University Hospitals of North Midlands NHS Trust

AGENDA | Trust Board - Part 1 (in Public)

Meeting held on Wednesday 10th June 2026, 9.30 am to 12.30 pm

Trust Boardroom, Third Floor, Springfield, RSUH

Time	No.	Agenda Item	Purpose	Lead	Format	Page No.
9:30	**PROCEDURAL ITEMS**					
15 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 8th April 2026	Approval	Ms J Small	Enclosure	**2**
	05	Matters Arising via the Post Meeting Action Log	Assurance	Ms J Small	Enclosure	**16**
10 mins	06	Questions from Members of the Public in relation to matters on the agenda	Information	Ms J Small	Verbal	-
10:00	**CHAIR AND CHIEF EXECUTIVE UPDATES**					
10 mins	07	Chair's Update	Information	Ms J Small	Verbal	-
10 mins	08	Chief Executive's Report – June 2026	Information	Dr S Constable	Enclosure	**17**
10 mins	09	Board Assurance Framework – Q4	Approval	Mrs C Cotton	Enclosure	**27**
10:30	**OUR PATIENTS: QUALITY, ACCESS & OUTCOMES**					
10 mins	10	Maternity & Neonatal PSIRF Investigation Report – Q4	Assurance	Mrs D Brayford	Enclosure	**66**
10 mins	11	Quality Account 2025/26	Approval	Mrs AM Riley	Enclosure	**68**
10 mins	12	UEC Improvement Journey	Assurance	Mrs K Thorpe	Enclosure	**143**
11:00 – 11:15 COMFORT BREAK						
11:15	**PERFORMANCE**					
	13	Integrated Performance Report – Month 1 and Committee Assurance Reports:				
15 mins	13a	• Quality, Access & Outcomes Committee Assurance Report (29-04-26 & 03-06-26) • Quality & Access Dashboard	Assurance	Prof K Maddock Mrs AM Riley/ Mrs K Thorpe	Enclosure	**149** **151** **153**
10 mins	13b	• People, Culture & Inclusion Committee Assurance Report (28-05-26) • People Dashboard	Assurance	Prof K Maddock Mrs J Haire	Enclosure	**207** **209**
15 mins	13c	• Finance & Business Performance Committee Assurance Report (27-04-26 & 01-06-26) • Finance Dashboard	Assurance	Ms T Bowen Mr M Oldham	Enclosure	**223** **225** **228**
11:55	**GOVERNANCE**					
5 mins	14	Audit Committee Assurance Report (30-04-26)	Assurance	Mrs M Monckton	Enclosure	**238**
10 mins	15	Fit and Proper Persons Annual Assurance Report	Assurance	Ms J Small	Enclosure	**240**
10 mins	16	Annual Evaluation of the Board and Committees including Rules of Procedure	Approval	Mrs C Cotton	Enclosure	**244**
12:20	**CLOSING MATTERS**					
5 mins	17	Review of Meeting Effectiveness Link to feedback form: https://forms.office.com/e/tydNkMB2Mj	Information	Ms J Small	Verbal	-
	18	Review of Business Cycle	Information	Ms J Small	Enclosure	**327**
12:25	**DATE AND TIME OF NEXT MEETING**					
	19	**Wednesday 12th August 2026, 9.30 am, Room 1, Postgraduate Medical Centre, County Hospital**				

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

Minutes of Meeting

Trust Board – Part 1 | 8th April 2026, 9.30 am to 12.05 pm

Trust Boardroom, Third Floor, Springfield

University Hospitals of North Midlands NHS Trust

Members Present:			
Name	**Initials**	**Title**	
Ms J Small	JS	Chair (Chair)	Voting
Ms T Bowen	TBo	Non-Executive Director	Voting
Prof 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
Prof S Toor	ST	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
Mrs J Haire	JH	Chief People Officer	Non-Voting
Mrs AM Riley OBE	AR	Chief Nurse	Voting
Mrs K Thorpe	KT	Interim Chief Operating Officer	Voting
Mrs L Whitehead	LW	Director of Estates, Facilities & PFI	Non-Voting

Apologies Received:			
Name	**Initials**	**Title**	
Mrs C Cotton	CC	Director of Governance & Communications	Non-Voting
Mrs A Freeman	AF	Chief Digital Information Officer	Non-Voting
Mr M Oldham	MO	Chief Finance Officer	Voting

In Attendance:		
Name	**Initials**	**Title**
Mrs N Hassall	NH	Deputy Director of Governance (representing Mrs Cotton & minutes)
Mrs S Proffitt	SP	Deputy Chief Finance Officer (representing Mr Oldham)

Members of Staff and Public: 6

No.	Agenda Item	Action
PROCEDURAL ITEMS		
1.	**Staff Story**	
018/2026	A video was played to Board members https://vimeo.com/1179154048/c46cd5dc10?fl=ip&fe=ec which highlighted Mr Ashique Ali's experience as patient following his lung transplant. Mrs Haire described how the video demonstrated compassionate leadership and stated that credit was due to his managers and colleagues for the way in which he was supported in his recovery and return to work. Dr Constable commented on the resilience demonstrated, noting the reasonable adjustments that had been put in place, including changes to on-call arrangements and Mr Ali's decision to undertake weekend working instead. Dr Adamson described Mr Ali as an inspiring colleague and thanked Mrs Haire and the wider team for illustrating how compassionate leadership principles are applied in practice. Miss Nicholson highlighted the importance of recognising that staff can also be patients, and noted the challenges associated with transitioning between	

	these roles. She reflected that the support provided by colleagues was a positive example that should be shared more widely across the organisation. Ms Bowen asked whether the team involved could share their approach to determining reasonable adjustments, to support learning across the Trust. Mrs Haire confirmed that this would be progressed and noted that compassionate and inclusive leadership approaches were embedded within leadership development programmes and aligned to the Trust's People Promises. Ms Small welcomed the story, noting that it brought the Trust's values and commitment to compassion to life, particularly through the ongoing support and connections maintained with colleagues during Mr Ali's recovery and return to work. **The Trust Board noted the story.**	
2.	**Chair's Welcome, Apologies and Confirmation of Quoracy**	
019/2026	Ms Small welcomed members to the meeting. Apologies were received as noted above and the meeting was confirmed as quorate. Ms Small noted that Dr Constable had been appointed as an Integrated Care System (ICS) Partner Member and would attend meetings as required. She highlighted that Dr Constable would bring his knowledge of the acute sector to inform and shape discussion and perspectives across the partnership, describing the role as both important and challenging, while offering opportunities to strengthen relationships with key system partners. Ms Small also recorded her thanks to Ms Bainbridge, who had left the Board in March, for the positive contribution she had made during her tenure. It was noted that Ms Bainbridge had previously chaired the People, Culture and Inclusion Committee (PCIC), and that recruitment to the Chair role was underway, with the aim of appointing in May.	
3.	**Declarations of Interest**	
020/2026	There were no declarations of interest raised.	
4.	**Minutes of the Meeting held 11th February 2026**	
021/2026	The minutes of the meeting held on 11th February were approved as a true and accurate record.	
5.	**Matters Arising via the Post Meeting Action Log**	
022/2026	There were no further updates to the action log.	
6.	**Questions from Members of the Public in relation to matters on the agenda**	
023/2026	No questions were received.	
CHAIR AND CHIEF EXECUTIVE UPDATES		
7.	**Chair's Update**	

024/2026	Ms Small provided an update on her recent engagement and visits across the organisation and externally. She advised that, in order to further develop her understanding of the Trust, she had met with Pharmacy Services and undertaken a tour of the Pharmacy Department. During this visit, she had gained insight into key challenges and priorities and noted that the team welcomed the opportunity for engagement and the visibility provided. Ms Small also reported visits to Physiotherapy and Occupational Therapy services, where she discussed how teams operate, the challenges associated with recruitment and retention, and how services were being transformed to improve patient care. In addition, she visited the Audiology Service as part of National Healthcare Science Week, which provided an opportunity to meet staff, understand their specialist roles and discuss opportunities to attract new entrants to the profession. She further advised that she had attended the Chief Nurse Fellowship Marketplace event and commented positively on the quality of the poster presentations. One presentation in particular highlighted the impact of delayed discharge linked to late medication, reinforcing the importance of pharmacy services. Regionally, Ms Small attended the NHS West Midlands Chairs and Chief Executives' meeting, where discussions focused on digital development and examples of how digital solutions were being used as enablers to improve services. Ms Small stated that she also attended the Corridor of Care Summit, noting the strong focus on improving patient experience and outcomes, and emphasised the importance of hospital flow in achieving this. She reported on a visit from Dame Sarah Jane Marsh, during which discussions took place regarding UHNM's approach, key challenges and how they were being addressed, including the support provided by the Get It Right First Time (GIRFT) team. Ms Small noted that both positive and challenging conversations were held and that the overall impression was favourable. Looking ahead, Ms Small advised that over the coming months she would attend the NHS Chairs meeting, host a visit to UHNM from the ICS System Chair, Mr Ian Green, and progress the shortlisting and interview process for the Non-Executive Director role. **The Trust Board noted the update.**	
8.	**Chief Executive's Report – April 2026**	
025/2026	Dr Constable provided an update and highlighted that the Trust was on the second day of resident doctor industrial action and was managing the impact following the bank holiday weekend. He reported that, at the time of the meeting, there were no ambulances waiting outside either site, which was noted as a crude operational indicator, although activity levels remained high, particularly during the evening period. Dr Constable also advised that the second Start of the Year conference was due to take place the following week. He noted that this would provide an opportunity to reflect on progress to date, mark the second year of the Trust's strategy, consider the direction of travel, and engage with over 500 staff across two sessions. Ms Bowen asked whether any early feedback had been received following the introduction of the Smoke Free policy. Dr Constable confirmed that a soft	

	launch had taken place and that there had been a reduction in smoking on site. He explained that vaping continued to be permitted in designated areas as a harm-reduction tool for existing smokers transitioning away from tobacco, while acknowledging the need to manage this carefully. Miss Nicholson recognised the phased approach and queried how the Trust would progress towards being fully smoke-free. Dr Constable advised that regular feedback was being received from subject-matter experts and that the approach was being considered through the smoking cessation group, noting that it was still early in the process. Miss Nicholson asked whether there were designated vaping areas for both staff and patients. Dr Constable confirmed that the same areas were currently being used and noted the importance of professional role-modelling, particularly where staff were in uniform or easily identifiable, while reiterating that the current arrangements were part of the transition period. **The Trust Board received and noted the update.**	
OUR PATIENTS: QUALITY, ACCESS & OUTCOMES		
9.	**UHNM PLACE Results 2025**	
026/2026	Mrs Whitehead provided an update on the Patient Led Assessment of the Care Environment (PLACE) inspection, which was carried out in autumn 2025, with results published at the end of February. She explained that the PLACE assessment considered the non-clinical environment, including cleanliness, food, maintenance, and how the environment supports privacy and dignity. Mrs Whitehead reported that the results were positive for the third consecutive year, with the Trust achieving scores above the national average and placing within the top three trusts across a number of domains. She also noted that qualitative feedback from assessors was favourable, describing the environment as clean and welcoming, and highlighting that patients appeared comfortable and calm despite high levels of activity. Mrs Whitehead emphasised that these results reflected the collective efforts of estates, clinical teams, and infection prevention and dietetics colleagues, whose contributions were essential to the quality of facilities provided. Mrs Riley commented that the results demonstrated the importance of support services, noting that high-quality care could not be delivered without them, and welcomed the recognition of their contribution. Ms Bowen welcomed the positive PLACE results. Ms Small described the findings as a testament to the work of teams across the organisation and highlighted the critical role of the care environment in supporting good patient care. She noted that clinicians relied on having the right environment in which to deliver care and that the results should be celebrated, recognising the contribution these teams make to patient outcomes. **The Trust Board received and noted the update.**	
10.	**Maternity & Neonatal PSIRF Investigation Report Q3**	
027/2026	Mrs Riley provided an update on the detailed review of cases discussed at the Quality, Access and Outcomes Committee (QAOC) in March, including the number of cases, those ongoing, and where actions had progressed.	

	Ms Bowen queried how the Trust's position compared with peers. Mrs Riley advised that she had not seen any benchmarked data to date but would explore this further, including checking with the Regional Chief Midwifery Officer to establish whether any comparative information was available. Ms Small noted that the information was received on a quarterly basis, which enabled the Board to monitor trends and changes over time. She highlighted the importance of understanding the detail underpinning the data and acknowledged that demographic analysis could be challenging. Mrs Riley confirmed that she would explore whether any regional or national comparisons could be identified. Dr Constable commented that governance and oversight arrangements in this area had evolved significantly. He emphasised that while headline numbers were important, each case was reviewed in detail, both internally and externally, with enhanced levels of scrutiny and vigilance. He noted that this work formed part of a broader and substantially changed national and organisational landscape. Mrs Riley clarified that not all cases referenced were necessarily negative. Professor Toor reflected that, through the QAOC, she had observed increased confidence in the governance arrangements and a clear journey towards more robust oversight and improved understanding of the data. Professor Maddock added that the information enabled the Trust to identify wider system issues and consider how it could better reach out to patients to ensure they were aware of how to access the best possible care. **The Trust Board received and noted the update.**	**AMR**
11.	**Urgent and Emergency Care Improvement Journey**	
028/2026	Mrs Thorpe provided an update on urgent and emergency care (UEC) performance and improvement. She advised that performance continued to be closely linked to patient flow and, while variation in ambulance handovers remained, an improving trend had been maintained overall. She explained that improvements in flow were the primary driver of progress in ambulance handover performance and reductions in time spent in the Emergency Department against both the four- and twelve-hour measures. Mrs Thorpe highlighted the continued use of escalation spaces within the Emergency Department and inpatient areas, noting that work was underway to review their use. She further advised that a new national reporting tool for escalation spaces had been implemented from April which would be reflected in future reports to support oversight. She reported that a UEC transformation change week had taken place in March, focusing on improvements across the entire patient pathway. This included changes to the use of corridor space, the introduction of a fit to sit model during daytime hours to improve flow within the Emergency Department, and changes to the Frailty Assessment Unit. Use of the discharge lounge had increased, supported by engagement with system partners to ensure patients requiring onward care outside hospital were able to access this more quickly. While some initial challenges were experienced during the transformation week, Mrs Thorpe noted that positive changes had been sustained and maintained, including throughout the period of industrial action, with further reporting to follow.	

	In response to a question from Professor Maddock regarding sustainability, Mrs Thorpe explained that the changes implemented were well-established practices known to be effective, with the emphasis placed on consistent delivery rather than introducing new initiatives. This included revised staffing models and repositioning frailty staff earlier in the patient journey to enable rapid assessment and intervention. She noted that while GIRFT support remained in place, teams were increasingly owning and leading improvement activity, with GIRFT acting in a supportive role. Dr Constable reflected that consistency would be a key theme at the forthcoming conference and acknowledged that UEC performance remained a significant challenge. He noted that while improvement had been achieved and performance felt stronger than the previous winter, further progress was required, adding that the work demonstrated what the organisation was capable of delivering. Mrs Monckton queried how the transformation programme and associated workstreams were structured, including how success would be measured and when improvements would be considered fully delivered. Mrs Thorpe explained that the focus was on achieving sustained improvement across all workstreams aligned to the patient journey through the hospital. She advised that priority actions were being taken forward with GIRFT support to deliver the greatest immediate impact, alongside alignment with Corridor Care best practice and high-impact actions to ensure comprehensive coverage and appropriate prioritisation. Mrs Thorpe added that while UEC improvement would remain an ongoing focus, the nature of the work would evolve over time. Mrs Monckton reflected that this represented a new approach to business-as-usual delivery, which Mrs Thorpe confirmed. Dr Constable added that efforts to improve performance against the four-hour standard were focused on addressing patient safety issues related to ambulance handovers, time in the Emergency Department, and twelve-hour waits. He noted that this required continuous improvement alongside a step change in approach, particularly in relation to corridor care. Ms Bowen asked about early discharges and the robustness of discharge data, as well as governance and assurance arrangements for UEC. Mrs Thorpe confirmed that discharge data was accurate and advised that the site team had taken ownership of the transitional discharge lounge. Since this change, and the introduction of dedicated staffing, improvements had been observed in utilisation and flow. She noted that further consideration was being given to identifying a larger space to support ongoing improvement. Mrs Thorpe advised that governance arrangements operated through the monthly UEC Improvement Group, with oversight provided through the Access Report. Miss Nicholson queried how learning and improvement in discharge processes were being shared with community partners, and how mindsets regarding service use were being influenced. Mrs Thorpe confirmed that system partners were embedded within the workstreams and that the programme was delivered as a collective system effort, rather than by the Trust alone. She noted that partners had adjusted their ways of working, including during the improvement week, particularly within frailty services. Ms Ashley referred to governance arrangements and advised that work was ongoing to ensure appropriate alignment with the Finance and Business Performance Committee, given that UEC formed part of the Trust's strategic programmes, and to avoid duplication of oversight.	

	Ms Small welcomed the paper and approach, highlighting the importance of flow-enabling behaviours and how these were embedded culturally. She asked how positive changes were being fed back to ensure sustainability. Mrs Thorpe advised that communications support had been used during the change week and that there was an intention to continue using communications to inform the wider organisation about changes, alongside leadership and cultural development supported by the Organisational Development team. Ms Small also highlighted the importance of ensuring patients and families understood how care processes were changing. Mrs Thorpe noted the need to consider how expectations were managed with patients during the first 72 hours of care, including focusing on recovery and return to usual living where appropriate. Dr Adamson reflected that this had also been recognised clinically, particularly where patients no longer required acute medical input and would recover more effectively at home. Mrs Riley added that there was a role for system partners in improving understanding of services available outside hospital, including through shared use of the directory of services to support confidence in discharge decisions. **The Trust Board received and noted the update.**	
OUR PEOPLE		
12.	**NHS Staff Survey 2025 Results**	
	Mrs Haire presented the staff survey results, noting that these had been discussed at the People, Culture and Inclusion Committee (PCIC) and were being presented to the Board for information and assurance. She advised that results had remained broadly stable during the reporting period, with reductions and small drifts mirroring national trends which did not represent a disproportionate deterioration for the Trust. Mrs Haire reported that the Trust was positioned in the lower half of its peer benchmarked group, but slightly above average for morale, which she noted reflected organisational resilience. She highlighted that the engagement and involvement score was 6.7 in the 2025 survey, compared to 6.8 in the previous year, representing a marginal decline in line with national trends. This metric captured advocacy, motivation and involvement and was a strategic measure within the Trust's strategy.	
029/2026	She drew attention to People Promise indicators, noting that 'we are always learning' continued to score relatively low and that completion of Personal Development Reviews (PDRs) remained an area of focus. Mrs Haire also highlighted a lack of clarity around career pathways, acknowledging that although extensive work was underway in this area, line management capability remained the single biggest driver of colleague experience. She advised that this would be a key focus of the forthcoming Start of the Year conference. The survey results also identified an opportunity to strengthen the 'we are a team' theme, reinforced through the staff story presented, alongside an increased focus on psychological safety and inclusion. Mrs Haire advised that a more detailed paper on Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) would be brought forward in due course. She noted that some progress had been made against these indicators following targeted action driven through staff networks, although outcomes were not yet at the desired level. She confirmed that staff survey data would be triangulated with the newly launched quarterly	

	People Pulse survey, commencing in April, and with Care Group metrics via performance reviews. Mrs Haire highlighted that priorities included learning and development, strengthening line manager fundamentals, improved communications support, greater consistency of practice and targeted Organisational Development intervention in areas requiring additional focus. Overall, Mrs Haire advised that acceptable assurance had been gained, based on the survey results, work undertaken to date and planned actions. Ms Bowen asked about response rates across the highest-, average- and lowest-performing areas. Mrs Haire advised that response rates had reduced nationally by around five percentage points and confirmed that the Trust's response rate was considered representative. Ms Bowen queried whether lower response rates correlated with poorer results and whether additional effort should be directed towards increasing responses. Mrs Haire advised that analysis suggested sustained improvement in some targeted areas, such as flexible working, over a three- to four-year period, despite some small recent drifts. She also noted that the Trust had explored approaches used by high-performing peers, including simplifying survey feedback, and was engaging with external organisations such as University College London to understand best practice. Dr Constable commented that the highest-performing organisations for patient outcomes often also demonstrated strong staff survey response rates and engagement, describing this as a proxy indicator for organisational health and ambition. Professor Toor referred to discussion at PCIC and emphasised the importance of line management as a critical action area, noting the need for sufficient capacity and resource. She queried what would be done differently in the coming year. Mrs Haire confirmed continued investment in line managers through leadership and Connects programmes, with foundations now in place to clarify expectations, strengthen accountability and drive organisational health in new ways. Mrs Riley added that work had been undertaken to understand the experience of leaders before and after the Covid pandemic, recognising that operating contexts had significantly changed, and that similar work may be required for specific staff groups. Mrs Proffitt noted that organisational change and consistency challenges within UEC services may also have influenced survey outcomes and suggested that future results would be informative. Ms Small welcomed the progress made and recognised that reduced uptake was consistent with national trends. She supported the focus on identifying two to three priority actions with the greatest potential impact and queried how Care Groups would be supported to deliver improvement. Mrs Haire confirmed that a senior leadership development programme was in place, with a reset from the top and increasing focus on directorate-level managers to reinforce skills, expectations and behaviours. Ms Small also highlighted ongoing Equality, Diversity and Inclusion challenges and asked how the Trust could further shift progress in this area. Mrs Haire advised that an EDI accountability framework had been established, with clear accountability placed on leaders and managers. Dr Adamson added that the	

	organisation had maintained a zero-tolerance approach to unacceptable behaviours, supported by clear values and continued People Team support. **The Trust Board received and noted the results.**	
13.	**Gender, Ethnicity and Disability Pay Gap Report 2025**	
030/2026	Mrs Haire presented the report, which was being provided to the Board for assurance. She advised that the Trust's workforce remained predominantly female at 76%, which was broadly in line with national figures. In relation to gender pay, Mrs Haire explained that the pay gap was largely driven by workforce composition within the medical workforce, with women comprising approximately 41% of medical staff and 30% of consultants. She noted that this reflected national pipeline challenges affecting progression into senior medical roles rather than evidence of unequal pay. A downward trend in the median gender pay gap was reported, supported by continued focus on talent pipelines. Mrs Haire reported that, overall, there was a pay advantage for colleagues from the global majority, reflecting the higher representation of medical staff within this group. However, she noted that challenges remained in relation to representation and progression, particularly into senior leadership roles, and that this continued to be a key area of focus linked to leadership development initiatives. In respect of disability, Mrs Haire highlighted that declared disability levels remained low at 5.7%. She noted the importance of continuing to improve the completeness and accuracy of ESR records and acknowledged that colleagues who had declared a disability were least represented within the highest pay quartile. She emphasised the need to build greater confidence among colleagues to disclose disabilities, supported by improvements in psychological safety and inclusive management practices. Overall, Mrs Haire advised that identifying and addressing structural barriers remained a priority. Professor Toor reflected on discussion at PCIC and emphasised the importance of considering intersectionality across all equality workstreams. She highlighted the need to support line managers to enable effective conversations around disability disclosure and inclusion. Ms Bowen queried the source of data relating to the steady increase in female representation year-on-year. Mrs Haire confirmed that this data had been drawn from Electronic Staff Records (ESR) records, including application-to-appointment conversion data and workforce records. Ms Bowen also asked about disability declaration processes, specifically whether colleagues could declare a disability without specifying details. Mrs Haire explained that demographic information was captured through recruitment processes and could be updated by individuals on ESR. She confirmed that any additional information would only be shared by consent and, where appropriate, by the employee, through Occupational Health, and was not otherwise routinely accessed. Ms Small commented on the importance of understanding the data in order to plan and respond effectively to identified challenges. She noted the significance of the programme of work underway and the need to ensure	

	robust systems were in place to support progression into senior roles. Mrs Haire outlined ongoing actions, including increasing diversity within management roles and debiasing recruitment practices. Ms Small commended the work undertaken. **The Trust Board received and noted the report.**	
PERFORMANCE		
14.	**Integrated Performance Report – Month 11 and Committee Assurance Reports:**	
031/2026	<u>Quality, Access & Outcomes Committee Assurance Report (05-03-26 & 02-04-26)</u> Professor Maddock presented the reports and highlighted that discussions at the Committee had been constructive and aligned closely with matters brought forward to the Trust Board. She advised that a spike in medication incidents within neonatal and maternity services had been identified, linked to the implementation of the Electronic Medicines Prescribing and Administration (eMPA) system. Professor Maddock assured the Board that none of the incidents were serious and confirmed that a detailed deep dive was underway to understand contributory factors and learning. Professor Maddock also reported positively on progress within clinical coding, noting that work had been undertaken to address backlogs, which had implications for both mortality data and financial reporting. She advised that new trainees had been recruited and that sufficient capacity was now in place to manage coding requirements going forward. Early improvements were being observed in Hospital Standardised Mortality Ratio (HSMR) and Summary Hospital-level Mortality Indicator (SHMI) metrics. An update was provided on the digital solution supporting 52-week wait harm reviews, with Professor Maddock welcoming the introduction of more consistent reporting to strengthen oversight. She further advised that the Committee had requested enhanced oversight of the use of escalation spaces, which would be reported through the Access Report going forward. Professor Maddock confirmed that a deep dive into readmissions was underway to understand an observed increase and inform appropriate actions. She also highlighted a population health update, noting encouraging progress including a reduction in neonatal mortality, which had been linked in part to smoking cessation activity. Other positive assurance was reported, including the reinstatement of Joint Advisory Group (JAG) accreditation for endoscopy services, and strong assurance in relation to sepsis management in paediatrics, with appropriate screening taking place and audit work incorporated into the ongoing audit cycle. Dr Constable welcomed the report and the positive comments on the quality of discussions within the Committee and the structured consideration of key domains of quality and safety. He emphasised the importance of Board-level assurance, noting that regaining JAG accreditation for endoscopy was particularly significant given the volume of activity in this area and its importance to patient safety and quality. He highlighted the need for continued focus on maintaining accreditation frameworks as part of routine assurance.	

	Quality & Access Dashboard Mrs Riley presented the dashboard and highlighted several areas of progress. She advised that the Trust had achieved both verbal and written Duty of Candour compliance for the first time in twelve months. She confirmed that an Avoidable Harm Working Group had commenced and reported that work under the Care Excellence Framework (CEF) was progressing well, with a reduction in bronze areas adding that all areas at County Hospital had been assessed as either gold or platinum. Mrs Riley noted that the Trust was transitioning from the Tendable audit system to Gnome and, as part of this process, was reviewing the draft CQC assessment framework to ensure alignment. Feedback would be provided to the Board once this work was complete. Dr Adamson provided an update on clinical effectiveness, highlighting a significant improvement in engagement and the early benefits of investment in clinical leadership. She reported positive feedback from the GIRFT programme and confirmed good progress with clinical audit activity, including focused work within paediatrics and the use of peer review processes. Ms Bowen referred to performance on formal complaints, noting that while the position had improved, response times remained above target. She observed that since June performance had been above the national average and queried whether capacity was sufficient to manage complaint volumes and whether trends reflected a national picture. Mrs Riley advised that, compared with peer organisations, the Trust had the fourth lowest number of complaints. She explained that escalation processes were in place to categorise complaints by complexity and to address delays in receiving input from clinical teams, acknowledging that further improvement was required. Dr Adamson added that continued investment in clinical leadership would support further improvements in complaint response times. Mrs Thorpe provided an update on access and flow. She advised that some benchmarking information had been included within the dashboard and that improvement was beginning to be seen in twelve-hour UEC performance. While four-hour performance remained challenging, there had been improvement in paediatric Emergency Department performance during March, with further improvement expected as progress continued to reduce ambulance handovers and twelve-hour waits. Mrs Thorpe reported that long waiters remained a pressure and she noted that industrial action had impacted activity levels and that, although the Trust had been asked to maintain activity at 95%, this had been particularly challenging following the bank holiday period. She also advised that cancer performance had improved against the 28- and 31-day standards as expected and that the Trust remained on trajectory for the 62-day standard. **The Trust Board received and noted the assurance report and dashboard.**	
032/2026	People, Culture and Inclusion Committee Assurance Report (01-04-26) Professor Toor presented the report and highlighted that the capacity pressures faced by the People Directorate were evident, noting that the ability to absorb additional demands remained limited and was reflected in the level of assurance provided.	

	She advised that there had been extensive discussion regarding the Medical Workforce Group, including improvements in engagement, a growing sense of ownership of workforce gaps, and robust challenge around actions to mitigate these challenges going forward. In relation to talent management and succession planning, Professor Toor noted that gaps and variation remained across Care Groups. While there was general confidence in the actions identified, concern was expressed regarding capacity and the organisation's ability to consistently implement plans at an operational level. Professor Toor reported that good assurance had been received in respect of nurse staffing. She also highlighted the Sexual Safety Programme, noting that enhanced oversight arrangements were in place, although further work remained to be completed. Dr Constable reflected on capacity challenges across enabling services, noting that while teams were operating leanly and effectively, this remained a constraint when seeking to deliver large-scale transformation. He advised that a phased recalibration of capacity was under active consideration and formed part of ongoing executive discussions. Ms Small queried the anticipated timeline for this work. Dr Constable confirmed that the latest iteration of proposals would be discussed at the Executive Team meeting in two weeks' time and would be brought forward to the relevant Committees in due course. <u>People Dashboard</u> Mrs Haire presented the dashboard and reported that the workforce position remained stable, particularly in respect of turnover and vacancy rates. She advised that vacancy levels remained low and reflected positively on workforce stability. Mrs Haire noted that sickness absence remained above target and continued to exceed the target, with a new level set within the national contract. She explained that sickness absence had increased over the winter period as anticipated and that work was underway to understand the interdependencies between sickness absence and temporary staffing. She further advised that use of temporary staffing remained low, with minimal agency usage. However, she highlighted that bank and agency arrangements would remain challenging into 2026/27. Ms Bowen queried the rolling twelve-month sickness absence position, noting that it had remained relatively static for some time, and asked how the Trust was addressing the gap between current performance and workforce assumptions. Mrs Haire confirmed that a one-percentage-point improvement in sickness absence represented a significant challenge and advised that the Trust was exploring a range of actions and perspectives to support improvement. **The Trust Board received and noted the assurance report and the People Dashboard.**	
033/2026	<u>Finance & Business Performance Committee Assurance Report (02-03-26 & 30-03-26)</u> Ms Bowen presented the assurance report and advised that the Trust's overall financial outlook had improved. However, she highlighted a number of	

continuing risks, including unfunded escalation capacity, a significant shortfall in the Cost Improvement Programme (CIP), and associated risks to winter planning.

Ms Bowen reported that for 2026/27, the CIP position attracted partial assurance, reflecting an increased target and gaps in delivery that continued to present a challenge. She advised that reporting would focus on delivery of the programme and noted positively that plans were more developed at this stage of the year compared with the previous year.

In relation to digital risks, Ms Bowen highlighted the issue of shadow IT, noting limited assurance regarding the capacity and capability of central teams and awareness of the associated risks. She confirmed that a programme of work was in place to strengthen digital governance and that this was being considered through the Audit Committee.

Ms Bowen advised that the Electronic Patient Record (EPR) programme remained at partial assurance. Preparatory work was progressing, but further progress was dependent on Treasury approval of funding, alongside an ongoing independent review of systems. She noted that quarterly updates would continue to be provided, including mitigating actions.

The business case process was also reported as providing partial assurance. Ms Bowen advised that the focus remained on ensuring delivery was aligned with the Trust's plans and that there was agreement on the need to strengthen grip and control over business case development. She confirmed that related risks would be reflected within the Board Assurance Framework.

Ms Bowen highlighted that acceptable assurance had been received in relation to Private Finance Initiative (PFI) performance, noting that this remained stable. She also noted positive findings from a number of internal audits.

The Committee had agreed to delegate authority to the Executive Team to approve expenditure of £1.5m for additional corporate capacity, as discussed earlier in the meeting, with further detail to be reported back to the Finance and Business Performance Committee in due course. In addition, the Committee approved substantive funding for frailty services.

<u>Finance Dashboard</u>

Mrs Proffitt presented the dashboard and advised that a £4.8 m deficit position had been agreed with NHS England. She confirmed that work was ongoing to finalise the year-end position and that the Trust expected to deliver its plan and achieve system-level break-even. She noted that the position was supported through a range of mitigation actions and non-recurrent CIP measures.

Mrs Proffitt reported that the capital programme remained on track, with delivery of a £99.3 m programme anticipated. She acknowledged the significant effort of the Capital Investment Group in achieving this position. She further advised that the Trust's cash position remained strong and ahead of plan.

Dr Constable reflected on the achievement of delivering against the agreed financial position, noting that this was testament to collective teamwork, albeit supported by non-recurrent measures. He highlighted that this had been achieved alongside some improvement in performance, without deterioration

	in quality or significant adverse impact on workforce metrics, providing a positive foundation on which to build. He also noted that system-wide collaboration had worked effectively and should be built upon in future planning. Mrs Monckton endorsed these comments, recognising the strength of the achievement given the level of financial uncertainty experienced in the previous year. Professor Maddock queried the reported capital underspend related to the Community Diagnostic Centre (CDC). Mrs Proffitt explained that this reflected deferred elements of the programme which had been re-profiled to manage delivery, while confirming that estates-related capital spend had been delivered. Ms Small thanked the teams involved for achieving the break-even position, acknowledging that this outcome had not been achieved without challenge. **The Trust Board received and noted the assurance report and dashboard.**	
CLOSING MATTERS		
15.	**Review of Meeting Effectiveness**	
034/2026	Members were asked to provide feedback via Microsoft forms.	
16.	**Review of Business Cycle**	
035/2026	No further comments were provided.	
DATE AND TIME OF NEXT MEETING		
17.	**Wednesday 10th June 2026, 9.30 am, Trust Boardroom, Third Floor, Springfield, Royal Stoke**	

Post Meeting Action Log

Trust Board Part 1 - Open

As at **03 June 2026**

Ref	Meeting Date	Agenda Item	Action	Assigned to	Due Date	Done Date	Progress Report	RAG Status
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	28/05/2026	Complete. Included in Q3/Q4 Speaking Up Report and presented to PCIC.	B
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	28/05/2026	Complete. Included in Q3/Q4 Speaking Up Report and presented to PCIC.	B
PTB/625	08/04/2026	Maternity & Neonatal PSIRF Investigation Report Q3	To explore whether regional or national benchmarking and comparative demographic analysis would be identified to support triangulation of quarterly data and strengthen understanding of trends over time.	Ann-Marie Riley	03/06/2026		Update to be included within the Q4 report. This will be in future reports in line with CNST requirements	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 | 10th June 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 8th April 2026, some of which are not covered elsewhere on the agenda for this meeting.

1. Annual Start the Year Conference

On 15th April, at the Bet365 Stadium, I was joined by nearly 500 colleagues for our second annual Start the Year Conference as we embark on the second year of our strategy. In view of the time and space constraints we ran it as two identical sessions, morning and afternoon.

Entitled '*Ambition, Belief, Change'* and setting the tone for the next 12 months, we did a look back on the last year, but mostly looked forward to the year, and indeed years, ahead. Hopefully, we struck the right balance between an honest and sober reflection on where we need to do better, alongside all of the good that we do and 'assets' we have in where we genuinely could be, delivering for our patients, our people and our population. We were joined by our keynote speaker, Ed Hollamby, who delivered some very practical tools for all of us in helping us understand ways that we could do things differently, acknowledging the 'uncomfortableness' of change.

We have already collated feedback and, in the spirit of continuous improvement, we will start planning for something even bigger and better (and even more inclusive) for next year.

2. Senior Leadership Changes

In May we said a heartfelt thank you and farewell to Professor Fidelma O'Mahony, consultant gynaecologist and obstetrician, honorary professor of clinical education and gynaecology and outgoing UHNM hospital dean for Keele Medical School, who is retiring.

Professor O'Mahony is well known through her long-standing work supporting medical education across UHNM. She has been part of a journey that began in 2003 when just 30 medical students first came into UHNM when the Keele Medical School was established.

Since then that number has grown significantly, and we now support around 360 clinical medical students across the Royal Stoke and County hospitals, along with a further 180 students gaining early clinical experience, plus students from other healthcare professions. Alongside this, over 60 consultants and specialist doctors hold educational leadership roles, with more than 250 clinicians contributing as tutors across UHNM.

That growth reflects just how much education is now part of everyday clinical life at UHNM, and Fidelma has played an important role in helping shape and support that over many years.

The Keele faculty is now representative of our population demographic and student cohort, coming from a range of ethnic and clinical backgrounds and at all stages in their career. This extends beyond medical personnel to clinicians with backgrounds in nursing, pharmacy, midwifery, imaging and surgical theatres. As a result, we have fostered collaboration with partner healthcare providers and educational stakeholders locally and nationally.

The Keele MBChB course is highly rated amongst students and colleagues as evidenced by high ranking in national medical school league tables and the national student survey. Our students report high levels of preparedness as newly qualified doctors on GMC league tables which is sheer testament and vote of confidence to the high quality and innovative clinical exposure they receive here at UHNM.

Always mindful of the vital pastoral side of the role, Fidelma has been a strong advocate for students throughout their time with us, helping to ensure they feel welcomed, supported and well prepared for life as a qualified doctor. One of the original objectives in establishing a medical school in North Staffordshire was to increase recruitment and retention of our local healthcare workforce. Locally we have benefited enormously in being a university teaching hospital in that we can now count Keele graduates as trainees and consultant colleagues in many specialities across the Trust including at senior management level, with many Keele graduates choosing to stay and work at UHNM, including 71 out of 172 newly qualified doctors staying on for their foundation training this year.

On behalf of UHNM, I would like to thank Fidelma for her leadership, much of which has been exercised through times of real change. Her commitment to education and the lasting impact she has had on students, colleagues and the wider Trust is significant. We wish her a happy and healthy retirement.

Dr Mark Poulson, Deputy Chief Medical Officer, has been appointed as the new UHNM undergraduate hospital dean.

3. A Night Full of Stars 2026

I am delighted to share that nominations for our annual staff awards evening, 'A Night Full of Stars' are open. So many nominations are already coming in. This event is always a highlight as it gives the whole organisation a chance to celebrate the people who make UHNM a special place to work and receive care.

This year's celebration will take place on Friday 2nd October at Kings Hall in Stoke-on-Trent, and we are already looking forward to an evening that shines a spotlight on the incredible work happening across UHNM.

Each year these awards give us the opportunity to recognise individuals and teams who consistently go above and beyond for our patients, their families and for each other. Across our hospitals colleagues demonstrate exceptional compassion, professionalism and commitment every single day and these awards allow us to highlight that remarkable contribution.

We have refreshed the award categories this year to better reflect the wide range of achievements across UHNM:

- Kindness and Compassion Award
- Collaboration Award
- Inclusion Award
- Excellence Award
- Rising Star - Clinical
- Rising Star - Non-Clinical
- Unsung Hero
- Colleague of the Year
- Team of the Year
- Outstanding Achievement Award
- Green Award

Nominations close on Friday 19th June at 5pm.

4. UHNM hosting West Midlands Imaging Network

The West Midlands Imaging Network (WMIN) is a collaborative programme across 15 NHS Trusts, delivering strategic transformation in imaging services. Dudley Group NHS Foundation Trust has handed over the hosting arrangements of the network to UHNM from 1st June 2026. I remain the Chair of the Network, on behalf of all the partner organisations.

Historically, UHNM has not played a significant role in network leadership across the West Midlands. However, in the last few years the Trust has successfully hosted the Gynaecology ODN (Operational Delivery Network) and has recently been asked to host the Robotic Surgery Community of Practice for the West Midlands.

As part of the Trust's Strategy, we have identified Networking and Collaboration as a Strategic Programme and it is in that context, at least in part, that this arrangement has been approved by Trust Board.

5. Mouth Care Matters

National Smile Month was an ideal opportunity to remind everyone at UHNM to 'Love your Smile'. Not only does a dentist check teeth and gums, but they also screen for oral cancer. Oral cancer rates are rising, so the sooner anything suspicious is checked the sooner patients can be referred.

In May the Mouth Care Matters team visited ward areas across UHNM to highlight that mouth care matters for our patients.

Mouth Care Matters (MCM) was originally funded by Health Education England to improve the oral health of hospitalised patients. Trusts, including UHNM, developed programmes to upskill nurses and other health professionals, including face-to-face training to support excellent mouth care.

Hospital inpatients are at increased risk of oral conditions such as severe dry mouth, ulceration and fungal infections. Poor oral health can affect eating and drinking, communication and increase the risk of infections including hospital-acquired pneumonia, resulting in an increased length of stay and additional treatment.

It is therefore important to ensure essential products are available on wards, including small-headed toothbrushes, non-foaming toothpaste, denture pots and dry mouth products. Elective patients are advised to bring their own, and as emergency admissions may not have prepared for hospital, wards should stock suitable items including products to relieve dry mouth and help remove dried secretions.

The Mouth Care Matters team and Quality team continue to deliver face-to-face training. Patient mouth care is a key element of CEF inspections. Mouth care assessments are completed within 24 hours (ideally 6-8 hours) and recorded twice daily.

6. Estates, Facilities and PFI Partnership Day

In May, we had another regular fixture in the UHNM Corporate Calendar - our Estates, Facilities and PFI Partnership Day, which brought colleagues and partners together, again at the Bet365 Stadium.

The day provided a valuable opportunity to come together across UHNM and our partner organisations to reflect on how strong, consistent partnership working continues to support the delivery of safe, effective and sustainable care for patients. It also reinforced the importance of taking time to step back from day-to-day pressures and focus on shared priorities, learning and continuous improvement.

We were joined by colleagues from Midlands Partnership University NHS Foundation Trust (MPFT), Healthcare Support (North Staffs) Ltd, Sodexo, Siemens Healthineers, NHS England and the Cabinet Office, alongside UHNM teams from across estates, facilities, care groups and corporate functions. The breadth of representation reflected the scale and maturity of our partnership working and the shared commitment across all organisations to deliver high-quality services for our patients.

The day opened with a strategic leaders panel, which included national insight from Simon Corben, Director and Head of Profession for NHS Estates and Facilities at NHS England. Discussions focused on the evolving role of estates and facilities within the wider NHS, and how integrated working models such as ours can help support long-term transformation and system priorities.

Throughout the day, a series of sessions explored key areas including operational performance, service improvement, workforce and culture, sustainability and innovation. A particular highlight was the service spotlight, which provided an opportunity to recognise and hear directly about the contribution of our estates and facilities teams in maintaining safe environments and enabling high-quality care every day.

The event also provided an opportunity to reflect on the strength of our partnership model, following UHNM's recent success at the Partnerships Awards, where we were recognised with the Best Operational Project award. This recognition is a testament to the commitment, collaboration and professionalism

demonstrated across all partner organisations, and the shared focus on delivering improvement through a genuine one-team approach.

I would like to extend my sincere thanks to all colleagues and partners who contributed to the day and to our private sector partners for their generous sponsorship of the day. In particular, I would like to recognise the continued dedication of our Estates, Facilities and PFI teams, whose work is fundamental to the safe and effective running of our hospitals and services.

7. Our new Community Diagnostic Centre in Hanley

In April we welcomed our first patients to the new Stoke-on-Trent Community Diagnostic Centre (CDC) in Hanley, a really important moment for UHNM and something that has been years in the making.

Patients will be able to access a wide range of tests and scans closer to home, including MRI, CT, ultrasound, X-ray, endoscopy, blood tests and physiological sciences such as cardiology, respiratory and sleep testing. The centre will be open seven days a week, 12 hours a day, and will provide up to 180,000 tests and scans each year.

Put simply, this is about making it easier for people to get the tests they need, more quickly and more conveniently. It means earlier diagnosis, quicker access to treatment, and a better overall experience for our patients, while also helping to reduce pressure on our hospital sites.

I want to take a moment to recognise the huge amount of work that has gone into getting us to today. Projects like this do not happen without a real team effort. Thank you to colleagues across estates, project management, clinical and diagnostic services, digital services, operations and corporate teams; it's a genuine whole-organisation achievement.

It's also great to see the opportunities this brings for our workforce, with around 150 new roles, including apprenticeships and specialist posts helping us build for the future.

8. Breast Care Unit at County Hospital

In April we opened yet another facility that reflects our commitment to improving care, experience and environments in response to what patients and staff tell us matters most.

Our new Breast Care Unit at County Hospital is an important step forward in being able to provide the best possible care and experience for our patients. This is another investment at County and underpins our commitment to make the very best use of some great facilities on this site.

It is a purpose-built space designed around what patients and staff have told us matters most and brings together one-stop clinics, imaging, outpatient care and support in one place, helping make what can be a very worrying time feel more joined-up, calmer and easier to navigate.

Many of the facilities we've been using at County were built decades ago and simply aren't right for how breast care works today. Referrals have increased significantly in recent years, and modern care means patients often have several tests on the same day. This new unit gives us the space, layout and equipment to do that properly.

It includes dedicated consultation and counselling rooms, improved treatment space and the latest diagnostic imaging. Just as important, it's been designed to feel right for patients, with privacy, dignity and a more welcoming environment at its heart. This includes a landscaped garden area, with UHNM Charity also supporting artwork, furnishings and the reception space to help create a more welcoming and calming environment.

The new unit won't increase capacity on its own, but it will improve experience and make pathways smoother. Most patients attending our clinics are reassured and able to go home the same day, and this new environment will help us do that in the best possible way.

9. Staffordshire Treatment Suite

May also saw the third anniversary of the Staffordshire Treatment Suite (STS) at County Hospital.

The STS was established to support faster access to planned care by providing dedicated space for day-case procedures, while also supporting the growing role of County Hospital as a centre for elective care within UHNM.

Built in two phases, the unit now has four fully operational treatment rooms and carries out a wide range of procedures under local anaesthetic including plastics, pain management, oculoplastic, ophthalmology, urology gynaecology, oral maxillofacial and vascular procedures. So far well over 5,000 patients have been treated.

As an ambulatory service, patients can attend for their consultation and procedure in one visit and return home the same day following recovery. This creates a more streamlined experience for patients and allows procedures that would previously have taken place in main theatres or outpatient areas to be carried out in a more appropriate setting.

In turn, this helps release capacity for more complex procedures and supports UHNM to treat more patients across our hospitals.

Our teams have embraced new ways of working to make the service such a success. For many of our theatre colleagues, STS introduced a very different model of care compared to a traditional theatre environment, and teams have worked incredibly hard to develop new processes, adapt quickly and create a service that is safe, efficient and focused on delivering the best possible experience for patients.

The success of the STS is very much a whole-team effort, and I would like to thank everyone involved over the past three years, including our theatre teams and support services such as HSDU, Estates and Clinical Technology, who help keep the unit running safely and smoothly every day.

10. Clinical Trials at UHNM

International Clinical Trials Day was marked on 20th May 2026 and was an important opportunity to celebrate the incredible difference research makes to patient care every single day at UHNM. Clinical trials are a fundamental part of modern healthcare, helping patients access pioneering treatments, innovative technologies and the latest advances in medicine closer to home.

At UHNM, research studies take place across our wards, clinics, laboratories and communities, supporting better care for local people now and in the future. We are proud to be a research-active Trust with internationally recognised teams delivering studies across a wide range of specialities including cancer, stroke, cardiology, trauma, children's services, respiratory medicine and motor neurone disease.

Research activity at UHNM continues to grow, with studies taking place across Royal Stoke and County hospitals in a wide range of specialities. This reflects the strength, expertise and ambition of not only our Research and Innovation department and Centre for NMAHP Research and Education Excellence (CeNREE), but the wider research endeavours of UHNM as well as the ongoing support of patients and local communities who choose to take part in research and help shape the future of healthcare.

This year also marks one year since the opening of the North Midlands Commercial Research Delivery Centre (CRDC) at Royal Stoke. Over the past 12 months, the centre has helped expand access to cutting-edge clinical trials and innovative treatments for patients across our region. By bringing together clinicians, academics and industry partners, the centre is supporting faster, more accessible delivery of research and further strengthening UHNM's position at the forefront of clinical innovation.

Clinical trials and research play a vital role in helping us develop better treatments and care pathways, improve patient outcomes and ensure people can access the latest advances in healthcare closer to home.

On International Clinical Trials Day, we took the opportunity to thank every patient, colleague and partner organisation who continues to support research and innovation at UHNM. This contribution is helping drive clinical progress and improve care for both current and future generations of patients.

11. Sustainability at UHNM

2025/26 has been a significant year in sustainability. Some fantastic work has been taking place across UHNM to make our hospitals greener and more sustainable.

Teams across both sites have found practical ways to reduce waste, cut carbon emissions and improve the way we work.

Some of the highlights include:

- Radiotherapy going paperless and saving more than 19,000 sheets of paper each year
- Fracture Clinic removing couch roll from clinics to reduce waste
- Oral and Maxillofacial teams improving recycling and reducing clinical waste emissions
- A UHNM-wide switch away from piped nitrous oxide, helping significantly reduce emissions
- Expanding the use of lower-carbon pain relief options for children aged five and over
- More recycling and food waste schemes being introduced across Royal Stoke

We now also have 27 teams taking part in our Low Carbon Care Framework, with colleagues across UHNM leading innovative ideas to make care more sustainable.

Looking ahead, plans for the coming year include launching a new Green Staff Award (as above), developing sustainable travel plans and working with Theatre teams on a major programme focused on reducing waste and promoting low carbon care.

12. International Nurses Day and the DAISY Award

Tuesday 12th May 2026, saw International Nurses Day. We took the opportunity to relaunch the DAISY Award to recognise and celebrate outstanding nursing care across our Trust.

Every day across UHNM, our nurses make an extraordinary difference to patients and families through their compassion, kindness and clinical excellence. Earlier this year, we were proud to present a DAISY Award to recognise exceptional nursing care at UHNM. That award marked the restart of our journey with the DAISY programme.

The DAISY Award is an internationally recognised programme, used by thousands of healthcare organisations around the world to say thank you to nurses who go above and beyond for patients, families and colleagues. It recognises not just what nurses do, but how they do it, with empathy, dignity and compassion at the heart of care.

The DAISY Award gives patients, families and colleagues the opportunity to nominate a nurse who has made a lasting difference to their experience of care. Nominations focus on acts of compassion, professionalism and clinical excellence that truly stand out.

DAISY Awards will be presented regularly across UHNM, ensuring that recognition is ongoing, meaningful and visible, not a one-off.

On International Nurses Day, we marked the day by celebrating all our nurses and the impact they have every day and by giving the public the opportunity to recognise this impact by relaunching the DAISY Award across UHNM.

The launch builds on the DAISY Award already presented and signals our commitment to making recognition of compassionate nursing care a core part of how we celebrate our people.

Our new DAISY nomination forms are available online via our website. Anyone can nominate, whether a patient, family member or colleague, by sharing a story about a nurse who made a difference.

13. Staff Networks at UHNM

On 13th May we marked National Staff Networks Day at UHNM again this year. It was a chance for us to pause, reflect, and celebrate the incredible role our staff networks play in shaping who we are as an organisation.

Last year, we came together to recognise the strength of our networks and the difference they make. This year, under the theme #UnitingForEquity, we had another opportunity - not just to celebrate - but to really acknowledge how far we have come and the impact we are continuing to build together.

Our staff networks bring colleagues together, challenge us to think differently, and help turn good intentions into meaningful action. They are such an important part of creating an inclusive culture at UHNM. They create spaces where colleagues can feel safe, heard and valued, and lived experience genuinely shapes how we think, lead and make decisions.

Over the past year, we have seen our networks grow in confidence, strength and influence. They have worked closely with leaders to make sure the voices of our people are not only heard but acted upon. Whether it's influencing policy, shaping initiatives, or leading conversations that challenge inequality, our networks show us that real change happens when we listen, and when we act.

14. Going Smokefree

In my April 2026 Board Report, I talked about our efforts to go smoke-free as a Trust. Two months on from launching this transition, I would like to take the opportunity to thank all colleagues for the positive and professional way that has been supported to achieve our ambition to provide a better environment for our staff, patients and visitors.

Becoming smoke-free represents a significant cultural shift and the approach taken across all services has been key to laying strong foundations for success. Since launch, the focus has been on ensuring that smoke-free UHNM is support-led, not enforcement-led, making help visible, accessible and compassionate for both patients and staff.

Early data from the outpatient tobacco dependency clinic (as part of the launch) demonstrates strong impact. Between September 2025 and February 2026, 352 patients have been supported, resulting in 97 confirmed quits, with up to 48 per cent of patients achieving a positive behaviour change (quit or reduction). For those seen face-to-face, outcomes are particularly strong, with a 54 per cent quit rate, highlighting the value of direct clinical intervention.

This level of impact is significant when considered in real-world terms. National modelling, including tools developed by Action on Smoking and Health, shows that supporting people to quit smoking reduces hospital admissions, complications and length of stay. Based on these estimates, 97 quits could equate to approximately 50 to 100 hospital bed days saved. In simple terms, this means patients recovering more quickly, fewer complications and more capacity available for those needing care, demonstrating how prevention work directly supports hospital flow and patient outcomes.

Encouragingly, staff engagement is also increasing. Between January and April, approximately one-third of those accessing the outpatient service were UHNM staff, reflecting a growing culture of role modelling healthier behaviours, reducing stigma and supporting workforce wellbeing.

Going smoke-free is a key part of our prevention agenda and commitment to our local population's health. Every contact presents an opportunity to identify tobacco dependence, offer brief advice through Making Every Contact Count (MECC) and connect people with effective support. Early intervention plays a vital role in preventing long-term conditions such as cancer, cardiovascular disease and COPD, improving outcomes both now and for future generations.

High-quality tobacco screening remains essential to sustaining smoke-free practice. When nicotine dependence is identified early, withdrawal symptoms can be anticipated and managed, patients are more comfortable and supported and fewer people need to leave clinical areas to smoke. A strong example of this can be seen in the Acute Medical Unit (AMU) at Royal Stoke and Ward 113 where teams have embedded digital tobacco screening and achieved sustained 100 per cent screening rates. This

demonstrates how screening, MECC and our smoke-free policy come together to improve patient experience and reduce disruption to care.

Ward and department leaders are encouraged to review their local tobacco screening data to identify opportunities for improvement and ensure staff are supported to deliver safe, effective, smoke-free care. The Tobacco Dependency Team is available to support teams, share best practice and review performance data, with a focus on continuous improvement and sustainability.

15. Transitioning from paediatric to adult care

One of the important responsibilities we have as a Trust is supporting children and young people as they grow and their healthcare needs change. Moving from paediatric to adult services is a significant milestone for any young person, but for those with long term conditions, neurodiversity or complex health needs it can feel particularly daunting, for them and for their families.

We know that when transition isn't handled well it can lead to gaps in care, young people disengaging from services and increased anxiety when reassurance and continuity matter most. That's why making improvements to the way we support young people through this transition is so important.

Every young person should feel prepared, supported and confident as they take their next step into adult services and is why we are working to strengthen how we plan and deliver the move from children's to adult care. We know that good transition doesn't happen overnight as it's a process (not a single event) and it works best when it starts early and is shaped with patients and their families rather than done to them.

Over the coming months, colleagues will begin to see a number of changes that are designed to support this approach. These include clearer expectations and guidance around transition planning, better communication between paediatric and adult services, the introduction of hospital passports, testing changes across services and more training opportunities for staff. Taken together, these improvements will help us deliver more consistent, joined up and person-centred transition care.

The aim is that every young person should experience a well-planned and coordinated transition that supports independence, maintains continuity of care and sets them up for positive long-term outcomes.

16. BMA Industrial Action

The next period of industrial action from resident doctors will begin at 7am on Monday 15th June and run until Friday 19th June.

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 will work hard to minimise disruption so that patients receive the care they need.

Some appointments may need to be postponed, and patients will be contacted directly if any changes affect them. The deliberate aim will be to keep disruption to a minimum while maintaining safe staffing and patient flow.

We will operate once again 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 will ensure that decisions about patient care and discharge will be made safely and effectively.

17. Employee and Team Recognition

Team of the Month (April 2026) – Clinical Technology Team

The team have achieved something quite exceptional - passing their (British Standards) BSI ISO 13485 audit with zero non-conformities. This is a rigorous, internationally recognised standard, and to meet it in that way provides real assurance around quality, safety and governance.

However, this is about more than that. It's about how the team works, the consistency, the attention to detail and the way they support each other and other teams across UHNM. It's critical to what we do, even if it's not always visible.

***Employee of the Month (April 2026)* – Dr Biju Thomas, Consultant Radiologist**.

This was a particularly special award and nomination, not least because it came from a doctor in specialist training. During a challenging on-call period Dr Thomas came in on his weekend off to carry out an urgent, life-saving procedure. This wasn't described as a one-off, this is how he works - supporting colleagues, stepping in when it matters and role modelling the behaviours we want to see. That point about role modelling is important. It's how we build culture, how we support each other and how we make sure those coming through our doors see what great care looks like in practice.

Chief Executive Award (April 2026) – Pharmacy Team

The award itself was in recognition of the team's work on the roll-out of the Electronic Prescribing and Medicines Administration (EPMA) systems across all adult inpatient areas. This is a significant milestone for us as an organisation. It's a big part of our digital journey, helping us improve how we manage medicines, strengthen communication between teams, and most importantly enhance patient safety.

What really came across to me was just how much work has gone into making this happen. These things don't land overnight, they take a huge amount of planning, persistence and teamwork and, as I heard, a fair few sideways and backwards steps along the way. That resilience and commitment to keep going is what has made the difference.

It's also important to say that the contribution from Pharmacy goes far beyond EPMA. So much of what they do happens behind the scenes, but it is absolutely central to how we function as a Trust, particularly in supporting patient flow and helping us get things right first time.

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

I have personally recognised the contribution of the following colleagues:

- Priaymol Thankachan - Staff Nurse, Emergency Department, RSUH
- Samantha Ball - Healthcare Assistant, Emergency Department, RSUH
- Mr Timothy Bullen - Consultant Colorectal Surgeon
- Mr Wareth Maamoun - Consultant Plastic Surgeon
- Jill Potts-Ayres - Director of Nursing, Planned Care
- Mr Oliver Priest - Consultant Surgeon
- Julie Woodworth and Team Ward 15, County Hospital
- Claire Carrick - Head of Orthoptics
- Ceri Sedgley - Chief AHP

Part 2: Consultant Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Consultant Glaucoma Ophthalmologist	Vacancy	Yes	27.4.26
Acute Medicine	Vacancy	Yes	2 posts – start date TBC
Consultant Clinical Oncologist	Vacancy	No	n/a
Consultant Gynae-Oncologist	Vacancy	Yes	TBC
Consultant in Nephrology	Vacancy	Yes	TBC
Consultant Fetal Medicine Obstetrician	Newly created	Yes	TBC

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

Post Title	Reason for advertising	Start Date
Paediatric Gastroenterology Consultant	Vacancy	7.4.26
Consultant Gastroenterologist	Vacancy	7.4.26
Consultant Glaucoma Ophthalmologist	Vacancy	27.4.26
Consultant in Infectious Diseases & Acute Medicine/Microbiology	Vacancy	5.5.26

The following table provides a summary of medical vacancies that closed without applications / candidates during April and May 2026:

Post Title	Closing Date
Gastro / Hepatology Consultant	10.4.26

Medical Management Appointments

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

Post Title	Reason for advertising	Appointed (Yes/No)	Start Date
Clinical Business Units Medical Director	Newly created	Yes	5 posts – start dates TBC
Clinical Lead for Cardiology	Vacancy	Yes	TBC
Clinical Lead for Thoracic Surgery	Vacancy	Yes	TBC

No medical management have taken up positions in the Trust during April and May 2026.

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

Executive Summary

Trust Board (Part 1) | 10th June 2026

Board Assurance Framework – Quarter 4

University Hospitals of North Midlands NHS Trust

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

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

Executive Summary

Situation

The Board Assurance Framework (BAF) is a dynamic document, reviewed and updated quarterly, which provides a structured approach to identifying and managing the key risks that could impact the delivery of the Trust's Strategic Priorities. It sets out the principal controls in place for each strategic risk and the assurance mechanisms used to assess their effectiveness.

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

This update reflects the position at Quarter 4 2025/26, as provided by Executive Leads, and incorporates final refinements to the executive summaries for each strategic risk to strengthen clarity, consistency and audit-readiness.

Background

The strategic risks within the 2025/26 Board Assurance Framework were reviewed and refreshed by the Executive Team and approved by the Board in April 2025, in line with the annual review process. For 2025/26, the BAF format was streamlined to focus on a single, consolidated document, improving accessibility and reducing duplication.

The revised risk appetite statement, also approved in April 2025, continues to inform the setting of target and tolerable risk scores. All strategic risks are aligned to the Trust's Strategic Priorities: Our People, Our Patients and Our Population. In addition, the primary issues identified by the Executive Team have been mapped to each strategic risk to strengthen clarity, ownership and accountability.

Assessment

Quarter 4 reflects a mixed but maturing assurance position across the Board Assurance Framework (BAF). While the majority of strategic risks remain above their target (tolerable) risk scores, assurance maturity has strengthened across several risks, and the BAF provides a clearer, more consistent account of the Trust's key risk exposures, control effectiveness and delivery constraints.

The update demonstrates improved clarity in risk articulation and greater consistency in executive summaries, alongside a more explicit distinction between progress against actions and evidence of sustained assurance. One strategic risk has reduced to its target score at Quarter 4, while the remaining risks continue to require sustained delivery and embedded controls before risk reduction can be supported.

A summary of the main changes in the BAF at Quarter 4 is set out below, with a focus on the robustness of the process undertaken to update risks, controls, assurance and actions.

Key Thematic Issues Emerging in Q4

- Sustained operational and system pressure continues to underpin several high-scoring strategic risks, particularly where improvement depends on consistent delivery over time rather than discrete milestones.
- Digital fragility and cyber resilience remain significant cross-cutting risks, reinforced by live incidents, legacy infrastructure and compliance gaps, despite some improvement in governance controls.
- Workforce capacity and governance constraints continue to affect assurance across multiple strategic risks, including sickness absence, pipeline risks and pressures on enabling functions (People Operations, workforce information, governance support).
- In-year financial control has strengthened, with one strategic risk reducing to target; however, financial sustainability remains the most significant risk, reflecting the structural and multi-year nature of recovery requirements.
- Capital and estates risks remain constrained by national funding limitations and extended statutory processes arising from the Building Safety Act, slowing delivery of mitigating actions.
- Research and Innovation governance has strengthened, although regulatory compliance and infrastructure capacity are not yet sufficiently embedded to support risk reduction.

Risk Profile Overview

- One strategic risk (BAF 6 – In-Year Financial Position) reduced to its target risk score at Quarter 4, supported by strengthened controls and completion of actions.
- Executive assurance improved in several areas through the removal of gaps in control and assurance following action completion; however, new gaps have also been identified, reflecting increased scrutiny and higher expectations around evidence of delivery and impact.
- BAF 7 (Financial Sustainability) remains at Extreme 25, the highest strategic risk, due to reliance on non-recurrent measures and undeveloped future-year savings plans.

Key Improvements

- Stronger consistency and clarity across executive risk summaries.
- BAF 6 achieved its target risk score, with all actions completed and no outstanding gaps in control or assurance.
- Reduction in gaps in control and assurance across several risks following completion of Quarter 3 and Quarter 4 actions.
- Improved governance arrangements in:
  - Digital transformation (removal of AI governance gap),
  - Research & Innovation (reconstitution of Executive Research & Innovation Group),
  - Estates governance (clarification of Client responsibilities under the Building Safety Act).

Areas of Ongoing Concern

- Several strategic risks remain stalled above target risk scores, not due to lack of activity, but due to insufficient evidence of sustained delivery at scale.
- Recurring action delays continue to arise from:
  - winter operational pressures and critical incidents,
  - reliance on external partners, national processes and regulatory approvals,
  - specialist capacity constraints within enabling functions.
- New assurance gaps have emerged in Quarter 4 as expectations have shifted from process completion to demonstrable impact, particularly in workforce governance, digital compliance and population health delivery.
- Internal audit findings remain relevant across multiple risks, including cyber security, digital governance, fraud/financial controls and procurement, reinforcing the importance of continued alignment between internal audit and BAF updates.

Internal Controls

- Action plan completion has continued during Quarter 4, with clear rationale documented where actions have been delayed.
- Where assurance reports were not received as planned, these have been explicitly rescheduled, maintaining transparency and consistency with prior quarters.
- The Quarter 4 BAF reflects improved discipline in:
  - articulating the link between controls, assurance and risk scores,
  - avoiding conflation of delivery progress with assurance sufficiency,
  - clearly recording the reasons why risk scores have moved or remain unchanged.

Key Recommendations

The Trust Board is asked to receive and approve the BAF for Q4.

University Hospitals of North Midlands NHS Trust

Board Assurance Framework

Quarter 4 | 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

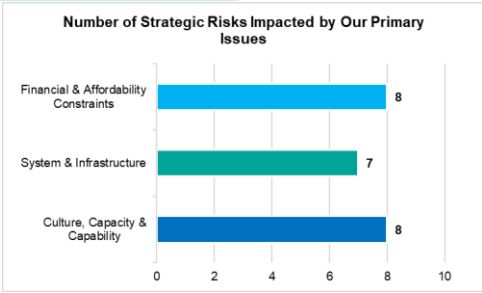
i.e. staff fatigue & burnout / workforce affordability & skills / digital and technological capacity

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	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	●	●	●	●	●	●	331 ↓	6 ↑	11 ↑	10 ↓	0 →	13 ↓	2 →	2 ↓	12 ↑	3 ↑	0 ↓	1 ↓
BAF 2	Inability to Design and Deliver Services that Address Local Population Needs	High 10 / Acceptable	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		●	●	●	●	●	0 ↓	0 →	1 ↑	0 →	0 →	1 →	0 ↓	3 ↑	6 ↑	3 ↑	0 →	0 →
BAF 3	Inability to Improve Workforce Sustainability & Organisational Culture	Ext 15 / Partial	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	●	●		●		●	134 ↓	0 →	9 ↑	3 ↓	0 →	5 ↑	3 →	8 ↑	3 ↑	0 ↓	2 ↓	4 ↑
BAF 4	Inability to Deliver Digitally Enabled Care Transformation	Ext 16 / Partial	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	●	●	●	●	●	●	103 ↓	0 →	2 ↑	0 →	0 →	1 →	6 ↓	3 ↓	13 ↑	0 ↓	3 ↑	0 →
BAF 5	Inability to Deliver Investment in Estate Infrastructure & Workforce	High 12 / Acceptable	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	●	●	●	●	●	●	96 ↓	2 ↑	0 ↓	0 →	0 →	1 ↑	15 →	1 →	2 ↑	0 ↓	1 ↓	6 ↑
BAF 6	Inability to Deliver In-Year Financial Position	Ext 20 / Partial	Ext 20 / Partial	High 12 / Acceptable	High 9 / Acceptable	High 9 / 31/03/2026	Cautious (1 - 9) ↓ Score reduced to the target score (High 9) in Q4	●	●	●	●	●	●	16 ↓	0 ↓	4 ↑	11 ↑	0 →	4 ↓	2 →	1 →	7 ↑	0 ↓	0 →	0 →
BAF 7	Inability to Deliver Financial Sustainability	Ext 20 / Partial	Ext 20 / Partial	Ext 25 / Partial	Ext 25 / Partial	High 12 / 31/03/2027	Cautious (1 - 9) ↔ Score has exceeded the tolerable score (10-12) since 2024/25	●	●	●	●	●	●	5 ↑	0 ↓	1 ↑	11 ↑	0 →	4 ↓	4 →	0 ↓	6 →	1 ↓	2 ↑	0 →
BAF 8	Inability to Sustain Research and Innovation Excellence	High 12 / Partial	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 →	2 ↑	3 ↓	0 ↓	8 ↑	2 ↓	1 →	1 →
							TOTAL	7	8	7	8	7	8							35 ↓	18 ↓	57 ↑	9 ↓	9 ↓	12 ↑

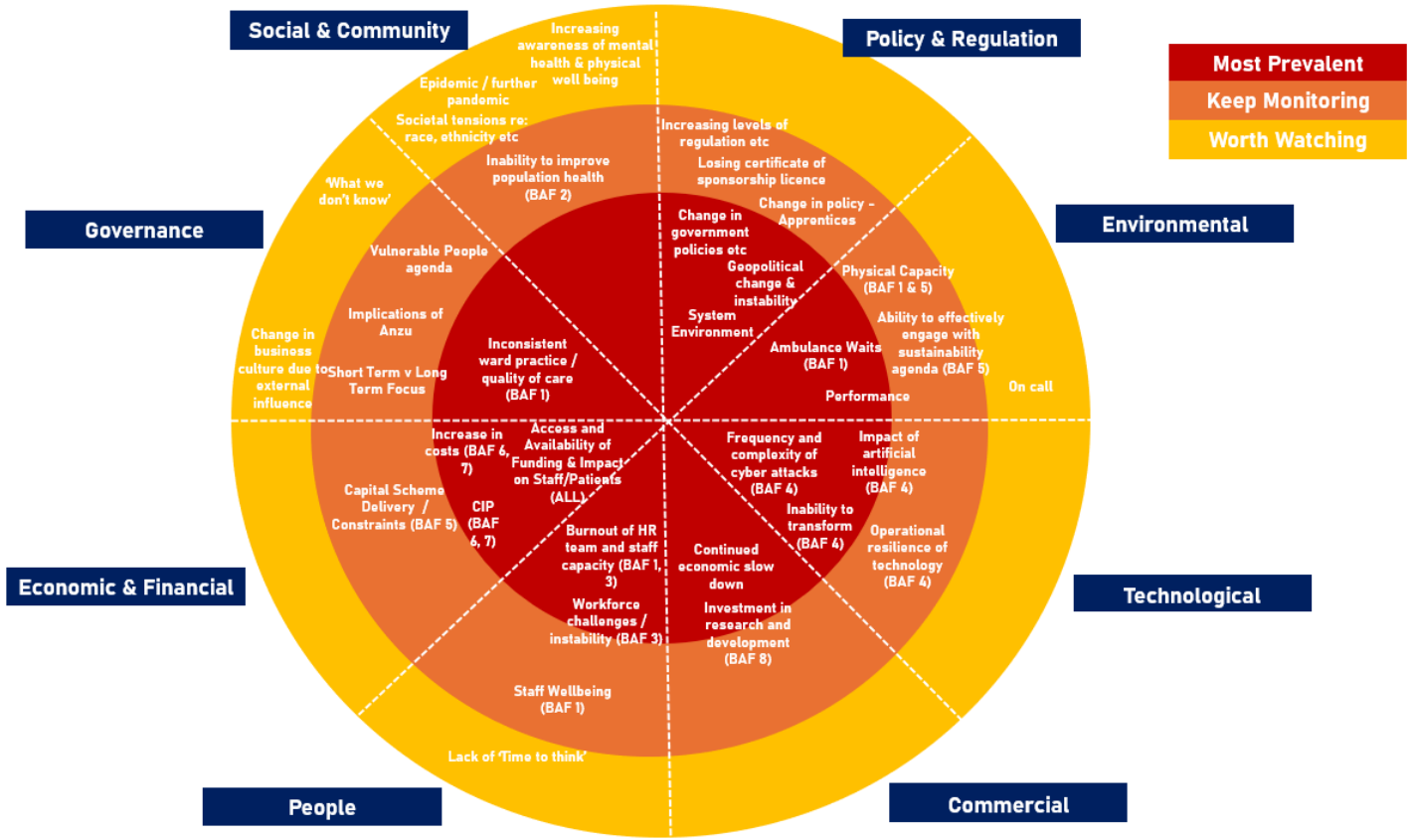
Positive Assurance

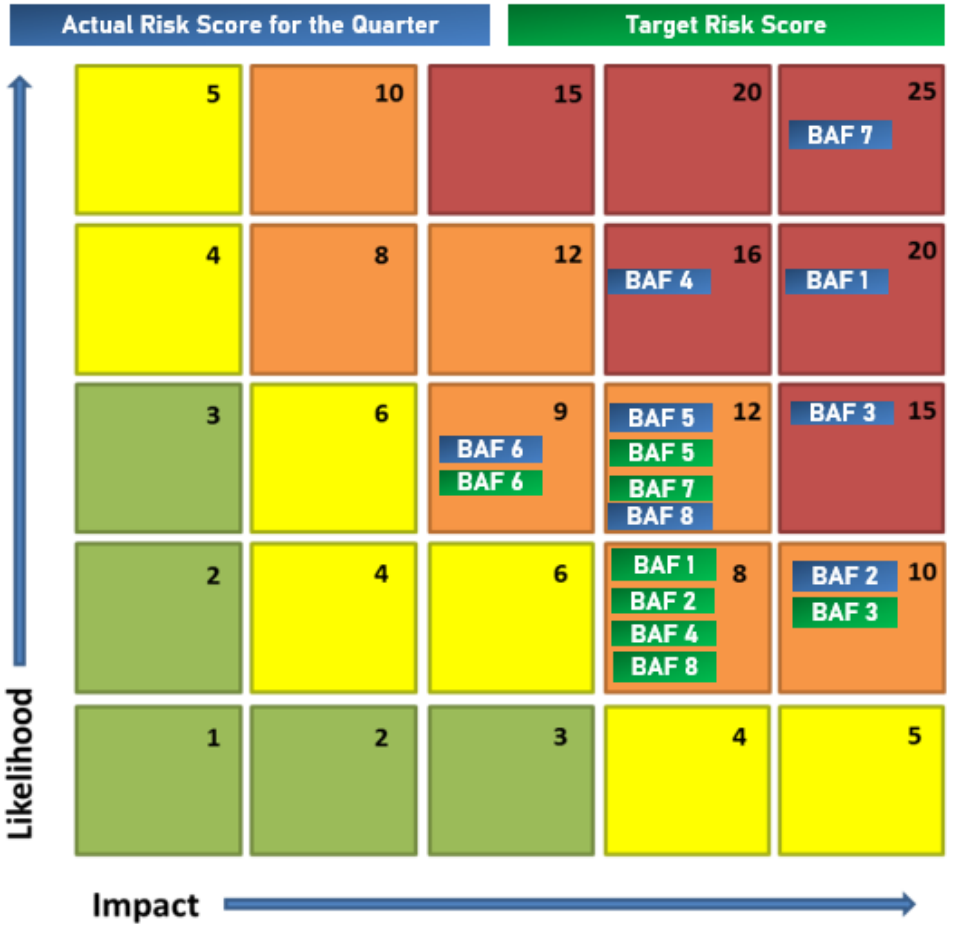
- 3 / 8 risks identified as providing acceptable assurance (→)
- 11% (↑) assurances were rated as significant assurance and 39% (↑) as acceptable assurance
- 66% (↑) of actions have been completed with 10% (↓) on track
- 2 / 8 risk scores are within the risk tolerance (→) and 1 / 8 risk score is in line with the risk appetite (→)

Matters of Concern

- 5 / 8 risks identified as providing partial assurance (→)
- 49% (↑) assurances were rated as partial assurance and 0% (→) identified as having no assurance
- 12% of assurance were not seen during Q4 (↓)
- 10% (↓) of actions are delayed and 14% (↑) 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

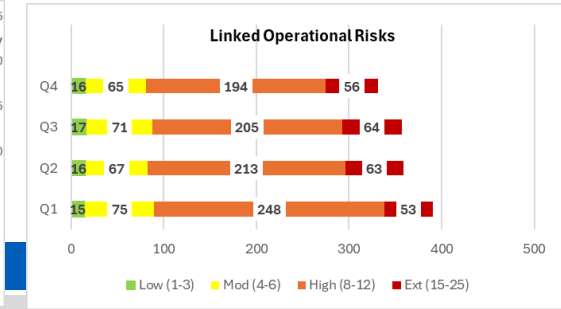
Cause:	If we experience limitations in workforce availability, equipment, service capacity, financial constraints, or, lack a culture of continuous improvement,
Event:	Then we may be unable to consistently deliver safe, timely and effective care across maternity services, urgent and emergency care (UEC), 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		Risk Appetite
Likelihood	4	4	4	4	2	31/03/2026 31/03/2027	Minimal 1 – 4
Consequence	4	5	5	5	4		Risk Tolerance
Risk Score	16	20	20	20	8		Mod/High 5 – 9



Overview – Summary of Key Q4 Changes

At Quarter 4, the risk remains Extreme at a score of 20, significantly above the target risk score of 8, reflecting the need to evidence sustained and embedded improvement rather than short-term recovery. While progress has been made, the cumulative impact of winter pressures and system constraints means the conditions required to support risk reduction have not yet been met. During the quarter, key safety and governance milestones were delivered, including completion of the EPMA rollout and achievement of CNST Year 7. Workforce capacity has remained broadly stable across registered staff groups; however, increased Band 3 Clinical Support Worker vacancies arising from the Band 2–3 review continue to present a residual capacity risk, which is being actively managed through targeted recruitment and development pathways. Operational improvement activity progressed through elective and non-elective improvement sprints and a system-wide UEC change week in March 2026. Although performance improved towards the end of the quarter, January and February performance, combined with ongoing winter pressures, means improvement has not yet been sufficiently sustained to justify a reduction in the risk score. The receipt of a Regulation 28 notice relating to Modified Early Obstetric Warning Score (MEOWS) implementation in non-maternity settings further reinforces the need for consistent, Trust-wide application of safety processes.

The linked operational risk profile supports this assessment and highlights sustained pressure across demand, capacity and patient flow, including extended waits across elective and urgent pathways, alongside constraints in diagnostics, imaging and pathology capability, and workforce capacity and staffing. These factors continue to drive delayed decision-making, prolonged length of stay and fragility in system flow, particularly during periods of peak demand. Additional linked risks relating to the resilience of enabling infrastructure, including digital systems and cyber security, estates and equipment reliability, and medicines and supply arrangements, demonstrate how failures in non-clinical services could rapidly translate into service disruption and patient safety risk. Regulatory and assurance-related risks, together with gaps in training and organisational learning, further amplify these pressures by limiting standardisation, oversight and the pace at which learning is embedded. Executive assurance for this risk remains Partial. The number of gaps in assurance has reduced from five to two, reflecting the completion of actions in Quarter 3. During Quarter 4, three further actions were completed, and three new actions were identified in response. One action remains problematic, reflecting the complexity of system-wide pressures and operational dependencies. Delays to remaining actions were primarily driven by winter operational pressures, the declaration of a critical incident, and the prioritisation of immediate patient safety and flow management. In summary, Quarter 4 demonstrates continued progress and strengthening assurance; however, the cumulative impact of sustained demand, capacity and resilience pressures means the gap to the target risk score remains, and the risk score has therefore been appropriately maintained this quarter.

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=42)

- 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
- Elective Oversight Group (weekly)
- 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)
- Nursing assurance system in place until 2026/27
- Nurse staffing establishment reviews undertaken every 6 months
- Performance and Risk Reviews
- People Plan in place
- Planned Care improvement board (monthly)
- Quality and Outcomes Group, with bi-monthly focus on Quality and Safety / Outcomes
- Quality, Access & Performance Strategic Plan
- 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
- 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
- UEC improvement board (monthly)
- UEC rapid improvement meetings (weekly)
- 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

Assurances Received and Rated – All Quarters

Assurance Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
7 Day Services Board Assurance Report												
Access Performance Report & Executive Recovery Oversight Group Highlight Report	M12	M1	M2	M3	M4	M5 | NR	M6	M7 - 04/12/2025	M8	M9	M10	M11
Allied Health Professional Workforce Establishment Review				☒		☒						
Bi-Monthly Nursing & Midwifery Staffing Report								☒				
Cancer 104+ Day Breach Analysis	☒			☒	Q4	NR				☒		
Care Excellence Framework (CEF) Summary / Staffing Report					Q4/Q1				☒	Q2		☒
Care Quality Commission Inspection Update	☒											
Chief Healthcare Scientist Update		☒										☒
Chief People Officer Report						☒				☒		
Chief Pharmacist Workforce Report						☒		☒				
Clinical Coding Update												
Community Diagnostic Centre (CDC) Business Case Update									NR			
County Elective Hub Review												
End of Life CQC Mock Review								04-Dec				
Endoscopy JAG Accreditation Report												
Health & Wellbeing Report												
Hospital Associated Thrombosis Increase November 2024 - February 2025												
Infection Prevention Board Assurance Framework	☒	Q4		Q1			Q2			Q3		
Infection Prevention Hospital Acquired Infection Report	Q4			☒	Q1		Q2			Q3		
Infection Prevention, Vaccination & Sepsis Team Annual Report												
Legal Services Annual Litigation & Inquest Report								04-Dec				
Major Trauma Peer Review		☒										
Maternity & Neonatal PSIRF Investigation Report					Q1			Q2 - 26/11/25			Q3	
Maternity & Neonatal Single Delivery Plan (SDP) Framework Internal Audit												
Maternity Dashboard					Q1			NR - 26/11				
Maternity Incentive Scheme (NHS Resolution)												
Maternity Outcomes Signal System (MOSS) Critical Safety Checklist								26-Nov				
Medical Examiner Service Update												
Medicines Optimisation & Safety Report		Q4					☒	Q1/Q2			☒	☒
Mental Health Report												Q3
Mortality Assurance Report				Annual		NR						
Operation Anzu Actions Review												
Patient Experience Report				Q4		Q1 | NR				Q3		
Patient Safety Incident Investigation Report	Q4			Q1			Q2			Q3		
Patient Waiting List Backlog						NR			☒	☒	NR - Verbal	
Perinatal Mortality Report					Q1			26-Nov				
PLACE Inspection Findings and Action Plan												
Population Health / Waiting Inequalities List Report				NR							☒	
Quality Performance Report	M12	M1 | NR	M2	M3 | NR	M4	M5 | NR	M6	M7 | NR	M8	M9 | NR	M10	M11
Readmissions Analysis						☒	☒	☒				
Regulation 28 Update												
Review of Fetal Growth Surveillance Systems and Associated Safety Risks												
Saving Babies Lives Care Bundle												
Sepsis in Children's Services			☒					04-Dec			☒	
Spinal and Cranial SSI Review								04-Dec				
Temporary Escalation Spaces (TES)												

Assurance Rating Key

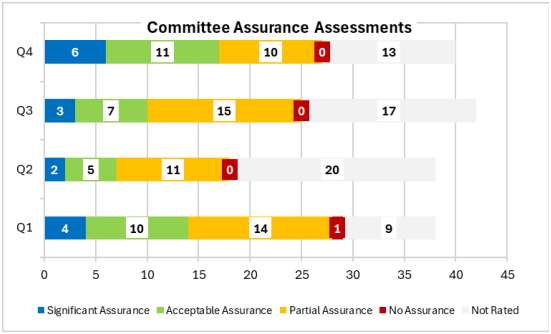
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

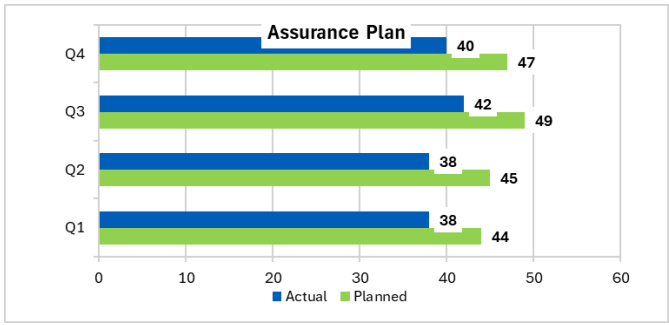
BAF 1: Inability to Sustain Safe and Effective Care Delivery

Executive 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

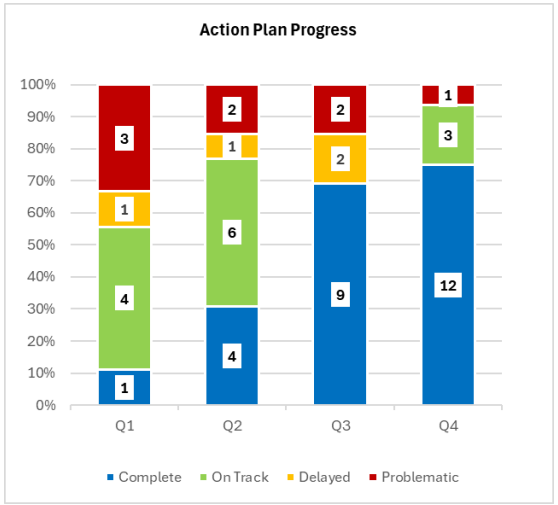
Committee Assurance Assessment & Plan





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 4)
Gaps in Assurance (n=2)	• Robust system is required for evaluating harm in patients waiting for elective procedures (action 1) • Reporting on trust escalation spaces (action 5)



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~~ 31/08/2026	Carry forward from Q1 2024/25. Digital team has completed the iPortal note and flagging functionality. Business intelligence team is developing the reporting framework, after which the approach will be launched with clinical teams. Launch is anticipated within the next four months, subject to readiness confirmation.				
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. Care Group-level effectiveness structures and processes are now established, providing a consistent foundation for oversight. Next phase to focus on working with Directorates and Departments to implement standardised meeting structures and protected time across all Care Groups, strengthening consistency and assurance.				
3	Deliver ePMA programme	~~31/12/2025~~ 31/01/2026	Roll out complete.				
4	To consider the action required to maintain future workforce requirements and pipelines	~~31/12/2025~~ 01/04/2026	Focused recruitment of B2 CSWs with a development package to achieve B3 within 18 months. 22 CN fellows completed the CNF fellowship programme; the next cohort has 37 fellows; we are now recruiting to the new CN fellowship for clinical support staff. Work to support advanced practice continues; we have commenced recruitment to the SNA-RNDA apprenticeship programme; bi- annual establishment review completed	N/A			
5	Reporting on escalation spaces to be taken to QAOC	30/04/2026	Reporting currently being reviewed and ensuring accurate data quality	N/A	N/A	N/A	
6	Corridor care improvement guide – gap analysis to be undertaken	30/04/2026		N/A	N/A	N/A	
7	Introduce national MEOWS across all areas	30/06/2026	Steering group set up, options appraisal paper developed and plan for roll out in development	N/A	N/A	N/A	

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

Quality, Access & Outcomes Committee | Director of Strategy

Risk Description

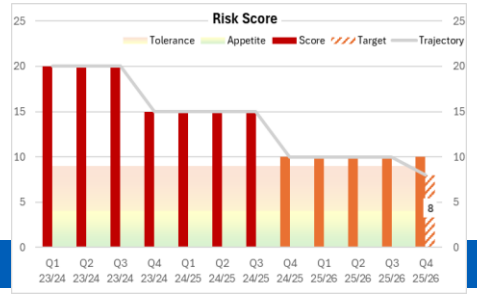
Cause:	If we are unable to work with partners to effectively design and deliver value-based services that meet the needs of our local population,
Event:	Then our ability to improve population health and reduce health inequalities may be significantly limited,
Effect:	Resulting in not moving from a system 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.

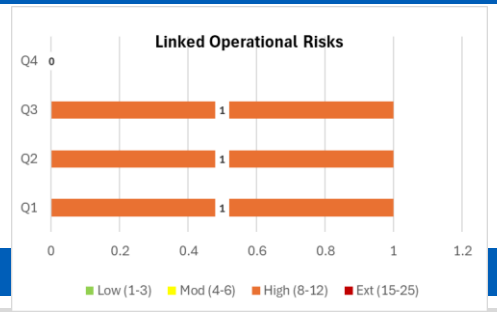
Potential to impact on our Strategic Priorities

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	5	4		Risk Tolerance
Risk Score	10	10	10	10	8		Mod/High 5 – 9





Overview – Summary of Key Q4 Changes

At Quarter 4, the risk score remains unchanged and above the target risk score of 8 therefore not achieving the target at year end. This reflects the need to demonstrate sustained, system-wide impact and consistent embedding of a population health approach, rather than early or pathway-specific improvement. During the quarter, progress continued in embedding population health and health inequalities considerations into service design and delivery. Improved use of population health intelligence, including segmentation by deprivation, ethnicity and geography, supported more targeted interventions across priority pathways, notably maternity, cancer screening, elective and peri-operative care. Early positive movement was reported in selected indicators, including reductions in maternal smoking, improved vaccination uptake, and strengthened intelligence relating to infant mortality and unwarranted variation. Progress also continued in scaling prevention and Making Every Contact Count, alongside preparation for implementation of the Smoke Free UHNM policy from April 2026, and the strengthening of the Trust's role as an anchor institution, including expansion of community-based diagnostics, employment pathways and targeted public health initiatives. Notwithstanding this progress, the residual risk remains unchanged. The scale and persistence of population health need, combined with ongoing data quality and completeness challenges, mean that improvement is not yet being delivered consistently across all care groups and pathways. In particular, the infrastructure required to embed prevention and population health approaches at scale is still maturing, limiting confidence that early improvements can be sustained, replicated or translated into demonstrable system-wide impact.

The linked operational risk profile reinforces this position, highlighting risks associated with incomplete or variable data, dependency on partner delivery, and the requirement to embed prevention capability consistently across services. Without sustained delivery at scale, these factors limit assurance that inequalities-focused interventions will deliver durable reductions in demand or improved outcomes across the population. Executive assurance for this risk remains Acceptable. Completion of three actions in Quarter 3 enabled the removal of one gap in control and one gap in assurance. However, this improvement has been offset by the identification of three new gaps in assurance during the year, reflecting increased scrutiny, expansion of scope, and a higher expectation of evidence of impact, rather than process maturity alone. During Quarter 4, two further actions were completed, and three new actions were identified to address emerging gaps and strengthen both delivery and assurance. While no actions are currently problematic, the presence of outstanding assurance gaps indicates that full assurance has not yet been achieved. In summary, Quarter 4 reflects continued progress, improved intelligence and strengthening maturity of population health approaches. However, due to the requirement for sustained delivery at scale, improved data completeness and further closure of assurance gaps, the conditions necessary to support a reduction to the target risk score have not yet been met. The risk score has therefore been appropriately maintained this quarter.

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) • Prevention and Making Every Contact Count Steering Group • Structured engagement and co-production mechanisms in place, including Patient & Public Leadership Council, VCSE partnerships and use of Health Equity Assessment Tool (HEAT) to inform service design for underserved groups • Sustainability programme, workforce wellbeing, community engagement, elective recovery active within care groups
Corporate (n=6)	• Anchor Institution Working Group and maturity framework in place to govern and evaluate UHNM's impact on employment, social value, sustainability and community health outcomes • 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 • Population health intelligence capability in place, including OHID funded analyst roles, PHM dashboards, elective and maternity inequalities tools, and ICS enabled datasets, supported by data quality improvement programmes • Public Health alliance in place between ICB, UHNM and Staffordshire County Council to improve cross working of consultant resource. • Regional Health Inequalities Network

Assurances Received and Rated – All Quarters

Assurance Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Population Health / Waiting Inequalities List Report				NR							☒	
Sustainability Bi-Annual Report												

Assurance Rating Key

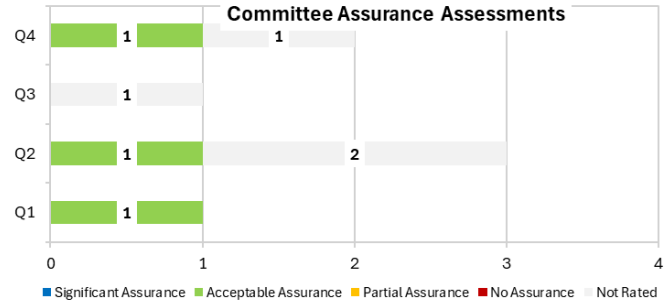
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

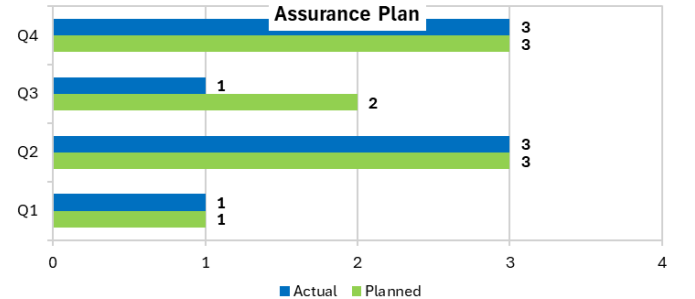
BAF 2: Inability to Design/Deliver Services that Address Local Population Needs

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

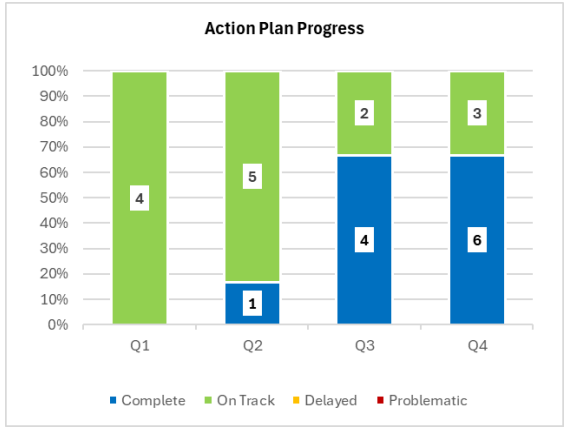
Committee Assurance Assessment & Plan





Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=0)	
Gaps in Assurance (n=3)	• Consistent translation into service redesign and commissioning decisions across all Care Groups (action 3) • Assurance is still developing regarding consistent co-production with underserved communities and demonstrable impact on service design (action 4) • Incomplete data on protected characteristics and digital exclusion continues to constrain full assurance that service design consistently meets the needs of all population groups (action 5)



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	The evidence base has been strengthened through the use of population health intelligence dashboards, pathway-specific inequalities tools and an outcomes framework. This demonstrates early impact in priority areas including maternity smoking cessation, vaccination uptake, infant mortality indicators and targeted prevention programmes.				
2	Raise regional and national profile of the programme	31/03/2026	The regional and national profile of the population health programme has been strengthened through UHNM leadership and representation at ICS, regional and national forums. This includes system leadership roles for priority programmes, participation in national health inequalities networks, and the sharing of UHNM good practice through regional and national events.				
3	Care Groups to develop and implement population health plans for priority pathways, using inequalities intelligence to inform service redesign and prevention activity.	2026/27	Care Groups continue to use pathway-specific population health intelligence, including deprivation, ethnicity and geography, to inform service planning and prioritisation across priority pathways such as maternity, elective and cancer care. While progress has been made, implementation remains phased and variable, reflecting differences in pathway maturity, data quality and supporting infrastructure. Further work is required to embed a consistent population health approach across all Care Groups and to evidence measurable impact at scale.	N/A	N/A	N/A	
4	Develop and implement a structured co-production and community engagement approach with underserved communities to inform service and pathway redesign.	2026/27	The Trust has continued to strengthen its approach to co-production and engagement with underserved communities. Targeted community outreach has been expanded across priority population groups, improving intelligence and informing pathway redesign, including within maternity and preventative services. However, the application of a fully structured and consistent co-production model remains variable, and further work is required to embed this systematically and demonstrate measurable impact on outcomes for underserved communities.	N/A	N/A	N/A	
5	Implement a programme to improve the quality and completeness of population health and protected characteristic data, strengthening population health intelligence and insight.	2026/27	Progress has been made in improving the quality and use of population health data, including increased use of ICS-enabled population health management tools and intelligence collaboration to support improved segmentation by deprivation, ethnicity and geography. Continued investment in population health intelligence capacity has strengthened analytical capability and insight to inform service design and address identified gaps, including risks associated with digital exclusion. However, challenges remain in achieving consistent completeness and accuracy of protected characteristic data across all services, and sustained improvement is required before the full impact on outcomes and risk reduction can be demonstrated.	N/A	N/A	N/A	

BAF 3: Inability to Improve Workforce Sustainability & Organisational Culture

People, Culture and Inclusion Committee | Chief People Officer

Risk Description

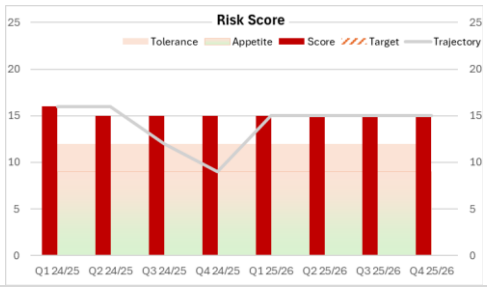
Cause:	If we are unable to achieve workforce sustainability through the implementation of an effective long term workforce plan – one that is underpinned by a positive, inclusive organisational culture,
Event:	Then, we may encounter significant challenges in attracting and retaining top talent, in addition 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.

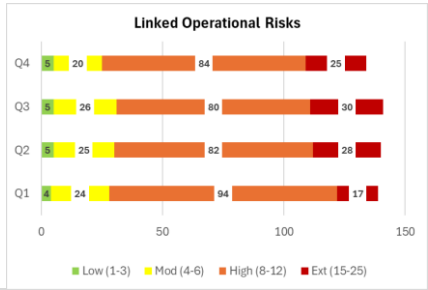
Potential to impact on Our Strategic Priorities

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





Overview – Summary of Key Q4 Changes

At Quarter 4, the risk remains unchanged and above the target risk score and above target. This reflects sustained workforce pressure and constrained assurance, despite progress against key elements of the People Plan. During Quarter 4, progress continued across the People Plan priorities of health and wellbeing, learning and development and workforce flexibility, providing moderate assurance that core controls are operating as intended. Delivery during the quarter included continued implementation of sexual safety actions, expansion of wellbeing initiatives, preparation for Trust-wide smoke-free implementation from April 2026, and ongoing investment in leadership development, mandatory training oversight and workforce reform. Core workforce metrics, including vacancy rate and time-to-hire, have continued to perform at or above target, and recruitment to priority services has progressed, reflecting sustained focus on workforce supply. Notwithstanding this progress, the residual risk remains unchanged due to several material assurance constraints. Sickness absence remains significantly above target, driven primarily by mental health, respiratory illness and musculoskeletal conditions, directly impacting workforce resilience, service continuity and reliance on temporary staffing. Apprenticeship uptake remains below plan, presenting a continuing risk to the future workforce pipeline and long-term capability, despite work underway to better align apprenticeships with workforce planning and talent management. In addition, variability in appraisal completion, particularly during winter pressures, limits assurance that performance management, development and cultural expectations are being applied consistently.

The linked operational risk profile reinforces this assessment and highlights persistent workforce shortages, fragile skill mix and limited organisational capacity across services. Recruitment and retention challenges, rising demand and continued reliance on temporary staffing contribute to rota gaps, performance breaches and cost pressures. In parallel, staff experience and wellbeing are affected by workload intensity, reduced protected time and constrained support functions, including People Operations capacity, workforce information, governance and digital enablement. These factors reinforce one another, increasing sickness absence, turnover and cultural risk, including reduced confidence to speak up, with cumulative impact on patient safety, compliance, operational performance and organisational reputation. Executive assurance for this risk therefore remains Partial. During Quarter 4, four new gaps in assurance were identified and during the quarter, two actions were completed; however, four actions remain problematic and two actions remain delayed. Delays have been driven by winter operational pressures, workforce capacity constraints, and dependencies on external and cross-cutting organisational changes, including national programme timelines and phased Care Group implementation. In summary, Quarter 4 demonstrates continued progress and active management of key workforce priorities. However, the combined impact of sustained workforce pressure, high sickness absence, pipeline risks and organisational capacity constraints means that full assurance has not yet been achieved, the gap to the target risk score remains, and the risk score has therefore been appropriately maintained this quarter.

BAF 3: Inability to Improve Workforce Sustainability & Organisational Culture

Key Controls Framework

Care Group (n=16)

- Apprenticeship targets in place and uptake against plan monitored
- Care Group Workforce Assurance Groups in place held monthly (and Divisional for EFP)
- 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
- 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. Mitigate risks of redundancy where possible.
- Cardiothoracic and Heart Centre Management Culture Review transitioning to Culture Improvement Oversight Group
- 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
- National Education Training Survey action plan in place with the aim of delivering a better learner and trainer experience
- Operational escalation plans in place, including for periods of Critical Incident and/or Industrial Action
- 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.
- 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
- Workforce plans in place and budgets transacted accordingly, including Cost Improvement Plans (CIP) delivery

Corporate (n=36)

- 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.
- BI and Workforce Information tracking and analysis of workforce data and demographics
- Care Group Performance and Risk Review meetings in place held bi-monthly
- 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; *subject to ICB/System changes in Q4.*
- Establishment Workforce Plan in place for 2025/26 and produced for 2026/27.
- Established Banks (workforce) in place – including Nursing, Medics, Admin & Clerical, and other groups
- 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
- 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
- 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 (and down) at the appropriate times in the year.
- Oversight and scrutiny of vacancy controls, including bank and agency usage - as part of system and local financial recovery
- Organisational culture and staff engagement improvement plans in place
- Pastoral model of support for colleagues going through HR/Employee relations processes
- 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
- People (HR) policies and procedures in place and reviewed in accordance with policy review governance.
- People Strategic Plan
- Strategic Workforce Executive Group meetings held quarterly
- Senior Leadership development programmes in place; with focus on supporting the leaders in the new care groups
- 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
- 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
- Values refreshed and launched in August 2025 alongside refreshed Behavioural Framework
- Violence and aggression reduction campaign ongoing (ref the seven point action plan)
- 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
- 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.

Assurances Received and Rated – All Quarters

Assurance Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Allied Health Professional Workforce Establishment Review				☒		☒						
Bi-Monthly Nursing & Midwifery Staffing Report								☒				
Chief Healthcare Scientist Update		☒										☒
Chief People Officer Report						☒				☒		
Chief Pharmacist Workforce Report						☒		☒				
Employee Relations Casework Trends (formerly Formal Case Activity Report)						☒						
Equality, Diversity & Inclusion Annual Report												
Equity and Inclusion Assurance Tool												
Gender Pay Gap Report												
Guardian of Safe Working Report		Q3		Q4		Q1		Q2 | NR		☒		Q3
Health & Wellbeing Report												
Insightful Provider Board												
Learning and Education Annual Report						☒						
Maternity & Neonatal Workforce Report								NR - 26/11				
Postgraduate Medical Education Report												
Resident Doctors 10 Point Plan						NR						
Results of Annual Staff Survey Report												
Sexual Safety Update												
Speaking Up Report				Q3 / Q4				Q1 & Q2				
Statutory & Mandatory Training Review												
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

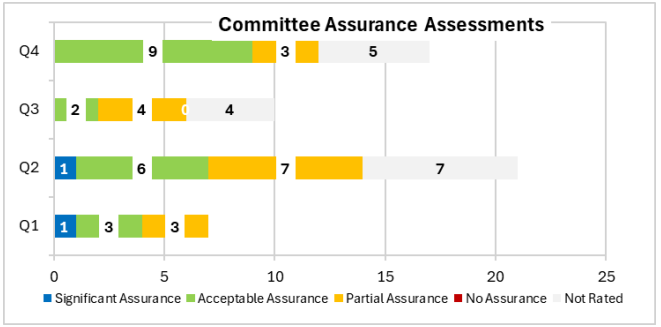
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

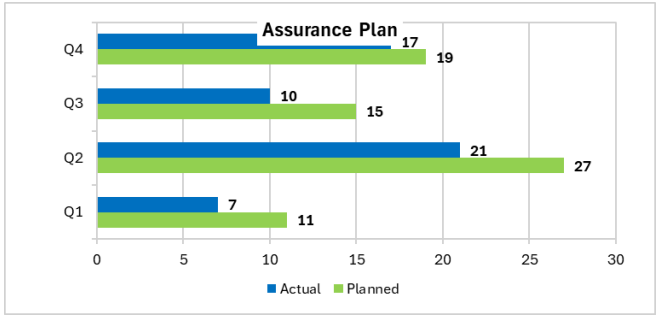
BAF 3: Inability to Improve Workforce Sustainability & Organisational Culture

Executive Assurance Assessment

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

Committee Assurance Assessment & Plan





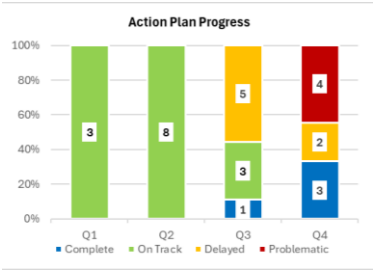
Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=3)

- 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, these (or an equivalent) were to be 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=8)

- Employment Relations caseload pressures remain high, with increasing volume and complexity of sexual safety and information governance-related cases (Action 6)
- Job Planning (for Medical Consultants) performance is not compliant with NHSE targets. Continued delays to job planning and policy review. (Action 5)
- Ongoing organisational change and structural redesign continues to generate staff uncertainty, impacting engagement, wellbeing and capacity for change (Action 1)
- Impact on the workforce of financial pressures (Trust and System), including CIP targets (pay and non-pay costs) (Action 4)
- Low response rates to the January Staff Voice Survey reduce the strength of engagement intelligence and triangulated assurance (Action 8).
- 2025 NHS National Staff Survey (NSS) – Results published in Q4 and robust action plans needed for FY26/27 (Action 8).
- Workforce capacity pressures across line management, People Operations and workforce information teams constrain delivery and oversight (Action 6)
- 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. Unsustainable demand linked to FOIs and workforce SARs. Regularly non-compliant with ICO guidelines re timescales. (Action 6)



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~~ 30/06/2026	Following a partial pause to the organisation structure redesign programme during winter pressures, work recommenced in Q4 on Phase 4, supported by Deloitte. Co-design workshops were held with Care Group Heads of Operations and Directorate Managers to develop 'as-is' and 'to-be' models. Progress has been slower than anticipated due to variation in current arrangements and challenges in achieving stakeholder consensus. Key design principles and the associated CIP opportunity are scheduled to be finalised in April 2026.	N/A			
2	To reinstate Care Group Workforce Assurance Groups	~~31/12/2025~~ ~~31/03/2026~~ 30/06/2026	Initial steps were taken by December 2025 to reinstate Care Group Workforce Assurance Groups, or equivalent arrangements; however, implementation during Q4 has been inconsistent across Care Groups. In the interim, workforce assurance continues to be monitored through Care Group performance reviews, the Strategic Workforce Group and the People, Culture & Inclusion Committee. The Chief People Officer will re-clarify the required model and expectations in Q1 2026/27 to support consistent implementation and embedding.	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	Payments relating to the AfC Band 2 to 3 Healthcare Assistant back-pay have been completed, including settlement for ex-employees and an additional cohort of Critical Care staff identified outside the original exercise. Outstanding appeals were reviewed during Q4 and payments made where upheld. Final outcome letters are being issued w/c 13 April 2026, at which point this action will be closed, subject to any subsequent legal claims.	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~~ 30/06/2026	During Q4, work with Finance enabled mitigation of the FY25/26 pay-related CIP pressures, where possible, through non-pay and some non-recurrent measures. While this has reduced immediate workforce impact, there remains no funding available for redundancy or transition costs, and concerns persist regarding potential impact in FY26/27. The use of fixed-term appointments in some staff groups has provided short-term flexibility but continues to contribute to workforce uncertainty. As a result, while in-year mitigation has been achieved, longer-term workforce impact remains a live risk.	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~~ 30/06/2026	The review of the Consultant Job Planning policy remains overdue. An external review was presented to the Executive Team in Q3, and the recommendation to undertake a full policy overhaul has been accepted. Progress was paused while additional data analysis was undertaken and further delay occurred in Q4, resulting in slippage to the planned policy review and the launch of the annual job planning cycle, now scheduled for April 2026. As a result, assurance against national job planning expectations and NHSE sign-off requirements remains constrained pending completion and implementation of the revised policy.	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~~ 30/06/2026	Due to competing demands and limited capacity during Q4, a business case to address resourcing and capability gaps in managing workforce-related DSARs has not yet been developed. Updated analysis undertaken during the quarter confirms a significant increase in both volume and complexity of requests, with volumes having more than tripled year-on-year. Interim mitigations are being explored, including testing the outsourcing of elements of the process; however, the Trust remains unable to consistently meet ICO timescales for complex cases. The issue spans People Operations, Digital Services and Legal Services, and discussions between the Chief People Officer and Chief Digital Officer are ongoing. The production of the business case has therefore been deferred to Q1 2026/27.	N/A			
7	Education, Training and Development Accountability Framework to be launched	~~31/12/2025~~ ~~31/03/2026~~ 30/06/2026	The launch of the Education, Training and Development Accountability Framework was delayed due to the national postponement of the NHS Management and Leadership Development (MALD) framework. National launch is now expected in April 2026. Local rollout of associated self-assessment tools and resources is planned during Q1 2026/27, following which Trust leadership development expectations and programme content will be reviewed and aligned. As a result, assurance from this framework is not yet fully realised.	N/A			
8	Detailed engagement and response data from the 2025 National Staff Survey to be received, analysed and triangulated with other engagement intelligence.	31/03/2026	Detailed analysis of the 2025 National Staff Survey results has been completed following publication on 12 March 2026. Findings have been communicated and presented across the Trust, and Care Groups and Divisions have commenced development of their 2026/27 engagement action plans. This action is now complete, with ongoing delivery and monitoring captured	N/A	N/A		

BAF 4: Inability to Deliver Digitally Enabled Care Transformation

Finance and Business Performance Committee | Chief Digital Information Officer

Risk Description

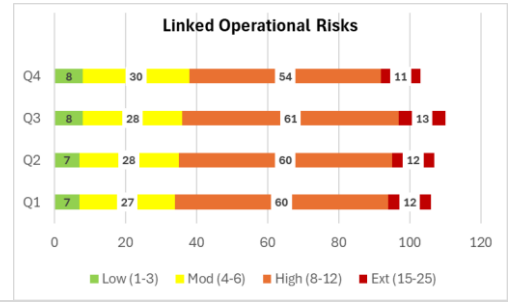
Cause:	If we are unable to deliver digitally enabled care transformation due to ongoing limitations in digital infrastructure, workforce capability, system interoperability, and financial constraints,
Event:	Then our capacity to innovate, modernise services and improve patient safety, care quality, and 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	4	2	31/03/2026	Minimal 1 – 4
Consequence	4	4	4	4	4		Risk Tolerance
Risk Score	16	16	16	16	8		Mod 5 – High 9



Overview – Summary of Key Q4 Changes

At Quarter 4, the risk remains Extreme at a score of 16 and has not reduced to the target score of 8 by March 2026. This reflects the persistence of material cyber, infrastructure and system-resilience risks, notwithstanding progress in priority digital transformation programmes. During Quarter 4, continued progress was made in advancing digitally enabled care, providing moderate assurance that key programmes are moving forward. Notable achievements included completion of the first phase of the Electronic Prescribing and Medicines Administration (EPMA) programme, representing a significant milestone in improving medicines safety, standardisation and clinical assurance. The Trust also progressed its Ambient Voice Technology (AVT) programme, with positive pilot performance, strong clinical engagement and completion of the regional procurement, enabling a planned transition from pilot to sustainable deployment. Work continued to pursue opportunities arising from the NHS England Frontline Productivity Programme; however, associated benefits remain prospective and not yet realised. Notwithstanding this progress, the residual risk remains unchanged. During the quarter, an active cyber security incident affecting medical devices and communication systems reinforced the Trust's exposure arising from legacy infrastructure, complex device estates and third-party dependencies. Ongoing incidents and performance issues with Careflow continued to impact operational reliability and clinical confidence, highlighting wider challenges relating to digital service resilience and vendor performance management. In addition, while an independent review of clinical systems was commissioned to provide objective assurance on safety, usability and fitness for purpose, the outcomes are not yet available and therefore cannot be reflected in the current risk score.

The linked operational risk profile reinforces this position and highlights cyber security exposure and technical obsolescence, including unsupported or end-of-life devices, software patching gaps, weaknesses in privileged access controls and reduced monitoring capability. Further linked risks relate to digital service resilience and availability, including network and clinical system outages, limited out-of-hours support and dependencies on critical infrastructure such as data centres and estates systems. Fragmented systems and limited interoperability continue to reduce visibility of the full patient record, drive manual workarounds and increase the risk of duplication or missed information. Additional risks relating to digital clinical safety and regulatory compliance, capacity and specialist skill constraints, and immature processes and fit-for-purpose tooling further constrain the Trust's ability to digitise pathways safely and at pace. Executive assurance for this risk therefore remains Partial. Three gaps in control and one gap in assurance were removed following completion of actions in Quarter 3. During Quarter 4, six actions were completed, strengthening key aspects of digital governance, delivery and oversight. However, the remaining three actions have been delayed, primarily due to dependencies on Care Group engagement, specialist IM&T capacity constraints, and the need to prioritise service stabilisation while responding to live cyber and system incidents. In summary, Quarter 4 demonstrates strengthened delivery momentum and improved strategic alignment, alongside tangible progress in digital capability. However, the persistence of cyber risk, system instability and ageing digital infrastructure means that sufficient assurance is not yet in place to support a reduction in the risk score, and the risk has therefore appropriately remained at Extreme 16 this quarter.

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=19)	• 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 • Digital Strategic Plan in place • Freedom of Information improvement plan developed • Frontline digitalisation investment approved • Independent review of clinical systems by Ethical Healthcare • 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

Assurances Received and Rated – All Quarters

Assurance Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Cyber Assessment Framework Follow Up Internal Audit												
Cyber Security Assurance Report												
Digital Services – Electronic Patient Record (EPR) Update												
Digital Services - IT Standards Update												
Digital, Data and Governance Group Highlight Report												
Internal Audit Report: Follow Up: IT Systems Managed by Operational Areas												
Internal Audit Report: Follow Up: Transformational and Major Change Project Management												
Transformation & Major Change Project Management & IT Systems Managed by Operational Areas (Shadow IT) Follow Up Internal Audit												

Assurance Rating Key

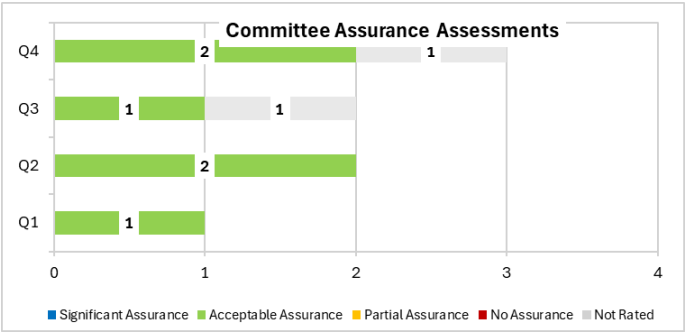
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

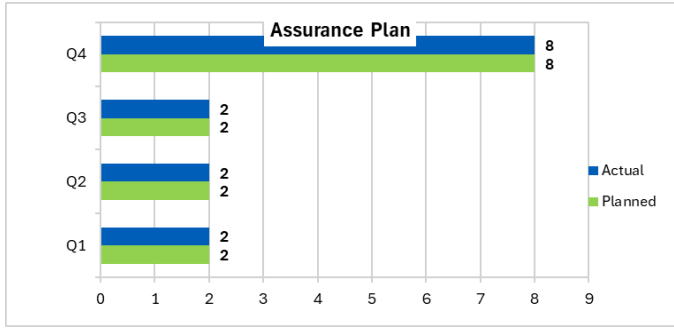
BAF 4: Inability to Deliver Digitally Enabled Care Transformation

Executive Assurance Assessment

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

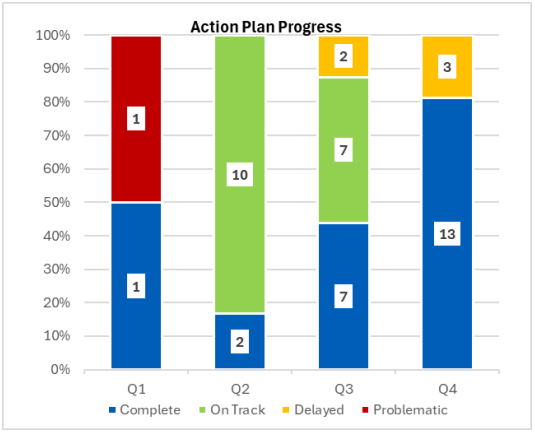
Committee Assurance Assessment & Plan





Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=6)	• Digital solutions are not consistently integrated (action 1) • Digital skills training insufficient for the wider workforce (action 3) • Incomplete or out of date Information Asset Ownership (action 8) • Review and upgrading of all 405 solutions not in place (action 2) • Shadow IT not operated in line with NHS standards (action 1) • Supply chain assessment for the procurement of services which are enabled by digital systems are not in place. (action 7)
Gaps in Assurance (n=3)	• Clinical Safety Assurance Reports not in place for all systems (action 4) • Benefits Realisation where the benefits sit outside of Digital Services (action 9) • Data Protection Impact Assessment (DPIAs) not in place for all systems (action 5)



Risk Management Action Plan

No	Action	Due Date	Progress Report	2025/26 Q1	Q2	Q3	Q4
1	Communications regarding the digital need process to reduce Shadow IT to be improved	~~30/10/2025~~ 31/03/2026	Communications to reduce Shadow IT have been strengthened. The Digital Request process is now clearly published on the Trust intranet and has been included in Trust-wide communications. Digital Business Relationship Managers have reinforced the process within Care Groups where these roles are in place, improving awareness and consistency. While the control is now established, further assurance is required to demonstrate consistent adoption and a reduction in Shadow IT behaviour across the Trust.	N/A			
2	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	A systems supplier register is now in place and structured by Care Group to support improved lifecycle management. The register is being progressively enriched with contract end dates and migration timescales; however, access to complete and consistent contract data remains challenging. Work is ongoing in collaboration with Procurement colleagues to validate and complete contract information and strengthen forward planning.	N/A			
3	Review modern training tools to enable enhanced training for the wider workforce	~~01/02/2026~~ 30/06/2026	This action has been temporarily deprioritised due to limited capacity within the training team and competing operational priorities. However, the recent launch of the NHS England Frontline Productivity Programme presents a new opportunity to accelerate progress. A specific funding category focused on Usability – Training and Digital Adoption, including the implementation of a modern Digital Adoption Platform (DAP), is being actively explored to support enhanced training and workforce adoption at scale.	N/A			
4	Work with Care Groups on getting their solutions clinically safety assessed	~~31/03/2026~~ 2026/27	Care Groups have been provided with their Information Asset Registers and a Trust-wide review has identified which systems require Clinical Safety Assurance and where gaps exist. The current position remains a significant concern, with only 9 of 352 systems having the required assurance in place. This position is now under active monitoring; however, progress is constrained by limited capacity within the Digital Business Relationship Manager function, impacting the pace at which Care Groups can be supported to address non-compliance.	N/A			
5	Introduce new governance structure holding Care Groups to account for Shadow IT, which does not meet NHS digital standards	31/03/2026	A new governance structure is now in place to hold Care Groups to account for locally managed digital solutions that do not meet NHS digital standards. Digital Business Relationship Managers attend Care Group governance meetings where these are in place, providing oversight and challenge. Digital standards have been finalised, signed off, and shared with Information Asset Owners and Care Group leads. Ongoing monitoring will take place through Care Group governance; however, progress is constrained by the limited number of Digital Business Relationship Managers available to support all Care Groups consistently.	N/A			
6	Establish a process for formal incident management process for digital clinical safety issues	31/03/2026	A formal incident management process for digital clinical safety issues is now in place. All digital clinical safety incidents are required to be raised through Datix and categorised as Digital, enabling consistent reporting, visibility, and oversight of clinical safety risks associated with digital systems.	N/A	N/A		
7	Work with Procurement colleagues on supply chain risk for service contracts.	~~01/04/2026~~ 30/06/2026	This action has not yet commenced as planned due to planned sickness absence. Work with Procurement colleagues to assess and strengthen supply chain risk for digital service contracts is to be initiated and prioritised within the next phase of delivery.	N/A	N/A		
8	Mandate Annual Information Asset Register Review as part of the annual cycle of business	01/04/2026	The Annual Information Asset Register (IAR) review has been formally embedded into the Trust's annual cycle of business for Digital Business Relationship Managers and Information Governance and is undertaken each March. This provides assurance that Information Asset Owners are correctly assigned and that no systems are omitted. This activity is now a formal component of the Trust's cyber assurance framework, which is a statutory requirement. Delivery is impacted by the limited number of Digital Business Relationship Managers, however all reasonable steps are being taken to maintain coverage and compliance.	N/A	N/A		
9	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	The requirement to assign named benefit owners and embed benefits realisation within the project lifecycle is now a standard part of the Trust's digital business case template. This approach can be evidenced in recent and emerging business cases, including Ambient Voice Technology (AVT) and Emergency Communications systems, where benefits ownership and realisation plans are clearly defined and tracked.	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

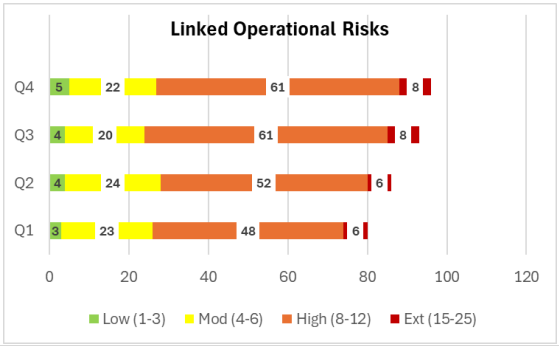
Cause:	If we are unable to secure sufficient investment to develop and modernise our estate infrastructure and workforce,
Event:	Then we may be unable to deliver high quality, responsive services in a safe, compliant, and sustainable environment,
Effect:	Resulting in non-compliance with national standards, 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



Overview – Summary of Key Q4 Changes

At Quarter 4, the risk remains stable at a score of 12, within risk tolerance, and has not reduced further. This reflects continued delivery progress balanced against ongoing national capital constraints, workforce pressures and emerging regulatory requirements, which together limit confidence in reducing the risk score at this stage. During Quarter 4, progress continued in advancing major capital schemes and strengthening the Trust's strategic and regulatory readiness. In response to the Building Safety Act 2022, the Trust clarified and strengthened governance arrangements for Higher Risk Buildings at Royal Stoke University Hospital. Agreement was reached with the PFI partner on a joint interpretation of the Act, with contractual alignment confirming the Trust's role as Client for works within PFI Higher Risk Buildings. This represents a material improvement in accountability and regulatory clarity; however, the introduction of additional statutory processes and extended regulatory timescales means that risk exposure associated with higher-risk estate cannot yet be reduced. Progress was also made in sustainability and climate resilience, including completion of multi-year feasibility work and approval to expand the Keep Warm, Keep Well energy scheme. Workforce mitigations continued through targeted recruitment, apprenticeships and seasonal over-recruitment; however, recruitment and retention challenges persist across key staff groups, particularly where estate condition and clinical environment constraints affect staff experience and productivity.

Executive assurance for this risk remains Acceptable. The linked operational risk profile reinforces this position, demonstrating a concentration of risks that are dependent on timely and sufficient investment in estate infrastructure and enabling workforce capacity. Key themes include identified fire safety and compartmentation gaps, which are subject to ongoing Fire Risk Assessments and associated management actions, alongside known shortfalls in aspects of clinical environments, including ventilation, isolation capacity and decontamination provision in specific areas. In relation to ventilation within the Emergency Department, interim urgent works were undertaken during the COVID response period, and subsequent limitations have been identified through structured review and are being addressed through feasibility and option appraisal work currently being progressed with the Capital team. Although these factors contribute to greater operational complexity and place stress on certain areas of the estate, they are addressed and supervised by relevant committees, with mitigation efforts and planned investments being prioritised as they become available, rather than posing unmanaged service risks. Additional linked risks highlight dependencies on the resilience of security and access control systems, digital and building management infrastructure, and financial exposure where delivery remains contingent on capital allocations, programme delivery capacity and external approvals, including land sale receipts. Collectively, these risks also impact workforce wellbeing and productivity and influence the Trust's ability to recruit and retain key staff groups. During Quarter 4, two actions were closed. However, remaining actions have been delayed, primarily due to national capital funding constraints, the additional governance and statutory requirements arising from the Building Safety Act, and dependencies on external approvals and partner organisations, which extend delivery timescales beyond the Trust's direct control. In summary, Quarter 4 demonstrates tangible progress in strengthening governance, regulatory readiness and sustainability planning. However, the cumulative impact of estate backlog pressures, capital constraints and newly introduced regulatory requirements means the conditions necessary to safely reduce the risk score have not yet been achieved. The focus for 2026/27 will therefore be on embedding these governance arrangements, prioritising statutory compliance and strengthening long term estate resilience to provide a more secure platform for future risk reduction.

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=12)	• Building Safety Act compliance arrangements are in place for Higher Risk Buildings at Royal Stoke, with a jointly agreed approach and contractual alignment with the PFI partner; the Trust acts as *Client* under the Act, with defined governance and oversight for design, construction and occupation in scope buildings. • 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 • Heat Network Optimisation Business Case • Low Carbon Care Framework • 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 and cluster-wide projects, grant funding applications, networking and best practice sharing, attendance at ICS and Midlands Greener Delivery Groups.

Assurances Received and Rated – All Quarters

Assurance Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Fire Safety Annual Report												
PFI 6 Monthly Exception 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

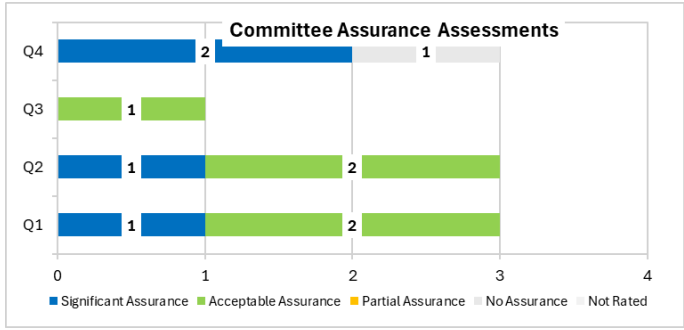
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

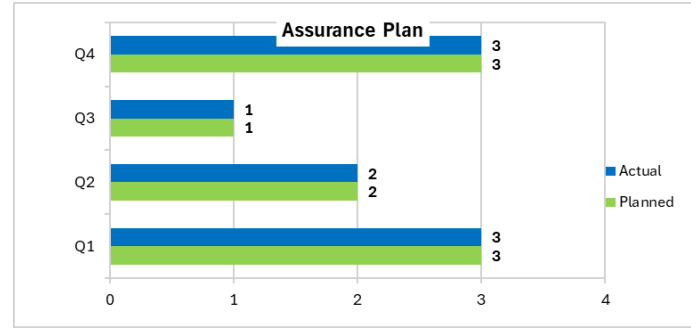
BAF 5: Inability to Deliver Investment in Estate Infrastructure & Workforce

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





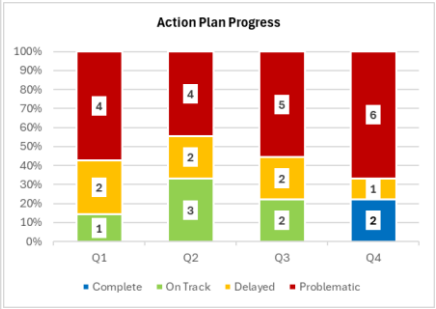
Gaps to be Addressed and Links to Action Plan

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 4)
- 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)



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	The Capital Team continues to work with Finance and NHS England to provide estates backlog data and identify potential funding sources. Previous rounds of NHS England Estates Safety Risk funding have secured additional investment to address immediate high-risk backlog items. However, the overall estates backlog remains high, with annual capital allocations not keeping pace with the growth of medium- and high-risk backlog across Royal Stoke and County sites, continuing to pose a risk to service continuity.				
2	Estates strategic plan	~~30/06/2025~~ ~~30/12/2025~~ ~~02/02/2026~~ 01/06/2026	An Estates & Facilities Strategic Plan has been produced and refreshed for alignment with other Trust strategic plans, and was considered by the Finance & Business Performance Committee in February 2026. Further update of the existing 2020–2025 Estates Strategy remains in progress, with completion constrained by competing operational pressures. Finalisation of the strategy is dependent on the outcome of the Trust's rightsizing work, which is required to inform future feasibility studies, costings and deliverability of planned developments.				
3	Supply chain partners	~~31/03/2025~~ 30/06/2026	The Capital Team continues to work with NHS England in accordance with national framework agreements for major building contracts, with contractor quality and performance monitored on a monthly basis and reported as required. Controls are in place for delivery oversight across the Trust's major capital schemes. However, capacity constraints within the supplier market continue to present risks in relation to performance, cost and service continuity, which are actively monitored through Estates and Facilities governance arrangements.				
4	Sustainability/net zero carbon	~~31/03/2025~~ ~~31/07/2025~~ ~~30/01/2026~~ ~~31/03/2026~~ 31/03/2027	Progress has been made across the Trust's sustainability and energy programmes. Feasibility work to support multi-year energy and sustainability schemes has been completed, improving preparedness for internal capital planning and future external grant funding opportunities. Approval has been granted to expand the Keep Warm, Keep Well community energy scheme, with contractual arrangements progressing. A report on the impact of climate change on the Trust estate and recommended adaptation and resilience actions has been submitted to Estates, Facilities and Property (EFP) governance and is progressing to the Executive Team. While a bid to the DESNZ Heat Network Efficiency Scheme was unsuccessful, identified works are planned to be funded through Trust capital in 2026/27 and 2027/28. Due diligence on Royal Stoke's connectivity to the proposed Stoke-on-Trent District Energy Network is underway; however, progress has been delayed due to external commercial issues, with the associated business case now expected later in 2026.				
5	Workforce	~~27/12/2024~~ ~~31/01/2025~~ ~~30/07/2025~~ ~~30/03/2026~~ 30/03/2027	Pay rates for Building and Engineering staff continue to be reviewed against the private sector, alongside ongoing work to minimise recruitment timelines and strengthen succession planning through enhanced training and education provision. Two new engineering apprentices have been successfully recruited and are now in post. Within Soft FM, approval has been granted for managed over-recruitment ahead of winter to support increased workload and service resilience, alongside the controlled use of agency staff as an interim measure while vacancies in Domestic and Catering services are addressed. Despite these mitigations, workforce capacity and market competitiveness remain ongoing risks requiring continued management.				
6	PFI partners / lender issues	~~30/08/2024~~ ~~31/03/2025~~ ~~31/07/2025~~ ~~30/03/2026~~ 31/09/2026	Remedial works to address PFI latent defect issues remain ongoing. Progress has been impacted by additional regulatory requirements arising from the Building Safety Act, which have introduced revised statutory processes and timescales for works within Higher Risk Buildings. These matters continue to be managed through established Estates, Capital and PFI governance arrangements.				
7	Building safety act	~~31/10/2025~~ ~~31/03/2026~~ 31/06/2026	In line with the Building Safety Act regulatory requirements for major projects at Royal Stoke, contractual agreement has been reached with the PFI partner confirming the Trust's role as Client for Trust-instructed and Trust-funded works within Higher Risk Buildings. Revised procedures are now in place, with the Capital Team responsible for design assurance, construction oversight and safe occupation processes. While these arrangements strengthen governance and accountability, statutory Building Safety Regulator processes introduce mandatory approval stages and timescales that constrain delivery. As a result, major projects are unlikely to be completed within a single financial year, impacting programme sequencing and limiting the scope for short-term risk reduction.				
8	Review impact of climate change	31/03/2026	Incorporated into action 4.	N/A			
9	To include quarterly updates on the Estates Strategy to the FBP	31/03/2026	Incorporated into action 2.	N/A			

BAF 6: Inability to Deliver In-Year Financial Position

Finance and Business Performance Committee | Chief Finance Officer

Risk Description

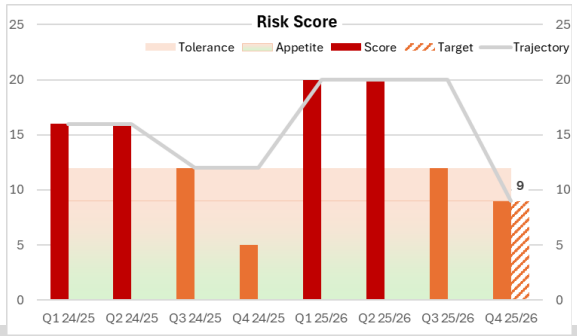
Cause:	If we, or system partners, are unable to manage within the financial assumptions underpinning the 2025/26 revenue plan,
Event:	Then we may be unable to deliver our agreed financial position for 2025/26,
Effect:	resulting in an increased level of external scrutiny and potential regulatory intervention, 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

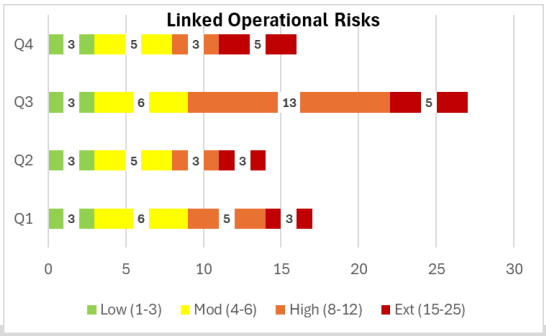
Potential to impact on Our Strategic Priorities

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





Overview – Summary of Key Q4 Changes

At Quarter 4, the risk has reduced to its target score of 9, achieving the target by March 2026. This reflects improved confidence in delivery of the agreed 2025/26 revenue plan, supported by strengthened financial grip and control, delivery of the in-year Cost Improvement Programme (CIP), and agreed system-level support and non-recurrent mitigations. Throughout Quarter 4, financial performance continued to be actively managed, with regular Executive and Finance & Business Performance Committee oversight of demand, activity, income and cost pressures. This reduced the likelihood of immediate regulatory escalation or loss of financial autonomy and provided sufficient assurance that the Trust can deliver its agreed in-year financial position. As a result, the risk score has appropriately reduced to the target level at year end.

The linked operational risk profile highlights the principal factors that have historically driven the risk of in-year financial deterioration, including failure to deliver planned savings, pay and non-pay cost pressures, income loss or leakage arising from activity and charging weaknesses, procurement and contract governance risks, and operational dependencies relating to assets, suppliers, stock and systems that could trigger unplanned costs or reduced income. During 2025/26, active mitigation of these issues through strengthened controls, system engagement and in-year management actions has reduced their immediate impact on delivery of the agreed financial plan. Executive assurance remains at acceptable for this risk, with no changes to gaps in control or assurance in Quarter 4. Both actions associated with this risk were completed as planned, further strengthening assurance over in-year financial delivery. In summary, Quarter 4 reflects delivery of the planned financial position, effective in-year financial control and closure of outstanding actions. While significant challenges remain in relation to financial sustainability beyond 2025/26, these risks are managed separately through BAF 7, and the achievement of the target risk score for in-year delivery is supported by sufficient assurance.

BAF 6: Inability to Deliver In-Year Financial Position

Key Controls Framework

Care Group (n=5)	• CIP meetings held • 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=11)	• 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 • Medium Term Plan submitted • 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

Assurances Received and Rated – All Quarters

Assurance Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Annual Accounts												
Audit Findings Report and Letter of Representation												
Business Case Review Schedule												
Cost Improvement Report												
Demand and Activity Performance Report		NR	☒	☒	☒	NR	NR	NR	NR			
Draft Financial Outlook												
Finance Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
Grip and Control: Medical Staff and Nursing Bank and Agency Controls Internal Audit												
Key Financial Controls Internal Audit												
Losses and Special Payments and Stock Write Offs												
Medicines Finance, Procurement and Supplies Report												
Overseas Visitors / Private Patient Policy Audit												
Procurement Report												☒
Productivity / Efficiency Performance Report		M1										☒
SFI Breaches relating to Procurement processes and Single Tender Waivers												
SFI Breaches relating to Salary Overpayments												

Assurance Rating Key

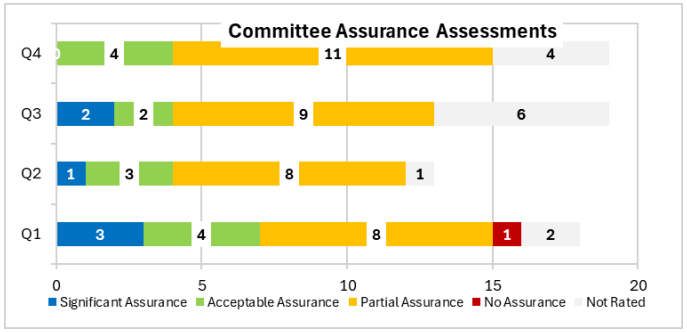
Blue	Significant
Green	Acceptable
Amber	Partial
Red	No Assurance
NR	Not Rated
☒	Not Received

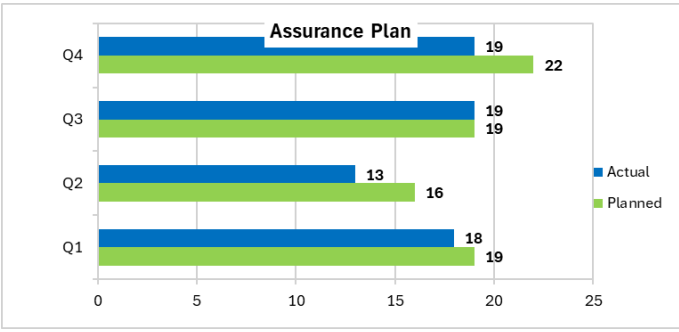
BAF 6: Inability to Deliver In-Year Financial Position

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

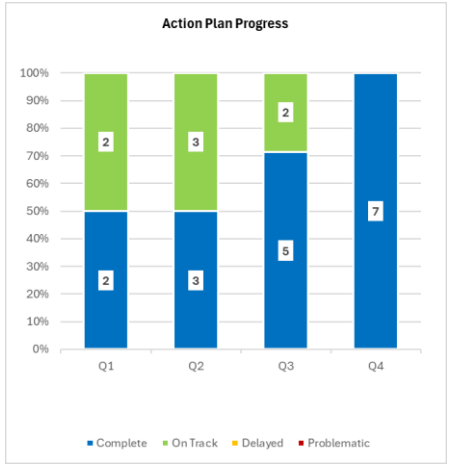
Committee Assurance Assessment & Plan





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 2)
Gaps in Assurance (n=1)	• Some CIP schemes to be worked up in detail (Action 1)



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	In-year Cost Improvement Programme (CIP) plans for 2025/26 have been identified and delivered as reflected in the Trust's forecast year-end financial position. Delivery of agreed schemes is embedded within the in-year financial position, with no reliance on additional new CIP schemes in Quarter 4. Financial performance and CIP delivery have been subject to sustained scrutiny through the Finance & Business Performance Committee, alongside strengthened grip and control measures, enabling the Trust to deliver its agreed 2025/26 revenue plan.				
2	Review of winter escalation areas to be undertaken	30/06/2026	A review of winter escalation areas was undertaken as part of post-winter performance and operational reporting. The Trust has stood down temporary winter escalation capacity in a controlled manner, with learning from winter schemes, tests of change and escalation areas reviewed through Finance & Business Performance Committee and Quality, Access & Outcomes Committee assurance processes. Ongoing impacts relating to activity, flow, productivity and affordability have been incorporated into forward planning, demand and activity reporting and 2026/27 operational and financial plans.	N/A	N/A		

BAF 7: Inability to Deliver Financial Sustainability

Finance and Business Performance Committee | Chief Finance Officer

Risk Description

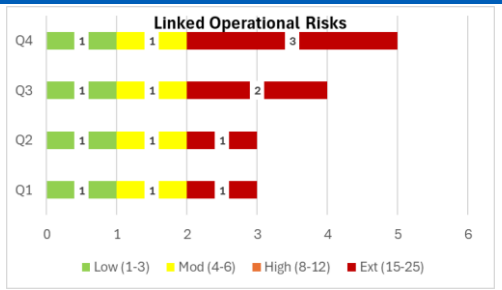
Cause:	If we are unable to manage within the assumptions made within the financial plan for 2025/26,
Event:	Then we will not reach a break-even position within the required timescales (currently 3 years),
Effect:	resulting in reduced availability of funding for essential investments, an increased level 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	5	3	31/03/2027	Cautious 1 – 9
Consequence	5	5	5	5	4		Risk Tolerance
Risk Score	20	20	25	25	12		High 10 - 12



Overview – Summary of Key Q4 Changes

At Quarter 4, the risk remains Extreme at a score of 25, and has not reduced towards the target risk score, continuing to represent the most significant strategic risk to the organisation. While the Trust is forecasting delivery of its agreed 2025/26 in-year financial position, this position remains reliant on non-recurrent measures, system-level support and challenging efficiency assumptions, and does not yet provide assurance of a sustainable return to break-even within the required three-year timeframe. Throughout Quarter 4, Finance & Business Performance Committee oversight continued to highlight the scale, pace and complexity of the financial recovery required. Material elements of future-year Cost Improvement Programmes (CIP) and productivity improvements remain under development, and delivery of the recovery trajectory is dependent on sustained system alignment, successful transformation, stabilisation of demand and improved productivity. Each of these remains subject to external, operational and workforce risk. As a result, the risk of increased regulatory scrutiny, constrained financial autonomy and reduced investment capacity remains active at year end.

The linked operational risk profile reinforces this assessment. The principal risks to financial sustainability continue to centre on the identification and delivery of recurrent savings (CIP) and income plans, underpinned by having sufficient workforce capacity and reliable, timely financial information. Failure to deliver future-year CIP schemes or the underlying efficiency assumptions would increase recurrent expenditure, weaken the Trust's financial position and further reduce flexibility to invest in clinically urgent and safety-critical priorities. In addition, persistent operational constraints, including bed capacity, elective utilisation and workforce availability, continue to limit elective throughput and associated income contribution. Gaps in financial system responsiveness and usability, including dependencies on System C, also constrain timely oversight and effective decision-making. Executive assurance for this risk remains Partial. One gap in assurance has been removed following completion of an action in Quarter 3. During Quarter 4, two further actions were completed. The remaining three actions remain on track, two of which were newly identified in Quarter 4 to address emerging risks and strengthen future-year planning and delivery arrangements. In summary, while in-year financial control has strengthened and actions continue to progress, these improvements have not yet translated into sufficient confidence in recurrent financial sustainability. The risk therefore remains Extreme, reflecting the requirement for sustained delivery of recurrent savings, workforce productivity improvements and system-wide transformation over multiple years before a reduction towards the target risk score can be credibly supported.

BAF 7: Inability to Deliver Financial Sustainability

Key Controls Framework

Care Group (n=4)	• Care Group attendance at Financial Improvement Oversight Group (monthly) • Executive Team controls in place to approve 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=6)	• Deloitte working with the Trust on identifying specific workstreams for improvement including a revision to the financial governance process • Executive Financial Improvement Oversight 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 • Medium Term Plan submitted • 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

Assurances Received and Rated – All Quarters

Assurance Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Annual Accounts												
Audit Findings Report and Letter of Representation												
Business Case Review Schedule												
Cost Improvement Report												
Demand and Activity Performance Report		NR	☒	☒	☒	NR	NR	NR	NR			
Draft Financial Outlook												
Finance Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
Grip and Control: Medical Staff and Nursing Bank and Agency Controls Internal Audit												
Key Financial Controls Internal Audit												
Medicines Finance, Procurement and Supplies Report												
Overseas Visitors / Private Patient Policy Audit												
Procurement Report												☒
Productivity / Efficiency Performance Report		M1										☒

Assurance Rating Key

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

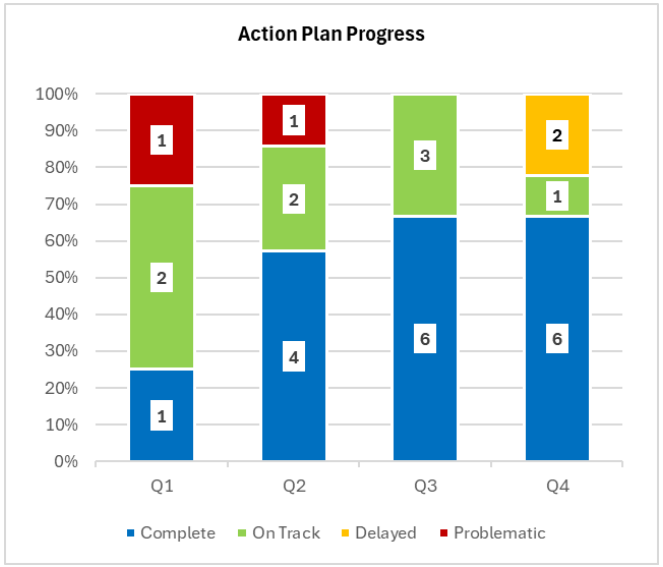
BAF 7: Inability to Deliver Financial Sustainability

Executive Assurance Assessment

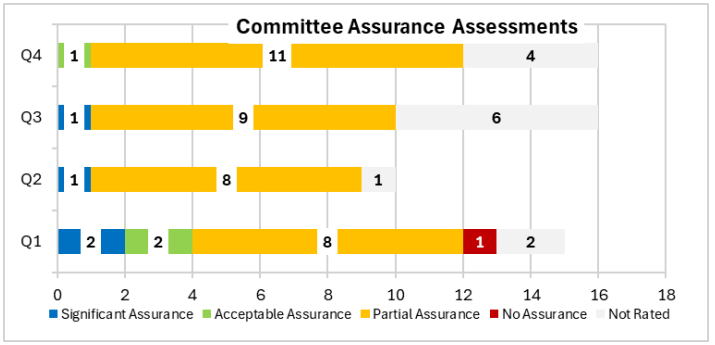
Significant	High level of confidence in delivery of existing mechanisms / objectives
Acceptable	General confidence in delivery of existing mechanisms / objectives
Partial	Some confidence in delivery of existing mechanisms / objectives, some areas of concern
None	No confidence in delivery

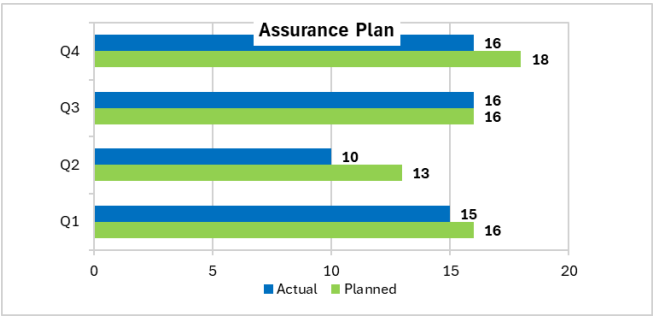
Gaps to be Addressed and Links to Action Plan

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 2) • Unclear on Trusts ability to access support for costs of potential redundancy may undermine CIP delivery in year (action 2)
Gaps in Assurance (n=0)	



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~~ 2026/2027	Work to identify and deliver recurrent Cost Improvement Programme (CIP) schemes continues as part of the Trust's medium-term financial recovery planning. Finance & Business Performance Committee papers from January to March 2026 highlight the scale of the recurrent efficiency challenge for 2026/27 and beyond, with strengthened governance now in place through revised CIP oversight arrangements, programme-based delivery and enhanced scrutiny of scheme readiness, deliverability and phasing. While recurrent opportunities have been identified across productivity, service line management and transformation programmes, material elements of the recurrent CIP programme remain under development and subject to further validation and system negotiation.				
2	To continue to work on the medium-term plan submission, including agreeing the associated contractual position	~~01/04/2026~~ 30/06/2026	Whilst the medium-term plan has been submitted, work remains ongoing with system partners to agree the associated contractual position. Finance & Business Performance Committee discussions from January to March 2026 highlighted the complexity and interdependencies within the medium-term plan, including activity assumptions, Cost Improvement Programme delivery and the impact of commissioning and contracting arrangements. The Trust continues to refine its financial and operational assumptions through system negotiation and Executive oversight to support submission of a credible and compliant plan.	N/A	N/A		
3	Work required on the long-term plan and the left shift, in order to reduce the cost base sustainably	2026/27	Work continues on the long-term plan and delivery of the Trust's strategic shifts, including the left shift from acute to community-based care, to reduce the cost base sustainably. Finance & Business Performance Committee discussions from January to March 2026 highlight the critical dependency on large-scale service transformation, productivity improvement and demand management to achieve recurrent cost reduction. These changes are being progressed through strategic programmes, medium-term planning and system collaboration; however, benefits are expected to accrue over the medium to long term and remain subject to delivery, capacity and system-level dependencies.	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

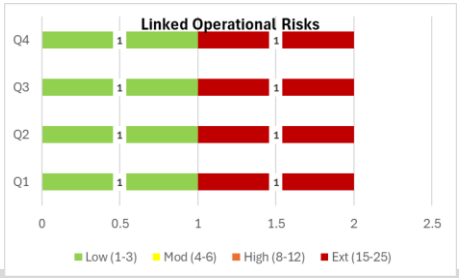
Cause:	If we are unable to deliver a comprehensive, ambitious and financially sustainable programme of research and innovation, and a culture that supports both,
Event:	Then our ability to provide high-quality, cutting-edge care will be compromised,
Effect:	resulting in a diminished reputation as a leading 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	3	2	31/03/2026	Open 1 - 12
Consequence	4	4	4	4	4		Risk Tolerance
Risk Score	12	12	12	12	8		Ext 15 - 16



Overview – Summary of Key Q4 Changes

At Quarter 4, the risk remains unchanged and above the target risk score, and has not reduced to target, reflecting the early stage of implementation of strengthened governance arrangements and the need to demonstrate sustained compliance and delivery before further assurance can be reported. During Quarter 4, governance arrangements for Research and Innovation were strengthened through the reconstitution of the Executive Research & Innovation Group, addressing a previously identified governance gap. The initial meeting focused on confirming scope, membership and oversight arrangements, with future meetings expected to provide clearer evidence of delivery and enable more informed consideration of future risk score movement. In addition, the Strategic Plans for Research and Innovation were approved, providing a clearer strategic framework. Further work is planned in Quarter 1 2026/27 to translate these plans into defined outputs and performance measures to support routine monitoring and assurance. During the quarter, an MHRA inspection identified a critical finding relating to the management and escalation of participant safety alerts. Actions are underway to strengthen controls, including improved use of clinical alerts to identify research participants and a review of pharmacy standard operating procedures. Leadership and capacity have also been strengthened through the appointment of a Deputy Director of Research & Innovation, with further work planned to confirm independent chairing arrangements and review the remit of the Research Strategy Oversight Forum, to provide clearer accountability and assurance.

The linked operational risk profile reinforces this assessment and highlights two interconnected vulnerabilities: the need to maintain robust regulatory compliance through an effective quality management system, and the requirement to scale research support infrastructure, including CeNREE, to meet rising demand. If not adequately addressed, these risks could result in non-compliance with GCP and MHRA requirements, regulatory enforcement action, financial loss and patient safety concerns. Constrained research support capacity also limits the Trust's ability to deliver against its Research & Innovation, Quality and People strategies, with potential adverse impact on the Trust's reputation as a research-active teaching hospital and its ability to attract and retain high-calibre clinical and academic staff. Executive assurance for this risk therefore remains Partial. Completion of actions in Quarter 3 enabled the removal of one gap in control and two gaps in assurance. During Quarter 4, three further actions were completed. However, two actions remain delayed, primarily due to dependencies on capacity within specialist support functions and the need to align local implementation with revised national guidance and inspection expectations. The remaining two actions remain on track, with delivery continuing into early 2026/27. In summary, Quarter 4 demonstrates meaningful progress in strengthening governance, leadership capacity and strategic direction for Research and Innovation. However, the early stage of implementation, outstanding MHRA-related actions and the requirement to evidence sustained regulatory compliance and delivery mean that sufficient assurance is not yet in place to support a reduction in the risk score at this stage. Continued Executive oversight is therefore required to ensure that improvements translate into demonstrable and sustained assurance.

BAF 8: Inability to Sustain Research and Innovation Excellence

Key Controls Framework

Care Group (n=6)	• Clinical Research Matron in post • CRDC rooms released to R&I so that they can now be furnished and opened as the CRDC • CeNREE Senior Health Researcher and Academic Development Officer recruited to on a substantive basis • 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 and Finance and Business Performance Committee • 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 and meetings being held • 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.

Assurances Received and Rated – All Quarters

Assurance Source	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
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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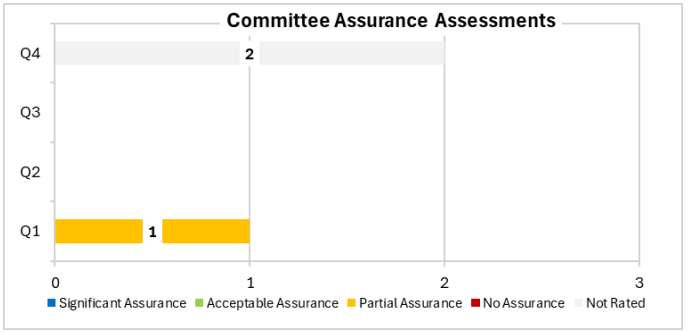
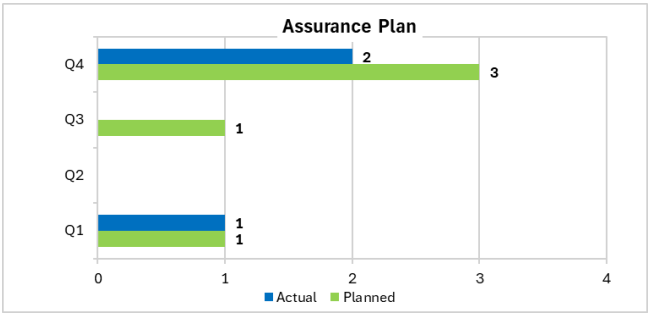
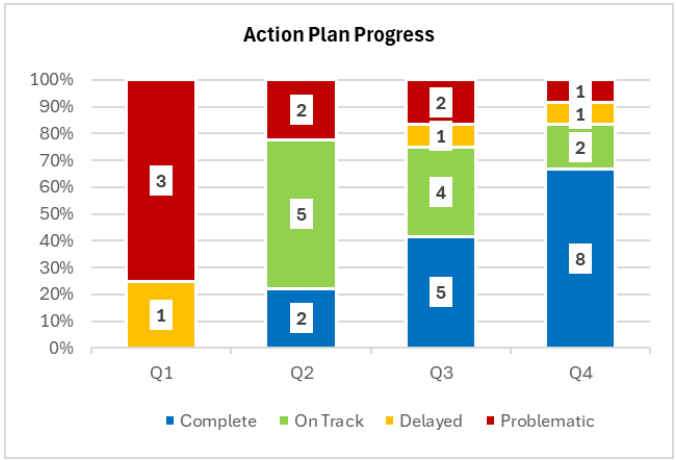
Committee Assurance Assessment & Plan





Gaps to be Addressed and Links to Action Plan

Gaps in Control (n=3)	• Mandatory GCP training for Principal/Chief Investigators (Action 3) • No dedicated Research Facility as seen within comparator regional Trusts (Action 4) • Insufficient pool of Principal Investigators across professions and specialties to support rapid growth of incoming studies via CRDC (action 7)
Gaps in Assurance (n=0)	



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 research lead posts currently awaiting approval.				
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	MHRA GCP triggered inspection took place February 2026.				
3	To act on the guidance from NIHR and MHRA regarding the Mandatory GCP training	~~31/12/2025~~ 28/04/2026	Communication is being sent out for awareness of the new GCP.	N/A			
4	NIHR application to be submitted regarding dedicated Research Facility	31/03/2028	Application in progress.	N/A			
5	Delivery team practitioners to be recruited	31/01/2026	Interviews held 8th April and 17th April 2026.	N/A	N/A		
6	Research Funding Opportunity – NIHR Regional Research Support Posts	31/01/2026	Awarded, 2 x 8b posts Regional Research Imaging Lead, and Regional Research Governance Lead, start June 2026 for 3 years	N/A	N/A		
7	Increase pool of Pis/Cis	31/12/2026	Continue to develop Research Capacity and Capability, Internship Programme	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.

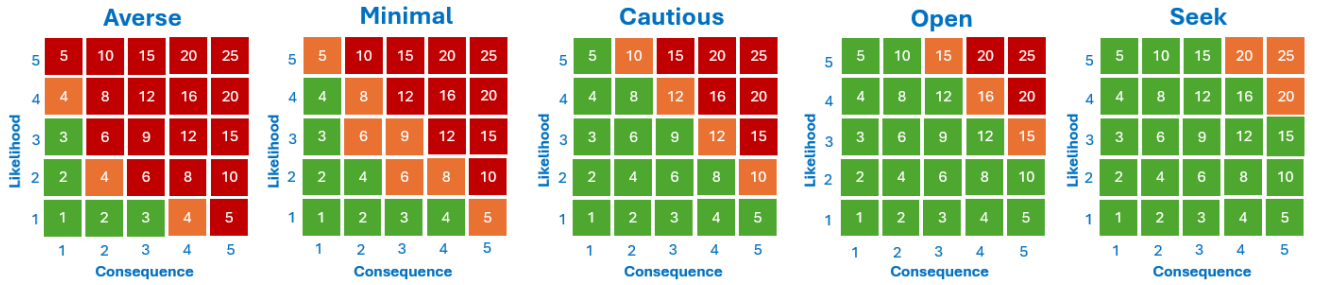
Financial Risk

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	**25**	10	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	**25**	9	(PC) Specialised Surgery
21481	1, 3	28/06/2021	Reduced Breast service (Imaging), due to vacancy within Breast Radiologist workforce.	16	20	20	**20**	4	(CSS) Clinical Support Services
34608	1, 3	01/12/2024	Trauma Floor 1:1 nursing assistant cost pressure	20	20	20	**20**	3	(PC) Specialised Surgery
32545	1, 3	30/05/2024	Demand on our People Operations services is greater than our resource capacity.	20	20	20	**20**	9	Central Functions Division
9036	1, 4	25/10/2017	Vulnerability to Cyber Attack	15	15	20	**20**	12	Central Functions Division
34619	1, 4	02/12/2024	Shadow IT and lack of system maintenance	20	20	20	**20**	5	Central Functions Division
25917	1, 5	30/09/2022	Suitability of Cohort Area (Known as Ambulance Assessment 7 - 10)	15	15	15	**20**	2	(UPC) Urgent and Acute Care
21697	6, 7	07/07/2021	Shortfall against 25/26 CIP Plans - high risk £49.2 and medium risk £7.1m	20	20	20	**20**	8	Central Functions Division
39469	1	02/03/2026	Timeliness of Endoscopy Incident Investigation and Duty of Candour Compliance	N/A	N/A	N/A	**16**	4	(CSS) Clinical Support Services
27156	1	07/02/2023	EMR/ESD Service - Lack of Operational Policy	16	16	16	**16**	6	(PC) Surgery
30149	1	23/10/2023	AAA Time to Surgery	16	16	16	**16**	4	(PC) Surgery
32034	1	12/04/2024	AAA Mobile Ultrasound Machines Renewal	12	16	16	**16**	6	(PC) Surgery
32807	1	19/06/2024	Head and Neck Cancer Delivery	16	16	16	**16**	4	(PC) Surgery
33959	1	07/10/2024	Colorectal Cancer Position	16	16	16	**16**	2	(PC) Surgery
38670	1	16/12/2025	Urology Cancer Position	N/A	N/A	16	**16**	2	(PC) Surgery
17805	1	13/07/2020	Lung Nodule Management	8	8	8	**16**	4	(UPC) Medicine
8660	1	20/09/2017	Follow up back log (outpatient appointments)	12	12	12	**16**	6	(UPC) Medicine
34051	1	16/10/2024	Neurology Follow Up Backlogs	9	12	16	**16**	8	(UPC) Specialised Medicine
9738	1	05/02/2018	Nurse Training	12	12	12	**16**	6	(UPC) Urgent and Acute Care
17873	1	16/07/2020	Inability to Off-load Patients from Ambulances (both sites)	16	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	**16**	4	(UPC) Urgent and Acute Care
24028	1	06/04/2022	Emergency Department Performance Standards not being achieved	16	16	16	**16**	6	(UPC) Urgent and Acute Care
26832	1	12/01/2023	Your Next Patient (Holding Areas Queues) Acute Medicine	16	16	16	**16**	4	(UPC) Urgent and Acute Care
26887	1	18/01/2023	Ineffective Clinical Effectiveness Provision	16	16	16	**16**	6	Central Functions Division
32464	1	20/05/2024	Incorrect use of bedrails	16	16	16	**16**	6	Central Functions Division

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ID	BAF Link	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group
38404	1	19/11/2025	Pathology demand management and activity increase	N/A	N/A	16	**16**	4	NMCPS
25469	1	04/08/2022	Delivery of constitutional cancer quality standards	16	16	16	**16**	4	Surgical Division
25471	1	04/08/2022	Follow Up Delays	16	16	16	**16**	4	Surgical Division
36230	3	29/04/2025	Clinical Photography Workforce shortfall	N/A	12	12	**16**	4	(CSS) Clinical Support Services
39235	4	11/02/2026	Risk of loss of function in Audiology due to PC issues	N/A	N/A	N/A	**16**	6	(PC) Surgery
34158	4	18/10/2024	Admin Account Authorisation	16	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	**16**	6	Central Functions Division
37929	4	09/10/2025	Lack of ECG uploads to iportal	N/A	N/A	16	**16**	4	Central Functions Division
35798	5	25/03/2025	Doors at STS	16	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	**16**	4	(UPC) Urgent and Acute Care
36963	5	04/07/2025	Weak Microsoft Authentication protocols many systems	N/A	16	16	**16**	4	Central Functions Division
37171	5	23/07/2025	China state-backed APT threats (HSA CareCert CC 4683)	N/A	16	16	**16**	4	Central Functions Division
39775	5	24/03/2026	Lack of Media Facilities	N/A	N/A	N/A	**16**	4	Central Functions Division
34188	6	29/10/2024	Non pay overspend - Histology send away activity	12	12	15	**16**	6	NMCPS
30986	8	11/01/2024	Centre for Research and Education Excellence (CeNREE) sustainability	16	16	16	**16**	6	Central Functions Division
39631	1, 3	11/03/2026	Senior Medical support to ACAH	N/A	N/A	N/A	**16**	6	(CSS) Clinical Support Services
39470	1, 3	02/03/2026	Endoscopy Matron	N/A	N/A	N/A	**16**	4	(CSS) Clinical Support Services
34113	1, 3	23/10/2024	Quality, Safety and Compliance Resource - Imaging	12	20	20	**16**	4	(CSS) Clinical Support Services
35274	1, 3	29/09/2025	Insufficient SLT workforce to meet clinical demand	N/A	16	16	**16**	4	(CSS) Clinical Support Services
37866	1, 3	30/09/2025	Insufficient workforce to deliver a safe dietetic service	N/A	16	16	**16**	4	(CSS) Clinical Support Services
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**	16	(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
37230	1, 3	28/07/2025	Oncology Gynaecology Delays	N/A	N/A	16	16	9	(CSS) Women and Children's
37497	1, 3	02/09/2025	SSDEC Staffing	N/A	16	16	16	4	(PC) Surgery
10381	1, 3	27/04/2018	Medical Staffing - Haematology	16	16	16	16	9	(UPC) Specialised Medicine
22969	1, 3	22/12/2021	Radiology Physics expert level staffing	6	9	9	16	6	(UPC) Specialised Medicine
29712	1, 3	14/09/2023	Consultant and Scientist Shortages in Neurophysiology	12	12	16	16	4	(UPC) Specialised Medicine
37345	1, 3	12/08/2025	EAU Nurse Staffing	N/A	N/A	12	16	2	(UPC) Specialised Medicine
33720	1, 3	16/09/2024	AEC Nursing Workforce	16	16	16	16	4	(UPC) Urgent and Acute Care
35094	1, 3	21/01/2025	Medical Staffing in ED Overnight & at Weekends	16	16	16	16	8	(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	16	8	Central Functions Division
20626	1, 3	05/11/2020	Low staffing levels for Phlebotomy at Cheshire Sites	12	12	12	16	6	NMCPS
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	16	12	Central Functions Division
38937	1	14/01/2026	Complex nutritional patients lacking medical plan	N/A	N/A	N/A	15	6	(CSS) Clinical Support Services
18664	1	28/09/2020	Gynaecology 52 Week Long Waits	15	15	15	15	6	(CSS) Women and Children's
32023	1	11/04/2024	Maternity Early Warning Scores not used for Maternity Patients outside of Maternity Dept	15	15	15	15	2	(CSS) Women and Children's
35516	1	26/02/2025	Endometriosis Backlog and Long Waits	15	15	15	15	4	(CSS) Women and Children's
35517	1	26/02/2025	Urogynae Backlog and Long Wait	15	15	15	15	4	(CSS) Women and Children's
33109	1	16/07/2024	Audiology Waiting List Backlog	15	15	15	15	5	(PC) Surgery
26808	1	09/01/2023	Holding Patients on the ED Corridor	12	15	15	15	4	(UPC) Urgent and Acute Care
37397	3	20/08/2025	Management of Sexual Safety Cases	N/A	20	20	15	10	Central Functions Division
30476	4	20/11/2023	NHS Financial position and procurement of System Wide EPR	15	15	15	15	5	Central Functions Division
38603	5	11/12/2025	Ambulatory Heart Failure Unit	N/A	N/A	15	15	4	(UPC) Specialised Medicine CBU
32486	1, 3	22/05/2024	Long Wait Patients in the Trauma Directorate	15	15	15	15	6	(PC) Specialised Surgery
25177	1, 3	08/07/2022	TB Workforce & Screening Service	6	6	6	15	3	(UPC) Medicine
19397	1, 3	21/12/2020	Impact of increased workload on service and Quality management system in Immunology	12	15	15	15	6	NMCPS

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ID	BAF Link	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group
38893	1, 4	09/01/2026	Duplicate Clinical Narrative Discharge Summary Letters (DSL)	N/A	N/A	N/A	**15**	2	Central Functions Division
20926	1, 5	30/04/2021	Emergency Department (Royal) Majors, Ambulatory & Children's Cubicle Doors	15	15	15	**15**	4	(UPC) Urgent and Acute Care
38524	4, 6, 7	04/12/2025	Implications and lack of response on SystemC Financial standing	N/A	N/A	15	**15**	5	Central Functions Division
38160	1	29/10/2025	Loss of ACAH referral Hub	N/A	N/A	12	**12**	3	(CSS) Clinical Support Services
37225	1	31/07/2025	Inadequate governance processes in place for Homecare Medicines to manage supplier performance and patient safety/experience	N/A	12	12	**12**	4	(CSS) Clinical Support Services
20435	1	16/03/2021	Paediatric Follow up Backlog	12	12	12	**12**	6	(CSS) Women and Children's
29165	1	20/07/2023	Diabetic Pump Contracts	12	12	12	**12**	4	(CSS) Women and Children's
33311	1	07/08/2024	Antenatal consultant clinic capacity	12	12	12	**12**	6	(CSS) Women and Children's
37521	1	04/09/2025	Stem Cell JACIE accreditation	N/A	N/A	12	**12**	4	(IPC) Specialised Medicine
17637	1	30/06/2020	Decline in cancer performance	12	12	12	**12**	8	(PC) Surgery
27953	1	12/04/2023	Lack of provision for patients requiring DIEP surgery	12	12	12	**12**	6	(PC) Surgery
30749	1	13/12/2023	Contact Lens/Low Visual Acuity (CL/LVA) Service Delivery	12	12	12	**12**	8	(PC) Surgery
32683	1	07/06/2024	Timely Reporting of Emergency MRI Results	12	12	12	**12**	4	(PC) Surgery
35797	1	25/03/2025	ENT On Call Crosscover	12	12	12	**12**	4	(PC) Surgery
36829	1	20/06/2025	Referral process for WET AMD patients	12	12	12	**12**	4	(PC) Surgery
29052	1	10/07/2023	TB pharmacy dispensing out of Cobridge (service ceasing)	4	4	4	**12**	4	(UPC) Medicine
24340	1	10/05/2022	Severe Asthma Service - impact once external funding ceases	12	12	12	**12**	3	(UPC) Medicine
31806	1	18/03/2024	No Psychological provision for renal patients	12	12	12	**12**	2	(UPC) Medicine
34302	1	17/07/2024	Diabetes patient Clinical follow up	9	12	12	**12**	4	(UPC) Medicine
34270	1	05/11/2024	Utilisation of Holistic Cancer Centre	12	20	12	**12**	6	(UPC) Specialised Medicine
17470	1	12/06/2020	Compliance with NEWS and escalation (Royal)	12	12	12	**12**	4	(UPC) Urgent and Acute Care
22934	1	15/12/2021	Lack of ECG Review/not following Chest Pain Process	9	9	9	**12**	4	(UPC) Urgent and Acute Care
8901	1	05/12/2013	Ensure correct blood sample management	12	12	12	**12**	3	Central Functions Division
11415	1	20/08/2018	End of Life - Portable battery powered syringe pumps.	12	12	12	**12**	9	Central Functions Division
32652	1	05/06/2024	Clinical Harm Review Process	12	12	12	**12**	6	Central Functions Division

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ID	BAF Link	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group
34519	1	22/11/2024	Delivery of Gestational Diabetes GTT Clinics	12	12	12	**12**	4	Central Functions Division
34789	1	02/12/2024	Corporate RTT (Referral to Treatment) Validation at UHNM	16	16	12	**12**	8	Central Functions Division
35351	1	11/02/2025	Clinic over runs	12	12	12	**12**	4	Central Functions Division
38901	1	12/01/2026	Inadequate Dissemination of non clinical Time-Critical Information During Emergencies	N/A	N/A	N/A	**12**	4	Central Functions Division
29812	1	27/09/2023	Replacement Medical Devices - Capital and Revenue Funding Risk	16	16	12	**12**	4	Estates, Facilities and PFI
31958	1	08/04/2024	MCHT Beckman Track & Stock yard (storage module)	16	16	16	**12**	6	NMCPS
25470	1	04/08/2022	Increasing waiting list size and patients waiting greater than 18 weeks for treatment	12	12	12	**12**	4	Surgical Division
37600	3	15/09/2025	Admin and Clerical Vacancies - Trauma Directorate	N/A	N/A	12	**12**	4	(PC) Specialised Surgery
32500	3	22/05/2024	TI Rates	12	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	**12**	4	Central Functions Division
39111	3	30/01/2026	Health and Safety Team Capacity	N/A	N/A	N/A	**12**	8	Central Functions Division
35090	4	21/01/2025	Rapid AI Linux OS Out of support	12	12	12	**12**	4	(CSS) Clinical Support Services
37662	4	17/09/2025	CVE - Cardiology PACS utilising ESXI 6.7 on VM's	N/A	N/A	12	**12**	4	(UPC) Specialised Medicine
8849	4	13/10/2017	Inappropriate use of mobile devices for work purposes	12	12	12	**12**	4	Central Functions Division
21784	4	06/08/2021	(CQC) Confidentiality, Integrity and Availability of Trust Information	12	12	12	**12**	4	Central Functions Division
33518	4	29/08/2024	Proactive audit & monitoring of patient record systems	12	12	12	**12**	4	Central Functions Division
34157	4	17/10/2024	DC1-SQLDB19 _ DC2-SQLDB20	12	12	12	**12**	6	Central Functions Division
34869	4	24/12/2024	Technical Debt	15	15	15	**12**	5	Central Functions Division
38343	4	14/11/2025	Aged assets that are end of life and out of support	N/A	N/A	12	**12**	8	Central Functions Division
38900	4	12/01/2026	Notification health record scanning solution will no longer be supported by the Supplier	N/A	N/A	N/A	**12**	4	Central Functions Division
37584	5	11/09/2025	Acute Care at Home Accommodation	N/A	N/A	12	**12**	4	(CSS) Clinical Support Services
28802	5	23/06/2023	Insufficient hub space and clinical room capacity for community midwifery teams	12	12	12	**12**	4	(CSS) Women and Children's
37840	5	30/09/2025	Lack of Audible Emergency Alarms in STS (Phase 2)	N/A	12	12	**12**	4	(PC) Surgical Support Services

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ID	BAF Link	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group
25353	5	21/07/2022	Sale of RI and COPD Land later than NHSE funding requirement of 24/25	12	12	12	**12**	6	Central Functions Division
30237	5	04/09/2023	PFI latent defects	12	12	12	**12**	4	Estates, Facilities and PFI
34099	5	21/10/2024	County Vertical Fire Compartmentation	N/A	N/A	12	**12**	6	Estates, Facilities and PFI
37357	5	14/08/2025	Fire and Smoke spread from the Holistic Care Centre to the Cancer Centre	N/A	N/A	12	**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	**12**	4	Estates, Facilities and PFI
29213	5	28/07/2023	ECT Cooper Building roof leaks	12	12	12	**12**	4	NMCPS
30787	5	14/12/2023	Histology Consultant Office Accommodation	8	12	12	**12**	4	NMCPS
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	**12**	4	(CSS) Clinical Support Services
33514	1, 3	29/08/2024	Ultrasound Imaging Workforce	12	12	12	**12**	4	(CSS) Clinical Support Services
35057	1, 3	17/01/2025	Inadequate Pharmacy Staffing to Emergency Departments	12	12	12	**12**	6	(CSS) Clinical Support Services
36825	1, 3	19/06/2025	Insufficient Homecare staffing to support continued patient growth and delivery of VAT cost-avoidance	N/A	12	12	**12**	4	(CSS) Clinical Support Services
28944	1, 3	03/07/2023	Deficit in appropriate numbers in Skilled Neonatal Specialist Nurses.	12	12	12	**12**	4	(CSS) Women and Children's
34410	1, 3	18/11/2024	Early Pregnancy Assessment Unit (EPAU) sustainability of services	N/A	N/A	12	**12**	6	(CSS) Women and Children's
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	**12**	4	(CSS) Women and Children's
17967	1, 3	23/07/2020	Medical Cover Cardiothoracic ICU	12	12	12	**12**	3	(PC) Specialised Surgery
32408	1, 3	14/05/2024	Clinical Perfusion- Inadequate Establishment & Staff Shortages	12	12	12	**12**	6	(PC) Specialised Surgery
36794	1, 3	16/06/2025	Clinical nursing staffing of the spinal deformity service	12	12	12	**12**	2	(PC) Specialised Surgery
25628	1, 3	01/09/2022	Ophthalmology Service Delivery	12	12	12	**12**	8	(PC) Surgery
31429	1, 3	14/02/2024	Audiology Staffing	12	12	12	**12**	4	(PC) Surgery
34960	1, 3	09/01/2025	AAA Screening Workforce - CST and Technicians	16	16	12	**12**	4	(PC) Surgery
37031	1, 3	10/07/2025	Stability of General Surgery Paediatric Service	N/A	12	12	**12**	3	(PC) Surgery
36962	1, 3	04/07/2025	Therapies provision to SSCU patients	N/A	12	12	**12**	6	(PC) Surgical Support Services

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ID	BAF Link	Opened	Risk Title	Risk Score (Q1)	Risk Score (Q2)	Risk Score (Q3)	Risk Score (Q4)	Risk Score (Target)	Division / Care Group
38447	1, 3	25/11/2025	Nursing workforce does not meet GPICS standards	N/A	N/A	16	**12**	4	(PC) Surgical Support Services
24837	1, 3	14/06/2022	Cystic Fibrosis workforce/service delivery	12	12	12	**12**	4	(UPC) Medicine
27071	1, 3	26/01/2023	NIV Service Workforce - Domiciliary service	12	12	12	**12**	4	(UPC) Medicine
29508	1, 3	01/09/2023	Inability to deliver hybrid closed loop pumps to type 1 diabetes patients	12	12	12	**12**	6	(UPC) Medicine
31807	1, 3	18/03/2024	No nursing Clinical Educator in post in Renal	12	12	12	**12**	2	(UPC) Medicine
29480	1, 3	30/08/2023	County and Ward 202 SACT Unit Staffing	12	9	9	**12**	2	(UPC) Specialised Medicine
37660	1, 3	17/09/2025	Radiotherapy Staffing	N/A	N/A	12	**12**	2	(UPC) Specialised Medicine
38908	1, 3	13/01/2026	Cardiac Assessment Nurse workforce issues	N/A	N/A	N/A	**12**	6	(UPC) Specialised Medicine
32891	1, 3	25/06/2024	Epilepsy Specialist Nursing Resource Availability	12	12	12	**12**	12	(UPC) Specialised Medicine
34801	1, 3	17/12/2024	Radiotherapy Physics Workforce	N/A	N/A	12	**12**	3	(UPC) Specialised Medicine
25228	1, 3	12/07/2022	Nurse Staffing CED	9	6	6	**12**	4	(UPC) Urgent and Acute Care
8523	1, 3	01/09/2017	AMU Workforce (both sites)	12	12	12	**12**	4	(UPC) Urgent and Acute Care
8580	1, 3	26/09/2019	(CQC) Medical staffing for the Emergency Department (both sites)	6	6	6	**12**	3	(UPC) Urgent and Acute Care
35330	1, 3	10/02/2025	County AMU nursing budget/establishment	12	12	12	**12**	4	(UPC) Urgent and Acute Care
35847	1, 3	31/03/2025	Lack of Pharmacy for ED Departments	12	12	12	**12**	4	(UPC) Urgent and Acute Care
27153	1, 3	07/02/2023	QI Academy Staffing under-resourced to deliver sustainable change	12	12	12	**12**	12	Central Functions Division
11294	1, 3	31/07/2018	NMCPS Pathology Histology Medical Capacity - dissection & reporting(achieving TAT)	12	12	12	**12**	6	NMCPS
20616	1, 3	01/08/2017	Insufficient Biomedical Scientific Staff Resource to Provide a Quality Haematology & Blood Transfusion Service at Macclesfield H	12	4	4	**12**	4	NMCPS
21591	1, 3	08/07/2021	Insufficient Clinical Staff to Support the NMCPS Microbiology Service	12	12	12	**12**	6	NMCPS
24818	1, 3	13/06/2022	RSUH/CH Biochemistry Staffing and Shift Cover	12	16	16	**12**	6	NMCPS
33912	1, 3	01/10/2024	Anticoagulation Management Service staffing	12	12	12	**12**	4	NMCPS
34265	1, 3	04/11/2024	Lipid clinic provision	16	16	12	**12**	6	NMCPS
38406	1, 3	19/11/2025	Cheshire Haematology Service Lead BMS presence	N/A	N/A	12	**12**	6	NMCPS
32551	1, 4	31/05/2024	Operational risk associated with the Pharmacy robot replacement	12	16	16	**12**	8	(CSS) Clinical Support Services

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
32033	1, 4	12/04/2024	AAA Screening operational charges and access	12	12	12	**12**	4	(PC) Surgery
31527	1, 4	26/02/2024	Auto-Contoring	12	12	12	**12**	6	(UPC) Specialised Medicine
23759	1, 4	14/03/2022	Inappropriate clinical decisions due to large number of digital systems in place	12	12	12	**12**	4	Central Functions Division
25682	1, 4	05/09/2022	(CQC) Unstructured records Management	12	12	12	**12**	4	Central Functions Division
30477	1, 4	20/11/2023	Lack of records retention in line with Code of Practice	12	12	12	**12**	4	Central Functions Division
28354	1, 4	23/05/2023	Blood Analyser Lantronix UDS box	12	12	12	**12**	4	NMCPS
34580	1, 4	27/11/2024	CIM Hold and Error Queue Management	12	12	12	**12**	4	NMCPS
34582	1, 4	27/11/2024	CIM Failovers	12	12	12	**12**	6	NMCPS
34594	1, 4	28/11/2024	Illegal Characters in SampleNet	12	12	12	**12**	6	NMCPS
34595	1, 4	28/11/2024	SampleNet Is Unable to Handle Time Changes	12	12	12	**12**	6	NMCPS
34965	1, 4	10/01/2025	No MFA for Winpath Enterprise (LIMS)	12	12	12	**12**	2	NMCPS
35039	1, 5	17/01/2025	Pharmacy Cancer walk-in cold store Ward 202 performance and capacity	12	12	12	**12**	2	(CSS) Clinical Support Services
28684	1, 5	14/06/2023	Lack of Clean Utility Room - Children's High Dependency	12	12	12	**12**	6	(CSS) Women and Children's
35126	1, 5	14/01/2025	Electrical High Voltage infrastructure capacity on Royal Stoke site	12	12	12	**12**	4	Estates, Facilities and PFI
34299	1, 6	07/11/2024	Teenage & Young Adults Cancer Service	N/A	N/A	12	**12**	3	(UPC) Specialised Medicine
26168	3, 4	26/10/2022	Pathology IT System Expertise	12	12	12	**12**	6	NMCPS
31185	4, 5	29/01/2024	DataCentre Air Conditioning EOL - Unfit for Purpose	12	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	**12**	4	Central Functions Division

Executive Summary

Trust Board (Part 1) | 10th June 2026

Maternity & Neonatal PSIRF Investigation Report – Q4

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**		**Assurance**	✓	**Agenda Item:**	10.
Author:	Catherine Hegarty, Quality & Risk Manager							
Executive Lead:	Anne-Marie Riley, Chief Nurse							

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

Risk Register Mapping		

Executive Summary

Situation

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

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

PMRT:

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

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

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

MNSI (formerly HSIB):

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

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

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

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

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

No of open maternity and neonatal PSIRF reviews:	
PMRT (Not reportable as PSII) PMRT (Reportable as PSII)	53 8 (incl. MNSI cases)
MNSI: In progress Final report received Actions plans developed and for approval through governance process	6 2 2 2
PSII (Local Priority)	2
AAR	12
Thematic Review	5
Case Record Review	1
Hot debrief	1

Assessment

In Quarter 4 there were 5 new incidents reported that met the criteria for PSII's:

- January 2026 2
- February 2026 2
- March 2026 1

Category of Incidents:

- 3 PMRT (potentially score C or above)
- 2 MNSI
- 0 PSII (local priority)

Duty of candour has been performed with families for all eligible incidents and information given in an accessible format.

Two final reports from MNSI have been received in Quarter 4 and action plans are in development to meet safety recommendations.

Assessment

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

Rationale

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

Key Recommendations

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

- All actions from PMRT and PSIRF investigations are monitored through the directorate outcomes meeting
- Clear process to ensure themes are highlighted and triangulated with all incidents, claims, complaints and inquests
- Continue to achieve 100% compliance in reporting all qualifying cases to MNSI and NHSR Early Notification scheme (ENS)
- Continue to ensure that all families that qualify for MNSI and ENS referral, receive information in a format that is accessible to them.
- Benchmark against the CNST MIS year 8 standards.

Executive Summary

Trust Board (Part 1) | 10th June 2026

Quality Account 2025/2026

NHS
University Hospitals of North Midlands
NHS Trust

Purpose:	**Information**		**Approval**	✓	**Assurance**		**Agenda Item:**	11.
Author:	Head of Quality, Safety & Compliance							
Executive Lead:	Chief Nurse							

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

Risk Register Mapping	
N/A	

Executive Summary

Situation

The attached is the latest draft of the Trust's annual Quality Account. The account summarises activity during 2025/2026. The content of the Quality Account is defined by the Quality Accounts letter issued by NHS Improvement and the NHS Quality Accounts Guidance which continues to apply. Noted NHS providers are no longer expected to obtain assurance from their external auditor on their Quality Account for 2020/21.

The Quality Account has been shared with external stakeholders for review, completion and return of the final Stakeholder comments from Integrated Care Board, Overview & Scrutiny Committees of both Stoke-on-Trent City Council and Staffordshire County Council and HealthWatch for both Stoke-on-Trent and Staffordshire following agreement/approval at Executive Quality & Outcomes Group (21st May 2026). The Quality Account was subsequently approved at the Quality, Access & Outcomes Committee (3rd June 2026).

The final account including the stakeholder comments will be published by 30th June 2026 following approval at the Trust Board meeting in June 2025.

Background

Part A of the Quality Account provides summary of Strategic Objectives, Quality Priorities and Objectives for 2026/2027 and how these will be measured and monitored as well as annual updates relating to our participation in clinical audit programmes, clinical research, PLACE Inspections, data quality results and Data, Security and Protection (DSP) Toolkit attainment levels. There are also updates provided in relation to Continuous Improvement, Care Quality Commission inspections and the Trust's own Clinical Excellence Framework visits.

Our Vision is to provide *"The best joined up care for **all**"* with 3 overarching priorities for Our People, Our Patients and Our Population.

The identified quality priorities for 2026/2027 are in line with the Our Vision and strategic priorities:

Improvement aim	Quality Improvements	Outcome
Improve patient safety & reduce avoidable harm	Reduce avoidable harm with implementation of harm free care actions across the Trust using focussed improvement support To strengthen deterioration recognition and escalation by improving timely observations and NEWS response processes Enhance infection prevention and antimicrobial stewardship	Reductions in avoidable harm and improved reliability of care will strengthen our safety culture and learning with improved outcomes for patients.
Improve staff health and wellbeing to enable high-	Strengthen wellbeing support and access to services by expanding access to staff support services and targeting support	Improved staff wellbeing, engagement and morale leads to enhanced workforce capacity and resilience to

quality, safe care	Improve leadership, engagement and workforce experience by strengthening line management capability and consistent people management practice	deliver high-quality care with improved continuity and patient outcomes
Improve patient experience and responsiveness of services	Improve experience of high-pressure services by supporting services to provide enhanced communication and patient support during delays Strengthen the complaints handling and learning and integrate complaints insights with PSIRF learning and reporting Embed inclusive patient-centred care by expanding patient leadership and coproduction in service design and improvement.	Good quality patient experience is at the heart of all we do and making patients/carers part of the learning and design will improve the quality of services we provide
Improve quality of care through learning, data and system insight	Embed PSIRF and system-based learning with increased patient/carer involvement Strengthen clinical effectiveness and outcome measurement by developing Trust-wide KPIs and patient outcomes framework whilst embedding GIRFT recommendations and pathway redesign across specialities Improve data quality, coding and insight for assurance by enhancing data completeness and reliability to support governance and decision-making	Patient Safety and patient outcomes are enhanced through our learning culture and practice based on evidence that we do things the right way to achieve best outcomes for our patients

Part B of the account reviews the Trust's Quality Performance for 2025/2026 against the priorities that were identified last year. These include both local and national results and how the indicators compare against the different targets that had been set.

Part C is currently awaiting completion as the stakeholder comments and will not be ready for inclusion until after 22nd June 2026. External Stakeholders have nationally defined 30-day consultation period to review the Quality Account and submit their statements.

Assessment

The Quality Account for 2025/2026 meets the statutory and regulatory requirements and includes all the required information. The final version of the Quality Account will include returned Stakeholder comments following receipt. These comments are included verbatim under Part C of the Quality Account.

There has been good engagement in the completion of the variation sections from identified leads and has been shared for external stakeholder comment.

Key Recommendations

The Trust Board is asked to:

- Note the Quality Account 2025/26 which has been reviewed and agreed at both Executive Quality & Outcomes Group and the Quality, Access & Outcomes Committee.
- Approve the Quality Account pending final external stakeholder comments to be returned prior to publication on Trust website by 30th June 2026.

NHS
University Hospitals of North Midlands
NHS Trust

Quality Account

2025/2026

Contents

Part A: Statement on Quality

Introduction to UHNM by Dr Simon Constable, Chief Executive

Welcome to the Quality Account for the University Hospitals of North Midlands NHS Trust (UHNM) for the reporting year **2025/2026**. This year has again been characterised by exceptional pressures across urgent and emergency care, rising workforce demands, sustained financial constraints, and growing complexity in the health needs of our local population. Despite this, UHNM colleagues have consistently embodied our values of *Kind, Excellent, and Together* by continuing to deliver safe, effective, and compassionate care.

We remain one of the largest hospital trusts in the West Midlands, serving approximately 3 million people. As a major trauma centre and provider of numerous tertiary services—including cardiothoracic surgery, neurosurgery, specialist orthopaedics, renal and dialysis services, neonatal intensive care and paediatric intensive care—we continue to play an essential role regionally and nationally.

This year has seen continued improvement in several key indicators, including reductions in avoidable harm, progress in addressing local health inequalities, enhancements in service accessibility, and the strengthening of our clinical effectiveness frameworks. At the same time, we have maintained strong performance in areas highlighted by previous Care Quality Commission (CQC) reviews, with particular recognition of the compassionate care provided by our teams.

Providing care in modern facilities, we offer a full range of general hospital and specialised services for approximately 3 million people. We employ around 12, 500 employees and we have around 1450 inpatient beds across our two sites.

We are one of the largest hospitals in the West Midlands and have one of the busiest emergency departments in the country, with an average of around 14, 000 patients attending each month across both of our sites. Many emergency patients are brought to us from a wide area, both by helicopter and ambulance, because of our Major Trauma Centre status covering the population of North Midlands and North Wales.

Our specialised services include cancer diagnosis and treatment, cardiothoracic surgery, neurosurgery, renal and dialysis services, neonatal intensive care, paediatric intensive care, trauma, respiratory conditions, spinal surgery, upper gastro-intestinal surgery, complex orthopaedic surgery and laparoscopic surgery.

Our Partnerships

We play a key role within the Staffordshire and Stoke-on-Trent Integrated Care System (ICS), which has partnership working at its very core. We work closely with health, social care and voluntary sector partners across Staffordshire and Stoke-on-Trent to deliver joined up and integrated care for our population. We also collaborate with many partners beyond the Staffordshire and Stoke-on-Trent system through a range of well-established relationships that span over a decade or more.

We partner with Keele University and the University of Staffordshire to deliver world leading scientific research and pioneering teaching and technologies, providing our clinicians and our leaders with the skills and experiences they need to work in our increasingly complex health and social care environment.

We play a leadership role, hosting and contributing to multiple regional and national clinical networks to deliver and improve specialist clinical services.

2. Statement on quality

This Quality Account covers the period from 1 April 2025 to 31 March 2026. Our UHNM teams here at UHNM remain committed to improving the quality, safety and experience of care for our patients and their families. We would like to express, on behalf of the Trust Board, our sincere thanks to colleagues for their professionalism, adaptability and compassion during another demanding year.

The quality of care our patients receive, and their experience of that care, are central to our mission. Through our 'Improving Together' approach and our ongoing embedding of Patient Safety Incident Response Framework (PSIRF) was of working, we continue to focus on learning from incidents and feedback, acting on what matters most to our patients, and making measurable improvements in care. We also continue to strengthen ward-to-board oversight through the Care Excellence Framework (CEF), supported by targeted improvement activity where wards or services need additional support with our Continuous Improvement academy applying structured quality improvement methods to address variation and reduce avoidable harm.

Throughout 2025/26 we have continued to monitor and respond to patient safety incidents and themes, recognising that sustained operational pressure, particularly within urgent and emergency care, can increase the risk of harm.

Our priorities include providing safe, effective care and preventing harm, guided by the best available evidence. By empowering and investing in our outstanding team, we ensure the highest standard of care and treatment, fostering pride in serving our community. Our ongoing professional development workshops and mentorship programmes have enabled our team to stay at the forefront of best practices, ensuring exceptional care for our patients.

Quality performance: what the Trust-wide data is telling us

We recognise the impact that operational pressure can have on safe care delivery. There remain ongoing challenges associated with long waits and flow, which can contribute to increased risk of hospital-acquired pressure damage and reduced ability to consistently deliver all aspects of care reliably. We are continuing to strengthen the oversight of temporary escalation spaces and continuous flow arrangements, to ensure risks are identified early, escalated appropriately and mitigations are implemented.

We have continued work to reduce harm from falls through targeted interventions, including focussed reviews for patients experiencing multiple falls and ongoing audits and learning activity. The falls with harm per month have continued to vary and require sustained attention, particularly in high-pressure admission portal areas.

We have also noted continued need to improve performance in relation to timely observations, which has remained below the Trust's target in the reported months and is recognised as a key contributor to risks associated with deterioration and escalation. Targeted improvement work is in place, including focused support to wards through clinical and digital teams and incorporation into local assurance and accreditation mechanisms.

Patient experience remains a key priority. Inpatient Friends and Family Test performance remains strong, while Emergency Department and Maternity results remain below target, with recurring themes including long waits and concerns about the waiting environment. We continue to work with teams to increase response rates, strengthen feedback loops and use patient experience intelligence to inform improvement.

We also recognise the importance of responding to concerns and complaints in a timely and compassionate way and whilst we acknowledge that the timeliness of responding to complaints remains above target, we have seen improvement in complaints response times compared to historic performance following a focus on, and refinement of, processes and escalation.

The Trust continues to monitor mortality indicators (HSMR and SHMI). The reports describe these measures as higher than expected, and they also describe contributory issues relating to clinical coding completeness/capacity and associated improvement work to strengthen data quality and assurance.

We remain committed to openness and learning when things go wrong. There have been improvements in Duty of Candour processes, including strengthened monitoring and escalation, with improved compliance reported during the latter part of the year.

Overall, we are proud of the commitment and compassion of our colleagues and the areas of progress made, while being clear about the priorities that require sustained focus. Our immediate emphasis remains on reducing avoidable harm, improving reliability in deterioration recognition (including timely observations), improving urgent and emergency care flow and experience, strengthening infection prevention and antimicrobial stewardship, and improving timeliness of complaints responses and data completeness that supports reliable insight and assurance.

Key themes from our quality reporting during 2025/26:

- **Learning and response to deterioration:** Calls for Concern (Martha's Rule) reporting became more consistent with national interpretation.
- **Avoidable harm focus (falls, pressure damage, infections, deterioration):** Trust-wide focus has continued on reducing avoidable harm, including targeted work on timely observations and pressure ulcer prevention, particularly where operational pressures create risks (including in urgent and emergency care pathways).
- **Infection prevention (C. difficile and E. coli):** C. difficile performance remained a challenge in-year, with the Trust reported as above the upper limit at key points. E. coli performance was closer to trajectory and reported as slightly under the year-to-date upper limit.
- **Timely observations and deterioration processes:** Timely observations declined from a peak in mid-2025 and remained materially below the 90% target through winter. However, we have seen recent improvements after the noted period of decline and at end of 2025/26 was at the best performance since reporting started.
- **Mortality indicators (HSMR/SHMI):** HSMR and SHMI remained higher than expected, with a continued focus on clinical coding capacity and improvement plans to address backlog and coding depth and completeness.
- **Duty of Candour:** Duty of Candour compliance improved materially following refined reporting and escalation processes supported by Care Group Patient Safety Managers within the new Care Group Organisational structure.
- **Patient experience (FFT):** Inpatient FFT remained strong, while ED and maternity FFT remained below target and were associated with themes such as long waits and patient experience concerns in emergency care settings.
- **Complaints timeliness:** While complaint responses times are still above the target rate there has been significant improvements following continued focus on process improvements.
- **Mixed sex accommodation breaches:** breaches remain driven by capacity constraints (particularly critical care), with improvement plans in place but there have been improvements during 2025/26 for the average breaches per month.

These themes reinforce our organisational focus on delivering safe, effective and caring services, while being transparent about where assurance is currently limited and where we must prioritise improvement.

Whilst we are proud of our achievements and improvements, we recognise the need for continued focus and improvements across our services.

What we will prioritise going forward:

In response to our quality and safety reporting and monitoring across the year, and recognising continuing operational pressures, we will maintain a strong focus on:

- reducing avoidable harm (including improving timely observations and deterioration processes, pressure damage, falls and hospital-acquired infection), with targeted improvement where data indicates risk;
- strengthening infection prevention and antimicrobial stewardship, with specific focus on C. difficile trajectory delivery;
- continuing improvement on ED and maternity experience measures (including addressing long waits and communication themes);
- improve the learning from complaints and increasing co-production opportunities, including where complaints and PSIRF learning overlap;

- addressing the drivers behind HSMR/SHMI, including the ongoing clinical coding improvement plan and related assurance reporting.

During 2025/2026 we prioritised the following key areas:

Safeguarding

The Safeguarding agenda at UHNM continues to encompass a comprehensive portfolio of work including Adult and Child Safeguarding, the Mental Capacity Act, Deprivation of Liberty Safeguards, Domestic Abuse, PREVENT counterterrorism, and the management of allegations against individuals in positions of trust (PiPoT). This year we have strengthened our processes for responding to PiPoT concerns, ensuring robust oversight, timely information-sharing, and partnership working across the system.

We remain committed to providing safe, responsive services for our vulnerable patient population across Stoke-on-Trent and Staffordshire, as well as supporting out-of-area patients. We work collaboratively with NSCHT, MPFT, the ICB, Local Authorities, Police, and specialist agencies to safeguard unborn babies, children, and adults. THINK FAMILY continues to be embedded in policy and practice to ensure a holistic approach to safeguarding.

This year we have continued to provide strategic leadership for the development, implementation, and monitoring of the safeguarding agenda across the Trust. Safeguarding training remains aligned to the Intercollegiate Document, with compliance monitored across divisions and reported to commissioners. We have continued to advise the Trust Quality and Safety Oversight Group on safeguarding priorities and emerging risks.

Regular audits have been undertaken to inform policy, practice, and quality improvement. Digital developments continue to enhance our oversight, with the safeguarding virtual dashboard now supporting improved visibility of adults and children with safeguarding concerns, including those with high-risk Domestic Abuse.

UHNM remains an active member of the Staffordshire and Stoke Safeguarding Partnership Boards. Quarterly internal Safeguarding Working Groups provide a forum for updates, escalation, and assurance. Quarterly assurance reports and the annual safeguarding report outline activity, developments, and priorities for the coming year. We remain focused on delivering the strategic priorities set by both Adult and Children's Safeguarding Boards, ensuring robust implementation and monitoring of the safeguarding assurance framework.

Vulnerable patients

Our Vulnerable Patient agenda includes Mental Health, Dementia, Learning Disability, and Autism.

Mental Health in acute settings remains a key priority. We continue to work closely with our local Mental Health Trusts to ensure legal compliance and safe care. Presentations of mental health concerns among both adults and children continue to rise, and we have strengthened our oversight of incidents involving patients with mental health needs. Regular audits assess legal compliance, highlight best practice, and identify areas for improvement.

Digital developments now provide enhanced oversight of patients with learning disabilities, autism, and those subject to mental health detentions. The quarterly Vulnerable Patient Working Group ensures divisions remain informed and compliant with policy and procedure and provides a forum for assurance and shared learning.

We continue to promote reasonable adjustments to ensure safe, effective care for patients with learning disabilities and autism across inpatient, outpatient, and emergency settings. Delivery of the Oliver McGowan Training has continued with outstanding feedback from colleagues.

Tissue Viability & Continence

Ensuring that our patients receive care to maintain their skin integrity and continence is of utmost importance to their dignity, experience, and treatment outcomes. Our specialist team is dedicated to providing the right equipment and competent employees with the knowledge and skills to deliver bedside care according to need, with continual review and improvements to this aspect of care delivery. We are learning from instances where care does not meet our high standards and strive to reduce issues that have resulted in omissions in care.

The Tissue Viability Team provide specialist input to wards and departments, whilst working in collaboration with other specialisms such as Plastics, Lymphoedema, Vascular and Podiatry to ensure our patients receive optimised care.

The rate of pressure ulcers reported as developing under UHNM care per 1,000 bed days followed a similar pattern to previous years in 2024/5, with some lower rates in summer and higher rates in winter. The average rate has not changed significantly however, and work continues to prevent this from increasing, or ideally reduce it, with a particular focus on cases where omissions in care are identified.

In the latter part of the year the team introduced the role of patient safety harm free care practitioners to work alongside wards requiring support with pressure ulcer prevention and continence as well as other educational needs. Education is provided on multiple platforms within both subjects and offered face to face, virtual or as an annual conference. Purpose T has been introduced to all inpatient areas to improve pressure ulcer risk assessment as part of a national initiative.

Going forward into 2025/2026 the team have already launched the role of Pressure ulcer prevention and continence champions. Improved seating and patient surfaces have been purchased for high-risk areas with particular emphasis within our Emergency Department. An ESR mandated training package has been created, as well as the Skin Health Booklet and electronic wound assessment, to improve clinicians' knowledge, assessments and documentation.

Collaborative working is underway across the ICB within both fields to improve the patient's pathway, reduce harm, and facilitate the needs of our patients.

We will continue to strive to reduce the number of pressure ulcers developed whilst our patients are at UHNM and ensure that colleagues have the required knowledge and skills to deliver evidence-based care and comply with National Initiatives.

Falls & Mobility

Our dedicated Quality and Safety team remains committed to promoting mobility and preventing falls.

The team provides tailored falls training to departments with a higher number of reported incidents. All staff have access to regular falls champion training and refresher courses. Injuries resulting from falls are continually reviewed using the PSIRF methodology, and ongoing improvements to this process are being made. In response to the National Patient Safety Alert regarding bed rail safety, a mandatory training program is being updated.

UHNM convenes a Falls steering group that works on various initiatives to reduce falls, including:

- Trialling decaffeinated coffee
- Promoting call bell awareness
- Implementing the Stay in the Bay initiative
- Conducting "Go, Look, Learn" exercises to highlight best practices and identify areas needing improvement
- Introducing a digital falls proforma
- Recognising patients who possess multiple fall risk factors

The Quality and Safety team carries out weekly audits in high reporting areas and uses the results to deliver targeted education, such as in Emergency portals and care of older adults.

Medications

We continue to capture medicine incidents and support colleagues in reporting concerns. Promoting adherence helps prevent errors and fosters an open reporting culture, ensuring continuous learning in medicines management. We strive to learn from mistakes, review systems and processes, and support colleagues in providing effective medications. This helps us review potential harms and identify lessons quickly, reducing risks for patients. The learning is then disseminated and monitored.

Areas with Good Progress during 2025/2026

We made good progress against our quality and safety priorities during the year, including:

Reduction in total patient falls per 1000 bed days and in falls resulting in any harm to patients per 1000 bed days in 2025/2026 compared to 2024/2025

Continued to embed the Patient Safety Incident Response Framework and approach to responding to incidents and system-based learning

Continued to exceed the national Friends and Family Test recommendation benchmark of 95% for Inpatients and Maternity Services

4 Patient Safety Partners as part of Patient Safety Incident Review Framework (PSIRF) implementation were in post and supporting patient safety initiatives

2 Patient Safety Specialists have completed the Level 3 and 4 National Training via Loughborough University with further 2 due to complete in 2026

Call for Concern (Martha's Rule) implemented across RSUH and co-designed our solution to component 3 (daily feedback from patients/families/carers) with patient involvement and Digital Support for ease for colleagues

Continued improvement in Sepsis Screening and IV antibiotics for inpatients, Emergency portals and Children

During 2025/2026, the Trust has not seen an increase in like for like numbers compared to 2024/2025 for Clostridium Difficile (C Diff)

Areas for Further Improvement during 2026/2027

Whilst we are proud of the progress made this year, we acknowledge that further improvement is necessary in several key areas to ensure the continued delivery of high-quality patient care and safety.

Emergency Department Waiting Times

We are committed to improving waiting times in the Emergency Department (ED). Reducing these waits is crucial in providing timely care for patients and alleviating pressure on frontline staff.

Elective Performance

Enhancing our elective performance remains a priority. This involves optimising the scheduling and delivery of planned procedures to minimise delays and ensure efficient patient flow.

Ambulance Handover Delays

We aim to further reduce ambulance handover delays. By streamlining processes, we seek to provide faster transitions for patients arriving by ambulance, thereby improving their experience and outcomes.

Sepsis Screening Compliance and Pathway

Continued improvement in sepsis screening compliance and pathway is essential. We strive to ensure early identification and intervention for sepsis, supporting better patient outcomes.

Reducing Harm from Falls

We are focused on further reducing harm resulting from falls. By reviewing and refining preventative measures, we aim to safeguard patients and minimise injuries.

Timely Observations Using Vitalpac Electronic System

Improving the recording of timely observations through the Vitalpac electronic system is a priority. Accurate and prompt documentation supports effective monitoring and care for our patients.

Hospital Acquired Pressure Ulcers and Deep Tissue Injuries

We continue to work towards reducing hospital acquired pressure ulcers and deep tissue injuries, especially those linked to lapses in care. Ongoing education and process refinement are central to achieving this goal.

Clostridium Difficile Cases

Reducing the number of Clostridium Difficile (C Difficile) cases remains an important focus. Through vigilant infection control and adherence to best practices, we aim to minimise occurrences and protect patient health.

This year has been challenging, with high demand for our services and complex operational pressures. Our colleagues have worked diligently to provide safe, compassionate, and high-quality care to as many patients as possible.

As Chair and Chief Executive of UHNM we are extremely proud how all our colleagues have faced the ongoing challenges and demonstrated the capabilities of our teams. Whilst there will undoubtedly be further challenges for UHNM, and the NHS as a whole, during 2025/2026 and beyond, we are confident that UHNM teams will continue to meet these challenges. We hope you enjoy reading the Quality Account and find it informative.

The Directors are required under the Health Act 2009, National Health Service (Quality Accounts) Regulations 2010 and National Health Service (Quality Account) Amendment Regulation 2011 and 2013 to prepare Quality Accounts for each financial year. The Department of Health has issued guidance on the form and content of annual Quality Account (which incorporate the above legal requirements).

In preparing the Quality Account, directors are required to take steps to satisfy themselves that:

- The Quality Account presents a balanced picture of the Trust's performance over the period covered.
- The performance information reported in the Quality Account is reliable and accurate.
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Account, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Account is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- The Quality Account has been prepared in accordance with Department of Health guidance.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the Quality Account.

Jackie Small
Chair

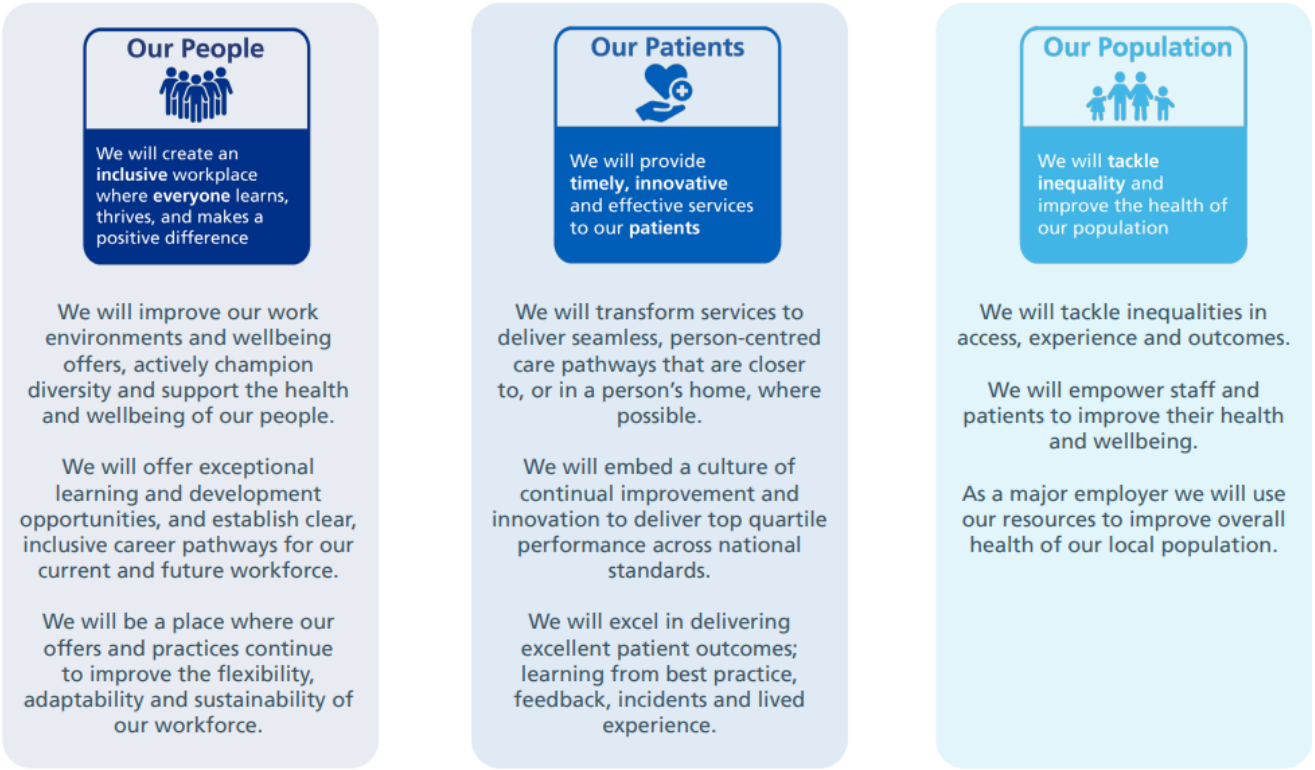
Dr Simon Constable
Chief Executive

3. Our Vision – The best joined-up care for *all*

Our strategy continues to guide our priorities and decisions over the next 10 years.

Our priorities

To achieve Our Vision we must respond to the changing requirements of the NHS as they emerge and operate in ever more challenging times. This means that we need to think further than the 'here and now' and continue to look beyond the boundaries of our organisation for inspiration. Our involvement in the ICS is crucial in enabling us to move towards our vision and to become a sustainable provider of healthcare services for generations to come.



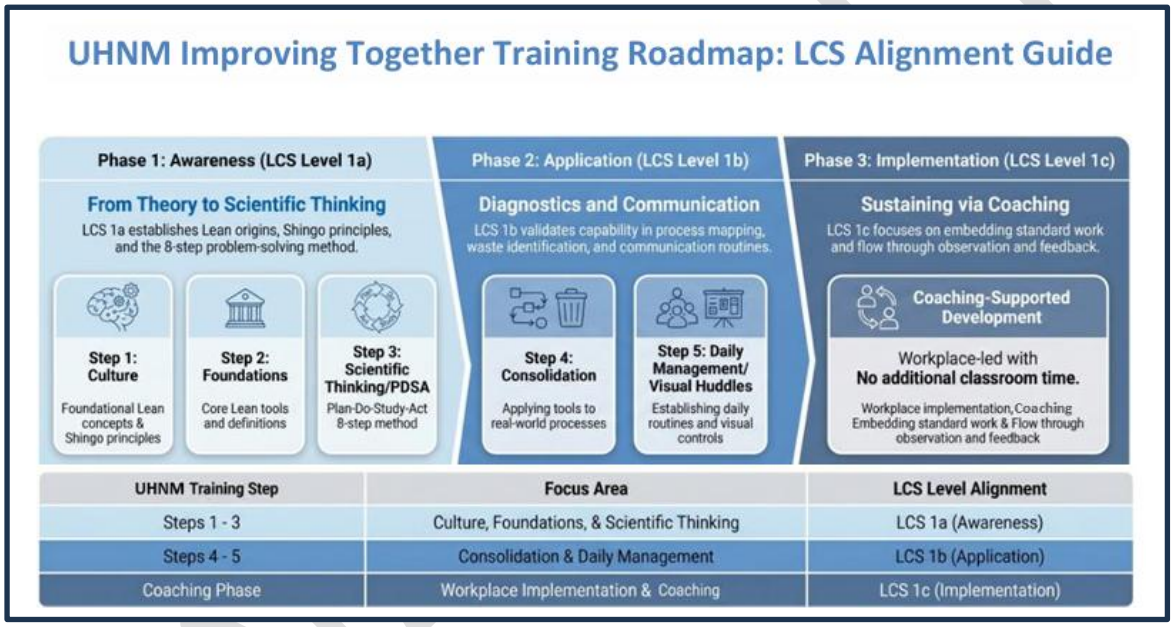
Our Vision is available via our website: www.uhnm.nhs.uk .

3.1 Priorities for improvement

Continuous Improvement (CI)

In line with the refreshed Trust Strategy 'Quality Improvement' (people closest to the patient being equipped with knowledge and skills and empowered to make changes that deliver measurable improvements in patient care) has evolved into Continuous Improvement, where we build QI into everyone's day to day work – it becomes how we do things around here. 2025/6 saw responsibility for making improvements and using the methodology being added into the updated job description template at the Trust.

Ensuring access to training, so everyone can meet the requirements of their job description, has been a key effort for the CI Academy over the last 12 months. The training programme now takes a stepwise approach, with Steps 1-4 available to all colleagues, providing them with key skills for making improvements. Step 5 supports team leaders and managers to create the environment in which improvement can thrive.

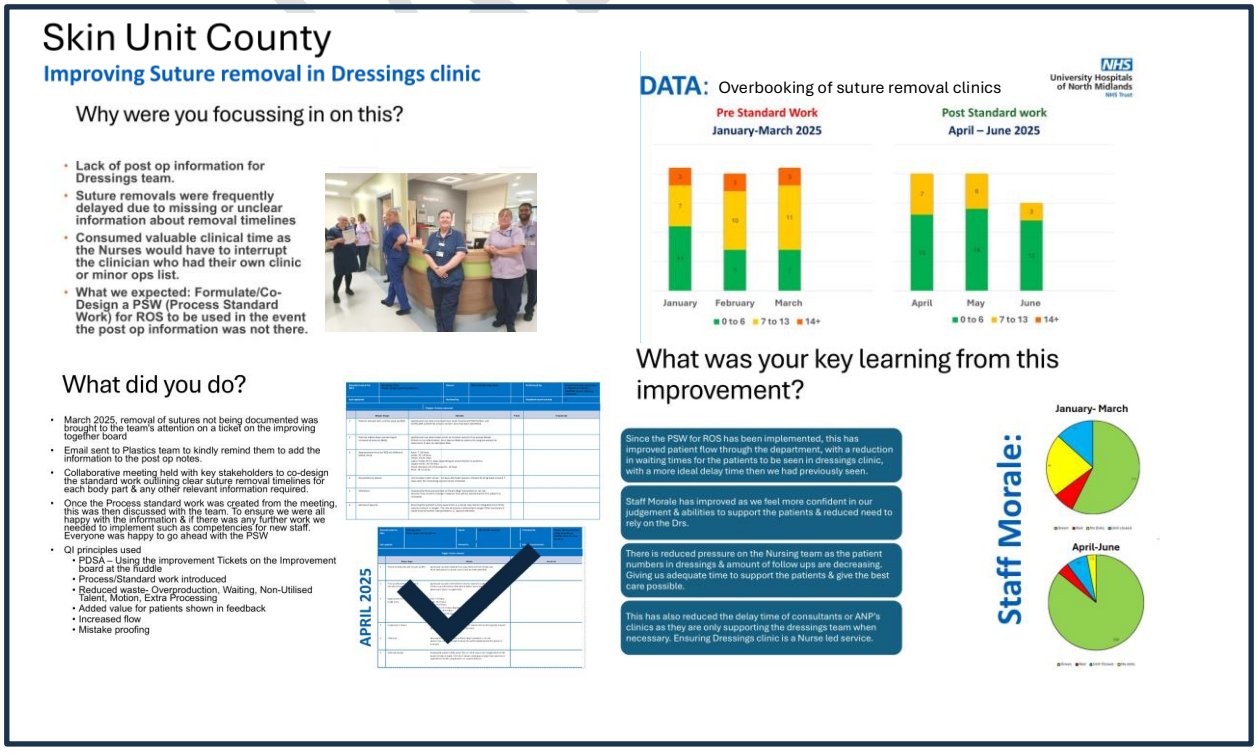


Over the past 12 months a further **2068** colleagues have been trained through **2973** training points, bringing the Trust total of staff with some level of improvement training on their ESR to **7018**. This training is accredited by the Lean Competency System (LCS), the industry standard for Lean training and since September 2024 **189** colleagues have taken the opportunity to convert their 'in-house' training into externally recognised and certified qualifications. The training sessions are highly rated by attendees with 98% being rated 4 or 5 stars.

The CI Academy are active in the LCS community space and hosted a Lean Community event at the Royal Stoke site in June 2025. Being part of this community ensures that the skills and reputation of the centre of excellence team continue to grow, alongside that of our organisation. In September 2025, the UHNM team were presented with the LCS 'Improvement for Good' award for their work in supporting teams at County Hospital and Maternity services in achieving their improved CQC ratings of 'GOOD'. Dr Ruth Bednall was individually recognised for her leadership in this space.

Looking to the future and the need for closer partnership working with colleagues in our Integrated Care System, the CI academy has begun to train improvement colleagues from partner organisations in preparation for the potential co-delivery of certified cross-system training. This will allow colleagues along patient pathways to use the same improvement approach to deliver improved care for our patients.

However, simply delivering training is not enough, the skills and knowledge need to be applied to make measurable improvements and there are many case studies to demonstrate this over the last 12 months we share a couple of these below.



Maternity Assessment Unit – Royal Stoke

March 2026

Blood Pressure Assessment Improvement

Why were you focussing in on this?

Background:

MAU was experiencing breaches in assessment times for Priority 2, 3 and 4 patients, with a particular concern around Priority 2 (highest risk) women.

A key risk group identified was women attending MAU with raised blood pressure. There was no routinely available data; assessment times were monitored via a manual audit from the K2 system, creating a single point of failure.

Understanding the problem:

The team came together to understand demand, flow and variation using:

- Manual data collection
- Visual review of breaches
- MDT discussion and reflection

SMART Aim:

Wouldn't it be great if assessment times for Priority 2, 3 and 4 women in MAU did not breach (by March 2026)?Prediction: If we made high-risk BP assessments quicker and more reliable, Priority 2 breaches would reduce and flow through MAU would improve.

What did you do?

Step 1 – Build reliable data: Co-designed standard work so any member of the team could extract and review K2 data. Removed reliance on a small number of individuals and enabled regular review of performance.

Step 2 – Analyse and share learning: Data showed breaches were predominantly in Priority 2 women with high blood pressure. Findings were shared with the wider MDT to build understanding and consensus.

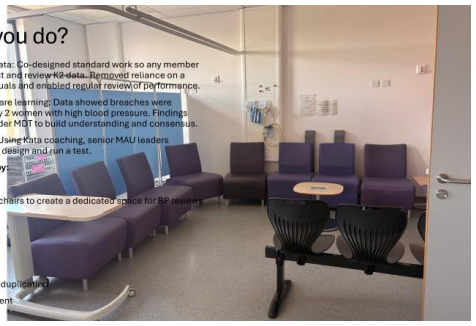
Step 3 – Test a change: Using kata coaching, senior MAU leaders coached one another to design and run a test.

A BP Bay was created by:

- Removing two beds
- Replacing them with chairs to create a dedicated space for BP reviews

QI principles used:

- PDSA cycles
- Standard work
- Increased flow
- Reduced waiting and duplication
- Strong MDT engagement



What impact have you had?

How do we know this was an improvement?

Following introduction of the BP Bay, the team has been able to:

- See more women in a timely way
- Reduce delays for high-risk BP assessments
- Improve flow through MAU, particularly at peak times

Staff report:

Greater clarity and confidence in managing BP presentations

Improved ability to prioritise high-risk women

Women are being assessed more promptly in an environment designed for their needs

Learning from testing:

Some delays to medical review were identified – highlighting the next improvement opportunity rather than a failure

What was your key learning from this improvement?

Key learning

- Good data is essential – creating standard work unlocked improvement.
- Small environmental changes can have a big impact on flow and safety.
- Kata coaching supported leaders to learn, test and adapt together.

Next steps – Adapt

Test a midwife-led discharge pathway for women attending MAU solely for BP review.

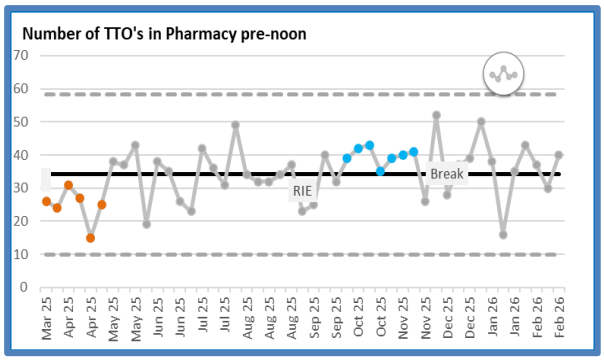
Reduce unnecessary waits for medical review where clinically appropriate.

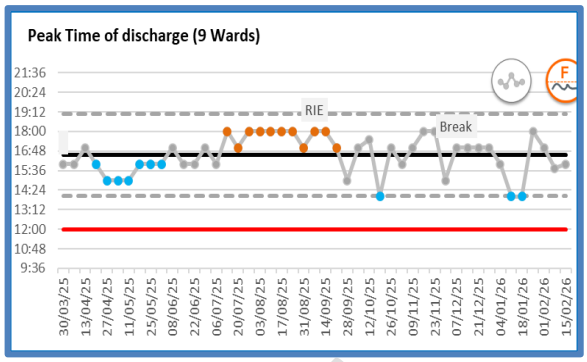
Future plans:

Continue iterative testing using PDSA cycles. Use learning from the BP Bay test to inform wider MAU flow improvements.

Over the past 5 years that the programme has been running, 56 frontline teams have been trained in this approach with 20 sustaining this over the longer term. Leadership has been seen to be fundamental to success, and Improving Together has not remained the focus in all areas over the last 12 months. With a change in corporate governance structures, approach and reporting following the implementation of the new Trust Strategy, the improvement methodology has featured less in the operations and business arena, and leadership has been distracted with organisational restructure. Recovery of previous levels of engagement with the methodology is a priority for 2026/7.

Through the late summer and autumn months the CI Academy team supported the Brilliant Basics programme seeking to improve timeliness of discharges from in-patient wards. They tested a different approach to improvement using a 'Kaizen' or 'Rapid Improvement Event' method. Working with the 9 wards that pull most patients from AMU, they first upskilled teams and leaders and then worked with them to develop standard processes for handover, board round and discharge letter preparation. This resulted in an improvement in the % of discharge prescriptions being received by Pharmacy before 12noon and some early improvement in moving the discharge profile earlier in the day (see graphs below). This however did not sustain through the implementation of ePMA and winter pressures. Valuable learning was identified, specifically, reinforcing the need for visible consistent leadership.





Following this the CI academy have focussed their support on the Quality agenda. Since the start of 2026 we have begun a more integrated approach to improvement, working with the Quality, Safety and Compliance nursing team in supporting teams who are 'Silver' (requires improvement) in their Care Excellence Framework (CEF) assessment. Using the CEF scorecard to guide improvement focus and the improvement huddles to facilitate team discussion and decision making, improvement to key quality metrics have rapidly emerged in the pilot wards. This approach is now being scaled and spread Trust wide. With a programme being developed to support the further CQC ambitions of the Trust.

Centre for Nursing, Midwifery and Allied Health Professions (NMAHP) Research and Education Excellence (CeNREE)

CeNREE was launched on 25th April 2022 in response to a desire from UHNM to have a service where research remains highly integrated with clinical practice throughout a clinical career. The UHNM 2025 Strategic Vision includes a goal to be a world-class centre of achievement, where patients receive the highest standards of care and the best people come to learn, work and research. This has led to the development of CeNREE and their mission statement:

The mission of the Centre for NMAHP Research and Education Excellence (CeNREE) is to create the most supportive environment possible so that our researchers, practitioners, and learners can do what they do best: improve clinical outcomes and experience through access to clinical research for colleagues and patients. Excellence will be applicable across the wider NHS through leadership and excellence in nursing, midwifery and allied health professional education, research and practice.

CeNREE asks our people to have three questions they always ask of their own clinical practice: Why are we doing this? Is there a better way? What does the evidence say? CeNREE supports our people to look at the evidence. If there is evidence, this can support improvement. If there is no evidence, CeNREE will support the development of new knowledge in terms of research that will improve patient outcomes through high quality, evidence-based care.

Alongside research, CeNREE also encompasses the education team, who provide the preceptorship programme, and a leadership and development team who provide the Chief Nurse Fellowship programme.

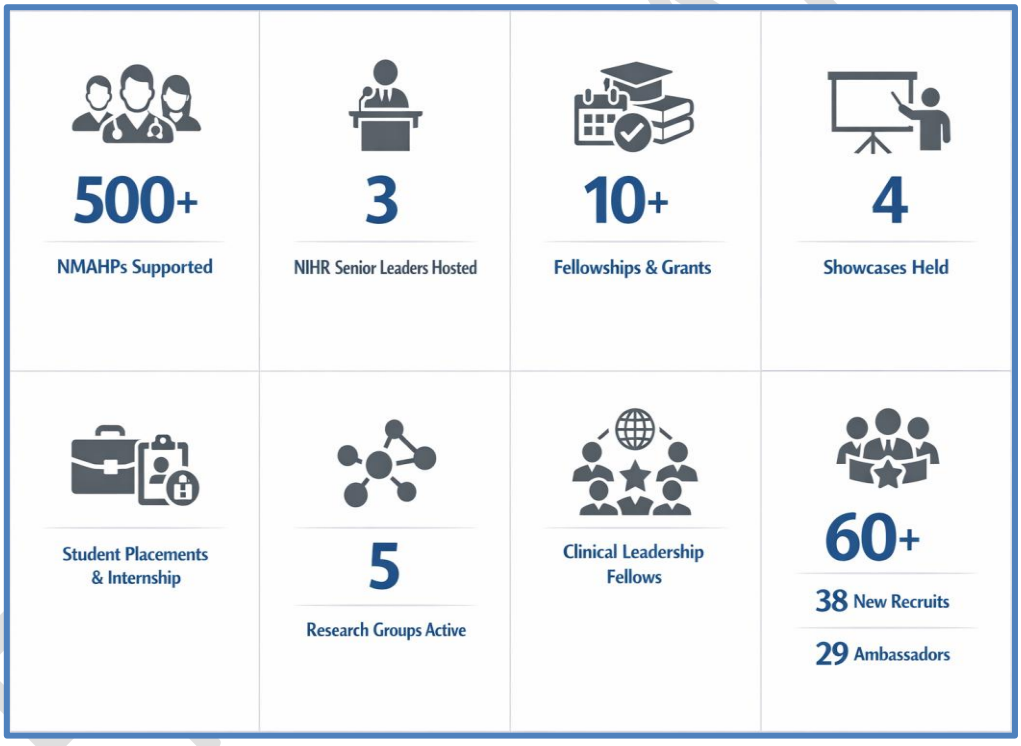
Our third cohort of CeNREE Fellows and Chief Nurse Fellows attending their 'graduation' alongside Chief Nurse Ann-Marie Riley OBE, and Programme Lead Rachel Houghton

This year CeNREE has again extended its portfolio of internal and external fellowship opportunities to provide colleagues of all professions with access to professional development tailored to organisational needs and encourage and energise colleagues to then consider and pursue more advanced opportunities. The infrastructure created by CeNREE is focused on the talent management of UHNM NMAHPs, developing a culture of professional curiosity and advanced knowledge and skills.

In their four years CeNREE:

- Have provided support to over 500 NMAHPs.
- Host three National Institute for Health and Care Research (NIHR) Senior Research Leaders.
- Have supported and continue to support six prestigious NIHR Pre-doctoral Clinical & Practitioner Academic Fellowship (PCAF), one NIHR Doctor Clinical and Practitioner Academic Fellowship (DCAF), one NIHR pre-application support grant, two NIHR West Midlands HCP Internship awards, four North Staffs Medical Institute grant and one UHNM Charity grant.
- Have hosted four successful showcases.
- Have hosted several student placements and an internship.

- Continue to facilitate 5 active research groups convened during the Catalyst event in November 2023, focused on Healthy Ageing, Workforce, Research Culture, Access and Health Inequalities, and Colleagues and Patient Quality, Risk and Experience.
- Actively participate in the CNO Research Transformation Leaders Network and the Council of Deans Health Clinical Academic Roles Implementation Network (CARIN) through the CeNREE Director providing a voice at a national level.
- Have hosted three NHS England Clinical Leadership Fellows.
- Have continued to facilitate an award-winning Preceptorship Programme.
- Have supported over 6**0** colleagues to graduate from the Chief Nurse Fellow Programme, including 28 from cohort 3, who also achieved LEAN certificates from the CI Academy.
- Have recruited a further **38** fellows to join cohort 4 of the fellowship programme, including nurses, midwives, AHPs, pharmacy technicians, pharmacists, and clinical scientists.
- Have appointed more Research Ambassadors to signpost colleagues to CeNREE support and encourage evidence-based practice, joining a total Ambassador Network of 29.



Going forward in 2026/27, CeNREE aims to continue to build on UHNM research capacity and capability, and to grow a critical mass of research leaders amongst non-medical professions, who are acknowledged nationally to be underrepresented in research highlighted in the Fit for the Future 10 year plan (NHS 2025) and the Office for Strategic Coordination of Health Research Report (CoDH 2025).

3.2 Delivering our Quality Priorities in 2026/2027

We developed our Quality Delivery Plan which sets our priorities for our patients, which aligned with the NHS Long Term Plan, our obligations under the Health and Social Care Act (2012) and the expectations of our regulators.

Ann-Marie Riley OBE
Chief Nurse

At UHNM we are committed to building a culture of continuous quality improvement, ensuring that our patients and colleagues are engaged and listened to. During 2025/2026 we have continued to implement our strategy along with the national Patient Safety Incident Response Framework (PSIRF).

Our continued development and embedding the principles of learning from incidents and near misses as part of PSIRF has seen the enhancement of our learning response tools, wider engagement in incident learning responses with internal and external partners and stakeholders. Our Patient Safety Partners and Patient Safety Specialists have continued to provide valuable support and insight in developing improvements and learning. This along with our continuing development of clinical effectiveness frameworks and active research programmes, will support improvements locally and to our wider population and system partners.

Our Patients

Prioritising our quality improvement areas

We have continued our focus on quality aligned to our strategic objectives and the recently published **Our Vision**.

Our aim is to provide timely, innovative and effective services to our patients.

Our plan has our Trust values firmly at its core. We continue to promote a compassionate culture through our values, which identify the attitude and behavioural expectations of our colleagues with inclusivity at the heart of our values.

UHNM have developed our priorities by using internal intelligence and engaging with variety of groups that use and access our services. Feedback has been gathered throughout 2025/26 through engagement and discussion with:

- Patient and families
- Colleagues
- Staff survey
- Integrated Care Board
- Hospital User Group
- External Stakeholders
- National Inpatient Survey
- World Patient Safety Day 2025

Our quality priorities for 2026/2027

For 2026/27, we will focus on reducing avoidable harm, strengthening system-based learning and data insight, improving patient experience through targeted, evidence-based improvement delivery whilst supporting a healthy, engaged workforce through improved wellbeing services and strengthened leadership, recognising staff experience as a key enabler of patient safety and quality.

Improvement aim	Quality Improvements	Outcome
Improve patient safety & reduce avoidable harm	Reduce avoidable harm with implementation of harm free care actions across the Trust using focussed improvement support To strengthen deterioration recognition and escalation by improving timely observations and NEWS response processes Enhance infection prevention and antimicrobial stewardship	Reductions in avoidable harm and improved reliability of care will strengthen our safety culture and learning with improved outcomes for patients.
Improve staff health and wellbeing to enable high-quality, safe care	Strengthen wellbeing support and access to services by expanding access to staff support services and targeting support Improve leadership, engagement and workforce experience by strengthening line management capability and consistent people management practice	Improved staff wellbeing, engagement and morale leads to enhanced workforce capacity and resilience to deliver high-quality care with improved continuity and patient outcomes
Improve patient experience and responsiveness of services	Improve experience of high-pressure services by supporting services to provide enhanced communication and patient support during delays Strengthen the complaints learning and integrate complaints insights with PSIRF learning and reporting Embed inclusive patient-centred care by expanding patient leadership and coproduction in service design and improvement.	Good quality patient experience is at the heart of all we do and making patients/carers part of the learning and design will improve the quality of services we provide
Improve quality of care through learning, data and system insight	Embed PSIRF and system-based learning with increased patient/carer involvement Strengthen clinical effectiveness and outcome measurement by developing Trust-wide KPIs and patient outcomes framework whilst embedding GIRFT recommendations and pathway redesign across specialities Improve data quality, coding and insight for assurance by enhancing data completeness and reliability to support governance and decision-making	Patient Safety and patient outcomes are enhanced through our learning culture and practice based on evidence that we do things the right way to achieve best outcomes for our patients

4. Patient Stories

"My partner and I really wanted to express our appreciation for the care given to our twin boys. I feel as though your team and department probably do not receive the gratitude which you deserve. Our journey was not always smooth due to the lack of incubators which we understand is not anyone's fault. There was a concern we might have to transfer to another hospital; however, we really appreciate being able to stay at Royal Stoke and have the care we wished for. By way of thanking you, we just wanted to list a few members of staff who we believe have made our whole experience such a good one. We have noted with gratitude their hard work and care as they are the reason our babies are here today so cannot thank them enough!

The first few moments meeting Rowena we felt more relaxed and supported as she was on the ball. She really looked after me when I could not eat waiting for my procedure. Rowena also got a consultant to come down and speak to us to get questions answered and to make some sort of plan. She was the first one to work out logically when I could eat by taking efforts to contact departments to work this out. I felt she supported us by getting the advice we needed and always looking out for my welfare. She would even use her breaks to come check and chat on us and even when not in care on her ward would still visit which just shows what type of caring person she is. I also felt more confident having surgery speaking to her. Vicki was a rock from day one in supporting both me and my partner. I feel as though we had great advice off everyone, however Vicki was the person who really got me so far with my breastfeeding and the reason for being able to then constantly breastfeed. I also felt her knowledge and advice for other matters was spot on. Vicki also made us laugh and felt as though she was not just my boys nurse but supported me at times of need. We felt as though we made a friend and not just someone being paid to care for our boys.

Theatre team: Phenomenal! That's the word I can only use as I did not expect the process to be so intense as it was but without the absolute kindness, caring and communication from the team I had, I am not sure it would have gone as smoothly.

The NICU team: All the nurses, especially Abi, are just angels sent down from heaven! These nurses do not ever take their eye off the ball showing 24/7 care and how they also communicate and work together in passing over the shifts. They also showed care for me not just my babies, especially Abi, checking on my welfare and never holding me back in being involved and letting me be able to connect with my babies in such a difficult environment. Constant care and impressive skills with such complex machinery. Leaving twin 1 on the night of my procedure was the hardest thing to do but the way they explained everything just gave me the boost to be able to leave."

"A small note to say a huge thank you. I have recently been under your care for breast cancer and you operated on me twice, 12 November and 31 December 2025. I feel extremely lucky that I received you as my surgeon. From the first time my husband and I met you, you put us at ease and made us feel comfortable. You gave us time and showed genuine care. You made me feel like I was the only patient under your watch.

The incisions you made during each operation, firstly on my left breast and then under my armpit, healed very quickly without any issues and were stitched to leave minimal, discrete scars, which leads me to think you are an exemplary surgeon. I truly feel that you are dedicated to your job, to helping people and you must feel great pride and satisfaction in your work.

Although I thanked you each time we met, I did not want to leave you in any doubt of my gratitude and hence wanted to put it in writing.

Please can you convey my sincere thanks to all of your team too. I met with several members of staff and nothing was too much trouble. Natasha and Sara were in attendance most times I met with you, and they were excellent at providing the necessary information and explanations – their manner mirrors your own, sincere and kind, and you work together seamlessly.

One final but important point I would like to mention – just prior to each operation, you touched me briefly on the shoulder. This meant so much to me, they filled me with confidence, warmth and comfort at a time I needed it most. Thank you."

5. Review of services

5.1 Care Quality Commission

UHNM is required to register with the Care Quality Commission (CQC) and our current registration status is registered without conditions.

The Trust is registered to provide the following services:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Diagnostic and screening procedures
- Family planning
- Maternity and midwifery services
- Surgical procedures
- Termination of pregnancies
- Treatment of disease, disorder, or injury

CQC have not conducted any formal inspections at UHNM during 2025/2026.

The table below shows the current overall UHNM rating by the five key domains and compares results to previous inspections:

Domain	August 2021 Ratings	October 2024 Ratings	
Safe	Requires Improvement	Requires Improvement	●
Effective	Requires Improvement	Good	●
Caring	Outstanding	Outstanding	★
Responsive	Requires Improvement	Requires Improvement	●
Well-Led	Good	Good	●
Overall	**Requires Improvement**	**Requires Improvement**	●

In April 2025, the CQC published its report following unannounced inspection of Maternity Services (undertaken 27th November 2024). The assessment was a focussed follow inspection. The final outcome of the assessment was to rate Maternity Services as Overall Good. The overall rating for the service, as well as the ratings for how safe and well-led the service, has improved from requires improvement to good.

The CQC said:

"We were pleased to see that leaders and staff working in maternity services at Royal Stoke University Hospital had acted on our feedback from the previous inspection and worked hard to make improvements. Women and people using these services now had a much safer and improved experience of their care and treatment. Behind this was an improvement in how well-led the service was which in turn supported staff to provide better care."

"Leaders now thoroughly reviewed incidents to identify improvements and shared learnings to reduce the risk of these happening again. They also held weekly risk meetings to help keep people admitted to the unit safe."

"The trust was proactive in seeking feedback from people and their families about their experiences of care. The service had an open culture where people felt comfortable raising concerns."

"Staff showed care and compassion when supporting families. Our inspection team spoke to a family member who described how staff were on hand to answer questions and provide reassurance during their pregnancy. Another mother talked about how staff had been confident, knowledgeable and kept her updated after the birth."

"Overall, the maternity team at Royal Stoke University Hospital should be proud of the improvements our inspection found. We have identified some areas where they can make continued progress, and we look forward to seeing their plans develop."

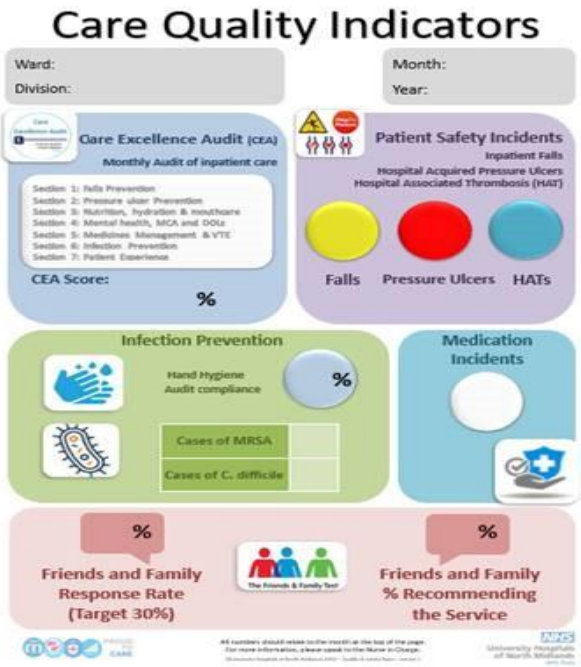
5.2 Care Excellence Framework

The Care Excellence Framework (CEF), developed at University Hospitals of North Midlands NHS Trust, is a unique, integrated tool of measurement, clinical observations, patient and colleagues interviews/feedback, benchmarking and improvements. The framework reviews the following:

- Safety
- Effectiveness
- Responsive
- Caring
- Well-led

This internal accreditation system, aligned with national quality standards and regulations, uses clinical data and intelligence to assure quality from ward to board. Wards or departments receive an overall award—bronze, silver, gold, or platinum—based on collected evidence.

The CEF has operated at UHNM since 2016, with ongoing reviews ensuring it remains applicable across the organization. Custom toolkits are provided for various departments, including inpatients, paediatrics, maternity, outpatients, theatres, and the emergency department, and are regularly updated with input from subject matter experts to address current needs and improvement areas



Each ward or department is assessed for assurance in specific domains. The CEF uses a supportive approach to encourage learning, improvement, and recognition. We continue to validate results using Mock Unannounced CQC inspections in wards, bringing in external ICB senior leaders for unbiased reviews based on CQC's criteria. This process ensures transparency, demonstrates measurable improvements, and helps benchmark excellence across the organisation.

During 2025/26, the Care Excellence Framework provided strengthened ward-to-board assurance through enhanced leadership oversight, workforce support and data-driven improvement. Alignment of staff feedback to the NHS People Promise strengthened the Well-led and culture domains, while Bronze-rated areas received targeted Professional Nurse Advocate restorative supervision to support delivery of safe and effective care.

Regular senior nursing and Patient Leader reviews were embedded for areas requiring improvement, enabling focused escalation, support and challenge based on CEF intelligence. The introduction of CEF scorecards to structure improvement huddles has sharpened grip on accreditation-critical metrics and supported early improvement. Work is now underway to expand CEF metrics beyond nursing, incorporating medical, AHP and operational indicators to further strengthen integrated quality assurance.

In 2025/2026 improvements to the Care Excellence Framework have been made including:

- Staff feedback explicitly aligned to the NHS People Promise, strengthening the "Well-Led" and culture components of CEF
- Bronze areas now have explicit access to Professional Nurse Advocate (PNA) support for restorative supervision and coaching, recognising workforce wellbeing as a quality enabler
- Bronze rated areas meet regularly with senior nursing leaders (Deputy Chief Nurse, Head of Nursing, Matron for Quality, Safety & Compliance) alongside a Patient Leader to review data, progress and support need
- Pilot use of CEF scorecards to guide improvement huddles, enabling wards to focus on metrics that directly influence accreditation outcomes
- Work to expand metrics beyond nursing, incorporating Medical, AHP and operational indicators into CEF criteria (in progress).

5.3 PLACE Inspection

UHNM completed its Patient-led assessments of the Care Environment (PLACE) inspections in Autumn 2025. UHNM achieved above the national average for all the domains for a third year running. The PLACE scores achieved in 2025 for UHNM, and its sites Royal Stoke and County Hospitals, demonstrate that the hospital environment for patients from a non-clinical perspective at UHNM continues to provide a positive experience for our patients. Good environments and services that respond to the needs of our patients really do matter and thanks go to all colleagues for their continued hard work and commitment in this area.

Special recognition goes to our Estates, Facilities and PFI Division for the vital part they play every day in continuing to maintain an excellent care environment and impacting positively on our patient and colleagues experience.

The table below outlines the site scores for Royal Stoke University Hospital and County Hospital plus the overall UHNM Trust organisation score alongside the national average for 2025.

Site Name	Cleanliness	Combined Food	Organisation Food	Ward Food	Privacy, Dignity & Wellbeing	Condition, Maintenance & Appearance	Dementia	Disability
Royal Stoke University Hospital	99.84%	96.43%	94.27%	96.99%	90.98%	99.23%	88.00%	91.47%
County Hospital	99.87%	95.51%	90.60%	97.92%	95.08%	99.27%	93.89%	94.01%
UHNM Trust Score 2025	99.85%	96.36%	93.99%	97.06%	91.29%	99.24%	88.45%	91.66%
National Average	98.55%	92.13%	N/A	N/A	89.37%	97.00%	85.68%	87.12%

Patient Representative Comments

In addition to completing score sheets on a pass, fail or qualified pass basis, patient assessors are encouraged to provide any supporting comments that the Trust may take on board. During the assessment the following quotes were noted

County Hospital: *"A great feel from the areas visited and patients seemed very comfortable."*

Royal Stoke Hospital: *"Confident first and last impressions overall, clean and tidy and an overall calm feeling despite being very busy."*

5.4 Participation in clinical audit

Clinical audit is an evaluation of the quality of care provided against agreed standards and is a key component of quality improvement. The aim of any clinical audit is to provide assurance and to identify improvement opportunities. The Trust has an agreed yearly programme of clinical audit which includes:

- National audit where specialties/directorates are asked to be involved;
- Corporate and divisional audits; and
- Local audits which clinical teams and specialties determine and reflect their local priorities and interests.

As part of the Clinical Audit Policy, any clinical audit carried out within the Trust should be registered with the Trust's Clinical Audit Team, and the team has a database monitoring audit progress.

The national clinical audits and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) enquiries that the Trust participated in, and for which data collection was completed during 2025/26 alongside the number of cases submitted are referred to in the tables below:

A process is in place to ensure that leads are identified for all the relevant national audits and NCEPOD.

National confidential enquiries

Following receipt of the reports, we undertake review of the recommendations and implement an improvement plan.

NCEPOD Study	UHNM Registered	Status
NCEPOD: Rehabilitation following critical illness	Yes	Completed
NCEPOD: Blood Sodium	Yes	Action Plan
NCEPOD: Acute Limb Ischaemia	Yes	Action Plan
NCEPOD: Emergency Procedures in Children and Young People	Yes	Action Plan
NCEPOD: Acute Illness in People with a Learning Disability	Yes	Awaiting national report
NCEPOD: Stabilisation of the critically ill child	Yes	Awaiting national report
NCEPOD: Pleural Procedures	Yes	Awaiting national report
NCEPOD: Rib Fractures	Yes	Data Collection

All published reports are received by the Trust and reviewed locally. A steering group is convened for each enquiry and local action plans are developed where necessary to ensure all relevant recommendations from NCEPOD are implemented. Implementation of the action plans is monitored centrally at the Trust's Executive Quality and Outcomes Group, chaired by the Chief Medical Officer to ensure full completion.

5.5 National Clinical Audits

These audits indicate our level of compliance with national standards and provide us with benchmark information on which to compare practice. The results of the audits inform the development of local action plans to improve patient care.

National Clinical Audit	UHNM Registered	% of cases submitted
BAUS - investigation and referral of women with recurrent urinary tract infection using recent Guidance (BOOMERANG)	Yes	100%
BAUS - Evaluating the Management Pathway for Suspected Testicular Cancer Referrals (EMPAST)	Yes	100%

Breast and Cosmetic Implant Registry	Yes	100%
British Spine Registry	Yes	100%
Case Mix Programme - Intensive Care National Audit and Research Centre (ICNARC)	Yes	100%
Cleft Registry and Audit Network (CRANE) continuous data collection	Yes*	100%
Emergency Medicine QIP: Adolescent Mental Health	Yes	100%
Emergency Medicine QIP: Care of Older People	Yes	100%
Emergency Medicine QIP: Mental Health Self Harm	Yes	100%
Emergency Medicine QIP: Time Critical Medications	Yes	100%
Epilepsy 12 – National Clinical Audit of Seizures and Epilepsies for Children and Young People	Yes	100%
Falls and Fragility Fracture Audit Programme: National Audit of Inpatient Falls	Yes	100%
Falls and Fragility Fracture Audit Programme: National Hip Fracture Database	Yes	100%
Falls and Fragility Fracture Audit Programme: The Fracture Liaison Service Audit	Yes	100%
Learning from Lives and Deaths in People with a Learning Disability and Autistic People (LeDeR)	Yes	100%
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE – UK Collaborative)	Yes	100%
National Adult Diabetes Audit: National Diabetes Core Audit	Yes	100%
National Adult Diabetes Audit: National Diabetes Footcare Audit	Yes	100%
National Adult Diabetes Audit: National Diabetes Inpatient Safety Audit	Yes	100%
National Adult Diabetes Audit: National Pregnancy in Diabetes Audit	Yes	100%
National Adult Diabetes Audit: Transition (Adolescents and Young Adults) and Young Type 2	Yes	100%
National Adult Diabetes Audit: National Gestational Diabetes Audit	Yes	100%
National Audit of Cardiac Rehabilitation	Yes	100%
National Audit of Care at the End of Life (NACEL)	Yes	100%
National Audit of Dementia	Yes	100%
National Bariatric Registry	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Metastatic Breast Cancer	Yes	100%
National Cancer Audit Collaborating Centre: National Audit of Primary Breast Cancer	Yes	100%
National Cancer Audit Collaborating Centre: National Bowel Cancer Audit	Yes	100%
National Cancer Audit Collaborating Centre: National Kidney Cancer Audit	Yes	100%
National Cancer Audit Collaborating Centre: National Lung Cancer Audit	Yes	100%

National Cancer Audit Collaborating Centre: National Non-Hodgkin Lymphoma Audit	Yes	100%
National Cancer Audit Collaborating Centre: National Oesophago-Gastric Cancer Audit	Yes	100%
National Cancer Audit Collaborating Centre: National Ovarian Cancer Audit	Yes	100%
National Cancer Audit Collaborating Centre: National Pancreatic Cancer Audit	Yes	100%
National Cancer Audit Collaborating Centre: National Prostate Cancer Audit	Yes	100%
National Cardiac Arrest Audit	No**	N/A
National Cardiac Audit Programme: National Adult Cardiac Surgery Audit	Yes	100%
National Cardiac Audit Programme: National Congenital Heart Disease Audit (NCHDA)	Yes	100%
National Cardiac Audit Programme: National Heart Failure Audit (NHFA)	Yes	100%
National Cardiac Audit Programme: National Audit of Cardiac Rhythm Management (CRM)	Yes	100%
National Cardiac Audit Programme: Myocardial Ischaemia National Audit Project (MINAP)	Yes	100%
National Cardiac Audit Programme: National Audit of Percutaneous Coronary Interventions	Yes	100%
National Cardiac Audit Programme: The UK Transcatheter Aortic Valve Implantation (TAVI) Registry	Yes	100%
National Cardiac Audit Programme: Left Atrial Appendage Occlusion (LAAO) Registry	Yes	100%
National Cardiac Audit Programme: Patent Foramen Ovale Closure (PFOC) Registry	Yes	100%
National Cardiac Audit Programme: Transcatheter Mitral and Tricuspid Valve (TMTV) Registry	Yes	100%
National Child Mortality Database (NCMD)	Yes	100%
National Comparative Audit of Blood Transfusion: 2025 Major Haemorrhage Audit	Yes	100%
National Emergency Laparotomy Audit (NELA): Laparotomy	Yes	100%
National Emergency Laparotomy Audit (NELA): No Laparotomy	Yes	100%
National Joint Registry	Yes	100%
National Major Trauma Registry	Yes	100%
National Maternity and Perinatal Audit (NMPA)	Yes	100%
National Neonatal Audit Programme	Yes	100%
National Ophthalmology Audit Database: National Cataract Audit	No***	N/A
National Ophthalmology Audit Database: Age Related Macular Degeneration Audit	No***	N/A
National Paediatric Diabetes Audit (NPDA)	Yes	100%
National Perinatal Mortality Review Tool (PMRT)	Yes	100%

National Asthma and COPD Audit Programme: COPD Secondary Care	Yes	100%
National Asthma and COPD Audit Programme: Adult Asthma Secondary Care	Yes	100%
National Asthma and COPD Audit Programme: Pulmonary Rehabilitation	Yes	100%
National Asthma and COPD Audit Programme: Children and Young People's Asthma Secondary Care	Yes	100%
National Vascular Registry	Yes	100%
Paediatric Intensive Care Audit Network (PICANet)	Yes	100%
Perioperative Quality Improvement Programme	Yes	100%
Sentinel Stroke National Audit Programme (SSNAP)	Yes	100%
Serious Hazards of Transfusion (SHOT): UK National Haemovigilance Scheme	Yes	100%
UK Cystic Fibrosis Registry: Adults	Yes	100%
UK Cystic Fibrosis Registry: Children	Yes	100%
UK Interstitial Lung Disease (ILD) Registry	Yes	100%
UK Parkinsons Audit	Yes	100%
UK Renal Registry Chronic Kidney Disease Audit	Yes	100%
UK Renal Registry National Acute Kidney Injury Audit	Yes	100%

*UHNM only provides demographic data to the Cleft Registry, further patient care is provided at specialist centres.
**University Hospitals of North Midlands NHS Trust is currently not signed up to this national audit as the Resuscitation Team do not have the funding or the resource to complete the audit. The collection, submission and verification of information require dedicated administrative support.
***University Hospitals of North Midlands NHS Trust is currently not signed up to this national audit as the Ophthalmology Team do not have access to the electronic system required to participate. A funding review is currently in progress.

Corporate and local clinical audits

A total of 120 clinical audit projects were completed by clinical audit team and a further 662 clinician led audit projects were registered during 2025/26. These audits help us to ensure that we are using the most up-to-date practice and identify areas where we can make further improvements. An example of improvements made in response to the audit results is:

Audit of Alcohol Assessments in UHNM Emergency Departments

Action	Co-ordinator	Status of Action
In order to improve the timely and effective identification and management of patients admitted to UHNM requiring support for alcohol misuse, the following actions will be undertaken:		
A new Prevention Practitioner role will be introduced at UHNM. This role will provide ongoing support, advice and training for ward/ clinic staff to enable them to effectively screen patients on arrival to UHNM.	Lead Alcohol Liaison Nurse	Complete
The above role will be supported by the provision of a new Alcohol Pathway which will enable Ward / Clinic staff to successfully manage patients based on their individual needs / circumstances. The pathway will inform staff which process to follow to ensure the best outcome for their patient including the provision of information and referral to appropriate services.	Lead Alcohol Liaison Nurse	Complete
The number of Alcohol Link Nurse roles within the Emergency Departments will be increased to ensure more patients are being screened in a timely manner	Lead Alcohol Liaison Nurse / Emergency Department Clinical Management Team	Complete
The Alcohol Liaison Team will work with the Emergency Departments to produce a list of key health issues / comorbidities that would trigger the need for alcohol screening. This will enable staff to efficiently identify patients who require additional support and will ensure the provision of a proactive treatment plan on admission	Lead Alcohol Liaison Nurse / Emergency Department Clinical Management Team	Complete
To determine if improvements in practice have taken place a re-audit will be undertaken.	Consultant Anaesthetist / Clinical Audit Team	2026/2027 Clinical Audit Programme

5.6 Clinical Effectiveness

A Clinical Effectiveness Framework has been developed with an accompanying delivery plan detailing the different steps to be taken to enable UHNM to achieve better performance outcomes, better patient outcomes and higher CQC ratings.

The framework aims are:

- **We will do the right thing for patients by ensuring decisions about health care are based on the best available, current, valid and reliable evidence.**
- **We will work in the right way by ensuring information is up to date, accurate and properly analysed and reviewed by people with the appropriate skills and competence to understand its significance.**
- **We will ensure patients have the right outcome through a robust mechanism of continuous improvement, assurance and evaluation.**

The framework, supported by a range of Clinical Effectiveness documents and procedures, describes the Trust's vision to apply the best knowledge, derived from research, clinical experience, and patient preferences to achieve optimum processes and outcomes of care for patients. The document empowers Care Groups to take ownership of their Clinical Effectiveness priorities, providing them with the necessary guidance and resources to achieve the above aims.

Requirements around the following are included:

- Care Group Meeting Structure– Governance Packs, terms of reference, attendance
- Provision of a Clinical Effectiveness Lead within each Care Group
- Process maps detailing receipt of external guidance, reports and audit results
- Reporting
- Risk management.
- Monitoring

Other key workstreams that are underway:

Patient Outcomes

Patient outcomes are the measurable changes in a patient's health, functional status, or quality of life resulting from healthcare interventions. These outcomes, which include clinical results, mortality rates, and patient-reported satisfaction, are crucial for assessing the effectiveness of care, adapting treatment plans, and shifting toward value-based healthcare models that prioritise patient-centred results.

The Clinical Effectiveness Team consistently work with Clinical Teams to embed best practice and provide assurance the patients are receiving optimum care, however, information around patient outcomes following the provision of intervention or surgery is not routinely collected.

Key aspects of patient outcomes include:

- Patient-Reported Outcome Measures (PROMs): These are tools used to measure a patient's health status or quality of life at a single point in time, commonly used in procedures like hip and knee replacements.
- Patient-Reported Outcomes (PROs): Reports directly from the patient about their health condition, such as symptoms or functional status, without interpretation by a clinician.
- Clinical Outcomes: Measurable data points such as infection rates, readmission rates, and survival rates, which reflect the quality of care and safety.
- Importance in Care: Measuring outcomes helps personalise care, improve communication between patients and clinicians, and guide research to develop more effective treatments

The Clinical Effectiveness Team are currently reviewing local and national processes to ascertain the feasibility of implementing a patient outcomes framework at UHNM.

Key Performance Indicators

Key Performance Indicators (KPIs) help track the quality of care, patient satisfaction and safety, ensuring that patients receive the best possible treatment. Although the Trust Quality Performance Report encompasses a Clinical Effectiveness update, there are currently no performance measures available. The following KPIs have been proposed from a Trust Wide perspective. Throughout 2026 / 27, the Clinical Effectiveness Team will be working with the Directorates to develop their own KPIs in relation to their Clinical Effectiveness priorities.

Getting It Right First Time at UHNM

During 2025/26, UHNM saw a significant increase in GIRFT activity, resulting in the development and implementation of action plans across five clinical specialities.

Clinical Areas Under GIRFT Review with Action Plans in Progress

The Clinical Effectiveness update for 2025/26 outlines the following areas and corresponding recommendations:

- Breast Surgery: *6 recommendations*
- General Surgery (on-site): *16 recommendations*
- Interventional Radiology (IR): *19 recommendations*
- Urology: *7 recommendations*
- Vascular Surgery: *17 recommendations*)

Key Themes Identified Across Specialties

Analysis of the GIRFT reviews across multiple specialties has highlighted several recurring themes that influence service delivery and improvement efforts.

- **Capacity and Flow Constraints:** Services are consistently facing challenges related to patient flow and operational capacity. These constraints impact the ability to deliver timely care and can lead to bottlenecks, especially in high-demand areas.
- **Workforce and Job Planning:** The need for robust workforce planning and effective job allocation has been identified as a priority. Ensuring that staffing levels and skill mixes are appropriate is critical for maintaining service quality and meeting patient needs.
- **Pathway Redesign:** There is a strong focus on redesigning clinical pathways to improve efficiency and patient outcomes. Streamlining processes and removing unnecessary steps can enhance the patient journey and optimise resource use.
- **Data and Coding Quality:** Accurate data collection and coding are essential for monitoring performance and informing decision-making. Improvements in this area are necessary to ensure that services are properly evaluated and that resources are allocated effectively.
- **Business Case and Capital/Estate Support:** Development of business cases and securing capital or estate support are prominent requirements, particularly within Interventional Radiology (IR) and Vascular services. Investment in infrastructure and resources is vital to support service growth and modernisation.

These recurring themes provide a framework for ongoing action planning and service development within the Trust, with particular emphasis on addressing operational challenges and supporting sustainable improvements across clinical areas.

Examples of actions/progress reported in 2025/26

- Planned Care documented the integration of findings from GIRFT and other site visits into a unified action plan. At the referenced time, this plan comprised 22 actions, with 7 actions completed.
- Vascular GIRFT themes included long waits (e.g., revascularisation delays), coding validation, POPS service considerations, readmissions coding accuracy, mortality review, and bed-base cohorting challenges.
- Interventional Radiology actions included estate/business case development (including possible MES inclusion), POA/SOP development, Bluespier rollout, patient information/consent improvements, training needs analysis, and anaesthetic access considerations.
- Urology actions included strengthening key pathways (e.g., haematuria), addressing follow-up backlog, job plan review for hot lists, and improving diagnostics turnaround and coding.
- Breast Surgery actions included improving day-case performance, theatre scheduling order, rationale for overnight stays, and workforce/service development for DIEP reconstruction.

5.7 Participation in clinical research

UHNM participates in clinical trials across the healthcare sector from novel interventions and drugs to device innovations which aim to improve quality of life and outcomes for our patients. Improving participation and engagement with clinical research is a high priority for UHNM.

As a centre of clinical and research excellence we participate in clinical trials from across the healthcare sector including novel interventions, new drugs and device innovations. These cutting-edge developments are translated into our day-to-day clinical practice. UHNM continues to sponsor homegrown Research with key areas including a multi-centre study with Birmingham Women's and Children's NHS Foundation trust looking at method for treating endometriosis**.**

There are several other key reasons why UHNM should participate in research. Being research active:

- is associated with better clinical and other patient outcomes;
- brings a range of finance benefits, including savings on medicines and colleagues time;
- improves UHNM's reputation;
- enhances recruitment and retention of high quality colleagues;
- improves knowledge and skills in provision of evidence-based practice;
- is key to our academic partnerships; and
- enhances patient experience.

For some studies, research practitioners, midwives and paediatric nurses work alongside clinical teams and support services to identify and consent potential research participants, discussing trials with patients and providing care throughout the studies. Research at UHNM is also conducted under the leadership of nurses, midwives, and allied health professionals (AHPs).

During 2025/26, we **recruited 837 participants to our portfolio of 264 active research studies**. With our new recruits and those being followed up from previous years, the income generated from recruitment activity this year has been our highest to date. This year, we opened 48 new studies to add to our portfolio, 18 of which were commercial studies, which is 2 more than we opened in the previous year.

During 2025/26, we achieved in first two key milestones in CRDC NM: the **UK's first recruitment for the Remedy 2 trial** and **Europe's first recruitment for the Tak 3001 trial**. This is a major achievement for UHNM and CRDC North Midlands.

Furthermore, the CQC is increasingly recognising the value of research, and it has been identified that research active organisations fare better in CQC inspections. A key development has been the recent agreement by CQC to include, for the first time, a question about research opportunities offered to patients in the CQC Annual Survey of Inpatient Experience.

Audience	Research	Innovation
Our People	Empower staff to take part in research activity to grow capacity and capability across the Trust.	Encourage and support colleagues to generate innovative approaches to enhance practice.
Our Patients	Increase and simplify access to research and ensure activity is patient-centred to secure better outcomes.	Generate and adopt innovative approaches to improve patient care and deliver better outcomes.
Our Population	Collaborate with partners to ensure research activity reflects the healthcare needs of our populations.	Work collegiately to harness innovation to tackle deep-rooted health inequalities.

5.8 Data Quality

The Data Quality Strategic Plans and Data Quality Assurance Group continued to provide strategic and operational assurance to the Executive Business Intelligence Group, led by the Chief Financial Officer, throughout 2025/26 and upwards to the Finance Committee. The corporate Data Quality Team has continued to provide assurance throughout the last year to support the improvement of data quality and the provision of excellent services to patients and other customers.

- The Data Quality Team continued to support UHNM colleagues, answering and resolving thousands of queries. The DQ User Support Process has been expanded to provide additional support, training and assurance of user understanding.
- The Data Quality Strategy Action Plan has been developed and is reviewed regularly to ensure compliance against delivery targets.
- As per the strategy, module 1 of the 'Important to Role' DQ e-learning is scheduled to go live on ESR in Q1 26/27 with further modules in development.
- Support for IT projects, particularly ePMA, also continued with testing, validation and systems expertise provided by the team.
- The operational data quality groups have been re-established following the Trust's restructuring to Clinical Business Unit, with representatives identified from all directorates. These groups fulfil an important role in the 'Data Quality Assurance Framework'.
- The Documentation Approval Group continues to review and approve the content of RTT and Data Quality training materials and guidance documents for accuracy before implementation.
- The Terms of Reference and Calendar of Business for the Data Quality Assurance Group have been approved for 26/27 ensuring they address data quality obligations to the CAF / Data Security and Protection Assurance Framework.

2025/26 has been another productive year for the data quality team and we aim to build on this throughout 2026/27 with the key focus being 'from reactive to proactive", supporting the strategic aims of the Trust.

5.9a Secondary Uses Service (SUS) Data Validity

UHNM submitted records to the Secondary Uses System (SUS) for inclusion in the Hospital Episode Statistics (HES) included in the latest published data. This is a single source of comprehensive data which enables a range of reporting and analysis in the UK. The figures below are for the period April 2025 to January 2026.

Valid NHS number performance is:

- 99.9% for admitted patient care; national performance is 99.7%.
- 100% for outpatient care; national performance is 99.8%.
- 100 % for Maternity care; national performance is 99.8%.

Valid Registered GP Code performance is:

- 100% for admitted patient care; national performance is 99.8%.
- 100% for outpatient care; national performance is 99.6%.
- 100% for Maternity care; national performance is 97.9%.

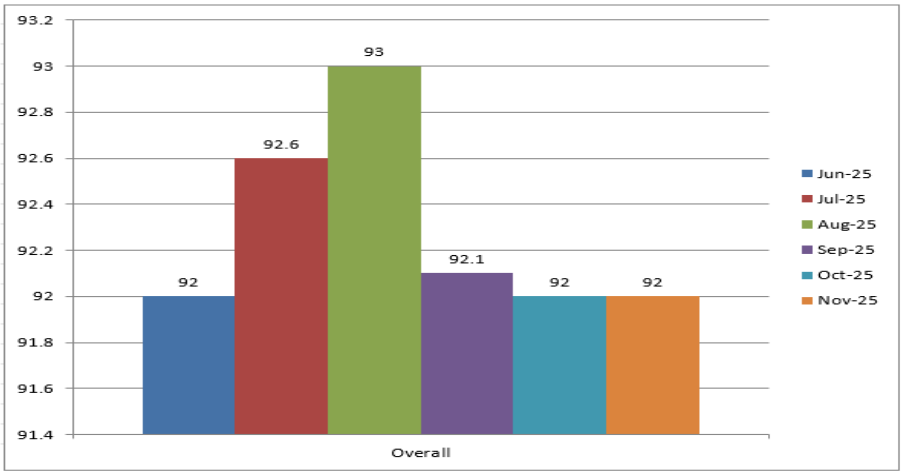
Valid Ethnic Category performance is:

- 96.5% for admitted patient care; national performance is 95.4%.
- 94.1% for outpatient care; national performance is 91.2%.
- 100% for Maternity care; national performance is 98.2%.

5.9b NHSE Data Quality Maturity Index

Additional benchmarking is carried out using the NHSE Data Quality Maturity Index (DQMI) dashboard. Throughout 2025/26 UHNM has consistently reported above the national average overall and on all Inpatient, Outpatient, ECDS and Maternity metrics. These are reported to the Data Quality Assurance Group and the Trust's Organisational Business Intelligence Group for assurance purposes.

UHNM - overall



National Averages

Month	Overall
Jun-25	86.5
Jul-25	86.3
Aug-25	87.6
Sep-25	87.1
Oct-25	86.7
Nov-25	86.3

5.10 Clinical Coding Accuracy Rate

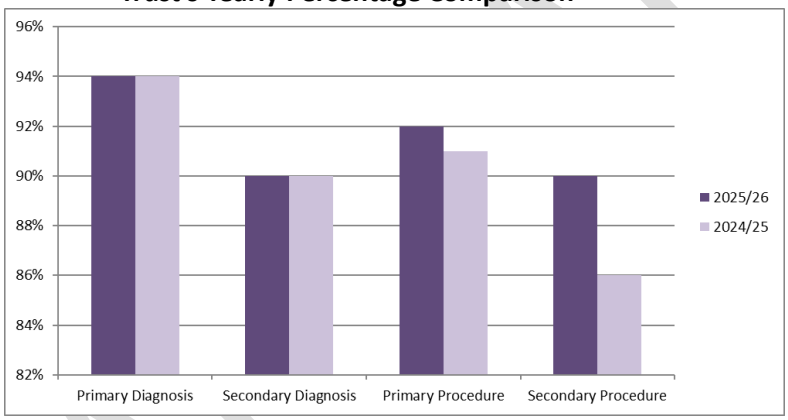
Annual audit

- The Cyber Assurance Framework / Data Security and Protection Toolkit (CAF /DSPT) clinical coding audit was carried out by the Trust's clinical coding auditors during 2025/26.
- An **overall 'Standards Met' attainment level**, which is the mandatory national requirement, was achieved across the audit with 3 of the 4 measures close to achieving the 'Standards Exceeded' attainment level:

Attainment Levels			
	Standards Met	Standards Exceeded	**Audit Results**
Primary Diagnosis	>90%	>95%	**94%**
Secondary Diagnosis	>80%	>90%	**90%**
Primary Procedure	>90%	>95%	**92%**
Secondary Procedure	>80%	>90%	**90%**

- The audit has identified **improvements** within the primary and secondary procedure accuracy.
- The accuracy of both primary and secondary diagnosis has been **maintained** since last year's audit.

Trust's Yearly Percentage Comparison



- All recommendations from the 2024/25 audit have been completed.
- Findings from the audit are fed back to all clinical coders to ensure lessons are learned and improve coding accuracy, working towards the 'Standards Exceeded' attainment level in next year's audit.

Coding Improvement Projects:

- The coding team are currently working IQVIA to identify areas for improvement both within the clinical coding process and clinical documentation used for coding purposes.
- The company has advised that the Trust's accuracy and depth of coding is significantly higher than other Trusts they've worked with. This has been confirmed by the lower-than-expected return rates from the analytics.
- The coding team are also working with Jigsaw Medical, in conjunction with the Trust's Digital Services and AI teams, to pilot automated coding of some high volume, low complexity activity.
- If successful, the plans are to automate some additional specialities.

Staff Audit Programme

- The internal audit programme continued throughout 2025/26 for all coding colleagues. The audit process is regularly reviewed and updated to provide a robust assurance process.
- Of the 31 staff audited in 2025/26, all achieved a minimum of the required 90% accuracy rate.

Training

- The Trust has a qualified Clinical Coding Trainer who annually reviews and updates the two-year training programme for trainee coders, including feedback from previous Trainees.

- The Trainer provides all mandatory national training, ensuring all coders are compliant with training requirements.
- The Trainer provided one Standards course in 2025/26 for 7 Trainee Coders and five Standards Refresher workshops for the continued development of the Lead Coders.
- All clinical coders have access to online training modules to enhance their knowledge and skill sets.

5.11 Data, Security and Protection (DSP) Toolkit attainment levels

This year was our first year in moving towards the revised DSP Toolkit; the cyber assessment framework (CAF). We achieved all standards, for June 2024 – June 2025 submission, with validation from our Internal Auditors. The Internal Audit report confirmed our overall risk rating across all five CAF objectives was low and the confidence level of the independent assessor in the veracity of the self-assessment was assessed as high. This demonstrates positive assurance in our approach to meeting all objectives. Our submission for June 2025 – June 2026 is ongoing and we are awaiting the findings from the Internal Audit review.

We took the opportunity to review our governance framework to ensure it still aligned to the reviewed CAF requirements; with the Digital Assurance Operational Group monitoring our organisational controls and the Cyber Security Operational Group monitoring our technical controls. The Audit Committee continues to seek assurance via the Cyber Assessment Report, encompassing our current position and delivery plan aligned to the Digital Strategy. On a more practical level we focused on Artificial Intelligence, supporting the AI Team with the development of a policy and governance and ethical framework, thereby setting out the agreed processes in commencing AI projects. We also focused our efforts in working with key specialist teams to develop DSP frameworks, setting out their framework in managing data.

Next year we will continue to focus on our due diligence with our suppliers (potential and current), ensuring they continue to align to best practices across digital systems, R&I and medical devices. Whilst the CAF is in its first year the National Team are keen to 'raise the bar' across several standards, which have been mapped out for the next 5 years. This means we will see an increase in the assurance required for those identified standards. Hence, we will be looking to develop a programme of work to assess our state of readiness and test our position via the Internal Audit review process. This will provide us with the opportunity to seek external validation, with time to implement any findings prior to our formal submission.

5.12 Seven-day services

The seven-day services standards were established to ensure that patients admitted as an emergency receive high quality consistent care, whatever day they enter hospital. Ten clinical standards for seven-day services in hospitals were developed and four of these subsequently identified as priorities based on their impact on patient outcomes.

These are:

- Standard 2 – Time to first consultant review;
- Standard 5 – Access to diagnostic tests;
- Standard 6 – Access to consultant-directed interventions; and
- Standard 8 – On-going review by consultant twice daily if high dependency patients, daily for others.

The importance of ensuring that patients receive the same level of high-quality care every day is reflected in the inclusion of these standards in the NHS Standard Contract. The CQC current hospital inspection regime features seven-day services under the effective key question.

In response to UHNM's consistent compliance with the standards, an assurance framework was developed which moved away from large scale audits to an overview of performance supported by a more focused review process.

A programme of clinical audit has been designed to monitor compliance, delegations of authority under Standard 8, and evidence of appropriate staffing levels, focusing on the following areas of practice:

- Consultant review
- Shared Decision Making
- Complex and on-going care needs
- Clinical handover process
- Provision of diagnostic services
- Provision of Consultant directed interventions.

5.13 Statement on Junior Doctor Rota Gaps and Guardian of Safe Working Hours Annual Report

In accordance with NHS England Quality Account guidance, the Trust includes this statement to meet the requirement set out in Schedule 6, paragraph 11b of the Terms and Conditions of Service for NHS Doctors and Dentists in Training (England) 2016 for a consolidated annual report on rota gaps and the actions being taken to reduce them.

During 2025/26, Guardian of Safe Working reports identified continuing rota gaps and workforce pressures affecting resident doctors, with vacant posts recorded at 34 in Quarter 1, improving to 19 in Quarters 2 and 3, before rising to 36 in Quarter 4. The most persistent vacancies during the year were in Emergency Medicine, Anaesthetics, Trauma, Acute and General Medicine, and Non-Divisional posts, with additional pressure in some specialties at different points in the year.

Across 2025/2026, exception reports totalled 1,038, rising markedly in Quarter 4 following the national changes to exception reporting introduced on 4 February 2026, which anonymised reports and increased reporting of missed breaks.

The Trust's annual improvement plan focuses on strengthening rota management and safe rostering arrangements, including closer monitoring of vacancy hotspots, formalising escalation pathways for short-notice sickness and cross-cover, reinforcing consultant ownership of safe rostering and rest breaks, and improving departmental responses to exception reports.

Administrative support for the exception reporting process has also been strengthened to improve the timeliness of processing, payments and follow-up actions. During the year, additional work has also been undertaken to communicate and embed the revised exception reporting arrangements, support educational supervisors and consultants to understand the new process, and monitor emerging themes so that rota design, workforce resilience and resident doctor wellbeing can be improved. While the revised reporting arrangements account for some of the increase in reported exceptions in Quarter 4, the reports demonstrate that rota gaps and workload pressures remain a material issue for the Trust and will continue to require active oversight and targeted improvement action during 2026/27.

Part B: Review of quality performance

6. Quality Priorities 2025/2026

In 2025/26, we identified specific priorities to focus on:

- **Improve patient safety & clinical effectiveness**
- **Improve staff health and wellbeing including person centred practice**
- **Improve patient experience**

Details of our performance against these priorities are provided in the following pages.

We use statistical process control (SPC) methods to draw two main observations of our performance against our key performance indicators (KPI's) along with a series of icons to describe what our performance data is telling us.

Table 1: Key quality Indicators Performance 2025/26 compared to 2024/25

Key Quality Performance Indicator	Target	2024/25 Performance	2025/26 Performance	
Induction of Labour	95%	98.0%	99.1%	↑
Maternity Triage	85%	92.9%	89.2%	↓
Patient Safety Incidents (PSI) rate per 1000 bed days	50.7	53.3	52.2	↓
PSI with moderate harm or above per 1000 bed days	0.6	0.6	0.7	↑
Patient Falls	5.6	5.0	4.6	↓
Patient Falls with harm per 1000 bed days	1.5	1.72	1.66	↓
Medication incidents per 1000 bed days	6.0	6.2	5.5	↓
Medication incidents % with moderate harm or above	5%	1.6%	1.4%	↓
Pressure Ulcers developed under UHNM per 1000 bed days	1.6	1.75	1.68	↓
Patient Safety Incident Investigation (PSII) instigated	N/A	31	14	↓
Never Events	0	9	4	↓
Venous Thromboembolism (VTE) Risk Assessment	95%	88	88%	→
Reported C Diffcile cases	144	169	169	→
Avoidable MRSA Bacteraemia cases	-	1	2	↑
Friends & Family Test: Inpatient	95%	95.7%	96%	↑
Friends & Family Test: Emergency Department	85%	66.9%	71.5%	↑
Friends & Family Test: Maternity	95%	86.4%	87.8%	↑
Sepsis: Adult Inpatient Screening	90%	95.4%	98.2%	↑
Sepsis: Adult Inpatient Intravenous Antibiotics in 1 hour	90%	99.1%	98.9%	↑
Sepsis: Emergency Portals Screening	90%	85.5%	92.5%	↑
Sepsis: Emergency Portals Intravenous Antibiotics in 1 hour	90%	81.9%	85.7%	↑
Sepsis: Children's Screening	90%	87.1%	91.6%	↑
Sepsis: Children's Intravenous Antibiotics in 1 hour	90%	50.0%	75.0%	↑
Sepsis: Maternity Screening	90%	78.9%	98.8%	↑
Sepsis: Maternity Intravenous Antibiotics in 1 hour	90%	78.7%	94.4%	↑
Hospital Standardised Mortality Ratio (HSMR)	100	126.17	129.90*	↑
Summary Hospital Mortality Index (SHMI)	100	113.29	119.53**	↑

*1st February 2025 – 31st January 2026

**1st January 2025 – 31st December 2025

Priority 1 To improve patient safety and clinical effectiveness

Quality, safety and patient experience remain our number one priority, and our strategy confirms our relentless commitment to the elimination of error, to systematic promotion of safety, embracing learning from our mistakes and those of others, changing our clinical services to improve the outcomes for patients and the delivery of excellent clinical results.
We said we would aim to achieve this by:

- Reducing our patient waiting lists and backlogs and maintain patient safety
- Reducing ambulance handover delays in conjunction with our partner providers
- Reducing avoidable harm
- Benchmarking against national best practice and assess our outcomes and effectiveness
- Improving how we share learning
- Introducing new national PSIRF programme and approaches
- Improving sepsis treatment and recognition of deteriorating patients;
- Evaluating and introducing new technologies and techniques for treating patients;
- Increasing the visibility of research and the capability of colleagues to lead research and provide evidence-based practice; and
- Continuing the delivery of the Improving Together Programme.

Performance for this priority has been monitored in 2025/26 using key indicators reported monthly through the Trust and Divisional Quality & Safety Reports. This section summarises these indicators' performance and their implications for our patients.

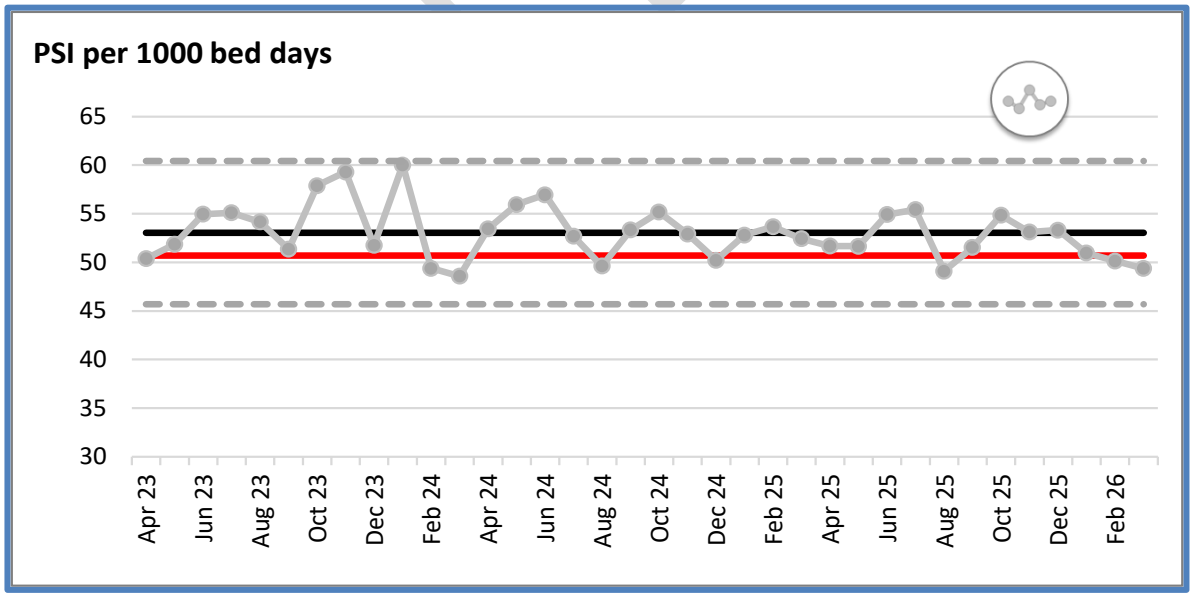
Patient Safety Incidents

We continue to prioritise patient safety by closely monitoring patient safety incidents (PSIs) as a critical indicator. These incidents are evaluated by the total number reported, the rate per 1,000 bed days, and the number and rate of incidents resulting in moderate harm or above.

Our commitment to enhancing services and patient care through thorough incident reporting, review, and identification of actionable insights remains unwavering. We encourage and promote the reporting of patient safety incidents and near misses which has seen consistency in total incidents reported from 26457 in 2024/25 to 26397 in 2025/26.

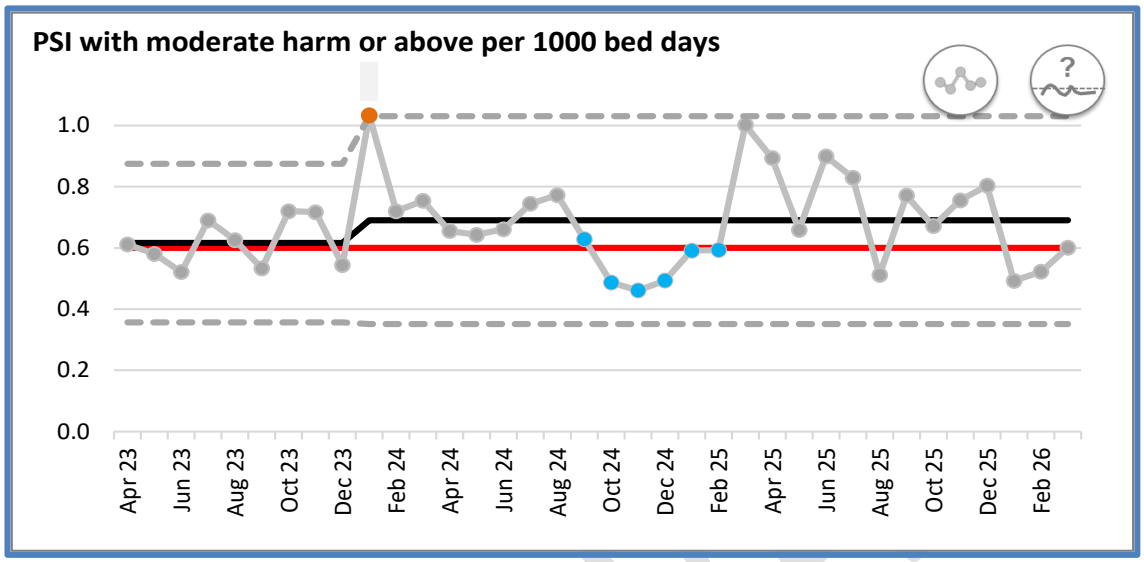
To ensure a comprehensive understanding of incident trends, we also assess the rate of reported incidents per 1,000 bed days, thus accounting for variations in activity levels throughout the year and this year's rate has remained relatively constant to previous year with 52.2 patient safety incidents reported per 1000 bed days.

During 2025/26, the Trust's overall PSI reporting rate has remained stable and consistent. This reflects continued engagement with reporting and learning from incidents and near misses utilising PSIRF systems-based approaches, and supports the early identification of risk, learning and improvement before harm occurs. The introduction of the Learning from Patient Safety Events (LFPSE) system and associated national reporting requirements did not adversely affect the stability of reporting rates when compared to previous periods.



While overall reporting has remained consistent, the rate of incidents reported as resulting in moderate harm or above has varied. As incident and near misses are reviewed, graded and closed there are changes to the level of harm attributed to incidents, therefore we continue to monitor both emerging signals and longer-term trends. The most common categories of incidents resulting in moderate harm or greater included treatment/procedure related, clinical assessment, patient falls, medication and maternity triggers.

The increase in the rate of incidents is reflected in the slight increase in the per bed rate resulting in moderate harm from 0.68 per 1000 bed days during 2024/25 to 0.70 per 1000 bed days in 2025/26, which remains below the long term mean rate. This trend reflects increased transparency in reporting.

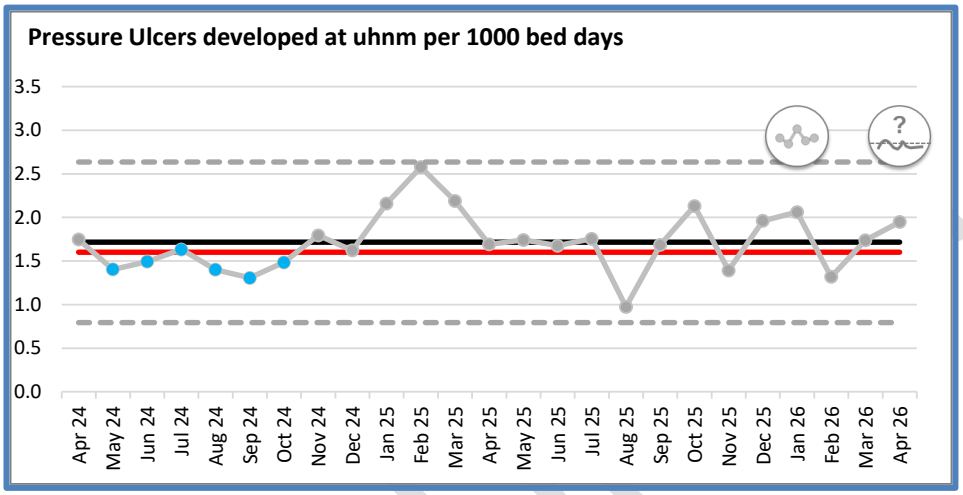


We continue to use thematic review and learning processes to ensure that learning is identified and translated into improvements in care. This includes reviewing harm profiles and incident themes (including those related to moderate harm and above), triangulating learning through Trust governance routes, and preparing to use nationally published LFPSE data as it becomes available to support benchmarking of reporting and outcomes.

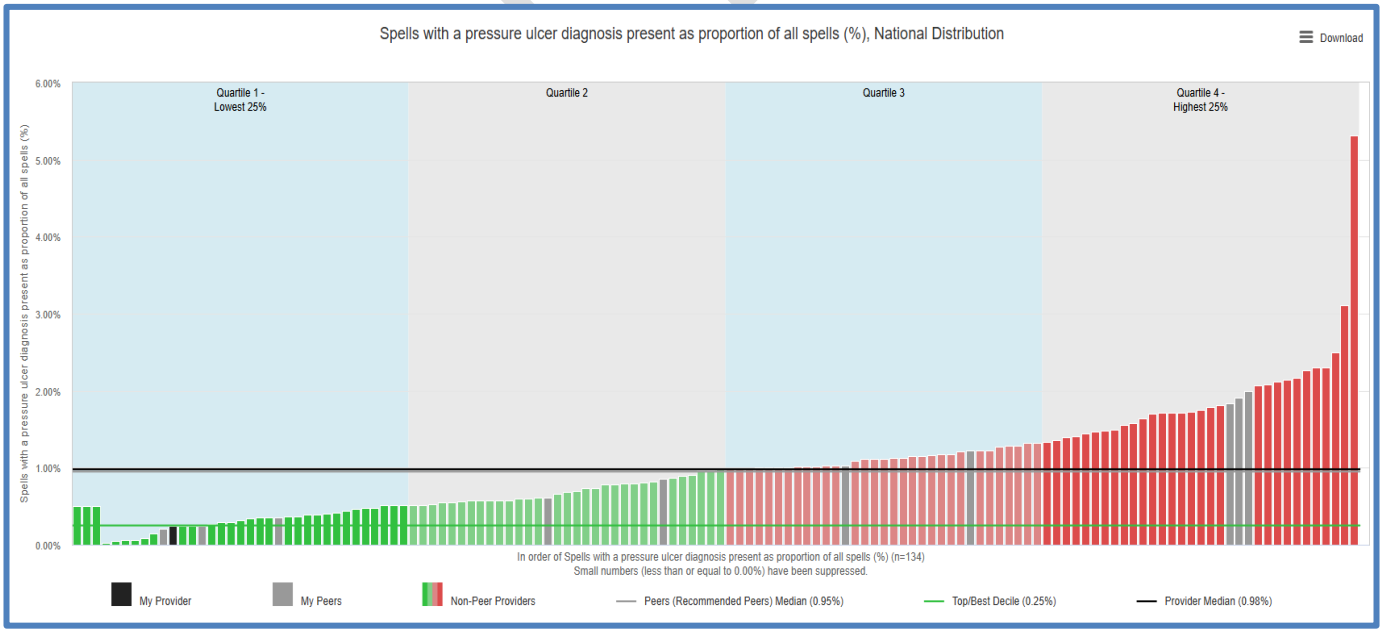
Pressure ulcers developed under UHNM Care

No significant change has been seen in the number of pressure ulcers reported as developing under UHNM care, or the rate per 1000 bed days in 2025-26 compared to previous years. In 2025-26 a total of 816 Category 2-4 pressure ulcers or Deep Tissue Injuries were reported. In 209 (26%) of these cases, lapses in care were identified on review. The number & proportion of cases with lapses identified was significantly lower at the beginning of the year, but the reduction does not appear to have been sustained.

The majority of lapses were a failure to document effective and timely repositioning in line with the prescription of care. The next most common lapse identified was the failure to document heel offloading.

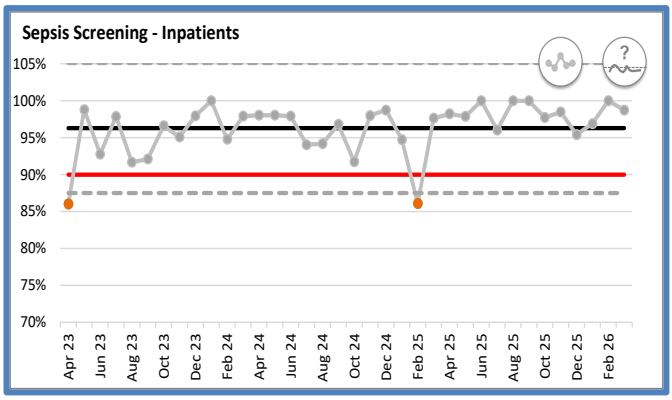


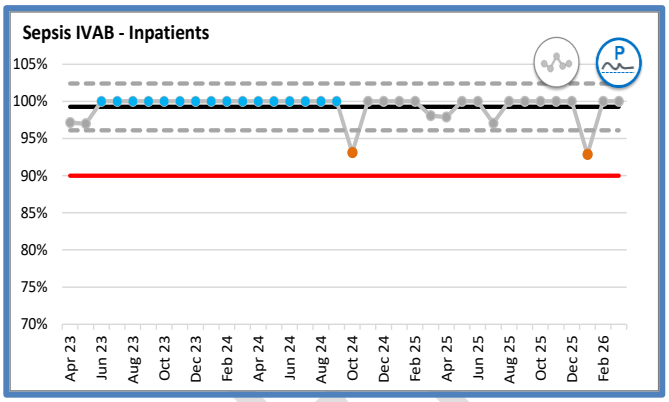
The chart below shows that UHNM is in the lowest quartile nationally for spells with a Pressure Ulcer diagnosis present as proportion of all inpatient spells.



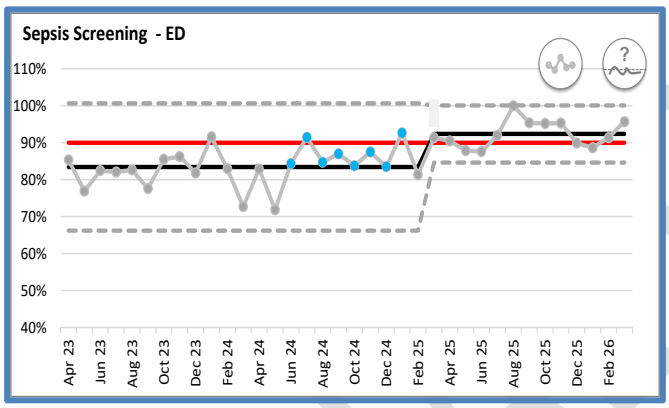
Sepsis recognition and treatment

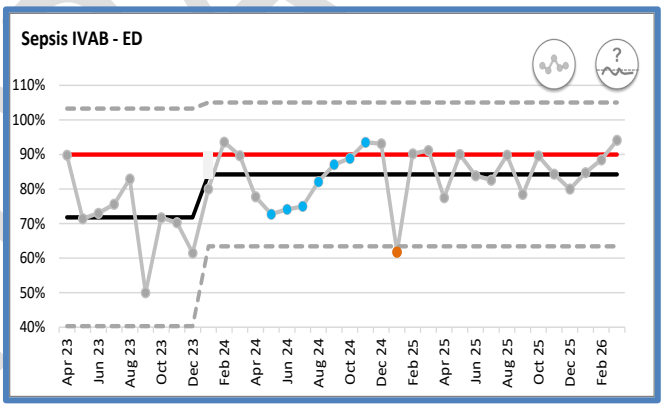
Inpatient areas have seen improvements in sepsis screening and Intravenous Antibiotics (IVAB) in one hour during 2025/2026. Sepsis screening improved from 95.4% to 98.2%. The IVAB in one hour has showed a very slight decrease from 99.1% to 98.9%.





Emergency Portals have seen improvement in screening and IVAB in one hour during 2025/2025. Sepsis screening increased from 85.5% to 92.5% and the IVAB in one hour from 81.9% to 85.7%.





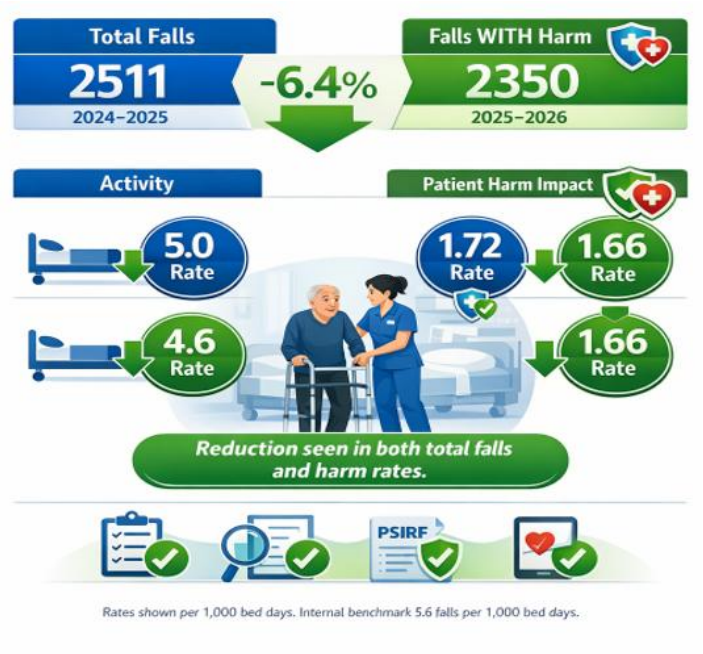
Actions and Next Steps

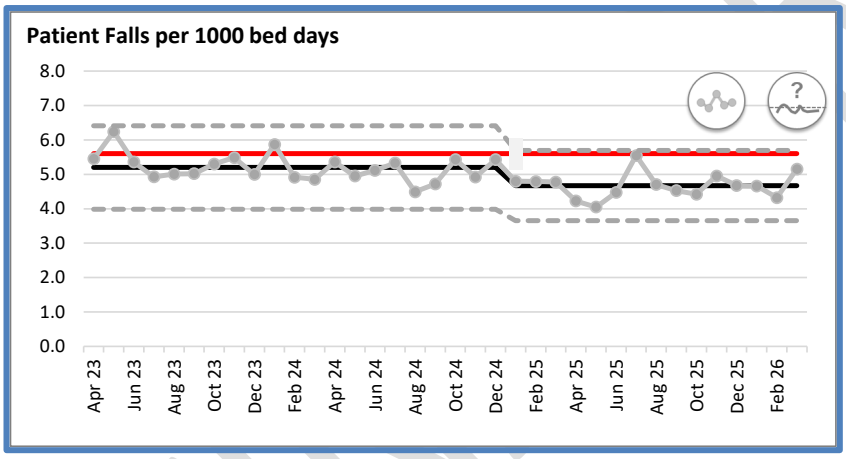
- The Sepsis Team continues to work collaboratively with ED Quality Nurses, Sepsis Champions, the senior team, and the ED Sepsis Lead to improve sepsis screening and intravenous antibiotic (IVAB) compliance.
- Regular visits and sepsis audits are ongoing across emergency portals, particularly within ED at RSUH, to support continuous improvement and monitor performance.
- Plans are in place to support World Sepsis Day, including awareness events across the Trust to further promote early recognition and treatment of sepsis.
- Multi-disciplinary training initiatives are being delivered to ensure an effective and co-ordinated team response to sepsis management.
- The Sepsis Team also continues to raise awareness of the importance of sepsis screening and IVAB compliance through involvement in Healthcare Assistant (HCA) induction and qualified nurses' preceptorship programmes.
- In addition, collaborative work with the maternity team remains ongoing, with training sessions provided to all members to support consistent and safe sepsis care

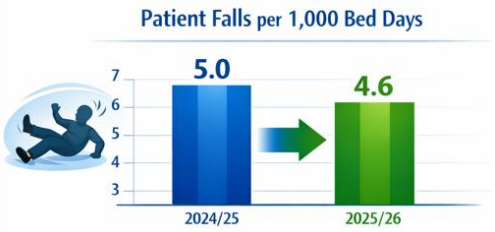
Patient falls

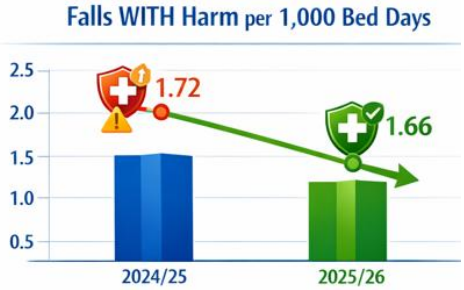
Patient falls remain the largest category of patient-related incidents within our organisation. During 2025-2026, there has been a further 6.4% reduction in total falls, with 2350 falls this year compared 2511 in 2024-2025. Additionally, the rate of falls per 1000 bed days has decreased from 5.0 to 4.6, continuing the steady improvement in reducing patient-related falls across the organisation. These reductions are contributing to better experiences and outcomes for patients

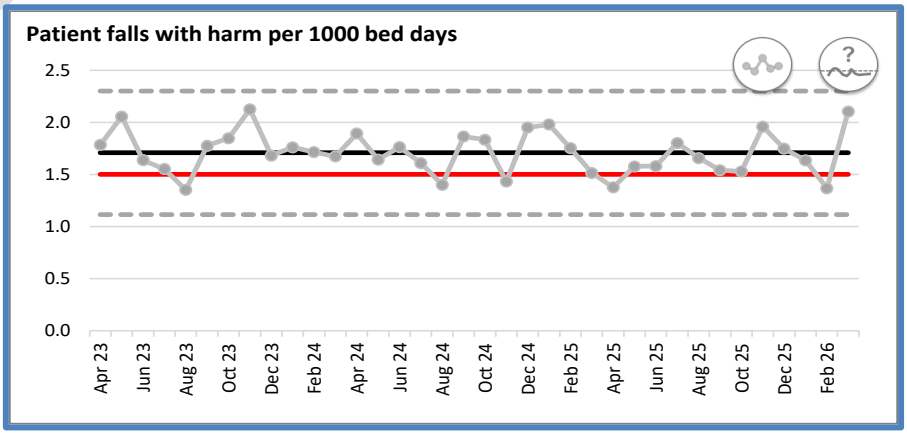
UHNM uses 5.6 falls per 1,000 bed days as an internal benchmark for improvement. This benchmark is likely to be adjusted in 2026-2027 as the Trust has consistently seen rates at or below this figure.











The reduction in patient falls, with harm decreasing from 1.72 per 1000 bed days in 2024/2025 to 1.66 in 2025/2026, highlights the impact of our Falls Prevention team. Their dedication and the consistent efforts of ward colleagues are yielding positive results over time, improving patient safety and outcomes.

Patient Safety Incident Response Framework and Incident reviews

We have continued to integrate the Patient Safety Incident Response Framework (PSIRF), which has replaced the Serious Incident Framework. The national PSIRF approach involves reviewing incidents through system reviews, concentrating on improvement rather than solely on the level of harm caused by incidents. Various types of PSIRF Learning Responses can be initiated, based on both national and local requirements and these include:

- Patient Safety Incident Investigation (PSII) – in-depth review of a single or cluster of incidents to understand what happened and how.
- Multidisciplinary Team Review – aims to through open discussion to agree the key contributory factors and system gaps that impact on safe patient care.
- Swarm Huddle – initiated as soon as possible after an event and involves and MDT discussion. Colleagues 'swarm' to the site to gather information about what happened and why and decide what needs to be done to reduce reoccurrence.
- After Action Review (ARR) – structured facilitated discussion of an event, based around four questions.

UHNM has been using the new learning response methodologies (to support incident investigations) and confidence is continuing to grow with the different approaches. These are supporting the improved compassionate engagement with patients, families and colleagues through direct contact and involvement where appropriate. This approach also enables a proportionate response to safety events.

During 2025/2026, we have commissioned a total of 203 PSIRF-related learning responses, compared to 237 during 2024/2025. The breakdown of these different types of learning responses is summarized below. The central aim of PSIRF is to identify learning opportunities and provide recommendations to address system and process changes that will mitigate or reduce the risk of similar incidents occurring in the future. PSIRF employs the Systems Engineering in Patient Safety (SEIPS) approach.

PSIRF Response	Q1	Q2	Q3	Q4	Total
PSIRF – After Action Review	12	10	12	15	**49**
PSIRF – Case Record Review	2	3	4	2	**11**
PSIRF – Diagnostic Imaging After Action Review	0	0	0	0	**0**
PSIRF – Falls Toolkit	9	6	12	3	**30**
PSIRF – Hot Debrief	0	2	0	1	**3**
PSIRF – Patient Safety Incident Investigation	6	5	5	6	**22**
PSIRF – Thematic Review	5	1	1	6	**13**
PSIRF – Tissue Viability Toolkit	11	12	34	5	**62**
PSIRF – VTE Toolkit	0	0	0	0	**0**
PSIRF – Being Open Conversation	2	1	2	4	**9**
PSIRF – Process Audit	0	0	0	0	**0**
PSIRF – Outcome audit	0	0	0	0	**0**
PSIRF – MDT Review	0	0	3	0	**3**
	48	**40**	**73**	**42**	**203**

During the review of incidents, a key stage of any PSII and the various incident responses that can be undertaken are to engage with and involve the patient and/or relatives. Their involvement is not compulsory, but they should always be asked if they wish to input into the incident response and identify any questions or concerns, they would like to address.

Since the introduction of PSIRF, we have improved our engagement with patients and relatives and all the Trust's PSIIs, both completed and ongoing, have involved the patients and/or their relatives. This has happened at the start of the review (as part of formal Duty of Candour), updates provided during the review and sharing the outcome of the review and talking through the report and its findings and recommendations.

We have 4 Patient Safety Partners in post and supporting patient safety initiatives and 2 Patient Safety Specialists also completed the Level 3 and 4 National Training via Loughborough University as part of the national Patient Safety Specialist (PSS) Cohort 1 training programme. During 2025/2026 an additional 2 colleagues have commenced their Level 4 and 4 Patient Safety Specialist training which is due to be completed by December 2026. These additional posts were funded internally whilst the PSS Training framework that was expected during 2025/2026 is awaited via NHS England.

During 2025/2026, and as planned in last year's Quality Account, we have continued to review and improve our engagement with patients and relatives during the review of incidents and the learning responses as part of PSIRF. We have successfully recruited an experienced senior nurse to a dedicated Patient Liaison role who has supported colleagues across the different Care Group in successfully and more meaningfully engaging with patients and/or relatives to gather their views and input to an incident as well as improving the feedback and sharing of outcomes from the learning responses.

There has also been development of the *Hear My Voice, Feel My Story* initiative which seeks to personalise the sharing of feedback from patients and/or relatives to help share learning from the learning responses.

Our learning responses, now, where possible and with the agreement and participation of the patient and/or relatives, a small outline of the person involved in the incident and how they were involved and felt.

Never Events

All incidents are thoroughly reviewed, and during 2025/2026, incident reviews were conducted for cases reported under the Never Events list. Patient Safety Incident Investigations, aligned with national PSIRF guidance, were undertaken to identify key learnings and support continuous improvement.

In 2025/2026, there were four never events reported, compared to nine in 2024/2025 and seven in 2023/2024:

- Misplaced Nasogastric Tube (July 2025) ID 374243
- Wrong Site Surgery (September 2025) ID 372573
- Wrong Implant / Prosthesis (October 2025) ID 381767
- Misplaced Nasogastric Tube (February 2026) ID 388401

Adopting the PSIRF methodology, both individual and thematic reviews were carried out, particularly regarding Nasogastric (NG) misplacement. The aim was to identify common themes and lessons learned to help prevent similar incidents from occurring in the future.

PSIRF & Never Event Learning

Following incidents classified as Never Events involving misplaced Nasogastric (NG) tubing within the Trust, individual Patient Safety Incident Investigations (PSIIs) were initially conducted and subsequently consolidated through a thematic review to identify key issues and actions. Reports and action plans have been presented at

the Risk Management Panel on multiple occasions to provide assurance that recommendations are being implemented and changes in practice are effectively embedded.

The comprehensive action plan addressing these Never Events outlines a series of measures pertaining to:

- Policy
- Documentation
- Systems
- Training
- Process
- Audit

The Risk Management Panel has received assurance and documented evidence confirming ongoing progress towards completion of these actions, which are scheduled for June 2026. The Trust is set to introduce a revised policy alongside updated LocSSIPs (Local Safety Standards for Invasive Procedures). Additionally, a training curriculum comprising both virtual and face-to-face learning modalities has been developed and is currently being rolled out, with competencies tracked in the e-roster system to transparently identify staff who have attained the necessary qualifications across the Trust.

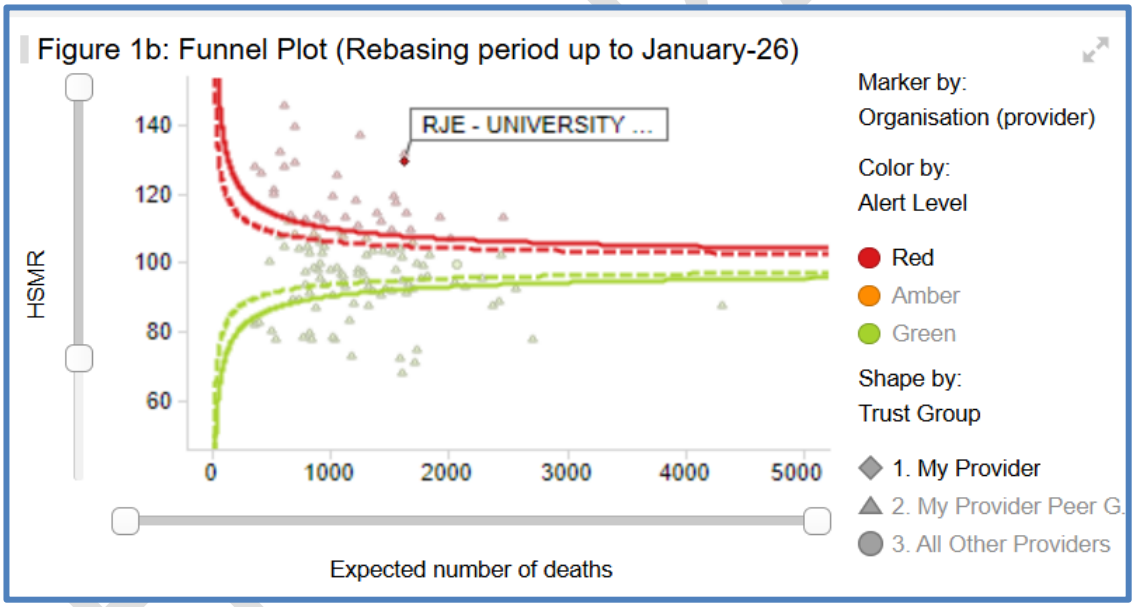
Mortality

The Trust's mortality rate with the current 12 month rolling Hospital Standardised Mortality Ratio (HSMR) score (February 2025 – January 2026) is 129.90. This means that UHNM's number of in-hospital deaths is higher than the expected range based on the type of patients that have been treated. This compares to 118.54 for February 2024 to January 2025.

HSMR is a system which compares a hospital's actual number of deaths with their predicted number of deaths. The prediction calculation takes account of factors such as the age and gender of patients, their diagnosis, whether the admission was planned or an emergency. If the Trust has a HSMR of 100, this means that the number of patients who died is exactly as predicted. If the HSMR is above 100 this means that more people died than would be expected, a HSMR below 100 means that fewer than expected died.

The Summary Hospital-level Mortality Indicator (SHMI) is a measure of mortality, developed by the Department of Health, and like HSMR, this measure compares actual number of deaths with our predicted number of deaths but includes patients who died in the hospital and those who died within 30 days of discharge.

Like HSMR the prediction considers factors such as age and gender of patients and their diagnosis. The current SHMI value for the Trust is 119.53 (higher than expected). This is a rolling 12-month measure and covers the period January 2025 – December 2025. The value for January 2024 to December 2024 was 112.82.



The Trust has observed an increase in mortality rates (HSMR and SHMI), which upon review, was attributed to issues with clinical coding. Specifically, not all patient records were fully coded, leading to a backlog.

Consequently, while all in hospital deaths were fully coded, the coding for other patient activities was not consistently accurate. Thus, while all patients dying from a given diagnosis were coded, all patients admitted with the same diagnosis were not necessarily coded, meaning percentage deaths from a given cause may not be accurate. Additionally, there was an increase in episodes categorised under "U codes," impacting the accuracy of mortality risk and standardization calculations.

To address these issues, efforts are underway to enhance coding accuracy with the assistance of Executive Directors and colleagues from the Integrated Care Board (ICB).

Monthly reviews of in-hospital deaths are conducted by the Trust's Mortality Review Group using initial mortality reviews and Structured Judgement Reviews (SJRs), please refer to following section *Learning from deaths – mortality reviews*, these reviews have not identified any concerns related to the increased mortality rates. Alongside qualitative reviews, the Trust continues to monitor the crude mortality rate, which has remained consistent and does not reflect the increases reported in HSMR and SHMI results.

Why are the two measures different?

Although similar the measures are not the same, one of the reasons that the SHMI is different is because unlike HSMR it looks at all patients who die within 30 days of leaving hospital.

Learning from deaths - mortality reviews

During 2025/26, the Trust continued to use its online Mortality Review Proforma to allow in hospital deaths to be electronically reported following review of the patient death. The outcomes of these reviews were included within Mortality Assurance Report presented at the Trust's Quality Governance Committee and reported to the Trust Board.

These reviews required reviewing clinicians to assess the care provided prior to death using the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) A-E categories and use the more detailed review proforma based on the Royal College of Physicians Structured Joint Review form as required following review of these deaths and in line with agreed review categories.

The Trust has completed 2,279 online proformas accounting for 66% of hospital deaths recorded during 2025/26. Each one of these deaths is assessed to classify the level of care the patient has. The overall number of mortality reviews submitted during 2025/26 is 3,384 (not related to a specific period of deaths). This compares with 3,132 forms completed for hospital deaths in 2024/25 (89%) and 3,356 forms completed during 2024/25 (not related to a specific period of deaths).

It should be noted that the mortality reviews are currently ongoing, and these figures relate to deaths in 2025/26 that have also had completed reviews submitted by 14th April 2026. There are deaths that are still being reviewed as part of the Trust's local Mortality and Morbidity Review Meetings but, whilst the deaths may have occurred in 2025/26, the reviews will be completed in 2026/27.

	2025/26 Total		Q1		Q2		Q3		Q4[1]	
Total number of deaths in reporting period	3477		828		760		920		969	
Total number of deaths in reporting period reviewed (% of total deaths)	2279	66%	693	84%	612	81%	643	70%	331	34%
Total number of reviewed deaths with suboptimal care identified – NCEPOD grade E (% of reviews)	3	0.1%	1	0.1%	1	0.2%	1	0.2%	-	-

* The Royal College of Physicians removed the scoring system on preventability following a national pilot. UHNM continue to use the NCEPOD classification system:
A: Good practice - a standard that you accept for yourself
B: Room for improvement - regarding clinical care

[1] As at time of updating the list of inpatient deaths ran up to March 2026 deaths

C: Room for improvement - regarding organisational care
D: Room for improvement - regarding clinical and organisational care
E: Less than satisfactory - several aspects of all of the above

A summary of the learning identified from the completed mortality reviews can be viewed following and does not just relate to those deaths where suboptimal care has been identified. The learning relates to where improvements can be made but did not directly contribute to a patient's death.

The following provides a thematic summary of issues identified during the Structured Judgment Review process that could be improved for SJRs submitted during 2025/2026:

1. Emergency Department Flow and Delays

Prolonged Emergency Department (ED) stays represented the most frequent problem. Patients often waited more than 12, 24, or even 48 hours for a ward transfer, with care sometimes delivered in corridors, resus overflow areas, or ambulances.

Although these delays rarely changed mortality outcomes, they negatively affected symptom control, dignity, continuity of care, and monitoring of deterioration. The issue was consistently attributed to bed pressures and capacity constraints.

2. Recognition and Escalation of Deterioration

Failures to recognize or act on deterioration were common. Issues included unacted-upon NEWS triggers, incomplete or infrequent observations (particularly overnight), and delayed senior or critical care review. In some cases, this represented a missed opportunity for escalation; in others it delayed timely palliation. Reliance on frailty or baseline observations sometimes masked acute deterioration.

3. End-of-Life Planning and RESPECT / DNACPR Failures

Failures surrounding RESPECT and DNACPR decisions were among the most concerning themes. Multiple patients underwent CPR despite documented wishes not to be resuscitated.

Contributing factors included poor visibility of electronic RESPECT forms, confusion between paper and electronic documentation, and inadequate handover between services. These incidents caused significant distress to families and staff and were often considered avoidable.

4. Communication Failures

Breakdowns in communication occurred both between clinical teams and between clinicians and families. Poor handover was particularly evident between ED, ward, and specialty teams, especially for outlier patients.

Families frequently report late or unclear communication regarding deterioration or changes in goals of care. Although discussions were often documented, issues remained around timing, clarity, and compassionate delivery.

5. Documentation and Information Continuity

Incomplete, inconsistent, or inaccessible documentation was a recurrent issue. Important reviews were sometimes recorded on parallel systems or not documented, compromising continuity and defensibility of care. Discharge summaries were occasionally unclear or incomplete, affecting subsequent admissions and specialty understanding of prior care.

6. Outliers, Ward Moves, and Specialty Access

Patients placed on non-specialist wards were often reviewed less frequently by their parent specialty teams. Frail and palliative patients experienced multiple ward moves driven by bed pressures.
These practices reduced continuity, delayed recognition of deterioration, and caused confusion for families and staff.

Cross-Cutting Observations

Across the dataset, organizational and system pressures were prominent contributors to problems in care. Recurring challenges included ED overcrowding, poor RESPECT form visibility, outlier governance issues, and documentation gaps. Learning frequently emphasized earlier goals-of-care discussions, clearer escalation pathways, and improved communication systems.

Hospital acquired infections

The Trust continues to strive to reduce the number of avoidable hospital-associated infections. Two of the key infection associated indicators that are used are Methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium Difficile (C Diff). During 2025/2026, the Trust has seen no reduction in like for like numbers compared to 2024/2025 for Clostridium Difficile and an in increase in Trust apportioned MRSA.

Indicator	2025-26 Target	2022/23	2023/24	2024/25	2025/26
To reduce C Difficile infections	144	144	180	169	169
To reduce MRSA infections (Trust apportioned)	0	1	4	1	2

Actions and Next Steps

- C Diff Nurse role fully embedded and the role is 50% focussed on patient reviews and 50% on colleagues training.
- Bi-weekly C Diff MDT meetings continue to take place
- Themes are reviewed on a monthly basis and learnings shared across the Trust as well being presented at IPCC and to the ICB.
- All C Diff cases measures are instigated and PSIRF process adhered
- C Diff awareness involving all clinical and medical colleagues continues
- Collaborative work with multidisciplinary team and Antimicrobial Stewardship Group
- Routine ribotyping of samples continues for samples from areas where we have periods of increased incidence only
- CURB -95 score added to Community Acquired Pneumonia (CAP) antimicrobial Microguide.
- Antimicrobial working group to remind clinical areas to send urine samples when UTI is suspected and ensure appropriate choice of antibiotic for treatment of UTI
- Additional oversight of C-Diff cases is being implemented where there is potential learning in terms of antibiotic use
- Big bed clean completed October 2025
- PSIRF process and monthly themes report continues
- Weekly AMS presence at County to support antimicrobial prescribing
- Commode cleaning day completed October 2025 and is now incorporated in the Big Bed Clean

Priority 2: To further develop staff wellbeing and experience

The health and wellbeing of our workforce is paramount and in 2025/26 associated activity related to our UHNM People Plan Domain 1 'We look after our people'

We said we would do this by:

- Continued promotion of the Staff Support and Counselling Service and Staff Physiotherapy Service to support colleague wellbeing and strong links with the top causes for sickness absence
- Publishing useful training videos and guides in collaboration with Optima Health to provide information and guidance to support managers on their referrals to our Occupational Health service provider
- Ongoing development of a Pastoral Support offer in collaboration with our People Operations leads to ensure we offer the right support to colleagues during and after employee relations cases
- Rest facilities maintained with the support of Staff Good Causes, providing the essential items for the purpose of wellbeing
- Continued offer of RESPOND training and an introduction to Psychological Safety (to support colleagues to undertake wellbeing conversations)
- Re-engaging our focus on menopause with an 'ask the experts' session
- Continuing to support Wellbeing Thursdays and Men's Health podcasts as well as introducing free Health Checks (40+) with Everyone Health which were positively received with more dates scheduled
- Launching new fiction collection in line with National Year of reading 2026 and pop-up Library also launched to promote wellbeing through the Trust's Library Services
- Becoming a completely Smoke Free Trust from 1 April 2026 across all sites – this has involved a phased approach including ratification of a Smoking Control Policy and the provision of wellbeing support for colleagues and patients.

In addition, we:

- Renewed the Trust's contract with Vivup (employee benefits & engagement platform) for 2026/27, with further plans and discussions evolving
- Launched additional annual leave purchase scheme for 2026/27, with all decisions communicated in March 2026, which further supports colleague wellbeing
- Provided responsive wellbeing support in Urgent and Emergency Care, supporting during critical incident
- Continued delivery of our Improving Together Programme methodology and training
- Provided colleagues with research, professional and academic development through CeNREE
- Continued to work in partnership with our Professional Nurse / Midwifery Advocates who offer restorative and career coaching support
- Updated self-assessment against assurance framework and sexual safety charter, including launching Sexual misconduct in the workplace NHSE eLearning and Sexual Misconduct Policy and People in Positions of Trust Policy which were both ratified and launched into the Trust – in addition, specialist training has been delivered to investigating officers, panel members and sexual safety champions.

Performance against the above is measured via our Staff Engagement metric, NHS Staff Survey, NHS People Pulse (National Quarterly Pulse Survey), Sickness Absence metric, Occupational Health and Counselling data.

Our People delivery plan clearly gives priority for colleague wellbeing and experience for the coming year 2026/27 including aims, objectives and measures for success. Performance against this priority and its aims has been monitored during 2025/26. The following section provides a summary of the performance for these indicators and what these results mean for our patients.

Freedom to Speak Up

Your voice matters at UHNM

During the 2025/26 reporting year, the Freedom to Speak Up (FTSU) service received 405 concerns from colleagues across UHNM. This represents a significant increase compared with previous years and may reflect several factors, including growing staff confidence in speaking up, expansion of the FTSU team, and increased visibility of the service across the organisation. It may also highlight emerging cultural or operational challenges requiring further attention.

Throughout the year, the team has continued to actively promote the service through regular ward and departmental visits, engaging with staff to reinforce the benefits of a healthy speaking-up culture at UHNM. In addition, the service has delivered face-to-face training sessions to a wide range of groups, including foundation year doctors, newly qualified preceptee nurses and nurse associates, new cohorts of care assistants, Chief Nurse Fellowship groups, and a variety of intra-departmental teams.

In February 2026, Wendy Nicholson MBE was appointed as the Trust's Non-Executive Director Lead for Freedom to Speak Up. The FTSU Champion network has continued to expand, with 32 fully trained Champions now in post across the organisation and ongoing interest from new applicants. This increased visibility has proven effective, with several colleagues accessing support following informal 'corridor conversations' with Champions.

The team has also continued engagement with local education providers, including the University of Staffordshire and Keele University, to strengthen systems and promote a positive speaking-up culture within our student population.

Looking ahead, the planned closure of the National Guardian's Office at the end of June 2026, with its core functions transferring to NHS England, presents both opportunities and potential challenges for current FTSU arrangements. The team welcomes this transition and remains committed to adapting and strengthening local speaking-up practices as national arrangements evolve.

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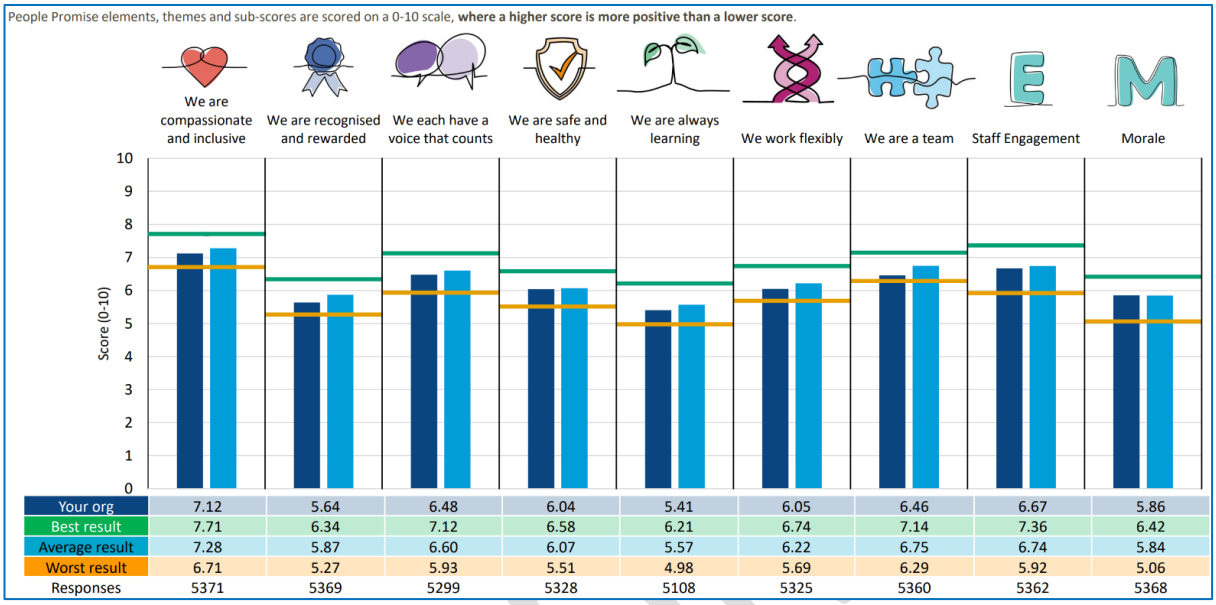
405 FTSU concerns raised in 2025/2026

Throughout the year we have seen an increase in the concerns being raised with our service, with 405concerns raised in 2025/2026 (compared to 269 concerns raised in 2024/25, 215 in 2023/24 and 169 in 2022/23), which we see as a positive reflection of the healthy speaking up culture we are building at UHNM.

2025 NHS Staff Survey

The results of the NHS Staff Survey are measured against two themes of staff engagement and morale as well as against seven national People Promises. 5,388 colleagues participated, representing a 41% response rate, which is lower than the previous year and below the benchmarking group's median of 47%.

Chart: National Benchmark Comparison



	We are compassionate and inclusive	We are recognised and rewarded	We each have a voice that counts	We are safe and healthy	We are always learning	We work flexibly	We are a team	Staff Engagement	Morale
Your org	7.12	5.64	6.48	6.04	5.41	6.05	6.46	6.67	5.86
Best result	7.71	6.34	7.12	6.58	6.21	6.74	7.14	7.36	6.42
Average result	7.28	5.87	6.60	6.07	5.57	6.22	6.75	6.74	5.84
Worst result	6.71	5.27	5.93	5.51	4.98	5.69	6.29	5.92	5.06
Responses	5371	5369	5299	5328	5108	5325	5360	5362	5368

Reflecting on the past 12 months

Following the NHS Staff Survey 2025 results, the Trust committed to focusing improvement activity on four People Promise areas: **We are safe and healthy (PP4); We are always learning (PP5)**; **We work flexibly (PP6)**; and **We are a team (PP7)**. These areas were identified as priorities based on colleague feedback and national benchmarking.

Over the past 12 months, targeted action has been taken at both corporate and local levels to respond to these commitments. This has included strengthening leadership capability, supporting colleague wellbeing, promoting flexible working, and providing organisational development support to teams where the data indicated the greatest need.

The NHS Staff Survey 2025 results indicate that, while these actions have helped to maintain overall stability during a challenging year, they have not yet translated into measurable improvement at scale, with small negative drifts seen across most of the four People Promise areas. We work flexibly did not demonstrate a statistically significant change, while We are always learning continues to be the Trust's lowest-scoring People Promise element. The Trust will continue to focus on this People Promise through targeted actions as part of our UHNM People Plan.

Staff Engagement

The overall Staff Engagement score for the Trust is 6.67 which is below the score for the benchmarking group average. Among the sub-scores which contribute to the Trust's overall Staff Engagement score, the Trust's score is equal to the benchmarking group average for Advocacy but falls below average for Motivation and

Involvement. Notably, within Advocacy, fewer colleagues now believe that care is the organisation's top priority.

Areas of focus for 2026/27

Based on the NHS Staff Survey 2025 results and national benchmarking, the Trust will maintain a focused, prioritised approach during 2026/27, concentrating on areas where improvement will have the greatest impact on colleague experience. The Trust's primary areas of focus will be:

We are always learning

This remains the Trust's lowest-scoring People Promise element. Activity during 2026/27 will focus on improving the quality and consistency of learning and development experience, including strengthening appraisal conversations, clarifying development pathways, and supporting colleagues to access learning opportunities that support both individual growth and service delivery.

The role of the line manager

The survey continues to demonstrate the critical influence of line managers on colleague experience. The Trust will prioritise strengthening the fundamentals of line management, including clear communication, regular support, and consistent application of people management practices, recognising that effective leadership is central to engagement, wellbeing and team performance.

Targeted organisational development support

Organisational development, culture and inclusion support will be targeted where the data indicates the greatest need, enabling focused intervention rather than blanket approaches. This will ensure resources are deployed effectively and aligned to the Trust's strategic priorities.

Colleague engagement and equality, diversity and inclusion will remain golden threads across all areas of focus. The Trust will continue to strengthen its approach to listening to colleague voice, including through the transition to the NHS People Pulse to support ongoing insight and national benchmarking.

In respect of Equality, Diversity and Inclusion, the Trust's results are a mixed picture when looking at the Workforce Race Equality Standards (WRES) and Workforce Disability Equality Standards (WDES) metrics in the 2025 NHS Staff Survey results. WRES findings indicate a widening gap in experience, with outcomes worsening for ethnically diverse colleagues while improving for white colleagues, particularly in relation to discrimination and bullying from managers and colleagues. This represents a clear priority for leadership and cultural focus. WDES results show some positive movement, including improved access to workplace adjustments; however, colleagues with a long-term condition or disability continue to report feeling significantly less valued.

The NHS Staff Survey data doesn't sit in isolation and must be seen in the context of the wider people metrics. Care Groups and Services have been asked to identify and communicate the three actions that matter most for their teams, informed by survey findings and wider people metrics. Senior leaders will continue to be supported with closing the feedback loop and communicating key messages across the Trust.

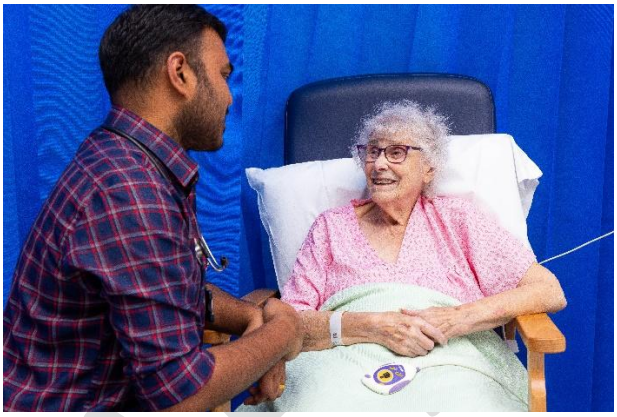
Although the NHS Staff Survey 2025 results show a slight downward shift, colleagues have been clear and consistent about the areas where they expect to see improvement, providing a clear direction for action. It is acknowledged overall that we have still further to go in comparison to our benchmarking group. Through our collective work at a corporate and local level we aim to continue to build on our successes, learn where things can be even better and most importantly act as a result of colleague feedback to ensure that the Trust is a great place to work and we continue to improve patient outcomes.



Priority 3: To improve patient experience

We said we would do this by:

- Improving the sharing of learning from patient feedback and involving patients in learning and improvement with a particular focus on ''seldom heard' patient groups.
- Developing the role of Patient Safety Partners and PSIRF implementation
- Ensuring that all research is aligned with Trust strategic priorities and includes outcomes that will benefit our patients.
- Formalising patient engagement and coproduction in research, patient safety programmes and improvement initiatives.



Performance against this priority and its aims has been monitored during 2025/26. The following section provides a summary of the performance for these indicators and what these results mean for our patients.

Patient Experience Team

UHNM's Patient Experience team aims to listen to diverse patient and carer voices and use inclusive feedback to improve the quality, safety, and fairness of healthcare for everyone. We work in partnership through co-production, supporting patients, carers, and communities to shape services, decisions, and improvements together. Throughout 2025–26, patient feedback directly informed service improvements, supporting safer, more inclusive and compassionate care. Complaint response times improved significantly, patient satisfaction remained above national averages, and co-production with patients and communities strengthened decision-making, particularly in high-pressure services and areas of inequality.

The teams' key contributions for 2025/2026 include:

- **Ensuring strengthened patient voice across the Trust**
  - We have expanded and actively facilitated the Hospital User Group (HUG), ensuring patient and carer insight informed service design, estates, catering, accessibility and discharge processes.
  - We have started to embed co-production in major projects, including the new Breast Care Unit, with specific engagement from people with disabilities and sensory loss.
  - We have progressed plans to establish a Patient & Public Engagement Council, to formally shape Trust decision-making in 2026.

- **Improved accessibility and inclusion**
  - We have led work with local Deaf communities and BSL providers to improve access to in-person interpreters, developing clear staff protocols.
  - We have supported Trust-wide improvement in wayfinding, including pilot use of visual, non-text-based directions and digital solutions.
  - We have ensured patient feedback influenced seating, navigation, parking information and website accessibility.

- **Oversight and learning from national patient surveys**

- We have coordinated the Trust's response to the CQC National Adult Inpatient Survey 2024, with improved scores in communication and no areas performing worse than peers.
- We have supported maternity survey insight and improvement actions, particularly around informed choice and post-discharge support.

- **Effective management of complaints and concerns**
  - We oversaw high-volume complaints and PALS activity, ensuring timely responses, compassionate handling and learning-focused outcomes.
  - We ensured learning from upheld and partially upheld complaints led to tangible service changes, including:
    - Enhanced triage and senior review in Emergency Care
    - Improved discharge communication and coordination
    - Clearer appointment and cancellation processes
  - We have strengthened executive escalation processes and assurance reporting.

- **Regulatory engagement and assurance**
  - We have coordinated and responded to CQC enquiries, safeguarding referrals and whistleblowing concerns, providing assurance on Trust actions.
  - We have managed Parliamentary and Health Service Ombudsman (PHSO) cases, ensuring action plans, apologies and compensation were delivered where required.

- **Triangulation of patient experience intelligence**
  - We have triangulated insight from complaints, PALS, FFT, compliments and surveys to identify themes, risks and opportunities for improvement and,
  - Used patient experience data to inform quality, safety and PSIRF discussions, ensuring the patient voice supported harm review and learning.

- **Friends and Family Test (FFT) oversight**
  - We have monitored FFT performance across inpatient, outpatient, emergency and maternity services.
  - We have used FFT free-text feedback to highlight positive practice and target areas for improvement, particularly within Emergency Care.

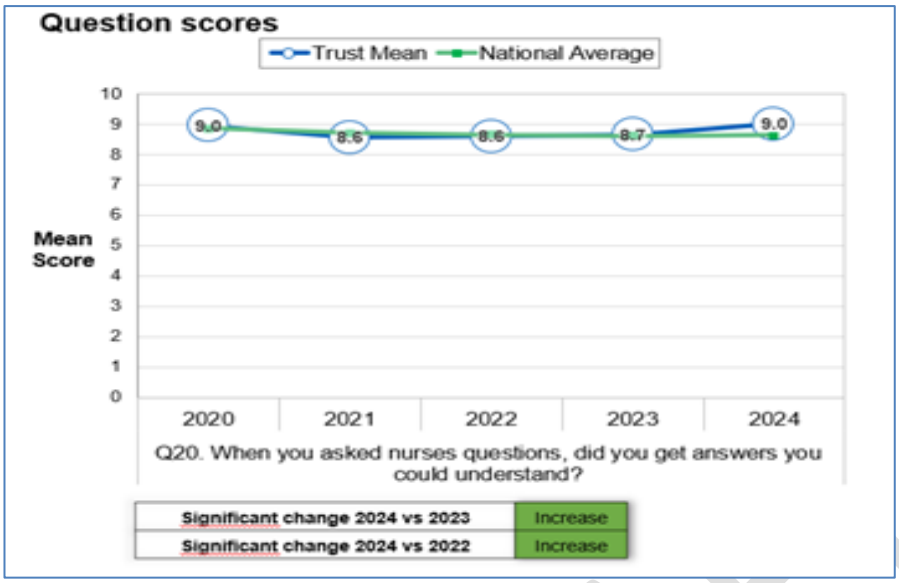
- **Recognition of positive care**
  - We have processed and shared a high volume of compliments, ensuring positive feedback was passed to teams and reinforced Trust values and
  - Highlighted examples of compassionate, dignified care—especially in emergency, maternity, frailty and end-of-life services.

- **End-of-life, spiritual and cultural care**
  - The Spiritual, Pastoral and Religious Care (SPaRC) team have ensured culturally sensitive care is provided for patients and families.
  - Have contributed to mock CQC inspections and improvement in end-of-life and bereavement care and
  - Strengthened partnerships with diverse community and faith groups to meet individual patient needs.

Annual Inpatient Survey

The 2024 Inpatient Survey results were published by the CQC in September 2025. 1,250 patients who were in hospital in November 2024 were invited to participate in the survey and the Trust had a 42% response rate, an improvement on the previous year. UHNM scored either "better than expected" or "somewhat better than expected" in 4 questions compared to other Trusts, and in 3 questions compared to last year.

The Trust did not score "worse" than other Trust's in any questions or in any questions compared with last year's results.



There has been a consistent improvement over the previous 2 years with regards to communication from nursing staff giving information patients can understand. Information regarding Health Literacy has been incorporated into all Nursing Assistant and Registered Nurse induction training by the Patient Experience Team which could be helping to support the improvement in this area.

Where patient experience is best

- ✓ **Individual needs:** Staff taking into account patients' individual needs: Religious needs
- ✓ **Individual needs:** Staff taking into account patients' individual needs: Language needs
- ✓ **Food:** Patients being able to get hospital food outside of set mealtimes
- ✓ **Waiting list:** Length of time on waiting list before hospital admission
- ✓ **Sleeping:** Patients not being prevented from sleeping at night

Where patient experience could improve

- ○ **Information about virtual wards:** Patients getting information about risks & benefits of continuing treatment on virtual wards
- ○ **Waiting in the hospital:** Length of time waited (in another location) before admission to a ward
- ○ **Help from staff to eat:** Patients' getting enough help from staff to eat meals
- ○ **Nurses:** Patients feeling there were enough nurses on duty to care for them
- ○ **Drink:** Patients getting enough to drink

Impacts of the Patient Experience Team:

- Patient feedback directly shaped service improvements, including clearer discharge information, improved appointment communication, better waiting-area comfort, and visible “You said, we did” actions across inpatient, outpatient and emergency settings
- Emergency Department environment and communication improved, including patient information cards for long waits, upgraded seating, pressure-relieving mattresses on all trolleys, and progress toward improved meal provision.
- Targeted safety and pathway improvements introduced following complaints, including enhanced triage training, senior clinical reviews for children presenting with collapse, and clearer oncology pathway communication
- Accessibility improved for patients with additional needs, including strengthened BSL interpreter pathways, better recording of reasonable adjustments, and co-designed improvements informed by disabled patients and VCSE partners.
- Cultural, spiritual and end-of-life care strengthened, evidenced through SPaRC activity, mock CQC feedback and positive family testimonials highlighting dignity, compassion and respect.

Complaints

The total number of complaints opened at Royal Stoke University Hospital during 2025/26 was 869 which is a 35% increase on the previous 2 years.

The total number of complaints opened at County Hospital during 2025/26 was 111 which is higher than the past 2 years and is in line with the pre-COVID 3-year average of 112.

During 2025/26, the Complaints Team has achieved the following:

- Strengthened early resolution, with consistently low escalation from PALS to formal complaints (around 2%), demonstrating effective, compassionate problem-solving
- Reduced our median complaint response times reduced by 10 working days with improvements sustained across the year despite rising complaint volumes and complexity. In total, the team have achieved a reduction of 20 working days for response times across 2 years.
- Significantly reduced the number of complaints opened longer than 6 months, including closure of several historic complaints.
- Restructured the escalation process to improve efficacy, sharing data with Care Groups to move from reactive chasing to proactive oversight.
- Complaints handling became safer, more joined-up, and more person-centred, especially in serious or complex cases with Closer Integration with PSIRF for Serious Complaints

Moving Forward- 2026/2027 Patient Experience Priorities.

We will develop a robust 5-year Patient Experience and Engagement Strategy to set out how UHNM listens to patients, learns from their experiences, and turns that insight into measurable improvements in care. The strategy will be informed by the significant volume of data collected through all channels of patient feedback.

1. Sustain and Further Reduce Complaint Response Times

Why:

- Although 2025/26 showed significant improvement, towards the latter part of the year, there was increased pressure due to complaint volumes and complexity.
- Rising volume of complaints means process resilience is now the risk, not willingness of the team to undertake the work.

Improvement

Build capacity and consistency in complaint handling:

- Clear ownership,
- Early resolution,
- Family-inclusive investigation (PSIRF-aligned).

2. Deepen and strengthen Co-production and Patient Leadership

Why:

- 2025/26 demonstrated the value of co-design in several projects however this now needs to be embedded across the organisation.
- Patient Carer Engagement Council is being established and needs to influence decision-making, not just consultation

Improvement:

Listen first and shape improvements in partnership with patients, carers and communities

- In service redesign,
- In complaints learning,
- In equality and experience priorities

Chair/Deputy Chair of the Patient & Carer Engagement Council

Being Deputy Chair of the UHNM Patient & Public Engagement Council means being an influential and approachable voice for local communities, ensuring that patients and the public feel listened to and represented. I believe this Council will help shape services that are more inclusive, responsive, and centred around people's real experiences.

In this role, alongside the Chair, I would hope to strengthen communication, co-production and be a champion underrepresented communities attending UHNM. We aim to encourage wider and more diverse participation and hope to achieve meaningful and visible improvements.

3. Use Triangulated Insight to Target Improvement

Why:

2025/26 has improved triangulation of data from complaints, PALS, FFT and incidents but there is uneven use of this data at ward/service level.

Improvement:

Develop and embed a single narrative of Patient Experience intelligence for Care Groups and Business Units which is:

- Routinely triangulated,
- Used to target support,
- Clearly reported as "learning and impact"

4. Embed Inclusivity and Reasonable Adjustments as "Business as Usual

Why:

- Complaints and PALS cases identified gaps in reasonable adjustments (e.g. BSL, sensory needs).
- Strong progress in 2025/26 but there is still a reliance on individual awareness.

Improvement:

Working closely with the Vulnerable Patients team, we will move from reactive to systematic delivery of inclusive care:

- Visible recording of reasonable adjustments,
- Clear staff escalation pathways,
- Active partnership with VCSE and seldom-heard group

5. Strengthen Communication at Key Points in a Patient's Journey

Why:

- Recurrent complaints and FFT themes highlight poor discharge communication, inconsistent messaging, medication delays, and anxiety at transfer and discharge.
- Improvement actions have been taken, but variation remains, especially in Unplanned Care and complex discharges.

Improvement

- Standardise clear, compassionate discharge communication Trust-wide, including:
  - Consistent verbal explanations,
  - Clear written summaries in accessible formats,
  - Named post-discharge contacts.
- Embed family/carer involvement as routine.

6. Support the clinical teams to improve Patient Experience in High-Pressure Services

Why:

- ED remains below national average satisfaction despite strong examples of good care.
- Persistent themes: waiting times, uncertainty, comfort, and communication
- Environmental and communication improvements have begun but need scaling.

Improvement:

Shift focus from waiting time management alone to experience during waits:

- Proactive communication,
- Comfort, dignity and basic needs,
- Clear safety-netting.

Part C: Statements from our key stakeholders

Staffordshire and Stoke-on-Trent Integrated Care Board

Quality Account - Staffordshire & Stoke on Trent Integrated Care Board

City of Stoke-on-Trent

Quality Account – Adult Social Care, Health Integration and Wellbeing Overview and Scrutiny Committee, Stoke on Trent City Council

Staffordshire County Council

Quality Account – Staffordshire County Council Overview and Scrutiny Committee

healthwatch Staffordshire

healthwatch
Stoke-on-Trent

Executive Summary

Trust Board (Part 1) | 10th June 2026

UEC Improvement Journey

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**		**Assurance**	✓	**Agenda Item:**	12.
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		
BAF1	Delivering responsive patient care	Ext 20

Executive Summary

Situation

This paper is to update board member on the situation with regard to UEC pressure and ambulance handover; and cover the Trust's improvement programme. This covers data up to the latest reported week at the time of writing which ends 16th May 26. We remain in tier 1 for national oversight for our UEC position. Industrial action took place during the reporting period on the charts 7/4/26 – 13/4/26.

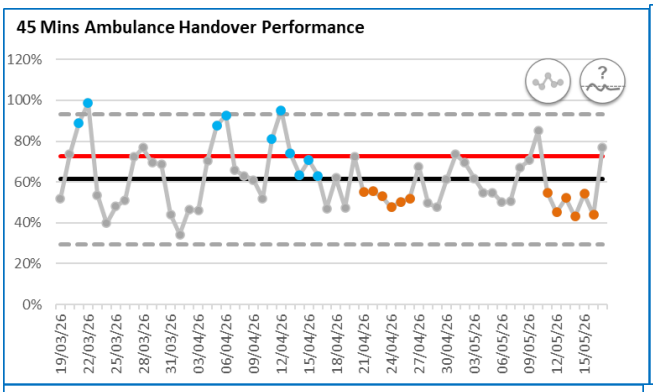
UHNM's UEC improvement data shows that ambulance handover delays are driven far more by internal flow than attendances as attendances remain broadly flat without significant variation. We see minimal correlation between overall ED attendances and handover performance – some of our busiest days have delivered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

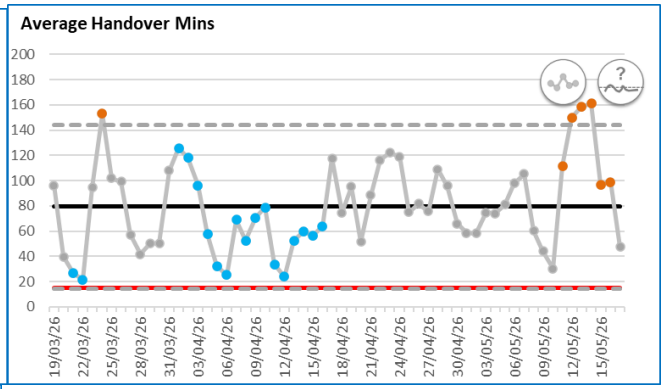
- faster CRTP (patients who are Clinically Ready to Proceed) movement
- ED time reduces from 8-9 hours to around 7-8 hours, and
- c.12 percentage-point improvement in <45-minute handovers.

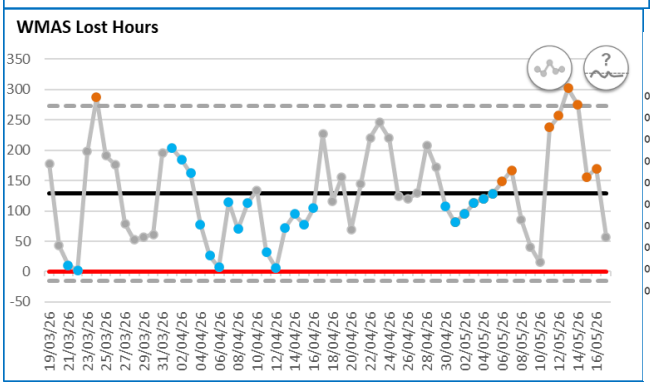
The evidence remains: when we get flow right early in the day, performance improves across the whole UEC pathway – ambulance handovers, ED 4-hour performance, and patient experience. Our programme focuses on making these flow-enabling behaviours routine every day. There has also been the identification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

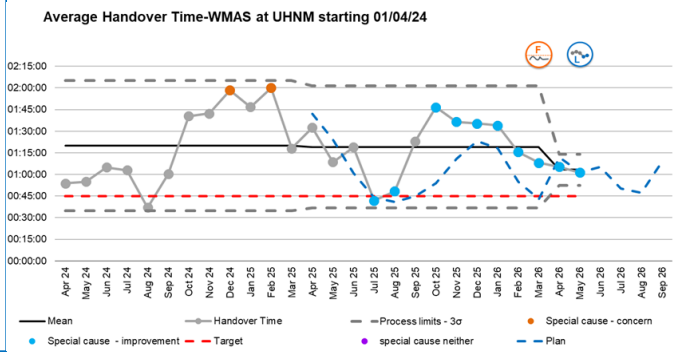
Although overall performance has not yet reached the desired standard for our patients, we have observed steady progress in the effectiveness of our UEC pathway, indicating that further improvement is achievable. There is no singular solution; however, ongoing and sustained efforts through the UEC improvement programme are facilitating positive change.

Ambulance Handover



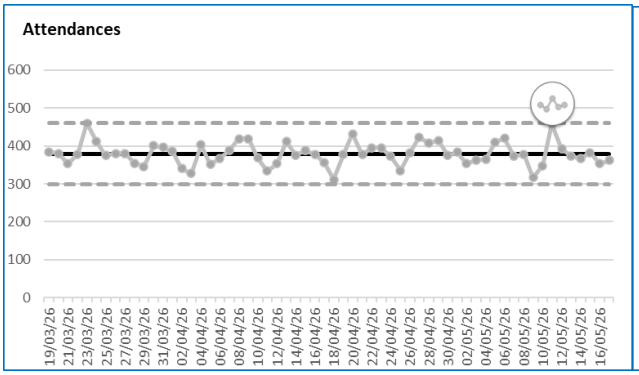


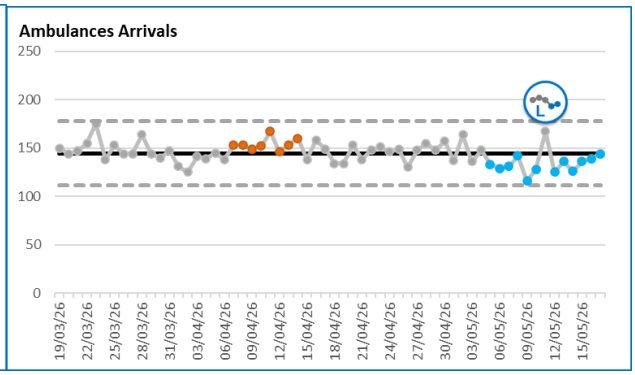




We continue to see variation in ambulance handover on a day to day basis, however when viewed with the monthly figures we are seeing month on month improvement which on a monthly basis is now being seen as statistically significant improvement.

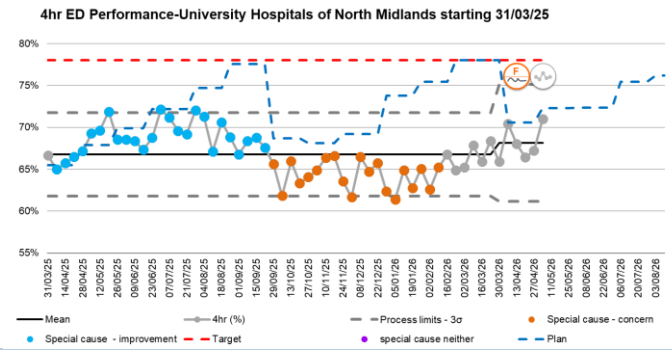
Attendances

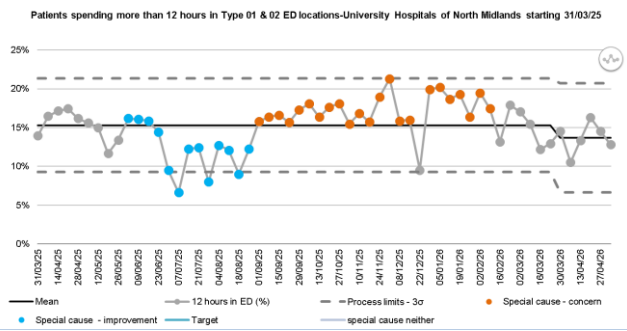


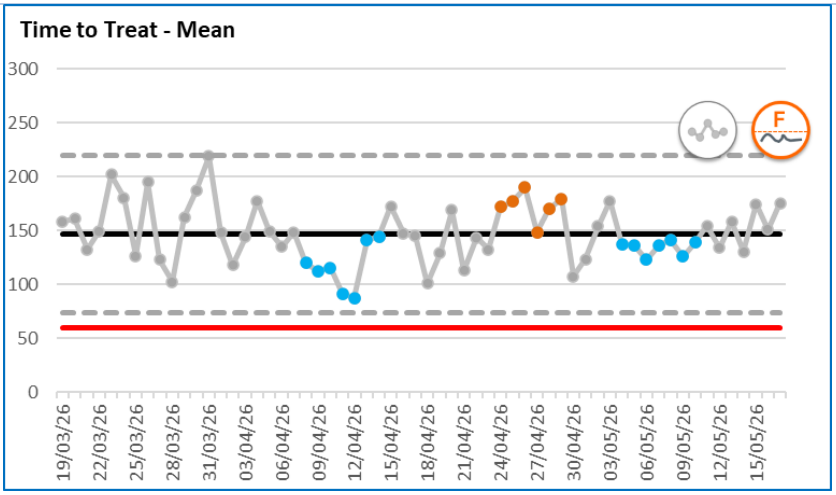


Attendances overall remain without variation; however ambulance attendances are down. This is not affecting total numbers to be treated.

Time in the Emergency Department

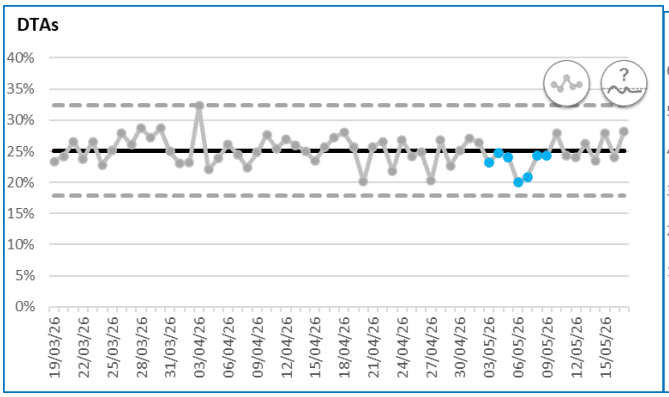


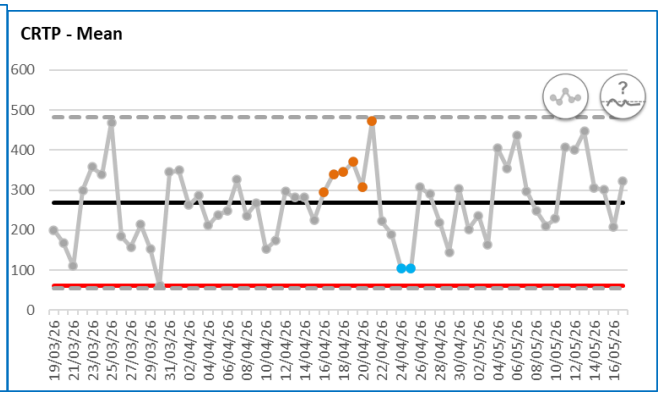




We continue to see variation in time to treatment on a day to day basis. However, we are seeing slight improvement in 4 hour and 12 hour performance, but not enough to be statistically significant.

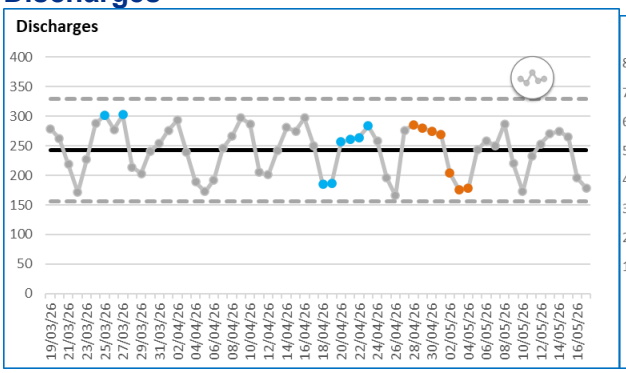
Decision to Admit and Clinically Ready to Proceed

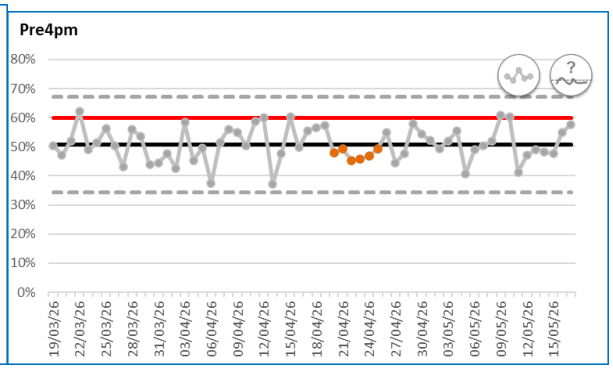




We have seen variation in both patients with a decision to admit and those who are clinically ready to proceed.

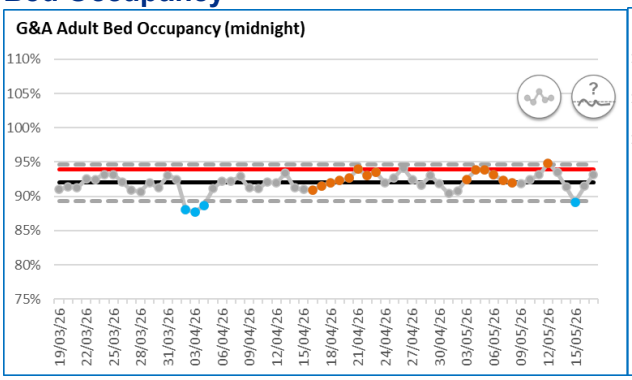
Discharges

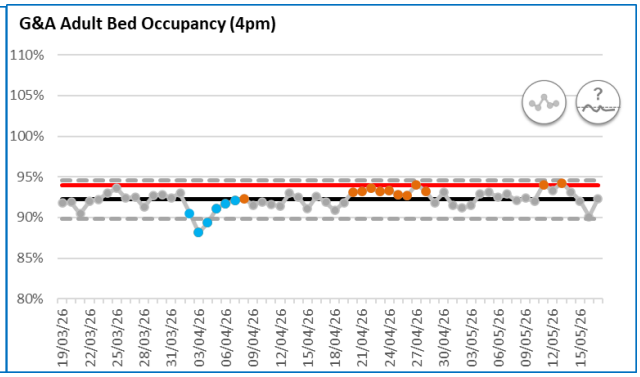




We continue to see variation in discharge on a day to day basis, however when viewed with the monthly figures we are seeing signs of improvement in bringing discharge earlier in the day.

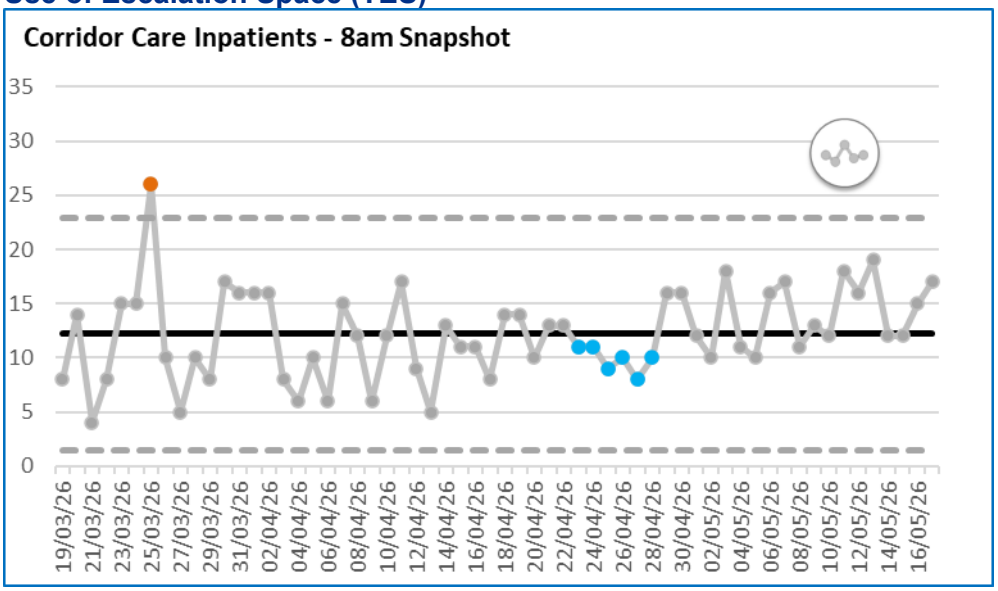
Bed Occupancy





Bed occupancy remains static

Use of Escalation Space (TES)



Above is the first time we have been able to report on the number of patients in Trust Escalation Space (TES) or receiving care on the corridor. We are working with teams on improving corridor care with the use of the GIRFT guidance 'Corridor Care Improvement Guide'. We continue to use escalation space on both ward and ED areas. This is audited on a daily basis and reported through Quality Committee.

UEC Transformation Programme

Our UEC improvement plan is now in place following the visits in January 2025 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 'UEC Recovery and Oversight Meeting'. This is being supported now by the UEC GIRFT team.

The final version of the programme is outlined below and has a weekly cadence in order to be agile and focused on its improvement work. The workstreams are outlined below and in bold the areas of intense work which are highest priority for immediate change.

UEC Programme

Programme SRO- Katy Thorpe
Programme Clinical lead- Dr Diane Adamson
Programme Nurse Lead – Ann-Marie Riley

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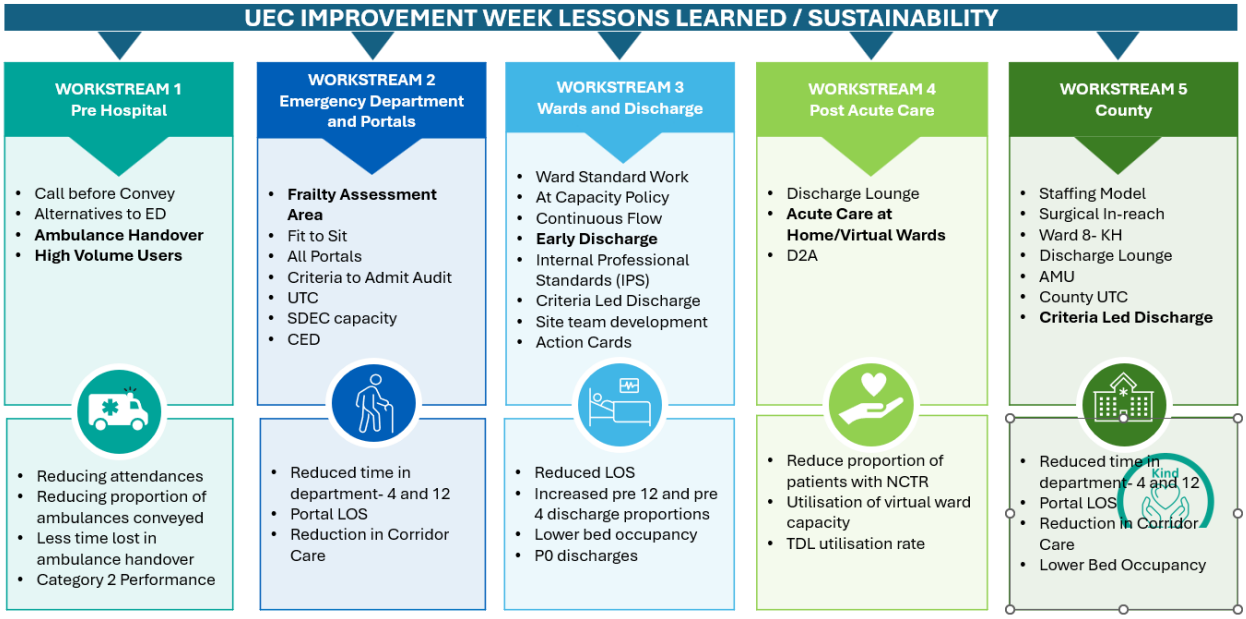
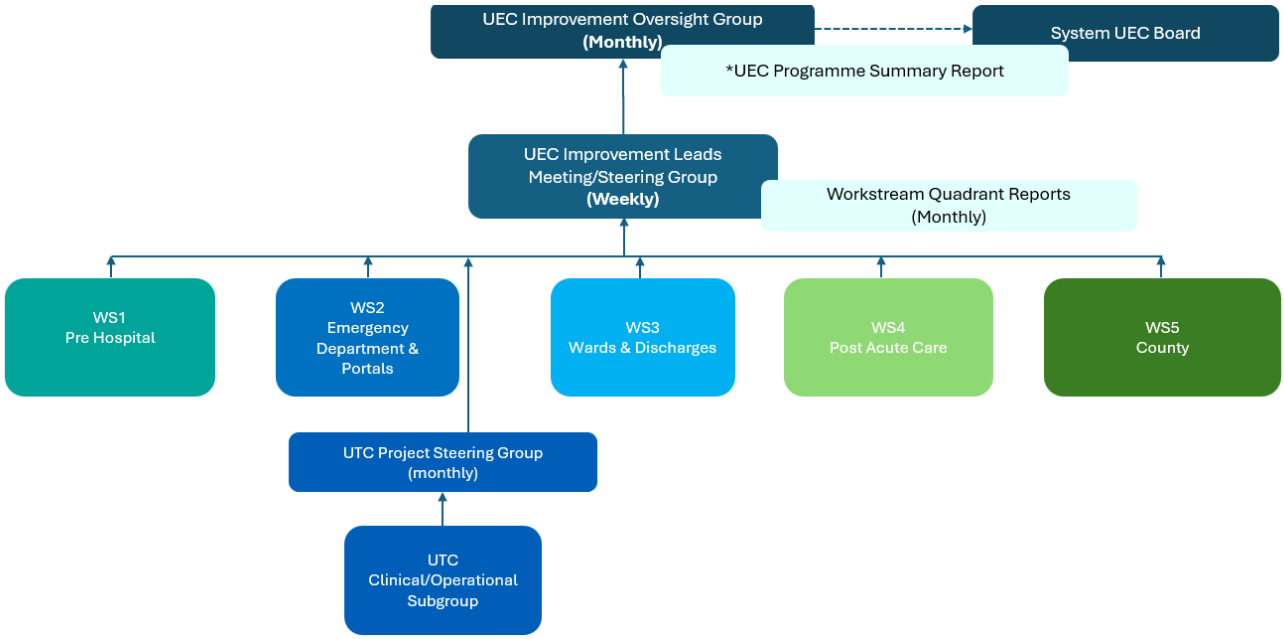


There is a clear governance structure in place for the improvement programme above



Conclusion

The report indicates that, although current performance remains below our expected standard for patient care, there are encouraging signs of ongoing improvement. This improvement does not triangulate with the suite of performance data shown in this report as indicators are not sustained consistently and do not always correlate with the dips or improvements in performance as would be expected. This requires a deeper review.

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

Key Recommendations

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

UEC Improvement Programme Quadrant Report - Summary
Month May 2026

University Hospitals of North Midlands NHS Trust

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

MATTERS OF CONCERN OR KEY RISKS TO ESCALATE

- Workforce pressures across system (ED senior decision makers, UTC recruitment, community capacity)
- ED flow delays: Long patient waits, ambulance offload delays and complex front-door pathways
- Discharge delays impacting flow (late discharge patterns, limited post-acute capacity)
- Workstreams at varying maturity – several still defining KPIs, governance and scope
- Dependencies on system partners (ICB, IDH, WMAS) impacting pace and delivery
- Infrastructure constraints (UTC build, estate capacity, temporary reductions in service capacity)

KEY PERFORMANCE MEASURE(S)

- ED performance (4-hour standard, 12-hour waits, ambulance offload delays)
- Inpatient flow

1. Length of Stay (LOS)
2. Long stay patients
3. Corridor care reduction

- Discharge performance

1. Pre-noon discharge rate (key system metric)
2. Pathway 0 discharges

- Post-acute flow

1. D2A pathway performance
2. Discharge lounge utilisation

- System metrics

1. Bed occupancy
2. Demand, capacity and utilisation across services

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

KEY ACHIEVEMENTS and ESCALATIONS

- All workstreams mobilised with governance, meeting structures and stakeholder engagement in place
- UHNM Change Week delivered – outputs informing priorities across all workstreams
- Key priority areas agreed across system: Admission avoidance (SPA, Call Before Convey, UCR)
- ED flow and frailty pathways
- Earlier discharge and ward flow
- Post-acute capacity and discharge lounges
- New/improved pathways progressing: Frailty SDEC operational and
- AMU in-reach model
- Virtual ward and acute care at home models
- Recruitment and workforce planning underway across ED, UTC and ward models
- Stronger collaboration across UHNM, ICB, MPFT and WMAS partners

ACTIONS and MILESTONES FOR NEXT PERIOD

- Finalise workstream governance, structures and KPIs across all areas
- Complete gap analysis and data insight development to inform priorities
- Improve patient flow across pathway: Simplify ED access, portals and streaming routes
- Increase pre-noon discharge performance and embed ward-level improvements
- Expand discharge lounge capacity and post-acute pathways
- Strengthen workforce models, particularly senior decision-making capacity
- Embed PDSA / continuous improvement approaches at ward and pathway level
- Improve system alignment (County model, neighbourhood working, cross-workstream integration)
- Progress priority programmes: SPA and admission avoidance schemes
- Frailty and same day emergency care
- Post-acute and community capacity models

Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE | 29th April 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• **Q3 Medicines Optimisation and Safety** report highlighted strong progress, including delivery of key projects and strengthened governance arrangements. However, the update also identified ongoing safety and assurance risks—particularly in radio-pharmacy, oncology prescribing systems, addressing out of date Patient Group Directions (PGDs), controlled drugs oversight, and clinical trials. As such partial assurance was noted and further assurance was to be provided in relation to the management of controlled drugs, via an annual report. • The Committee noted the challenges in respect of **Pharmacy** workforce for ophthalmology, controlled drugs, anticoagulation stewardship and Emergency Department, and that several areas required targeted business cases to address resource shortfalls and single points of failure. • The Committee received assurance from the **Executive Quality and Outcomes Group** on progress in endoscopy and actions following an unannounced HTA visit. An external review had been commissioned in response to comparative national mortality data, and preparatory work underway to ensure a thorough and transparent review. Members emphasised the importance of capturing all learning, understanding the national context, and securing robust external assurance. • Partial assurance was provided on progress in **clinical effectiveness**, including strong engagement with Get It Right First Time (GIRFT) action plans and improved support for national audit submissions to address timeliness and completeness. Work was underway to strengthen internal outcomes reporting using trust-level data to mitigate delays in national audit publication. • The Committee noted the recent statistically significant improvements in **non-elective and emergency care performance**, particularly within paediatric pathways, supported by enhanced senior clinical decision-making during periods of industrial action. However, performance remained below the required standard and as such partial assurance was provided, noting that sustaining improvement was recognised as a key risk. Learning from recent operational changes would inform next steps, with an emphasis on team ownership, clinically led decision-making, and continuous improvement to prevent regression. • The Committee noted significant improvements in **elective care** performance, including faster diagnostic standards and reductions in waiting times across several pathways. However, persistent challenges remained in eliminating 65-week waits, particularly within ENT and orthopaedics. Continued targeted action was underway to address these backlogs, with a focus on specialty-specific recovery plans and sustaining recent improvements. • The Committee received partial assurance on the Trust's internal **cancer peer review** process, which continued in the absence of an external mandate. It was noted that the review identified significant workforce pressures—notably in speech and language therapy, dietetics, and breast radiology—impacting patient pathways. Actions were underway through workforce reviews and business cases, and the West Midlands Cancer Alliance was to be invited to future reviews to strengthen assurance and avoid duplication. • The update on the implementation of the **chaperoning** policy highlighted strong progress in training uptake and use of structured electronic clinical notes. However, compliance with record-keeping remained inconsistent across some specialties, driven by system and process barriers. A time-limited task and finish group had been established, with the Committee clear that chaperoning compliance was non-negotiable once appropriate practical enablers were in place. As such partial assurance was agreed. • The Committee received an update on C. difficile performance via the **Infection Prevention** Q4 report, noting that the year-end trajectory was not met; however, there was no evidence of ward-based transmission, and it was noted that c-difficile performance reflected wider national increases in infection rates and challenges in classification linked to sample timing. As such, partial assurance was noted.	• The Committee reviewed the **Quarter 4 BAF** and agreed that, while action delivery and specific mitigations have progressed, overall risk scores appropriately remained static due to sustained system pressures and unresolved strategic risks. Discussion highlighted limitations in risk weighting and assurance, particularly in distinguishing between actions that stabilise risk and those that deliver long-term strategic improvement. A revised approach will be developed for Q1 to better reflect severity, harm, and access impacts, with committee input to strengthen assurance and clarity on risk trajectory. • Further assurance to be provided to a future meeting from endoscopy following the **Joint Advisory Group** reaccreditation. • To provide assurance in relation to the themes and actions taken in respect of low compliance with statutory timescales for sharing **child protection medical reports**. • To confirm the reasons why **paediatric** patients required admission for dietetic review. • Further update on **chaperoning** to be provided in 3 months following the re-audit.

Positive Assurances to Provide	Decisions Made
• The Committee received an update on **cancer** patients treated beyond 104 days, noting that delays were multifactorial, with urology identified as the specialty contributing the highest number of breaches. A thematic review was underway to understand underlying causes, alongside patient-level harm reviews, which to date had identified no harm in completed cases, providing acceptable assurance.	• The Committee approved the **Q4 BAF.** • The Committee approved the **Terms of Reference** for the Committee.

• **M12 quality performance** report demonstrated **acceptable assurance** although concerns remain regarding harm pressures, lapses in care, and mixed-sex accommodation breaches. In addition, the implementation of Martha's Rule was noted, with data showing that a proportion of calls led to changes in management, providing assurance that the process was functioning as intended and that awareness was increasing. The Committee welcomed the increase in VTE compliance which was improving following the introduction of ePMA. • The Committee received the annual **end of life care** report, noting completion of significant scoping work to understand current provision and patient need, alongside the development of a refreshed strategic direction aligned with national priorities. Progress included the establishment of a strategic partnership with Marie Curie to support innovation, shared learning, and research and the Committee agreed with a rating of **acceptable assurance**.	• The Committee approved the **Clinical Audit Programme** for 2026/27.

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Comments on effectiveness were sought via MS Forms.	• The Committee noted cross-committee issues arising from **cancer peer review** findings, particularly in relation to staff workload pressures and shortages in dietetic and speech and language therapy support. It was agreed that risks would be escalated to People, Culture and Inclusion Committee for further action and monitoring, recognising their potential impact on patient pathways and the need for coordinated oversight at system level.

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 Q4	1	Ext 20	Not applicable	Approval	8.	UHNM Internal Cancer Peer Review Report 2025	1	Ext 20	Partial	Assurance
2.	Committee Effectiveness 2025/26	-	-	Not applicable	Approval	9.	Cancer 104+ day Breach Report Q3 2025/26	1	Ext 20	Acceptable	Assurance
3.	Executive Quality & Outcomes Group Highlight Report (16-04-26)	1	Ext 20	Not applicable	Information	10.	Quality Performance Report – M12 2025/26	1	Ext 20	Acceptable	Assurance
4.	Clinical Effectiveness Update	1	Ext 20	Partial	Assurance	11.	Chaperoning Update	1	Ext 20	Partial	Assurance
5.	Clinical Audit Programme 2026/27	1	Ext 20	Not applicable	Approval	12.	Infection Prevention Report Q4 2025/26	1	Ext 20	Partial	Assurance
6.	Medicines Optimisation Report Q3/Q4 2025/26	1	Ext 20	Partial	Assurance	13.	Infection Prevention Board Assurance Framework	1	Ext 20	Partial	Assurance
7.	Access Performance Report M12 2025/26	1	Ext 20	Partial	Assurance	14.	End of Life Care Annual Report 2025/26	1	Ext 20	Acceptable	Assurance

Highlight Report

QUALITY, ACCESS & OUTCOMES COMMITTEE | 3rd June 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The Committee received the **maternity and neonatal workforce report**, which provided **partial assurance**, noting ongoing recruitment and retention actions alongside progress within the neonatal workforce, but with significant gaps in Allied Health Professional provision impacting therapy services and risk exposure. A business case is in development to address these gaps, with the Committee highlighting the need for Board-level oversight, alongside further scrutiny of risk scoring and the impact on patient safety, and clarity on how specialist roles are supporting workforce capability and resilience. • The Committee received a report presenting a review of 25 neonatal deaths occurring in 2024, of which 11 met **MBRACE** reporting criteria. The report was presented with specific reference to the MBRRACE 2024 neonatal mortality report which informed the commissioned external review. All neonatal deaths had been reviewed through the Perinatal Mortality Review Tool (PMRT) and reported to the Trust Mortality Group. The report did not highlight any areas of concern, but it was felt to be prudent to note **partial assurance** until the outcome of the external review was received. • The Committee received the **neonatal critical care review**, noting ongoing workforce gaps impacting compliance with required standards and delivery of specialist roles, with interim arrangements in place pending recruitment. A phased approach to workforce strengthening was underway, with risks recognised and prioritised through the risk register. Progress towards accreditation was noted, alongside the need to refresh the neonatal implementation plan to support continued service development and assurance; **partial assurance** was provided. • The Committee received the **access performance** report, noting improvements in urgent and emergency care and cancer performance up to April, followed by a deterioration in May driven by increased attendances and system pressures. Ongoing challenges were highlighted in relation to long elective waits, although all patients had been clinically risk assessed with no harm identified, alongside rising demand within the Emergency Department and corridor care usage. Work was underway to strengthen data analysis and system understanding, with mitigations including the planned opening of the Urgent Treatment Centre to support flow and performance recovery; **partial assurance** was provided. • The update from the **Executive Quality and Outcomes Group** noted that current safeguarding resource levels were sufficient but would be escalated if demand increases. The importance of strengthening trust-wide dissemination of learning from incidents was highlighted, alongside concerns regarding a reduction in incident reporting in specific areas, with further work planned to ensure learning opportunities are fully captured and embedded across the organisation.	• Update to be provided to a future meeting on next steps associated with the **neonatal implementation** plan.

Positive Assurances to Provide	Decisions Made
• The Committee received the **maternity dashboard**, noting pressures across quality outcomes, workforce and service demand, including higher than expected neonatal mortality, staffing gaps and capacity challenges within the Maternity Assessment Unit. Benchmarking identified a number of areas performing in the lower quartile, with actions in place to strengthen data reporting and trend analysis, whilst targeted improvement work and system-level engagement were being progressed to address demand, patient experience and pathway resilience. The Committee concluded with **acceptable assurance.** • The Committee received updates on **incident reviews**, noting 5 cases reported in Quarter 4, with key learning identified around referral processes, risk assessment and medication errors, alongside ongoing review of HIE cases. A thematic review of **CTG monitoring** highlighted issues in escalation, caesarean classification, theatre access and consent, with targeted actions in place to strengthen training and escalation processes; **acceptable assurance** was provided. • The Committee noted progress to strengthen parental engagement in **Perinatal Mortality** reviews, including improved feedback mechanisms and adoption of trauma-informed approaches, alongside the development of a targeted cultural and leadership plan, triangulating staff feedback and insight to support sustained improvement and enhanced professional practice; **significant assurance** was provided. • The Committee noted that full implementation of the **Saving Babies Lives Care Bundle** had been achieved, with all indicators rated green in quarter four, providing **significant assurance**. Ongoing monitoring arrangements are in place to ensure sustained compliance and continued improvement in outcomes.	• The Committee considered the proposed re-establishment of a specific Maternity Quality Committee given increasing reporting demands. It was agreed to consider this further upon the completion of national reviews to avoid potential duplication. • The Committee approved the draft **Quality Account**, subject to minor amendments to enhance presentation and accuracy.

• The Committee reviewed activity relating to **planned home births**, noting that delivery rates remain below the national average, with all cases receiving appropriate MDT oversight and no harm identified. **Significant assurance** was provided and analysis highlighted key themes influencing decisions to birth outside guidance, including previous experience and patient choice, with ongoing monitoring in place and further national guidance awaited to inform future service development and assurance. • The Committee received the quarterly **audit of consultant attendance**, noting 99% compliance with CNST requirements and that appropriate action had been taken in relation to the single delayed attendance. In light of the high level of compliance and effective management of the exception, the Committee agreed that the audit provided **significant assurance**. • The Committee received an update on **criteria for locum employment** and compensatory rest, noting alignment with Royal College of Obstetrics and Gynaecology guidance and the implementation of robust processes to support safe practice. Progress had been made in promoting a culture that enables consultants to declare when they are not fit to work; however, the Committee recognised that full implementation of compensatory rest requirements and wider recommendations, including 24-hour consultant presence, will require significant investment and should be considered as part of future strategic planning. **Significant** and **acceptable assurance** was provided.	
Comments on the Effectiveness of the Meeting	**Cross Committee Considerations**
Comments on effectiveness were sought via MS teams.	

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Maternity Quality & Safety Oversight Group Assurance Report (11-05-26)	-	-	Not applicable	Information	9.	NCCR Bi-annual Action Plan	1	Ext 20	Partial	Assurance
2.	Maternity Dashboard	1	Ext 20	Acceptable	Assurance	10.	Re-Audit of Consultant Attendance at Required Situations Q4 2025/26	1	Ext 20	Significant	Assurance
3.	Maternity & Neonatal PSIRF Investigation Report – Quarter 4 2025/26 • CTG Thematic Review	1	Ext 20	Acceptable	Assurance	11.	Criteria for: • Employing Long-term Locum Doctors • Employing Short-term Locum Doctors • Compensatory Rest for Consultants and Senior SAS Doctors			Significant Significant Acceptable	Assurance
4.	Perinatal Mortality Report Tool Q4 25/26	1	37385 High 9 38334 High 10	Significant	Assurance	12.	Access Performance Report Month 1 26/27 • UEC Highlight Report	1	Ext 20	Partial	Assurance
5.	Maternity & Neonatal Workforce Report	1	Ext 20	Partial	Assurance	13.	Executive Quality & Outcomes Group Highlight Report (21-05-26)	1	Ext 20	Not Applicable	Information
6.	Saving Babies Lives Care Bundle V3 – UHNM Compliance Q4 2025/26	1	Ext 20	Significant	Assurance	14.	Quality Account 2025/26	1	Ext 20	Not Applicable	Approval
7.	Annual MBRRACE Report and Action Plan	1	Ext 20	Partial	Assurance	15.	Quality Performance Report – Month 1 2026/27	1	Ext 20	Not Applicable	Information
8.	Planned Homebirth Quarter 4 2025/26			Significant	Assurance						

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Integrated Performance Report

Month 01 Performance

2026/27

Kind Excellent Together

University Hospitals of North Midlands NHS Trust

Contents

Statistical Process Control

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

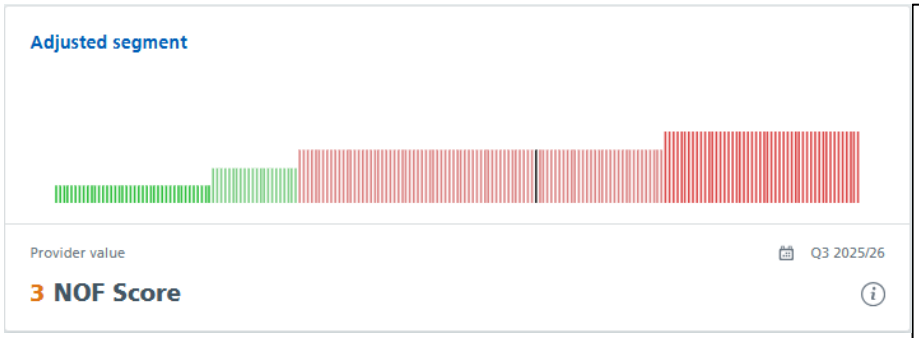
Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

Oversight Framework Summary

University Hospitals of North Midlands NHS Trust

Headlines	Data period	Provider value	Peer average	National value	National value method	Chart
Adjusted segment			Q3 2025/26 3	NOF Score	Provider value	
Average metric score			Q3 2025/26 2.47	NOF Score	Provider value	
Unadjusted segment			Q3 2025/26 3	NOF Score	Provider value	
Financial override	Q3 2025/26	No	Yes	Yes	Provider median	

Domain Scores	Data period	Provider value		Chart
Access to services domain segment	Q3 2025/26	3	NOF Score	
Access to services domain score	Q3 2025/26	2.57	NOF Score	
Effectiveness and experience of care domain segment	Q3 2025/26	2	NOF Score	
Effectiveness and experience of care domain score	Q3 2025/26	2.16	NOF Score	
Patient safety domain segment	Q3 2025/26	3	NOF Score	
Patient safety domain score	Q3 2025/26	2.67	NOF Score	
People and workforce domain segment	Q3 2025/26	2	NOF Score	
People and workforce domain score	Q3 2025/26	2.49	NOF Score	
Finance and productivity domain segment	Q3 2025/26	3	NOF Score	
Finance and productivity domain score	Q3 2025/26	2.35	NOF Score	



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

Overall score in quarter two was 2.43, a slight deterioration in quarter three 2.47, broken down as:

- Access to services from 2.41 to 2.57
- Effectiveness and experience from 2.19 to 2.16
- Patient Safety from 2.86 to 2.67
- People and workforce remains from 2.53 to 2.49
- Finance and productivity remains from 2.36 to 2.35.

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Effectiveness and Experience

University Hospitals of North Midlands NHS Trust

Effectiveness and experience of care	Data period	Provider value		Chart
Effectiveness and experience of care domain segment	Q3 2025/26	2	NOF Score	
Effectiveness and experience of care domain score	Q3 2025/26	2.16	NOF Score	

Patient experience	Data period	Provider value	Peer average	National value	National value method	Chart
CQC inpatient survey satisfaction rate score	Q3 2025/26	2	NOF Score	Provider value	
Summary Hospital-level Mortality Indicator score	Q3 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	Q3 2025/26	1.48	NOF Score	Provider value	
Average number of days from discharge ready date to actual discharge date (including zero days)	Dec 2025	0.31	0.80	0.83	Provider median	

UHNM score well in this domain, with a score of 2.16 a slight improvement since quarter two of 2.19.

Patient Experience – both metric scores remain the same as in quarter two.
Effective flow and discharge – slight improvement in score from 0.39 to 0.31.

Patient Safety

University Hospitals of North Midlands NHS Trust

Patient Safety Domain Score	Data period	Provider value		Chart
Patient safety domain segment	Q3 2025/26	3	NOF Score	
Patient safety domain score	Q3 2025/26	2.67	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			Q3 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			Q3 2025/26 3.79	NOF Score	Provider value	
Number of MRSA bacteraemia cases (12 months)	To Dec 2025	9.00	7.00	3.00	Provider median	
Proportion of C. difficile infections score			Q3 2025/26 3.06	NOF Score	Provider value	
Proportion of C. difficile infections versus threshold (12 months)	To Dec 2025	1.24	1.10	1.12	Provider median	
Proportion of E. coli bacteraemia score			Q3 2025/26 1	NOF Score	Provider value	
Proportion of E. coli bacteraemia versus threshold (12 months)	To Dec 2025	0.97	1.17	1.17	Provider median	

UHNM remain in segment 3 for this domain, with an improved score of 2.67 in quarter three, compared to quarter two at 2.86.
This improvement is a result of the scores for CDiff and EColi rates improving since quarter two.
Although MRSA value has deteriorated since quarter two from 8 to 9 in quarter three, this remains higher than the peers value of 7 and the national value of 3.

Quality & Access | Overview

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

Overview from the Chief Nurse and Chief Medical Officer

How are we doing against our trajectories and expected standards?

We met the required performance across a range of metrics and the NMAHP workforce remains stable. We are currently ranked 3rd out of 205 organisations for registered nurse turnover and ranked 21st out of 138 organisations for registered Midwife turnover. Focused recruitment continues to reduce the current CSW vacancies. We have a range of processes to assess and triangulate safe staffing requirements, fill rates, staff experience and quality metrics and outcomes; and subsequent supportive interventions when and if required.

We did not meet the required target in March across a number of metrics including falls with harm, DOC, pressure ulcers with lapses in care, FFT in ED and maternity, VTE, HAT, 3rd and 4th degree tears and mixed sex accommodation breaches. There are some promising improvements in timely observations with March seeing another increase in performance – we are now 8% off target performance. Complaints response times also continues to reduce.

UHNM has moved into the blue zone on the regional maternity heatmap (just 3 points from the lowest scoring organisations).

There have been 9 Calls for Concern (Martha's Rule) during April 2026: Of the 9 cases referred in March: 8 qualified for a review, 5 had documented advice only and 3 had a change in management including IV antibiotics commenced, end of life care pathway commenced and transfer to ICU/HDU.

There are a number of emerging challenges which are affecting safe and effective management of cardiothoracic theatres. A risk summit will take place and further information provided to the Committee in due course. Focused oversight is in place for both AMU RSUH (Bronze CEF), and ward 228

What is driving this?

There is focused work across Planned and Unplanned to reduce avoidable harm. The support programme for Silver CEF areas, led by the Quality Team and the Continuous Improvement team, is proving to support teams to drive improvement across a range of metrics and to also increase CEF accreditation standards.

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

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

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

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

Quality& Access | Overview

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust

Overview from the Chief Nurse and Chief Medical Officer

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

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

In response to the increase in Category 4 pressures ulcers the Care Group Medical and Nursing Directors will meet with the relevant clinical teams to oversee action plans and repeat of Category 4 pressure damage will result in the team being required to meet the Chief Nurse and Chief Medical Officer.

With regards to the external review commissioned to consider the MBRACE data; the agreed TOR have been shared with the ICB and CQC for transparency, the requested data is collated is available to the team

The IP focused audit across UEC and wards who consistently have continuous flow patients is now concluded and the results will be reported to Committee.

We have had a high number of applications to join our Patient Council.

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

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

What can we expect in future reports?

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

We will update the Committee on the change from Tendable to Genome and also update on progress with the refreshed accreditation process.

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

The External review considering the MBRACE data will completed in September but the Committee will be briefed if any escalations are received during the course of the review.

Quality & Access | Dashboard

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KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
HSMR (Rolling 12-months)	Feb 26	123.8	100.0			120.5	113.0	127.9
PSI per 1000 bed days	Apr 26	47	51			53	47	58
PSI with moderate harm or above per 1000 bed da	Apr 26	0.5	0.6			0.7	0.3	1.0
Patient Falls per 1000 bed days	Apr 26	4.8	-			4.7	3.7	5.7
Patient falls with harm per 1000 bed days	Apr 26	2.1	1.5			1.7	1.1	2.3
Medication incidents per 1000 bed days	Apr 26	4.5	6.0			5.8	4.6	7.0
Medication incidents with moderate harm or above	Apr 26	1%	5%			1%	-1%	4%
Never Events reported	Apr 26	0	0			1	-2	3
PSIIs instigated	Apr 26	0	0			2	-4	8
Duty of Candour verbal	Apr 26	93%	100%			91%	69%	114%
Duty of Candour written (letter sent within 10 worki	Apr 26	93%	100%			81%	46%	115%
Pressure Ulcers developed at uhnm per 1000 bed	Apr 26	1.9	1.6			1.7	0.8	2.6
Pressure ulcers with lapses in care per 1000 bed d	Apr 26	0.6	-			0.5	0.2	0.8
Trust Apportioned Infections	Apr 26	45	-			50	28	71
Avoidable cases of MRSA Bacteraemia	Apr 26	0	0			0	0	1
HAI and COHA cases of C.Diff toxin	Apr 26	13	12			14	5	23
HAI E.Coli Bacteraemia Cases	Apr 26	18	19			20	7	33
Sepsis Screening - Inpatients	Apr 26	97%	90%			97%	89%	104%
Sepsis IVAB - Inpatients	Apr 26	100%	90%			99%	95%	103%
Sepsis Screening - ED	Apr 26	95%	90%			93%	85%	100%
Sepsis IVAB - ED	Apr 26	89%	90%			84%	64%	104%
Sepsis Screening - Maternity	Apr 26	89%	90%			98%	90%	106%
Sepsis IVAB - Maternity	Mar 26	100%	90%			98%	89%	106%
Sepsis Screening - Childrens	Apr 26	97%	90%			91%	79%	102%
Sepsis IVAB - Childrens	Aug 25	100%	90%			61%	-28%	150%

KPI	Latest month	Measure	Target	Variation	Assurance	Mean	Lower process limit	Upper process limit
VTE Risk assessment Rate (timely) - data from eP	Apr 26	83%	95%			84%	#N/A	#N/A
Hospital Associated Thrombosis Rate	Apr 26	1.4	-			1.0	0.2	1.8
Care hours per patient day (safe staffing)	Apr 26	9.2	-			9.2	9.0	9.5
Timely Observations	Apr 26	82%	90%			80%	78%	82%
UHNM Inpatients - Friends & Family Test (% recom	Apr 26	96%	95%			96%	94%	98%
UHNM A&E - Friends & Family Test (% recommen	Apr 26	78%	85%			70%	60%	79%
UHNM Maternity - Friends & Family Test (% recom	Apr 26	90%	95%			87%	73%	100%
Complaints - % closed within 25/40/60 working day	Feb 26	35%	-			26%	3%	50%
Written complaints rate per 10,000 spells	Apr 26	46	-			35	23	47
Mixed Sex Accommodation Breaches Reported	Apr 26	126	-			104	68	140
Maternity Induction of Labour - Breach performanc	Apr 26	100%	95%			98%	96%	101%
Maternity Assessment Unit Triage within 15 minute	Apr 26	86%	85%			90%	80%	100%
3rd/4th degree tears	Apr 26	9	-			8	1	15
Neonatal deaths	Apr 26	1	-			2	-1	5

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

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

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

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

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

Related Strategy and Board Assurance Framework (BAF)

Quality Strategy

The best joined-up care for *all*

BAF Risk	Q1 (2025/26)		Q2		Q3		Q4 (2024/25)	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 1: Delivering Positive Patient Outcomes	High 12	Acceptable	High 12	Acceptable			High 12	Acceptable

Quality & Access | [PSIs per 1000 bed days]

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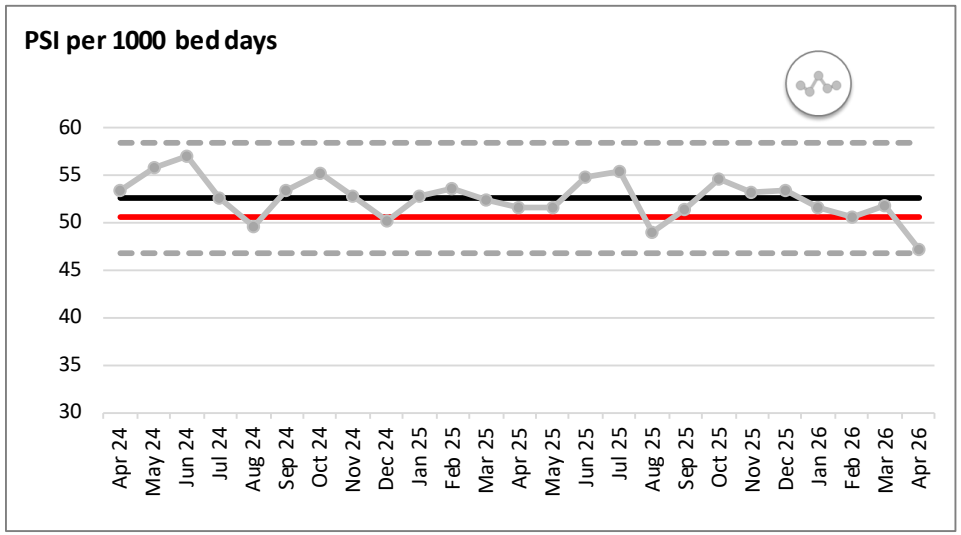

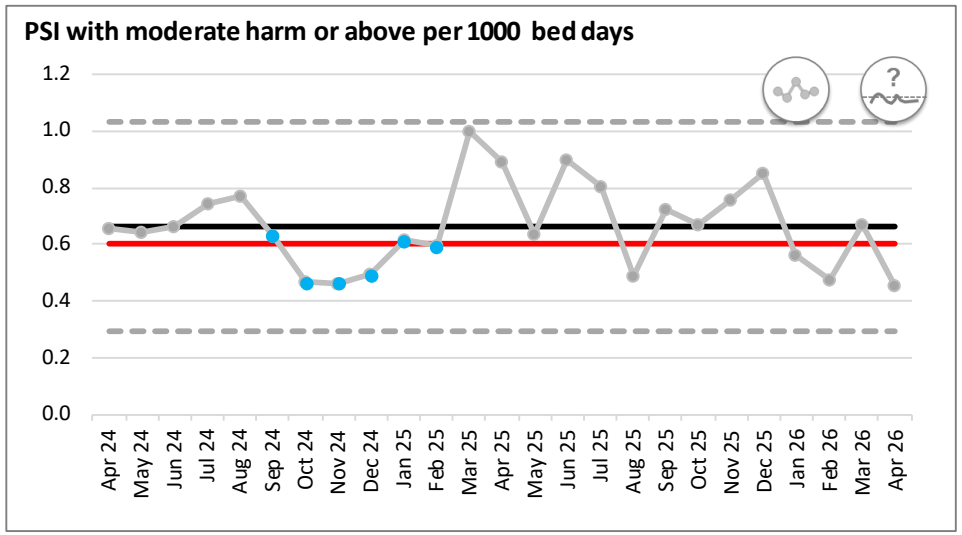

What is driving this performance?

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

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

What are we doing about it?

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

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

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

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

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

Quality & Access | [Patient Falls]

Provide safe, effective and caring services

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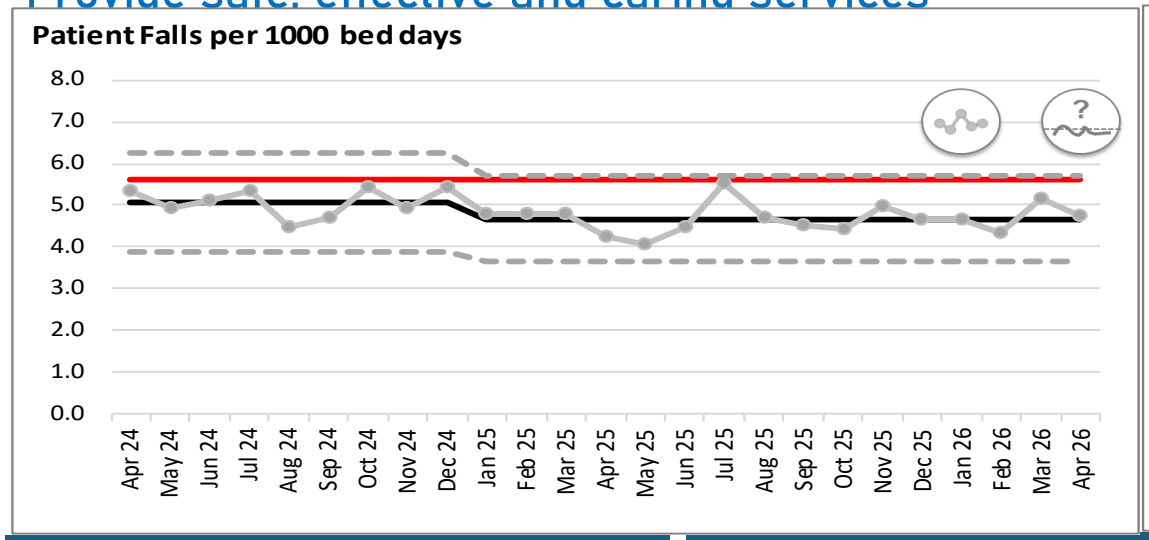

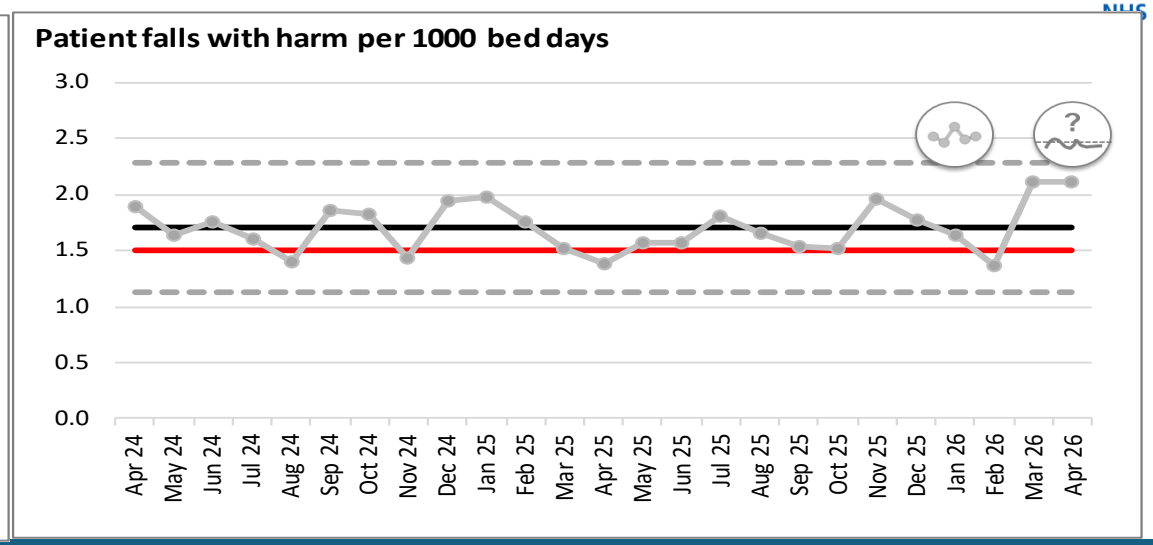

What is driving this performance?

Top reporters in April 2026: Stoke AMU – 13 falls, Stoke ED – 13 falls. Neither of these numbers is significantly higher than usual.

3 falls resulting in a serious injury were reported in April, on the following wards: 78, SSU, AMRA.

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?

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

The harm free educators have supported AMU. Discussions have taken place with the ED team regarding changes to documentation.

Falls toolkits were completed on the 3 injuries. All patients required assistance with mobility, none of them had pressed the call bell to ask for assistance. Actions were discussed with the ward teams.

Further new falls champion and refresher days have taken place.

New N/A falls presentation has been delivered.

Ward reviews have commenced that address all aspects of falls. This has included communicating with the staff to identify any barriers to care and for them to discuss any concerns with us. This information is discussed and fed back to the ward sisters. Matron of the areas and the ward sisters are then being asked to complete a Go Look Learn with the team to share good areas of practice. If there are areas of improvements that are required, this will be discussed with the team at the time of the visit. Collectively agreed actions will be made that will hopefully provide assurances.

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

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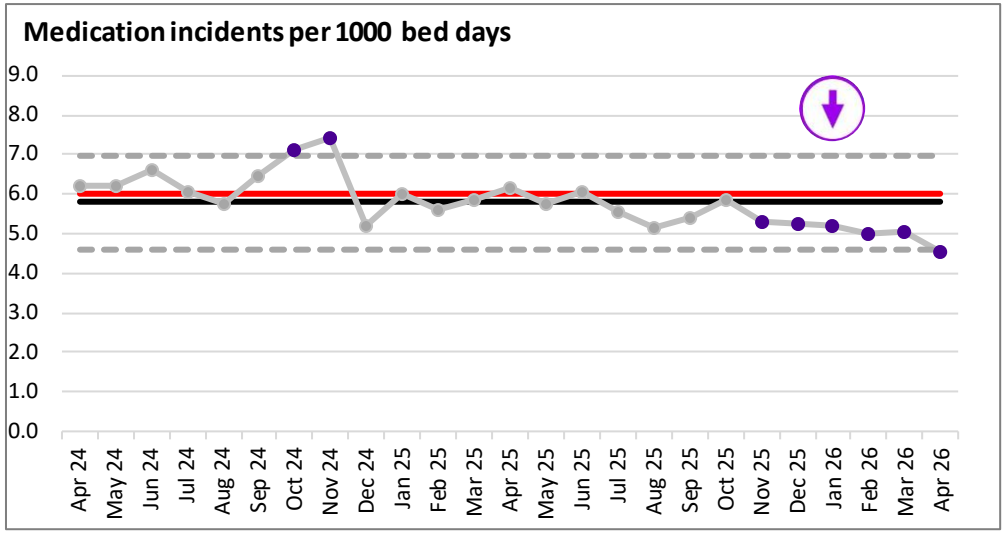

What is driving this performance?

Reducing trend is noted as concern as it provides less opportunity to learn from low and no-harm incidents.

Care Groups strengthened governance and learning via dedicated working groups/Pharmacy review, routine trend monitoring, and increased use of ePMA to improve prescribing and assurance

What are we doing about it?

1. Theatres Controlled Drug audit report (data collection period Jan / Feb 26) completed, to present at Trust MOSG May 25. Urgent improvement needed & further scoping for digital opportunities.
2. Medicine Storage Audit Tool & CD Audit Tool being reviewed with regional tool. Project to move audits to Genome to improve visibility.
3. Work continues to review and update Trust Policy MM06 (Prescribing, Storage, Supply and Administration of Controlled Drugs). SOPS have been drafted and engagement with nursing / other teams under way. An SOP for the Management of FP10s will be a new addition to MM06.
4. Risk review in progress regarding the CD requirements for Schedule 3 Gabapentinoids, UHNM currently a regional outlier with minimum legally required standards in place.
5. Review around introducing single-nurse administration of "Oramorph" (Morphine sulphate 10mg/5ml oral solution) in progress.
6. Collaborative project between Diabetes Teams, diabetes pharmacist & medicine safety team to produce the SOP for the pilot of self-administration of insulin on diabetes wards. SOP approved by Insulin Safety Group & going to MOSG for approval May 2025.
7. UHNM Safety Alerts & Learning Alerts produced & circulated in response to specific incidents e.g. risk of adverse effects from counterfeit / unlicensed GLP-1s obtained by patients online.
8. NICU have completed an extensive review with improvements regarding medicines safety.

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

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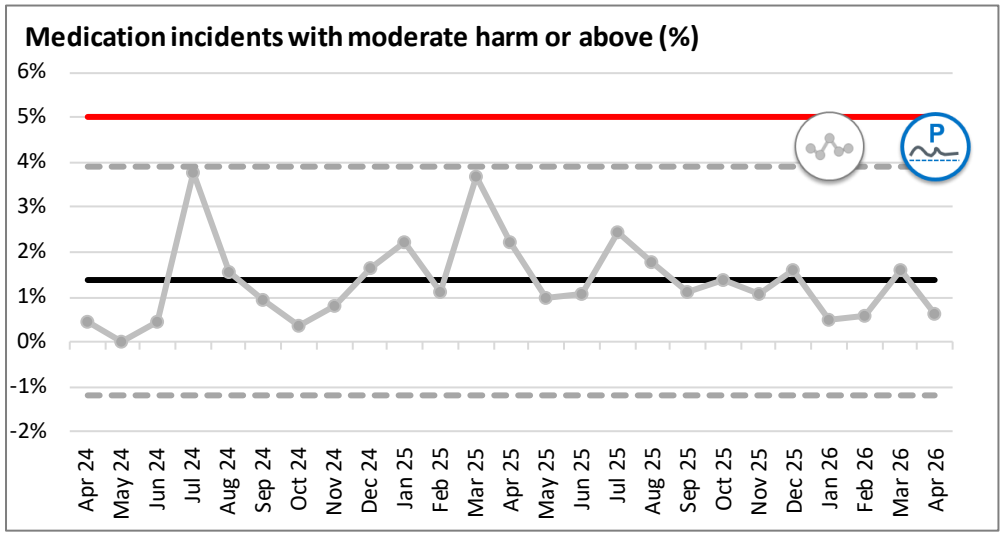

What is driving this performance?

In April 2026 there was 1 incident reported that was categorised as moderate harm or above that related to learning outside of the Trust.

Reporting is within usual monthly variation and remains consistently below the benchmark rate, offering positive reassurance that this standard is being met.

What are we doing about it?

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

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

ID	Incident Date	Location	Subcategory	Description	Actions

Quality & Access | [Never Events & PSIIs]

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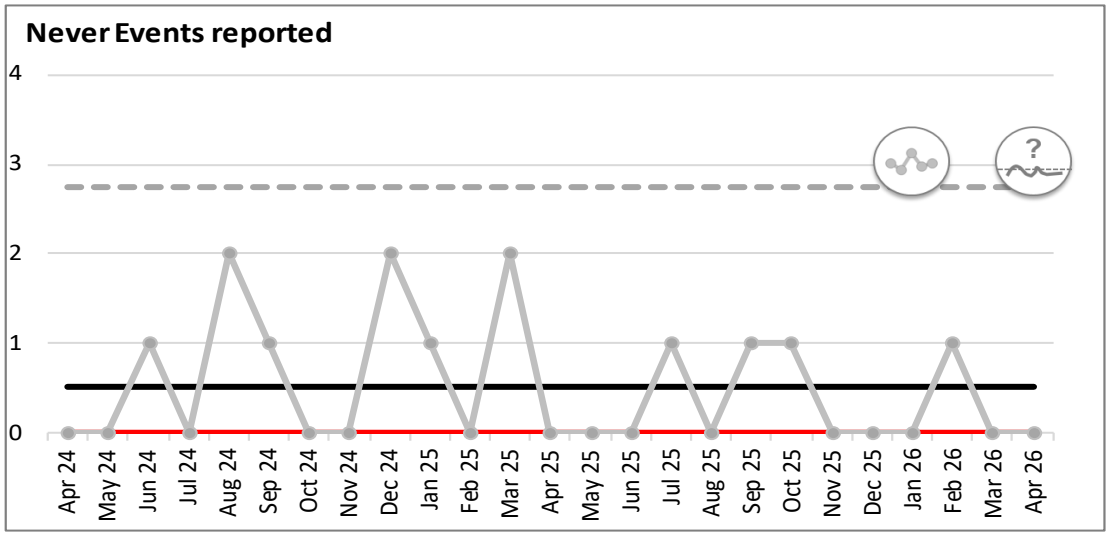

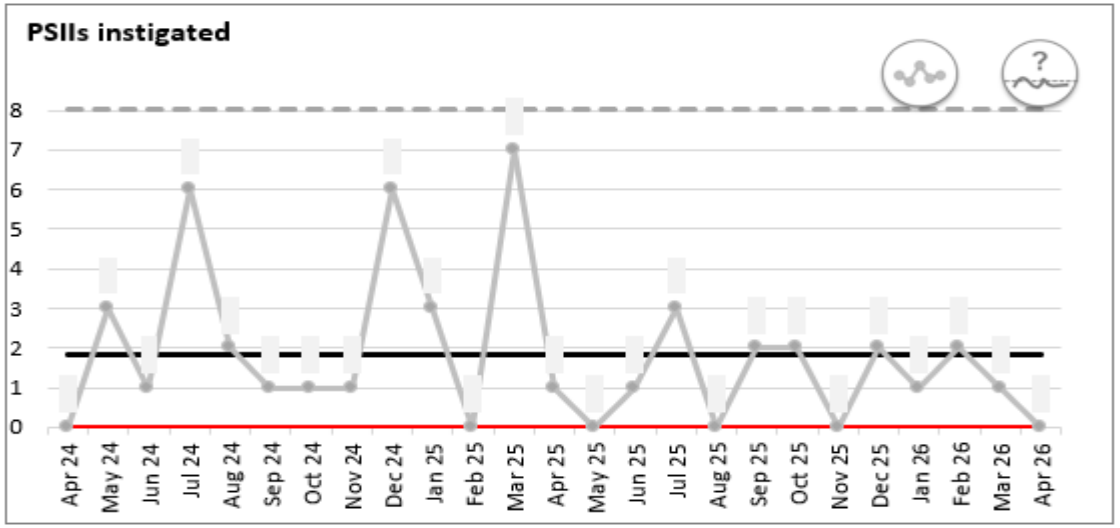

What is driving this performance?

No never events were identified during April 2026.

No new PSII were commissioned during April 2026).

What are we doing about it?

We continue to formulate learning response reports when a PSII is commissioned, recent changes to Never Event reporting no longer stipulates a PSII is required and we adopt proportionate responses to ensure any learning is identified and shared.

Quality & Access | [Duty of Candour]

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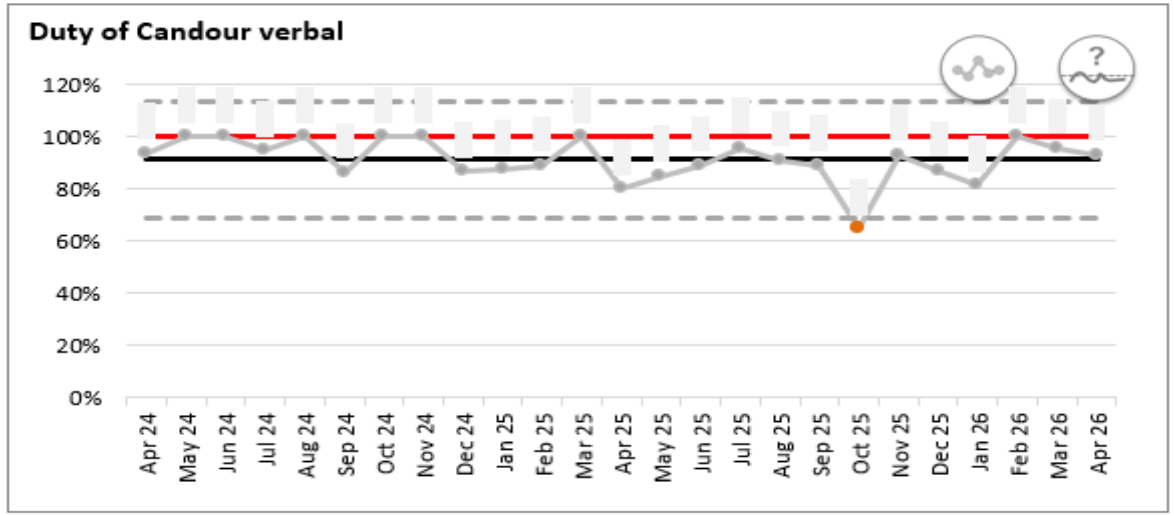

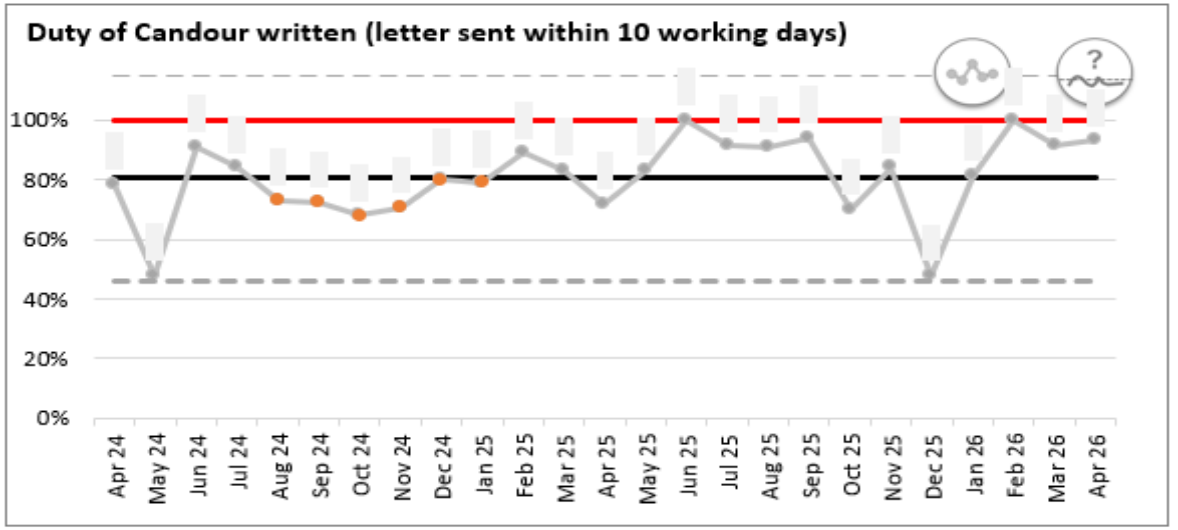

What is driving this performance?

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

15 out of the 16 incidents that formally triggered duty of candour in April met compliance for verbal and written (93.7%).

What are we doing about it?

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

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

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

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

University Hospitals of North Midlands NHS Trust

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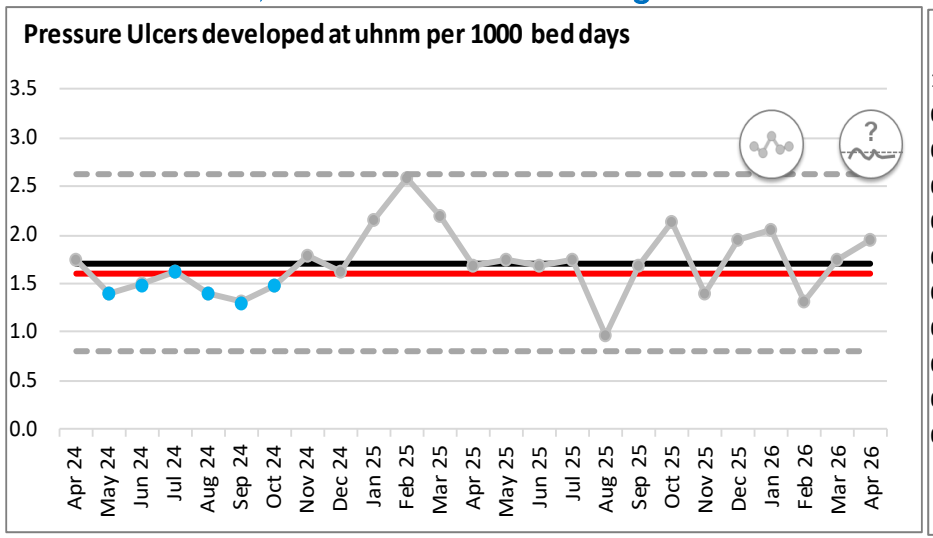

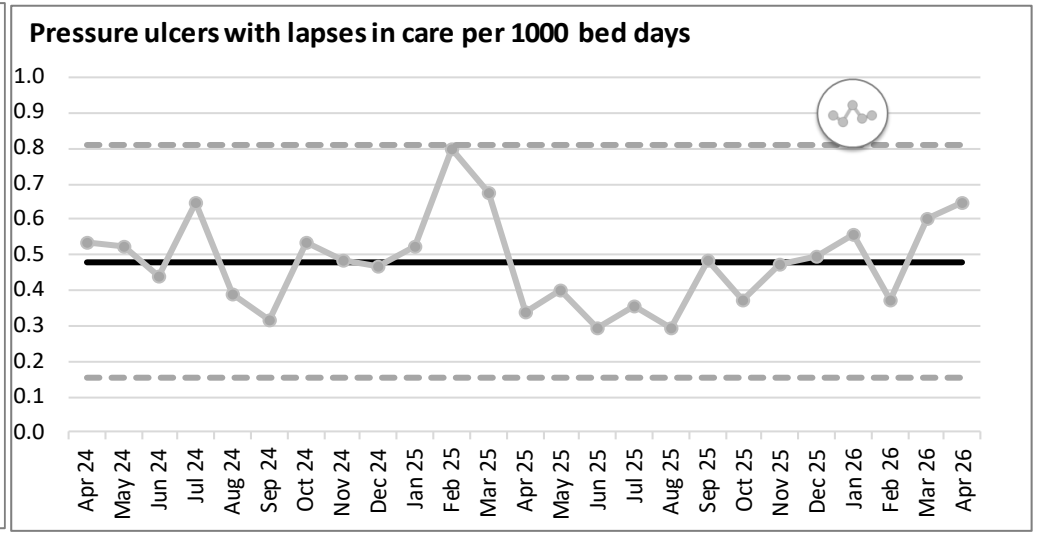

Type of Lapses Mar 2026	Total
Management of repositioning – position not changed	19
Management of repositioning - timeliness	15
Management of heel offloading	3

What is driving this performance?

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

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

There has been an increase in hospital acquired category 4 pressure ulcers. Senior teams have been notified of this.

What are we doing about it?

- Areas who have reported multiple HAPU within a singular month are invited to steering group to provide assurance for improvements
- Harm free care action plan being created for standardised actions and having a unified approach
- Huddles taking place to discuss category 4 hospital acquired pressure ulcers, where care groups are invited
- Implementing a new escalation process in the event of Cat 4 PU whereby the ward manager and consultant will meet with the Care Group Nurse and Medical Directors to discuss improvement plans to prevent further cases. In the event of further cases in the same ward/dept the ward leader and consultant will meet with the Chief Nurse and Medical Director.
- Thematic review to be undertaken in relation to the Category 4 HAPU across the Care Groups and report to Patient Safety Group
- Audits being completed by the Quality and Safety team to support improvements
- Champions programme commenced in March for the 2026 year, encouraged with cascading education
- To discuss with OD and training to review ESR package as mandatory training
- Safety alert shared for ongoing issues with mattresses and the cells
- Prompt cards being developed for staff, supporting with pressure prevention and categorisation
- Task and finish group set up and looking at unnecessary catheterisations
- ED trolley mattresses fully implemented; thematic reviews completed with staff education and Datix feedback
- Acute Medicine: daily pressure checklist, strengthened audits and assurance meetings

Quality & Access | [Trust Apportioned Infections & MRSA Bacteraemia

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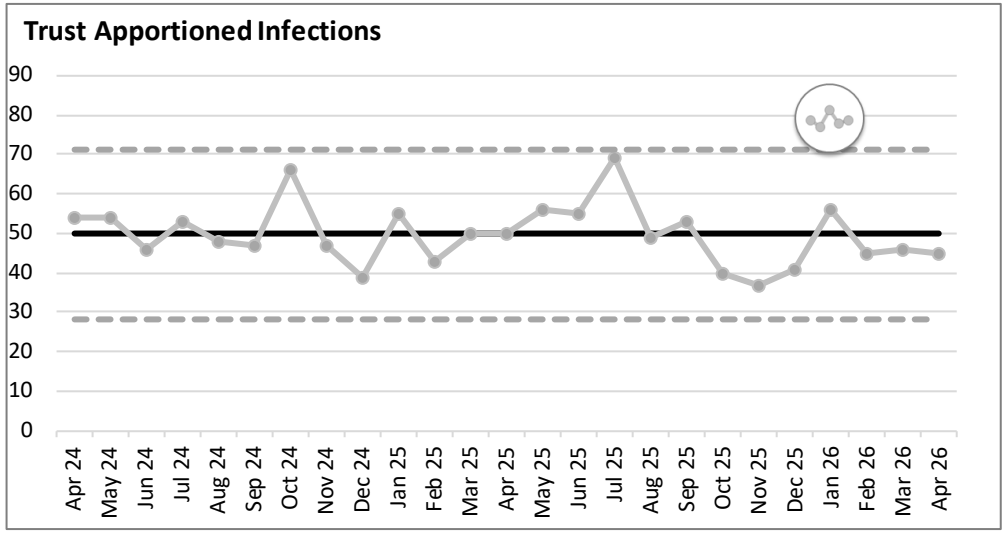

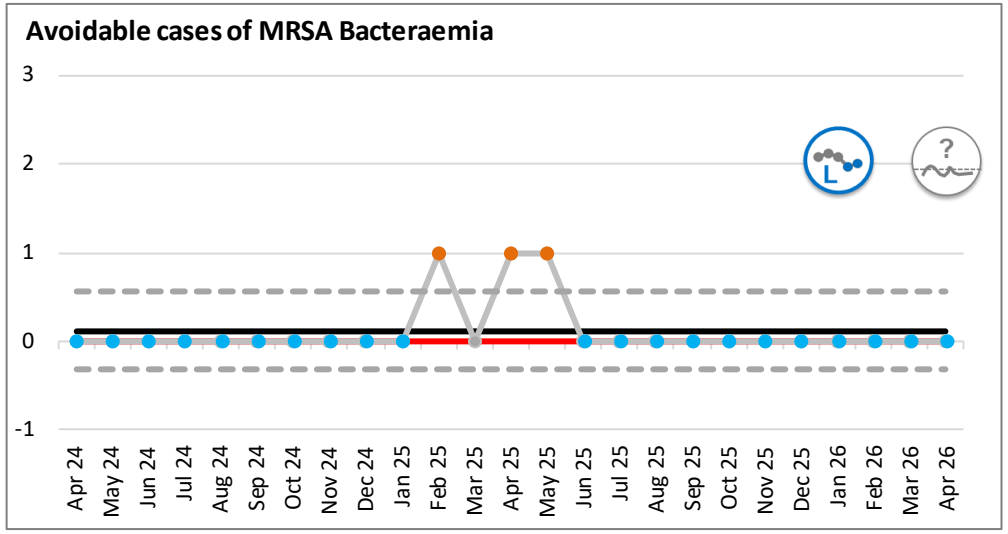

What is driving this performance?

Trust Apportioned Infections
Numbers remain within the usual range.

MRSA-b
No MRSA Bacteraemia cases reported since May 2025.

What are we doing about it?

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

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

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

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

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

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

Provide safe, effective and caring services

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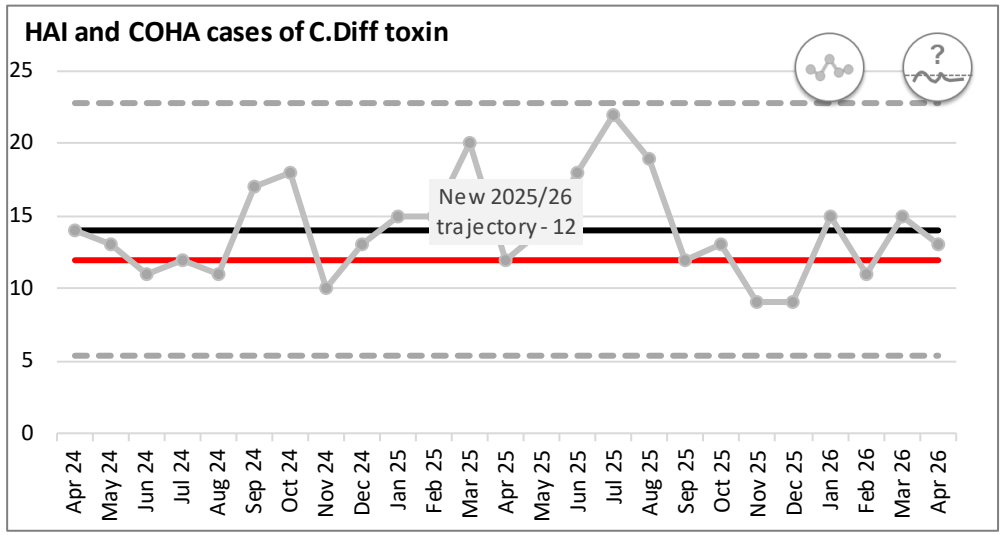

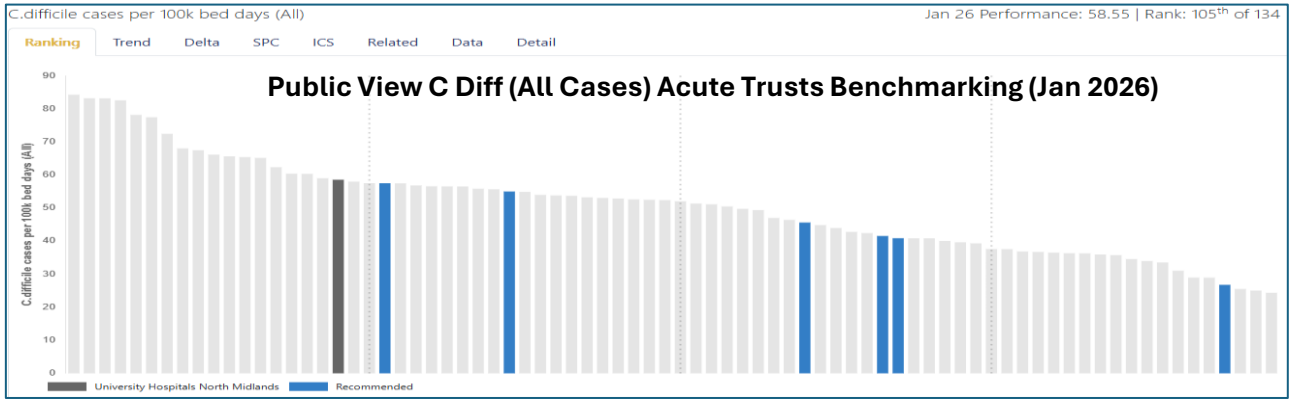

What is driving this performance?

C diff has been declared a National Incident by the UKHSA due to the increased number of cases throughout England; work is ongoing to try to understand the reasons behind this.

There have been 13 reported C diff cases in April 2026 – 8 x HAI and 5 x COHA
There have been three wards with a period of increased incidence reported in April - 1 with 2 COHA cases at Royal Stoke and 1 with 2 HAI cases and 1 with 1 HAI + 1 COHA at County.

The 2026/27 objective for C-Diff haven't been issued to date.

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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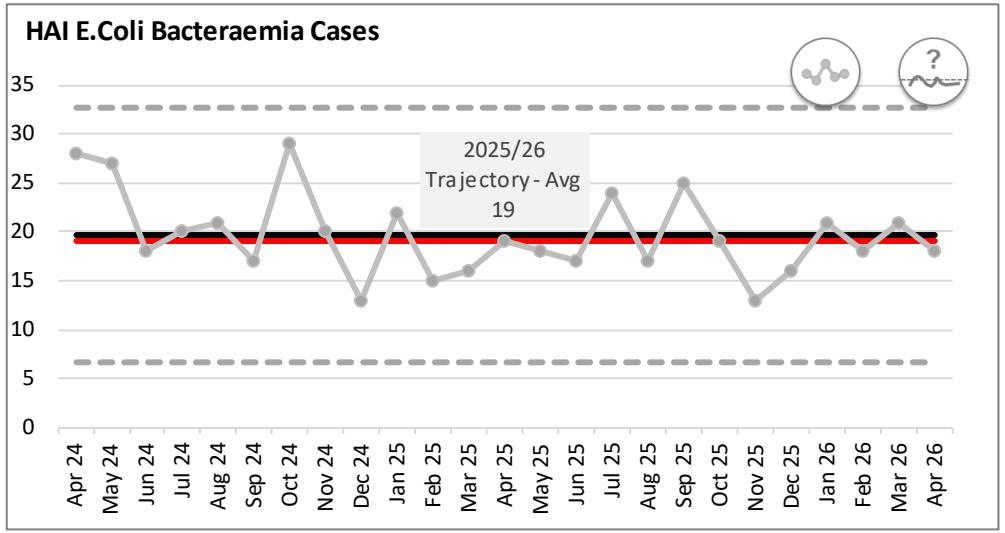
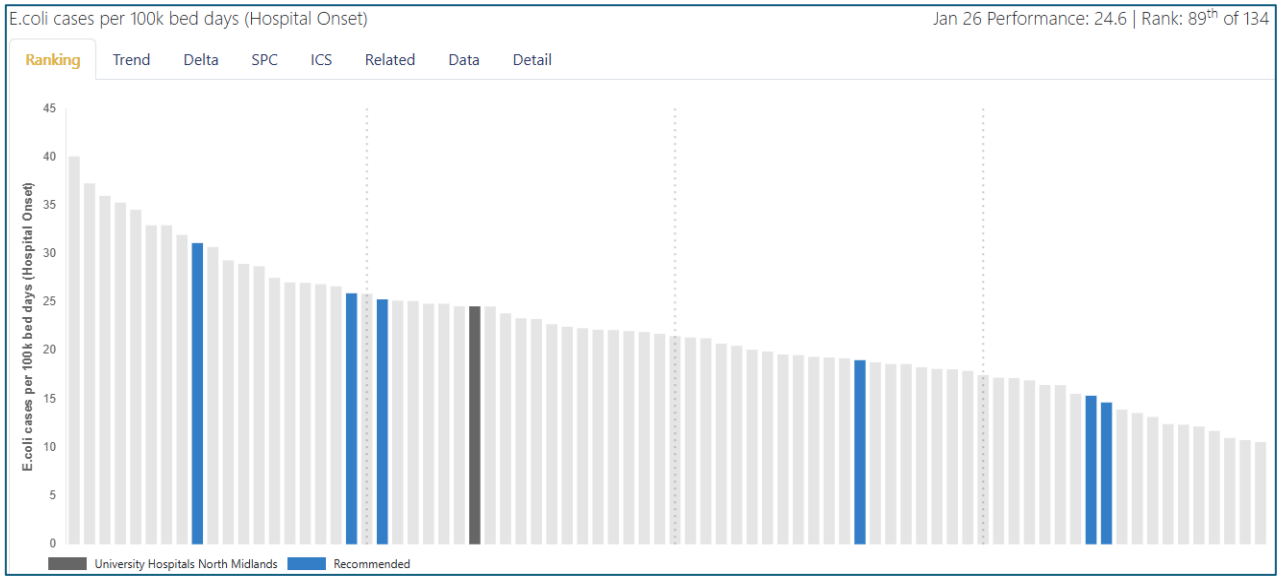


Public View Hospital Onset E.Coli Acute Trusts Benchmarking (Jan 2026)



What is driving this performance?

The target trajectory for 2026/27 hasn't been issued by NHSE to date.

As at April 2026 we have had 18 Trust apportioned cases (9 * HAI and 9 * COHA) which is below the average of the previous 12 months.

What are we doing about it?

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

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

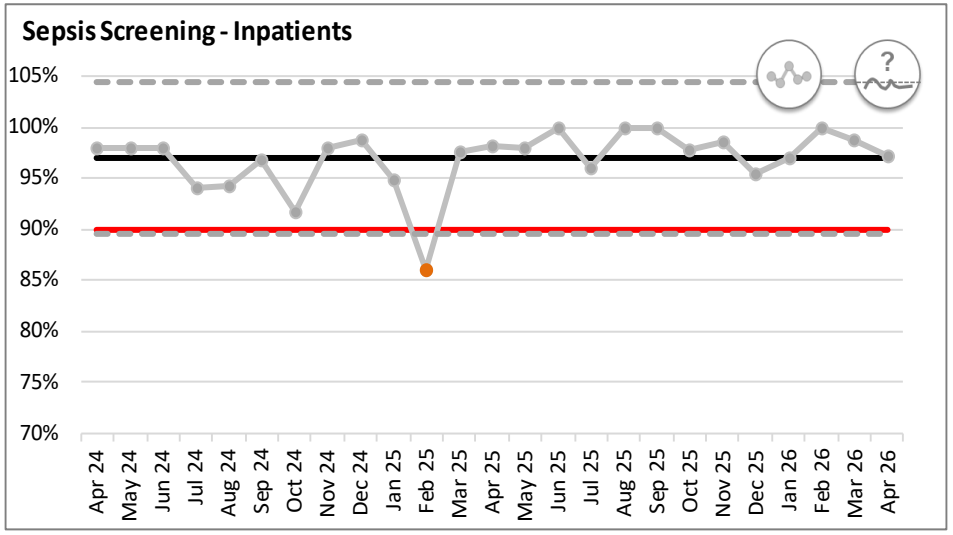
Early identification, rapid screening and enhanced terminal cleans prioritised

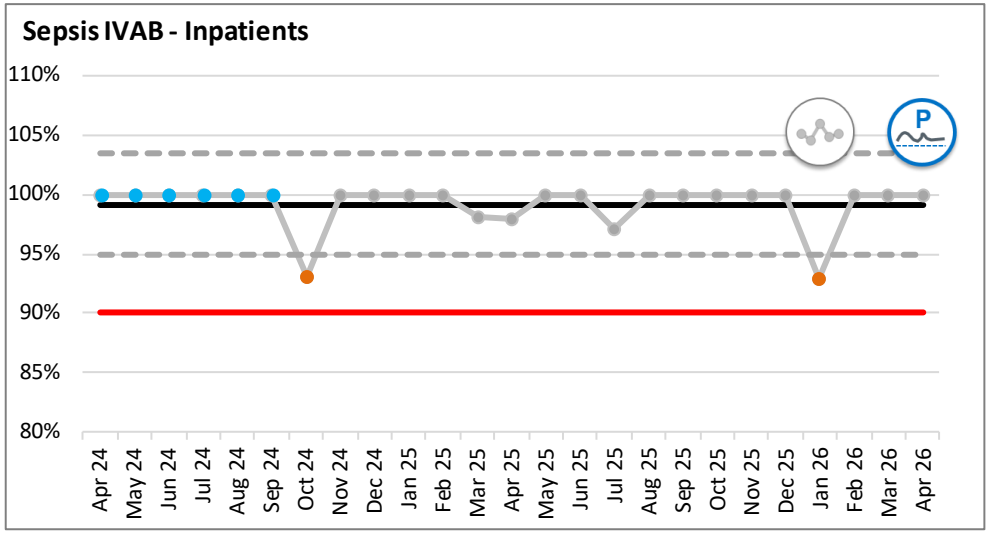
We are also reviewing patient blood results to check for indications of dehydration.
There is also an ongoing collaborative work around CAUTI with external colleagues. UHNM Task Finish group is also being established.

Quality & Access | [Sepsis – Adult Inpatient]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is driving this performance?

Inpatient screening compliance was within the usual range in April 2026 and has consistently exceeded the target since Mar-25.
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 109 cases were reviewed in April; there were 3 missed screens. 74 cases were identified as red flag sepsis, with 56 receiving an alternative diagnosis. Leaving 18 patients of which all 18 were already on antibiotics. There was 0 newly identified sepsis requiring IVAB within the hour.

What are we doing about it?

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

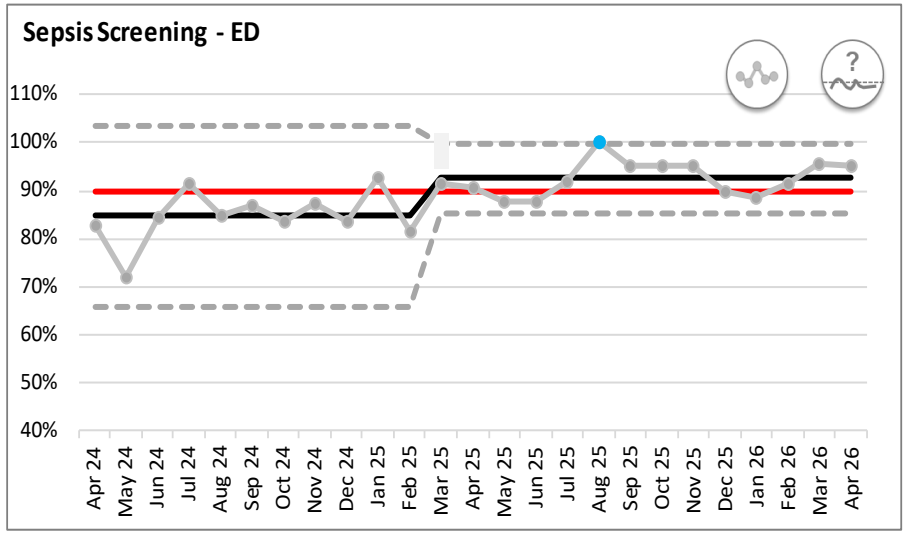
The sepsis will continue to provide sepsis kiosks/ drop- in sessions to targeted clinical areas.

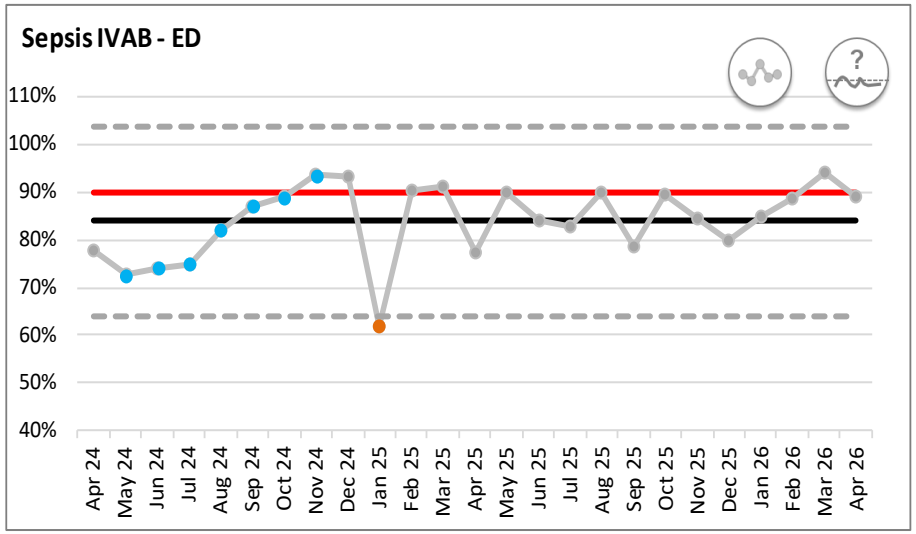
The sepsis team will continue to create drop-in training sessions for band 3s for all inpatient departments.

Quality & Access | [Sepsis – Emergency Portals]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is driving this performance?

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

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

In April, 148 cases were reviewed with 7 missed sepsis screens. 109 cases were identified as red flag sepsis – 73 had an alternative diagnosis, 15 were already on IV antibiotics. Leaving 21 newly identified sepsis patients. 4 of these patients received IV antibiotics outside the target 1 hour window.

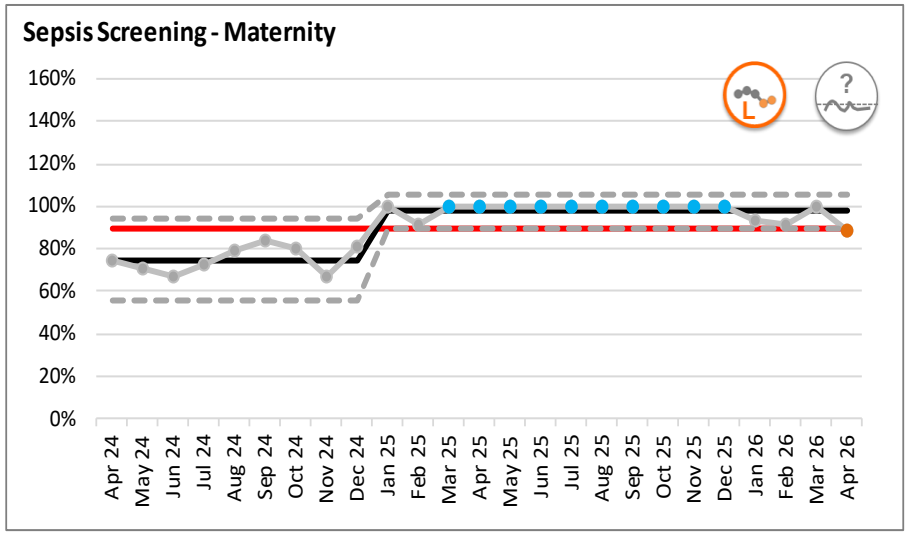
What are we doing about it?

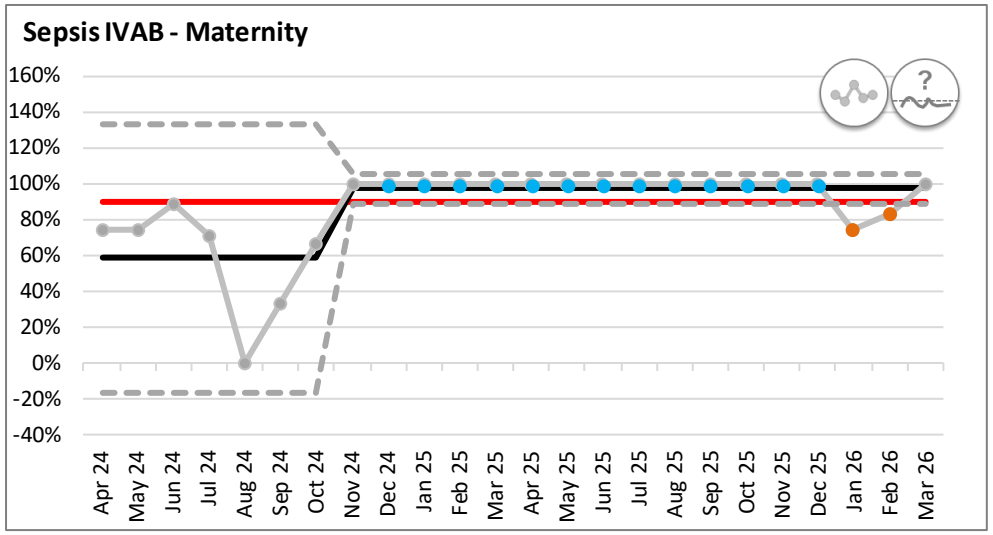
- The sepsis team continue by closely monitor compliance by visiting and auditing ED regularly.
- Regular meetings with ED senior team with robust actions in place.
- Face to face sepsis induction / training for new nursing staff, nursing assistant and medical staff continue.
- Introduced Deteriorating 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.
- ED Pit stop model under review; Improving Together huddles introduced; Tendable checklists introduced pending IT rollout

Quality & Access | [Sepsis – Maternity]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is driving this performance?

A total of 12 cases were audited from the emergency portal MAU in April and there were 0 missed screens. 6 cases were reviewed for inpatients, and there were two missed sepsis screens.

For emergency portals, there was 3 red flag sepsis and all three had an alternative diagnosis.

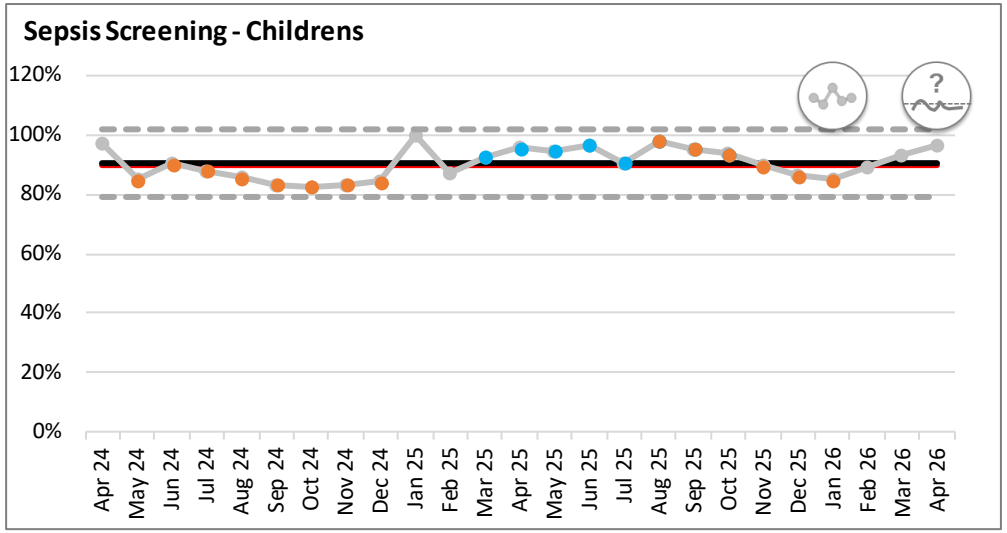
What are we doing about it?

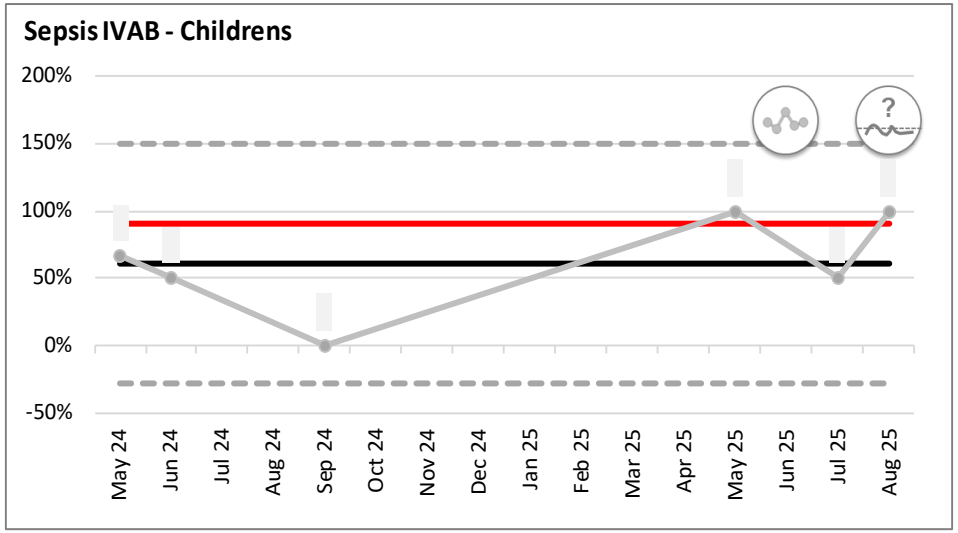
Monthly maternity skills drill is now replaced with ad hoc sepsis sessions in each clinical area
Monthly audits undertaken and embedded with Lead Midwife for Sepsis.
The sepsis team continue to provide sepsis kiosks/ drop- in sessions to targeted clinical areas.
The sepsis team will create further awareness and plan collaborative work with maternity educators and senior team.
Visual prompts and flowcharts embedded in clinical areas

Quality & Access | [Sepsis – Children]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





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 22 cases audited for emergency portals with 1 missed screens in April. 3 cases were audited for inpatients with 0 missed sepsis screens.

No true red flag sepsis have been identified from the randomised audits in the emergency portals or inpatients since August 2025.

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 | [VTE & Hospital Associated Thrombosis]

Provide safe, effective and caring services

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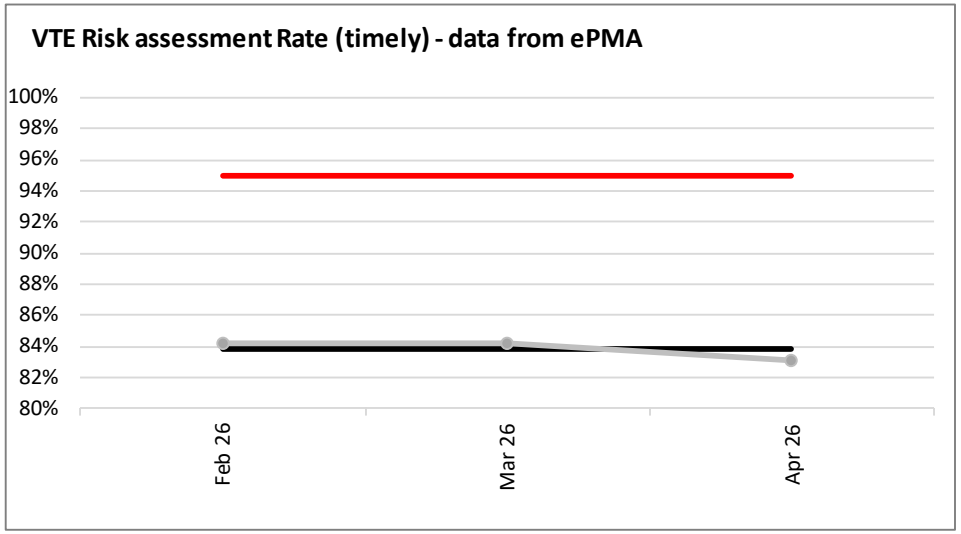
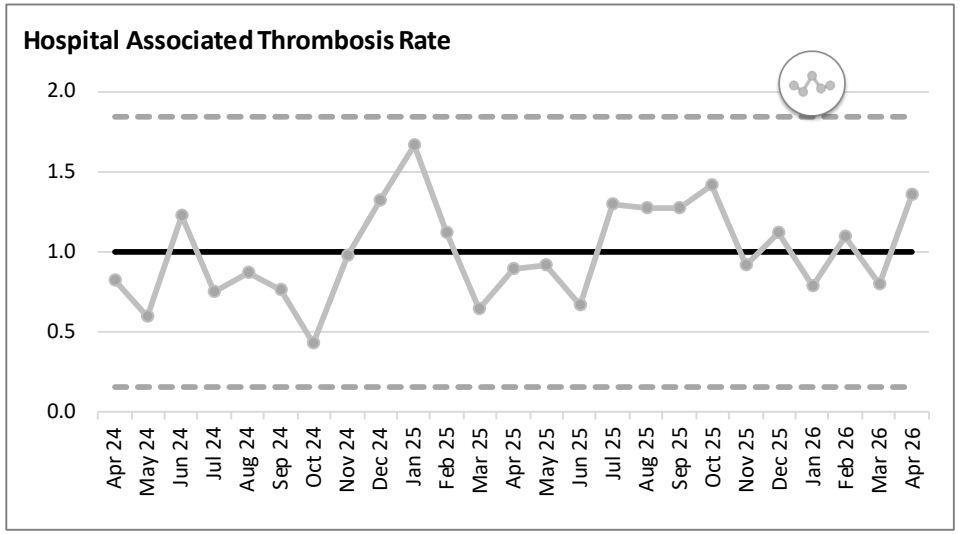




What is driving this performance?

Timely assessment means within 12h of admission to a ward.

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

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

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

What are we doing about it?

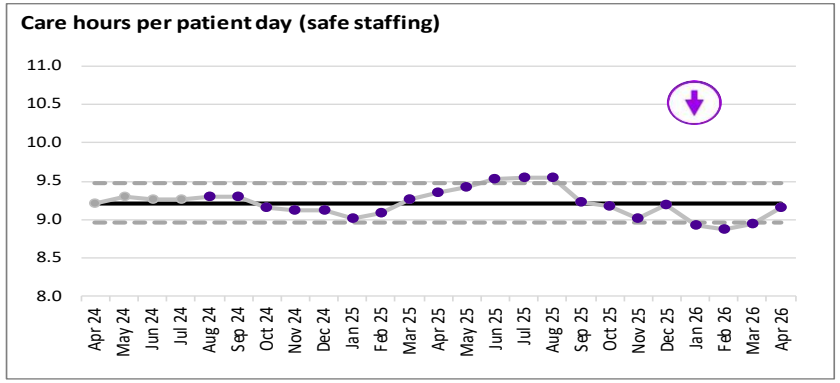
Work has begun with Royal Stoke ED to incorporate VTE Risk assessment, which now appears on the A&E Dashboard, highlighting all patients requiring a VTE risk assessment.
Communication and awareness of the requirement to complete a VTE risk assessment when clerking patients in the ED is ongoing with Resident Doctors in admission portals.
VTE Risk assessment awareness will be the focus of Thrombosis Week in May 2026, as part of the campaign VTE Clinician Champions are being sought to champion the cause.

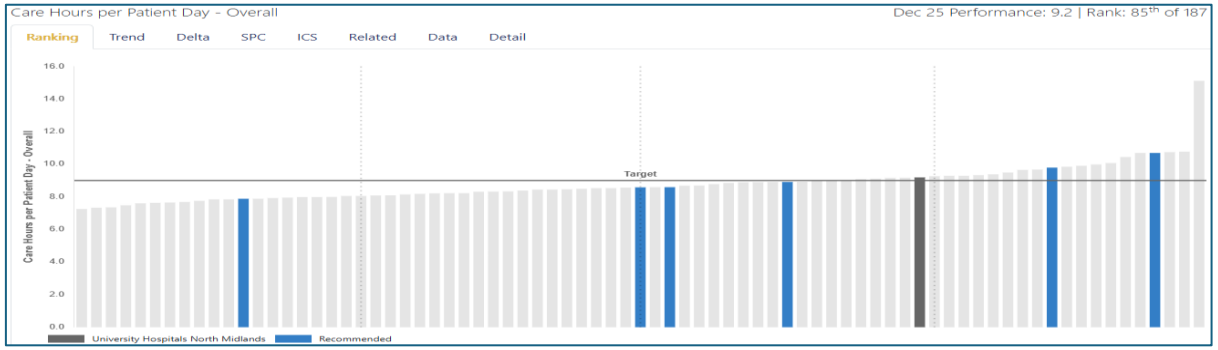
There has been an increase in Hospital Associated Thrombosis whereby patients have not been prescribed the appropriate prophylaxis following the full introduction of ePMA. The VTE Steering Group will be reviewing the incidents at the next meeting in May 2026

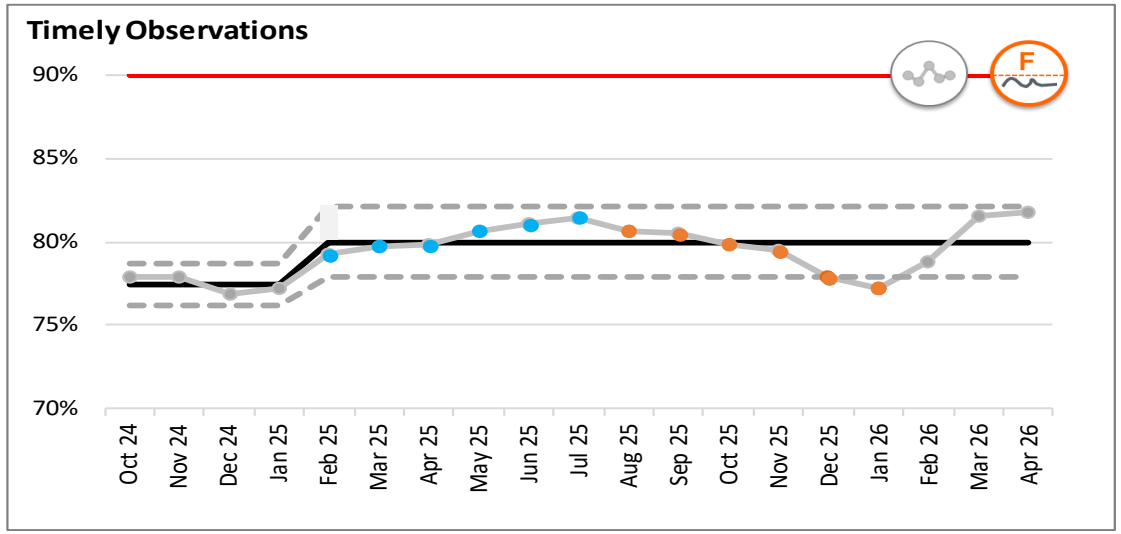
Quality & Access | [Safe staffing & Timely Observations]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust







What is driving this performance?

Care hours per patient day (CHPPD)

- The decline in CHPPD due to CSW shortages now appears to be in reverse.

Timely Observations

The proportion of observations recorded as timely in April 2026 was 82%, a record high by a small margin. However, only 11 wards/departments met the 90% target in April and 7 wards had compliance below 75%: Wards 78, 76a, 12, 113, 106, 108, 109

What are we doing about it?

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

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

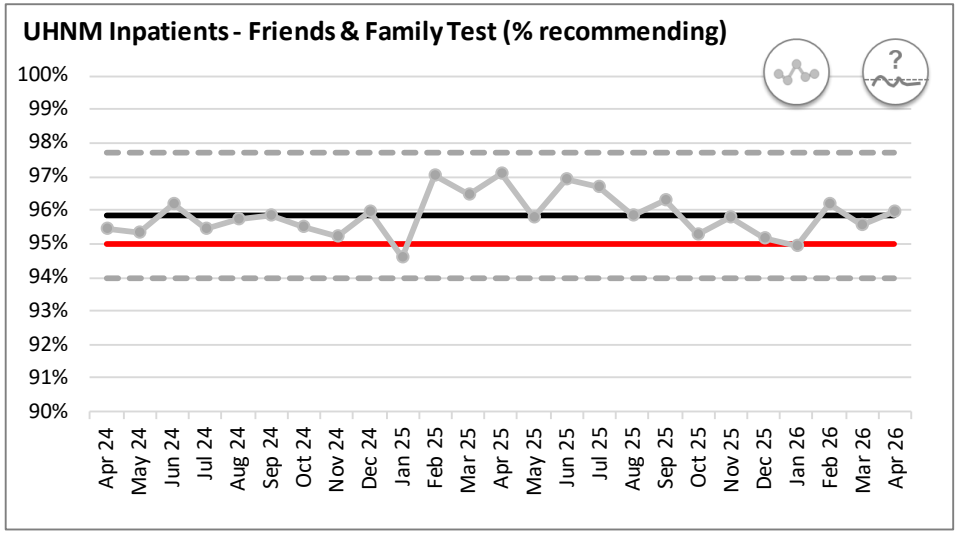
Individual area support and offer to attend the bronze ward review where appropriate.

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

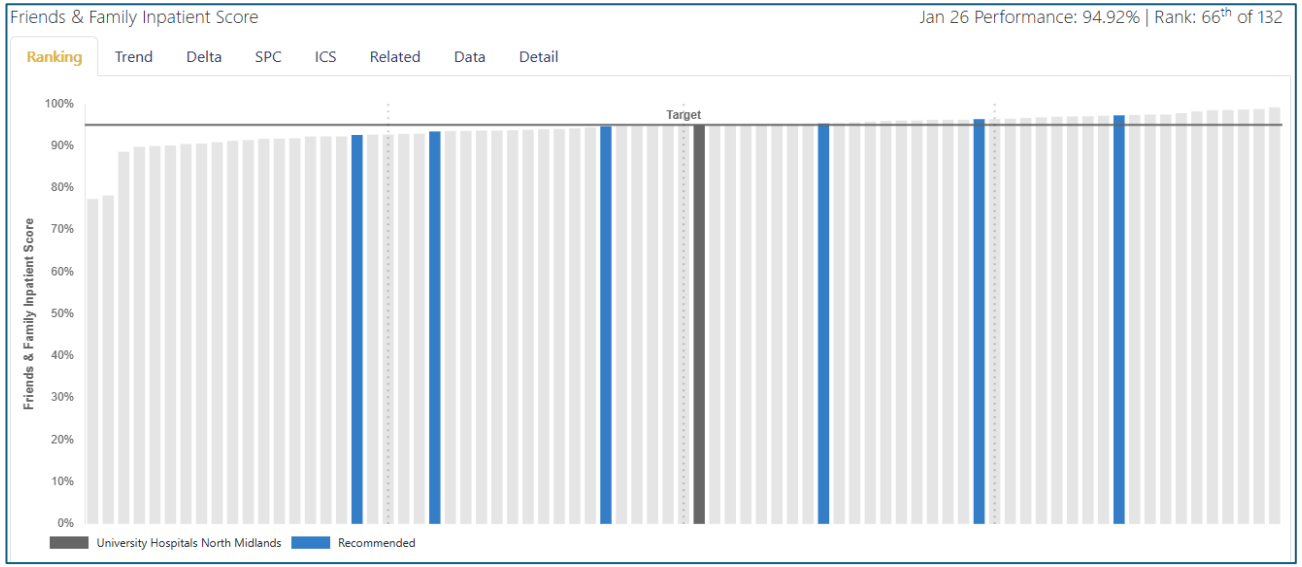
Quality & Access | [Friends & Family Test - Inpatients]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Public View FFT Inpatients Acute Trusts Benchmarking (Jan 2026)



What is driving this performance?

The monthly satisfaction rate for inpatient areas was within the usual range in April 2026. The average rate remains above the national average of 95% (Feb 2026 NHS England).

In April 2026, a total of 3127 responses were collected from 65 inpatient and day case areas equating to a 28% return rate, which is within the usual range.
Average Care Group Scores are as follows:

- Unplanned - 19% response rate, 96% satisfaction score
- Planned - 38% response rate, 96% satisfaction (30% response target met since Apr-24)
- CSS (excluding Maternity, see separate slide) - 29 % response rate since Apr-25, 99.7% satisfaction score

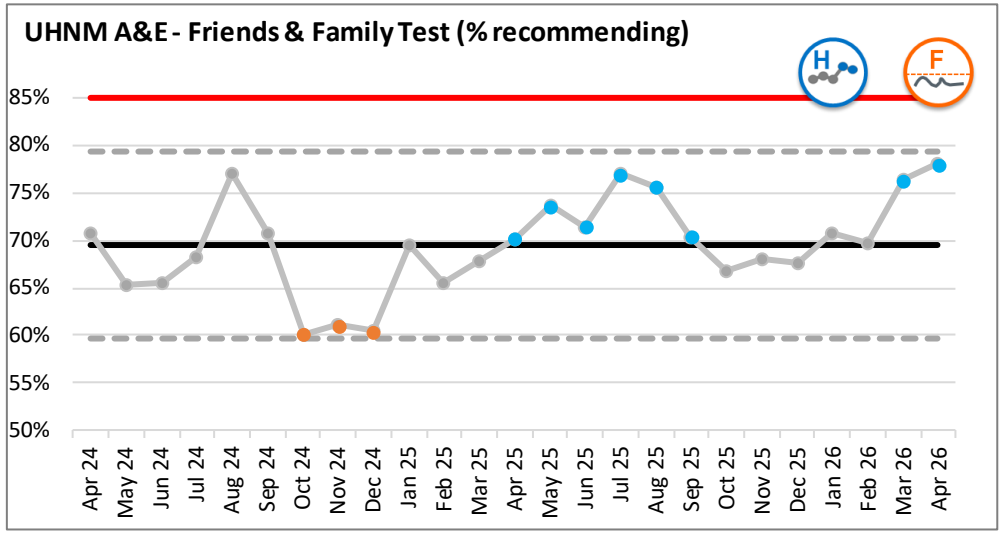
What are we doing about it?

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.

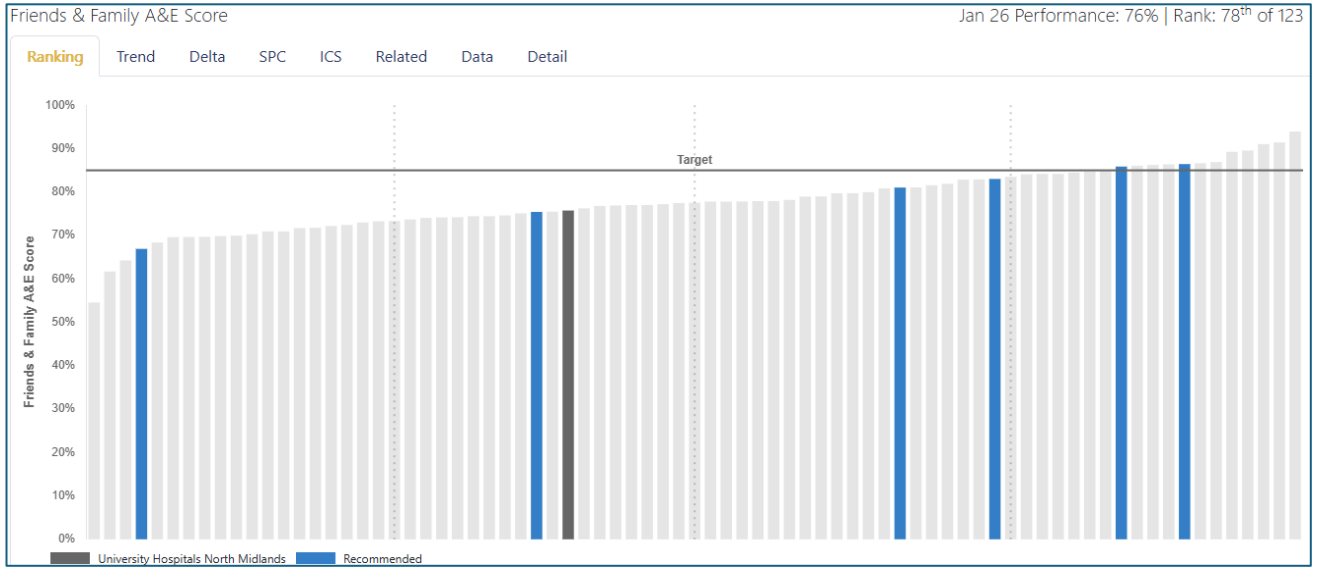
Quality & Access | [Friends & Family Test – ED]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



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



What is driving this performance?

The Trust received 1361 responses in April 2026 - a 15% response rate which is significantly above average. Satisfaction rates remains slightly below the national average of 79% (NHS England March 2026) at 76% although the rate was significantly above average in March & April. ED County has a higher response and recommend rate at 14% and 86% respectively. ED Royal Stoke have 11% response rate and 71% recommend rate.

UHNM is 32nd out of 125 Trusts for the number of responses in ED and 90th out of 125 Trusts for the percentage positive results (NHS England March 26).

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

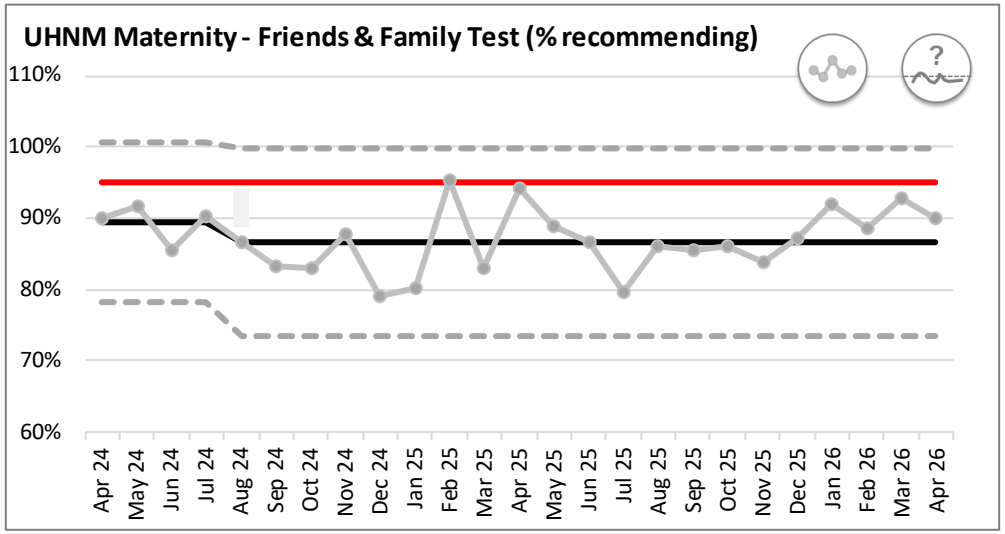
What are we doing about it?

- Simplified ED survey" now only containing the mandatory "Overall, how was your experience of our service?" with the 6 response options ("very good" through to "very poor" or "don't know" in place.
- 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]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



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% (March 2026 NHS E).

There were a total of 109 surveys received in April 2026 across all 4 touch-points (ante-natal, birth, post-natal ward; post-natal community) with 41 of these being collected for the "Birth" touch-point, making the response rate 8% which is within the usual range. The average satisfaction scores are Ante-natal: 80%, 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.

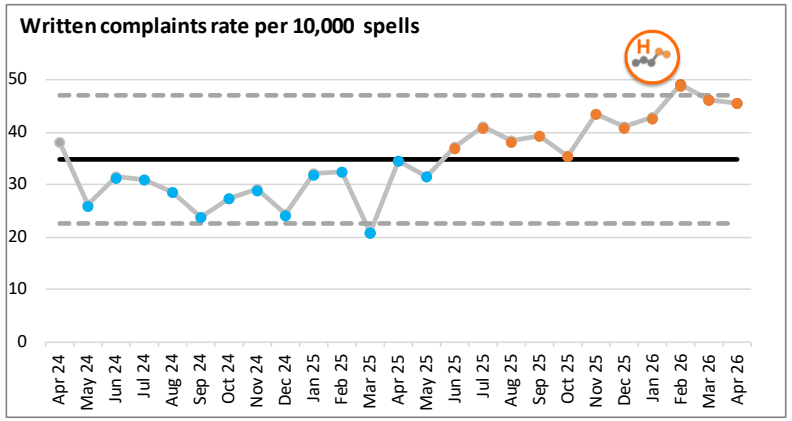
Look at incorporating the questions from the National Maternity Survey which requires the most improvement into the FFT survey.

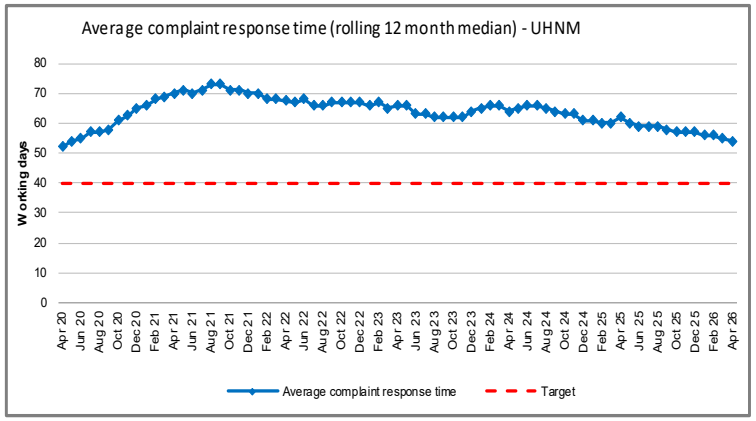
Discuss with management team with regards to increasing survey completion for post-natal community

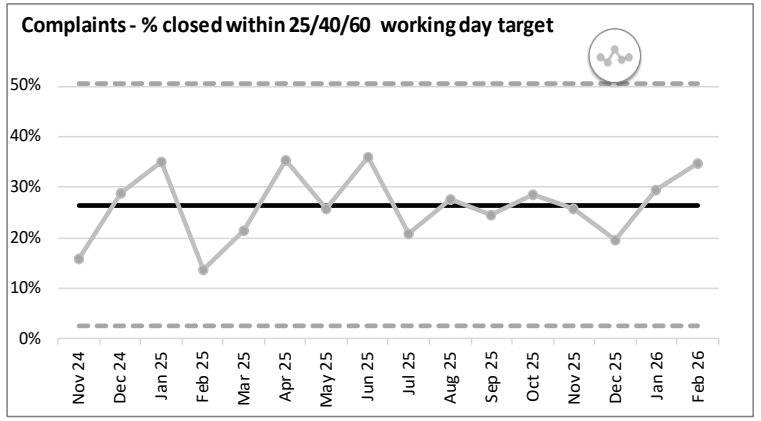
Quality & Access | [Formal Complaints]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust







What is driving this performance?

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

68 complaints were closed in April 2026, with a median average response time of 53 working days (chart displays the rolling 12-month average). It is worth noting that although not yet meeting the response target we have reduced the average response time by 20 days since the peak in 2021.

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

313 complaints were open at the end of May 2026, of which:

- 2 had been open longer than 12 months
- 35 had been open 6 – 12 months
- 68 had been open 3 – 6 months

The percentage of complaints closed within their allocated 25/40/60 working day target remains within the usual range around an average of 27%.

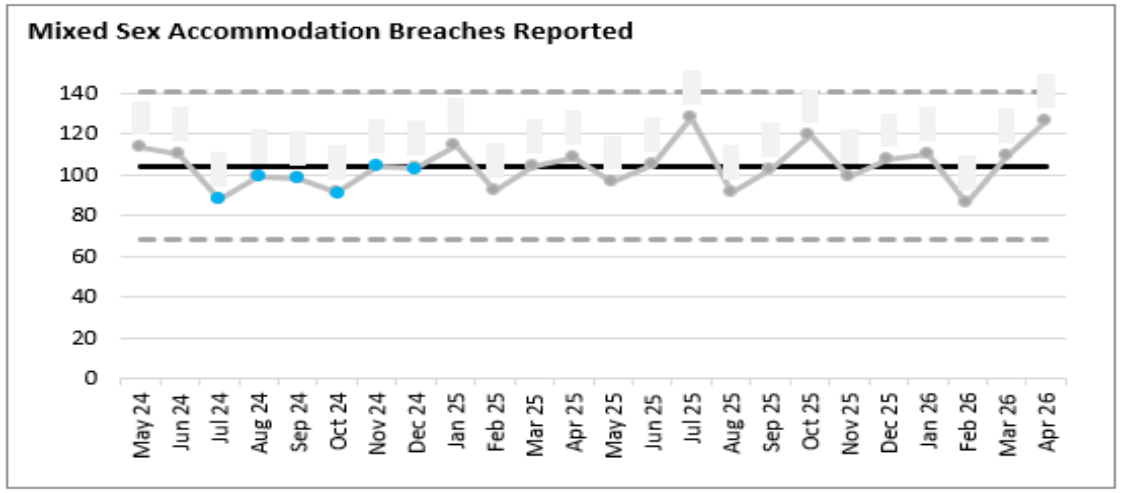
What are we doing about it?

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

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust



Public View MSA Breaches Acute Trusts Benchmarking (Jan 2026)

What is driving this performance?

April 2026 reported 126 Mixed sex accommodation breaches with and overall reduction since the high point in July 2025. The number of mixed sex accommodation breaches was within the usual range, based on the previous numbers show, the in-month increase is above the long-term mean.

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

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

What are we doing about it?

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

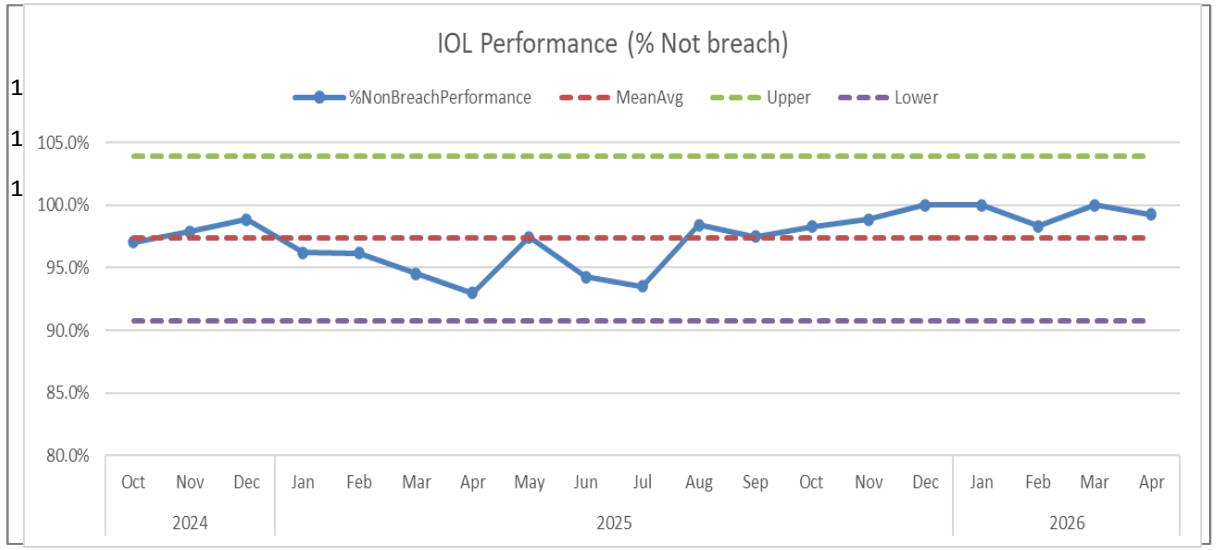
We hope that these two improvements will support us in narrowing down where delays are occurring and support improvements to breach numbers as well as support BI improvements which with provide a more robust reporting solution.

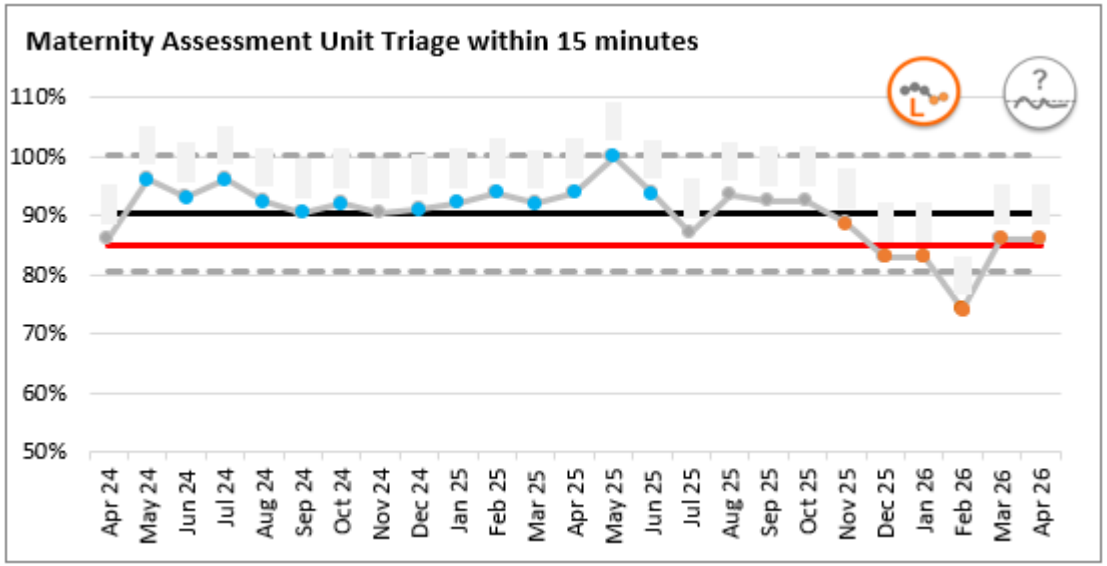
Continued incident reporting via Datix will be completed for each week of breaches in critical care/SSCU with individual incident reports for any ward-based breaches.

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

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust





What is driving this performance?

Core IOL midwifery workforce provides consistency within the department to ensure on going timely admissions. Collaborative input with the Consultant Obstetricians to ensure the workload is organised and prioritised appropriately.. Compliance with IOL for April is 100%

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 was met with April's data at 86%

What are we doing about it?

Induction of Labour (IOL)

- Daily review and escalation of IOL breaches, including patient safety huddles.
- Ongoing work of the IOL Improvement Group to refine pathways and flow.
- Sustained staffing improvements, including full recruitment to core IOL posts.
- Continued use of mechanical IOL methods (e.g. Dilapan) to support flow and patient experience.

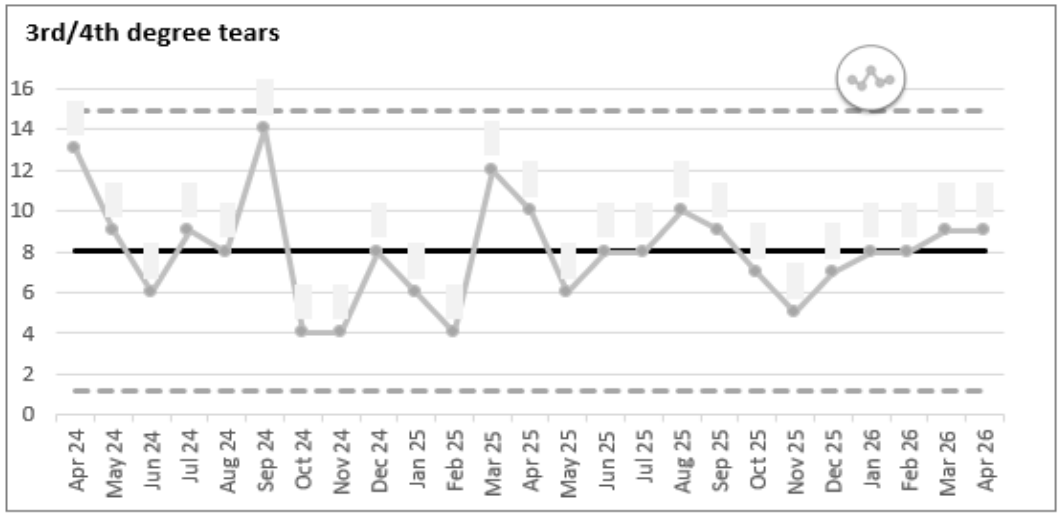
Maternity Triage

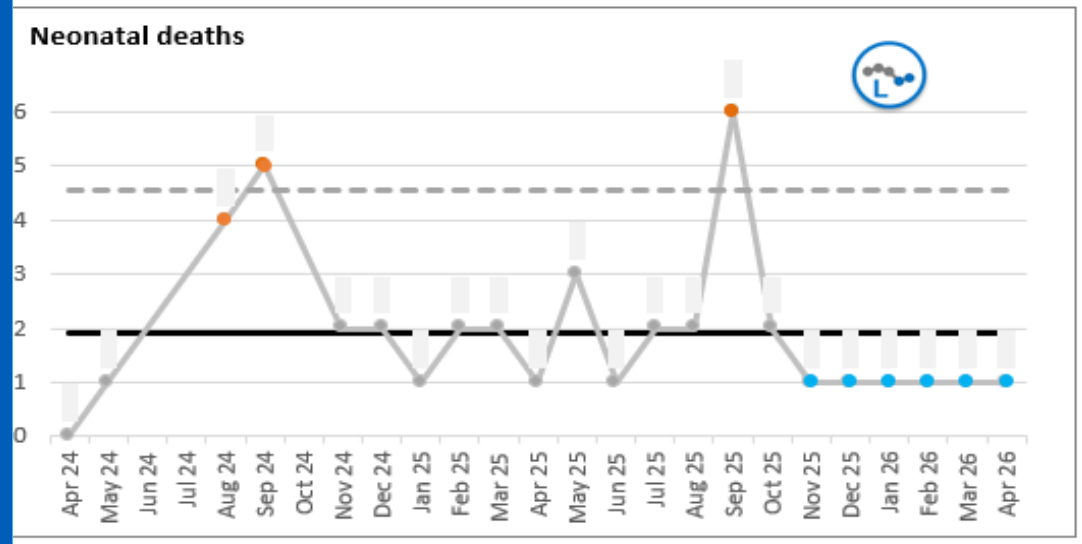
- Continued monitoring through MAU Improvement Group with daily review of breaches.
- Use of Datix and safety huddles to support learning and escalation.
- Refresh of A3 improvement plan to support sustainability.
- Workforce stabilisation (MSW and clerical roles) to support flow and performance.

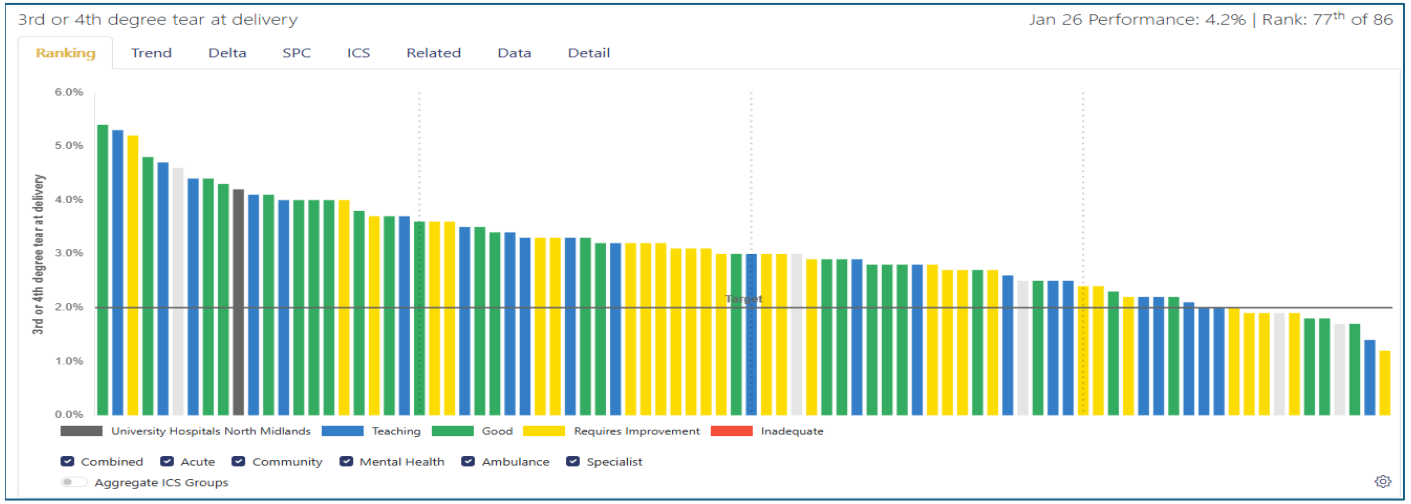
Quality & Access | [3rd/4th degree tears & Neonatal deaths]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust







What is driving this performance?

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

Neonatal deaths
1 recorded death during April 2026.

What are we doing about it?

3rd & 4th Degree Tears (OASI)

- Timely Datix submission and review to support rapid learning.
- Ongoing audit and review by the Perineal Health Team.
- Targeted training and feedback informed by emerging themes.

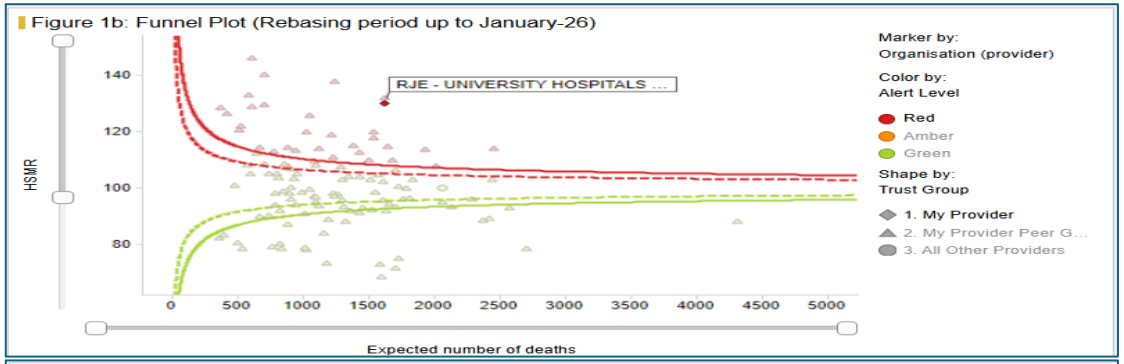
Neonatal Deaths

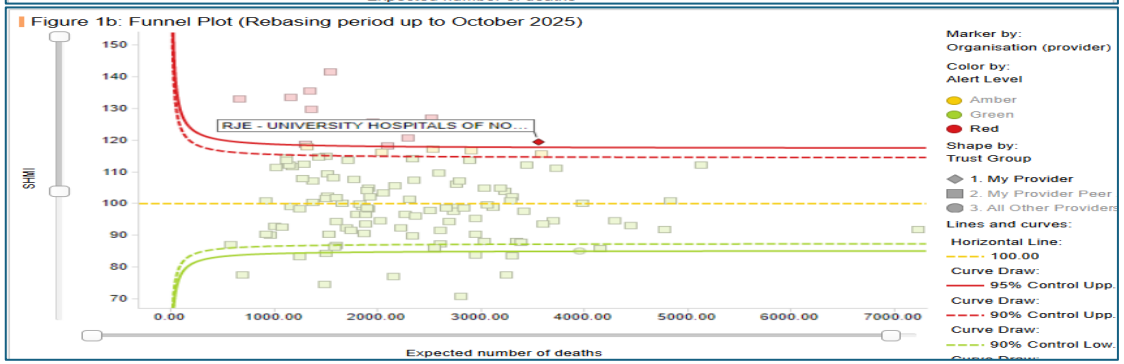
- Rapid obstetric and neonatal reviews for all cases.
- Full investigation via PMRT, with reporting through Directorate, Care Group and Trust Board.
- Continued external assurance through WMPN and MIS Year 7 standards.

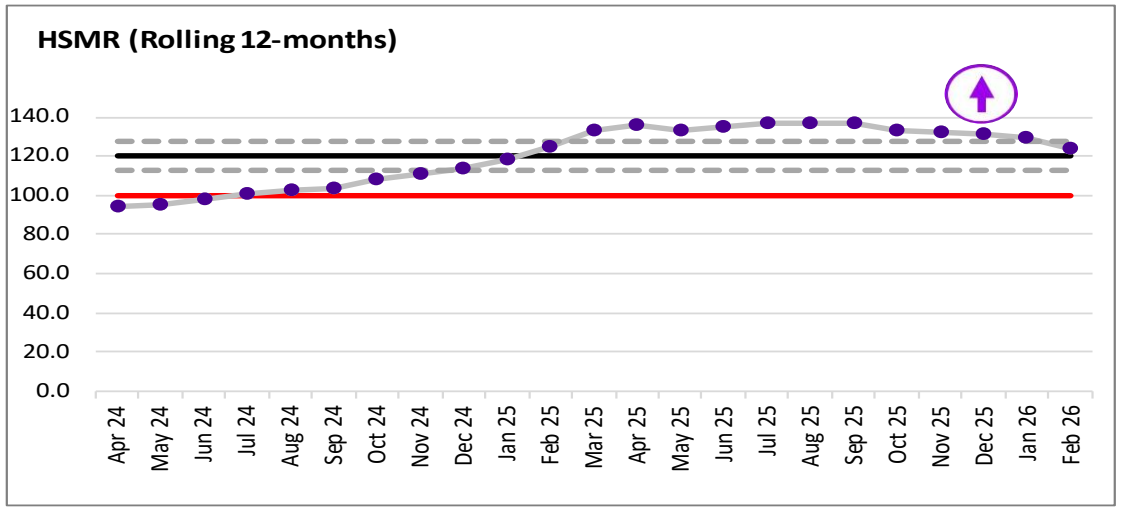
Quality & Access | [HSMR / SHMI]

Provide safe, effective and caring services

University Hospitals of North Midlands NHS Trust







What is driving this performance?

UHNM HSMR remains higher than expected based on case mix and standardisation for current 12-month period (March 2025 – February 2026). The current 12-month HSMR is 123.76 There have been continued in-month reductions in monthly HSMR since August 2025 following full data refresh and submission.

UHNM SHMI also remains higher than expected at 118.85 for current 12-month period (February 2025 –January 2026).

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, October and December 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:

2025	Nat/PSA	Closed	Nat/PSA/2026/003/DHSC	Shortage of dinoprostone 3mg vaginal tablets and 1mg/2.5ml vaginal gel	08/04/26	20/04/26	Final Approval / Sign Off confirmed at Patient Safety Group 21/04/2026	

Open / Overdue Alerts:

Year	Alert Type	CAS Status	Alert Reference Number	Alert Title/Device	Date Issued	Deadline Date	Comments	Actions
2023	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.
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 April 2026 UHNM received 1 new Patient Safety Alert that was applicable to the Trust, the action plan was completed 17/04/26 and signed off at PSG on 21/04/26.

There are 2 NHS Patient Safety Alerts that remain open and actions are ongoing to ensure that the necessary requirements of the alerts are being effectively implemented.

What are we doing about it?

Quality & Access | [Clinical Effectiveness]

Provide safe, effective and caring services

NHS University Hospitals of North Midlands NHS Trust

2 External Accreditations undertaken during Q4

- JAG Accreditation – Accreditation status has been reinstated. A meeting has been arranged for June 2026 for the Clinical Team to meet with the inspection team to discuss progress.

Key actions –

- Gap analysis currently being undertaken against the new standards
- Sedation SOP

- Peer Review of Children's and Teenage and Young Adult Cancer Services – Paediatric Oncology Shared Care Unit and TYA Designated Hospital:
  - 13 noticeable achievements identified
  - 22 gaps identified

Key actions –

- The recommendations have been incorporated into the Child Health Delivery Plan. Actions will be prioritised / triangulated with other actions currently being considered as part of the Child Health Clinical Effectiveness programme

- During Q4 UHNM continued to review guidance published by NICE. There are currently 21 pieces of NICE guidance awaiting final implementation. There is good engagement from the Clinical Teams and delays vary from the provision of bespoke clinics, ratification of new polices and the introduction of new patient pathways.
- 4 National Audit published during Q4:
  - Fracture Liaison Database
  - Lung Cancer
  - National Paediatric Diabetes
  - National Maternity & Perinatal Audit
- Work is ongoing around 4 NCEPOD projects during Q4:
  - Emergency Procedures in Children and Young People – National Report has been published. Action plan currently being developed
  - Pleural Procedures – Case Note data collection complete. Organisation Questionnaire currently being completed.
  - Stabilisation of the critically ill child - Case Note data collection complete. Organisation Questionnaire currently being completed.
  - Rib Fractures – Case Note data collection complete. Awaiting publication of the Organisational Questionnaire

- 5 GIRFT visits were undertaken during Q2 / Q3 and the Trust is continuing work around the action plan development for the following clinical specialties:
  - Breast Surgery
  - General Surgery
  - Vascular
  - Urology
  - Interventional Radiology
- 4 LocSSIP audits were published during Q4:
  - 3 Significant Assurance
  - 1 Significant Assurance with Minor Improvements
- 19 Clinical Audits were published in Q4:
  - 10 Significant Assurance
  - 8 Significant Assurance with Minor Improvements
  - 1 No Assurance

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

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 Assurance Meeting
- Provision of Directorate and Care Group Quality Outcome Meetings to support oversight and ownership of Clinical Effectiveness priorities by the Care Group
- Provision of overarching Care Group Clinical Effectiveness action plan to ensure triangulation and avoid duplication of work:
  - Child Health
  - Respiratory
  - Vascular
- Care Group Clinical Effectiveness Managers recruited to support the Care Groups.
- Care Group Governance and Clinical Effectiveness Leads in post.
- Consideration being given to Speciality, Care Group and Trsutwide Clinical Effectiveness KPIs

Access to Services

University Hospitals of North Midlands NHS Trust

Access to Services	Data period	Provider value		Chart
Access to services domain segment	Q3 2025/26	3	NOF Score	
Access to services domain score	Q3 2025/26	2.57	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	Q3 2025/26	2.11	NOF Score		Provider value	
Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Dec 2025	62.60%	55.70%	60.90%	Provider median	
Difference between planned and actual 18 week performance score	Q3 2025/26	1	NOF Score		Provider value	
Difference between planned and actual 18 week performance	Dec 2025	0.20%	-3.05%	-1.82%	Provider median	
Percentage of patients waiting over 52 weeks for elective treatment score	Q3 2025/26	2.84	NOF Score		Provider value	
Percentage of patients waiting over 52 weeks for elective treatment	Dec 2025	1.84%	2.52%	1.56%	Provider median	
Percentage of patients waiting over 52 weeks for community services score	Q3 2025/26	1	NOF Score		Provider value	
Percentage of patients waiting over 52 weeks for community services	Dec 2025	0.00%	1.05%	0.42%	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	Q3 2025/26	2.99	NOF Score		Provider value	
Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral (quarter)	To Dec 2025	75.76%	73.60%	77.61%	Provider median	
Percentage of patients treated for cancer within 62 days of referral score	Q3 2025/26	3.64	NOF Score		Provider value	
Percentage of patients treated for cancer within 62 days of referral (quarter)	To Dec 2025	61.61%	64.30%	71.48%	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	Q3 2025/26	3.78	NOF Score		Provider value	
Percentage of emergency department attendances admitted, transferred or discharged within four hours (quarter)	To Dec 2025	65.37%	72.27%	73.05%	Provider median	
Percentage of emergency department attendances spending over 12 hours in the department score	Q3 2025/26	3.21	NOF Score		Provider value	
Percentage of emergency department attendances spending over 12 hours in the department (quarter)	To Dec 2025	10.47%	9.27%	8.17%	Provider median	

UHNM's access metrics show mixed performance with small variation between Q2 and Q3.

Elective Care – each metric either seeing a deterioration in the score or score remains the same as Q2. All metrics are better than peer average.

Cancer Care – 62 day cancer seeing a deterioration since Q2 from 2.84 in Q2 to 3.64 in Q3 and behind both peer and national averages.

Urgent and Emergency Care – 4 hour performance has seen a deterioration since Q2, however 12 hour performance has improved from 12.51% in Q2 to 10.47% in Q3.

Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

How are we doing against our trajectories and expected standards?

Non-Elective

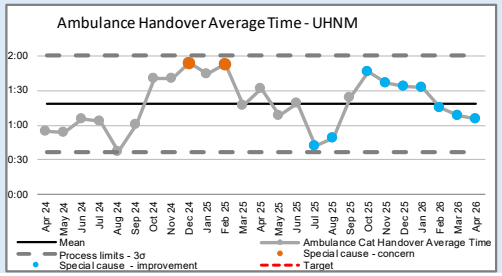
Validated 4-hour performance was 68.2% for April, up 1.88% from 66.4% in March. Performance trajectory in April was 70.6%, which we fell short by 2.4% - the best performance versus plan in over 12 months. By site, RSUH performance was 45.6% vs a target of 45.9%, and County 61.6% vs a target of 66.1%.

2169 patients waited longer than 12 hours in ED against a plan of 1890 (variance of -279). This is 136 less than March, and the lowest recorded for 8 months. By site, 1976 at RSUH and 206 at County. Overall performance was 8.7% against a target of 7.6%.

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 had also increased.

5394 ambulances arrived at UHNM in April and 66.94% of these were handed over within 45 minutes vs a plan of 68.71%. This has meant that during April 1783 patient waited in an ambulance for longer than 45 minutes before being handed over, compared to 1831 in March. Average handover time in April was 1 hour and 5 minutes, a 2-minute improvement from March, and 6 minutes better than plan. It is also noticeably better than April 25, where handovers averaged 1 hour 46 minutes.

The Trust remains in tier 1 for our UEC performance.



Elective

Cancer:
Combined faster diagnosis standard performance final March position was reported at 80.97% better than trajectory of 80.09%. Provisional April position is currently at 81.02% against a trajectory of 79.01%.
31-day final March position was reported at 95.62%. April position is currently unvalidated at 91.94% against a trajectory of 93.03%.
Combined 62-day performance final March position was reported at 73.20% against a trajectory of 75.01%. Provisional April position is currently at 62.82% against a trajectory of 66.12%; this position is expected to improve through validation.

Diagnostics:
March's DM01 validated performance was 78.2% against trajectory of 97%. Current performance is 78% (17/05).

RTT:
April overall RTT performance is currently 63.5%; 0.4% off plan
Our 52-week performance is monitored as a % of patients on our total waiting list who are over 52 weeks. For the month of April, 52-week actuals increased from 1.83% to 1.9%. This standard is to achieve by the end of the year is to get to 1%
RTT % Waiting 1st Contact recovered in April, with performance being 75.3%; 0.2% 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 and Cancer, however UHNM are no longer in Tier 2 for our Diagnostic performance.

Quality & Access | Overview

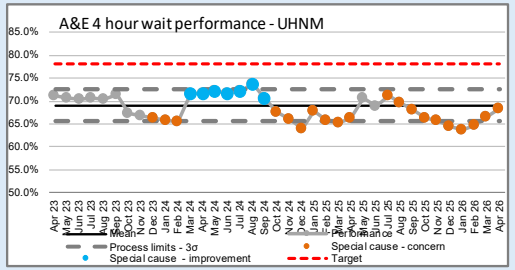
University Hospitals of North Midlands NHS Trust

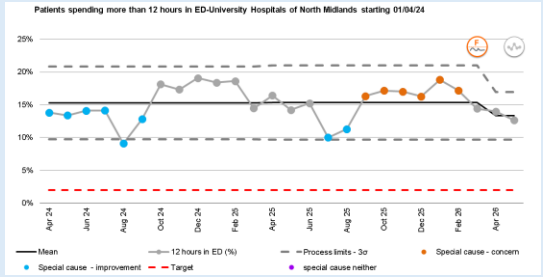
Overview from the Chief Operating Officer

What is driving this?

Non-Elective

- 4 and 12 hour performance has improved in month, as have ambulance handovers. Despite this, we remain an outlier for ambulance handover performance. In April 2026 average handover time was 1 hour and 5 minutes, down 2 minutes from March, and 45 minutes faster than the same month last year.
- We saw 25,099 Attendances in April, which is a marginal reduction in the volume of attendances in March, but is still above the mean, and is c800 more than the same month last year.
- ED conversion rate remains higher than target – with weekly performance in April ranging from 42% to 46%, all significantly above target of 30%
- Acuity remains challenged in ED presentations with 60% for Resus or Majors
- Corridor Care remains in use, in both ED and continuous flow risk assessed spaces, however both areas have demonstrated a marginal reduction in the numbers of patients over 45m in April compared to March.





Elective

Cancer performance is recovering and UHNM have modelled a sustainable backlog trajectory, that will enable achievement of submitted 62-day treatment performance trajectories, by reducing the disproportionate backlog of patient waiting to be treated. For FDS February, March and April position shows performance ahead of plan. Strong recovery for 31-day is taking grip. Specialties performing well include Breast, Lung and Skin, however challenges in access to surgical capacity remain within Gynae, Colorectal, and Urology. Within the 31-day cohort of patients breaching surgery, the main delay reason is attributable to lack of capacity in colorectal, gynae and urology tumour sites. There are Surgical capacity constraints (including robotics) affecting Gynae, Colorectal and Skin. Complex pathways i.e. multiple investigations, second look biopsies, molecular and genetics testing also impacts referral to treatment timelines.

MRI is now showing as the majority contributor for UHNMs overall DM01 performance. MRI is now 69.6% with 1.5% 13-week breaches now contributing to UHNMs position. Non-Obstetric Ultrasound was the majority contributor for UHNMs overall DM01 performance variance against the national standard; NOUS unvalidated performance is now 85.7. An increase in performance of 9.3% in the last 4 weeks.

Performance has deteriorated slightly in April to 64.06% (validated) but is still ahead of plan. Total PTL has increased significantly from 65,401 in March to 68,549 in April. There are several factors contributing to this – lower than average removal rate sustained throughout April and into May, exacerbated by Easter and school holidays; higher than average addition rate throughout April (barring second week of school holidays), reduction in activity, validation, and tracking following Sprints ending.
The number of 78 week has improved in April - 1 patient – a joint procedure with 2 surgeons and a custom-made implant. 65-week waits have deteriorated in April, up to 104 from 80 in March. There is some risk with the extensive validation work underway of pop-up long waiters – these will be managed through the trust's "uncorrected breaches" process. Specialties which impact are Orthopaedics, ENT, Ophthalmology, Oral Max-Facs and Gynaecology.

Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

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

Non-Elective

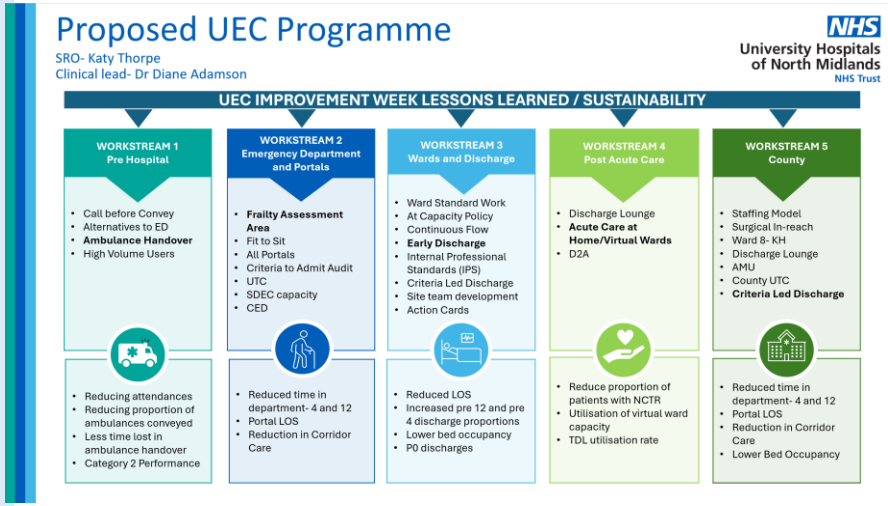
- Our UEC improvement plan has been in place since April 2025 but has been refreshed and relaunched in March 26
- The focus of the workstreams has been prioritised, with High Impact Task and Finish Groups being established to deliver Rapid Improvement in key areas
- Each workstream now has a clear Executive SRO, Corporate sponsor, Care Group SROs, Clinical lead and Improvement support, complemented by the work of the GIRFT UEC team
- Governance of the workstreams has been simplified and strengthened, with a focus on continuous improvement
- We continue to meet weekly with the national GIRFT leads, focusing on rapid improvement actions to improve ambulance handover performance, reduce 12 hour in dept volumes and reduce corridor care
- FEAU streaming ToC continues to pull Frail and Elderly demand direct from ED into FEAU, supporting the earlier streaming of patients to emergency portals. Since 23/03 3 bays have been protected to maximise this model
- UTC building works has been delayed due to a failure in the concrete pour, with opening of the UTC delayed to 31st July 2026
- Continue to improve the streaming tool at the front door to maximise utilisation of EHPC slots, average for April 65%. Work ongoing around missed opportunities.
- Ringfenced nursing for CDU to maintain progress from RIW. Averaging in excess of 20 patients per day through CDU. Ringfenced CED consultant to support with 4-hour performance, sustained improvement for 7 weeks.
- Continue to maximise push to portals to reduce the number of patients within the department who could subsequently end up on the corridor
- Planned opening of the UTC – this was due early July, but has been delayed to July month end

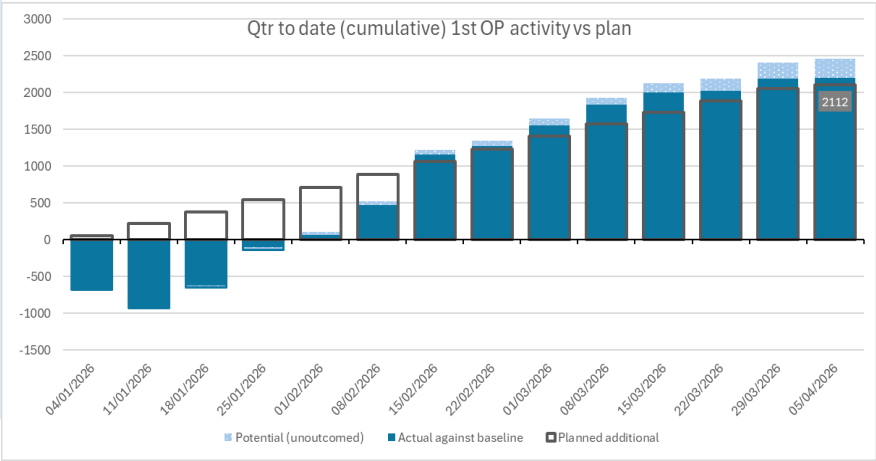
Elective

Improvement plans in cancer with associated trajectories by tumour site to reduce the diagnosed and undiagnosed backlog of patient 62 days will continue to be monitored and developed. Delays due to histopathology (in line with other centres regionally) will need to be offset by further improvements in patients' pathways. Collaborative working group in process between Histopathology, Directorates and Cancer Services to identify specimens for reporting on appropriate triage pathway - Cancer Team have implemented an automated solution with pathology.

Rollout of MBI Rova continues – extension of licence for a further 12 months. 3 directorates are now utilising Rova, with plans for the rest of the relevant directorates to be onboard by July. 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.

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





Quality & Access | Overview

University Hospitals of North Midlands NHS Trust

Overview from the Chief Operating Officer

What can we expect in future reports?

Non-Elective

- Whilst we remain below trajectory, our April performance is closest to trajectory in more than 12 months.
- Our performance remains below the standard we aspire to deliver, but noticeable improvement in 4-hour, 12-hour and ambulance handover times are encouraging. Of particular note is our ambulance offload performance when compared to the same period last year.
- The utilisation of corridor care has marginally reduced and will be tracked and monitored in both real-time and in retrospect within our governance framework.
- Improved admission avoidance for Frailty patient cohort as a result of protecting Frailty SDEC bays to maximum capacity
- Pending embedding learnings from the criteria to admit audit; a reduction in conversion rate
- The complexity of the 5 yearly Statutory Maintenance Programme for the PFI is an added complexity for the summer months. The operational and estates teams are working hard to mitigate the risk and minimise impact on patients and performance.
- The current 26/27 improvement trajectory does not return us to the national standard until year 3 but does represent a significant and ambitious improvement compared to our current and historic performance.

Elective

For RTT position, UHNM expect to improve in line with our planning trajectories and an ongoing reduction in our longest waiting patients. For 1st new contact, work has started to understand the Ophthalmology increase; a reduction in independent sector cataract capacity within the ICS in 2024/25 has likely had an impact.

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

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

Activity v. Plan to be tracked against elective metrics as part of new year plan.

Quality & Access | Dashboard

University Hospitals of North Midlands NHS Trust

KPI	Latest month	Measure	Target	Variation	Assurance
UEC 4 Hour Performance	Apr 26	68.2%	77.1%		F
UEC 4 Hour Performance (Aged <18)	Apr 26	92.0%	77.1%	H	P
Over 12 hours in ED	Apr 26	2169	-		
Over 12 hours in ED (Aged <18)	Apr 26	19	-		
Ambulance Handover Average Time	Apr 26	01:05:34	00:49:12	L	?
Corridor Care ED	Apr 26	1946	-		
Corridor Care Inpatient (8am)	Apr 26	337	-		
Cancer 28 Day FDS	Apr 26	81.0%	82.7%	H	?
Cancer 31 Day Combined	Apr 26	91.9%	94.8%		?
Cancer 62 Day Combined	Apr 26	62.8%	80.5%		F
Diagnostics DM01 Performance	Apr 26	75.5%	99.0%	H	F
RTT Performance - <18 Weeks	Apr 26	63.5%	70.3%	H	F
RTT Performance - % 52+ Weeks	Apr 26	1.9%	1.0%	L	F
RTT Performance - % Waiting 1st Contact	Apr 26	75.3%	78.1%	H	F
RTT Performance - <18 Weeks (Aged <18)	Apr 26	72.0%	70.3%	H	?
RTT Performance - % 52+ Weeks (Aged <18)	Apr 26	1.8%	1.0%	L	F
RTT Performance - % Waiting 1st Contact (Aged <18)	Apr 26	85.5%	78.1%		P

Related Strategy and Board Assurance Framework (BAF)

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

Assurance Grid

University Hospitals of North Midlands NHS Trust

Assurance / Variation Key

Assurance

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

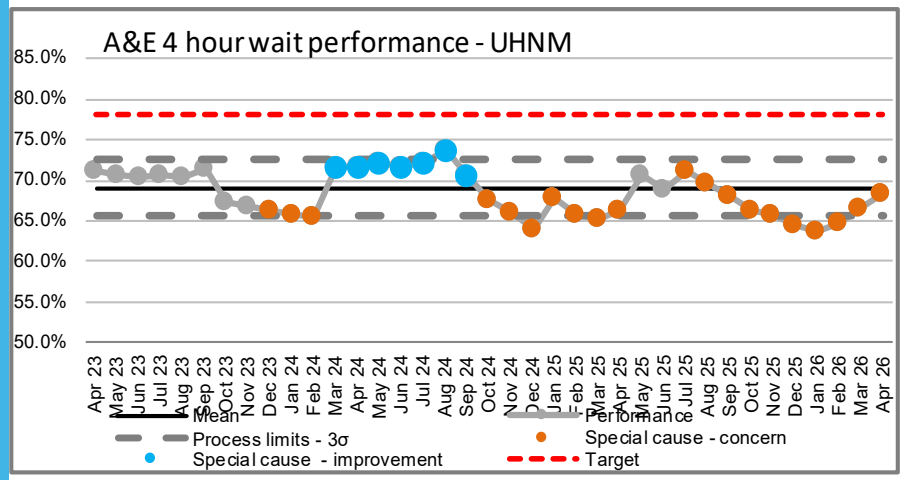
Variation

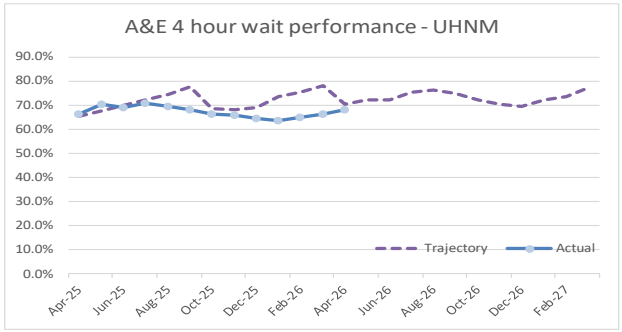
	H / L	H / L
Common cause – no significant change	Special cause of concerning nature or higher pressure due to (H)igher or (L)ower values	Special cause of improving nature or lower pressure due to (H)igher or (L)ower values

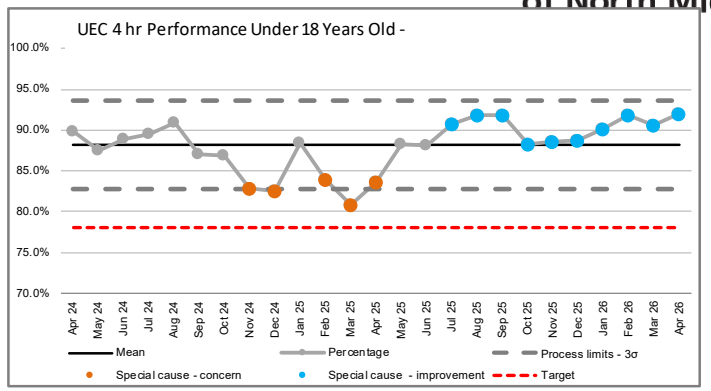
VARIATION \ ASSURANCE	P	?	F	No Target
H / L	UEC 4 Hour Performance (Aged <18)	Ambulance Handover Average Time Cancer 28 Day FDS RTT Performance - <18 Weeks (Aged <18)	Diagnostics DM01 Performance RTT Performance - <18 Weeks RTT Performance - % 52+ Weeks RTT Performance - % Waiting 1st Contact RTT Performance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

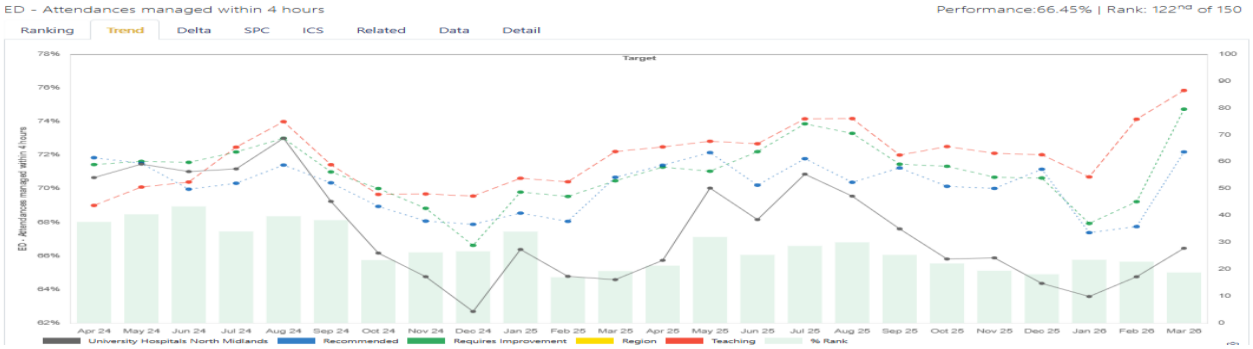
Quality & Access | UEC 4-hour Target

University Hospitals of North Midlands NHS Trust









Variation	Assurance	Monitoring against plan	Jan 26	Feb 26	Mar 26	Apr 26
	Target 78%	Actual	63.6%	64.8%	66.5%	68.2%
Background		Plan	73.8%	75.5%	78.0%	70.6%
The percentage of patients admitted, transferred or discharged within 4 hours of arrival at A&E		Variance	-10.2%	-10.6%	-11.5%	-2.4%

What is the data telling us?

Validated 4-hour performance was 68.2% for April, up from 66.4% in March.

We came off original trajectory in September and as such, plan was adjusted. For April, plan was 70.6%, which we fell short by just 2.4% – the best performance to plan in over 12 months. By site, RSUH performance was 45.6% vs a target of 45.9%, and County 61.6% vs a target of 66.1%.

Overall admitted performance was 39.7% vs a target of 38.4%. By site, RSUH 39.1%, above target of 37.1%, County 41.8% vs a target of 43.5%.

Overall Non-admitted performance was 58.1% vs a target of 61.8%. By site, RSUH 51.6% vs a target of 54.3%, County 70.3% vs a target of 76.1%.

What are we doing about it?

The UTC project for Royal Stoke continues to progress. Anticipated opening date of July 2026.

Continue to improve the streaming tool at the front door to maximise utilisation of EHPC slots, average for April 65%. Work ongoing around missed opportunities.

ED in-reach ToC live to improve the timeliness of specialty input in ED – continues to be funded.

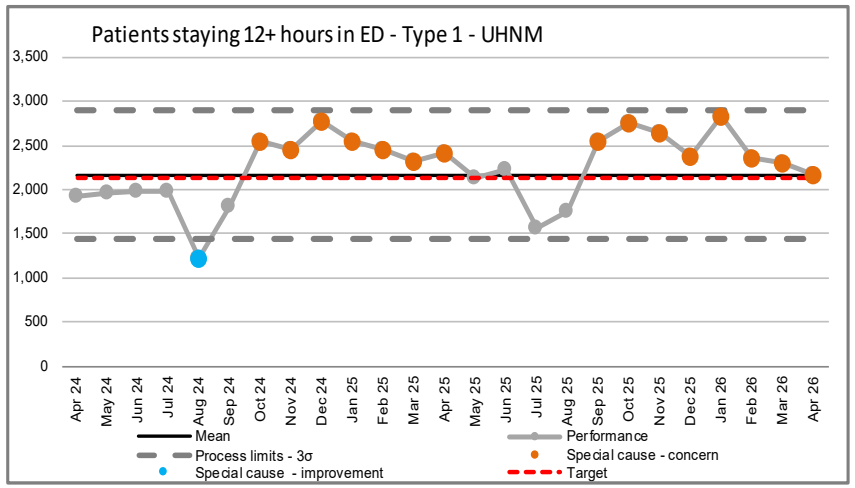
Managed to establish and maintain 2 Frailty SDEC bays enabling quicker pull / offload for this cohort of patients, which is significant proportion of ambulance conveyances.

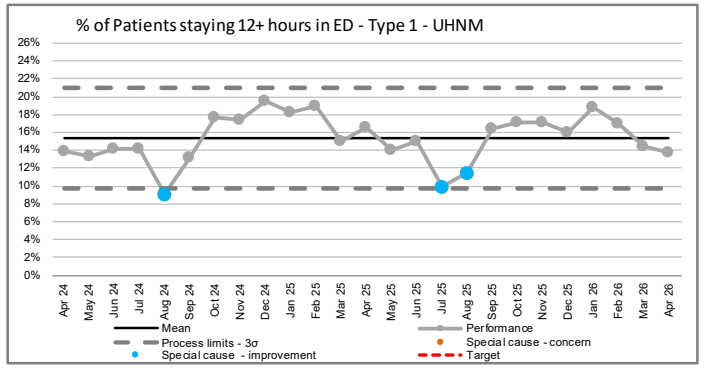
Ringfenced nursing for CDU to maintain progress from RIW. Averaging in excess of 20 patients per day through CDU.

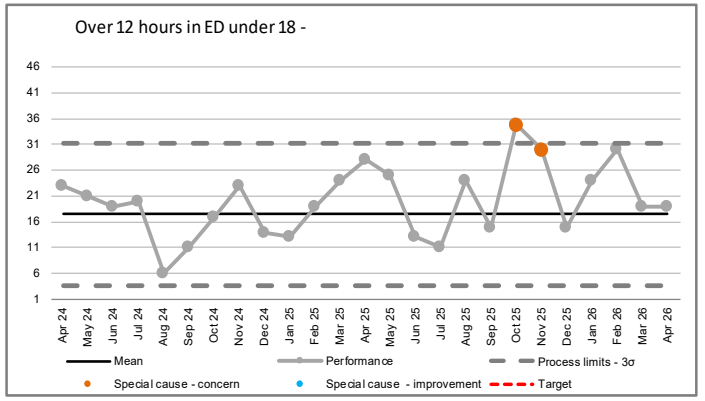
Ringfenced CED consultant to support with 4-hour performance, sustained improvement for 7 weeks.

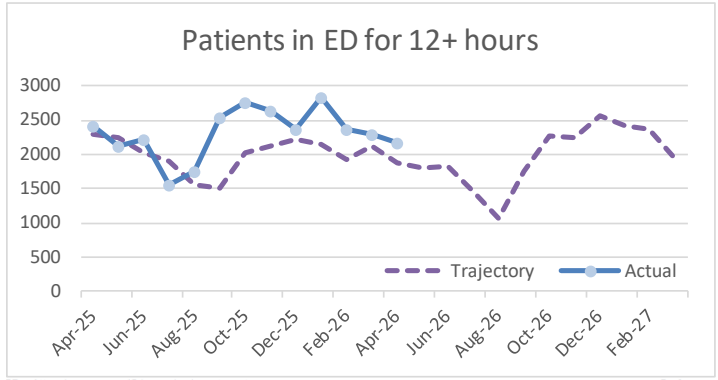
Quality & Access | Over 12-hours in ED From Arrival

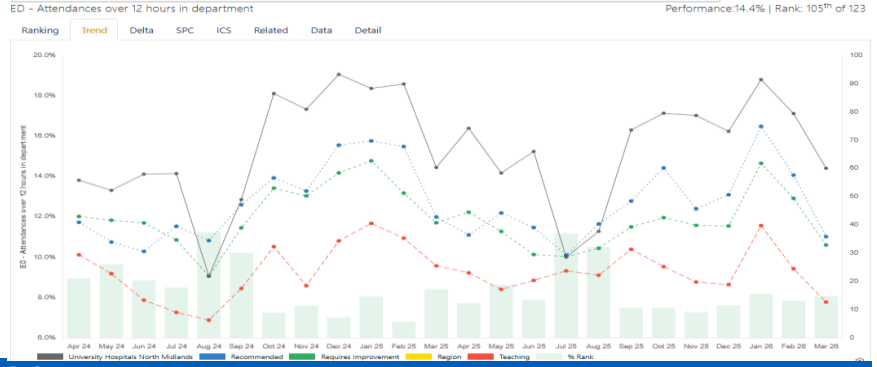
University Hospitals of North Midlands NHS Trust











Variation	Assurance		Monitoring against plan				
				Jan 26	Feb 26	Mar 26	Apr 26
	Target	2128	Actual	2,827	2,370	2,304	2,169
Background			Plan	2,149	1,930	2,128	1,890
The number of patients admitted,transferred or discharged over 12 hours after arrival at A&E			Variance	678	440	176	279

What is the data telling us?

In April, 2169 patients waited longer than 12 hours in ED against a plan of 1890 (variance of -279). This is 136 less than March, and the lowest recorded for 8 months. By site, 1976 at RSUH and just 206 at County.

Overall performance was 8.7% against a target of 7.6%. Important to note that County continues to support RSUH with ambulance diverts.

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 due to challenged flow.

What are we doing about it?

Work is ongoing around UTC as per previous slide to support with maximising streaming. Expected to be in mid-July.

Specialty in-reach in ED is speeding up time to be seen, and this ToC continues to be funded.

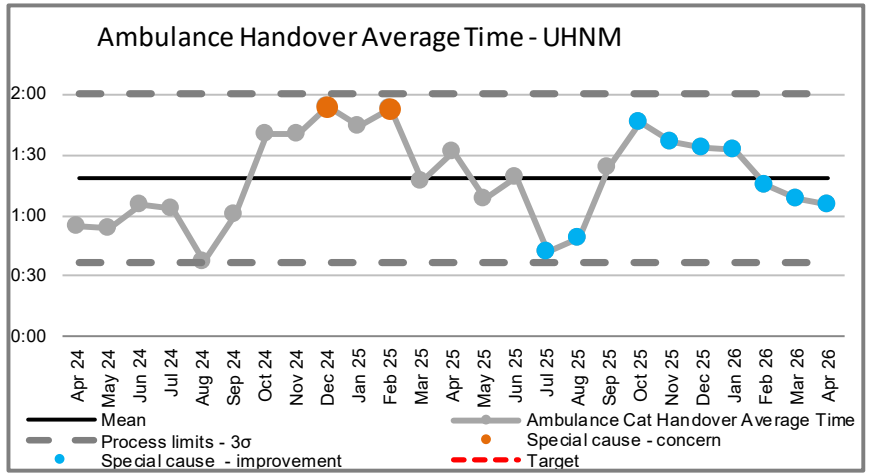
Continue to work on improving flow with GIRFT colleagues.

Re-launch of the UEC workstreams to provide new impetus around flow improvement work.

Continue to gather data around specialty in-reach delays to escalate recurrent IPS issues.

Quality & Access | Ambulance Handover Average Time

University Hospitals of North Midlands NHS Trust

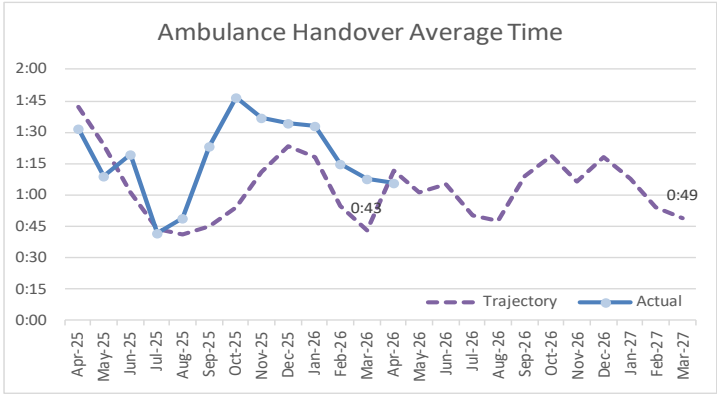


Variation	Assurance
L	F
	Target 0:00:00

Background

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

Monitoring against plan	Jan 26	Feb 26	Mar 26	Apr 26
Actual	1:33:11	1:15:04	1:07:57	1:05:34
Plan	1:18:00	0:55:00	0:43:00	1:11:49
Variance	0:15:11	0:20:04	0:24:57	-0:06:15



What is the data telling us?

5394 ambulances arrived at UHNM in April – 66.94% of these were handed over within 45 minutes vs a plan of 68.71%.

This has meant that during April 1783 patient waited in an ambulance for longer than 45 minutes before being handed over, compared to 1831 in March.

By site: RSUH was 61.5% down from 62.62%, and County 90.57% up from 87.13% in March. County was impacted by a number of diverts within the month and still performed better than the previous 8 months.

Average handover time in April was 1 hour and 5 minutes, a 2-minute improvement from March, and 6 minutes better than plan.

This has been achieved despite net loss in medical beds with escalation areas closing and flipping back to Planned Care.

What are we doing about it?

Concern around May onwards and impact of maintenance programme, net loss of c.15 beds across Medicine for the next 4 months.

Change in ED processes such as reduced diagnostic requests sees patients time spent in ED reduced, supporting with departmental flow.

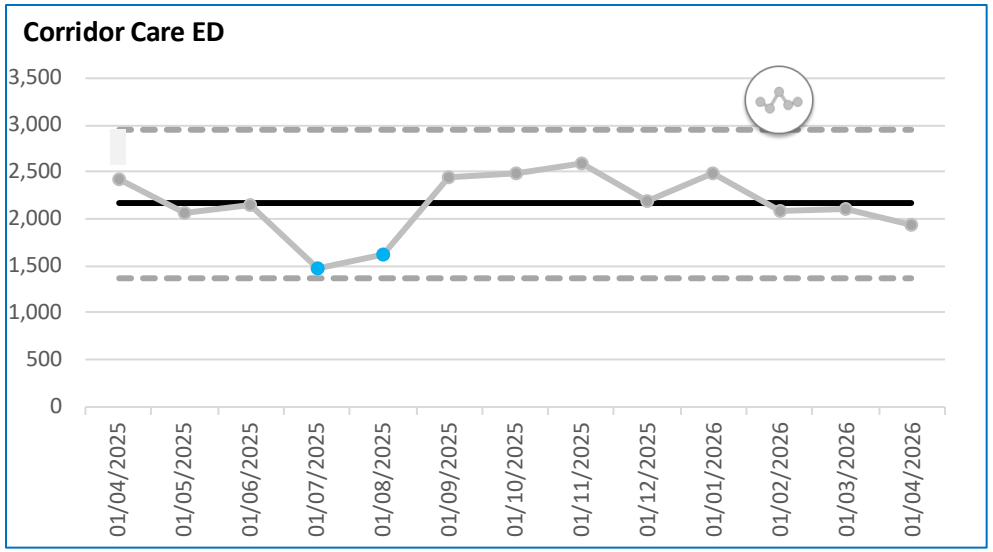
Managed to establish and maintain 2 Frailty SDEC bays enabling quicker pull / offload for this cohort of patients, which is significant proportion of ambulance conveyances.

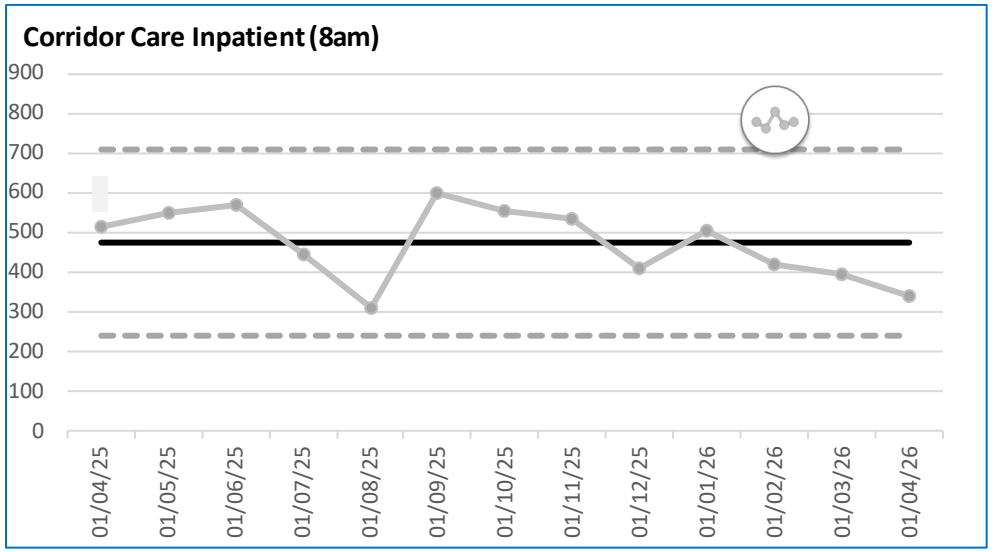
Reduction in conversion rate supports with minimising patient numbers in department, improving available space to offload ambulances.

Continue to staff the additional RAT consultant shifts to provide early senior decision making, and safe management of patients on ambulances held outside the hospital.

Quality & Access | Corridor Care

University Hospitals of North Midlands NHS Trust





What is the data telling us?

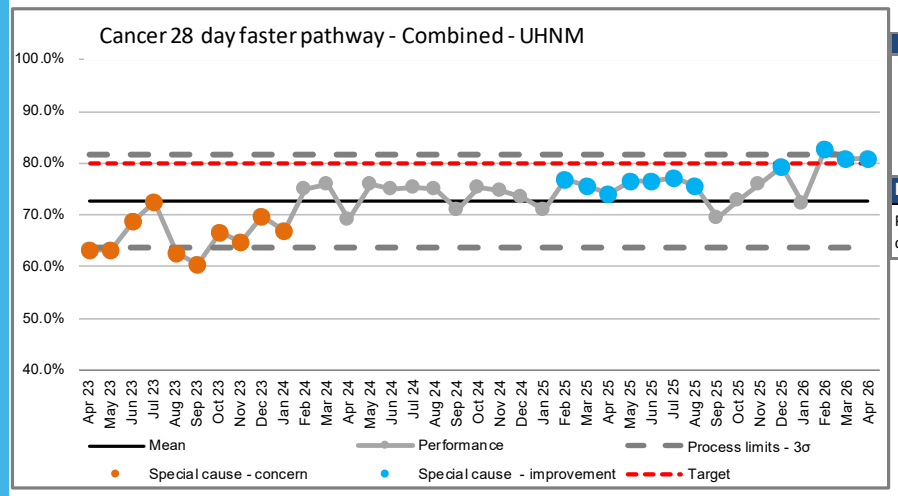
- There was a reduction in the total number of patients cared for on the ED corridor in April, when compared with March, and 205 less patients on the corridor in April vs January
- This means that there has been a consistent downward trend in corridor occupancy for 3 consecutive months
- The number of patients cared for on the corridor in April 2026 is 20% lower than the number in the same month last year (2025)

What are we doing about it?

- Continue to work on reducing DTA's through CTA learnings
- Continue to establish Majors seating 'fit-to-sit' area where possible to increase Majors capacity, caring for patients within the Majors footprint with improved dignity / safety vs the corridor
- Continue to maximise push to portals to reduce the number of patients within the department who could subsequently end up on the corridor
- Reduction in diagnostic requests to minimise unnecessary long waits in the department

Quality & Access | Cancer 28 Day FDS

University Hospitals of North Midlands NHS Trust



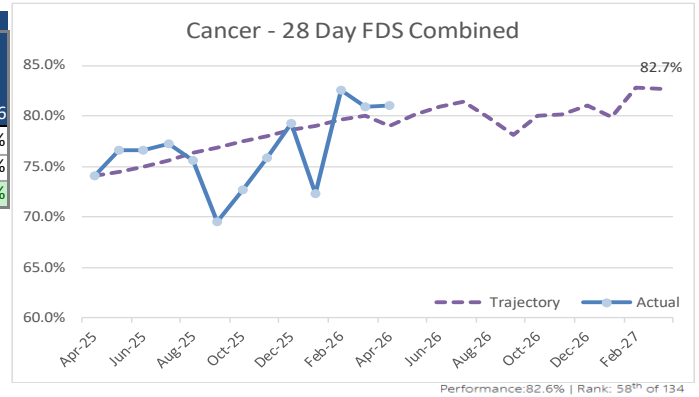
Variation	Assurance
H	?

Target	80%

Background

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

Monitoring against plan	Jan 26	Feb 26	Mar 26	Apr 26
Actual	72.3%	82.6%	81.0%	81.0%
Plan	79.1%	79.6%	80.1%	79.0%
Variance	-6.8%	3.0%	0.9%	2.0%



What is the data telling us?

- The final January position was reported at 72.30% against a trajectory of 79.09%
- The final February position was reported at 82.61% against a trajectory of 79.63%
- The final March position was reported at 80.97% against a trajectory of 80.09%
- The provisional April position is currently at 81.02% against a trajectory of 79.01%

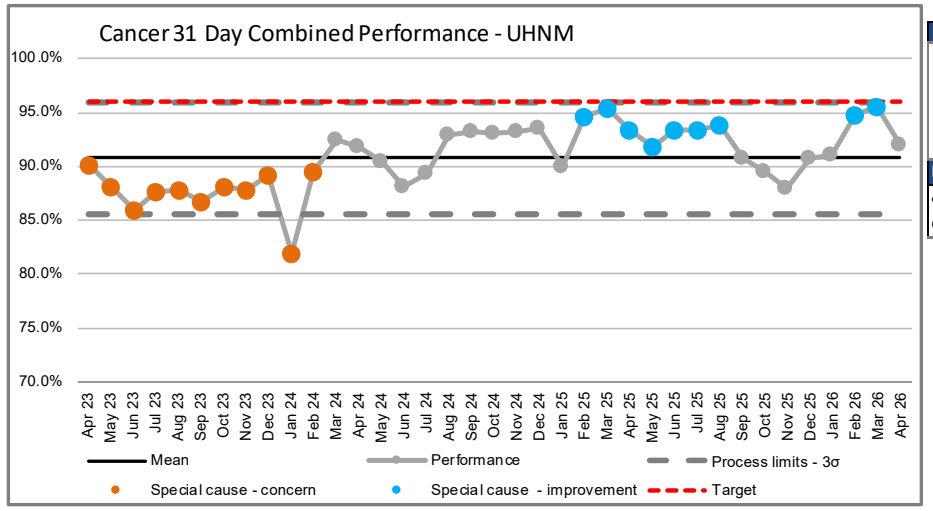
- There is good performance among most specialties.
- Specialties performing particularly well include Skin, Breast and Gynae.
- Specialties falling below standard include H&N, Colorectal & Urology.

What are we doing about it?

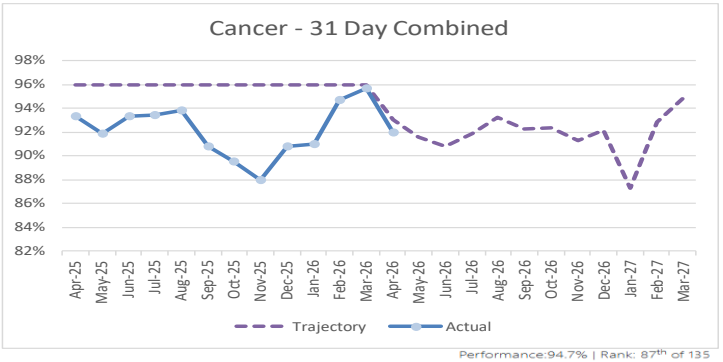
- The standard has been achieved in Feb and March – predicted to achieve in April also.
- Maintaining oversight through the Cancer Delivery Group meetings to bring focus on operational delivery for improvement plans and adherence to agreed trajectories for 26/27.
- A breakdown of cancer diagnosed versus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

Quality & Access | Cancer 31 Day Combined

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan				
				Jan 26	Feb 26	Mar 26	Apr 26
	Target	96%	Actual	91.0%	94.7%	95.6%	91.9%
Background			Plan	96.0%	96.0%	96.0%	93.0%
% patients beginning their treatment for cancer within 31 days following an urgent GP referral for suspected cancer			Variance	-5.0%	-1.3%	-0.4%	-1.1%



What is the data telling us?

- The final January position was reported at 90.99%
- The final February position was reported at 94.70%
- The final March position was reported at 95.62%
- The provisional April position is currently at 91.94% against a trajectory of 93.03%

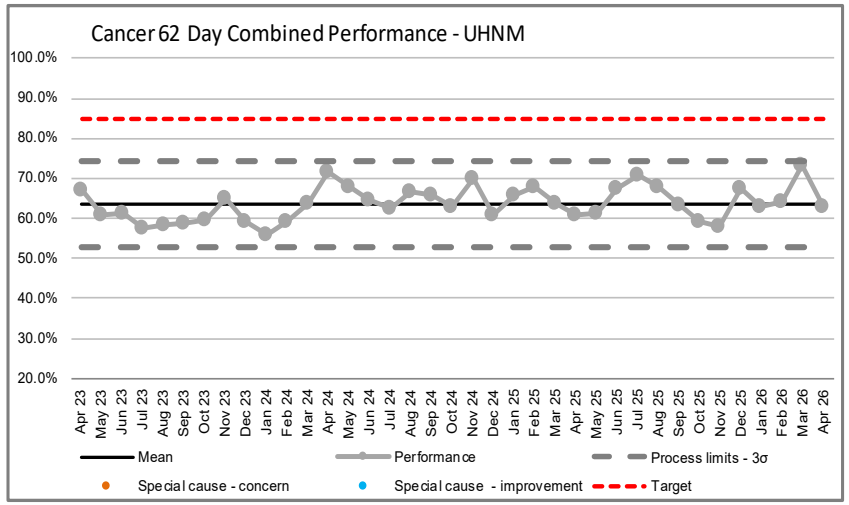
- Strong performance reported in February and March. Specialties performing well include Breast, Lung and Skin, however challenges in access to surgical capacity remain within Gynae, Colorectal, and Urology.
- Within the 31-day cohort of patients breaching surgery, the main delay reason is attributable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

What are we doing about it?

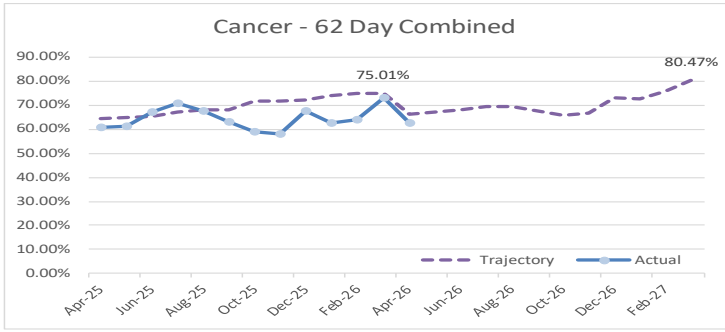
- The Trust and specialties are actively reviewing theatre capacity to ensure utilisation of all capacity available.
- Escalation of surgical capacity constraints at all appropriate forums such as Cancer Delivery Group, Specialty Improvement Groups, Cancer Services Strategy Group & Elective Oversight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

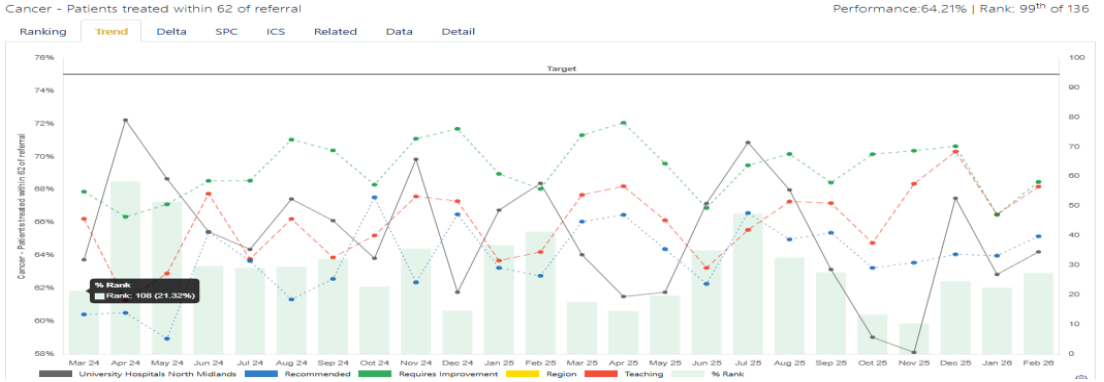
Quality & Access | Cancer 62 Day Combined

University Hospitals of North Midlands NHS Trust



Variation	Assurance		Monitoring against plan	Jan 26	Feb 26	Mar 26	Apr 26
		Target 85%	Actual	62.8%	64.2%	73.2%	62.8%
Background			Plan	74.2%	74.9%	75.0%	66.1%
% patients beginning their treatment for cancer within 62 days following an urgent GP referral for suspected cancer			Variance	-11.3%	-10.7%	-1.8%	-3.3%





What is the data telling us?

- The final January position was reported at 62.84% against a trajectory of 74.18%
- The final February position was reported at 64.21% against a trajectory of 74.87%
- The final March position was reported at 73.20% against a trajectory of 75.01%
- The provisional April position is currently at 62.82% against a trajectory of 66.12%

- 73% performance in March 26 was close to the 75% trajectory and the highest performing month of the past 3 years.

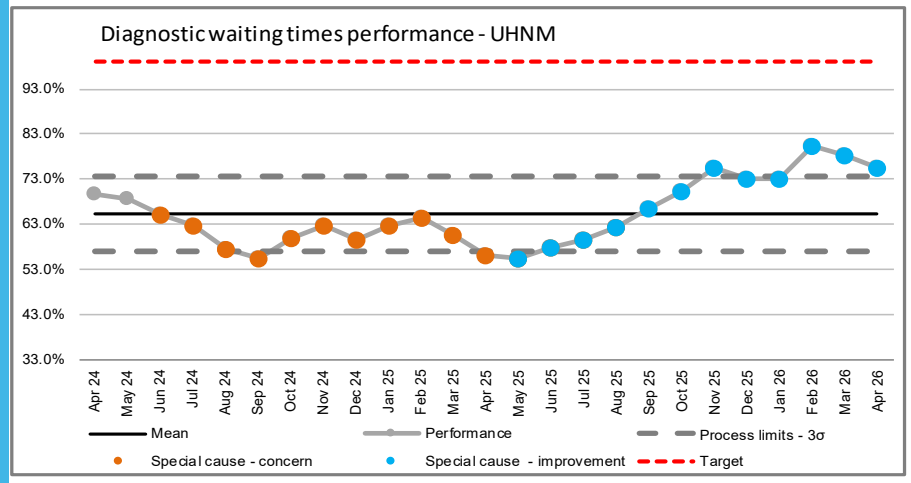
- Surgical capacity constraints (including robotics) affecting Gynae, Colorectal and Skin.
- Complex pathways (i.e. multiple investigations, second look biopsies, molecular and genetics testing) impact referral to treatment timelines, particularly in Lung.

What are we doing about it?

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

Quality & Access | Diagnostics DM01 Performance

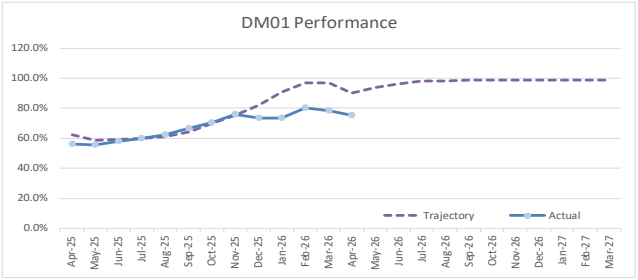
University Hospitals of North Midlands NHS Trust

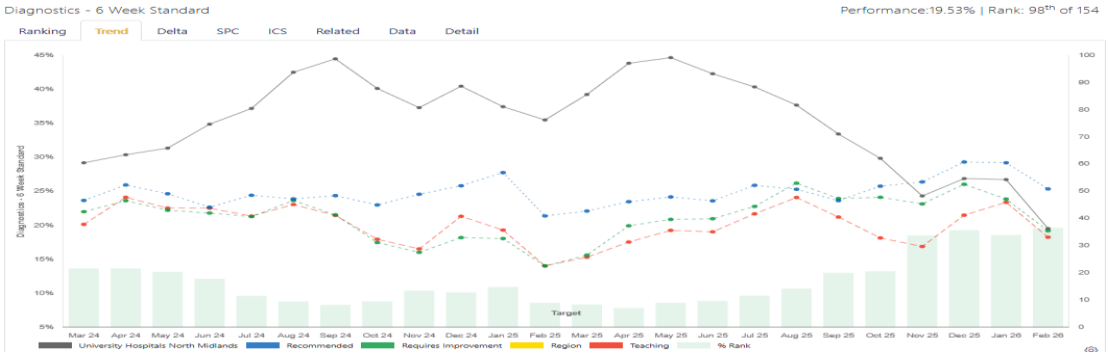


Variation	Assurance		Monitoring against plan				
				Jan 26	Feb 26	Mar 26	Apr 26
	Target	99.0%	Actual	73.3%	80.5%	78.2%	75.5%
			Plan	90.8%	96.8%	97.0%	90.3%
			Variance	-17.5%	-16.3%	-18.9%	-14.8%

Background

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





What is the data telling us?

March's DM01 validated performance was 78% against trajectory of 97%. Current performance is 78% (17/05) 95% being the national standard.

MRI is now showing as the majority contributor for UHNMs overall DM01 performance. MRI is now 69.6% with 1.5% 13-week breaches now contributing to UHNMs position.

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

- NOUS unvalidated performance is now 85.7. An increase in performance of 9.3% in the last 4 weeks

Neurophysiology continues to be a diagnostic specialty of concern due to locum and short-term workforce cover (ERF).

Echocardiography is also noted as performance at 46.6%, with an action plan for recovery requested through care group.

What are we doing about it?

MRI

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

Neurophysiology

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

Echocardiography

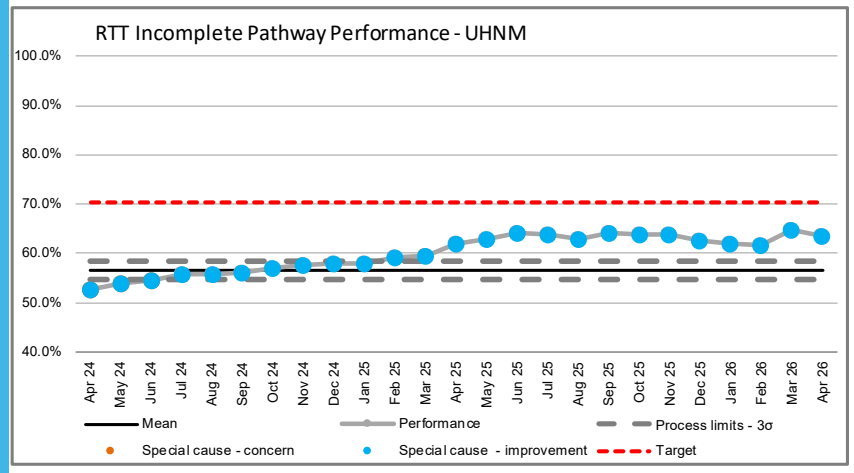
Recovery plan for Echo requested through care group to be monitored through Diagnostic Cell

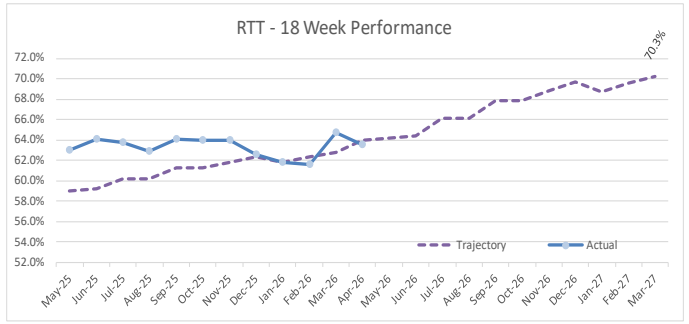
Cystoscopy

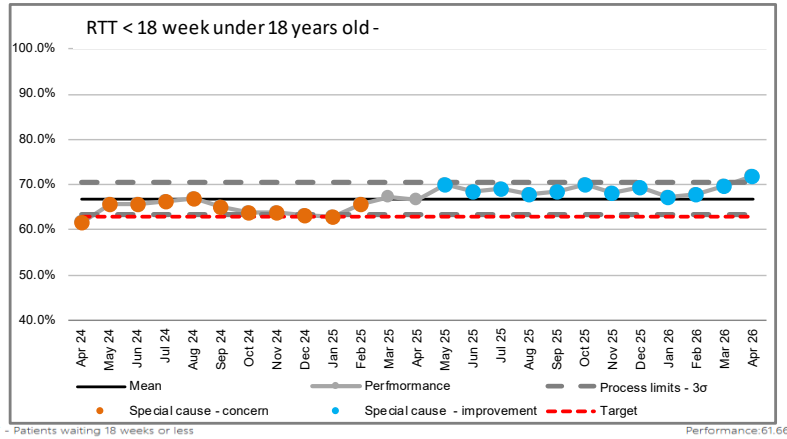
DQ still showing poor performance; directorate working with informatics to ensure correct patient data is tracked through

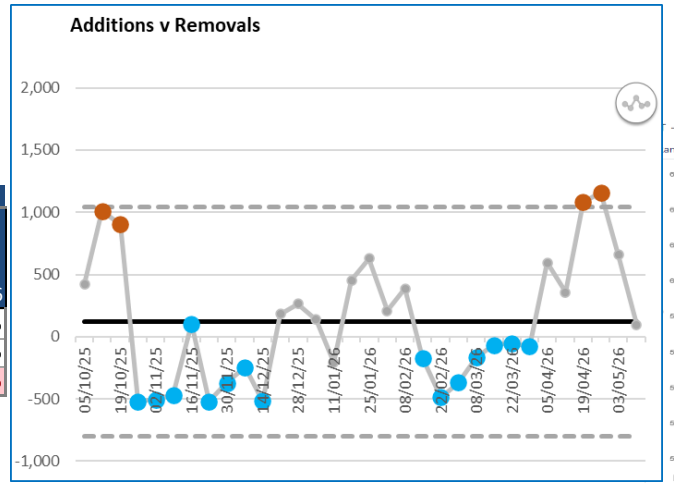
Quality & Access | RTT Performance

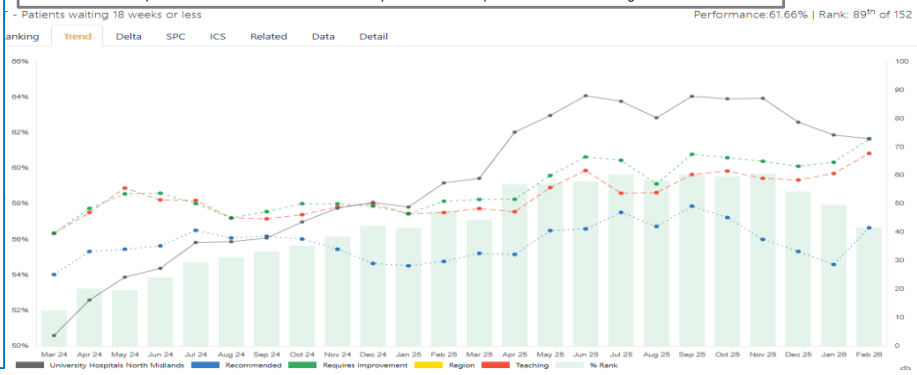
University Hospitals of North Midlands NHS Trust











Variation	Assurance		Monitoring against plan				
				Jan 26	Feb 26	Mar 26	Apr 26
	Target	70%	Actual	61.9%	61.6%	64.7%	63.5%
Background			Plan	61.8%	62.4%	62.8%	63.9%
The percentage of patients waiting less than 18 weeks for treatment.			Variance	0.0%	-0.7%	1.9%	-0.4%

What is the data telling us?

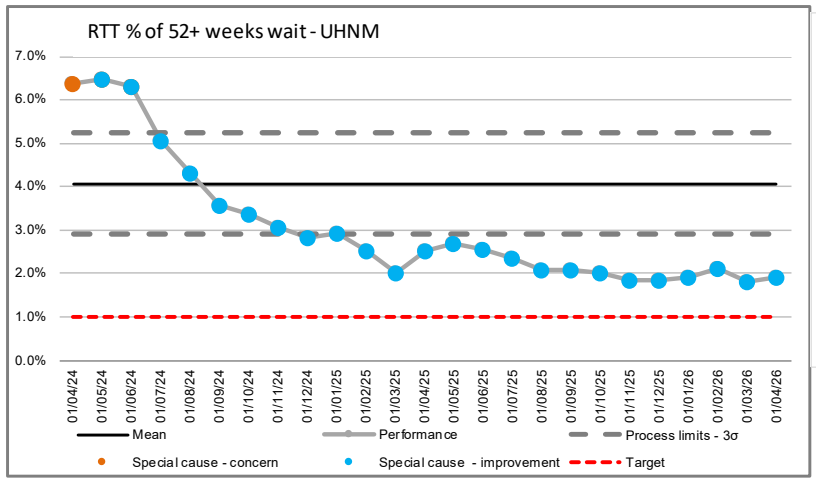
- Performance has deteriorated slightly in April to 64.06% (validated) but is still ahead of plan.
- Total PTL has increased significantly from 65,401 in March to 68,549 in April. There are several factors contributing to this – lower than average removal rate sustained throughout April and into May, exacerbated by Easter and school holidays; higher than average addition rate throughout April (barring second week of school holidays), reduction in activity, validation, and tracking following Sprints ending.

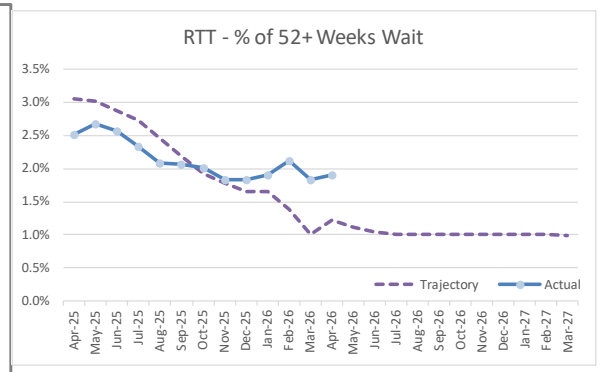
What are we doing about it?

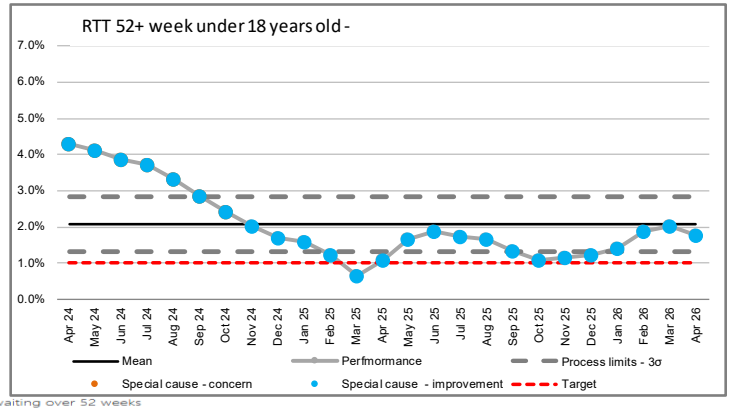
- Rollout of Rova continues – extension of licence for a further 12 months.
- Detailed action plan now in place to allocate vacant theatres and stand up targeted extra lists for services with long waiters

Quality & Access | RTT Performance – % 52+ Weeks

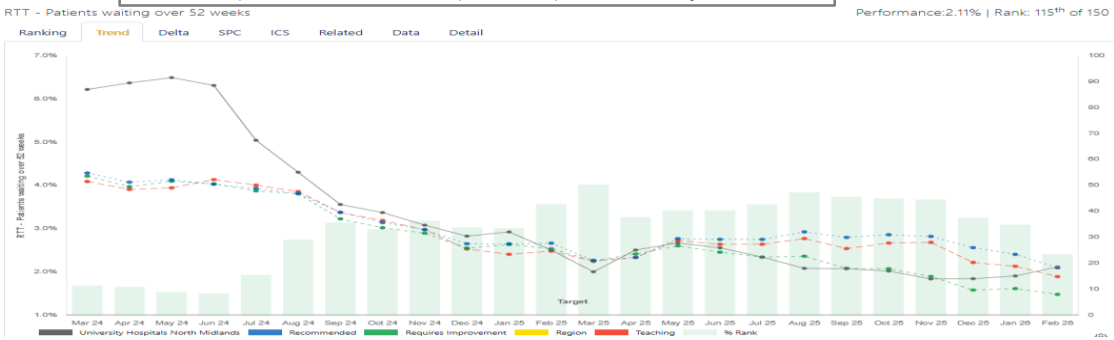
University Hospitals of North Midlands NHS Trust







Variation	Assurance		Monitoring against plan				
				Jan 26	Feb 26	Mar 26	Apr 26
	Target	1.00%	Actual	1.91%	2.12%	1.83%	1.90%
Background			Plan	1.65%	1.39%	1.00%	1.22%
The percentage of patients on a RTT pathway who have waited longer than 52 weeks for treatment compared to the total number of open RTT pathways.			Variance	0.3%	0.7%	0.8%	0.7%



What is the data telling us?

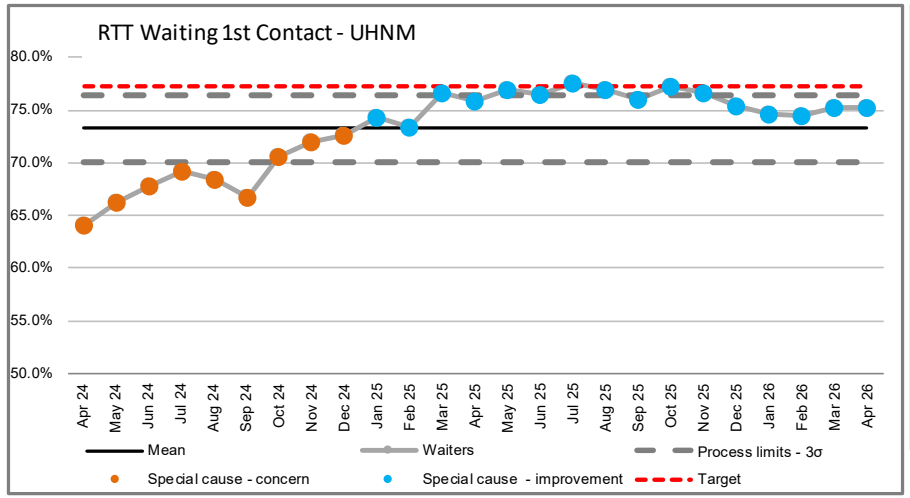
- Percentage of total PTL above 52 weeks has seen a reduction during bringing us closer to plan
- 52 week actuals has increased slightly from 1,197 to 1,285
- This cohort is extensively validated, so there's not much scope for improvement through validation alone

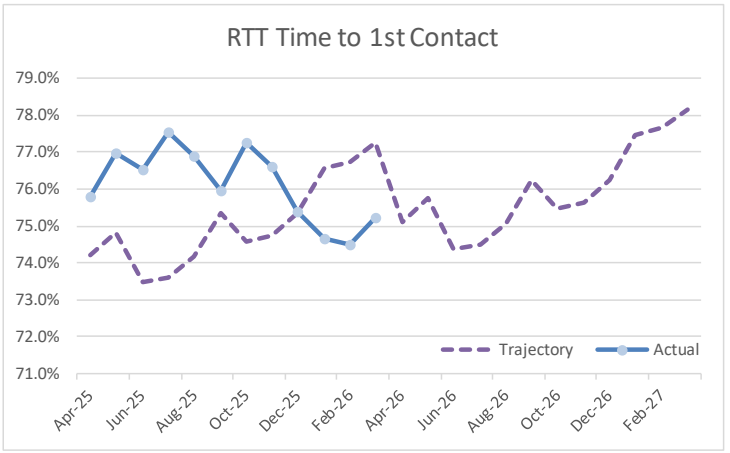
What are we doing about it?

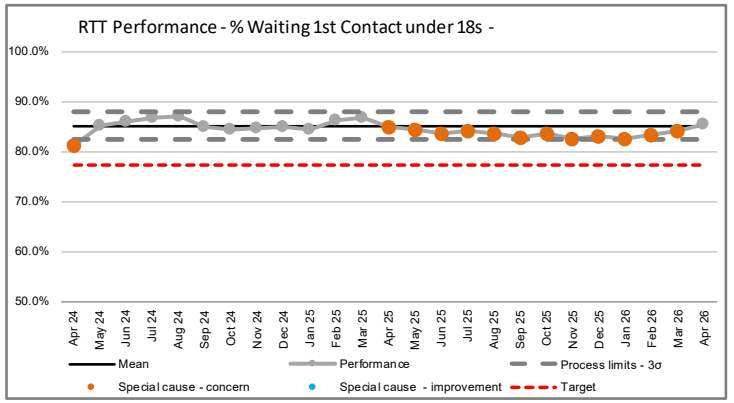
- Gynae Recovery funding approved at execs to deliver substantial additional activity through weekend and STS working; activity against recovery to be tracked separately on a week-by-week basis
- The ROVA validation tool also highlights pathways where actions have not been taken, and groups pathways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

Quality & Access | RTT % Waiting 1st Contact

University Hospitals of North Midlands NHS Trust







Variation	Assurance		Monitoring against plan				
				Jan 26	Feb 26	Mar 26	Apr 26
	Target	77.3%	Actual	74.7%	74.5%	75.2%	75.3%
Background			Plan	76.6%	76.7%	77.3%	75.1%
Of all patients waiting for first event after referral - the percentage that are waiting under 18 weeks			Variance	-1.9%	-2.2%	-2.0%	0.2%

What is the data telling us?

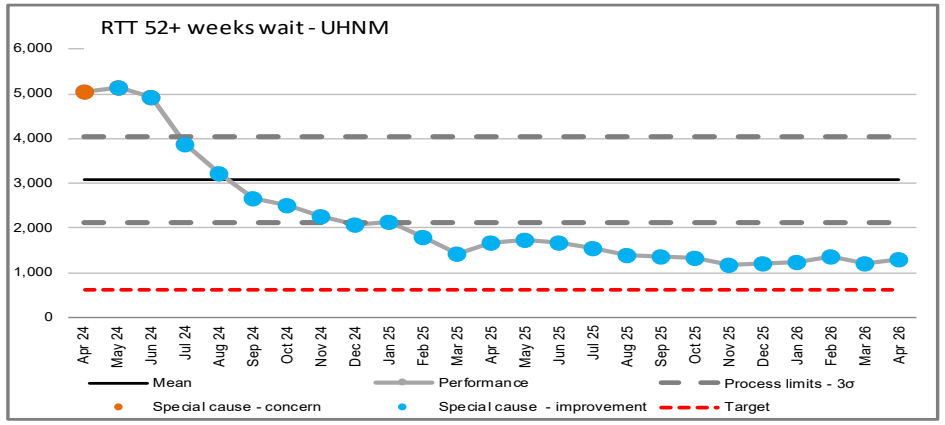
- UHNM is a regional leader on this metric and has been continually ahead of plan
- Time to first contact has reduced and is now off plan, at 74.7%
- The Elective sprint increasing the volume of Outpatient 1st New Activity in Q4 has brought the trust further back on plan

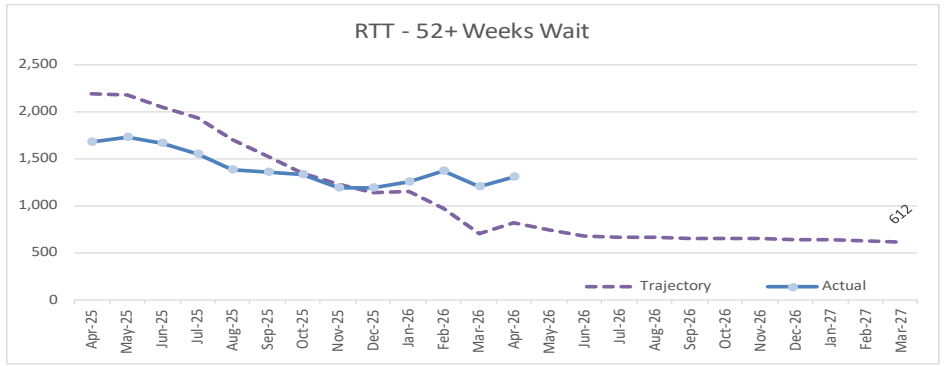
What are we doing about it?

- 52-week 1st contact for patients by March '26 are required to be seen by January '26. Performance being tracked weekly through EOMG
- 30 patients waiting at 52 weeks end of April had not had their first appointment by then, of which 13 were Ophthalmology.

Quality & Access | RTT No. of Long Waiting Patients

University Hospitals of North Midlands NHS Trust





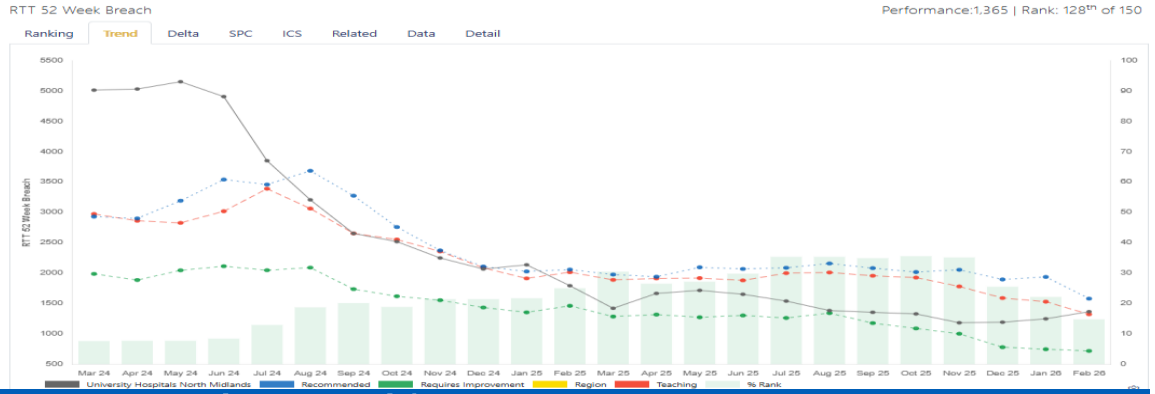
Variation	Assurance

Target	612

Background

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

Monitoring against plan	Jan 26	Feb 26	Mar 26	Apr 26
Actual	1,248	1,370	1,197	1,303
Plan	1,151	969	700	812
Variance	97	401	497	491
65+	84	109	83	106
78+	6	6	6	2
104+	0	0	2	0



What is the data telling us?

- The number of 78 week has improved in April - 1 patient – a joint procedure with 2 surgeons and accustom-made implant.
- 65 week waits have deteriorated in April, up to 104 from 80 in March.
- There is some risk with the extensive validation work underway of pop-up long waiters – these will be managed through the trust's "uncorrected breaches" process
- Particular specialties which impact are Orthopaedics, ENT, Ophthalmology, Oral MaxFacs and Gynaecology.

What are we doing about it?

- Micromanaging long waiting patients at daily / weekly PTL meetings – meetings stepped up to 3 times weekly in some directorates
- Cohorts of patients identified and non-admitted prioritised for urgent next steps
- Orthopaedics & Spinal now running through weekends through County Hub
- ERF funding approved to increase evening and weekend operating capacity
- Although numbers have increased this month, the proportion of long waiters which are non-admitted is decreasing, demonstrating improvements earlier on in the pathway bringing down waiting times in the mid-longer term. **In January, 44% of patients waiting 65+ and 38% of those waiting 52+ weeks had not yet reached a decision to admit, versus 24% and 33% respectively in April.**

Highlight Report

PEOPLE CULTURE & INCLUSION COMMITTEE | 28th May 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• The **Workforce Plan** provided **partial assurance**, with an update provided on the three-year workforce plan, noting significant required reductions in substantive, bank and agency staffing, with associated delivery risks. While some improvement in temporary staffing spend had been achieved, challenges remain in reducing bank usage. The Committee emphasised the need for clear communication and a strategic approach to workforce transformation, aligned to service delivery and patient outcomes. • The Committee received the refreshed **Chief People Officer** report, noting **partial assurance** reflecting ongoing workforce challenges alongside progress in culture, wellbeing and transformation initiatives. Significant progress on sexual safety was highlighted, supported by strong delivery against the assurance framework. The Committee also noted continued focus on workforce risks, including capacity and staff wellbeing, with further insight on staff stress to inform future action. • **Guardian of Safe Working** report provided **partial assurance**, with a significant increase in reports following system changes noted, particularly relating to missed breaks, with associated administrative and workload pressures. Actions were in place to strengthen oversight and support, including additional resource, with continued focus on addressing workload pressures, particularly during out-of-hours periods. • The Committee received the **Freedom to Speak Up** report, noting an increase in concerns raised both locally and nationally, with key themes including workforce pressures and behaviours. As such **partial assurance** was agreed. While some progress had been made in responding to concerns, variability in handling and barriers to speaking up remain, and the Committee emphasised the need to strengthen consistency, visibility and organisational learning.	• An updated paper on the consultant vacancy trajectory, including recruitment plans and tracking through executive team, to be brought to a future meeting. • Identify and include named leads responsible for each action in the **resident doctors' 10 point plan** for the next meeting's action plan update. • Establish links with the sexual safety liaison officer and/or sexual health and harassment officers to ensure integration with the safe space initiative for **doctors**. • Develop and share simple case studies and consider producing podcasts to improve engagement and awareness of **staff equality networks**, especially among frontline and clinical staff.

Positive Assurances to Provide	Decisions Made
• The Committee noted good compliance with elements of the **resident doctors 10 point plan** and continued focus on locally prioritised areas. Progress on sexual safety was highlighted, alongside ongoing challenges with induction and rotations, with continued emphasis on staff feedback, monitoring and alignment with Freedom to Speak Up arrangements. **Acceptable assurance** was agreed. • **Medical Workforce Group** highlighted strengthened controls over bank and agency usage and a reduction in spend, although overall costs remain above prior year due to increased workload. A targeted consultant recruitment campaign was being planned to reduce reliance on temporary staffing, with wider consideration of a more strategic, long-term approach to workforce recruitment to support financial sustainability. • **Acceptable assurance** was provided by the **safe staffing report**, and the Committee noted the improvement in fill rates and benchmark positioning, with assurance that patient safety was being maintained despite pressures. Concerns were highlighted regarding a material planned care budget discrepancy and ongoing neonatal workforce challenges, alongside the impact of staff redeployment on morale, with continued oversight required. • **Acceptable assurance** was provided by the **Employee Relations** report, noting sustained high case volumes and associated pressures on timeliness, with average case duration remaining above target. Key risks include case backlog, duration and the financial impact of suspensions. The Committee noted ongoing actions to strengthen governance, improve case management and enhance organisational learning, supported by improved data tracking, training and accountability. • The Committee received an update on the **Responsible Officer Advisory Group**, noting strengthened governance arrangements, including enhanced scrutiny of case management, duration and use of external investigators. The Committee was assured that robust processes were in place to manage complex and long-running cases, with appropriate challenge and oversight maintained. • The Committee received the **Staff Equality Networks Annual Report**, noting continued progress in advancing diversity and inclusion alongside challenges in engagement. **Acceptable assurance** was provided, and the Committee highlighted the importance of strengthening visibility, leadership and alignment with Freedom to Speak Up, with a focus on priority areas including anti-racism and neurodiversity. • The Committee received **internal audit** findings, noting **reasonable assurance** for HR recording processes and **substantial assurance** for DBS checks, reflecting strengthened controls and oversight. Ongoing actions were in place to support continuous improvement, including enhanced documentation, data integration and alignment with wider case management system developments.	• No decisions were required to be made.

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Comments on effectiveness were sought via MS Teams.	• Cross-committee considerations focussed on ensuring clear lines of accountability and appropriate committee oversight. An item relating to cancer peer review and patient access was agreed as more appropriately aligned to the **Quality, Access & Outcomes Committee** (QAOC), with PCIC contributing only where workforce capacity implications arise. • In addition, discussion on the workforce cost improvement programme highlighted that while PCIC could receive assurance through workforce indicators (e.g. bank and agency use), there was a lack of clarity on expectations for oversight of transformation impacts. It was agreed that further clarification was required from the **Finance & Business Performance Committee** regarding the specific remit and reporting framework for PCIC.

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Resident Doctors 10 Point Plan	3	15	Acceptable	Assurance	7.	Guardian of Safe Working Report Q4	3	15	Partial	Assurance
2.	Medical Workforce Group Highlight Report (05-05-26)	3	15	Not applicable	Information	8.	Employee Relations Case Trend Report Q3/Q4	3	15	Acceptable	Assurance
3.	Safe Staffing Report – April 2026	1, 3	15	Acceptable	Assurance	9.	Responsible Officer Advisory Group Highlight Report (24-03-26)			Not applicable	Information
4.	Workforce Plan Update	3	15	Partial	Assurance	10.	UHNM Equality Staff Networks Annual Report	3	15	Acceptable	Assurance
5.	Chief People Officer Report & Sexual Safety Update	3	15	Partial	Assurance	11.	HR Record Keeping – Disciplinary Checks & DBS Checks Internal Audits	3	15	Acceptable Significant	Assurance
6.	Speaking Up Report Q3/Q4	3	15	Partial	Assurance						

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Integrated Performance Report

Month 01 Performance

2026/27

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Contents

Statistical Process Control

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

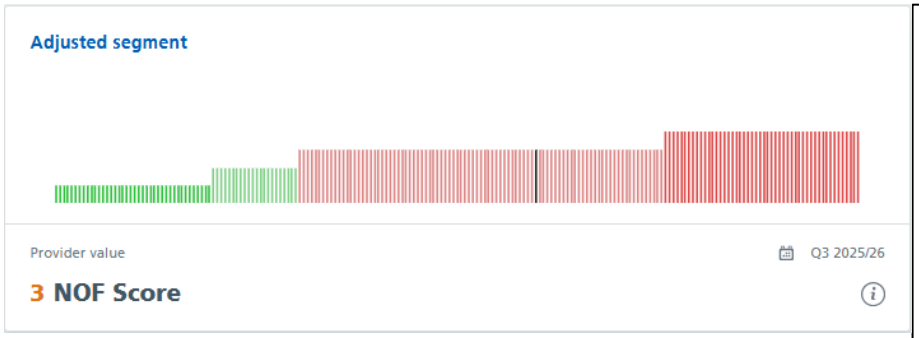
Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

Oversight Framework Summary

University Hospitals of North Midlands NHS Trust

Headlines	Data period	Provider value	Peer average	National value	National value method	Chart
Adjusted segment			Q3 2025/26 3	NOF Score	Provider value	
Average metric score			Q3 2025/26 2.47	NOF Score	Provider value	
Unadjusted segment			Q3 2025/26 3	NOF Score	Provider value	
Financial override	Q3 2025/26	No	Yes	Yes	Provider median	

Domain Scores	Data period	Provider value		Chart
Access to services domain segment	Q3 2025/26	3	NOF Score	
Access to services domain score	Q3 2025/26	2.57	NOF Score	
Effectiveness and experience of care domain segment	Q3 2025/26	2	NOF Score	
Effectiveness and experience of care domain score	Q3 2025/26	2.16	NOF Score	
Patient safety domain segment	Q3 2025/26	3	NOF Score	
Patient safety domain score	Q3 2025/26	2.67	NOF Score	
People and workforce domain segment	Q3 2025/26	2	NOF Score	
People and workforce domain score	Q3 2025/26	2.49	NOF Score	
Finance and productivity domain segment	Q3 2025/26	3	NOF Score	
Finance and productivity domain score	Q3 2025/26	2.35	NOF Score	



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

Overall score in quarter two was 2.43, a slight deterioration in quarter three 2.47, broken down as:

- Access to services from 2.41 to 2.57
- Effectiveness and experience from 2.19 to 2.16
- Patient Safety from 2.86 to 2.67
- People and workforce remains from 2.53 to 2.49
- Finance and productivity remains from 2.36 to 2.35.

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People and Workforce

People and workforce	Data period	Provider value		Chart
People and workforce domain segment	Q3 2025/26	2	NOF Score	
People and workforce domain score	Q3 2025/26	2.49	NOF Score	

Retention and Culture	Data period	Provider value	Peer average	National value	National value method	Chart
Sickness absence rate score	Q3 2025/26	2.35	NOF Score	Provider value	
Sickness absence rate (quarter)	To Sep 2025	5.13%	5.23%	5.24%	Provider median	
NHS staff survey engagement theme sub-score score	Q3 2025/26	2.62	NOF Score	Provider value	
NHS staff survey engagement theme sub-score	Dec 2024	6.84	6.78	6.88	Provider median	

UHNM remain in segment 2 in this domain, with an improved score of 2.49 in quarter three, compared to 2.53 in quarter two.
Although a deterioration in the sickness absence rate in quarter three to 5.13% from 4.83% in quarter two, it suggests that other providers performed worse than UHNM as the overall domain score improved. UHNM performed better than peers and the national average.

Staff survey scores remain unchanged.

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

Sickness absence remains above our expected standard of 3.39%. In-month sickness decreased to 5.12% while the rolling 12-month cumulative sickness rates increased slightly to 5.39%. Overall, sickness absences continue to be driven by stress and anxiety, followed by other musculoskeletal problems and then other gastrointestinal problems, as the second and third most common reasons. In April, 340 episodes of Cold, Cough, Flu, and Chest & Respiratory conditions were reported, compared to 458 episodes in March — representing a 25.8% month-on-month decrease.

Turnover and ***vacancy*** metrics continue to perform well against our expected standards. The turnover rate in April 2025 remains low, at 7.5%, which is consistently below our 11% target, for the last 3 years. Vacancies remain low at 7.8%, which is linked to the cost improvement profile and changes to the budgeted establishment. Colleagues in post increased in Registered Nursing (+9.76 fte) and Infrastructure (+1.1 fte) with all remaining staff groups seeing slight decreases.

Agency costs increased to 1.5%, in March 2026, from 1.0% in March 2026, which is below the threshold set by NHS England. In real-terms, overall agency usage decreased to 107.73 WTE in April from 132.54 WTE in March 2026, which is 32 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. April saw a further decrease in the in-month sickness absence percentage, influenced by seasonal fluctuations associated with a reduction in the episodes of cold, cough & flu, and Covid-19.

Agency expenditure was 32 WTE above plan, with all staff groups performing below plan, except for Medical & Dental who are 21 WTE above plan due to vacancies and maternity leave, while Other ST & T are 2 WTE above plan due to supporting the Cardiac Perfusionist service. Agency use is also influenced by the additional scrutiny at executive and care group level which is having the desired effect in reducing overall agency spend, with some agency activity being converted to bank expenditure, as well.

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People | Overview

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Overview from the Chief People Officer

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

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

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

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

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

What can we expect in future reports?

As we move through Spring and into the Summer, we should see a continued stabilisation in sickness absence reasons associated with gastrointestinal, cold & flu, and Covid-19 related symptoms.

April's Industrial Action impacted on April's bank use with an additional 27% use in Medical & Dental seen. The Industrial Action which is expected in June, will also have a similar effect on the use of temporary staffing. 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%	7.5%	7.5%			
Staff Vacancy Rate	8.0%	4.4%	7.8%			
Sickness Absence (In Month)	3.4%	5.4%	5.1%			
Appraisal (PDR)	95.0%	81.8%	81.3%			
Agency Utilisation	3.2%	1.0%	1.5%			
Employee Engagement	7.2	6.6	6.4			

Related Strategy and Board Assurance Framework (BAF)

People Strategy

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 3: Sustainable Workforce	Ext 16	Partial	Ext 15	Partial	Ext 15	Partial		

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People | Employee Engagement

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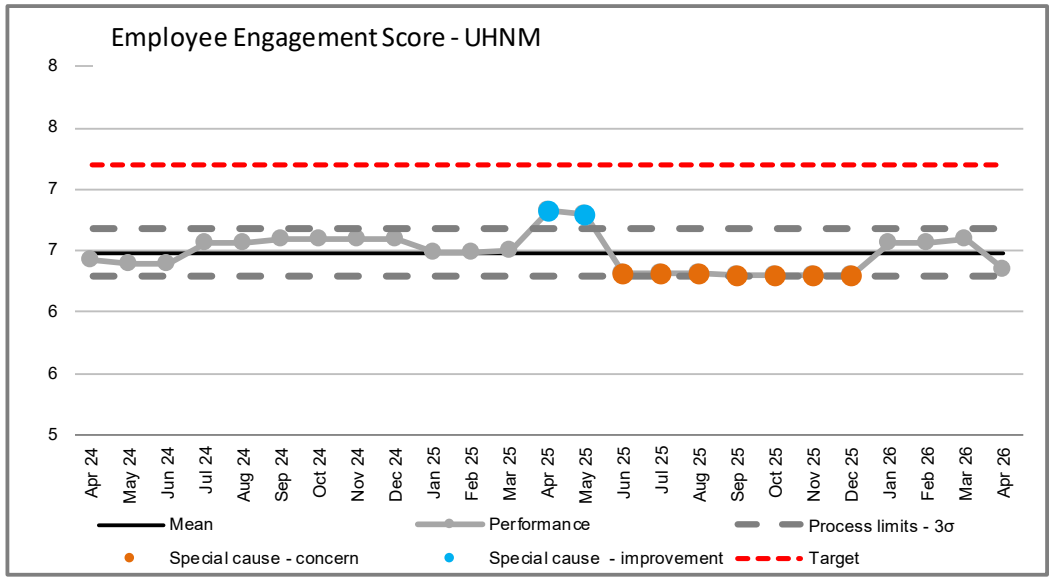

Variation	Assurance
	F

Target	Feb 26	Mar 26	Apr 26
7.2	6.6	6.6	6.4

Background

What is the data telling us?

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

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

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

What are we doing about it?

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

Sustained operational pressures continue to impact on overall employee engagement.

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

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People | Sickness Absence in Month

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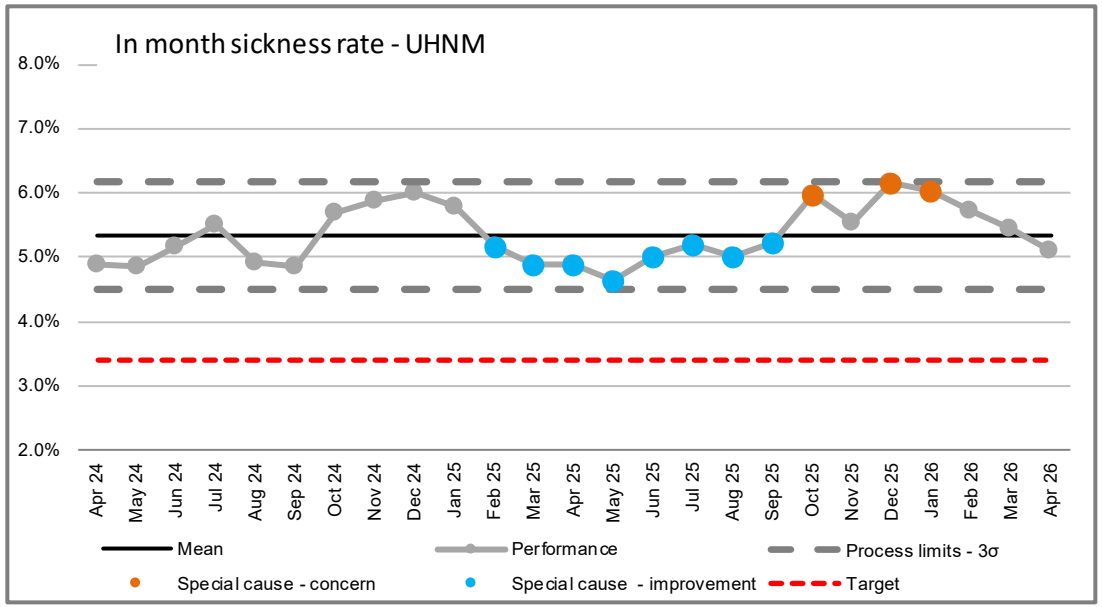


Variation	Assurance
	

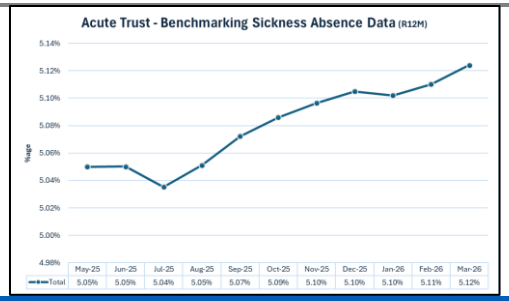
Target	Feb 26	Mar 26	Apr 26
3.4%	5.7%	5.4%	5.1%

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 Mar-26 - 5.1%)



What is the data telling us?

The rolling 12-month average sickness absence rate increased to 5.39% (5.38% in March 2026) against the target of 3.4%.

The in-month sickness absence decreased to 5.12% in April (5.44% in March 2026) with stress and anxiety seeing the largest decrease of -1.2%, with gastrointestinal problems and other musculoskeletal problems increasing by 0.5% and 0.6% respectively.

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

What are we doing about it?

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

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

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

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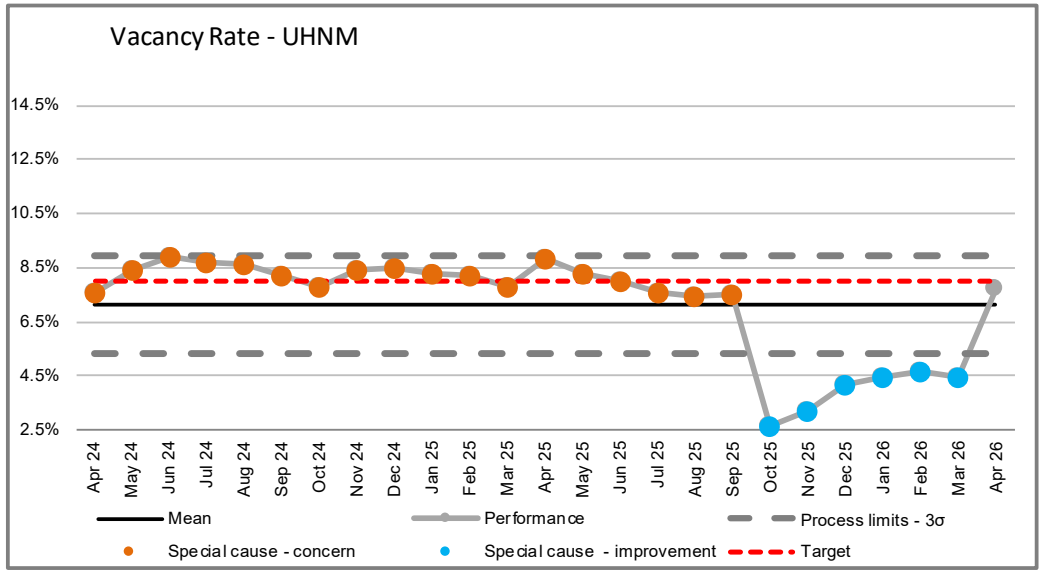
People | Vacancy Rate

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance

Target	Feb 26	Mar 26	Apr 26
8%	4.7%	4.4%	7.8%

Background

Based on Full Establishment (Substantive, Bank & Agency)

Vacancies at 30-04-26	Budgeted Establishment	Staff In Post fte	Vacancies	Vacancy %	Previous Month
Medical and Dental	1,872.81	1,663.38	209.43	11.18%	8.56%
Registered Nursing	3997.60	3844.23	153.37	3.84%	-1.62%
All other Staff Groups	7092.64	6450.20	642.44	9.06%	6.65%
Total	12,963.05	11,957.80	1,005.25	7.75%	4.43%

What is the data telling us?

April's vacancy rate increase, to 7.8%, from March's low vacancy rate of 4.4% is linked to the budgeted establishment and a realignment of the cost improvement profile, which came into effect from 1st April 2026.

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

Colleagues in post increased in April 2026 by 9.35 fte, budgeted establishment increased by 461.72 fte, which increased the vacancy fte by 452.37 fte.

[*Note: the Staff in Post fte is a snapshot at a point in time, so may not be the final figure for 30/04/26]

What are we doing about it?

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

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

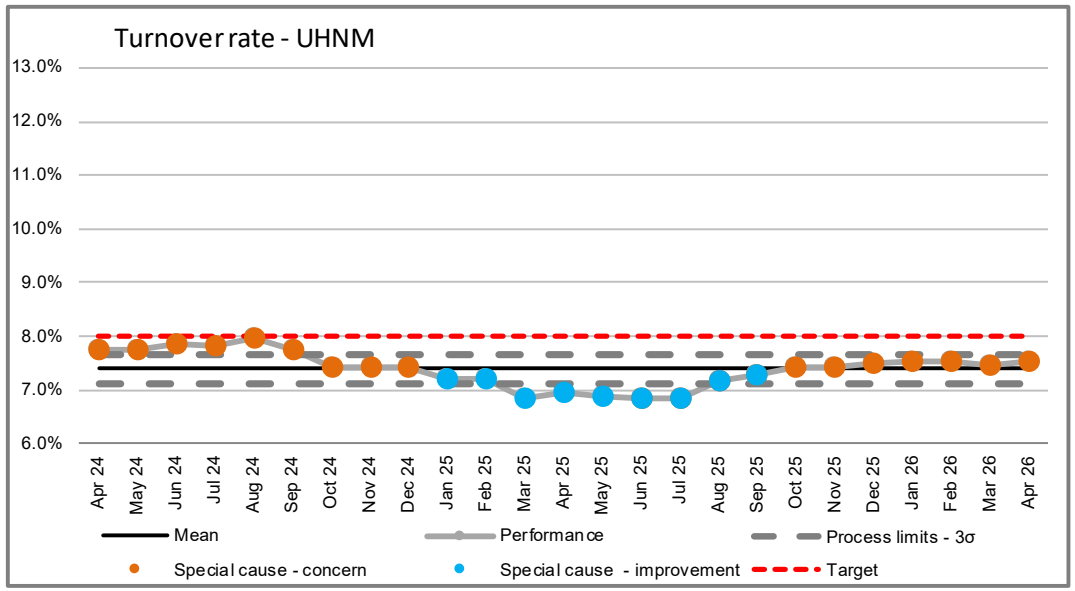
We continue our targeted spotlights on our colleagues, which supplement our recruitment campaigns.

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

People | Turnover Rate

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance
H	P

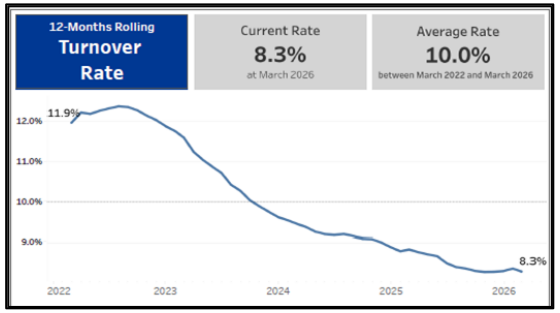
Target	Feb 26	Mar 26	Apr 26
8.0%	7.5%	7.5%	7.5%

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 March 2026)



What is the data telling us?

April 2026's turnover rate remained static at 7.5% for the fifth consecutive month, 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, April included the Smoke Free Campaign and the Tobacco Dependency Team's support, as part of improving staff health and wellbeing.

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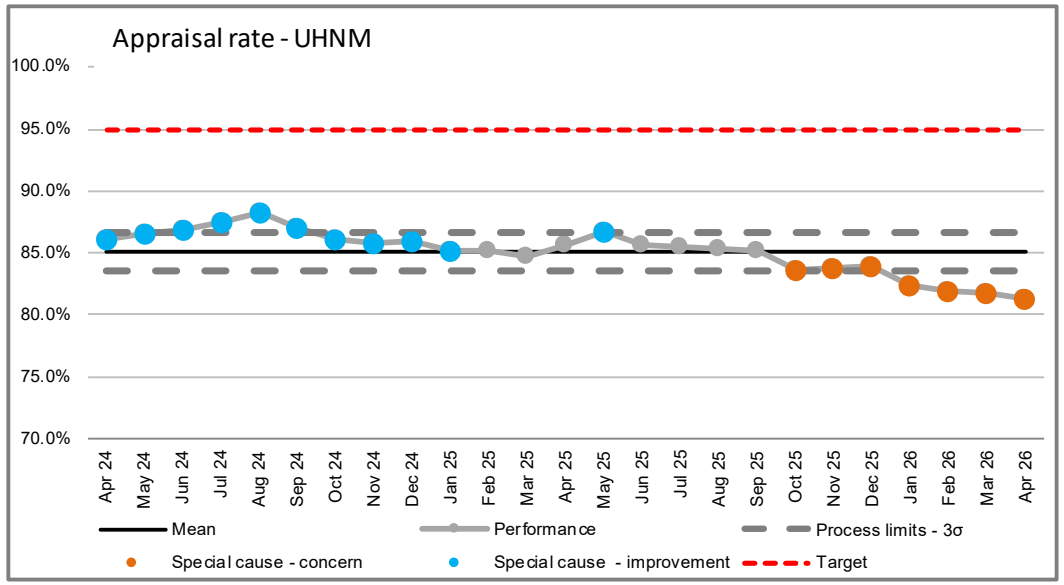
People | Appraisal Rate

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance
L	F

Target	Feb 26	Mar 26	Apr 26
95%	82.0%	81.8%	81.3%

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.

March's appraisal rates decreased to 81.3% from 81.8 % in March 2026, although Estates, Facilities and PFI Division remain consistently achieving above the target, at 95.76% for April 2026.

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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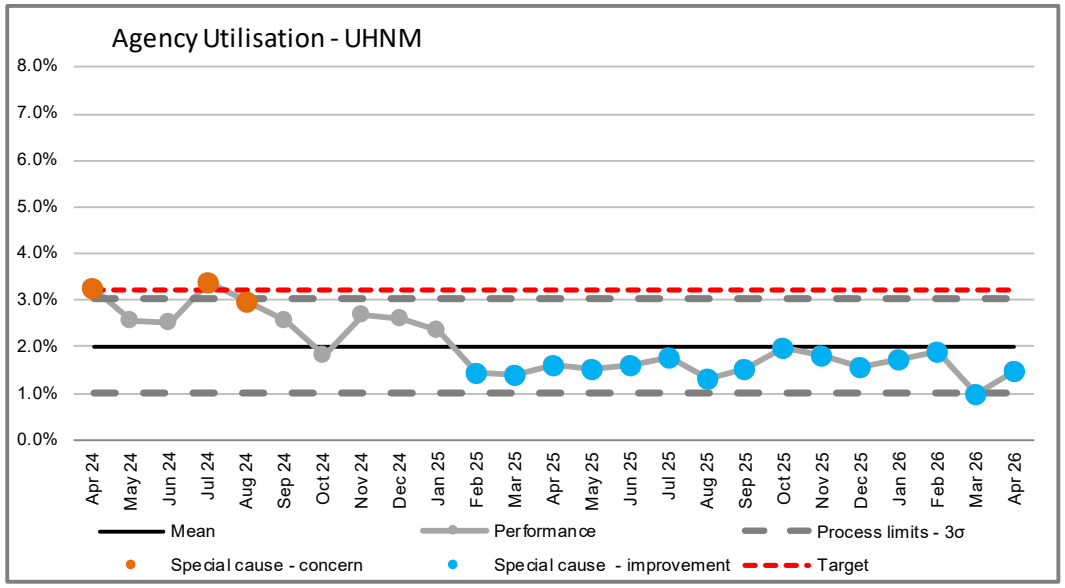
People | Agency Utilisation

Creating a great place to work for everyone

University Hospitals of North Midlands NHS Trust



Variation	Assurance
	

Target	Feb 26	Mar 26	Apr 26
3.2%	1.9%	1.0%	1.5%

Background

Agency cost as a percentage of total pay cost

What is the data telling us?

Agency cost is calculated as a percentage of the total Pay Costs, which increased to 1.5% in April 2026, (1.0% in March 2026).

In real-terms, overall agency usage reduced to 107.73 WTE in April from 132.54 WTE in March 2026, which is 32 WTE above plan, driven by vacancies and maternity leave, in Medical & Dental, and high use in Cardiac Perfusionists (due to vacancies and skills shortages) and Clinical Coding.

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

What are we doing about it?

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

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Highlight Report

Finance & Business Performance Committee | 27th April 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate

- Key discussion on the **Board Assurance Framework** (BAF) for Q4 focused on financial sustainability (BAF 7), noting that while the in-year financial position achieved plan, the longer-term sustainability risk remained extreme due to structural pressures. It was noted that Q1 BAF planning was due to commence, including aligning key actions to delivery of the associated strategic programmes.
- The **digital services** assurance report was provided, with progress noted in reducing the overall number of systems in use and improvements in governance over digital clinical safety and cyber compliance. However, members expressed continuing concern regarding legacy systems, capacity constraints within care groups, and inconsistent compliance with digital assurance standards. The Committee set a clear expectation of firmer controls going forward, including stronger executive grip on non-compliant systems, clearer ownership, and improved visibility of progress over time.
- The update on Trust **productivity and efficiency** performance, including benchmarking data and alignment with the Cost Improvement Programme (CIP) provided **partial assurance**, reflecting the gap between current productivity gains and national expectations, with continued scrutiny requested on theatre utilisation and delivery trajectory. Members noted that while planning activity and benchmarking maturity had strengthened, delivery risk remains significant given the scale of improvement required.
- The 2026/27 **CIP** position and progress against NHS England development milestones was provided with members noting recent positive movement in schemes progressing from "opportunity" into "development" and "delivery", whilst acknowledging that a material gap remained when reported externally to NHS England due to non-recurrent elements. The Committee supported a firmer escalation approach for schemes not progressing and recognised this as an important learning from the previous year. Partial assurance was agreed.
- The Committee emphasised that the underlying **financial** position remained a significant strategic challenge and requested continued focus on sustainable workforce and capacity reduction to support medium-term recovery. As such **partial assurance** was agreed.
- An update on the **Strategic Delivery Unit** was provided, and the Committee supported the proposed shift from the previous model to a revised governance approach, centred on a new Strategic Programme Group chaired by the Chief Executive. Members welcomed the move from a "push" to a "pull" model, reflecting the increasingly granular and time-bound commitments set out in the Medium-Term Plan. The Committee agreed that progress to date warrants **partial assurance**, noting it has taken time for the model to be established.
- The **Transformation** update, presented a refreshed articulation of the Trust's strategic programmes, aligned to national priorities which had been expanded to include financial recovery as a discrete programme. Members welcomed the clearer linkage between strategy, programmes and national direction, and the recognition that transformation activity occurred at multiple levels across the organisation, not solely within strategic programmes.

Major Actions Commissioned / Work Underway

- Quarter 1 **BAF** to include assurance regarding business case grip and control and the impact of the increases in inflation. Additions were also to be made to the heat map to the social and community and commercial opportunities sections.
- To develop a summary assurance report outlining executive grip and control over **investments** approved between £250k–£500k, including the number, value, purpose and alignment of with Trust strategy.
- To strengthen assurance regarding the **SDU**, the Committee requested a time-limited programme of monthly highlight reports to the Committee, focusing on whether the new group was operating as intended (including attendance, grip and control, and adherence to its terms of reference), rather than outcomes.
- Future **transformation** updates to demonstrate delivery confidence and address key gaps such as clearer articulation of delivery milestones and impact, explicit visibility of culture change, confirmation of programme management capacity, and alignment with the forthcoming capacity and capability paper. The Committee requested that the transformation programme return to Executive discussion before re-submission and asked that more granular delivery reporting be brought back to Committee as soon as possible.

Positive Assurances to Provide

- The annual **effectiveness** review was presented, demonstrating that the Committee continued to operate effectively and in line with good governance practice. Feedback highlighted strong chairing, a positive and respectful culture, and high-quality discussion and challenge. A small number of improvement themes were identified which had been incorporated into the Committee's forward work programme for 2026/27.
- The **bi-annual sustainability and net zero performance** report was considered, and the Committee endorsed the overall **acceptable assurance** rating. Members welcomed strong progress, including implementation of low-carbon clinical initiatives, reduced emissions from anaesthetic gases, and improved targeting of community energy support. The report also highlighted emerging climate-related risks, including adaptation and resilience, which were being developed through the governance route for potential escalation. Members supported closer alignment between the Net Zero agenda and the Trust's strategic transformation programmes.
- The update on **Premises Assurance Model (PAM) and Estates Returns Information Collection (ERIC)** provided **acceptable assurance**. Members noted continued work to address areas requiring improvement and acknowledged the increasing estates backlog position, driven by inflationary pressures and refreshed condition surveys. Assurance was provided that high-risk patient safety issues were prioritised within available capital funding and members requested clearer narrative in future reports when significant cost increases were reported, to support understanding of drivers and mitigations.
- The **Month 12 finance** report was received, and the Committee commended the Executive team for delivering an in-year financial position very close to plan despite considerable system and operational pressures. Members noted a strong capital outturn, cash position ahead of plan, and improvements in agency expenditure, while recognising increasing reliance on bank staffing.
- **Significant assurance** was provided on **procurement** performance, including delivery of significant savings, system-wide collaboration and expanding regional procurement leadership.

Decisions Made

- The Committee reviewed the Q4 **BAF** for risks within its remit (BAF risks 4–8) and confirmed that the risk scores, assurance assessments and action positions accurately reflected the Trust's position at the end of March 2026.
- Updated **Terms of Reference** were approved, subject to final Board approval as part of the Rules of Procedure.
- The Committee approved the Trust's approach to the **National Cost Collection submission**, confirming that appropriate capacity, capability and milestone planning were in place. Authority was delegated to the Chief Financial Officer to sign off the submission, with assurance to be provided back to the Committee following completion.
- The Committee formally approved mobilisation of **Community Diagnostic Centre** pathways following confirmation of funding from NHS England. Members welcomed confirmation that funding included recognition of additional estate-related costs and the Committee congratulated the team on CDC go-live.
- The Committee approved the following **e-REAFs**; 18079, 18064, 18063, 18053, 18031, 17992, 17991, 17982, 17758, 17733 and 18075.

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Comments on effectiveness were sought via MS Forms.	• It was agreed that responsibility for oversight of the total workforce WTE levels and overall workforce controls were to be considered by the People, Culture and Inclusion 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 Q4 25/26	4,5,6, 7,8	Various	Not Applicable	Approval	8.	Productivity Report	6, 7	9 25	Partial	Assurance
2.	Committee Effectiveness 2025/26	-		Not Applicable	Approval	9.	CIP 2026/27 Update	6, 7	9 25	Partial	Assurance
3.	Sustainability and Net Zero Carbon (NZC) Bi-annual Performance Report	5	High 12	Acceptable	Assurance	10.	Finance Report – Month 12 2025/26	6, 7	9 25	Partial	Assurance
4.	Premises Assurance Model (PAM) and Estates Return Information Collection (ERIC)	5	High 12	Acceptable	Assurance	11.	National Cost Collection Pre-Submission Report 2025/26	-		Not applicable	Approval
5.	Digital Services - IT Standards Update	5	Ext 16	Partial	Assurance	12.	Procurement Update Report	6,7	9 25	Significant	Assurance
6.	Strategy Delivery Unit Update	ALL	Various	Partial	Assurance	13.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-		Not applicable	Approval
7.	Transformation Update	ALL	Various	Not applicable	Information						

Highlight Report

Finance & Business Performance Committee | 1st June 2026

University Hospitals of North Midlands NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• **Partial assurance** was provided by the new **annual business case review** report. The Committee noted that delivery of planned benefits continued to be impacted by recruitment challenges, particularly in medical roles. Members emphasised the need to strengthen post-investment review arrangements, including clearer assessment of realised benefits, ongoing cost justification, residual risk, and impact on strategic objectives. • The Committee received an update on the **2026/27 Cost Improvement Programme** (CIP), noting a material gap between the £81 m requirement and schemes identified to date. Whilst 100% of CIPs had not been identified by the target of the end of May, a revised trajectory of completion by the end of Quarter 1 had been identified. Early delivery performance was also behind plan, with shortfalls linked to design gaps, planning misalignment and delays in workforce schemes. The Committee highlighted risks relating to phasing, non-recurrent reliance and delivery of recurrent savings, and noted that a revised trajectory is in development, with ongoing refinement of forecasting and assurance as further data becomes available, as such **partial assurance** was provided. • The Committee received the Month 1 **finance** report, noting a reported deficit of £6.5m, £3.5m adverse to plan, driven by industrial action, CIP under-delivery and income shortfalls; **partial assurance** was agreed. Controls on agency and bank spend had been strengthened, with early indications of improved oversight. • The Committee noted risks within the **capital** programme, including the removal of £7.7m linked to Project STAR, and approved the proposed amendments. • **Partial assurance** was provided by the **Project STAR** land disposal strategy, noting the differences between the offer and valuation. Risks associated with holding the Royal Infirmary site were highlighted, and associated costs were approved. The Committee was assured on due diligence and approved the proposed approach. • The Committee received an update on **IT standards** and system consolidation, noting continued progress in reducing the number of systems, albeit at pace constrained by complexity, as such **partial assurance** was agreed. The Committee emphasised the need for strengthened assurance, including clearer visibility of emerging risks such as Shadow AI and confirmation that digital funding requirements are consistently reflected in business cases, alongside continued oversight of new system introductions.	• Future **annual business case reviews** to include enhanced transparency on funding pipelines. • Consider and propose proactive measures to address recurring recruitment challenges, particularly for medical workforce, in future **business case** investments. • Further update to be provided on the **Phase 1 Outpatient Transformation Programme** to clearly articulate benefits realisation and demonstrate delivery and alignment with the financial plan. • To consider how to proactively ensure that funding for new **digital** systems is included as a line item in business cases, making it a front-of-mind requirement. • Provide a separate table for Shadow AI systems in future **IT standards** updates, highlighting their enhanced and new types of risks for committee oversight.

Positive Assurances to Provide	Decisions Made
• The Committee considered the update on **Corporate Capacity: Enabling Strategic Delivery** and associated resource investment, noting that Executive-approved funding would support delivery through strengthened governance arrangements. The Committee welcomed the consistent approach and clarity provided by integrated change framework set out within the update. • The Committee received an update on the **Outpatient Transformation Programme** and proposed investment in phase two, noting early improvements from phase one, with full benefits realisation still to be confirmed. • The Committee received the **Digital Data and Governance Group** highlight report, noting the temporary pause of the EPR programme and ongoing capital pressures. The Committee noted progress in delivering key programmes, including the successful completion of the Community Diagnostic Centre project.	• The Committee approved the amendments to the 26/27 **capital** plan and revised plan value of £73.3 m. • The Committee approved **e-REAFs** 17957, 17959, 18144, 18201, 18299, 18314, 18151 and 18336. • The Committee approved the phased disposal strategy for **Project STAR** including additional holding costs with a further report to be provided to the Committee of the final disposal route and agreed land value. • The Committee approved the finalised version of the **strategic programmes.** • Approval was granted for the proposed resource allocation for **corporate capacity**, subject to further development of clear KPIs and success measures, with arrangements in place to ensure ongoing oversight and accountability through established programme governance structures. • Support was given for progression of the phase two **Optimising Capacity and Productivity in Outpatients** business case, subject to NHS England approval. • The Committee approved the Terms of Reference for the **Digital Data and Governance Group.**

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Comments on effectiveness were sought via Microsoft Forms	• The Committee considered cross-committee feedback on **organisational resource** constraints, noting these pressures were systemic rather than committee-specific. Assurance was provided that capacity prioritisation was agreed at Executive level; however, the Committee emphasised the need to strengthen risk identification and ensure related workforce and capacity risks were explicitly captured and integrated within the Board Assurance Framework.

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Business Case Review Update – Annual Review	-	-	Partial	Assurance	6.	Corporate Capacity: Enabling Strategic Delivery	ALL	-	Not Applicable	Approval
2.	Cost Improvement Programme 2026/27 Update	6, 7	Ext 25	Partial	Assurance	7.	Optimising Capacity and Productivity in Outpatients (Phase 2)	1		Not Applicable	Approval
3.	Finance Report – Month 1 2026/27	6, 7	High 12 / Ext 25	Partial	Assurance / Approval	8.	Digital Services - IT Standards Update	4	34619 Ext 20 / 34869 Ext 15	Partial	Assurance
4.	Authorisation of New Contract Awards, Contract Extensions and Non-Purchase Order (NPO) Expenditure	-	-	Not Applicable	Approval	9.	Executive Digital Data and Governance Group Highlight Report (30-04-26) • Terms of Reference	-	-	Not applicable	Information / Approval
5.	Project STAR Land Disposal	5	High 12	Partial	Approval						

Since 14th March to 14th May 2026, 6 contract awards over £1.5 m were made, as follows:

- **NOM4898 Non-Emergency and High Dependency Patient Transport Service UHNM,** supplied by Starcross Ltd T/A BEARS, for the period 01/09/2026 – 31/08/2030 (plus an option to extend for 24 additional months – Value included in the eREAF), at a total cost of £13,198,899.59, providing savings of £456,966.59 (Cost Reduction) and £44,655 (Negated Inflation) approved on 8th April 2026.
- **NOM7006 Financial Recovery Support – Continuation of Service,** supplied by Deloitte LLP, for the period 09/02/2026 – 07/08/2026, at a total cost of £1,996,920, providing savings of £210,408 (inc. VAT) – Cost Avoidance, approved on 21st April 2026.
- **NOM6780 Linen and Laundry Services UHNM,** supplied by Ellis/Berendsen Healthcare Ltd, for the period 01/09/2026 – 31/08/2030, at a total cost of £18,402,773, approved on 6th May 2026.
- **MED6141/MED9951/MED9957 Surgical Drapes and Gowns Services UHNM,** supplied by Ellis/Berendsen Healthcare Ltd, for the period 01/09/2026 – 31/08/2030, at a total cost of £5,949,373, providing savings of £1,649,101 - Cost Avoidance, approved on 6th May 2026.
- **MED0007 Supply of Hips and Knee Implants,** supplied by Smith & Nephew Stryker, for the period 01/11/2026 – 31/07/2027, at a total cost of £1,583,189.47, approved on 6th May 2026.
- **NOM4373 Staff Benefits Scheme,** supplied by Perkbox (Previously Smehci Ltd/Vivup), for the period 01/02/2026 – 31/08/2027, at a total cost of £1,588,010, providing savings of £120,000, approved on 6th May 2026.

NHS
University Hospitals of North Midlands
NHS Trust

Integrated Performance Report

Month 01 Performance

2026/27

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University Hospitals of North Midlands NHS Trust

Contents

Statistical Process Control

University Hospitals of North Midlands NHS Trust

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

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

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

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

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

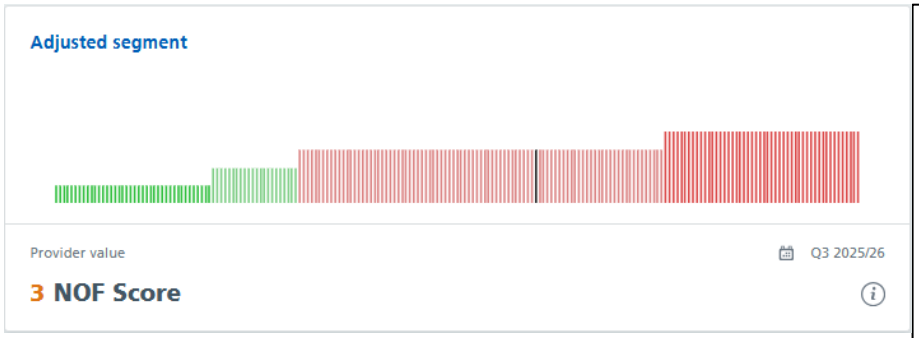
Where icons indicate an area needs attention, you could give more detail by attaching the full SPC chart and narrative describing the context, issues and actions in an appendix.

Oversight Framework Summary

University Hospitals of North Midlands NHS Trust

Headlines	Data period	Provider value	Peer average	National value	National value method	Chart
Adjusted segment			Q3 2025/26 3	NOF Score	Provider value	
Average metric score			Q3 2025/26 2.47	NOF Score	Provider value	
Unadjusted segment			Q3 2025/26 3	NOF Score	Provider value	
Financial override	Q3 2025/26	No	Yes	Yes	Provider median	

Domain Scores	Data period	Provider value		Chart
Access to services domain segment	Q3 2025/26	3	NOF Score	
Access to services domain score	Q3 2025/26	2.57	NOF Score	
Effectiveness and experience of care domain segment	Q3 2025/26	2	NOF Score	
Effectiveness and experience of care domain score	Q3 2025/26	2.16	NOF Score	
Patient safety domain segment	Q3 2025/26	3	NOF Score	
Patient safety domain score	Q3 2025/26	2.67	NOF Score	
People and workforce domain segment	Q3 2025/26	2	NOF Score	
People and workforce domain score	Q3 2025/26	2.49	NOF Score	
Finance and productivity domain segment	Q3 2025/26	3	NOF Score	
Finance and productivity domain score	Q3 2025/26	2.35	NOF Score	



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

Overall score in quarter two was 2.43, a slight deterioration in quarter three 2.47, broken down as:

- Access to services from 2.41 to 2.57
- Effectiveness and experience from 2.19 to 2.16
- Patient Safety from 2.86 to 2.67
- People and workforce remains from 2.53 to 2.49
- Finance and productivity remains from 2.36 to 2.35.

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Finance and Productivity

University Hospitals of North Midlands NHS Trust

Finance and productivity	Data period	Provider value		Chart
Finance and productivity domain segment	Q3 2025/26	3	NOF Score	
Finance and productivity domain score	Q3 2025/26	2.35	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			Q3 2025/26 1	NOF Score	Provider value	
Planned surplus/deficit score			Q3 2025/26 1	NOF Score	Provider value	
Planned surplus/deficit	Apr 2025	0.00%	-2.03%	0.00%	Provider median	
Variance year-to-date to financial plan score			Q3 2025/26 1	NOF Score	Provider value	
Variance year-to-date to financial plan	Dec 2025	0.00	-1.34	0.00	Provider median	

Productivity Please note: In Q1 2025/26, the implied productivity metric for ICBs applied only to acute trusts. This was later expanded to all trust types, so Q1 figures are not directly comparable with later quarters.	Data period	Provider value	Peer average	National value	National value method	Chart
Implied productivity level score			Q3 2025/26 3.71	NOF Score	Provider value	
Implied productivity level	Sep 2025	-1.80%	4.10%	2.60%	Provider median	

UHNM score for this domain saw a slight improvement from 2.36 in quarter two to 2.35 in quarter three.
Variance YTD to financial plan saw a marginal improvement from 0.01 to 0.00 in quarter three.
Implied Productivity level saw an improvement from -3.91% in quarter two to -1.80% in quarter three, but remains below peer and national averages.

Finance | Financial Summary

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

This report presents the financial performance of the Trust for April 2026 (Month 1).

The Trust reported a deficit of £6.5m for the 2026/27 financial year, which is a £3.0m overspend against plan.

Income: The income at month 1 is below plan by £0.2m, which relates to patient income £0.8m below plan and operating income £0.5m above plan.

Expenditure: Total expenditure is overspent by £3.5m. Pay expenditure was £70.8m in Month 1, generating an overspend of £2.9m in month. The month 1 position includes a £1.6m of cost relating to the industrial action. Non-pay expenditure in Month 1 is £42.5m against a plan of £42.0m, resulting in a £0.6m overspend in month.

CIP: The Trust had a £73.1m CIP target for 2026/27. At Month 1, it has delivered £1.8m of in-year savings, an under performance of £1.1m against the £2.8m target.

Capital: There was minimal capital expenditure in Month 1, there have been amendments to the plan which have reduced the planned funding and expenditure by £7.7m, due to the removal of the £7.7m expected capital receipt resulting from the sale of surplus land at the RI/COPD sites.

Statement of Financial Position: The Month 1 Statement of Financial Position shows total assets employed of £282.1m. The cash balance is £76.5m against a plan of £60.4m, details of the differences are provided within the report.

Related Strategy and Board Assurance Framework (BAF)

BAF Risk	Q1		Q2		Q3		Q4	
	Risk	Assurance	Risk	Assurance	Risk	Assurance	Risk	Assurance
BAF 6: Inability to Deliver In-Year Financial Position	Ext 20	Partial	Ext 20	Partial	High 12	Acceptable		
BAF 7: Inability to Deliver Financial Sustainability	Ext 20	Partial	Ext 20	Partial	Ext 25	Partial		

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Finance | Income and Expenditure

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

The Trust has reported a £6.5m deficit at for the 2026/27 financial year, which is a £3.5m overspend to the planned £3.0m deficit. The below table summarises the Income and Expenditure position at Month 1.

Income & Expenditure Summary Month 01 2026/27	Annual Budget £m	In Month		
		Budget £m	Actual £m	Variance £m
Income From Patient Activities	1,221.2	101.5	100.8	(0.8)
Other Operating Income	97.5	8.2	8.7	0.5
Total Income	**1,318.8**	**109.7**	**109.5**	**(0.2)**
Pay Expenditure	(807.2)	(67.9)	(70.8)	(2.9)
Non Pay Expenditure	(478.0)	(42.0)	(42.5)	(0.6)
Total Operational Costs	**(1,285.2)**	**(109.9)**	**(113.4)**	**(3.5)**
EBITDA	**33.6**	**(0.2)**	**(3.9)**	**(3.7)**
Interest Receivable	2.6	0.2	0.4	0.2
PDC	(4.8)	(0.4)	(0.4)	(0.0)
Finance Cost	(31.4)	(2.6)	(2.6)	(0.0)
Other Gains or Losses	0.0	0.0	0.0	0.0
Surplus / (Deficit)	**0.0**	**(3.0)**	**(6.5)**	**(3.5)**

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Finance | CIP

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

The Trust has a £73.1m CIP target for 2026/27. At Month 1, it has delivered £1.8m of in-year savings, which is £1.1m below the month 1 plan of £2.8m. The month 1 position includes £1.2m of non-recurrent saving which were not planned to deliver until later in the financial year. The earlier deliver of these non-recurrent CIP is mitigation part of the under delivery of recurrent schemes. The table below summaries the month 1 position.

Cash Releasing Efficiency Savings	Plan	Actual	Variance
	30/04/2026	30/04/2026	30/04/2026
	YTD	YTD	YTD
	£'000	£'000	£'000
Recurrent			
Pay - Recurrent	976	150	(826)
Non-pay - Recurrent	906	321	(585)
Income - Recurrent	948	101	(846)
Total recurrent efficiencies	**2,830**	**572**	**(2,258)**
Non recurrent			
Pay - Non-recurrent	0	0	0
Non-pay - Non-recurrent	0	1,207	1,207
Income - Non-recurrent	0	0	0
Total non-recurrent efficiencies	**0**	**1,207**	**1,207**
Total Efficiencies	**2,830**	**1,779**	**(1,051)**

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Finance | Capital

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

The tables below set out the revised 2026/27 capital plan, reflecting updates to pre-committed items following the 2025/26 outturn and other in-year changes. Committee approval is now required for the revised plan.

Total capital funding and expenditure for the full year has reduced by £7.7m, from £81.0m to £73.3m.

This is mainly driven by the removal of £7.7m capital funding linked to the sale of surplus land at the Royal Infirmary and COPD sites. There is significant uncertainty over the timing of the sale and subsequent capital receipt and therefore in order to strategically manage the capital programme we have removed this funding and the associated spend. This reduces the risk of the Trust over-committing spend against schemes in the capital programme which cannot then be fully funded in year, leading to potential slippage of essential schemes.

Should the capital receipt from the land sale be received during 2026/27 then there is a mechanism by which the Trust can apply to the NHSE for the funding to be rolled forward in part or in full to a future year, although this would need approval.

UHNM Capital Expenditure Plan	Plan 2026/27 March 2026 £m	2025/26 Outturn changes £m	2026/27 changes £m	Revised Plan 2026/27 £m
Pre-committed items - PFI and Loans				
PFI re-payment of liability	23.738	0.000	0.000	23.738
PFI lifecycle commitments	3.237	0.000	0.000	3.237
PFI Managed Equipment Scheme	1.518	0.000	0.000	1.518
Repayment of IFRS16 leases	4.608	0.000	0.000	4.608
Total PFI and IFRS16 lease repayments commitments	**33.101**	**0.000**	**0.000**	**33.101**
Pre-committed schemes				
Finance salaries	0.072	0.000	0.002	0.074
Estates salaries	0.730	0.000	0.024	0.754
IM&T salaries	0.388	0.000	0.013	0.401
AI salaries - BC	0.335	0.000	0.011	0.346
PFI enabling costs	0.200	0.000	0.000	0.200
Network & Comms BC525	1.062	0.010	0.000	1.072
LED lighting BC546	0.462	0.000	0.000	0.462
IM&T computer hardware refresh BC569	3.187	(0.060)	0.000	3.127
ED ambulance off - enabling ward moves	0.305	0.000	0.000	0.305
Endoscopy works 7th room - PDC allocation prior yrs	0.731	0.000	0.000	0.731
Completion of estates safety funding LTHW and chiller	0.745	0.000	0.000	0.745
Completion of CDC enabling	0.700	0.000	0.600	1.300
Completion of County Breast Unit	0.150	0.000	0.068	0.218
Completion of CDC IM&T	0.000	0.040	0.000	0.040
CDC pathways - 25/26 brokerage	0.720	(0.327)	0.000	0.393
CDC Endoscopy 4th room - 25/26 brokerage	1.000	0.000	0.000	1.000
Frontline digitalisation EPR 2025/26	0.400	(0.078)	0.000	0.322
Negative pressure - compliance	0.200	0.000	0.000	0.200
EPMA - outpatients	0.210	0.000	0.000	0.210
PDC physiological science brought forward	0.235	0.000	0.000	0.235
Maternity - improvement to breavement services/estate	0.129	0.000	0.000	0.129
Project Star - RI remedial work	0.000	0.010	0.000	0.010
Managing H&S risk register - BC562	0.000	0.043	0.000	0.043
Elective Hub - TBC	0.000	0.195	0.000	0.195
Pathology LIMS slippage	0.000	0.305	0.000	0.305
Royal Stoke ED healthcare planning feasibility	0.000	0.047	0.000	0.047
Central Contingency & risk	0.500	0.000	0.000	0.500
Total pre-committed schemes	**12.461**	**0.185**	**0.718**	**13.364**

UHNM Capital Expenditure Plan	Plan 2026/27 March 2026 £m	2025/26 Outturn changes £m	2026/27 changes £m	Revised Plan 2026/27 £m
Capital Planning Prioritised Schemes				
Care Group allocation - £2m additional funding	2.000	0.000	(2.000)	0.000
Stryker Power tools RemB	0.220	0.000	0.000	0.220
Operating tables x 4 for County Theatres	0.135	0.000	0.000	0.135
Respiratory Clearance Devices	0.014	0.000	0.000	0.014
Windows 11 Upgrades for Diagnostic Equipment in Neurophysiology	0.093	0.000	0.000	0.093
Screening Room - CH room 4	0.500	0.000	0.000	0.500
Micro Plastic sets	0.057	0.000	0.000	0.057
UPS Replacements	0.080	0.000	0.000	0.080
MAU Wall removal	0.014	0.000	0.000	0.014
Replacement of Echo Blood Grouping analyser	0.026	0.000	0.000	0.026
Medical Gas Equipment	0.150	0.000	0.000	0.150
Replacement of RO plant	0.200	0.000	0.000	0.200
Cardiac Cath Lan - Cardiology PACS replacement	0.020	0.000	0.000	0.020
Audiology -County soundproofing	0.630	0.000	0.000	0.630
Refurbishment of RSUH Cancer Centre Pharmacy including Cold Store	0.728	0.000	0.000	0.728
PET-CT Autoinjector	0.058	0.000	0.000	0.058
Royal Stoke road enhancements	0.300	0.000	0.000	0.300
Sedation Equipment - Capnography BC required	0.000	0.000	0.156	0.156
Heidi ambient voice technology AI solution BC required	0.000	0.000	0.377	0.377
County High-Definition Procedural Screens - X4 Rooms	0.000	0.000	0.087	0.087
Safety Works to Royal Stoke Heilipad - BC required	0.000	0.000	0.776	0.776
Total Capital Planning Prioritised Schemes	**5.225**	**0.000**	**(0.604)**	**4.621**
Other corporate schemes				
IFRS16 Lease liability re-measurement	0.200	0.000	0.000	0.200
Vehicles lease renewals	0.415	0.000	0.000	0.415
Heart Lung by-pass equipment replacement	1.500	0.000	0.000	1.500
Urology robot (lease)	0.305	0.000	0.000	0.305
Roache sakura equipment (IFRS16)	0.225	0.000	0.000	0.225
Heat Network Efficiency Scheme	0.729	0.000	0.000	0.729
Digital pathology - lease extension	0.000	0.000	0.000	0.000
Small value lease renewals/extensions	0.000	0.000	0.000	0.000
County modular theatre - lease extension or remediation costs (Feb 28)	0.000	0.000	0.000	0.000
Mammography machines - lease extension	0.000	0.000	0.000	0.000
Total Other corporate schemes	**3.374**	**0.000**	**0.000**	**3.374**

UHNM Capital Expenditure Plan	Plan 2026/27 March 2026 £m	2025/26 Outturn changes £m	2026/27 changes £m	Revised Plan 2026/27 £m
Capital sub-group (ICB allocation)				
IMT Sub Group Total Funding	1.750	0.000	0.000	1.750
2025/26 slippage	0.552	0.000	0.000	0.552
Medical Devices Sub Group	2.500	0.000	0.000	2.500
Estates Sub Group Total Funding	2.000	0.000	0.000	2.000
Estates safety - additional allocation	1.694	0.000	0.000	1.694
Health & Safety compliance	0.150	0.000	0.000	0.150
Net zero carbon (sustainability) initiatives	0.000	0.000	0.000	0.000
Total Capital Sub-Groups	**8.646**	**0.000**	**0.000**	**8.646**
Total Internal Capital Expenditure	**29.706**	**0.185**	**0.114**	**30.005**
Funding to allocate/(shortfall)	8.578	0.163	(8.079)	0.662
Total Operational Capital/internally funded expenditure	**71.385**	**0.348**	**(7.965)**	**63.768**
Externally Funded PDC				
PDC Constiutional standards Royal Stoke UTC Estates	2.694	0.000	0.000	2.694
PDC Constiutional standards Royal Stoke UTC Digital	0.616	0.000	0.000	0.616
PDC Constitutional Standards Stoke Discharge Lounge	0.300	0.000	0.000	0.300
PDC Constituional Standards UTC County	2.100	0.000	0.000	2.100
PDC Constiutional standards Urgent Emergency Care	0.000	0.000	0.000	0.000
PDC Constitutional Standards Mental Health ED	0.000	0.000	0.000	0.000
PDC Constituional Standards Interventional radiology 3	2.600	0.000	0.000	2.600
PDC Pathology LIMS	1.300	0.000	(0.030)	1.270
Total Additional CRL / PDC Funded expenditure	**9.610**	**0.000**	**(0.030)**	**9.580**
Total Capital Expenditure	**80.995**	**0.348**	**(7.995)**	**73.348**

UHNM Capital Funding Plan	Plan 2026/27 March 2026 £m	2025/26 Outturn changes £m	2026/27 changes £m	Revised Plan 2026/27 £m
Total PFI and IFRS16 lease repayments commitments	33.101	0.000	0.000	33.101
Total ICB capital allocation	26.051	0.000	0.000	26.051
Elective Care Capital Incentive Scheme - RTTS	2.000	0.000	0.000	2.000
PDC Estates Safety	1.694	0.000	0.000	1.694
PDC Constiutional standards Urgent Treatment Centre	3.310	0.000	0.000	3.310
PDC Constitutional Standards Stoke Discharge Lounge	0.300	0.000	0.000	0.300
PDC Constitutional Standards UTC County & discharge	2.100	0.000	0.000	2.100
PDC Constiutional standards Urgent Emergency Care	0.000	0.000	0.000	0.000
PDC Constitutional Standards mental health ED	0.000	0.000	0.000	0.000
PDC Constitutional Standards Interventional radiology 3	2.600	0.000	0.000	2.600
PDC Pathology LIMS	1.300	0.000	(0.030)	1.270
Land disposal - RI/COPD	7.700	0.000	(7.700)	0.000
Other disposals	0.425	0.000	0.000	0.425
Charitable funds	0.000	0.000	0.000	0.000
Internal resources capital to revenue	0.400	0.000	(0.400)	0.000
Internal resources - VAT and accruals release	0.014	0.348	0.135	0.497
Total capital funding	**80.995**	**0.348**	**(7.995)**	**73.348**
Funding to be allocated/(shortfall)	**0.000**	**0.000**	**0.000**	**0.000**

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Finance | Balance Sheet

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

Statement of Financial Position	31/03/2026	30/04/2026		
	Actual £m	Plan £m	Actual £m	Variance £m
Property, Plant & Equipment	732.3	731.6	732.0	0.4
Right of Use Assets	21.8	21.7	21.7	(0.0)
Intangible Assets	12.1	14.2	14.2	(0.0)
Trade and other Receivables	1.0	1.1	1.0	(0.1)
Total Non Current Assets	**767.3**	**768.6**	**768.9**	**0.3**
Inventories	21.4	21.4	21.2	(0.3)
Trade and other Receivables	51.2	47.7	45.4	(2.3)
Asset held for sale	7.7	7.7	7.7	-
Cash and Cash Equivalents	88.1	60.4	76.5	16.0
Total Current Assets	**168.4**	**137.2**	**150.7**	**13.4**
Trade and other payables	(136.9)	(106.3)	(123.8)	(17.5)
Borrowings	(28.8)	(28.8)	(28.7)	0.1
Provisions	(1.1)	(1.1)	(1.1)	-
Total Current Liabilities	**(166.7)**	**(136.1)**	**(153.5)**	**(17.4)**
Borrowings	(482.2)	(480.6)	(480.6)	(0.0)
Provisions	(3.4)	(3.4)	(3.4)	-
Total Non Current Liabilities	**(485.7)**	**(484.0)**	**(484.0)**	**(0.0)**
Total Assets Employed	**283.3**	**285.8**	**282.1**	**(3.7)**
Financed By:				-
Public Dividend Capital	775.6	775.6	775.6	-
Retained Earnings	(692.0)	(694.1)	(697.8)	(3.7)
Revaluation Reserve	199.7	204.3	204.3	-
Total Taxpayers Equity	**283.3**	**285.8**	**282.1**	**(3.7)**

Highlight Report

AUDIT COMMITTEE | 30th April 2026

NHS
University Hospitals of North Midlands
NHS Trust

Matters of Concern / Key Risks to Escalate	Major Actions Commissioned / Work Underway
• 73 **internal audit actions** were continuing to be monitored of which 20 had been delayed/problematic, as such **partial assurance** was provided. Updates were provided in relation to the actions being taken to close the actions which had remained open for some time. • The number of overdue **policies** had increased slightly to 28 since the previous meeting, despite 10 policies having been received since the previous meeting a dual rating of **partial assurance** for compliance versus **acceptable assurance** for the processes in place, was agreed. • **Cyber security assurance** report provided **partial assurance** reflecting known gaps in technical debt, privileged access management, and cyber resilience. While strong governance arrangements and regular independent assessments were in place, progress in closing these gaps was constrained by financial capacity. The Committee discussed whether the current pace of mitigation was sufficient given the Trust's low risk appetite for cyber security, noting that although the risk appetite was clearly defined, the organisation cannot yet fully quantify or manage its residual risk.	• The cost of retrospective clinical safety reviews for high-risk **shadow IT systems** to be weighed against the potential safety, financial, and operational risks of inaction to inform the Trust's risk assessment. • Future **internal audit action** tracking reports to highlight which actions had become further overdue since the last meeting and provide confidence on delivery of all remaining actions. • Future reporting on **out of date policies**, to include policies at risk of becoming overdue before the next meeting, alongside a review of whether the policy timetable starts early enough to prevent slippage.

Positive Assurances to Provide	Decisions Made
• Return rates for **declarations of interest** stood at 80% as at April 2026. • 3 **internal audits** had been finalised, 2 of which received **substantial assurance** (DBS checks and BAF/Risk Management) and 1 with **reasonable assurance** (HR record keeping). 2 audits were being finalised which would complete the 2025/26 internal audit plan. • The draft **annual internal audit report** concluded with the opinion that the Trust has an **adequate and effective framework** for risk management, governance and internal control. • The Committee agreed with an **acceptable assurance** rating for the process undertaken to review and update the **Board Assurance Framework** for Q4. • **Acceptable assurance** was provided by the **local counter fraud annual report and conflicts of interest review,** with strong assurance in relation to proactive counter fraud activity, effective management of referrals, and a green rating across all functional standards, including the failure to prevent fraud offence. The Committee was assured by the growing use of automated checks, which identified a small number of declarations requiring follow-up and potential overlaps between staff and suppliers • The **draft financial statements** 2025/26 had been submitted in line with statutory reporting deadlines and an update was provided on the Trust's key statutory duties. As such **significant assurance** was provided. • £1.7 m of **losses and special payments** were reported for the year 2025/26 and **acceptable assurance** was agreed in relation to the processes in place. • The Committee received an update on **Standing Financial Instruction** (SFI) breaches and overpayments, noting an increase primarily linked to delays in processing termination and change forms. The adequacy of existing controls was discussed, alongside opportunities to strengthen processes, including the potential use of automation and AI. The Committee agreed that, while improvement is required, the current level of control provided **acceptable assurance**, subject to ongoing monitoring and process enhancement.	• The Committee approved the 2026/27 **Internal Audit Plan** subject to further consideration by the Executive regarding possible inclusion of transformation (wider than cost improvement) and artificial intelligence, as well as consideration of what cross cutting themes could be considered in each audit. • The **Terms of Reference** were approved. • The Committee approved and recommended the proposed **bad debt** write-offs of £555,000, to the Trust Board.

Comments on the Effectiveness of the Meeting	Cross Committee Considerations
• Comments on effectiveness were sought via MS Forms.	• **Shadow IT** report being considered by Finance and Business Performance with regular reporting introduced.

Summary Agenda

No.	Agenda Item	BAF Mapping			Purpose	No.	Agenda Item	BAF Mapping			Purpose
		BAF No.	Risk	Assurance				BAF No.	Risk	Assurance	
1.	Audit Action Tracker	Various		Partial	Assurance	8.	Committee Effectiveness 2025/26	-		Not applicable	Approval
2.	Corporate Governance Report	Various		Acceptable Partial	Assurance	9.	Draft Annual Report 2025/26	-		Not applicable	Information
3.	Internal Audit Progress Report: • HR Record Keeping – Disciplinary Records • DBS Check Process • Risk Management / BAF	Various		Reasonable Substantial Substantial	Assurance	10.	LCFS 2025/26 Annual Report Conflicts of Interest (COI) Review	-		Not assessed	Assurance
4.	Draft Annual Internal Audit Report 2025/26	All		Adequate	Assurance	11.	Draft Annual Accounts 2025/26	6, 7	9 25	Not applicable	Information
5.	2026/27 Internal Audit Plan	All		Not applicable	Approval	12.	Losses and Special Payments Update Q4 2025/26	6,7	9 25	Acceptable	Approval Assurance
6.	Cyber Security Assurance Report	4	Ext 16	Partial	Assurance	13.	SFI Breaches and Single Tender Waivers Q4 2025/26	6,7	9 25	Acceptable	Assurance
7.	Board Assurance Framework Q4 2025/26	All		Acceptable	Assurance		SFI Breaches related to Late Termination and Change Forms Q4 2025/26	6,7	9 25	Acceptable	Assurance

Executive Summary

Trust Board (Part 1) | 10th June 2026

Fit and Proper Persons Annual Assurance 2025/26

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**		**Assurance**	✓	**Agenda Item:**	
Author:	Nicola Hassall, Deputy Director of Governance							
Lead:	Jackie Small, Chair							

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

Risk Register Mapping
No associated risks

Executive Summary

Situation

This paper provides the annual assurance on the application of the Fit and Proper Persons Test (FPPT) for 2025/26, in line with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and Trust Policy G27. It confirms whether Board members meet the required standards of integrity, competence, and professional conduct, and supports the Trust's annual declaration to NHS England.

Background

The Trust operates a comprehensive FPPT framework, including:

- Annual and on-appointment checks for all Board members
- Independent external assurance checks (Gatenby Sanderson)
- Completion of Board Member references for leavers

During 2025/26 22 Board members were in scope, with 18 subject to annual review following leavers and a secondment.

Assessment

All required checks have now been completed, including:

- Self-attestations, DBS checks, appraisal confirmation and internal assurance checks
- Independent external checks covering good character, financial standing, and professional registration

No concerns have been identified through:

- Internal processes
- External assurance checks
- Senior review by the Chair, Chief Executive and Senior Independent Director

Key Recommendations:

The Trust Board is asked to:

1. Note the outcome of the 2025/26 FPPT assurance process
2. Take assurance that appropriate systems and processes are in place and operating effectively
3. Confirm that all in-scope Board members meet the FPPT requirements
4. Approve submission of the annual declaration to NHS England

Fit and Proper Persons Annual Assurance Report 2025/26

May 2026

University Hospitals of North Midlands NHS Trust

1. Background

As per Trust Policy G27 Fit and Proper Persons (FPPT), checks are undertaken for all Board Members (substantive, interim and those on secondment to other organisations) on an annual and on-appointment basis. In addition, for any Board Members leaving the Trust, Board Member References are completed.

During the period 1 April 2025 to 31 March 2026, 22 Board members were in scope for consideration. Of these:

- 3 Board members left prior to the commencement of the annual review process
- 1 Board member was on secondment, with tenure concluding 31 March 2026 therefore their 2025 checks remained valid

Accordingly, 18 Board members were subject to the 2025/2026 annual assurance process.

2. Annual Assurance Checks

Annual checks were undertaken between January and April 2026.

The Deputy Director of Governance obtained the following for each applicable Board member:

- Fit and Proper Person Signed Self-Attestation
- DBS Disclosure (undertaken every 3 years)
- Confirmation of any Disciplinary Findings or Grievances (gross misconduct, serious misconduct or mismanagement)
- Confirmation of any Whistleblowing / Speaking Up concerns
- Confirmation of last appraisal
- Confirmation of annual training and development (Executives only)

Position at year-end:

- Self-attestations: 18 / 18 complete
- DBS checks: 18 / 18 compliant (with 3 due for renewal during 2026/27)
- Appraisals: All applicable Board members completed
- Remaining checks (Employee Relations / Speaking Up / training compliance): completed and verified with no matters of concern identified.

3. External Assurance Checks

Following agreement by the Nomination and Remuneration Committee, Gatenby Sanderson was utilised to undertake independent checks.

Consistent with the approach agreed in 2025:

- 17 annual external checks were completed NB. For the remaining Board member their full checks were undertaken on appointment and therefore were not duplicated.

Checks covered:

Good Character

- Social media screening across major platforms
- Disqualified Directors Register check
- Charity Commission Removed Trustees register

Financial Soundness
- Insolvency and bankruptcy checks
- UK civil litigation (including employment tribunals)

7
Professional Registration
- GMC, NMC and Chartered Accountancy registration (where applicable)

The outcomes of these checks were reviewed by the Deputy Director of Governance and provided to:
- The Chair (for Chief Executive and Non-Executives)
- The Chief Executive (for Executives)

Each was asked to confirm:
- Whether they were aware of any behaviours inconsistent with Trust values or policies
- Whether they were aware of any relevant settlement agreements

No concerns were identified through these checks.

4. On Appointment Checks

The following checks are undertaken prior to a Board member commencing in post. During 2025/26 these were completed for the Chief Medical Officer.

Checks include:
- Full employment checks (CV, references, right to work, qualifications, occupational health, etc.)
- Board Member References
- Declaration of Interests
- Signed FPPT Self-Attestation
- DBS Disclosure
- Professional registration checks (Executives)
- Financial, insolvency and disqualification checks
- Social media screening

5. Board Member References

During 2025/26, 5 Board Member References were completed and retained on file for leavers:
- Lisa Thomson – Director of Communications (1 June 2025)
- Gary Crowe – Non-Executive Director (31 August 2025)
- Andrew Hassell – Associate Non-Executive Director (31 January 2026)
- Matthew Lewis – Chief Medical Officer (31 March 2026)
- Louise Bainbridge – Non-Executive Director (31 March 2026)

6. Disclosure and Barring Service Checks

Following previous Committee and Board discussions, and external advice received during 2025, the Trust has maintained a proportionate approach to DBS screening.

Enhanced DBS checks apply to:
- Chair
- Chief Executive
- Chief Digital Transformation Officer
- Chief Medical Officer
- Chief Nurse
- Chief Operating Officer

Standard DBS checks apply to all other Board members.

7. Outcome of the Annual Fit and Proper Persons Checks

Following completion of all annual and on-appointment checks:

- 18 / 18 in-scope Board members have been confirmed as fit and proper
- No issues of concern were identified through:
    - self-declarations
    - internal checks
    - external assurance processes

Confirmation has been:

- Reviewed and agreed by the Chair, Chief Executive and Senior Independent Director (as applicable)
- Recorded on ESR
- Supported by evidence retained within individual personnel files

Overall, the Trust is compliant with the Fit and Proper Persons Regulations for 2025/26.

8. Independent External Review (2025/26)

During 2025/26, the Trust commissioned an independent investigation following a concern raised via an external avenue. The investigation, undertaken by an external provider (Ibex Gale), commenced in August 2025 and concluded with a final report issued in November 2025, with the overall conclusion that no findings were identified requiring further action in relation to individual fitness to hold office. A small number of process improvements were identified which have been implemented to further strengthen the robustness and consistency of the Trust's FPPT arrangements. In line with national requirements, a summary of the review, including key dates and actions taken, will be included within the Trust's submission to NHS England.

9. Conclusion

The Trust has undertaken a robust and comprehensive Fit and Proper Persons assurance process during 2025/26, aligned to both regulatory requirements and best practice.

All required checks have been completed, with external validation supporting the assessment of Board members integrity, professional standing and financial probity. No matters of concern have been identified.

10. Recommendations

The Trust Board is asked to:

1. Note the contents of the report
2. Take assurance that the Fit and Proper Persons Test has been appropriately applied for 2025/26
3. Confirm that all in-scope Board members meet the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
4. Approve submission of the annual FPPT return to NHS England

Executive Summary

Trust Board (Part 1) | 10th June 2026

Board and Committee Effectiveness Review and Governance Framework Update (2025/26)

University Hospitals of North Midlands NHS Trust

Purpose:	**Information**		**Approval**	✓	**Assurance**	✓	**Agenda Item:**	16.
Author:	Nicola Hassall, Deputy Director of Governance							
Lead:	Claire Cotton, Director of Governance & Communications							

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

Risk Register Mapping		
	No associated risks	

Executive Summary:

Situation

The annual Board Effectiveness Evaluation and Committee Effectiveness Reviews for 2025/26 have been completed. The purpose of these reviews is to provide the Trust Board with assurance regarding the effectiveness of its leadership, governance and oversight arrangements, and to identify targeted opportunities for continuous improvement in line with the NHS Code of Governance and the NHS England Well-Led Framework.

Background

The reviews were undertaken using structured, evidence-based approaches:

- The Board evaluation was conducted through an anonymised questionnaire aligned to the Insightful Board framework, covering strategic leadership, quality oversight, culture, information and system working.
- Committee effectiveness reviews were undertaken across all Board Committees, incorporating feedback on effectiveness, attendance, governance arrangements and forward planning.

Both processes:

- included strong participation from Board and Committee members.
- combined quantitative and qualitative feedback.
- have identified improvement actions which are to be embedded into forward plans and governance arrangements.

The Rules of Procedure form part of the Trust's governance architecture alongside Standing Orders, Standing Financial Instructions (SFIs) and the Scheme of Reservation and Delegation of Powers, and have been reviewed to ensure continued alignment.

Assessment

Overall Position

The findings from both reviews provide strong assurance that the Trust Board and its Committee structure are operating effectively, with:

- high levels of engagement and attendance
- a positive and values-led culture
- effective governance and assurance arrangements

The feedback across both reviews is predominantly developmental rather than corrective, indicating a mature governance framework with a clear focus on continuous improvement.

Board Effectiveness – Key Findings

The evaluation demonstrates that the Board is:

- effective and well-led, with strong confidence in culture, strategic intent and assurance discipline.
- values-led, with high levels of psychological safety, constructive challenge and inclusive behaviours.
- strategically engaged, with strong involvement in shaping the Trust's long-term direction and priorities.

Key areas of strength include:

- strong Board culture and behaviours, with very high levels of positive feedback.
- effective oversight of quality and patient safety, supported by clear escalation arrangements.
- improving quality of Board information and Committee assurance, supporting decision-making.

Committee Effectiveness – Key Findings

The Committee structure is assessed as operating effectively, providing robust assurance to the Board. Consistent strengths across Committees include:

- strong and effective leadership and chairing.
- an open, inclusive and psychologically safe culture supporting constructive challenge.
- high-quality scrutiny and assurance, including effective triangulation of information.
- well-structured papers and meetings, supporting informed discussion and decision-making.
- strong Executive engagement and transparency.

Attendance across Committees was strong and, alongside the proportion of positive responses, shows improvement compared to the previous year.

Key Cross-Cutting Development Themes

While overall effectiveness is strong, both reviews identify a small number of consistent, high-impact areas for further development:

1. Strengthening Line-of-Sight from Strategy to Delivery

- Greater visibility of milestones, key performance indicators and benefits realisation.
- Stronger linkage between strategy, the Board Assurance Framework and system priorities.
- Enhanced forward-looking scenario planning.

2. Enhancing Quality, Triangulation and Insight in Information

- Continued improvement in the synthesis and clarity of Board and Committee papers.
- Greater use of triangulated data to support insight and decision-making.
- Clearer differentiation between assurance, decision and information.

3. Elevating Patient Experience and Population Impact

- More systematic triangulation of patient experience, complaints and staff insight.
- Stronger focus on population outcomes and system impact alongside safety and performance.

4. Strengthening Strategic Focus and Forward Planning

- Increased use of structured forward plans, deep dives and horizon scanning.
- Greater emphasis on strategic discussion within Board and Committees.

5. Embedding and Extending Board Culture

- Continuing to embed the Board's positive, values-led culture across the wider organisation.
- Ensuring visibility of leadership behaviours during periods of transformation.

6. Strengthening Accountability and Assurance Clarity

- Clearer articulation of assurance levels, risks and gaps.
- Stronger ownership and delivery of actions across Committees.

Governance Framework and Rules of Procedure

The revised Rules of Procedure have been developed to:

- reflect learning from the effectiveness reviews, including revised Terms of Reference
- enhance clarity of decision-making, assurance and risk reporting
- ensure full alignment with Standing Orders, SFIs and the Scheme of Reservation and Delegation

The revisions strengthen:

- clarity of Board and Committee roles and responsibilities
- consistency of agenda structure and decision-making requirements

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

Key Recommendations:

The Trust Board is asked to:

1. **Note** the findings of the Board Effectiveness Review
2. **Note** the findings of the Committee Effectiveness Reviews
3. **Approve** the revised Rules of Procedure
4. **Endorse** the proposed actions to further strengthen governance arrangements

University Hospitals of North Midlands NHS Trust

Board Effectiveness Evaluation

Summary 2025/26

Kind Excellent Together

Introduction

University Hospitals of North Midlands NHS Trust

This report presents the findings of the 2026 Board Effectiveness Evaluation and provides assurance to the Trust Board on the effectiveness of its leadership, governance and oversight arrangements. The evaluation supports our responsibilities under the NHS Code of Governance and the NHS England Well-Led Framework and contributes to ongoing self-assessment and continuous improvement of Board effectiveness.

- The review was undertaken using a structured questionnaire aligned to the Insightful Board framework.
- The report summarises areas of strength, identifies opportunities for further development, focussing on the effectiveness of the unitary Board, and proposes proportionate improvement actions.
- Board effectiveness through the lens of the Trust's Strategy, the best joined-up care for *all*, and the three strategic priorities of Our People, Our Patients and Our Population has been considered. The evaluation therefore reflects not only how effectively the Board operates, but how well it enables integration, system leadership and joined-up decision-making in support of these priorities.

Executive Summary

University Hospitals of North Midlands NHS Trust

The Board is effective and well-led, with strong confidence in culture, strategic intent and assurance discipline. The evaluation is developmental, identifying a small number of priority areas to strengthen line-of-sight, integration and forward-looking oversight.

Key Strengths

- Values-led culture and constructive challenge.
- Strong strategic intent and Board engagement in strategy.
- Improving quality of information and committee assurance.

Priority Development Areas

- Strategy delivery assurance and scenario planning.
- Elevating patient experience and population impact.
- Clearer synthesis and insight in Board information

So What…

- Focus on fewer, higher-impact improvements embedded into Board development, BAF oversight and committee assurance.

Methodology

University Hospitals of North Midlands NHS Trust

- The Board Effectiveness Evaluation was conducted through a confidential, anonymised questionnaire circulated to all Trust Board members.

- The questionnaire was designed to reflect the core domains of the Insightful Board, including:
  - Strategic leadership and system alignment
  - Quality, safety and patient experience oversight
  - Population health, access and equity
  - Culture, behaviours and Board dynamics
  - Information quality, assurance and decision-making
  - External partnership working and system leadership

- The evaluation combined quantitative ratings (using a standard agreement scale) and qualitative free-text responses to capture insight, nuance and examples. Free-text themes are presented in this report in aggregate to preserve anonymity.

- All Board Members participated, providing a representative view across executive and non-executive perspectives and enabling robust thematic analysis.

Overall Assessment

University Hospitals of North Midlands NHS Trust

- High overall Board effectiveness and compliance with Well-Led expectations
- Strong culture, constructive challenge and strategic engagement
- Assurance discipline is maturing but inconsistent in places
- Board is self-aware and receptive to development

Overall, this evaluation provides assurance, with findings that are predominantly developmental rather than corrective.

	Strategic Leadership & Direction	Quality, Safety, Patient Experience & Access	Board Culture & Behaviours	Board Information, Papers & Insight	System Leadership & Partnership
Number of Positive Responses (≈)	81%	73%	94%	84%	94%

NB. Percentages are the approximate proportion of respondents selecting Agree/Strongly Agree across questions within each domain.

Strategic Alignment of Findings

University Hospitals of North Midlands NHS Trust

Our People

- Strong assurance that the Board is effective in setting and role-modelling a positive, inclusive and compassionate culture.
- Board members recognised the value of Board development, visible leadership and time spent on culture, wellbeing and leadership behaviours.
- Opportunities for further strengthening in relation to future workforce planning, skills development and the visibility of workforce transformation at system level.

Our Patients

- Strong arrangements in place for the oversight of quality and patient safety, with clear escalation routes and effective use of safety intelligence.
- Confidence in the Board's oversight of harm, risk and compliance requirements.
- Further development to strengthen the Board's use of patient experience intelligence, particularly triangulation of complaints, feedback and softer intelligence to identify emerging themes

Our Population

- Positive endorsement of the Board's intent and direction on population health, prevention and system working.
- Recognised improvements in partnership working and alignment with system priorities.
- Opportunity to strengthen how the Board evidences its impact on population outcomes through clearer targets, improved data and greater visibility of system-level delivery.

Strategic Leadership and Direction

University Hospitals of North Midlands NHS Trust

Board Assurance

- The Board provides effective strategic leadership in shaping the Trust's vision, purpose and long-term direction.
- There is strong confidence in the development and approval of The Best Joined-Up Care for *All*.
- The Board demonstrates active engagement in shaping enabling strategies and long-term ambition.

≈ 81% positive responses

Evidence

- Quantitative responses show a high level of agreement on the Board's effectiveness in strategic leadership.
- Qualitative feedback was consistent across Executive and Non-Executive Directors, particularly highlighting the value of Board development sessions and challenge prior to strategy approval.
- Respondents identified a clear sense of shared purpose and strategic coherence across people, patients and population priorities.

> ***"The production of the UHNM Strategy, setting out our long-term ambition 'The best joined-up care for all', has given the organisation a clear identity and shared purpose."***

> ***"Board development sessions have been intrinsic to shaping the strategy and have kept the conversation live and active at Board level."***

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Strategic Leadership and Direction

University Hospitals of North Midlands NHS Trust

Areas for Development

- Limited visibility of milestones, KPIs and benefits realisation
- Weaker line-of-sight between strategy, BAF and system priorities
- Need for structured horizon scanning (5-10 years)
- Clearer articulation of future operating and system models
- Less consistent Board-level visibility of regulatory delivery and assumptions

> ***The overall strategy has been published, but without detailed milestones and KPIs we cannot yet be assured about delivery or alignment with the wider system***

> ***There is a lot going on internally and it can be hard to see the wood for the trees – greater clarity on priorities at any moment in time would help.***

Opportunity: Strengthen Board-level line-of-sight between strategic ambition, delivery plans, system dependencies and assurance, including clearer milestones, KPIs and forward-looking scenario planning.

Quality, Safety, Patient Experience & Access Oversight

University Hospitals of North Midlands NHS Trust

Board Assurance

- The Board has effective and mature arrangements in place to oversee quality and patient safety.
- There is confidence in escalation routes and the Board's visibility of key safety risks.
- Safety governance provides a strong platform for assurance and regulatory oversight.

≈ 73% positive responses

Evidence

- Quantitative responses indicate strong confidence in the Board's oversight of patient safety and quality.
- Feedback consistently referenced effective Committee assurance, internal safety intelligence and clear escalation mechanisms.
- Confidence in safety oversight was notably stronger and more consistent than in other aspects of quality assurance.

> ***"As a Board we regularly receive assurance around patient safety, and I am confident we have the systems to escalate safety concerns to the Board."***

Quality, Safety, Patient Experience & Access Oversight

University Hospitals of North Midlands NHS Trust

Areas for Development

- Patient experience less systematically triangulated than safety
- Limited integration of complaints, Datix, feedback and staff insight
- Concern that Board-level narratives may feel curated

Opportunity: Embed patient experience and access as core components of Board assurance, ensuring triangulated insight is considered alongside safety, performance and finance.

> ***I'm less convinced that we are able to escalate patient experience concerns in a systematic or triangulated way.***

> ***We could better understand the patient journey across multiple disciplines, and use complaints, staff feedback and Datix together to identify emerging safety and experience issues.***

Board Culture, Behaviours and Dynamics

University Hospitals of North Midlands NHS Trust

Board Assurance

- Board culture is one of the Trust Board's clearest strengths.
- The Board role-models inclusive, compassionate and values-led behaviours.
- Constructive challenge and psychological safety are well-established.

≈ 94% positive responses

Evidence

- Very high levels of agreement were recorded across all culture-related questions.
- Qualitative feedback was highly consistent between Executive and Non-Executive Directors.
- Respondents repeatedly highlighted trust, honesty and respectful challenge as defining features of Board dynamics.

> ***"Over the past 12 months the Board has really embedded a culture of psychological safety and kindness – this should remain a visible and non-negotiable priority."***

> ***"There is honesty and openness between the executives and the Board – challenge is welcomed and responded to positively."***

Board meetings – summary feedback

Informal feedback gathered throughout 2025/26 indicates that Board meetings were consistently well chaired, constructive and values-led, with open discussion and appropriate challenge. Members valued the focus on strategic and assurance issues, effective use of Committee highlight reports, and high-quality Board development sessions. Areas for refinement related primarily to meeting mechanics and agenda management, including time allocation, handling of public questions, paper navigation and managing full agendas, rather than the effectiveness of governance or decision-making.

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Board Culture, Behaviours and Dynamics

University Hospitals of North Midlands NHS Trust

Areas for Development

- Translating Board culture into lived organisational experience
- Reinforcing positive behaviours during transformation
- Maintaining connection, visibility and feedback loops

Opportunity: Extend the positive Board culture beyond the Boardroom, ensuring behaviours modelled at Board level are consistently experienced across the organisation during periods of change.

> ***We do well as a Board in isolation but sometimes struggle to get this message across beneath the Board.***

Board Information, Papers and Insight

University Hospitals of North Midlands NHS Trust

Board Assurance

- The quality of Board and Committee papers has improved significantly.
- Committee assurance and reporting arrangements effectively support Board oversight.
- Information generally provides a good platform for decision-making and challenge.

≈ 84% positive responses

Evidence

- Quantitative feedback indicates strong and improving confidence in paper quality.
- Respondents consistently referenced clearer executive summaries and recommendations.
- Committee Highlight Reports were widely recognised as an effective assurance mechanism for escalation and oversight.

> ***Most papers are now very concise and easy to digest, and things have improved greatly since I started as a NED.***

> ***"Executive summary templates provide clear framing, strategic alignment and risks."***

Board Information, Papers and Insight

University Hospitals of North Midlands NHS Trust

Areas for Development

- Volume and synthesis
- Analytical depth and triangulation
- Clarity of purpose (assurance / decision / information)

Opportunity: Improve the consistency of synthesis, triangulation and analytical insight in Board and Committee information, ensuring papers consistently support forward-looking discussion and decision-making.

> ***We get lots of detail, which is fine if you see it all the time, but we could do better at summarising and providing genuine insight into what the data is telling us.***

> ***There are times where data is presented without analysis – more use of data and interpretation would help underpin decision-making.***

System Leadership and Partnership Working

University Hospitals of North Midlands NHS Trust

Board Assurance

- The Board's approach to system engagement and partnership working has strengthened.
- Relationships with system partners are more constructive and collaborative.
- There is clear recognition of the Trust's role as a system partner, not just an acute provider.

≈ 94% positive responses

Evidence

- Quantitative responses show high confidence in the Board's intent and approach to system working.
- Qualitative feedback consistently referenced improved relationships and engagement by Executives and Non-Executive Directors.
- Respondents recognised progress over the past 12 months, particularly in tone and visibility.

> ***"There is an enhanced level of importance being given to relationships with partners – doing more of this, not less, is working well.***

> ***Board and individual executives work well with the ICS, especially with changed leadership at system level."***

System Leadership and Partnership Working

University Hospitals of North Midlands NHS Trust

Areas for Development

- Board sees engagement, not always the impact
- Limited visibility of outcomes, shared accountability and benefit

Opportunity: Enhance Board-level oversight of system working by strengthening visibility of impact, shared accountability and system-level outcomes for the population.

> ***"Not enough evidence has been provided at Board level to understand the impact of joint working with provider collaboratives – there is very little data."***

> ***"We need to share system risk in the same way we shared ED risk internally – with agreed KPIs and a mapped journey so the system absorbs the challenge collectively."***

Improvement Actions

University Hospitals of North Midlands NHS Trust

Focus Area	Board Development Action	Action Owner
Strategic Leadership & Direction	By September 2026, the Board will approve and oversee a structured annual programme of strategic delivery assurance, including: • clear milestones, KPIs and benefits realisation for each strategic programme; • explicit alignment to the BAF and system priorities; • consideration of a board development session on horizon scanning and scenario planning over a 5–10 year timeframe	Director of Strategy
Quality, Safety, Patient Experience & Access	By December 2026, the Board will implement a standard approach to Board-level patient experience assurance, ensuring: • routine triangulation of patient experience, complaints, staff feedback and Datix intelligence; • explicit consideration of patient experience and access within Board discussions alongside safety, finance and performance; • clarity on escalation routes to Board and Committees where emerging experience-related risks are identified.	Chief Nurse
Board Culture, Behaviours & Dynamics	During 2026/27, the Board will extend its values-led culture beyond the Boardroom by: • embedding culture, behaviours and psychological safety as a standing theme within the Board development programme; • receiving at least one annual assurance discussion on how Board behaviours and leadership expectations are being experienced across the organisation during transformation.	Chief People Officer
Board Information, Papers & Insight	By October 2026, the Board will agree and embed refined and consistent standards for Board and Committee reporting, requiring: • clear differentiation between assurance, decision and information items; • improved synthesis and analytical commentary within executive summaries; • routine use of triangulated data to support forward-looking Board discussion.	Director of Governance & Communications
System Leadership & Partnership Working	By March 2027, the Board will enhance its oversight of system leadership and partnership working by: • agreeing a small number of shared system outcomes and indicators relevant to the Trust's strategic priorities; • receiving periodic (at least annual) Board-level assurance on the impact of partnership working, including shared risks, dependencies and benefits for the population.	Director of Strategy

Delivery will be overseen through Board development, the well-led action plan, the BAF and relevant Committee assurance routes.
Impact will be reviewed through improvements in Board assurance visibility (milestones and KPIs), triangulation of patient experience, and clarity and synthesis of Board information

Conclusion

University Hospitals of North Midlands NHS Trust

- The 2026 Board Effectiveness Evaluation provides assurance that the Trust Board is operating effectively and in line with NHS Well-Led expectations. Across all six thematic areas, the evaluation highlights a Board that is values-led, strategically engaged and increasingly mature in its assurance role, with strengths in culture, constructive challenge and clarity of purpose.

- The feedback received is primarily developmental rather than corrective, with consistent themes focused on improving line-of-sight, integration and maturity, rather than addressing fundamental weaknesses. The Board's task is therefore to build on a strong foundation and focus on a small number of high-impact improvements that will strengthen effectiveness as complexity, transformation and system dependency increase.

Conclusion

University Hospitals of North Midlands NHS Trust

Board Focus – 2026/27

- Strengthening the link between strategy, delivery and assurance
- Deepening strategic foresight and scenario planning
- Elevating patient experience and population impact within assurance
- Continuing to refine information quality and insight
- Translating Board culture into organisational impact

These priorities will be embedded into board development, the well-led action plan and BAF.

University Hospitals of North Midlands NHS Trust

Committee Effectiveness Reviews

Summary 2025/26

Kind Excellent Together

Introduction

University Hospitals of North Midlands NHS Trust

This report presents the findings of the 2026 Committee Effectiveness review and provides assurance to the Trust Board on the effectiveness of its Committees. The evaluation supports our responsibilities under the NHS Code of Governance and the NHS England Well-Led Framework and contributes to ongoing self-assessment and continuous improvement of Board and Committee effectiveness.

- Annual review undertaken in line with the Trust's Rules of Procedure and best practice requirements for Board Committees covering committee effectiveness, forward business cycle planning, and any proposed updates to the Terms of Reference.

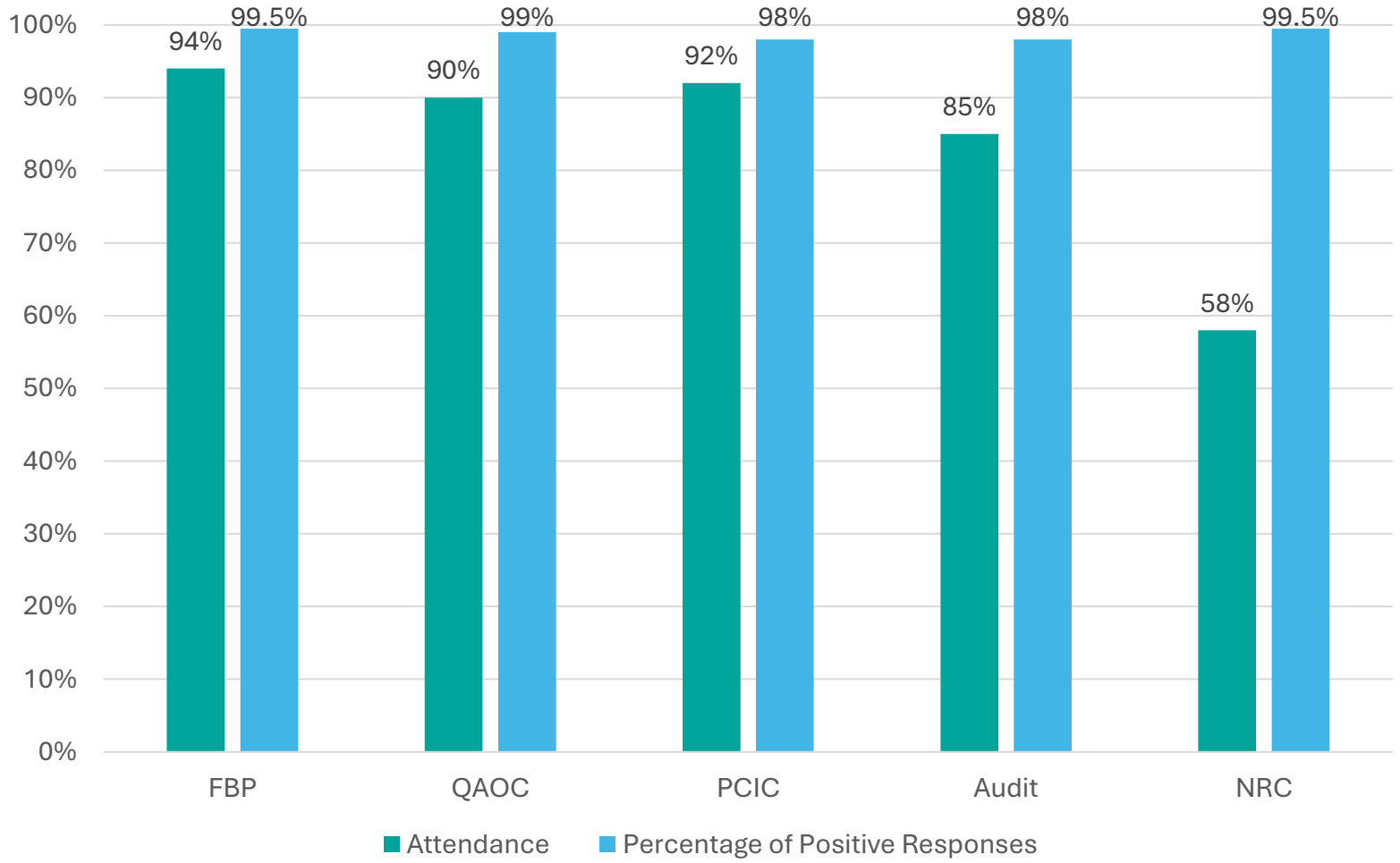
- An annual summary of the Committee's work has also been prepared to capture delivery and achievements over the year.

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

Comparison of Committee Attendance | Committee Effectiveness Responses

University Hospitals of North Midlands NHS Trust

Attendance for all but the Nomination & Remuneration Committee, was above the expected 75% attendance rate for the year (although it should be noted that all meetings were quorate). In addition, the percentage of positive responses for all Committees was better than the 2024/25 reviews.



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Committee Effectiveness - Key Strengths

University Hospitals of North Midlands NHS Trust

Strong and Effective Leadership

- Committee Chairs are consistently recognised as highly effective, visible and approachable, providing clear structure and direction
- Meetings are well chaired and well managed, balanced between pace and depth of discussion

Open, Inclusive and Psychologically Safe Culture

- Across all Committees members felt able to speak openly and challenge constructively, with a strong sense of psychological safety and mutual respect
- Culture aligned with Trust values, inclusive and supportive behaviours

High Quality Challenge and Rigorous Scrutiny

- Committees demonstrate constructive challenge rather than passive assurance with a willingness to test assumptions and probe risk
- Evidence of meaningful debate, focus on assurance beyond reassurance.

Effective Assurance and Use of Information

- Strong ability to bring together multiple sources of assurance (audit, performance, risk, etc.) and triangulate evidence to form a coherent view
- Growing alignment between committee business, BAF risks, strategy and key priorities

Committee Effectiveness - Key Strengths

University Hospitals of North Midlands NHS Trust

High Quality Papers and Structured Meetings

- Papers described as clear, thorough and well prepared, supporting informed discussion and decision-making
- Meetings were well structured and run to time while allowing space for deeper discussion where needed

Strong Executive Engagement and Transparency

- Executive Directors consistently in attendance; open, responsive and engaged
- Confidence from members that difficult issues are surfaced and addressed and that transparency is strong

Appropriate Skills, Experience and Committee Composition

- Committees seen as having the right balance of skills and expertise with appropriate attendance from Executives and subject matter expert

Committee Effectiveness - Key Improvement Themes

University Hospitals of North Midlands NHS Trust

For the 2024/25 review, 11 improvement actions were completed. Following the 2025/26 reviews, 15 improvement actions were identified, the themes for which are listed below.

Strengthening Quality and Clarity of Assurance

- Further improving the clarity, structure and accessibility of papers and reports.
- Ensuring all reports clearly articulate the assurance being provided, key risks, gaps and conclusions.
- Supporting more concise, impact-focused reporting to enable effective scrutiny.

Enhancing Strategic Focus and Use of Committee Time

- Greater use of deep dives and themed sessions and structured agenda planning.
- Enabling Committees to focus on complex or high-risk areas, avoid congested agendas and support more strategic discussion rather than operational detail.

Improving Planning, Forward Look and Horizon Scanning

- Strengthening use of annual work programmes / forward plans / business cycles.
- Improving anticipation of key decisions and assurance requirements.

Strengthening Accountability and Delivery Discipline

- Supporting clearer ownership of actions with realistic delivery timescales.
- Enhancing oversight of action completion and responsiveness.

Note. Specific actions will be added to the respective Committee post meeting action logs for monitoring and oversight.

Conclusion

University Hospitals of North Midlands NHS Trust

- Overall, the 2026 Committee Effectiveness review indicates that the Committee structure is operating effectively, with generally strong engagement, solid attendance, and improved feedback compared with 2024/25.

- The findings provide assurance to the Trust Board that Committee arrangements continue to support responsibilities under the NHS Code of Governance and the NHS England Well-Led Framework.

- While performance is positive overall, the review also highlights targeted opportunities to strengthen effectiveness further. Continued monitoring, self-assessment, and follow up on agreed actions will help maintain momentum and support a culture of continuous improvement across Board and Committee governance.

University Hospitals of North Midlands NHS Trust

Rules of Procedure

May 2026

Contents

About University Hospitals of North Midlands NHS Trust

What we do

University Hospitals of North Midlands NHS Trust (UHNM) provides services across two main hospital sites; Royal Stoke University Hospital and County Hospital, and our Community Diagnostics Centre (CDC) opened in May 2026.

Providing care in modern facilities, we offer a full range of general hospital and specialised services for approximately 3 million people. We employ around 13,000 colleagues and we have around 1,450 inpatient beds across our two sites.

We are one of the largest hospitals in the West Midlands and have one of the busiest emergency departments in the country, with an average of approximately 14,000 patients attending each month across both of our sites. As a Major Trauma Centre, we receive emergency patients from a wide geographical area by both ambulance and helicopter, serving the North Midlands and North Wales.

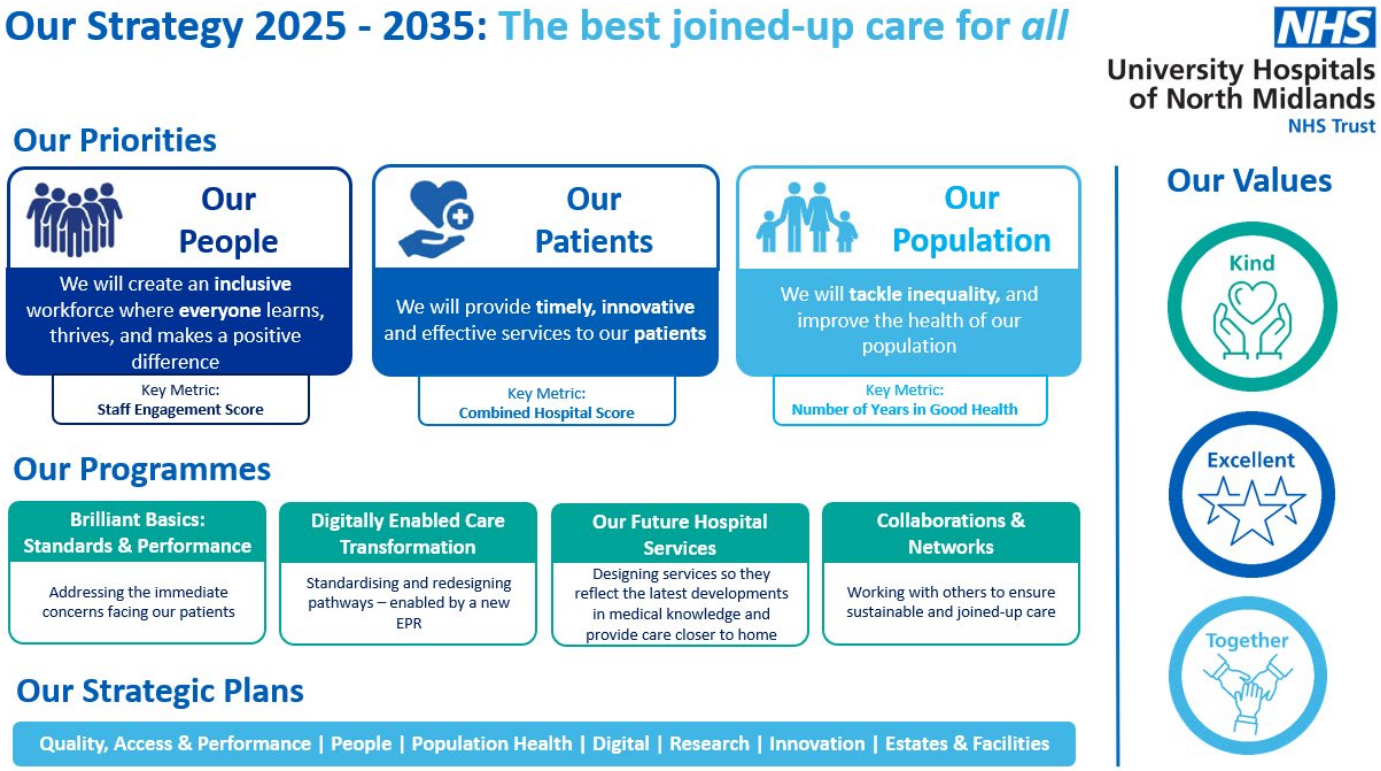
Our specialised services include cancer diagnosis and treatment, cardiothoracic surgery, neurosurgery, renal and dialysis services, neonatal intensive care, paediatric intensive care, trauma, respiratory conditions, spinal surgery, upper gastro-intestinal surgery, complex orthopaedic surgery and laparoscopic surgery.

We work with partners across Staffordshire, Stoke-on-Trent and beyond to deliver joined-up care, including local authorities, the voluntary sector and NHS provider partners. We have well established relationships with Keele University and the University of Staffordshire to support research, innovation, education and workforce development. Our partnerships help us to improve access, quality and outcomes for patients, and to plan services that meet local needs.

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

Our refreshed strategy was officially launched in April 2025, setting out our strategic framework and vision: "The best joined-up care for *all*".

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



These Rules of Procedure set out how the Board discharges its responsibilities for decision-making, assurance, and risk oversight, including how it uses information (e.g. BAF, committee assurance) to inform its decisions.

1. Introduction

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

NHS Trusts are principally governed primarily by:

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

The Trust's functions are conferred by this legislation. In addition, the Trust has statutory powers to jointly fund projects with local authorities, voluntary organisations and other bodies.

To support effective governance, we have adopted:

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

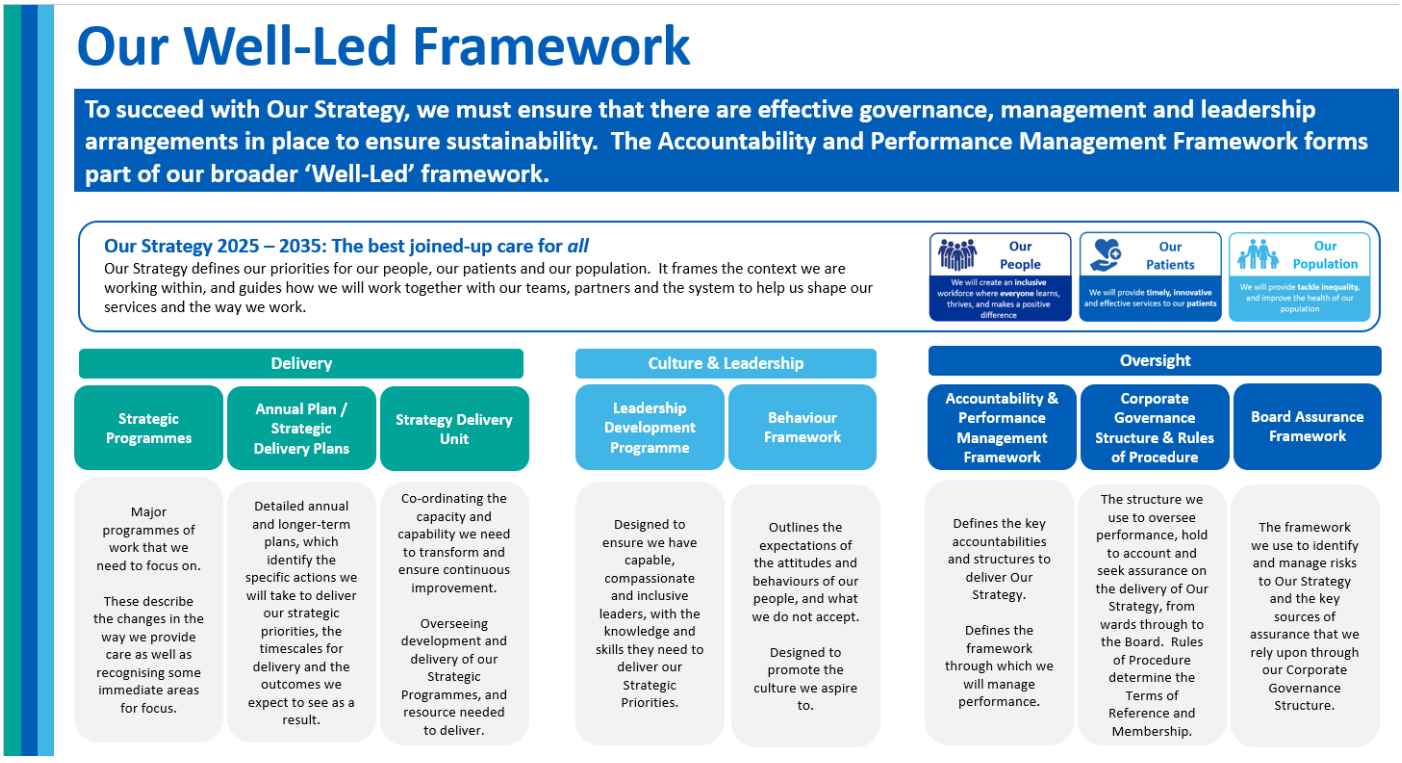
We are also subject to all other relevant statutory and legal requirements applicable to our operations.

These Rules of Procedure operate in conjunction with, and are subordinate to, the Trust's Standing Orders (G19), Standing Financial Instructions (F01), and Scheme of Reservation and Delegation of Powers (F02), which together define the statutory framework, financial governance, and decision-making authorities of the Trust. The documents are maintained separately from the Rules of Procedure.

Where interpretation is required:

- Standing Orders: Chair's ruling is final
- Standing Financial Instructions: Chief Financial Officer provides advice, with the Chair acting as final arbiter where required
- Scheme of Delegation: interpretation aligned to its provisions and supporting policies

This document also forms part of our wider Well-Led Framework, alongside the Accountability and Performance Management Framework:



2. Definitions

Accountable Officer	The NHS officer responsible for the stewardship of public funds and assets. At University Hospitals of North Midlands NHS Trust, this role is held by the Chief Executive.
Associate Member	An individual appointed to carry out specific statutory or non-statutory duties delegated by the Board. These duties must be formally recorded in a Trust Board minute or equivalent documentation.
Board	The collective body comprising the Chair, Executive Directors, and Non-Executive Directors.
Budget	A financial plan proposed for a defined period, supporting the delivery of its functions. Budgets may also include associated workforce and workload plans.
Chair of the Trust	Appointed by NHS England, the Chair leads the Board and ensures it discharges its responsibilities effectively. In the Chair's absence, the Vice Chair assumes these duties.
Chief Executive	The Accountable Officer, responsible for overall leadership and performance.
Commissioning	The process of assessing needs and securing healthcare and related services within available resources.
Committee	A committee or sub-committee formally established and appointed by the Board.
Committee Member	An individual formally appointed by the Board to serve on, or chair, a Committee.
Contracting and Procurement	The systems and processes for acquiring goods, services and works, and for disposing of surplus or obsolete assets.
Employee (Officer)	Any individual employed, or holding a paid appointment or office.
Executive Director (Officer Member)	An officer responsible for specific duties as outlined in the Standing Orders and Standing Financial Instructions.
Funds held on trust	Funds held by the Trust either at incorporation, received via statutory instrument, or accepted under powers granted by the NHS Act 2006 (as amended). These may include charitable and non-charitable funds.
Member	An Executive or Non-Executive Director of the Board, depending on context.
NHS Trust (Membership and Procedure) Regulations 1990	Refers to the foundational statutory framework for the governance, constitution, and proceedings of NHS Trusts.
Non-Executive Director (Non-Officer Member)	A Board member who is not an officer and is not deemed to be one under regulation 1(3) of the Membership, Procedure and Administration Arrangements Regulations.
Scheme of Reservation and Delegation of Powers	A document outlining the powers reserved by the Board and those delegated to others for the detailed application of Trust policies and procedures.
Senior Independent Director (SID)	A Non-Executive Director who acts as a point of contact for concerns that cannot be resolved through the Chair, Chief Executive, Executive Directors, or Director of Governance & Communications.
Standing Orders (SOs)	Rules governing the conduct of business and proceedings.
Standing Financial Instructions (SFIs)	Detailed financial policies and procedures adopted to ensure sound financial governance.
The Trust	Refers to University Hospitals of North Midlands NHS Trust.
Vice Chair	A Non-Executive Director appointed to act in the Chair's absence.

3. Governance

The Trust Board (the Board) of University Hospitals of North Midlands NHS Trust is responsible for setting the strategic direction of the organisation, providing oversight of performance and delivery, and ensuring accountability to patients, staff and stakeholders in an open and effective manner.

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

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

- the evolving needs of an ageing population.
- the need to work collaboratively with system partners.
- workforce shortages.
- financial pressures and slower budget growth.

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

NHS Trusts are expected to conduct their affairs with integrity and effectiveness, thereby maintaining public, patient and stakeholder confidence. The Board is ultimately responsible for the organisation's overall performance, governance and stewardship.

4. Statutory Framework

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

- Chair of the Trust, appointed by NHS England on behalf of the Secretary of State for Health and Social Care.
- Six Non-Executive Directors, providing independent oversight and challenge.
- Five Executive Directors, including the Chief Executive and the Chief Finance Officer.

The Trust's principal place of business is Royal Stoke University Hospital, Newcastle Road, Stoke-on-Trent, Staffordshire, ST4 6QG. Services are also provided at County Hospital, Weston Road, Stafford, ST16 3SA and the Community Diagnostics Centre (CDC), Etruria Way, Hanley, ST1 5NQ.

Further details, including the Board's organisational structure and committee structure, are set out in Appendices 1 and 2.

5. The Board and Exercise of Statutory Powers

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

- ensuring high standards of corporate governance and promoting a culture of integrity and propriety.
- establishing the strategic direction and priorities of the organisation.
- providing oversight of the effective and efficient delivery of plans and statutory functions.
- promoting and embedding quality across all activities and services.
- monitoring performance against agreed objectives, targets and regulatory requirements.
- ensuring that all Board members, individually and collectively, uphold the Seven Principles of Public Life as set out by the Committee on Standards in Public Life: selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

The Board operates on the principle of unitary responsibility, meaning that decisions are made collectively and all members are accountable for them. The Board exercises those functions reserved to it under the Scheme of Reservation and Delegation of Powers (F02). All other powers are delegated in accordance with that Scheme.

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

6. Meetings and Proceedings of the Board

6.1 Meetings of the Board

- Ordinary meetings of the Board will be held at regular intervals, at such times and locations as the Board may determine, in accordance with the annual Calendar of Business.
- The Board may invite any individual to attend all or part of a meeting, as appropriate.
- Meetings will ordinarily be held in person. Where appropriate, members may attend virtually via Microsoft Teams. Meetings will normally be held at either Royal Stoke University Hospital or County Hospital, depending on operational requirements.
- Board members are expected to attend a minimum of four Board meetings in any rolling 12-month period.

6.2 Admission of the Public and Press

- The Board operates in an open and transparent manner while safeguarding confidentiality where required.
- The Chair may issue directions regarding meeting arrangements, including the accommodation of the public and press, in accordance with the Public Bodies (Admission to Meetings) Act 1960, to enable the orderly conduct of Board business.
- The Board may resolve to exclude the public and press from all or part of a meeting where publicity would be prejudicial to the public interest, by reason of the confidential nature of the business to be transacted or for other special reasons stated in the resolution.
- Members of the public and press will not attend meetings of committees or sub-committees unless specifically invited.

Confidential Business

- Any business conducted by the Board in private session, following the exclusion of the public and press, will be treated as confidential. This includes matters of a confidential, commercially sensitive, legal or regulatory nature.
- Board members, Directors and employees in attendance must not disclose the contents of papers marked 'In Confidence', or minutes headed 'Items Taken in Private', outside the Trust without express permission.
- This restriction also applies to any discussions held in private session relating to such papers or reports.

Recording and Transmission of Meetings

- The recording or transmission of Board meetings by members of the public or press is not permitted.
- Any exception requires the prior approval of both the Chair and the Chief Executive, granted in advance of the meeting.

6.3 Board Meeting Agenda and Papers

- Under normal circumstances, the agenda for each Board meeting will be circulated electronically to members at least five working days in advance.
- All agenda items will clearly identify whether they are presented for decision, assurance or discussion.
- Supporting papers will accompany the agenda wherever possible and will be circulated no later than three clear working days before the meeting, except in cases of urgency.
- For meetings held in public, the agenda and supporting papers will be published on the Trust's website at least three working days before the meeting.

Order of Business

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

Late Papers and Additional Business

- Late papers may only be introduced with the prior permission of the Chair.
- No business other than that set out on the agenda will be considered unless the Chair determines that it is appropriate to do so.

Confidentiality of Board Papers

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

Security of Confidential Documents

- Board members are expected to access papers electronically wherever possible. Where printed copies are required, members must ensure that confidential Board papers are not left unattended or otherwise accessible to unauthorised individuals.

6.4 Extraordinary Meetings of the Board

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

6.5 Power to Call Meetings of the Board

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

6.6 Chairing of Meetings

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

6.7 Procedure at Meetings of the Board

The person presiding over the meeting, will be responsible for:

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

Written Comments from Absent Members

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

Decision-Making and Voting

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

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

For each decision, the Board should be provided with:
- Purpose of decision.
- Options considered.
- Risks and implications.
- Sources of assurance.
- Recommendation.

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

Note: No resolution will be passed if it is unanimously opposed by all Executive Directors present or by all Non-Executive Directors present.

- The minutes will record the numerical outcome of any vote (votes for, against, and abstentions). Individual votes will not be attributed unless a member specifically requests this immediately after the item concludes.

Deferral and Delegation of Decisions
- The Board may agree to defer a decision to allow for further information or consideration. The reason for deferral and the proposed timeline for revisiting the item will be recorded in the minutes.
- The Board may also delegate a decision on an agenda item to the Chair. Any such delegation will be formally recorded in the minutes.

Virtual Approval
In exceptional circumstances, where urgent matters arise between formal meetings, and following consultation with the Chief Executive or another Executive Director, the Chair may authorise a decision to be made by email. In such cases:
- Papers will be circulated by the Corporate Governance Office.
- The decision shall be confirmed by a majority of those Board members responding, provided that at least five Directors with voting rights respond, including not fewer than three Non-Executive Directors.
- The Chair retains the right to exercise a second and casting vote if required.

This method shall only be used where the matter is time-critical or where consideration at a formal meeting would not materially assist the decision-making process. The matter shall be reported to the next formal meeting and accompanied by a clear explanation of the reasons for the urgent decision.

6.8 Quorum of the Board

- No decisions shall be taken at a meeting of the Board unless a quorum is present.
- A quorum will consist of at least five Directors with voting rights, including a minimum of three Non-Executive Directors.
- Non-Executive Directors must be in the majority. The Chair, if present, will count as one of the Non-Executive Directors.

Quorum Exclusions

- An individual attending in place of an Executive Director, without formal appointment to act in that capacity, shall not count towards the quorum. However, an existing non-voting Executive Director who has been formally appointed to represent a voting Executive Director during a period of absence shall count towards the quorum.
- If a Board member is disqualified from participating in a discussion or vote due to a declared conflict of interest, they will no longer count towards the quorum for that item.
- If the quorum is lost due to such disqualification, the item in question may not be discussed or voted upon, and this will be recorded in the minutes. The meeting will then proceed to the next item of business.

Remote Participation

- Participation is expected to be in person, but in exceptional circumstances, members may join via Microsoft Teams. Such members will be deemed present and counted towards the quorum.

Inquorate Meetings

If a meeting is not quorate within 30 minutes of the scheduled start time, or becomes inquorate during the course of the meeting, then the meeting will either:

- Be adjourned to a time, date, and place determined by the members present, or
- Continue as an informal meeting, during which no formal decisions may be taken.

6.9 Minutes of the Board

- The minutes of each Board meeting, along with a Post-Meeting Action Log, will be prepared and submitted for approval at the next scheduled meeting. The approval of the minutes will be formally recorded.
- No discussion will take place on the minutes except to correct inaccuracies or where the Chair deems discussion appropriate (e.g. matters arising).

The minutes will include:

- The names of all Board members present, any other individuals in attendance and any apologies received from absent Board members.
- Any declarations of interest.
- Any withdrawals from the meeting due to a declared conflict of interest.
- Minutes will clearly reflect the key points of discussion, including the level of challenge, the assurance provided, and any residual risks or uncertainties. Where sensitive matters (e.g. personnel) are discussed, the minutes will reflect the substance of the discussion in general terms.
- Once approved, the minutes will be published on the website as part of the papers for the next scheduled public Board meeting.

6.10 Emergency Powers

- In emergency or urgent circumstances, powers reserved to the Board may be exercised jointly by the Chair and Chief Executive, following consultation with at least two Non-Executive Directors, in accordance with Standing Orders.

Any such decision must be reported to the next formal Board meeting held in public session, formally ratified and accompanied by a clear explanation of the reasons for the emergency decision.

6.11 Delegation of Powers

- University Hospitals of North Midlands NHS Trust remains ultimately accountable for all Trust functions, including those delegated to Committees, the Chair, the Chief Executive, Executive Directors, or other employees. To maintain effective oversight, the Board requires regular information on the exercise of delegated functions.
- The list of matters reserved for Board decision does not preclude other matters being referred to the Board at its discretion.
- All powers delegated by the Board may be reassumed at any time, and the Board reserves the right to revoke or vary any delegation.
- The Board delegates to each of its committees, the authority to discharge functions within their respective terms of reference, except for matters explicitly reserved to the Board.

The Chief Executive is responsible for preparing and maintaining the Scheme of Delegation (Trust Policy F02), which outlines:

- Functions to be performed personally by the Chief Executive.
- Functions delegated to Committees and individual employees.

All powers delegated by the Chief Executive may, where necessary, be reassumed by the Chief Executive.

Delegated powers are exercised on the understanding that:

- They will not be used in any matter likely to cause public concern or damage the reputation of the Trust.
- Appropriate expert advice will be sought where necessary.
- Any associated costs can be met within the authorised budget.

- The Corporate Governance Office is responsible for maintaining a record of all delegated powers, authorities, and discretions.
- In the absence of an employee to whom powers have been delegated, those powers may be exercised by the relevant Executive Director, unless alternative arrangements have been approved by the Board.
- If the Chair is absent, powers delegated to them may be exercised by the Vice Chair in relation to Board matters, and by the Chief Executive, following appropriate consultation with the Board and Executive Directors.

6.12 Role of Accountable Officer and Standing Financial Instructions

The Chief Executive serves as the Accountable Officer. In this capacity, the Chief Executive is personally responsible for ensuring that:

- Public funds entrusted to the Trust are properly safeguarded.
- Resources are used effectively, efficiently, and economically.
- The Trust complies with all relevant statutory and regulatory requirements.

Financial governance is further supported by the Standing Financial Instructions (SFIs), set out in Policy F01 – Standing Financial Instructions. These instructions:

- Define the financial responsibilities, policies, and procedures to be followed across the organisation.
- Ensure that all financial transactions are conducted in accordance with legal and government requirements.
- Promote probity, accuracy, economy, efficiency, and effectiveness in the use of public funds.
- Provide a clear framework of procedures and rules for all employees to follow.

Note. Approval thresholds for expenditure and business cases are defined within the Standing Financial Instructions (F01) and Scheme of Reservation and Delegation of Powers (F02) and must be followed in all cases.

6.13 Personal Conflicts of Interest

- If a Board or Committee member has a known or potential material and relevant interest—whether direct or indirect, pecuniary or non-pecuniary—that a fair-minded and informed observer would consider presenting a real possibility of bias, they must declare the nature of the interest or duty.

Declaration Process
Declarations may be made:

- At the meeting, either at the start or at the relevant agenda item.
- In advance, in writing to the Corporate Governance Office.

- If declared in advance, the Chair will inform the meeting before the item is discussed.
- If a member becomes aware of a conflict during discussion, they must declare it immediately.

Participation in Discussion
Once a declaration is made and fully explained, the Board or Committee members present will decide unanimously whether, and to what extent, the individual may:

- Participate in the discussion.
- Remain in the room.
- Access related written materials.

- If required to leave the meeting, the Chair may allow the individual to make a brief statement before withdrawing.
- The decision and rationale will be recorded in the minutes.

Conflicts Involving the Chair

- If the Chair has a relevant interest, they must declare it and seek the agreement of the Board or Committee regarding their participation.
- If it is agreed that the Chair should not participate, another member will be appointed to chair the discussion for that item.
- The decision and extent of the Chair's access to papers will be recorded in the minutes.

Employees in Attendance

- Employees who are not Board or Committee members but are in attendance must also declare any relevant interests.
- If a conflict is identified, the Chair may instruct the employee to withdraw from the discussion.

Policy Reference

- All Board members, Committee members, and employees are subject to the provisions of Trust Policy G16 – Standards of Business Conduct, which outlines the full arrangements for managing conflicts of interest.

6.14 Allowances for Non-Executive Members of the Board

Non-Executive Directors are entitled to claim reimbursement of reasonable expenses incurred in the discharge of their duties, in accordance with Trust policy.

7. Meetings and Proceedings of Committees

Where no specific provision is made for Committees, the principles and procedures applicable to the Board will apply. In the event of any inconsistency between these Rules of Procedure and a Committee's Terms of Reference, the Terms of Reference will prevail.

Committee Governance Packs, including Terms of Reference, membership and business cycles, are set out in Appendices 9 to 13.

7.1 Appointment of Committees

- The Board may establish Committees for any purpose within its functions and will define their powers and responsibilities.
- The Board will appoint members to each Committee.
- The Committee Chair will be a Board member, unless otherwise specified (e.g. where the Chief Executive, as Accountable Officer, is required to chair).

- The Board will review the structure and scope of each Committee's activities regularly.
- The Board will approve and may amend the Terms of Reference for each Committee.

7.2 Meetings of a Committee

- Committees will meet at such intervals as their members may determine. Each Committee will determine the time and location of its meetings.

7.3 Extraordinary Meetings of a Committee

- In urgent circumstances, the Committee Chair may convene an extraordinary meeting at such time and place as they determine.

7.4 Attendance at Committee Meetings

- Any Board member may attend and speak at a Committee meeting with the permission of the Committee Chair.
- Board members who are not appointed members of the Committee shall not be entitled to vote.
- Where an appointed Committee member is unable to attend, a suitably senior deputy may attend with delegated authority and may count towards the quorum where permitted by the Committee's Terms of Reference.

7.5 Chairing of Committee Meetings

- The Committee Chair, if present, will preside over all meetings.
- In the absence of the Committee Chair, a Non-Executive Director who is a member of the Committee, or another Board member nominated by the Committee Chair, will preside.
- The conduct of the meeting will be determined by the person presiding.

7.6 Quorum of Committees

- A Committee meeting will be quorate when at least half of its total membership is present, including at least one Non-Executive Director, unless otherwise specified in the Committee's Terms of Reference.

7.7 Minutes of Committees

- A member of the Corporate Governance Office will act as Secretary to each Committee.
- The Secretary will record the minutes of each meeting, which will be submitted to the next meeting of the Committee for approval or amendment.
- Minutes will be made available to all Board members through the Corporate Governance Office.

7.8 Committee Reporting to the Board

- Following each Committee meeting, the Corporate Governance Office will prepare, on behalf of the Committee Chair, a summary report for presentation to the next Board meeting.

This report will highlight:
- Level of assurance.
- Matters requiring Board decision or escalation.
- Actions taken.
- Decisions taken.

- Each Committee will undertake an annual effectiveness review against its Terms of Reference and membership arrangements. The outcome of that review shall be reported to the Board in accordance with the Annual Business Cycle.

7.9 Prohibition on Delegation of a Committee's Function

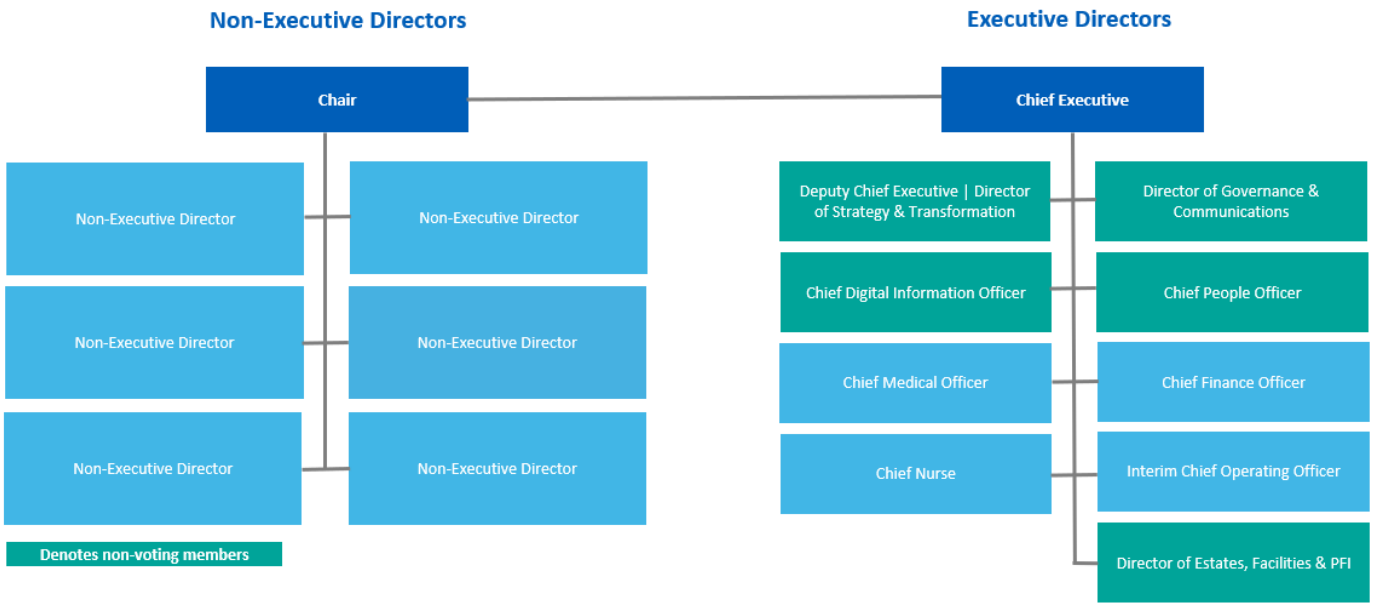
- A Committee may not delegate its functions to any other group or individual unless expressly authorised to do so by the Board through its Terms of Reference.

8. Other Documents Relevant to these Rules of Procedure

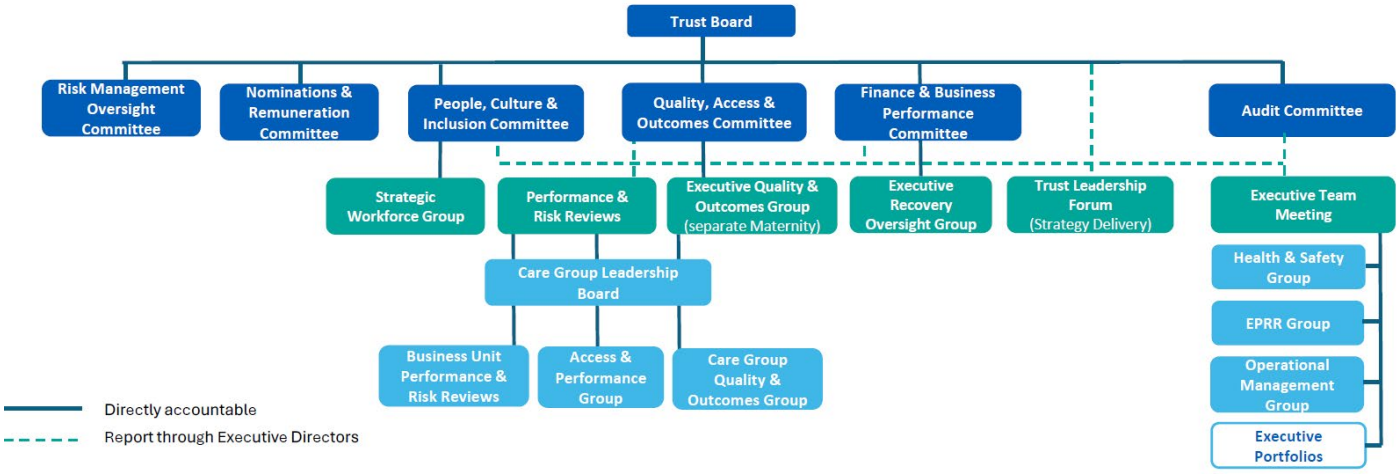
The following documents should be read in conjunction with the Rules of Procedure:

- F01 Standing Financial Instructions
- F02 Scheme of Delegation
- G19 Standing Orders
- G16 Standards of Business Conduct
- Trust Values, Behaviours and Standards Framework
- Accountability and Performance Framework

Appendix 1 – Trust Board Organisation Chart



Appendix 2 – Corporate Governance Structure



Appendix 3 - Code of Conduct for Board Members

To justify the trust placed in me by patients, service users and the public, I will always uphold these standards while serving the NHS.

I understand that care, compassion and respect for others are central to quality in healthcare. I also recognise that the purpose of the NHS is to improve the health and wellbeing of our people, patients and population: supporting them to remain mentally and physically well, to recover when they are ill, and, where full recovery is not possible, to live as well as possible to the end of life.

I understand that I must act in the interests of patients, service users and the communities I serve, and that I must uphold the law and act fairly and honestly in all my dealings.

Introduction

All members of NHS Boards are expected to work to the highest personal and professional standards. They should understand and be committed to the practice of good governance and to the legal and regulatory frameworks within which they operate. As individuals, they must understand both the extent and the limitations of their personal responsibilities.

This Code of Conduct has been developed in line with a range of existing standards relevant to the healthcare sector. The standards set out in this Code are consistent with the Nolan Principles of Public Life and with existing regulatory frameworks applying to professionals and senior managers working in the NHS.

In addition, this Code of Conduct should be read alongside the Values, Behaviours and Standards Framework.

Purpose

Senior leadership roles frequently require individuals to navigate complex and difficult decisions. Those decisions must balance the legitimate, and sometimes competing, needs of individuals, communities, the healthcare system and the wider public interest.

This Code of Conduct is intended to support consistent and well-founded judgment in such circumstances through the application of shared values and principles. It is structured in three parts:

- **Part 1** sets out the standards expected of Board members and provides a framework to guide judgment through the consistent application of values and principles.
- **Part 2** sets out expectations for Board conduct and behaviours, including behavioural standards aligned to our values of Kind, Excellent and Together, to help ensure that Board meetings are effective and focused.
- **Part 3** outlines the individual and collective roles and responsibilities of Board members.

Part 1: Standards for Board Members

All Board members should understand and be committed to the practice of good governance and to the legal and regulatory frameworks in which they operate. As individuals they must understand both the extent and limitations of their personal responsibilities, such as the differences in role of executive and non-executive Board members. To justify the trust that has been placed in them by patients and the public they must adhere to these standards of personal behaviour, technical competence and business practice.

3.1 Personal Behaviours

Board members must commit to:

- The values of the **NHS Constitution** in the treatment of colleagues, patients and their families and carers and the community, and in the design and delivery of services for which they are responsible.
- Promoting **equality, diversity and inclusion** in the treatment of colleagues, patients and their families and carers, and the community, and in the design and delivery of services for which they are responsible.
- Promoting **human rights** in the treatment of colleagues, patients, their families and carers, and the community, and in the design of services for which they are responsible.
- The **duty of candour** to ensure that 'patients/their families are told about patient safety incidents that affect them, receive appropriate apologies, are kept informed of investigations and supported to deal with the consequences'. This applies to patient safety incidents that occur during care provided and that result in moderate harm, severe harm or death. This also applies to suspected incidents which have yet to be confirmed, where the suspected result is moderate harm, severe harm or death.
- The requirements as set out by the Care Quality Commission in relation to the **Fit and Proper Persons Test.**
- Ensuring the safeguarding of **public funds**, taking appropriate measures to ensure resources are used efficiently, economically and effectively. In addition, Board members should refer to the Standards of Business Conduct Policy, in terms of receipt of gifts and hospitality.

In addition to acting as role models for Our Values, Board members must apply the following principles in their work and relationship with others:

Responsibility	I will be fully accountable for my work and the decisions that I make, for the work and decisions of the Board, including delegated responsibilities, and for the employees and services for which I am responsible.
Honesty	I will act with honesty in all my actions, transactions, communications, behaviours and decision-making, and will resolve any conflicts arising from personal, professional or financial interests that could influence or be thought to influence my decisions as a Board member.
Openness	I will be open about the reasoning, reasons and processes underpinning my actions, transactions, communications, behaviours and decision-making and about any conflicts of interest.
Respect	I will treat patients and service users, their families and carers, the community and colleagues with dignity and respect at all times.
Professionalism	I will take responsibility for ensuring that I have the relevant knowledge and skills to perform as a Board member and that I reflect on and identify any gaps in my knowledge and skills and will participate constructively in appraisal of myself and others. I will adhere to any professional or other codes by which I am bound.
Leadership	I will lead by example in upholding and promoting these Standards and use them to create a culture in which their values can be adopted by all.
Integrity	I will act consistently and fairly by applying these values in all my actions, transactions, communications, behaviours and decision-making, and always raise concerns if I see harmful behaviour or misconduct by others.

3.2 Technical Competence

For themselves and the organisation, Board members must seek:

- to make sound decisions individually and collectively;
- excellence in the safety and quality of care, patient experience and accessibility of services; and
- long-term financial sustainability and best value for the benefit of patients, service users and the wider community.

This will be achieved through:

- always placing the safety of patients and service users, the quality of care and patient experience first, while enabling colleagues to do the same;
- demonstrating the skills, competencies and judgment necessary to fulfil their role, and engaging in training, learning and continuing professional development;
- having a clear understanding of the business and financial aspects of the organisation's work, and of the wider business, financial and legal context in which it operates;
- making effective use of their own expertise and that of colleagues, while working within the limits of their competence and knowledge;
- understanding their role and powers, the legal, regulatory and accountability frameworks within which they operate, and the distinction between Executive and Non-Executive roles;
- working collaboratively and constructively with others, contributing to discussion, challenging decisions and raising concerns effectively;
- publicly upholding decisions taken by the Board through due process for as long as they remain a member of the Board;
- thinking strategically and developmentally;
- seeking and using evidence as the basis for decisions and actions;
- understanding the health needs of the population served;
- reflecting on personal, Board and organisational performance, and on how their behaviour affects those around them, while supporting colleagues to do the same;
- considering the impact of decisions on services, the people who use them and employees;
- listening to patients and service users, their families and carers, the community and colleagues, and ensuring that people are involved in decisions that affect them;
- communicating clearly, consistently and honestly with patients and service users, their families and carers, the community and colleagues, ensuring that messages are understood; and
- respecting patients' rights to consent, privacy, confidentiality and access to information, as provided for in data protection and freedom of information law and guidance.

3.3 Business Practices

For themselves and for the organisation, Board members must seek:

- to ensure that the organisation is equipped to serve its patients, service users and the wider community;
- to be fair, transparent, measured and thorough in decision-making and in the stewardship of public money; and
- to be prepared to be held publicly to account for the organisation's decisions and its use of public money.

This will be achieved through:

- declaring any personal, professional or financial interests and ensuring that they do not interfere with actions, communications, behaviours or decision-making, including withdrawing from decisions where a conflict may reasonably be perceived;
- taking responsibility for ensuring that harmful behaviour, misconduct or system weaknesses are addressed and learned from, and raising any such concerns identified;
- challenging any practices that could inhibit the reporting of concerns by members of the public, employees or Board members about standards of care or conduct;
- ensuring that patients and service users, and their families, have clear and accessible information about the choices available to them so that they can make informed decisions;
- being open about the evidence, reasoning and rationale behind decisions about budget, resource and contract allocation;
- seeking assurance that the organisation's financial, operational and risk management frameworks are sound, effective and properly used, and that the values in these standards are reflected in the design and delivery of services;
- ensuring that the organisation's contractual and commercial relationships are honest, lawful, regularly monitored and compliant with best practice in the management of public money;
- working in partnership and co-operating with local and national bodies to support the delivery of safe, high-quality care;
- ensuring that the organisation's dealings are made public unless there is a justifiable and properly documented reason for not doing so; and

- ensuring that effective complaints and whistleblowing procedures are in place and used. Board members must actively support a culture of openness and transparency, including the Freedom to Speak Up agenda. Concerns raised by employees, patients or the public must be treated seriously and handled in accordance with the Speaking Up Policy. Board members should ensure that Freedom to Speak Up Guardians are visible, accessible and supported in their role to promote a safe environment for raising concerns.

Part 2: Board Meetings Protocol & Procedures

An effective Board promotes a clear collective understanding of the organisation's purpose, culture, values and expected behaviours in the conduct of its business. In particular, it:

- provides clear direction to management;
- demonstrates inclusive leadership and behaviours consistent with the culture and values it has established for the organisation; and
- makes well-informed, high-quality decisions based on a clear understanding of the organisation's business and performance.

Robust and constructive challenge depends on a number of factors being in place, including the provision of timely information in an appropriate format, a suitable meeting environment, effective chairing, constructive Board behaviours and a culture in which challenge is encouraged and accepted.

Where Board members are not fully engaged throughout a meeting, or where behaviours fall below the expected standard, the quality of discussion and decision-making may be adversely affected. This may also indicate that Board papers are not sufficiently clear, focused or capable of supporting effective scrutiny and challenge.

4.1 Before the Meeting

- Board members are expected to read the agenda and supporting papers in advance of the meeting and prepare any questions or points of challenge for discussion at the appropriate time.
- Board members should be clear about the decision, assurance or discussion being sought in relation to each item.
- Where clarification or further information is required in advance, this should be sought through the Corporate Governance Office.
- Apologies should be submitted in advance and, where appropriate, arrangements made for a deputy to attend, ensuring that they are fully briefed.
- Where a member is aware that they will need to leave before the end of a scheduled meeting, the Chair should be informed in advance. This should be avoided wherever possible.

4.2 During the Meeting

- Board members must declare any actual or potential conflicts of interest relating to matters on the agenda.
- No part of the meeting shall be audio or visually recorded unless expressly authorised in advance. Where such recording is permitted, the Chair shall notify the meeting accordingly.

4.3 Focussing on the Agenda

- Board members are expected to give their full attention to the business of the meeting and should not undertake other duties at the same time.
- Mobile phones should be placed on silent. Where a member is expecting an urgent call, the Chair should be informed in advance.
- Private conversations during the meeting, whether spoken or written, should be avoided.

4.4 Contributing to the Discussion

- Board members should indicate to the Chair when they wish to contribute and should wait to be invited to speak, so as not to interrupt another member. All comments and discussion should be directed through the Chair.
- When invited to speak, members should do so clearly, concisely and at a volume audible to all attendees, including the minute-taker. Jargon and unnecessary acronyms should be avoided.
- When presenting papers, members should assume that the papers have been read and should focus on the key salient points.
- Members should respect the role of the Chair in facilitating debate, summarising discussion and clarifying decisions.
- Members should listen attentively and respectfully to others, noting any points they wish to raise and avoiding interruption while another person is speaking.
- Members should ensure that their body language reflects attention, participation and engagement.
- Concerns about inappropriate behaviour or language should be raised through the Chair at the time, or afterwards if preferred.
- Members should offer challenge in a constructive, professional and respectful manner.
- Members should seek clarification where necessary.

4.5 Unitary Board

- Board members should understand their role within the meeting and the requirement for the Board to act as a corporate body, rather than in pursuit of personal interests or the interests of another organisation or constituency.
- Members should avoid acting in a territorial or personal manner and should contribute to the collective responsibility and corporate nature of the Board.
- Constructive challenge should be regarded positively as a means of testing the robustness of papers, proposals and arguments.
- Members should respect the diversity of views expressed and should neither give nor take offence in the course of constructive debate.

4.6 Accountability

- Members should seek guidance or clarification from the Chair during the meeting, or from the Director of Governance & Communications outside the meeting, where they have concerns about a particular course of action.
- Members must maintain the confidentiality of confidential matters.

4.7 After the meeting

- Board members should participate in any post-meeting review intended to improve the effectiveness of future meetings.
- A summary of actions agreed shall be prepared and circulated by the Corporate Governance Office following the meeting. Board members are expected to review the action summary, complete any actions assigned to them in a timely manner, and report progress as required. A central log of Board actions shall be maintained by the Corporate Governance Office.
- Draft minutes shall normally be circulated within one working week of the meeting. Members should review them promptly and submit any proposed amendments to the Corporate Governance Office at the earliest opportunity to support timely approval at the next meeting.
- Members must observe the confidentiality and sensitivity of matters discussed and ensure that all papers are stored securely.
- Members should remember that decisions are taken collectively by the Board and that accountability for those decisions remains collective.
- Where there are concerns raised that the etiquette has not been adhered to, the Chair or Chief Executive as appropriate will take necessary action.

These behaviours are essential to robust decision-making, effective challenge and high-quality assurance. They support the Board's ability to discharge its governance responsibilities effectively and should be demonstrated consistently in all Board and Committee interactions.

5.1 Chair and Chief Executive

The Chair and Chief Executive have complementary roles in the leadership of the Board and the organisation. In summary:

- The Chair leads the Board and is responsible for its effectiveness; and
- The Chief Executive leads the Executive and the organisation.

5.2 Roles of Board Members

There are distinct roles for different members of the Board. These are set out in the following table:

	Chair	Chief Executive	Non-Executive Director	Executive Director
Formulate Strategy	Ensures that the Board develops a clear vision and objectives to support delivery of the organisation's purpose.	Leads the development of the organisation's vision and strategy.	Brings independent perspective, external expertise and constructive challenge to strategy development.	Leads the development of strategic proposals, drawing on relevant professional and clinical expertise.
Ensure Accountability	Holds the Chief Executive to account for delivery of the strategy. Ensures that Board committees supporting accountability are appropriately constituted.	Leads the organisation in delivering the strategy. Establishes effective performance management and control arrangements. Acts as the Accountable Officer.	Holds the Executive to account for delivery of the strategy. Provides purposeful, constructive scrutiny and challenge. Chairs, or serves as a member of, key committees supporting accountability.	Leads implementation of the strategy within their area of responsibility.
Shape Culture	Provides visible leadership in developing a positive organisational culture and ensures that this is reflected and modelled in their own behaviour and in the Board's behaviour and decision-making. Supports a constructive Board dynamic that enables contributions from all directors.	Provides visible leadership in developing a positive organisational culture and ensures that this is reflected in their own behaviour and in that of the Executive.	Actively supports and promotes a positive organisational culture and reflects this in their own behaviour. Provides a safe point of access to the Board for colleagues wishing to speak up.	Actively supports and promotes a positive organisational culture and reflects this in their own behaviour.
Context	Ensures that all Board members are appropriately briefed on the external context.			
Intelligence	Ensures that the Executive understands the Board's requirements for accurate, timely and clear information.	Ensures the provision of accurate, timely and clear information to the Board.	Seeks assurance regarding the integrity of financial and quality information.	Takes principal responsibility for providing accurate, timely and clear information to the Board.
Engagement	Acts as a key ambassador for the organisation and supports strong	Provides leadership for effective communication and for building strong	Ensures that the Board acts in the best interests of the public.	Leads engagement with specific internal or external

	Chair	Chief Executive	Non-Executive Director	Executive Director
	partnerships with patients and the public, clinicians and employees, key institutional stakeholders and regulators.	partnerships with patients and the public, clinicians and employees, key institutional stakeholders and regulators.	The Senior Independent Director provides an additional point of access to the Board where appropriate.	stakeholder groups, as appropriate.

6. Monitoring Compliance with the Code of Conduct

Compliance with this Code of Conduct, and the overall effectiveness of Board behaviours and conduct, shall be reviewed regularly, including through post-meeting reflection where appropriate.

7. References

- Cabinet Office, Code of Conduct for Board Members of Public Bodies, June 2019.
- Council for Healthcare Regulatory Excellence, Standards for Members of Boards and Governing Bodies in England, January 2012.
- Professional Standards Authority, Standards for Members of NHS Boards and Clinical Commissioning Group Governing Bodies in England.
- National Leadership Council, The Healthy NHS Board: Principles for Good Governance, February 2010.

Appendix 4 – Trust Board Business Cycle 2026/27

Title of Paper	Executive Lead	Apr	Jun	Aug	Oct	Dec	Feb
		8	10	12	7	9	10
PROCEDURAL ITEMS							
Patient / Staff Story	Chief Nurse / Chief People Officer	Staff	Pt	Staff	Pt	Staff	Pt
Chairs Update	Chair						
Chief Executives Report	Chief Executive						
Board Assurance Framework	Director of Governance & Comms		Q4	Q1		Q2	Q3
OUR PATIENTS: QUALITY, ACCESS & OUTCOMES							
Quality, Access & Outcomes Committee Assurance Report	Director of Governance & Comms						
Mortality Assurance Annual Report	Chief Medical Officer						
Maternity Serious Incident Report	Chief Nurse	**Q3**					
Annual Saving Babies Lives & Maternity Care Bundle Report	Chief Nurse						
Annual MOSS Alert Safety Check	Chief Nurse						
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI						
Bi Annual Nurse Staffing Assurance Report	Chief Nurse						
Quality Account	Chief Nurse						
Winter Plan	Chief Operating Officer						
NHS Resolution Maternity Incentive Scheme	Chief Nurse						
Quality, Access & Performance Strategic Plan Update	Chief Nurse / Chief Medical Officer / Chief Operating Officer						
Integrated Performance Report	Various						
OUR PEOPLE							
People, Culture & Inclusion Committee Assurance Report	Director of Governance						
Staff Survey Report	Chief People Officer						
Gender, Ethnicity and Disability Pay Gap Report	Chief People Officer						
Speaking Up Report	Director of Governance						
Revalidation	Chief Medical Officer						
Workforce Disability Equality and Workforce Race Equality Reports	Chief People Officer						
Equality, Diversity and Inclusion Annual Report	Chief People Officer						

Title of Paper	Executive Lead	Apr	Jun	Aug	Oct	Dec	Feb
		8	10	12	7	9	10
People Strategic Plan Update	Chief People Officer						
OUR POPULATION							
Population Health Strategic Plan Update	Director of Strategy						
FINANCE AND BUSINESS PERFORMANCE							
Finance & Business Performance Committee Assurance Report	Director of Governance						
Annual Report and Accounts including Going Concern	Chief Finance Officer						
Annual Plan	Director of Strategy						
Financial Plan including Capital Programme	Chief Finance Officer						
Standing Financial Instructions	Chief Finance Officer						
Scheme of Reservation and Delegation of Powers	Chief Finance Officer						
OUR STRATEGIC PLANS							
Digital Strategic Plan Update	Chief Digital Information Officer						
Research Strategic Plan Update	Chief Medical Officer						
Innovation Strategic Plan Update	Director of Strategy						
Estates & Facilities Strategic Plan Update	Director of Estates, Facilities & PFI						
GOVERNANCE							
Audit Committee Assurance Report	Director of Governance						
Fit and Proper Persons Annual Assurance Report	Director of Governance						
Anchor Institution Update	Director of Strategy & Communications						
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer						
Annual Evaluation of the Board Committees	Director of Governance						
Annual Review of the Rules of Procedure	Director of Governance						
Well-Led / Provider Capability Integrated Action Plan	Director of Governance						
Risk Management Policy	Director of Governance						
Complaints Policy	Chief Nurse						

All Board papers should demonstrate a clear link to the Trust's strategic objectives and relevant Board Assurance Framework risks.

Appendix 5 – Annual Effectiveness Evaluations

NB. Separate checklists are in place for the Audit Committee.

Name of Committee:	
Chair:	
Date of Effectiveness Review:	

Processes

To be completed by the Chair with the assistance of the Corporate Governance Office if required and presented to the relevant Board Committee.

Area / Question	Yes	No	Comments
Composition, Establishment and Duties			
Does the Committee have written terms of reference, and have they been approved by the Board?			
Are the terms of reference reviewed annually?			
Are the outcomes of each meeting reported to the next Trust Board meeting?			
Does the Committee prepare an annual report on its work and performance?			
Has the Committee established a plan of matters to be dealt with across the year?			
Are Committee papers distributed in sufficient time for members to give them due consideration?			
Has the Committee been quorate for each meeting this year?			
Does the Committee have clear purpose / duties?			
Are you clear about your role and responsibilities as Committee Chair?			
Does everyone contribute to the meeting - is there something which could be done to encourage this?			
Do some people dominate the agenda? Do they need to be managed differently?			
Are papers clear about why they are being brought to the Committee?			

Committee Effectiveness

The following questions are asked to each member of the Committee, whereby they are asked to either strongly agree, agree, disagree, strongly disagree as well as providing specific comments on what works well, what doesn't work well and suggestions for improvement.

- The committee has set itself a series of objectives for the year
- The committee has made a conscious decision about the information it would like to receive
- Committee members contribute regularly to the issues discussed
- The committee is aware of the key sources of assurance and who provides them
- The committee has the right balance of experience, knowledge and skills to fulfil its role
- The committee ensures that the relevant Executive Director attends meetings to enable it to understand the reports and information it receives
- The committee is fully briefed on key risks and any gaps in control
- The committee environment enables people to express their views, doubts and opinions
- Members hold their assurance providers to account for late or missing assurances
- Decisions and actions are implemented in line with the timescale set down
- The quality of committee papers received allows committee members to perform their roles effectively
- Members provide real and genuine challenge – they do not just seek clarification and/or reassurance

- The committee challenges management and other assurance providers to gain a clear understanding of their findings
- Debate is allowed to flow, and conclusions reached without being cut short or stifled
- Each agenda item is ‘closed off’ appropriately so that the committee is clear on the conclusion; who is doing what, when and how, and how it is being monitored
- At the end of each meeting the committee discuss the outcomes and reflect on decisions made and what worked well or not so well
- The committee provides a written summary report of its meetings to the Board including items for escalation
- The Board challenges and understands the reporting from the Committee
- The committee has requested ‘deep dives’ into areas of concern
- Membership and attendance at the committee enables the committee to cover all aspects of its terms of reference
- The committee chair has a positive impact on the performance of the committee
- Committee meetings are chaired effectively
- The committee chair allows debate to flow freely and does not assert their own views too strongly
- The committee chair provides clear and concise information to the Board on committee activities and gaps in control
- I have experienced instances where members behaviours were not in line with our values
- In cases where members displayed behaviours not in line with Trust values, the Chair addressed this appropriately during the meeting
- I would feel empowered to provide feedback to individuals at the time, or afterwards, where inappropriate behaviours were displayed during the meeting

Appendix 6 – Annual Governance Report Template

Introduction

The xxx Committee is established under delegated authority from the Board and operates in accordance with approved Terms of Reference, which reflect relevant national best practice. The Committee comprises xx Non-Executive Directors and met on xx occasions during xx, discharging its responsibilities in accordance with those Terms of Reference.

Following each meeting, a summary report from the Committee Chair is presented to the public Trust Board. These reports highlight the key areas of discussion and challenge, decisions taken, matters referred or escalated as appropriate, and any recommendations to the Board.

During the year, the Committee comprised of the following membership:

- xx

Other individuals, including xx, were invited to attend the Committee during xx for all or part of meetings at the request of the Committee Chair.

Key Areas of Work and Achievements against the Terms of Reference

During the year, the Committee monitored progress against its approved business cycle, as set out below.

Compliance with the Committee's key responsibilities is evidenced through the actions and matters set out in the following sections.

- xxx

Review of the Effectiveness and Impact of the Committee

The Committee has actively discharged its responsibilities during the year and has undertaken a self-assessment of its effectiveness.

Emerging Issues and Priorities for xxx

- xxx

Attendance Matrix

All meetings of the Committee held during xx were quorate.

	Attended		Apologies– Deputy in attendance		Apologies		Not in Post

Members:		A	M	J	J	A	S	O	N	D	J	F	M

The average attendance rate of members, including deputies where applicable, was xx%.

Conclusion

The Committee is satisfied that this annual report accurately reflects the work of the Committee during xx and demonstrates how it has discharged its responsibilities during the year. The Committee has reviewed xxx. In addition, there are no matters of which the Committee is aware at this time that have not been appropriately disclosed.

Appendix 7 – Agenda Template

NHS
University Hospitals of North Midlands
NHS Trust

AGENDA | TITLE OF MEETING

DATE

Venue

Time	No.	Agenda Item	Purpose	Lead	Format
	PROCEDURAL ITEMS				
	01	Chair's Welcome, Apologies and Quoracy	Information		Verbal
	02	Declarations of Interest	Information		Verbal
	03	Minutes of the Meeting held xxx	Approval		Enclosure
	04	Matters Arising via the Post Meeting Action Log	Assurance		Enclosure
	HEADING				
	05				
	06				
	HEADING				
	07				
	08				
	HEADING				
	09				
	10				
	GOVERNANCE				
	11				
	12				
	CLOSING MATTERS				
	13	Review of Meeting Effectiveness & Attendance: • What worked well / was helpful • What didn't work well / hindered us • What will we do differently next time	Information		Verbal
	14	Any Other Business	Information	All	Verbal
	DATE AND TIME OF NEXT MEETING				
	15				

Appendix 8 – Minutes Template

Minutes of Meeting

Name of Meeting | Date of Meeting

University Hospitals of North Midlands NHS Trust

Members Present:		
Name	Initials	Title

Apologies Received:		
Name	Initials	Title

In Attendance:		
Name	Initials	Title

No.	Agenda Item	Action
PROCEDURAL ITEMS		
01	Chair's Welcome, Apologies and Confirmation of Quoracy	
	xx	
02	Declarations of Interest	
	xx	

Finance & Business Performance Committee

University Hospitals of North Midlands NHS Trust

Committee Governance Pack

April 2026

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Finance & Business Performance Committee (the Committee). The Committee is a Committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference or otherwise by the Board in its Scheme of Delegation.

On behalf of the Trust Board, the Committee provides independent oversight, scrutiny and assurance on the Trust's financial stewardship, operational performance, productivity, digital modernisation and estates optimisation. The Committee ensures that risks, interdependencies and impacts on strategic objectives are clearly articulated, triangulated and escalated to the Trust Board where appropriate.

The Committee is authorised by the Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or without the Trust as it considers necessary.

Membership

- Tanya Bowen, Non-Executive Director (Chair)
- Margaret Monckton, Non-Executive Director
- Non-Executive Director (vacant)
- Diane Adamson, Chief Medical Officer
- Helen Ashley, Director of Strategy and Transformation
- Claire Cotton, Director of Governance
- Mark Oldham, Chief Finance Officer
- Sally Proffitt, Deputy Chief Finance Officer
- Katy Thorpe, Interim Chief Operating Officer

Attendance at Meetings

Other Executive Directors may be asked to attend by the Committee Chair. Other individuals may be invited to attend all or part of any meeting as and when appropriate and necessary.

Members are required to attend at least 10 out of 12 meetings per year. Regular attenders are expected to maintain a good standard of attendance and should attend meetings at least once per quarter.

If by exception members are unable to attend, they must advise the Chair of the Committee and enquire whether a deputy is required (if a deputy attends, they must be able to fully participate in the meeting but will have no voting rights).

Attendees who are deputising for members and/or regular attenders must be properly briefed by the person they are deputising for; on the content of the meeting and the item they are presenting.

The Trust's Chair will not be a member of the Committee but is authorised to observe any meetings of the Committee.

The Committee may also invite other senior officers of the Trust and other specialist advisors (internal or external) to present papers on an ad-hoc basis. Such attendees will hold no voting rights.

Quorum

A quorum for the Committee will be four members, to include two Non-Executive and two Executive Directors of the Board.

Frequency of Meetings

The Committee will meet on a monthly basis.

Reporting

The Committee will report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings will be formally recorded, and the discussion will be summarised by the Corporate Governance Team for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust Board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee will be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings.
- Agreement of agendas with the Chair and preparation, collation, and circulation of papers no later than five working days before the next meeting.
- Ensuring that those invited to each meeting, attend.
- Taking the minutes and helping the Chair to prepare reports to the Trust Board.
- Keeping a record of matters arising and action points to be carried forward between meetings.
- Arranging meetings for the Chair.
- Advising the Committee on pertinent issues/areas of interest/policy developments.

Duties

On behalf of the Trust Board, the purpose of the Committee is to provide assurance to the Trust Board on the effective stewardship of the Trust's financial resources and the delivery of its strategic and operational performance objectives. The Committee will scrutinise financial performance, strategic delivery and transformation, sustainability, productivity and activity, digitalisation, and estates and facilities management.

The Committee will:

- Receive assurance on the development and delivery of the Trust's digital, research, innovation and estates strategic programmes that support the delivery of Our Strategy, including scrutiny of delivery outcomes and the systematic application of learning to optimise the use of resources.
- Consider financial strategies, prior to submission to Trust Board for approval.
- Ensure that all business cases demonstrate robust financial analysis, risk assessment, workforce impact, benefits realisation, deliverability and interdependency mapping prior to approval or recommendation to the Trust Board.

- Receive robust assurance that business cases are being delivered in line with agreed plans, that intended benefits and milestones are realised, and that learning from delivery outcomes is evidenced annually, including assessment of return on investment.
- Receive assurance regarding financial related strategic risks, and their mitigation plans, through the Board Assurance Framework on a quarterly basis.
- Escalate matters to Trust Board as agreed by the Committee.

The duties of the Committee are as follows:

Finance

- Receive assurance on the Trust's financial performance against plan.
- Scrutinise the development and delivery of the annual financial plan, medium-term and long-term financial strategy.
- Receive assurance regarding implementation of financial risk management and mitigation strategies.
- Monitor cash flow, capital expenditure, and efficiency savings.

Strategy Delivery and Transformation

- Monitor progress against the Trust's strategic objectives and transformation programmes.
- Provide assurance on the alignment of transformation initiatives with financial and operational goals.
- Review business cases for major investments and service changes.
- Provide assurance on the effectiveness of the Trust's capacity and capability to deliver business cases and major change and transformation programmes in line with agreed plans, including identifying and reviewing learning from delivery on an annual basis to strengthen grip, control and areas for improvement.

Research and Innovation

- Receive assurance regarding implementation of the research and innovation strategies.

Sustainability

- Receive assurance regarding the development and implementation of the Trust's Green Plan and sustainability strategy.
- Received assurance on performance against sustainability targets, including carbon reduction and energy efficiency.
- Ensure sustainability is embedded in financial and operational planning.

Productivity and Activity

- Receive assurance on performance of productivity metrics and operational efficiency indicators.
- Receive assurance on delivery of activity plans, including elective recovery and waiting list targets.
- Scrutinise benchmarking data and improvement plans.

Digitalisation

- Provide oversight of the Trust's digital strategy and major digital transformation projects.
- Scrutiny of data quality, digital infrastructure resilience and clinical system stability.
- Monitor the implementation of electronic patient records (EPR) and digital infrastructure.
- Ensure digital investments deliver value and improve patient care and operational efficiency.

Estates and Facilities

- Receive assurance regarding the implementation of the estates strategy, including capital development and maintenance programmes.
- Receive assurance on performance of facilities management services.
- Ensure alignment of estates planning with clinical and strategic priorities.

General Committee Duties

- To prepare an Annual Report for the Board each year to review the Committee's work in discharging its duties against its Terms of Reference. The report will cover the previous financial reporting period.

- To identify any risks which may prevent the achievement of the Annual Business Cycle and ensure that these are assessed and placed on the Trust's Risk Register/Board Assurance Framework as appropriate.
- To report any exceptions to the Annual Business Cycle to the Board.
- Review and approve the Committee Annual Report, Annual Business Cycle and Terms of Reference of any Groups that have a direct report to the Committee.

Responsibility for Risk Management

The Committee will consider the Trust's strategic risks of a non-clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:

- Current and target risk scores.
- Impact that the risk has on strategic objectives.
- Controls and assurances in place for each risk.
- The actions and timescales for closing gaps in controls and assurances and mitigating the risk.

The relevant Executive Director responsible for each strategic risk will be accountable at the Committee for responding to challenge and scrutiny of the Committee.

Behaviours and Conduct

Trust Values

Members will be expected to conduct business in line with the Trust values and objectives.

Members of, and those attending, the committee will behave in accordance with the trust's rules of procedure, standing orders, and standards of business conduct policy.

Equality and Diversity

Members must demonstrably consider the equality and diversity implications of decisions they make.

Relationship with Other Committees

Relationship with the Audit Committee

As a Committee of Trust Board, it is important that the Committee minimises areas of overlap with the Audit Committee. Therefore, the following specific areas of responsibility will be excluded from the Committee agenda:

- Audit – External and Internal
- Approval of Annual Report and Accounts
- Approval of Standing Financial Instructions and Scheme of Delegation
- Local Counter Fraud Specialist work
- Local Security Management Specialist work
- Assurance in relation to Cyber Security

The Committee will also have key relationships with other Committees of the Board, in particular:

- People, Culture & Inclusion Committee
- Quality, Access & Outcomes Committee

The Committee will ensure clear alignment of risks, assurances and escalations with other Board Committees, particularly where matters span financial, operational, digital, workforce or quality domains. Overlaps will be minimised and escalations clearly signposted.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
27th April 2026	9.30 am – 12.00 pm	MS Teams	20th April 2026
1st June 2026	9.30 am – 12.00 pm	MS Teams	25th May 2026
29th June 2026	9.30 am – 12.00 pm	MS Teams	22nd June 2026
3rd August 2026	9.30 am – 12.00 pm	MS Teams	27th July 2026
3rd September 2026	9.30 am – 12.00 pm	MS Teams	27th August 2026
28th September 2026	9.30 am – 12.00 pm	MS Teams	21st September 2026
26th October 2026	9.30 am – 12.00 pm	MS Teams	19th October 2026
30th November 2026	9.30 am – 12.00 pm	MS Teams	23rd November 2026
21st December 2026	9.30 am – 12.00 pm	MS Teams	14th December 2026
1st February 2027	9.30 am – 12.00 pm	MS Teams	25th January 2027
1st March 2027	9.30 am – 12.00 pm	MS Teams	22nd February 2027
5th April 2027	9.30 am – 12.00 pm	MS Teams	29th March 2027

C. Annual Business Cycle

Report Title	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Authorisation of Contract Awards												
Board Assurance Framework												
Budget Setting Framework												
Business Case Review Schedule		Annual										
Capital Plan												
Changing the NHS Landscape												
Committee Effectiveness												
Cost Improvement Report											2027/28	
Demand and Activity Performance Report												
Digital Strategy Delivery												
Digital, Data and Governance Group Highlight Report												
Draft Financial Outlook												
Emergency Preparedness, Resilience and Response (EPRR) Core Standards Assurance												
Estates & Facilities Strategy Delivery												
Executive Groups Governance Pack												
Finance Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
Innovation Strategy Delivery												
Internal Audit Reports (as required)												
Medicines Finance, Procurement and Supplies Report												
Medium Term Plan Update											2027/28	
Organisational Capacity and Capability												
Overseas Visitors / Private Patient Policy Audit												
PFI 6 Monthly Exception Report												
Premises Assurance Model (PAM) and Estates Return Information Collection (ERIC) Annual Report												
Procurement Report												
Productivity / Efficiency Performance Report												
Research Strategy Delivery												
Strategic Programmes Update												
Sustainability Bi-Annual Report												
Transformation Update												

Quality, Access & Outcomes Committee

University Hospitals of North Midlands NHS Trust

Committee Governance Pack

April 2026

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Quality, Access & Outcomes Committee (the Committee). The Committee is a non-executive committee of the Trust Board and has no executive powers, other than those specifically delegated in these terms of reference or otherwise by the Trust Board in its Scheme of Delegation. In discharging its responsibilities, the Committee will focus on assurance, oversight and governance rather than the operational management of services.

The Committee is authorised by the Trust Board to investigate any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee.

The Committee is authorised by the Trust Board to obtain legal or other independent professional advice and to secure the attendance of persons with relevant experience and expertise from within or external to the Trust as it considers necessary.

Membership

- Katie Maddock, Non-Executive Director (Chair)
- Sunita Toor, Non-Executive Director (Vice-Chair)
- Wendy Nicholson, Non-Executive Director
- Di Adamson, Chief Medical Officer
- Claire Cotton, Director of Governance & Communications
- Ann-Marie Riley, Chief Nurse
- Katy Thorpe, Chief Operating Officer
- Jamie Maxwell, Head of Quality Safety & Compliance

Attendance at Meetings

It is expected that other Executive Directors will be invited to attend on an ad-hoc basis, depending on the items being covered by the Committee.

Regular Attendees

Other individuals may be invited to attend all or part of any meeting as and when appropriate.

Members are required to attend at least 10 out of 12 meetings per year. Regular attenders are expected to maintain a good standard of attendance and should attend meetings at least once per quarter.

If by exception members are unable to attend, they must advise the Chair of the Committee and enquire whether a deputy is required (if a deputy attends they must be able to fully participate in the meeting but will have no voting rights).

Attendees who are deputising for members and/or regular attenders must be properly briefed by the person they are deputising for, on the content of the meeting and the item they are presenting.

Quorum

A quorum for the Committee will be four members, to include two Non-Executive and one Executive Director of the Board.

Frequency of Meetings

The Committee will meet on a monthly basis.

Reporting

The Committee will report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings will be formally recorded. Following each meeting, a formal highlight report will be submitted to the Trust Board summarising key discussions, decisions, levels of assurance and matters for escalation.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee will be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation, and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The purpose of the Committee is to provide assurance to the Trust Board on the delivery of the Trust's clinical and quality priorities within Our Strategy, including access, outcomes, safety and improvement, and on whether delivery risks are being effectively identified, mitigated and escalated"

The primary duties of the Committee are to provide assurance to the Trust Board, of the level, adequacy and maintenance of governance, risk management and internal control across quality, access and outcomes activities in line with the five Care Quality domains.

Safe

- Review the risk and adequacy of assurance of patient safety (the avoidance, prevention and improvement of adverse outcomes). Ensuring that internal and external assurances of patient safety are regularly reviewed and the strength of assurances evaluated.
- Seek assurance on the risks arising from operational performance and patient flow, including the potential impact on quality and patient safety relating to discharge, referral to treatment times, urgent and elective care (including cancer) and diagnostics.
- Receive assurance that external reports on patient safety that have an impact on acute care have been reviewed, considered and any learning adopted. This will include national inquiries; quality reports; safety alerts; Department of Health and Social Care reviews; NHS England; and professional bodies with the responsibility for the performance of staff, (Royal Colleges, accreditation bodies etc)

Effective (Patient Outcomes)

- Review risks and the adequacy of assurance in relation to clinical effectiveness and patient outcomes, including alignment with CQC quality domains and external standards.
- Review the assurance that the clinical audit programme is aligned with the key strategic and operational risks.
- Receive assurance in relation to compliance with the Mental Health Act

Caring

- Review risks and the adequacy of assurance of patient experience, via review of the action plans to address the outcomes of patient surveys; patient experience tracker results; complaints and comments; patient stories; external reports such as CQC; Healthwatch; Overview and Scrutiny Committees etc.

Responsive

- Review risks and receive assurance on performance against access and waiting time standards and the quality impact of changes to service provision, including Quality Impact Assessments.
- Oversee operational performance to ensure delivery of the NHS Constitutional targets and objectives within the Annual Plan
- Consider the operational performance management control framework

Other Assurance Functions

- Monitor progress against strategic quality and access objectives, ensuring delivery plans remain aligned to the Trust's strategy and do not compromise patient safety or experience.
- Review the risks and assurances to compliance with the CQC registration requirements.
- Review the process and methodology for production of the quality account ensuring that it meets the Trust legal obligations and duties.
- Review any investigations of activities which are within its terms of reference.
- Review the findings of other significant governance and risk reports, both internal and external to the organisation, and will consider any implications for the governance of the Trust.
- Monitor operational management and implementation of policies to ensure internal control and assurance of quality and operational governance.
- Ensure alignment of quality risks, mitigations and assurance with relevant Board committees, including People, Culture & Inclusion and Finance & Business Performance.

Management

- Request and review reports and positive assurances from directors and managers on the overall accuracy of information in respect of governance, risk management and internal control.
- Request specific reports from individual functions within the Trust as they may be appropriate to the overall arrangements set out above.

General Committee Duties

- Prepare an Annual Report for the Board each year to review the Committee's work in discharging its duties against its Terms of Reference. The report will cover the previous financial reporting period.
- Identify any risks which may prevent the achievement of the Annual Business Cycle and ensure that these are assessed and placed on the Trust's Risk Register/Board Assurance Framework as appropriate.
- Report any exceptions to the Annual Business Cycle to the Board.
- Review and approve the Annual Report, Annual Business Cycle and Terms of Reference of any Groups that have a direct report to the Committee.

Responsibility for Risk Management

The Committee will consider the Trust's strategic risks of a clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:

- Current and target risk scores
- Impact that the risk has on strategic objectives
- Controls and assurances in place for each risk
- The actions and timescales for closing gaps in controls and assurances and mitigating the risk

The relevant Executive Director responsible for each strategic risk will be accountable at the Committee for responding to challenge and scrutiny of the Committee. The Committee will ensure that assurances provided are outcome-focused and that actions address root causes rather than symptoms.

Relationship with Other Committees

The Committee will have a key relationship with other Committees of the Board, in particular:

- People, Culture & Inclusion Committee
- Finance & Business Performance Committee

Matters for consideration / referral to other Committees of the Board will be done so via the Committee Assurance Reporting mechanism.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
29th April 2026	1.00 pm – 3.30 pm	Trust Boardroom	22nd April 2026
3rd June 2026	1.00 pm – 3.30 pm	MS Teams	27th May 2026
1st July 2026	1.00 pm – 3.30 pm	Trust Boardroom	24th June 2026
5th August 2026	1.00 pm – 3.30 pm	MS Teams	29th July 2026
2nd September 2026	1.00 pm – 3.30 pm	Trust Boardroom	26th August 2026
30th September 2026	1.00 pm – 3.30 pm	MS Teams	23rd September 2026
28th October 2026	1.00 pm – 3.30 pm	Trust Boardroom	21st October 2026
2nd December 2026	1.00 pm – 3.30 pm	MS Teams	25th November 2026
23rd December 2026	1.00 pm – 3.30 pm	MS Teams	16th December 2026
3rd February 2027	1.00 pm – 3.30 pm	Trust Boardroom	27th January 2027
3rd March 2027	1.00 pm – 3.30 pm	MS Teams	24th February 2027
7th April 2027	1.00 pm – 3.30 pm	Trust Boardroom	31st March 2027

C. Annual Business Cycle

Report Title	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
7 Day Services Board Assurance Report												
Access Performance Report & Executive Recovery Oversight Group Highlight Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
Board Assurance Framework	Q4			Q1			Q2			Q3		
Cancer 104+ Day Breach Analysis												
Care Excellence Framework (CEF) Summary / Staffing Report		Q3 & Q4			Q1			Q2			Q3	
Care Quality Commission Inspection Update												
Chaperoning Update / Audit												
Clinical Audit Plan												
Clinical Effectiveness Update												
Committee Effectiveness												
Controlled Drugs Annual Report												
End of Life Annual Report												
Engagement Strategy												
Executive Groups Effectiveness Reviews / Terms of Reference												
Executive Quality & Outcomes Group Assurance Report												
Get It Right First Time Update												
Infection Prevention Board Assurance Framework	Q4			Q1			Q2			Q3		
Infection Prevention Hospital Acquired Infection Report	Q4			Q1			Q2			Q3		
Infection Prevention, Vaccination & Sepsis Team Annual Report												
Internal Audit Reports (as required)												
Legal Services Annual Litigation & Inquest Report												
Long-term/Short-term Locum Doctors in Obstetrics & Gynaecology Audit												
Looked after Children Annual Report												
Maternity & Neonatal Cultural Improvement Plan 2025-2027												
Maternity & Neonatal PSIRF Investigation Report		Q4			Q1			Q2			Q3	
Maternity & Neonatal Services (NHS England Rapid Independent Investigation)												
Maternity & Neonatal Single Delivery Plan												
Maternity & Neonatal Workforce Annual Plan												
Maternity & Neonatal Workforce Report												
Maternity Consultant Attendance Audit												
Maternity Dashboard		Q4			Q1			Q2			Q3	
Maternity Incentive Scheme (NHS Resolution)												
Maternity Quality & Safety Oversight Group Assurance Report												
Medical Examiner Service Update												
Medicines Optimisation & Safety Report	Q3/Q4			Q1			Q2			Q3		
Mental Health Report			Q4			Q1			Q2			Q3
Mortality Assurance Report												
Mortuary Board Assurance (Fuller Report)												
Organ and Eye/Tissue Donation Update												
Our Patients Strategy Delivery												
Paediatric Audiology Position Statement												
Patient Experience Report	Q3			Q4			Q1			Q2		
Patient Safety Incident Investigation Report	Q4			Q1			Q2			Q3		
Patient Waiting List Backlog												
Perinatal Mortality Report												
PLACE Inspection Findings and Action Plan												
Population Health / Waiting Inequalities List Report												
Population Health Strategy Delivery												
Quality Account												
Quality Impact Assessment Report												
Quality Performance Report	M12	M1	M2	M3	M4	M5	M6	M7	M8	M9	M10	M11
Readmissions Analysis												
Resuscitation Annual Report												
Safeguarding Adults Annual Report												
Safeguarding Children Annual Report												
Saving Babies Lives Care Bundle												
Self-Assessment into Previous Inquiries / Investigation Recommendations												
Vulnerable Patients Annual Report												
Winter Close Down Report												
Winter Plan												

People, Culture & Inclusion Committee

University Hospitals of North Midlands NHS Trust

Committee Governance Pack

April 2026

A. Terms of Reference

Constitution and Authority

The Trust Board hereby resolves to establish a Committee of the Board to be known as the People, Culture & Inclusion Committee (the Committee).

The Committee is a Non-Executive Director–led assurance committee of the Trust Board, responsible for providing independent oversight, scrutiny and assurance to the Board on matters relating to people, culture, equality, diversity and inclusion, and workforce sustainability.

The Committee supports the Board in discharging its statutory, regulatory and governance responsibilities by:

- Overseeing compliance with workforce-related legislation, national directives and best practice
- Providing assurance on the delivery and strategic impact of the Trust's People Strategy and related programmes
- Ensuring that workforce considerations are fully integrated into Trust strategy, planning and risk management

The Committee does not have executive decision-making authority and is not responsible for the operational delivery of workforce activity, which remains the responsibility of Executive Directors.

The Committee is authorised by the Trust Board to:

- Investigate any matter within its Terms of Reference
- Seek any information it requires from any employee of the Trust (all employees are directed to co-operate with any such request)
- Obtain legal or other independent professional advice, and
- Secure the attendance of individuals with relevant experience or expertise (internal or external) where required to support its assurance role

Membership

- Non-Executive Director (Chair)
- Sunita Toor, Non-Executive Director (Vice-Chair)
- Katie Maddock, Non-Executive Director
- Wendy Nicholson, Non-Executive Director
- Diane Adamson, Chief Medical Officer
- Claire Cotton, Director of Governance & Communications
- Jane Haire, Chief People Officer
- Ann-Marie Riley, Chief Nurse

Attendance at Meetings

Other Executive Directors and senior leaders may be invited to attend on an ad-hoc basis, depending on the agenda.

Other individuals may be invited to attend all or part of any meeting, as appropriate, to provide assurance, advice or expert input. Such attendees will have no voting rights.

Members are expected to attend at least four of the six meetings per year.

Regular attendees are expected to maintain a good standard of attendance and to attend at least once per quarter.

Where a member is unable to attend, they must inform the Chair in advance. Deputies may attend by exception but must be appropriately briefed and able to contribute fully; deputies will not have voting rights.

The Trust Chair is not a member of the Committee but may attend meetings as an observer.

Quorum

A quorum for the Committee will be four members, to include two Non-Executive and two Executive Directors of the Board.

Frequency of Meetings

The Committee will meet six times a year.

Reporting

The Committee will report to the Trust Board on how it discharges its responsibilities.

The minutes of Committee meetings will be formally recorded, and the discussion will be summarised by the Corporate Governance Team on behalf of the Chair for inclusion within a report to be submitted to the next available Trust Board meeting. This summary will also draw attention to the Trust Board of any issues requiring disclosure or action.

The Committee will undertake an annual effectiveness evaluation against their Terms of Reference and Membership, the outcome of which will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee will be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The Committee will provide assurance to the Board that:

- The Trust has a credible, deliverable People Strategy, aligned to corporate strategy and values
- Progress against the People Strategy is monitored using appropriate workforce metrics, trends and intelligence
- Workforce and cultural risks are identified, understood and managed

In discharging this role, the Committee will:

- Provide assurance to the Trust Board on the delivery of the People Strategy and its contribution to the achievement of the Trust's strategic objectives, including workforce sustainability, culture, leadership and inclusion.
- Oversee workforce indicators including recruitment, retention, wellbeing, culture, freedom to speak up, equality and inclusion.
- Receive assurance that workforce policies and procedures are compliant with legislation and subject to regular review.
- Scrutinise management responses to workforce-related internal and external audit findings.
- Receive assurance on leadership and management development, talent and succession planning, apprenticeships and widening participation.
- Review staff experience and engagement intelligence, including survey outcomes and qualitative feedback.
- Oversee equality, diversity and inclusion strategy, progress and statutory reporting.
- Receive the Guardian of Safe Working Hours report on behalf of the Board.
- Receive bi-annual Freedom to Speak Up reports.
- Receive assurance on workforce transformation, including clinical workforce models.
- Receive and scrutinise mandated workforce returns (including equality, revalidation and safe staffing).
- Ensure workforce implications of financial and operational plans are explicitly considered.

General Committee Duties

The Committee will:

- Prepare an Annual Report to the Trust Board summarising how it has discharged its duties.
- Identify emerging workforce-related risks and ensure appropriate escalation.
- Report any exceptions to the Annual Business Cycle.
- Review and approve the Annual Business Cycle, Terms of Reference and effectiveness arrangements for any groups reporting directly to the Committee.

Responsibility for Risk Management

The Committee will consider the Trust's strategic risks of a non-clinical nature and for each strategic risk, on a quarterly basis through the Board Assurance Framework, assess:

- Current and target risk scores
- Impact that the risk has on strategic objectives
- Controls and assurances in place for each risk
- The actions and timescales for closing gaps in controls and assurances and mitigating the risk

The relevant Executive Director responsible for each strategic risk will be accountable at the Committee for responding to challenge and scrutiny of the Committee.

Relationship with Other Committees

The Committee will have a key relationship with other Committees of the Board, in particular:

- Quality, Access & Outcomes Committee
- Finance and Business Performance Committee

Matters for consideration / referral to other Committees of the Board will be done so via the Committee Assurance Reporting mechanism.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
28th May 2026	9.30 am – 12.00 pm	MS Teams	21st May 2026
30th July 2026	9.30 am – 12.00 pm	MS Teams	23rd July 2026
24th September 2026	9.30 am – 12.00 pm	MS Teams	17th September 2026
26th November 2026	9.30 am – 12.00 pm	MS Teams	19th November 2026
28th January 2027	9.30 am – 12.00 pm	MS Teams	21st January 2027
1st April 2027	9.30 am – 12.00 pm	MS Teams	25th March 2027

C. Annual Business Cycle

Report Title	May	July	Sept	Nov	Jan	Mar
Allied Health Professional Workforce Establishment Review						
Annual Staff Survey Report						
Appraisal and Revalidation Annual Report						
Armed Forces Annual Report 2025/26						
Bi-Monthly Nursing & Midwifery Staffing Report						
Board Assurance Framework		Q1			Q3	
CeNREE Update						
Chief Healthcare Scientist Update						
Chief People Officer Report	P1	P2	P3	P1	P2	P3
Chief Pharmacist Workforce Report						
Committee Effectiveness						
EDI Accountability Framework						
Employment Relations Activity Report						
Equality, Diversity & Inclusion Annual Report						
Executive Groups Terms of Reference						
Fire Safety Annual Report						
Flexible Working Report						
Freedom To Speak Up Accountability Framework						
Gender Pay Gap Report						
Guardian of Safe Working Report	Q4	Q1		Q2	Q3	
Health & Safety Accountability Framework						
Health and Safety Group Assurance Report						
Health and Safety Report		Q4		Q1/Q2		
Internal Audit - DBS Checks						
Internal Audit - HR Record Keeping – Disciplinary Records						
Internal Audit Reports (as required)						
Learning and Education Annual Report						
Mandatory Learning Oversight Assurance Report						
Medical Workforce Group Assurance Report						
Nursing & Midwifery Staffing Establishment Review						
People Strategic Plan						
Postgraduate Medical Education Report						
Resident Doctors 10 Point Plan						
Responsible Officer Advisory Group Highlight Report						
Security Management Annual Report						
Sexual Safety Update	Verbal					
Speaking Up Report	Q3/Q4			Q1/Q2		
Staff Network Annual Report						
Strategic Workforce Group Highlight Report						
Talent and Succession Planning Update						
Undergraduate Medical School Report						
Violence Prevention and Reduction Update						
Wellbeing Report						
Workforce Plan Update 2026/27						
Workforce Race and Workforce Disability Equality Standard						
Workforce Transformation Programmes						

Audit Committee

Committee Governance Pack

April 2026

University Hospitals of North Midlands NHS Trust

A. Terms of Reference

Constitution and Authority

The Board hereby resolves to establish a Committee of the Board to be known as the Audit Committee (the Committee). The Committee is a non-executive committee of the Board and has no executive powers, other than those specifically delegated in these terms of reference.

The Committee is authorised by the Board to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the Committee. The Committee is authorised by the Board to obtain outside legal or other independent professional advice and to secure the attendance of outsiders with relevant experience and expertise if it considers this necessary.

Membership

The Committee is appointed by the Board from amongst the Non-Executive Directors of the Trust and will consist of the following:

- Mrs Margaret Monckton, Non-Executive Director (Chair)
- Ms Tanya Bowen, Non-Executive Director
- Professor Katie Maddock, Non-Executive Director
- Non-Executive Director (vacant)

The Chair of the organisation will not be a member of the Committee. In addition, other Non-Executives are invited to attend as required.

Attendance at Meetings

Members are required to attend at least 4 out of 5 meetings per year. Regular attenders are expected to maintain a good standard of attendance.

The Chief Finance Officer and appropriate internal and external audit representatives will normally attend meetings.

The Local Counter Fraud Specialist will attend a minimum of two committee meetings a year.

The Chief Executive will be invited to attend and discuss, annually with the Committee, the process of assurance that supports the Annual Governance Statement. They will also attend when the Committee considers the draft annual report and accounts.

Executive Directors may attend for specific agenda items relevant to their portfolio, where this supports focused discussion and proportionate use of senior resources.

The Corporate Governance team will provide appropriate support to the Chair and Committee members.

At least once a year, the Committee should meet privately with the external and internal auditors.

Access

The head of internal audit and representative of external audit have a right of direct access to the chair of the committee. This also extends to the local counter fraud specialist.

Quorum

A quorum will be two non-executive members.

Frequency of Meetings

The Committee will hold a minimum of five meetings per annum. The External Auditors or Head of Internal Audit may request an additional meeting if they consider that one is necessary.

Reporting

The Committee will report to the Board on how it discharges its responsibilities.

The minutes of the Committee meetings will be formally recorded and made available to all members of the Committee.

The Corporate Governance Office will submit a report following each Committee meeting, on behalf of the Committee Chair, for presentation at the next Open Trust Board. The report will summarise the decisions made as well as highlighting any items for escalation.

The Committee, led by the Chair, will undertake an annual effectiveness evaluation against their Terms of Reference and Membership. The outcome will be reported to the Board in accordance with the Annual Business Cycle.

The Committee will report to the Board at least annually on its work in support of the Annual Governance Statement, specifically commenting on:

- The fitness for purpose of the assurance framework
- The completeness of and how embedded risk management is in the organisation
- The effectiveness of governance arrangements
- The appropriateness of the evidence that shows compliance with regulatory requirements

The Committee's annual report will also describe how the Committee has fulfilled its terms of reference and give details of any significant issues that the committee considered in relation to the financial statements and how they were addressed.

An annual Committee Effectiveness evaluation will be undertaken and reported to the Committee and the Board.

The Committee will review these terms of reference, at least annually as part of the annual committee effectiveness review and recommend any changes to the board.

Administrative Support

The Committee will be supported administratively by the Corporate Governance Team whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board

- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair
- Advising the Committee on pertinent issues/areas of interest/policy developments

Duties

The Committee's duties/responsibilities can be categorised as follows:

Governance, Risk Management and Internal Control

The Committee will review the adequacy and effectiveness of the system of governance, risk management and internal control, across the whole of the organisation's activities (clinical and non-clinical), that supports the achievement of the organisation's objectives. This includes quarterly review of the Board Assurance Framework to assess the adequacy of controls, assurance sources and alignment to strategic risks. The Committee will also review the adequacy and effectiveness of the organisation's policy governance framework, including assurance on policy ownership, review cycles and compliance.

In particular, the Committee will review the adequacy and effectiveness of:

- all risk and control related disclosure statements (in particular the annual governance statement), together with any accompanying head of internal audit opinion, external audit opinion or other appropriate independent assurances, prior to submission to the board
- the underlying assurance processes that indicate the degree of achievement of the organisation's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies for ensuring compliance with relevant regulatory, legal and code of conduct requirements and any related reporting and self-certifications, including the NHS Code of Governance and NHS Provider licence
- the policies and procedures for all work related to counter fraud, bribery and corruption as required by the NHS Counter Fraud Authority (NHSCFA).

The Committee will also receive and scrutinise assurance on the effectiveness of the Trust's cyber security arrangements, including oversight of related risks, controls and mitigation plans.

In carrying out this work the Committee will primarily utilise the work of internal audit, external audit and other assurance functions, but will not be limited to these sources. It will also seek reports and assurances from directors and managers as appropriate, concentrating on the over-arching systems of governance, risk management and internal control, together with indicators of their effectiveness.

This will be evidenced through the Committee's use of an effective assurance framework to guide its work and the audit and assurance functions that report to it.

As part of its integrated approach, the Committee will have effective relationships with other key committees (for example, the Quality, Access & Outcomes Committee) so that it understands processes and linkages. However, these other Committees must not usurp the Committee's role.

Internal Audit

The committee will ensure that there is an effective internal audit function that meets the *Public sector internal audit standards, 2017* and provides appropriate independent assurance to the committee, Chief Executive and Board. This will be achieved by:

- considering the provision of the internal audit service and the costs involved
- reviewing and approving the annual internal audit plan and more detailed programme of work, ensuring that this is consistent with the audit needs of the organisation as identified in the assurance framework
- considering the major findings of internal audit work (and management's response), and ensuring coordination between the internal and external auditors to optimise the use of audit resource

- Monitoring the timeliness and quality of management responses to internal audit recommendations and ensure that long-standing or repeated overdue actions are appropriately escalated.
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the organisation
- monitoring the effectiveness of internal audit and carrying out an annual review.

External Audit

The Committee will review and monitor the external auditors' independence and objectivity and the effectiveness of the audit process. In particular, the Committee will review the work and findings of the external auditors and consider the implications and management's responses to their work. This will be achieved by:

- considering the appointment and performance of the external auditors, as far as the rules governing the appointment permit (and make recommendations to the board when appropriate)
- discussing and agreeing with the external auditors, before the audit commences, the nature and scope of the audit as set out in the annual plan
- discussing with the external auditors their evaluation of audit risks and assessment of the organisation and the impact on the audit fee
- reviewing all external audit reports, including the report to those charged with governance (before its submission to the board) and any work undertaken outside the annual audit plan, together with the appropriateness of management responses
- ensuring that there is in place a clear policy for the engagement of external auditors to supply non-audit services.

Other Assurance Functions

The Committee will review the findings of other significant assurance functions, both internal and external to the organisation, where relevant to the governance, risk management and assurance of the organisation.

These may include, but will not be limited to, any reviews by Department of Health and Social Care arm's length bodies or regulators/ inspectors (for example, the Care Quality Commission, NHS Resolution) and professional bodies with responsibility for the performance of staff or functions (for example, Royal Colleges, accreditation bodies).

In addition, the Committee will review the work of other committees within the organisation, whose work can provide relevant assurance to the audit committee's own areas of responsibility. In particular, this will include any committees covering safety/ quality, for which assurance from clinical audit can be assessed, and risk management.

Counter Fraud

The Committee will satisfy itself that the organisation has adequate arrangements in place for counter fraud, bribery and corruption that meet NHSCFA's standards and will review the outcomes of work in these areas.

With regards to the Local Counter Fraud Specialist it will review, approve and monitor counter fraud work plans, receiving regular updates on counter fraud activity, monitor the implementation of action plans and discuss NHSCFA quality assessment reports.

The Committee will oversee compliance with the Economic Crime and Corporate Transparency Act (ECCTA) requirements, including assurance on the organisation's "Failure to Prevent Fraud" arrangements and associated controls.

Financial Reporting

The Committee will monitor the integrity of the financial statements of the organisation and any formal announcements relating to its financial performance.

The Committee should ensure that the systems for financial reporting to the board, including those of budgetary control, are subject to review as to the completeness and accuracy of the information provided.

The Committee will review the annual report and financial statements before submission to the board, or on behalf of the board where appropriate delegated authority is place, focusing particularly on:

- the wording in the annual governance statement and other disclosures relevant to the terms of reference of the committee
- changes in, and compliance with, accounting policies, practices and estimation techniques
- unadjusted misstatements in the financial statements
- significant judgements in preparation of the financial statements
- significant adjustments resulting from the audit
- letters of representation

Management

The Committee will request and review reports, evidence and assurances from directors and managers on the overall arrangements for governance, risk management and internal control.

The Committee may also request specific reports from individual functions within the organisation (for example, compliance reviews or accreditation reports).

Relationship with other Committees:
As a Committee of the Trust Board, it is important that the Committee minimises areas of overlap. Therefore, the following specific areas of responsibility will be excluded from the Committee agenda:

- Issues around clinical risk management including receiving assurance from the clinical audit function will be considered at the Quality, Access and Outcomes Committee
- The effectiveness of the arrangements in place for allowing staff to raise (in confidence) concerns about possible improprieties in financial, clinical or safety matters and ensuring that any such concerns are investigated proportionately and independently, will be considered at the People Committee.
- Reporting on compliance with the fit and proper persons test will be considered by the Nominations and Remuneration Committee.

The Committee will ensure active triangulation of assurance with other Board Committees, sharing relevant insights to support a cohesive organisation-wide assurance framework.

Governance Regulatory Compliance
The Committee will review the organisation's reporting on compliance with the NHS Provider Licence and NHS code of governance as required. The Committee will satisfy itself that the organisation's policy, systems and processes for the management of conflicts, (including gifts and hospitality and bribery) are effective including receiving reports relating to non-compliance with the policy and procedures relating to conflicts of interest.

Behaviours and Conduct

Trust Values
Members will be expected to conduct business in line with the trust values and objectives. Members of, and those attending, the committee will behave in accordance with the trust's rules of procedure, standing orders, and standards of business conduct policy.

Equality and Diversity
Members must demonstrably consider the equality and diversity implications of decisions they make.

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
30th April 2026	12.45 pm – 3.00 pm	Via MS Teams	23rd April 2026
19th June 2026	9.30 am – 11.00 am	Via MS Teams	12th June 2026
6th August 2026	12.45 pm – 3.00 pm	Via MS Teams	30th July 2026
29th October 2026	12.45 pm – 3.00 pm	Via MS Teams	22nd October 2026
4th February 2027	12.45 pm – 3.00 pm	Via MS Teams	28th January 2027

C. Annual Business Cycle

To assist in the management of business over the year the following annual workplan will be maintained, capturing the main items of business at each scheduled meeting.

Report Title	April	June	July	Oct	Jan
Accountability & Performance Framework					
Accounting Policies Update					
Annual Accounts					
Annual Accounts Timetable					
Annual Report and Annual Governance Statement					
Audit Findings Report and Letter of Representation					
Audited Accounts and Financial Statements and Analytical Review					
Auditor's Annual Report					
Board Assurance Framework					
Clinical Audit Programme					
Committee Effectiveness					
Corporate Governance Report					
Cyber Security Assurance Report					
External Audit Plan					
External Audit Progress Report					
External Audit Review of Effectiveness					
Going Concern					
Internal Audit Annual Report and Opinion					
Internal Audit Plan 2026/27					
Internal Audit Recommendation Tracker					
Internal Audit Review of Effectiveness					
Issues for Escalation from Committees					
LCFS Annual Report					
LCFS Annual Work Plan					
LCFS Progress Report					
LCFS Review of Effectiveness					
Losses and Special Payments and Stock Write Offs					
Medicines Write Off Report					
SFI Breaches relating to Procurement processes and Single Tender Waivers					
SFI Breaches relating to Salary Overpayments					

Nominations and Remuneration Committee

Committee Governance Pack

March 2026

University Hospitals of North Midlands NHS Trust

A. Terms of Reference

Constitution and Authority

The Trust Board hereby resolves to establish a Committee of the Board to be known as the Nominations and Remuneration Committee (the Committee). The Committee has no executive powers, other than those specifically delegated in these terms of reference.

The Committee is authorised by the Trust Board to take action in respect of any activities within its Terms of Reference. The Committee is authorised by the Trust Board to obtain, at the Trust's expense, outside legal or other professional advice on any matters within its terms of reference.

Membership

The Committee will comprise all Non-Executive Directors of the Trust Board, all of whom are invited to attend Committee meetings. The Chair of the Trust Board will serve as Chair of the Committee.

Where the Committee is required to consider matters relating to the Trust Board Chair, including succession planning or performance, the Senior Independent Director will be invited to chair the meeting.

Attendance at Meetings

Only members of the Committee have the right to attend committee meetings. However, other individuals and advisers may be invited to attend all or part of any meeting as and when appropriate.

It is expected that the following members of staff will regularly attend Committee meetings in an advisory capacity:

- Chief Executive. The Chief Executive will be excluded from meetings when their own remuneration is being considered.
- Chief People Officer. The Chief People Officer will be excluded from meetings when their own remuneration is being considered.
- Director of Governance & Communications. The Director of Governance & Communications will be excluded from meetings when their own remuneration is being considered.

Quorum

The quorum necessary for the transaction of business will be two members, one of whom should normally be the Committee Chair or, in their absence, a nominated Non-Executive Director.

Frequency of Meetings

The Committee will meet at least four times a year, and otherwise as required.

In exceptional or urgent circumstances, the Committee Chair may take decisions on behalf of the Committee within these Terms of Reference, following consultation with appropriate members, with such decisions reported to the next available Committee meeting.

Reporting

The minutes of Committee meetings will be formally recorded and will be available for Board members on request.

The Committee will undertake an annual effectiveness evaluation against its Terms of Reference, membership and ways of working, and will agree any actions required to further strengthen effectiveness. The outcome will be reported to the Trust Board in accordance with the Annual Business Cycle.

Administrative Support

The Committee will be supported administratively by the Deputy Director of Governance, whose duties in respect of this include:

- Calling of meetings
- Agreement of agendas with the Chair and preparation, collation and circulation of papers no later than five working days before the next meeting
- Ensuring that those invited to each meeting, attend
- Taking the minutes and helping the Chair to prepare reports to the Trust Board (as required)
- Keeping a record of matters arising and action points to be carried forward between meetings
- Arranging meetings for the Chair

Duties

In discharging its duties, the Committee will seek assurance that appropriate processes, controls, due diligence and value-for-money considerations are in place, and that decisions are compliant with relevant legislation, national guidance and the Trust's governance framework.

Remuneration

- To agree the remuneration and terms of service arrangements for Executive Directors (i.e. Board voting and non-voting members), the Chief Executive and posts assigned to the Very Senior Manager framework.
- To oversee the contractual arrangements for Executive Directors and, when required, consider issues relating to remuneration, terms of service and performance issues for Very Senior Managers.
- To review additional non-pay benefits.
- To review severance packages which fall outside the standard provisions of the Contract of Employment*
- To receive assurance that complex or high-risk remuneration, redundancy or severance matters have been subject to appropriate Executive-level review and due diligence prior to submission to the Committee.
- To take account of assurance provided by the Audit Committee in respect of value-for-money, control and compliance, where relevant.
- To ensure that the Annual Report includes a report on the remuneration arrangements for Executive Directors and the Chief Executive, including those who have joined or left the Trust during the financial year.
- Receive assurance as to off-payroll and interim Board payments

*** Severance Packages Approval Levels**
Severance packages which fall outside the standard provisions of the Contract of Employment must be calculated using standard guidelines. Any proposal to make payments outside of the current guidelines are subject to the approval of HM Treasury, via NHS England (NHSE).

Redundancy Payments
The Committee must seek assurance on the process, calculations, compliance and value-for-money considerations relating to redundancy payments and approve any redundancy payments of £10,000 or above. Any payments below these thresholds can be agreed by the Chief Executive / Chief Finance Officer / Chief People Officer outside of the meeting with notification being made to the next meeting of the Committee.

Tribunal Settlements
The Committee must consider / approve tribunal settlements which are £10,000 or above. Any payments below this threshold can be agreed by the Chief Executive, Chief People Officer and Chief Finance Officer outside of the meeting with notification being made to the next meeting of the Committee. In circumstances where a decision regarding a settlement of £10,000 or above is urgent, a decision can be made through discussion with the Chair. Again, this would need to be reported to the next meeting of the Committee.

Nominations

- The appointment of the Chief Executive is the responsibility of the Chair. This process will be supported by NHS England. The Chair will assemble an appropriate panel with relevant expertise and experience in respect of the appointments process.
- To regularly review the structure, size and composition (including the skills, knowledge, experience and diversity) required of Non-Executive Directors of the Board and make recommendations to the Board with regards to any changes.
- To consider and make recommendations to the Trust's Board on any proposals to changes in the structure of the Board and any proposals to increase or decrease the number of voting Executive Directors and/or Non- Executive Directors. The Trust Board should approve such changes.
- When a decision is taken to change the structure of the Board and/or a vacancy arises on the Trust Board, the Committee may seek advice from the Chief People Officer with regard to the recruitment process to be adopted.
- Before an appointment is made by the Board, the Committee will evaluate the balance of skills, knowledge, experience and diversity on the Board, and, in the light of this evaluation, prepare a description of the role and capabilities required for a particular appointment.
- To consider the person specification when Non-Executive vacancies arise.
- To consider the re-appointment of any Non-Executive Directors at the conclusion of their specified term of office having given due regard to their performance and ability to continue to contribute to the Board in the light of the knowledge, skills and experience required
- To give full consideration to succession planning for all Board Members in the course of its work, taking into account the challenges and opportunities facing the organisation, and the skills and expertise needed on the Board in the future.
- To monitor and evaluate the performance of the individual Directors (with the advice of the Chief Executive).
- To develop, monitor and seek feedback on a process for the evaluation of performance and contribution on the part of the Chair and Non-Executive Directors.
- To annually review the time required for Non-Executive Directors. Performance evaluation should be used to assess whether the Non-Executive Directors are spending enough time to fulfil their duties.
- To keep up to date and fully informed about strategic issues and commercial changes affecting the Trust and the environment in which it operates.
- Receive the annual declaration of the Chair in respect of the Board Members complying with the Fit and Proper Persons regulation and receive evidence-based assurance that all newly appointed executive directors including the Chief Executive are deemed Fit and Proper.
- Approve any remedial action plan to address non-compliance with the Fit and Proper Persons regulation.
- Approval of membership of Board Committees as appropriate, in consultation with the chairpersons of those Committees

B. Annual Schedule of Meetings

Date	Time	Venue	Deadline for Papers
Tuesday 2nd June 2026	10.30 am – 12.00 pm	MS Teams	26th May 2026
Tuesday 1st September 2026	10.30 am – 12.00 pm	MS Teams	25th August 2026
Tuesday 1st December 2026	10.30 am – 12.00 pm	MS Teams	24th November 2026
Tuesday 2nd March 2027	10.30 am – 12.00 pm	MS Teams	23rd February 2027

C. Annual Business Cycle

Agenda Category	Assurance Source	Exec Lead	BAF	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Remuneration	Redundancy Payments / Tribunal Settlements £10,000 and above	CPO													
Remuneration	Remuneration and terms of service for Executive Directors and Chief Executive	CPO													
Remuneration	Remuneration Section of Annual Report	DoG													
Remuneration	Off-payroll and Interim Board payments	CPO													
Remuneration	Pension Restructuring Payment Scheme Review	CPO													
Nominations	Changes to the Composition of the Trust Board	Chair													
Nominations	Executive / Non-Executive Appointments	Chair / CEO													
Nominations	Non-Executive Director Performance Reviews & Review of Time Required & Succession Planning	Chair													
Nominations	Annual Non-Executive Director Skills Analysis & Committee Membership	DoG													
Nominations	Executive Director Performance Reviews	CEO													
Nominations	Succession Planning & Talent Management	CPO													
Governance	Fit and Proper Persons Declarations	DoG													
Governance	Committee Effectiveness	DoG													

Trust Board

2026/27 BUSINESS CYCLE

KEY TO RAG STATUS	
Paper rescheduled for future meeting	
Paper rescheduled for next meeting	
Paper taken to meeting as scheduled	

Title of Paper	Executive Lead	Apr	Jun	Aug	Oct	Dec	Feb	Notes
		8	10	12	7	9	10	
PROCEDURAL ITEMS								
Patient / Staff Story	Chief Nurse / Chief People Officer	Staff	Pt	Staff	Pt	Staff	Pt	
Chairs Update	Chair							
Chief Executives Report	Chief Executive							
Board Assurance Framework	Director of Governance		Q4	Q1		Q2	Q3	
OUR PATIENTS: QUALITY, ACCESS & OUTCOMES								
Quality, Access & Outcomes Committee Assurance Report	Director of Governance							
Mortality Assurance Annual Report	Chief Medical Officer							
Maternity Serious Incident Report	Chief Nurse	**Q3**	**Q4**					
Annual Saving Babies Lives & Maternity Care Bundle Report	Chief Nurse							
Annual MOSS Alert Safety Check	Chief Nurse							
PLACE Inspection Findings and Action Plan	Director of Estates, Facilities & PFI							
Bi Annual Nurse Staffing Assurance Report	Chief Nurse							
Quality Account	Chief Nurse							
Winter Plan	Chief Operating Officer							
NHS Resolution Maternity Incentive Scheme	Chief Nurse							
Quality, Access & Performance Strategic Plan Update	Chief Nurse / Chief Medical Officer / Chief Operating Officer							TBC
Integrated Performance Report	Various							
OUR PEOPLE								
People, Culture & Inclusion Committee Assurance Report	Director of Governance							
Staff Survey Report	Chief People Officer							
Gender, Ethnicity and Disability Pay Gap Report	Chief People Officer							
Speaking Up Report	Director of Governance							
Revalidation	Chief Medical Officer							
Workforce Disability Equality and Workforce Race Equality Reports	Chief People Officer							
Equality, Diversity and Inclusion Annual Report	Chief People Officer							
People Strategic Plan Update	Chief People Officer							TBC
OUR POPULATION								
Population Health Strategic Plan Update	Director of Strategy							TBC
FINANCE AND BUSINESS PERFORMANCE								
Finance & Business Performance Committee Assurance Report	Director of Governance							
Annual Report and Accounts including Going Concern	Chief Finance Officer							To be considered by Extraordinary Trust Board in June
Annual Plan	Director of Strategy							
Financial Plan including Capital Programme	Chief Finance Officer							
Standing Financial Instructions	Chief Finance Officer							
Scheme of Reservation and Delegation of Powers	Chief Finance Officer							
OUR STRATEGIC PLANS								

Digital Strategic Plan Update	Chief Digital Information Officer							TBC
Research Strategic Plan Update	Chief Medical Officer							TBC
Innovation Strategic Plan Update	Director of Strategy							TBC
Estates & Facilities Strategic Plan Update	Director of Estates, Facilities & PFI							TBC
GOVERNANCE								
Audit Committee Assurance Report	Director of Governance							
Fit and Proper Persons Annual Assurance Report	Director of Governance							
Anchor Institution Update	Director of Strategy & Communications							TBC
Emergency Preparedness Annual Assurance Statement and Annual Report	Chief Operating Officer							
Annual Evaluation of the Board Committees	Director of Governance							
Annual Review of the Rules of Procedure	Director of Governance							
Well-Led / Provider Capability Integrated Action Plan	Director of Governance							
Risk Management Policy	Director of Governance							Next due for review February 2027
Complaints Policy	Chief Nurse							Next due for review November 2027