University Hospitals of North Midlands NHS Trust

AGENDA | Trust Board - Part 1 (in Public)

Meeting held on Wednesday 11th February 2026 at 9.30 am to 12.20 pm

Trust Boardroom, Third Floor, Springfield, RSUH

Time	No.	Agenda Item	Purpose	Lead	Format	BAF Link
9:30	**PROCEDURAL ITEMS**					
20 mins	01	Patient Story	Information	Mrs AM Riley	Verbal	
5 mins	02	Chair's Welcome, Apologies and Confirmation of Quoracy	Information	Ms J Small	Verbal	
	03	Declarations of Interest	Information	Ms J Small	Verbal	
	04	Minutes of the Meeting held 10th December 2025	Approval	Ms J Small	Enclosure	
	05	Matters Arising via the Post Meeting Action Log	Assurance	Ms J Small	Enclosure	
10 mins	06	Questions from Members of the Public in relation to matters on the agenda	Information	Ms J Small	Verbal	
10:05	**CHAIR AND CHIEF EXECUTIVE UPDATES**					
10 mins	07	Chair's Update	Information	Ms J Small	Verbal	
10 mins	08	Chief Executive's Report – February 2026	Information	Dr S Constable	Enclosure	
10 mins	09	Board Assurance Framework – Q3	Assurance	Mrs C Cotton	Enclosure	All
10:35	**OUR PATIENTS: QUALITY, ACCESS & OUTCOMES**					
10 mins	10	Maternity Incentive Scheme – Year 7 Declaration	Approval	Mrs D Brayford	Enclosure	1
15 mins	11	UEC Pressure and Ambulance Handover Update	Assurance	Mrs K Thorpe	Enclosure	1
11:00 – 11:15 COMFORT BREAK						
11:15	**PERFORMANCE**					
	12	Integrated Performance Report – Month 9 and Committee Assurance Reports:				
20 mins	12a	• Quality, Access & Outcomes Committee Assurance Report (23-12-25 & 05-02-26) • Quality & Access Dashboard	Assurance	Prof K Maddock Mrs AM Riley/ Mrs K Thorpe	Enclosure	1
15 mins	12b	• People, Culture & Inclusion Committee Assurance Report (04-02-26) • People Dashboard	Assurance	Mrs L Bainbridge Mrs J Haire	Enclosure	3
20 mins	12c	• Finance & Business Performance Committee Assurance Report (22-12-25 & 02-02-26) • Finance Dashboard	Assurance	Ms T Bowen Mr M Oldham	Enclosure	6, 7
12:10	**GOVERNANCE**					
5 mins	13	Audit Committee Assurance Report (05-02-26)	Assurance	Mrs M Monckton	Enclosure	
12:15	**CLOSING MATTERS**					
5 mins	14	Review of Meeting Effectiveness Link to feedback form: https://forms.office.com/e/tydNkMB2Mj	Information	Ms J Small	Verbal	
	15	Review of Business Cycle	Information	Ms J Small	Enclosure	
12:20	**DATE AND TIME OF NEXT MEETING**					
	16	**Wednesday 8th April 2026, 9.30 am, Trust Boardroom, Third Floor, Springfield, Royal Stoke**				

Questions from the Public - Please submit questions in relation to the agenda, by 9.00 am 9th February to nicola.hassall@uhnm.nhs.uk

Minutes of Meeting

Trust Board – Part 1 | 10th December 2025

9.30 am to 12.05 pm

Trust Boardroom, Third Floor, Springfield

University Hospitals of North Midlands NHS Trust

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

Apologies Received:			
Name	**Initials**	**Title**	
Mrs C Cotton	CC	Director of Governance & Communications	Non-Voting
Ms J Small	JS	Chair	Voting

In Attendance:		
Name	**Initials**	**Title**
Mrs D Brayford	DB	Interim Director of Midwifery (item 10)
Mrs J Dickson	JD	Deputy Director of Communications
Mrs N Hassall	NH	Deputy Director of Governance (minutes)

Members of Staff and Public: 6

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Staff Story**	
120/2025	Mrs Haire introduced the staff story which was shared with members of the Trust Board via the following link: https://vimeo.com/1143082832/9b56da3e8e?fl=ip&fe=ec The video showcased the Trust's collaboration with local colleges to support T-Level students across various departments. This initiative provides mutual benefits by enhancing students' understanding of healthcare roles and contributing to the Trust's future recruitment pipeline. Miss Nicholson noted the current attrition rates among T-Level students and welcomed opportunities for learners to gain deeper insight into the requirements of healthcare careers. Ms Ashley enquired whether similar training opportunities were available at the Stafford campus and County Hospital. Mrs Haire agreed to confirm the availability of these placements.	**JH**

	Professor Toor commended the personalised approach to learning, highlighting how the programme adapts to individual student interests and development needs. **The Trust Board noted the patient story.**	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
121/2025	Prof Toor welcomed members to the meeting. Apologies were received as noted above and the meeting was confirmed as quorate.	
3.	**Declarations of Interest**	
122/2025	There were no declarations of interest raised.	
4.	**Minutes of the Meeting held 8th October 2025**	
123/2025	The minutes of the meeting held on 8th October were approved as a true and accurate record.	
5.	**Matters Arising via the Post Meeting Action Log**	
124/2025	Professor Toor highlighted that two actions had been completed. PTB/617 - Mr Oldham highlighted that he had provided an update on coding to the Quality, Access and Outcomes Committee (QAOC) an outcome from which was to identify specific indicators which may be impacted by the lack of coding which was in progress. PTB/618 – Mrs Haire highlighted that the IPR nursing vacancies reflected headroom and bank and agency, whilst overall nurse vacancies continued to be low.	
6.	**Questions from Members of the Public in relation to matters on the agenda**	
125/2025	Professor Toor explained that Mr Syme had provided questions which would be covered during the meeting. At the end of the meeting, Mr Syme requested clarification on the following: Mr Syme referred to UEC performance and given that the UEC Recovery Plan and trajectory were considerably "off plan", he queried whether a modified recovery trajectory for UEC been discussed and agreed with NHS England to get the recovery plan trajectory back on plan specifically Ambulance Handovers within 45 minutes. He questioned what was required to get the UEC recovery plan back on track? Mrs Thorpe confirmed that the trajectory had been discussed and reiterated the aim to return to that position. The Trust continued to be under Tier 1 oversight and scrutiny from NHS England. The Get It Right First Time (GIRFT) Urgent and Emergency Care programme was providing support, albeit with a regulatory mindset, and feedback was being given directly to NHS England on the work undertaken. Regional and national NHS England visits had taken place to support this work.	

	Dr Constable noted that the number of undertakings had reduced and that work with GIRFT formed part of this improvement. It was agreed that a single version of the narrative would be shared with all internal and external stakeholders to ensure clarity and consistency, avoiding multiple or conflicting accounts. Mr Syme requested clarification on the differences between the Your Next Patient (YNP) approach and the continuous flow model. Mrs Riley explained that, where necessary, every ward was required to undertake additional patient risk assessments, collating information on available space and liaising with the site and on-call teams to determine the most appropriate approach based on Emergency Department pressures. Mr Syme queried ownership of responsibilities, particularly in relation to discharged patients and how discharge lounges and patient transport factored into the process. Mrs Riley confirmed that the site team coordinated these arrangements and worked closely with care groups to identify requirements. Mrs Riley emphasised that patients would be placed in the right location with the appropriate team; however, the experience might differ from that of being admitted directly to a designated bed space. Mr Syme queried the process for managing patient flow to other organisations. Mrs Thorpe explained that the Integrated Discharge Team (IDT) held responsibility for coordinating flow out of the organisation and the system operated using a collective scoring approach supported by action cards. System partners participated in site calls and strategic calls throughout the day to review scores and make decisions collaboratively. These decisions were taken regularly and were overseen by the IDT.	
CHAIR AND CHIEF EXECUTIVE UPDATES		
7.	**Chief Executive's Report – October 2025**	
126/2025	Dr Constable reported the following key points: • Flu had been a significant factor in patient and staff absences, with cases four times higher than the same period last year. Dr Constable provided figures for patients within the organisation affected by flu, RSV, and Covid. • The Trust lost just under 2,000 ambulance hours in the previous week; the highest level recorded in 2025. A critical incident was declared on 8 December, in line with several other regional Trusts. Although ambulance crews were no longer being held, the organisation remained at escalation level 4, which was to be reviewed later that day. • There had been a positive system-wide response coordinated by the ICB, although further improvement was required. Dr Constable acknowledged that ambulance handover delays remained an issue, driven by high conveyance rates and limited alternative pathways. Patients without clinical priority often experienced the longest waits, reinforcing the need for suitable alternatives. He emphasised that prioritising patients with the greatest clinical need was essential for safety. • Whilst progress had been made in planned care, unplanned care continued to present challenges. GIRFT Urgent and Emergency Care (UEC) team remained engaged with Emergency Department teams to address these issues. Ms Bowen noted that, despite operational pressures, there had been positive developments. She highlighted a recent visit to the team and welcomed the Commercial Research Delivery Centre (CRDC), describing it as a significant step forward for UHNM as a University teaching hospital.	

	Professor Hassell raised the issue of the impending resident doctor industrial action and its potential impact on elective activity. Dr Constable confirmed that some elective activity had been stood down during the critical incident but assured the Board that efforts would continue to maintain elective operating and minimise disruption. Mrs Thorpe added that, during the previous industrial action, elective activity had been maintained at 92% to 93% but anticipated greater challenges this time due to the Christmas period and the need to ensure staff rest. Planning was underway to mitigate these risks. Professor Toor asked whether lessons had been learned from previous industrial actions. Mrs Thorpe confirmed that learning from earlier incidents had been applied successfully which continued to inform current practice. Hot debriefs were also undertaken immediately after, with learning captured by the EPRR team. Professor Toor congratulated Dr Adamson on her appointment as substantive Chief Medical Officer and Mrs Riley on receiving the inaugural PEN/DAISY Lifetime Achievement Award. Ms Bowen also commended Mrs Whitehead on her recent staff award. **The Trust Board received and noted the update.**	
8.	**Board Assurance Framework – Quarter 2**	

127/2025	Mrs Hassall presented the Quarter 2 Board Assurance Framework (BAF) and highlighted the following:
	• All eight strategic risks continued to pose a threat to the Trust's ability to deliver its strategic priorities, with "Our Patients" identified as the most impacted priority, as every risk affected this area.
	• The most critical risks related to the Trust's financial position and sustainability (BAF 6 and BAF 7), both scoring Extreme 20, which exceeded the agreed risk tolerance. These scores reflected ongoing challenges in achieving the required in-year financial position and ensuring long-term sustainability. The risk associated with the inability to sustain safe and effective care delivery also increased to Extreme 20 for Quarter 2, primarily due to Emergency Department waits affecting patient outcomes.
	• Two of the eight risks provided acceptable assurance, while the remainder were rated as partial. Approximately 23% of actions had been completed, 60% were on track, 4% were delayed, and 13% were problematic. The quarter also saw an increase in actions identified to address gaps in control and assurance, indicating a more targeted approach to risk management.
	• Following Committee discussions, further refinement was planned for Quarter 3, focusing on:
	  ○ Closing the gap between current risk scores and tolerance.
	  ○ Defining the actions required to achieve target scores.
	  ○ Reviewing whether the current risk appetite remained appropriate.
	  ○ Additional detail regarding any slippage in actions would also be provided.
	
	Mrs Bainbridge acknowledged the work undertaken on action planning.
	
	The Trust Board received and approved the Board Assurance Framework for Quarter 2.	

OUR PATIENTS: QUALITY, ACCESS & OUTCOMES		

09.	**Urgent and Emergency Care Pressures, Ambulance Handovers & Winter Plan**	
128/2025	Mrs Thorpe provided an operational update and highlighted the following: • The Trust remained off trajectory for four-hour target performance and ambulance handovers, although performance against 12-hour waits had improved slightly compared to plan. This was set against the backdrop of the recent declaration of a critical incident. • Increased use of assessment areas had been introduced, supported by the GIRFT team, including direct access pathways, changes to the frailty model, and enhanced rapid assessment processes. The discharge facilitator team had been redeployed to support complex discharges in an integrated manner, including weekend coverage. Daily representation from care groups at winter command meetings ensured patient flow was managed as effectively as possible. • Improvements had been observed since the GIRFT UEC team had provided support, including reductions in 12-hour waits, shorter time spent in the Emergency Department for both ambulatory patients and those awaiting beds, and increased patient streaming. • The Trust had increased the use of escalation spaces, including temporary ward areas and corridor spaces in the Emergency Department (ED), alongside a shift from the YNP model to a continuous flow approach. This aimed to move patients out of ED as pressure built, spreading risk across the organisation rather than concentrating it in ED. System partners had provided assurance that similar models were being implemented to decompress discharge delays. Mrs Riley noted that the Royal College of Nursing was currently debating the use of temporary spaces and corridors, which the Trust agreed should be avoided where possible. However, dynamic risk assessments were undertaken daily, and it was considered safer for patients to be accommodated in monitored spaces rather than waiting in the community. No harm had been identified to date, although staff and patient experience was recognised as being negatively affected. Work to decompress the system continued with the aim of eliminating the need for such spaces. Professor Maddock welcomed the collaborative approach with system partners and queried progress with West Midlands Ambulance Service. Mrs Thorpe confirmed two areas of work; weekly audits of ambulance conveyances to identify patients who may not have required attendance, with learning shared through the Provider Collaborative and UEC improvement programme and ongoing discussions regarding the feasibility and risks associated with implementing a 45-minute handover maximum. Ms Bowen queried whether the performance trajectory had been recalibrated. Mrs Thorpe confirmed adjustments had been made when delays for the Urgent Treatment Centre (UTC) became apparent, and that current efforts focused on returning to the original trajectory. The next opportunity for formal recalibration would be during the planning round for 2026/27. She acknowledged that achieving the plan over winter, particularly in January, was unlikely, but anticipated improvement in February and March once the UTC became operational. Dr Constable agreed this was challenging but reiterated the commitment to strive towards the agreed plan. Ms Bowen asked whether additional bed capacity was being fully utilised. Mrs Thorpe confirmed that capacity was in place, but occupancy remained routinely above 100%, indicating significant pressure. Ms Bowen also queried the impact of weekly system reviews on demand	

	forecasting. Mrs Thorpe noted that patients continued to present at the front door, often due to difficulties accessing appropriate services elsewhere. Community programmes were in development to address these issues. Dr Adamson reported early engagement with nursing homes and the Hospital Ambulance Liaison Officer (HALO), with multiple visits planned to strengthen relationships. Ms Bowen raised concerns regarding shared urgency across system partners, noting that while risk had been distributed, ownership of transformation within partner organisations remained limited. Mrs Riley highlighted recent urgent reviews of Discharge to Assess capacity and length of stay, with internal changes implemented to reduce delays. Ms Ashley emphasised the need to identify themes and opportunities for improvement within existing resources and suggested future collaboration with Midlands Partnership NHS Foundation Trust (MPFT) on respiratory pathways, which would require co-design. **The Trust Board received and noted the update.**	
10.	**Maternity and Neonatal PSIRF Investigation Report – Quarter 2**	
129/2025	Mrs Brayford provided an update and highlighted the following: • A detailed report had been presented, outlining actions taken and considered within the governance structure. • Four incidents had been raised, with each action scrutinised for appropriateness and timeliness. • Reference was made to recent media interest regarding maternity services. The Trust had achieved Safety Action 1 and secured 98% compliance with the Perinatal Mortality Review Tool (PMRT), which had been externally reviewed to ensure independence and avoid self-assessment. • Families affected by incidents had been involved in the investigation process, with the Trust continuing to prioritise family engagement to ensure their voices were heard. It was confirmed that 100% of families had been offered the opportunity to contribute to incident investigations. **The Trust Board agreed with acceptable assurance received and noted the update.**	
11.	**Nurse Staffing Establishment Review**	
130/2025	Mrs Riley provided an update and highlighted the following with regards to the review, which had been brought to the board to provide assurance on the process undertaken to complete the review: • The establishment review normally completed bi-annually, had missed one cycle due to ongoing work regarding the Band 2–3 workforce and consideration of spend on enhanced observations of care. A review was undertaken in line with developing workforce standards, and a detailed paper had been considered by the People, Culture and Inclusion Committee. • The numbers presented were consistent with previous versions of the establishment review. Despite efforts to fill vacancies and manage turnover, overall absence remained above the 21.5% uplift. A paper was therefore to be taken to the Executive Team for consideration of this element.	

	• A pilot had been completed for enhanced observations of care, and any future business cases would exclude enhanced observations, with a corporate solution to be considered. Care groups would be responsible for developing business cases, and ward establishments would not change until such cases were approved. Ms Bowen queried the financial impact of staffing on bank costs. Mrs Riley confirmed that bank usage was currently above requested levels, with safe staffing maintained through temporary spend. Temporary areas were staffed, and work was underway to convert posts to substantive roles and improve efficiency. Mrs Haire added that the workforce plan included bank and agency profiling, with a headroom of 21%. However, higher maternity leave, sickness, and escalation had resulted in actual spend exceeding planned levels. Mrs Monckton asked whether the Trust was compliant with the Safer Nursing Care Tool. Mrs Riley confirmed compliance was achieved through temporary staffing, although funding alignment remained an issue. Mrs Monckton noted that a business case to increase substantive resources should, in theory, deliver savings on agency and bank costs and Mrs Riley agreed. Dr Constable emphasised the need to ensure open spaces were staffed while maintaining financial efficiency, ideally through substantive appointments. He queried the influence of other healthcare professionals on establishment requirements. Mrs Riley confirmed that the tool, endorsed by NICE, tended to underestimate rather than overestimate needs, and having the right staff reduced harm, litigation, and length of stay. She stressed the importance of using the tool correctly, supported by triangulation with other data sources. Professor Hassell sought assurance that these considerations were feeding into the Trust's strategy and financial planning. Mrs Haire confirmed that, if business cases were approved, the shift from bank to substantive staffing would occur, although total costs might not reduce immediately. **The Trust Board received and noted the update.**	
OUR PEOPLE		
12.	**Speaking Up Report Quarter 1 & Quarter 2 2025/26**	
131/2025	Mrs Hassall presented the biannual Speaking Up report, which had previously been discussed at the People, Culture and Inclusion Committee, and highlighted the following: • A record number of concerns had been raised during the reporting period, totalling 185. This increase was attributed to enhanced resources and greater staff confidence in raising issues. Additionally, over 20 new Freedom to Speak Up (FTSU) Champions had been appointed, creating a more diverse and representative network. • The main themes continued to relate to inappropriate attitudes and behaviours, with behaviour-related issues accounting for approximately 50% of all concerns—consistent with long-standing trends. • The recent announcement regarding the closure of the National Guardian's Office would require the Trust to adapt its approach, and further information was awaited. • A reduction in reports of detriment had been observed in addition future priorities included improving case management and data integrity, reviewing detriment procedures, and increasing service visibility.	

	Mrs Bainbridge referred to the feedback obtained from colleagues which indicated that 78% of respondents would speak up again which was positive, however she queried whether work was underway to understand why the remainder would not. Mrs Hassall agreed to obtain this information from Mr Irving. Ms Bowen referred to progress in obtaining a holistic view of themes, hotspots, and cultural issues and Mrs Haire confirmed that work was progressing on the design of a Professional Standards and Culture Group, with a recent workshop held involving representatives from across the organisation. Fragmented data systems had been identified as a barrier to triangulation, and scoping work was underway for an integrated case management solution. The culture group was expected to go live in the next quarter, with a business case for the case management system anticipated within 6–9 months. Professor Hassell raised the issue of thematic reviews, particularly regarding race and the approach to tackling related concerns. Mrs Haire confirmed that this had emerged through Speaking Up and the Ethnic Diversity Network Group, which had developed guidance on the matter. The topic had been considered by the Executive Team, and further work was expected in Quarter 4. Dr Constable highlighted the need to ensure alignment between FTSU and patient safety concerns and he queried whether the right tools were being deployed and suggested this should be kept under review. Ms Bowen asked about the representativeness of FTSU Champions and whether sufficient coverage existed. It was agreed that this would be reviewed by the People, Culture and Inclusion Committee (PCIC), including diversity breakdown, and that visibility of champions across the organisation should be improved. **The Trust Board received and noted the report.**	**NH** **NH**
PERFORMANCE		
13.	**Integrated Performance Report – Month 7 and Committee Assurance Reports:**	

132/2025	<u>Quality, Access & Outcomes Committee Assurance Report (07-11-25, 26-11-25 & 04-12-25)</u>
	
	Professor Hassell highlighted the following matters:
	• A detailed report was presented on the care of patients nursed in escalation spaces. Two key points were noted:
	  ○ It was accepted that care in these areas was not desirable, and such use was avoided wherever possible.
	  ○ This practice had significant consequences for patient experience and staff morale. The Committee also received information regarding fire evacuation routes along the corridors and recommended against the use of these spaces. It was agreed that close monitoring would continue, with audit updates on the utilisation of escalation areas to be provided.
	• The Committee received an excellent presentation on the 'Hear My Voice, Feel My Story' initiative and agreed that it should be brought to the Board in February.
	• The Committee was informed of an outlier in spinal and cranial surgical site infections, which had led to actions within theatres. These actions	

included addressing significant cultural components. A follow-up report was requested.

- A detailed report on medicines optimisation was presented. The key theme identified was the absence of appointments to certain positions, often medical, which were sessional commitments extending beyond medicines optimisation responsibilities.
- The Committee received a significant piece of work involving triangulation from multiple sources in terms of end of life care. The main finding was a strong, compassionate culture, although some areas for improvement were identified. A delivery plan was agreed, with an update to be provided in six months.
- The Committee noted excellent, high-quality work in the area of looked after children and vulnerable patients, alongside challenges regarding sustainability, which require ongoing attention.

Professor Maddock welcomed the rollout of EPMA.

Ms Bowen referred to the care of looked after children and raised concerns regarding gaps in named doctor and nurse provision. Professor Hassell clarified that the issue was not the absence of a named doctor for specific children, but rather the overarching role. It was noted that all children were assessed and oversight was maintained; however, the limited resource meant that the number of hours available to sustain this function was constrained. The number and complexity of looked after children had increased, creating sustainability challenges. The Committee noted that a business case had been supported to address this issue.

Mrs Thorpe reported on diagnostic standards, confirming that performance was tracking ahead of trajectory. She highlighted a backlog in non-obstetric ultrasound, which was being managed in line with the recovery plan. There remained a gap in endoscopy delivery, with 225 slots per month currently provided. A bridging case had been approved to maintain capacity until the Community Diagnostic Centre opened, and delivery was ongoing.

Miss Nicholson highlighted several matters relating to maternity services:

- There had been two recent coroner's cases whereby the coroner raised issues in one case, but no concerns were identified in the second.
- Additional resource was required to complete Perinatal Mortality Review Tool (PMRT) processes, and a request to proceed had been prepared.
- The Committee heard of several initiatives aimed at improving quality of care. The Maternity Outcomes Signal System (MOSS) had been piloted and received positive feedback, although it was acknowledged that initial implementation would create a short-term burden on teams. The system was expected to support triangulation of data.
- A re-audit of consultant attendance showed improvements, with compliance achieved and results viewed positively.
- Neonatal workforce planning was progressing well, with Birthrate Plus requirements met and additional posts approved through a business case. Recruitment to these posts was underway.

Mrs Riley confirmed that papers reviewed by the Committee demonstrated compliance with all requirements for the Clinical Negligence Scheme for Trusts (CNST). While external confirmation was still pending, it was assumed that the standards would be met.

<u>Quality & Access Dashboard</u>
Mrs Riley highlighted the following matters:

	• Support had been provided for ward accreditation, progressing from bronze and silver to gold standards. Work was underway to engage with the new Nursing and Midwifery framework, which would be presented to the Committee in Q4/Q1. A co-design approach with staff was being adopted to define what excellence means to them. • Temporary escalation spaces were being monitored via Tendable, and Executive wellbeing walks were included as part of this oversight. • Appointments had been made for the Patient Leadership Chair and Vice Chair roles. Consideration was being given to how the patient voice could be better heard from ward to Board. Professor Hassell referred to NHS Oversight Framework (NOF) data showing nine MRSA cases in the last year, whereas internal data indicated three cases. It was agreed that Mrs Riley would check the difference in measurement approaches. Miss Nicholson asked how the voice of young people was being captured. Mrs Riley confirmed that work was underway to develop mechanisms for incorporating children's voices. Ms Bowen raised concerns regarding complaints response times, noting that only 27% were closed within target, which was frustratingly low. Mrs Riley acknowledged that while the trend had improved, performance remained outside target. An escalation process was in place, and a review of the patient and public experience portfolio was ongoing, which was expected to lead to further changes. Ms Bowen described how complaints could be used for persona analysis to understand what a person's experience might look like. Mrs Riley agreed to link with Ms Bowen separately on this matter. Dr Constable noted that the Executive team had discussed complaints management and agreed on the need to return to basics and review the overall approach. Mrs Freeman shared that persona work had been undertaken at Mid Cheshire NHS Foundation Trust to support service planning and recruitment to hospital user groups, which could be replicated locally but would require robust population health data. **The Trust Board received and noted the assurance report and dashboard.**	**AMR** **AMR**
133/2025	<u>Finance & Business Performance Committee Assurance Report (03-11-25 & 01-12-25)</u> Ms Bowen presented the Committee's assurance report and highlighted the following key points: • The Trust reported a deficit of £10.4 million, which was in line with the plan. Deficit support funding had been confirmed. Risks remained in relation to underperformance in elective activity. • Work was ongoing to identify and implement measures to achieve breakeven. • The capital plan had been reduced in-year due to previously articulated delays; no further changes were reported. • The approach to cost improvement (CIP) had changed. Instead of focusing on 2025/26, the Trust was working with Deloitte to analyse the drivers of the deficit and develop schemes for 2026/27. Planning for CIPs for 2026/27 had already commenced.	

	• The Committee reviewed activity and demand performance, noting efforts to avoid overlap and address coding issues in activity counting. Assurance was provided that there was no impact on patients, although further assurance was requested. • The Emergency Preparedness, Resilience and Response (EPRR) report indicated partial compliance. The Committee commended the team for their work, while noting resource challenges that would need to be addressed in the coming year. • A presentation on NHS productivity was received. • The Committee sought assurance regarding the effectiveness of the Strategy Delivery Unit, including capacity and capability for transformation, sustained behavioural change, and organisational learning to enable transformation. • Delays were reported in relation to the Project STAR land sale. • The Committee welcomed the stronger framework for BAF action planning and the work being undertaken to identify slippage. • The update on the transformation programme was positive and comprehensive; however, assurance was reduced to partial for a number of reasons. • Non-Executive Directors had been invited to attend the Executive Recovery Oversight Group (EROG) to consider the medium-term plan. <u>Finance Dashboard</u> Mr Oldham highlighted the following points regarding current financial performance: • At Month 7, the forecast deficit stood at £13 million. Work was ongoing to achieve a system balance position, with discussions taking place with system Chief Finance Officers to explore whether this could be offset and to identify a further route for £6 million. The expectation was to outline this route during the forthcoming Performance Review Meeting with NHS England on 12th December. • The impact of delays to Project STAR on the capital programme were being mitigated and work was in progress and would be finalised and reported to the Finance and Business Performance Committee. • A session was scheduled in Part 2 to review the financial plan for 2026/27, which remained a work in progress. • The current year's CIP programme was heavily reliant on non-recurrent schemes, which would have implications for 2026/27. **The Trust Board received and noted the assurance report and dashboard.**	
134/2025	<u>People, Culture and Inclusion Committee Assurance Report (03-12-25)</u> Mrs Bainbridge provided an overview of the Committee's recent discussions and highlighted the following key points: • The Committee noted ongoing challenges with vacancies but acknowledged significant progress and good work taking place. • Ongoing capacity challenges were reported, driven by organisational change, operational pressures, and delivery of the strategy. While some resource had been provided for employee relations, further resources were under consideration. The Committee requested additional assurance regarding capacity. • The Committee welcomed sight of several updated policies and held robust discussions on ensuring sufficient capacity and support for implementation.	

- Reports in in terms of learning, education, and health and wellbeing provided acceptable assurance.

Ms Bowen queried whether the business case for the People Directorate could be delivered at the required speed given current pressures. Mrs Haire confirmed that some resource had already been agreed and recruitment completed, with additional investment in the Sexual Safety Liaison Office (SLO). Further resource requirements had been costed and were under consideration for prioritisation, enabling rapid progression if approved.

Ms Ashley acknowledged the work required to pull the case together and noted similar pressures in other areas. Professor Toor emphasised the need for assurance on implementation of new policies and their alignment with other priorities, highlighting that delivery would be challenging without adequate resource.

Mrs Haire confirmed that four additional posts had been added to the People Directorate in anticipation of new policies, alongside investment in the SLO office. However, she noted that further resource may be required given current pressures and the standstill position.

Mrs Bainbridge reiterated that the Committee required assurance that the work could be delivered or reprioritised as necessary. Dr Constable highlighted competing calls on investment for the next financial year and the need for a balanced approach. Ms Bowen noted the link to financial discussions regarding capacity. Dr Constable added that discussions were ongoing with NHS England and flagged that Model Health consistently demonstrated that the organisation was very lean in corporate functions, which was recognised nationally.

<u>People Dashboard</u>

Mrs Haire provided an update on the latest People Dashboard and highlighted the following key points:

- Sickness absence increased in October, with a notable rise in staff absences due to flu and respiratory illnesses.
- Turnover and vacancy rates remained low at 7.4%. The vacancy rate had dropped to 2.7%, which was considered an anomaly and would need to be rebased and recalibrated.
- The nursing profile continued to increase, in line with the strategy to convert bank staff to substantive posts.
- Agency usage remained low; however, more stretching targets were set for 2026/27, and plans were being developed to address these moving forward.
- Appraisal compliance remained below target, reflecting organisational pressures. Estates, Facilities and PFI exceeded its target at 96%, which was linked to engagement work undertaken within that division.
- The response rate for the national staff survey was 41%, which was lower than the previous year.
- Key areas of focus included improving appraisal compliance, enhancing staff experience, managing sickness absence, strengthening controls on temporary workforce usage, and maintaining vacancy control panels.

Ms Bowen queried whether there was an issue with data collection given the reported vacancy rate. Mrs Haire explained that the establishment had been reduced in line with CIP changes, which likely accounted for the anomaly. A deep dive would be undertaken.

	Ms Bowen asked about the current mask policy in relation to sickness levels. Mrs Riley confirmed that masks had been introduced in the Emergency Department and for nursing staff caring for high-risk patients some time ago, and patients and visitors were being advised to wear masks in other areas. **The Trust Board received and noted the assurance report and dashboard.**	
GOVERNANCE		
14.	**Audit Committee Assurance Report (06-11-25)**	
135/2025	Mrs Monckton highlighted the following points: • Enhancements to the BAF were welcomed, providing increased transparency in corporate governance. The level of organisational risk was discussed, including consideration of whether the current risk appetite remained appropriate. The Committee reflected on the need to ensure focus on the right priorities given the volume of risks being managed. • Concerns were raised regarding the Strategic Delivery Unit, as highlighted by the Finance, Business and Performance Committee. • The Committee noted that some policies remained out of date and expressed ongoing concern, with a continued focus on reducing this backlog. Professor Maddock queried whether enhancements to communications around phishing were pre-emptive to which Mrs Freeman confirmed. **The Trust Board received and noted the assurance report.**	
15.	**EPRR Core Standards Assurance**	
136/2025	Mrs Thorpe highlighted the following points: • The Committee considered the detailed report presented at the Finance, Business and Performance (FBP) Committee and the process had followed a confirm-and-challenge approach. • Performance was slightly improved compared to last year, with key areas of focus identified, including testing business continuity plans, ensuring availability of loggists, and progressing the mass casualty plan. These were recognised as critical areas of work going forward, alongside consideration of team resourcing. Ms Bowen noted that a number of exercises required partner involvement and confirmed that FBP had sought assurance on collaboration and joint working. It was observed that progress had been made in putting exercises in place. Mrs Thorpe added that compliance testing of policies remained essential. While some cross-system exercises had been undertaken, further testing would be required going forward. **The Trust Board received and noted the report.**	
CLOSING MATTERS		
16.	**Any Other Business**	
137/2025	Dr Constable highlighted that he had received an email of a positive patient story within the Emergency Department and he shared this with the Board.	

17.	**Review of Meeting Effectiveness**	
138/2025	Members were asked to provide feedback via MS forms.	
18.	**Review of Business Cycle**	
139/2025	No further comments were provided.	
DATE AND TIME OF NEXT MEETING		
18.	**Wednesday 11th February 2026, 9.30 am, Trust Boardroom, Third Floor, Springfield, Royal Stoke**	

Post Meeting Action Log

Trust Board Part 1 - Open

As at **04 February 2026**

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
PTB/619	10/12/2025	Staff Story	To confirm the availability of similar t-level training placements at the Stafford campus and County Hospital.	Jane Haire	11/02/2026	16/12/2025	Confirmed that students are on placements at County Hospital, who attend NSCG at Stafford. Students have been placed in radiography, therapies, orthopaedic/elderly care wards and dermatology.	B
PTB/620	10/12/2025	Speaking Up Report Quarter 1 & Quarter 2 2025/26	To obtain information from Mr Irving on the reasons and themes 22% of respondents indicated they would not speak up again.	Nicola Hassall	28/05/2026		To be provided within the Q3/Q4 Speaking Up Report, which is due ot be presented to the PCIC in May	GB
PTB/621	10/12/2025	Speaking Up Report Quarter 1 & Quarter 2 2025/26	People, Culture and Inclusion Committee (PCIC) to review the representativeness and diversity breakdown of FTSU Champions.	Nicola Hassall	28/05/2026		To be provided within the Q3/Q4 Speaking Up Report, which is due ot be presented to the PCIC in May	GB
PTB/622	10/12/2025	Integrated Performance Report - Month 7	To check and clarify the difference in measurement approaches between NHS Oversight Framework (NOF) data showing nine MRSA cases and internal data indicating three cases.	Ann-Marie Riley	11/02/2026		**Update to be provided at the meeting**	GB
PTB/623	10/12/2025	Integrated Performance Report - Month 7	To liaise with Ms Bowen regarding the use of complaints data for persona analysis to better understand patient experience.	Ann-Marie Riley	11/02/2026		**Update to be provided at the meeting**	GB

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

Chief Executive's Report
Trust Board | 11th February 2026

University Hospitals of North Midlands NHS Trust

Part 1: Highlight Report

This report provides the Trust Board with an overview of a range of strategic and operational issues since the last public meeting on 10th December 2025, some of which are not covered elsewhere on the agenda for this meeting.

1. Local ICB Context

In 2025 NHS England approved a clustering arrangement between NHS Shropshire, Telford and Wrekin Integrated Care Board (ICB) (NHS STW) and NHS Staffordshire and Stoke-on-Trent ICB (NHS SSOT). The 'clustering approach' was focused on facilitating greater collaboration and improving the sharing of functions across the two systems.

The aim is to support the ICBs to commission improved outcomes for patients, in line with their new role as a Strategic Commissioner. This will enable the ICBs to deliver against the 10 Year Health Plan ambitions, whilst reducing their running cost envelope. Under the cluster arrangements the two ICBs will continue to operate as separate legal entities.

Work to support successful clustering between the two ICBs is happening at pace, following the appointment of a single Chair, CEO and Executive Team. However, to fully realise the efficiencies needed, NHS England has issued new guidance indicating an expectation for ICBs in a cluster to merge. Any future changes in ICB geographical coverage will need to be conscious of both the NHS provider relationships and the proposed Local Government devolution and reform agenda.

The merger process for ICBs, including NHS STW and NHS SSOT, will therefore be led by NHS England. While further detail is awaited, the ICB cluster is working towards April 2027 as the deadline for full integration and the creation of a new joint ICB, subject to NHSE approval.

Members of the NHS STW and SSOT Board in Common were asked to endorse and support the direction of travel towards merger at their meeting in public on Thursday 29th January 2026, and to confirm that the two existing ICBs be dissolved and a single ICB created in April 2027. This single ICB would cover the wider geographical areas of Shropshire, Telford and Wrekin, Staffordshire and Stoke on Trent.

2. Robotic Surgery at UHNM

On 4th February 2026 there was a special UHNM Charity-hosted 'Robotics Excellence Showcase', which brought together clinicians, patients, colleagues, partners and supporters to celebrate what has been a remarkable decade of innovation here at UHNM. It was a reminder of just how far we've come, and how much further we can still go.

Since introducing our first robotic system at the Royal Stoke in 2014, more than 5,000 patients have now benefitted from robotic-assisted surgery across specialities including urology, colorectal surgery and gynaecology.

Robotic-assisted surgery is transforming patient care. It allows our surgeons to perform complex keyhole procedures with far greater precision, leading to less blood loss, reduced post-operative pain, shorter hospital stays and quicker recovery times. It also supports more efficient theatre use, increased surgical capacity and fewer complications, all of which directly benefit our patients and our services.

At the showcase, we heard directly from clinicians and patients about the difference this technology makes. Those in attendance were also able to 'use' the robots themselves, which really brought the technology to life beyond the operating theatre. Having our 5,000th patient share their experience alongside the surgeons who helped build this programme was also a special moment.

I am delighted to confirm that UHNM has now secured a hugely generous £12 million investment from the Denise Coates Foundation, thanks to the support of UHNM Charity. This investment will help establish UHNM as the UK's largest robotic surgery centre, enabling us to expand robotic-assisted surgery across a wider range of specialities including complex and emergency procedures.

The funding will expand capacity within existing services, helping more than 1,000 additional patients each year, as well as creating dedicated time and space for training and education.

We are incredibly fortunate as a Trust to be so well aligned with our UHNM Charity, which is proactive, ambitious and widely respected. The difficult part, securing this level of funding, has been achieved. Now our responsibility is to make this investment count for our population by delivering better, more joined-up pathways and continuing to push for improvement.

This ambition links closely with other exciting developments across UHNM. At the end January, alongside Executive Team colleagues, I visited the Stoke-on-Trent Community Diagnostic Centre (CDC) to see the progress of what will be a truly fantastic facility in the heart of the community. It will be coming online soon and will be a real game changer for our services, exactly the kind of forward-thinking development we should be doing.

3. Ambulance Handover Delays and Release to Respond

We all know that every minute matters when a patient arrives at hospital by ambulance. How quickly we receive and assess them is not just a performance metric, it directly affects patient safety, clinical outcomes and the experience of people in our care.

Improving ambulance handover times is our number one improvement priority, upon which so many other things are dependent. We have made some progress already. In November to December 2024 our average handover time was, sadly, 2 hours 13 minutes. For that same period in 2025, it was 1 hour 39 minutes. An improvement of 34 minutes but no way near good enough. During 2025, the national average ambulance handover time across NHS trusts was 27 minutes. At UHNM, the average was one hour and 31 minutes. That massive difference matters.

Ambulance handover delays are one of the most significant pressures we face, and we know we must do better for all our patients.

In the week commencing 12th January 2026 we launched *Release to Respond*, a new national hospital-wide test of change building on what we have done already to improve flow, reduce delays and ensure patients get the right care, in the right place, at the right time.

Release to Respond is a whole-hospital approach, undertaken in conjunction with the West Midlands Ambulance Service, to facilitate a maximum ambulance handover time of 45 minutes. It is not about rushing or cutting corners. Safety always comes first. But being organised, responsive and joined up allows us to provide safer, more compassionate care for everyone.

This is about how we work together across ED, wards, diagnostics, clinical and corporate teams, to keep patients moving safely through our hospitals. It's about recognising that every handover, every decision and every delay has an impact beyond our immediate area.

4. Business Continuity and Critical Incidents

We declared Critical Incidents because of severe operational (UEC) pressure beyond Operating Escalation Level (OPEL) 4 on 8th December – 10th December 2025 and on 14th – 16th January 2026.

Additionally, on January 6th 2026, in addition to the above operational pressures we managed two other significant problems. Firstly, we had an issue at County Hospital in the morning where the external phone lines were down in a snow-related incident. Red-phones and crash calls were all tested and were working normally, and the problem was resolved in the afternoon.

We also declared a business continuity incident due to IT issues with System C and the flow of information from CareFlow into iPortal which was impacting our business intelligence dashboards. This meant that

whilst CareFlow remained operational and orders, results, EPMA and observations/vitals were unaffected within CareFlow, there were brief periods when some functionality was lost and iPortal and dashboards were not receiving updates. This meant that some patient information may have been missing or out of date, particularly for patients new to us or those with recent changes. This impacted how we managed patient flow, from ED all the way through to our wards.

Our Digital Team and our supplier worked very hard on a resolution.

5. Ann-Marie Riley OBE

At the end of December 2025, I was finally able to share that our Chief Nurse, Ann-Marie Riley, was awarded an Officer of the Order of the British Empire (OBE) in the New Year Honours List.

This fabulous national recognition reflects not only Ann-Marie's exceptional contribution to nursing leadership, inclusion and patient care, but also the values and ambitions we hold here at UHNM.

I am delighted that Ann-Marie has been recognised for being an inspirational and thoughtful clinical leader who consistently puts patients first – something we have all been aware of for a long time. She has an unwavering belief that the patient voice must sit at the heart of everything we do and she has worked tirelessly to embed that principle into our decision-making at UHNM. Her leadership is grounded in compassion, professionalism and a deep commitment to continuous improvement – for patients, for staff and for the wider NHS.

Under Ann-Marie's leadership, we have seen significant and tangible progress. Nursing and midwifery vacancies have reduced; retention has improved and our focus on learning and development has strengthened. The establishment of the Centre for Nursing, Midwifery and Allied Health Professionals Research and Education Excellence (CeNREE) and the Chief Nurse Fellowship Programme are just two examples of how she has created opportunities for people to grow, innovate and lead.

Quality improvement has also been central to Ann-Marie's work. She has played a key role in driving Care Quality Commission improvements across our services, with medical care and maternity services now rated as good. Most notably, County Hospital has moved from an overall rating of requires improvement to good – a milestone that had not been achieved for more than a decade. This represents an extraordinary collective achievement and speaks volumes about the culture Ann-Marie has helped to create.

Her leadership was instrumental in UHNM being named 2024 Nursing Times Employer of the Year for Nurses and Midwives. Importantly, Ann-Marie is now sharing this learning with chief nurses across the region. Collaboration, openness and learning from one another are hallmarks of her leadership, and the impact of her work is being felt far beyond our organisation.

Ann-Marie's influence is also felt nationally. She was one of the first nurse leaders to implement the End PJ Paralysis campaign, recognising its benefits for patient recovery and dignity. In 2023, she received the Chief Nursing Officer for England Award for the pastoral support provided to international nurses, and she continues to champion equality, diversity and inclusion across the profession while leading research to support the development of others.

What makes Ann-Marie's OBE especially meaningful is her humility. She is always quick to recognise the contribution of others and to highlight the teams she works alongside every day. She leads with values, sets the highest standards and demonstrates what is possible through true teamwork and exceptional nursing leadership.

6. Performance Improvement

Despite the continued challenges in urgent and emergency care, it is important that we take moment to recognise progress, celebrate success and acknowledge the hard work of everyone working together in pursuit of excellence.

Firstly, I am delighted that we have secured an additional £2 million in capital funding from NHS England after delivering one of the strongest improvements in elective care performance anywhere in the country.

This success comes from the first round of the 2025/26 National Elective Care Capital Incentive Scheme, which rewards significant, sustained progress in reducing patient waits.

Between April and September 2025, we achieved the eighth-largest improvement in Referral-to-Treatment (RTT) performance nationally of all acute trusts — while also meeting key criteria to reduce long waits.

In a letter congratulating the Trust, Sir James Mackey, Chief Executive of NHS England, praised the scale of the achievement, calling it: "*An outstanding achievement that reflects the sustained commitment and hard work of your clinical and operational teams… Your progress sets a strong example for other providers across the country.*"

The £2 million will be used flexibly by us to support further transformation and improve access to care for patients across Staffordshire and Stoke-on-Trent and beyond. This is national recognition of the exceptional effort being made by everyone every day, despite the pressures we face, and is something of which we should all feel immensely proud. Although similarly we acknowledge that we still have much work to do, especially in the number of patients waiting more than 65 weeks.

Whilst we are cautiously marking national recognition, it is also good to acknowledge small improvements in our position in the NHS league tables, published in December by NHS England.

The performance tables are designed to give patients, the public and NHS colleagues a clearer view of how trusts across the country are performing as part of a wider commitment to transparency and accountability, allowing people to explore how organisations compare both overall and within individual services. They come with all sorts of "health warnings" as I have said before but, as a single indicator, they are not an unhelpful benchmark in a complex environment.

Along with all other trusts we are placed into one of four performance segments based on key measures including elective waiting times, A&E standards and ambulance response times. Segment one represents those with the fewest challenges, while segment four contains those facing the most. A small number of providers with the most significant issues are placed in segment five and receive intensive support through the national recovery support programme.

The NHS is placing a strong focus on financial recovery, any trust in deficit is automatically placed into segment three, regardless of wider performance. This is where UHNM currently sits. Within this group, we ranked 79 out of 134 acute and specialist trusts for quarter two, a slight improvement from 83 last quarter.

While our league table position reminds us that we have more to do, the elective care funding — and the performance improvement behind it — shows that we are moving in the right direction. We will continue focusing on improving urgent and emergency care, reducing our longest waits and strengthening performance across all services.

7. Electronic Prescribing and Medicines Administration (EPMA)

Electronic Prescribing and Medicines Administration (EPMA) is now live across all our adult inpatient areas.

This is a huge milestone for UHNM and one of which we should all be proud. Thanks to the hard work, commitment and expertise of colleagues right across the organisation, we have successfully made the move away from paper drug charts. That means greater efficiency in how we manage medicines, improved communication between teams. Most importantly, it means enhanced patient safety.

EPMA is well established across healthcare and the NHS, with around 75 per cent of Trusts now using it. At UHNM, we know this journey has not been straightforward. We have tried to implement EPMA before and, for a variety of reasons, were unable to sustain it. That history makes this achievement even more significant. We are now firmly live and able to join our peers in realising the long-term benefits that EPMA can bring.

Evidence from across the NHS shows that EPMA supports safer care by reducing medication errors, introducing alerts and safety checks tailored to individual patients and medicines and improving audit trails,

record-keeping and communication. Evaluations in 2024 found that trusts using EPMA experienced better coordination, fewer delays in medicines administration and improved outcomes and experiences for patients. This is good news for our patients and for our staff who deliver medicines day in, day out.

I know the implementation phase has been challenging. It has required real perseverance, flexibility and teamwork from clinical and digital colleagues alike, against a backdrop of sustained operational pressure which adds yet another layer of complexity. By working together, we have not only gone live but also improved processes and experiences for staff and patients. As with any major digital change, we know there is still more to do, particularly in supporting timely discharge and improving patient flow, and this will continue to be a key focus.

There will be opportunities coming up to share feedback on the system, the equipment and the project as a whole. Your insight is vital as we move from implementation into optimisation, so please do take part when these opportunities arise.

Finally, thank you to the EPMA team made up of nurses, pharmacists, doctors, technicians, digital and technical experts, project managers, the business change team and our industry partners who have worked tirelessly to make this possible.

8. Race Equality Week

From 2nd – 8th February, we joined organisations across the UK to mark Race Equality Week 2026 - a week created to spark hope, inspire action, and keep momentum alive in tackling race inequality, long after other awareness events have passed.

The theme this year, #ChangeNeedsAllOfUs, is a clear reminder: progress does not happen by chance. While awareness of race inequality is growing, too many colleagues still experience microaggressions, and systemic change takes courage, commitment, and collective action. Each of us has a part to play, as leaders, as teammates, as fellow human beings.

Race Equality Week offered us a chance to reflect together as colleagues sharing a common purpose and responsibility.

There were several ways colleagues could get involved, including:

- Race Equality Matters put together practical and reflective resources — from toolkits and conversation guides to the 5-Day Challenge, a series of short daily exercises exploring allyship, communication, and small everyday actions that foster meaningful cultural change.
- Our Ethnic Diversity Network meeting on 4th February.
- Our Drop-In Sessions to learn more about our ongoing work to promote race equality across UHNM, sharing how a team could engage more and tell us what support, actions, or changes would help.

9. THRIVE

We have announced an exciting development for nursing, midwifery and AHP colleagues across UHNM.

We are beginning the co-creation of THRIVE, a new internal accreditation programme that will be built by us, for us. This is a significant opportunity to shape an approach that truly reflects our values, recognises the realities of practice at UHNM, and celebrates the excellent care our teams provide every day.

THRIVE is being developed as an alternative to national accreditation schemes such as Magnet and Pathway to Excellence, tailored specifically to our organisation. Rather than adopting a model designed elsewhere, we are choosing to design something that speaks directly to our people, our patients, and our communities.

THRIVE will be grounded in our UHNM THRIVE framework and will complement and strengthen our existing Care Excellence Framework (CEF) accreditation programme. Together, these approaches will support professional development, quality improvement and a positive workplace culture across nursing, midwifery and AHP services.

The programme will be shaped around six core pillars:

- T – Together
- H – Healthy Workplace
- R – Recognised
- I – Improve / Research / Innovate
- V – Value for Patients
- E – Excellent Leaders

These pillars reflect what matters most to us such as how we work together, how we support our people, how we recognise excellence and how we continually improve care for our patients.

10. Our Freedom to Speak Up Champions

A healthy speaking-up culture is essential in an organisation such as ours, and we are continuing to be able to have an impact to strengthen and improve the culture here at UHNM. Making sure we have a culture where colleagues feel empowered and supported to raise concerns without fear of reprisal is imperative because it directly impacts patient safety, staff wellbeing, and overall quality of care. We work in a high-pressure environment where rapid decisions and complex interventions are routine, and where we face daily pressures on our time and resource. When individuals speak up about potential risks, unsafe practices, or systemic issues, it enables us to intervene early, prevent harm, and foster continuous improvement.

Moreover, we know that an open culture promotes psychological safety, reduces stress, and strengthens teamwork, which is critical for delivering compassionate, high-quality care. Ultimately, encouraging and valuing staff voices is not just a moral imperative, it is a cornerstone of clinical excellence and organisational resilience.

Following a successful campaign last summer we successfully recruited our first Freedom to Speak Up Champions. More than 30 colleagues have now completed their training and are currently carrying out the role across the organisation. December saw the largest number of concerns raised at UHNM in a calendar month with 47 colleagues speaking up through the Freedom to Speak Up service. We would now like to extend our network of champions further to build on this improved confidence of staff to raise issues when they have them. The role of a Freedom to Speak Up (FTSU) Champion is to actively promote the values of openness, transparency and psychological safety, ensuring that all staff feel confident and supported to raise concerns.

Champions act as visible role models for speaking up, demonstrating integrity and inclusivity in their daily interactions. They engage with colleagues across their department to build trust, raise awareness of the importance of speaking up and challenge cultural or behavioural barriers that may discourage it. Additionally, FTSU Champions provide clear signposting to appropriate support such as our FTSU Guardians, helping staff navigate the process of raising concerns effectively. Through proactive engagement, education and advocacy, they play a vital part in embedding a culture where every voice is valued and concerns are addressed promptly and fairly, ultimately contributing to safer patient care and a healthier working environment.

11. BMA Industrial Action

The 14th period of industrial action from resident doctors since March 2023 began at 7am on Wednesday 17th December and ran until Sunday 22nd December.

Industrial action inevitably comes with pressures for patients, the public, and for everyone working across our hospitals.

During the strike, life-critical care will always come first, with urgent and emergency services remaining our top priority. Elective and cancer services continued wherever possible, and our teams worked hard to minimise disruption so that patients receive the care they need.

Some appointments may have needed to be postponed, and patients were contacted directly if any changes affected them. The deliberate aim was to keep disruption to a minimum while maintaining safe staffing and patient flow.

We operated under a critical-incident approach, with Care Group leadership teams on call for industrial action, supported by strategic and tactical oversight around the clock. This ensured that decisions about patient care and discharge were made safely and effectively.

12. Hospital Radio Stafford

Hospital Radio Stafford exists to bring a bit of comfort, company and normality to patients while they are in hospital. Whether someone is feeling worried, lonely or missing home, a familiar song or a friendly voice can make a real difference.

The team broadcasts directly from their studio at County Hospital and currently have 15 volunteer presenters who visit the wards at County six days a week (Monday to Saturday). They get around 120-150 different requests for music each week covering every taste and genre with staff often joining in with requests and chats too.

The team are also keen to showcase our UHNM staff through the 'Behind the Scenes at County Hospital' feature, So far around 20 members of staff have been interviewed, chatting about their roles and playing their favourite music. I believe I have a slot coming up in March!

There is also the regular Friday afternoon visit to the Renal Unit at County for a show affectionately known as 'The Steak & Kidney Club' which is dedicated to staff and patients on the Unit.

Our volunteers vary from working professionals to retirees and include our oldest volunteer who is 90 years young and a jazz specialist. Everybody gives their time freely and has a desire to help others. Hospital Radio Stafford is funded entirely by our members, our fundraising activities and the occasional public donation.

Patients at County Hospital can listen live via their bedside entertainment console, with those at Royal Stoke able to tune in via our website.

13. December Musical Events

In December 2025 there were a couple of some exceptionally professional UHNM musical events.

On Sunday 7th December I attended Stoke Minister for the University Hospital Choir's 16th Christmas Concert. Suitably festive music from the Choir, the smaller group called Bel Canto and soloists filled Stoke Minister in a positively uplifting fashion. The evening also saw the "official" musical retirement of Musical Director, Sue Pantin, who actually retired from the Trust some time ago, but had continued in her musical role ever since.

On Saturday 13th December at Newcastle Baptist Church, there was also an evening of music performed at The University Hospital Orchestra Christmas Concert, celebrating the festive season with a selection of pieces. Jane Haire, Chief People Officer, also had the opportunity to say a few words on my behalf for Mr Chris Satur, Cardiothoracic Surgeon, who is also the University Hospital Orchestra Conductor. Jane was able to recognise his long service at UHNM, over 22 years, and to wish him well in his retirement from the Trust later that month.

14. Employee and Team Recognition

UHNM Hero Award – Play Team, Staffordshire Children's Hospital at Royal Stoke

In January I had the privilege of recognising a team whose teamwork and compassion have made a lasting difference to a patient and her family.

The Play Team, made up of play co-ordinators, specialists and assistants, were presented with a UHNM Hero Award by Maddie and Dean Meigh, whose daughter Robyn recently spent 40 days in the care of staff on Ward 217 for a series of tests for a degenerative neurological condition.

These awards are particularly special because they come directly from patients and families, who take the time to share their heartfelt thanks for the care and support they have received. In her nomination, Maddie described the team's care as "impeccable and holistic", writing:

"*They supported Robyn through procedures, helped ease her fears, and made her room feel bright and welcoming. They also took the time to support me as a parent, always listening and reassuring, and went above and beyond to make our stay as comfortable as possible."*

The Play Team's creativity, warmth, and dedication are also an example of our values in action, and example of the incredible impact we can have when we work together.

Appreciation of UHNM staff from patients, family, visitors, and colleagues
I have personally recognised the contribution of the following colleagues:

- Jonathon Capel, Charge Nurse - Ward 210, RSUH
- Kath Potter, Legal Services Manager
- Mr Chandra Cheruvu, Consultant Surgeon
- Professor Ajith George, Consultant Head and Neck Surgeon
- Mr Sankaran Narayanan, Consultant Breast Surgeon
- Dr Apurna Jegannathan, Consultant Oncologist
- Alicia Hand and Team Pre-Admissions Team, RSUH
- Ryan Dunford, Volunteer
- Anthony Barrett, Advanced Nurse Practitioner - Urology
- Rob Gordon, Head of Imaging
- Dr Caroline Connolly, Consultant Oncologist
- Sue Pantin, Musical Director - University Hospital Choir
- Judi Lawton, Chair - University Hospital Choir
- Professor Amit Arora, Consultant Geriatrician
- Amy Freeman, Chief Digital Information Officer
- Daniel Smith, Diagnostic Radiographer - Imaging
- Karen Dowden Staff Nurse - ED, RSUH
- Dr Andrew Bennett, Specialty Doctor - ED, RSUH
- Dr Ann Marie Morris, Deputy Chief Medical Officer
- Dr Steve Lord, Consultant Intensivist
- Mr Damian McClelland, Consultant Orthopaedic Surgeon & Clinical Director
- Dr Rajeev Desai, Consultant Gastroenterologist
- Dr Seema Desai, Consultant Microbiologist

Part 2: Consultant Appointments

The following table provides a summary of consultant medical staff interviews which have taken place during December 2025 and January 2026:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Infectious Diseases and Acute Med	Vacancy	Yes	TBC
Consultant Paediatrician with special interest epilepsy	Vacancy	Yes	TBC
Consultant Gastroenterologist	Vacancy	Yes	1 post 01/01/2026 1 post TBC
Paediatric Gastroenterology Consultant	Vacancy	Yes	TBC

The following table provides a summary of medical staff who have taken up positions in the Trust during December 2025 and January 2026:

Post Title	Reason for advertising	Start Date
Consultant Neonatologist	Vacancy	05/01/2026
Consultant in Palliative Medicine	Newly Created	12/01/2026

The following table provides a summary of medical vacancies that closed without applications / candidates during December 2025 and January 2026:

Post Title	Closing Date	Notes
Consultant Chemical Pathologist	28/01/2026	No applications

Medical Management Appointments

The following table provides a summary of medical management interviews which have taken place during December 2025 and January 2026:

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Clinical Director – Head, Neck & Skin Directorate	Vacancy	Yes	01/02/2026
Clinical Lead for Acute Medicine	Vacancy	Yes	TBC
Care Group Clinical Information Officer	Vacancy	Yes	TBC

The following table provides a summary of medical management who have taken up positions in the Trust during December 2025 and January 2026:

Post Title	Reason for advertising	Start Date
Care Group Medical Director	Vacancy	05/01/2026

No medical management vacancies closed without applications/candidates during December 2025 and January 2026.

Executive Summary

Trust Board (Open) | 11th February 2026

Board Assurance Framework – Quarter 3

University Hospitals of North Midlands NHS Trust

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

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

Executive Summary

Situation

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

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

This latest update reflects the position at Quarter 3 2025/26, as provided by Executive Leads. It is now being presented to the Board following consideration and scrutiny by Committees in February 2026.

Background

The strategic risks within the 2024/25 Board Assurance Framework (BAF) were reviewed and refreshed by the Executive Team and subsequently approved by the Board in April 2025, in line with the annual review process. For 2025/26, the BAF format has been streamlined to focus on the key elements of the summary BAF, eliminating the need for two separate documents. The revised risk appetite statement—also approved by the Board in April 2025—has informed the setting of tolerable risk scores. All risks have been aligned with the updated Strategic Priorities: Our People, Our Patients, and Our Population and, as discussed during the April Board session, the primary issues identified by the Executive Team have been mapped to each strategic risk to enhance clarity and accountability.

Assessment

Quarter 3 saw continued pressures across several strategic risk areas, with some notable improvements in financial risk profiles and stabilising progress within prevention and population health programmes. While positive assurance increased in several domains, the majority of strategic risks continue to exceed their target (tolerable) risk scores, driven by operational constraints, workforce challenges, digital fragility, estates limitations, and financial sustainability pressures.

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

Key Thematic Issues Emerging in Q3

- Operational flow and Emergency Department pressures continue to drive high-scoring risks linked to clinical service delivery.
- Ongoing digital fragility remains a significant cross-cutting concern, including dependency on ageing systems, clinical safety compliance gaps and areas of shadow IT.
- Workforce capacity and capability challenges are evident across multiple Care Groups, contributing to several interconnected risks.
- Financial risks show a mixed picture, with improvement in the in-year position but continued concerns around longer-term sustainability.
- Constraints on capital funding continue to slow progress on key estates programmes, compounded by emerging requirements under the Building Safety Act.
- Research & Innovation activity remains within risk appetite, though workforce pressures and performance against national targets continue to affect funding and responsiveness.

Risk Profile Overview

- Five of eight strategic risks remain at partial assurance.
- Two risks have reached acceptable assurance levels.
- One risk (BAF 1) remains at an extreme score with partial assurance.
- New gaps in control and assurance have been identified in:
  – Digital compliance
  – Workforce governance
  – Estates statutory compliance

– Financial sustainability

Key Improvements

- BAF 6 risk has reduced following system support and mitigation of two previously identified gaps
- Progress made in addressing specific digital governance gaps, including strengthened AI governance processes.
- Research governance oversight has improved through the reconvening of the Executive Research & Innovation Group.

Areas of Deterioration / Ongoing Concern

- BAF 7 has increased to a score of 25, now the highest-scoring risk.
- Workforce-related gaps in assurance have widened due to undelivered actions and inconsistent governance arrangements.
- Additional digital system compliance issues have emerged, including Data Protection Impact Assessment (DPIA) and Digital Technology Assessment Criteria (DTAC) shortfalls.
- Ongoing capital funding constraints continue to delay improvements required to strengthen estates-related risk controls.

Internal Controls

- Action plan completion stands at 46%, with delays driven largely by operational pressures and external dependencies.
- Several planned assurance reviews were not completed within the quarter but have been rescheduled, consistent with trends seen in Q1 and Q2.

Key Recommendations

The Trust Board is asked to receive and approve the BAF for Q3.

University Hospitals of North Midlands NHS Trust

Board Assurance Framework

Quarter 3 | 2025 - 2026

Kind Excellent Together

Strategic Framework and Threat to Strategic Priorities

Our Priorities

Our People

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

Key Metric:
Staff Engagement Score

Our Patients

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

Key Metric:
Combined Hospital Score

Our Population

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

Key Metric:
Number Years in Good Health

Number of Strategic Risks Threatening Our Priorities

7	8	7

Our Values

- Kind
- Excellent
- Together

Our Programmes

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

Our Strategic Plans

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

Our Primary Issues

Culture, Capacity & Capability

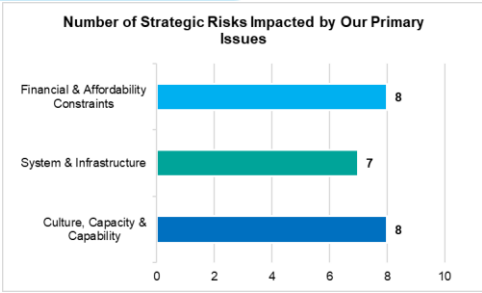
i.e. staff fatigue & burnout / workforce affordability & skills / digital and technological capacity

System & Infrastructure

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

Financial & Affordability Constraints

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



Summary

BAF No.	Risk Title	Risk Score & Assurance Assessment Q1	Q2	Q3	Q4	Target	Risk Appetite	Strategic Priorities			Primary Issues			No. of Linked Risks	Committee Assurance Assessment: Significant	Acceptable	Partial	None	NR	Gaps in Control	Gaps in Assurance	Action Plan Progress: Complete	On Track	Delayed	Problematic
BAF 1	Inability to Sustain Safe and Effective Care Delivery	Ext 16 / Partial	Ext 20 / Partial	Ext 20 / Partial		High 8 / 31/03/2026 31/03/2027	Minimal (1 - 4) ↑ Score has exceeded the tolerable score (5-9) since 2022/23	●	●	●	●	●	●	357 ↓	3 ↑	7 ↑	15 ↑	0 →	17 ↓	2 ↓	5 ↑	9 ↑	0 ↓	2 ↑	2 →
BAF 2	Inability to Design and Deliver Services that Address Local Population Needs	High 10 / Acceptable	High 10 / Acceptable	High 10 / Acceptable		High 8 / 31/03/2026	Minimal (1 - 4) ↑ Score has exceeded the tolerable score (5-9) since 2023/24		●	●	●	●	●	1 →	0 →	0 ↓	0 →	0 →	1 ↓	1 →	1 →	4 ↑	2 ↓	0 →	0 →
BAF 3	Inability to Improve Workforce Sustainability & Organisational Culture	Ext 15 / Partial	Ext 15 / Partial	Ext 15 / Partial		High 10 / 31/03/2027	Cautious (1 - 9) ↑ Score has exceeded the tolerable score (10-12) since 2024/25	●	●		●		●	141 ↑	0 ↓	2 ↓	4 ↓	0 →	4 ↓	3 →	5 ↑	1 ↑	3 ↓	5 ↑	0 →
BAF 4	Inability to Deliver Digitally Enabled Care Transformation	Ext 16 / Partial	Ext 16 / Partial	Ext 16 / Partial		High 8 / 31/03/2026	Minimal (1 - 4) ↑ Score has exceeded the tolerable score (5-9) since 2022/23	●	●	●	●	●	●	110 ↑	0 →	1 ↓	0 →	0 →	1 ↑	9 ↑	4 →	7 ↑	7 ↓	2 ↑	0 →
BAF 5	Inability to Deliver Investment in Estate Infrastructure & Workforce	High 12 / Acceptable	High 12 / Acceptable	High 12 / Acceptable		High 12 / Achieved Q1 2025	Cautious (1 - 9) Score has remained within the tolerable score (10-12) since 2022/23	●	●	●	●	●	●	93 ↑	0 →	1 →	0 →	0 →	0 →	15 →	1 →	0 →	2 ↓	2 →	5 ↑
BAF 6	Inability to Deliver In-Year Financial Position	Ext 20 / Partial	Ext 20 / Partial	High 12 / Acceptable		High 9 / 31/03/2026	Cautious (1 - 9) ↓ Score reduced to the tolerable score (10-12) in Q3	●	●	●	●	●	●	27 ↑	3 ↑	2 ↓	9 ↑	0 →	6 ↑	2 ↓	1 ↓	5 ↑	2 ↓	0 →	0 →
BAF 7	Inability to Deliver Financial Sustainability	Ext 20 / Partial	Ext 20 / Partial	Ext 25 / Partial		High 12 / 31/03/2027	Cautious (1 - 9) ↑ Score has exceeded the tolerable score (10-12) since 2024/25	●	●	●	●	●	●	4 ↑	1 →	0 →	9 ↑	0 →	6 ↑	4 →	1 →	6 ↑	3 ↑	0 →	0 ↓
BAF 8	Inability to Sustain Research and Innovation Excellence	High 12 / Partial	High 12 / Partial	High 12 / Partial		High 8 / 31/03/2026	Open 1 - 12 ↔ Score is in line with risk appetite (1-12)	●	●	●	●	●	●	2 →	0 →	0 →	0 →	0 →	0 →	4 →	2 ↓	5 ↑	4 ↓	1 ↑	2 →
							TOTAL	7	8	7	8	7	8							40 ↓	20 →	37 ↑	23 ↓	12 ↑	9 →

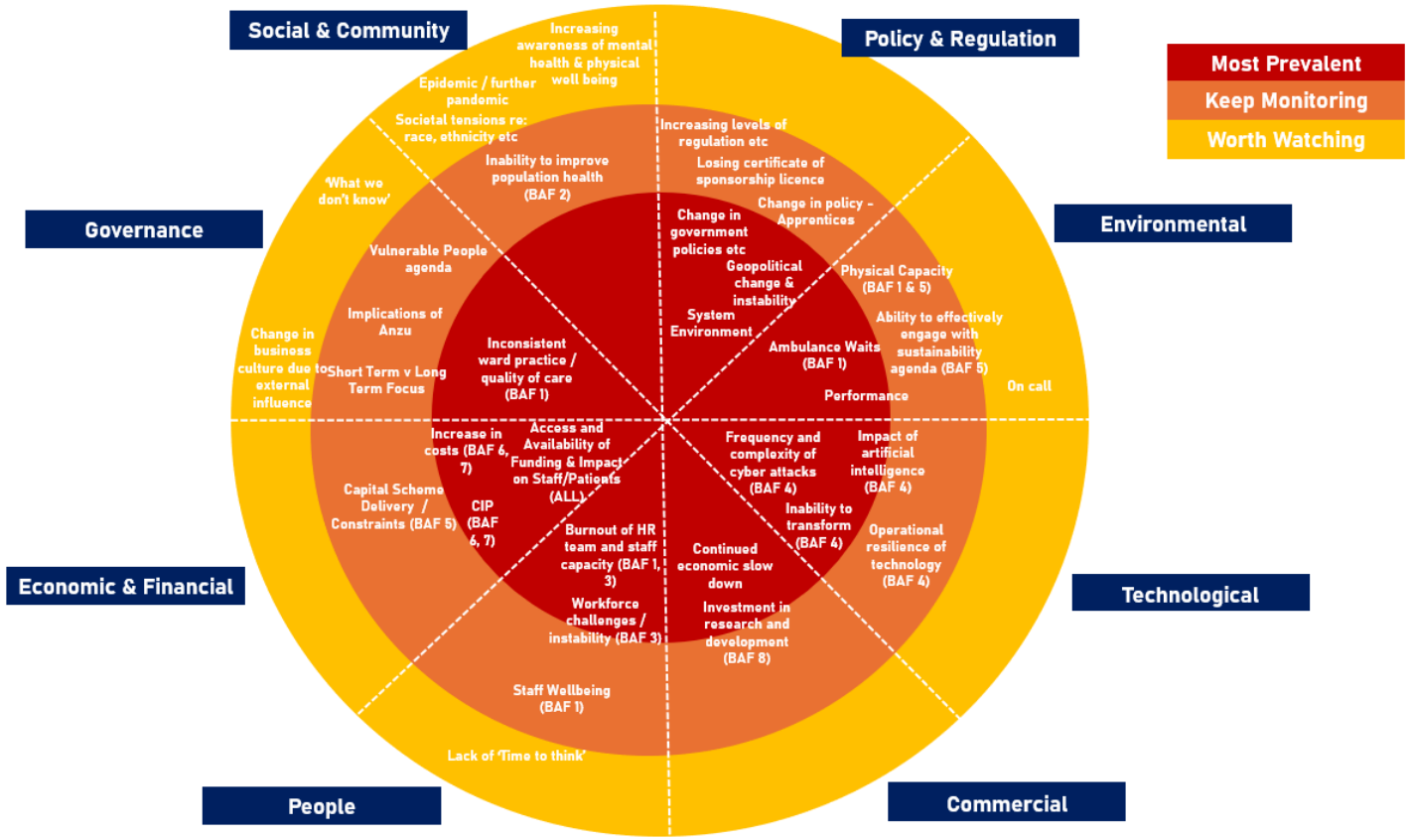
Positive Assurance

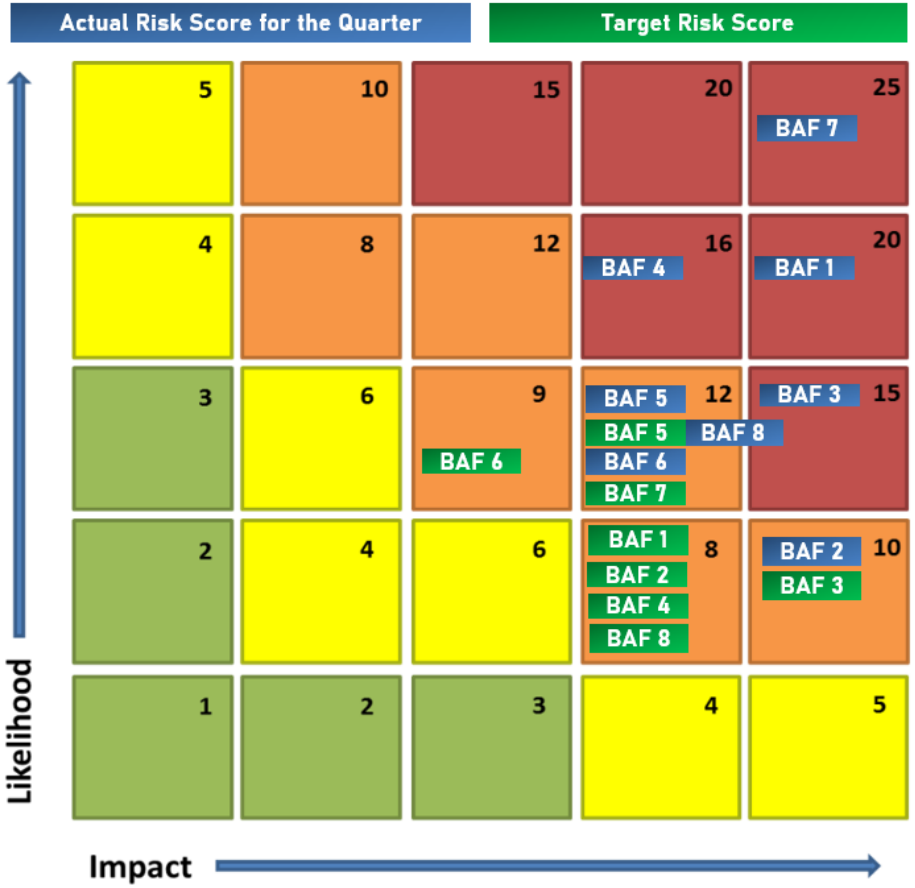
- 3 / 8 risks identified as providing acceptable assurance (↑)
- 8% (↑) assurances were rated as significant assurance and 14% (↓) as acceptable assurance
- 46% (↑) of actions have been completed with 28% (↓) on track
- 2 / 8 risk scores are within the risk tolerance (↑) and 1 / 8 risk score is in line with the risk appetite

Matters of Concern

- 5 / 8 risks identified as providing partial assurance (↓)
- 40% (↑) assurances were rated as partial assurance and 0% (→) identified as having no assurance
- 17% of assurance were not seen during Q2 (↑)
- 15% (↑) of actions are delayed and 11% (↓) problematic
- 5 / 8 risk scores are above the tolerance (↓)

Risk Radar & Heat Map





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

BAF 1: Inability to Sustain Safe and Effective Care Delivery

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

Risk Description

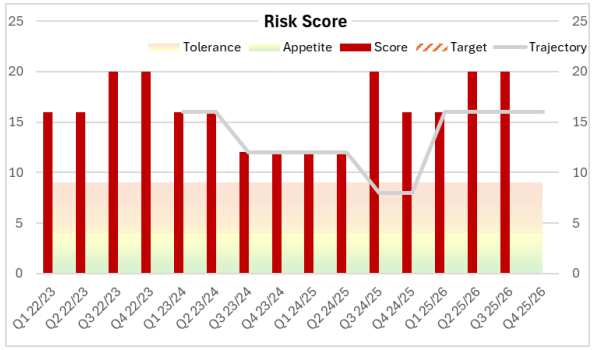
Cause:	If we experience limitations in workforce availability, equipment, service capacity, financial constraints, or, lack a culture of continuous improvement,
Event:	Then we may be unable to consistently deliver safe, timely and effective care across maternity services, urgent and emergency care (UEC),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

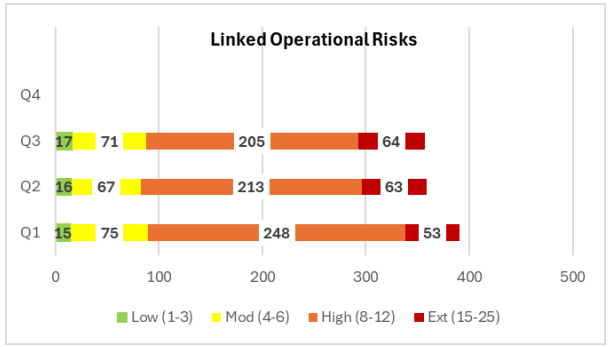
Potential to impact on our Strategic Priorities

Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

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





Executive Overview – Rationale for Risk Score and Progress made in Quarter 3

Following discussion at QAOC in Quarter 2, and given the winter pressures, the risk score for Quarter 3 has remained the same as Quarter 2 at Extreme 20, rather than reducing to Extreme 16. However, the trajectory for Quarter 4 remains the same at Extreme 16, which is expected to be achievable given the work being undertaken to improve ambulance offloads and the additional elective activity which is due to come online.

A number of mitigating actions have continued to be taken including the support from the Get it Right First Time UEC team. This has focused on reducing ambulance handovers, system multi-disciplinary reviews, improving ward and discharge processes, front door improvements such as the frailty SDEC, strengthened bed and site management, infection prevention and system surge planning / winter review. As at November, 77 / 90 planned acute beds had been opened and 30 / 30 planned discharge to assess bed capacity delivered across Haywood and Cheadle.

We have also seen continued and fairly consistent requirements for temporary escalation spaces to be used both day and night. A quality system visit to Royal Stoke ED took place on 2 December 2025 which was positive – this will be presented to QAOC. We have also continued to see increased hospital acquired infection rates which is subject to increased monitoring and support from NHS England, although there are no current concerns from an NHSE perspective.

What is this telling us?

The current risk score remains above the target (tolerable) risk score of High 8, representing a gap of 12 points. The key factors contributing to this gap relate to the need to complete our improvement programmes the timing of which is expected to complete within 2026/2027.

The number of linked risks have slightly decreased from Q2, although there continues to be the highest number of operational risks linked to this strategic risk. These risks relate to workforce shortages, delays in access to care, digital and cyber vulnerabilities, and ageing estates and equipment, all of which undermine the Trust's ability to deliver safe, timely and effective services. These issues, combined with gaps in quality, safety and regulatory compliance, create significant potential for patient harm, worsening performance against national standards, financial pressures, and reputational damage.

BAF 1: Inability to Sustain Safe and Effective Care Delivery

Key Controls Framework

Care Group (n=13)	• Capacity calls in place x4 daily, including Executive Director and Care Group attendance • Care Group referral to treatment (RTT) meetings held twice weekly • Clinical staff recruitment, induction, mandatory training, registration and revalidation • County Elective Hub Group meetings held twice monthly • Diagnostic cell in place • Directorate Mortality and Morbidity meetings held monthly, to review deaths and discuss cases including input from Medical Examiner and use of Structured Judgement Reviews • Elective Improvement Programme • Safe medical, nursing, midwifery and Allied Health Professional (AHP) staffing levels defined for all areas • Tumour site cancer patient tracking list (PTL) meetings held weekly • Urgent and Emergency Care Improvement Programme • Validation plan to ensure all patients >52 weeks are validated • Weekend planning meetings held weekly • Weekly elective oversight management group
Corporate (n=36)	• Accountability & Performance Framework • Birth Rate Plus staffing assessment for midwifery services • Birthrate plus business case approved • Cardiology business case approved • Capacity, demand, organisational and system bed model completed • Care Excellence Framework with enhanced patient-led monitoring for bronze review panel meetings • Child Health Tier 2 Resident Doctor business case approved • Clinical policies, procedures, guidelines, pathways, supporting documentation and IT systems in place • Clinical Audit Programme in place • Corporate escalation process in place regarding current operational status and action required • Community Diagnostic Centre business case approved • County Hospital Daycase Unit in place • County Frailty business case approved • CT and MRI Scanner business case approved • Elective Hub business case approved • Elective Caesarean Section Maternity Theatre Sessions and Uplift in Maternity Theatre Staffing Recurrent Investment business case approved • Electronic Prescribing and Medicines Administration (EPMA) System piloted and being rolled out • Executive Recovery Oversight Group • Internal rapid handover process within Emergency Department • Maternity and Neonatal Single Delivery Plan Framework • Medical Workforce Group • Mortality Review Group • Nephrology Service - sustainability and recurrent investment in the medical, nursing and administration workforce (Phase 1) • Nurse staffing establishment reviews undertaken every 6 months • Performance and Risk Reviews • People Plan in place • Quality and Outcomes Group, with bi-monthly focus on Quality and Safety / Outcomes • Respiratory business case approved • Robotic Assisted Surgery Expansion business case approved • Strategic Delivery Unit with responsibility for delivery of strategic plans • Strategic Oversight of all site calls introduced in Quarter 3 • Surgical Site Infections and theatre cleanliness deep dives undertaken and reported through the appropriate governance structure • Transitional Care (BAPM) action plan in place • Urgent Treatment Centre business case approved • Winter planning staffing approved • Winter escalation capacity opened ahead of schedule
System (n=12)	• Care Quality Commission (CQC) registration • Get It Right First Time UEC Team in place and providing support • Healthwatch and Maternity and Neonatal Voices Partnership (MNVP) Meetings • Integrated Care Board (ICB) quality, safety and compliance meetings • Provider Collaborative in place • Screening Quality Assurance Services (SQAS) Assessments • System Executive ambulance improvement Task and Finish Group meetings held on a weekly basis • System partners meetings held, including with West Midlands Ambulance Service, on a weekly basis • System Planned Care Board in place • System Urgent Emergency Care Board in place • Tiering calls chaired by Regional NHSE with regards to urgent and planned care performance • Winter calls with System Partners regarding urgent and emergency care, held daily

Key Assurances Received - Quarter 1, 2 & 3

Assurance Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec
7 Day Services Board Assurance Report									
Access Performance Report & Executive Recovery Oversight Group Highlight Report	M12	M1	M2	M3	M4	M5 | NR		04-Dec	
Allied Health Professional Workforce Establishment Review				☒		☒			
Bi-Monthly Nursing & Midwifery Staffing Report								☒	
Cancer 104+ Day Breach Analysis	☒			☒	Q4	NR			
Care Excellence Framework (CEF) Summary Report					Q4/Q1				☒
Care Quality Commission Inspection Update	☒								
Changing the NHS Landscape									NR
Chief Healthcare Scientist Update		☒							
Chief People Officer Report						☒			
Chief Pharmacist Workforce Report						☒		☒	
Clinical Coding Update									
Clinical Effectiveness Update	NR				☒	☒	☒		☒
Community Diagnostic Centre (CDC) Business Case Update									NR
County Elective Hub Review									
ED Corridor Support							NR		
End of Life CQC Mock Review								04-Dec	
Executive Quality & Outcomes Group Assurance Report	NR	NR	☒	NR	NR	NR	NR	04/12 - NR	NR
Health & Wellbeing Report									
Hospital Associated Thrombosis Increase November 2024 - February 2025									
ICB Quality Assurance Visit Reports		NR							
Infection Prevention Board Assurance Framework	☒	Q4		Q1			Q2		
Infection Prevention Hospital Acquired Infection Report	Q4			☒	Q1		Q2		
Infection Prevention, Vaccination & Sepsis Team Annual Report									
Legal Services Annual Litigation & Inquest Report								04-Dec	
Long-term/Short-term Locum Doctors in Obstetrics & Gynaecology Audit		NR						NR - 26/11	
Lower Limb Wound Pathway Update								NR - 4/12	
Major Trauma Peer Review		☒							
Maternity & Neonatal PSIRF Investigation Report					Q1			26-Nov	
Maternity & Neonatal Services (NHS England Rapid Independent Investigation)					NR				
Maternity & Neonatal Single Delivery Plan (SDP) Framework Internal Audit									
Maternity & Neonatal Voices Partnership Feedback Report		☒			☒			☒	
Maternity and Neonatal Investigation / Taskforce (NHSE Letter)			NR						
Maternity and Neonatal Single Delivery Plan (SDP) Framework Internal Audit									
Maternity Consultant Attendance Audit					☒			NR - 26/11	
Maternity Dashboard					Q1			NR - 26/11	
Maternity Outcomes Signal System (MOSS) Critical Safety Checklist								26-Nov	
Maternity Quality & Safety Oversight Group Assurance Report		NR			NR			NR - 4/12	
Medical Examiner Service Update									
Medical Workforce Group Assurance Report								☒	
Medicines Optimisation & Safety Report		Q4					☒	Q1/Q2	
Mortality Assurance Report				Annual		NR			
National Neonatal Audit Programme (NNAP) Outlier for Bronchopulmonary Dysplasia (BPD) for 2024 Assurance						NR			
Nurse Staffing Establishment Review		☒		NR				NR	
Operation Anzu Actions Review									
Patient Council Update									NR
Patient Experience Report				Q4		Q1 | NR			
Patient Safety Incident Investigation Report	Q4			Q1			Q2		
Patient Story: Hear My Voice, Feel My Story							NR		
Patient Waiting List Backlog						NR			☒
Perinatal Mortality Report					Q1			26-Nov	
PLACE Inspection Findings and Action Plan									
Quality Account		NR							
Quality Impact Assessment Report					☒	NR			
Quality Improvement Project Update: Bedside Screening and Treatment for Early Onset Neonatal Sepsis								NR - 26/11	
Quality Performance Report	M12	M1 | NR	M2	M3 | NR	M4	M5 | NR	M6	M7 | NR	M8
Readmissions Analysis						☒	☒	☒	
Regulation 28 Update									
Saving Babies Lives Care Bundle									
Sedation Guidelines and Abandoned Procedures							NR		
Sepsis in Children's Services			☒					04-Dec	
Spinal and Cranial SSI Review								04-Dec	
Stay in the Bay						NR			
Temporary Escalation Spaces (TES)									
Urgent Treatment Centre Update				NR	NR				
Waiting Inequalities List Report				NR					
Winter Close Down Report			☒	NR					

Assurance Rating Key

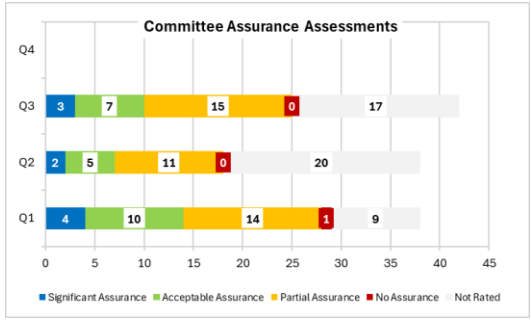
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

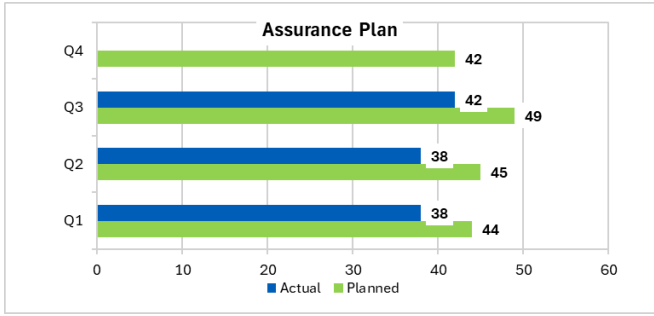
BAF 1: Inability to Sustain Safe and Effective Care Delivery

Executive Assurance Assessment

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

Committee Assurance Assessment & Plan





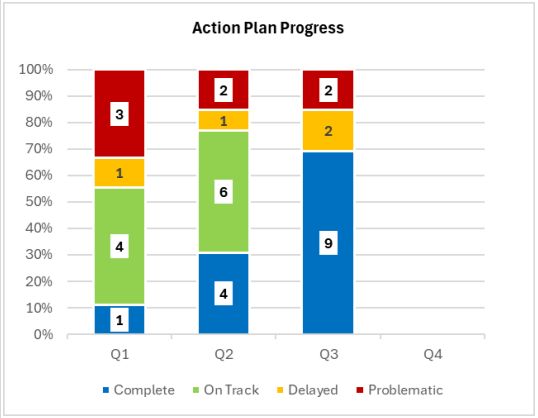
Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=2)	• Clinical effectiveness provision within Care Groups to be embedded (action 2) • Inability to maintain future workforce requirements and pipelines (action 6)
Gaps in Assurance (n=5)	• Robust system is required for evaluating harm in patients waiting for elective procedures (action 1) • Coding issues identified in relation to SHMI and HSMR (action 5) • Assessment of quality of care in relation to use of temporary escalation spaces (action 7) • Tendable contract due to expire 2026/2027 (action 8) • To further enhance Provider Collaborative support for UEC pathways and deflect attendances from ED in addition to discharge pathways to community services, over and above current plans (action 9)

What is this data telling us?

The executive assurance rating assessment continues to be rated as partial, although there has been an increase in the number of positive assurances received by Committees in Q3. The number of assurance reports not seen as planned in the quarter remained the same as Q1 and Q2, and these have been rescheduled. Following completion of an action in Q2, two gaps in control have been mitigated.

Five actions have been completed in Q3, compared to the seven which had planned to have been completed. Reasons for the delay in the 2 actions relate to winter pressures and the declaration of critical incident in addition to the ongoing work on the medium-term plan, with the timescale aligned with the national submission. There remains two problematic actions, and updates in relation to these two items are regularly provided to QAOC.



Risk Management Action Plan

No	Action	Due Date	Progress Report	2025/2026 Q1	Q2	Q3	Q4
1	Harm review process for long wait patients to be integrated and enhanced	~~31/12/2024~~ ~~31/03/2025~~ ~~01/10/2025~~ 01/04/2026	Carry forward from Q1 2024/25. Update provided to QAOC, where it was highlighted that due to capacity constraints within the digital team, progress had been paused, as such the due date has been moved to reflect this.				
2	Embed clinical effectiveness processes within Care Groups, to provide oversight of patient outcome data	~~31/12/2024~~ ~~31/03/2025~~ 01/02/2026	Carry forward from Q1 2024/25. Update on clinical effectiveness to be discussed at QAOC.				
3	Deliver ePMA programme	~~31/12/2025~~ 31/01/2026	Carry forward from Q1 2024/25. Pilot completed and the last phase of the roll out was paused due to the Critical Incident. The last phase is planned to take place in January.				
4	Review of national patient safety review and to consider how patient experience can be incorporated into standalone groups	31/12/2025	Patient Council Chair and Vice Chair now appointed. Work will commence with them to support the development of co-production opportunities and to embed the patient voice into care group governance. Proposed plan regarding this to be presented to QAOC.				
5	Identify actions to resolve the coding backlog and identify interim assurance for HSMR/SHMI	~~31/08/2025~~ 31/10/2025	Coding is now fully complete from April 2025. A paper regarding this was considered by QAOC in October 2025 and acceptable assurance provided.				
6	To consider the action required to maintain future workforce requirements and pipelines	~~31/12/2025~~ 01/04/2026	This is being considered as part of the medium-term plan, therefore due date moved to reflect submission dates.	N/A			
7	To obtain further assurance in relation to the risk assessment and use of temporary escalation spaces	31/12/2025	Audit process now in place led by care group leadership teams which will be included in the weekly executive meeting pack	N/A			
8	To consider the action required to continue with the nursing assurance system, given the impending end date for Tendable	31/12/2025	A business case has been written and will be considered by the Executive Team.	N/A			
9	To further embed the Provider Collaborative Operational Group	31/12/2025	Interim Director of Operations introduced for Provider Collaborative to embed working relationships.	N/A			

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

Quality, Access & Outcomes Committee | Director of Strategy

Risk Description

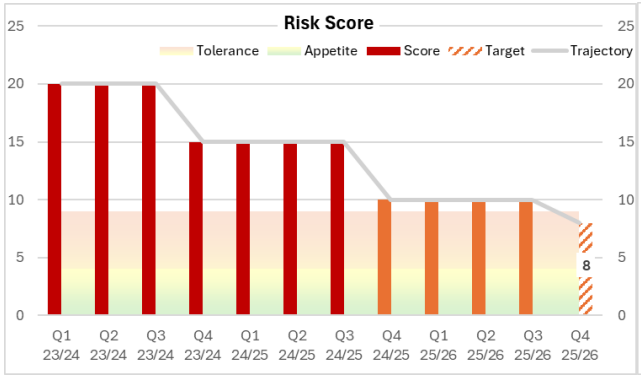
Cause:	If we are unable to work with partners to effectively design and deliver value-based services that meet the needs of our local population,
Event:	Then our ability to improve population health and reduce health inequalities may be significantly limited,
Effect:	Resulting in not moving from a system that focuses on treating sickness to one that prioritises prevention. This will result in the number years people live in good health and inequalities widening further and an unsustainable demand for hospital based services.

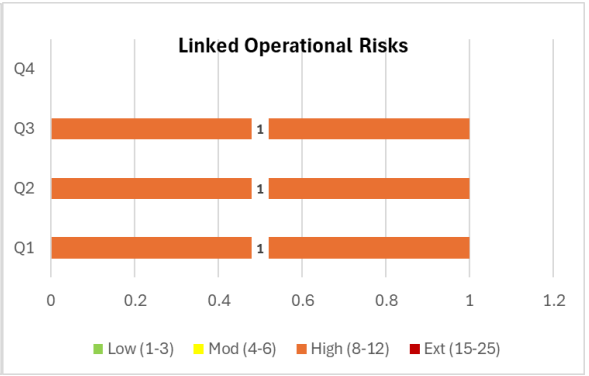
Potential to impact on our Strategic Priorities

Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

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





Executive Overview – Rationale for Risk Score and Progress made in Quarter 3

The risk score remains unchanged for this quarter. Clear progress is being made with clinical teams across prevention (Tobacco Dependency Treatment, Alcohol Care, Flu Vaccination and working with ICS partners to develop a system-wide approach to obesity). In addition, there is consistent work being undertaken to reduce high local rates of infant mortality and improve cancer screening uptake. There has been engagement work completed with local harder to reach communities and community groups, which will be continued in Q4.

The intention is to review the risk score in line with the outcome of this work, so there is a clear body of evidence in support. The work is on track – recognising that this is a part of a longer shift within the NHS from sickness to prevention.

What is the data telling us?

The current risk score has continued to remain the same as Q1 and Q2, slightly above the target (tolerable) risk score of High 8, representing a gap of 2 points. However, the risk remains on trajectory to achieve the target (tolerable) risk score by March 2026 following the completion of actions in Q4.

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

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

Key Controls Framework

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

Key Assurances Received - Quarter 1, 2 & 3

Assurance Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Changing the NHS Landscape									NR
Partnerships and Collaboration							☒		
Quality Impact Assessment Report					☒	NR			
Sustainability Bi-Annual Report									
Waiting Inequalities List Report				NR					

Assurance Rating Key

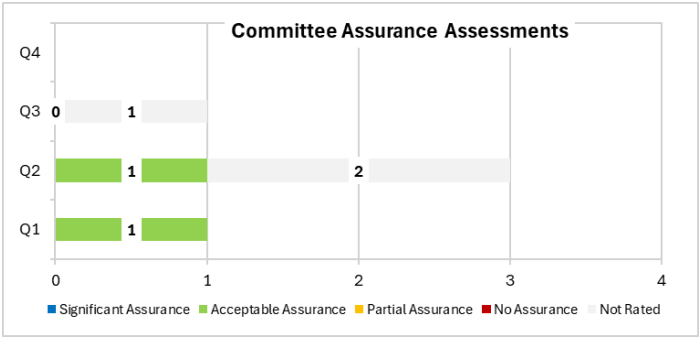
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

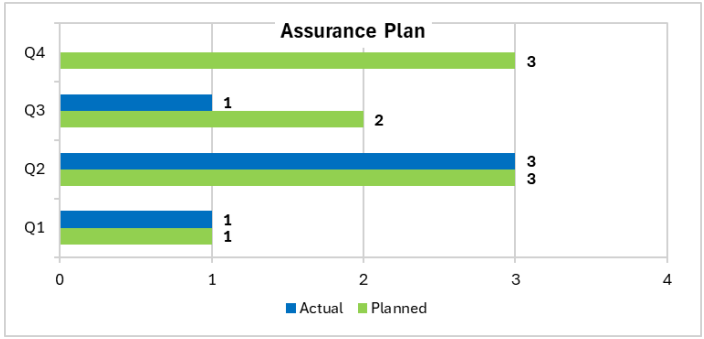
BAF 2: Inability to Design/Deliver Services that Address Local Population Needs

Executive Assurance Assessment

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

Committee Assurance Assessment & Plan





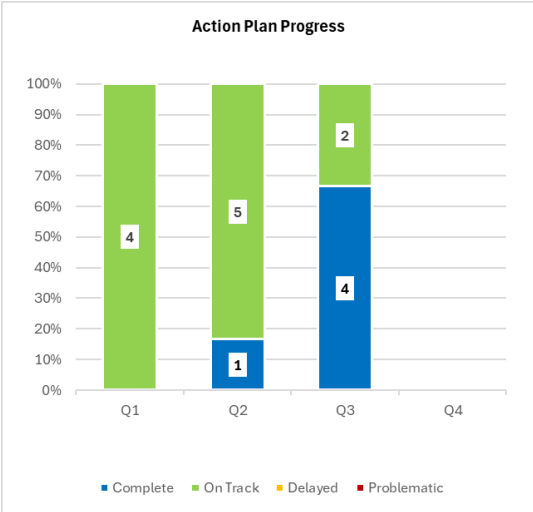
Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=1)	• With the change in executive portfolios, the lead for anchor work needs to be clarified (action 4)
Gaps in Assurance (n=1)	• The committee reporting requirements are being reconfigured to align with the revised Trust Governance (action 5)

What is this data telling us?

The executive assurance rating assessment continues to be rated as acceptable, and work is continuing to increase reporting on health inequalities to QAOC. The source of assurance considered in Q3 was not rated and one assurance report was not considered in the quarter as planned and has been rescheduled.

Three actions have been completed in Q2 as planned, with the remaining two actions on target to be delivered by the end of Q4.



Risk Management Action Plan

No	Action	Due Date	Progress Report	2025/26 Q1	Q2	Q3	Q4
1	Evidence base to confirm impact of interventions, to reduce health inequalities and prevent ill-health	31/03/2026	On track to deliver, with particular focus on infant mortality, vaccination, cancer, elective care, weight management, tobacco dependency and alcohol.				
2	Interventions to target workforce access and health	31/12/2025	In December 2025, initial plans to implement smoke free hospital campus' in 2026 were approved and detailed planning is now underway. Further work is underway to link datasets to help identify potential areas for workforce inequality.				
3	Raise regional and national profile of the programme	31/03/2026	On track to deliver by 31/03/26				
4	To confirm the lead for Anchor Institution following change in Executive portfolios	30/11/2025	Complete – Executive Lead confirmed as Director of Strategy / Deputy Chief Executive	N/A			
5	To improve the level of assurance provided to QAOC	31/12/2025	Changes made to the business cycle to incorporate updates on Health and Wellbeing Strategy progress.	N/A			

BAF 3: Inability to Improve Workforce Sustainability & Organisational Culture

People, Culture and Inclusion Committee | Chief People Officer

Risk Description

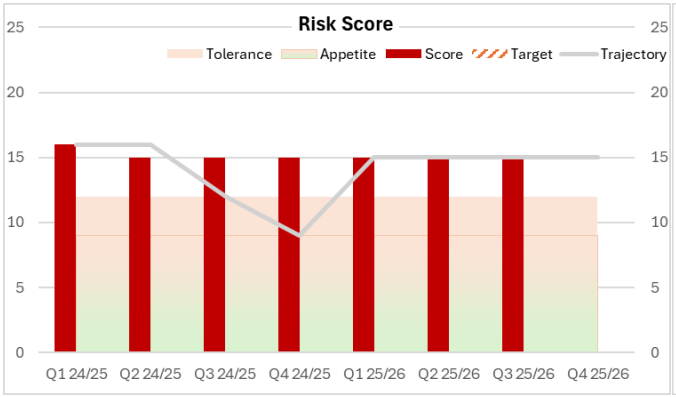
Cause:	If we are unable to achieve workforce sustainability through the implementation of an effective long term workforce plan – one that is underpinned by a positive, inclusive organisational culture,
Event:	Then, we may encounter significant challenges in attracting and retaining top talent, in addition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

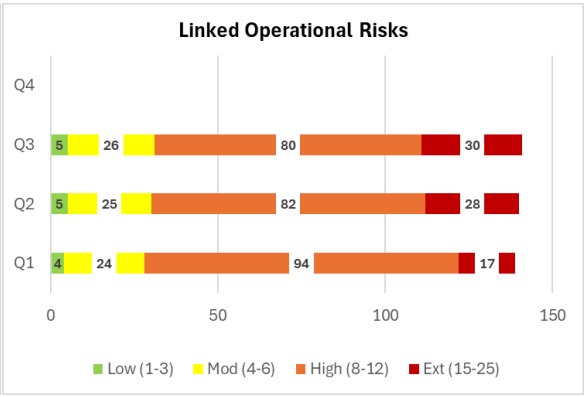
Potential to impact on Our Strategic Priorities

Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

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





Executive Overview – Rational for Risk Score and Progress made in Quarter 3

The risk score for Q3 has remained the same and on trajectory. The Trust continues to maintain strict financial recovery controls, with vacancy, turnover and agency spend all performing better than target through Q3. Vacancy levels remain below the 8% stretch target, partly due to workforce budget reductions, and agency costs are well-contained at 1.77% YTD. Sickness has remained stable at 5.3%. Major organisational change has progressed, including the redesign from four divisions to three Care Groups and realignment of leadership tiers, which—while necessary—has created disruption for some teams. Key workforce cost pressures and savings include the completion of the HCA Band 2–3 back-pay exercise (£4.9m) and delivery of c.£600k recurrent savings from the MARS process. Demand for People Directorate services continues to exceed capacity, with notable pressure in People Operations and Workforce Information, and with rising complexity in Employee Relations cases, Subject Access Requests and Freedom of Information requests. Significant progress has been made on strategic priorities for "Our People," including health and wellbeing, learning and development, flexibility, sexual safety initiatives, and wider equality, diversity and inclusion activity. Engagement activity included the annual Staff Awards and completion of the 2025 National Staff Survey (41% response rate, with early indications of stable results).

What is this telling us?

The current risk score remains above the target (tolerable) risk score of High 18, representing a gap of 5 points. The key factors contributing to this gap relate to limited Care Group capacity, temporary gaps in workforce governance during the transition to new Care Group structures, and wider financial pressures including CIP requirements. Assurance is further constrained by below-target medical Job Planning compliance and rising volumes of complex DSAR/FOI requests that exceed current capacity. Together, these factors limit the level of assurance and prevent risk reduction at the required pace..

The number of linked risks has slightly increased from Q2, with the risk continuing to have the second highest number of operational linked risks when compared to other strategic risks. These cross-cutting issues centre on workforce shortages, service capacity pressures, quality and safety vulnerabilities, governance gaps, and financial and operational strain—leading to delays in care, challenges meeting national standards, and sustained impact on staff wellbeing and service resilience.

BAF 3: Inability to Improve Workforce Sustainability & Organisational Culture

Key Controls Framework

Care Group (n=16)

- Care Group Workforce Assurance Groups in place held monthly (and Divisional for EFP)
- Clinical Business Unit Performance Review Meetings held bi-monthly within the three clinical Care Groups
- Care Group workforce organisation structure re-design and/or TUPE processes delivered in accordance with agreed governance and employment legislation.
- Partnership Agreements for UHNM as lead provider/employer in place with appropriate governance e.g. for NMCPS and the North Midlands and Black Country Procurement Group.
- Workforce plans in place and budgets transacted accordingly, including Cost Improvement Plans (CIP) delivery
- Apprenticeship targets in place and uptake against plan monitored
- Care Group, Divisional and Corporate Functions monitoring of staffing levels subject to vacancy controls.
- Care Group Medical Directors responsible for oversight of annual Job Planning sign off
- Internal deployment and redeployment of staff to support safer staffing levels
- Insourcing contracts in place in key areas to support the operational recovery plan
- Medical Rota Coordinators aligned to Care Groups to support operational planning
- Operational escalation plans in place, including for periods of Critical Incident and/or Industrial Action
- Culture improvement programme and plans in place
- National Education Training Survey action plan in place with the aim of delivering a better learner and trainer experience
- Retention initiatives in place; including key focus on the NHS People Promise areas and our Trusts Values
- Staff engagement / NHS National Staff Survey metrics and associated action plans are reviewed at Performance and Risk Review Meetings

Corporate (n=35)

- 2025-35 Strategy and delivery plan for 'Our People' priorities, including key highlights key strategic areas of focus and programmes of activity for our workforce for 2025/26.
- Care Group Performance and Risk Review meetings in place held bi-monthly
- Local negotiation consultative committee meetings held regularly held with our Trade Union colleagues e.g. LNC and TJNCC.
- Medical Workforce Assurance Group – scheduled to happen bi-monthly
- People (HR) policies and procedures in place and reviewed in accordance with policy review governance.
- Strategic Workforce Executive Group meetings held quarterly
- BI and Workforce Information tracking and analysis of workforce data and demographics
- Care Group model. This also includes the Fundamentals of Medical Leadership & Management
- Chief Allied Health Professional (AHP) and Chief Healthcare Scientist roles in place with annual reporting
- Education leads and teams working with providers across the System to enhance opportunities for learning and the education experience for our trainees
- Establishment Workforce Plan in place for 2025/26
- Established Banks (workforce) in place – including Nursing, Medics, Admin & Clerical, and other groups
- Mandatory Learning Oversight Group (MLOG) Terms of Reference refreshed
- Medical Staffing weekly meetings to review rotas, gaps and progress against recruitment
- Nurse Establishment Reviews reported twice yearly
- Operational Escalation / Winter Planning Group stood up at the appropriate time in the year.
- Oversight and scrutiny of vacancy controls, including bank and agency usage - as part of system and local financial recovery
- People Operations resource increase, recruitment progressed in line with approved business case
- Pipeline of approved business cases in key areas profiled into the workforce establishment to enable tracking of vacancies and workforce supply
- Senior Leadership development programmes in place; with focus on supporting the leaders in the new care groups
- Talent and succession planning in place
- Unplanned absences tracked daily (via the Empactis system) to support local planning
- UK Visas and Immigration (UKVI) data gap understood and mitigated with visa compliance system introduced and supplemented by auditing right to work checks
- Work-flow recruitment management system to track and optimise on-boarding processes with ongoing general recruitment drives
- Workforce requirements for corporately led transformation programmes identified
- Equality, Diversity and Inclusion Accountability Framework launched
- Established Staff Networks with task and finish groups as appropriate for specific in year priorities.
- Flexible working action plan reviewed with priority actions identified
- Organisational culture and staff engagement improvement plans in place
- Pastoral model of support for colleagues going through HR/Employee relations processes
- Sexual Safety Liaison Officer in post
- Sexual safety action plan in place, and new policy and training launched alongside Persons in a Position of Trust
- Values refreshed and launched in August alongside refreshed Behavioural Framework
- Violence and aggression reduction campaign ongoing (ref the seven point action plan)
- Wellbeing offerings and activities in place with a monthly calendar of events

System (n=5)

- CMO reporting to NHSE on compliance with job planning sign off
- ICS People, Culture and Inclusion workstream member
- Member of the National NHS Staff Council, to help shape and influence national policy.
- NHSE regional and national oversight; including review meetings. NHS Employers support to workforce leaders.
- National target for agency reduction with associated national and system controls for non-clinical agency expenditure

Key Assurances Received - Quarter 1, 2 & 3

Assurance Source	May	July	Sept	Nov
Allied Health Professional Workforce Establishment Review		☒	☒	
Appraisal and Revalidation Annual Report			NR	
Armed Forces Report 2024/25			NR	
Bi-Monthly Nursing & Midwifery Staffing Report				☒
Changing the NHS Landscape				NR
Chief Healthcare Scientist Update	☒			
Chief People Officer Report			☒	
Chief Pharmacist Workforce Report			☒	☒
Employee Relations Casework Trends			☒	
Equality, Diversity & Inclusion Annual Report				
Equity and Inclusion Assurance Tool				
Guardian of Safe Working Report	Q3	Q4	Q1	Q2 | NR
Health & Wellbeing Report				
Job Planning Spotlight		NR		
Learning and Education Annual Report			☒	
Maternity & Neonatal Workforce Report				NR - 26/11
Medical Workforce Group Assurance Report				☒
Nurse Staffing Establishment Review	☒	NR		NR
People Plan		☒		
Postgraduate Medical Education Report				
Resident Doctors 10 Point Plan			NR	
Sexual Safety Charter Assurance Framework			NR	
Sexual Safety Update				
Speaking Up Report		Q3 / Q4		Q1 & Q2
Statutory & Mandatory Training Review				
Strategic Workforce Group Assurance Report		NR		☒
Talent and Succession Planning Update	☒			☒
Undergraduate Medical School Report	☒			
Violence Prevention and Reduction Update				
Workforce Plan Update				
Workforce Race and Workforce Disability Equality Standard				

Assurance Rating Key

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

BAF 3: Inability to Improve Workforce Sustainability & Organisational Culture

Executive Assurance Assessment

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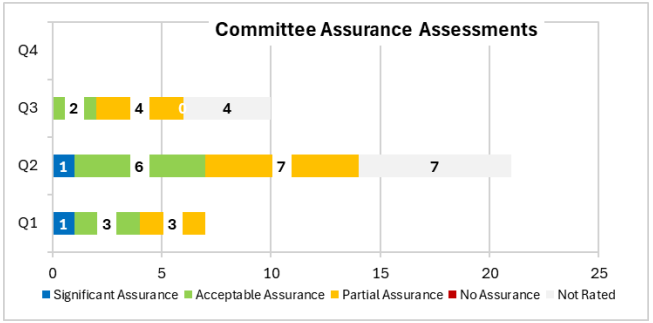
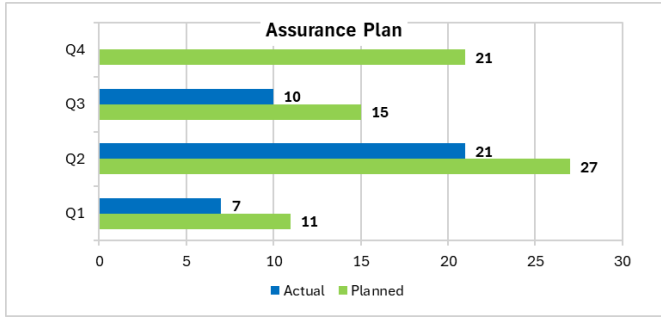
Committee Assurance Assessment & Plan





Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=3)

- Care Group capacity to effectively manage and drive their People Plans (action 1).
- Transition of the Clinical Divisions to three Care Groups during Q2 and Q3 saw the Care Groups standing down their 'old' divisional Workforce Assurance Groups, with the intention of having these (or an equivalent) re-established by Q4 (action 2).
- Risk in respect of the programme for up banding of Healthcare Support Workers from Agenda for Change Band 2 to 3; particularly in respect to the cost of (a) forward pay and (b) back-pay (action 3).

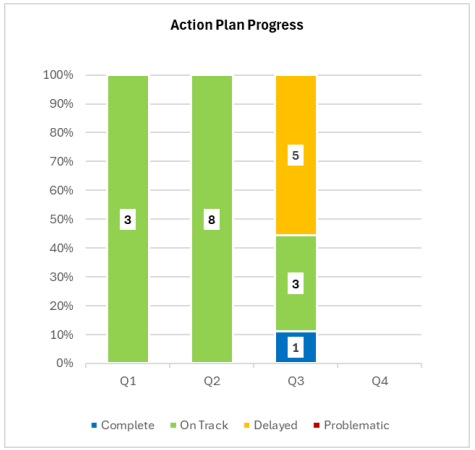
Gaps in Assurance (n=5)

- Impact on the workforce of financial pressures (Trust and System), including CIP targets (pay and non-pay costs). (action 4)
- Job Planning (for Medical Consultants) performance is not compliant with NHSE targets (action 5)
- Workforce related Data Subject Access Requests [DSAR] and workforce related Freedom of Information Act requests [FOIA] requests continue to be a challenge with an ever-increasing number and complexity of requests received and inadequate resources to handle them. Regularly non-compliant with ICO guidelines re timescales. (action 6)
- UHNM's FY25/26 Mutually Agreed Resignations Scheme (MARS) outcomes to be determined (action 7)
- 2025 NHS National Staff Survey (NSS) – UHNM's response rate in Q3 was 41% which was very slightly lower than last year (action 9).

What is this data telling us?

The executive assurance assessment continues to be rated as partial and the majority of assurances presented in Q3 were rated as partial, with 5 items not seen as planned which have been rescheduled. The number gaps in control have remained the same as Q2 although an additional gap in assurance has been identified, alongside an associated new action.

One action has been completed in Q3 compared to the six which had planned to be completed. Themes regarding the delay in completion include some actions having been slowed by paused work pending external reviews, while others having been affected by complex and increased operational demand. Additionally, actions linked to national programmes have been delayed due to slippage in national timelines, requiring local plans to be extended to maintain alignment. Overall, these factors have collectively contributed to revised delivery dates into Q4.



Risk Management Action Plan

No	Action	Due Date	Progress Report	2025/26 Q1	Q2	Q3	Q4
1	To release the pressure on Care Groups capacity in order to manage and drive their People plans	31/03/2026	During Q3 the organisation completed transition work from the first three phases of the redesign, prompting the Executive Team to endorse the temporary pause to protect operational resilience. Phase 4 of the organisational structure redesign was therefore paused from mid-November to mid-February, although essential Tier 4 design work and limited smaller change processes continue by exception.	N/A			
2	To reinstate Care Group Workforce Assurance Groups	~~31/12/2025~~ 31/03/2026	Initial steps have been taken to re-establish Workforce Assurance Groups across the three Care Groups, but implementation has been inconsistent and requires a fully standardised approach in Q4. Progress will be monitored through Care Group performance reviews, the Strategic Workforce Group, and PCIC to ensure the forums are effectively embedded.	N/A			
3	Payments to be made in October regarding the Band 2 to 3 Healthcare Assistants back pay lump sum	~~31/10/2025~~ 31/03/2026	The back-pay lump-sum payments were processed in October as planned, with over 1,000 staff receiving non-pensionable payments totalling approximately £5m funded from reserves. Around 200 cases remain unresolved, with final negotiations with Trade Unions—covering five additional categories—scheduled for January 2026, and any further agreed payments to be completed in Q4.	N/A			
4	Mitigate the [detrimental] impact on the workforce of financial pressures (Trust and System), including CIP targets and identified schemes (pay and non-pay costs).	31/03/2026	Working with Finance, unachievable pay-related CIP has been mitigated where possible through non-pay measures, some of which are non-recurrent. Delivery of the 2025/26 Workforce Plan remains highly challenging, particularly given the significant workforce-reduction target, which is dependent on wider demand-management strategies.	N/A			
5	To review the approach to job planning for consultants (policy HR45 and procedures) and to identify efficiencies and improve performance against NHSE targets for sign off.	~~31/12/2025~~ 31/03/2026	The review of the Consultant Job Planning policy is now around 12 months overdue. An external report was presented in Q3, and although actions were paused pending Deloitte's data review, the recommendation for a full policy overhaul has been accepted, with the CMO due to restart the review in January 2026.	N/A			
6	Business case to be identified, in order to address the inadequacy of resources to respond to workforce related FOIs and SAR's	~~31/12/2025~~ 31/03/2026	Work began in December on developing a business case to address the sharp rise and increasing complexity of workforce-related SARs, which have quadrupled compared to last year. As this is an organisation-wide issue involving People Operations, Digital Services (Data, Security & Protection), and Legal Services, a fully costed business case will be submitted in Q4.	N/A			
7	Outcome of the MARS scheme to be confirmed and approved	31/10/2025	From the 106 MARS applications received, fifteen employees left the organisation on 7 December 2025 and a further two are expected to leave on 31 March 2026. Subject to the final two settlement agreements being completed in Q4, the scheme will deliver an estimated recurrent annual pay saving of around £600k (including on-costs), with final figures to be confirmed in Q1 2026/27.	N/A			
8	Education, Training and Development Accountability Framework to be launched	~~30/11/2025~~ 31/03/2026	The NHS Leadership and Management Framework has been subject to phased development and revision, with draft standards and competencies originally expected for autumn 2025 and full rollout of tools in early 2026, though feedback has required further refinement. We will review the final launch once issued and align our expectations and leadership programme content accordingly - due date therefore extended due to national delay.	N/A			
9	Detailed engagement and response data from the staff survey to be received and analysed	31/03/2026	Action not yet due	N/A	N/A		

BAF 4: Inability to Deliver Digitally Enabled Care Transformation

Finance and Business Performance Committee | Chief Digital Information Officer

Risk Description

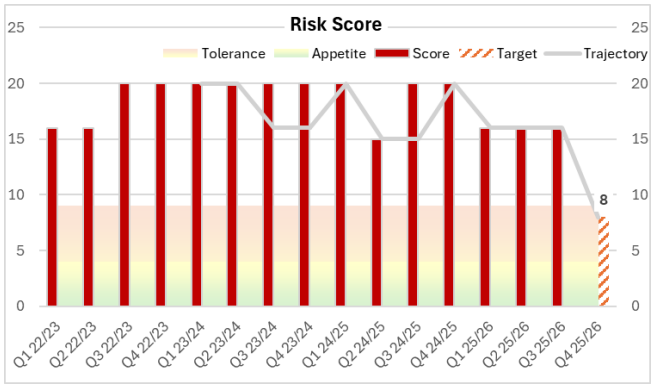
Cause:	If we are unable to deliver digitally enabled care transformation due to ongoing limitations in digital infrastructure, workforce capability, system interoperability, and financial constraints,
Event:	Then our capacity to innovate, modernise services and improve patient safety, care quality, and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

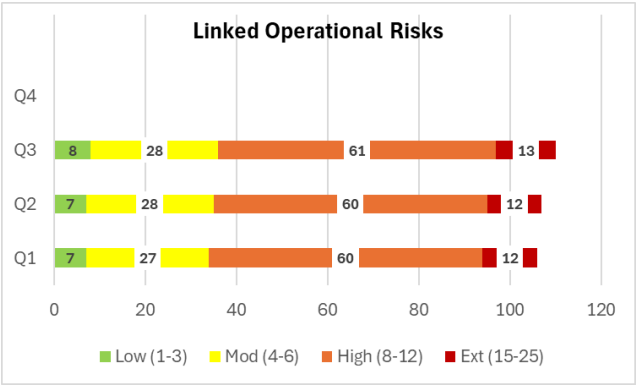
Potential to impact on Our Strategic Priorities

Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

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





Executive Overview – Rationale for Risk Score and Progress made in Quarter 3

Progress on the ePMA rollout has been affected by a critical incident and industrial action, pausing implementation and contributing to a high volume of support requests that have created a significant backlog and impacted staff productivity. Work to strengthen governance around shadow IT, DPIA and DTAC compliance is underway, but substantial gaps remain, with only a small proportion of systems meeting required safety and data-protection standards. Engagement with Care Groups has improved oversight, yet full assurance is not achievable until robust plans, compliance evidence and consistent governance are in place, meaning assurance remains partial at this stage.

What is this telling us?

The current risk score remains above the target (tolerable) risk score of High 8, representing a gap of 8 points. The gaps in control and assurance demonstrate that core elements of digital governance, safety assurance, compliance, infrastructure resilience, and workforce capability are not yet at a level required to effectively control the risk. Until these areas are addressed and evidence of sustained improvement is in place, the level of uncertainty—and therefore risk—remains higher than the target risk appetite allows.

The number of linked risks has increased from Q2; continuing with the third highest number of linked operational risks when compared to other strategic risks. The Trust faces significant operational risk associated with digital infrastructure fragility, cyber security vulnerabilities, data quality weaknesses, and fragmented clinical systems. These risks collectively threaten the confidentiality, integrity and availability of clinical information and digital services and present potential for patient safety impacts, delays in diagnosis or treatment, service disruption, and inability to meet national clinical and regulatory standards.

BAF 4: Inability to Deliver Digitally Enabled Care Transformation

Key Controls Framework

Care Group (n=14)	• Capital programme engagement to secure funds of replacement of out of support hardware and software and for additional investment to support clinical transformation • Clinical engagement through Chief Medical Information Officer (CMIO) and Chief Nurse Information Officer (CNIO) along with digital nurses, midwives, pharmacists and divisional CMIOs • Clinical safety officers in place and trained • Device lifecycle management business case approved allowing equipment >5 years old to be replaced • Digital Business Partners attending Care Group Boards • Digital operational groups (bi-monthly); ensuring digital initiatives align with national mandates and strategic goals • Digital Pathology Scanning Capacity expanded • Digital service continuity plans annually tested • Information Asset Register with assigned information asset owners • National guidelines regularly reviewed to identify any gaps in compliance • LIMS and Order Communications Results and reporting system implemented • Risk registers regularly reviewed and updated • Shadow IT register shared with Care Groups • Training programmes remain ongoing, tied to the rollout of new technologies and systems
Corporate (n=17)	• Artificial Intelligence team structure in place • AI Steering Group in place • Change Assurance Board reviews and approves the introduction or upgrade of digital systems, ensuring risks are assessed and mitigated before go-live. • Dedicated digital business change team to support local business change, system owners, and project managers • Digital and Data Security Protection Group monitors active management of IM&T risks via monthly Risk Register Reports • Digital accountability framework in place • Digital maturity assessments to enable the prioritisation of core capabilities • Digital services management print lease contract approved • Digital services support standards documented and sent to system owners • Digital policies in place • Freedom of Information improvement plan developed • Frontline digitalisation investment approved • Production and review of clinical safety case reports for new systems. • Regular benchmarking (e.g., KLAS, HIMSS, NHS Digital Maturity Assessment) and benefits realisation reporting • Regional Cyber Security Operations Centre live with over 450 servers reporting to the Security Information and Event Management System (SIEM) • Structured risk assessment workshops led by qualified Clinical Safety Officers, bring together system users, owners, and technical teams to proactively identify and mitigate hazards before and during new system implementation. • Scheduled audits of digital, cyber, and data protection controls
System (n=6)	• Active engagement in ICS-wide digital projects and shared care records • Data protection toolkit completed, and improvement plan agreed with NHS England • Digital Health Clinical Information Officer (CIO) Network member • EPR Business Case approved and submitted to region • Regional and national innovation networks contributions • West Midlands Imaging Network outline business case approved

Key Assurances Received - Quarter 1, 2 & 3

Assurance Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Changing the NHS Landscape								NR	
Cyber Assessment Framework Follow Up Internal Audit									
Cyber Security Assurance Report									

Assurance Rating Key

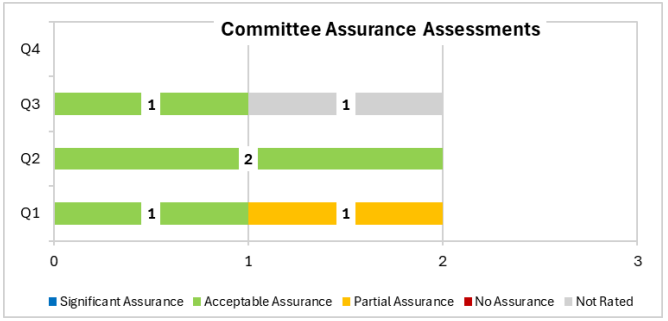
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

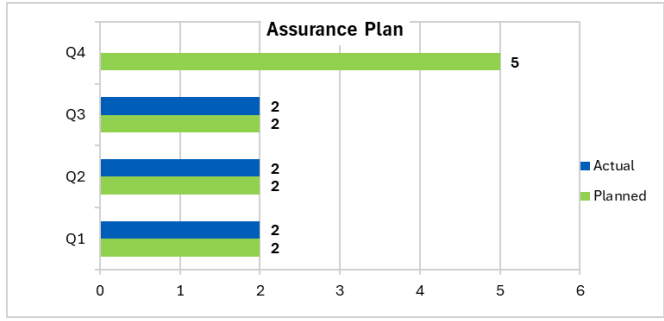
BAF 4: Inability to Deliver Digitally Enabled Care Transformation

Executive Assurance Assessment

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

Committee Assurance Assessment & Plan





Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=9)	• Digital solutions are not consistently integrated (action 3) • Digital skills training insufficient for the wider workforce (action 5) • Funding is limited and significantly less than the suggested 5% (action 10) • Incomplete or out of date Information Asset Ownership (action 13) • Nationally mandated standards not yet met (action 1) • Obsolete technology in use (action 2) • Review and upgrading of all 405 solutions not in place (action 4) • Shadow IT not operated in line with NHS standards (action 3) • Supply chain assessment for the procurement of services which are enabled by digital systems are not in place. (action 12)
Gaps in Assurance (n=4)	• Clinical Safety Assurance Reports not in place for all systems (action 6) • Benefits Realisation where the benefits sit outside of Digital Services (action 14) • Data Protection Impact Assessment (DPIAs) not in place for all systems (action 8) • Digital Technology Assessment Criteria (DTAC) not in place for all systems (action 7)

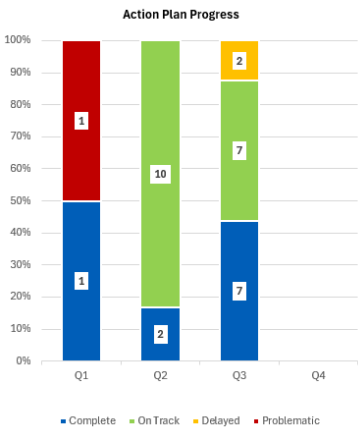
What is the data telling us?

The executive assurance rating assessment continues to be rated as partial although both items presented in Q3 were seen as planned, one of which received an acceptable assurance rating. Two additional gaps in control have been identified in quarter, with associated new actions identified and whilst one gap in assurance has been mitigated (AI governance) an additional gap has been identified.

Five actions have been completed in Q3, compared with the planned seven. The two actions which have been delayed have experienced delays primarily due to incomplete engagement and outstanding work within Care Groups. These dependencies on Care Group input have collectively slowed delivery and extended timescales.

Risk Management Action Plan

No	Action	Due Date	Progress Report	2025/26 Q1	Q2	Q3	Q4
1	Map current systems against NHS Digital and NHS England standards	01/12/2025	7 out 181 in scope systems have DCB0160 in place. 9 out of the 352 in scope systems have both DPIA and DTAC in place.	N/A			
2	Identify and risk assess obsolete hardware/software	01/01/2026	Requirement for replacement hardware has been included in the capital plan.	N/A			
3	Communications regarding the digital need process to reduce Shadow IT to be improved	~~30/10/2025~~ 31/03/2026	Communication to take place with Care Group Leads first then to the wider Trust. Meetings have been held with 2 out of 3 Care Groups to talk through the standards and process	N/A			
4	Systems supplier map for systems managed by IT and Care Groups to be undertaken, including contract end dates and timescales to migrate, to aid lifecycle management	~~01/01/2026~~ 31/03/2026	The system map of which systems are managed by Digital Services, and which are managed by Care Groups is complete and the Care Groups have their list of information assets. The register of contract end dates and migration timescales is 90% complete for Digital Services information assets. It has not started for Care Group information assets.	N/A			
5	Review modern training tools to enable enhanced training for the wider workforce	01/02/2026	Action not yet due	N/A			
6	Work with Care Groups on getting their solutions clinically safety assessed	31/03/2026	Action not yet due	N/A			
7	Mandate DTAC completion as part of system onboarding and annual review. Escalate non-compliant systems through digital governance committees for remediation or retirement	01/01/2026	Mandate now in place.	N/A			
8	Introduce new governance structure holding Care Groups to account for Shadow IT, which does not meet NHS digital standards	31/03/2026	Action not yet due	N/A			
9	AI oversight committee to be established to monitor deployments of all ID and obtain assurance on safety	01/12/2025	The AI Steering Group is now in place. Before any AI system is implemented (that we know about), we undertake a rigorous governance process for every system, and the policy document which covers this will be presented at the January meeting for final approval.	N/A			
10	Report on corporate services benchmarking to be considered by Executives, to consider the investment level in digital services	01/11/2025	Report considered by Executive Team.	N/A			
11	Establish a process for formal incident management process for digital clinical safety issues	31/03/2026	Action not yet due	N/A	N/A		
12	Work with Procurement colleagues on supply chain risk for service contracts.	01/04/2026	Action not yet due	N/A	N/A		
13	Mandate Annual Information Asset Register Review as part of the annual cycle of business	01/04/2026	Action not yet due	N/A	N/A		
14	As part of any business case to implement digital systems or processes ensure benefits have assigned benefit owners and build benefits realisation into project lifecycle.	01/05/2026	Action not yet due	N/A	N/A		



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

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

Risk Description

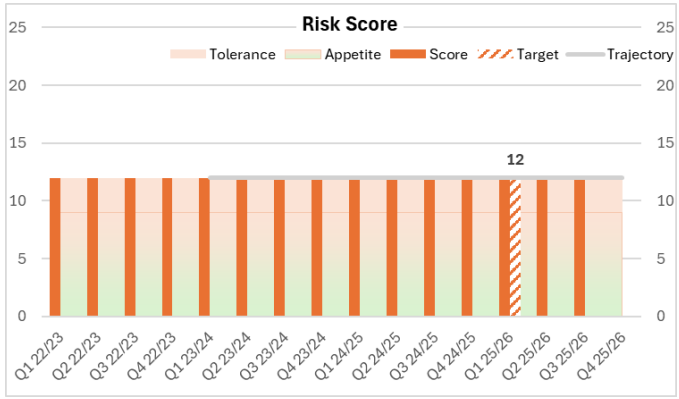
Cause:	If we are unable to secure sufficient investment to develop and modernise our estate infrastructure and workforce,
Event:	Then we may be unable to deliver high quality, responsive services in a safe, compliant, and sustainable environment,
Effect:	Resulting in non-compliance with national standards,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

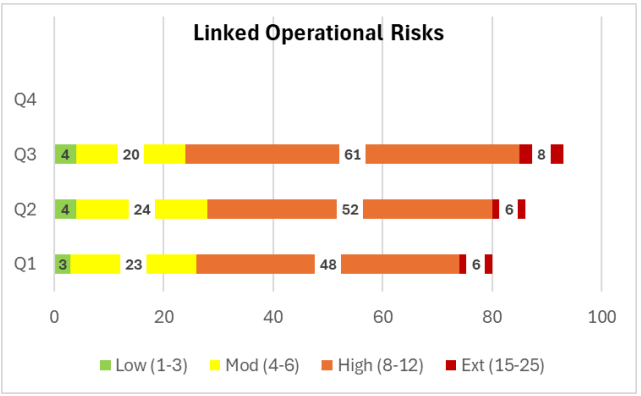
Potential to impact on Our Strategic Priorities

Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

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





Executive Overview – Rationale for Risk Score and Progress made in Quarter 3

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

The capital team continues to work closely with regional colleagues to secure additional backlog safety funding, with UHNM already benefiting from two allocations for 2025/26 and bids now being prepared for the 2026/27 round. Work is also underway on a climate-resilience paper outlining future capital and revenue requirements, and the estates team continues to face significant recruitment challenges for skilled craft staff despite repeated advertising. Progress is being made on implementing the Building Safety Act requirements for the acute PFI estate, with early schemes and design work now testing compliance processes and regulator response times.

What is this telling us?

The current risk score continues to be at target and within the tolerable risk score of High 12.

The number of linked risks has increased from Q2, with the fourth highest number of linked operational risks compared to other strategic risks. The operational risks collectively point to significant fragility in estate infrastructure, fire safety systems, digital resilience, clinical accommodation, and equipment reliability, all of which undermine safe, effective and efficient service delivery, impact patient and staff safety, and create substantial compliance and financial risks for the organisation.

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

Key Controls Framework

Care Group / Service (n=3)	• Estate condition: Planned Preventative Maintenance programme; competent Estates staff / Authorised persons; KPIs monitored through CEF / Environmental Audits, Maintenance Operational Board; Operational Policies, Service Specifications PFI, 6 Facet Survey • Fire Safety / Security Policies; Protocols, Guidelines; patrolling, CCTV, Risk Assessments in place • Sustainability / Net Zero Carbon (NZC): Sustainable Development Steering Group (biannual), Sustainability Working Groups (monthly), Nitrous Oxide Waste Reduction Group (to meet NHSE funding T&Cs), Public Sector Decarbonisation Scheme (PSDS) Group (to meet DESNZ funding T&Cs) Sustainability and NZC capital investment subgroup, NZC Trust Board Lead (Director EFP), Clinical NZC lead
Corporate (n=11)	• Capital team / programme in place and audited by External Audit annually • Capital refurbishment targeted as appropriate to address significant risk backlog, with risk assessments undertaken to inform management, maintenance, testing & inspection regime • Estate Condition - Capital bids against prioritised list of Estate 6 Facet Findings with subsequent approval via Capital Investment Group • Estate Strategy – Clinical & System Strategy and independent review used to inform content • Fire/Security: 'On the spot' fire improvement notices, Fire Safety KPIs & ad-hoc audits/inspections • Fire Safety and Security close working with local Police and visibility on site • Green Plan 2025/26-28/29 approved • Heat Network Optimisation Business Case • Low Carbon Care Framework approved and launched • Project STAR Business Case • Sustainability / NZC: Biannual Sustainability performance report to Finance and Business Performance Committee
System (n=6)	• Collaborative working with system partners on estate infrastructure and sustainability agenda, members of key working groups to drive transformation and efficiency in these areas • Jointly agreed interpretation of Building Safety Act between Trust and PFI partner and contractual agreement has been reached between UHNM and Project Co (PFI) • Liaison with NHS England and Department of Health PFU on PFI material issues • Participation in National Programme Strategic Supplier Relationship Management (SSRM) hosted by Cabinet Office & HM Treasury • Statutory maintenance programme – Maintenance Operational Board. • Sustainability / NZC: Work with external partners regarding zero-capital solutions, system-wide projects, grant funding applications, networking and best practice sharing, attendance at ICS and Midlands Greener Delivery Groups.

Key Assurances Received - Quarter 1, 2 & 3

Assurance Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Fire Safety Annual Report									
PLACE Inspection Findings and Action Plan									
Premises Assurance Model (PAM) and Estates Return Information Collection (ERIC) Annual Report									
Security Management Annual Report									
Sustainability Bi-Annual Report									

Assurance Rating Key

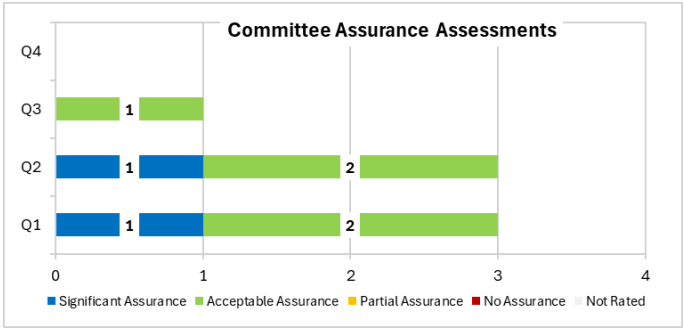
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

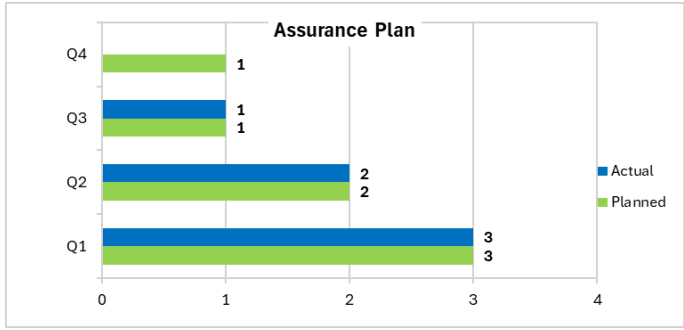
BAF 5: Inability to Deliver Investment in Estate Infrastructure & Workforce

Executive Assurance Assessment

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

Committee Assurance Assessment & Plan





Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=15)

- Maintenance backlog programme underfunded; this will see a continued rise in backlog figures over next 5-year plan (Retained Estates) (Action 1)
- Sustainability / NZC programme: whilst additional capital investment funding has been identified, it remains underfunded overall, which will result in missed opportunities in delivering revenue and carbon savings (Action 4)
- Clinical strategies gap, and lack of completed feasibilities to deliver agreed clinical plans and Royal Institute of British Architects (RIBA) stage 2 designs and budget costs to match emergency funding as this becomes available to bid for (Action 2)
- Expansion space for modulars at Royal Stoke not able to be expanded, rightsizing to drive development and refurbishment in the right place to ensure sustainable development control plan (DCP), with a phase delivery approach, 5–10-year DCP. (Action 2)
- National NHS framework suppliers limited, bidding for large amounts of NHS funded work, national procurement means one supplier can win multiple schemes and therefore drive resource issues, which can impact programme and cost. (Action 3)
- Sustainability / NZC completed feasibility studies are limited in number resulting in a risk of inability to utilise capital when it becomes available (Action 4)
- Existing NHS estate is designed to current NHS and Chartered Institute of Building Services Engineers (CIBSE) guidance which currently does not account for the constantly increasing summer hotter prolonged periods, and colder winter snaps. Real risk to estate infrastructure resilience (Action 8)
- Capital & revenue funding limited, to deliver identified carbon reduction schemes, required to meet nationally mandated targets (Action 1)
- Challenges with pay and the ability to recruit and retain our skilled workforce with private sector pay comparison to agenda for change (AFC) (Action 5)
- Ageing workforce with a risk of losing site knowledge onto future apprentices which can only be funded via current establishment budget (Action 5)
- Lack of ability to over recruit in areas of high turnover, resulting in bank and overtime whilst we recruit replacement substantive posts (Action 5)
- Lack of training budget within current funding to upskill workforce for evolving and more digital and technical infrastructure. Becoming more reliant of external contractors at premium costs (Action 5)
- Remedial works for PFI Latent Defects to be concluded (Action 6)
- Rightsizing work to inform Estate Strategy and Development Control Plan to be concluded (Action 2)
- Supply Chain Partners – small number of suppliers operating across many hospital Trusts impacting on supplier resilience, flexibility and confidence in programme and cost model delivery. Significant schemes underway in year include CDC, Elective Hub, UTCs and Breast Care (Action 3)

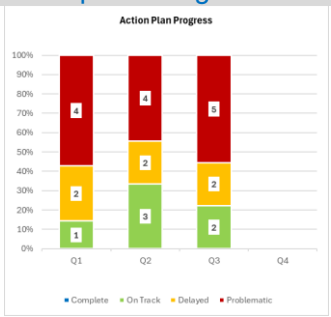
Gaps in Assurance (n=1)

- Estates Strategic Plan produced and to be considered, alongside other Strategic Plans at Finance and Business Performance Committee (Action 2)

What is the data telling us?

The executive assurance assessment continues to be rated as acceptable assurance and the one source of assurance was presented in Q3 as planned and an acceptable rating. The number of gaps in control and assurance remain the same as at Q2.

No actions have been completed in Q3 compared the planned two. Overall delivery is being slowed by structural capital funding constraints, new regulatory requirements under the Building Safety Act that significantly extend project timelines, and dependencies on external partners such as NHSE frameworks and PFI arrangements. Together, these factors limit the Trust's ability to accelerate estates and capital programmes, resulting in unavoidable delays across multiple strategic actions.



Risk Management Action Plan

No	Action	Due Date	Progress Report	2025/26 Q1	Q2	Q3	Q4
1	Capital funding	~~28/06/2024~~ ~~31/12/2024~~ ~~31/03/2025~~ ~~30/06/2025~~ 30/06/2029	Carry forward from Q1 2024/25. Capital Team continue to work with Finance and NHSE teams to provide backlog data and identify sources of funding. Previous rounds of NHSE Estates Safety Risk allocation have seen successful additional allocation to address immediate high and significant risk Estates backlog. Backlog remains high with annual allocations below the growth of medium to high-risk Estates services at RSUH and County sites, which poses risks to service continuity.				
2	Estates strategic plan	~~30/06/2025~~ ~~30/12/2025~~ 02/02/2026	Refreshed and incorporated, alongside other Strategic Plans, for consideration at Finance and Business Performance Committee on 02/02/26. Our Estate Strategy is in final stages of production and will be presented to FBPC in once complete. But will still be outstanding the rightsizing outputs for the overall DCP.				
3	Supply chain partners	~~31/03/2025~~ 30/06/2026	Capital team continue to work with NHSE regarding major project building contracts in line with NHSE framework agreements. Monthly monitoring of contractor quality and performance, to inform NHSE, is carried out by Capital team. Major projects for 25/26; New Breast Care building at County, UTC at RSUH, CDC at Hanley.				
4	Sustainability/net zero carbon	~~31/03/2025~~ ~~31/07/2025~~ ~~30/01/2026~~ 31/03/2026	Due diligence on the connectivity of RSUH to the proposed SoT District Energy Network (DEN) is underway. Business case expected completion: April 2026. Proposal to expand the community energy scheme Keep Warm, Keep Well. Expected completion: Dec 25. A multi-scheme feasibility study is proposed for sustainability schemes that could be delivered 26/27 and 28/29. This will mitigate the risk of being unable to apply for capital grant funding opportunities and improve preparedness for the increased capital allocation internally. Expected completion: April 2026				
5	Workforce	~~27/12/2024~~ ~~31/01/2025~~ ~~30/07/2025~~ 30/03/2026	Continue to review building and engineering agenda for change pay rates vs that of the private sector and Estates recruitment and retention business case. Ongoing work with recruitment to ensure shortest timeline for recruitment and developing further training opportunities within current establishment, via learning and education plan, to provide succession planning within technical areas. Two new engineering apprentice positions successfully recruited to and are now in post.				
6	PFI partners / lender issues	~~30/08/2024~~ ~~31/03/2025~~ ~~31/07/2025~~ 30/03/2026	Supplemental Agreement for N&C Variation formally concluded. Remedial works for PFI Latent Defect Issues on-going, delays partially linked to Building safety act challenges.				
7	Building safety act	~~31/10/2025~~ 31/03/2026	Contractual agreement has now been reached with Project Co on how Trust-funded changes will be delivered within the Royal Stoke PFI high-risk buildings under the Building Safety Act, with UHNM now acting as the "Client" and the Capital Team required to complete all design-stage duties before construction can proceed. While good progress has been made in establishing this new process, compliance with the Building Safety Regulator's statutory timelines means major projects will take significantly longer—typically spanning multiple financial years—before approval, construction and occupation can be completed.				
8	Review impact of climate change	31/03/2026	A review is underway to on how to mitigate the impact of a changing climate and the risk that this poses to the UHNM estate (clinical and non-clinical) and its infrastructure. This will guide infrastructure decision making and outline indicative costs.	N/A			
9	To include quarterly updates on the Estates Strategy to the FBP	31/03/2026	Presented to the Trust Board in November 2025, following which quarterly progress updates will be scheduled on the FBP business cycle	N/A			

BAF 6: Inability to Deliver In-Year Financial Position

Finance and Business Performance Committee | Chief Finance Officer

Risk Description

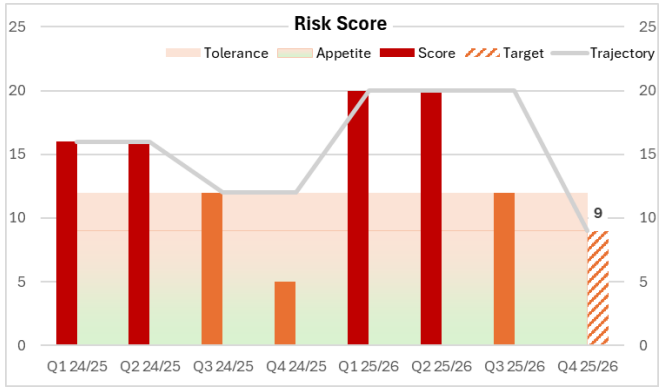
Cause:	If we, or system partners, are unable to manage within the financial assumptions underpinning the 2025/26 revenue plan,
Event:	Then we may be unable to deliver our agreed financial position for 2025/26,
Effect:	resulting in an increased level of external scrutiny and potential regulatory intervention,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

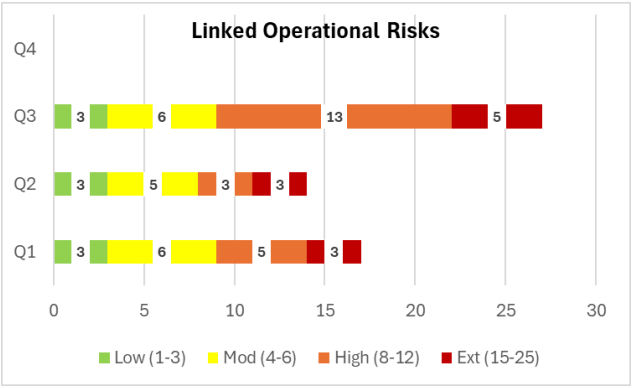
Potential to impact on Our Strategic Priorities

Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

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





What is the data telling us?

The current risk score has reduced towards the target (tolerable) risk score of High 9 and is now within the tolerance level of 10 – 12. The level of risk appetite has been set on cautious based on the risk relating to financial management.

The number of linked risks has increased compared to Q2. The main themes in relation to these operational risks reflect pressures across workforce planning, financial sustainability, procurement and contracting controls, income recovery, elective capacity, and services reliant on external funding. Core vulnerabilities include gaps in workforce capability, significant CIP and cost pressures, weaknesses in procurement and stock management, risks to charging processes, constraints on elective activity, and reduced charitable funding impacting specialist services. Collectively, these risks pose potential impacts on patient safety, service quality, financial performance, and organisational resilience.

Executive Overview – Rationale for Risk Score and Progress made in Quarter 3

The risk score for Q3 has reduced to High 12, in addition the trajectory for Q4 and target score has decreased. This is due to a reduction to the unmitigated risk and receiving support from system partners whereby the potential route to breakeven has been identified – as such the assurance assessment has also improved to 'acceptable'.

In addition, the gap in control regarding potential under delivery of elective work has been resolved, due to the funding which has been agreed by commissioners. Of the £10m deficit position, £4m remains at risk as at 30/12/25. The outstanding risk continues to be the impact of winter escalation areas remaining open, over and above the funded budget.

BAF 6: Inability to Deliver In-Year Financial Position

Key Controls Framework

Care Group (n=5)	• CIP meetings held, chaired by Chief Operating Officer • Executive Team approving and monitoring spend against Elective Recovery Fund • Performance Management meetings in place with the Care Groups with financial performance included as a driver metric. Additional executive focus through Executive Recovery Oversight Group • Recovery plans being prepared by the services for underperforming areas on elective activity and financial forecast • Standing Financial Instructions (SFIs), scheme of delegation and approval structure for any additional expenditure in place
Corporate (n=10)	• Audit Committee oversight of system of internal control such as SFI breaches, write offs etc • Enhanced workforce controls for nursing and medical staffing including increased understanding of banks staffing spend • Executive Recovery Oversight Group in place • Finance report to Finance and Business Performance Committee (FBP) with associated scrutiny; enhanced to include run rate performance and impact of activity levels of income recovery • Forecast undertaken monthly to identify best, likely and worst-case ranges reported through FBP • Future investments guidance issued to the Care Groups in that only investment requests where significant patient safety risks are involved will be considered and any additional investments will now need to go through the double lock • Non-recurrent mitigations well understood but constantly assessed and quantified • Reset of the bed model and final allocation of system capacity funding undertaken • Strategy Delivery Unit in place • Vacancy and workforce controls enhanced
System (n=5)	• External auditor review of reported financial position • Internal audit programme to be utilised depending on changing risks in financial plan • PWC assessment of Grip and Control measures • System Recovery Programme • Varying the pace of investment to provide additional mitigation

Key Assurances Received - Quarter 1, 2 & 3

Assurance Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Annual Accounts									
Audit Findings Report and Letter of Representation									
Audited Accounts and Financial Statements and Analytical Review			NR						
Business Case Review Schedule									
Changing the NHS Landscape								NR	
Cost Improvement Report									
Demand and Activity Performance Report		NR	☒	☒	☒	NR	NR	NR	NR
Draft Financial Outlook									
Failure to Prevent Fraud - Gap Analysis							NR		
Finance Report	M12	M1	M2	M3	M4	M5	M6	M7	M8
Grip and Control: Medical Staff and Nursing Bank and Agency Controls Internal Audit									
Losses and Special Payments and Stock Write Offs									
Medicines Finance, Procurement and Supplies Report									
Overseas Patients Activity				☒					
Overseas Visitors / Private Patient Policy Audit									
Procurement Report									
Productivity Deep Dive								NR	
Productivity Performance Report									
SFI Breaches relating to Procurement processes and Single Tender Waivers									
SFI Breaches relating to Salary Overpayments									

Assurance Rating Key

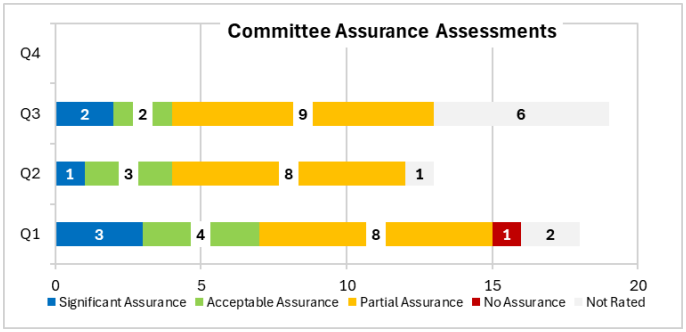
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

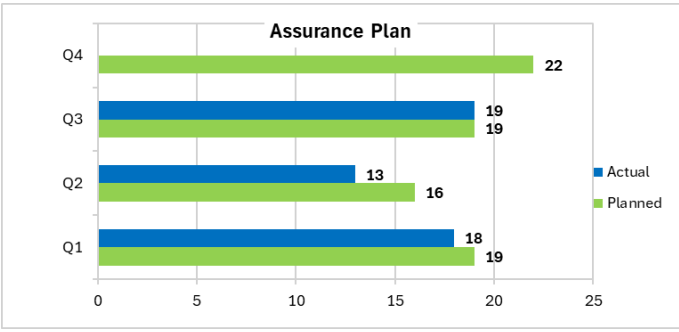
BAF 6: Inability to Deliver In-Year Financial Position

Executive Assurance Assessment

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

Committee Assurance Assessment & Plan





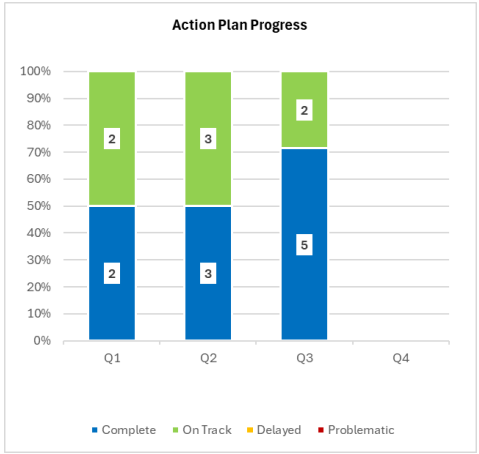
Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=2)	• Recurrent CIP versus non-recurrent (Action 1) • Risk of winter and ability to remain within the winter funding envelope (action 4)
Gaps in Assurance (n=1)	• Some CIP schemes to be worked up in detail (Action 1)

What is the data telling us?

The executive assurance assessment continues to be rated has improved to acceptable assurance given the actions taken in Q2 and impact on reducing the risk score. All sources of assurance was presented in Q3 as planned, with 4 having received positive ratings, and the majority being rated as partial assurance. Two gaps in control and one gap in assurance have been mitigated, with an additional gap in control identified, alongside an associated new action.

Two actions have been completed in Q3, with no delays identified.



Risk Management Action Plan

No	Action	Due Date	Progress Report	2025/26 Q1	Q2	Q3	Q4
1	Identification and delivery of recurrent CIP	31/03/2026	Ongoing reports provided to FBP detailing progress and delivery. Outcome of recalibration exercise reported in October 2025.				
2	Ensure delivery of elective targets	31/03/2026	Complete. Elective recovery programme submitted to NHSE as part of undertakings and funding now agreed therefore no further action required for 2025/26.				
3	Deep dives to take place to understand increase in bank spend	31/12/2025	Complete. Continued work undertaken with the ICB and enhanced controls now in place	N/A			
4	Review of winter escalation areas to be undertaken	30/06/2026	Action not yet due.	N/A	N/A		

BAF 7: Inability to Deliver Financial Sustainability

Finance and Business Performance Committee | Chief Finance Officer

Risk Description

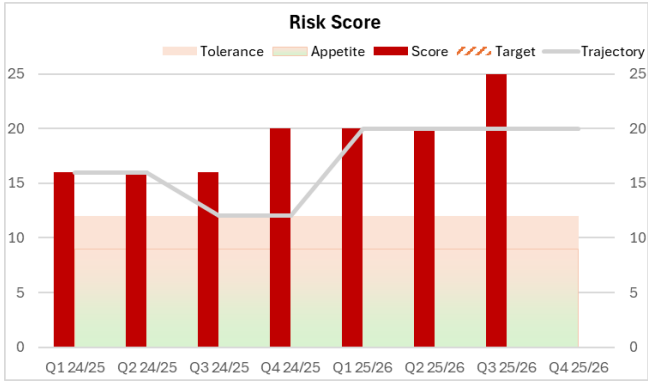
Cause:	If we are unable to manage within the assumptions made within the financial plan for 2025/26,
Event:	Then we will not reach a break-even position within the required timescales (currently 3 years),
Effect:	resulting in reduced availability of funding for essential investments, an increased level of external scrutiny (level 5) and potential regulatory intervention, loss of autonomy over financial and strategic investment decision making within the Trust, breach of statutory financial duties, adverse impact on the Trust's ability to deliver sustainable and high-quality care.

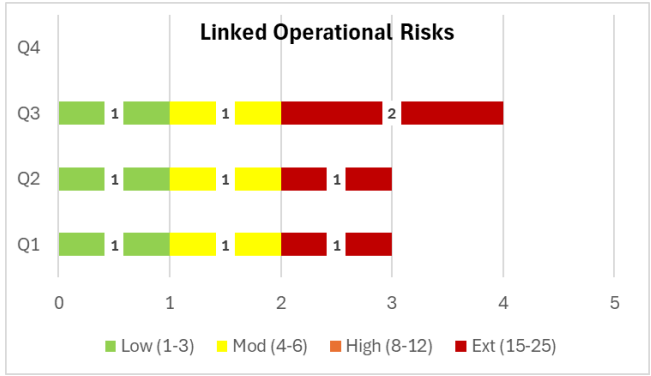
Potential to impact on Our Strategic Priorities

Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

	Q1	Q2	Q3	Q4	Target		Risk Appetite
Likelihood	4	4	5	4	3	31/03/2027	Cautious 1 – 9
Consequence	5	5	5	5	4		Risk Tolerance
Risk Score	20	20	25	20	12		High 10 - 12





What is the data telling us?

The current risk score remains above the target (tolerable) score with a gap of 13 points, relating to the ability identify sufficient recurrent cost improvement savings.

The number of linked risks has slightly increased in Q3, with the third lowest across all strategic risks. The main themes in relation to the linked operational risks relate to significant pressures across workforce capacity, CIP delivery, and elective service throughput. Failures in strategic workforce planning, combined with substantial CIP delivery challenges, present material risks to financial sustainability and constrain the Trust's ability to invest in quality and safety improvements. Additionally, capacity limitations threaten elective recovery trajectories and income generation. Collectively, these risks indicate cross-cutting impacts on patient safety, service resilience, financial performance, and long-term strategic delivery.

Executive Overview – Rationale for Risk Score and Progress made in Quarter 3

The risk score for Q3 has increased based upon remaining gap in CIP as identified by initial work undertaken on the medium-term plan. The main risks for sustainability relate unbundling the non elective block and identification and delivery of recurrent CIP. It is anticipated that the score for Q4 will reduce, although it is anticipated that this will not reduce to the initial trajectory of 16, given the ongoing work being undertaken on the medium-term plan, and the associated timelines to agree the associated financial trajectory with NHSE. Further work remains ongoing in terms of finalising the contract including associated assumptions in relation to activity and demand.

Workstreams have been identified by Deloitte which are being worked up. This includes strengthening financial governance including weekly delivery meetings and changing the role of the Executive Recovery Oversight Group (EROG).

BAF 7: Inability to Deliver Financial Sustainability

Key Controls Framework

Care Group (n=4)	• Care Group attendance monthly Financial Recovery Group • Executive Team approval of additional investment up to £250,000 • Performance Management meetings in place with the Care Groups with financial performance included as a driver metric. • Standing Financial Instructions and scheme of delegation
Corporate (n=5)	• Deloitte working with the Trust on identifying specific workstreams for improvement including a revision to the financial governance process • Executive Financial Recovery Group established to give oversight of CIP delivery both corporate schemes and Care Group targets. • Finance report in place to Finance and Business Performance Committee with associated scrutiny; enhanced to include run rate performance and impact of activity levels of income recovery. • Future investments guidance issued to the Care Groups in that only investment requests where significant patient safety risks are involved will be considered and any additional investments will now need to go through the double lock • Reset of the bed model and final allocation of system capacity funding undertaken
System (n=2)	• External audit programme in place • Internal audit programme adjusted to reflect changing risks in financial plan

Key Assurances Received - Quarter 1, 2 & 3

Assurance Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec
Annual Accounts									
Audit Findings Report and Letter of Representation									
Audited Accounts and Financial Statements and Analytical Review			NR						
Business Case Review Schedule									
Changing the NHS Landscape								NR	
Cost Improvement Report									
Demand and Activity Performance Report		NR	☒	☒	☒	NR	NR	NR	NR
Draft Financial Outlook									
Failure to Prevent Fraud - Gap Analysis							NR		
Finance Report	M12	M1	M2	M3	M4	M5	M6	M7	M8
Grip and Control: Medical Staff and Nursing Bank and Agency Controls Internal Audit									
Medicines Finance, Procurement and Supplies Report									
Overseas Patients Activity				☒					
Overseas Visitors / Private Patient Policy Audit									
Procurement Report									
Productivity Deep Dive								NR	
Productivity Performance Report									

Assurance Rating Key

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

BAF 7: Inability to Deliver Financial Sustainability

Executive Assurance Assessment

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

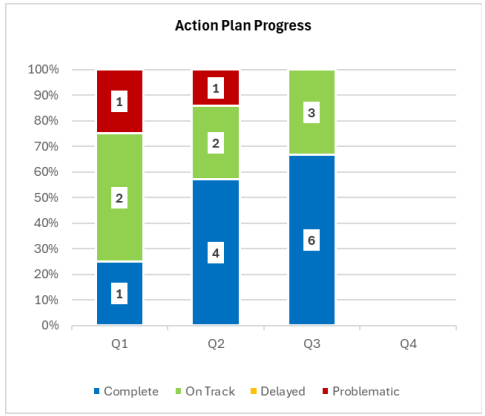
Gaps to be Addressed and Links to Action Plan

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

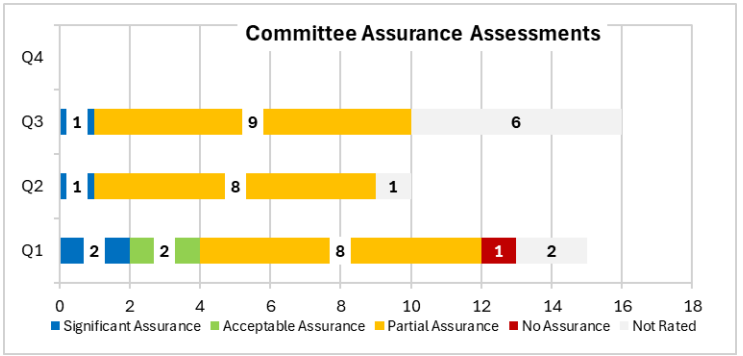
What is this data telling us?

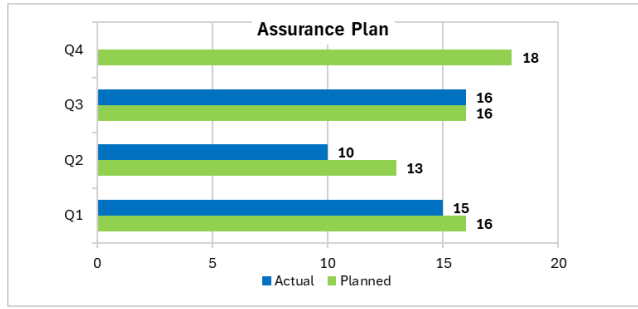
The executive assurance assessment continues to be rated as partial assurance, with the majority of committee assurance having the same rating. All sources of assurance were presented in quarter as planned with the same number of gaps in control and assurance as at Q2.

Two actions have been completed in Q3 in addition to two new actions having been identified, with no delays identified.



Committee Assurance Assessment & Plan





Risk Management Action Plan

No	Action	Due Date	Progress Update	2025/26 Q1	Q2	Q3	Q4
1	Identification and delivery of recurrent CIP	31/03/2026	Although similar action for 2024/25 - reset for 2025/26. Ongoing reports provided to FBP detailing progress and delivery.				
2	Ensure delivery of elective targets	31/03/2026	Complete. Elective recovery programme submitted to NHSE as part of undertakings – funding agreed for 2025/26				
3	Tough decisions	~~31/01/2025~~ ~~31/05/2025~~ 31/12/2025	Complete. Options previously identified have been reviewed.				
4	To continue to work on the medium-term plan submission, including agreeing the associated contractual position	01/04/2026	Action not yet due.	N/A	N/A		
5	Work required on the long-term plan and the left shift, in order to reduce the cost base sustainably	2026/27	Action not yet due.	N/A	N/A		

BAF 8: Inability to Sustain Research and Innovation Excellence

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

Risk Description

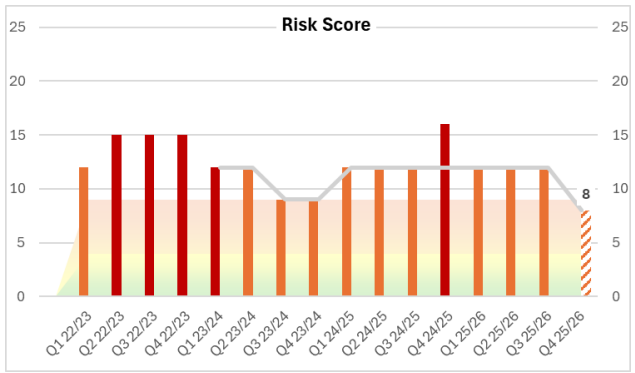
Cause:	If we are unable to deliver a comprehensive, ambitious and financially sustainable programme of research and innovation, and a culture that supports both,
Event:	Then our ability to provide high-quality, cutting-edge care will be compromised,
Effect:	resulting in a diminished reputation as a leading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

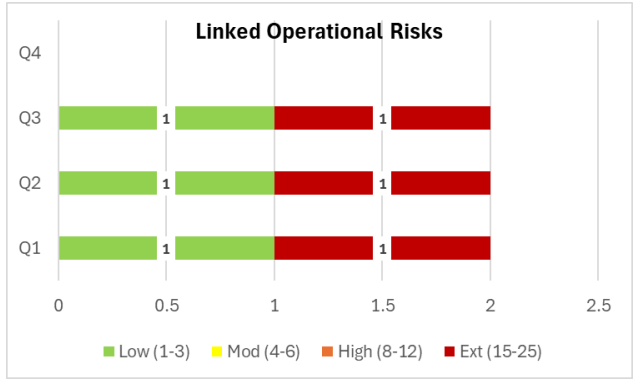
Potential to impact on Our Strategic Priorities

Potential to be impacted by our Primary Issues

Risk Scoring and Trajectory

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





What is the data telling us?

The current risk score remains within the risk appetite score of 1 – 12.

The number of linked risks has remained the same as Q2, with the second lowest number of operational linked risks across all strategic risks. These risks relate to MHRA regulatory requirements and workforce sustainability.

Executive Overview – Rationale for Risk Score and Progress made in Quarter 3

During Q3, agreement was reached to reconvene the Executive Research & Innovation Group, addressing a key assurance gap from previous BAF updates. The first meeting will take place in Q4, after which the risk score will be reviewed.

The UHNM Innovation Manager has now been appointed substantively, and the Executive Team has approved the substantive establishment of CeNREE fixed-term posts from 1 March and 1 April 2026 to maintain support for research growth in under-represented professions.

Participant recruitment remains lower than comparable trusts due to limited delivery team capacity, resulting in reduced RRDN funding for 2026/27. Capacity pressures in support services, which are not protected for research, are also delaying study approvals and setup, preventing consistent achievement of the Government's 150-day target and potentially affecting future funding.

BAF 8: Inability to Sustain Research and Innovation Excellence

Key Controls Framework

Care Group (n=5)	• Clinical Research Matron in post • CRDC rooms released to R&I so that they can now be furnished and opened as the CRDC • Research Operations and Leadership Meeting within the R&I department to coordinate and support operational activities. • Recruitment monitoring and forecasting are being utilised within the R&I department to align with growth-oriented strategic objectives, with forecasts contributing to feasibility assessments. • UHNM Innovation Manager recruited to on a substantive basis
Corporate (n=7)	• Clinical Education Centre to provide a dedicated base for a range of research, education, learning and development teams to come together supported by the Executive Team • Interim Chair appointed to the Research Strategy and Innovation Strategy Delivery Oversight Group • Patient, Public Involvement and Engagement Lead appointed • Research Strategy Delivery Oversight Forum terms of reference being updated to reflect Strategic Delivery Plans and ensure appropriate arrangements in place to provide oversight of delivery • Strategic Delivery Plans for Research and Innovation codesigned through Research Strategy Delivery Oversight Forum • Strategic Delivery Plans for Research and Innovation endorsed through Board Development Session 12th November 2025 (along with all other SDPs) • Widening out the R&I Directorate staff recruitment for delivery beyond nursing to include midwives, AHP's and other research active professions (e.g. recent appointment of Physician Associate as Band 7 lead research practitioner)
System (n=7)	• Active programme to improve relationships with both Keele University and University of Staffordshire at organisational level – this will include research agenda – Strategic Partnership Agreements now in place with both Universities • Active participation in the Communities of Practice for the National Contract Value Review • Closer working with MPFT – Work force training & recruitment • Keele and UHNM have agreed revised process for medical joint appointments between the two organisations • National strategies from the Chief Nurse Office for England, the Chief Midwifery Office for England and the Chief Allied Health Professional Office for England, which will support implementation of CeNREE priorities. • UHNM is a part of SSHERPa, contributing to the ICS research agenda – SSHERPa expanding remit to include Innovation • UHNM is a member of the West Midlands R&D Research Forum.

Key Assurances Received - Quarter 1, 2 & 3

Assurance Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec
CeNREE Update								☒	

Assurance Rating Key

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

BAF 8: Inability to Sustain Research and Innovation Excellence

Executive Assurance Assessment

Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
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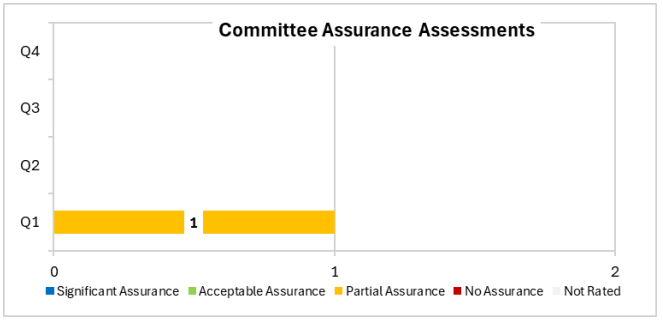
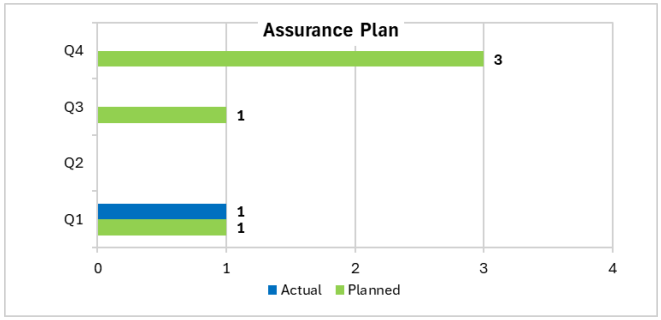
Committee Assurance Assessment & Plan





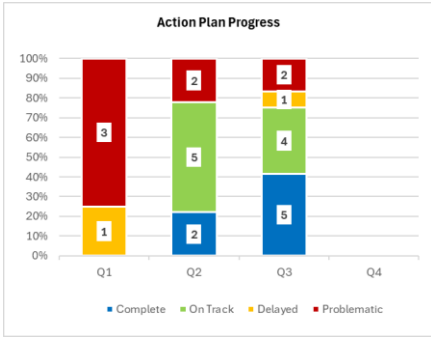
Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=4)	• No key performance indicators for reporting research engagement/risk at Executive level e.g. number of joint appointments and number of research active staff (Action 3) • Mandatory GCP training for Principal/Chief Investigators (Action 5) • No dedicated Research Facility as seen within comparator regional Trusts (Action 6) • Insufficient pool of Principal Investigators across professions and specialties to support rapid growth of incoming studies via CRDC (action 8)
Gaps in Assurance (n=2)	• Lack of reporting from research and innovation KPIs into Exec level Committees (Action 3) • The current governance arrangements require strengthening to ensure there is sufficient visibility on the breadth of research and innovation activity and associated risks and responsibilities (Action 7)

What is this data telling us?

The executive assurance assessment continues to be rated as partial assurance and work remains ongoing to increase the number of assurances received by Committees in relation to this risk, as the one source of assurance planned for Q3 was not seen and has been rescheduled. Whilst one gap in control has been mitigated, an additional gap has been identified, with a new associated action. In addition, a gap in assurance has been mitigated in Q2.

Three new actions have been identified in Q3 and three actions have been completed compared the planned five action. The reasons for delay relate to finalisation of the Care Group structure, alongside the requirement for the Research Governance Manager to implement and communicate revised national GCP training guidance ahead of the extended compliance deadline.



Risk Management Action Plan

No	Action	Due Date	Progress Update	2025/26 Q1	Q2	Q3	Q4
1	Research to form part of Care Group Board Agendas	~~30/09/2024~~ ~~31/03/2025~~ ~~30/09/2025~~ ~~31/12/2025~~ 30/06/2026	Care Group structure finalised. Care group research leads to be approved before advertising.				
2	Commissioning an external specialist to review QMS prior to MHRA inspection	~~30/09/2024~~ ~~31/12/2024~~ ~~30/06/2025~~ ~~31/12/2025~~ 30/01/2026	External Specialist commissioned 01.12.2025, MHRA inspection taking place 8th & 9th January				
3	Agree KPIs for research reporting that best inform the Exec team on status/risks and responsibilities	31/12/2025	Exec R&I group to be reconvened with first meeting to be held in Q4 2025/26.	N/A			
4	Paper to be presented to the Executive Team regarding future investment in CeNREE resourcing	31/03/2026	Complete. Paper presented December 2025, substantive posts agreed and interviews to be held.	N/A			
5	To act on the guidance from NIHR and MHRA regarding the Mandatory GCP training	~~31/12/2025~~ 28/04/2026	Research Governance Manager to facilitate and communicate the new training, before the revised deadline of 28.04.2026	N/A			
6	NIHR application to be submitted regarding dedicated Research Facility	31/03/2028	CRF status, Estate space required to be released to R&I, NIHR application to be submitted 2027/28	N/A			
7	To enhance reporting regarding research and innovation into Committees	31/12/2025	Exec R&I group to be reconvened with first meeting to be held in Q4 2025/26.	N/A			
8	Delivery team practitioners to be recruited	31/01/2026	Vacancy panel required to expedite approval of R&I vacancies, where they are externally funded for posts. Exec R&I group will support with communicating vacancy need.	N/A	N/A		
9	Research Funding Opportunity – NIHR Regional Research hub	31/01/2026	Research Imaging Lead band 8b, to support Research Set up across the North Midlands Research Governance Lead band 8b to support multilocation collaborations for commercial research delivery.	N/A	N/A		
10	Increase pool of Pis/Cis	31/12/2026	Care Group Research Lead posts to be approved and appointed. RRDN Strategic Funding bid to be submitted for 3xBand 8a Research Development Leads (non-medical professions) to support research capacity and capability growth and enable increase to PI/CI pool	N/A	N/A		

Risk Appetite Framework

Appendix 1

Risk Types

Clinical Risk

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

Operational Risk

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

Workforce Risk

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

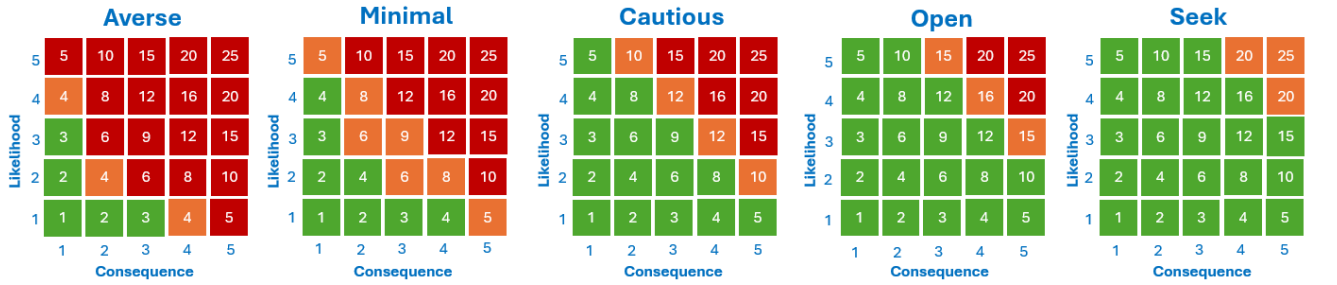
Financial Risk

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

External Risk

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

Risk Appetite and Tolerance Levels



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

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

Appendix 2 - Linked Risks

ID	BAF Link	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group
34791	1, 4	16/11/2024	Careflow Product Reliability and Availability	25	25	**25**		10	Central Functions Division
33427	1	19/08/2024	Non Medical Referring - Protocols	20	20	**20**		6	(CSS) Clinical Support Services
34083	1	18/10/2024	County ED boarding patients overnight	12	20	**20**		1	(UPC) Urgent and Acute Care
37397	3	20/08/2025	Management of Sexual Safety Cases	N/A	20	**20**		10	Central Functions Division
38509	5	22/10/2025	Lack of Suitable Office Accommodation for 4 x General Medicine Consultants	N/A	N/A	**20**		4	(UPC) Medicine
21481	1, 3	28/06/2021	Reduced Breast service (Imaging), due to vacancy within Breast Radiologist workforce.	16	20	**20**		4	(CSS) Clinical Support Services
26921	1, 3	20/01/2023	Radiology Reporting Backlog - MSK	8	16	**20**		4	(CSS) Clinical Support Services
32545	1, 3	30/05/2024	Demand on our People Operations services is greater than our resource capacity.	20	20	**20**		9	Central Functions Division
34113	1, 3	23/10/2024	Quality, Safety and Compliance Resource - Imaging	12	20	**20**		4	(CSS) Clinical Support Services
34608	1, 3	01/12/2024	Trauma Floor 1:1 nursing assistant cost pressure	20	20	**20**		3	(PC) Specialised Surgery
35614	1, 3	06/03/2025	patient pathways affected by lack of non medical referrer oversight and governance	20	20	**20**		4	(CSS) Clinical Support Services
9036	1, 4	25/10/2017	Vulnerability to Cyber Attack	15	15	**20**		12	Central Functions Division
34619	1, 4	02/12/2024	Shadow IT and lack of system maintenance	20	20	**20**		5	Central Functions Division
32463	1, 6, 7	16/05/2024	Risk of not achieving £8.5 million contribution to County Elective Hub	N/A	N/A	**20**		9	(PC) Specialised Surgery
21697	6, 7	07/07/2021	Shortfall against 25/26 CIP Plans - high risk £49.2 and medium risk £7.1m	20	20	**20**		8	Central Functions Division
17873	1	16/07/2020	Inability to Off-load Patients from Ambulances (both sites)	16	16	**16**		4	(UPC) Urgent and Acute Care
20448	1	17/03/2021	Patient LOS above 48 hrs on AMU - against Internal Standards	16	16	**16**		4	(UPC) Urgent and Acute Care
24028	1	06/04/2022	Emergency Department Performance Standards not being achieved	16	16	**16**		6	(UPC) Urgent and Acute Care
25469	1	04/08/2022	Delivery of constitutional cancer quality standards	16	16	**16**		4	Surgical Division
25471	1	04/08/2022	Follow Up Delays	16	16	**16**		4	Surgical Division
26832	1	12/01/2023	Your Next Patient (Holding Areas Queues) Acute Medicine	16	16	**16**		4	(UPC) Urgent and Acute Care
26887	1	18/01/2023	Ineffective Clinical Effectiveness Provision	16	16	**16**		6	Central Functions Division
27156	1	07/02/2023	EMR/ESD Service - Lack of Operational Policy	16	16	**16**		6	(PC) Surgery

Appendix 2 - Linked Risks

ID	BAF Link	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group
30149	1	23/10/2023	AAA Time to Surgery	16	16	16		4	(PC) Surgery
31958	1	08/04/2024	MCHT Beckman Track & Stock yard (storage module)	16	16	16		6	NMCPS
32034	1	12/04/2024	AAA Mobile Ultrasound Machines Renewal	12	16	16		6	(PC) Surgery
32464	1	20/05/2024	Incorrect use of bedrails	16	16	16		6	Central Functions Division
32807	1	19/06/2024	Head and Neck Cancer Delivery	16	16	16		4	(PC) Surgery
33959	1	07/10/2024	Colorectal Cancer Position	16	16	16		2	(PC) Surgery
34051	1	16/10/2024	Neurology Follow Up Backlogs	9	12	16		8	(UPC) Specialised Medicine
36050	1	14/04/2025	Challenges with Trust PGD sign off procedures	20	16	16		2	(CSS) Clinical Support Services
38670	1	16/12/2025	Urology Cancer Position	N/A	N/A	16		2	(PC) Surgery
28595	4	01/06/2023	COIN Network	12	12	16		4	Central Functions Division
34158	4	18/10/2024	Admin Account Authorisation	16	16	16		4	Central Functions Division
34277	4	06/11/2024	Need viable solution for redaction software for SARs and suitable available resource to act as data handlers	16	16	16		6	Central Functions Division
37929	4	09/10/2025	Lack of ECG uploads to iportal	N/A	N/A	16		4	Central Functions Division
35798	5	25/03/2025	Doors at STS	16	16	16		4	(PC) Surgical Support Services
36591	5	21/05/2025	Fire Risk Royal Stoke Emergency Department due to Beds/Trolleys in corridors and circulation spaces	N/A	N/A	16		4	(UPC) Urgent and Acute Care
36963	5	04/07/2025	Weak Microsoft Authentication protocols many systems	N/A	16	16		4	Central Functions Division
37171	5	23/07/2025	China state-backed APT threats (HSA CareCert CC 4683)	N/A	16	16		4	Central Functions Division
22641	6	15/11/2021	Blood Sciences Managed Service Contract tender	16	20	16		4	NMCPS
30986	8	11/01/2024	Centre for Research and Education Excellence (CeNREE) sustainability	16	16	16		6	Central Functions Division
10381	1, 3	27/04/2018	Medical Staffing - Haematology	16	16	16		9	(UPC) Specialised Medicine
18842	1, 3	05/10/2020	Gaps within the Junior Medical Rota	16	16	16		6	(CSS) Women and Children's
24818	1, 3	13/06/2022	RSUH/CH Biochemistry Staffing and Shift Cover	12	16	16		6	NMCPS
26995	1, 3	20/01/2023	Radiology Reporting Backlog - Body Radiology	12	16	16		4	(CSS) Clinical Support Services
26997	1, 3	20/01/2023	Radiology Reporting Backlog - Neuro Radiology	12	16	16		4	(CSS) Clinical Support Services
29712	1, 3	14/09/2023	Consultant and Scientist Shortages in Neurophysiology	12	12	16		4	(UPC) Specialised Medicine
32149	1, 3	24/04/2024	MNG Consultant workforce recruitment	16	16	16		8	(CSS) Women and Children's

Appendix 2 - Linked Risks

ID	BAF Link	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group
32806	1, 3	19/06/2024	Deficit in Neonatal AHP's provision for Speech & Language Therapy and Occupational Therapist support within NICU at UHNM	6	16	16		16	(CSS) Women and Children's
33426	1, 3	19/08/2024	Non Medical Referring - Management Resource	16	16	16		6	(CSS) Clinical Support Services
33720	1, 3	16/09/2024	AEC Nursing Workforce	16	16	16		4	(UPC) Urgent and Acute Care
34138	1, 3	24/10/2024	Workforce Information team's resource / capacity is significantly less than the current and growing demands on the service	16	16	16		8	Central Functions Division
34826	1, 3	13/12/2024	Child Health Rota remains a 1:7- The Tier 2 resident doctor cover does not meet service need.	16	16	16		4	(CSS) Women and Children's
35094	1, 3	21/01/2025	Medical Staffing in ED Overnight & at Weekends	16	16	16		8	(UPC) Urgent and Acute Care
35274	1, 3	29/09/2025	Insufficient SLT workforce to meet clinical demand	N/A	16	16		4	(CSS) Clinical Support Services
35962	1, 3	26/03/2025	Fragility of ILD service - nursing	16	16	16		4	(UPC) Medicine
37230	1, 3	28/07/2025	Oncology Gynaecology Delays	N/A	N/A	16		9	(CSS) Women and Children's
37497	1, 3	02/09/2025	SSDEC Staffing	N/A	16	16		4	(PC) Surgery
37866	1, 3	30/09/2025	Insufficient workforce to deliver a safe dietetic service	N/A	16	16		4	(CSS) Clinical Support Services
38447	1, 3	25/11/2025	Nursing workforce does not meet GPICS standards	N/A	N/A	16		4	(PC) Surgical Support Services
38739	1, 3	23/12/2025	Lack of Staff within Maternity Theatres	N/A	N/A	16		4	(PC) Surgical Support Services
29744	1, 4	18/09/2023	Cardiac Imaging Storage	12	12	16		2	(CSS) Women and Children's
32551	1, 4	31/05/2024	Operational risk associated with the Pharmacy robot replacement	12	16	16		8	(CSS) Clinical Support Services
32544	3, 6	30/05/2024	UHNM negotiations underway to upband & backpay all AfC B2 Healthcare Support Workers who have been delivering work at B3.	16	16	16		12	Central Functions Division
18664	1	28/09/2020	Gynaecology 52 Week Long Waits	15	15	15		6	(CSS) Women and Children's
26808	1	09/01/2023	Holding Patients on the ED Corridor	12	15	15		4	(UPC) Urgent and Acute Care
32023	1	11/04/2024	Maternity Early Warning Scores not used for Maternity Patients outside of Maternity Dept	15	15	15		2	(CSS) Women and Children's
33109	1	16/07/2024	Audiology Waiting List Backlog	15	15	15		5	(PC) Surgery

Appendix 2 - Linked Risks

ID	BAF Link	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group
35516	1	26/02/2025	Endometriosis Backlog and Long Waits	15	15	**15**		4	(CSS) Women and Children's
35517	1	26/02/2025	Urogynae Backlog and Long Wait	15	15	**15**		4	(CSS) Women and Children's
37324	1	08/08/2025	IOL on Blossom Suite not receiving daily medical review as part of ward round	N/A	N/A	**15**		4	(CSS) Women and Children's
30476	4	20/11/2023	NHS Financial position and procurement of System Wide EPR	15	15	**15**		5	Central Functions Division
34869	4	24/12/2024	Technical Debt	15	15	**15**		5	Central Functions Division
36083	4	16/04/2025	Display of antibiotic sensitivity results in iPortal	10	15	**15**		5	NMCPS
34188	6	29/10/2024	Non pay overspend - Histology send away activity	12	12	**15**		6	NMCPS
19397	1, 3	21/12/2020	Impact of increased workload on service and Quality management system in Immunology	12	15	**15**		6	NMCPS
32486	1, 3	22/05/2024	Long Wait Patients in the Trauma Directorate	15	15	**15**		6	(PC) Specialised Surgery
31724	1, 4	11/03/2024	Non clinical users able to order on behalf of clinician for IRMER requests	15	15	**15**		5	Central Functions Division
20926	1, 5	30/04/2021	Emergency Department (Royal) Majors, Ambulatory & Children's Cubicle Doors	15	15	**15**		4	(UPC) Urgent and Acute Care
25917	1, 5	30/09/2022	Suitability of Cohort Area (Known as Ambulance Assessment 7 - 10)	15	15	**15**		2	(UPC) Urgent and Acute Care
34369	1, 5	13/11/2024	ECC Patient toilet facilities safety and prevention	15	15	**15**		8	(UPC) Urgent and Acute Care
8660	1	20/09/2017	Follow up back log (outpatient appointments)	12	12	**12**		6	(UPC) Medicine
8901	1	05/12/2013	Ensure correct blood sample management	12	12	**12**		6	Central Functions Division
9738	1	05/02/2018	Nurse Training	12	12	**12**		6	(UPC) Urgent and Acute Care
11415	1	20/08/2018	End of Life - Portable battery powered syringe pumps.	12	12	**12**		9	Central Functions Division
12699	1	15/02/2019	High Acuity Emergency Patients	12	12	**12**		4	(UPC) Urgent and Acute Care
14958	1	29/10/2024	Triage Times (Royal) In Adults and Children's ED	16	12	**12**		6	(UPC) Urgent and Acute Care
17470	1	12/06/2020	Compliance with NEWS and escalation (Royal)	12	12	**12**		4	(UPC) Urgent and Acute Care
17637	1	30/06/2020	Decline in cancer performance	12	12	**12**		8	(PC) Surgery
20435	1	16/03/2021	Paediatric Follow up Backlog	12	12	**12**		6	(CSS) Women and Children's
24025	1	06/04/2022	ILD Service - increased demand as a result of prescribing changes	12	12	**12**		4	(UPC) Medicine

Appendix 2 - Linked Risks

ID	BAF Link	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group
24213	1	29/04/2022	Enhanced Primary Care (EhPC) Service Staffing and Demand	12	12	**12**		3	(UPC) Urgent and Acute Care
24340	1	10/05/2022	Severe Asthma Service - impact once external funding ceases	12	12	**12**		3	(UPC) Medicine
25470	1	04/08/2022	Increasing waiting list size and patients waiting greater than 18 weeks for treatment	12	12	**12**		4	Surgical Division
26529	1	28/11/2022	Leighton Hospital Hyper-Acute Stroke Pathway	12	12	**12**		4	(UPC) Specialised Medicine
27953	1	12/04/2023	Lack of provision for patients requiring DIEP surgery	12	12	**12**		6	(PC) Surgery
28881	1	30/06/2023	Breast Screening community locations	12	12	**12**		2	(CSS) Clinical Support Services
29165	1	20/07/2023	Diabetic Pump Contracts	12	12	**12**		4	(CSS) Women and Children's
29812	1	27/09/2023	Replacement Medical Devices - Capital and Revenue Funding Risk	16	16	**12**		4	Estates, Facilities and PFI
30573	1	30/11/2023	Inability to support patient pathway turnaround times in MRI due to not being able to secure sufficient GA slots to meet demand	12	12	**12**		4	(CSS) Clinical Support Services
30749	1	13/12/2023	Contact Lens/Low Visual Acuity (CL/LVA) Service Delivery	12	12	**12**		8	(PC) Surgery
31806	1	18/03/2024	No Psychological provision for renal patients	12	12	**12**		2	(UPC) Medicine
32124	1	22/04/2024	Service Level Agreement between SaTH & Leighton for IR Referrals	12	12	**12**		6	(CSS) Clinical Support Services
32423	1	15/05/2024	Interruption to Plasma Service due to Machine Failure	12	12	**12**		4	(UPC) Medicine
32652	1	05/06/2024	Clinical Harm Review Process	12	12	**12**		6	Central Functions Division
32683	1	07/06/2024	Timely Reporting of Emergency MRI Results	12	12	**12**		4	(PC) Surgery
33311	1	07/08/2024	Antenatal consultant clinic capacity	12	12	**12**		6	(CSS) Women and Children's
33928	1	02/10/2024	Noncompliance with requirements of the Fetal anomaly screening programme (FASP) & saving babies lives pathways	12	12	**12**		4	(CSS) Clinical Support Services
34050	1	14/10/2024	Neurology Toxic Non MS Drug Monitoring	12	12	**12**		6	(UPC) Specialised Medicine
34270	1	05/11/2024	Utilisation of Holistic Cancer Centre	12	20	**12**		6	(UPC) Specialised Medicine
34302	1	17/07/2024	Diabetes patient Clinical follow up	9	12	**12**		4	(UPC) Medicine
34519	1	22/11/2024	Delivery of Gestational Diabetes GTT Clinics	12	12	**12**		4	Central Functions Division
34789	1	02/12/2024	Corporate RTT (Referral to Treatment) Validation at UHNM	16	16	**12**		8	Central Functions Division
35166	1	27/01/2025	Central access for Specialised Medicine	12	12	**12**		4	(UPC) Medicine
35351	1	11/02/2025	Clinic over runs	12	12	**12**		4	Central Functions Division

Appendix 2 - Linked Risks

ID	BAF Link	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group
35466	1	21/02/2025	RSUH/CH Haematology Advia 2120 reliability	12	12	**12**		4	NMCPS
35708	1	03/03/2025	RTT Delivery - outpatient capacity/wait times to achieve 52wks	12	12	**12**		6	(UPC) Medicine
35797	1	25/03/2025	ENT On Call Crosscover	12	12	**12**		4	(PC) Surgery
36829	1	20/06/2025	Referral process for WET AMD patients	12	12	**12**		4	(PC) Surgery
36830	1	20/06/2025	Ward 111 Band 3 staff members are unable to provide basic tracheostomy care	12	12	**12**		4	(PC) Surgery
32500	3	22/05/2024	TI Rates	12	12	**12**		6	Central Functions Division
33184	3	24/07/2024	Inability to provide timely management of Freedom to Speak Up Cases	12	12	**12**		4	Central Functions Division
34115	3	23/10/2024	Inability to comply with compensatory rest due to on call requirements	12	12	**12**		6	(CSS) Clinical Support Services
37600	3	15/09/2025	Admin and Clerical Vacancies - Trauma Directorate	N/A	N/A	**12**		4	(PC) Specialised Surgery
8849	4	13/10/2017	Inappropriate use of mobile devices for work purposes	12	12	**12**		4	Central Functions Division
21784	4	06/08/2021	(CQC) Confidentiality, Integrity and Availability of Trust Information	12	12	**12**		4	Central Functions Division
33097	4	01/03/2024	Reduced Security Support - (Sophos exemptions) for the Omnicell Automated Dispensing Cabinets	12	12	**12**		4	(CSS) Clinical Support Services
33518	4	29/08/2024	Proactive audit & monitoring of patient record systems	12	12	**12**		4	Central Functions Division
34157	4	17/10/2024	DC1-SQLDB19 _ DC2-SQLDB20	12	12	**12**		6	Central Functions Division
35090	4	21/01/2025	Rapid AI Linux OS Out of support	12	12	**12**		4	(CSS) Clinical Support Services
35318	4	06/02/2025	Biochemistry RSUH Track system	12	12	**12**		4	NMCPS
25353	5	21/07/2022	Sale of RI and COPD Land later than NHSE funding requirement of 24/25	12	12	**12**		6	Central Functions Division
28802	5	23/06/2023	Insufficient hub space and clinical room capacity for community midwifery teams	12	12	**12**		4	(CSS) Women and Children's
29213	5	28/07/2023	ECT Cooper Building roof leaks	12	12	**12**		4	NMCPS
30237	5	04/09/2023	PFI latent defects	12	12	**12**		4	Estates, Facilities and PFI
30787	5	14/12/2023	Histology Consultant Office Accommodation	8	12	**12**		4	NMCPS
34099	5	21/10/2024	County Vertical Fire Compartmentation	N/A	N/A	**12**		6	Estates, Facilities and PFI
36884	5	27/06/2025	Inability to accommodate the Endoscopy Booking & Manager Team in current location	16	12	**12**		4	(CSS) Clinical Support Services
36966	5	04/07/2025	Outdated and vulnerable 7-Zip installs	N/A	12	**12**		4	Central Functions Division

Appendix 2 - Linked Risks

ID	BAF Link	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group
37357	5	14/08/2025	Fire and Smoke spread from the Holistic Care Centre to the Cancer Centre	N/A	N/A	**12**		6	Estates, Facilities and PFI
37358	5	14/08/2025	Fire and smoke spread in the Trent Building upper floor as a result of bin storage on the Hospital Street	N/A	N/A	**12**		4	Estates, Facilities and PFI
37840	5	30/09/2025	Lack of Audible Emergency Alarms in STS (Phase 2)	N/A	12	**12**		4	(PC) Surgical Support Services
8523	1, 3	01/09/2017	AMU Workforce (both sites)	12	12	**12**		4	(UPC) Urgent and Acute Care
11294	1, 3	31/07/2018	NMCPS Pathology Histology Medical Capacity - dissection & reporting(achieving TAT)	12	12	**12**		6	NMCPS
15664	1, 3	13/01/2020	Liver Mortality - CQC actions	12	12	**12**		4	(UPC) Medicine
17967	1, 3	23/07/2020	Medical Cover Cardiothoracic ICU	12	12	**12**		3	(PC) Specialised Surgery
20626	1, 3	05/11/2020	Low staffing levels for Phlebotomy at Cheshire Sites	12	12	**12**		6	NMCPS
21591	1, 3	08/07/2021	Insufficient Clinical Staff to Support the NMCPS Microbiology Service	12	12	**12**		6	NMCPS
21719	1, 3	29/07/2021	Medicine Safety Officer Vacancy	12	12	**12**		4	(CSS) Clinical Support Services
24837	1, 3	14/06/2022	Cystic Fibrosis workforce/service delivery	12	12	**12**		4	(UPC) Medicine
25152	1, 3	06/07/2022	Insufficient trained staff in Pharmacy Technical Services to deliver aseptic products including chemotherapy to the Trust	12	12	**12**		4	(CSS) Clinical Support Services
25628	1, 3	01/09/2022	Ophthalmology Service Delivery	12	12	**12**		8	(PC) Surgery
26996	1, 3	20/01/2023	Radiology Reporting Backlog - Paed Rad	N/A	N/A	**12**		4	(CSS) Clinical Support Services
27071	1, 3	26/01/2023	NIV Service Workforce - Domiciliary service	12	12	**12**		4	(UPC) Medicine
27153	1, 3	07/02/2023	QI Academy Staffing under-resourced to deliver sustainable change	12	12	**12**		12	Central Functions Division
28944	1, 3	03/07/2023	Deficit in appropriate numbers in Skilled Neonatal Specialist Nurses.	12	12	**12**		4	(CSS) Women and Children's
29508	1, 3	01/09/2023	Inability to deliver hybrid closed loop pumps to type 1 diabetes patients	12	12	**12**		6	(UPC) Medicine
31429	1, 3	14/02/2024	Audiology Staffing	12	12	**12**		4	(PC) Surgery
31807	1, 3	18/03/2024	No nursing Clinical Educator in post in Renal	12	12	**12**		2	(UPC) Medicine
32408	1, 3	14/05/2024	Clinical Perfusion- Inadequate Establishment & Staff Shortages	12	12	**12**		6	(PC) Specialised Surgery
32490	1, 3	22/05/2024	Insufficient Epilepsy CNS cover.	12	12	**12**		4	(CSS) Women and Children's
32891	1, 3	25/06/2024	Epilepsy Specialist Nursing Resource Availability	12	12	**12**		12	(UPC) Specialised Medicine

Appendix 2 - Linked Risks

ID	BAF Link	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group
33270	1, 3	20/08/2024	Breast Care Service	9	12	**12**		4	(PC) Surgery
33514	1, 3	29/08/2024	Ultrasound Imaging Workforce	12	12	**12**		4	(CSS) Clinical Support Services
33539	1, 3	29/08/2024	Non Obstetric Ultrasound (NOUS) Performance - DM01 compliance	16	12	**12**		4	(CSS) Clinical Support Services
33912	1, 3	01/10/2024	Anticoagulation Management Service staffing	12	12	**12**		4	NMCPS
34265	1, 3	04/11/2024	Lipid clinic provision	16	16	**12**		6	NMCPS
34410	1, 3	18/11/2024	Early Pregnancy Assessment Unit (EPAU) sustainability of services	N/A	N/A	**12**		6	(CSS) Women and Children's
34801	1, 3	17/12/2024	Radiotherapy Physics Workforce	N/A	N/A	**12**		3	(UPC) Specialised Medicine
34960	1, 3	09/01/2025	AAA Screening Workforce - CST and Technicians	16	16	**12**		4	(PC) Surgery
35057	1, 3	17/01/2025	Inadequate Pharmacy Staffing to Emergency Departments	12	12	**12**		6	(CSS) Clinical Support Services
35330	1, 3	10/02/2025	County AMU nursing budget/establishment	12	12	**12**		4	(UPC) Urgent and Acute Care
35847	1, 3	31/03/2025	Lack of Pharmacy for ED Departments	12	12	**12**		4	(UPC) Urgent and Acute Care
36794	1, 3	16/06/2025	Clinical nursing staffing of the spinal deformity service	12	12	**12**		2	(PC) Specialised Surgery
36962	1, 3	04/07/2025	Therapies provision to SSCU patients	N/A	12	**12**		6	(PC) Surgical Support Services
37031	1, 3	10/07/2025	Stability of General Surgery Paediatric Service	N/A	12	**12**		3	(PC) Surgery
37337	1, 3	11/08/2025	Consultant pa assurance	N/A	12	**12**		8	(CSS) Clinical Support Services
37345	1, 3	12/08/2025	EAU Nurse Staffing	N/A	N/A	**12**		2	(UPC) Specialised Medicine
37669	1, 3	17/09/2025	Head and Neck Workforce	N/A	12	**12**		4	(PC) Surgery
23759	1, 4	14/03/2022	Inappropriate clinical decisions due to large number of digital systems in place	12	12	**12**		4	Central Functions Division
25682	1, 4	05/09/2022	(CQC) Unstructured records Management	12	12	**12**		4	Central Functions Division
26427	1, 4	16/11/2022	Use of Q-pulse as electronic quality management system	16	12	**12**		6	NMCPS
28354	1, 4	23/05/2023	Blood Analyser Lantronix UDS box	12	12	**12**		4	NMCPS
29217	1, 4	28/07/2023	Egrow digital plotting for height and weight	12	12	**12**		2	(CSS) Women and Children's
30129	1, 4	24/10/2023	Inpatient E-notification initial report not enabled	12	12	**12**		2	(CSS) Clinical Support Services
30477	1, 4	20/11/2023	Lack of records retention in line with Code of Practice	12	12	**12**		4	Central Functions Division

Appendix 2 - Linked Risks

ID	BAF Link	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group
31527	1, 4	26/02/2024	Auto-Contoring	12	12	**12**		6	(UPC) Specialised Medicine
32033	1, 4	12/04/2024	AAA Screening operational charges and access	12	12	**12**		4	(PC) Surgery
33424	1, 4	19/08/2024	Non Medical Referring - Ownership and Maintenance of the Database	20	12	**12**		6	(CSS) Clinical Support Services
33674	1, 4	23/07/2024	Sectra PACS Imaging - No Security Endpoint protection	12	12	**12**		12	(CSS) Clinical Support Services
34580	1, 4	27/11/2024	CIM Hold and Error Queue Management	12	12	**12**		4	NMCPS
34582	1, 4	27/11/2024	CIM Failovers	12	12	**12**		6	NMCPS
34594	1, 4	28/11/2024	Illegal Characters in SampleNet	12	12	**12**		6	NMCPS
34595	1, 4	28/11/2024	SampleNet Is Unable to Handle Time Changes	12	12	**12**		6	NMCPS
34965	1, 4	10/01/2025	No MFA for Winpath Enterprise (LIMS)	12	12	**12**		2	NMCPS
28684	1, 5	14/06/2023	Lack of Clean Utility Room - Children's High Dependency	12	12	**12**		6	(CSS) Women and Children's
35039	1, 5	17/01/2025	Pharmacy Cancer walk-in cold store Ward 202 performance and capacity	12	12	**12**		2	(CSS) Clinical Support Services
35126	1, 5	14/01/2025	Electrical High Voltage infrastructure capacity on Royal Stoke site	12	12	**12**		4	Estates, Facilities and PFI
34299	1, 6	07/11/2024	Teenage & Young Adults Cancer Service	N/A	N/A	**12**		3	(UPC) Specialised Medicine
26168	3, 4	26/10/2022	Pathology IT System Expertise	12	12	**12**		6	NMCPS
31185	4, 5	29/01/2024	DataCentre Air Conditioning EOL - Unfit for Purpose	12	12	**12**		4	Central Functions Division
32119	4, 5	21/04/2024	Insufficient storage capacity for IM&T goods in Digital Hub	N/A	N/A	**12**		4	Central Functions Division

Executive Summary

Trust Board (Open) | 11th February 2026

Maternity (Perinatal) Incentive Scheme – Year 7

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**	✓	**Assurance**		**Agenda Item:**	10.
Author:	Donna Brayford, (Acting) Director of Midwifery							
Executive Lead:	Ann-Marie Riley, Chief Nurse and Maternity Safety Champion							

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

Executive Summary

Situation

The University Hospitals of North Midlands can demonstrate that they have met all ten safety actions of the Maternity (Perinatal) Incentive Scheme Year Seven. The Trust Board is asked to give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution.

Background

Now in its seventh year of operation, NHS Resolution's Maternity (Perinatal) Incentive Scheme (MIS) continues to support safer maternity and perinatal care by driving compliance with ten Safety Actions, which support the national maternity ambition to reduce the number of stillbirths, neonatal and maternal deaths, and brain injuries from the 2010 rate by 50% before the end of 2025.

The MIS applies to all acute Trusts that deliver maternity services and are members of the Clinical Negligence Scheme for Trusts (CNST). As in previous years, members will contribute an additional 10% of the CNST maternity premium to the scheme creating the CNST MIS fund. Trusts that can demonstrate they have achieved all ten of the safety actions in full will recover their trust's element of the contribution relating to the CNST MIS fund and this will be returned to the source of the initial CNST payment. They will also receive a share of any unallocated funds.

Assessment

All ten safety actions have been met. Further detail regarding specific evidence in relation to the standards has been provided to the Quality, Access and Outcomes Committee.

An action plan has been developed for:

- Safety Action 3 – Transitional care services are currently not in line with British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice. Readmissions from community are not currently re admitted to Transitional Care within maternity services. Action Plan in progress.
- Safety Action 4 – Neonatal Nursing budgeted establishment is not in line with BAPM standards.
- Safety Action 7 – The current Maternity and Neonatal Voice Partnership infra structure is not in line with MNVP guidance. Action plan in progress.

Key Recommendations

The Trust Board is asked to give their permission to the Chief Executive Officer (CEO) to sign the Board declaration form prior to submission to NHS Resolution.

Safety Action 1: Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths that occurred from 1 December 2024 to 30 November 2025 to the required standard? Yes

Required Standard	Compliance
a) Notify all deaths: All eligible perinatal deaths should be notified to MBRRACE UK within seven working days	**100% compliant**
b) Seek parents' views of care: For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 1 December 2024 onwards	**100% compliant**
c) Review the death and complete the review: For deaths of babies who were born and died in your Trust from 1st December 2024 onwards multi-disciplinary reviews using the PMRT should be carried out; 95% of reviews should be started within two months of the death, and a minimum of 75% of multi-disciplinary reviews should be completed and published within six months.	**100% compliant**
For a minimum of 50% of the deaths reviewed an external member should be present at the multi-disciplinary review panel meeting and this should be documented within the PMRT	**92% compliant**
d) Report to the Trust Executive: Quarterly reports of reviews of all deaths should be discussed with the Trust Maternity and Board Level Safety Champions and submitted to the Trust Executive Board on an ongoing basis from 1 December 2024	**100% compliant**

Safety action 2: Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard? Yes

This relates to improving the quality and completeness of the submission to the Maternity Services Data Set (MSDS).

Required Standard	Compliance
a) July 2025 data contains valid birthweight information for at least 80% of babies born in the month: this requires the recorded weight to be accompanied by a valid unit entry. (Relevant data tables include MSD401; MSD405).	**100% compliant**
b) July 2025 data contains valid ethnic category (mother) for at least 90% of women booked in the month: not stated, missing, and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (Relevant data tables include MSD001; MSD101)	**99.1% compliant**

Select organisation: UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST

Select reporting month: July 2025

Note: This edition of the dashboard now contains the final July data on which Trusts are assessed. It is expected that the dashboard will be refreshed less frequently following this assessment edition.

CNST: Safety Action 2 results for UNIVERSITY HOSPITALS OF NORTH MIDLANDS NHS TRUST for July 2025

1.

Indicator	Numerator	Denominator	Rate	Result
Birthweight DQ	430	430	100.0	Passed

Pass rate: 80%

2.

Indicator	Numerator	Denominator	Rate	Result
Ethnicity DQ	555	560	99.1	Passed

Pass rate: 90%

Safety action 3: Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?

Yes, but an action plan is required

Required Standard	Compliance
a) Be able to evidence progress towards a transitional care pathway from 34+0 in alignment with the British Association of Perinatal Medicine (BAPM) Transitional Care Framework for Practice and submit this to your Trust and the neonatal Operational Delivery Network (ODN) on behalf of the LMNS Boards. Required standard: Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice	**Action Plan Required ***
Local policy/pathway of TC admission criteria based on BAPM framework for Transitional Care and meeting a minimum of at least one element of HRG XA04	**Compliant**
b) Drawing on insights from themes identified from any term or late preterm admissions to the neonatal unit, undertake at least one quality initiative to decrease admissions and/or length of stay/ mother separation.	**Compliant****

***** Pathways of care into transitional care (TC) are in place which includes babies between 34+0 and 35+6 in alignment with the BAPM Transitional Care Framework for Practice – except babies readmitted from the community for:

- Excessive weight loss and/or poor suck feeding requiring complementary nasogastric tube feeds
- Haemolytic disease requiring enhanced phototherapy and/or assessment of serum bilirubin 4 – 6 hourly.

This cohort of patients currently are admitted to the children's ward. An action plan has been developed to re admit to transitional care within maternity services.

** The neonatal team are implementing bedside cannulation. Currently a baby is taken to the neonatal unit for cannulation following delivery for treatment of early onset sepsis separating them from their mother who remains on labour ward. This does not support early bonding and initiation and breastfeeding. An update of progress has been presented to the LMNS and safety champions

Safety action 4: Can you demonstrate an effective system of clinical workforce planning to the required standard?

Yes

Required Standard	Compliance
Obstetric medical workforce:	
a) Has the Trust ensured that the following criteria are met for employing short-term (2 weeks or less) locum doctors in Obstetrics and Gynaecology on tier 2 or 3 (middle grade) rotas. Currently work in their unit on the tier 2 or 3 rota or have worked in their unit within the last 5 years on the tier 2 or 3 (middle grade) rota as a postgraduate doctor in training and remain in the training programme with satisfactory Annual Review of Competency Progressions (ARCP) or hold a Royal College of Obstetrics and Gynaecology (RCOG) certificate of eligibility to undertake short-term locums.	**Compliant. Audit identified no short-term locums**
b) Trusts/organisations should implement the RCOG guidance on engagement of long-term locums and provide assurance that they have evidence of compliance.	**Compliant. Audit demonstrated 1 long-term locum**
c) Trusts/organisations should monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology' into their service when a consultant is required to attend in person. Episodes where attendance has not been possible should be reviewed at unit level as an opportunity for departmental learning with agreed strategies and action plans implemented to prevent further non-attendance.	**Compliant. Audit undertaken and action plan in place and shared with relevant forums***

* In Q1, a consultant attended in 97% of clinical situations and in Q2, a consultant attended in 99% of clinical situations.

Required Standard	Compliance
Anaesthetic medical workforce:	
a) A duty anaesthetist is immediately available for the obstetric unit 24 hours a day and should always have clear lines of communication to the supervising anaesthetic consultant. Where the duty anaesthetist has other responsibilities, they should be able to delegate care of their non-obstetric patients to be able to attend immediately to obstetric patients. (Anaesthesia Clinical Services Accreditation (ACSA) standard 1.7.2.1).	**Compliant**
Neonatal medical workforce:	
a) Does the neonatal unit meet the relevant British Association of Perinatal Medicine (BAPM) national standards of medical staffing?	**Compliant**
Neonatal nursing workforce:	**Action plan required***
a) Does the neonatal unit meet the BAPM neonatal nursing standards	

* If the requirements have not been met, Trust Boards should agree a workforce action plan and evidence progress against any workforce action plan developed previously to address deficiencies and share with the LMNS and ODN.

The BAPM standard for qualified in speciality nurses (QiS) is 79.2%. UHNM currently sit at 70% therefore an education and action plan has been devised. An action plan has been completed and shared with the LMNS and ODN. BAPM guidance has changed and requires that transitional care nurses are reported as not providing 'direct nursing care'. This has created a deficit of 10.84 WTE nurses within the current Neonatal unit. A workforce action plan is in progress which has been shared with the LMNS and ODN.

Safety action 5: Can you demonstrate an effective system of midwifery workforce planning to the required standard? **Yes**

Required Standard	Compliance
1) Submit a midwifery staffing oversight report that covers staffing/safety issues to the Board every 6 months that includes the following points:	
a) Has a systematic, evidence-based process to calculate midwifery staffing establishment been completed in the last three years?	**Compliant. Assessment completed in July 2025. Business case approved October 2025**
b) Can the Trust Board evidence midwifery staffing budget reflect establishment as calculated?	**Compliant**

Safety action 6: Can you demonstrate you are on track for compliance with all elements of the Saving Babies' Lives care bundle version 3? **Yes**

Required Standard	Compliance
a) Have you agreed with the ICB that Saving Babies' Lives Care Bundle, version 3, is fully in place or will be in place and can you evidence the Trust Board has had oversight of this progress?	**Compliant***
b) Have you continued quarterly discussions between the Trust and the LMNS/ICB from year 6 and be able to demonstrate that at least 2 quarterly discussions have taken place in year 7 to track compliance with the care bundle? These quarterly meetings included details of element specific improvement work being undertaken including evidence of generating and using the process and outcome metrics for each element. There is a regular review of local themes and trends with regard to potential harms in each of the six elements.	**Compliant. 2 meetings have taken place including all elements.**

Required Standard	Compliance
Following these meetings, has the LMNS determined that sufficient progress have been made towards implementing SBLCBv3, in line with a locally agreed improvement trajectory? Is there evidence of sharing of examples and evidence of continuous learning by individual Trusts with their local ICB, neighbouring Trusts and NHS Futures where appropriate?	

*Where full implementation is not in place, compliance can still be achieved if the ICB confirms it is assured that all best endeavours, and sufficient progress, have been made towards full implementation, in line with the locally agreed improvement trajectory. UHNM have achieved 91% compliance.

Implementation Progress

Intervention Elements	Description	Element Progress Status (Self assessment)	% of Interventions Fully Implemented (Self assessment)	Element Progress Status (LMNS Validated)	% of Interventions Fully Implemented (LMNS Validated)
Element 1	Smoking in pregnancy	Partially implemented	60%	Partially implemented	60%
Element 2	Fetal growth restriction	Partially implemented	95%	Partially implemented	95%
Element 3	Reduced fetal movements	Fully implemented	100%	Fully implemented	100%
Element 4	Fetal monitoring in labour	Fully implemented	100%	Fully implemented	100%
Element 5	Preterm birth	Fully implemented	100%	Fully implemented	100%
Element 6	Diabetes	Partially implemented	83%	Partially implemented	83%
All Elements	TOTAL	Partially implemented	91%	Partially implemented	91%

Safety action 7: Listen to women, parents and families using Maternity and Neonatal services and coproduce services with user

Yes, action plan required

Required Standard	Compliance
a) Trusts should work with their LMNS/ICB to ensure a funded, user-led Maternity and Neonatal Voices Partnership (MNVP) is in place which is in line with the Delivery Plan and MNVP Guidance (published November 2023) including supporting: • Infrastructure • Strategic influence and decision-making. • Engagement and listening to families	**Action plan required***
b) Trusts should ensure an action plan is coproduced with the MNVP following annual CQC Maternity Survey data publication (due each January), including joint analysis of free text data, and progress monitored regularly by Safety Champions and LMNS Board	**Compliant**

* The current MNVP infrastructure is not in line with MNVP guidance. This was escalated to the LMNS and regional midwifery team. An action plan has been developed and is in progress.

Safety action 8: Can you evidence the following 3 elements of local training plans and 'in-house' one day multi professional training?

Yes

Required Standard	Compliance
a) Fetal monitoring and surveillance: 90% of the following staff groups from 1st December 2024 -30th November 2025	**Compliant. Overall 92%**
b) Maternity emergencies and multidisciplinary training (PROMPT): 90% of staff groups from 1st December 2024- 30th November 2025	**Compliant. Overall 95%**

Required Standard	Compliance
c) At least one emergency scenario is to be conducted in the clinical area, ensuring full attendance from the relevant wider professional team, including theatre staff and neonatal staff.	**Compliant. Live drills run on regular basis**
d) Neonatal Basic Life Support: 90% of staff groups from 1st December 2024-30th November 2025	**Compliant. Staff groups between 94% - 100%**

Safety Action 9: Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues? **Yes**

Required Standard	Compliance
a) Are all Trust requirements of the Perinatal Quality Surveillance Model (PQSM) fully embedded?	**Compliant**
b) Has a non-executive director (NED) has been appointed and is visibly working with the Board Safety Champion (BSC)?	**Compliant**
c) Is a review of maternity and neonatal quality and safety undertaken by the Trust Board (or an appropriate trust committee with delegated responsibility) quarterly using a minimum data set and presented by a member of the perinatal leadership team to provide supporting context?	**Compliant**
d) Does the regular review include a review of thematic learning informed by PSIRF, themes and progress with plans following cultural surveys or equivalent, training compliance, minimum staffing in maternity and neonatal units, and service user voice feedback	**Compliant**
e) Do you have evidence of collaboration with the local maternity and neonatal system (LMNS)/ICB lead, showing evidence of shared learning and how Trust-level intelligence is being escalated to ensure early action and support for areas of concern or need, in line with the PQSM.	**Compliant**
f) Ongoing engagement sessions with staff as per year 5 of the scheme. Progress with actioning named concerns from staff engagement sessions are visible to both maternity and neonatal staff and reflects action and progress made on identified concerns raised by staff and service users from no later than 1 July 2025	**Compliant**
g) Is the Trust's claims scorecard is reviewed alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level Safety Champions at a Trust level (Board or directorate) meeting quarterly (at least twice in the MIS reporting period)?	**Compliant**
h) Evidence in the Trust Board minutes that Board Safety Champion(s) are meeting with the Perinatal leadership team at a minimum of bi-monthly (a minimum of three in the reporting period) and that any support required of the Trust Board has been identified and is being implemented.	**Compliant**
i) Evidence in the Trust Board (or an appropriate Trust committee with delegated responsibility) minutes that progress with the maternity and neonatal culture improvement plan is being monitored and any identified support being considered and implemented.	**Compliant**

Safety Action 10: Have you reported 100% of qualifying cases to Maternity and Newborn Safety Investigations (MNSI) programme and to NHS Resolution's Early Notification (EN) Scheme from 8th December 2024 to 30th November 2025? **Yes**

Required Standard	Compliance
a) Have you reported of all qualifying cases to MNSI from 8 December 2024 to 30 November 2025?	**Compliant – all 9 incidents reported as PSIIs**
b) Have you reported of all qualifying EN cases to NHS Resolution's Early Notification (EN) Scheme from 8 December 2023 until 30 November 2024?	**Compliant**
c) Have all eligible families received information on the role of MNSI and NHS Resolution's EN scheme?	**Compliant**

Required Standard	Compliance
d) Has there been compliance, for all eligible cases, with regulation 20 of the Health and Social Care Act 2008 Regulated Activities) Regulations 2014 in respect of the duty of candour?	**Compliant**
e) Has Trust Board had sight of Trust legal services and maternity clinical governance records of qualifying MNSI/ EN incidents and numbers reported to MNSI and NHS Resolution?	**Compliant**
f) Has Trust Board had sight of evidence that the families have received information on the role of MNSI and NHS Resolution's EN scheme?	**Compliant**
g) Has Trust Board had sight of evidence of compliance with the statutory duty of candour?	**Compliant**
h) Have you completed the field on the Claims reporting wizard (CMS), whether families have been informed of NHS Resolution's involvement, completion of this will also be monitored, and externally validated?	**Compliant**

Executive Summary

Trust Board | 11th February 2026

UEC Pressure and Ambulance Handover Update

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**		**Assurance**	✓	**Agenda Item:**	11.
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	20 (extreme)

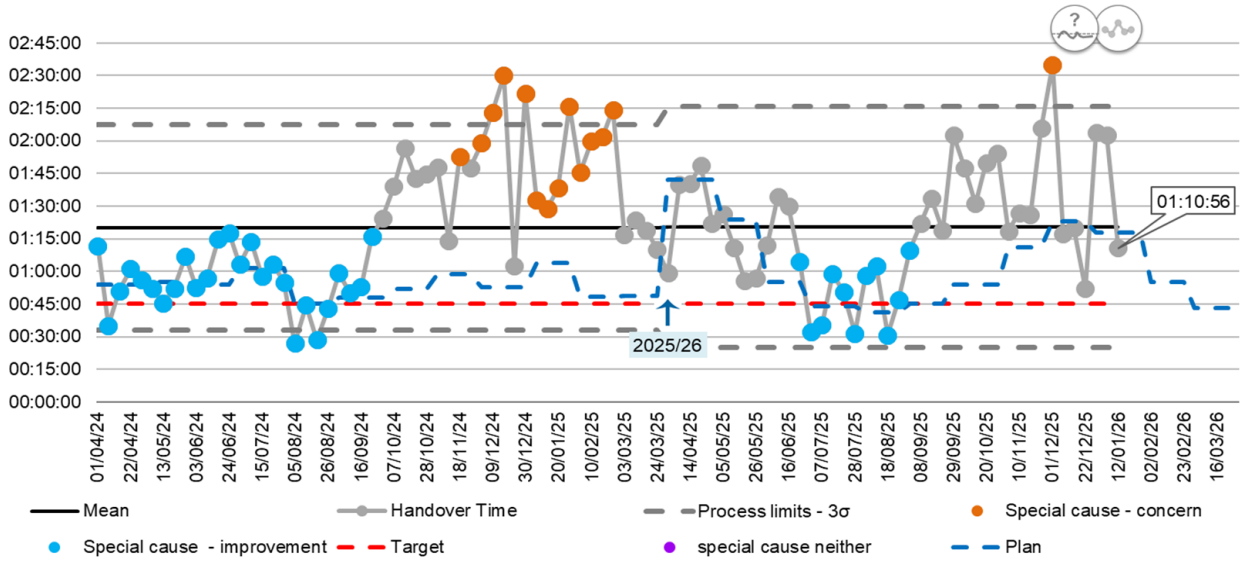
Executive Summary

Situation

- This paper is to update board members on the situation with regard to UEC pressure and ambulance handover delays.
- This covers data up to the latest reported week which was 12/01/2026
- We remain in tier 1 for national oversight for our UEC position.
- Industrial action took place during the reporting period 17/12 – 22/12

Ambulance Handover

Average Handover Time-WMAS at UHNM starting 01/04/24



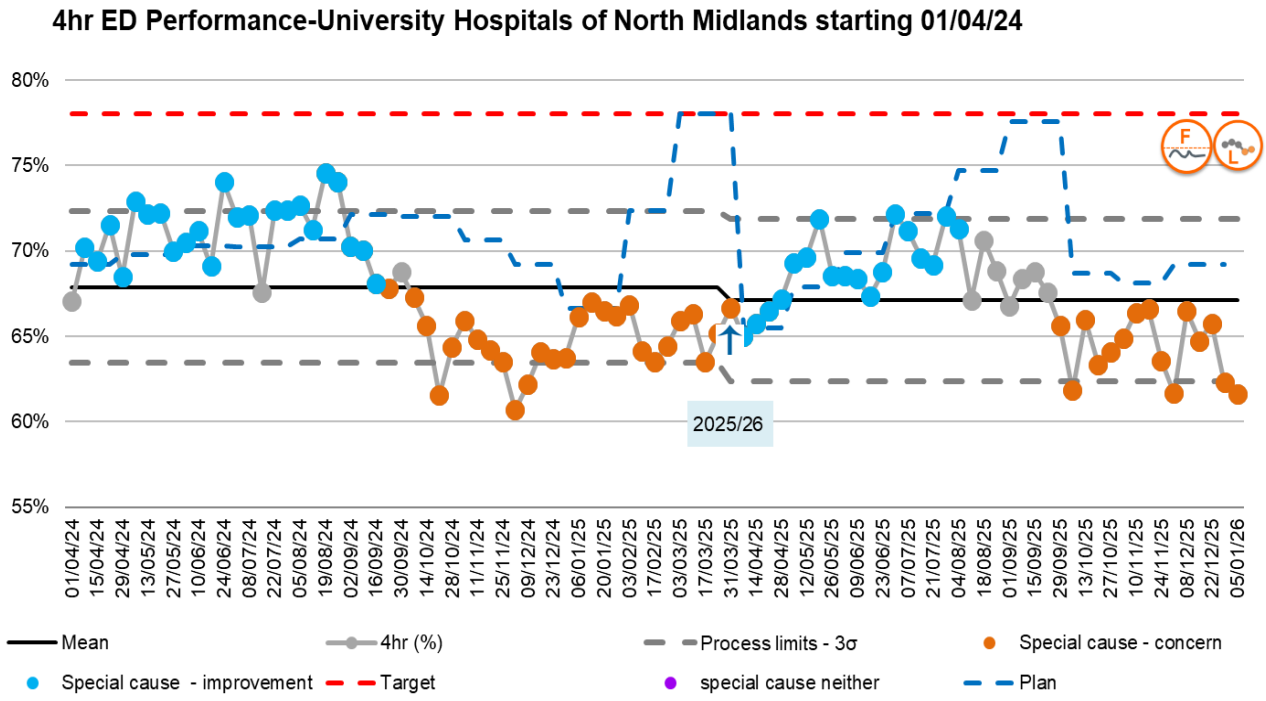
Average Handover Time

- Average Handover Time last week dropped by approximately 52 minutes to 1hr 10mins 56secs, with January reporting as worse than plan at 1hr 38mins 8secs
- Handover Trajectory for last week was 66.4%, up 20.3% on the previous week. January is reporting as 54.7%, down 8.4% on December
- Time Lost (> 15mins) due to handover reduced by 928 hours to 1,088 hours from 2,016 hours

Category 2 Response Time

- Category 2 Response Times for the latest week (w/e 18th January) have not yet been published and will be updated when available.

Four Hour Performance

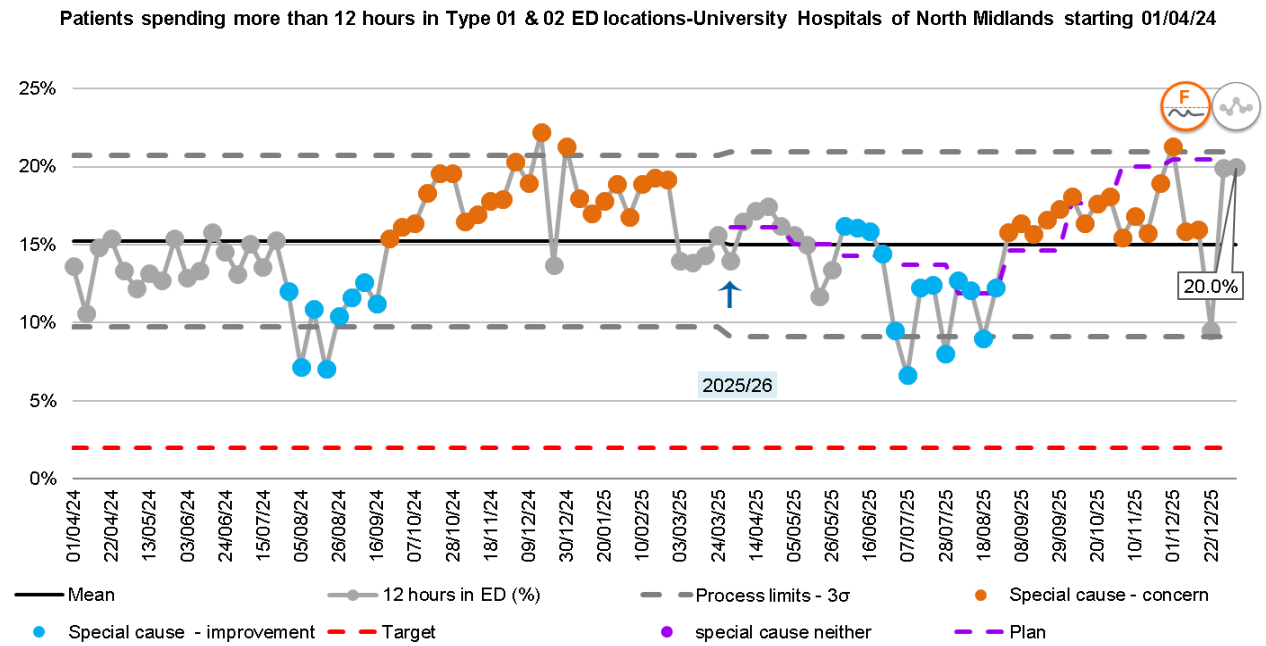


- 4hr Performance last week improved by 3.3% against the previous week, climbing to 64.7%.
- January is reporting as 62.7%, 11.1% worse than plan.
- UHNM reported a 9.9% increase in attendances with all Types locations experiencing increases.

Paediatric 4hr Performance

- Last week Type 1 Paediatrics performance deteriorated by 8.2% against the previous week, falling to 76.2%. the previous weeks had shown an improving trend up to 85%.

12 Hour Performance



- Provisional 12hr performance for last week is not currently available and will be updated next week,
- Provisional 12hr performance for the latest week available (w/e 11th Jan) deteriorated marginally to 20%.
- January is currently reporting as 20.1%, 0.9% better than plan

Tactical Mitigating Actions

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

Reducing Ambulance Handover

- Go live of Release to Respond plan w/c 19th January with a phased approach to reduce Ambulance handover delays in situ. Oversight and monitoring is in place via the SCC.
- X-Ray Car scheme went live week of 12th January. Data from initial period regarding demand and impacts being complied.
- Continuation of system workstream and monitoring in place with a daily tracker monitored via SCC, escalations via System calls as required.
- Consultant assigned to Rapid Assessment and Treatment (RAT) ambulances on arrival at RSUH, this continues within ED where possible, or on the ambulance as it arrives when not.
- Focus remains on sustaining performance in line with system plan however, operational challenges continue to remain prevalent including walk-in demand, acuity challenges and IPC.

System Multi-Disciplinary Review

- Review of ED Conveyances MDT completed with themes and trends to be shared via relevant governance. System partners agreed meeting cycle will reduce to monthly.

Ward Process & Discharge

- Support operational pressures, continuation of Planned Care capacity being 'flipped' to support unplanned demand across the UHNM footprint.
- UHNM discharge targets now agreed
- Therapist in the Integrated Discharge Hub mobilised 3rd November for 4 weeks. This has continued pending full review
- UHNM LOS continues to be supported by GIRFT UEC team with positive outcomes,

Front Door

- UTC – Capital/building works commenced and on track for January with x-ray coming online est. June.
- Standard work developed for oversight of Trust Escalation Space – now reported through Quality and Access committee.
- Frailty SDEC– continuing to see increasing number of patients assessed and discharged same day. This service has now begun to accept direct streaming of ambulances for suitable patients and is now working on a developed model.
- At Capacity and OPEL Framework strengthened and progressing through approval process.
- Improvement in EhPC slot utilisation, despite the ongoing UTC building works.

Bed & Site Management

- CSMs recruited and shadowing/training period continues.
- UHNM operating GOLD Command in operation with associated GIRFT UEC coaching. GOLD Command competency framework in development with GIRFT UEC colleagues. This will continue throughout the winter period.

Infection Prevention

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

- Twice daily IP review of inpatient areas, & restrictions with 7-day service cover.

Integrated Care Coordination (ICC)

- Total Referrals under ICC (In-hours & Out of Hours) for the week commencing 12th January rose by 74 to 1,439, the highest level recorded.
- Overall redirection rate for all incoming calls was 48.5%, down 2.9% from the previous week.
- In-hours deflection rate 47.1%. Total number of HCP/Telephony referrals for w/c 05.01.26 was 539 with a redirection rate of 76.6%. Record numbers of call before you convey numbers received into ICC In-hours received last week, with 55 referrals being received in one day.
- Out of hours deflection rate 54.9%. W/C 05.01.26 – Telephony referrals (37) had an 94.6% redirection rate; and CAD portal referrals (165) had a 45% redirection rate,
- Last week saw 101 potential Ambulance conveyances likely to have arrived at UHNM deflected to alternative pathways, up 11 on the previous week

System Surge Planning/Winter Review

- Winter capacity schemes 18 current schemes, with 11 on track or completed, with 3 currently at risk and 4 schemes with alternative provision being sought to support mitigations or unable to mobilise. Spot purchasing of D2A beds continues to support system pressures.

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'. This is being supported now by the GIRFT team (previously ECIST)

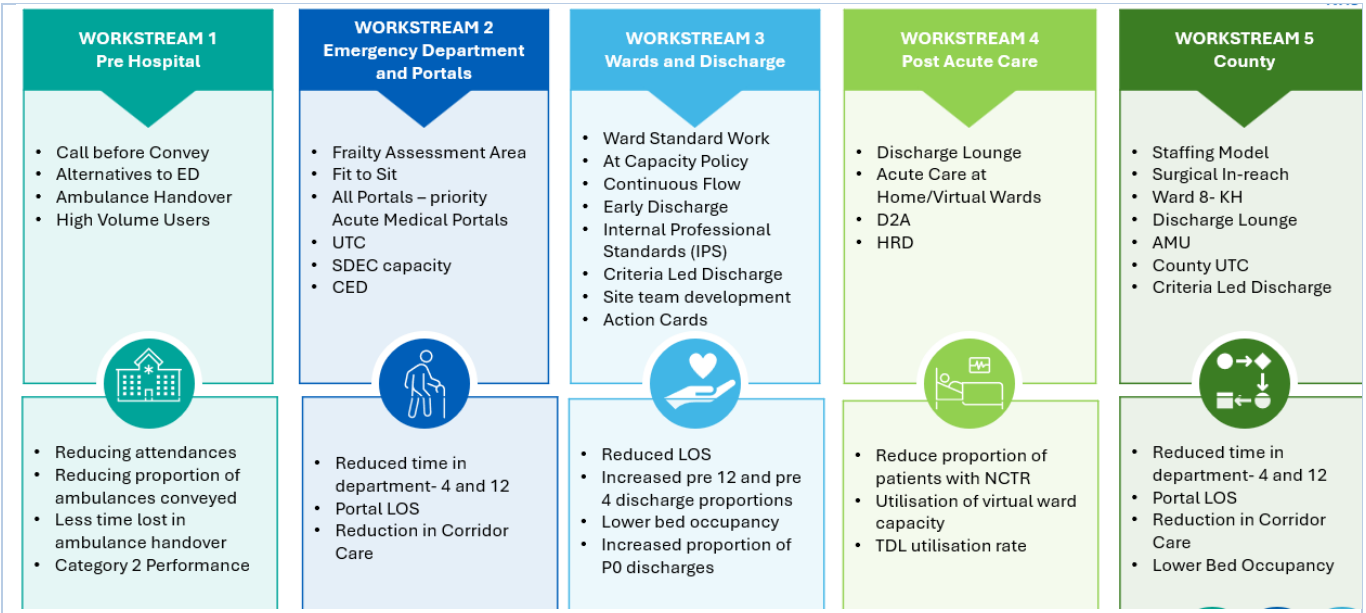
Early Impact of Improvement

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

This month has seen the launch of our internal professional standards, supported by policy. In reach from respiratory, gastro and frailty into medical portals which sees patients reviewed twice daily to support reducing length of stay.

We have also during January launched 'Release to Respond' which is our pathway to 45 minute handover, during this we have seen early results of handover times reducing from 139 minutes to 95 minute; although there is significant daily variation.

The UEC recovery program is maintained; however is now being moved to a weekly oversight for specific items in order to embed and improve on the initial findings and results from our 'Release to Respond' programme. Below is the high level outline to the programme.



This is now being worked up into the next phase of immediate supported work with the GIRFT UEC team.

Conclusion

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

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

Key Recommendations

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

Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE | 23rd December 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• **Mortality indices (HSMR/SHMI)** remain higher than expected; assurance currently partial. The Committee was "not assured" about trends given continuing elevation, with members asking for explicit clarity on coding completeness/compliance timelines ("freeze/flex" cycles) and whether some months remain partially coded; the lack of visibility on coding compliance remained a key concern. • **Clinical Effectiveness** governance & attendance**:** Low attendance and ownership within care groups were flagged as a persisting issue, linked in part to the restructure. January check-ins with care groups were requested to test their governance and challenges. • **National clinical audit** submissions**:** Multiple areas were struggling to complete national audit data; the Committee stressed that reorganisation was not a sufficient explanation and expected timely submission going forward. • **NICE guidance** implementation gaps: unclear status of implementation for recent asthma guidance and full sepsis (ED) time rules; assurance was uncertain and required formal confirmation. • **JAG accreditation** lost primarily due to sedation concerns; while a recovery plan was in train, accreditation was currently not held. • **Speech & Language Therapy (SALT)** workforce risks: Significant shortage impacting emergency, elective, and cancer pathways; recruitment/business case work was underway but lead-times were long. • Deterioration within **Structured Judgement Reviews** outcomes: Proportion of poor/very poor care rose from 2% to 7% (small numbers – 4 cases - but still material for learning); themes included delays in assessment/diagnostics, medication errors, documentation failures. • **Readmissions** risk**:** Although improved, the Trust remained above expected for emergency readmissions (see Positive Assurances for trajectory).	• **Coding** depth & compliance transparency: Further analysis of coding depth and compliance to month-end cut-offs requested; coders asked to present percentages of fully coded spells and depth metrics (targeting January rather than February if possible). • **Clinical Effectiveness** governance reset: January assurance check-ins with care groups; EQOG continuing to deploy triumvirate model and timetabled job plan sessions for audit/CE work. • **NICE** guidance audit/implementation: Follow-up required on asthma and sepsis compliance in ED; responsibilities identified but assurance needed. • **JAG** accreditation recovery: Safer sedation actions and executive oversight ongoing to meet re-accreditation timescales. • **SALT** workforce plan: Business case being prepared; recruitment pipeline to address emergency/elective/cancer impacts. • Stroke service review and Children & Young People **peer review**: Stroke review in progress; final peer review report expected January. • **National audit** submissions discipline: Care-group audit lists with submission dates to be enforced to remove historical gaps. • **Readmissions** deep-dives: Focus on outlier CCS groups (non-specific chest pain, acute/chronic tonsillitis, connective tissue diseases) and pathway review (noting changes such as AMU attendances counted via CareFlow rather than admissions).

Positive Assurances to Provide	Decisions Made
• **Patient Council / patient voice**: Appointment of Chair and Vice Chair confirmed; a plan to integrate patient voice into governance with a paper due before end of Q4. • Executive **Quality & Outcomes Group** (EQOG): A triumvirate working model (medic + AHP + nursing + governance lead) was being embedded to drive ownership and clinical effectiveness; posts were being filled (including a "quick care" nurse role mentioned) and foundations are in place to improve engagement. • **JAG** reaccreditation pathway: An Executive-led working group was active, focusing on safer sedation; there was reasonable confidence accreditation could be regained within the permitted window. • **Mortality** learning system strengthening: Clear process described - cases rated poor/very poor are presented at Mortality Review Group, triangulated with Medical Examiner (ME), PALS/complaints, and Risk Management Panel oversight; Board-style PSIRF lessons-learned summaries to be mirrored in the mortality quarterly. • Family engagement: **Martha's Rule** had been fully rolled out; triangulation of concerns via ME, PALS and Bereavement Services • **Readmissions** trend improving: Standardised relative risk fell from ~118.08 to ~112.32 over the latest period; reductions in actual readmissions outpaced reductions in expected readmissions/discharges, indicating real improvement, albeit still above expected.	There were no items requiring decision.

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

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Resuscitation Service Annual Report 2024/25	1	**34423 (Ext 20)** **26815 (High 9)**	**Partial**	Assurance	**5.**	Patient Council Update	-	**-**	**Not Applicable**	Information
2.	Quality Performance Report – Month 8 2025/26	1	**-**	**Partial**	Assurance	**6.**	Executive Quality & Outcomes Group Highlight Report (11-12-25)	1	-	**Not Applicable**	Assurance
3.	Access Performance Report Month 8 25/26	1	**-**	**Partial**	Assurance	**7.**	Mortality Assurance Report Q2 2025/26	1	**-**	**Partial**	Assurance
4.	Temporary Escalation Spaces (TES) Update	1	**-**	**Acceptable**	Assurance	**8.**	Readmissions Analysis	1	**Ext 20**	**Partial**	Assurance

Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE | 5th February 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• Three matters of concern raised by **Quality and Outcomes Group** in relation to oncology iron infusions with a paper to be provided to the Committee. In addition, working groups had been set up in respect of maternity early warning systems and tracheostomy care, in order to take forward actions for improvement • Partial assurance was provided by the **Infection Prevention Board Assurance Framework** (BAF), with a slight improvement to reducing blood culture delays and progress in taking forward food hygiene audit training. • The **Infection Prevention Hospital Acquired Infection** report for Q3 highlighted that 2 MRSA bacteraemia's occurred in November although post infection review meetings deemed these as unavoidable. Work remained ongoing in relation to sepsis screening within Royal Stoke Emergency Department. • The Committee noted marginal improvements in **urgent and emergency care p**erformance, including better ambulance handover times, while recognising that overall performance remained below target and was being hindered by cultural challenges. Members emphasised the critical need for strengthened medical leadership and forthcoming business cases to support investment in clinical and operational roles, alongside a more directive operational planning approach with enhanced external oversight. • Q2 **Patient Experience** report noted improved National Inpatient Survey results—particularly in communication—alongside the establishment of a new patient carer council and planned structural changes to strengthen complaints handling amid a 19% rise in formal complaints. Members also discussed opportunities to better showcase positive feedback, with plans to expand the visibility of compliments and 'you said, we did' actions across patient areas.	• It was suggested that research be undertaken to understand the impact of the **chaperoning** policy on front line practice, in addition to the impact on patients, to inform feedback to national teams. • To consider what additional assurance was required to be provided in relation to Our Population **strategic plan,** with the Consultant in Public Health to be invited to a future meeting. • Additional action added to the **Infection Prevention BA**F in relation to antimicrobial resistance with a further update to be provided to the Board in February. • Work ongoing to determine any correlation between overcrowding and increased **infection** rates. • Further work to be undertaken with care group leads to address the dip in timely observations compliance as identified by the M9 **quality performance** report
Positive Assurances to Provide	**Decisions Made**
• The Committee welcomed the update provided on **chaperoning**. It was noted that an internal audit was to be undertaken by the end of Quarter 4. In addition, regular monthly audits were being planned. • The Committee considered the **BAF** for Q3, particularly scrutinising BAF 1 and BAF 2. It was noted that a detailed Board discussion was expected in March on risk appetite, tolerance, and the difference between aspiration and pragmatism. • The Committee welcomed the high number of **flu vaccinations** provided to staff. • In terms of **elective** and **cancer performance**, the faster diagnostic standard had dipped in performance as expected but remained on its recovery trajectory. Diagnostic performance remained on plan with non-obstetric ultrasound improvements noted. RTT remained on plan although winter pressures had impacted on the number of patients with long waits. The Committee noted the additional support put in place from NHS England. • The Committee received an update on **paediatric audiology**, noting progress in IQIPS manager recruitment, continued thematic review of historic cases, and the reclassification of one moderate-harm incident to low harm while a second remained under assessment. Assurance was provided around ongoing oversight and forthcoming actions and given the progress made acceptable assurance was agreed. • Q3 **patient safety incident investigation** (PSII) report highlighted 5 incidents having been reported, 1 of which related to a never event. Assurance was also provided in terms of the ongoing reviews from the Risk Management Panel of the closure of recommendations and completion of actions. • Q2 **Care Excellence Framework** (CEF) report highlighted that the majority of wards assessed had been identified as either gold or platinum; there remained two wards with a bronze rating and additional monitoring and support had been put in place for those areas	• The Committee approved the **Strategic Plans** for Our Patients and Our Population • The Committee approved the **Maternity Incentive Scheme** Year 7 declaration of compliance for all 10 safety actions, which was to be ratified by the Board in February

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
Comments on effectiveness were sought via MS Forms after the meeting	• Additional metrics regarding children's services and acute care at home being considered for inclusion at care group level and escalated up to the Committee • Additional capacity business case to be considered by Finance and Business Performance Committee in March which will include additional clinical capacity and support

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Board Assurance Framework Q3 25/26	1	Ext 20	Not Applicable	Approval	7.	Paediatric Audiology Update	1	33109 Ext 15 31492 High 12	Acceptable	Assurance
2.	Strategic Plans: • Our Patients • Population Health	1	Ext 20	Not Applicable	Approval	8.	PSII Quarterly Report (Q3 2025-2026)	1	Ext 20	Acceptable	Assurance
3.	Executive Quality & Outcomes Group Highlight Report (29-01-26)	1	Ext 20	Not assessed	Assurance	9.	Patient Experience Report Q2 2025/26	1	Ext 20	Partial	Assurance
4.	Access Performance Report Month 9 – 25/26	1	Ext 20	Partial	Assurance	10.	Care Excellence Framework (CEF) Report Q2 2025/26	1	Ext 20	Partial Acceptable	Assurance
5.	Infection Prevention Board Assurance Framework Q3 2025/26 • Antimicrobial Stewardship	1	Ext 20	Partial	Assurance	11.	Maternity (Perinatal) Incentive Scheme – Year 7	1	Ext 20	Significant	Approval
6.	Infection Prevention Quarterly Report Q3 2025/26	1	Ext 20	Partial	Assurance	12.	Quality Performance Report – Month 9 2025/26	-	-	-	Information

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Integrated Performance Report

Month 09 Performance

2025/26

Kind Excellent Together

University Hospitals of North Midlands NHS Trust

Contents

Statistical Process Control

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

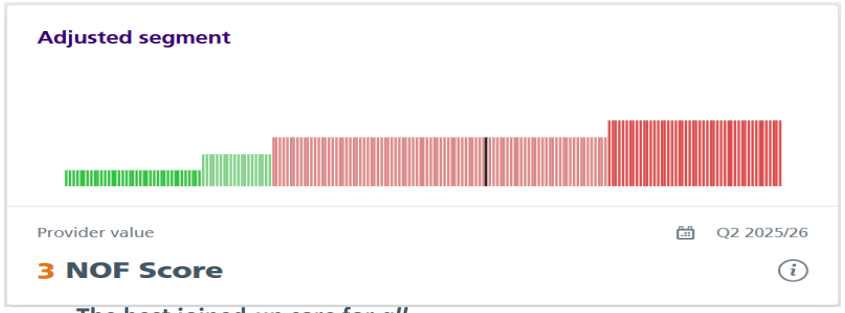
Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

National Oversight Framework Summary

University Hospitals of North Midlands NHS Trust

Headlines	Data period	Provider value	Peer average		National value	National value method	Chart
Adjusted segment			Q2 2025/26	3	NOF Score	Provider value	
Average metric score			Q2 2025/26	2.43	NOF Score	Provider value	
Unadjusted segment			Q2 2025/26	3	NOF Score	Provider value	
Financial override	Q2 2025/26	No	Yes		Yes	Provider median	
Is the organisation in the Recovery Support Programme?	Q2 2025/26	No	No		No	Provider median	

Domain Scores	Data period	Provider value		Chart
Access to services domain segment	Q2 2025/26	3	NOF Score	
Access to services domain score	Q2 2025/26	2.41	NOF Score	
Effectiveness and experience of care domain segment	Q2 2025/26	2	NOF Score	
Effectiveness and experience of care domain score	Q2 2025/26	2.19	NOF Score	
Patient safety domain segment	Q2 2025/26	3	NOF Score	
Patient safety domain score	Q2 2025/26	2.86	NOF Score	
People and workforce domain segment	Q2 2025/26	2	NOF Score	
People and workforce domain score	Q2 2025/26	2.53	NOF Score	
Finance and productivity domain segment	Q2 2025/26	3	NOF Score	
Finance and productivity domain score	Q2 2025/26	2.36	NOF Score	



UHNM remains in segment 3 for quarter two.
UHNM demonstrates a balanced performance across the NOF domains, with very little change from quarter one.

Overall score in quarter one was 2.47, quarter two is 2.43, broken down as:

- Access to services from 2.55 to 2.41
- Effectiveness and experience from 2.17 to 2.19
- Patient Safety from 2.63 to 2.86
- People and workforce remains at 2.53
- Finance and productivity remains at 2.36.

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NOF - Effectiveness and Experience

University Hospitals of North Midlands NHS Trust

Effectiveness and experience of care							Data period	Provider value		Chart
Effectiveness and experience of care domain segment							Q2 2025/26	2	NOF Score	

Patient experience	Data period	Provider value	Peer average	National value	National value method	Chart
CQC inpatient survey satisfaction rate score			Q2 2025/26	2	NOF Score	Provider value
Summary Hospital-level Mortality Indicator score			Q2 2025/26	3	NOF Score	Provider value

Effective flow and discharge	Data period	Provider value	Peer average	National value	National value method	Chart
Average number of days from discharge ready date to actual discharge date (including zero days) score			Q2 2025/26	1.58	NOF Score	Provider value

Additional contextual measures - non scoring	Data period	Provider value	Peer average	National value	National value method	Chart
Number of sections of the CQC maternity survey to be banded as "worse" or "much worse" than expected	2024	1	0	0	Provider median	

UHNM score well in this domain, with a score of 2.19 a slight improvement since quarter one of 2.17.
Patient Experience – both metric scores remain the same as in quarter one.
Effective flow and discharge – slight improvement in score from 0.40 to 0.39.

Contextual metric has been added, definition describes:

Number of sections of the CQC maternity survey to be banded as "worse" or "much worse" than expected

Count of the number of the 10 sections of the CQC maternity survey that have a banded score of 1 "Much worse than expected" or 2 "Worse than expected".

NOF - Patient Safety

University Hospitals of North Midlands NHS Trust

Patient Safety Domain Score	Data period	Provider value		Chart
Patient safety domain segment	Q2 2025/26	3	NOF Score	
Patient safety domain score	Q2 2025/26	2.86	NOF Score	

Patient safety Please note that the MRSA, C-Difficile and E-Coli scores each carry a one third weighting	Data period	Provider value	Peer average	National value	National value method	Chart
NHS Staff Survey - raising concerns sub-score score			Q2 2025/26 2.71	NOF Score	Provider value	
NHS Staff survey - raising concerns sub-score	2024	6.37	6.32	6.42	Provider median	
Number of MRSA bacteraemia cases score			Q2 2025/26 3.74	NOF Score	Provider value	
Number of MRSA bacteraemia cases (12 months)	To Sep 2025	8.00	6.00	3.00	Provider median	
Proportion of C. difficile infections score			Q2 2025/26 3.24	NOF Score	Provider value	
Proportion of C. difficile infections versus threshold (12 months)	To Sep 2025	1.31	1.13	1.18	Provider median	
Proportion of E. coli bacteraemia score			Q2 2025/26 2.04	NOF Score	Provider value	
Proportion of E. coli bacteraemia versus threshold (12 months)	To Sep 2025	1.03	1.19	1.18	Provider median	

UHNM remain in segment 3 for this domain, with a score of 2.86 in quarter two, down from 2.63 in quarter one.
This movement is a result of the scores for CDiff and EColi rates deteriorating since quarter one for UHNM.
Although MRSA value has improved since quarter one from 9 to 8 in quarter two, this remains significantly higher than the peers value of 4 and the national value of 3.

Quality & Access | Overview

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NHS
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Overview from the Chief Nurse and Chief Medical Officer

How are we doing against our trajectories and expected standards?

We met the required performance across a range of metrics and the NMAHP workforce remains stable. We have a range of processes to assess and triangulate safe staffing requirements, fill rates, staff experience and quality metrics and outcomes; and subsequent supportive interventions when and if required. Where possible national benchmarking using Public View has been included for the available indicators. The Recommended Trusts for comparison (blue columns) are Nottingham University Hospitals, UHCW, UHDB, University Hospitals of Leicester and East Lancashire Hospitals.

We have exceeded the national requirement for 50% of front line staff to receive their flu vaccination (current position 53.2%).

We are top quartile across the Midlands across a number of metrics relating to the blood culture pathway. We are currently 0.6% under the YTD target upper limit for e-Coli.

There have been 15 Calls for Concern (Martha's Rule) during December 2025: Call numbers have increased following confirmation from regional teams around recording and what is defined as a "review". "A review doesn't specifically have to be a physical review of the patient, more a rapid clinical assessment by an independent response team: the outcome of the review can be patient not deteriorating and the outcome would be documented advice". The numbers at UHNM are now more reflective of the national picture. Of the 15 cases referred in December: 12 were reviewed, 10 with documented advice and 2 requiring further clinical review, which initiated a change in treatment plan for both, inc IV fluids, pain and secretion management and further diagnostics.

The last phase of the ePMA rollout was paused due to the recent critical incident but recommenced w/c 12 Jan.

The CN has now started to receive feedback directly from families who have used our maternity services - this is not to replace the complaints process but offers families the opportunity to share their experience, speak to myself or the Director of Midwifery if they wish, and highlight staff who had a positive impact on their experience. 3 response to date – very positive feedback in relation to the service but an ask to review the chairs in MAU which are uncomfortable.

What is driving this?

We failed to meet the required target for a number of metrics including DOC verbal and written, VTE assessments, C-Diff (20 cases above YTD target upper limit), complaint response time (however this is the best performance since July 2020), timely observations, patient falls with harm per 1000 bed days (5), medication incidents with moderate harm or above (1), single sex accommodation breaches, ED Sepsis IVAB, FFT in ED and maternity, and HSMR/SHMI.

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.

The current performance is at the level of limited assurance.

There has been continued poor performance in relation to VTE assessments due to poor recording of date and time of the assessment. The last phase of the ePMA rollout is in progress and so we should shortly be able to report performance directly from the ePMA system

Quality& Access | Overview

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Overview from the Chief Nurse and Chief Medical Officer

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

Intensive and specific corporate support to Bronze CEF wards continues and is proving impactful and continues to support areas CEF Silver wards. We are in the process of setting up specific improvement work to support County to achieve Outstanding and RSUH to achieve GOOD –this is initially a 12 month improvement programme. We will keep the CQC updated on progress throughout. Engagement sessions continue with NMAHPs colleagues into the New Year to co-design a new Excellence Framework that will replace the current CEF – this will be presented to Committee once completed. The CN is supporting regional work to develop a suite of quality metrics that can be used to benchmark against other providers. The second phase of this engagement is underway to agree the metrics and measures we will use.

Focused project work continues for our Non-Medical Prescribers database and maturity matrix.

We have introduced new digital audits for our temporary escalation spaces which we are reported to Executive meeting weekly – any required escalations will be reported to the Committee.
The CN has met with the regional IP lead re our ongoing challenges to reduce HAIs –she did not report any concerns for UHNM but did mention a theory she has that potential overcrowding is contributing to infection rates across the region. The CN has offered to review our processes and practice across the UEC pathways and areas that accommodate consistent continuous flow patients.
The CN has reached out to then MPFT CN to consider working collaboratively to review a cohort of frail elderly patients to better understand the community offers and pathways available to support more timely discharge from hospital.

We have secured recurrent funding for the core Oliver McGowan training team; and for the core research team within CeNREE

HSMR Continues to be higher than expected. Previously identified issues with clinical coding and capacity issues impacted ability to fully code all inpatient activity. Clinical Coding papers have been provided at Executive level and Quality, Access & Outcomes Committee on uncoded activity and the different submission deadlines (Flex, Freeze and Post Reconciliation). A more detailed report is now being produced to review and monitor submission figures and progress with improvement plans for recruitment of trainees and contract coders. Improvement Plan has been written and will be reviewed and assurance sought on progress at Mortality Review Group

What can we expect in future reports?

We will update the committee quarterly on progress with the CQC/CEF improvement work

The IP review across UEC and wards will be conducted during February and reported to the Committee once the report is completed (March/April).

We will confirm the outcome of the review of the chairs in MAU

Will share the TOR for the collaborative work with MPFT and future outcomes if agreed by MPFT

Quality & Access | [PSIs per 1000 bed days]

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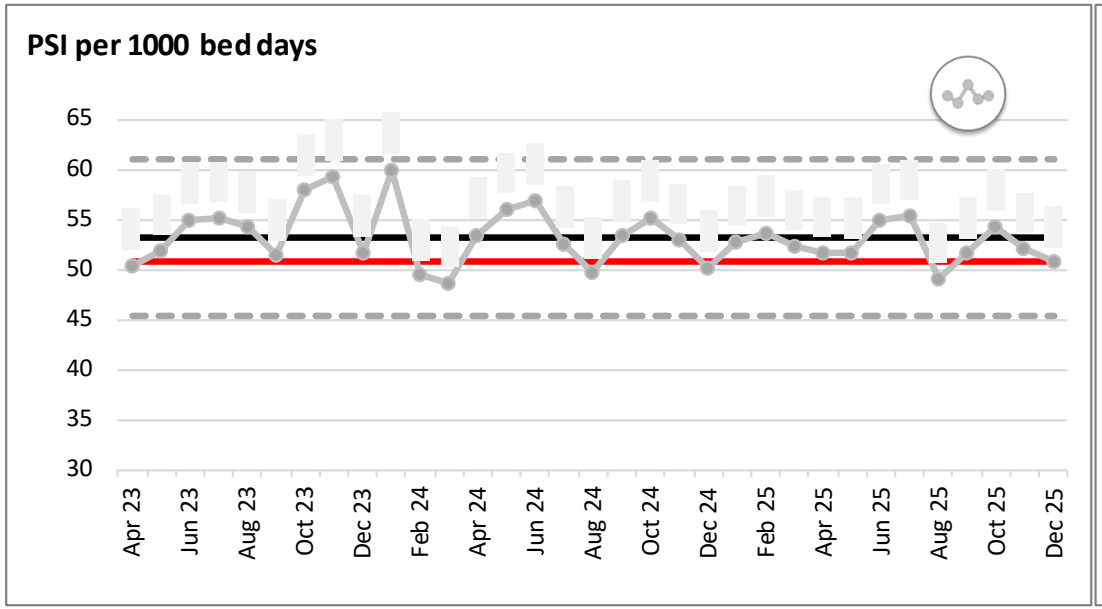

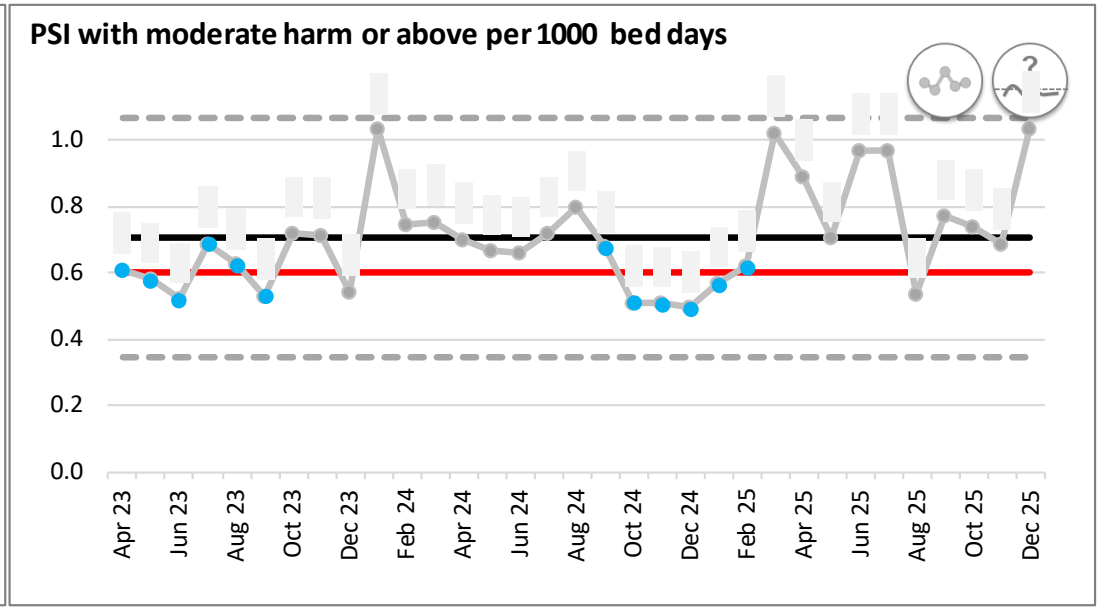

What is driving this performance?

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

The rate of PSIs reported as resulting in moderate harm or greater has varied considerably but the average remains consistent since 2024. The latest month's data is very likely to change (usually downward) as incidents are reviewed.

The most common Categories of incidents resulting moderate harm or greater in the past 6 months to Nov-25 were Treatment/procedure, Clinical assessment, Patient Falls, Accident, Medication and Maternity triggers.

What are we doing about it?

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

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

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

Quality & Access | [Patient Falls]

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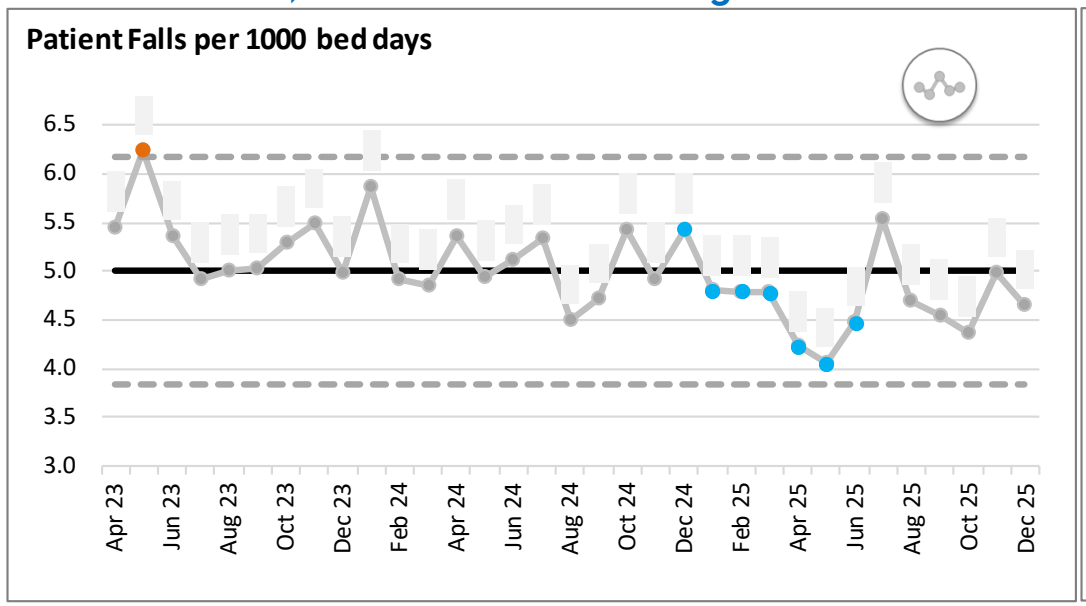

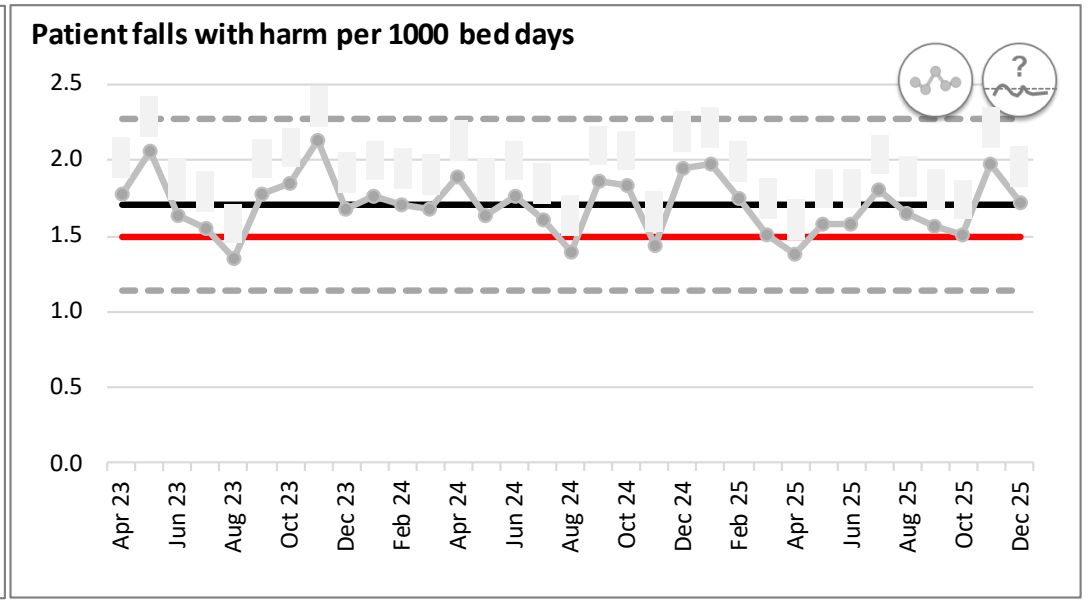

What is driving this performance?

The average rate of reported patient falls was within the usual range in December 2025. The rate of patient falls resulting in harm has remained consistent since June 2023. Top reporters in November 2025: Stoke AMU – 16 falls, Stoke ED – 13 falls, County Ward 1 – 9 falls. None of these numbers for December were significantly higher than in previous months.

5 falls resulting in a serious injury were reported in December, on the following wards: Ward 12, Ward 223, Ward 230, SSU, Stoke ED (all n=1)

It is important to note that a fall resulting in serious injury does not automatically raise red flags for any ward. Each incident is investigated to determine whether adequate precautions were implemented, and the findings are summarised on the right.

What are we doing about it?

Toolkits have been completed on those patients where moderate and severe harm has occurred. Actions and assurances were discussed for the individual cases.

Unwitnessed falls remain high. Go Look Learn to take place to provide assurance stay in the bay is taking place.

Thematic review underway of falls with injuries.

Observational and falls audits have taken place, the results have been discussed with the relevant teams.

N/A induction has been delivered.

Process in place to remove the faulty pyjamas that have been creating a trip/slip hazard.

Maternity bed rail risk assessment is now on the K2 system.

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

University Hospitals of North Midlands NHS Trust

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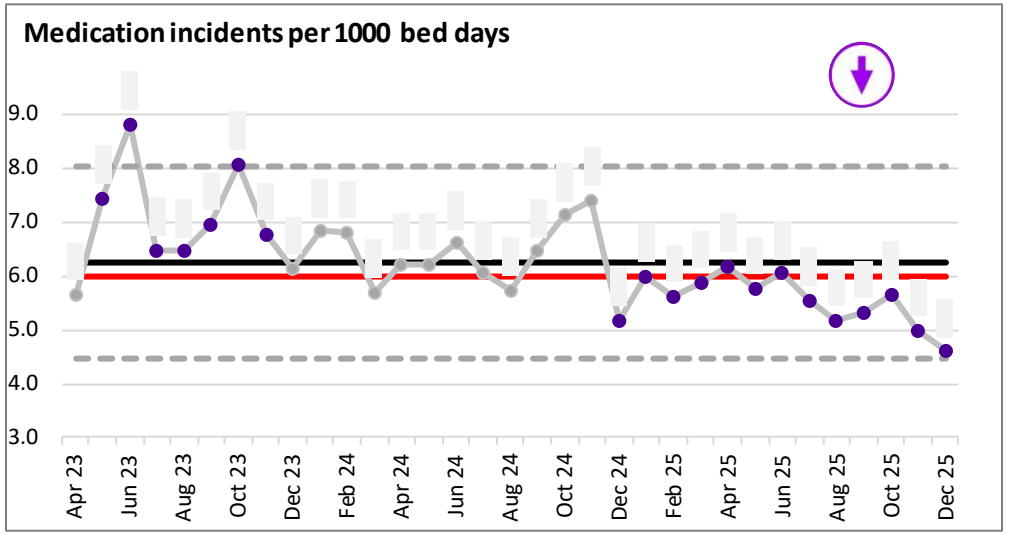

What is driving this performance?

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

What are we doing about it?

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

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

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

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

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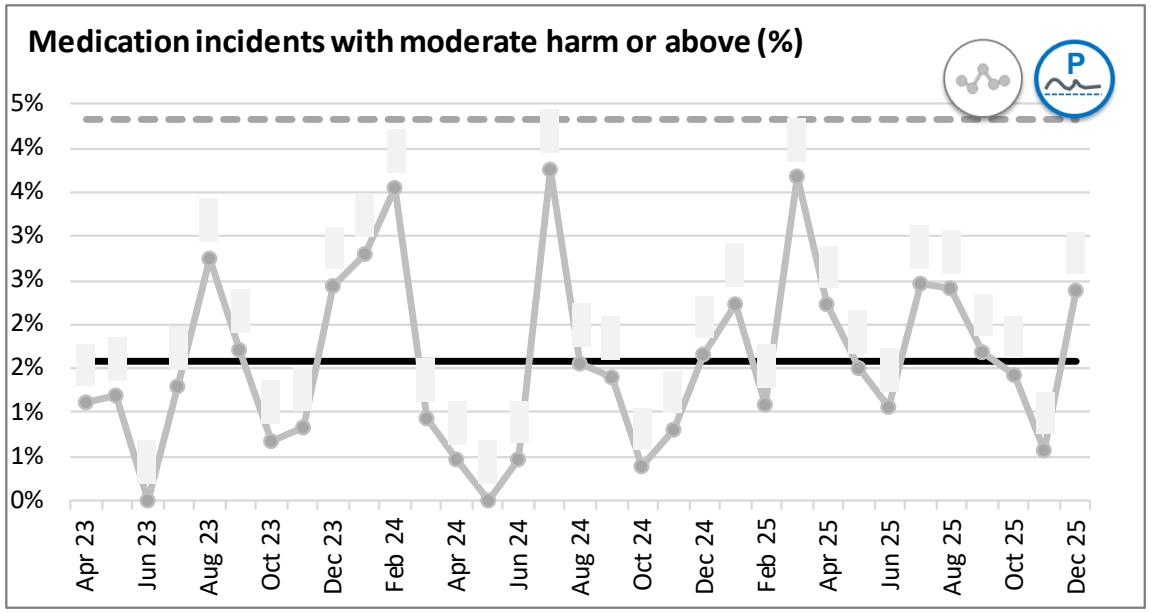

What is driving this performance?

In December 2025 there were 4 incidents reported that were categorised as moderate harm, 1 was rejected and 2 were downgraded to no physical harm and low physical harm. Reporting falls within usual monthly variation and remains consistently below the benchmark rate, offering positive reassurance that this standard is being met.

What are we doing about it?

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

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

ID	Incident Date	Location	Subcategory	Description	Actions
388084	15/12/2025	External	Failure to discontinue treatment/review medication.	Patient is suspected to have had edoxaban and apixaban in combination, same confirmed by pharmacy that medication had been administered. Patient admitted with worsening haematoma.	Informed doctor caring for patient, who discussed with reg and informed CT as patient awaiting scan. apixaban already on hold as per day plan

Quality & Access | [Never Events & PSIIs]

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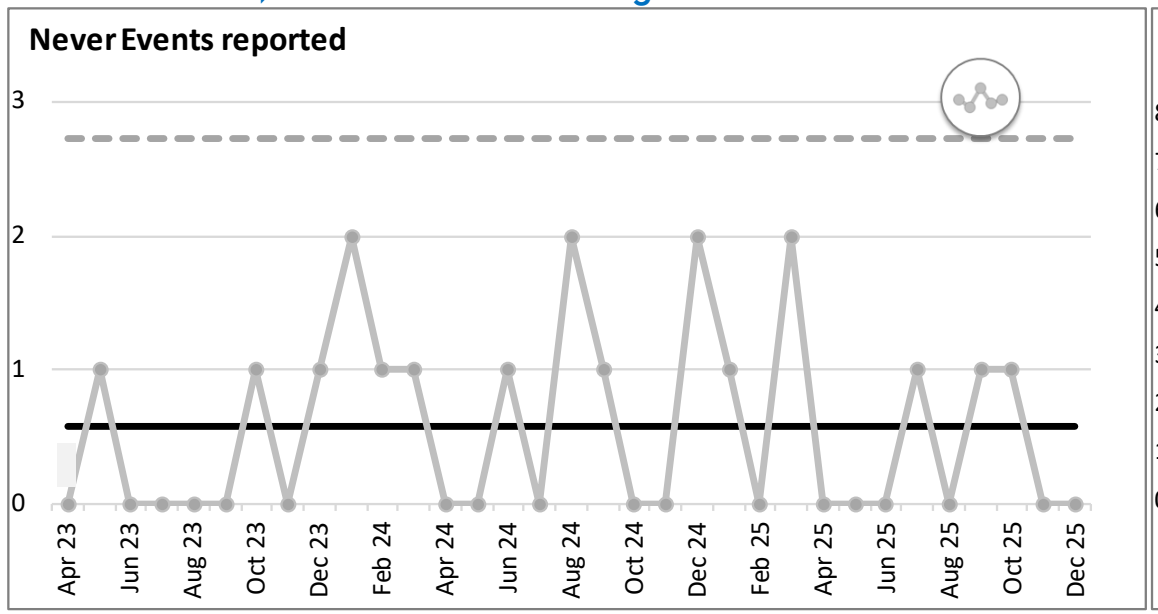

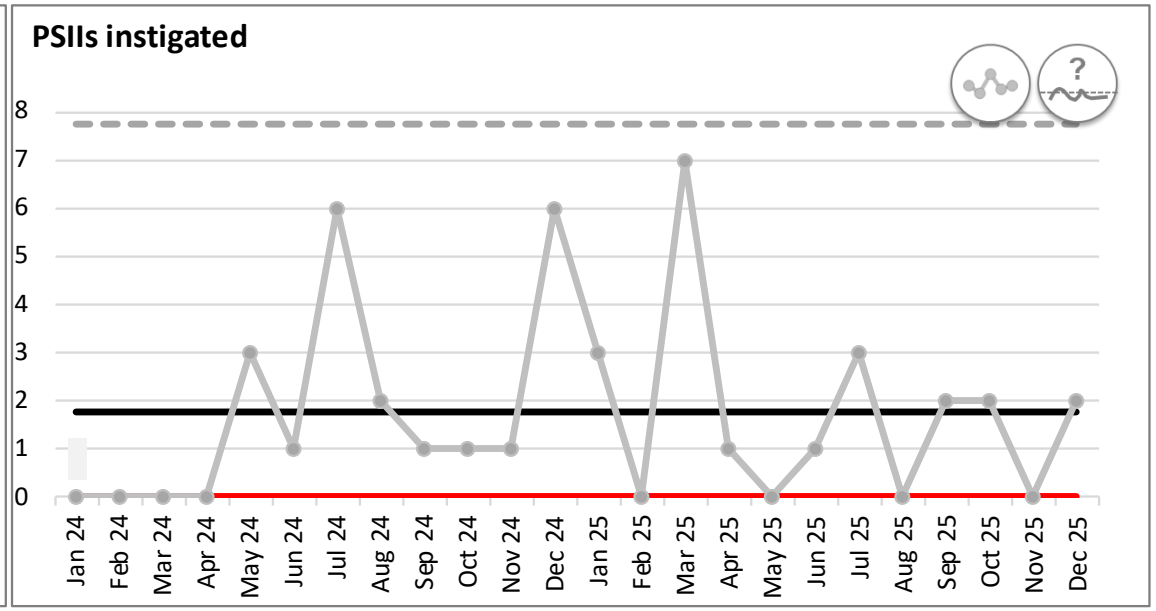

What is driving this performance?

No never events were identified during December 2025.

2 new PSII were commissioned during December 2025.

What are we doing about it?

PSIIs agreed following initial review of incidents and completed mortality review. Independent response leads have been appointed to review systems and process learning for the incidents below:

A missed perforation of a hollow viscus leading to severe septic shock and death.

A delayed diagnosis of aortic dissection leading to cardiac arrest and death.

Quality & Access | [Duty of Candour]

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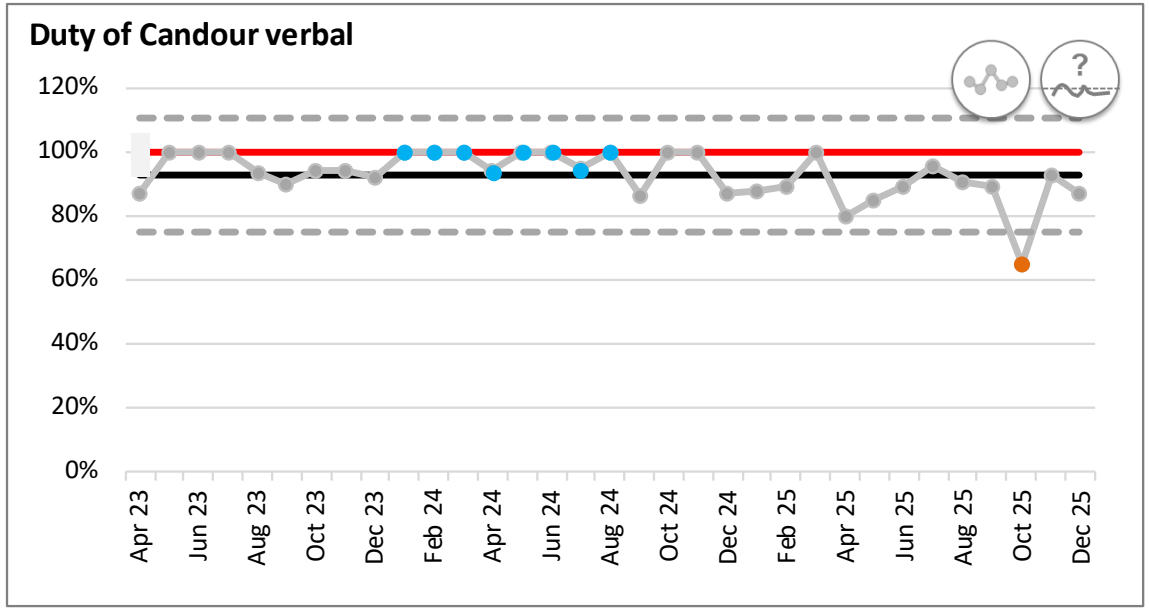

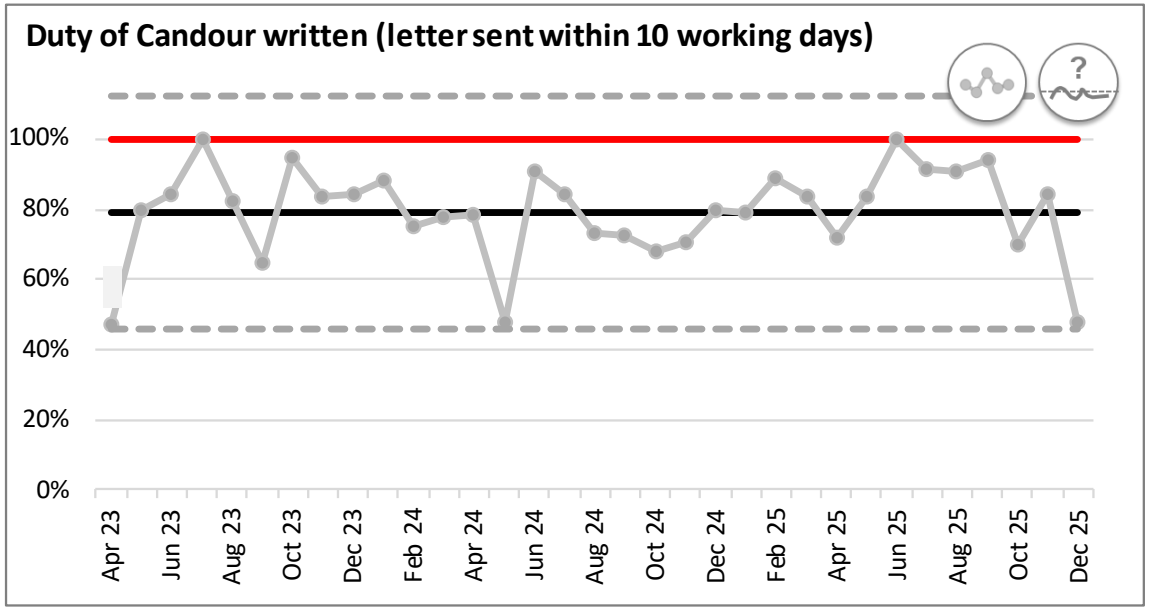

What is driving this performance?

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

20 out of 23 incidents that formally triggered duty of candour in December. (86.9%) have had verbal discussions recorded within Datix. Out of the 23 cases, 11 of them met the 10-working day internal target (47.8%). There were 10 cases breaching in unplanned, this was due to reduced monitoring of compliance due to staff changes within the QSC supporting the Care group. Other delays were due to discussions around agreement on LoH and conflicting demands not enabling staff to use management time to undertake tasks due to clinical pressures

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

What are we doing about it?

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

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

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

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

Provide safe, effective and caring services

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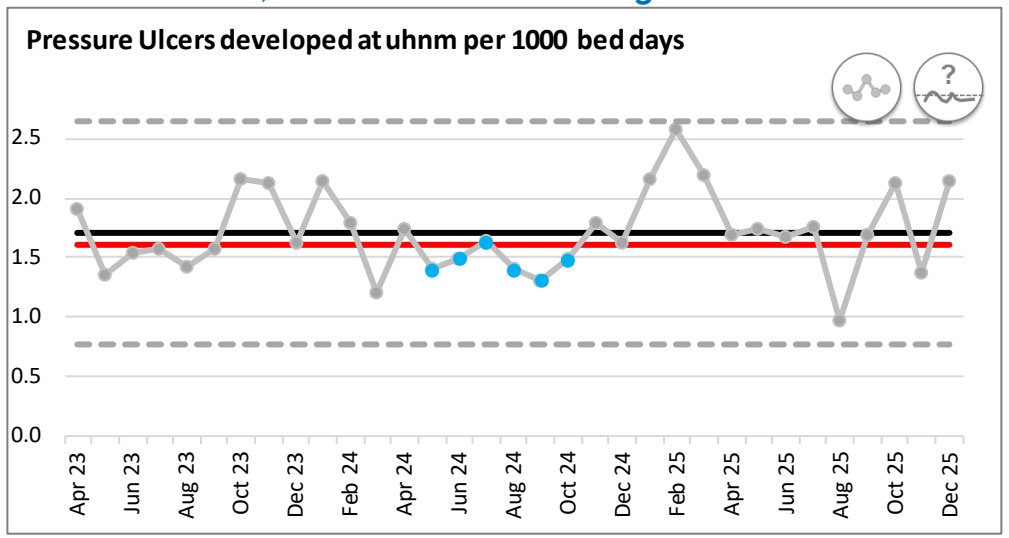

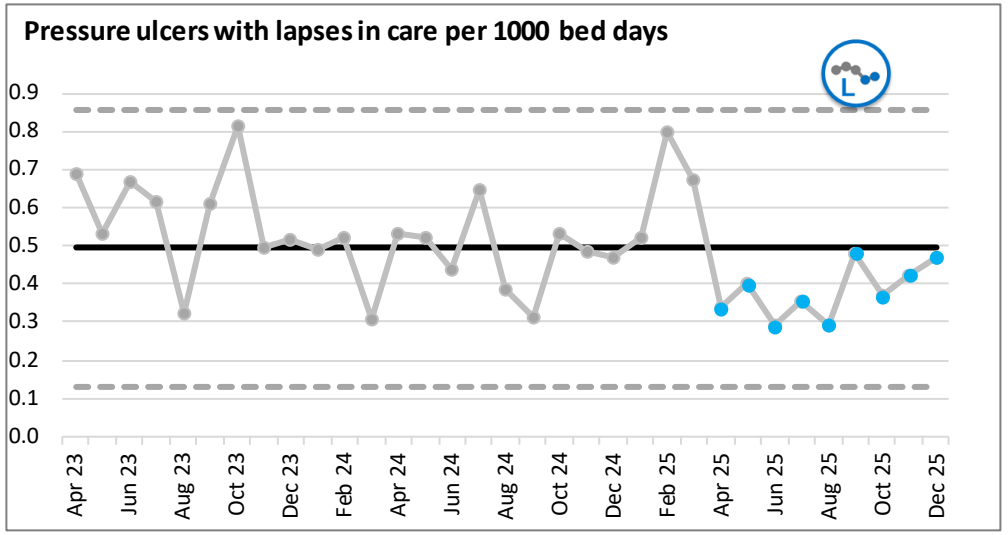

Type of Lapses Dec 2025	Total
Management of repositioning	12
Management of heel offloading	2
Management of device	2

What is driving this performance?

The rate of pressure ulcers reported as developing under UHNM care was within the usual range in December 2025. Numbers of Category 2's & 3's were within normal limits, but numbers of DTI's were significantly above average in October & December.

The rate of pressure ulcers with lapses in care identified has just remained below the average for 9 consecutive months, based on cases reviewed as of the 3rd of the month, which may indicate significant change.

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

15 urethral splits were reported in December 2025, 8 of which were noted to have lapses in care (1 TBC). This is not significantly higher than numbers seen since Jul-24.

What are we doing about it?

An update to be gained from OD and Training regrading the ESR education package
Assurance panels are now part of Tissue Viability steering group which allows for stakeholder feedback and peer support with actions. They are supported by the SSR for Q&S
Prompt cards being printed for staff to include categorisation, pressure ulcer prevention and pathways
Champions programme complete for 2025- new agenda drafted for 2026
Thematic reviews to be completed for hospital acquired pressure ulcers following approval of SOP. This will include gaining staff feedback.
ED Stoke have had further mattresses are being ordered to provide a standard surface.
Observational audits have been completed on areas where concerns have been voiced.
The immediate interventions protocol have been printed for wards and an electronic version is available for staff to implement actions for pressure prevention upon identifying pressure damage.
Categorising guidance has been provided for urethral erosions. The catheter summit aims to reduce unnecessary catheterisation through agreed actions.
Bariatric and specialist seating hire now goes through Medstrom to bespoke patient care. Standardise seating has also been agreed to ensure wards are ordering preapproved equipment with built in pressure relieving cushions.

Quality & Access | [Trust Apportioned Infections & MRSA Bacteraemia

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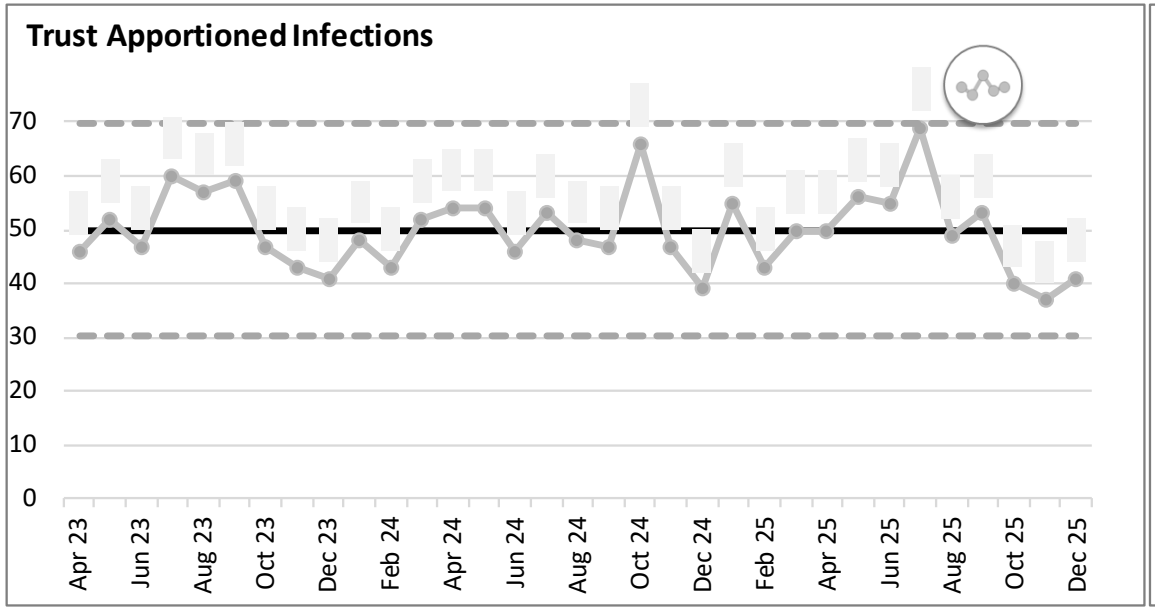

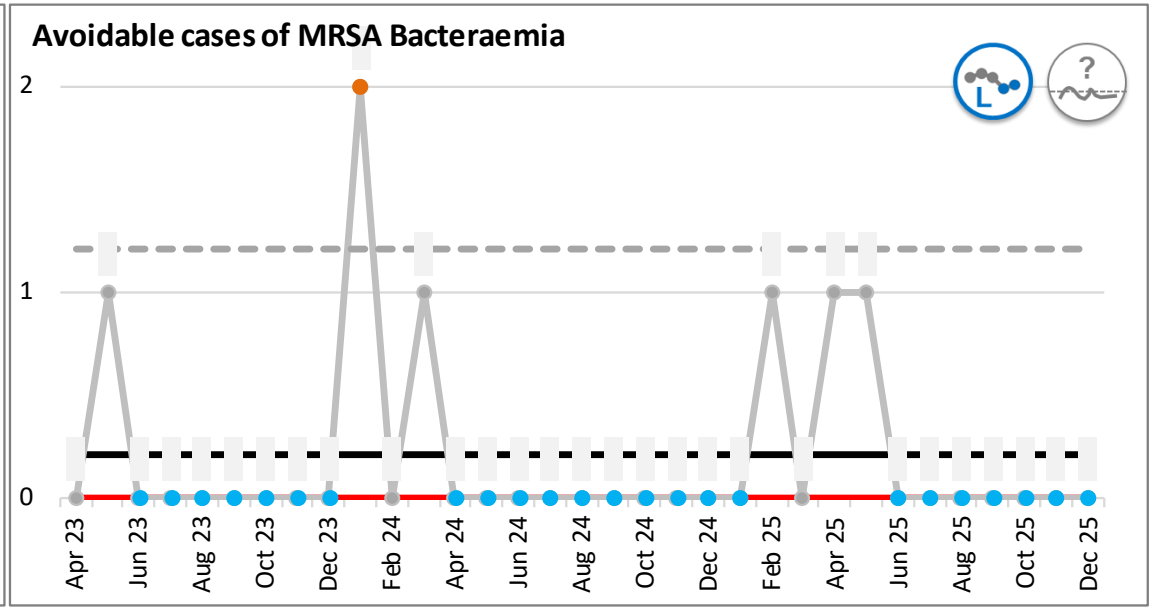

What is driving this performance?

Trust Apportioned Infections
Numbers remain within the usual range.

MRSA-b
No MRSA Bacteraemia cases reported for December 2025.

What are we doing about it?

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

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

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

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

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

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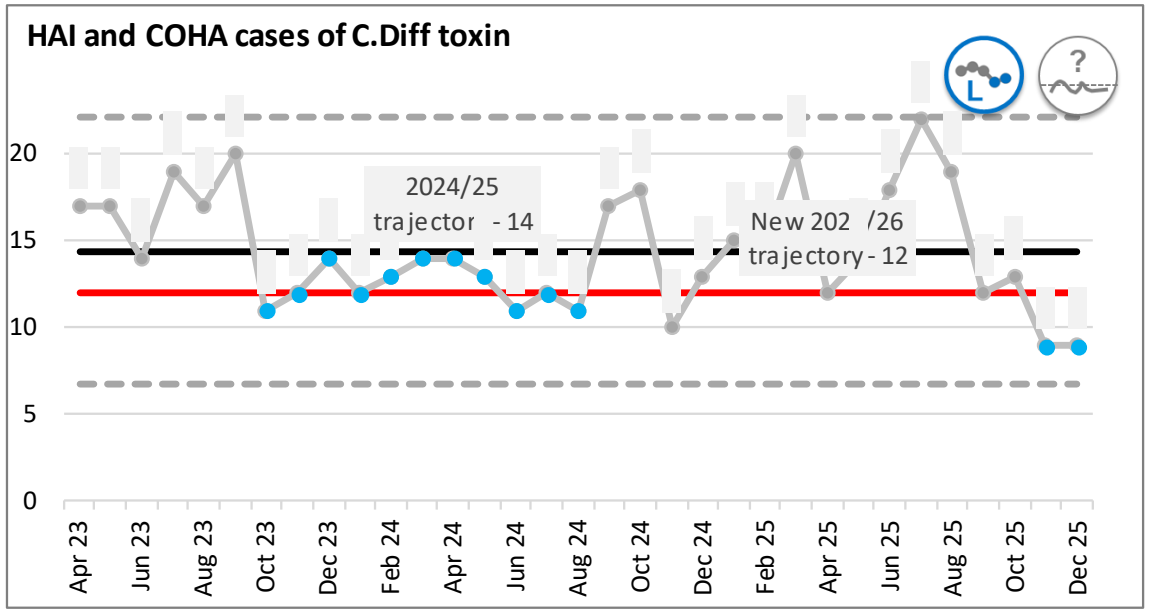

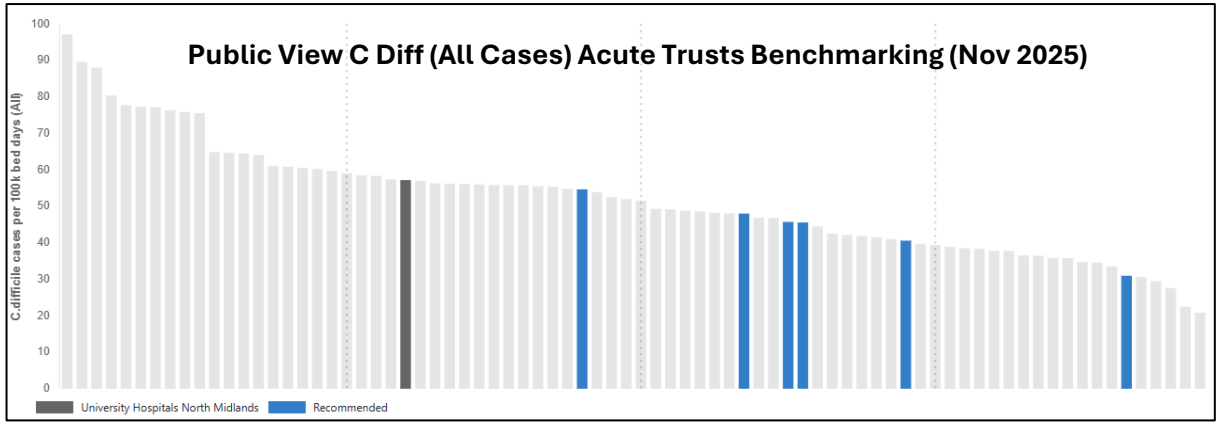

What is driving this performance?

The monthly number of C-Diff cases was significantly below average in November & December 2025. C diff has been declared a National Incident by the UKHSA due to the increased number of cases throughout England; work is ongoing to try to understand the reasons behind this.

There have been 9 reported C diff cases in December 2025 - 8 x HAI and 1 x COHA
There have been two wards with periods of increased incidence reported in December - one with 2 HAI cases and one with 1 HAI + 1 COHA.

The 24/25 objective for C-Diff is 179 cases or less.
The 25/26 objective for C-Diff is 144 cases or less. This was released in June 2025.
As at December 2025 we have had 128 Trust apportioned cases (84 * HAI and 44 * COHA) versus a year to date upper limit of 108 (19% over the upper limit).

What are we doing about it?

- Routine ribotyping of samples continues for samples from areas where we have periods of increased incidence only
- CURB -95 score added to CAP antimicrobial Microguide (Eolas)
- Antimicrobial working group to remind clinical areas to send urine samples when UTI is suspected and ensure appropriate choice of antibiotic for treatment of UTI
- Additional oversight of C-Diff cases is being implemented where there is potential learning in terms of antibiotic use. ePMA will further support for antibiotic auditing.
- Big bed clean commenced from 9th July 2025 & repeated in Oct 2025 IP week
- PSIRF process and monthly themes report
- Weekly AMS presence at County to support antimicrobial prescribing
Commode cleaning day completed January 2025 and October 2025. Aim for twice yearly.
- The existing Pneumonia guidelines were reviewed, revised and ratified through ASG and launched to prescribers in early January 2025. Key changes involve the reduction in the use of Co-Amoxiclav in CAP, with a focus on using the narrower spectrum oral antimicrobials where possible or a prompt IV to oral switch
- There has been a deterioration in the number of late sampling for patients admitted with diarrhoea resulting in classification as hospital onset.
- There has been several repeat sampling of known C diff cases outside the 28-day period resulting in a patient being included multiple times, education is provided by IP

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

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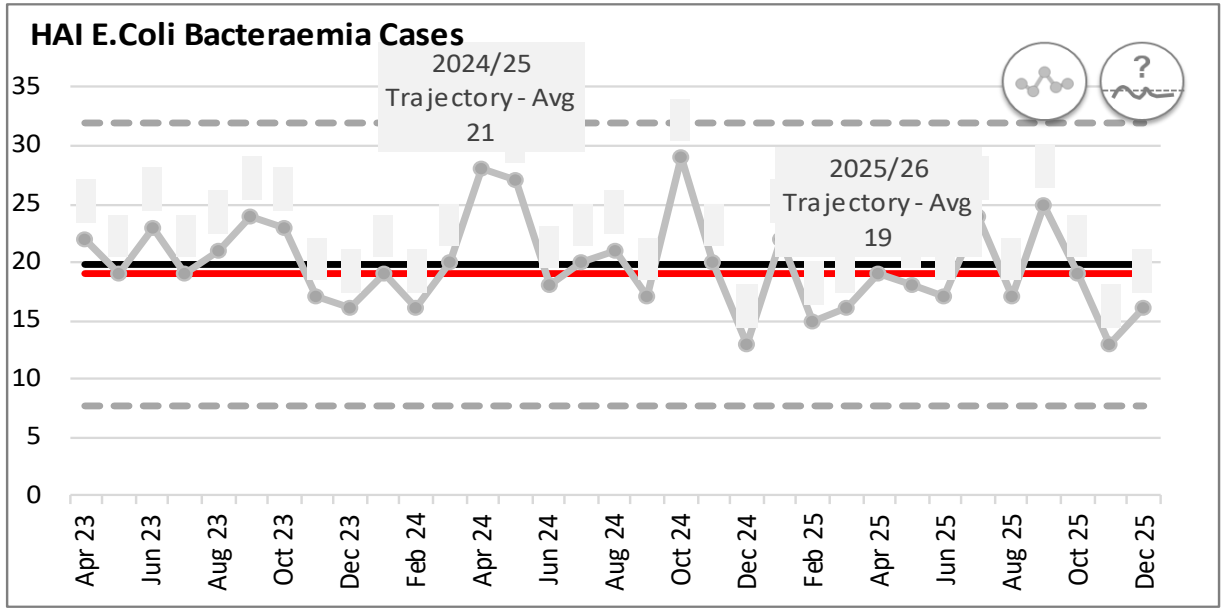

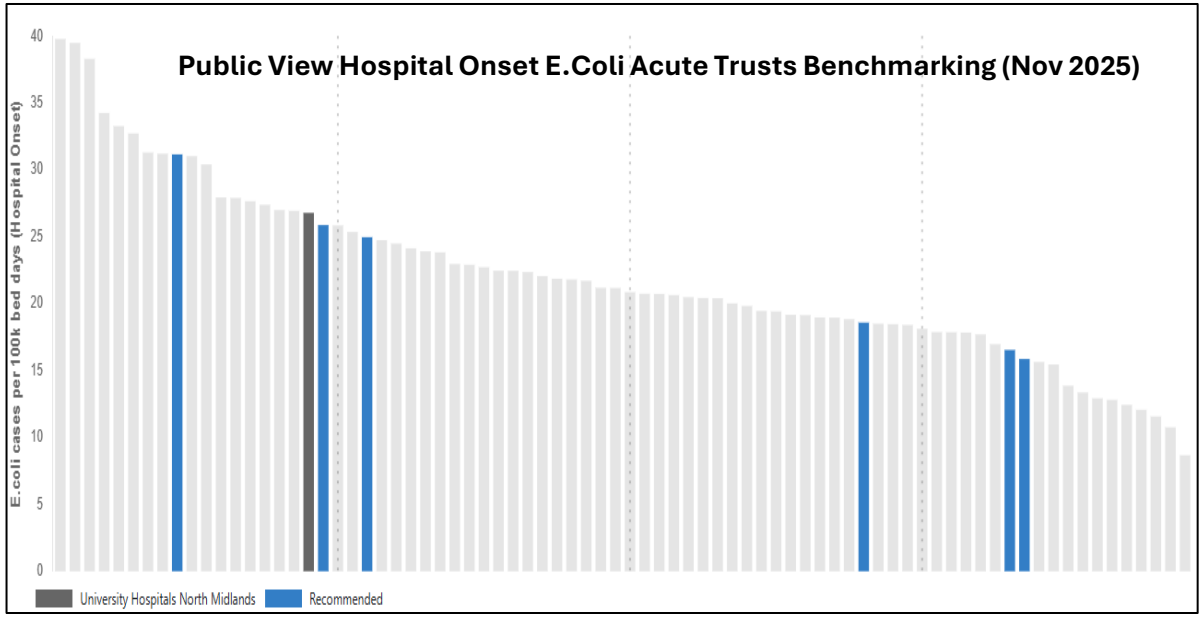

What is driving this performance?

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

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

As at December 2025 we have had 169 Trust apportioned cases (92 * HAI and 77 * COHA) versus a year to date upper limit of 173 (2.6% under the upper limit).

What are we doing about it?

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

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

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

Quality & Access | [Sepsis – Adult Inpatient]

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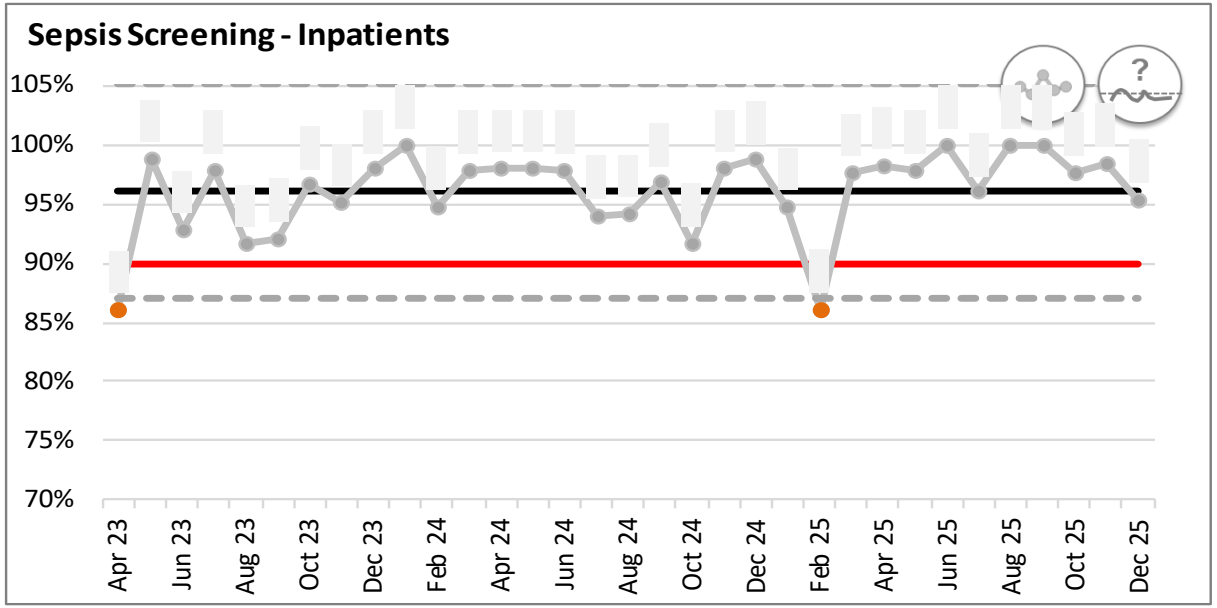

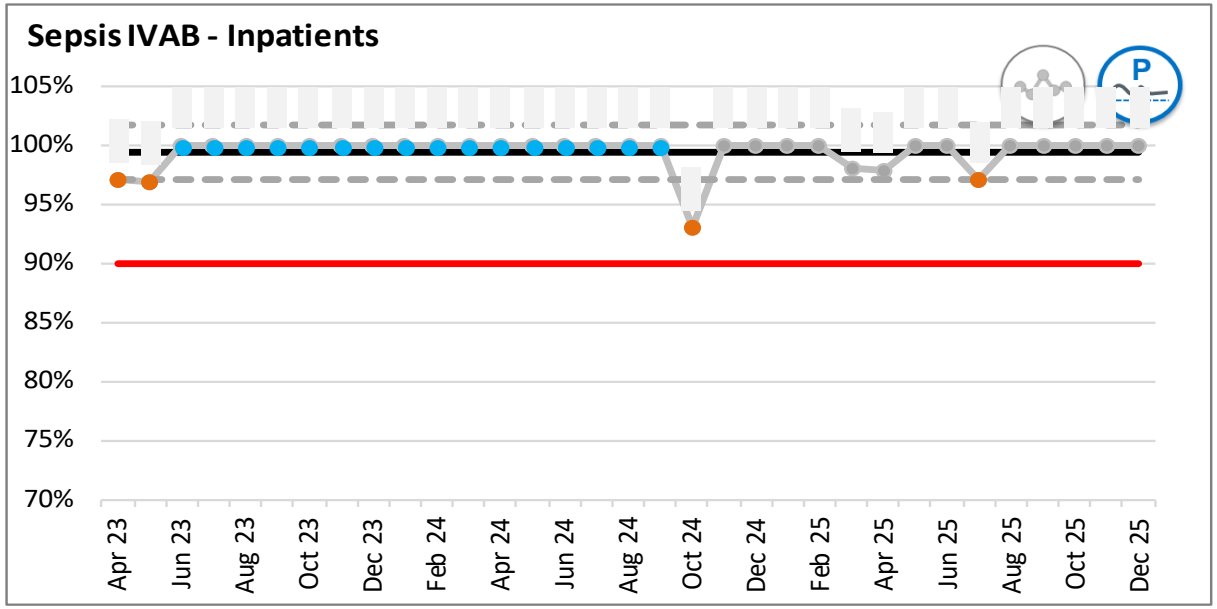

What is driving this performance?

Inpatient screening compliance was within the usual range in December 2025.
Average compliance for IVAB administration within one hour appears to far exceed the target, though the uncertainty in these rates is likely to be significant due to the difficulty in finding the small number of patients requiring new antibiotics due to sepsis.

A total of 131 cases were reviewed in December; there were six missed screens. Among these, 95 cases were identified as red flag sepsis, with 53 receiving an alternative diagnoses, leaving 42 patients of which 41 were already on antibiotics. Leaving 1 new identified sepsis and IVAB were given within the hour.

What are we doing about it?

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

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

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

Quality & Access | [Sepsis – Emergency Portals]

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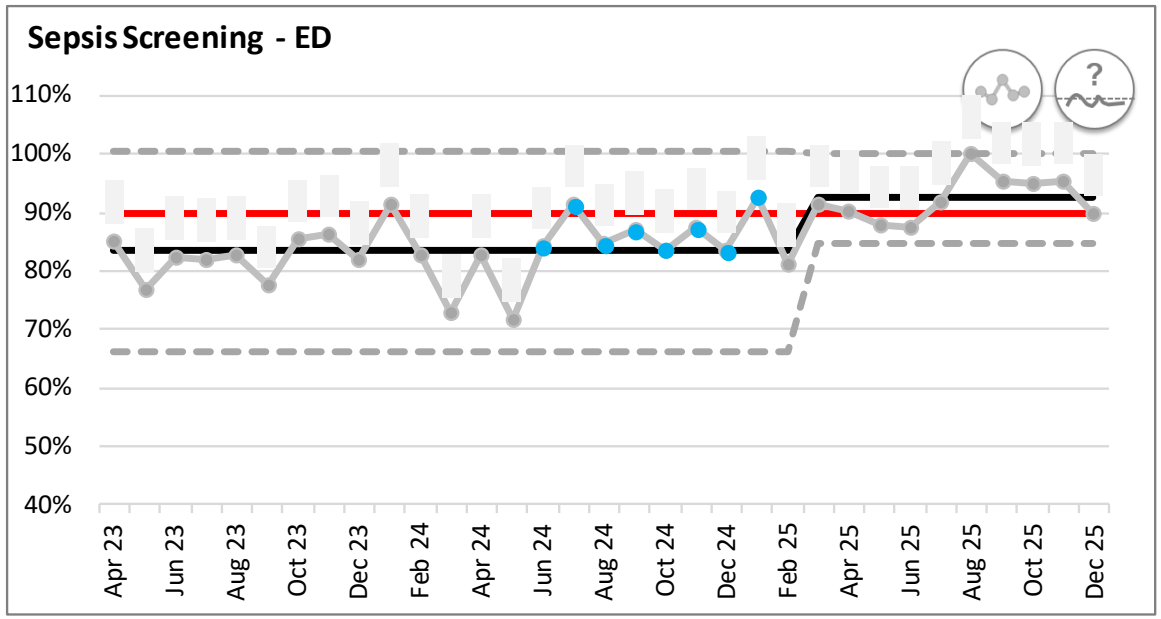

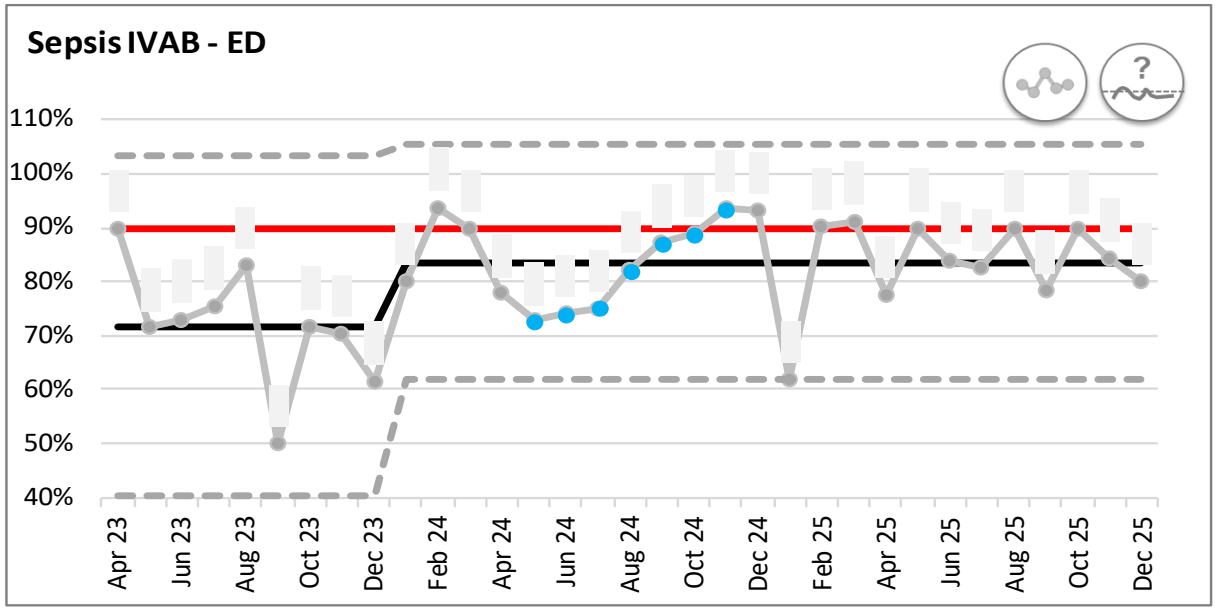

What is driving this performance?

Average compliance for adult emergency portals screening remains above the 90%, but current performance does not yet offer assurance that the target will be met every month.

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

In December, 148 cases were reviewed with 15 missed sepsis screens. Among these, 112 cases were identified as red flag sepsis. 77 of these had an alternative diagnosis, 18 were already on IV antibiotics. Leaving 17 newly identified sepsis patients. 7 of these patients received IV antibiotics outside the target 1 hour window.

What are we doing about it?

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

Quality & Access | [Sepsis – Children]

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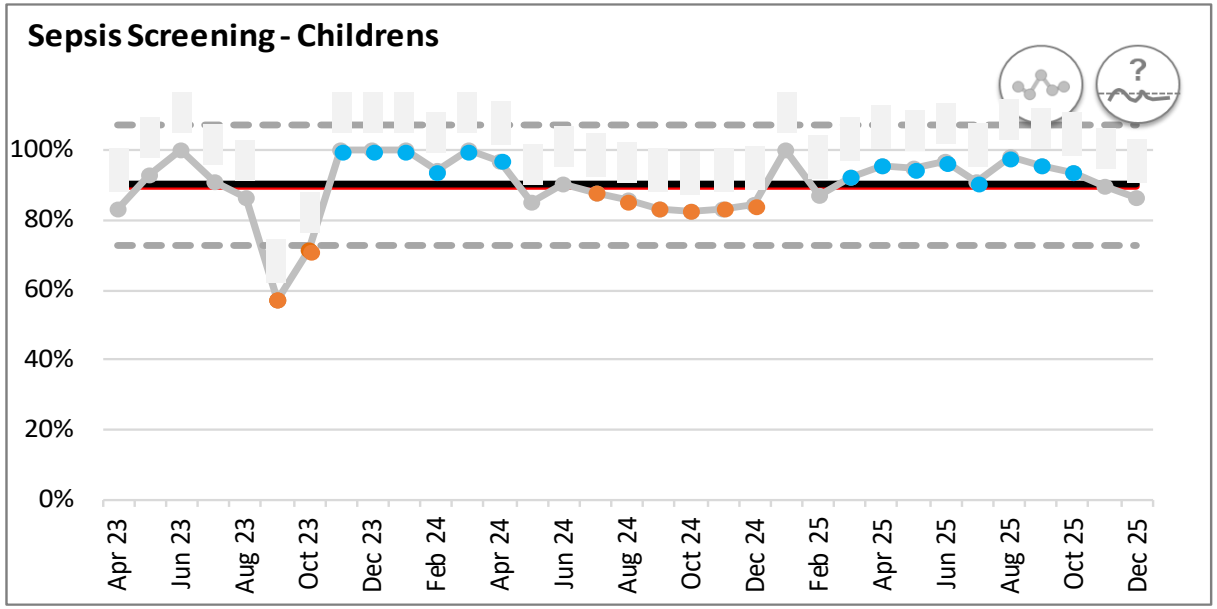

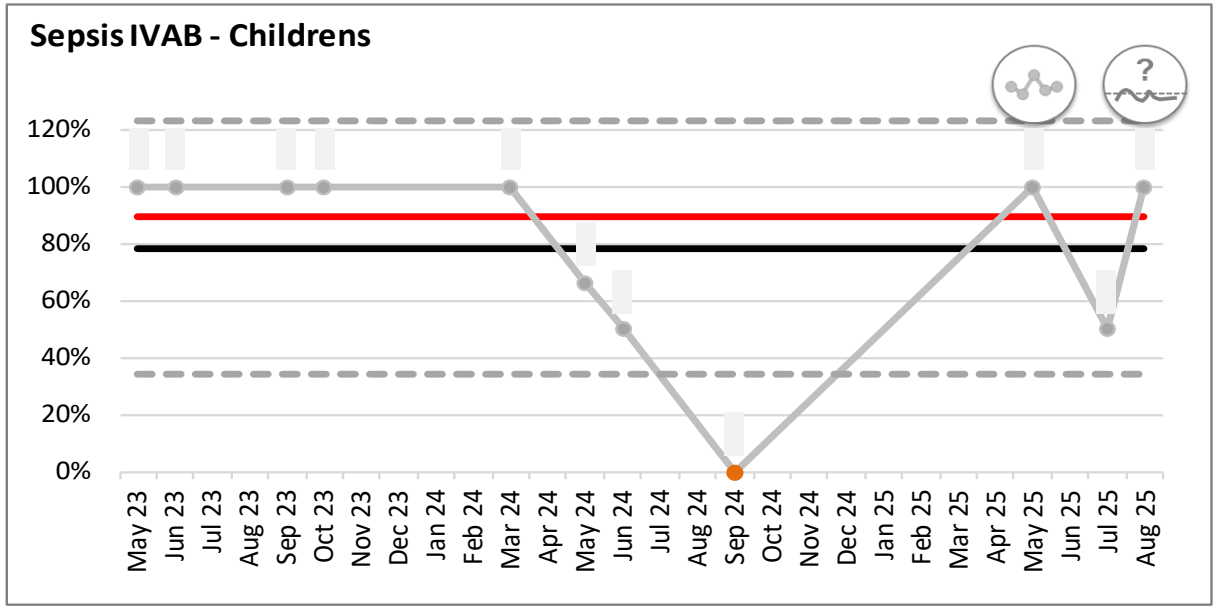

What is driving this performance?

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

There were 32 cases audited for emergency portals with no missed screens in December. 14 cases were audited for inpatients with 8 missed sepsis screens. No true red flag sepsis were identified from the randomised audits in the emergency portals or inpatients.

What are we doing about it?

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

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

Quality & Access | [Sepsis – Maternity]

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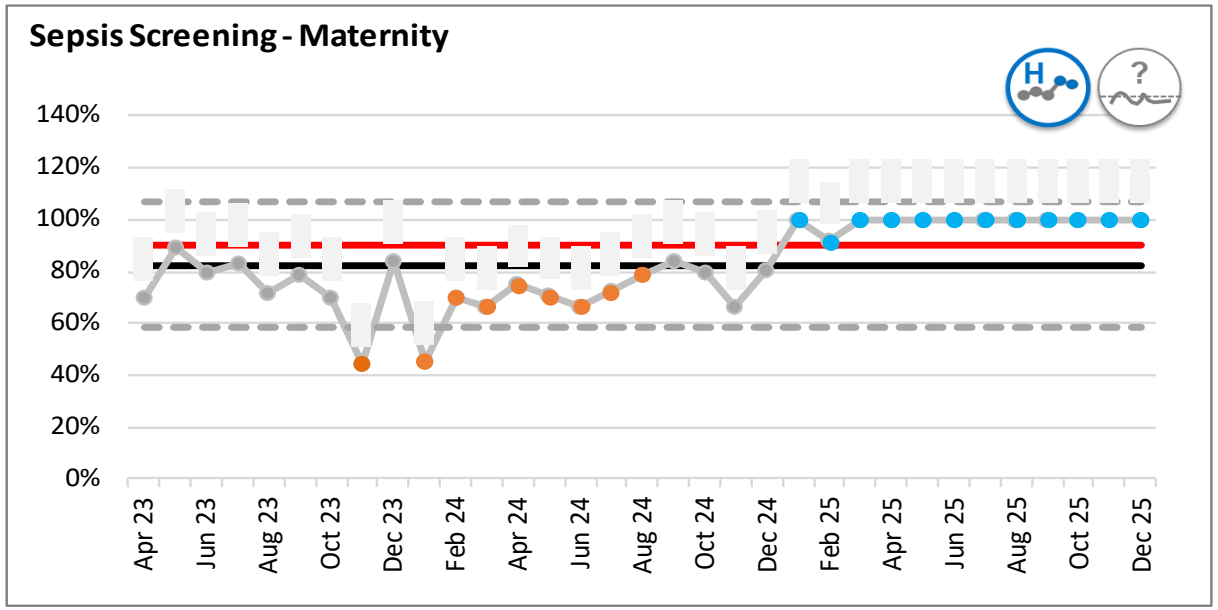

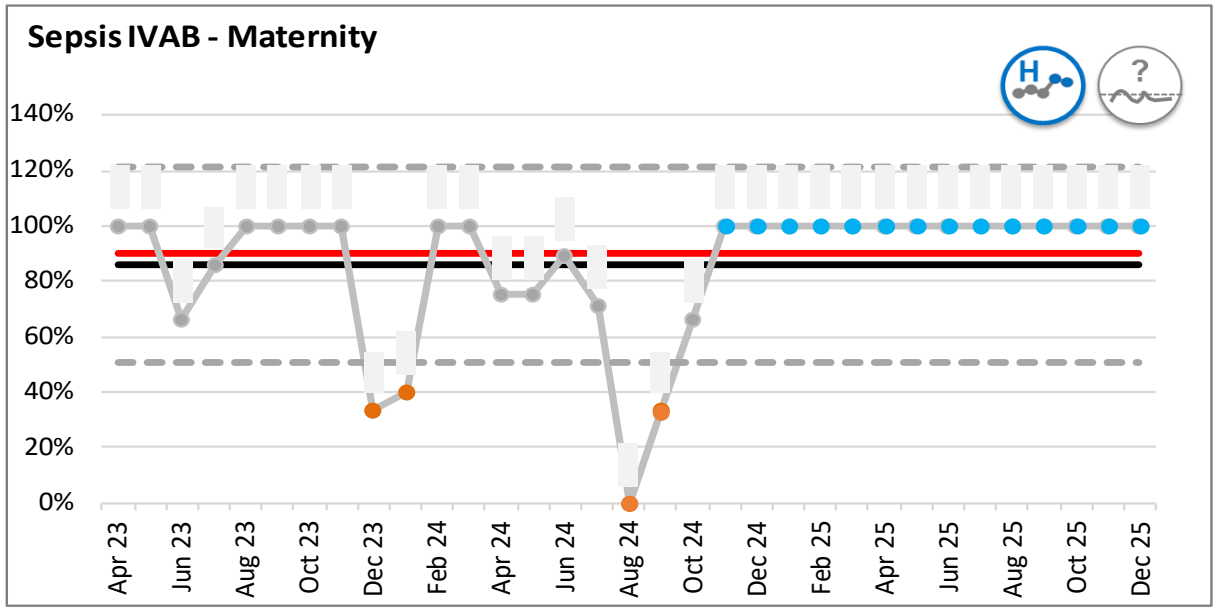

What is driving this performance?

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

A total of 17 cases were audited from the emergency portal MAU in December and 5 cases reviewed for inpatients, and there were no missed sepsis screens. For emergency portals, there was 3 newly identified sepsis patients and they all received IVAB within the hour.

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 | [VTE & Hospital Associated Thrombosis]

Provide safe, effective and caring services

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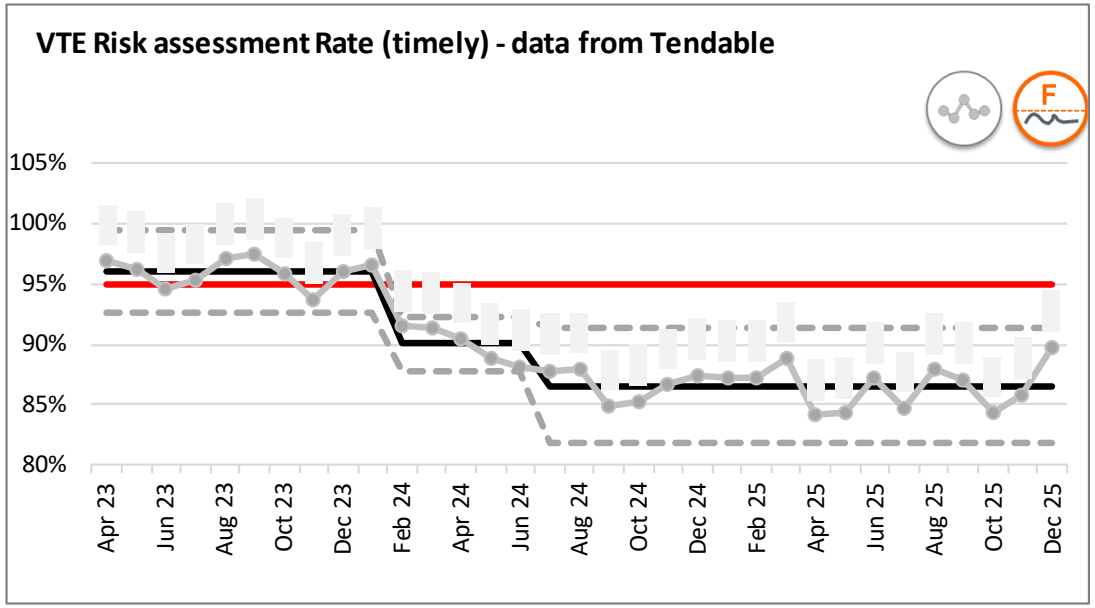

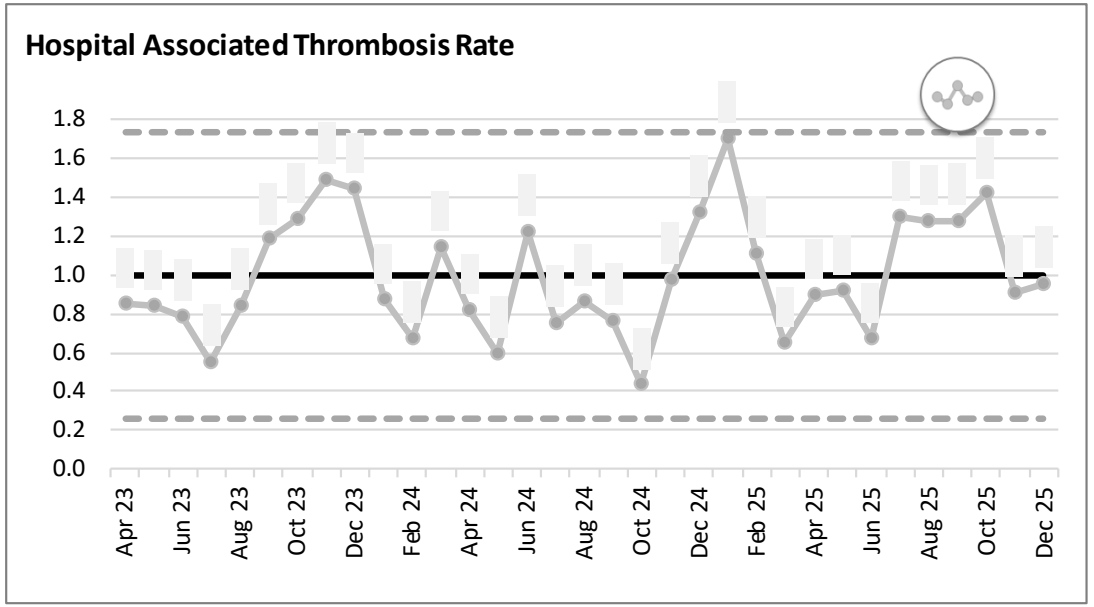

What is driving this performance?

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

Low performance is largely due to the failure to document the date and time of the assessments: in December 7% of charts audited were missing date or time, and only 1% of assessments had not been completed at all. 98% of prophylaxis doses are given, or reasons documented if withheld.

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

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

What are we doing about it?

EPMA once fully introduced will provide an accurate picture of VTE risk assessment completion.

Changes to VTE risk assessment requirements
NICE guidance (NG89) amendment September 2025 all medical, surgical and trauma patients should be assessed for VTE risk as soon as possible after admission and in accident and emergency, if they have not been admitted within 12 hours. Work has begun with Royal Stoke ED to incorporate VTE Risk assessment.

Key Themes identified from HAT Investigations completed using ePMA; Reassessment of risk. Without the chart rewrite every 2 weeks, some patients have been seen to only have an initial VTE risk assessment. Risk reassessment will head up this year's Thrombosis Week campaign

Quality & Access | [Safe staffing & Timely Observations]

Provide safe, effective and caring services

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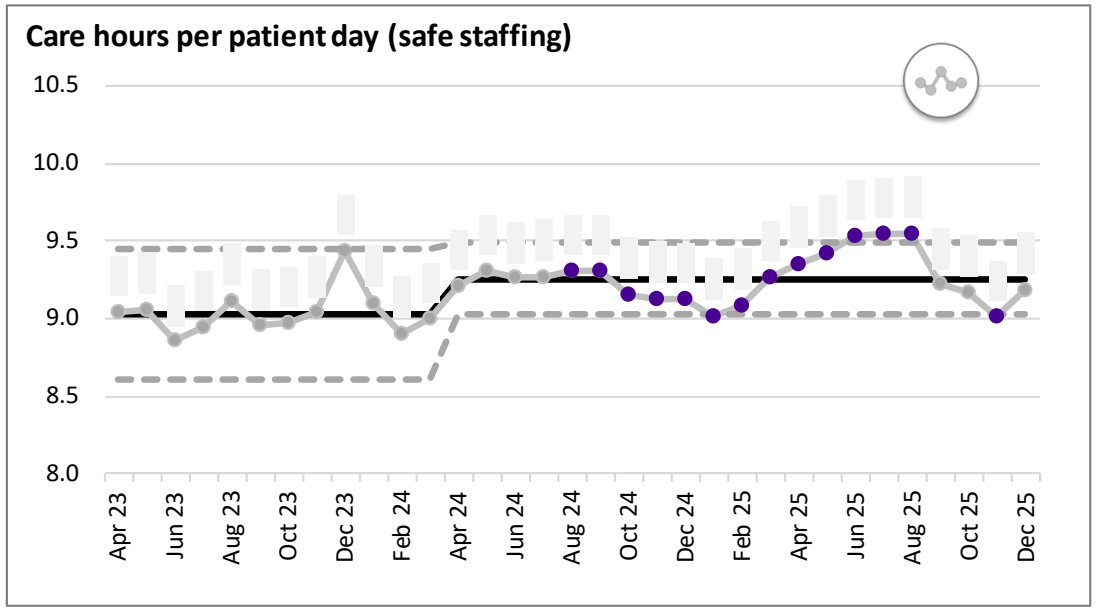

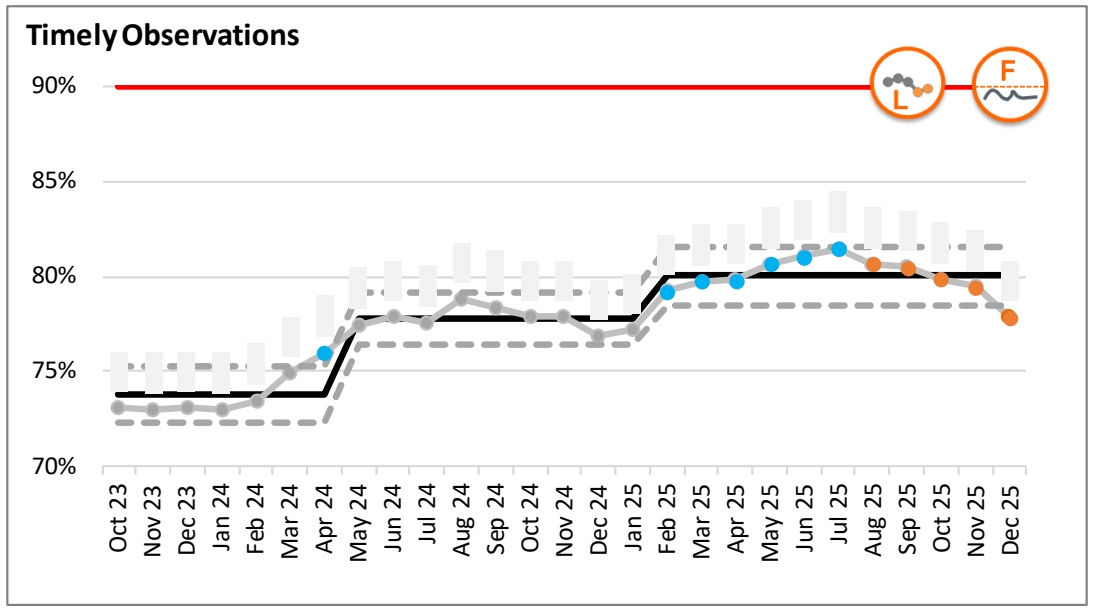

What is driving this performance?

Care hours per patient day (CHPPD)

- After peaking in the summer, CHPPD has been nearer previous levels since September 2025.

Timely Observations

The proportion of observations recorded as timely in December 2025 was 78%. Compliance peaked in July 2025 some way below the target, and has been falling ever since.

- Only 9 wards/departments met the 90% target in December.
- 12 wards had compliance below 70%, 10 of which are under Medicine CBU: Wards 128, 113, 15, 12, 78, 79, 81, FEAU, 124, 76a.

What are we doing about it?

Individual Wards and Departments continue to be reviewed and monitored as part of the monthly Performance Review process and actions are identified to improve compliance. Planned and Unplanned Care Groups have timely observations as a driver metric and there is a corporate A3 Improvement Project underway considering additional actions required to improve overall compliance/performance.

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

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

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

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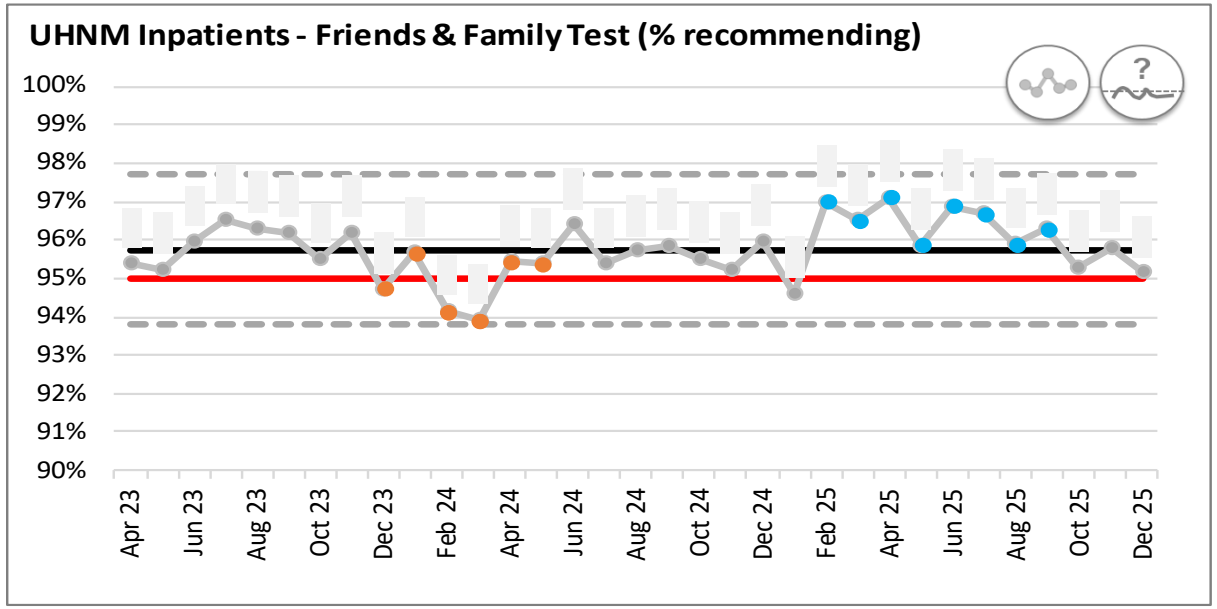

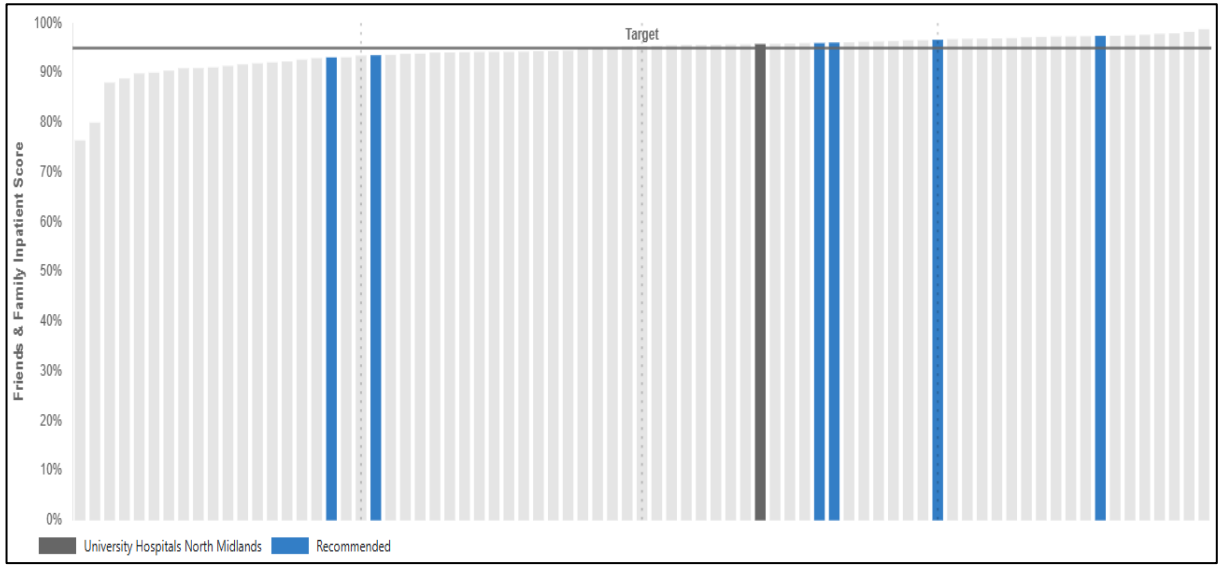

What is driving this performance?

After a period of significantly higher rates earlier in the year the monthly satisfaction rate for inpatient areas was within the previous usual range in December 2025. The average rate remains above the national average of 95% (Oct 2025 NHS England- last data).

In December 2025, a total of 2425 responses were collected from 65 inpatient and day case areas equating to a 20% return rate, which is within the usual range.
Average Care Group Scores are as follows:

- Unplanned - 18% response rate, 95% satisfaction score
- Planned - 37% response rate, 96% satisfaction (30% response target met since Nov-23)
- CSS (excluding Maternity, see separate slide) - 23 % response rate since Apr-25, 99% satisfaction score

CSS's response rate (Children & young people's Directorate) was significantly higher between Apr - Oct-25, but was closer to the previous range in November & December.

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.
FFT areas of celebration and areas for improvement to be shared monthly at Patient Experience Group.

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

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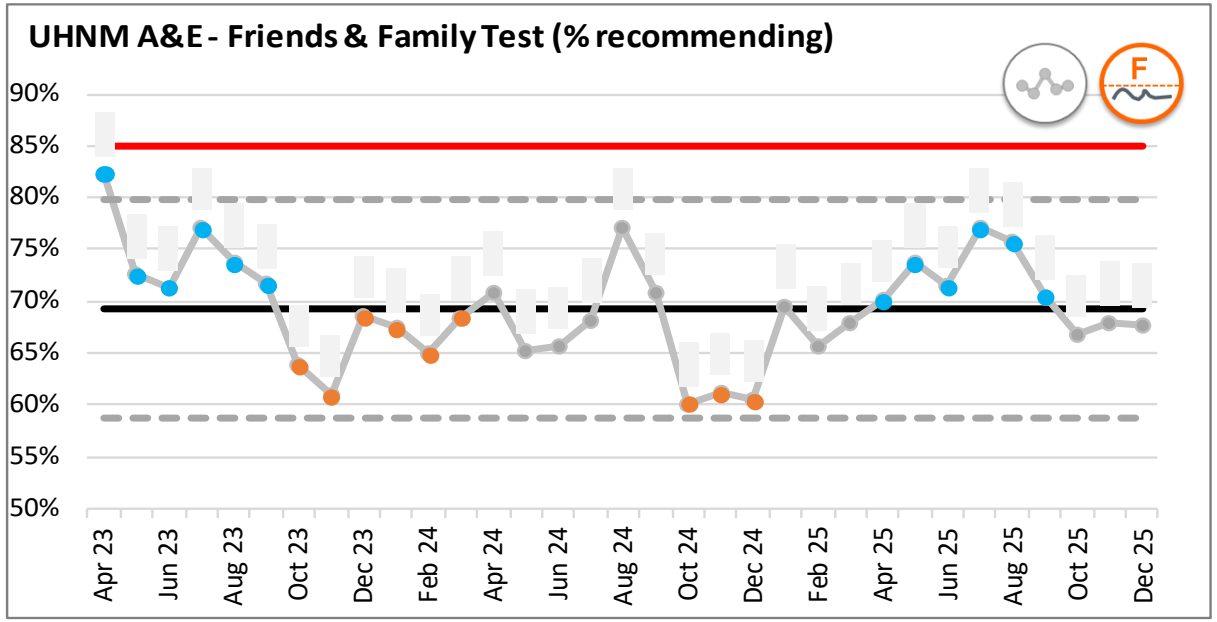

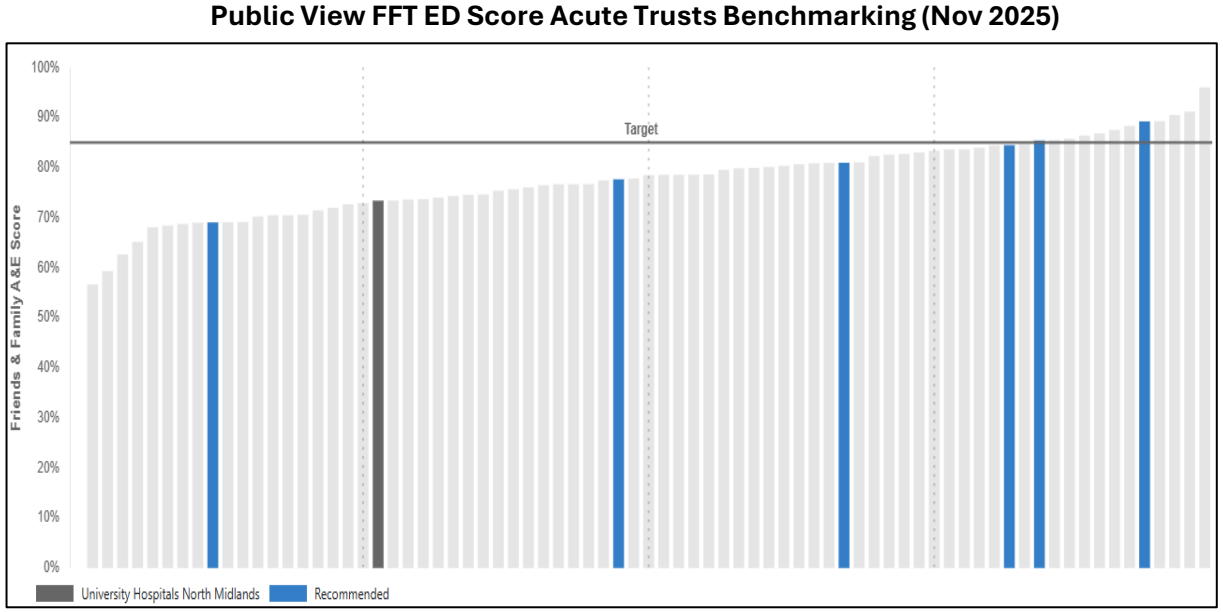

What is driving this performance?

The Trust received 765 responses in December 2025 - a 9% response rate which is within the usual range. Satisfaction rates remains somewhat below the national average of 77% (NHS England Oct 2025) and have varied considerably over the past couple of years.

UHNM is 29th out of 125 Trusts for the number of responses in ED and 100th out of 125 Trusts for the percentage positive results (NHS England Oct 2025).

Themes for improvement from December 2025 continue to be long waits for both sites. Patients reporting to feeling unsafe in the waiting room at Stoke due to other patients has also come up several times over the last few months

What are we doing about it?

- Simplified ED survey" now only containing the mandatory "Overall, how was your experience of our service?" with the 6 response options ("very good" through to "very poor" or "don't know" in place.
- QR code made visible throughout the department.
- Consideration to alternative methods of sharing QR code such as “business cards” available on reception and throughout the department.
- Dept Leads to consider how to make improvements with regards to communication in relation to staff attitude and patients feeling dismissed.

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

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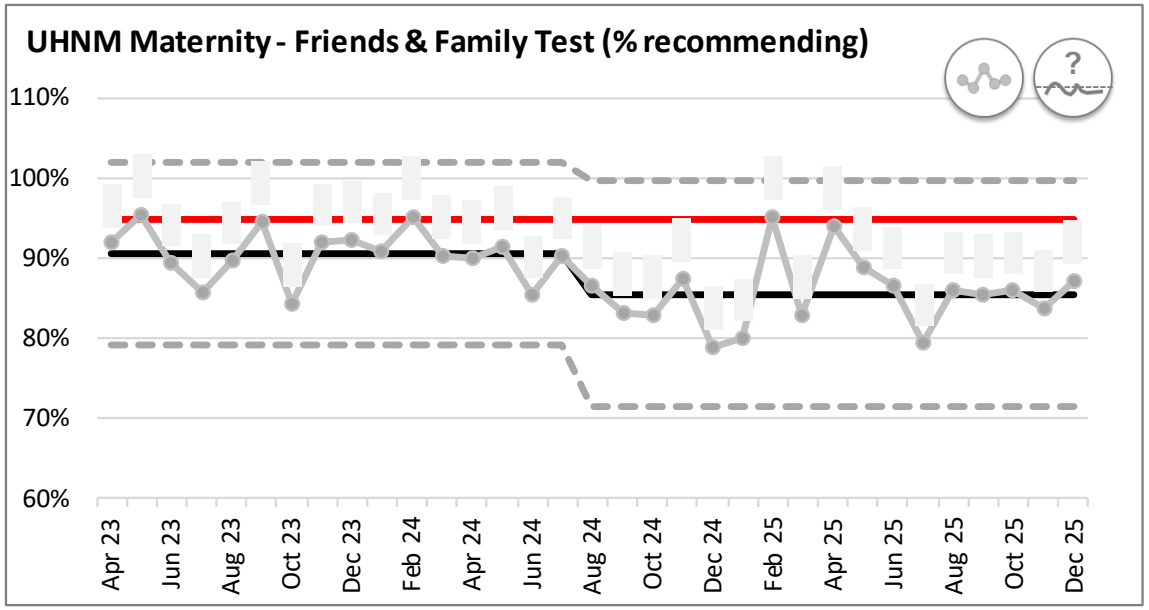

What is driving this performance?

The average % recommending has remained around 86% since 2024, somewhat below the 95% target. Nationally, the overall recommend rate is 92% (Oct 2025 NHS E).

There were a total of just 63 surveys received in December 2025 across all 4 touch-points (ante-natal, birth, post-natal ward; post-natal community) with 21 of these being collected for the "Birth" touch-point, making the response rate 5% which was within the usual range. The average satisfaction scores are Ante-natal: 81%, Birth: 90%, Post-natal ward: 90%, Post-natal community: 91%. 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 | [Formal Complaints]

Provide safe, effective and caring services

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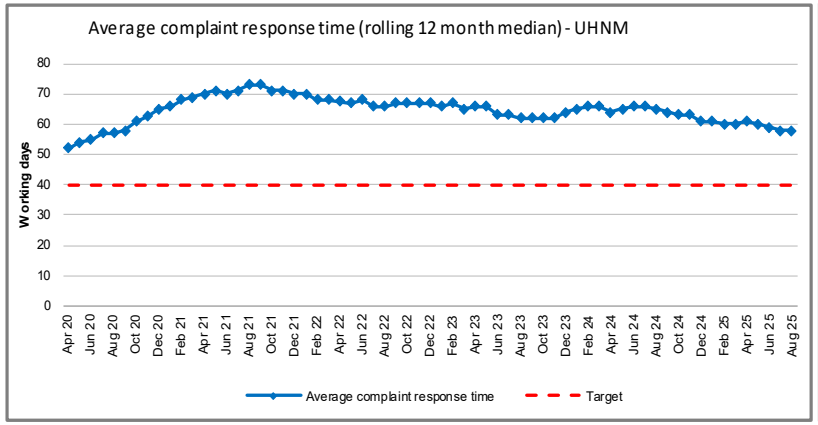

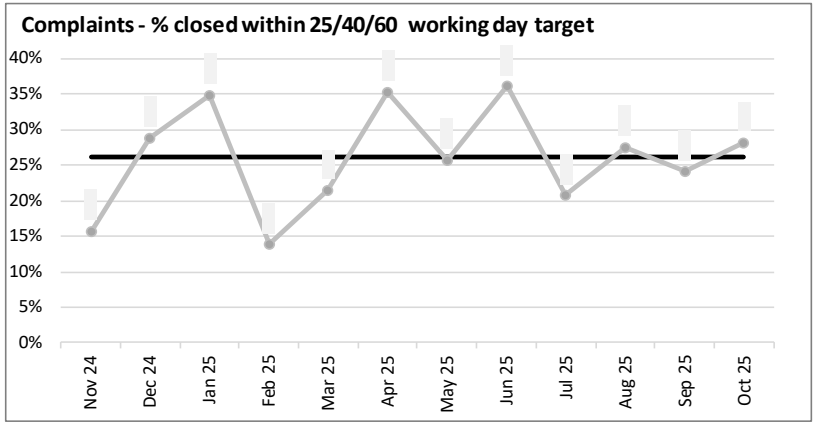

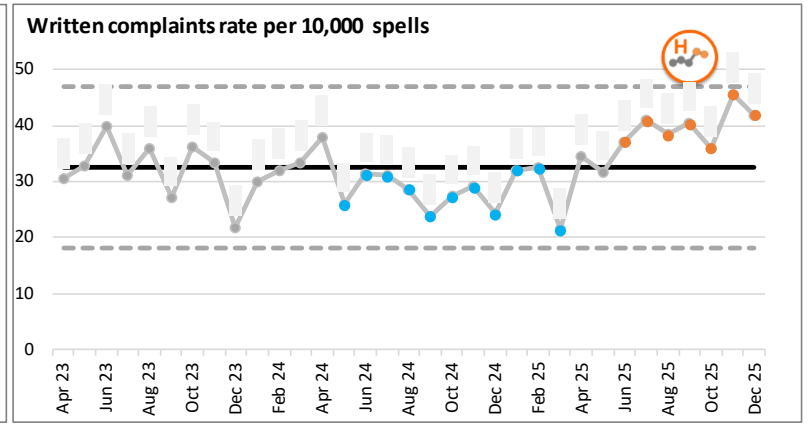

What is driving this performance?

66 complaints were closed in December 2025, with a median average response time of 50 working days.
The chart shows the average complaint response time peaked in 2021 but has been on a downward trajectory since mid 2024, though it remains some way above the 40 working day target.

287 complaints were open at the end of December 2025, of which:

- 11 had been open longer than 12 months
- 22 had been open 6 – 12 months
- 65 had been open 3 – 6 months

Since November 2024 complaints received have been assigned a target resolution time of 25/40/60 working days, and as of the first week of January, 26% of complaints opened between November 2024 and October 2025 were closed within target.

The rate of formal complaints opened has been above average since Jun-25, which may be significant.

What are we doing about it?

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

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

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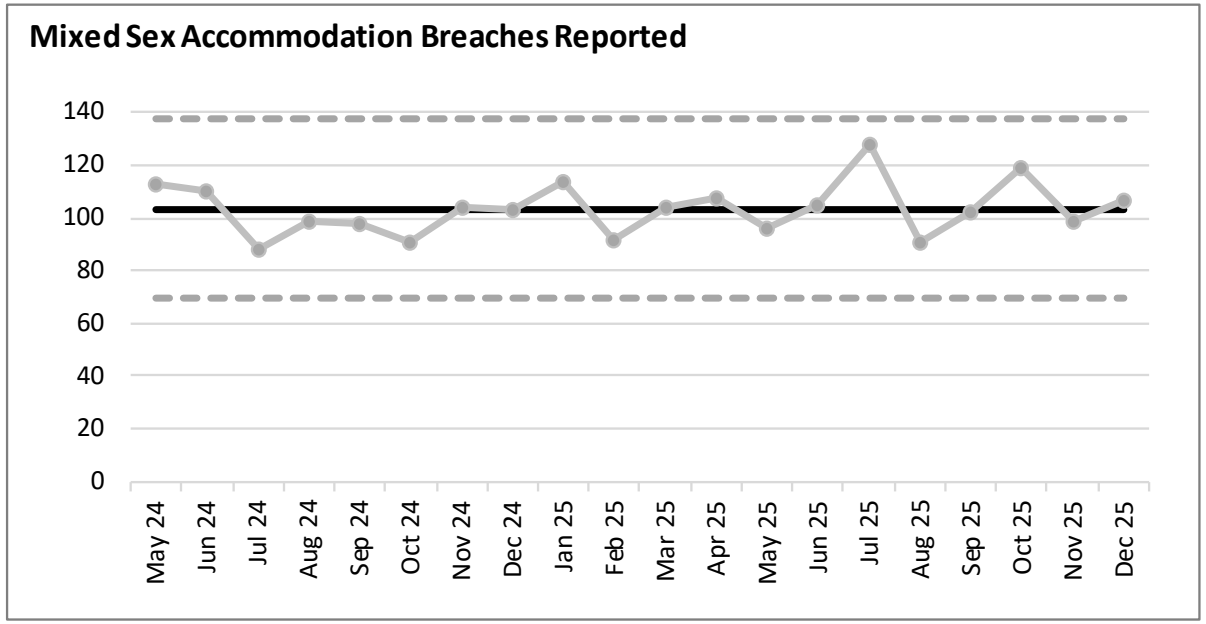

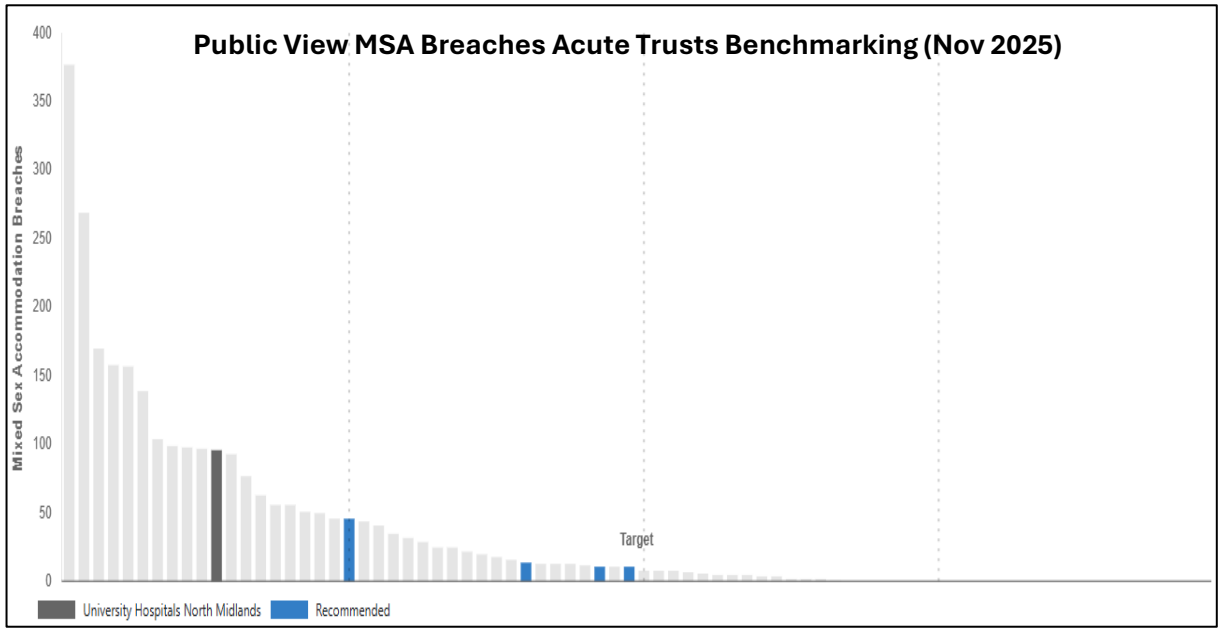

What is driving this performance?

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

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

What are we doing about it?

An improvement plan has been created to ensure a planned approach to the reduction of breaches. On going pressure on the Trust continues to impact on bed availability and the ability to timely step down patients from ITU. The site operations team continue progress work to digitally record step downs and to accurately record breach times within iPortal.

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.

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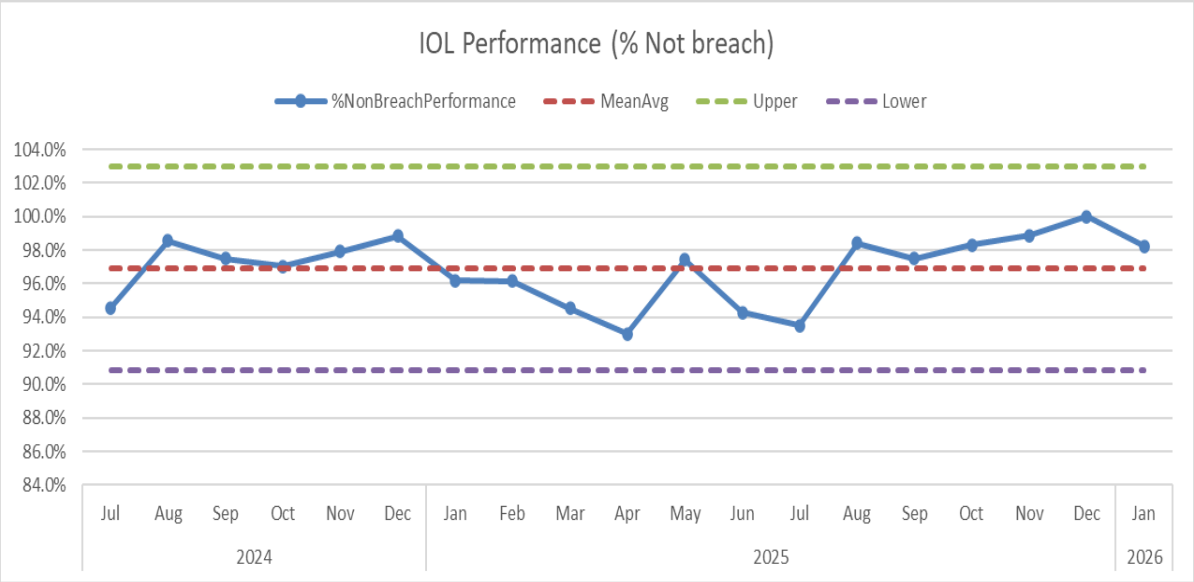
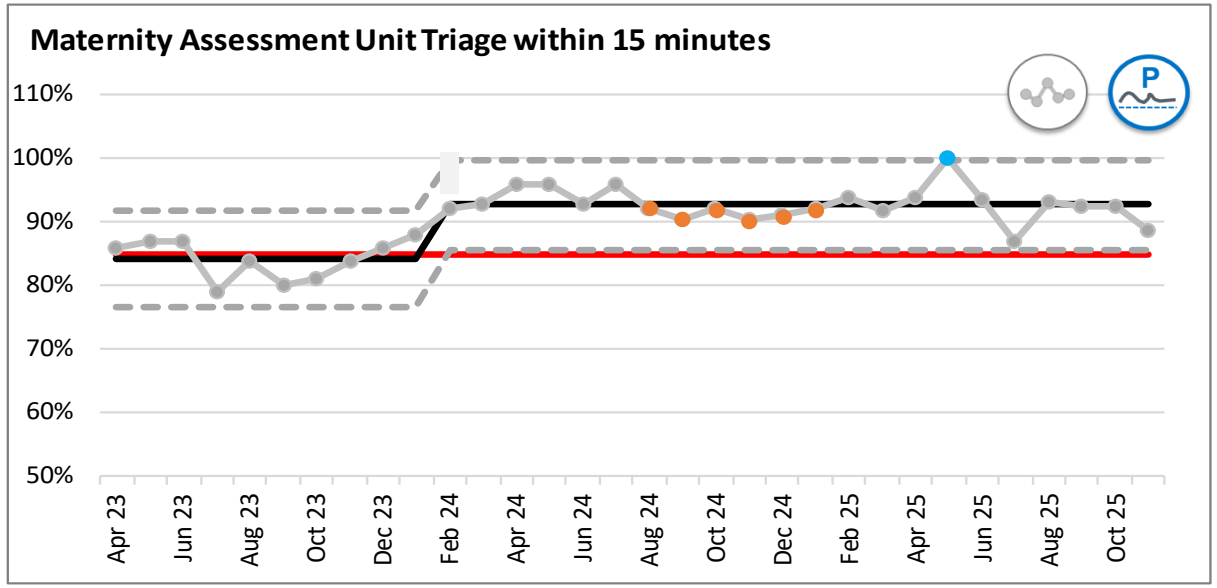
Quality & Access | [Induction of Labour & MAU Triage]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is driving this performance?

The target of 95% for timely admission of women for induction of labour has been consistently achieved since January 2024, with December being 100%- PLEASE NOTE: following extensive work with the analytics team, we have updated the way we review and validate IOL breaches. Manual validation has only been applied from August 2025 onwards, so any figures before this in this new SPC chart, should be treated as 'validated' and will not account for clinical breach validation as per previous charts.

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

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

The target set of 85% of patients to be seen within 15 minutes on MAU has been consistently met since December 2023 and December's data was 88.6%.

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

What are we doing about it?

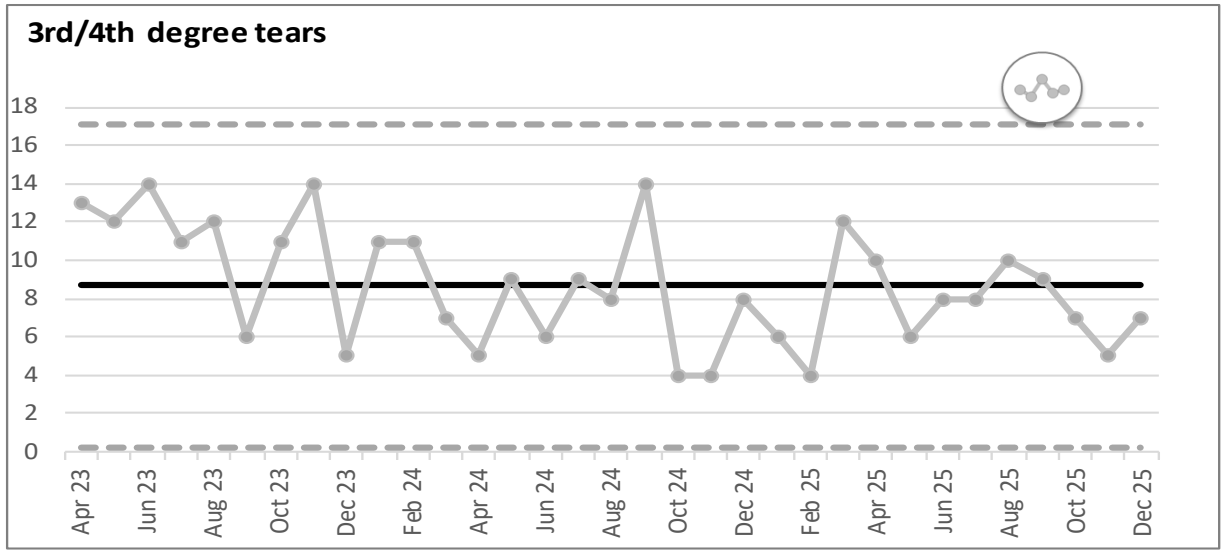
Any IOL breaches are safety netted and incident reported for full review through the internal governance process. IOL Datix are grouped into an IOL Improvement group tab, allowing a refined audit & review with focus on IOL themes.
Any IOL breaches or potential breaches are discussed daily at the patient safety huddle and escalated. Admission will be offered prior to breaching when this is forecast. A consultant will review all patients to determine if they were a 'true' breach.
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 and core vacancies now recruited.

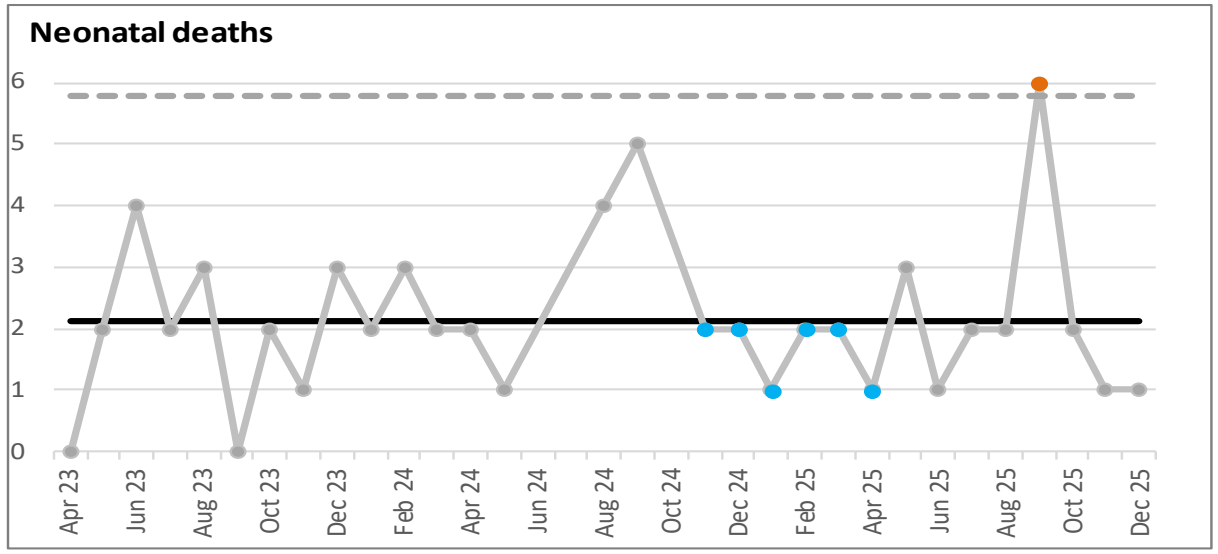
The MAU improvement group meet monthly to continue to discuss and sustain the driver metrics.
All MAU timing breaches are reviewed daily via audit and individual cases are investigated if evidence of potential harm.
MAU triage breaches are included in daily patient safety huddle and reported via the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

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is driving this performance?

3rd/4th degree tears
Average numbers remain consistent around 9 per month.

Neonatal deaths

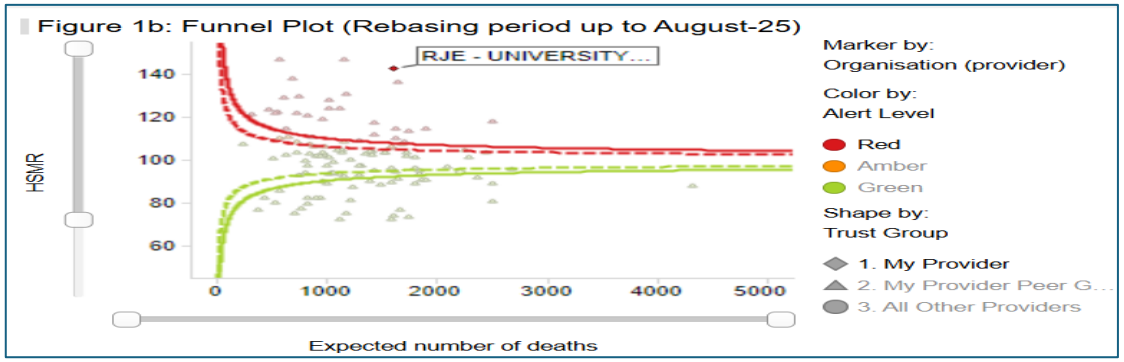
What are we doing about it?

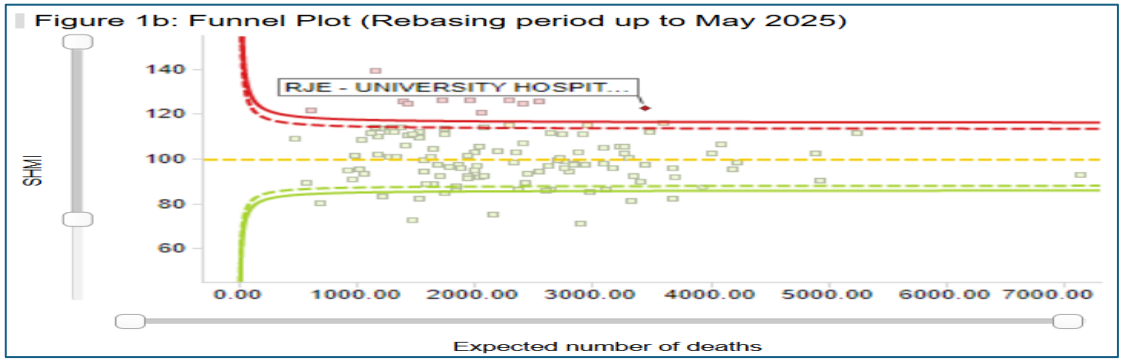
Excellent Together

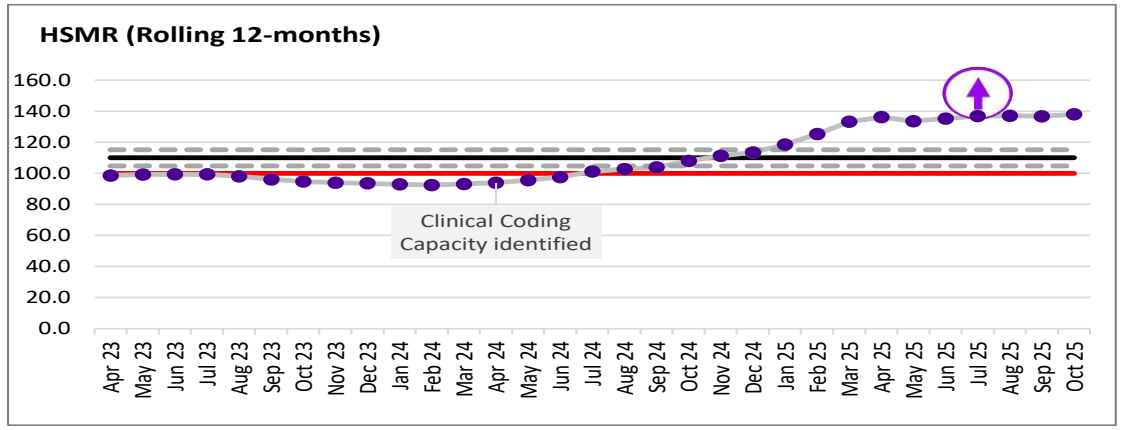
Quality & Access | [HSMR / SHMI]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust







What is driving this performance?

UHNM HSMR remains significantly higher than expected based on case mix and standardisation for current 12-month period (November 2024 – October 2025). The current 12-month HSMR is 138.04

UHNM SHMI also remains higher than expected at 122.52 for current 12-month period (August 2024 – July 2025) but has decreased from previous 12-month period 121.98.

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

What are we doing about it?

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

Kind
Excellent
Together

Quality & Access | [NPSA Alerts received and overdue]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

New Alerts received:

Year	Alert Type	CAS Status	Alert Reference Number	Alert Title/Device	Date Issued	Deadline Date	Comments	Actions
2025	Nat/PSA	Open	NatPSA/2025/008/NHSPS	Risk associated with adult breathing circuits lacking a patent exhalation route	11/12/25	12/06/26	The National Patient Safety Team are aware of patients who have come to harm or been exposed to potential harm because the breathing circuit to which they were connected was incorrectly assembled.	Organisations should identify a clinical lead and form a working group to develop local guidance and visual aids for the assembly, connection and reconnection of breathing circuits.
	Nat/PSA	Closed	NatPSA/2025/007/DHSC	Supply of Licensed and Unlicensed Epidural Infusion Bags	02/12/25	12/12/25	There are supply issues affecting epidural bags from Sandoz (licensed) and Fresenius Kabi (unlicensed) containing: • bupivacaine only • bupivacaine and fentanyl • levobupivacine and fentanyl.	Establish a short life working group chaired by a lead anaesthetist to look at product use/alternatives and a plan.

Year	Alert Type	CAS Status	Alert Reference Number	Alert Title/Device	Date Issued	Deadline Date	Comments	Actions
2023	Nat/PSA	Overdue	Nat/PSA/2023/ 010 MHRA	Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls.	31/08/23	01/03/24	Awaiting final confirmation of updated ESR Stat & Mand training from the Mandatory Learning Oversight Group. When confirmed the alert will be closed. Extraordinary meeting planned to review training.	ESR Training to be updated
2025	Nat/PSA	Open	Nat/PSA/2025/005/NHSPS	Harm from delayed administration of rasburicase for tumour lysis syndrome	09/09/25	09/03/26	Pharmacy liaising with various areas within the trust. i.e. emergency care, Haematology/Oncology, Critical Care.	
2025	Nat/PSA	Open	Nat/PSA/2025/006/NHPS	Harm from Allergic reaction due to misinterpretation of prescription.	20/11/25	20/11/25	There are reports of healthcare staff recording a patients penicillin allergy as penicillamine allergy in the EPMA. This look-a-like sound-a-like error risks a patient with a known penicillin allergy being administered a penicillin base antibiotic and having a potentially fatal reaction.	Work with digital systems to develop/deploy additional built in mitigations to reduce inadvertent recording of the wrong allergy.

What is driving this performance?

In December 2025, UHNM received 2 new Patient Safety alert related to medication safety and kit assembly. The medication alert was closed within the timeframe of 2 weeks.
In addition, there are 3 NHS Patient Safety Alerts that remain open and 1 of these remains overdue
The overdue alert has been addressed, and actions are ongoing to ensure that the necessary requirements of the alerts are being effectively implemented.

What are we doing about it?

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

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

Quality & Access | [Clinical Effectiveness]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

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

What are we doing about it?

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

What are we doing about it?

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

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

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

NOF - Access to Services

University Hospitals of North Midlands NHS Trust

Access to Services	Data period	Provider value			National value method	Chart
Access to services domain segment			Q2 2025/26	3 NOF Score		
Access to services domain score			Q2 2025/26	2.41 NOF Score		

Elective Care	Data period	Provider value	Peer average	National value	National value method	Chart
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment score			Q2 2025/26 1.97	NOF Score	Provider value	
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Sep 2025	64.05%	58.86%	61.18%	Provider median	
Difference between planned and actual 18 week performance score			Q2 2025/26 1	NOF Score	Provider value	
Difference between planned and actual 18 week performance	Sep 2025	2.74%	0.37%	-0.04%	Provider median	
Percentage of patients waiting over 52 weeks for elective treatment score			Q2 2025/26 2.65	NOF Score	Provider value	
Percentage of patients waiting over 52 weeks for elective treatment	Sep 2025	2.07%	2.74%	2.07%	Provider median	
Percentage of patients waiting over 52 weeks for community services score			Q2 2025/26 1	NOF Score	Provider value	
Percentage of patients waiting over 52 weeks for community services	Sep 2025	0.00%	0.03%	0.46%	Provider median	

Cancer Care	Data period	Provider value	Peer average	National value	National value method	Chart
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral score			Q2 2025/26 2.96	NOF Score	Provider value	
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral (quarter)	To Sep 2025	74.15%	74.33%	76.04%	Provider median	
Percentage of patients treated for cancer within 62 days of referral score			Q2 2025/26 2.84	NOF Score	Provider value	
Percentage of patients treated for cancer within 62 days of referral (quarter)	To Sep 2025	67.42%	65.47%	69.28%	Provider median	

Urgent and Emergency Care	Data period	Provider value	Peer average	National value	National value method	Chart
Percentage of emergency department attendances admitted, transferred or discharged within four hours score			Q2 2025/26 3.56	NOF Score	Provider value	
Percentage of emergency department attendances admitted, transferred or discharged within four hours (quarter)	To Sep 2025	69.30%	74.00%	75.70%	Provider median	
Percentage of emergency department attendances spending over 12 hours in the department score			Q2 2025/26 3.29	NOF Score	Provider value	
Percentage of emergency department attendances spending over 12 hours in the department (quarter)	To Sep 2025	12.51%	11.69%	8.61%	Provider median	

UHNM's access metrics show mixed performance with small variation between quarter one and quarter two.

Elective Care – each metric either seeing an improvement in the score or score remains the same as quarter one.

Cancer Care – both metrics have seen an improvement in the score since quarter one. 62 day performance from 3.36 in quarter one to 2.84 in quarter 2.

Urgent and Emergency Care – both metrics have seen an improvement in the score since quarter one.

Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

How are we doing against our trajectories and expected standards?

Non-Elective

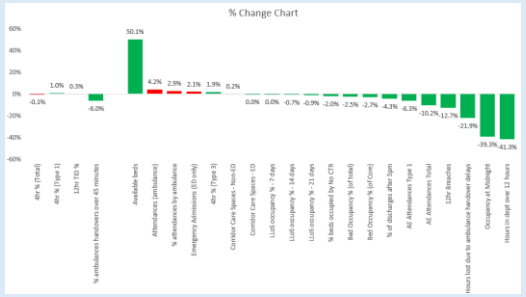
For the 4-hour standard in UEC our validated performance deteriorated to 64.4% in December from 65.9% in November. This is 4.8%pts behind our trajectory of 69.2%, which has now adjusted to account for the late delivery of the UTC programme. The national target for this standard is 78%.

In December 2,382 patients waited longer than 12 hours in our Emergency Department against a plan of 2,213. This is almost 300 fewer patients waiting longer than 12 hours compared to November, but 169 more patients than the trajectory.

5542 ambulances arrived at UHNM in November – 62.85% of these were handed over within 45 minutes. This is an improvement from November, where this figure was 53.64%, despite receiving an increased volume of ambulances in December compared to November. The County site performance is significantly better than the Royal Stoke site (RSUH was 58.91%, up from 47.55%, and County 79.08% almost identical to November's 78.78%).

This has meant that during December 2059 patients waited in an ambulance for longer than 45 minutes, this compares to 2498 patients in November – a reduction of 439. Average handover time remained broadly the same with a marginal improvement from November, from 1h36 to 1h35m, but was significantly improved compared to December 2024, by more than 36 minutes.

GIRFT UEC comparison report comparing last 30 days to the previous 30 days demonstrating some encouraging signs of improvement (19/1/26):



The Trust remains in tier 1 for our UEC performance.

Elective

Cancer:
The combined faster diagnosis standard performance final November position was reported at 75.84% against a trajectory of 78.07%; 2.2 off plan, but this was predicted. Provisional December position is currently at 80.3% against a trajectory of 78.6%; 1.7% ahead of plan (Data Completeness of around 99.2%).
31-day final November validated performance was reported at 88.0%; 8% off plan. Provisional December position is currently at 88.1%; 7.9% off plan.
Combined 62-day performance final November position was reported at 58.10% against a trajectory of 71.67%; 13.6% off plan. Provisional December position is currently at 65.9% against a trajectory of 72.4%; 6.5% off plan.

Diagnostics:
November DM01 validated performance was 75.7% against trajectory of 75.2%; 0.5% ahead of plan. 95% being the national standard
December DM01 unvalidated performance is 71.5% against trajectory of 81.8%. DM01 recovery continues to track in line with plan, although December's position will dip, recovery is expected quickly.

RTT:
Decembers overall RTT performance was 62.5%; ahead of plan by 0.1% (62.4%)
Our 52-week performance is monitored as a % of patients on our total waiting list who are over 52 weeks. For the month of December, 52-week plan reduced from 1.79% to 1.65%; 52-week actuals is tracking at 1.87%; 0.2% behind plan
This standard to achieve by the end of the year is to get to 1%
UHNM are ahead of our planned trajectory for wait for first appointment and is a regional leader on this metric at 75.4%, the plan for this is 75.3%; 0.1% ahead of plan

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

The Trust continues to be in Tier 2 for Planned Care, 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 4.8%pts behind our revised improvement trajectory. Seasonal activity increases have been seen earlier than anticipated, with 24,139 attendances in December, a reduction of 1,195 compared to November.

In response to the increased Demand, our Winter Plan has been enacted earlier than planned, with ward 102 (RSUH) transitioning from Planned Care to Unplanned, Ward 112 supporting cohorted outliers alongside trauma patients, and Ward 8 (County) being mobilised.

We continue to work alongside colleagues from the GIRFT UEC team, focusing on Ward processes and Length of Stay, Site Command and Control and have relaunched our Internal Professional Standards. Continuous Flow remains in place and is being enacted to the agreed protocol, which is currently in the process of being strengthened. Professor Tim Briggs led the Clinical Operational Standards Workshop, with good clinical engagement.

The system Home for Winter campaign was a success, achieving occupancy of 78% heading into Christmas day.

Metric	Target	Previous	Latest	Variation	Assurance	R12M Trend	01/01/2025	01/02/2025	01/03/2025	01/04/2025	01/05/2025	01/06/2025	01/07/2025	01/08/2025	01/09/2025	01/10/2025	01/11/2025	01/12/2025
UEC 4 Hour Performance	78%	65.9%	64.4%				66.3%	64.5%	64.6%	65.6%	70.0%	68.3%	70.9%	69.6%	68.0%	66.3%	65.9%	64.4%
UEC 4 Hour Performance (Aged <18)	78%	88.6%	88.7%				88.5%	83.9%	80.8%	83.6%	88.3%	88.1%	90.7%	91.8%	91.9%	88.3%	88.6%	88.7%
Over 12 hours in ED	2,128	2,644	2,382				2,552	2,449	2,332	2,420	2,130	2,225	1,559	1,759	2,546	2,765	2,644	2,382
Over 12 hours in ED (Aged <18)	0	30	15				13	19	24	28	25	14	11	24	15	35	30	15
Ambulance Handover Average Time	00:43:00	01:36:41	01:34:11				01:44:27	01:53:43	01:17:35	01:31:36	01:08:50	01:19:13	00:42:06	00:48:52	01:23:36	01:46:43	01:36:41	01:34:11

Elective

Overall, Cancer performance is recovering, and is on track to align back to set trajectories by Jan-Feb '26. For FDS, after falling below trajectory for only 3 months out of the year so far, HNM expect to be back on track and overachieving against trajectory in December. Most 31-day breaches are attributable to patients receiving surgery as either a first or a subsequent cancer treatment above the 31-day breach range. Particularly first Skin treatments account for a high number of 31-day breaches. For 62-day performance Breast, Colorectal, Gynae, Head & Neck, Skin & Upper GI are below their trajectories. Skin performance is particularly challenged owing to capacity for diagnostics and treatment which is significantly impacting on overall Trust performance from September onwards

Non-Obstetric Ultrasound is the majority contributor for overall DM01 performance variance. Non obstetric ultrasound has dipped over the month of December due to annual leave but is still in line with the trajectory developed to meet 95% DM01 performance by March 2026. DM01 position has improved by 8% over the last 6 months due to NOUS recovery. Unvalidated NOUS performance is now 52.2%.

RTT Performance has improved significantly through extensive validation work completed by MBI, the Corporate Validation Team and the Care Groups. UHNM rank against acute trusts has continued to improve, and move from 98th, 3 months ago to 61st. Validated month end position in Total WL size has seen an increase in December from 64,479 to 64,716.

The number of 78-week breaches has increase from 1 to 3 in December; due to Corneal surgeons unplanned absence. The increase in patients waiting >65weeks to be treated is due to UEC pressures and Christmas downtime. 65-week waits have increased from 46 in November to 69 in December. There is some risk with the extensive validation work underway of pop-up long waiters – these will be managed through the trust's "uncorrected breaches" process. Specialties which impact are Orthopaedics, ENT, Ophthalmology and Gynaecology. The rate of reduction of patients waiting over 65 week shows that most of these patients are on admitted pathways who require an RSUH bed for a complex procedure requiring some combination of specific surgeons, surgical robots and extended theatre time.

Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

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

Non-Elective

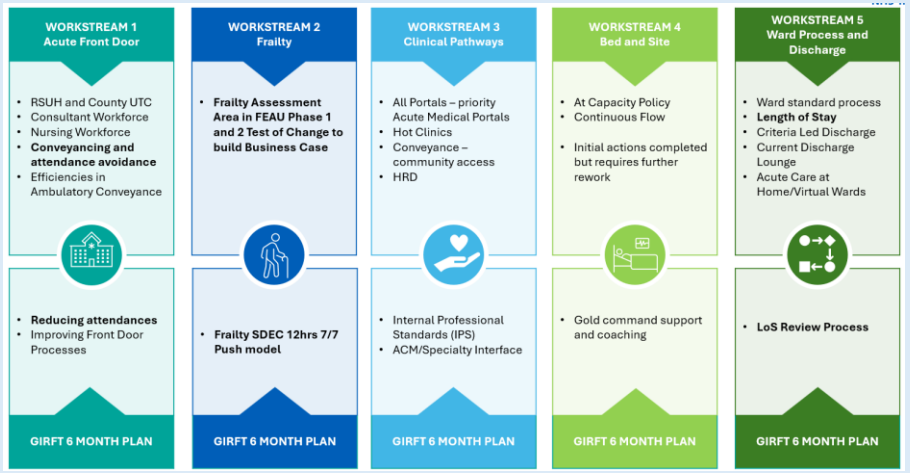
- Our UEC improvement plan has been in place since April 2025.
- The focus of the workstreams has been mapped to the work of the GIRFT UEC team, focusing on the high impact actions to derive maximal performance improvement.
- Clear governance of the workstream remains in place, with strengthened operational grip and control of performance in recent weeks.
- Command and Control of site meetings, with senior accountable officer engagement from each Care Group continues.
- GIRFT are supporting our site management away days.
- Winter plans are being enacted to create additional capacity and to improve flow.
- System partners have supported with additional capacity to reduce the volume of delayed discharges
- UTC Phase 1 is now complete, with phase 2 expected to deliver in June.
- Test of Change for Release to respond demonstrated some positive initial results, alongside some challenges with sustainability.

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. Recovery plans are expected to align UHNM back to trajectory by January 2026.

As our UEC improvement programme develops, elective bed capacity will be given back to support our elective programme of work.

The digital and operational teams have worked with external partners to develop a process to validate the majority of our c700,000 patients on our waiting lists. Validation work will continue at pace to deliver the asks of the National validation sprint. Work so far has targeted known areas of challenge with data quality and clock stop capture, which is disproportionally patients waiting 18+ weeks. 60% of the patients waiting <18 weeks have yet to be seen, as opposed to 30% of those waiting above 18 weeks; less risk of error. The ROVA validation tool has been carrying out automated validation for 2 months, which will continue to extend to the entire waiting list. This has shown nearly 2000 pathways which can be closed, leading to an indicative improvement in performance of 1.3%.



Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

What can we expect in future reports?

Non-Elective

Whilst we are tracking 4.8% percentage points below the revised trajectory in December, we remain optimistic that the work of GIRFT UEC, our relaunch of the UEC Improvement plan and the focus of our 45-minute test of change will all support a return to the trajectory over the coming months.

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

Elective

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

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

County Elective Hub is live, with extended Weekend and evening sessions now in place. Notably procedure numbers will significantly increase across County Theatres with activity to be tracked against delivery, specifically for Orthopaedics / General Surgery / Gynaecology. Gynaecology has showed notable 52-week recovery through use of the Hub, with 110 patients / pathways being removed in the last 5 weeks; 8.12% decrease to 5.97% 52-week breaches.

Quality & Access | Dashboard

University Hospitals of North Midlands NHS Trust

Metric	Target	Previous	Latest	Variation	Assurance	R12M Trend
UEC 4 Hour Performance	78%	65.9%	64.4%			
UEC 4 Hour Performance (Aged <18)	78%	88.6%	88.7%			
Over 12 hours in ED	2,128	2,644	2,382			
Over 12 hours in ED (Aged <18)	0	30	15			
Ambulance Handover Average Time	00:43:00	01:36:41	01:34:11			
Cancer 28 Day FDS	80%	75.8%	80.3%			
Cancer 31 Day Combined	96%	88.0%	88.1%			
Cancer 62 Day Combined	75%	58.1%	65.9%			
Diagnostics DM01 Performance	97%	75.7%	71.5%			
RTT Performance - <18 Weeks	63%	63.9%	62.5%			
RTT Performance - % 52+ Weeks	1%	1.8%	1.9%			
RTT Performance - % Waiting 1st Contact	77%	76.6%	75.4%			
RTT Performance - <18 Weeks (Aged <18)	63%	68.3%	69.4%			
RTT Performance - % 52+ Weeks (Aged <18)	1%	1.1%	1.2%			
RTT Performance - % Waiting 1st Contact (Aged <18)	77%	82.7%	83.1%			

Related Strategy and Board Assurance Framework (BAF)

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

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Assurance Grid

University Hospitals of North Midlands NHS Trust

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

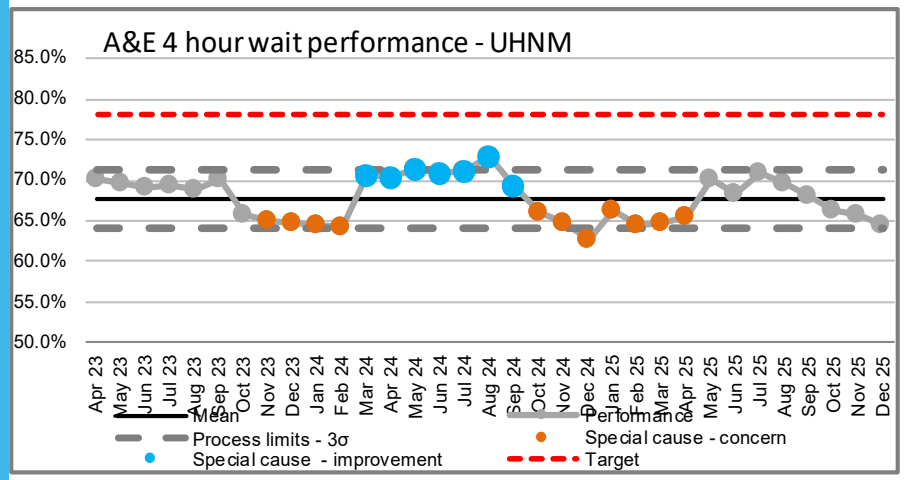
VARIATION	P	?	F	No Target
H / L	UEC 4 Hour Performance (Aged <18) RTT Performance - % Waiting 1st Contact (Aged <18)	RTT Performance - <18 Weeks (Aged <18)	RTT Performance - <18 Weeks RTT Performance - % 52+ Weeks RTT Performance - % Waiting 1st Contact RTT Performance - % 52+ Weeks (Aged <18)	
Common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

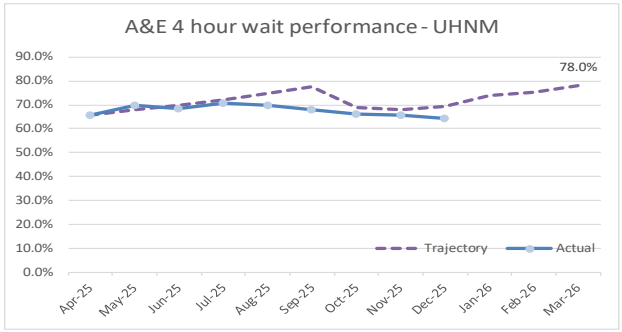
The best joined-up care for *all*

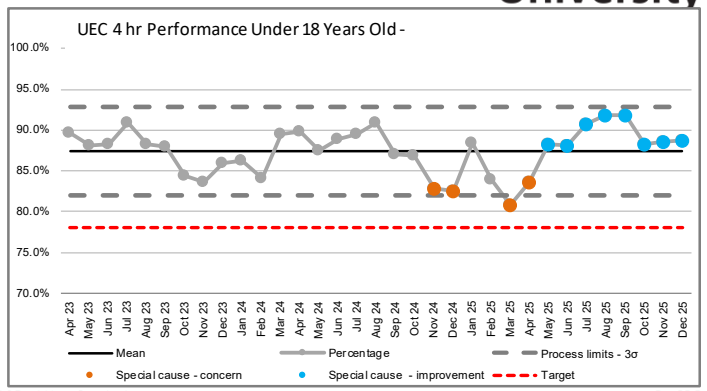
Kind Excellent Together

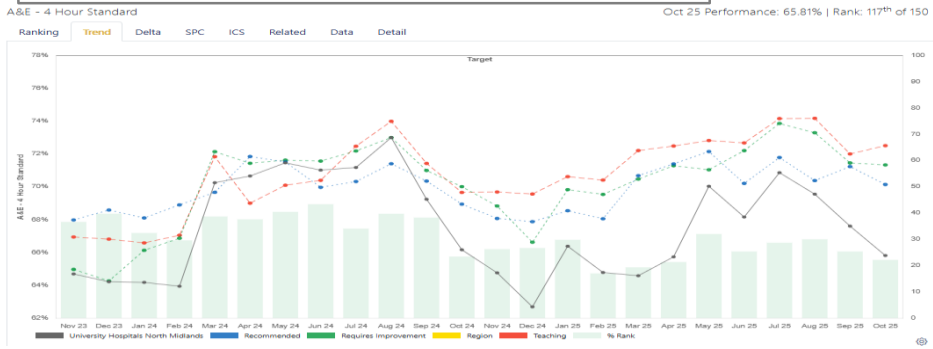
Quality & Access | UEC 4-hour Target

University Hospitals Midlands NHS Trust









Variation	Assurance	Monitoring against plan				
			Sep 25	Oct 25	Nov 25	Dec 25
	Target 78%	Actual	68.0%	66.3%	65.9%	64.4%
Background		Plan	77.6%	68.7%	68.1%	69.2%
The percentage of patients admitted, transferred or discharged within 4 hours of arrival at A&E		Variance	-9.6%	-2.4%	-2.2%	-4.8%

What is the data telling us?

Validated 4-hour performance was 64.4% for December, a marginal reduction from 65.9% in November.

We came off original trajectory in September and as such, plan was adjusted. For December, plan was 69.2%, which we fell short by 4.8%. By site, RSUH performance was 40.8% vs a target of 37.2%, and County 55.9% vs a target of 42.9%.

Overall admitted performance was 38.3% vs a target of 23.8%. By site, RSUH 37.5%, above target of 23.1%, County 41.2% vs a target of 26.1%.

Overall Non-admitted performance was 50.5% vs a target of 51.4%. By site, RSUH 43.9% vs a target of 50.9%, County 64.3% vs a target of 52.4%.

What are we doing about it?

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

Continue to improve the streaming tool at the front door to increase utilisation of EHPC slots, currently at c.80%. Expectation to increase to 90% in January.

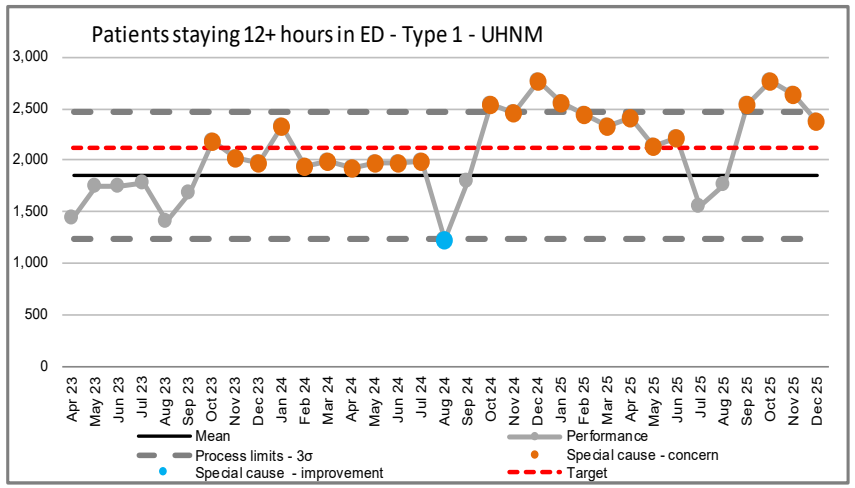
Review of current standard work and development of medical and nursing standard work for navigation and triage and for the ambulance offloads.

AMRA is now open 24/7 which will see a number of patients pulled from ED overnight (c.10) which will have a small positive impact on 4-hour performance.

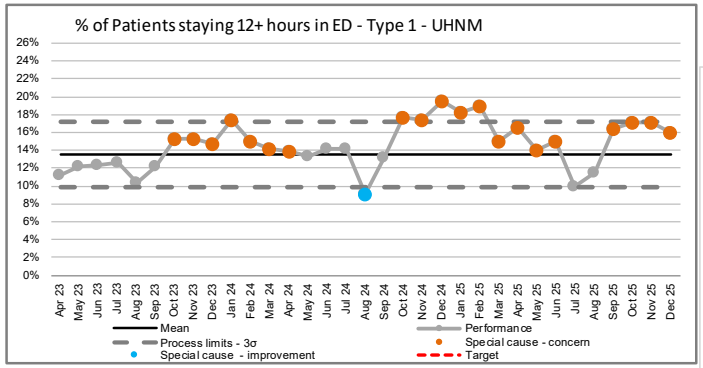
Related to 'release to respond' additional medical resource being planned for, which will support with 4-hour performance by creating flow and capacity within ED.

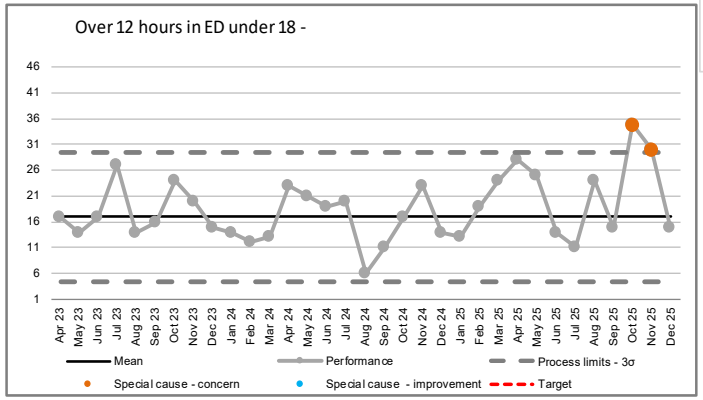
Quality & Access | Over 12-hours in ED From Arrival

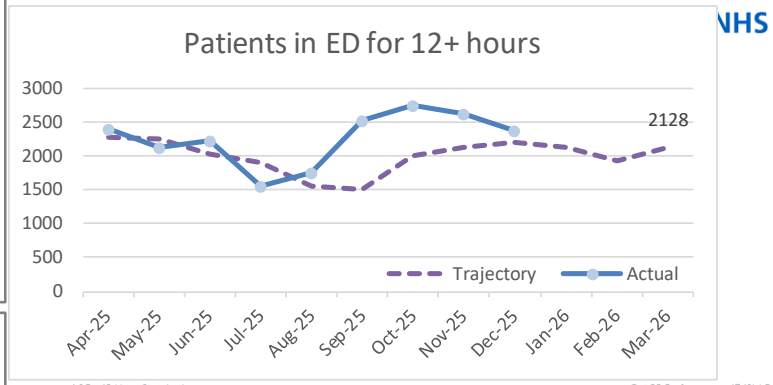
University Hospitals of North Midlands NHS Trust

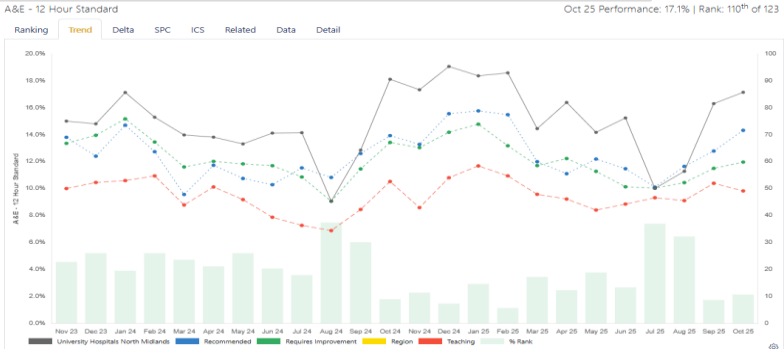


Variation	Assurance		Monitoring against plan				
				Sep 25	Oct 25	Nov 25	Dec 25
	Target	2128	Actual	2,546	2,765	2,644	2,382
Background			Plan	1,502	2,021	2,133	2,213
The number of patients admitted,transferred or discharged over 12 hours after arrival at A&E			Variance	1044	744	511	169









What is the data telling us?

In December 2382 patients waited longer than 12 hours in ED against a plan of 2,213 (variance of -169). By site, 2160 at RSUH and 228 at County. Overall performance was 9.9% against a target of 13.4%.

Performance had been tracking along trajectory, however with the earlier than planned arrival of winter and increased acuity has meant length of stay in our deeper bed base has also increased. The impact of this has seen a growing number of DTA's in ED and longer waits experienced for patients.

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

What are we doing about it?

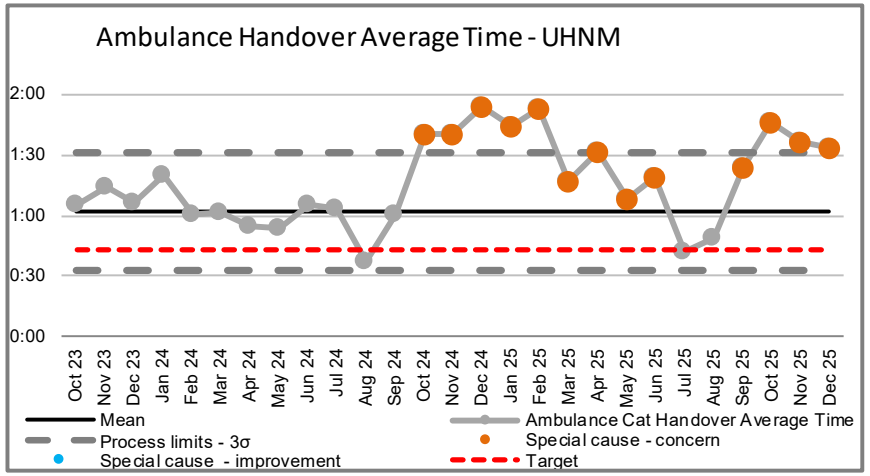
The Frailty test of change will continue to support in the same way, for this cohort of patients. Early data suggests around 40 patients pulled per week direct to FEAU (160 per month). However, due to site pressures the scope for this is often halved, losing 1 of the 2 bays to bed patients. Care Group are mobilising a plan to relocate 218, creating a bed gain of circa 12 beds, on top of protecting the 2 bays to maintain Frailty SDEC at full capacity.

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

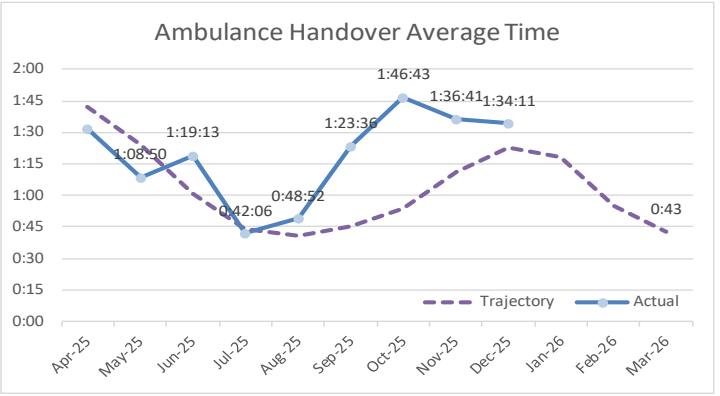
Through both tests of change, in excess of 500 patients per month could be diverted to portals supporting improved 4 and 12-hour performance.

Quality & Access | Ambulance Handover Average Time

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan	Sep 25	Oct 25	Nov 25	Dec 25
		Target 0:43:00	Actual	1:23:36	1:46:43	1:36:41	1:34:11
Background			Plan	0:45:00	0:54:00	1:11:00	1:23:00
The average time taken for patients to be handed over from Ambulances arriving at UHNM.			Variance	0:38:36	0:52:43	0:25:41	0:11:11



What is the data telling us?

5542 ambulances arrived at UHNM in November – 62.85% of these were handed over within 45 minutes. This is a marginal improvement from November, where this figure was 53.64.

This has meant that during December 2059 patients waited in an ambulance for longer than 45 minutes, this compares to 2498 patients in November – a reduction of 439.

By site: RSUH was 58.91%, up from 47.55%, , and County 79.08% almost identical to November's 78.78%.

Average handover time in November was 1 hour and 34 minutes, a 2-minute improvement from November, but still 11 minutes off-plan, and 51 minutes off target.

What are we doing about it?

An ambulance handover test of change which focussed on a RAT (rapid assess and treat) model was started on 13/10, but quickly stopped due to lack of sufficient space to deliver the RAT model appropriately. The Doctor for this test of change has been maintained to support the assessment of patients on arrival of the ambulance.

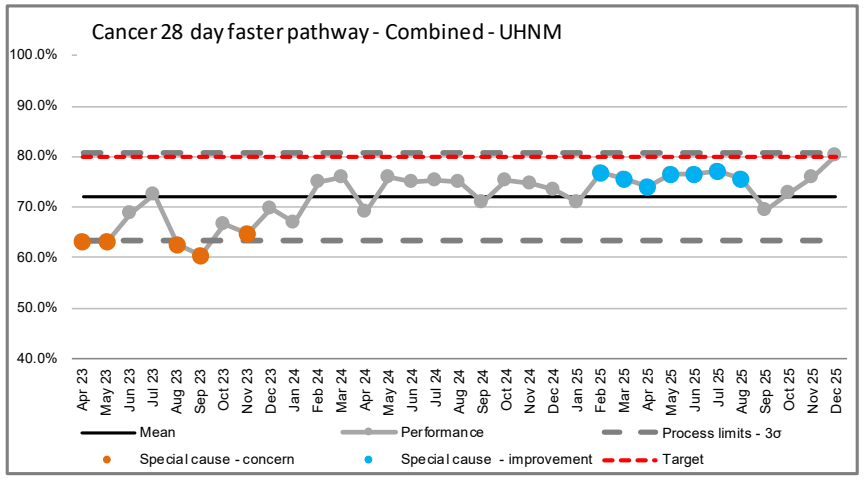
Positive progress is being made to improve streaming pathways to FEAU, alongside AMRA now operating 24/7. These changes will enhance patient flow from the ED, supporting quicker ambulance offloads in some cases.

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

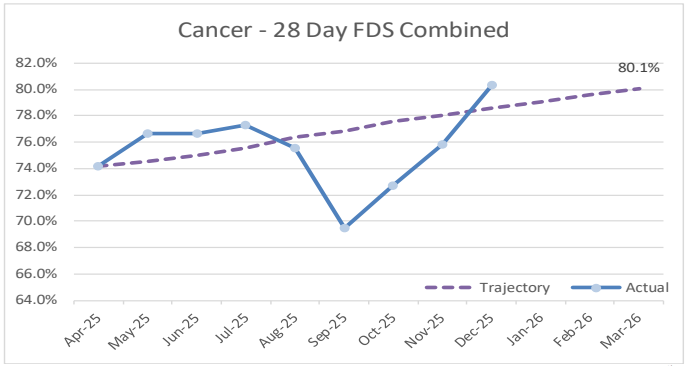
As of 14/01 the 'release to respond' initiative will go live, with a focus on offloading ambulances over 90 mins, with a week-by-week reduction in this target to 60 minutes, and then 45 minutes. Through a re-launch of IPS and additional workforce being financially supported the hope is significant improvements will be made in handover performance at the back end of January onwards.

Quality & Access | Cancer 28 Day FDS

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				Sep 25	Oct 25	Nov 25	Dec 25
	Target	80%	Actual	69.5%	72.7%	75.8%	80.3%
Background			Plan	76.9%	77.5%	78.1%	78.6%
Performance of confirmation or exclusion of cancer communicated with patients within the 28 day timeframe.			Variance	-7.4%	-4.8%	-2.2%	1.7%



What is the data telling us?

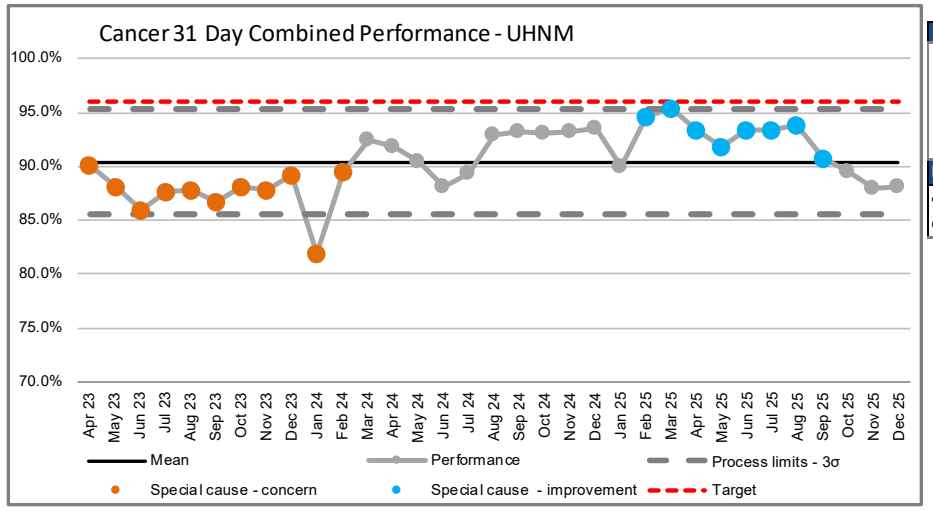
- The final November position for FDS was reported at 75.84% against a trajectory of 78.07%
- The provisional December position is currently at 80.34% against a trajectory of 78.63%
- After falling below trajectory for only 3 months out of the year so far, HNM expect to be back on track and overachieving against trajectory by December.
- Specialties performing well include Breast and Gynae. Skin have also improved the position in December.

What are we doing about it?

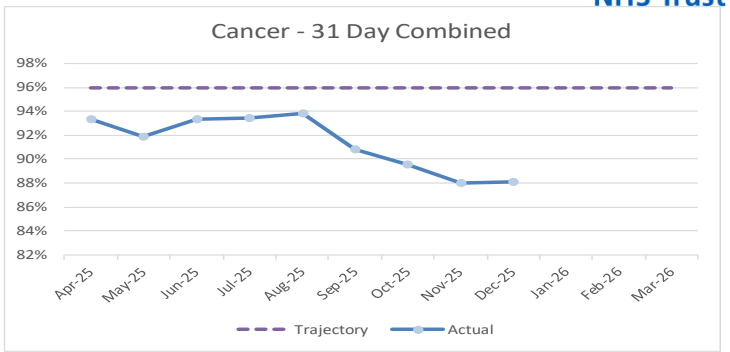
- Maintaining the Cancer Delivery Group meetings to bring focus on operational delivery for improvement plans and adherence to agreed trajectories for 25/26.
- High level escalations sent weekly as part of all cancer PTL escalations for senior oversight and daily oversight by the Cancer Team, escalating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

Quality & Access | Cancer 31 Day Combined

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				Sep 25	Oct 25	Nov 25	Dec 25
	Target	96%	Actual	90.8%	89.6%	88.0%	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	-5.2%	-6.4%	-8.0%	-7.9%



What is the data telling us?

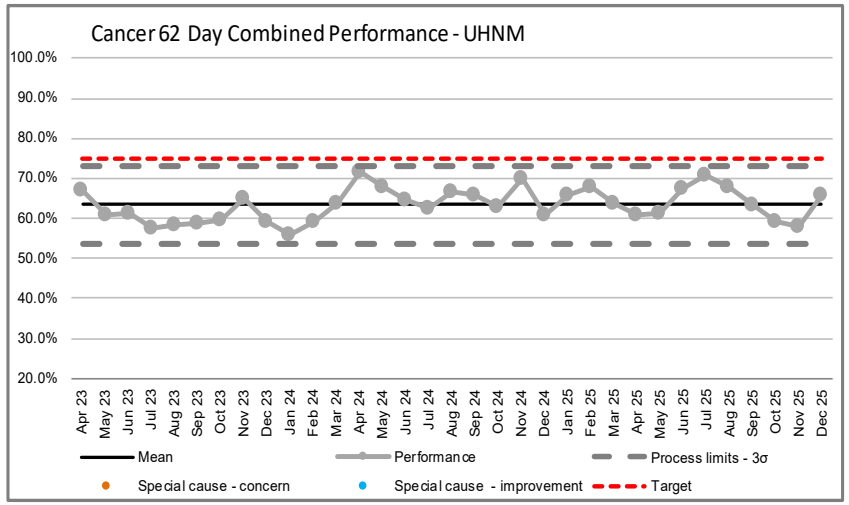
- The final November position for 31 days was reported at 87.98%
- The provisional December position is currently at 88.08% - a predicted improvement since the previous month
- Specialties performing well include Breast, H&N, Lung and Upper GI, however challenges in access to surgical capacity remain within Gynae, Colorectal and Skin.
- The majority of 31-day breaches are attributable to patients receiving surgery as either a first or a subsequent cancer treatment above the 31-day breach range. Particularly first Skin treatments account for a high number of 31 day breaches.
- Within the 31-day cohort of patients breaching surgery, the main delay reason is attributable to lack of capacity in skin, colorectal, gynae and urology tumour sites.
- Radiotherapy and Systemic Anti Cancer Treatments have also seen a slight deterioration of performance. Current waits for Skin Oncology first appointments are at 4 weeks.

What are we doing about it?

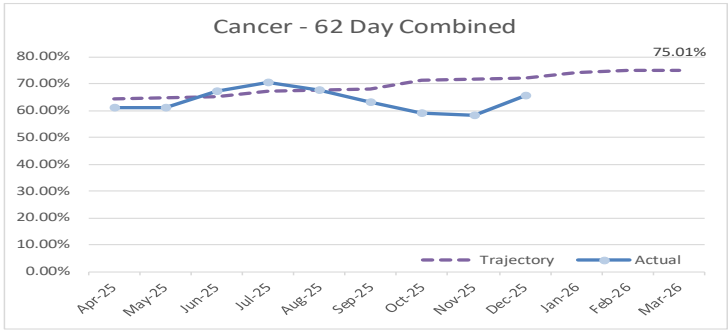
- The Trust and specialties are actively reviewing theatre capacity to ensure utilisation of all capacity available.
- Escalation of surgical capacity constraints at all appropriate forums such as Cancer Delivery Group, Specialty Improvement Groups, Cancer Services Strategy Group & Elective Oversight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

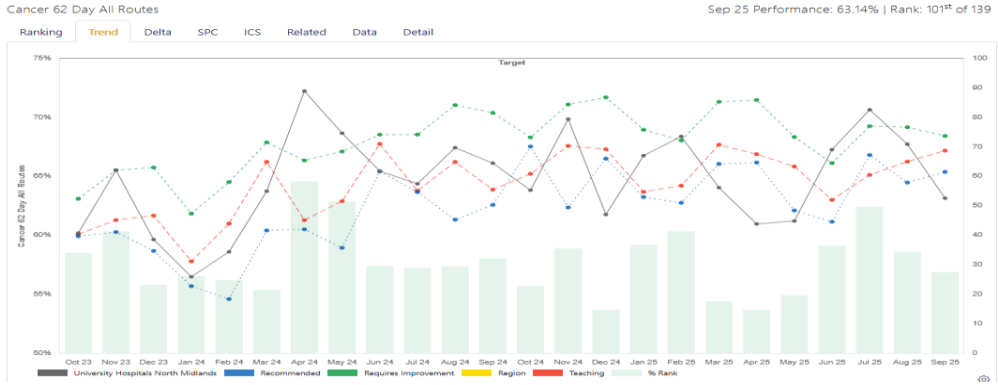
Quality & Access | Cancer 62 Day Combined

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				Sep 25	Oct 25	Nov 25	Dec 25
	Target	75%	Actual	63.1%	59.0%	58.1%	65.9%
Background			Plan	68.1%	71.5%	71.7%	72.4%
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer			Variance	-4.9%	-12.5%	-13.6%	-6.5%





What is the data telling us?

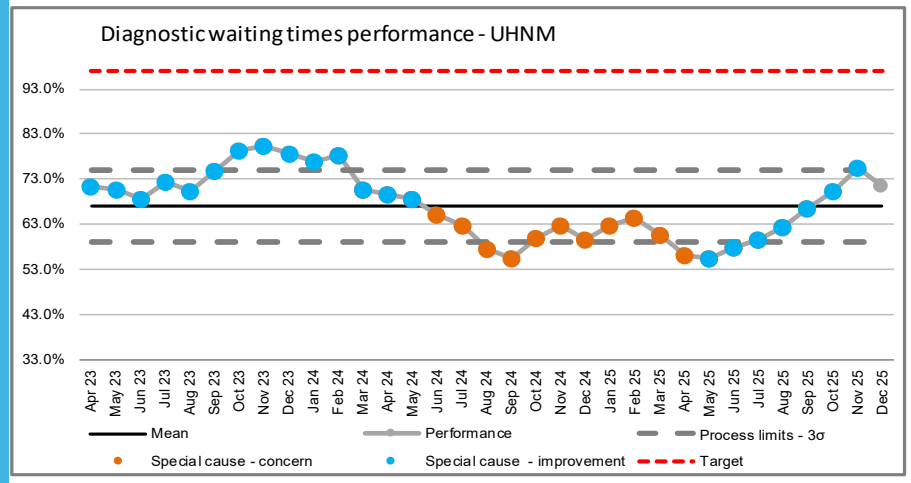
- The final November position was reported at 58.10% against a trajectory of 71.67%
- Higher number of breaches in Skin has contributed to the declining position, with additional activity secured with an outsourced provider.
- Analysis shows that excluding Skin, UHNM would've achieved closer to 65% against the 62-day combined standard in November.
- The December provisional position is currently at 65% with validation on-going.
- Breast, Colorectal, Gynae, Head & Neck, Skin & Upper GI are below their trajectories.
- Skin performance is particularly challenged owing to capacity for diagnostics and treatment which is significantly impacting on overall Trust performance from September onwards.
- Surgical capacity constraints (including robotics) affecting Gynae, Colorectal and Skin.
- Complex pathways (i.e. multiple investigations, second look biopsies, molecular and genetics testing).

What are we doing about it?

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

Quality & Access | Diagnostics DM01 Performance

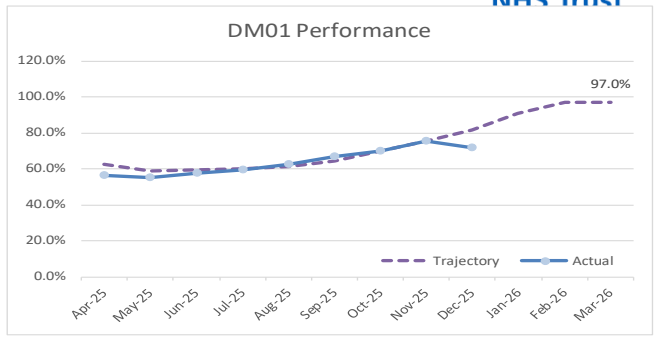
University Hospitals of North Midlands NHS Trust

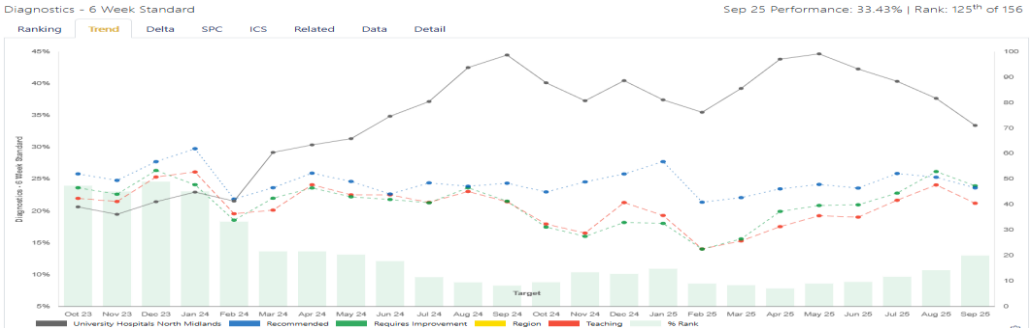


Variation	Assurance		Monitoring against plan				
				Sep 25	Oct 25	Nov 25	Dec 25
	Target	97.0%	Actual	66.6%	70.2%	75.7%	71.5%
			Plan	64.5%	69.6%	75.2%	81.8%
			Variance	2.1%	0.6%	0.5%	-10.3%

Background

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





What is the data telling us?

Decembers DM01 validated performance was 71.5% against trajectory of 81.8%. 95% being the national standard.

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

- NOUS position has dipped over Christmas to 52.2%. This has also impacted on the Trusts DM01 position, which also declined by 4%
- NOUS unvalidated performance is now 52.5%

Endoscopy is also a major contributor to overall DM01 performance

- Clear step changes of improvement; Sept 92% and Oct 97% , Nov 100%, Dec 99%

Neurophysiology is emerging as a diagnostic specialty of concern due to locum and short-term workforce cover (ERF)

What are we doing about it?

Non obstetric Ultrasound

- NOUS is expected to recover performance in January
- NOUS backlog position continues to improve (previous fortnightly position in brackets) current breakdown as follows:
    - Total waiting for an appointment = 7,626 (7,933)
    - Total under 6 weeks = 3,200 (3,305)
    - Total between 6 and 13 weeks = 3,136 (2,893)
    - Total over 13 weeks = 1,290 (1,735)

Endoscopy

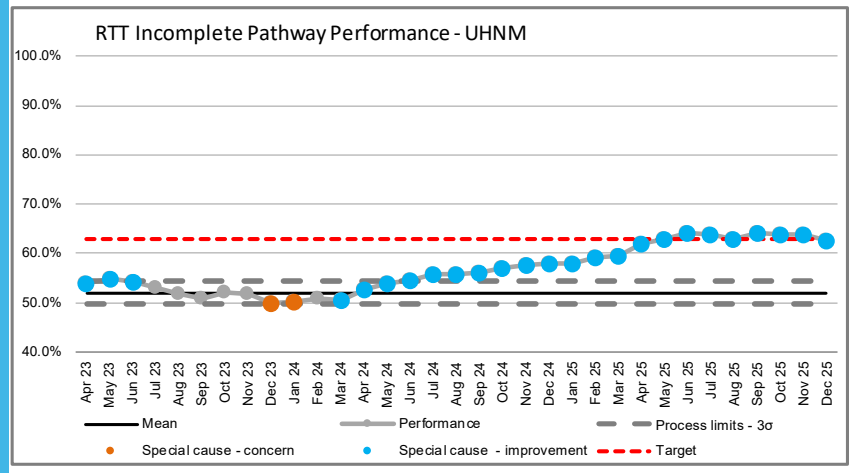
- Full business case approved by execs for Nov to March to bridge CDC gap until April 26.
- Consultant only slots will need WLI support from Gastro Consultants; Gastro aware and looking to support

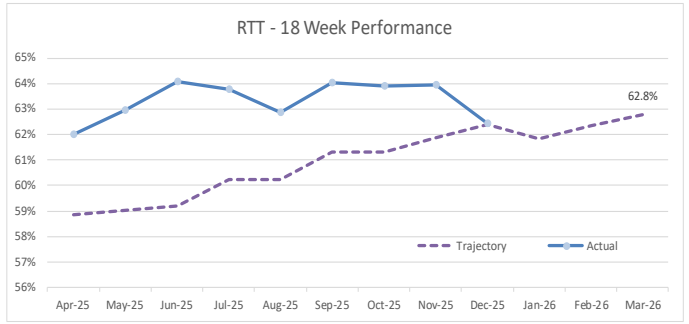
Neurophysiology

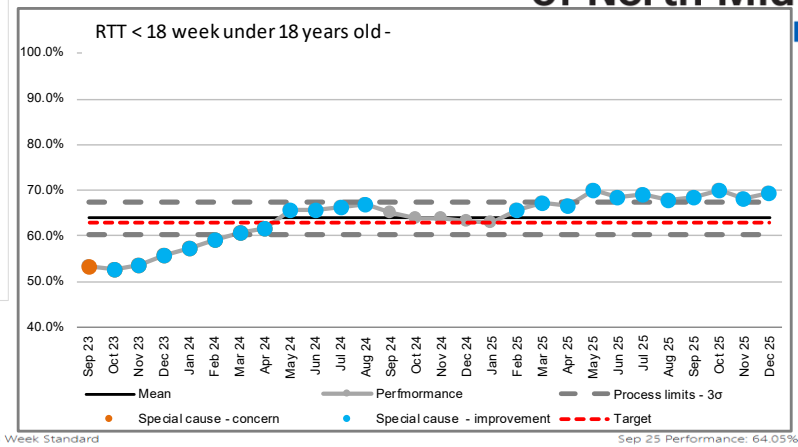
- Revenue for diagnostics for 26/27 available to cover 12-month workforce gap whilst BC written

Quality & Access | RTT Performance

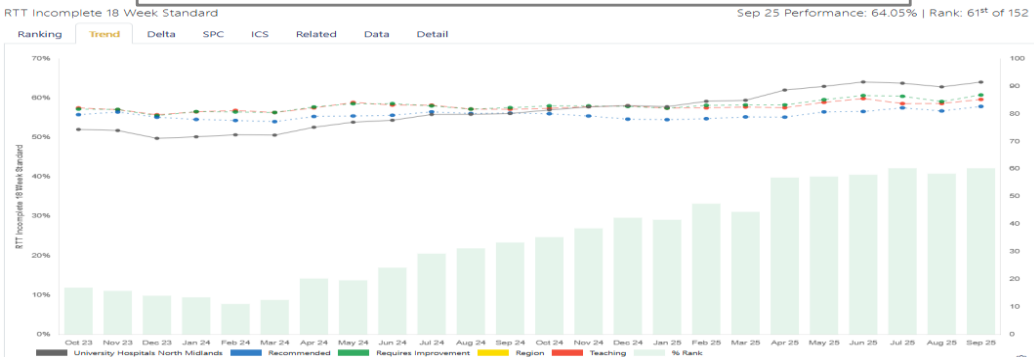
University Hospitals of North Midlands NHS Trust







Variation	Assurance		Monitoring against plan				
				Sep 25	Oct 25	Nov 25	Dec 25
	Target	63%	Actual	64.1%	63.9%	63.9%	62.5%
Background			Plan	61.3%	61.3%	61.9%	62.4%
The percentage of patients waiting less than 18 weeks for treatment.			Variance	2.7%	2.6%	2.1%	0.1%



What is the data telling us?

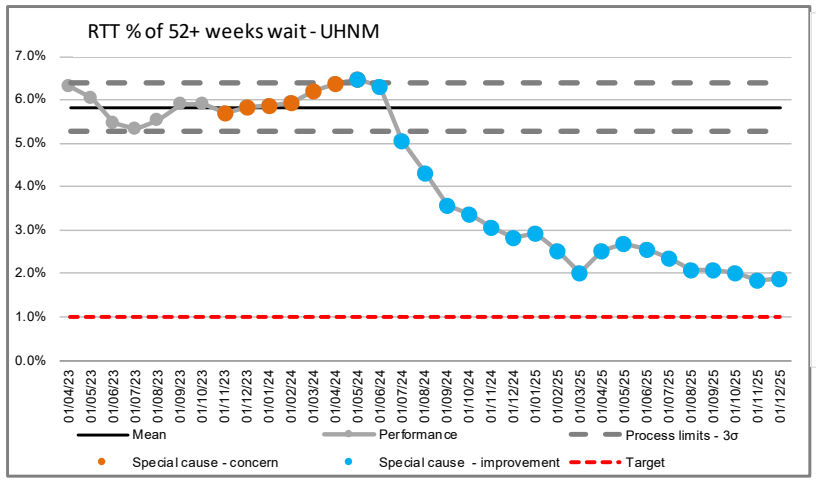
- Performance has deteriorated slightly during December, due to the combination of UEC pressures, increased leave during the holiday period, and industrial action. Performance is still however, slightly above plan.
- Rank against acute trusts is stable 61st.
- Validated month end position in increased slightly in December, from 64,479 to 64,716.

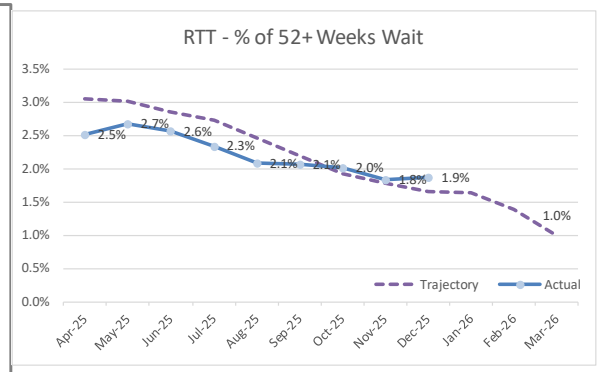
What are we doing about it?

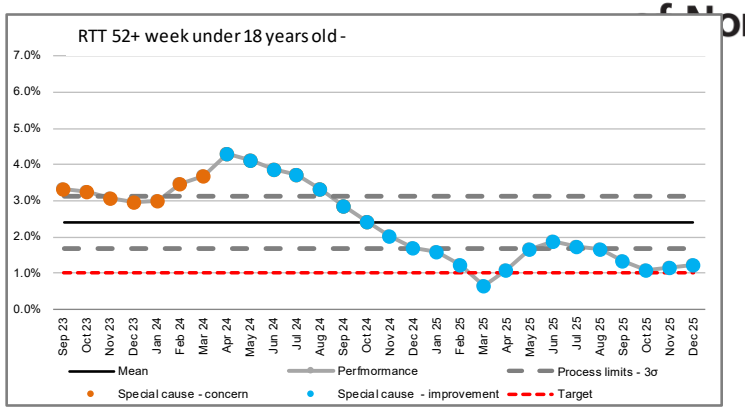
- Work so far has targeted known areas of challenge with data quality and clock stop capture, which is disproportionally patients waiting 18+ weeks. 60% of the patients waiting <18 weeks have yet to be seen, as opposed to 30% of those waiting above 18 weeks; less risk of error
- The ROVA validation tool has now commenced automated validation, leading to almost 4,000 pathways being closed in a 2 month period.
- Rollout of Rova to the Care Groups will commence in January to support improvements in both validation and tracking.

Quality & Access | RTT Performance – % 52+ Weeks

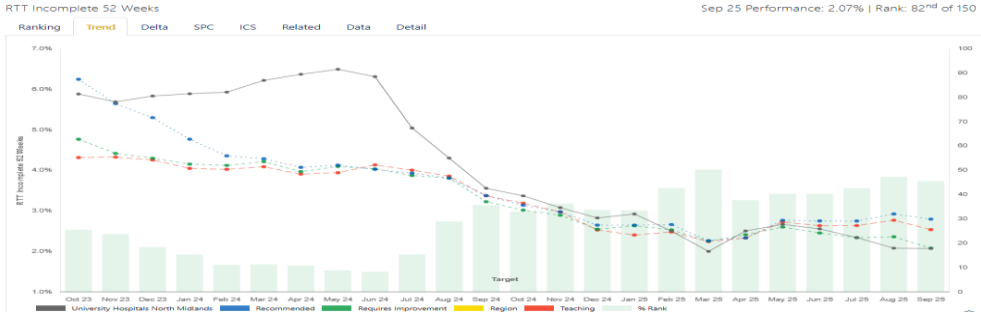
University Hospitals of North Midlands NHS Trust







Variation	Assurance		Monitoring against plan				
				Sep 25	Oct 25	Nov 25	Dec 25
	Target	1.00%	Actual	2.07%	2.02%	1.83%	1.87%
Background			Plan	2.19%	1.93%	1.79%	1.65%
The percentage of patients on a RTT pathway who have			Variance	-0.1%	0.1%	0.0%	0.2%



What is the data telling us?

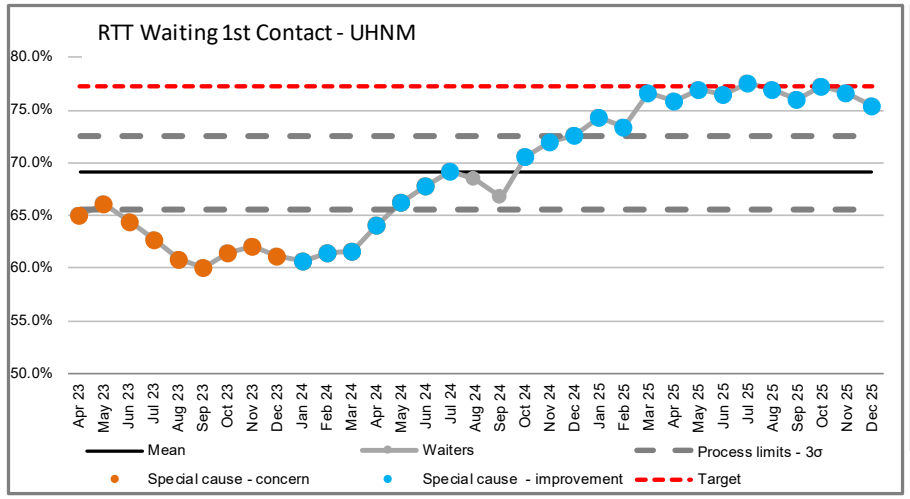
- Percentage of total PTL above 52 weeks has increased slightly during December, albeit slightly behind plan.
- 52 week actuals has saw a small increase in December from 1,183 to 1,192. Although the proportion of our waiting list waiting above 52% has continually reduced, the cumulative effect of extended 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

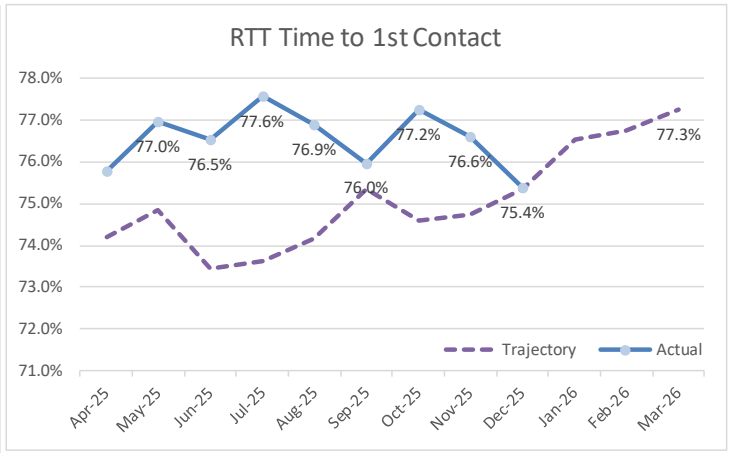
What are we doing about it?

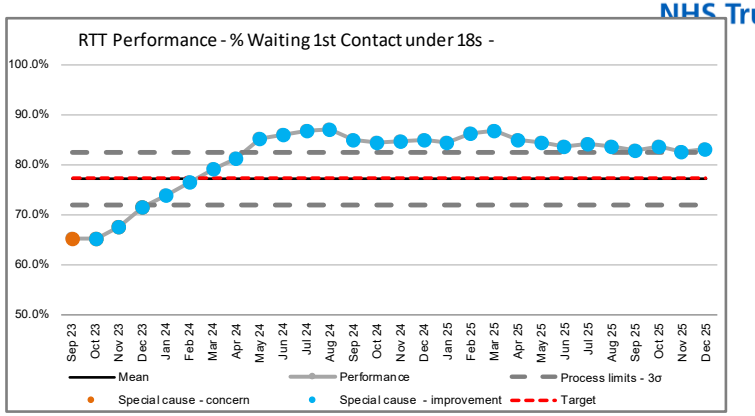
- Gynae Recovery funding approved at execs to deliver substantial additional activity through weekend and STS working; activity against recovery to be tracked separately on a week-by-week basis
- The ROVA validation tool also highlights pathways where actions have not been taken, and groups pathways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

Quality & Access | RTT % Waiting 1st Contact

University Hospitals of North Midlands NHS Trust







Variation	Assurance		Monitoring against plan				
				Sep 25	Oct 25	Nov 25	Dec 25
	Target	77.3%	Actual	76.0%	77.2%	76.6%	75.4%
Background			Plan	75.4%	74.6%	74.7%	75.3%
Of all patients waiting for first event after referral - the percentage that are waiting under 18 weeks			Variance	0.6%	2.7%	1.9%	0.1%

What is the data telling us?

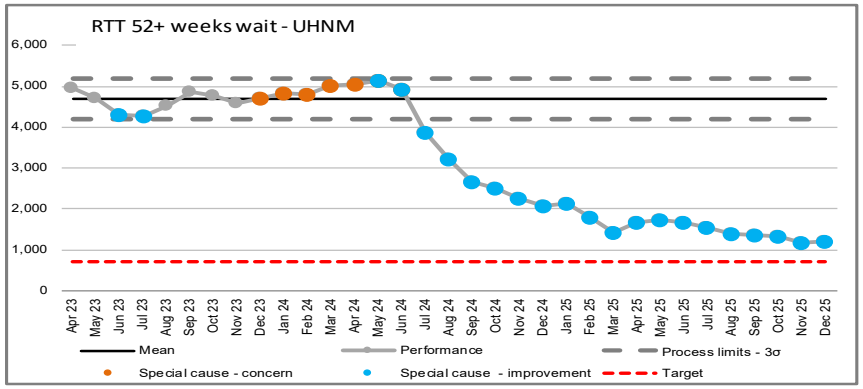
- UHNM is a regional leader on this metric and ahead of plan
- Time to first contact performance remains strong at 75.4% against a plan of 75.3%
- The Elective sprint increasing the volume of Outpatient 1st New Activity in Q4 will accelerate this progress even further.

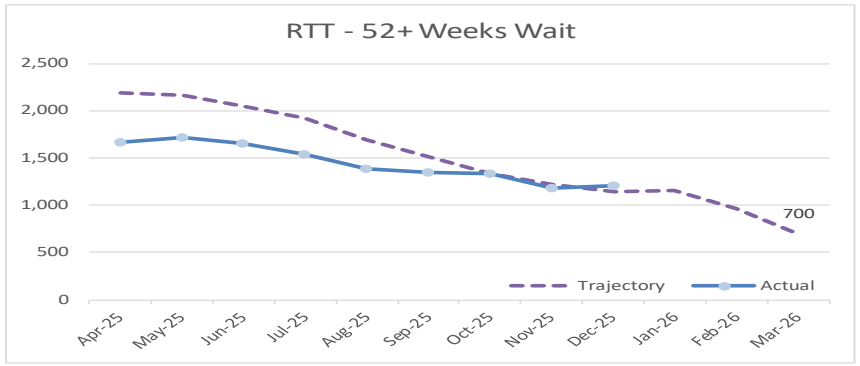
What are we doing about it?

- 52-week 1st contact for patients by March '26 are required to be seen by January '26. Performance being tracked weekly through EOMG
- Q4 1st new OPD for January live; February and March proposal to be taken to execs
- ERF papers approved, and mobilisation has been quicker than expected for outpatient clinics
- Increased validation of Cardiology pathways for patients awaiting 1st contact, as not all should be on an RTT pathway
- Work to understand the Ophthalmology increase is underway; a reduction in independent sector cataract capacity within the ICS in 2024/25 has likely had an impact

Quality & Access | RTT No. of Long Waiting Patients

University Hospitals of North Midlands NHS Trust





Variation	Assurance

Target	700

Background

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

Monitoring against plan	Sep 25	Oct 25	Nov 25	Dec 25
Actual	1,355	1,330	1,183	1,210
Plan	1,520	1,341	1,224	1,138
Variance	-165	-11	-41	72
65+	100	75	46	69
78+	3	1	1	3
104+	0	0	0	0

What is the data telling us?

- The number of 78 week breaches did increase slightly in December, up to 3 from 1 in November.
- 65 week waits have increased in December, up to 66 from 46. Although an increase, this was an improvement on forecasts earlier in the month.
- There is some risk with the extensive validation work underway of pop-up long waiters – these will be managed through the trust's "uncorrected breaches" process
- Particular specialties which impact are Orthopaedics, ENT, Ophthalmology, and Gynaecology.

What are we doing about it?

- Micromanaging long waiting patients at daily / weekly PTL meetings
- Cohorts of patients identified and non-admitted prioritised for urgent next steps
- UEC pressures impacted on admitted long wait operating
- Orthopaedics & Spinal now running through weekends through County Hub

- ERF funding approved to increase evening and weekend operating capacity

Highlight Report

PEOPLE CULTURE & INCLUSION COMMITTEE | 4th February 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• **BAF3 – Workforce Sustainability and Culture** remains an Extreme risk although progress being made against key priorities, such as sexual safety, leadership and line management as well as Staff Survey priorities • **Medical Workforce Group** highlighted some vacancies and hard to recruit areas, as well as needing to reduce bank / agency spend to ensure sustainability and affordability • **Strategic Workforce Group** escalated risks in relation to funding for pre-registration technician training posts, apprenticeship funding for level 7 and financial wellbeing for non-funded biomedical science students, as well as the broader strategic workforce plan • **Health & Safety Group** highlighted capacity concerns within the team which are impacting on the delivery of key priorities, mitigations are being identified	• A review of reporting to the Committee is being undertaken to ensure alignment with the **Insightful Board** metrics and assurance on delivery of our Strategic Plan for Our People • Rest and wellbeing facilities, flexible working education, training and development, course fee reimbursement and peer lead engagement mechanisms were identified as areas requiring further development in the **Junior Doctors 10 Point Plan** although it was agreed for some governance support to be provided to ensure this is accurately reflected • Significant work remains underway in relation to the Agenda for Change deal – job evaluation for nursing and midwifery

Positive Assurances to Provide	Decisions Made
• **Acceptable Assurance** for the **Junior Doctors 10 Point Plan** as compliant or partial compliance was identified against most elements of the plan, as well as high regional survey response rates and clear alignment to national trajectories in amenities, induction and safety related training, in addition UHNM is in the top quartile for medical education • **Acceptable Assurance** for the **Chief Pharmacist Workforce Report** although further work needed to address vacancies, de-escalate risk, improve flexibility and training opportunities • **Acceptable Assurance** for nurse staffing reporting, as it provides a clear basis for Care Groups to identify actions needed and areas of risk although future reports will be categorised by Care Group. UHNM overall fill rate noted as 92% (overall registered nurse fill rate 93%, overall unregistered fill rate 91%). • **Acceptable Assurance** for the Sexual Safety Update, as extensive work has been undertaken on policies, practice, training, support and communication as well as introduction of the Sexual Safety Liaison Officer/ 39/50 actions in the national charter have been confirmed with evidence. • **Acceptable Assurance** for the **Violence Prevention and Reduction** report given the level of compliance with national standards	• Approval of the **Strategic Plan for Our People** which underpins our overarching strategy • Approval of the **Education, Training and Development Accountability** Framework

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
Online form circulated after the meeting.	Safe Staffing Report triangulation with Quality, Access & Outcomes Committee.

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Board Assurance Framework Q3 2025/26	3	Ext 15	Not Applicable	Approval	7.	Strategic Plan: Our People	3	Ext 15	Not Applicable	Approval
2.	Resident Doctors 10 Point Plan	3	Ext 15	Not assessed	Assurance	8.	Strategic Workforce Group Highlight Report	3	Ext 15	Not assessed	Assurance
3.	Medical Workforce Group Assurance Report (06-01-26)	3	Ext 15	Not assessed	Assurance	9.	Education, Training & Development Accountability Framework			Not Applicable	Approval
4.	Chief Pharmacist Workforce Report	3	High 12 35057 High 12 36825 High 12 25152	Acceptable	Assurance	10.	Sexual Safety Update			Acceptable	Assurance
5.	Bi-Monthly Staffing Report	3	Ext 15	Acceptable	Assurance	11.	Violence Prevention and Reduction Report			Acceptable	Assurance
6.	Agenda for Change Non Pay Deal: Job Evaluation – Nursing and Midwifery			Not Applicable	Information	12.	Executive Health & Safety Group Highlight Report (16-12-25)			Not assessed	Assurance

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Integrated Performance Report

Month 09 Performance

2025/26

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Contents

Statistical Process Control

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

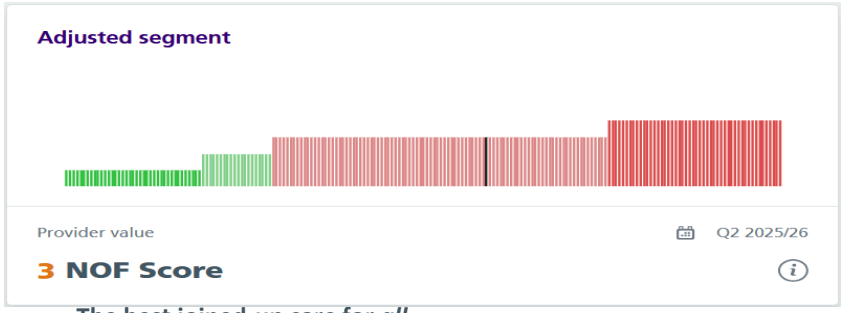
Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

National Oversight Framework Summary

University Hospitals of North Midlands NHS Trust

Headlines	Data period	Provider value	Peer average		National value	National value method	Chart
Adjusted segment			Q2 2025/26	3	NOF Score	Provider value	
Average metric score			Q2 2025/26	2.43	NOF Score	Provider value	
Unadjusted segment			Q2 2025/26	3	NOF Score	Provider value	
Financial override	Q2 2025/26	No	Yes		Yes	Provider median	
Is the organisation in the Recovery Support Programme?	Q2 2025/26	No	No		No	Provider median	

Domain Scores	Data period	Provider value		Chart
Access to services domain segment	Q2 2025/26	3	NOF Score	
Access to services domain score	Q2 2025/26	2.41	NOF Score	
Effectiveness and experience of care domain segment	Q2 2025/26	2	NOF Score	
Effectiveness and experience of care domain score	Q2 2025/26	2.19	NOF Score	
Patient safety domain segment	Q2 2025/26	3	NOF Score	
Patient safety domain score	Q2 2025/26	2.86	NOF Score	
People and workforce domain segment	Q2 2025/26	2	NOF Score	
People and workforce domain score	Q2 2025/26	2.53	NOF Score	
Finance and productivity domain segment	Q2 2025/26	3	NOF Score	
Finance and productivity domain score	Q2 2025/26	2.36	NOF Score	



UHNM remains in segment 3 for quarter two.
UHNM demonstrates a balanced performance across the NOF domains, with very little change from quarter one.

Overall score in quarter one was 2.47, quarter two is 2.43, broken down as:

- Access to services from 2.55 to 2.41
- Effectiveness and experience from 2.17 to 2.19
- Patient Safety from 2.63 to 2.86
- People and workforce remains at 2.53
- Finance and productivity remains at 2.36.

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NOF - People and Workforce

University Hospitals of North Midlands NHS Trust

People and workforce	Data period	Provider value		Chart
People and workforce domain segment	Q2 2025/26	2	NOF Score	
People and workforce domain score	Q2 2025/26	2.53	NOF Score	

Retention and Culture	Data period	Provider value	Peer average	National value	National value method	Chart
Sickness absence rate score	Q2 2025/26	2.43	NOF Score	Provider value		
NHS staff survey engagement theme sub-score score	Q2 2025/26	2.62	NOF Score	Provider value		

Additional contextual measures - non scoring	Data period	Provider value	Peer average	National value	National value method	Chart
National Education and Training Survey "Overall experience" survey score	2024	72.09%	73.71%	77.03%	Provider median	

Data in this domain remains unchanged since quarter one.

Contextual metric has been added, definition describes:

National Education and Training Survey "Overall experience" survey score

Percentage of respondents to rate their overall educational experience at the trust as positive

People | Overview

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Overview from the Chief People Officer

How are we doing against our trajectories and expected standards?

Our most recent *Staff Engagement* score was 6.3 for July 2025, slightly down from the score of 6.8 for April 2025, against a target of 7.2. The Staff Voice Survey is now collected quarterly, but has been paused for the 2025 National Staff Survey, and will re-commence in January 2026.

Sickness absence remains above our expected standard of 3.39%. Both the in-month and 12-month cumulative sickness rates increased to 6.15% and 5.28%, respectively, reflecting the increase in reported Cold, Cough and Flu cases. Overall, sickness absences continue to be driven by stress and anxiety, followed by cold, cough, flu and then other musculoskeletal problems, as the second and third most common reasons. In December, 934 episodes of Cold, Cough, Flu, and Chest & Respiratory conditions were reported, compared to 623 episodes in November — representing a 50% increase.

Turnover and *vacancy* metrics continue to perform well against our expected standards. The turnover rate in December 2025 remains low, at 7.5%, which is consistently below our 11% target, for the last 3 years. Vacancies remain low at 4.2%, in line with Month 7's modelling of the 567 WTE CIP workforce reduction. Colleagues in post increased in Registered Nursing (+6.8), with Infrastructure, ST&T, Medical and Dental, and Support to Clinical people all reducing by a combined total of -29 fte, while the overall vacancy rate increased slightly, to 4.2% due to an increase in the total budgeted establishment and the aforementioned decrease in colleagues in post.

Agency costs decreased to 1.56%, in December 2025, from 1.81% in November 2025, which is below the threshold set by NHS England. In real-terms, overall agency usage decreased slightly to 102.99 WTE in November from 103.41 WTE in December, which is 7.2 WTE above plan.

What is driving this?

Sickness absence is driven by many factors, including stress and anxiety and seasonal changes such as colds, cough and chest & respiratory problems. December saw a marked increase in in-month sickness absence, influenced by seasonal fluctuations associated with episodes of cold, cough & flu, and Covid-19.

Agency expenditure was 7.2 WTE above plan, driven by Medical & Dental being above plan due to vacancies, maternity leave and sickness absence, and cardiac perfusionist vacancies, in Registered ST & T, with all other staff groups below plan. Agency use is also influenced by the additional scrutiny at executive and care group level which is having the desired effect in reducing overall agency spend, with some agency activity being converted to bank expenditure, as well.

People | Overview

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Overview from the Chief People Officer

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

The staff voice has moved to quarterly (with the survey open for 14 days) for FY24/25 to prevent survey fatigue and to allow more time for the divisions & care groups to review and respond to feedback 'you said, we will'.

Sickness absence continues to be monitored at directorate performance reviews. Areas with over 8% or of concern are supported by the People Advisors, focusing on long term sickness cases. Our people are also provided with many online and in-person resources, to improve their personal resiliency when coping with work-related stress. A review of policy compliance of the top 10 cases for short and long term absence continues across all divisions/care groups.

Agency Expenditure remains subject to continued scrutiny through the Care Group Performance Reviews and the Medical Workforce Assurance Group. There is also regular focus at ICB level on workforce numbers, agency spend and controls. Additional data sources are being provided to allow for more granular discussions, via the new temporary staffing dashboard, which is updated on a weekly basis. Deloitte are also working with us to identify other opportunities to reduce temporary staffing expenditure.

The system-level controls implemented in our Electronic Rostering solution for all nursing and midwifery rosters continue to serve as the primary layer of control, complemented by the scrutiny provided through Divisional/Care Group Performance Reviews.

What can we expect in future reports?

As we move further into the New Year we may see a stabilisation in sickness absence reasons associated with gastrointestinal, cold & flu, and Covid-19 related symptoms, but may be influenced by any deterioration in the weather. When combined with underlying increases in stress and anxiety, we may continue to see high absence rates, over the coming months, until Spring arrives.

Without further Industrial Action, agency usage should reduce slightly and may track close to plan in January 2026. Despite this, and the additional scrutiny, of agency expenditure, the on-going elective recovery programme activity, and the continued need for escalation capacity and the additional demand in theatres and endoscopy services, and in the emergency portals, there are still many influences demanding the need for agency.

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People | Dashboard

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Metric	Target	Previous	Latest	Variation	Assurance	R12M Trend
Staff Turnover (R12M)	11.0%	7.4%	7.5%	L	P	
Staff Vacancy Rate	8.0%	3.2%	4.2%	L	?	
Sickness Absence (In Month)	3.4%	5.5%	6.2%	H	F	
Appraisal (PDR)	95.0%	83.8%	83.9%		F	
Agency Utilisation	3.2%	1.8%	1.6%	L	?	
Employee Engagement	7.2	6.3	6.3	L	F	

Related Strategy and Board Assurance Framework (BAF)

People Strategy

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

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People | Employee Engagement

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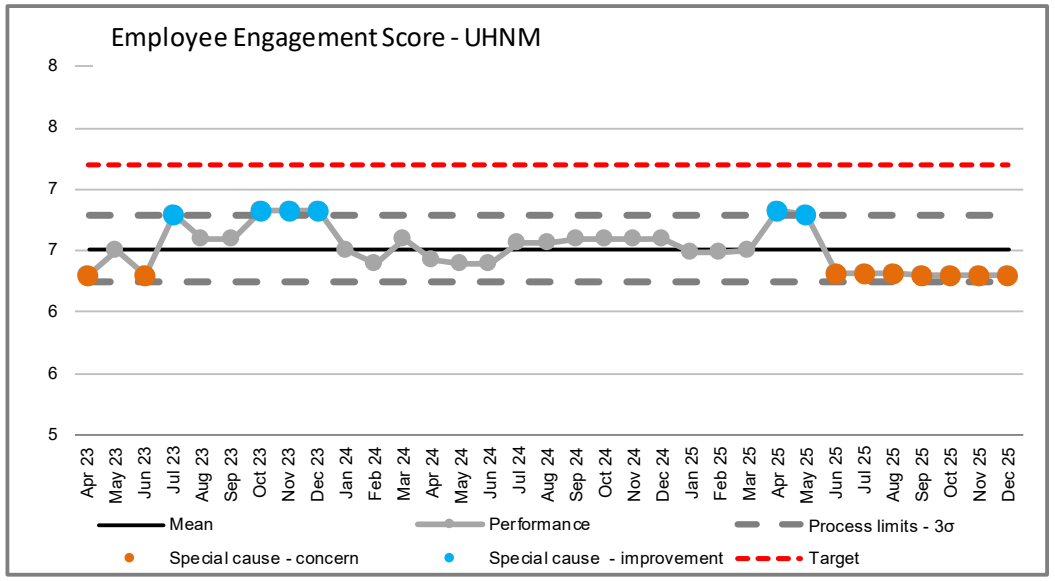

Variation	Assurance
L	F

Target	Oct 25	Nov 25	Dec 25
7.2	6.3	6.3	6.3

Background

What is the data telling us?

Our most recent Staff Engagement score was 6.3, for July 2025, down from the score of 6.8 for April 2025, against a target of 7.2.

The Staff Voice Survey is now collected quarterly and has been paused during the 2025 National Staff Survey period, and will recommence for January 2026.

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

What are we doing about it?

The survey has moved to quarterly (with the survey open for 14 days) for FY24/25 to prevent survey fatigue and to allow more time for the divisions & care groups to review and respond to feedback 'you said, we will'. The next reportable period is January 2026.

Sustained operational pressures continue to impact on overall employee engagement.

All Divisions and Care Groups will develop their staff survey response plans and have a driver metric for staff engagement, once the 2025/26's data is available.

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People | Sickness Absence in Month

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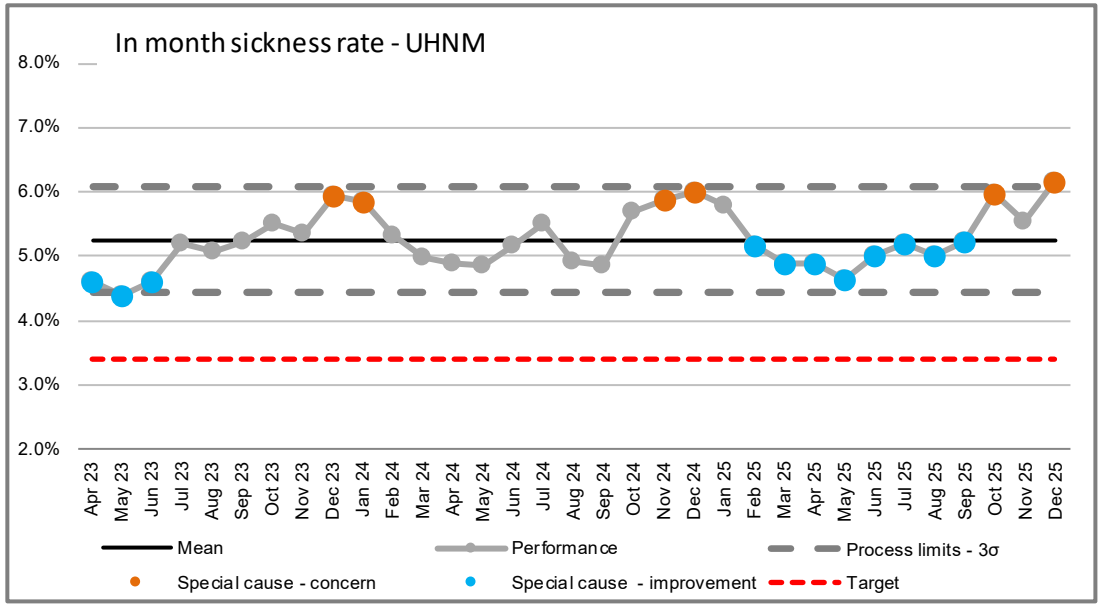


Variation	Assurance
H	F

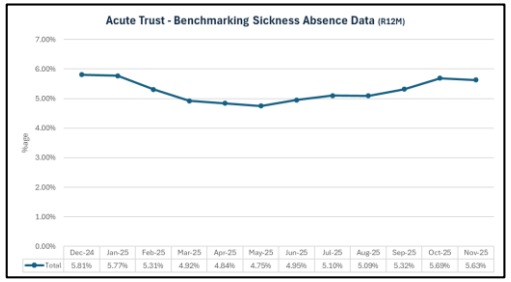
Target	Oct 25	Nov 25	Dec 25
3.4%	6.0%	5.5%	6.2%

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 Nov 2025- 5.63%)



What is the data telling us?

The rolling 12-month average sickness absence rate increased to 5.28% (5.25% in November 2025) against the target of 3.4%.

The in-month sickness absence increased to 6.15% in December (5.53% in November 2025) with Cold, Cough, Flu – influenza seeing the largest increase of 4.1%, and stress & anxiety increasing by 0.8%, while other musculoskeletal problems decreased by 2.1%.

In rank order (highest first), the top 3 reasons for absences during November were: (1) Anxiety/stress/depression/other psychiatric illnesses, (2) Cold, Cough, Flu – influenza, (3) Other musculoskeletal problems.

What are we doing about it?

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

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

Clinical & Scientific Services Care Group - Deep dives into hot spot/high absence areas to target interventions as well as continuing absence surgeries.

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People | Vacancy Rate

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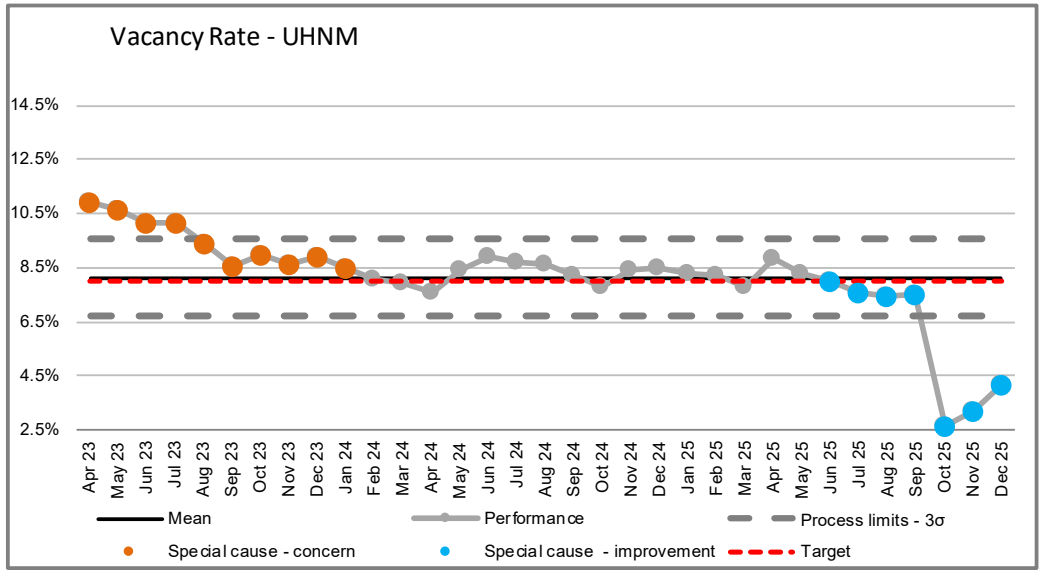

Variation	Assurance
	

Target	Oct 25	Nov 25	Dec 25
8%	2.7%	3.2%	4.2%

Background

Based on Full Establishment (Substantive, Bank & Agency)

Vacancies at 31-12-25	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,802.99	1,636.79	166.20	9.22%	8.56%
Registered Nursing	3723.58	3798.88	-75.30	-2.02%	-3.29%
All other Staff Groups	6826.87	6400.66	426.21	6.24%	5.27%
Total	12,353.44	11,836.33	517.11	4.19%	3.18%

What is the data telling us?

December's low vacancy rate of 4.2% (3.2% in November) continues to reflect our alignment to the modelling of the 567 WTE CIP workforce reduction, which came into effect from October 2025 budgeted establishment, onwards.

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

Colleagues in post decreased in December 2025 by -20 fte, budgeted establishment increased by 107.4 fte, which increased the vacancy fte by 127.44 fte.

[*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 31/12/25]

What are we doing about it?

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

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

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

(The national provider workforce return report defines the overall staff vacancies as the variance between the current total staff in post and the planned (budgeted) establishment. Total staff in post includes substantive, bank and agency WTE and as such not all "reported vacancies" are being recruited to, to allow for temporary staffing use.)

People | Turnover Rate

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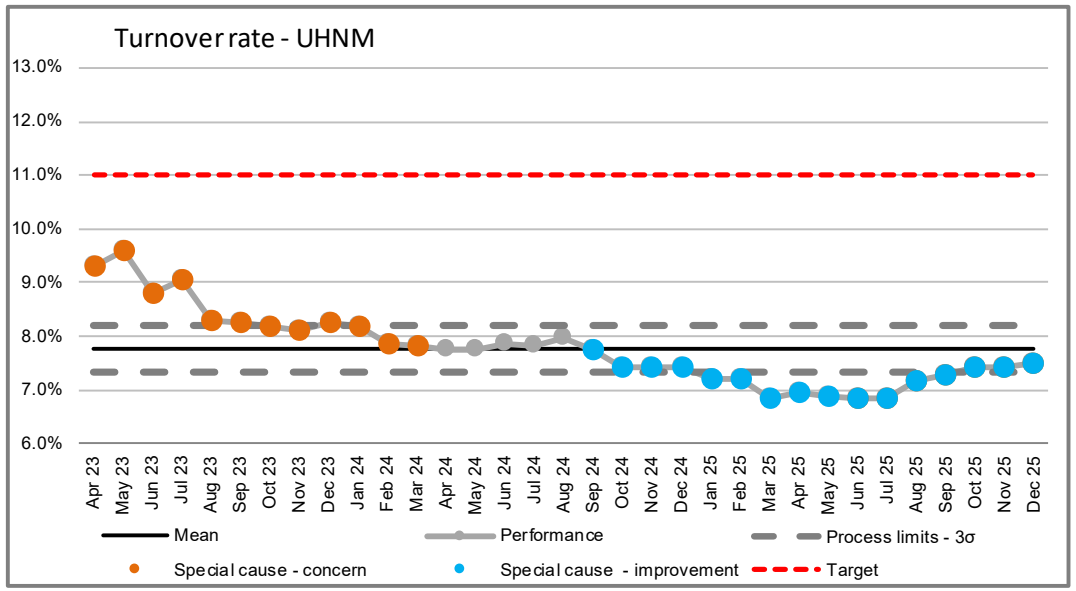


University Hospitals of North Midlands NHS Trust

Variation	Assurance
H	P

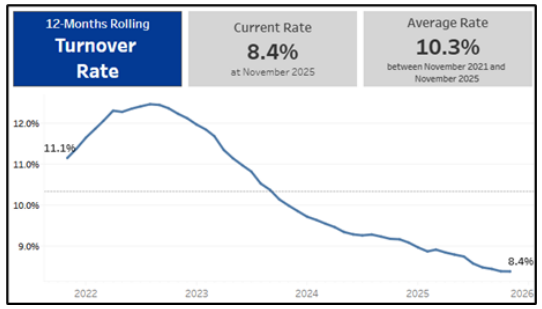
Target	Oct 25	Nov 25	Dec 25
11.0%	7.4%	7.4%	7.5%

Background

Turnover rate.

Based on the most recent benchmarking data, comparing ourselves against other Acute Trusts, our overall turnover is much lower.

(Benchmarking data effective October 2025)



What is the data telling us?

December 2025's turnover rate increased slightly to 7.5%, from 7.4% in November 2025, which is consistently below the Trust's 11% target, for almost three years.

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

What are we doing about it?

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

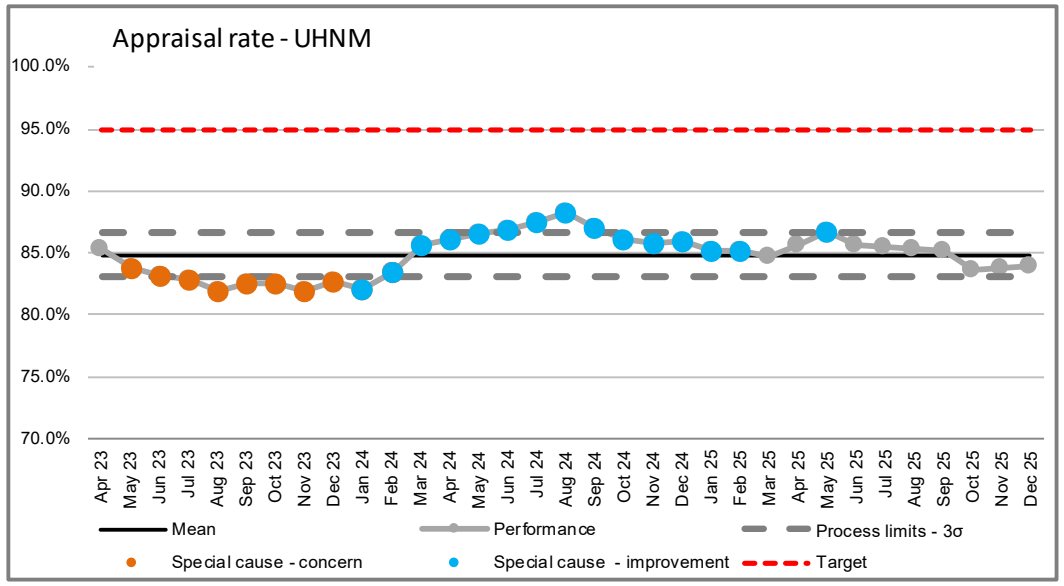
- Medical Staffing finishing school.
- Employment of a People Promise (Retention) Manager who currently continues in a fixed term post.
- Monthly targeted campaigns aligned to our Trust Values. For example, the *UK Disability History Month*, continued into December, which is an annual UK event which raises awareness of the history and achievements of disabled people, while celebrating their contributions, and promotes equality.

Kind Excellent Together

People | Appraisal Rate

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	F

Target	Oct 25	Nov 25	Dec 25
95%	83.6%	83.8%	83.9%

Background

Percentage of people who have had a documented appraisal within the last 12 months.

What is the data telling us?

Performance Development Reviews (PDR's) continue to perform below our 95% target.

December's appraisal rates increased to 83.9% from 83.8% in November 2025, with Estates, Facilities and PFI Division consistently achieving above the target, at 96.41% for December 2025.

The Divisions & Care Groups continue to monitor and review their PDR performance.

What are we doing about it?

NMCPS - All out of date PDR's are scheduled with line managers.

Planned Care– Monthly compliance report, with a focus on hotspots.

Unplanned Care – Weekly updates reports on compliance. With focused assistance on those areas with the lowest compliance.

Clinical & Scientific Services Care Group – Weekly performance reports and assurance meetings.

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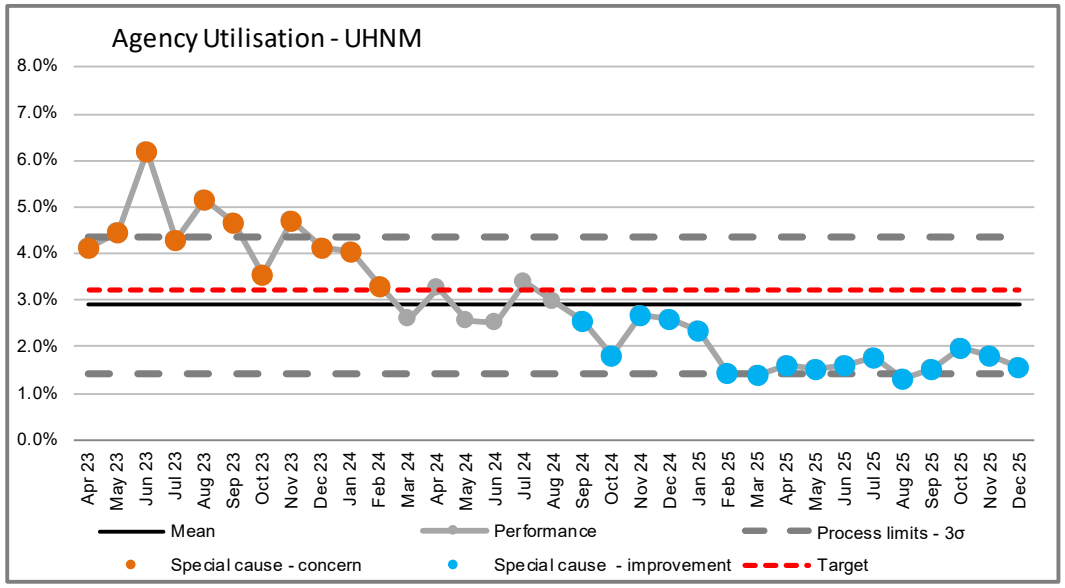
People | Agency Utilisation

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Oct 25	Nov 25	Dec 25
3.2%	2.0%	1.8%	1.6%

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 1.56% in December 2025, (1.81% in November 2025).

In real-terms, overall agency usage decreased to 102.99 WTE in December from 103.41 WTE in November 2025, which is 7.18 WTE above plan, driven by Medical & Dental's vacancies, maternity leave and sickness absence, and cardiac perfusionist vacancies, in Registered ST & T, with all other staff groups below plan.

Executive and divisional/care group level scrutiny, in addition to the software level controls would appear to be having the desired effect of keeping the overall agency usage within plan. We have had no off-framework agency use for 12 months.

What are we doing about it?

- Agency use is monitored and discussed at monthly divisional/care group meetings. This includes reviewing long-term agency use.
- All current in-sourcing contracts are reviewed monthly, to ensure that they do not breach rules regarding off-framework agency use.
- All off-framework agency arrangements have been reviewed and all off-framework use ceased at the end of July 2024.
- System level controls have been implemented in our Electronic Rostering solution, for all nursing & midwifery rosters, which now require Matron level authorisation prior to being filled by either bank and/or agency. These additional controls appear to be having the desired effect in controlling the use of bank and agency, through higher levels of scrutiny by the senior clinical nursing teams.

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Highlight Report

Finance & Business Performance Committee | 22nd December 2025

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• **CIP Delivery:** Only 71% of the £75m target was QIA-approved, with a recurrent gap and reliance on non-recurrent measures. High-risk schemes (theatres, endoscopy, workforce) have not delivered as planned. • **Financial Sustainability:** The underlying deficit was £25.3m, with income underperformance and risk of further deterioration if unfunded capacity or CIP shortfalls persist. • **Workforce Pressures:** Overspends in staffing due to bank/agency use and recruitment challenges. • **Operational Performance:** High ED attendances and conversion rates, with concerns about data reliability and coding. • **CDC Income Risk:** No confirmed recurrent income for expanded CDC activity, creating a £3.5m exposure. Equipment lead times may impact readiness. • **Business Case Reviews:** Several reviews were overdue or not delivering intended benefits. • **Theatres & Endoscopy:** Ongoing concerns about productivity and utilisation; further assurance and deep dives requested.	• **CIP & Financial Recovery:** Accelerated review of high-risk schemes, new recurrent schemes for 2026/27, and strengthened governance. • **CDC Implementation:** Recruitment and equipment procurement underway; subject to securing income with NHSE/ICB. • **Productivity:** Relaunch of Service Line Reporting, development of specialty productivity summaries, and integration of improvement methodologies. • **Data & Coding:** Actions to resolve ED coding issues and improve project management; full report due in January. • **Business Case Review:** Enhanced tracking of delivery milestones and benefits realisation. • **Theatres & Endoscopy:** Programme refresh and enhanced assurance in future reports. • **Workforce Controls:** Review of organisational capacity risks from vacancy controls.
Positive Assurances to Provide	**Decisions Made**
• **CDC Programme:** All six NHSE diagnostic pathway bids were successful, securing capital and revenue funding. Mobilisation is on track, with new services due to start in 2026. • **Private Patient & Overseas Visitors:** Annual audits provided significant assurance, with only minor administrative errors and robust compliance processes in place. • **Diagnostics & Productivity:** Diagnostics (DM01) performance had improved, driven by ultrasound capacity and effective management. Productivity and efficiency programmes are in place, with regular benchmarking and targeted interventions. • **Financial Position:** Month 8 deficit (£8.2m) was on plan, with strong cash balances and capital spend monitored. System partners were supportive of a break-even position, and NHSE deficit funding is expected. • **Capital Programme:** Remains on track, with further NHSE capital opportunities being explored.	• Approval of **capital expenditure** profile for medical equipment in order to proceed with procurement • Approval in principle of the **clinical activity** profile and recruitment timetable in order to commence the process pending confirmation of recurrent income from NHSE/ICB and sign off of the internal activity plan.
Comments on the Effectiveness of the Meeting	**Cross Committee Considerations**
A feedback form was available for Committee members to complete after the meeting.	

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	CDC Business Case update	-		**Not Assessed**	Approval	6.	CIP Report	6, 7	**Various**	**Partial**	Assurance
2.	Changing the NHS Landscape	2	**10 High**	**N/A**	Discussion	7.	Productivity Update	6, 7	**Various**	**Partial**	Assurance
3.	Business Case Review Update	6, 7	**Various**	**Partial**	Assurance	8.	Finance Report – Month 8 2025/26 • Medium Term Planning Framework	6, 7	**Various**	**Partial**	Assurance
4.	Annual Audit: Private Patient Policy Compliance Overseas Visitors Policy Compliance	6, 7	**Various**	**Significant**	Assurance	9.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-		**Not Applicable**	Approval
5.	Demand and Activity Performance Report – Month 8 2025/26	6, 7	**Various**	**Not Assessed**	Assurance						

Highlight Report

Finance & Business Performance Committee | 2nd February 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate

- The Committee queried the capability in place to deliver the **strategic plans** and whether the finances were in place to support delivery. It was noted that a business case was to be considered in due course in terms of the future capacity required to deliver the strategy
- It was queried where CIP featured in the **strategic plans** and it was noted that the plans for 2026/27 were transformational savings and as such would be aligned to strategic plans
- The Committee referred to the ongoing risk in relation to management of **shadow IT** and requested additional assurance regarding the capacity, capability and focus to manage and mitigate the associated risk
- The Committee queried whether the risk score for the **Board Assurance Framework (BAF)**, risk 4 was reflective of current issues identified by the **Digital, Data and Governance Group** report. It was noted that the issues identified in January would be considered alongside the risk score for Q4.
- It was noted that the score for BAF 7 had increased to the most extreme risk on the **BAF**. It was noted that whilst it was anticipated to reduce slightly in Q4 this was dependent on the completion of the medium-term plan and whether the Trust was able to submit a compliant plan
- The Committee received an update on the **medium year plan**, covering the requirements for integrated financial, workforce, activity, and capital plans. The current financial position was reviewed, noting a significant underlying deficit and substantial efficiency challenges.
- **Medicines, finance, procurement and supplies** report highlighted challenges with the financial threshold for NICE technology appraisals which could increase medicine costs and the number of treatments. In addition, a potential cost pressure of £1 m was anticipated as a result of an increase in national reference price for ophthalmology treatments although a biosimilar was to be identified to offset the value
- **Demand and activity** M9 performance demonstrated continued Emergency Department pressures and attendances with high acuity. It was noted that specialty-level tracking would be integrated into future reports. The Committee agreed that the provided **partial assurance**.
- **Cost improvement programme** actions ongoing to understand the impact of the 2025/26 savings on the 2026/27 programme as opposed to identifying new cost improvement savings for 2025/26
- M9 **financial performance** demonstrated £6.1 m deficit to date in line with plan, although the underlying deficit stood at £30.1 m. The year end deficit was forecast at £6.9 m an improvement of £3.1 m since M8, and work remained ongoing to reach a break-even position.

Major Actions Commissioned / Work Underway

- To reconsider the 'why' for the **research plan** and revise, focussing on prevention and outcomes
- Business case to be considered by the Committee in March, in terms of addressing future capacity requirements aligned with delivering our **strategic** objectives
- Further information to be provided on how **strategic programmes** will be overseen, and how the topline metrics for people, patients and population will be monitored. Metrics and timelines for **strategic plans** to be considered in March
- Update on the progress of the **Electronic Patient Record (EPR)** business case to be provided to the Committee
- Additional assurances to be included within **BAF** for Q4 such as strategic plans and the business case for additional capacity. In addition, it was agreed to expand on the statement within BAF 8 regarding the 150 day target, given this related to commercial firm capacity and compliance, as opposed to internal capacity.
- NHS England business case and analysis from FourEyes to be provided to the Committee for additional assurance in respect of the **outpatients** business case
- Best, likely and worst-case scenarios to be provided to the Board in consideration of the **medium-term plan** including the assumptions used

Positive Assurances to Provide

- **Medicine, finance, procurement and supplies** report highlighted that medicines expenditure was projected to be £4 m less than anticipated, due to the uplift previously enacted. In addition, cost improvement savings were expected of £3.5 m for the year.
- **Capital** programme expected to recover and to be delivered in line with plan at year end
- In terms of working towards delivering a year end break even position, the Committee welcomed the discussions and assistance received from system partners in this regard

Decisions Made

- The Committee received and approved the **strategic plans** for Digitalisation, Estates & Facilities, Research and Innovation
- The Committee approved the optimising capacity and productivity **business case** for outpatients
- The Committee approved the **business case** to support delivery of the financial plan
- The Committee approved the increase to the **capital programme** from £95.1 to £99.5 m
- The Committee approved **e-REAFs** 17522, 17528, 17504, 17081, 17576, 17452 and 17692

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
A feedback form was available for Committee members to complete after the meeting.	• To ensure **highlight** reports from executive groups include what action is being taken to mitigate any areas of concern / key risks

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping				Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk		Assurance	
1.	Strategic Plans: Digital / Estates & Facilities / Research / Innovation	4, 5, 8	**Various**	**N/A**	Approval	6.	Demand and Activity Performance Report – M9	6, 7	**12**	**25**	**Partial**	Assurance
2.	Digital, Data and Governance Group Highlight Report (28-01-26)	4	**Ext 16**	**Partial**	Assurance	7.	Medicines Finance, Procurement and Supplies Report Q1	6, 7	**12**	**25**	**Partial**	Assurance
3.	Board Assurance Framework Q3	ALL	**Various**	**Not assessed**	Assurance	8.	Cost Improvement Programme Report	6, 7	**12**	**25**	**Partial**	Assurance
4.	Optimising Capacity and Productivity in Outpatients Business Case	1, 6, 7	**Various**	**N/A**	Approval	9.	Finance Report – M9	6, 7	**12**	**25**	**Partial**	Assurance
5.	Medium Term Planning Framework: Business Case to Support Delivery of the Plan	1, 3, 4, 5, 6, 7	**Various**	**N/A**	Approval	10.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order Expenditure	6, 7	**12**	**25**	**N/A**	Approval

Appendix 1 - Contract Awards and Approvals

Since 14th November to 14th January 2026, 5 contract awards over £1.5 m were made, as follows:

- **CDC Soft FM Services,** supplied by Sodexo, for the period 01/03/26 - 28/02/31, at a total cost of £3,993,234, providing negated inflation savings of £28,032 Y2 to 5, approved on 14th November 2025
- **Pharmacy Wholesale Agreement,** supplied by Mawdsley, Alliance, AAH, Phoenix, for the period 01/07/24 - 30/06/26, at a total cost of £63,637,410, approved on 14th November 2025
- **Outsourcing of Radiology Reporting,** supplied by Medica, for the period 01/05/2017 - 31/09/2025, at a total cost of £3,000,000, providing cost reduction savings of £600,000 and £105,300 negated inflation savings, approved on 25th November 2025
- **Endoscopy Consumables,** supplied by Olympus/ Cook/ Boston/ Bard & Erbe/ Medtronic/ Steris/ Aquilant/ PennaMed, all via NHS Supply Chain, for the period 01/12/25 – 30/11/26, at a total cost of £2,774,216, providing cost avoidance savings of £261,059, approved on 11th December 2025
- **Reusable Sharps Containers,** supplied by Sharpsmart Ltd., for the period 04/02/26 - 03/02/29, at a total cost of £1,988,307.00, providing negated inflation savings of £19,005 and £16,288 cost avoidance savings, approved on 7th January 2026

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 09 Performance

2025/26

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University Hospitals of North Midlands NHS Trust

Contents

Statistical Process Control

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

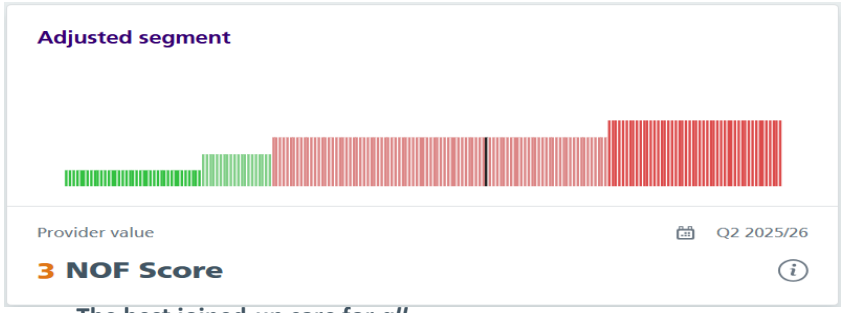
Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

National Oversight Framework Summary

University Hospitals of North Midlands NHS Trust

Headlines	Data period	Provider value	Peer average		National value	National value method	Chart
Adjusted segment			Q2 2025/26	3	NOF Score	Provider value	
Average metric score			Q2 2025/26	2.43	NOF Score	Provider value	
Unadjusted segment			Q2 2025/26	3	NOF Score	Provider value	
Financial override	Q2 2025/26	No	Yes		Yes	Provider median	
Is the organisation in the Recovery Support Programme?	Q2 2025/26	No	No		No	Provider median	

Domain Scores	Data period	Provider value		Chart
Access to services domain segment	Q2 2025/26	3	NOF Score	
Access to services domain score	Q2 2025/26	2.41	NOF Score	
Effectiveness and experience of care domain segment	Q2 2025/26	2	NOF Score	
Effectiveness and experience of care domain score	Q2 2025/26	2.19	NOF Score	
Patient safety domain segment	Q2 2025/26	3	NOF Score	
Patient safety domain score	Q2 2025/26	2.86	NOF Score	
People and workforce domain segment	Q2 2025/26	2	NOF Score	
People and workforce domain score	Q2 2025/26	2.53	NOF Score	
Finance and productivity domain segment	Q2 2025/26	3	NOF Score	
Finance and productivity domain score	Q2 2025/26	2.36	NOF Score	



UHNM remains in segment 3 for quarter two.
UHNM demonstrates a balanced performance across the NOF domains, with very little change from quarter one.

Overall score in quarter one was 2.47, quarter two is 2.43, broken down as:

- Access to services from 2.55 to 2.41
- Effectiveness and experience from 2.17 to 2.19
- Patient Safety from 2.63 to 2.86
- People and workforce remains at 2.53
- Finance and productivity remains at 2.36.

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NOF - Finance and Productivity

University Hospitals of North Midlands NHS Trust

Finance and productivity	Data period	Provider value		Chart
Finance and productivity domain segment	Q2 2025/26	3	NOF Score	
Finance and productivity domain score	Q2 2025/26	2.36	NOF Score	

Finance Please note that only the combined finance score contributes to the domain score	Data period	Provider value	Peer average	National value	National value method	Chart
Combined finance score	Q2 2025/26	1	NOF Score	Provider value		
Planned surplus/deficit score	Q2 2025/26	1	NOF Score	Provider value		
Variance year-to-date to financial plan score	Q2 2025/26	1	NOF Score	Provider value		
Variance year-to-date to financial plan	Sep 2025	0.01	-0.15	0.00	Provider median	

Productivity	Data period	Provider value	Peer average	National value	National value method	Chart
Implied productivity level score	Q2 2025/26	3.73	NOF Score	Provider value		

UHNM score for this domain remains at 2.36 for quarter two due to only one metric being refreshed, Variance year-to-date to financial plan. Although the data has been refreshed, the score for this metric remains as 1 (on plan or better).

Finance | Financial Summary

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

This report presents the financial performance of the Trust for December 2025 (Month 9).

The Trust reported a deficit of £6.1m at Month 9, which is in line with the planned figure of £6.2m. However, after accounting for non-recurring support and adjusting for industrial action, the underlying deficit stands at £30.1m.

Income: The income is underperforming by £4.5m, mainly due to lower-than-expected income from pass-through devices and drugs (which are offset by reduction in non-pay spend), and a delay in Community Diagnostic Centre income. The month 9 position includes £4.4m additional income for industrial action costs.

Activity: The month 9 Elective Inpatients and Outpatient activity is £8.4m below the plan.

For 2025/26, it has been agreed with the ICB that any under performance against the ERF target will be re-invested as non-recurrent deficit support funding. Therefore, for Staffordshire and Stoke ICB the income level for the ERF funding reflects the agreed plan.

Expenditure: There is a year to date pay overspend of £2.3m, which includes cumulative industrial action costs totalling £3.3m (offset by £4.4m funding received in M9). Non-pay is underspent by £5.0m, mainly due to lower expenditure for pass through devices and drugs (offset by an under recovery of income).

Financial Outlook 2025/26: The Trust's updated forecast indicates a year-end deficit of £6.9m, representing a £3.1m improvement since Month 8. This improvement reflects the confirmation of industrial action (IA) support funding. At system level, a breakeven position is now forecast, with surpluses expected from MPFT and Combined Healthcare. However, risks remain within the revised forecast due to ongoing winter pressures. The position will continue to be monitored closely, with financial governance rigorously applied.

CIP: The Trust has a £74.8m CIP target for 2025/26. At Month 9, it has delivered £35.6m of in-year savings against a planned £48.3m, with £6.9m delivered non-recurrently above the original £15.9m non-recurrent plan. The Trust is forecasting £32.2m of recurrent savings, which will roll forward into 2026/27 this is a shortfall of £40.2m.

Capital: The capital income and expenditure forecast for 2025/26 is £99.5m which an increase of £4.98m from Month 8. A breakdown of the movement is shown in **Appendix 1**. The year-to-date position shows spend of £54.4m against plan of £62.3m, with the underspend mainly relating to CDC Phase 1 and Breast Care Unit. Expenditure is expected to recover and is being closely monitored. The Committee is asked to approve the changes to the capital forecast.

Statement of Financial Position: The Month 9 Statement of Financial Position shows total assets employed of £262.8m. The cash balance is £55.6m against a plan of £69.0m. Payroll payments are higher than plan due to impact of pay awards however the Trust has also received higher than plan income from Commissioners to offset the overall impact. Cash reduced by £33.3m from Month 8 and this is due to the timing of invoice payments. Cash is currently £13.4m below plan, £10m of which is due to spend on PDC funded capital projects being incurred in advance of drawing down the PDC cash.

System Position: The system Month 9 position has a favourable variance of £1.1m from the planned deficit of £16.0m.

Financial Risks: Several risks have been recognised that may negatively impact the Trust's financial standing, such as extra unfunded escalation capacity, a shortfall in meeting CIP plans, and winter planning challenges. If the financial position worsens, appropriate mitigation measures will need to be implemented.

Related Strategy and Board Assurance Framework (BAF)

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

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Finance | Income and Expenditure

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

The Trust has delivered a £6.1m deficit at Month 9, which is in line with the planned deficit of £6.2m. Below summarises the Income and Expenditure position at Month 9.

Income & Expenditure Summary Month 09 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	1,220.6	101.5	104.8	3.3	915.3	909.4	(5.9)
Other Operating Income	98.7	8.3	8.6	0.3	73.9	75.3	1.4
Total Income	**1,319.3**	**109.8**	**113.4**	**3.6**	**989.1**	**984.7**	**(4.5)**
Pay Expenditure	(784.7)	(64.0)	(67.0)	(3.0)	(593.3)	(595.6)	(2.3)
Non Pay Expenditure	(502.4)	(41.2)	(41.9)	(0.8)	(377.9)	(372.9)	5.0
Total Operational Costs	**(1,287.1)**	**(105.1)**	**(108.9)**	**(3.8)**	**(971.2)**	**(968.6)**	**2.6**
EBITDA	**32.2**	**4.7**	**4.6**	**(0.2)**	**18.0**	**16.1**	**(1.8)**
Interest Receivable	2.6	0.2	0.4	0.2	2.0	4.1	2.2
PDC	(4.8)	(0.4)	(0.4)	(0.0)	(3.6)	(3.9)	(0.2)
Finance Cost	(30.0)	(2.5)	(2.5)	(0.0)	(22.5)	(22.6)	(0.1)
Other Gains or Losses	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Surplus / (Deficit)	**(0.0)**	**2.0**	**2.1**	**0.0**	**(6.2)**	**(6.1)**	**0.0**
Industrial action costs less funding			(3.3)	(3.3)		(1.2)	(1.2)
Non recurrent CIPs & mitigation			(6.5)	(6.5)		(22.8)	(22.8)
Underlying Surplus/(Deficit)	**(0.0)**	**2.0**	**(7.7)**	**(9.8)**	**(6.2)**	**(30.1)**	**(24.0)**

Finance | CIP

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

The Trust has a £74.8m CIP target for 2025/26. At Month 9, it has delivered £35.6m of in-year savings against a planned £48.3m, with £6.9m delivered non-recurrently above the original £15.9m non-recurrent plan. The Trust is forecasting £32.2m of recurrent savings, which will roll forward into 2026/27 this is a shortfall of £40.2m.

	Plan 31/12/2025 YTD £'000	Actual 31/12/2025 YTD £'000	Variance 31/12/2025 YTD £'000
Recurrent			
Pay - Recurrent	22,114	7,037	(15,077)
Non-pay - Recurrent	7,610	4,901	(2,709)
Income - Recurrent	2,628	805	(1,823)
Total recurrent efficiencies	**32,352**	**12,743**	**(19,609)**
Non recurrent			
Pay - Non-recurrent	6,628	10,120	3,492
Non-pay - Non-recurrent	6,625	11,960	5,335
Income - Non-recurrent	2,666	753	(1,913)
Total non-recurrent efficiencies	**15,919**	**22,833**	**6,914**
Total Efficiencies	**48,271**	**35,576**	**(12,695)**

Finance | Capital

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

The tables below set out the capital expenditure forecast for 2025/26 of £99.53m. The increase from Month 8 is due to changes in funding, including £4.0m from NHSE and £0.7m PDC funding for pathways and urology.

At Month 9 capital expenditure is £54.4m against a plan of £62.3m, an underspend of £7.9m. Of this expenditure £17.0m is in relation to the payments committed under the PFI or IFRS16 leases. The main areas of underspend are in relation to the significant PDC funded schemes for the CDC enabling works (£2.5m) and the County Breast Unit (£1.0m). There are no significant risks in relation to capital expenditure being in line with plan by the year end.

UHNM Capital Expenditure Plan 2025/26	Revised Capital Plan £m	Forecast outturn £m	Variance £m	YTD plan M9 £m	YTD actual M9 £m	Variance £m	RAG bid status
Pre-committed items - PFI and Loans							
PFI re-payment of liability	14.900	14.900	0.000	11.175	11.175	0.000	
PFI lifecycle commitments	2.268	2.268	0.000	1.854	1.854	0.000	
PFI PACS refresh - increase to PFI liability	0.200	0.200	0.000	0.000	0.000	0.000	
PFI MES - increase to PFI liability TBC	7.131	7.131	0.000	0.737	0.737	0.000	
Repayment of IFRS16 leases	4.272	4.272	0.000	3.204	3.204	0.000	
Total PFI and IFRS16 lease repayments commitments	**28.771**	**28.771**	**0.000**	**16.970**	**16.970**	**0.000**	
Investment items							
PFI enabling costs	0.181	0.065	0.116	0.041	0.041	0.000	
Network & Comms BC525	0.748	0.462	0.286	0.462	0.074	0.388	
LED lighting BC546	0.427	0.431	(0.004)	0.068	0.068	0.000	
IM&T computer hardware refresh BC569	2.142	1.455	0.687	1.142	0.656	0.486	
Investment funding for new business cases 25/26	0.250	0.306	(0.056)	0.182	0.182	0.000	
Project Star - RI remedial work	0.010	0.010	0.000	0.006	0.006	0.000	
ED ambulance off - enabling ward moves	0.006	0.006	0.000	0.006	0.006	0.000	
Endoscopy works 7th room - PDC ICB allocation TBC	0.009	0.009	0.000	0.009	0.009	0.000	
Completion of County Holding Bay	0.074	0.074	0.000	0.074	0.059	0.015	
Managing H&S risk register - BC562 (from £500k)	0.043	0.000	0.043	0.000	0.000	0.000	
Endoscopy BC GI PHYS BC583	0.130	0.130	0.000	0.130	0.130	0.000	
Royal Stoke high voltage upgrade BC required	0.752	0.752	0.000	0.704	0.221	0.483	
Printer lease refresh BC591	0.593	0.593	0.000	0.593	0.593	0.000	
Elective hub 24/25 BC brought forward spend	0.632	0.932	(0.300)	0.632	0.490	0.142	
County CT replacement	1.200	0.000	1.200	0.000	0.000	0.000	
SoN CIG	0.100	0.161	(0.061)	0.000	0.000	0.000	
Day Case completion costs	0.000	0.097	(0.097)	0.093	0.093	0.000	
SoN Fortinet licences	0.000	0.399	(0.399)	0.000	0.000	0.000	
PSDS - completion of business case	0.000	0.286	(0.286)	0.286	0.258	0.028	
Sustainablity Heat Network - Busness Case design fees	0.000	0.110	(0.110)	0.000	0.000	0.000	
SoN - Shine ambulatory unit	0.000	0.061	(0.061)	0.061	0.061	0.000	
Removal of Covid staff wellbeing cabins	0.000	0.075	(0.075)	0.075	0.026	0.049	
SoN Stryker trollies	0.000	0.111	(0.111)	0.041	0.041	0.000	
Endoscopy equipment replacement	0.000	0.000	0.000	0.000	0.000	0.000	
Central Contingency & risk	0.000	0.000	0.000	0.000	0.000	0.000	
Funding to allocate/(shortfall)	(0.373)	(0.010)	(0.363)	0.000	0.000	0.000	
Total Pre committed Investment items	**6.924**	**6.515**	**0.409**	**4.605**	**3.014**	**1.591**	
Capital sub-group (ICB allocation)							
IMT Sub Group Total Funding	2.535	1.774	0.761	1.794	0.694	1.100	
Medical Devices Sub Group	3.600	3.600	0.000	2.167	1.688	0.479	
Estates Sub Group Total Funding	5.462	6.019	(0.557)	3.465	2.737	0.728	
Health & Safety compliance	0.156	0.156	0.000	0.055	0.032	0.023	
Net zero carbon (sustainability) initiatives	0.100	0.024	0.076	0.025	0.025	0.000	
Total Capital Sub-Groups	**11.853**	**11.573**	**0.280**	**7.506**	**5.176**	**2.330**	

UHNM Capital Expenditure Plan 2025/26	Revised Capital Plan £m	Forecast outturn £m	Variance £m	YTD plan M9 £m	YTD actual M9 £m	Variance £m	RAG bid status
IFRS16 leases							
Lease liability re-measurement	0.200	0.200	0.000	0.200	(0.009)	0.209	
IFRS16 Guy Hilton	0.010	0.010	0.000	0.010	0.010	0.000	
IFRS 16 New Vehicles lease	0.188	0.188	0.000	0.024	0.024	0.000	
IFRS16 Leighton and Macclesfield Path Beckman	1.036	1.036	0.000	0.644	0.737	(0.093)	
IFRS16 Endoscopic Equipment renewal/expansion	1.511	0.113	1.398	0.113	0.094	0.019	
IFRS16 Stoke and County Pathology (Siemens lease ext Sep 26)	0.301	0.301	0.000	0.000	0.000	0.000	
IFRS16 Bridge Centre	0.143	0.143	0.000	0.000	0.000	0.000	
IFRS16 Replacement meters gluclose keytone testing BC	0.000	0.433	(0.433)	0.000	0.000	0.000	
IFRS16 Sharman Close lease extension to 2030	0.000	0.758	(0.758)	0.000	0.000	0.000	
IFRS16 Medtronic Nitron	0.000	0.073	(0.073)	0.073	0.073	0.000	
IFRS16 Payroll offices lease renewal (2 yrs)	0.066	0.066	0.000	0.066	0.066	0.000	
Total IFRS 16 leases	**3.455**	**3.321**	**0.134**	**1.130**	**0.995**	**0.135**	
Total Internal Capital Expenditure programme	**51.003**	**50.180**	**0.823**	**30.211**	**26.155**	**4.056**	
Additional CRL / Externally Funded PDC (multi-year schemes)							
CDC phase 1 medical equipment	1.879	1.879	0.000	0.945	0.945	0.000	
CDC IM&T	0.223	0.063	0.160	0.000	0.000	0.000	
CDC phase 1 estates enabling	22.555	21.855	0.700	17.481	14.926	2.555	
CDC phase 1 cost pressure	0.595	0.595	0.000	0.000	0.000	0.000	
CDC endoscopy expansion	3.100	0.000	3.100	0.000	0.000	0.000	
CDC endoscopy expansion - programme costs	0.000	0.516	(0.516)	0.000	0.000	0.000	
CDC endoscopy expansion - 4th endoscopy room equipment	0.000	0.000	0.000	0.000	0.000	0.000	
CDC endocopy expansion - feasibility study	0.000	0.300	(0.300)	0.000	0.000	0.000	
TIF 2 PDC (Breast Unit)	9.086	8.936	0.150	8.300	7.323	0.977	
TIF 2 PDC (Breast Unit) cost pressure	0.430	0.530	(0.100)	0.000	0.000	0.000	
Frontline Digitalisation - PDC funded 2024/25	1.120	1.120	0.000	0.928	0.928	0.000	
Frontline Digitalisation EPR - PDC funded 2024/25	0.680	0.280	0.400	0.000	0.000	0.000	
Charitable funded expenditure	3.834	4.848	(1.014)	3.266	3.266	0.000	
Externally Funded PDC (2025/26 schemes)							
PDC Constitutional Standards Urgent Treatment Centre - enabling	7.775	2.140	5.635	0.575	0.268	0.307	
PDC Urgent Treatment Centres - programme costs	0.000	0.000	0.000	0.000	0.000	0.000	
PDC Constitutional Standards Imaging and MRI	2.583	2.583	0.000	0.119	0.119	0.000	
PDC Constitutional Standards Equipment for Physiological Science	0.590	0.460	0.130	0.059	0.059	0.000	
PDC County Discharge Lounge	2.375	0.000	2.375	0.000	0.000	0.000	
PDC Elective equipment	0.839	0.539	0.300	0.000	0.000	0.000	
PDC - Cyber security funding	0.000	0.072	(0.072)	0.000	0.000	0.000	
PDC Digital Pathology Scanners	0.827	0.827	0.000	0.000	0.000	0.000	
PDC - Histopathology Modernisation BC	0.000	0.179	(0.179)	0.000	0.000	0.000	
PDC Pathology LIMS	1.628	1.628	0.000	0.447	0.447	0.000	
Total Additional CRL / PDC Funded expenditure	**60.119**	**49.350**	**10.769**	**32.120**	**28.281**	**3.839**	
Total Capital Expenditure	**111.122**	**99.530**	**11.592**	**62.331**	**54.436**	**7.895**	

UHNM Capital Funding Plan -2025/26	Revised Capital Plan £m	Forecast outturn £m	Variance £m	YTD plan M9 £m	YTD actual M9 £m	Variance £m	RAG bid status
Total PFI and IFRS16 lease repayments commitments	28.771	28.771	0.000	16.970	16.970	0.000	
Total ICB capital allocation	22.456	27.211	4.755	14.955	13.863	(1.092)	
PDC CDC (including expansion)	18.100	18.100	0.000	11.900	11.900	0.000	
PDC County Breast Unit completion	3.000	3.000	0.000	3.000	3.000	0.000	
PDC Estates Safety	3.593	4.767	1.174	2.250	2.250	0.000	
PDC Constiutional standards Urgent Treatment Centre	7.775	2.340	(5.435)	0.268	0.268	0.000	
PDC Constitutional Standards Equipment for Physiological Science	0.590	0.590	0.000	0.000	0.000	0.000	
PDC Constitutional Standards Imaging and Diagnostic	2.583	2.583	0.000	1.200	0.000	(1.200)	
PDC Constitutional Standards Elective	0.839	0.839	0.000	0.000	0.000	0.000	
PDC Constituional Standards Discharge Lounge	2.375	0.000	(2.375)	0.000	0.000	0.000	
PDC Pathology LIMS	1.628	1.628	0.000	0.447	0.000	(0.447)	
PDC Digital Pathology	0.828	0.828	0.000	0.000	0.000	0.000	
PDC Pathways and Urology funding	0.000	0.720	0.720	0.000	0.000	0.000	
PDC - Cyber security funding	0.000	0.072	0.072	0.000	0.000	0.000	
PDC - Decarbonisation	0.000	0.004	0.004	0.000	0.000	0.000	
PDC - Histopathology Modernisation BC	0.000	0.179	0.179	0.000	0.000	0.000	
Disposal of RI/COPD	10.900	0.000	(10.900)	0.000	0.000	0.000	
Other disposals	0.789	0.789	0.000	0.000	0.000	0.000	
Charitable funds	3.834	4.848	1.014	3.266	3.266	0.000	
Internal resources (including capital to revenue transfer)	3.061	2.261	(0.800)	0.000	0.000	0.000	
Total capital funding	**111.122**	**99.530**	**(11.592)**	**54.256**	**51.517**	**(2.739)**	
Funding to be allocated/(shortfall)	**0.000**	**0.000**	**(0.000)**				

Kind Excellent Together

Finance | Balance Sheet

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

Balance sheet as at Month 9	31/03/2025	31/12/2025		
	Actual £m	Plan £m	Actual £m	Variance £m
Property, Plant & Equipment*	715.7	728.6	727.8	(0.8)
Right of Use Assets*	23.1	20.4	21.4	1.0
Intangible Assets*	16.0	14.4	14.4	0.0
Trade and other Receivables	1.1	1.1	1.1	0.1
Total Non Current Assets	**755.9**	**764.5**	**764.8**	**0.3**
Inventories	19.2	18.7	22.2	3.5
Trade and other Receivables	43.5	54.4	59.8	5.5
Asset held for sale*	10.9	10.9	10.9	-
Cash and Cash Equivalents	84.2	69.0	55.6	(13.3)
Total Current Assets	**157.8**	**152.9**	**148.6**	**(4.3)**
Trade and other payables	(129.4)	(134.4)	(137.0)	(2.7)
Borrowings	(20.3)	(25.7)	(19.6)	6.0
Provisions	(8.5)	(9.3)	(1.5)	7.9
Total Current Liabilities	**(158.2)**	**(169.4)**	**(158.1)**	**11.3**
Borrowings	(490.3)	(484.1)	(490.1)	(6.0)
Provisions	(2.8)	(2.3)	(2.3)	(0.0)
Total Non Current Liabilities	**(493.0)**	**(486.4)**	**(492.4)**	**(6.0)**
Total Assets Employed	**262.5**	**261.6**	**262.8**	**1.1**
Financed By:				-
Public Dividend Capital	734.9	734.9	734.9	0.0
Retained Earnings	(680.7)	(681.7)	(678.4)	3.2
Revaluation Reserve *	208.3	208.3	206.3	(2.0)
Total Taxpayers Equity	**262.5**	**261.6**	**262.8**	**1.2**

Finance | Conclusion

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

The Trust reported a deficit of £6.1m at Month 9 matching the planned figure. However, after accounting for non-recurring support and adjusting for industrial action, the underlying deficit stands at £30.1m.

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's updated forecast indicates a year-end deficit of £6.9m, representing a £3.1m improvement since Month 8. This improvement reflects the confirmation of industrial action (IA) support funding.

The Trust has a £74.8m CIP target for 2025/26. At Month 9, it has delivered £35.6m of in-year savings against a planned £48.3m, with £6.9m delivered non-recurrently above the original £15.9m non-recurrent plan. The Trust is forecasting £32.2m of recurrent savings, which will roll forward into 2026/27 this is a shortfall of £40.2m.

The capital income and expenditure forecast for 2025/26 is £99.5m which an increase of £4.98m from Month 8. A breakdown of the movement is shown in the Capital slide. The year-to-date position shows spend of £54.4m against plan of £62.3m, with the underspend mainly relating to CDC Phase 1 and Breast Care Unit. Expenditure is expected to recover and is being closely monitored.

The Month 9 Statement of Financial Position shows total assets employed of £262.8m. The cash balance is £55.6m against a plan of £69.0m. Payroll payments are higher than plan due to impact of pay awards however the Trust has also received higher than plan income from Commissioners to offset the overall impact. Cash reduced by £33.3m from Month 8 and this is due to the timing of invoice payments. Cash is currently £13.4m below plan, £10m of which is due to spend on PDC funded capital projects being incurred in advance of drawing down the PDC cash.

Risks have been identified that could deteriorate the Trust's financial position, including additional unfunded capacity, industrial action and shortfall against CIP plans, Mitigations will need to be put in place if there is a deterioration in the financial position.

Highlight Report

AUDIT COMMITTEE | 5th February 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• 12 / 64 delayed and problematic actions identified by the **internal audit action tracker**. Additional assurances were provided by Executive Leads in terms of closing these down and ensuring any revised target dates were realistic and achievable, as such partial assurance was provided. • The Committee considered the updates provided within the **Corporate Governance** report in relation to declarations of interest and sponsorship. It was agreed to undertake a deep dive into companies providing sponsorship and assessing potential conflicts and it was agreed to consider this as part of the Local Counter Fraud Speciality (LCFS) review for 2027. Given the number of outstanding policies to be reviewed it was agreed that the report provided partial assurance despite the positive level of detail included. • Following completion of the **LCFS pre-employment review**, the risk in relation to pre-employment checks remained at High 8 and the risk in relation to temporary agency and locum staff at Moderate 4, with 22 actions to be undertaken by the People Directorate in response. • IT systems managed by operational areas follow up **internal audit** review concluded with some progress with additional assurance provided in respect of the ongoing actions being taken. • **Cyber Security Assurance** report provided partial assurance whereby delivery plans had been provided to address any areas of improvement required following completion of the internal audit and pen test.	• To provide additional information within **Corporate Governance** updates on the work undertaken to identify and mitigate potential conflicts of interest.
Positive Assurances to Provide	**Decisions Made**
• **Corporate Governance** report highlighted a declaration of interest rate of 68%. • Reasonable assurance was provided by the Pathology Service Governance and Key Financial Controls **internal audits,** and good progress had been made by the transformation and major change project management recommendations. • The Committee noted the process undertaken to update the **Board Assurance Framework** for Q3 and agreed that his provided acceptable assurance. While discussions with the Board on risk appetite and tolerance are scheduled for March, the Committee welcomed the effectiveness of the updated report and the additional assurance it provided. • The Committee received and noted the actions identified and associated timelines following completion of the **Failure to Prevent Fraud** gap analysis. • **Counter Fraud Progress** report highlighted continuing actions taken to complete the conflicts of interest and economic crime and corporate transparency act local proactive exercises. • Assurance was provided on progress against prior **External Audit** actions, coverage of the cost improvement programme and medium-term financial planning, supported by external input from Deloitte. • The Committee received the Q3 report on **losses, special payments and overseas debt write-offs,** noting the high year-to-date total driven by the write-off of aged overseas visitor debt. Acceptable assurance was provided on the robustness of debt recovery and provision practices, and the Committee agreed to consider future benchmarking or internal audit review for additional assurance. • The Committee received the Q3 reports on **single tender waivers, SFI breaches and salary overpayments**, noting improvements in breach numbers and strengthened compliance supported by ongoing training. Acceptable assurance was provided on overpayment recovery processes, and the Committee agreed to significant assurance for salary overpayments. • The Committee noted the annual report and accounts timetable for preparing the **2025/26 accounts**	• The Committee approved F09 Losses and Special Payments **policy** and RM01 Risk Management policy • The Committee noted and approved the **Counter Fraud Work Plan 2026/27** • The Committee received and approved the **External Audit Plan for 2025/26**, noting the identified significant risks, materiality levels and the scope of the value for money review. • The Committee approved the revision of **accounting policies** in readiness for preparing the 2025/26 accounts • The Committee approved that the 2025/26 accounts be prepared on a **going concern** basis

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Comments on effectiveness were sought via MS Forms	• Cost of inaction analysis to be considered as part of the review of the **business case template** the outcome of which is to be provided to the Finance and Business Performance Committee • Ongoing assurance provided to Finance and Business Performance in terms of the actions being taken to reduce risks associated with **Shadow IT**

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Internal Audit Progress Report • Follow Up: IT Systems Managed by Operational Areas • Pathology Service Governance • Follow Up: Transformation and Major Change Project Management • Key Financial Controls	Various		Some Progress Reasonable Good Progress Reasonable	Assurance	9.	Counter Fraud Work Plan 2026/27	-		Not Applicable	Approval
2.	Audit Action Tracker			Partial	Assurance	10.	External Audit Plan	-		Not Applicable	Approval
3.	Corporate Governance Report			Partial	Assurance	11.	Losses and Special payments Update Q3 2025/26	6, 7		Acceptable	Assurance
4.	Cyber Security Assurance report	4	Ext 15	Partial	Assurance	12.	SFI Breaches and Single Tender Waivers Q3 2025/26	6, 7		Acceptable	Assurance
5.	Board Assurance Framework Q3 2025/26	All		Acceptable	Assurance	13.	SFI Breaches related to Late Termination and Change forms Q3 2025/26	6, 7		Significant	Assurance
6.	Failure to prevent Fraud – Gap Analysis Action Plan			Not Assessed	Assurance	14.	Accounting Policies Update	-	-	Not Applicable	Approval
7.	• F09 Losses and Special Payments Policy • RM01 Risk Management Policy			Not Applicable	Approval	15.	Going Concern Assessment 2025/26	-		Not Applicable	Approval
8.	Counter Fraud Progress Report: - National Recruitment Review	-		Not Assessed	Assurance		Annual Accounts Timetable	-		Not Applicable	Information

Trust Board

2025/26 BUSINESS CYCLE

KEY TO RAG STATUS	
Paper rescheduled for future meeting	
Paper rescheduled for next meeting	
Paper taken to meeting as scheduled	

Title of Paper	Executive Lead	May	July	Oct	Dec	Feb
		7	9	8	10	11
PROCEDURAL ITEMS						
Patient / Staff Story	Chief Nurse / Chief People Officer	Pt	Staff	Pt	Staff	Pt
Chief Executives Report	Chief Executive					
Board Assurance Framework	Director of Governance	Q4		Q1	Q2	Q3
OUR PATIENTS: QUALITY, ACCESS & OUTCOMES						
Quality, Access & Outcomes Committee Assurance Report	Director of Governance					
Care Quality Commission Action Plan	Chief Nurse					
Mortality Assurance Annual Report	Chief Medical Officer					
Maternity Serious Incident Report	Chief Nurse					
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI					
Bi Annual Nurse Staffing Assurance Report	Chief Nurse					
Quality Account	Chief Nurse					
Winter Plan	Chief Operating Officer					
NHS Resolution Maternity Incentive Scheme	Chief Nurse					
Quality, Access & Performance Strategic Plan Update	Chief Nurse / Chief Medical Officer / Chief Operating Officer					
Integrated Performance Report	Various					
OUR PEOPLE						
People, Culture & Inclusion Committee Assurance Report	Director of Governance					
Staff Survey Report	Chief People Officer					
Gender Pay Gap Report	Chief People Officer					
Raising Concerns Report	Director of Governance					
Revalidation	Chief Medical Officer					
Workforce Disability Equality and Workforce Race Equality Reports	Chief People Officer					
Equality, Diversity and Inclusion Annual Report	Chief People Officer					
People Strategic Plan Update	Chief People Officer					
Bi-Annual Establishment Review (Other Professions)	Chief People Officer					

Title of Paper	Executive Lead	May	July	Oct	Dec	Feb
		7	9	8	10	11
OUR POPULATION						
Population Health Strategic Plan Update	Director of Strategy					
FINANCE AND BUSINESS PERFORMANCE						
Finance & Business Performance Committee Assurance Report	Director of Governance					
Revenue Business Cases / Capital Investment / Non-Pay Expenditure £1,500,001 and above	Director of Strategy		N/A		N/A	
Annual Report and Accounts including Going Concern	Chief Finance Officer					
Annual Plan	Director of Strategy					MTP
Financial Plan including Capital Programme	Chief Finance Officer					
Standing Financial Instructions	Chief Finance Officer					
Scheme of Reservation and Delegation of Powers	Chief Finance Officer					
OUR STRATEGIC PLANS						
Digital Strategic Plan Update	Chief Digital Information Officer					
Research Strategic Plan Update	Chief Medical Officer					
Innovation Strategic Plan Update	Director of Strategy					
Estates & Facilities Strategic Plan Update	Director of Estates, Facilities & PFI					
GOVERNANCE						
Audit Committee Assurance Report	Director of Governance					
Fit and Proper Persons Annual Assurance Report	Director of Governance					
Anchor Institution Update	Director of Communications					
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer					
Annual Evaluation of the Board Committees	Director of Governance					
Annual Review of the Rules of Procedure	Director of Governance					
Board Development Programme	Director of Governance					
Well-Led Self Assessment	Director of Governance					
Risk Management Policy	Director of Governance					
Complaints Policy	Chief Nurse					