of appraisal workload to avoid year-end bottlenecks - Bringing forward March 2026 appraisals to February or earlier to create headroom Further information can be provided to PCIC should this be required.	B
PTB/610	08/01/2025	System & Partners Dashboard	To include further narrative to explain what was being measured on page 159	Helen Ashley	~~12/03/2025~~ 09/07/2025	03/07/2025	As a result of the revised corporate governance structure, population health metrics will form part of reporting into the Quality, Access and Outcomes Committee.	B
PTB/612	12/03/2025	Maternity and Neonatal Serious Incident Report – Quarter 3	To obtain comparative data regarding the number of MNSI cases reported each quarter and take this to QGC.	Ann-Marie Riley	05/06/2025	03/07/2025	The maternity team have confirmed that this data is not readily available.	B
PTB/614	07/05/2025	Urgent and Emergency Care (UEC) Pressures, Ambulance Handover and Winter Update	To consider the additional information which could be provided as national / comparator context within future reports	Katy Thorpe	~~09/07/2025~~ 06/08/2025		Information to be included within reports to Part 2 due to this not being readily available in the Public domain.	A
PTB/615	07/05/2025	People Dashboard	To take the point regarding increase in agency usage from February to March to PCI in addition to providing an update on the actions being taken to review rostering practices to avoid such increases in the future.	Jane Haire / Kay Myatt	30/07/2025		Action not yet due.	GB

Chief Executive's Report
Trust Board | 9th July 2025

University Hospitals of North Midlands NHS Trust

Part 1: Highlight Report

This report provides the Trust Board with an overview of a range of strategic and operational issues since the last public meeting on 7 May 2025, some of which are not covered elsewhere on the agenda for this meeting.

1. National and Regional Context

The focus on access targets and finances continue during the current financial year. At the time of writing (1 July 2025) we await the publication of the NHS 10-year plan.

The new NHS Oversight Framework 2025/26 describes a consistent and transparent approach to assessing integrated care boards (ICBs) and NHS trusts and foundation trusts, ensuring public accountability for performance and providing a foundation for how NHS England works with systems and providers to support improvement.

The 1-year framework sets out how NHS England will assess providers and ICBs, alongside a range of agreed metrics, promoting improvement while helping us identify quickly where organisations need support.

The framework will be reviewed in 2026/27 to incorporate work to implement the ICB operating model and to take account of the ambitions and priorities in the 10 Year Health Plan.

The framework is supported by a focused set of national priorities, including those set out in the planning guidance for 2025/26, aiming to strengthen local autonomy. These are presented alongside wider contextual metrics that reflect medium-term goals in areas such as inequalities and outcomes. The contextual metrics do not constitute part of the score but will inform how NHS England responds to segmentation.

The NHS priorities and operational planning guidance 2025/26 made it clear that achieving a financial reset this year is a priority. It set the expectation that every ICB and provider must deliver a balanced net system financial position in collaboration with its system partners. NHS England will identify organisations that are not performing and take quick action. The approach to assessment will mean that unless providers are delivering a surplus or breakeven position, their segmentation will be limited to no better than 3.

The improvement approach will be based on the results of our assessment and tailored to the support providers in each delivery segment need. Discussions about performance will be led by colleagues at NHS England who are experienced in addressing delivery challenges, with a focus on offering informed evidence and practical guidance that is grounded in a deep understanding of the operational challenges faced.

The full NHS Oversight Framework document can be found at: https://www.england.nhs.uk/long-read/nhs-oversight-framework-2025-26/

A summary document that details the main areas covered in the last Integrated Care Board (ICB) meeting that took place on 15 May 2025.is attached as Appendix 1.

A summary document that details the main areas covered in the last Integrated Care Partnership (ICP) meeting on 2 June 2025 is attached as Appendix 2.

2. County Day Case Unit

On 6 June I was joined by Stafford MP Leigh Ingham and our Chair Jackie Small as we officially opened our new Day Case Unit at County Hospital. This new facility is part of our long-term aim to transform County into a surgical hub to enable us to offer thousands more patients quicker access to vital surgery.

This new unit will make a real difference to the way we care for patients needing colorectal, upper gastrointestinal, orthopaedic or ENT procedures. By increasing our capacity from 15 beds to 28, we can focus on high-volume, low-complexity procedures in a dedicated elective setting; this safeguards theatre time, reduces cancellations, and delivers more consistent care to patients who are waiting.

It's a well-designed, spacious and welcoming space and will improve the patient journey from start to finish. It's both calming and confidence-inspiring from the moment patients walk through the door.

Whilst the physical completion of this unit was earlier this year and we have been welcoming patients since April, it was a great opportunity to recognise the hard work, planning, and teamwork that have gone into making it possible.

This development follows the opening of the Staffordshire Treatment Suite and the North Midlands Hand Centre, and these changes are helping us protect planned surgery from the pressures of emergency care and future-proofing our services at County for years to come.

We also know that for patients, quicker access to treatment can make a big difference, not only in terms of physical health but in quality of life and peace of mind.

3. Stoke Centenary Celebrations

Early June saw some significant celebrations for the City of Stoke-on-Trent, alongside the celebrations we held at Royal Stoke and County.

It was a great honour to celebrate our own local remarkable milestone on June 5 2025: exactly one hundred years since one of our hospitals was granted its Royal title by King George V, the same day that the Borough of Stoke-on-Trent was officially recognised as a city during a visit by King George and Queen Mary - the great grandparents of our current King.

On June 5 1925, our hospital, then called the North Staffordshire Infirmary, was renamed the North Staffordshire Royal Infirmary, cementing its reputation as one of the most significant hospitals outside of London at the time. That same day, Stoke-on-Trent received city status, recognising the vital role it played as the heart of the pottery industry.

A particularly powerful moment in our own centenary celebration was the opening of the time capsule from its sealed lead box, hidden beneath the foundation stone for nearly 100 years. It was a treasure trove of artefacts from the time including a pristine one-pound note, a sovereign coin, newspapers, an annual report and a letter written to the King by my predecessor at the time.

The opening of the time capsule, in the presence of the Deputy Lord Mayor, local councillors and our Chair, Jackie Small, was simply one of a series of big civic events over a four-day period for the city. I attended a civic lunch at Stoke-on-Trent College prepared and served by the wonderful catering students there, followed by an Extraordinary City Council Meeting in King's Hall.

4. UHNM Volunteers

Volunteers' Week is a national UK-wide campaign held annually from the first Monday in June to celebrate and recognise the vital contributions of volunteers. Now in its 40th year, this week provided a powerful platform to thank both current and former volunteers, highlight the incredible diversity of their roles, and showcase how volunteering strengthens our communities by uniting people from all walks of life.

At UHNM we are proud to have around 250 volunteers who, in the past year alone, contributed over 5,000 hours of dedicated support to our patients, staff, and visitors. These volunteers play an essential role in the patient journey, offering immeasurable support, kindness, and compassion. Their diverse

backgrounds, skills, and experiences enrich the services we provide and make a tangible difference every day.

Volunteering is not just a gift to others - it also brings immense benefits to the volunteers themselves. Over 80 per cent of volunteers report improved mental wellbeing, and nearly half note positive impacts on their physical health. It also helps boost confidence, self-esteem, and a sense of connection to others.
Our UHNM Volunteer Services offer a wide range of opportunities, including:

- Contributing to community wellbeing
- Increasing confidence and self-esteem
- Reducing isolation and encouraging social connections
- Gaining new skills and knowledge
- Supporting personal growth and fulfilment
- Opportunities that align with personal interests - often leading to substantive roles within the Trust
- Student placements for those starting out in healthcare careers

To mark the beginning of Volunteers' Week, we were pleased to welcome VAST, a local organisation supporting the Voluntary, Community and Social Enterprise (VCSE) sector in Stoke-on-Trent and North Staffordshire.

VAST runs several impactful programmes, such as Volunteering for Health and Community Health Champions, that empower individuals to make a real difference in their communities. They also support the Staffordshire and Stoke-on-Trent ICP Volunteer Managers Network.

4. Green Achievements

Climate change and health are inextricably linked, therefore the NHS and its staff are pivotal to improving the environmental impact of the care we deliver. Benefits to greener practice include better health and improved wellbeing for our patients, population and staff.

Our first Green Plan was created in 2022 in response to the NHS announcing its ambition to become the world's first 'Net Zero Carbon Health Service'. Since then, we have achieved so much by working together and with our partners. A few of the many, many examples are included below:

- We have reduced the Trust carbon footprint by 5,256 tonnes – 14% since 2019/20.
- Our network of over 300 'SWITCH to a Sustainable UHNM' Champions have worked hard to spread the word within their teams to encourage those small everyday changes that make a big difference.
- Pockets of good practice in clinical and non-clinical areas are sprouting green shoots across the Trust, for example:
  - Green practice in Endoscopy
  - Redesign of outpatient care pathways in Urology outpatients reducing patient travel to hospital
  - 90% reduction in paper in the adult orthoptics service
  - Re-usable water bottles for radiotherapy patients
- We have eliminated Desflurane, an anaesthetic gas which is more than 2,500 times more potent as a greenhouse gas than carbon dioxide (CO_2). We have also reduced our use of Nitrous Oxide and Entonox by 25% since 2019/20 and are continuing to do so this year with the help of an NHSE grant award.
- We have expanded the solar panelling on both our sites, not only generating clean energy but also funds to invest directly into our Keep Warm Keep Well scheme, which provides external support to our most vulnerable patients whose health conditions are at risk of being exacerbated by living in a cold and damp home.
- £5.4m investment to reduce direct CO_2 emissions from our buildings: replacement of old gas boilers with air source heat pumps, removing the inefficient centralised stream generation and installed LED lighting and solar panelling (mainly funded through The Department for Energy Security and Net Zero (DESNZ) grant funding).
- Partnering with Stoke-on-Trent City Council to procure gas and electricity, reducing a potential cost pressure by £7m and delivering some of the lowest unit prices in the country.

- Introduction of our Cycle to Work salary sacrifice scheme to encourage cycling as an accessible option for many of our staff. We have teamed up with Staffordshire Police to offer free bike tagging and maintenance for our staff and members of the public.
- Walking routes and nature gardens created at both sites encouraging biodiversity and space for staff, patients and visitors to access nature.
- Installation of 48 electric vehicle charging points on site saving 22 tonnes of carbon dioxide equivalent emissions in the last year just from the cars plugged in to those charging points.
- Coloured plates are being trialled for patient meals reducing food waste and improving patients' experience of mealtimes.
- Recycling bins were introduced at County Hospital and have now arrived at Royal Stoke's office buildings.

Our refreshed Green Plan for 2025/26 – 2028/29 will focus much more on our population's health and low carbon care, with staff development and digital transformation as enablers.

5. Peri-operative Optimisation

Here at UHNM we are proud to be implementing a vital NHS initiative designed to improve surgical outcomes and enhance the experience of our patients: the Early Screening, Risk Stratification and Optimisation in Perioperative Pathways Programme.

Developed by NHS England in collaboration with the Centre for Perioperative Care and the Royal College of Anaesthetists, this programme addresses the growing backlog of elective surgery. It places a strong focus on early intervention, ensuring that every patient on an elective or emergency surgical pathway receives high-quality, well-coordinated care and is in the best shape possible before surgery.

The aim is simple yet significant: to provide patients with a smoother journey to surgery, minimise delays due to avoidable clinical reasons, and use the perioperative period as an opportunity to improve health and reduce health inequalities. To deliver on this, the programme outlines five core requirements as part of the NHS Standard Contract:

1. Early Risk Screening: All patients must be screened for perioperative risk factors as early as possible in their surgical journey.
2. Targeted Optimisation Support: Patients identified with risk factors should receive support to improve their health and surgical readiness.
3. Regular Contact While Awaiting Surgery: Patients on the waiting list should be contacted at least every three months to confirm they still need the procedure and to assess any changes in their health status.
4. Assessment Before Surgery Dates Are Set: A surgical date should only be given once a patient is medically optimised through a Pre-Assessment Medical Screening (PreAMS).
5. Shared Decision-Making: Patients must be involved in discussions around the risks, benefits, alternatives, and likely outcomes of surgery to make fully informed decisions.

At UHNM, we're adopting a digital-first approach to support these standards. Digital tools will help us assess patients' readiness for surgery, prioritising them based on urgency and medical complexity. This allows for:

- Early diagnostic testing
- Timely referrals to specialist services
- Improved planning and patient flow during the perioperative period
- Improved planning and theatre scheduling

By managing both urgent and routine surgical cases more efficiently, we reaffirm our commitment to delivering high-quality, timely, and patient-centred care for all our surgical patients

Delivering care in the most appropriate setting will help us better utilise day surgery and County services, free up capacity for more complex cases, appropriately identify and use high dependency and intensive care beds while lowering hospital stays and complications and improving patient experience.

It will support our patients to prepare for surgery with prehabilitation and recover more quickly with enhanced recovery programmes and return to normal life sooner and hopefully more satisfied with their overall care.

This programme is a transformative step in our elective care recovery plan and represents a collective commitment to improving surgical care outcomes for our community. By identifying and addressing risks earlier, involving patients in their care, as well as the right clinic teams at the right time and leveraging digital innovation, we are building a more efficient and equitable surgical care pathway at UHNM. Together, we can ensure every patient receives the right care, in the right place, at the right time.

6. A Night Full of Stars

In professions where people give so much of themselves every day, taking the time to acknowledge and celebrate those who go above and beyond is more than just a nice gesture, it is essential. Whether it's a quiet act of compassion, a ground-breaking innovation, or the support of a colleague, recognising excellence lifts us all. It reinforces our shared values, boosts morale, and strengthens our collective commitment to providing the very best care and is why, at UHNM, we are proud to celebrate those shining examples through our regular team of the month and employee of month awards and my own awards. But a key part of our programme of recognition is our annual staff awards: A Night Full of Stars.

Nominations for 2025 opened on 16 June and this is our chance to shine a spotlight on the remarkable individuals and teams who go above and beyond every day to make UHNM a place of compassion, excellence, and innovation. Each year, A Night Full of Stars honours the extraordinary contributions of our staff - those who bring our values to life and make a real difference to patients, families, colleagues, and the wider community.

This is a summary of the award categories for 2025:

- ***Kindness and Compassion Award -*** Celebrates someone who consistently demonstrates warmth, empathy, and humanity in every interaction—bringing comfort and care to patients, families, and colleagues alike.
- ***Collaboration Award -*** Recognises those who champion teamwork and cross-boundary partnerships to improve patient care and staff experience, with kindness and inclusion at the heart of their approach.
- ***Inclusion Award -*** Honours individuals or teams who are making UHNM a fairer, more inclusive place—ensuring everyone feels seen, valued, and supported, regardless of background or identity.
- ***Excellence Award -*** For those who set the standard through outstanding care, leadership, or innovation—driving improvements and inspiring excellence across the organisation.
- ***Rising Star Award -*** Celebrates emerging talent who are already making a big impact and show exceptional promise for the future through learning, leadership, and growth.
- ***Unsung Hero Award -*** Recognises those whose vital contributions often go unnoticed but are deeply felt—quiet champions who keep UHNM running smoothly with skill and dedication.
- ***Colleague of the Year Award -*** For a peer who uplifts others with their support, encouragement, and teamwork—someone who helps their colleagues thrive in good times and bad.
- ***Team of the Year Award -*** Honours a team whose unity, resilience, and innovation have achieved outstanding results and contributed significantly to UHNM's success.
- ***UHNM Charity Award -*** Recognises individuals or teams who have gone above and beyond to support the UHNM Charity through fundraising, volunteering, or advocacy, making a tangible difference to patient and staff wellbeing.

This year, we are also excited to introduce a brand-new category - the People's Choice Award - and, for the first time ever, we're inviting patients, families, and members of the public to nominate. Personally, I will be choosing the recipient of the Outstanding Achievement Award to acknowledge truly exceptional impact, celebrating leadership, innovation, and dedication that goes far beyond expectations.

7. Ehlers Danlos Syndromes

Serendipity has introduced a group of multidisciplinary staff to each other who, despite their training and familiarity with the NHS, have all struggled to access the right professional support for their shared connection to a complex, often misunderstood medical condition: Ehlers-Danlos Syndrome (EDS).

EDS refers to a group of 13 heritable disorders of connective tissue, caused by genetic faults in collagen - the protein that supports skin, joints, blood vessels, and many internal organs. The exact features depend on the subtype, but many forms affect multiple systems. Particularly under-recognised is Hypermobile EDS (hEDS) and Hypermobility Spectrum Disorder - conditions now believed to affect up to 1 in 500 people. Despite this, diagnosis is often delayed by over a decade, and management is inconsistent.

Symptoms can appear unrelated, fluctuate, or be invisible - making EDS difficult to recognise. Common issues include joint dislocations, gastrointestinal problems, cardiovascular symptoms, dysautonomia, and spontaneous CSF leaks. Many individuals are initially misdiagnosed with anxiety or other psychosomatic disorders, leading to frustration and feelings of dismissal - especially during transitions from paediatric to adult care.

To address this, the UHNM EDS Awareness Group has worked collaboratively across departments, including:

- Research and Development to explore the gap between care needed and care delivered
- Health Records and IM&T to quantify and identify prevalence
- Grand Round sessions to educate clinicians
- Engagement with the Nursing Preceptorship Team and Occupational Therapy students

The group has also partnered with UHNM Charity, EDS-UK and Prem Management to produce a compelling short film, "*EDS: The Raw and Honest Truth*." This poignant documentary shares the lived experiences of individuals linked to UHNM, shedding light on the daily realities of living with EDS - from chronic pain and dislocations to the emotional weight of invisibility and misdiagnosis.

From an occupational perspective, staff living with EDS often require reasonable adjustments to continue working safely and sustainably. Yet awareness of their needs and the condition itself remains limited, contributing to workplace barriers that should be avoidable with the right support.

8. Red4Research Day 2025

Patient care can often be guided by tradition and experience. Research generates new knowledge, introducing innovative, evidence-based interventions or improvements in services to enhance care. It fosters advanced skills and new perspectives, improving critical thinking and helping to address complex challenges. Additionally, research creates a culture of learning, curiosity, autonomy, and initiative. It boosts the reputation of the ward, department, and Trust, ultimately increasing patient confidence and outcomes.

At UHNM, we are a research active organisation, which means we actively seek and support the development and delivery of potentially the best innovative new treatments, pathways and experiences for our patients.

The Centre for NMAHP Research and Education Excellence (CeNREE) is dedicated to supporting nurses, midwives, and allied health professionals in advancing their research careers. CeNREE offers assistance with fellowship and grant applications that focus on important clinical questions aligned to UHNM's strategic priorities, as well as mentorship and guidance on integrating evidence into clinical practice. Similarly, the Research and Innovation (R&I) team supports doctors in advancing their research careers, facilitating the development of innovative drugs and treatments through cutting-edge research.

On 20 June 2025, there was a celebration of #Red4Research Day. This national event brings together everyone involved in research, including patients, the public, NHS staff, academics, and industry partners. This annual initiative aims to raise awareness of the vital role that health and care research plays in improving patient outcomes.

9. Schwartz Rounds

Schwartz Rounds are a structured forum where colleagues can discuss the emotional and social aspects of their work. They offer a safe space for staff to share experiences, reflect on challenges, and feel more supported. Schwartz Rounds aim to:

- Reduce stress
- Improve communication

- Foster a more compassionate culture across UHNM

They provide an evidence-based structured but informal forum where all staff, clinical and non-clinical, can come together to discuss the emotional and social aspects of working in healthcare.

Rounds can help staff feel more supported in their jobs, allowing them the time and space to reflect on their roles. Evidence shows that staff who attend rounds feel less stressed and isolated, with increased insight and appreciation for each other's roles.

Schwartz Rounds take place once a month at UHNM, either at County Hospital or Royal Stoke and all are welcome. The round starts with an introduction from the facilitator(s) leading the round. Usually, three panellists then speak about their experiences relevant to the topic of the round, and then a discussion is opened to anyone in audience who wishes to share their own emotions and experiences. However, it is also a time for reflection and silences are common and normal in Schwartz Rounds.

10. Employee and Team Recognition

i) UHNM Awards

Since my last Board report I have made the following UHNM awards:

Chief Executive Award – June 2025: Sue Thomson, Clinical Director of Pharmacy

It was a real privilege to join pharmacy colleagues as we celebrated the career of Sue Thomson, Clinical Director of Pharmacy, as she retired after nearly 20 years in post.

So much has changed in that time — from the days of working in the old hospital buildings, to the transition into our modern, purpose-built PFI facility. Sue has been a constant presence throughout that transformation, steering the pharmacy service through every challenge and opportunity with professionalism, clarity, and an unwavering focus on quality. Early in her tenure, she led the complex and successful relocation of pharmacy services into the new hospital and oversaw the centralisation of pharmacy aseptic production at the Royal Stoke site – a milestone achievement that brought greater consistency, quality, and safety to our services.

As an Honorary Senior Lecturer at Keele University School of Pharmacy, Sue has strengthened vital academic partnerships and championed education, research and innovation in many areas including cancer services. Sue leaves a legacy of excellence: a service grounded in patient safety, strong governance, skilled and confident teams, and a clear strategic direction for the future. I was very pleased to be able to wish her a happy and healthy retirement, surrounded by the thriving department she leaves behind.

Chief Executive Award – June 2025: Emyr Phillips, Deputy Director of Infection Prevention

I was also able to surprise Emyr Phillips, Deputy Director of Infection Prevention, for all his expertise and diligence that went into managing an infection outbreak back in April. NHS England and the UK Health Security Agency (UKHSA) have given us special recognition for the way this was managed, so it was only fitting I followed their lead.

I was also very mindful that during the depths of winter, Emyr was a constant and reassuring presence at the daily 0930 calls that I led as we navigated the challenges that the British winter brings. Winter was tough obviously, but the way our IP teams continually support correct clinical decision-making and patient flow, meant that things could have been worse.

UHNM Hero Award – May 2025: Sharon Seadon, Community Midwife

I was delighted to pay a visit the Stoke-on-Trent Family Hub in Shelton to surprise one of our community midwives with a well-deserved UHNM Hero award. Wanting to be part of the patient's journey throughout their pregnancy, Sharon Seadon has worked in the community for 18 years.

We were joined by Sophie Jebb Bowman and her six-month-old son Harvey.

There were a few special things in the nomination that really jumped out at me. Sharon was decribed by Sophie as a, "*committed, caring and supportive midwife*", "*my absolute hero who was a thorough professional, committed to both mine and my baby's welfare*", and "*a huge credit to the NHS*".

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

I have also personally recognised the contribution of the following colleagues:

- Ann Egerton - Ward 232
- Anu Stephen - Ward 222
- Liju Joseph John - SHINE Clinic
- Jessy Rajan - Ward 128
- Charlotte Ahmad - Ward 226
- Omar Estoesta - Ward 226
- Ashley Trevor - Ward 226
- Lisa Dean Nurse - Ward 12, County
- Mr Lester James - Consultant Urologist
- Tasha Dabbs - Ward 110
- Lisa Watts, Colorectal Nurse Specialist - Colorectal Surgery
- Dr Caroline Connolly, Consultant Oncologist
- Lydia Lunnun - Ward 102
- Tariqul Islam - Neurology
- Marium Gulrez - Elderly Care Medical Staff
- Prof Brendan Davies - Consultant Neurologist
- Dr Mohammad Janjua - Critical Care, Anaesthetic Medical Staff
- Yousef Hyder - Neurology
- Ward 201, RSUH
- Ward 127, RSUH
- Ward 15, County
- FEAU, County
- Ward 12, County
- SAU, RSUH
- Ward 110, RSUH
- Urology Department
- Mr Vinay Jasani - Consultant Orthopaedic Surgeon
- Dr Krishna Banavathi - Consultant Microbiologist
- Rebecca Huntley, Head of Patient Experience
- Pip Mulligan, Head of Nursing
- Beccy Kirkham – Divisional Director of Operations
- Mel Mountford - Head of Nursing
- Janice Carter - Head of Performance
- Rachel Sutton - Nursing Associate, Ward 111
- Elaine Andrews - Deputy Director of Strategy
- Emma Gaskin - Dietician, Critical Care
- Alanis Roberston - Staff Nurse, ED - RSUH
- Chris Bird - Deputy Director of Strategy
- Mike Brown - Head of Soft FM
- Dr Tony Cadwgan, Consultant Physician - Infectious Diseases
- Dr Sanjeev Nayak, Consultant Interventional Neuroradiologist
- Mandy Markhall - Divisional Director of Operations

Part 2: Consultant Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Breast Surgeon	Vacant post	Yes	4.8.2025
Consultant Obstetrics & Gynaecology	Newly created	Yes	1.9.2025
Consultant Neurosurgery-Vascular & Skull	Newly created	Yes	16.5.25
Consultant Acute Medicine	Vacant post	Yes	TBC
Consultant GI and Urological Radiologist	Vacant post	Yes	TBC
Consultant Obs & Gynae Endo	Newly created	Yes	1.7.2025
Consultant in Renal Medicine	Newly created	TBC	TBC
Consultant Haematology/Oncology Imaging and Uroradiology	Newly created	Yes	TBC
Consultant Plastic Surgeon (Complex Skin Trauma)	Vacant post	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Consultant Oncologist – Head & Neck and UGI Cancers	Vacant post	19.5.2025
Consultant Neurosurgeon	Newly created	16.5.2025

No medical vacancies closed without applications / candidates during May and June 2025.

Medical Management Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Care Group Medical Director	Secondment cover	Yes	9.6.25
Deputy Clinical Director - Gynaecology	Newly created	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Care Group Medical Director	Secondment cover	9.6.25
Clinical Lead - Digital and Innovation	Vacant post	1.6.25
Clinical Lead - Interventional Radiology	Vacant post	28.5.25
Clinical Lead - Neuro and ENT Imaging	Vacant post	1.6.25

The following table provided a summary of medical management vacancies that closed without applications/candidates during May and June 2025.

Post Title	Closing Date	Notes
Clinical Lead for Clinical Haematology	25.6.25	No applications

NHS
Staffordshire and Stoke-on-Trent
Integrated Care Board

Integrated Care Board Briefing

Staffordshire and Stoke-on-Trent ICB Meeting

15 May 2025

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

This briefing aims to keep partners informed of the discussions at the NHS Integrated Care Board (ICB) meeting in public. To watch the recording and read the papers visit the ICB website.

ICB Chair and Chief Executive update

- David Pearson, Chair, and Peter Axon, Chief Executive Officer, presented the report.
- The Chair paid tribute to Peter Axon and Paul Brown, Chief Finance Officer, as it was their final ICB Board meeting. The Chair shared thanks to the outstanding contribution they have made nationally and locally, including their contributions to the establishment of the Integrated Care Board.
- The Chair shared thanks to David Wakefield, Chair of University Hospital of North Midland's NHS Foundation Trust, who is stepping down in his role, and welcomed Jackie Small who is stepping into the role as interim Chair.
- The Chair also shared thanks to Alan White, the outgoing leader of Staffordshire County Council, for his ongoing service and engagement with the ICB and Integrated Care Partnership (ICP).
- The Chair welcomed councillor Ian Cooper, who has been elected as leader for Staffordshire County Council.
- The Chair referenced the Fit and Proper Person Test as an important part of the governance undertaken on Board members, noting that the process is being returned to NHS England at the end of May, and it will be reported on formally at the next Board meeting in July.
- Peter Axon commented on the ICB cost reduction work as part of the ICB Reform, stating that the ICB are working at pace to get to the deadline submission point (30 May 2025) for a clear understanding of how we will achieve cost reduction. Peter added that the pace of this work is rapid, and updates will be provided at future Board meetings.
- Peter Axon stated that there is a lot of work ongoing around the operating plan, noting the scale of the challenge as significant.
- Peter Axon added that we are in the process of creating a committee to oversee the risks and mitigations associated with failure of delivering these processes, which will be underpinned by working groups and reported on formally to the Board.

The Board thanked the Chair and Peter Axon for the report. The Board thanked executives and all staff members the rapid work being undertaken following the Blueprint and objectives for the ICB.

Local Dental plan

- Paul Edmondson-Jones, Chief Medical Officer, Sarah Jeffrey, Director of Primary Care, and Tracy Cox, Associate Director of Primary Care, presented the report.
- Sarah Jeffrery stated that work is ongoing locally to improve the current position, including the Local Dental Health Equity Audit which has been carried out by a consultant in dental public health.
- Sarah Jeffery noted that this has provided a wide range of data intelligence and patient feedback, which has been used to prioritise targeted action, improve access and reduce health inequalities.
- Sarah Jeffery stated that the audits have supported the identification of 12 initial priority areas with the poorest level of oral health and lowest level of access to services. Sarah noted the overall aim is to improve access to NHS dentistry across all of Staffordshire and Stoke-on-Trent, not just the 12 areas identified.

- Sarah Jeffery advised that the increase to the rates of pay to local dentists means that we are in line with the West Midlands average, and therefore more likely to recruit and retain dentists locally over a longer period of time.
- Sarah Jeffrey stated that as per the governments guidance to ensure more urgent dentistry is available, urgent appointments will be allocated daily, and patients will be able to access this by going through a dental advice line that directs patients to the nearest dentist with same-day availability. Sarah added that this will be supported by a communications campaign so patients know where they can access urgent care.
- Sarah Jeffrery added that plans also include investing more in the oral health improvement and prevention team, who will support schools with teeth brushing techniques, along with support for residents in care homes, particularly focusing on areas of deprivation.
- Sarah Jefferey concluded that in summary, the plan focuses on the following areas: To make sure the right activity is in the right place, to ensure there is earlier prevention for younger people and support for older people, and to provide easier access for people in Staffordshire and Stoke-on-Trent to urgent care services without compromising routine activity.
- Sarah Jeffery advised that the plan has been approved through the joint commissioning arrangements of the West Midlands wide governance.

The Chair thanked Sarah Jefferey for the report. The Board asked for more information around the communications plan and messaging to the public. Sarah Jefferey assured the Board that along with a wider campaign, they are working closely with the communications team on a focused approach to identify relevant channels to reach people within the twelve priority areas identified. The Board was asked about the incentive 'golden hello' scheme and how this will ensure retention of dentists locally. Sarah Jefferey advised this is a national scheme, and the significant factor in retaining dentists locally is the increase of pay rates for dentists in Staffordshire and Stoke-on-Trent. Nadeem Ahmed, NHS Birmingham and Solihull ICB, assured the Board that conditions within the scheme outline that if practitioners were to leave before the end of their agreed period, the money given through the scheme will need to be paid back. The Board was asked how the dentistry plan will be monitored to measure progress against key performance indicators, and if plans need to be adjusted, how this will be factored in. Tracey Cox assured the Board that the team will continue to monitor data and refresh the equity audit to ensure resources are utilised effectively.

The Board endorsed and noted the recommendations presented to them.

National Planning Submission and Re-submission

- Peter Axon, Chief Executive Officer, and Paul Brown, Chief Financial Officer, presented the report.
- The Chair commented that this planning round has been incredibly challenging, noting that all partner members have engaged assertively and fully with the process.
- The Chair stated that local authority members have recorded their concerns around the scale of the ask and have reinforced the requirements for effective impact assessments to be carried out.
- The Chair added that following a full and robust discussion, the Board formally approved the 2025/2026 system plan at the closed Board meeting on 25 March. The Chair noted that as part of the submission of the plan and associated templates to NHS England, it was recognised that further work would be required to ensure that robust quality impact assessments have been completed.

- The Chair reinforced the quality and safety of our services as paramount, with steps being taken to ensure that additional non-executive member scrutiny is deployed through the Quality and Safety Committee. The Chair noted that Julie Holder, Non-Executive Chair of the Audit Committee, will review the System Board Assurance Framework and associated risk registers to ensure that they reflect the risks presented in the planning assumptions and manage these effectively.
- The Chair noted the consideration of the internal audit role in providing added assurance around the delivery of the plan throughout the year, alongside working with NHS England to regularly review the safety and delivery of the plan.
- The Chair stated that the Board has signed off the plan, noting that it is financially balanced but contains significant risk, which requires forensic scrutiny throughout the year to ensure the objectives are delivered safely alongside financial delivery.
- Peter Axon stated that going forward, work will involve converting the plan into detailed deliverables alongside implementation, changing certain ways of working, improving quality and the transition from reactive to proactive services, all in an inclusive way across the system.
- Paul Brown shared thanks to providers and local authority colleagues in forming the plan that is within the resources but also delivers on the major objectives that were set out.
- Paul Brown added that in terms of finance, the £306m efficiency plan is almost 10% of our revenue and resource limit. Paul noted that there is a weekly process of executives coming together to look at building plans, with the level of risk reducing as the plans are being worked through.
- Paul Brown stated that ongoing work involves working through all schemes and developing quality impact assessment assessments for each, which is to be completed by the end of May.
- Paul Brown added that there are plans for reductions in the workforce that is just short of 1100 full time equivalents, and a large proportion that is aimed at reducing agency and bank staff, with the focus being a substantive workforce.
- Paul Brown also noted the challenging activity plan, which has been agreed as a system to plan for a 3% increase of volume recognising the growth of population. Paul advised this is a very significant productivity gain that the system is planning to make.

The Chair thanked Peter Axon and Paul Brown for the report. The Chair stated that as the plan moves forward, every articulated piece needs to move forward together including the quality oversight, the delivery needs and the working of the subcommittee of the Board.

The Board accepted the ask to formally sign off the system plan for 2025/2026, which is a financially balanced plan compliant with the majority of the national ambitions and targets, and to note the refreshed assurance statements that will be returned to NHS England.

Update on Intensive and Assertive Community Mental Health Care

- Elizabeth Disney, Chief Transformation Officer, and Nicola Bromage, Associate Director of Mental Health, Learning Disabilities and Autism, presented the report.
- Elizabeth Disney introduced the report noting the work has been instigated nationally following a CQC special review into mental health services at Nottingham Mental Health Services, Nottingham Healthcare Foundation Trust.
- Elizabeth Disney stated the ask is to ensure there are clear policies and practices in place for patients with serious mental illness who require intensive community treatment and follow up care where engagement is a challenge.
- Nicola Bromage stated that the paper provides an update on the action plan that previously went to Board in October 2024 but additionally outlines the 10 key

recommendations for ICB's following the independent review into the care and treatment of Valdo Calocane.

- Nicola Bromage added that the paper also includes progress against those actions, along with new actions that have been picked up following the Clare Murdoch letter, and what is required in terms of implementation.
- Nicola Bromage noted that the 'staying safe from suicides' work requires trusts to implement new risk assessment procedures. Nicola advised that following a clinically led review of all ICB plans, there are recommendations in terms of good practice.
- Nicola Bromage stated that a series of webinars have taken place issuing several guiding principles to understand what an intensive, assertive outreach approach would look like. Nicola added that this includes elements around key workers, care and family engagement and multi-agency working.
- Nicola Bromage stated that a document around the Personalised Care Framework is currently out for consultation. Nicola explained that this document outlines the standards that aim to guarantee all individuals with a serious mental illness to receive a minimum level of high quality, personalised care and treatment, which will be organised and coordinated across multiple teams to inform the action plan going forward.
- Nicola Bromage stated that both Midlands Partnership NHS Foundation Trust and North Staffordshire Combined Healthcare Trust have task and finish groups in place with a strong organisational process embedded.
- Nicola Bromage noted the delay in the 'Right Care Right Person' planning, reassuring the Board that following the National Partnership Agreement, ongoing conversations are taking place with Staffordshire Police, West Midlands Ambulance Service (WMAS) and the Fire and Rescue service in continuing to improve that response.
- Nicola Bromage explained that the actions which require significant investment have been put on hold, and moving forward, plans include consolidating the recent guidance and adapting plans to reflect the consultation around the Personalised Care Framework.

The Chair thanked Elizabeth Disney and Nicola Bromage for the report. The Chair asked how this will feed into assurance processes for the ICB whilst linking in local providers. Nicola Bromage responded that a deep dive has taken place with the Quality and Safety Committee and this process will continue throughout the year. Josie Spencer, Chair of the Quality and Safety Committee, added that a great amount of detailed work has taken place and shared thanks to all involved. The Board asked about the CQC reviews that are expected to take place following the actions that have been pushed back due to no additional resources. Nicola Bromage explained that the national team are correlating information around what systems have said that they need to deliver to make sure that this cohort of patients is effectively cared for. Nicola Bromage added that it is still to be determined in terms of what the future model will look like, but ongoing work will continually look at the improvements that can be made within current resources. Additionally, the Board requested more detail around timescales and numbers of people participating in training to be included within future reports. The Board noted and accepted the recommendations presented to them.

Quality and Safety Report

- Becky Scullion, Director of Nursing Quality Assurance and Improvement, presented the report.
- Becky Scullion stated that following the CQC improvements against University Hospitals of North Midlands NHS Trust (UHNM), they have received a good rating and

all the section 29a warning notice requirements have been lifted. Becky added that University Hospitals of Derby and Burton (UHBD) were also inspected in December 2024, and the outcome report for this is still pending.

- Becky Scullion highlighted that the working age adults and psychiatric intensive care unit at MPFT was reinspected by CQC, to which they received good ratings.
- Becky Scullion commented on the Home and Host Commissioner pilot which has been rolled out across the Integrated Care System (ICS), stating that two hospitals have opened within Staffordshire and Stoke-on-Trent to support the ambition of placing patients within a 50-mile radius of their home area and the compliance rate of 83%.
- Becky Scullion added that following the implementation plans set out to reduce the number of people waiting for wheelchair services, routine quality visits have been undertaken with progress being monitored. Becky noted that whilst there has been continued improvement to the waiting list over the past ten months, work is still required to strengthen the approach towards ensuring patients are waiting well.
- Becky Scullion advised that work is still ongoing around the Paediatric Hearing Programme to achieve the targets that have been set in the delivery of improvements across both MPFT and UHNM services. Becky noted that the 5-year lookback review at UHNM has now been commissioned, with the outputs following the review expected towards the end of quarter two or quarter three.
- Becky Scullion advised the Board of the alignment and close working with the efficiency working group and Finance and Performance Committee regarding the Quality Impact Assessments (QIA) process.

The Chair thanked Becky Scullion for the report. Josie Spencer echoed that the QIA outcomes and adherence are reported to the Quality and Safety Committee tri-annually, with some changes and more scrutiny expected within the next report due in June 2025.

The Board accepted the acknowledgements and recommendations presented to them.

Quality and Safety AAA Chairs Report

- Josie Spencer, Chair of the Quality and Safety Committee, presented the report.
- Josie Spencer stated that work is ongoing around the infectious disease response commissioning guidance for ICB's. Josie noted that a gap analysis has been undertaken, but there are some risks outstanding that need to be managed. Josie added that this work will come back to the committee in six months' time to ensure full assurance.
- Josie Spencer advised that the committee has received the final report on the progress being made in relation to All Age Continuing Health Care and the transition from the CSU into the ICB, with positive feedback received regarding this process.
- Josie Spencer informed the Board that the Quality and Safety Committee approved the Mental Health, Learning Disability and Autism Host/Home Commissioner Standard Operating Procedure, along with endorsing the Staffordshire and Stoke-on-Trent Alcohol Strategy.

The Chair thanked Josie Spencer for the report. The Board accepted and acknowledged the recommendations presented to them.

Staffordshire and Stoke-on-Trent Health and Care Senate AAA Chairs Report - March

- Paul Edmondson-Jones, Chief Medical Officer, presented the report.
- Paul Edmondson-Jones highlighted the technical items for noting from the Integrated Medicines Optimisation Group summary, the approval of the gynaecology pathway for

the system, noting this as an important document as part of the Women's Health strategy, and the All-Age Palliative Care and End of Life strategy.

The Chair thanked Paul Edmondson-Jones for the report. The Board received and noted the recommendations presented to them.

Staffordshire and Stoke-on-Trent Health and Care Senate AAA Chairs Report - April

- Paul Edmondson-Jones, Chief Medical Officer, presented the report.
- Paul Edmondson-Jones highlighted the Integrated Medicines Optimisation Group summary, the Ear Wax Removal Policy and Individual Funding Request Policy to note for approval.

The Chair thanked Paul Edmondson-Jones for the report. The Board received and noted the recommendations presented to them.

ICS Finance and Performance Report

- Paul Brown, Chief Finance Officer and Phil Smith, Chief Delivery Officer, presented the report.
- Paul Brown noted the year-end position as successful in getting to the control total of £17.8m variance to plan, which was agreed with the regional team.
- Paul Brown highlighted the work that has been undertaken within Continuing Healthcare as a real success in reducing spend as a result of having less intrusive packages of care, whilst continuing to improve lives for people and patients. Paul credited Heather Johnson and Claire Underwood for this work, and shared thanks to Neil Carr, Chief Executive at Midlands Partnership University NHS Foundation Trust, for his support and the support of his team within the system collaborative.
- Phil Smith stated that March saw a continuation of pressures around urgent and emergency care, noting that demand was the highest recorded within one month since pre-pandemic. Phil added that this has somewhat settled since going into the new financial year, and the four-hour target has improved.
- Phill Smith stated that there continues to be significant challenges in terms of ambulance response times and handover times, with UHNM reporting an average handover of 1 hour, 32 minutes in April.
- Phil Smith shared that a learning event was held earlier in the week bringing all partners together with a particular focus on critical incidents and the learning from these. Phil stated that following this, findings will be reported to the Finance and Performance Committee and then to the Board.
- Phil Smith stated that following a previous report around the impact of planned care procedures due to the the pressures of urgent and emergency care, the impact is still felt. Phil explained the aim was to eliminate 65 week waits by the end of March, but the year ended with an additional 233. Phil explained that despite this, annually, we saw 10,000 less people on the waiting list across our population.
- Phil Smith was pleased to share that we're currently ahead of plan in terms of the reduction around 52 week waits, and the plan for this year is to clear the 65 week waits by July 2025 and continue productivity through the summer months before heading into the winter period.

The Chair thanked Paul Brown and Phill Smith for the report. The Board received the recommendations presented to them.

Finance and Performance Committee AAA Chairs Report - April

- Josie Spencer, Chair of the Quality and Safety Committee, presented the report.
- Josie Spencer noted the overarching financial and efficiency figures in the plan that are going to be a real challenge alongside workforce reduction.
- Josie Spencer stated that as a committee, full assurance will be ensured in terms of the progress of the plan and early sight of any risks and issues.
- Josie Spencer assured the Board that there will be a clearer understanding of delivery following June's meeting, and associated risks will be discussed in more detail following this.

The Chair thanked Josie Spencer for the report. The Board noted and acknowledged the recommendations presented to them.

Finance and Performance Committee AAA Chairs Report - May

- Josie Spencer, Chair of the Quality and Safety Committee, presented the report.
- Josie Spencer advised that the system and performance group regularly provide a formal assurance report to the committee, which outlines specific areas of concern to ensure a greater focus on these areas.
- Josie Spencer highlighted an escalation regarding mental health and the access/ wait times for autism assessments. Josie assured the Board that SPG are looking into this in more detail and will provide a report to the committee in due course.
- Josie Spencer noted the policies that have been approved by the committee including the mental health assessment payment policy, along with a business case that will be put forward to the West Midlands CAMHS provider collaborative around supporting children and young people with challenging behaviour.

The Chair thanked Josie Spencer for the report. The Board noted and acknowledged the recommendations presented to them.

ICS People Culture and Inclusion Committee Report

- Mish Irvine, Chief People Officer, presented the report.
- Mish Irvine stated that the system reported a position of 1271 over the operational planning figure as per the end of the financial year. Mish advised that this is broken down by 880 more substantive colleagues than we'd expected to see.
- Mish Irvine stated that although the agency figure reported at 1.6 against a target of 3.2%, assurance processes need to be clear, along with articulating CIP programmes, the risk involved in delivering them, the workforce numbers and deployment of workforce that will enable them to be delivered safely.
- Mish Irvine stated that work is ongoing with finance colleagues within provider organisations to understand the reason for variance, and actions are being taken through the People, Culture and Inclusion Committee and the Finance and Performance Committee.

The Chair thanked Mish Irvine for the report. The Board acknowledged the recommendations presented to them.

ICS People Culture and Inclusion Committee AAA Chairs Report

- Shokat Lal, Non-Executive Chair of People, Culture and Organisational Development Committee, presented the report.
- Shokat Lal highlighted the escalation around workforce growth and mitigations.
- Shokat Lal advised that the committee will continue to closely monitor the data around variations and bring more detailed feedback to the Board in due course.

The Chair thanked Shokat Lal for the report. The Board received the recommendations presented to them.

Staffordshire and Stoke-on-Trent ICB Strategic Commissioning and Transformation Committee AAA Chairs Report

- Julie Houlder, Non-Executive Chair of the Audit Committee, presented the report.
- Julie Houlder advised that a positive discussion around NHS reset had taken place in their latest meeting, which was led by Elizabeth Disney.
- Julie Houlder stated that the role of this committee is increasingly important as further guidance is received around strategic commissioning for outcomes.
- Julie Houlder advised the committee will continue to be mindful about the interface between the Strategic Commissioning Transformation Committee and the Transition Committee.

The Chair thanked Julie Houlder for the report. The Board received and noted the recommendations presented to them.

Staffordshire and Stoke-on-Trent ICB Audit Committee AAA Chairs Report

- Julie Houlder, Non-Executive Chair of the Audit Committee, presented the report.
- Julie Houlder advised that the committee met to approve the submission of the draft annual report and accounts.
- Julie Houlder noted that the committee received a positive outcome of the audit undertaken by Grant Thornton on the 2023/2024 Mental Health Investment Standard.
- Julie Houlder added that the committee agreed on the 2025/2026 internal audit plan, noting this will need to be reviewed in line with the assurance of processes to support the delivery of the plan.
- Julie Houlder advised that there is nothing to alert the Board to regarding the annual report and accounts, which is going out to audit.
- Julie Houlder shared thanks to all involved in the production of report, noting it was produced in tight timescales.

The Chair thanked Julie Houlder for the report. The Board received and noted the recommendations presented to them.

Staffordshire and Stoke-on-Trent ICB Remuneration Committee AAA Chairs Report

- Shokat Lal, Non-Executive Chair of People, Culture and Organisational Development Committee, presented the report.
- Shokat Lal noted the ratification of the appointment of the Chief Finance Officer for an interim period.

The Chair thanked Shokat Lal for the report. The Board received and noted the recommendations presented to them.

NHS Staffordshire and Stoke-on-Trent Integrated Care Board

Date and time of next meeting in public: 17 July 2025 at 1pm held in public, in person at the Midlands Partnership NHS Foundation Trust Headquarters Boardroom, Mellor House, St George's Hospital, Corporation Street, Stafford, ST16 3SR.

Staffordshire and Stoke-on-Trent Integrated Care System

Integrated Care Partnership Briefing

Staffordshire and Stoke-on-Trent Integrated Care Partnership (ICP) Meeting

June 2025

This briefing aims to keep partners and members of the public informed of the discussions at the NHS Integrated Care Partnership (ICP) meeting.

Alcohol Strategy

This is public health strategy underpinned by data, evidence of good practice, engagement with stakeholders and produced through partnership from the Integrated Care System. Our vision for the Alcohol Strategy:

“Staffordshire and Stoke-on-Trent to be a place where alcohol-related harm is minimised, to improve the health and wellbeing of our local population, making Staffordshire and Stoke-on-Trent the healthiest places to live and work.”

The reason for an alcohol-specific focus:

- An estimated 10 million people in England regularly exceed the Chief Medical Officers’ low-risk drinking guidelines, including 1.7 million who drink at higher risk and around 600,000 who are dependent on alcohol.
- Shifting patterns of alcohol consumption, with consumption increasing in those with alcohol user disorder during and after the COVID-19 pandemic.
- An estimated 79% of people living with alcohol dependency in Staffordshire and Stoke-on-Trent are not in contact with treatment.
- Evidence shows that on average, every £1 spent on treatment immediately delivers £3 of benefit and significantly more in the longer term.
- Alcohol harm costs society in England £27.44 billion each year with an estimated cost to Staffordshire and Stoke-on-Trent Integrated Care System (ICS) of £449million, of which an estimated £81million is on health and care services.
- Alcohol-related deaths have increased with risk factors including being male, living in rural areas, increased deprivation and occurring most frequently in the population aged 50-69 years.
- There hasn’t been a national alcohol strategy since 2012, and strategic focus has been more on reducing drug harm.
- The opportunity to address harmful impacts of alcohol on our population is clear from different system strategy and assessments of need.

What is our response?

We have taken a joint public health approach to the strategy and its development.

Extensive engagement has taken place, and we have undertaken an evidence review ensuring we have a strategy that is rooted in the needs of the local population.

We have conducted an Alcohol Needs Assessment, which has been instrumental in providing data-driven insights and evidence to help us prioritise our areas of focus.

The Alcohol Needs Assessment provides valuable insight into how alcohol misuse and dependency is impacting the local population's health and wellbeing with evidence gathered from data provided by local and national partners, stakeholder views and research.

Staffordshire and Stoke-on-Trent Integrated Care System

Alcohol Needs Assessment outcome high-level summary:

- Our communities are affected by the significant availability of alcohol.
- Our social care system is burdened by alcohol-related disability and housing issues.
- Our health and care system is struggling with alcohol-related liver disease and health impacts from alcohol.
- Our criminal justice system has significant alcohol needs in prison and probation services.
- Our economy is paying more per capita for alcohol-related conditions than average in England.

Priorities of the Alcohol Strategy:

- Universal Prevention: Prevent the use of alcohol or to change behaviours so alcohol misuse and alcohol released crime is prevented from happening
- Targeted Prevention: Halt the progression of alcohol misuse by early identification and prompt support, reducing alcohol-related harm.
- Treatment and Recovery: Rehabilitate people with established alcohol misuse/dependence by providing tailored, effective support and recovery interventions.
- Enforcement and Criminal Justice: Manage the availability of alcohol and developing innovative criminal justice solutions/practices to reduce alcohol misuse or alcohol-related offending and recidivism.
- Attitudinal Change: Change attitudes and behaviours towards alcohol at a societal, community and personal level.

Neighbourhood Health and Care Programme

The Neighbourhood Health and Care Programme aims to create healthier communities, helping people of all ages live healthy, active and independent lives for as long as possible while improving their experience of health and social care, and increasing their agency in managing their own care. This will be achieved by better connecting and optimising health and care resource through three key shifts at the core of the government's health mission:

- From hospital to community: providing better care close to, or in people's own homes, helping them to maintain their independence for as long as possible, only using hospitals when it is clinically necessary for their care.
- From treatment to prevention: promoting health literacy, supporting early intervention and reducing health deterioration or avoidable exacerbations of ill health.
- From analogue to digital: greater use of digital infrastructure and solutions to improve care.

Our vision

The population of Staffordshire and Stoke-on-Trent can access health and care services that can meet their needs proactively, shifting the focus from hospital to community and delivering care closer to home.

Our mission

- To develop a Neighbourhood Health and Care Programme which promotes integrated working between the NHS, local government, social care and partners to create healthier communities.
- To implement a consistent model of care that is fit for the future and enables person-centred and proactive health and care to be delivered close to home (own home or community setting).

Staffordshire and Stoke-on-Trent Integrated Care System

- Ensure equity of access, experience and outcomes for residents across Staffordshire and Stoke-on-Trent and support a move to a more sustainable financial position, investing in prevention and care in home, or community settings.

Our places

- Place – Accountability and Planning
    - Staffordshire
    - Stoke-on-Trent
- Localities – Delivery
    - Four localities in Stoke-on-Trent
    - Eight districts and boroughs in Staffordshire
- Neighbourhoods – Change
    - People and Communities
    - Wards, Primary Care Networks (PCNs), villages, parishes

Key principles

We will build upon the work of the Integrated Care System (ICS) portfolios to enhance and strengthen key areas to:

- Utilise population health level data to use segmentation and risk-stratification methodologies to identify those most at risk.
- Prioritise proactive preventative care services.
- Ensure our population know how to access the right care they need and support themselves to self-care.

We will work effectively with general practice and community and hospital specialist care (on both acute and community hospital sites) to reduce unplanned and inappropriate use of hospital resources and increase the ability of people to live independently for as long as safely possible. We will do this by:

- Enhancing our proactive care model for those with long-term conditions and frailty through the development of integrated community neighbourhood teams (building upon Fuller Stocktake report).
- Strengthening our out of hospital services for those people who are at risk of admission and need support in a crisis.
- Increase the numbers of people utilising digital/tech-enabled care to manage their own conditions.
- Supporting a community-based workforce that has the capacity, the capability and the morale to make a difference in people's lives.
- Living within the financial means available to the healthcare system of Staffordshire and Stoke-on-Trent.
- Making best use of local estate and capital budgets, and minimising risk to patients' health from inadequate facilities.

In our first year (2025/26) we will prioritise:

- Six core components for consistency
    1. Population Health Management
    2. Modern General Practice
    3. Standardising Community Health Services
    4. Neighbourhood Multidisciplinary Teams (MDTs)
    5. Integrated Intermediate Care ('Home First' Approach)
    6. Urgent Neighbourhood Services

Staffordshire and Stoke-on-Trent Integrated Care System

- Integrating services to improve coordination, starting with those with the most complex needs (7% of the population, responsible for approximately 46% of hospital costs).
- Scaling successful approaches to benefit more people.
- Evaluating impact to ensure better outcomes and effective use of resources.

- For 2025/26 through the standardisation and scaling of the initial six components, we are asking systems to focus on the innermost circle (on the diagram to the right) to prevent people spending unnecessary time in hospital and care homes. As core relationships between the local partners grow stronger, we expect systems to focus increasingly on the outer circles (on the diagram to the right).

Integrated Neighbourhood Teams – where we want to be in Staffordshire and Stoke-on-Trent

- Person health outcomes: Improvement in clinical health metrics and reduction in hospital admissions and readmissions.
- Service efficiency: Timeliness of care delivery and increased number of people supported within a neighbourhood.
- User satisfaction: High satisfaction scores and positive feedback from community engagement.
- Service performance: Effective coordination and communication, adherence to care protocols and guidelines.
- Cost effectiveness: Reduction in overall health and care costs and savings from decreased hospital admissions and improved preventative care.
- Community engagement: Active participation of the community in health programmes and success of outreach and education initiatives.

Implementing Integrated Neighbourhood Teams in Staffordshire and Stoke-on-Trent

- Quarter 1 (25/26): Initial assessment and strategic planning
- Quarter 2 (25/26): Operating model
- Quarter 3 (25/26): Pilot implementation
- Quarter 4 (25/26): Further rollout
- Quarter 1 (26/27): Monitoring and evaluation

Community engagement will take place throughout all quarters.

Staffordshire and Stoke-on-Trent Integrated Care System

Improving Population Health – Population Health Management (PHM)

PHM is an approach that underpins all our community transformation work including:

- Locality Improvement Framework (LIF)
- Core20 PLUS5 (adults)
- Core20 PLUS5 (children and young people)
- Neighbourhood development
- Inclusion groups
- Presentation programmes/projects

Feedback

The partnership split into groups to discuss and capture feedback on the following topics of discussion:

- What should / can partners bring to the neighbourhood programme?
- How do we build upon the work currently underway?
- How to we support people to look after their own health?

The following points were fed back to the group:

- Anchor institutions were discussed and leveraging their assets within communities.
- Identify clinical needs or vulnerabilities and enable follow-up support.
- Recognising that not one size fits all, tailored approaches are needed.
- Acknowledgement that different partners contribute uniquely.
- Stronger collaboration with Fire and Rescue and Police services was highlighted.
- Engagement with community team is essential to understanding local assets.
- Importance of:
    - Consistent language and common purpose
    - Simplifying messages to support clarity
    - Balancing immediate action with longer-term commissioning changes
    - Creating space for joint service development.
- Universal commitment to collaboration.
- Build on existing work rather than reinventing the wheel.
- Opportunity for a mapping exercise to identify and build upon existing programmes and assets.
- Emphasis on the importance of data:
    - Data sharing is essential for informed decision making
    - Supports deeper understanding of patient and population needs.
- Need to shift the focus to prevention to achieve real impact.
- Tackling health inequalities by rejection of one-size fits all solutions
- Services must be delivered in ways that reflect community preference and realities.
- We need to help people to understand how to access services.
- Focus on improving health literacy not just for patients, but also for families, carers and the wider community.
- It is important that we understand and map current resources and investments.
- Cross-boundary issues were noted as a challenge to service consistency.
- There is a need for flexibility, especially as PCNs often span multiple geographical boundaries.

Date and time of next meeting: Monday 1st September 2025, 3pm – 5pm, via MS Teams.

Executive Summary

UHNM Trust Board | 9th July 2025

Annual Plan 2025/26

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**	✓	**Assurance**		**Agenda Item:**	7.
Author:	Chris Bird, Deputy Director – Strategy & Innovation							
Executive Lead:	Helen Ashley, Director of Strategy							

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

This report presents the Annual Plan 2025/26 for approval by the Trust Board.

The Annual Plan includes a summarised view of the operating landscape including national policy and planning requirements, regional and system commitments and the actions we will take throughout 2025/26 to support delivery of our new 10-year strategy.

This final version of the Annual Plan builds on contributions from all strategic plan authors, review by Executive Directors and feedback from a Board Development session.

It is designed to be a standalone document which acts to set out the Trusts areas of focus and the measures by which we will monitor our progress. However, it is important to view this Plan as a companion piece to our recently launched Strategy 2025-2035 and there is a deliberate framing of this Annual Plan in the context of our strategic priorities and programmes.

It is recognised there are a number of challenges impacting on healthcare delivery and the monitoring of delivery of this plan will be important to provide assurance that progress is being maintained. It is envisaged there will be a half-year update in Autumn 2025 and a final report as part of the year end process.

Key Recommendations

The Trust Board is invited to approve the Annual Plan 2025/26.

University Hospitals of North Midlands NHS Trust

Annual Plan

2025-2026

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Contents

University Hospitals of North Midlands NHS Trust

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University Hospitals of North Midlands NHS Trust

Introduction

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Introduction

University Hospitals of North Midlands NHS Trust

Welcome from our Chief Executive

Welcome to our annual plan for 2025/26.

This plan sets out our priorities for the year ahead and how these align to national policy together with our own Trust strategy and system commitments.

Our priorities are set against a backdrop of well-documented pressures on the health service. These challenges are perhaps best summarised through the Lord Darzi review published in November 2024. This plan will not restate these challenges but does take the important themes emerging from that investigation; hospital to community, analogue to digital and sickness to prevention, and uses them as catalysts for a renewed focus how we can best respond and continue to improve services for our Patients, our People and our Population.

As we enter 2025/26, the Trust has published a new ten-year strategy with an ambition to become a leader in health through harnessing innovation to drive transformational change.

We are dedicated to investing in our people, improving the health and wellbeing of our community, delivering safe and patient-centred care and advancing services through research, innovation and education.

For 2025/26 our focus will be on the two key challenges facing the Trust:

- Sustained improvement in our Urgent and Emergency Care performance
- Delivery of a Cost Improvement Plan

We recognise that improvement in these areas will require a significant effort and that is why we have established an Executive Recovery Oversight Group to ensure collective executive level ownership of our plans and progress.

We will not achieve our aspirations in isolation. It is imperative we work with our system partners to address health inequalities, secure early opportunities for intervention, enhance community-based provision and work collaboratively to support timely discharges that can promote recovery and independence.

In parallel to these two particular areas of focus, the Trust will also continue to maintain and enhance the quality and safety of our services and improve patient outcomes through four strategic programmes of change; Brilliant Basics, Digitally enabled care, our future hospital and Partnerships and Collaborations

2025/26 is set to be a significant year for the Trust as the first year of our new strategy takes root. As this plan unfolds, the scale of our ambition will become clear and we recognise that supporting our colleagues to achieve these ambitions will be critical to our success.

We are confident that the commitment and hard work of our staff, our focus on improving patient care and our collaborations with external partners means we are well placed to deliver our core services alongside our transformation programmes.

Dr Simon Constable
UHNM Chief Executive

Who we are and what we do

University Hospitals of North Midlands NHS Trust

We are one of the largest teaching trusts in the country with a team of over 13,000 people providing high quality, compassionate care in modern facilities.

We provide a wide range of acute and specialist services for a population of approximately three million people and have circa 1,450 beds across our two sites at Royal Stoke University Hospital (including the Staffordshire Children's Hospital), Stoke-on-Trent and County Hospital, Stafford.

We are proud to have a growing international reputation for the innovative treatments we provide and pioneer through our research, education and university partnerships.

We work closely with health, social care and voluntary sector partners across and Staffordshire and Stoke-on-Trent to deliver joined up and integrated care for our population.

We also collaborate with many partners beyond the Staffordshire and Stoke-on-Trent system through a range of well-established relationships that span over a decade or more

Our Strategic Context

Whilst the ambitions for clinical care and academic achievement described within our previous strategy, '2025 Vision' remain, the NHS landscape has changed. There is a much greater emphasis on partnership and collaboration, and Covid-19 shifted our focus and required us to work differently.

These changes have given us opportunity to reconsider our strategic direction and the future for our staff, and the services we provide for our patients and our population. However, we could not have done that without hearing their views and so our future plans have been shaped by the feedback we have received.

Our Strategy: Plan on a Page

The best joined-up care for *all*

University Hospitals of North Midlands NHS Trust

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 provide **tackle inequality,** and improve the health of our population

Key Metric:
Number of Years in Good Health

Our 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 provide care closer to home

Collaborations & Networks

Working with others to ensure sustainable and joined-up care

Our Strategic Plans

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

Our Values

Annual Plan 2025/26

University Hospitals of North Midlands NHS Trust

Delivering our Strategy through the annual plan

This UHNM Annual Plan sets out how we will work throughout 2025/26 to respond to national policy, deliver national planning requirements and make progress against our strategic ambitions.

At its base, is our new Strategy 2025-2035 which commits to a set of strategic priorities which will guide all our actions over the next ten years.

2025/26 is the first year of our strategy and we have used it to build our annual plan to ensure there is alignment across the multitude of influences that shape our work programme.

The following pages describe the synergy between the national policy landscape, regional collaborations and system-wide partners and how these have been translated into a delivery programme for the year wrapped around our strategic plans.

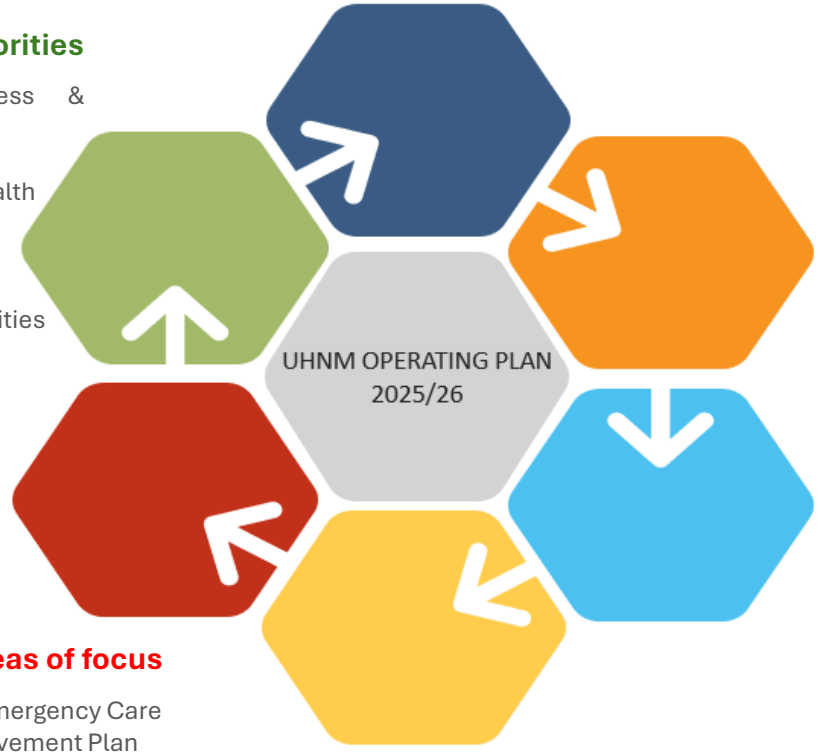
National Context

3 big shifts:

i) Hospital to community
ii) Sickness to prevention
iii) Analogue to digital

2025/2026 Priorities

i) Quality, Access & Performance
ii) People
iii) Population Health
iv) Digital
v) Research
vi) Innovation
vii) Estates & Facilities



NHS Planning Guidance

i) Reduce elective waits
ii) Improve A&E waiting times & ambulance response times
iii) Improve access to general practice & urgent dental care
iv) Improve MH & LD care

NHS Planning Guidance - System

i) Live within allocated budget
ii) Maintain focus on quality & safety
iii) Address inequalities & shift towards prevention

Areas of focus

i) Urgent & Emergency Care
ii) Cost Improvement Plan

UHNM Strategic Framework

i) Priorities
ii) Programmes
iii) Plans
iv) Operational Priorities)

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Areas of focus 2025/26

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National Policy and planning

University Hospitals of North Midlands NHS Trust

National Policy

Hospital to Community	Analogue to Digital	Sickness to Prevention
• Bringing care closer to where people live, including through a new neighbourhood health service to deliver more proactive and personalised care	• Rolling out new technologies and digital approaches to modernise the NHS, including bringing together a single patient record, owned by the patient, shared across teams, putting people in control of their own health	• Shortening the amount of time people spend in ill-health by preventing illnesses before they happen as well as earlier identification and management of chronic conditions

10 Year Plan

2025-26 NHS Planning Guidance

- Reducing the time people wait for elective care
- Improving A&E and ambulance response times
- Enhancing access to general practice and urgent dental care
- Improving mental health and learning disability services
- Improving access to Children and Young People's mental health services
- Living within the budget allocated, reducing waste and improving productivity
- Maintaining collective focus on the overall quality and safety of services
- Addressing inequalities and shift towards prevention

Regional Oversight 2025/26	• NHS England will implement revised oversight arrangements starting in June to support and monitor delivery of the 2025/26 Operating Plan • Membership – NHSE Midlands, ICB & UHNM – other NHS providers invited by exception • Areas of focus: • i) Performance trajectories – finance, workforce, UEC & Elective, Cancer & Diagnostics • Ii) Quality Assurance • Iii) Strategic Enablers – UEC, Elective, Workforce & Digitisation

Regional & System Context

University Hospitals of North Midlands NHS Trust

Integrated Commissioning Business Plan 2025/2026

Improve Health outcomes	•Commissioning high quality, patient centred specialised services
Ensure financial sustainability	•Optimising resource allocation and reducing inefficiencies
Strengthen system-wide collaboration	•Between NHS England, ICBs, providers and other stakeholders
Support innovation & digital transformation	•To enhance service accessibility and efficiency
Reduce health inequalities	•By addressing gaps in care provision and ensuring equitable access to specialised services

The table above offers a summary of the aims outlined in the Integrated Commissioning Business Plan 2025/26.

The landscape of Delegated Specialised Commissioning continues to evolve as part of the national policy ambition to align commissioning closer to populations. As we start 2025/26. the landscape is as follows:

- Delegated - Primary Pharmacy, Optometry and Primary & Secondary Dental Services (delegated April 2023), Acute (delegated April 2024) & Mental Health, Learning Disabilities & Autism (delegated April 2025)
- Retained – Pharmacy, Screening, Vaccination, Health & Justice, Specialised MH, LD&A

Closer collaboration between NHS England and ICSs will take place throughout 2025/26 with further delegations planned for future years

Staffordshire & Stoke-on-Trent System Priorities

Improving outcomes in population health & health inequalities	Improving delivery of elective care services	Improving cancer services and outcomes in cancer care	Delivering improvements in Children & Young People services & maternity care
Improving Urgent & Emergency Care & delivering more care at home	Promoting healthy ageing & managing frailty	Delivering more services though primary care to support transformation	Growing and improving mental health services

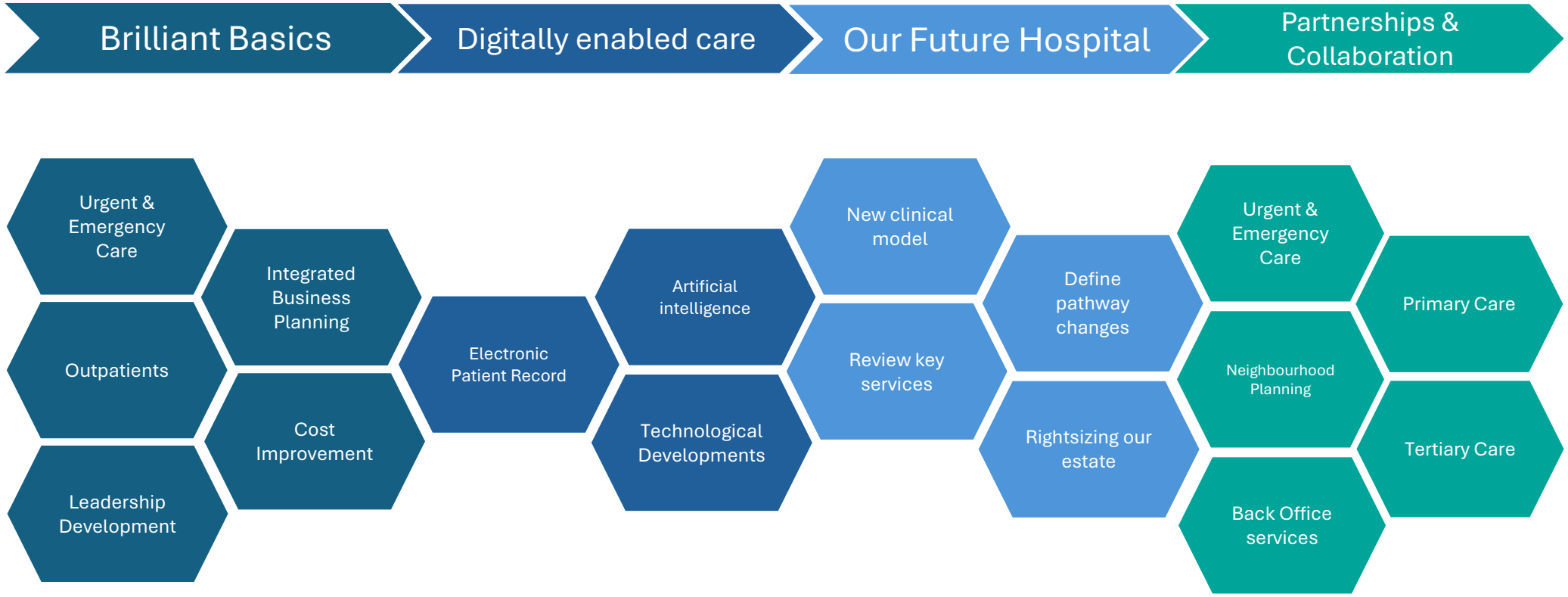
- UHNM plays a key role in the Staffordshire & Stoke-on-Trent Integrated Care System (SSoT ICS) in a partnership with other NHS providers and local government
- Alongside our own priorities, we contribute to the delivery of system-wide objectives as articulated through the Integrated Care Partnership strategy and Joint Forward Plan
- All SSoT ICS partners have agreed a number of areas of focus and these provide a strong sense of synergy with both national planning requirements and the Trust's own ambitions
- The delivery of UHNMs priorities in 2025/26 will require the proactive support of our partners and achievement of those priorities will in turn, enable delivery of the system-wide commitments
- The Trust's strategic direction places a renewed emphasis on our ability to collaborate with partners and this is reflected in the Strategic Programme – Collaborations & Partnerships and each of the five areas within that programme will progress our commitment to integrated working

Strategic Programmes

University Hospitals of North Midlands NHS Trust

Our new 10-year strategy is supported through a series of strategic programmes which will act to bring a cohesive and coordinated approach to the transformation of service delivery – this will include how it is delivered, where it is delivered and who delivers it

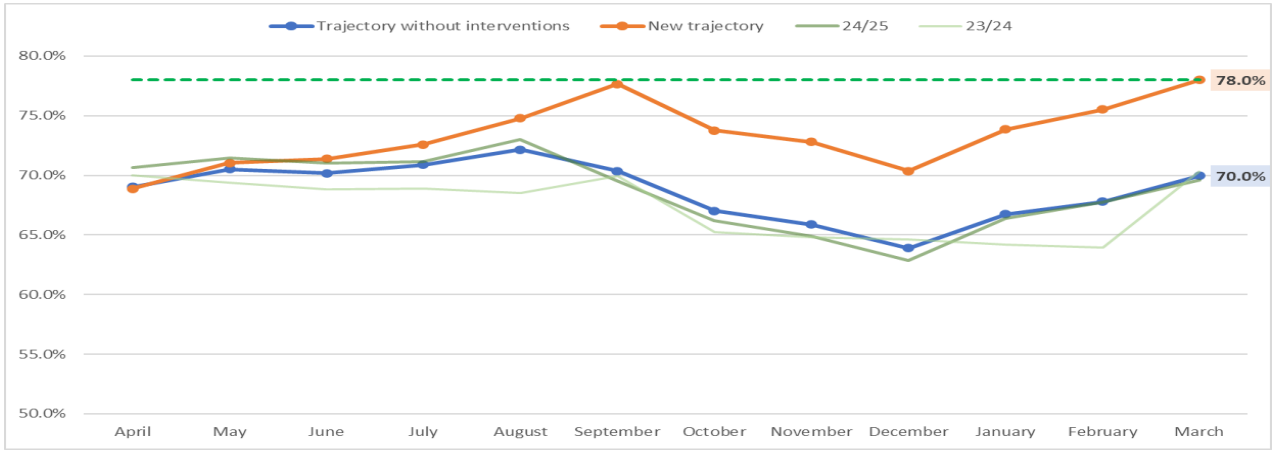
These programmes will be delivered over a multi-year period and will have an evolving focus as component parts are implemented.



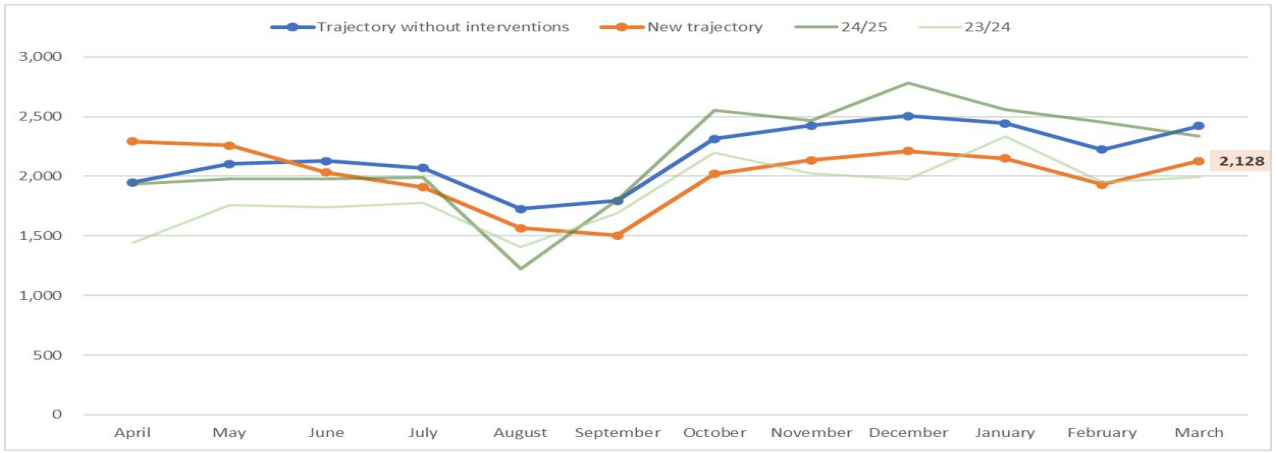
UHNM Priority – UEC Recovery

University Hospitals of North Midlands NHS Trust

Improve A&E 4 hour target to 78% by March 2026



Improve 12 hour waits to 2024/25 position



Summary

- UEC Recovery programme established with five workstreams:
  - Front Door
  - Frailty
  - Clinical Pathways
  - Bed & site management
  - Ward Processes
- All schemes have Senior Responsible Officer capacity in place and supported through robust project documentation including time-specific actions and milestones
- All workforce related measures have been allocated to Divisions to enable a consolidated approach with localised flexibility
- Further opportunities being rapidly assessed for inclusion

Risks to Delivery

- Capacity & capability of teams in delivering change at scale and pace
- Demand
- Lack of alignment with partner plans

Mitigations

- Executive Recovery Oversight Group provides grip & control
- Senior Management capacity in place to support recovery & reporting
- PMO support to proactively support teams

UHNM Priorities – Cost Improvement

University Hospitals of North Midlands NHS Trust

Cost Improvement Programme 2025/2026

Area	Scheme	Exec Owner	2025/26 £m	2026/27 £m
Non-Elective	Reduction IP capacity through UEC recovery	COO	6.7	10.7
Elective	Endoscopy | Elective Improvement Programme	COO	4.5	5.0
Workforce Controls	OT to bank | Nurse Bank Rate | Nurse Agency | Off cap bookings | Extra shift payments | Ward Spend	CPO	7.6	9.1
Diagnostic		DOS	1.3	2.0
Medicines	Drug switches	CMO	1.0	1.1
Procurement	Procurement work plan | negated inflation	CFO	1.8	2.0
Loan Kit		COO	2.3	3.0
Divisional targets	Discretionary spend	DOS	4.6	4.6
Pay underspend		CFO	5.0	5.0
Investment slippage	Non-recurrent	CFO	5.0	0.0
Other flexibilities	Non-recurrent balance sheet measures	CFO	5.0	0.0
CIP Target March 2025			**44.8**	**42.5**
Establishment reviews		DOS	15.0	30.0
Further non-recurrent opportunities	PYE of establishment reviews | further pay underspends	DOS	15.0	0
CIP Target April 2025			**74.8**	**72.5**

Summary

- UHNM financial plan assumes a CIP delivery of £75m
- The CIP programme is delivered via:
  - Service &/or pathway redesign £12.5m (across Non-Elective, Elective and other areas)
  - Workforce reviews £27.6m (not including any workforce impact of other schemes)
  - Changes to practice £5.1m (e.g. drug switches)
  - Discretionary spend reviews £4.6m
  - Other non-recurrent measures £25m
- Non-recurrent measures account for c33% of the plan and will require further efficiencies in 26/27 to offset them
- All workforce related measures have been allocated to Divisions to enable a consolidated approach with localised flexibility
- Further opportunities being rapidly assessed for inclusion

Risks to Delivery

- Capacity & capability of teams in delivering cost reduction programmes
- Schemes require further work up to be fully validated

Mitigations

- Executive Recovery Oversight Group provides grip & control
- Senior Management capacity in place to support recovery & reporting
- PMO support to proactively support teams

University Hospitals of North Midlands NHS Trust

Performance & Resources

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Finance & Capital Plan

University Hospitals of North Midlands NHS Trust

The UHNM financial plan reflects the pressures that all NHS Trusts are experiencing in a difficult operating environment.

Planning priorities and success measures:

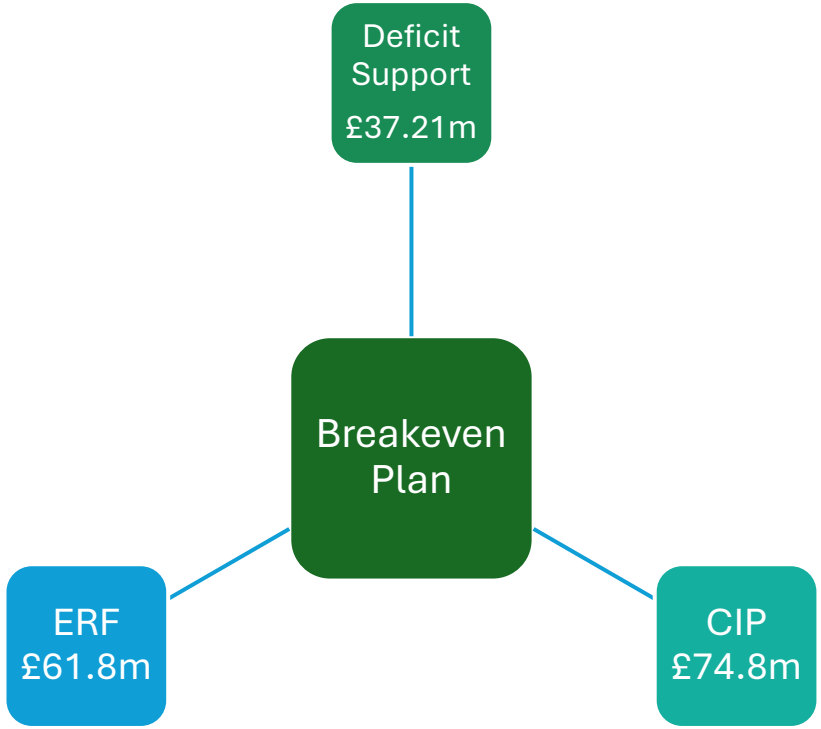
- The Trust has submitted a breakeven plan with an assumed share of £37.2m for deficit support
- A total CIP requirement of £74.8m is included within the financial plan, of which £25.0m is non-recurrent
- The financial plan includes £61.8m of Elective Recovery Fund
- The capital plan has been set at £90.8m

To comply with national planning rules, the Trust is also required to introduce a number of measures to improve the productivity and efficiency of the services it delivers. This includes:

- 30% reduction on agency staff spend (from M8 24/25 forecast outturn)
- 10% reduction on bank staff spend (from M8 24/25 forecast outturn)
- 50% reduction in corporate cost growth (from 2018 benchmarks)

Delivery of the financial plan, including monitoring of the key planning assumptions, is routed through the Finance, Business & Performance Committee.

Additional scrutiny is provided through the Executive Recovery Oversight Group established during 2025/26 as a reflection of the sustained focus on financial recovery in this year



Performance

University Hospitals of North Midlands NHS Trust

The table on the right provides an overview of our planning assumptions against the Key National Priorities and Objectives.

Planning priorities and success measures:

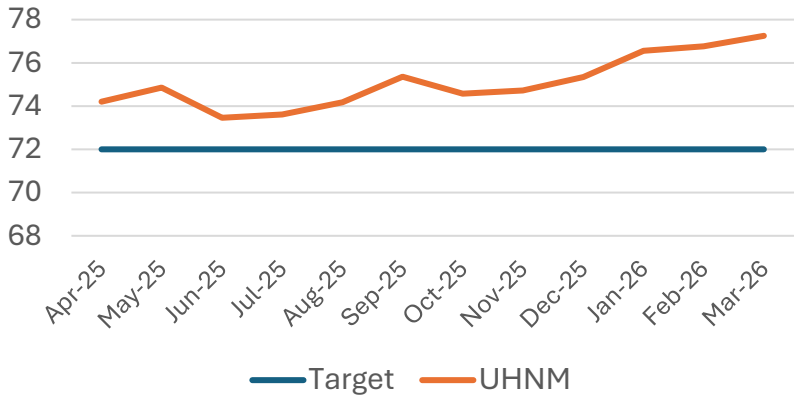
- By March 2026 improve the percentage of patients waiting <18 weeks for treatment to 65% and for first appointment to 72% nationally, with every trust delivering a minimum 5% point improvement.
- By March 2026 reduce the proportion of people waiting >52 weeks for treatment to less than 1% of the total waiting list.
- By March 2026 enhance cancer care pathways, including faster diagnostics and specialist-led procedures. 62-day cancer standard to 75% and 28- day cancer Faster Diagnosis Standard to 80%.
- Reach minimum of 78% patients admitted, discharged and transferred from Emergency Departments within 4 hours.

Key National Priorities and Objectives	March 2026 Target	UHNM Plan	Compliant?
Elective waiting times			
Percentage of people waiting less than 18 weeks for treatment	62.8%	62.8%	
Reduce the proportion of people waiting more than 52 weeks for treatment to less than 1% of the total waiting list	700	700	
Time to first appointment	77.0%	77.0%	
Enhance cancer care pathways including faster diagnostics and specialist-led procedures			
62-day cancer standard	75.0%	75.0%	
28-day faster diagnostic standard	80.0%	80.0%	
Urgent & Emergency Care			
Reach minimum of 78% patients admitted, discharged and transferred from Emergency Departments within 4 hours	78.0%	78.0%	

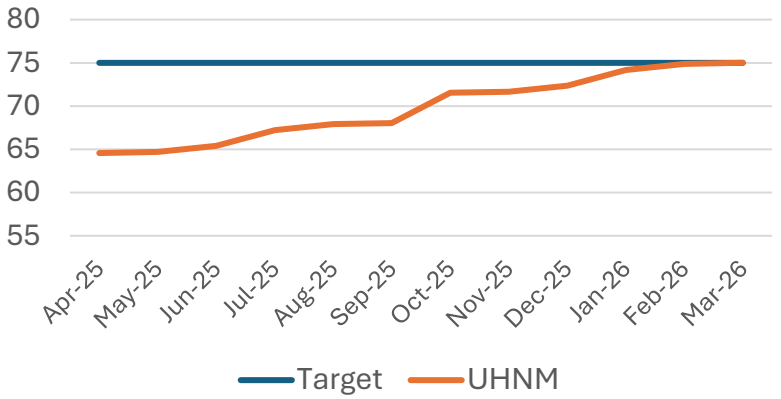
Performance Trajectories

University Hospitals of North Midlands NHS Trust

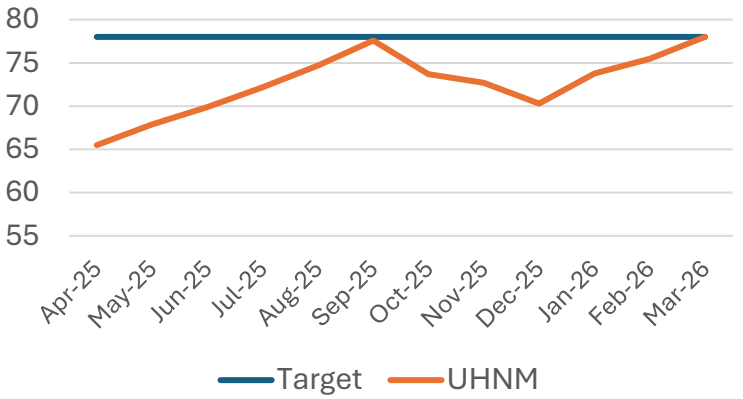
Time to first appointment – 72% < 18 wks



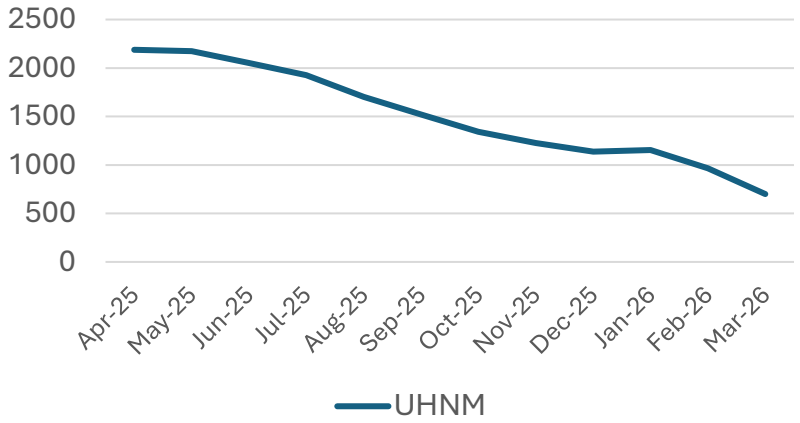
Cancer 62 day pathway



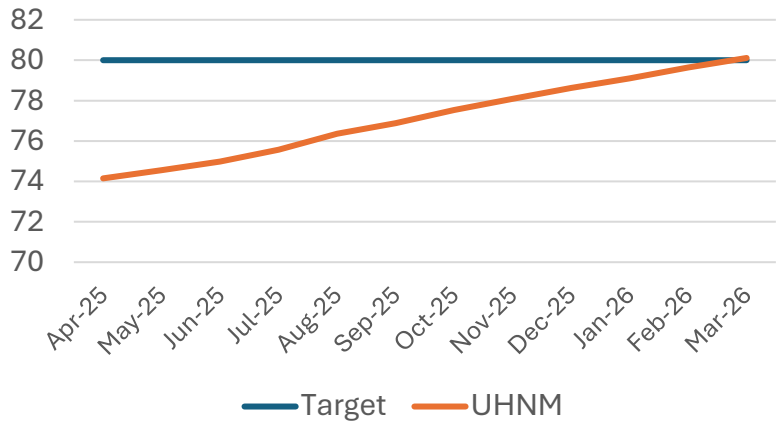
A&E 4 hours



Proportion of people waiting > 52 weeks



Cancer 28 day wait – faster diagnostic standard



Performance Improvement

- The charts on this slide show the extent of the performance improvement needed in order for the Trust to achieve the national standards by March 2026
- Each metric is supported by a detailed plan with clear actions and timelines
- Performance is monitored in detail at Board level through the Integrated Performance Report

Activity & Workforce

University Hospitals of North Midlands NHS Trust

Point of Delivery	Volume
Day Case	104,848
Elective	14,701
Outpatients	773,278
Outpatient Procedures	129,056
Non-Elective	88,034
Total	**1,109,917**

Annual Workforce Plan	Baseline		Plan	
	Staff in post	Establishment	Staff in post	Establishment
	31 March 2025		31 March 2026	
	WTE	WTE	WTE	WTE
Total workforce (WTE)	13,157.14	12,795.47	12,286.50	12,289.68
Total Substantive	11,788.32	12,795.47	11,389.19	12,289.68
Total Bank	1,149.33		801.50	
Total Agency	219.49		95.81	

The activity plan has been prepared on the basis of capacity and demand and reflects an aggregated position of the activity plans signed off by each clinical area.

Activity levels are monitored to ensure that patients are receiving timely access to services and that income assumptions are on track

The workforce plan includes a number of key assumptions:

- additional WTEs for any new business cases signed off
- retraction of WTE's for non-recurrent work in 2024/25
- a reduction of 162 WTEs for bank and agency in line with national planning requirements on premium pay
- a reduction of 567 WTEs from October 2025 aligned to transformation to support financial recovery

Workforce numbers are actively monitored to ensure there is sufficient capacity and skill mix to deliver the agreed activity levels balanced against national and local planning assumptions

The Trust will continue with the existing vacancy control processes to ensure Executive level oversight to decisions to recruit and/or replace staff

University Hospitals of North Midlands NHS Trust

Monitoring & reporting

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Our Well-Led Framework

NHS University Hospitals

To succeed with Our Strategy, we must ensure that there are effective governance, management and leadership arrangements in place to ensure sustainability. The Accountability and Performance Management Framework forms part of our broader 'Well-Led' framework.

Our Strategy 2025 – 2035: The best joined-up care for *all*

Our Strategy defines our priorities for our people, our patients and our population. It frames the context we are working within, and guides how we will work together with our teams, partners and the system to help us shape our services and the way we work.

Our People
We will create an **inclusive** workforce 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 provide **tackle inequality,** and improve the health of our population

Delivery

Strategic Programmes	Annual Plan / Strategic Delivery Plans	Strategy Delivery Unit
Major programmes of work that we need to focus on. These describe the changes in the way we provide care as well as recognising some immediate areas for focus.	Detailed annual and longer-term plans, which identify the specific actions we will take to deliver our strategic priorities, the timescales for delivery and the outcomes we expect to see as a result.	Co-ordinating the capacity and capability we need to transform and ensure continuous improvement. Overseeing development and delivery of our Strategic Programmes, and resource needed to deliver.

Culture & Leadership

Leadership Development Programme	Behaviour Framework
Designed to ensure we have capable, compassionate and inclusive leaders, with the knowledge and skills they need to deliver our Strategic Priorities.	Outlines the expectations of the attitudes and behaviours of our people, and what we do not accept. Designed to promote the culture we aspire to.

Oversight

Accountability & Performance Management Framework	Corporate Governance Structure & Rules of Procedure	Board Assurance Framework
Defines the key accountabilities and structures to deliver Our Strategy. Defines the framework through which we will manage performance.	The structure we use to oversee performance, hold to account and seek assurance on the delivery of Our Strategy, from wards through to the Board. Rules of Procedure determine the Terms of Reference and Membership.	The framework we use to identify and manage risks to Our Strategy and the key sources of assurance that we rely upon through our Corporate Governance Structure.

Performance Management

Performance and Risk Reviews

University Hospitals of North Midlands NHS Trust

Performance and Risk Reviews are undertaken in the form of a structured, comprehensive review, led by the Executive Team for each Care Group and by the Care Group triumvirate / quadrumvirate for their Clinical Business Units.

Care Group Performance and Risk Reviews are held bi-monthly, and all Executive Directors will participate in holding to account, as appropriate. Our revised approach to these reviews aims to remove duplication of reporting and discussion, and to ensure that a joined-up view of the Care Groups performance can be formulated, through triangulation of available information. The reviews will be an opportunity to discuss emerging issues and track progress against any agreed improvement plans.

We have developed a balanced scorecard, which will form the basis of each Care Group's performance assessment. The balanced scorecard will be produced centrally by our Performance and Information team and is based on a selection of high-level metrics which have been determined by Executive Directors, relevant to their portfolio. Care Groups are required to provide supporting narrative to the data provided.

The balanced scorecard is complemented by:

- a comprehensive Care Group Integrated Performance Report (IPR) and it is expected that the Care Group will have scrutinised their IPR with sufficient rigour, though their Care Group Board prior to their Performance and Risk Review.
- A summary of the Care Groups risks, scoring 15 or above, in line with the Risk Management Policy.

Other sources of information available will also be used to triangulate data and inform any decision on *segmentation, action required, or the associated support or intervention needs of the Care Group. For example, this might include the Care Group's Clinical Effectiveness Framework, including guidelines on best practice, audit, accreditations, Model Hospital, GIRFT, legal scorecards and claims. Other sources might include internal / external reviews, health and safety concerns, Coroner or speaking up concerns, staff and patient surveys.

We will also consider the extent to which the Care Group is collaborating with other Care Groups, teams, to improve organisational performance.

Performance and Risk Review Standard Agenda

1	Achievements
2	Balanced Scorecard
3	Integrated Performance Report
4	Clinical Effectiveness / other sources of information
5	Risks
6	*Segmentation Confirmation and Next Steps

All information relevant to the Performance and Risk Review will be held through a central Microsoft Teams Channel. Care Groups are required to ensure that the papers for their Care Group Board are made available through this platform, so that they can be scrutinised, if necessary.

The arrangements set out here are expected to be replicated by Care Groups for their Clinical Business Units.

**the segmentation aspect of this framework will be implemented in a second phase as our approach matures.*

University Hospitals of North Midlands NHS Trust

2025/26 Operational Priorities

Our operational priorities explain what we will do in the coming year to deliver our strategic plans.

2025/26 Operational Priorities

University Hospitals of North Midlands NHS Trust

Quality, Access & Performance

- We will reorganise our clinical structures, governance and assurance processes to support delivery of upper quartile performance
- Ensure our data accurately reflects our access performance and activity, which is available in real time to inform clinical decisions and strategic direction
- Embed accountability for quality and performance metrics for the Clinical groups
- Design and deliver UEC recovery plan (IPS/clinical pathways/site management/link to community transformation/ED and acute med/clinical portals and assessment areas/UTC)
- Standardised ward work and discharge (UEC and elective)
- Strengthen triumvirate leadership (across Clinical, nursing and ops, both leadership/joint working and the basics)
- We will ensure effective medical leadership & job planning for all our consultants to ensure best use of time, skills for benefit of patients and their teams
- Bring a relentless focus on using GIRFT standards to drive clinical efficiency, effectiveness and productivity
- Develop our County Elective hub ensuring provision is right for local people and development of skills
- Standardised outpatient clinic ways of working and clinical pathways
- Strengthen the patient voice in Co-production opportunities
- Develop a new Nursing, Midwifery and AHP excellence framework
- Develop and launch a person-centred practice framework
- Continue to improve research opportunities for Nurses, Midwives, AHPs, pharmacists and clinical scientists.

People

- Develop an improvement plan to address the health wellbeing within our workforce, aligned to top reasons for absence and the physical health inequality priorities in our population.
- We will develop and deliver year 1 of our sexual safety in the workplace plan.
- We will develop and launch our new values and behaviours, aligning this to our work on reward and recognition
- We will develop, offer and deliver a multi-disciplinary senior leaders development programme 2025-2027, and align our wider leadership offerings against the NHSE Management and Leadership Framework.
- We will refresh and redesign a multi professional middle management clinical management and leadership programme.
- Working with education partners, we will work develop our current and future workforce with a focus on work experience, entry level opportunities, digital skills, career development support and advancing practice.
- We will act on the Race Equality Task and Finish Group's recommendations to foster inclusive recruitment and talent management, eliminate racism, and build a truly anti-racist organisation.
- We will continue to promote and offer flexible working for existing and potential employees through our campaign and support work.

PHM

- Address inequalities in access, experience and outcomes
- Improve health and wellbeing through a coordinated programme approach
- Use our resources as a major employer to improve the overall health of our population
- Enhance organisational capability to deliver strategic priorities

2025/26 Operational Priorities

University Hospitals of North Midlands NHS Trust

Digital

- Full business case outcome and route to procurement to support planning stages of implementing an EPR solution
- Implementation of an EPMA solution to improve care, quality, move from analogue to digital and reduce risk.
- Upgrading and standardising our end-user-compute for compliance with Windows 11
- Network and telephony transformation to continue consolidating systems between sites and upgrading the infrastructure that supports our critical systems and communications
- Driving efficiencies through AI solutions such as ambient AI for clinicians
- Elective care brilliant basics (outpatients/planned care) including but not exclusive to standardising outpatient clinic structures, increasing use of digital tools, standardising patient communications and reducing printing

Estates, Facilities & PFI

- Delivery of major capital transformation projects, consistent with Trust's Capital Plan i.e. UTCs, County Breast, Project STAR, Rightsizing & continued progression of CDC.
- Delivery of EFP services that enable the provision of high quality, safe clinical care and good staff experience, evidenced through the achievement of above national average scores against PLACE and 'Good' overall for PAM.
- Delivery of improvement projects that optimise our estate and address innovation of our services, delivering our EFP CIP target of £2.6m and PFI savings that deliver a c£3.9m corporate CIP contribution.
- Progress innovative energy procurement and low carbon technologies to support attainment of Net Zero Targets, in line with the Trust's Green Plan's ambition and targets.
- Improve recruitment and retention rates across EFP, offer clear and inclusive career pathways and flexibility to support the sustainability of our future workforce, continue to deliver innovative recruitment practices i.e. Project Search and Care Leavers.

Research

- Increase coordination of PPIE networks
- Establish the Commercial Research Delivery Centre
- Begin work to establish a dedicated facility – repurposing space within the Clinical Education Centre
- increase collaboration with neighbouring Higher Education Institute's and NHS Trusts
- Growing capacity to deliver research at UHNM
- Growing capacity & capability via research engaged and research active staff
- Growing collaborative HEI Honorary & Joint appointments

Innovation

- Publish a clear statement of ambition and the challenges innovation can support
- Promote the visibility of the innovation team and the support they offer by developing our internet presence and publishing an Impact Report
- Work with colleagues to join-our approach to innovation, research, transformation and quality improvement
- Strengthen relationships with key partners to accelerate the pace and scale of change

2025/26 Measures

University Hospitals of North Midlands NHS Trust

- The Trust launched its new 10-year strategy in May 2025.
- The strategy includes a significant amount of transformation work that will be delivered throughout the life span of the strategy.
- 2025/26 acts as the first year of delivery and through our Annual Plan, we have established specific measures and key performance indicators that will enable us to track the progress we are making towards achieving our strategic priorities
- These will be reported to the Trust Board on a quarterly basis to ensure transparency and visibility

	Our People	Our Patients	Our Population
Strategic Priorities	We will create an inclusive workforce where everyone learns, thrives and makes a positive difference	We will provide timely, innovative and effective services to our patients	We will tackle inequality and improve the health of our population
	Metric: Staff Engagement Score	Metric: Combined Hospital Score	Metric: Number of Years in Good Health
2025/26 Measures	• Complete transition to new Care Group structure • Reduce sickness absence • Improve staff engagement • Improve National Staff Survey scores • Achieve premium staff spend reductions	• Achieve national standard for patients admitted, transferred from Emergency Department within four hours • Achieve national standard for elective waiting times • Achieve national standard for cancer pathways • Deliver major transformation capital projects • Implement Electronic Prescribing & Medicines Administration system	• Delivery of Financial Plan • Open the Community Diagnostic Centre • Delivery of Net Carbon Zero targets as part of the Trust's Green Plan • Increase referrals to Tobacco Dependency Treatment • Open Commercial Research Delivery Centre

Executive Summary

Trust Board | 9th July 2025

UEC Pressure and Ambulance Handover Update

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**	✓	**Approval**		**Assurance**		**Agenda Item:**	8.
Author:	Katy Thorpe, Chief Operating Officer							
Executive Lead:	Katy Thorpe, Chief Operating Officer / Ann Marie Riley, Chief Nurse / Diane Adamson, Chief Medical Officer							

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

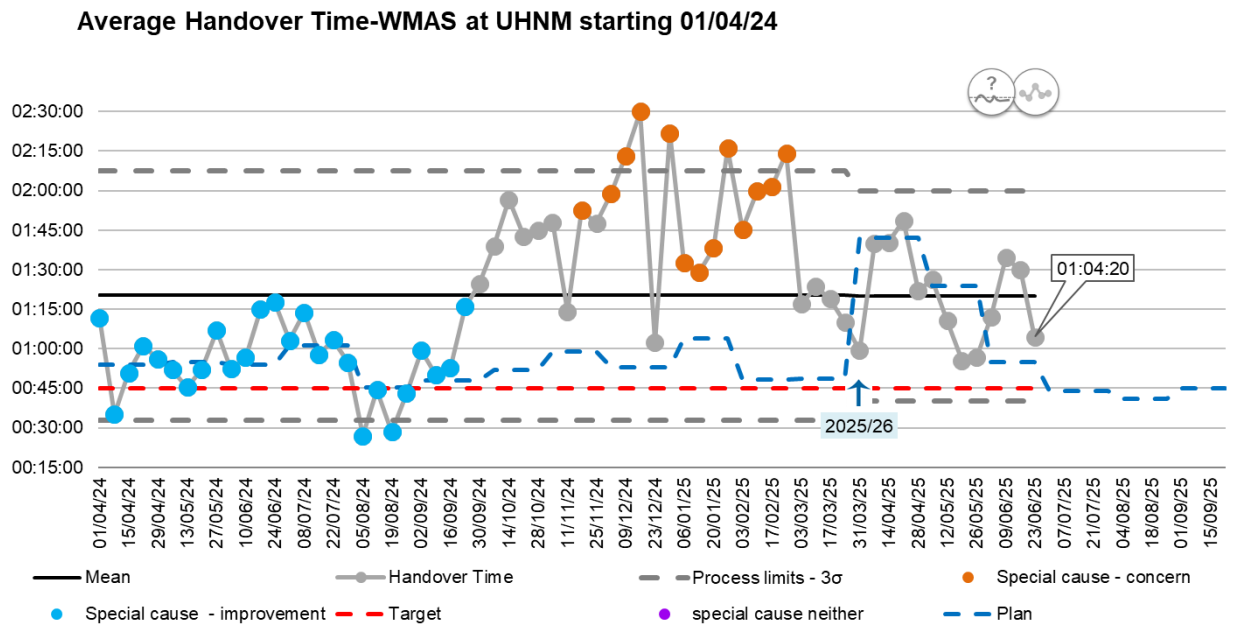
Risk Register Mapping		
BAF4	Delivering responsive patient care	15 (extreme)

Executive Summary

Situation

- This paper ais to update board member on the situation with regard to UEC pressure and ambulance handover delays.
- This covers data up to the latest reported week which was 23rd June 2025
- We are currently in tier 2 for national oversight for our UEC position.

Ambulance Handover



Average Handover Time

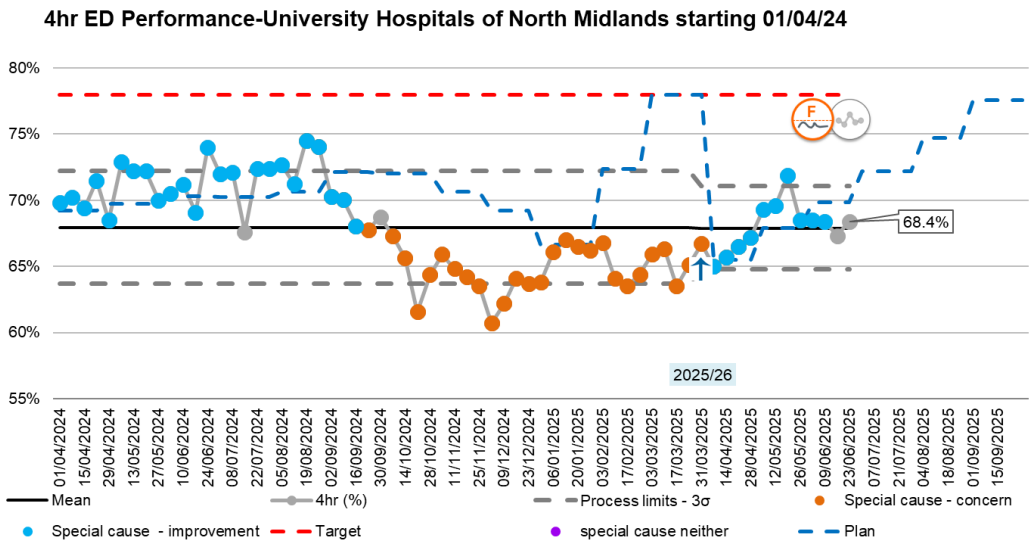
- Average Handover Time last week improved by 25½ minutes to 1hr 04mins 20secs, ~9½ minutes above plan for June.
- Handover Trajectory for latest week was 69.2%, up ~ 16% on the previous week.
- Time Lost (> 15mins) due to handover reduced by over 500 hours to 1,006 hours from 1,556 hours.

Category 2 Response Time

- Category 2 Response Time for the week ending 22nd June 25 improved to 30m 33s from 34m 44s.

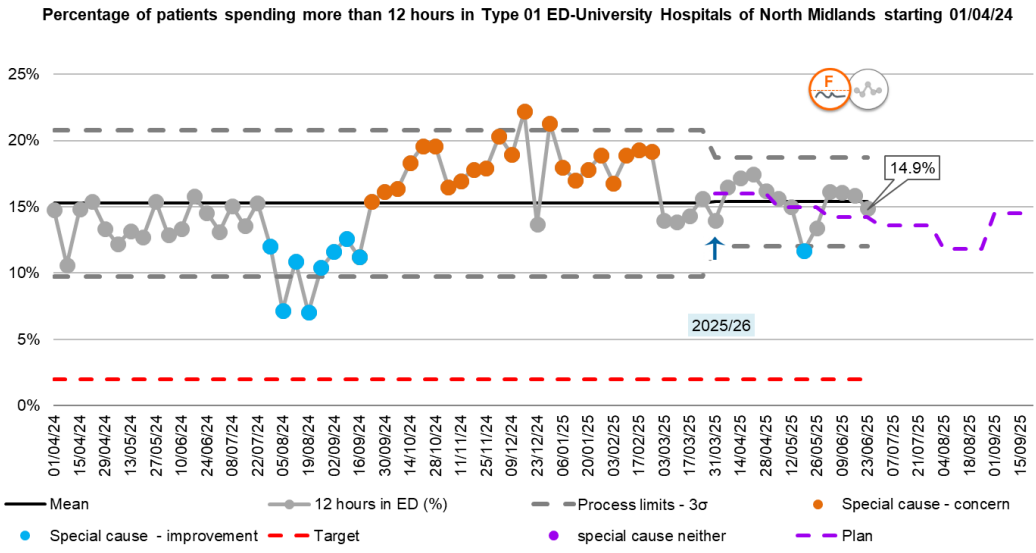
- This placed the system 5th regionally and 16th nationally.
- 4-week average of 29m 10s placed the system 5th regionally and 17th nationally.

Four Hour Performance



- Last week saw an improvement in performance over the previous week with a rise of 1.1% to 68.4%.
- June's current position of 68% is 1.9% below the plan for the month.
- UHNM reported a 3% increase in overall attendances last week with growth reported at Type 1, 2 and 3 sites.
- Type 01 Paediatrics dropped by 1.2% to 73.8%, with June currently reporting as 76.6%, up 0.5% on May

12 Hour Performance



- Provisional performance for last week (partial week) was 14.87%, down 1% on the previous week of 15.9% but above the plan figure for June of 14.23%.

Tactical Mitigating Actions

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

ICC

- 82.5% diversion rate for Call Before Convey referrals.
- Engagement sessions booked with WMAS hubs in Stafford and Lichfield

- Meeting arranged for colleagues to visit ICC.
- Meeting arranged to review palliative and EoL data with ICB portfolio manager for EoL to identify improvement opportunities.
- Liaison with High Intensity Users team and CRIS team to encourage Care Home use of ICC number through their interactions with Care Homes when on site
- WMAS colleagues have been added to distribution for ICC daily, weekly and monthly data
- Commitment made by team for ICC to record frailty scores.

HALO Model

- Model commenced on 1st June.
- Recruitment for the remaining 0.5 WTE ongoing to facilitate the full model is ongoing.
- Feedback regarding mobilisation remains positive to time.
- Meetings remain in place bi-weekly to support mobilisation.

Reducing Ambulance Handover

- Continuation of system workstream and monitoring in place with Daily tracker monitored via SCC, escalations via System calls as required.
- Implementation of 24/7 HALO model progressing as per update above.
- Focus remains on recovery of performance in line with system plan.
- County hospital performance continues to maintain over 80%, with 87% of 45-minute performance for the month of June
- Operational challenges continue to remain prevalent including walk-in attendances, demand and acuity challenges.
- Investigation continues to be undertaken by NHSE/WMAS regarding erroneous data reporting of handovers.

Ward Process & Discharge

- Discharge Lounge development at both sites to support earlier in the day discharges continues – space identified at both locations. Deputy Chief Nurse & Der Director of Strategy leading capital bid. Task & Finish group taking forward. Capacity modelling analysis of key wards to establish right size ongoing, Test of Change planned.
- Co-design new standard work for LoS Meetings across the UHNM sites.
- Proposal has been developed for the creation of the Criteria Led Discharge project
- Assessment of outputs from audits undertaken across discharge pathways to support identification of additional learning opportunities for the discharge facilitator transfer work ongoing. To be adapted into action plans.
- D2A productivity workstream in place. External support for the Demand & Capacity review for the workstream & ECST supporting Clinical Pathway audit complete. Findings to be assessed & presented to shape action/improvement plans.
- System Ward support – embedding actions & learning from reporting. Assessment of outputs, actions & opportunities.
- Specific actions in relation to enhanced clinical information now in place to deliver improvement in communication and accuracy of information shared on Transfer of Care document.
- Virtual Ward workstream focus on maximisation of flow via utilisation of the WIS Board (electronic ward board), expected date of discharge and the creation of demand list
- HRD project coordination investment secured. Recruitment ongoing. Anticipate full mobilisation by Sept-25.

Front Door

- Conveyance audit completed. Workshop held with system partners on Friday June 20. Findings reviewed. Actions & outputs agreed. Actions to be prioritised by acute provider collaborative.
- Navigation & triage process revised and Test of Change underway.

Bed & Site Management

- SHREWD metrics review being undertaken to maximise SHREWD utilisation. Operational & clinical/nursing leads to review.
- Revised clinical operational flow policy amended/updated to ensure infrastructure reflects care group structure. Implementation underway.

- Test of Change taking place beginning 3rd July to support early moves out of ED using our existing policies.

UEC Transformation Programme

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

We have concluded the process to pull ED and Acute Medicine out of our Medical Division with an improvement leadership team reporting directly to our executive triumvirate to support specifically front door changes while more time is then given to our Unplanned Care Group to support ward improvement. This team have specific high impact deliverable; co-located UTC, front door process, front door flow and portal alignment for first 48 hours of care. There is a three month delivery period for this work seeing this Clinical Business Unit being integrated back into Unplanned Care Group at the end of September 2025.

Expected Impact

The trajectory has been set for the year through the annual planning. These trajectories are included in the integrated performance report and are taken through Quality, Access and Outcomes Committee. These are also shown on the SPC chart included in this pack.

Conclusion

This report notes the current performance for our UEC pathways which had been improving in line with trajectory, had then seen challenge for the first two weeks of June, but are now showing movement quickly back towards trajectories, we acknowledge is not the performance we want for our patients or population.

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

Key Recommendations

- *The Board is asked to receive the update RE UEC*
- *The Board is asked to note the actions being taken*

Highlight Report

EXECUTIVE RECOVERY OVERSIGHT GROUP | 23rd June 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• **Operational performance** for month 2 had slightly improved but overall performance remained challenged. In particular, ambulance handover times remained significantly above target and there were inconsistencies in weekly performance. The planning for 45 minute ambulance handovers was also not yet embedded and as such there was a risk of non-compliance with the national UEC plan • **WS1** highlighted challenges with planning permission delays with Stoke on Trent City Council which could impact on the build programme and operational timeline - this had been escalated to senior planners. In addition, the revenue model for the Urgent Treatment Centre (UTC) remained unresolved with a risk of underfunding • **WS5** highlighted ongoing challenges with medical engagement and support from Organisational Development had been identified	• **WS3** reviewing portals and entry routes prior to implementing any required changes • **Senior Responsible Officers** to be reallocated across all workstreams to ensure accountability and balanced workload • Deep dive into **ward closure schemes** and portals initiated to assess operational and financial impact

Positive Assurances to Provide	Decisions Made
• **WS1** focussing on reviewing ED staffing, visiting other Trusts to inform the front door streaming model, and the formation of stakeholder groups for Urgent Treatment Centre • **WS2** focussing on front door impact and identifying changes which could be taken forward without additional funding • **WS3** focussing on stakeholder engagement to prevent conveyances and improving access • Test of change undertaken within **WS4** following organisational restructure and feedback from care groups was to be gathered	• The group noted the agreement to prioritise **scheme developments for** NHS England by the deadline of 30th June

Comments on the Effectiveness of the Meeting
• Meeting structure to be further refined to provide clarity and efficiency. Strong engagement across divisions noted

No.	Agenda Item	Purpose	No.	Agenda Item	Purpose
1.	Terms of Reference	Information	4.	Month 1 Finance Performance	Information
2.	Month 1 Operational Performance	Information	5.	2025/26 CIP Update	Information
3.	UEC Recovery Workstream Updates • Workstream 1 (WS1) Front Door Processes • Workstream 2 (WS2) Frailty • Workstream 3 (WS3) Clinical Pathways • Workstream 4 (WS4) Bed & Site Management • Workstream 5 (WS5) Ward Process & Discharge	Information			

Executive Summary

Trust Board | 9th July 2025

Maternity and Neonatal PSIRF Investigation Report: Quarter 4

University Hospitals of North Midlands NHS Trust

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

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

Risk Register Mapping		
23361	Number of open adverse incidents and root cause analysis investigations	**High (8)**

Executive Summary

Situation

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

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

PMRT:
Standardised perinatal mortality review tool which supports high quality standardised perinatal reviews on the principle of 'review once, review well'.

The tool will be used to review the Maternity care, neonatal care and bereavement care for all families who have:

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

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

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

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

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

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

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

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

Background

Ockenden recommendations and CNST requirements state that trust boards and ICB's must have oversight of maternity serious incidents on a quarterly basis.

Assessment

In Quarter 4 there was 1 new incident reported that met the criteria for PSII

- January 2025 0
- February 2025 1
- March 2025 0

Category of Incidents:

- 0 PMRT (Potentially score C or above)
- 1 MNSI (also referred to ENS)

No of open maternity and neonatal Serious Incidents (under the former SI framework):	1
Investigation in progress:	0
Investigations completed/awaiting to be presented and closed by Risk Management Panel and ICB SI Group:	0
No of open maternity and neonatal PSIRF reviews:	
PMRT (Not reportable as PSII) PMRT (Reportable as PSII)	28 4
MNSI: In progress Final report received Actions plans developed and for approval through governance process	7 3 2 2
AAR	7
Thematic Review	1
Case Record Review	2

Duty of candour is performed with families for all eligible incidents and information given in an accessible format. Two final reports from MNSI have been received in Quarter 4 and action plans are being developed to meet safety recommendations.

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

Rationale
All incidents are reviewed weekly at the Obstetric and Neonatal risk meeting to identify any immediate learning or themes. A rapid review of care is completed for incidents that meet the national reporting criteria or are considered of moderate harm or above. *Incidents that meet the criteria for PMRT or MNSI will follow a robust review process and any immediate actions or local reviews will be implemented as a result of a rapid review or a PSIRF response review.*

Key Recommendations

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

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

Highlight Report

QUALITY GOVERNANCE COMMITTEE | 5th June 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate

- Whilst the metrics associated with 4 and 12 hour Urgent and Emergency Care (UEC) **performance**, ambulance handover times and cancer 28 day faster diagnostics were on trajectory for April, these remained below the actual target and as such partial assurance was agreed
- **Cancer performance** was being particularly impacted by colorectal, gynaecology, head and neck and urology specialties, with targeted actions being taken. In addition, **DM01 performance** continued to be below target due to challenges with non-obstetric ultrasound
- There continued to be a number of **long wait patients** waiting to be seen, particularly for gynaecology, ear, nose and throat and orthopaedic specialties
- 4 / 10 standards in relation to the **Infection Prevention Board Assurance Framework** remained outstanding. The Committee noted the actions being taken to address these areas, in particular an audit of blood culture delays, actions required to address bathroom facilities in the Trent building and introduction of an isolation risk assessment tool for side rooms, as such partial assurance was agreed
- **Cancer 104 day breach analysis** for Quarter 3 identified 94 patients who breached 104 days, 61 of which were referred by the GP beyond 104 days and 33 related to screening / consultant upgrades beyond 104 days. In addition, there remained issues in terms of clinical engagement on reviewing patients, although actions had been agreed with the multidisciplinary team with the aim of reviewing 50%. Partial assurance was therefore agreed
- **Medicines optimisation and safety** highlighted challenges with lack of medical representation at the safe medications group and this was to be addressed by a review of the Chief Medical Officer portfolio. In addition, the lack of medication safety officer was highlighted, and it was agreed to provide an update on addressing this risk at the next meeting. Themes were also emphasised regarding storage of medicines, in particular controlled drugs, as well as missed doses, although the introduction of an Electronic Prescribing and Medicines Administration (ePMA) system was expected to address the latter. Due to these issues, the Committee agreed with the partial assurance rating
- Two patient safety incidents were highlighted within the **maternity dashboard** in addition to two incidents of moderate harm and above.

Major Actions Commissioned / Work Underway

- Focussed audit included within the clinical audit programme, on consultant reviews (standard 8 of **7 day services**)
- Look back exercise to be undertaken in September including benchmarking, for the **Medical Examiner Service**
- Benchmarking for **organ donation** to be provided in future reports
- Assurance to be provided of the actions being taken to address the administration of **Patient Group Directions** and associated lack of infrastructure
- To expand on the narrative regarding Hospital Standardised Mortality Rate (HSMR) within the **Quality Account** in addition to providing clarification of the reason for not taking part in the national cardiac arrest audit
- To clarify the scoring used for neonatal and perinatal deaths, to better understand the performance highlighted within the **regional maternity heatmap**
- To provide the output of the regional review of reducing barriers for **pregnant women** for whom English is not their first language
- To provide assurance in respect of the actions being taken to implement the new NICE guidance in relation to **falls**

Positive Assurances to Provide

- The Committee received an overview of the **constitutional targets** for elective and non-elective care and the associated success measures to be monitored during 2025/26
- An update on **7 day services** highlighted the achievement of the standards with particular improvements in timeliness of review. Challenges in terms of weekend inpatient reviews were highlighted and issues in the ability to audit the standards due to the lack of an Electronic Patient Record (EPR) was noted. Whilst it was recognised that an audit of standard 8 remained outstanding, the Committee agreed with a rating of acceptable assurance
- Significant assurance was provided by the **medical examiner** update, whereby the Committee noted the positive reputation of the service in terms of consistently meeting or exceeding national guidance and the provision of a 7 day service. Actions were also being taken with the ICB on education within primary care, of the importance of effective and timely administration of deaths
- Significant assurance was provided by the **organ and eye/tissue donation** update whereby 2025 was the best year for organ donations, with 42 consented donations leading to 95 people receiving transplants. In addition, 116 corneas were received by NHS Blood and Transplant eye banks from UHNM.
- The **Care Quality Commission (CQC) action plan** was closed due to the outstanding actions moving to business as usual, and acceptable assurance was provided. It was agreed that the learning points from recent reports would be provided to the Committee in 6 months
- The **maternity dashboard** highlighted that the number of midwife vacances at the end of March were 11.5 WTE, and the Trust had received applications from 450 applicants for newly qualified midwives. The Committee concluded with a rating of acceptable assurance
- Acceptable assurance was provided for the **Maternity and Neonatal Patient Safety Incident Framework (PSIRF) Investigation Report** whereby one patient safety incident was referred to the Maternity and Newborn Safety Investigation (MNSI) in quarter. An update was also provided on the number of open reviews being investigated and the learning which had subsequently been identified
- The **maternity and neonatal workforce** report highlighted the ongoing actions being taken to address the findings from the Birthrate Plus ® review and acceptable assurance was provided. The Committee particularly welcomed the recruitment and retention data
- The Committee welcomed the improvement in external representation at **Perinatal Mortality Reviews** following focussed work with another NHS provider
- Four **ICB Quality Assurance Visits** had been undertaken for Royal Stoke and County Hospital. These identified that long waits were the biggest challenge, in addition to escalation of corridor care and the impact on patient experience. It was noted that future assurance visits were being planned for other areas of the Trust

Decisions Made

- The Committee approved the draft **Quality Account** pending inclusion of final stakeholder comments and updates as requested

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Members welcomed the conversation and inclusion of access	• None identified

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Operational Performance Standards / Access Performance Report Month 1 25/26	4	Ext 20	Partial	Assurance	11.	Quality Account 2024/25	1	Ext 16	Not applicable	Approval
2.	Executive Recovery Oversight Group Highlight Report (19-05-25)	4	Ext 20	Not rated	Assurance	12.	Maternity & Neonatal Quality & Safety Oversight Group Assurance Report (12-05-25)	1	Ext 16	Not rated	Assurance
3.	7 Day Service Assurance Report	1	Ext 16	Acceptable	Assurance	13.	Maternity Dashboard: Q4 2024/25 / March 2025	1	Ext 16	Acceptable	Assurance
4.	Quality & Safety Oversight Group Highlight Report (22-05-25)	1	Ext 16	Not rated	Assurance	14.	Maternity & Neonatal PSIRF Investigation Report • MNSI Referrals	1	Ext 16	Acceptable	Assurance
5.	Infection Prevention Board Assurance Framework	1	Ext 16	Partial	Assurance	15.	Maternity & Neonatal Workforce Report Q3/Q4 2024/25	1	Ext 16	Acceptable	Assurance
6.	Cancer 104+ Day Breach Analysis Q3 2024/25	1, 4	16 / 20	Partial	Assurance	16.	Maternity Single Delivery Plan Q4 24/25	1	Ext 16	Acceptable	Information
7.	Medical Examiner Service Update	1	Ext 16	Significant	Assurance	17.	Saving Babies Lives Care Bundle V3	1	Ext 16	Significant	Information
8.	Organ and Eye/Tissue Donation Update	-		Significant	Assurance	18.	Perinatal Mortality Report Tool Q4 2024/25	1	Ext 16	Significant	Information
9.	Medicines Optimisation and Safety Report Q4 2024-25	1	ID 35039	Partial	Assurance	19.	Criteria for Employing Short-term / Long-term Locum Doctors in Obstetrics & Gynaecology			Not applicable	Information
10.	CQC Action Plan Update	1	ID 15788 ID 23842 ID 24028 ID 25682 ID 9738	Acceptable	Assurance	20.	Quality Performance Report – Month 1 2025/26 • Nuclear Medicine IR(ME)R Inspection Report • ICB Quality Assurance Visit Reports	1	Ext 16	Not applicable	Information

University Hospitals of North Midlands NHS Trust

Integrated Performance Report

Month 02 Performance

2025/26

Kind Excellent Together

Data Quality & Statistical Process Control

University Hospitals of North Midlands NHS Trust

Data Quality Assurance Indicators (DQAI) are used in this report to help give context and assurance as to the reliability and quality of the data being used. The STAR Indicator provides assurance around the processes used to provide the data for the metrics reported on. The four Data Quality domains are each assessed and assurance levels for each are indicated by RAG status.

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.

Explaining Each Domain:

Domain		Assurance Sought
S	Sign Off and Validation	Is there a named accountable executive, who can sign off the data as a true reflection of the activity? Has the data been checked for validity and consistency with executive officer oversight?
T	Timely & Complete	Is the data available and up to date at the time of submission or publication? Are all the elements of required information present in the designated data source and no elements need to be changed at a later date?
A	Audit & Accuracy	Are there processes in place for either external or internal audits of the data and how often do these occur (annual / one off)? Are accuracy checks built into collection and reporting processes?
R	Robust Systems & Data Capture	Are there robust systems which have been documented according to data dictionary standards for data capture such that it is at a sufficient granular level?

Sign Off & Validation

Timely & Complete

Audit & Accuracy

Robust Systems & Data Capture

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RAG Rating Key:

	Good level of assurance for the domain
	Reasonable Assurance with an action plan to move into Good
	Limited or No Assurance for the domain with an action plan to move into Good

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

Kind Excellent Together

Assurance Grid

University Hospitals of North Midlands NHS Trust

Failing

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

VARIATION	ASSURANCE: Pass	Hit and Miss	Fail	No Target
Special Cause - Improvement	Maternity Triage Sepsis - Adult Inpatient IVAB UEC 4 Hour Performance		RTT Performance - <18 Weeks RTT >52 Weeks %	
Common Cause	Induction of Labour Sickness Absence (R12M)	Patient Safety Incidents rate per 1000 bed days Patient Safety Incidents with moderate harm and above per 1000 bed days Patient falls with harm per 1000 bed days Medication Incidents per 1000 bed days Medication Incidents % with moderate harm or above Patient Safety Incident Investigation (PSII's) instigated Never Events per month Pressure ulcers developed under UHNM per 1000 bed days Family & Friends Test - Inpatient Family & Friends Test - Maternity Sepsis - Adult Inpatient Screening Sepsis - ED Portals Screening Sepsis - ED Portals IVAB Sepsis - Childrens Screening Sepsis - Maternity Screening Staff Vacancy Rate Cancer 31 Day Combined	Family & Friends Test - ED Single Sex Breaches Appraisal (PDR) Employee Engagement Cancer 28 Day FDS Cancer 62 Day Combined	
Special Cause - Concern	RTT - Time to First Seen %	Staff Turnover (R12M) Agency Utilisation Over 12 hours in ED	Diagnostics DM01 Performance	

Worsening

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Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Nurse and Chief Medical Officer

How are we doing against our trajectories and expected standards?

We continue to see continual improvements across a range of metrics and the NMAHP workforce remains stable.

We have met the required targets across a range of metrics including induction of labour, MW triage, falls per 1000 bed days, medication incidents with moderate harm or above, duty of candour verbal, pressure ulcers with lapses in care, avoidable MRSA bacteraemia, c-diff, e-coli, FFT inpatients, timely sepsis screening and IVAB across most areas, hospital acquired thrombosis. FFT inpatients.

We failed to meet the required target for DOC written, falls with harm, pressure ulcers developed at UHNM, VTE assessments, single sex accommodation breaches (all in critical care), FFT in ED and maternity, and HSMR. There are no new never events to report.

Given the recent improved CQC ratings, and the improving quality performance, I would suggest we discuss and agree a move from limited to reasonable assurance.

What is driving this?

Single sex breaches were all in critical care and caused by an inability to transfer patients to wards due to capacity constraints. There are no reported concerns re privacy and dignity for any of these breaches. Potential coding issues impacting on HSMR performance has been discussed previously at the Committee.

There has been continued poor performance in relation to VTE assessments due to poor recording of date and time of the assessment; however incidences of HAT are below target in month.

Quality& Access | Overview

University Hospitals of North Midlands

Overview from the Chief Nurse and Chief Medical Officer

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

Our work continues with all services across the Trust in our education and implementation of the National PSIRF methodologies and principles for incident responses and learning.

Intensive and specific corporate support to Bronze CEF wards continues and is proving impactful. A review of CEF is planned to scope the potential to broaden the assessment process across the MDT and therefore areas are assessed as a whole team.

Engagement sessions are planned with nursing leadership teams to determine which administrative processes do not add value to patients or colleagues with a view to us removing any we can.

Call for Concern (Martha's Rule) has now been implemented across RSUH. We are working to co-design our solution to component 3 (daily feedback from patients/families/carers) Designed with Patient involvement and Digital Support for ease for staff.

EPMA project continues –we are awaiting confirmation regarding a potential launch of the pilot at County.

Focused project work commenced for our Non-Medical Prescribers database and maturity matrix, Work ongoing in ensuring this is robust.

What can we expect in future reports?

We are working with Wigan Hospital Trust to enhance our awareness and approach to addressing Poor Behaviours within our EDI work and share an approach to our anti-racism work.

We are focusing on a thematic review around patients who abscond from ED to source learning and further understanding.

The CN is SRO to develop a regional nursing and midwifery excellence accreditation framework. The task and finish group is formed and have started meeting with the regional team. We will share more information with the committee as that work progresses.

CQC reviewed our Nuclear Medicine Department, an action plan has been submitted and accepted, relevant letters attached in committee papers.

Quality & Access | Dashboard

University Hospitals of North Midlands NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance	NHS Oversight Framework	Undertakings	2024/25 Priorities	R12M Trend
Induction of Labour	95.0%	99.0%	100.0%						
Maternity Triage	85.0%	94.0%	100.0%						
Patient Safety Incidents rate per 1000 bed days	50.7	49.7	48.0						
Patient Safety Incidents with moderate harm and above per 1000 bed days	0.6	0.9	0.8						
Patient falls with harm per 1000 bed days	1.5	1.4	1.6						
Medication Incidents per 1000 bed days	6.0	5.8	4.9						
Medication Incidents % with moderate harm or above	0.50%	3.00%	1.00%						
Patient Safety Incident Investigation (PSII's) instigated	0.0	0.0	2.0						
Never Events per month	0.0	0.0	0.0						
Pressure ulcers developed under UHNM per 1000 bed days	1.6	1.7	1.9						
Family & Friends Test - Inpatient	95.0%	97.0%	95.8%						
Family & Friends Test - ED	85.0%	70.0%	73.7%						
Family & Friends Test - Maternity	95.0%	94.0%	89.0%						
Sepsis - Adult Inpatient Screening	90.0%	98.0%	98.0%						
Sepsis - Adult Inpatient IVAB	90.0%	100.0%	100.0%						
Sepsis - ED Portals Screening	90.0%	90.0%	88.0%						
Sepsis - ED Portals IVAB	90.0%	78.0%	90.0%						
Sepsis - Childrens Screening	90.0%	96.0%	95.0%						
Sepsis - Childrens IVAB	90.0%	#N/A	100.0%						
Sepsis - Maternity Screening	90.0%	100.0%	100.0%						
Sepsis - Maternity IVAB	90.0%	100.0%	100.0%						

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

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

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

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

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

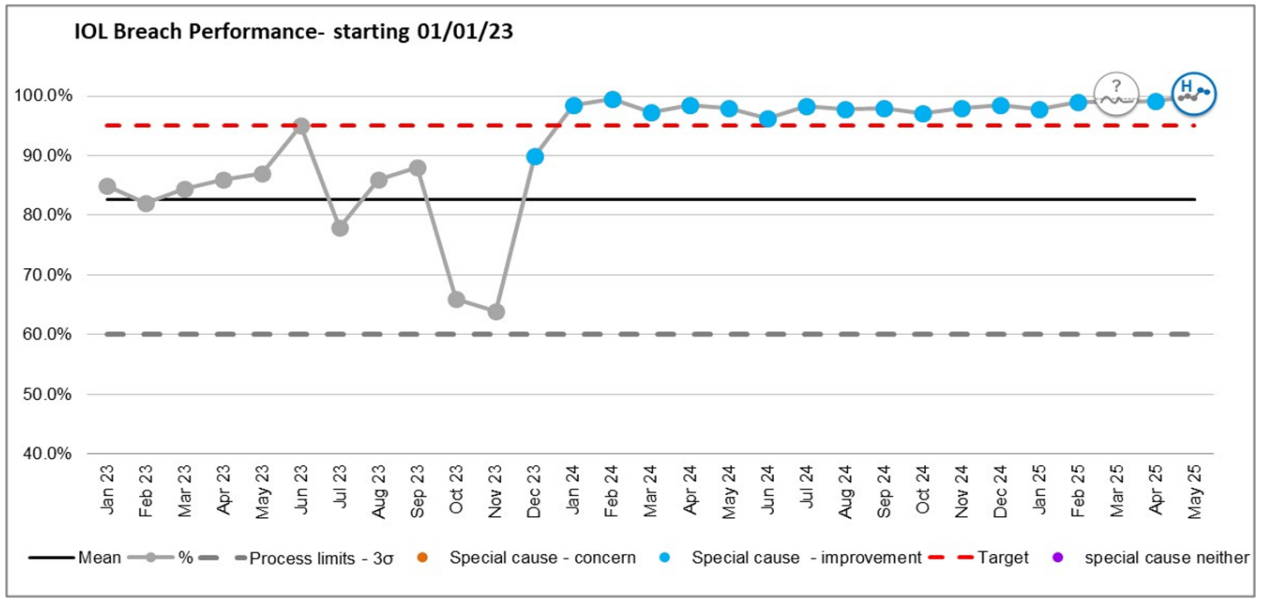
Related Strategy and Board Assurance Framework (BAF)

Quality Strategy

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 1: Delivering Positive Patient Outcomes							High 12	Acceptable

Quality & Access | [Induction of Labour]

University Hospitals of North Midlands NHS Trust



What is the data telling us?

The target of 95% for timely admission of women for induction of labour has been consistently achieved since January 2024.

Core IOL midwifery workforce provides consistency within the department to ensure on going timely admissions.

Collaborative input with the Consultant Obstetricians to ensure the workload is organised and prioritised appropriately.

Ongoing IOL improvement group highlights any process changes that are required to ensure timely admissions.

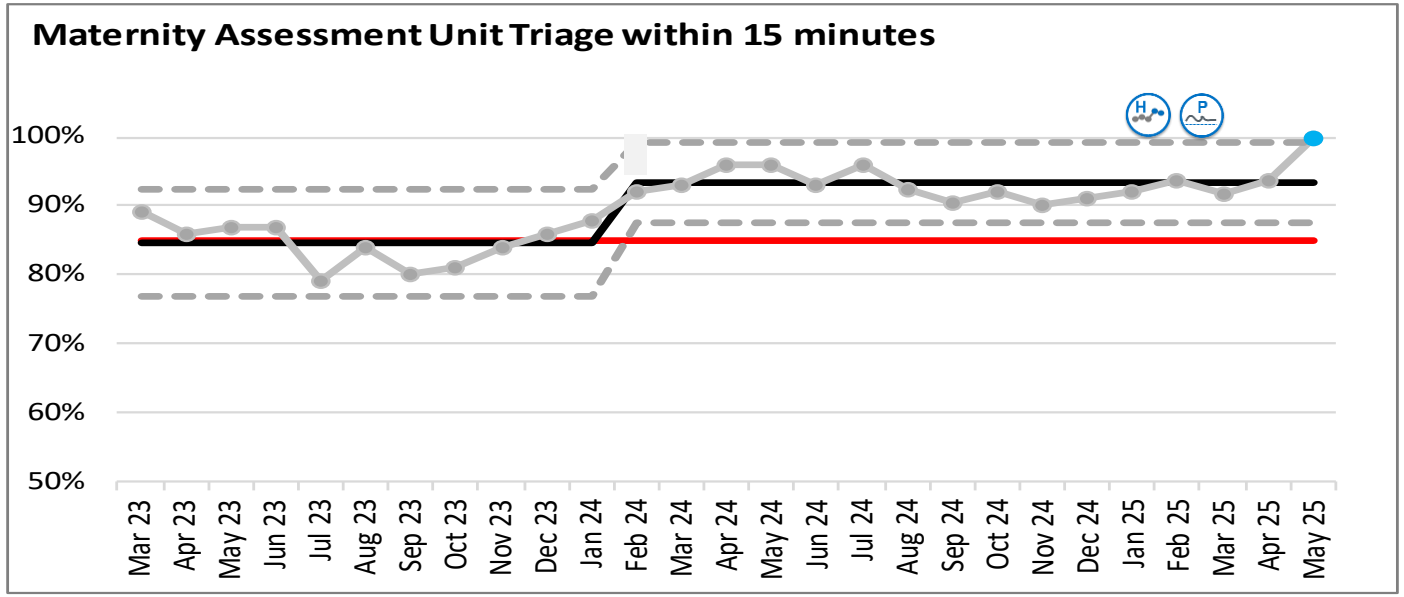
Consultant lead for IOL supports multi disciplinary working.

What are we doing about it?

Any IOL breaches are safety netted and incident reported for full review through the internal governance process.
IOL Datix are grouped into an IOL Improvement group tab, allowing a refined audit & review with focus on IOL themes.
Any IOL breaches are discussed daily at the patient safety huddle and escalated.
Any IOL breaches will have a well being appointment with a medical review and if necessary admitted for observation (admission will be offered prior to breaching when this is forecast)
Prioritisation occurs daily by the on call Consultant Obstetrician for all IOL's booked for that day- this will include any deferred IOL.
All midwifery induction core vacancies now recruited. Additional recruited trained midwives will commence post in the unit from October sustaining progress made and keeping timely flow during the IOL process.
Dilapan , mechanical IOL method introduced since May 2024. When accepted as an IOL method it gives certainty of cervical changes aiding planning and flow in the unit along with patient satisfaction.

Quality & Access | [Maternity Triage]

University Hospitals of North Midlands NHS Trust



What is the data telling us?

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

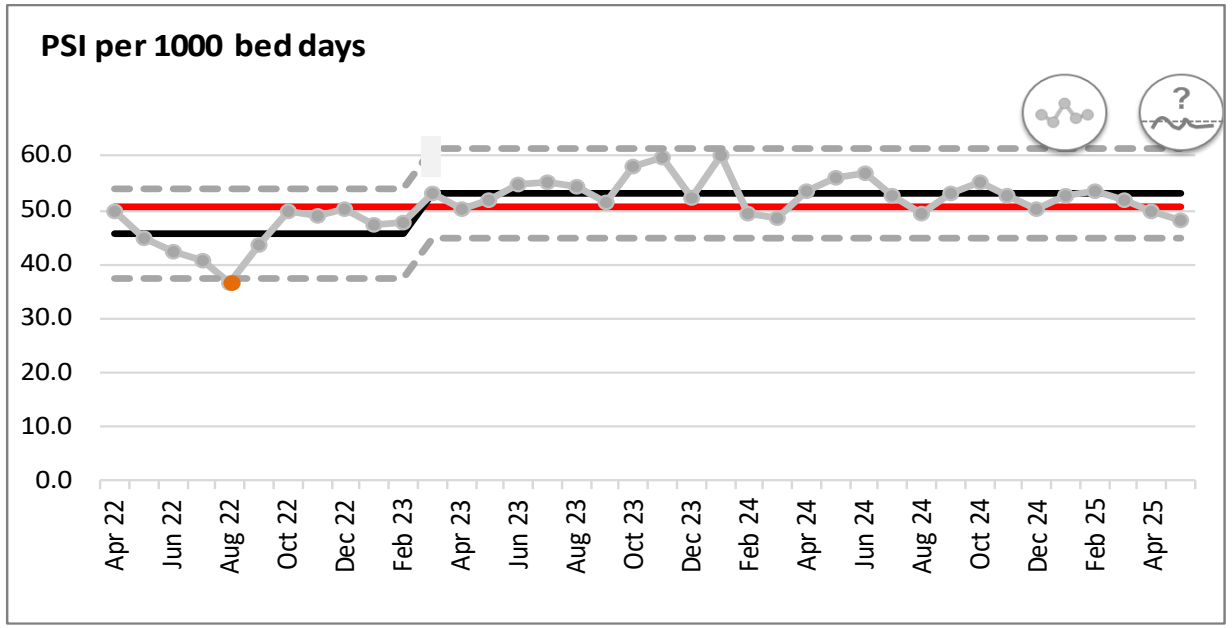
The development of the MAU improvement group in December 2023 and implementation of actions have contributed to the improvement and sustained reduction in MAU breaches

What are we doing about it?

The MAU improvement group meet monthly to continue to discuss and sustain the driver metrics.
All MAU timing breaches are reviewed daily via audit and Datix are submitted if there is evidence of potential harm so that individual cases can be investigated.
MAU triage breaches are included in daily patient safety huddle and reported via the daily sitrep
This metric has met the Improving Together parameters to move from a driver to a watch metric. The A3 will be refreshed to focus on sustainability of current performance. The watch metric will be reviewed at the Executive Performance Review Meeting with the Division.
MSW and ward clerk staff are now fully recruited which aids flow through the department sustaining our improvement.

Quality & Access | [PSIs per 1000bed days]

University Hospitals of North Midlands NHS Trust



What is the data telling us?

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

At present, there are no notable fluctuations in reporting rates, with the average slightly surpassing the previously documented NRLS average for Acute Trusts (the new national LFPSE data release is expected soon).

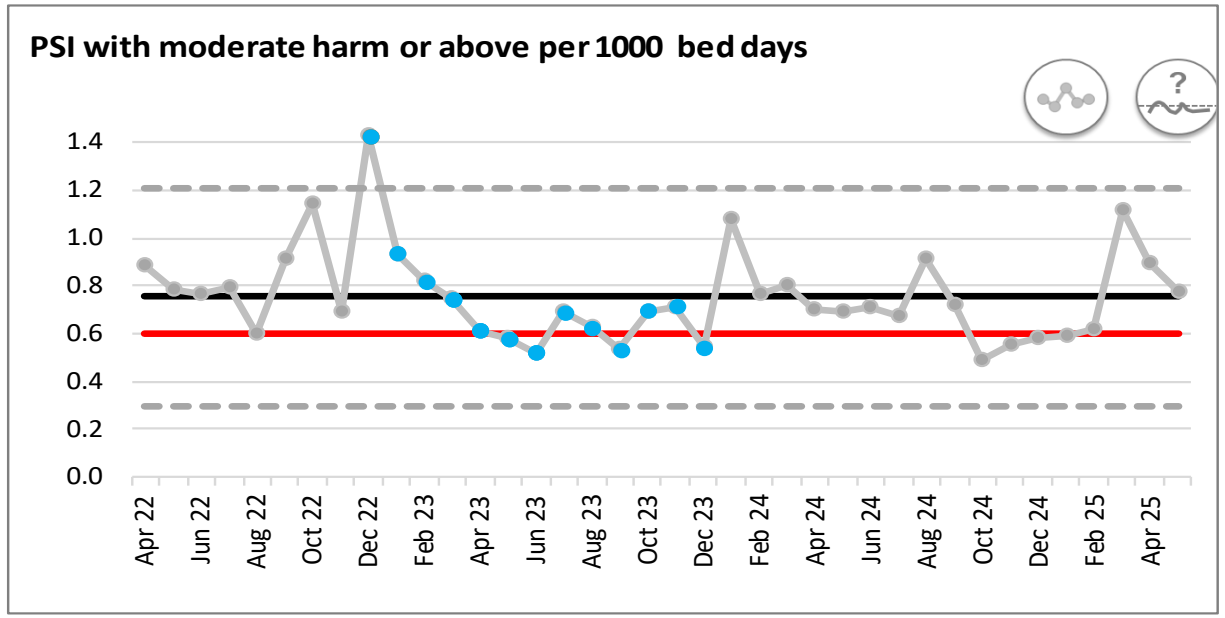
What are we doing about it?

Will continue to monitor the internal reporting rates and identify if there are any specific reasons for reduced rate per 1000 bed days.

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 | [PSIs moderate harm & above per 1000 bed days]

University Hospitals of North Midlands NHS Trust



What is the data telling us?

The rate of PSIs reported as resulting in moderate harm or greater has remained within a consistent range since Dec-23.

Further interrogation of the data does not identify any unusually high numbers of incidents in any Division, Directorate, Category, Subcategory or level of harm. The most common Categories were Treatment/procedure, Medication, Clinical assessment and Accident / Incident, all of which are often among the most prevalent.

What are we doing about it?

Reviewing harm profile and locations / categories for moderate harm and above incidents.

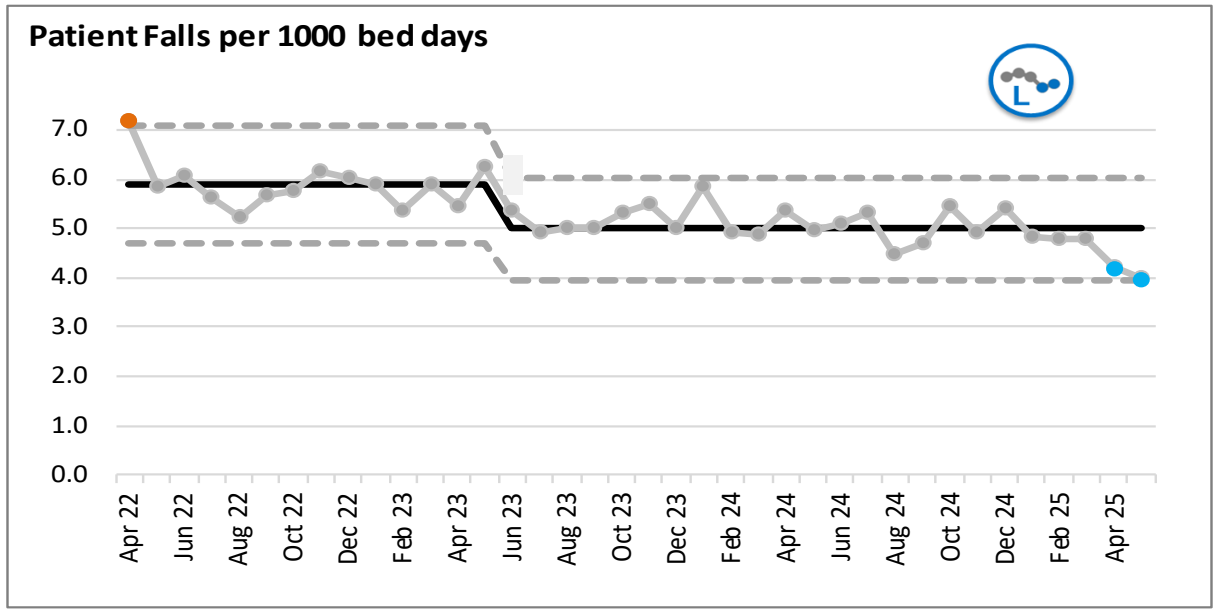
To support PSIRF principles we are reviewing learning and proportionate responses to incident reviews templates.

We are completing thematic reviews to ensure wider learning is captured and actions to improve the quality and safety of care delivered are in place.

We are working closely with our Patient Safety Partners and Communications Team to develop new approaches to share patient stories and support further learning and actions to improve the quality and safety of care delivered are in place.

Quality & Access | [Patient Falls per 1000 bed days]

University Hospitals of North Midlands NHS Trust



What is the data telling us?

The average rate of reported patient falls per 1000 bed days was significantly lower than average in April & May 2025. Divisional rates do not show any significant changes, but significantly lower numbers have been reported within the Trauma Directorate in April & May.

The areas reporting the highest numbers of falls in May 2025 were:
Royal Stoke AMU – 15 falls, Royal Stoke ED – 10 falls, Ward 1 – 10 falls
Some of these areas are often among the top reporters, but only Ward 1 reported borderline significant numbers of falls in May, compared to previous months.

What are we doing about it?

From the 35 falls across the 3 areas there was 1 injury reported on AMU.

ECC and AMU have a high turnover of patients. These patients are acutely unwell and often have low blood pressure due to sepsis and delirium due to infection.

The Q&S team visit the areas weekly to discuss falls and improvement requirements.

We are discussing to ask if it is feasible for the 4AT assessment on the Admission Care Pathway to become mandatory.

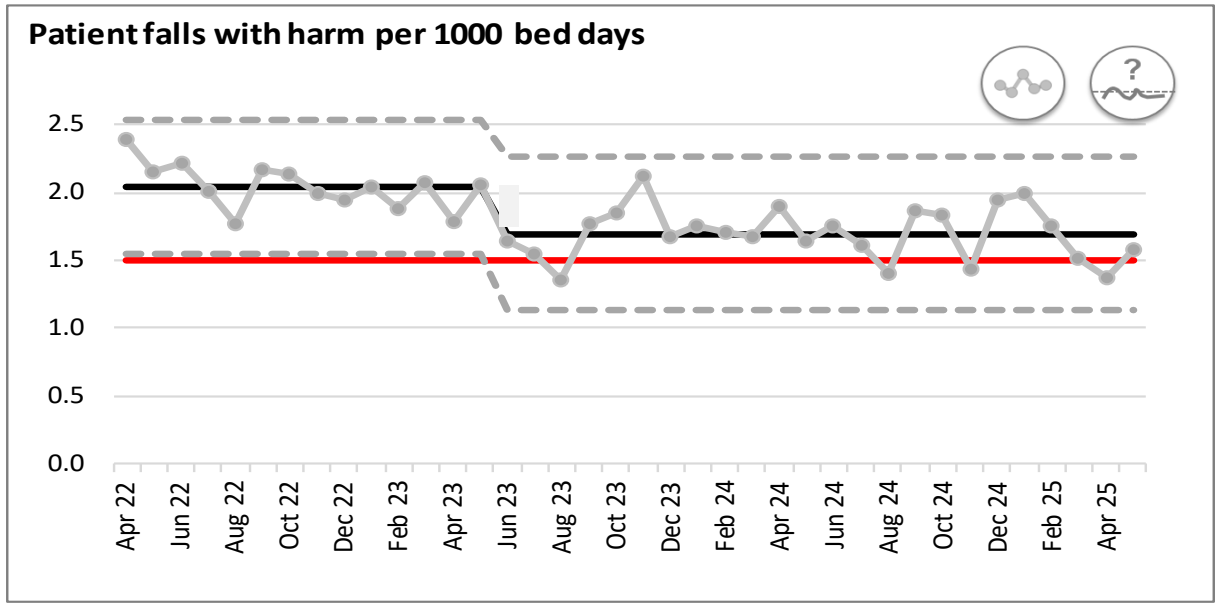
Recording lying and standing blood pressures have improved; however overall compliance is poor. Q&S audits confirm this. We are working across the trust to improve compliance.

It has been discussed if the harm free educators can support ECC and AMU.

Ward 1 had a falls audit completed in May showing there was compliance in many areas. The 2 actions were to fully complete the MFRA and to record a lying and standing blood pressure. They also had a patient that was a multiple faller.

Quality & Access | [Patient Falls with harm per 1000 bed days]

University Hospitals of North Midlands NHS Trust



What is the data telling us?

The incidence of patient falls resulting in harm has remained consistent since June 2023, falling within the usual range in May 2025.

The wards reporting falls resulting in serious injuries in May were: Royal Stoke AMU, Coronary Care Unit, Ward 109, Ward 201, Ward 223.

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 in the box next to this text.

What are we doing about it?

Information on those patients that have suffered an injury from a fall has been collected from May. There has been 6 falls since the process began. 5 of the falls have been unwitnessed. The Q&S team are asking the area's if the wards can place tables in the bays and for the staff to remain in the bays.

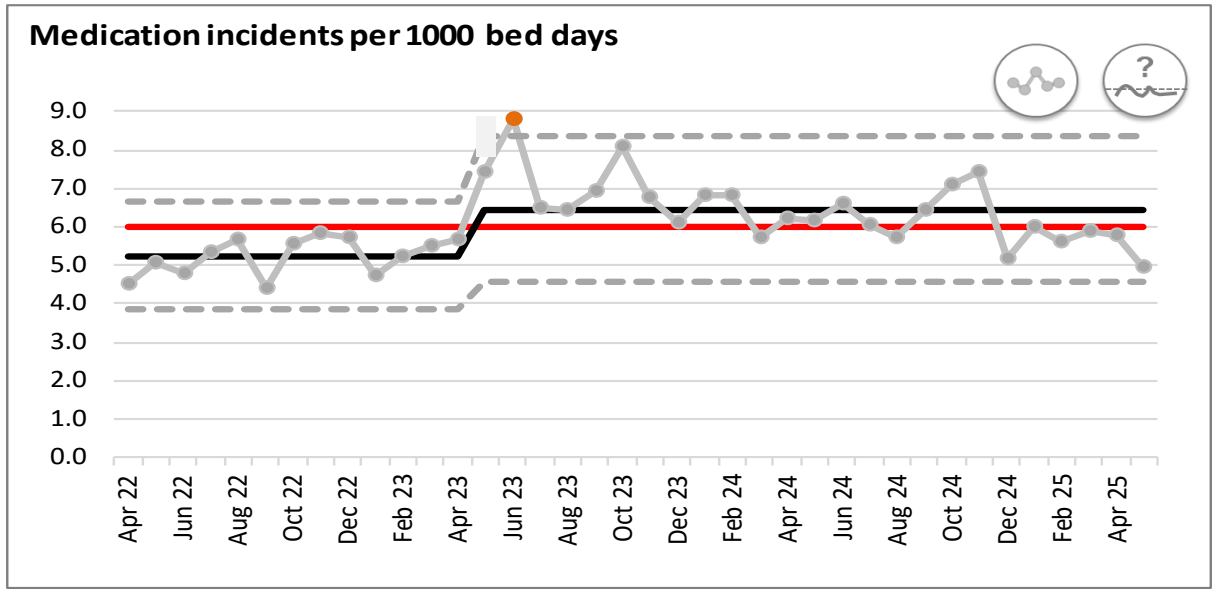
Falls champion training has been delivered.

PSIRF toolkits were completed for the 5 serious injuries. Two of the patients were on telemetry and staff reported patients had syncope's. Two patients had fallen in the early hours of the morning; however, they could mobilise independently. The 5th patient had not pressed the call bell to ask for assistance. Most of the learning and actions discussed were from steps that were not taken post fall.

Awaiting confirmation that the bed rail training can be placed back on to ESR.

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

University Hospitals of North Midlands NHS Trust



What is the data telling us?

The rate of reported medication-related incidents remains within the usual range; nonetheless, recent months show a declining trend, although this shift is not statistically significant.

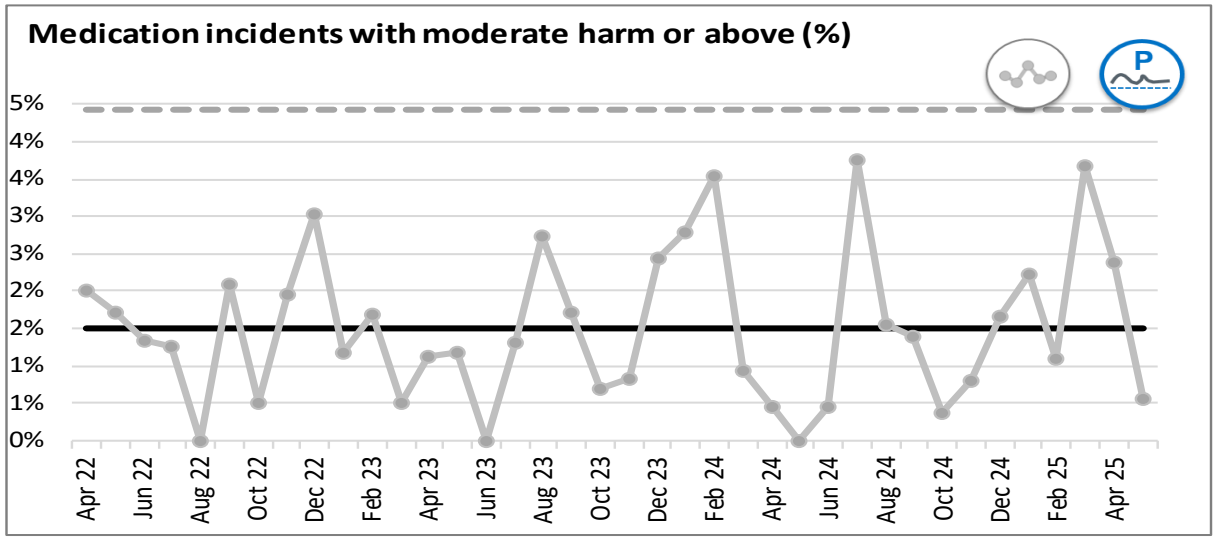
What are we doing about it?

Controlled Drug audit and Theatres Controlled Drug audit reports completed – requires improvement as per escalation at the end of 2024. All areas issues with own self-assessment tools to support improving key patient safety and CD governance themes e.g. evidence of witness signatures for administration and waste late 2024. Next round of audits under way.
On-going supports and leadership provided regarding suspicious losses of Codeine phosphate 30mg tablets. Guideline &SBAR tool produced to collate learning from this on-going theme, ensure prompt escalation, staff wellbeing and the right teams are involved.
Improving missed doses of time critical medicines on admission:
Insulin Safety Group drafting SOP for self-administration of insulin pilot. Phase 1 will be on the diabetes wards.
Peri-operative insulin pump guidance approved for use – awaiting addition to the guidelines. Has been shared in the meantime.
Working with ED to review of missed doses of time critical medicines & proposal for a self-administration pilot in ED for a specific patient group yet to be confirmed (e.g. Parkinsons).
Missed doses audit data collection completed, await report & review of missed doses incidents completed for 24/25 financial year – themed review to follow.

- Combination products are also a factor e.g. co-codamol.
- Trust Learning Alert produced and shared across the Trust on key actions and support to staff

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

University Hospitals of North Midlands NHS Trust



What is the data telling us?

In May 2025, one incident was reported that resulted in moderate harm, which falls within usual monthly variation and remains consistently below the benchmark rate, offering positive reassurance that this standard is being met.

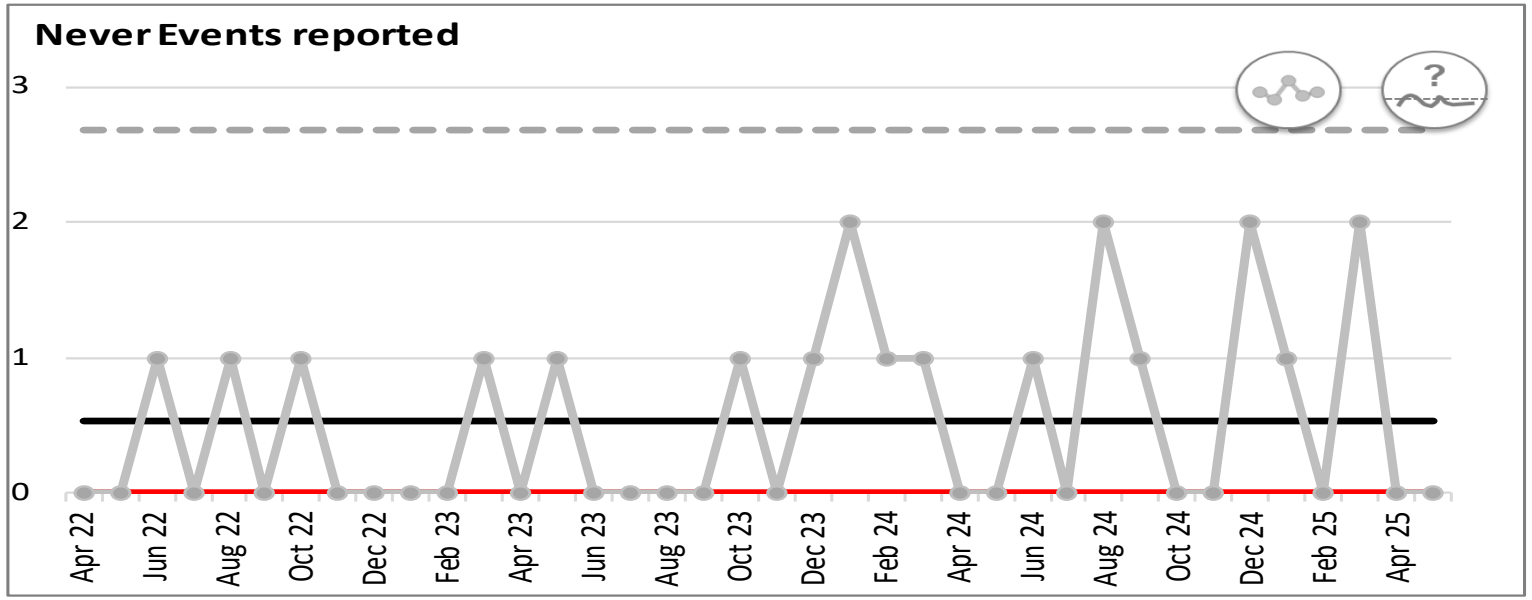
What are we doing about it?

The reported incidents are reviewed and assessed via the Pharmacy Safe Medications Team along with input from the relevant clinical areas to share learning and actions.

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

Quality & Access | [Never Events per month]

University Hospitals of North Midlands NHS Trust



What is the data telling us?

There has been 0 reported Never Events during May 2025.

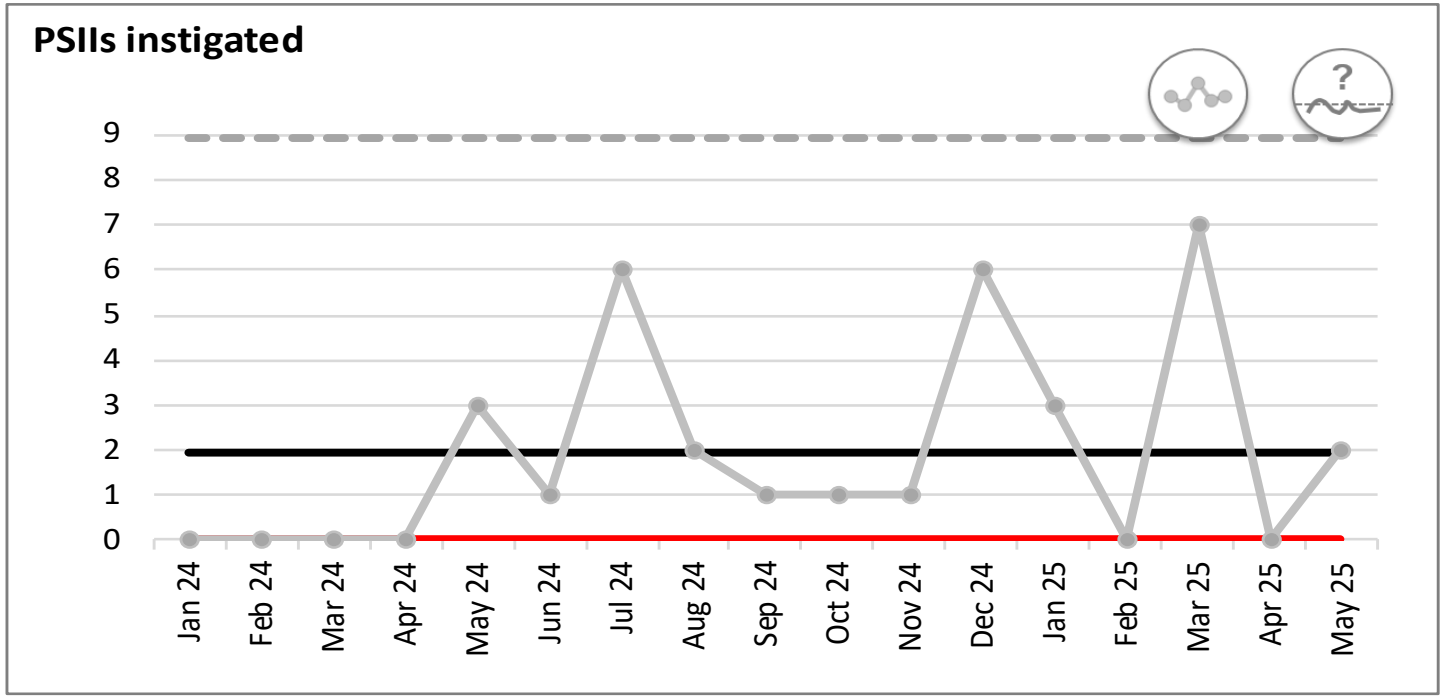
What are we doing about it?

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

Assurances and updates on actions and sustainability of the actions are provided to RMP prior to agreeing closure. The overarching action plan following the Wrong Site Surgery / incorrect lesion removal was approved at RMP in March 2025.

Quality & Access | [PSIIs per month]

University Hospitals of North Midlands NHS Trust



What is the data telling us?

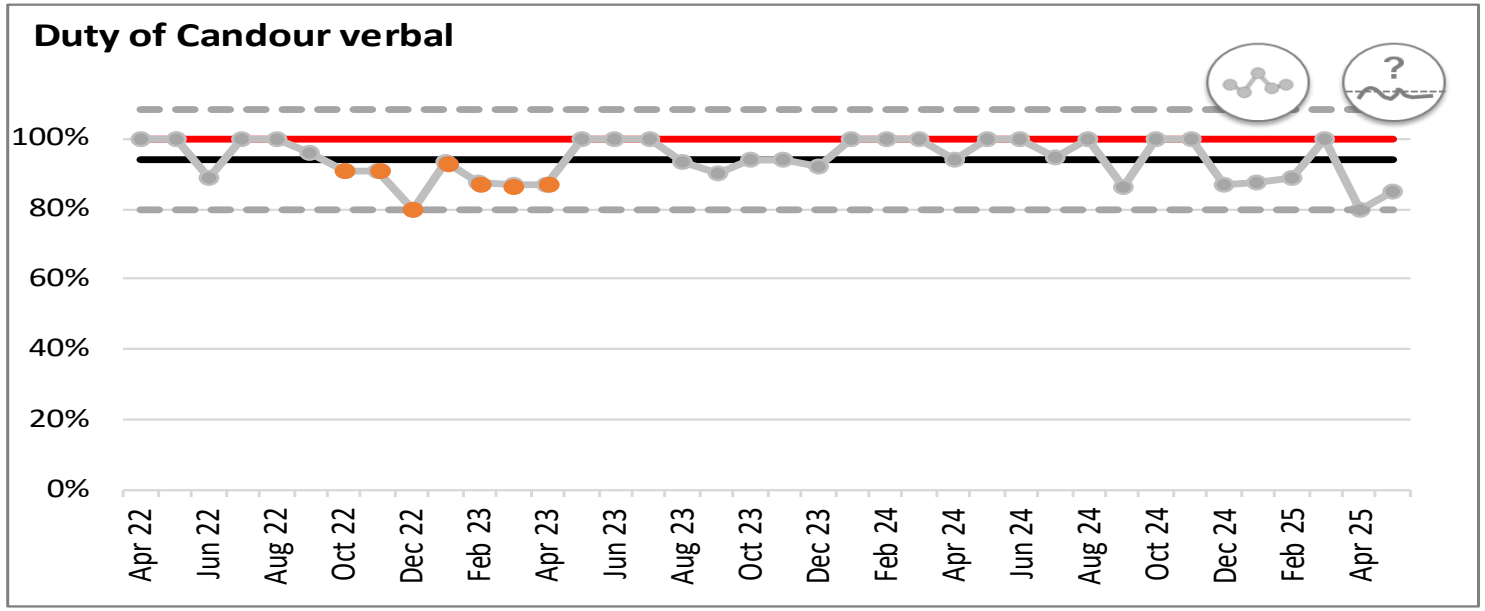
We have reported 2 new PSIIs being undertaken during May 2025.

What are we doing about it?

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

Quality & Access | [Duty of Candour – verbal/formal notification]

University Hospitals of North Midlands NHS Trust



What is the data telling us?

The implementation of the verbal Duty of Candour has not been consistently reflected in the Datix records.

In May 2025, there were 24 instances that formally activated the Duty of Candour

What are we doing about it?

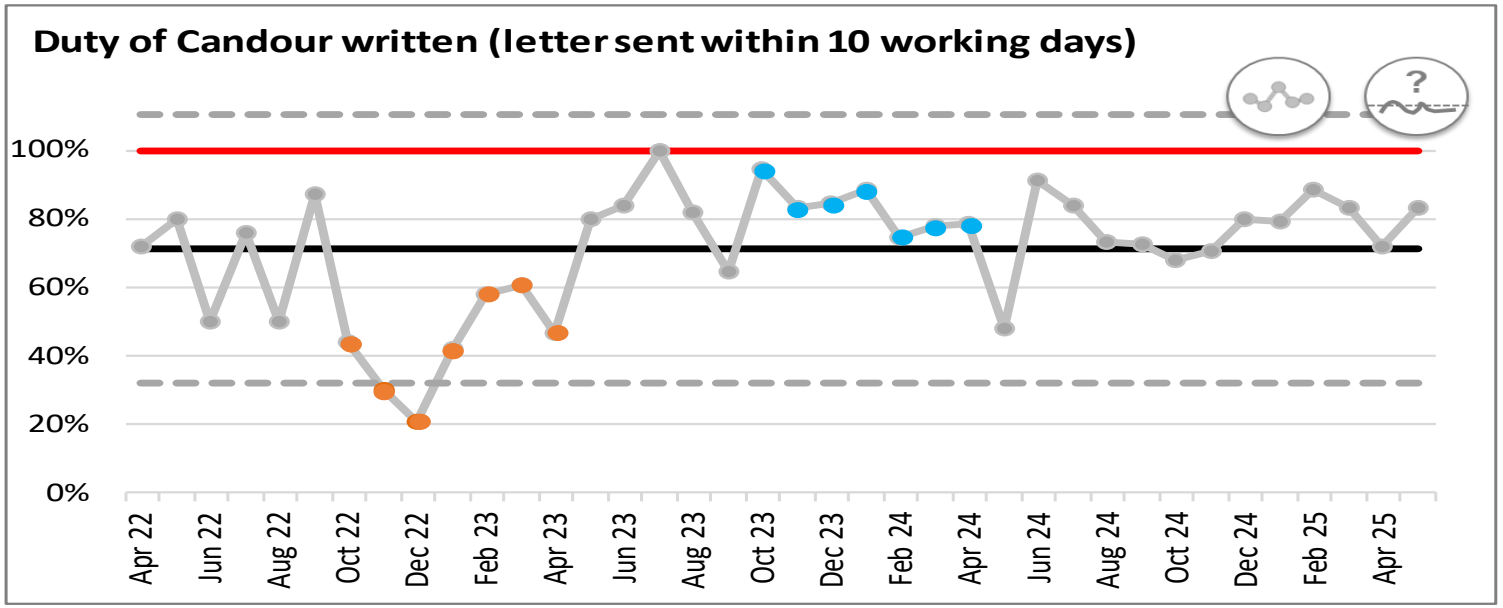
We are continuing to work with individual areas and with Divisional Teams to continue to raise the importance of undertaking Duty of Candour and being open with patients and their relatives when things go wrong.

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

We are monitoring compliance to ensure actions taken continue to be effective in maintaining timely compliance with duty of candour completion.

Quality & Access | [Duty of Candour – written notification]

University Hospitals of North Midlands NHS Trust



What is the data telling us?

Although we have yet to reach the goal of providing 100% of Duty of Candour letters to patients and/or their relatives within 10 working days of identifying an incident, there has been a noticeable improvement in performance during recent months, which exceeds the long-term average rate.

It is important to highlight that while some cases are logged as exceeding the 10-working day target, they do complete the process and ultimately provide written notifications to the patients and/or their relatives.

Out of 24 cases, 4 did not meet the 10-working day target; Nevertheless, all cases have successfully issued written notifications, albeit beyond the 10-working day timeframe.

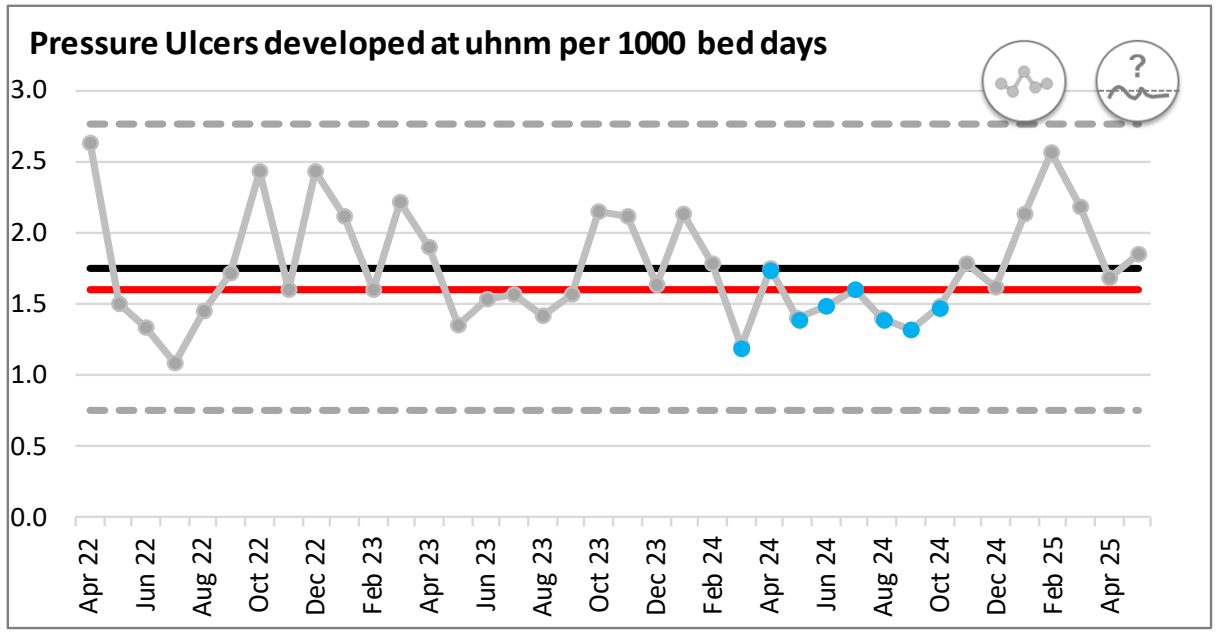
What are we doing about it?

Divisions are reviewing the cases of noncompliance and following up with respective areas to work on improving the timely completion and evidencing that letters have been sent out.

We continue to work with and support al the clinical teams in completing the written Duty of Candour notification letters.

Quality & Access | [Pressure ulcers developed at UHNM per 1000 bed days]

University Hospitals of North Midlands NHS Trust



What is the data telling us?

The rate of pressure ulcers reported as developing under UHNM care was within the usual range in May 2025.

Each specific category of pressure damage were also within normal limits.

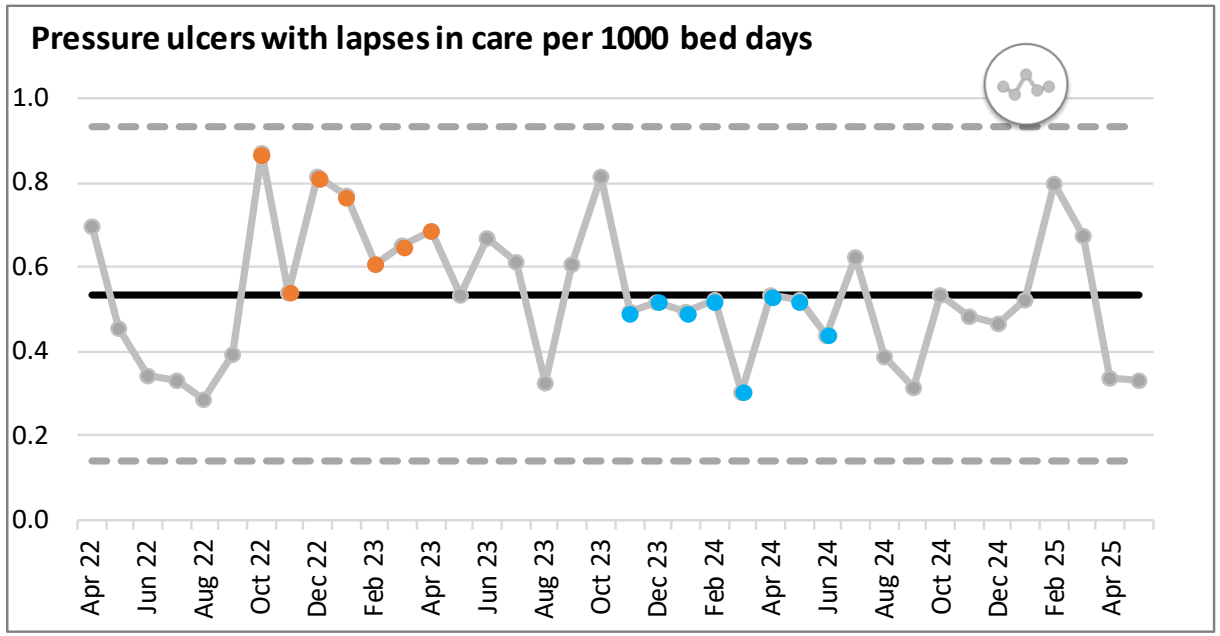
In May 2025, there were 8 reported cases of urethral splits, of which 3 were noted to have lapses in care, with one lapse pending confirmation. This number falls within the normal range.

What are we doing about it?

ESR package to be completed and sent to Statutory and Mandatory Training group.
Prompt cards are being printed which will include supporting pressure prevention, categorisation, and appropriate pathways
Skin Health booklet now available to order. Video will be created to support staff with completing the booklet.
The electronic wound assessment has been approved, just waiting for a go live date.
Consultant Connect trial completed. Looking at an imaging app that links to the PAC system and I-Portal to roll out wider.
New chairs have been delivered to ED Stoke. New surfaces delivery date to be arranged
Changes to ED documentation going to governance meeting to improve documentation including assessments, surface, and categorisation
Next champions programme day will be in June.
Positive conversations taken place for the MDT meeting of the HA category 4. To look at changing the focus to gain staff engagement
Harm free educators delivering educators within the departments.

Quality & Access| [Pressure ulcers with lapses in care per 1000 bed days]

University Hospitals of North Midlands NHS Trust



Type of Lapses - May 2025	Total
Management of repositioning	12
Management of device	2
Management of non-concordance	1
Management of continence	1

What is the data telling us?

In May the rate of pressure ulcers with lapses in care identified was within the usual range, based on cases reviewed as of the 3rd of the month. The table above right shows the most frequently observed lapses in care.

The wards/departments with more than one case identified for May are as follows:
Stoke ED (4), Ward 103 (2)

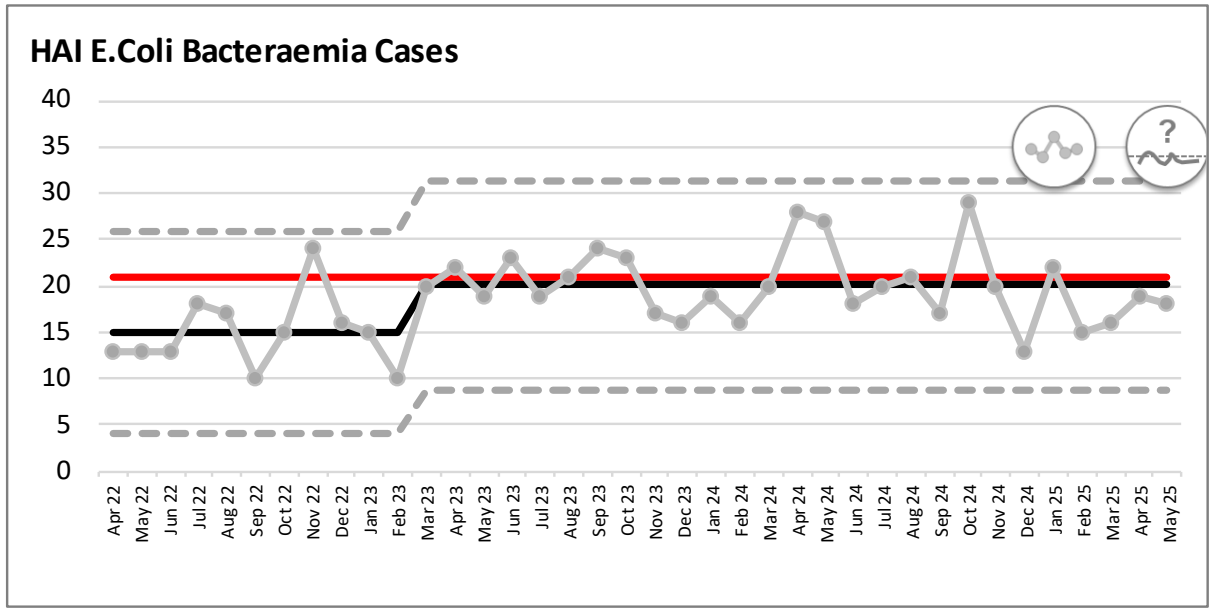
On average, approximately 31% of the pressure ulcers reported as developing under UHNM care, where lapses in care have been noted, have been observed since April 2022.

What are we doing about it?

PSIRF toolkit and action plans to be completed to gain assurances of improvements.
ED looking at completing a thematic review and have one action plan to manage increase and the number of incidents.
Multiple reporting areas attend steering group to discuss action plan, give assurances on improvements and share learning. Areas will have visits from the Quality and Safety team prior to attending assurance panel.
Looking at how to identify multiple reporting areas sooner to offer support for longer.

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

University Hospitals of North Midlands NHS Trust



What is the data telling us?

The monthly number of E.coli cases shows no significant changes since 2023, with the average being 20, just below the target.

The target trajectory for 2024/25 has been provided by NHSE, setting a maximum monthly average of 21 cases. As in previous years, this figure encompasses both Hospital-Acquired Infections (HAI) and Community-Onset Healthcare-Associated Infections (COHA).

What are we doing about it?

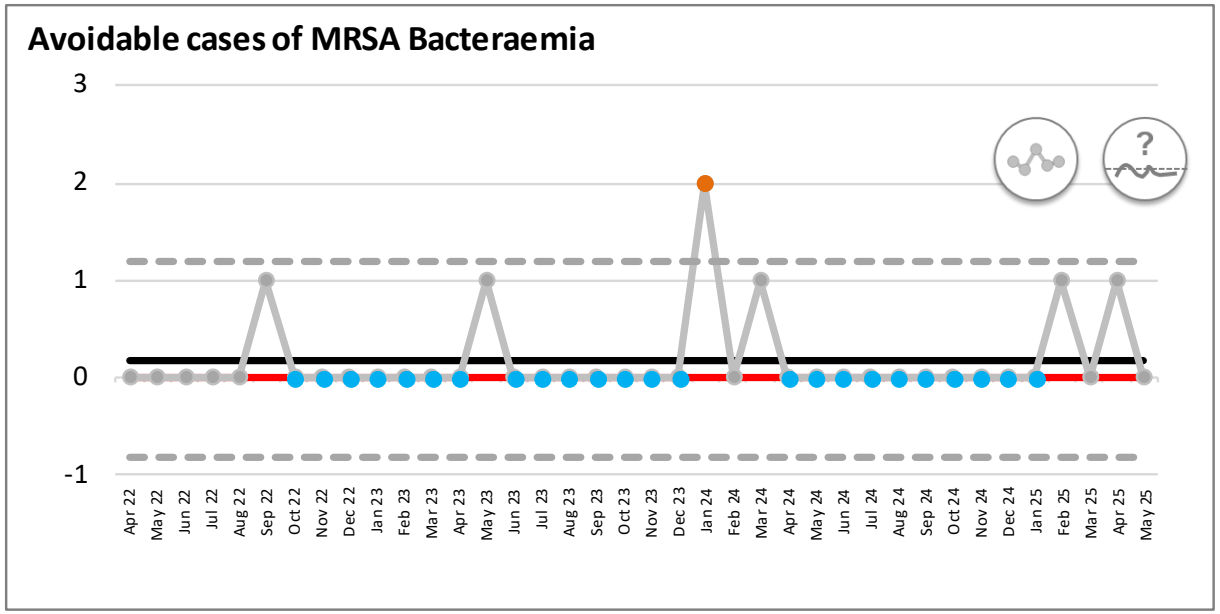
ICB-wide E.coli rates are also high and have been awarded a grant to look into potential reasons for these higher than expected rates. There is now a Health Economy stream for e coli work to identify what our root causes are and if they match national themes.

Additionally the ICB have established a T&F group to look at urinary tract infections.

We are also reviewing patient blood results to check for indications of dehydration.

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

University Hospitals of North Midlands NHS Trust



What is the data telling us?

There are two cases in May 2025, one case from Maternity ward was deemed avoidable and lessons implemented (follow-up meeting organised to review Maternity Screening Policy). The other case from NICU, was deemed unavoidable, all UHNM policies followed in NICU. Multidisciplinary meeting held, a learning alert has been re-issued May 2025 Trust wide to highlight importance of the screening policy.

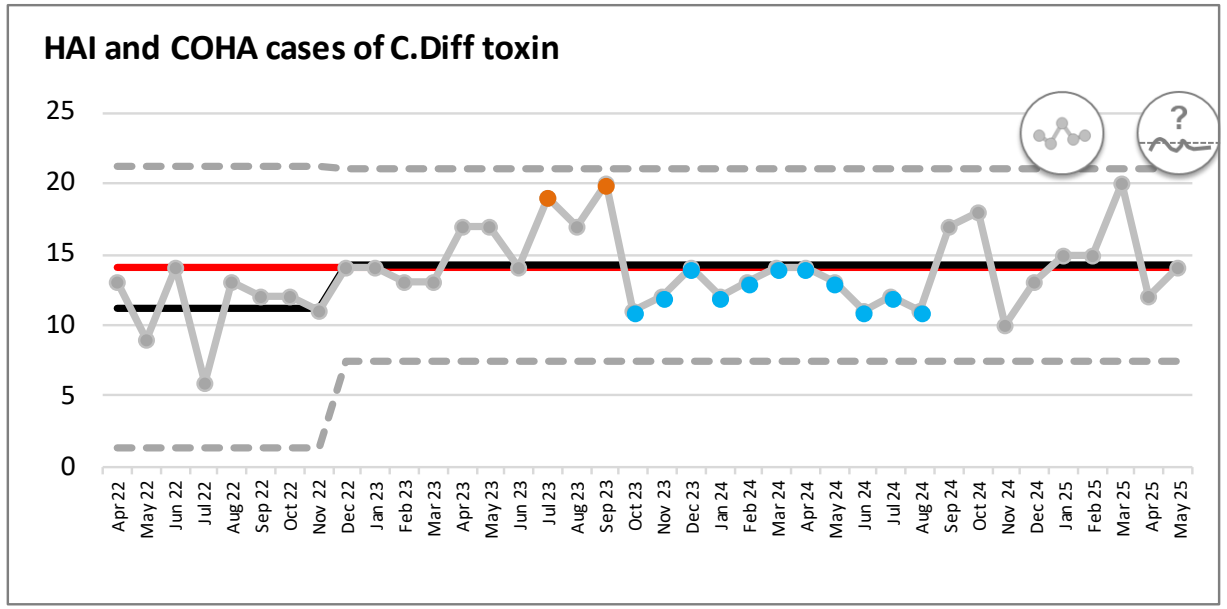
What are we doing about it?

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

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

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

University Hospitals of North Midlands NHS Trust



What is the data telling us?

There have been 14 reported C diff cases in May 2025.11 x HAI and 3 x COHA
There have been three periods of increased incidence reported in May, however one area with different ribotyping and awaiting two typing results .

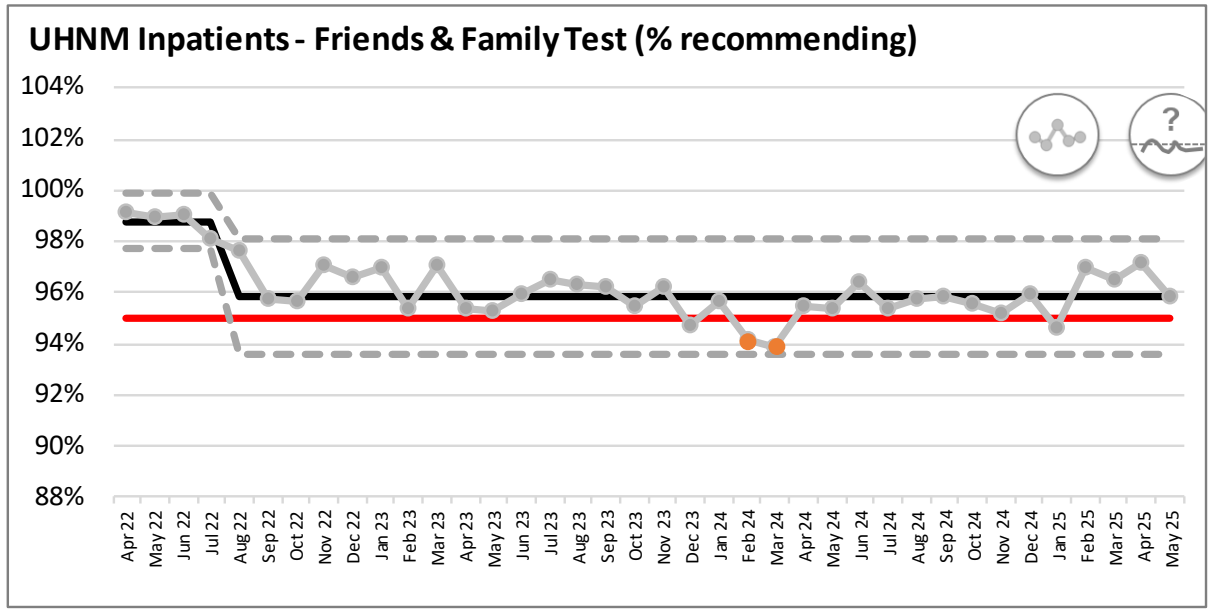
The 24/25 objective for C-Diff is 179 cases or less. We are one of only 17% of Trust regionally (22% nationally) achieving a reduction in line with the target reduction in Watch and Reserve Antimicrobials

What are we doing about it?

- Routine ribotyping of samples continues for samples from areas where we have periods of increased incidence only
- CURB -95 score added to CAP antimicrobial Microguide .
- Antimicrobial working group to remind clinical areas to send urine samples when UTI is suspected and ensure appropriate choice of antibiotic for treatment of UTI
- Additional oversight of C-Diff cases is being implemented where there is potential learning in terms of antibiotic use
- Big bed clean completed October 2024
- PSIRF process and monthly themes report
- Weekly AMS presence at County to support antimicrobial prescribing
- Commode cleaning day completed January 2025, aim for twice yearly
- The existing Pneumonia guidelines were reviewed, revised and ratified through ASG and launched to prescribers in early January. Key changes involve the reduction in the use of Co-Amoxiclav in CAP, with a focus on using the narrower spectrum oral antimicrobials where possible or a prompt IV to oral switch

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

University Hospitals of North Midlands NHS Trust



What is the data telling us?

The monthly satisfaction rate for inpatient areas was within the usual range based on previous months. The average rate remains above the national average of 95% (Jan 2025 NHS England).

In May 2025, a total of 2719 responses were collected from 67 inpatient and day case areas equating to a 24% return rate, which is close to the 25% average.
Average Divisional Scores are as follows:

- Network- 26% response rate 97% satisfaction score
- Surgery- 29% response rate 94% satisfaction score
- Medicine- 22% response rate 94% satisfaction score
- CWCSS (excluding Maternity, see separate slide)- 12% response rate 99% satisfaction score

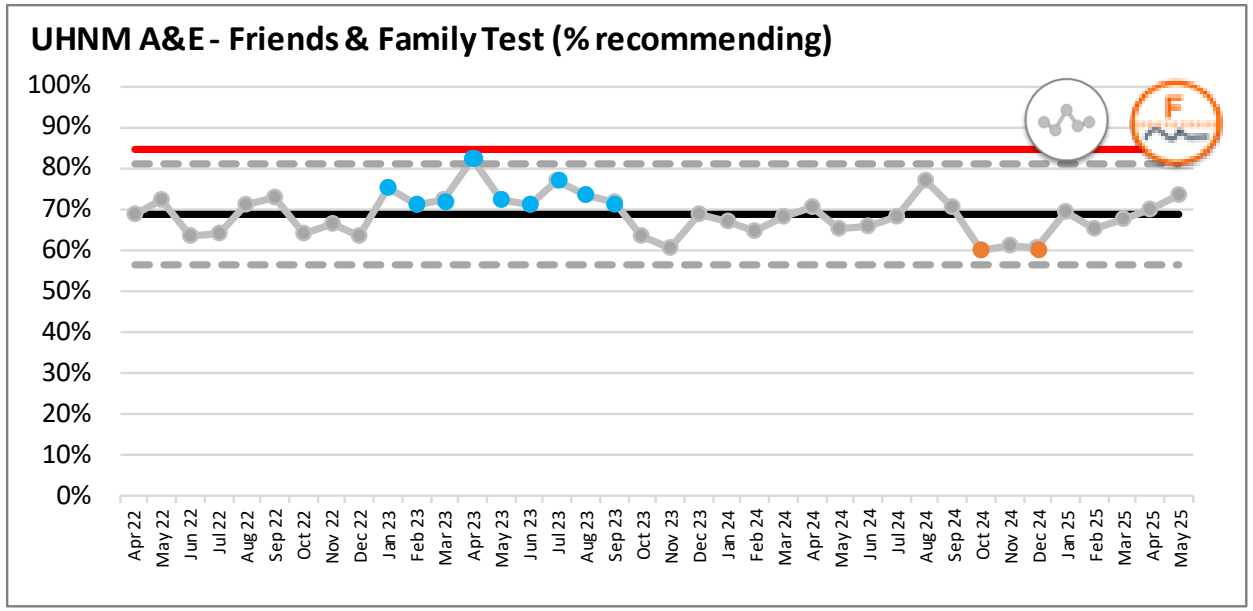
No significant shifts or trends are currently evident in Divisional response rates or satisfaction scores.

What are we doing about it?

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

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

University Hospitals of North Midlands NHS Trust



What is the data telling us?

The Trust received 873 responses in May 2025 - a 9% response rate which is close to the 8% average. The average satisfaction rate of 69% remains somewhat below the national average of 80% (NHS England Jan 2025).

UHNM is 37th out of 124 Trusts for the number of responses in ED and 98th out of 124 Trusts for the percentage positive results (NHS England Jan 2025).

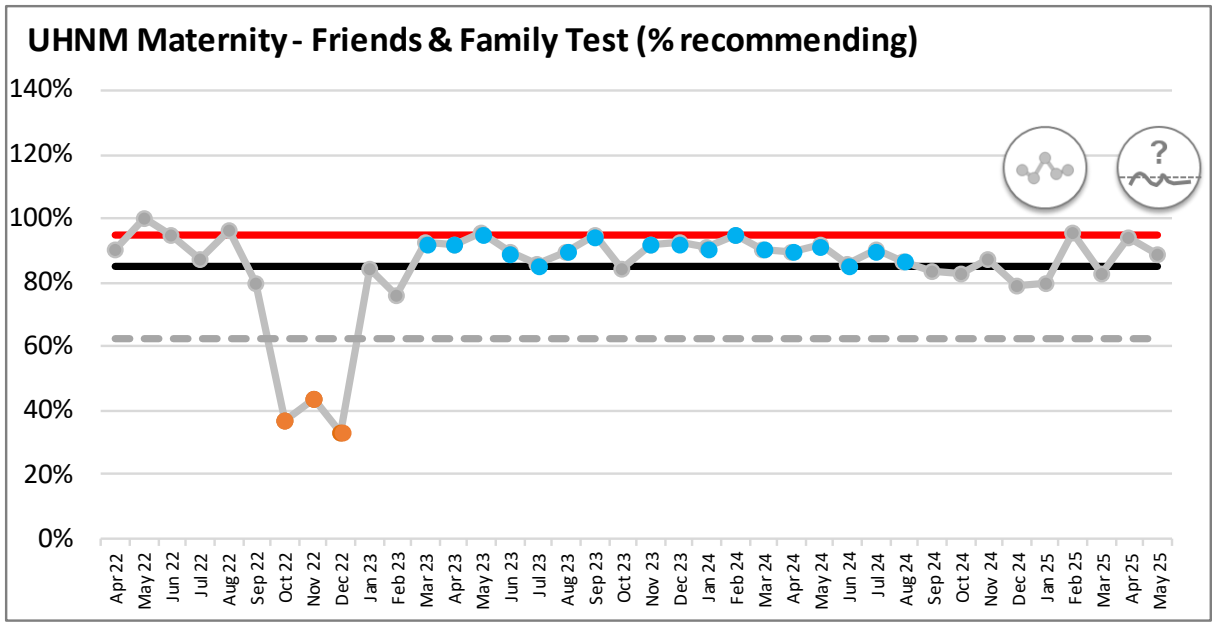
Themes for improvement from May 2025 continue to be long waits for both sites. Feeling dismissed and rude staff was a common theme from Stoke Site, while County Site received comments regarding small waiting area and lack of pain relief. Childrens ED comments were largely positive.

What are we doing about it?

- The digital system is not able to support more than one submission point each survey as each submission would then become a new survey. Therefore, to simplify, a trial period commenced from Feb 25 with the "ED Survey" now only containing the mandatory "Overall, how was your experience of our service?" with the 6 response options ("very good" through to "very poor" or "don't know". This commenced end of January 2025.
- QR code made visible throughout the department.
- Consideration to alternative methods of sharing QR code such as “business cards” available on reception and throughout the department.
- Dept Leads are going to ensure mobile phone numbers are recorded in the "mobile" phone part of iPortal (not just "contact number") to ensure Netcall can pick up for text.
- Postcards with only the mandated question and free text question will be made available.

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

University Hospitals of North Midlands NHS Trust



What is the data telling us?

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

There were a total of 109 surveys received in May 2025 across all 4 touch-points (ante-natal, birth, post-natal ward; post-natal community) with 38 of these being collected for the "Birth" touch-point, making the response rate 7% (the average response rate being 9%). The average satisfaction scores are Ante-natal: 81%, Birth: 91% and Post-natal ward: 91%. No Post-natal community surveys have been received since October 2024. No significant shifts or trends are currently evident in any of these satisfaction scores.

What are we doing about it?

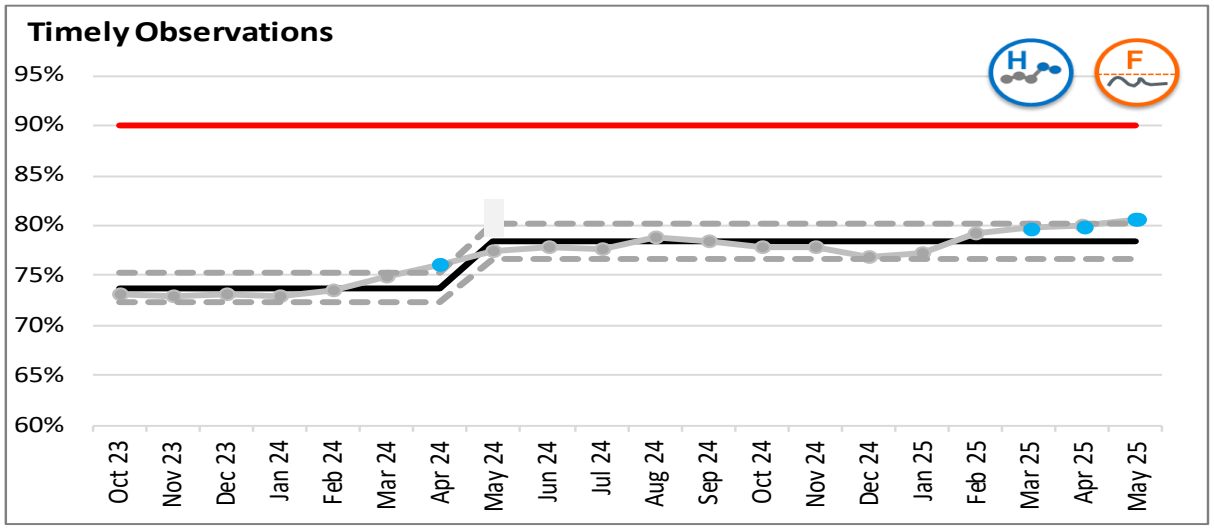
Continue to monitor the efficacy of collecting feedback via text message
Proposal put forward for "business cards" with QR code. Waiting confirmation from Management team.

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

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

Quality & Access | [Timely Observations]

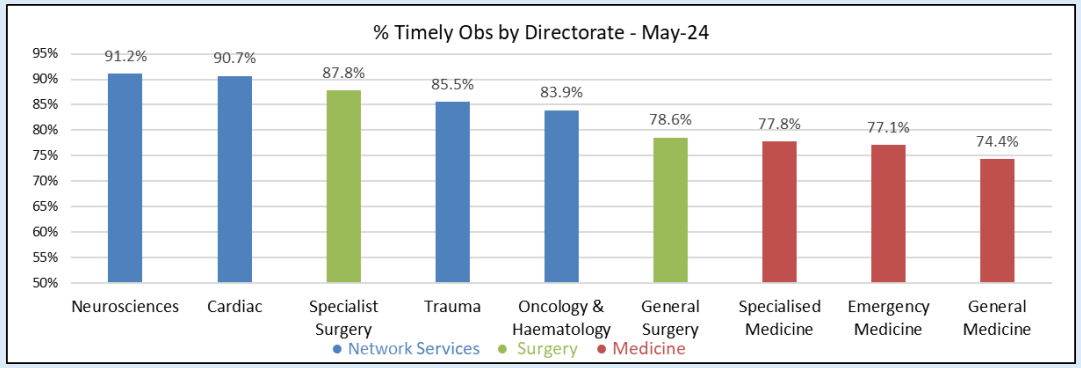
University Hospitals of North Midlands NHS Trust



What is the data telling us?

The proportion of observations recorded as timely in May 2025 was 81%, a record high by a small margin but still some way below the 90% target.

Compliance appears to be slowly improving in all Divisions, and in all Directorates except Neurosciences (whose average is already 91%), Oncology & Haematology (average 84%) and Emergency Medicine (average 77%).



What are we doing about it?

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

Medicine, Surgery and Network Divisions have timely observations as a driver metric and there is a corporate A3 Improvement Project underway considering additional actions required to improve overall compliance/performance.

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

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

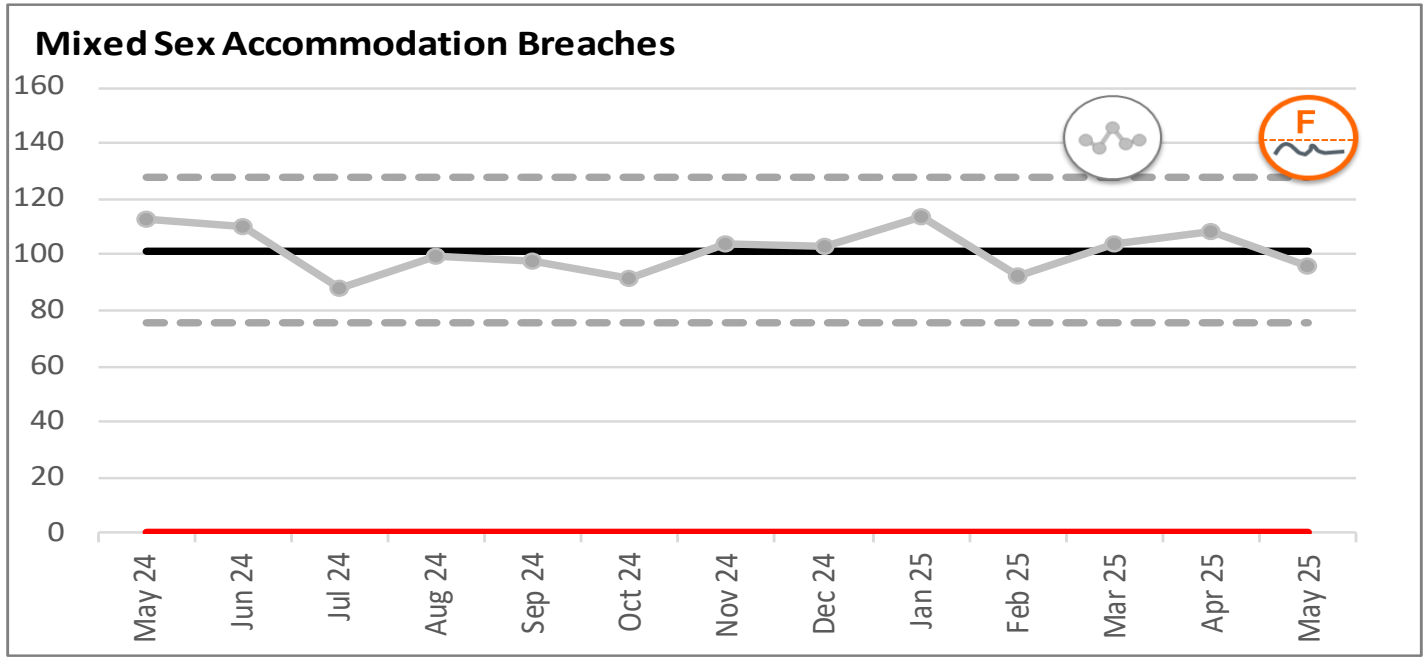
Expecting delivery of new iPad mini in the next month and a refresh of devices will be rolled out soon as practicable resource dependant, date to be confirmed Joint drop-in refresher session re NEWS 2 and timely observation.

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

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

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

University Hospitals of North Midlands NHS Trust



What is the data telling us?

As of May 2025, the figures have decreased and are also below the monthly average derived from the first thirteen months of data collection. At present, SPC calculations cannot be performed to determine the upper and lower control limits.

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

What are we doing about it?

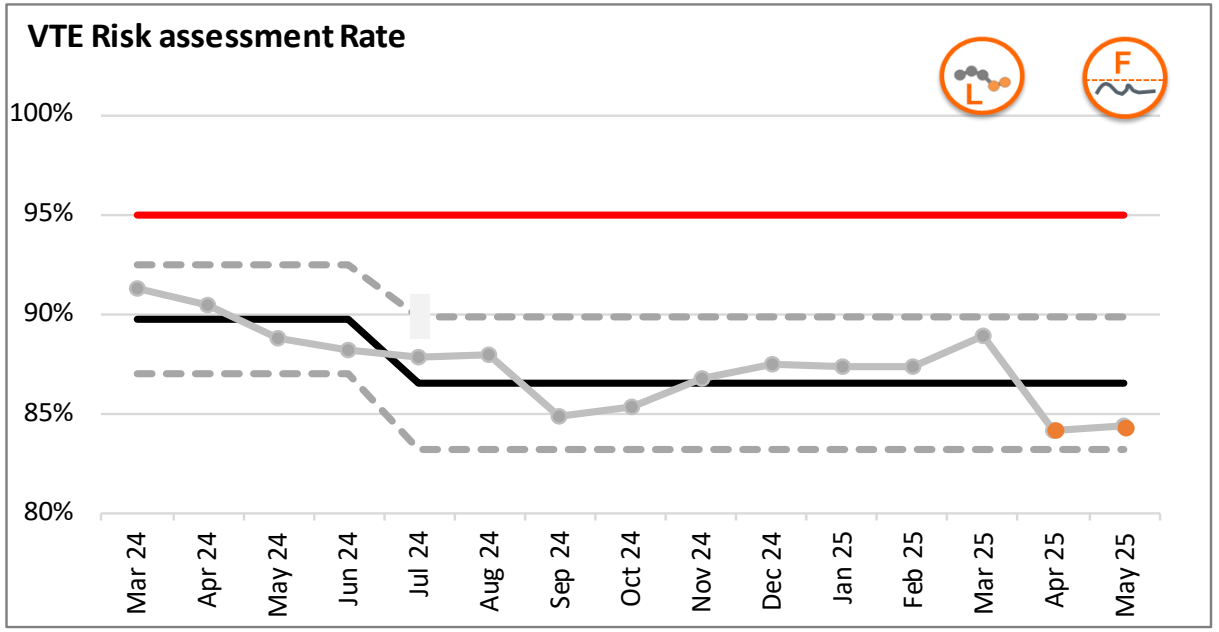
An improvement plan is being created to ensure a plan approach to the reduction of breaches. This will include a review of policy and SOPs relating to Single Sex Accommodation, tracking of breach incidents, including reasons and review of patient feedback/complaints, inclusion of step-down needs into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

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

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

Quality & Access | [VTE Risk Assessment Completion]

University Hospitals of North Midlands NHS Trust



What is the data telling us?

The NICE guideline stipulates that a VTE risk assessment must be performed within 12 hours of a patient's admission, with a national target of 95% compliance.

Each ward is tasked with reviewing the VTE assessments in 10 patient records monthly using Tendable, which acts as a verification tool. The specific question asked in Tendable is, “Has the VTE risk assessment been completed within 12 hours of admission?”

Issues with performance are primarily related to the failure to document the date and time of the assessments, leading to a significant lack of assurance regarding the completion of these risk assessments.

What are we doing about it?

All Divisions discussed work to improve VTE performance within Performance Review Meetings with Executives

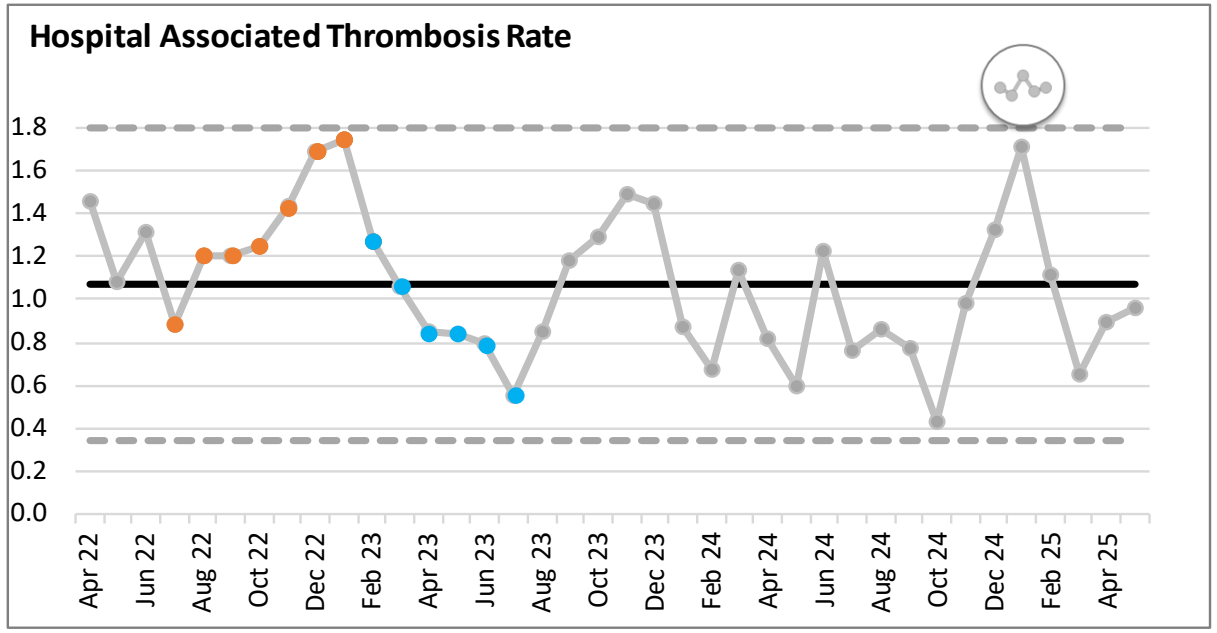
EPMA once introduced will provide accurate assurance of VTE risk assessment completion. There has been previous considerations for changing the data collection process but it was agreed that this would not be feasible or proportionate with the imminent introduction of EPMA which as stated will address the issue with accurate recording of VTE risk assessments.

Current news and the Quality & Safety Newsletter to raise awareness of the importance of recording an accurate a date and time, areas with the lowest compliance are also being visited by SSR Quality & Safety

Q1 data from NHS England has not yet been published; previously no specification had been made from NHS England for ‘on admission’ which now refers to within 14hours from the Decision to admit. Feedback from National VTE forum is that many organisations are submitting data from 24 hours and not 14 hours as specified by NHS England, which will not be reflected in the submissions.

Quality & Access | [Hospital Associated Thrombosis rate]

University Hospitals of North Midlands NHS Trust



What is the data telling us?

The Hospital Associated Thrombosis rate shows significant variability while still staying within control limits. Seasonal patterns seem to emerge, with observed rises in December and January over the last three years.

It is crucial to highlight that the decreased compliance in completing VTE Risk assessments reported in the past year does not seem to correlate with a notable rise in the rate of Hospital Associated Thrombosis.

What are we doing about it?

17 cases of Hospital Associated Thrombosis (HAT) were identified April 2025 and investigations are in progress.

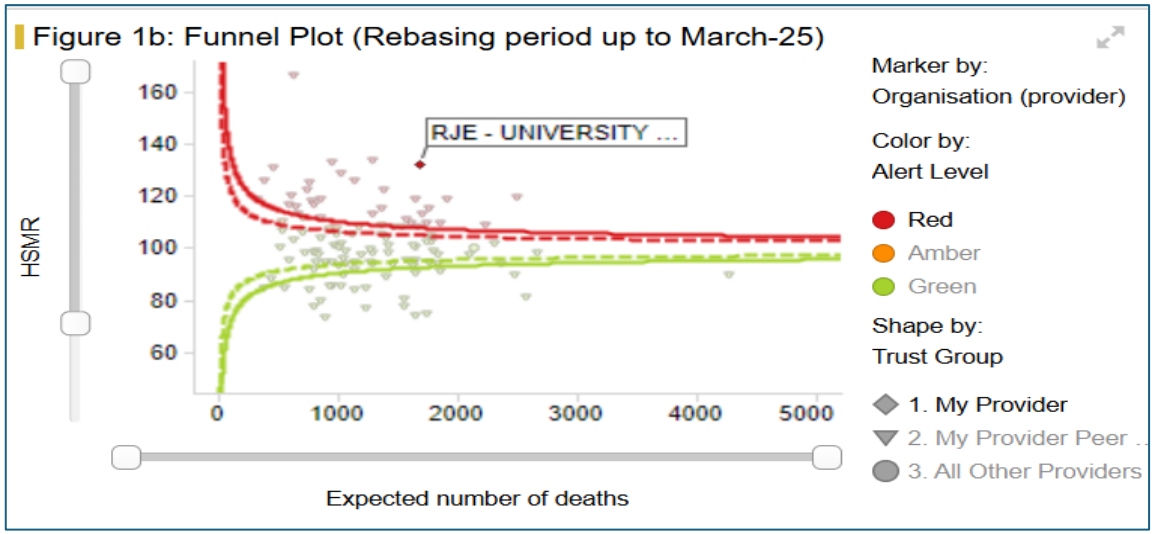
Key Themes identified from HAT Investigations; Missed doses of prophylactic Dalteparin with no clear rationale recorded and inconsistent daily recording of mechanical thromboprophylaxis.

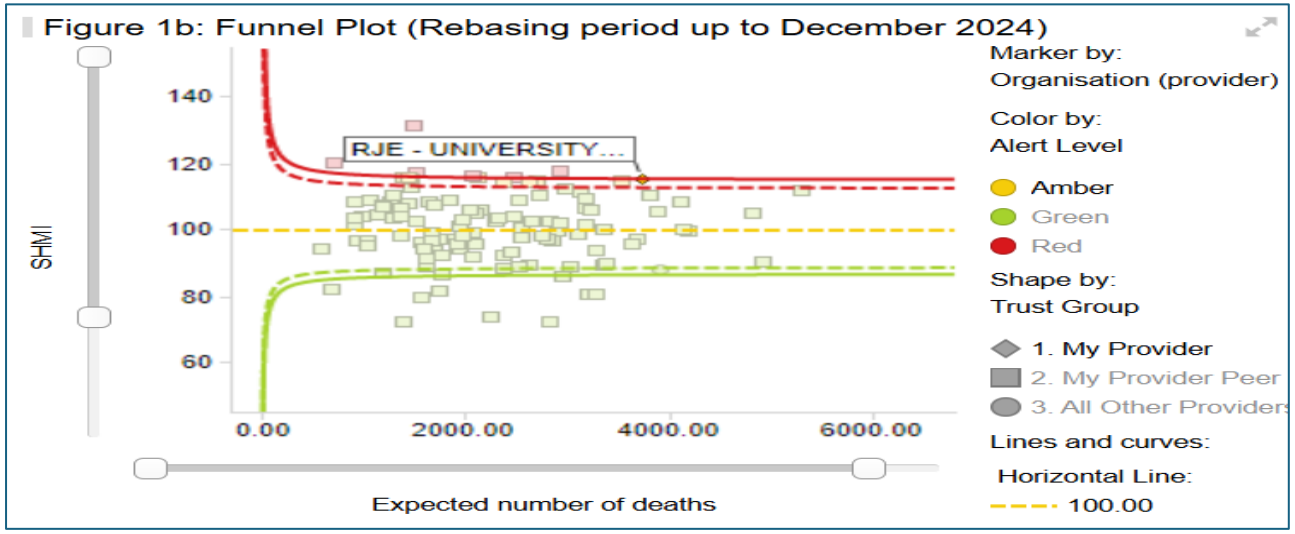
The VTE Steering Group are reviewing a number of potential QI projects for next year which will aim to reduce harm and raise awareness

Numbers have been lower since, coinciding with a reduction of viral illnesses.
Education continues to be provided to junior Doctors at their induction and ad hoc divisionally.

Quality & Access | [HSMR / SHMI]

University Hospitals of North Midlands NHS Trust





What is the data telling us?

UHNM HSMR is significantly higher than expected based on case mix and standardisation for current 12-month period (April 2024 – March 2025). The current 12-month HSMR is 131.8 compared to 124.79 in previous report.

UHNM SHMI is still within expected ranges at 115.3 for current 12-month period (March 2024 – February 2025) but has increased from previous 12-month period with 114.24

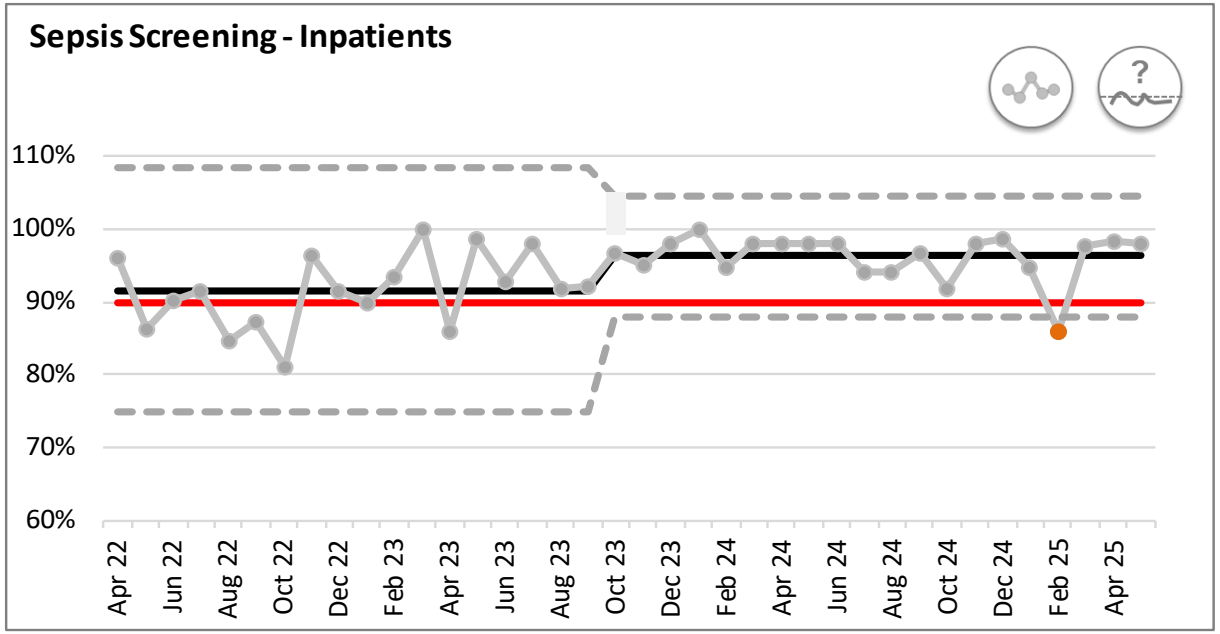
The HSMR/SHMI issue re coding backlog continues. We have not noted a similar increase in the Trust's crude mortality rate at same time as the HSMR increases and therefore the increase appears to be linked with the coding issues. The rolling 12-month crude rate has decreased comparing current 12-month period (2.38%) with previous 12-month period (2.45%)

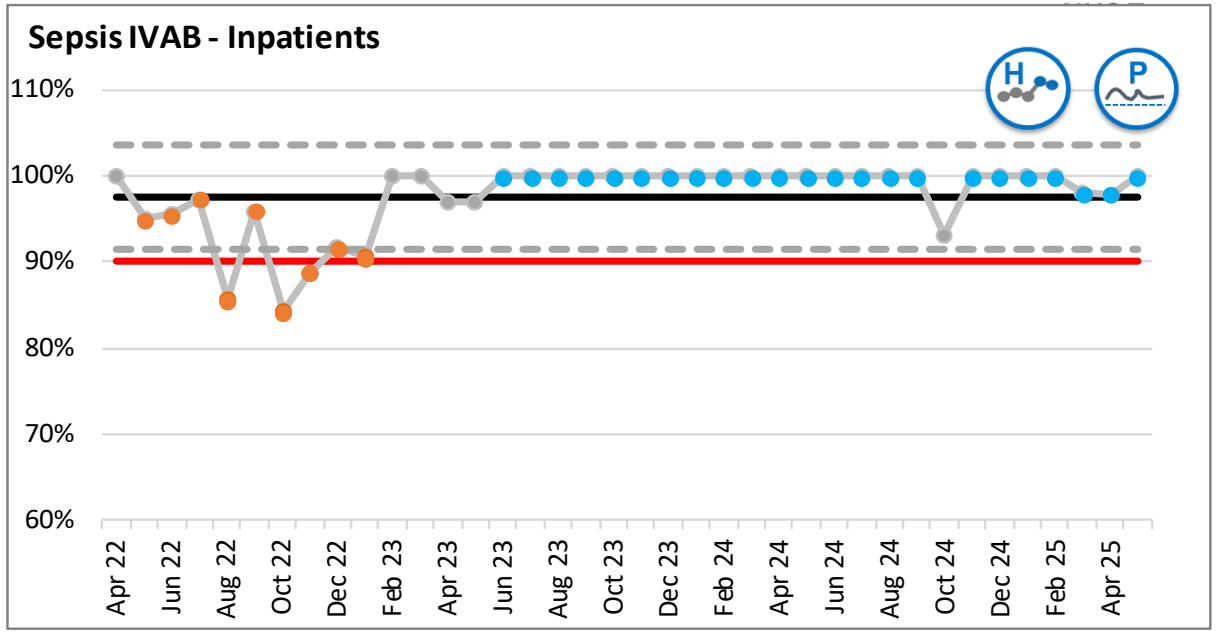
What are we doing about it?

- Have not seen changes in outcomes of the completed mortality reviews / SJRs highlighting ant concerns in practice linked to the period of increased HSMR
- Clinical Coding options are under consideration to address the backlog and will be confirmed during June / July 2025. Additional internal mortality monitoring/reporting to be included at Mortality review Group whilst the backlog options are agreed and implemented.
- Clinical Coding have provided full coding for all April 2025 activity and to await update to April HSMR/SHMI to assess implications/improvements in the monthly figures compared to the months when not all activity was fully coded.
- Remains under review and have shared update with QGC and ICB.

Quality & Access | [Sepsis – Adult Inpatient]

University Hospitals of North Midlands





What is the data telling us?

In May 2025, inpatient departments met the target for screening and IVAB administration within one hour.

A total of 95 cases were reviewed, revealing 2 missed screenings. Among these, 68 cases were identified as red flag sepsis, with 36 receiving alternative diagnoses. Additionally, 30 patients were already undergoing IVAB treatment.

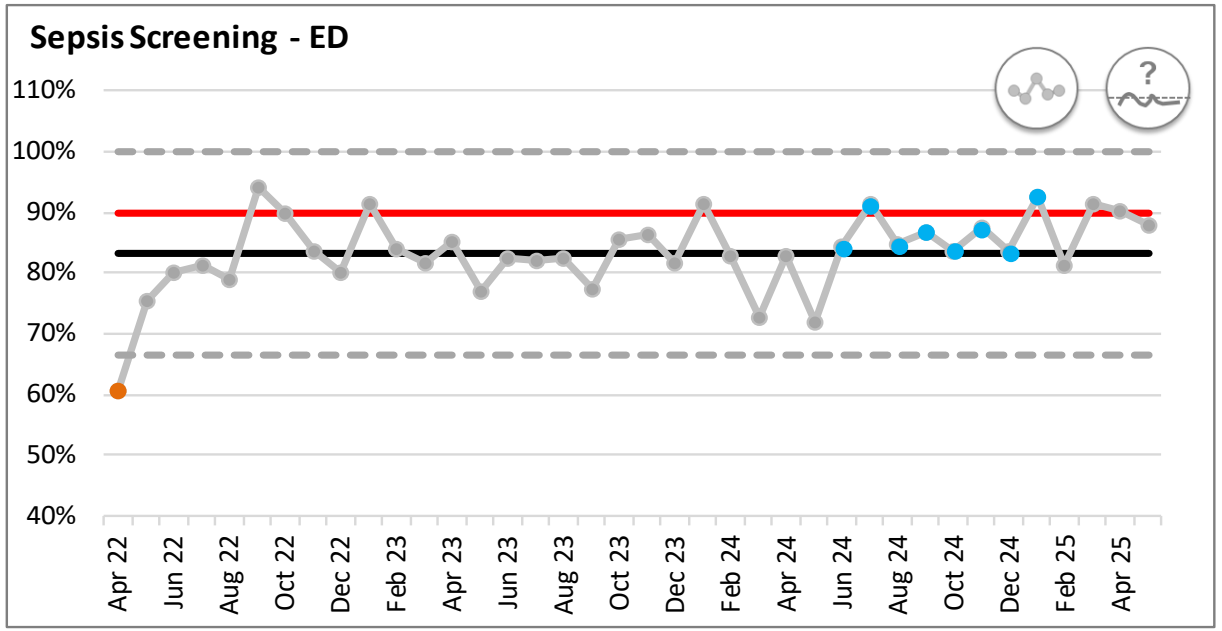
What are we doing about it?

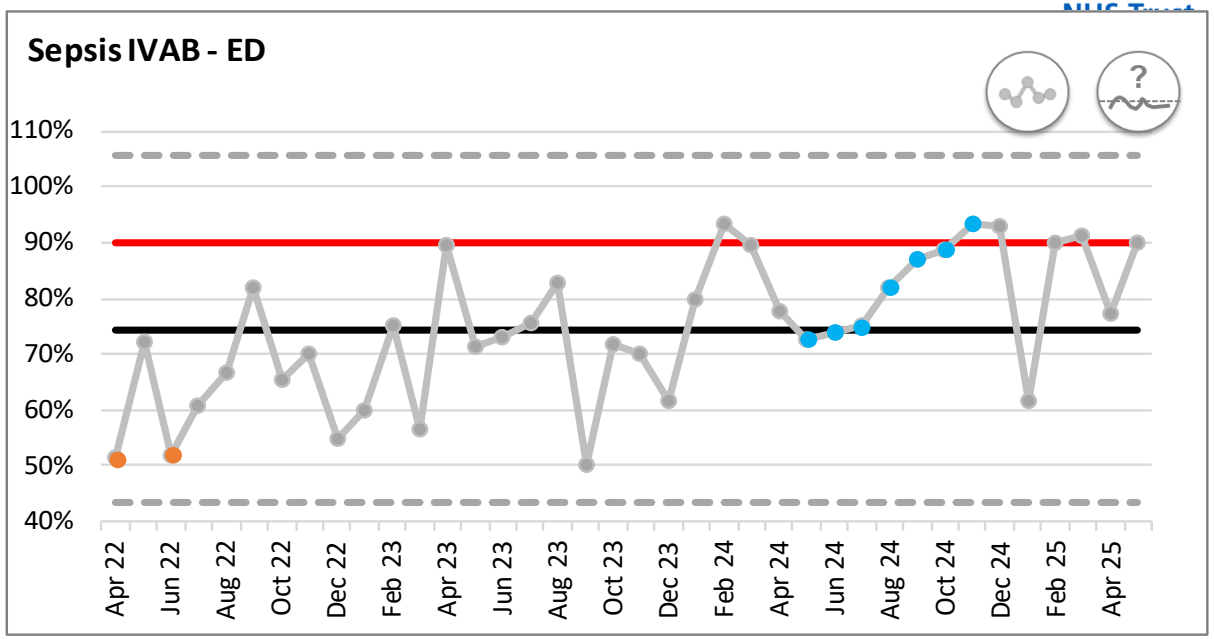
Band 3 sepsis training is ongoing.

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

Quality & Access | [Sepsis – Emergency Portals]

University Hospitals of North Midlands NHS Trust





What is the data telling us?

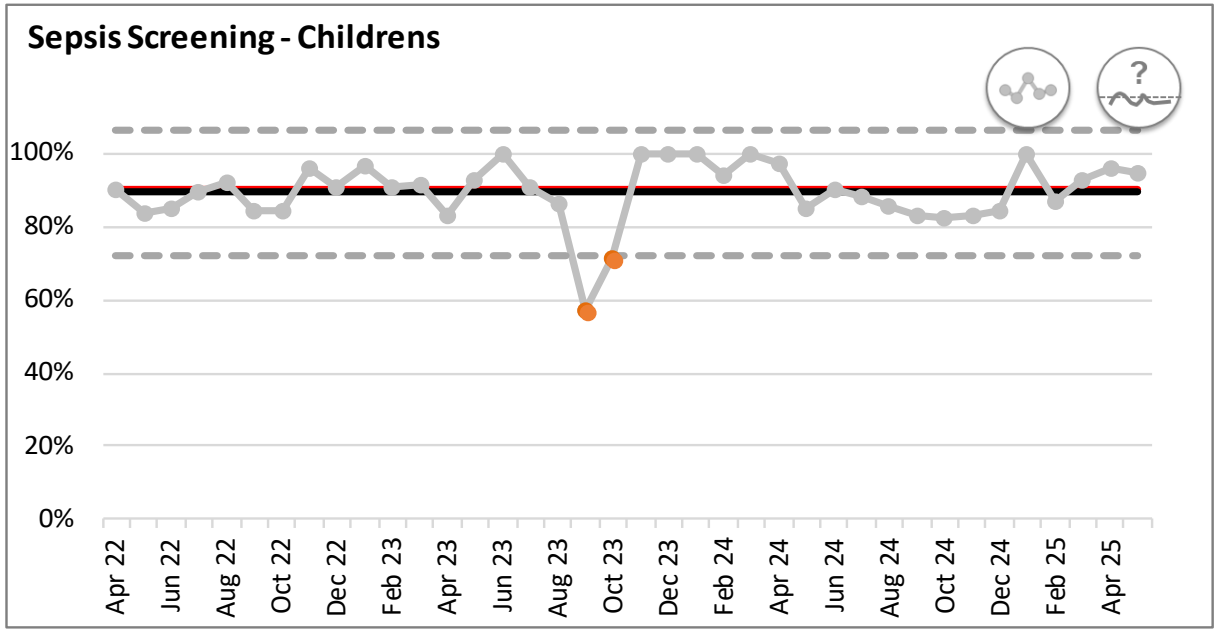
Adult Emergency portals screening has failed to meet the target most months since February 2022. . However, for May 61 cases were audited with only 8 missed screens to give a 87% compliance.
IVAB within 1 Hr has been significantly better since January 2024. For the month of May they have achieved 75%.
Out of cases there were 41 red flag sepsis in which 7 patients were already on IVAB. 25 patients had an alternative diagnosis leaving 9 newly identified sepsis patients. 4 patients received IVAB outside the target 1 hour window.

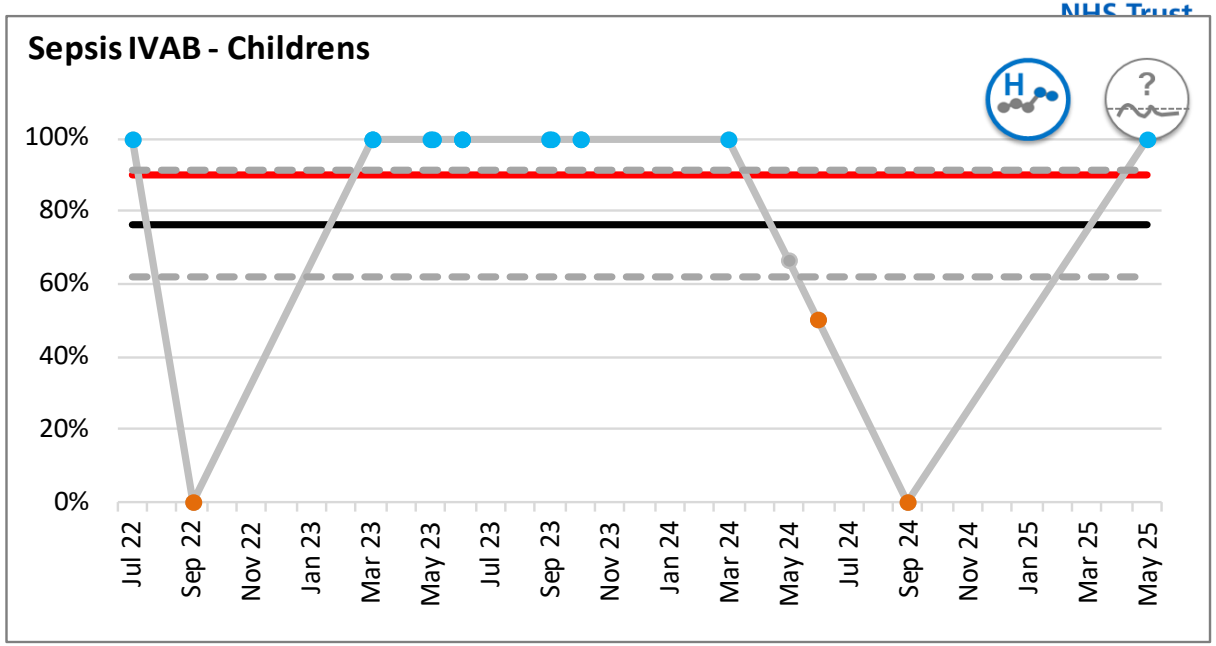
What are we doing about it?

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

Quality & Access | [Sepsis – Children]

University Hospitals of North Midlands NHS Trust





What is the data telling us?

We continue to see only a small number of children trigger with PEWS >5 and above inpatient areas. Most inpatient paediatrics are already on oral or IV antibiotics prior to trigger of PEWS >5
There were 11 cases audited for emergency portals with no missed screening.
No true red flag sepsis was identified from the randomised audits in the emergency portals or inpatients.

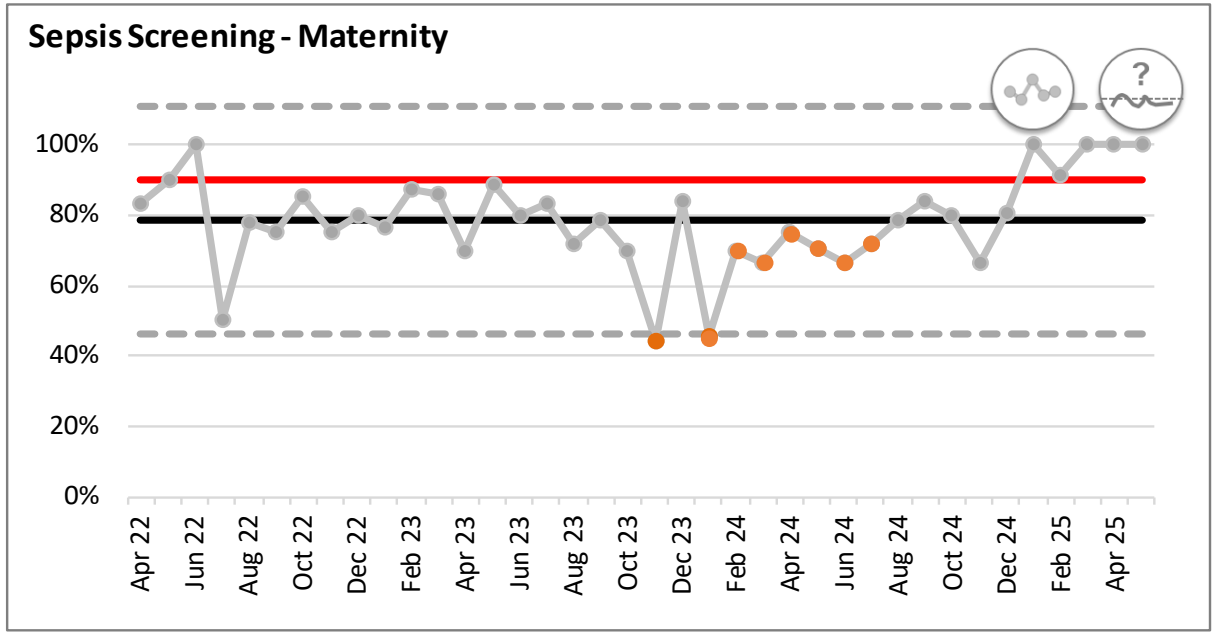
What are we doing about it?

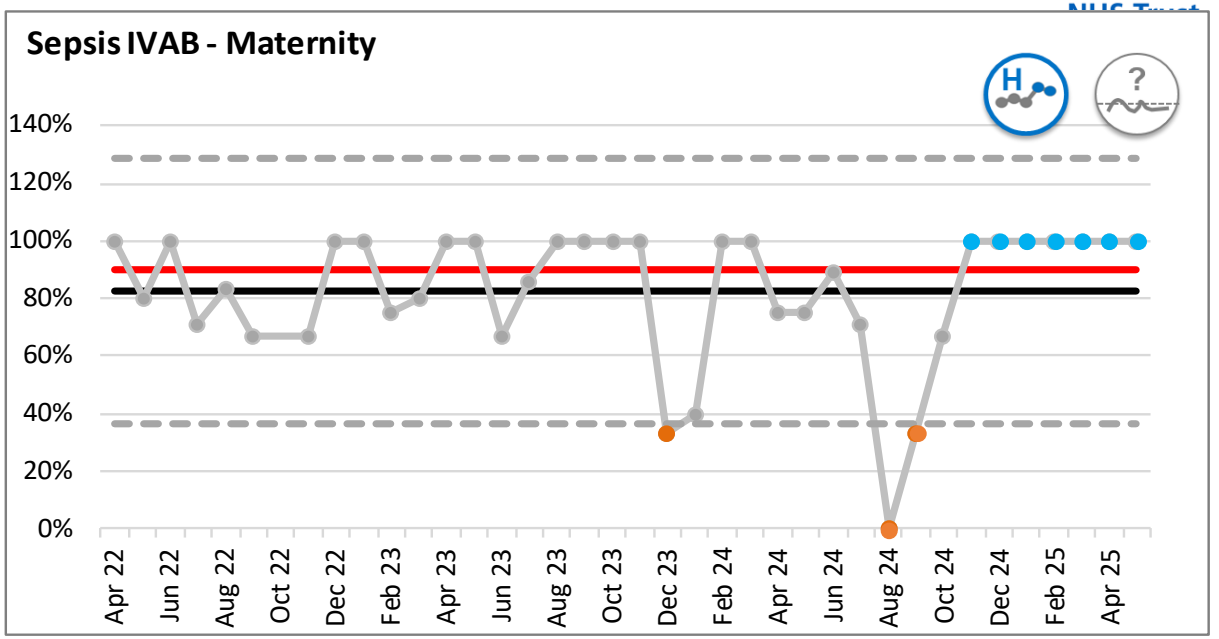
The sepsis team has continued to adjust the audit process in emergency portals to take smaller samples over a wider range of dates to give a more comprehensive perspective.

The children department has now implemented the national PEWS chart and sepsis screening tool guidelines.

Quality & Access | [Sepsis – Maternity]

University Hospitals of North Midlands NHS Trust





What is the data telling us?

Maternity audits regarding screening compliance have met the target over the past three months.

The compliance target for administering IVAB within one hour for both inpatient and emergency portals was also established. However, IVAB compliance is assessed using a limited number of cases.

A total of 6 cases were audited from the emergency portal MAU, and there were no missed screenings.

What are we doing about it?

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

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

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

Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

How are we doing against our trajectories and expected standards?

Non-Elective

For the 4 hour standard in UEC our validated performance is 70.0% for May which is an improvement of 4.4% on the validated April position 65.6%. We submitted an improvement trajectory, and this performance is above that trajectory. The national target for this standard is 78%.

In May 2129 patients waited longer than 12-hour in our Emergency Department compared with a validated position of 2420 patients in April, which is positive shift in performance from last month by 291 patients. This equates to a decrease of 21% of patient waiting greater than 12-hors aggregated LOS from arrival.

Average handover time for ambulances attending our sites in May was 1hr 8mins compared to 1hr 31mins in April - all categories. The planning/improvement target agreed for May was 1hr 24mins and thus, we are below the agreed target, but continued improvement is urgently required both meet the locally agreed interim standard of 45minute and move to the nationally agreed standard of 18 minutes. We continue to see an increase in Category Type 3 and Type 4 conveyances which we are examining through an ambulance conveyance audit and workshop planned for 20th June 2025. To note, this is unvalidated data.

The Trust continues to be monitored in tier 2 for our UEC performance.

Elective

Cancer: The combined faster diagnosis standard performance has demonstrated improvement over the past year. FDS performance in May, although unvalidated currently is 79.4%; performance overachieves against trajectory of 74.5%. The 31-day April 2025 performance at 93.4%, with Colorectal and Skin achieving below 90% due to surgical constraints; May is still unvalidated. Combined 62-day performance final April 2025 data showed performance of 61.0% against trajectory of 64.6%

Diagnostics: May DM01 data is unvalidated at time of writing this report however current performance was at 55.4% against the 95% six-week standard. Non-Obstetric Ultrasound is the majority contributor for overall DM01 performance variance with performance at 29.7%.

RTT: Overall RTT performance is 62.97%; 4% above trajectory which is 59%, the standard for this is 63%.
Our 52-week performance is monitored as a % of patients on our total waiting list who are over 52 weeks, currently this is 2.77% which is better than our planned trajectory of 3.05%. This standard to achieve by the end of the year is to get to 1%.
We are ahead of our planned trajectory for wait for first appointment at 76.78%, the target for this is 77.3%.

While this is positive for our standards, we continue to have patients waiting over 65 weeks, this has been impacted upon by our UEC position over Winter for orthopaedics and aligned to National pressures we are still seeing challenges in ENT. 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. As we get back to our normal operating rhythm, there is a backlog of elective patients who would have been treated during this period, effectively doing some of January-March's work in April.

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

Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

What is driving this?

Non-Elective

4-hour performance is in line with the agreed improvement trajectory, Actual 70.0% verses a target of 67.9%.

Total attendance activity for May was 25,509, this is for all types and all portals. This is an increase of 1,129 or 4.43% compared to April. This is considered a normal seasonal variation in terms of attendances based on previous national modelling and known experiences. To note, May consists of 2 Bank Holidays and a half term break. A marked increase of type 3 and 4 attendees was also noted. Flow for our patients from our Emergency Departments into inpatient bed base remained challenging due largely to discharge profiles and lengths of stay not aligning to the number of patients requiring beds. This is demonstrated by the number of patients held in ED with a decision to admit daily. We did, however, note a reduction in overall aggregated >12+ length of stay in our Emergency Department

May has seen a reduced number of 'restricted bed capacity' due to IP restrictions, although there was still a high demand for side room capacity. This highlights discharge profiles and length of stay as areas of concern in terms of accessing inpatient capacity.

Both the capacity of our Emergency Departments (overcrowding) and the profile of ambulance arrivals has impacted on the ability to offload in a timely manner. There are improvement opportunities identified where handover reporting, and release process can reduce the amount of time patients wait to be handed over and ambulance crews wait in our departments. The capacity for spaces in portals and in the deeper bad base is also seeing a significant number of patients being held in ED with a decision to admit has continued, however, as part of the UEC Improvement Programme, access to all known emergency portals is being scrutinised.

Elective

The improvements in cancer diagnostic performance when compared to last year, has been achieved due to an increase in capacity using West Midlands Cancer Alliance alongside a focus on lower performing pathways (Gynae, Colorectal and Urology) with associated improvement plans now in place. This has been alongside focused pathway work.

Non-Obstetric Ultrasound is the majority contributor for overall DM01 performance variance. Non obstetric ultrasound performance has deteriorated to 29.7%, and there are 10,787 patients waiting over 6 weeks for their scan; this is a positive improvement which is ahead of trajectory of 40 less patients waiting over 6 weeks for their scan. A new trajectory has been developed to map through all the workstreams impacting NOUS with a view to delivering 95% DM01 by March 2026. All workstreams would need to deliver fully and additional in-sourcing would also be required to deliver this position. BMUS guidance has now been turned on when vetting all new referrals and this standard has also been applied through validation to our current waiting list. This will bring US in line with other Trusts in the region in terms of vetting parameters. It is anticipated that this will reduce conversion of referrals to scans by approximately 15%

The reduction in patients waiting >65weeks to be treated has been possible due to an increase in capacity funded through ERF. The current slow down in treating our longest waiting patients has been driven by the increased pressure on our beds coming from our UEC pathways, but also the delay for reallocation of ERF initiatives to align with the performance standards for this year, and planning rounds. The volume of patients waiting 65 weeks increased to 233 in May. The rate of reduction of patients waiting over 65 week has slowed due in large part to UEC pressures; most of these patients are on admitted pathways who require an RSUH bed for a complex procedure requiring some combination of specific surgeons, surgical robots, extended theatre time.

Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

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

Non-Elective

Our UEC improvement plan has now been in place since April 2025. We appointed a UEC Recovery Director to support in making these changes reporting directly to Chief Operating Officer for cross organisational change. We have also started the process to pull ED and Acute Medicine out of our Medical Division with an improvement leadership team reporting directly to our executive triumvirate to support specifically front door changes while more time is then given to our Medical Division to support ward improvement. This will be for a period of 6-12 months.

Our improvement programme across UEC is now in place and detailed below. This has a governance structure which seen fortnightly accountability meetings, this reports to our CEO led 'Executive Recovery Oversight Meeting'.

There are now 6 workstreams due to the decision to extract the UTC Delivery programme form Workstream 1. We now have appointed an Operations Director for Strategic Programmes. This post will oversee not just UEC but several other essential delivery programmes that impact on UEC delivery

- Front door process – this aims to address our ED staffing, standard work and portals.
- Frailty – this aims to embed our County Frailty model, transform our frailty model at the Stoke site and link into the community transformation of frailty services
- Clinical pathways – this aims to address our acute medical pathways and also review our current assessment/portal areas and redesign clinical pathways where needed
- Bed and site management – this aims to address the challenges of operationally the processes we follow and governance around our site management team and its integration with our new Care Group Structure. They will also review and amend our escalation processes
- Ward Processes-This workstream looks at improving ward function, discharge lounge facilities and our 'YNP' process
- Urgent Treatment Centres: Royal Stoke and County.

Alongside this there are tactical actions taken on a daily basis

The Provider Collaborative is supporting a community transformation programme which aims to support patients in not needing acute care, and to support earlier discharge to community services.

Elective

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

As our bed capacity continues to be challenged clinical colleagues in services heavily impacted by the pause in elective surgery are in conversation with other NHS providers exploring the possibility of use of theatres and wards to continue to treat our longest waiting patients. We are also exploring using capacity within the independent sector, where clinically appropriate. The transfer of patients to the CDC at Cannock started in February having been delayed to ensure that processes supporting transfer are safe and effective.

The digital and operational teams have worked with external partners to develop a process to validate the majority of our c700,000 patients on our waiting lists; MBI ROVA Artificial Intelligence validation business case has now been approved, and validation has commenced, with configuration and testing now underway. MBI ROVA and manual validation is tracked weekly, with updates reported to NHSE on a weekly basis to show progress

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

We have experienced a continued underperformance in our UEC trajectories, but with the revised UEC Improvement Programme under the direction and leadership of the Improvement Programme Director, it is expected that this will begin to resolve our UEC performance – this will need to be systematic and prioritised.

Going forward, improvements in 4-hour performance, 12 hour and ambulance handover delays will be tracked and monitored daily. We have seen the correlation between improvements in flow and these indicators.

The revised OPEL indicators for 2024/2026 have gone live and now include 10 indicators as opposed to 8 – our OPEL framework Trust escalation protocols are being adjusted to support this as part of the UEC recovery programme.

Elective

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

With the increased focus on improving cancer pathways through improvement plans along with a sustained increase in validation, we expect to see continued / sustained improvements in cancer performance

County Elective Hub went live on the 7th April. Notably procedure numbers have increased significantly across County Theatres by 9% to date; activity increase to be tracked against delivery, specifically for Orthopaedics / General Surgery / Gynaecology

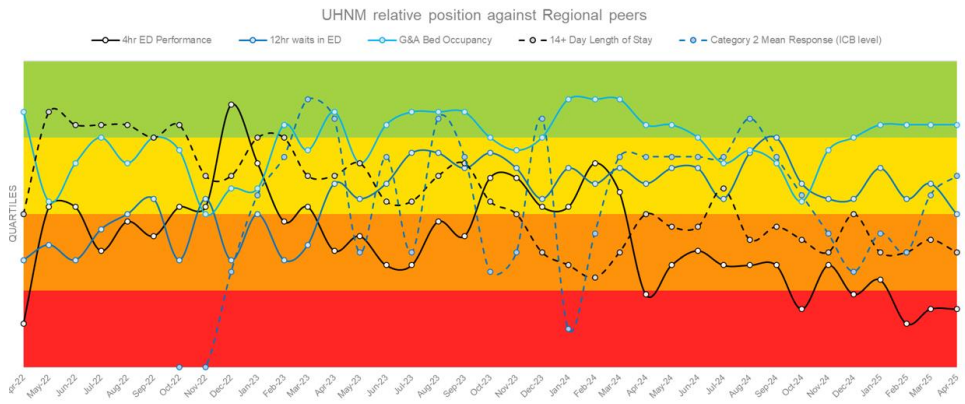
Quality & Access | Dashboard

University Hospitals of North Midlands NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance	R12M Trend
UEC 4 Hour Target	78%	65.6%	70.0%			
Over 12 hours in ED	2,128	2,420	2,129			
Ambulance Handover Average Time	00:43:00	01:31:36	01:08:50			
Cancer 28 Day FDS	80%	74.1%	79.4%			
Cancer 31 Day Combined	96%	93.4%	88.1%			
Cancer 62 Day Combined	75%	61.0%	55.0%			
Diagnostics DM01 Performance	97%	56.2%	52.9%			
RTT Performance - <18 Weeks	63%	62.0%	61.9%			
RTT Performance - % 52+ Weeks	1%	2.5%	2.7%			
RTT Performance - % Waiting 1st Contact	77%	75.8%	77.0%			

Relative position against Midlands Trusts

For 4hr ED Performance, 12hr waiting in ED, G&A Bed Occupancy, 14+ day Length of Stay and WMAS Category 2 Mean Response*



*Monthly Category 2 Mean Response is a comparison between the 11 ICBs served by WMAS & EMAS and is extrapolated from weekly data which is only available from October 2022

Related Strategy and Board Assurance Framework (BAF)

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 4: Delivering Responsive Patient Care	Ext 20	Partial	Ext 15	Partial	Ext 20	Partial	Ext 20	Partial

Assurance Grid

University Hospitals of North Midlands NHS Trust

Strategic Priority Domain Metrics Key

Quality metrics shown in blue text
Responsive metrics shown in pink text
People metrics shown in orange text
Improving & Innovating metrics shown in purple text
System & Partners metrics shown in green text
Resources metrics shown in teal text

Assurance / Variation Key

Assurance

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

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

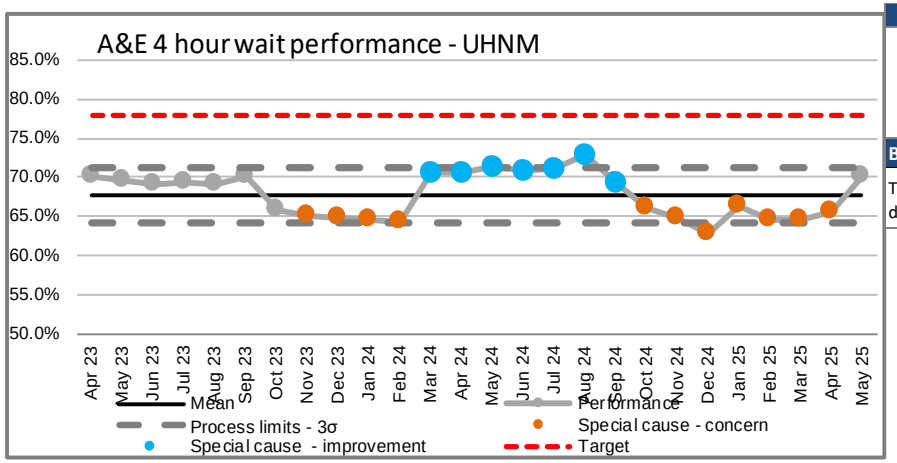
VARIATION \ ASSURANCE	Pass	Hit and Miss	Fail
Special Cause - Improvement			RTT Performance - <18 Weeks RTT Performance - % 52+ Weeks RTT Performance - % Waiting 1st Contact
Common Cause		Ambulance Handover Average Time Cancer 28 Day FDS	UEC 4 Hour Target Cancer 31 Day Combined Cancer 62 Day Combined
Special Cause - Concern		Over 12 hours in ED	Diagnostics DM01 Performance Theatre Utilisation

The best joined-up care for *all*

Kind Excellent Together

Quality & Access | UEC 4 hour Target

University Hospitals of North Midlands NHS Trust

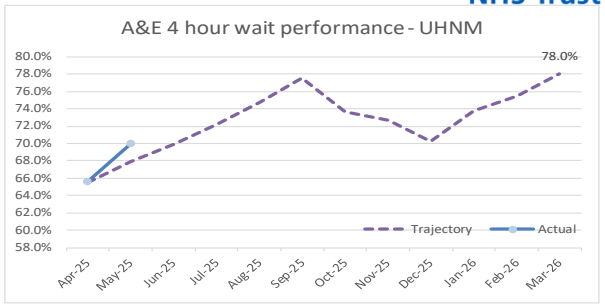


Variation	Assurance
	F
	Target 78%

Background

The percentage of patients admitted, transferred or discharged within 4 hours of arrival at A&E

Monitoring against plan	Feb 25	Mar 25	Apr 25	May 25
Actual	64.5%	64.6%	65.6%	70.0%
Plan	72.4%	78.0%	65.5%	67.9%
Variance	-7.9%	-13.4%	0.1%	2.1%



What is the data telling us?

Validated Performance is 70% for May which has improved since last month at 65.6%.
The submitted improvement trajectory against the 4hr standard set for May was on target (target 67.9% vs Actual 70%).

The teams ongoing work to improve this performance metric is evidenced in the increase from the increase in performance and performing on target last month and above target this month.

Type 1 4hr performance for Royal Stoke was 43% which has increased by 4.7% since last month from 38.3%.
Performance over the last 12 months has been an average of 40.31%.
Type 1 4hr performance for County was 67.9% which has increased by7.8% since last month from 60.1%.
Performance over the last 12 months has been an average of 64.89%

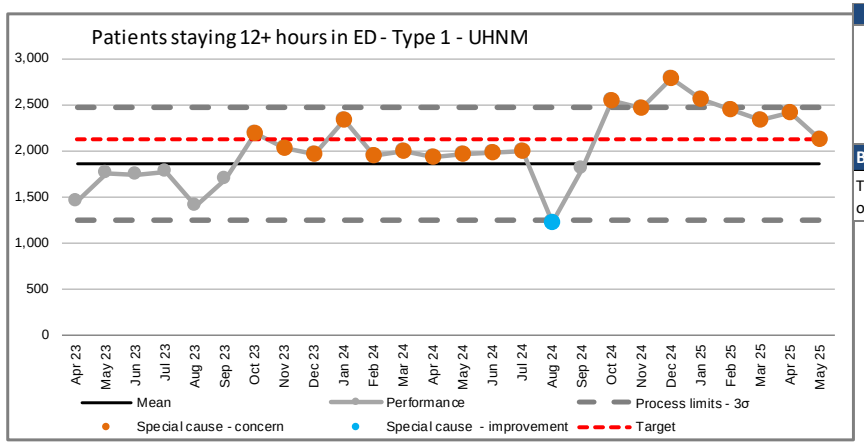
We are ranked as 103th out of 142 trusts which is a positive move up of 16 Ranking places since March 2025.

What are we doing about it?

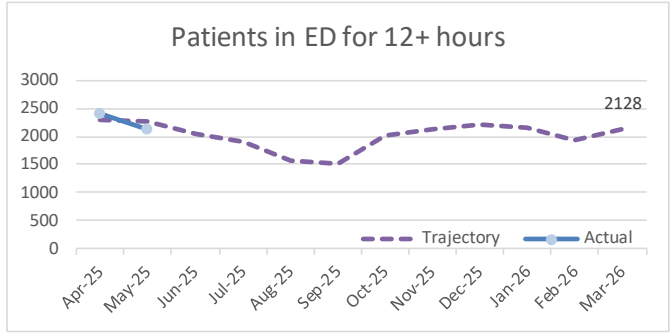
- The UEC Improvement Programme has now been refreshed and is supported by 5 workstreams designed to recovery, sustainability and delivery resilience.
- Development of co-located UTCs County and Royal sites
- Develop clinical model delivery model for UTCs
- ED Staffing review – align to the demand profile and the future UTC model
- Review of current standard work and development of medical and nursing standard work plan.
- Development of a new clinical model for the frailty assessment unit
- High Risk of Delayed Transfer of Care prediction tool trial commenced on 2nd December to support deflections from the ED and work continues with the development of pathways to support deflection from ED and reduction of reattendances.
- The actions above have been time-lined and are built into our planned recovery trajectory which you can see in the top right-hand graph.

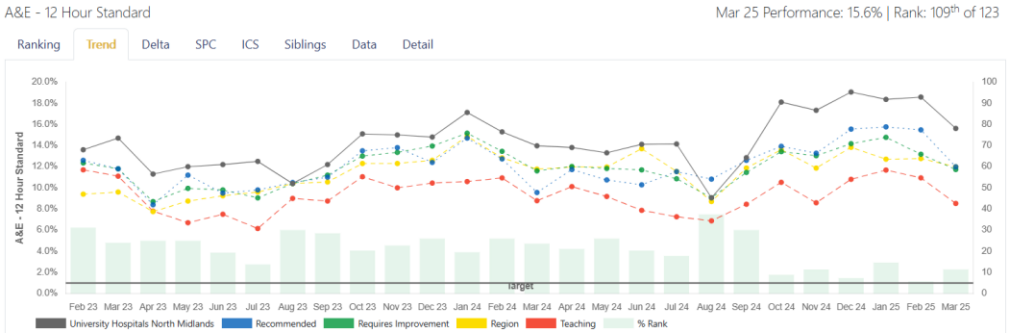
Quality & Access | Over 12 hours in ED From Arrival

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				Feb 25	Mar 25	Apr 25	May 25
	Target	2128	Actual	2,449	2,332	2,420	2,129
Background			Plan	0	0	2,291	2,259
The number of patients admitted,transferred or discharged over 12 hours after arrival at A&E			Variance	2449	2332	129	-130





What is the data telling us?

In May 2129 patients waited longer than 12-hour in our ED compared with 2420 patients in April, which is a decrease of 291 compared to last month.

The performance trajectory for May was 2259 , which demonstrates a positive against plan of 130.

Note, there has been a decreasing trend since January in the number of patients waiting over 12 hours.

Ranking for May is not yet available but should demonstrate an improved position.

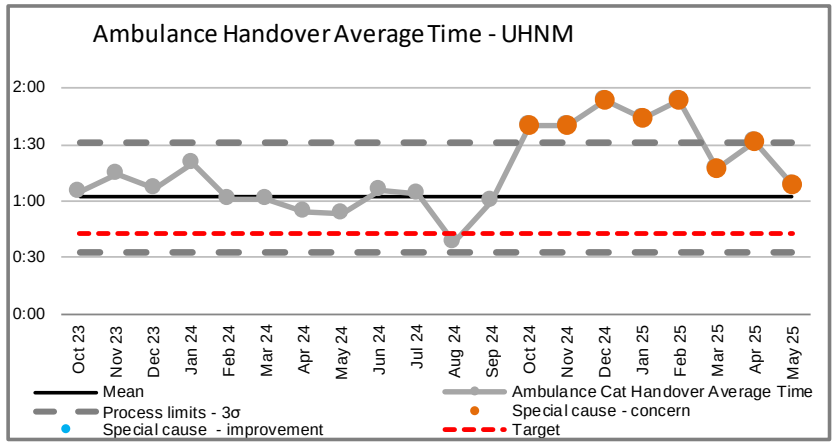
What are we doing about it?

- The UEC Improvement Programme has now been refreshed and is supported by 5 workstreams designed to recovery, sustainability and delivery resilience. The programmes which will support 12 hours are:
- Clinical & Frailty Pathways;
  - Review of demand and capacity across portals to streamline access
  - Current service provision review
  - Benchmark against best practice models
  - Following the positive impact of the implementation of a Frailty Assessment Unit (FAU) at the County site over winter this unit will continue.
- Ward Standard Work, Develop sustainable standard work on wards that supports flow
- Note: The HRD tool is being incorporated into the ward standard work to support flow.
- Development of a discharge lounge across both sites that supports timely flow and preventing patients remaining longer in hospital than they need.
- Discharge planning subgroup that is undertaking case reviews to identify areas of improvement.

The actions above have been time-lined and are built into our planned recovery trajectory which you can see in the top right-hand graph.

Quality & Access | Ambulance Handover Average Time

University Hospitals of North Midlands NHS Trust

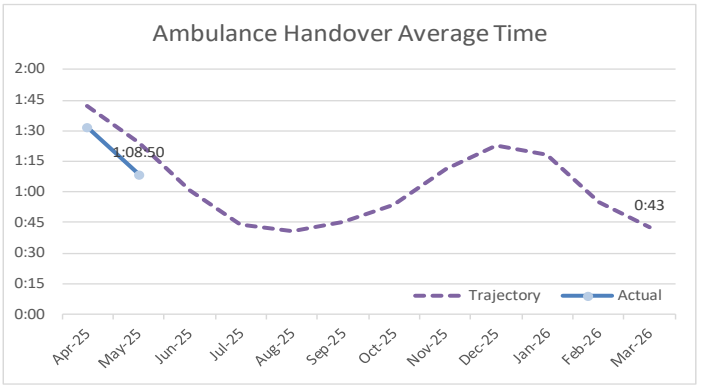


Variation	Assurance	Target	0:43:00

Background

The average time taken for patients to be handed over from Ambulances arriving at UHNM.

Monitoring against plan	Feb 25	Mar 25	Apr 25	May 25
Actual	1:53:43	1:17:35	1:31:36	1:08:50
Plan	#N/A	#N/A	1:42:00	1:24:00
Variance	#N/A	#N/A	-0:10:24	-0:15:10



What is the data telling us?

Average handover time in May was recorded at 1hr 8 min and demonstrated an improvement in performance from last month by 23 min from 1hr 31 min in April.

The target for May was 1hr 24 which was achieved at 1hr 8 min.

We continue to work with colleagues at WMAS on overall ambulance handover reduction.

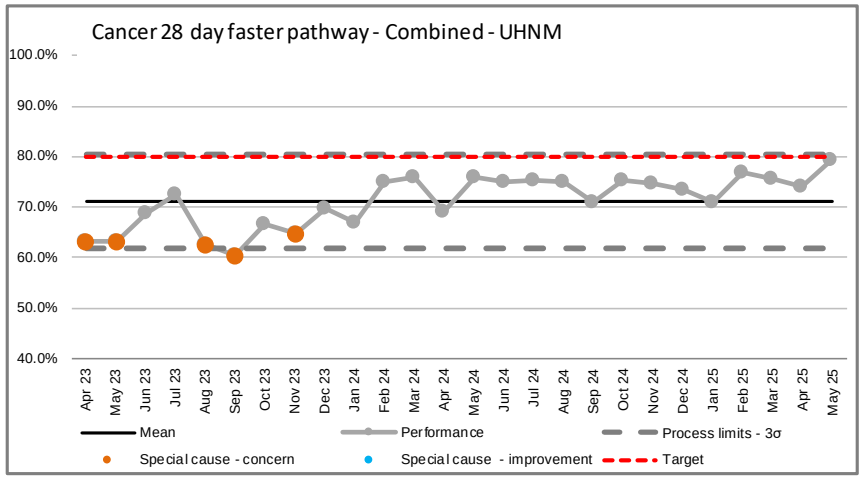
Of note: this is unvalidated data

What are we doing about it?

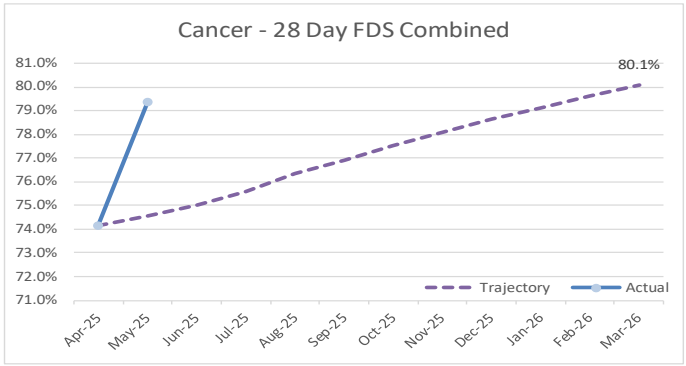
- The UEC Improvement Programme has now been refreshed and is supported by 5 workstreams designed to recovery, sustainability and delivery resilience.
- The Bed & Site Management workstream is development and continues to mature
  - Site management function review
  - Enhance infrastructure within operations
  - Review of patient flow resource
  - Standardisation of processes including escalation levels – test of change planned
- A review of escalation and triggers to support reduction in ambulance handover delays in partnership with WMAS is in train to replicate the London Ambulance Service model of no greater than 45minutes to offload. .
  The corridor in the emergency department is utilised to support the risk of reducing the waiting ambulances.
- A revised HALO provision to cover 24/7 has been approved by The Urgent and Emergency Care Board and formal notification of funding has been received from the ICB. The new specification has been agreed and the timescale for implementation has been suggested end of May. Recruitment has been completed. The specification has been agreed, and recruitment has taken place, the ICB has now released the agreed funding.
- 'Regular daily contact with WMAS is in place to ensure confidence in actions taken and where possible deflects or diverts to County or Burton are agreed to support timely ambulance release

Quality & Access | Cancer 28 Day FDS

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				Feb 25	Mar 25	Apr 25	May 25
	Target	80%	Actual	76.8%	75.6%	74.1%	79.4%
Background			Plan	77.2%	77.3%	74.1%	74.5%
Performance of confirmation or exclusion of cancer communicated with patients within the 28 day timeframe.			Variance	-0.4%	-1.7%	0.0%	4.8%



What is the data telling us?

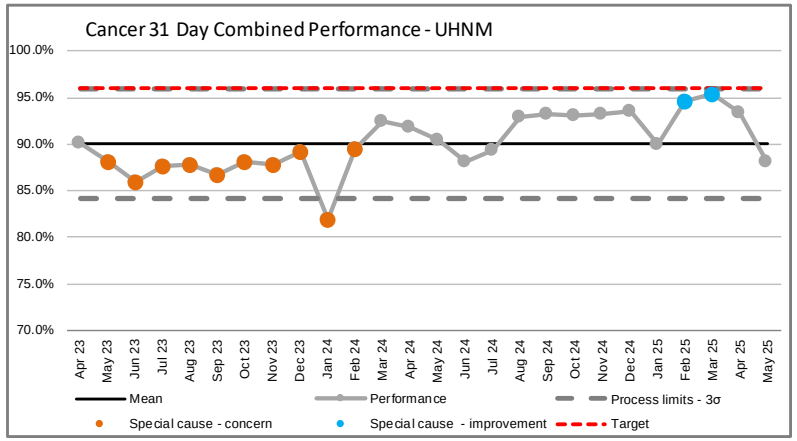
- May 2025 data, while unvalidated, shows performance at 79.4%. Performance overachieves against trajectory of 74.5%
- Colorectal, Haematology, Lung & Urology were below their trajectories for the month of April 2025
- Gynaecology are performing above trajectory, current provisional performance 75.86% for May 2025
- Continue to see year on year improvement for this standard

What are we doing about it?

- Newly established monthly Cancer Delivery Group meetings now brings focus on operational delivery for improvement plans and adherence to agreed trajectories for 25/26
- High level escalations sent weekly as part of all cancer PTL escalations for senior oversight
- WMCA funding bids put forward with a focus on increased ANP and navigator workforce
- Collaborative work stream between Histopathology, Cancer Services and Directorates to escalate suspected cancer specimens, reducing duplication, ensuring correct specimens are escalated appropriately and reducing unnecessary email traffic

Quality & Access | Cancer 31 Day Combined

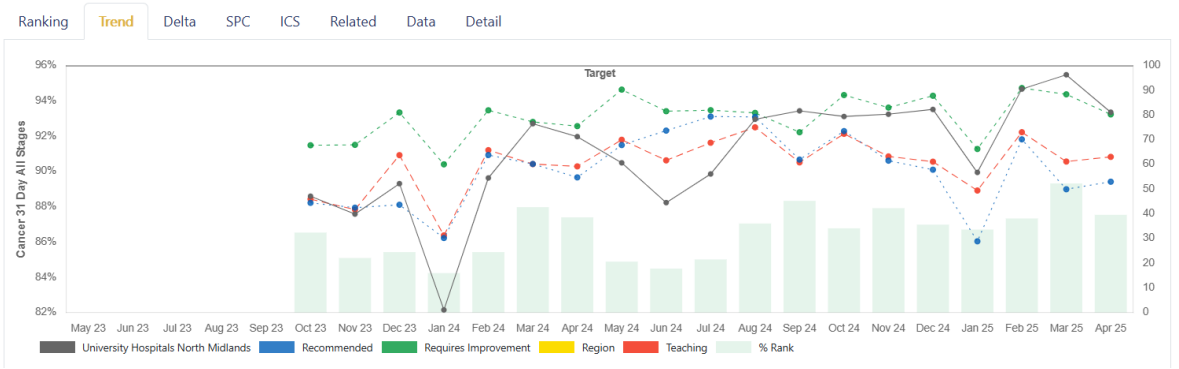
University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
	F			Feb 25	Mar 25	Apr 25	May 25
	Target	96%	Actual	94.7%	95.5%	93.4%	88.1%
Background			Plan	96.0%	96.0%	96.0%	96.0%
% patients beginning their treatment for cancer within 31 days following an urgent GP referral for suspected cancer			Variance	-1.3%	-0.5%	-2.6%	-7.9%

Cancer 31 Day All Stages

Apr 25 Performance: 93.4% | Rank: 82nd of 135



What is the data telling us?

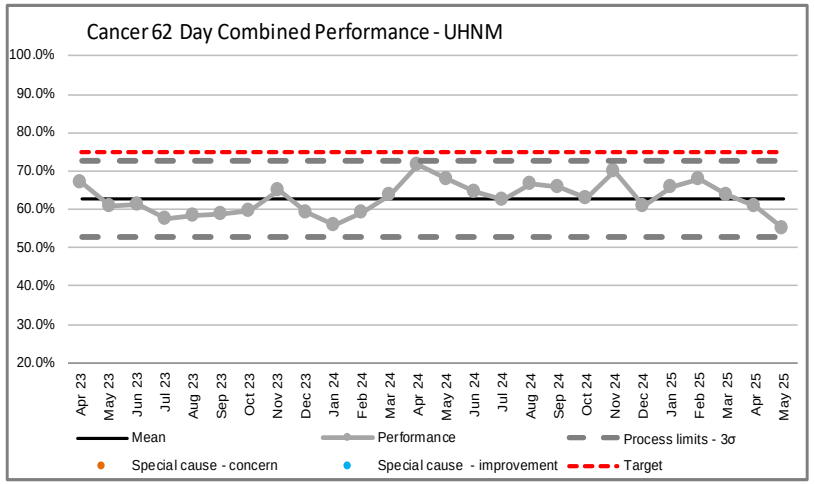
- May 2025 unvalidated position shows performance at 88.1%; this is expected to improve through validation
- April 2025 performance showed a slight reduction to 93.4%, with Colorectal and Skin achieving below 90% due to surgical constraints
- Access to the robot continues to contribute to delays across all surgical specialities

What are we doing about it?

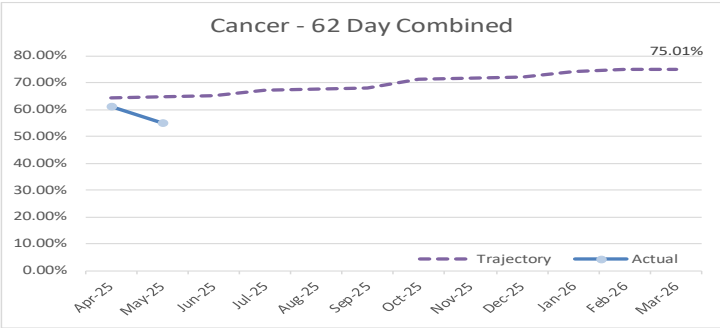
- Access to robotic procedures are prioritised through the oversight group
- Cancer Services currently undergoing recruitment for Data Quality Lead that will focus on validations and modelling best practice from performing sites
- Newly devised tracking structure developed for Skin patients to allow patients booked outside of target for treatment to be identified quickly
- Newly established monthly Cancer Delivery Group meetings to focus on operational delivery of improvement plans, with special focus on Oncology

Quality & Access | Cancer 62 Day Combined

University Hospitals of North Midlands NHS Trust

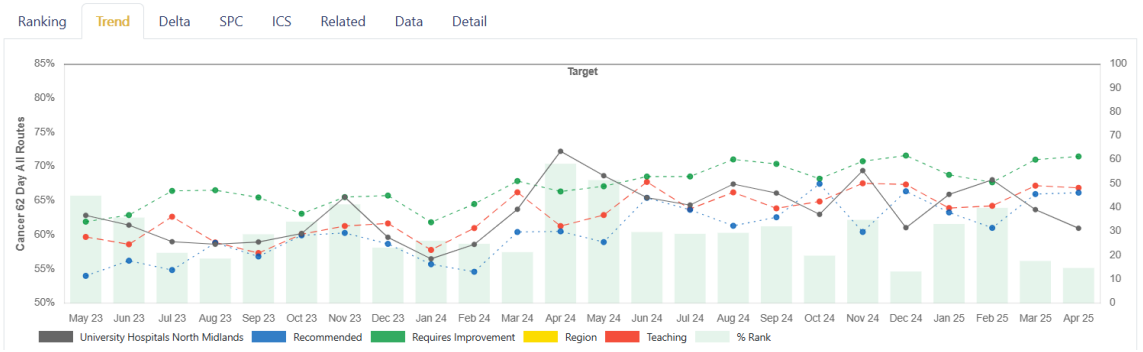


Variation	Assurance		Monitoring against plan				
				Feb 25	Mar 25	Apr 25	May 25
	Target	75%	Actual	68.1%	63.7%	61.0%	55.0%
Background			Plan	69.8%	70.0%	64.6%	64.7%
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer			Variance	-1.7%	-6.3%	-3.6%	-9.7%



Cancer 62 Day All Routes

Apr 25 Performance: 60.96% | Rank: 117th of 137



What is the data telling us?

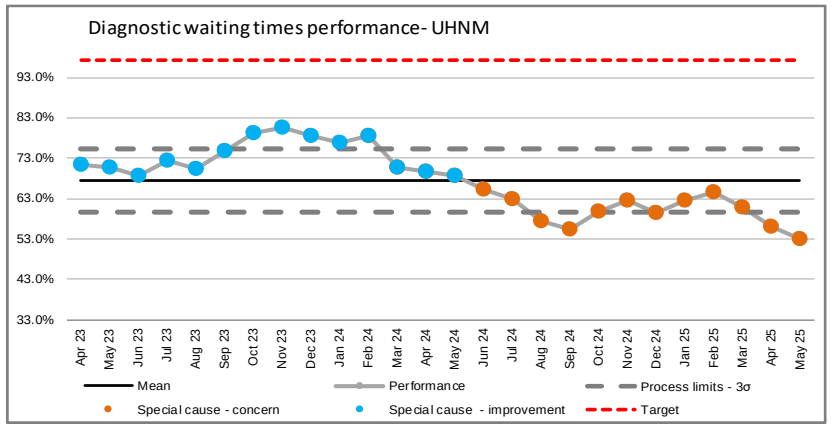
- Unvalidated May 2025 position is showing at 55.0% against trajectory of 64.7%
- Final April 2025 data showed performance of 61.0% against trajectory of 64.6%
- Gynae, Haematology, Head & Neck, Skin & Urology were below their trajectories for the month of April 2025
- Delays to oncology first new appointments affecting Breast & Colorectal
- Surgical capacity constraints including robotics affecting Gynae, Colorectal and Skin

What are we doing about it?

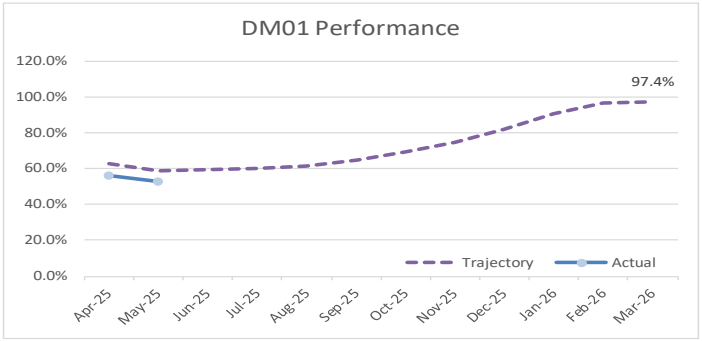
- Increased oversight and adherence to improvement plans for support services such as pathology and radiology to bring down TAT in the diagnostic phase of challenged pathways, managed through CDG
- PMO style pathway reviews being undertaken will be for Gynae in mid July 2025.
- Validation work to ensure Cancer Waiting Times guidance is being applied appropriately is planned 4 weeks ahead of upload to ensure an accurate position is reported – recruitment underway for Cancer Services hosted Cancer Validation Lead to enable more timely validation work
- Theatre utilisation and access to the robot being discussed regularly at EOG
- Locum Oncologist commenced to support Colorectal
- Collaborative working group in process between Histopathology, Directorates and Cancer Services to identify specimens for reporting on appropriate triage pathway (iPortal list for gynae has gone live this week)
- Cancer services working with oncology to gain weekly oversight of oncology capacity

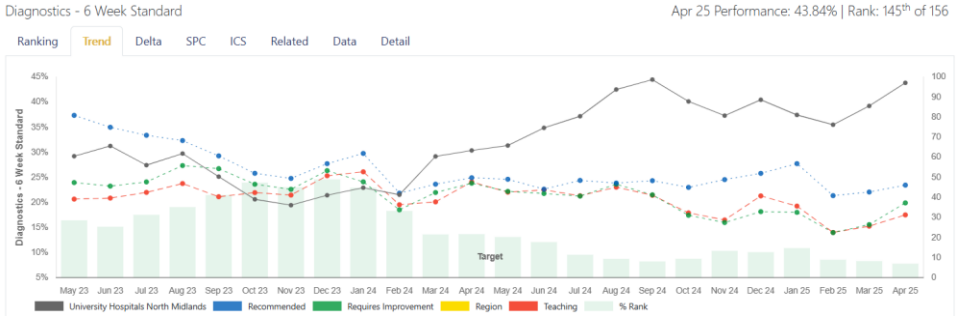
Quality & Access | Diagnostics DM01 Performance

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan	Feb 25	Mar 25	Apr 25	May 25
L	F						
	Target	97.4%	Actual	64.5%	60.8%	56.2%	52.9%
Background			Plan	78.0%	78.4%	62.6%	58.6%
The percentage of patients waiting less than 6 weeks for the diagnostic test.			Variance	-13.5%	-17.6%	-6.4%	-5.7%





What is the data telling us?

May DM01 data is unvalidated at time of writing this report however current performance was at 55.4% against the 95% six-week standard. Non-Obstetric Ultrasound is the majority contributor for overall DM01 performance variance. Non obstetric ultrasound performance has deteriorated to 29.7%, but there are 10,787 patients waiting over 6 weeks for their scan; this is a positive below trajectory of 40 less patients. Other major contributors that impact on DM01 is Echocardiogram and Endoscopy performance:

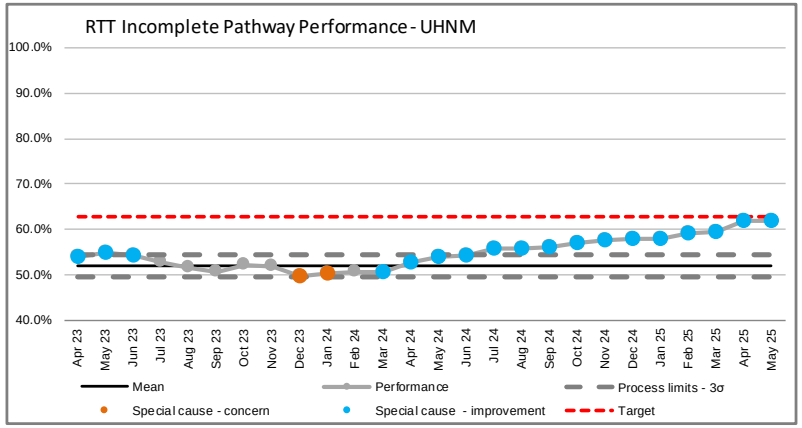
- Echocardiogram performance had improved of late from Jan 25 with current performance is now at 86.4% and 2 remaining patient's to be appointed over 13 weeks. 1 agency post has been appointed to cover a 12-month maternity to avoid further deterioration in performance trajectory approved via execs
- Endoscopy performance has increased to 98.3% against DM01 for the month of May. The late referrals received from the ICB have now all been seen. ERF paper was not approved, therefore need to scope how capacity can meet demand prior to CDC go-live.

What are we doing about it?

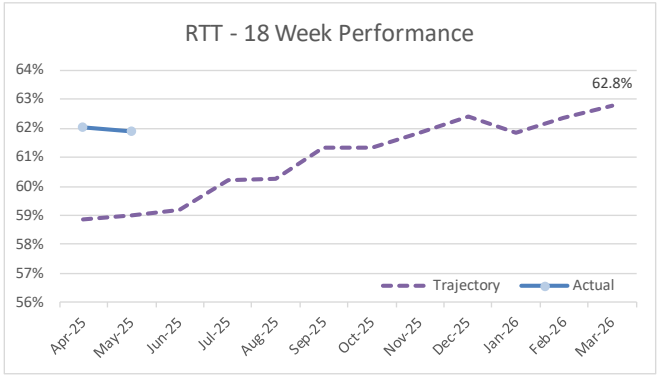
- Non obstetric Ultrasound
- A new trajectory has been developed to map through all the workstreams impacting NOUS with a view to delivering 95% DM01 by March 2026. All workstreams would need to deliver fully and additional in-sourcing would also likely be required to deliver this position
- US oversight group has been established to pull together all workstreams within US to ensure that they can be tracked against anticipated yield and improvement plan for each workstream
- Applying BMUS to all new NOUS referrals the decision has been made to re-vet the entire NOUS backlog against BMUS guidelines. 3000 patients left to vet. Of 12,000 patients vetted, 1000 ID'd for removal; circa 8% removal
- BMUS guidance has now been turned on when vetting all new referrals, and explains why performance has deteriorated even though backlog has reduced; patients under 6 weeks are being removed from the overall PTL. This will bring US in line with other Trust in the region in terms of vetting parameters. It is anticipated that this will reduce conversion of referrals to scans by approximately 15%
- New partial booking process being developed to support with new referrals coming into the department. RWT indicated this reduced demand by approximately 20%. This will commence with letters being sent to patients in June. As such, impact on waiting lists will take effect by August based on required notice periods

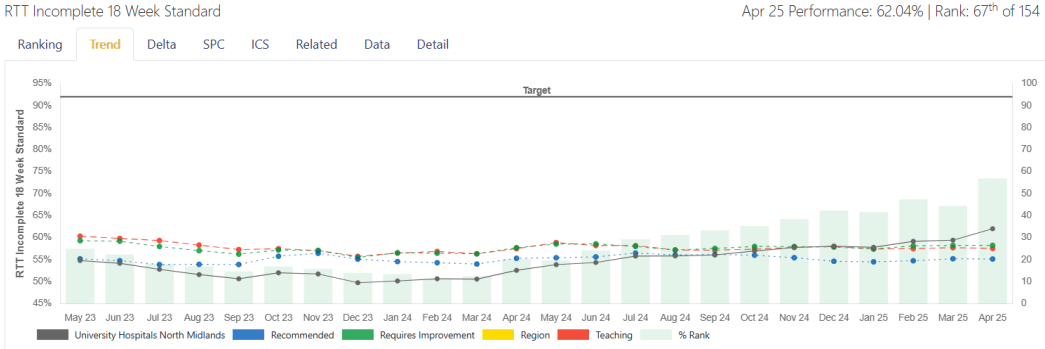
Quality & Access | RTT Performance

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				Feb 25	Mar 25	Apr 25	May 25
	Target	63%	Actual	59.2%	59.4%	62.0%	61.9%
Background			Plan	92.0%	92.0%	58.9%	59.0%
The percentage of patients waiting less than 18 weeks for treatment.			Variance	-32.8%	-32.6%	3.2%	2.8%





What is the data telling us?

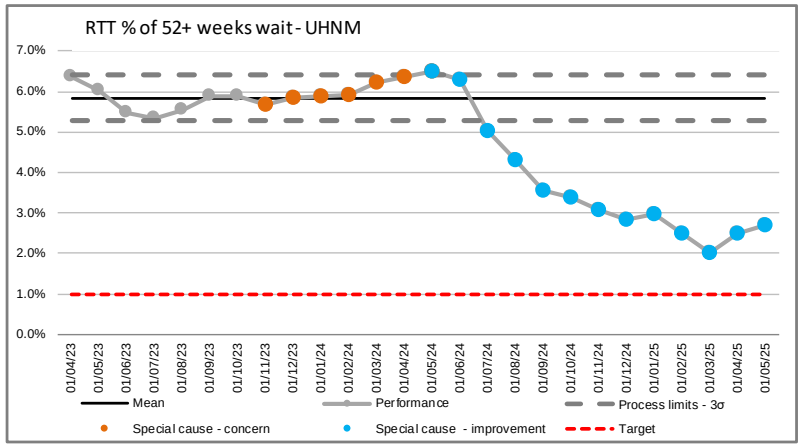
- Performance has improved significantly through extensive validation work completed by MBI, the Corporate Validation Team and the Care Groups. Performance is 62.97%; 4% above trajectory which is 59%
- Validated month end position is Total WL size has also decreased by 4000, although this rate will slow down as the data quality of the waiting list improves.

What are we doing about it?

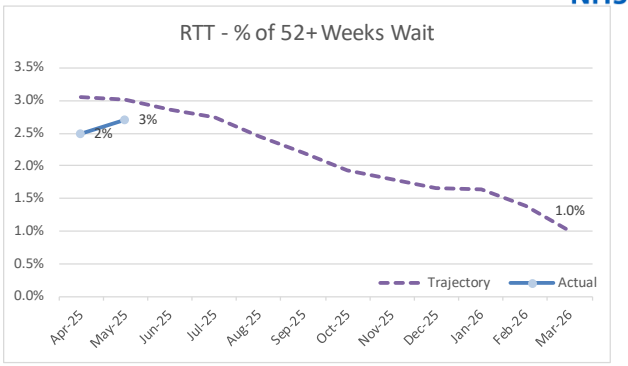
- Validation work will continue at pace to deliver the asks of the national validation sprint
- Work so far has targeted known areas of challenge with data quality and clock stop capture, which is disproportionally patients waiting 18+ weeks. 60% of the patients waiting <18 weeks have yet to be seen, as opposed to 30% of those waiting above 18 weeks; less risk of error
- The ROVA validation tool will start the automated validation, this will extend to the entire waiting list. This may show a large number of removals in the <18w cohort. Performance, validation and corrections will be closely monitored to ensure performance standards are met. It is anticipated that this will be live during June 2025.

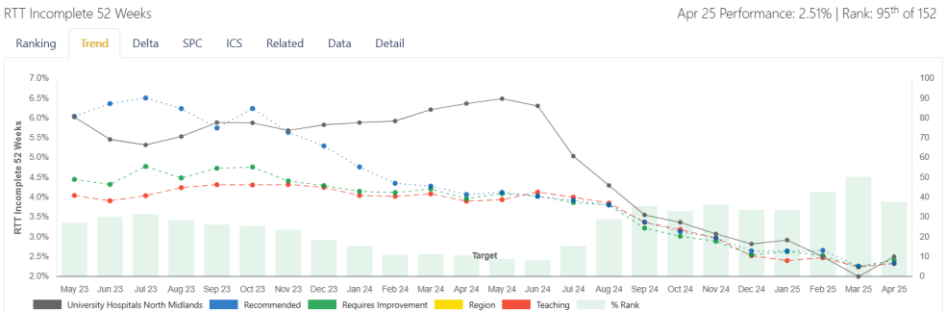
Quality & Access | RTT Performance – % 52+ Weeks

University Hospitals of North Midlands NHS Trust



Variation	Assurance	Monitoring against plan				
			Feb 25	Mar 25	Apr 25	May 25
	Target 1.00%	Actual	2.51%	2.00%	2.50%	2.71%
Background		Plan			3.05%	3.01%
The percentage of patients on a RTT pathway who have		Variance			-0.6%	-0.3%





What is the data telling us?

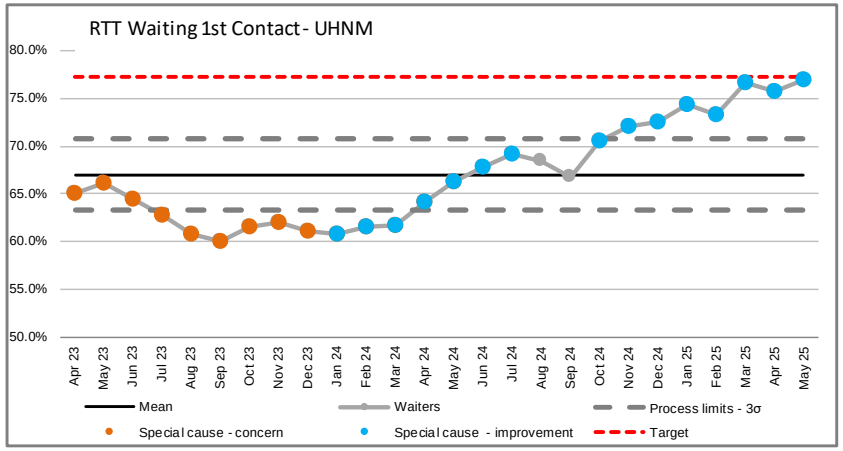
- Although the proportion of our waiting list waiting above 52% has continually reduced, the cumulative effect of extended UEC pressures has slowed down progress
- This cohort is extensively validated, so there's not much scope for improvement through validation alone
- Another factor influencing this is the reduction in total waiting list size, so the unavoidable side effect of the validation programme is an increase in the percentage of the waiting list over 52 weeks

What are we doing about it?

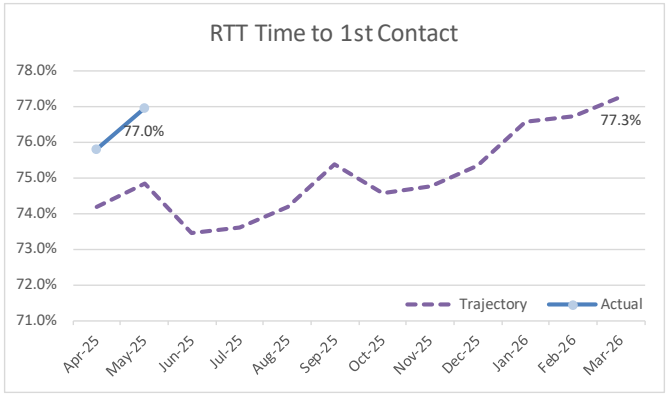
- The ROVA validation tool also highlights pathways where actions have not been taken, and groups pathways awaiting the same action for easier tracking of patients at all stages of the pathway
- Validation data is captured systematically in terms of what errors are being made and in which services, allowing 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

Quality & Access | RTT % Waiting 1st Contact

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
H	F			Feb 25	Mar 25	Apr 25	May 25
	Target	77.3%	Actual	73.4%	76.7%	75.8%	77.0%
Background			Plan	#N/A	#N/A	74.2%	74.8%
Of all patients waiting for first event after referral - the percentage that are waiting under 18 weeks			Variance	#N/A	#N/A	1.6%	2.1%



What is the data telling us?

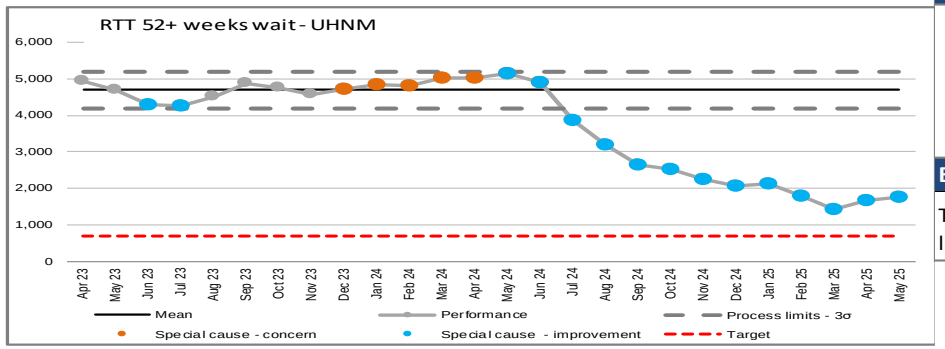
- UHNM is a regional leader on this metric and ahead of plan. April had dipped slightly due to the Easter holiday period and reduction in TI clinics funded by ERF but has increased again in May.

What are we doing about it?

- ERF papers approved, and mobilisation has been quicker than expected for outpatient clinics

Quality & Access | RTT No. of Long Waiting Patients

University Hospitals of North Midlands NHS Trust



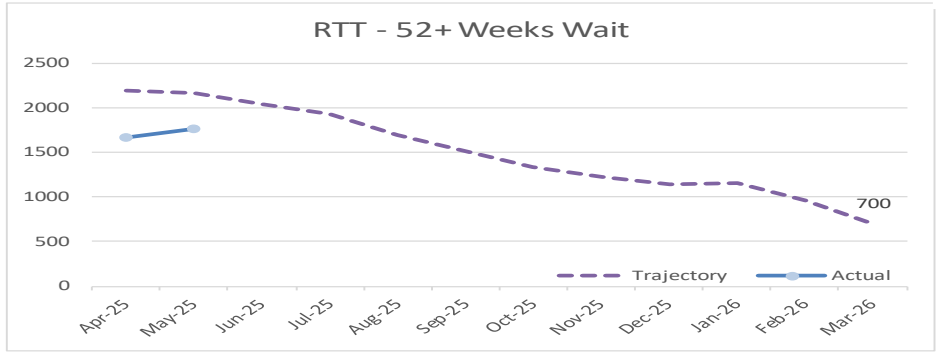
Variation	Assurance
L	F

Target	700

Background

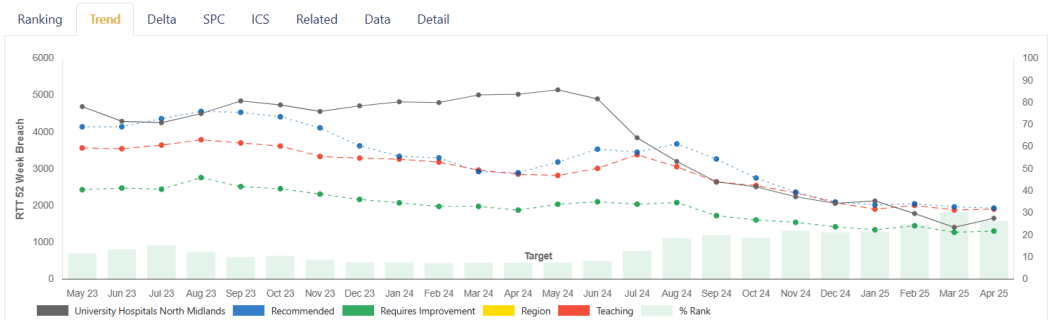
The number of patients on a RTT pathway who have waited longer than 52 weeks for treatment.

Monitoring against plan	Feb 25	Mar 25	Apr 25	May 25
Actual	1797	1423	1672	1771
Plan	5606	5192	2190	2172
Variance	-3809	-3769	-518	-401
65+	215	186	215	#N/A
78+	7	7	26	#N/A
104+	3	0	3	#N/A



RTT 52 Week Breach

Apr 25 Performance: 1,665 | Rank: 112th of 152



What is the data telling us?

- Our overall ranking has improved from 115th out of 153 reporting Trust to 106th out of 152 reporting Trusts
- The number of 78 week breaches has increased in May to 31 from 26 in April. This is due in large part to cumulative effects of UEC pressures – most of these patients are on admitted pathways who require an RSUH bed for a complex procedure requiring some combination of specific surgeons, surgical robots, extended theatre time
- 65 week waits have also increased to 233 from 220 in April, for the same reasons.
- 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 and Gynaecology.

What are we doing about it?

- Micromanaging long waiting patients at daily/weekly PTL meetings
- ERF funding approved to increase evening and weekend operating capacity
- Orthopaedics & Spinal exploring with ICB the opportunity of transferring patients to Nuffield & Ramsay

Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE | 4th July 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate

- Continued risk in terms of the **Urgent and Emergency Care** (UEC) trajectory becoming more challenging given the dependence on the larger transformative pieces of work with partners.
- **62 day cancer** performance was off trajectory, due to colorectal cancer and surgical access, and additional actions were to be considered by the Executive Team
- Challenges with **long wait** patients were identified, particularly for Ear, Nose and Throat (ENT), gynaecology and orthopaedics. There was confidence that ENT and gynaecology would be able to recover, although Orthopaedics was expected to be more difficult
- **Patient waiting list** backlog highlighted the progress being made in testing an electronic system to obtain prospective harm reviews although **partial assurance** was provided due to the delays in conducting the reviews
- Month 2 **Quality Report** highlighted underperformance for targets in relation to written duty of candour, falls with ham, pressure ulcers developed at UHNM, venous thromboembolism (VTE), single sex breaches within critical care, friends and family test in both Emergency Department and Maternity in addition to the Hospital Standardised Mortality Ratio (HSMR).
- In terms of the **mortality assurance** report, the Committee agreed to decrease the assurance rating to **no assurance**, due to the ongoing issues in relation to the coding backlog and the unreliability of data. This was due to the length of time this had been an issue and lack of immediate resolution. The Committee was however assured that morbidity, mortality and learning from deaths meetings continued to take place and additional assurance processes were in place in terms of completion of structured judgement reviews, and medical examiner review of deaths.
- The update on **Hospital Associated Thrombosis** (HAT) was agreed as providing **partial assurance** given 21 cases had evidence of incomplete risk assessments between November 2024 and February 2025. However, the Committee were assured that no avoidable cases had been identified

Major Actions Commissioned / Work Underway

- **Deep dives** to be undertaken to provide additional assurance in respect of key areas of harm and assessing vulnerabilities for our population
- Update to be provided to the Committee in terms of the **Electronic Prescribing and Medicines Administration** (EPMA) project and the continuing delays and mitigating actions
- To link in with peers with regards to the assessment of **duty of candour** in order to address the issues identified in terms of the new Patient Safety Response and Incident Framework (PSRIF) approach which may be contributing to delays
- Further assurance was requested in terms of **mortality** and the actions to be taken to address the backlog in coding in the interim whilst coders were being trained
- The Committee requested changes to be made to the **Annual Mortality Assurance** Report before being resubmitted to the Committee
- Further assurance was requested in terms of the 5 **HAT** risk assessments which were not completed and reasons for this
- **Major Trauma Peer Review** highlighted that 3 of the 4 concerns had been met however the Committee requested sight of the actions to address the general concerns so that acceptable assurance could be provided, in addition to providing additional information in addressing the gap in relation to orthoplastics
- Gap analysis to be undertaken in relation to the NHS England request in terms of **maternity and neonatal care** and to be provided to the Committee

Positive Assurances to Provide

- **UEC** metrics (4 hour, 12 hour and average ambulance handover time) were on trajectory although it was recognised that further improvement was required. In addition, there remained variation in performance in month, but this was being dealt with in a quicker timeframe
- **Referral to Treatment Times** (RTT) continued to maintain a positive trajectory
- **Acceptable assurance** was agreed for the Month 2 **Quality Report** given the improvements in Care Quality Commission ratings and the metrics which had improved to date. The Committee welcomed the introduction of deep dives which would provide further assurance, the outcome of which would be considered when determining future assurance ratings.
- Updates on the actions taken in relation to **Paediatric Audiology Service** were provided to the Committee which provided **acceptable assurance**. The outstanding actions related to confirmation of funding for audiometric booths and advertising to an Improving Quality in Physiological Services (IQIPs) Manager was to take place
- **Reasonable assurance** was provided following completion of the internal audit into **Maternity and Neonatal Action Plan: Single Delivery Plan (SDP) Framework**

Decisions Made

- The Committee approved the Terms of Reference for the **Executive Recovery Oversight Group**

Comments on the Effectiveness of the Meeting

- The Committee welcomed the discussion held and it was felt that the hybrid approach to meeting worked
- Committee members also welcomed the challenge and discussion of assurance ratings

Cross Committee Considerations

- No further considerations identified

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Access Performance Report Month 2 25/26	1		Partial	Assurance	6.	Paediatric Audiology Service Update	1	ID33109 ID31492	Not assessed	Assurance
2.	Executive Recovery Oversight Group Highlight Report (23-06-25) & Terms of Reference	1, 7/8		N/A	Approval	7.	Major Trauma Peer Review	1		Acceptable	Assurance
						8.	Mortality Assurance Report Q4 2024/25	1	ID36869	No assurance	Assurance
3.	Patient Waiting List Backlog	1	-	Partial	Assurance	9.	Annual Mortality Assurance Report 2024/25	1		Not assessed	Assurance
4.	Quality Performance Report – Month 2 2025/26	1	-	Acceptable	Assurance	10.	Internal Audit: Maternity and Neonatal Action Plans: Single Delivery Plan (SDP) Framework	1	-	Acceptable	Assurance
5.	Hospital Associated Thrombosis Increase November 2024 - February 2025	1	-	Partial	Assurance	11.	NHSE Letter on Maternity and Neonatal Investigation / Taskforce	-	-	N/A	Information

Highlight Report

Finance & Efficiency Committee | 2nd June 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• **Finance performance** for month 1 was on plan although actions were being taken to understand the reason for the £0.8 m overspend on bank expenditure. It was agreed that future updates would provide additional information in terms of workforce and any associated risks and partial assurance was agreed • An update was provided on **cost improvement savings** following the initial meeting of the Executive Recovery Oversight Group. It was noted that future updates would focus on delivery of associated milestones as well as ensuring any associated risks were identified and partial assurance was agreed	• To confirm the revenue budget available for the capital charges in addition to confirming the amount to be funded by all Trusts, for the **LIMS business case** • Review after 6 months to be provided for the **Robotic Assisted Surgery** business case, to understand the progress on the savings that can be made on the future cost pressure • To provide a detailed operational plan for closing any wards as a result of the **Frailty Service business case**, ensuring strategic alignment of any resources • To provide further clarification in terms of the **Endoscopy Elective Recovery Funding (ERF) bid** and links with the Community Diagnostic Centre • Updates to be provided in future **CIP** reports on progress against key themes such as workforce. • To ensure that **business case reviews** were brought to the Committee in line with the recommendations from the recent internal audit, particularly considering whether deep dives were required for significant projects, alongside the usual summary
Positive Assurances to Provide	**Decisions Made**
• Acceptable assurance was agreed for the **bi-annual sustainability and net zero carbon** report with positive assurances focussed on the receipt of grant funding in 2024/25 and continuing development of partnerships. In addition, a new Green Plan was in development	• The Committee approved **Business Cases** BC-0602, BC-0606, BC-0607 • The Committee approved the cases for **Elective Recovery Funding** (ERF) in principle, given the need to ensure these remained within the specific cost envelope and prioritised accordingly to achieve the constitutional standards • The Committee approved the updated base **capital expenditure plan** • The Committee approved **e-REAFs** 16282, 16251, 16192, 16320 and 16369
Comments on the Effectiveness of the Meeting	**Cross Committee Considerations**
• No further comments were made	• To consider any issues in relation to third party provider risks following the discussion on the LIMS case, with the Audit Committee

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	BC-0602: LIMS and order Communications Results and Reporting System Implementations	5	Ext 20	Not applicable	Approval	6.	CIP Report	7, 8	6 20	Partial	Assurance
2.	BC-0606: Robotic Assisted Surgery – UHNM Expansion Business Case	1, 4	16 20	Not applicable	Approval	7.	Executive Recovery Oversight Group Highlight Report (19.05.25)	7, 8	6 20	Not rated	Assurance
3.	BC-0607: County Hospital Frailty Service	4	Ext 20	Not applicable	Approval	8.	Productivity / Efficiency Performance Report Month 1 2025/2026	4	Ext 20	Not rated	Assurance
4.	ERF Bids update	4	Ext 20	Not applicable	Approval	9.	Sustainability and Net Zero Carbon (NZC) Bi-Annual Performance Report	6	High 12	Acceptable	Assurance
5.	Finance Report – Month 1 2025/2026	7, 8	6 20	Partial	Assurance	10.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure			Not applicable	Approval

Highlight Report

Finance & Efficiency Committee | 30th June 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• **Partial assurance** was provided by the **Business Case Review Update** which recognised the ongoing actions identified in respect of improving the approach going forwards. • **Partial assurance** was agreed for the **County Elective Hub** update given the delays which had previously been incurred • The Trust remained on plan for **financial performance** as at month 2, with a deficit of £6.9 m and forecasted break-even position by year end. It was noted that the cost improvement programme (CIP) was on target, in part due to the vacancy controls in place. However, there remained risks which could deteriorate the financial position in terms of income shortfalls due to lower than planned activity, and the potential shortfall in CIP particularly those in relation to length of stay improvements and bed base realignment, as such **partial assurance** was provided • **Partial assurance** was provided by the **CIP** update whereby there remained £38 m at risk, of the £75 m target. It was noted that the approach to move towards financial recovery was being considered, implications of which would be provided to the committee in due course. • The quarterly update on **productivity** was provided, which highlighted specific areas of improvements such as theatre performance. **Partial assurance** was provided, and feedback was sought on any additional items which could be considered in future updates with opportunities for further scrutiny through deep dives, once the productivity is established.	• To agree the approach outside of the Committee in terms of receipt of **business case reviews**, improving their effectiveness and concluding the outstanding actions in respect of this • To provide an update to the Trust Board as required in relation to **Project STAR** and the associated land sale • Further paper to be provided to the Committee in relation to the **capital programme** • The **cross-committee consideration** from Audit Committee regarding major programmes and the impact on the Trusts' longer term financial sustainability was discussed and will be developed for future reporting at the Committee • Further discussions to take place, in terms of merging the strategy and transformation business cycle into the Finance and Efficiency Committee, as appropriate, to provide ongoing oversight

Positive Assurances to Provide	Decisions Made
• The Committee received an update on the progress with **Project STAR** in terms of the bids received and the planning application was progressing. Further assurance was requested by the Committee in terms of ensuring getting the best value from the bid, and any risk to the project after completion of groundworks	• The Committee approved **Operation Anzu Workforce** business case for the year 2025/26, subject to review by the Risk Management Oversight Committee. It was noted that the case was an acceptable short-term response and any requests for funding for future years would be subject to further review to ensure this met the Trust's requirements • The Committee approved the increase in the **capital programme** of £2.4 m for the discharge lounge given this was fully funded • The Committee **approved** the following Electronic Request for Executive Approvals (e-REAF) Linen and Laundry Services (16257), Surgical Drapes and Gowns (16258), Telephony Support Services (16399), Insourced Endoscopy Diagnostic Services (16341), Intuitive da Vinci Xi Surgical Robot (16482), Critical Care Acella Beds (16472), Maintenance of CDC Equipment (16391), Supply of Recombinant Coagulation Factors (16404), Direct Engagement Model – PwC Clarity (16417), Supply of MOD staff (15993) • The Committee approved the Terms of Reference for the **Executive Recovery Oversight Group**

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• No comments were provided	• **Operation Anzu Business Case** to be provided to the Risk Management Oversight Committee to ensure the business case met the needs of the Trust in addition to clarifying which risks the business case sought to mitigate

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Project STAR – Planning, Marketing and Land Disposal	6	12	Significant	Information	5.	CIP Report	7/8	-	Partial	Assurance
2.	Operation Anzu Workforce Resources	-	Multiple	N/A	Approval	6.	Productivity Update	7/8	-	Partial	Assurance
3.	Business Case Review Update • County Elective Hub Update	-	-	Partial	Assurance	7.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-	-	N/A	Approval
4.	Finance Report – Month 2 2025/26	7/8	-	Partial	Assurance	8.	Executive Recovery Oversight Group Terms of Reference	-	-	N/A	Approval

Appendix 1 - Contract Awards and Approvals

Since 14th April to 14th June 2025, 2 contract awards over £1.5 m were made, as follows:

- **Cytotoxic Dose Banded - Chemo, Immunotherapy and Monoclonal Medicines,** supplied by Quantum Pharmacutical, Sciensus Pharma, Qualasept Bath ASU & Baxter, for the period 01.07.25 – 31.06.26, at a total cost of £14,000,000, approved on 7th May 2025
- **BioMérieux Managed Service Contract,** supplied by BioMérieux, for the period 01.05.25 – 30.04.30, at a total cost of £12,000,000, providing savings of £496,000, approved on 7th May 2025

University Hospitals of North Midlands NHS Trust

Integrated Performance Report

Month 02 Performance

2025/26

Kind Excellent Together

Data Quality & Statistical Process Control

University Hospitals of North Midlands NHS Trust

Data Quality Assurance Indicators (DQAI) are used in this report to help give context and assurance as to the reliability and quality of the data being used. The STAR Indicator provides assurance around the processes used to provide the data for the metrics reported on. The four Data Quality domains are each assessed and assurance levels for each are indicated by RAG status.

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.

Explaining Each Domain:

Domain		Assurance Sought
S	Sign Off and Validation	Is there a named accountable executive, who can sign off the data as a true reflection of the activity? Has the data been checked for validity and consistency with executive officer oversight?
T	Timely & Complete	Is the data available and up to date at the time of submission or publication? Are all the elements of required information present in the designated data source and no elements need to be changed at a later date?
A	Audit & Accuracy	Are there processes in place for either external or internal audits of the data and how often do these occur (annual / one off)? Are accuracy checks built into collection and reporting processes?
R	Robust Systems & Data Capture	Are there robust systems which have been documented according to data dictionary standards for data capture such that it is at a sufficient granular level?

Sign Off & Validation

Timely & Complete

Audit & Accuracy

Robust Systems & Data Capture

The best joined-up care for *all*

RAG Rating Key:

	Good level of assurance for the domain
	Reasonable Assurance with an action plan to move into Good
	Limited or No Assurance for the domain with an action plan to move into Good

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

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Assurance Grid

University Hospitals of North Midlands NHS Trust

Failing

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

VARIATION	ASSURANCE: Pass	Hit and Miss	Fail	No Target
Special Cause - Improvement	Maternity Triage Sepsis - Adult Inpatient IVAB UEC 4 Hour Performance		RTT Performance - <18 Weeks RTT >52 Weeks %	
Common Cause	Induction of Labour Sickness Absence (R12M)	Patient Safety Incidents rate per 1000 bed days Patient Safety Incidents with moderate harm and above per 1000 bed days Patient falls with harm per 1000 bed days Medication Incidents per 1000 bed days Medication Incidents % with moderate harm or above Patient Safety Incident Investigation (PSII's) instigated Never Events per month Pressure ulcers developed under UHNM per 1000 bed days Family & Friends Test - Inpatient Family & Friends Test - Maternity Sepsis - Adult Inpatient Screening Sepsis - ED Portals Screening Sepsis - ED Portals IVAB Sepsis - Childrens Screening Sepsis - Maternity Screening Staff Vacancy Rate Cancer 31 Day Combined	Family & Friends Test - ED Single Sex Breaches Appraisal (PDR) Employee Engagement Cancer 28 Day FDS Cancer 62 Day Combined	
Special Cause - Concern	RTT - Time to First Seen %	Staff Turnover (R12M) Agency Utilisation Over 12 hours in ED	Diagnostics DM01 Performance	

Worsening

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Finance | Financial Summary

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

This report presents the financial performance of the Trust for May 2025 (month two).

The Trust has delivered a £6.9m deficit in line with the planned deficit for month two.

Income: The income and expenditure analysis reveals key variances, including lower-than-expected income from pass-through devices and drugs, and a delay in Community Diagnostic Centre income.

Activity: The Trust must address the underperformance in Elective and First Attendance to avoid financial repercussions. The ongoing negotiations with the ICB and the implementation of action plans by the Financial Recovery Board are crucial steps in ensuring financial stability.

Expenditure: There is a slight underspend in pay expenditure and a notable reduction in agency expenditure. Non pay is underspent by £2.8m YTD.

CIP: The Trust has a £74.8m CIP target for 2025/26, with planned savings met in month two.

Capital: The capital expenditure plan for 2025/26 is increasing from £99.5m to £101.9m. The year-to-date position shows a spend of £5.9m against plan of £6.5m, mainly related to the CDC and TIF 2 Breast Unit schemes.

Statement of Financial Position: The month two Statement of Financial Position shows total assets employed at £256.3m. The cash balance at month two is £62.9m against a plan of £68.2m.

System Position: The system month position has an adverse variance of £2.2m from the planned deficit.

Financial Risks: Several risks have been identified that could deteriorate the Trust's financial position, including additional unfunded capacity, shortfall against CIP plans, and lower activity levels than required to meet ERF income targets. Mitigations will need to be put in place if there is a deterioration in the financial position.

Finance | Income and Expenditure

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

The Trust has delivered a £6.9m deficit at month two, which is in line with the planned deficit of £6.9m. The table below summarises the Income and Expenditure position at month two.

Income & Expenditure Summary Month 02 2025/26	Annual Budget £m	In Month			Year to Date		
		Budget £m	Actual £m	Variance £m	Budget £m	Actual £m	Variance £m
Income From Patient Activities	1,196.2	99.8	97.9	(2.0)	199.6	195.8	(3.7)
Other Operating Income	99.0	7.8	8.0	0.2	15.8	16.1	0.3
Total Income	**1,295.2**	**107.7**	**105.9**	**(1.8)**	**215.4**	**211.9**	**(3.5)**
Pay Expenditure	(760.4)	(65.7)	(65.4)	0.2	(131.7)	(131.6)	0.1
Non Pay Expenditure	(502.3)	(42.6)	(41.3)	1.3	(85.3)	(82.5)	2.8
Total Operational Costs	**(1,262.8)**	**(108.3)**	**(106.7)**	**1.6**	**(216.9)**	**(214.0)**	**2.9**
EBITDA	**32.4**	**(0.6)**	**(0.8)**	**(0.2)**	**(1.5)**	**(2.1)**	**(0.6)**
Interest Receivable	2.4	0.2	0.4	0.2	0.4	1.0	0.6
PDC	(4.8)	(0.4)	(0.5)	(0.1)	(0.8)	(0.9)	(0.1)
Finance Cost	(30.0)	(2.5)	(2.5)	0.0	(5.0)	(5.0)	0.0
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Surplus / (Deficit)	**(0.0)**	**(3.3)**	**(3.3)**	**(0.0)**	**(6.9)**	**(6.9)**	**(0.0)**

Finance | CIP

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

The Trust has a £74.8m CIP target for 2025/26. To month two, the Trust is reporting £4.1m savings in year, against a target of £4.1m, however, £1.6m is being delivered non-recurrently above the original non recurrent plan of £0.6m. The table below summarises the month two position:

	Plan Plan 31/05/2025 YTD £'000	Actual Actual 31/05/2025 YTD £'000	Variance Variance 31/05/2025 YTD £'000
Recurrent			
Pay - Recurrent	1,981	327	(1,654)
Non-pay - Recurrent	704	569	(135)
Income - Recurrent	584	573	(11)
Total recurrent efficiencies	**3,269**	**1,469**	**(1,800)**
Non recurrent			
Pay - Non-recurrent	584	2,143	1,559
Non-pay - Non-recurrent	250	106	(144)
Income - Non-recurrent	0	385	385
Total non-recurrent efficiencies	**834**	**2,634**	**1,800**
Total Efficiencies	**4,103**	**4,103**	**(0)**

Finance | Capital

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

The tables below set out the updated base case capital expenditure plan for 2025/26. The overall plan has increased from £99.5m in month one to £101.9m. The increase relates to the additional bid submitted to NHSE in June for the discharge lounges for £2.4m.
The year-to-date position shows a spend of £5.9m against a plan of £6.5m, the spend mainly relates to the CDC and TIF 2 Breast Unit schemes.

UHNM Capital Expenditure Plan - interim 25/26	PAF Approved Base Case £m	Movements £m	Revised Base Case £m	YTD plan M2 £m	YTD actual M2 £m
Pre-committed items - PFI and Loans					
PFI re-payment of liability	14.9		14.9	2.5	2.5
PFI lifecycle commitments	2.3		2.3	0.4	0.4
PFI PACS refresh - increase to PFI liability	0.2		0.2	0.0	0.0
PFI MES - increase to PFI liability TBC	7.5		7.5	1.2	0.0
Repayment of IFRS16 leases	4.3		4.3	0.7	0.7
Total PFI and IFRS16 lease repayments commitments	**29.1**	**-**	**29.1**	**4.8**	**3.6**
Investment items					
PFI enabling costs	0.2		0.2	0.0	0.0
Network & Comms BC525	0.7		0.7	0.0	0.0
LED lighting BC546	0.4		0.4	0.0	0.0
Pharmacy Robot BC487 - BC to be updated	0.0		0	0.0	0.0
IM&T computer hardware refresh BC569	2.1		2.1	0.0	0.0
EPMA	0.1		0.1	0.0	0.0
Investment funding for new business cases 25/26	0.3		0.3	0.0	0.0
Central Contingency & risk	0.0		0	0.0	0.0
Project Star - RI remedial work	0.01		0.01	0.0	0.0
ED ambulance off - enabling ward moves	0.3		0.3	0.0	0.0
Endoscopy works 7th room - PDC ICB allocation TBC	0.4		0.4	0.0	0.0
Completion of County Holding Bay	0.1		0.1	0.0	0.0
Omnicell Cabinet for AMU - BC yet to be approved	0.0		0	0.0	0.0
Managing H&S risk register - BC562 (from £500k)	0.04		0.04	0.0	0.0
Bowel screening year 4 BC yet to be approved	0.0		0	0.0	0.0
Endoscopy BC GI PHYS BC583	0.0		0	0.0	0.0
Low temperature Hot Water Pipework - details TBC	0.2		0.2	0.0	0.0
Royal Stoke high voltage upgrade BC required	0.8		0.8	0.0	0.0
Theatre stock management system BC required	0.0		0	0.0	0.0
Printer lease refresh BC591	0.6		0.6	0.0	0.0
Elective hub 24/25 brought forward spend	0.4		0.4	0.0	0.2
PDC brokerage/re-badging	(0.0)		- 0.0	0.0	0.0
Total Pre committed Investment items	**6.6**	**-**	**6.6**	**-**	**0.2**
Capital sub-group (ICB allocation)					
IMT Sub Group Total Funding	3.6		3.6	0	0.1
IM&T lap top top-slice	0.0		0	0	0.0
Medical Devices Sub Group	3.6		3.6	0	0.0
Medical devices fleet replacement	0.0		0	0	0.0
Estates Sub Group Total Funding	5.4		5.4	0	0.1
Health & Safety compliance	0.2		0.2	0	0.0
Net zero carbon (sustainability) initiatives	0.1		0.1	0	0.0
Total Sub Groups	**12.9**	**0**	**12.9**	**0**	**0.18**

UHNM Capital Expenditure Plan - interim 25/26	PAF Approved Base Case £m	Movements £m	Revised Base Case £m	YTD plan M2 £m	YTD actual M2 £m
New IFRS16 leases (previously classified as operating leases and charged to revenue)					
Lease liability re-measurement	0.2		0.2	0.0	0.0
IFRS16 Guy Hilton	0.02		0.02	0.0	0.0
IFRS 16 New Vehicles lease	0.0		0	0.0	0.0
IFRS16 Sports Medicine (Arthrex)	0.0		0	0.0	0.0
IFRS16 Leighton and Macclesfield Path Beckman ext Sep 25 onwards (3 yrs) BC required	0.8		0.8	0.0	0.0
IFRS16 Macclesfield track upgrade contingency	0.0		0	0.0	0.0
IFRS16 Endoscopic Equipment - Aquilant lease	1.5		1.5	0.0	0.0
IFRS16 Stoke and County Pathology (Siemens lease ext Sep 26) BC required	0.5		0.5	0.0	0.0
IFRS16 Payroll offices lease renewal (2 yrs)	0.1		0.1	0.0	0.0
IFRS16 Fresenius equipment lease renewal	0.0		0	0.0	0.0
Total IFRS 16 leases	**3.1**	**0.0**	**3.1**	**0.0**	**0.0**
Total Internal Capital Expenditure programme	**51.8**	**0.0**	**51.8**	**4.8**	**4.0**
Additional CRL / Externally Funded PDC					
CDC phase 1 medical equipment	1.9		1.9	0.0	0.0
CDC IM&T	0.2		0.2	0.0	0.0
CDC phase 1 estates enabling	22.6		22.6	0.7	0.9
CDC phase 1 cost pressure - BC will be required for approval	0.0		0.0	0.0	0.0
CDC endoscopy expansion - BC required by NHSE	3.1		3.1	0.0	0.0
TIF 2 PDC (Breast Unit)	9.1		9.1	1.0	0.9
PDC UHNM Urgent Treatment Centre BC required by NHSE	7.8		7.8	0.0	0.0
PDC imaging and MRI - ICB bid submission to NHSE	0.0		0.0	0.0	0.0
PDC Equipment for Physiological Science - ICB bid submission to NHSE	0.0		0.0	0.0	0.0
PDC County Discharge Lounge BC required	0.0	2.4	2.4	0.0	0.0
PDC SDEC/SAU BC required	0.0		0.0	0.0	0.0
PDC Elective equipment - approval of o/s required	0.0		0.0	0.0	0.0
PDC CT scanner replacement - BC required	0.8		0.8	0.0	0.0
Digital - EPR PDC funded 2024/25	1.8		1.8	0.0	0.1
Charitable funded expenditure	0.5		0.5	0.0	0.0
Total Additional CRL / PDC Funded expenditure	**47.8**	**2.4**	**50.2**	**1.7**	**1.9**
Total Capital Expenditure	**99.5**	**2.4**	**101.9**	**6.5**	**5.9**

Finance | Balance Sheet

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

Statement of Finance Position	31/03/2025	31/05/2025		
	Actual £m	Plan £m	Actual £m	Variance £m
Property, Plant & Equipment	715.7	713.5	714.5	1.0
Right of Use Assets	23.1	22.9	22.4	(0.6)
Intangible Assets	16.0	13.2	13.7	0.5
Trade and other Receivables	1.1	1.1	1.1	0.0
Total Non Current Assets	**755.9**	**750.7**	**751.6**	**0.9**
Inventories	19.2	18.7	18.4	(0.3)
Trade and other Receivables	43.5	54.4	63.6	9.3
Asset held for sale	10.9	10.9	10.9	-
Cash and Cash Equivalents	84.2	68.2	62.9	(5.3)
Total Current Assets	**157.8**	**152.2**	**155.8**	**3.7**
Trade and other payables	(129.4)	(123.6)	(131.0)	(7.4)
Borrowings	(20.3)	(21.3)	(19.5)	1.8
Provisions	(8.5)	(9.3)	(8.9)	0.5
Total Current Liabilities	**(158.2)**	**(154.2)**	**(159.3)**	**(5.1)**
Borrowings	(490.3)	(490.1)	(489.5)	0.7
Provisions	(2.8)	(2.3)	(2.4)	(0.1)
Total Non Current Liabilities	**(493.0)**	**(492.4)**	**(491.8)**	**0.6**
Total Assets Employed	**262.5**	**256.3**	**256.3**	**0.0**
Financed By:				-
Public Dividend Capital	734.9	734.9	734.9	0.0
Retained Earnings	(680.7)	(686.9)	(687.0)	(0.0)
Revaluation Reserve	208.3	208.3	208.3	-
Total Taxpayers Equity	**262.5**	**256.3**	**256.3**	**(0.0)**

Finance | Conclusion

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

The Trust has delivered a £6.9m deficit in line with the planned deficit for month two. The income and expenditure analysis reveals key variances, including lower-than-expected income from pass-through devices and drugs, and a delay in Community Diagnostic Centre income.

The Trust must address the underperformance in Elective and First Attendance to avoid financial repercussions. The ongoing negotiations with the ICB and the implementation of action plans by the Financial Recovery Board are crucial steps in ensuring financial stability.

There is a slight underspend in pay expenditure and a notable reduction in agency expenditure. Non pay is underspent by £2.8m YTD.

The Trust has a CIP target for 2025/26, with planned savings met in month two.

The capital expenditure plan for 2025/26 has increased by £2.4m to £101.9m, with year-to-date spend mainly related to the CDC and TIF 2 Breast Unit schemes.

The month two Statement of Financial Position shows total assets employed at £256.3m, with a cash balance slightly below plan.

The system month position has an adverse variance from the planned deficit.

Several financial risks have been identified that could deteriorate the Trust's financial position, including additional unfunded capacity, shortfall against CIP plans, and lower activity levels.

Highlight Report

PEOPLE CULTURE & INCLUSION COMMITTEE | 5th June 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Partial assurance was provided by the **Chief People Officer** report, largely due to actions for 2025/26 having only just commenced. It was also noted that **apprenticeship** uptake remained low. • The continued pressure on the **People Directorate** was highlighted, noting the level of resource in place compared to demand, and as such the Committee noted the potential for this to impact on associated metrics. It was noted that whilst the pressures reflected the wider challenges within the organisation, there was also issued in terms of support required from the wider organisation in terms of line manager compliance and a need to consider potential scaling up opportunities with other organisations. • New **national job profiles** had been issued for nursing and midwifery staff at Bands 4 to 9. The implications from this were to be considered at a regional level to identify a consistent approach in taking forward actions, and the associated risk of the ability for the People Directorate to manage this additional workload was to be articulated in addition to the risk in relation to potential cost pressures. • **Job planning** currently at circa 65% sign off and it was agreed to provide a further update on this at the next meeting • Partial assurance was agreed for the **wellbeing** update which despite demonstrating key achievements in relation to delivering the wellbeing plan, staff engagement, flexible working and fitness initiatives, recognised that further work was required to understand which wellbeing offers were making a difference. Sickness absence had remained static therefore actions were ongoing with occupational health to support staff in relation to the highest reason for absence; stress, anxiety and depression as well as the areas identified within the staff survey (musculoskeletal, and work-related stress). It was agreed to provide a further update on wellbeing in 6 months as opposed to an annual update, due to the additional assurance which was required • Partial assurance was provided by the **CeNREE** update with the main areas of concern relating to demand (>300 contacts) which were exceeding resource. The Committee concluded that whilst there was confidence in the delivery of the centre, there were reservations on the sustainability of the model • Partial assurance was provided by the **health and safety** update, with the main challenges relating to statutory and mandatory training, whereby the training package was being reviewed, in addition a decline in RIDDOR reporting was noted. • 300 exception reports were reported within Quarter 3 as highlighted by the **Guardian of Safe Working** report. New changes on exception reporting were expected to be implemented in September and it was anticipated that this would result in a greater number of reports. Due to the number of exception reports not being fully reviewed by supervisors, partial assurance was provided.	• Further assurance to be provided to the Committee in respect of completion of divisional plans in response to the **staff survey** findings • An update on the actions taken to improve the investigation process for **disciplinary cases** to be provided to the next meeting • Further information to be provided to the Committee in relation to the Band 4 to 9 **job profile** review • Briefing to be taken to Nomination and Remuneration Committee in June on the new **Very Senior Manager (VSM) pay framework** • Detailed update on progress against **the workforce reduction plan** to be provided • **Benchmarking** for People Directorate services to be provided • To amend future **wellbeing** reports to highlight the interventions being taken within potential hotspots, the support for line managers and clarification of data to ensure this accurately reflected all activities being undertaken by the Organisational Development team • To provide assurance in relation to the actions being taken to improve **RIDDOR** compliance

Positive Assurances to Provide	Decisions Made
• Improvements in agency, vacancy and turnover metrics and the staff engagement score were noted within the **Chief People Officer** report • **Medical Education** Annual Report provided acceptable assurance noting the improvements in areas such as surgery and medical specialties although red flags remained in some areas with new appointments to college tutors being made in response to this. The Trust ranked 9 out of 20 when compared to peers and training scores remained stable • Acceptable assurance was provided by the **fire safety** annual report with positive achievements particularly highlighted in respect of nominated fire safety leads, completion of training, improvements in ad hoc fire drills and continued investment in fire protection • Acceptable assurance was provided by the **statutory and mandatory training** update, and the Committee welcomed the work being undertaken to identify the actions required as a result of the new mandatory learning framework, which aimed to standardise learning material and enabled passporting of learning between organisations • It was noted that work had concluded on the **Aspergillus** investigation within Theatres, with a question-and-answer session to be held with Staff in June • Significant assurance was provided by the **equity and inclusion assurance** tool undertaken by NHS Midlands, noting good progress against the 6 high impact actions, with a focus on 2 actions for 2025/26; ethnicity and disability pay gaps and addressing bullying, harassment and abuse	• No decisions were required to be made

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
Medical representation was noted as being essential and it was agreed that this would be addressed for future meetings. The Committee welcomed the conversations held and the summaries provided by presenters. The Committee noted that given the current pressures within the organisation it needed to balance future conversations in terms of seeking assurance and recognising the level of stretch within the team, in addition to the need for wider organisational support	• **Benchmarking** on corporate services to be provided to Finance and Efficiency Committee as part of the productivity update

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Chief People Officer Report	2	Ext 16	Partial	Assurance	6.	Health & Safety Report Q4 2024/2025		ID 18673 ID 22876	Partial	Approval
2.	Wellbeing Report	2	Ext 16	Partial	Assurance	7.	Executive Health & Safety Group Highlight Report (20.5.25)		-	Not rated	Assurance
3.	Post-Graduate Medical Education Annual Report		ID 16652	Acceptable	Assurance	8.	Guardian of Safe Working Report Q3 2024/2025	2	ID 24272 ID 18842	Partial	Assurance
4.	CeNREE (Centre of Research and Education Excellence) Update	9	ID 30986	Partial	Assurance	9.	Statutory & Mandatory Training Review	2	Ext 16	Acceptable	Information
5.	Fire Safety Annual Report 2024/2025	6	High 12	Acceptable	Assurance	10.	Equity & Inclusion Assurance Tool	2	Ext 16	Significant	Assurance

University Hospitals of North Midlands NHS Trust

Integrated Performance Report

Month 02 Performance

2025/26

Kind Excellent Together

Data Quality & Statistical Process Control

University Hospitals of North Midlands NHS Trust

Data Quality Assurance Indicators (DQAI) are used in this report to help give context and assurance as to the reliability and quality of the data being used. The STAR Indicator provides assurance around the processes used to provide the data for the metrics reported on. The four Data Quality domains are each assessed and assurance levels for each are indicated by RAG status.

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.

Explaining Each Domain:

Domain		Assurance Sought
S	Sign Off and Validation	Is there a named accountable executive, who can sign off the data as a true reflection of the activity? Has the data been checked for validity and consistency with executive officer oversight?
T	Timely & Complete	Is the data available and up to date at the time of submission or publication? Are all the elements of required information present in the designated data source and no elements need to be changed at a later date?
A	Audit & Accuracy	Are there processes in place for either external or internal audits of the data and how often do these occur (annual / one off)? Are accuracy checks built into collection and reporting processes?
R	Robust Systems & Data Capture	Are there robust systems which have been documented according to data dictionary standards for data capture such that it is at a sufficient granular level?

Sign Off & Validation

Timely & Complete

Audit & Accuracy

Robust Systems & Data Capture

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RAG Rating Key:

	Good level of assurance for the domain
	Reasonable Assurance with an action plan to move into Good
	Limited or No Assurance for the domain with an action plan to move into Good

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

Kind Excellent Together

Assurance Grid

University Hospitals of North Midlands NHS Trust

Failing

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

VARIATION	ASSURANCE: Pass	Hit and Miss	Fail	No Target
Special Cause - Improvement	Maternity Triage Sepsis - Adult Inpatient IVAB UEC 4 Hour Performance		RTT Performance - <18 Weeks RTT >52 Weeks %	
Common Cause	Induction of Labour Sickness Absence (R12M)	Patient Safety Incidents rate per 1000 bed days Patient Safety Incidents with moderate harm and above per 1000 bed days Patient falls with harm per 1000 bed days Medication Incidents per 1000 bed days Medication Incidents % with moderate harm or above Patient Safety Incident Investigation (PSII's) instigated Never Events per month Pressure ulcers developed under UHNM per 1000 bed days Family & Friends Test - Inpatient Family & Friends Test - Maternity Sepsis - Adult Inpatient Screening Sepsis - ED Portals Screening Sepsis - ED Portals IVAB Sepsis - Childrens Screening Sepsis - Maternity Screening Staff Vacancy Rate Cancer 31 Day Combined	Family & Friends Test - ED Single Sex Breaches Appraisal (PDR) Employee Engagement Cancer 28 Day FDS Cancer 62 Day Combined	
Special Cause - Concern	RTT - Time to First Seen %	Staff Turnover (R12M) Agency Utilisation Over 12 hours in ED	Diagnostics DM01 Performance	

Worsening

The best joined-up care for *all*

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People | Overview

Creating a great place to work for everyone

University Hospitals of North Midlands 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 6.82 for April 2025, up from the score of 6.48 for January 2025, against a target of 7.2. The Staff Voice Survey is now collected quarterly, meaning the next scoring will not occur until July 2025.

Sickness absence remains above our expected standard of 3.39%. In month we have seen a decrease to 4.64%, while the 12-month cumulative rate reduced slightly to 5.26%, from 5.29% in April 2025. The main driver of this continues to be stress and anxiety, followed by other musculoskeletal problems and gastrointestinal problems, as the second and third most common reasons.

Turnover and *vacancy* metrics continue to perform well against our expected standards. The turnover rate in April 2025 remained extremely low, at 6.9%, which remains consistently below our 11% target, for more than 2 Years. Vacancies decreased to 8.29% (8.85% in April 2025). The main drivers of this were increases across Registered Nursing (+3.87), ST&T (+16.35), Support to Clinical Staff (+4.9), Infrastructure (+1.09) with Medical & Dental reducing (-3.14). These overall increases were counter-balanced by a 61.11 fte reduction in the total budgeted establishment.

Agency costs decreased to 1.52%, in May 2025, from 1.59% in April 2025, which is below the threshold set by NHS England. In real-terms, overall agency usage decreased to 97.2 WTE in May 2025 from 120.73 WTE in April 2025, which is 7.82 WTE below 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. May saw a noticeable in-month reduction in sickness absence, influenced by decreases in the usual seasonal changes, and especially Cold, Cough, Flu – Influenza problems which saw a 1.7% decrease in May 2025.

Agency expenditure was 7.82 WTE below plan, influenced by the additional scrutiny at executive and divisional level which appears to also be having the desired effect in reducing overall agency spend, with some agency activity being converted to bank expenditure, as well.

People | Overview

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust

Overview from the Chief People Officer

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

The staff voice has moved to quarterly (with the survey open for 14 days) for FY24/25 to prevent survey fatigue and to allow more time for the divisions 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.

Agency Expenditure remains subject to continued scrutiny through the Divisional 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, including the recent launch of a new temporary staffing dashboard, which is updated on a weekly basis.

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 Performance Reviews.

What can we expect in future reports?

As the weather continues to improve, we may see some further reductions in sickness absence rates, associated with absence reasons which are generally associated with seasonal fluctuations.

Agency is currently under plan, but we expect agency usage to track slightly above plan in June 2025, once the pre-requisite agency invoices, for April & May are received and transacted. Despite this, and the additional scrutiny, of agency expenditure, the on-going elective recovery programme activity, and the continued need for escalation capacity and the additional demand in theatres and endoscopy services, and in the emergency portals, still influences the need for agency.

People | Dashboard

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University Hospitals of North Midlands NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance	R12M Trend
Staff Turnover (R12M)	8.0%	6.8%	7.0%			
Staff Vacancy Rate	8.0%	7.8%	8.9%			
Sickness Absence (R12M)	3.4%	4.9%	4.9%			
Appraisal (PDR)	95.0%	84.6%	85.6%			
Agency Utilisation	3.2%	1.4%	1.6%			
Employee Engagement	7.2	6.5	6.8			

Related Strategy and Board Assurance Framework (BAF)

People Strategy

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 2: Sustainable Workforce	Ext 16	Acceptable	Ext 15	Acceptable	Ext 15	Acceptable	Ext 15	Acceptable

People | Employee Engagement

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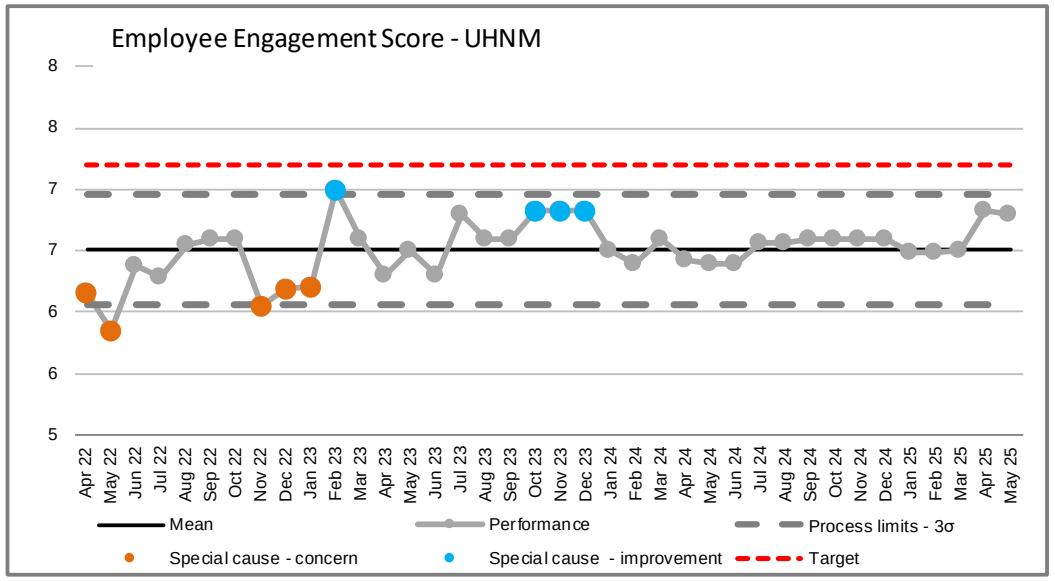

Variation	Assurance
	F

Target	Mar 25	Apr 25	May 25
7.2	6.5	6.8	6.8

Background

What is the data telling us?

Our most recent Staff Engagement score was 6.82, for April 2025, up from the score of 6.48 for January 2025, against a target of 7.2.

The Staff Voice Survey is now collected quarterly, meaning the next scoring period will open from 1st July 2025. (The most recent score will be used in the intervening months.)

The National Staff Survey achieved an overall 45% response rate, which is comparable to the 44.9% response rate we achieved in 2023/24.

What are we doing about it?

The survey has moved to quarterly (with the survey open for 14 days) for FY24/25 to prevent survey fatigue and to allow more time for the divisions to review and respond to feedback 'you said, we will'. The next reportable period is April 2025.

Sustained operational pressures continue to impact on overall employee engagement.

All Divisions are developing staff survey response plans and have a driver metric for staff engagement.

People | Sickness Absence in Month

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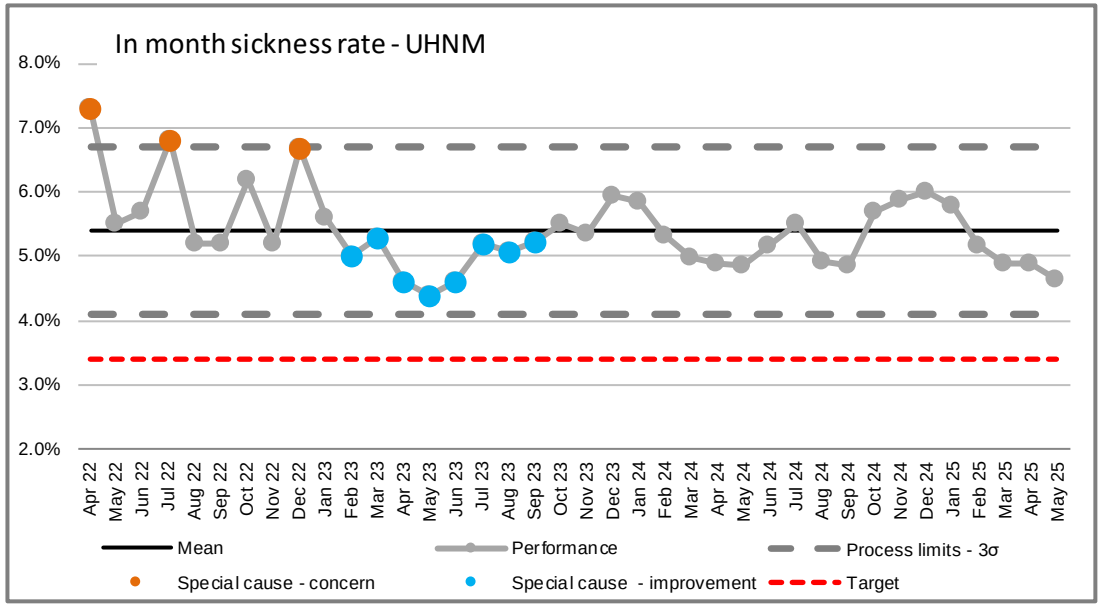
University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

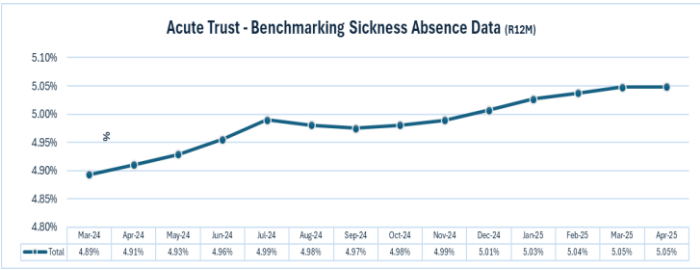
Target	Mar 25	Apr 25	May 25
3.4%	4.9%	4.9%	4.6%

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 April 2025- 5.05%)



What is the data telling us?

The rolling 12-month average sickness absence rate reduced slightly to 5.26% (5.29% in April 2025) against the target of 3.4%.

The in-month sickness absence decreased to 4.64% in May (4.90% in April 2025) with Other Musculoskeletal problems seeing the biggest increase of 1.7%, followed by a 1.5% increase in Anxiety/stress/depression/other psychiatric illnesses.

In rank order (highest first), the top 3 reasons for absences during May were: (1) Anxiety/stress/depression/other psychiatric illnesses, (2) Other musculoskeletal problems, (3) Gastrointestinal problems, which saw Cold, Cough, Flu – influenza dropping to the 6th most common reason.

What are we doing about it?

Medicine Division - sickness absence continues to be monitored at directorate performance reviews. Areas with over 8% or of concern are supported by the People Advisor focusing on long term sickness cases.

Surgery Division – assessment of hotspot areas for long and short term absences to provide targeted support including re-training.

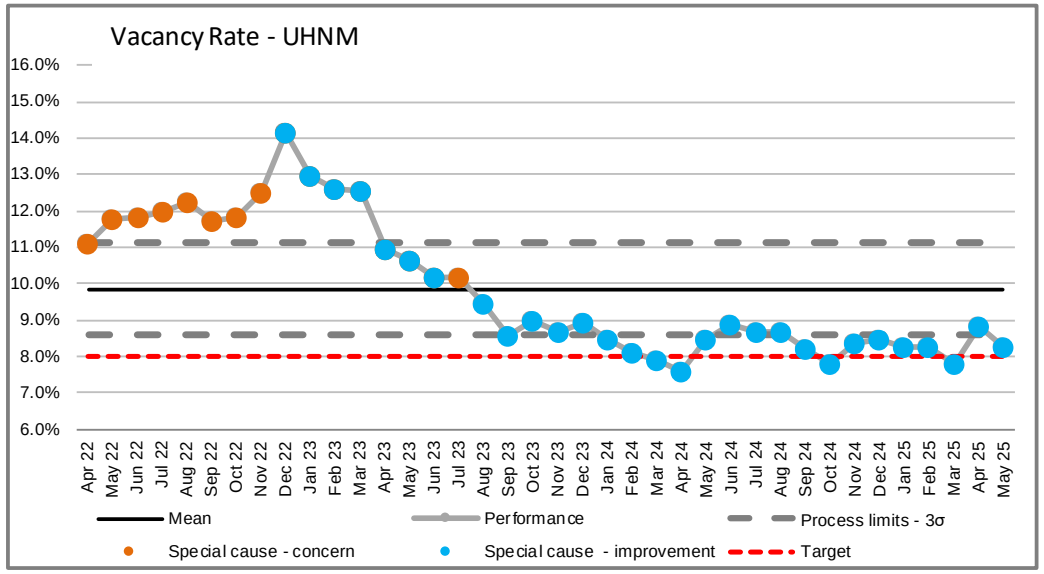
Network Division - commenced sickness assurance meetings.

Women's Children's and Clinical Division - Deep dives into hot spot/high absence areas to target interventions as well as continuing absence surgeries.

People | Vacancy Rate

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

Target	Mar 25	Apr 25	May 25
8%	7.8%	8.9%	8.3%

Background

Based on Full Establishment (Substantive, Bank & Agency)

Vacancies at 31-05-25	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,831.08	1,595.88	235.20	12.84%	12.56%
Registered Nursing	3862.96	3646.40	216.56	5.61%	6.54%
All other Staff Groups	7087.52	6479.82	607.70	8.57%	9.16%
Total	12,781.56	11,722.10	1,059.46	8.29%	8.85%

What is the data telling us?

The summary of vacancies, by staff groupings, saw a 0.56% decrease in the overall vacancy rate. The reasons for this are explained below.

Low vacancies and turnover rates signify on-going successes in recruitment and retention processes, although a slight reduction in the overall budgeted establishment, has also had an impact.

Colleagues in post increased in May 2025 by 16.17 fte, across Registered Nursing (+3.87), ST&T (+16.35), Support to Clinical Staff (+4.9), Infrastructure (+1.09) with Medical & Dental reducing (-3.14). Budgeted establishment decreased by 61.11 fte, which decreased the vacancy fte by -77.28 fte overall.

[*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 31/05/25]

What are we doing about it?

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

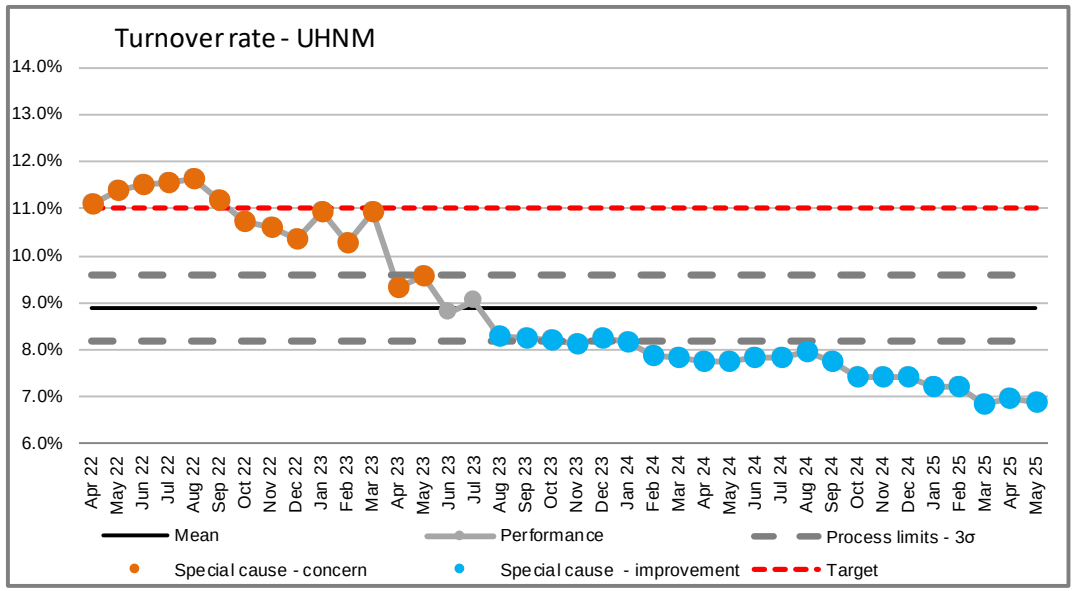
Targeted social media campaigns continue, advertising that our organisation is a great place to work.

We continue our targeted spotlights on our colleagues, which supplement our recruitment campaigns.

People | Turnover Rate

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

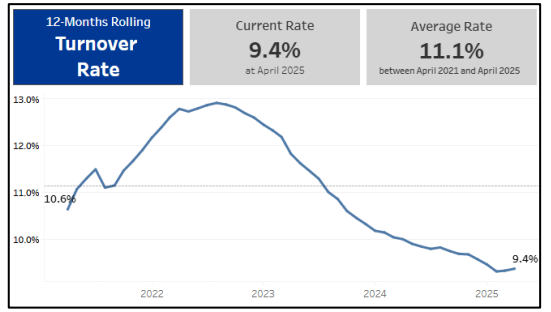
Target	Mar 25	Apr 25	May 25
11.0%	6.8%	7.0%	6.9%

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 April 2025)



What is the data telling us?

The turnover rate in May 2025 remains extremely low, at 6.9% (7.0% in April 2025), which is consistently below the Trust's 11% target, for more than two years.

Or overall turnover rates are also well below the national averages when compared to other Acute Trusts.

What are we doing about it?

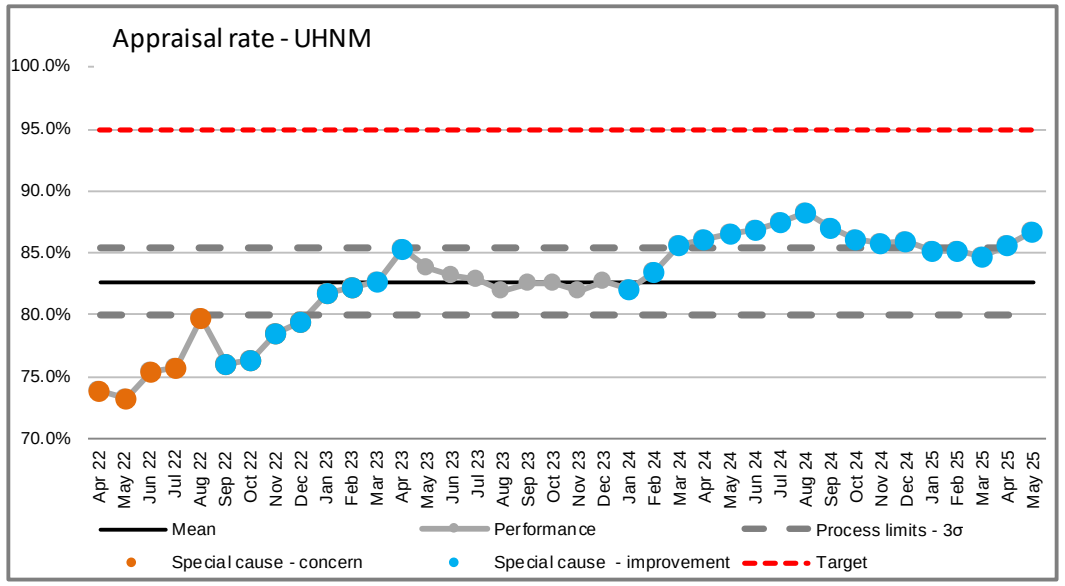
Turnover continues to perform well against our expected standards, reflecting our programmes of work which make this a great place to work. Some recent examples include :

- Medical Staffing finishing school.
- Employment of a People Promise (Retention) Manager who started in a fixed term post.
- Monthly targeted campaigns aligned to our four People Promise areas of focus. For example, People Promise 1 'We are compassionate and inclusive': May included the Equality, Diversity & Human Rights Week.

People | Appraisal Rate

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	F

Target	Mar 25	Apr 25	May 25
95%	84.6%	85.6%	86.7%

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.

May's appraisal rates increased to 86.7% from 85.6% in April 2025, which is a marked improvement for all Divisions, with Estates, Facilities and PFI Division achieving a compliance rating of 97.93%.

The Divisions 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.

Network Division - Weekly PDR compliance hotspot and assurance meetings.

Surgery Division – Monthly compliance report, with a focus on hotspots.

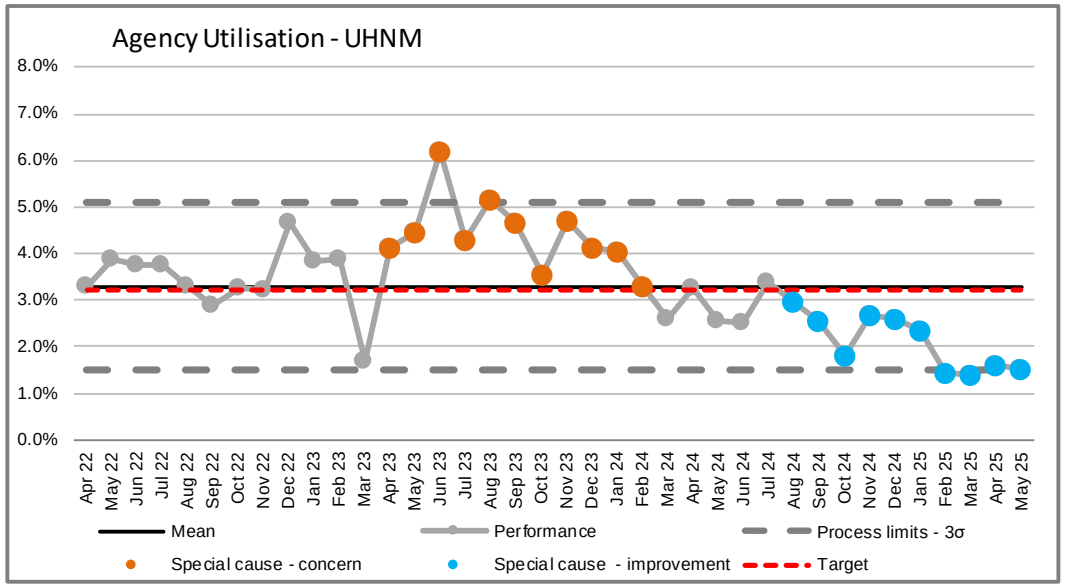
Medicine Division – Weekly updates reports on compliance. With focused assistance on those areas with the lowest compliance.

WCCSS – Weekly performance reports and assurance meetings.

People | Agency Utilisation

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Mar 25	Apr 25	May 25
3.2%	1.4%	1.6%	1.5%

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 decreased to 1.52% in May 2025, (1.59% in April 2025).

In real-terms, overall agency usage decreased to 97.2 WTE in May from 120.73 WTE in April 2025, which is 7.82 WTE below plan.

Executive and divisional 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.

What are we doing about it?

- Agency use is monitored and discussed at monthly divisional 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.

Executive Summary

Trust Board | 9th July 2025

Annual Committee Effectiveness Reviews and Revised Rules of Procedure 2025/26

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**	✓	**Assurance**	✓	**Agenda Item:**	11.	
Author:	Nicola Hassall, Deputy Director of Governance								
Lead:	Claire Cotton, Director of Governance								

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

Risk Register Mapping		
	No associated risks	

Executive Summary:

Situation

In line with best practice, each Committee of the Trust Board annually reflects on their own performance and effectiveness. The review comprises of three parts; feedback from the Chair and Committee members, an annual summary of the key areas of work and achievements against the Terms of Reference and revision of the Committee Governance Pack, taking into account any issues raised by the effectiveness review and annual report.

The first element of this report presents the outcomes of the 2024/25 Committee Effectiveness Reviews across all Board Committees (excluding the Strategy & Transformation Committee, following changes to the Corporate Governance Structure). The second part of the document is the revised Rules of Procedure, which is brought for approval, and provides the formal framework for the conduct of Board and Committee business, ensuring compliance with statutory obligations, NHS England guidance, and best practice in governance. Each Committee Governance Pack (which were revised as part of the effectiveness reviews) is also appended to the document for completeness.

Background

Each Committee review has been undertaken and presented to Committees for approval. The reports provided assurance in respect of attendance data, effectiveness ratings, and identified actions for improvement.

The Rules of Procedure define how the Board and its Committees operate, including:

- The statutory basis and composition of the Board
- Procedures for meetings, decision-making, and delegation
- Standards of conduct and behaviour for Board members
- Governance structures and committee terms of reference

Assessment

Committee Effectiveness 2024/25

Members and regular attendees of the various Board Committees were asked to complete a self-assessment questionnaire regarding the effectiveness of the Committees during 2024/25. In addition, a Committee Process checklist was completed by each Chair of the Committee.

The results of the process indicate a broad consensus that all Board Committees have been effective in the discharge of their duties, and this is further supported by the content of the Committee Annual Reports. The above processes identified 11 actions to be taken forward to further enhance effectiveness and these will be monitored by respective Committees. These actions related to:

- agenda and meeting management
- governance and oversight
- report quality and assurance
- committee member engagement and feedback
- executive leadership and accountability

Revised Rules of Procedure 2025/26

The revised Rules of Procedure have been comprehensively reviewed and updated to reflect:

- The Trust's strategic direction (2025–2035)
- Revised governance arrangements
- Updated meeting templates in line with the corporate branding
- Revised Terms of Reference for each Committee*, following completion of the effectiveness reviews. It should be noted that further changes may be made to respective Business Cycles upon completion of the Insightful Board metrics mapping exercise. Additionally, Executive Director membership is under review, and any proposed changes will be considered by the relevant Committees.

* The revised Terms of Reference for the Finance and Business Performance Committee have been omitted from the document as these are due to be discussed at its meeting in July. Whilst the Committee approved their Terms of Reference in April, these are subject to further change given the transition to its new remit of financial performance, strategic delivery and transformation, sustainability, productivity and activity, digitalisation, and estates and facilities management.

The document aligns with NHS England's Well-led Framework and incorporates the Nolan Principles of Public Life. It supports effective leadership, accountability, and assurance across the Trust.

Key Recommendations:

The Trust Board is asked to **note**:

- the outcomes of the self-assessment process.
- that annual reports for each Committee have been considered by the respective Committees.
- that revised Committee Governance Packs have been approved by each Committee, and incorporated within the Rules of Procedure for 2025/26 (with the exception of Finance and Business Performance which will be added once agreed by the Committee in July 2025)
- that the Deputy Director of Governance will make amendments to the respective Committee business cycles as required, following completion of the Insightful Board mapping exercise

The Trust Board is asked to **approve** the revised Rules of Procedure for 2025/26, incorporating the Trust Board Business Cycle and Committee Governance Packs.

Review of Committee Effectiveness 2024/25
May 2025

University Hospitals of North Midlands NHS Trust

1. Introduction

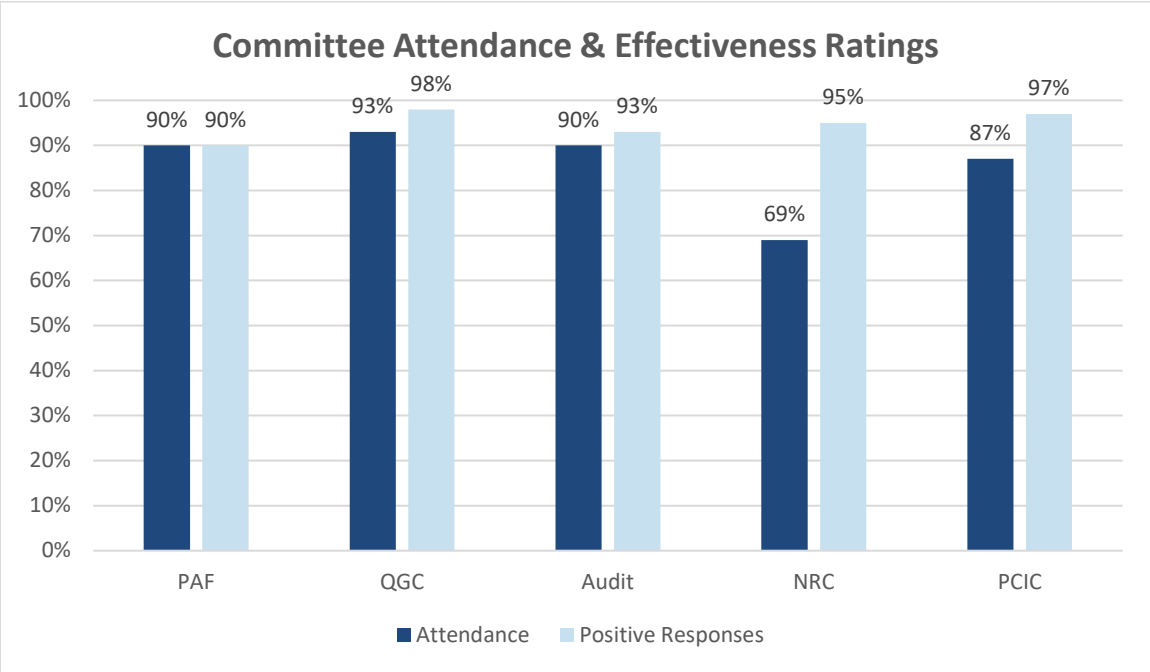
As part of the Trust's governance arrangements, and as set out within the Trust's Rules of Procedure, members and regular attendees of Board Committees were asked to complete a self-assessment questionnaire regarding the effectiveness of the Committees during 2024/25. The questionnaires were based on good practice guidance and a Committee Processes questionnaire was completed by the Deputy Director of Governance on behalf of the Chair of the Committee.

In addition, an annual report for each Committee was prepared which summarised the purpose of the Committee, membership and attendance, key items of business which were covered during the year and actions taken.

The outcomes of these reports have been considered by each Committee, whereby actions for improvement were identified based on the responses provided. In addition, each Committee has approved its revised Committee Governance Pack, which was also amended taking into account the responses from the Committee effectiveness process.

2. Comparison of Attendance and Responses to Committee Effectiveness Questions for all Committees

Attendance for all but the Nomination & Remuneration Committee, was above the expected 75% attendance rate for the year (although it should be noted that all meetings were quorate). In addition, the percentage of positive responses for the majority of Committees was better or in line with the 2023/24 reviews.



3. Outcome of Individual Committee Annual Reports and Effectiveness Reviews

For the 2023/24 review, 10 improvement actions were completed. Following the 2024/25 review, 11 improvement actions were identified, as listed below and these will be added to the respective Committee post meeting action logs for monitoring and oversight.

Committee	Action	Action Lead	Due Date	Progress Update
PAF	Agendas to continue to be set in advance and shared with key Executives and the Chair, to assess the time required for each item, agree areas of focus based on urgency and importance, in addition to considering whether additional extraordinary meetings are required	Jason Dutton	30/09/25	On track – agendas continue to be shared in advance
PAF	Business Cycle to be refreshed in line with the change in focus once the revised Corporate Governance Structure has been approved	Nicola Hassall	30/08/25	On track – to be updated following insightful board mapping
PAF	Report authors for all reports to be reminded of the opportunity to attend Effective Report Writing Training in order to ensure executive summaries and recommendations are clear, in addition to highlighting the way in which multiple perspectives and data sources could be provided in order to triangulate the sources of assurance	Jason Dutton	30/09/25	On track - authors of reports for all Committees to be provided with the details of the training
PAF	Specific feedback from each Committee Effectiveness review to be shared with the Chair for consideration	Nicola Hassall	31/07/25	On track - to be summarised and provided to Ms Small
QGC	Committee members to continue to provide feedback in respect of when they feel papers may require further improvement	Committee Members	2025/26	Ongoing – Committee members to advise as required
QGC	Executive Directors to ensure that those presenting items on the agenda are fully briefed beforehand in order to field any related questions	Executive Directors	2025/26	Ongoing – Exec Directors to brief their deputies in advance
QGC	Committee members to advise of the way in which they would like to include the patient voice i.e. by case study or further walkabouts	Head of Patient Experience	2025/26	On track – action being considered by Head of Patient Experience
Audit	To continue to ensure Executive Directors are present when relevant internal audits are being considered in order to respond to any specific queries	Jason Dutton	2025/26	Ongoing – oversight of internal audit recommendations provided to Executive Team
NRC	Where possible, papers are to be circulated in advance to meetings as opposed to utilising presentations	Nicola Hassall	2025/26	Ongoing – papers to be provided in advance as routine
PCIC	Where the Chair is unable to attend the subsequent Trust Board meeting, an alternative Non-Executive Director will be nominated to provide the update from the Committee	Nicola Hassall	2025/26	Ongoing – when apologies are provided in advance, alternative arrangements put in place
PCIC	Focus of future agendas to take into account any specific reports in relation to addressing key strategic priorities as part of the people plan / staff survey results	Jane Haire	2025/26	Ongoing

4. Conclusion

The Committee effectiveness reviews have led to actionable improvements across all Committees. Updated Terms of Reference and Governance Packs reflect these changes.

5. Key Recommendations

The Trust Board is asked to note:

- the outcomes of the self-assessment process.
- that annual reports for each Committee have been considered by the respective Committees.
- that revised Terms of Reference have been approved by each Committee, and incorporated within the Rules of Procedure for 2025/26

University Hospitals of North Midlands NHS Trust

Rules of Procedure

July 2025

Contents

About University Hospitals of North Midlands NHS Trust

What we do….

University Hospitals of North Midlands NHS Trust (UHNM) was established in November 2014 following the integration of University Hospital of North Staffordshire NHS Trust and Mid Staffordshire NHS Foundation Trust. We operate two hospitals: Royal Stoke University Hospital and County Hospital.

We provide care in modern, well-equipped facilities and offer a comprehensive range of general and specialist services to a population of approximately 3 million people. Our workforce comprises around 12,500 employees, and we have approximately 1,450 inpatient beds across our two sites.

UHNM is one of the largest hospital trusts in the West Midlands and home to one of the busiest emergency departments in the country, with an average of 14,000 attendances per month across both sites. As a designated Major Trauma Centre, we receive emergency patients from a wide geographical area, including by helicopter and ambulance, serving as the specialist centre for North Midlands and North Wales.

Our specialist services include:

- Cancer diagnosis and treatment
- Cardiothoracic surgery
- Neurosurgery
- Renal and dialysis services
- Neonatal and paediatric intensive care
- Trauma and spinal surgery
- Respiratory medicine
- Upper gastrointestinal and complex orthopaedic surgery
- Laparoscopic surgery

We play a central role in the Staffordshire and Stoke-on-Trent Integrated Care System (ICS), working in close partnership with health, social care, and voluntary sector organisations to deliver integrated, patient-centred care. We also maintain long-standing collaborations beyond the ICS footprint, built over more than a decade.

UHNM partners with Keele University and Staffordshire University to deliver world-leading research, education, and innovation. These partnerships help equip our clinicians and leaders with the skills and experience needed to thrive in an increasingly complex health and care environment.

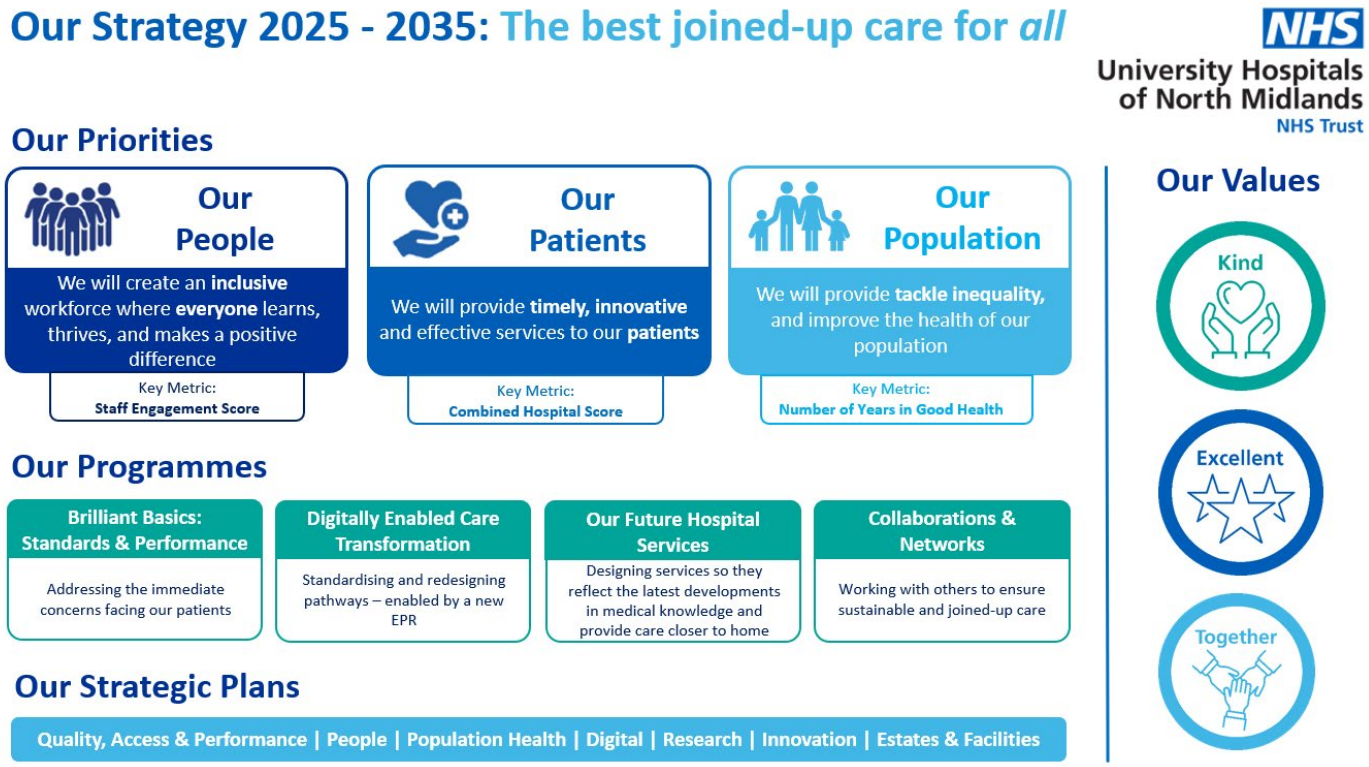
We also work closely with our Private Finance Initiative (PFI) partners through exemplary relationships recognised by the Cabinet Office Supplier Relationship Management Programme (SSRM).

As a regional and national leader, UHNM hosts and contributes to multiple clinical networks, helping to shape and improve specialist services across the NHS.

Our Strategy 2025-2035: The best joined-up care for *all*

Our refreshed strategy was developed through extensive consultation during 2024/2025 and officially launched in April 2025. It sets out our strategic framework and vision: "The best joined-up care for *all*".

This vision is underpinned by our values and by three strategic priorities; Our People, Our Patients and Our Population. To deliver on these priorities and respond to the national 10-year health plan, we have established four key programmes as highlighted below:



1. Introduction

University Hospitals of North Midlands NHS Trust (the Trust) is a statutory body established on 4 November 1992 under The North Staffordshire Hospital NHS Trust (Establishment) Order 1992 No. 2559. The Trust's name was most recently amended in 2014 under The University Hospitals of North Midlands NHS Trust (Establishment Amendment) Order 2014 No. 2844.

NHS Trusts are governed primarily by:

- The National Health Service Act 2006
- The Health and Social Care Act 2012
- The Health and Care Act 2022, which introduced further amendments

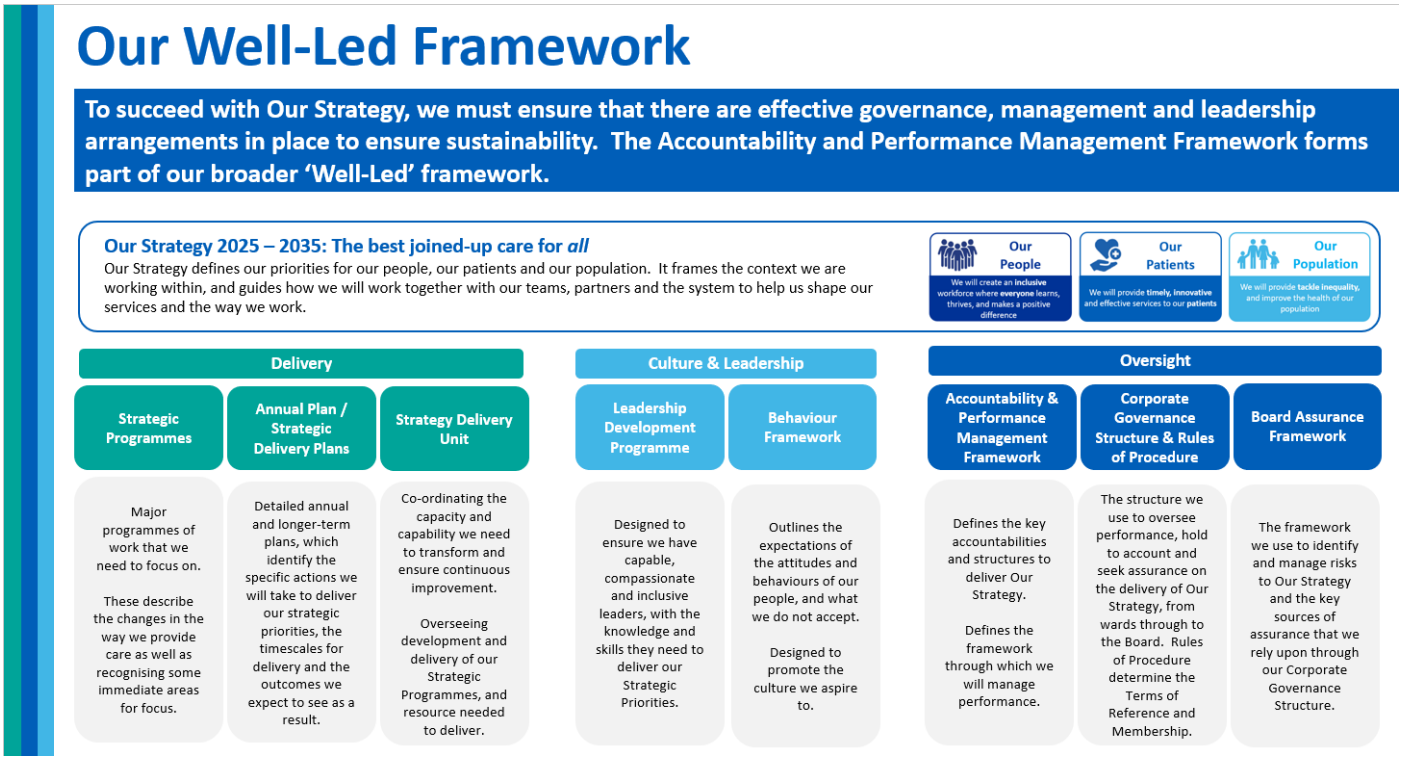
The functions of the Trust are conferred through this legislation. In addition, the Trust holds statutory powers to jointly fund projects with local authorities, voluntary organisations, and other bodies.

To ensure effective governance, we adopt:

- Standing Orders, which regulate its proceedings and business
- Standing Financial Instructions (SFIs), which form an integral part of the Standing Orders and define individual responsibilities

These documents are maintained separately from the Rules of Procedure, and we are also subject to all other relevant statutes and legal provisions applicable to operations.

In addition, this document forms part of our wider Well-Led Framework alongside the Accountability and Performance Management Framework:



2. Definitions

Accountable Officer	The NHS officer responsible for the stewardship of public funds and assets. At University Hospitals of North Midlands NHS Trust, this role is held by the Chief Executive.
Associate Member	An individual appointed to carry out specific statutory or non-statutory duties delegated by the Board. These duties must be formally recorded in a Trust Board minute or equivalent documentation.

Board	The collective body comprising the Chair, Executive Directors, and Non-Executive Directors.
Budget	A financial plan proposed for a defined period, supporting the delivery of its functions. Budgets may also include associated workforce and workload plans.
Budget Administrator	An employee with delegated authority from a Budget Manager (up to £5,000 including VAT) to manage income and expenditure for a specific cost centre or group of cost centres.
Budget Manager	An employee with delegated authority from a Budget Holder (up to £25,000 including VAT) to manage finances for a specific cost centre or group of cost centres.
Budget Holder	A Director or employee with delegated authority from the Chief Executive (up to £50,000 including VAT) to manage finances for a defined area of the organisation.
Chair of the Trust	Appointed by NHS England, the Chair leads the Board and ensures it discharges its responsibilities effectively. In the Chair's absence, the Vice Chair assumes these duties.
Chief Executive	The Accountable Officer, responsible for overall leadership and performance.
Commissioning	The process of assessing needs and securing healthcare and related services within available resources.
Committee	A committee or sub-committee formally established and appointed by the Board.
Committee members	Individuals formally appointed by the Board to serve on or chair specific committees.
Contracting and procuring	The systems and processes for acquiring goods, services, construction works, and for disposing of surplus or obsolete assets.
Employee (Officer)	Any individual employed, or holding a paid appointment or office.
Executive Director (Officer Member)	An officer responsible for specific duties as outlined in the Standing Orders and Standing Financial Instructions.
Funds held on trust	Funds held by the Trust either at incorporation, received via statutory instrument, or accepted under powers granted by the NHS Act 2006 (as amended). These may include charitable and non-charitable funds.
He/she or his/her	These terms are used interchangeably and apply to all genders, referring to the post holder regardless of gender identity.
Member	An Executive or Non-Executive Director of the Board, depending on context.
Membership, Procedure and Administration Arrangements Regulations	Refers to the NHS Membership and Procedure Regulations (SI 1990/2024) and any subsequent amendments.
Non-Executive Director (Non-Officer Member)	A Board member who is not an officer and is not deemed to be one under regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.
Scheme of Reservation and Delegation of Powers	A document outlining the powers reserved by the Board and those delegated to others for the detailed application of Trust policies and procedures.
Senior Independent Director (SID)	A Non-Executive Director who acts as a point of contact for concerns that cannot be resolved through the Chair, Chief Executive, Executive Directors, or Director of Governance.
SO's	Rules governing the conduct of business and proceedings.
Standing Financial Instructions (SFIs)	Detailed financial policies and procedures adopted to ensure sound financial governance.
The Trust	Refers to University Hospitals of North Midlands NHS Trust.
Vice Chair	A Non-Executive Director appointed by the Board to act in the Chair's absence.

3. Governance

The Trust Board of University Hospitals of North Midlands NHS Trust plays a vital role in setting the strategic direction, leading the organisation, overseeing operations, and ensuring accountability to patients, employees, and stakeholders in an open and effective manner.

Good governance is central to effective leadership. It enables meaningful challenge, clear accountability, and responsible decision-making. Corporate governance refers to the system by which organisations are directed and controlled, ensuring transparency, integrity, and stewardship. While the Board provides strategic oversight, day-to-day operational management is delegated to the Executive Directors and the management teams they lead.

As outlined in NHS England's Well-led Framework, NHS Trusts operate in increasingly complex environments. These challenges include:

- The evolving needs of an ageing population
- The imperative to work collaboratively with system partners
- Workforce shortages
- Financial pressures and slower budget growth

In this context, Trust Boards must maintain robust oversight of care quality, operational performance, and financial sustainability. They must also be agile in responding to new models of care and resource constraints, while continuing to deliver safe, high-quality, and sustainable services.

NHS Trusts are expected to conduct their affairs with integrity and effectiveness, building public, patient, and stakeholder confidence. The Trust Board is ultimately responsible for all aspects of the organisation's performance and governance.

4. Statutory Framework

The Board of University Hospitals of North Midlands NHS Trust (UHNM) is constituted in accordance with statutory requirements and comprises:

- Chair of the Trust – appointed by NHS England on behalf of the Secretary of State for Health and Social Care
- Six Non-Executive Directors – bringing independent oversight and expertise
- Five Executive Directors – including the Chief Executive and the Chief Finance Officer, responsible for operational leadership and delivery

The principal place of business is: Royal Stoke University Hospital, Newcastle Road, Stoke-on-Trent, Staffordshire, ST4 6QG. We also deliver services at: County Hospital, Weston Road, Stafford, ST16 3SA.

Further details, including the Board's organisational structure and the Board Committee structure, are provided in Appendices 1 and 2.

5. The Board and Exercise of Statutory Powers

The Board of University Hospitals of North Midlands NHS Trust shares a unitary responsibility for the effective governance and strategic leadership of the organisation. Its key responsibilities include:

- Ensuring high standards of corporate governance and promoting a culture of integrity and propriety
- Establishing the strategic direction and priorities
- Overseeing the effective and efficient delivery of plans and statutory functions
- Promoting and embedding quality across all activities and services
- Monitoring performance against agreed objectives, targets, and regulatory requirements
- Ensuring that all Board members, individually and collectively, uphold the Seven Principles of Public Life (as set out by the Committee on Standards in Public Life: [Selflessness, Integrity, Objectivity, Accountability, Openness, Honesty, Leadership])

The Board operates on the principle of unitary responsibility, meaning that all decisions are made jointly and all members are accountable for those decisions.

All Board members are subject to the Code of Conduct, detailed in Appendix 3. Any member who significantly or persistently fails to comply with these Rules of Procedure may be considered in breach of their duties and will be managed in accordance with our policies and procedures.

6. Meetings and Proceedings of the Board

6.1 Meetings of the Board

- Ordinary meetings of the Board shall be held at regular intervals, at times and locations determined by the Board and outlined in the annual Calendar of Business
- The Board may invite any individual to attend all or part of a meeting, as appropriate
- Meetings are held in person although there is the opportunity to join virtually (via Microsoft Teams). Locations will either be within Royal Stoke University Hospital or County Hospital, depending on operational needs
- Board members are expected to attend a minimum of four Board meetings within any rolling 12-month period

6.2 Admission of the Public and Press

- The Board operates in an open and transparent manner, whilst ensuring that matters of confidentiality are maintained as such
- The Chair may issue directions regarding meeting arrangements, including the accommodation of the public and press, in accordance with the Public Bodies (Admission to Meetings) Act 1960. These directions ensure that Board business can be conducted without interruption or disruption
- The Board may resolve to exclude the public and press from all or part of a meeting when publicity would be prejudicial to the public interest—due to the confidential nature of the business or for other special reasons stated in the resolution
- Members of the public and press are not permitted to attend meetings of committees or sub-committees, unless specifically invited

Confidential Business

- Any business conducted by the Board in private (i.e. issues of a confidential nature, of commercial sensitivity or specific legal and regulatory issues), following the exclusion of the press and public, shall be treated as confidential
- Board members, Directors, and employees in attendance must not disclose the contents of papers marked ‘In Confidence’ or minutes headed ‘Items Taken in Private’ outside of the Trust, without express permission
- This restriction also applies to any discussions held in private session relating to such reports or papers

Recording and Transmission of Meetings

- The recording or transmission of Board meetings by members of the public or press is not permitted
- Exceptions may be made only with the prior approval of both the Chair and the Chief Executive, granted in advance of the meeting

6.3 Board Meeting Agenda and Papers

- Under normal circumstances, the agenda for each Board meeting will be circulated in a digital format, to members at least five working days in advance
- Supporting papers will accompany the agenda wherever possible and will be dispatched no later than three clear working days before the meeting, except in cases of emergency
- For meetings held in public, the agenda and supporting papers will be published on the website (www.uhnm.nhs.uk) at least three working days prior to the meeting

Order of Business

- The order of business shall follow the published agenda unless otherwise directed by the Chair
- The Chair may, at their discretion or at the request of another Board member, alter the order of business at any stage during the meeting
- The agenda will be primarily based on the Business Cycle approved by the Board (see Appendix 4)

Late Papers and Additional Business

- Late papers may only be proposed at a Board meeting with the prior permission of the Chair
- No other business, beyond that listed on the agenda, will be considered unless the Chair deems it appropriate for discussion

Confidentiality of Board Papers

- Board members must treat any papers marked private and confidential with the utmost discretion
- Such papers should not be discussed with individuals outside the Board or Trust employees unless explicitly agreed by the Chair
- If external consultation is necessary, members must ensure that those consulted are made aware of, and respect, the confidential nature of the information

Security of Confidential Documents

- Whilst all board members are asked to access their papers digitally, when printed versions are required, members must take care not to leave confidential Board papers unattended or in locations where they may be accessed by unauthorised individuals

6.4 Extraordinary Meetings of the Board

- In cases of urgency, the Chair may determine that an extraordinary meeting of the Board be held. The timing and arrangements for such a meeting shall be at the Chair's discretion

6.5 Power to Call Meetings of the Board

- The Chair may call a meeting of the Board at any time if, in their opinion, an urgent matter has arisen
- If two or more Board members submit a signed written request for a meeting, the Chair must, as soon as practicable and within seven calendar days of receiving the request, arrange for a meeting to be held within 28 calendar days of the request date

6.6 Chairing of Meetings

- The Chair, if present, shall preside over all meetings of the Board
- In the absence of the Chair, the Vice-Chair shall preside
- If both the Chair and Vice-Chair are absent, a Non-Executive Director, chosen by the members present, shall preside over the meeting
- The procedure at meetings shall be determined by the presiding Chair

6.7 Procedure at Meetings of the Board

The Chair, or the person presiding over the meeting, shall be responsible for:

- Preserving order and ensuring that all Board members have a fair opportunity to express their views
- Determining all matters of order, competency, and relevancy
- Deciding the order in which members speak
- Determining whether a vote is required, and how it is to be conducted

Written Comments from Absent Members

Board members who are unable to attend a meeting may submit written comments on agenda items. These may be circulated to those present and read aloud at the appropriate point in the meeting.

Decision-Making and Voting
As a unitary board, decisions will normally be made by consensus. On occasion, where consensus cannot be reached, a formal vote will be taken in the following circumstances:

- When the Chair believes there is a significant divergence of opinion, and no clear consensus has emerged
- When a Board member present requests a vote
- When the Chair deems a vote necessary for any other reason

Voting procedures:

- A decision shall be determined by a majority of votes from members present and voting
- In the event of a tie, the Chair (or presiding member) shall have a second and casting vote
- At the Chair's discretion, votes may be taken by oral expression, show of hands, or paper ballot
- If at least one-third of members present request it, voting may be recorded to show how each member voted (except in the case of a paper ballot)
- Proxy voting is not permitted. A member must be present at the time of the vote to participate
- A manager formally appointed to act up for an Executive Director may exercise voting rights (this includes existing non-voting Executive Directors representing a voting Executive in times of absence)
- A manager attending without formal acting-up status may not vote. The status of Executive Directors must be recorded in the minutes

Note: No resolution will be passed if it is unanimously opposed by all Executive Directors present or by all Non-Executive Directors present.

- The minutes will record only the numerical outcome of any vote (votes for, against, and abstentions). Individual votes will not be attributed unless a member specifically requests this immediately after the item concludes

Deferral and Delegation of Decisions

- The Board may agree to defer a decision to allow for further information or consideration. The reason for deferral and the proposed timeline for revisiting the item will be recorded in the minutes
- The Board may also delegate a decision on an agenda item to the Chair. Any such delegation will be formally recorded in the minutes

Virtual Approval
In exceptional circumstances, where urgent matters arise between formal meetings, and following consultation with the Chief Executive or another Executive Director, the Chair may authorise a decision to be made by email. In such cases:

- Papers will be circulated by the Deputy Director of Governance
- A decision may be confirmed by a majority of Board members
- The Chair retains the right to exercise a second and casting vote if required

This method will only be used when the matter is time-critical or where discussion at a formal meeting would not materially benefit the decision-making process.

6.8 Quorum of the Board

- No approvals shall be transacted at a meeting of the Board unless a quorum is present
- A quorum shall consist of at least five Directors with voting rights, including a minimum of three Non-Executive Directors
- Non-Executive Directors must be in the majority. The Chair, if present, shall count as one of the Non-Executive Directors

Quorum Exclusions

- An individual attending on behalf of an Executive Director without formal acting-up status shall not count towards the quorum, although existing non-voting Executive Directors representing a voting Executive in times of absence will count towards the quorum
- If a Board member is disqualified from participating in a discussion or vote due to a declared conflict of interest, they shall no longer count towards the quorum for that item

- If the quorum is lost due to such disqualification, the item in question may not be discussed or voted upon, and this shall be recorded in the minutes. The meeting shall then proceed to the next item of business

Remote Participation

- Participation is expected to be in person, but in exceptional circumstances, members may join via Microsoft Teams. Such members shall be deemed present and counted towards the quorum

Inquorate Meetings

If a meeting:

- Is not quorate within 30 minutes of the scheduled start time, or
- Becomes inquorate during the course of the meeting,

then the meeting shall either:

- Be adjourned to a time, date, and place determined by the members present, or
- Continue as an informal meeting, during which no formal decisions may be taken

6.9 Minutes of the Board

- The minutes of each Board meeting, along with a Post-Meeting Action Log, shall be prepared and submitted for approval at the next scheduled meeting. The approval of the minutes will be formally recorded
- No discussion shall take place on the minutes except to correct inaccuracies or where the Chair deems discussion appropriate (e.g. matters arising)

The minutes shall include:

- The names of all Board members present, any other individuals in attendance and any apologies received from absent Board members
- Any declarations of interest
- Any withdrawals from the meeting due to a declared conflict of interest

- Minutes will summarise key points of discussion. Where sensitive matters (e.g. personnel) are discussed, the minutes will reflect the substance of the discussion in general terms
- Once approved, the minutes will be published on the website as part of the papers for the next scheduled public Board meeting

6.10 Emergency Powers

- In the event of an emergency, the Chair, after consulting with the Chief Executive, may exercise the functions of the Board

Any such decision must be:

- Reported to the next formal Board meeting held in public session
- Formally ratified by the Board
- Accompanied by a clear explanation of the reasons for the emergency decision

6.11 Delegation of Powers

- University Hospitals of North Midlands NHS Trust remains ultimately accountable for all Trust functions, including those delegated to Committees, the Chair, the Chief Executive, Executive Directors, or other employees. To maintain effective oversight, the Board requires regular information on the exercise of delegated functions
- The list of matters reserved for Board decision does not preclude other matters being referred to the Board at its discretion
- All powers delegated by the Board may be reassumed at any time, and the Board reserves the right to revoke or vary any delegation
- The Board delegates to each of its committees the authority to discharge functions within their respective terms of reference, except for matters explicitly reserved to the Board

The Chief Executive is responsible for preparing and maintaining the Scheme of Delegation (Trust Policy F02), which outlines:

- Functions to be performed personally by the Chief Executive
- Functions delegated to Committees and individual employees

All powers delegated by the Chief Executive may also be reassumed by them if necessary

Delegated powers are exercised on the understanding that:

- They will not be used in any matter likely to cause public concern or damage the reputation
- Appropriate expert advice will be sought where necessary
- Any associated costs can be met within the authorised budget

- The Corporate Governance Office is responsible for maintaining a record of all delegated powers, authorities, and discretions
- In the absence of an employee to whom powers have been delegated, those powers may be exercised by the relevant Executive Director, unless alternative arrangements have been approved by the Board
- If the Chair is absent, powers delegated to them may be exercised by the Vice Chair in relation to Board matters, and by the Chief Executive, following appropriate consultation with the Board and Executive Directors

6.12 Role of Accountable Officer and Standing Financial Instructions

The Chief Executive serves as the Accountable Officer. In this capacity, the Chief Executive is personally responsible for ensuring that:

- Public funds entrusted us are properly safeguarded
- Resources are used effectively, efficiently, and economically
- We comply with all relevant statutory and regulatory requirements

Financial governance is further supported by the Standing Financial Instructions (SFIs), set out in Policy F01 – Standing Financial Instructions. These instructions:

- Define the financial responsibilities, policies, and procedures to be followed across the organisation
- Ensure that all financial transactions are conducted in accordance with legal and government requirements
- Promote probity, accuracy, economy, efficiency, and effectiveness in the use of public funds
- Provide a clear framework of procedures and rules for all employees to follow

Note: All proposed expenditure exceeding £1.5 million must be formally approved by the Board.

6.13 Personal Conflicts of Interest

- If a Board or Committee member has a known or potential material and relevant interest—whether direct or indirect, pecuniary or non-pecuniary—that a fair-minded and informed observer would consider presenting a real possibility of bias, they must declare the nature of the interest or duty

Declaration Process

Declarations may be made:

- At the meeting, either at the start or at the relevant agenda item
- In advance, in writing to the Corporate Governance Office

- If declared in advance, the Chair will inform the meeting before the item is discussed
- If a member becomes aware of a conflict during discussion, they must declare it immediately

Participation in Discussion

Once a declaration is made and fully explained, the Board or Committee members present will decide unanimously whether, and to what extent, the individual may:

- Participate in the discussion
- Remain in the room

- Access related written materials

- If required to leave the meeting, the Chair may allow the individual to make a brief statement before withdrawing
- The decision and rationale will be recorded in the minutes

Conflicts Involving the Chair
- If the Chair has a relevant interest, they must declare it and seek the agreement of the Board or Committee regarding their participation
- If it is agreed that the Chair should not participate, another member will be appointed to chair the discussion for that item
- The decision and extent of the Chair's access to papers will be recorded in the minutes

Employees in Attendance
- Employees who are not Board or Committee members but are in attendance must also declare any relevant interests
- If a conflict is identified, the Chair may instruct the employee to withdraw from the discussion

Policy Reference
- All Board members, Committee members, and employees are subject to the provisions of Trust Policy G16 – Standards of Business Conduct, which outlines the full arrangements for managing conflicts of interest

6.14 Allowances for Non-Executive Members of the Board

Non-Executive members of the Board are entitled to seek reimbursement of reasonable expenses incurred in the exercise of duties in accordance with Trust Policy.

7. Meetings and Proceedings of Committees

Where no specific provisions are outlined for Committees, the principles and procedures applicable to the Board shall apply. In cases of inconsistency between these provisions and a Committee's Terms of Reference, the Terms of Reference shall take precedence.

Committee Governance Packs, including Terms of Reference, Membership, and Business Cycles, are available in Appendices 9–13.

7.1 Appointment of Committees

- The Board may establish Committees for any purpose within its functions and shall define their powers and responsibilities
- The Board shall appoint members to each Committee
- The Chair of each Committee shall be a Board member, unless otherwise specified (e.g. where the Chief Executive, as Accountable Officer, is required to chair)
- The Board shall review the structure and scope of each Committee's activities regularly
- The Board shall approve and may amend the Terms of Reference for each Committee

7.2 Meetings of a Committee

- Committees shall meet at regular intervals, as determined by their members. Each Committee shall decide the time and location of its meetings

7.3 Extraordinary Meetings of a Committee

- In urgent circumstances, the Committee Chair may convene an extraordinary meeting at a time and place of their choosing

7.4 Attendance at Committee Meetings

- Any Board member may attend and speak at a committee meeting with the permission of the Committee Chair
- Board members who are not formal Committee members may not vote
- If a formal Committee member is unable to attend, a suitably senior deputy may attend with full delegated authority, and may be counted for quorum purposes, where appropriate

7.5 Chairing of Committee Meetings

- The Committee Chair, if present, shall preside over all meetings
- In their absence, a Non-Executive Board member who is also a Committee member, or a Board member nominated by the Chair, shall preside
- The procedure at meetings shall be determined by the presiding Chair

7.6 Quorum of Committees

- A Committee meeting shall be quorate when at least half of its total membership is present, including at least one Non-Executive Board member, unless otherwise specified in the Committee's Terms of Reference.

7.7 Minutes of Committees

- A member of the Corporate Governance Office shall act as Secretary to each Committee
- The Secretary shall record the minutes of each meeting, which shall be submitted to the next Committee meeting for confirmation or amendment
- Minutes shall be made accessible to all Board members via the Corporate Governance Office

7.8 Committee Reporting to the Board

- Following each Committee meeting, the Corporate Governance Office shall prepare a summary report on behalf of the Committee Chair for presentation at the next Board meeting

This report will highlight:

- Key risks and escalations
- Actions taken
- Recommendations to the Board

- Each Committee, led by the Deputy Director of Governance (on behalf of the Chair), shall conduct an annual effectiveness review against its Terms of Reference and Membership. The outcome will be reported to the Board in line with the Annual Business Cycle

7.9 Prohibition on Delegation of a Committee's Function

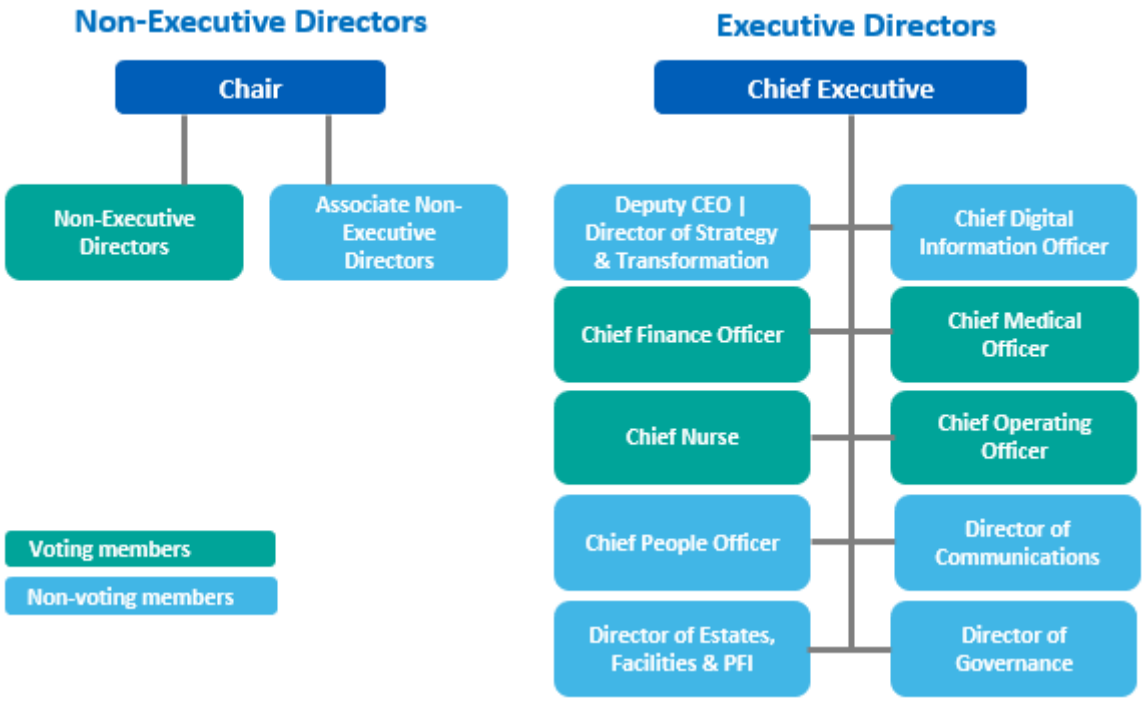
- Committees may not delegate their functions to any other group or individual unless explicitly authorised by the Board in their Terms of Reference

8. Other Documents Relevant to these Rules of Procedure

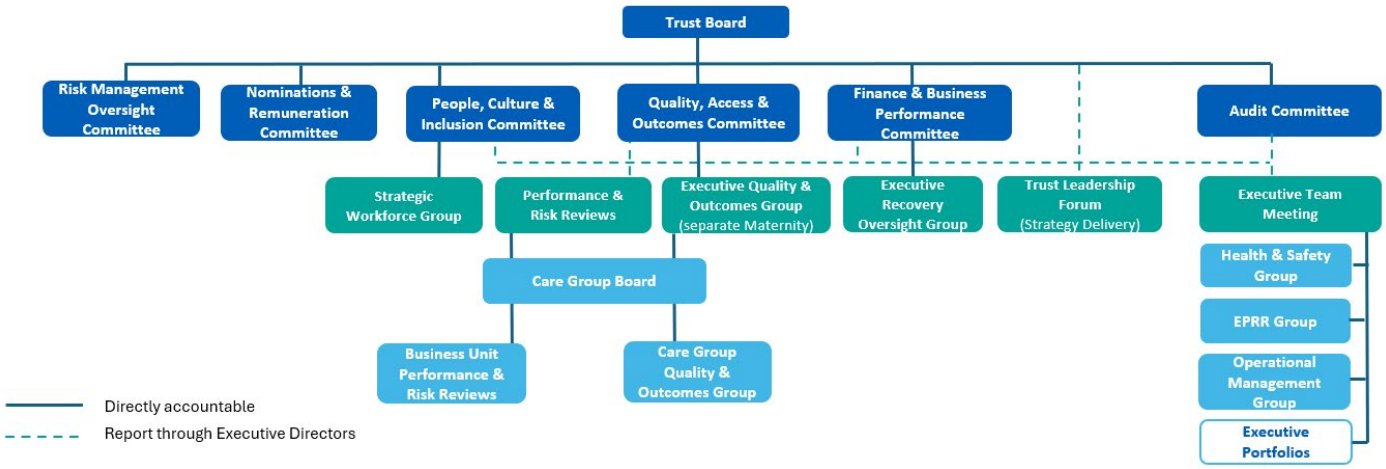
The following documents should be read in conjunction with the Rules of Procedure:

- F01 Standing Financial Instructions
- F02 Scheme of Delegation
- G19 Standing Orders
- G16 Standards of Business Conduct
- Trust Values, Behaviours and Standards Framework
- Accountability and Performance Framework

Appendix 1 – Trust Board Organisation Chart



Appendix 2 – Corporate Governance Structure



Appendix 3 - Code of Conduct for Board Members

To justify the trust placed in me by patients, service users and the public, I will abide by these standards at all times when at the service of the NHS.

I understand that care, compassion and respect for others are central to quality in healthcare; and that the purpose of the NHS is to improve the health and wellbeing of our people, patients and population, supporting them to keep mentally and physically well, to get better when they are ill and when they cannot fully recover, to stay as well as they can to the end of their lives.

I understand that I must act in the interests of patients, service users and the community I serve, and that I must uphold the law and be fair and honest in my dealings.

Introduction

All members of NHS Boards are expected to work to the highest personal and professional standards and should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals, they must understand both the extent and limitations of their personal responsibilities.

This Code of Conduct has been developed in line with a range of existing standards relevant to the healthcare sector. The standards set out within this Code are consistent with the Nolan Principles on Public Life and with existing regulatory frameworks applying to professionals and senior managers working in the NHS.

In addition, the Code of Conduct should be read alongside the Values, Behaviours and Standards Framework.

Purpose

Senior leadership roles can frequently require individuals to address dilemmas in difficult decisions. Their decisions must balance the potentially conflicting but legitimate needs of individuals, communities, the healthcare system and taxpayers.

- Part 1 of this Code of Conduct is designed to provide a framework to guide judgment in these circumstances, through a consistent application of values and principles
- Part 2 sets out etiquette for Board members, including behavioural expectations aligned to our values of Kind, Excellent and Together, to help ensure that Board meetings are effective and focused
- Part 3 provides an outline of the individual and collective roles and responsibilities of Board members

Part 1: Standards for Board Members

All Board members should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities, such as the differences in role of executive and non-executive Board members. To justify the trust that has been placed in them by patients and the public they must adhere to these standards of personal behaviour, technical competence and business practice.

3.1 Personal Behaviours

In the treatment of patients and service users, their families and their carers, the community and colleagues, and in the design and delivery of services for which they are responsible, Board members must commit to:

- The values of the **NHS Constitution** in the treatment of colleagues, patients and their families and carers and the community, and in the design and delivery of services for which they are responsible
- Promoting **equality, diversity and inclusion** in the treatment of colleagues, patients and their families and carers, and the community, and in the design and delivery of services for which they are responsible
- Promoting **human rights** in the treatment of colleagues, patients, their families and carers, and the community, and in the design of services for which they are responsible
- The **duty of candour** to ensure that 'patients/their families are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and supported to deal with the consequences'. This applies to patient safety incidents that occur during care provided and that result in moderate harm, severe harm or death. This also applies to suspected incidents which have yet to be confirmed, where the suspected result is moderate harm, severe harm or death
- The requirements as set out by the Care Quality Commission in relation to the **Fit and Proper Persons Test**
- Ensuring the safeguarding of **public funds**, taking appropriate measures to ensure resources are used efficiently, economically and effectively. In addition, Board members should refer to the Standards of Business Conduct Policy, in terms of receipt of gifts and hospitality

In addition to acting as role models for Our Values, Board members must apply the following principles in their work and relationship with others:

Responsibility	I will be fully accountable for my work and the decisions that I make, for the work and decisions of the Board, including delegated responsibilities, and for the employees and services for which I am responsible.
Honesty	I will act with honesty in all my actions, transactions, communications, behaviours and decision-making, and will resolve any conflicts arising from personal, professional or financial interests that could influence or be thought to influence my decisions as a Board member
Openness	I will be open about the reasoning, reasons and processes underpinning my actions, transactions, communications, behaviours and decision-making and about any conflicts of interest
Respect	I will treat patients and service users, their families and carers, the community and colleagues with dignity and respect at all times
Professionalism	I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a Board member and that I reflect on and identify any gaps in my knowledge and skills and will participate constructively in appraisal of myself and others. I will adhere to any professional or other codes by which I am bound
Leadership	I will lead by example in upholding and promoting these Standards and use them to create a culture in which their values can be adopted by all.
Integrity	I will act consistently and fairly by applying these values in all my actions, transactions, communications, behaviours and decision-making, and always raise concerns if I see harmful behaviour or misconduct by others.

3.2 Technical Competence

For themselves and the organisation, Board members must seek:

- To make sound decisions individually and collectively
- Excellence in the safety and quality of care, patient experience and the accessibility of services
- Long term financial stability and best value for the benefit of patients, service users and the community

This will be done through:

- Always putting the safety of patients and service users, the quality of care and patient experience first, enabling colleagues to do the same
- Demonstrating the skills, competencies and judgment necessary to fulfil their role and by engaging in training, learning and continuing professional development
- Having a clear understanding of the business and financial aspects of the organisations work and of the business, financial and legal contexts in which it operates
- Making best use of expertise and that of colleagues while working within the limits of their own competence and knowledge
- Understanding their role and powers, the legal, regulatory and accountability frameworks and guidance within which they operate and the boundaries between the executive and non-executive
- Working collaboratively and constructively with others, contributing to discussions, challenging decisions and raising concerns effectively
- Publicly upholding all decisions taken by the Board under due process for as long as they are a member of the Board
- Thinking strategically and developmentally
- Seeking and using evidence as the basis for decisions and actions
- Understanding the health needs of the population served
- Reflecting on personal, Board and organisational performance and how their behaviour affects those around them; and supporting colleagues to do the same
- Looking for the impact of decisions on the services provided, on the people who use them and on employees
- Listening to patients and service users, their families and carers, the community and colleagues and making sure people are involved in decisions that affect them
- Communicating clearly, consistently and honestly with patients and service users, their families and carers, the community and colleagues, ensuring that messages have been understood
- Respecting patients' rights to consent, privacy and confidentiality and access to information, as enshrined in data protection and freedom of information law and guidance

3.3 Business Practices

For themselves and for the organisation, Board members must seek:

- To ensure the organisation is fit to service its patients and service users, and the community
- To be fair, transparent, measured and thorough in decision making and in the management of public money
- To be ready to be held publicly to account for the organisation's decisions and for its use of public money

This will be done through:

- Declaring any personal, professional or financial interests and ensure that they do not interfere with actions, transactions, communications, behaviours or decision making, removing themselves from decision making when they might be perceived to do so
- Taking responsibility for ensuring that any harmful behaviour, misconduct or systems weaknesses are addressed and learnt from, and taking action to raise any such concerns identified
- Condemning any practices that could inhibit the reporting of concerns by members of the public, employees or Board members about standards of care or conduct
- Ensuring that patients and service users and their families have clear and accessible information about the choices available to them so that they can make their own decisions
- Being open about the evidence, reasoning and reasons behind decisions about budget, resource and contract allocation
- Seeking assurance that the organisations financial, operational and risk management frameworks are sound, effective and properly used and that the values in these standards are put into action in the design and delivery of services
- Ensuring that the organisations contractual and commercial relationships are honest, legal, regularly monitored and compliant with best practice in the management of public money
- Working in partnership and co-operating with local and national bodies to support the delivery of safe, high-quality care

- Ensuring that the organisations dealings are made public, unless there is a justifiable and properly documented reason for doing so

- Ensuring that effective complaints and whistleblowing procedures are in place and in use. Board members must actively support a culture of openness and transparency, including the Freedom to Speak Up agenda. Concerns raised by employees, patients, or the public must be treated seriously and handled in accordance with the Speaking Up Policy. Board members should ensure that Freedom to Speak Up Guardians are visible, accessible, and supported in their role to promote a safe environment for raising concerns

Part 2: Board Meetings Etiquette & Procedures

An effective Board develops and promotes its collective vision of the purpose, culture, values and the behaviours it wishes to promote in conducting its business. In particular it:

- Provides direction for management
- Demonstrates inclusive and diverse leadership, displaying and promoting behaviours consistent with the culture and values it has defined for the organisation
- Makes well-informed and high-quality decisions based on a clear line of sight into the business

Ensuring robust and appropriate challenge depends on a number of factors being in place: the right information in the right format in advance of the meeting; an appropriate setting; length of the meeting; well chaired; appropriate boardroom behaviours and the encouragement of a culture where challenge is accepted.

If Board members are not fully engaged throughout the duration of a Board meeting, and behaviours are poor, decision-making will be impaired. It may be possible that Board papers are failing to engage members, consequently not stimulating directors to ask questions and challenge assumptions behind recommendations.

4.1 Before the Meeting

- Upon receipt of the Board papers, read the agenda, and any supporting papers ahead of the meeting and prepare questions to be raised at the appropriate time, or think of suggestions to resolve problems
- Be clear on the decision that is being asked for
- Request further information ahead of the meeting or seek clarification, from the Corporate Governance Office (including highlighting typographical and other errors not of material consequence), where appropriate
- Submit apologies, and where appropriate arrange for a deputy to attend (ensuring they are well-briefed)
- If you are aware that you have to leave before the end of a scheduled meeting, inform the Chair beforehand. However, this should be avoided whenever possible

4.2 During the Meeting

- Declare any potential or existing conflicts of interest with regard to any matter on the agenda
- Unless there are specific reasons for doing so, no part of the meeting should be visually, or audio recorded. If such recording is agreed the Chair must inform the meeting beforehand

4.3 Focussing on the Agenda

- Dedicate attention to the purpose of the meeting and refrain from performing other duties at the same time
- Turn mobile phones to silent and if you need to answer an urgent call, the Chair should be forewarned
- Refrain from holding private conversations with others at the meeting (whether spoken or written)

4.4 Contributing to the Discussion

- Attract the Chair's attention when wishing to contribute to the discussion and wait until the Chair indicates that you may speak so as to avoid interrupting a fellow Board member. Direct comments and discussion through the chair
- When invited to speak by the Chair, do so clearly, concisely and at a volume that all attendees can hear (especially the minute-taker), without shouting. Avoid the use of jargon and acronyms
- When presenting papers, assume these have been read by members and highlight the key saliant points
- Throughout the meeting be respectful of the role of the chair in encouraging debate, summarising discussion and clarifying decisions made
- Listen attentively and respectfully to others, making notes of any points to raise when an opportunity to respond arises; do not interrupt when others are speaking
- Ensure body language demonstrates participation and engagement in the meeting
- Challenge inappropriate behaviour/language from other Board members at the time via the Chair or after the meeting if preferred
- Be constructive and professional in imparting an opinion, information or providing challenge
- Seek clarification when necessary

4.5 Unitary Board

- Board members should know and understand their role at the meeting and the need for the Board to act as a corporate body (i.e. not to pursue self-interest or the interest of another body)
- Board members should not act territorially/personally and should remember the need to contribute to the corporate nature of the Board
- Regard and welcome challenge as a test of the robustness of papers and arguments presented
- Do not cause offence or take offence, accept the diversity of opinions and views presented

4.6 Accountability

- Seek professional guidance/clarification from the Chair during the meeting (or Director of Governance outside the meeting) wherever there may be any concern about a particular course of action
- Keep confidential matters confidential

4.7 After the meeting

- Participate and contribute to any post-meeting review with a view to making future meetings more effective
- A summary of actions agreed will be produced and circulated by the Corporate Governance Office after the meeting. Board members must read the action summary and complete any relevant tasks and report back appropriately on their completion in a timely manner. A central log of all actions agreed by the Board will be maintained by the Corporate Governance Office
- Draft minutes will be produced within one working week after the meeting. These should be read with a view to clarifying matters and sending amendments to the Corporate Governance Office at the earliest opportunity. This should help to reduce the time taken approving the minutes at the next Board meeting
- Observe the confidentiality and sensitivity of matters discussed at the meeting and ensure that all papers are stored safely
- Remember that decisions were taken collectively by the Board and therefore that responsibility remains collective too

Where there are concerns raised that the etiquette has not been adhered to, the Chair or Chief Executive as appropriate will take necessary action.

5.1 Chair and Chief Executive

The Chair and Chief Executive have complimentary roles in Board leadership. In essence, these two roles are:

- The **Chair** leads the Board and ensures the effectiveness of the Board
- The **Chief Executive** leads the executive and the organisation

5.2 Roles of Board Members

There are distinct roles for different members of the Board. These are set out in the following table:

	Chair	Chief Executive	Non-Executive Director	Executive Director
Formulate Strategy	Ensures the Board develops vision and clear objectives to deliver organisational purpose	Leads vision, strategy development process	Brings independence, external skills and perspectives and challenge to strategy development	Takes lead role in developing strategic proposals – drawing on professional and clinical expertise (where relevant)
Ensure Accountability	Holds CEO to account for delivery of strategy Ensures that Board committees which support accountability are properly constituted	Leads the organisation in the delivery of strategy Establishes effective performance management arrangements and controls Acts as Accountable Officer	Holds the executive to account for the delivery of the strategy Offers purposeful, constructive scrutiny and challenge Chairs or participates as member of key committees which support accountability	Leads implementation of strategy within functional areas
Shape Culture	Provides visible leadership in developing a positive culture for the organisation, and ensures that this is reflected and modelled in their own and in the Boards behaviour and decision making Board culture: Leads and supports a constructive dynamic within the Board, enabling contributions from all directors	Provides visible leadership in developing a positive culture for the organisation and ensures that this is reflected in their own and the executive's behaviour and decision making	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour Provides a safe point of access to the Board for whistle blowers	Actively supports and promotes a positive culture for the organisation and reflects this in their own behaviour
Context	Ensures all Board members are well briefed on external context	Ensures all Board members are well briefed on external context		
Intelligence	Ensures requirements for accurate, timely and clear information to Board / directors are clear to executive	Ensures provision of accurate, timely and clear information to Board / directors	Satisfies themselves of the integrity of financial and quality intelligence	Takes principal responsibility for providing accurate, timely and clear information to the Board
Engagement	Plays a key role as an ambassador, and in building strong partnerships with: • Patients and public • Clinicians and employees • Key institutional stakeholders	Plays a key leadership role effective communication and building strong partnerships with: • Patients and public • Clinicians and employees • Key institutional	Ensures Board acts in best interests of the public Senior independent director is available to members	Leads on engagement with specific internal or external stakeholder groups

	Chair	Chief Executive	Non-Executive Director	Executive Director
	• Regulators	stakeholders • Regulators		

6. Monitoring Compliance with the Code of Conduct

Overall effectiveness will be reviewed after each meeting.

7. References

- Cabinet Office: Code of Conduct for Board Members of Public Bodies, June 2019 https://www.gov.uk/government/publications/code-of-conduct-for-board-members-of-public-bodies/code-of-conduct-for-board-members-of-public-bodies-june-2019#general-conduct
- Council for Healthcare Regulatory Excellence: Standards for members of Boards and governing bodies in England January 2012 https://www.professionalstandards.org.uk/sites/default/files/attachments/standards-for-members-of-nhs-boards-ccg-bodies-advice.pdf
- Professional Standards Authority: Standards for members of NHS Boards and Clinical Commissioning Group governing bodies in England https://www.professionalstandards.org.uk/sites/default/files/attachments/Standards%20for%20members%20of%20NHS%20boards%20and%20CCGs%202013.pdf
- National Leadership Council: The Healthy NHS Board, Principles for Good Governance, February 2010 https://www.leadershipacademy.nhs.uk/wp-content/uploads/2012/11/NHSLeadership-TheHealthyNHSBoard.pdf

Appendix 4 – Trust Board Business Cycle 2025/26

Title of Paper	Executive Lead	May	July	Oct	Dec	Feb
		7	9	8	10	11
PROCEDURAL ITEMS						
Patient / Colleague Story	Chief Nurse / Chief People Officer	Pt	Col.	Pt	Col.	Pt
Chief Executives Report	Chief Executive					
Board Assurance Framework	Director of Governance	Q4		Q1	Q2	Q3
OUR PATIENTS: QUALITY, ACCESS & OUTCOMES						
Quality, Access & Outcomes Committee Assurance Report	Director of Governance					
Care Quality Commission Action Plan	Chief Nurse					
Maternity Serious Incident Report	Chief Nurse					
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI					
Biannual Nurse Staffing Assurance Report	Chief Nurse					
Quality Account	Chief Nurse					
Winter Plan	Chief Operating Officer					
NHS Resolution Maternity Incentive Scheme	Chief Nurse					
Quality, Access & Performance Strategic Plan Update	Chief Nurse / Chief Medical Officer / Chief Operating Officer					
Integrated Performance Report	Various					
OUR PEOPLE						
People, Culture & Inclusion Committee Assurance Report	Director of Governance					
Staff Survey Report	Chief People Officer					
Gender Pay Gap Report	Chief People Officer					
Raising Concerns Report	Director of Governance					
Revalidation	Chief Medical Officer					
Workforce Disability Equality Report	Chief People Officer					
Workforce Race Equality Standards Report	Chief People Officer					
People Strategic Plan Update	Chief People Officer					
Bi-Annual Establishment Review (Other Professions)	Chief People Officer					
OUR POPULATION						
Population Health Strategic Plan Update	Director of Strategy					
FINANCE AND EFFICIENCY						

Title of Paper	Executive Lead	May	July	Oct	Dec	Feb
		7	9	8	10	11
Finance & Business Performance Committee Assurance Report	Director of Governance					
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,500,001 and above	Director of Strategy					
Annual Report & Accounts including Going Concern	Director of Governance / Chief Finance Officer		**Jun**			
Annual Plan	Director of Strategy					
Financial Plan including Capital Programme	Chief Finance Officer					
Standing Financial Instructions	Chief Finance Officer					
Scheme of Reservation and Delegation of Powers	Chief Finance Officer					
OUR STRATEGIC PLANS						
Digital Strategic Plan Update	Chief Digital Information Officer					
Research Strategic Plan Update	Chief Medical Officer					
Innovation Strategic Plan Update	Director of Strategy					
Estates & Facilities Strategic Plan Update	Director of Estates, Facilities & PFI					
GOVERNANCE						
Audit Committee Assurance Report	Director of Governance					
Fit and Proper Persons Annual Assurance Report	Director of Governance					
Anchor Institution Update	Director of Communications					
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer					
Annual Evaluation of the Board and its Committees	Director of Governance					
Annual Review of the Rules of Procedure	Director of Governance					
Board Development Programme	Director of Governance					
Well-Led Self-Assessment	Director of Governance					
Risk Management Policy	Director of Governance					
Complaints Policy	Chief Nurse					

Appendix 5 – Annual Effectiveness Evaluations

NB. Separate checklists are in place for the Audit Committee.

Name of Committee:	
Chair:	
Date of Effectiveness Review:	

Processes

To be completed by the Chair with the assistance of the Corporate Governance Office if required and presented to the relevant Board Committee.

Area / Question	Yes	No	Comments
Composition, Establishment and Duties			
Does the Committee have written terms of reference, and have they been approved by the Board?			
Are the terms of reference reviewed annually?			
Are the outcomes of each meeting reported to the next Trust Board meeting?			
Does the Committee prepare an annual report on its work and performance?			
Has the Committee established a plan of matters to be dealt with across the year?			
Are Committee papers distributed in sufficient time for members to give them due consideration?			
Has the Committee been quorate for each meeting this year?			
Does the Committee have clear purpose / duties?			
Are you clear about your role and responsibilities as Committee Chair?			
Does everyone contribute to the meeting - is there something which could be done to encourage this?			
Do some people dominate the agenda? Do they need to be managed differently?			
Are papers clear about why they are being brought to the Committee?			

Committee Effectiveness

The following questions are asked to each member of the Committee, whereby they are asked to either strongly agree, agree, disagree, strongly disagree as well as providing specific comments on what works well, what doesn't work well and suggestions for improvement.

- The committee has set itself a series of objectives for the year
- The committee has made a conscious decision about the information it would like to receive
- Committee members contribute regularly to the issues discussed
- The committee is aware of the key sources of assurance and who provides them
- The committee has the right balance of experience, knowledge and skills to fulfil its role
- The committee ensures that the relevant Executive Director attends meetings to enable it to understand the reports and information it receives
- The committee is fully briefed on key risks and any gaps in control
- The committee environment enables people to express their views, doubts and opinions
- Members hold their assurance providers to account for late or missing assurances
- Decisions and actions are implemented in line with the timescale set down
- The quality of committee papers received allows committee members to perform their roles effectively
- Members provide real and genuine challenge – they do not just seek clarification and/or reassurance

- The committee challenges management and other assurance providers to gain a clear understanding of their findings
- Debate is allowed to flow, and conclusions reached without being cut short or stifled
- Each agenda item is 'closed off' appropriately so that the committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored
- At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well or not so well
- The committee provides a written summary report of its meetings to the Board including items for escalation
- The Board challenges and understands the reporting from the Committee
- The committee has requested 'deep dives' into areas of concern
- Membership and attendance at the committee enables the committee to cover all aspects of its terms of reference
- The committee chair has a positive impact on the performance of the committee
- Committee meetings are chaired effectively
- The committee chair allows debate to flow freely and does not assert their own views too strongly
- The committee chair provides clear and concise information to the Board on committee activities and gaps in control
- I have experienced instances where members behaviours were not in line with our values
- In cases where members displayed behaviours not in line with Trust values, the Chair addressed this appropriately during the meeting
- I would feel empowered to provide feedback to individuals at the time, or afterwards, where inappropriate behaviours were displayed during the meeting

Appendix 6 – Annual Governance Report Template

Introduction

The xxx Committee is established under Board delegation with approved terms of reference that reflects best practice available nationally. The Committee consists of xx Non-Executive Directors, has met on xx occasions throughout xx and has discharged its responsibilities. An outcome summary of each meeting of the Committee is formally reported to the Public Trust Board via the Committee Chair. The report has highlighted key points of discussion, challenge, decisions made, referral of items as appropriate and recommendations to the Board.

During the year, the Committee comprised of the following membership:

- xx

Other individuals such as the xx have been invited to attend the Committee during xx, for all or part of meetings at the request of the Committee Chair.

Key Areas of Work and Achievements against the Terms of Reference

During the year the Committee has monitored the progress made in delivering the business cycle, as can be seen below:

Compliance with the key responsibilities is evidenced by the actions identified in the following sections:

- xxx

Review of the Effectiveness and Impact of the Committee

The Committee has been active during the year in discharging its responsibilities and has undertaken a self-assessment of its effectiveness.

Emerging Issues and Objectives for xxx

- xxx

Attendance Matrix

All the meetings of the Committee held during xx were quorate.

	Attended		Apologies Given – Deputy sent		Apologies Given		Not in Post

Members:		A	M	J	J	A	S	O	N	D	J	F	M

The average attendance of members (or deputies) at the Committee was xx%.

Conclusion

The Committee is of the opinion that this annual report is reflects the work of Committee during xx and that the Committee has reviewed xxx. In addition there are no matters that the Committee is aware of at this time that have not been disclosed appropriately.

Appendix 7 – Agenda Template

NHS
University Hospitals of North Midlands
NHS Trust

AGENDA | TITLE OF MEETING

DATE

Venue

Time	No.	Agenda Item	Purpose	Lead	Format
	PROCEDURAL ITEMS				
	01	Chair's Welcome, Apologies and Quoracy	Information		Verbal
	02	Declarations of Interest	Information		Verbal
	03	Minutes of the Meeting held xxx	Approval		Enclosure
	04	Matters Arising via the Post Meeting Action Log	Assurance		Enclosure
	HEADING				
	05				
	06				
	HEADING				
	07				
	08				
	HEADING				
	09				
	10				
	GOVERNANCE				
	11				
	12				
	CLOSING MATTERS				
	13	Review of Meeting Effectiveness & Attendance: • What worked well / was helpful • What didn't work well / hindered us • What will we do differently next time	Information		Verbal
	14	Any Other Business	Information	All	Verbal
	DATE AND TIME OF NEXT MEETING				
	15				

Appendix 8 – Minutes Template

Minutes of Meeting

Name of Meeting | Date of Meeting

University Hospitals of North Midlands NHS Trust

Members Present:		
Name	Initials	Title

Apologies Received:		
Name	Initials	Title

In Attendance:		
Name	Initials	Title

No.	Agenda Item	Action
PROCEDURAL ITEMS		
01	Chair's Welcome, Apologies and Confirmation of Quoracy	
	xx	
02	Declarations of Interest	
	xx	

Appendix 10 – Quality, Access & Outcomes Committee

Committee Governance Pack

April 2025

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Quality, Access & Outcomes Committee (the Committee). The Committee is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference or otherwise by the Trust Board in its Scheme of Delegation.

The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or external to the Trust as it considers necessary.

Membership

- Associate Non-Executive Director (Chair)
- Non-Executive Director (Vice-Chair)
- Non-Executive Director
- Associate Non-Executive Director
- Chief Medical Officer
- Director of Governance
- Chief Nurse
- Chief Operating Officer
- Head of Quality Safety & Compliance

Attendance at Meetings

It is expected that other Executive Directors will be invited to attend on an ad hoc basis, depending on the items being covered by the Committee.

Regular Attendees

Other individuals may be invited to attend all or part of any meeting as and when appropriate.

Members are required to attend at least 10 out of 12 meetings per year. Regular attenders are expected to maintain a good standard of attendance and should attend meetings at least once per quarter.

If by exception members are unable to attend, they must advise the Chair of the Committee and enquire whether a deputy is required (if a deputy attends, they must be able to fully participate in the meeting but will have no voting rights).

Attendees who are deputising for members and/or regular attenders must be properly briefed by the person they are deputising for; on the content of the meeting and the item they are presenting.

Quorum

A quorum for the Committee shall be four members, to include two Non-Executive and one Executive Director of the Board.

Frequency of Meetings

The Committee shall meet on a monthly basis.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Office for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Office whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation, and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The purpose of the Committee is to assure the Trust Board of the organisation's performance against quality, access and outcomes objectives.

The primary duties of the Committee are as follows:

- To provide assurance to the Trust Board, of the level, adequacy and maintenance of governance, risk management and internal control across quality, access and outcomes activities in line with the five Care Quality domains.

Safe

- The Committee will review the risk and adequacy of assurance of patient safety (the avoidance, prevention and improvement of adverse outcomes). Ensuring that internal and external assurances of patient safety are regularly reviewed and the strength of assurances evaluated.
- The Committee will seek assurance on operational performance and the potential impact on patient safety in relation to patient flow, discharges, referral to treatment times, urgent and elective care (including cancer) performance and diagnostics
- Receive assurance that external reports on patient safety that have an impact on acute care have been reviewed, considered and any learning adopted. This will include national inquiries; quality reports; safety alerts; Department of Health and Social Care reviews; NHS England; and professional bodies with the responsibility for the performance of employees, (Royal Colleges, accreditation bodies etc)

Effective (Patient Outcomes)

- Review the risks and adequacy of assurance of compliance with the CQC relevant Outcomes
- Review the assurance that the clinical audit programme is aligned with the key strategic and operational risks.

- Receive assurance in relation to compliance with the Mental Health Act

Caring
- Review risks and the adequacy of assurance of patient experience, via review of the action plans to address the outcomes of patient surveys; patient experience tracker results; complaints and comments; patient stories; external reports such as CQC; Healthwatch; Overview and Scrutiny Committees etc.

Responsive
- Review risks and the receive assurance on performance against access and waiting times and any changes to service provision (i.e. QIAs)
- To oversee operational performance to ensure delivery of the NHS Constitutional targets and objectives within the Annual Plan
- To consider the operational performance management control framework

Other Assurance Functions
- Review the risks and assurances to compliance with the CQC registration requirements.
- Review the process and methodology for production of the quality account ensuring that it meets the Trust legal obligations and duties.
- Review any investigations of activities which are within its terms of reference.
- Review the findings of other significant governance and risk reports, both internal and external to the organisation, and shall consider any implications for the governance of the Trust.
- Monitor operational management and implementation of policies to ensure internal control and assurance of quality and operational governance.

Management
- The Committee shall request and review reports and positive assurances from directors and managers on the overall accuracy of information in respect of governance, risk management and internal control.
- The Committee may also request specific reports from individual functions within the Trust as they may be appropriate to the overall arrangements set out above.

General Committee Duties
- To prepare an Annual Report for the Board each year to review the Committee's work in discharging its duties against its Terms of Reference. The report will cover the previous financial reporting period.
- To identify any risks which may prevent the achievement of the Annual Business Cycle and ensure that these are assessed and placed on the Trust's Risk Register/Board Assurance Framework as appropriate.
- To report any exceptions to the Annual Business Cycle to the Board.
- Review and approve the Annual Report, Annual Business Cycle and Terms of Reference of any Groups that have a direct report to the Committee.

Responsibility for Risk Management
The Committee shall consider the Trust's strategic risks of a clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:
- Current and target risk scores
- Impact that the risk has on strategic objectives
- Controls and assurances in place for each risk
- The actions and timescales for closing gaps in controls and assurances and mitigating the risk

The relevant Executive Director responsible for each strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.

Behaviours and Conduct

Trust Values

Members will be expected to conduct business in line with the trust values and objectives.

Members of, and those attending, the committee shall behave in accordance with the trust's rules of procedure, standing orders, and standards of business conduct policy.

Equality and Diversity
Members must demonstrably consider the equality and diversity implications of decisions they make.

Relationship with Other Committees

The Committee will have key relationships with other Committees of the Board, in particular:

- People, Culture & Inclusion Committee
- Finance and Business Performance Committee

Matters for consideration / referral to other Committees of the Board will be done so via the Committee Assurance Reporting mechanism.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
29th April 2025	09.00 am – 12.00 pm	Trust Boardroom	22nd April 2025
5th June 2025	09.30 am – 12.30 pm	MS Teams	29th May 2025
4th July 2025	09.00 am – 12.00 pm	Trust Boardroom	27th June 2025
31st July 2025	09.30 am – 12.30 pm	MS Teams	24th July 2025
5th September 2025	09.00 am – 12.00 pm	Trust Boardroom	29th August 2025
2nd October 2025	09.30 am – 12.30 pm	MS Teams	25th September 2025
7th November 2025	09.00 am – 12.00 pm	Trust Boardroom	31st October 2025
4th December 2025	09.30 am – 12.30 pm	MS Teams	27th November 2025
24th December 2025	09.00 am – 12.00 pm	Trust Boardroom	17th December 2025
5th February 2026	09.30 am – 12.30 pm	MS Teams	29th January 2026
5th March 2026	09.30 am – 12.30 pm	Trust Boardroom	26th February 2026
2nd April 2026	09.30 am – 12.30 pm	MS Teams	26th March 2026

C. Annual Business Cycle

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	29	05-Jun	04-Jul	31	28	02-Oct	07-Nov	04-Dec	24	05-Feb	05-Mar	02-Apr
SAFE												
Quality & Safety Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
Medicines Optimisation		Q4		Q1			Q2			Q3		
Infection Prevention Board Assurance Framework	Q4	→		Q1			Q2			Q3		
Infection Prevention Report	Q4			Q1			Q2			Q3		
Sepsis in Children's Services												
Infection Prevention, Vaccination & Sepsis Team Annual Report												
Care Excellence Framework (CEF) Summary / Staffing Report												
Safeguarding Adults Annual Report												
Safeguarding Children Annual Report												
Looked after Children Annual Report												
Patient Safety Incident Investigation & Serious Incident Highlight Report	Q4			Q1			Q2			Q3		
Mortality Report			Q4 / Annual									
Bereavement / Medical Examiner Update												
Legal Services Annual Litigation & Inquest Report												
Fuller Inquiry Update & Gap Analysis												
Resuscitation Annual Report												
Paediatric Audiology Position Statement												
Patient Waiting List Backlog												
Cancer 104+ Day Breach Analysis		→										
Operational Performance Report												
Winter Plan												
Winter Close Down Report												
Executive Recovery Oversight Group Assurance Report												
EFFECTIVE												
Annual Clinical Audit Plan												
Clinical Effectiveness Update												
Vulnerable Patients Annual Report												
Readmissions Analysis												
Self-Assessment into Previous Inquiries / Investigation Recommendations												
CARING												
Patient Experience Report												
End of Life Annual Report												
Organ Donation and Transplantation Annual Report												

Title of Paper	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
	29	05-Jun	04-Jul	31	28	02-Oct	07-Nov	04-Dec	24	05-Feb	05-Mar	02-Apr
RESPONSIVE												
Population Health Strategic Plan Update												
PLACE Inspection Findings and Action Plan												
7 Day Services Board Assurance Report												
Quality Impact Assessment Report												
WELL-LED												
Quality, Access & Performance Plan Update												
Board Assurance Framework	Q4			Q1			Q2			Q3		
GOVERNANCE												
Assurance Report from Quality & Outcomes Group												
Care Quality Commission Inspection Update												
Committee Effectiveness												
Chaperoning Policy												
Quality Account												
Executive Groups Effectiveness Reviews / Terms of Reference												
Internal Audit Reports (As required)												
MATERNITY AND NEONATAL QUALITY GOVERNANCE												
Maternity Dashboard												
Maternity and Neonatal PSIRF Investigation Report												
Maternity & Neonatal Workforce Report												
Maternity and Neonatal Single Delivery Plan												
Annual Maternity & Neonatal Workforce Plan												
NHS Resolution Maternity Incentive Scheme												
Annual Update on Saving Babies Lives Care Bundle												
Maternity and Neonatal Voices Partnership Feedback Report												
Perinatal Mortality Report												
Bi-annual Consultant Attendance												
Bi-annual Criteria for Employing Long-term/Short-term Locum Doctors in Obstetrics & Gynaecology Audit												
Maternity Quality & Safety Oversight Group Assurance Report												

Appendix 11 – People, Culture & Inclusion Committee

Committee Governance Pack

April 2025

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the People, Culture & Inclusion Committee (the Committee).

The Committee is a non-executive committee of the Trust Board and has powers to ensure that the Board is able to act in accordance with legislation, compliance or direction requirements inclusive of workforce legislation and to be fully appraised of the strategic impact of our People Plan.

The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or external to the Trust as it considers necessary.

Membership

- Non-Executive Director (Chair)
- Non-Executive Director (Vice-Chair)
- Non-Executive Director
- Associate Non-Executive Director
- Chief Medical Officer
- Director of Governance
- Chief People Officer
- Chief Nurse
- Director of Communications

Attendance at Meetings

It is expected that other Executive Directors will be invited to attend on an ad hoc basis, depending on the items being covered by the Committee.

Regular Attendees

Other individuals may be invited to attend all or part of any meeting as and when appropriate.

Members are required to attend at least 4 out of 6 meetings per year. Regular attendees are expected to maintain a good standard of attendance and should attend meetings at least once per quarter.

If by exception members are unable to attend, they must advise the Chair of the Committee and enquire whether a deputy is required (if a deputy attends, they must be able to fully participate in the meeting but will have no voting rights).

Attendees who are deputising for members and/or regular attenders must be properly briefed by the person they are deputising for; on the content of the meeting and the item they are presenting.

The Trust's Chair shall not be a member of the Committee but is authorised to observe any meetings of the Committee.

The Committee may also invite other senior officers of the Trust and other specialist advisors (internal or external) to present papers on an ad-hoc basis. Such attendees will hold no voting rights.

Quorum

A quorum for the Committee shall be four members, to include two Non-Executive and two Executive Directors of the Board.

Frequency of Meetings

The Committee shall meet six times a year.

Reporting

The Committee shall report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings shall be formally recorded, and the discussion will be summarised by the Corporate Governance Office on behalf of the Chair for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust Board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Office whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The Committee is responsible for ensuring that people matters are considered and planned into Trust Strategy and service delivery and shall include the following duties:

Workforce and Organisational Development

- To approve and receive regular progress updates on the people strategic plan
- To monitor the progress and effectiveness of workforce strategic plan against corporate strategy, organisational values and workforce experience, as measured by key workforce performance indicators.
- To approve new workforce / organisational development projects and practices, paying particular attention to the impact on patient experience, quality, efficiency, equality and diversity and workforce.
- To receive assurance that workforce policies are regularly reviewed and updated as required and in line with current legislation.
- To monitor progress associated with workforce recommendations arising from internal audits

- To approve the development, implementation and evaluation of leadership and management development, talent management and succession planning, wellbeing plans and apprenticeship and widening participation activity.
- To review and analyse the experiences of our employees and how we involve and engage with them to support successful and sustainable organisation and cultural change
- To take an overview of the equality, diversity and inclusion policy and achievement of goals
- To receive and consider the quarterly Guardian of Safe Working Hours report on behalf of the Board
- To receive and consider the bi-annual Speaking Up Report
- To consider clinical workforce transformation issues
- To review and approve mandated workforce reporting returns including workforce equality, revalidation and safe staffing reports.
- To provide assurance to the Board that the Trust is compliant with relevant HR legislation and best practice
- To ensure that the workforce implications of financial plans are thoroughly considered and taken into account
- To ensure that current and future workforce issues and developments are fully reflected in business and financial plans and forecasts
- To ensure the Trust is continually reviewing current ways of working and developing new ways of working that are designed to encourage employees to maximise their effectiveness in delivering the Annual Plan
- To review the impact of people and organisational development strategies and plans on business performance and associated targets

General Committee Duties

- To prepare an Annual Report for the Board each year to review the Committee's work in discharging its duties against its Terms of Reference. The report will cover the previous financial reporting period.
- To identify any risks which may prevent the achievement of the Annual Business Cycle and ensure that these are assessed and placed on the Trust's Risk Register/Board Assurance Framework as appropriate.
- To report any exceptions to the Annual Business Cycle to the Board.
- Review and approve the Annual Report, Annual Business Cycle and Terms of Reference of any Groups that have a direct report to the Committee.

Responsibility for Risk Management

The Committee shall consider the Trust's strategic risks of a non-clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:

- Current and target risk scores
- Impact that the risk has on strategic objectives
- Controls and assurances in place for each risk
- The actions and timescales for closing gaps in controls and assurances and mitigating the risk

The relevant Executive Director responsible for each strategic risk shall be accountable at the Committee for responding to challenge and scrutiny of the Committee.

Behaviours and Conduct

Trust Values

Members will be expected to conduct business in line with the trust values and objectives.

Members of, and those attending, the committee shall behave in accordance with the trust's rules of procedure, standing orders, and standards of business conduct policy.

Equality and Diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

Relationship with Other Committees

The Committee will have a key relationship with other Committees of the Board, in particular:

- Quality, Access & Outcomes Committee
- Finance and Business Performance Committee

Matters for consideration / referral to other Committees of the Board will be done so via the Committee Assurance Reporting mechanism.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
4th June 2025	09.00 am – 12.00 pm	MS Teams	28th May 2025
30th July 2025	09.00 am – 12.00 pm	MS Teams	23rd July 2025
1st October 2025	09.00 am – 12.00 pm	MS Teams	24th September 2025
3rd December 2025	09.00 am – 12.00 pm	MS Teams	26th November 2025
4th February 2026	09.00 am – 12.00 pm	MS Teams	28th January 2026
1st April 2026	09.00 am – 12.00 pm	MS Teams	25th March 2026

C. Annual Business Cycle

Title of Paper	May 04-Jun	Jul 30	Sept 01-Oct	Nov 03-Dec	Jan 04-Feb	Mar 01-Apr
PEOPLE						
Chief People Officer Report						
Our People Plan						
Postgraduate Medical Education Report						
Medical School Quality Report		→				
Appraisal and Revalidation Annual Report						
Nurse Staffing Establishment Review		→				
Allied Health Professional Workforce Establishment Review						
Chief Pharmacist Workforce Report						
Chief Healthcare Scientist Update		→				
CenREE Update						
Talent and Succession Planning Update		→				
Learning and Education Annual Report						
Health and Safety Report	Q4	Q1		Q2	Q3	
Fire Safety Annual Report						
Security Management Annual Report						
Violence Prevention and Reduction Update						
CULTURE						
Results of Annual Staff Survey Report						
Health and Wellbeing Review						
Guardian of Safe Working Report	Q3	Q4/Q1				
Employee Relations Casework Trends (formerly Formal Case Activity Report)						
Freedom to Speak Up		Q3 / Q4		Q1 & Q2		
Positive and Inclusive Culture Programme						
INCLUSION						
Workforce Race and Workforce Disability Equality Standard						
Equality, Diversity & Inclusion Annual Report						
Gender Pay Gap Report						
GOVERNANCE						
Strategic Workforce Group Assurance Report						
Health and Safety Group Assurance Report						
Board Assurance Framework		Q1			Q3	
Committee Effectiveness						
Executive Groups Terms of Reference						

Appendix 12 – Audit Committee

Committee Governance Pack

April 2025

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Membership

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust and shall consist of the following:

- Non-Executive Director (Chair)
- Non-Executive Director
- Associate Non-Executive Director

The Chair of the organisation shall not be a member of the Committee. In addition, other Non-Executives are invited to attend as required.

Attendance at Meetings

Members are required to attend at least 4 out of 5 meetings per year. Regular attenders are expected to maintain a good standard of attendance.

The Chief Finance Officer and appropriate internal and external audit representatives shall normally attend meetings.

The Local Counter Fraud Specialist will attend a minimum of two committee meetings a year.

The Chief Executive will be invited to attend and discuss, annually with the Committee, the process of assurance that supports the Annual Governance Statement. They will also attend when the Committee considers the draft annual report and accounts. All other Executive Directors will be invited to attend, particularly when the Committee is discussing areas of risk or operation that are the responsibility of that director.

The Corporate Governance Office shall provide appropriate support to the Chair and Committee members.

At least once a year, the Committee should meet privately with the external and internal auditors.

Access

The head of internal audit and representative of external audit have a right of direct access to the chair of the committee. This also extends to the local counter fraud specialist.

Quorum

A quorum shall be two non-executive members.

Frequency of Meetings

The Committee will hold a minimum of five meetings per annum. The External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

Reporting

The Committee shall report to the Board on how it discharges its responsibilities.

The minutes of the Committee meetings shall be formally recorded and made available to all members of the Committee.

The Corporate Governance Office will submit a report following each Committee meeting, on behalf of the Committee Chair, for presentation at the next Open Trust Board. The report will summarise the decisions made as well as highlighting any items for escalation.

The Committee, led by the Chair, will undertake an annual effectiveness evaluation against their Terms of Reference and Membership. The outcome will be reported to the Board in accordance with the Annual Business Cycle.

The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness of and how embedded risk management is in the organisation
- The effectiveness of governance arrangements
- The appropriateness of the evidence that shows compliance with regulatory requirements

The Committee's annual report will also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed.

An annual Committee Effectiveness evaluation will be undertaken and reported to the Committee and the Board.

The Committee will review these terms of reference, at least annually as part of the annual committee effectiveness review and recommend any changes to the board.

Administrative Support

The Committee shall be supported administratively by the Corporate Governance Office whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The Committee's duties/responsibilities can be categorised as follows:

Governance, Risk Management and Internal Control

The Committee shall review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives.

In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board
- the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider licence
- the policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHS Counter Fraud Authority (NHSCFA).

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (for example, the Quality, Access & Outcomes Committee) so that it understands processes and linkages. However, these other Committees must not usurp the Committee's role.

Internal Audit

The committee shall ensure that there is an effective internal audit function that meets the *Public sector internal audit standards, 2017* and provides appropriate independent assurance to the committee, Chief Executive and Board. This will be achieved by:

- considering the provision of the internal audit service and the costs involved
- reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resource
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit

The Committee shall review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the board when appropriate)
- discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- reviewing all external audit reports, including the report to those charged with governance (before its submission to the board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

Other Assurance Functions

The Committee shall review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.

These may include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/ inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of employees or functions (for example, Royal Colleges, accreditation bodies).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the audit committee's own areas of responsibility. In particular, this will include any committees covering safety/ quality, for which assurance from clinical audit can be assessed, and risk management.

Counter Fraud

The Committee shall satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and shall review the outcomes of work in these areas.

With regards to the Local Counter Fraud Specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

Financial Reporting

The Committee shall monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Committee shall review the annual report and financial statements before submission to the board, or on behalf of the board where appropriate delegated authority is place, focusing particularly on:
- the wording in the annual governance statement and other disclosures relevant to the terms of reference of the committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted misstatements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letters of representation

Management

The Committee shall request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, compliance reviews or accreditation reports).

Governance Regulatory Compliance

The Committee shall review the organisation's reporting on compliance with the NHS Provider Licence and NHS code of governance as required.

The Committee shall satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

Behaviours and Conduct

Trust Values
Members will be expected to conduct business in line with the trust values and objectives.

Members of, and those attending, the committee shall behave in accordance with the trust's rules of procedure, standing orders, and standards of business conduct policy.

Equality and Diversity
Members must demonstrably consider the equality and diversity implications of decisions they make.

Relationship with Other Committees

As a Committee of the Trust Board, it is important that the Committee minimises areas of overlap. Therefore, the following specific areas of responsibility will be excluded from the Committee agenda:

- Issues around clinical risk management including receiving assurance from the clinical audit function will be considered at the Quality, Access and Outcomes Committee
- The effectiveness of the arrangements in place for allowing employees to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensuring that any such concerns are investigated proportionately and independently, will be considered at the People, Culture & Inclusion Committee.
- Reporting on compliance with the fit and proper persons test will be considered by the Nominations and Remuneration Committee.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
1st May 2025	12.45 pm – 3.00 pm	Via MS Teams	24th April 2025
20th June 2025	9.15 am – 10.30 am	Via MS Teams	13th June 2025
31st July 2025	12.45 pm – 3.00 pm	Via MS Teams	24th July 2025
6th November 2025	12.45 pm – 3.00 pm	Via MS Teams	30th October 2025
5th February 2026	12.45 pm – 3.00 pm	Via MS Teams	29th January 2026

C. Annual Business Cycle

To assist in the management of business over the year the following annual workplan will be maintained, capturing the main items of business at each scheduled meeting.

Title of Paper	Executive Lead	Apr	Jun	Jul	Oct	Jan
		01-May	20	31	06-Nov	05-Feb
GOVERNANCE						
Private Internal and External Audit Discussions	Audit Committee					
Board Assurance Framework	Director of Governance	Q4		Q1	Q2	Q3
Annual Report and Annual Governance Statement	Director of Governance					
Issues for Escalation from Committees	Director of Governance					
Internal Audit Recommendation Tracker	Director of Governance					
Undertakings	Director of Governance					
Corporate Governance Report	Director of Governance					
Cyber Security Assurance Report	Chief Digital Information Officer					
Committee Effectiveness	Director of Governance					
FINANCE						
Annual Accounts	Chief Financial Officer					
Audited Accounts and Financial Statements and Analytical Review	Chief Financial Officer					
Going Concern	Chief Financial Officer					
Pharmacy Directorate - Medicines Write Off Report	Chief Financial Officer					
Losses and Special Payments and Stock Write Offs	Chief Financial Officer					
SFI Breaches relating to Procurement processes and Single Tender Waivers	Chief Financial Officer					
SFI Breaches relating to Salary Overpayments	Chief Financial Officer					
Accounting Policies Update	Chief Financial Officer					
Annual Accounts Timetable	Chief Financial Officer					
INTERNAL AUDIT						
Internal Audit Progress Reports	Internal Audit					
Internal Audit Annual Report and Opinion	Internal Audit					
Approval of Internal Audit Plan	Internal Audit					
Effectiveness of Internal Audit	Audit Committee					
EXTERNAL AUDIT						
External Audit Plan	External Audit					
External Audit Progress Report	External Audit					
Audit Findings Report and Letter of Representation	External Audit					
Auditor's Annual Report	External Audit					
Informing the Audit Risk Assessment	External Audit					
Effectiveness of External Audit	Audit Committee					
COUNTER FRAUD						
Counter Fraud Annual Plan	Counter Fraud					
LCFS Annual Report	Counter Fraud					
Counter Fraud Progress Report	Counter Fraud					
Review of Effectiveness of LCFS	Audit Committee					
CLINICAL AUDIT						
Annual Clinical Audit Programme	Medical Director					
INTERNAL AUDIT PLAN						

Appendix 13 – Nominations & Remuneration Committee

Committee Governance Pack

April 2025

A. Terms of Reference

Constitution and Authority

The Trust Board hereby resolves to establish a Committee of the Board to be known as the Nominations and Remuneration Committee (the Committee). The Committee has no executive powers, other than those specifically delegated in these terms of reference.

The Committee is authorised by the Trust Board to take action in respect of any activities within its Terms of Reference. The Committee is authorised by the Trust Board to obtain, at the Trust's expense, outside legal or other professional advice on any matters within its terms of reference.

Membership

The Committee shall comprise at least three members, all of whom shall be Non-Executive Directors. The Chair of the Trust Board may also serve on the Committee.

- Chair (Chair)
- Non-Executive Director
- Associate Non-Executive Director
- Non-Executive Director

In addition, all other Non-Executive Directors are invited to attend the meeting should they wish. At such time when the Committee is required to consider matters in relation to the Chair i.e. consideration of successor, the Senior Independent Director will be invited to Chair the meeting.

Attendance at Meetings

Only members of the Committee have the right to attend committee meetings. However, other individuals and advisers may be invited to attend all or part of any meeting as and when appropriate.

It is expected that the following members will regularly attend Committee meetings in an advisory capacity:

- Chief Executive. The Chief Executive will be excluded from meetings when their own remuneration is being considered.
- Chief People Officer. The Chief People Officer will be excluded from meetings when their own remuneration is being considered.
- Director of Governance. The Director of Governance will be excluded from meetings when their own remuneration is being considered.

Quorum

The quorum necessary for the transaction of business shall be two members.

Frequency of Meetings

The Committee shall meet at least four times a year, and otherwise as required.

Reporting

The minutes of Committee meetings shall be formally recorded and will be available for Board members on request.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee shall be supported administratively by the Deputy Director of Governance, whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board (as required)
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair

Duties

Remuneration

- To agree the remuneration and terms of service arrangements for Executive Directors (i.e. Board voting and non-voting members), the Chief Executive and posts assigned to the Very Senior Manager framework.
- To oversee the contractual arrangements for Executive Directors and, when required, consider issues relating to remuneration, terms of service and performance issues for Very Senior Managers.
- To review additional non-pay benefits.
- To review severance packages which fall outside the standard provisions of the Contract of Employment*
- As appropriate, the Audit Committee will provide a Value for Money (VfM) view on severance packages as per the agreed thresholds set by NHS England.
- To ensure that the Annual Report includes a report on the remuneration arrangements for Executive Directors and the Chief Executive, including those who have joined or left the Trust during the financial year.
- Receive assurance as to off-payroll and interim Board payments

*** Severance Packages Approval Levels**
Severance packages which fall outside the standard provisions of the Contract of Employment must be calculated using standard guidelines. Any proposal to make payments outside of the current guidelines are subject to the approval of HM Treasury, via NHS England (NHSE).

Redundancy Payments
The Committee must consider/approve any redundancy payments which are £10,000 or above. Any payments below these thresholds can be agreed by the Chief Executive / Chief Finance Officer / Chief People Officer outside of the meeting with notification being made to the next meeting of the Committee.

Tribunal Settlements
The Committee must consider / approve tribunal settlements which are £10,000 or above. Any payments below this threshold can be agreed by the Chief Executive, Chief People Officer and Chief Finance Officer outside of the meeting with notification being made to the next meeting of the Committee. In circumstances where a decision regarding a settlement of £10,000 or above is urgent, a decision can be made through discussion with the Chair. Again, this would need to be reported to the next meeting of the Committee.

Nominations

- The appointment of the Chief Executive is the responsibility of the Chair. This process will be supported by NHS England. The Chair shall assemble an appropriate panel with relevant expertise and experience in respect of the appointments process.
- To regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) required of Non-Executive Directors of the Board and make recommendations to the Board with regards to any changes.
- To consider and make recommendations to the Trust's Board on any proposals to changes in the structure of the Board and any proposals to increase or decrease the number of voting Executive Directors and/or Non- Executive Directors. The Trust Board should approve such changes.
- When a decision is taken to change the structure of the Board and/or a vacancy arises on the Trust Board, the Committee may seek advice from the Chief People Officer with regard to the recruitment process to be adopted.
- Before an appointment is made by the Board, the Committee will evaluate the balance of skills, knowledge, experience and diversity on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment.
- To consider the person specification when Non-Executive vacancies arise.
- To consider the re-appointment of any Non-Executive Directors at the conclusion of their specified term of office having given due regard to their performance and ability to continue to contribute to the Board in the light of the knowledge, skills and experience required
- To give full consideration to succession planning for all Board Members in the course of its work, taking into account the challenges and opportunities facing the organisation, and the skills and expertise needed on the Board in the future.
- To monitor and evaluate the performance of the individual Directors (with the advice of the Chief Executive).
- To develop, monitor and seek feedback on a process for the evaluation of performance and contribution on the part of the Chair and Non-Executive Directors.
- To annually review the time required for Non-Executive Directors. Performance evaluation should be used to assess whether the Non-Executive Directors are spending enough time to fulfil their duties.
- To keep up to date and fully informed about strategic issues and commercial changes affecting the Trust and the environment in which it operates.
- Receive the annual declaration of the Chair in respect of the Board Members complying with the Fit and Proper Persons regulation and receive evidence-based assurance that all newly appointed executive directors including the Chief Executive are deemed Fit and Proper.
- Approve any remedial action plan to address non-compliance with the Fit and Proper Persons regulation.
- Approval of membership of Board Committees as appropriate, in consultation with the chairpersons of those Committees

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
Tuesday 3rd June 2025	10.30 am – 12.00 pm	MS Teams	28th May 2025
Tuesday 2nd September 2025	10.30 am – 12.00 pm	MS Teams	27th August 2025
Tuesday 4th November 2025	10.30 am – 12.00 pm	MS Teams	28th October 2025
Tuesday 6th January 2026	10.30 am – 12.00 pm	MS Teams	30th December 2025
Tuesday 3rd March 2026	10.30 am – 12.00 pm	MS Teams	24th February 2026

C. Annual Business Cycle

Title of Paper	Lead	Jun	Sep	Nov	Jan	Mar	CQC	Notes
		3	2	4	6	3	KLOE?	
REMUNERATION								
Redundancy Payments / Tribunal Settlements £10,000 and above	Chief People Officer							As required
Remuneration and terms of service for Executive Directors and Chief Executive	Chief People Officer							As required - pay uplift discussion dependent on national guidance
Remuneration Section of Annual Report	Chief People Officer							Provided to Audit Committee due to timing
Off-payroll and Interim Board payments	Chief People Officer							As required
Pension Restructuring Payment Scheme Review	Chief People Officer							
NOMINATIONS								
Changes to the Composition of the Trust Board	Chairman						**1.1**	As required
Executive / Non-Executive Appointments	Chief Executive / Chairman						**1.1**	As required
Non-Executive Director Performance Reviews & Review of Time R	Chairman						**1.1**	
Annual Non-Executive Director Skills Analysis & 2024/25 Committee Membership	Director of Governance						**1.1**	
Executive Director Portfolios	Chief Executive						**1.1**	
Executive Director Performance Reviews	Chief Executive						**1.1**	
Non-Executive Director Succession Planning	Chairman						**1.4**	
Succession Planning & Talent Management	Chief Executive						**1.4**	
GOVERNANCE								
Fit and Proper Persons Declarations	Director of Governance						**1.1**	
Committee Effectiveness	Director of Governance						**4.1 / 4.2**	
AD HOC								

Executive Summary

Trust Board | 9th July 2025

Board Seminar Programme 2025/26

University Hospitals of North Midlands NHS Trust

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

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

Risk Register Mapping
No associated risks

Executive Summary:

Situation

The Board Seminar Programme for 2025/26 is being provided to the Trust Board for approval. The document aligns Board seminar sessions with the Trust's strategic priorities whilst ensuring a balanced focus on development, strategic items and items of business.

Background

The Board Seminar Programme is a key mechanism for supporting effective governance, strategic oversight, and continuous learning. The 2025/26 programme builds on the priorities identified in the previous year and incorporates new areas of focus, as identified by Board Members, aligned with the Trust's vision of delivering "the best joined-up care for *all*."

Assessment

The programme for 2025/26 has been developed through discussions with Executive Directors and comprises a variety of topics including 'must dos', emerging developments and operational/strategic challenges, aligned to our Strategic Priorities.

Sessions are grouped under the four strategic programmes:

- Brilliant Basics
- Digitally Enabled Care Transformation
- Our Future Hospital Services
- Collaborations and Networks

In addition, each session is categorised as:

- Developmental – supporting Board learning and capability.
- Strategic – shaping long-term direction and risk oversight.
- Business-as-Usual – providing operational updates and assurance.

As per previous years, there is opportunity to expand and flex the programme accordingly throughout the year.

Key Recommendations:

The Trust Board is asked to approve the programme which will remain agile and will flex accordingly throughout the year depending on changing priorities.

University Hospitals of North Midlands NHS Trust

Board Seminar Programme

2025/26

Kind

Excellent

Together

Board Seminars 2025/26

University Hospitals of North Midlands NHS Trust

- Programme of sessions identified, based on annual priorities and items carried forward from 2024/25
- Indicative timescales included for consideration / confirmation
- Additional areas for consideration to be identified as required throughout the year

April 2025 to September 2025

NHS University Hospitals of North Midlands NHS Trust

Topic	Session Lead	Strategic Programme	Purpose	9th April	7th May	11th June	9th July	6th August
Accountability & Developing the Organisation	COO	Brilliant Basics	Business | To understand recent changes in organisational structure and the implications for accountability and leadership	●				
Board Assurance Framework 2025/26	DoG	All	Strategic | To agree the strategic risks and ensure alignment with the Trust's objectives	●				
Financial / Urgent and Emergency Care Recovery	DoS / CFO / COO	Brilliant Basics	Business | To provide assurance on the governance arrangements for financial and urgent care recovery		●			
Annual Plan	DoS	Our Future Hospital Services	Strategic | To shape and provide input into the Annual Plan prior to final approval			●		
UHNM Staff Networks	CPO	Collaborations & Networks	Business | To receive an update on the work, impact and challenges of staff networks and their contribution to inclusion			●		
Freedom to Speak Up	DoG	Brilliant Basics	Business | To update on current progress and challenges in relation to Freedom to Speak Up			●		
Sexual Safety	CPO / CMO / CN	Brilliant Basics	Strategic | To update on the national and local context in relation to sexual safety, progress made to date and the governance in place				●	
Winter Plan De-brief	COO	Brilliant Basics	Business | To reflect on the effectiveness of the winter plan and identify learning for future planning				●	
Operation Anzu	CMO	Brilliant Basics	Strategic | To understand the implications of Operation Anzu and the Trust's response to date					●
Birthrate +	CN	Brilliant Basics	Business | To review maternity staffing levels and workforce planning in line with the guidance					●
Sustainability	DEF&PFI	Brilliant Basics	Strategic | To review progress against the Green Plan and agree future priorities					●
Rightsizing	DoS	Our Future Hospital Services	Strategic | To understand the progress in aligning services and capacity with future demand					●

October 2025 to March 2026

NHS University Hospitals of North Midlands NHS Trust

Topic	Session Lead	Strategic Programme	Purpose	15th October	12th November	10th December	7th January	11th March
Enabling Strategies Half Year Update	DoS	All	Strategic | To assess progress against strategic delivery plans	●				
External Training on Managing Reputational Risk & Corporate Affairs	DoG	Brilliant Basics	Developmental | To build Board capability in managing reputational risk particularly in light of Operation Anzu	●				
Assurance / Board Maturity Matrix	DoG	Brilliant Basics	Strategic | To assess the Board's maturity using a structured framework and agree development priorities	●				
Annual Cyber Security Training	CDIO	Brilliant Basics	Developmental | To ensure Board members are up to date on cyber risk and security responsibilities		●			
Board Insights / Personalities	CPO	Brilliant Basics	Developmental | To explore individual and collective personality preferences among Board members with the aim of improving self-awareness, interpersonal understanding, and Board effectiveness		●			
Freedom to Speak Up: Annual Self Assessment	DoG	Brilliant Basics	Strategic | To complete the annual self-assessment and reflect on the Trust's speaking up culture		●			
Charity	DoC	Collaborations & Networks	Strategic | To review the current position of UHNM charity, exploring strategic opportunities for growth and engagement, and agreeing the future direction and priorities			●		
Annual Counter Fraud Training	CFO	Brilliant Basics	Business | To meet statutory training requirements and understand current fraud risks and controls				●	
Artificial Intelligence, Genome Sequencing & Robotics	CDIO	Digitally Enabled Care Transformation	Strategic | To explore emerging technologies and their implications for care delivery and workforce				●	
Strategic Risks - Board Assurance Framework	DoG	All	Strategic | To agree the Strategic Risks for 2026/27 Board Assurance Framework.					●
Annual Plan	DoS	Our Future Hospital Services	Strategic | To agree the Annual Plan and Annual Delivery Plans					●

Trust Board

2025/26 BUSINESS CYCLE

KEY TO RAG STATUS	
Paper rescheduled for future meeting	
Paper rescheduled for next meeting	
Paper taken to meeting as scheduled	

Title of Paper	Executive Lead	May	July	Oct	Dec	Feb	Notes
		7	9	8	10	11	
PROCEDURAL ITEMS							
Patient / Staff Story	Chief Nurse / Chief People Officer	Pt	Staff	Pt	Staff	Pt	
Chief Executives Report	Chief Executive						
Board Assurance Framework	Director of Governance	Q4		Q1	Q2	Q3	
OUR PATIENTS: QUALITY, ACCESS & OUTCOMES							
Quality, Access & Outcomes Committee Assurance Report	Director of Governance						
Care Quality Commission Action Plan	Chief Nurse						Action plan closed down at QAOC in June 2025
Maternity Serious Incident Report	Chief Nurse						
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI						
Bi Annual Nurse Staffing Assurance Report	Chief Nurse						
Quality Account	Chief Nurse						Taken to June's Private Board
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						TBC
Integrated Performance Report	Various						
OUR PEOPLE							
People, Culture & Inclusion Committee Assurance Report	Director of Governance						
Staff Survey Report	Chief People Officer						
Gender Pay Gap Report	Chief People Officer						
Raising Concerns Report	Director of Governance						
Revalidation	Chief Medical Officer						
Workforce Disability Equality Report	Chief People Officer						
Workforce Race Equality Standards Report	Chief People Officer						
People Strategic Plan Update	Chief People Officer						TBC
Bi-Annual Establishment Review (Other Professions)	Chief People Officer						TBC
OUR POPULATION							
Population Health Strategic Plan Update	Director of Strategy						TBC
FINANCE AND EFFICIENCY							
Finance & Business Performance Committee Assurance Report	Director of Governance						
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,500,001 and above	Director of Strategy		N/A				
Annual Report and Accounts including Going Concern	Chief Finance Officer						Considered by Extraordinary Trust Board in June
Annual Plan	Director of Strategy						Considered at Board Seminar
Financial Plan including Capital Programme	Chief Finance Officer						
Standing Financial Instructions	Chief Finance Officer						Next due for review February 2026
Scheme of Reservation and Delegation of Powers	Chief Finance Officer						Next due for review February 2026
OUR STRATEGIC PLANS							
Digital Strategic Plan Update	Chief Digital Information Officer						TBC

Title of Paper	Executive Lead	May 7	July 9	Oct 8	Dec 10	Feb 11	Notes
Research Strategic Plan Update	Chief Medical Officer						TBC
Innovation Strategic Plan Update	Director of Strategy						TBC
Estates & Facilities Strategic Plan Update	Director of Estates, Facilities & PFI						TBC
GOVERNANCE							
Audit Committee Assurance Report	Director of Governance						
Fit and Proper Persons Annual Assurance Report	Director of Governance						
Anchor Institution Update	Director of Communications						
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer						
Annual Evaluation of the Board Committees	Director of Governance						
Annual Review of the Rules of Procedure	Director of Governance						
Board Development Programme	Director of Governance						
Well-Led Self Assessment	Director of Governance						Next annual review - July 2025
Risk Management Policy	Director of Governance						Next due for review February 2027
Complaints Policy	Chief Nurse						Next due for review November 2027
Closed Only:							
Risk Management Oversight Committee Assurance report	Various						
MHPS	Chief People Officer						